Bartlett Regional Hospital

BOARD OF DIRECTORS
AGENDA
April 26, 2016
5:15 p.m.
Administration Boardroom

Mission Statement

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

I. ROLL CALL

II. APPROVE AGENDA

III. PUBLIC PARTICIPATION — **10 minutes**

IV. SPECIAL ORDER OF BUSINESS

V. CONSENT AGENDA

A. Minutes from the March 22, 2016 Board of Directors meeting (Pg. 3) — **5 minutes**
B. March Financials/recap of FY17 Budget presentation to CBJ/King & Spalding update/Meditech staff hours for Meditech implementation (Pg. 8)

VI. OLD BUSINESS

A. Legal Services plan – CEO (action) (Pg. 24) — **20 minutes**
B. Compliance – Appoint Compliance Officer/Plans for Compliance audit by outside resource
C. Quality and Risk Management program - staffing

VII. NEW BUSINESS

- CEO Evaluation process and timeline — **10 minutes**
- Strategic discussion – Substance abuse recovery — **30 minutes**

VIII. MEDICAL STAFF REPORT — **10 minutes**

IX. MANAGEMENT REPORTS — **20 minutes**

A. Chuck Bill, CEO (Pg. 26)
    - Trauma assessment findings (Pg. 27)

B. Billy Gardner, CCO
C. Dallas Hargrave, HR
D. Sally Schneider, CBHO

X.	**COMMITTEE REPORTS**	**20 minutes**
	A. STANDING COMMITTEE REPORTS	
	1. Executive Committee – Nancy Davis	
	2. Finance Committee – Linda Thomas	
	3. Board Quality Committee – No meeting scheduled	
	4. Planning Committee – Brenda Knapp	
	5. Bartlett Foundation – Bob Storer	
	6. Rainforest Recovery Center – Lauree Morton	
	B. AD HOC COMMITTEE REPORTS	**10 minutes**
	1. Governance/Bylaws – Bob Storer	
	2. CAMHU – Mark Johnson	
XI.	**PRESIDENT'S REPORT**	**5 minutes**
XII.	**BREAK**	**10 minutes**
XIII.	**EXECUTIVE SESSION**	**20 minutes**
	A. Credentialing report (Pg. 42)	
	B. Patient Safety Dashboards (BLUE FOLDER)	
	C. Human Resource matters, specifically related to ongoing union negotiations	
XIV.	**BOARD CALENDAR - May** (Pg. 45)	**5 minutes**
XV.	**BOARD COMMENTS AND QUESTIONS**	**10 minutes**
XVI.	**ADJOURNMENT**	

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

Board of Directors
Minutes
March 22, 2016

DRAFT

CALLED TO ORDER AT 5:20 p.m., BY NANCY DAVIS, PRESIDENT

ATTENDANCE

Nancy Davis, President
Lauree Morton, Vice-President
Mary Borthwick, Secretary
Bob Storer, Past President
Brenda Knapp
Dr. Cate Buley
Marshal Kendziorek
Linda Thomas (by phone)
Mark Johnson (by phone)

ABSENT

None

OTHERS PRESENT

Chuck Bill, CEO
Billy Gardner, CCO
Alan Ulrich, CFO
Dallas Hargrave, HR
Sally Schneider, CBHO
Kendri Cesar, Sonosky, Chambers
Jane Sebens, CBJ Law
Dr. Fisher, Chief of Staff
Maria Gladziszewski, CBJ Liaison
Toni Petrie, Executive Assistant
Jim Strader, Community Relations
Bob Bartholomew, CBJ Finance Director

APPROVAL OF THE AGENDA

APPROVAL OF THE MINUTES – ***Mr. Kendziorek made a MOTION to approve the minutes from the February 23, 2016 Board of Directors meeting as amended. Ms. Thomas seconded and they were approved.***

CONSENT AGENDA - ***Mr. Kendziorek made a MOTION to accept the consent agenda. Ms. Knapp seconded and it was approved.***

A. February 2016 financials

B. Omnicell (Operating Room Medication Dispenser $367,028.59) – Approved at Finance Committee meeting March 17, 2016 (Capital)

C. Leverage (Cisco Firewall $107,500.00) Approved at Finance Committee meeting March 17, 2016 (Capital)

CBJ Legal Services – Mr. Bill reported that CBJ has doubled the cost of legal service for the next two years based on the prior two years methodology. Mr. Bill and Mr. Ulrich met with Amy Mead, CBJ Attorney and Bob Bartholomew, CBJ Finance Director, to discuss this. Mr. Bill said the new dollar amount was not included in the hospital's FY17 budget.

Mr. Bartholomew gave an overview of how the cost allocation works with the City and Bartlett. Ms. Thomas and Ms. Borthwick asked to have copies of the breakdown on the cost allocation given to the Board.

Mr. Storer suggested improving communication between CBJ Law and to have legal counsel reside on the hospital's campus. Ms. Knapp would like to have a discussion on what types of things need to go to legal for review and its appropriateness. Ms. Thomas would like to see a breakdown on the legal services CBJ has been providing.

Ms. Sebens said moving forward she would like to see work not so repetitive. Mr. Bill said if we had an in-house attorney, they could also provide compliance oversight. Ms. Thomas suggested getting a lower cost FTE like a paralegal. Mr. Storer will work with Mr. Bill on the legal services arrangement.

NEW BUSINESS:

FY17 Operating Budget – Mr. Ulrich gave an overview on the FY Operating Budget (included in the packet).

Mr. Storer made a MOTION to approve the FY17 Operating budget as presented. Dr. Buley seconded. Mr. Storer thanked Management for their improvements on the budget process. ***The motion passed with unanimous consent.***

FY17 Capital Budget - Mr. Ulrich gave an overview on the FY Capital Budget (included in the packet). ***Mr. Kendziorek made a MOTION to approve the FY17 Capital Budget. Ms. Knapp seconded and it was approved by unanimous consent.***

DRAFT

MEDICAL STAFF REPORT:

Mr. Kendziorek made a MOTION to approve the credentialing report as presented. Dr. Buley seconded and it was approved by unanimous consent.

Rules and Regulations – There was a change in language of a committee on the Rules and Regulations Medical Staff Committees. Utilization Review has been changed to Case Management, and some changes to the duties of the Committee were added. ***Ms. Thomas made a MOTION to approve the Rules and Regulations change. Mr. Storer seconded and it was approved by unanimous consent.***

MANAGEMENT REPORTS:

CEO Report – Mr. Bill gave a brief overview of his CEO Report on the State Legislature and Provider Tax being pushed down the road. He met with Dr. Gluck, the Medical Director for VMMC's outreach program and talked about Oncology and Ophthalmology. Mr. Bill reported David Sandberg with Focus and Execute was on campus to help directors enter their goals for 2016. Mr. Bill also gave an update on the summer hospitalist program. He said we will have Neonatal Resuscitation (NRP) mostly covered by the hospitalists.

CFO Report – Mr. Ulrich thanked the Board for approving the FY17 budget. There will be an IT Steering Committee scheduled soon.

CCO Report – Mr. Gardner reported due to increased assaults on staff, we are getting an electronic badge system that will notify everyone at the nurses' station if they get assaulted by a patient. The nurses will also utilize a violence screening tool on patients. The Pharmacy has revised policies and procedures to better manage controlled substances in the organization. We are purchasing medication dispensing machines in the operating room. Mr. Gardner also reported we are awaiting our CAP (College of American Pathologists) site visit in the Lab.

HR Report – Mr. Hargrave gave an update on the Class and Compensation Study. He reported they still have approximately 100 reconsiderations to go through. He also reported union negotiations will be starting back up on April 13th.

CBHO Sally Schneider – Ms. Schneider reported she is restructuring programs on MHU and RRC. She is also updating job descriptions to give people clear expectations of their duties.

COMMITTEE REPORTS:

Executive Committee – Ms. Davis reported the Committee met and discussed the email policy, management of fees policy and the IT Steering Committee Charter. Ms. Davis

DRAFT

reported there was a meeting on March 8th at 7 a.m., for Medical Staff to ask questions regarding Title 40 changes. She reported the Board will work on the CEO evaluation in April. The target is to complete the evaluation by the May board meeting. Also discussed was re-working the agenda to be more efficient with the Board's time.

Finance Committee – Ms. Thomas reported the Finance Committee reviewed two policies. We are currently working on three external reviews. The State of Alaska is reviewing FY15 Medicare Cost Report. That will be the basis for the next four year reimbursement. Another audit we had was with a CPA Firm working with CMS to confirm the data we submitted for 2013 for Meaningful Use. Mr. Ulrich submitted a report to the Rural Demonstration Project for the services that were provided in FY15. The Finance Committee made a recommendation to continue using King and Spaulding and directed management to move forward.

Board Quality Committee – Dr. Buley reported the Committee met and discussed adding a board member to MSQIC and it was decided not to do that. Kim Schneider, the new CAM in the Emergency Department will represent the ED on trauma reports from ED at the Quality Committee. It was decided the QAPI reports will be done a separate meeting. The first one is May 4th. Dr. Buley reported there was good brainstorming session on goals for 2016.

Bartlett Foundation – Mr. Storer reported they are still working on the plans for the Gala. The annual donation from this event has changed to obstetrical Tracevue for women in labor rather than the Topography in Radiology.

AD HOC COMMITTEE REPORTS:

Governance – Mr. Storer reported he and Mr. Kendziorek are attending a Governance Institute conference in April. Mr. Storer would like to see the Governance Committee and the Bylaws Committee merge into one committee. Mr. Storer will chair the Committee and work with Ms. Borthwick moving forward.

Child Adolescent Mental Health Unit (CAMHU) – Mr. Johnson reported the Committee met and had Moss Adams on the phone to discuss the feasibility study on the CAMHU. Mr. Johnson reported the Division of Behavioral Health put out a study about a year ago focusing on child and adolescents in Southeast Alaska that he would like to find a copy of.

Ms. Morton made a MOTION to extend the meeting to 9:15. Mr. Storer seconded and it was approved by unanimous consent.

Bylaws – Ms. Borthwick encouraged the Board to read through the Bylaws and the Board Manual and get recommended changes back to her.

DRAFT

BREAK – 8:02 p.m.

Back in session at 8:10 p.m.

PRESIDENT'S REPORT:

Ms. Davis reported the Board, staff and the Assembly had a joint meeting and felt it went really well. The Assembly approved the $1.00 a year lease for the Bartlett Foundation to occupy space in the Juneau Medical Building. Management presented the ideas around Title 40 and what the goals are. They discussed the two shared CBJ resources agreements we have in place with HR and CBJ Law. Mr. Bill presented an update on the impacts on Medicaid Expansion and Reform as well as the Rural Demonstration Project at the meeting. They discussed the CAMHU project and the process moving forward with the feasibility study.

Ms. Davis handed out a document that discussed ways to increase efficiency by moving the Board meeting to a different day of the month.

Mr. Kendziorek made a MOTION to go into executive session at 8:32 p.m., to discuss Human Resource matters related to employee contract negotiations and budget, Patient Safety Dashboards and Review of outside counsel memo regarding Pension Cost Reimbursement Appeal. The motion passed with unanimous consent.

8:32 p.m.

Out of executive session at 9:10 to extend meeting until 10:00 p.m.

Back in executive session at 9:11 p.m., to continue the discussion on discuss Human Resource matters related to employee contract negotiations and budget, Patient Safety Dashboards and Review of outside counsel memo regarding Pension Cost Reimbursement Appeal.

Out 9:30 executive session

The April calendar was reviewed.

BOARD COMMENTS:

Ms. Thomas would like to get input on having an outside Compliance Review Firm look into Bartlett's Compliance. Mr. Bill is looking at sources and will have it within the 60 day window of his being the interim Compliance Officer.

Adjourned 9:41 p.m.

DRAFT

Bartlett Regional Hospital
March 2016 Financial Operating Summary

In March, Bartlett had a gain of $801,000 as compared to a budgeted gain of $113,000 as the hospital recorded three extraordinary events in March:

1. After reviewing credit balances classified as Accounts Receivable, PFS identified $1.1 million of credit balances that should have been credited to contractual allowances. (PFS continues to review credit balances to ensure proper recording in the financial records.)
2. An error in the Operating Room's transition to Meditech 6.x resulted in missing Operating Room charges for billable equipment. PFS recorded charges of $400,000 for the three months (December through February) with an estimated net revenue of $188,000. PFS and Operating Room staff are reviewing March charges.)
3. Depreciation for the Meditech program was adjusted to a 5 year depreciable life rather than a 3 year life – reducing expenses $180,000.

