Bartlett Regional Hospital

AGENDA
QUALITY BOARD TEAM MEETING
Wednesday, July 15, 2020 – 4:15 p.m.
Bartlett Regional Hospital Boardroom / Zoom Video Conference

Public may participate telephonically by calling 1-800-315-6338- Access code 86591

Mission Statement

Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

Call to Order

Approval of the minutes – 05.13.2020 Pg. 2

Standing Agenda Items:

- 2020 BOD Quality Dashboard Pg. 5

New Business: July Quality Report Pg. 7

- Hospital Compare Website
- Press Ganey Patient Feedback Update
- Value-Based Purchasing Overview

Next Scheduled Meeting: September 9, 2020 4:15 p.m.

Bartlett Regional Hospital

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

Board Quality Committee
May 13, 2020
Minutes

Called to order at 4:15 pm by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig (Chair), Kenny Solomon- Gross, Lindy Jones

Staff: Charles Bill, CEO, James Caldwell, Director of Quality, Rose Lawhorne, CNO, Bradley Grigg, CBHO, Gail Moorehead, Director of Education, Dallas Hargrave, HR Director, Mary Crann, Risk Manager, Megan Costello, Chief Legal Officer, Deborah Koelsch, RN Clinical Quality Data Coordinator, Billy Gardner, COO, Kevin Benson, CFO

Approval of the minutes – 04 16 2020 Quality Meeting – *minutes approved as written.*

Old Business: Mr. Caldwell had asked Press Ganey to change personal identifier to something other than birthdate. That cannot be changed. There is an uptake of surveys returned since eForms. The front desk hand sanitizer has been watched by the front desk is kept full.

New Business:
Sepsis: Deb K. Gave a description of what a quality measure is. A quality measure are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions and organizational structure that are associated with the ability to provide high-quality health care. They are the tools to help us provide the best patient care. The sepsis measure is reported on hospital compare. The sepsis measure determines if there is documentation of the presence of severe sepsis. Q1 we had 36 cases that had a sepsis diagnosis. 16 cases were excluded from the data. Some of the exculsions are viral infections, patient placed on comfort care. We had 20 cases in the denominator and we passed all the measures for 12 of the cases. The documentation requirements are clinical criteria by the MD in the chart. Deb K. showed the slides from hospital care. We are meeting the measure at 59% the AK average is 55%. The sepsis measure rate by quarter shows us at about 60%. We have room to improve numbers. The next chart is the sepsis fallouts from January 2018 – March 2020. The cases were 217 and it shows our fallouts. The highest fallouts are antibiotics and lactate. The ISTAT timeline 8/2019 use was started in ED, January the cartridges were stopped due to recall. March, 2020 clearance for given. Dr. Jones said all inpatients are being tested for COVID and that he believed the ISTAT machine would help in the missed lactates, timing of antibiotics. He was concerned the COVID patient flow would or could create some timing issues on the septic population.
It was noted after questions CMS has made some reporting optional.

Nurse Residency Program Update

Gail Moorehead is reporting on the Nurse Residency Program one year follow up. At this time all the RN graduates that were hired last May are still working at Bartlett. This is a 100% retention rate. The national averages state that 17.9% of new graduates leave their first position in less than one year. The goals of the residency program were to reduce the use of contract nurses, have an 80% retention rate of the new nurses and provide the nurses with training in multiple departments. Besides retaining all our new nurses as of May 1, 2020, the nurses have all successfully achieved advancement to the next level on the nursing clinical ladder and 5 out of 10 have completed float contracts with other departments. The total payroll cost of this program for the 10 nurses was $147,709 with the average per nurse as $14,471.
Mr. Gross thanked Ms. Moorehead for the information, and was very complimentary of the program, and encouraged the hospital to publicize the results.
Ms. Hagevig and Mr. Bill discussed funding and how nursing schools were being funded. It was clarified that much of the State money coming from the university is now flowing into APN programs aimed at behavioral health per Bradly Gregg.
Dr. Jones wanted to be sure everyone understood the importance of the nursing program here, that the graduates were exceptional, and we needed to do all we could to recruit as many as possible.

Risk Management

Mary Crann reports on the RL Solutions updates and changes. The new changes include a follow up checklist that gives help for the Directors to follow up using a shared mental model. Ms. Crann also stated that the resolutions and outcomes have been changed to make the process standardized. The resolutions are designed to be sustainable if changes need to be made after a root cause analysis is done. As of May 6 we have 59 COVID related occurrence reports and there are 52 open risk files with no sign-offs. We want to look at our process and make sure the events are signed off and complete. Mr. Caldwell wanted to acknowledge the Directors and SLT leaders are working hard to identify the events and how we can improve patient safety.

Microsystems 2.0 Life after COVID-19

Mr. Caldwell states that MS 2.0 is the framework to work through process improvement. Respect for people is the cornerstone of continuous improvement. The shingo concepts looks at safety culture and scores you. The respect for people is the cornerstone of what we want to achieve. We are looking at using the basic common language including respect, accountability, seek to understand, seek perfection, common language, data drive, a learning culture and a just culture. The basis of the program will be using PDSA cycle that will make the right thing to do the easy thing to do. Mr. Caldwell stated that a culture is hard to define and we need to develop our own culture with shared knowledge, beliefs, values, attitudes towards a culture of improvement. This is not new to Bartlett but a refresh of what we have and building upon it. This is not a flavor of the month but how we do business. The Swiss cheese principle talks about accidents happen because there were weaknesses in systems and how supervision is done, preconditions and acts.

Overview of Covid -19

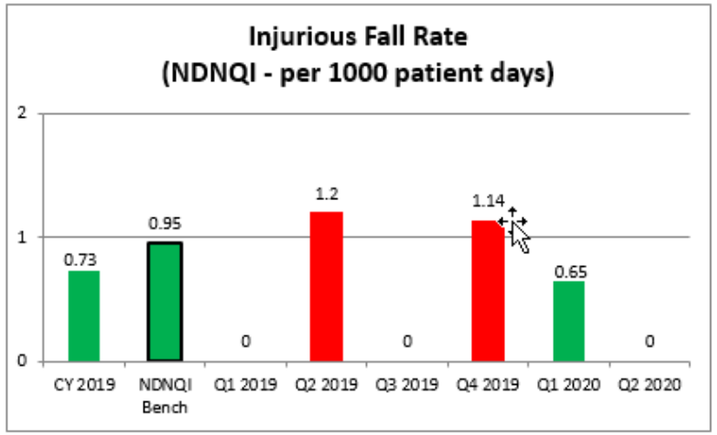
Mr. Caldwell reported that we have 29 cases in community and there are 8 people being monitored based on 2 active cases. On May 18th and 19th there will be testing of the homeless

