



AGENDA
CCMC AUTHORITY BOARD OF DIRECTORS
CCMC CONFERENCE ROOM
February 22, 2018 at 6:00PM
REGULAR MEETING

AT CCMC, WE BELIEVE THAT HEALTHY PEOPLE CREATE A HEALTHY COMMUNITY.

Board of Directors

Kristin Carpenter exp. 3/20
April Horton exp. 3/19
Sally Bennett exp. 3/19
Dorne Hawxhurst exp. 3/18
Amanda Wiese exp. 3/18

CCMC CEO

Scot Mitchell

OPENING: Call to Order

Roll Call – April Horton, Dorne Hawxhurst, Kristin Carpenter, Sally Bennett and Amanda Wiese. Establishment of a Quorum

A. APPROVAL OF AGENDA

B. CONFLICT OF INTEREST

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS (Speaker must give name and agenda item to which they are addressing.)

1. Audience Comments (limited to 3 minutes per speaker).
2. Guest Speaker

D. BOARD DEVELOPMENT

1. Community Health Needs Assessment

Pgs 1- 5

E. APPROVAL OF MINUTES

1. January 31, 2018 Regular Meeting Minutes

Pgs 6-9

F. REPORTS OF OFFICER and ADVISORS

1. Board Chair Report – Kristin Carpenter
2. CEO Report – Scot Mitchell, CEO
3. Finance Report – Lee Holter, CFO
4. Nursing Report – Tammy Pokorney, CNO
5. Quality Improvement Report – Kelly Kedzierski, RN
6. Sound Alternatives Report – Lykia Lorenz, Executive Director

Pgs 10-13

Pgs 14-20

Pgs 21-56

Pgs 57-58

Pg 59

G. CORRESPONDENCE

H. ACTION ITEMS

I. DISCUSSION ITEMS

1. Board – Staff Communication
2. Costs involved with visiting Specialists
3. Strategic Plan

L. AUDIENCE PARTICIPATION (limited to 3 minutes per speaker)

Members of the public are given the opportunity to comment on matters which are within the subject matter jurisdiction of the Board and are appropriate for discussion in an open session.

M. BOARD MEMBERS COMMENTS

N. EXECUTIVE SESSION

1. Pursuant to AS 42.40.170 Executive Sessions; please see #3

O. ADJOURNMENT

For a full packet, go to www.cityofcordova.net/government/boards-commissions/health-services-board

*Executive Session: Subjects that may be considered in executive session are: 1) Matters, immediate knowledge of which would clearly have an adverse effect upon the finances of the public entity; 2) Subjects that tend to prejudice the reputation and character of any person, provided that the person may request a public discussion; 3) Matters which by law, municipal charter, or ordinance are required to be confidential; 4) Matters involving consideration of governmental records that by law are not subject to public disclosure; 5) Direction to an attorney or labor negotiator regarding the handling of specific legal matters or labor negotiations.

Community Health Needs Assessment Establishing Health Priorities Reporting Document

Introduction

Cordova Community Medical Center (CCMC) participated in a Community Health Assessment process administrated by the National Rural Health Resource Center (The Center) of Duluth, Minnesota. In the winter of 2016, The Center conferred with leaders from the hospital to discuss the objectives of a community health needs assessment including key informant interviews and a facilitated discussion to establish health priorities. Results were presented during an on-site discussion with representatives from the hospital board and community to review the assessment and key informant findings and to identify community health priorities.

Description of Community Served

CCMC provided The Center with market share demographics and utilization to aid in distribution of a random, stratified distribution sample for the assessment. Key informant interviews were also facilitated via phone in January 2017 representing various community stakeholders.

Input from Broad Interests

- Conducted key informant interviews: participants represented key stakeholders such as healthcare providers, community leaders, seniors and young parents. Seven people participated in total. Each session was approximately 30 minutes in length and included the same questions. The questions and discussions at the focus groups were led by Kami Norland and Sally Buck of the Center. No identifiable information is disclosed in the summary to maintain confidentiality.

Prioritized Health Needs

On Wednesday, January 18, 2017 members of the hospital board, hospital leadership and key healthcare and community stakeholders (the Team) were assembled to begin the process to identify the top community health needs. This Team participated in a discussion regarding the state and national health care environment and review of the assessment and key informant findings. The Team then rated the community health needs based on the ability of the hospital to respond to the needs of the community. The top community health needs identified were:

Disclaimer: The National Rural Health Resource Center strongly encourages an accounting professional's review of this document prior to submission to the IRS.

Cordova Community Medical Center
January 18, 2017

- Education of health services
- Increased access to specialty care, including: home health, personal care attendants, respite care and OB/GYN
- Access to services, including the enhancement of community collaborations
- Building the local workforce
- Enhancing substance abuse services

These needs were then evaluated based on urgency, feasibility within the hospital's resources, existing community strengths, and opportunities to partner with other local organizations. The Team discussed each of the identified health needs.

The Team identified what CCMC can do to address the gaps in health in the community as their goal. A facilitation method designed to achieve group consensus-based decisions that respects the diversity of participant perspectives, inspires individual action and moves the group toward joint resolve and action was utilized. This method creates awareness about new relationships between data and acknowledges the level of the group's consensus at any given moment. The conversation is aimed towards identifying actions CCMC can take towards addressing the community's top health needs identified.

Team members began by individually brainstorming potential actions to address this goal. Team members then shared their ideas with a partner and identified the top potential actions they wished to share with the full group. These potential actions were posted on a Conversation Board for all to read and discuss. After the actions were organized, the Team collectively developed objectives to describe the potential activities CCMC could pursue as outlined in the table below.

Cordova Community Medical Center
January 18, 2017

Strategies	Build Collaborations*	Enhance Communication and Education	Grow Marketing	Develop the workforce	Improve Community "Buy-in"	Explore Business Developments
Objectives	<ul style="list-style-type: none">• Coordinating services between ICHC & CCMC• Coordinate specialty services• Coordinated effort to develop & improve OB/GYN• Arrange more collaboration with other providers• Collaborate on health fairs• Collaborate with outside hospital for ICH, cardiology, renal and other specialties• Partner with other local healthcare providers• Set goals and deadlines for Cordova Coalition <p>*This strategy was identified as the most important and most difficult to address as trust and "getting past old wounds" was needed. Also, the public perception of healthcare organizations "fighting" needs to be resolved and trust needs to be restored in the community, per Team feedback</p>	<ul style="list-style-type: none">• Provide education classes through CCMC and SA• Expand "doc talks"• Maintain "doc talks"• Continue with "lunch with the CEO" educational sessions• Invite guest speakers to present to the community• Restart hospital newsletter• Provide healthcare articles through newspaper & social media• Outreach services to churches	<ul style="list-style-type: none">• Continue social media marketing• Create a text alert system• Welcome to Cordova tours• Annual BBQ• Advertise thru a variety of media outlets including box holder mail out	<ul style="list-style-type: none">• Offer job shadowing *noted as the easiest task to complete• Develop student shadowing opportunities	<ul style="list-style-type: none">• Promote community ownership of healthcare services• Inspire advocacy for healthcare ownership	<ul style="list-style-type: none">• Prepare for a pharmaceutical facility at CCMC• Evaluate shared rental space for specialists

This list of potential activities identified by the Team will be reviewed by hospital leadership and compared to existing promotional and outreach service offerings. Hospital leadership will then operationalize a plan of actions to address the identified health goal by completing the Community Health Assessment Action Plan Worksheet.

Dissemination

- CCMC will post a summary of the community health needs assessment findings and implementation strategy online at www.cdvcmc.com.
- CCMC disseminated a press release of the community health needs assessment findings and implementation strategy in the local newspaper.

Implementation Strategy

- Hospital leadership assembled to operationalize the community health assessment action plan which identifies the objectives, organization's responsible, a timeline, a list of partners and resources, and how the objective will be measured for success (see Community Health Assessment Action Plan)

Disclaimer: The National Rural Health Resource Center strongly encourages an accounting professional's review of this document prior to submission to the IRS.

Resolution to Approve Community Health Needs Assessment Implementation Plan

Whereas the board of Cordova Community Medical Center (CCMC) approved of and oversaw the implementation of a Community Health Assessment process for the purpose of improving community health status and meeting Internal Revenue Service mandates enacted through the Patient Protection and Affordable Care Act;

Now therefore be it resolved that the board of CCMC does hereby adopt this resolution to accept the Community Health Needs Implementation Plan presented on this day to address to the following community health strategies:

- Build collaborations
- Enhance communication and education
- Grow marketing
- Develop the workforce
- Improve community "buy-in"
- Explore business developments

Upon vote taken, the following voted:

For:

Against:

Whereupon said Resolution was declared duly passed and adopted this 9th day of February 2017.

Timothy L. Gipe, Chairman 02/09/2017
Health Service Board

Adam Michael CEO 9 Feb 2017
CCMC CEO

Disclaimer: The National Rural Health Resource Center strongly encourages an accounting professional's review of this document prior to submission to the IRS.

Minutes
CCMC Authority – Board of Directors
CCMC Admin Conference Room
January 31, 2018 at 6:00pm
Regular Meeting

CALL TO ORDER AND ROLL CALL –

Kristin Carpenter called the Board Meeting to order at 6:02pm.

Board members present: **April Horton, Dorne Hawxhurst, Kristin Carpenter, and Sally Bennett.**

A quorum was established. 4 members present.

CCMC staff present: Scot Mitchell, CEO; Lee Holter, CFO; Tammy Pokorney, CNO, and Faith Wheeler-Jeppson, Executive Admin Assistant.

A. APPROVAL OF AGENDA

M/ Bennett S/ Horton “move to approve the Agenda.”

4 yeas, 0 nay

Motion passed.

B. CONFLICT OF INTEREST ~ None

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS

1. **Audience Participation** ~ None

2. **Guest Speaker** ~ None

D. BOARD DEVELOPMENT

1. **Board and Staff Communication**

Kristin Carpenter reviewed an article from the Blue Avocado highlighting points on what types of communications the Board can and cannot have with non-profit organizations staff. A copy of the current CCMC policy written by the previous board regarding board communication with staff.

E. APPROVAL OF MINUTES

M/ Bennett S/ Hawxhurst “move to approve the December 7, 2017 Regular Meeting Minutes and the December 22, 2017 Special Meeting Minutes as amended”. (December 22, 2017 minutes amended to reflect \$550,000 under item I.)

4 yeas, 0 nay

Motion passed.

F. REPORT OF OFFICERS AND ADVISORS

1. **Board Chair Report ~ Kristin Carpenter** reported that she had spoken with Dr. Buttner and he is really enthusiastic about how things are going at CCMC. Dr. Buttner also spoke with Kristin about the potential for collaboration with the Residency Program at Providence and possibly sharing time with Ilanka. Kristin also wanted to recognize and give kudos to the Medical Center for the work they did in evacuating the hospital at 2am, thank you.