In the nine months ending March, Bartlett gained $456,800 which was ($612,800) below the budgeted gain of $1,069,600. The year-to-date budget included an estimated $3,000,000 CMS stipend for the Rural Demonstration Project. Year-to-date earnings were $457,000 against a budgeted gain of $1,070,000.

Analysis of March

1. The Hospital's combined March patient days (711) were 12% below budget (809). Total Hospital charges, though, were 12% ($1.1 million) over budget.
   A. Med-Surgery patient days were below budget by 65 days. Year-to-date patient days were 8% under budget.
   B. Critical Care patient days were above budget by 11 days. Year-to-date days remained 14% under budget.
   C. Mental Health patient days increased for the second month in a row although March days were still 6% under budget. The Department's Patient Days are now 10% below budget for the year-to-date period.
   D. RRC's average census of 12 patients per day was 5% above budget. Year-to-date patient days remained 38% (1,386) below budget. RRC Outpatient visits increased by 17% from February activity to March activity.
2. The correction of contractual allowances detailed above caused March Deductions from Revenue to fall to 35.3%. In the year-to-date nine months, contractual allowances are 40.2% of charges.
3. Total Expenses were $688,000 over budget:
   A. Compensation to physicians and staff exceeded budget by $407,000 (12%). Bartlett accrued 1% of compensation ($40,000 per month) in anticipation of possible compensation adjustments. Senior Leadership and Department Managers are focusing on departmental compensation and overtime as compared to patient census.
   B. Supplies for the Operating Room, pharmacy and facilities contribute to the increased March expense.
   C. The Hospital expended software maintenance expenses related to new Meditech-related hardware and software.

Analysis of Nine Months through March

1. The Hospital's total charges were $5.8 million over budget (5.7%).

Bartlett Regional Hospital
March 2016 Financial Operating Summary

2. Contractual Allowances were $4.1 million over budget. Contributing factors included $3 million budgeted in the current year-to-date period for the Rural Demonstration Project and the Hospital's higher-than-budgeted charges.
3. Operating Expenses were $2.2 million (3%) over budget. Management and Department Managers are reviewing the detail supporting year-to-date activity.
   A. Salaries, Wages, Contract Labor and Employee Benefits were $2.1 million over budget.
   B. Materials and Supplies were $800,000 over budget with increased charges.
   C. Favorable variances in totaling $1.2 million in Utilities, Maintenance & Repairs, and Other Operating Expenses.

Comparison to Prior Year
In the nine months ending March 2016, Bartlett's Net Income was $1.6 million below the $2.0 gain recorded in year-to-date March 2015. As noted, Bartlett had received $2.1 million in CMS Rural Demonstration Project funds in the prior year. Operating Expenses (compensation, benefits, maintenance and depreciation) for the Meditech project negatively impacted current year results.

The Dashboard Report has been modified to provide more pertinent data.

- In addition to in-patient admissions, the report shows "Observation" admissions – an out-patient classification that doesn't experience the same level of charges or reimbursement as in-patient admissions.
- Endoscopy cases are differentiated from out-patient surgeries.

Days Cash on Hand has increased from 64 days to 72 days. Following the Meditech conversion, PFS has focused on collecting outstanding Accounts Receivable. With strong collections, Accounts Receivable have fallen $2.3 million from February. The Unbilled Accounts Receivable have been reduced by $1.3 million a total of $3.4M.

BARTLETT REGIONAL HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
FOR THE MONTH AND YEAR TO DATE OF March 2016

MTD ACTUAL	MTD BUDGET	MTD $ VAR	MTD % VAR	Prior Year MTD ACTUAL		YTD ACTUAL	YTD BUDGET	YTD $ VAR	YTD % VAR	PRIOR YTD ACTUAL	PR YTD % VAR
					Gross Patient Revenue:						
$ 3,282,761	$ 3,233,456	$ 49,305		$ 3,453,033	1. Inpatient Revenue	$ 30,164,971	$ 29,799,506	$ 365,465	1.2%	$ 30,680,070	-1.7%
$ 787,427	$ 892,896	$ (105,469)		$ 970,313	2. Inpatient Ancillary Revenue	$ 9,259,958	$ 8,228,858	$ 1,031,100	12.5%	$ 8,817,196	5.0%
$ 4,070,189	$ 4,126,352	$ (56,163)	-1.4%	$ 4,423,347	3. Total Inpatient Revenue	$ 39,424,928	$ 38,028,364	$ 1,396,564	3.7%	$ 39,497,266	-0.2%
$ 6,541,467	$ 5,358,264	$ 1,183,203	22.1%	$ 5,073,593	4. Outpatient Revenue	$ 53,648,538	$ 49,381,704	$ 4,266,834	8.6%	$ 48,119,355	11.5%
$ 10,611,656	$ 9,484,616	$ 1,127,040	11.9%	$ 9,496,939	5. Total Patient Revenue - Hospital	$ 93,073,466	$ 87,410,068	$ 5,663,398	6.5%	$ 87,616,621	6.2%
$ 259,663	$ 334,483	$ (74,820)	-22.4%	$ 304,008	6. RRC Inpatient Revenue	$ 1,941,470	$ 3,082,580	$ (1,141,110)	-37.0%	$ 3,031,123	-35.9%
$ 31,672	$ 39,782	$ (8,110)	-20.4%	$ 39,925	7. RRC Outpatient Revenue	$ 282,604	$ 366,607	$ (84,003)	-22.9%	$ 372,775	-24.2%
$ 1,768,800	$ 1,318,036	$ 450,764	34.2%	$ 1,337,182	8. Physician Revenue	$ 13,546,773	$ 12,146,985	$ 1,399,788	11.5%	$ 11,401,738	18.8%
$ 12,671,791	$ 11,176,917	$ 1,494,874	13.4%	$ 11,178,054	9. Total Gross Patient Revenue	$ 108,844,313	$ 103,006,240	$ 5,838,073	5.7%	$ 102,422,257	6.3%
					Deductions from Revenue:						
$ (406,558)	$ 1,074,631	$ 1,481,189	137.8%	$ 1,779,084	10. Inpatient Contractual Adj	$ 16,282,278	$ 9,903,765	$ (6,378,513)	-64.4%	$ 12,400,822	31.3%
$ 2,643,288	$ 1,927,195	$ (716,093)	-37.2%	$ 1,590,234	11. Outpatient Contractual Adj	$ 14,551,685	$ 17,760,989	$ 3,209,304	18.1%	$ 16,281,204	-10.6%
$ 391,908	$ 73,495	$ (318,413)	-433.2%	$ -	12. Physician Services Contractual Adj	$ 1,810,401	$ 663,454	$ (1,146,947)	-172.9%	$ -	#DIV/0!
$ 17,193	$ 35,670	$ 18,478	51.8%	$ 14,943	13. Other Deductions	$ 190,323	$ 328,738	$ 138,416	42.1%	$ 342,844	-44.5%
$ 1,352,440	$ 615,436	$ (737,004)	-119.8%	$ 560,664	14. Charity care	$ 4,481,491	$ 5,671,851	$ 1,190,360	21.0%	$ 3,947,788	13.5%
$ 475,147	$ 578,135	$ 102,988	17.8%	$ 559,602	15. Bad debt expense	$ 6,413,498	$ 5,328,093	$ (1,085,405)	-20.4%	$ 6,575,627	-2.5%
$ 4,473,418	$ 4,304,562	$ (168,856)	-3.9%	$ 4,504,528	16. Total Deductions from Revenue	$ 43,729,675	$ 39,656,890	$ (4,072,785)	-10.3%	$ 39,548,285	10.6%
20.7%	*27.5%*			*30.1%*	*% Contractual Adjustments / Total Gross Patient Revenue*	*30.0%*	*27.5%*			*28.0%*	
14.4%	*10.7%*			*10.0%*	*% Bad Debt & Charity Care / Total Gross Patient Revenue*	*10.0%*	*10.7%*			*10.3%*	
35.3%	*38.5%*			*40.3%*	*% Total Deductions / Total Gross Patient Revenue*	*40.2%*	*38.5%*			*38.6%*	
$ 8,198,372	$ 6,872,355	$ 1,326,017	19.3%	$ 6,673,526	17. Net Patient Revenue	$ 65,114,637	$ 63,349,350	$ 1,765,287	2.8%	$ 62,873,971	3.6%
$ 169,620	$ 197,733	$ (28,113)	-14.2%	$ 155,354	18. Other Operating Revenue	$ 1,461,181	$ 1,822,296	$ (361,115)	-19.8%	$ 2,291,836	-36.2%
$ 8,367,992	$ 7,070,088	$ 1,297,904	18.4%	$ 6,828,880	19. Total Operating Revenue	$ 66,575,819	$ 65,171,646	$ 1,404,173	2.2%	$ 65,165,807	2.2%
					Expenses:						
$ 3,182,036	$ 2,843,295	$ (338,741)	-11.9%	$ 3,102,758	20. Salaries, Wages & Contract Labor	$ 28,088,810	$ 26,203,730	$ (1,885,080)	-7.2%	$ 26,418,244	6.3%
$ 276,998	$ 208,893	$ (68,105)	-32.6%	$ 273,078	21. Physician Wages	$ 1,911,525	$ 1,925,154	$ 13,629	0.7%	$ 1,854,493	3.1%
$ 1,438,343	$ 1,399,643	$ (38,700)	-2.8%	$ 1,472,388	22. Employee Benefits	$ 13,114,375	$ 12,899,157	$ (215,218)	-1.7%	$ 13,106,179	0.1%
$ 4,897,377	$ 4,451,831	$ (445,546)	-10.0%	$ 4,848,224		$ 43,114,710	$ 41,028,041	$ (2,086,669)		$ 41,378,916	4.2%
59%	63%			71%	% Salaries and Benefits / Total Operating Revenue	65%	63%			63%	
$ 593,502	$ 603,194	$ 9,692	1.6%	$ 762,683	23. Medical Professional Fees	$ 5,511,970	$ 5,559,020	$ 47,050	0.8%	$ 5,204,545	5.9%
$ 219,455	$ 179,733	$ (39,722)	-22.1%	$ 165,901	24. Non-Medical Professional Fees	$ 1,902,800	$ 1,656,462	$ (246,338)	-14.9%	$ 1,532,056	24.2%
$ 767,247	$ 705,564	$ (61,683)	-8.7%	$ 657,478	25. Materials & Supplies	$ 7,313,694	$ 6,490,362	$ (823,332)	-12.7%	$ 6,332,788	15.5%
$ 111,330	$ 159,517	$ 48,187	30.2%	$ 126,514	26. Utilities	$ 1,040,493	$ 1,470,128	$ 429,635	29.2%	$ 1,172,841	-11.3%
$ 348,217	$ 238,698	$ (109,519)	-45.9%	$ 167,758	27. Maintenance & Repairs	$ 1,797,669	$ 2,199,860	$ 402,191	18.3%	$ 1,753,497	2.5%
$ 89,721	$ 43,469	$ (46,252)	-106.4	$ 27,155	28. Rentals & Leases	$ 455,403	$ 400,608	$ (54,795)	-13.7%	$ 315,507	44.3%
$ 37,626	$ 39,575	$ 1,949	4.9%	$ 37,912	29. Insurance	$ 341,059	$ 364,726	$ 23,667	6.5%	$ 358,325	-4.8%
$ 553,258	$ 551,520	$ (1,738)	-0.3%	$ 562,065	30. Depreciation & Amortization	$ 5,307,706	$ 5,082,774	$ (224,932)	-4.4%	$ 5,132,073	3.4%
$ 56,056	$ 54,164	$ (1,892)	-3.5%	$ 57,242	31. Interest Expense	$ 508,137	$ 499,168	$ (8,969)	-1.8%	$ 514,825	-1.3%
$ 72,880	$ 96,948	$ 24,068	24.8%	$ 110,141	32. Other Operating Expenses	$ 547,019	$ 893,488	$ 346,469	38.8%	$ 878,051	-37.7%
$ 7,746,668	$ 7,124,213	$ (622,455)	-8.7%	$ 7,523,073	33. Total Expenses	$ 67,840,658	$ 65,644,637	$ (2,196,021)	-3.3%	$ 105,952,341	-36.0%
$ 621,324	$ (54,125)	$ 675,449	-1247.9%	$ (694,193)	34. Income (Loss) from Operations	$ (1,264,840)	$ (472,991)	$ (791,849)	167.4%	$ 592,383	-313.5%
					Non-Operating Revenue						
$ 25,459	$ 14,444	$ 11,015	76.3%	$ 18,264	35. Interest Income - General	$ 234,553	$ 133,122	$ 101,431	76.2%	$ 182,657	28.4%
$ 154,284	$ 152,948	$ 1,336	0.9%	$ 115,846	36. Other Non-Operating Revenue	$ 1,487,119	$ 1,409,568	$ 77,551	5.5%	$ 1,247,546	19.2%
$ 179,743	$ 167,392	$ 12,351	7.4%	$ 134,110	37. Total Non-Operating Revenue	$ 1,721,672	$ 1,542,690	$ 178,982	11.6%	$ 1,430,203	20.4%
$ 801,067	$ 113,267	$ 687,800	607.2%	$ (560,083)	38. Net Income (Loss)	$ 456,832	$ 1,069,699	$ (612,867)	-57.3%	$ 2,022,586	-77.4%

