

# Bartlett Regional Hospital

**AGENDA**  
**BOARD OF DIRECTORS MEETING**  
**Tuesday, January 25, 2022; 5:30 p.m.**  
**BRH Boardroom and Zoom/Videoconference**

Board members and designated staff will meet in person to the extent possible.  
Public, staff and Board members wishing to attend virtually may access the meeting via the following link <https://bartletthospital.zoom.us/j/93293926195>

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

<b>I.</b>	<b>CALL TO ORDER</b>		<b>5:30</b>
<b>II.</b>	<b>ROLL CALL</b>		<b>5:32</b>
<b>III.</b>	<b>APPROVE AGENDA</b>		<b>5:34</b>
<b>IV.</b>	<b>PUBLIC PARTICIPATION</b>		<b>5:35</b>
<b>V.</b>	<b>CONSENT AGENDA</b>		<b>5:45</b>
	A. December 28, 2021 Board of Directors Meeting Minutes	(Pg.3)	
	B. January 8, 2022 Strategic Planning Work Session Minutes	(Pg.9)	
	C. November 2021 Financials	(Pg.17)	
<b>VI.</b>	<b>OLD BUSINESS</b>		<b>6:00</b>
	➤ COVID update		
<b>VII.</b>	<b>MEDICAL STAFF REPORT</b>		<b>6:05</b>
<b>VIII.</b>	<b>COMMITTEE MINUTES/REPORTS</b>		<b>6:10</b>
	A. January 12, 2022 Draft Quality Committee Meeting Minutes	(Pg.22)	
	➤ Annual Management Plans – <b>ACTION ITEM</b>	(Pg.24)	
	B. January 14, 2022 Draft Finance Committee Minutes	(Pg.86)	
	<b>ACTION ITEMS</b>		
	➤ \$4 Million appropriation for Behavioral Health Facility	(Pg.88)	
	➤ \$325,000 appropriation for ED renovation project	(Pg.91)	
<b>IX.</b>	<b>MANAGEMENT REPORTS</b>		<b>6:20</b>
	A. Legal Management Report	(Pg.92)	
	B. HR Management Report	(Pg.93)	
	C. CNO Management Report	(Pg.95)	
	D. CBHO Management Report	(Pg.97)	
	E. COO Management Report	(Pg.102)	

	F. CFO Management Report	(Pg.107)	
	G. CEO Management Report	(Pg.111)	
<b>X.</b>	<b>CEO REPORT / STRATEGIC DISCUSSION</b>		<b>6:30</b>
<b>XI.</b>	<b>CBJ LIAISON REPORT</b>		<b>6:35</b>
<b>XII.</b>	<b>PRESIDENT REPORT</b>		<b>6:40</b>
<b>XIII.</b>	<b>BOARD CALENDAR – February 2022</b>	(Pg.112)	<b>6:55</b>
<b>XIV.</b>	<b>BOARD COMMENTS AND QUESTIONS</b>		<b>7:00</b>
<b>XV.</b>	<b>EXECUTIVE SESSION</b>		<b>7:05</b>
	A. Credentialing Report		
	B. January 4, 2022 Medical Staff Meeting Minutes		
	C. Patient Safety Dashboard		
	D. Legal and Litigation		
	E. Campus Planning		

*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.)*

*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.)*

<b>XVI.</b>	<b>ADJOURNMENT</b>		<b>7:30</b>
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**NEXT MEETING – Tuesday, February 22, 2022; 5:30p.m.**

# Bartlett Regional Hospital

Minutes  
BOARD OF DIRECTORS MEETING  
December 28, 2021 – 5:30 p.m.  
BRH Boardroom / Zoom videoconference

**CALL TO ORDER** – Meeting called to order at 5:32 p.m. by Kenny Solomon-Gross, Board President. Roll call taken.

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

Kenny Solomon-Gross, President	Rosemary Hagevig, Vice-President	Mark Johnson, Secretary
Brenda Knapp	Lance Stevens	Deb Johnston
Hal Geiger	Iola Young	<i>Lindy Jones, MD</i>

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

<i>Jerel Humphrey, Interim CEO</i>	<i>Kevin Benson, CFO</i>	<i>Kim McDowell, CNO</i>
<i>Dallas Hargrave, HR Director</i>	<i>Vlad Toca, COO</i>	<i>Karen Forrest, Interim CBHO</i>
<i>Keegan Jackson, MD, COS</i>	<i>Michelle Hale, CBJ Liaison</i>	<i>Barbara Nault, Legal Advisor</i>
<i>Robert Palmer, CBJ Law</i>	<i>Sarah Griffith, Elgee Rehfeld</i>	<i>Karen Tarver, Elgee Rehfeld</i>
<i>Joseph Roth, MD</i>	Anita Moffitt, Executive Assistant	

**APPROVE AGENDA** – Request made to move the Compliance Update from Old Business to the Board Compliance and Audit Committee Report section. **MOTION** by Ms. Hagevig to approve the agenda as amended. Mr. Geiger seconded. *There being no objections, agenda approved as amended.*

**PUBLIC PARTICIPATION** – None

**CONSENT AGENDA** - **MOTION** by Ms. Hagevig to approve the consent agenda as presented. Ms. Knapp seconded. *There being no objection, the November 23, Board of Directors meeting minutes and October 2021 Financials approved.*

**NEW BUSINESS**

**Financial Audit Review** – Sarah Griffith, of Elgee Rehfeld, introduced herself as the partner in charge of the BRH stand-alone financial statement audit. She then recognized Zoom participant Karen Tarver as the auditor in charge of the CBJ audit and acknowledged Adam Sykes' involvement in the BRH audit, especially as it pertains to the Revenue Cycle. A summary level of the June 30, 2021 financial statement audit to be presented this evening. BRH grants, which are subject to federal and state single audits, are included in CBJ's audit and is not yet complete. It was noted that BRH is an enterprise fund included in the CBJ ACFR. Copies of the letter to the board and the audited financial statements are included in tonight's packet. Ms. Griffith provided an overview of the timing and audit process. A draft form of the audit results had been presented at the December 10<sup>th</sup> Finance Committee meeting with most of the board members in attendance. Financial statements were issued in its final form on December 15<sup>th</sup>. Financial statement audit results were unmodified, meaning financial statements are materially correct. The financial statements contain significant estimates to the following: 1) Net Pension Liability, OPEB Assets and Liabilities and Deferred inflows and outflows. 2) Patient Accounts receivable 3) Provider relief funds. Draft financial statements were prepared by Elgee Rehfeld based on accounting system and management provided data. Management retains responsibility of the financial statements by reviewing the draft and accepting it. She reported there were no material audit adjustments identified this year. Statement of Net Position overview provided. Total assets: \$172 million compared to \$162 million the prior year. Total liabilities: \$101 million compared to \$96 million

the prior year. Net position of BRH is \$65 million. Pension adjustments required by GASB have significant impact on financial statement. Taking into account all of the assets, liabilities and accruals associated with the net pension and OPEB obligations, it was a \$2 million decrease in expense. Summarized income statement overview provided: \$118 million in revenues compared to \$103 million the prior year. Expenses of \$122 million compared to \$105 million in prior year. Change in net position \$4 million compared to \$8 million in prior year. Suggestions for improvement provided as part of the audit and discussed at length with management, Board President and Finance Committee Chair. A finding of deficiency in internal control over financial reporting related to purchasing processes, specifically surrounding credit cards identified. Auditor recommendation associated with this is that BRH perform an entity wide risk assessment of the organization and ensure there are policies and procedures in place to mitigate any risks. Another matter identified, that did not rise to the level of a finding, is related to gift card purchasing and requirements to be reported as taxable compensation to employees. Management has an action plan in place to address these issues. There are no prior year comments to report on. CBJ state single audit results are pending and there could be findings or issues as a result of the programs being audited. The single audit was not issued at the time of the financial statements audit due to late guidance from the federal government pertaining to how to audit some of the programs CBJ has. Results are anticipated to be completed in January. The entity wide financial statement audit results, however, will be presented to the Assembly on January 4<sup>th</sup>. She expressed thanks and appreciation for BRH staff during this process, specifically Mr. Benson, Ms. Robert and the rest of the accounting team. They were great to work.

**MOTION by Ms. Johnston that the Board accept the audited Financial Statement Report and Letter to the Board. Mr. Stevens seconded. There being no objections, MOTION approved.** Mr. Solomon-Gross thanked Ms. Griffith and Ms. Tarver for their diligence and wished them a happy new year.

**MEDICAL STAFF REPORT** – Dr. Jackson noted the December 7<sup>th</sup> meeting was very brief and reported the following: There had been a presentation of the high sensitivity troponin protocol/test used to rule out heart attack. ER physicians and hospitalist worked together to educate other providers on this test. A second reading and request for approval of the Bylaws revision to Article 8.9 related to physicians and other practitioners in training. Approval of the revision was unanimous. Conversion of old charts from Meditech Magic to Meditech Expanse not complete yet. Discussion held about the need to provide Meditech Magic training to new providers so they can access old charts. Physician Health and Wellness committee survey will be open until January 1<sup>st</sup>. This survey is to help identify what providers in the community want and need. Election of officers for 2022 was held. Dr. Nicholas Rosenfeld elected Vice Chief of Staff and Dr. Amy Dressel, Secretary/Treasurer. Dr. Joseph Roth replaces Dr. Keegan Jackson as Chief of Staff.

**MOTION by Mr. Stevens to accept the Article 8.9, Physicians and other Practitioners in Training Medical Staff Bylaw revision. Ms. Hagevig seconded.** Clarification provided for Mr. Geiger that although it is our process, there had been nothing written in the bylaws outlining the requirement that physicians and practitioners in training will be directly supervised by a credentialed physician of the medical staff. Ms. Knapp obtained confirmation that this bylaw revision has been reviewed and approved by legal and the Medical Staff. Mr. Geiger identified a clerical error, “Trainee” in the last sentence should not be capitalized, and made a friendly amendment to the **MOTION**, by laws approved with the correction of clerical error identified. Mr. Stevens agreed. There being no objection or further discussion, Medical Staff Bylaws revision to Article 8.9, Physicians and other Practitioner in Training approved as amended.

#### **COMMITTEE REPORTS:**

**Physician Recruitment** – Draft minutes from the November 30<sup>th</sup> meeting in the packet. Mr. Johnson reported the Committee approved the recruitment of one orthopedic surgeon and one neurologist. Three orthopedic surgeons have or are leaving the practice in a few months. There will be no local neurologist after Dr. Hunter-Joerns’ retirement this month. Mr. Humphrey stated the orthopedic surgeon we need would need to be able to provide total joint care. **MOTION by Mr.**

*Johnson on behalf of the Physician Recruitment committee that the Board approve recruitment of one orthopedic surgeon and one neurologist. Ms. Johnston seconded. There being no objection, MOTION approved.* Mr. Humphrey stated that Dr. Hightower has held discussions with Dr. Garcia about joining Juneau Bone and Joint Center but does not know if anything has come of those discussions. Mr. Stevens initiated discussion about the need for recruitment of a female general surgeon. Personal knowledge of people forgoing surgery or leaving Juneau to seek care from female surgeon noted by Mr. Stevens. Mr. Johnson has heard the same and suggested if we had a female surgeon in town, perhaps patient numbers would increase. Locum services provided by Dr. Jennifer Schmidt are limited due to contractual issues, not credentialing issues. Dr. Jones stated that if we continue with locum coverage, we need to look at the parameters. Mr. Humphrey will continue discussions with Drs. David and Ben Miller and key stakeholders about this specialty. Physician Recruitment Committee meeting will be scheduled for further discussions.

**Planning Committee** - Mr. Stevens reported the draft minutes from the December 3<sup>rd</sup> meeting accurately reflect the meeting. He noted that due to the weather, he's not sure if the Crisis Stabilization building project is still on track.

**Committee of the Whole** – Draft minutes from the December 9<sup>th</sup> meeting in the packet. Mr. Solomon-Gross reported it was a good meeting. Loren Jones and Kim Russel's presentations provided valuable information and there was more direction given from the Board than he had expected.

**Finance Committee** – Ms. Johnston noted the bulk of the December 10<sup>th</sup> meeting was spent talking about the financial audit. She stated the draft minutes, included in the packet, accurately reflect the conversations of the meeting.

**Board Compliance and Audit Committee:** Ms. Young reported draft minutes from the December 20<sup>th</sup> meeting, included in the packet, accurately reflect the meeting. She then provided the following compliance update: She and Mr. Solomon-Gross attended a meeting with Mr. Humphrey and Mr. Overson to discuss additional resources for the Compliance Department. A decision has been made to hire one FTE, recruitment process has begun. Mr. Solomon-Gross noted that Mr. Overson has provided the CEO a list of the top priority compliance projects currently being worked on. He also stated that an outside company will provide the compliance training for the Board in 2022.

#### **MANAGEMENT REPORTS:**

**Legal Report** – Ms. Nault reported that she is working with the Compliance Director on drafting a new service line policy. She is reviewing contracts related to the hospital's sleep lab and a software agreement for respiratory therapy services. She provided the following updates on the 340B program: A voluntary disclosure letter has been prepared and circulated for input. We are waiting for a reconciliation being prepared by Verity, Bartlett's contract pharmacy administrator, and 340B Direct, the pharmacy administrator. This reconciliation is relevant to determining specific refunds due to manufacturers. This is expected to be received next week. She continues to work with senior leadership on the contracting process improvement.

**HR Report** – Mr. Hargrave highlighted the COVID vaccination policy, incentive pay for employees to work extra shifts and traveler pay market place changes from his written report. He also reported that the scope of services in our current contract with BE Smith, not only covers providing interim leadership, but also executive recruitment. He, Mr. Solomon-Gross and Kim Russel believe the correct path to move forward with executive recruiters is to engage with BE Smith under the current contract. BE Smith is an industry leader in executive search firms specializing in rural areas. If the Board would prefer not to use BE Smith, an RFP can be issued to find a new firm. Doing so will add months to the CEO recruitment efforts. Mr. Stevens and Mr. Geiger expressed support in moving ahead with BE Smith. Mr. Hargrave given direction to engage BE Smith to recruit a new CEO.

**CNO Report** – Ms. McDowell reported there has been no COVID patients in house over the last week and a half but there has been an increase in positive cases in the ED. In response to Ms. Knapp's query, Dr. Jones said it hasn't been genetically sequenced here, but we have to assume the Omicron variant is present in Juneau. In response to Ms. Hagevig, he reported that BRH has ample test supplies but home test kits are being used up very quickly and in short supply.

**CBHO Report** – Ms. Forrest reported her written reports will now include a section of overarching system improvements. Behavioral Health is trying to stabilize nursing services. An interim nursing director for Behavioral Health will start on January 10<sup>th</sup>. Traveler rate of pay has been increased to be in line with national averages. Rainforest Recovery has 7 of 8 beds filled. MHU is starting to get patients through statewide referrals and has 6 of 7 beds filled with patients from out of area. She is working on policy development and refinement. Mr. Johnson asked how patients get into the Applied Behavioral Analysis program and noted the long wait list. Ms. Forrest stated this is a first come, first served program. There is great need for this highly intensive program and she suggests expanding it if financially feasible. Ms. Young asked how utilization of the part time pediatrician in BOPS is working out. Ms. Forrest reported staff is working with IT to pull requested data. The pediatrician is reviewing intakes for medical input and following up with primary care physicians (PCPs) when there are areas of concern or gaps in medical information. She also provides pediatric consults for behavioral health staff and helps with facilitated exams for younger patients receiving services and being prescribed controlled substances through telehealth providers. The pediatrician works part time hours and the number of kids coming in without primary care providers is relatively low. This is a new position and still under development. We are gathering data for more thorough conversations about the work happening in this position and to share with the board. Dr. Jones reported his sense is that this position is used to facilitate the provision of care in the behavioral health aspect given our current situation with telemedicine physicians. It is not in competition with the private practices. It makes it easier for people to get needed mental health services. His opinion is that this position has been successful and has not entered down the slippery slope of Bartlett providing primary pediatric care.

**COO Report** – Mr. Toca reported Diagnostic Imaging (DI) has seen increases from the prior 12 months by 17%. Marketing efforts of bone density scans have been successful, numbers have increased by 300%. The Joint Commission (TJC) survey went very well for DI. All open positions in the lab have been filled. The team is trying to be proactive to address supply issues in the lab and pharmacy. Speech Therapy has reduced the number of patients on the waitlist for services from 60 to 30. The pharmacy is the first in Alaska to provide Jelmyto, a new cancer treatment. It's a very effective medication but requires a lot of coordination between the OR, Infusion Therapy and the Pharmacy to administer. The pharmacy was recognized by TJC surveyors for being small but mighty. Departments throughout the hospital did amazingly well during the survey. There was a significant increase in visitor engagement on our website and social media pages thanks to our marketing efforts. Erin Hardin has been hired as the new Director of Marketing. She will begin her new role on January 23<sup>rd</sup>. Mr. Geiger initiated discussion about what the marketing graphics represent in Mr. Toca's report. He recommends, in the future, using bigger captions, with terms defined, to explain the graphics. Mr. Solomon-Gross agrees and looks forward to seeing next month's report in an easier to read fashion.

**CFO Report** – Mr. Benson reported we continue to work on the corrective action plan that has been developed to address the deficiency identified during the audit process. Many of the steps have already been implemented and we will continue to work on the rest of the action plan going forward. In time there will be a follow-up review to see if there is any aspect of the deficiency that has been missed. He noted it's now calendar year end so the finance department is working on year end taxes and other year-end reporting requirements. Mr. Solomon-Gross asked why Medicaid suspended \$3.8 Million in BRH claims as noted in the CFO report. Mr. Benson explained that this was due to a programming change in Medicaid's billing system made effective July 1<sup>st</sup>. There was an issue with a particular pharmaceutical that was not mapped correctly within the Medicaid processing system and when the system encountered a claim with that code, it kicked it out for review or suspended processing. We were in communication with the state to determine what the issue was. The issue hasn't been resolved yet but the state had asked if they could process claims, having that particular issue to get the rest of the claim paid. After getting their software issue resolved, they will reprocess the claims and pay whatever funds should be forthcoming. As of last Thursday, a lot of those claims were released. For \$3.5 Million in charges, we received \$2 Million. They still have to resolve their software issue and reprocess the claims. Mr. Johnson obtained confirmation that this issue affected all hospitals.

**CEO Report** – Mr. Humphrey is anxious to get a handle on the issue with general surgery. The Physician Recruitment Committee will reconvene at some point soon. He continues to meet with key stakeholders and physicians. Mr. Stevens congratulated the team for the great job on TJC survey and asked about the engineer reviewer still to come in late December. Mr. Humphrey acknowledged staff did an outstanding job with a great team effort and expressed appreciation for Mr. Solomon-Gross and Ms. Hagevig's attendance during the survey. The engineer reviewer had come on December 20<sup>th</sup> for a couple of days. There were a few findings but nothing major and some were fixed immediately. Mr. Stevens obtained confirmation that the physician call space is out for bid now and should be completed in about 5 months.

Discussion held about asbestos abatement for the project. The delay in the project has been due to decommissioning the old IT processors currently in that space.

**CBJ Liaison report** – Ms. Hale had no report but wanted staff and Board members to know how impressed she is by their dedication and hard work.

**PRESIDENT REPORT** – Mr. Solomon-Gross thanked outgoing Chief of Staff, Dr. Keegan Jackson. He read a letter of acknowledgment of Dr. Jackson's time in this position. As a thank you, a leaf will be engraved with Dr. Jackson's name on it and put on the Bartlett Regional Hospital Foundation's Giving Tree. Dr. Jackson expressed thanks and said it's been an eye opening experience. Dr. Roth introduced as the new Chief of Staff. He thanked everyone for their time and said he hopes the pandemic mellows out and makes things easier next year than it has been in the past two. Dr. Jackson noted Dr. Roth has been in this role before and he is heavily involved in the Alaska State Medical Association. She is looking forward to being his past Chief of Staff this year. Mr. Solomon-Gross acknowledged TJC report was very favorable. He wants senior leaders and directors to know how much he and the rest of the board appreciate how dedicated and hardworking BRH staff is. He noted that the facilities department had been commended as having the cleanest shop the surveyor has ever seen and both surveyors were very complimentary of staff. Ms. Hagevig gave an extra shout out to Gail Moorehead for her leadership throughout the survey process. Mr. Solomon-Gross noted the Strategic Planning retreat will be held on Saturday, January 8<sup>th</sup>.

**ELECTION OF BOARD OFFICERS** – Mr. Solomon-Gross opened the floor for nomination of calendar year 2022 Board Officers.

- Board President – Ms. Knapp nominated Kenny Solomon-Gross for a second term as Board President and provided many compelling reasons for doing so. Mr. Geiger seconded. Mr. Solomon-Gross accepted the nomination. No other nominations. ***MOTION by Ms. Hagevig that nominations be closed and unanimous ballot approved. Ms. Knapp seconded. There being no objection, Mr. Solomon-Gross approved for Board President.*** Mr. Solomon-Gross thanked everyone for their vote of confidence and promises to work as hard next year as he has this past year.
- Vice President – Ms. Knapp nominated Ms. Hagevig for Board Vice-President and provided many compelling reasons for doing so. Ms. Hagevig accepted the nomination. No other nominations. ***MOTION by Mr. Stevens that nominations be closed and unanimous ballot approved. Ms. Knapp seconded. There being no objection, Ms. Hagevig approved for Board Vice President.***
- Secretary – Mr. Stevens nominated Deborah (Deb) Johnston for Board Secretary. Mr. Johnson seconded. Ms. Johnston accepted the nomination. No other nominations. ***MOTION by Ms. Hagevig that nominations be closed and unanimous ballot approved. Ms. Knapp seconded. There being no objections, Ms. Johnston approved for Board Secretary.***

Mr. Solomon-Gross recognized Mr. Johnson for his time on the Executive Committee and his 8 years on the board. Whether in agreement or not, Mr. Solomon-Gross values Mr. Johnson's opinions and greatly appreciates him for making him look at things differently. He was very helpful on the Executive Committee and in supporting Mr. Solomon-Gross during his first year as Board President. (Mr. Johnson noted he may have served the role as devil's advocate.) Mr. Solomon-Gross extended a welcome to the Executive Committee to Ms. Johnston and noted Mr. Stevens will remain on the committee as the past president.

**BOARD CALENDAR** – January calendar reviewed. Planning Committee meeting will not be held on January 7<sup>th</sup>. No other changes. Mr. Solomon-Gross will have new committee assignments to Ms. Moffitt by Tuesday of next week.

