# Bartlett Regional Hospital

**AGENDA**
**BOARD OF DIRECTORS MEETING**
**Tuesday, September 27, 2022; 5:30 p.m.**
**Zoom Meeting**

**This virtual meeting is open to the public and may be accessed via the following link:**
https://bartletthospital.zoom.us/j/93293926195

**or call**
**1-888-788-0099 and enter webinar ID 932 9392 6195**

**I. CALL TO ORDER**

**II. ROLL CALL**

**III. APPROVE AGENDA**

**IV. PUBLIC PARTICIPATION**

**V. CONSENT AGENDA**
A. 08 23, 2022 Board of Directors Meeting Minutes (Pg.3)
B. July 2022 Financials (Pg.9)

**VI. OLD BUSINESS**
A. Covid Update – Kim McDowell
B. Family Practice Building Acquisition – Nate Rumsey

**VII. NEW BUSINESS**
A. Charity Care Program – Bob Tyk (Pg.18)
B. Medical Respite – Bob Tyk (Pg.26)
C. CEO Goals – Kenny Solomon-Gross **ACTION ITEM** (Pg.28)

**VIII. MEDICAL STAFF REPORT** - Dr. Roth

**IX. COMMITTEE MINUTES/REPORTS**
A. September 2, 2022 Draft Planning Committee Minutes – Brenda Knapp (Pg.29)
B. September 9, 2022 Draft Finance Committee Minutes – Deb Johnston (Pg.32)

**X. MANAGEMENT REPORTS**
A. CEO Report – David Keith (Pg.34)
B. CFO Report – Bob Tyk (Pg.46)
C. HR Report – Dallas Hargrave (Pg.49)
D. CCO Report – Kim McDowell (Pg.52)

E. CBHO Report – Tracy Dompeling (Pg.55)
F. Legal Report – Barbra Nault (Pg.57)

**XI. CBJ LIAISON REPORT –** Michelle Hale

**XII. PRESIDENT REPORT –** Kenny Solomon-Gross

**XIII. BOARD CALENDAR –** October 2022 (Pg.58)

**XIV. BOARD COMMENTS AND QUESTIONS**

**XV. EXECUTIVE SESSION**

A. Credentialing Report
B. September 6, 2022 Medical Staff Meeting Minutes
C. Patient Safety Dashboard
D. Legal and Litigation

*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 and, the patient safety dashboard.*

*And*

- *To discuss possible BRH litigation, specifically a candid discussion of facts and litigation strategies with the BRH and Municipal attorney. (Unnecessary staff and Medical Chief of staff may be excused from this portion of the session.)*

**XVI. ADJOURNMENT**

**NEXT MEETING –** Tuesday, October 25, 2022; 5:30 p.m.

# Bartlett Regional Hospital

**Minutes**
**BOARD OF DIRECTORS MEETING**
**August 23, 2022 – 5:30 p.m.**
**Virtual Meeting via Zoom**

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

**BOARD MEMBERS PRESENT** *(Zoom attendees italicized)*

| | | |
|---|---|---|
| Kenny Solomon-Gross, President | Brenda Knapp, Vice President | Deb Johnston, Secretary |
| *Mark Johnson* | Hal Geiger | Iola Young |
| *Max Mertz* | Lisa Petersen | *Lindy Jones, MD* |

**ALSO PRESENT** *(Zoom attendees italicized)*

| | | |
|---|---|---|
| David Keith, CEO | Bob Tyk, Interim CFO | Kim McDowell, CCO |
| Dallas Hargrave, HR Director | *Tracy Dompeling, CBHO* | *Joseph Roth, MD* |
| *Barbara Nault, Legal Advisor* | *Robert Palmer, CBJ Attorney* | *Michelle Hale, CBJ Liaison* |
| Anita Moffitt, Executive Assistant | Nathan Overson, Compliance | Nate Rumsey, Bus. Dev. |

**INTRODUCTION OF CEO –** Mr. Keith reported he had a very busy, fruitful first week. He thanked the board for allowing him to be here in this role. He has met with most of the Board members and looks forward to meetings with the rest.

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

**PUBLIC PARTICIPATION – None**

**CONSENT AGENDA –** ***MOTION by Mr. Geiger to approve the consent agenda. Ms. Knapp seconded. There being no objection, the July 26, 2022 Board of Directors Minutes, August 16, 2022 BRH & Assembly Joint Committee Minutes and the May and June 2022 Financials approved.***

**OLD BUSINESS**

**Covid-19 Update -** Ms. McDowell reported 2 Covid positive patient in house. One is an incidental finding and neither are on ventilators. 8 employees out with Covid, this is the lowest number of employee positivity we've had in a while. PPE and testing supplies are good. Staffing is short but is not Covid related.

**Family Practice Building Acquisition –** Mr. Solomon-Gross reported the BRH and Assembly Joint Committee met last week to discuss the acquisition of the Family Practice building and have sent it back to the Board for action. Ms. Knapp expressed her support for moving forward with the purchase. Reasons: It would allow BRH to have a presence in the Valley, protect the local practice currently in the building, address some of our needs for space to possibly expand our services or provide housing. It seemed that the Assembly would support a zoning change to allow more flexibility in the use of this property. Mr. Johnson questioned whether costs for maintenance, upgrades and parking needs had been considered. Mr. Solomon-Gross stated the underground tank is the biggest issue identified and the seller would take care of it, the other issues are minor. Mr. Johnston raised the question about the need for a Certificate of Need (CON) and what BRH is planning to use the property for. If BRH purchases the property to act as a landlord, a CON would not be needed as no beds are being added and it is under the $1.5 Million

threshold. A review would need to be conducted if other medical services are to be considered. Dr. Jones said the benefits outweigh any potential issues and a decision should be made to move forward with the purchase. Mr. Mertz and Ms. Johnston agreed. Discussion held about what we can and can't do based on the zoning of the property. Mr. Johnson and Ms. Young expressed concern that there are better ways to spend the money for BRH and the community than buying this property. Mr. Johnson initiated discussion about where the physicians currently in the building would go if not allowed to stay in their current location. Dr. Jones stated his opinion that there is a high probability Family Practice would disband as there is nowhere for the providers to go that would not require a very large investment in remodeling a new location. Discussion held about rent; all tenants must pay fair market value. Ms. Petersen expressed concern for the number of patients that would be displaced if a local medical practice closed. She also noted the rents BRH would collect will help offset the cost of buying the property. Mr. Mertz requested a motion be made before further discussion.

***MOTION by Ms. Johnston that BRH move forward with the purchase of the Family Practice building located in the valley. Ms. Knapp seconded.***

Mr. Keith stated it's an interesting conundrum and not ideal. From a strategic standpoint, BRH needs opportunity space in order to move forward as it currently has zero space available to be able to expand. With BRH's current space shortage, this property could probably be put into use immediately. He suggested that perhaps there is an opportunity with those physicians as well as BRH has no primary care strategy. Physician employment models are growing and whoever owns primary care, owns the physician landscape in the growth opportunities.

Mr. Johnson stated this purchase was not part of the Master Facility Plan and expressed concern that if we purchase this property to assist these providers, we would be setting precedence for assisting other providers in the future.

Mr. Solomon-Gross requested a roll call vote be taken to move forward with the purchase of the Family Practice building. **MOTION approved by a 7-2 vote. (**Mr. Solomon-Gross, Ms. Knapp, Ms. Johnston, Mr. Geiger, Mr. Mertz, Ms. Petersen and Dr. Jones voted yes. Mr. Johnson and Ms. Young voted no.)

**NEW BUSINESS**

**Land Acknowledgement –** Mr. Solomon-Gross stated land acknowledgements are made at the beginning of School Board and Assembly meetings. Ms. Young feels a land acknowledgement is very important and a meaningful way to show respect to the indigenous people. An ad-hoc committee will be formed. It will be charged to hold meetings to gather public comment and to bring a recommendation back to the full Board for consideration. Mr. Geiger volunteered to chair this committee, Erin Hardin will be the BRH staff representative. Mr. Solomon-Gross and Mr. Geiger will meet tomorrow to discuss who else should be on the committee. Mr. Solomon-Gross thanked Ms. Young for bringing this matter to his attention.

**MRI & CT Replacement Appropriations Request** – Mr. Tyk reported the bids for the MRI & CT replacement project have come in much higher than the architect's estimates (estimate $1.4M, costs $3.5M). Staff requests the Board recommend an approval of an appropriation request of an additional $1,185,900 for this project to be funded from BRH Fund Balance. If approved, it will be forwarded to the CBJ Public Works and Facilities Committee and the CBJ Assembly for approval. ***MOTION by Ms. Johnston that the Board approve the increase in the estimated costs, based on the lowest bid received, and move the request for the additional $1,185,900 to the Assembly for approval. Ms. Knapp seconded.*** Mr. Keith asked why the over run and if this is a systemic challenge here. Mr. Tyk reported the estimators believe the inflated bids are due to a combination of subcontractors bidding the project are busy with other projects at the moment. The cost of materials also continues to increase. Mr. Solomon-Gross requested a roll call vote. ***MOTION* to request the Assembly approve an appropriation of an additional $1,185,900 for the MRI & CT replacement project unanimously approved.**

**MEDICAL STAFF REPORT –** Dr. Roth had left the meeting and was unavailable to give a report. Dr. Jones reported August 2nd Medical Staff meeting was business as usual.

**COMMITTEE REPORTS**:

**Planning Committee –** Minutes from the August 9th meeting in the packet. Ms. Knapp reported these meetings are very informative and all Board members are encouraged to attend when able to do so. An action item came out of the last meeting for the Board to conceptually approve staff's recommendation of developing the 3rd OR suite. Staff is to bring relative costs, timelines and cost benefit information to the Planning and Finance Committees for consideration and a final recommendation to the Board. BRH currently has 2 ORs in operation, a 3rd is used for storage of supplies and equipment. The Master Facility plan included a project to replace lights and booms in the 2 operational ORs. Rather than doing this project now and pulling everything out again in the future, a recommendation has been made for renovation of the 3rd OR and installation of lights, booms and electrical upgrades in all 3 surgical suites. These electrical upgrades would allow us to prepare for the inevitable changes of the future, such as robotic surgery. A 3rd OR would allow more services to bring in more revenue and will also allow us to continue to have two operational ORs available while one is shut down for the work to be done ***MOTION by Ms. Knapp on behalf of the Planning Committee that the Board approve the concept of moving forward with the development of a third OR, understanding we already have the space that will need to be cleaned out to serve this purpose.*** Staff will come back with cost estimates, timelines and cost benefit information. Ultimately, staff will present information about equipment, such as robotics. It was noted that leasing options no longer require purchasing robots. Mr. Keith stated his opinion that in terms of robotics, a conceptual idea is a great start as a service line approach. Dr. Jones expressed concern about the ability to staff a 3rd OR and what the surgeons' demands would be for OR time. Discussion held about the motion. Mr. Geiger questioned if a motion is needed since it is an operations matter. Ms. Knapp stated staff had requested the Board's conceptual approval before they expended a lot of manpower on it. Mr. Solomon-Gross supports conceptually approving the idea of accepting the recommendation of developing a 3rd OR. Mr. Mertz suggests Mr. Solomon-Gross and Mr. Keith determine the process for bringing these types of thing forward in the future. **There being no further discussion and no objections, *MOTION* approved.**
Ms. Knapp reported information about the delays for the ED expansion project are in the Planning Committee minutes included in the packet. The request to use the GC/CM (General Contractor/Construction Manager) procurement process has not gone before the Assembly for approval yet due to Mr. Palmer's recommendation to wait for the determination of the Certificate of Need (CON). Mr. Keith reported we have received a determination that a CON is not required for the Behavioral Health building but have not received a determination for the ED expansion project.

**Finance Committee** – Ms. Johnston reported the minutes from the August 12th meeting, included in the packet, accurately reflect the discussions from the meeting. She noted that bad debt is much higher than any other year we've had. This will be looked at closely to determine why. As we go through the audit process we'll get a better understanding. In response to Mr. Solomon-Gross, Mr. Tyk reported we are working with CBJ on an RFP to get a third party to help us collect bad debt. Questions about outsourcing self-pay are still coming in from interested parties to clarify what we are looking for. We hope to have all questions answered and responses to the RFP back in a couple of weeks. Ms. Johnston explained that the purpose for outsourcing self-pay is for collecting payment. Bad debt on the financial statements don't necessarily relate to collections. Bad debt expense is an estimate of what we think we won't be able to collect and will be favorably affected if we improve our collections. Clarification provided that we are not looking for a collection agency, we are looking for help in processing self-pay accounts. (BRH has 6,200 self-pay accounts and only one person processing them.)

**Board Compliance and Audit Committee –** Ms. young reported minutes from the August 19th meeting in the packet are accurate. She is very pleased with what the committee has been able to accomplish over the last few months. The 340B Oversight Committee is up and functioning as is the New Service Line Committee.
Mr. Keith introduced Nate Rumsey. Mr. Rumsey is the newly hired Business Development Analyst. He will assist Mr. Keith, the Planning Committee and others with service line development, strategic planning and other things of that nature. Mr. Rumsey thanked the Board and Senior Leaders for allowing him to speak. He expressed appreciation for the opportunity to be on board and able to support BRH in moving ahead with strategic initiatives. It's been a good first

month and he looks forward to learning more about the hospital and seeing how we can expand into the future. He is recently retired from the Coast Guard with a background in engineering, project management and process improvement.

**MANAGEMENT REPORTS:**

**Legal Report –** Ms. Nault reported the following: Since the last meeting, the 340B pharmacy contract voluntary disclosure is essentially complete; letters have been sent to all of the affected manufacturers with proposed repayments, a 90-day status report submitted to HRSA and another to be submitted in 90 days. Mr. Overson is working with pharmacy and finance on this project. Her firm continues to work with Senior Leadership, Contract Manager and Director of Physician Services as needed on various services agreements for different specialties. Working with CBJ Law on an amendment to the Applied Behavioral Analyst services agreement with the Juneau School District. Working with Behavioral Health, Compliance and CBJ Law related to parental consent issues for hospital admissions of minors. Working with Behavioral Health on a proposed arrangement for physician oversight services. Finished negotiating a third party agreement for a consultant to review the Medical Staff Services office processes and are working with Contract Manager and Senior Quality Director on an additional external peer review resource. Mr. Mertz obtained confirmation that BRH did a self-disclosure for 340B and that HRSA reviewed the corrective action plan and made no requests to modify it. The 340B Oversite Committee has been implementing the plan. Ms. Nault will provide a copy of the corrective action plan included in the letter submitted to HRSA. Mr. Overson identified the members of the 340B Oversite Committee. A request made to include those names in his report for next month's Board meeting.
Mr. Palmer thanked Ms. Nault for all of her work. He had nothing to add to the Family Practice Building and Certificate of Need topics already discussed. There will be more to report on these topics at a later date.

In response to Mr. Mertz, Mr. Overson reported there are two parts to the 340B program. The internal pharmacy function has worked well for years and we will continue to move forward with it. The contract pharmacy portion of the 340B program began in 2019. Through monitoring and auditing of that portion of the program, it was determined that there were some challenges that caused us to pause and take a look at corrective action. It is still undetermined whether we will continue with the third party, contract pharmacy portion. Mr. Keith will have discussions with Mr. Overson and others about the risk vs. reward and a decision will be made. Mr. Solomon-Gross expressed thanks and appreciation for Ms. Nault's assistance in navigating issues last month while Mr. Palmer was out of town and prior to Mr. Keith's arrival.

**HR Report** – Mr. Hargrave highlighted traveler utilization from his report. Traveler pay strategy changed in December 2021 to keep up with the national average and to keep us competitive. Traveler pay is slowly starting to come down and we are trying to hire more permanent staff. He reported that he and Mr. Tyk are conducting initial interviews for a permanent CFO. The next step in the recruitment process is to schedule candidate interviews with Senior Leadership. In response to Mr. Mertz, he reported we are advertising in HFMA, Indeed.com, LinkedIn and AHHA (Alaska Hospital and Healthcare Association). There is some internal head hunting being done but we have not engaged with an external head hunter or recruitment agency. We do have a consultant conducting an analysis for executive pay but pay is negotiable and will depend on experience. Mr. Mertz stated he would like to see a program implemented that targets former Juneau youth and residents to come back and fill vacant positions.

**CCO Report** – Mr. Geiger requested clarification about the downtime solution noted in Ms. McDowell's report. This is a repository that allows patient data to be accessed when Meditech is off line. Mr. Solomon-Gross thanked her for her thorough report.

**CBHO Report –** Ms. Dompeling reported we have received a letter from the Commissioner's Officer confirming that we do not need a CON for the Crisis Care Center (CCC). Agnew : Beck was on site, lots of discussion with key leaders throughout BRH talking about programming and service development. Internal discussions held about staffing levels needed to provide service, HR and Finance are reviewing a spreadsheet with all positions to help determine salaries. Along with this information, Agnew : Beck will look at the services for which we will be able to bill and the rate of reimbursement for services to give us a financial oversite for what we are looking at for the CCC. She hopes to have accurate numbers available by next month's meeting. Discussion held about ways to entice applicants. Recruitment will start no later than October.

**CFO Report** – Mr. Tyk reported the finance department is currently short staffed and we are a little behind on closing out the month of July. Sam Muse has replaced Blessy Robert as the Controller, the Grant Accountant and Senior Accountant have left to work for SEARHC and the Accounts Payable person is now the CFO's assistant. (She is currently filling both

roles until her replacement comes on board mid-September.) Interview of Senior Accountant applicant scheduled. These issues are not affecting the audit preparation as Ms. Robert had been doing a lot of that remotely. Preliminary field work by the auditors had been done about 1.5 months ago. The audit is scheduled to begin on September 6th. Mr. Mertz initiated discussion about why the two accountants went to work for SEARHC. Mr. Tyk is confident that Mr. Muse is going to be able to shape this department so it becomes more than it's ever been. Mr. Mertz stated it's important for the new CFO to have a focus on returning BRH to being a preferred place of employment. Stable accounting functions are critical to operations. Mr. Geiger received clarification that MCR is Medicare and MCD is Medicaid. He initiated discussion about case mix index. The case mix index changes reimbursement every month. In response to Ms. Knapp, Mr. Hargrave reported we have an RFP (Request for Proposals) for a 3rd party to conduct a competitive wage analysis as part of our retention strategy. Discussion held about an early out program for self-pay accounts, self-pay discounts, service rates and patient leakage. Dr. Jones stated that JEMA (Juneau Emergency Medical Associates) has been working collaboratively with BRH on its charity care program; Mr. Tyk will provide an update about this program at next month's Board meeting.