- 2. CEO's Report** ~ Scot Mitchell, CEO reported that his written CEO report is in the packet, and that the new format is reflective of our strategic plan. The Federal Statement of Deficiencies has been received and the Plans of Correction have been submitted. A Lunch with the CEO has been scheduled for February 20, 2018, Scot asked for a Board member to attend, and Kristin offered to attend the February lunch. Scot has been working on ways to reduce the expenses with Health Insurance, he will be providing more details as they come available.
- 3. Finance Report** ~ Lee Holter, CFO reviewed the November 2017 financial information provided in the packet with the board. A few highlights on the Dash board, cash was up at the beginning of the month, as was accounts payable. The Days in AR are down, and Net Income YTD is down \$315,000 compared to last year we're doing better. Swing Bed Acute Census is at 5.6 compared to .5 this time last year.
- 4. Quality Improvement Quarterly Report** ~ Tammy Pokorney, CNO explained to the board what the QAPI program is and why it is essential to have one, along with a PIP (Performance Improvement Project). She also explained that Point Click Care is the EHR for Long Term Care and the first phase goes live tomorrow, and Relias will be the new learning/training management program for the facility will go live the middle of March, and this all marries up with ADP on the HR onboarding portion.

G. CORRESPONDENCE ~ None

H. ACTION ITEMS

1. The 2018 Quality Assurance Performance Program (QAPI) Plan

M/ Hawxhurst S/ Bennett "I move that the CCMC Authority Board of Directors approve the 2018 Quality Assurance Performance Program (QAPI) Plan."

4 yeas, 0 nay

Motion passed.

2. IT Support Service Provider

M/ Bennett S/ Horton "I move that the CCMC Authority Board of Directors authorize Scot Mitchell, CEO to enter into an agreement with Arctic IT to provide IT support services to CCMC."

4 yeas, 0 nay

Motion passed.

3. Electronic Health Record System

M/ Horton S/ Bennett "I move that the CCMC Authority Board of Directors authorizes Scot Mitchell, CEO to enter into an agreement with Evident, LLC and TruBridge to move forward with the purchase and implementation of a new CCMC Electronic Health Record system."

3 yeas, 1 nay

Motion passed.

I. DISCUSSION ITEMS

1. Response to Earthquake and Tsunami on January 23rd, 2018.

Scot Mitchell provided a timeline of the hospital response, the notification of the ICS, staff recall notification and full evacuation of patients/residents from the time that he realized that we had a tsunami warning until all residents/patients were safely returned back to CCMC from the evacuation site without incident.

3. Strategic Planning

Scot Mitchell provided a tutorial to the Board on how to access and use the CCMC Strategic Planning webpage. The Organizational Chart section with the employees, their position within the facility and their goals were reviewed. The next section shown was marked Mission which includes the Stakeholder Needs, Mission, Vision, and Values. The Strategy section was reviewed, that category has the Strategic Objectives which are based on the Studeer Group Pillars of Excellence. Those include Service, Quality, Finance, People, Growth, Community, and CCMC's Action Items from the 2017 LTC Survey. Goals is the next group, within Goals there are strategies, goals and then tasks that are assigned to specific employees. There is a section to provide updates on the progress of each task as work has been done. There is a section for Graphs, and the last is the Dashboard. The Board has been set up on this system so you can go in and look at the progress.

J. AUDIENCE PARTICIPATION - None

K. BOARD MEMBERS COMMENTS

Carpenter ~ Kudo on the evacuation, and again I think that Dr. Buttner is pretty excited to get involved in the Cordova Community.

Hawxhurst ~ I echo what Kristin said.

Bennett ~ Good job.

Horton ~ Good job.

L. EXECUTIVE SESSION

1. Pursuant to AS 42.40.170 Executive Sessions; please see reason # 3.

M/ Hawxhurst S/ Bennett "I move to go into Executive Session for matters which by law, municipal charter, or ordinance are required to be confidential and matters involving consideration of governmental records that by law are not subject to public disclosure."

The Board entered into the Executive Session at 9:05pm

The Board came out of Executive Session at 9:43pm

M. ADJOURNMENT

M/ Bennett S/ Horton “I move to adjourn the meeting.”
Carpenter declared the meeting adjourned at 9:44pm.

Prepared by: Faith Wheeler-Jeppson



CEO Report to the CCMC Authority Board of Directors
February 22, 2018
Scot Mitchell, CEO

The Big Picture

There has been a lot of activity in Washington lately. We've had two short-lived government shutdowns and President Trump has recently released his 2019 budget request to Congress. This budget request includes significant cuts to the Medicare and Medicaid programs. While there is little chance that the President's proposed budget will become a reality, it does provide a glimpse into his priorities, some of which are not friendly to CCMC. Below are some highlights of how the budget request could impact our facility and community.

- This budget request espouses legislation that would repeal and replace the individual marketplace subsidies and Medicaid expansion under the Affordable Care Act (ACA) with grants. This would give states a lot of discretion in how they use the grants. This would save the federal government \$675 billion over 10 years.
- If passed as is, the budget would reduce Medicare funding by \$554 billion over 10 years. Some of the specific impacts on Medicare are:
 - Reduce bad debt payments to providers from 65% to 25%, saving \$37 billion over 10 years.
 - Reduce uncompensated care payments to hospitals by \$70 billion over 10 years.
 - Creation of a unified post-acute care payment system would reduce payments to providers by \$80 billion over 10 years. This would negatively impact our nursing home.
 - Telehealth services would be covered under Medicare Advantage plans. This would have no federal budget impact, but could help us as we research expanding our telehealth program.
 - Eliminate some of the reporting burden and payment penalties in the Electronic Health Record (EHR) Meaningful Use program.
 - The budget would spend \$1.1 billion over 10 years to reform the Medicare appeals process to reduce the backlog of pending appeals.
 - Medical liability reforms, such as capping non-economic damages, creating safe harbors when clinical standards are followed and federal guidance on state health tribunals, and other changes would save \$52 billion over 10 years.
 - Simplifies the Merit-Based Incentive Payment System (MIPS) for physicians.
- There are numerous legislative and regulatory changes to the Medicaid program that would provide states with more flexibility, as well as restrict eligibility, program funding and hospital payments resulting in more than \$1.4 trillion in savings. There are some changes that would result in some of the savings from the ACA repeal and replace language that would be applied to a new grant program that would cover a portion of the Medicaid population. Below are some of the specific Medicaid proposals:
 - The Medicaid Disproportionate Share Hospital payment reductions would be continued for another three years resulting in savings of \$19.5 billion over 10 years.
 - Limit Medicaid reimbursement for public hospitals so that payment could not exceed the cost of providing services to Medicaid beneficiaries.

- Require documentation of satisfactory immigration status before receipt of Medicaid benefits would save \$2.2 billion over 10 years.
- An increase in co-payments for non-emergency use of hospital emergency rooms would save \$1.3 billion over 10 years.
- State Medicaid programs would be required to cover all FDA approved opioid use disorder treatment, saving \$865 million over 10 years.
- Make non-emergency Medicaid transportation coverage optional.
- The 340B drug program is still a target in this proposal. Here are some of the changes proposed:
 - A new user fee would be imposed on all drugs purchased by covered entities, like CCMC's retail pharmacy, increasing \$16 million in revenue in 2019 alone.
 - HRSA will receive more regulatory authority over the 340B program and all covered entities would be required to report on how they use savings from the program to benefit low-income and uninsured individuals.
 - CMS would be allowed to apply savings from the reduction in payments to 340B eligible hospitals in a non-budget neutral manner.
 - The savings from hospitals that provide uncompensated care equaling at least 1% of their patient care costs would be redistributed on their share of aggregate uncompensated care. If a hospital does not meet this threshold, their savings would be returned to the Medicare Trust Funds.
- The proposed budget would provide an additional \$10 billion in additional discretionary funds for 2019 for opioids and mental health.
- There are a couple non-health care related initiatives in the requested budget that could potentially help Cordova:
 - \$100 billion are added for incentive programs that would provide matching funds to state and localities for infrastructure programs such as transportation, airports, ports and waterways, flood control, hydropower, drinking water facilities, water resources, etc.
 - \$50 billion for a rural infrastructure program that would provide block grants to states to support projects specifically targeted to rural areas with populations less than 50,000. This program would focus on investments in rural broadband, transportation, water and waste, power and electric and water resources.

In addition to the national and local matters we are dealing with, the Alaska State Legislature recently convened and we expect additional cuts to State programs and Medicaid funding this year. I will be traveling to Juneau later this month to meet with our elected representatives to encourage them to support efforts that will assist CCMC as we continue our improvement efforts.

Status Updates

Service:

- The implantation of the PointClickCare (PCC) EHR system for the nursing home is going very well. Tammy Pokorney, Chief Nursing Officer, has been doing an amazing job with this project. The first phase, the billing and MDS components, went live on February 1, 2018. The second phase includes the clinical documentation components, and it is scheduled to go live on March 1st. Tammy has established an aggressive training program for the nursing staff, physicians, and ancillary staff to adequately prepare everyone for this new system. PCC will drastically improve our clinical documentation, which was one of the major issues we encountered during our recent nursing home surveys.
- After the Board approved the purchase of the new Thrive EHR system for the hospital last month, we have started the initial phases of the implementation of that system. The build for Thrive will be much more complex than the PCC system. Due to the complexity of this system, along with the many other technology-related projects that we have ongoing at CCMC, we've worked with Evident to change our go-live date with the Thrive

EHR to August of this year. In the coming weeks we will work with Evident to develop an implantation plan for our staff.

- As I have been updating you in recent months, we have been working diligently to develop improvement plans for Sound Alternatives. Lykia Lorenz, Executive Director, has been on board since October and has been learning our systems and working with outside consultants to help us develop plans for moving our behavioral health programs forward. Lykia has provided a written report to the Board on her activities and will be at the meeting to answer any questions you might have.

Quality:

- The Board approved the nursing home 2018 Quality Assurance/Performance Improvement (QAPI) plan last month. The first Performance Improvement Project (PIP) has been underway for several weeks now. This PIP is geared towards helping us provide consultative services to our nursing home residents, which are not currently available at CCMC. Tammy Pokorney has taken the lead to help us get this project off the ground, and has already made improvements in this area.
- Kelly Kedzierski, Quality Improvement Coordinator, has been doing a great job of bringing our Quality program up to required standards. She has spent a lot of time working with all the CCMC staff to bring everyone up to speed with this program. Kelly has also provided a written report on the status of our Quality Improvement program.
- The 2017 quality metrics for the Merit-based Incentive Payment System (MIPS) for Dr. Blackadar were recently submitted to CMS. This is one of the federally-mandated quality reporting systems that put a big burden on smaller facilities such as ours. Kelly Kedzierski has spent several months abstracting patient records and working with the medical staff to select appropriate measures. Had we not completed this attestation process, CMS would have reduced the payments we receive for Dr. Blackadar's service in 2019 by 4%.