**BOARD COMMENTS AND QUESTIONS** – Mr. Johnson noted that he has seen amazing progress at Bartlett in the 8 years he has served on the board, Behavioral Health being an example. He feels there is value, in recording for history, how much progress has been made at this hospital. We now provide a lot of services that people used to have to go somewhere else to receive. While it’s happened gradually, it continues to progress. Ms. Hagevig agrees and sighted Oncology as a good example. Mr. Solomon-Gross congratulated Dr. Jones, Ms. Johnston and Mr. Geiger for their reappointment to the Board. Mr. Stevens reported that he will be taking on a new role in the company he works for and will be transitioning to Anchorage at some point in the new year. He will continue to provide as much guidance and participation to the board as possible until that time comes, probably mid to late year. Most meeting participation will be virtual. Ms. Hale congratulated Mr. Stevens. Mr. Stevens will keep the Board and Assembly abreast of his status.

**EXECUTIVE SESSION – MOTION by Mr. Stevens 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, the patient safety dashboard and 340B updates.*

*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.** The Board entered executive session at 7:17 p.m., after a 5-minute break. They returned to regular session at 8:35 p.m.

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

Mr. Stevens reported that coming out of Executive Session, the Board gave direction to Senior Leadership regarding campus planning.

Mr. Solomon-Gross thanked everyone for their time and wished all a safe and happy new year.

**ADJOURNMENT:** 8:36 p.m.

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

# Bartlett Regional Hospital

## MINUTES - STRATEGIC PLANNING WORK SESSION

January 8, 2022 – 9:00 a.m.

Zoom videoconference

**CALL TO ORDER** – The Strategic Planning work session was called to order at 9:00 a.m. by Kenny Solomon-Gross, Board President

### BOARD MEMBERS PRESENT

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

### ALSO PRESENT

Jerel Humphrey, Interim CEO	Kevin Benson, CFO	Kim McDowell, CNO
Vlad Toca COO	Karen Forrest, Interim CBHO	Dallas Hargrave, HR Director
Joseph Roth, MD, COS	Amy Dressel, MD	Nicholas Rosenfeld, MD
Keegan Jackson, MD	Mila Cosgrove	

\*\*Michelle Hale and Robert Palmer joined the meeting for the executive session

**OVERVIEW OF STRATEGIC PROCESS** - Mr. Solomon-Gross stated our strategic objective is to come up with a good plan that will serve Bartlett well into the future without having to recreate the wheel. He acknowledged holding the meeting via Zoom is harder than doing so in person, thanked everyone for attending and then introduced Mila Cosgrove as the facilitator of the meeting. Ms. Cosgrove welcomed everyone. She stated today's meeting would follow a fairly traditional format; review the mission, vision and values, do a SWOT analysis and review currently established key objectives in the strategic plan. After doing that, we'll take a look at the high level strategic objectives. Most of the time today will be looking at key initiatives that the board wants to tackle. She stated it is important stay up at policy level and not get into the weeds. We have a tightly scripted agenda and while back and forth discussion is important, if it starts getting too off-track, she will bring it back on track. Mr. Hargrave will keep track of things on the side and this will be shown throughout the day to help attendees keep track as well. In an effort to easily see the board members, she requested that all but board members turn their cameras off unless addressing the board and to use the raise hand feature when wanting to speak. She requested cross talk be kept to a minimum and using the chat feature if there is a need to communicate with someone. She noted that she and Mr. Hargrave are running the meeting in the background since Ms. Moffitt was unable to attend and requests patience from attendees as they work through things. When we get to the key initiatives, break out rooms will be used for small group discussions and then reported back to the whole group. Everyone will get the opportunity to work with everyone else at some point. Several breaks will be provided throughout the day, including a break for lunch and she will try to wrap up by 2:00pm or sooner.

**FINANCIAL OVERVIEW** – Mr. Benson provided a high level financial overview. He stated that over the last few years, BRH operated with a positive bottom line, the last 2–3 years range around 2-3%. Members of the community don't think the hospital should be in the business of making money, however, our net income plus our depreciation expense (a non cash expense) provides the organization the funds to help supply our capital needs. A healthy bottom line is crucial to the success of the organization in being able to accomplish its mission. Observed over the last five years is a steady increase in net operating revenues. He noted that 2020 was fairly flat due to shut down of elective outpatient services for 6 weeks as a result of COVID but picked up in 2021. 2022 is also projected to show a healthy increase. Two-thirds of our expenses are salary and benefit related. As services increase, staffing must also increase. This puts BRH in a bind if they ever need to reduce or hold expenses in terms of how it's to be done without touching salaries, wages and staffing. In

order to maintain expenses, they would have to look at cutting services or finding savings within that area. 2017-2019 had very limited capital expenditures and had a corresponding impact to cash balances. As capital spending was limited, BRH was able to increase cash balances. This is good but necessitated the need to play catch up in capital spending for equipment replacement, project maintenance, etc. 2020 and 2021 show significant increase in capital expenditures and dipping into cash balances in 2021 to fund those projects. Moving forward, net income plus depreciation expense, about \$10 Million a year, can be assigned to capital purchases. The main point he would like to make is that operations need to be sufficient to meet the capital needs of the organization on an annual basis. In response to Ms. Young's query, Mr. Benson responded that the CARES funding is reflected in the income statement in the amount of \$6 Million for 2020 and \$7 Million in 2021. These funds have allowed BRH to be whole from the impact of COVID. Net operating revenues are not reflective of the CARES funding however, without this funding, BRH would have shown net operating losses. Through February 2020, FY20 was looking fantastic with a strong bottom line and growing revenues and then everything came to a screeching halt. The expenses incurred to COVID mitigation affected BRH very adversely; the checkbook was open and BRH did what needed to be done to safely continue operations. Mr. Stevens observed the capital spending went up due to the COVID crisis as well. The important thing is that BRH is projected to come out of it stronger than when it went in when we're forecasting the next year based on the current trend. Ms. Knapp feels our challenge moving forward without the CARES funding, is to make sure our revenues are meeting the expenditures. Ms. Johnston clarified that while the CARES funding offset enough of the expenses of the loss of revenue to keep us from a negative net income, it's not break even. We lost more than we gained from the CARES funding but it helped us from being in the negative. Had we not had the COVID crisis, we would have been in a much better financial position than we are today. Mr. Benson agreed and stated we continue to have COVID related expenses. We have received additional funds of almost \$4 Million in FY22 and as a result, we have to document whether these funds are going to go to lost revenues or COVID related expenses. We are having no issues identifying costs associated with COVID that would not have been incurred without that event.

**REVIEW PROGRESS ON CURRENT STRATEGIC OBJECTIVES** - Mr. Humphrey provided a high level overview of the recent accomplishments on current objectives document included in the packet. We have started Crisis Intervention services; it's going really well. We implemented the testing analyzer from Roche which did exceptionally well for us in terms of return on investment at the height of usage but testing numbers have dropped off recently. We achieved a net income of \$8 Million in FY20 and \$4 Million in FY21. We completed a hospital comparison on our prices for services and validated that they are competitive. Construction is underway for the Crisis Stabilization Unit with an anticipated completion and opening in May 2023. CBJ Assembly approved a bond issue of \$20 Million for the Emergency Room expansion and the Crisis Stabilization projects. We have developed a Certified Nurses Aid program which is going well. Because of COVID and other things, we have implemented retention programs for our existing staff and new hires to continue onboarding of much needed clinical staff. We received our final report for our recent Joint Commission Survey. It went extremely well. The surveyors were very positive in terms of what we were doing, how we are conducting ourselves and documenting our activities. We will be working on some corrective actions but for the most part, we are in very good shape. We are very pleased with our overall 5-star rating from Medicare on Quality measures for treating heart attacks, pneumonia readmission rates and safety of care. Lastly, after reviewing our compliance program, actions have been taken to strengthen it. He noted that Mr. Benson has submitted his resignation as the CFO. He and Mr. Hargrave are working to recruit a possible replacement and hope to bring her onboard before Mr. Benson's departure on January 28<sup>th</sup>. Dr. Jones expressed appreciation for the reports and the stabilization Mr. Humphrey has brought to the organization. He thanked Mr. Benson for the work he has done financially and stated that he will be missed.

**UPDATE STRATEGIC PLAN** - Ms. Cosgrove stated she hopes the quick review of the financials and the progress review has given a foundation from which to work. She noted the last time the board revisited the strategic plan was in September 2020.

**Review Mission, Vision and Values** – Ms. Cosgrove provided an overview of Bartlett's Mission, Vision and Values to make sure they are still pertinent.

**Mission** – BRH provides its community with quality patient centered care in a sustainable manner.

**Vision** – BRH will be the best community hospital in Alaska

**Values** – At BRH we C.A.R.E

**Courtesy** – We act in a positive, professional and considerate manner, recognizing the impact of our actions on the care of our patients and the creation of a supportive work environment.

**Accountability** – We take responsibility for our actions and their collective outcomes; working as an effective, committed and cooperative team.

**Respect** – We treat everyone with fairness and dignity by honoring diversity and promoting an atmosphere of trust and cooperation. We listen to others, valuing their skills, ideas and opinions.

**Excellence** – We choose to do our best and work with a commitment to continuous improvement. We provide high quality, professional healthcare to meet the changing needs of our community and region.

Mr. Solomon-Gross, Ms. Hagevig, Dr. Jones and Ms. Johnston support leaving the wording as is. Ms. Knapp agrees for the most part but in our Vision, being the best community hospital in Alaska bothers her. She noted you could be the best in Alaska and still not be very good. It also sounds like we're in competition with other hospitals when we should be cooperating with each other and working together. Mr. Johnson agreed with Ms. Knapp. Ms. Young feels the Mission statement could use some improvement and suggested "We provide the community with exceptional patient centered care in a sustainable manner". She also feels we need to add something to our vision that we are actively engaged in driving forward the health of our community. Mr. Solomon-Gross suggested addressing these changes in the Governance Committee. Mr. Geiger agreed as during this meeting is not the appropriate time. Changes will be made through the Governance Committee. Ms. Young, and others are requested to write their ideas and submit them to the committee for review.

**SWOT Analysis** – Ms. Cosgrove noted looking at a SWOT analysis is a way to get a quick picture of the current environment. As the board moves into the planning process and starts working on specific initiatives and board actions, it'll be doing so within the container of what is seen around them both from internal and external perspectives. While there doesn't need to be consensus on these things, it is important that as a board, there is an opportunity to surface the issues seen as influencing BRH's world. Strengths and weaknesses are looking at the internal organization. Strengths, whether tangible or intangible, are what is making BRH successful and why it's in a good place. Weaknesses are things that are making it difficult to succeed. The important things about weaknesses is that because they are internal, they should be mostly controllable and should be able to be influenced directly through planning activities. Looking at the external environment, opportunities are factors that could be leveraged to the organizations' s advantage. Generally, there is limited or no control over external factors. Challenges, also external, are things that might impair success. There is limited or no ability to control them but they are still acting upon you as you carry out your operations.

Mr. Cosgrove asked the board members to take 5 minutes to jot down their individual thoughts about the strengths, weaknesses, opportunities and threats to the organization. A round robin discussion held when the time was up.

Responses to each area:

- Strengths – dedicated staff; balance sheet; excellent leadership despite our challenges, good facility, supportive community; excellent reputation locally, regionally, statewide and with regulatory agencies; strong alliances with other community service providers; broad range of services for a small community; good campus plan/layout; ability to gear up for COVID successfully; CMS and Medicare ratings are excellent; ability to recruit temporary help
- Weaknesses – key leadership positions in transition; absence of quantitative measurement and adaptation except for financials; out migration of services; for long term, lack of space – land for growth as we expand to provide additional services; labor shortages; lack of planning for post-COVID realities and impacts; recruiting for long term staffing; electronic medical records; inability to provide certain service lines which leads to other issues as noted; compliance review for new programs/service lines
- Opportunities – partnership and expansion of workforce development; property options to consider that may help address space issues with other entities; strategic alliances with other entities to improve service lines; ECG study showed it was a good time to partner or affiliate with another entity; accelerating momentum to virtual care coupled with people's hesitation to travel; generate hospital-based services; expanding service lines such as behavioral health or inpatient dialysis; telemedicine; increasing health care presence in tourism industry
- Threats – COVID pandemic – don't know the length; some unhappiness amongst the medical staff; competition, in particular providers with deep pockets; it's difficult for BRH to act quickly given its status as a public entity, we can't act as quickly as the competition and have an obligation to act as if we are in the private sector because it's the environment we operate in; stagnant population, it's not growing but is aging; keeping physicians – housing issues, facility constraints, etc.; SEARHC's aggressive move to provide healthcare to the greater Juneau

community, particularly services that would otherwise provide income to BRH; charter constraints that limit how and where we can provide healthcare; continuing changes in healthcare funding streams – Medicare, Medicaid, ACA, etc. and external funding sources; campus expansion due to land constraints at current facility limits service line expansion; national nursing and other labor shortages; inflation cycle

She stated the intent of this exercise was to prime the pump as we begin to think about initiatives that the board should undertake to leverage strengths and opportunities or to resolve / mitigate opportunities and threats. Mr. Johnson noted there is a statute or state law that allows boroughs to form health districts with neighboring boroughs. This could be a way to get around some of the charter constraints. Ms. Cosgrove suggests he bring this up again when we begin looking at objectives and key initiatives. Ms. Knapp noted legal issues was not mentioned as a challenge but we should always keep that in mind. While this is a very good reminder, Ms. Cosgrove suggests leaving this for Compliance and Quality issues. She then called for a 10 minutes' recess before diving into strategic objectives.

**Review/Update Strategic Objectives** – Ms. Cosgrove noted the strategic objectives, included in the packet, originated from the Focus and Execute process and are tied to Studer's pillars for hospital operations and governance. She noted Services, Financial, Facility, People, Quality and Safety and Compliance are the 6 objective areas identified. Each one will be reviewed and a determination made whether there needs to be adjustments or not. Strategic objectives should be a bigger picture spanning a 5 – 10-year term even though some may be enduring, such as compliance. Discussions held about each of the following objectives and initiatives:

***Services – Develop and maintain a service portfolio that meets community needs and is sustainable.***

Ms. Knapp feels this statement is still applicable today. Mr. Geiger noted strategic is a term borrowed from the military. Strategic goals, in a military setting have to be somewhat specific and there has to be a balance between specificity and generality. He feels this objective should be a bit more specific. While Ms. Cosgrove agrees that we need to get to a level where we need to be more specific about what we're going to do, it's not at this level. There will be an opportunity later to say how are we going to get there and what strategic initiatives are we going to adopt. Ms. Johnston stated that this objective implies a stopping point, that we develop services and maintain them but don't continue to look forward to what needs to change. She thinks this is a continuing process where we review it regularly and do make changes. Mr. Solomon-Gross agreed with Mr. Geiger and then stated that not only do we want to maintain, but we want to grow a service portfolio that meets the community needs. He suggested it to say "develop, maintain and grow". Ms. Knapp agreed with this change. Mr. Stevens suggested changing "meets community needs" to "is responsive to community needs". The services objective changed to: ***Develop, maintain and grow a service portfolio that is responsive to community needs and is sustainable.***

***Financial – Improve net income to \$3.7 Million by the end of FY2020.*** Ms. Cosgrove observed this one is outdated and was meant to address not relying on the Rural Demonstration Project funding. Ms. Hagevig noted the Rural Demonstration Project has been renewed and will be here for a while. She also does not feel that putting a dollar amount is appropriate because our funding environment has changed significantly. Mr. Stevens suggested moving the Financial objective to above Compliance and say "to maintain a positive net income so that we can accomplish the above goals and objectives". Ms. Hagevig agreed. Ms. Johnston wants everyone to understand that just a positive net income is not enough. We need to make sure that we have sufficient positive net income for growth. Ms. Knapp agreed and said we also need to recognize that we need to maintain enough of the number of days of operating reserves that we want to keep on the books. This is sometimes difficult to justify to the Assembly but it's important to have a cushion so we have the resources available to respond should an emergency situation, such as COVID, come up. Ms. Cosgrove suggested tweaking the wording to say "maintain a positive net income and sufficient cash reserves to accomplish the above goals and objectives". Mr. Geiger suggested adding the adjective "real" before "positive net income". That would indicate that we want this to account for inflation. Mr. Stevens suggested "develop a revenue and net income stream that maintains cash reserves while facilitating above goals and objectives". As there is no objection to this language, the financial objective changed to: ***Develop a revenue and net income stream that maintains cash reserves while facilitating above goals and objectives.***

***Facility – Update the existing campus plan to identify major replacement needs and options for future revenue growth.***

Ms. Knapp suggested "services lines" also needs to be included for future growth. Ms. Hagevig noted a lot of work has been done on the campus plan since we last did this exercise. This is an ongoing responsibility and she is looking for something that really identifies where we are with campus planning. Mr. Stevens stated he is not fond of the word

maintain but suggests “*maintain a comprehensive campus plan that identifies major replacement needs...*” Ms. Hagevig and Ms. Knapp agreed with these changes. Mr. Solomon-Gross noted that we have a GANTT chart as a part of our campus plan and wonders how we can add it as we go forward. Mr. Stevens identifies that as a comprehensive plan that not only identifies the replacements needs of the existing building but options for the future. The details in the GANTT chart would be used in the planning committee. Dr. Jones isn’t worried about the plan but the campus. He suggests removing the word plan and say “*to maintain a comprehensive campus*” Mr. Stevens agreed. Ms. Johnston suggested changing “identify” to “address” which goes with the continuing review and modification. Ms. Hagevig agrees with removing “plan” but cautions there may be pushback from people who want to use the word plan and see the plans on paper. They don’t realize how quickly some of our options change so, as we go forward, we’ve got to be more specific in the items we put under this particular objective. Mr. Geiger stated our overarching strategic goal is to maintain the campus, not the plan. After further discussion, facility objective changed to: ***Maintain a comprehensive campus. Address major replacement needs and options for future service lines and revenue growth.***

**People – Create an atmosphere that enhances employee and physician satisfaction and improves our ability to recruit and retain.** Mr. Geiger would like to add “Improve our alliance with private clinics”. Mr. Solomon-Gross expressed caution in how we handle this as we don’t want to appear to be favoring one clinic over another. He suggested instead of alliance, say communication. This should apply to all physicians and not just physician clinics. Ms. Knapp suggested we should take a step back as alliance has certain connotations and seems to indicate an affiliation or partnership. In any healthcare community, there is a continuum of care with the hospital at the most intensive end as it provides inpatient and outpatient services. Maybe we should focus this on being responsible for the development and support of a health service network in the community that would include private providers, non-profit providers, pharmacies, etc. Taking a leadership role will help deal with competition as well. Mr. Stevens suggested “improve strategic alliances and communication to maintain a community continuum of care”. Ms. Johnston liked what Mr. Stevens suggested and said we need to maintain good relationships with all of the stakeholders in the community, not just providers and pharmacies. She wants to make sure we capture the broader spectrum of stakeholders. Mr. Stevens suggested “Create an atmosphere that enhances employee, physician and stakeholder satisfaction to improve our ability to recruit and retain”. Mr. Geiger feels these changes now make this objective not specific enough. He would still like to make a specific pitch for the clinics. Mr. Solomon-Gross noted this would fall into the bucket (initiatives) listed under the objectives. The objective should not be so specific. Dr. Jones and Ms. Hagevig suggest leaving it at this high level. In response to Mr. Solomon-Gross, Mr. Geiger stated he is fine with this. Ms. Cosgrove noted the statement is important as it relates to the strategic objectives but wonders if it should be in the people section instead of in services. Ms. Hagevig feels it is in the right section and said there will probably be similar action items under multiple categories. Mr. Geiger agreed. People objective changed to: ***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.***

**Quality and Safety – Meet Joint Commission requirements and Alaskan and national quality and safety measures.** Dr. Jones stated that the Joint Commission (TJC) and quality measures are important but they don’t define a quality organization. We’re not so worried about Joint Commission or Alaskan and national quality measures, we’re concerned about providing the best quality to the people we serve. Mr. Geiger referenced notes he had taken at the Leadership conference regarding eliminating harm, improving performance and increasing affordability. He feels these are good goals. Mr. Solomon-Gross stated that one of the things that came out of TJC survey is that the surveyor always asks staff what they are doing to keep the facility safe for patients. She reported that BRH was the only hospital that every employee was able to give an answer. It’s important to keep our staff educated on the importance of quality and safety measures. Ms. Johnston agrees that the language here is just maintenance and doesn’t get us to the level of excellence going above and beyond. Ms. Hagevig said it’s important not to lose the national accreditation piece and suggested it be listed as an initiative. Quality and Safety objective changed to: ***Provide excellent community centered care that improves outcomes, maximizes safety, improves access and affordability and is in compliance with national and state regulations.***

**Compliance – Maintain compliance at all levels while accomplishing the above goals.** Ms. Knapp does not like the inclusion of “above goals”. Ms. Young would like it to be more specific to say “maintain robust, proactive compliance programs at all levels while maintaining our strategic goals”. Mr. Solomon-Gross suggested “develop and maintain a robust, proactive compliance program at all levels”. Ms. Knapp reminded everyone that at one time, we had a Quality and Compliance Committee but broke them out in an effort to identify in CMS audits how serious we were about compliance.

The intent of the compliance committee was narrowly focused on being in compliance with statutes and regulations. The Quality Committee was broader in what it looked at as far as service delivery. We don't need to get too broad with compliance. Ms. Cosgrove suggested using "expand and maintain" as one option or "continuously improve a robust proactive compliance program". After further discussion, compliance objective changed to: ***Continuously improve a robust, proactive compliance program at all levels while maintaining our strategic goals.***

Ms. Cosgrove noted we have come to a natural break in the process and asked if attendees would prefer to break for an early lunch or move on to the next assignment. She will email the newly edited strategic objectives document and leave it up on a shared screen as requested. The meeting recessed for lunch at 11:43am and resumed at 12:05.

Ms. Cosgrove identified the next steps in the process. She said we have identified our big buckets, created our strategic objectives and will now work on creating key initiatives. She asked participants to think about the more specific layer that the board or staff should engage in to achieve those bigger objectives. When thinking about key initiatives, decide whether it's something the board needs to do specifically or whether it's something that shifts to staff. Board members will be broken up into groups of three and placed into breakout rooms for this exercise. Each rotation will put people into a different group. Groups will have 12 minutes to identify 2-4 key initiatives that the board would like to engage in or feel are critical to achieving the key objectives just defined. The goal is to have the entire conversation in 25 minutes so when you return from your breakout sessions, one designated person from each group will report. We will move quickly to be able to get through them all. Quality, Safety and Compliance will probably be combined. She explained how breakout rooms work and how to get in and out of them. It will be board members only in the breakout rooms. The first objective to be discussed is services. Board members put into breakout rooms.