**CEO Report** – Mr. Keith reported he's had a lot of meetings with physicians, community leaders, Board members, Senior Leaders, management staff, etc. Through the very welcoming community, he has learned they want a stronger hospital with more local services. He stated that BRH leaders and staff need to put their attention on BRH, he and the Board will handle the concerns with SEARHC. He has requested data to help determine why there is a problem with staff recruitment and retention. He will look for opportunities to bring the medical community and BRH back into alignment. Leadership team and staff will work with the Planning Committee to enhance the strategic plan and add some refinements. An operational plan will be built to support the strategic plan. He observed that Senior Leadership is adjusting to his management style. They are eager to engage and want to be more proactive. Managers are still nervous with a wait and see attitude. There is a lot of positive energy and they are looking to Senior Leadership for guidance. He thinks some of the Board members are nervous as well. His goal is to build trust that we can bring solutions to the table to build consensus and move forward. There is a lot of opportunity for improvement but BRH is not as broken you think. He thanked the Board for allowing him to be here. Mr. Solomon-Gross expressed appreciation for Mr. Keith's efforts so far.

**CBJ LIAISON REPORT –** Ms. Hale welcomed Mr. Keith and thanked him for his clear, honest style. She stated BRH has a well-functioning Board and expressed appreciation for the questions they have been asking. She reported she and her mother were very impressed by the follow-up care provided to her mother after her Covid experience. Ms. McDowell will share Ms. Hale's appreciation with the staff.

**PRESIDENT REPORT –** Mr. Solomon-Gross is excited to attend the Leadership Conference with other Board members, Mr. Keith and Ms. McDowell. Kim Russel will also be in attendance. Ms. Knapp reported that every year is different. The most current information regarding the health care industry will be provided. Board members split up to attend different sessions and gather at dinner to share what they've learned. Mr. Solomon-Gross highlighted that he has written a letter of support for CBJ's Safe Streets (included in the packet). He thanked Ms. McDowell for providing the data included in the letter.

**BOARD CALENDAR –** September calendar reviewed. The Quality meeting will be deferred until October. A Governance Committee meeting will be determined at Thursday's Governance meeting. Mr. Solomon-Gross and Mr. Geiger will discuss the ad-hoc Committee tomorrow.

**BOARD COMMENTS AND QUESTIONS** – Mr. Geiger expressed thanks to the BRH staff and Valley Medical Staff for bringing his new granddaughter into the world. Mr. Mertz thanked Ms. Young for writing "The Hospital". He was very pleased to read it as it speaks to the challenges BRH is facing. He feels very strongly that there is a need for BRH to be an independent hospital and that the Board needs to focus on what we need to do to remain independent long term.

**EXECUTIVE SESSION** – ***MOTION by Mr. Geiger to recess into executive session to discuss several matters as written in the agenda:***

- *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 and, the patient safety dashboard.*

*And*

- *To discuss possible BRH litigation, specifically a candid discussion of facts and litigation strategies with the BRH and Municipal attorney. (Unnecessary staff and Medical Chief of staff may be excused from this portion of the session.)*

*And*

- *To discuss information presented that the immediate knowledge of which would clearly have an adverse effect upon the finances of BRH; that being a discussion about campus planning. (Unnecessary staff and Medical Chief of staff may be excused from this portion of the session.)*

***Ms. Johnston* seconded.** Mr. Solomon-Gross reminded attendees that all information to be discussed in executive session is confidential. Attendees are to ensure there are no unauthorized people in the room with them or able to hear the conversations.

The Board entered executive session at 8:06 p.m. after a 5-minute recess. They returned to regular session at 8:16 p.m.

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

**ADJOURNMENT:** 8:16 p.m.

**NEXT MEETING:** 5:30 p.m. – Tuesday, September 27, 2022

To: BRH Finance Committee
From: Robert C. Tyk, FHFMA
Interim Chief Financial Officer

**Re: July Financial Performance**

I am changing the format of my monthly report for the new fiscal year. The report now will have an overview, then the income statement review, balance sheet review and then the dashboard and financial indicators. This will facilitate a better flow during the Finance Committee meeting.

## Overview

The month of July began the new fiscal year as a bust. July is the third month in a row where Bartlett Regional Hospital (BRH) lost over a million dollars…$1,448,768 to be exact. Volumes were for the most part, at or slightly above the budget and better than the prior year. Gross revenues continue to run in the $18-million-dollar range but deductions from revenue and expenses continue to undermine the gross revenue numbers.

## Income Statement

Hospital inpatient and outpatient gross revenues stayed in the same ranges as they have been for the past five months. Gross revenues from BH services decreased while the physician revenues increased significantly. As has been mentioned In prior months, the physician revenue number is tied to the inpatient behavioral health services which is not an accurate classification that will be corrected in the coming months.

Deductions from revenue as a percentage of gross patient revenue grew again to over 50%. As was mentioned last month, bad debt is a calculation based on accounts receivables which grew again in the month of July. Until we can release more Medicaid claims being held for the NDC number issue, this will continue to run at a higher rate.

Salaries/contract labor and benefits though lower than last months on a pure dollar amount, had a higher percentage of total operating revenue. This is a result of the total operating revenue decreasing FTE count is higher than it could

be but we will never know by how much until BRH has a true productivity system by which we can measure ourselves against it. We are currently looking for such a system. The balance of the expenses for the most part were less than what was budgeted.

**Balance Sheet**

The balance sheet showed some significant changes in July. Cash and cash equivalents increased along with Bonds Payable as the new bond was booked for BRH. Now the cash number is a bit more robust.

Patient AR also increased as was mentioned above because we are still holding a large number of Medicaid claims due to the issue with correct NDC numbers. We were informed by our IT department that the fix has gone through test and was moved to live where PFS staff will be reviewing the fixes. Claims should go out next week which will cause the Patient AR to decrease in September.

Prepaid expenses also increased from prior months though they consistently run in the $3 million range.

**Dashboard/Financial Indicators**

On the Dashboard report, the volumes for the most part are comparable to the budget and a bit better than the prior year numbers. One number sticks out as an anomaly and that is Radiology tests. This will be investigated.

On the Financial Indicators page, we can see the increase in Days cash on hand from the booking of the bond issue. Days in AP are good at 37.5 days.

At the bottom of the report we can see that DNFB and DNSP are both above the benchmark again because of the Medicaid claims being held. We will be reviewing the benchmarks in the next few months and making some changes to what is measured and more than likely to the benchmark since these numbers are fairly old.

**Conclusion**

Some of the same issues that have plagued BRH in the past, continue to be an issue. Mr. Keith has shown that he understands where an organization such as BRH needs to be and will be putting plans in place to make the needed changes.

Respectfully submitted

BARTLETT REGIONAL HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
FOR THE MONTH AND YEAR TO DATE OF JULY 2022

| 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: | | | | | | |
| $4,215,688 | $5,032,805 | -$817,117 | -16.2% | $4,061,506 | 1. | Inpatient Revenue | $4,215,688 | $5,032,805 | -$817,117 | -16.2% | $4,061,506 | 3.8% |
| $1,140,316 | $1,315,215 | -$174,899 | -13.3% | $1,088,109 | 2. | Inpatient Ancillary Revenue | $1,140,316 | $1,315,215 | -$174,899 | -13.3% | $1,088,109 | 4.8% |
| $5,356,004 | $6,348,020 | -$992,016 | -15.6% | $5,149,615 | 3. | Total Inpatient Revenue | $5,356,004 | $6,348,020 | -$992,016 | -15.6% | $5,149,615 | 4.0% |
| $11,360,235 | $11,691,512 | -$331,277 | -2.8% | $10,954,397 | 4. | Outpatient Revenue | $11,360,235 | $11,691,512 | -$331,277 | -2.8% | $10,954,397 | 3.7% |
| $16,716,239 | $18,039,532 | -$1,323,293 | -7.3% | $16,104,012 | 5. | Total Patient Revenue - Hospital | $16,716,239 | $18,039,532 | -$1,323,293 | -7.3% | $16,104,012 | 3.8% |
| $182,885 | $262,822 | -$79,937 | -30.4% | $277,165 | 6. | RRC Patient Revenue | $182,885 | $262,822 | -$79,937 | -30.4% | $277,165 | -34.0% |
| $199,460 | $493,818 | -$294,359 | -59.6% | $379,236 | 7. | BHOPS Patient Revenue | $199,460 | $493,818 | -$294,359 | -59.6% | $379,236 | -47.4% |
| $1,205,276 | $1,202,027 | $3,249 | 0.3% | $887,205 | 8. | Physician Revenue | $1,205,276 | $1,202,027 | $3,249 | 0.3% | $887,205 | 35.9% |
| $18,303,860 | $19,998,199 | -$1,694,340 | -8.5% | $17,647,618 | 9. | Total Gross Patient Revenue | $18,303,860 | $19,998,199 | -$1,694,340 | -8.5% | $17,647,618 | 3.7% |
| | | | | | | Deductions from Revenue: | | | | | | |
| $3,188,205 | $3,095,143 | -$93,062 | -3.0% | $2,926,642 | 10. | Inpatient Contractual Allowance | $3,188,205 | $3,095,143 | -$93,062 | -3.0% | $2,926,642 | 8.9% |
| -$350,000 | -$350,000 | $0 | | -$308,333 | 10a. | Rural Demonstration Project | -$350,000 | -$350,000 | $0 | | -$308,333 | |
| $4,768,716 | $4,660,180 | -$108,536 | -2.3% | $3,209,053 | 11. | Outpatient Contractual Allowance | $4,768,716 | $4,660,180 | -$108,536 | -2.3% | $3,209,053 | 48.6% |
| $719,575 | $591,002 | -$128,573 | -21.8% | $532,233 | 12. | Physician Service Contractual Allowance | $719,575 | $591,002 | -$128,573 | -21.8% | $532,233 | 35.2% |
| $25,242 | $25,480 | $238 | 0.9% | $27,490 | 13. | Other Deductions | $25,242 | $25,480 | $238 | 0.9% | $27,490 | 0.0% |
| $64,841 | $121,457 | $56,616 | 46.6% | $68,924 | 14. | Charity Care | $64,841 | $121,457 | $56,616 | 46.6% | $68,924 | -5.9% |
| $766,855 | $297,203 | -$469,652 | -158.0% | $494,245 | 15. | Bad Debt Expense | $766,855 | $297,203 | -$469,652 | -158.0% | $494,245 | 55.2% |
| $9,183,434 | $8,440,465 | -$742,969 | -8.8% | $6,950,254 | 16. | Total Deductions from Revenue | $9,183,434 | $8,440,465 | -$742,969 | -8.8% | $6,950,254 | 32.1% |
| *45.5%* | *41.7%* | | | *37.8%* | | *% Contractual Allowances / Total Gross Patient Revenue* | *45.5%* | *41.7%* | | | *36.0%* | |
| *4.5%* | *2.1%* | | | *3.2%* | | *% Bad Debt & Charity Care / Total Gross Patient Revenue* | *4.5%* | *2.1%* | | | *3.2%* | |
| *50.2%* | *42.2%* | | | *39.4%* | | *% Total Deductions / Total Gross Patient Revenue* | *50.2%* | *42.2%* | | | *39.4%* | |
| $9,120,426 | $11,557,734 | -$2,437,309 | -21.1% | $10,697,364 | 17. | Net Patient Revenue | $9,120,426 | $11,557,734 | -$2,437,309 | -21.1% | $10,697,364 | -14.7% |
| $365,270 | $385,034 | -$19,764 | -5.1% | $384,737 | 18. | Other Operating Revenue | $365,270 | $385,034 | -$19,764 | -5.1% | $384,737 | -5.1% |
| $9,485,696 | $11,942,768 | -$2,457,072 | -20.6% | $11,082,101 | 19. | Total Operating Revenue | $9,485,696 | $11,942,768 | -$2,457,073 | -20.6% | $11,082,101 | -14.4% |
| | | | | | | Expenses: | | | | | | |
| $4,400,364 | $4,919,528 | $519,164 | 10.6% | $4,287,441 | 20. | Salaries & Wages | $4,400,364 | $4,919,528 | $519,164 | 10.6% | $4,287,441 | 2.6% |
| $267,548 | $441,174 | $173,626 | 39.4% | $340,047 | 21. | Physician Wages | $267,548 | $441,174 | $173,626 | 39.4% | $340,047 | -21.3% |
| $633,674 | $79,325 | -$554,349 | -698.8% | $260,085 | 22. | Contract Labor | $633,674 | $79,325 | -$554,349 | -698.8% | $260,085 | 143.6% |
| $2,374,084 | $2,634,592 | $260,509 | 9.9% | $2,391,791 | 23. | Employee Benefits | $2,374,084 | $2,634,592 | $260,509 | 9.9% | $2,391,791 | -0.7% |
| $7,675,670 | $8,074,619 | $398,950 | 4.9% | $7,279,364 | | | $7,675,670 | $8,074,619 | $398,950 | 4.9% | $7,279,364 | 5.4% |
| 80.9% | 67.6% | | | 65.7% | | % Salaries and Benefits / Total Operating Revenue | 80.9% | 67.6% | | | 65.7% | |
| $38,713 | $74,616 | $35,903 | 48.1% | $47,612 | 24. | Medical Professional Fees | $38,713 | $74,616 | $35,903 | 48.1% | $47,612 | -18.7% |
| $326,821 | $406,221 | $79,400 | 19.5% | $370,966 | 25. | Physician Contracts | $326,821 | $406,221 | $79,400 | 19.5% | $370,966 | -11.9% |
| $221,282 | $224,542 | $3,260 | 1.5% | $115,394 | 26. | Non-Medical Professional Fees | $221,282 | $224,542 | $3,260 | 1.5% | $115,394 | 91.8% |
| $1,305,218 | $1,341,083 | $35,865 | 2.7% | $1,578,544 | 27. | Materials & Supplies | $1,305,218 | $1,341,083 | $35,865 | 2.7% | $1,578,544 | -17.3% |
| $121,693 | $149,550 | $27,857 | 18.6% | $126,518 | 28. | Utilities | $121,693 | $149,550 | $27,857 | 18.6% | $126,518 | -3.8% |
| $426,346 | $420,978 | -$5,368 | -1.3% | $422,017 | 29. | Maintenance & Repairs | $426,346 | $420,978 | -$5,368 | -1.3% | $422,017 | 1.0% |
| $86,650 | $67,006 | -$19,644 | -29.3% | $51,930 | 30. | Rentals & Leases | $86,650 | $67,006 | -$19,644 | -29.3% | $51,930 | 66.9% |
| $74,882 | $80,114 | $5,232 | 6.5% | $81,323 | 31. | Insurance | $74,882 | $80,114 | $5,232 | 6.5% | $81,323 | -7.9% |
| $594,379 | $667,571 | $73,192 | 11.0% | $610,049 | 32. | Depreciation & Amortization | $594,379 | $667,571 | $73,192 | 11.0% | $610,049 | -2.6% |
| $32,973 | $112,179 | $79,206 | 70.6% | $49,359 | 33. | Interest Expense | $32,973 | $112,179 | $79,206 | 70.6% | $49,359 | -33.2% |
| $93,683 | $149,128 | $55,445 | 37.2% | $126,611 | 34. | Other Operating Expenses | $93,683 | $149,128 | $55,445 | 37.2% | $126,611 | -26.0% |
| $10,998,310 | $11,767,607 | $769,298 | 6.5% | $10,859,687 | 35. | Total Expenses | $10,998,310 | $11,767,607 | $769,298 | 6.5% | $10,859,687 | -1.3% |
| -$1,512,614 | $175,161 | -$1,687,775 | -963.6% | $222,414 | 36. | Income (Loss) from Operations | -$1,512,614 | $175,161 | -$1,687,775 | -963.6% | $222,414 | -780.1% |
| | | | | | | Non-Operating Revenue | | | | | | |
| $1,988 | $45,124 | -$43,136 | -95.6% | $100,378 | 37. | Interest Income | $1,988 | $45,124 | -$43,136 | -95.6% | $100,378 | -98.0% |
| $61,858 | $63,351 | -$1,493 | -2.4% | $132,744 | 38. | Other Non-Operating Income | $61,858 | $63,351 | -$1,493 | -2.4% | $132,744 | -53.4% |
| $63,846 | $108,475 | -$44,629 | -41.1% | $233,122 | 39. | Total Non-Operating Revenue | $63,846 | $108,475 | -$44,629 | -41.1% | $233,122 | -72.6% |
| -$1,448,768 | $283,636 | -$1,732,404 | -610.8% | $455,536 | 40. | Net Income (Loss) | -$1,448,768 | $283,636 | -$1,732,404 | -610.8% | $455,536 | 418.0% |
| -15.95% | 1.47% | | | 2.01% | | Income from Operations Margin | -15.95% | 1.47% | | | 2.01% | |
| -15.27% | 2.37% | | | 4.11% | | Net Income | -15.27% | 2.37% | | | 4.11% | |