Finance:

- We continue to work with the City to research a new pharmacy benefits program for the hospital and City employees. We have had a couple more meetings on this project, and are awaiting some additional data from our Third Party Administrator to help with the due diligence. This could be the first step in helping to reduce the cost of our health insurance, all while improving the health status of our employees. We are also starting to look at changes to our employee benefits program and pay practices that could help us save additional funds and streamline our internal practices.
- As I've mentioned to you many times before, our PERS debt obligations are unsustainable for CCMC. After numerous discussions, we have been able to work with the PERS office to help us at least get a temporary solution which will allow us to submit the employee contributions along with the facility 5% match, and not have to make the additional 17% tax payment at the same time. This doesn't help us with the long term debt obligations, but it does allow us to get the employee contributions submitted sooner. We continue to discuss other options that CCMC has for trying to eliminate this untenable situation with PERS. This will also be one of the main areas of focus that I have when I speak with our elected representatives in Juneau later this month.
- You have also heard many times about the significant issues we have had with the Centriq EHR system that CCMC has had since 2015. With the new Thrive system, we expect major improvement in the financial systems that will allow us to be more effective and efficient from that standpoint. Lee Holter, Chief Financial Officer, has been spending an inordinate amount of time trying to correct these problems since he arrived at CCMC. It is not a stretch to say that Lee has to deal with these issues every day. Having a new accounting system that is accurate, will also help us improve our billing processes to help increase cash flow.

People:

- The Relias Learning Management System that I discussed last month is still being implemented. Not only will this system improve our staff development and training programs, it is integrated with the PCC nursing home EHR system. This allows our staff to seamlessly perform training for the PCC system on the Relias system.

- We continue to encounter issues with the new ADP payroll system. We've spent a lot of time working with ADP to fix the problems, most of them are on their side, but we also have some improvements to make with our payroll practices as well. As I mentioned above, we have some pay and benefits practices that very uncommon, and we are in the initial stages of researching changes that will help improve our payroll system. Once this ADP system gets all the bugs worked out of it, it should be an improvement over our previous system, giving employees more control and access to their pay and benefits data anytime they want. It will also help us improve our staff recruitment processes.

Growth:

- We continue to look for specialty physicians who are interested in coming to CCMC for outpatient specialty clinics. We are currently performing the primary source verification credentialing for an OB/GYN physician. We've also had several discussions with another pediatrics group for additional pediatric clinics in Cordova. We've talked with an Orthopedic surgeon who is also interested in specialty clinics here at CCMC. We are still searching for Cardiology and Podiatry physicians, and will continually evaluate the need for additional specialties.
- We are performing the primary source verification credentialing for a psychiatrist who will perform tele-behavioral health visits in Sound Alternatives.
- As a result of the QAPI PIP project mentioned above, we've had some preliminary discussions with a couple Speech Therapists and an Occupational Therapist who are interested in providing services at CCMC.
- We are currently performing the primary source verification credentialing for a Psychiatrist who will provide telemedicine visits in Sound Alternatives.
- In the month of January, we filled 864 prescriptions in the retail pharmacy. We continue to receive praise from the community members who are using this service. The 340B drug pricing program is running smooth as well.

Community:

- We continue to work on the action items developed during the Community Health Needs Assessment (CHNA) process in 2016. The pharmacy mentioned above was one of the items that the community wanted us to do. Several of the specialty clinics noted above were also on the CHNA.
- We continue to explore various cost-effective methods to let the community know more about our services. Social media, radio, newspaper, and other media are ways we are experimenting to find what works best for us.
- I continue to have monthly meetings with Ilanka Community Health Center and the Native Village of Eyak to look at collaborative opportunities.
- I will be having a "Lunch with the CEO" on February 20th. This is a vehicle for me to spend some time with key stakeholders in the community to give them an overview of the current activities within the healthcare industry from a national standpoint as well as an update on the status of CCMC's various improvement projects.



Monthly Financial Statements

DECEMBER 2017

February 22, 2018

To the Board
December Financial Statements

Balance Sheet and Financial Statement are PreAudit

Balance Sheet Assets

Cash was up due to funds received from the City the last week of the Year
Budgeted funds and funds for Drug store transaction.
Inventory adjusted to actual count and addition of Retail Pharmacy Inventory

Balance Sheet Liabilities

AP was up
Third party (Medicare) increased due continued shift in payer mix
due to Medicaid Swingbed Revenue
City debt increase due to funds received at the end of the year.

Income Statement

Retail Pharmacy revenue added in revenue section.
Contractual adjustments show increased Medicare and Medicaid allowances
Other revenue shows negative for December due to reclass of City funds received in prior periods

Year to Date numbers

Revenue above budget
Contractuals above budget due to change in payer mix
Expenses are under budget and under prior year.

Days in AR were 85.4 in December vs 82.4 in November
Days in Cash bounced up to 36.9 days at the end of December

Sincerely,
Lee Holter
CFO
Cordova Community Medical Center

Cordova Community Medical Center
Balance Sheet

	UNAUDITED	w/Audit entries	
	<u>12/31/2017</u>	<u>11/30/2017</u>	<u>12/31/2016</u>
ASSETS			
Current Assets			
Cash	1,032,510	694,422	96,239
Net Account Receivable	1,594,507	1,506,524	914,115
Third Party Receivable	-	-	0
Other Receivables	-	-	83,394
Prepaid Expenses	81,892	52,498	28,681
Inventory	218,465	188,503	138,786
Total Current Assets	2,927,374	2,441,947	1,261,215
Property, Plant & Equipment			
Land	122,010	122,010	122,010
Buildings	7,006,762	7,006,762	7,006,762
Equipment	6,772,970	6,772,970	6,759,816
Construction in Progress	279,382	117,567	17,228
Subtotal PP&E	14,181,123	14,019,309	13,905,815
Less Accumulated Depreciation	(10,708,246)	(10,659,121)	(10,151,420)
Total Property & Equipment	3,472,877	3,360,188	3,754,395
Other Assets			
PERS Deferred Outflow	1,218,788	1,218,788	1,218,788
Total Other Assets	1,218,788	1,218,788	1,218,788
Total Assets	7,619,040	7,020,923	6,234,398
LIABILITIES AND FUND BALANCE			
Current Liabilities			
Accounts Payable	1,008,102	1,211,928	570,571
Payroll & Related Liabilities	444,284	49,973	520,914
Third Party Settlement Payment	610,185	565,394	0
Interest & Other Payables	12,122	11,462	6,045
Long Term Debt-- City	4,024,627	3,477,563	3,093,124
Other Current Long Term Debt	47,190	50,007	74,137
Total Current Liabilities	6,146,511	5,366,326	4,264,791
Long Term Liabilities			
2015 Net Pension Liability	6,907,864	6,907,864	6,907,864
Total Long Term Liabilities	6,907,864	6,907,864	6,907,864
Deferred Inflows of Resources			
Pension Deferred Inflow	77,000	77,000	77,000
Total Deferred Inflows	77,000	77,000	77,000
Total Liabilities	13,131,375	12,351,190	11,249,655
Net Position			
Unrestricted Fund Balance	2,460,523	2,460,523	2,460,523
Temporary Restricted Fund Balance	13,035	13,035	13,035
Prior Year Retained Earnings	(7,488,816)	(7,488,816)	(4,086,354)
Current Year Net Income	(497,078)	(315,010)	(3,402,462)
Total Net Position	(5,512,335)	(5,330,268)	(5,015,258)
Total Liabilities & Net Position	7,619,040	7,020,923	6,234,397

Cordova Community Medical Center
Gross AR Aging and Days in AR
December 2017

TOTAL	0 - 30	31 - 60	61 - 90	91 - 120	121+	Totals	Dec Days In AR
Gross A/R	126,415	106,379	82,025	57,901	178,536	551,256	18.1%
Commercial	199,580	20,477	128,382	21,957	55,902	426,299	14.0%
Medicare	489,406	84,426	109,813	84,031	274,647	1,042,323	34.1%
Medicaid	282,294	52,744	5,069	2,916	59,721	402,743	13.2%
Long Term Care	24,273	11,961	7,288	5,635	9,637	58,795	1.9%
Other Govt payers	-	-	283	1,220	247,872	249,375	8.2%
Extended Pymt Terms	74,033	14,325	23,609	24,040	108,629	244,636	8.0%
Private Pay	5,792	2,397	-	1,086	67,950	77,224	2.5%
Work Comp	1,201,793	292,709	356,469	198,786	1,002,894	3,052,652	100.0%
Totals	39.4%	9.6%	11.7%	6.5%	32.9%	100.0%	85.4
						<u>102,232</u>	Credit Balances

Cordova Community Medical Center
Income Statement

December 2017				Year To Date			
UNAUDITED							
Actual	Budget	Variance	Prior Yr	Variance	Budget	Prior Yr	Variance
REVENUE							
41,414	165,101	(123,687)	82,024	(40,610)	1,624,784	815,846	113,286
368,593	22,287	346,306	43,447	325,147	311,431	677,714	2,405,045
374,613	362,253	12,360	326,394	48,219	4,253,494	4,198,233	203,849
101,116	67,349	33,767	72,689	28,428	918,224	877,601	296,386
145,010	199,846	(54,836)	160,352	(15,342)	2,765,718	2,534,872	(29,647)
22,495	54,606	(32,111)	18,327	4,168	671,107	456,386	(51,812)
50,482	-	50,482	-	50,482	-	-	50,633
1,103,724	871,442	232,282	703,232	400,492	10,544,758	9,560,651	2,987,740
DEDUCTIONS							
-	13,549	(13,549)	-	-	163,250	184,869	(174,851)
297,416	126,580	170,836	133,159	164,257	1,525,110	1,529,223	1,999,744
1,731	24,834	(23,103)	14,073	(12,342)	299,250	339,400	3,119
299,147	164,963	134,184	147,232	151,915	1,987,610	2,053,492	1,828,011
75,107	28,057	47,050	83,394	(8,287)	467,671	494,411	(127,621)
82,475	66,581	15,894	132,958	(50,484)	1,109,695	1,382,513	(305,919)
(223,829)	10,594	(234,423)	(133,366)	(90,463)	176,600	650,396	(494,885)
(66,247)	105,232	(171,479)	82,986	(149,234)	1,753,966	2,527,320	(928,425)
738,330	811,711	(73,381)	638,986	99,344	10,311,114	10,034,479	231,304
EXPENSES							
360,580	321,773	38,807	338,558	22,021	4,183,040	3,570,859	533,761
157,152	163,882	(6,730)	274,521	(117,369)	2,130,360	2,139,396	(376,362)
94,058	130,194	(36,136)	136,558	(42,500)	1,712,985	2,358,381	(704,582)
860	2,323	(1,463)	1,640	(780)	27,700	30,587	11,653
97,718	35,375	62,343	65,291	32,427	417,679	438,748	182,181
6,466	2,206	4,260	7,486	(1,020)	26,450	75,073	4,512
8,220	9,138	(918)	21,174	(12,954)	109,700	184,595	(55,526)
109,230	102,465	6,765	108,782	449	1,210,204	1,236,003	34,473
7,316	3,762	3,554	2,202	5,115	44,948	67,350	13,601
14,595	17,951	(3,356)	7,188	7,407	217,808	192,873	(4,840)
968	4,163	(3,195)	8,563	(7,595)	50,000	103,875	(29,100)
49,125	43,750	5,375	45,285	3,840	525,000	550,522	6,304
15,289	12,226	3,063	10,617	4,672	146,690	161,496	18,651
921,577	849,208	72,369	1,027,865	(106,287)	10,802,564	11,131,696	(365,272)
(183,248)	(37,497)	(145,751)	(388,879)	205,631	(491,450)	(1,097,217)	596,576
1,180	-	-	-	-	-	-	-
(182,068)	(37,497)	(144,571)	(388,879)	206,811	(491,450)	(1,097,217)	600,145