After returning from breakout session, the following services initiatives identified:

1. Recruitment of specialists; Ortho, Neurology, General Surgery
2. Build on work we have done with respect to affiliations and partnerships with other healthcare organizations to help us grow our service lines
3. Enhance our relationship with healthcare providers that are currently in our community (this item may be moved under the people objective)
4. Build on the success of behavioral health through telehealth. Develop a comprehensive telehealth department at BRH to help develop new service lines.
5. Identify ancillary service lines we can provide from physician referrals for services not available in Juneau
6. Evaluate how BRH can become a provider of telehealth services to support physician recruitment
7. Explore how to have hospital run clinics

Discussion held about the need to prioritize the list or not and how to determine if initiatives are staff or board work. Mr. Geiger noted some of these are complicated ideas and require more time to give them the consideration they deserve. Ms. Cosgrove wants to make sure there is time to touch each of these areas within today's time limit. Mr. Stevens suggests that after initiatives are identified and prioritized, they should go to the Executive Committee to assign to committees to work on, whether they are staff or board assigned objectives, to make sure they get done. The committees will flush them out to a higher degree and put parameters and expectations around each statement. Trying to do this today, is going to take too long. Ms. Cosgrove provided the option to dive in at a deeper level today and schedule another meeting to finish up or do as Mr. Stevens suggests. It was determined that initiatives would be identified and prioritized today and will move to the Executive Committee to assign. Initiatives will be prioritized through a poll at the end of the meeting.

Board members were put into breakout rooms and given 10 minutes to identify key initiatives for facility. The following initiatives identified:

1. Move decisively on proposed property acquisitions
2. Evaluate what needs to be on campus versus off. Consider moving admin services and storage off campus to maximize space for clinical services
3. Continue to monitor strategic goals for facilities
4. Evaluate off campus acquisitions to support continuum of care and relieve on campus pressure
5. Evaluate service line needs and determine if property growth is the best alternative to support expanded care
6. Develop proformas for additional service lines, change of use, and acquisitions to properly evaluate return on investment (ROI)
7. Educate board on equipment replacement and maintenance schedules

8. Evaluate current technology on site and best practices to prioritize replacement and new equipment needs. Stay up to date with equipment and technology

Board members were put into breakout rooms and given 10 minutes to identify key initiatives for people. The following initiatives identified:

1. Enhance our relationship with healthcare providers that are currently in our community (moved from list of service initiatives)
2. Measure, evaluate and adapt with respect to employees, doctors and stakeholders
3. Expand workforce development programs “build your own and they will come”
4. Improve our alliances with existing primary care clinics
5. Attract new providers to fill in holes in existing services in Juneau
6. Pickup discussion about provider wellness that the medical staff has initiated
7. Develop relationship with SEARHC to reach mutually agreeable goals to ensure best health care for our community
8. Move toward finding resolutions to electronic medical record (EMR) system
9. Possible hospital run clinics by hospital employed providers

Board members were put into breakout rooms and given 10 minutes to discuss key financial initiatives. The following initiatives identified:

1. Evaluate the current guidelines to identify the unrestricted number of days’ cash on hand that are required, based on COVID experience
2. Ensure we have the proper executive team to manage finances and assure adequate financial controls
3. Look at current income streams including commercial, Medicare, and Medicaid
4. Keep an eye on inflation, provider shortages, and labor shortages. It is unlikely that there will be additional COVID funds
5. Look at profitable service lines and see how reimbursement rates are impacting revenues. Can new service lines be added that will pay for themselves. Utilize Moss Adams tools
6. Look at locums, travelers, etc. to see how it compares to BRH staff
7. Continue focus on marketing initiatives
8. Evaluate how new competition is impacting profitable service lines

Board members were put into breakout rooms to discuss key initiatives for Quality and Safety and Compliance. The following initiatives were identified for quality and safety:

1. Legal consultation regarding certificate of need compliance for ER expansion
2. Develop additional quality measures beyond those that are mandated beyond accreditation or regulation
3. Provide full explanation of any harm that shows up on the dashboard. For items that are repeated, provide a full report back to board on action taken
4. Develop quality initiatives beyond the regulatory requirements that are meaningful to the community
5. Stay current on technology and resources to facilitate risk management, data security, and employee safety
6. Keep a robust education program along with staff training
7. Improve graphical and statistical information presented to the board

The following initiatives identified for compliance:

1. Make sure information from Compliance Officer is presented in a way that is concise, understandable and not redundant
2. Keep a robust education program along with staff training

Ms. Cosgrove stated that because we are over on time, we will not have time to prioritize today. A survey monkey will be sent out after the meeting. She will consolidate the information from today’s meeting to include in the next board packet. Ms. Hagevig stated that she does not feel there will be enough time at a regular board meeting for the discussions that need to happen and suggests a work session. Mr. Solomon-Gross and Mr. Hargrave will review the responses to the survey monkey prioritizing the initiatives and decide if there is need for longer conversations in a Committee of the Whole meeting or if it can be done in a 15 or 20-minute portion of the next board meeting. After the strategic plan is approved, he will work with the Mr. Hargrave, Ms. Cosgrove and the Executive Committee to formulate how we put it into the committees moving forward.

Mr. Solomon-Gross thanked Ms. Cosgrove for facilitating the meeting, her leadership is greatly appreciated. If need be, she may be asked to attend the board meeting and help facilitate the conversation. Ms. Cosgrove thanked everyone and wished good luck for the next task. Mr. Solomon-Gross called for a brief recess to be taken at 2:19 pm. Meeting resumed at 2:25 pm.

**EXECUTIVE SESSION - *Motion by Mr. Stevens, to recess into executive session as written in the agenda 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 attendees may be excused from this portion of the session.)***

There being no objection, the meeting entered at executive session at 2:26 pm and returned to regular session at 2:45 pm

Mr. Stevens reported that coming out of the Executive Session, the board provided Senior Leadership with direction regarding campus planning.

**COMMENTS AND QUESTIONS** – Mr. Solomon-Gross said it's been a long day and thanked everyone for their hard work. Mr. Hargrave told everyone to be on the lookout for a survey monkey. Everyone will have one week to complete the survey. Mr. Stevens thanked senior leadership and the medical staff that attended today's meeting; now is the time to start providing your input to some of these priorities and other things that have been put out there and how we can work together. Mr. Solomon-Gross noted he will be making some changes to committee assignments and will send those out in a couple of days.

**ADJOURNMENT** – 2:46 pm

DRAFT

# Bartlett Regional Hospital

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DATE: January 7, 2021  
TO: BRH Finance Committee  
FROM: Kevin Benson, Chief Financial Officer  
RE: November Financial Performance

After two months of strong patient volumes, November saw a bit of a lull. Both inpatient and outpatient revenues were under budget by 24% and 9% respectively. The decrease of inpatient revenue was a result of decreased patient days in the CCU (17%) and the mental health unit (55%). The decrease of outpatient revenue was mainly a result of decreased surgical procedures (20%).

After Rainforest, BHOPS and physician revenue, the month ended -\$1,615,000 (-9.4%) less than budget for Gross Patient Revenue.

After deductions from revenues, Net Patient Revenue was -\$1,686,000 (-17.9%) less than budget.

BRH received additional Relief Funds of \$1,820,000 in November that was realized through Other Operating Revenues. As a result, Total Operating Revenue finished \$-339,000, or 3.3% less than budget.

Total Expenses were slightly over budget, finishing at \$-73,000 (-0.7%) over budget, yielding an Operating Loss of \$489,000 as compared to a budgeted Operating Loss of -\$77,000. After Non-Operating Income, Net Loss finished at \$325,000. After five months, the Net Income is \$331,000, for a 0.62% margin.

Items of interest incurring in November were as follows:

- Cash collections from patient care exceeded \$10 million for the first time ever. This was partially a result of high revenues seen in September and October. Contributing to this was the collection from the state Medicaid program from claims delayed since July 1<sup>st</sup> due a software upgrade.
- Cash balances increased \$3.2 million from increased collections and the Provider Relief Funds deposit.

**Bartlett Regional Hospital  
Dashboard Report for November 2021**

Facility Utilization:	CURRENT MONTH					YEAR TO DATE			
	Actual	Budget	% Over (Under) Budget	Prior Year	% Over (Under) Pr Yr	Actual	Budget	% Over (Under) Budget	Prior Year
<b>Hospital Inpatient: Patient Days</b>									
Patient Days - Med/Surg	397	366	8%	386	2.8%	2,297	1,866	23%	1,843
Patient Days - Critical Care Unit	81	98	-17%	84	-3.6%	512	499	3%	502
Avg. Daily Census - Acute	15.9	15.5	3%	15.7	1.7%	18.4	15.5	19%	15.3
Patient Days - Obstetrics	62	61	1%	57	8.8%	313	313	0%	327
Patient Days - Nursery	47	51	-7%	60	-21.7%	235	259	-9%	274
<b>Total Hospital Patient Days</b>	<b>587</b>	<b>576</b>	<b>2%</b>	<b>587</b>	<b>0.0%</b>	<b>3,357</b>	<b>2,937</b>	<b>14%</b>	<b>2,946</b>
Births	26	25	5%	24	8.3%	126	127	0%	133
<b>Mental Health Unit</b>									
Patient Days - Mental Health Unit	108	240	-55%	163	-33.7%	798	1,224	-35%	876
Avg. Daily Census - MHU	3.6	8.0	-55%	5.4	-33.7%	5.2	8.0	-35%	5.7
<b>Rain Forest Recovery:</b>									
Patient Days - RRC	120	240	-50%	167	0.0%	805	1,224	-34%	185
Avg. Daily Census - RRC	4	8.0	-50%	6	0.0%	5	8.0	-34%	1.2
Outpatient visits	28	85	-67%	80	-65.0%	210	433	-52%	378
<b>Inpatient: Admissions</b>									
Med/Surg	54	56	-4%	57	-5.3%	323	286	13%	277
Critical Care Unit	37	35	6%	37	0.0%	207	179	16%	180
Obstetrics	29	27	9%	25	16.0%	138	136	2%	142
Nursery	25	25	1%	24	4.2%	125	127	-1%	133
Mental Health Unit	15	20	-26%	15	0.0%	123	104	18%	104
<b>Total Admissions - Inpatient Status</b>	<b>160</b>	<b>163</b>	<b>-2%</b>	<b>158</b>	<b>1.3%</b>	<b>916</b>	<b>831</b>	<b>10%</b>	<b>836</b>
<b>Admissions - "Observation" Status</b>									
Med/Surg	83	61	36%	54	53.7%	367	310	18%	299
Critical Care Unit	30	26	16%	28	7.1%	116	132	-12%	132
Mental Health Unit	5	2	117%	1	400.0%	18	12	53%	11
Obstetrics	14	14	1%	11	27.3%	76	70	8%	67
Nursery	0	0	0%	0	0.0%	0	0	0%	0
<b>Total Admissions to Observation</b>	<b>132</b>	<b>103</b>	<b>28%</b>	<b>94</b>	<b>4.8%</b>	<b>577</b>	<b>524</b>	<b>10%</b>	<b>509</b>
<b>Surgery:</b>									
Inpatient Surgery Cases	38	49	-22%	38	0.0%	231	248	-7%	247
Endoscopy Cases	87	86	1%	91	-4.4%	428	439	-3%	424
Same Day Surgery Cases	75	115	-35%	107	-29.9%	474	586	-19%	588
<b>Total Surgery Cases</b>	<b>200</b>	<b>250</b>	<b>-20%</b>	<b>236</b>	<b>-15.3%</b>	<b>1,133</b>	<b>1,273</b>	<b>-11%</b>	<b>1,259</b>
Total Surgery Minutes	13,446	17,884	-25%	16,651	-19.2%	76,755	91,210	-16%	91,322
<b>Outpatient:</b>									
Total Outpatient Visits (Hospital)									
Emergency Department Visits	834	936	-11%	863	-3.4%	5,249	4,775	10%	4,755
Cardiac Rehab Visits	0	56	-100%	57	-100.0%	187	287	-35%	286
Lab Visits	1,384	283	389%	266	420.3%	8,352	1,443	479%	1,402
Lab Tests	9,422	9,620	-2%	9,479	-0.6%	50,415	49,060	3%	48,776
Radiology Visits	782	788	-1%	711	10.0%	4,010	4,021	0%	4,000
Radiology Tests	2,155	2,295	-6%	2,123	1.5%	11,765	11,704	1%	10,455
Sleep Study Visits	29	22	32%	13	123.1%	122	112	9%	127
<b>Physician Clinics:</b>									
Hospitalists	249	228	9%	217	14.7%	1,237	1,165	6%	1,133
Bartlett Oncology Clinic	87	83	5%	85	2.4%	484	423	14%	426
Ophthalmology Clinic	46	92	-50%	78	-41.0%	342	468	-27%	480
Behavioral Health Outpatient visits	658	394	67%	407	61.7%	3,211	2,011	60%	1,962
Bartlett Surgery Specialty Clinic visits	232	224	3%	242	-4.1%	1,119	1,144	-2%	1,115
	1,272	1,022	24%	1,029	23.6%	6,393	5,212	23%	5,116
<b>Other Operating Indicators:</b>									
Dietary Meals Served	15,302	19,484	-21%	19,820	-7.2%	78,324	99,370	-21%	95,866
Laundry Pounds (Per 100)	374	369	1%	357	-2.9%	1,938	1,881	3%	1,863

**Bartlett Regional Hospital  
Dashboard Report for November 2021**

Facility Utilization:	CURRENT MONTH				YEAR TO DATE			
	Actual	Budget	% Over (Under) Budget	Prior Year	Actual	Budget	% Over (Under) Budget	Prior Year
<b>Financial Indicators:</b>								
Revenue Per Adjusted Patient Day	3,868	4,999	-22.6%	4,206	5,253	25,496	-79.4%	22,117
Contractual Allowance %	48.5%	43.6%	11.2%	39.2%	41.6%	43.6%	-4.6%	43.9%
Bad Debt & Charity Care %	1.5%	1.3%	16.0%	2.1%	2.8%	1.3%	112.4%	1.0%
Wages as a % of Net Revenue	60.4%	52.1%	16.1%	52.5%	49.4%	52.1%	-5.1%	52.7%
Productive Staff Hours Per Adjusted Patient Day	21.2	23.9	-11.2%	20.8	26.4	125.5	-79.0%	112.0
Non-Productive Staff Hours Per Adjusted Patient Day	3.4	4.2	-19.6%	4.1	4.1	20.6	-80.2%	19.6
Overtime/Premium % of Productive	10.31%	10.97%	-6.0%	10.97%	7.86%	6.65%	18.2%	6.65%
Days Cash on Hand	61	61	-0.6%	119	59	61	-3.4%	115
Board Designated Days Cash on Hand	151	152	-0.6%	132	147	152	-3.4%	132
Days in Net Receivables	55.2	55	0.0%	48	55.2	55	0.0%	48
					<b>Actual</b>	<b>Benchmark</b>	<b>% Over (Under)</b>	<b>Prior Year Month</b>
Total debt-to-capitalization (with PERS)					56.3%	33.7%	67.1%	61.9%
Total debt-to-capitalization (without PERS)					14.9%	33.7%	-55.8%	15.7%
Current Ratio					4.93	2.00	146.6%	7.26
Debt-to-Cash Flow (with PERS)					9.51	2.7	252.3%	9.17
Debt-to-Cash Flow (without PERS)					2.52	2.7	-6.7%	2.32
Aged A/R 90 days & greater					42.1%	19.8%	112.6%	48.3%
Bad Debt Write off					1.2%	0.8%	50.0%	-0.5%
Cash Collections					92.9%	99.4%	-6.5%	98.4%
Charity Care Write off					1.4%	1.4%	0.0%	1.6%
Cost of Collections (Hospital only)					4.6%	2.8%	64.3%	4.5%
Discharged not Final Billed (DNFB)					10.4%	4.7%	121.3%	13.8%
Unbilled & Claims on Hold (DNSP)					10.4%	5.1%	103.9%	13.8%
Claims final billed not submitted to payor (FBNS)					0.0%	0.2%	-100.0%	0.00%
POS Cash Collection					0.1%	21.3%	-99.5%	0.0%

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

MONTH ACTUAL	MONTH BUDGET	MO \$ VAR	MTD % VAR	PR YR MO		YTD ACTUAL	YTD BUDGET	YTD \$ VAR	YTD % VAR	PRIOR YTD ACT	PRIOR YTD % CHG
Gross Patient Revenue:											
\$3,192,673	\$4,468,455	-\$1,275,782	-28.6%	\$3,583,449	1. Inpatient Revenue	\$20,297,820	\$22,789,073	-\$2,491,253	-10.9%	\$19,185,804	5.8%
\$950,044	\$985,844	-\$35,800	-3.6%	\$1,005,371	2. Inpatient Ancillary Revenue	\$5,757,399	\$5,027,808	\$729,591	14.5%	\$4,944,659	16.4%
\$4,142,717	\$5,454,299	-\$1,311,582	-24.0%	\$4,588,820	3. Total Inpatient Revenue	\$26,055,219	\$27,816,881	-\$1,761,662	-6.3%	\$24,130,463	8.0%
\$9,976,299	\$10,041,775	-\$65,476	-0.7%	\$8,884,031	4. Outpatient Revenue	\$54,669,754	\$51,213,052	\$3,456,702	6.7%	\$49,143,437	11.2%
\$14,119,016	\$15,496,074	-\$1,377,058	-8.9%	\$13,472,851	5. Total Patient Revenue - Hospital	\$80,724,973	\$79,029,933	\$1,695,040	2.1%	\$73,273,900	10.2%
\$166,861	\$337,696	-\$170,835	-50.6%	\$183,121	6. RRC Patient Revenue	\$1,249,313	\$1,722,250	-\$472,937	-27.5%	\$231,073	440.7%
\$413,225	\$266,088	\$147,137	55.3%	\$198,440	7. BHOPS Patient Revenue	\$1,969,741	\$1,357,055	\$612,686	45.1%	\$1,124,840	75.1%
\$827,856	\$1,041,683	-\$213,827	-20.5%	\$1,059,633	8. Physician Revenue	\$4,896,730	\$5,312,588	-\$415,858	-7.8%	\$5,052,729	-3.1%
\$15,526,958	\$17,141,541	-\$1,614,583	-9.4%	\$14,914,045	9. Total Gross Patient Revenue	\$88,840,757	\$87,421,826	\$1,418,931	1.6%	\$79,682,542	11.5%
Deductions from Revenue:											
\$2,917,302	\$3,015,532	\$98,230	3.3%	\$2,601,641	10. Inpatient Contractual Allowance	\$13,697,448	\$15,356,716	\$1,659,269	10.8%	\$13,732,919	-0.3%
-\$350,000	-\$225,000	\$125,000		-\$308,333	10a. Rural Demonstration Project	-\$1,525,000	-\$1,125,000	\$400,000		-\$308,333	
\$4,414,193	\$3,986,249	-\$427,944	-10.7%	\$2,962,538	11. Outpatient Contractual Allowance	\$21,960,076	\$20,329,854	-\$1,630,222	-8.0%	\$18,369,130	19.5%
\$547,175	\$700,627	-\$153,452	21.9%	\$597,049	12. Physician Service Contractual Allowance	\$2,838,362	\$3,573,200	-\$734,838	-20.6%	\$3,147,223	-9.8%
\$23,902	\$14,348	-\$9,554	-66.6%	\$12,669	13. Other Deductions	\$121,749	\$73,174	-\$48,575	-66.4%	\$65,660	0.0%
\$216,604	\$127,997	-\$88,607	-69.2%	\$98,884	14. Charity Care	\$635,502	\$652,785	-\$17,283	2.6%	\$619,214	2.6%
\$23,326	\$100,379	-\$77,053	76.8%	\$208,034	15. Bad Debt Expense	\$1,878,099	\$511,933	-\$1,366,166	-266.9%	\$215,862	770.0%
\$7,792,502	\$7,720,132	-\$72,370	-0.9%	\$6,172,482	16. Total Deductions from Revenue	\$39,606,236	\$39,372,662	-\$233,573	-0.6%	\$35,841,675	10.5%
48.5%	44.9%			41.3%	% Contractual Allowances / Total Gross Patient Revenue	41.6%	44.9%			43.9%	
1.5%	1.3%			2.1%	% Bad Debt & Charity Care / Total Gross Patient Revenue	2.8%	1.3%			1.0%	
50.2%	45.0%			41.4%	% Total Deductions / Total Gross Patient Revenue	44.6%	45.0%			45.0%	
\$7,734,456	\$9,421,409	-\$1,686,953	-17.9%	\$8,741,563	17. Net Patient Revenue	\$49,234,521	\$48,049,164	\$1,185,358	2.5%	\$43,840,867	12.3%
\$2,170,951	\$823,195	\$1,347,756	163.7%	\$963,535	18. Other Operating Revenue	\$4,287,145	\$4,198,297	\$88,848	2.1%	\$7,037,254	-39.1%
\$9,905,407	\$10,244,604	-\$339,197	-3.3%	\$9,705,098	19. Total Operating Revenue	\$53,521,666	\$52,247,461	\$1,274,206	2.4%	\$50,878,121	5.2%
Expenses:											
\$4,184,946	\$4,499,601	-\$314,655	7.0%	\$4,157,691	20. Salaries & Wages	\$21,636,616	\$22,947,950	\$1,311,334	5.7%	\$20,816,528	3.9%
\$347,759	\$307,345	-\$40,414	-13.1%	\$257,326	21. Physician Wages	\$1,787,592	\$1,567,461	-\$220,131	-14.0%	\$1,446,397	23.6%
\$141,874	\$98,047	-\$43,827	-44.7%	\$170,042	22. Contract Labor	\$912,533	\$500,040	-\$412,493	-82.5%	\$848,956	7.5%
\$2,371,632	\$2,311,603	-\$60,029	-2.6%	\$2,263,256	23. Employee Benefits	\$12,081,943	\$11,789,192	-\$292,751	-2.5%	\$11,319,113	6.7%
\$7,046,211	\$7,216,596	-\$170,385	2.4%	\$6,848,315	70.6% % Salaries and Benefits / Total Operating Revenue	\$36,418,684	\$36,804,643	-\$385,959	1.0%	\$34,430,994	5.8%
71.1%	70.4%					68.0%	70.4%			67.7%	
\$40,688	\$83,228	-\$42,540	51.1%	\$106,254	24. Medical Professional Fees	\$306,241	\$424,456	-\$118,215	27.9%	\$541,282	-43.4%
\$416,828	\$169,360	-\$247,468	-146.1%	\$335,603	25. Physician Contracts	\$1,818,714	\$863,735	-\$954,979	-110.6%	\$1,235,943	47.2%
\$199,503	\$238,987	-\$39,484	16.5%	\$231,726	26. Non-Medical Professional Fees	\$899,583	\$1,218,841	-\$319,258	26.2%	\$968,241	-7.1%
\$1,241,206	\$1,216,152	-\$25,054	-2.1%	\$852,366	27. Materials & Supplies	\$7,330,428	\$6,202,300	-\$1,128,128	-18.2%	\$7,008,524	4.6%
\$126,857	\$128,152	\$1,295	1.0%	\$108,728	28. Utilities	\$603,891	\$653,558	-\$49,667	7.6%	\$536,454	12.6%
\$318,644	\$371,509	-\$52,865	14.2%	\$377,084	29. Maintenance & Repairs	\$2,246,129	\$1,894,693	-\$351,436	-18.5%	\$2,141,766	4.9%
\$76,991	\$37,574	-\$39,417	-104.9%	\$59,712	30. Rentals & Leases	\$276,123	\$191,624	-\$84,499	-44.1%	\$251,545	9.8%
\$66,224	\$54,299	-\$11,925	-22.0%	\$43,745	31. Insurance	\$351,200	\$276,923	-\$74,277	-26.8%	\$231,699	51.6%
\$640,504	\$627,434	-\$13,070	-2.1%	\$672,414	32. Depreciation & Amortization	\$3,141,960	\$3,199,917	-\$57,957	1.8%	\$3,349,476	-6.2%
\$49,761	\$49,261	-\$500	-1.0%	\$50,909	33. Interest Expense	\$246,580	\$251,228	-\$4,648	1.9%	\$254,759	-3.2%
\$171,096	\$129,006	-\$42,090	-32.6%	\$84,005	34. Other Operating Expenses	\$658,420	\$657,817	-\$603	-0.1%	\$434,630	51.5%
\$10,394,513	\$10,321,558	-\$72,955	-0.7%	\$9,770,861	35. Total Expenses	\$54,297,953	\$52,639,735	-\$1,658,218	-3.2%	\$51,385,313	-5.7%
-\$489,106	-\$76,954	-\$412,152	535.6%	-\$65,763	36. Income (Loss) from Operations	-\$776,287	-\$392,274	-\$384,013	97.9%	-\$507,192	53.1%
\$102,277	\$164,383	-\$62,106	-37.8%	\$104,883	37. Interest Income	\$511,013	\$838,356	-\$327,343	-39.0%	\$512,862	-0.4%
\$62,201	\$74,580	-\$12,379	-16.6%	\$72,992	38. Other Non-Operating Income	\$595,948	\$380,355	\$215,593	56.7%	\$380,120	56.8%
\$164,478	\$238,963	-\$74,485	-31.2%	\$177,875	39. Total Non-Operating Revenue	\$1,106,961	\$1,218,711	-\$111,750	-9.2%	\$892,982	24.0%
-\$324,628	\$162,009	-\$486,637	300.4%	\$112,112	40. Net Income (Loss)	\$330,674	\$826,437	-\$495,763	60.0%	\$385,790	14.3%
-4.94%	-0.75%			-0.68%	Income from Operations Margin	-1.45%	-0.75%			-1.00%	
-3.28%	1.58%			1.16%	Net Income	0.62%	1.58%			0.76%	

