Bartlett Regional Hospital

BOARD OF DIRECTORS
December 19, 2013
6:00 p.m.
Administration Boardroom
Agenda

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

CALL TO ORDER

ROLL CALL

Public Participation

Approval of Minutes – November 26, 2013 (Pg. 2)

OLD BUSINESS:
ER Call Coverage Policy (action required)

STANDING COMMITTEE REPORTS
Executive Committee – Linda Thomas reports
Board Education Plan – Reed Reynolds presents (Pg. 7)
Finance Committee – Lauree Morton, reports
November Financials (recommend approval) (Pg. 8)
Planning Committee – Kristen Bomengen reports (Pg. 11)
Committee Charter development (recommend approval)
Quality Committee – Nancy Davis reports (Pg. 14)
A. 2014 Risk Management Plan (recommend approval) (Pg. 18)
B. 2014 Patient Safety/Quality Assessment/Performance Improvement Plan (recommend approval) (Pg. 24)

AD HOC COMMITTEE REPORTS
CEO Selection Committee – Kristen Bomengen reports (Pg. 44)
Bylaws Committee – Mary Borthwick reports
Nominating Committee – Mary Borthwick reports

COMMUNITY BOARD UPDATES
BRH Foundation – Kristen Bomengen reports
Rainforest Recovery Board – Lauree Morton reports

CEO report – Jeff Egbert reports
A. Physician Billing Agreement (recommend approval) (blue folder)
B. Remote Clinic Physician Agreements (6) (recommend approval) (blue folder)
C. Physician Employment Agreement (recommend approval) (blue folder)

Chief of Staff report – Ben Miller, DO reports (Pg. 45)

Board President's report – Linda Thomas reports

Executive session to discuss matters which are confidential by law and impact the finances of the hospital which include;

Legal Matter Update – Jeff Egbert reports (blue folder)

Compliance report - Jeff Egbert reports (blue folder)

New Business
A. January calendar (Pg. 47)
B. Annual Board calendar (Pg. 48)
C. Board Comments

Board of Directors meeting
November 26, 2013
Robert Valliant Center

Meeting called to order at 5:15 p.m.

Roll call

Linda Thomas, President
Alex Malter, M.D., Secretary
Kristen Bomengen (by phone)
Mary Borthwick
Nancy Davis (by phone)
Reed Reynolds, Vice President (by phone)
Bob Storer, Past President
Nate Peimann, M.D.
Lauree Morton

Public participation – Mark Smith, M.D., interim at SEARHC, told the Board that he is very interested in the permanent CEO position at BRH. Ms. Thomas thanked him for his interest.

Approval of the minutes – Mr. Storer made a MOTION to approve the minutes from October 21, 2013. Ms. Borthwick seconded and they were approved as presented.

Introductions: Ms. Thomas welcomed Jeff Egbert, Interim CEO, to the hospital. Mr. Egbert gave an overview of his background to the audience.

CEO report – Mr. Egbert said he is very impressed with our hospital and staff. He is working to regain some forward momentum on key projects that have been identified by the Board. He has been doing frequent rounding in the hospital, attending staff meetings as well as meeting with physicians and the leadership team on a bi-weekly basis. He has made himself available to everyone with an open door policy and has given out his cell phone number as well. The employee newsletter, “The Bartlett Buzz” has been reinstated.

Mr. Egbert announced Bartlett Regional Hospital Received a Press Ganey 2013 Success Story Award in Recognition of demonstrated leadership, implemented organizational change and improved performance in Clinical Quality. The award was received for work done in preventing blood clots among hospitalized patients. This award represents an important recognition from the industry’s leader in measuring, understanding and improving the patient experience.

Mr. Egbert gave a recommendation from the Administrative team for the EMR (electronic medical records system). He included some suggestions from the previous steering committee in the packet of pros and cons (see attached). He requested the Board give him permission to move in a direction to begin formulating an IT strategy for the organization. Then we would begin a process of engaging physicians and employees in meaningful ways so we can finalize a proposal and answer a lot of lingering questions that are out there.

Discussion:
Mr. Storer – It's less with what we choose and more of how we get there. With the final recommendation, he hopes it would include a project manager to define how this will be implemented. Mr. Egbert said that will be a key point in moving forward. There needs to be an evaluation on how many IT staff we will need and make sure our system is kept current.

Ms. Thomas said it seems like cost is the primary driver in choosing Meditech. Ms. Thomas asked if other systems that cost the same or less were considered and would we be looking at those at all in the next couple of months. She questioned whether the Board should designate just a specific dollar amount to move forward and leave it to Administration to determine the specific system recommendation.

Mr. Egbert said we have not recently looked at other systems, but when we started we evaluated 6 and worked down to 2 systems. Cerner was the first choice, but the cost was very high and the decision was made to cancel the contract and seek a more affordable system. He doesn't believe we should open it back up to all 6 and redo that work. BRH hasn't kept pace with the current Meditech Magic System, so it has rendered the product less productive. In the Fall of 2014 we will be able to re-attest for phase one compliance with meaningful use with it, but in 2015 we need to be able to attest to phase two compliance which has a lot more physician utilization of computerized order entry systems, etc. as well as some patient portal improvements and inter activity with physician's offices which we currently don't have. Mr. Egbert said this delayed decision may have worked to our benefit in that Meditech 6.0 that was analyzed by the committee a couple of years ago has now been improved and is now being installed in hospitals as version 6.1.

Dr. Peimann – He read Mr. Egbert's analysis, but drew a different conclusion. Meditech has changed a lot and is a valuable system and worth our time and effort to look at. It also recognizes that any system we pick right now is a 10-15 year commitment in moving forward. With that in mind, there's also the importance in looking at what other systems have changed since the hospital's last review, that would be in our price range and do they have similar or better opportunities for us as we look 10-15 years down the road. He's not suggesting that we start at ground zero. He understands the preference for Meditech. There also may be better systems that now rise to the top that didn't two years ago that we might not have considered. It may be worth a quick look, small drill down, is this something we should consider to bring back to the Board. He said we have opportunity to make a decision, but not in a rushed way so we get the best product for our dollars. He also supports the concept that Mr. Egbert is recommending. He wants to make sure we have the support to bridge to our providers that are using different systems.

Ms. Thomas asked what the time certain is at this point for the decision to be made by the Board on spending the money. Mr. Egbert said he could do what Dr. Peimann is asking by exploring some of the other systems doing a quick drill down concurrently while working seriously with Meditech,. If something rises to the top as an integrated system, then we will step back and formalize a deeper analysis. He would envision having something solid by way of an IT strategic plan with pricing from Meditech, etc., by our January meeting, having sat down with Meditech and our Medical Staff members in a meaningful way that we are taking this serious as a top contender system.

Ms. Thomas said she felt comfortable delegating the authority to Administration to actively move forward with the plan Mr. Egbert has suggested, concurrently looking at other systems that are reasonable costs and focusing on Meditech in the meetings with physicians, staff and Meditech.

Reports:
President's report – Ms. Thomas gave an overview from the Board training that was held on November 20th. She said it went really well. There were healthy discussions and she suggests doing this training again. The Board members that attended also felt it was very useful. Dr. Peimann said he felt selecting and partnering with your CEO was important. The second one was continue to develop your board and board governance. He said there were some opportunities for the Board to improve.

Ms. Thomas said one of the Board's most important job is to hire a permanent CEO to lead our organization. The members on this committee are Kristen Bomengen (Chair), Mary Borthwick and Alex Malter, M.D. Ms. Thomas asked Mila Cosgrove to provide the Board with an update on where the committee is at on this process. Ms. Cosgrove said they have reviewed various options in moving forward like whether or not to use a search firm or do this ourselves. Ms. Bomengen said their recommendation was to proceed ourselves through our HR Department, then to assess the responses. The committee put together a scheduled timeline for this process.

Ms. Thomas said we are coming up on the Assembly appointments to the Board. The HR meeting is next Thursday where they will be interviewing the candidates. Two of our current Board members will be going for their second term.

Ms. Thomas appointed the nominating committee to propose a slate of officers for 2014. Reed Reynolds and Mary Borthwick will serve on the committee. They will bring their recommendations to the December Board meeting.

Ms. Thomas mentioned Mr. Brough's resignation and wanted to thank him for his financial stewardship over the last year.

Executive Committee report – Ms. Thomas said there was discussion on the training and facilitator for the board education. Mr. Reynolds will be doing a presentation at the December Board meeting on the information he compiled for a two year cycle of Board education.

Planning Committee – Dr. Peimann said the On Call Committee met and they are happy to report that we have full orthopedic coverage for the remainder of the year while continuing discussions. Mr. Egbert is involved in discussions with pediatricians to cover pediatrics and NRP. Ms. Thomas said we had a deadline of December 31st for the policy regarding call coverage to become permanent if no recommendations were brought back from the Medical Staff. She asked Dr. Peimann if the medical staff would have a proposal by then. Dr. Peimann said he is not prepared to speculate, but he will try and get a proposal by then or have suggested revised language for the Board to consider.

Finance Committee report – Dr. Malter reports;

Dr. Malter reviewed the financial statement reports with the Board.

Dr. Malter made a MOTION to approve the financials. Ms. Borthwick seconded and they were approved.

Mr. Reynolds asked why, if our census is down, the staffing is up and our overhead premium is so high. Dr. Malter said his impression is that there has been a lot of training going on which has increased extra hours.

EHR- Mr. Egbert gave an update on this during his CEO report. Dr. Malter said the Finance Committee was comfortable with the discussion and recommendations that were made.

Medicaid Appeals update – Mr. Brough gave the Finance Committee an update on the Medicaid appeals and feels we got a fair deal with HSS on what we get for our rates and what gets included. It's several million dollars that we will be getting. Dr. Malter expressed his appreciation to Mr. Brough that it turned out so well. There needs to be authorization for the Board President to approve the Medicaid settlement that was approved by the Board.