12

29													Cumulative	Monthly
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average	
Hosp Acute+SWB Avg. Census														
FY 2017 ADC	3.1	3.8	4.5	4.5	4.5	3.1	5.3	4.4	4.5	5.6	5.8		4.6	
FY 2016	0.8	1.9	1.3	2.0	1.7	2.2	1.2	0.3	0.7	1.1	0.5		1.2	
FY 2015	1.1	0.2	2.0	2.3	2.0	2.7	0.9	1.5	0.7	0.5	0.1		1.2	
Acute Admits														
FY 2017	9	7	7	5	4	1	10	6	8	2	4	69	5.8	
FY 2016	6	8	3	8	9	5	7	5	6	10	8	81	6.8	
FY 2015	1	1	4	6	5	2	5	1	5	3	1	39	3.3	
Acute Patient Days														
FY 2017	32	22	29	23	28	2	49	12	16	18	5	10	246	20.5
FY 2016	16	15	18	22	26	20	11	10	18	22	15	17	210	17.5
FY 2015	2	3	7	8	16	3	10	2	11	6	7	2	77	6.4
SWB Admits														
FY 2017	5	3	2	1	2	0	1	0	0	3	1	1	19	1.6
FY 2016	2	2	0	2	1	3	1	0	1	2	1	2	17	1.4
FY 2015	1	1	3	3	2	0	0	3	1	0	0	15	1.3	
SWB Patient Days														
FY 2017	64	84	109	111	111	90	114	124	120	157	163	171	1,418	118.2
FY 2016	9	40	23	37	28	46	25	0	3	11	1	14	237	19.8
FY 2015	31	3	55	60	46	78	18	45	11	11	19	0	377	31.4
CCMC LTC Admits														
FY 2017	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FY 2016	1	0	0	0	0	0	2	0	0	0	0	3	0.3	0
FY 2015	0	0	0	1	1	2	1	2	2	1	0	10	0.8	0
CCMC LTD Resident Days														
FY 2017	310	280	310	300	310	300	310	310	300	310	300	310	3,650	304.2
FY 2016	310	290	310	297	310	298	292	310	300	310	300	310	3,637	303.1
FY 2015	310	280	308	287	307	300	274	273	388	309	300	310	3,646	304
CCMC LTC Avg. Census														
FY 2017	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0		10.0	
FY 2016	10.0	10.0	10.0	9.9	10.0	9.9	9.4	10.0	10.0	10.0	10.0		9.9	
FY 2015	10.0	10.0	9.9	9.6	9.9	10.0	8.8	8.8	12.9	10.0	10.0		10.0	
ER Visits														
FY 2017	49	35	47	49	53	55	75	68	53	43	42	35	604	50.3
FY 2016	52	45	52	52	59	79	85	74	51	55	37	53	694	57.8
FY 2015	23	46	49	40	104	73	104	97	47	56	37	39	715	59.6

12

12



P: (907) 424-8000 | F: (907) 424-8116
P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

Date: February 14, 2018
To: CCMC Authority Board of Directors
From: Chief Nursing Officer, Tammy Pokorney, RN
RE: Nursing Report

February 2018 Nursing Activity Update:

1. Staffing:
 - a. Nursing staff continues to have rotational turnover but there are two projected permanent positions-one full time and one part time-expected to be filled in March.
 - b. All CNA positions are currently filled although with the fluctuant census of late (as many as 18 patients/residents of higher acuity) we are considering PRN/temp staffing locally.
 - c. The Dietary/Activities staffing is adequate, although volunteers are always welcome.
2. Census:
 - a. LTC census is 10 residents. Currently, we have 4 Swing beds occupied. Highest census was 18.
3. The ongoing challenges:
 - a. Technology innovations-See #4.
 - b. Training-requirements for compliance and innovations require additional time.
 - c. Traveler staff turnover-attempting to hire more permanent staff.
 - d. Surveys-have occupied the leadership staff as we continue to establish processes that are sustainable and measurable.
4. Systems being implemented at this time:
 - a. Point Click Care-go live 3/1 for all documentation for Long Term Care; goal is single electronic system for the residents and CMS compliance with quality programs inherent in the software.
 - b. Relias Learning Management System-go live 3/31 for all education services of staff. Currently building training plans to support the compliance as a facility but also to educate staff on changing healthcare trends.
5. Attached is the quality report for:
 - a. Abaqis for Long Term Care. (sample completed in last 60 days)
 - b. Partnership for Patients.
 - c. Mountain Pacific report on Reducing Healthcare-Acquired Conditions in Nursing Homes.

Please let me know if there are any questions.

Tammy Pokorney
CNO

MDS 3.0 Report

025028: Cordova Community Medical Center Long-Term Care, Cordova, AK

Report Filter:

- Analysis Period End Date: **19-Mar-2018**
- Random QAPI Sample: **December 2017**
- Resident Group(s): **LTC**

Residents included: 10

Accidents

Accident Hazards - Wandering to a Dangerous Place (Most Recent FULL MDS) (QP298)



Activities of Daily Living

Incidence of Decline in ADLs (Previous & Most Recent (excl. Adm.) MDS) (QP290)



Bed Mobility



Transfer



Locomotion on Unit



Locomotion off Unit



Dressing



Eating



Toileting



Behavioral and Emotional Status

Increase in Physical Abuse (Admission-90 MDS) (QP043a)



Increase in Resistance to Care (Admission-90 MDS) (QP106a)



Increase in Resistance to Care (Previous-Most Recent MDS) (QP106b)



Bladder or Bowel Incontinence

Continence Decline Since Admission (Admission-90 MDS) (QP047)



Communication and Sensory Problems (Includes Hearing and Vision)

Lack of Corrective Action for Visual Problems (Most Recent MDS) (QP213)

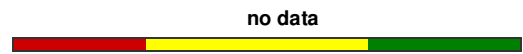


Lack of Corrective Action for Auditory Problems (Most Recent MDS) (QP214)

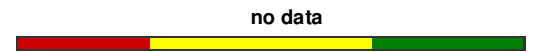


Dental Status and Services

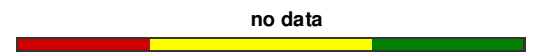
Oral/Dental Problems (Most Recent FULL MDS) (QP217)



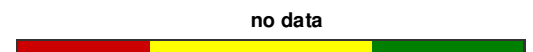
Broken Denture



No Natural Teeth



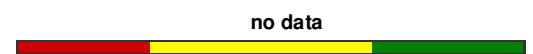
Abnormal mouth tissue



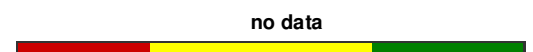
Obvious cavity



Inflamed, bleeding gums



Mouth, facial pain



Hydration

Prevalence of Dehydration (Most Recent MDS) (QP015)



Dehydration



Volume Depletion



Infections (non-UTI related)

Wound Infection (Most Recent MDS) (QP061)



Nutrition

Prevalence of Weight Loss (Most Recent MDS) (QP013)



Physical Restraints

Prevalence of a Daily Device (Most Recent MDS) (QP022)



Trunk Restraint (In Bed)



Limb Restraint (In Bed)



Trunk Restraint (In Chair)



Limb Restraint (In Chair)



Chair Prevents Rising



Positioning, Mobility and Range of Motion

Incidence of Decline in Functional Range of Motion (Previous-Most Recent MDS) (QP018)



Range of Motion in Upper Extremities



Range of Motion in Lower Extremities



Pressure Ulcers

Prevalence of Stage 1-4 Pressure Ulcers (High Risk) (Most Recent MDS) (QP024_H)



Pressure Ulcer



Additional Active Diagnoses - 707/E86.9



Prevalence of Stage 1-4 Pressure Ulcers (Low Risk) (Most Recent MDS) (QP024_L)



Pressure Ulcer



Additional Active Diagnoses - 707/L89



Tube Feeding

Prevalence of Tube Feeding (Most Recent MDS) (QP014)



Urinary Catheter or Urinary Tract Infection

Prevalence of Indwelling Catheters (Most Recent MDS) (QP010)



Prevalence of Urinary Tract Infections (Most Recent MDS) (QP012)



Residents With Flagged Assessments

QCLI: Accident Hazards - Wandering to a Dangerous Place (Most Recent FULL MDS) (QP298)

Name	Identifier	Room Number	Assessment Date(s)
------	------------	-------------	--------------------

Wandering

No residents were flagged for this care area.

QCLI: Incidence of Decline in ADLs (Previous & Most Recent (excl. Adm.) MDS) (QP290)

Name	Identifier	Room Number	Assessment Date(s)
------	------------	-------------	--------------------

Bed Mobility

No residents were flagged for this care area.

Transfer

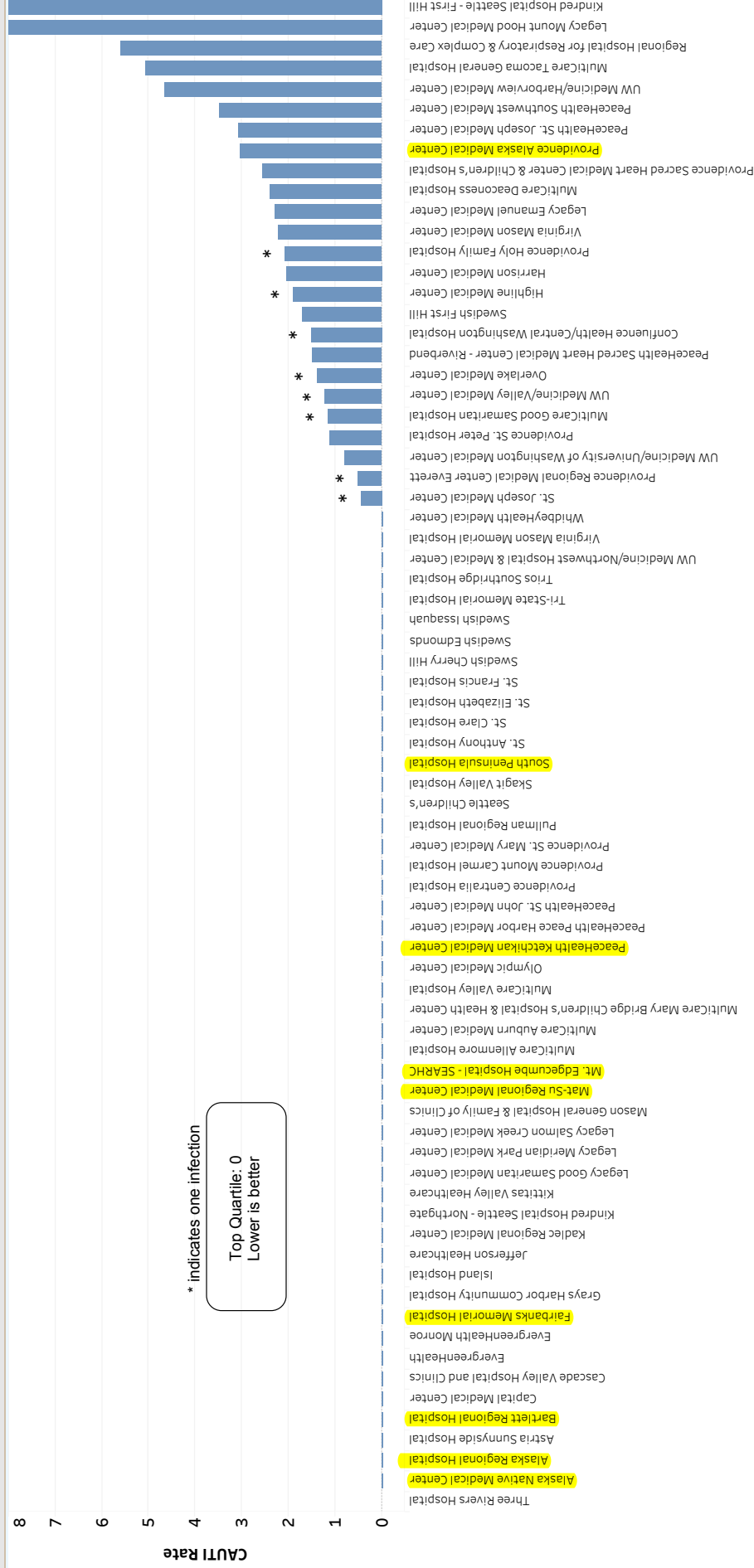
No residents were flagged for this care area.