BARTLETT REGIONAL HOSPITAL  
BALANCE SHEET  
November 30, 2021

	<u>November-21</u>	<u>October-21</u>	<u>November-20</u>	<u>CHANGE FROM PRIOR FISCAL YEAR</u>
<b>ASSETS</b>				
Current Assets:				
1. Cash and cash equivalents	19,700,052	16,455,972	36,007,775	(16,307,723)
2. Board designated cash	30,341,553	30,435,406	35,719,904	(5,378,351)
3. Patient accounts receivable, net	17,302,598	19,597,839	14,135,598	3,167,000
4. Other receivables	906,110	1,371,110	(876,477)	1,782,587
5. Inventories	3,985,020	3,714,914	3,825,453	159,567
6. Prepaid Expenses	2,939,487	3,086,651	2,553,548	385,938
7. Other assets	31,937	31,937	28,877	3,060
8. Total current assets	75,206,757	74,693,829	91,394,678	(16,187,922)
Appropriated Cash:				
9. CIP Appropriated Funding	18,853,710	19,406,354	4,163,554	14,690,156
Property, plant & equipment				
10. Land, bldgs & equipment	152,031,616	151,850,022	145,924,595	6,107,020
11. Construction in progress	11,100,753	10,696,859	6,881,459	4,219,294
12. Total property & equipment	163,132,369	162,546,881	152,806,054	10,326,314
13. Less: accumulated depreciation	(104,715,882)	(104,075,498)	(97,390,628)	(7,325,254)
14. Net property and equipment	58,416,487	58,471,388	55,415,432	3,001,061
15. Deferred outflows/Contribution to Pension Plan	12,654,846	12,654,846	12,403,681	251,165
<b>16. Total assets</b>	<b>165,131,800</b>	<b>165,226,412</b>	<b>163,377,344</b>	<b>1,754,459</b>
<b>LIABILITIES &amp; FUND BALANCE</b>				
Current liabilities:				
17. Payroll liabilities	2,523,324	2,411,287	2,335,104	188,220
18. Accrued employee benefits	4,974,135	5,108,615	4,844,802	129,333
19. Accounts payable and accrued expenses	2,613,628	2,307,757	1,962,013	651,615
20. Due to 3rd party payors	2,367,164	2,392,930	4,250,857	(1,883,693)
21. Deferred revenue	956,168	999,335	(1,144,552)	2,100,720
22. Interest payable	445,609	189,178	263,838	181,771
23. Note payable - current portion	910,000	910,000	870,000	40,000
24. Other payables	456,756	404,654	416,869	39,887
25. Total current liabilities	15,246,784	14,723,756	13,798,931	1,447,853
Long-term Liabilities:				
26. Bonds payable	17,350,000	17,350,000	17,260,000	90,000
27. Bonds payable - premium/discount	111,164	84,065	1,152,380	(1,041,216)
28. Net Pension Liability	62,063,897	62,063,897	64,954,569	(2,890,672)
29. Deferred In-Flows	4,884,297	4,884,297	4,318,200	566,097
30. Total long-term liabilities	84,409,358	84,382,259	87,685,149	(3,275,791)
31. Total liabilities	99,656,142	99,106,015	101,484,080	(1,827,938)
32. Fund Balance	65,475,658	66,120,395	61,893,262	3,582,396
<b>33. Total liabilities and fund balance</b>	<b>165,131,800</b>	<b>165,226,412</b>	<b>163,377,344</b>	<b>1,754,459</b>

# Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 [www.bartletthospital.org](http://www.bartletthospital.org)

## Board Quality Committee January 12, 2022 Minutes

Called to order at 3:31 p.m. by Board Quality Committee Chair, Lindy Jones

**Board Members:** Mark Johnson\*, Hal Geiger\*, Lindy Jones\*

**Staff:** Gail Moorehead\*, Marc Walker\*, Charlee Gribbon\*, Deborah Koelsch\*, Jeannette Lacey\*, Jerel Humphrey\*, Kim McDowell\*, Dallas Hargrave\*, Vlad Toca\*, Karen Forrest\*, Miranda Dumont\*

**Guests:** None

*Mark Johnson made a MOTION to approve the minutes from September 8, 2021 Board Quality Meeting. Lindy Jones seconded, they are approved.*

*Old Business: None*

*Standing Agenda Items:*

### **2021 BOD Quality Dashboard – Deborah Koelsch**

- Deborah Koelsch went over the dashboard which is included in the packet. Dr. Jones would like Deborah to ensure the Emergency Department is reminded of the sepsis criteria.
- Miranda Dumont briefly described the Press Ganey and HCAHPS scores. Our hospital wide scores have increased overall except in the Emergency Department. Dr. Jones noted that lack of visitors could be a contributing factor to decreased scores.

*New Business:*

### **Utilization Management Plan – Jeannette Lacey**

- Jeannette reviewed the Utilization Management Plan updates. There are minimal updates this year. All updates can be found in the packet.

### **Infection Prevention Plan – Charlee Gribbon**

- Charlee shared her evaluation of the 2021 Infection Prevention Evaluation. She went over the 2021 goals and outlined if the measurements were met. Hand hygiene goals were not met in either BRH's observations or through PG scores. The Surgical Site Infection goal was not met with a 0.4 per 100 procedures infection rate. Dr. Jones asked why she believed the rate increased. Charlee explained that during the ED chart reviews she did not see that the patients were not bathed. Kim McDowell explained that supply

chain issues affected the ability to provide full body wipes in the Emergency Department. The Hospital Acquired Infections goal was not met with C. Diff cases rising from 3 in 2020 to 4 in 2021. We did not meet the influenza vaccination goal. We have 95.5% vaccinated at this time. There were no incidences of hospital acquired infection of COVID. We have 98.8% of staff and providers vaccinated. The last goal of reducing the risk of hospital acquired infection (HAI) transmission through surface contamination.

- Charlee shared her risk assessments of hospital acquired infections. She is focusing on Surgical Site Infections, C.DIFF, MRSA and Respiratory Protection.
- No changes were made to her Infection Prevention Plan or the Risk Assessment. The community assessment was changed due to small population changes. Charlee went over the Infection Prevention goals for 2022, which mirror the goals from 2021.

#### **Environment of Care Management Plan – Mark Walker**

- Marc Walker reported on the Environment of care outcomes of 2021. The results of the five programs goals are provided in the packet. The management plans have no changes for the upcoming year. The 2022 goals were presented and are available in the packet.

#### **Patient Safety and Quality Improvement – Gail Moorehead**

- Gail Moorehead reviewed the Patient Safety and Quality Improvement plan for 2022 which is available in the packet. Gail shared the evaluation of the 2021 plan outcomes along with the goals for 2022.

#### **Environmental Health and Safety Program – Gail Moorehead**

- Gail shared the new Environmental Health and Safety Program outline for the next few years. The outline and goals are available in the packet for review.

**Motion made to approve the summary of the 2021 and the 2022 annual plan packets and forward to full board for approval made by Dr. Lindy Jones, seconded by Mark Johnson. Hearing no objections, the motion passes.**

**Adjournment: 4:41 p.m.**

**Next Quality Board meeting: March 9<sup>th</sup> at 3:30 pm**

## **Bartlett Regional Hospital**

Title: **UTILIZATION MANAGEMENT PLAN**

Department/s: All Clinical Departments

Original Date: 10/1997

Author: Jeannette Lacey, LMSW, ACM

Updated: 12/2021<sup>10</sup>

### **PURPOSE:**

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

### **DEFINITIONS:**

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

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

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

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

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

### **Policy**

- A. The Board of Directors of Bartlett Regional Hospital has delegated the responsibility for the performance of utilization review activities to the Case Managers (CM) with the Utilization Review Committee as the oversight committee.
- B. The Utilization Management Plan is based on CMS conditions of participation, The Joint Commission standards, and Interqual and/or MCG criteria for healthcare utilization and seeks to resolve problems that cause or result in either deficient or excessive resource utilization. The plan will be reviewed at least annually by the Utilization Review Committee.

- C. The Utilization Management Plan recognizes the authority of KEPRO and the assessment and monitoring of review activities performed by KEPRO.
- D. Utilization management and review are integral parts of the Process Improvement Plan at BRH and will be under the auspices of the CFO with direct reporting to the Utilization Review Committee.
- E. Scope of Review: All patients, regardless of payment sources, shall be evaluated to ensure that resources are utilized properly. The Case Managers (CM) will be responsible for the process of maintaining and monitoring the effective utilization of hospital facilities, services, and resources related to inpatients and patients placed in observation status. This shall include, but not be limited to:
  - E.1. Performing admission, concurrent, discharge and retrospective reviews to assess for medical necessity
  - E.2. Identifying the appropriate level of care
  - E.3. Managing length of stay
  - E.4. Assessing potential transfers from lateral or higher levels of care
  - E.5. Managing denials and appeals
  - E.6. Tracking and monitoring utilization patterns and professional services furnished, including drugs and biologicals.
  - E.7. Identifying available discharge care resources to develop a post-acute care plan that is compliant with CMS guidelines.
  - E.8. Requesting secondary review or Utilization Review Committee involvement as necessary.
- F. CM will collaborate with physicians to support the utilization management process by:
  - F.1. Maintaining open lines of communication.
  - F.2. Reviewing admission status based on accepted criteria and CMS rules and discussing concerns with the provider.
  - F.3. Reviewing continued stay documentation and identifying possible changes or additions to ensure that documentation supports physician intent.
  - F.4. Coordinating care conferences with the physician and treatment team as indicated.
  - F.5. Involving the physician in the discharge planning process.
  - F.6. Coordinating physician participation in the appeal process.
- G. Patients that do not meet inpatient criteria may be placed in observation status by the admitting provider if observation criteria are met. Those patients who do not meet criteria for inpatient care or observation services shall be notified by the CM that the services are not covered and that the individual or family may be responsible for payment of the services. The appropriate Hospital Issued Notice of Non

Coverage(HINN) or Advanced Beneficiary Notification (ABN)will be given to the patient or their representative.

H. Utilization Review Committee Composition:

H.1. Credentialed medical staff, at least 2 of which will be doctors of medicine or osteopathy. H.2. Staff from the Case Management (CM) Department

H.3. Staff from the Health Information Management (HIM) Department

H.4. Staff from the Quality Department.

H.5. Reviews may not be conducted by any individual who has a direct financial interest in the hospital; or was professionally involved in the care of the patient whose case is being reviewed.

I. Utilization Review Committee Functions: The Committee

I.1. Will meet quarterly

I.2. Will review

i.Outlier cases

ii. Denials

iii.Compliance with the 2-Midnight Rule

iv. Readmissions

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

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

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

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

I.6. Provide education and communicate with individual providers when rules or polices are not followed. Escalate concerns when recurrent or significant.

## SCOPE

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

### PROCEDURE: Utilization Review

- A. Preadmission certification for outpatient procedures, surgical procedures, specialties care and inpatient admissions (if required) will be the responsibility of the provider's office.
- B. Patient Access Services will perform insurance verification and notify the Case Management of reviews requested by payers at the time of verification.
- C. Medical Necessity: Hospital inpatient services under Medicare Part A, section1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis.
  - C.1. Registered Nurse Case Manager (RNCM) will determine if medical documentation supports medical necessity for admissions and continued stay

- based on established industry criteria that are intended for use as a guideline in conjunction with sound clinical judgment.
- C.2. Admission reviews will be performed within the first business day following admission
  - C.3. A secondary review may be initiated if the RNCM is unable to determine medical necessity for the admission.
  - C.4. Concurrent stay reviews will be based on the attending physician’s reasons and plan for continued stay, discharge plans, and other documentation. Case Management will remain in contact with the attending physician, the business office and the payer during the hospital stay to resolve questions and to share information regarding discharge plans.

**References**

- (1) Medicare Hospital Manual section 230
- (2) CMS Conditions of Participation 482.30 Utilization Review
- (3) CMS Conditions of Participation 412.80 Outlier Cases
- (4) Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care ~~and Behavioral Health Care~~, current edition, 202119

**Attachments**

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

**Attachment #1**

Bartlett Regional Hospital

HIM/UM Denied Days Status Report

Date:

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

**Attachment # 2**

Bartlett Regional Hospital  
Medicare Outlier Status Report

Patient Name	Account #	Admission Date	Discharge Date	LOS	ELOS	Charges	Admitting Diagnosis/ Procedures	Disposition/ Outlier Problem	CM Reviewer	Appropriat e timing of D/C planning?	What else could have been done differently?	Reason for outlier
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**Attachment #3**

Bartlett Regional Hospital  
Utilization Management Report

Q3 CY2021

**Denials**

	Initial Days Denied	Days Reversed/obs/in appeal	Days Upheld
Totals			
Aetna			
Blue Cross			
Medicaid			
UHC			
Other			

<b>Medicare Monitoring</b>		Notes
CMI		
1- day stays		
Observation >/= 2MN		
Outliers- Total		
Psych		
Placement		
EOL		
Complex Medical		
Social		
Other		

<b>Readmissions</b>		Notes
All Cause		
Medicare Readmissions		
AMI		
HF		
Pneumonia		
COPD		
THA/TKA		
Sepsis		
Stroke		
Other		

**BARTLETT REGIONAL HOSPITAL  
INFECTION PREVENTION and CONTROL PLAN 2022 Draft**

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

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

**Infection Prevention and Control Plan Reviewed by:**

	Signature	Date
Infection Prevention and Control Committee Chair	David Miller MD	1/7/2022
Quality and Process Improvement Director	Gail Moorehead MSN, NPD-BC, CMSRN, CPHQ	1/7/2022
Infection Preventionist	Charlee Gribbon RN, MPH, CIC	1/7/2022

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January 7, 2022

## **Bartlett Regional Hospital**

### **Infection Prevention and Control Plan 2022**

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

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

- 1 Early identification of infections, both expected and unexpected.
- 2 Timely implementation of interventions when infections or risks thereof are identified.
- 3 Analysis of organizational and individual practices that impact transmission of infection.
- 4 Implementation of evidence-based practices known to reduce the transmission of infection.
- 5 Education of healthcare workers, patient, families, and visitors on infection risk-reduction practices.
- 6 Limitation of unprotected exposure to pathogens throughout the organization.
- 7 Interact with community health agencies through activities such as surveillance and emergency preparedness to respond to community outbreaks and special pathogens (novel strains such as COVID-19, or Ebola).
- 8 Manage effectively the seasonal influx of potentially infectious patients during Southeast Alaska's tourist season.
- 9 Enhancement of hand hygiene practices by all persons within the hospital system.
- 10 Minimization of the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.
- 11 Incorporation of guidelines and recommendations published by regulatory or accrediting agencies, and professional organizations, to provide current evidence-based infection prevention strategies and policies.
- 12 Provision of Employee Health services, including appropriate screening, testing, immunization, counseling, and education for staff and others who have the potential for exposure to communicable disease.

## **Infection Prevention and Control Program Oversight and Organization Authority and Responsibility**

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

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

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

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

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

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

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

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

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

A.5. Time-sensitive or critical issues:

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

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

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

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

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

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

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

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

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

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

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

A.5.2.5.1.3. Medical Staff Executive Committee Chair.

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

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

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

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

### ***Risk Assessment and Prioritization of Goals (IC 01.04.01)***

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

### ***Geographic Location and Community Environment***

Bartlett Regional Hospital is a community-owned acute care hospital licensed for a total of 71 inpatient beds and 10 residential substance abuse treatment facility beds in the Rainforest Recovery Center. In addition to the communities of Juneau and Douglas, we serve all the Southeast Alaska communities of Yakutat, Skagway, Haines, Sitka, Hoonah and Angoon. The primary and secondary service area has a combined population estimate of 46,653. Bartlett serves a 29,991-square-mile region in the northern part of Southeast Alaska. Juneau, the largest city in the region and the capital of Alaska is accessible only by water or air. The population of the city and borough of Juneau is 31,848 ([US Census, 2021](#)). This includes 5.8 % who are under 5 years of age, 21.5% persons who are under 18 years, and 12.5 % that are over 65 years of age. (US Census, 2021) The underserved and disadvantaged population includes: 7.9% with a [disability and under 65 years of age](#); and 11.8 % under 65 years of age without health insurance. (US Census, 2021) Additionally, 7.7% of Juneau residents are living in poverty (US Census, 2021).

### ***Characteristics of the Population Served***

Bartlett Regional Hospital is the largest provider of hospital services in Southeast Alaska. It serves a diverse community of residents. Tourism expands the service area population by approximately 30% from May to September each year, welcoming visitors from 50 or more countries. These include the workers for the fisheries, mining and tourism agencies that are seasonal; approximately 27,000 people work seasonally in Southeast Alaska every year; 70% are non-residents, and many are foreign born from high TB incidence countries. The fisheries, mining and cruise ships provide tight living quarters for their seasonal employees, which may increase the incidence of any disease. The cruise lines bring tourists and workers from many different countries. BRH must consider ship quarantine or influx of infectious diseases. This seasonal influx in local population presents ongoing significant potential for mass trauma and communicable disease outbreak, requiring BRH to maintain careful surveillance, awareness of global emerging infectious disease trends (Pandemic or Novel strains of Influenza, COVID-19, MDR Tuberculosis, CRE, Ebola, etc.) and to maintain an updated emergency management and surge capacity plan.

The Alaska Department of Health and Social Services [2019](#) TB Summary Brief Report shows that Alaska's TB infection rate was 7.9 cases per 100,000 people, representing a slight decrease from the previous year (AK SOE, 2020). Alaska still has the highest TB incidence rate in the nation, and is nearly three times the national average of 2.7 cases per 100,000 people. Southeast Alaska's incidence rate has decreased from 2.7 to 1.4 cases per 100,000.

### ***Results of Analysis of Bartlett Regional Hospital Infection Prevention Data***

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

### ***Evaluation of the Infection Control and Prevention Plan***

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

### ***Care, Treatment, and Services Provided***

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

### ***Employee Health***

Bartlett Regional Hospital provides a safe working environment for its approximately 745 employees and 79 licensed independent providers. 567 (76 %) are full or part time scheduled and working on campus. This is accomplished through coordination of Infection Prevention policies and practices, and through the services provided by the Employee Health Program such as Hepatitis B vaccination, TB testing, and screening for immunity to vaccine-preventable diseases. Employees that handle or contact hazardous drugs participate in the medical surveillance program. Employee illnesses are categorized and logged daily by the Central Staffing Office and Employee Health Nurse, and analyzed by Employee Health. The goal is to identify and mitigate infectious conditions that may pose a risk to patients, visitors, or staff, and to ensure that staff are immune to vaccine-preventable diseases.