Dr. Malter made a MOTION to approve the Medicaid Settlement agreement. Lauree Morton seconded and it was approved by a roll call vote.

Foundation update – Ms. Bomengen said the Foundation Board has undergone a lot of changes. They have decided not to do the Women's Expo in January, but it may occur later in the year. Mr. Egbert said the Foundation is sponsoring the annual tree lighting ceremony at the hospital on December 4th and Santa will be there passing toys out to kids.

Quality – Ms. Borthwick reminded the Board that there had been a suggestion at the Foraker workshop to change the agenda some. One of the things the Quality Committee discussed was that the Board should think about spending more time discussing the hospital's mission, quality patient centered care.

Joint Conference Committee – Ms. Thomas reports
The items discussed were the on call schedule, staff categories and essential services which all tie in together. They discussed the CEO recruitment and competencies in looking for the CEO. A lot of what arose was re-building trust with the medical staff. Also discussed, was JEMA is looking at doing their own coding and to see how to improve that along with billing. Dr. Malter said the Medical Staff is hopeful that we will put in a Hospitalist program by the summer to help fill in the call schedule gaps.

Strategic goals and objectives update – Ms. Thomas said we will be revisiting that in December to do a review and then hopefully in January to update the goals/strategies for the next three years.

Dr. Peimann said the Medical Staff Bylaws changes for staff categories was an item that was tabled for this meeting and it needs to be addressed.

Dr. Peimann made a MOTION to table the staff category change to a time when a revised bylaws staff categories change can be brought before the Board for reconsideration. Dr. Malter seconded the MOTION passed by roll call vote.

Discussion:
Dr. Malter said there isn't a mechanism how the medical staff changes get to the Board and we should figure out a process.

Dr. Malter made a MOTION to go into executive session at 6:20 p.m., to discuss personnel matters which are confidential by law and items that could impact the finances of the hospital. Ms. Borthwick seconded and it was approved.

The Board came out of executive session at 7:25 p.m.

Dr. Malter made a MOTION to direct Administration to continue working with AETNA to develop a preferred provider agreement that was discussed in executive session. Mr. Reynolds seconded the MOTION and it passed by a roll call vote.

Dr. Peimann asked if the intent was to enter into an agreement. Dr. Malter accepted that as a friendly amendment. Mr. Storer seconded and it passed by a roll call vote.

Ms. Davis made a MOTION to direct Administration to recognize the staff of BRH for the commitment to quality care and for the receipt of the Press Ganey Award for quality. Ms. Bomengen seconded the motion and it was approved by a roll call vote.

Dr. Miller presented the credentialing report. ***Dr. Peimann made a MOTION to approve the report as presented. Ms. Borthwick seconded the MOTION and it was approved.***

The December calendar was reviewed and there were changes made.

Board comments:
Dr. Peimann recognized BRH's participation in the Front Street Clinic discussions.

Ms. Thomas attended the Chamber of Commerce meeting where they spoke highly about the Oncology Clinic and of the hospital. There were businesses that offered to help with the flights and hotel rooms with Cancer Connection at this meeting. Ms. Thomas asked if the Bylaws will be coming to the Board in December for approval. Ms. Borthwick said yes.

Ms. Davis – She thanked Ken Brough for the information on our settlements for Medicaid appeals and appreciates pulling us through some complicated situations. She is excited to hear the media reports on Jeff Egbert have had a very positive tone. Also, several articles have been posted on Egnyte for the Board to read at their leisure.

Meeting adjourned at 7:48 p.m.

Options for Board Education

It has long been felt that a more structured orientation and continuing education program be developed and used by the Board. Some thoughts for the Board's consideration follow. It should be noted that strong administrative buy-in and support is absolutely required if any form of Board education is to have a significant impact.

Orientation: A two year orientation, given the general consensus that two years are required before a board member is fully prepared.

1st Year	Subject	Speaker	2nd Year	Subject	Speaker	Notes
Jan	Organizational chart	CEO	Jan	Regulations	CEO	
Feb	Financial statements	CFO	Feb	Efficiency, productivity	VM	
Mar	Committees	Bd president	Mar	Systems methodologies	VM	
Apr	CE – Full Board		Apr	CE – Full Board		
May	Financial ratios, revenue cycle	CFO	May	Information technology	CIO	
Jun	Medical Staff	Chief of Staff	Jun	Electronic health record	CIO	
Jul	BRH budgets – op, cap, labor	CFO	Jul	Legal considerations	Dick	
Aug	CE – Full Board		Aug	CE – Full Board		
Sep	Quality measures	Bethany	Sep	Health care industry	CEO	
Oct	Compliance	John	Oct	History and trends	CEO	
Nov	Clinical microsystems	CNO	Nov	Insurance	CEO	
Dec	CE – Full Board		Dec	CE – Full Board		

The plan shown above envisions monthly 1 to 1.5 hour presentations. Alternatives include 1) one three hour session each quarter, 2) one three hour session each month finishing the entire two year sequence in one year.

Speakers might be from the hospital, from local and/or state government, local and/or state organizations based in Juneau, experts brought in, or experts made available via Skype.

Where appropriate BRH examples would be used. Sessions could be enhanced with selected readings, routine reviews of current healthcare literature and from discussion of events occurring both nationally and in Alaska.

It might help to have a single person coordinate the entire educational program for a variety of reasons.

The national move towards board member certification should certainly be taken into consideration.

Continuing Education: Assuming an effective orientation program, continuing education could be operated three times per year during the months of Apr, Aug, Dec. CE would feature topics of current interest presented using one or more of the mechanisms listed above.

In addition the Board could consider joint attendance of a conference or workshop such as Estes Park every three years.

Bartlett Regional Hospital

Statement of Income November 2013

	Current Month	Budget	$ Variance	YTD	YTD Budget	$ Variance
INPATIENT REVENUE (Hospital)						
ROUTINE INPATIENT REVENUE	1,465,453	1,765,067	(299,614)	9,075,467	9,732,987	(657,520)
ANCILLARY INPATIENT REVENUE	1,593,636	1,961,018	(367,382)	11,278,645	10,729,846	548,799
TOTAL INPATIENT REVENUE (Hospital)	**3,059,089**	**3,726,085**	**(666,996)**	**20,354,112**	**20,462,833**	**(108,721)**
OUTPATIENT REVENUE	4,457,163	4,612,251	(155,088)	25,691,266	25,269,137	422,129
TOTAL PATIENT REVENUE (Hospital)	**7,516,252**	**8,338,336**	**(822,084)**	**46,045,378**	**45,731,970**	**313,408**
RRC REVENUE	372,697	390,453	(17,756)	1,898,746	1,849,400	49,346
PHYSICIAN REVENUE	1,045,105	1,103,278	(58,173)	6,232,307	6,177,096	55,211
TOTAL PATIENT REVENUE All Sources	**8,934,054**	**9,832,067**	**(898,013)**	**54,176,431**	**53,758,466**	**417,965**
OTHER REVENUE	300,406	163,735	136,671	1,041,335	886,622	154,713
TOTAL GROSS REVENUE	**9,234,460**	**9,995,802**	**(761,342)**	**55,217,766**	**54,645,088**	**572,678**
REVENUE DEDUCTIONS						
CONTRACTUAL	1,295,625	2,690,190	(1,394,565)	14,328,114	14,567,504	(239,390)
CHARITY CARE/BAD DEBT	701,601	917,092	(215,491)	4,217,905	4,966,089	(748,184)
TOTAL REVENUE DEDUCTIO	**(1,997,226)**	**(3,607,282)**	**1,610,056**	**(18,546,019)**	**(19,533,593)**	**987,574**
TOTAL NET REVENUE	**7,237,234**	**6,388,520**	**848,714**	**36,671,747**	**35,111,495**	**1,560,252**
OPERATING EXPENSES						
SALARIES & WAGES	2,851,658	2,585,360	266,298	14,337,809	13,881,208	456,601
BENEFITS	1,176,847	1,263,867	(87,020)	6,405,866	6,449,927	(44,061)
FEES-PHYSICIAN	447,277	450,296	(3,019)	2,510,930	2,513,802	(2,872)
FEES-OTHER	246,271	282,726	(36,455)	1,120,067	1,471,005	(350,938)
SUPPLIES	659,702	714,455	(54,753)	3,346,483	3,791,814	(445,331)
UTILITIES	187,117	172,840	14,277	792,644	866,846	(74,202)
REPAIRS & MAINTENANCE	141,376	255,976	(114,600)	853,328	1,336,495	(483,167)
LEASES & RENTALS	52,953	36,703	16,250	176,715	205,736	(29,021)
INSURANCE	45,045	56,183	(11,138)	238,754	290,175	(51,421)
INTEREST EXPENSE	160,955	101,914	59,041	806,148	509,585	296,563
OTHER EXPENSES	37,594	16,797	20,797	166,246	105,550	60,696
TOTAL OPERATING EXPENSES	**6,006,795**	**5,937,117**	**69,678**	**30,754,990**	**31,422,143**	**(667,153)**
DEPRECIATION & AMORTIZATION	590,180	548,154	42,026	2,986,147	2,794,686	191,461
TOTAL OPERATING COSTS	**6,596,975**	**6,485,271**	**111,704**	**33,741,137**	**34,216,829**	**(475,692)**
NET OPERATING INCOME	**640,259**	**(96,751)**	**737,010**	**2,930,610**	**894,666**	**2,035,944**
NON-OPER INCOME/EXPENSE						
INTEREST INCOME - GENERAL	5,694	5,689	5	37,364	30,807	6,557
OTHER INCOME	117,834	112,991	4,843	648,428	611,847	36,581
TOTAL NON-OPERATING	**123,528**	**118,680**	**4,848**	**685,792**	**642,654**	**43,138**
NET INCOME/LOSS	**763,787**	**21,929**	**741,858**	**3,616,402**	**1,537,320**	**2,079,082**

