

Bartlett Regional Hospital

AGENDA
BOARD OF DIRECTORS MEETING
Tuesday, January 28, 2020; 5:30 p.m.
Bartlett Regional Hospital – Boardroom

Until further notice, before each regularly scheduled board of directors meeting, board members will be touring individual departments between 5:00-5:30pm. January's Departments – HR/HIM

I.	CALL TO ORDER		5:30
II.	ROLL CALL		5:35
III.	APPROVE AGENDA		5:40
IV.	PUBLIC PARTICIPATION		5:45
V.	CONSENT AGENDA		5:50
	A. December 19, 2019 Board of Directors Minutes	(Pg. 3)	
	B. November 2019 Financials	(Pg. 8)	
VI.	BOARD EDUCATION		
	Exit Survey Process – Cindy Carte, Human Resources Manager	(Pg. 12)	5:55
VII.	MEDICAL STAFF REPORT		6:15
	A. December 3, 2019 Medical Staff Minutes	(Pg. 22)	
	B. Chief of Staff Report	(Pg. 28)	
VIII.	OLD BUSINESS		6:20
	A. Campus Plan update		
	B. Crisis Intervention update		
IX.	COMMITTEE REPORTS		6:35
	A. December 20, 2019 Planning Committee Minutes	(Pg. 29)	
	B. January 8, 2020 Draft Board Quality Committee Minutes	(Pg. 32)	
	QUALITY COMMITTEE ACTION ITEMS:		
	1. 2020 Risk Management Plan	(Pg. 37)	
	2. 2020 Infection Prevent Plan and 2019 Evaluation	(Pg. 43)	
	3. 2020 Environment of Care Plan and 2019 Evaluation	(Pg. 66)	
	4. 2020 Patient Safety and Quality Improvement Plan and 2019 Evaluation	(Pg. 92)	
	C. January 17, 2020 Draft Planning Committee Minutes	(Pg.103)	
	➤ Community Health Needs Assessment	(Pg.106)	
	D. January 17, 2020 Draft Finance Committee Minutes	(Pg.134)	

X.	MANAGEMENT REPORTS		6:45
	A. CLO Management report	(Pg. 136)	
	B. HR Management report	(Pg. 137)	
	C. CNO Management report	(Pg. 139)	
	D. COO Management report	(Pg. 143)	
	E. CBHO Management report	(Pg. 147)	
	➤ RRC Observation Report	(Pg. 151)	
	F. CFO Management report	(Pg. 154)	
	G. CEO report	(Pg. 157)	
	➤ Lobbyist Request	(Pg. 158)	
	➤ Cataract Volume Demands	(Pg. 159)	
XI.	CEO REPORT / STRATEGIC DISCUSSION		6:50
XII.	PRESIDENT REPORT		7:00
	A. Committee Assignments	(Pg. 160)	
	B. Leadership Conference	(Pg. 161)	
XIII.	EXECUTIVE SESSION		7:05
	A. Credentialing report (BLUE FOLDER)		
	B. Patient Safety Dashboard (BLUE FOLDER)		
	C. Legal and Litigation Review		
	<i>Motion by xx, to recess into executive session to discuss several matters:</i>		
	○ <i>Those which by law, municipal charter, or ordinance are required to be confidential or involve consideration of records that are not subject to public disclosure, specifically the patient safety dashboard and the credentialing report.</i>		
	<i>And</i>		
	○ <i>To discuss possible BRH litigation, specifically a candid discussion of the facts and litigation strategies with the BRH attorney. (Unnecessary staff and Medical Chief of staff are excused from this portion of the session.)</i>		
XIV.	BOARD CALENDAR	(Pg. 170)	7:15
XV.	BOARD COMMENTS AND QUESTIONS		7:20
XVI.	ADJOURNMENT		7:30

Bartlett Regional Hospital

Minutes

BOARD OF DIRECTORS MEETING

December 19, 2019 – 5:30 p.m.

Robert F. Valliant Boardroom

CALL TO ORDER – The Board of Director's meeting was called to order at 5:32 p.m. by Lance Stevens, Board President

BOARD MEMBERS PRESENT

Lance Stevens, President	Rosemary Hagevig, Vice President	Bob Urata, MD, Secretary
Brenda Knapp	Marshal Kendziorek	Mark Johnson
Kenny Solomon-Gross	Deb Johnston	

ABSENT - Lindy Jones, MD

ALSO IN ATTENDANCE

Chuck Bill, CEO	Kevin Benson, CFO (phone)	Billy Gardner, COO
Dallas Hargrave, HR Director	Rose Lawhorne, CNO	Megan Costello, CLO
Michelle Hale, CBJ Liaison	Don Schneider, MD, COS	Thomas Davis, Lab
Sarah Griffith, CPA	Karen Tarver, CPA	Adam Sykes, CPA
Anita Moffitt, Executive Assistant		

APPROVAL OF THE AGENDA – Mr. Stevens stated that in order to accommodate Dr. Urata's early departure to catch a plane, Board Nominations will be moved up on the agenda and will be held after the Board Education. ***MOTION by Mr. Johnson to approve the agenda as amended. Ms. Knapp seconded. Agenda approved as amended.***

PUBLIC PARTICIPATION – None, however Rashah McChesney, reporter from KTOO and former BRH employee, Deb Manowski were in attendance to observe. Newly appointed board member, Iola Young observed the meeting via Zoom video conferencing.

CONSENT AGENDA – ***MOTION by Mr. Johnson to approve the consent agenda. Ms. Hagevig seconded. Consent agenda approved.***

FINANCIAL AUDIT PRESENTATION – Sarah Griffith, CPA, Partner of Elgee Rehfeld, LLC introduced herself, Karen Tarver, CPA and Partner and Adam Sykes, CPA and Manager of Elgee Rehfeld. She then provided an overview of the results from the June 30, 2019 audit of BRH stand-alone financial statements. BRH grants are included in the CBJ entity wide audit. BRH is an enterprise fund included in the CBJ CAFR. A detailed audit report had been presented at the December 11 Finance Committee meeting. Draft Financial Statements are based on accounting system and management provided data. Management retains responsibility of the financial statements by reviewing the draft and accepting it. The audit opinion is that financial statements are materially correct. None of the findings were considered to be significant or systemic in nature. Adjustments to GASB 68 and 75 were performed as a service by Elgee Rehfeld. The balance sheet shows total current assets of about \$90 million; non-current assets about \$60 million and total assets, including some pension related accruals, of about \$164 million. Total liabilities of \$105 million and a total net worth of \$53 million at year end. Pension related accruals and liabilities totaled \$64 million. Operating revenues were \$102 million; operating expenses

were \$103 million; non-operating revenues and expenses resulted in a total change in net position of just over \$4 million. The stand-alone audit was a clean audit, there were no suggestions for improvement communicated to the BOD for internal controls. There was one major program noncompliance and significant deficiency in internal controls finding in the entity-wide audit. The state grants related to the DHSS Sobering Center were over-reported to include costs from FY20 resulting in a small amount paid back to the state. This issue was largely due to turnover in staff. The person that prepared the report was no longer here to provide information as to how the report was prepared.

Dr. Urata stated that the Finance Committee has reviewed the detailed report and approved it. ***Motion made by Dr. Urata to accept the audit report. Mr. Johnson seconded. Motion approved.***

BOARD EDUCATION - Improvements in Lab Efficiency

Thomas Scott Davis provided an overview of the proven success of the liquid plasma product in reducing blood wastage, the benefits of the i-STAT to the ER and future quality indicators and the success of Six Sigma applications in the hospital lab. In 2017, 73 out of 651 fresh frozen blood units that went out the door for transfusion were wasted due to thawing of product. After bringing in a liquid plasma product which would maintain plasma volume in 2018, numbers dropped to 35/689. In 2019, only 15/777 are wasted. Mr. Scott reported on the efficiency of using i-STAT at the bedside to obtain vital test results in a matter of minutes. He is working with Kim McDowell to develop i-Stat quality parameters. They will begin with the check in and triage process. i-STAT testing allows ED physicians to begin treatment much quicker and will integrate into standard protocols. The amount of blood needed for testing is much less than the amount needed for standard blood analyzers. An overview was provided of the Six Sigma process calibration for the chemistry analyzers. The goal is to reduce the error rate of any process to less than 3.4 parts per million. By creating more accurate calibrations, the need to repeat tests is reduced and eases the burden on the technicians.

BOARD NOMINATIONS AND ELECTION OF OFFICERS – The nominations process of board officers was discussed. Mr. Stevens opened the floor for nominations of calendar year 2020 officers.

- Board President: ***Ms. Knapp nominated Mr. Stevens for Board President. Ms. Hagevig seconded. Mr. Johnson nominated Ms. Hagevig for President. Ms. Hagevig declined. Roll call vote taken. Mr. Stevens unanimously approved for Board President.***
- Vice-President: ***Dr. Urata nominated Mr. Kendziorek for Vice-President. Mr. Johnson nominated Ms. Hagevig for Vice-President. Ms. Knapp seconded.*** Both nominees gave brief statements to support their nomination as Vice-President. Roll call vote taken. Ms. Johnston, Mr. Solomon-Gross, Mr. Johnson, Ms. Knapp, Ms. Hagevig and Mr. Stevens voted in favor of Ms. Hagevig. Dr. Urata and Mr. Kendziorek voted in favor of Mr. Kendziorek. ***Ms. Hagevig approved for Vice-President by majority vote.***
- Secretary: ***Ms. Knapp nominated Mr. Solomon-Gross for Secretary. Ms. Hagevig seconded.*** Roll call vote taken. ***Mr. Solomon-Gross unanimously approved for Secretary.***

Medical Staff Report – Dr. Schneider noted the November 5th Medical Staff meeting minutes are in the board packet. The December 3rd meeting was mostly business as usual. The 2020 Medical Staff Leadership: Joy Neyhart, MD is Chief of Staff, Keegan Jackson, MD is Vice-President and Nobel Anderson, MD will continue on as Secretary.

OLD BUSINESS:

CAMPUS PLAN UPDATE – Mr. Bill reported that Corey Wall, from Jensen Yorba Wall will be at tomorrow morning's 7:00am Planning Committee meeting to present a draft of the final Master Facility Plan. There may be some adjustments made to the plan before it comes to the full board in January.

CRISIS INTERVENTION UPDATE – Mr. Bill reported that based on CBJ engineering estimates, the budget ended up with about \$7 million for a two story facility with an additional \$2 million to include a parking garage underneath. North Wind Architects is redesigning the plan to decrease the costs of the original \$14 million plan. There will be a presentation for senior leadership next week of the most recent iteration. Two designs will be presented of the same building, one with a parking garage and one without. Flex rooms to accommodate separation of children from adults as the needs of each group fluctuate are included in the plans. BRH is on the cutting edge with the Crisis Intervention Center and is an integral part of where the state wants to go with behavioral healthcare. They are looking at us to craft a template that can be replicated across the state. Further discussion about parking was held. The campus plan will include an analysis of campus parking needs.

COMMITTEE REPORTS:

Finance Committee – Dr. Urata reported that the minutes from the December 11th Finance Committee meeting are in the packet. He reported that the financial audit had been discussed in detail. The cost report, prepared by Moss Adams, had also been presented. From the cost report, we are now able to complete the two studies in progress, the efficiency study and the Moss Adams analysis for profit margins of each department. These results will be presented sometime next spring.

Board Compliance – Dr. Urata reported that the quarterly Board Compliance meeting was held on December 18th. There had been committee education and training as well as a review of the compliance dashboard. It has been determined that we should have an outside entity look at our compliance program to make sure it is rigorous enough. That last time this had been done was 2 ½ years ago.

Mr. Stevens presented Dr. Urata with a letter of appreciation and a plaque for the many years he has served on the Board of Directors. Dr. Urata served on the board from 1994-2005 and from 2017 – 2019. A leaf will be made in Dr. Urata's honor and placed on the Bartlett Regional Hospital Foundation's Giving Tree. Dr. Urata said it has been a pleasure to work with the many board members over the years, that he enjoyed serving and that he had learned a lot. He received a round of applause as he left the meeting at 6:28pm to catch his plane.

Joint Conference – Mr. Stevens provided a recap of the December 17th Joint Conference meeting of the Executive Committee and the Medical Staff Executive Committee. Changing of Medical Staff officers, topics discussed at prior board meetings, Crisis Intervention Center, Master Facility Plan and the Provider Network Assessment RFP had been discussed.

MANAGEMENT REPORTS: Appreciation was expressed for the informative reports provided by management. Ms. Costello requests that she be informed of any committee she should be assigned to or meetings she should attend. She also noted that she is working with the CBJ purchasing office to provide training to BRH staff on contracting requirements. This training is to take place in January. Mr. Solomon-Gross commended the CNO for the hand off report and daily huddles as a great program.

CEO REPORT – Mr. Bill reported that he had a really good meeting this morning with CBJ about the CIP process and the construction process. Because of lengthy delays in replacing air handlers and addressing ventilation issues in the surgical department, a meeting was called to develop a plan to maximize and improve our CIP process. The CIP process is used by CBJ engineering to prioritize

projects. A Gantt chart will be used to identify each step involved in getting through the approval process to be able to work on those projects. Mr. Bill noted that CBJ has a line item in their capital budget for deferred maintenance and proposed that BRH do the same. The board would approve funds dedicated to deferred maintenance during the CIP approval process without getting bogged down in the details of each project. This would eliminate the many layers of approval currently needed. (The recommended amount for a facility of this size is \$5 million.) Mr. Bill will work with finance to develop a plan to present to the board. BRH and CBJ will continue to work together improve the CIP process and ensure that BRH projects get the proper priority. Ms. Costello and CBJ purchasing will train staff to ensure compliance of CBJ purchasing codes and contract negotiations to help speed up that part of the process.

Mr. Bill stated that he and his wife, Sue, have continued with their annual holiday tradition of purchasing poinsettias for each of the board members as a way to say thank you for allowing them to be here.

In his meeting with CBJ this morning, Mr. Bill learned that CBJ is looking at a contract for a 30 bed assisted living facility. He reported that he had been approached last week by the local organization that took over the JYS property for the intention of building a 17 bed assisted living facility. They would like to partner with BRH for rehab services.

A discussion was held about the DHSS response to a court order demanding a plan that will solve the problem of Title 47 patients being held in the EDs and in jails for extended periods of time.

PRESIDENT REPORT – Mr. Stevens presented Dr. Schneider with a letter of recognition and appreciation for his service as Chief of Staff this past year. A leaf will also be made in Dr. Schneider's honor and placed on the Bartlett Regional Hospital Foundation's Giving Tree.

Mr. Stevens said it's been a great year with a lot of moving parts put in place to help us look forward to the future. He's excited for the years to come for our community hospital.

Executive Session – *Motion made by Mr. Kendziorek to recess into executive session as written in the agenda, with the exception of the Legal and Litigation Review, to discuss several matters:*

- *Those which by law, municipal charter, or ordinance are required to be confidential or involve consideration of records that are not subject to public disclosure, specifically the patient safety dashboard, the confidential chief of staff report, and the credentialing report.*

Mr. Johnson seconded. Motion approved. The committee took a three minute break and then entered executive session at 6:56 pm. They returned to regular session at 7:07 pm.

- A. Credentialing report (BLUE FOLDER): ***Motion by Mr. Johnson to approve the credentialing report as written. Ms. Knapp seconded. Credentialing recommendations approved.***
- B. Confidential Chief of Staff Report (BLUE FOLDER): No action to be taken. The Board reviewed the confidential chief of staff report.
- C. Patient Safety Dashboard (BLUE FOLDER): No action to be taken. The Board reviewed the Patient Safety Dashboard.

BOARD CALENDAR – January calendar reviewed. Mr. Johnson will be out of town and requests to call in for the January Board of Directors meeting. Mr. Solomon-Gross will be out of town and requests the Finance Committee meeting be moved to a January 15th (later moved to January 17th). Committee assignments will take place at the January board meeting. Mr. Stevens will respond to Mayor Weldon to propose January 15th or 21st for the joint meeting of the CBJ Assembly and the BRH Board. A Planning Committee meeting date will be determined at tomorrow morning's meeting.

BOARD COMMENTS AND QUESTIONS – Dr. Schneider said he learned a lot over the past year and thanked the board members for what they do and for taking the medical staff seriously. It is very clear that everyone is invested in what happens to the hospital and its patients. He has always been proud of BRH and staff and is now proud of the board too. Ms. Hagevig initiated a conversation about a committee of the whole. Mr. Bill reminded everyone to pick up their poinsettias. Ms. Hale reported that there were some very good, pointed comments about Bartlett during the board member interviews. Ms. Hagevig recommends new board member, Iola Young, attend as many committee meetings as possible to get up to speed on what's going on. It was noted that she did attend the Finance Committee meeting and participated in tonight's meeting via teleconference. Mr. Stevens wished everyone a safe and happy holiday.

ADJOURNMENT – 7:20 p.m.

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801

907.796.8900

www.bartletthospital.org

DATE: January 8, 2019

TO: BRH Finance Committee

FROM: Kevin Benson, Chief Financial Officer

RE: November Financial Performance

After 4 months of increased activity and revenues, November saw slower a reduction to more normal budget levels. Inpatient days were 7% less than budget yielding revenues that were 3% less than budget. Outpatient volumes were both over and under budget and resulted in outpatient revenues that were 3% over budget. Total hospital revenue finished almost right on budget exceeding expected revenue by \$52,000 (0.4%). BOPS revenue exceeded budget by \$74,000 (39%) which offset decreased revenues from Rainforest Recovery and Physician revenues. This resulted in total revenues of \$15,040,000 that were \$55,000 (0.4%) greater than budget.

Deductions were less than budget by \$349,000 or 5%. An analysis of deductions show that BRH is benefiting from improvements made in the revenue cycle process. Other Revenue was over budget by \$337,000 this resulted in Total Operating Revenues that were \$741,000 greater than budget.

Expenses exceeded budget by \$636,000 or 7.5%. This variance was driven by increased staff costs and benefits. This resulted in an Operating Income of \$147,000 or a 1.6% Margin. After Non-Operating Income the final Net Income is \$383,000 or a Net Income percent of 4.1%. For the year BRH has a Net Income of \$4.2 million or 8.57% well in excess of budget (\$1.5 million) and the prior year (\$1.8 million).

Other Significant Items:

- 340B revenue for the month grew to \$145,000. After expenses BRH saw a net benefit of \$125,000.
- Contract labor continues to decrease as first year nursing staff gain proficiency. In the four previous months the variance was \$151,000 and for November was \$58,000.
- On-Behalf payments made by the State of Alaska on behalf of BRH are now made on a monthly basis. This funding is now being recorded on a monthly basis and reflects an unbudgeted increase of \$95,000 of Benefit Costs and an offsetting unbudgeted corresponding amount to Non-Operating Revenue.

Bartlett Regional Hospital
Dashboard Report for November 2019

Facility Utilization:	CURRENT MONTH					YEAR TO DATE			
	Actual	Budget	% Over (Under) Budget	Prior Year	Prior Month (October)	Actual	Budget	% Over (Under) Budget	Prior Year
Hospital Inpatient: Patient Days									
Patient Days - Med/Surg	420	412	2%	415	400	2,146	2,130	1%	2,075
Patient Days - Critical Care Unit	80	89	-10%	80	101	492	460	7%	457
Patient Days - Swing Beds	0	0	0%	0	0	0	0	-100%	0
Avg. Daily Census - Acute	16.7	16.7	0%	17	16.2	17.2	16.9	2%	16.5
Patient Days - Obstetrics	47	67	-30%	52	67	347	345	1%	341
Patient Days - Nursery	38	62	-39%	52	47	272	310	-12%	314
Total Hospital Patient Days	585	631	-7%	599	615	3,257	3,245	0%	3,187
Births	19	26	-27%	22	23	124	170	-27%	141
Mental Health Unit									
Patient Days - Mental Health Unit	268	332	-19%	290	277	1,259	1,495	-16%	1,481
Avg. Daily Census - MHU	8.9	11.1	-19%	9.7	9	8.2	9.8	-16%	9.7
Rain Forest Recovery:									
Patient Days - RRC	321	290	11%	319	274	1,475	1,715	-14%	1,630
Avg. Daily Census - RRC	11	9.7	11%	10.6	9	10	11.2	-14%	10.7
Outpatient visits	17	19	-9%	32	32	123	95	29%	106
Inpatient: Admissions									
Med/Surg	59	69	-15%	61	72	405	360	13%	369
Critical Care Unit	36	40	-9%	44	38	223	205	9%	204
Obstetrics	19	27	-31%	22	27	134	140	-4%	141
Nursery	19	29	-34%	23	23	125	150	-17%	145
Mental Health Unit	42	37	14%	37	35	191	190	1%	181
Total Admissions - Inpatient Status	175	202	-13%	187	195	1,078	1,045	3%	1,040
Admissions - "Observation" Status									
Med/Surg	53	57	-7%	58	54	287	295	-3%	305
Critical Care Unit	23	33	-30%	39	23	154	170	-9%	175
Mental Health Unit	1	2	0%	5	4	11	10	10%	8
Obstetrics	14	19	-25%	18	15	95	95	0%	87
Nursery	0	1	-100%	0	0	1	5	-80%	2
Total Admissions to Observation	91	111	-18%	120	96	548	575	-5%	577
Surgery:									
Inpatient Surgery Cases	48	48	-1%	47	50	272	250	9%	262
Endoscopy Cases	91	97	-6%	86	105	449	500	-10%	479
Same Day Surgery Cases	90	88	2%	82	125	492	455	8%	407
Total Surgery Cases	229	233	-2%	215	280	1,213	1,205	1%	1,148
Total Surgery Minutes	16,775	14,939	12%	14,840	19,060	86,090	74,584	15%	74,584
Outpatient:									
Total Outpatient Visits (Hospital)									
Emergency Department Visits	1,044	1,214	-14%	1,115	1,110	6,172	6,275	-2%	6,308
Cardiac Rehab Visits	45	74	-39%	67	53	332	385	-14%	348
Lab Visits	408	288	42%	253	831	2,067	1,485	39%	1,258
Lab Tests	9,451	9,291	2%	10,067	13,055	54,600	48,005	14%	45,064
Radiology Visits	774	841	-8%	711	916	4,100	4,345	-6%	3,901
Radiology Tests	2,149	2,526	-15%	2,670	2,408	12,674	13,050	-3%	12,912
Sleep Study Visits	29	23	28%	30	33	142	115	23%	117
Physician Clinics:									
Hospitalists	159	205	-22%	154	340	1,146	1,060	8%	914
Bartlett Oncology Clinic	82	81	1%	62	78	425	420	1%	328
Ophthalmology Clinic	58	N/A	N/A	-	83	107	N/A	N/A	-
Behavioral Health Outpatient visits	274	400	-31%	238	83	1,746	1,980	-12%	2,238
Bartlett Surgery Specialty Clinic visits	235	315	-25%	286	382	1,392	1,625	-14%	1,496
	808	1,001	-19%	740	966	4,816	5,085	-5%	4,976
Other Operating Indicators:									
Dietary Meals Served	30,329	25,187	20%	22,365	31,351	146,894	130,135	13%	124,569
Laundry Pounds (Per 100)	354	395	-10%	393	375	1,907	2,040	-7%	2,006

BARTLETT REGIONAL HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
FOR THE MONTH AND YEAR TO DATE OF NOVEMBER 2019

<u>MONTH</u> <u>ACTUAL</u>	<u>MONTH</u> <u>BUDGET</u>	<u>MO \$ VAR</u>	<u>MTD % VAR</u>	<u>PR YR MO</u>		<u>YTD ACTUAL</u>	<u>YTD BUDGET</u>	<u>YTD \$ VAR</u>	<u>YTD % VAR</u>	<u>PRIOR YTD</u> <u>ACT</u>	<u>PRIOR YTD</u> <u>% CHG</u>
					Gross Patient Revenue:						
\$4,337,720	\$4,379,973	-\$42,253	-1.0%	\$4,330,526	1. Inpatient Revenue	\$24,060,782	\$22,337,902	\$1,722,880	7.7%	\$21,811,909	10.3%
\$827,133	\$970,546	-\$143,413	-14.8%	\$894,096	2. Inpatient Ancillary Revenue	\$5,100,340	\$4,949,809	\$150,531	3.0%	\$4,827,514	5.7%
\$5,164,853	\$5,350,519	-\$185,666	-3.5%	\$5,224,622	3. Total Inpatient Revenue	\$29,161,122	\$27,287,711	\$1,873,411	6.9%	\$26,639,424	9.5%
\$8,480,540	\$8,242,727	\$237,813	2.9%	\$7,479,251	4. Outpatient Revenue	\$45,966,043	\$42,037,934	\$3,928,109	9.3%	\$40,324,679	14.0%
\$13,645,393	\$13,593,246	\$52,147	0.4%	\$12,703,873	5. Total Patient Revenue - Hospital	\$75,127,166	\$69,325,645	\$5,801,521	8.4%	\$66,964,103	12.2%
\$327,272	\$365,671	-\$38,399	-10.5%	\$350,954	6. RRC Patient Revenue	\$1,536,208	\$1,864,919	-\$328,711	-17.6%	\$1,730,113	-11.2%
\$262,438	\$188,539	\$73,899	39.2%	\$186,568	7. BHOPS Patient Revenue	\$1,299,581	\$961,567	\$338,014	35.2%	\$876,954	48.2%
\$805,401	\$838,359	-\$32,958	-3.9%	\$806,121	8. Physician Revenue	\$5,036,488	\$4,275,618	\$760,870	17.8%	\$3,960,460	27.2%
\$15,040,504	\$14,985,815	\$54,689	0.4%	\$14,047,516	9. Total Gross Patient Revenue	\$82,999,443	\$76,427,749	\$6,571,694	8.6%	\$73,531,629	12.9%
					Deductions from Revenue:						
\$2,731,964	\$3,092,636	\$360,672	11.7%	\$2,920,095	10. Inpatient Contractual Allowance	\$16,263,891	\$15,741,600	-\$522,291	-3.3%	\$14,629,574	11.2%
-\$308,333	-\$308,333	\$0		-\$308,333	10a. Rural Demonstration Project	-\$1,541,667	-\$1,541,667	\$0		-\$1,541,667	
\$2,737,114	\$2,976,097	\$238,984	8.0%	\$2,569,965	11. Outpatient Contractual Allowance	\$15,786,748	\$15,178,100	-\$608,648	-4.0%	\$14,044,195	12.4%
\$692,982	\$399,393	-\$293,589	-73.5%	\$289,421	12. Physician Service Contractual Allowance	\$3,060,943	\$2,036,901	-\$1,024,042	-50.3%	\$1,762,135	73.7%
\$12,883	\$16,043	\$3,160	19.7%	\$12,285	13. Other Deductions	\$71,081	\$81,815	\$10,734	13.1%	\$74,610	0.0%
\$148,545	\$122,131	-\$26,414	-21.6%	\$153,897	14. Charity Care	\$274,700	\$622,865	\$348,165	55.9%	\$623,096	-55.9%
\$253,680	\$319,715	\$66,035	20.7%	\$106,696	15. Bad Debt Expense	\$1,978,299	\$1,630,549	-\$347,750	-21.3%	\$1,670,523	18.4%
\$6,268,835	\$6,617,682	\$348,848	5.3%	\$5,744,026	16. Total Deductions from Revenue	\$35,893,994	\$33,750,163	-\$2,143,831	-6.4%	\$31,262,465	14.8%
38.9%	43.2%			41.1%	% Contractual Allowances / Total Gross Patient Revenue	40.4%	43.1%			39.3%	
2.7%	2.9%			1.9%	% Bad Debt & Charity Care / Total Gross Patient Revenue	2.7%	2.9%			3.1%	
41.7%	44.2%			40.9%	% Total Deductions / Total Gross Patient Revenue	43.2%	44.2%			42.5%	
\$8,771,669	\$8,368,133	\$403,537	4.8%	\$8,303,490	17. Net Patient Revenue	\$47,105,449	\$42,677,586	\$4,427,863	10.4%	\$42,269,164	11.4%
\$504,257	\$166,679	\$337,578	202.5%	\$136,908	18. Other Operating Revenue	\$2,181,723	\$850,048	\$1,331,675	156.7%	\$725,751	200.6%
\$9,275,926	\$8,534,812	\$741,114	8.7%	\$8,440,398	19. Total Operating Revenue	\$49,287,171	\$43,527,634	\$5,759,537	13.2%	\$42,994,914	14.6%
					Expenses:						
\$3,815,032	\$3,535,584	-\$279,448	-7.9%	\$3,515,041	20. Salaries & Wages	\$19,084,367	\$18,031,480	-\$1,052,887	-5.8%	\$17,268,336	10.5%
\$319,712	\$273,904	-\$45,808	-16.7%	\$281,347	21. Physician Wages	\$1,614,874	\$1,396,914	-\$217,960	-15.6%	\$1,377,662	17.2%
\$114,197	\$56,444	-\$57,753	-102.3%	\$286,033	22. Contract Labor	\$950,727	\$287,853	-\$662,874	-230.3%	\$1,389,088	-31.6%
\$2,104,430	\$1,764,602	-\$339,828	-19.3%	\$1,656,921	23. Employee Benefits	\$9,948,701	\$8,999,521	-\$949,180	-10.5%	\$7,912,899	25.7%
\$6,353,371	\$5,630,534	-\$722,837	-12.8%	\$5,739,342		\$31,598,669	\$28,715,768	-\$2,882,901	-10.0%	\$27,947,985	13.1%
68.5%	66.0%			68.0%	% Salaries and Benefits / Total Operating Revenue	64.1%	66.0%			65.0%	
\$65,018	\$77,240	\$12,222	15.8%	\$78,193	24. Medical Professional Fees	\$380,323	\$393,930	\$13,607	3.5%	\$375,620	1.3%
\$290,686	\$202,736	-\$87,950	-43.4%	\$280,185	25. Physician Contracts	\$1,175,475	\$1,033,945	-\$141,530	-13.7%	\$1,210,753	-2.9%
\$164,867	\$175,391	\$10,524	6.0%	\$141,290	26. Non-Medical Professional Fees	\$754,303	\$894,492	\$140,189	15.7%	\$782,915	-3.7%
\$965,554	\$1,045,302	\$79,748	7.6%	\$1,178,511	27. Materials & Supplies	\$5,652,808	\$5,330,961	-\$321,847	-6.0%	\$5,412,990	4.4%
\$140,207	\$127,959	-\$12,248	-9.6%	\$123,276	28. Utilities	\$620,675	\$652,589	\$31,914	4.9%	\$528,652	17.4%
\$301,472	\$323,080	\$21,608	6.7%	\$255,840	29. Maintenance & Repairs	\$1,826,664	\$1,647,692	-\$178,972	-10.9%	\$1,519,209	20.2%
\$42,213	\$54,891	\$12,678	23.1%	\$45,623	30. Rentals & Leases	\$260,266	\$279,935	\$19,669	7.0%	\$278,500	-6.5%
\$40,882	\$48,967	\$8,085	16.5%	\$89,314	31. Insurance	\$230,874	\$249,739	\$18,865	7.6%	\$315,128	-26.7%
\$586,841	\$646,750	\$59,909	9.3%	\$622,985	32. Depreciation & Amortization	\$2,899,455	\$3,298,427	\$398,972	12.1%	\$3,056,252	-5.1%
\$52,453	\$51,078	-\$1,375	-2.7%	\$53,777	33. Interest Expense	\$262,263	\$260,498	-\$1,765	-0.7%	\$268,884	-2.5%
\$125,222	\$108,748	-\$16,474	-15.1%	\$95,258	34. Other Operating Expenses	\$635,425	\$554,568	-\$80,857	-14.6%	\$423,562	50.0%
\$9,128,787	\$8,492,676	-\$636,110	-7.5%	\$8,703,594	35. Total Expenses	\$46,297,198	\$43,312,544	-\$2,984,656	-6.9%	\$42,120,449	-9.9%
\$147,139	\$42,136	\$105,003	249.2%	-\$263,196	36. Income (Loss) from Operations	\$2,989,973	\$215,090	\$2,774,883	1290.1%	\$874,465	241.9%
\$101,649	\$105,000	-\$3,351	-3.2%	\$29,325	37. Interest Income	\$507,799	\$535,500	-\$27,701	-5.2%	\$144,756	250.8%
\$134,586	\$156,929	-\$22,344	-14.2%	\$215,555	38. Other Non-Operating Income	\$725,156	\$800,341	-\$75,185	-9.4%	\$812,576	-10.8%
\$236,235	\$261,929	-\$25,695	-9.8%	\$244,880	39. Total Non-Operating Revenue	\$1,232,955	\$1,335,841	-\$102,886	-7.7%	\$957,333	28.8%
\$383,373	\$304,065	\$79,308	-26.1%	-\$18,312	40. Net Income (Loss)	\$4,222,927	\$1,550,931	\$2,671,996	-172.3%	\$1,831,799	-130.5%
1.59%	0.49%			-3.12%	Income from Operations Margin	6.07%	0.49%			2.03%	
4.13%	3.56%			-0.22%	Net Income	8.57%	3.56%			4.26%	

BARTLETT REGIONAL HOSPITAL
BALANCE SHEET
November 30, 2019

	<u>November-19</u>	<u>October-19</u>	<u>November-18</u>	<u>CHANGE FROM PRIOR FISCAL YEAR</u>
ASSETS				
Current Assets:				
1. Cash and cash equivalents	33,045,522	36,002,451	36,372,832	(3,327,310)
2. Board designated cash	38,508,116	38,326,130	35,525,624	2,982,492
3. Patient accounts receivable, net	16,783,273	15,407,448	12,838,340	3,944,934
4. Other receivables	2,107,527	2,268,421	2,749,022	(641,495)
5. Inventories	3,081,425	3,036,776	2,636,284	445,141
6. Prepaid Expenses	965,327	1,206,567	2,095,655	(1,130,328)
7. Other assets	28,877	28,877	28,877	-
8. Total current assets	94,520,067	96,276,670	92,246,634	2,273,434
Appropriated Cash:				
9. CIP Appropriated Funding	4,678,117	4,678,117	1,178,300	3,499,817
Property, plant & equipment				
10. Land, bldgs & equipment	151,641,044	151,102,996	148,037,085	3,603,960
11. Construction in progress	1,088,165	1,004,610	209,242	878,923
12. Total property & equipment	152,729,209	152,107,606	148,246,327	4,482,883
13. Less: accumulated depreciation	(100,377,543)	(100,029,241)	(94,086,977)	(6,290,566)
14. Net property and equipment	52,351,666	52,078,367	54,159,351	(1,807,684)
15. Deferred outflows/Contribution to Pension Plan	14,415,000	14,415,000	8,564,873	5,850,127
16. Total assets	165,964,850	167,448,154	156,149,158	9,815,694
LIABILITIES & FUND BALANCE				
Current liabilities:				
17. Payroll liabilities	1,869,093	1,483,992	1,567,324	301,769
18. Accrued employee benefits	3,666,193	3,743,046	3,469,387	196,806
19. Accounts payable and accrued expenses	2,929,113	2,962,314	2,121,454	807,659
20. Due to 3rd party payors	1,908,165	3,713,928	105	1,908,060
21. Deferred revenue	(1,824,686)	(1,391,935)	3,097,034	(4,921,720)
22. Interest payable	272,287	204,216	279,881	(7,593)
23. Note payable - current portion	845,000	845,000	820,000	25,000
24. Other payables	330,626	286,291	294,076	36,551
25. Total current liabilities	9,995,791	11,846,852	11,649,261	(1,653,468)
Long-term Liabilities:				
26. Bonds payable	18,130,000	18,130,000	18,975,000	(845,000)
27. Bonds payable - premium/discount	1,332,842	1,348,462	1,524,617	(191,774)
28. Net Pension Liability	72,600,321	72,600,321	62,996,347	9,603,974
29. Deferred In-Flows	6,172,883	6,172,883	9,841,533	(3,668,650)
30. Total long-term liabilities	98,236,046	98,251,666	93,337,497	4,898,549
31. Total liabilities	108,231,837	110,098,518	104,986,758	3,245,081
32. Fund Balance	57,733,011	57,349,636	51,162,399	6,570,613
33. Total liabilities and fund balance	165,964,850	167,448,154	156,149,158	9,815,694

Human Resources Employee Exit Surveys

Dallas Hargrave, HR Director

Cindy Carte, HR Manager

Rick Morrison, HR Generalist (Recruiter)

Michelle Darrah, HR Technician

Tiffany Ridle, HR Technician

January 28, 2020

Bartlett Microsystems 😊

Improvement Goal

- We are working to further improve the employee exit survey process.
- We chose this project because:
 - We want to improve the relevance of our exit survey questions to gain valuable feedback in order to improve aspects of our organization, better retain employees, and reduce turnover.
 - We want to increase our response rates.
- Our goal is to provide an easy to use process increasing our response rates while still providing valuable information to the organization.



