Bartlett Regional Hospital

AGENDA
BOARD OF DIRECTORS MEETING
Tuesday, March 23, 2021; 5:30 p.m.
Bartlett Regional Hospital Zoom/Teleconference
Public may follow the meeting via the following link https://bartletthospital.zoom.us/j/93293926195
or call
1-253-215-8782 and enter webinar ID 932 9392 6195

I.	**CALL TO ORDER**		**5:30**
II.	**ROLL CALL**		**5:32**
III.	**APPROVE AGENDA**		**5:34**
IV.	**PUBLIC PARTICIPATION**		**5:35**
V.	**CONSENT AGENDA**		**5:45**
	A. February 23, 2021 Board of Directors Minutes	(Pg.3)	
	B. March 15, 2021 Special Board of Directors Meeting Minutes	(Pg.8)	
	C. January 2021 Financials	(Pg.9)	
VI.	**NEW BUSINESS**		**5:55**
VII.	**OLD BUSINESS**		**6:00**
VIII.	**MEDICAL STAFF REPORT**		**6:05**
IX.	**COMMITTEE REPORTS**		**6:10**
	A. March 10, 2021 Draft Board Quality Committee Meeting Minutes	(Pg.14)	
	1. HIM/Utilization Management Plan – **ACTION ITEM**	(Pg.18)	
	2. Risk Management Plan – **ACTION ITEM**	(Pg.28)	
	3. Infection Prevention Plan – **ACTION ITEM**	(Pg.34)	
	4. Environment of Care Plan – **ACTION ITEM**	(Pg.50)	
	5. Patient Safety & Quality Improvement Plan – **ACTION ITEM**	(Pg.78)	
	B. March 12, 2021 Draft Planning Committee Meeting Minutes	(Pg.93)	
	C. March 15, 2021 Draft Physician Recruitment Meeting Minutes	(Pg.96)	
	1. Dr. Dressel Letter to the Committee and Board	(Pg.98)	
	2. Behavioral Health Pediatrician - **ACTION ITEM**	(Pg.103)	
	D. March 18, 2021 Draft Finance Committee Meeting Minutes	(Pg.105)	
	➢ FY2022 Budget - **ACTION ITEM**	(Pg.106)	
X.	**MANAGEMENT REPORTS**		**6:25**
	A. Legal Management report		
	B. HR Management report	(Pg.116)	
	C. CNO Management report	(Pg.117)	

D. COO Management report (Pg.122)
E. CBHO Management report (Pg.126)
1. SOA Response to PHE Declaration Expiry (Pg.130)
2. Dr. Pasek CV (Pg.131)
F. CFO Management report (Pg.133)

XI. CEO REPORT / STRATEGIC DISCUSSION **6:35**
A. COVID-19 Update

XII. PRESIDENT REPORT **6:40**

XIII. BOARD CALENDAR – April 2021 (Pg.138) **6:45**

XIV. BOARD COMMENTS AND QUESTIONS **6:50**

XV. EXECUTIVE SESSION **6:55**
A. Credentialing report
B. March 2, 2021 Medical Staff Meeting Minutes
C. Patient Safety Dashboard
D. Union Negotiations
E. Legal and Litigation Review

Motion by xx, to recess into executive session 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 credentialing report, Medical Staff Meeting minutes, the patient safety dashboard and union negotiations.*

And

- *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.)*

XVI. ADJOURNMENT **7:30**

Bartlett Regional Hospital

Minutes
BOARD OF DIRECTORS MEETING
February 23, 2021 – 5:30 p.m.
Zoom videoconference

CALL TO ORDER – Meeting called to order at 5:30 p.m. by Kenny Solomon-Gross, Board President

BOARD MEMBERS PRESENT

Kenny Solomon-Gross – President	Rosemary Hagevig, Vice-President	Mark Johnson, Secretary
Brenda Knapp	Lance Stevens	Lindy Jones, MD
Iola Young	Hal Geiger	

ABSENT – Deb Johnston

ALSO PRESENT

Kevin Benson, Interim CEO/CFO	Billy Gardner, COO	Rose Lawhorne, CNO
Bradley Grigg, CBHO	Dallas Hargrave, HR Director	Robert Palmer, City Attorney
Barbara Nault, Legal Advisor	Keegan Jackson, MD, COS	Michelle Hale, CBJ Liaison
Anita Moffitt, Executive Assistant	Gail Moorehead, Quality Director	Kris Muller (BRH Staff)
Debbie Kesselring, BRH Staff	Joy Neyhart, DO	Joe Wanner (Guest)
Jeremy Hsieh (Guest)	KRoseman (Guest)	LAJ New (Guest)

APPROVE AGENDA – ***MOTION by Ms. Knapp to approve the agenda as written. Ms. Hagevig seconded. There being no objections, agenda approved.***

PUBLIC PARTICIPATION – None

CONSENT AGENDA - ***MOTION by Ms. Hagevig to approve the consent agenda as written. Mr. Johnson seconded. There being no objections, consent agenda approved.***

NEW BUSINESS – None
OLD BUSINESS – None

MEDICAL STAFF REPORT – Dr. Jackson reported that the upgrade to Meditech Expanse electronic medical record (EMR) was discussed at the February 2nd Medical Staff meeting. Go live date for this EMR system is Monday, March 1st. Upgrade happening due to end of support for Meditech 6.0 (our current version) and upgrade will also allow for the outpatient component for Behavioral Health to go live as well. Also discussed was the Emergency Department's (ED) continued use of T-Systems and when they would switch over to the same software system the rest of the hospital uses. Mr. Bill had expressed at the Medical Staff meeting that it is the expectation that the ED would move to the Meditech Expanse EMR system. Dr. Jones voiced concerns of switching to Meditech and questions if there is a better system available to help improve patient care. Brief discussion held about Bartlett's decision to choose Meditech over Cerner. It was noted that conversion to a new system is frustrating to learn and very costly in time and money. Affiliations with other organizations may offer more opportunities in our choice of EMR system. Ms. Knapp stated that this is a matter for the new CEO to consider. Dr. Jones and other ED staff will visit Island Hospital in Anacortes, WA to see Meditech Expanse in the ED setting. It was stated that BRH needs one EMR system that is user friendly for all providers and assists in providing quality patient care. Dr. Jackson reported

that the role of Oncology nurse practitioners was also discussed at the Medical Staff Meeting. Ms. Hagevig clarified that the Medical Staff Executive Committee is to review the revised policy for the Oncology Nurse Practitioner role before sending it back to the Credentials Committee.

COMMITTEE REPORTS:

CEO Recruitment Committee Meeting – Minutes from the 8 CEO Recruitment meetings held since the January Board of Directors meeting are in the packet.

Physician Recruitment Committee Meeting – Minutes from the February 9th meeting are in the packet. Mr. Johnson reported the following were discussed: Pediatric care and Pediatric care in behavioral health, General Surgery, Medical Oncology and Urology. Mr. Grigg and Dr. Gartenberg are to write a position description and scope of work for the position in behavioral health and will discuss at the March 15th meeting. Also to be discussed are updates on recruitment of another General Surgeon, Medical Oncologist, Psychiatrists and Urologist. We have received notice that Dr. Saltzman is closing his practice. Mr. Grigg stated that providing pediatric behavioral healthcare is not an effort to become a primary care provider and the job description will have clear caveats as set forth by the committee. Ms. Lawhorne reported that nurse practitioners are working in the outpatient Oncology Clinic and are working through the credentialing process for infusion therapy. There are no applicants for a Medical Oncologist at this time and recruitment efforts have been escalated. Ms. Knapp initiated discussion about the recruitment of Psychiatrists. Mr. Grigg reported that we are in the offer phase of recruitment of 2 full time Psychiatrist. He also noted that it is cheaper to hire 3 full time Psychiatrist than to hire 2 full time locums. Local pediatric providers have been included in discussions regarding pediatric care in behavioral health and will have the opportunity for review and comment on the job description to be provided by Mr. Grigg. Mr. Grigg noted the importance of having more staff psychiatrists on board to help develop a succession plan in anticipation of Dr. Gartenberg's future retirement.

Planning Committee Meeting – Minutes from the February 12th meeting are in the packet. Mr. Stevens reported that several items that came out of the Planning Committee meeting will be discussed during the Finance report. Two actions taken were: 1) Combining items C1-C3, ventilation upgrades in patient rooms and the ED addition, in the master facility plan into one project because of the overlapping nature of the projects. There is a request for facilitating the design phase process. 2) Four items were added to the project priority list; a physician call room, power conditioner, stress test room renovation and replacement of fire doors. Some of these projects are such a high priority they were presented to Finance to request money so we can start taking action. The rest of the committee updates are noted in the COO report.

Board Compliance and Audit Committee – Minutes from the February 17th meeting are in the packet. Ms. Young reported that the third party review of our compliance program is just getting started. We expect the review to be completed in about 12 weeks. The committee will meet again after receiving the draft report. It is recommended to have a review every two to three years. The last one was conducted in 2017. This review did go through the RFP process.

Governance Committee Meeting – The minutes from the February 18th meeting are in the packet. Ms. Knapp reported that the charges of the committee were reviewed. There are three major areas of responsibility. Two specific areas are the annual review of the bylaws and the board policy and procedure manual to identify necessary updates. Another area, not discussed is the responsibility for establishing criteria for the annual board self-evaluation of performance. We also look at board education and training needs. The third major area of responsibility of this committee is to keep apprised of current standards and regulations. This area will be important when we begin looking at affiliations with other organizations after the new CEO is hired. Reviews of the bylaws and policy and procedures manual will not begin until after mid-year as these were completed near the end of last year.

Finance Committee Meeting – Draft minutes from the January 8th meeting are in the packet. Mr. Stevens reported that finances were reviewed. It was noted that births are down but we expect COVID bump soon. BRH finished almost $1M short on revenue but was able to realize the rest of the $13.2 Million of CARES Act funding that had been received. Also noted, a supply correction of $500K was made due to a technical issue that is being resolved to prevent future errors. There are two action items coming out of the Finance Committee. The first item is the purchase of the clinic building located at 3225 Hospital Drive. Mr. Solomon-Gross reported that he had a conflict of interest with this matter and passed the gavel to Ms. Hagevig for this action item. ***Mr. Stevens stated the Finance Committee is moving to the board a***

recommendation to purchase the clinic building not to exceed $2.5 Million with encouraged negotiation on behalf of the City. At Ms. Kanpp's request, Mr. Stevens provided highlights of construction costs provided by Nathan Coffee. Even with the costs of repairs, this building is in a good price point per square foot vs. building a new building and it provides value to BRH at the price being offered. Mr. Geiger expressed concerns about the 30 year old heating/mechanical system and the cost of replacement and about fuel tank leakage near Salmon Creek. Mr. Johnson also expressed concerns about other repair costs and is cautious of spending money right now. Mr. Benson provided justification for purchase and identified proposed usage of the building. Mr. Geiger initiated discussion about renovation plans and who would do them. Ms. Knapp noted that Mr. Coffee's observation is that while the building is not new and needs some work, it is a serviceable office building that is reasonably well maintained. She is still in favor of moving ahead. It is unknown if an assessment has been done to see if an additional floor could be supported on top of the clinical side of the building as suggested in Mr. Coffee's report. Ms. Hagevig no longer opposes purchasing this building and feels that it is in Bartlett's best interest to be in control of this property instead of the competition. She then raised the issue of parking availability. Mr. Stevens noted that our lease expires next year. We pay $181,000 a year for that space but would recapture that cost from the purchase price in 10-13 years if we use that space as it is. He also stressed that we will need space to relocate people if we move ahead with the master facility plans and we can sell the building when we no longer need it. Hearing no further discussion, a roll call vote taken for the following:

Should the Bartlett Board recommend to the Borough Assembly that the purchase of this building proceed? Purchase not to exceed $2.5 Million with encouraged negotiation on behalf of the City. Motion passes 4-3. Yes votes from Mr. Stevens, Ms. Hagevig, Ms. Knapp and Dr. Jones. No votes from Mr. Geiger, Mr. Johnson and Ms. Young. (Mr. Solomon-Gross and Ms. Johnston did not vote.)

Mr. Stevens noted the door replacement project with fire doors being a major component, will come out of approved maintenance funds but will need to go through the RFP process because costs are projected to be about $300,000. Fire doors are considered to be a life safety matter and updates must be submitted to CMS every 90 days until completed. Consolidation of projects C1-C3 (ventilation upgrades and ED addition) moves from the Planning Committee, through the Finance Committee to the Board, a **MOTION** ***to approve $425,000 in design fees for the combined $7 Million project.*** In response to Mr. Johnson's question, Mr. Benson said funding would come from internal reserves and would need to go through the appropriation process. Mr. Stevens suggested working with our own internal finance and CBJ finance departments, determining the best source of funds would be an appropriate conversation. There being no further discussion a roll call vote taken for the following: ***Approve $425,000 per the estimate by CBJ Engineer for architectural group to design this combined $7 Million project.*** **Motion** ***passed unanimously.***

Mr. Solomon-Gross thanked the committees for their thorough reports.

MANAGEMENT REPORTS:

Legal report – Ms. Nault provided a summary of the projects her company has been working on. Mr. Palmer will provide litigation updates during executive session.

HR report – Mr. Hargrave noted details about the Studer Leadership Development program are in his report. Mr. Stevens asked how many nurse graduates have been placed in various departments. Ms. Lawhorne responded that we have 4-5 that are being considered for positions right now. That does not include the class that will be graduating in the spring.

CNO report – No questions. Mr. Solomon-Gross is happy to see the start of a CNA program at BRH.

COO report – Mr. Gardner stated the power conditioner is a high priority project as a means to protect BRH from damages due to power surges. A power surge over the weekend (the second one since November) effected equipment throughout the hospital; MRI and CT scanners, lighting in the ED and trauma bay, dryers, televisions and multiple IS system failures. The MRI is still down and parts are delayed due to weather down south. Staff in facilities, IS department and contractors have worked around the clock to try to get these issues resolved. The power conditioner project is currently in the design phase and needs to be expedited. A meeting is to be held with Nathan Coffee, CBJ Engineering; Greg Smith, CBJ Contract Administrator and the City Manager to find a way to expedite this process by using emergency orders. These issues do affect patient safety and operations. Ms. Hale said the right steps are being taken and while we want to expedite it, we must do it legally. A timeframe cannot be established until the design phase is complete and the scope of the project is known. Ms. Hagevig initiated discussion about what fast tracking this project means. Mr. Palmer reported that the Assembly still has an Emergency Declaration in effect and it does allow for certain contracting procurement provisions to be expedited. In addition, our procurement code does have "escape valves" for these types of

situations. The COVID lab is operational now that first run of sample batches crossed over with no issues. We will be doing procedural and inpatient testing. Beacon will be our first client with a Memorandum of Understanding in place. Senator Murkowski spent an hour in the lab last week discussing the testing equipment, ongoing operational costs and supply chains and how the Governor's Emergency Order affects us. Dr. Jones is very excited to have this machine and for the opportunities it allows us to respond to the community needs. He expressed appreciation for everyone's hard work. Siemens is on campus and ready to repair the MRI when the parts come in. Mr. Gardner reported that we had an x-ray machine go down in fluoroscopy too and Siemens will also repair that equipment. Mr. Geiger initiated conversation about the increase in Radiologist shifts. Work has begun by Schmolck Mechanical on the ASU-11/Endo fan. Estimated completion date is April 13th. There is a three day down time planned for the OR while the work is being done. The ED triage building is up and operational. This has been announced through public notices, the radio and our Facebook page.
CBHO report – Mr. Grigg reported that we have received a $1 Million check from Premera Pacific Northwest for capital funds towards the Crisis Stabilization project. We are working on a press release to acknowledge all of the donors that have contributed to this capital project to this point. Mr. Solomon-Gross expressed appreciation for the success stories provided in Mr. Grigg's written report. Ms. Knapp initiated a conversation about the cause of the increase in children receiving behavioral health services, most are COVID related.
CFO report – Mr. Benson reported that we are in the third week of budget meetings with managers to plan next year's budget. There is a bit of guesswork involved due to COVID impacts but it should be ready for review at the next Finance Committee meeting. Mr. Benson identified for Mr. Geiger, the acronyms used to identify the departments listed in the written CFO report. He also identified Jellyfish as a patient communication tool to help with registration and patient flow. In planning the budget for the next fiscal year, which begins July 1st, we do not anticipate any cruise activity through the fall of this year but do for spring of 2021.
CEO REPORT – Mr. Benson reported that the health emergency declaration was allowed to expire in Alaska making it the only state that doesn't have one in effect. It's anticipated that the House will work to reinstate that declaration. Discussion was held about what the impact the emergency declaration has on hospital operations. Telehealth services continue to be paid for by Medicaid. We have renewed our participation in the Rural Demonstration Project for another 5 years; the effective start date July 1, 2020. State surveyors have recently identified 6 deficiencies that place BRH out of compliance with Medicare conditions of participation. BRH must communicate within a 10 day timeframe, a corrective action plan that needs to be in place within 90 days. Most items identified are easily fixed and center on infection control. Ms. Knapp asked that the deficiency report be shared with the Board of Directors. Ms. Moffitt will forward the information. Meetings are being held to discuss how to cover the current roles filled by Kathy Callahan when she retires on April 30th.

MOTION ***by Ms. Hagevig to extend the meeting to 8:30 pm. Mr. Stevens seconded. There being no objections,*** **MOTION** ***approved.***

Mr. Benson reported that we have no active COVID cases in the hospital. He also reported that he has asked Mr. Bill to continue on as our ASHNHA and legislative liaison. Mr. Solomon-Gross and Mr. Benson are to discuss other members of the senior leadership team attending ASHNHA meetings.

PRESIDENT REPORT – Mr. Solomon-Gross highlighted the Governance Institute's upcoming webinars and conferences. Thursday's webinar is "How to Hire a CEO". He encourages registration so the recording will be available to those unable to attend the live session. He also encourages Board members to attend one of the Leadership Conferences offered. Discussion held about resuming in person Board and Committee meetings. Ms. Hagevig suggested that we may be able to try this out during our CEO recruitment processes. Mr. Stevens suggested starting with committee meetings to allow us to work out any issues with placement and audio recordings. As several Board members are agreeable, Ms. Moffitt will begin working on a plan to safely accommodate hybrid meetings.

BOARD CALENDAR – March calendar reviewed. No changes requested. It was clarified that the Planning Committee meetings are to be held on the third Friday of each month beginning in April. Finance meetings are normally held the second Friday of each month but have requested to postpone by one week in March. Because of this, the Planning meeting moved up a week. Mr. Hargrave said we are tentatively looking to do most of the CEO finalist process on Friday, the 19th with a potential for the Board to conduct interviews that afternoon or the morning of Saturday, March 20th. The timing

depends on what happens in executive session today. Once the finalists are confirmed, an announcement will be sent out and work will begin on travel arrangements for the candidates. Board members are encouraged to keep their calendars clear on those two dates.

BOARD COMMENTS AND QUESTIONS – None

EXECUTIVE SESSION – **MOTION** ***by Mr. Stevens to recess into executive session as written in the agenda 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 credentialing report, Medical Staff Meeting minutes, the patient safety dashboard and union negotiations.*

  And

- *To discuss pending litigation related to BRH, specifically a candid discussion of the facts and legal strategies with BRH's attorneys;*

  And

- *To discuss subjects that tend to prejudice the reputation and character of any person, namely applicants for the Chief Executive Officer (BRH Board and Dallas Hargrave only.)*

Ms. Hagevig **seconded.**

Mr. Solomon-Gross called for a recess before going into executive session. The Board took a recess from 7:42 p.m. until 7:47 p.m.

The Board entered executive session at 7:47 p.m. and returned to regular session at 9:38 p.m.

MOTION ***by Ms. Hagevig to approve the credentialing report as presented. Mr. Johnson seconded. There being no objections, credentialing report approved.***

Mr. Stevens reported that during executive session, guidance was provided to our legal team for legal matters and to our labor bargaining team for contract negotiations. Ms. Knapp reported that guidance was also provided to HR Director on proceeding with candidate recruitment for the CEO position.

ADJOURNMENT – 9:42 p.m

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NEXT MEETING: 5:30 p.m. -Tuesday, March 23, 2021

Bartlett Regional Hospital

Minutes
SPECIAL BOARD OF DIRECTORS MEETING
March 15, 2021 – 12:00 p.m.
Zoom videoconference

CALL TO ORDER – Meeting called to order at 12:03 p.m. by Kenny Solomon-Gross, Board President

BOARD MEMBERS PRESENT

Kenny Solomon-Gross – President	Rosemary Hagevig, Vice-President	Mark Johnson, Secretary
Brenda Knapp	Lance Stevens	Deb Johnston
Iola Young	Hal Geiger	

ABSENT – Lindy Jones, MD

ALSO PRESENT – Dallas Hargrave, HR Director

APPROVE AGENDA – Agenda approved

PUBLIC PARTICIPATION – None

EXECUTIVE SESSION – **MOTION** ***by Ms. Knapp to recess into executive session as written in the agenda to discuss matters which are confidential or involve consideration of materials that are not subject to public disclosure at this time, specifically the CEO candidate selection materials. Ms. Hagevig*** **seconded.**

The Board entered executive session at 12:04 p.m. and returned to regular session at 12:48 p.m.

Mr. Solomon-Gross reported there was no action taken during executive session.

ADJOURNMENT – 12:49 p.m

Bartlett Regional Hospital

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

DATE: March 11, 2021

TO: BRH Finance Committee

FROM: Kevin Benson, Chief Financial Officer

RE: January Financial Performance

Bartlett Regional Hospital continued to incur decreases in inpatient volumes resulting in an inpatient revenue shortfall of $1.5 million (-25%). After seven months, inpatient revenues are $8.6 million (-21%) behind the budget target. Outpatient revenues were slightly short of budget by $330,000 (-3.5%). Year-to-date, outpatient revenue has performed well and is currently running $1.0 million (1.5%) ahead of budget and 6.2% greater than the prior year.

Rainforest Recovery was only 14% short of budgeted revenue even though operating at 66% capacity. BHOPS is steadily increasing volumes and generating greater revenues and finishing the month 6% ahead of budget. Physician revenue was short of budget by 6% reflecting the reduction in professional fees due to lower inpatient volumes. Total Gross Patient Revenue finished $1.9 million short of budget or -11%.

Deductions from Revenue was less than budget commensurate with the reduction of revenue by $1.0 million or 13%.

Net Patient Revenue finished $857,000 or 9% less than budget. Having recorded all of the Provider Relief Funds, we are no longer able to supplement lost revenues with CARES funds. Therefore, Total Operating Revenue finished $911,000 (-9.2%) less that budget.

Expenses exceeded budget by $290,000 or 3%. The biggest variance was in the area of salaries and benefits. Salaries continued to exceed budget due to increased staff for Covid-19 compliance. Benefits exceeded budget due to having three PERS payments in January. As a result, Bartlett finished with an Operating Loss of $1.2 Million. A donation was recorded in Non-Operating Income of $1.0 million from Premera for the Crisis Stabilization project. Therefore, Net Income reflected a small loss of $13,000. After seven months, BRH has a small Net Income of $808,000 or 1.14%.