### ***Emergency Preparedness***

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

# 2022

# Infection Prevention and Control Plan

# Draft

## 2022 Infection Control Plan Goals

Infection Prevention Goal #1	Measurable Objective	Strategies	Responsible Parties	Measurement/ Evaluation Goal Met or Unmet.
<p>► Improve compliance with CDC Hand Hygiene Guidelines (NPSG 07.01.01, EP1).</p>	<p>BRH hand hygiene rates will be improved by 10% over 2021's hand hygiene compliance rate by 9/30/2022.</p> <p>Directors of units that have direct contact with patients will contribute to data collection, with the shared goal of observing 200 hand hygiene moments per unit, per month.</p>	<ol style="list-style-type: none"> <li>1. Enlist Hand Hygiene Observations from directors of patient care areas.</li> <li>2. Utilize Smartsheets to collect data and share compliance rates.</li> <li>3. Plan and implement Hand Hygiene awareness and educational campaign.</li> <li>4. Work with Patient and Family Engagement Team to encourage more patient feedback regarding Hand Hygiene.</li> </ol>	<p>Nursing Administration, Directors &amp; Supervisors, Patient Care staff, Infection Prevention.</p>	<p>BRH hand hygiene compliance rate will increase by 10% over 2021 (65%) hospital wide rates. Patient reported (Press-Ganey) hand hygiene scores will increase by 5% over 2021's reported rates. (72.3%)</p> <p>Observations collected in each unit, per month will meet or exceed 200.</p>

<b>Infection Prevention Goal #2</b>	<b>Measurable Objective</b>	<b>Strategies</b>	<b>Responsible parties</b>	<b>Measurement/ Evaluation</b>
▶ Reduce surgical site infections by reducing risk of infection.	Reduce surgical site infection rate at or below 0.3 per 100 procedures by 12/31/2022.	<ol style="list-style-type: none"> <li>1. Monitor staff compliance with pre procedural bathing.</li> <li>2. Utilize dietary consult pre-op to reduce risk of perioperative hyperglycemia.</li> <li>3.</li> </ol>	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	<p>Measure surgical site infection rates and compare to 2021.</p> <p>Rate will be ≤ 0.3 infections per 100 procedures.</p>
<b>Infection Prevention Goal #3</b>	<b>Measurable Objective</b>	<b>Strategies</b>	<b>Responsible parties</b>	<b>Measurement/Evaluation</b>
▶ Decrease the risk of acquiring health care associated C. difficile. (NPSG 07.03.01)	Limit the risk of HAI C. difficile transmission and reduce HAI CDI rates to 2 infections per 10,000 patient days by 12/31/2022.	<ol style="list-style-type: none"> <li>1. Ensure adherence to testing only symptomatic patients.</li> <li>2. Utilize 2 step testing to identify only toxigenic cases.</li> <li>3. Increase utilization of Sterile Meryl for all terminal cleaning.</li> <li>4. Ensure appropriate cleaning and disinfection products (sporicidal) are available for C. difficile rooms and area is cleaned per protocol.</li> <li>5. Prohibit unnecessary antibiotic use.</li> </ol>	Nursing, EVS, Infection Prevention, pharmacy, medical staff, laboratory and all staff.	<p>Measure C. difficile infection rates and compare to 2021 baseline.</p> <p>There will be no increase in HAI- C. Difficile rates for 2021.</p>

		6. Increase hand hygiene compliance		
<b>Infection Prevention Goal #4</b>	<b>Measurable Objective</b>	<b>Strategies</b>	<b>Responsible parties</b>	<b>Measurement/Evaluation</b>
► Prepare for and protect staff, patients and our community from respiratory pathogens in a efficient and safe manner. (IC.02.04.01)	1. Maintain full time/ part time scheduled staff influenza & COVID vaccination at rates 98 % or greater for the 2022-2023 season.	<ol style="list-style-type: none"> <li>1. Participation in the influenza and COVID-19 prevention plan is mandatory.</li> <li>2. Unvaccinated staff are required to wear barrier masks.</li> <li>3. Enforce standard precautions are in use for any aerosol-generating procedure.</li> <li>4. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH.</li> </ol>	Leadership, all staff, IC, and employee health	<p>Full time/ part time scheduled staff compliance rate will be at 98% or greater by November 30, 2022.</p> <p>Report data via NHSN.</p>

References:

Alaska Community Database Online DCRA Information Portal (2021) Juneau, Alaska. Retrieved from <https://dced.maps.arcgis.com/apps/MapJournal/index.html?appid=3635942ba31c40f094e6249f9d07431c>

Section of Epi (2019) Alaska TB Summary Brief. Retrieved from

<http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/TB/2019%20AK%20TB%20Summary.pdf>

<http://dhss.alaska.gov/dph/Epi/id/Pages/tb.aspx>

United States Census Bureau. (2020) Quick Facts: Juneau City and Borough, Alaska. Retrieved from:

<https://www.census.gov/quickfacts/juneaucityandboroughalaskacounty> (Census)

# BARTLETT REGIONAL HOSPITAL

## Environment of Care

### Annual Report

CY 2021

#### Approvals

Environment of Care Committee: December 16, 2021

Performance Improvement Council: (scheduled January 12, 2022)

Board Quality: (scheduled January 12, 2022)



# INTRODUCTION

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

- Safety Management (Gail Moorehead Sr. Director Quality Review)
- Security Management (Gail Moorehead Sr. Quality Review)
- Hazardous Materials and Waste Management (John Fortin Laboratory Department Director)
- Medical Equipment Management (Kelvin Schubert Maintenance Supervisor)
- Utility Systems Management (Kelvin Schubert Maintenance Supervisor)

In addition, the BRH Life Safety Management Program is integrated with the EOC Program.

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

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

Membership of the EOC Committee is comprised of:

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

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

This report highlights the activities of the EOC Program in Calendar Year 2021. For each of the major areas, it is organized as follows:

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

# SAFETY MANAGEMENT

## SCOPE

### No Changes

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

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

### ACCOMPLISHMENTS

- Development of Environmental Health and Safety Program
- Creation of Environmental Health and Safety Manager Role
- Ongoing workplace violence work through WSHA in the Emergency Department
- Workplace Violence Prevention Plan in development
- Hazard risk assessments performed for new or changed workflow or spaces due to COVID-19



### PROGRAM OBJECTIVES

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

Objectives	Met / Not Met	Comments and Action Plans
Enforce current safety practices for staff, patients, physicians, and visitors	Met	EOC Rounds were completed as and follow-up rounds were conducted to monitor specific regulatory survey findings.
Comply with all relevant safety standards and regulations	Met	Continue Safety Program development by Environmental Health and Safety Manager
An annual evaluation of the scope, objectives, key performance indicators, and the effectiveness of the Safety Management plan and programs is conducted.	Met	Completed via this document.

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

### PERFORMANCE MEASURES

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

Safety Management Performance Measures 2021	Target	Outcome	Comments and Action Plan
Create a new and efficient way to meet the Joint Commission requirements to collect information on staff's knowledge of Employee Safety topics and to survey the physical environment (replace SWARMS)	100%	100%	<b>Met</b> There is a new Relias employee swarm online for staff to complete in December. This will be uploaded and reevaluated annually.
Reduce OSHA recordable injuries to staff by 50% (7 for 2020)	3 or less	6	<b>Not Met</b> The past year had 6 OSHA reportable cases. The committee has determined that this goal will continue for 2022 and they will dive deeper into the cases to determine what further actions need to be taken to reduce this number.

## EFFECTIVENESS

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

### GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2022:

- Development of Tracking and evaluation of workplace violence incidents and review of post event interventions.
- Create more opportunities for frontline staff participation in the program

The proposed performance measures for these goals are:

<b>Safety Management Proposed Performance Measures for 2022</b>	<b>Target</b>	<b>Comments &amp; Action Plan</b>
<b>AIM: Recruit and retain frontline worker for the workforce safety and security committee to meet OSHA standards.</b>	<b>Complete 100%</b>	
<b>AIM: Reduce OSHA recordable injuries to staff by 30% in 2022 (6 for 2021)</b>	<b>4 or less</b>	
<b>AIM: Conduct a Risk Assessment on at least one high risk process area per year.</b>	<b>Complete 1 FMEA</b>	
<b>AIM: Complete a ligature risk assessment and mitigation of ligature risks on MHU. This will include any identified concerns from 2021 survey.</b>	<b>Complete 100%</b>	

# SECURITY MANAGEMENT

## SCOPE (No Change)

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

## ACCOMPLISHMENTS

- PES program implemented in the Emergency Room to respond to patients in behavior crisis.
- Additional employee badge proximity readers have been added to security doors throughout the hospital to enhance security in those areas. More to be added in 2022 along with enhanced lockdown capabilities.
- Security response to physically limit control points to the hospital as a response to COVID-19 safety precautions.
- The hospital appropriately responded to dynamic visitor policy and visitor incident directives based on needs assessment.
- New Psychiatric Emergency Services staff has supported the security response requests in the Emergency room.



## PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
To provide education to personnel on the elements of the Security Management Plan	<b>Met</b>	New employee education and required annual safety/security education
To control access to and egress from sensitive areas	<b>Met</b>	Secure and Sensitive areas policy

Objectives	Met / Not Met	Comments and Action Plans
To reduce the risk of security incidents	<b>Met</b>	The Safety and Security Committee meets to discuss violence prevention policies, education and exercises. Threats to public safety will be mitigated by a combination of physical and procedural controls. The Safety and Security Committee discusses potential solutions and makes recommendations to improve the safety and security of patients, visitors and staff.
To address security concerns of patients, visitors, personnel and property.	<b>Met</b>	The Safety and Security Committee meets to discuss violence prevention policies, education and exercises. Threats to public safety will be mitigated by a combination of physical and procedural controls. The Safety and Security Committee discusses potential solutions and makes recommendations to improve the safety and security of patients, visitors and staff.

## PERFORMANCE MEASURES

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

Security Management Performance Measures 2021	Target	Outcome	Comments and Action Plan
Create variable lock down procedures for active threat events to the hospital, RRC, BSSC, BMOC and both admin buildings. All external exits to hospital, RRC, and both admin buildings are to have badge reader access capabilities	Procedure In place and hardware installed	Complete	<b>Met</b>  Badge readers: 100% complete. Current lockdown options adequate, but in the process of requesting additional devices which will expand lockdown options.
Finalize disruptive patient contract, including actionable consequences to enable staff to maintain a safe and secure environment independent of calling for law enforcement.	Complete Document	Partially Complete	<b>Partially Met</b>  Risk Management is in contact with CBJ Legal to finalize the document.

## EFFECTIVENESS

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

## GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2022

The following goals/opportunities for improvement have been identified:

- **Improve Safety:** Ensuring staffing for two security guards per shift for greater than 60% of shifts and have all security personnel attend advanced de-escalation training.
- **Decrease Potential for Workplace Violence:** Implementation of virtual patient sitter equipment in our inpatient units. Development of tools to share patient alters throughout the entire organization

The proposed performance measures for these goals are:

<b>Security Management Proposed Performance Measure for 2022</b>	<b>Target</b>
<b>Improve Safety Through Security</b>  <b>AIM:</b> Staff 2 security guards per shift	60%
<b>Improve Safety Through Security</b>  <b>AIM:</b> Have all security personnel attend advanced de-escalation training.	100%
<b>Decrease Potential for Workplace Violence</b>  <b>AIM:</b> Implementation of virtual patient sitter equipment in our inpatient units.	Implement program
<b>Decrease Potential for Workplace Violence</b>  <b>AIM:</b> Development of tools to share patient alters throughout the entire organization (Edie or other program) that will share potential concerns for patient violence and history.	Develop tools and implement

# HAZARDOUS MATERIALS & WASTE MANAGEMENT

## SCOPE (No Change)

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

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

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

## ACCOMPLISHMENTS

- Hazardous Communication Plan review completed in November 2021
- Continued communication for follow up with Pharmaceutical waste, by assuring department labeling.
- The subcommittee maintained all policies and procedures as per compliance needs. Subcommittee will update policies and procedures as indicated by Risk or Quality.
- Assured that safety features (eye wash, showers) are maintained per compliance. Assured general knowledge of Haz-Mat concerns are brought to the employees through use of Relias.
- Review of all areas to assure they have current Safety Data sheets.



## PROGRAM OBJECTIVES

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

<b>Objectives</b>	<b>Met / Not Met</b>	<b>Comments &amp; Action Plan</b>
To assure Nursing Departments are familiar with the pharmaceutical waste process.	<b>Met</b>	Nearly all departments have demonstrated competency in this objective.

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

### **PERFORMANCE MEASURES**

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

<b>HazMat Management Performance Measures 2021</b>	<b>Target</b>	<b>Outcome</b>	<b>Comments and Action Plan</b>
<b>AIM:</b> How do you find a Safety Data Sheet at Bartlett Regional Hospital?	100%	89%	Continue Educating Staff
<b>AIM:</b> How many elements are included in a Safety Data Sheet?	86%	81%	Continue Educating Staff
<b>AIM:</b> What section on a Safety Data Sheet addresses First Aide?	83%	83%	
<b>AIM:</b> Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?	100%	63%	Continue Educating Staff
<b>AIM:</b> What is the difference between an Incidental Spill/Fumes vs a Non Incidental Spill/Fumes?	59%	50%	Continue Educating Staff
<b>AIM:</b> How often must an eyewash, shower or personal wash bottle be checked?	100%	71%	Continue Educating Staff
<b>AIM:</b> If your unit has a common bottle of Methanol, you must have at a minimum a plumbed eyewash station on the unit?	13%	88%	

HazMat Management Performance Measures 2021	Target	Outcome	Comments and Action Plan
<b>AIM:</b> You are wasting a partial dose of Phenergan. Where do you waste this liquid medication?	75%	98%	
<b>AIM:</b> You are giving a half dose of Coumadin and you need to waste the other half. Where do you waste it?	63%	97%	
<b>AIM:</b> You are cleaning up after a procedure. There are 4x4 gauzes saturated with body fluids/blood. Where do you throw away the saturated gauzes?	95%	99%	

### EFFECTIVENESS

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

### GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2022

- Based on review of results, the committee will review Relias training in December 2021. The current training can be modified to assure understanding of staff for specific topics.
- Review of SDS in each department
- Moving Bartlett's SDS's to CBJ MSDS online. This will allow more access by Bartlett Staff.

The proposed performance measures for these goals will include:

<b>Hazardous Materials &amp; Waste Management Proposed Performance Measures 2022</b>	<b>Target</b>
<b>AIM:</b> How do you find a Safety Data Sheet at Bartlett Regional Hospital?	100%
<b>AIM:</b> How many elements are included in a Safety Data Sheet?	81%
<b>AIM:</b> What section on a Safety Data Sheet addresses First Aide?	83%
<b>AIM:</b> Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?	100%
<b>AIM:</b> What is the difference between an Incidental Spill/Fumes vs a Non Incidental Spill/Fumes?	50%
<b>AIM:</b> How often must an eyewash, shower or personal wash bottle be checked?.	100%
<b>AIM:</b> At locations where hazardous chemicals are handled by employees <b>proper eyewash and body drenching equipment</b> shall be available no more than 10 feet from the work station(s).	88%
<b>AIM:</b> You are wasting a partial dose of Phenergan. Where do you waste this liquid medication?	98%
<b>AIM:</b> You are giving a half dose of Coumadin and you need to waste the other half. Where do you waste it?	97%
<b>AIM:</b> You are cleaning up after a procedure. There are 4x4 gauzes saturated with body fluids/blood. Where do you throw away the saturated gauzes?	98%

# LIFE SAFETY MANAGEMENT

## SCOPE (No Changes)

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

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

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

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

To test and maintain the fire alarm and detection systems,

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

## ACCOMPLISHMENTS

- Life Safety Code requirements reviewed as compliant with current TJC standards.
- Life safety walk-through of the ABA office completed. Fire plan and evaluation completed for ABA office and is being put into policy.
- Assessed our business occupancy buildings' compliance with TJC's new standards. Collaborated with the property owners to ensure compliance and safety of the buildings.
- We have been using Smartsheets to collect data and evaluate the knowledge of Life Safety topic of employees.
- Life Safety Day was a successful educational opportunity for staff/ departments. Staff and providers were very engaged.
- Facilities hands-on training for staff to practice PASS with a fire extinguisher was a success
- Provided numerous TJC safety topics to staff on Life Safety standards and compliance.



## PROGRAM OBJECTIVES

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

The Environment of Care Committee has evaluated the objectives and determined that there are minimal opportunities for improvement. The Program continues to Life Safety Management in a positive proactive manner

## PERFORMANCE MEASURES

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

Life Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
<b>AIM:</b> Refine the process for accounting for all people following a fire evacuation.	100%	80%	This measure is an on-going process. During our Life Safety Day, we swarmed staff and asked about whom their designated person was to account for staff. We sent out a smartsheet to staff with our Life Safety day swarm questions for a larger feedback

			for staffs' understanding. We provided just in time training on this process and encouraged departments to identify a designated person for both shifts. In our swarm we discussed when a department would actually be evacuating the hospital/ building and our process based on policy.
<b>AIM:</b> Provide an education campaign to clinical staff to learn about what is expected with an evacuation, where the fire containments are, and how to horizontal or vertically evacuate when needed.	100%	100%	During our Life Safety Day, we provided just in time training to all departments in the hospital on these processes and surveys staff for their understanding. We used a visual to provide the education and gave real examples. This topic was also identified to be discussed in NEO
<b>AIM:</b> Refine our process for horizontal and vertical evacuations of patients and collaborate with facilities to support providing a follow-up education plan to staff on our current process through Relias.	100%	80%	This topic and process was discussed during our life safety day to staff. We are working with Staff Development on including the different evacuation types to the regulatory Fire Safety training for staff in Relias.
<b>AIM:</b> Work with Facilities to support updating the addressable locations system in the Administration Building to have up-to-date titles, fire pull and fire point locations.	100%	33%	We have 33% completed. This will continue to be a work in progress and stay on our performance measures for 2022.

**EFFECTIVENESS**

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

**GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2022**

- Continue to work with Staff Development to complete Relias education for evacuations and hospital specific training.
- Recruiting more subcommittee members and avoid cancelling monthly meetings due to no attendance.
- Complete updating the addressable location system in the Administration Building.
- Review all fire drill reports to ensure compliance and identify topics for staff education.

The proposed performance measures for these goals include:

<b>Life Safety Proposed Performance Measures for 2022:</b>	<b>Target</b>	<b>Comments and Action Plan</b>
<b>AIM:</b> Work with Facilities to support updating the addressable locations system in the Administration Building to have up-to-date titles, fire pull and fire point locations	100%	
<b>AIM:</b> Provide annual hands-on training to staff for using PASS with a fire extinguisher.	100%	
<b>AIM:</b> The subcommittee will review 100% of the fire drill reports and use reports to identify areas to provide education to staff.	100%	
<b>AIM:</b> Track, monitor and report required fire inspections and corrective actions to the subcommittee to ensure compliance and identify topics for staff education.	100%	

# UTILITY SYSTEMS MANAGEMENT

## SCOPE (Grammatical Changes Only)

The scope of the Utility Systems Management Plan is to define the process by which utility systems in use at Bartlett Regional Hospital are monitored and maintained. A safe, comfortable patient care and treatment environment shall be provided by managing the risks associated with safe operation and the functional reliability of the hospital's utility systems.

## ACCOMPLISHMENTS

- Successfully migrated systems to our VxBlock
- Completed upgrade of all UPS units across the hospital
- Changed our Wi-Fi network to WiFi-6
- Boosted the cellular signal into the basement level of the hospital
- Several upgrades to systems including a new firewall set
- Upgraded AHU-11 Supply and Return Fan (Operating Rooms) to house new Nortek wall fans with Variable Frequency Drives with electronic controls.
- Improved plumbing to domestic hot water heat exchanges, making it easier to service and disassemble each unit.
- Hosted Cole Industrial, Inc. to receive factory boiler training for three maintenance mechanics.
- Installed an emergency water feed port for steam boilers
- Installed a glycol system upgrade to ASU#1 heating coil



**Maintenance Storeroom before**



**Maintenance Storeroom after**

## PROGRAM OBJECTIVES

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

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

## PERFORMANCE MEASURES

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

Utilities Management Performance Measures 2021	Target	Outcome	Comments and Action Plan
<b>AIM:</b> Review and rewrite preventative maintenance procedures.	70%	60%	<b>Partially Met;</b> This will be a multi-year project to review and rewrite all procedure
<b>AIM:</b> Create and maintain an inventory control program in TMS for the Maintenance Department.	50%	25%	<b>Partially Met;</b> This will be a multi-year project to review and rewrite all inventories.

## EFFECTIVENESS

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

## GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2022

- Continue working toward completion of the multiyear goals
- Replace a closed-loop water chiller that has reached its end of life. It needs major components replaced and it is more cost effective to replace the unit rather than fix the failing or failed parts.

The proposed performance measures for the plan objectives include:

Utilities Management Proposed Performance Measures 2022	Target	Comments and Action Plan
<p><b>AIM:</b> Review and rewrite preventative maintenance procedures. Make certain all utility equipment has an asset number assigned with a PM schedule in the Electronic Equipment Management Program (TMS). The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components and utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance program.</p>	<p><b>90%</b></p>	<p>This will be a multi-year project to review and rewrite all inventories. (It was learned through experience this year that reviewing all assets with their preventative maintenance procedures was a loftier goal than possible to achieve. Adding new assets to the mix caused the opportunity of improvement to be even greater. Work this year has been focused on writing procedures for new assets as they are added to the management program. Ongoing</p>
<p><b>AIM:</b> Create and maintain an inventory control program in TMS for the Maintenance Department. For all parts: reducing the load of unused and outdated stock as well as maintaining adequate stock to perform necessary tasks. This has been a multi-year project. Last year we remodeled the storeroom: walls painted, floor floated and painted, and new racks and shelving installed. This year we were able to organize stock and reduce the amount of unused and outdated inventory.</p>	<p>Percent of the overall project</p>	<p>See comparative photos contained in this report.</p>

<p>We have divided this project into smaller sections.</p> <ol style="list-style-type: none"> <li>1. Sort and condense inventory into a smaller footprint. This will not only include the main stock room but items yet left in the basement of the old Bartlett Outpatient Services building (BOPS). We will be moving and organizing inventory into the refrigeration container located next to the Bartlett House. Last year we completed 50% of step 1. We look forward to completing 100% as of November 2022.</li> <li>2. Quantify each item with manufacturer description and stock numbers. This will include placing each item into a known “warehouse” and known “bin location”. We have purchased supporting hardware to begin making location and UPC labels. We are working toward completing 50% of Section 2 by November 2023.</li> <li>3. Enter inventory into the TMS system, learn how to add and remove supplies, and assign their use to an individual work order with replacement pricing. This process will allow us to monitor minimum inventory stock levels. We are anticipat this to be completed by November 2024.</li> </ol>	<p>Nov 2022 100%</p> <p>Nov 2023 50%</p> <p>Nov 2024 100%</p>	
<p><b>AIM:</b> Document and report all utility failures during the year 2022</p>	<p>100%</p>	

# MEDICAL EQUIPMENT MANAGEMENT

## SCOPE (NO CHANGE)

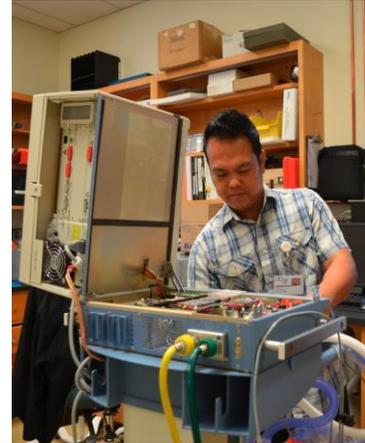
The Medical Equipment Management Plan is designed to define the processes by which Bartlett Regional Hospital provides for the safe and proper use of medical equipment used in the patient care setting.

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

## ACCOMPLISHMENTS

Program activities highlights for 2021 include:

- Placed into service, 13 new Hill-Rom Stretchers.
- Placed in service a new Steris Washer in CSR.
- Placed into service new beds in MS department.
- Calibration of all Biomed Test Equipment.