Data Analysis

- **Baseline (our starting point):**
 - Total staff separations in 2019 = 133
 - Number of Exit Surveys sent in 2019 = 105
 - Number of Exit Surveys returned in 2019 = 57Over half of the surveys sent back were not fully completed
- **Data collection method & frequency:**
 - Gap Analysis
 - Brainstorming (If we, Then we)



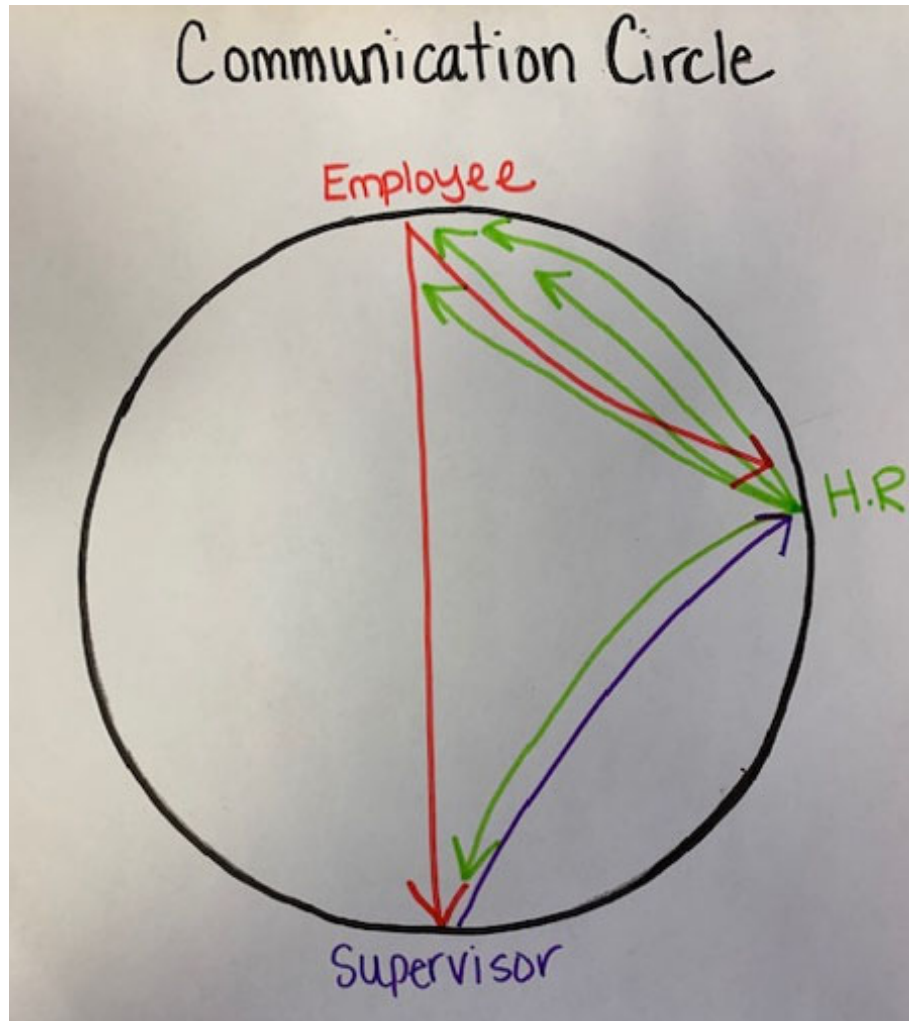
Source

Bartlett Microsystems ☺

Data/ Gap Analysis

Take Aways:

- HR sends 4 notices
- When the first is sent prior to employee's last day of work the response rate increases
- Temp or Casual employees typically do not respond to current survey



Data/ Gap Analysis

If We / Then We

- | | |
|---|--|
| 1. Move the personal identifier to the End of the survey | 1. Employees may feel more comfortable completing the survey rather than being scared away in the beginning |
| 2. Clean up our format by reducing redundancies in questions | 2. Reduce the time it takes to complete the survey – increase responsiveness |
| 3. Adjust the way employees rate
1.Always, Sometimes, Never
2.Agree, Neutral, Disagree | 3. May reduce confusion or waffling on how to answer |
| 4. Review all questions to ensure they are clear and align with the info we want to know | 4. We end up with OTHER being used frequently and it does not provide info for BRH to act on |
| 5. Create a separate survey for Casual PRN staff being termed | 5. Increase our response rates because the information being asked is more relevant |

Change Management

- Action Plan:
 - Modify current Exit Survey
 - Clarify questions, update rating scale, and make format more user friendly
 - Create Exit Survey for non-benefited staff (temp/Cas)
 - Send initial notice to employees while still employed
- Challenges / Barriers:
 - Times when HR is not notified timely of separation
 - Ensure questions truly align with the data we are after



Change Management

Before

Reason(s) For Leaving: Please check all that apply and explain answers below

CAREER OPPORTUNITY

- ☐ More Desirable Position
- ☐ Compensation
- ☐ Benefits
- ☐ Retirement
- ☐ Other

WORKING ENVIRONMENT

- ☐ Lack of Recognition
- ☐ Shift Work
- ☐ Quality of Supervision
- ☐ Work Conditions
- ☐ Other

PERSONAL

- ☐ Moving From Area
- ☐ Self-Employment
- ☐ Health Condition
- ☐ Continue Education
- ☐ Other

After

What prompted you to seek alternative employment?

<input type="checkbox"/> Type of Work	<input type="checkbox"/> Quality of Supervision
<input type="checkbox"/> Compensation	<input type="checkbox"/> Work Conditions
<input type="checkbox"/> Lack of Recognition	<input type="checkbox"/> Family Circumstances
<input type="checkbox"/> Company Culture	<input type="checkbox"/> Career Advancement Opportunity
<input type="checkbox"/> Business/Product Direction	<input type="checkbox"/> Other: _____

* If Other is selected, a comment will be required.



Solve

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Conclusions

- Following implementation of changes:
 - Review and evaluate response rates quarterly to assess impact of changes on response rates
 - Use data collected throughout the year to provide leadership with trends and ideas on how to better recruit and retain staff
 - Assist in implementing changes that may result from the survey trends



Sustain / Monitoring

- HR will continuously monitor our process for sending exit survey information to employees
- Survey results will be monitored on a quarterly basis
- Information regarding responses will be shared with leadership on an ongoing basis with an annual overview at the end of 2020



Sustain

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Thank you!

Questions?

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**Bartlett Regional Hospital
Medical Staff Meeting
Tuesday, December 3, 2019 at 6:15 p.m. – BRH Café
MINUTES**

MEMBERS PRESENT:

Allen, Carly DO	Benjamin, Mimi, MD
Buley, Catherine, MD	Dressel, Amy, MD
Gartenberg, Joanne, MD	Huang, Eugene, MD
Jackson, Keegan, MD	Keirstead, Linda, MD
Kim, Daniel, MD	Laktonen, Alberta, MD
Luhrs, Kayla, MD	Maier, Anya, MD
Moxley, Kelly DPM	Neyhart, Joy, DO, Vice-Chief of Staff
Peimann, Catherine, MD	Peimann, Nathan, MD
Roth, Joseph, MD	Saltzman, Michael, MD
Schlicht, Allan, MD	Schneider, Don, Jr., MD, Chief of Staff
Schwarting, Ted, MD	Shanley, Theresa, MD, Past-Chief of Staff
Sheufelt, Janice, MD	Standerwick, Anne, MD
Strickler, Steven, DO	Thompson, James, MD
Totten, Jodie, MD	Valentine, Priscilla, MD
Vanderbilt, Burton, MD	

MEMBERS ABSENT:

Banyas, Michael, MD	Bellows, Blaise, MD
Benjamin, Brian, MD	Blanco, Jessica, DMD
Bowman, J. Russel, DO	Brooks, Beatrice, MD
Brown, Kenneth, MD	Bursell, John, MD
Cook, Jeannette, MD	Delsman, Erica, MD
Dooley, Laura, MD	Dunn, Taylor, MD
Garcia, Gustavo, MD	Greer, Steven, MD
Gruchacz, Pamela, MD	Haddock, Nathaniel, MD
Harrah, Daniel, MD	Hernandez, Dorothy, MD
Herron, Kacy MD	Hightower, Charles, MD
Jones, Lindy, MD	Kilgore, Kimberly, MD
Kirk, J. Kennon, MD	Malpass, Thomas, MD
Malter, Alex, MD	Mather, Luke, MD
McPherson, Alan, MD	Miller, David, MD
Mulcahy, Allison, MD	Newbury, Nicholas, DO
Odell, Michael, MD	Olsen, Eric, MD
Peterson, Quigley, MD	Raster, John, MD
Schellack, Gregg, DO	Schultz, Charles, DDS
Scott, Jessica, MD	Skan, Paul, MD
Sonkiss, Joshua, MD	Taintor, Matthew, MD
Than, Nandi, MD	Urata, Robert, MD
Welling, Richard, MD	

MEMBERS EXCUSED:

Anderson, Noble, MD, Secretary/Treasurer	Miller, Benjamin, DO
Schmidt, Jennifer, MD	

- I. **CALL TO ORDER:** The regular Medical Staff meeting was called to order by Dr. Don Schneider, Jr., Chief of Staff at 6:17 p.m.
- II. **INTRODUCTION OF GUESTS:** None.

III. APPROVAL OF MINUTES: The minutes from the November 5, 2019 Medical Staff regular scheduled meeting was unanimously approved as written.

IV. OLD BUSINESS:

A. Administration – Chuck Bill, CEO

1. **November 2019 Board Report** – Reviewed.
2. **FY20 State of Alaska Operating Budget** – It has been reported that the State of Alaska Department of Health and Human Services (DHSS) could run out of funds as early as February 2020. They need approximately \$200/M to supplement the operating budget with \$100/M slated for Medicaid.
3. **BRH Affiliation RFP** – The Hospital has posted an RFP that will study its network development for expanding the resource in the community. This has gone through the BRH Board of Directors and is now at CBJ Assembly.
4. **Vehicle Charging Stations** – CBJ Assembly has made a request to install charging stations for vehicles. The plan is to coordinate this project to occur at the same time as the construction on Hospital Drive. The location of these charging stations still need to be determined. One location being considered is installing a station in the physician parking due to the access to electricity. This would not be convenient for patients, however would keep the prices at around \$100,000. If located elsewhere the cost will increase. The location for the charging stations are yet to be determined.
5. **BRH Board of Directors (BOD) Candidates** - Eleven applicants have applied for a position to serve on the BRH Board of Directors (BOD). Lance Stevens and Mark Johnson have submitted their reappointment application. As part of the medical community, Dorothy Hernandez, MD, Steve Strickler, DO, Norvin Perez, MD, and Iola Young, PAC have made application. Selection will be made on Thursday, December 5, 2019.
6. **Physician Burnout** – The Hospital is considering offering some type of physician burnout assistance program via the Physician Health and Wellness Committee (PHWC). Dr. Joanne Gartenberg has been consulted to see if she is available to assistance with the program.
7. **Petersburg Medical Center (PMC)** - The telehealth psychiatry program with Petersburg Medical Center now has 26 new patients, which is a mixture of both adult and child patients.
8. **Rainforest Recovery Center (RRC)** - The newly constructed Rainforest Recovery Center (RRC) is completely shelled in, with windows being installed next week.

Chief Operating Officer – William Gardner, COO

1. **November 2019 Board Report** – Reviewed.

B. Chief Nursing Officer – Rose Lawhorne, CNO

1. **November 2019 Board Report** – Reviewed.
2. **March of Dimes Nurse of the Year Award** – Claire Geldhof, RN and Sara Roemeling were one of the recipients of the 2019 March of Dimes Nurse of the Year award. Andrea Foldenauer, RN and J. Steve Reese, RN were honored in memoriam.

3. **Philips Monitors Upgrade** – Due to a back order issue, there will be a delay in receiving the upgraded Philips Monitors.
- C. Finance – Kevin Benson, CFO**
1. **November 2019 Board Report** – Reviewed.
 2. **FY21 Budget Process** – The FY21 budget process will begin in January 2020. Any equipment requests need to be given to the Department Director or a Senior Leader.
 3. **BRH Finances** – October volumes were busy and the 2nd quarter of this fiscal year continue to be financially strong. The audit has been completed. Medicare cost report filed and accepted with CMS.
- D. Behavioral Health – Bradley Grigg, CBHO**
1. **November 2019 Board Report** – Reviewed.
- E. Other Senior Leadership Board Reports**
1. **CBJ/BRH Legal November 2019 Board Report** – Reviewed.
 2. **Human Resources November 2019 Board Report** – Reviewed.
- F. Meditech Expanse – Scott Chili, Director of Information Systems**
1. **Downtime** – On Monday, November 11, 2019 there was a planned scheduled downtime for maintenance, however it lasted longer than anticipated. Due to the unexpected obstacles that occurred during the downtime, additional resources will be in place such as an incident command structure that includes enhanced communication.
 2. **Meditech Upgrade** – On Thursday, December 5, 2019 there will be downtime in the Meditech Expanse environment.
 3. **Pediatric EEG** – Virginia Mason Medical Center Adult tele-EEG continues to be successful. The Pediatric tele-EEG has not yet begun as the particulars are still being worked out.
- G. Hospitalist – Mimi Benjamin, MD**
1. **Rapid Response** – In the event the Hospitalist are available, they respond to Rapid Response codes. The Medical Staff were reminded that when the Hospitalist respond, they are there to assist and not to be a consultant.
 2. **Timely Consultations** – Currently, there is no definition in the BRH Medical Staff Bylaws that outline what is considered a “timely” consultation. Since it is not clear as to what is expected, the Hospitalist will work out a policy within the team.
 3. **Up-to Date Subscription** - The Hospital participates in an Up-to-Date subscription that is available for all physicians. It was reported that every time a provider accesses information, the system tracks it and a CME is offered.
 4. **Medical Staff Quality Improvement Committee (MSQIC)** – Beginning in January 2020, Dr. Bob Urata will be stepping down as Chair of the MSQIC. Dr. Mimi Benjamin will become the new Chair of the Committee.
 5. **Physician Score Cards** -As part of the Joint Commission and CMS regulation, the Hospital participates in the Ongoing Professional Practice

Evaluation (OPPE) by creating physician score cards. This information is reviewed by the MSQIC and at the time of reappointment by the Credentials Committee.

6. **Communication Between Committees** – In order to keep topics confidential, the Committee is developing a standardize way to communicate with service lines and Committees. When topics are discussed outside the MSQIC it could jeopardize the peer review process making it discoverable.

H. **Other** – None.

V. **NEW BUSINESS:**

A. **Committee Reports:**

1. **Critical Care Committee** – Minutes in packet.
2. **Medical Staff Quality Improvement Committee**
 - a. **Appendix A Charter** - Reviewed.
3. **Surgical Services Committee** – There was an increase in infections in the Surgical Services Department during 2018. New sanitizing and sterilizing processes were instituted, which decreased the infection rate. Discussion is ongoing regarding whether or not to staff a night nurse to assist with the burden of being on-call. The Surgical Services team have been mentoring the new recent nursing graduates. Block time still continues to be an issue.
4. **Pharmacy & Therapeutics Committee** - Minutes in packet. Various changes in medication for long-term patients.
5. **Infection Control Committee** - Minutes in packet.
6. **HIM/UR Committee** – No report.
7. **Credentials Committee** – No report.
8. **OB/Neonatal Committee** – No report.
9. **Provider Education Committee** – No report.
10. **Medicine/Pediatric Committee** – Conducted chart reviews. The Medical Staff was reminded to document when they respond to a Rapid Response code.
11. **Trauma Committee** - Met. Next meeting is January 9, 2020.
12. **Emergency Care Committee** - No report.
13. **Physician Health and Wellness Committee** - No report.
14. **Behavioral Health Quality Committee** - Next meeting is December 4, 2019.
15. **IT Steering Committee** - No meeting.
16. **Meditech Clinical Software Committee** - Had several meetings this month.
17. **Physician EHR Committee** - No meeting.
18. **Physician Recruitment Committee** -No report.

B. **Nominations for 2020 MSEC Leadership**

1. **Vice-President** – Keegan Jackson, MD was nominated and approved for 2020.
2. **Secretary/Treasurer** – Noble Anderson, MD was nominated and reelected for 2020.

C. Meditech Minute – Joyce Chambers, RN – *Previously discussed by Scott Chile*

D. Clinical Documentation Information (CDI) – Amy Deer, RN

1. **Documentation Minutes** – Don Schneider, Jr., MD, Danny Kim, MD, Nandi Than, MD, and Robert Urata, MD were recognized for their documentation for chronic and permanent A-fib.
2. **Atrial Fibrillation 2020 ICD-10 Code Update** –Reviewed.

E. Tumor Board Meeting, Thursday, December 5, 2019 – FYI.

F. Other

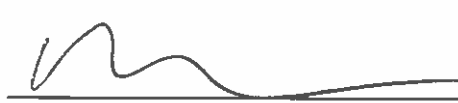
1. **Two Views on Addiction CME** – On Thursday, December 5, 2019 Joshua Sonkiss, MD will be giving a 2 hours CME presentation at Centennial Hall on the subject of addiction.
2. **Vaping Injuring Reporting** – In the event a provider treats an adolescent or child for a respiratory illness caused by vaping, this needs to be reported to the State Epidemiology.

VI. BOARD OF DIRECTORS REPORT: October 22, 2019 – Reviewed.
November 26, 2019 - Not Available.

VII. NEXT MEETING: The next Medical Staff meeting will be on **January 7, 2020** at 6:15 p.m.

VIII. ADJOURNMENT: There being no further business, the Medical Staff meeting was adjourned at 7:00 p.m.

CME – The CME presentation this evening was presented by **Mohan Mallipeddi, MD – Virginia Mason Medical Center –General and Bariatric Surgery on “Obesity’s Bedfellows”**



Don Schneider, Jr., MD

12/19/19

(Date)

Chief of Staff Report

Mortality Matrix

December 2019

Mortality Matrix <i>(lower numbers better)</i>					
	Baseline	BRH 12-Month Rolling	Target	Best in Class	Improvement Initiatives
Death Rate in Low-Mortality DRGs (PSI 2) per 1000	CY 2019: (0/424)=0.0	= 0.0	<0.35		
Mortality by Condition					
AMI 30-Day Mortality	CY 2019: (0/6)=0%	= 0% (0/6)	Achievement 14.93%	Benchmark 12.67%	
COPD 30-Day Mortality	CY 2019: (2/20)=10%	↑ 10% (2/20)	Achievement 7.67%	Benchmark 6.13%	No increase in deaths from last month, but drop in denominator
HF 30-Day Mortality	CY 2019: (2/32)= 6.25%	↓ 6.25% (2/32)	Achievement 13.96%	Benchmark 12.03%	
Pneumonia 30-Day Mortality	CY 2019: (0/46)=0%	↓ 0% (0/46)	Achievement 11.77%	Benchmark 9.05%	
Sepsis Mortality (in-hospital)	CY 2019: (1/89)=0%	↓ 1.12% (1/89)	Average 11.56%	HIIN Goal 9%	PI Team “code sepsis”

Achievement and Benchmark Sources: Value Based Purchasing Guide. AMI, COPD, HF from FY2021 Guide, Pneumonia from FY 2020 guide

Target for Death Rate in Low Mortality DRGs Source: AHRQ Patient Safety Indicators v6. 0 Benchmark Data Tables, July 2018

Sepsis Mortality Targets: Partnership for Patients, Quality Benchmarking System, HIIN baseline and target

At or Exceeding Best in Class
At or Exceeding Achievement Threshold
Opportunity for Improvement
Problem Area

↑	Rate higher than prior report
=	No change from prior report
↓	Rate lower than prior report

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Minutes
Planning Committee
December 20, 2019 – 7:00 a.m.
Bartlett Regional Hospital Boardroom

Called to order at 7:00 a.m., by Planning Committee Chair, Marshal Kendziorek

Planning Committee and Board Members: Lance Stevens, Rosemary Hagevig, Marshal Kendziorek, Kenny Solomon-Gross, Brenda Knapp and Mark Johnson,

Staff: Chuck Bill, CEO, Dallas Hargrave, HR Director, Rose Lawhorne, CNO, Billy Gardner, COO and Anita Moffitt, Executive Assistant

Mr. Solomon-Gross made a MOTION to approve the minutes from November 21, 2019. Ms. Knapp seconded. Minutes approved as written.

PUBLIC PARTICIPATION – None

Project Updates: Mr. Gardner noted the following projects are ready for design phase II: fire alarm for the Medical Arts building, Central Sterile Processing room in OR, endo fans in ASU11. These should be ready to go out to bid in 4 – 5 weeks. OR renovations will not take place until November. The ED waiting room area is to have walls constructed and bullet resistant glass installed for staff safety. This will go out to bid and construction will begin as soon as possible. Pharmacy clean room construction is going well but the hoods have been delayed. The completion date for this project is January 20. The Gift Shop/Coffee Bar completion date is set for January 17.

Community Healthcare Needs Assessment: Mr. Bill reported that we are in the final phases of the physician needs analysis based on demographics and national standards. This will be completed by the end of the year and presented to the board in January. Meetings will be scheduled with physicians to get their input about specialty and sub-specialty services currently provided by primary care physicians. A discussion was held about wants vs needs and how helpful the survey responses will be in providing the information we need. Mr. Bill is working with CBJ purchasing to finalize the wording of the Provider Network Study RFP so it can go out either today or Monday.

Campus Plan Update: Corey Wall provided a summary overview of current floor plans. It has been identified that under 15% of additional space is needed to meet anticipated future needs. We currently have 209,425 square feet for the whole building, 28,936 more are needed. The following were noted:

- Portions of the original first floor have not been renovated since the sixties and need abatement.
- Food service is too small and there is no way to expand. Moving it to a different location would provide the 17,000 square feet needed to expand all of the other departments on the first floor.
- The ED has the most space needs. A proposed plan to push the outer ED wall south 28 feet and move the ambulance bay was presented. This would provide just under 5,000 additional square feet. Security and a 24 hour pharmacy could be located near the new entrance and would allow this area of the hospital to be locked down from the rest of the hospital after hours.
- Proposed plans for separating the women's imaging center from the radiology department were discussed. This would open up more space for the radiology department. Plans propose putting the women's imaging center on the first floor where security offices are currently located.

These high level conceptual plans were based off of feedback from every department regarding their current and future needs. Detailed design and functionality are important and will require additional staff input as each project moves forward. The plans will be shared with staff when the final design is closer to being finished. The pros and cons of doing additions in stages was discussed. Pushing to the south is not ideal but really the only option available.

A discussion was held about the need for an emergency access road to the back of the hospital. \$90,000 is to be put into the CIP to look at options for an emergency access road. Mr. Johnson suggested making a strong case that the community needs an alternative route in case Egan Drive is ever shut down so DOT may help with funding. Mr. Wall highlighted some of the challenges in putting in an emergency access road due to the elevation of the hillside. The possibility of moving Wildflower Court to a location further from the hospital and using that space for medical facilities was discussed.

With an increase in services and staff and losing spaces due to construction, parking needs to be addressed. Multiple options for parking were discussed. One option is to build a parking garage on the hillside south of the hospital with an entrance on Egan Drive. Building on the hillside would be expensive, requiring the purchase of the adjacent property and excavating the hillside. A hillside garage would address the elevation challenges of accessing the south entrance and provide an alternative to Egan Drive access. Plans were also discussed for building a garage to the north of the hospital adjacent to the Johnson Youth Center property. This would be more convenient to patients but would be a significant visual impairment for patient rooms..

Mr. Wall turned the focus on proposed additions to the north side of the facility. He noted that the 30,000 feet of additional space needed would most likely happen here. A proposal for building a three storied addition where the physical therapy area and the Juneau Medical Center building is located was presented. This would be done in two phases and give more space than needed to

meet future needs. Doing this in two phases would allow time to address the medical office building. The “domino” pieces for this addition as well as the OR renovation were discussed.

Mr. Johnson expressed concern about building space we “might” need in the future and said we need to try to be as efficient as we possibly can. Mr. Kendziorek views these plans as reasonable options for the future, not concrete plans. We do need to have a high level view to understand the issues and to have a plan of action a decade out.

FUTURE AGENDA ITEMS - Continued discussion of the Campus Plan

COMMENTS – A meeting will be held before the next board meeting to continue these discussions. These are long term plans and need to be looked at systematically. Doing so sends a message to the community that we are looking ahead and planning for the future. Mr. Bill will talk about this during his next Action Line session. A suggestion was made to make this a meeting of the Committee of the Whole to have more people on the board participating in these discussions.

Mr. Wall provided one more option to ease congestion; the Medical Arts building could go away and open up space. This would enhance the whole entry and allow for a nicer drive that comes through and right back out Hospital Drive.

A discussion was held about building above the boiler room and renovation of the lab. The boiler room issues have to be resolved before we can build above it.

Next meeting: 7:00 a.m. – January 17, 2020.

Adjourned - 8:25 a.m.

Bartlett Regional Hospital

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Board Quality Committee January 8, 2020 Minutes

Attendance: Rosemary Hagevig (BOD), Charles Bill (CEO), Sarah Hargrave (Quality Director), Rose Lawhorne (CNO), Deborah Koelsch (Clinical Quality Coordinator), Carmi Clark (Quality Data Analyst), Gail Moorehead (Education Director), Billy Gardner (COO), Bradley Grigg (CBHO), Lindy Jones, MD (BOD), Mary Crann (Risk Manager), Charlee Gribbon (Infection Preventionist), Marc Walker (Facilities Director), Megan Costello (Chief Legal Officer)

Approval of the minutes – November 13, 2019 – *minutes approved as written.*

Standing Agenda Items:

Quality Dashboard (reported quarterly) – Ms. Hargrave reviewed the Board Quality Dashboard. Patient Satisfaction Overall from all areas in the hospital looks very strong. The HCAHPS Quarter 4 results shows outstanding scores for Communication with Nurses and Communication with Doctors. The Bedside Shift reporting facilitated by Autumn Muse (RN Clinical Program Specialist) and nursing unit directors likely helped increase our HCAHPS scores. There is a dip on the Care Transition section, but after looking on the report, there was only one patient who answered “disagree”. Most of the patients answered “agree” instead of the top box “strongly agree”. We will continue to monitor this domain. Severe Sepsis/ Septic Shock Measure has exceeded our goal. The 30-day Hospital Heart Failure Rate looks good. The Screening for Metabolic Disorders Quarter 4 results data is incomplete. There is one Sentinel Event this quarter; follow up meeting with The Joint Commission is scheduled early February.

New Business:

The following documents need to be formally approved by the Board at the next meeting. Board Quality approved January 8, 2020.

- 2020 Risk Management Plan
- 2020 Infection Prevention Plan and 2019 Evaluation
- 2020 Environment of Care Plan and 2019 Evaluation
- 2020 Patient Safety and Quality Improvement Plan and 2019 Evaluation

Board Quality Committee Charter Review

Board Quality Committee Charter Review changes are approved by the Board Quality Committee.

The Person and Family Engagement Community Liaison added to the Board Quality Committee Charter membership.

Ms. Hargrave explained the CMS Partnership for Patients Adaptation and adding patients' voice to the decision table. Additionally, Bedside Shift reporting and Social determinants of health have also been implemented in the hospital.

Risk Management Plan

There are few changes in the Risk Management Plan CY2020.

Ms. Crann added that Ms. Hargrave's Leadership heavily affected the Just Culture of the hospital. The number of occurrence reports are increasing, as a sign of increased transparency.

Utilization Plan

Deferred to March

Infection Prevention Plan

The 2019 and 2020 Infection Prevention and Control Goals and Plans were presented.

Infection Prevention Goal #1 – Improve compliance with CDC Hand Hygiene Guidelines – BRH hospital wide compliance is 71%, goal not met. The plan for improvement is to share data directly with bedside staff electronically and post in staff areas. The issue that Ms. Gribbon came across is there is no consistent observer.

Press Ganey patient survey results for the question "staff washed their hands" increased by 3% over 2018 reported rates. Inpatient "Staff wash their hands before exam" top box scores shows 73% for 2018 and 79% for 2019.

Infection Prevention Goal #2 – Reduce surgical site infection by Improving patient skin prep and decolonization; Improving surface cleaning and disinfection; implementing a nasal decolonization protocol for all NHSN/high risk procedures. The Goal Met, 2019 SSI Rate is 0.29 infections per 100 procedures. The 2018 rate is 0.83

Ms. Gribbon and Ms. Hargrave implemented a vigorous process that made a difference and helped achieve the goals.

Decrease the risk of acquiring health care associated C difficile Goal #3 – Goal met, 2018 HAI Rate is 2.08, 2019 HAI rate is 1.89 infections per 10,000 patient days. This is a 10% decrease.

The Emergency Supply Inventory project will be finished February 2020.

Ms. Gribbon also presented the 2020 Infection Control Plan Goals. Furthermore, Ms. Gribbon mentioned a few strategies that she wants to incorporate in her FY2020 goals for example; monitor staff compliance with patient skin and nasal decolonization, increase utilization of Sterile Meryl, improve staff, patient and visitor knowledge and utilization of transmission-based isolation PPE and signage.

Ms. Hargrave announced that Ms. Gribbon received her certification in Infection Control and Prevention this month. Ms. Hagevig has asked that the Board be made aware that Ms. Gribbon has obtained her Certification in Infection Control and Prevention (CIC).

Environment of Care Management Plan

The goal of the Environment of Care (EOC) Programs are to provide a safe, functional and effective environment for patients, staff and visitors. The EOC Program encompasses five programs; Safety Management, Security Management, Hazardous and Waste Management, Utilities Management and Medical Equipment Management. In addition, two other areas are included in the environment of care. Emergency Management and Life Safety Management.