Bartlett Regional Hospital
Dashboard Report for January 2021

	CURRENT MONTH					YEAR TO DATE			
Facility Utilization:	**Actual**	**Budget**	**% Over (Under) Budget**	**Prior Year**	**Prior Month (Dec)**	**Actual**	**Budget**	**% Over (Under) Budget**	**Prior Year**
Hospital Inpatient:Patient Days									
Patient Days - Med/Surg	407	386	6%	296	383	2,633	2,675	-2%	2,817
Patient Days - Critical Care Unit	88	96	-9%	85	93	683	668	2%	652
Patient Days - Swing Beds	0	0	0%	0	0	0	0	0%	0
Avg. Daily Census - Acute	16.0	15.6	3%	12	15.4	15.4	15.6	-1%	16.1
Patient Days - Obstetrics	69	69	0%	73	46	442	479	-8%	480
Patient Days - Nursery	53	54	-1%	65	35	362	372	-3%	381
Total Hospital Patient Days	**617**	**605**	2%	**519**	**557**	**4,120**	**4,195**	-2%	**4,330**
Births	24	25	-3%	27	18	175	171	2%	172
Mental Health Unit									
Patient Days - Mental Health Unit	82	279	-71%	261	121	1,079	1,935	-44%	1,736
Avg. Daily Census - MHU	2.6	9.0	-71%	8.4	4	5.0	9.0	-44%	8.1
Rain Forest Recovery:									
Patient Days - RRC	198	399	-50%	252	173	556	2,770	-80%	2,056
Avg. Daily Census - RRC	6	12.9	-50%	8.1	6	3	12.9	-80%	9.6
Outpatient visits	92	19	375%	18	139	609	565	8%	167
Inpatient: Admissions									
Med/Surg	51	80	-36%	65	64	392	554	-29%	535
Critical Care Unit	30	45	-33%	40	33	243	310	-22%	303
Obstetrics	27	27	1%	30	20	189	185	2%	187
Nursery	24	25	-3%	27	18	175	172	2%	173
Mental Health Unit	16	37	-57%	35	20	140	259	-46%	255
Total Admissions - Inpatient Status	**148**	**213**	-31%	**197**	**155**	**1,139**	**1,480**	-23%	**1,453**
Admissions -"Observation" Status									
Med/Surg	47	57	-17%	65	71	417	393	6%	399
Critical Care Unit	26	30	-14%	32	25	183	211	-13%	211
Mental Health Unit	1	3	-61%	2	3	15	18	-15%	17
Obstetrics	10	19	-48%	19	17	94	133	-29%	132
Nursery	0	0	-100%	0	0	0	1	-100%	1
Total Admissions to Observation	**84**	**109**	-23%	**118**	**116**	**709**	**756**	-6%	**760**
Surgery:									
Inpatient Surgery Cases	49	53	-7%	58	49	345	365	-6%	368
Endoscopy Cases	96	92	4%	106	100	620	639	-3%	648
Same Day Surgery Cases	119	104	15%	122	111	818	719	14%	732
Total Surgery Cases	**264**	**248**	6%	**286**	**260**	**1,783**	**1,722**	4%	**1,748**
Total Surgery Minutes	16,586	15,437	7%	18,958	17,474	125,382	107,060	17%	121,275
Outpatient:									
Total Outpatient Visits (Hospital)									
Emergency Department Visits	910	1,243	-27%	1,178	941	6,606	8,621	-23%	8,496
Cardiac Rehab Visits	56	65	-14%	68	56	398	452	-12%	452
Lab Visits	317	402	-21%	323	319	2,038	2,791	-27%	2,692
Lab Tests	9,454	9,057	4%	9,006	9,743	67,973	62,693	8%	72,965
Radiology Visits	767	840	-9%	756	796	5,563	5,824	-4%	5,700
Radiology Tests	2,207	2,468	-11%	2,315	3,506	16,168	17,829	-9%	17,167
Sleep Study Visits	24	29	-17%	21	7	158	200	-21%	191
Physician Clinics:									
Hospitalists	194	237	-18%	223	257	1,584	1,647	-4%	1,621
Bartlett Oncology Clinic	96	83	15%	59	79	601	578	4%	550
Ophthalmology Clinic	82	55	50%	94	78	640	378	69%	107
Behavioral Health Outpatient visits	550	385	43%	356	437	2,949	2,672	10%	2,428
Bartlett Surgery Specialty Clinic visits	252	209	21%	335	250	1,617	1,448	12%	1,974
	1,174	969	21%	1,067	1,101	7,391	6,724	10%	6,680
Other Operating Indicators:									
Dietary Meals Served	21,267	30,346	-30%	29,614	22,663	139,796	210,462	-34%	208,262
Laundry Pounds (Per 100)	364	384	-5%	372	381	2,608	2,661	-2%	2,651

Bartlett Regional Hospital
Dashboard Report for January 2021

	CURRENT MONTH				YEAR TO DATE			
Facility Utilization:	**Actual**	**Budget**	**% Over (Under) Budget**	**Prior Year**	**Actual**	**Budget**	**% Over (Under) Budget**	**Prior Year**
Financial Indicators:								
Revenue Per Adjusted Patient Day	4,981	4,909	1.5%	4,283	5,716	4,571	25.0%	4,311
Contractual Allowance %	43.9%	43.0%	2.2%	40.0%	43.9%	43.0%	2.2%	40.6%
Bad Debt & Charity Care %	0.6%	2.7%	-76.0%	4.8%	1.2%	2.7%	-56.8%	3.0%
Wages as a % of Net Revenue	54.8%	47.7%	14.9%	47.4%	53.7%	47.3%	13.6%	46.6%
Productive Staff Hours Per Adjusted Patient Day	28.7	23.3	23.2%	20.1	31.4	18.5	69.9%	18.3
Non-Productive Staff Hours Per Adjusted Patient Day	5.5	3.8	43.1%	3.6	5.3	2.9	80.5%	2.9
Overtime/Premium % of Productive	7.33%	7.97%	-8.0%	7.97%	6.64%	7.12%	-6.8%	7.12%
Days Cash on Hand	105	110	-4.0%	103	103	110	-6.5%	100
Board Designated Days Cash on Hand	127	132	-4.0%	161	124	132	-6.5%	161
Days in Net Receivables	50.0	50	0.0%	58	50.0	50	0.0%	58

	Actual	**Benchmark**	**% Over (Under)**	**Prior Year**
Total debt-to-capitalization (with PERS)	58.2%	33.7%	72.7%	63.0%
Total debt-to-capitalization (without PERS)	14.6%	33.7%	-56.6%	16.0%
Current Ratio	8.33	2.00	316.5%	10.15
Debt-to-Cash Flow (with PERS)	8.99	2.7	233.0%	6.99
Debt-to-Cash Flow (without PERS)	2.26	2.7	-16.4%	1.78
Aged A/R 90 days & greater	46.7%	19.8%	135.9%	52.6%
Bad Debt Write off	0.1%	0.8%	-87.5%	1.4%
Cash Collections	85.3%	99.4%	-14.2%	97.9%
Charity Care Write off	0.2%	1.4%	-85.7%	0.7%
Cost of Collections (Hospital only)	4.7%	2.8%	67.9%	4.2%
Discharged not Final Billed (DNFB)	12.7%	4.7%	170.2%	17.0%
Unbilled & Claims on Hold (DNSP)	12.7%	5.1%	149.0%	17.1%
Claims final billed not submitted to payor (FBNS)	0.0%	0.2%	-100.0%	0.04%
POS Cash Collection	1.9%	21.3%	-91.1%	2.1%

BARTLETT REGIONAL HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
FOR THE MONTH AND YEAR TO DATE OF JANUARY 2021

MONTH ACTUAL	MONTH BUDGET	MO $ VAR	MTD % VAR	PR YR MO			YTD ACTUAL	YTD BUDGET	YTD $ VAR	YTD % VAR	PRIOR YTD ACT	PRIOR YTD % CHG
						Gross Patient Revenue:						
$3,455,235	$4,888,204	-$1,432,969	-29.3%	$4,268,141	1.	Inpatient Revenue	$26,084,099	$34,217,428	-$8,133,329	-23.8%	$32,273,418	-19.2%
$1,012,500	$1,038,561	-$26,061	-2.5%	$902,828	2.	Inpatient Ancillary Revenue	$6,809,101	$7,269,872	-$460,771	-6.3%	$6,852,817	-0.6%
$4,467,735	$5,926,765	-$1,459,030	-24.6%	$5,170,969	3.	Total Inpatient Revenue	$32,893,200	$41,487,300	-$8,594,100	-20.7%	$39,126,235	-15.9%
$9,255,812	$9,589,171	-$333,359	-3.5%	$9,200,382	4.	Outpatient Revenue	$68,125,964	$67,124,172	$1,001,792	1.5%	$64,138,217	6.2%
$13,723,547	$15,515,936	-$1,792,389	-11.6%	$14,371,351	5.	Total Patient Revenue - Hospital	$101,019,164	$108,611,472	-$7,592,308	-7.0%	$103,264,452	-2.2%
$281,503	$328,332	-$46,829	-14.3%	$267,731	6.	RRC Patient Revenue	$785,234	$2,298,337	-$1,513,103	-65.8%	$2,148,806	-63.5%
$294,802	$279,058	$15,744	5.6%	$278,236	7.	BHOPS Patient Revenue	$1,719,050	$1,953,415	-$234,365	-12.0%	$1,876,994	-8.4%
$979,867	$1,043,627	-$63,761	-6.1%	$1,130,215	8.	Physician Revenue	$7,073,051	$7,305,399	-$232,348	-3.2%	$7,109,338	-0.5%
$15,279,719	$17,166,953	-$1,887,235	-11.0%	$16,047,533	9.	Total Gross Patient Revenue	$110,596,499	$120,168,623	-$9,572,124	-8.0%	$114,399,590	-3.3%
						Deductions from Revenue:						
$2,465,059	$3,293,371	$828,312	25.2%	$3,190,842	10.	Inpatient Contractual Allowance	$18,850,210	$23,053,587	$4,203,377	18.2%	$20,403,995	-7.6%
$0	$0	$0		-$308,333	10a.	Rural Demonstration Project	$0	$0	$0		-$308,333	
$3,750,569	$3,422,941	-$327,628	-9.6%	$2,898,447	11.	Outpatient Contractual Allowance	$25,431,524	$23,960,580	-$1,470,944	-6.1%	$22,120,427	15.0%
$495,063	$660,029	$164,966	25.0%	$634,850	12.	Physician Service Contractual Allowance	$4,305,784	$4,620,200	$314,416	6.8%	$4,276,212	0.7%
$12,592	$15,182	$2,590	17.1%	$16,435	13.	Other Deductions	$90,630	$106,273	$15,643	14.7%	$100,193	0.0%
$37,242	$71,347	$34,105	47.8%	$112,811	14.	Charity Care	$759,847	$499,434	-$260,413	-52.1%	$521,575	45.7%
$61,333	$389,629	$328,296	84.3%	$651,678	15.	Bad Debt Expense	$523,939	$2,727,400	$2,203,461	80.8%	$2,883,925	-81.8%
$6,821,858	$7,852,499	$1,030,641	13.1%	$7,196,730	16.	Total Deductions from Revenue	$49,961,934	$54,967,474	$5,005,540	9.1%	$49,997,994	-0.1%
43.9%	*43.0%*			*41.9%*		*% Contractual Allowances / Total Gross Patient Revenue*	*43.9%*	*43.0%*			*40.6%*	
0.6%	*2.7%*			*4.8%*		*% Bad Debt & Charity Care / Total Gross Patient Revenue*	*1.2%*	*2.7%*			*3.0%*	
44.6%	*45.7%*			*44.8%*		*% Total Deductions / Total Gross Patient Revenue*	*45.2%*	*45.7%*			*43.7%*	
$8,457,861	$9,314,454	-$856,594	-9.2%	$8,850,803	17.	Net Patient Revenue	$60,634,565	$65,201,149	-$4,566,584	-7.0%	$64,401,596	-5.8%
$492,161	$546,687	-$54,526	-10.0%	$339,763	18.	Other Operating Revenue	$10,464,033	$3,826,821	$6,637,212	173.4%	$2,846,493	267.6%
$8,950,022	$9,861,141	-$911,119	-9.2%	$9,190,566	19.	Total Operating Revenue	$71,098,598	$69,027,970	$2,070,628	3.0%	$67,248,089	5.7%
						Expenses:						
$4,163,761	$3,947,431	-$216,330	-5.5%	$3,777,495	20.	Salaries & Wages	$29,326,718	$27,377,327	-$1,949,391	-7.1%	$26,581,421	10.3%
$348,084	$369,340	$21,256	5.8%	$320,025	21.	Physician Wages	$2,121,890	$2,561,548	$439,658	17.2%	$2,238,778	-5.2%
$126,486	$128,752	$2,266	1.8%	$93,925	22.	Contract Labor	$1,113,602	$892,971	-$220,631	-24.7%	$1,210,010	-8.0%
$2,456,915	$2,203,016	-$253,899	-11.5%	$1,916,357	23.	Employee Benefits	$16,016,594	$15,278,959	-$737,635	-4.8%	$14,002,326	14.4%
$7,095,246	$6,648,539	-$446,707	-6.7%	$6,107,802			$48,578,804	$46,110,805	-$2,467,999	-5.4%	$44,032,535	10.3%
79.3%	67.4%			66.5%		% Salaries and Benefits / Total Operating Revenue	68.3%	66.8%			65.5%	
$68,724	$81,313	$12,589	15.5%	$24,809	24.	Medical Professional Fees	$683,538	$563,953	-$119,585	-21.2%	$526,766	29.8%
$344,797	$170,108	-$174,689	-102.7%	$169,506	25.	Physician Contracts	$1,874,613	$1,179,794	-$694,819	-58.9%	$1,568,707	19.5%
$115,049	$174,322	$59,273	34.0%	$162,077	26.	Non-Medical Professional Fees	$1,337,764	$1,209,011	-$128,753	-10.6%	$1,116,386	19.8%
$1,133,149	$1,219,340	$86,191	7.1%	$1,370,875	27.	Materials & Supplies	$10,068,046	$8,456,753	-$1,611,293	-19.1%	$8,152,264	23.5%
$129,898	$143,393	$13,495	9.4%	$128,887	28.	Utilities	$789,344	$994,449	$205,105	20.6%	$896,471	-11.9%
$385,140	$432,222	$47,082	10.9%	$294,824	29.	Maintenance & Repairs	$2,959,534	$2,997,694	$38,161	1.3%	$2,529,073	17.0%
$63,040	$52,299	-$10,741	-20.5%	$41,278	30.	Rentals & Leases	$364,139	$362,716	-$1,423	-0.4%	$341,634	6.6%
$43,647	$53,793	$10,146	18.9%	$39,858	31.	Insurance	$340,930	$373,078	$32,148	8.6%	$310,590	9.8%
$585,284	$677,442	$92,158	13.6%	$589,896	32.	Depreciation & Amortization	$4,518,594	$4,204,840	-$313,754	-7.5%	$4,078,286	10.8%
$50,909	$51,245	$336	0.7%	$52,453	33.	Interest Expense	$356,577	$355,410	-$1,167	-0.3%	$367,169	-2.9%
$124,901	$145,714	$20,813	14.3%	$87,922	34.	Other Operating Expenses	$662,346	$1,010,532	$348,186	34.5%	$797,371	-16.9%
$10,139,784	$9,849,730	-$290,054	-2.9%	$9,070,187	35.	Total Expenses	$72,534,229	$67,819,035	-$4,715,193	-7.0%	$64,717,252	-12.1%
-$1,189,762	$11,411	-$1,201,173	-10526.4%	$120,379	36.	Income (Loss) from Operations	-$1,435,631	$1,208,935	-$2,644,566	-218.8%	$2,530,837	-156.7%
						Non-Operating Revenue						
$101,391	$104,049	-$2,659	-2.6%	$103,517	37.	Interest Income	$715,562	$721,634	-$6,072	-0.8%	$713,910	0.2%
$1,074,927	$100,472	$974,455	969.9%	-$326,210	38.	Other Non-Operating Income	$1,528,615	$696,834	$831,781	119.4%	$510,294	199.6%
$1,176,318	$204,521	$971,796	475.2%	-$222,693	39.	Total Non-Operating Revenue	$2,244,177	$1,418,468	$825,709	58.2%	$1,224,204	83.3%
-$13,444	$215,932	-$229,376	106.2%	-$102,314	40.	Net Income (Loss)	$808,546	$2,627,403	-$1,818,857	69.2%	$3,755,041	78.5%
-13.29%	0.12%			1.31%		Income from Operations Margin	-2.02%	1.75%			3.76%	
-0.15%	2.19%			-1.11%		Net Income	1.14%	3.81%			5.58%	

BARTLETT REGIONAL HOSPITAL
BALANCE SHEET
January 31, 2021

	January-21	December-20	January-20	CHANGE FROM PRIOR FISCAL YEAR
ASSETS				
Current Assets:				
1. Cash and cash equivalents	32,427,186	34,239,541	28,242,074	4,185,112
2. Board designated cash	35,512,770	35,824,845	39,266,128	(3,753,358)
3. Patient accounts receivable, net	13,865,116	13,030,156	16,420,030	(2,554,913)
4. Other receivables	(353,955)	(252,703)	2,382,342	(2,736,297)
5. Inventories	3,318,451	3,341,683	3,255,837	62,615
6. Prepaid Expenses	3,021,336	2,828,828	662,287	2,359,049
7. Other assets	28,877	28,877	28,877	-
8. Total current assets	87,819,781	89,041,227	90,257,575	(2,437,792)
Appropriated Cash:				
9. CIP Appropriated Funding	3,597,217	4,163,554	4,678,117	(1,080,901)
Property, plant & equipment				
10. Land, bldgs & equipment	146,734,223	146,403,489	142,709,147	4,025,076
11. Construction in progress	7,609,601	7,105,584	5,107,629	2,501,973
12. Total property & equipment	154,343,824	153,509,073	147,816,776	6,527,049
13. Less: accumulated depreciation	(98,559,626)	(97,974,462)	(93,671,326)	(4,888,300)
14. Net property and equipment	55,784,198	55,534,613	54,145,451	1,638,748
15. Deferred outflows/Contribution to Pension Plan	12,403,681	12,403,681	14,415,000	(2,011,319)
16. Total assets	159,604,877	161,143,075	163,496,143	(3,891,263)
LIABILITIES & FUND BALANCE				
Current liabilities:				
17. Payroll liabilities	1,064,006	671,459	744,650	319,356
18. Accrued employee benefits	5,186,823	4,772,028	3,606,792	1,580,031
19. Accounts payable and accrued expenses	2,391,091	3,131,977	3,153,198	(762,108)
20. Due to 3rd party payors	4,051,027	4,250,857	2,602,005	1,449,022
21. Deferred revenue	(3,264,431)	(3,009,812)	(2,223,521)	(1,040,910)
22. Interest payable	1	329,797	-	1
23. Note payable - current portion	910,000	870,000	870,000	40,000
24. Other payables	205,294	127,203	143,080	62,213
25. Total current liabilities	10,543,811	11,143,509	8,896,204	1,647,605
Long-term Liabilities:				
26. Bonds payable	16,350,000	17,260,000	17,260,000	(910,000)
27. Bonds payable - premium/discount	1,122,279	1,137,329	1,301,604	(179,325)
28. Net Pension Liability	64,954,569	64,954,569	72,600,321	(7,645,752)
29. Deferred In-Flows	4,318,200	4,318,200	6,172,883	(1,854,683)
30. Total long-term liabilities	86,745,048	87,670,098	97,334,808	(10,589,760)
31. Total liabilities	97,288,859	98,813,607	106,231,012	(8,942,155)
32. Fund Balance	62,316,020	62,329,465	57,265,129	5,050,891
33. Total liabilities and fund balance	159,604,877	161,143,075	163,496,143	(3,891,263)

Bartlett Regional Hospital

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

Board Quality Committee
March 10, 2021
Minutes

Called to order at 3:30 pm by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig* (Chair), Mark Johnson*, Lindy Jones*, Iola Young

Staff: Gail Moorehead, Director of Quality, Kevin Benson, CFO/Interim CEO, Billy Gardner, COO, Dallas Hargrave, HR Director, Charlee Gribbon, Infection Preventionist, Nathan Overson, Compliance Director, Deborah Koelsch, RN Clinical Quality Data Coordinator, Rebecca Embler, Quality Systems Analyst

Guests: Ursula Iha, Pharmacy Director, Jeannette Lacey, Case Management Director

Approval of the minutes – 01 13 2021 Quality Committee Meeting – *minutes approved as written.*

Old Business: No old business discussed.

New Business:
BOD Quality Dashboard

- Deb Koelsch did not present the Quality Scorecard measure results for Q4 2020, because they are the same as presented last month.
- Rebecca Embler did not present the Patient Experience and HCAHPS results for Q4 2020, because they are the same as presented last month.
- Deb and Rebecca will look at new metrics to showcase on months that there is no new quarterly data.

HIM/Utilization Management Plan

- Jeannette Lacey presented on Case Management Annual Plan; CM has responsibility of UM plan with partnership of physician committee; at end of 2019, review was in process; at beginning of 2020, committee was not ready to meet due to COVID.
- This plan outlines how CM requests physician review and partners with physician committee (i.e. how partner with MedStaff when things need to be addressed); looking at Medicare outliers, how Bartlett is following rules and observation; overall utilization of services and compliance with CMS rules.
- Some formatting changes were made to make plan more readable.

- Sections H & I were added; H: Utilization Review Committee Composition outlines who participates in UR Committee; I: Functions of Committee added in order to clarify how each group serves as liaison.
- Updated references to be more current.
- **Motion made to adopt plan and send to next BOD meeting; seconded and ordered.**

Risk Management Plan

- **Motion made to adopt plan and send to next BOD meeting; seconded and ordered.**

Infection Prevention Plan

- **Motion made to adopt plan and send to next BOD meeting; seconded and ordered.**

Environment of Care Management Plan

- **Motion made to adopt plan and send to next BOD meeting; seconded and ordered.**

Patient Safety and Quality Improvement Plan

- **Motion made to adopt plan and send to next BOD meeting; seconded and ordered.**

All plans approved and motion to send to BOD.

Antimicrobial Stewardship

- Evan Deisen, Chris Sperry, Dr. M Benjamin, and others from the lab comprise this group.
- Ursula Iha started the presentation with a definition of Antimicrobial Stewardship; we monitor certain groups of antibiotics in order to manage the use of each.
- The first chart shows Carbapenems use; this drug is very effective, so try to limit its use; we put in place safeguards to accomplish this; results of these safeguards has been effective, as seen in the graph.
- The second chart shows Fluoroquinolones use; this drug has some unfavorable side effects, so also try to limit use of this drug.
- The third and fourth charts are Fluoroquinolones and Broad Spectrum Cephalosporin use; use of these drugs have remained below the goal, so not as concerned with use.
- The fifth chart is Vancomycin use; this is not part of partnerships for patients, so we track this unofficially, and do not have a goal value.
- The sixth chart is Clindamycin use; this is the only drug that went above goal over the time period; high use in August was due to multiple patients needing reduced toxin production, and this drug is effective for that; the team is watching this closely since it went above the goal; will continue to monitor in 2021.
- Lindy Jones asked who the point of contact is to ask about these drug usages. Ursula said Evan Deisen and Chris Sperry can provide insight and recommendations
- Did not include opioid use or hypoglycemia, but can provide that data.

CMS Survey Update

- Gail Moorehead discussed that Bartlett had unexpected CMS survey (DHSS contracted); complaint on Infection Prevention area; surveyors looked at front door screenings, employee screening; Bartlett got cited for 6 broad areas, and submitted CAP a week ago that is being reviewed; this is significant because Bartlett wants to stay complaint with CMS; some of the corrective actions already implemented are:
    - More readily-available hand sanitizer and training for front-door staff to ensure guests and employees are using that.
    - Back door ER entrance is now the Triage Building, and that's where patients will be screened, banded and hand-sanitized; limited access through the door.
    - CDC recommends all staff and visitors get screened when they enter the hospital; Bartlett documentation was not 100%, so the process has been improved so that employees can ensure they are documenting their screening daily.
    - Providing more education around symptoms and steps to take if symptoms are felt.
- Waiting for follow-up survey in 45-60 days.

Patient Safety Survey

- Gail Moorehead presented on the Patient Safety survey. Survey will be going out next week (Patient Safety week) to all employees; survey on Patient Safety is required every two years by Joint Commission; leaders maintain culture of safety throughout hospital; this is method to collect anonymous feedback and input from frontline staff.
- Survey questions include topics such as occurrence reporting, workload, safety, environment, supervisor and leader interaction, staffing, communication, unit rating on patient safety.
- Survey is standard from AHRQ, so that results are standard across all hospitals; Bartlett has also included optional questions related to our Electronic Health Record (EHR), since currently upgrading to Expanse (Meditech); can evaluate impact of this upgrade on patient safety.
- At the end of the survey, there is an open text box for other feedback as well.
- Will have rough draft of results by May Board Quality meeting.
- Lindy Jones asked how the survey is sent out; it is sent out to staff via email (hosted in SurveyMonkey).

Other

- Mark Johnson asked how the Expanse (Meditech) transition is going. The system went live last Monday; there were some issues early on, and IT team is working through tasks that needed to be fixed or modified; 280 items on list, and only 59 outstanding.
- Rose Lawhorne brought up that Alaska was just rated #2 for Healthcare Quality from Becker Hospital Reviews, and expressed Thank You to the Quality team and frontline teams. Gail added that Bartlett is a 5-star rated hospital as well. Both topics will be included for the BOD meeting.

- Shout out to Gail for organizing Centennial Hall vaccine clinics, as well as everyone else involved to make this happen for Juneau. Over 400 volunteers have helped out so far.

Adjourned at 4:10 pm

Next Quality Board meeting: May 12, 2021 @ 3:30pm

Bartlett Regional ~~Hospita~~~~Bartlett Regional Hospital~~

Title: **UTILIZATION MANAGEMENT PLAN**

Department/s: All Clinical Departments

Original Date: 10/1997 Author: Jeannette Lacey, LMSW, ACM

Updated: ~~12/2018~~12/2020

PURPOSE:

1. The Utilization Management Plan is an organization wide, interdisciplinary approach to balancing the quality, cost, and risk concerns in the provision of patient care.
2. This plan strives to promote appropriate resource utilization and discharge planning in accordance with CMS and to maintain high levels of integrity in keeping with the mission statement and vision of ~~BRH~~Bartlett Regional Hospital.

DEFINITIONS:

Milliman Care Guidelines (MCG): published by MCG Health, uses evidence-based best practices and care planning tools across the continuum of care to evaluate medical necessity and track length of stay (LOS).

Interqual Level of Care Criteria (IQ): published by McKesson Health Solutions, uses condition-specific, general and extended stay subsets to evaluate for medical necessity.

Utilization Management (UM): is evaluation of the medically necessary appropriateness and efficiency in the use of healthcare service, procedures and facilities.

Utilization Review (UR): is the process of determining whether all aspects of a patient's care, at every level, are medically necessary and appropriately delivered.

Secondary Review: is a review performed by a physician with the contracted secondary review service, Sound– Physician Advisory Services, when the IQ or MCG screening criteria suggest a different patient status or level of care other than that ordered by the patient's physician and/or for a potential quality concern.

Policy

A. The Board of Directors of Bartlett Regional Hospital has delegated the responsibility for the performance of utilization review activities to the Case Managers (CM) with the ~~Health Information Management/Case Management (HIM/CM)~~ Utilization Review Committee as the oversight committee.

B. The Utilization Management Plan is based on CMS conditions of participation, The Joint Commission standards, and Interqual and/or MCG criteria for healthcare utilization and seeks to resolve problems that cause or result in either deficient or excessive resource utilization. The plan will be reviewed at least annually by the ~~Health Information Management/Case Management~~ Utilization Review Committee.

~~C. All patients, regardless of payment source, shall be evaluated to ensure that resources are utilized appropriately.~~

~~D. The written Scope of Services will serve to identify and delineate the activities of the department.~~

C. The Utilization Management Plan recognizes the authority of KEPRO and the assessment and monitoring of review activities performed by KEPRO.