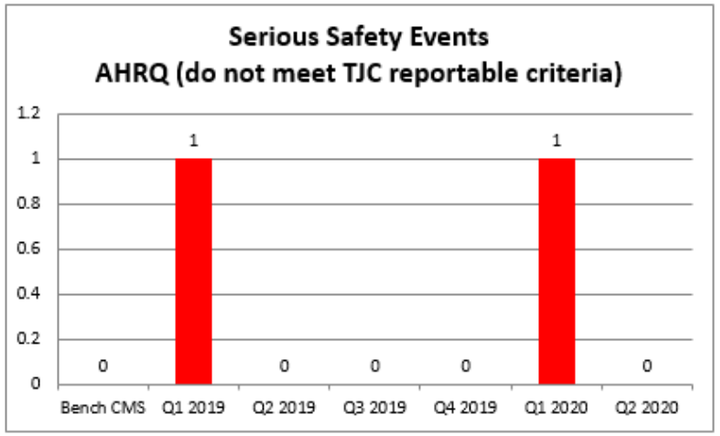
population. There will be shelters in Centennial Hall if there are any positive fallouts from the testing. We have 20 Cepheid and 85 Abbott quick tests. We continue to work on how to get more tests in the community. The state now has agreed to run tests at another lab and we now have results within 48 hours for send out tests. Mr. Gross asked how logistically we are testing the homeless population. Mr. Caldwell said that they would be going to where the homeless are living. The tests are voluntary but there will be incentives given such as a grocery store gift card. There are about 150 people in the homeless group and public health would like to get about 50% of them tested. Dr. Jones stated that they are not seeing many people with respiratory symptoms. The outside tent is set up for triage. He stated that testing is a concern. The Abbott test is not as reliable as necessary. The community testing is being done by CCFR and they will be assisting with the homeless testing. The long-term strategy for Juneau will be to increase testing. Dr. Jones is looking at a machine for testing locally to relieve Juneau's need to send out tests to Anchorage. Mr. Gross talked about how the homeless testing will happen. Dr. Jones stated that the CCFR CARES program is the community testing sites and they also go to homes to do testing. He believes that they will be leading testing. Mr. Bill stated in the Unified Incident Command meeting that there are 20 people living at the campground. They plan to test at the JACC, the campground, Glory Hall and other locations that they have identified homeless residents congregating. The Housing First will be pushed back to start taking 10 people in June, July and August.

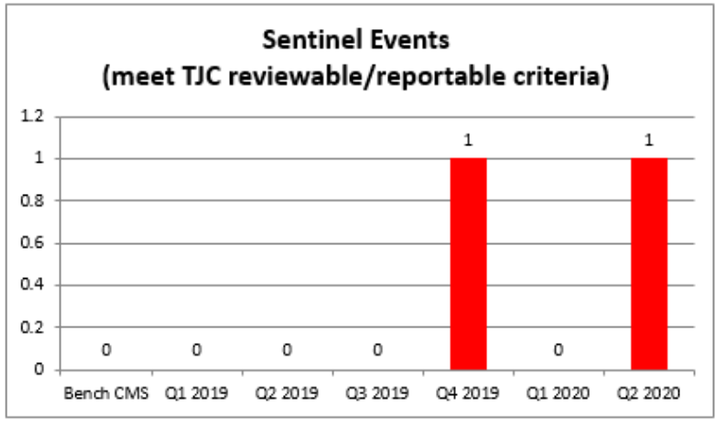
Next Quality Board meeting:

Adjourned at 5:26 pm

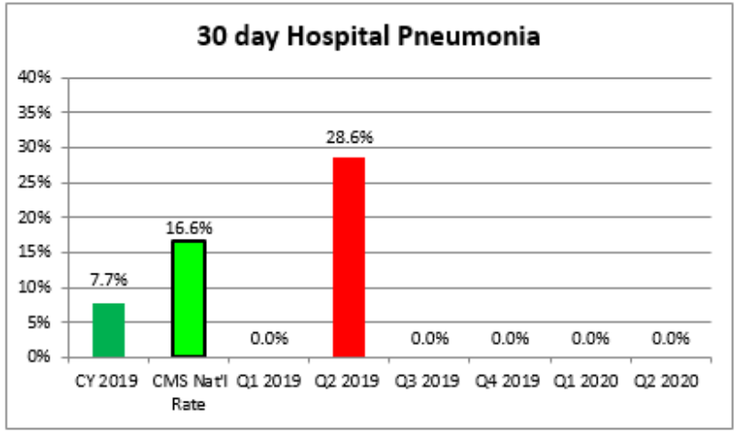
RISK MANAGEMENT - lower is better

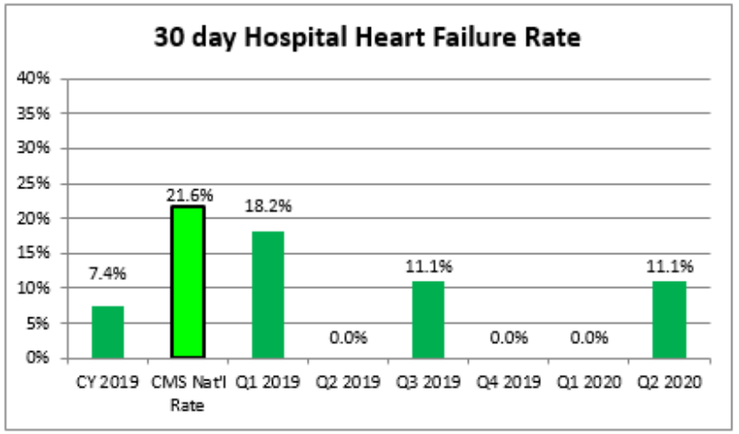


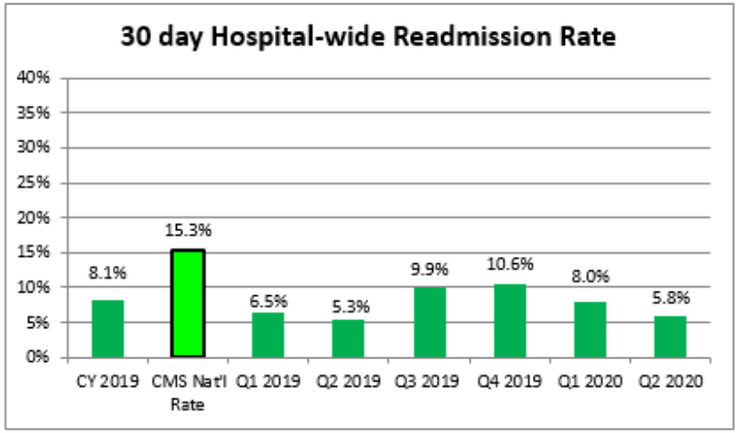




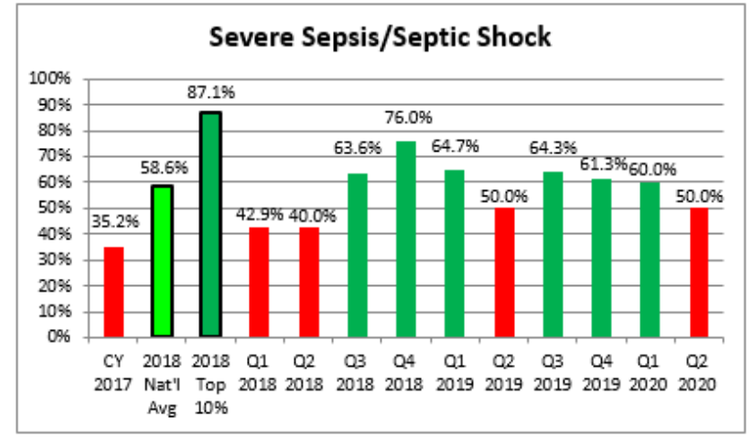
READMISSION RATES - lower is better

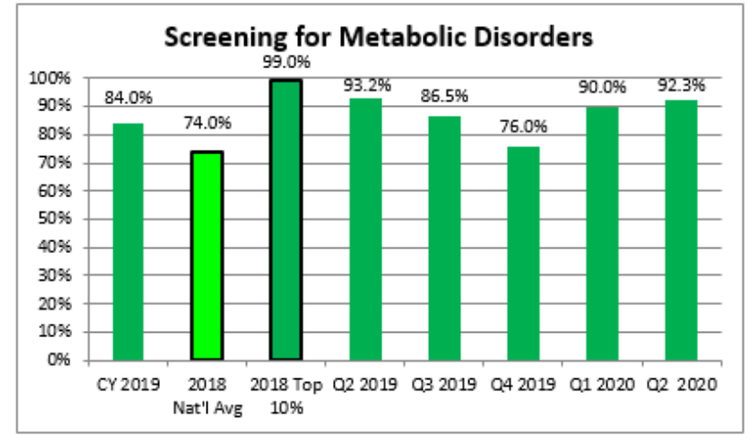






CORE MEASURES - higher is better





Notes:

RISK MANAGEMENT: **Fall rates** are per the NDNQI definition: Med/Surg and CCU only with injury/minor or greater).