- Safety Management Chaired by Nathan Overson
 - The accomplishment for the committee in 2019 include completing a comprehensive AKOSH consultation and the implementation of a revised Asbestos Management program. There were four-performance measure set by the committee last year and they were all met. Based on 2019 outcomes the Safety Committee has develop three areas of focus for 2020. These areas are to Reduce Workplace Violence, Reduce Workforce Injuries and update our working at heights program to increase employee safety.
- Security Management Mike Lopez
 - The accomplishment for the committee were prioritization and initialization of afterhours lockdown program and security officer training with JPD for drug an paraphernalia identification. The three performance measures set by the committee for 2019 were met with partial compliance. The area in need of improvement was completion of department swarms. The committee is reevaluating the swarm process for 2020. The 2020 goals and opportunities for improvement set by committee are to Increase Facility-wide Security Afterhours, Improve Customer Satisfaction and Improve the Security Camera System Functionality.

- Hazardous materials and Waste Management John Fortin
 - The accomplishment included updating the Hazard Communication plan and clearing up processes around pharmaceutical waste disposal. The performance measures set for 2019 were met with varying degrees of success. The committee was fairly aggressive setting quite a few goals and falling just ever so slight short of their goals. Goals and Opportunities for improvement in 2020 mirror 2019 with new strategies for how to meet them.
- Life Safety Management Plan
 - The accomplishment of the committee are the following: completion of annual test, inspection, the repairs to fire alarm system per NFPA standards as well as assessed risk and implemented Interim Life Safety Measures (ILSM) for the BOPS temporary location in the Juneau Medical Center, and implemented a multi-day fire watch for RRC while the fire alarm system was being upgraded. There were three performance measures set and were met with varying degrees of success due to workloads and staffing shortages within the maintenance department. For 2020, the committee will be using the same Goals as set in 2019 including one new goal; proactively establishing fire response plan for the new RRC and BOPS locations.
- Utilities Management Program
 - Accomplishments include installation of a new steam boiler control system increasing fuel efficiency. As well as installation of energy efficient computer access layer switches around the hospital. These systems require less power and the demand for facility cooling is reduced. Performance measures set were partially met. These goals are multi-year projects that have seen substantial movement in the right direction. Goals and Opportunities for improvement in 2020 include UPS replacements, computer system and mechanical system upgrades.
- Medical Equipment Management and Utilities Management chaired by Kelvin Schubert
 - The accomplishment of the group includes implementation of several new medical equipment systems as well as being part of the team evaluating new anesthesia machines. Goals and Opportunities for Improvement for 2020 have been established and include providing training opportunities for Biomed staff on specialty pieces of medical equipment and develop a process for receiving, assigning, monitoring end of life and disposal of medical equipment.
- Emergency Management
 - The accomplishment of the committee includes specialty training, community and regional involvement in emergency planning as well as conduction a closed point of distribution exercise.

Patient Safety and Quality Improvement

There are few changes on the CY2020 Patient Safety and Quality Improvement Plan compared to CY2019 Goals.

All CY 2019 Metrics have been met. Ms. Hargrave presented the CY2020 Metrics.

Mr. Bill shared how Ms. Hargrave helped make positive changes in our hospital's culture. This will be the last Quality Board meeting for Ms. Hargrave.

Next Quality Board meeting: March 11, 2020 4:15PM

Adjourned at 5:30 pm

[illegible]

January 28, 2020 Board of Directors
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AUTHORITY AND RESPONSIBILITY

Board of Directors

The Board of Directors of Bartlett Regional Hospital is responsible for the quality and effectiveness of the patient care provided by the medical staff and other professional and support staff. It sets expectations, directs, and supports Bartlett Regional Hospital's (BRH) governance and management activities which include supporting the Risk Management Program to minimize preventable harm to patients, employees, visitors and property. It has the final authority and responsibility for the program, but delegates the authority and accountability for the operation of the program to the Administrative and Medical Staff of BRH. It appoints, through the Chief Executive Officer, a Director of Quality. The Director of Quality is responsible for the Risk Management program. It recognizes the importance of a Risk Management Program and provides resources and support to prevent such events that may result in injury to patients, staff, or visitors, property damage, financial loss, or damage to the facility's reputation.

Risk Management Supervision

The Director of Quality supervises the Risk Manager and Patient Safety Officer (RM&PSO) and acts as a designee of the Chief Executive Officer. S/He has the responsibility for monitoring, coordinating, planning, and implementing all loss prevention activities and programs that have as their goal a safe environment for patients, employees, and visitors to the hospital. Trending and tracking of potential problems are included in this responsibility as well as the integration of information with the Performance Improvement Committee (PIC) and the Environment of Care (EOC) Committee.

Medical Staff

The Medical Staff actively participates in peer review via the identification of potential risk in clinical areas that represent a significant source of actual or potential patient injury. This is achieved through clinical criteria to identify specific cases with potential risk in the clinical aspects of patient care and safety.

PURPOSE AND PHILOSOPHY

The purpose of the Risk Management Plan is to support the mission and vision of Bartlett Regional Hospital to provide patient centered quality care in a sustainable manner. Risk Management fulfills this by acting to protect, patients, staff and visitors from injury, physical property from damage and financial assets from being wasted. Risk Management acts to support BRH's reputation and standing in the community.

The focus of the risk management plan is to provide an ongoing, comprehensive, and systematic approach to reducing vulnerabilities. Risk management activities include identifying, investigating, analyzing, and evaluating risks, followed by selecting and implementing the most appropriate methods for correcting, reducing, managing, transferring and/or eliminating them.

The philosophy of the Risk Management Program is that patient safety and risk management is the responsibility of each employee of Bartlett Regional Hospital. Teamwork and active participation among management, providers, and staff are essential for an efficient and effective risk management program._ The Risk Manager plays a central role in leading the organization towards fulfilling the mission and vision of BRH to provide patient centered sustainable quality care.

SCOPE

Risk Management is a systematic process of identifying, evaluating and alleviating practices and/or situations that pose risk of harm to patients, visitors and staff of BRH. Emphasis is placed on advocating the exercise of loss prevention strategies intended to preserve the resources of Bartlett Regional Hospital and its professional staff from loss attributed to professional liability.

The Risk and Quality Management activities at BRH are mutually compatible and interdepartmental and are part of the organization's performance improvement system. BRH's Risk Management Program is designed to comply with all federal and state regulatory requirements. Resources are provided to the Quality and Risk Management Department via the Director of Quality. The integration of hospital risk management with quality assurance activities ensures information about patient care and safety are exchanged.

STRUCTURE

Risk management activities are established by BRH leaders, based on needs assessments, as guided by the mission, vision, and core values, and as defined by strategic and operational plans, budgets, resource allocation, and standards.

Board of Directors

The Board of Directors receives and reviews reports through the performance improvement structure, summarizing the findings of the Risk Management Program via the Hospital Performance Improvement Committee (PIC), the Environment of Care (EOC) Committee, and reports by the Risk Manager & Patient Safety Officer or Director of Quality. The Board of Directors designates the Director of Quality and the Risk Manager & Patient Safety Officer to function

as the Grievance Committee for complaint processing that cannot be resolved by the department managers.

Senior Leadership Team:

The Senior Leadership Team (SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief Clinical Officer, Chief Behavioral Health Officer, Chief Legal Officer and Director of Human Resources, ensures that an integrated patient safety program is operationalized, and assumes responsibility for the strategic direction and integration of all Risk Management activities. Patient safety culture survey results provide feedback on workplace safety practices, communication, teamwork, adverse event reporting, and leadership to help guide vision and goals of the organization. The SLT is responsible to assure that key strategies and/or processes of the organization are identified and prioritized, and that the efforts of Risk Management support and integrate the strategic objectives of the organization and feedback from all community and hospital connections. SLT supports transparency in communication related to the risk management process.

Departments

Individual departments are responsible for quality management, regulatory compliance, and risk management activities relative to the services they provide. Progress on departmental risk management activities are submitted in writing when warranted to the Risk Manager and Director of Quality.

RISK MANAGEMENT PROCESS

Risk management and quality improvement are complementary and continuous processes that link activities to BRH's mission and strategic plan. The risk management process ensures all employees have a risk management philosophy and are the first line of defense. The process should be outcome oriented measured by quality indicators and dashboards.

METHODS

Establishing a consistent definition and measurement process supports the goal of preventing harm and delivering safe care to patients by allowing rapid identification of Serious Safety Events, quick mitigation to prevent further harm, and consistent evaluation of prevention methods. A clear and consistent plan for conducting investigations is imperative along with establishing common definitions and a shared mental model.

Risk Management activities include:

1. Review and triage occurrence reports completed by staff and providers in the occurrence reporting software system.
2. Prioritize events, hazards, and system vulnerabilities utilizing the Safety Assessment Code (SAC) Matrix.

3. Measure and report frequency and severity of events to transform risk management into a pro-active program.
4. Ensure timely execution of Root Cause Analysis, mitigation, and corrective action plans using the RCA2 guidelines and tools.
5. Collaborate with the Director of Quality identifying near misses or trends and utilizing evidence-based tools for process improvement and quality assessment activities.
6. Collaborate with the Director of Quality to communicate data and investigation findings to the BOD, SLT and staff.
7. Participation in litigation processes by attending depositions, supporting staff, providing documentation, and acting as liaison to BRH legal counsel.
8. Report potential medical malpractice liabilities to the risk manager at the City and Borough of Juneau and appropriate insurance liability carriers and agents.
9. Identify, investigate, and report Sentinel Events as required by Joint Commission standards.
10. Identify, investigate and report Serious Reportable Events required by the National Quality Forum.
11. Model and support evidence-based risk reduction concepts and tools to improve communication, and other high risk areas.
12. Review quality performance indicators to evaluate risks and strategies.
13. Review of patient grievances and responding following BRH policy, Centers for Medicare and the Medicaid Conditions of Participation Patient Rights regulations.
14. Evaluate grievance data using system analysis with a grievance committee and incorporate into QAPI
15. Collaborate with the Director of Quality in completing a patient safety culture survey and developing risk and quality plans that incorporate staff input and participation.
16. Collaborate with the City and Borough of Juneau (CBJ) risk managers in litigation, property damage, and employee events and attend and participate in Joint Safety meetings.

COMMUNICATION

Communication of risk management availability and outcomes to all levels of BRH is vital. Conclusions, recommendations, and actions are communicated to leadership, and/or individuals responsible for implementing and coordinating improvements through various presentations or reports. Examples of meetings where relevant information may be reported include:

1. Medical Staff Service Line meetings
2. Individual Department Staff meetings (when appropriate)

3. Board and/or Hospital Quality Committee reports
4. Management Team meeting
5. Patient Safety Committee Meeting
6. Patient Grievance Committee

An annual review and revision of the risk management plan and objectives are provided to the Hospital Process Improvement Committee and the Board of Directors.

2019 Infection Prevention and Control Plan Evaluation

2019 Infection Control Plan Goals

Infection Prevention Goal #1	Measurable Objective	Strategies	Responsible Parties	Measurement/ Evaluation Goal Met or Unmet.
<p>► Improve compliance with CDC Hand Hygiene Guidelines</p> <p>(NPSG 07.01.01, EP1).</p>	<p>BRH hand hygiene rates will be improved by 3% over 2018's hand hygiene compliance rate by 12/31/2019.</p>	<p>1. Continue with financial compensation for observation.</p> <p>2. Form Hand Hygiene task force to develop meaningful, evidenced based education, and useful interventions that will ultimately improve compliance.</p> <p>3. Consistently sharing data in a timely fashion with staff regarding compliance.</p> <p>4. Involve patients and families in efforts to monitor compliance with Hand Hygiene.</p> <p>5. Educate visitors, patients and families on proper hand hygiene.</p>	<p>Nursing Administration, Patient Care staff, Infection Prevention, Employee Health, Patients and visitors.</p>	<p>BRH hand hygiene compliance rate will be \geq 80% hospital wide.</p> <p>GOAL NOT MET</p> <p>BRH hospital wide compliance is 71%.</p> <p>Plan for improvement: Share data directly with bedside staff electronically and post in staff areas. Engage with bedside staff ways to improve and increase awareness that are meaningful to them.</p> <p>IP will compare Press-Ganey reported hand hygiene.</p> <p>Patient reported (Press-Ganey) hand hygiene scores will increase by 3 % over 2018's reported rates.</p> <p>GOAL MET</p>

				Inpatient "Staff wash their hands before exam" top box % 2018 (n=345) 73% 2019 (n=298) 79%
Infection Prevention Goal #2	Measurable Objective	Strategies	Responsible parties	Measurement/ Evaluation
<p>► Reduce surgical site infections by</p> <p>A: Improving patient skin prep and decolonization.</p> <p>B: Improving surface cleaning and disinfection.</p> <p>C: Implementing a nasal decolonization protocol for all NHSN/ high risk procedures.</p> <p>D: Improving antibiotic choice and dosage.</p>	Decrease surgical site infection to previously low baseline rate of 0.6 per 100 procedures by 12/31/2019.	<p>A1. Improve preoperative skin prep for all patients going to OR from ED, MS, CCU, and OB.</p> <p>A2. Ensure Pre Assessment Teaching to prepare patients with adequate decolonization and skin prep at home is done through auditing.</p> <p>B1. Ensure terminal OR cleaning is done effectively through auditing.</p> <p>B2. Implement and monitor usage of UV light robot for enhanced terminal cleaning.</p> <p>B3. Continue monitoring of surface ATP levels to show effective terminal surface cleaning.</p> <p>C1. Implement nasal decolonization protocol for all NHSN reported procedures.</p> <p>D1. Use order sets for</p>	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	<p>Measure surgical site infection rates and compare to 2018. Rate will be less than 0.6 infections per 100 procedures. 2018 rate is 0.83 per 100 procedures.</p> <p>GOAL MET</p> <p>2019 SSI Rate is 0.29 infections per 100 procedures.</p>

		procedures to ensure optimal dose for weight is achieved, and recommended antibiotic for type of procedure is selected.		
Infection Prevention Goal #3	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Decrease the risk of acquiring health care associated C. difficile. (NPSG 07.03.01)	Limit the risk of HAI C. difficile transmission and decrease HAI CDI rates by 10 % by 12/31/2019.	1. Reinforce and update education on recommended specimen testing. 2. Utilize UV light robot for all isolation terminal cleaning. 3. Ensure appropriate cleaning and disinfection products (bleach) are available for C. difficile rooms and area is cleaned per protocol. 4. Prohibit unnecessary antibiotic use.	Nursing, EVS, Infection Prevention, laboratory and all staff.	Measure C. difficile infection rates and compare to 2018 baseline. There will be a 10% decrease in HAI- C. Difficile rates for 2019. Goal Met 2018 HAI Rate is 2.08 2019 HAI Rate is 1.89 infections per 10,000 patient days This is a 10% decrease
Infection Prevention Goal #4	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Decrease the risk health care associated MRSA transmission in the facility. (NPSG 07.03.01)	Return to zero inpatient transmissions of healthcare-acquired MRSA infections for 2018.	1. Continue to measure and report MRSA infection transmission for 2018. 2. Study, compare and implement improved disinfection product for surface	All staff who enter patient rooms, patients, families and visitors. EVS and Infection Prevention.	There will be zero (0) transmission of MRSA or HAI MRSA infections from patient to patient or staff. Goal Not Met

		cleaning. 3. Implement cleaning product that is safe for patients and families to use. 4. Continue to monitor effectiveness of surface cleaning and report monthly data to EVS manager. 5. Educate staff, patients, and visitors on hand hygiene compliance and surface cleaning with admission. 6. Continue to monitor MRSA infections and report via NHSN.		There were 2 cases of HAI or HO MRSA. This is a rate of 0.85 infections per 1000 patient days. This is the same rate as 2018.
Infection Prevention Goal #5	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Prepare for and protect staff, patients and our community from influenza exposure at BRH in an efficient and safe manner. (IC.02.04.01)	1. Maintain staff influenza vaccination at rates 96.6 % or greater for the 2019-2020 influenza season. 2. For core Full Time Scheduled Employees, have 98% compliance by October 16 th 2019.	1. Participation in the influenza prevention plan is mandatory. 2. Unvaccinated staff are required to wear barrier masks. 3. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH.	Leadership, all staff, IC, and employee health	Staff compliance rate will be at 96.6% or greater by November 30, 2019. Full Time Scheduled Employees will be at 98% compliance. Report data via NHSN. Goal Met All Active Staff = 93% All Full-time & Part-time Scheduled staff= 99% as of November 30, 2019.

Infection Prevention Goal #6	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
Evaluate current Emergency Supply of Personal Protective Equipment (PPE), ensure proper types and amounts are available.	Current Emergency Supply of PPE will be inventoried by 12/31/2019. A ready supply of PPE will always be available and in current stock supply in Materials Management	<ol style="list-style-type: none"> 1. Develop a standardized protocol for identifying, maintaining and storing proper PPEs. 2. Organize a team to develop plan and protocols for identifying, maintaining and storing proper types and amounts of PPEs for the following: <ul style="list-style-type: none"> -Seasonal Influenza -Pandemic Influenza -Special Pathogen Outbreaks 3. Plan will be added as an annual agenda item during the first IP Committee Meeting of the year. 4. Inventories audited 2 times a year by MM director and IP. 5. Table Top exercise simulating disaster scenario dependent on assessment of PPE will be 	Materials Management, Emergency Management Team, Infection Prevention and Employee Health.	<p>Successful Tabletop Exercise requiring quick assessment of PPE available and how to procure additional PPE if needed. This will be conducted with EMT, Facilities, IP and MM by 12/31/2019.</p> <p>Goal Met</p> <p>Inventory done 2/2019 Replenish outdated supply done 2/2019</p> <p>96-hour plan <u>done by EMTcommittee</u> November 2019-January 2020.</p> <p>Table Top with EMT, MM, IP December 17, 2019</p>

		conducted.		
Infection Prevention Goal #7	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
Choose and implement cleaning product that is safe and effective by March 31 2019.	ICP Committee will have selected the best disinfectant, and implemented the change by 3/31/2019. IP will monitor effectiveness of cleaning practices as shown by cleaning audits done every quarter.	<ol style="list-style-type: none"> 1. Study available products and present choices to ICP committee in February 2019. 2. Cost analysis of change will be completed. 3. Verification of cleaning will be audited with use of objective measures such as ATP swabbing of surfaces and observation of cleaning practices. 	EVS, Infection Prevention, Education, Nursing Directors and all patient care staff.	<p>4 audits will be done in 2019. Cleaning processes will match what is expected and trained. ATP audits will show improvement of 1% or greater each audit.</p> <p>Goal Met</p> <p>4 Audits completed Since product change, audits have helped with training and compliance. ATP measurement is being monitored. There is not enough data since product change to show 1% improvement since product change.</p> <p>EVS leadership change July 2019 Product Change August 2019 Data collection Change October 2019</p>

**BARTLETT REGIONAL HOSPITAL
INFECTION PREVENTION and CONTROL PLAN 2020**

This plan is developed with input and collaboration from the following:

- Infection Prevention and Control Committee
- Medical Staff
- Quality and Process Improvement
- Department Managers

Infection Prevention and Control Plan Reviewed by:

	Signature	Date
Infection Prevention and Control Committee Chair	Dr. David Miller	
Quality and Process Improvement Director	Sarah Hargrave RN, MSN	
Infection Preventionist	Charlee Gribbon RN, BSN	12/16/2019

Bartlett Regional Hospital

Infection Prevention and Control Plan 2020

Mission: To provide a safe environment across the continuum of settings for all patients, visitors, and healthcare workers through the prevention of infection transmission and the provision of a safe environment.

Objectives: The objectives of the Bartlett Regional Hospital (BRH) Infection Prevention and Control Program (IPC) are:

- 1 Early identification of infections, both expected and unexpected.
- 2 Timely implementation of interventions when infections or risks thereof are identified.
- 3 Analysis of organizational and individual practices that impact transmission of infection.
- 4 Implementation of evidence-based practices known to reduce the transmission of infection.
- 5 Education of healthcare workers, patient, families, and visitors on infection risk-reduction practices.
- 6 Limitation of unprotected exposure to pathogens throughout the organization.
- 7 Interact with community health agencies through activities such as surveillance and emergency preparedness to respond to community outbreaks and special pathogens (such as Ebola).
- 8 Manage effectively the seasonal influx of potentially infectious patients during Southeast Alaska's tourist season.
- 9 Enhancement of hand hygiene practices by all persons within the hospital system.
- 10 Minimization of the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.
- 11 Incorporation of guidelines and recommendations published by regulatory or accrediting agencies, and professional organizations, to provide current evidence-based infection prevention strategies and policies.
- 12 Provision of Employee Health services, including appropriate screening, testing, immunization, counseling, and education for staff and others who have the potential for exposure to communicable disease.

Infection Prevention and Control Program Oversight and Organization Authority and Responsibility

PURPOSE: To institute any surveillance, prevention, and control measures when there is reason to believe that any patient or personnel may be in danger of a hospital acquired infection or infectious disease (IC 01.01.01)

A. The Infection Prevention and Control (IPC) Committee:

A.1. The Infection Prevention team is made up of the Chair of the Infection Prevention and Control Committee (IPCC), which directs the IPC program and one full-time Infection Preventionist.

A.1.1. In accordance with Medical Staff Bylaws and/or Rules and Regulations, the physician members of the Infection Prevention and Control Committee are appointed by the Chief of the Medical Staff.

A.1.2. The appointed term is reevaluated on a yearly basis.

A.1.3. The IPC Program will identify and evaluate potential risk factors (including environmental factors) and monitor trends in incidence of epidemiologically relevant infections at BRH. This is achieved through effective surveillance, evaluation and communication to senior leadership, hospital stakeholders, medical staff, employees, and community.

A.1.4. The ICP Plan is updated on an annual basis, reviewed and approved by the IPC Committee. This update is based on a review of the prior calendar year's activities, surveillance program, risk assessments and goals (IC 01.05.01). The review of the prior calendar year's activities, surveillance program, risk assessments and goals will be completed and approved by the IPC Committee during the first quarter of the upcoming calendar year and will be implemented in second quarter of the calendar year. (IC 01.03.01)

A.2. Members of the Infection Prevention and Control (IC) Committee and/or the Infection Preventionist have the authority to institute surveillance, prevention, and control measures.

- A.2.1. Where there is reason to believe that any patient or personnel may be in danger of acquiring a hospital acquired infection or communicable disease; control measures may include closure of rooms, units, departments, or management of hospital visitors.
- A.2.2. The Chair of the IPC Committee and/or the Infection Preventionist (or designee) have the authority to establish controls to reduce and stop the spread of infection and communicable disease, including the ordering of microbiological cultures and TB testing when indicated.
- A.3. The IPC committee oversees the infection prevention process through evaluation, analysis and interpretation of the infection prevention data. The performance-improvement framework is used to design, measure, assess and improve the organization's performance of the surveillance, prevention and control of infection. The committee is responsible for approving and documenting the selection of surveillance programs designed to improve the quality of care.
 - A.3.1. Clinical interaction through education, quality improvement efforts, and communication is maintained to increase the effective application of infection prevention and control principles.
 - A.3.2. The BRH leadership provides adequate resources (human, informational, physical, and financial) to support infection prevention and control activities. (IC 01.02.01)
- A.4. BRH services include emergency care, surgical, critical care, obstetrics, general medical, diagnostic imaging (mammography, CT, MRI, ultrasound and radiology), laboratory, chemo/infusion therapy, oncology, hematology, physical/occupational/speech therapy, mental health inpatient treatment, outpatient psychiatric, chemical dependency residential and outpatient treatment, and sleep studies.
 - A.4.1. New programs or services within the hospital will have to be evaluated by an Infection Control Risk Assessment (ICRA). More frequent reviews may be initiated depending on emerging diseases, changes in services or identification of specific risks in populations served. If significant change occurs, the IPC Program will respond in a timely manner, review/approve a plan with the multidisciplinary IPC Committee and re-prioritize risks as necessary.

A.5. Time-sensitive or critical issues:

A.5.1. The scheduled quarterly meeting of the IPC Committee may not be timely to address time-sensitive issues. In the event that time-sensitive issues endanger life or create a patient or employee safety concern, immediate action will be taken to alert those necessary to correct the situation.

A.5.2. Issues or situations of any level of criticality may be brought to the attention of the committee members through the Infection Preventionist, Case Managers, Department Directors, other medical or unit staff, or the Quality/ Risk Management department.

A.5.2.1. Critically significant situations should be brought to the attention of the IPC Committee physician chair as soon as they are identified.

A.5.2.2. The level of criticality should guide committee decisions for referral or action when an infection safety issue is identified.

A.5.2.3. Actions appropriate for the IPC Committee chair to take may include:

A.5.2.3.1.1. Calling an *ad hoc* IPC Committee meeting, if appropriate for timely response.

A.5.2.3.1.2. Directly contacting the physician chair of the committee that has authority over the situation.

A.5.2.4. The IPC Committee chair may directly contact another staff (physician or Senior Leaders) who has authority to correct the critical situation without further delay.

A.5.2.5. When a safety issue is identified, and the committee requires additional information or resources, the committee will bring the issue immediately to the attention of one of these functioning committees:

A.5.2.5.1.1. Committee Chair of the specific Service Line wherein the threat is occurring.

A.5.2.5.1.2. Medical Staff Quality Improvement Committee (MSQIC) Chair.

A.5.2.5.1.3. Medical Staff Executive Committee Chair.

- A.5.3. IPC Committee and medical staff will collaborate with others as appropriate to make decisions based on patient/employee safety.
- A.5.4. All situations that are identified, their level of criticality, actions taken, and any follow up recommendations will be reported through the IPC Committee to the MSQIC and/or Hospital Quality Council (HQC), as appropriate.
- A.6. The Infection Prevention and Control Committee reviews and approves, annually all hospital-wide and department-specific policies and procedures related to the infection surveillance, prevention, and control programs of the IPC Committee and all departments.
- A.7. Physicians, Quality Management, Nurses and the Infection Preventionist actively pursue continuing education in Infection Prevention and Control and collaborate with local, state, and national experts in infection prevention to maintain a working knowledge base. Competency and continuing education is required and is maintained annually.
- A.8. The IPC Committee operates as a review organization, and so is entitled to the protections offered by Alaska Statute (AS 18.23.030) and federal law.
- A.9. The minutes of the Infection Prevention Control Committee are forwarded to the Medical Staff Executive Committee.
- B. The Infection Preventionist is designated as the Infection Prevention and Control Officer, and is responsible to develop and implement policies governing control of infection and communicable disease.
 - B.1. In the absence of the Infection Preventionist (after hours or during periods of leave), the House Supervisor will assume responsibility for daily infection prevention and surveillance, ensuring that isolation protocols are initiated and/or discontinued for patients as indicated.
 - B.2. The Infection Preventionist will monitor infection prevention activities throughout the organization, with special emphasis on the surgical suite, central sterile processing, environmental services, the kitchen, and nursing units. This monitoring will include regular surveillance and observation activity. (NPSG 07.05.01)

- B.2.1. The IP will monitor hand hygiene compliance facility-wide on a monthly basis.
 - B.2.1.1. Department managers will assist in recruiting and retaining unit Hand Hygiene Champions.
 - B.2.1.2. IC will report compiled information obtained from these observations to department leaders, facility leadership, and all staff.
- B.2.2. The Infection Preventionist will notify the appropriate regulatory agency, to include but not limited to, the Alaska Department of Health and Social Services (DHSS), State of Alaska (SOA) Section of Epidemiology or Centers for Disease Control and Prevention (CDC) of any mandatory reportable disease or epidemiological important organism in a timely manner. (IC.01.05.01 & IC.02.01.01)
 - B.2.2.1. The IC program at BRH will use an epidemiological approach consisting of surveillance, routine analysis, and emerging threat identification through collaboration with microbiology, DHSS, SOA Section of Epidemiology, CDC, community partners, and employees.
 - B.2.2.2. BRH will communicate with community partners (DHSS, SOA, other facilities, physician's offices, clinics, and other hospitals) of known or discovered infectious events or patient movement in a timely manner for continual surveillance, education, and prevention of infectious disease transmission.
- B.2.3. The Infection Preventionist will act in an advisory and supportive role to ensure the safety and health of patients, employees, visitors, and contractors during renovation, construction, and maintenance at the hospital.
 - B.2.3.1. IC will collaborate with a multi-disciplinary team to perform Infection Control Risk Assessment (ICRAs) on all construction, renovation, and maintenance projects being performed at the hospital.
- B.2.4. The Infection Preventionist will act in an advisory and supportive role to ensure that high quality disinfection, sterilization, and safe use of non-critical, semi-critical, and critical reusable medical equipment (RME) is maintained.
- B.2.5. The Infection Preventionist will oversee and provide guidance to Employee Health and Infection Prevention that includes but is not limited to: Respiratory Protection Program, Immunization screening, TB screening, and correct PPE utilization (IC.02.04.01).

B.2.6. The Infection Preventionist will assist in the organizational Emergency Preparedness to include, but not limited to, pandemic respiratory viral illness, emerging special pathogens, influx of infectious patients, and natural disasters. (IC.01.06.01).

B.2.7. IPC will participate in the Clinical Product Review Committee to facilitate and approve new safety engineered devices/supplies.

Risk Assessment and Prioritization of Goals (IC 01.04.01)

The Infection Prevention and Control Committee, in collaboration with hospital leadership, identifies risks for transmitting and acquiring infection within the organization, based on the many factors discussed below. The Committee will develop a risk assessment at least annually, or when significant changes materially change risk prioritization (noted below), using information from all applicable committees and individuals as appropriate. Consideration will be given to those issues that are high risk, high volume, and/or problem prone, and to new techniques or procedures, or related to emerging trends. The Committee will develop action plans to address these issues (see Risk Assessment and current Prioritization List). The factors to be addressed in the risk assessment include, at a minimum: device related infections, antimicrobial stewardship plan, hand hygiene, influenza, medical devices, and transmission based organisms/diseases.

Geographic Location and Community Environment

Bartlett Regional Hospital is a community-owned acute care hospital licensed for a total of 56 inpatient beds and 16 residential substance abuse treatment facility beds in the Rainforest Recovery Center. In addition to the communities of Juneau and Douglas, we serve all the Southeast Alaska communities of Yakutat, Skagway, Haines, Sitka, Hoonah and Angoon. The primary and secondary service area has a combined population estimate of 52,771. Bartlett serves a 29,991-square-mile region in the northern part of Southeast Alaska. Juneau, the largest city in the region and the capital of Alaska is accessible only by water or air. The population of the city and borough of Juneau is 32,241 (CDRA, 2019) This includes 6% who are under 5 years of age, 18.7% that are aged 6-19 years, and 9.2% that are over 65 years of age. The underserved and disadvantaged population includes 7.9% with a disability and under 65 years of age, 13.4 % under 65 years of age without health insurance, and 7.3% (2365 persons) which live below the poverty line, and 9.8 % (3169 persons) below 125% of the poverty line.

Characteristics of the Population Served

Bartlett Regional Hospital is the largest provider of hospital services in Southeast Alaska. It serves a diverse community of residents. Tourism expands the service area population by approximately 30% from May to September each year, welcoming visitors from 50 or more countries. These include the workers for the fisheries and tourism agencies that are seasonal; approximately 27,000 people work seasonally in Southeast Alaska every year; 70% are non-residents, and many are foreign born from high TB incidence countries. The fisheries and cruise ships provide tight living quarters for their seasonal employees, which may increase the incidence of any disease. The cruise lines bring tourists and workers from many different countries. BRH must consider ship quarantine or influx of infectious diseases. This seasonal influx presents ongoing significant potential for mass trauma and communicable disease outbreak, requiring BRH to maintain careful surveillance, awareness of global emerging infectious disease trends (Pandemic or Novel strains of Influenza, MDR Tuberculosis, CRE, Ebola, etc.) and to maintain an updated emergency management and surge capacity plan.

The Alaska Department of Health and Social Services 2018 TB Summary Brief Report shows that Alaska's TB infection rate was 8.5 cases per 100,000 people, an increase from the previous two years (AK SOE, 2019). Alaska has the highest TB incidence rate in the nation, and is nearly three times the national average of 2.8 cases per 100,000 people. Southeast Alaska has an incidence rate of 2.7 cases per 100,000.

Results of Analysis of Bartlett Regional Hospital Infection Prevention Data

Bartlett Regional Hospital conducts hospital-wide surveillance for all types and categories of infection. The surveillance results from surgical site infections (SSI), device-related infections (Central Line Associated Blood Stream Infection[CLABSI], Catheter Associated Urinary Tract Infection [CAUTI], Ventilator Associated Events [VAE], Methicillin-Resistant Staphylococcus Aureus [MRSA], and Clostridium Difficile [C-Diff]) rates and communicable disease exposure events are reviewed for variance and reported to hospital leaders, the Patient Safety Committee, the Critical Care Committee, and medical staff as appropriate. A yearly Infection Prevention and Control Plan and a summary analysis of the prior year's plan, goals, strategies, activities, and issues are submitted annually to the Governing Board.

Evaluation of the Infection Control and Prevention Plan

Plan evaluation is an ongoing process that is measured and reported annually by comparing the described measurable objective to the observations/measurements as described in the plan. If the objective is met, then that particular goal is considered to be met for the plan year.