BARTLETT REGIONAL HOSPITAL
BALANCE SHEET
March 31, 2016

	31-Mar	29-Feb	30-Jun	CHANGE FROM PRIOR YEAR
ASSETS				
Current Assets:				
1. Cash and cash equivalents	16,260,111	14,522,106	18,739,770	(2,479,659)
2. Board designated cash	24,153,567	24,390,314	26,094,607	(1,941,040)
3. Patient accounts receivable, net	20,298,268	20,540,037	16,767,420	3,530,848
4. Other receivables	3,000,190	3,097,909	1,492,475	1,507,715
5. Inventories	1,714,395	1,658,969	1,693,690	20,705
6. Prepaid Expenses	775,966	779,967	715,577	60,389
7. Other assets	77,763	62,763	150,057	(72,294)
8. Total current assets	66,280,260	65,052,065	65,653,596	626,664
Appropriated Cash:				
9. CAMHU and other funds	5,344,580	5,344,580	5,327,673	16,907
Property, plant & equipment				
10. Land, bldgs & equipment	147,934,358	147,676,639	146,197,471	1,736,887
11. Construction in progress	5,981,369	5,973,741	3,647,567	2,333,802
12. Total property & equipment	153,915,727	153,650,380	149,845,038	4,070,689
13. Less: accumulated depreciation	(87,374,743)	(86,813,605)	(82,487,260)	(4,887,483)
14. Net property and equipment	66,540,984	66,836,775	67,357,778	(816,794)
15. Deferred outflows/Contribution to Pension Plan	2,989,061	2,989,061	2,989,061	-
16. Total assets	141,154,885	140,222,481	141,328,108	(173,223)
LIABILITIES & FUND BALANCE				
Current liabilities:				
17. Payroll liabilities	1,965,951	1,650,461	965,006	1,000,945
18. Accrued employee benefits	2,885,004	2,840,250	2,830,011	54,993
19. Accounts payable and accrued expenses	2,519,394	2,839,054	3,123,001	(603,607)
20. Due to 3rd party payors	1,354,622	1,354,622	1,471,357	(116,735)
21. Deferred revenue	102,124	102,124	31,839	70,285
22. Interest payable	978,716	922,660	-	978,716
23. Note payable - current portion	838,851	820,556	745,000	93,851
24. Other payables	996,117	961,421	887,006	109,111
25. Total current liabilities	11,640,779	11,491,148	10,053,220	1,587,559
Long-term Liabilities:				
26. Bonds payable	19,677,888	19,677,888	21,725,957	(2,048,069)
27. Bonds payable - premium/discount	2,082,940	2,101,235	2,251,617	(168,677)
28. Net Pension Liability	32,827,474	32,827,474	32,827,474	-
29. Deferred InFlows	3,792,691	3,792,691	3,792,691	-
30. Total long-term liabilities	58,380,993	58,399,288	60,597,739	(2,216,746)
31. Total liabilities	70,021,771	69,890,436	70,650,959	(629,187)
32. Fund Balance	71,133,114	70,332,046	70,677,150	455,964
33. Total liabilities and fund balance	141,154,885	140,222,482	141,328,109	(173,223)

Bartlett Regional Hospital
Dashboard Report for March 2016
(Reduced Content following Meditech Conversion)

Facility Utilization:	CURRENT MONTH Actual	Budget	% Over (Under) Budget	Prior Year	YEAR TO DATE Actual	Budget	% Over (Under) Budget	Prior Year
Inpatient:Patient Days								
Patient Days - Med/Surg	250	315	-20.6%	315	2,960	3,207	-7.7%	3,207
Patient Days - Critical Care Unit	77	66	16.7%	66	605	701	-13.7%	701
Avg. Daily Census - Acute	10.5	12.3	-14.2%	12.3	13.0	14.2	-8.8%	14.2
Patient Days - Obstetrics	61	74	-17.6%	74	627	789	-20.5%	789
Patient Days - Nursery	46	59	-22.0%	59	497	614	-19.1%	614
Births	26	28	-7.1%	28	260	271	-4.1%	271
Patient Days - Mental Health Unit	277	295	-6.1%	295	2,122	2,355	-9.9%	2,355
Avg. Daily Census - MHU	8.9	9.5	-6.1%	9.5	7.7	8.6	-9.9%	8.6
Total Patient Days	**711**	**809**	-12.1%	**809**	**6,811**	**7,666**	-11.2%	**7,666**
Inpatient: Admissions								
Med/Surg	58	74	-21.6%	74	620	626	-1.0%	626
Critical Care Unit	31	27	14.8%	27	306	298	2.7%	298
Obstetrics	26	30	-13.3%	30	294	279	5.4%	279
Nursery	27	30	-10.0%	30	284	278	2.2%	278
Mental Health Unit	61	26	134.6%	26	344	295	16.6%	295
Total Admissions to Inpatient Status	**203**	**187**	8.6%	**187**	**1,848**	**1,776**	4.1%	**1,776**
Admissions for "Observation" Status								
Med/Surg	54							
Critical Care Unit	24							
Mental Health Unit	1							
Obstetrics	24							
Nursery	1							
Total Admissions to Observation Status	**104**							
Surgery:								
Inpatient Surgery Cases	26	28	-7.1%	28	353	306	15.4%	306
Endoscopy Cases	89							
Same Day Surgery Cases	106	216		216	1,746	1,906	-8.4%	1,906
Total Surgery Cases	**221**	**244**	-9.4%	**244**	**2,099**	**2,212**	-5.1%	**2,212**
Total Surgery Minutes	13,968	17,131	-18.5%	17,131	143,274	154,671	-7.4%	154,671
Outpatient:								
Total Outpatient Visits (Hospital)								
Emergency Department Visits	1,314	1,268	3.6%	1,268	11,422	11,335	0.8%	11,335
Cardiac Rehab Visits	83	48	72.9%	48	358	316	13.3%	316
Lab Tests	8,193	7,686	6.6%	7,686	76,227	68,577	11.2%	68,577
Radiology Procedures	2,211	2,211	0.0%	2,211	17,817	19,030	-6.4%	19,030
Sleep Studies	24	18	33.3%	18	187	164	14.0%	164
Rain Forest Recovery:								
Patient Days - RRC	358	342	4.7%	342	2,310	3,696	-37.5%	3,696
Avg. Daily Census - RRC	12	11	4.7%	11	8	13	-37.5%	13
Outpatient visits	297	259	14.7%	259	2,160	2,727	-20.8%	2,727
Physician Clinics:								
Specialty Clinic Visits	1,086	813	33.6%	813	8,593	8,196	4.8%	8,196

Bartlett Regional Hospital
Dashboard Report for March 2016
(Reduced Content following Meditech Conversion)

	CURRENT MONTH				YEAR TO DATE			
Facility Utilization:	**Actual**	**Budget**	**% Over (Under) Budget**	**Prior Year**	**Actual**	**Budget**	**% Over (Under) Budget**	**Prior Year**
Financial Indicators:								
Revenue Per Adjusted Patient Day	5,942	5,283	12.5%	5,664	6,018	5,142	17.0%	5,341
Contractual Allowance %	20.9%	32.8%	-36.3%	35.6%	30.2%	32.8%	-7.9%	33.1%
Bad Debt & Charity Care %	14.4%	12.6%	14.4%	11.8%	10.0%	12.6%	-20.5%	12.0%
Wages as a % of Net Revenue	42.2%	44.4%	-5.0%	50.6%	46.1%	44.4%	3.8%	45.0%
Productive Staff Hours Per Adjusted Patient Day	36.0	36.2	-0.6%	38.7	41.7	34.4	21.1%	35.7
Non-Productive Staff Hours Per Adjusted Patient Day	4.4	3.6	21.7%	3.9	5.4	4.6	17.3%	4.8
Overtime/Premium % of Productive	4.17%	6.59%	-36.7%	6.59%	6.50%	5.92%	9.8%	5.92%
Days Cash on Hand	72	137	-47.9%	137	72	143	-49.9%	143
Board Designated Days Cash on Hand	84	35	143.9%	35	84	35	143.9%	35
Days in Net Receivables	84	67	25.7%	67	84	67	25.5%	67

March

in-patient	Unbilled A/R	0-30	31-60	61-90	91-120	121-150	151 +	A/R Total	Grand Total Billed & unbilled
Aetna	140,188	261,859	484,236	244,846	85,317	136,165	206,115	1,418,537	1,558,725
Blue Cross	243,979	406,265	347,829	397,307	225,647	118,458	50,783	1,546,288	1,790,267
Com	25,294	161,931	264,208	289,890	226,562	79,044	156,748	1,178,384	1,203,679
Medicaid	877,587	1,144,320	963,853	1,162,546	780,054	413,958	1,159,866	5,624,596	6,502,184
Medicare	1,095,079	740,224	558,401	365,037	148,648	101,220	32,536	1,946,066	3,041,146
Other		55,849	13,310	109,926	72,506	10,960	169,656	432,207	432,207
Other - DBH									-
SEARHC	27,494	77,835	94,179	41,483	52,263	5,380	61,038	332,178	359,672
Self	153,286	113,638	192,982	61,093	58,862	61,991	2,780,648	3,269,215	3,422,501
VA	1,225	36,270	27,479	128,978	161,370	58,540	257,688	670,325	671,550
Worker's	44,409	41,842		15,737	19,273		889	77,741	122,150
in-patient	2,608,542	3,040,033	2,946,478	2,816,842	1,830,500	985,717	4,875,968	16,495,539	19,104,080

out-patient	Unbilled A/R	0-30	31-60	61-90	91-120	121-150	151 +	A/R Total	Grand Total Billed & unbilled
Aetna	709,707	899,633	264,772	125,069	112,541	106,898	722,759	2,231,671	2,941,378
Blue Cross	529,645	578,331	230,670	182,610	246,650	139,722	212,042	1,590,025	2,119,670
Com	212,722	444,034	332,774	208,479	209,588	110,465	646,713	1,952,053	2,164,774
Medicaid	478,886	710,767	317,603	176,222	145,650	256,692	434,061	2,040,995	2,519,881
Medicare	767,980	732,934	178,235	187,810	94,585	103,852	280,622	1,578,039	2,346,019
Other	8,804	24,372	53,344	13,993	21,449	79,841	446,600	639,599	648,402
Other - DBH									-
SEARHC	74,401	200,546	202,204	137,165	123,513	125,044	280,225	1,068,696	1,143,096
Self	67,413	317,170	402,165	510,051	323,839	305,581	4,591,323	6,450,128	6,517,541
VA	43,744	108,266	72,232	171,304	104,630	55,825	96,654	608,911	652,655
Worker's	11,333	80,434	131,805	100,295	100,653	50,503	178,959	642,649	653,982
out-patient	2,904,634	4,096,489	2,185,804	1,812,998	1,483,097	1,334,421	7,889,957	18,802,765	21,707,399