BARTLETT REGIONAL HOSPITAL
12 MONTH ROLLING INCOME STATEMENT
FOR THE PERIOD JULY 21 THRU JULY 22

| | July-21 | August-21 | September-21 | October-21 | November-21 | December-21 | January-22 | February-22 | March-22 | April-22 | May-22 | June-22 | July-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gross Patient Revenue: | | | | | | | | | | | | | |
| 1. Inpatient Revenue | $4,061,506 | $3,831,558 | $4,824,972 | $4,387,111 | $3,192,673 | $3,672,150 | $4,412,846 | $3,829,268 | $3,872,858 | $3,587,976 | $3,929,079 | $3,968,043 | $4,215,688 |
| 2. Inpatient Ancillary Revenue | $1,088,109 | $1,169,065 | $1,337,900 | $1,212,281 | $950,044 | $1,073,788 | $1,160,613 | $981,373 | $1,081,410 | $1,096,773 | $928,481 | $1,049,117 | $1,140,316 |
| 3. Total Inpatient Revenue | $5,149,615 | $5,000,623 | $6,162,872 | $5,599,392 | $4,142,717 | $4,745,938 | $5,573,459 | $4,810,641 | $4,954,268 | $4,684,749 | $4,857,560 | $5,017,160 | $5,356,004 |
| 4. Outpatient Revenue | $10,954,397 | $11,142,418 | $10,874,045 | $11,722,594 | $9,976,299 | $11,143,687 | $10,491,837 | $10,234,016 | $11,452,789 | $11,222,953 | $11,601,673 | $11,242,830 | $11,360,235 |
| 5. Total Patient Revenue - Hospital | $16,104,012 | $16,143,041 | $17,036,917 | $17,321,986 | $14,119,016 | $15,889,625 | $16,065,296 | $15,044,657 | $16,407,057 | $15,907,702 | $16,459,233 | $16,259,990 | $16,716,239 |
| 6. RRC Patient Revenue | $277,165 | $300,261 | $277,183 | $227,844 | $166,861 | $252,501 | $190,248 | $243,856 | $211,413 | $208,848 | $249,944 | $196,884 | $182,885 |
| 7. BHOPS Patient Revenue | $379,236 | $355,268 | $434,612 | $387,400 | $413,225 | $574,433 | $406,510 | $391,780 | $624,646 | $390,417 | $456,653 | $529,944 | $199,460 |
| 8. Physician Revenue | $887,205 | $1,182,691 | $856,222 | $1,142,756 | $827,856 | $854,494 | $775,989 | $898,164 | $897,198 | $1,060,736 | $1,076,229 | $862,360 | $1,205,276 |
| 9. Total Gross Patient Revenue | $17,647,618 | $17,981,261 | $18,604,934 | $19,079,986 | $15,526,958 | $17,571,053 | $17,438,043 | $16,578,457 | $18,140,314 | $17,567,703 | $18,242,059 | $17,849,178 | $18,303,860 |
| Deductions from Revenue: | | | | | | | | | | | | | |
| 10. Inpatient Contractual Allowance | $2,843,309 | $2,716,381 | $3,185,293 | $2,260,163 | $2,917,302 | $2,807,374 | $3,082,649 | $2,671,339 | $2,791,603 | $2,490,383 | $2,972,366 | $3,105,403 | $3,188,205 |
| 10a. Rural Demonstration Project | -$225,000 | -$225,000 | -$225,000 | -$725,000 | -$350,000 | -$350,000 | -$350,000 | -$350,000 | -$350,000 | -$350,000 | -$350,000 | -$350,000 | -$350,000 |
| 11. Outpatient Contractual Allowance | $3,209,053 | $4,163,123 | $4,822,166 | $5,351,541 | $4,414,193 | $4,173,471 | $4,207,232 | $4,270,949 | $4,780,143 | $4,827,998 | $4,860,343 | $5,284,968 | $4,768,716 |
| 12. Physician Service Contractual Allowance | $532,233 | $627,808 | $544,518 | $586,628 | $547,175 | $475,883 | $452,923 | $494,154 | $515,089 | $576,784 | $781,557 | $407,030 | $719,575 |
| 13. Other Deductions | $27,490 | $22,266 | $26,208 | $21,883 | $23,902 | $21,140 | $20,316 | $22,490 | $20,832 | $25,302 | $27,821 | $27,703 | $25,242 |
| 14. Charity Care | $68,924 | $73,565 | $188,462 | $87,947 | $216,604 | $45,611 | $132,111 | $30,914 | $86,009 | $114,562 | $143,248 | $56,435 | $64,841 |
| 15. Bad Debt Expense | $494,245 | $596,260 | $296,308 | $467,961 | $23,326 | $1,011,727 | $281,765 | $9,964 | $198,141 | $493,288 | $725,275 | -$344,442 | $766,855 |
| 16. Total Deductions from Revenue | $6,950,254 | $7,974,403 | $8,837,955 | $8,051,123 | $7,792,502 | $8,185,206 | $7,826,996 | $7,149,810 | $8,041,817 | $8,178,317 | $9,160,610 | $8,187,097 | $9,183,434 |
| *% Contractual Allowances / Total Gross Patient Revenue* | *36.0%* | *40.5%* | *44.8%* | *39.2%* | *48.5%* | *40.4%* | *42.4%* | *42.7%* | *42.6%* | *42.9%* | *45.3%* | *47.3%* | *45.5%* |
| *% Bad Debt & Charity Care / Total Gross Patient Revenue* | *3.2%* | *3.7%* | *2.6%* | *2.9%* | *1.5%* | *6.0%* | *2.4%* | *0.2%* | *1.6%* | *3.5%* | *4.8%* | *-1.6%* | *4.5%* |
| *% Total Deductions / Total Gross Patient Revenue* | *39.4%* | *44.3%* | *47.5%* | *42.2%* | *50.2%* | *46.6%* | *44.9%* | *43.1%* | *44.3%* | *46.6%* | *50.2%* | *45.9%* | *50.2%* |
| 17. Net Patient Revenue | $10,697,364 | $10,006,858 | $9,766,979 | $11,028,863 | $7,734,456 | $9,385,847 | $9,611,047 | $9,428,647 | $10,098,497 | $9,389,386 | $9,081,449 | $9,662,081 | $9,120,426 |
| 18. Other Operating Revenue | $220,586 | $364,698 | $816,211 | $550,548 | $2,170,951 | $3,342,074 | $353,598 | $351,197 | $1,068,226 | $888,429 | $365,743 | $430,405 | $365,270 |
| 19. Total Operating Revenue | $10,917,950 | $10,371,556 | $10,583,190 | $11,579,411 | $9,905,407 | $12,727,921 | $9,964,645 | $9,779,844 | $11,166,723 | $10,277,815 | $9,447,192 | $10,092,486 | $9,485,696 |
| Expenses: | | | | | | | | | | | | | |
| 20. Salaries & Wages | $4,287,441 | $4,350,677 | $4,217,486 | $4,596,066 | $4,184,946 | $4,448,979 | $4,187,133 | $4,172,073 | $4,501,362 | $4,317,359 | $4,357,166 | $4,497,152 | $4,400,364 |
| 21. Physician Wages | $340,047 | $349,470 | $401,311 | $349,004 | $347,759 | $235,235 | $310,416 | $329,545 | $273,221 | $444,317 | $422,325 | $260,633 | $267,548 |
| 22. Contract Labor | $260,085 | $146,297 | $180,317 | $183,959 | $141,874 | $116,802 | $131,180 | $209,851 | $259,925 | $199,136 | $789,120 | $820,571 | $633,674 |
| 23. Employee Benefits | $2,391,791 | $2,363,594 | $2,351,367 | $2,603,560 | $2,371,632 | $2,384,712 | $2,390,367 | $2,192,232 | $2,502,779 | $2,527,370 | $2,427,959 | $2,434,120 | $2,374,084 |
| | $7,279,364 | $7,210,038 | $7,150,481 | $7,732,589 | $7,046,211 | $7,185,728 | $7,019,096 | $6,903,701 | $7,537,287 | $7,488,182 | $7,996,570 | $8,012,476 | $7,675,670 |
| % Salaries and Benefits / Total Operating Revenue | 66.7% | 69.5% | 67.6% | 66.8% | 71.1% | 56.5% | 70.4% | 70.6% | 67.5% | 72.9% | 84.6% | 79.4% | 80.9% |
| 24. Medical Professional Fees | $47,612 | $89,756 | $85,053 | $43,133 | $40,688 | $50,370 | $103,234 | $165,961 | $41,788 | $54,167 | $63,462 | $48,386 | $38,713 |
| 25. Physician Contracts | $370,966 | $463,251 | $251,085 | $316,585 | $416,828 | $326,380 | $390,072 | $322,387 | $325,313 | $249,694 | $412,311 | $514,752 | $326,821 |
| 26. Non-Medical Professional Fees | $115,394 | $199,537 | $153,952 | $231,198 | $199,503 | $194,816 | $251,322 | $203,518 | $211,847 | $181,852 | $209,768 | $246,454 | $221,282 |
| 27. Materials & Supplies | $1,436,187 | $1,541,901 | $1,526,388 | $1,442,389 | $1,241,206 | $1,553,150 | $1,344,539 | $1,354,348 | $1,346,888 | $1,281,281 | $1,435,271 | $1,331,112 | $1,305,218 |
| 28. Utilities | $126,518 | $105,215 | $100,105 | $145,196 | $126,857 | $157,087 | $253,444 | $199,502 | $187,642 | $117,421 | $214,545 | $98,852 | $121,693 |
| 29. Maintenance & Repairs | $422,017 | $361,725 | $559,794 | $583,950 | $318,644 | $456,037 | $434,349 | $440,614 | $448,823 | $468,289 | $521,697 | $435,114 | $426,346 |
| 30. Rentals & Leases | $51,930 | $43,326 | $47,645 | $56,231 | $76,991 | $97,199 | $48,761 | $60,069 | $84,113 | $64,215 | $77,726 | $51,336 | $86,650 |
| 31. Insurance | $81,323 | $68,839 | $72,913 | $61,900 | $66,224 | $60,796 | $65,724 | $120,075 | $102,592 | $70,720 | $67,712 | $66,848 | $74,882 |
| 32. Depreciation & Amortization | $610,049 | $607,718 | $642,412 | $641,278 | $640,504 | $640,537 | $645,931 | $600,353 | $606,903 | $598,119 | $585,394 | $584,119 | $594,379 |
| 33. Interest Expense | $49,359 | $49,154 | $49,154 | $49,154 | $49,761 | -$241,751 | $34,580 | $32,973 | $32,973 | $32,973 | $32,973 | $32,973 | $32,973 |
| 34. Other Operating Expenses | $126,611 | $129,278 | $110,601 | $120,834 | $171,096 | $119,674 | $119,261 | $186,388 | $125,175 | $97,288 | $191,849 | $127,071 | $93,683 |
| 35. Total Expenses | $10,717,330 | $10,869,738 | $10,749,583 | $11,424,437 | $10,394,513 | $10,600,023 | $10,710,313 | $10,589,889 | $11,051,344 | $10,704,201 | $11,809,278 | $11,549,493 | $10,998,310 |
| 36. Income (Loss) from Operations | $200,620 | -$498,182 | -$166,393 | $154,974 | -$489,106 | $2,127,898 | -$745,668 | -$810,045 | $115,379 | -$426,386 | -$2,362,086 | -$1,457,007 | -$1,512,614 |
| Non-Operating Revenue | | | | | | | | | | | | | |
| 37. Interest Income | $100,378 | $104,340 | $100,903 | $103,116 | $102,277 | $102,195 | $100,015 | $102,268 | $2,698 | $600 | $835 | $733 | $1,988 |
| 38. Other Non-Operating Income | $132,744 | $63,838 | $65,029 | $272,136 | $62,201 | $61,340 | $62,183 | $59,617 | $61,897 | $57,400 | $64,348 | $64,269 | $61,858 |
| 39. Total Non-Operating Revenue | $233,122 | $168,178 | $165,932 | $375,252 | $164,478 | $163,535 | $162,198 | $161,885 | $64,595 | $58,000 | $65,183 | $65,002 | $63,846 |
| 40. Net Income (Loss) | $433,742 | -$330,004 | -$461 | $530,226 | -$324,628 | $2,291,433 | -$583,470 | -$648,160 | $179,974 | -$368,386 | -$2,296,903 | -$1,392,005 | -$1,448,768 |

BARTLETT REGIONAL HOSPITAL
BALANCE SHEET
July 31, 2022

| | July-22 | June-22 | July-21 | CHANGE FROM PRIOR FISCAL YEAR |
|---|---|---|---|---|
| ASSETS | | | | |
| Current Assets: | | | | |
| 1. Cash and cash equivalents | 22,211,019 | 25,960,461 | 18,147,141 | 4,063,878 |
| 2. Board designated cash | 28,944,179 | 28,737,198 | 32,902,802 | (3,958,624) |
| 3. Patient accounts receivable, net | 20,620,575 | 18,966,587 | 17,024,913 | 3,595,662 |
| 4. Other receivables | 1,346,190 | 1,490,648 | 4,289,693 | (2,943,503) |
| 5. Inventories | 3,236,548 | 3,613,561 | 3,312,784 | (76,236) |
| 6. Prepaid Expenses | 3,371,478 | 1,717,382 | 3,021,672 | 349,806 |
| 7. Other assets | 32,939 | 32,935 | 30,378 | 2,561 |
| 8. Total current assets | 79,762,928 | 80,518,772 | 78,729,383 | 1,033,544 |
| Appropriated Cash: | | | | |
| 9. CIP Appropriated Funding | 28,560,714 | 28,560,714 | 14,298,992 | 14,261,723 |
| Property, plant & equipment | | | | |
| 10. Land, bldgs & equipment | 153,308,451 | 153,025,325 | 149,852,618 | 3,455,833 |
| 11. Construction in progress | 18,209,189 | 18,510,117 | 10,432,601 | 7,776,588 |
| 12. Total property & equipment | 171,517,640 | 171,535,442 | 160,285,219 | 11,232,421 |
| 13. Less: accumulated depreciation | (109,403,986) | (108,913,879) | (102,194,394) | (7,209,592) |
| 14. Net property and equipment | 62,113,654 | 62,621,568 | 58,090,831 | 4,022,830 |
| 15. Deferred outflows/Contribution to Pension Plan | 12,654,846 | 12,654,846 | 12,654,846 | - |
| 16. Total assets | 183,092,142 | 184,355,896 | 163,774,048 | 19,318,097 |
| LIABILITIES & FUND BALANCE | | | | |
| Current liabilities: | | | | |
| 17. Payroll liabilities | 3,322,640 | 2,849,971 | 997,915 | 2,324,724 |
| 18. Accrued employee benefits | 4,650,759 | 4,822,998 | 5,158,114 | (507,355) |
| 19. Accounts payable and accrued expenses | 4,030,238 | 4,609,541 | 3,157,168 | 873,070 |
| 20. Due to 3rd party payors | 2,708,665 | 2,708,665 | 1,894,462 | 814,203 |
| 21. Deferred revenue | 1,123,835 | 649,002 | 1,128,835 | (5,000) |
| 22. Interest payable | 16,175 | 105,323 | - | 16,175 |
| 23. Note payable - current portion | 1,030,000 | 1,030,000 | 910,000 | 120,000 |
| 24. Other payables | 83,469 | 1,000 | 182,945 | (99,476) |
| 25. Total current liabilities | 16,965,781 | 16,776,500 | 13,429,439 | 3,536,341 |
| Long-term Liabilities: | | | | |
| 26. Bonds payable | 35,005,000 | 35,005,000 | 17,350,000 | 17,655,000 |
| 27. Bonds payable - premium/discount | 2,796,398 | 2,800,664 | 125,783 | 2,670,615 |
| 28. Net Pension Liability | 62,063,897 | 62,063,897 | 62,063,897 | - |
| 29. Deferred In-Flows | 4,884,297 | 4,884,297 | 4,884,297 | - |
| 30. Total long-term liabilities | 104,749,592 | 104,753,858 | 84,423,977 | 20,325,615 |
| 31. Total liabilities | 121,715,373 | 121,530,358 | 97,853,416 | 23,861,956 |
| 32. Fund Balance | 61,376,769 | 62,825,538 | 65,920,630 | (4,543,861) |
| 33. Total liabilities and fund balance | 183,092,142 | 184,355,896 | 163,774,048 | 19,318,097 |

BARTLETT REGIONAL HOSPITAL
12 MONTH ROLLING BALANCE SHEET
FOR THE PERIOD JULY 21 THRU JULY 22

| | July-21 | August-21 | September-21 | October-21 | November-21 | December-21 | January-22 | February-22 | March-22 | April-22 | May-22 | June-22 | July-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ASSETS | | | | | | | | | | | | | |
| Current Assets: | | | | | | | | | | | | | |
| 1. Cash and cash equivalents | 20,222,641 | 18,285,324 | 18,422,022 | 16,455,972 | 19,700,052 | 22,950,807 | 22,205,736 | 21,662,275 | 7,464,732 | 5,045,343 | 7,271,871 | 5,967,974 | 22,211,019 |
| 2. Board designated cash | 34,296,146 | 33,094,973 | 32,232,554 | 30,435,406 | 30,341,553 | 30,266,907 | 29,706,760 | 30,174,095 | 29,552,067 | 29,926,473 | 27,375,730 | 27,374,717 | 28,944,179 |
| 3. Patient accounts receivable, net | 17,050,534 | 17,748,521 | 17,440,451 | 19,597,839 | 17,302,598 | 15,965,465 | 16,652,127 | 16,843,857 | 16,560,522 | 17,502,612 | 18,180,691 | 18,966,587 | 20,620,575 |
| 4. Other receivables | 3,664,168 | 31,400 | 1,264,736 | 1,371,110 | 906,110 | 588,186 | 684,114 | 584,230 | 1,236,682 | 1,583,406 | 1,323,543 | 1,501,123 | 1,346,190 |
| 5. Inventories | 3,312,784 | 3,367,771 | 3,511,679 | 3,714,914 | 3,985,020 | 3,803,022 | 3,763,829 | 3,681,705 | 3,531,828 | 3,537,649 | 3,642,059 | 3,613,561 | 3,236,548 |
| 6. Prepaid Expenses | 3,134,789 | 2,922,731 | 3,075,080 | 3,086,651 | 2,939,487 | 2,801,467 | 2,653,187 | 2,800,205 | 2,453,787 | 2,203,501 | 1,893,949 | 1,717,382 | 3,371,478 |
| 7. Other assets | 30,377 | 30,377 | 30,377 | 31,937 | 31,937 | 31,937 | 31,937 | 31,937 | 31,937 | 31,937 | 31,937 | 32,937 | 32,939 |
| 8. Total current assets | 81,711,439 | 75,481,097 | 75,976,899 | 74,693,829 | 75,206,757 | 76,407,791 | 75,697,690 | 75,778,304 | 60,831,555 | 59,830,921 | 59,719,780 | 59,174,281 | 79,762,928 |
| Appropriated Cash: | | | | | | | | | | | | | |
| 9. CIP Appropriated Funding | 11,932,679 | 18,854,017 | 18,854,017 | 19,406,354 | 18,853,710 | 18,301,848 | 17,244,030 | 17,164,683 | 32,263,003 | 32,229,681 | 29,145,697 | 28,560,714 | 28,560,714 |
| Property, plant & equipment | | | | | | | | | | | | | |
| 10. Land, bldgs & equipment | 149,599,849 | 149,897,827 | 151,396,219 | 151,850,022 | 152,031,616 | 152,194,817 | 152,409,795 | 152,463,783 | 152,782,632 | 152,973,023 | 153,025,175 | 153,025,325 | 153,308,451 |
| 11. Construction in progress | 8,767,880 | 10,769,368 | 9,724,991 | 10,696,859 | 11,100,753 | 11,827,784 | 12,743,862 | 12,846,504 | 13,572,285 | 14,423,945 | 17,812,831 | 18,510,117 | 18,209,189 |
| 12. Total property & equipment | 158,367,729 | 160,667,195 | 161,121,210 | 162,546,881 | 163,132,369 | 164,022,601 | 165,153,657 | 165,310,287 | 166,354,917 | 167,396,968 | 170,838,006 | 171,535,442 | 171,517,640 |
| 13. Less: accumulated depreciation | (102,194,394) | (102,791,929) | (103,434,220) | (104,075,498) | (104,715,882) | (105,356,299) | (105,939,110) | (106,539,343) | (107,146,246) | (107,744,366) | (108,329,760) | (108,913,879) | (109,403,986) |
| 14. Net property and equipment | 56,173,335 | 57,875,266 | 57,686,990 | 58,471,383 | 58,416,487 | 58,666,302 | 59,214,547 | 58,770,944 | 59,208,671 | 59,652,602 | 62,508,246 | 62,621,563 | 62,113,654 |
| 15. Deferred outflows/Contribution to Pension Plan | 12,403,681 | 12,403,681 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 | 12,654,846 |
| 16. Total assets | 162,221,134 | 164,614,061 | 165,172,752 | 165,226,409 | 165,131,800 | 166,030,788 | 164,811,114 | 164,368,778 | 164,958,074 | 164,368,049 | 164,028,570 | 163,011,403 | 183,092,142 |
| LIABILITIES & FUND BALANCE | | | | | | | | | | | | | |
| Current liabilities: | | | | | | | | | | | | | |
| 17. Payroll liabilities | 997,915 | 1,435,323 | 1,700,778 | 2,411,287 | 2,523,324 | 832,124 | 1,236,761 | 1,312,176 | 1,744,778 | 2,118,075 | 2,580,462 | 2,849,971 | 3,322,640 |
| 18. Accrued employee benefits | 5,158,329 | 5,197,548 | 5,161,912 | 5,108,615 | 4,974,135 | 4,792,357 | 4,713,630 | 5,154,183 | 5,183,342 | 5,312,132 | 5,368,868 | 4,822,998 | 4,650,759 |
| 19. Accounts payable and accrued expenses | 2,703,162 | 3,007,066 | 3,172,598 | 2,307,757 | 2,613,628 | 3,469,843 | 3,693,454 | 3,328,898 | 2,792,501 | 2,027,105 | 3,390,582 | 4,609,541 | 4,030,238 |
| 20. Due to 3rd party payors | 99,234 | 2,152,164 | 4,046,626 | 2,226,263 | 2,367,164 | 2,341,398 | 2,315,632 | 2,289,866 | 2,702,887 | 2,704,813 | 2,706,739 | 2,708,665 | 2,708,665 |
| 21. Deferred revenue | 654,388 | 611,221 | 1,042,502 | 999,335 | 956,168 | 913,002 | 869,835 | 826,668 | 783,502 | 740,335 | 697,168 | 649,002 | 1,123,835 |
| 22. Interest payable | (30,075) | 63,059 | 126,119 | 189,178 | 445,609 | 120,490 | (72,885) | 53,414 | 90,653 | 127,892 | 165,131 | 105,323 | 16,175 |
| 23. Note payable - current portion | 910,000 | 910,000 | 910,000 | 910,000 | 910,000 | 910,000 | 1,030,000 | 1,030,000 | 1,030,000 | 1,030,000 | 1,030,000 | 1,030,000 | 1,030,000 |
| 24. Other payables | 182,945 | 1,097,658 | 321,793 | 404,654 | 456,756 | 160,707 | 242,979 | 244,290 | 325,418 | 375,354 | 458,446 | 1,000 | 83,469 |
| 25. Total current liabilities | 10,675,898 | 14,474,039 | 16,482,328 | 14,557,089 | 15,246,784 | 13,539,921 | 14,029,406 | 14,239,495 | 14,653,081 | 14,435,706 | 16,397,396 | 16,776,500 | 16,965,781 |
| Long-term Liabilities: | | | | | | | | | | | | | |
| 26. Bonds payable | 16,350,000 | 16,350,000 | 17,350,000 | 17,350,000 | 17,350,000 | 17,350,000 | 16,230,000 | 16,230,000 | 16,230,000 | 16,230,000 | 16,230,000 | 16,230,000 | 35,005,000 |
| 27. Bonds payable - premium/discount | 1,040,075 | 1,026,169 | 97,971 | 84,065 | 111,164 | 105,471 | 99,779 | 95,512 | 91,246 | 86,979 | 82,713 | 78,446 | 2,796,398 |
| 28. Net Pension Liability | 64,954,569 | 64,954,569 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 | 62,063,897 |
| 29. Deferred In-Flows | 4,318,200 | 4,318,200 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 | 4,884,297 |
| 30. Total long-term liabilities | 86,662,844 | 86,648,938 | 84,396,165 | 84,382,259 | 84,409,358 | 84,403,665 | 83,277,973 | 83,273,706 | 83,269,440 | 83,265,173 | 83,260,907 | 83,256,640 | 104,749,592 |
| 31. Total liabilities | 97,338,742 | 101,122,977 | 100,878,493 | 98,939,348 | 99,656,142 | 97,943,586 | 97,307,379 | 97,513,201 | 97,922,521 | 97,700,879 | 99,658,303 | 100,033,140 | 121,715,373 |
| 32. Fund Balance | 64,882,392 | 63,491,084 | 64,294,259 | 66,287,061 | 65,475,658 | 68,087,202 | 67,503,735 | 66,855,577 | 67,035,553 | 66,667,170 | 64,370,267 | 62,978,263 | 61,376,769 |
| 33. Total liabilities and fund balance | 162,221,134 | 164,614,061 | 165,172,752 | 165,226,409 | 165,131,800 | 166,030,788 | 164,811,114 | 164,368,778 | 164,958,074 | 164,368,049 | 164,028,570 | 163,011,403 | 183,092,142 |