Care, Treatment, and Services Provided

Bartlett Regional Hospital's current strategic plan notes twenty-four services that are provided on campus. High-risk and high volume services are included in the risk assessment process.

Employee Health

Bartlett Regional Hospital provides a safe working environment for its approximately 670 employees, of which 493 (74%) are full or part time scheduled. This is accomplished through coordination of Infection Prevention policies and practices, and through the services provided by the Employee Health Program such as Hepatitis B vaccination, annual TB testing, and screening for immunity to vaccine-preventable diseases. Employee illnesses are categorized and logged daily by the House Supervisor, and analyzed by the Infection Preventionist. The goal is to identify and mitigate infectious conditions that may pose a risk to patients, visitors, or staff, and to ensure that staff are immune to vaccine-preventable diseases.

Emergency Preparedness

Bartlett Regional Hospital maintains readiness to respond to both internal and external threats and emergencies through its Emergency Management Plan, Emergency Management Team, Environment of Care Committees, and Infection Prevention Committee and Policy Manual.

2020 Infection Prevention and Control Plan

2020 Infection Control Plan Goals

Infection Prevention Goal #1	Measurable Objective	Strategies	Responsible Parties	Measurement/ Evaluation Goal Met or Unmet.
<p>► Improve compliance with CDC Hand Hygiene Guidelines</p> <p>(NPSG 07.01.01, EP1).</p>	<p>BRH hand hygiene rates will be improved by 5% over 2019's hand hygiene compliance rate by 12/31/2020.</p> <p>Press-Ganey hand hygiene scores will increase by 5 % over 2019's reported scores.</p>	<ol style="list-style-type: none"> 1. Continue with financial compensation for staff that observe hand hygiene. 2. Update Hand Hygiene Observer training with Staff Development. 3. Consistently meet with Directors regarding data collection from each unit and staff compliance. 4. Share data directly in a timely fashion with staff regarding compliance. 5. Work with Patient and Family Engagement Team to encourage more patient feedback regarding Hand Hygiene. 6. IP will talk directly with visitors, patients and families on proper hand hygiene. 7. IP will compare Press-Ganey reported hand hygiene. 	<p>Nursing Administration, Patient Care staff, Infection Prevention, Employee Health, Patients and visitors.</p>	<p>BRH hand hygiene compliance rate will be \geq 75% hospital wide.</p> <p>Patient reported (Press-Ganey) hand hygiene scores will increase by 5% over 2019's reported rates.</p>

Infection Prevention Goal #2	Measurable Objective	Strategies	Responsible parties	Measurement/ Evaluation
► Reduce surgical site infections by reducing risk of infection.	Maintain surgical site infection rate at or below 0.3 per 100 procedures by 12/31/2020.	<ol style="list-style-type: none"> 1. Monitor staff compliance with patient skin and nasal decolonization via EMR. 2. Reduce the number of sterile processing failures/ reprocessing/ IUSS. 3. Continue to monitor ATP in OR suites and use Sterile Meryl daily in OR. 4. Develop glucose screening plan for all surgical patients with BMI \geq 30. 5. Installation of new washer/sterilizer. 6. Increase competencies of all OR staff in Sterile Processing. 	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	Measure surgical site infection rates and compare to 2019. Rate will be \leq 0.3 infections per 100 procedures.
Infection Prevention Goal #3	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Decrease the risk of acquiring health care associated C. difficile. (NPSG 07.03.01)	Limit the risk of HAI C. difficile transmission and maintain HAI CDI rates of 2 infections per 10,000 patient days by	<ol style="list-style-type: none"> 1. Continue to monitor compliance for recommended specimen testing. 2. Increase utilization of Sterile Meryl for terminal cleaning of all isolation rooms. 3. Ensure appropriate cleaning 	Nursing, EVS, Infection Prevention, pharmacy, medical staff, laboratory and all staff.	Measure C. difficile infection rates and compare to 2019 baseline. There will be no increase in HAI- C. Difficile rates for 2020.

	12/31/2020.	and disinfection products (bleach) are available for C. difficile rooms and area is cleaned per protocol. 4. Reduce unnecessary antibiotic use through Antimicrobial Stewardship Program.		
Infection Prevention Goal #4	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Decrease the risk health care associated MRSA transmission in the facility. (NPSG 07.03.01)	Return to zero inpatient transmissions of healthcare-acquired MRSA infections for 2020.	1. Continue to measure and report MRSA infection transmission. 2. Encourage compliance with hand hygiene and appropriate glove use. 3. Increase utilization of Sterile Meryl for terminal cleaning of all isolation rooms. 3. Continue to monitor effectiveness of surface cleaning and report monthly data to EVS manager. 4. Educate staff, patients, and visitors on hand hygiene compliance and surface cleaning with admission. 5. Continue to monitor MRSA	All staff who enter patient rooms, patients, families and visitors. EVS and Infection Prevention.	There will be zero (0) transmission of MRSA or HAI MRSA infections in 2020.

		infections and report via NHSN.		
Infection Prevention Goal #5	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
<p>► Prepare for and protect staff, patients and our community from influenza exposure at BRH in an efficient and safe manner. (IC.02.04.01)</p>	<p>1. Maintain full time/ part time scheduled staff influenza vaccination at rates 98 % or greater for the 2020-2021 influenza season.</p>	<p>1. Participation in the influenza prevention plan is mandatory. 2. Unvaccinated staff are required to wear barrier masks. 3. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH. 4. Participate in statewide influenza infection prevention meetings. 5. Increase public awareness of importance of vaccination. 6. Organizational campaign regarding benefits of immunization.</p>	<p>Leadership, all staff, IC, and employee health</p>	<p>Full time/ part time scheduled staff compliance rate will be at 98% or greater by November 30, 2020.</p> <p>Report data via NHSN.</p>
Infection Prevention Goal #6	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
<p>Improve staff, patient and visitor knowledge and utilization of transmission-based isolation PPE and signage.</p>	<p>New isolation signs will be developed and implemented by 12/31/2020.</p>	<p>1. Develop multidisciplinary team to update information on isolation signs. 2. Develop patient and family education about transmission-based precautions.</p>	<p>Nursing, Staff Development, Infection Prevention and Employee Health.</p>	<p>Isolation signs will be printed and in use by 12/31/2020.</p> <p>10% of Nursing staff will be audited on donning and doffing skills.</p>

		3. Present new signage to staff using interactive and engaging methods of education. 4. Audit 10% of nursing staff on PPE donning and doffing skills.		
Infection Prevention Goal #7	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
Reduce the risk of HAI transmission attributable to surface contamination.	ATP pass rates will improve be 90% by 12/31/2020	1. Verification of cleaning will be audited with use of objective measures such as ATP swabbing of surfaces and observation of cleaning practices.	EVS, Infection Prevention, Education, Nursing Directors and all patient care staff.	Monthly surface cleaning audits will be done in 2020. All high touch surfaces will show a 90% ATP pass rate.

References:

Alaska Community Database Online DCRA Information Portal (2019) Juneau, Alaska. Retrieved from <https://dced.maps.arcgis.com/apps/MapJournal/index.html?appid=3635942ba31c40f094e6249f9d07431c>

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BARTLETT REGIONAL HOSPITAL

Environment of Care

Annual Report

CY 2019

Approvals

Environment of Care Committee: November 17, 2019

Performance Improvement Council: (scheduled January 8, 2020)

Board Quality: (scheduled January 8, 2020)



INTRODUCTION

The goal of the Environment of Care (EOC) Program is to provide a safe, functional and effective environment for patients, staff and visitors. The EOC Program encompasses the following five programs/areas:

- Safety Management (Nathan Overson Director of Compliance and Employee Safety)
- Security Management (Mike Lopez Security Supervisor/Emergency Preparedness Coordinator)
- Hazardous Materials and Waste Management (John Fortin Laboratory Department Director)
- Medical Equipment Management (Kelvin Schubert Maintenance Supervisor)
- Utility Systems Management (Kelvin Schubert Maintenance Supervisor)

In addition, the BRH Emergency Management and Life Safety Management Programs are integrated with the EOC Program, ensuring the hospital's overall preparedness for emergencies and disaster response.

The EOC Program and work groups are overseen by the EOC Committee. The EOC Committee and work groups:

- Identify risks and implements systems that support safe environments.
- Works to ensure that hospital staff are trained to identify, report and take action on environmental risks and hazards.
- Sets and prioritizes the hospital's EOC goals and performance standards and assesses whether they are being met.
- Works with the BRH Joint Commission Coordinator to ensure the hospital is compliant with the EOC-related requirements of all applicable regulatory bodies.

Membership of the EOC Committee is comprised of:

- Program managers for each of the five EOC Management Programs, Emergency Management and Life Safety Management Programs.
- Representatives from Nursing, Infection Control, Clinical Laboratory, Environmental Services, Quality Management, Human Resources and Senior Leadership.

EOC projects and initiatives include opportunities for improvement identified during ongoing hazard surveillance, risk assessment and other EOC activities to promote a culture of safety awareness.

This report highlights the activities of the EOC Program in Calendar Year 2019. For each of the major areas, it is organized as follows:

- Scope
- Accomplishments
- Program Objectives
- Performance Measures
- Effectiveness
- Opportunities for Improvement

SAFETY MANAGEMENT

SCOPE

Bartlett Regional Hospital's commitment to a safety management plan is designed to provide a physical environment free of unmitigated hazards and to manage staff activities to minimize the risk of human injury. It shall ensure that personnel are trained to interact effectively in their environment and with the equipment they use. All elements of the Environment of Care (EOC) are incorporated or serve to support the BRH Safety Management Plan.

The Safety Management Plan incorporates an interactive process involving and affecting all of Bartlett Regional Hospital's employees, contractors, patients, and visitors.

ACCOMPLISHMENTS

- AKOSH consultation visit for health and safety compliance and identified hazard abatement was completed.
- A new Asbestos Management Program and Policy has been put into place.
- Analysis of hospital after-hours access was finalized.
- Establishment of Policy Management Committee.
- Duress Alarm program evaluation and enhancement
- Began workplace violence pilot through WSHA in the emergency department



PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
Hire and orient an Employee Safety Officer.	Met	Nathan Overson has graciously accepted this role.
The hospital identifies safety and security risks. Departmental Safety Swarms are conducted in all areas of the work environment. Additional risk assessments are conducted when trend data suggests.	Met	Safety Swarms are conducted twice annually in patient care areas and annually in non-patient care areas. Enhancement to Duress Alarm procedures conducted.

Objectives	Met / Not Met	Comments and Action Plans
The Environmental of Care (EOC) rounds include all areas of the hospital. All patient care areas are inspected at least twice a year, and other areas are inspected annually.	Met	EOC Rounds were completed as required in all areas, and follow-up rounds were conducted to monitor specific regulatory survey findings. Action Plan: Update schedule to include Juneau Medical Center.
The hospital manages its environment during demolition, renovation, or new construction to reduce risks.	Met	Continue to incorporate Infection Prevention and Safety Management in Construction Planning.
An annual evaluation of the scope, objectives, key performance indicators, and the effectiveness of the Safety Management plan and programs is conducted.	Met	Completed via this document.

The Environment of Care Committee has evaluated these objectives for the Safety Management Program and determined that they have been met.

PERFORMANCE MEASURES

The following measures provide the Environment of Care Committee with information needed to evaluate performance of the Safety Management Program activities and to identify further opportunities for improvement:

Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
Perform a BRH needs assessment from the Workforce Safety Measures evaluation performed by ASHNA; implement all required/prioritized elements.	Implement 100% of required and prioritized elements	100%	Met Still room to enhance identified elements.
Identify and assess BRH's compliance with AKOSH program requirements (goal outlined in Focus & Execute).	100% AKOSH programs assessed	100%	Met
Increase staff, visitor and patient safety by implementing an after-hours Facility Lockdown Program (goal outlined in Focus & Execute).	100%	100%	Met Project to be completed in house. Committee's new role is to advise priority of rollout and track progress of project.
Develop additional and more specific training to offer staff around De-Escalation/Crisis Intervention/Violence Reduction/Restraints.	100%	100%	Met Efficacy analysis ongoing

EFFECTIVENESS

Effectiveness is based on how well the goals are met and how well the scope of the performance metrics fit current organizational needs. The Safety Management Program has been evaluated by the Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020:

- Reduce Workplace Violence: Combine and enhance all the workplace violence elements.
- Reduce Workforce Injuries: Create reports to review and analyze the following indicators with the intent to identify ways to reduce injuries.
- Safety: Implement a comprehensive working at heights program at BRH, aimed at improving staff safety.

The proposed performance measures for these goals are:

Safety Management Proposed Performance Measures for 2020	Target	Comments & Action Plan
AIM: Combine and enhance all the workplace violence elements (policies, procedures and related training curriculum) into a complete comprehensive program.	Complete 100%	All updates will be reviewed and approved by multi-disciplinary EOC Committee.
AIM: Create reports to review and analyze the following indicators with the intent to identify ways to reduce injuries: <ul style="list-style-type: none">• Number of recordable lost workdays• Injuries by cause• Injuries by body part• Needle sticks and body fluid exposures.	Complete 100%	A multi-disciplinary team will be used including members from Risk Management and Human Resources.
AIM: Implement a comprehensive working at heights program at BRH, aimed at improving staff safety.	Complete 100%	Continue to work with Facilities Management, CBJ Safety and AKOSH Consultation to improve existing plan.

SECURITY MANAGEMENT

SCOPE (No Change)

Bartlett Regional Hospital's Security Management Plan is to provide a program that shall protect employees, patients and visitors from harm, and define the responsibilities, reporting structure and action for maintaining a secure environment. This plan includes all facilities and activities directly related to Bartlett Regional Hospital.

ACCOMPLISHMENTS

- After-hours lockdown project initialized.
- Safety and security taskforce created new anti-violence signs and placed throughout the hospital.
- Class given on the topic of “De-Escalation of Extreme States – Communication with Aggressive, Mentally Ill and Emotionally Disturbed Individuals”.
- Juneau Police Department training for security officers on identification of Drugs and Paraphernalia Identification.



PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
The hospital takes action to minimize or eliminate identified security risks in the physical environment.	Met	BRH Security Supervisor attends daily safety huddles. BRH adjusts security patrols and response procedures as needed. e.g. Second security officer posted on night shifts with a priority to post in the ED. Progress continues towards achieving afterhours lock-down of the facility.
When a security incident occurs, the hospital follows its identified procedures.	Met	Hospital staff follow established protocols for security incidents as outlined in the BRH Emergency Code Directory.
The hospital establishes a process for continually monitoring, internal reporting and proactive risk assessments to identify potential security risks.	Met	Accomplished through reports to the EOC Committee and annual Security Management plan updates. Continue to use the BRH Occurrence Reporting System.

Objectives	Met / Not Met	Comments and Action Plans
The hospital reports and investigates incidents of damage to its property or the property of others.	Met	Reports are reported through the BRH Occurrence Reporting System.
The hospital will utilize a multi-disciplinary safety and security team to review all policies, procedures and operations to identify and respond to hazards that exist currently and plan for future threats.	Met	The Safety and Security Committee meets to discuss violence prevention policies, education and exercises. Threats to public safety will be mitigated by a combination of physical and procedural controls. The Safety and Security Committee discusses potential solutions and makes recommendations to improve the safety and security of patients, visitors and staff.

PERFORMANCE MEASURES

An analysis of the program objectives and performance measures is used to identify opportunities to resolve security issues and evaluate the effectiveness of the program. Additionally, it provided the Environment of Care Committee with information that can be used to adjust the program activities to maintain performance or identify opportunities for improvement.

Security Management Performance Measures	Target	Outcome	Comments and Action Plan
Continue development of 1:1 sitters program to provide relief for Security Officers in the ED. Measure is percent of time Officers are relived.	90%	95%	Met
Staff knowledge of Armed Intruder Procedures. Data collected during departmental swarms.	80%	96%	Met
Swarms completed and logged	100%	73%	Partially Met; committee membership changes drove new direction, this made swarm completion challenging. The committee will evaluate the process to possibly develop an alternative to swarms.

EFFECTIVENESS

Effectiveness is based on how well the goals are met and how well the scope of the performance measures fit current organizational needs. The Security Management Program has been evaluated by the Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

The following goals have been identified:

- **Increase Facility-wide Security Afterhours** – BRH has successfully identified process's and systems needed to better protect the hospital, patients and employees afterhours. The committee will continues assist in the prioritization of needed systems.
- **Improve Customer Satisfaction:** The Security Management Committee will help improve customer satisfaction by working towards decreasing the number of In-patient property loss incidents.
- **Improve the Security Camera System Functionality:** In order to ensure the security of BRH, the Security Camera System must be highly functional and reliable.

The proposed performance measures for these goals are:

Security Management Proposed Performance Measure for 2020	Target
Increase Facility-wide Security Afterhours AIM: BRH will complete prioritized security systems installations over the next year to equate to approximately 55% of the overall project. These installations will be as follows: <ul style="list-style-type: none">• Secure facility to limit after-hours access to the ED• Move Vending Machines• Development of patient visitor policy/procedure• Installation of select internal door security systems	55% of the overall project. = 20% = 10% = 5% = 20%
Improve Customer Satisfaction AIM: BRH will improve customer satisfaction by decreasing the number of in-patient property loss incidents.	BRH will be measured on its ability to prevent in-patient property loss incidents: Decrease incidents by 50% In 2019 there were 16 in-patient property loss incidents.
Improve the Security Camera System Functionality AIM: Assess the existing security camera systems to drive an improvement project recommendation. Steps to complete the assessment include: <ul style="list-style-type: none">• Inventory Systems 10%• Develop Needs Assessment 40%• Compare current capabilities against needs assessment to identify gaps 40%• Present recommendations 10%	The Security Committee will be measured on its ability to achieve the following: 100% Completion

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HAZARDOUS MATERIALS & WASTE MANAGEMENT

SCOPE (No Change)

It is the practice of Bartlett Regional Hospital to comply with all federal and State of Alaska laws and regulations relating to the proper and safe handling and disposal of all hazardous materials and waste. Bartlett Regional Hospital provides comprehensive healthcare and health promotion for the people of Juneau and communities of northern Southeast Alaska.

To this effort Bartlett Regional Hospital provides a healthy and safe environment for our patients, visitors and staff by maintaining a process to effectively manage hazardous materials and waste throughout the facility.

The program also works to control the risk of exposures to hazardous components such as asbestos in existing building materials which may be disturbed during construction and renovation activities.

ACCOMPLISHMENTS

- Hazardous Communication Plan was updated.
- Better communication for follow up with Pharmaceutical waste, by assuring department labeling.
- The subcommittee maintained all policies and procedures as per compliance needs. Subcommittee will update policies and procedures as indicated by Risk or Quality.
- Assured that safety features (eye wash, showers) are maintained per compliance. Assured general knowledge of Haz-Mat concerns are brought to the employees through use of SWARMS.
- Review of all areas to assure they have current Safety Data sheets.



PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments & Action Plan
To assure items in departments have current SDS information in our system, and that staff are able to access the SDS.	Partially Met	Swarm data indicates this objective has been partially met. The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
To assure staff are able to safely identify spill clean-up resources.	Met	Staff were able to describe spill containment locations and competence in their use.

To assure staff understand waste streams: White, Red, Sharps and Liquids.	Met	This objective has been met as demonstrated by staff during swarms and as evidenced by compliance with disposal requirements.
To assure Nursing Departments are familiar with the pharmaceutical waste process.	Partially Met	Nearly all departments have demonstrated competency in this objective. Committee members will continue to work with Department Directors as needed and will continue to monitor compliance through swarms.

The Environment of Care Committee has evaluated the objectives and determined that there are minimal opportunities for improvement. The Program continues to direct hazardous materials and waste management in a positive proactive manner.

PERFORMANCE MEASURES

The following measure provide the Environment of Care Committee with information needed to evaluate performance of the Hazardous Materials and Waste Management Program activities and to identify further opportunities for improvement:

Security Management Performance Measures	Target	Outcome	Comments and Action Plan
Review area for products that need Safety Data Sheets. Ask staff to find one item in the system. Need to assure items are uploaded to MSDS Online. Ask when last time staff had Hazardous Communication training	100%	90.9%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
When would it be necessary to initiate a code "Orange"? Does staff know the difference between incidental vs non-incidental spill? Make sure to clarify this includes fumes as well.	95%	90.6%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
Staff identifies location and knows how to use spill buckets.	85%	90.5%	Met
Does staff know how to dispose of Hazardous materials, batteries, etc? Refer staff to Hazardous Material Disposal policy 8360.304. Note: only week supply of batteries at any time. Batteries should have taped ends	90%	87.7%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.

Eye wash and shower stations are checked weekly (ER, OB, Maintenance, Kitchen, Lab, Histo, Laundry, Pharmacy, Respiratory Therapy, INF, DI, BSSC)	100%	93.1%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
Nursing Departments – verify staff is familiar with the pharmaceutical waste process. Check area for organization	95%	93.6%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
Does staff understand waste streams? White, Red and Sharps will go to local landfill. Liquids must be segregated or poured down drain. Cannot be in Sharps	85%	90.6%	Met

EFFECTIVENESS

Effectiveness is based on how well the scope fits current organizational needs and the degree to which current performance metrics result meet stated performance goals. The Environment of Care Committee has evaluated the Hazardous Materials and Waste Management Program and considers it to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2015-2016

- **(Continued from previous reporting year) Improve employee understanding of current hazardous spill cleaning practices.** During 2020 the committee will work to expand employee knowledge around hazardous spill cleanup.
- **(Continued from previous reporting year) Enhance (chemical) hazard communication at BRH.** During 2020 the committee will work to expand employee knowledge of the content and use of the SDSs and product labels.
- **(Continued from previous reporting year) Enhance waste stream segregation at BRH.** During 2020 the committee will work with departments as needed to assure understanding of waste stream segregation.
- **(Continued from previous reporting year) Assure safety systems are ready if needed.** During 2020 the committee will continue to monitor safety systems such as eye wash stations.

The proposed performance measures for these goals will include:

Hazardous Materials & Waste Management Proposed Performance Measures 2020	Target
<p>AIM: Review area for products that need Safety Data Sheets. Ask staff to find one item in the system. Need to assure items are uploaded to MSDS Online.</p> <p>Ask when last time staff had Hazardous Communication training</p>	<p>100% Same as 2019</p>
<p>AIM: When would it be necessary to initiate a code “Orange”? Does staff know the difference between incidental vs non-incidental spill?</p> <p>Make sure to clarify this includes fumes as well.</p>	<p>95% Same as 2019</p>
<p>AIM: Can staff identify the location and know how to use chemical spill buckets? Ask what could spill which bucket would be used. <u>(MS, CCU, OB, ER, Laundry, Pharmacy, RT, INF, DI, BSSC, OR)</u></p>	<p>90% Adjusted from 2019</p>
<p>AIM: Does staff know how to dispose of Hazardous materials, batteries, etc? Refer staff to Hazardous Material Disposal policy 8360.304.</p> <p>Note: only one week supply of batteries at any time. Batteries should have taped ends.</p>	<p>90% Same as 2019</p>
<p>AIM: Eye wash and shower stations are checked weekly (ER, OB, Maintenance, Kitchen, Lab, Histo, Laundry, Pharmacy, Respiratory Therapy, INF, DI, BSSC)</p>	<p>100% Same as 2019</p>
<p>AIM: Nursing Departments – Verify staff familiar with pharmaceutical waste. Check area for labels on the disposal buckets. Pre-label before putting into use.</p>	<p>95% Same as 2019</p>
<p>AIM: Does staff understand waste streams. White, Red and Sharps will go to local landfill. Liquids must be segregated or poured down drain. Cannot be in Sharps.</p>	<p>90% Adjusted from 2019</p>

LIFE SAFETY MANAGEMENT

SCOPE (No Changes)

To provide an environment of care that is fire-safe and to design processes to prevent fires and protect patients, staff, and visitors in the event of a fire.

To assure that the building is in compliance with applicable Federal, state and local codes and standards, and National Fire Protection Association (NFPA) 101, 2012 standards for hospitals,

To provide education to personnel on the elements of the Life Safety Management Program including organizational protocols for response to, and evacuation in the event of a fire,

To assure that personnel training in the Life Safety Management Program is effective,

To test and maintain the fire alarm and detection systems,

To institute interim life safety measures during construction or fire alarm or detection systems failures.

ACCOMPLISHMENTS

- Completed annual test, inspection, and repairs to fire alarm system per NFPA standards.
- Assessed risk and implemented Interim Life Safety Measures (ILSM) for the BOPS temporary location in the Juneau Medical Center, and implemented a multi-day fire watch for RRC while the fire alarm system was being upgraded.
- Obtained funding to design and replace the JMC Fire Alarm system.
- Began integration of current campus-wide fire alarm systems to SARA (Situational Awareness Response Assistant).



PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Notes/Action Plan(s)
The Life Safety Management Plan defines the hospital's method of protecting patients, visitors, and staff from the hazards of fire, smoke, and other products of combustion and is reviewed and evaluated at least annually.	Met	At a minimum, annually review the BRH Fire Plan.
The fire detection and response systems are tested as scheduled.	Met	The Fire Alarm system serving BRH is routinely tested and repaired as necessary.
Summaries of identified problems with fire detection, NFPA code compliance, fire response plans, drills and operations in aggregate, are reported to the EOC Committee.	Met	Any problems or deficiencies of the fire alarm system are reported to the Environment of Care (EOC) Committee.
Fire extinguishers are inspected monthly, and maintained annually, are placed in visible, intuitive locations, and are selected based on the hazards of the area in which they are installed.	Met	Fire extinguishers are inspected regularly, and as required. All extinguishers are appropriate to their use and location.
Annual evaluations are conducted of the scope and objectives of this plan, the effectiveness of the programs defined, and the performance measures.	Met	Items monitored in the annual report and fire drills are assessed for effectiveness and improvement.

PERFORMANCE MEASURES

Life Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
Finalize, and use Life Safety work order report for better tracking and evaluation of Life Safety priorities.	100%	50%	Partially Met; the committee will continue to work closely with the Maintenance Supervisor to finalize the report layout.
Incorporate tracking and monitoring of regulated inspection and testing schedules for Life Safety systems/elements of the hospital into the agenda of the committee.	100%	95%	Partially Met; continue to refine the requirements with the assistance of the Joint Commission Survey Coordinator.
Replace all 50 year old sprinkler heads in the facility.	100%	100%	Met

EFFECTIVENESS

The multi-disciplinary Environment of Care Committee has evaluated the Life Safety Management Program and considers it to be effective based on the objectives and performance metrics indicated in the Plan.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

- Establish and incorporate Fire Response Plans for RRC/BOPS new locations.
- Monitor ILSM for on-going construction projects within.
- Monitor the replacement of the JMC fire alarm system to assure timely completion.
- Update Life Safety Swarms process and complete for all units/departments
- Finalize Life Safety work order report for better tracking and evaluation of Life Safety priorities.

The proposed performance metrics for these goals include:

Life Safety Proposed Performance Measures for 2020:	Target	Comments and Action Plan
AIM: Establish and incorporate Fire Response Plans for RRC/BOPS new location.	100%	Develop and implement staff trainings on revised fire response plans.
AIM: Update Life Safety Swarms process and complete for all units/departments.	100%	Review and revise swarm questions and continue to monitor outcomes from swarms for each department.

UTILITY SYSTEMS MANAGEMENT

SCOPE (No Changes)

The Utility Systems Management Plan monitors and evaluates the utility systems in use at Bartlett Regional Hospital. A safe, comfortable patient care and treatment environment shall be provided by managing the risks associated with safe operation and the functional reliability of the hospital's utility systems. The major utility systems include but are not limited to: electrical distribution, water and waste systems, vertical transportation (elevators), communication systems, heating, ventilation and air conditioning (HVAC) and medical gases.

ACCOMPLISHMENTS

- Removal of an old domestic hot water distribution manifold that had been abandoned in place.
- Replacement of domestic hot water recirculation piping, section by section, that have developed pinhole leaks. This will be an ongoing project due to the extent of the failure. We have replaced and repaired many other leaking pipe fittings
- Updating the lighting system with modern LED bulbs and fixtures. Areas still needing fluorescent T-12 bulbs removed are the three OR's, Laboratory and parts of the kitchen. Other fluorescent and high pressure lighting has been and will continue to be replaced as specific areas are identified.
- The hospital steam boiler fuel system has had major components replaced. The underground fuel tank dip port was updated. Both fuel feed pumps were replaced. Some plumbing was rerouted in an attempt to receive better draft of fuel from the tank. Replaced a defective fuel tank monitoring system for the purpose of watching the fuel level, bottom tank water level, and tank interstitial spaces.
- Installed a new steam boiler control system. The new Cleaver Brooks "Hawk 4000" is a PLC-based, complete control package for systems that require precise fuel-to-air ratio control with options for O2 trim and variable-speed drive controls in one integrated package. Advanced features include economizer control and draft control. It is anticipated that there will be a significant return on our investment.
- The main emergency generator control panel has been moved to a lower elevation into an adjacent room behind closed doors. This was a move to position the operator into an area where the sound dB level is within OSHA standards. The move has also allowed the operator to not stand on a ladder while recording meter readings during operation.
- Installation of energy efficient computer access layer switches around the hospital is now complete. They require less power consumption and the demand for facility cooling is also decreased.
- Deploying ultra-small-form-factor Personal Computers, PCs, with LED monitors requiring 40% less power consumption.
- We have been able to remove all battery operated exit lights within the hospital and replace them with lights that do not have batteries. Batteries are not required in these units because



they are energized by the electrical Critical Branch powered by the emergency generator.

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
The hospital minimizes the occurrence of unplanned utility systems failures or interruptions.	Met	Inventory of equipment for major utility systems maintained in equipment database including PM documentation.
The hospital provides preventative maintenance of the utility systems ensuring reliability.	Met	Documentation of activities is entered into TMS, the automated work order system.
The hospital monitors and investigates all utility system problems, failures or user errors to learn from each occurrence in order to minimize reoccurrence of failures or errors.	Met	Documentation of activities is entered into TMS, the automated work order system.
The hospital reduces the potential for organizational-acquired illness.	Met	This is assured through preventive maintenance and annual quality assurance check of ventilation system pressure relationships and air exchange rates.

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Program continues to direct utilities management in a proactive manner.

PERFORMANCE MEASURES

Utilities Management Performance Measures	Target	Outcome	Comments and Action Plan
Review and rewrite preventative maintenance procedures.	33%	30%	Partially Met; This will be a multi-year project to review and rewrite all procedure. (This year's goal was not met for lack of manpower to perform the work.)
Create and maintain an inventory control program in TMS for the Maintenance Department.	30%	25%	Partially Met; This will be a multi-year project to review and rewrite all inventories.

EFFECTIVENESS

The Utility Management Program has been evaluated by the EOC Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

- Replace (6) UPS units in the network closets with newer models that are more energy efficient.
- Removing (4) large UPS units in the datacenter and replacing with one UPS unit that has N+1 redundancy and is more energy efficient to support new network and server hardware infrastructure.
- (7) racks of computer equipment are being decommissioned and making space for the new VxBlock hardware.
- Replace feed piping to and from the underground fuel tank to bring it into compliance with EPA Standards.
- Replace fan unit AHU 11 which provides air to the Operation Rooms. This fan has failed many times in the past few years causing the OR surgical schedules to be canceled.
- Install a glycol heat exchanger on AHU 1 to prevent the freezing of the heating coil at cold temperatures. This is the oldest air handling unit in the hospital that services the Medical Surgical section of the hospital.
- Replace a closed-loop water chiller that has reached its end of life. It needs major components replaced and it is more cost effective to replace the unit rather than fix the failing or failed parts.
- Replace glycol feeder tank in Z1 that has come to end of life and needs to be replaced because of rust in the tank and old feed motor technology. This services the heat recovery system on Supply Fan 1.
- Design and install a workable ventilation system that services the Laboratory. This department is extremely hot in the summer and spaces exceed environmental limits for many of the reagents stored and used in the unit. This problem is closely related to the ventilation of the boiler room. The boiler room has historically been excessively hot and the Lab is located directly above

The proposed performance measures for the plan objectives include:

Utilities Management Proposed Performance Measures 2020	Target	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures.	50%	The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components and utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations. This will be a multi-year project.

AIM: Create and maintain an inventory control program in TMS for the Maintenance Department.	50%	Reducing the load of unused and outdated stock to help assure the maintenance of adequate stock for perform of necessary tasks. This will be a multi-year project to clean out old stock.
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MEDICAL EQUIPMENT MANAGEMENT

SCOPE

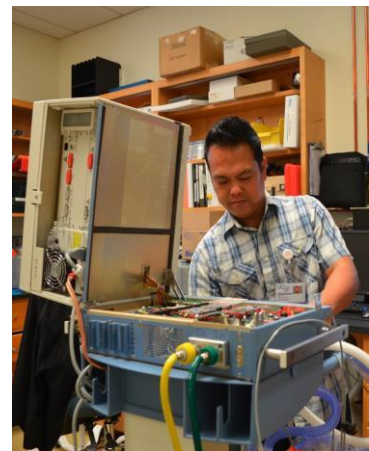
The Medical Equipment Management Plan is designed to define the processes by which Bartlett Regional Hospital provides for the safe and proper use of medical equipment used in the patient care setting.