March	Unbilled A/R	0-30	31-60	61-90	91-120	121-150	151 +	A/R Total	Grand Total Billed & unbilled
Aetna	849,895	1,161,492	749,008	369,914	197,858	243,062	928,874	3,650,209	4,500,104
Blue Cross	773,624	984,596	578,499	579,917	472,297	258,180	262,825	3,136,313	3,909,937
Com	238,016	605,966	596,982	498,369	436,150	189,510	803,461	3,130,437	3,368,453
Medicaid	1,356,474	1,855,087	1,281,456	1,338,768	925,703	670,650	1,593,927	7,665,591	9,022,065
Medicare	1,863,059	1,473,159	736,636	552,847	243,233	205,072	313,158	3,524,105	5,387,164
Other	8,804	80,221	66,654	123,918	93,955	90,801	616,256	1,071,806	1,080,609
Other - DBH	-	-	-	-	-	-	-	-	-
SEARHC	101,894	278,380	296,383	178,648	175,776	130,424	341,262	1,400,874	1,502,768
Self	220,699	430,808	595,147	571,143	382,701	367,572	7,371,971	9,719,343	9,940,042
VA	44,969	144,536	99,711	300,283	266,000	114,365	354,342	1,279,236	1,324,205
Worker's	55,742	122,277	131,805	116,032	119,926	50,503	179,848	720,391	776,132
March Total	5,513,175	7,136,521	5,132,282	4,629,841	3,313,597	2,320,138	12,765,925	35,298,304	40,811,479

FY16 Capital Budget List - as of 3/31/16							
DEPT #	DEPARTMENT	DESCRIPTION	Approved FY 2016 Capital Budget	Substitution	PO's Issued & Capital Purchases to 3/31/16	Remaining Budget	
9500	Administration	CAMHU	1,000,000			1,000,000	
9500	Administration	Facility Master Plan	1,000,000		337,000	663,000	OR humification 112k plus bldg mgmt 225k?
6191	Clinic	Meditech EMR software	250,000			250,000	
6191	Clinic	Park Place equipment for EMR	50,000			50,000	
6211	CSR	WASHER / DISINFECTOR	104,062			104,062	
8110	Dietary	Automatic Meat Slicer	5,386			5,386	
8110	Dietary	Cleveland Steamer 2 door	11,600			11,600	
8110	Dietary	Expresso Barista Bar	6,100			6,100	
8110	Dietary	Fryer with filtration system	10,937			10,937	
8110	Dietary	Ice Machine (Scotsman's)	5,846			5,846	
8110	Dietary	Ovens, Garland Master 450 stackable/2 ea	19,493			19,493	
8360	Facilities	Centrifugal Generator	1,200,000			1,200,000	
8360	Facilities	IT Server Room Cooling (Pre-design & cost est completed)	75,000		48,354	26,646	
8360	Facilities	O.R. Humidifiers & Controls upgrade	200,000		250,000	(50,000)	Approved 7/28/15 Board Meeting
8360	Facilities	OB Blinds	20,000			20,000	
7013	Histology	Cryo Stat	25,000			25,000	
7013	Histology	Slide Stainer	40,000		40,221	(221)	
9200	IS	Cisco/Smartnet Networking Equipment	65,000		55,869	9,131	
9200	IS	Citrix Farm	160,000			160,000	
9200	IS	Mammo Plus	28,000			28,000	
9200	IS	OpSus Recover	-			-	
9200	IS	Fluke Networks Wireless Analyzer	61,791		45,240	16,551	Approved 8/28/15 Board Meeting
9200	IS	API Healthcare Software Upgrade			28,840	(28,840)	
9200	IS	NetApp Performance Shelves	40,000		112,868	(72,868)	Approved 7/28/15 Board Meeting
9200	IS	NetApp Secondary Capacity Shelves	45,000		115,626	(70,626)	Approved 7/28/15 Board Meeting
9200	IS	VM Ware	160,000		76,665	83,336	Approved 7/28/15 Board Meeting
9200	IS	Cisco Unified Computing System (UCS) Expansion	220,000		188,169	31,831	Approved 7/28/15 Board Meeting
9200	IS	Wireless Access Point Upgrade	-		202,092	(202,092)	Approved 7/28/15 Board Meeting
9200	IS	Cisco ASA with Firepower Services (thru Leverage Info Sys)			107,431	(107,431)	
9200	IS	Fujitsu 6800 Hi0Vol Scanner			15,857	(15,857)	
7047	Mammography	Breast Tomosynthesis w/biopsy capability Vendor: Hologic	450,000			450,000	
6010	MedSurg	Hill Rom Versa Care Bed upgrade with Bed alarm sensor	12,000			12,000	
6010	MedSurg	TC 300 treatment chair - multi positional chair/stretcher	9,000			9,000	
6210	Operating Room	Hologic MYO SURE & Aquilex Fluid Control Sys			34,255	(34,255)	MR approved 2/12/16 by W Gardner
6210	Operating Room	Hologic Novasure - GYN ablation procedures			15,230	(15,230)	MR approved 2/12/16 by W Gardner
6210	Operating Room	7.3 CANNULATED SCREW SET	59,000			59,000	
6210	Operating Room	CYSTO CAMERAS	27,664			27,664	
6210	Operating Room	Fluoroscan InSight-FD Mini C-arm System	71,500		73,700	(2,200)	
6210	Operating Room	OLYMPUS TOWERS AND SCOPES	680,000		565,922	114,078	
6210	Operating Room	OR / SDS AUTOMATIC BADGE ENTRY DOORS	40,000			40,000	
6210	Operating Room	SONOSITE ULTRASOUND and Power Pack	68,608		66,053	2,555	Approved 10/20/15 Board Meeting
6210	Operating Room	THUNDERBEAT	25,000		18,218	6,782	Approved 8/28/15 Board Meeting
6210	Operating Room	Steris Sterilizers			18,461	(18,461)	
6210	Operating Room	Endoscopy Machines Maintenance			1,955	(1,955)	
6210	Operating Room	Cook Medical LMA StoneBreaker			9,700	(9,700)	MR approved 2/12/16 by W Gardner
6210	Operating Room	Stryker Medium Bone Cordless Driver 4			30,772	(30,772)	
6210	Operating Room	Zimmer Auto Tourniquet Sys 4000			11,266	(11,266)	
8390	Patient Access	FormFast	104,000		26,300	77,700	
8390	Patient Access	PAS Emergency Discharge Window	55,000			55,000	
8390	Patient Access	Software	129,500		98,250	31,250	Approved 10/20/15 Board Meeting
7070	Pharmacy	Refrigerator for chemo drugs	10,000			10,000	
7070	Pharmacy	Omnicell medication mgmt delivery system			367,029	(367,029)	
9420	Quality Review	Medisolv ENCOR e-Measures Software			14,400	(14,400)	
6170	Respiratory Therapy	Philips ST801 Stress test System	25,700		25,700	-	
		Total FY 2016 Capital	6,570,187	-	3,001,442	3,568,745	

BARTLETT REGIONAL HOSPITAL
ESTIMATED COST FOR IN-HOUSE LABOR WORKING ON MEDITECH PROJECT

Department	Estimated Total Hours	Wages for Hours on Project	Estimated Benefits (30%)	Total Wages
KK & Clinical	1,059	$42,825	$12,848	$55,673
Joyce & Clinical	1,710	$74,540	$22,362	$96,902
Surgery	865	$39,098	$11,729	$50,827
Physical Therapy	1,214	$63,287	$18,986	$82,273
Case Management	469	$22,524	$6,757	$29,281
Staff Development	14	$796	$239	$1,035
MHU	155	$7,669	$2,301	$9,970
Material Mgmt	423	$21,298	$6,389	$27,687
Health Info Mgmt	370	$16,502	$4,951	$21,453
LAB & Histology	1,099	$52,687	$15,806	$68,493
Info Technology	4,601	$224,897	$67,469	$292,366
Diagnostic Imaging	1,840	$92,570	$27,771	$120,342
Finance	1,606	$84,941	$25,482	$110,424
Patient Financial Services	540	$23,101	$6,930	$30,032
Patient Registration	1,600	$67,280	$20,184	$87,464
Human Resources	304	$11,264	$3,379	$14,643
Total	17,869	$845,280	$253,584	$1,098,864

DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 FAX: 410-786-5298

MODEL FORM F: PROPOSED JOINT SCHEDULING ORDER

Date of Request: April 21, 2016
PRRB Case Numbers: 15-1656; 15-3267
Provider/Group Name: Bartlett Regional Hospital
Provider/Group FYEs: 6/30/2011; 6/30/2012
Provider No: 02-0008
Intermediary/MAC: Cahaba SafeGuard Administrators

I. Introduction

The Provider and the Intermediary ("Parties") have consulted regarding the issues remaining in these appeals and the upcoming position paper deadlines, May 1, 2016 for both case numbers 15-1656 and 15-3267. This Proposed Joint Scheduling Order is submitted to reflect the discussions of the respective representatives who believe that a resolution of this appeal is possible without the need for a Board hearing.

A. Resolved Issues - Under a TAB LABELED 1, identify appealed issues resolved by the parties.

B. Conditionally Resolved Issues - Under a TAB LABELED 2, identify issues on which conditional resolution has been reached. Include for each conditionally resolved claim:

1. A brief statement of the issue.
2. A description of the conditions on which resolution is based, including dates, actions, and audit methodologies required by the parties.

C. Unresolved Issues - Under a TAB LABELED 3, identify issues that have not been resolved. Include for each unresolved issue:

1. A brief statement of the issue.
2. A brief statement of the material facts and indicate whether they are disputed.
3. For claims that cannot be resolved because of a question of law, briefly state each party's legal position and the authorities relied upon.
4. Listing of documentation exchanged to date.
5. If the parties expect the case to require discovery, or a voluntary exchange and analysis of data, create a detailed timetable/schedule for that exchange. This

schedule will supersede the timelines in the regulations as permitted by 42 C.F.R. 405.1853(e)(3).

D. Identify a mutually agreed upon month and year for hearing. May 2018. **This date should not be less than 180 days from the last documentation deadline set in C.5 above.** (The Board typically will not schedule a case less than a year after the filing of the appeal unless a special circumstance exists; however, the Board will consider accelerated hearing requests (See Rule 31) at any time).

E. Signatures – The undersigned have agreed that this document accurately identifies all issues in Case Nos. 15-1656; 15-3267, and the parties have agreed upon the deadlines set forth in this document. The parties understand that the Board's issuance of a hearing date on or after the requested hearing date in D. above will constitute the Board's acceptance of all other proposed JSO deadlines. All other deadlines and evidence cut offs will be controlled by the parties' JSO unless the Board advises otherwise. The parties must meet all deadlines within the JSO, including agreed upon written modifications, even if the hearing is scheduled later than requested.

Provider Representative:	**Intermediary Representative**
Daniel J. Hettich	James Lowe
Print Name	**Print Name**
Provider Rep/King & Spalding	Audit Dept. Manager/Cahaba Safeguard Admin.
Title/Organization	**Title/Organization**
______________________	______________________
Signature	**Signature**
____________	____________
Date	**Date**

1. Resolved Issues

N/A

2. Conditionally Resolved Issues

Issue #1: Whether the Intermediary should correct the Provider's rural community hospitals demonstration project settlement for its fiscal year ending June 30, 2012 by using the DRG Weight *Fraction* from the PS&R, rather than the DRG Weight, to calculate the case-mix adjustments.

The Parties agree to resolve this issue and, as indicated in the below schedule, the Intermediary agrees to issue a revised NPR for both appeals by November 1, 2017.

3. Unresolved Issues

Issue #1: Whether contributions made by the State of Alaska towards meeting Provider's pension obligations that exceed 22% of Provider's payroll can be counted as a "reasonable cost" by Provider for purpose of Medicare reimbursement in fiscal years ending June 30, 2011 and June 30, 2012? Provider recorded the State of Alaska's contribution to the Public Employees Retirement System ("PERS") as a cost and the associated revenue as "non-operating revenue." For each fiscal year, the MAC has denied the inclusion of PERS contribution on Provider's cost reports.

Provider contends that Provider Reimbursement Manual (PRM-1) § 2156 ("Allowable Costs of Government Support Services to State and Local Governmental Providers") supports its position that the employee benefit plan expense is an allowable cost. Bartlett Regional Hospital is affiliated with the City and Borough of Juneau, Alaska, the State of Alaska's capital city.