SSEs: An event that is a deviation from generally accepted practice or process that reaches the pt and cause severe harm or death.

READMISSION RATES: **Pneumonia and Heart Failure**: patient is readmitted back to the hospital within 30 days of discharge for the same diagnosis.

30 day: patient is readmitted back to the hospital with 30 days of discharge for any diagnosis.

CORE MEASURES: **Sepsis**: measure that demonstrates use of evidenced based protocols to diagnose and treat Sepsis.

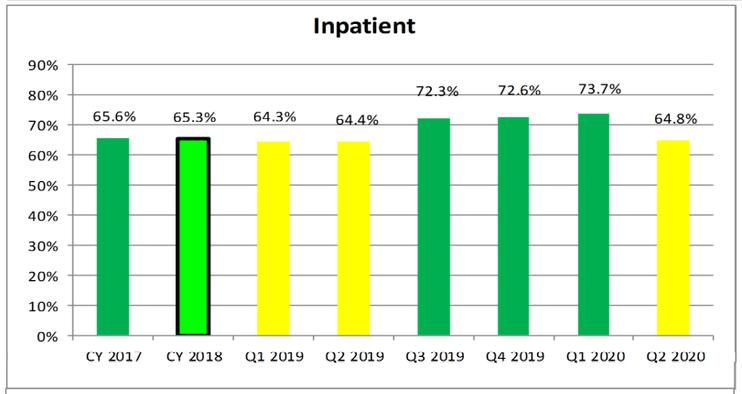
Screening for Metabolic Disorders: % of psychiatric patients with antipsychotics for which a metabolic screening was completed in 12 months prior to discharge

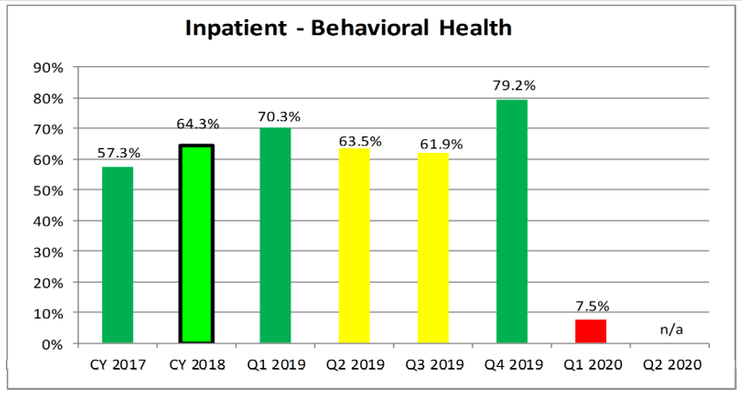
Indicates Benchmark ■
https://www.medicare.gov/hospitalcompare/search.html?

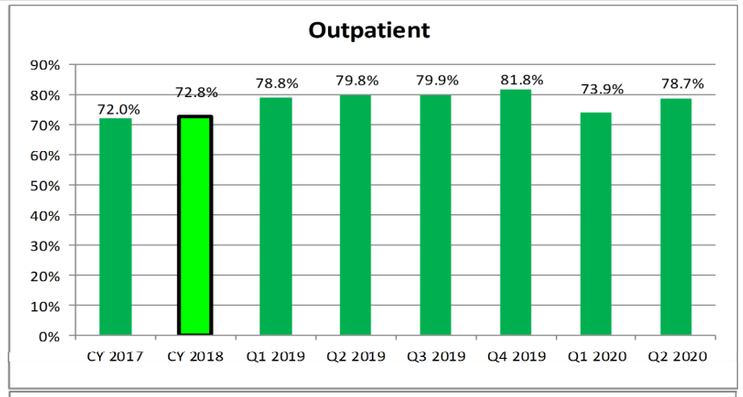
BOARD OF DIRECTORS QUALITY SCORECARD—

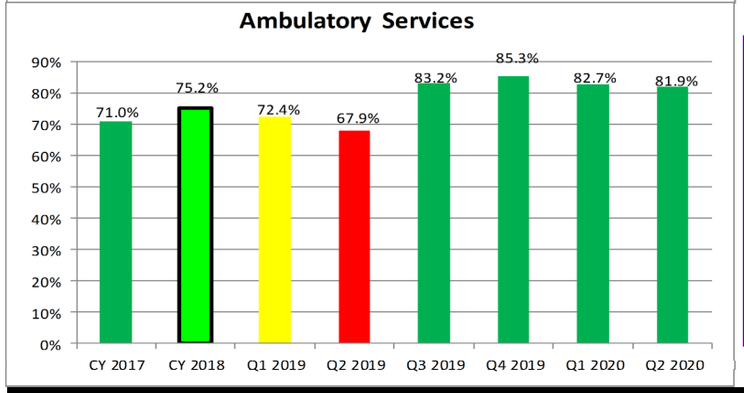
At or above benchmark
Within 5% of benchmark
< 5% of benchmark

PATIENT EXPERIENCE







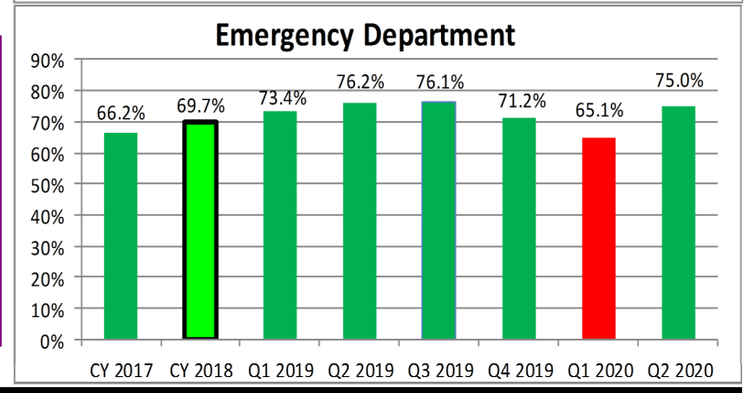


Notes on Patient Experience:

Press Ganey is the vendor for CMS Patient Experience and HCAHPS Scores. The data are publically reported.

HCAHPS Hospital Consumer Assessment of Healthcare Providers & Systems; includes only Med/Surg, ICU and OB.

Top Box HCAHPS results are reported on Hospital Compare as "top-box," "bottom-box" and "middle-box" scores. The "top-box" is the most positive response to HCAHPS Survey items.