The physical and clinical risks of all equipment used in the diagnosis, treatment, monitoring and care of patients will be assessed and controlled.

ACCOMPLISHMENTS

Program activities highlights for 2019 include:

- Approval for new anesthesia machines in the Operating Rooms.
- Placed into service, 100 new IV (Intravenous) pumps and poles. Training was performed for hospital staff on proper use of IV pumps.
- Placed into service 15 new PCA's (Patient-Controlled Analgesia) units for pain control.
- Received new ultrasound units for the CCU (Critical Care Unit) and OB (Obstetrics).
- Calibration of all Biomed Test Equipment.



PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Comments and Action Plan
The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory.	Met	Inventory is kept in the Computerized Maintenance Management System Database (TMS), categorized by risk level and associated with all related historical records.
The hospital identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current hospital experience.	Met	As evident in TMS software
Annual evaluations are conducted of the scope, objectives of this plan, the effectiveness of the programs defined, and the performance monitors	Met	The Environment of Care Committee reviews and approves the annual plan.

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Medical Equipment Management Program continues to direct medical equipment procurement and maintenance in a proactive manner.

PERFORMANCE MEASURES

Equipment Management Performance Measures	Target	Outcome	Comments and Action Plan
Reduce the average level of “unable to locate for PM” items to below 5% per month.	80%	95%	Met ; This goal was met by removing equipment from PM inventory list that had not been found in many years.
Maintain semi-annual PM completion rate for life support equipment of 100%.	100%	100%	Met

Have all biomed personnel achieve at least two certifications within the next 12 months. Promoting a centralized system for receiving, assigning, monitoring end of life of medical unit and disposal of equipment.

EFFECTIVENESS

The Medical Equipment Management Program has been evaluated by the multi-disciplinary Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT FOR 2020

- Lead Biomed would like to take classes for the repair of the Drager Apollo Anesthesia Machine.
- Need to check Vents and Gas Analyzers from Respiratory Department. They need to be sent to Germany for service.
- Needing a larger Biomed shop.
- Needing a centralized system for receiving, assigning, monitoring end of life of medical unit and disposal of equipment
- Pharmacy needs to purchase new Vaporizers.

The proposed performance measures for 2020 are:

Medical Equipment Management Proposed Performance Measures	Target	Comments & Action Plan
AIM: To promote proactive equipment replacement. Medical equipment needs to be managed within a unified system. We propose to identify the unified system by February 2020	100%	Researching the market for capable systems that match the Biomedical department tasks and performance metrics, and develop a proposed solution.

<p>AIM: Within the new system we propose to capture all new equipment at time of implementation and enter 100 pieces of existing equipment into the account by August 2020. The system should record the purchasing and receiving dates, implementation and assignment of equipment, monitor and document end of life and disposal of each piece of medical equipment.</p>	<p>100%</p>	

EMERGENCY MANAGEMENT

SCOPE (No Changes)

Bartlett Regional Hospital's Emergency Management Program is designed to assist the hospital in preparing for emergencies and disasters so the hospital experiences the least amount of damage to human lives and property, and maximizes the continuity of services. This effort is led by a multi-disciplinary team of staff through the Emergency Management Committee.

Emergency management is the art and science of managing complex systems and multi-disciplinary personnel to address events across "all-hazards," and through the phases of mitigation (including prevention), preparedness, response and recovery. This Emergency Management Program utilizes best practices to ensure the Program's activities are executed properly and consistent with other responding and receiving organizations.

The program considers a full range of risks that could potentially impact Bartlett Regional Hospital either directly or indirectly. The program and its efforts are designed to reduce risk to the organization's stakeholders, property and operations. This mission is fulfilled through an ongoing process of assessing threats, mitigating risk and reducing vulnerabilities, planning and policy development, capability and resource building and acquisition, training and practical application through drills and exercises.

The Emergency Management Plan and the Emergency Operations Plan apply to all members of hospital administration and staff, in all departments. In addition, this plan applies to all non-staff members who, in the course of their duties, find themselves performing work activities on hospital property, including (but not limited to) clinical providers, technicians, contractors, students, hospital ancillary staff, volunteers, and traveling or rotating personnel from other institutions.

ACCOMPLISHMENTS

- 10/16/19 three members (Charlee Gribbon, Megan Taylor and Mike Lopez) of the Hospital Emergency Management team attended Texas A&M Engineering Extensive service (TEEX) "Personal Protective measures for Biological events".
- 7/10/19 Emergency Management Team member (Megan Taylor) sent to Sitka and attend the Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure.
- EMT member Charlee Gribbon attended the "Communicable Disease Response Maritime Table Top Exercise Planning Meeting".
- Continued providing Hospital Incident Command System Basics training for BRH managers and supervisors.
- Hospital staff members attended Alaska Department of Health and Social Services, Section of Emergency Programs, 2019 Hale Borealis Forum.
- Hospital participated with the Juneau Airport Emergency plan activation with casualties transported to the Hospital.
- Conducted Closed Point of Distribution (POD) exercise. Surpassing last year's total of shots given.



PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Comments and Action Plans
The hospital conducts an annual hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the potential impact and consequences of those events. The HVA is updated when significant changes occur in the hospital's services, infrastructure, or environment.	Met	Updated and shared with CBJ.
The hospital develops and maintains a written all-hazards Emergency Operations Plan that describes the response procedures to follow when emergencies occur. The plan and associated tools facilitate management of the following critical functions to ensure effective response regardless of the cause or nature of an emergency: <ul style="list-style-type: none"> • Communications • Resources and Assets • Safety and Security • Staff Responsibilities and Support • Utilities and Critical Systems • Patient Clinical and Support Activities 	Met	Improved, tested, and revised PAS activation steps of the Emergency Operations Plan.
The hospital implements its Emergency Operations Plan when an actual emergency occurs.	Met	11/5/19 - Hospital responded to an internal disaster, Sprinkler system discharged on the first floor due to vandalism. 11/11/19 Network issues, creating downtime plan activation.
BRH's emergency response plan and incident command system facilitate an effective and scalable response to a wide variety of emergencies and are integrated into and consistent with the Department of Public Health Disaster Plan and the City and Borough of Juneau Emergency Operations Plan, and are compliant with the National Incident Management System (NIMS).	Met	Demonstrated plan effectiveness and scalability during the 7/20/19 Juneau Airport Emergency Exercise with casualties transported to the Hospital and on a smaller scale the 11/11/19 Network issues, creating downtime plan activation.
The hospital trains staff for their assigned emergency response roles.	Met	<ul style="list-style-type: none"> • New Employee Orientation • HICS Section training conducted for ICS sections. • ICS 300 and 400 Training
The hospital conducts exercises and reviews its response to actual emergencies to assess the appropriateness, adequacy and effectiveness of the Emergency Operations Plan, as well as staff knowledge and team performance.	Met	Completed After Action Reports and performance evaluations for two actual emergencies and two multi-functional exercises.

Annual evaluations are conducted on the scope, and objectives of this plan, the effectiveness of the program, and key performance indicators.	Met	Annual Evaluation by the Emergency Management Committee completed on 11/06/19.
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The Emergency Management Team and the Environment of Care Committee have evaluated these objectives and determined that they have been met. The program continues to direct emergency management preparedness and response in a positive and proactive manner.

PERFORMANCE MEASURES

Performance Measures	2019 Goal	2019 Results	Comments & Action Plan
AIM: Measure Performance During Rounding. Minimum of 2 rounds per year in Patient Care Areas and one per year in Non-patient areas to demonstrates operational ability of the Emergency Management Plan by measuring the percent of general staff able to verbalize knowledge and duties related to activities required of them in a disaster	95%	90%	Partially Met. Continuing focus on department specific HICS trainings for staff. Primary issues are understanding the difference between department specific and hospital wide roles. Continue to monitor and assist Department Director with developing more clear Department Specific Plans to ensure critical actions are completed.

EFFECTIVENESS

The Emergency Management program has been evaluated and is considered to be effective by both the Emergency Management Committee and the Environment of Care Committee. The program continues to direct and promote emergency and disaster preparedness and response capabilities in a proactive manner.



GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

- Continue providing training on the Hospital Incident Command System (HICS) for all Incident Management Team members, department supervisors and management level staff.
- Improve overall documentation of incident and completion of HICS Job Action Sheets and appropriate HICS forms.

The proposed performance metrics for these goals include:

Emergency Management Proposed Performance Measures for 2020	Target	Comments & Action Plan
AIM: Staff Will Be able to verbalize knowledge and duties related to activities required of them in a disaster. This measure demonstrates operational ability of the Emergency Management Plan.	95%	Continued from Prior Year due to Staff Turnover. Continue to monitor and assist Department Director with developing more clear Department Specific Plans to ensure critical actions are completed.
AIM: Management Staff (that are integral to the Incident Command structure) Will Be able to verbalize knowledge and duties related to activities required of them in a disaster. This measure demonstrates operational ability of the Emergency Management Plan.	95%	Implementation of new forms, repeated prompts during drills and activations, and new required check-out procedures should help to ensure more thorough completion of documentation.

PATIENT SAFETY and QUALITY IMPROVEMENT PLAN

CY 2020



Issued: August 2010
Revised: December 2019

Submitted by: Sarah Hargrave, MS, RN, CPHQ

Purpose

The purpose of the Patient Safety and Quality Improvement (PSQI) Plan for Bartlett Regional Hospital (BRH) is to describe how the organization monitors the care provided to our patients to assure that the BRH mission is fulfilled and to describe the components of the Quality Program.

Mission of Bartlett Regional Hospital: To provide the community with quality, patient-centered care in a sustainable manner.

The PSQI Plan is established by the hospital and is supported and approved by the governing body, which has the responsibility of monitoring all aspects of patient care and services.

The Bartlett Regional Hospital Quality Program provides for the development, implementation, and maintenance of an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The program reflects the complexity of the hospital's organization and services; involves all hospital departments and services, (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

Quality Framework

The primary goals of the plan are to continually and systematically plan, design, measure, assess, and improve performance of critical focus areas, improve healthcare outcomes, reduce and prevent medical / health care errors. The BRH PSQI Plan uses the Institute of Medicine (IOM) framework to describe overarching aims of a quality health care system. The IOM identifies the following as key characteristics:

- Safe: Avoiding harm to patients from the care that is intended to help them
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- Patient-Centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waste and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

To achieve these aims, the Quality Program works to:

- Establish and maintain a culture of patient safety to prevent inadvertent harm to patients. This culture focuses on safety where we openly report mistakes and take action to make improvements in our processes.
- Assure mechanisms are in place for staff and providers to provide safe, quality clinical services and demonstrate improvement in patient outcomes.
- Assess performance with objective and relevant measures to achieve quality improvement goals in an organization-wide, systematic approach in collaboration with patients and families.
- Continually assess and assure compliance with regulatory and accrediting bodies, including the CMS Conditions of Participation, The Joint Commission, and other regulatory bodies.
- Promote systems thinking and effective teamwork in care design and delivery.
- Monitor patient satisfaction, and support providers, staff, and departments to focus on areas where the patient experience may be improved.

- Optimize allocation of resources to reduce waste and ensure the delivery of safe, efficient, equitable, and effective care.
- Partner with colleagues, providers, staff, programs and services to help create and maintain a work environment that is safe, purposeful, meaningful and where we can take joy in our work.
- Annually evaluate the objectives, scope, and organization of the improvement program; evaluate mechanisms for reviewing monitoring, assessment, and problem-solving activities in the performance improvement program; and take steps to improve the program.

Authority and Scope

The Board of Directors of Bartlett Regional Hospital is ultimately responsible for the quality of care provided by the hospital. The Board of Directors provides that an ongoing, comprehensive and objective mechanism is in place to assess and improve the quality of patient care, to identify and resolve documented or potential problems and to identify further opportunities to improve patient care. The Board reviews the quality of patient care services provided by medical, professional, and support staff. The Board of Directors delegates operational authority and responsibility for performance improvement to the Chief Executive Officer and the Chief of the Medical Staff.

The Medical Staff, through its by-laws, rules and regulations, service lines, and committees, measures patient care processes, and assesses and evaluates quality and appropriateness, and is thus able to render judgments regarding the competence of individual practitioners. Coordination of these activities occurs through the Medical Staff Executive Committee and the Chief of the Medical Staff.

Organizational performance improvement is a hospital-wide activity under the direction of hospital leadership, and in collaboration with medical staff. Everyone at Bartlett Regional Hospital is responsible to improve the quality of care provided. It is the responsibility of hospital leadership to establish a culture of quality and assure performance improvement activities are given a high priority among department activities.

The scope of the Quality Program is broad to include any strategic or operational priorities, and all organizational departments and units that impact the aim of the IOM framework described earlier. Quality and safety activities are addressed throughout the organization and reported through the Hospital Performance Improvement Committee, which then reports to the Board of Directors.

The review and improvement of the Environment of Care (EOC) is under the direction of the Environment of Care Committee, which meets regularly and facilitates timely corrective action as environmental safety issues are identified. The EOC Team routinely reviews activities related to all seven Management Plans for the Environment of Care.

Structure and Reporting

The Board of Directors has established a Quality Committee to communicate information to the Board of Directors concerning the hospital quality program and the mechanisms for monitoring and evaluating quality, identifying and resolving problems, and identifying opportunities to improve patient care.

The Quality Program operations are carried out by the organization's administration, medical staff, clinical, and organizational support services. The Medical Staff Executive Committee and the Hospital Performance Improvement Committee provide the oversight responsibility for performance improvement activity monitoring, assessment and evaluation of patient care services provided throughout the organization. The Senior Director of Quality is responsible for the day-to-day operations of the Quality Program, and reports directly to the Chief Executive Officer.

Components of the Program:

While having influence and supporting organizational quality across the hospital, the Quality Program is made up of a variety of components that broadly include: Core Measure monitoring, abstraction, and data submission; Patient Satisfaction, Accreditation (both Joint Commission and CMS); Risk Management; Patient Safety; Infection Prevention and Control; Complaint Management; and, Medical Staff Quality.

The medical staff monitors, assesses, and evaluates the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges through the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important issues in patient care or safety are identified and resolved.

Medical Staff Service Line committees' roles and responsibilities as they relate to PI include: reviewing and analyzing data, making recommendations, taking actions where necessary and reporting to Medical Staff Executive Committee and the General Medical Staff through Committee chairs.

- At routine meetings of the medical staff or among its various committees, these quality of services will be reviewed, assessed and evaluated:
 - Operative / Invasive Procedure Monitoring
 - Medication Management
 - Information Management Function
 - Blood and Blood Product Use
 - Pharmacy and Therapeutics Function
 - Mortality Review
 - Risk Management
 - Infection Control
 - Utilization Management
 - Other processes as determined by the individual committee
 - Patient care and quality control activities in all clinical areas are monitored, assessed, and evaluated
 - Assessment of the performance of the patient care and organizational functions are included.
- As necessary, relevant findings from performance improvement activities performed are considered part of:
 - Reappraisal / reappointment of medical staff members, and
 - The renewal or revision of the clinical privileges.

The Hospital Performance Improvement Committee is an administrative committee responsible for identifying and reporting on performance improvement issues that affect patient care and services.

The purpose of the Hospital Performance Improvement Committee is to identify and prioritize performance improvement issues within each Department, encourage accountability, and review the effectiveness of performance improvement activities. Departments are responsible for conducting continuous quality improvement on services and care delivery.

Reporting:

The results of the department-level initiatives are reported to the Hospital Performance Improvement Committee on a regular schedule.

Data related to Patient Safety issues including (but not limited to) medication incidents are reviewed at the Hospital Performance Improvement Committee.

Functions involving both the Medical Staff and the hospital are addressed through a joint effort directed and organized by the Medical Staff leadership and the relevant hospital committees and/or administrative leadership. In these cases, reporting of results will be routed both through the relevant Medical Staff committee, and hospital committee or leadership team.

Relevant quality-related results of Medical Staff committees are reported to the Medical Executive Committee and General Medical Staff Body.

Patient Safety

The Patient Safety Program is designed to improve patient safety, reduce risk, and respect the dignity of those we serve by promoting a safe environment.

A culture of safety is a core value for the organization. Safety is led from the top. In an organization with a refined culture of patient safety, events are reported, safety is transparent and safety events are disclosed. Hospital leaders work to ensure the following characteristics exist in the organization:

- Everyone is empowered and expected to stop and question when things don't seem right
- Everyone is constantly aware of the risks inherent in what the organization does
- Learning and continuous improvement are true values. There is non-punitive response, feedback, and communication about errors.
- Effective teamwork is a requirement, and leadership provides mechanisms for staff to improve the functioning of teams.
- Removing intimidating behavior that might prevent safe behaviors
- Resources and training are provided to take on improvement initiatives

The scope of patient safety includes adverse medical / health care events involving patient populations of all ages, visitors, hospital / medical staff, students and volunteers. Aggregate data from internal (IT data collection, occurrence reports, questionnaires / surveys, clinical quality measure reports, etc.) and external resources (Sentinel Event Alerts, evidence-based medicine, etc.) are used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The severity categories for medical / health care events include:

- No Harm – an act, either of omission or commission, either intended or unintended, or an act that does not adversely affect patients
- Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome
- Hazardous (Latent) Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Root Cause Analysis or Focused Review – Structured and systematic process for evaluating the steps, systems, and processes that led up to a Significant or Sentinel event, with an eye toward identifying root and proximal causes that are within the organization's control operationally or financially
- Significant Event – an unexpected occurrence of substantial adverse impact to patient safety or to organizational integrity that does not meet the definitions of "Sentinel Event" but that warrants intensive root cause analysis; or any process variation for which a recurrence carries a significant chance of a serious adverse outcome
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of life, limb, or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a

significant chance of a serious adverse outcome resulting in the former. Additionally, any event otherwise defined by the Joint Commission as “reviewable / reportable,” which may change from time to time.

The responsibilities of the Director of Quality include oversight of the Patient Safety Officer and compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of this plan, and acceptance of accountability for measurably improving safety and reducing errors. Tasks include, but are not limited to:

1. Discussion with the patient/family/caregivers regarding adverse outcomes:
 - a. Sentinel Events impacting the patient’s clinical condition – The Patient Safety Officer or the Director of Quality notifies the care-giving physician about informing the patient / family / caregivers in a timely fashion (within 48-72 hours). Should the care-giving physician refuse or decline communication with the patient / family / caregivers, the Chief of Staff is notified by the Patient Safety Officer or the Director of Quality.
 - b. Events not impacting the patient clinical condition, but causing a delay or inconvenience – The Director of Quality or the Administrator On-Call determine the need for communication with the patient / family / caregiver in the interest of patient satisfaction.
2. Response to actual or potential patient safety risks is through a collaborative effort of multiple disciplines. This is accomplished by:
 - a. Reporting of potential or actual occurrences through the Occurrence Reporting system by any employee.
 - b. Communication between the Patient Safety Officer and the Facility Safety Officer (FSO) to assure a comprehensive knowledge of not only clinical, but also environmental, factors involved in providing an overall safe environment. Communication and consultation occurs with the City and Borough of Juneau’s safety team for all environmental related issues.
 - c. Reporting of patient safety and operational safety measurements / activity to the performance improvement oversight group, the hospital Performance Improvement Committee.
3. The mechanism for identification and reporting a Sentinel Event / other medical error is indicated in policies, (*Sentinel Event Policy* and *Occurrence Reporting Policy*). A root cause analysis of processes, conducted on either a Sentinel Event or Significant Event, are discussed with the Senior Leadership Team and the Medical Staff Quality Improvement Committee, as appropriate.
4. In support of our core values and belief in the concept that errors occur chiefly due to a breakdown in systems and processes, staff involved in an event with an adverse outcome are supported by:
 - a. A non-punitive approach and without fear of reprisal,
 - b. Resources such as EAP or Union representation, if the need to counsel the staff is required
5. Patient safety measures are a focus of our activities and may include review of adverse drug events, health care acquired infections, “never” events, CMS No Pay events, and other data and incidents. This may be based on information published by TJC Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient / family suggestions / expectations, or process outcomes.
6. Processes are assessed to determine the steps when there is or may be undesirable variation (failure modes). Information from internal or external sources is used to minimize risk to patients affected by the new or redesigned process.
7. Solicitation of input and participation from patients and families in improving patient safety are accomplished by:

- a. Conversations with patients and families from nursing director on administrative rounds
 - b. Comments from Patient Satisfaction surveys, patient feedback forms, telephone or in-person conversations, or letters
 - c. Comments from patient Complaints or Grievances
8. Procedures used in communicating with families the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:
 - a. Patient's Rights statements
 - b. Patient Responsibilities—A list of patient responsibilities are included in the admission information booklet.
 - c. Evaluating informational barriers to effective communication among caregivers.
 9. The following methods are used to maintain and improve staff competences in patient safety science:
 - a. Providing information and orientation to reporting mechanisms to new staff in orientation training.
 - b. Providing on-going training to staff on patient safety initiatives and methods as applicable.
 - c. Evaluating staff's willingness to report medical errors through the AHRQ Culture of Patient Safety Survey.
 10. Data Analysis:
 - a. The hospital routinely analyses data to proactively identify quality and patient safety risks, and uses data analyses to develop and monitor responses.

Performance Improvement Methodology

The Bartlett Microsystems methodology is used to drive continuous performance improvement of systems and processes related to patient care, patient safety, and workflow efficiency throughout the organization. An accelerated approach may be used for improvement that has been identified through data-driven reports such as patient satisfaction surveys, improvement that may not require a multi-disciplinary approach, single-process improvement issues or goals, or where sufficient information is available to identify the improvements needed.

Quality improvement priorities are those areas and issues that are high risk, high volume, or problem prone areas. The following are routinely considered when selecting quality improvement initiatives: Incidence, prevalence, severity of problems; effect on health outcomes, patient safety and quality of care.

The Bartlett Microsystems methodology is a structured and systematic improvement process that includes:

1. **See:** Identifying opportunities for improvement
2. **Source:** Finding root causes of variation
3. **Solve:** Using manageable steps to get improvement ideas
4. **Sample:** Developing and testing changes
5. **Sustain:** Monitoring changes so improvements stick

Data Collection and Analysis

The data analysis program will include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes.

BRH measures, analyzes, and tracks quality indicators and other aspects of performance that assess processes of care, hospital service and operations. The data analysis in the Quality program incorporates quality indicator data including patient care data, and other relevant data. The hospital uses the data collected to

monitor the effectiveness and safety of services and quality of care. The frequency and detail of data collection is specified by the hospital's governing body.

Performance measures for processes that are known to jeopardize the safety of patients or associated with sentinel events are routinely monitored. At a minimum, performance is monitored related to the following processes:

- Management of hazardous conditions
- Medication management
- Complications of operative and other invasive procedures
- Blood and blood product documentation
- Restraint use
- Outcomes related to resuscitation
- National Patient Safety Goals
- Organ procurement effectiveness: conversion rate data is collected and analyzed and when reasonable, steps are taken to improve the rate.
- Core Measures
- Healthcare Acquired Conditions

Other sources of data include (but are not limited to) the following:

- Indicators and screens including functions and services, which may be departmental, inter-departmental, Medical Staff related, or hospital-wide.
- Occurrence reports and risk management events
- Patient/customer complaint and grievance data
- Patient/customer, employee, and Medical Staff satisfaction data
- Resource utilization data
- National benchmark data

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by the medical staff service line or clinical committees, are reported to the Hospital Performance Improvement Committee or Medical Staff Quality Improvement Committee (MSQIC) on an annual or other basis as designated.

Strategic Quality Objectives

Please see Appendix A for the evaluation of the prior year plan, and the current year's objectives and measures.

Annual Evaluation

The organizational performance improvement program is evaluated for effectiveness at least annually and revised as necessary. This is to assure the appropriate approach to planning processes of improvement, setting priorities for improvement, assessing performance systematically, implementing improvement activities on the basis of assessment, and maintaining achieved improvements.

Confidentiality

All information related to performance improvement activities performed by the medical staff or hospital personnel in accordance with this plan is confidential per AS 18.23.030, AS 18.23.070(5), and 42 USC 11101 60.10 (HCQIA).

Confidential information may include (but is not limited to): medical staff committee meetings, dashboards, hospital committee minutes, electronic data gathering and reporting, occurrence reporting, and clinician scorecards.

Approval

The Performance Improvement Plan is approved by the Chief Executive Officer, Medical Staff Executive Committee, and the Board of Directors annually.

Chief Executive Officer

Date

Chief of Medical Staff

Date

Board Chair

Date

Appendix A

Evaluation of 2019 PSQI Plan:

Accomplishments:

- Integration of department quality improvement reports in each board meeting
- Initiation of daily safety huddles
- Ongoing Antimicrobial Stewardship work group
- Successful metrics for Partnership for Patients ASHNA/WSHA collaborative
- Completion of AHRQ Culture of Patient Safety Survey

2019 Goals

Quality Goal	CY 2019 Metric	Outcome
Reduce Healthcare Acquired Infections	Reduce surgical site infection rate to 0.6/100 or less by 12/31/2019. (Source: Infection Preventionist)	Met. As of 11/30/19, the SSI rate for the year has fallen to 0.29/100 cases. Efforts to reduce SSIs included the implementation of a “Nose to Toes” program, increased environmental cleaning, improved antibiotic dosing, staff and physician education, and use of an UV light for disinfection.
Fully implement RCA2 methodology for occurrence reporting system to improve learning and action to improve safety.	Complete at least 5 root cause analyses using RCA2 methodology by 12/31/2019 (Source: Quality Director)	Met. As of 12/10/19, 13 analyses have been completed using the RCA2 methodology. In September the Patient Safety Committee reviewed the prior quarters’ action plans. This feedback loop will continue regularly with the Patient Safety Committee.
Improve Bartlett’s Culture of Patient Safety	Provide Team STEPPS training to 90% of staff by 12/31/19 (Source: Staff Development/ Relias software)	Met. 95% of all staff have completed training.
Demonstrate Antimicrobial Stewardship Leadership within the Juneau community	Maintain overall antimicrobial stewardship rate of 270 or less through 2019 (Source: QBS, Partnership for Patients)	Met. Bartlett has maintained an average of only 173 days of therapy/1,000 patient days, well below the goal of 270 days of therapy/1,000 patient days.
Assess need for PI Methodology and Infrastructure revision.	Initiate training for 50% of managers on PI methods by 12/31/2019. (Source: Quality Director)	Partially met. A general overview of Clinical Microsystems was provided to managers present at the Performance Improvement Committee in May, 2019.
Update Ongoing Professional Practice (OPPE) to include claims-based and patient experience metrics for relevant specialties	Revise Family Practice and Internal Medicine scorecards to include at least 1 claims-based metric and one patient experience metrics by 12/31/2019. (Source: OPAL scorecards through Credentialing Committee of provider types)	Met. Internal medicine and family practice scorecards were updated, reviewed and approved at committees and have begun to be distributed to physicians. In addition, we have metric approvals for surgeons, anesthesiologists, pediatrics, obstetrics, and eICU providers. We are in the final stages of approval for emergency physicians and

		psychiatry.
Improve compliance with Sepsis core measure	Increase annual percentage of compliance to at least 55% by 12/31/2019 (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)	Met. The calendar year average exceeds 56% compliance with the bundle elements. Ongoing efforts by the Sepsis PI team have resulted in additional education, documentation changes, and the implementation of a “Code Sepsis” checklist throughout the hospital. The monthly trendline slope from January to October is 2.15.

Quality Goal	CY 2020 Metric
Demonstrate Antimicrobial Stewardship Leadership within the Juneau community	Maintain overall antimicrobial stewardship rate of 200 days of therapy/1000 patient days or less through 2020 (Source: QBS, Partnership for Patients)
Fully incorporate a cross-sectional Patient Safety Committee to review and assure corrective action plans from RCA2s are met and sustainable.	The Patient Safety Committee will meet at least twice to review RCA2 corrective action plans. (Source: Quality Director)
Improve Bartlett’s Culture of Patient Safety	The Team STEPPS implementation team will implement at least 1 hand-off communication project to address intradepartmental communication. (Source: Staff Development Director)
Improve compliance with Sepsis core measure	Increase annual percentage of compliance to at least 58% by 12/31/2020 (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)
Assure workforce	Hire and onboard Quality Director

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Minutes

Planning Committee

January 17, 2020 – 7:00 a.m.

Bartlett Regional Hospital Classrooms 205A&B

Called to order at 7:00 a.m., by Planning Committee Chair, Marshal Kendziorek

Planning Committee and Board Members: Lance Stevens, Marshal Kendziorek, Kenny Solomon-Gross, Iola Young and Brenda Knapp,

Staff: Chuck Bill, CEO, Kevin Benson, CFO, Rose Lawhorne, CNO, Billy Gardner, COO, Dallas Hargrave, HR Director, Megan Costello, CLO, Bradley Grigg, CBHO and Anita Moffitt, Executive Assistant

Also in attendance: David Sandberg (via video conference) and Corey Wall

Mr. Solomon-Gross made a MOTION to approve the minutes from December 20, 2019. Minutes approved as written.

PUBLIC PARTICIPATION – None

Community Healthcare Needs Assessment: David Sandberg of Cycle of Business (COB) provided an overview of the findings of the Community Health Needs Assessment conducted by COB. Discussion was held about areas serviced by BRH and how they are identified in this report. Resources used to obtain information were from: County Health Rankings, current census data, Community Health needs survey. Mr. Sandberg provided a breakdown of the demographics, the high ratio of health risk factors and the process to develop and distribute the survey to the community. Results of the survey centered on a few key areas: utilization of BRH services, specialty services, mental health care and robotic surgery. Areas that BRH does a good job in as well as areas that could use improvement were identified for both Supportive Services as well as Demographic Services. The top two barriers to using BRH were identified as cost and availability of specialists. Senior Leadership reviewed the results of the survey and identified several areas of concerns to explore. These areas, as well as the physician analysis will be discussed during the strategic planning session. Physician staffing and physician to population ratio was discussed. It was noted that the survey itself is really a wants assessment, not a needs assessment and is meant to be community wide, not just for the hospital. Mr. Solomon-Gross initiated a conversation about the sample size of respondents. Ms. Knapp noted that responses may not be as accurate as we would like due to the wording of some of the questions. Discussion was also held about why people have the perception they do about mental health services available. Mr. Kendziorek noted that this is not a statistical survey, but an indicative one and is very valuable. Final conclusions to the overall survey would need to take into consideration the

fact that the outlying service areas are very different demographically than Juneau. Ms. Costello made a recommendation to eliminate the first section of the report referencing 501 (c) (3) hospitals and their requirements.

Mr. Bill will coordinate a meeting with a representative group of physicians to review the numbers and make some conclusions about specialty groups vs. family practice. Many of our family practice physicians also provide specialty care. The board will need to decide if the family practice driven model is the right model for Juneau or if we need to add more specialists. The provider network assessment will provide additional data to take under consideration during this strategic planning process. Mr. Solomon-Gross suggested including mid-level practitioners when looking at the provider mix.

Project Updates: No questions or comments regarding the project updates included in the packet. Mr. Grigg reported that RRC still on schedule for end of May/mid-June completion. Mr. Bill noted the Crisis Stabilization Unit is still in the design phase. The original estimated cost was \$13 million. By downsizing the overall square footage and changing some of the finishing options, it is now down to about \$10.5 million, with parking.

Campus Plan Update: Corey Wall is here to continue discussions from the December 20th meeting. For planning purposes and to move forward, he is hoping to get approval of the foundational document recommending size increases to certain departments. The next step is to use this information for specific project recommendations and get a little more definition about how those would work and how they would be phased in. A discussion was held about how the Community Health Needs Assessment will integrate with the campus plan. The biggest increase in space is in the services departments. The first floor area where laundry, materials management, cafeteria, etc. are located has not been abated or updated since 1968. Renovating the lab and the first floor at the same time would allow the heat issues in the lab to be resolved and is listed as a priority. A discussion was held about space and wait times for emergency services. It was noted that staffing and functionality are two different things. Other options for meeting emergency service needs during tourist season that do not including increasing space, were discussed.

A discussion was held about a dam failure and an emergency access road. Also discussed was the addition of a south entrance to BRH from Egan Drive via a parking garage. Realistically, this is not an option. There is an active plan to build an emergency access road from Egan Drive should the dam break however, a road should be built before an emergency happens. Mr. Bill reported that he has already discussed this project with CBJ. Money is in the CIP for a study to be conducted.

Barriers preventing campus expansion on the hillside behind the Juneau Medical Center were noted. The possibility of obtaining Wildflower Court and moving them to another location was discussed. Demolishing the Juneau Medical Center building to add a 3 story addition to the north side of the hospital would require finding space for the providers in that building. This addition would provide plenty of space to meet our needs as well as accommodate offices currently in the Juneau Medical Center. An off campus location for some outpatient services was discussed. It would need to be within 250 yards of campus to meet hospital based billing and reimbursement guidelines. There would be a lot of planning and phasing required to demolish the Juneau

Medical Center and renovate the OR. Surgical services renovation options were presented. Food services needs to move due to its prime location in the hospital. Options for an addition to the south addition were presented. This will allow expansion of the lab and address the heat issues. Discussion was held about boiler usage.

Mr. Wall summarized the takeaways from today's meeting: The square footage numbers presented are good to continue with. The priority is still to try to solve the issues of the lab, first floor and the Emergency Department. We are going to remove the south parking option. Building a parking garage on the north side is too expensive so will be dropped way down on the priority list to be considered at some point in the future.