~~E.~~ Utilization management and review are integral parts of the Process Improvement Plan at BRH and will be under the auspices of the CFO with direct reporting to the ~~HIM/CM Committee.~~

D. ~~The Case Managers~~ Utilization Review Committee.

~~F.~~E. Scope of Review: All patients, regardless of payment sources, shall be evaluated to ensure that resources are utilized properly. The Case Managers (CM) will be responsible for the process of ~~measuring and assessing,~~ maintaining and monitoring the effective utilization of hospital facilities, services, and resources related to inpatients and patients placed in observation status. This shall include, but not be limited to:

~~F~~E.1. ~~Managing LOS~~
~~F.2. Monitoring use of bed days~~
~~F.3. Managing transfers~~
~~F.4. Identifying the appropriate level of care~~
~~F.5. Managing denials and appeals~~
~~F.6. Performing admission, concurrent, discharge and retrospective reviews~~
~~F.7. Tracking and monitoring cost and quality (Including examining patterns of utilization)~~
~~F.8. Identifying available discharge care resources and coordinating with Social Work Case Managers (SWCM) to develop a post-acute care plan that is compliant with CMS guidelines.~~
~~F.9..Requesting secondary review or HIM/CM Committee involvement as necessary.~~

~~G. The Utilization Management Plan recognizes the authority of Livanta and the assessment and monitoring of review activities performed by Livanta. Outliers will be reviewed by the HIM/CM Committee.~~

~~H. Patient and physician confidentiality will be maintained at all times in accordance with the BRH compliance policy and peer review laws of the State of Alaska. Case Management daily work and/or studies will be available only to representatives of the Medicare intermediary, third party payers, Livanata, the attending physician, members of the HIM/CM Committee, the hospital administrator and the Bartlett Regional Hospital Board of Directors.~~

~~I. The CM will keep the physician involved in the utilization management process by:~~
~~I.1. Maintaining open lines of communication.~~

I.2. Reviewing admission status based on accepted criteria and clarifying admission status with physician if in question and recommending a change to an appropriate status (ultimately it is physician's prerogative to decide the status).

I.3. Reviewing continued stay documentation and identifying needed changes or additions to ensure that documentation supports 'physician intent.'I.4. Coordinating care conferences with the physician and treatment team as indicated.

I.5. Involving physician in the discharge planning process.

J. The CM will consult with the appropriate physician(s) serving on the HIM/CM Committee regarding identified patient care matters.

K.. The CM will involve the medical staff in Appeals and Denials through direct communication to provide the information needed to deal with the appeal or denial.

Patients that do not meet admission criteria may be admitted to observation status by the admitting provider if observation criteria are met. Those patients who do not meet criteria for inpatient care or observation services shall be notified by the CM that the services are not covered and that the individual or family may be responsible for payment of the services. The appropriate Hospital Issued Notice of Non Coverage(HINN) or Advanced Beneficiary Notification (ABN)will be given to the patient or their representative.

M. Case Management will present a report at the quarterly HIM/CM Committee on those patients who are considered outliers in length of stay or costs (data as defined by HIM/CM Committee), with readmissions prioritized, and identify the reasons that caused the outlier status.

N. Members of the HIM/CM Committee (including physician members as needed) will perform chart reviews quarterly for identified outliers, utilizing the identified audit tool, and make recommendations for service improvement as identified.

SCOPE

Applies to Case Management Coordination for all BRH inpatients and observation patients.

PROCEDURE:

A. Preadmission certification for outpatient procedures, surgical procedures, specialties care and inpatient admissions (if required) will be the responsibility of the provider's office.

B. Patient Access Services will perform insurance verification and inform the Case Management Department within 1 business day of required reviews.

C. Medical Necessity:Hospital inpatient services under Medicare Part A, section1814(a) of the SocialSecurity Act requires physician certification of the medical necessity that such services be provided on an inpatient basis.

C.1. Registered Nurse Case Manager (RNCM) will determine if medical documentation supports medical necessity for admissions and continued stay based on established industry criteria that are intended for use as a guideline in conjunction with sound clinical judgment.

C.2. Admission reviews will be performed within the first business day following admission

C.3. If RNCM is unable to determine the necessity for admission RNCM will initiate a secondary review.

C.4. Concurrent stay reviews will be based on the attending physician's reasons and plan for continued stay, discharge plans and other documentation. Case Management will remain in contact with the attending physician, the business office and the payer during the hospital stay to resolve questions and to share information regarding discharge plans.

References

(1) Certified Professional Utilization Review Study Guide
Interqual Products Group 2013

(2) Federal Register Volume 66, No. 231

(3) Livanta Quality Improvement Organization
ICD 10-CM and ICD-10 PCS, current volume

(4) Interqual Level of Care Criteria: Acute Adult / Acute Pediatric
McKesson Health Solutions 2016

(5) Medicare Hospital Manual section 230.6E

(6) Health Utilization Management Standards, Version 5.0
URAC 2006

(7) CMS Conditions of Participation 482.30 Utilization Review

(8) Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care and Behavioral Health Care, current edition

Attachments

(1) Health Information Management/Case Management Committee report form templates:
1. Denied Days Status Report
2. Outlier Status Report
3. Utilization Management Report with Medicare Monitoring Summary

Performing admission, concurrent, discharge and retrospective reviews to assess for medical necessity

E.2. Identifying the appropriate level of care

E.3. Managing length of stay

E.4. Assessing potential transfers from lateral or higher levels of care

E.5. Managing denials and appeals

E.6. Tracking and monitoring utilization patterns and professional services furnished, including drugs and biologicals.

E.7. Identifying available discharge care resources to develop a post-acute care plan that is compliant with CMS guidelines.

E.8.Requesting secondary review or Utilization Review Committee involvement as necessary.

F. CM will collaborate with physicians to support the utilization management process by:
F.1. Maintaining open lines of communication.
F.2. Reviewing admission status based on accepted criteria and CMS rules and discussing concerns with the provider.
F.3. Reviewing continued stay documentation and identifying possible changes or additions to ensure that documentation supports physician intent.
F.4. Coordinating care conferences with the physician and treatment team as indicated.
F.5. Involving the physician in the discharge planning process.
F.6. Coordinating physician participation in the appeal process.

G. Patients that do not meet inpatient criteria may be placed in observation status by the admitting provider if observation criteria are met. Those patients who do not meet criteria for inpatient care or observation services shall be notified by the CM that the services are not covered and that the individual or family may be responsible for payment of the services. The appropriate Hospital Issued Notice of Non Coverage(HINN) or Advanced Beneficiary Notification (ABN)will be given to the patient or their representative.

H. Utilization Review Committee Composition:
H.1. Credentialed medical staff, at least 2 of which will be doctors of medicine or osteopathy. H.2. Staff from the Case Management (CM) Department
H.3. Staff from the Health Information Management (HIM) Department
H.4. Staff from the Quality Department.
H.5. Reviews may not be conducted by any individual who has a direct financial interest in the hospital; or was professionally involved in the care of the patient whose case is being reviewed.

I. Utilization Review Committee Functions: The Committee

I.1. Will meet quarterly

I.2. Will review

i.Outlier cases

ii. Denials

iii.Compliance with the 2-Midnight Rule

iv. Readmissions

I.3. May make determinations regarding admissions or continued stays. These may be made by one physician member if the attending concurs with the determination or fails to present their views when offered the opportunity; Determinations must be made with two physician members in all other cases. (See policies for CC44 and CCW2 for specific processes).

I.3. Support HIM, CM, and Clinical Documentation Integrity functions as defined in the Medical Staff Rules and Regulations.

I.4. Make recommendations regarding identified utilization or documentation matters.

I.5. Serve as a liaison to the medical staff regarding issues reviewed by the committee.

SCOPE

Applies to Case Management Coordination for all BRH inpatients and observation patients.

PROCEDURE: Utilization Review

A. Preadmission certification for outpatient procedures, surgical procedures, specialties care and inpatient admissions (if required) will be the responsibility of the provider's office.

B. Patient Access Services will perform insurance verification and notify the Case Management of reviews requested by payers at the time of verification.

C. Medical Necessity: Hospital inpatient services under Medicare Part A, section1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis.

C.1. Registered Nurse Case Manager (RNCM) will determine if medical documentation supports medical necessity for admissions and continued stay based on established industry criteria that are intended for use as a guideline in conjunction with sound clinical judgment.

C.2. Admission reviews will be performed within the first business day following admission

C.3. A secondary review may be initiated if the RNCM is unable to determine medical necessity for the admission.

C.4. Concurrent stay reviews will be based on the attending physician's reasons and plan for continued stay, discharge plans, and other documentation. Case Management will remain in contact with the attending physician, the business office and the payer during the hospital stay to resolve questions and to share information regarding discharge plans.

References

(1) Medicare Hospital Manual section 230
(2) CMS Conditions of Participation 482.30 Utilization Review
(3) CMS Conditions of Participation 412.80 Outlier Cases
(4) Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care and Behavioral Health Care, current edition, 2019

Attachments

(1) Health Information Management/Case Management Committee report form templates:
1. Denied Days Status Report
2. Outlier Status Report
3. Utilization Management Report with Medicare Monitoring Summary

Attachment #1

Bartlett Regional Hospital

HIM/UM Denied Days Status Report

Date:

Visit #	Admission Date	Discharge Date	LOS	Admitting Diagnosis	Days Auth	Days Denied	Insurance	Status

Attachment # 2

Bartlett Regional Hospital

Medicare Outlier Status Report

Patient Name	Account #	Admission Date	Discharge Date	LOS	ELOS	Charges	Admitting Diagnosis/ Procedures	Disposition/ Outlier Problem	CM Reviewer	Appropriate timing of D/C planning?	What else could have been done differently?	Reason for outlier
Patient Name	Account #	Admission Date	Discharge Date	LOS	ELOS	Charges	Admitting Diagnosis/ Procedures	Disposition/ Outlier Problem	CM Reviewer	Appropriate timing of D/C planning?	What else could have been done differently?	Reason for outlier

Attachment #3

Bartlett Regional Hospital
Utilization Management Report

Q4 CY2018			
Denials			
		Reversed	**Upheld**
Initial			
Aetna			
Blue Cross			
Medicaid			
Other			
Medicare Monitoring		Notes	
CMI			
1- day stays			
Observation > 2MN			
Outliers			
Psych			
Placement			
EOL			
Complex Medical			
Social			
Other			

Q4 CY2018			
Denials			
		Reversed	**Upheld**
Initial			
Aetna			
Blue Cross			
Medicaid			
Other			
Medicare Monitoring		Notes	
CMI			
1- day stays			
Observation > 2MN			
Outliers			
Psych			
Placement			
EOL			
Complex Medical			
Social			
Other			

Bartlett Regional Hospital
RISK MANAGEMENT PLAN
CY ~~2020~~2021

Issued: July 1, 2010
Revised: ~~December 18, 2019~~January 8, 2021
Submitted by: ~~Mary Crann, RN, MSN, CPHRM~~Nathan Overson, CHC

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~~Compliance and Risk. The Director of ~~Quality~~ Compliance and Risk 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~~Compliance and Risk is the Risk Manager and Employee Safety Officer. The Risk Manager works closely with the Lead Security Officer, and the Quality Director who is also the Patient Safety Officer. ~~(RM&PSO) and~~The Risk Manager 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 the Risk Manager in close coordination with the Quality Director who helps facilitate the peer review process as a representative of hospital administration. The Quality Director in conjunction with the Medical Staff identifies~~clinical criteria to identify~~ specific patient cases with potential risk in the clinical aspects of patient care and safety.

PURPOSE AND PHILOSOHY

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~~these vulnerabilities.

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 Department and the Compliance & Risk ~~Management~~ Department via the Director of Quality and the Compliance & Risk Department. 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 Chief Executive Officer the responsibility for the patient grievance process who ~~Director of Quality and~~delegates to the Risk Manager the responsibility of managing the patient and visitor complaint process. ~~& Patient Safety Officer to function~~The Performance Improvement Committee (PIC) serves as the Grievance Committee for ~~complaint processing that cannot be resolved by the department managers~~a system analysis approach to investigate system concerns or issues.

Senior Leadership Team:

The Senior Leadership Team(SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief ~~Clinical~~ Operations Officer, Chief Nursing 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 patient 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; the Risk Manager will work closely with Quality to ensure change elements are 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~~RCA best practice 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 function of the PIC 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~~Performance Improvement Committee (PIC)

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

BARTLETT REGIONAL HOSPITAL
INFECTION PREVENTION and CONTROL PLAN 2021

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

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

Infection Prevention and Control Plan Reviewed by:

	Signature	Date
Infection Prevention and Control Committee Chair	~~Dr.~~ David Miller MD	1/11/2021
Quality and Process Improvement Director	~~Sarah Hargrave RN, MSN~~ Gail Moorehead MSN, NPD-BC, CMSRN, CPHQ	1/11/2021
Infection Preventionist	Charlee Gribbon RN, BSN, CIC	1/11/2021

Bartlett Regional Hospital

Infection Prevention and Control Plan 2021

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 (novel strains such as COVID-19, or ~~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, enhanced cleaning methods, and/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, respiratory pathogens 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 (SOE), 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 (DHHS, 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 Occupational Health~~safety~~ and ~~health~~ Safety Program Specialist is coordinating the health and safety program for ~~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 current Risk Assessment and Prioritization List). The factors to be addressed in the risk assessment include, at a minimum: Hospital Acquired Infections, Antimicrobial Stewardship , Hand Hygiene, influenza and novel respiratory pathogens, medical devices, occupational exposures, and ~~transmission-based~~ infectious 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~~31,974 (US Census, 2019) This includes 5.7~~6~~% who are under 5 years of age, 21.1% persons who are under 18 years~~18.7% that are aged 6-19 years~~, and 14~~9.2~~% that are over 65 years of age. (US Census, 2019) The underserved and disadvantaged population includes: 7.9% with a disability and under 65 years of age; and ~~,~~10.9 % under 65 years of

age without health insurance. (US Census, 2019) Additionally, ~~7.3% (2365 persons) which live below the poverty line, and 9.8 % (3169 persons) live below 125% of the poverty line.~~ 6.3% of Juneau residents are living in poverty (US Census, 2019).

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, mining 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, mining 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 in local population 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 *Clostridioides difficile* ~~Clostridium Difficile~~ [CDI ~~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~~ 743 employees, of which 611~~493~~ (82~~74~~%) are full or part time scheduled and working on campus. 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. Employees that handle or contact hazardous drugs participate in the medical surveillance program. Employee illnesses are categorized and logged daily by the ~~House Supervisor~~Central Staffing Office and Employee Health Nurse, and analyzed by ~~the Infection Preventionist~~Employee Health. 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.

2021

Infection Prevention and Control Plan

2021 Infection Control Plan Goals

Infection Prevention Goal #1	Measurable Objective	Strategies	Responsible Parties	Measurement/ Evaluation Goal Met or Unmet.
►Improve compliance with CDC Hand Hygiene Guidelines (NPSG 07.01.01, EP1).	BRH hand hygiene rates will be improved by 5% over 2020's hand hygiene compliance rate by 12/31/2021. Press-Ganey hand hygiene scores will increase by 5 % over 2020's reported scores.	1. Form Hand Hygiene Champion Group to meet quarterly on compliance tracking. 2. Develop shared place to show compliance rates to hospital. 3. Consistently and more directly meet with observers to encourage more observation. 5. Work with Patient and Family Engagement Team to encourage more patient feedback regarding Hand Hygiene. 6. IP will round/talk directly with visitors, patients and families on proper hand hygiene. 7. IP will compare Press-Ganey reported hand hygiene.	Nursing Administration, Patient Care staff, Infection Prevention, Employee Health, Patients and visitors.	BRH hand hygiene compliance rate will increase or be equal to 2020 hospital wide rates. Patient reported (Press-Ganey) hand hygiene scores will increase by 5% over 2020's reported rates.

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 12/31/2021.	1. Monitor staff compliance with patient skin and nasal decolonization. 2. Reduce the number of sterile processing failures. 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 ≥ 30. 5. Decrease the risk of contamination of surgical instruments. 6. Work towards JC Surgical Center of Excellence.	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	Measure surgical site infection rates and compare to 2020. Rate will be ≤ 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	1. Continue to monitor compliance for recommended specimen testing.	Nursing, EVS, Infection Prevention, pharmacy, medical staff, laboratory and all staff.	Measure C. difficile infection rates and compare to 2020 baseline.

	per 10,000 patient days by 12/31/2020.	2. Increase utilization of Sterile Meryl for all isolation terminal cleaning. 3. Ensure appropriate cleaning and disinfection products (sporicidal) are available for C. difficile rooms and area is cleaned per protocol. 4. Prohibit unnecessary antibiotic use.		There will be no increase in HAI- C. Difficile rates for 2020.
Infection Prevention Goal #4	**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 full time/ part time scheduled staff influenza vaccination at rates 98 % or greater for the 2021-2022 influenza season.	1. Participation in the influenza prevention plan is mandatory. 2. Unvaccinated staff are required to wear barrier masks. 3. Enforce standard precautions are in use for any aerosol-generating procedure. 3. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH. 4. Participate in state wide influenza infection prevention meetings.	Leadership, all staff, IC, and employee health	Full time/ part time scheduled staff compliance rate will be at 98% or greater by November 30, 2021. Report data via NHSN.

		5. Increase public awareness of importance of vaccination.		
Infection Prevention Goal #5	**Measurable Objective**	**Strategies**	**Responsible parties**	**Measurement/Evaluation**
Maintain established COVID prevention, employee heath monitoring, and associated policies.	1. Employee health will continue to track and monitor Employee symptoms, testing, and quarantine.	1. Continue to monitor State Public Health mandates. 2. Continue to provide COVID vaccinations as needed for identified staff. 3. Continue to monitor, test, and quarantine staff according to current mandates and Infection Control Policies through Employee Health. 2. Ensure all staff are provided adequate PPE. 3.Develop action plan to scale activities on an as needed basis depending on the tourism season.	Nursing, Staff Development, Infection Prevention and Employee Health.	Measure HAI COVID infections for 2021. There will be no HAI COVID cases identified for 2021.
Infection Prevention Goal #7	**Measurable Objective**	**Strategies**	**Responsible parties**	**Measurement/Evaluation**

Reduce the risk of HAI transmission risk attributable to surface contamination.	ATP pass rates will improve be 90% by 12/31/2021	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.	All high touch surfaces will show a 90% ATP pass rate.

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BARTLETT REGIONAL HOSPITAL

Environment of Care

Annual Report

CY 2020

Approvals
Environment of Care Committee: November 12, 2020
Performance Improvement Council: (scheduled January 12, 2021)
Board Quality: (scheduled January 12, 2021)

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 (Nathan Overson Director of Compliance and Employee Safety)
- 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.

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 2020. For each of the major areas, it is organized as follows:

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

SAFETY MANAGEMENT

SCOPE

No Changes

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

- Crystalline Silica Dust Protection evaluation performed at BRH
- Workplace hazard assessment performed for employee work stations for COVID-19
- Addition of Plexiglas screens throughout the hospital (offices/public areas/break areas)
- Ongoing workplace violence work through WSHA in the Emergency Department and HR
- Hazard risk assessments performed for new or changed workflow or spaces due to COVID-19Hazard
- Reduction in lost time injuries over prior year
- Reduction in serious injuries (level of treatment) to staff
- No OSHA defined workplace exposures to COVID-19 (different from COVID-19 reporting requirements)
- Better integration with CBJ safety programs and initiatives
- Better analysis and review of employee related occurrences over 2019
- Better alignment of the organization safety program with AKOSH and OSHA regulations over 2019

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
Identify opportunities to improve safety performance	**Met**	Hazard risk assessments performed for new or changed workflow or spaces due to COVID-19Hazard
Provide regular safety education to all staff	**Met**	New employee education and required annual safety education

Objectives	Met / Not Met	Comments and Action Plans
Enforce current safety practices for staff, patients, physicians, and visitors	**Met**	EOC Rounds were completed as and follow-up rounds were conducted to monitor specific regulatory survey findings.
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
Combine and enhance all the workplace violence (WPV) elements (policies, procedures and related training curriculum) into a complete comprehensive program.	100%	100%	**Met** Many of the program elements have been successfully made more comprehensive. Due to the dynamic nature this program it is still in a state of enhancement review. Additional resources and initiatives such as our current participation in a WPV workgroup hosted by the Alaska State Hospital and Nursing Home Association (ASHNHA) is informing many of these enhancements.

Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
Create reports to review and analyze the following indicators with the intent to identify ways to reduce injuries: • Number of recordable lost workdays • Injuries by cause • Injuries by body part • Needle sticks and body fluid exposures	100%	100%	**Met**
Implement a working-at-heights (WAH) program	100%	0%	**Changed Direction** Focus of this goal has changed to support CBJ and BRH integration of WAH program. Initiative now in early stages (also includes Confined Space Entry and Hearing Conservation etc.).

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 2021:

- Outline emphasis areas, specific tasks and responsibilities for areas supported or proposed to be supported by the CBJ Safety program that would meet the needs of the BRH Safety program and identifying efficiencies and alignment of the two programs where appropriate.
- Conducted a feasibility review of having the CBJ Safety Officer have a workstation onsite at the BRH campus for a scheduled amount of time to promote additional ease of collaboration between BRH and CBJ.

The proposed performance measures for these goals are:

Safety Management Proposed Performance Measures for 2021	Target	Comments & Action Plan
AIM: Create a new and efficient way to meet the Joint Commission requirements to collect information on staff's knowledge of Employee Safety topics and to survey the physical environment (replace SWARMS)	**Complete 100%**	All updates will be reviewed and approved by multi-disciplinary EOC Committee.
AIM: Reduce OSHA recordable injuries to staff by 50% (7 for 2020)	**3 or less**	A multi-disciplinary team will be used including members from Risk Management and Human Resources.

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

- A comprehensive 1:1 sitter training to respond to a broader scope of 1:1 sitter scenarios .
- Additional employee badge proximity readers have been added to security doors throughout the hospital to enhance security in those areas. More to be added in 2021 along with enhanced lockdown capabilities.
- Security response to physically limit control points to the hospital as a response to COVID-19 safety precautions.
- The hospital appropriately responded to dynamic visitor policy and visitor incident directives based on needs assessment.
- Security role appropriately prioritized to ED screening entrance to ensure safety and security of screening staff in the screening tent.
- New Psychiatric Emergency Services staff has supported the security response requests in the Emergency room.

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.

Objectives	Met / Not Met	Comments and Action Plans
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.
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 2020	Target	Outcome	Comments and Action Plan
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: • 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%	55% of the overall project. = 20% = 10% = 5% = 20%	**Met**
Improve Customer Satisfaction **AIM:** BRH will improve customer satisfaction by decreasing the number of in-patient property loss incidents.	**Decrease incidents by 50%** In 2019 16 in-patient property Loss incidents	Decreased by 44% In 2020 there were 9 Property Loss incidents	**Partially Met**
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: • Inventory Systems 10% • Develop Needs Assessment 40% • Compare current capabilities against needs assessment to identify gaps 40% • Present recommendations 10%	50% of the entire project 10% 40% 40% 10%	33% of the entire project =10% =10% =10% =3%	**Partially Met** Available man-hours to work towards this goal have been minimal.

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 2021

The following goals have been identified:

- **Improve Safety**: The Security Management Committee will Improve Safety by creating variable lock down procedures for active threat events to the Hospital, RRC, BSSC, BMOC and both Admin Buildings. All external exits to hospital, RRC, and both Admin Buildings are to have badge reader access capabilities.
- **Decrease Potential for Workplace Violence:** The Security Management Committee will decrease the potential for workplace violence by Finalizing the disruptive patient contract, including actionable consequences to enable staff to maintain a safe and secure environment; independent of calling for law enforcement.

The proposed performance measures for these goals are:

Security Management Proposed Performance Measure for 2021	Target
Improve Facility Safety Through Security **AIM:** BRH will Improve Safety by creating variable lock down procedures for active threat events to the Hospital, RRC, BSSC, BMOC and both Admin Buildings. All external exits to hospital, RRC, and both Admin Buildings are to have badge reader access capabilities.	Procedures in place and hardware installed.
Decrease Potential for Workplace Violence **AIM:** BRH will decrease the potential for workplace violence by Finalizing the disruptive patient contract, including actionable consequences to enable staff to maintain a safe and secure environment; independent of calling for law enforcement.	Complete the Document.

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

- Creation of the Hazardous Materials Relias training
- Maintained volumes to remain as a small quantity generator, <220 lbs.
- 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.

Objectives	Met / Not Met	Comments & Action Plan
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.

PER*FORMANCE 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:

HazMat Management Performance Measures 2020	Target	Outcome	Comments and Action Plan
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.	100%	92%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
AIM: When would it be necessary to initiate a code "Orange"? Does staff know the difference between incidental vs non-incidental spill?	95%	59%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
AIM: Staff Understand that eye wash and shower stations are to be checked weekly (ER, OB, Maintenance, Kitchen, Lab, Histo, Laundry, Pharmacy, Respiratory Therapy, INF, DI, BSSC)	100%	76%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
AIM: Staff know how to dispose of Hazardous materials, batteries, etc? Refer staff to Hazardous Material Disposal policy 8360.304	90%	95.52%	**Met;**

HazMat Management Performance Measures 2020	Target	Outcome	Comments and Action Plan
AIM: Nursing Departments – Verify staff familiar with pharmaceutical waste. Check area for labels on the disposal buckets. Pre-label before putting into use.	95%	75%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.

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 2021

- The Hazardous Materials committee transferred collection of performance measures to the hospitals education program, called Relias. Using similar format used with Swarms, the committee took the questions and created a training, with a test to collect performance measures. The Hazardous Materials was the first of the EOC committees to create this process. The challenge is the lack of ability to set benchmarks, as this is a new system. For this reason, 2020 will be the starting point for most questions, which benchmarks will be set for 2021.
- Committee decision based on compliance needs by TJC, CAP or CMS, requires 100% for three specific Relias questions from 2020. Our scores maintained mostly the same from 2019, which shows human error, which indicates continued review and process of Relias to maintain standards.
  - Committee decision to maintain Goals/Benchmark to 100% for the following Relias questions:
    - How do you find a Safety Data Sheet at Bartlett Regional Hospital?
    - Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?
    - How often must an eyewash, shower or personal wash bottle be checked?