**Bartlett Regional Hospital**
**Dashboard Report for July 2022**

| | CURRENT MONTH | | | | | YEAR TO DATE | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Facility Utilization:** | **Actual** | **Budget** | **% Over (Under) Budget** | **Prior Year** | **% Over (Under) Pr Yr** | **Actual** | **Budget** | **% Over (Under) Budget** | **Prior Year** |
| ***Hospital Inpatient:Patient Days*** | | | | | | | | | |
| Patient Days - Med/Surg | 536 | 558 | -4% | 470 | 14.0% | 536 | 558 | -4% | 470 |
| Patient Days - Critical Care Unit | 93 | 100 | -7% | 92 | 1.1% | 93 | 100 | -7% | 92 |
| Avg. Daily Census - Acute | 20.3 | 21.2 | -4% | 18.1 | 12.1% | 20.3 | 21.2 | -4% | 18.1 |
| Patient Days - Obstetrics | 73 | 64 | 14% | 83 | -12.0% | 73 | 64 | 14% | 83 |
| **Total Hospital Patient Days** | **702** | **721** | **-3%** | **645** | 8.8% | **702** | **721** | -3% | **645** |
| Births | 29 | 25 | 15% | 29 | 0.0% | 29 | 25 | 15% | 29 |
| Patient Days - Nursery | 62 | 49 | 26% | 65 | -4.6% | 62 | 49 | 26% | 65 |
| ***Mental Health Unit*** | | | | | | | | | |
| Patient Days - Mental Health Unit | 101 | 159 | -36% | 161 | -37.3% | 101 | 159 | -36% | 161 |
| Avg. Daily Census - MHU | 3.3 | 5.1 | -36% | 5.2 | -37.3% | 3.3 | 5.1 | -36% | 5.2 |
| ***Rain Forest Recovery:*** | | | | | | | | | |
| Patient Days - RRC | 169 | 167 | 1% | 200 | -15.5% | 169 | 167 | 1% | 200 |
| Avg. Daily Census - RRC | 5 | 5.4 | 1% | 6 | -15.5% | 5 | 5.4 | 1% | 6 |
| Outpatient visits | 49 | 44 | 12% | 45 | 8.9% | 49 | 44 | 12% | 45 |
| ***Inpatient: Admissions*** | | | | | | | | | |
| Med/Surg | 70 | 68 | 3% | 70 | 0.0% | 70 | 68 | 3% | 70 |
| Critical Care Unit | 47 | 59 | -20% | 39 | 20.5% | 47 | 59 | -20% | 39 |
| Obstetrics | 28 | 27 | 2% | 33 | -15.2% | 28 | 27 | 2% | 33 |
| Nursery | 31 | 25 | 23% | 29 | 6.9% | 31 | 25 | 23% | 29 |
| Mental Health Unit | 15 | 25 | -39% | 25 | -40.0% | 15 | 25 | -39% | 25 |
| **Total Admissions - Inpatient Status** | **191** | **204** | -6% | **196** | -2.6% | **191** | **204** | -6% | **196** |
| ***Admissions -"Observation" Status*** | | | | | | | | | |
| Med/Surg | 57 | 73 | -22% | 83 | -31.3% | 57 | 73 | -22% | 83 |
| Critical Care Unit | 35 | 25 | 38% | 21 | 66.7% | 35 | 25 | 38% | 21 |
| Mental Health Unit | 3 | 4 | -16% | 4 | -25.0% | 3 | 4 | -16% | 4 |
| Obstetrics | 11 | 15 | -28% | 20 | -45.0% | 11 | 15 | -28% | 20 |
| **Total Admissions to Observation** | **106** | **117** | -10% | **128** | -19.1% | **106** | **117** | -10% | **128** |
| ***Surgery:*** | | | | | | | | | |
| Inpatient Surgery Cases | 59 | 49 | 21% | 60 | -1.7% | 59 | 49 | 21% | 60 |
| Endoscopy Cases | 95 | 89 | 7% | 83 | 14.5% | 95 | 89 | 7% | 83 |
| Same Day Surgery Cases | 96 | 104 | -8% | 102 | -5.9% | 96 | 104 | -8% | 102 |
| **Total Surgery Cases** | **250** | **242** | 3% | **245** | 2.0% | **250** | **242** | 3% | **245** |
| Total Surgery Minutes | 17,639 | 16,168 | 9% | 17,204 | 2.5% | 17,639 | 16,168 | 9% | 17,204 |
| ***Outpatient:*** | | | | | | | | | |
| Total Outpatient Visits (Hospital) | | | | | | | | | |
| Emergency Department Visits | 1,181 | 1,030 | 15% | 1,236 | -4.4% | 1,181 | 1,030 | 15% | 1,236 |
| Cardiac Rehab Visits | 115 | 32 | 262% | 99 | 16.2% | 115 | 32 | 262% | 99 |
| Lab Tests | 10,113 | 10,003 | 1% | 10,226 | -1.1% | 10,113 | 10,003 | 1% | 10,226 |
| Radiology Tests | 931 | 2,398 | -61% | 2,376 | -60.8% | 931 | 2,398 | -61% | 2,376 |
| Sleep Study Visits | 7 | 21 | -67% | 29 | -75.9% | 7 | 21 | -67% | 29 |
| ***Physician Clinics:*** | | | | | | | | | |
| Hospitalists | 246 | 245 | 1% | 244 | 0.8% | 246 | 245 | 1% | 244 |
| Bartlett Oncology Clinic | 100 | 97 | 3% | 96 | 4.2% | 100 | 97 | 3% | 96 |
| Ophthalmology Clinic | 125 | 73 | 70% | 78 | 60.3% | 125 | 73 | 70% | 78 |
| Behavioral Health Outpatient visits | 626 | 666 | -6% | 575 | 8.9% | 626 | 666 | -6% | 575 |
| Bartlett Surgery Specialty Clinic visits | 276 | 231 | 20% | 205 | 34.6% | 276 | 231 | 20% | 205 |
| **Total Physician Clinics** | **1,373** | **1,312** | **5%** | **1,198** | **14.6%** | **1,373** | **1,312** | **5%** | **1,198** |
| ***Other Operating Indicators:*** | | | | | | | | | |
| Dietary Meals Served | 7,479 | 17,757 | -58% | 15,699 | -36.0% | 7,479 | 17,757 | -58% | 15,699 |
| Laundry Pounds (Per 100) | 390 | 577 | -32% | 398 | -4.8% | 390 | 577 | -32% | 398 |

**Bartlett Regional Hospital**
**Financial Indicators for July 2022**

| Facility Utilization: | CURRENT MONTH Actual | Budget | % Over (Under) Budget | Prior Year | YEAR TO DATE Actual | Budget | % Over (Under) Budget | Prior Year |
|---|---|---|---|---|---|---|---|---|
| ***Financial Indicators:*** | | | | | | | | |
| Revenue Per Adjusted Patient Day | 5,180 | 5,790 | -10.5% | 4,697 | 5,180 | 5,790 | -10.5% | 4,697 |
| Contractual Allowance % | 45.5% | 40.0% | 13.8% | 36.0% | 45.5% | 40.0% | 13.8% | 36.0% |
| Bad Debt & Charity Care % | 4.5% | 2.1% | 117.0% | 3.2% | 4.5% | 2.1% | 117.0% | 3.2% |
| Wages as a % of Net Revenue | 58.1% | 47.1% | 23.5% | 45.7% | 58.1% | 47.1% | 23.5% | 45.7% |
| Productive Staff Hours Per Adjusted Patient Day | 26.4 | 26.6 | -0.8% | 22.5 | 26.4 | 26.6 | -0.8% | 22.5 |
| Non-Productive Staff Hours Per Adjusted Patient Day | 4.0 | 4.1 | -2.8% | 3.7 | 4.0 | 4.1 | -2.8% | 3.7 |
| Overtime/Premium % of Productive | 8.20% | 7.92% | 3.5% | 6.96% | 8.20% | 7.92% | 3.5% | 6.96% |
| Days Cash on Hand | 66 | 62 | 6.7% | 77 | 66 | 62 | 6.7% | 77 |
| Board Designated Days Cash on Hand | 171 | 161 | 6.7% | 143 | 171 | 161 | 6.7% | 143 |
| Days in Net Receivables | 68.1 | 68 | 0.0% | 48 | 68.1 | 68 | 0.0% | 48 |
| Days in Accounts Payable | 37.5 | 38 | 0.0% | 362 | 37.5 | 38 | 0.0% | 362 |
| Total CMI | 1.25 | | | | | | | |
| MCR CMI | 1.39 | | | | | | | |
| MCD CMI | 1.12 | | | | | | | |

| | Actual | Benchmark | % Over (Under) | Prior Year Month |
|---|---|---|---|---|
| Total debt-to-capitalization (with PERS) | 63.1% | 33.7% | 87.1% | 56.9% |
| Total debt-to-capitalization (without PERS) | 25.7% | 33.7% | -23.8% | 14.5% |
| Current Ratio | 4.70 | 2.00 | 135.1% | 3.53 |
| Debt-to-Cash Flow (with PERS) | (10.83) | 2.7 | -501.1% | 16.26 |
| Debt-to-Cash Flow (without PERS) | (4.41) | 2.7 | -263.5% | 4.14 |
| Aged A/R 90 days & greater | 49.3% | 19.8% | 148.8% | 47.4% |
| Bad Debt Write off | 1.4% | 0.8% | 78.6% | -0.6% |
| Cash Collections | 74.1% | 99.4% | -25.4% | 85.8% |
| Charity Care Write off | 0.4% | 1.4% | -74.1% | 0.3% |
| Cost of Collections (Hospital only) | 6.0% | 2.8% | 115.4% | 5.2% |
| Discharged not Final Billed (DNFB) | 11.2 | 4.7% | 23694.9% | 10.6% |
| Unbilled & Claims on Hold (DNSP) | 17.4 | 5.1% | 34048.2% | 13.0% |
| Claims final billed not submitted to payor (FBNS) | 4.24 | 0.2% | 211887.0% | 0.00% |
| POS Cash Collection | 1.8% | 21.3% | -91.4% | 6.2% |

The Case Mix Index (CMI) is the average relative DRG weight of a hospital's inpatient discharges, calculated by summing the Medicare Severity-Diagnosis Related Group (MSDRG) weight for each discharge and dividing the total number of discharges.

# Bartlett Regional Hospital

Write-Offs July 2022

| | | |
|---|---|---|
| One Time PPD Ins | | |
| RRC/MCR NO Enrollment | | |
| Compliance/Risk/Adminstrative | | |
| SP Prompt Pay Disc | $16,903.79 | 180 |
| Medicare Patient <120 days | | |
| Authorization/Alert Missing | $10,837.75 | 5 |
| 1115 Waiver Svcs on Commercial Ins | $7,464.00 | 24 |
| Denied Appeals /Exhausted/Timely | $73,939.54 | 10 |
| BOPS Provider NOT Eligible to Bill | | |
| Mental Health BD MHU, RRC BOPS | | |
| No Provider Enrollment | | |
| | $109,145.08 | 219 |
| | | |
| Collections | | |
| One Time Ins PPD | | |
| Collections SPPPD | $96,272.59 | 180 |

**July 2022 ME Totals**

- Charity $64,300.32
- Claims on hold 67 $2.5 Million (NDC Issue)
- POS Collections $6,205,32
- Cares Adjustments $39,697.94
- HRSA PMTS $0.00

Molecular Lab Revenue $141,100.00

To: Robert C. Tyk, FHFMA
Interim Chief Financial Officer

From: Tami Lawson-Churchill
Director of Patient Financial Services

Re: BRH Charity Care Program

The BRH Charity Care Program allows patients to receive medically necessary services at no charge or a reduced charge, when they meet program eligibility requirements. The adjustment is based on household size and income. The financial screening requires last year's tax return or W2 and a minimum of 3-month worth of paystubs. We also require 3 months of bank statements or a certification from the patient that they do not have a bank account.

The patient must first also apply for Alaska Medicaid. We have staff certified by the State of Alaska to conduct Medicaid Presumptive Eligibility. We screen each self-pay patient for Medicaid at the time of service. During normal business hours, our financial counselor will meet with each self-pay patient and conduct a financial screening based on financial need. After hours, the admissions staff will screen the patient for Medicaid Eligibility as well as provide them with a CFC application.

The financial counselor will follow up with the patient the following business day and assist with any questions regarding the application or eligibility requirements. Additionally, the financial counselor also assists patients with applying for Medicare, Medicaid and/or other financial resources available.

After financial screening has been completed, the notification of acceptance or ineligibility are sent by mail to the patient. The final decision is made by the Director of Patient Financial services. Patients that do not qualify for a full write off are asked to complete a payment plan for the remaining portion of their balance. Notice of acceptance is only for the services requested. Persons may be required to reapply for future services. Charity care does not cover services rendered and billable by an independent medical professional. Charity also does not cover any service that has already been sent to an outside collection agency for collection.

The income guidelines are updated annually in accordance with the Alaska Federal Poverty Guidelines. CFC applications are available in our patient financial services department, by mail and on our website. Patient compliance with these requirements is necessary for program approval. If the patient is non responsive, a decision cannot be made.

The Prima Facie clause within our policy allows special approval for homeless and behavioral health patients. These patients are processed on a case by case basis.

**Bartlett Regional Hospital**

Title: Charity Care

Department/s: Patient Financial Services

**PURPOSE:** To outline Bartlett Regional Hospital's charity care program ("Bartlett Care") to qualifying patients of Bartlett Regional Hospital, Rainforest Recovery Center or Bartlett Outpatient Psychiatry who receive care from the hospital, facility or clinic.

Some services such as physician fees for anesthesiology, pathology or radiology and services from other providers of care are not subject to a reduction of fees as defined in this document.

**DEFINITIONS**

1. **Catastrophic Illness**: A medical condition that results in health care costs that exceeds a person's income, or which compromises financial independence, reducing him/her to subsistence or near-poverty levels.

2. **Charity Care:** A provider's policy to provide healthcare services at a discount to individuals who meet the established criteria.

3. **Clinician:** A health care practitioner (physician, nurse practitioner, *physicia*n assistant, etc.) that works as a care giver of a patient in a hospital, skilled nursing facility, clinic or patient's home. The clinician diagnoses, prescribes treatment, treats and discharges patients from therapy.

**4.** **Co-Insurance**: Any portion of the incurred charges for which the patient or his/her guarantor is financially responsible. The co-insurance could include co-pays, deductibles, or co-insurance as defined by the patient's (guarantor's) health insurance policy.

5. **Family:** Using the Census Bureau definition, a group of two or more people who reside together and whom are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance. Civil unions, as recognized by state or city statute, can also be considered "family".