Locomotion on Unit

No residents were flagged for this care area.

Patient Safety Comparison Report - January 2018 Release

**Catheter Associated Urinary Tract Infection (CAUTI) ICU Rate
2017 Q3 Distribution**



Definition: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN), CAUTIs per 1,000 urinary catheter days.
Data Source: CDC NHSN

Washington State Hospital Association - for questions or support in improving results, please contact JeniferG@wsa.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Catheter Associated Urinary Tract Infection (CAUTI) Non-ICU Rate 2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). CAUTIs per 1,000 urinary catheter days.
Data Source: CDC NHSN

Washington State Hospital Association - for questions or support in improving results, please contact jennifer5@wsha.org.

Decision Support

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Central Line Associated Bloodstream Infections (CLABSI) ICU Rate 2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN), number of central line associated bloodstream infections per 1,000 central line days.
Data Source: CDC NHSN

Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wshta.org.

Partnership for Patients

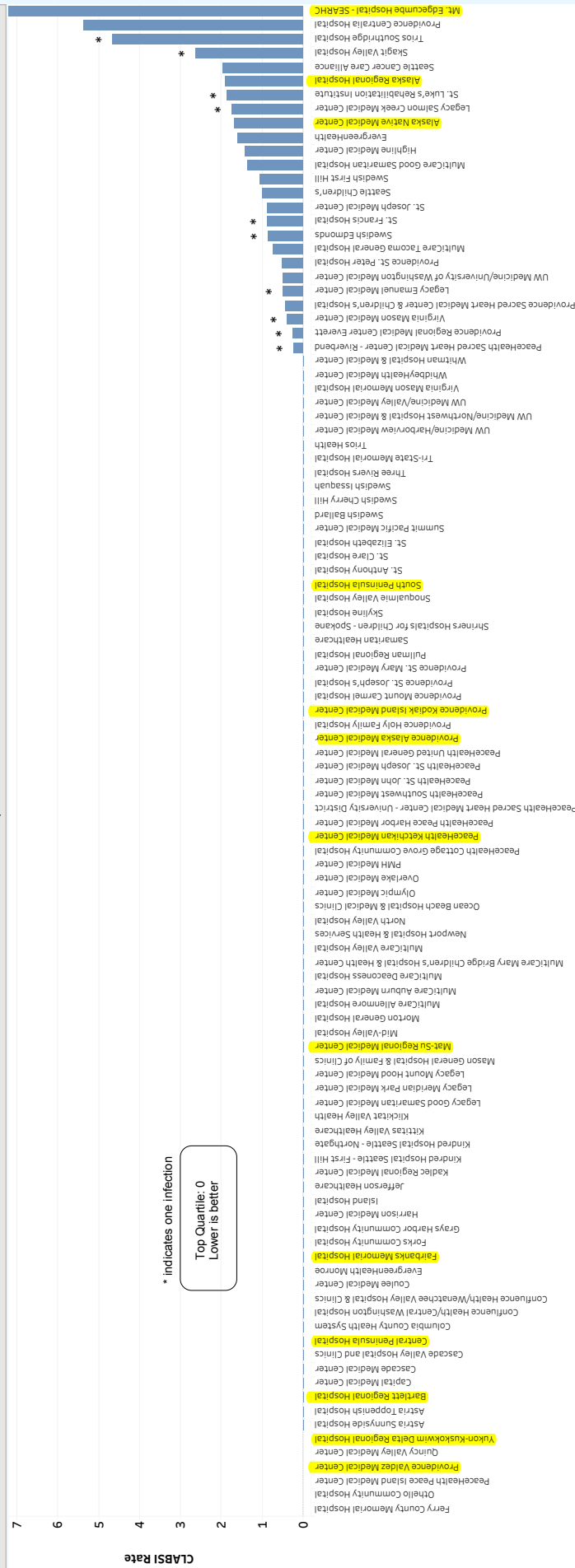
ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION



Washington State Hospital Association

Patient Safety Comparison Report - January 2018 Release

Central Line Associated Bloodstream Infections (CLABSI) Non-ICU Rate 2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN), number of central line associated bloodstream infections per 1,000 central line days.

Data Source: CDC NHSN

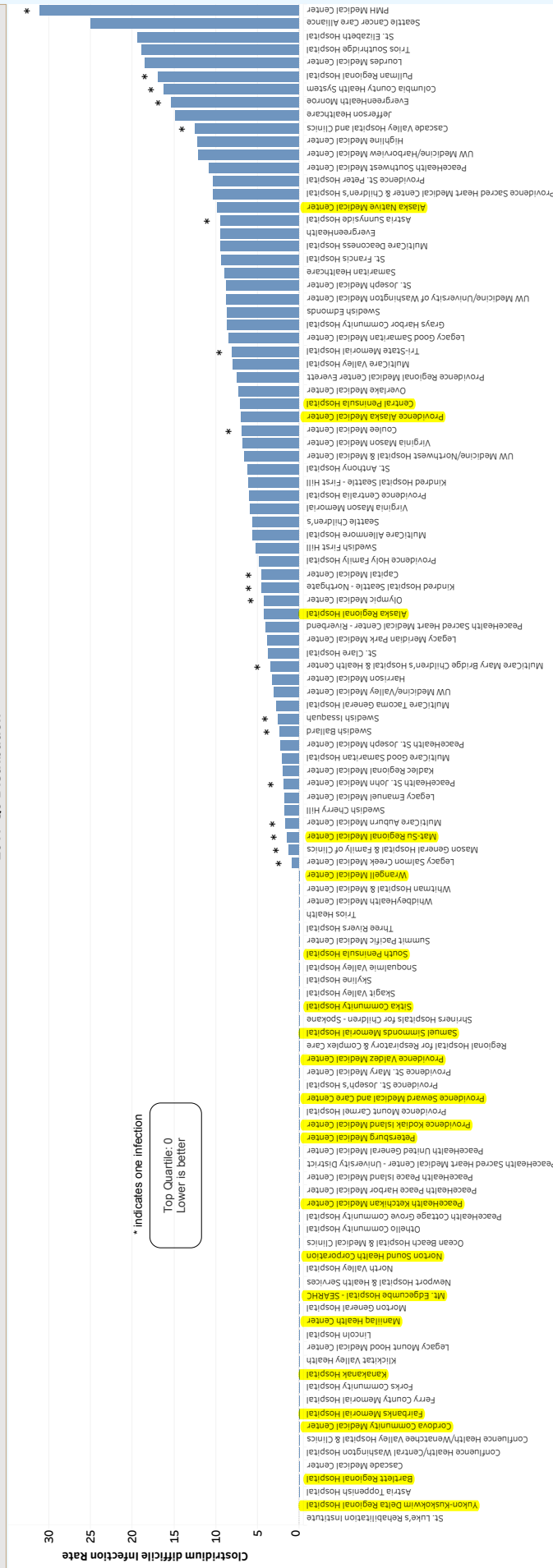
Washington State Hospital Association - for questions or support in improving results, please contact JemiferC@wsaha.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Clostridium difficile Infection (CDI) Rate 2017 Q3 Distribution



Definition: Facility CDI Healthcare Facility-Onset Incidence Rate = Number of all healthcare facility-onset (HO) Clostridium difficile infections (CDI) laboratory-identified (LabID) events per month in the facility / number of patient days for the facility x 10,000.
Data source: Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)

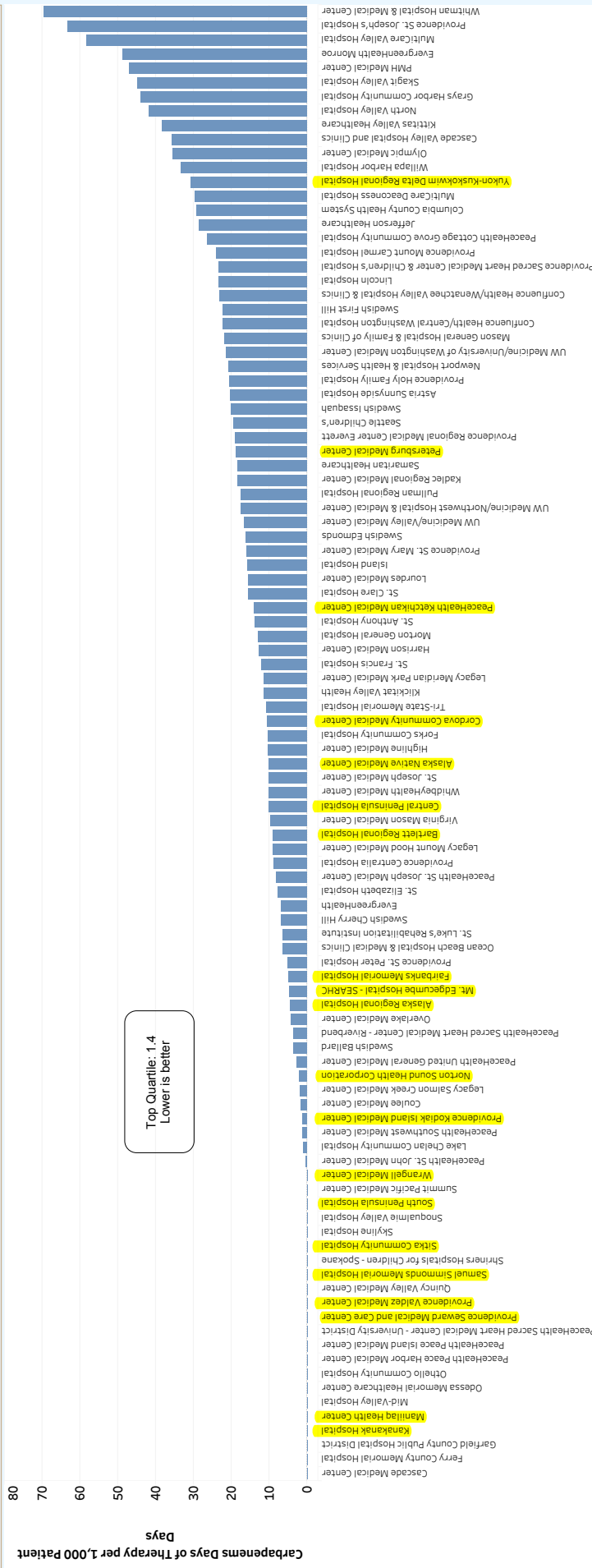
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsha.org.