HCAHPS RESULTS

CAHPS	2018	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020*	CMS Achievement Threshold	CMS Benchmark (top perf.)
	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	01/2018-12/2018	01/2018-12/2018
Overall Rating (0-10)	74.1 ☐	72.3 ☐	70.6 ☐	79.1☐	75.0 ☐	69.4 ☐	71.6☐	80.8☐	71.6☐	82.1 ☐	78.2☐	71.37%	85.18%
Comm w/Nurses	81.4 ☐	82.8☐	77.3☐	85.6☐	80.6 ☐	85.3 ☐	84.2☐	85.2☐	88.5☐	95.1 ☐	89.0☐	79.18%	87.53%
Comm w/ Doctors	84.5 ☐	86.5 ☐	81.0☐	85.0☐	86.3 ☐	90.6 ☐	83.5☐	89.4☐	92.0☐	94.0 ☐	86.6☐	79.72%	87.85%
Response of Hosp Staff	76.3 ☐	72.6 ☐	77.8 ☐	80.3☐	73.9 ☐	83.8 ☐	68.6☐	78.4☐	77.7☐	84.3 ☐	80.7☐	65.95%	81.29%
Comm About Medicines	66.0 ☐	73.0 ☐	67.1☐	63.6☐	60.6 ☐	60.8 ☐	71.6☐	70.0☐	70.2☐	79.4 ☐	72.6☐	63.59%	74.31%
Cleanliness & Quietness of Hospital Environment	72.5 ☐	75.8 ☐	72.1 ☐	72.7 ☐	69.7 ☐	64.0 ☐	66.6☐	74.9☐	79.2☐	73.9 ☐	73.3☐	65.46%	79.41%
Discharge Information	86.8 ☐	85.3 ☐	87.7 ☐	87.2☐	86.9 ☐	88.3 ☐	88.6☐	89☐	88.2☐	96.8 ☐	92.1☐	87.12%	91.95%
Care Transitions	55.3 ☐	58.4 ☐	51.2☐	55.8☐	56.5 ☐	58.0 ☐	57.1☐	64.0☐	58.3☐	59.3 ☐	53.1☐	51.69%	63.11%

*through May 2020

6/24

A business lives & breathes on "word of mouth" reviews of its service, hospitals are no exception

Bartlett Regional Hospital

QUALITY in Community Healthcare™

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

Agenda

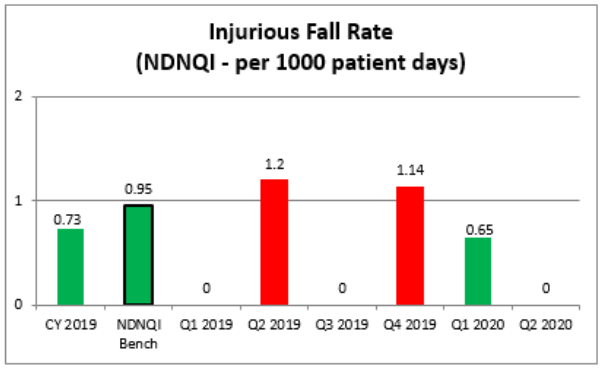
- Quality Scorecard
- Hospital Compare Website
- Press Ganey Update
- Value-Based Purchasing Overview & Update

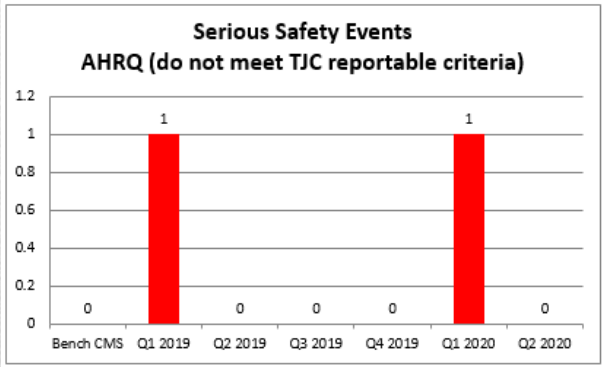
CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

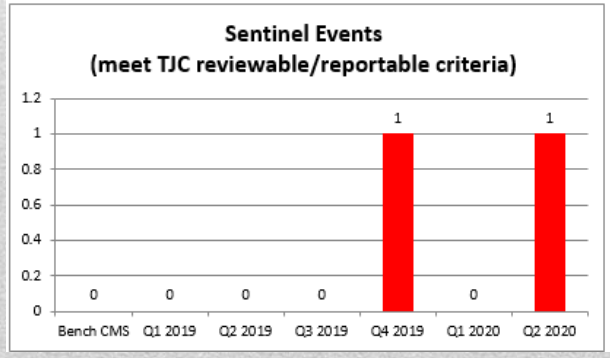
Bartlett Regional Hospital

Quality Scorecard

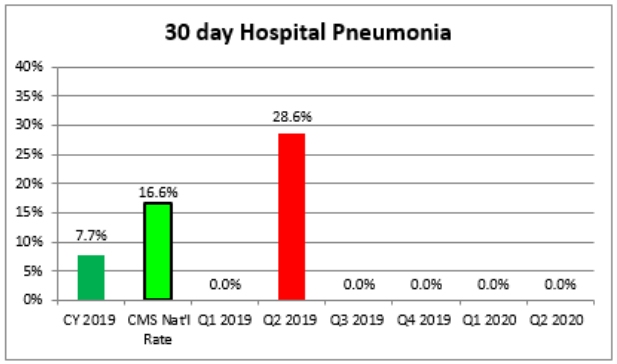
RISK MANAGEMENT – *lower is better*

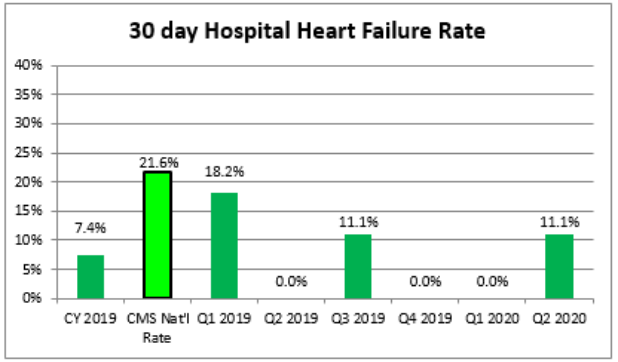


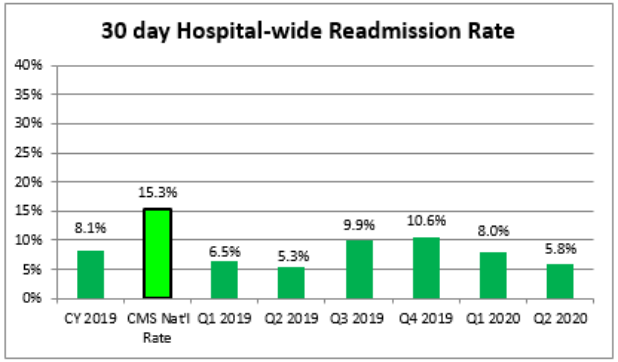




READMISSION RATES – *lower is better*







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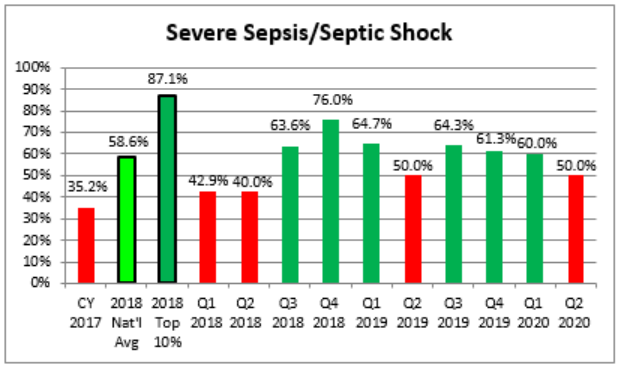