6. F**amily Income:** Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

   A. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts,

educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;

B. Noncash benefits (such as food stamps and housing subsidies) do not count;
C. Determined on a post-tax basis;
D. Excludes capital gains or losses; and
E. If a person lives with a family, includes the income of all family members (Non- relatives, such as housemates, do not count).

**7. Government Program:** An insurance program or funding subsidy available to patients for which the patient or the guarantor must prepare an application.

8. **Health Insurance:** A type of insurance coverage that pays for medical and surgical expenses that are incurred by the insured. Health insurance can either reimburse the insured for expenses incurred from illness or injury or pay the care provider directly. Health Insurance can include coverage through an employer benefit plan, an individually-owned benefit plan, coverage from a governmental entity. It can also include workers compensation insurance through the employer. Health insurance for Native Americans or Alaska Natives have distinct enrollment, coverage and payment requirements.

9. **Presumptive Eligibility:** The program defined by the State of Alaska that allows Bartlett's staff to determine if the patient qualifies for Medicaid insurance coverage. This coverage is in effect for 45 days. The patient must comply with Medicaid's application procedures.

10. **Uninsured:** The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

11. **Underinsured:** The patient has some level of insurance or third party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

## STATEMENT OF POLICY:

Bartlett Regional Hospital is committed to providing Bartlett Care to persons who have healthcare needs and are uninsured, underinsured, and/or ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual and family financial situation. In order to manage its resources responsibly and to allow Bartlett Regional Hospital to provide the appropriate level of assistance to persons in need, the Board of Directors establishes these guidelines for the provision of patient charity care.

The Bartlett Care program is not considered a substitute for personal responsibility. Patients are expected to cooperate with Bartlett Regional Hospital's procedures for obtaining other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual and/or family's ability to pay.

- Important! The patient will not be eligible for Bartlett Care if (s)he 1) Does not prepare an application for Medicaid and/or 2) Does not speak with a Bartlett financial representative.
- **Exception**: Behavioral health patients who are unable to complete the required steps for charity care, payment plans or other requirements will not have their accounts sent to collections.

**PROCEDURE:**

A. **Services Eligible under this Policy**. For purposes of this policy, "charity" refers to healthcare services provided without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:
   A.1. Emergency medical services provided in an emergency room setting;
   A.2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual
   A.3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
   A.4. Medically necessary services, as documented by a clinician's written referral .

B. **Services Excluded under this Policy.** Services not considered medically necessary, including but not limited to: cosmetic surgery, sterilizations (including reversals), and elective treatments for morbid obesity are specifically excluded.

C. **Presumptive Financial Assistance Eligibility.** Bartlett Regional Hospital could choose to grant Bartlett Care based solely on the initial documentation received from the patient or guarantor.

   There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Bartlett can request adequate information provided by the patient or through other sources which could provide sufficient evidence to provide the patient with charity care assistance.

   In the event there is no evidence to support a patient's eligibility for Bartlett Care, Bartlett staff could use alternative resources in determining estimated income amounts for the basis of determining charity care eligibility and potential discount amounts.

D. **Determination of Financial Need**
   D.1. Financial needs will be determined in accordance with procedures that involve an individual assessment of financial need; and may
      D.1.1. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
      D.1.2. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay;

D.1.3. Include reasonable efforts by Bartlett Regional Hospital and the patient to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;

D.1.3.1. Denial of these services is a requirement for patients who might reasonably expect to receive them

D.1.4. Take into account the patient's available assets – to exclude (i) The first $500 of cash in the patient's bank, (ii) The patient's primary residence and (iii) The patient's primary vehicle.

D.1.5. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

D.2. Bartlett Regional Hospital values stewardship and patients will be treated with dignity in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and Bartlett Regional Hospital shall notify the patient or applicant in writing within 60 days of receipt of a completed application.

E. **Patient Charity Guidelines.** Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels of Alaska (FPL) in effect at the time of the determination, as follows:

E.1. Patients whose family income is at or below 138% of the Alaska FPL are eligible to receive 100% write-off.

E.2. Patients whose family income is between 139% and 150% of the Alaska FPL are eligible to receive 75% write-off.

E.3. Patients whose family income is between 151% and 200% of the Alaska FPL are eligible to receive 50% write-off.

E.4. Patients whose family income is between 201% and 250% of the Alaska FPL are eligible to receive 25% write-off.

E.5. Patients whose family income exceeds 250% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as **catastrophic illness** or medical indigence, at the discretion of Bartlett Regional Hospital.

F. **Communication of the Charity Program to Patients and the Public.** Notification about charity available from Bartlett Regional Hospital, which shall include a contact number, shall be disseminated by Bartlett Regional Hospital by various means, which may include, but are not limited to, the publication of notices in self-pay letters sent to patients and by posting notices in the emergency room, admitting and registration departments, and patient financial services offices that are located on facility campuses, and at other public places as Bartlett Regional Hospital may elect. Information shall also be included on facility websites. Such information shall be provided in English as well as Spanish, and interpreted for other non-English speaking or limited-English speaking patients who cannot understand the writing and/or explanation. Referral of patients for charity may be made by any member of the Bartlett Regional Hospital staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious

sponsors. The patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws, may make a request for charity.

G. **Relationship to Collection Policies.** Bartlett Regional Hospital management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from Bartlett Regional Hospital and a patient's good faith effort to comply with his or her payment agreements with Bartlett Regional Hospital. For patients who qualify for charity and who are cooperating in good faith to resolve their hospital bills, Bartlett Regional Hospital may offer extended payment plans to eligible patients. Refer to Bartlett's Payment Arrangement policy. **Exception**: Behavioral health patients who are unable to complete the required steps for charity care, payment plans or other requirements will not have their accounts sent to collections.

H. **Regulatory Requirements.** In implementing this Policy, Bartlett Regional Hospital management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

| Approval/Review/Revision | | | | | |
|---|---|---|---|---|---|
| __/__/ 2015 | Finance Committee of Board of Directors | | | | |
| 4/7/22 | Revised to include BH non-collection efforts | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Bartlett Regional Hospital Charity Care Program/Rainforest Recovery Center Care Program | | | | | |
|---|---|---|---|---|---|
| **2022 Poverty Guidelines** | | | | | |
| | | | | | |
| **Numbers in Household** | **100% Write-off** | **75% Write-off** | **50% Write-off** | **25% Write-off** | **NO Write-off** |
| | | | | | |
| | 100% | 75% | 50% | 25% | NO |
| 1 | $0 - $23,446 | $23,447 - $25,486 | $25,487 - $33,980 | $33,981 - $42,475 | $42,476 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| 2 | $0 - $31,588 | $31,589- $34,335 | $34,336 - $45,780 | $45,781- $57,225 | $57,226 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| 3 | $0 - $39,730 | $39,731 - $43,185 | $43,186- $57,580 | $57,581- $71,975 | $71,976 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| 4 | $0 - $47,872 | $47,873- $52,035 | $52,036- $69,380 | $69,381 - $86,725 | $86,726 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| 5 | $0 - $56,014 | $56,015 - $60,885 | $60,886 $81,180 | $81,181 - $101,475 | $101,476 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| 6 | $0 - $64,156 | $64,157-$69,735 | $69,736 - $92,980 | $92,981 - $116,225 | $116,226 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| 7 | $0 - $72,298 | $72,299 - $78,585 | $78,586- $104,780 | $104,781- $130,975 | $130,976 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| 8 | $0 - $80,440 | $80,441 - $87,435 | $87,436 - $116,580 | $116,581 - 145,725 | $145,726 |
| | *Net Income* | *Net Income* | *Net Income* | *Net Income* | *and over* |
| | | | | | |
| For families/households with more than 8 persons, add $5,900 for each additional person | | | | | |

Juneau Medical Respite- September 15, 2022

The Juneau Medical Respite program was initially implemented as a pilot project in 2010 to address isolation needs associated with the flu. It was intended to provide safe, short-term housing, food, and medical follow up when an individual living in homelessness contracted a contagious illness and was unable to return to a shelter or congregate living environment. Due to the success of the project, it received continued funding of roughly $5,000 per year, with equal contributions from BRH and CBJ. In more recent years, prior to the pandemic, funding moved to the Juneau Community Foundation. The Juneau Coalition on Housing and Homelessness receives a large block grant each year that they divide between programs as the Coalition determines. Medical Respite had been receiving $5,000 per year. We requested an increase this year due to the significant increase in need. We were recently notified that we have $13,000 available to us through that fund with some additional rollover funds from FY22. We expect to get more information about amount in about a month.

Initial program partners included Bartlett, the VA, Juneau Economic Development Council/Alaska Development Council (JEDC/ADC), Hospice and Home Care, and the Glory Hall. Referrals were coordinated through BRH Case Managers and came from the inpatient setting, the emergency department, community clinics, or shelter managers. Generally, stays were expected to be 3-5 days in length, but would occasionally be extended based on circumstances. Case managers coordinated the rooms and notified JEDC, the Glory Hall, and Hospice and Home Care. The Glory Hall delivered meals and Hospice and Home Care visited the patient in the hotel and provided any ongoing evaluation and skilled care needed. They also made recommendations if someone needed an extension. Once the person checked out, the hotel sent the bill to JEDC/ADC and they cross-referenced with the details the Case Manager sent them about the referral. Then JEDC/ADC paid the bill.

Over time, the VA became less directly involved and contacted BRH CM if they had a referral. Hospice and Home Care discontinued doing home visits at the hotel. We then worked closely with Front Street Clinic, and occasionally other community clinics based on patient provider and needs, to support follow up medical evaluations and recommendations for continuation of stay if needed. With the strong community collaboration, the program continued to be very successful. It has been presented as a model for other communities to replicate at the Alaska Coalition on Housing and Homelessness and we have received inquiries from others about how to implement a similar program.

In March of 2020, medical respite needs increased with the pandemic. We quickly depleted funds available at JEDC/ADC. BRH contributed an additional $5,000 March 16, 2020, then BRH and CBJ contributed another $10,000 each on April 10, 2020. When those funds were depleted, the billing from the primary hotel we used then moved from JEDC/ADC to CBJ and FEMA funding was secured to cover costs of quarantine and isolation. When other hotels were needed, the costs were covered by BRH and then reimbursed by CBJ. The Glory Hall continued providing meals to everyone in medical respite, Front Street Clinic continued to be involved, and CCFR Mobile Integrated Health (MIH) became heavily involved in supporting medical needs for those in medical respite.

After the Hospital Incident Command System (HICS) and the CBJ Emergency Operations Center (EOC) were stood up in March, 2020, the Quarantine and Isolation Task Force was put together from both groups. Jeannette Lacey, Director of Case Management, Patient Tracking lead under the HICS Planning Section, and Scott Ciambor, who at the time was the CBJ Chief Housing Officer, was assigned as the EOC counter-part. The task force included other members from BRH, CBJ, Capital City Fire and Rescue (CCFR),

State of Alaska Public Health, and local shelter managers. This task force met a couple times per week early in the pandemic, then spread out to once weekly, then every other week. The group met for two years between March 2020 and March 2022, ending when the EOC was discontinued.

Operational decisions regarding use of medical respite were made through the task force. Public Health offered recommendations regarding isolation and quarantine lengths of stay and testing frequency based on CDC guidelines for quarantine in high-risk congregate populations. CCFR was greatly involved with testing, both individually and with mass testing efforts after outbreaks in congregate settings. Regular updates regarding medical respite use were provided to the HICS and the EOC. There was continued discussion with CBJ Finance after March of 2022 as we continued receiving federal funding through June 30, 2022.

The primary hotel used for medical respite that billed to CBJ has been booked out since March of 2022 and all medical respite needs were met with other hotels and covered by BRH with reimbursement from CBJ. Hotels were booked through the summer with tourism, various community events, as well cruise ship passengers and crew isolating due to COVID-19. Due to very limited rooms, blocks were rented in anticipation of isolation needs through August, 2022. There was one person in quarantine in early September, and we just added a new person today. We expect this number to ebb and flow, but do not expect to need to hold rooms through the winter months. Summer will continually pose significant challenges in having enough lodging available for quarantine.

Federal funding ended June 30, 2022. Efforts are in progress to define a more sustainable, long-term system, beyond the previous program as we expect to have continued increase in utilization from what we had prior to the COVID-19 pandemic.

Potential CEO goals as drafted by the Governance Committee on Aug. 26, 2022

1. Evaluate the current electronic medical records system and identify improvements to ensure this system meets user expectations. Measures of success: (1) conversion of the Emergency Department's T-systems to MEDITECH Expanse, (2) improvement in physician satisfaction with the system as measured by a future physician satisfaction survey (See Goal 4.).

2. Expand orthopedics and ophthalmology service lines. Measure of success: a 5% increase in volumes for each service line. (Note that in FY 22 orthopedics had 742 cases, so a 5% increase would be an additional 37 cases; in FY 22 ophthalmology had 412 cases, so that a 5% increase would be an additional 20 cases.)

3. Establish a formal board orientation process for new board members. Measures of success: (1) an orientation program formalized, and (2) all board members oriented.

4. Improve physician satisfaction with the hospital, and develop a statistically valid overall physician satisfaction and engagement score that can be monitored into the future. Measures of success: (1) measured improvement in physician satisfaction and engagement, (2) the existence of a valid measurement process.

5. Reduce traveler (locums) expenses. Measure of success: a reduction in traveler expenses of 20%. (Note that in FY 22 contract labor cost $3.44 million; a 20% reduction would be approximately $688 thousand.)

# Bartlett Regional Hospital

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

Planning Committee Meeting Minutes
September 2, 2022 – 12:00 p.m.
Zoom Videoconference

**Called to order at 12:01 p.m., by Planning Committee Chair, Brenda Knapp.**

**PLANNING COMMITTEE* AND BOARD MEMBERS PRESENT:** Brenda Knapp*, Max Mertz*, Kenny Solomon-Gross, Deb Johnston, Hal Geiger and Iola Young

**ALSO PRESENT:** David Keith, Bob Tyk, Kim McDowell, Dallas Hargrave, Sara Dodd, Nate Rumsey, Nathan Overson, Jeanne Rynne, and Anita Moffitt

**APPROVAL OF AGENDA –** ***Mr. Mertz made a MOTION to approve the agenda as written. Mr. Solomon-Gross seconded. There being no objections, agenda approved.***

**PUBLIC PARTICIPATION –** None

**APPROVAL OF THE MINUTES – Mr. Mertz** ***made a MOTION to approve the minutes from the August 9, 2022 Planning Committee meeting. Mr. Solomon-Gross seconded. There being no objections, minutes approved.***

**OLD BUSINESS:**
**Family Practice Building Update –** Mr. Keith reported the purchase of the Family Practice building will be presented for public comment at the September 12th Assembly meeting. Staff continues to discuss the strategic value of the Family Practice Building.

**Catholic Community Services (CCS) –** Mr. Keith reported having met with CCS two times about Hospice and Home Health Services (HHHS). A list of questions is being compiled by the attorneys, program officials and BRH staff to help with our due diligence. This questionnaire will be shared with CCS by Wednesday of next week and they will share their questions with BRH. This process will allow us to find out everything on the front end, not on the tail end. CCS is not one business model, it's three. We are trying to differentiate our interest, which is HHS, from the other two. We need to understand their funding streams and discern why HHHS is not profitable. Information will be shared with the Board. Ms. Knapp stated CCS has been around a long time and used to be very viable. HHHS are very important to have to help keep people out of the hospital. Making this work could be one way to expand or enhance our service lines. Mr. Keith stated we don't know what we will be able to take on or offer until we get more information.

**Master Facility Plan and Timeline –** Ms. Rynne reported the facility plan and timeline, included in the packet, are up to date. Mr. Keith reported that he has requested a meeting of BRH and CBJ staff to validate the cost and timelines of these projects. This facility plan may need a refresh and to be tweaked with regard to our revenue stream and support for it. Ms. Knapp thanked Mr. Keith for taking this step.

**Current Projects Update –** Ms. Rynne provided an overview of the project update list included in the packet. The site improvements are nearly done. Carver Construction has been hired to conduct investigatory work for the window replacement of the Administration building. The problem is not with the windows, it's with the vapor barrier. A rain screen system and new vapor barrier will probably be put on the building. We should have more detail with cost estimates by next month's meeting. Bids for the MRI/CT Scanner replacement came in 65-70% higher than estimated. It is believed that the higher rates are due to lack of competition. The Board did approve an appropriation of funds for this

project to be presented to the Assembly on September 12th for approval. This project should be complete by November 2023. Mr. Mertz asked if Mr. Keith has been able to focus on these projects. Mr. Keith stated this is incredibly important to him and he is just now getting his hands around it. BRH has issues with its project planning process; construction management and costs are critical to our success in what we can and can't afford. Mr. Mertz wants to make sure BRH is not continuing with projects just because they are on the list. Mr. Keith stated SLT, engineers and staff will have discussions to make sure things line up with our strategic priorities and the strategic plan will be realigned. In the next 30-45 days, he said he and the team will be well versed on the projects. Because of cost escalations and logistic challenges, we need to make sure our revenue streams are strong enough to support our strategic and capital initiatives. We will be very strategic in our approach and will be able to articulate why we've made our decisions. Mr. Solomon-Gross reported that he and Mr. Keith have already discussed Mr. Keith's plans.

**Bops / Crisis Stabilization Project Update –** Ms. Rynne reported construction is moving along and still on schedule for completion by March of 2023. Mr. Mertz asked Mr. Keith what his view is on the program for this building and how we can best move forward based on our budget. Mr. Keith reported he has not yet seen pro-forma for this project. Mr. Tyk and Ms. Dompeling are working to complete one. We have made a commitment to the program, which is great for the community, but we do need to know what the impact is. Mr. Geiger asked if we wanted to repurpose this building, are we locked into the building by grants. Ms. Rynne is unable to answer about the grants, but stated that architectural changes were made to the plans to use steel instead of wood and added extra fire proofing to allow flexibility of use in the future. Ms. Knapp observed that grants were not usually for buildings themselves but for reimbursable services. She and Mr. Mertz encourage Mr. Tyk to look into this. Mr. Mertz questions whether this building is going to solve the behavioral health problems in the community. Ms. Knapp stated we need to work collaboratively with JAMHI, Juneau Youth Services and other organizations to address the needs of the community and to ensure we are not duplicating services. Mr. Keith responded that a program assessment will be conducted and if we haven't established a mental health consortium in the community, we should have. Ms. Knapp feels that BRH should be the leader in a mental health consortium. Mr. Tyk reported a CON was not needed for the Crisis Stabilization Center because we were one of the first in the state to build one. There were grants associated with this program, but not the building. He cautioned that a lot of things had been promised that may not come to pass and that a proformas had not been conducted. If we decide to not use this building for a Crisis Stabilization Center, it may cause a problem from the state's standpoint and is a concern we would have to pay attention to. Mr. Keith agrees the Board and Committee should demand a review of the program and have an understanding of the financial implications and its impact but asks the committee not get too far ahead of what staff is already doing. He and Ms. Dompeling will bring a full program review to the Board when it is completed, hopefully within the next 60 days. Mr. Keith is to bring an update on where we are at the October Planning Committee meeting.