Bartlett Regional Hospital

Statement of Income November 2013

	Current Month	Prior Year Month	$ Variance	YTD	YTD Prior Year	$ Variance
INPATIENT REVENUE (Hospital)						
ROUTINE INPATIENT REVENUE	1,465,453	1,760,648	(295,195)	9,075,467	9,944,980	(869,513)
ANCILLARY INPATIENT REVENUE	1,593,636	1,817,728	(224,092)	11,278,645	9,955,460	1,323,185
TOTAL INPATIENT REVENUE (Hospital)	**3,059,089**	**3,578,376**	**(519,287)**	**20,354,112**	**19,900,440**	**453,672**
OUTPATIENT REVENUE	4,457,163	4,478,669	(21,506)	25,691,266	25,254,229	437,037
TOTAL PATIENT REVENUE (Hospital)	**7,516,252**	**8,057,045**	**(540,793)**	**46,045,378**	**45,154,669**	**890,709**
RRC REVENUE	372,697	370,940	1,757	1,898,746	1,852,134	46,612
PHYSICIAN REVENUE	1,045,105	993,298	51,807	6,232,307	6,390,081	(157,774)
TOTAL PATIENT REVENUE All Sources	**8,934,054**	**9,421,283**	**(487,229)**	**54,176,431**	**53,396,884**	**779,547**
OTHER REVENUE	300,406	185,924	114,482	1,041,335	957,771	83,564
TOTAL GROSS REVENUE	**9,234,460**	**9,607,207**	**(372,747)**	**55,217,766**	**54,354,655**	**863,111**
REVENUE DEDUCTIONS						
CONTRACTUAL	1,295,625	2,704,587	(1,408,961)	14,328,114	14,109,660	218,454
CHARITY CARE/BAD DEBT	701,601	708,308	(6,708)	4,217,905	5,163,302	(945,397)
TOTAL REVENUE DEDUCTIO	**(1,997,226)**	**(3,412,895)**	**1,415,669**	**(18,546,019)**	**(19,272,962)**	**726,943**
TOTAL NET REVENUE	**7,237,234**	**6,194,312**	**1,042,922**	**36,671,747**	**35,081,693**	**1,590,054**
OPERATING EXPENSES						
SALARIES & WAGES	2,851,658	2,605,533	246,125	14,337,809	14,093,607	244,202
BENEFITS	1,176,847	1,259,224	(82,377)	6,405,866	6,475,198	(69,332)
FEES-PHYSICIAN	447,277	436,606	10,671	2,510,930	2,359,113	151,817
FEES-OTHER	246,271	404,538	(158,267)	1,120,067	1,836,955	(716,888)
SUPPLIES	659,702	728,698	(68,996)	3,346,483	3,722,768	(376,285)
UTILITIES	187,117	174,348	12,769	792,644	818,042	(25,398)
REPAIRS & MAINTENANCE	141,376	182,589	(41,213)	853,328	1,024,255	(170,927)
LEASES & RENTALS	52,953	39,291	13,662	176,715	205,061	(28,346)
INSURANCE	45,045	48,130	(3,085)	238,754	273,685	(34,931)
INTEREST EXPENSE	160,955	105,455	55,500	806,148	527,407	278,741
OTHER EXPENSES	37,594	14,142	23,452	166,246	60,236	106,010
TOTAL OPERATING EXPENSES	**6,006,795**	**5,998,554**	**8,241**	**30,754,990**	**31,396,327**	**(641,337)**
DEPRECIATION & AMORTIZATION	590,180	587,015	3,165	2,986,147	2,943,822	42,325
TOTAL OPERATING COSTS	**6,596,975**	**6,585,569**	**11,405**	**33,741,137**	**34,340,150**	**(599,013)**
NET OPERATING INCOME	**640,259**	**(391,257)**	**1,031,516**	**2,930,610**	**741,544**	**2,189,066**
NON-OPER INCOME/EXPENSE						
INTEREST INCOME - GENERAL	5,694	19,580	(13,886)	37,364	18,711	18,653
OTHER INCOME	117,834	103,147	14,687	648,428	542,607	105,821
TOTAL NON-OPERATING	**123,528**	**122,727**	**801**	**685,792**	**561,319**	**124,474**
NET INCOME/LOSS	**763,787**	**(268,530)**	**1,032,317**	**3,616,402**	**1,302,862**	**2,313,540**

Bartlett Regional Hospital

Balance Sheet for Nov 2013

	Beginning of Month	End of Month	$ Change Month	Beginning of Year	End of Month	$ Change YTD
Current Assets:						
Operating Cash	19,301,515	19,081,464	(220,051)	17,136,608	19,081,464	1,944,856
Board Designated Cash	15,312,514	15,255,253	(57,261)	8,871,900	15,255,253	6,383,353
Net Accounts Receivable	18,495,293	18,281,744	(213,549)	21,002,045	18,281,744	(2,720,301)
Other Current Assets	1,999,212	2,621,058	621,847	2,829,365	2,621,058	(208,307)
Total Current Assets	55,108,534	55,239,520	130,986	49,839,918	55,239,520	5,399,602
Appropriated Cash	5,484,920	5,484,920	-	5,899,453	5,484,920	(414,533)
Fixed Assets:						
Plant, Prop, Equip.	71,822,567	71,279,845	(542,722)	64,107,782	71,279,845	7,172,063
CIP	3,120,629	3,197,751	77,121	13,026,435	3,197,751	(9,828,685)
Total Assets	135,536,650	135,202,035	(334,615)	132,873,588	135,202,035	2,328,447
Current Liabilities:						
Accounts Payable	1,564,167	1,752,915	188,748	2,694,555	1,752,915	(941,640)
Payroll and Related Liabilites	4,337,007	3,144,794	(1,192,214)	3,492,163	3,144,794	(347,369)
Other Current Liabilities	1,783,823	1,710,045	(73,777)	1,970,941	1,710,045	(260,896)
Total Current Liabilities	7,684,997	6,607,753	(1,077,243)	8,157,658	6,607,753	(1,549,905)
Long Term Liabilities:						
Bonds	25,468,864	25,447,705	(21,159)	26,393,579	25,447,705	(945,874)
Total Long Term Liabilities	25,468,864	25,447,705	(21,159)	26,393,579	25,447,705	(945,874)
Total Liabilities	33,153,860	32,055,458	(1,098,402)	34,551,238	32,055,458	(2,495,779)
Total Fund Balance	102,382,790	103,146,577	763,787	98,322,351	103,146,577	4,824,226
Total Liabilities and Equity	135,536,650	135,202,035	(334,615)	132,873,588	135,202,035	2,328,447

Bartlett Regional Hospital

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

Planning Committee
December 12, 2013
Minutes

Board member attendance: Nate Peimann, MD, Nancy Davis and Kristen Bomengen

Staff attendance: Jeff Egbert, Interim CEO, Ken Brough, CFO, Billy Gardner, CNO

Approval of Minutes – Ms. Davis made a **MOTION** to approve the minutes from the October 10, 2013 regular meeting. Ms. Bomengen seconded. The minutes were approved with the following changes to the last paragraph: Mr. Reynolds made a recommendation **for full Board consideration** to approve two RFP's for an adult hospitalist and an adult/peds hospitalist.

Board Committee Charter Development – Mr. Egbert recommended that each Board Committee develop and forward to the Board for approval, a job description in the form of a Committee Charter. The purpose is to assist in hardwiring consistent and predictable processes between the Board, Board Committees, and Administration. Each Committee will need to determine the following:

1. Scope of responsibility
2. Committee job description/charter
3. Annual work plan

Once outlined, future Committee members and Administration will be able to refer to these documents in developing the annual work plans and performance expectations on ongoing basis.

Mr. Egbert obtained sample committee charters from the www.GreatBoards.org website, which provided basic objectives for each committee. This information will be shared with members of the Board to consider when reviewing the job descriptions of each Committee.

Mr. Egbert reported that it would be of benefit for the organization to review and revise it's 3-5 year strategic plan. He feels it is crucial to have a current one in place as a living document reviewed and updated annually as it serves to provide direction and context to the work of the organization. The longer range strategic plan had been discussed by previous Administration under Quorum management, however has not been kept adequately updated. Strategic plans outline a path for items that impact our organization over a longer time horizon of a three to five year period. In the interest of time as well as limited availability of hospital resources, Mr. Egbert will be requesting authorization to utilize outside resources to assist with developing some of the more specialized components of our strategic plan such as the 3-5 year Information Management (EMR) Plan.

Ms. Davis reported that she is a strong supporter of a "committee charter system", which ensures consistency for both Administration and Committees in the event there are changes in leadership or committee membership. Using this method provides a great tool which would be useful to incorporate into our current Board Manual which is currently being reviewed for revision and updating.

Ms. Bomengen made a **MOTION** to inform the Board that the Planning Committee will develop a charter for the Planning Committee and recommend that all other Committees consider developing a charter as well. Ms. Davis seconded. **MOTION** unanimously approved.

Ms. Bomengen reported that CBJ ordinance states that we must have a Maintenance and Building Committee. It does not mention a Planning Committee. This is one example of an item the Planning Committee will address in its charter, meeting the CBJ ordinance requirement.

Dr. Nate Peimann proposed to work with Mr. Egbert to develop a Planning Committee Charter for review at the January 2014 Planning Committee meeting. Committee members are welcome to e-mail their ideas to be considered for the charter.

Mr. Egbert explained that responsibilities are delegated to the Board Committees who then report back to the Board for action. The only committee authorized to act on behalf of the Board is the Executive Committee which reports its actions to the full Board for ratification at its next regularly scheduled meeting. The committees will conduct research and perform the due diligence required to make informed recommendations to the Board for approval. Having this process

codified is the first step in evolving toward an effective utilization of the consent agenda and streamlining Board meetings.