## PROGRAM OBJECTIVES

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

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

## PERFORMANCE MEASURES

Equipment Management Performance Measures	Target	Outcome	Comments and Action Plan
<p><b>AIM:</b> Within a new system, we propose to capture all new equipment at time of implementation and enter 100 pieces of existing equipment into the account by August 2021. The system should record the purchasing and receiving dates, implementation and assignment of equipment, monitor and document end of life and disposal of each piece of medical equipment.</p>	100%	10%	<p><b>Not Met</b></p> <p>System needs to be coordinated with Material Management, Accounting and Biomed. Being a multi-department project adds complexity and time. This system is still considered a priority and work will continue towards completing this goal in 2022.</p>
<p><b>AIM:</b> Work with Material Management to develop a process for disposing of surplus medical equipment and implement disposal within 3 months of removing it from the Medical Equipment inventory.</p>	100%	100%	<p><b>Met</b></p>
<p><b>AIM:</b> To organize and complete TMS PM updates by the end of the March 2021.</p>	100%	100%	<p><b>Met</b></p> <p>This process is still considered as needing improvement and work will continue in 2022.</p>

## EFFECTIVENESS

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

## GOALS AND OPPORTUNITIES FOR IMPROVEMENT FOR 2022

- Continue to improve TMS PM updates.
- Have all Biomed personnel achieve at least two certification within the next 12 months.
- Schedule in house TMS training by (June 1 2022)

The proposed performance measures for 2022 are:

Medical Equipment Management Proposed Performance Measures	Target	Comments & Action Plan
<p><b>AIM:</b> Review and update preventative maintenance procedures. These activities and associated frequencies are in accordance with manufacturers' recommendations.</p>	<p><b>100%</b></p>	<p>By march of 2022, develop a plan to update all risk one preventative maintenance procedure.</p>
<p><b>AIM:</b> Within the new system we propose to capture all new equipment at time of implementation and enter 100 pieces of existing equipment into the account by December 2022. The system should record the purchasing and receiving dates, implementation and assignment of equipment, monitor and document end of life and disposal of each piece of medical equipment.</p>	<p><b>100%</b></p>	<p>Action Plan for 2022 to improve implementation and assignment of 100 pieces of new equipment.</p>
<p><b>AIM:</b> • Continue to improve TMS PM updates.</p>	<p><b>100%</b></p>	<p>Ongoing process</p>

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QUALITY MANAGEMENT PLAN

Patient Safety, Process Improvement

**CY 2022**



Issued: August 2020  
Revised: December 27,2021

Submitted by: Gail Moorehead, MHL, RN, NPD-BC, CMSRN, CPHQ, CPPS

## Purpose

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

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

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

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

## Quality Framework

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

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

To achieve these aims, the Quality Program works to:

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

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

## Authority

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

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

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

## Scope

The Quality Management Program has been laid out by the Center for Medicaid and Medicare services (CMS) in the Conditions of Participation. CMS 482.21 states that we must “*develop, implement, and maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program. The hospital’s governing body must ensure that the program reflects the complexity of the hospital’s organization and services; involved all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its program for review by CMS*”. PSQI is a systematic process that identified, evaluated and alleviates systems, processes or situations that pose risk of harm to patients, visitors and staff of BRH.

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

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

## Structure and Reporting

### Board of Directors

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

### Senior Leadership

The Senior Leadership Team (SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, Chief Nursing Officer, Chief Behavioral Health Officer, and Chief Human Resources Officer ensure that an integrated patient safety program is institutionalized and assumes the responsibility for the strategic direction and development of the patient safety program. Patient safety culture survey results provide feedback on patient safety practices, communication, teamwork, adverse event reporting, and leadership to help guide the vision and goals of the organization. The SLT is responsible to assure that key strategies and/or processes of the organization are identified and prioritized. SLT supports transparency in communication related to patient safety and potential process changes.

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

### Departments

Individual departments are responsible for the quality management, regulatory compliance and risk reduction/identification activities related to the service lines they provide. Progress on department based activities are reported through the Quality committee structures.

### Components of the Program:

While having influence and supporting organizational quality across the hospital, the Quality Program is made up of a variety of components that broadly include: core measure monitoring, abstraction, and data submission; patient satisfaction, accreditation (both The Joint Commission and CMS CoPs); Risk Management; Patient Safety; Infection Prevention and Control; and, Medical Staff Quality.

### Medical Staff

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

Medical Staff service line committees' roles and responsibilities as they relate to QAPI include: reviewing and analyzing data, making recommendations, taking actions where necessary and reporting to Medical Staff Executive Committee and the general medical staff through Committee chairs.

- At routine meetings of the medical staff or among its various committees, these quality of services will be reviewed, assessed and evaluated:
  - Operative / Invasive procedure monitoring
  - Medication management

- Information management functions
  - Blood and blood Product Use
  - Pharmacy and therapeutics Functions
  - Mortality review
  - Risk management
  - Infection control
  - Utilization management
  - Other processes as determined by the individual committee
  - Patient care and quality control activities in all clinical areas are monitored, assessed, and evaluated
  - Assessment of the performance of the patient care and organizational functions are included.
- As necessary, relevant findings from performance improvement activities performed are considered part of:
    - Reappraisal / reappointment of medical staff members, and
    - Renewal or revision of clinical privileges.

The Hospital Performance Improvement Committee is an administrative committee responsible for identifying and reporting on performance improvement issues that affect patient care and services as described in the Medical Staff Bylaws and Rules and Regulations.

#### Hospital Performance Improvement Committee

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

#### **Reporting:**

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

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

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

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

#### **Patient Safety**

The Patient Safety Program is designed to improve patient safety, reduce risk, and respect the dignity of those we serve by promoting a safe environment while providing patient centered quality care in a sustainable manner.

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

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

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

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

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

1. Discussion with the patient/family/caregivers regarding adverse outcomes:
  - a. Sentinel Events impacting the patient's clinical condition – The Director of Quality notifies the care-giving physician about informing the patient / family / caregivers in a timely fashion (within 48-72 hours). Should the care-giving physician refuse or decline communication with the patient / family / caregivers, the Chief of Staff is notified by the Director of Quality.
  - b. Events not impacting the patient clinical condition, but causing a delay or inconvenience – The Director of Quality or the Administrator On-Call determine the need for communication with the patient / family / caregiver in the interest of patient satisfaction.

2. Response to actual or potential patient safety risks is through a collaborative effort of multiple disciplines. This is accomplished by:
  - a. Review and triage reports of potential or actual occurrences through the Occurrence Reporting system by any employee.
  - b. Prioritize events, hazards and system/process weaknesses using the Safety Assessment Code (SAC) Matrix.
  - c. Measure, report and collaborate with key stakeholder the frequency and severity of events to facilitate QAPI opportunities.
  - d. Identify, investigate and report Sentinel Events to the Joint Commission based on our policy.
  - e. Identify, investigate, and report serious reportable events required by the National Quality Forum.
  - f. Communication between the Director of Quality and the Facility Safety Officer (FSO) to assure a comprehensive knowledge of not only clinical, but also environmental, factors involved in providing an overall safe environment. Communication and consultation occurs with the City and Borough of Juneau’s safety team for all environmental related issues.
  - g. Reporting of patient safety and operational safety measurements / activity to the performance improvement oversight group, the hospital Performance Improvement Committee.
  
3. The mechanism for identification and reporting a Sentinel Event / other medical error is indicated in policies, (*Sentinel Event Policy* and *Occurrence Reporting Policy*). A root cause analysis of processes, conducted on either a Sentinel Event or Significant Event, are discussed with the Senior Leadership Team and the Medical Staff Quality Improvement Committee, as appropriate.
  
4. In support of our core values and belief in the concept that errors occur chiefly due to a breakdown in systems and processes, staff involved in an event with an adverse outcome are supported by:
  - a. A non-punitive approach and without fear of reprisal based on a Just Culture
  - b. Resources such as EAP or Union representation, if the need to counsel the staff is required
  
5. Patient safety measures are a focus of our activities and may include review of adverse drug events, healthcare acquired infections, “never” events, CMS No Pay events, and other data and incidents. This may be based on information published by TJC Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient / family suggestions / expectations, or process outcomes.
  
6. Processes are assessed to determine the steps when there is or may be undesirable variation (failure modes). Information from internal or external sources is used to minimize risk to patients affected by the new or redesigned process.
  
7. Solicitation of input and participation from patients and families in improving patient safety are accomplished by:
  - a. Conversations with patients and families from nursing director on administrative rounds
  - b. Comments from Patient Satisfaction surveys, patient feedback forms, telephone or in-person conversations, or letters
  - c. Comments from patient Complaints or Grievances
  
8. Procedures used in communicating with families the organization’s role and commitment to meet the patient’s right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:
  - a. Patient’s Rights statements
  - b. Patient Responsibilities—A list of patient responsibilities are included in the admission information booklet.
  - c. Evaluating informational barriers to effective communication among caregivers.

9. The following methods are used to maintain and improve staff competences in patient safety science:
  - a. Providing information and orientation to reporting mechanisms to new staff in orientation training.
  - b. Providing on-going training to staff on patient safety initiatives and methods as applicable.
  - c. Evaluating staff's willingness to report medical errors through the AHRQ Culture of Patient Safety Survey.
  
10. Data Analysis:
  - a. The hospital routinely analyses data to proactively identify quality and patient safety risks, and uses data analyses to develop and monitor responses.
  - b. Reporting our data to a patient safety organization (PSO) to provide comparison and benchmarks against state and national standards.
  - c. Review quality performance indicators to evaluated potential risks and opportunities to develop strategies to reduce risk and improve patient safety.

## Performance Improvement Methodology

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

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

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

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

## Data Collection and Analysis

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

*BRH measures, analyzes, and tracks quality indicators and other aspects of performance that assess processes of care, hospital service and operations. The data analysis in the Quality program incorporates quality indicator data including patient care data, and other relevant data. The hospital uses the data collected to monitor the effectiveness and safety of services and quality of care. The frequency and detail of data collection is specified by the hospital's governing body.*

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

- Management of hazardous conditions

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

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

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

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

## **Strategic Quality Objectives**

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

## **Annual Evaluation**

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

## **Confidentiality**

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

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

## **Approval**

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

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Chief Executive Officer

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Date

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Chief of Medical Staff

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Date

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Board Chair

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Date

## Appendix A

### Evaluation of 2021 PSQI Plan:

#### Accomplishments:

- AHRQ Culture of Patient Safety Survey completed
- Reduction of total patient falls
- Implementation of Smart Sheet Dashboards for communication related to COVID.
- Development and creation of Environmental Health and Safety Program Plan and dedicated position
- Successful metrics with the Partnership for Patients ASHNA/Telligen collaborative

Quality Goal	CY 2021 Metric	Outcome
Fully incorporate a cross-sectional Patient Safety Committee to review and assure corrective action plans from RCA2s are met and sustainable.	The Patient Safety Committee will meet at least twice to review RCA2 corrective action plans. (Source: Quality Director)	Exceeded. Patient Safety Committee has identified and completed three RCA2 and developed corrective action plans. (Source: Quality Director)
Culture of Patient Safety Survey	AHRQ Culture of Patient Safety Survey will be administrated to all clinical staff and providers.	Completed in May 2021. Evaluated and feedback provided to units. Next Survey will be 2023
Improve compliance with Sepsis core measure	Increase annual percentage of compliance to at least 58% by 12/31/2020 (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)	Met. The annual compliance for the Sepsis core measure was 58% for all quarters of 2020. (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)
Reduce Inpatient Fall Rates	Reduce inpatient total fall rate to 5/1000 patient days by 7/31/2021. Maintain rate through 12/31/2021. (Source: Patient Harm Dashboard, QBS)	Our total fall rate for 2021 is 4.3 per 1000 patient days.

#### 2022 Goals

Quality Goal	CY 2022 Metric
Develop PI Methodology onboarding orientation for all new management team members	Initiate training for new management team to include: Directors, Supervisors and Leads by July 2022. Provide training for 75% of new leaders within 90 days of hire by 12/31/2022(Source: Quality Director)
Update Ongoing Professional Practice (OPPE) to include metric comparison with peers	Revise scorecards and provide data to providers based on metrics that include personal scores and

	peer based rates. (Source: Scorecards through Credentialing Committee of provider types)
Maintain Sepsis core measure compliance at or above national average. Current national average 60%.	Maintain annual percentage of compliance to at least 60% through 12/31/2022. (Source: Encore D, Early Management Bundle/Severe Sepsis/Shock, Annual Percentage)

Environmental Health and Safety Program Plan  
Bartlett Regional Hospital  
CY 2022

## Environmental Health and Safety Program

### Mission

Bartlett Regional Hospital strives to create a safe work environment for all employees through increased staff awareness and accountability, improved notification and investigation which results in continual development of safety programs and procedures.

### Purpose

- Ensure safe and healthful working conditions for BRH employees, contractors.
- Establish and maintain an effective and comprehensive EHS program.
- Promote specific opportunities for employee involvement in the operation of the EHS program.
- Prevent or minimize the number of occupationally related illnesses or injuries among BRH personnel. Improve staff experience and morale while decreasing amount of time lost from work and workers' compensation claims due to occupational illness and injury.
- Prevent or minimize the number of injuries and illnesses of patients, consultants, employees, private contractors, visitors, and other members of the public within BRH facilities.

### Establishment and Maintenance of Required OSHA programs.

- Development and implementation of Occupational Safety and Health (OSH) programs and procedures applicable to local operations.
- Employee safety and health orientation and training.
- Development, promotion, and distribution of educational materials and activities designed for patients, employees, and the general public.
- Reporting and analysis of injuries, occupational diseases, and property damage incidents.

### Technical Assistance.

- On OSH problems to establish acceptable procedures, work methods, and personal protective equipment, thus integrating sound OSH principles into operational instructions and processes.
- This includes but is not limited to support documents and consultations from National Institute of Occupational Safety and Health (NIOSH), Federal Occupational Health Program, AKOSH, American Hospital Association, and The Joint Commission.

EHS Goal #1	Strategies	Responsible Parties	Evaluation
Collaborate with Human Resources, Department Directors, and staff to complete Job Safety Analyses- Foundation for entire OSHA program.	-Collaborate to group jobs into classifications. -Collaborate to fill out template for each classification. -Include staff and Directors to provide direct insights regarding hazards in the workplace.	-EHS Program Manager -Human Resources -Department Directors -Applicable Staff	-Jobs grouped into classifications -Templates filled out. -Staff input solicited and documented.  Jobs sorted into appropriate OSHA required programs.
EHS Goal #2	Strategies	Responsible Parties	Evaluation

Review and Revise Bloodborne Pathogen (BBP) Program	<ul style="list-style-type: none"> <li>-Provide deep dive on AKOSH and OSHA BBP program requirements.</li> <li>-Provide deep dive on BRH's current practices</li> <li>-Revise BRH program, policies, and procedures to match AKOSH and OSHA requirements</li> <li>- Collaborate with applicable parties to integrate program elements into BRH operations</li> </ul>	<ul style="list-style-type: none"> <li>-EHS Program Manager</li> <li>-Applicable Directors</li> <li>-Infection Prevention</li> <li>-Employee Health</li> </ul>	Complete, comprehensive, functional BBP program that meets all necessary requirements.
EHS Goal #3	Strategies	Responsible Parties	Evaluation
Revise as needed Respiratory Protection Program (RPP) and Bloodborne Pathogen (BBP) program Training	<ul style="list-style-type: none"> <li>-Review AKOSH and OSHA requirements for awareness and task trainings.</li> <li>-Review required curriculum</li> <li>-Collaborate with Staff Development to Identify trainers and ensure they are trained.</li> <li>-Collaborate with applicable parties to ensure trainings are taken and documentation is available for all regulatory agencies.</li> </ul>	<ul style="list-style-type: none"> <li>-EHS Program Manager</li> <li>-Staff Development</li> </ul>	Complete, comprehensive, functional training programs for RPP and BBP programs that meet AKOSH and OSHA requirements.
EHS Goal #4	Strategies	Responsible Parties	Evaluation
Oversee CBJ Safety Officer role within BRH	<ul style="list-style-type: none"> <li>-Weekly Meetings</li> <li>-CBJ Safety Officer Logic Model that outlines duties at BRH</li> </ul>	<ul style="list-style-type: none"> <li>-EHS Program Manager</li> <li>-CBJ Safety Officer</li> </ul>	CBJ role increased and documented by weekly accomplishments and developed programs.
EHS Goal #5	Strategies	Responsible Parties	Evaluation
Work with BRH staff to assist in developing Workplace Violence Prevention program that meets AKOSH recommendations.	<ul style="list-style-type: none"> <li>-Review OSHA guidelines regarding Workplace Violence</li> <li>-Collaborate with staff and Directors to advance Workplace Violence prevention strategies.</li> </ul>	<ul style="list-style-type: none"> <li>-EHS Program Manager</li> <li>-Chief Nursing Officer</li> <li>-Applicable Staff and Director</li> </ul>	<ul style="list-style-type: none"> <li>-Identified Program Elements</li> <li>-Documentation of program elements in operation.</li> </ul>

EHS Goal #6	Strategies	Responsible Parties	Evaluation
Chair the Safety and Security Subcommittee of the EOC	Regularly held Meetings	-EHS Program Manager -S&S Committee Members	-Meeting minutes as documentation of regularly held meetings.
EHS Goal #7	Strategies	Responsible Parties	Evaluation
Provide safety walk-throughs of building with Staff Development and TJC point person.	Monthly Walk-throughs through identified departments.	-EHS Program Manager	-Documentation of monthly walk through of respective departments.
EHS Goal #8	Strategies	Responsible Parties	Evaluation
Review and Revise Hazwoper Program at BRH	-Provide deep dive of what AKOSH and OSHA requires for Hazwoper Program -Provide deep dive of what BRH has in place for current Hazwoper program -Revise current BRH program to meet AKOSH program requirements. -Collaborate with applicable parties to integrate program elements into BRH operations	-EHS Program Manager -Respective Directors	-Complete, comprehensive, functioning Hazwoper program that meets all AKOSH and OSHA requirements.
EHS Goal #9	Strategies	Responsible Parties	Evaluation
Collaborate with team to complete Water Management Plan.	-Review requirements. -Collaborate to ensure complete plan -Collaborate to Integrate water monitoring, testing, and corrective actions into BRH operations	-EHS Program Manager -Water Management Taskforce	-Completed Plan -Elements integrated within BRH Operations
EHS Goal #10	Strategies	Responsible Parties	Evaluation
Member of the Environment of Care (EOS) Committee	-Attend meetings -Chair Safety and Security subcommittee -Provide updates to the EOC meeting as needed.	-EHS Program Manager -EOC Committee Members	-Attendance at meetings

# Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 [www.bartletthospital.org](http://www.bartletthospital.org)

## Finance Committee Meeting Minutes – Zoom Meeting January 14, 2022 at 12:00pm

Called to order at 12:01 p.m. by Finance Chair, Deb Johnston.

**Finance Committee (\*) & Board Members:** Deb Johnston\*, Hal Geiger\*, Lance Stevens\*, Kenny Solomon-Gross, Rosemary Hagevig, and Iola Young.

**Staff & Others:** Jerel Humphrey, CEO, Kevin Benson, CFO, Karen Forrest, CBHO, Vlad Toca, COO, Kim McDowell, CNO, Dallas Hargrave, HR Director, Blessy Robert, Director of Accounting, Kris Muller, Seanna O’Sullivan, Gage Thompson, Megan Rinkenberger, and Tiara Ward, CBJ.

**Public Comment:** None

*Mr. Stevens made a MOTION to approve the minutes from the December 10, 2021 Finance Committee Meeting. Mr. Geiger seconded, and they were approved.*

### Covid-19 Update – Kim McDowell, CNO

BRH has four patients with Covid-19. Primarily due to staffing shortages and illness, the nursing departments are tight on beds. They are talking about how to make sure patient care locations are being used efficiently for the amount of care (and therefore staffing) needed. Due to pharmacy staffing shortage, they have designated a “runner” for each shift. BRH has restricted the use of Monoclonal Antibodies because Regeneron, that was previously used and readily available, isn’t effective against the Omicron variant. The new treatment that is effective against Omicron is much less available, and therefore has restricted use for the particularly vulnerable.

Regarding expanding available beds, the trouble is finding the staff to attend to more patients. BRH is not under Crisis Standards of Care, and is maintaining normal operations, but are needing to get creative to do so.

### November 2021 Financial Review – Kevin Benson, CFO

After two months of strong patient volumes, November saw a bit of a lull. Both inpatient and outpatient revenues were under budget by 24% and 9% respectively. The decrease of inpatient revenue was a result of decreased patient days in the CCU (17%) and the mental health unit (55%). The decrease of outpatient revenue was mainly a result of decreased surgical procedures (20%). After RRC, BOPS and physician revenue, the month ended -\$1,615,000 (-9.4%) less than budget for Gross Patient Revenue. After deductions from revenues, Net Patient Revenue was -\$1,686,000 (-17.9%) less than budget. Total Expenses were slightly over budget, finishing at \$-73,000 (-0.7%) over budget, yielding an Operating Loss of \$489,000 as compared to a budgeted Operating Loss of -\$77,000. After Non-Operating Income, Net Loss finished at \$325,000. After five months, the Net Income is \$331,000, for a 0.62% margin.

BRH received additional Relief Funds of \$1,820,000 in November that was realized through Other Operating Revenues. As a result, Total Operating Revenue finished \$-339,000, or 3.3% less than budget.

Items of interest incurring in November were as follows:

- Cash collections from patient care exceeded \$10 million for the first time ever. This was partially a result of high revenues seen in September and October. Contributing to this was the collection from the state Medicaid program from claims delayed since July 1<sup>st</sup> due to a software upgrade.
- Cash balances increased \$3.2 million from increased collections and the Provider Relief Funds deposit.

### Crisis Stabilization Appropriation – Kevin Benson, CFO

Mr. Benson reviewed the memo in the packet outlining the request for an additional \$4 million to cover additional costs incurred due to supply shortages and other changes made in the design to accommodate market and demand changes.

*Mr. Stevens made a MOTION to move the appropriation request of \$4 million for the Behavioral Health Facility to the BRH Board of Directors for approval, and on to the CBJ Assembly for approval. Mr. Geiger seconded, and the motion passed.*

**ED Addition Appropriation – Kevin Benson, CFO**

Mr. Benson reviewed the memo in the packet outlining the need for an additional \$325,000 for the design phase of the ED Addition and Renovation project.

*Mr. Stevens made a MOTION to move the appropriation request for an additional \$325,000 to move the project through the design phase, forward to the BRH Board of Directors for approval, and on to the CBJ Assembly for approval. Mr. Geiger seconded, and the motion passed.*

**Next Meeting: Friday, February 11<sup>th</sup>, 2022 at 12:00 via Zoom**

**Additional Comments:** Many members of the BOD expressed their gratitude to Kevin for all his work and attention to detail, since this is the last Finance Committee Meeting that he will be participating in.

**Adjourned at 12:33 p.m.**

## DRAFT MEMO TO BRH Finance Committee

DATE: January 14, 2022

TO: Deb Johnston, Chair  
BRH Finance Committee

SUBJECT: BRH Behavioral Health Facility  
Recommendation for additional appropriation request

### Executive Summary

In March 2021, the Bartlett Regional Hospital Board of Directors unanimously approved an appropriation of \$2.75 million from the BRH internal reserves to add an additional floor to the new BRH Behavioral Health Facility project that was recently bid and awarded to Dawson Construction. Since that time, the construction market has experienced significant escalation due to supply chain issues related to the Covid-19 pandemic.<sup>1</sup> Average material prices increased 23% in one year as of August 2021.<sup>2</sup> Consequently, the cost per square foot of the project is coming in 8% higher than the original project as bid in March 2021, yielding a total project funding shortfall of \$4.0 million. Additional funds are needed by late February/early March to avoid adverse impacts to the construction schedule.