**Emergency Department (ED) Expansion Project Update -** Ms. Rynne reported progress since the last meeting. She, Ms. Koester and Mr. Overson met with the City Attorney to discuss the GC/CM (General Contractor/Construction Manager) ordinance. It will go before the Assembly on September 12th for its first reading and for public hearing and adoption on October 24th. The project is moving into the design development phase. This should be complete and ready for review and updated cost estimates in late September. It will be good timing for soliciting an RFP for a GC/CM. Mr. Mertz asked Mr. Keith if he has had time to dive into this project. Mr. Keith has and reported there is concern about the CON for the project and if we don't get a determination from the state within two weeks, we will begin working on the application to have it ready for submission. There is a dollar threshold associated with a CON and since there's a lot of cost creep in this project, we have to be cautious. Mr. Overson reported a conversation with Mr. Palmer, Ms. Rynne and Ms. Koester. Mr. Palmer agreed with a plan that addressed legal concerns about the regulatory CON rules and moving forward with the GC/CM process. If we do have to move forward with the CON application, we would conservatively have an answer by January 2023. Ms. Rynne reported we should be at the end of the construction document phase by early January. We can get through this document phase without exceeding the $1.5 Million threshold but would definitely have to stop until we have a CON before moving into construction phase if one is required. She noted there is a difference of opinion on the interpretation of the expenditure cap. Mr. Overson has a meeting this afternoon to get clarification from the state as to whether we have the ability to move ahead with construction activities, such as turning dirt, up to the $1.5 Million. He stated he has no concern that they are going to deny our request but we are working on the application at the same time we are asking for a determination. He doesn't see any regulation concerns with the CON at this point. Ms.

Knapp expressed concern about the public comment phase of a CON and wondered if we might encounter objections from SEARHC. Mr. Overson reported conversations with the state about what it would look like if SEARHC did object. SEARHC is Indian Health Services through the federal government and are not required to follow the state's CON process. Mr. Mertz stated that if SEARHC is serving members outside of their beneficiaries, they should be held to the same CON requirements and we should not set down on this. Mr. Keith noted this is a legitimate concern being discussed by the Alaska Hospital and Healthcare Association (AHHA), has been reported to Senator Sullivan and will probably become an issue on Senator Murkowski's desk. Mr. Mertz stated this is more than a political question, the Board needs to deliberate this with our legal counsel to determine if it's something we should pursue as the sole community provider hospital for Juneau. Ms. Knapp and Mr. Solomon-Gross agree that we need to push this matter. Ms. Johnston stated she does not want us to lose sight of the risk of costs for the expansion escalating while we are waiting if we have a protracted CON process. We should potentially expect requests for additional funding for the project.

**Strategic Goal Initiatives –** Mr. Rumsey provided an update on the strategic initiatives and the development of a comprehensive the strategic plan. Strategic initiatives were forwarded to the management team and directors. Mr. Keith met with managers and directors to discuss the importance of aligning departmental work plans with the strategic initiatives. Working with senior leadership, directors and managers, Mr. Rumsey is to facilitate the creation of long and short term objectives, tactics and priorities. Strategic initiatives are currently at varying levels of work activity and progress towards completion. Once we determine specific measurable tactics to advance the initiatives and clearly identify responsibilities and timelines, we will be better suited to report out the status to the Board. He provided an overview of a Gantt chart, included in the packet, showing what has been done so far and the plans for moving ahead. He noted this is conceptual at this point and will take a couple of months to get some of these work plans in order. His intent is to strengthen the organizational ownership and buy in of the strategic planning process through a combination of advocacy, coordination, training and support to create a more robust planning cycle. He recommends a one-year refresh cycle, working through the Board of Directors and Planning Committee, to adjust, adapt and streamline our strategic initiatives. He also recommends a 3 year reimagine cycle where we would have a complete revisiting of the strategic thinking and strategy developing process. His goal is to thoroughly create a shared vision of Bartlett's future, instill a sense of ownership of the strategic initiatives across the organization, provide a systematic means of communicating responsibility, accountability and urgency. This would free the Board and the Planning Committee to focus on strategic thinking and desired outcomes for the organization into the future. Ms. Knapp expressed her appreciation for the work put into this plan. Mr. Mertz expressed his appreciation and said he really wants to focus on communications about how this ties into the operational plan and looking at it again after a year. BRH needs to improve community engagement by making sure Juneau understands the importance of this independent hospital through marketing, advertising and community events. Ms. Knapp agreed and stated that our strength is going to depend on our alliances and cooperation in working with and supporting other healthcare entities in the community. We need to move towards those alliances as soon as possible. Mr. Rumsey's response to Mr. Mertz is that once work plans are identified at the functional level in the organization, we are going to have to prioritize which elements we are going to tackle in any given year. This is not just about the strategic plan, it's about strategic planning that needs to be a continuous process for it to add value to the organization. Ms. Knapp thanked Mr. Rumsey for his presentation.

**Comments –** Ms. Knapp thanked everyone for their questions and input. Mr. Mertz said it was an excellent meeting. Mr. Solomon-Gross thanked Mr. Rumsey and told him he's glad to have him on board.

**Next Meeting –** 12:00 p.m., October 7, 2022

**Adjourned –** 1:12 p.m.

**Finance Committee Meeting Minutes – Zoom Meeting**
**September 9th, 2022 at 12:00pm**

**Called to order at 12:00 p.m. by Finance Chair, Deb Johnston.**

**Finance Committee (*) & Board Members:** Deb Johnston*, Hal Geiger*

**Staff & Others:** Robert Tyk, Interim CFO; David Keith, CEO; Dallas Hargrave, HR Director; Blessy Robert, Controller; Kris Muller, Senior Accountant; Sharon Price, Executive Assistant to CFO.

**Public Comment:** None

***Ms. Johnston made a MOTION to approve the minutes from the August 12th, 2022 Finance Committee Meeting. Mr. Keith seconded, and they were approved.***

**July 2022 Financial Review – Bob Tyk**

July is the third month in a row where Bartlett Regional Hospital (BRH) lost over a million dollars ($1,448,768.00). Volumes were at or slightly above the budget and better than the prior year. Gross revenues continue to run in the $18 million dollar range but deductions from revenue and expenses continue to undermine the gross revenue numbers.

**Income Statement**

Hospital inpatient and outpatient gross revenues stayed in the same ranges as they have been for the past five months. Gross revenues for BH services decreased while the physician revenues increased significantly. As has been mentioned in prior months, the physician revenue number is tied to the inpatient behavioral health services which is not an accurate classification. This will be correct in the coming months. Deductions from revenue as a percentage of gross patient revenue grew again to over 50%. Bad debt, which is calculated based on accounts receivables, grew again in the month of July. Until we can release more Medicaid claims being held for the NDC number issue, this will continue to run at a higher rate. Salaries/contract labor and benefits, though lower than last months, had a higher percentage of total operating revenue. This is a result of the total operating revenue decreasing FTE count is higher than it could be but we will never know by how much until BRH has a true productivity system by which we can measure ourselves against it. We are currently looking for such a system. The balance of the expenses for the most part were less than what we budgeted.

Mr. Keith says that we recognize that there is a labor and productivity problem. Mr. Tyk pulled report that shows that 25% of the workforce was added in just the last two years.

**Balance Sheet**

The balance sheet showed some significant changes in July. Cash and cash equivalents increased along with Bonds Payable as the new bond was booked for BRH. Patient AR also increased because we are still holding a large number of Medicaid claims, as mentioned above. We were informed by our IT department that the fix has gone through a test and was moved to live where PFS staff will be reviewing the fixes. Claims should go out next week which will cause the Patient AT to decrease in September. Prepaid expenses also increased from prior months though they consistently run in the $3 million range.

**Dashboard/Financial Indicators**

The volumes, for the most part, are comparable to the budget and are better than the prior year numbers. The number of Radiology test this month is incorrect and it will be investigated and updated. This error is most likely due to the accounting department being short staffed. The Financial Indicators page shows the increase in Days cash on hand from the booking of the bond issue. Days in AP are good at 37.5 days. The DNFB and DBSP are both above the benchmark again because of the Medicaid claims being held. We will be reviewing the benchmarks in the next few months and making changes to what is measured and more than likely to the benchmark since these numbers are fairly old. We can do this by comparing ourselves to other Alaskan hospitals of similar size. Mr. Tyk said he will also follow up on getting an accurate dietary meal numbers as its showing that it dropped by half.

**Write-Offs**

Mr. Tyk said, during the Revenue Cycle meeting, they talked about a claim (about $300k) that continues to be denied by Aetna. Because of the denial of the initial admission, the patient couldn't be transferred to a rehabilitation facility. Mr. Tyk will be working with Mr. Keith about filing a suit against Aetna.

***Ms. Johnston made a MOTION as moving forward, to have the full BOD approve the financial statements. Mr. Geiger agreed and approved. Ms. Johnston seconded and it will be presented to the full BOD in the next meeting.***

**Charity Care**

Mr. Tyk worked with Tami Churchill, Director of PFS (Patient Finance Services), to outline how we run this program. We have state certified on-site staff who can conduct Medicaid eligibility. We screen every self-pay patient for Medicaid at the time of service and help with the application process. We utilize the Alaskan Federal Poverty Guidelines to determine the requirements for the application. The decision to move a claim into charity is made by the Director of PFS. If a patient doesn't qualify for the full write-off, they will be given a payment plan for any remaining balance. There is a special clause for homeless and mental health.

**Next Meeting:** ***Friday, October 14th at Noon, via Zoom***

**Additional Comments:** None

**Adjourned at 12:44 p.m.**

# CEO Report to the Board

**September, 2022**

**David Keith, CEO**

**100- Day Plan**: Although my first 30-days will conclude in October, meetings with the community, hospital departments, Providers, City and State officials will be ongoing. Based on my meetings and interviews with stakeholders, the next 70 days includes formulation of plans to address the major themes below. Please note that SLT members will be addressing these issues directly with the Board and formalized plans executed. Many SLT members and their staff are already addressing these issues and will elaborate their actions in more detail:

- **FTE (labor) and Cost Management**: The institution has evidence of being over-staffed since 2019 e.g., refer to Premier Workforce Solutions Operations Advisor Project Assessment. Departments assume their budgets are static, thus continue their expenditures despite major revenue losses (millions) for the past three months. Projects and expenditures are also over budget due to cost overruns and change orders. The result is financial loss and continued reliance on Days-Cash-on-hand for financial support, which is diminishing rapidly. The SLT is putting into place criteria and a process to better manage labor costs. Please note there will be no draconian efforts to reduce FTE such as a reduction in force. The SLT will also directly prioritize and manage construction projects and initiatives.

- **Nurse and Allied Health Recruitment and Retention:** Ability to recruit and retain adequate nursing and allied health professionals is thwarting growth. The result is an ongoing dependence on locums and incentive pay, long holds in the ED (Emergency Department), long patient length of stay, delayed discharges and diversions of patients

to other hospitals. Turnover is adversely impacting the Hospital's history of strong clinical acumen. Traditional Human Resource recruiting and retention means will be examined, and changes made to the recruiting process in order to be more flexible, creative and agile. Housing will also require a unique approach, which is perceived as an impediment to successful recruitment and retention.

- **Organizational Structure:** The organizational structure of the Hospital is under review and may be modified in an effort to bring about clarity of function, aligned scope of work, and increased productivity. The current lines of authority may contribute to a misunderstanding of roles and reporting responsibilities. Work product goals and objectives of leaders need strengthening. This effort will increase organization agility and accountability and improve span of control.

- **Physician Alignment:** Physicians and BRH must continue to pursue mutually beneficial alignment e.g., striving for what best for patients, providers, Hospital, and especially the community. Lack of alignment thwarts service-line growth strategies, contributes to adverse out-migration, and negatively impacts the standard-of-care. It ultimately leads to revenue degradation, increased physician and community dis-satisfaction and difficulty with physician succession planning. Improving alignment includes, but not limited to achieving a fully-integrated MEDITECH EMR (electronic medical record); improved "ease-of-use" of hospital services, and achieving major improvements to the OR (Operating Room) facility and management processes.

- **Master Facilities Planning:** Lack of available space is the rate-limiting factor impacting the MFP (master facility plan). Much of the campus space is already consumed with little to no "opportunity space". Opportunity space is necessary for "domino" movement of services and programs. The Plan will be modified to ultimately address the need to transform from in-patient to out-patient services. It is somewhat vague on the migration of services away from the campus. However, the recent approval to

purchase the Family Practice Building off campus provides immediate non-leased space for short-term needs, and long-term growth opportunity. Options for the Family Practice Building are now being considered.

- **Behavioral Health Enterprise:** The operations and financial performance expectations for the new Behavioral Health building and services will be quantified. The absence of a pro-forma is concerning, considering the construction cost overruns, hiring of personnel and lack of financial reimbursement data. The result is an unknown impact on the budget and operations of BRH. A review and audit is being planned for.

- **Patient Throughput:** The Hospital is experiencing major patient throughput issues including multiple ED holds, diversion of potential patients, long admissions due to lack of placement and rescheduling of procedures. Poor throughput results in poor customer satisfaction, provider, nurse and staff dissatisfaction, and an inefficient system negatively impacting the bottom line. Nurse leaders have identified the "pinch" points and are sharing their constructive ideas with the SLT. Additional consultative support and study in the near future may be necessary.

**Solorad Radiology Agreement**: An exclusive agreement with significant changes has been presented to Solorad for consideration. The Agreement has been reviewed by Legal, CFO (Chief Financial Officer) and the CEO (Chief Executive Officer). The goal of the Agreement is to provide Solorad flexibility and opportunity to successfully meet BRH (Bartlett Regional Hospital) expectations within a designated time-frame; and BRH the flexibility to build on the successful relationship, otherwise pivot to a new provider. The goal is to ensure access to quality radiologic services to the community of Juneau.

**Catholic Community Services**: Meetings between Catholic Community Services (CCS) and BRH are underway and both entities are now in the process of conducting necessary due-diligence. Attorneys from both sides are assisting in the due-diligence process. The goal is to determine

the type and scope of a relationship between CCS and BRH in order to salvage the CCS Home Health and Hospice programs in Juneau. It would appear that CCS and BRH could have strong alignment due to their missions and services.

**Wild Flower Court Nursing Home:** Wild Flower Court Nursing Home (WFC) is awaiting the arrival of their interim Administrator this October in anticipation of further discussions between WFC and BRH on achieving a stronger relationship. WFC is a critical service to the community of Juneau, and its mission aligns closely with BRH.

**MEDITECH Expanse:** Mr. Scott Chille, Director of Information Systems has selected not to return to BRH and opted to move on to new employment. Mr. Sam Norton, will be transitioning to BRH as an interim employee and providing leadership to the IS (Information Systems) department. Sam has years of hospital IS experience; has ample experience with MEDITECH Expanse; and is well versed in physician engagement as part of any conversion or optimization process. Mr. Norton will be addressing the Board in a future meeting (Resume Attached).

**CFO Recruitment:** Chief Financial Officer Recruitment continues with additional interviews scheduled this month. Many good candidates lacked required hospital experience, or have removed themselves from consideration.

**Erin Hardin - Community Relations/Marketing**

Strategic Priority #1 – Services: Develop, maintain, and grow a sustainable service portfolio that is responsive to community needs

- **Hospital Website:** Focusing externally, a major effort is currently underway to improve the hospital's overall website with an emphasis on refreshing service line pages. The major goals of the website refresh are to build trust with the community, improve credibility, and increase digital presence. This helps maintain and grow the service line portfolio. The website serves as the hospital's digital 'front door' and is the primary

means by which we publicly communicate about the value of our organization and our services. Left untouched for too long, the website has become outdated, sharing inaccurate information and ultimately portraying the hospital as slow to respond. As previously shared, a content audit has been completed and shared with appropriate staff. Service line pages are currently being rewritten. Additionally, new professional photography and videography of the hospital has been done to be incorporated into the website refresh. This new imagery will be multipurpose and serve as stock footage for other hospital efforts, such as recruitment marketing.

- **Branding Strategy:** Focusing internally, components of a branding strategy for the hospital are currently being developed. A strong, consistent brand is needed in order to showcase and expand our organization's service line capabilities in a competitive healthcare market. This includes collaboration with the Business Development Strategist, Nathan Rumsey, on gathering and accessing hospital and statewide data about our facility's market share, clinical trends, population health, and more in order to make actionable recommendations. This strategy includes a brand system 'refresh' and building a hospital branding and communications guide for all staff that will include information about our brand voice and identity, our value proposition, graphic standards (logo, color palette, etc.), communications templates, and more. The BRH brand identity needs to be present in the hospital and the community in a clear, consistent, and high-impact way.

Strategic Priority #3 – People: Create an atmosphere that enhances employee, physician, and stakeholder satisfaction to improve our ability to recruit and retain. Improve strategic alliances and communication to maintain a community continuum of care.

- **Onboarding/Orientation:** Focusing internally, a cross-team effort to review all existing onboarding/orientation processes (physician, staff, leadership, board) is currently underway. The major goals are to enhance employee and physician satisfaction, align processes, and ensure consistency. Following the first meeting, Community Relations is

leading the research on current and potential technology solutions for delivery of orientation. The next meeting is scheduled to occur by the end of September and will include a cross-walk and mapping of current orientation processes.

- **Employee Recognition:** Focusing internally, the CEO has asked that we create additional opportunities to recognize staff for their outstanding care and service to our patients. The major goal is to reconnect to the community by give extra well-deserved kudos to staff directly related to the accolades received from community members. When a community member informs the hospital of outstanding care (via letter, phone call, etc.) the staff member will be recognized at the first available opportunity by the CEO. This will include a photo opportunity that will be shared on the hospital's social media, mentioning both staff and community member names (with permission). A Juneau 'gold star' pin is under development to be given to staff who have received recognition by a community member.

**Nate Rumsey – Business Development/Strategy**

Strategic Priority #1 - Services: Develop, maintain, and grow a sustainable service portfolio that is responsive to community needs.

- **Telehealth:** Bartlett is currently partnered with Providence St. Joseph Health for EICU and Telestroke services. Recent Bartlett and community assessments have identified increased telehealth service as both a community need, and a potentially significant differentiator for Bartlett service offerings. Recent partnership proposals from Harborview Medical Center and Virginia Mason Medical Center, which could offer expanded specialty service offerings to Bartlett patients, are currently being evaluated. Additionally, discussions with Providence to determine the viability of expansion of virtual care services within our existing partnership are being explored.

- **Service Lines:** The New Service Line Committee met on September 7th to discuss the most appropriate process to evaluate and support new service and new service line proposals. On October 6th the Committee will meet again to finalize procedural, communication, training, and policy recommendations for the Committee and for new service and new service line proposals, as well as to review two "seed" projects. This will allow new services to been considered for approval while establishing a proof of concept for the Committee.