The proposed performance measures for these goals will include:

Hazardous Materials & Waste Management Proposed Performance Measures 2021	Target
AIM: How do you find a Safety Data Sheet at Bartlett Regional Hospital?	100%
AIM: How many elements are included in a Safety Data Sheet?	86%
AIM: What section on a Safety Data Sheet addresses First Aide?	83%
AIM: Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?	100%
AIM: What is the difference between an Incidental Spill/Fumes vs a Non Incidental Spill/Fumes?	59%
AIM: If your unit has a common bottle of Methanol, you must have at a minimum a plumbed eyewash station on the unit?	13%
AIM: How often must an eyewash, shower or personal wash bottle be checked?.	100%
AIM: You are wasting a partial dose of Phenergan. Where do you waste this liquid medication?	75%
AIM: You are giving a half dose of Coumadin and you need to waste the other half. Where do you waste it?	63%
AIM: You are cleaning up after a procedure. There are 4x4 gauzes saturated with body fluids/blood. Where do you throw away the saturated gauzes?	96%

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

- Life Safety Code requirements reviewed as compliant with current TJC standards .
- Fire plan and evaluation completed for Juneau Medical Center Building (BOPS.
- Hospital updated and completed Life Safety prints for the hospital building.
- Facilitated a site visit for the Fire Marshall to evaluate the Juneau Medical Center building.
- Risk assessment and Interim Life Safety Plan for BOPS completion and supported a process to monitor compliance with the plan.
- Better way to collect data and evaluate the knowledge of Life Safety topic of employees.

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.

The Environment of Care Committee has evaluated the objectives and determined that there are minimal opportunities for improvement. The Program continues to Life Safety 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 Life Safety Management Program activities and to identify further opportunities for improvement:

Life Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
AIM: Establish and incorporate Fire Drill/process for RRC/Withdrawal Unit and BOPS new location	100%	100%	**Met**.
Update Life Safety Swarms process and complete for all units/departments	100%	85%	**Partially Met:** We have implemented a new process through Smart Sheet.

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 2021

- Creating Life Safety Swarms education in Relias for annual training and use Smart sheets monitor and track responses to training. Use Smart sheet data to identify areas needing additional education for staff.
- Refine our process for horizontal and vertical evacuations of patients and collaborate with facilities to support providing a follow-up education plan to staff on our current process through Relias and monitor and track through Smart sheets.

The proposed performance measures for these goals include**:**

Life Safety Proposed Performance Measures for 2021:	Target	Comments and Action Plan
AIM: Refine the process for accounting for all people following a fire evacuation.	100%	
AIM: Provide an education campaign to clinical staff to learn about what is expected with an evacuation, where the fire containments are, and how to horizontal or vertically evacuate when needed.	100%	
AIM: Refine our process for horizontal and vertical evacuations of patients and collaborate with facilities to support providing a follow-up education plan to staff on our current process through Relias.	100%	
AIM: Work with Facilities to support updating the addressable locations system in the Administration Building to have up-to-date titles, fire pull and fire point locations.	100%	

UTILITY SYSTEMS MANAGEMENT

SCOPE (Minor 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), Medical Gases, Helipad System, Fire Alarm and Detection System and the Fire Sprinkler System.

ACCOMPLISHMENTS

- We installed cameras in a few Patient Rooms in MHU (for patient and staff safety.).
- Installed two new camera servers with 90-day recording capacity.
- Decommissioned all legacy access layer switching hardware across the hospital campus (11) and re-cabled all network closets to improve access and reduce airflow restriction.
- Decommissioned (2) legacy racks of equipment to make room for new VxBlock hardware and improved airflow in the main datacenter.
- Replaced all large UPS units (10) across the hospital including the main datacenter.
- Constructed 2 COVID tents.
- Constructed walls for ED Isolation room (cast and suture) with additional (HEPA) High-efficiency particulate air ventilation filters and booster fan.
- Added grease duct access doors in kitchen hood system for better entree for cleaning.
- Added electrical disconnects to kitchen griddle for safer hood cleaning by staff.

Maintenance Storeroom before

Maintenance Storeroom after

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

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

Utilities Management Performance Measures 2020	Target	Outcome	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures.	50%	40%	**Partially Met**; This will be a multi-year project to review and rewrite all procedure
AIM: Create and maintain an inventory control program in TMS for the Maintenance Department.	50%	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 2021

- 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
- Catalog and scan all historical blueprints to electronic format.
- 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 Operating 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.

The proposed performance measures for the plan objectives include:

Utilities Management Proposed Performance Measures 2021	Target	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures. Make certain all utility equipment has an asset number assigned with a PM schedule in the Electronic Equipment Management Program (TMS). 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 or with strategies of an alternative equipment maintenance program.	**60%**	This will be a multi-year project to review and rewrite all inventories. (It was learned through experience this year that reviewing all assets with their preventative maintenance procedures was a loftier goal than possible to achieve. Adding new assets to the mix caused the opportunity of improvement to be even greater. Work this year has been focused on writing procedures for new assets as they are added to the management program. Ongoing

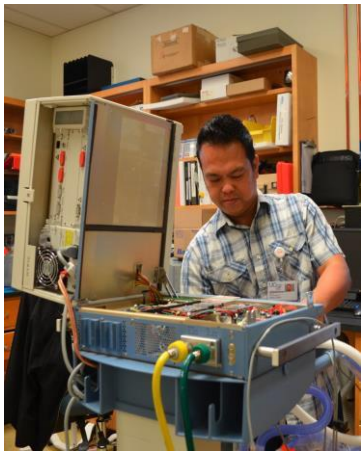
Utilities Management Proposed Performance Measures 2021	Target	Comments and Action Plan
AIM: Create and maintain an inventory control program in TMS for the Maintenance Department. For all parts: reducing the load of unused and outdated stock as well as maintaining adequate stock to perform necessary tasks. This will be a multi-year project to clean out old stock. Even though we were not able to enter inventory locations and quantities as proposed, we were able to reduce the load of unused and outdated inventory. The store room has been remodeled: walls painted, floor floated and painted, and new racks and shelving installed. We have worked at organizing and purging old unused equipment that is left over from assets that are no longer in the hospital. Major strides have been accomplished. We propose to break this project into smaller sections. 1. Sort and condense inventory into a smaller footprint. This will not only include the main stock room but items yet left in the basement of the old Bartlett Outpatient Services building (BOPS). We will be moving and organizing inventory into the refrigeration container located next to the Bartlett House. We are about 50 percent complete on this major first step. We anticipate step one on the project will be significantly completed by this time next year, November 2021. 2. Quantify each item with manufacturer, description and stock numbers. This will include placing each item into a known “warehouse” and known “bin location”. 3. Enter inventory into the TMS system and learn how to add and remove supplies assigning their use to an individual work order with replacement pricing.	Percent of the overall project Nov 2021 30% Nov 2022 50% Nov 2023 100%	See comparative photos contained in this report.

MEDICAL EQUIPMENT MANAGEMENT

SCOPE (NO CHANGE)

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 2020 include:

- Placed into service, 52 new TR 300 PARP.
- Received 6 new ultrasound units for the DI.
- Placed into service 8 new beds in MS department.
- Placed a new sonic cleaner into Central Sterile.
- 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
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%	15%	**Not Met**; This process is still considered as needing improvement and work will continue in 2021.
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.	100%	0%	**Not Met;** This goal is directly tied to the goal listed above and is also still considered as needing improvement, work will continue in 2021.

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 2021

- Need to organize and complete TMS PM updates by the end of the March 2021.

The proposed performance measures for 2021 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.

Medical Equipment Management Proposed Performance Measures	Target	Comments & Action Plan
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.	**100%**	
AIM: Work with Material Management to develop a process for disposing of surplus medical equipment and implement disposal within 3 months of removing it from the Medical Equipment inventory.	**100%**	
AIM: To organize and complete TMS PM updates by the end of the March 2021.	**100%**	

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

- New Committee Chairperson has been appointed.
- All existing policies have been reviewed.
- Missing documents (COOP and Mass Casualty) identified.
- 96 Hour Tool completed, improved with Smartsheet integration.

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: • 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**	Covid Activities
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 throughout 2020.
The hospital trains staff for their assigned emergency response roles.	**Met**	• 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.
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.

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	2020 Goal	2020 Results	Comments & Action Plan
AIM: Completion of Joint Commission required 96hr plan.	**100%**	**100%**	**Met.** The goal shifted direction as new priorities were developed with new Chairmanship.
AIM: Annual Hazard and Vulnerability Assessment.	**100%**	**100%**	**Met.** The goal shifted direction as new priorities were developed with new Chairmanship.
AIM: Annual update of the Continuity of Operations Plan**.**	**100%**	**100%**	**Met.** The goal shifted direction as new priorities were developed with new Chairmanship.

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 2021

- Cross-sectional positioning of EMT.
- Integration and alignment of EMT with CBJ/Public Health, particularly of Unified Command Structure and Incident Management Structures.

The proposed performance measures for these goals include:

Emergency Management Proposed Performance Measures for 2021	Target	Comments & Action Plan
AIM: HVA Updated with Inclusion of CBJ and Public Health HVAs	**100%**	
AIM: EOP Reviewed and Updated Annually, Inclusion of 96 Hr. Tool.	**100%**	
AIM: COOP Created and Approved by All Designated Personnel.	**100%**	
AIM: Staff Survey to Evaluate Willingness to Respond.	**100%**	
AIM: Community Resource Survey following completion of COOP.	**100%**	
AIM: Notify CBJ of gaps in resources and request collaborative solutions.	**100%**	

Survey on Patient Safety

Hospital Survey on Patient Safety

This survey asks for your opinions about patient safety issues, medical error, and event reporting and will take about 20 minutes to complete. If a question does not apply to you or you don't know the answer, please select "Does Not Apply or Don't Know."

The Culture of Patient Safety Survey is completed every two years and the feedback you give in this survey is anonymous. Please take your time and give open feedback so we can identify opportunities for improving Patient Safety.

* 1. What is your position in this hospital?

- ☐ Registered Nurse
- ☐ Advanced Practice Nurse
- ☐ Certified Nursing Assistant/Behavioral Health Assistant
- ☐ Physician
- ☐ Pharmacist/Pharmacy Technician
- ☐ Dietitian
- ☐ Physical, Occupational, or Speech Therapist
- ☐ Other (please specify)

- ☐ Respiratory Therapist
- ☐ Social Worker, Case Manager
- ☐ Laboratory Technician
- ☐ Director, Supervisor, Department Manager, Clinical Leader
- ☐ Senior Leader, Executive
- ☐ Facilities
- ☐ Food Services

- ☐ Environmental Services
- ☐ Information Technology, Health Information Services, Clinical Informatics
- ☐ Security
- ☐ Unit Clerk, Office Staff - Clinical Based
- ☐ Administrative Staff, Office Staff - non clinical based

* 2. Think of your "unit" as a work area, department, or clinical area of the hospital where you spend MOST of your time. What is your primary unit or work area in the hospital?

- [ ] Medical/Surgical
- [ ] Critical Care
- [ ] OB
- [ ] Emergency Room
- [ ] Operating Room/PACU
- [ ] Same Day Care
- [ ] Mental Health Services
- [ ] Rehabilitation Services PT/OT/Speech
- [ ] Respiratory Therapy
- [ ] Laboratory
- [ ] Environmental Services/Laundry
- [ ] Rainforest Recovery Center
- [ ] Patient Access Services
- [ ] Facilities
- [ ] Food Services
- [ ] Quality/Risk Management/Staff Development
- [ ] Food Services
- [ ] Infusion Services
- [ ] Physician Services/Oncology
- [ ] Hospitalist Service
- [ ] Physicians- Independent Providers
- [ ] Behavioral Health Outpatient Services
- [ ] Information Services
- [ ] Other (please specify)

3. **SECTION A: Your Unit/Work Area**

How much do you agree or disagree with the following statements about your unit/work area?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. In this unit, we work together as an effective team.	○	○	○	○	○	○
2. In this unit, we have enough staff to handle the workload.	○	○	○	○	○	○
3. Staff in this unit work longer hours than is best for patient care.	○	○	○	○	○	○
4. This unit regularly review work processes to determine if changes are needed to improve patient safety.	○	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
5. This unit relies too much on temporary, float or PRN staff.	○	○	○	○	○	○
6. In this unit, staff feel like their mistakes are held against them.	○	○	○	○	○	○
7. When an event is reported in this unit, it feels like the person is being written up, not the problem.	○	○	○	○	○	○
8. During busy times, staff in this unit help each other.	○	○	○	○	○	○
9. There is a problem with disrespectful behavior by those working in this unit.	○	○	○	○	○	○
10. When staff make errors, this unit focuses on learning rather than blaming individuals.	○	○	○	○	○	○
11. The work pace in this unit is so rushed that it negatively affects patient safety.	○	○	○	○	○	○
12. In this unit, changes to improve patient safety are evaluated to see how well they worked.	○	○	○	○	○	○
13. In this unit, there is a lack of support for staff involved in patient safety errors.	○	○	○	○	○	○
14. This unit lets the same patient safety problems keep happening.	○	○	○	○	○	○

4. **SECTION B: Your Supervisor, Manager, or Clinical Leader**

How much do you agree or disagree with the following statements about your immediate supervisor, manager, or clinical leader?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.	○	○	○	○	○	○
2. My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it mean taking shortcuts.	○	○	○	○	○	○
3. My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.	○	○	○	○	○	○

5. **SECTION C: COMMUNICATION:**

How often do the following things happen in your unit/work area?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. We are informed about errors that happen in this unit.	○	○	○	○	○	○
2. When errors happen in this unit, we discuss ways to prevent them from happening again.	○	○	○	○	○	○
3. In this unit, we are informed about changes that are made based on event reports.	○	○	○	○	○	○
4. In this unit, staff speak up if they see something that may negatively affect patient care.	○	○	○	○	○	○
5. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.	○	○	○	○	○	○
6. When staff in this unit speak up, those with more authority are open to their patient safety concerns.	○	○	○	○	○	○
7. In this unit, staff are afraid to ask questions when something does not seem right.	○	○	○	○	○	○

6. **SECTION D: Reporting Patient Safety Events**

Think about your unit/work area:

	Never	Rarely	Sometimes	Most of the time	Always	Does Not Apply or Don't Know
1. When a mistake is caught and corrected before reaching the patient, how often is this reported?	○	○	○	○	○	○
2. When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?	○	○	○	○	○	○

7. In the past 12 months, how many patient safety events have YOU reported?

- ☐ None
- ☐ 1 - 2
- ☐ 3 - 5
- ☐ 6 - 10
- ☐ 11 - or more

8. **SECTION E: Patient Safety Rating**

How would you rate your unit/work area on patient safety?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

9. **SECTION F: Your Hospital**

How much do you agree or disagree with the following statements about your hospital?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. The actions of hospital management show that patient safety is a top priority.	○	○	○	○	○	○
2. Hospital management provides adequate resources to improve patient safety.	○	○	○	○	○	○
3. Hospital management seems interested in patient safety only after an adverse event happens.	○	○	○	○	○	○
4. When transferring patient from one unit to another, important information is often left out.	○	○	○	○	○	○
5. During shift changes, important patient care information is often left out.	○	○	○	○	○	○
6. During shift changes, there is adequate time to exchange all key patient care information.	○	○	○	○	○	○

10. **SECTION G: Empowerment to Improve Efficiency**

How much do you agree or disagree with the following statements about your unit/work area?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does Not Apply or Don't Know
1. We are encouraged to come up with ideas for more efficient ways to do our work.	○	○	○	○	○	○
2. We are involved in making decisions about changes to our work processes.	○	○	○	○	○	○
3. We are given opportunities to try out solutions to workflow problems.	○	○	○	○	○	○

11. **SECTION H: Efficiency and Waste Reduction**

How often do the following statements apply to your unit/work area?

	Never	Rarely	Sometimes	Most of the time	Always	Does Not Apply or Don't Know
1. We try to find ways to reduce waste (such as wasted time, material, steps, etc.) in how we do our work.	○	○	○	○	○	○
2. In our unit, we are working to improve patient flow.	○	○	○	○	○	○
3. We focus on eliminating unnecessary tests and procedures for patients.	○	○	○	○	○	○

12. **SECTION I: Patient Centeredness and Efficiency**

How much do you agree or disagree with the following statements about your unit/work area?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Does Not Apply or Don't Know
1. In our unit, we take steps to reduce patient wait time.	○	○	○	○	○	○
2. We ask for patient or family member input on ways to make patient visits more efficient.	○	○	○	○	○	○
3. Patient and family member preferences have led to changes in our workflow.	○	○	○	○	○	○

13. **SECTION J: Supervisor, Manager, or Clinical Leader Support for Improving Efficiency and Reducing Waste**

How much do you agree or disagree with the following statement about your supervisor, manager, or clinical leader?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does Not Apply or Don't Know
1. Recognizes us for our ideas to improve efficiency.	○	○	○	○	○	○
2. Provides us with reports on our unit performance.	○	○	○	○	○	○
3. Takes action to address workflow problems that are brought to his or her attention.	○	○	○	○	○	○
4. Places a high priority on doing work efficiently **WITHOUT** compromising patient care.	○	○	○	○	○	○

14. **SECTION K: Experience With Activities to Improve Efficiency**

In the past 12 months, have you done the following activities to improve efficiency, add value or reduce waste in your hospital?

	Yes	NO
1. I received training on how to identify waste and inefficiencies in my work.	○	○
2. I helped map a workflow process to identify wasted time, materials, steps in a process.	○	○
3. I have shadowed/follow patients in this hospital to identify ways to improve their care experience.	○	○
4. I looked at visual displays or graphs to see how well my unit was performing.	○	○
5. I made a suggestion to management about improving an inefficient work process.	○	○
6. I made a suggestion to management about improving patient's care experiences.	○	○
7. I served on a team or committee to make a work process more efficient.	○	○
8. I monitored data to figure out how well an activity to improve efficiency was working.	○	○

15. **SECTION L: Overall Rating**

Overall, how would you rate your unit/work area on each of the following areas?

	Poor	Fair	Good	Very Good	Excellent
1. Patient Centered: Is responsive to individual patient preferences, needs and values.	○	○	○	○	○
2. Effective: Provides services based on scientific knowledge to all who could benefit.	○	○	○	○	○
3. Timely: Minimizes waits and potentially harmful delays.	○	○	○	○	○
4. Efficient: Ensures cost-effective care (avoids waste, overuse and misuse of services).	○	○	○	○	○

16. **Your Hospital's Electronic Health Record (EHR) System**

Do you use your hospital's Electronic Health Record system(s) to enter or review patient information?

- ○ Yes
- ○ No - [Go to Background questions]

17. **SECTION M: EHR Patient Safety and Quality Issues**

If you used more than one EHR system, please think about the one you use the most. The following items describe things that can affect patient safety and quality when using EHR systems. **In the past 3 months,** how many times did you discover the following issues with the EHR system in your hospital?

	None	1-5 times	6-10 times	11-20 times	21-50 times	More than 50 times	Does Not Apply or Don't Know
1. Information was not complete	○	○	○	○	○	○	○
2. Information was not accurate	○	○	○	○	○	○	○
3. Important information was hard to find	○	○	○	○	○	○	○
4. Information was entered into the wrong patient health record	○	○	○	○	○	○	○
5. Incorrect information was copied and pasted	○	○	○	○	○	○	○

18. **SECTION N: EHR System Training**

How much do you agree or disagree with the following statements?

	Strongly disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. We are given enough training on how to use our EHR system.	○	○	○	○	○	○
2. Training on our EHR system is customized for our work area.	○	○	○	○	○	○
3. We are adequately trained on what to do when our EHR system is down.	○	○	○	○	○	○

19. **SECTION O: EHR and Workflow/Work Process**

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. There are enough EHR workstations available when we need them.	○	○	○	○	○	○
2. Our EHR system requires that we enter the same information in too many places.	○	○	○	○	○	○
3. There are too many alerts or flags in our EHR system.	○	○	○	○	○	○

20. **SECTION P: EHR System Support and Communication**

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree or Dsagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. Problems with our EHR system are resolved in a timely manner.	○	○	○	○	○	○
2. We are asked for input on ways to improve our EHR system.	○	○	○	○	○	○
3. We are made aware of issues with our EHR system that could lead to errors.	○	○	○	○	○	○

21. **SECTION Q: Overall EHR System Rating**

How satisfied or dissatisfied are you with your hospital's EHR system

- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Satisfied
- ◯ Very Satisfied

22. **BACKGROUND QUESTIONS**

How long have you worked in this hospital?

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ 11 or more years

23. In this hospital, how long have you worked in your current unit/work area?

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ 11 or more years

24. Typically, how many hours per week do you work in this hospital?

- ◯ Less than 30 hours per week
- ◯ 30-40 hours per week
- ◯ More than 40 hours per week

25. In your staff position, do you typically have direct interaction or contact with patients?

- ◯ Yes, I typically have direct interaction or contact with patients.
- ◯ No, I typically do NOT have direct interaction or contact with patients.

26. Please feel free to provide any comments about how things are done or could be done in your hospital that might affect patient safety.

Bartlett Regional Hospital

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

Planning Committee Meeting Minutes
March 12, 2021 – 12:00 p.m.
Bartlett Regional Hospital Boardroom / Zoom Videoconference

Called to order at 12:00 p.m., by Planning Committee Chair, Lance Stevens.

Planning Committee* and Board Members: *Lance Stevens, *Hal Geiger, Rosemary Hagevig, and Brenda Knapp.

Also Present: Kevin Benson, Billy Gardner, Bradley Grigg, Rose Lawhorne, Marc Walker, Gail Moorehead, Anita Moffitt, Nathan Coffee, Jeanne Rynne, Michelle Hale and Rachael Byrd

PUBLIC PARTICIPATION – None

APPROVAL OF THE MINUTES – ***Mr. Geiger made a MOTION to approve the minutes from February 12, 2021 Planning Committee meeting. There being no objections, minutes approved.***

BRH PLANNING COMMITTEE MEETING INVITATION TO CBJ – An invitation to attend today's meeting had been sent to Mayor Weldon, Michelle Hale and Rorie Watt to discuss Bartlett's role in Community Health. It has been determined that a separate meeting, to include the new CEO, will be held to discuss this topic. Ms. Hale felt the invitation had been unclear about what was to be achieved and requests clearer communications in the future. Mr. Stevens stated that Community Health and Bartlett's role had been raised as a concern in the community and is part of the goals of the Assembly. BRH has not received guidance and what the expectations are. The Assembly and BRH need to work together to develop a plan to meet the community needs. Ms. Knapp noted that CBJ had a Health Department in the past, separate from State's Health Department and the hospital. They provided community oriented public health services such as vaccinations and ran its own mental health center. She suggests a historical look at what that Health Department used to provide and see if what the city is feeling a lack of now, is something in that arena. Ms. Hagevig highlighted reasons the department was eliminated and agrees that there may have been some significant services that fell through the cracks when it closed. She feels that BRH has done a great job at stepping up to the plate to fill the needs where it can and suggests an analysis be conducted to help identify the needs of the community. Ms. Hale encourages the Board to ask her, as the CBJ liaison, what the thought was when the Assembly came up with this goal. She said the Assembly wants to make sure that BRH is coordinating with other entities for all of the community services provided. They also want to understand what voids there are, who should be doing what and how to communicate that among all the parties. Ms. Knapp suggests specific examples of what functions or work products that the assembly feel are missing would be very helpful.

COVID STATUS – Ms. Moorehead provided a COVID status update while participating in today's community vaccination clinic at Centennial Hall. In a partnership with SEARHC, 2,200 doses are to be given today and tomorrow. Another 2,000 doses will be given next week during the clinics scheduled to

take place Monday through Saturday. We have received an extra allocation of 1,100 doses from the State and will hold another clinic on March 23rd. Everyone over the age of 16 is now eligible to receive a vaccine. We have 250–300 community volunteers helping with these clinics. Approximately 75% of BRH staff are vaccinated at this time and approximately 30% of the community will be vaccinated by the end of March. The one dose, Johnson and Johnson vaccine is starting to be administered in the community. There is a vaccination clinic for veterans scheduled to take place at the Coast Guard station on Saturday. A brief discussion was held about why people have not received vaccines yet. Juneau is the leader in Alaska and Alaska is leading the nation in vaccinations.

MASTER FACILITY PLAN UPDATE – Mr. Gardner provided an update to the changes made to the project priority list. He reported that the Board approved combining the Emergency Department (ED) renovation with the ventilation upgrade at the last Board meeting. This is reflected in the revised Master Facility Plan under C-1. In addition, the Board had also approved $425,000 to begin the design phase of the ED addition, ventilation upgrade. Nathan Coffee has requested an action from the Public Works and Facilities Committee to approve and request appropriation of $425,000 from the Assembly for these projects.

CURRENT PROJECTS STATUS - Mr. Gardner reported the Gantt chart has been adjusted due to the changes and reminded everyone that the master facility plan and Gantt chart are fluid documents. He then reported the following updates on ongoing projects:

- ED Waiting Area/PAS Window was completed and need for changes were identified. Maintenance has met with the department and is currently getting prices for the requested changes. The work will be done by contractors and BRH maintenance staff.
- Underground fuel line replacement – Currently being worked on by CBJ Engineering. Taku Engineering was awarded the contract. A meeting will be held next week to discuss timeline.
- ASU-1 heating oil conversion to glycol – Bid opened up on March 9th. Schmolck Mechanical was awarded the contract.
- Fire door replacement and door upgrades for security – CBJ has set up an account for this project under deferred maintenance dollars. Professional Services Term Contract Solicitation has gone out with a response request by March 11th.

COBAS 6800 ROCHE ANALYZER/ MASS TESTING UPDATE – Mr. Gardner reported that this analyzer has had minor breakdowns on two occasions. BRH staff was able to repair equipment the first time but not the second time. A technician had to be flown in to make repairs. Cepheid Analyzer was used to process tests during the downtime. Legal has finished the review of contracts to establish relationships with other entities needing this testing. We have tried to establish contracts with Beacon, Coeur Mining and UnCruise Adventures but they are not returning our calls. We are also reaching out to local schools and Capstone and will continue to try to offer these services to other outside entities. We are currently running about 50 samples a day. Ms. Hale will speak to Ms. Cosgrove to try to get people on-board. There is a lot of concern about the drop in testing. It was noted that some medical clinics in town are able to provide testing. In response to Ms. Hagevig's questions about BRH reaching out to other communities about providing testing and looking at other applications for this testing equipment, Mr. Gardner responded yes, we have reached out. As far as other testing, it would cost BRH more to run the tests this machine is capable of than it would to send them out.