In addition, in 1983, Congress removed the requirement that a "restricted" grant or gift, that is, a grant or gift designated for a specific purpose, such as medical education (or pension costs), had to be included as an offset against the costs associated with the designated program. *See* Omnibus Reconciliation Act of 1980 (Pub. L. 96-499) § 1134.

The MAC contends that these costs were not incurred by, or attributable to, the Provider and points to the fact that Alaska deposited the monies directly with PERS rather than paying the monies to the Provider.

Although this case does require the development of some facts, such as the nature of the relationship between the Provider and the State of Alaska, no material facts are currently in dispute.

While some documentation was exchanged as part of the cost report audit process, no documentation has yet been exchanged as part of the appeal process. The schedule for such an exchange is detailed below.

PROPOSED SCHEDULE

August 1, 2016

The Provider will transmit to the MAC documentation relevant to this appeal issue including:

- Excerpts from its Audited Financial Statements
- Schedules used to prepare the cost reports
- Actuarial Determination of Required Contributions
- City and Borough of Juneau's participation agreement with the State for the PERS
- GAAP Standards for On-behalf payments
- Actuary's Reports
- Excerpts from CBJ's Financial Statements regarding on-behalf payments
- Excerpts from the State of Alaska's Financial Statements
- Relevant sections of the Public Employee's Retirement System (PERS) manual

November 1, 2016

The MAC will inform the Provider of any additional documentation and information that it needs to review in order to fully assess the issue and develop its position.

January 1, 2017

The Provider will furnish the MAC with any additional documentation or information requested.

April 1, 2017

The MAC will inform the Provider whether the issue is resolvable and, if not, it will provide a brief description of its position of why it believes the costs are unallowable, based on the documentation provided.

June 1, 2017

The Provider will furnish the MAC with comments on the MAC's position and a brief statement of its own position and key legal authorities. The Provider will include any additional supporting documentation.

August 1, 2017

If the issue is resolvable, the MAC will submit finalized adjustments to the Provider.

September 1, 2017

The Provider will submit comments regarding the MAC's adjustments (if any).

November 1, 2017

If the issue is resolvable, MAC will issue revised Notices of Program Reimbursement ("NPR") implementing the adjustments.

In the event that these issues cannot be resolved, the following timeline is proposed for both fiscal years:

- The Provider's Final Position Paper with exhibits will be due approximately 90 days before the scheduled hearing date (due date = February 1, 2018).
- The MAC's Final Position Paper with exhibits will be due approximately 60 days before the scheduled hearing date (due date = March 1, 2018).
- The Provider's (optional) Responsive Brief will be due approximately 30 days before the scheduled hearing date (due date = April 1, 2018).
- Witness lists will be submitted 30 days before the scheduled hearing date.
- A final set of position papers and exhibits will be exchanged by the Parties and submitted to the Board 5 to 7 days before the scheduled hearing date.

May 2018

The hearing will be scheduled for May 2018.

Bartlett Regional Hospital

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

White paper for Bartlett Regional Hospital
Board of Directors
Re:
Evolution of Bartlett's legal services
April 4, 2016

Two years ago, Bartlett entered into a 2-year agreement with CBJ Law, whereby CBJ Law provided primary legal counsel for $130,000 a year. Jane Sebens was identified as the attorney from CBJ that would provide these services and Dick Monkman, with Sonosky Chambers was retained to provide healthcare specific legal support at $60,000 a year.

This model has struggled, partly due to Jane being inundated with Bartlett contracts that had never conformed to CBJ requirements in the past, but mostly due to poor communication and lack of structure to support better communication and more efficiency.

Amy Mead and Chuck Bill met several times to discuss how to improve this situation resulting in Bartlett creating an onsite Contracts Management position and CBJ Law using an online project tracking tool. Amy and I agreed that the relationship should continue and that basic healthcare needs would shift to Hall-Render since Sonoksy Chambers was unwilling to continue on retainer.

Prior to announcing those decisions, we were informed by CBJ Finance that we would be allocated $270,000 for CBJ Law costs. Alan Ulrich and I met with CBJ Manager, Deputy Manager, Finance Director and their staff to protest this increase, which was conveyed to us at the last minute of FY17 budget preparation. There was no offer to change that allocation so I notified Amy Mead and Kim Kiefer that I would need to take this back to the Board for their knowledge and feedback. The Board was understandably concerned and CBJ's Finance Director, Bob Bartholomew offered to reduce the allocation cost by $100,000, which was more in line with our budget. While accepting the $100,000 reduction, we also brainstormed through other possible structures and I was instructed to explore other options, perhaps an attorney based at Bartlett that could improve communication and add value.

I eagerly accepted that challenge and asked Bob Storer to assist me in the process since he had been closely engaged in this issue to this point and he agreed.

After some strategy discussions, Bob Storer and I met with Amy and Jane on 3/31/16. It was a very positive meeting and Amy agreed with our position that a CBJ attorney based at Bartlett is the optimal model to improve productivity and communications by building the attorney as part of the Bartlett team, not an outside consultant. Ideally, this attorney will have some healthcare law background and will allow us to decrease the wage of Hall-Render, keeping the overall change close to budget neutral. The onsite attorney will meet with Senior Leadership on a weekly basis, gaining a much better knowledge of Bartlett's operations, issues and priorities. He/She will be able to provide counsel in real time, proactively managing risk. I would assign Risk Management and Compliance directly to the Bartlett attorney, giving these crucial functions the oversight they need.

Amy and I will be working together over the next several weeks to define the structure and identify the individual for this position.

I am excited about these changes and believe Bartlett will benefit from this structure.

CEO Report

April 26, 2016

A couple items of note for April.

Some clarity is developing with what the State Legislature's plans are regarding Medicaid Reform. The area that will undergo the most dramatic change in FY17 will be Behavioral Health. Bartlett is well positioned with our existing services and leadership, including Dr. Hiestand and Sally Schneider to take advantage of these changes. With the budget still not adopted, there still is the possibility for some changes that will impact Bartlett.

We received the financial report on the Trauma Level IV State assessment. It contained several recommendations and identified many strengths (see attached).

Denise Plano accepted the position of Director of Quality and Patient Safety. She brings excellent credentials and will start June 6th.

I met with two members of the consulting firm, Agnew-Beck who are preparing a business/analysis plan of the Hospice services for Catholic Community Services. It is evident that this essential piece of the continuum of care in Juneau continues to struggle.

A reminder that Hospital Week is May 8-14. We will have a variety of celebrations and the Board is invited to participate. Details to follow.

LEVEL IV TRAUMA VERIFICATION REVIEW
BARTLETT REGIONAL HOSPITAL
JUNEAU, ALASKA
January 26, 2016

I. PURPOSE OF REVIEW

A. Type of Review:

A verification review for a Level IV Trauma Center was conducted at Bartlett Regional Hospital on January 26, 2016 by Dr. Frank Sacco and Julie Rabeau, R.N., EMSRN

B. Requested Review:

This review was done at the request of the Bartlett Regional Hospital Board of Directors, Administration, and Staff. Bartlett Regional Hospital (BRH) desires to improve the organization and delivery of health care services as well as achieve optimal health and trauma care for individuals and communities.
The official designating authority in Alaska is the Department of Health and Social Services Section of Emergency Programs.

C. Previous Level IV Reviews:

Bartlett Regional Hospital has participated in a previous Level IV review May 14, 2012. There was a Level III consultation conducted by the American College of Surgeons Committee on Trauma (ACS-COT) in 1993 and 1999.
It was reported to the review team that BRH arranged for a site visit from ACS-COT in fall of 2016 for a preliminary consultation for Level III Designation.

II. PRE-HOSPITAL

A. Pre-Hospital System:

Capital City Fire/Rescue (CCFR) falls under the City and Borough of Juneau (CBJ) management. They serve a 15,000-square-mile region in the northern part of Southeast Alaska. Approximately 55,000 people reside in their service area, with most communities inaccessible by road.
The Fire Chief reports to the CBJ City Manager and the CBJ Assembly. CCFR has a dedicated EMS training officer who ensures that licensure education and requirements are met. Shift captains are responsible for supervising care/day-to-day operations and providing/coordinating training to maintain EMS competence. There are two staffed fire stations, with jurisdiction of the Juneau area split between the two. Both stations also serve as a back-up for the other firehouse as needed. There are three additional fire stations covered by volunteer staff. CCFR provides biannual paramedic refresher courses for all paramedics. The medical director is Dr. Timothy "Quigley" Peterson who is also an ED physician at BRH. He holds bimonthly run reviews and training sessions for each shift in addition to regular shift training each week. Dr. Quigley attends monthly ED Quality Improvement meetings. Dr. Peterson develops and approves medical care protocols applied by medics and prepares presentations for the Southeast Region EMS Symposium (SEREMS) annually.
Dr. Alan McPherson, is currently serving as the Trauma Medical Director at BRH, and chairs the Trauma Committee. The EMS QI strengths and weaknesses identified in the Trauma Committee are reported to CCFR captains by Dr. Quigley Peterson. Dr. Peterson also holds

collaborative, interactive training and run reviews on each shift. Bartlett regularly provides a venue for the run reviews. Quality of care is discussed and strategies for improvement of care are discussed at these reviews. In addition, trauma training provided by BRH is extended to CCFR personnel. The ED Director visited each CCFR shift in 2014 to request feedback on interdepartmental processes and relations. The feedback was compiled and reviewed by the ED Director, ED Medical Director, and CCFR Medical Director. Processes were changed as needed to improve patient flow, quality of handoff, and patient care. BRH ED has an open door policy for EMS personnel to spend time shadowing physicians and nurses to gain education and patient care skills. This takes place several times a year, particularly with medics who are newly licensed. Conversely, ED nurses are invited to attend run reviews and complete “ride-alongs” with CCFR shifts in order to gain a better understanding of the issues faced in the prehospital setting. BRH participates in disaster drills biannually with USCG personnel. BRH also collaborate with USCG in community disaster response committees. Nurses and base managers from Guardian Flight and Air Lift Northwest (ALNW) are invited to attend our trauma committee meetings and participate in quality improvement activities. At times the ALNW Medical Director, Richard B. Utarnachitt, will call in to the meetings to facilitate case reviews or provide input.

1. Air Ambulance / Medevac:

The aero medical medevac system consists of Airlift Northwest locally-based dedicated aircraft and crews that are activated by the Emergency Department physician. Those patients needing transport to Anchorage or Seattle are stabilized and transported via the Airlift Northwest medevac service or Guardian Flight service. Capital City Fire Department, Juneau Police Department, or the Alaska State Troopers have the ability to dispatch air medical services from the scene. The U.S. Coast Guard has a rotor and a rescue boat that can be activated emergently when conditions limit fixed wing medevac access. Commercial air transportation is another alternative as indicated. Air travel is 561 miles to Anchorage Level II Trauma Centers, 907 miles to Seattle, Level I Trauma Center.

2. Ground Ambulance

Fire/EMS crews support the local prehospital response. Capital City Fire Department (CCFD) is the local EMS. The EMS service offers advanced life support (ALS) capabilities utilizing Mobile Intensive Care Paramedics as the highest level of care. There are fulltime paid and volunteer staff. Two main fire houses exist as well as three additional fire houses that rely on volunteer staff for response. The Medical Director provides oversight of medical functions and protocols for local EMS. He is active in teaching prehospital personnel as previously stated. Most of these runs have short transport times. Bartlett ED also has a liaison to CCFR for improved communication. The Trauma Nurse Coordinator reviews all trauma data, including prehospital care, and communicates information with the Trauma Committee which filters back to the CCFR Medical Director, Dr. Timothy Petersen. EMS QI feedback is given to EMS via the Medical Director/CCFR Medical Director. CCFR has a representative on the Trauma Committee, but attendance is poor. The CCFR Medical Director collaborates interactive training and run reviews for all EMS personnel based on feedback from the BRH QI Committee.
BRH has a dedicated phone and radio for communication with prehospital providers in Juneau. It was reported that cell phone coverage is lost at mile marker 23 and Auk Bay 10-15 minutes away this can delay in EMS calling trauma activation.

3. State EMS Involvement

The Alaska Council on Emergency Medical Services (ACEMS) is a body of eleven members appointed by the Governor to advise the Department of Health and Social Services on the overall development of a statewide, comprehensive emergency medical services system. The hospital does not have representation on ACEMS. The hospital does have representation on the Southeast Region EMS Board (SEREMS).