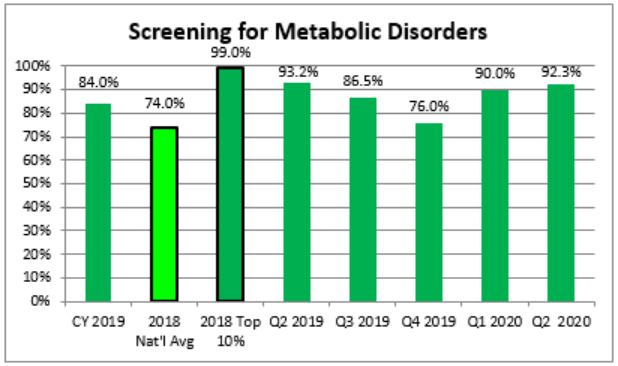

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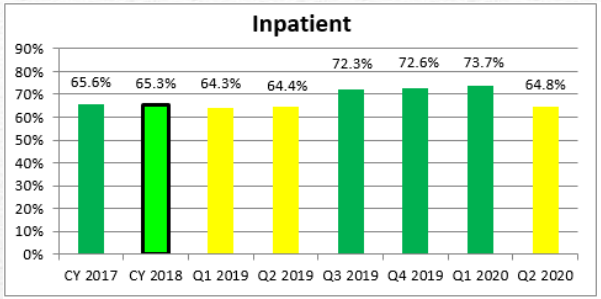
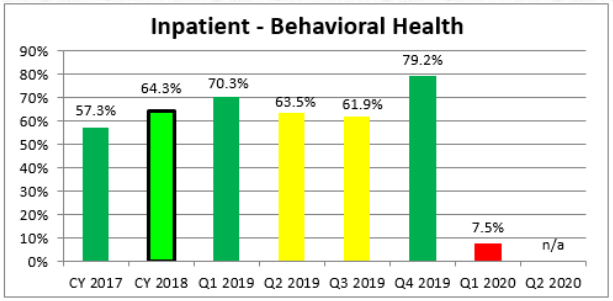
CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

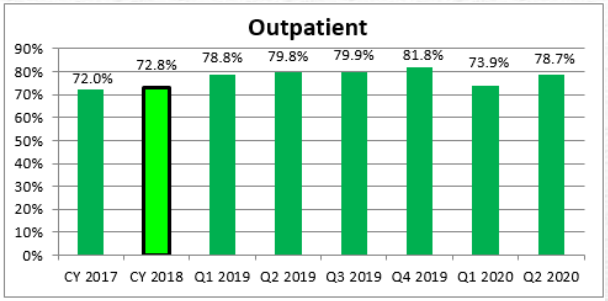
Bartlett Regional Hospital

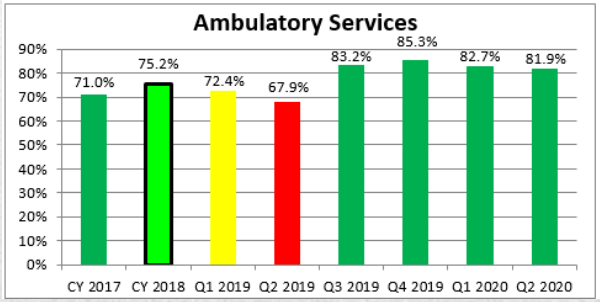
Quality Scorecard

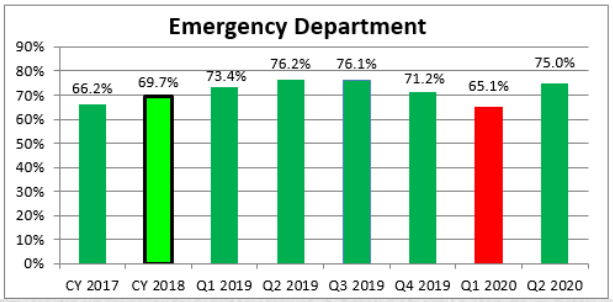
PATIENT EXPERIENCE











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HCAHPS RESULTS

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Comm About Medicines	66.0 ▼	73.0 ▲	67.1▼	63.6▼	60.6 ▼	60.8 ▲	71.6▲	70.0▼	70.2▲	79.4 ▲	72.6▼	63.59%	74.31%
Cleanliness & Quietness of Hospital Environment	72.5 ▲	75.8 ▲	72.1 ▼	72.7 ▲	69.7 ▼	64.0 ▼	66.6▲	74.9▲	79.2▲	73.9 ▲	73.3▼	65.46%	79.41%
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ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

Hospital Compare Website

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ALASKA'S CAPITAL CITY

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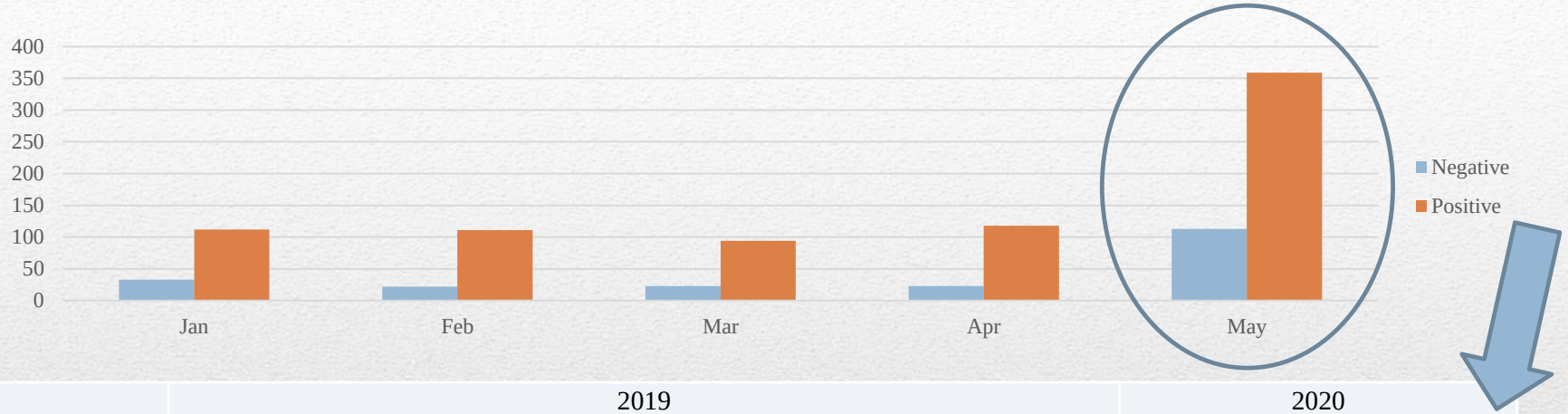
Lets go there now!