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Patient Safety Comparison Report - January 2018 Release

Antimicrobial Stewardship (ASP) Carbapenems Days-of-Therapy 2017 Q3 Distribution



Definition: Total number of days of therapy over total number of patient days * 1,000 (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

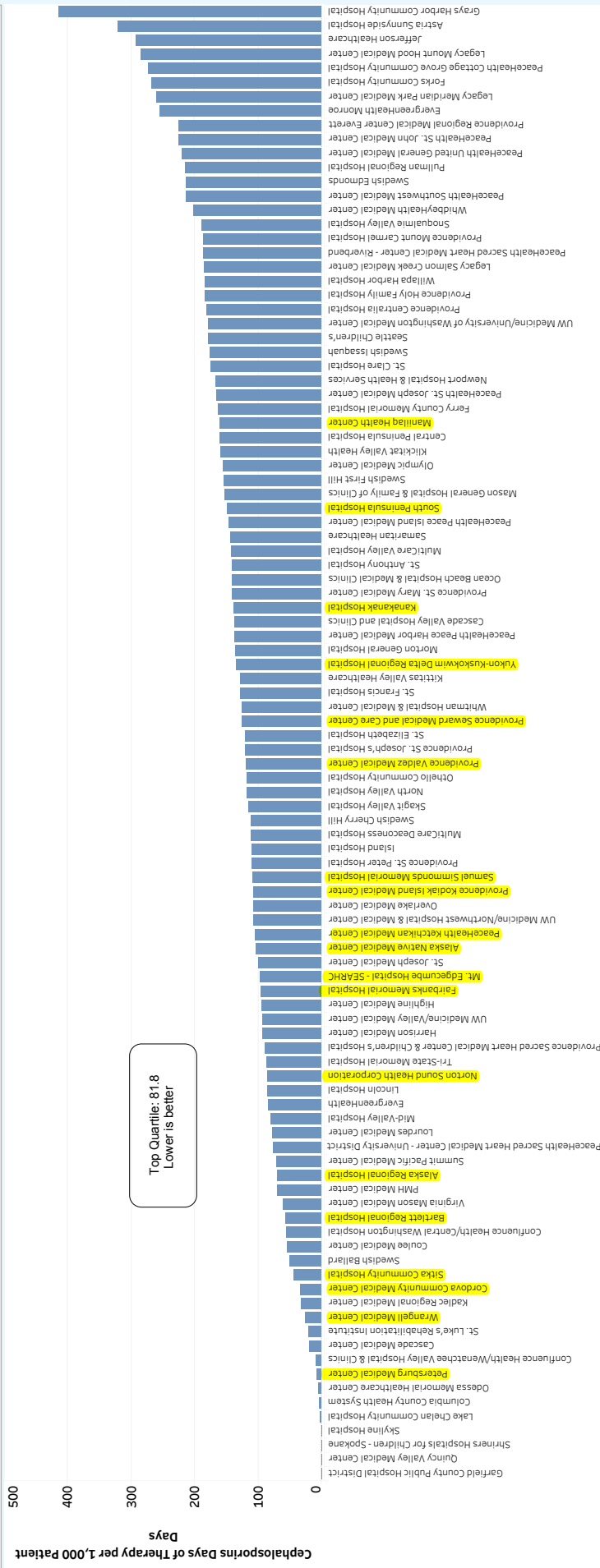
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsaha.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Antimicrobial Stewardship (ASP) Cephalosporins Days-of-Therapy 2017 Q3 Distribution



Definition: Total number of days of therapy over total number of patient days * 1,000 (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsa.org.

Decision Support

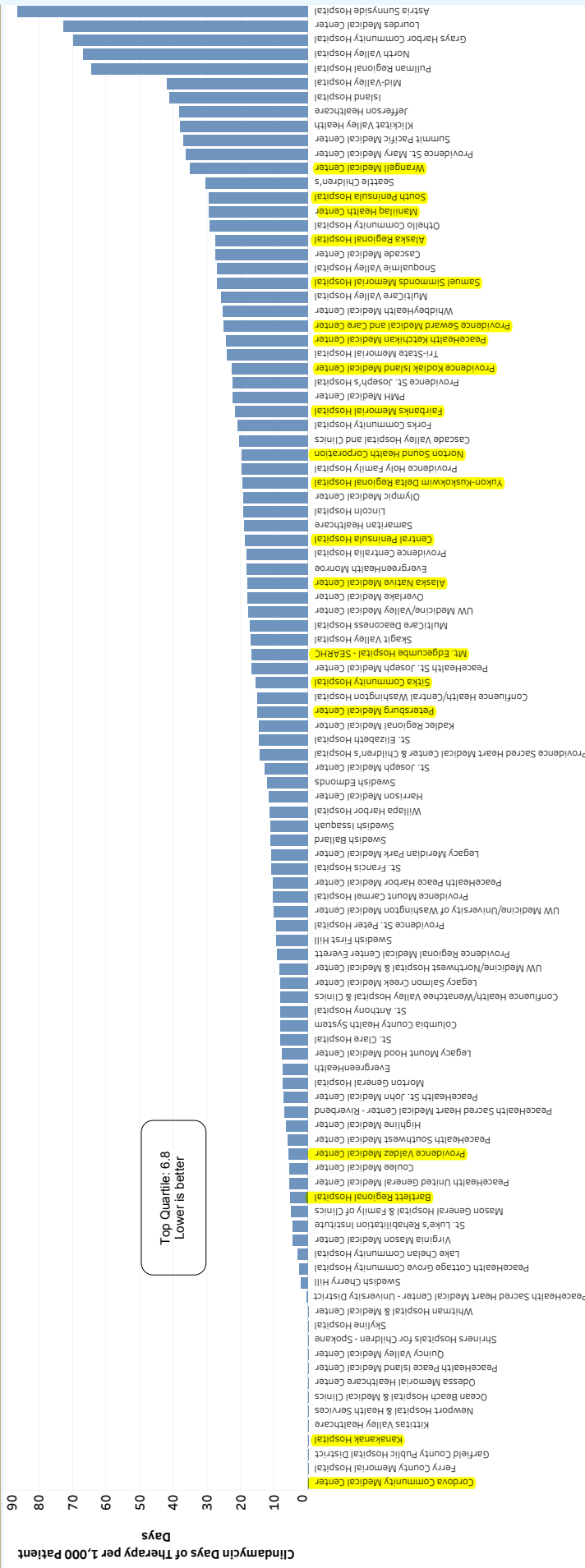
7

Partnership for Patients



Patient Safety Comparison Report – January 2018 Release

Antimicrobial Stewardship (ASP) Clindamycin Days-of-Therapy 2017 Q3 Distribution



Definition: Total number of days of therapy over total number of patient days * 1,000 (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

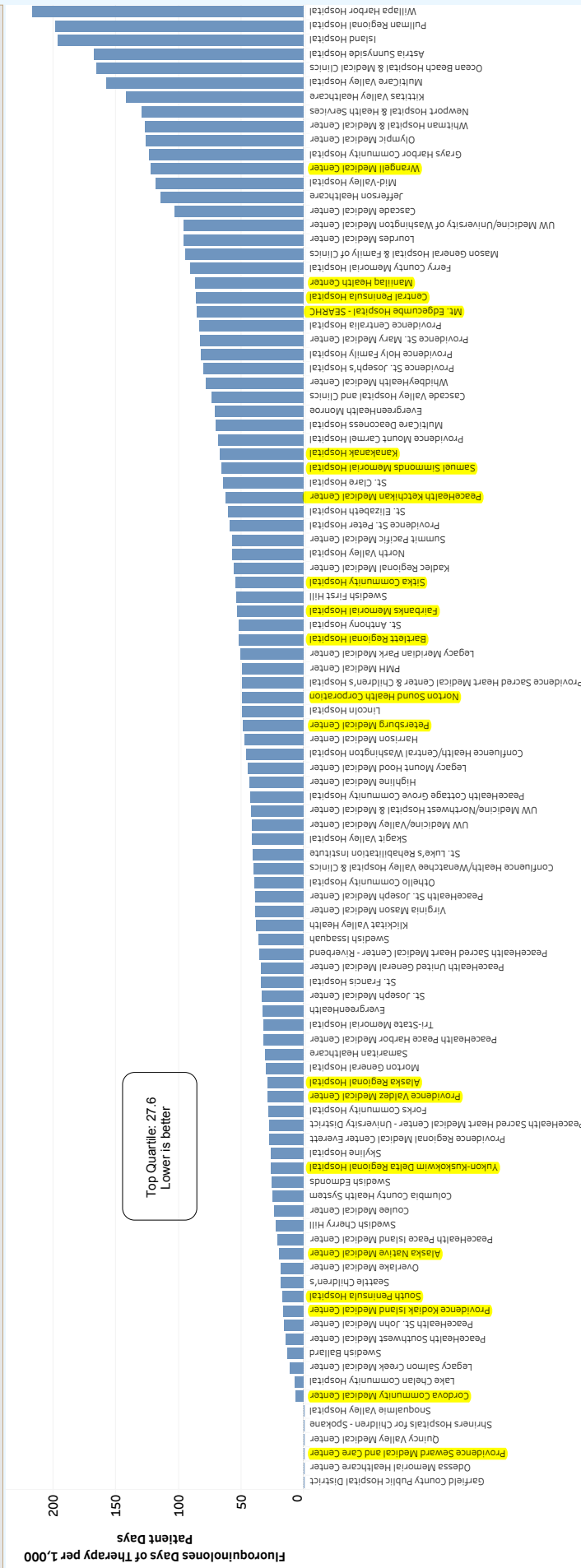
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsa.org.