ASU-11 FAN UPDATE – This ventilation system controls humidity, pressure, air exchanges and temperatures in the OR. The old fan is being replaced due to end of life and inability to get repair parts. Replacement equipment has started to arrive. A thirty day notice will be given to the OR Director when all parts are here to give staff and surgeons notice about down time to conduct the work. The OR will be

down for three days, Saturday and Sunday accounting for two of them. This project is on schedule for the estimated completion date of April 13th. The C-section room will be available for emergency surgeries during the downtime.

STRESS TEST VOLUMES – There is an average of 15 stress tests performed monthly. Renovation to stress test space is being conducted because it is too small to accommodate the multiple people in the room with the patient undergoing treadmill stress testing to meet social distancing requirements.

POWER CONDITIONER UPDATE – Nathan Coffee collaborated with CBJ, BRH and outside vendors to present the plan included in the packet. Recent power surges have caused significant damage throughout the hospital making this a high priority project. 9 surge suppression devices will be installed by the end of March at selected power panels while work with PDC mechanical will continue to address the larger issue. These surge protectors will protect equipment in all patient care areas. Power conditioning options for phase two will be presented after a thorough investigation by PDC. Phase one of this project is not to exceed $50K. As the scope of work is not yet defined, a timeline cannot be provided.

BOPS / CRISIS STABILIZATION PROJECT UPDATE – Mr. Grigg reported that we had a proposal out for bid for this project. Feedback about original timeframe of completion in the summer of 2022 suggests this is not realistic due to shipping delays and supply shortages. The price of wood has increased by 170% since April 2020 making this project more expensive. Mr. Coffee reported that lead time on engineered beams are now months as opposed to weeks. To address this, a second base bid option has been added to extend the contract approximately 5 ½ months. This would move completion of the project to December 2022. We anticipate bids to come in high but hope to award one by using deductive alternates. Discussions with the selected contractor will be held to help identify less expensive options to save funds while not compromising functionality of the facility. The bid is scheduled to open March 16th. So as not to have to pull the project and redesign the building, the bid has to be awarded before alternate options are discussed.

REVIEW EXISTING AND PLANNED COMMUNITY HEALTH INITIATIVES – BRH staff will review what is currently being done by the hospital and will share this information with the Planning Committee. This information will be shared with CBJ representatives when the meeting to discuss community health needs is held.

Future Agenda Items: Nothing noted

Comments: Mr. Stevens thanked everybody for their hard work. Discussion held to determine a new day for future meetings. The third Friday of each month does not work due to unavailable space for in person meetings. It was determined that the Planning Committee meetings should be held before the monthly Finance meetings to help the flow of the approval process. The first Friday of each month was identified as a good day. Ms. Moffitt will confirm this day and time will work for Ms. Young.

Next meeting: 12:00pm, Friday – April 2nd

Adjourned – 12:59 p.m.

Bartlett Regional Hospital

PHYSICIAN RECRUITMENT COMMITTEE
March 15, 2021 5:00 pm Minutes

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

Members Present: Mark Johnson, Chair, Steve Strickler, DO, Lindy Jones, MD, John Raster, MD, Iola Young, Catherine Peimann, MD, Kevin Benson, CEO-Interim, Kathy Callahan, Dir. Physician Services
Guests: Joanne Gartenberg, MD, Amy Dressel, MD, Bradley Grigg, CBHO, Rose Lawhorne, CNO Kenny Solomon-Gross, Anita Moffitt, Rosemary Hagevig, Hal Geiger, Cindy Carte, Dallas Hargrave

I. **Called to Order 5:02 pm via Zoom**

II. **Public Participation Invitation- None**

III. Mark Johnson called the meeting to order. Mr. Johnson asked Members to review the minutes from the September 15, 2020 meeting. A **MOTION** to approve was made by Lindy Jones, MD and seconded by Steven Strickler, DO and approved.

IV. **Pediatrician in Behavioral Health Program –** Bradley Grigg, CBHO provided a draft position description as requested at the February Recruitment Committee meeting for the proposed position. Dr. Joanne Gartenberg and Bradley Grigg provided assurances that the position would work in conjunction with the current pediatric providers as soon as the child and family are stabilized. The committee acknowledged the letter provider to the committee by Dr. Amy Dressel expressing concern for this action. There was a short discussion by the group.

V. **Updates:**

   a. **General Surgery:** Kathy provided a report that BRH hosted one site visit in February and that the candidate is interested. At that time there was concern by the local surgeons if there is adequate volume of cases to support a third surgeon. The second site visit was cancelled until this is sorted out by the committee. Dr. David Miller provided an email requesting reconsideration of the decision to recruit. A discussion occurred and the point was raised that having adequate call coverage is not an equivalent to having a permanent third surgeon. A motion was made by John Raster, MD and seconded by Steve Strickler, DO to place a temporary hold on the recruitment until there is a permanent CEO.

b. **Psychiatry:** Dr. Gartenberg provided a report on her efforts to find permanent psychiatry staff has been difficult. They are currently recruiting for a Psychiatric Addiction Specialist, Inpatient Psychiatrist, Child Psychiatrist and Adult Outpatient Psychiatrist. These positions are covered with temporary and locum providers and supported by permanent Advanced Nurse Practitioners. A discussion was held about overall recruitment strategies that might enhance the success rates for the existing efforts.
c. **Medical Oncology:** Kathy reported that there is not any activity in the medical oncologist search.
d. **Neurology:** Kathy reported that there is no activity in this area.
e. **Urology:** Dr. Saltzman submitted a letter to the hospital giving one week's notice of closure of his practice on February 28th. Kevin Benson reported that he and Kathy had a telephone conversation with a urology group in Anchorage who expressed a willingness to provide temporary coverage with a provider in Juneau. This arrangement will need to be navigated by the new CEO.

MOTION ***by Dr. Strickler to move into executive session for committee deliberation to include committee members and Kathy Callahan, Anita Moffitt, Cindy Carte, Joanne Gartenberg, MD, Rosemary Hagevig, Hal Geiger, Kenny Solomon-Gross, Bradley Grigg, Kevin Benson, Rose Lawhorne. Dr. Raster seconded.*** Committee entered executive session at 5:50 pm and returned to regular session at 6:19 pm.

Motion: A motion to recommend to the BOD a recruitment effort for a .6 FTE Pediatric Behavioral Health Physician was made by Dr. Lindy Jones and seconded by Dr. Steve Strickler. Anita called a roll call vote: Mark Johnson, Dr. Catherine Peimann, Dr. John Raster, Dr. Lindy Jones, Dr. Steve Strickler all voted in favor. Iola Young voted against. Motion passes 5-1

Meeting adjourned at 6:23 pm

GLACIER PEDIATRICS, LLC
Amy Dressel, M.D.
Kim Gardner, F.N.P. • Lauren Hopson, P.N.P.

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Updated March 9th 2021

Mr. Kevin Benson, Interim CEO Bartlett Regional Hospital

Bartlett Regional Hospital Board of Directors

Bartlett Hospital Physician Recruitment Committee Members

To Whom It May Concern,

This is a letter to follow up on two different meetings discussing pediatrics in Juneau, Alaska at Bartlett Regional Hospital (BRH) in first part of 2021.

The most recent discussion was on February 9th to discuss placement of a general pediatrician in the Bartlett Outpatient Psychiatry Services (BOPS) office to function as a case manager. This previously was discussed in fall 2020 with Mr. Bradley Grigg (BRH CBHO) and myself along with my business partner Kim Gardner, PNP, and we were led to believe that this was not a current need nor was it being "planned on". No additional disucssion was ever approached. The meeting for physician recruitment for a pediatric provider BOPS position was brought up suddenly without any prior discussion with the Juneau general pediatric providers and was concerning. It was apparent to me at that meeting that there is a decrease in understanding of what primary care does for mental health. In the past, there has been intermittent mental health help for pediatrics, and as a result the primary care pediatricians here at Glacier Pediatrics have been working with different resources to provide diagnoses, treatment and care coordination for any child or adolescent having mental health issues (both in state and out of state). We also had a partnering mental health practice for a while in our office space and realized how helpful that was. We discussed with Mr. Grigg possibly having clinicians housed at Glacier Pediatrics (and are still interested in this possibility). Glacier Pediatrics has worked hard to maintain mental health and behavioral appointments into our schedules on a regular basis as well as implemented telehealth so that these patients can be seen in an appropriate time and place. It is widely known that the best practice is to have children in a medical home with

their primary care physician helping to coordinate meds, drug levels, refills, etc. During COVID it has been noted that numbers of children seeking services at BOPS has increased (also noted in multiple articles, journals that serious mental health issues like suicidality have increased this year as well). What a great time for BOPS to focus on what it does well-- like counseling patients and treating/ following significant mental health issues instead of getting into expanding into pediatric primary care. Therefore, we at Glacier Pediatrics strongly oppose having a general pediatrician in the BOPS clinic but we support the hiring of a case manager. Due to the increased need for psychiatric care due to COVID and the desire for primary care help, would it be helpful to BRH BOPS for different primary care providers provide services there (i.e each office send a provider aka do week on call at BOPS)? It would get providers there sooner as well and possibly help during this "time of crisis". Of note: both providers from Glacier Pediatrics, SEARHC and Valley Medical Care were present at this meeting and all vocalized their concern over the proposal and need to have issues researched further with all members involved.

Another issue to consider with BOPS having a primary care provider is around the issues of call-- currently there are proposals (see below) outlining the need for more primary care peditrics providers in town to "cover" the call schedule--if there is a provider at BOPS that would add to the pool of pediatric providers in town who are not adding to the call pool and therefor causing a bigger issue with the "pool" of pediatric providers. Also it would add further issues in regards to possible need for further recrutment (if there was an increased need) -- would Bartlett says, in the future, "there are enough pediatricians in town" and not help support those who help staff the hospital by recruitment efforts when necessary?

An additional topic of discussion at this meeting was the desire for help around diagnosing patients with autism. At the current time there are a couple types of providers who can diagnose autism spectrum disorders in the state of Alaska. These are specialist (like pediatric neurologist or neurodevelopmental pediatricians (who have undergone extra years of training)) and psychologist, neuropsychologist and/ or psychiatrist. There has been talk about " classes" for primary care providers to be able to diagnose but this has not happened in the state of Alaska yet. For clarification on the use of providers who had additional creditials (such as the LEND program) I will quote the LEND program itself: The LEND program that University of Alaska Anchorage has created helps medical providers "training to provide family-centered coordinated systems of health care and related services to improve the health of infants, children and adolescents who have, or are at risk for developing, autism or other developmental disabilities". Someone who has been through the program can help coordinate care for issues around diagnosed developmental issues. Since the need is greater for diagnosis, we also support BOPS at either working with or obtaining a neurodevelopmental physician for helping diagnose the patients they serve. It is super helpful that BOPS has a neurpsychologist who will perform testing and can help with diagnosis as well.

We were grateful to BOPS when more clinicians and counselors were available to help with the load and when there were pediatric specific providers available for increased psychiatric needs. This last couple years has brought tremendous growth to BOPS through use of nurse practioneers, clinicians, as well as recent development of crisis stabilizaton team!! This has been incredibly helpful for the Juneau pediatric population. These recent changes also included a play-based clinician for children"too young for 'talking therapy' ", and we were relieved that they were willing to take Medicaid patients. At Glacier Pediatrics we work with many different counselors in Juneau and try to help care coordinate as we can; currently we have had a hard time getting any information, including patient records, from BOPS when patients (or parents) sign the BOPS release of information . We worked hard to refer as many patients as possible to help the new counseling program get "up and running" and feel as those efforts were not reciprocated.

It has also been stated that patients "have a hard time getting primary care in Juneau". At this time no one from BOPS has reached out to us (at Glacier Pediatrics) or to any other local health care providers asking if we would be willing to do primary care for children who are being seen there. At this time I can also confirm that we at Glacier Pediatrics have space for new patients. Also, this was discussed with other primary care providers in town and both Valley Medical, SEARHC and Family Practice Physicians all stated they have room and are willing as well.

This leads into the second pediatric issue. At the meeting on January 22nd with previous BRH CEO Mr. Bill, Interim BRH CEO Mr. Benson and phyisicians from Rainforest Pediatric Care (Drs. Neyhart and Kilgore) as well as Dr. Hernandez (representing Valley Medical Care) and Dr. Jackson (representing SEARHC) as well as myself and my partner Kim Gardner, PNP, the topic of BRH owning/ running/ maintaining a primary care pediatric clinic was discussed. At this meeting it was stated that "Bartlett is not interested in competing with local clinics and not interested in primary care unless there is a need". We have appreciated having another primary pediatric care clinics in town as many patients/ parents do want options. The providers at Glacier Pediatrics were saddened to hear of the possible desire to to close Rainforest Pediatric Care. It has been helpful to have colleagues to consult on difficult patients and we at Glacier Pediatrics have been willing and have continued to cover both practices for phone calls after hours on weekends. However, the current state of pediatric patients in Juneau was discussed at that meeting and it was determined that the existing clinics who see pediatrics (Glacier Pediatrics, Valley Medical, SEARHC and Family Practice Physicians) would be willing and able to "absorb" patients if there was no further Rainforest Pediatric Care. Since the BRH has stated it remains dedicated to not encroaching on existing primary care and therefor driving them out of business, it seems there is no need for an additional clinic to be opened at this time by BRH.

The idea of certain phyisicans not being able to "handle" specific pediatric patients/ cases was also brought up. Currently the majority of children in our town are seen at family practice run

clinics and most likely will continue to be served by them in the future. Even Rainforest Pediatric Care asks family medicine doctors to cover their clinic when Drs. Neyhart or Kilgore are not available . I do recognize that the training for a pediatrician is different from that of family medicine physicians but feel as though many of our colleagues work hard to stay educated as well as take certification classes to keep skills "up to date" and therefore do a good job caring for Juneau pediatric patients. Also, currently the majority of specialists available to consult on patient needs and the willingness to be available for co-managing patients with chronic medical conditions are impressive and helpful (from both here in Alaska and in Seattle). There is no reason to believe that BRH would need to contract with specialists if there was one less pediatric clinic in town.

Also concerns over "hospital call coverage" were discussed. With the addition in last couple years of hospitalists to the call rotation at BRH, the number of call days that need "covering" by pediatric providers has significantly decreased. The hospitalist program has been committed to covering at least half of the month with providers who also provide pediatric support (and have done an excellent job doing so). In the past, I myself covered 30 out of 31 days per month of pediatric call for 3 years and did so without compensation and minimal breaks. I would have no difficulties covering the current need of 12 to 15 days a month (less than some of the subspecialist in Juneau currently). In addition, I reviewed that if I were not available for certain call days that several family medicine and/ or additional pediatric providers are currently willing to cover a few days of call a month as well in order to help keep the call schedule covered. So there would not be a lag in call coverage at Bartlett without the additional pediatric providers.

The last point brought forward was aging population of pediatric providers in Juneau and "lack of interested" younger pediatricians. I do agree that this is an issue overall for Juneau medical community and needs further exploration. One of the ways we can help work through this is by using allied health professionals more, which something Juneau and, in general, BRH is behind on but currently exploring and working on. In addition, the concern over continuing to keep a primary care practice in business during COVID was noted to be stressful and "not profitable". We at Glacier Pediatrics have experienced this as well and have made several adaptations to how we operate, schedule and see patients in order to continue to serve Juneau's pediatric population. We also remain committed to this communty and want to see pediatrics prosper as much as possible. We also are continuing to try to help pediatric specialists provide outreach clinics here to help further the health of Juneau's younger population.

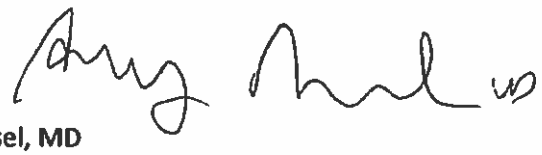
In summary, there is a need for expanded psychiatric services in Juneau and we support continuing with what we have/ We at Glacier Pediatrics also agree more neurodevelopmental assessments are needed as well as crisis stabilization and case management but don't agree that this can be accomplished with a primary care pediatrician. There needs to be more open communication with primary care and BOPS (which we at Glacier Pediatrics look forward to). Currently there is enough primary care availability in Juneau so additional resources are not

required and future of pediatric care needs to be looked into more vigorously. Also the pediatric provider call schedule will continue to be covered by existing staff/ providers even if there are a couple of providers absent but adding to the "pool" of providers who live in town but do not provider call / coverage services in Juneau would be detrimental.

A discussion of possible committee to look at issues around pediatrics was brought up and I gladly volunteered to join (and am still interested if this goes forward). I am highly dedicated to the pediatric population of Juneau, involved not only in BRH pediatric care but also through several boards I have sat on, volunteered at and/or helped create (including JYS, AWARE, JAHC, Juneau Parks and Rec, FASD, SAFE CAC , cleft palate team).

Hopefully this helps answers some of the questions BRH Board members have as well as clarifies some of the information given previously. I will gladly talk to any BRH administration, physician, BOPS, BRH Board members about information included within this letter. I have been happy to work at Bartlett for past 21 + years (providing extra coverage and filling in frequently when needed, doing extra work on committees, coordinating pediatric call schedule as well as serving as previous chief of staff for more than 3 years, all uncompensated) and hope that the right decision can be made for Juneau's pediatric population. I thank you for reading this. Please feel free to reach out with any concerns.

Sincerely



Amy Dressel, MD

adressel@glacierpediatricsllc.com

907-321-3768

APPENDIX A: Job Description

PHYSICIAN'S DUTIES AND RESPONSIBILITIES
Behavioral Health Pediatrician

GENERAL DESCRIPTION

- Provider is hired and qualified to integrate behavioral health specific pediatric services to patients engaged in behavioral health services at Bartlett Regional Hospital
- These services may also be available for the dependents of chronic adult psychiatric patients who have challenges navigating community health resources.
- Provider will remain in the office and be available during scheduled shifts.
- Provider will provide consultation services to behavioral health medical providers and therapists, regarding medical and psychiatric co-morbidities and developmental disabilities.
- NO CALL REQUIREMENTS AT THIS TIME

QUALIFICATIONS

• Licensed physician and member of Bartlett Regional Hospital Medical Staff
• Training and/or experience in pediatric medicine
• Career interest in pediatric medicine, behavioral health and developmental disabilities
• Advanced Cardiac Life Support certification

ACCOUNTABLE TO

Behavioral Health Medical Director/Chief of Staff

DUTIES AND RESPONSIBILITIES

1. Participates in communications with Behavioral Health Medical Director, timely as necessary.
2. Follows the latest Joint Commission standard policies, procedures, and medical protocols regarding patient care.
3. Ensures the success of the Behavioral Health Pediatric services by encouraging teamwork and participation.
4. Interact with the hospital staff, community partners, and specialists to ensure appropriate and timely patient care, patient transfers, and patient referrals.
5. Evaluate acute medical issues identified during psychiatric assessment, counseling or medication management visits, including acute illness, chronic illness, FASD, child abuse and neglect.
6. Liaison with primary care providers in the community, improving access to both medical and behavioral health services.
7. Coordinate the transition of patients coming out of residential psychiatric or behavioral treatment centers as they reenter Juneau with coordination of care for local medical community.
8. Participate in the Behavioral Health QI committee
9. Regularly attend other medical staff committees, as negotiated with Chief of Staff.
10. Provide direct patient care in Behavioral Health Pediatric patients for the agreed upon shifts per four-week block with the obligation to find coverage once the schedule is finalized.
11. Contributes to an efficient operation of the practice, completing and submitting billing and completing documentation in a timely manner.

12. Work cooperatively and supportively with Behavioral Health Leadership to ensure services are available and cost effective, meeting quality and regulatory guidelines.

Quality

1. Promote/ensure patient satisfaction in all areas of patient care delivery.

2. Supports the development and maintenance of continuous quality improvement programs by participating in the following:
   a. monitoring and supporting medical quality improvement plan and peer review processes.
   b. continuous monitoring and assurance of compliance of physician quality of care/safety programs.

3. Responsible for other duties that may be defined in the bylaws of the hospital Medical Staff and/or as designated by the Chief Executive Officer, Chief of Staff, Behavioral Health Medical Director and/or their designees.

Bartlett Regional Hospital

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

Finance Committee Meeting Minutes
Zoom Meeting – March 18, 2021

Called to order at 12:00 p.m. by Deb Johnston.

Finance Committee* & Board Members present: Deb Johnston*, Lance Stevens*, Brenda Knapp*, Kenny Solomon-Gross, Rosemary Hagevig, Hal Geiger, and Iola Young.
Staff & Others: Kevin Benson, CFO, Billy Gardner, COO, Dallas Hargrave, HR Director, Rose Lawhorne, CNO, Bradley Grigg, CBHO, Blessy Robert, Director of Accounting, Willy Dodd, Kris Muller, Megan Rinkenberger, and Tiara Ward, CBJ.

Public Comment: None

Ms. Knapp made a MOTION to approve the minutes from the February 19, 2021 Finance Committee Meeting. Mr. Stevens seconded, and they were approved.

January 2021 Financial Review – Kevin Benson, CFO

There was a decrease in total admissions (31%), leading to a decrease in inpatient revenue by 25%. This is consistent with previous months. Lower volumes in MHU contribute to this as well. Outpatient revenues continued to be strong. RRC is open at 66% capacity. BOPS continued to be strong. Physician revenue was close to budget. Total revenue was $1.8M short of budget. There was a decrease in discounts, and net patient revenue was $850K short of budget. Provider relief funds have been depleted and no more are expected. There was a loss of $1.2M, and non operating income was just under $1.2M. There was a donation from Premera for $1M for Crisis Stabilization. Generally breaking even for the month overall.

FY22 Budget Presentation – Kevin Benson, CFO

The budget process reviews 80 Departments and 1200 GL accounts. FY22 was a difficult year to budget for, not knowing how the pandemic would affect tourism, etc. There was an assumption that the current numbers would continue. Anticipated a near return to pre-Covid numbers for RRC. Outpatient activity also anticipated a near return to pre-Covid numbers. FY20 realized $6M in CARES Act funding, and $7M in FY21. BRH did not budget for any relief funds, but there is a possibility that some may be available. A cost of living increase was also applied, as approved by the board. An opportunity for GPO savings of 31% discovered by potentially changing GPO providers. The cost for running the Molecular Lab is also included in the budget. Repair and Maintenance costs have increased due to Covid responses (ventilation, barriers, etc), but should decrease again in the coming year, likely not to pre-Covid numbers though. The budget can absorb capital spending of $9.5M before reserves would need to be accessed. The capital budget is about $5M. Most significant is the replacement of the CT scanners, with the MRI machine to follow in FY23.

Applied Behavioral Analysis incorporates certified clinicians to focus on skills building and behavior in those on the Autism spectrum. All services are reimbursable. Tied to school district, SEARHC, and others in community to serve a need. Negotiating with Mental Health Trust Authority for startup help funds.

Crisis Stabilization – Kevin Benson, CFO

The final construction bid came in at $8.4M. This goes to the city for acceptance on the evening of 03/22/2021.

Next Meeting: April 9, 2021 at 12:00pm via Zoom.

Board Comments: None

Adjourned – 1:04 p.m.

Bartlett Regional Hospital
Operating and Capital Budgets
Budget Year 2022

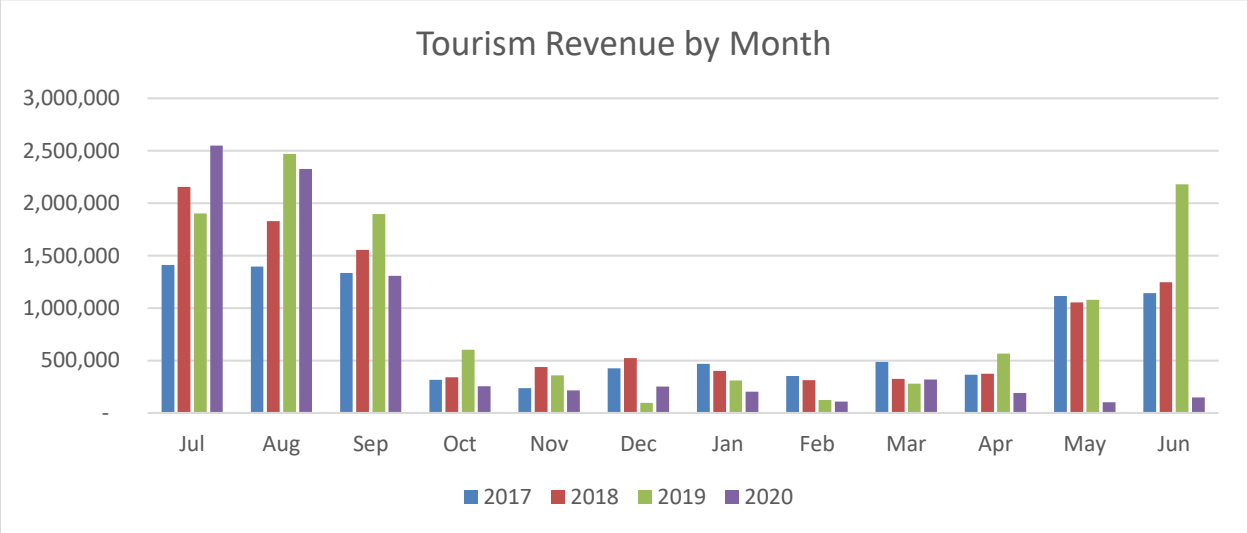
2021 Operating Budget Framework:

The operating budget for FY2022 is going to be challenging. It is unknown when Covid will no longer be impacting operations and reducing volumes and revenues. The return of cruise ships and tourists is also a mystery. In addition, spending to provide a response to the pandemic was increased for staffing, supplies and equipment. BRH was kept whole financially through the end of December for lost revenues and increased spending by $13 million of Provider Relief Funds. Those dollars are no longer available unless additional funding is appropriated.