Strategic Goals – Dr. Nate Peimann pointed out that item two of the strategic goals says that a three year strategic plan with prioritized annual goals had been completed and approved by the Planning Committee and the Board. This is incorrect as it should say it is in process, full 5 year strategic plan to be developed. He also feels that the CEO performance review should be completed by the Executive Committee.

Continuing Board Education should be listed as in progress, nearly complete. Reed Reynolds will give an update on his 2 year plan for this at next week's board meeting.

Review of Governance Model was assumed to refer to Board Member Mr. Reynolds's assessment of Board Member skills with recommendations to the Assembly for future Board Member selection.

Board education and development is being developed by Mr. Reynolds out of the Executive Committee.

Dr. Nate Peimann feels that exploring swing beds, CAMHU and partnering with SEARHC should be delegated to Administration to be evaluated and if viable brought back to Planning to include in the Strategic Plan and priority setting processes.

Mr. Egbert emphasized that the MAP list of goals for 2014 needs to be more focused and in line with the developing long range strategic plan. Priorities out to be limited to 3 or 4 goals in each area listed. We need consider in our 3-5 year plan, a breakdown of initiatives that will strengthen our key service line offerings.

Meeting adjourned.

Bartlett Regional Hospital

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

Board QA Committee
Minutes
Friday, December 6, 2013 1200-1330

Called to order: at 1205 by N. Davis
Present: N. Davis (BOD), K. Bomengen (BOD), B. Gardner (CNO), J. Egbert (CEO), K. Brough (CFO), B. Rogers (QM), T. Duncan (QM)
Excused/Absent: M. Borthwick (BOD – excused); N. Peimann (BOD)
Minutes: October 30, 2013 minutes approved

ITEM	DISCUSSION / ACTIVITY	ACTION / RECOMMENDATION	RESPONSIBILTY
NEW BUSINESS			
Quality Components for Upcoming Strategic Plan	Group discussed potential strategic goals for next year. Many goals already existing are still in progress, and would need to continue on to next year's strategic plan. Kristen discussed how valuable attending the HQIC meetings has been for her in helping to understand and appreciate the BRH Quality structure and operations. Bethany mentioned that other Board members have made similar comments. Kirsten recommended considering a rotation through HQIC for all Board members, perhaps a requirement to attend one meeting per year. Jeff discussed the potential for streamlining the current Quality structure, including combining meetings and reports so that they do not need to be provided multiple different times in multiple different ways each month. He would like to see the Quality process become more engaging for Board members, physicians, and staff.	***Jeff and Bethany*** to meet and design a recommendation for a strategic goal for streamlining the BRH Quality structure.	**J. Egbert, B. Rogers**
OLD BUSINESS			
a. Quality Recognition and Promotion Discussion **1. CEO Thank You Notes**	Bethany informed the Committee of Dr. Mimi Benjamin's invitation to participate with The Joint Commission's Center for Transforming Healthcare program at a national quality summit in January, related to BRH's participation in a physician-to-physician handoff improvement project. Jeff briefly discussed the new iteration of the *Bartlett Buzz* newsletter, and highlighted positive patient experiences in the ED and outpatient clinics. Ideas discussed for recognizing quality efforts and performance, including presentations by staff/departments in a larger forum with broader attendance than the QA Committee.	Discussion.	
2. IHI *Boards on Board* Program	Nancy discussed the IHI *Boards on Board* Program's emphasis on Quality having equity in agenda time for Board meetings, compared to other topics such as Finance. Ken described his experience at a previous facility where this standard was strictly enforced, and the positive impact this had on		

	operations. Jeff contends that a more streamlined quality structure would help create intrinsic motivation for Board members to engage in quality.		**B. Rogers**
b. 2014 PI and RM Plans for Approval	The redline versions of the Plans were emailed out to Committee members for review in October. One minor change was recommended to the RM plan, adding "Board Quality Committee" to the Communication plan.	***Bethany*** to make the change to the RM plan, and forward clean versions of the two plans, and an executive summary, to Toni for distribution to the full Board prior to the Board meeting. ***Motion passed to forward the 2014 PI and RM Plans to the full board with recommendations to approve.*** This should be included on the Consent Agenda.	
STANDING REPORTS			
Quality Operations and Structure		Informational.	
1. Physician Quality	Bethany reported that our vendor, Press Ganey, is sunsetting its OPPE product as of Jan. 31, 2014. She is working with the MSQIC to identify a recommendation for a new vendor. FPPE processes continue to function well, and no complaints about physicians have risen to the level of requiring referral to the Physician Wellness Committee in 6-8 months.		
2. Clinical Microsystems	Intensive Microsystems training and projects are temporarily on hold while half of the facility PI Coordinator position is on maternity leave and the other half of the position is posted and awaiting applicants. In the meantime, the Quality department is conducting organization-wide PI work as needed related to identified Risk Management, Regulatory, Patient Satisfaction, or other needs.		
3. HQIC	Bethany updated the Committee on recent department-level QAPI projects reported to HQIC in the past 6 months (for a complete list, see slides). Jeff reiterated the value in streamlining quality reporting, so that the Board members could enjoy greater detail on these "good news" reports. Bethany discussed efforts on improving patient safety and the environment of care, as well as trends in patient complaints (billing, ED) and occurrence reports (inpatient falls).		
Quality Outcomes Measures			
1. Patient Satisfaction	Bethany reviewed 3Q 2013 results for patient satisfaction, particularly HCAHPS scores. Scores decreased in all domains, excepting Care Transitions. This is a very atypical result, and requires further drill-down to identify the cause. The Committee members speculated on several potential reasons		

	for the change. A change in a single quarter does not constitute a trend, and should not be construed as such. One domain where a trend was noted was in Responsiveness of Hospital Staff, where scores have steadily declined over the past 12 months. This, in concert with an increasing inpatient Fall rate, have prompted a special review and Falls Team, which includes Bethany, Billy, Liz Bishop (M/S Manager), and Sara Parker (Risk Manager).		
2. 2x2 Mortality Matrix	The Mortality Matrix was reset for the new Fiscal Year, so the dashboard contains 1 quarter's worth of data. We had 7 non-CCU comfort care deaths, and two deaths that occurred in the CCU and not on comfort care. Both non-comfort care deaths will be reviewed through the usual peer review process.	***Bethany*** to inform the Committee if the pending reviews of the two non-comfort care deaths identify any issues of concern.	**B. Rogers**
OTHER DISCUSSION			
None.	None.	None.	
ADJOURNMENT			
Next Meeting: *January 15, 2014 1200-1300*		Submitted by: Bethany Rogers, QM	
Abbreviations Used: *BOD – Board of Directors; QA – Quality Assurance; QM – Quality Management; ED – Emergency Department; IHI – Institute for Healthcare Improvement; FY – Fiscal Year; PI – Process Improvement; RM – Risk Management; QAPI – Quality Assessment / Performance Improvement; HQIC – Hospital Quality Improvement Committee; OPPE – Ongoing Professional Practice Evaluation; FPPE – Focused Professional Practice Evaluation; MSQIC – Medical Staff Quality Improvement Committee; HCAHPS – Healthcare Consumer Assessment of Hospital Providers and Systems; M/S – Medical Surgical Unit; CCU – Critical Care Unit*			

Executive Summary of Changes to Annual Plans
CY 2014

Performance Improvement Plan:

- **Substantive Changes:**
  - Pg. 11 – Methodology:
    - Description of, and references to, "Clinical Microsystems" changed to "Bartlett Microsystems"
    - Outline of Bartlett Microsystems structure revised to reflect simplified, more accessible version of improvement methodology to better fit organization (methodology is fundamentally unchanged, but titles and process steps are streamlined and simplified)
- **Non-substantive Changes** (throughout document)**:**
  - Grammar, punctuation
  - Changes to position titles to reflect current naming conventions
  - References to medical staff "department(s)" changed to "service line(s)"

Risk Management Plan:

- **Substantive Changes:**
  - Pg. 6 – Communication:
    - "Board reports" changed to "Board and/or Board Quality Committee reports"
- **Non-substantive Changes** (throughout document)**:**
  - Grammar, punctuation
  - Changes to position titles to reflect current naming conventions
  - References to medical staff "department(s)" changed to "service line(s)"

Bartlett Regional Hospital
RISK MANAGEMENT PLAN
CY 2014

Issued:	July 1, 2010
Revised:	August 2013
Submitted by:	Bethany Rogers, RN, CPHQ, Quality Director

AUTHORITY AND RESPONSIBILITY

Board of Directors

The Board of Directors of Bartlett Regional Hospital (BRH) supports the Risk Management Program in order to minimize risks to patients, employees and visitors. The Board of Directors has the final authority and responsibility for the program, but delegates the authority and accountability for the operation of the program to the Administrative and Medical Staff of BRH. It authorizes and supports the establishment of the Environment of Care Committee and appoints, through the Chief Executive Officer, a Director of Quality. The Director of Quality is responsible for the Regulatory / Risk Manager and the Risk Management program. The Board of Directors receives and reviews reports through the performance improvement structure, summarizing the findings of the Risk Management Program via the Hospital Quality Improvement Committee (HQIC), the Environment of Care (EOC) Committee, and reports by the Director of Quality. The Board of Directors designates the Director of Quality and the Regulatory / Risk Manager to function as the Grievance Committee for complaint processing.

Risk Management

The Director of Quality acts as a designee of the Chief Executive Officer, and has the responsibility for monitoring, coordinating, planning, and implementing all loss prevention activities and programs that have as their goal a safe environment for patients, employees, and visitors to the hospital. Trending and tracking of potential problems are included in this responsibility as well as the integration of information with the HQIC and the EOC Committee.