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Antimicrobial Stewardship (ASP) Fluoroquinolones Days-of-Therapy 2017 Q3 Distribution

2017 Q3 Distribution



Definition: Total number of days of therapy over total number of patient days * 1,000 (Cefepime, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

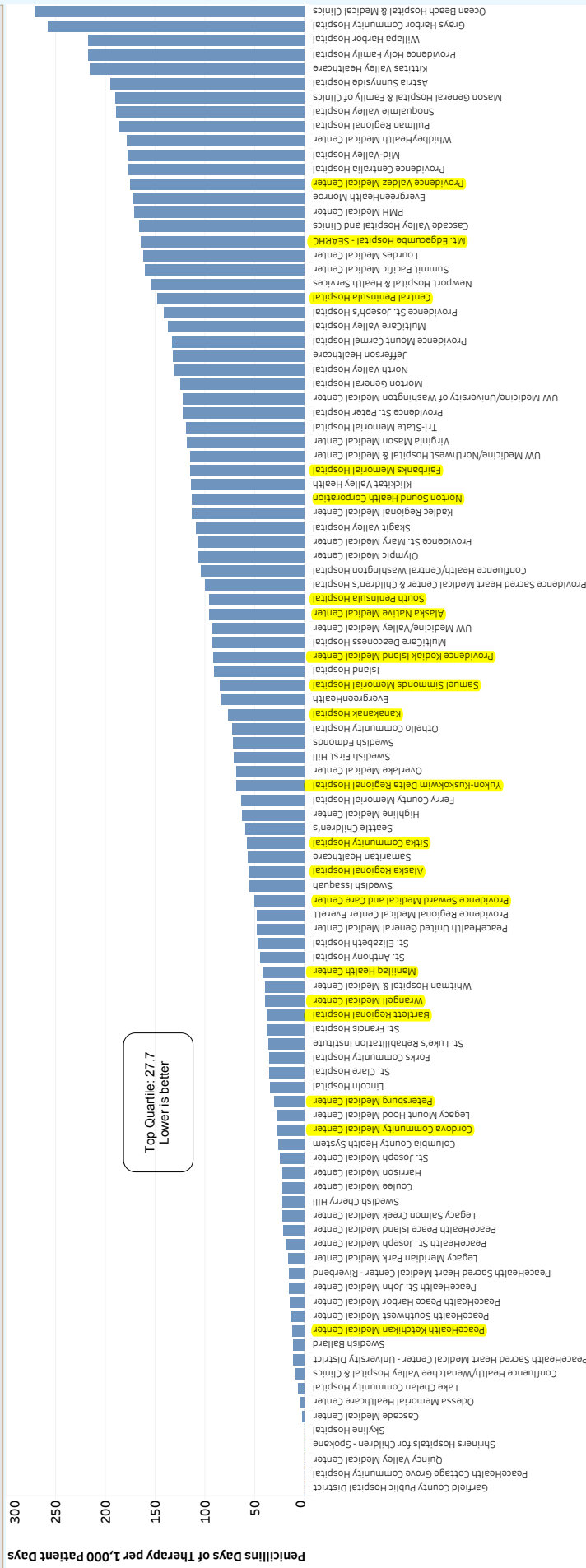
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsa.org.

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Patient Safety Comparison Report - January 2018 Release

Antimicrobial Stewardship (ASP) Penicillins Days-of-Therapy 2017 Q3 Distribution



Definition: Total number of days of therapy over total number of patient days * 1,000 (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

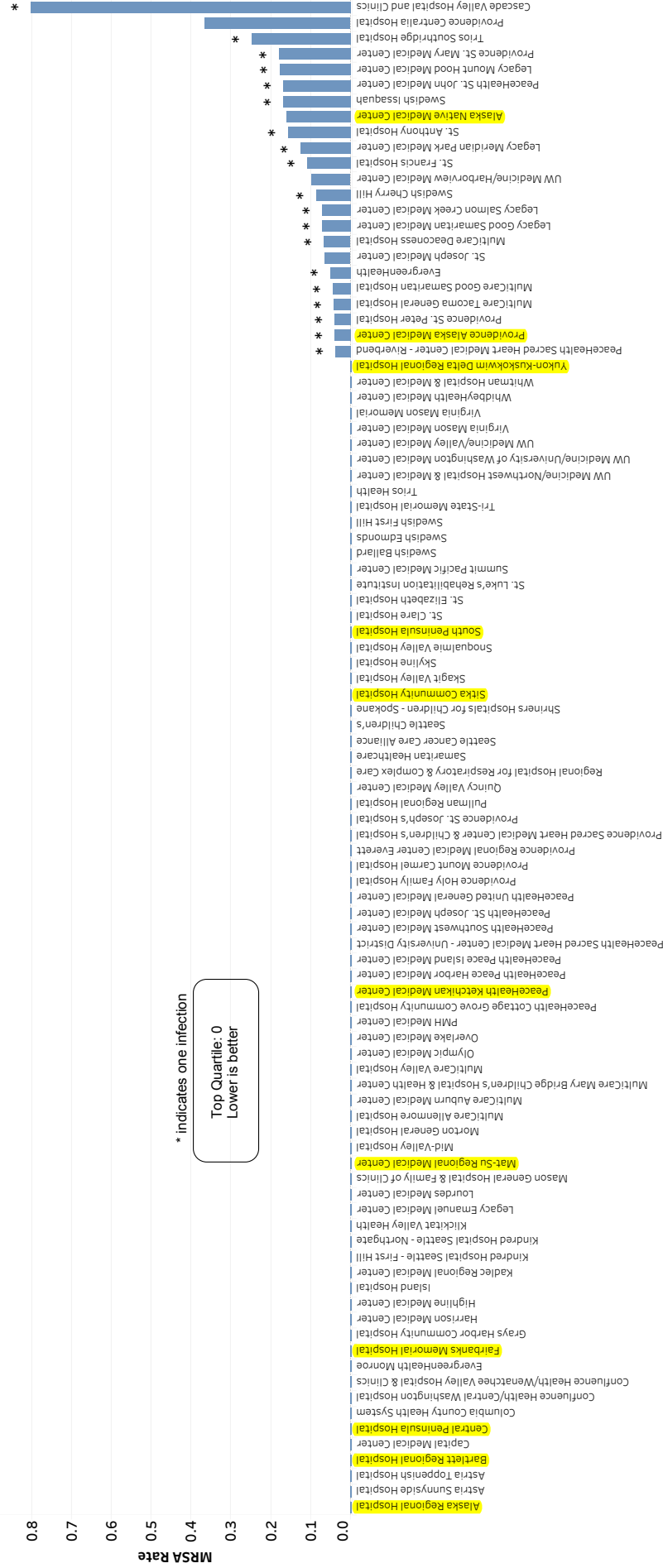
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsa.org.

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Patient Safety Comparison Report - January 2018 Release

Methicillin-Resistant Staphylococcus Aureus (MRSA) 2017 Q3 Distribution



Definition: Methicillin-Resistant Staphylococcus Aureus (MRSA) Blood Incident LabID Rate is the number of MRSA Blood Incident LabID Count per 1,000 patient days.

Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN)

Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsaha.org.

Partnership for Patients

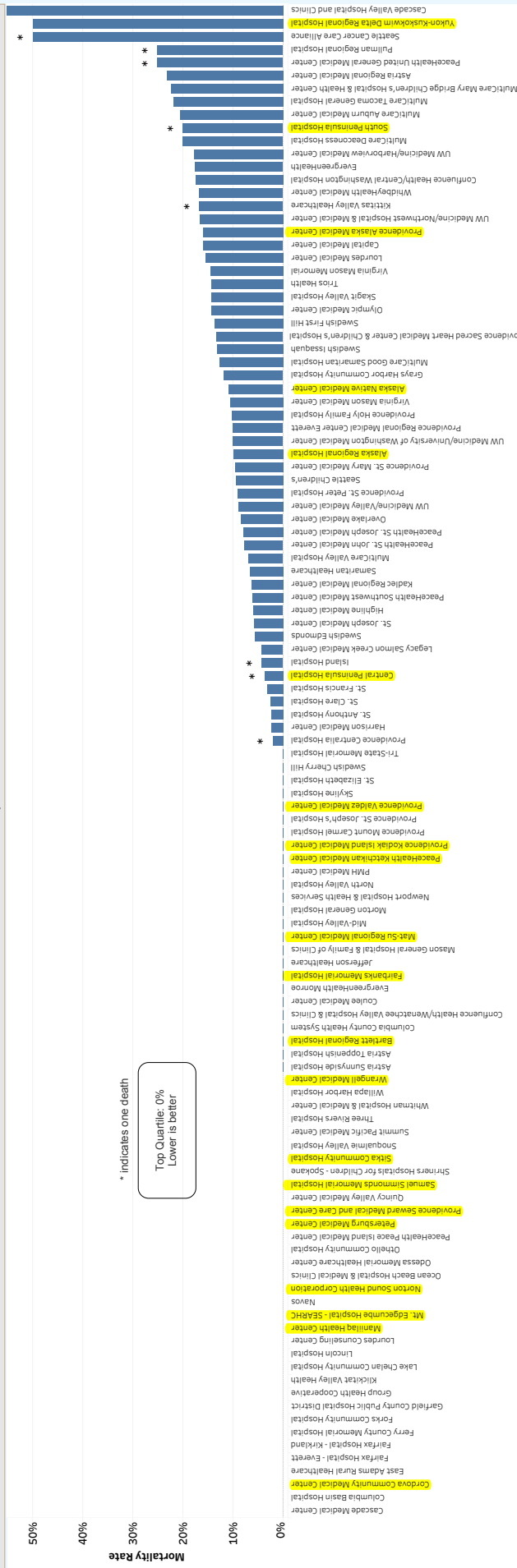
ALASKA STATE HOSPITALS & NURSING HOME ASSOCIATION

Washington State Hospital Association

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Severe Sepsis and Septic Shock Mortality Rate

2017 Q3 Distribution

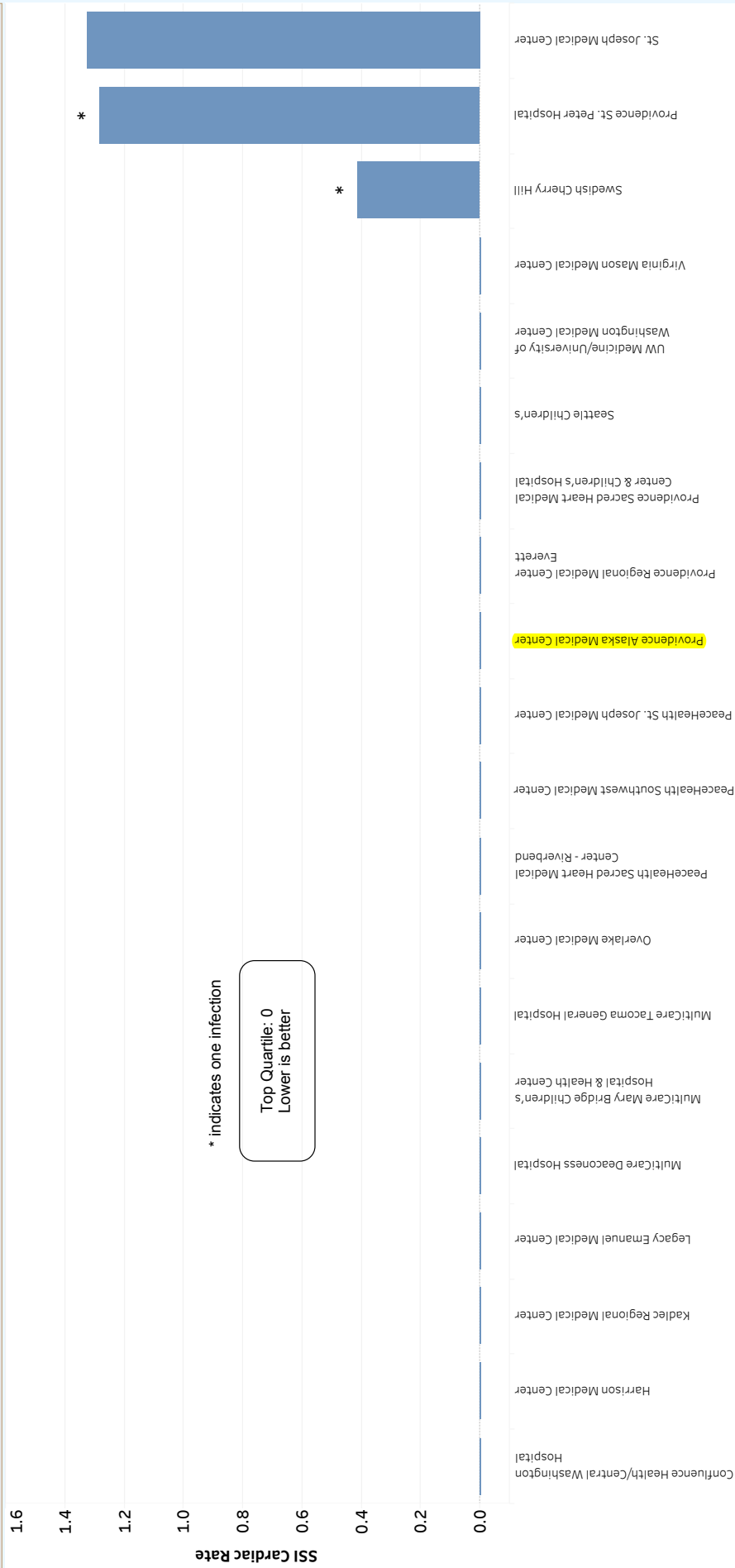


Definition: Hospital deaths related to Severe Sepsis and Septic Shock (All Ages) from the number of patients diagnosed with Severe Sepsis and Septic Shock (Excludes Comfort Care Patients) (with ICD-9 or ICD-10 codes).
Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS)

Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsa.org.