BRH is projected to incur an Operating Loss of $2.8 million dollar in FY21. FY2022 will be a year preparing to right-size the expense side of the Income statement to be commensurate with volumes and revenues.

Unknowns:

- It is not known if there will be additional Provider Relief Funds available to BRH. Included in the $1.9 trillion stimulus legislation was $8.3 billion for rural hospital which BRH would qualify as a Sole Community Provider. However, the details of what BRH will receive has yet to be provided. At this point additional funding is not included in the budget.
- The return of tourism revenue is also not known. The chart below depicts the impact of the loss of this revenue. The budget includes approximately half of what is normal tourist revenue. It is assumed there will be some tourism later in the summer and return to normal the spring of 2022.



Hospital and Clinic

Patient Volumes and Revenues: BRH has seen volumes impacted by covid. Listed below are the assumptions driving volumes and revenues:

- BRH was averaging 16.0 patients per prior to covid. There was a significant decrease in the second half of FY2020 due to covid driving the fiscal year average to drop to 14.4 patients per day. In FY 2021 the average had climbed to 15.5. The budget assumes this average will be maintained. The
- The budget assumes the Mental Health Unit will open admissions up to the entire state of Alaska. Through the pandemic only patients from southeast Alaska were accepted. Historically, a majority of mental health patients came from outside of southeast Alaska. This will increase volumes to be more consistent with pre-covid volume. This will increase volumes from 5.5 patients per day to 8.0.
- The Rainforest Recovery Unit was closed during the pandemic and opened operations in early October 2021. It has been running at covid capacity with only private rooms and has a waiting list. It is assumed the occupancy will run at 8 residents per day. This will generate revenues of $4.1 million or 300% more than is projected in FY21.
- The Withdrawal Management unit is assumed to average 2 patients per day consistent with the volumes seen since becoming operational earlier this year. This additional revenue generated by this program is excepted to be $870,000.
- BHOPS is budgeted to be at the same volume as FY21. Having stabilized staffing, it is hoped volumes will continue to increase but being conservative the volumes will remain elevl.
- Outpatient volumes are difficult to predict and are budgeted to remain the same as 2021. It seems probable that Emergency Room visits will eventually increase but to be conservative the budget stays at the same volume as FY2021.
- Physician service volumes are expected to remain consistent with FY2021. There is recruitment taking place for both an Oncologist and a Urologist. It would be speculative to budget for these services given the difficulty and time required to successfully recruit these specialties.
- A 4% price increase will be implemented at the start of the fiscal year. A pricing study was completed in preparation for the 2022 budget (see attachment 1). The study compared BRH to 14 hospitals in Alaska and Washington and was based on CMS charge data. The study shows that BRH has a very competitive pricing structure.

Discounts and Deductions:

- 65% of the 4% price increase will have no effect on what BRH gets paid, therefore there will be a significant increase in deductions.
- The Rural Demonstration Project was renewed this past December. The 5-year participation term expired for Bartlett on June 30, 2020. The renewal goes retroactive to this date. This means BRH will receive cost-based reimbursement for it inpatient Medicare patients. Previously, this amount was estimated to be $3.7 million. The reduction of inpatient volumes and revenues will reduce this reimbursement to $2.7 million.

Other Income:

- Provider Relief Funds of $6 million was recorded in FY20 and another $7 million in FY21. While it is

believed that additional funding will be available in FY22, it is not being included in the budget. The $10 million of in Other Operating Revenue includes $5 million of grant funding that has been awarded to Bartlett. The remaining balance is consistent with the balance in FY19.

Salaries and Wages:

- The current covid required staffing is included in the budget. In the event the tourist season reopens and additional staff is needed for an increase in volume, the costs for this group will be reassigned to departments as needed.
- There will be few staffing changes included in the 2022 budget. There are new programs being added in the Behavioral Health arena. The staff changes that will take place are as follows:
    - Withdrawal Management was approved in FY2021 and began operations in October. A full year of staffing will add 12 FTE's (Full Time Equivalents) to the budget.
    - A new department of Applied Behavioral Analysis is being proposed for FY2022. This program will add 4.6 FTE's.
- A cost of living increase of 3.0%.was incorporated into the budget.
- Having learned over the course of the past 3 years that Contract Labor will be incurred to cover staff turnover until replacement staff are hired. Therefore, there is more expense in the budget than in past years. It is hoped that reliance on Contract Labor will be reduced as turnover has slowed down due to covid and hopefully through the Student Loan Payment program implements at the end of December.

Employee Benefits:

- Benefits will remain the same as 2021. However, there will be a 7.5% Health Insurance increase in premiums paid by BRH. BRH has a self-funded health insurance program combined with CBJ. In the past the plan has maintained a healthy fund balance. However, that fund balance is being drawn down over the past number of years as medical spending has exceeded current funding. The good news has been there were no increases since 2014 to BRH or staff but it needs increased funding over the next 2 years to maintain the positive fund balance.

Physician Contract:

- This expense is anticipated to be reduced as psychiatrists are brought on as employed staff and the expense transferred to Salaries and Wages.

Materials and Supplies:

- Materials and supplies were difficult to project into FY2022. This expense spiked significantly during the covid response. There were large increases for Personal Protective Equipment (PPE), oxygen, pharmaceuticals and reference lab fees for send out covid test. This spike continued into FY2021. It is believed there will still be increased supply costs but at a more moderate level. The cost of molecular testing supplies was taken into account at $1.0 million. Finally, effective July 1, 2021 Bartlett will change to a new Group Purchasing Organization (GPO), a move that is expected to save $3.0 million through lower pricing.

Utilities:

- Utilities expense fluctuates with the weather and price changes. Expense was added to account for the utility cost for the Bartlett Specialty and Surgical Clinic.

Maintenance and Repairs:

- The narrative for Maintenance and Repairs is very similar to that of Materials and Supplies. This expense increased with the preparations and changes made to adjust to covid. This expense will moderate and should return to pre-covid levels.

Rentals and Leases:

- Rental and lease expense will decrease with the purchase of the Bartlett Specialty and Surgical Clinic.

Insurance:

- Bartlett is provided insurance coverage through CBJ's city-wide insurance policies. A notice was received to inform us that premiums for insurance plans would be increasing this year. It is not known what the increase will be so an estimated increase of 10% was added.

Depreciation:

- A depreciation schedule was run and projected into FY2022. There were a number of assets that became fully depreciated in FY2021 which reduced depreciation. FY2022 capital acquisitions were factored into the projection using a half year calculation.

Interest:

- Interest expense decreased slightly as principal is retired annually according to the debt amortization schedule of the bond issue.

Bartlett Regional Hospital
Statistics for the Budget Year Ending June 20, 2022

Facility Utilization:	Actual FY 2017	Actual FY 2018	Actual FY2019	Actual FY2020	Projected 2021	Budget FY2022	Change FY20 to FY21	Change FY21 to FY22
Hospital Inpatient:Patient Days								
Patient Days - Med/Surg	4,723	4,795	4,476	4,251	4,452	4,452	4.7%	0.0%
Patient Days - Critical Care Unit	969	1,062	1,077	1,009	1,190	1,190	17.9%	0.0%
Avg. Daily Census - Acute	**15.6**	**16.0**	**15.2**	**14.4**	**15.5**	**15.5**	**7.3%**	**0.0%**
Patient Days - Obstetrics	853	804	805	790	746	746	-5.6%	0.0%
Patient Days - Nursery	749	702	722	622	618	618	-0.6%	0.0%
Total Hospital Patient Days	**7,294**	**7,363**	**7,080**	**6,672**	**7,006**	**7,006**	**5.0%**	**0.0%**
Births	333	315	325	287	302	302	5.2%	0.0%
Mental Health Unit								
Patient Days - Mental Health Unit	2,809	3,493	3,341	2,454	1,994	2,920	-18.7%	46.4%
Avg. Daily Census - MHU	7.7	9.6	9.2	6.7	5.5	8.0	-18.7%	46.4%
Rain Forest Recovery:								
Patient Days - RRC	3,697	3,936	3,975	2,838	716	2,920	-74.8%	307.8%
Avg. Daily Census - RRC	10	10.8	10.9	7.8	2.0	8.0	-74.8%	307.8%
Outpatient visits	1,045	721	303	328	1,034	1,034	215.2%	0.0%
Inpatient: Admissions								
Med/Surg	958	881	828	811	682	682	-15.9%	0.0%
Critical Care Unit	474	487	479	476	426	426	-10.5%	0.0%
Obstetrics	343	331	335	316	324	324	2.5%	0.0%
Nursery	351	332	335	289	302	302	4.5%	0.0%
Mental Health Unit	500	544	429	253	248	248	-2.0%	0.0%
Total Admissions - Inpatient Status	**2,626**	**2,575**	**2,406**	**2,145**	**1,982**	**1,982**	**-7.6%**	**0.0%**
Admissions -"Observation" Status								
Med/Surg	600	652	683	667	740	740	10.9%	0.0%
Critical Care Unit	344	346	390	356	314	314	-11.8%	0.0%
Mental Health Unit	23	21	31	29	28	28	-3.4%	0.0%
Obstetrics	273	188	219	202	168	168	-16.8%	0.0%
Nursery	3	12	7	2	-	0	-100.0%	0.0%
Total Admissions to Observation	**1,243**	**1,219**	**1,330**	**1,256**	**1,250**	**1,250**	**-0.5%**	**0.0%**
Surgery:								
Inpatient Surgery Cases	551	594	557	562	592	592	5.3%	0.0%
Endoscopy Cases	1,056	1,137	1,221	917	1,048	1,048	14.3%	0.0%
Same Day Surgery Cases	1,270	1,233	1,153	1,135	1,398	1,398	23.2%	0.0%
Total Surgery Cases	2,877	2,964	2,931	2,614	3,038	3,038	16.2%	0.0%
Total Surgery Minutes	192,833	178,815	184,710	188,905	217,592	217,592	15.2%	0.0%
Outpatient:								
Total Outpatient Visits (Hospital)								
Emergency Department Visits	16,243	15,913	14,539	13,093	11,392	11,392	-13.0%	0.0%
Cardiac Rehab Visits	1,145	837	1,045	752	684	684	-9.0%	0.0%
Lab Visits	3,924	3,707	3,035	3,977	3,442	3,442	-13.5%	0.0%
Lab Tests	115,721	115,768	112,461	113,220	117,038	117,038	3.4%	0.0%
Radiology Visits	10,434	10,227	9,367	8,614	9,592	9,592	11.4%	0.0%
Radiology Tests	28,438	29,821	30,311	26,318	27,922	27,922	6.1%	0.0%
Sleep Study Visits	212	287	311	304	268	268	-11.8%	0.0%
Physician Clinics:								
Hospitalists	2,445	2,973	2,280	2,320	2,780	2,780	19.8%	0.0%
Bartlett Oncology Clinic	655	757	846	862	1,010	1,010	17.2%	0.0%
Opthalmology Clinic	N/A	N/A	N/A	107	1,116	1,116	943.0%	0.0%
Behavioral Health Outpatient visits	N/A	N/A	N/A	4,353	4,798	4,798	10.2%	0.0%
Bartlett Surgery Specialty Clinic visits	3,688	4,678	3,628	3,016	2,730	2,730	-9.5%	0.0%
	6,788	**8,408**	**6,754**	**10,658**	**12,434**	**12,434**	**16.7%**	**0.0%**
Other Operating Indicators:								
Dietary Meals Served	233,711	264,982	327,287	300,896	237,058	237,058	-21.2%	0.0%
Laundry Pounds (Per 100)	3,571	4,841	4,776	4,252	4,488	4,488	5.6%	0.0%

BARTLETT REGIONAL HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
FOR THE BUDGET YEAR ENDING JUNE 30, 2021

	Actual FY 2017	Actual FY 2018	Actual FY 2019	Actual FY 2020	Projected FY 2021	Budget FY 2022	YTD % VAR
Gross Patient Revenue:							
1. Inpatient Revenue	44,901,557	48,249,464	49,315,947	48,061,895	45,257,728	54,366,082	20.1%
2. Inpatient Ancillary Revenue	11,967,312	12,403,151	10,858,901	10,603,590	11,593,204	11,994,443	3.5%
3. Total Inpatient Revenue	56,868,869	60,652,615	60,174,848	58,665,485	56,850,932	66,360,525	16.7%
4. Outpatient Revenue	83,268,288	88,584,979	98,176,935	103,133,108	117,740,304	122,449,916	4.0%
5. Total Patient Revenue - Hospital	140,137,157	149,237,594	158,351,783	161,798,594	174,591,236	188,810,441	8.1%
6. RRC Patient Revenue	3,669,861	4,261,001	4,171,399	2,664,511	1,007,462	4,108,644	307.8%
7. BHOPS Patient Revenue	193,804	176,720	2,478,345	3,040,990	2,848,496	2,962,436	4.0%
8. Physician Revenue	8,882,932	10,231,684	10,006,086	10,744,464	12,186,370	12,673,825	4.0%
9. Total Gross Patient Revenue	152,883,753	163,906,998	175,007,613	178,248,559	190,633,564	208,555,345	109.4%
Deductions from Revenue:							
10. Inpatient Contractual Allowance	28,100,239	32,220,709	35,483,854	34,054,576	32,770,302	36,652,360	11.8%
10a. Rural Demonstration Project	(6,899,351)	(3,866,693)	(3,699,996)	(3,700,000)	(2,700,000)	(2,700,000)	0.0%
11. Outpatient Contractual Allowance	26,426,690	31,237,089	34,944,251	36,350,861	43,361,910	48,498,679	11.8%
12. Physician Service Contractual Allowance	4,934,656	5,738,046	5,159,877	6,474,834	7,621,444	8,524,301	11.8%
13. Other Deductions	224,915	205,845	173,535	176,691	156,076	174,565	11.8%
14. Charity Care	767,664	1,519,195	1,082,498	1,090,598	1,445,210	1,557,297	7.8%
15. Bad Debt Expense	4,139,400	648,984	3,066,546	3,174,104	925,210	1,221,034	32.0%
16. Total Deductions from Revenue	57,694,213	67,703,175	76,210,564	77,621,663	83,580,152	93,928,236	12.4%
% Contractual Allowances / Total Gross Pat Rev	*39%*	*40%*	*41%*	*41%*	*44%*	*45%*	2.4%
% Bad Debt & Charity Care / Total Gross Pat Re	*3%*	*1%*	*2%*	*2%*	*1%*	*2%*	20.6%
% Total Deductions / Total Gross Pat Rev	*38%*	*41%*	*44%*	*44%*	*44%*	*45%*	2.7%
17. Net Patient Revenue	95,189,540	96,203,823	98,797,049	100,626,896	107,053,412	114,627,110	7.1%
18. Other Operating Revenue	2,128,963	2,040,072	4,713,981	14,510,984	14,943,744	10,015,553	-33.0%
19. Total Operating Revenue	97,318,504	98,243,894	103,511,030	115,137,879	121,997,156	124,642,663	2.2%
Expenses:							
20. Salaries & Wages	38,232,761	40,448,063	42,318,786	46,562,577	50,325,916	54,574,011	8.4%
21. Physician Wages	2,459,297	2,481,668	3,365,983	3,735,925	3,547,612	3,739,369	5.4%
22. Contract Labor	2,825,500	2,344,388	3,128,019	1,768,952	1,974,232	1,192,906	-39.6%
23. Employee Benefits	33,352,970	22,741,753	21,798,521	24,413,625	27,119,358	28,295,632	5.5%
	76,870,528	68,015,872	70,611,309	76,481,079	82,967,118	87,801,918	5.8%
% Salaries and Benefits / Total Operating Rev	79%	69%	68%	66%	68%	70%	
24. Medical Professional Fees	813,862	939,526	961,500	965,031	1,229,628	1,012,588	-17.7%
25. Physician Contracts	2,577,719	3,622,534	2,622,926	2,472,343	3,059,632	2,060,546	-32.7%
26. Non-Medical Professional Fees	2,571,048	2,592,676	1,883,186	2,095,725	2,445,430	2,907,699	18.9%
27. Materials & Supplies	11,350,496	11,012,692	12,918,764	14,050,846	17,869,794	14,796,317	-17.2%
28. Utilities	1,314,928	1,453,486	1,487,682	1,471,762	1,318,892	1,559,128	18.2%
29. Maintenance & Repairs	3,083,324	3,135,804	3,777,711	4,535,336	5,148,788	4,520,016	-12.2%
30. Rentals & Leases	568,516	774,421	619,667	609,337	602,200	457,141	-24.1%
31. Insurance	526,496	495,081	701,158	524,306	594,568	660,631	11.1%
32. Depreciation & Amortization	7,359,593	7,422,119	7,196,120	7,185,318	7,866,620	7,633,791	-3.0%
33. Interest Expense	666,110	653,430	638,664	622,780	611,336	599,334	-2.0%
34. Other Operating Expenses	1,058,985	807,823	1,378,727	1,284,023	1,074,888	1,569,278	46.0%
35. Total Expenses	108,761,605	100,925,464	104,797,415	112,297,884	124,788,894	125,578,388	0.6%
	(11,443,102)	(2,681,570)	(1,286,386)	2,839,995	(2,791,738)	(935,726)	-66.5%
Non-Operating Revenue							
37. Interest Income	337,009	590,905	2,393,728	3,031,416	1,228,344	2,000,000	62.8%
38. Other Non-Operating Income	3,161,755	4,016,890	1,774,397	877,141	907,376	907,382	0.0%
39. Total Non-Operating Revenue	3,498,764	4,607,794	4,168,125	3,908,557	2,135,720	2,907,382	36.1%
40. Net Income (Loss)	(7,944,336)	1,926,227	2,881,740	6,748,552	(656,018)	1,971,656	-400.5%
Income from Operations Margin	-11.76%	-2.73%	-1.24%	2.47%	-2.29%	-0.75%	-67.2%
Net Income	-8.16%	1.96%	2.78%	5.86%	-0.54%	1.58%	-394.2%

Bartlett Regional Hospital
5 Year Capital Plan
For the Budget Year 2022

Department	Description	Priority	FY2022	FY2023	FY2024	FY2025	FY2026	Additional Comments
01.7044-CT Scan	CT Replacement	1 - Patient Safety/Compliance	$1,869,918			$1,500,000	$1,500,000	2 CT Machines replacements
01.9200-Information Services Mgmt	MEDITECH ED Module -> Moving to FY2022							Budget Rolling forward from FY21 to FY22. Moving away from T-System to MEDITECH ED Module. Interfacing between two EHR's is a patient safety issue and T-System is no longer innovating their product. Costs continue to increase and functionality is not improving.
		1 - Patient Safety/Compliance	$350,000					Moving to FY2022
01.9200-Information Services Mgmt	Virtual Desktop Expansion	2 - End of Life/Revenue Enhancer/Cost Saver	$250,000	$125,000			$250,000	Increasing virtual desktop footprint to entire hospital to include badge-tap single sign-on ability.
01.9200-Information Services Mgmt	VxBlock server blade expansion and storage expansion FY 2022-2026 allocating for continual expansion of the VxBlock for more storage and sever hardware.	2 - End of Life/Revenue Enhancer/Cost Saver	$200,000	$200,000	$200,000	$200,000	$200,000	Server and Storage needs are continually growing. The new system allows us to easily expand. Includes VMware licensing as well.
01.7070-BRH Pharmacy	Omnicell cabinets	2 - End of Life/Revenue Enhancer/Cost Saver	$160,600					The Omnicells in the OR, Endoscopy room, and pharmacy Controlled Substance Manager are sun setting, and will not be serviceable after 12/31/21.
01.9200-Information Services Mgmt	MEDITECH Web Ambulatory Expansion for BMOC & BSSC -> Moving to FY2022							Eclinical to Meditech. Rollover from FY21, but estimating at a higher amount, since the original estimate did not include BMOC. Cost may be less to bring BMOC and BSSC onto Web Ambulatory module. ROI will be paid back in less than 2-years due to eClinicalWorks cost of $15K/month.
		1 - Patient Safety/Compliance	$140,000					Moving to FY2022
01.7070-BRH Pharmacy	Omnicell CPM Standalone (Central Pharmacy Manager)	3 - Future End of Life/Nice to have	$115,000					Pharmacy inventory manangement system.
01.6010-Med/Surg	Hill-Rom Centrella Smart bed							255 bed need a total of 25 bed replacement with 1 355 36 inch wound care pressure bed. All beds include top of line mattresses. 8 beds per year to order. 2023 would be the last year to upgrade beds on the MS unit. 12/21/2020 Received 8 new beds (255 standard style beds after power surge fried circuits on several of older beds.)
		2 - End of Life/Revenue Enhancer/Cost Saver	$100,536	$81,683				
01.6172-Cardio/Pulmonary Rehab	Patient Monitoring system	3 - Future End of Life/Nice to have	$100,000					
01.8210-Laundry	Washers	2 - End of Life/Revenue Enhancer/Cost Saver	$100,000					
01.6080-Obstetrics	Badge-activated automatic main OB doors, and access doors between OB and CCU	1 - Patient Safety/Compliance	$80,000					This estimate was generated by Marc with facilities. Please see the attached email from him, detailing the breakdown and funding from the FY22 Deferred Maintenance Fund.
01.6213-Same Day Surgery	Electric patient stretchers	1 - Patient Safety/Compliance	$75,745					
01.8200-Environmental Services	Med/Surg Curtains	1 - Patient Safety/Compliance	$75,000					
01.8360-Facilities Management	Plow Truck	2 - End of Life/Revenue Enhancer/Cost Saver	$75,000					
01.9200-Information Services Mgmt	Policy / Document Management System replacement	1 - Patient Safety/Compliance	$75,000					This is to replace policy tech and will be added to RL system. 75K is the implementation cost, expecting for this to be far less than that. $15,000 will be our ongoing maintenance cost that will need to be added to our maintenance contract budget going forward.
01.6170-Respiratory Therapy	Pulmonary Function Testing Equipment	2 - End of Life/Revenue Enhancer/Cost Saver	$60,000					
01.8360-Facilities Management	Sec officer defensive tools	1 - Patient Safety/Compliance	$60,000					TBD

Bartlett Regional Hospital
5 Year Capital Plan
For the Budget Year 2022

Department	Description	Priority	FY2022	FY2023	FY2024	FY2025	FY2026	Additional Comments
01.7013-Histology	LaserTrack PH-8 cassette printer	1 - Patient Safety/Compliance	$55,095					Cassette printer used with tissue from OR which is placed in processor, which allows printing of patient information to include barcodes. Needed for enhancements with XPANSE to improve process flow in Histology. Current system is manual. Department did attempt 4 years ago to acquire similar unit, but unit was not compatible, so was returned.
01.7070-BRH Pharmacy	pharmacy shelving	2 - End of Life/Revenue Enhancer/Cost Saver	$50,000					The current shelves are at end of life, do not work well, and attempts to repair have failed.
01.7013-Histology	DRS tissue stainer	2 - End of Life/Revenue Enhancer/Cost Saver	$45,900					Current DRS was purchased in 2001. Assett 001659 is aging equipment. Fully depreciated
01.6020-Critical Care	ICU Hil Rom Bed	1 - Patient Safety/Compliance	$44,000					carry over from FY 21, new bed not purchased
01.6020-Critical Care	ICU Beds	1 - Patient Safety/Compliance	$44,000		$44,000			Replacement
01.9200-Information Services Mgmt	Computer Replacements	2 - End of Life/Revenue Enhancer/Cost Saver	$40,000	$40,000	$40,000	$40,000	$40,000	Don't need 250K if Virtual desktop is approved. 40K would be sufficient for computer replacement needs that are not part of virtual desktop. Replacing 25% of our computer fleet each year so that we are on a 4-year lifecycle
01.6210-Operating Room	New documentation software for endoscopy	2 - End of Life/Revenue Enhancer/Cost Saver	$35,000					Complete new laparoscopic, arthroscopic, GYN, and GU video system $500,000 +
01.6210-Operating Room	Pediatric EGD scope	1 - Patient Safety/Compliance	$32,914					This scope will be used when young children have accidently swallowed button, coins..
01.7041-Diagnostic Radiology	Patient monitor	1 - Patient Safety/Compliance	$30,000					
01.7070-BRH Pharmacy	surveillance software	1 - Patient Safety/Compliance	$30,000					Software for controlled substance surveillance.
01.9200-Information Services Mgmt	MEDITECH Staff Gateway Module for HR	2 - End of Life/Revenue Enhancer/Cost Saver	$25,000					Rolling forward budget from FY21 to FY22. HR module for managing benefits and can remove some of the Taleo modules to offset the cost. Much easier integration with our MEDITECH environment and reduced duplicate data entry.
01.7010-Lab	Osmometer, micro sample	1 - Patient Safety/Compliance	$21,304					To replace analyzer assett 003354. Fully depreciated, > 10 yrs old
01.6230-Emergency Dept	ED Stretchers with scales (2 new each year)	1 - Patient Safety/Compliance	$20,000	$20,000	$20,000	$20,000		Replacement. Current guidelines for stroke care and heart attack care REQUIRE that patients get weighed, as the medications given to dissolve clots is weight based. Not having a way to accurately get a patients weight places them at risk for either receiving to little medication or to much. Currently we have one bed scale, which is in constant state of repair as it a refurbished model. The goal would be to have all ED strecthers with scales.
01.8360-Facilities Management	Potable ICRA Containment Wall System	1 - Patient Safety/Compliance	$20,000					This wall system will help ensure quality reliable dust containment dure small renovation projects. They can also double as the wall portion of a rapidly deployed isolation area eliminating plastic sheeting used for walls.
01.7013-Histology	Recycler for Xylene	2 - End of Life/Revenue Enhancer/Cost Saver	$18,495					Replacement Recycler for Xylene – current unit >12yrs. Asset 0384, Fully depreciated
01.6222-Infusion Therapy	Replace or upgrade patient care equipment	2 - End of Life/Revenue Enhancer/Cost Saver	$15,000					
01.7070-BRH Pharmacy	Ultra-cold Freezer	1 - Patient Safety/Compliance	$14,500					The ultra cold freezer is needed for the Pfizer COVID vaccine. Bartlett is serving as the mini-depot for community vaccines.
01.8110-Dietary	Temperature monitoring software for refrigerators	2 - End of Life/Revenue Enhancer/Cost Saver	$14,000					
01.7010-Lab	Blood Bank Cell Washer	1 - Patient Safety/Compliance	$8,063					New to replace manual process. Used mostly with NB screening, which cells need to be washed to assure reactions are clear.
01.7010-Lab	10 Kva battery backup	1 - Patient Safety/Compliance	$7,993					Found that battery located in maintenance is not working and not designed for amp pull from 3 analyzers that are attached. For two main Chemistry and our Hematology, need a minimum of 6 Kva, but would like larger for future - 10 Kva. There will be cost for installation.
01.7013-Histology	Link system for G2	1 - Patient Safety/Compliance	$6,600					This allows us to connect the G2 coverslipper to the DRS tissue stainer
01.8360-Facilities Management	Interior Genie Lift	3 - Future End of Life/Nice to have	$6,000					To safely reach difficult elevated interior areas
01.6080-Obstetrics	2 Hospital Grade breast pumps, and 1 breastmilk warmer	2 - End of Life/Revenue Enhancer/Cost Saver	$5,150					2 current breast pumps are end of life, and having a temperature-controlled breastmilk warmer will increase safety surrounding the warming of frozen donor milk.