Strategic Priority #2 – Facility: Maintain a comprehensive campus. Address major replacement needs and options for future service lines and revenue growth.

- **Family Practice Building:** On September 12th, the Assembly formally approved ordinance appropriating $2.4M for the purchase of the Family Practice Building. A walkthrough of the building and grounds with BRH leadership and CBJ Lands and Resources is scheduled for September 23rd. Of the building's 10,440 sqft available, 9,350 sqft is currently being leased to three tenants, leaving 1,090 sqft of unleased space. BRH is working with legal counsel to evaluate existing leases and draft new lease agreements. Initial alternatives to leverage new property in alignment with strategic initiatives have been identified.

- **Catholic Community Services Home Health and Hospice:** A due diligence request was sent to CCS leadership on September 7th. A formal response is anticipated during the week of September 19th. Nathan Overson and I will engage with appropriate stakeholders, share and translate the findings to BRH senior leadership, and will assist in the development of a finite and succinct plan of action to recommend to the Board.

**Nathan Overson – Compliance & Legal**

Strategic Goal #6 Compliance: Continuously improve a robust, proactive compliance program at all levels while maintaining our strategic goals.

- **Certificate of Need:** Our Request for Determination (RFD) was reviewed by the State. It was determined that a full certificate of need application is required for the Emergency Room renovation/expansion project. We have anticipated this possibility and will be able to submit the application on Wednesday, September 28th. The time estimate for an application decision by the State, including a clarification period, public comment period, and review by the Commissioner's Office is mid-January 2023.

Strategic Goal #1 - Services: Develop, maintain, and grow a sustainable service portfolio that is responsive to community needs.

- **340(B) Contract Pharmacy:** A decision was made to not renew the contract pharmacy portion of the 340(B) program through Health Resources and Services Administration (HRSA). As a result, we have terminated the associated contracts. Though the internal pharmacy portion of the 340(B) program was renewed and continues to be valuable to the Bartlett, the strategic value of the contract pharmacy was determined to not be aligned with Bartlett's goals at this time.

**Sara Dodd - Physician Services**

Strategic Priority #1 – Services: Develop, maintain, and grow a sustainable service portfolio that is responsive to community needs

- **Active recruitments:** We are actively recruiting for an Orthopedic Surgeon, Medical Oncologist and an Ophthalmologist. No viable candidates identified to date.

**Mimi Benjamin, MD – Hospitalists**

Strategic Priority #3 – People: Create an atmosphere that enhances employee, physician, and stakeholder satisfaction to improve our ability to recruit and retain. Improve strategic alliances and communication to maintain a community continuum of care.

- **Staffing:** The hospitalist service continues to recruit more casual hospitalists to help with staffing. This allows for flexibility in the physician's schedules which has been identified as an attractive part of their job and one of the reasons they stay as BRH hospitalists. We have had very little attrition since the hospitalist service was formed in 2016. Hospitalists have agreed to do 2-year rotations as medical director. While not ideal, this would prevent the recruitment of another medical director unfamiliar with Bartlett. Dr. Greer would be first and will interview with CEO prior to any decision making.

Strategic Priority #4 – Financial: Develop a revenue and net income stream that maintains cash reserves while facilitating above goals and objectives.

- **CDI (Clinical documentation integrity):** The hospitalists continue to work diligently on CDI. Drs. Benjamin and Anderson sit on the HIM (Health Information Management) committee along with coders and staff to improved CDI. CDI is critical to an accurate case-mix-index (CMI) and which translates to improved reimbursement. Data on CDI and CMI impact by the hospitalists will be shared in a future Board meeting.

Strategic Priority #5: Quality and Safety: Provide excellent community centered care that improves outcomes, maximizes safety, improves access and affordability and is in compliance with national and state regulations.

- **Antibiotic Stewardship (committee formed in 2016):** Dr. Benjamin serves as medical director for the Antibiotic Stewardship Committee. This is a robust committee that meets quarterly, to ensure Hospital compliance with JCAHO (Joint Commission) recommendations for antibiotic stewardship. Optimizing the use of antibiotics is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance. Antibiotic stewardship programs can help clinicians improve clinical outcomes and minimize harms by improving antibiotic prescribing. Program outcomes will be shared with the Board in future meetings.

# SAM NORTON

**EXECUTIVE IT LEADER / CIO** with an established record of delivering exceptional results. Customer-focused approach to leveraging current and advanced technology in support of organizational mission. A talented, innovative, and energetic IT leader who instills confidence, excellence, and a culture of positive change. A highly effective professional, problem solver, relationship builder, team builder and coach with excellent project management, strategic planning, analysis and process improvement, and vendor-customer relations skills. Deep experience with complexities of executive and operational IT leadership roles, including cybersecurity, planning, and program management. Experience with enterprise and mission critical systems such as ERPs and EHRs and others. A results-oriented leader with the capability to impact operating efficiencies and influence organizational behavior and culture. Key expertise:

| | | |
|---|---|---|
| IT Planning and Strategy | Cybersecurity, Compliance, HIPAA | Digital transformation |
| Program / Project Management | Technology assessment | Implementation / Conversion |
| Team Building /Development | Vendor Relations, Negotiations | Process and Quality Improvement |

## PROFESSIONAL EXPERIENCE

An extensive record of helping healthcare organizations improve value derived from technology investments across the country. Professional expertise enabling positive results and dramatic improvements for organizations facing multiple challenges. Typical engagements call for urgency from a skilled technology leader with focus both as a leader and hands-on manager, negotiator, project expert, change agent, and a innovative leader who is quality-focused and improvement oriented.

Interim CIO engagements over the last 10 years, averaging 14 months, include service for the following organizations:

- McAlester Regional Health Center (OK) – interim Chief Information Officer 10/20 - 5/21
- Good Shepherd Rehabilitation Network Hospitals (PA) – interim CIO 6/19 – 12/19
- Regional West Health Services (NE) – interim Chief Information Officer 9/17 – 11/18
- Indiana Regional Medical Center (PA) – interim Chief Information Officer 3/16 – 4/17
- Benefis Health System (MT) – interim Chief Information Officer 4/14 – 12/15
- Palomar Health System (CA) – Executive Project Manager 12/13 – 4/14
- St. Luke's Health System (TX) – Chief Information Security Officer 8/11 – 11/13

Completed in-depth IT assessments covering broad range of topics leading to recommened improvement plans. Led health systems IT teams, working closely with executives and physicians in technology and strategic planning, system selection, joint venture and consolidation initiatives, contract negotiations, enterprise EHR implementations, risk mitigation, team development and more. Serve as executive IT leader to establish governance, grow and develop teams, lead technology revitalization, security assessments and technology roadmaps. Prior experience includes serving as CIO for multi-hospital systems, large academic system, consultant for outsourcing and applications vendors, and as a national user group president for a leading health system vendor. Instrumental in developing shared services, coordinating resources with multiple hospital systems, and in consolidating IT services within multi-hospital systems to improve performance. Experience with Cerner, EPIC, Meditech and other EHRs.

Prior roles include CIO for multi-hospital systems, Executive IT Consultant, Applications manager, outsourcing executive manager, sales support, developer, researcher, adjunct professor, regular US Army Officer, and more.

## EDUCATION AND CERTIFICATIONS

| | |
|---|---|
| **University of Tennessee**, *Knoxville, TN* | Baccalaureate of Science – Engineering Mechanics – *with Honors* |
| **Johns Hopkins University**, *Baltimore, MD* | Masters in Computer Science – *with Honors* |
| **University of New Orleans, New Orleans LA** | Certificate, Product Line Management / mini MBA |

**Certified Professional in Healthcare Information and Management Systems** (CPHIS)
**Project Management Professional** (2007)

**SAM NORTON**
**ADDITIONAL ACCOMPLISHMENTS AND EXPERIENCE**

CIO (Contract) - Rebuilt IT department after Covid-19 impact, completed Meditech EHR implementation, developed project and cybersecurity roadmap and gained exeutive approval. Implemented numerous missing security policies and controls. McAlester Regional Health Center, OK 2020-2021

CIO (Contract) – Completed IT assessment and built project portfolio including IT security roadmap and remitiation plan. Completed Cerner upgrade. Co-led analytics committee with Chief Medical Officer. Provided AR/Financial and other education to executives and leadership. Good Shepherd Rehabilitation Network Hospitals, PA 2019

CIO (Contract) - Renegotiated EHR vendor agreements with corrected scope and timeline saving $~2.8M. Led successful implementation of EHR. Build application to manage role-based access. Led joint IT planning with 6 regional health centers leading to joint IT projects. Gained approval for increased cybersecurity capital and added security position. Updated security assessment and developed mitigation plans to address vulnerabilities. Regional West Health Services, NE 2017-2018

CIO (Contract) - Led administrators and physicians through strategic planning and EHR system selection, developed technology implementation plans, negotiated multiple vendor agreements. Coordinated joint venture due diligence and proposal between neighboring health systems. Prepared EHR implementation plan. Updated out-of-date technology, addressing risks and preparing for EHR. Developed staffing plan including cybersecurity roles. Updated security policies and insurance coverage. Indiana Regional Medical Center, PA 2016-2017

CIO (Contract) – Expanded IT services, including regional telehealth services. Developed IT Governance and led enterprise IT selection of new EHR. Implemented IT service and project methodologies. Implemented analytics department.. Developed informatics team and improved clinical workflows. Completed significant technology upgrades. Formed, staffed, and training cybersecurity department. Reduced operating expenses by $5M+. Benefis Health System, MT 2014-2015

Project Consultant (Contract) – Senior project manager for technology and EHR deployment in newly constucted state-of-the-art hospital. Provider relations with improved engagement and adoption, and project advisor for 3 large hospitals during EMR implementation. Palomar Health System, CA 2013-2014

Chief Information Security Officer – Advised and help guide 6-hospital system with multiple clinics through successful EPIC implementation. Improved technical and administrative security controls and services throughout the enterprise. Implemented security controls and directed security audits. Servered on numerous enterprise leadership committees. St. Luke's Health System, TX 2011-2013

Director, Information Systems (Interim) –Led EHR deployment and upgrades with a myriad of clinical improvement and meaningful use initiatives revitalizing information systems; team building, coaching and mentoring, project planning, improving service delivery. Installed governing IT processes improving performance and project delivery, formulated system replacement / upgrade strategies, led in expansion of HIE. Beebe Medical Center, DE 2010-2011

Director, Information Systems / Biomedical Engineering, Telecommunications (Interim)
Recruited to Memorial Hospital on gulf coast through turnaround period for Katrina. Resolved significant vendor, product and service issues making needed improvements and establishing excellent customer support. Renegotiated all major contracts saving over $500,000 annually. Prepared pro forma demonstrating $11M+ ROI from ARRA related initiatives. Led physicians to select new EHR and integrat newly acquired physician clinics. Directed security audit recommendeing technical, process, and management changes. Memorial Hospital, MS 2008-2009

Executive Director Information Systems (Interim)
Led 200+ member IT staff during transition, merger and consolidation of multiple IT departments. Guided technical and application projects, and developed staffing models and plans, including consolidation of IT departments. Developed and managed $40M+ operating budget. Directed and coached managers to support key initiatives with customer focus. Led IT managers in technology and life-cycle planning and other improvements, including use of Studer and Six-Sigma techniques. Mercy Health Partners, OH 2008

Various executive roles in IT Outsourcing 1999-2007
Led large organizational transistions to IT outsourcing in several states. Provided sales support and analysis of opportunities. Led team to complete due diligance for new opportunities.

## SAM NORTON
## ADDITIONAL ACCOMPLISHMENTS AND EXPERIENCE

Other healthcare engagements and positions have included leading in establishing both hybrid and shared service deliver systems for multiple sites, IT strategic planning for multiple ambulatory and acute health systems including multi-hospital organizations and regional health systems; recommending strategies and performing due diligence regarding outsourcing services, providing interim IT leadership, coordinating shared IT system implementations and deployments, and shared services between multiple health systems such as applications, network, and service desk. Engagements have included clients in each region of the country from Maine to Florida, from South Dakota to South Carolina, from Mississippi to Montana, and from California to Connecticut. In each there have been an opportunity to learn and grow, as well as make significant contributions.

## ADDITIONAL EXPERIENCE

- Adjunct Professor East Tennessee State University, University of Texas, and Texas Women's University
- Experienced speaker / presenter at national user groups
- Global and National Disaster Relief leadership experience, including Ukraine most recently
- Application development in manufacturing, medical, and agricultural research
- US Army Veteran (Captain), Meritorious Service Medal Award
- Active community volunteer and leader

Bartlett Regional Hospital

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

**September 27, 2022 CFO Board Report**
**Robert Tyk, Interim CFO**

Accounting report – Sam Muse

- New AP Specialist, Daisy Hamby, started 9/19/2022
- New Senior Accountant, Jennifer Knight, starts on 10/3/2022
- New Grant Manager, Noelle Dersé, starts on 10/31/2022
- Financial Statement Audit is underway and to be completed in the next month
- Medicare Cost Report Audit for 6/30/2021 is currently ongoing
- Preparation of the 6/30/2022 cost report is underway

**Health Information Management (HIM) – Rachael Stark**

- HIM continues analyzing all inpatient, surgery, clinical and emergency room visits daily. Due to the analyst departing Bartlett, we have all been doing this function for the past few weeks.
- We also release records from Bartlett Outpatient Psychiatry, Rainforest, and Bartlett Regional Hospital. We now have a fillable form on our web page that has seen an increase in release for records. We have put a drop down box so patients can choose between BOPS, RRC and Bartlett.
- HIM is monitoring our Fair Warning application which looks for inappropriate access into the Medical Records. That program is working really well and we are meeting every two weeks with their team. We will continue to reach out to employees who get flagged for inappropriate access. We are looking to add another parameter to watch for inappropriate access from outside clinics. This would enable us to grant access to outside clinics and to be able to watch for any abuses to that access.

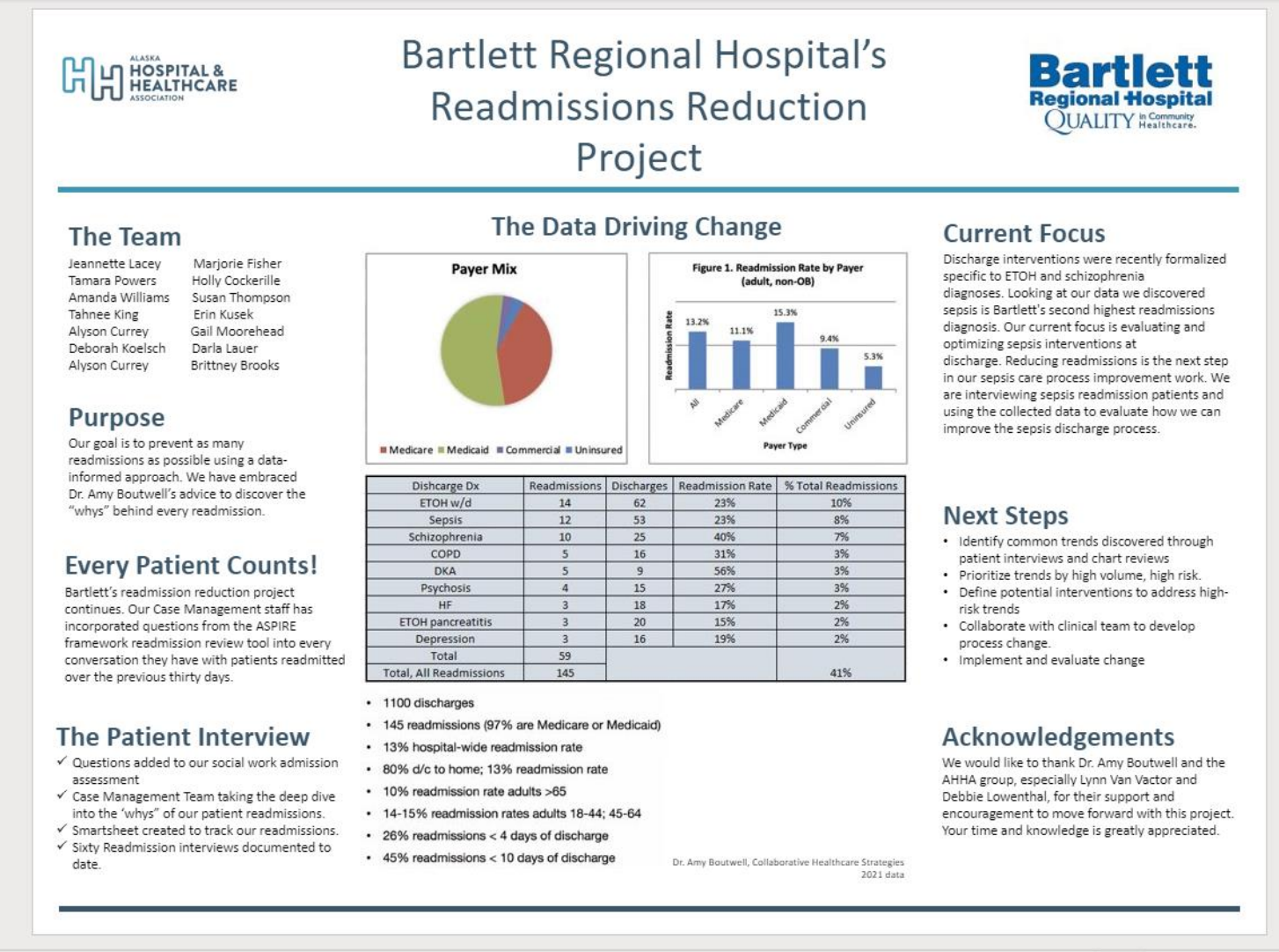
**Case Management – Jeannette Lacey**

1. Case Mix Index

| | August 2022 CMI | | |
|---|---|---|---|
| Total IN | 151 | CMI | 1.37 |
| MCR In | 49 | CMI | 1.58 |
| MCD In | 54 | CMI | 1.3 |

2. Hospice and Home Care Services:
    - BRH CM was notified on August 26 that Hospice and Homecare would no longer be taking referrals. As of Sept 24 they will have one nurse. That nurse also gave notice and their last day is Oct 19. They are working on identifying travel nurses.
    - BRH staff, CCFR Mobile Integrated Health (MIH), community primary care providers, Public Health, and Hospice staff met September 14 to brainstorm ideas regarding how to fill the gap to support end-of-life care needs while Hospice services are unavailable. More discussion to come with that group.
3. Hello Baby:
    - Rachel Gladhart, our perinatal nurse case manager/OB patient navigator presented as a panelist during the statewide Medications for Addictions Treatment conference. We are so grateful for this important program for our SE communities.

4. Readmissions Project:
    - Jeannette Lacey, director of CM, and Deb Koelsch, clinical quality coordinator, are presenting a poster on the BRH readmissions project at the Alaska Hospital and Healthcare Association statewide conference next week.