Medical Staff

The Medical Staff actively participates in peer review via the identification of potential risk in clinical areas that represent a significant source of actual or potential patient injury. This is achieved through clinical criteria approved by the Medical Staff to identify specific cases with potential risk in the clinical aspects of patient care and safety.

PURPOSE AND PHILOSOHY

The purpose of the BRH Risk Management process is to support the mission and vision by ensuring the delivery of safe, quality patient care, as defined by the patients we serve, the physicians who practice here, and regional and professional standards.

The philosophy of the Risk Management process is implementation of an effective and continual program to measure, assess and improve performance.

Through examination and improvement in culture and process, we believe we can enhance our organization's mission, improve the quality of patient care provided, and enhance customer satisfaction.

BRH aligns the organizational strategies and departmental risk management activities, allowing individuals to align their own personal work habits and goals to support these key strategic processes.

To achieve our vision, we believe we must focus on two basic levels in the organization: culture and process improvement. We recognize that organizational culture is the system supporting the environment of care delivered to our patients, and must be championed by all leaders to be successfully embraced by employees. We further recognize that process improvement contributes to quality patient care by improving the methodologies of work. Through examination and improvement in culture and process, we believe we can enhance our organization's mission, improve the quality of patient care provided, and enhance customer satisfaction.

GOALS AND INITIATIVES

The goal of the Risk Management plan at BRH is to identify, evaluate and alleviate practices and/or situations that pose harm to patients, visitors and staff. Risk management will promote a "culture of safety" without blame, to protect patients, visitors, and staff from avoidable harm.

The Organizational Risk Management initiatives include:

- Identifying and prioritizing key processes that promote optimum outcomes.

- Aligning medical staff risk management activities with those of BRH and working collaboratively to integrate efforts.

- Improving patient safety and minimizing risk factors that may contribute to unanticipated outcomes.

SCOPE

Risk Management is a systematic process of identifying, evaluating and alleviating practices and/or situations that pose harm to patients, visitors and staff of BRH. The Board of Directors of Bartlett Regional Hospital recognizes the importance of a Risk Management Program and provides resources and support to prevent such events that may result in injury to patients, staff, or visitors as well as property damage, loss, or damage to the facility's reputation.

The risk management plan is designed to protect the assets and revenue from a single loss or an accumulation of losses that could significantly affect its financial stability. Emphasis is placed on advocating the exercise of loss prevention strategies intended to preserve the resources of Bartlett Regional Hospital and its professional staff from loss attributed to professional liability.

The Risk and Quality Management activities at BRH are mutually compatible and interdepartmental and are part of the organization's performance improvement system. BRH's Risk Management Program is designed to comply with all federal and state regulatory requirements. Resources are provided to the Quality and Risk Management Department via the Regulatory / Risk Manager and the Director of Quality.

Access to healthcare services at BRH is delivered through an integrated continuum of health and wellness programs, acute care, and ambulatory care. Bartlett Regional Hospital delivers patient care in a variety of settings across the continuum to fulfill the mission, vision and core values of BRH. All relevant individuals, professions, and departments are involved in planning and designing improvement activities. Everyone is accountable for risk management processes.

STRUCTURE

Risk management activities are established by BRH leaders, based on needs assessment, as guided by the mission, vision, and core values, and defined by strategic and operational plans, budgets, resource allocation, and standards.

Board of Directors

The Board of Directors of Bartlett Regional Hospital bears the ultimate responsibility for assuring the quality and effectiveness of the patient care services provided by the medical staff and other professional and support staff. The Leaders set expectations, direct, and support BRH governance and management activities.

Senior Leadership Team (SLT):

The SLT, comprised of the Chief Executive Officer, Chief Financial Officer, Chief Nursing Officer, and Director of Human Resources, ensures that an integrated patient safety program is operationalized, and assumes responsibility for the overall strategic direction and integration of all Risk Management activities. It is the responsibility of the SLT to set expectations, plan, assess, measure and contribute to the general management of the quality process, and provide the communication and education link between the internal quality activities and the

Board of Directors. The SLT is responsible to assure that key strategies and/or processes of the organization are identified and prioritized, and that the efforts of Risk Management support and integrate the strategic objectives of the organization and feedback from all community and hospital connections. Resources are allocated as needed for performance improvement, patient safety, and infection control.

Departments

Individual departments are responsible for quality management and risk management activities within their departments relative to the services they provide. Progress on departmental risk management activities are submitted in writing when warranted to the Director of Quality, and for review at HQIC. Departments, as required by regulatory agencies, will monitor quality control data.

RISK MANAGEMENT PROCESS

Successful Risk Management activities begin at the strategic planning stage. Leaders place priority on monitoring and improving high volume, high risk, and problem prone processes. Emergent needs, such as sentinel events, problems identified through data collection and assessment, changes in environment of care or community, changes in regulatory requirements, and/or significant changes in patient matters, and/or increased evidence of medical/legal matters, also influence the process of prioritizing risk management activities.

METHODS

The science of Risk Management is dependent on local standards of care for informed decision making. The hospital dashboards are used to display internal data over time and provide comparisons with benchmarks, targets and goals. Control charts and local standards of care are used to determine clinical significance and clinical experts are expected to identify significant patterns and/or trends. Risk Management methodologies include:

1. Electronic filing and review of occurrences house wide
2. Review of patient complaints and grievances
3. Participation in active litigation processes
4. Process improvement based on mitigation of identified risks
5. Review of quality or trends of certain activities
6. Customer satisfaction surveys and patient suggestions
7. Customer complaints
8. Internal employee opinion surveys
9. Comparative data from other facilities and/or data bases
10. Internal and external benchmarking activities

11. Sentinel events, near misses, or trends from quality assessment activities
12. Current literature and best practice guidelines
13. Medical record, patient complaints, and quality data in various studies

COMMUNICATION

Communication of risk management outcomes to all levels of BRH is vital. Conclusions, recommendations, and actions are communicated to leadership, and/or individuals responsible for implementing and coordinating improvements through various presentations or reports. Examples of meetings where relevant information may be reported include:

1. Medical Staff Service Line meetings
2. Individual Department Staff meetings (when appropriate)
3. Board and/or Board Quality Committee reports
4. Management Team meeting

An annual review and revision of the risk management plan and objectives are provided to HQIC and forwarded to SLT and the Board of Directors.

PATIENT SAFETY / QUALITY ASSESSMENT / PERFORMANCE IMPROVEMENT PLAN

CY 2014

Issued: August 2010
Revised: August 2013
Submitted by: Bethany Rogers, RN, CPHQ

PURPOSE

The purpose of the Patient Safety / Quality Assessment / Performance Improvement Plan for Bartlett Regional Hospital (BRH) is to ensure that the governing body, medical staff, and professional service staff consistently endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal, controllable risk. The plan allows for a systematic, coordinated, continual data-driven approach to improving performance, focusing upon the processes and mechanisms that address these values.

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple hospital departments and disciplines in establishing plans, processes, and mechanisms that comprise performance improvement activities at BRH. The Plan is established by the medical staff and Hospital Quality Improvement Council (HQIC), and is supported and approved by the governing body, which has the responsibility of monitoring all aspects of patient care and services (including contracted services) from the time of the patient's initial participation with any of the services provided by BRH, including diagnosis, treatment, recovery and discharge activities. These activities are monitored in order to identify and resolve any breakdowns that may result in suboptimal patient care and safety, while striving to continually improve and facilitate positive patient outcomes.

This Plan describes key hospital and medical staff performance improvement activities and delineates the respective roles and responsibilities of the Board of Directors, the medical staff, and hospital leadership in developing, implementing, evaluating and coordinating a comprehensive plan. The Plan promotes high-quality patient care, the safety of patients, visitors, physicians, and employees, and aims to continually improve processes and services with the goal of improving patient outcomes.

GOALS & OBJECTIVES

The primary goals of the Plan are to continually and systematically plan, design, measure, assess, and improve performance of critical focus areas, improve healthcare outcomes, and reduce and prevent medical / health care errors. To achieve these goals, the Plan strives to:

- Incorporate quality planning throughout the organization;
- Provide a systematic mechanism for the organization's appropriate individuals, departments, and professions to function collaboratively in their efforts toward performance improvement, providing feedback and learning throughout the organization;
- Provide for an organization-wide program that assures the organization designs processes well (with special emphasis on design of new, or revisions in established, services), and systematically measures, assesses,

and improves its performance to achieve optimal patient health outcomes using a collaborative, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others. Process design contains the following focus elements:

- Consistency with the organization's mission, vision, values, goals, objectives, and plans
- Meets the needs of individuals served, staff and others
- Use of clinically sound and current data sources (e.g. practice guidelines, relevant literature and clinical standards)
- Is based upon sound business practices
- Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this institution
- Utilizes the results of performance improvement, patient safety and risk reduction activities
- Assures that the improvement process is organization-wide, monitoring, assessing and evaluating the quality and appropriateness of patient care, patient safety practices and clinical performance to resolve identified problems and improve performance.
- Appropriately reports information to the Governing Board, providing leaders with the information needed to ensure quality patient care and safety.
- Communicates necessary information among departments and services when problems or opportunities to improve patient care and patient safety practices involve multiple departments/services.
- Tracks identified problems and action plans to ensure improvement or problem resolution.
- Uses information from departments/services and the findings of discrete performance improvement activities and adverse patient events to detect trends, patterns of performance, or potential problems that affect multiple departments/services.

- Annually evaluates the objectives, scope, and organization of the improvement program; evaluates mechanisms for reviewing the effectiveness of monitoring, assessment, and problem-solving activities in the performance improvement program; revises as necessary.

The organization incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions or services.