Mr. Bill stated that the board will need to formally accept the Jensen Yorba Wall report at the January or February board meeting. The report will be used at Strategic Planning to help identify priorities and timelines. A more specific plan with narrowed down options would be ideal. Senior Leadership will work on this.

FUTURE AGENDA ITEMS - Continued discussion of the Campus Plan

Next meeting: To be determined

COMMENTS – Mr. Kendziorek thanked Mr. Wall and commended him on the excellent work.

Adjourned - 8:50 a.m.

COMMUNITY HEALTH NEEDS ASSESSMENT

BARTLETT REGIONAL HOSPITAL

2019-2020



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PART A: CHNA

HISTORY OF BARTLETT REGIONAL MEDICAL CENTER COMMUNITY HEALTH NEEDS ASSESSMENTS

The Community Health Needs Assessment became a requirement for 501c3 hospitals with the implementation of the Affordable Care Act beginning in 2012. Under the ACA. It was designed to ensure that tax exempt status was going to hospitals that were actually trying to serve their communities in the best way. Government hospitals like Bartlett Regional Hospital (BRH) were exempt from this requirement, as it was only reserved for 501c3 Hospitals.

Many hospitals that are either for profit or are not a 501(c)(3) organization, have seen the benefits of a CHNA and have chosen to conduct a CHNA in order to better understand and serve their community. Bartlett Regional Hospital (BRH) engaged Cycle of Business to:

- ◆ Complete a Community Health Needs Assessment (CHNA) report
- ◆ Provide Bartlett Regional Hospital with a better understanding of the community they serve
- ◆ Provide information needed for BRH to better understand specific health needs and plan for services that will improve the health of the people they serve
- ◆ Integrate results into the BRH strategic plan ensuring completion of the plan.

THE BRH COMMUNITY HEALTH NEEDS ASSESSMENT:

Bartlett Regional Hospital has always tried to stay abreast of the services needed in their community. They have had a belief that understanding the community and making sure you are staffed to meet the needs of that community will always ensure patient loyalty and the best quality healthcare in the community. As a result, over the years, BRH has looked into

what services people are needing that BRH was not providing. They have analyzed leakage reports and conducted a physician staffing analysis in order to better meet the needs of the community. This year BRH decided to conduct a Community Health Needs Assessment as a final piece to the puzzle. The information derived from all these efforts will be utilized to verify their services meet the needs of the community and they are staffing appropriately so fewer people have to leave the community for their healthcare needs.

SERVICE AREA:

The Primary Service Area for Bartlett Regional Hospital pulls mainly from the residents of the City and Borough of Juneau Alaska. However the Secondary Service Area expands to areas as far north as Skagway and as far south as Wrangle. Because of the remoteness of the cities in Alaska and the difficulty of travel to neighboring cities and hospitals, the people in BRH's Total Service Area have limited access to the hospital.

Community	Zip Code	Population-2015
Douglas, AK	99824	2,111
Angoon, AK	99820	479
Juneau, AK	99801	29,164
Gustavus, AK	99826	442
Haines, AK	99827	2,602
Hoonah, AK	99829	777
Petersburg, AK	99833	3,202
Skagway, AK	99840	986
Wrangell, AK	99929	2,338
Estimated Potential For Total Service Area Population		42,101

The population of the City and Borough of Juneau is 31,754. This population is made up of just 3 zip codes covering the Cities of Juneau, Angoon and Douglas. There are also surrounding areas between these areas that are included in that Primary Service Area. This secondary service area adds an additional 10,347 to the population served to bring the total to 42,101.



Bartlett Regional Hospital Total Service Area

PROCESSES AND METHODOLOGY

Completion of the BRH Community Health Needs Assessment (CHNA) followed an outline designed by the Center for Rural Health at the University of North Dakota for the North Dakota Critical Access Hospitals. The sections of this CHNA generally follow their suggested methodology but were slightly modified to meet the needs of BRH and requirements of their RFP.

Two meetings were held to complete the CHNA. An initial meeting to discuss the survey as well as a follow-up meeting to discuss the results. The survey was conducted in between meetings to gather appropriate data to make final decisions on which health needs were appropriate to address in this fiscal year.

The first meeting was a general review of health information on a Borough level. After that meeting, Bartlett Regional Hospital reviewed and refined an electronic survey that would be distributed throughout the service area and in local businesses. The survey was further revised in conjunction with Cycle of Business and Bartlett Regional Hospital to ensure the questions asked would help Senior Leadership and the Board decide on the best course of action for the Hospital. Before the survey was distributed to the community special care was taken to ensure the verbiage was inclusive.

A second meeting was held with Senior Leadership to review the information from the survey and prioritize the most important health issues that could and should be addressed given the resources of Bartlett Regional Hospital. Key findings from the survey were looked at to see what needed to be addressed by the hospital and what needed to be given priority.

As the survey was reviewed by the Senior Leadership team, areas of focus and clarification were outlined. The Senior Leadership Team wanted to ensure the CHNA was not only dealing with the opinions of the community, they wanted to make sure they had the data to make appropriate decisions. Finally a revised CHNA was prepared and taken to the Board of Directors for their input and approval.

RESOURCES AND SECONDARY INFORMATION:

The CHNA for Bartlett Regional Hospital Utilized Data From:

County Health Rankings. Since it began in 2010, County Health Rankings ranks the health of nearly every county in the nation and is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The program awards grants to local coalitions and partnerships working to improve the health of people in their communities. The information received from this website appears to be from 2016.

Current Census Data. The United States Government conducts a census every few years to gather data on certain demographics in the country. The last census data for Juneau, AK was conducted in 2015.

Survey Conducted Through the Hospital and Community. A survey was designed in conjunction with Cycle of Business and Bartlett Regional Hospital to gather information from the community on the immediate needs of the population.

Broad Interests of the Community Were Considered:

Special care was used to find individuals in the community who could help define the health care needs of the community representing the youth, the elderly, and varied cultures.

The individuals involved in the initial meeting were asked to review the survey and give their input on the needs of the hospital. Additional efforts were made to reach out to the community in general to give input on the survey. A link to the survey was sent out to the major employers in the community. Employers and community members were contacted personally.



Bartlett Regional Hospital has some of the best imaging equipment in the state.

PARAMETERS FOR DATA COLLECTION

COB and BRH used the most recent population and demographic information available to ensure the community needs were being met. This included gathering national statistics of the services area as well as the demographics of the service area. The federal government also tracks certain health statistics across the U.S. by county. This information was compiled to give a good baseline of where certain health needs were being met and areas that needed improvement.

DEMOGRAPHICS:

The demographics for the area were collected through the use of census data and other reports. Unfortunately the latest data was only as recent as the 2015 census. Although exact population and demographic information may vary slightly from that articulated in the CHNA, the outcomes of the CHNA will not be affected by any minor discrepancies.

The population of the Borough of Juneau, AK is estimated for 2015 at approximately 31,754. Due to the fact the additional zip codes from the secondary service area we incorporated into this analysis only make up a small portion of the population served, we will use the demographic data from Juneau to represent the secondary service areas. Therefore, based on what we know from Juneau:

- 67% of the population are between the ages of 18 and 64
- 18% are 60 or older

Age

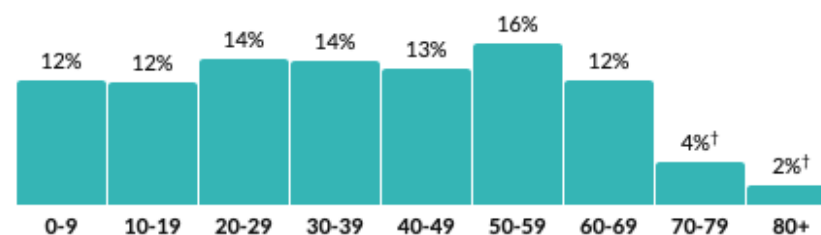
38

Median age

about the same as the figure in the Juneau, AK Micro Area: 38

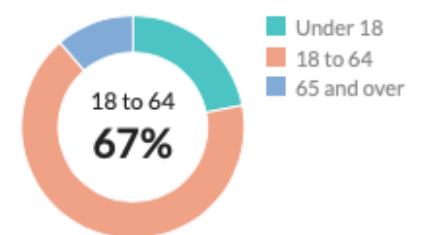
about 10 percent higher than the figure in Alaska: 33.9

Population by age range



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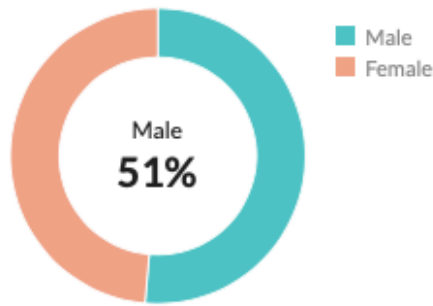
Population by age category



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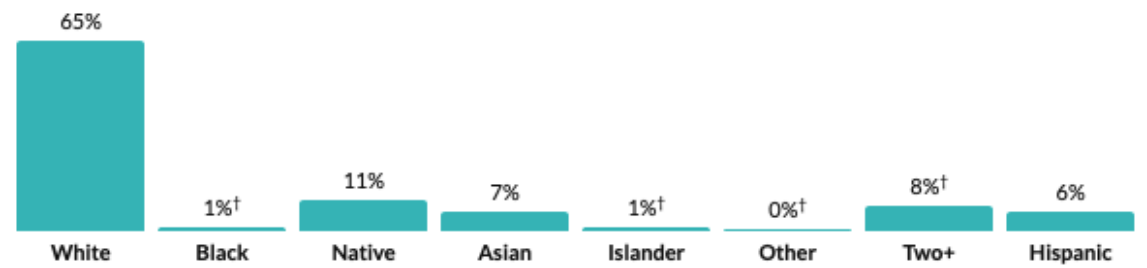
- 49% of the population identify as women
- 65% are white and 11% are Native Alaskan, 7% are Asian, while 6% regard themselves as Hispanic

Sex



[Show data / Embed](#)

Race & Ethnicity



* Hispanic includes respondents of any race. Other categories are non-Hispanic.

[Show data / Embed](#)

- 96% of Juneau residents have graduated from high school compared to the Alaska average of 92.4%.
- 40.3% of Juneau residents have a Bachelor's degree or Higher.
- This is 1.4 times the rate of the rest of Alaska which is only about 29%.

Educational attainment

96%

High school grad or higher

about the same as the rate in the Juneau, AK Micro Area: 96%

a little higher than the rate in Alaska: 92.4%

40.3% ±2.1%

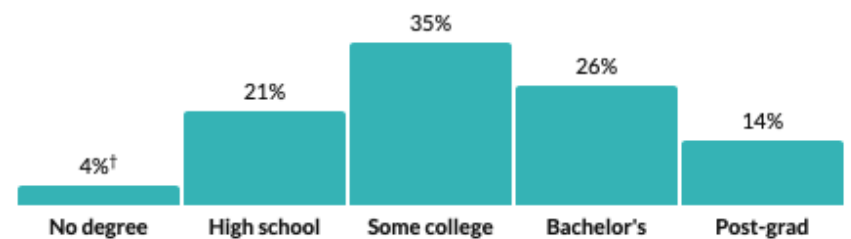
(8,998 ±476)

Bachelor's degree or higher

about the same as the rate in the Juneau, AK Micro Area: 40.3% 8,998 (±2.1% / ±476)

about 1.4 times the rate in Alaska: 29% 137,821 (±0.5% / ±2,424)

Population by minimum level of education

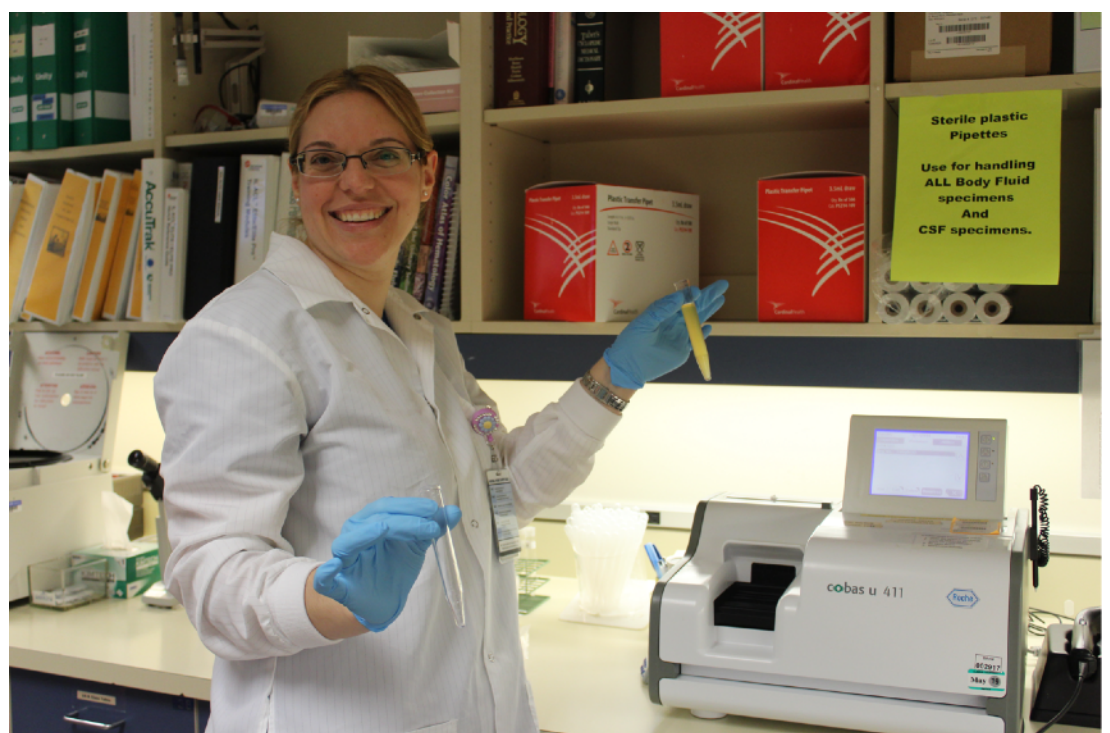


* Universe: Population 25 years and over

[Show data / Embed](#)

"BRH DOES AN OUTSTANDING JOB PROVIDING ESSENTIAL SERVICES TO THE COMMUNITY OF JUNEAU WITH A LIMITED AMOUNT OF FUNDING"

Survey Participant



Bartlett Regional Hospital offers a full range of laboratory services to the community

- The median household income in the Borough of Juneau is \$90,749 with a per capita income of \$41,904.
- 7.4% of the population live in poverty
- 13% of the population of Juneau Borough live without health insurance. This 13% of uninsured people is 3% less than the state of Alaska which is 16%.

Income

\$41,904

Per capita income

about the same as the amount in the Juneau, AK Micro Area: \$41,904

about 20 percent higher than the amount in Alaska: \$35,065

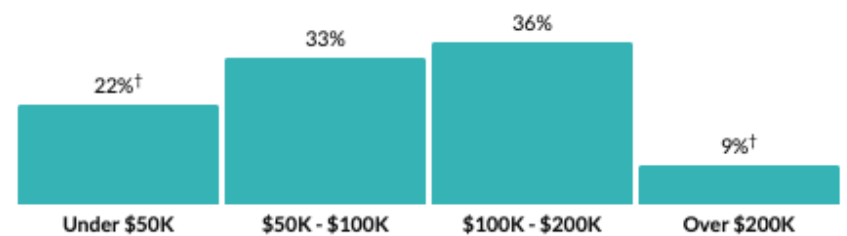
\$90,749

Median household income

about the same as the amount in the Juneau, AK Micro Area: \$90,749

about 20 percent higher than the amount in Alaska: \$76,114

Household income



[Show data / Embed](#)

Poverty

7.4%

Persons below poverty line

about the same as the rate in the Juneau, AK Micro Area: 7.4%†

about three-quarters of the rate in Alaska: 10.2%

Children (Under 18)



■ Poverty
■ Non-poverty

[Show data / Embed](#)

Seniors (65 and over)



■ Poverty
■ Non-poverty

[Show data / Embed](#)

The Borough of Juneau has some areas that are advantageous to the people who live there. 100% of the people report having access to exercise. The 13% of people without insurance is relatively low and they have extremely good ratios of patient to provider for Primary Care, Mental Health, and Dental.

On the other hand Juneau has a fairly high ratio in the following health risk factors:

- Excessive drinking is above top performing counties
- Alcohol impaired driving deaths (Half of all automobile deaths)

According to the County Health Rankings website, in half of all driving accidents where there is at least one fatality, alcohol was a contributing factor.

	Juneau County	Top Performers	Alaska
Adult Smoking	18%	14%	19%
Adult Obesity	29%	26%	30%
Excessive Drinking	22%	13%	19%
Alcohol Impaired Driving Deaths	50%	13%	37%

- STDs including HIV are much higher than we would like to see

	Juneau County	Top Performers	Alaska
HIV per 100,000	69	49	109
Sexually Transmitted Infections per 100,000	494.6	152.8	771.6
Teen Births per 1000	17	14	30

- Drug overdose almost 3 times what we would like to see
- Mammogram Screenings should be higher
- Flu Vaccinations 35% lower than top performers

	Juneau County	Top Performers	Alaska
Life Expectancy	79.5	81	78.5
Premature Death	7,900	5,400	8,200
Mammography Screenings	33%	49%	33%
Flu Vaccinations	34%	52%	32%
Drug Overdose	29	10	18

Premature death is another area of concern. This number is calculated by taking the cumulative number of years people die in the community before reaching their 75th birthday and extrapolating that number for a population of 100,000 residents. For Juneau the equivalent of 7900 years would be lost between the time people die and their 75th birthday if Juneau had a population of 100,000. In the state of Alaska 8,200 years are lost per 100,000, However the CDC would like to see those rates closer to 5,400 per 100,000.

One other point of concern is that drug overdoses in Juneau are almost 3 times the national average and almost 66% more than the State of Alaska. This concerning health factor was supported later with the results of the CHNA survey. Mental and Behavioral Health issues were the most common concern of the respondents in open ended questions.

THE PROCESS

MEETINGS WITH COMMUNITY MEMBERS AND FOCUS GROUPS

Initial meeting:

On October 4 and 5 of 2019 a meeting was held with members of the community who demographically, represented the people of the community. Special care was taken to ensure all people would be represented in the results of the survey. This meant reaching out to large employers as well as special interest groups who would help ensure all demographics were well represented. Discussions took place to review a template of the survey to be distributed, and suggestions were made to ensure the survey would be acceptable to all potential respondents.

The focus group recognized that health care needs may differ between genders, ethnicity, sexual preference and age. The focus group also pointed out that Juneau has a growing LGBTQ+ population and each subset of that group would have unique needs. As a result, the survey was written to be inclusive and ensure that everyone would feel comfortable in responding to the question.

The survey was also written to go beyond the current national data that is readily available. BRH wanted to be able to specifically look at the results needed to meet the service needs of the community. They also wanted to staff the hospital with the appropriate physician mix.



Bartlett Regional Hospital has state of the art 3D Mammogram services

DISTRIBUTION OF SURVEY

After reviewing and revising the CHNA survey, BRH sent a link to the survey out to community members who represented the population at large and specific demographics within the community. The representatives then forwarded that link to their respective communities in order to ensure the population was appropriately represented in the answers of the survey. Additional links to the survey were also placed on the hospital's website and radio interviews were given to make sure the community would

know how to access the survey.

After giving the community 3 weeks to respond to the survey, the responses were gathered and analyzed to be presented to the Senior. Leadership staff.

COMMUNITY ENGAGEMENT

The community was well represented in the initial meeting where the process and a description of their assistance was discussed. Bartlett staff wanted to ensure the broad interests of the community were taken into consideration. The participants gave important insight into what needed to be included in the survey and how to make sure certain specialties were brought to the public to insure what services were most needed.

253 members of the community responded to the survey. Respondents appeared to cover all the demographics of the community. Their feedback covered health needs of the community but also social challenges and suggestions for improving access to care. They were candid in their responses and gave the hospital information that will assist them as they improve on their service to the community. The feedback from this survey will be utilized to develop a strategic plan for the year 2020 and beyond.

THE RESULTS

SURVEY RESULTS

Results of the survey centered around a few key areas.

Utilization: The hospital is currently not being utilized by the community as one would expect. 57% of the respondents said they do not use BRH for their main healthcare. 56% of the respondents had received some of their healthcare from hospitals outside of Juneau in the last 3 years. The reasons for this varied, but dealt mainly with specialties the patient needed. Due to the nature of specialties and what BRH offers, it is possible that some of the respondents could be using BRH for primary care only to be referred outside for specialties that are not available in Juneau.

There were also concerns about insurance coverage as well as the cost to the patient. Alaska has a higher cost of healthcare than other areas in the lower States. This concern showed itself throughout the survey.

Specialties: Recruitment is always difficult in rural hospitals. Due to the remoteness of the area and the limited number of people in the area, it has been difficult to hire and retain specialists. This has made it more important than ever to ensure the specialties provided by a hospital such as Bartlett Regional Hospital are specialties that are supported by the community and ensure the physician is able to have enough business to make it viable.

The Community Health Needs Assessment mentioned several specialties that will need to be explored. Those specialties included, Cardiology, Endocrinology, Nephrology, Neurology, Orthopedics, Oncology among others. Developing a responsible plan for growth in the specialties will take more research beyond the CHNA, however, the information in the CHNA will assist in focusing our attention in the correct areas. BRH will review the results of the survey, comparing them to current hospital data to see how those requested specialties line up with existing physicians as well as needed specialists. Based on the need, the expressed desire to have someone local, and the financial feasibility, BRH will decide on which specialties need to be filled, methods for filling them, and the timeline for doing so.

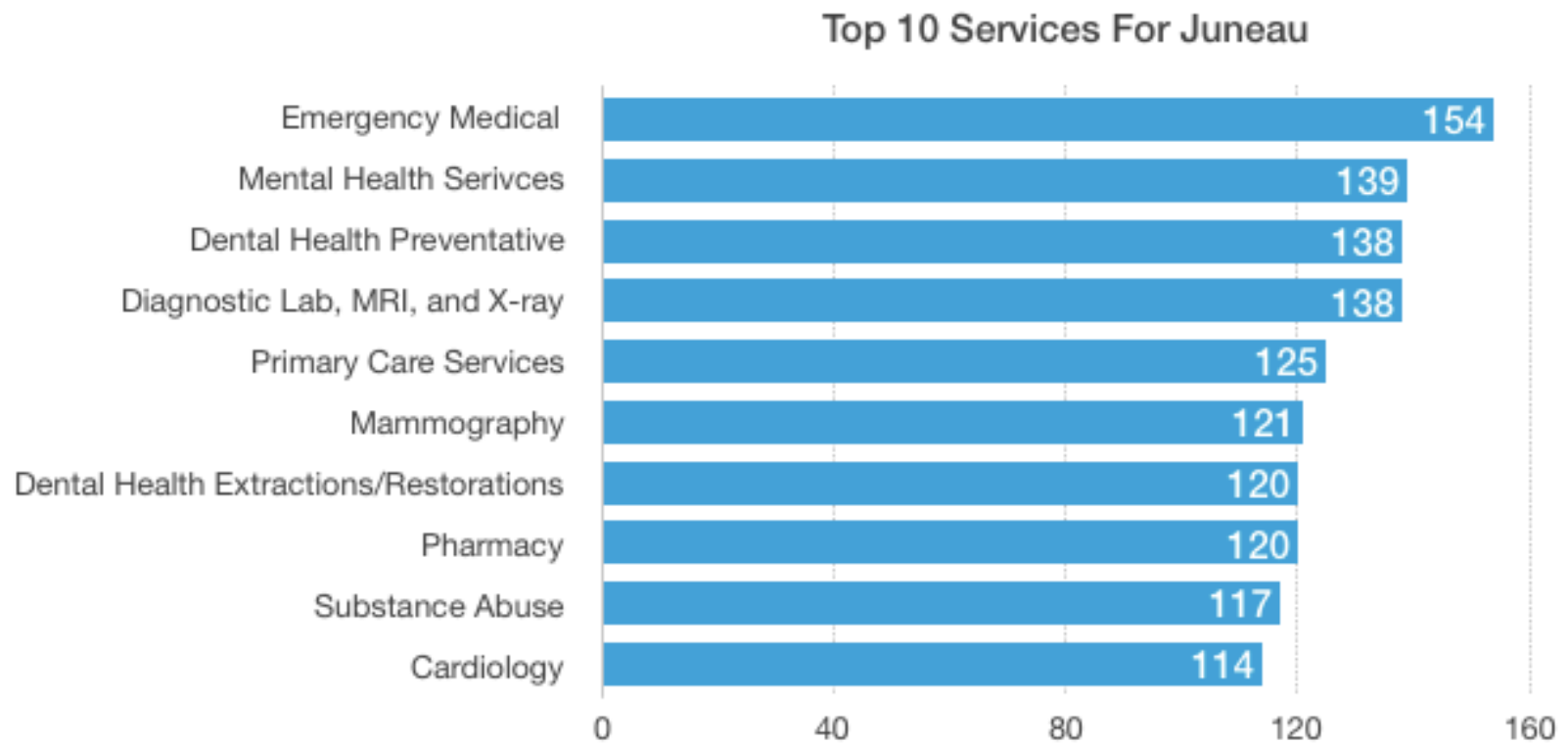
Mental Health: Mental health was referred to more than any other topic in the open ended questions. It appears that Mental and Behavioral health is a concern that affects almost every member of the community. Areas specifically mentioned were mental health among the homeless population, grief counseling, and drug and alcohol addiction. As mentioned above, Juneau faces nearly four times the level of alcohol related driving deaths, nearly three times the level of drug overdoses, and nearly twice the level of excessive drinking as the top performing counties in the nation.

Bartlett already has a robust Mental health program which includes:

1. 16 bed residential substance abuse recovery program
2. Large behavioral outpatient service
3. 12 bed locked adult mental health unit
4. 8 bed crisis intervention center under development with separate beds for Adults and Youth

Additional insights from the survey:

When asked what services the respondent, a member of their family, or a person they know from the community utilized, respondents prioritized the following at the top 10 services. Many of these are already provided by BRH.



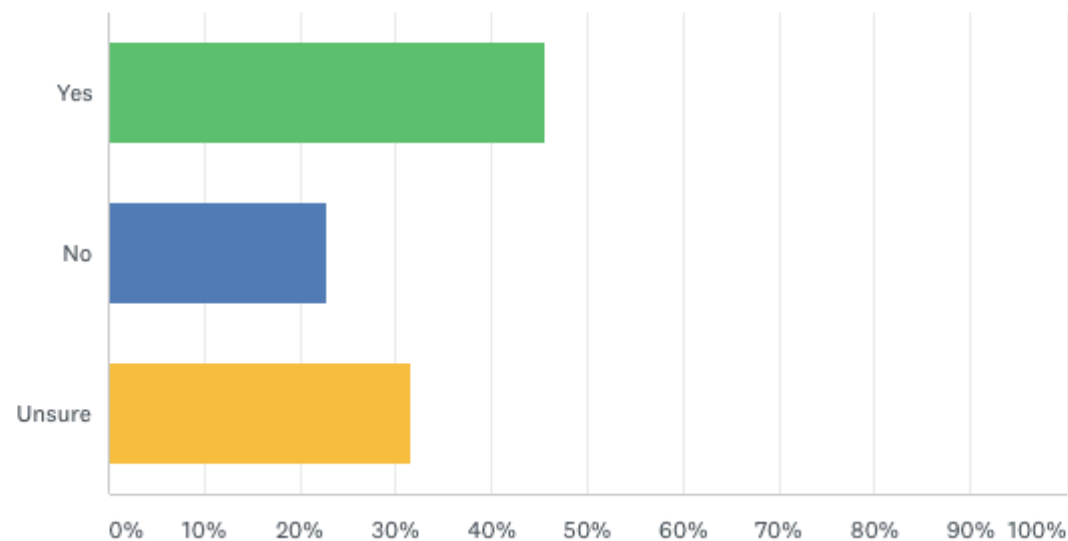
Robotic Surgery:

Robotic surgery is becoming more prevalent in the industry and many newer physicians are being trained to use them for specialty procedures during medical school and their internships. Some rural hospitals are finding they are unable to recruit specialists who are trained and rely on these machines. There are concerns about how patients, as well as physicians, would feel about bringing these services to Juneau.

When asked, “Would you be open to having a robot used for a surgery performed on you or a loved one?” 45% of the respondents said yes, 32% were unsure, and 23% said no.

Would you be open to having a robot used for a surgery performed on you or a loved one?

Answered: 250 Skipped: 3



Supportive Services:

When asked about how people felt about the supportive services BRH provides to their patients, the top five services where BRH was doing well were as follows.

1. Follow-up /Discharge Planning
2. Referral to Other Locations
3. Health Education
4. Help Understanding Recommended Medical Care
5. Care Management

However, there were areas where BRH could improve. These areas include:

1. Bariatric Services
2. Translation
3. Help With Enrollment Services for Medicaid
4. Medical Supplies For In Home Use
5. Transportation

Transportation issues were multifaceted with difficulties coming to Bartlett from surrounding areas because the Governor of Alaska has cut funding for the Ferry. This has made transportation difficult for some people.

The second area of transportation concerns dealt with Air Transport from Juneau to outside hospitals that can better serve certain healthcare needs. Juneau has three separate transportation companies each requiring an annual fee. These companies take shifts to fly people out when needed. Juneau residents are concerned the transporter they have chosen may not be the on duty service when they need it.

Demographic Services:

When looking at areas BRH does well in servicing the health needs of the community, positive results were seen in the following categories:

1. Adults
2. Children
3. Women Of Child Bearing Age
4. People Eligible for Medicare / Seniors
5. Schools

However, there are a few groups where the community felt needs were not being met. Those groups included:

1. Transgender Community
2. People with no insurance
3. The Homeless
4. People with Behavioral Health Needs and Substance Abuse Issues
5. People with minimal insurance

When asked what aspects of healthcare are most important to the community, it was interesting to see the perspective of the people of Juneau. The top five most important areas to the residents revolved mostly around taking charge of their own health. They were:

1. Access to healthy foods
2. Scheduled Appointments
3. Urgent Care
4. Convenient Pharmacy
5. More active care management by your primary care practitioners

Barriers to Using BRH:

When asked if there were barriers to using BRH only 29% of the respondents said there were. The top two reasons they gave were Cost and the availability of Specialist. However, when asked where people had actually received care in the last 24 months, the main reasons for getting care outside of BRH or its clinics were because of lack of specialties at BRH. Cost was the least common answer.

When asked in what areas the people of Juneau would like additional information and learning to help them stay healthy, Addiction Recovery and Substance Abuse took the top two position. They were followed by Depression and Anxiety, Diet and Nutrition, with Smoking/vaping rounding out the top 5.

	HIGHLY APPLICABLE	APPLICABLE	NOT APPLICABLE	TOTAL
▼ Addiction Recovery	56.31% 125	18.02% 40	25.68% 57	222
▼ Substance Abuse	57.34% 125	19.72% 43	22.94% 50	218
▼ Depression or Anxiety	55.36% 124	28.57% 64	16.07% 36	224
▼ Diet/Nutrition	44.59% 99	41.89% 93	13.51% 30	222
▼ Smoking/Vaping	45.41% 99	28.44% 62	26.15% 57	218



**Bartlett Medical
Oncology
Center: Bringing
the best cancer
treatment to
Southeast Alaska.**

IMPLEMENTATION PLAN

Senior Leadership reviewed the results of the survey in order to create a structured Implementation plan. During this meeting several areas of concern were identified as areas BRH would like to explore as they prepare for an upcoming strategic planning session. These areas, as well as the physician analysis will be discussed in the upcoming strategic planning session this spring.

Enhance Patient Navigation:

Residents mentioned they would like more help in navigating their healthcare. This included educating the population around what to do when they have a condition and how to work with the BRH, their Insurance Company and what to do once they are released.

Getting the right Physician/Specialist mix:

BRH will be working with the local physician group to review the physician assessment and how those numbers align with the current staffing levels.

Develop a faster way for people to move through the ER:

BRH would like to reduce the time in the ER and become more efficient in dealing with wait times and service there.

Dealing with the 5% cut on medicaid payments:

The State of Alaska has cut 5% in reimbursements from medicaid. This loss can negatively affect the organization's ability to support programs that don't cover their cost.

What to do about state employee cutbacks/less insured people

With cutbacks in government employees, fewer people have insurance. This has had a negative effect on the hospital. BRH is looking into what if anything can be done to prepare for such cutbacks and loss of covered people.

Ferry and Air Evacuation transportation issues.

Transportation can be an issue in remote areas. The government has cut back on the number and frequency of Ferry Transportation to Juneau. In the CHNA survey people from BRH's Secondary Service Area expressed concern they were not able to

get to BRH for services. In addition, survey participants mentioned they would like to see a better solution for Air Evacuation issues. Maybe with a program that covers all carriers.

Partner with state on health plans for employees and retirees

BRH would like to explore with the State what can be done to help employees and retirees keep their health insurance.

Mental Health/Behavioral Health

Even though BRH has a fairly robust Mental Health Program and is building a new facility to assist both adults and teens. They would like to ensure the needs of the community are covered and that the community is aware of what is offered.