4. 911 Service:

Juneau area has an enhanced 911 system with dispatch covering EMS and police department needs. Dispatch tones out the fire department staff closest to the event. If the event is in an area where a volunteer system is in place, both volunteers and fulltime staff is paged to the scene. Once EMS arrives, care is initiated and the designated individual contacts the ED with scene/patient status as early as possible. EMS personnel can request trauma activation based on specific criteria in CCFR policy. The ED MD initiates the trauma team activation, and requests any other resources necessary and available. Patients are transported to the ED based on acuity, ability of transporting units, and always considering worst-case scenario. Two main staffed fire houses exist as well as three additional fire houses with units that rely on volunteer staff for response.
The central EMS/police dispatch is notified via phone call. USCG central command receives alerts for need for Coast Guard response. Based on location and severity of complaint, EMS units/rope rescue/mountain rescue/water rescue teams with appropriate personnel for the event are dispatched to scene from the closest CCFR staffed and volunteer stations or by USCG according to their protocols. At minimum, an ambulance and fire truck respond to every medical call with 3-5 personnel. USCG responders are activated through the USCG dispatch facility or via the local 911 dispatch. Air medevacs are activated through the vendor-specific transfer center by the requesting location or with the assistance of the ER MD if necessary. The ambulance is chosen first by contractual agreements, then availability of provider in concert with patient needs. (E.g. ALNW will be activated outside of the SEARHC contract with Guardian Flight if patient condition is such that the patient could come to harm waiting for Guardian Flight to be available.) Commercial airlines or Alaska Marine Highway may transport patients under specific circumstances.

B. Regional Disaster Plan:

Two BRH representatives, including the BRH Emergency Management Team (EMT) chair, Mr. Mike Lopez, sit on the Local Emergency Planning Committee (LEPC) and assist with planning local and regional disaster and mass casualty drills. Mr. Lopez participates in community wide disaster training in the annual Emergency Preparedness expo and the local Community Emergency Response Team (CERT). He is a member of the Southeast Alaska Health Care Coalition, bringing southeast communities together in disaster preparedness support, training, and collaboration. BRH sends representatives to the annual Hospital Preparedness Conference to gain knowledge and improve the disaster preparedness and outreach of this facility. BRH exercises disaster drills with local agencies, including CCFR, United States Coast Guard, Airlift Northwest, Guardian Flight, Cruise Line Agencies, University of Alaska, and Alaska Electric Light and Power, among others, and participates in table-top exercises with members of

surrounding communities. BRH has Memorandums of Agreement/Transfer Agreements with regional clinics to assist in the decompression of those areas in times of disaster. BRH also maintains MOAs with local facilities willing to assist in evacuation of patients or care of low acuity patients in a mass casualty event. BRH representatives have led efforts to develop a local resource/surge capacity list and cooperative alliance of healthcare facilities to promote a collaborative approach and test disaster preparedness within the healthcare community in times of disaster. The focus of disaster events for BRH center around real type events; cruise ship, plane crash, fish processing plants. All new employees receive disaster response training as part of the onboarding process... Mr. Lopez provides review of disaster response and employee roles and responsibilities in staff meetings annually. Each hospital unit maintains a manual that contacts Bartlett's Emergency Operations Plan (EOP) to be activated in times of disaster. This manual can also be found online in Bartlett's policies and procedures. All staff know where to locate this manual and the policies online.

III. HOSPITAL INFORMATION

A. Hospital Description:

Bartlett Regional Hospital is managed by the City and Borough of Juneau (CBJ). The BRH Board of Directors report to the City and Borough of Juneau assembly. The senior leadership team members (CEO, CBHO, CFO, and COO) are employees of CBJ.
Bartlett Regional Hospital is located in Southeast Alaska. The hospital's operations are administered by the City and Borough of Juneau. Bartlett Regional Hospital is licensed for a total of 57 inpatient beds and 16 residential substance-abuse treatment facility beds in the Rainforest Recovery Center. The hospital serves a 15,000-square-mile region in the northern part of Southeast Alaska. Approximately 55,000 people reside in our service area, with most communities inaccessible by road.

B. Campus Facilities:

All hospital services are located on a single campus.

C. Hospital Beds:

BED TYPE	NUMBER
Licensed	59
Staffed ED Beds	12
Staffed Pediatric Beds	interchangeable

2015 Census data is as follows:

CENSUS	NUMBER
Average	27.4
Adult	25.52
Pediatric (does not include newborns)	2.07

Trauma patient census for reporting year is as follows: 2015

CENSUS	NUMBER
Emergency Room Visits	15,147
Trauma-related ED visits/reporting years	145
Trauma admissions reporting years	76
Trauma transfers	35 ED/ 7 inpatient = 42

D. Hospital Commitment:

Facility commitment is evidenced by support in the following areas: injury prevention, acute trauma care, long-term and/or rehab care, and staff education. There appears to be commitment to trauma care as evidenced by the Hospital Board Trauma Resolution and by the Medical Staff Resolution. Bartlett has an allocated budget for the trauma program. This includes funding for the trauma coordinator and registrar responsibilities, trauma-related travel and education, and trauma equipment and supplies.

E. Injury Prevention:

A fall prevention program is supported by the hospital. BRH requires all patient care providers to remain current in Crisis Prevention Intervention (CPI) and Behavioral Emergency Response Team (BERT) training; as part of training, staff receives back safety training and BRH has purchased numerous patient transfer devices. Hazardous Materials training is offered to a team and BRH has created a response code orange for any Haz Mat occurrence to minimize injury/illness related to the event. BRH also supports for trauma-related education for all staff (TNCC, ACLS, PALS, ABLS, and ENPC).
BRH provides a venue and funds to support community safety training:

- Annual community health fairs and health expos such as Southeast Alaska Outdoor Safety Expo—Ready, Set, Survive—offer booths and training on Gun Safety, Water Safety, Helmet Safety, Car seat Safety, Bike Safety, disaster preparedness.
- Traumatic Brain Injury: classes for community members that assists individuals in improving activities and communication—specific topics/treatment is based on patient needs within the group.
- Tai Chi for Elderly—focuses on improving balance and falls/injury prevention.
- Team Survivor Yoga Therapy for balance improvement and injury prevention and is available to adults of any age.
- Joint Replacement classes—pre- and post-surgical classes that assist in strengthening to prevent post-surgical injuries and promote return to quality of life.

- Parkinson's therapy class—assists patients in healthy living and maintenance of maximum, injury-free mobility as long as possible.
- Safe Sitter classes—training for teens on infant and child safety.
- Parent support groups—(Baby-Parent Time) assists parents in interacting safely with infants and children and provides guidance on dealing with the challenges of child-raising. A goal is to assist parents in managing stress and reduction of domestic violence.
- SART program—Bartlett's SANE coordinator participates in this community based sexual assault response team that offers community education regarding sexual assault and domestic violence (eg. Domestic Violence and Sexual Assault Education and Advocacy Training)
- Children, Adolescents, and Grief/Mental Health/Suicide Prevention Program—(Suicide Coalition, Adverse Childhood Experiences and Family Trauma in Primary Care) BRH offers a venue for mental health community awareness, injury prevention efforts, and education. Case management and mental health personnel/providers participate in several community-based efforts to manage mental health crises in a healthy way according to Trauma Informed Care guidelines, and improve healthy management of issues thus reducing violence, suicide and traumatic injuries and deaths.
- Trauma Informed Care—caring for emotional needs of trauma patients/crisis intervention related care
- Responder Ready—a disaster response, mass casualty class offered to the public
- Better Breathers—educational, conditioning therapy classes for individuals with respiratory disorders
- Local Emergency Planning Committee—Bartlett provides a venue and holds two seats on this committee that focuses on disaster preparedness and training in the community.

IV. Support of Trauma Care:

Bartlett Regional Hospital supports acute trauma care as evidenced by providing 24/7 ED physician in-house with a midlevel provider coverage during peak hours. 24/7 Orthopedic, general surgery, and anesthesia on-call coverage is provided. BRH has expanded ancillary services with 24/7 respiratory therapy, laboratory, microbiology, blood bank, and radiology to include CT coverage. On call MRI coverage is provided after hours. BRH also supports, although there is a limited cost reimbursement, for trauma-related education for all staff (TNCC, ACLS, PALS, ABLS, and ENPC). BRH ED has the Trauma Informed Care program which it offers to patients.
The review committee noted the lack of physician subspecialist participation in the trauma program or trauma committees.
BRH has arranged for a site visit from ACS-COT in fall of 2016 for a preliminary consultation for Level III Designation. We are also recruiting for additional surgeons with an interest in trauma care to assist us in pursuing Level III Designation status.

A. Long-Term Care and/or Rehab Care:

BRH maintains a collaborative relationship with the local long-term care facilities (Pioneer Home, Wildflower Court) and Hospice and Home Care; elderly safety classes are hosted and taught by BRH physical rehabilitation staff; BRH offers rehab services to inpatients, but also supports case management to coordinate ongoing treatment on an outpatient basis as well (physical/ occupational/ speech therapy and wound care for all ages). BRH has a social worker/case management department that helps coordinate care for inpatients, Rainforest Recovery Center, and mental health patients. This service has been expanded to include focused work on ED patients as well. For inpatients, PT/OT/functional assessments are completed at bedside with follow up care provided as needed. For outpatients, BRH maintains a fully operational rehabilitation/wound care program. BRH has a social worker/case management department that helps coordinate care for inpatients, Rainforest Recovery Center, and mental health patients. This service has been expanded to include focused work on ED patients as well. For inpatients, PT/OT/functional assessments are completed at bedside with follow up care provided as needed. For outpatients BRH maintains a fully operational rehabilitation/wound care program.

B. Trauma Education:

BRH maintains a website that includes free CEUs on diverse topics including trauma and injury prevention. The ED Director developed a triage class for staff on the evaluation and triage of patients entering the ED. This included a review of many conditions, including occult conditions in a patient status post trauma. The course also provided an overview of the TNCC protocol for evaluating trauma patients and a thorough overview of the 5-Level Emergency Severity Index (ESI) for consistency in triage and classification of ED patients. BRH also has hosted many other classes available to staff, some of which include Emergency Operations and Incident Command. Certified Emergency Nurse Review course was offered to staff and extended to nurses from local and regional facilities in southeast Alaska. BRH has a limited education cost reimbursement plan to assist staff members who seek continuing education. BRH offers 48 paid hours per year per employee to use for conferences, educational events or continuing education opportunities. In addition, BRH offers certification pay to any staff to takes initiative to maintain certifications in their areas of expertise. Currently 82% of RNs working in the ED are CEN certified. Nurses who provide trauma care to patients are not required to take TNCC, but the course is highly recommended. It was reported that after the January 25-26, 2016 TNCC class, at minimum, 50% will be current in TNCC. 30% of staff is current in ENPC.

V. TRAUMA CARE

A. Procedure for handling more than one injured patient arriving simultaneously in the emergency department:

If multiple trauma patients arrive simultaneously, then collaboration between the ED charge nurse and physician on-call occurs and determination is made as to whether additional staff are needed. Additional personnel are called in as appropriate. It was reported there is not a problem in securing additional staff when needed. The Nursing supervisor is notified of situation as soon as ED is aware, and any additional resources converge in the ED from in-house units, or outside the hospital for patient needs. Ancillary departments are alerted to send staff to the ED to await incoming trauma patients to expedite care.

The shift nursing supervisor has a master list of staff with contacts. This information is also maintained online and can be accessed from any computer within the hospital. Some ancillary departments have a call tree to alert staff to an emergency situation. ED physicians and any

other physicians can request that specific specialties or physician colleagues be contacted to assist with emergency or disaster patient care situations. A thorough plan for management of emergency situations can be located in the BRH EOP, and can be used for any situation that stresses the system, and is not limited to area-wide disasters. Staff receives training upon hire, with subsequent annual trainings and biannual drills to exercise this plan.
ED staff and physicians evaluate existing ED patient needs, triage incoming patients, and allocate resources appropriately. Nursing supervisor is notified of situation as soon as ED is aware, and any additional resources are contacted by the supervisor or Patient Access Services. Ancillary departments are also alerted to send staff to the ED to await the arrival of the patients and expedite care. Patient condition is prioritized and care is given efficiently through collaboration within the healthcare team. The 5-Level Emergency Severity Index or Disaster Plan in the EOP is used to guide triage of incoming patients, depending on the scenario.