PATIENT SAFETY

We are focused on the dignity of persons we serve. The Patient Safety Program is designed to improve patient safety, reduce risk, and respect the dignity of those we serve by promoting a safe environment. We recognize that effective medical / health care error reduction requires an integrated and coordinated approach. Our plan relates specifically to a systematic hospital-wide program to minimize physical injury, accidents, and undue psychological stress during hospitalization. The organization-wide safety program will include all activities contributing to the maintenance and improvement of patient safety.

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering this environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical / health care errors; and integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about medical / health care errors
- Incorporate recognition of patient safety as an integral job responsibility
- Provide education on patient safety in job-specific competencies
- Encourage recognition and reporting of medical / health care errors and risks to patient safety without judgment or placement of blame
- Involve patients in decisions about their health care and promote open communication about medical errors / consequences which occur
- Collect and analyze data, evaluate care processes for opportunities to reduce risk, and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Support knowledge transfer to effect behavioral changes within our facility by sharing of information.

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

- No Harm – an act, either of omission or commission, either intended or unintended, or an act that does not adversely affect patients
- Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome
- Hazardous Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Focused Review (Near Miss / Hit) – any process variation for which a recurrence carries a significant chance of a serious adverse outcome
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of life, limb, or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome resulting in the former

The responsibilities of the Director of Quality include compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of this Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and timely response to reports concerning workplace conditions.

1. Discussion with the patient/family/caregivers regarding adverse outcomes:
   a. Sentinel Events impacting the patient's clinical condition – The Director of Quality notifies the care-giving physician about informing the patient / family / caregivers in a timely fashion (within 48-72 hours). Should the care-giving physician refuse or decline communication with the patient / family / caregivers, the Chief of Staff is notified by the Director of Quality. The patient / family / caregivers are not contacted without the notification of the care-giving physician involved.
   b. Events not impacting the patient clinical condition, but causing a delay or inconvenience – The Director of Quality or the Chief Nursing Officer

determine the need for communication with the patient / family / caregiver in the interest of patient satisfaction.

2. Components of the organization are integrated through a collaborative effort of multiple disciplines. This is accomplished by:
   a. Reporting of potential or actual occurrences through the Occurrence Reporting system by any employee in every department.
   b. Communication between the Director of Quality and the Facilities Safety Officer (FSO) to assure a comprehensive knowledge of not only clinical, but also environmental, factors involved in providing an overall safe environment.
   c. Reporting of patient safety and operational safety measurements / activity to the performance improvement oversight group, the Hospital Quality Improvement Committee (HQIC).

3. The mechanism for identification and reporting a Sentinel Event / other medical error is indicated in policies, (Sentinel Event Policy, 9420.002 and Occurrence Reporting Policy, 9420.008). A root cause analysis of processes, conducted on either a Sentinel Event or Focus Review, are discussed with the Senior Leadership Team and the Medical Staff Quality Improvement Committee, as appropriate.

4. In support of our core values and belief in the concept that errors occur chiefly due to a breakdown in systems and processes, staff involved in an event with an adverse outcome are supported by:
   a. A non-punitive approach and without fear of reprisal,
   b. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
   c. Resources such as EAP, or Union representation if the need to counsel the staff is required

5. Patient safety measures are a focus of our activities and may include review of adverse drug events, health care acquired infections, “never” events, CMS No Pay events, and other data and incidents. This may be based on information published by TJC Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient / family suggestions / expectations, or process outcomes.

6. Processes are assessed to determine the steps when there is or may be undesirable variation (failure modes). Information from internal or external sources is used to minimize risk to patients affected by the new or redesigned process.

7. The procedures for immediate response to medical/health care error are as follows:
    a. Staff obtain required orders to support the patient's clinical condition.
    b. Significant adverse events:
        i. Staff immediately report the event to the supervisor (either the nursing directors or the house supervisor if the event occurs during off-hours).
        ii. The supervisor immediately communicates the event to the Director of Quality or the Regulatory / Risk Manager to initiate investigation and follow-up actions.
        iii. Staff complete the Occurrence Report to preserve information.
        iv. The FSO is notified by the Director of Quality of any situations of potential environmental risk to others.
        v. The Director of Quality or Regulatory / Risk Manager follows usual protocols to investigate the error and coordinate the factual information / investigation for presentation, review and action by the RCA Team.

8. Solicitation of input and participation from patients and families in improving patient safety are accomplished by:
    a. Conversations with patients and families from nursing director or administrative rounds
    b. Comments from Patient Satisfaction surveys, patient feedback forms, telephone or in-person conversations, or letters
    c. Presentations to the Board of Directors' Quality Committee by patients and/or families
    d. Comments from patient Complaints or Grievances

9. Procedures used in communicating with families the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:
    a. Patient's Rights statements
    b. Patient Responsibilities—A list of patient responsibilities are included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.
    c. Evaluating informational barriers to effective communication among caregivers.

10. Methods to assure in-services, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:
    a. Providing information and reporting mechanisms to new staff in orientation training.

b. Providing ongoing education, including reporting mechanisms.
c. Evaluating staff's willingness to report medical errors.

11. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:
    a. The minutes / reports of the HQIC are submitted to the Medical Staff Executive Committee and Board of Directors.
    b. These monthly reports will include ongoing activities including data collection presented in various ways, which may include statistical process control charts, analysis, actions taken, and monitoring for the effectiveness of actions.
    c. Regular written / verbal report of significant HQIC activities to the Board Quality Committee.

12. External Reporting
    a. A high-risk or error-prone process is selected for concentrated activity, ongoing measurement and periodic analysis via a Failure Mode Effects Analysis (FMEA) every 18 months.
    b. External reporting is completed in accordance with all state, federal, and regulatory body rules, regulations and requirements.

13. The Director of Quality or Regulatory / Risk Manager submits reports to the HQIC and Board of Directors, which may include:
    a. Definition of the scope of occurrences including sentinel events, focused reviews and serious occurrences
    b. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
    c. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.

ACTIVITIES

The scope of the organizational plan includes an overall assessment of the efficacy of performance improvement activities, with a focus on continually improving care provided and patient safety practices conducted throughout the organization.

The program consists of these focus components:

- Performance improvement,
- Patient safety,
- Quality assessment and improvement,
- Quality control activities.

Collaborative and specific indicators of both processes and outcomes of care are designed, measured and assessed by all appropriate departments / services and disciplines in an effort to improve patient safety and organizational performance. These

indicators are objective, measurable, based on up-to-date knowledge and experience, and are structured to produce statistically valid, data-driven, performance measures of care or processes. This mechanism also provides for evaluation of improvements and the stability of these improvements over time.

- The scope of the organizational performance improvement program includes performance of the following medical staff and organizational functions:
    - The monitoring, assessment and evaluation of patient care and the clinical performance of all individuals with clinical privileges.

- At routine meetings of the medical staff committees, these services will be reviewed, assessed and evaluated:
    - Operative / Invasive Procedure Monitoring
    - Medication Management
    - Information Management Function
    - Blood and Blood Product Use
    - Pharmacy and Therapeutics Function
    - Mortality Review
    - Risk Management
    - Infection Control
    - Utilization Management
    - Other processes as determined by the individual committee
    - Patient care and quality control activities in all clinical areas are monitored, assessed, and evaluated
    - Assessment of the performance of the patient care and organizational functions are included.

- Relevant findings from performance improvement activities performed are considered part of:
    - Reappraisal / reappointment of medical staff members, and
    - The renewal or revision of the clinical privileges.

ORGANIZATION

To achieve fulfillment of the objectives, goals and scope of the Organizational PI Plan, the organizational structure of the program is designed to facilitate an effective system of monitoring, assessment and evaluation of the care and services provided throughout the organization.

The Board of Directors is responsible for establishing, maintaining, and supporting an ongoing quality improvement program. This responsibility is carried out by the organization’s administration, the medical staff, nursing, and organizational support services. The organization's leaders set expectations, develop plans, and implement procedures to assess and improve the quality of the organization's governance, management, clinical, and support processes. The organization's leaders include members of the Board of Directors, the Senior Leadership Team, and the Executive

Committee of the Medical Staff.

With authority delegated by the Board of Directors, the medical staff and the organization's administration strives to improve and assure the provision of quality patient care through the monitoring, assessment and evaluation of performance measurements and outcomes.

The medical staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important issues in patient care or safety are identified and resolved.

The Medical Staff Executive Committee and the HQIC provide the oversight responsibility for performance improvement activity monitoring, assessment and evaluation of patient care services provided throughout the organization.

The HQIC's roles and responsibilities include ensuring that important processes and activities are measured, assessed and improved systematically throughout the organization; determining the approach to Quality Assessment and Performance Improvement (QAPI); approving annual priorities and required resources to implement / support PI activities; reporting to Board of Directors; reviewing results of studies, teams, and ongoing measurement activity or additional actions required; approving communication processes to share outcomes of PI; approving changes and parameters for interdisciplinary teams; and reviewing annual assessment of PI activities.

Medical Staff Service Line committees' roles and responsibilities as they relate to PI include: reviewing and analyzing data, making recommendations, taking actions where necessary, and reporting to the General Medical Staff through Committee chairs.

The HQIC has designated responsibility to ensure patient safety. Patient safety is evaluated with a dedication to implementation and monitoring of the effectiveness of the patient safety activities. The scope of patient safety activities includes ongoing assessment, using internal and external knowledge and experience, to prevent adverse event occurrence, and maintain and improve patient safety. Data reports of medication incidents are reviewed at the HQIC. The HQIC reviews at least one (1) high-risk safety process for proactive risk assessment (FMEA) every 18 months. Patient safety information reporting includes concurrent data / information related to ongoing patient safety and medical error issues, as well as information related to the proactive risk assessment and improvement endeavors.