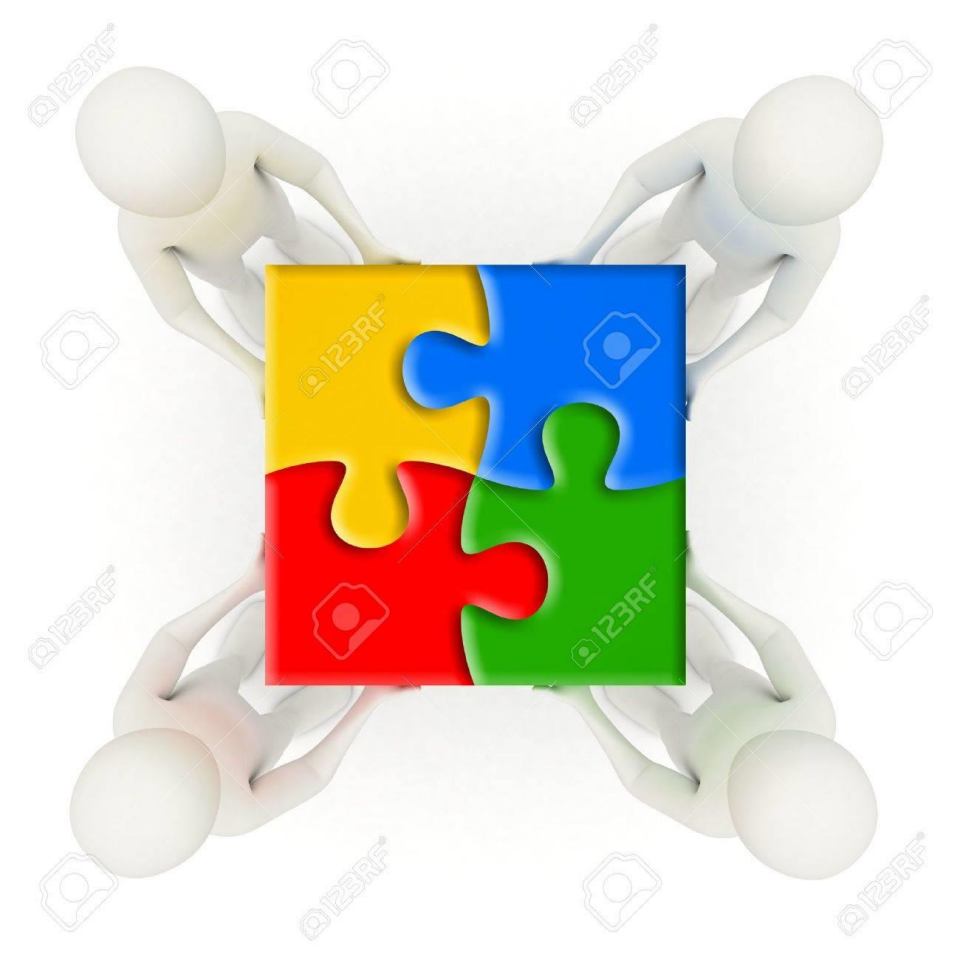
Press Ganey Patient Feedback



	2019												2020				
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Ambulatory																	
Internet																	**25**
Paper	21	12	24	24	22	11	16	21	8	22	15	8	16	16	12	21	12
BH																	
Paper	58	21	6	25	39	39	17	24	21	26	23	21					
ED																	
Internet																**25**	**216**
Paper	35	30	32	48	15	49	91	43	91	40	43	45	38	36	16	28	13
Inpatient																	
Paper	65	46	28	37	39	52	67	103	120	53	21	22	26	30	48	38	31
Outpatient																	
Internet																**8**	**159**
Paper	39	26	19	31	4	48	69	35	59	45	29	36	65	51	41	21	16
Grand Total	218	135	109	165	119	199	260	226	299	186	131	132	145	133	117	141	472

Bartlett Regional Hospital

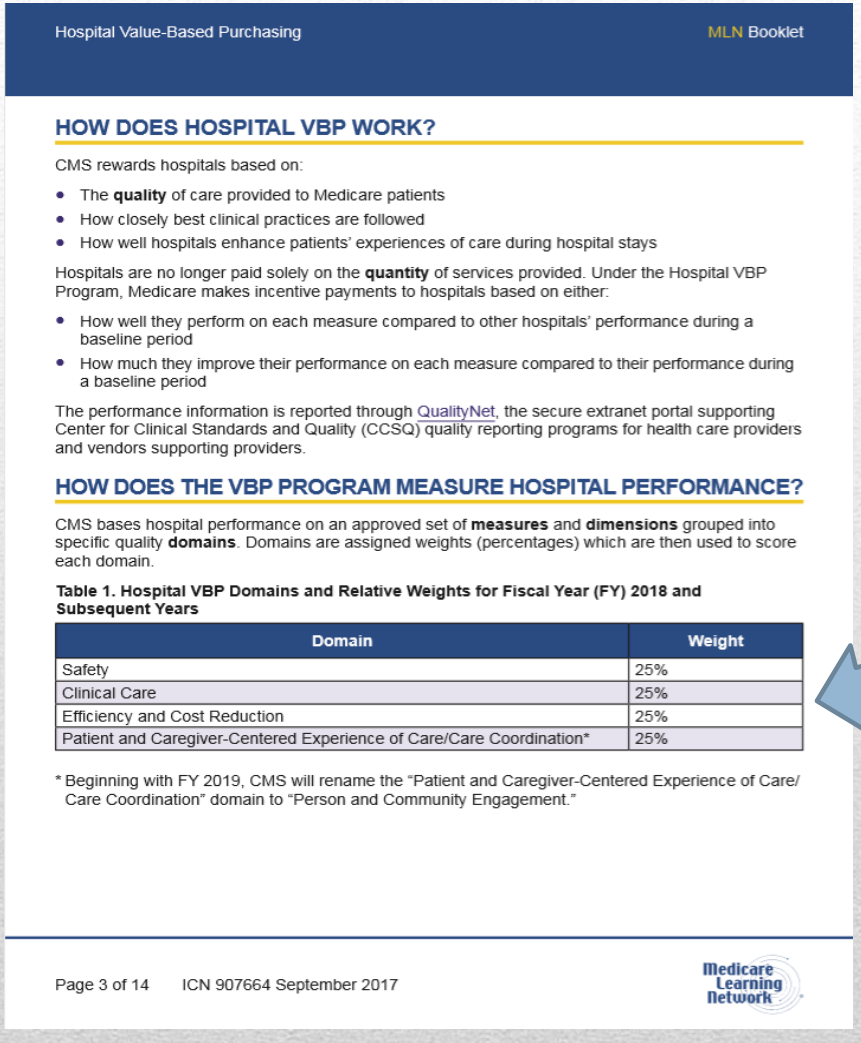
Value-Based Purchasing



CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

Overview



Hospital Value-Based Purchasing MLN Booklet

HOW DOES HOSPITAL VBP WORK?

CMS rewards hospitals based on:

- The **quality** of care provided to Medicare patients
- How closely best clinical practices are followed
- How well hospitals enhance patients' experiences of care during hospital stays

Hospitals are no longer paid solely on the **quantity** of services provided. Under the Hospital VBP Program, Medicare makes incentive payments to hospitals based on either:

- How well they perform on each measure compared to other hospitals' performance during a baseline period
- How much they improve their performance on each measure compared to their performance during a baseline period

The performance information is reported through QualityNet, the secure extranet portal supporting Center for Clinical Standards and Quality (CCSQ) quality reporting programs for health care providers and vendors supporting providers.

HOW DOES THE VBP PROGRAM MEASURE HOSPITAL PERFORMANCE?

CMS bases hospital performance on an approved set of **measures** and **dimensions** grouped into specific quality **domains**. Domains are assigned weights (percentages) which are then used to score each domain.

Table 1. Hospital VBP Domains and Relative Weights for Fiscal Year (FY) 2018 and Subsequent Years

Domain	Weight
Safety	25%
Clinical Care	25%
Efficiency and Cost Reduction	25%
Patient and Caregiver-Centered Experience of Care/Care Coordination*	25%

* Beginning with FY 2019, CMS will rename the "Patient and Caregiver-Centered Experience of Care/ Care Coordination" domain to "Person and Community Engagement."