B. Trauma Data: 2015

Trauma/Statistical Data (obtain from State Trauma Registry)

1. Total number of ED visits for reporting year: 15,147 (1/1-12/31/2015)

2. Total number of trauma-related ED visits for reporting year: 512 patients presented with trauma-related chief complaints (falls, motor vehicle collisions, etc.)] 145 ruled into the trauma criteria based on diagnosis code (ICD9-10)

3. Number of hospital trauma admissions for one year: 76

4. Number of hospital trauma transfers for one year: 35 from ED/7 from inpatient= total 42 transfers

5. Number of trauma registry patients admitted or transferred by ISS:

	Admitted	Transferred	Mortality
a) ISS <= 8:	43	15	0
b) ISS 9-15:	30	18	0
c) ISS 16-24:	1	0	1
d) ISS >= 25:	0	0	0

C. Transfers:

Bartlett Regional Hospital has 7 formal transfer agreements outside of their facility with submitted MOU's to the reviewers.

D. Trauma Nurse Coordinator/Trauma Registry Abstractor:

Shutney Frisbie is the Trauma Coordinator and Trauma Registrar. Jennifer Talley RN continues to assist with the trauma registry. The hospital submits to the Alaska Trauma Registry and the National Trauma Data Bank (NTDB). The hospital has submitted data through December 31, 2015 and is current according to statute. The Trauma Coordinator does not utilize the trauma registry data for performance improvement.

V. HOSPITAL FACILITIES

A. Emergency Department:

Dr. Alan McPherson is the Medical Director of the Emergency Department.
There are ten ED physicians who provide coverage to the emergency room. There are two full-time General Surgeons, Dr. Ben Miller who works for BRH and Dr. David Miller who is in private practice. Locum general surgeons also cover general surgery call. Two Pediatricians are on staff.
The hospital does have a formal two-tier activation system specific for trauma patients. Three ED RN's which includes the Nursing Supervisor respond to the activation. Nursing staff from the CCU may be pulled if additional staff is required. BRH also maintains a Rapid Response Team and a Code Blue Team.
There does not seem to be a problem in securing additional nursing and physician staff when needed emergently. There is a written policy regarding call back of off-duty staff for emergencies.
The BRH trauma staff expressed continued difficulty in obtaining a receiving physician for transferred patients to Anchorage. The staff stated this has led to a delay in care for patients, and leads to transferring patients to Harborview with a better defined process.
All the necessary equipment was identified and quickly located for the surveyors. There is a pediatric Broselow system in place. The ambulance has direct access into the emergency department. There are 12 ED beds, 5 monitored beds, and 2 portable monitors. Emergency resuscitation equipment is readily available in the emergency room to include Bair huggers, Level 1 transfuser, glide scope, intraosseous gun, 1 vent, 3 RSI kits, and a trauma cart. The ED has an Omni Cell Pxysis. The chest tube collection chambers have an auto transfuser component. The inability to warm the ED and OR rooms is a weakness, especially in a facility that deals with a significant number of hypothermic patients. The ED is trialing for purchase a Zoll Temperature Management System-Thermogard XP, a warming/cooling device used for trauma or otherwise critical patients. The ED maintains a warmer filled with warm fluids and blankets for patient warming.
Upgrades to the electronic health record documentation continue to improve trauma templates. Trauma-specific order sets have been created to improve consistency and efficiency of ordering care for patients. The order sets list tests and nursing interventions that meet care standards for trauma. The physician can quickly scan the list and select the studies applicable to the specific patient.
GCS charts are placed at head of beds in rooms where trauma/neuro patients are assigned for care. This was an identified solution to the inconsistent and incorrect usage of Glasgow Coma Scale (GCS) in head-injured patients since the last review.
The ED acquired a bedside ultrasound for FAST exams, ultrasound-guided peripheral IV and central line access to improve rapid assessment. The ED held inter-agency educational events for Intraosseous (IO) insertion, ultrasound-guided peripheral IV, and trauma training courses held with a nurse-driven policy currently under development.
ED trauma medications were collaborated with medevac teams and EMS to research efficacy of medications. BRH trained staff and providers and acquired new medications for use in trauma patients: tranexamic acid for TBI patients and prothrombin complex concentrate for warfarin reversal.
The ED screens all adult for alcohol and drug use but do not have a formal SBIRT program. They can utilize the resources of the Rainforest Recovery Center and mental health and substance abuse counselors who are on call 24/7. They have inpatient and outpatient detox program. The mental health unit and medical/surgical units can be used for inpatient detox and

the patients are transferred to the outpatient program if the evaluation at time of discharge indicates that the patient is accepting of the outpatient program. If there is no room available, BRH Case Management works to find out-of-state programs and helps coordinate services for the patient.

B. Radiology:

The Radiology department is easily accessible to the ED. Israel Ginn, Radiology Director, was available for the review and answered all questions regarding radiology. They have radiology and CT capabilities open 24 hours and weekends and get their films read emergently by radiology service in house or on call 24/7. CTA for adult and pediatric patients are performed at BRH. It was reported that the protocols for CTA are performed by the MRI/CT techs. The ED physician will do the initial radiograph read and there are 2 radiologists on staff. Telerad by Nighthawk is used at night, and there is call in for multiple or x-rays or CT reads. There is ultrasonography and a technician available on site or on call; it is not routinely used in the evaluation of trauma patients because most ED physicians are able to perform their own FAST exams for trauma patients. BRH has a 16 slice and a 128 slice CT scanners and an MRI both within close proximity to the ED. There is a 30 minute response for a back-up tech for trauma surgical patients. Once a study is complete, it is stored in their electronic repository, the PACS system. During business hours, the ED MD completes a preliminary read of the study, documenting his initial interpretation. The radiologist completes the final reading and contacts the ED MD immediately if his/her interpretation differs from the preliminary read. Outside normal business hours, the ED again completes the initial interpretation, documenting in the study the impression. The image is immediately pushed to a teleradiology group whose radiologist completes an immediate read and faxes back the impression. If significant issues are identified, the radiologist contacts the ED MD to discuss the findings by phone. Then during business hours, the BRH radiologist verifies the teleradiology reading and communicates with the MD on duty if any conflicting information is recognized.

C. Operating Room:

Bartlett Regional Hospital has three general operating suites, one endoscopy suite, a recovery room and central sterile supply services. Surgical coverage is available 24 hours a day. The OR is open weekdays from 0700-2330 with on call staff available within 30 minutes.

D. ICU:

Bartlett Regional Hospital has12 monitored CCU beds with a 4 patient daily census average. 2-3 RN's are scheduled in the ICU daily. The hospital has hardwired 7 of the 12 rooms for EICU scheduled to go live January 31, 2016.

E. Clinical Laboratory / Blood Bank:

Lab Director John Fortin was available for the review .The lab is staffed 24/7 days a week. The lab has improved its turnaround time for stat lab values to 10-30 minutes. The ED does not run ISTAT's due to cost. The Lab Director stated the close proximity of the ED to the lab allows for ISTATS to be run if indicated. Trauma activations have a pre-printed trauma panel which the physician may select all or check specific tests. The Blood typing takes approximately 15" and

cross matching approximately 30". BRH is supplied blood by Blood Bank of Alaska. To receive additional blood products to the hospital is airplane driven within a 24 hour period. The hospital has improved the ability to thaw plasma more efficiently through a new defroster purchased since the last review with Trauma Care Funds. No blood is stored in the Emergency Department, but a policy exists for emergency release, (6 units of PRBC's and 6 units FFP). There is a mass transfusion protocol (MTP). Lab does not currently review or audit the start/stop times of the MTP. During the trauma consultation, the ED Nurse Manager stated that there can be a delay in care when point of care testing is needed for CT's. Lab QA tracks CBC, troponin turn-around times for less than 1 hour. Since the consult, a focus group was formed under the Chief Nursing Officer Leadership. Lab hours have been shifted to provide better coverage during peak hours and to improve turnaround times.

Blood Product Inventory Levels (units)	
O positive	25
O negative	8
A positive	15
A negative	2
B positive	2
AB positive	2
Fresh Frozen Plasma	30
Pooled Cryoprecipitate	4
Platelets	0 (requested from Seattle as needed)

VI. SPECIALTY SERVICES

A. Burn Care:

The hospital has the capability of stabilizing burn patients. Transfer agreements are in place with Harborview Medical Center. Bartlett Regional Hospital has treated 11 burn patients during the reporting year. One burn admission and 3 transfers were noted during this reporting period. Transfer protocols are followed according to EMTALA regulations. Major burns are dressed in dry, sterile dressings for transport and the Parkland Fluid resuscitation guideline protocol is followed for fluid resuscitation. BRH has a burn policy in effect.

B. Spinal Cord Injuries:

The hospital has the capability of stabilizing and treatment of stable spinal cord or suspected spinal injuries. For the reporting period, there were 2 spinal cord injuries and 2 spinal skeletal injury patients treated at Bartlett Regional Hospital. Two spinal cord injuries patients were transferred to another facility. Transfer protocols are followed according to EMTALA regulations. A spinal cord injury policy and transfer policy exists. Unstable patients remain in c-spine immobilization during air ambulance transfer to the trauma center. Neurological checks are done hourly at a minimum (more often as needed).

C. Organ Procurement:

There is a written policy regarding organ procurement and donation. Lifecenter Northwest and Life Alaska Donor Services are the organ donation services utilized by BRH. The Emergency

Room Physician and the Nursing Supervisor speak with the family regarding organ procurement.

D. Social Services:

The hospital has social services within their facility and a crisis intervention program in the community. Counseling is available for families.

VII. QUALITY IMPROVEMENT

A. Overview:

The Trauma QI program has been in a state of flux. It was reported to the review team that there was a lapse in the trauma coordinator position which caused the trauma committee meetings and trauma program to go virtually dormant from 8/2214-5/21/15. The Emergency Care Committee (ECC) has been following trauma QI. Dr. Quigley attends the ECC committee and closes the loop by report to CCFD. Shutney Frisbie, RN is the current Trauma Coordinator and is bringing the QI and trauma program up to date.

B. Quality Improvement:

The Trauma Coordinator reviews reports from EMR, and evaluates care as part of the chart reviews/data entry for the trauma registry. She compiles and prepares cases for the trauma committee according to QI filters/complexity of cases and/or care process concerns to the Trauma Committee (TC) for review. Quality reporting from the TC is brought to the next monthly ECC for discussion if action items, care changes, or policy concerns have been identified in the TC. Other reviews can be initiated in the committee at the request of any care providers with concern as well. The attending physician/surgeon/care providers involved in the care gives the perspective on the patient care event. The TMD facilitates dialog about each case discussed. As needed, a QI plan is established and implemented with follow up by either the TC or another appropriate QI committee, all of whose reporting structure converges within the Medical Staff Quality Improvement Committee (MSQIC). The review committee identified a large overlap of the ECC and Trauma Committee, nor incentive of physicians through hospital obligation to sit on the Trauma Committee. The review committee noted the lack of physician subspecialist participation in the trauma committee.
If the information needs to be disseminated to other med staff members, the quality committee that identifies the need for communication assumes responsibility for the communication. If information needs to be communicated with BRH staff, the senior leader represented on each team alerts the appropriate director of the concerns, and it is disseminated to staff by unit directors as appropriate. Information is disseminated to committees through the reporting structure. The chair of the committee (or designee) assumes the responsibility for communicating up to MSQIC or laterally to other committees that need to receive the information. Information also is passed to the Quality Department representative on the committees, to the Quality director and to SLT. Additionally, the CCO communicates to other SLT members and with department directors for communication to staff. SLT members deliver information to their direct reports as needed. This info is relayed via the committee structure, staff meetings, emails, and posted meeting minutes on the hospital intranet.
BRH current classification of deaths is; unanticipated mortality with opportunity for improvement, mortality without opportunity for improvement, or anticipated mortality with opportunity for

improvement. This has been added to the Quality Review form. Medical Director/ECC/TC; MSQIC/OR committee or other committees as needed review all deaths.
Trauma Committee meeting minutes, Emergency Care Committee meeting minutes and a Quality Report PowerPoint BOD presentation were provided as examples of QI projects with loop closure.