METHODOLOGY

The Bartlett Microsystems methodology is used to improve functions and processes

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

Performance improvement data is collected, measured and assessed in a systematic and ongoing manner in order to assess variation and the need for improvement. Due to the differences in the types of data collected, assessment methodologies may vary. Individual case review data and peer review results are assessed and improved on a case-by-case basis and documented in committee minutes as appropriate. Whenever feasible, assessment and improvement methodologies include analysis of summary data, focus on the underlying process or system and on interdisciplinary collaboration.

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

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

The following actions promote performance improvement:

- Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and determine how serious the possible effect is on the patient.
- For the most critical effects, conduct a root-cause analysis or use other quality management tools to determine why the undesirable variation leading to that effect may occur.
- Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation.
- Test and implement the redesigned process.
- Identify and implement measures of the effectiveness of the redesigned process.
- Implement a strategy for maintaining the effectiveness of the redesigned process over time

Performance measures for processes that are known to jeopardize the safety of patients or associated with sentinel events are routinely monitored. At a minimum, performance measured related to the following processes, as appropriate to care and services provided, are monitored with approval of, and at the suggested frequency of, the HQIC:

- Management of hazardous conditions
- Medication management

- Operative and other invasive procedures
- Blood and blood product use
- Restraint use
- Outcomes related to resuscitation
- Appropriateness of pain management
- Care or services to high-risk populations
- National Patient Safety Goals
- Organ procurement effectiveness: conversion rate data is collected and analyzed and when reasonable, steps are taken to improve the rate.

REPORTING FORMAT

The findings, conclusions, recommendations, and actions taken to improve performance and the results of actions taken are documented and reported through established channels.

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by the medical staff service line committees and ancillary or nursing, is reported to the HQIC or MSQIC on an annual or other basis as designated.

The HQIC, through its minutes, Medical Staff representative, or the Director of Quality, reports to the Medical Staff Executive Committee on a routine basis. The HQIC provides the Board of Directors with a report of relevant findings from performance improvement activities.

ANNUAL EVALUATION AND APPROVAL

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

ACCOUNTABILITY

The Board of Directors of Bartlett Regional Hospital is ultimately responsible for the quality of care provided by the hospital. The Board of Directors shall provide that an ongoing, comprehensive and objective mechanism is in place to assess and improve the quality of patient care, to identify and resolve documented or potential problems and to identify further opportunities to improve patient care. The Board discharges this responsibility by establishing organizational priorities, allocating the necessary resources, appropriately delegating responsibility for the overall management of performance improvement activities and subsequently measuring the results of those

activities. The Board reviews the quality of patient care services provided by medical, professional, and support staff.

The Board of Directors delegates operational authority and responsibility for performance improvement to the Chief Executive Officer and the Chief of the Medical Staff. Through coordination of activities between these two individuals, the hospital-wide approach to organizational performance improvement is developed and implemented.

The Chief Executive Officer and the Chief of the Medical Staff, acting through the HQIC and MSEC respectively, coordinate the program by assessing organizational needs, establishing priorities, providing necessary resources and measuring outcomes of all performance improvement activities using organizational goals, statutory and regulatory requirements, and other measurement standards.

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

SCOPE

Organizational Performance Improvement is a hospital-wide activity. All Medical Staff departments and all hospital clinical and support services participate in planning, designing, measuring, analyzing and implementing opportunities to improve care and organizational performance.

Medical Staff functions are performed by the Medical Staff as described in the Medical Staff Bylaws and/or Rules and Regulations.

Administrative and other non-clinical functions are performed by hospital committees, departments, and through interdisciplinary team-based activities as approved by the HQIC.

Functions involving both the Medical Staff and the hospital are addressed through a joint effort directed and organized by the Medical Staff leadership and the HQIC.

Safety activities are addressed throughout the organization and reported through the HQIC, which then reports to the Board of Directors. These activities focus on patients, the hospital staff, and medical staff. The Director of Quality has primary oversight responsibility with regard to regulatory standards. Other individuals with key responsibilities are the Regulatory / Risk Manager, and the Director of Facilities Services who functions as the Facilities Safety Officer. These individuals are active participants

on the Environment of Care Committee, which meets regularly and facilitates timely corrective action as safety issues are identified. The EOC Team routinely reviews activities related to all the 7 Management Plans for the Environment of Care.

The Director of Pharmacy and the Regulatory / Risk Manager are primarily responsible for medication safety activities and risk reduction strategies related to medication error reduction.

ORGANIZATION

Board of Directors

The Hospital Board of Directors has the overall responsibility for the improvement of organizational performance and the quality of patient care as described above. The Chief Executive Officer, Chief Nursing Officer, the Chief of the Medical Staff, and the Director of Quality have operational responsibility for the development and implementation of an integrated, coordinated, and interdisciplinary approach to performance improvement. An overview of the performance improvement activities is reviewed at least semi-annually at the Board of Directors QA Committee meeting.

Medical Staff Executive Committee

The Medical Staff Executive Committee (MSEC) fulfills the overview capacity of the performance and quality improvement requirements by receiving and acting on outcomes data and recommending actions or further investigation. The Medical Staff is organized into service lines or committees as described in the Medical Staff Bylaws. MSEC's responsibilities include:

- Analyzing reports and medical records referred for peer review according to the criteria established by the MSEC (delegated to the Medical Staff Quality Improvement Committee).
- Making recommendations for action and policy / procedure changes to the Hospital, Board of Directors, and Medical Staff regarding performance improvement.

Medical Staff Committees

Medical Staff Committees are responsible for the tasks of reviewing the performance of practitioners granted privileges by the service line, as well as measuring and assessing the performance of important patient care processes. The chair of each Medical Staff Committee shall provide for an ongoing, systematic process for assessing and improving the quality of patient care provided.

The functions of the Medical Staff Committees include:

- Conducting a continuous and systematic review of the quality and appropriateness of care delivered by members of the service line, including (but not limited to) peer review of individual cases referred to the committee by members, other departments and committees, risk management; and cases which fail to meet departmental screening criteria.
- Coordinate with hospital staff and departments an interdisciplinary review of the following functions:
  - Surgical care and other operative invasive procedures
  - Medication and nutrition usage evaluation
  - Medical record review for clinical pertinence
  - Blood usage evaluation
  - Preoperative, postoperative, and pathological finding discrepancies
- Develop and review interdisciplinary studies based on the service's scope of practice in order to improve the delivery of patient care.
- Recommend educational activities based on review findings, new standards or technology, identified need, or other sources of input to improve the quality and appropriateness of patient care.
- Develop and implement changes to correct identified problems or improve existing processes, and measure and evaluate the response to those changes in improving patient care.
- Use findings of the performance improvement process in peer review and evaluation of the competence of individuals with clinical privileges when the findings of the performance improvement process are relevant to the performance of an individual.
- Report to the Medical Staff Executive Committee as needed regarding:
  - Performance issues and problems that appear to involve multiple disciplines or services.
  - Improvements identified through performance and peer review activities.
  - Interventions taken to improve performance.
  - Results of the effectiveness of actions taken.

Hospital Quality Improvement Council

The Hospital Quality Improvement Council (HQIC) is an administrative committee responsible for identifying performance improvement issues that affect patient care and service of Bartlett Regional Hospital.

The purpose of the HQIC is to identify and prioritize performance improvement issues, encourage accountability, and review the effectiveness of activities through the systematic and continuous measurement of administrative and clinically directed processes and systems.

Goals of the HQIC include:

- Provision for coordination and integration of performance improvement activities by maintaining a process through which performance improvement

information is reviewed and appropriate follow-up recommendations are made.
- Communication of performance improvement activities and findings to all pertinent hospital staff, medical staff and the Board of Directors, and to provide for their active participation in the program.
- Identification of the continuing education needs of clinical, administrative and support personnel relative to the performance improvement process.
- Coordination of performance improvement activities and findings with those of the facility's utilization management, risk management, infection control, safety management, medical staff credentialing, and medical records functions.
- Addressing management and quality of service issues which arise as a direct or indirect result of performance improvement activities.
- Maintaining a non-punitive environment in which healthcare errors are reported and reduced and the importance of patient safety is a priority.
- Review of management objectives on an annual basis and provision of continuity between management and performance improvement objectives.

Membership on the HQIC is composed of leaders of the organization including (but not limited to) the Chief Executive Officer, Chief Nursing Officer, and representation from the following stakeholders:

- Board of Directors Representative
- Quality Management
- Risk Management
- Labor Union
- Medical Staff
- Human Resources
- Staff Development
- Clinical Nursing Services
- Pharmacy
- Environment of Care Committee

Quality and Process Improvement Department

The Quality and Process Improvement (QPI) department of the hospital coordinates and manages the daily administrative activities of the Patient Safety Program, assists in the development of mechanisms for improving organizational performance, and assists departments and committees with performance improvement activities as requested.

The Quality Director:

- Provides support for data collection and analysis, including the ongoing, systematic review of data sources and aggregate reports.
- Assists in the dissemination of findings and reports.

- Assists hospital and Medical Staff departments and committees in identifying important processes to measure, assess and improve.
- Develops data collection tools and reporting formats, as appropriate, to enhance uniformity and prevent duplication of effort.
- Attends meetings of Medical Staff service lines. Assists in preparation of reports to the Medical Staff Executive Committee and the Board of Directors as appropriate.
- Monitors pertinent state and federal regulations, standards and guidelines, as well as private initiatives in performance measurement and improvement.
- Assists in identification of continuing education needs and other corrective actions.
- Responds to identification of patient safety risks through patient, hospital staff, or medical staff complaints, analysis of occurrence reports, and active litigation.

Hospital Departments

With assistance from the QPI Department, each department or service annually selects quality indicators with a focus on indicators which are high risk, high volume, and/or problem prone, important to customers, important to staff, or related to mission or strategic objectives, taking into account incidence, prevalence and/or severity.

Each department director provides for an ongoing and systematic process for measuring, assessing, and improving the quality of services, and patient satisfaction.