Bartlett Regional Hospital
5 Year Capital Plan
For the Budget Year 2022

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01.9200-Information Services Mgmt	Camera System. Future years: 2022-2025 budgeting for expansion or replacements.	1 - Patient Safety/Compliance	$5,000	$5,000	$5,000	$5,000		New camera system across the hospital. 125 cameras with artificial intelligence, 10-years cloud based storage, HD/4K resolution, 5-years support contract. Will remove 2 exisiting systems that we have in place currently and decrease the storage footprint on the network (currently 2TB of space). Future years: 2022-2025 budgeting for expansion or replacements.
01.9200-Information Services Mgmt	Wireless Access Points and 2nd Wireless Controller for High-Availability	2 - End of Life/Revenue Enhancer/Cost Saver	$5,000	$5,000	$5,000	$5,000	$5,000	Replacement of our wireless access points (8 years old and EOL). Add a second wireless controller for High Availability. Would be advantageous to have this upgraded as we Go-Live with Expanse this year. Future years: budgeting for increased capacity/expansion to include cabling.
01.9500 - Executive Office	Contingency	3 - Future End of Life/Nice to have	$514,189					
01.6080-Obstetrics	Labor and Delivery beds (1/yr)	3 - Future End of Life/Nice to have		$25,000	$25,000	$25,000		Replacement
01.7010-Lab	Chemistry and Immunoassay analyzer	1 - Patient Safety/Compliance		$115,000				To replace analyzer assett 003706, end of life (10 yrs). Will be fully depreciated by time of request
01.7042-Ultrasound	Unltrasound Reaplacement	1 - Patient Safety/Compliance		$138,398			$175,000	updates and transducers cut from 2019 purchase
01.7045-MRI	MRI Replacement	1 - Patient Safety/Compliance		$2,600,000				Current MRI was purchased in 2008
01.7047-Mammography	3D Mammography Replacement	1 - Patient Safety/Compliance					$400,000	New in 2017. Estimating Life is 10 years
01.7070-BRH Pharmacy	Upgrade 3rd floor cleanroom	1 - Patient Safety/Compliance		$1,000,000				The current cleanroom does not meet the updated USP 797 physical requirements.
01.7070-BRH Pharmacy	Infusion pump integration	1 - Patient Safety/Compliance		$250,000				Infusion pump integration with Meditech. Not sure if Meditech will be able to do this, or if we'll have to use Iatric.
01.8200-Environmental Services	Carpet Extractor	1 - Patient Safety/Compliance		$15,000				
01.8200-Environmental Services	ED/OB/CCU Curtains	1 - Patient Safety/Compliance		$75,000				
01.8200-Environmental Services	Sterile Meryl	1 - Patient Safety/Compliance			$100,000			
01.8200-Environmental Services	SDS Curtains	1 - Patient Safety/Compliance				$75,000		
01.8210-Laundry	Driers	1 - Patient Safety/Compliance		$80,000				
01.8360-Facilities Management	RRC Passenger Van	2 - End of Life/Revenue Enhancer/Cost Saver					$50,000	Current Van Purchased in 2016
01.8360-Facilities Management	John Deere	1 - Patient Safety/Compliance		$30,000				
01.8360-Facilities Management	Med Tester	1 - Patient Safety/Compliance			$15,000			Biomed Equipment Safety Test
01.8360-Facilities Management	Commons Furniture	2 - End of Life/Revenue Enhancer/Cost Saver		$25,000	$25,000	$25,000	$25,000	Phased Replacement
01.8360-Facilities Management	Campus Wide Radio System	2 - End of Life/Revenue Enhancer/Cost Saver		$100,000				
01.8360-Facilities Management	Jeep	2 - End of Life/Revenue Enhancer/Cost Saver		$35,000	$35,000			

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01.8360-Facilities Management	Bobcat	2 - End of Life/Revenue Enhancer/Cost Saver					$90,000	Purchased new in 2019
01.9530-Compliance	Need more warehouse storage space. Materials are stored too close to the fire suppression system in MM even when inventory are at minimum levels (18" storage rule)	1 - Patient Safety/Compliance					?	Consider moving this initiative to facilities projects: Employee, visitor, patient safety. Part of the Hospital Facilities Master Plan.
Total			**$5,000,000**	**$4,965,081**	**$514,000**	**$1,895,000**	**$2,735,000**	

Bartlett Regional Hospital

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Management Report from
Dallas Hargrave, Human Resource Director
March 2021

- **CEO Recruitment Process.** Much time has been spent over the last month by HR staff on helping coordinate this Board process.

- **Union Negotiations.** An update will be provided in executive session.

- **"Best Places to Work in Healthcare" employee survey.** BRH is participating in the "Best Places to Work in Healthcare" program created by Modern Healthcare and the Best Companies Group again this year. The program is designed to recognize outstanding places of employment in Healthcare and provide employers with feedback from employees. Throughout the month of April, all employees that receive an online survey via email. We will receive our results later in the summer and will be able to compare our results to the 2009 results—the last time this survey was completed by employees.

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March 2021 Nursing Report
Rose Lawhorne, CNO

Nursing Administration

- According to US News and World Report, Alaska is #2 in the country for Quality Healthcare! Alaska ranks #22 overall, #47 for health care access, and #33 for public health. The hardworking providers and staff of BRH have contributed to the success of our state. This is a testament to our efforts.
  Link: https://www.beckershospitalreview.com/rankings-and-ratings/5-top-states-for-healthcare-ranked-by-us-news-world-report.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=7665D9020134C5B
- The Centers for Medicare & Medicaid Services (CMS) maintains a national, consumer-oriented website called Hospital Compare. The site provides facility performance data, and allows patients to compare hospitals. BRH recently received an overall five-star ranking on Hospital Compare! This rating will be visible on the website on April 1, 2020.
  Link: https://www.medicare.gov/care-compare/?providerType=Hospital&redirect=true
- Congratulations to all of our certified nurses! March 19th is Certified Nurses Day! Thank you to these hard working professionals who meet the needs of our patients and go the extra mile to become certified in their specialty areas.
- We have posted an application for the certified nursing assistant (CNA) training program on our internal human resources website. Employees can apply for the first cohort starting in the coming weeks. Staff looking for professional development opportunities will commit to 18 months of employment at BRH upon successful completion of the program and state certification exam, and will be eligible to work as CNAs in our patient care areas.
- Gail Moorehead, Senior Quality Director, the infection prevention team, BRH staff, and community providers have contributed time and energy to the efforts to vaccinate Juneau. The vaccination events have provided quality service to our community and we are grateful for their work.
- We are working as an incident command team to relax visitor restrictions so that our patients can receive greater support from loved ones during their stay in our hospital. This contributes to improved patient satisfaction and emotional health as they heal. Thanks to Gail Moorehead, our Planning Section Chief, for coordinating the updates of our incident directives.
- A culture of patient safety survey has been disseminated to all staff at BRH. The results will be compiled in May and reported to the Agency for Healthcare Research and Quality (AHRQ) for comparison to other similar facilities.
- We are engaged in early conversations to establish a coordinated response to support staff after patient care crises occur. These may include difficult or traumatic resuscitations, episodes of violence against staff, or other similar situations that create high stress for our teams. Members of the medical staff and nursing leadership team will plan and implement a coordinated response for care teams immediately following these events to ensure that

those involved feel supported and are offered resources to navigate the stress often associated with highly stressful circumstances.

Obstetrics (OB) Department

- We rolled out our new process for patient/family debriefing. Recent data shows that approximately 25-35% of women nationwide classify their delivery as traumatic, regardless of the acuity or severity of delivery events. Given this statistic, it is imperative that we take time with families to create a space to discuss events that surrounded their labor, delivery, or newborn care. We are excited to be able to offer this addition to patient-centered care.
    - OB nurses are working collaboratively with OB and Pediatric providers to create the time and space to debrief deliveries and newborn care that met certain criteria (hemorrhage, unscheduled cesarean sections, special care nursery admissions, etc.)
    - We have created two debrief forms (maternal and newborn) to help guide discussions and provide helpful resources for families.
- We also rolled out our new process improvement project regarding fetal or neonatal loss.
    - After much interagency collaboration, all consents for OB, pathology, and the mortuary have been consolidated into a single form.
    - A resource guide was developed for patients and their families, listing local, online, specialty (grandparents, etc.) supports available to them. We also purchased books that help explain loss and support parents as they guide older children through the experience.
    - The Meditech electronic health record (EHR) has been updated to include patient education and order sets to ensure that care is consistent from one patient to the next.
    - A "master binder" was created to guide physicians and nurses through documentation and supplemental forms.
    - One of our CNAs created beautiful keepsake boxes for items we send home with families.
- We officially hired a Plans of Safe Care Coordinator, Rachel Gladhart! Rachel is an outstanding community provider. We are incredibly fortunate that she has accepted the position and will be joining the OB and case management teams in this new role in April!
- At the end of March we will be hosting a large "super-user training" for nurses in preparation for integration of our fetal monitoring software, Intellispace, with Meditech. This integration will eliminate paper charting and will automate the transfer of monitoring and labor documentation directly to the EHR. It will also provide a pathway for information to flow between charting systems, significantly improving efficiency.

Critical Care Unit (CCU)

- Training of two new nurses is going well. One nurse transferred to us from Med Surg and should be working independently by the end of April. The other is a new graduate and should complete the preceptorship by July.
- Our efforts to improve reporting of critical lab values continues to be successful. In February, we saw 96% success, with only one miss.
- Several CCU nurses are studying for the Certified Critical Care Nurse (CCRN) exam. This difficult certification process speaks to our level of professionalism on CCU. We currently have 11 nurses that are CCRNs.

- With new developments in healthcare, so also comes new supplies that must be managed and stored. We have completed an effort to reorganize supplies on the unit, creating easy access and streamlining the work of providers and nurses. The team also developed a locator binder that guides staff to equipment needed to deliver high-quality care.
- Collaboration between our CCU staff and the team that offers eICU support is essential to meet the needs of our acutely ill patients. Comprehensive information sharing promotes integrated care. We developed a rounding checklist to streamline delivery of information to the remote staff so that they have critical information at their fingertips. The checklist includes elements such as ventilation status, use of vasopressors, sedation weaning status, important lab values, deep vein thrombosis (DVT) prophylaxis, code status, and any pertinent events that have occurred in the past 24 hours.

Emergency Department (ED)

- Our new screening building is open and in use. Signs have been posted to direct patient and visitor flow. The ED entrance has a badge reader on doors to prevent individuals from bypassing the screening staff. Screeners inside the building use a remote control to open the hospital doors once people are screened and able to enter the main facility.
- We are working on a survey for ED and Diagnostic Imaging (DI) teams to identify challenges that impede patient flow between the two departments. Once issues are identified, the ED and DI directors will work collaboratively to identify improvements and effect change, then resurvey the staff. We plan to complete this process with each department to ensure that patients remain in the center of all we do.
- Care of critically ill patients often requires delivery of medications that require accurate weights to determine dose. As many of our patients cannot safely stand due to their injuries or medical issues, we are unable to obtain precise weights. We are in the process of replacing our beds with stretchers that have built-in scales. This will increase safety for our patients who are unable to stand, but for whom we need an accurate weight for medication dosing.
- We are working with our ED educator to organize orientation packets for new nurses joining the ED. One packet will be tailored for new graduates who participate in weekly discussions to develop goals and evaluate progress. The other packet will address the needs of seasoned ED nurses who require a simplified orientation process.
- The ED director is working with our SEARHC colleagues to give ED providers and staff "read only" access to the clinic's EHR. This access will allow the ED team to obtain current diagnoses/problem lists, medications, history and physical exams, and diagnostic study results for patients who present for care. With this information, the providers can make informed care decisions.

Surgical Services

- Pre-procedure COVID testing is transitioning to our new BRH molecular lab. Same Day Surgery (SDS) and Pre-Admission Testing (PAT) teams are working closely with Robin Marks from the lab to establish new processes. The community testing site will collect the samples and then process them through our lab.
- SDS/PAT experienced a smooth downtime during the Meditech Expanse upgrade on March 8th.
    - Clinical informaticists trained nurses as "super users" several weeks in advance.

    - Lori Holte, Surgical Services clinical informaticist, worked closely with an SDS nurse to develop downtime forms specific to the patients arriving during the downtime.
    - Directly after the transition, Lori Holte facilitated effective communication with the Expanse support team regarding post-upgrade issues.
    - The Clinical Information Technology (IT) team has continued to assist us in working through challenges related to the upgrade. They have been responsive and efficient in investigating and addressing problems.
- Our Surgical Services Compassion Committee, SOS, continues to blossom, and we have defined our vision and mission.
    - Vision: We are an informal committee dedicated to recognizing the positive effects of gratitude and working together as a strong team.
    - Mission: Promote an atmosphere of teamwork to support each other, to celebrate each other, practice gratitude, offer grace, and to be there for each other.
- SDS is busier than ever. One year ago, a full day consisted of 12 cases. We are now consistently managing 12-16 or more cases per day. We often turn over beds four or more times per day. Our team is working collaboratively to meet the needs of our patients.
- We are dedicated to continuous improvement of culture in Surgical Services. Part of this process is to solicit feedback regarding staff and providers, and address problems that arise. The first of the Pulse 360 surveys have been sent to staff who will offer feedback regarding providers assigned to them.
- We continue to monitor and improve efficiency in patient flow. We are tracking delayed start times, particularly related to issues within our control (e.g. availability of equipment and supplies for cases). We have seen few delays and will continue to monitor.
- Training of two new surgical techs is progressing. They are doing very well.
- The new Clinical Manager, Vinh Le, is becoming more comfortable in his new role and taking on more daily activities. He demonstrates thoughtful communication and sound decision making. The Surgical Services leadership team is working proactively to ensure that efforts are collaborative and well-coordinated. Thanks to our Surgical Services leaders for your dedication.
- Central Sterile Reprocessing (CSR) staff recognize the importance of streamlined processes to ensure that equipment needed for cases each day is available and ready for use. Process improvement efforts have reduced tray turnover times and improved consistency in restocking of implantable screws and plates. The team members' collaborative work has effected positive changes. Thank you to our CSR staff!
- Preparations for installation of the new heating, ventilation, and air conditioning (HVAC) system are underway and scheduled to take place April 9-12.
- Plans for remodeling CSR are also underway. This project will include adding a second washer, offering redundancy in the system and ensuring that cases can proceed if one washer fails or requires preventive maintenance. No date has been set for the remodel.

Medical Surgical Unit

- Med Surg is reviewing the management of hazardous materials on the unit, particularly related to spill response.
    - We are working with members of the HazMat Committee to evaluate the spill response kit and ensure that all critical supplies are available for any spill that may occur.

    - We are also collaborating with the Pharmacy and Therapeutics Committee to evaluate medication management, particularly chemotherapy, if administration is required for an admitted patient. Elements being evaluated include standards for management of the agents, risk associated with their use, and response to spills.
- We are continuing to work with Clinical IT to follow up on issues related to Meditech Expanse. These typically pertain to access, documentation, and information flow through the medical record.
- One of the benefits of being part of the nursing profession is the flexibility a single license offers. Nurses often begin their careers on Med Surg, where patients are typically stable, and they gain experience managing diverse disease processes, injury types, and delivery of care to patients of all ages. Several nurses have decided to expand their roles to other areas, and transferred to other departments within the hospital to broaden their experience. We have hired two new nurses and have engaged our seasoned staff to begin training them.
- A nurse from the Quality Department is coming to the next Medicine and Pediatrics Committee to offer training to our medical staff on quality measures reviewed by the committee. We have also coordinated future committee training with pharmacy and infection prevention.
- The project to improve storage and charging of inventory has been completed. This will improve charge capture and revenue. Another scanner was added to the supply room to improve nurse efficiency. Scanning rates are being tracked to ensure that supplies used are being charged accurately. Thanks to the Med Surg team and Materials Management for your collaboration to improve this system.
- A work group is reviewing the template used to check in with patients after discharge. We call every patient who has received a total joint replacement to answer any questions and make sure they are set up for success at home. The group is modifying questions asked and updating the process.

Oncology/Infusion Therapy

- Infusion Therapy and Bartlett Medical Oncology staff and nurse practitioners are collaborating in a work group. Our goals include developing an integrated oncology/infusion therapy program, improving patient safety, streamlining workflow between the two practices, and refining processes.
- Infusion Therapy completed the training and orientation of two nurses. They will allow us to extend operating hours as needed to meet patient volumes and needs, and will provide coverage for essential education and training.

Bartlett Regional Hospital

March 23, 2021 Board Report
Billy Gardner, Chief Operating Officer

Diagnostic Imaging Department (Paul Hawkins)

- New PACS Admin applicants received, recruitment ongoing.
- Ultrasound candidates are being recruited, tight market, no applicants with minimum qualifications in months. Currently have 1 permanent staff and 4 open positions. New Ads have been placed by HR. Candidate recruited by BRH has been recruited by local physician, we should consider no compete clause.
- Reviewing class specifications for DI positions.
- Expanse go live on March 1st went well for the diagnostic imaging module.
- Mammography routine screening should be 6 weeks after the patients second COVID vaccine to avoid false positive exams and we are checking with patients when scheduling screenings, this is for asymptomatic patients only. We would like this information on the BRH website and COVID Portal.
- https://www.clinicalimaging.org/article/S0899-7071(21)00020-6/fulltext
- SBI_OnePg_no_crop.pdf (sbi-online.org)
- Patient workflow and Covid precautions continue to be a top priority.
- Power surge on February 19th caused significant failure of radiology equipment.
- Budget was submitted.

Future Plan

- Offer Cardiovascular and Vascular Screenings to promote wellness.
- Fill remaining ultrasound vacancies.
- New MRI and upgrade of CT Scanners. Faster higher quality MRI exams and new CT exams will benefit out patients and visitors. Technology has changed dramatically since our purchase of the existing scanner in 2006.
- Script Sender project is delayed until PACS admin is filled. Orders into DI from referring physicians can be automated with CPT code and ICD-10 code compatibility verification and streamlined prior authorization. This will also make sure supporting diagnosis codes for new (AUC) appropriate use criteria are provided.

Maintenance Department (Marc Walker)

- ED Waiting Area/ PAS Window: Began 12/17/2020 – current estimated completion date of 01/23/2021. As PAS staff are able to see what they agreed to they are asking for a few changes. The changes will not be allowed to be part of this contract as term contract limits have been exceeded. Maintenance has met with the department and is currently gathering prices for the requested changes. The additional doorway exiting the waiting area is being scheduled with the contractor. Angelita, our Patient Access Services Director, has approved construction plan and we are moving forward with signed quotes. About 32 hours of the work will be performed in house and the rest will be contracted out (approximately $10k).
- ED Ortho/ Trauma rooms: Professional Services contract in place and design team is working through the design. Project estimated completion date updated to August 2 2021.
- Cardiac Rehab space expansion: Professional Services Fee Proposal received. CBJ is putting together the contract and negotiating fees.
- ASU-11/Endo Fan: Materials have started to arrive and we are getting close to being able to issue the 30 day notice for OR downtime. Estimated Substantial Completion 04/13/202. Exhaust Fan and Variable Frequency Drive arrived in Juneau March 16th. Inspected and everything arrived undamaged. 30 Day Notice for downtime will be given by OR Director, Jim Jurrens. C-section room on OB is not affected by shutdown and will be included in the OR Director's back up plan.
- Physician Call room update: Professional Services contract being established by CBJ Contracts
- Side Walk Phase 1 Replacement: Currently being worked on by CBJ Engineering and Dowl. Meeting with BRH on the January 6th to confirm the project scope. Construction estimate $1.2M, Professional Services $120K (Deferred Maintenance) Estimated Bid first week of March 2021. Construction 4 months middle of summer 2021
- Underground Fuel Line Replacement: Currently being worked on by CBJ Engineering. Construction estimate $120K, Professional Services $25K (Deferred Maintenance). Estimated Bid mid-March 2021. Construction 2 months' early summer 2021. Professional Services Contract awarded to Taku Engineering.
- New South Entrance: Currently being worked on by CBJ Engineering and Dowl.
- Hospital Drive: On hold until Spring.
- CSR Equipment upgrade: Awaiting Final Design from PDC Engineers. PDC Working with the OR Director to finalize equipment lists.
- ASU 1 Conversion to Glycol: 100% drawings completed 12/21. Construction estimate $125K, Professional Services estimate $25K (Deferred Maintenance). Construction 3 weeks, estimated project completion date of 04/30/2021 Bid opening March 9th.
- RRC Siding and Window Replacement: The project is out to bid with a bid opening date of 03/31/21.
- Behavioral Health Facility: The project is currently out to bid with a bid opening date of 03/16/21.

- Fire Door Replacement and door upgrades for security: CBJ has set up an account for the project using BRH Deferred Maintenance Dollars for funding. CBJ Contracts has sent out a Professional Services Term Contract Solicitation with a response request date of March 11th. NorthWind Architects has been awarded the Professional Services Contract for this project.

- The electrical engineers flew down to Juneau this week and surveyed our electrical panels. (March 8th) Specifications were developed and the assigned Electrical Contractor will be ordering 9 surge suppressors that will supplement the ones we already have in place. The 9 suppressors will be installed on 9 Primary Hospital Emergency Distribution Panels. This will only be a primary defense against surges. The contractor will air freight the suppressors in and anticipates installation by the end of the month.

- The design team will continue to develop the complete system that will likely include secondary suppressors and a system to clean up transitions to and from generator power.

Pharmacy Department (Ursula Iha)

- The pharmacy staff is busy with COVID-19 vaccine ordering, inventory tracking, and assisting with PODs.
- Infectious disease pharmacists are revising protocols for dosing vancomycin using Bayesian area under the curve dosing model for MRSA infections which can help achieve therapeutic concentrations quicker, and with fewer blood levels.
- Pharmacists continue to stay abreast of the expanding research for COVID-19 treatments, including the monoclonal antibody tocilizumab.
- The Meditech Expanse update did not greatly change the pharmacy module internally, but there are occasional glitches with partner systems that communicate prescription data between Meditech and other systems. The informatics pharmacist is assisting with optimization.
- Policy reviews are ongoing, and this month staff is focusing on updating procedures for management of hazardous drugs to align with current practice and USP 800 guidelines.

Physical Therapy (James "Rusty" Reed)

- Inpatient PT, OT, ST services has been up and down. Orthopedic surgeries have been down. These tend to fluctuate.
- Foot traffic has been a little slower with new outpatient referrals.

- We are continuing to move forward with implementing the Jellyfish Health platform for appointment reminders and other functionalities to make us more efficient. Go live is 3/31.
- Our wound care has been a little slower due to SEARHC starting their own wound program after the hiring of a wound care nurse and requiring their beneficiaries to attend their service provider.
- We are continuing to provide teletherapy sessions where appropriate
- Pediatrics is beginning to open a bit as we have expanded scheduling. We are currently averaging 8-10 visits per day on campus and averaging about 8 teletherapy visits per day. **It is my understanding that Bartlett Behavioral Health is starting an ABA (Applied Behavior Analysis) program with an offsite location. This program and our PEDS program working together would really flourish. Since COVID there is a big demand for this.**
- We have brought in an OT traveler to cover the gap in our OT service line. She is doing a really good job.
- We continue to look for a casual OT to hire.
- We have started our new documentation platform Expanse and we are continuing to work out the kinks in order to increase our efficiency.

Respiratory Therapy Department (Robert Follett)

- Working with IT in the Upgrade of Trace master ECG management system, project planning meeting occurring weekly, beginning testing phase.
- In-services planed with OR nursing.

Cardiac and Pulmonary Rehab

- Created new service: supervised exercise therapy for peripheral artery disease.