REVISIONS TO PHYSICIAN RECOMMENDATIONS

In 2015 BRH hired MJ Philps and Associates to conduct a Hospital Development Plan for Medical Staff and Hospitalists. This report was designed to give a better understanding of the staffing needs at Bartlett Regional Hospital based on population and a number of widely accepted physician to population ratios. This report identified a number of areas where BRH could modify their existing staffing models and better meet the population models.

Cycle of Business took the MJ Philps Study and compared the identified staffing needs to the feedback on the Community Health Needs Assessment Survey. This was done to ensure the recruiting efforts were focused on staffing that met population needs as well as the specific health needs of BRH's primary and secondary service areas.

Recommended physician to population ratios were reviewed based on the same studies used for the Michael Philps Study of 2015. Declining populations also impacted the number of physicians needed at BRH.

These numbers were then matched to survey information as well as data from BRH databases to calculate the correct physician mix. BRH and Cycle of Business also addressed the prioritization of specialty need in an effort to bring in the right services first.

Other options such as Telehealth and Traveling Physicians were also discussed as strategies to meet the current and upcoming needs of the population.

FINAL PRESENTATION TO BOARD

Senior Leadership met to review the information from the CHNA survey. This information outlines the wants and desires of the community. It gave insight into areas the respondents considered were important to the health of the community. However, there were areas of concern that weighed heavily on the community that may not have been as wide spread of a concern as the CHNA survey made them out to be. These false positives were a result of recent government cutbacks coming directly from the Governor's office. Before taking information that may have been disproportionately influenced by recent news stories, the results of the survey were matched against data from the hospital. This allowed BRH to take the most important topics directly to the board for consideration and allowed BRH to focus their energies on the right areas.

The Final presentation to the board will be given after the Senior Leadership team has had a chance to review and create a recommended implementation plan. Additional steps will be taken to convert the more general action plan to more specific actions during the Strategic Planning session planned for Spring of 2020.

PART B: UPDATED PHYSICIAN ANALYSIS

BACKGROUND:

In 2015 Bartlett Regional Hospital contracted with Michael J Philps & Associates to analyze the number of physicians currently working with BRH. The purpose of this study was to ensure the correct level of staffing to handle the healthcare needs of the community. Recommended levels of physicians by specialty were based on ratios of physician per 100,000 residents and then adjusted based on the population of the BRH primary service area.

Cycle of Business has revisited those numbers and that methodology and revised the numbers accordingly. Some specialties BRH is currently offering were not included in the original analysis. COB has added those specialties to the current analysis and included

recommended staffing based on current nationally accepted staffing levels. Adjustments were made in the formulas to scale appropriately. Finally the specialists were given a staffing relevance ranking based on the level of concern stated in the Community Health Needs Assessment. This allows BRH to prioritize the recruiting efforts of staff based, not only on the shortage of physicians but also on the wants of the community.

CONSIDERATIONS:

The levels stated in this survey are based on current levels. In 2015 the projected staffing, numbers were based on expected population for the year 2020. During the last 4 years the population of Juneau Borough has not grown according to expected growth rates. In fact, the population has decreased slightly. As a result COB has recommended staffing to current population and not for growth.

When calculating staffing levels this year, several organizations that project physician numbers have adjusted their 2015 calculations for what the appropriate staffing levels should be as of 2019. Those numbers have been modified for 2019 when calculating blended averages. Even though the same companies were used where possible, the recommended numbers of those companies varied slightly. COB also found in some cases there were no updated numbers for certain specialties.

A few points to mention are around Oncology and Geriatrics. These specialties are focused mainly on the elderly. Therefore, the blended averages were also multiplied by the percent of the population most effected to get a better idea of how many physicians to consider. In the case of Juneau, 28% of the population are 60 or older. Once the blended averages were reached, 28% of those numbers were used as the recommended number of physicians needed based on appropriate demographics.

CALCULATING PHYSICIAN STAFFING AVERAGES:

Exhibit 1 is designed to give a blended average of physicians required given the population size of BRHs primary service area. The numbers used were based on the 4 sources used in 2015. For some specialties recommended numbers were not available from the original sources, and therefore COB utilized the numbers available to them from other sources. In those cases the recommended ratio was placed in the Solucient column in Exhibit 1.

An area that needed special consideration was the right staffing levels based on current mix of Family Medicine physicians vs OB/GYN. All national numbers were based on OB/GYN levels. BRH has several Family Medicine physicians that also do OB work. They have only

one physician who specializes in Obstetrics and Gynecology. Current physician levels confirm that BRH has more than enough physicians to fill Family Medicine positions. For the size of the Primary Service Area, between 10.0 and 13.5 Family Medicine physicians are recommended. BRH currently has a total of 19 FTEs in this category. On the other hand, for the population size, 3.5 to 4.7 OB/GYN physicians are recommended. BRH currently has 1 physician who specializes in OB/Gynecological work. Therefore it might make sense to replace retiring Family Medicine physicians with OB/GYNs in order to balance the mix. (See Exhibit 2)

In the case of certain specialties, the numbers of specialists were difficult to find. Also in the case of specialties like Geriatrics and Oncology, the specialty is either exclusively or primarily used by the elderly. The rationale for the numbers presented in these specialties are explained in the appendix.

PHYSICIAN DEFICITS AND OVERAGES:

Bartlett Regional Hospital wanted to see where the community had appropriate resources and where they had deficits. Recommended staff levels were calculated and compared to current FTEs in order to decide where to focus efforts. Information from the CHNA was also reviewed in order to help prioritize areas where the community might have needs waiting to be filled.

A unique characteristic is the population adjustments needed for the tourist months. Juneau is a port on many Alaskan Cruise lines. This leads to the population increasing dramatically over those months. For 6 months out of the year an additional 11,111 people per day are coming to the area. This brings its own set of problems, one of which is staffing for potential illnesses that may occur.

Exhibit 1: Physician Calculations

COB calculated the physician staffing levels based on non-tourist season populations as well as tourist season populations in order to get a better idea of what the levels of staffing should be. They are also reflected in Exhibit 2 above.

NEXT STEPS:

BRH will discuss the staffing levels with the physician groups covering the area, to decide on correct staffing. They will discuss the areas that showed up in the CHNA as levels of

Calculation Of Physical Ratios Blended Averages For Seasonal Changes

	Academy Physicians	GMENAC	AMA	Solucient	Blended Average	By Population of Juneau in off Season	By Population of Juneau in Tourist Season	Off Season Staffing	Tourist Season Staffing
Anesthesiology	7.0	9.1	13.4		9.8	31.754%	42.865%	3.1	4.2
Cardiology	1.0	3.2	7.3	4.2	3.9	31.754%	42.865%	1.2	1.7
Dermatology	2.0	2.9	3.7	3.1	2.9	31.754%	42.865%	0.9	1.3
Emergency Medicine	2.7	5.5	9.3	12.3	7.5	31.754%	42.865%	2.4	3.2
Family Medicine	40	25.2	38.3	22.5	31.5	31.754%	42.865%	10.0	13.5
Family Practice / OB	9.1	9.9	14.7	10.2	11.0	31.754%	42.865%	3.5	4.7
Gastroenterology	2.0	2.7		3.5	2.7	31.754%	42.865%	0.9	1.2
General Surgery	10	9.7	13.9	6	9.9	31.754%	42.865%	3.1	4.2
Geriatrics	Numbers unavailable See Appendix for calculations							3.8	5.1
Gynecology	9.1	9.9	14.7	10.2	11.0	31.754%	42.865%	3.5	4.7
Hospitalist			10	4.0	7.0	31.754%	42.865%	2.2	3.0
Internal Medicine	12.8	28.8		19	20.2	31.754%	42.865%	6.4	8.7
Nephrology		1.1	2.6	0.7	1.5	31.754%	42.865%	0.5	0.6
Neuro Surgery	1	1.1	1.9		1.3	31.754%	42.865%	0.4	0.6
Neurology	1.3	3.4	5.0	1.8	2.9	31.754%	42.865%	0.9	1.2
Oncology	2.5	3.7		1.08	2.4	31.754%	42.865%	0.8	1.0
Opthamology	5.0	4.8	6.5	4.7	5.3	31.754%	42.865%	1.7	2.3
Orthopedic Surgery	3.3	6.2	8.6	6.1	6.1	31.754%	42.865%	1.9	2.6
Otolaryngology	2.0	3.3	3.5	2.8	2.9	31.754%	42.865%	0.9	1.2
Pathology	4.1	6.5	6.1		5.6	31.754%	42.865%	1.8	2.4
Pediatrics	7.3	15	18.4	13.9	13.7	31.754%	42.865%	4.3	5.9
Plastic Surgery	2.0	1.1		2.2	1.8	31.754%	42.865%	0.6	0.8
Podiatry				4.9	4.9	31.754%	42.865%	1.6	2.1
Psychiatry	10	23.2	13.6	6.3	13.3	31.754%	42.865%	4.2	5.7
Pulmonologist	1.0	1.5	3.5	1.3	1.8	31.754%	42.865%	0.6	0.8
Radiation Oncology*			1.28		1.3	31.754%	42.865%	0.4	0.5
Radiology	8.0	8.9	11		9.3	31.754%	42.865%	3.0	4.0
Urology	3.3	3.2	3.7	2.9	3.3	31.754%	42.865%	1.0	1.4

concern with the population. They will also look at what specialties they are seeing that are currently being referred outside of the area for services. In deciding on the proper specialty — patient — population ratio, BRH will be able to better meet the demands of the community.

Once the staffing levels are decided, BRH will need to look deeper into the feasibility of certain roles and staffing levels. This will be part of the Strategic Planning sessions planned for spring of 2020.

BRH Medical Staff With Work Adjustments, Consulting And Retirement									
Physician Priority from CHNA	Specialty	BRH Medical Staff FTEs	FTEs with Work Adjustment & Consulting	Physicians Over Age 61	FTEs With Work Adjustment, Consulting & Retirement	Recommended Staffing levels Non Tourist Season	Recommended Staffing levels Tourist Season	Physicians Needed (Non Tourist Season)	Physicians Needed (Tourist Season)
	Anesthesiology	4	3	1	2	3.1	4.2	1.1	2.2
2	Cardiology	0	0.4	0	0.4	1.2	1.7	0.8	1.3
6	Dermatology	0	0.1	0	0.1	0.9	1.3	0.8	1.2
1	Emergency Medicine	11	8.3	2	6.3	2.4	3.2	-3.9	-3.1
	Family Medicine	3	0	0	3	10	13.5	7	10.5
4	Family Medicine / OB	18	17	1	16	3.5	4.7	-12.5	-11.3
	Gastroenterology					0.9	1.2	0.9	1.2
	General Surgery	5	2.3	2	2.3	3.1	4.2	0.8	1.9
	Geriatrics	0	0	0	0	3.8	5.1	3.8	5.1
	Gynecology	1	1		1	3.5	4.7	2.5	3.7
	Hospitalist	8	6.5	0	6.5	2.2	3.0	-4.3	-3.5
	Internal Medicine	4	3	0	3	6.4	8.7	3.4	5.7
	Nephrology	0	0.1	0	0.1	0.5	0.6	0.4	0.5
	Neuro Surgery					0.4	0.6	0.4	0.6
7	Neurology	0	0	0	0	0.9	1.2	0.9	1.2
	Oncology	3	1	2	-1	0.8	1.0	1.8	2.0
	Ophthalmology	0.5	0	0	0.5	1.7	2.3	1.2	1.8
3	Orthopedic Surgery	5	5	0	5	1.9	2.6	-3.1	-2.4
	Otolaryngology	0.2	0.2	0	0.2	0.9	1.2	0.7	1.0
	Pathology	2	1.4	1	0.4	1.8	2.4	1.4	2.0
5	Pediatrics	3	3	0	3	4.3	5.9	1.3	2.9
	Plastic Surgery	0	0	0	0	0.6	0.8	0.6	0.8
	Podiatry	1	0.5	0	0.5	1.6	2.1	1.1	1.6
	Psychiatry	3	3	0	3	4.2	5.7	1.2	2.7
	Pulmonologist	0	0	0	0	0.6	0.8	0.6	0.8
	Radiation Oncology*	1	1	0	1	0.4	0.5	-0.6	-0.5
	Radiology	3	2.4	0	2.4	3.0	4	0.6	1.6
8	Urology	1	0.5	0	0.5	1.0	1.4	0.5	0.9

Exhibit 2: Physician Staffing Report

APPENDIX

Rationale for numbers.

Geriatrics: This was a difficult number to find. None of the reference studies had calculated for geriatrics. COB was able to find a US News and World Report article in which the American Society of Gerontology gave some statistics. These were that about 30 percent of the 65 and older patient population will need a geriatrician and that one geriatrician can care for 700 patients. Given the population of Juneau during tourist season and the off season, COB calculated the needed geriatrician numbers as follows.

Calculation for Gerentologists				
Population of Juneau / Season	Percent of population considered Elderly	Percent of population likely to use a Geriatrician	Number of patients a Geriatrician can handle in a year	Geriatrician FTE
31,754	28%	30%	700	3.8
42,865	28%	30%	700	5.1
Reference	https://health.usnews.com/health-news/patient-advice/articles/2015/04/21/doctor-shortage-who-will-take-care-of-the-elderly			

Radiation Oncology: COB was unable to find credible numbers for Radiation Oncologists as well. Most of the tables had numbers for a category called Hematology/Oncology. This number was used to for the calculation of Medical Oncologists in our study. However, the only numbers available for Radiation Oncologists were based on the Supply of Radiation Oncologists Rather than the Demand for them. COB then calculated what the supply would dictate based on the the percentage of population likely to get cancer and the percentage of cancer patients likely to use radiation for treatments. In just new patients based on 2020 estimates, Juneau would need a .2 FTE increase to the existing demand. This validated an estimate for Radiation Oncologists as a percentage of the supply side as a starting point and then consulting with the existing oncology practice in Juneau to decide on what would be most appropriate.

Radiation Oncology Calculations					
2020 Expected New Cancer Cases in U.S.	Expected 2020 U.S. population	Percentage of population likely to get cancer	Juneau Population	Number of Juneau residents likely to get cancer	Population likely to Use Radiation Oncologist
1,956,916	333,546,000	0.59%	31,754	186.3	54.0
Patients per Radiation Oncologist per year	FTE for Radiation Oncologist for new patients in 2020				
250	0.2				



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Finance Committee Meeting Minutes BRH Boardroom – January 17, 2020

Called to order at 12:02 p.m. by.

Finance Committee* & Board Members: Mark Johnson*, Deb Johnston*, Kenny Solomon-Gross, Iola Young

Staff: Kevin Benson, CFO, Billy Gardner, COO, Bradley Grigg, CBHO, Chuck Bill, CEO, Dallas Hargrave, HR Director, Rose Lawhorne, CNO, and Megan Rinkenberger, Executive Assistant.

Other attendees: Tiara Ward, CBJ

Mr. Johnson made a MOTION to approve the minutes from the December 11, 2019 Finance Committee Meeting. Ms. Johnston noted no objections and they were approved.

November 2019 Finance Review – Kevin Benson, CFO

Following four months of increased activity and revenues well above budget expectations, November saw slower volumes and was an at-budget month. Mr. Benson expressed gratitude for the work the Revenue Cycle team here at BRH where BRH is realizing lower discounts. As a result, net patient revenue was \$400K over budget. Total expenses were \$636K over budget. Salaries and wages were over budget due to overtime. This correlates with leave due to illness, which required overtime to cover. More callbacks also resulted in more overtime. Mr. Johnson requested a future summary of the 340B program, which will be provided at a future meeting.

Deferred Maintenance – Chuck Bill, CEO

Mr. Bill explained when BRH has a construction or repair project there is a very lengthy and involved process involving an amount of back and forth between parties. This results in an extended lead time before a project can get underway. By designating an amount to be used as Deferred Maintenance which could be budgeted and approved through CIP, these funds could be used for unplanned and unforeseen costs. Funds would be available much sooner and project timelines could be greatly streamlined. Mr. Bill suggests doing this in the upcoming budget. Ms. Johnston asks if we have a deferred maintenance schedule. Mr. Benson explains that departments are asked to submit expected projects for the next five years, but many repairs cannot be anticipated. Those are the projects that would apply to the flat amount line item. Finance committee members approved the request to add this to FY21 budget planning.

CIP – Kevin Benson, CFO

The chart provided in the packet is for the purpose of information sharing, and items can be adjusted as projects near. This sharing is done to ensure resources aren't overextended locally and so that other enterprises are aware of projects for planning purposes. Mr. Bill stated that the deferred maintenance line item will be added to the chart before submission. Crisis Stabilization is in the process of negotiating architect fees, then the project is expected to move forward. The plan will be presented to the board with, and without, a parking structure. The chart will be updated with timelines, priorities, and expected costs for next board meeting.

Budget Calendar – Kevin Benson, CFO

Budget process is beginning and will consume much of the rest of January and February. For this reason, Mr. Benson asked that the February Finance Meeting be later in the month. The committee members agreed. Mr. Johnson requested that acronyms in future packet documents be spelled out for clarity. FY21 is being developed to include the Rural Demonstration Project (RDP), but alternate budget will be produced as well in case the RDP doesn't get renewed. PERS denial lawsuit still underway and a decision may not be made for a year or two.

Next Meeting: Friday, February 21, 2020 at 12:00 p.m. in BRH Boardroom

Adjourned – 12:40 p.m.

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January 22, 2020 Management Report From CLO

Topics*

- General contract revision and meetings with vendors
- Risk management/litigation monitoring and related consults
- General legal review and response to subpoenas, filing motions in court as needed
- Risk-related legal consultations with CEO, Risk Manager, Compliance, and Quality Director
- HIPAA and medical records policies and procedures review
- Contract and Purchasing training for BRH managers
- Training on Peer Review for Medical Staff

*Full project report available at month's end to Board members upon request.

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Management Report from Dallas Hargrave, Human Resource Director January 2020

Report Period - 2nd Quarter FY20 (October, November, December)

New Hires	57
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Separations	18 All Other Separations
	2 Retirement
	20 Casuals/temp
Total	40

Contract/Travelers	4 OR RN
	2 Med/Surg RN
	1 MHU RN
	1 CCU RN
	1 OR Tech
	1 Clin Lab Scientist
	1 CSR Tech
	1 Ultrasound Tech
	2 RT
	3 Dietitian
Total	17

Hard to Recruit	RN's	FT	All Dept
Vacancies	Forensic Nurse Examiner II	Casual	Emergency
	Dietitians	FT	Nutrition Services
	Psychiatrist	FS	Mental Health Unit
	ED RN Case Manager	FT	Case Management

All Employee Turnover		
All Employee Types	FT Employees	All Others
4.56%	3.53%	6.86%

657 Employees
FS/FT employees = 453
All others = 204

Nurse Turnover		
All Nurse Types	FT Nurses	All Others
0.50%	0.81%	0.00%

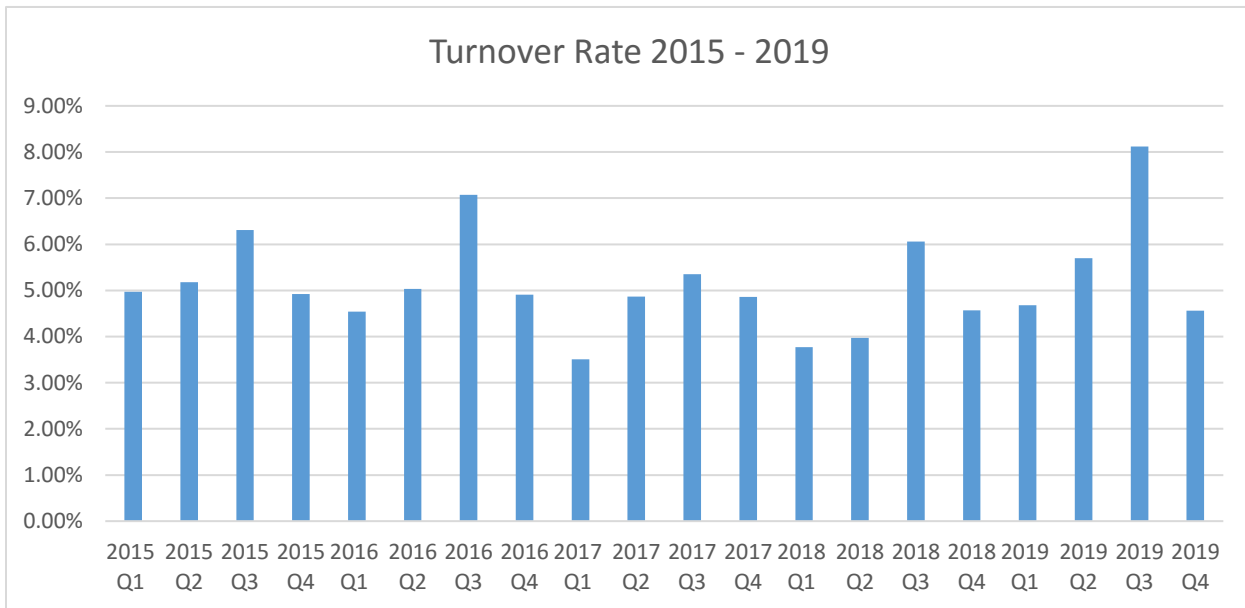
201 Nurses
FS/FT = 122
All others = 79

Grievances	0
Arbitration Cases	0

Reported Injuries	
Department	Brief overview
Operating Room	Skin tear/patient waking up from anesthesia
Operating Room	Needlestick
Operating Room	Skin Rash
Mental Health Unit	Chemical in eye/hotpack burst while activated
Mental Health Unit	Head & back injury/ Patient hit staff
Mental Health Unit	Face/ patient hit staff
Mental Health Unit	Abrasion/Patient hit RN
Medical/Surgical	Skin piercing/ scissors in patients bed
Medical/Surgical	Skin tear/confused patient dug fingernails into RN's arm.
Medical/Surgical	Shoulder Strain/patient pushed RN while eloping.
Facilities/Security	Pulled muscle while assisting patient
Obstetrics	Needlestick
Emergency Dept.	Thumb strain/ restraining violent patient
Emergency Dept.	Exposure to mucous in eye/ broken swab stick splashed in eyes.

Turnover Rate (2015-2019)

Calendar Year	2015	2016	2017	2018	2019
Q1 (Jan-Mar)	4.97%	4.54%	3.51 %	3.77%	4.68%
Q2 (Apr-Jun)	5.18%	5.03%	4.87%	3.97%	5.70%
Q3 (Jul-Sep)	6.31%	7.07%	5.35%	6.06%	8.12%
Q4 (Oct-Dec)	4.92%	4.91%	4.86%	4.57%	4.56%



2019 Exit Survey Summary

- 133 total separations
- 105 Exit Surveys sent out
- 57 Exit Surveys submitted
- 54% response rate

Reasons Leaving (more than one box may be checked)

Career Opportunity		Working Environment		Personal	
11	More Desirable Position	5	Lack of Recognition	29	Moving From Area
5	Compensation	5	Shift Work	0	Self-Employment
3	Benefits	8	Quality of Supervision	11	Health Condition
11	Retirement	8	Working Conditions	13	Continue Education
30	Other	30	Other	20	Other

Years of Service

23	0-2 years
14	2-4 years
8	4-7 years
3	7-10 years
9	10 years or more

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January 2020 Nursing Report

Rose Lawhorne, CNO

Nursing

- Bedside report has been implemented on three inpatient units since the summer. Patient feedback has been positive and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores related to communication with nurses have shown statistically significant improvement from the mid-80s to the high-90s! Great job to our teams who developed and implemented effective communication and hand-off processes.
- Most of our new graduate nurses are now working independently. The coordinated effort to hire and train a cohort of local residents joining our nursing profession has been successful. Thanks to our nursing directors and preceptors, staff development, and to the new graduates who are now investing in our hospital and community.
- Philips monitors have been installed. The new equipment that reflects patient respiratory and cardiac status is working well and liked by the end users. Thanks to our teams in nursing, IT, and maintenance for your assistance in accomplishing this significant task.
- The nursing directors attended training on January 17th. Sarah Cole from Human Resources reviewed personality types, communication techniques, and offered strategies for working together as a team. Attendees enjoyed the experience and bonded over a great many laughs.
- Nursing capital requests have been submitted. We solicited input from physicians and other non-nursing colleagues. The next focus will be to prepare operating budgets.

Critical Care Unit

- We will host a Beacon Award Reception on February 19th at 5:00p.m. in the BRH Gallery. Our Critical Care Team received the Bronze Beacon Award, bestowed by the American Association of Critical Care Nurses (AACN). This award evaluates Critical Care Units in six categories: skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership. The rigorous application process ensures that the care environment is healthy, fosters collaboration, and supports quality patient care. This award is a testament to the dedication of Audrey and her team. Congratulations to you all!
- Robert Follett, Respiratory Therapy Director, is offering a class on ventilator management for nurses. The training will review pathophysiology, respiratory conditions, airway management, ventilator operation and troubleshooting.
- Starting on Monday evening, January 20th, we will be trialing new peripheral intravenous catheter (PIVO) devices which allow us to draw blood through an IV site, eliminating the need for direct lab draw with a needle. The goal is to use PIVO on all patients in the hospital who require a blood draw and have intravenous access.

- We are working with Providence Alaska Medical Center in Anchorage to upgrade our eICU equipment. We will be getting new cameras and screens by the end of February.
- We are working with Staff Development and the ED to train more nurses in performing ultrasound-guided IV starts. This offers direct visualization of deep veins and helps get access for people with fragile or deep veins. Training will start the end of January and should help us get quicker access to patient that are difficult IV sticks.

Surgical Services

- The Surgical Services Leadership Team worked with their team to develop a departmental Mission Statement:
Bartlett Regional Hospital Surgical Services Department is committed to providing compassionate, high-quality care through teamwork, utilizing evidence-based standards, and preserving patient dignity and autonomy.
- Our new nurses are working independently. We are proud of them for completing the Periop 101 program, clinical training, and for their commitment to the surgical services team.
- A new focus for our Operating Room (OR) Educator will be to streamline and refine sterile processing and offer competencies and education to staff.
- Autumn Muse presented a creative and well-received game of “JAHCO Jeopardy!” at their last staff meeting. The exercise provided training in Joint Commission requirements for our hospital accreditation. Staff gave the exercise great reviews, and they look forward to another episode.
- Same Day Surgery (SDS) and Pre-Admission Testing (PAT) have identified the 2020 National Patient Safety Goals (NPSGs) and are discussing a goal each week.
- SDS, Post-Anesthesia Care Unit (PACU) and OR are developing a “handoff card” to be laminated and worn with our identification badges. The cards will be implemented for use from SDS to OR, OR to PACU, and PACU to Phase II recovery care. The goal of the handoff cards is to help staff give accurate, consistent, and complete handoff reports every time, thus meeting NPSGs and increasing patient safety.
- PAT and SDS staff have rallied to meet patient needs over the holidays: staff members have come in early, stayed late, and have worked on their days off to help cover staffing needs and provide safe patient care. Thank you to our dedicated staff!
- Dr. Kopstein experienced another successful cataract clinic day! We are actively working to improve the process, such as making sure patients are informed of their arrival time in a prompt manner, as well as continuing patient education throughout their experience.

Obstetrics

- Lauren Beason, OB Director, will attend the Alaska Perinatal Quality Collaborative (AKPQC) conference in January. She will accept a Gold Facility Award for our OB quality team’s exemplary work to develop a program that reduces hypertension-related severe maternal morbidity. With Bartlett’s outstanding successful compliance with new Joint Commission regulations, Lauren has been asked to share our story and offer strategies to those who are struggling to implement their programs. Congratulations to Lauren and her team!

- Our two new graduate nurses have been fully trained and are working independently!

Infusion Therapy

- We have established a process whereby treatment summaries are sent to primary care providers after each chemotherapy infusion. We hope to facilitate better continuity of care and consistently transfer relevant patient care information for improved quality for our patients.
- The infusion therapy team has begun a process to provide gift bags filled with self-care items to all patients initiating chemotherapy. A cup with herbal tea, a journal, pens, and hand sanitizer will be among items included in the bags for our patients. A sign at the entry states “Expect a Miracle”. Patients have expressed how much this has encouraged them in their journeys, and have adopted this as the slogan for infusion therapy. The gift bags will display the BRH Infusion Therapy logo with this mantra.

Medical Surgical Department

- A plan is in place for reorganizing the storage area on med surg. New shelving units are on order. This project is anticipated to increase efficiency of patient care, improve inventory management, and offer associated cost savings.
- New graduates are now working independently and we are supporting them in ongoing professional advancement.
- We have hired and trained a new unit clerk.
- We have purchased special devices to assist in the care of Alzheimer’s and dementia patients. Activity boards, vests, and lap pillows offer tactile activities (ties, zippers, etc.) that keep the patients occupied and calm.
- Capital purchase of new bladder scanner was completed with the equipment on the unit and available for use.
- Step-by-step downtime procedure has been developed and submitted to the work group for inclusion with organizational plan.
- We are developing an enhanced suicide screening assessment for Med Surg. Additionally, we are preparing to include a psychiatric assessment for boarded adolescent patients awaiting transfer. This addition to our electronic health record will take place after the Expanse upgrade.
- Have requested alert buttons to be used by staff caring for patients with a history of violence. This alert system calls immediate assistance for staff who are in an unsafe situation and need immediate support from others.

Emergency Department

- Kim McDowell, ED Director, and our trauma nurse coordinator have spent recent months preparing for the Level IV trauma reverification on January 14th. The site visit went exceptionally well, and we expect to receive full reverification as a Level IV Trauma Center in about a month. Thanks to Dr. Lindy Jones, Dr. Blaise Bellows, Dr. Jodie Totten, the ED physicians, Kim, Chailly Clayton, Trauma Nurse Coordinator, and the ED team for their efforts to ensure that quality

systems are in place to ensure that the care provided is exemplary. The review team was impressed with our facility and our trauma program.

- Kim is continuing to work with three other facilities and the Washington State Hospital Association (WSHA) on a Workplace Violence (WPV) Pilot Program. Measures to improve safety of the patient care environment and hospital staff are being piloted in our facility. Kim has been asked to represent the WPV work group at a Workplace Violence Prevention Learning Collaborative on March 19th in Seattle to review the project. Great job, Kim!
- Bedside report will be implemented in ED in the coming weeks to improve communication with patients and their families/friends.
- Formal process for daily director rounding will begin in February in ED, with Kim checking in on patients to build rapport and support the care plan.
- Two new graduates are now working independently.
- Downtime procedures are being improved. Areas of focus include refining processes related to sending orders, receiving results, and having ED-specific guidelines for downtime organized into a reference binder for easier access and clear direction.
- The ED team is looking forward to the waiting room entry remodel in the next several months to improve safety of staff and patients before the influx of patients this summer.

Bartlett Regional Hospital

Chief Operating Officer, Billy Gardner

Board Report

Tuesday, January 28, 2020

Physical Rehabilitation (James Reed)

- We have addressed our Adult Speech care wait list and it currently sits at 0.
- We have had an increase in our wound care referrals and currently have 3 on our waiting list. We plan to address quickly.
- We have reduced our Speech Peds wait list down from 15 to 7.
- We have reduced our OT adult wait list to 1 and expect to get them in very soon
- We are looking at and addressing our number of cancellations and no shows. We have spoken with Scott about the Televox notification system.
- Started tracking our out patient referrals per physician and have spoken to Drs. Hightower and Garcia in order to market our department and let them know what we can do for them in caring for their patients.

Respiratory Therapy (Robert Follett)

- Upgrade on Tracemaster ECG management system in que for project scheduling.
- New capital equipment being deployed - Non-invasive ventilators and ECG carts.
- Developing new test policy and procedure for High Altitude Stimulating Testing. This test will assist providers in determining if selected patients are fit to fly. Meditech documentation review in progress.

Pharmacy (Ursula)

- We are kicking off two new projects this month. One is cleanroom software with capability for barcode verification. The other project is a risk assessment algorithm for hazardous medications.
- Two pharmacists are working on a course in antimicrobial stewardship sponsored by the Society of Infectious Disease Pharmacists.
- Two pharmacists attended the American Society of Health System Pharmacists Midyear Clinical Meeting.

Campus projects/Facilities report (Marc Walker)

- PHARMACY REMODEL/ GIFT SHOP: The Pharmacy clean room nears its substantial completion date of 02/14/20. The pharmacy hoods arrived earlier this week and await contractor installation. Silver Bow Construction Company has worked with our infection control nurse, Charlee Gribbon, and our Facilities

Director, Marc Walker, to ensure full compliance with ICRA standards. ICRA (Infection Control Risk Assessment) standards ensure we keep both our patients and our staff in a safe environment during the construction process. This week work continues with flooring, wall coverings, painting, and HVAC controls. Next week will begin casework installation.

The Bartlett Hospital Foundation Gift shop and Coffee bar work continues with mechanical and electrical rough-in, taping and painting, case work installation and flooring. Estimated substantial completion is 01/28/2020 and Final completion date is set for 01/31/2020. Bartlett Hospital Foundation Director, Maria Uchytel, is in regular attendance of our weekly project meetings. We will be planning a ribbon cutting ceremony for the completion of this project and will publish details soon.