Each department or service is responsible for initiating and evaluating corrective action in response to findings, as well as those of accrediting agencies, other regulatory agencies and third-party payers.

Each hospital department collects regular (e.g. monthly, quarterly, annual) indicator data, monitors results, and reports to the HQIC as requested. When monitored results do not meet expected goals, departments must provide an explanation and account of corrective actions being taken.

Each department or service ensures that identified problems and concerns are followed through to resolution.

Each department or service must select corrective actions most appropriate to the problems or concerns identified. These may include, but are not limited to: training or continuing education programs, new or revised policies, procedures or processes; individual counseling; proctoring; and sanctions or other disciplinary actions.

Each clinical department having an affiliation with a patient care contracted service may consider selecting a quality indicator for that service, and monitor, analyze, and report to the HQIC.

Collection and Analysis of Data

Data is collected and analyzed to ensure that actions taken are based on:

- Processes and outcomes, such as core measures, operative and invasive care, medication use and any medication use investigation studies.
- Comprehensive performance indicators, such as department-specific monitors.
- High risk, high volume, and problem-prone activities, such as review of complaints and occurrence reports, compliance with patient safety goals, and findings from Failure Mode Effects Analyses (FMEA).
- Significant risk events, such as conducting root-cause analyses.
- Individual performance and competence, such as compliance with policy and procedures.

Sources of Data

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

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

ANNUAL EVALUATION

An annual assessment of the PI Plan including the results of PI activities is completed to ensure that improvement processes result in continuous and sustained improvement of patient care and services. The review specifically addresses the structure, process, and outcomes of improvement activities. The Board of Directors is included in the annual assessment process and the assessment of the effectiveness of the program in order to make evolutionary changes that keep BRH on the cutting edge of safe, effective, efficient, and appropriate patient care and services.

CONFIDENTIALITY

All information related to performance improvement activities performed by the medical staff or hospital personnel in accordance with this plan is confidential.

Confidential information may include (but is not limited to): the medical staff committee

minutes, dashboards, hospital committee minutes, electronic data gathering and reporting, untoward incident reporting and clinical profiling.

Some information may be disseminated on a “need to know basis” as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proved a "need to know basis” as approved by the Medical Staff Executive Committee, hospital administration and/or the Board of Directors.

ACKNOWLEDGEMENT

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

_____	_____
Chief Executive Officer	Date
_____	_____
Chief of Medical Staff	Date
_____	_____
Quality Physician Advisor (MSQIC Chair)	Date
_____	_____
Board Chair	Date

Stages of Development on the Pathway to High Reliability

(Consistency of Safety & Quality Performance Over Long Periods of Time)

	Beginning	Refining	Maturing	Facility Assessment
Leadership				
Quality Activities	Quality activities focused on regulatory requirements	Chief Executive officer leads proactive quality agenda	Organization commits to goal of high reliability for all clinical services	**Maturing**
Quality Prioritized	Strategic importance of quality improvement not recognized	Board reviews adverse events	Organization aims for near zero failure rates in some vital clinical processes	**Refining**
Quality Rewarded	Metrics for quality goals not part of strategic plan or incentive compensation	Organization sets a few measurable quality aims	Staff rewards system prominently reflects accomplishment of quality goals	**Refining**
Information Technology Support	Information technology provides little support for quality improvement	Information technology supports some quality and safety initiatives	Information technology is integral to sustaining quality improvement	**Refining**
Physician Engagement	Physicians not actively engaged in quality improvement	Physician leaders champion quality goals in some areas	Physicians routinely lead quality efforts	**Refining**
Safety Culture				
Safety Culture Program	No specific program to assess safety culture	Establishing a safety culture is accorded high priority by leaders at all levels	Safety culture is well established	**Beginning / Refining**
Safety Culture Implementation	No assessment of trust or intimidating behavior	First measures of safety culture deployed	Measurement of safety culture is well established	**Maturing**
Safety Culture Embedded	Root cause analyses limited to most serious adverse events; close calls not recognized or evaluated	Beginning initiatives to encourage reporting and analysis of close calls	Regular reporting of close calls and unsafe conditions leads to early problem resolution	**Refining**
Process Improvement				
Use of PI Tools	No formal quality management / improvement system	Organization commitment to strong quality improvement tools	Process improvement tools used throughout the organization	**Refining / Maturing**
Organizational Engagement in PI	External requirements are focus of improvement efforts	Training of selected staff in PI beginning	PI used throughout organization; patients also engaged in redesigning care processes	**Refining**
Mandatory Implementation of PI	No commitment to sustainable improvement	Improvement tools are used to achieve gains in quality and safety, in addition to routine business processes	Mandatory PI training of all staff; PI proficiency required for career advancement	**Refining**

BRH CEO Recruitment Timeline (DRAFT)

22-Nov-13		18-Nov	25-Nov	2-Dec	9-Dec	16-Dec	23-Dec	30-Dec	6-Jan	13-Jan	20-Jan	27-Jan	3-Feb	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May
	WHO	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
Pre Recruitment Phase (2 weeks)																										
Subcommitee Recommendation	SC																									
Board Review & Approval of Recruitment Plan	FB																									
Recruitment Phase (8 weeks)																										
Finalize Job Posting	SC																									
Advertise Position	Staff																									
Interact with Recruiters	Staff																									
Selection Criteria Phase (Ongoing)																										
Identify qualities needed in CEO	FB																									
Determine Initial Screen Critieria	SC																									
Develop Selection Process	FB																									
Draft onboarding plan	FB																									
Screening Phase (Ends 2 weeks beyond job closing)																										
Review Resumes	Staff																									
Conduct Initial Phone Interviews	Staff																									
Internet Search Process	Staff																									
Selection of Candidates for SC interviews	SC																									
First Full Interview	SC																									
Initial pre check	Staff																									
Choose Finalists	SC																									
Contact Finalists to verify interest	Staff																									
Selection Phase																										
Arrange for Candidate travel	Staff																									
Selection Process	FB																									
Board Deliberation	FB																									
Final Reference Check	Staff																									
Offer Phase																										
Negotations with successful candidate	EC																									
Complete compliance checks	staff																									
Finalize onboard plan	EC																									
Onboarding Phase																										
Candidate Relocation Assistance	Staff																									
Candidate Start Date																										

BOD Subcommittee (SC)
Full Board (FB)
Staff
BOD Executive Committee (EC)
New CEO

Revised 12/16/13

Credentials Committee
Hospital Privileges for the Board of Director's Consideration
Tuesday, December 19, 2013 5:15 p.m. – Robert F. Valliant Center Boardroom

REAPPOINTMENTS TO THE MEDICAL STAFF:

Name	Category	Privileges In
1. Beth A. Baker, MD	**Consulting**	**Sleep Study Interpretation**

Dr. Beth A. Baker graduated from the University of Wisconsin in 1976. Dr. Baker is a physician for Internal Medicine Associates.

2.	**Greg Gerboth, MD**	**Consulting**	**Sleep Study Interpretation**

Dr Gregory D. Gerboth graduated from the Medical College of Wisconsin in 1987. Dr Gerboth is a physician for Internal Medicine Associates.

3.	**John Kennon Kirk, MD**	**Active**	**Family Medicine w/OB, Tubal Ligation, D&C, 4th Degree Repair, C-Section Assist, Exercise Stress Treadmill, and Conscious Sedation**

Dr. John K. Kirk graduated from the Eastern Virginia Medical School in 2007. Dr. Kirk is a family medicine physician for S.E.A.R.H.C. - Cedar.

REQUEST TO CHANCE STATUS:

1. **Maureen Longworth, MD -** (Courtesy to Honorary)
2. **Jessica Scott, MD -** (Courtesy to Active)

REQUEST FOR WITHDRAWAL:

1. **Steven Brick, MD –** (Consulting – Vrad; Teleradiology)
2. **Heidi Lopez-Coonjohn, MD –** (Active – BRH MHU/BOPS; Psychiatry, Child/Adolescent Psychiatry, and Chemical Dependency Detox)
3. **Charles Hoot, MD –** (Consulting – Vrad; Teleradiology)

LOCUM TENENS:

1. **William C. Brauns, MD –** (LocumTenens.com; Psychiatry and Chemical Dependency Detox)

REQUEST FOR ADDITIONAL EXPANDED PRIVILEGES:

1. **Jessica Scott, MD –** (Courtesy; Family Practice Physicians; Lexiscan)

TELERADIOLOGY:

1. **Dhawal Goradia, MD -** (Consulting – Vrad; Teleradiology)
2. **Laura Hotchkiss, MD -** (Consulting – Vrad; Teleradiology)
3. **Kamran Janjua, MD -** (Consulting – Vrad; Teleradiology)

4. **Gregory Kenyherz, MD -** (Consulting – Vrad; Teleradiology)
5. **Larry Kessler, MD -** (Consulting – Vrad; Teleradiology)
6. **Michael Rethy, MD -** (Consulting – Vrad; Teleradiology)

January 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6 N Executive Committee BR	7	8	9 N Planning Committee BR	10	11
12	13	14 7 Credentials Committee BR	15 N Quality Assurance Committee BR	16 3:00-4:30 Compliance Com BR 5:15 Finance Committee BR	17	18
19	20 N- Bartlett Foundation BR	21	22	23	24	25
26	27	28 5:15 Board of Directors BR	29	30	31 9-00 QIC BR	

\

Board of Director's meetings for 2014	
Tuesday, January, 28, 2014	
Tuesday, February 25, 2014	
Tuesday, March 25, 2014	
Tuesday, April 22, 2014	
Tuesday, May 27, 2014	
Tuesday, June 24, 2014	
Tuesday, July 22, 2014	
Tuesday, August 26, 2014	
Tuesday, September 23, 2014	
Tuesday, October 28, 2014	
Tuesday, November 25, 2014	
Tuesday, December 23, 2014	