### Background

The Board's decision to add another floor to this fully designed and construction ready project were driven by the following circumstances:

- BRH was unable to purchase the 14,220 sq. ft. office building located at 3225 Hospital Drive which houses a ~5,500 sq. ft. BRH clinical program. The BRH lease on the clinic space expires December 2022, and it is not likely that it will be renewed. BRH recognized the need to add permanent space at the current hospital campus to house this program.
- BRH leadership recognized that they often outgrow their facilities before new construction is completed. BRH has seen a significant increase in their behavioral health outpatient services just during the one-year design of this new facility and anticipated that the facility would be over-capacity when completed. BRH wanted the ability to expand their outpatient program beyond the limitations of the original design.

This decision to add the additional floor led to the appropriation of an additional \$2.75 million, approved by the Assembly in June 2021. Approximately \$2 million of the appropriation was earmarked for construction cost while the remaining 30% was allocated for additional design fees and other related project costs. This brought the total project funding to \$13.75 million.

At about the same time, wood prices escalated by 30% prompting CBJ to explore the option of changing the building framing system from wood to structural steel. Furthermore, the structural analysis of adding an additional floor to the project brought to light that the added load would exceed the lateral performance capabilities of a plywood diaphragm, thereby necessitating the switch to structural steel.

The combination of the added load of the additional floor and the added weight of structural steel framing, in comparison to wood, required that the foundation supports increase accordingly.

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<sup>1</sup> Faegre Drinker Biddle & Reath LLP, (2021, July 21), *Material Cost Escalation, Delays and Covid-19: Managing Risk in Challenging Times*. JD Supra. <https://www.jdsupra.com/legalnews/material-cost-escalation-delays-and-3911119/>

<sup>2</sup> Sherman, Erik, (2021, October 15), *Construction Sees No End to High Materials Costs, Labor Availability*. GlobeSt.com. <https://www.globest.com/2021/10/15/construction-sees-no-end-to-high-materials-costs-labor-availability/?slreturn=20220008161238>

Consequently, the foundation footprint grew by about 14%. Please see the chart below for a summary of the building square footage increases.

**Impacts to Building Square Footage**

	<b>Project as Bid March 2021</b>	<b>Additional Floor</b>	<b>Change from Wood to Structural Steel Framing</b>
<b>Number of Stories</b>	2 + Parking Level	3 + Parking Level	3 + Parking Level
<b>Net impact to SF</b>		4,650	2,710
<b>Total SF</b>	<b>14,576</b>	<b>19,226</b>	<b>21,936</b>
<b>% increase</b>		32%	14%

A benefit of changing the framing system to structural steel afforded the opportunity to further future-proof the new Behavioral Health Facility by providing the ability to upgrade the occupancy classification from an R-4 (R = Residential) to an I-2 (I = Institutional). R-4 limits the facility to a maximum of 16 patients, all of whom must be able to respond to an emergency situation without physical assistance from staff. The I-2 occupancy classification permits a medical facility used for 24-hour custodial care of more than five persons who are not capable of self-preservation.

In addition to the structural steel framing system, spray-on fire proofing of exposed steel beams is required to meet the Type II-A fire resistive construction requirements for an I-2 occupancy classification. While this added approximately \$150,000 to construction costs, BRH Senior Leadership decided to move forward with this approach to preserve the option for more flexible use of the facility in the future.

These major changes in scope have not come without an impact to the project schedule. The original construction completion date at time of bid award was June 2022. We have recently been experience delays due the extreme cold temperatures and heavy snowfall. The current estimated construction completion date is April 2023. Below is a summary of the key project metrics illustrating the impact of the major scope changes.

<b>Project Metrics</b>	<b>At Bid Award - April 2021</b>	<b>January 2022</b>	<b>Notes</b>
Construction Contract Amount	\$8,459,200	\$13,786,200	January contract total based on executed and pending change orders to date associated with the additional floor and change to structural steel.
Project Square Footage	14,756	21,936	
Cost/SF	\$573	\$628	8% increase
Total Project Cost (TPC)	\$13,750,000	\$17,749,728	\$4.0 million shortfall
Construction % of TPC	62%	78%	
Other Project Costs % of TPC	38%	22%	Other project costs include additional design services, construction administration, special inspections, furnishings and equipment, CBJ project management, etc.
Completion Date	June 30, 2022	April 30, 2023	Current completion date is estimated, yet to be executed by change order.

Mitigation Measures

Dawson Construction, NorthWind Architects, BRH Senior Leadership, and CBJ have been working as a team to mitigate cost and time impacts going forward. We have expedited change orders to avoid known material pricing increases and to expedite long-lead equipment materials to the extent possible. Several traditionally readily available materials have now become long-lead items with the current supply-chain issues. Toward the end of mitigating cost and time increases, we have encumbered maximum funds available. Additional funding will be needed by late February/early March to avoid further schedule impacts to construction.

For scopes of work that occur later in the construction sequence, we are seeking competitive pricing, re quoting some scopes of work, and exploring alternative materials that meet the design intent more cost effectively.

**Action Requested**

Staff requests that BRH Finance Committee recommend an appropriation request of \$4.0 million to be funded from BRH reserves to the BRH Board of Directors and to the CBJ Assembly for approval.

## DRAFT MEMO TO BRH Finance Committee

DATE: January 14, 2022

TO: Deb Johnston, Chair  
BRH Finance Committee

SUBJECT: BRH Emergency Department Addition and Renovation  
Recommendation for appropriation request

At the February 23, 2021 meeting, the Bartlett Regional Hospital Board of Directors unanimously approved an appropriation of \$425,000 from the BRH internal reserves to begin design for the BRH Emergency Department (ED) Addition and Renovation project. The appropriation was approved by the Assembly establishing CIP fund B55-083.

In 2021, BRH was authorized to sell \$12 million in bonds to fund the total cost of this project. This amount is included in the CBJ CIP request for Fiscal Year 2023 and is anticipated to be appropriated July 1, 2022.

CBJ issued a Request for Proposals for architectural services to begin design work on the ED Addition and Renovation in August 2021. The successful proposer was Architects Alaska out of Anchorage. Fee negotiations have concluded and the design contract has been issued for the predesign and concept development phases. Along with CBJ project management time, the predesign and concept development fees have encumbered the majority of the current appropriation. *An additional appropriation of \$325,000 is needed to award the project through the design development phase which is scheduled to be completed at the end of June 2022. This will keep the project on schedule, heading toward a bid advertisement date for construction in October 2022. The balance of the design contract (preparation of construction and bidding documents) will be awarded once the balance of funds are appropriated July 1, 2022.*

The project will expand the Emergency Department and perform ventilation and related improvements in adjacent portions of the hospital. The project will also provide permanent space to isolate and triage patients due to Covid-19. This project is part of BRH's long-range plan of improvements to the hospital campus.

### **Action Requested**

Staff requests that BRH Finance Committee recommend an appropriation request of \$325,000 to the BRH Board of Directors and to the CBJ Assembly for approval.

# **Bartlett Regional Hospital**

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 [www.bartletthospital.org](http://www.bartletthospital.org)

## **January 25, 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

# Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 [www.bartletthospital.org](http://www.bartletthospital.org)

## Management Report from Dallas Hargrave, Human Resource Director January, 2022

Report Period - 2nd Quarter FY22 (October, November, December)

New Hires	66
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Separations	30	All Other Separations	
	4	Retirement	
	12	Casuals/temp	
<b>Total</b>	<b>46</b>		

Contract/Travelers	1	CSR Tech	
	1	CCU RN	
	2	ED RN	
	1	Respiratory Therapist	
	3	Ultrasound Tech	
<b>Total</b>	<b>8</b>		
These numbers do not include the Emergency Travelers - We have 10 Emergency Travelers as of 12.31.21			

Hard to Recruit Vacancies	Position Title	Status	Department
	Forensic Nurse Examiner II	Casual	Emergency
	CDI Social Work Case Manager	FT and PT	Case Management
	Echo/Vascular Technologist	FT	Diagnostic Imaging
	Ultrasound Technologists	FT	Diagnostic Imaging
	CT Technologist	FT	Diagnostic Imaging
	Physical Therapist	FT	Rehabilitation Services
	Security Officer	FT	Facilities
	Ophthalmic Technician	Casual	BSSC
	RNs	FT	ALL UNITS

All Employee Turnover		
All Employee Types	FT Employees	All Others
6.38%	3.00%	18.50%

**720**  
**Employees**  
 FS/FT employees = 565  
 All others = 156

Nurse Turnover		
All Nurse Types	FT Nurses	All Others
4.95%	1.75%	10.29%

**182**  
**Nurses**  
 FS/FT = 114  
 All others = 68

Grievances	1 Pending
Arbitration Cases	0

Reports of Injury	
Department	Brief overview
Operating Room	Needlestick
Facilities	Needlestick
BOPS	Slip and Fall on ice
Obstetrics	Needlestick
Emergency Department	Scratch to eye by paper
Emergency Department	Concern of potential Covid 19 exposure
Emergency Department	Concern of potential Covid 19 exposure
Diagnostic Imaging	Neck strain from lifting
CCU	Concussion from opening car door in parking lot to leave
Rehabilitation Services	Needlestick

# Bartlett Regional Hospital

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## January 2022 Nursing Report

Kim McDowell, CNO

### Obstetrics (OB) Department

- Lauren Beason, Director of OB, presented at the AKPQC (Alaska Perinatal Quality Collaborative) Learning session – focusing on the work Bartlett achieved by transitioning our model of care from NAS (Neonatal Abstinence Scoring) to ESC (Eat, Sleep Console). This is a key model change the state is hoping to push out to all Alaska facilities. Lauren also serves as a faculty expert for the current quality collaborative initiative.
- OB continues to lay the groundwork in knowledge surrounding ACLS (advanced cardiac life support) requirements - as we are hosting live classes for staff in early February to complete their ACLS training. Upon concluding the ACLS certification, we will be continuing to work with the OR in preparation for transitioning to OB staff starting to recover C-section patients in the PACU (post anesthesia care recovery unit) phase.
- OB has 8 RNs who are either up for review of their advanced clinical ladder standing, or applying for advancement in January. If all new applicant's reviews are accepted, we will have a total of 11 RN IV's and V's on OB!
- Finally, we are very excited to be accepting another CNA transfer from WMU, Anya McLaughlin. Anya has been a part of Bartlett's family for a few years now, and we are excited she is joining the OB team!

### Medical/Surgical

- Med/Surg continues to have a high census, averaging just above twenty patients/day, with being full or close to being full for the last week or so.
- Two of the emergency workers got extensions from the state, and will be staying until 2/4, which will help tremendously with staffing.
- Charting was streamlined for a number of our longer-term patients, to minimize late-night interruptions for our long-term patients and decreases the documentation load on nurses.
- We've been very fortunate to have the CNAs-in-training on our floor, especially with the high census. They've been extremely helpful with patient care.

## **Infusion and Chemotherapy Department**

- Infusion Therapy had a challenging week during the beginning of January with staff out due to illness. Alison Maxey, RN was a champion and kept the department going to ensure patients received their care. A big thanks to those that filled in and helped to staff the department as well.

## **Surgical Services Department**

- Central Sterile Re-Processing Renovation project is complete! Our new washer has reduced the washing time from about 45 minutes to 25 which has made a huge difference for our staff.
- SDS has been getting a facelift. We have been working hard on updating the department and getting rid of obsolete equipment. Facilities has also done an excellent job at painting.
- We have been expanding our education opportunities for staff. We recently had one of our vendors, Arthrex, come in and provide hands on education for some of their orthopedic products. This included an artificial shoulder that allows the staff to try using some of their suture anchors. They have left the training resources, so staff can continue to learn the product.

# Bartlett Regional Hospital

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January 19, 2022 Behavioral Health Board Report  
Karen Forrest, Interim Chief Behavioral Health Officer

## Overarching System Improvements

### **Recruiting and retaining staff psychiatrists; reducing reliance on locum tenens**

*Progress: Dr. Kathy Gallardo, full-time staff psychiatrist, joins team January 24, 2022*

### **Stabilizing nursing staffing**

*Progress: Interim Behavioral Health Nursing Director interview January 20, 2022*

*BRH increased travel nurse pay; one traveling nurse hired to begin in February 2022*

*State again extended contracts for emergency nurses*

*RRC Nurse Manager position filled*

### **Increasing utilization of Rainforest Recovery Center (RRC) and Mental Health Unit (MHU)**

*Progress: RRC one-day count January 19, 2021 shows 7 of 8 beds filled;*

*MHU same day count showed 9 of 12 beds filled*

### **Planning for Crisis Residential Stabilization Services (CRSS)**

*Progress: Building of facility continues to progress; BRH team reviewing 1115 Medicaid Waiver requirements to optimize services; completion estimated May 2023*

### **Clarifying and establishing operational protocols**

*Progress: Protocols for Psychiatric Emergency Services developed in collaboration with Case Management Department*

### **Standardizing employment contracts/agreements**

*Progress: Analysis of agreements is underway, led by BRH contracts staff*

### **Addressing The Joint Commission (TJC) survey draft findings**

*Progress: Work is underway to address the 8 behavioral health-related findings*

**PSYCHIATRIC PROVIDER LIST:** Bartlett Behavioral Health currently has two employed psychiatrists, two psychiatrists under independent contractor status, and two employed full-time psychiatric nurse practitioners. Recruiting continues for full-time psychiatrists (adult, child, and addictions). In addition, there are two full-time and two part-time locum tenens psychiatrists. All of these psychiatrists and nurse practitioners, with the exception of two locum tenens psychiatrists, provide on-call services.

- **Dr. John Tarim**, Psychiatrist (Independent Contractor), provides full-time psychiatric services to patients at Rainforest Recovery Center (RRC). Serves as Acting Medical Director for RRC.
- **Dr. Helen Short**, Staff Psychiatrist, provides full-time psychiatric services on the Mental Health Unit (MHU). Serves as Acting Medical Director for MHU.
- **Dr. Monika Karazja**, Staff Psychiatrist, provides full-time psychiatric services on a 3 month on, 3 months off schedule (currently off)
- **Dr. Joshua Sonkiss**, Psychiatrist (Independent Contractor), provides part-time telehealth outpatient services to adolescents and adults, and provides full-time onsite coverage on MHU and Rainforest Recovery Center (taking call) as needed. Serves as Acting Medical Director for Bartlett Outpatient Psychiatric Services (BOPS), including Psychiatric Emergency Services (PES) and Crisis Intervention Services (CIS).

- **America Gomez**, Psychiatric Mental Health NP (full-time BRH Employee), provides outpatient services for children, adolescents, and adults
- **Cynthia Rutto**, Psychiatric Mental Health NP (full-time BRH Employee), provides outpatient services for children, adolescents, and adults; also serves as a lead provider for the Community Based Crisis Intervention Services Program.
- **Dr. Marna Schwartz**, Behavioral Health Pediatrician (part-time BRH employee) provides services through BOPS to ensure primary care needs of pediatric BH patients are being met
- **Nicholas White**, Psychiatric Mental Health NP (Independent Contractor), provides part-time telehealth outpatient services to adults (completes contract early Feb 2022).

**LOCUM PSYCHIATRISTS:**

- **Dr. Stephanie Chen** provides part-time telehealth outpatient services to children and adolescents.
- **Dr. Judy Engelman** provides part-time telehealth outpatient services to adults.
- **Dr. Alvin Fineman** returned in December to provide full-time onsite psychiatric services to patients at RRC for six months
- **Dr. Eli Oates** returned in December and provides full-time onsite psychiatric services to patients in MHU for three months
- **Dr. Mariam Garuba** provides prn weekend call coverage on site
- **Locums Who Completed Agreements in December**
  - **Dr. Valerie Clemons** provided full time outpatient services to children and adolescents, part time telehealth and part time on site. She is the child psychiatric provider for the Community Based Crisis Intervention Services Program
  - **Dr. Magdalena Naylor** provided part-time telehealth outpatient services for adults
  - **Dr. David White** provided part-time telehealth outpatient services for children and adolescents

**ADULT MENTAL HEALTH UNIT (MHU) 12 BEDS:**

- December data:
  - 22 admissions, 24 discharges
  - Average Daily Census = 4.38
  - Average Length of Stay (LOS) = 5.91
- Referrals from outside Southeast have increased; patients are primarily from out-of-region. One-Day Count 01/19/22 showed all but one patient from outside Juneau
- State of Alaska extended emergency nurses through mid-March with staggered departure; first nurse departure extended an additional 2 weeks. This continues to mitigate nursing shortage.
  - recruiting for full-time, part-time and prn nurses
  - travel nurse pay was increased – one traveler nurse hired for the MHU to start Feb 2022
- Annual environmental suicide risk assessment completed on MHU with mitigation plans being developed

**RAINFOREST RECOVERY CENTER (RRC) RESIDENTIAL TREATMENT 8 BEDS:**

- December data:
  - 1 admission, 4 discharges
  - Average Daily Census = 5.74
  - Average LOS = 28.25

- Completed program = 4
- Applicants residing in Southeast Alaska are prioritized; applications statewide are accepted
- Waitlist doubled this month from 14 to 28
- Nurse Manager position now filled with promotion of current RRC nurse

**RRC WITHDRAWAL MANAGEMENT UNIT (WMU):**

- December data:
  - 10 admissions, 9 discharges
  - Average Daily Census = 1.09
  - Average LOS = 3.54
- Currently closed due to nursing staffing levels
- Transfer to/from RRC protocols under development; WMU protocols for lab draws still under review

**RRC OUTPATIENT TREATMENT:**

- December data:
  - 43 persons served
  - 105 therapy and medication management appointments held
- Services include Medication Assisted Treatment and ASAM Assessments
- Prioritizes patients awaiting admission to or transitioning from residential treatment utilizing a combination of virtual/in person outpatient treatment model

**BARTLETT OUTPATIENT PSYCHIATRIC SERVICES (BOPS):**

- December data:
  - 584 medication management and therapy appointments held (882 scheduled)
  - 14% no-showed; 20% cancelled
- Annual data reflects a 33% increase in number of patients served in 2021 over 2020
- 2021 data reflects 63 children up to age 9 were served; 43 children served aged 10-12
- BOPS delivers outpatient services through a hybrid telehealth/in-person model
- Acting Medical Director working with billing staff to optimize outpatient billing codes
- Psychiatric providers will receive commercial CPT code training
- Target caseloads established for psychiatric providers
- Standardized suicide risk assessments selected for all service lines; to be incorporated into electronic health record
- Provider departures and internal transfers of patients to be completed end of January; Dr. Gallardo to join team January 24, 2022

**PSYCHIATRIC EMERGENCY SERVICES (PES):**

- December data:
  - 40 patients assessed for psychiatric emergency services
  - 36 adults; 6 children/adolescents
  - 19 day-time assessments; 21 evening/night-time assessments
- The Psychiatric Emergency Services team provides evaluations in the emergency room twenty-four hours a day seven days a week

- Clinicians also address crisis phone calls; cover MHU when therapists are out (i.e. therapy groups, assessments, treatment planning); and provide follow-up calls for nighttime PES clinicians and referrals made to the Crisis Intervention Services team
- Recruitment underway for casual status PES clinician, to cover as needed for PES clinicians (4.0 FTEs)

**CRISIS INTERVENTION SERVICES COMMUNITY BASED TEAM (CIS):**

- December data:
  - 8 new patients were referred to CIS
  - 54 therapy and crisis intervention appointments were provided
- The CIS team consists of two therapists and four navigators who provide in home and community supports for individuals and their families following a crisis assessment by PES clinician
- Program provides outpatient supports assisting individuals and families through crisis by offering psychiatric evaluations, counseling and skill-building services and connecting to outpatient resources
- Services are reimbursable under “Crisis Intervention” under the State Medicaid Plan and the 1115 Behavioral Health Medicaid Waiver

**CRISIS STABILIZATION FACILITY UPDATE:**

- Work continues to progress slightly delayed due to weather; foundation underway
- Facility needs will need to be identified and ordered as we prepare for the opening
- Ground Breaking Ceremony scheduled for May 2022
- Facility completion estimated May 2023
- The 14% increase in square footage due to structural steel framing was primarily an increase in wall thicknesses at the perimeter and steel columns (i.e. absorbed by the building), with the rest distributed proportionally throughout the facility

**APPLIED BEHAVIOR ANALYSIS (ABA) CLINIC:**

- December data:
  - 12 patients received 1:1 services in home and school settings
  - 8 more patients working through intake process
  - total caseload reaching 20, which is approximate team capacity
  - current waitlist is growing; now 68 patients
  - 183 appointments attended; 122 attended; 31% cancelled; 2% no-showed
- ABA serves individuals with autism from the ages of two to twenty-one
- ABA Team includes:
  - 1 FTE Board Certified Behavioral Analyst who serves as the ABA Director
  - 5 FTE ABA Technicians (one of which begins in January)
    - One ABA Technician recently passed Assistant Behavior Analyst certification and working on licensing
    - Two new ABA Technicians are working on board certifications
  - 1 FTE Administrative Staff
- ABA Director continues to provide consultation to Juneau School District on BRH contract for several hours weekly; includes behavioral assessments, interventions and staff training for teams

**FY22 GRANTS UPDATE:**

**State of Alaska DBH Grants\* awarded in July include:**

<b><u>Grant</u></b>	<b><u>Award Amount</u></b>
RRC Residential Treatment Operational Grant	\$404,000
RRC Withdrawal Management (Detox) Operations Grant	\$101,000
Emergency Grant to Address Mental Health and Substance Use Disorder During COVID-19 (updated grant title)	\$222,000

\* Additional DHSS/DBH Behavioral Health Grant opportunities may also come from the ARPA (COVID Recovery) funding.

<b><u>Other Grants</u></b>	<b><u>Award Amount</u></b>
Juneau Community Foundation – Community Navigator Program	\$210,000
Juneau Community Foundation – Community Navigator vehicle	\$ 25,000

# Bartlett Regional Hospital

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## January 25, 2022 Board Report

Vlad Toca, COO

### Food Service/Dietary – Felipe Ogoy

- Breakfast operating hours have changed in the cafeteria to accommodate and manage the client flow with adequate staffing serving our hot bar standard menu.
- Celebrating the arrival of two staff members joining our team. They will perform important patient safety diet responsibilities by monitoring the tray line for accuracy and delivering orders placed in our Meditech system.
- Mindful menu changes were made to incorporate a plant-based option as a Grab and Go order. This is practical, and it allows us to serve more people while being ideal in preparation convenience for our staff.
- Product availability is being managed carefully due to recent late freights and the availability of product choice.
- The new temperature monitoring system has arrived and will be installed shortly.

### Cardio/Pulmonary, Respiratory Therapy & Sleep Lab – Nelea Fenumiai

- New cardiac rehab software installation by LSI is scheduled for 1/24.
- Respiratory therapy is in good shape, fully staffed, and maintaining adequate oxygen levels.
- Sleep studies are picking up at normal capacity after a pause in December due to contractor availability. They are looking for a full-time position in Juneau to add two extra nights of studies.