- **HOSPITAL ACCESS ROAD PROJECT:** The scope of this project has flexed over the past year. It began as a simple resurface of the Hospital Access road and grew to include: Major CBJ water line improvements, sidewalk and drainage reconfigurations with regrade, parking lot reconfigurations, lighting demo/install with security cameras and four electric car charge station installs to name a few. The project costs and time requirements also grew. On 12/18/2019 we met with CBJ and the engineering firm Dowl to discuss our plans. It has been determined that in anticipation of the new master facilities plan being delivered, it would not make sense to do a multi-million dollar investment into these improvements and then have to deconstruct them based upon the recommendations found in the new report (Master Facility Plan). Our plan moving forward is to scale back and do what is necessary at this time--- basically install a new water line with CBJ and then repave the surface of Hospital Access drive from just before the bus stop (this is where the road is really bad) to the end of the road. This will improve the surface for traffic, allow the water line to be installed, and give us time to analyze the Master Facility Plan without a huge investment of resources.
- **OR AIRHANDLERS** (supply fan11, Endoscopy ventilation, CSR equipment) — These three projects were combined into a single project to minimize OR downtime. We will revisit with stakeholders to set a begin date that makes sense for the organization due to February's date not being achievable. The Professional Service Contract is in place with Notice to Proceed (NTP) issued 12/11/2019. 100% bid ready documents due no later than 45 days after NTP (01/25/2020).

Other Ongoing Projects:

Juneau Medical Center Fire Alarm System Replacement:

- Professional Service Contract is in place with NTP issued 12/11/2019
- 100% bid ready documents due no later than 45 days after NTP 01/25/2020.

Ground Floor PAS Security Window:

- Professional Service Contract in Place with NTP issued 01/04/2020
- 100% bid ready documents due no later than 25 days after NTP 01/29/2020.

Supply Fan 1 Heating Coil Conversion to Glycol:

- Conceptual Design and Cost estimation submitted.
- Currently planning Phase 2 go ahead from BRH Administration.

Laboratory Ventilation Upgrades:

- Conceptual Design and Cost estimation submitted.
- Currently planning Phase 2 go ahead from BRH Administration.

Chiller 2 Replacement:

- Conceptual Design and Cost estimation submitted.
- Currently planning Phase 2 go ahead from BRH Administration.

After Hours Lock Down:

- Chuck, Billy and Marc met 12/30/2019 and established a phased rollout plan.
- First Phase:
 - Single corridor door from ED to cafeteria corridor access control device installation completed 01/03/2020.
 - Double doors to stairwell across from the ED waiting area access control device installation completed 01/09/2020
 - Elevator access control. Awaiting quote anticipated the week of 01/13/2020
 - Move Vending Machines to the ED waiting area install power completed 01/09/2020
 - Remove carpet from area where vending machines will reside and replace with Luxury Vinyl Plank. Currently awaiting estimate with uncertain delivery date at this time.
 - After Hours Visitor Control policy currently being worked on by Risk Management and Nursing.

RRC Detox Project:

- Update provided by Bradley

BOPS/Crisis Stabilization:

- Update Provided by Bradley

Maintenance Shop/Ground Floor Breakroom update (All work done in-house except flooring):

- Maintenance Shop:
 - Flooring Installation complete 12/06/2019
 - New Lighting Installation complete 12/10/2019
 - New tool boxes and cabinets installation complete 01/02/2020

- New Work Station installation complete 12/13/2019
- Painting Complete 12/02/2019
- New parts storage systems awaiting delivery and installation
- Break room:
 - New furnishings complete (Recycled from BOPS)
 - Painting Complete 12/28/2019
 - New Casework Complete 12/28/2019

Phillips Wireless Access Point Ceiling Panel Installation:

- Contractor secured, price estimate approved and contract initiated.
- Work completed 01/08/2020

Ground Floor Water Damage:

- Contractor secured, price estimated approved and contract initiated
- Asbestos Abatement Complete
- Wall repairs mostly complete with a few areas still in the works with an estimated completion the second week of February
- Wall protections and corner guards awaiting arrival with an estimated completion the second week in February.
- Breakroom door and frame replacement awaiting arrival estimated completion is the second week in February.

Server Room Power for New UPS and Servers:

- IT, Maintenance and the contracted Electrician is currently working with an electrical engineer to develop a power installation plan that minimizes system down time.
- The estimated completion date is yet to be determined

Kitchen Exhaust Hood Retrofit to meet current standards:

- Estimate approved 04/07/2019
- Contractor Completed work 12/29/2019

OR Locker Rooms Locker Replacement:

- Conceptual design completed OR and Facilities
- Materials list completed
- Price quotes, currently being worked on by Materials Management

Hot water Piping Installation for Lab Eye Wash:

- Contractor secured and price quote Complete
- PO issued and contract sent to Contractor for signature 12/30/2019
- NTP awaiting contractor signature
- Estimated completion date is 30 days after the NTP.

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January 2020 Behavioral Health Board Report

Bradley Grigg, CBHO

- Psychiatry Update:

- **Dr. Joanne Gartenberg** (BRH Employee) providing administrative oversight to BH Medical Staff in addition to seeing patients at RRC, BOPS, and covering MHU (including call).
- **America Gomez, Psychiatric Mental Health NP** (BRH Employee), is providing outpatient services to children, adolescents, and adults in addition to taking call.
- **Dr. Joshua Sonkiss** (BRH Contractor) continues to provide coverage at BOPS, and twice monthly weekend coverage on MHU. Dr. Sonkiss also leads our formal psychiatric consult service, providing psych consults throughout BRH departments upon request from a physician.
- **Tina Pleasants, Psychiatric Mental Health NP** (BRH Employee) is providing weekday morning coverage at RRC, afternoon coverage at BOPS, and weekend coverage on MHU. Alternating RRC duties with Dr. Joshua Sonkiss
- **Cynthia Rutto, Psychiatric Mental Health NP** (NEW BRH Employee) is providing weekday coverage at MHU, and occasional weekend coverage on MHU, assisting with our formal psychiatric consult service, providing psych consults throughout BRH departments upon request from a physician.
- **Dr. James McGovern** (Locum) is a Board Certified Adolescent and Adult Psychiatrist who joined BRH in January 2020 for a 6-month assignment. He will provide a combination of MHU coverage in addition to Outpatient Services to children and adolescents at BOPS.

- Psychiatry Recruitment Update:

- **Dr. Gartenberg interviewed 1 new applicant in December who is interested in full time employment; specifically, Mental Health Unit coverage. We are moving forward with next steps to get this psychiatrist on site for a formal interview.**

- Rainforest Recovery Center:

- During Detox/Assessment Center Construction, RRC continues to operate at 12 bed capacity.
- Daily Average of 10.5 patients in December 2019, with an average length of stay 23 days.

- **Mental Health Unit:**
 - Daily Average of 8 patients per day in December 2019, with an average length of stay 7 days.

- **Bartlett Outpatient Psychiatric Services:**
 - We continue to evidence a significant growth in the number of patients and visits at BOPS. **As of December 31, 2019 BOPS has 397 unique and active patients engaged in outpatient services.** Of those 397:
 - 241 are adults
 - 121 are children/adolescents
 - 35 are Petersburg patients (children and adults)
 - **Staff Recruitment Update:** BOPS is excited to announce the arrival of the 5th Master's Level Therapist, Beth Johnson. Her family is in town, and she begins work on or around January 27. Her primary focus will be children and adolescent therapy services.

- **Psychiatric Emergency Services (PES):**
 - We have now provided PES coverage in the Emergency Department for 5 months. On average, 4 patients experiencing a Behavioral Health Emergency are seen daily for evaluation by a Master's Level Therapist.
 - In December 2019, PES staff provided Emergency Behavioral Health Assessments for 124 patients in the Emergency Department.
 - In January, PES Staff assessed 23 youth in the Emergency Department. Of those 23, it was determined that 17 would have met criteria for admission into a formal Crisis Stabilization Program. 6 of these youth were admitted to the Med/Surg "Safe Room" while the remaining were connected with outpatient services same or next day to try and stabilize the family situation in a least restrictive setting.
 - BH is working with Finance to provide revenue/expense data as to the new PES Program.

- **Petersburg Medical Center Outpatient Psychiatry Update:**
 - No BRH coverage provided at BRH physically in Petersburg in December; however, telemedicine services were facilities throughout the month of December.
 - Both a psychiatrist and therapist will be on site at Petersburg Medical Center the 3rd week of January seeing new patients.
 - We continue to alternate psychiatric providers on site to ensure parity and quality of patients served. Each psychiatric provider who goes to Petersburg assumes those patients seen on their telemedicine caseload moving forward.
 - Feedback from Petersburg continues to be positive both from the Medical Center and from patients.

- It is anticipated that our therapist, Kira Phillips, will carry a caseload of 20-25 adolescent patients from Petersburg in addition to her outpatient caseload that also currently includes 20 Juneau based adolescents.
- **Grants Update:**
 - **Crisis Stabilization:**
 - Bartlett Behavioral Health was awarded a \$2 million grant (\$1.5 million operational/\$500k capital) to develop and implement this program.
 - We are expending the FY19 operating dollars for staffing costs associated with serving patients under “Crisis Stabilization” Status on our Medical Unit (Safe Room). Since January 1, 2019 we have served 28 children and adolescents under “Crisis Stabilization” Status in the Safe Room and ED Psychiatric Room combined.
 - **Other Crisis Grant Opportunities:**
 - **CAPITAL FUNDING UPDATES:**
 - Alaska MH Trust awarded \$200,000 FY20 capital funding. We anticipate applying again for FY21 funding.
 - Premera verbally committed \$1,000,000 FY20 capital funding while attending the MH Trust Planning Meeting where we were awarded the \$200,000.
 - Rasmuson Foundation: Process continues to move forward. Grant request is for their Tier II capital grant program for \$800,000 for FY21 funding.
 - Murdoch Foundation: Letter of Inquiry has been submitted. We have applied for their Tier II grant which historically awards \$100,000-\$600,000 per capital project. We are awaiting next steps from Murdoch.
 - Conoco Phillips Grant Foundation: We have submitted a Letter of Interest for Capital Funding. We are awaiting next steps from Conoco.
 - **Rainforest Detox & Assessment Center Update:**
 - See attached 1/21/2020 Observation Report for latest updates.
 - We are still on track for a June 2020 completion.

- **Crisis Stabilization Design Update:**

- North Wind Architects (“NWA”) was announced as the awardee for the design and project management of this construction project.
- October 2-4: NWA facilitated a kick-off conference that hosted numerous BRH Departments to discuss:
 - The introduction of the Crisis Stabilization Concept.
 - Facility layout requirements (per Joint Commission and Alaska DBH Regulation requirements)
 - Impact of the Crisis Program on BRH ancillary services (EVS, Facilities, Food Services, Pharmacy, IT, Meditech, etc.)
 - Interviews with adults and parents of youth who have navigated the Behavioral Health System in Juneau
 - Development of 3 conceptual designs.
- Next steps include:
 - CBJ and NWA continue to work through the Fee Service negotiation phase. Nathan Coffee, CBJ Architects, estimates this should be completed by February 15th.

- **Crisis Stabilization Capital Budget Update:**

- The Design RFP outlined an original budget for a \$7.5 million project to build a two story facility that housed both Crisis Stabilization and BOPS. This RFP also asked for an optional estimated budget to include a parking garage that would provide an additional 15-18 parking spots at an additional cost of \$1.5 million. Total \$9 million **(with an anticipated cost of \$425/square foot for the Crisis/BOPS floors)**
- Pursuant to several meetings with CBJ Architects, NWA, and BRH Staff, **CBJ now anticipated the construction cost to run closer to \$500/square foot for Crisis and BOPS, or an 18% increase.**
- The current design has an estimated capital cost of \$10.5 million given this increase.



Daily Observation Report

ENGINEERING DEPARTMENT

CIP Engineering, Third Floor

230 So. Franklin Street, Marine View Center

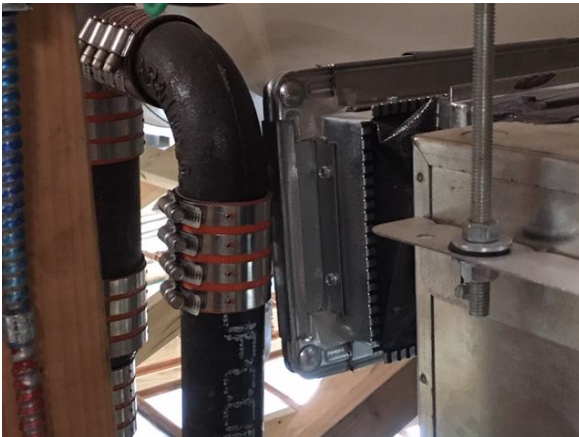
Project: Rainforest Recovery Center Detox Addition, CBJ Contract # BE19-173
Contractor: Alaska Commercial Contractors
Date/Time: Tuesday, January 21, 2019 – 7:30 am
Weather: Low Overcast/Fog, 34 degrees
Report by: Nathan Coffee, CBJ Project Manager, 586-0895

Onsite Workforce:

Trades	# of Persons	Major Equipment / Notes
General – AK Commercial Contractor(ACC)	1+7+0	Chad + crew + Ben
Electrical – Chatham Electric (CE)	0+0	Jake + crew
Mechanical – Inside Passage (IP)	0+1	Kyle + crew
Mech Insul – AIS	0	
Ductwork – Metalworks (MW)	0	

Description of Work:

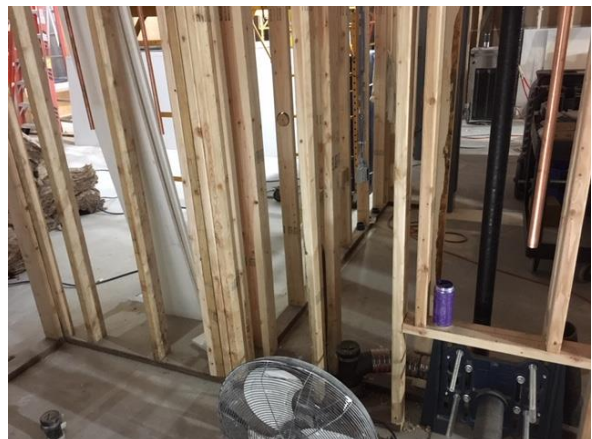
1. MW was scheduled to begin AHU-1 install work this week but was not yet onsite at time of visit. MW installed EF-1 and remaining exhaust duct and outside hood last week and received CBJ Permits approval on Friday. I am a bit concerned about the contact of the unit with the vent piping in the attic as this could generate some noise during fan operation due to potential vibration. There should be some isolation between the fan and the vent piping.



2. ACC has six workers installing GWB, cleaning up, and related activities. GWB is installed in patient rooms and offices with the exception of Office 121 that is still being used to store electrical materials. ACC has installed floor protections at all locations and has one worker beginning to mud and tape the GWB.



3. IPM has one worker onsite and is continuing with install of domestic water piping which Chad noted will be inspected today at 3pm. Chad said that Kyle was supposed to be onsite at some point. There is still a lot of work left to accomplish so am uncertain if IPM will be able to complete all domestic water piping in time for the inspection. Noted that heat piping near GL B that conflicted with hose bib has been fully insulated prior to being reconfigured.



4. CE was not onsite at time of visit. CE has installed most of the power to the TV data locations. CE has installed 5 of the required 6 data drops in Detox Watch 163 and CBJ is continuing to work on RFP pricing for the changes to Detox Watch 163 electrical.



5. ACC has removed large oil fired heater due to increase in outdoor air temperature which sent interior temperatures up to 80 degrees per Chad. ACC continues to dry base of stud bays with a combination of fans and heaters.



Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900

www.bartletthospital.org

January 28, 2020 Board Report Kevin Benson, CFO

FINANCE/ACCOUNTING – Blessy Robert

- Completed FY21 Budget preparation. The rest of January and much of February will be spent meeting with department managers on the development of the budget.
- The Accounting department is leading the upgrade of API (Time and Attendance system) from version 2015 to 2019. The upgraded version is loaded in a test environment and is being tested and fixed to eliminate problems that have developed over the years resulting in many manual processes.
- Noridian (CMS) is auditing the Cost Reports from FY2017 and FY2018 concurrently. This requires time to research answers to their many questions. This is challenging as the current staff were not involved in the preparation of those reports. It seems the audit requests are coming to an end.
- The department experienced turnover of 3 of 6 positions in the last 6 months. New staff training has been completed and staff feels the department is well positioned to make improvements and be a resource for the organization going forward.

HIM – Rachael Stark

- We are continuing our validation of scanned documents into the EMR. We had some vacations for the holidays so we are working on catching up coding.
- We are also preparing for the Meditech upgrade to Expanse and the ambulatory product.

PFS – Tami Lawson-Churchill

- PFS welcomed our new receptionist Alianna Chille in December and we are thrilled to have her! We are currently interviewing for our new Fiscal Lead to replace our Collection Supervisor position. We hope to have interviews completed and a selection made by the beginning of February.
- We are in the process of building our BOPS Ambulatory Module in Meditech and things moving along nicely.
- We are working closely with Lori Holte to get dictionaries (OR/SUR/MM/CDM) cleaned up
- We are continuing to audit accounts for charge integrity and rebilling these as necessary

PAS – Angelita Rivera

- ACCESS Passport newest version has been loaded, PAS staff have been using since Tuesday. Currently documenting any issues that arise. Looks like so far so good with this version.
- Just got notice from an employee that will be leaving Juneau in May, so we hope to recruit for this position early with plenty of time to have them up and running by tourist season.

IS – Scott Chille

Projects:

- Hardware Infrastructure refresh (**VxBlock**) – at Reliable Transport – awaiting UPS install
 - Given UPS delays, may have to delay install of VxBlock until after Expanse GoLive March 12th, so early April timeframe to begin install and migrations.
- **UPS** delivery January 13-14th / install dependent on multiple factors – timeline forthcoming from electricians (expect 4-week build which will put us into mid-February)

- **MEDITECH** – migration to new VxBlock environment – UNSURE at this time
- **PACS** upgrade and migration kick-off call yesterday – DELAYED pending VxBlock install
- **MEDITECH Expanse** – software installation into TEST environment COMPLETE
 - Both builds are happening concurrently: Go Live for Expanse is March 12, 2020; Go Live for Ambulatory is 9/1/2020.
- **Completed Milestones - Expanse**
 - Expanse software delivered to TEST environment 11/5/19.
 - Physician Advisory Committee (PAC) assembled
 - a. Physician Champion, Acute: Dr. Dorothy Hernandez
 - b. Physician Champion, Ambulatory: Dr. Joanne Gartenberg
 - c. PAC working with Physician EHR Committee for duration of Expanse project.
 - d. Regular, bi-monthly meetings to discuss document template design and workflows.
- **Completed Milestones – Ambulatory**
 - Ambulatory dictionaries delivered week of 11/17/19
 - Weekly meetings with behavioral health group + Ambulatory Physician Champion
 - Revenue Cycle and Front Office teams meeting weekly
 - Integrated team meetings bimonthly
- **Future Milestones - Expanse**
 - Parallel and Integrated testing: Mid-January
 - Super Users identified/trained: Late-January
 - End user training: February
 - Command center: March 12th – 26th; 24/7 support x2 weeks
- **Future Milestones – Ambulatory**
 - Meditech onsite for Dictionary Training: December 9-12th
 - Meditech onsite for Applications Training: April 7- 9th; May 5-8th; June 9-11th
 - Meditech pre-Live visit, TBD
 - Super user/end user training: August 2020
- **Project List (Attached)**
- **Department Updates:** Recruiting for **two** Help Desk Technician positions
- **Information Security:** Phishing Test results and Awareness Training stats

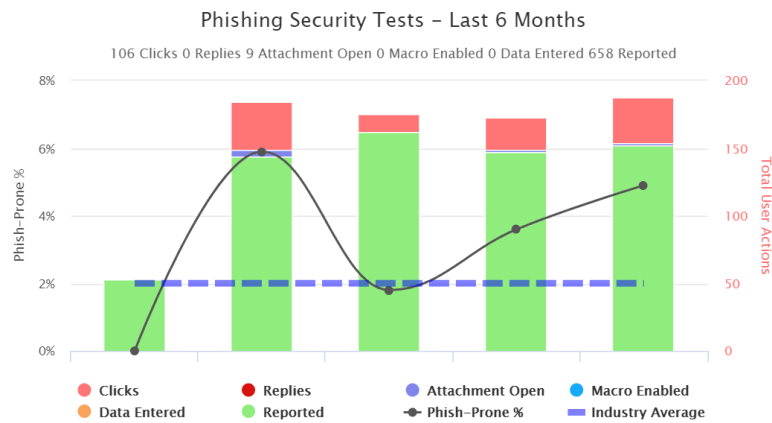
Organization's Risk Score



19.4

See our [Virtual Risk Officer \(VRO\) Guide](#) for details about how Risk Scores are calculated.

Phishing



[See more phishing reports](#)

Industry Benchmark Data ?	
YOUR LAST PHISH-PRONE%	4.9%
INDUSTRY PHISH-PRONE%	2%
Industry: <input type="text" value="Healthcare & Pharmaceuticals"/>	
Company Size: <input type="text" value="Medium (250-1000 users)"/>	
Program Maturity: <input type="text" value="1 Year"/>	

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801

907.796.8900

www.bartletthospital.org

January 2020 Board Report

Chuck Bill, CEO

Despite, or perhaps because of, the 3 holidays since our December 21st Board meeting, the New Year has started out with a bang!

- The governor presented his budget to the legislature – Flat Funding Medicaid at the anticipated final numbers for FY2019 that of course continues the 5% cut we received and allows for no inflation adjustments for the third year in a row. At the same time he is vetoing several grants, primarily to Behavioral Health, which will harm BRH if the legislature does not overturn them. Representative Andi Story’s office reached out to me to identify the scope of the dollars involved at Bartlett. We have provided the attached analysis.
- On January 9th, I was in Anchorage for a day long ASHNHA meeting of the Executive and Legislative Committees to work on agendas and priorities for the coming year. We had a two hour meeting with DHSS Commissioner Crum, Deputy Commissioner Wall and Medical Director, Anne Zink, MD. The conversation was congenial and mutually supportive but with little actual meat at this time. We have also had a series of more productive meetings with DHSS and Fairbanks Hospital around the “Morse” judgement requiring DHSS to fix the Behavioral Health systems problems with boarding patients in the E.D.s and corrections facilities, and how that affects our D.E.T. programs.
- On January 14th, I was back in Anchorage to meet with the American Heart Association and DHSS along with other Alaska Stakeholders about a grant to create a statewide data gathering process to identify gaps in the care continuum for heart attacks. This is in the early phases of discussion but may not add much value to the state system already in place.
- On January 15th, the joint meeting of the Bartlett Board and the Assembly went very well.
- We continue our search for a Quality and Patient Safety Director to replace Sarah Hargrave.

From: [Charles E. Bill](#)
To: [Anita L. Moffitt](#)
Subject: FW: Lobbyist request
Date: Tuesday, January 21, 2020 11:37:42 AM

From: Bradley F. Grigg
Sent: Thursday, January 16, 2020 1:16 PM
To: Charles E. Bill <cbill@bartlettshospital.org>
Subject: RE: Lobbyist request

Chuck,

Please see below:

Of our 4 grants with DHSS, 2 (Both for RRC) are Federally Funded as pass through monies through DHSS. **Total Federal Grant Dollars \$579,267.46 (roughly 40% of our total operating grants from DHSS).** Let me know if you need additional information.

Grantee Name	Grant Award Number	Grant Program Type	Grant Funds Awarded	BHTRG FED SAPT 93_959	BHTRG ADTP	BHTRG ACHI GFMH \$3
Bartlett Regional Hospital - Rainforest Recovery Center	602-208-20015	Comprehensive Behavioral Health Treatment and Recovery Program	\$404,267.46		\$404,267.46	
Bartlett Regional Hospital - Rainforest Recovery Center	602-239-20010	Sobering Center, Withdrawal Mgt & Res SUD	\$175,000.00			\$175,000.00
Bartlett Regional Hospital - Rainforest Recovery Center	602-208-20016	Comprehensive Behavioral Health Treatment and Recovery Program	\$101,066.87	\$101,066.87		
Bartlett Regional Hospital - Rainforest Recovery Center	602-239-20004	Sobering Center, Withdrawal Mgt & Res SUD	\$800,000.00			\$800,000.00

Bradley F. Grigg, MA
Chief Behavioral Health Officer
Bartlett Regional Hospital
3260 Hospital Drive
Juneau, Alaska 99801
Office: 907.796.8583
Cell: 907.723.0548

"Action springs not from thought, but from a readiness for responsibility."
— Dietrich Bonhoeffer

From: Charles E. Bill
Sent: Wednesday, January 15, 2020 3:59 PM
To: Bradley F. Grigg <bgrigg@bartlettshospital.org>
Subject: Lobbyist request

I met with two CBJ lobbyists today. They have asked if we can provide them with the \$ and the impact of Federal Grants we receive for Behavioral services.

From: [Charles E. Bill](#)
To: [Anita L. Moffitt](#)
Subject: FW: Cataract volume demands
Date: Monday, January 27, 2020 11:12:04 AM

-----Original Message-----

From: Andrew Kopstein
Sent: Sunday, January 26, 2020 10:19 AM

Subject: Cataract volume demands

Dear Colleagues,

Thank you for your tremendous support of our fledgling cataract surgery program in Juneau. We are frankly overwhelmed by the positive response from the community— and this has led to reconsideration of methods to improve timely access to CE/IOL for all citizens of SE Alaska.

We currently have 99 patients in the queue to obtain cataract surgery on the first eye. We are prioritizing the bilaterally blind (<20/200) patients, followed by unilaterally blind patients, followed by those seeking second eye surgery in a timely manner and those who are impaired for occupational tasks. I would like to hear your thoughts on this prioritization scheme, which is certainly subject to adjustment based on your feedback.

The Bartlett Hospital staff is phenomenal— this small community hospital has now allowed me to schedule up to 18 cases out of a single OR room in one day, starting in February. I am not sure if anyone in this group is aware of how impressive this is, especially after just 5-6 surgery days thus far. We are looking for opportunities to add capacity to accommodate our growing volume, and will be exploring the possibility of increasing the monthly number of surgery days in the near future.

Your help with post-op care has been much appreciated. This helps us keep our clinic spots open for new consults, as we work through our growing wait list. I will be most interested to hear your feedback about fine-tuning our postop protocol during our February meeting, which I hope most of you can attend.

Until then, please do not hesitate to call/text/email with any current concerns or suggestions!

Sincerely yours,
Andy

Sent from my iPhone
External Email: Be cautious with URLs and Attachments.

Board Committee and Liaison Assignments 2020

Executive Committee

President – Lance Stevens
Vice President – Rosemary Hagevig
Secretary – Kenny Solomon-Gross
Brenda Knapp – Past President

Finance Committee

Deb Johnston., Chair
Mark Johnson
Brenda Knapp

Planning Committee

Marshal Kendziorek, Chair
Iola Young
Kenny Solomon-Gross

Governance Committee

Brenda Knapp, Chair
Rosemary Hagevig
Kenny Solomon-Gross

Quality Committee

Rosemary Hagevig, Chair
Lindy Jones, M.D.
Kenny Solomon-Gross

Compliance and Audit Committee

Marshal Kendziorek, Chair
Iola Young
Deb Johnston

Physician Recruitment

Mark Johnson, Chair
Lindy Jones, M.D.

Joint Conference Committee

Executive Committee of Board (Board President serves as Chair; Board VP is Vice Chair)
Executive Committee of Medical Staff
Representatives of Administration

BRH Foundation (2nd Tuesday of each month noon)

Rosemary Hagevig, Liaison

Credentialing (2nd Tuesday of each month 7:00 a.m.)

Rosemary Hagevig, Liaison



April 2020 Leadership Conference

REGISTER →

April 26–29, 2020

Fairmont Scottsdale Princess

Scottsdale, Arizona

[View more information →](#)

Leading the Health System of the Future, Today

INTENTIONAL GOVERNANCE

Excel in governance performance integrity to build the health system of the future

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Maintain "true north": zero harm and STEEP care for every patient, every time, everywhere

DIGITAL INTELLIGENCE

Build competencies in AI, predictive analytics, and virtual care to transform the business of healthcare

EMBOLDEN STRATEGY

Address the risks of not taking risk and lead in the face of uncertainty

COMPETITION TO COLLABORATION

Ensure that all partnerships help achieve the Triple Aim

Who should attend our conferences?

Board Chairs, Board Members, Healthcare Executives, & Physician & Nurse Leaders

EDUCATION—a valuable resource to stay abreast of current topics in healthcare and board governance with the opportunity to earn continuing education credits.

INSPIRING PRESENTATIONS—engaging and relevant content to foster learning opportunities and team building for boards, healthcare executives, and medical staff leadership.

NETWORKING—network with like organizations facing similar challenges.

SPECIAL PROGRAMS & SESSIONS—participate in specific tracks and special sessions in conjunction with our Leadership Conferences.

LOCATION—our conferences are held at various locations across the United States to enhance the learning experience.



[Overview](#) **[Agenda](#)** [Hotel/Travel](#) [Education](#)

[REGISTER](#)

Leadership Conference

April 26–29, 2020 | Scottsdale, Arizona

Fairmont Scottsdale Princess

[REGISTER NOW](#)

Agenda

April 26, 2020

Registration

11:00 AM-6:00 PM

Registration

> The Changing Demands of Physician Leadership in Evolving Health Systems

1:00 PM-2:15 PM

Physician Leader Track

> Catalyzing Digital Transformation in Healthcare

2:30 PM-4:00 PM

Concurrent Session

> To Thrive, Survive or Implode: Whether & How Local Hospitals Make It

2:30 PM-4:00 PM

Concurrent Session

> Learning as a Strategic Asset: Building a Coaching Culture

2:30 PM-4:00 PM

Concurrent Session

> Healthcare Reboot: Megatrends

4:15 PM-6:00 PM

Keynote Address

Networking Reception

6:00 PM-7:00 PM

Networking Reception

April 27, 2020

Networking Breakfast

7:30 AM-8:30 AM

Networking Breakfast

> Through the Consumer's Eyes: Healthcare in the Post-Era

8:30 AM-9:30 AM

General Session

> Enterprise Risk: Understanding, Measuring, & Taking Action

9:45 AM-10:45 AM

General Session

> The Digital Front Door

11:00 AM-12:00 PM

General Session

Networking Lunch

12:00 PM-1:00 PM

Networking Lunch

> Building a Reliable Culture of Safety or Reducing Variations: What is the Board's Role?

1:00 PM-2:30 PM

Concurrent Session

> Evolution of System Governance Structure in the U.S.

1:00 PM-2:30 PM

Concurrent Session

- Designing the High-Performance Physician Team in the Era of Physician Burnout
1:00 PM-2:30 PM

Concurrent Session

- Governance Learning Cohort Networking Discussion
2:45 PM-3:45 PM

Governance Learning Cohort Networking Discussion

April 28, 2020

Networking Breakfast

7:30 AM-8:30 AM

Networking Breakfast

- How the Reshaping of Consolidation Is Remaking Healthcare
8:30 AM-9:30 AM

General Session

- Healthcare Bond Ratings
9:45 AM-10:45 AM

General Session

> Intentional Governance: Board's & Quality

11:00 AM-12:30 PM

Concurrent Session

> Why & How Trustees Own the Leadership Culture of the Institutions They Govern

11:00 AM-12:30 PM

Concurrent Session

> Board Oversight of the Hospital Medical Staff: More Important & More Challenging Than Ever!

11:00 AM-12:30 PM

Concurrent Session

> Chair/CEO Lunch (Invitation Only)

12:45 PM-1:45 PM

Special Session

April 29, 2020

Networking Breakfast

7:30 AM-8:30 AM

Networking Breakfast

> Next Generation Healthcare: Using Innovation to Disrupt the Disruptors

8:30 AM-9:30 AM

General Session

> Measuring & Moving What Matters: Advancing Well-Being in the Nation

9:45 AM-11:00 AM

General Session

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2020 Governance Support Forum

Check back for more information coming soon

September 12–13, 2020

The Broadmoor

Colorado Springs, Colorado



September 2020 Leadership Conference

Check back for more information coming soon


September 13–16, 2020

The Broadmoor

Colorado Springs, Colorado

February 2020

****All meetings are held in BRH Boardroom unless otherwise noted****

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10	11 7:00am Credentials Committee BR (NOT A PUBLIC MEETING)	12 7:00am Finance Committee BR (PUBLIC MEETING)	13	14	15
16	17  PRESIDENTS DAY	18	19	20	21	22
23	24	25 **5:00pm – see below 5:30pm Board of Directors BR (PUBLIC MEETING)	26	27	28	29

Committee Meeting Checkoff:

Board of Directors – 4th Tuesday every month

Board Compliance – 2nd Tuesday every 3 months (Mar, Jun, Sept, Dec)

Board Quality- 2nd Wednesday every 2 months (Jan, Mar, May, July, Sept, and Nov.)

Executive – As Needed

Finance – 2nd Wednesday every month

Joint Planning – As needed

Physician Recruitment – As needed

Governance – As needed

Planning – As needed

***Board members will be touring the Pharmacy Department from 5:00 – 5:30pm on February 25th unless canceled due to member or department unavailability.