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Medicare Learning Network

The Value-Based Program is designed to reward, or punish hospitals based on the comparative scores of many basic hospital functions:

CITY AND BOROUGH OF JUNEAU ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

Scorecard

FY 2022 Hospital Value-Based Purchasing Guide

Payment adjustment effective for discharges from October 1, 2021 through September 30, 2022

Clinical Outcomes — 25%

Baseline Period July 1, 2012–June 30, 2015 | **Performance Period** July 1, 2017–June 30, 2020

Measures	Threshold	Benchmark
30-Day Mortality, Acute Myocardial Infarction (MORT-30-AMI)	0.861793	0.881305
Coronary Artery Bypass Graft (CABG) Surgery 30-Day Mortality Rate (MORT-30-CABG)	0.968210	0.979000
30-Day Mortality, Heart Failure (MORT-30-HF)	0.879869	0.903608
30-Day Mortality, COPD (MORT-30-COPD)	0.920058	0.936962

Baseline Period July 1, 2012–June 30, 2015 | **Performance Period** September 1, 2017–June 30, 2020

Measure	Threshold	Benchmark
30-Day Mortality, Pneumonia (MORT-30-PN)	0.836122	0.870506

Baseline Period April 1, 2012–March 31, 2015 | **Performance Period** April 1, 2017—March 31, 2020

Measure	Threshold	Benchmark
↓Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Complication Rate(COMP-HIP-KNEE)	0.029833	0.021493

Person and Community Engagement — 25%

Baseline Period January 1–December 31, 2018 | **Performance Period** January 1–December 31, 2020

HCAHPS Survey Dimensions	HCAHPS Performance Standards Floor (%)	Threshold (%)	Benchmark(%)
Communication with Nurses	15.73	79.18	87.53
Communication with Doctors	19.03	79.72	87.85
Responsiveness of Hospital Staff	25.71	65.95	81.29
Communication about Medicines	10.62	63.59	74.31
Hospital Cleanliness and Quietness	5.89	65.46	79.41
Discharge Information	66.78	87.12	91.95
Care Transition	6.84	51.69	63.11
Overall Rating of Hospital	19.09	71.37	85.18

Safety — 25%

Baseline Period January 1–December 31, 2018 | **Performance Period** January 1–December 31, 2020

Measures (Healthcare-Associated Infections)	Threshold	Benchmark
↓Central Line-Associated Bloodstream Infections (CLABSI)	0.633	0.000
↓Catheter-Associated Urinary Tract Infections (CAUTI)	0.727	0.000
↓Surgical Site Infection (SSI): Colon	0.749	0.000
↓SSI: Abdominal Hysterectomy	0.727	0.000
↓Methicillin-resistant *Staphylococcus aureus* (MRSA)	0.748	0.000
↓*Clostridium difficile* Infection (CDI)	0.646	0.047

Efficiency and Cost Reduction — 25%

Baseline Period January 1–December 31, 2018 | **Performance Period** January 1–December 31, 2020

Measures	Threshold	Benchmark
↓Medicare Spending per Beneficiary (MSPB)	Median Medicare Spending per Beneficiary ratio across all hospitals during the *performance period*	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the *performance period*

FY 2022 Value-Based Payments Funded by 2.0% Withhold

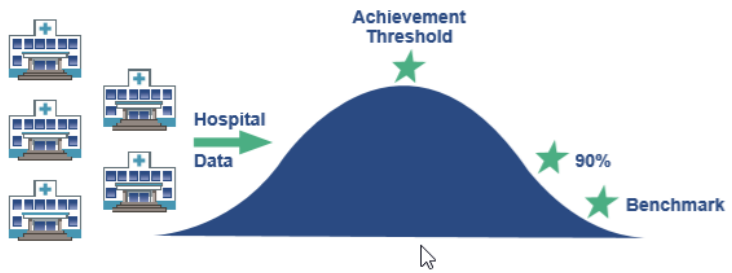
↓ = Lower Values Indicate Better Performance

CITY AND BOROUGH OF JUNEAU ALASKA'S CAPITAL CITY

How a Score is Calculated

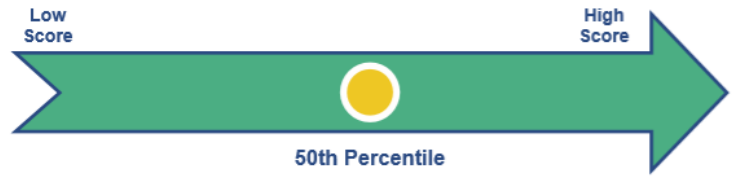
Benchmark: Average (mean) performance of the top 10 percent of hospitals during the baseline period

Figure 1: Benchmark



Achievement Threshold: Performance at the 50th percentile (median) of hospitals during the baseline period

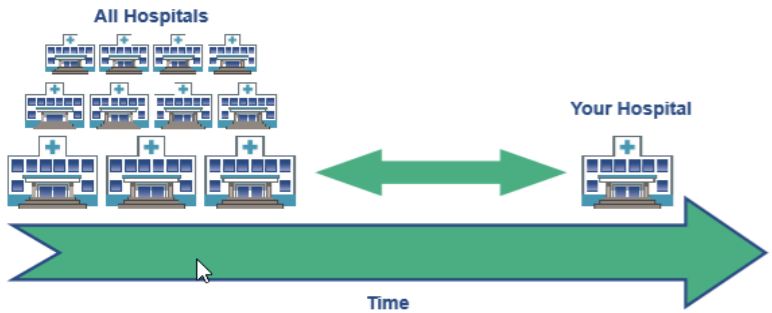
Figure 2: Achievement Threshold



To determine the domain scores, CMS adds points across all measures.

- **Achievement points** are awarded by comparing an individual hospital's rates during the performance period to all hospitals' rates from the baseline period:
  - Hospital rates at or above benchmark = 10 Achievement points
  - Hospital rates below the Achievement threshold = 0 Achievement points
  - Hospital's rate is equal to or greater than the Achievement threshold but less than the benchmark = 1–9 Achievement points

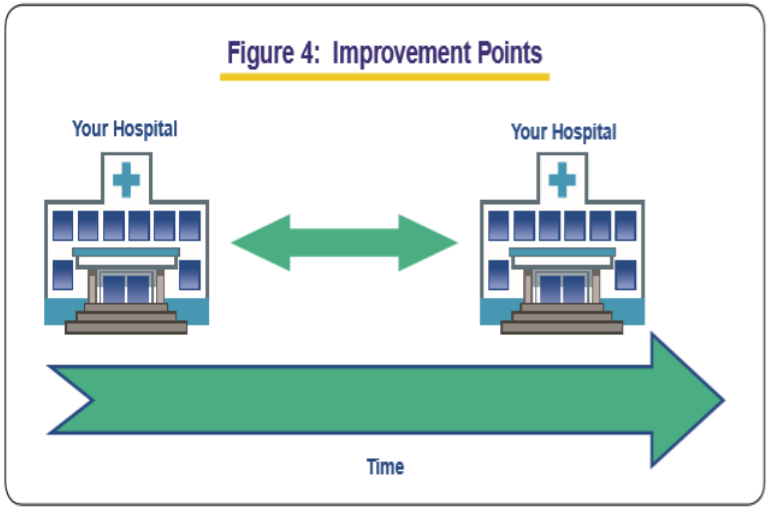
Figure 3: Achievement Points



- **Improvement points** are awarded by comparing an individual hospital's rates during the performance period to that same individual hospital's rates from the baseline period:
  - Hospital rates at or above benchmark = 9 Improvement points
  - Hospital rates at or below baseline period score = 0 Improvement points
  - Hospital's rate is greater than its baseline period score but below the benchmark = 0–9 Improvement points

Bartlett Regional Hospital

How a Score is Calculated



The Patient Experience of Care/Person and Community Engagement domain score is the sum of a hospital's HCAHPS base score and that hospital's HCAHPS Consistency score.