### Diagnostic Imaging (DI) – Paul Hawkins

- We are welcoming 3 Ultrasound travel techs to our team that started at the beginning of January. They are helping support a busy flow of patients. Our volumes are divided into three buckets where 43% are outpatient, 38% come through our emergency department, and 16% are inpatient orders.
- Our volumes are staying steady with a total of 1969 visits for the month of December, combined between the nine departments in D.I. with an overall 91% productivity over the past 12 rolling months. The highest volumes are with X-ray, CT, and Ultrasound departments.
- Script Sender project is on track, allowing automated orders for referring physicians and departments such as P.T. This will have CPT and ICD-10 code compatibility solidify our paperless

process and streamline the new appropriate use criteria (AUC) verification along with prior authorization via Infinx.

- The first new dual-energy C.T. scanner will be installed in February/March, allowing for Brain perfusion C.T., coronary artery CTA, and Calcium scoring exams. The second scanner will be installed in April/May, and the MRI in late summer 2022. Architects and engineers will visit the C.T. and MRI rooms next week to make a better assessment and finalize the cooling requirements.
- We are maximizing our follow-up patient outreach to patients after significant radiology findings. This is something that CMS and The Joint Commission expect the imaging department to track.
- Joint commission deficiencies were managed, and a corrective action plan was added to the smart sheet tracking tool of findings.
- Covid-19 plan for staff roles and flow was finalized for our staff. This identifies cross-training opportunities if we have low staffing to continue operations.

### **Laboratory – John Fortin**

#### **Statistics**

- Volumes for December were slightly below numbers seen for the same period from last year for Histology at 374 exams and Laboratory at 8,474 exams. Laboratory was down 11% and Histology 9%. Molecular volumes maintained the same as seen in November 2021 at 3,679 exams. Profits are expected to be below for both Laboratory and Histology as seen from 2020.
- Two new employees did start and completed an initial orientation. Steve Alvarado, who is now in his 3<sup>rd</sup> week of orientation/competency as a Laboratory Aide, is gaining needed knowledge and will be placed on normal schedule rotation with a new schedule, which started 1/9/21. Nathan Schroeder is now on his 2<sup>nd</sup> week of orientation/competency. Nathan starts rotation in Processing and Blood Bank with new schedule, starting on 1/9/22. Being a Clinical Laboratory Scientist, full orientation does take two months.
- Med Tox UDS is now live with all validations completed. Currently, the lab is still ordering POC kits from Identify for BOPS, but all laboratory testing now uses the Med Tox system. This new system relies on an analyzer to read and interpret versus a manual system.
- Still seeing occasional supply issues with all vendors for laboratory supplies. This includes Cardinal orders, Siemens, Abbott, and Blood Works N.W. The staff has monitored inventories and placed early purchase orders to maintain testing. The Laboratory monitors and communicates as needed with memos to providers and supervisors. We ran out of reagents for

in-house C-Reactive Protein during December, but new reagents arrived on January 7<sup>th</sup>. As of the week of January 10<sup>th</sup>, we can offer all normal testing.

#### **PT/OT – James "Rusty" Reed**

- One P.T. and one PTA are on maternity leave.
- Our casual O.T. has now retired, and this will require us to look at other ways to utilize current O.T. staff most efficiently with possible adjusting of schedules.
- We continue to lack adequate space resulting in a pediatric waitlist for all three disciplines, P.T., O.T., S.T. We continue modifying schedules to best meet the need by opening on Saturdays.
- Service lines for P.T. O.T. disciplines have been down this month due to staff illness, COVID, and weather conditions resulting in cancellations and no-shows. Volumes for wound care have remained steady.
- We are looking at a 3<sup>rd</sup> party to do our prior medical authorizations, similar to what DI is doing.

#### **Pharmacy – Ursula Iha**

- Requests for monoclonal antibodies increased with the latest surge of COVID cases. Unfortunately, only one of the three products available, sotrovimab (Xevudy), is effective for the omicron variant. The supply of sotrovimab is scarce, and use is limited to patients who meet qualifications using tiered Therapeutics Guidelines developed by the State of Alaska Crisis Care Committee.
- Bartlett pharmacy has requested an allocation and is developing a process to administer a new monoclonal antibody, a combination of tixagevimab and cilgavimab (Evusheld), available for pre-exposure prophylaxis. It is indicated for patients with immunocompromised status due to medical conditions such as chemotherapy, immune suppression for transplants, or advanced or untreated HIV. A single dose may give long-lasting protection.
- There is a nationwide shortage of saline flushes used to maintain intravenous access, and Bartlett was very close to exhausting our supply just before the holidays. The pharmacy staff developed processes to manually produce the prefilled syringes in our cleanroom to enable patients to receive intravenous medications.
- Drug shortages due to supply chain disruptions and COVID delays keep the pharmacy staff, especially our pharmacy purchaser, Carlo Riparip, busy locating sufficient supply through alternative sources and recommending substitutions.
- Pharmacy Technician preceptor, Krischelle Batac, is orienting two new full-time pharmacy technicians. She enjoys teaching and contributing to this valuable investment in the department's resiliency.

- The pharmacy staff is working with a new surgeon from Alaska Retinal to assure that the preferred medications are available for cataract surgeries.

**BMOC/BSSC/SEPS – Sara Dodd, Frances Jones**

**Bartlett Medical Oncology Center (BMOC)**

- We are participating in a multidisciplinary approach of a new novel agent for immunocompromised patients at high risk of Covid.
- The go-live for Orders in the lab interface has been pushed to the end of January. The Results piece of the interface is live and functioning well.
- We are working through staffing changes in the Oncology Patient Navigator position with Case Management.

**Bartlett Surgery and Specialty Clinic (BSSC)**

- Due to the surge in Covid numbers and weather conditions, we've had an increase in the number of patients rescheduling/ delaying care. We are working with patients to ensure that everyone is rescheduled appropriately.
- Multiple staff/families affected by Covid in the last 2-weeks; staffing is currently stable.
- Dr. Schmidt will provide locum coverage in the last week of February.
- Dr. Zumbro had his first Juneau Ophthalmology clinic, providing two days of injections. The clinic went very well, and Dr. Zumbro was a pleasure to work with.
- We have a casual Ophthalmology Technician beginning training next week. With this addition, patient flow and efficiency will improve.
- The lease for our current location is up in December 2022. We may need assistance from Zeiss and BRH IT to plan for the relocation and setup of ophthalmology lanes and imaging setup. Once our new site is determined, we can begin preparing for the move and setup time, disruption of patient care, updating our forms, website, business cards, and insurance enrollments.

**Southeast Physician Services (SEPS)**

- Contracting
  - BSSC: Multiplan – As of 12/17/21, UHC cannot grant the same rate at the hospital. We will run an analysis and counter with carve-outs; UHC – As of 12/17/21, we received sample rates, but UHC is still drafting an agreement.
  - BMOC: Multiplan – No contract can be initiated until Multiplan patients are seen; UHC – As of 12/17/21, received sample rates, but UHC is still drafting an agreement.
  - SAS: AETNA – As of 12/22/21, contract signed. Effective February 1<sup>st</sup>, 2022; B.C. – As of 12/10/21, contract signed. Effective January 1<sup>st</sup>, 2022; MODA – As of 12/17/21, contract signed. Effective February 1<sup>st</sup>, 2022;

MULTIPLAN – As of 01/19/22 waiting on the proposal; UHC – As of 01/14/22, Dr. Looney's counterproposal was denied.

- SRC: AETNA – As of 01/14/22, sent a request to increase rates on carve-outs; MODA – As of 01/14/22, sent request to increase rates on carve-outs; MULTIPLAN – As of 01/14/22, sent request to increase rates on carve-outs; UHC – As of 01/18/22, holding off on contracting.
- Officially live with M.D. Audits as of 01/18/22 with three scheduled post-go live meetings to develop a standardized process.
- Welcoming our new hire, Tracy Wiard, Fiscal Tech I. Start date 01/23/22.
- Price Transparency
  - State – BSSC, BMOC, and SAS top 10 codes were sent to PFS to post at the hospital. They were waiting on provider approval for SRC before posting.
  - Federal – Final documents for BSSC and BMOC will be completed by Friday and uploaded to the BRH portal.
- No Surprise Act
  - Clinics and billing staff were briefed on the current process.

### **Marketing & Strategy – Amanda Black**

#### **Bartlett Regional Hospital Website Updates:**

- BRH homepage website continues to be updated to reflect accurate service lines information and calendar of our classes.
- Social media ads were created for the Cancer Prevention and Survivorship Seminar Nutrition Series. Cooking class to be rescheduled by Dieticians due to Covid surge.
- Implementation and applications discovery with Marketo for marketing analytics software completed. Legal and I.T. review in progress.
- Facebook posts were created for various services, departments, special interests for a total of 30 posts. Our paid ads campaigns reached 22,238 individuals with 808 direct engagements by the public in the last month.
- Smartsheet workspace was created for Out-of-Stock notifications with our supply chain department to improve tracking and automated updates. The process allows Supply Chain to automatically send reports to department leads for review, push attention to needed items, and build in auto-replies with an archive repository.

# Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900

[www.bartletthospital.org](http://www.bartletthospital.org)

## January 25, 2022 Board Report

Kevin Benson, CFO

### Finance – Blessy Robert

- Preparing for budget season with Directors to develop FY2023 budget.
- Mailing out W2's and 1099's by January 31<sup>st</sup>.
- First payroll of the calendar year were processed with the updated tax amounts. Holidays are usually a challenging time to complete payrolls accurately and on time. Tracy did a great of processing them as accurately as possible and on time in spite of the rough weather we experienced in Juneau.
- Preparing for our second quarter grant reporting and round 2 of Provider Relief Fund (PRF) reporting.
- Finalizing December financial close.
- Working on Policy updates and creating new policies.

### Health Information Management – Rachael Stark

- HIM has a new team member who started December 27, 2021, named Linda Mattson. She is currently being trained. We also have people out for leave.
- We have seen an increase in coding for the Molecular Lab with the latest variant. We continue to work with Lab, PAS and PFS to ensure we have all the components to compliantly code and bill these items.
- There also is an increase with the BOPS accounts for coding. We have also started coding for the ABA clinic.
- 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 weekly 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.
- We have contracted with an outside company to perform an audit of our coding for the Bartlett Outpatient Psychiatric Clinic. The records were uploaded last week and hope to have the findings by the end of the month.
- We have started our yearly purge of old records and this project will continue through the year.

### Materials Management – Willy Dodd

- Materials Management continues to struggle with supply chain issues. With the help of Amanda Black in Marketing, we have developed a Smartsheet to communicate backordered supplies to the departments. This project will allow an easier flow of information between MM and the Departments and vice versa.
- The storage unit housing the vast majority of our backup supply of PPE collapsed earlier this month. We are working with Facilities and the building owner to determine if any of those supplies will be salvageable, or if it is a total loss.

### Information Systems – Scott Chille

#### Projects

- **Microsoft365/Office365 migration:** Tenant migration completed. Exchange mailbox migration in progress.
- **Imprivata Single Sign-On and EPCS project:** in progress and pilot departments are very happy with the product. Rolling implementation by department to commence per the attached schedule depending on COVID impact in the hospital and staffing levels.

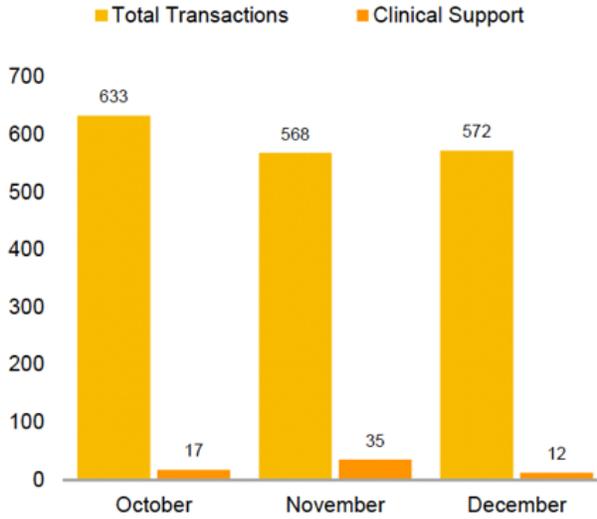
#### Department Updates

- New Clinical Systems Trainer for Clinical IS Department is being onboarded.

#### Call Volumes (HelpDesk and Clinical IS): Previous Quarter

Volume Review:

- 1.72% abandoned over 10 seconds
- 13.3 second average speed to answer



Information Security

- **Log4j issue is still being monitored**
  - **NO adverse events were identified on our systems or within our network.** We are continually monitoring the situation for any changes or updates and will update SLT and the BOD if anything is noted.
- **Rapid7 Incident Detection and Response Report:** No MITRE ATT&CK Techniques detected in December 2021. Major uptick in processed events. 199 Million/Day vs. 13 Million due to increased reporting capability from our new firewalls.

### Ingress Locations

Last 24 hours

Legend: Success (Green), Failure (Red), Unspecified (Grey)

Mapbox

### Latest Processes

Last 28 Days

Unique	Rare
continuity_distributedsync.exe	1
continuity.exe	1
devicemanager.exe	1
launcher_api.exe	1
nmap.exe	1
i3300.exe	1
jan10 census.exe	1
tch17_v5405_20190624_121918.exe	1
tch17svc.exe	1
tcscsvcs.exe	1

### Investigations

Last 28 days

Riskiest alerts	Recently-created alerts	Recently-accessed investigations
Ingress from Domain Admin Domain admin account kabredahl authenticated vi... Created: Dec 20, 2021 5:05:36 PM <span style="float: right;">513</span>	Attacker Behavior Detected Suspicious Authentication - M247 Created: Jan 14, 2022 9:07:31 AM <span style="float: right;">3</span>	Suspicious Authentication - M247 Created: Jan 14, 2022 9:07:31 AM Last accessed: Jan 14, 2022 9:07:31 AM
Ingress from Domain Admin Domain admin account kabredahl authenticated vi... Created: Dec 27, 2021 9:38:35 PM <span style="float: right;">267</span>	Multiple Country Authentications Account anelson@barlethospital.org authenticat... Created: Jan 13, 2022 12:05:51 PM <span style="float: right;">2</span>	Account anelson@barlethospital.org authenticat... Created: Jan 13, 2022 12:05:51 PM Last accessed: Jan 13, 2022 12:23:14 PM
Attacker Behavior Detected Suspicious Authentication - M247 Created: Dec 24, 2021 7:52:35 AM <span style="float: right;">11</span>	Attacker Behavior Detected Attacker Tool - CrackMapExec Created: Jan 12, 2022 2:10:44 PM <span style="float: right;">0</span>	Attacker Tool - CrackMapExec Created: Jan 12, 2022 2:10:44 PM Last accessed: Jan 12, 2022 2:28:54 PM
Attacker Behavior Detected Suspicious Authentication - M247 Created: Dec 31, 2021 8:12:34 AM <span style="float: right;">11</span>	Attacker Behavior Detected Attacker Tool - CrackMapExec Created: Jan 12, 2022 2:05:38 PM <span style="float: right;">0</span>	Attacker Tool - CrackMapExec Created: Jan 12, 2022 2:05:38 PM Last accessed: Jan 12, 2022 2:34:41 PM

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

*Rapid7 MDR Hunt Report:*  
Rapid7 Managed Detection and Response · December 2021

**Executive Summary**

The Rapid7 Managed Detection and Response (MDR) service captured hunt data from **832 endpoints**.  
Rapid7 did not identify any indicators of compromise via hunt data during the month of November.

The MDR service relies on multiple methods of compromise detection within client environments. In addition to real-time alerting, MDR performs frequent collection of forensically-relevant data using the InsightIDR endpoint agent to identify historical indicators of compromise and malware that cannot be captured in real-time.

- **Cybereason (Endpoint Detection and Response) Report: December**

# Executive Summary

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

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

No Malop/PUPs were detected this month.

- **Attacks on Bartlett network have remained constant over the last quarter with a slight decline in the last 30 days, but still significantly higher than our previous baseline in March of 2020.**
  - Remaining vigilant in our efforts to keep the attack surface LOW and continuing to actively block bad activity and hunt down all alerts.

Attacks on Bartlett Network					
	As of March-15 2020	As of Oct-08	As of Nov-08	As of Dec-08	As of Jan-09 2022
Per Minute	86	3905	3920	3425	3687
Per Hour	5,160	234,300	235,200	205,500	221,220
Per Day	123,840	5,623,200	5,644,800	4,932,000	5,309,280
Per Week	866,880	39,362,400	39,513,600	34,524,000	37,164,960
Per Month	3,839,040	174,319,200	174,988,800	152,892,000	164,587,680
Per Year	45,201,600	2,052,468,000	2,060,352,000	1,800,180,000	1,937,887,200

- **Security Awareness Risk Score and Phishing Campaign:**



### Security Awareness Proficiency Assessment (SAPA)



Industry Benchmark Data ?

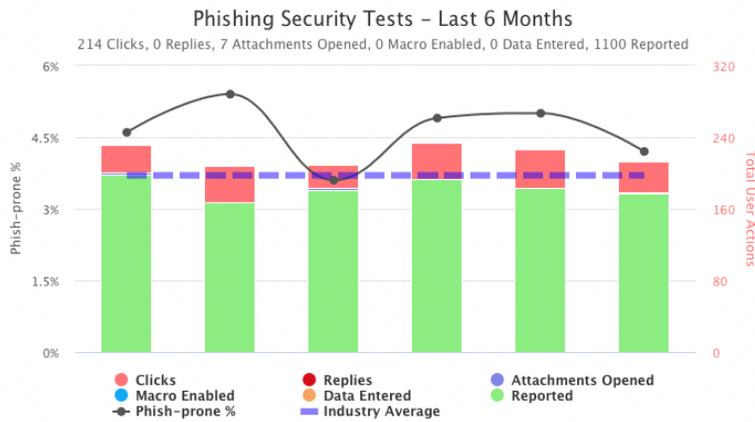
Organization's SAPA Score: **58%**

Industry SAPA Score: **63.7%**

Industry: Healthcare & Phar

Organization Size: Medium (250-100)

### Phishing



Industry Benchmark Data ?

Account Average Phish-prone %: **4.9%**

Last Campaign Phish-prone %: **4.2%**

Industry Phish-prone %: **3.7%**

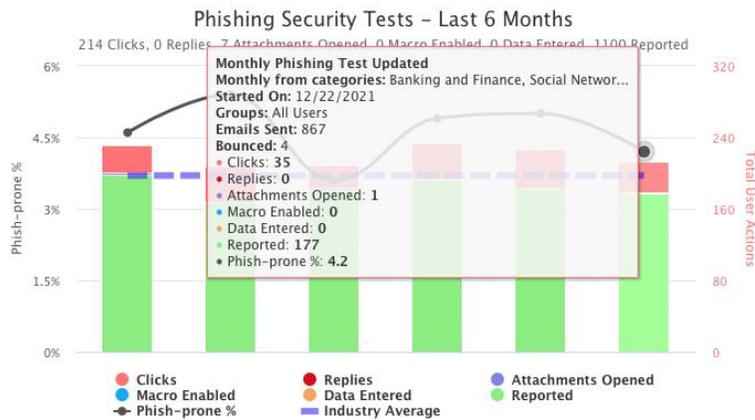
Industry: Healthcare & Phar

Organization Size: Medium (250-100)

Program Maturity: 1 Year

Industry Benchmark Chart Data

### Phishing



Industry Benchmark Data ?

Account Average Phish-prone %: **4.9%**

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Industry Benchmark Chart Data

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## January 2022 Board Report Jerel Humphrey, Interim CEO

- Attended monthly key stakeholder meetings (medical staff, management and board)
- Met with Press Ganey executive to review coaching focus for Kim McDowell
- Reviewed history of EMR with Dr. Benjamin. There is still a lot of work to do with this system
- Continue to work with and support Dr. Garcia to recruit a total bone and joint orthopedic surgeon
- Chaired the monthly Incident Command Team meeting. It is important for us to prepare for possible disasters/earthquakes
- Continue to review organizational structure at Bartlett. With the resignation of Kevin Benson, it is important to look at what, if any, changes should be made
- Getting organized for the ED expansion project
- Continue to meet monthly with Rorie Watt and Robert Palmer to discuss key issues between Bartlett and CBJ
- Pulled resources together to support Dr. Joy Neyhart as she deals with tragic death of her partner Dr. Kim Kilgore

### Compliance and Risk Report supplied by Nathan Overson

- Finalizing the 340B Contract Pharmacy analysis. Working with the contract pharmacy's third party vendor to true up all outstanding accumulations, which will allow us to start quantifying repayment amounts for drug manufacturer.
- Reviewing physician contract, bylaw, payment workflow mapping and review.
- New service line policy and procedure creation in process.
- Working with revenue cycle team on the Surprise Billing Act and Price Transparency compliance initiative.
- Working with Behavioral Health, Emergency Department and Nursing supervisors on court ordered mental commitment process improvement and education.
- Working with legal to develop patient/visitor search and seizure policy and procedure.

## February 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 agenda.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3 5:15pm Strategic Planning Work Session <b>(PUBLIC MEETING – no public comment)</b>	4 12:00pm Planning Committee <b>(PUBLIC MEETING)</b>	5
6	7	8 7:00am Credentials Committee <b>(NOT A PUBLIC MEETING)</b>	9	10	11 12:00pm Finance Committee <b>(PUBLIC MEETING)</b>	12
13	14	15	16	17	18	19
20	21 	22 5:30pm Board of Directors <b>(PUBLIC MEETING)</b>	23	24 12:00pm Board Governance Committee <b>(PUBLIC MEETING)</b>	25	26
27	28					

### Committee Meeting Checkoff:

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

Joint Conference – Every 3 months  
 Physician Recruitment – As needed  
 Governance – As needed  
 Planning – As needed

## FEBRUARY 2022 - BRH Board of Directors and Committee Meetings

**BRH Strategic Planning Work Session 5:15pm Thursday, February 3<sup>rd</sup>**

<https://bartletthospital.zoom.us/j/97786237464>

Call 1 888 788 0099 Meeting ID: 977 8623 7464

\*\*There will be no public comment during this meeting.\*\*

**BRH Planning Committee 12:00pm Friday, February 4<sup>th</sup>**

<https://bartletthospital.zoom.us/j/94747501805>

Call 1 888 788 0099 Meeting ID: 947 4750 1805

**BRH Finance Committee 12:00pm Friday, February 11<sup>th</sup>**

<https://bartletthospital.zoom.us/j/98733610436>

Call 1 888 788 0099 Meeting ID: 987 3361 0436

**BRH Board of Directors Meeting 5:30pm Tuesday, February 22<sup>nd</sup>**

<https://bartletthospital.zoom.us/j/93293926195>

Call 1 888 788 0099 Meeting ID: 932 9392 6195

**BRH Board Governance Committee 12:00pm Thursday, February 24<sup>th</sup>**

<https://bartletthospital.zoom.us/j/93756515617>

Call 1 888 788 0099 Meeting ID: 937 5651 5617