QI filters related to trauma care:

- Hourly vital signs
- Hourly neuro checks
- Patients re-intubated within 48 hours of extubation
- Urgent, unplanned surgery > 14 hours after admission
- Unplanned return to the OR
- Seen in the ED within the last 72 hours
- Cervical spine injury/fracture identified in the ED
- Complex cases that require specialist involvement
- Codes
- Deaths
- Medevacs
- Admissions

QI committees at BRH who review trauma care as well as the membership of those committees were provided. Attendance is required for all committee members. Committees meet monthly, every other month, or every quarter. A Committee Assignment List 2016 for frequency of meetings was provided to the review committee.
All committees report quality issues to MSQIC. Provider issues are forwarded from MSQIC to the Credentials Committee for consideration with the credentialing process. As needed, the Quality Director loops in the Senior Leadership Team of major facility issues or provider issues. In general, the Board of Directors only receives informational items and is not part of the decision making process unless a major ethics or care is being raised that could have legal implications.

QI Committees:

- Medical Staff Quality Improvement Committee (MSQIC)
- Emergency Care Committee (ECC)
- Trauma Committee (TC)
- Surgical Services Committee
- Medical/Pediatrics Committee (Med/Peds)
- Critical Care Committee (CCC)
- Pharmacy and Therapeutics Committee (P&T)

C. Documentation:

Documentation is generally good on patients in the ED.
Obtaining feedback from accepting facilities of transfer patients at Harborview, Anchorage hospitals and air medical transport has improved. The addition of a feedback form included in every medevac packet which is returned to the ED Director. The TNC has set up access to BRH patient records in the Harborview system. The Trauma Committee is continuing to evaluate methods to consistently achieve feedback from Anchorage area hospitals by using the Trauma Program Managers as a resource.
The Screening Brief Intervention and Referral to Treatment (SBIRT) program for admitted trauma patients needs to be formalized.

V.

B. Registry Program:

The hospital participates in the state trauma registry and is current per statute. Data is current through 12/25/15 at the time of review. The registrar runs trauma patient reports from their primary EMR, Meditech, developed from ICD9/10 codes. The trauma registrar collects any paper records and EMS run sheets, and uses their EMR to research radiology reports and laboratory studies, along with any other documentation available. She enters the data into the Alaska Trauma Registry. The trauma registry data is not obtained concurrently during the patient's admission.

VII. CHART REVIEW PROCESS

A. Quality of Care / Documentation:

1. CASE REVIEWS:
Ten charts were reviewed. In general, the care and decision-making process was timely, appropriate and fairly well documented with the exception of loop closure.

2. Chart Availability:
The charts were readily available and readable which facilitated the chart review.

IX. SUMMARY

A. Criteria Deficiencies:
1 There is no SBIRT program in place.
2. Not all nurses have trauma training TNCC or ATCN.
3. There needs to be evidence of at least 4 trauma committee meetings with adequate documentation of attendance and minutes annually.

B. Strengths:
1. For a level IV center the availability of subspecialty resources including anesthesia, general surgery, and orthopedics is a tremendous asset.
2. The ED physician staff is well trained and there has been little turnover.
3. Physician documentation is good.
4. Rose Lawhorne and Dr. MacPherson are committed to improving trauma care.
5. There has been the development of a trauma activation process since the last visit and it incorporates the prehospital providers in activating resources when appropriate.
6. Medical direction and medical control is done by the physicians of the Bartlett ED. There is a good relationship with the prehospital providers and there are opportunities for integrated training.
7. Good communication and relationship with the aeromedical services.
8. Massive blood transfusion has been developed and implemented since the last visit.
9. Excellent availability of ancillary services and presence of radiologists at trauma activations.

C. Weaknesses:
1. The PI program needs better documentation of minutes and recommendations. Due to a retirement last year there was a lapse in trauma committee meeting which have recently restarted.

2. Inconsistent participation of general surgeons and orthopedists in the trauma program. This is not a requirement for level IV verification but is important to improving care in the community.
3. Patients with minor head or minor traumatic injuries have been medevac'd to Seattle, not for a higher level of care but because there was no provider willing to admit them. This is an added financial and social burden to the patient and the system.
4. We did not see reviews of transfer or pediatric patients
5. ED trauma flow sheets are difficult to follow.

D. RECOMMENDATIONS:

1. Make sure all nurses involved in care of injured patients complete trauma training.
2. Review your trauma activations for over and under triage.
3. Develop SBIRT training for nurses.
4. Monitor use of massive Blood Transfusion Protocol for timeliness and resource utilization and also its applicability to other areas such as obstetrics.
5. Consider obtaining trauma manikin for staff and prehospital provider training.
6. Have trauma coordinator work with state trauma program manager and other Level IV coordinator to review and streamline trauma PI program and documentation.
7. Physician participation on the trauma committee should be considered as meeting the bylaw requirement for med staff participation on hospital committees.
8. Classify deaths according to American College of Surgeons Committee on Trauma guidelines: Expected death without opportunity for improvement
   Expected death with opportunity for improvement, unexpected death.
9. Consider obtaining Zoll temperature management system.
10. Continue to work on the trauma performance improvement program.
11. Review guidelines for screening of blunt carotid and vertebral injuries.
12. Start following and documenting the prehospital filters that were sent out to the Level IV centers last year.
13. Clarify the roles of the Emergency Care Committee and the Trauma Committee.
14. Consider a consultation from the American College of Surgeons to clarify for administration and the medical staff requirements needed to become a level III center. After this it would be for the board and the community to decide if this fits their vision of what they want from their community hospital.

____

Frank Sacco, M.D.

____

Julie Rabeau R.N. EMSRN

Credentials Committee
Hospital Privileges for Board of Director's Consideration
Tuesday, April 26, 2016 5:15 p.m. – Robert F. Valliant Center Boardroom

REAPPOINTMENT APPLICATIONS:

Name		**Category**	**Privileges In**
1.	**Samuel L. Abbate, MD**	**Consulting**	**Endocrinology**

Dr. Samuel L. Abbate graduated from the University of IL at Chicago College of Medicine in 1984. Dr. Abbate is an board certified endocrinologist for Adonai Diabetes & Endocrinology Center in Wasilla.

2.	**Noble Anderson, MD**	**Active**	**Family Medicine w/OB**

Dr. Noble E. Anderson graduated from the Temple University School of Medicine in 2001. Dr. Anderson is a board certified family medicine w/ob physician for SEARHC - Spruce.

3.	**Amy E. Dressel, MD**	**Active**	**Pediatrics and Newborn, Lumbar Puncture, Pediatric Resuscitation, UVC/UAC Insertion**

Dr. Amy E. Dressel graduated from the University of Colorado School of Medicine in 1996. Dr. Dressel is a pediatrician for Glacier Pediatrics.

4.	**Alvin J. Fineman, MD**	**Locum**	**Psychiatry, Adolescent Psychiatry, and Chemical Dependency Detox**

Dr Alvin J. Fineman graduated from the Ruprecht-Karls-Universitat in 1977. Dr Fineman is a psychiatrist for Locum Tenens.com.

5.	**Alan S. Gross, MD**	**Associate**	**Outpatient Radiology (per Diagnostic Imaging Department Policy and Procedures - and Deemed Appropriately by the Radiologist), Laboratory, (Except those requiring injections of medications), Physical/Occupational Therapy, Nutritional/Diabetes Consults, EEG, Pulmonary Tests, and Sleep Studies (May not order Cardiac Rehab Holder Monitor and Event Recorder, Infusion Therapy, Interventional Therapy, Respiratory Therapy and Other Pulmonary Tests)**

Dr. Alan S. Gross graduated from the University of Washington School of Medicine in 1989. Dr. Gross is a board certified orthopedic surgeon for Petersburg Medical Center.

6. Peter B. Hulman, MD Consulting Nephrology

Dr. Peter B. Hulman graduated from the University of Texas Medical School at San Antonio in 1983. Dr. Hulman is a board certified physician for Alaska Kidney Consultants.

7. Richard Rome, MD Consulting Radiology, Teleradiology, and Fluoroscopy

Dr Richard S. Rome graduated from the Boston University School of Medicine in 1977. Dr Rome is a board certified radiologist at Laredo Medical Center in Texas.

8. Jeffrey Zuckerman, MD Locum Tenens Radiology

Dr. Jeffrey A. Zuckerman graduated from the University of Texas Medical School at San Antonio in 1989. Dr. Zuckerman is a board certified radiologist for Fairbanks Ultrasound.

LOCUM TENENS:

1. Emad K. Abdel-Fattah, MD Locum Tenens Pediatric and Pediatric Newborn)

Dr. Emad K. Abdel-Fattah graduated from the Aims Shams University Faculty of Medicine in 1977. Dr. Abdel-Fattah is a physician who is board certified pediatrician for Locum Tenens.com.

2. Fredrick L. Yost, MD Locum Tenens General Surgery, Lap Chole/Appendectomy, Sentinel Node Biopsy, Endoscopy, Colonoscopy, Parathyroidectomy, PEG, and Fluoroscopy

Dr. Fredrick L. Yost graduated from the John A. Burns School of Medicine in 1989. Dr. Yost is a board certified general surgeon who works at Queens Hospital in Hawaii.

PHYSICIAN ASSISTANT STUDENT:

1. **Robert Bidwell, PAS -** (University of Washington MEDEX Northwest; BRH Emergency Department; Evaluate and Treat Patients, History and Physical/Orders/Progress Notes (Co-Signed), Scrub and Assist in Minimally Invasive Procedures, and other Duties Under Direct Supervision of Sponsoring Physician Per BRH P&P 9500.105b)

PHYSICIAN ASSISTANT STUDENT (EXTENSION):

1. **Nathaniel Ruiz, PAS –** (Heritage University; John Raster, MD; Evaluate and Treat Patients, History and Physical/Orders/Progress Notes (Co-Signed), Scrub and Assist in Minimally Invasive Procedures and other Duties Under Direct Supervision of Sponsoring Physician Per BRH P&P 9500.105b)

MEDICAL STUDENT:

1. **Bryn Chowchuvech, MSIV -** (University of Washington SOM; Valley Medical Care; Evaluate and Treat Patients, History and Physical/Orders/Progress Notes (Co-Signed), Scrub and Assist in Minimally Invasive Procedures, Colonoscope, Including C-Section,/Vaginal Births, and other Duties Under Direct Supervision of Sponsoring Physician Per BRH P&P 9500.105b)
2. **Katherine Grette, MSIV -** (University of Washington SOM; BRH Emergency Department; Evaluate and Treat Patients, History and Physical/Orders/Progress Notes (Co-Signed), Scrub and Assist in Minimally Invasive Procedures, and other Duties Under Direct Supervision of Sponsoring Physician Per BRH P&P 9500.105b)
3. **Jennifer Nguyen, MSIV -** (University of Washington SOM; BRH Emergency Department; Evaluate and Treat Patients, History and Physical/Orders/Progress Notes (Co-Signed), Scrub and Assist in Minimally Invasive Procedures, and other Duties Under Direct Supervision of Sponsoring Physician Per BRH P&P 9500.105b)

Medical Staff\BOD\2016\2016 04 26 BOD Summary.doc

May 2016

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2 12:15 Executive Committee BR	3	4 5:15 Board Quality/QAPI reports BR	5 3:00 Compliance Committee BR	6 12:00 Governance/Bylaws Committee BR	7
8 Hospital Week	9 Hospital Week	10 7:00 Credentialing Committee BR Hospital Week	11 3:00 Hospital Quality Council BR Hospital Week	12 Hospital Week	13 Hospital Week	14 Hospital Week
15	16	17	18	19 5:15 Finance Committee BR	20	21
22	23	24 5:15 Board of Directors BR	25	26	27	28
29	30	31				

Executive Committee: Nancy Davis, Chair, Lauree Morton, Mary Borthwick, Bob Storer, SLT (public)
Joint Conference: Nancy Davis, Lauree Morton, Mary Borthwick, Bob Storer, SLT and Med/Exec (not public)
Planning Committee: Brenda Knapp, Chair, Mary Borthwick, Marshal Kendziorek, Lauree Morton, Nancy Davis (public)
Finance Committee: Linda Thomas, Chair, Mark Johnson, Bob Storer, Dr. Buley, Nancy Davis (public)