- **Consistency points** are awarded by comparing an individual hospital's HCAHPS Survey dimension rates during the performance period to all hospitals' HCAHPS Survey rates from a baseline period:
  - If a hospital's performance on all HCAHPS dimensions is at or above Achievement threshold = 20 Consistency points
  - If any HCAHPS dimension rate is at or below the worst-performing hospital's performance on that dimension during the baseline period = 0 Consistency points
  - If the lowest HCAHPS dimension score is greater than the worst-performing hospital's rate but less than the Achievement threshold = 0–20 Consistency points

CMS calculates a hospital's **Total Performance Score (TPS)** by:

1. Combining the greater of either the hospital's Achievement or Improvement points for each measure to determine a score for each domain
2. Multiplying each domain score by a specified weight (percentage)
3. Adding the weighted domain scores

WHAT ARE THE HOSPITAL VBP PROGRAM PERFORMANCE PERIODS?

A Hospital VBP Program **performance period** is a designated time span used to capture data that shows how well a hospital is performing. CMS compares data collected for each participating hospital during the performance period to that hospital's data during a **baseline period** to determine the Improvement score. The participating hospitals performance period data is compared to the Achievement Threshold for **all** hospitals during the baseline period to determine the Achievement score.

Table 5. Baseline and Performance Periods for FY 2018

Domain	Baseline Period	Performance Period
Safety: PSI-90	July 1, 2010–June 30, 2012	July 1, 2014–Sept. 30, 2015
Safety: PC-01, CAUTI, CLABSI, SSI, CDI, MRSA	Jan. 1, 2014–Dec. 31, 2014	Jan. 1, 2016–Dec. 31, 2016
Clinical Care	Oct. 1, 2009–June 30, 2012	Oct. 1, 2013–June 30, 2016
Efficiency and Cost Reduction	Jan. 1, 2014–Dec. 31, 2014	Jan. 1, 2016–Dec. 31, 2016
Patient and Caregiver-Centered Experience of Care/ Care Coordination	Jan. 1, 2014–Dec. 31, 2014	Jan. 1, 2016–Dec. 31, 2016

Table 6. Baseline and Performance Periods for FY 2019

Domain	Baseline Period	Performance Period
Safety: PC-01, CAUTI, CLABSI, SSI, CDI, MRSA	Jan. 1, 2015–Dec. 31, 2015	Jan. 1, 2017–Dec. 31, 2017
Clinical Care: MORT-30-AMI, MORT-30-HF, MORT-30-PN	July 1, 2009–June 30, 2012	July 1, 2014–June 30, 2017
Clinical Care: THA/TKA	July 1, 2010–June 30, 2013	Jan. 1, 2015–June 30, 2017
Efficiency and Cost Reduction	Jan. 1, 2015–Dec. 31, 2015	Jan. 1, 2017–Dec. 31, 2017
Person and Community Engagement	Jan. 1, 2015–Dec. 31, 2015	Jan. 1, 2017–Dec. 31, 2017

Table 7. Baseline and Performance Periods for FY 2020

Domain	Baseline Period	Performance Period
Safety: PC-01, CAUTI, CLABSI, SSI, CDI, MRSA	Jan. 1, 2016–Dec. 31, 2016	Jan. 1, 2018–Dec. 31, 2018
Clinical Care	July 1, 2010–June 30, 2013	July 1, 2015–June 30, 2018
Efficiency and Cost Reduction	Jan. 1, 2016–Dec. 31, 2016	Jan. 1, 2018–Dec. 31, 2018
Person and Community Engagement	Jan. 1, 2016–Dec. 31, 2016	Jan. 1, 2018–Dec. 31, 2018

QualityNet has Domain Weighting Quick Reference Guides available which include the domain, measures, baseline and performance periods, threshold and benchmark rates, and payment adjustment effective dates for each FY on one page.

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

Current Scores

Performance Period
January 1, 2018 – December 31, 2018

Base Operating DRG Payment Amount Reduction	Value-Based Incentive Payment Percentages	Net change in Base Operating DRG Payment Amount
2.0000000000%	3.4310998595%	+1.4310998595%

On average, over the last 3 years the Acute Care facility side of BRH averages approximately $16,000,000 annually in Medicare payments from claims submitted.

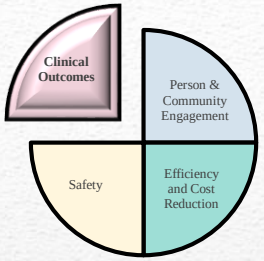
Therefore 2% would be approximately $320,000, and the additional 1.43% of value-based incentive is worth $228,976.

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

Clinical Outcomes

Lower is better



Baseline Period: 07/01/2010 - 06/30/2013 **Performance Period:** 07/01/2015 - 06/30/2018
Complication Measure
Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty Complication Rate

FY 2020 Baseline Period Totals		FY 2020 Performance Period Totals	
Number of Eligible Discharges	**Baseline Period Rate**	**Number of Eligible Discharges**	**Performance Period Rate**
95	0.039237	135	0.021797

HVBP Metrics				
Achievement Threshold	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
0.032229	0.023178	9	10	10

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

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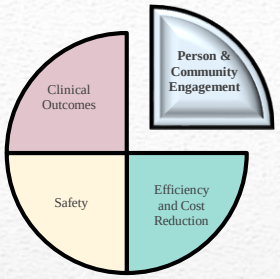
Person & Community Engagement

Higher is better



HCAHPS Dimensions
Communication with Nurses

Baseline Period Rate	Performance Period Rate	Floor	Achievement Threshold	Benchmark
80.98%	82.78%	51.80%	79.08%	87.12%

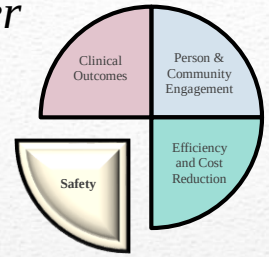
Improvement Points	Achievement Points	Dimension Score
2	5	5

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

Safety

Lower is better



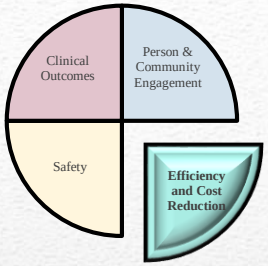
Baseline Period: 01/01/2016 - 12/31/2016 **Performance Period:** 01/01/2018 - 12/31/2018	**FY 2020 Baseline Period Totals**			**FY 2020 Performance Period Totals**		
Healthcare Associated Infections	**Number of Observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**	**Number of Observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**
Clostridium difficile Infection	2	3.393	0.589	3	7.039	0.426

HVBP Metrics				
Achievement Threshold	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
0.852	0.091	3	6	6

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Efficiency and Cost Reduction

Lower is better



Baseline Period: 01/01/2016 - 12/31/2016 **Performance Period:** 01/01/2018 - 12/31/2018
Efficiency Measures
Medicare Spending per Beneficiary (MSPB)

FY 2020 Baseline Period Totals			FY 2020 Performance Period Totals		
MSPB Amount (Numerator)	Median MSPB Amount (Denominator)	MSPB Measure	MSPB Amount (Numerator)	Median MSPB Amount (Denominator)	MSPB Measure
$17,158.74	$20,308.36	0.844910	$19,289.64	$21,628.15	0.891876

HVBP Metrics				
Achievement Threshold	Benchmark	Improvement Points	Achievement Points	Measure Score
0.987067	0.844147	0	6	6

Bartlett Regional Hospital

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