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March 2021 Behavioral Health Board Report
Bradley Grigg, Chief Behavioral Health Officer

- **March Psychiatry Staff/Locum Provider List**:**

    - **Dr. Joanne Gartenberg** Behavioral Health Medical Director
    - **America Gomez,** Psychiatric Mental Health NP (Full Time BRH Employee), is providing outpatient services to children, adolescents, and adults in addition to taking call.
    - **Cynthia Rutto,** Psychiatric Mental Health NP (Full Time BRH Employee), is providing inpatient outpatient services to children, adolescents, and adults in addition to taking call. Cyndy is also a lead provider for our Community Based Crisis Intervention Services Program.
    - **Nicholas White,** Psychiatric Mental Health NP (Part Time Independent Contractor) is providing telehealth outpatient services to adults via BOPS.
    - **Dr. Stephanie Chen** (Locum Psychiatrist) is providing part time telehealth outpatient service to and consultation for children and adolescents
    - **Dr. Judy Engleman** (Locum Psychiatrist) is providing part time telehealth outpatient services to adults
    - **Dr. Monika Karazja** (Locum Psychiatrist) is providing full time inpatient services on MHU in addition to outpatient services to adults. Her current assignment is through May 2021.
    - **Dr. David White** (Locum Psychiatrist) is a Child & Adolescent Psychiatrist who is providing full time outpatient services to children and adolescents at BOPS and through PES. He is also the clinical lead for the development of the Community Based Crisis Stabilization Program. Dr. White has signed a one-year commit to BRH (through October 2021)
    - **Dr. Al Fineman** (Locum Psychiatrist) is providing full time psychiatric services to patients admitted to Rainforest Recovery Center Residential Treatment and Withdrawal Management

**** We continue to recruit for full time MHU inpatient, full time RRC, and full time BOPS psychiatric employed providers in order to lessen our current dependence on locums coverage. Currently we are negotiating with 3 potential psychiatrists for employment.**

- **RAINFOREST RECOVERY CENTER:**
    - **RRC Residential Treatment Update:**
        - February daily utilization near or at 100%
        - Admissions remain only from Southeast Alaska
        - Capacity remains at 8 (75%)
        - Current Waitlist is 22
        - Weekly in-house patient COVID testing
        - Biweekly in-house RRC staff COVID testing
        - Masking requirements

    - **RRC Withdrawal Management (Detox) Update:**
        - February average daily utilization was 2 patients (current capacity is 4).
        - 44 patients served; 11 of which transitioned from Withdrawal Mgmt. Unit to Residential Treatment. 10 others transitioned to outpatient services through RRC.
        - Staffing includes 1 RN and 1 CNA per 12-hour shift.
        - 24/7 admissions; most comment admissions are directly from ED, in addition to transfers from Medical and direct admits from primary care providers

    - **RRC Outpatient Treatment Update:**
        - We currently have 41 patients enrolled receiving:
            - 100% virtual treatment*
            - Medication Assisted Treatment
            - Assessment
            - Individual & Group Treatment Sessions
            - Patients participate anywhere from 1-10 hours per week in treatment, depending on individual needs.

      *** In April 2020, we will begin seeing outpatients in person, ensuring COVID safety precautions are in place for patients coming into RRC.**

    - **RRC Community Navigator Program Update:**
        - 4 FTE Navigators who identify/accept community referrals/provide intensive case management for adults who are identified as high risk due to homelessness, substance use disorder, and mental health disorders
        - February 2020 – 52 unique individuals served in the community.

- **Adult Mental Health Unit (MHU):**
    - February daily average census was 5.4 patients
    - MHU continues to only accepting patients from Southeast Alaska.
    - Average length of stay for February was 17 days.

- **Bartlett Outpatient Psychiatric Services (BOPS):**
    - BOPS outpatient operations continue to be 100% virtual*
        - 7.5 FTE therapists are delivering telehealth counseling services from their home offices/BOPS Clinic.
        - 3.5 Psychiatric providers are delivering telehealth psychiatric / medication management form their home offices/BOPS Clinic.
        - The DAY Psychiatric Emergency Services Therapist and Psychiatric Provider are on site during their on-call day.
        - **Please see attached email re: the Emergency Declaration expiration and DHSS/DBH's response to the ongoing need for flexibility around telehealth services due to COVID-19**
    - **February 2020 Stats:**
        - 566 patient encounters
        - No show rate remained under 20% (significantly below national average of 23%)
        - February evidenced a significant increase in outpatient psychiatric referrals from SEARHC when compared to the last 12 months.
        - March stats will show a temporary decrease in patient appointments due to us moving to 50% appointments for the first two weeks of Meditech Expanse Upgrade

    * **In April 2020, we will begin seeing outpatients in person, ensuring COVID safety precautions are in place for patients coming into RRC.**

- **Updates on Continued Expansion of BOPS Outpatient Supports:**
    - BOPS has hired a Neuropsychologist to meet the growing need of individuals meeting the need for neuro-psych evaluations to better determine a plan of treatment for this population of patients. Dr. Adrienne Pasek has been hired as a locum neuro psychiatrist and will begin in April. Her CV is attached. The current community need for these evaluations are:
        - BOPS: 50 patients
        - Juneau School District: 50+
        - We are working with primary pediatric providers to determine their level of need
    - BOPS is currently in the planning phase of opening an Applied Behavioral Analysis Clinic to better provide "in community services" to Juneau and Southeast Alaska families with you on the autism spectrum and who have other complex behavioral challenges.

- Bartlett Oncology and BOPS are partnering to serve oncology patients and their families who evidence signs of increased depression and anxiety. Services will begin in March 2021.
- Erin Maloney, BOPS Therapist, is partnering with Sarah Gress, RN, to co-facilitate a community support group for families who are experiencing Perinatal Bereavement.

- **<u>Psychiatric Emergency Services (PES):</u>**
  - February 2021:
    - 118 patients assessed in the Emergency Department experiencing a Behavioral Health Crisis,
      - 87 Adults
      - 31 Children/Adolescents
        - 6 admitted to MedSurg for recommended higher level of care (NorthStar)
        - 18 referred to our Crisis Intervention Services Team (See below)
        - It was determined that 24 of the 31 youth assessed would have been appropriate for our future Crisis Stabilization Unit.

- **Crisis Intervention Community Based Services (CIS):**
  - The CIS team consists of 2 Therapists and 5 Youth/Family Navigators who provide in home and community supports for youth/families who are discharged after a crisis assessment being completed in the Emergency Staff.
  - Dr. David White, Child & Adolescent Psychiatrist, is our clinical lead for this
  - Goal of the program is to provide ongoing supports to assist families through their crisis by offering counseling and skills building services.
  - All services delivered are reimbursable under "Crisis Intervention" under the State Medicaid Plan. For non-Medicaid families, we continue to work with payers in terms of reimbursement.
  - In February, CIS served 24 families with short term intensive crisis supports to help them. This included:
    - Psychiatric Evaluation
    - Individual/Family Therapy
    - Navigation Services

From: abha-members-only@googlegroups.com [mailto:abha-members-only@googlegroups.com] **On Behalf Of** Tom Chard
Sent: Wednesday, February 17, 2021 4:17 PM
To: Tom Chard <tom@alaskabha.org>
Subject: Fwd: SOA Response to PHE Declaration expiry

FYI…

Alaska Behavioral Health Association
P.O. Box 32917 Juneau, Alaska 99803-32917
Tom Chard (CEO) | 907-321-5778 | tom@alaskabha.org
Jerry Jenkins (COO) | 907-317-9655 | jerry@alaskabha.org
www.alaskabha.org | www.facebook.com/akbehavioralhealth

Alaska's Behavioral Health Association (ABHA) has over 70 members including profit and non-profit, tribal and non-tribal, mental health and substance abuse treatment providers serving kids and adults across Alaska. We are continually working to improve access to quality, cost-effective treatment services. Learn more about ABHA at www.alaskabha.org.

---------- Forwarded message ---------
From: **Alaska Division of Behavioral Health** <AlaskaDHSS@public.govdelivery.com>
Date: Wed, Feb 17, 2021 at 7:56 PM
Subject: State of Alaska's Declaration of Public Health Disaster Emergency expired 2/14/2021
To: <tom@alaskabha.org>

Providers,

As of February 14, 2021, the State of Alaska's Declaration of Public Health Disaster Emergency (DD), which was in place to manage its response to COVID-19, expired. While certain authorities under the DD have expired, the Department of Health and Social Services (DHSS) is making every effort to minimize potential disruption to interactions between Alaskans and DHSS as we transition out of the DD.

Accordingly, until further instructed by the Governor or the Alaska Legislature:

1. DHSS will continue to operate its COVID-19 response under the same guidance and direction that had previously been provided, which includes all prior waived or suspended statutes and regulations.
2. DHSS will continue to manage its Medicaid program under the federal authorities outlined in the federal blanket waivers, the 1135 Waiver, and the Appendix K approvals, since those authorities are tied to the federal public health emergency and are not dependent on a state declaration.
3. DHSS will continue to work with our federal partners to ensure a smooth transition for vaccinations, therapeutics, and other critical services that DHSS had been managing under the Declaration.
4. All mitigation efforts for the health and safety of state employees will remain in effect.

The end of this disaster declaration does not mean the virus is gone and we can stop taking measures to keep ourselves and others healthy and safe. DHSS' primary concern remains the health and safety of all Alaskans, and we will continue to consider that paramount concern in our decisions as we navigate the next phase of the state's response to COVID-19.

Dr. Adrienne Pasek, Psy. D., QME
Licensed Clinical Psychologist, PSY23321
Qualified Medical Examiner
3940 Broad Street, Unit 7228
San Luis Obispo, CA 93401
(949) 201-5779
draepasek@gmail.com

OVERVIEW OF EXPERIENCE

Extensive forensic psychology expertise. Over a decade of providing neuropsychological and psychological assessments, including testing, scoring, feedback, report writing, and expert testimony. Expertise in education, corrections, law enforcement, worker compensation, disability, child custody, social services, and legal/justice areas. Experience in crisis management including stress management, suicide prevention, and post-traumatic stress disorder treatment. Proven abilities in communicating medical results, concepts, and analyses in concise easily understood language for both layperson and psychology professionals.

HIGHLIGHTS OF EXPERIENCE

February 2010-present- As an independent contractor, I routinely perform a variety of assessments including, but not limited to, psychological evaluations for autism, learning disabilities, developmental delays, child custody, law enforcement, and worker's compensation. I have performed neuropsychological evaluations for the geriatric population as well as evaluations for the California Department of Corrections and Rehabilitation as an Offender with Mentally Health Disorder evaluator and as an examiner for the California Department of Social Services Disability Determinations. As a Qualified Medical Examiner for the Department of Workers Compensation – Medical Unit, I perform medical examinations to provide expert opinion on medical condition of injured workers. I am experienced and proficient with many assessment scales routinely assessing individuals from ages 2 years and up including the geriatric population. I work closely with other professionals to ensure individuals receive the highest quality of care.

March 2015-November 2016 - I provided pre-screening assessments for applicants applying for positions with the California Department of Corrections and Rehabilitation. My duties included interviewing applicants, interpreting tests, and then writing the determination report.

October 2007-January 2010- Psychological Assistant and Organizational Development trainer, The Counseling Team International. I provided brief short-term psychotherapy as needed to individuals, couples, and families. I also provided trainings and presentations, nationwide, to law enforcement agencies and to the military. I am knowledgeable and experienced in a variety of subject areas including managing stress, suicide prevention, and Post-Traumatic Stress Disorder (PTSD) interventions. I also provided conflict

resolution assistance and training to various agencies and organizations throughout California. I also volunteered my time with a Qualified Medical Examiner to become experienced in providing assessments and testing.

March 2006- December 2009- Executive Director & Mediator, Inland Valleys Justice Center. I provided leadership in developing programs, organizational procedures, and financial plans for the Los Angeles and San Bernardino Court systems. I provided numerous mediations and arbitrations, many of which were high conflict divorces. I maintained official records and documents, and ensured compliance with federal, state and local regulations and was accountable for maintaining sound financial practices and for preparing a yearly budget that operated within budget guidelines. I also wrote many grants, all accepted, to enhance development of more programs.

August 1998-July 2004 Educational Consultant; various Charter Schools in the Sacramento area. Provided written monthly reports that included extensive documentation and the use of a database. I was a liaison, an educator, a consultant, and a counselor meeting the educational goals and objectives for each student. I developed and provided individual programs for each student, compiling data, and using strategic planning and implementation skills. I maintained customer satisfaction while balancing the legal requirements of the school district. The populations were diverse and often had the added challenges of learning English as their second language while continuing their studies.

August 1987-June 1998 Teacher, Alternative Education. Performed the regular duties and assignments of a junior high school, high school, and adult school educator. Additionally, I worked as the on-site Language Development Specialist. I developed and implemented a unique award-winning program to create a more positive learning environment, which included providing structure and regular contact with parents.

EDUCATION and CERTIFICATIONS

Qualified Medical Examiner, State of California, Department of Industrial Relations, Department of California Worker's Compensation
Psy. D., California Graduate Institute of Professional Psychology
M.A., National University, Organizational Psychology and Human Resource Management, Sacramento, California
Certificate of Mediation and Conflict Management, Professional Mediation Associates, San Raphael, California
Advanced Mediation Certificate, California Lawyers for the Arts, Malibu, California
Certificate D'Assiduite, French language competency certificate, Hyeres & Paris France
Certificate in Crisis Incident Stress Debriefing

Bartlett Regional Hospital

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

March 23, 2021 Board Report
Kevin Benson, CFO

FINANCE – Kevin Benson

- Completed interviews for the Grants Manager position. 6 candidates were interviewed and an offer extended to a very capable and qualified individual.
- Completed the FY2022 Operational and Capital budgets.
- Continuing the testing new API time clocks for installation.

HIM – Rachael Stark

- We are continuing to work on our purging process for RRC and Bartlett Regional Hospital charts.
- A new full-time person started for the Release of Information position.
- Fair Warning had a soft roll out on February 1, 2021. So far there have been no reportable breaches and the product seems to be working very well. We had another soft roll out of the next policy on March 1, 2021, for access related to neighbors. We have had no reportable breaches so far.
- We have had some issues with Meditech Expanse which was rolled out March 1, 2021. We are trying to make sure we have the same functionality as we had before.

PFS – Tami Lawson-Churchill

- Overall cash collections for the month of February was just under $6.4 Million
- Medicaid Provider Self-Audit has been completed for BRH, BOPS and RRC, and has been submitted to the State with no overpayment findings
- Price estimator tool is now available through the BRH website. We are still working to finalize all requirements related to both State and Federal regulations
- Ambulatory Expanse is LIVE and working smoothly for PFS
- MedAssets will be discontinued as of 4/1/21 and replaced with Optum CDM Expert

PAS – Angelita Rivera

- Jellyfish Update – Going LIVE with PT/OT/ST the end of the month, soft roll out March 24, 2021. New functionality will be available for patients that opt into the Jellyfish notification. Patients will get appointment notifications from their cellular device and will have the ability to update demographics, upload insurance information and provide consent for service via Jellyfish.

Case Management – Jeannette Lacey

COVID-19 – HICS Patient Tracking Unit under the Planning Section:

- We continue to work with CBJ, CCFR, and other community partners to support the needs of our unsheltered population. We have had an on-going need for quarantine and isolation in medical respite, particularly when individuals arrive from out of town and go directly to a shelter.
- Vaccines with Persons Experiencing Homelessness

- We built a tracking system in Smartsheets, the same tool we have been using to track testing and positive cases, to track vaccine doses and due dates. There were some initial challenges with providing second doses to persons experiencing homelessness, but the task force has been able to identify solutions, including support from Community Navigators, and offering clinics at shelter locations, to improve delivery.
    - Our partners with SEARHC/Front Street Clinic have taken the lead on providing the vaccine to this population and we are incredibly grateful for their efforts and commitment to ensuring these vaccines are provided.
    - As of 3/12/21, 70 first doses and 38 second doses have been provided.
    - Education about the vaccine has also been a focus area with support from CCFR and Public Health.
- Honoring anniversaries- As a department, we are having discussions about honoring what we have been through this past year.

ASHNHA Medicaid DRG work group:

- We continue to prepare for the change to Medicaid DRGs this summer, which will double the number of charts reviewed for Clinical Documentation Integrity (CDI) which impacts our quality measures and reimbursement.
- Due to this change, we are going to recruit for a second CDI specialist. We're also working with Health Information Management and 3M to ensure we have the tools needed support this change.

New Programs:

- OB Patient and Family Navigator – CM is partnering with OB and we have hired for this new position after being awarded contract funding from the State of Alaska as part of the Plans of Safe Care Initiative to provide this service. This navigator will receive referrals from community clinics, ideally as early in pregnancy as possible, to provide comprehensive support to families before, during, and after the child is born. The focus is on prevention and de-stigmatization in an effort to prevent separation of Alaskan families.
- Oncology Patient Navigator – CM is partnering with the Bartlett Medical Oncology Center to recruit for this new position. It is a much needed role to optimize the services we are providing. It will offer comprehensive support to patients and families with a potential or new diagnosis of cancer for oncology patients in SE Alaska. This position will facilitate care transitions through diagnosis, treatment, survivorship, and end-of-life care. The goal of navigation is to reduce cancer morbidity and mortality by eliminating barriers to timely access to cancer care, which may be financial, psychological, logistic, or related to communication or the health care delivery system.

Other Staffing:

- Hospitalist Coordinator- We have hired a second hospitalist coordinator in a part-time position to overlap with our full-time coordinator, which provides administrative assistance to the Hospitalist Service and the Case Management Department. This will allow us to provide additional support to the teams and weekend and vacation coverage.

IS – Scott Chille

Projects:

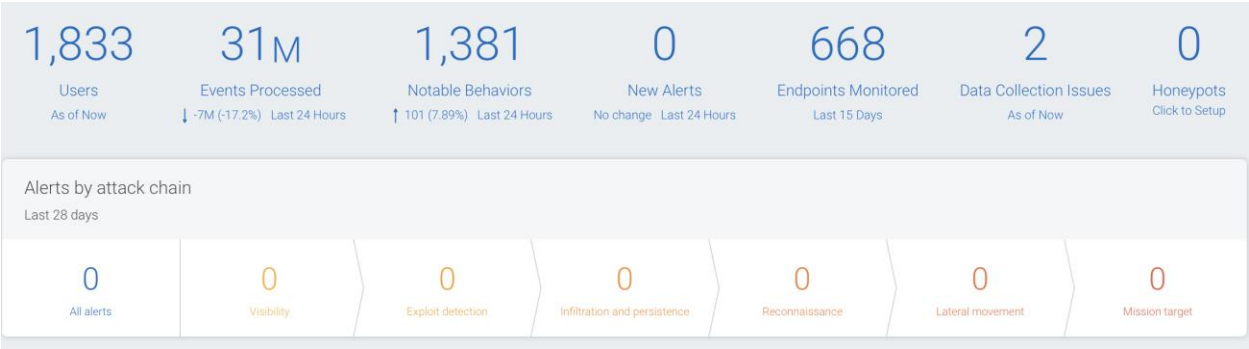
- **MEDITECH Expanse** – Go-Live in progress and **very successful** so far
- **Wireless Upgrade** - complete
- **Philips iECG (Tracemaster View)** in-progress: expected completion **April 2021**
- **Philips Intellispace Perinatal** Interface project: expected completion **May 2021**
- **Project Schedule Attached**

Department Updates:

- Still recruiting for a PACS Administrator – selected a candidate and then he backed out. Position is reposted. Interviewing another candidate Tuesday.

Information Security:

- Massive Microsoft Exchange (email) vulnerability and hack "HAFNIUM" was announced on March 2nd and a patch was released to fix the issue. We patched our systems on March 4th (our earliest opportunity) and combed through several logs to determine if we had an Indicators of Compromise (IOC's). We found that we had been scanned but **NOT compromised in any way**.
    - We have several layers of defense in place to catch any nefarious activity and none of them alerted any sort of compromise so we are confident that we have not been compromised via this threat/vulnerability combination.
- **Rapid7 Incident Detection and Response Report**
    - No MITRE ATT&CK Techniques detected in Q4 2020



- **Rapid7 Hunt Report**
    - Each month we perform an active hunt campaign starting with the presumption that we are already compromised and then look for evidence of said compromise including lateral movement, credential compromise/re-use, pivoting, malware, data exfiltration, etc.

Rapid7 MDR Hunt Report:
Bartlett Regional Hospital

Rapid7 Managed Detection and Response · February 2021

Executive Summary

The Rapid7 Managed Detection and Response (MDR) service captured hunt data from **894 endpoints** in the Bartlett Regional Hospital environment for the month of February via the InsightIDR endpoint agent. Rapid7 did not identify any indicators of compromise via hunt data during the month of February.

The MDR service relies on multiple methods of compromise detection within client environments. In addition to real-time alerting, MDR performs frequent collection of forensically-

relevant data using the InsightIDR endpoint agent to identify historical indicators of compromise and malware that cannot be captured in real-time.

- **Cybereason (Endpoint Detection and Response) Report**
  - **January**

Executive Summary

The following table shows the number of Malop detections (alerts) in your environment for the current month. Entries are separated by severity.

5 - Critical	4 - High	3 - Elevated	2 - Moderate	1 - Low	PUP
0	0	0	0	0	0

No Malop/PUPs were detected this month.

  - **February**

Executive Summary

The following table shows the number of Malop detections (alerts) in your environment for the current month. Entries are separated by severity.

5 - Critical	4 - High	3 - Elevated	2 - Moderate	1 - Low	PUP
0	0	0	0	0	0

No Malop/PUPs were detected this month.

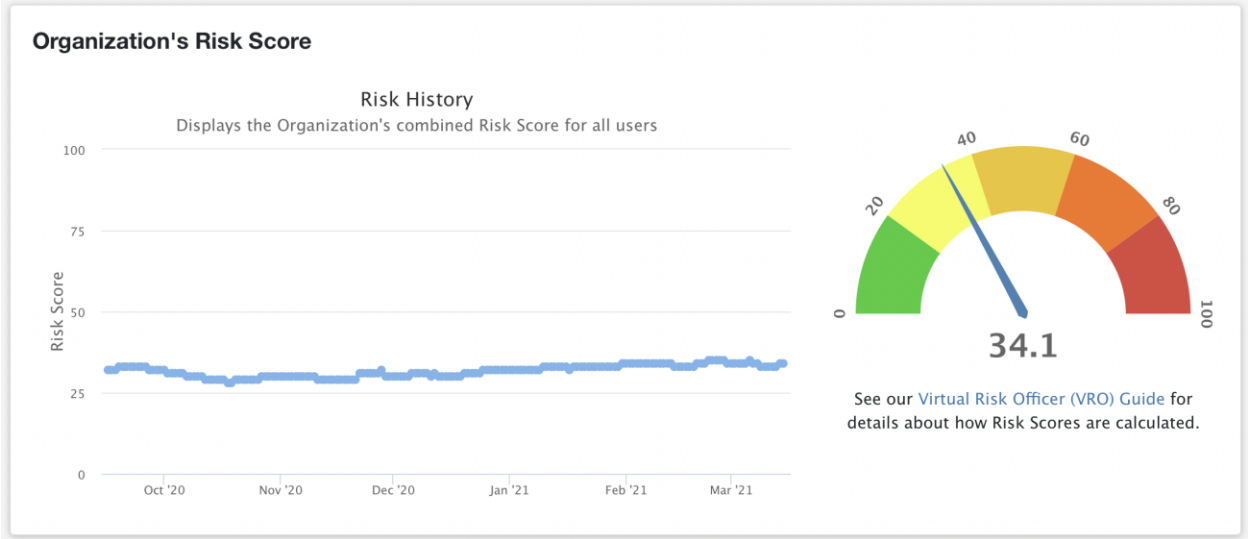
For details about root cause detection see the relevant section.

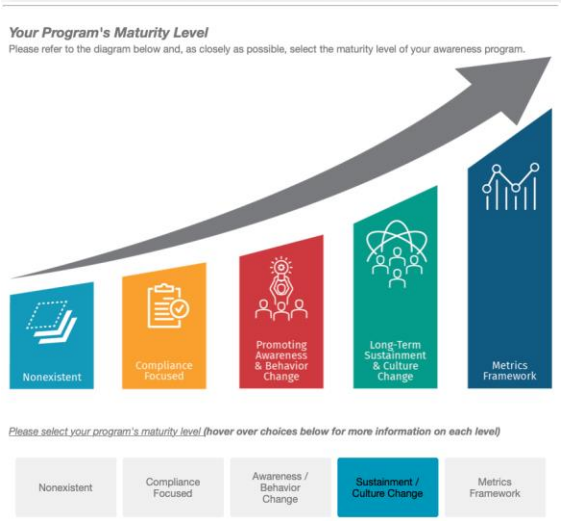
- **Attacks on Bartlett network continue to be sustained at a much higher level than one year ago**

Attacks on Bartlett Network						
	As of March-15 2020	As of Dec-5	As of Jan-08	As of Feb-08	As of Mar-08	
Per Minute	86	1020	1230	1046	1109	
Per Hour	5,160	61,200	73,800	62,760	66,540	
Per Day	123,840	1,468,800	1,771,200	1,506,240	1,596,960	
Per Week	866,880	10,281,600	12,398,400	10,543,680	11,178,720	
Per Month	3,839,040	45,532,800	54,907,200	46,693,440	49,505,760	
Per Year	45,201,600	536,112,000	646,488,000	549,777,600	582,890,400	

- New Training campaign launching this week

- Security Awareness Program has reached Long-Term Sustainment & Culture Change over the last 2-years from Non-existent/Compliance Focused in 2017-2018





April 2021

*****Until further notice: To encourage social distancing, participants wishing to join public meetings are encouraged to do so by using the video conference meeting information listed on the next page and at the top of each meeting's agenda.**

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

Committee Meeting Checkoff:
Board of Directors – 4th Tuesday every month
Board Compliance and Audit – 1st Wednesday every 3 months (Jan, April, July, Oct.)
Board Quality- 2nd Wednesday every 2 months (Jan, Mar, May, July, Sept, and Nov.)
Executive – As Needed
Finance – 2nd Friday every month

Joint Planning – As needed
Physician Recruitment – As needed
Governance – As needed
Planning – 1st Friday every month

APRIL 2021 - Bartlett Regional Hospital Board of Directors and Committee Meetings

BRH Planning Committee 12:00pm Friday, April 2nd
https://bartletthospital.zoom.us/j/94747501805
Call 1 253 215 8782 Meeting ID: 947 4750 1805

BRH Finance Committee 12:00pm Friday, April 9th
https://bartletthospital.zoom.us/j/98393405781
Call 1 253 215 8782 Meeting ID: 983 9340 5781

BRH Board of Directors Meeting 5:30pm Tuesday, April 27th
https://bartletthospital.zoom.us/j/93293926195
Call 1 253 215 8782 Meeting ID: 932 9392 6195