Bartlett Regional Hospital's Readmissions Reduction Project

## The Team

Jeannette Lacey, Tamara Powers, Amanda Williams, Tahnee King, Alyson Currey, Deborah Koelsch, Alyson Currey, Marjorie Fisher, Holly Cockerille, Susan Thompson, Erin Kusek, Gail Moorehead, Darla Lauer, Brittney Brooks

## Purpose

Our goal is to prevent as many readmissions as possible using a data-informed approach. We have embraced Dr. Amy Boutwell's advice to discover the "whys" behind every readmission.

## Every Patient Counts!

Bartlett's readmission reduction project continues. Our Case Management staff has incorporated questions from the ASPIRE framework readmission review tool into every conversation they have with patients readmitted over the previous thirty days.

## The Patient Interview

- ✓ Questions added to our social work admission assessment
- ✓ Case Management Team taking the deep dive into the 'whys" of our patient readmissions.
- ✓ Smartsheet created to track our readmissions.
- ✓ Sixty Readmission interviews documented to date.

## The Data Driving Change







| Dishcarge Dx | Readmissions | Discharges | Readmission Rate | % Total Readmissions |
|---|---|---|---|---|
| ETOH w/d | 14 | 62 | 23% | 10% |
| Sepsis | 12 | 53 | 23% | 8% |
| Schizophrenia | 10 | 25 | 40% | 7% |
| COPD | 5 | 16 | 31% | 3% |
| DKA | 5 | 9 | 56% | 3% |
| Psychosis | 4 | 15 | 27% | 3% |
| HF | 3 | 18 | 17% | 2% |
| ETOH pancreatitis | 3 | 20 | 15% | 2% |
| Depression | 3 | 16 | 19% | 2% |
| Total | 59 | | | |
| Total, All Readmissions | 145 | | | 41% |

- 1100 discharges
- 145 readmissions (97% are Medicare or Medicaid)
- 13% hospital-wide readmission rate
- 80% d/c to home; 13% readmission rate
- 10% readmission rate adults >65
- 14-15% readmission rates adults 18-44; 45-64
- 26% readmissions < 4 days of discharge
- 45% readmissions < 10 days of discharge

Dr. Amy Boutwell, Collaborative Healthcare Strategies
2021 data

## Current Focus

Discharge interventions were recently formalized specific to ETOH and schizophrenia diagnoses. Looking at our data we discovered sepsis is Bartlett's second highest readmissions diagnosis. Our current focus is evaluating and optimizing sepsis interventions at discharge. Reducing readmissions is the next step in our sepsis care process improvement work. We are interviewing sepsis readmission patients and using the collected data to evaluate how we can improve the sepsis discharge process.

## Next Steps

- Identify common trends discovered through patient interviews and chart reviews
- Prioritize trends by high volume, high risk.
- Define potential interventions to address high-risk trends
- Collaborate with clinical team to develop process change.
- Implement and evaluate change

## Acknowledgements

We would like to thank Dr. Amy Boutwell and the AHHA group, especially Lynn Van Vactor and Debbie Lowenthal, for their support and encouragement to move forward with this project. Your time and knowledge is greatly appreciated.

5. Alaska Transitions of Care

    Alaska hospitals meeting to discuss and address challenges with transitions of care:

    During our meeting on August 30, Beth Goldstein with the Office of Public Advocacy joined us to review some of the processes and changes with establishing a public guardian and to listen to some of the concerns and challenges experienced from the hospital setting. She was able to offer suggestions/strategies on how to work more efficiently with OPA. She is also willing to offer education to individual hospitals.

**Patient Financial Services (PFS) – Tami Lawson-Churchill**

- Overall cash collections for the month of August is up from prior month at just over $9.3 Million
- PFS working on an RFP with the city for assistance with early out collections process
- PFS is still working with Pharmacy and Tegria to resolve NDC quantity discrepancies. Error rates are decreasing and we hope to have this resolved within the week. In the meantime, PFS is manually correcting these NDC units before sending claims out to the payer.
- PFS is preparing to offer a limited PFD discount program for patients with older account balances

**Materials Management (MM) – Willy Dodd**

- Materials Management completed departmental inventory counts on CCU and MedSurg in August and will work throughout the remaining departments on an ongoing basis throughout the year. These regular counts will help keep inventory levels accurate and spread expenses throughout the year, rather than just during our year-end inventory count.

- MM is trialing and selecting a new handheld device for use in MM and in several departments. We will be working with the nursing staff to ensure they get a chance to trial the devices, as a primary user for issuing patient chargeable supplies. This device is currently on site and MM staff will start using it first, followed by clinical testing for the nursing staff. The current device is very similar to our older models.

- MM has encountered an issue with our EDI ordering process, which has caused delays in our ordering process and subsequently led to delays in receipt of supplies. We are working with IT, Meditech and Cardinal Health to resolve the issue.

**Information Systems – Scott Chille**

**Projects**

- **Multi-Factor Authentication Project: [DELAYED]** Roll-out to all staff and providers for all remote authentication like Citrix, VPN, and Office365 access. Email blast and how-to guides sent out.
- **Office365 Native Application Install:** Ongoing by department through September. Installing latest versions of Office applications across the organization to take advantage of native features within the applications for better communication and collaboration.
- **MEDITECH Expanse Web Presentation Layer (WPL):** Departmental rollouts starting early August thru December/January.

**Department Updates**

- Interim Director, Sam Norton starts Monday September 19th

**Information Security**

- **Rapid7 Incident Detection and Response Report**
  - No MITRE ATT&CK Techniques detected in August 2022
- **Rapid7 Hunt Report:**
  - Hunt data from **879 endpoints** did not identify any indicators of compromise.
- **Cybereason (Endpoint Detection and Response) Report:**
  - **0** MalOps detected in August 2022

# Bartlett Regional Hospital

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## Human Resource Report

## September 2022

**Dallas Hargrave, HR Director**

**Recruitment and Retention Initiatives:**

- **CFO Recruitment:** The CFO position has been posted and we continue to interview the most qualified candidates. The position is being advertised nationally. Although the CEO will eventual hire the CFO, we intend to involve Board Members Deb Johnston and Max Mertz in the recruitment process for any finalists.

- **Market Wage Analysis:** The Request for Proposals (RFP) for a third party consultant to conduct a market wage analysis has been completed and we are in the process of negotiating the contract with the selected responder. Once the contract is complete, the approximate timeframe that this work will be completed will be determined and shared with the Board. The completed market wage analysis provides a comparison of our pay rates to other hospitals in Alaska and the Pacific Northwest. Additionally, the analysis supports a path forward on other recruitment and retention efforts.

- **Engagement of High School and College Students:** Members of our HR team are busy coordinating engagement with students at various levels. On 2 September, BRH recruiters met with potential applicants at the University Alaska Southeast (UAS) annual campus kick-off event with the goal of identifying prospective candidates. HR staff are coordinating with high school staff to introduce careers at the hospital to Juneau students, working with Homebridge (home school option

in the Juneau District) to plan for student job shadowing at BRH., and preparing to meet with Juneau high school juniors and seniors at the college and career fair at Juneau Douglas High School (JDHS) in October. The college and career fair at JDHS will involve students from Thunder Mountain and Yaakoosge high schools in the morning, students from JDHS in the afternoon, and parents and other community members in the evening. HR will be sending recruiters to job fairs at the University of Alaska Anchorage (UAA) and University of Alaska Fairbanks (UAF) in November.

- **Social Media Campaign:** HR and Marketing are developing social media strategies to increase BRH awareness and access potential candidates interested in an Alaska experience. The campaign, (under development), will provide a more far-reaching opportunity to connect with casual job seekers in the lower-48. Social media tools will be utilized to measure contacts and effectiveness. More information will be forthcoming to the Board.

- **Foreign Workers:** Human Resources has engaged with two companies that recruit potential foreign applicants to fill hard-to-recruit positions in the hospital. The two specific companies with whom we have engaged work with will be targeting applicants from the Philippines. HR is working with the Pilipino community to solicit support and identify potential candidates.

**CEO Goals:** The HR Director met with Governance Committee Chair Hal Geiger and Board President Kenny Solomon-Gross on September 20 to review the draft of the annual CEO goals. The Board President and CEO have reviewed and agreed to the goals as presented in the board packet for approval. As a reminder, the Board committed to presenting Mr. Keith with annual goals within 60 days of starting in the CEO position.

**Onboarding Initiative:** The HR Director assembled a team to begin assessing and improving our current orientation or onboarding practices for employees, board members, physicians, and

leaders. The goal is to improve the orientation process and ensure target audiences receives accurate, concise and meaningful information. Coordination with stakeholders includes examining current practices, content, and development of a consistent "look and feel" across the different orientation processes at the hospital. A kick-off meeting on September 14 led to the initial goals: 1) solicit survey responses by those who have experienced the onboarding at the hospital recently; 2) researching modern methods of communicating onboarding content; 3) conducting a process mapping exercise to look for overlap in content between the different onboarding practices.

**Employee Housing:** The HR Director and Business Development Strategist met with the Planning Manager and Housing Planner and the City and Borough of Juneau Community Development Department (CDD) on August 29, 2022. To begin the process of identifying opportunities to improve housing availability in a manner that can benefit both the hospital and the community. Housing availability (real or perceived) is often noted as a barrier for potential and current employees to become employed and remain employed in Juneau. Addressing housing availability will likely be a key strategic recruitment and retention initiative at the Hospital.

**Leadership Reporting Structure:** The CEO has requested that the HR Director lead the effort to review the current reporting structures for Senior Leaders including the CEO. The effort is to bring about improved communication, span of control, and clarity of function. The goal is to improve decision making and increase accountability among leaders. The HR Director will work with other senior leaders to present changes to leadership organizational structure that will increase organizational agility and accountability in early November.

# Bartlett Regional Hospital

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

**CCO Report**

**September 2022**

**Kim McDowell CCO**

Attended the Alaska Hospital and Healthcare (AHHA) conference. The conference focused on strategies to address workforce, organizational sustainability, and employee burnout. Through the conference I was able to make contact with many leaders who shared their successes with building their workforce. They accomplished this by engaging high school students in early exposure to healthcare with appropriate job roles. I was also approached by Nightingale College who would like to use BRH as their clinical site to host their nursing students who live in Juneau. This would be the third nursing school BRH would host clinicals for. This will give BRH another avenue to recruit nurses.

Another great opportunity that came from the conference is that AHHA is looking for hospitals to partake in a pilot program looking at employee burnout, in conjunction with Dr. Shapiro who focuses on employee wellbeing. I have requested BRH be considered for this pilot that will help BRH address burnout with our teams and create resilience. This will improve employee satisfaction, and wellbeing.

**Obstetrics Department (OB)**

- BRH is sponsoring a "Real Talk" Walk/Run on October 22nd at the Airport Trail. This walk/run is to raise awareness for many of the challenges surrounding pregnancy and early motherhood. This includes pregnancy and infant loss, birth trauma, infertility, perinatal mental health, and so many other important topics. We are really looking forward to engaging with the community and sharing many of the outstanding resources and support groups that Bartlett Regional Hospital offers. We looked forward to this becoming an annual event.

- The September drill for OB focused on stat C-Sections in the main OR (in the event the OB OR is unavailable). We had **19 OB RNs** in attendance for this drill! A big thank you to Leanne Dapcevich and Hailey Pusich for running the outstanding drill.

- OB/Neonatal Committee educational chart review happened on Monday September 19th. We welcomed back Dr. Harding, perinatologist from Swedish in Seattle, and Dr. Johnson, neonatologist from Providence in Anchorage as our expert reviewers and educators. We had a strong turnout of OB providers and nurses in attendance and a wealth of new knowledge and information was shared.

**Surgical Services:** Bartlett Regional Hospital Surgical Services Assessment by QHR Health identified several key opportunities for improvement. The assessment identified processes and resources needed to effectively manage the service line and improve nurse, tech and physician satisfaction. The results have and will be shared with appropriate stakeholders including the SLT. Action plans are being developed and will be shared with the Board.

- In process of getting third OR open, so needed construction can occur while continuing to have two OR rooms always available for services. Once complete, BRH will have the opportunity to have three OR rooms functional for services. This will increase number of surgical cases BRH can accommodate.

- Three OR Tech trainees will begin the OR Tech Program as of October 5th. The goal is to ensure an adequate number of techs to support and increase the number of surgical cases and improve surgical volume throughput. Having an optimal number of OR Techs will improve provider and staff satisfaction.

- Select nurses, new to the OR, will begin training via the Association of periOperative Nurses (AORN) starting October 5th. Having an optimal number of OR nurses will increase surgical throughput and improve provider and staff satisfaction.

**Cardio/Pulmonary, Respiratory Therapy & Sleep Lab Department:** Cardiac Rehab is using Telehealth to provide services to patients that suffer from long COVID. Using Telehealth will allow BRH to reach patients that may have difficulty with mobility, as well as those in outlying communities.

**Nutrition Services:** Dietary Manager is setting up databases for ingredient and recipe information in the Dietary Food Management system (DFM). This will allow access to the USDA, and US Foods database to obtain nutrient information for patient menus. Once this step is complete, the plan is to integrate DFM with Meditech so the room service function can be used for our patients. Having patients be able to order room service electronically would alleviate the need for paper menus, it will streamline processes, and improve patient and staff satisfaction.

**Medical-Surgical Unit:** Med/Surg will be implementing Age- Friendly Health Systems. With the number of older adults 65 and over rapidly growing, care often becomes more complex to manage, and older adults can suffer harm events while in a health system. The 4Ms- What Matters, Medication, Mentation and Mobility, is designed to make care of older adults with complex needs more manageable. This implementation will help reduce falls and provide an area of focus that has not been purposeful in patients' care. This will enhance the patient experience, improve patient satisfaction, as well as decreasing risk to our older patients.

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**September 27, 2022 Behavioral Health Board Report**

**Tracy Dompeling, Chief Behavioral Health Officer**

**Crisis Stabilization and Observation Services:** Construction of the building which will house the new Crisis Stabilization and Observation service lines, along with several other Bartlett Behavioral Health services, continues to progress on schedule. Work is underway with our consultants, Agnew::Beck, to identify a plan for program development and service line implementation. Salary/Wages/Benefits as well as other expenses have been provided to Agnew::Beck to formulate a Pro-forma of our anticipated net income from these service lines. This Pro-forma will be available to senior leadership within two to three months after the billing modeling process is developed based on specific services planned.

**Crisis Observation/Crisis Now Site Visit:** Team members from Bartlett as well as community stakeholders (JAMHI Health and Wellness, Capital City Fire and Rescue, Juneau Police Department, and City and Borough of Juneau) are traveling next week with representatives from Agnew :: Beck and The Alaska Mental Health Trust to conduct a site visit at RI International. This organization in Tempe, Arizona is a best practice innovative site on which most of the Crisis Now models used throughout Alaska and the nation have been developed. This is an opportunity for Juneau community stakeholders to observe the services, meet with local stakeholders, and provide opportunity for more informed Crisis Observation development in Juneau. The Alaska Metal Health Trust is providing the funding for the team travel. This site-visit provides opportunity for Bartlett to develop a sustainable service portfolio that is responsive to our community needs.

**Chris Kyle Hospital Site Visit**: Chief Clinical Officer Kim McDowell and I had the opportunity to participate in a site visit at the Chris Kyle Hospital in Anchorage - operated by NorthStar. The inpatient community-based program performs both 3.7 and 4.0 ASAM (American Substance Abuse Management - levels of care) withdrawal management services. This program is recommended by the Division of Behavioral Health as a model program for the reopening of Bartlett's Withdrawal

Management Unit, providing increased level of services and revenue opportunities. These services performed on the Withdrawal Management Unit will eliminate the need for Med-Surg beds to be utilized in this capacity, favorably impacting patient throughput.

**Individual Behavioral Health Service Lines**

- **Behavioral Health Outpatient Services (BOPS):** With a reduction in the waitlist and increased clinical capacity, psychiatric appointments are readily available, and staff are working diligently to schedule patients for assessments and treatment. Ongoing recruitment for administrative staff is occurring and the incoming Practice Manager is already hard at work identifying efficiencies for workflow and patient care through observation and discussion with staff and providers.

- **Crisis Intervention Services:** Certification with Alaska Division of Behavioral Health was completed to add Home Based Treatment Services under the Medicaid 1115 waiver as a billable service.

- **Rainforest Recovery Center:** Ongoing conversations with Bartlett Infectious Disease to determine safe ways to admit new patients to the program that will not require a reduction in capacity. In an effort to establish effective management of COVID-19 currently and in the future, ongoing evaluation of admission practices is necessary.

- **Mental Health Unit:** Currently recruiting for four full-time Nurses. A recent PRN transfer from within Bartlett, and the use of travel nurses in the upcoming weeks, will allow for an increase in bed capacity (currently capped between 5-6 patients depending on acuity) while staffing allows. Both voluntary and involuntary inpatient psychiatric services are important resources for our local community and statewide. Increasing bed capacity allows for fewer holds in emergency departments and Med-Surg units and more appropriate psychiatric care for our community members and all Alaskans.

Bartlett Regional Hospital

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# September 27, 2022
# Management Report
# From Studebaker Nault and CBJ Law

- Status report on completed projects
- Status report on pending projects and contract negotiations
- Status report on consultations with Department and Hospital leadership

# October 2022

*****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 | 3 | 4 | 5 | 6 | 7<br>12:00 Planning Committee<br>(PUBLIC MEETING) | 8 |
| 9 | 10 | 11<br>7:00am Credentials Committee<br>(NOT A PUBLIC MEETING) | 12 | 13<br>12:00 Board Governance Committee<br>(PUBLIC MEETING) | 14<br>12:00pm Finance Committee<br>(PUBLIC MEETING) | 15 |
| 16 | 17 | 18<br>  | 19 | 20 | 21 | 22 |
| 23 | 24 | 25<br>5:30pm Board of Directors<br>(PUBLIC MEETING) | 26 | 27 | 28 | 29 |
| 30 | 31<br>  | | | | | |

**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 Conference – Every 3 Months**
**Physician Recruitment – As needed**
**Governance – As needed**
**Planning – 1st Friday every month**

# OCTOBER 2022 - BRH Board of Directors and Committee Meetings

**BRH Planning Committee 12:00pm Friday, October 7th**
https://bartletthospital.zoom.us/j/94747501805
Call 1 888 788 0099 Meeting ID: 947 4750 1805

**BRH Board Governance Committee Meeting 12:00pm Thursday, October 13th**
https://bartletthospital.zoom.us/j/91301657597
Call 1 888 788 0099 Meeting ID: 913 0165 7597

**BRH Finance Committee 12:00pm Friday, October 14th**
https://bartletthospital.zoom.us/j/94088630653
Call 1 888 788 0099 Meeting ID: 940 8863 0653

**BRH Board of Directors Meeting 5:30pm Tuesday, October 25th**
https://bartletthospital.zoom.us/j/93293926195
Call 1 888 788 0099 Meeting ID: 932 9392 6195