Patient Safety Comparison Report - January 2018 Release

**Surgical Site Infection (Cardiac) Rate
2017 Q3 Distribution**



Definition: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN). Deep incisional and Organ/Space SSI per 100 operative procedures (Cardiac surgery, Coronary artery bypass graft with both chest and donor site incisions [CBGB], Coronary artery bypass graft with chest incision only [CBGC], Colon, Hip prosthesis, Knee prosthesis, Abdominal hysterectomy).

Data Source: CDC NHSN.

Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsha.org.

Patient Safety Comparison Report - January 2018 Release

Surgical Site Infection (Colon) Rate 2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN). Deep incisional and Organ/Space SSI per 100 operative procedures (Cardiac surgery, Coronary artery bypass graft with both chest and donor site incisions [CBGC], Coronary artery bypass graft with chest incision only [CBGC], Colon, Hip prosthesis, Knee prosthesis, Abdominal hysterectomy).

Data Source: CDC NHSN.

Patient Safety Comparison Report - January 2018 Release

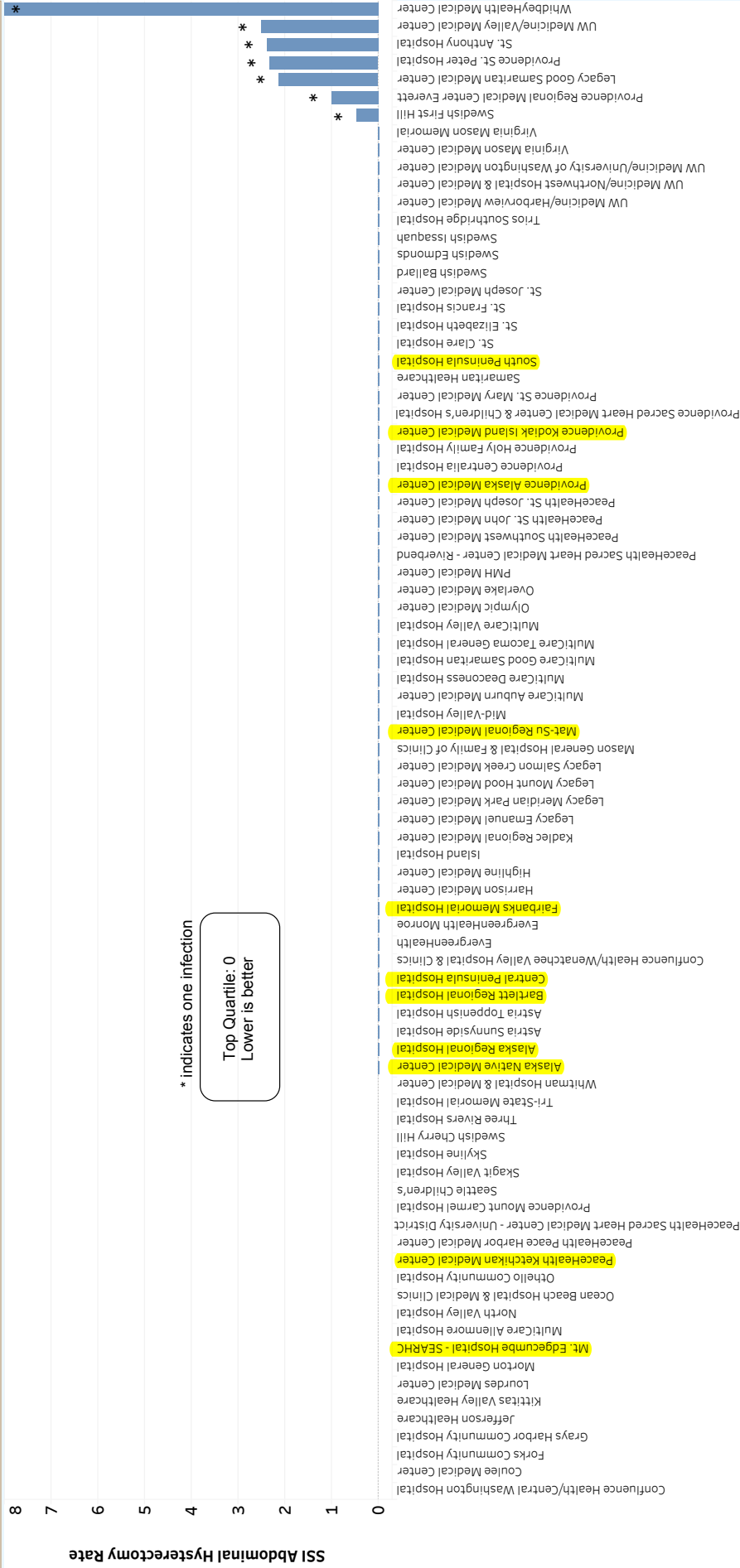
Surgical Site Infection (Hip and Knee) Rate
2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN). Deep incisional and Organ/Space SSI per 100 operative procedures (Cardiac surgery, Coronary artery bypass graft with both chest and donor site incisions [CBGB], Coronary artery bypass graft with chest incision only [CBGC], Colon, Hip prosthesis, Knee prosthesis, Abdominal hysterectomy).
Data Source: CDC NHSN.

Patient Safety Comparison Report - January 2018 Release

Surgical Site Infection (Abdominal Hysterectomy) Rate 2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN). Deep incisional and Organ/Space SSI per 100 operative procedures (Cardiac surgery, Coronary artery bypass graft with both chest and donor site incisions [CBGG], Coronary artery bypass graft with chest incision only [CBGC], Colon, Hip prosthesis, Knee prosthesis, Abdominal hysterectomy).

Data Source: CDC NHSN.

Patient Safety Comparison Report - January 2018 Release

Ventilator Associated Events (VAE): Infection-Related Ventilator-Associated Complications IVAC
2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN), Total number of confirmed VAC and IVAC per 1000 ventilator days.
Data Source: CDC NHSN

Washington State Hospital Association - for questions or support in improving results, please contact JenniferC@wsha.org.

Patient Safety Comparison Report - January 2018 Release

Ventilator Associated Events (VAE): Ventilator-Associated Condition VAC
2017 Q3 Distribution



Definition: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN), Total number of confirmed VAC and IVAC per 1000 ventilator days.

Data Source: CDC NHSN

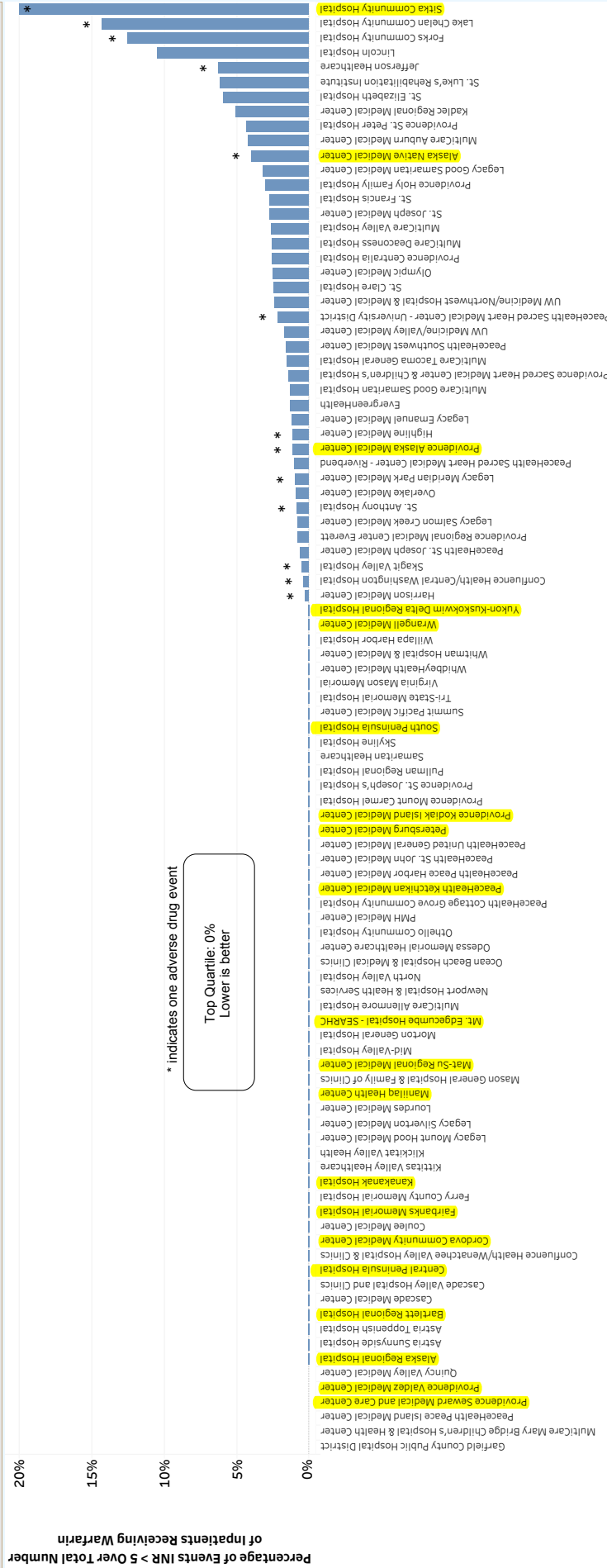
Washington State Hospital Association - for questions or support in improving results, please contact JenniferC@wshta.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Adverse Drug Events Anticoagulants: Option 1 2017 Q3 Distribution



Definition: Number of patient events with an INR >5 after any warfarin administration (for patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) on warfarin. A patient that has multiple elevated INRs will be counted as one event until it drops below 3.5 and rises above 5 again. Exclusions: emergency department readings, patients admitted for trauma, patients with liver failure diagnosis, and patients given argatroban before warfarin.

Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System

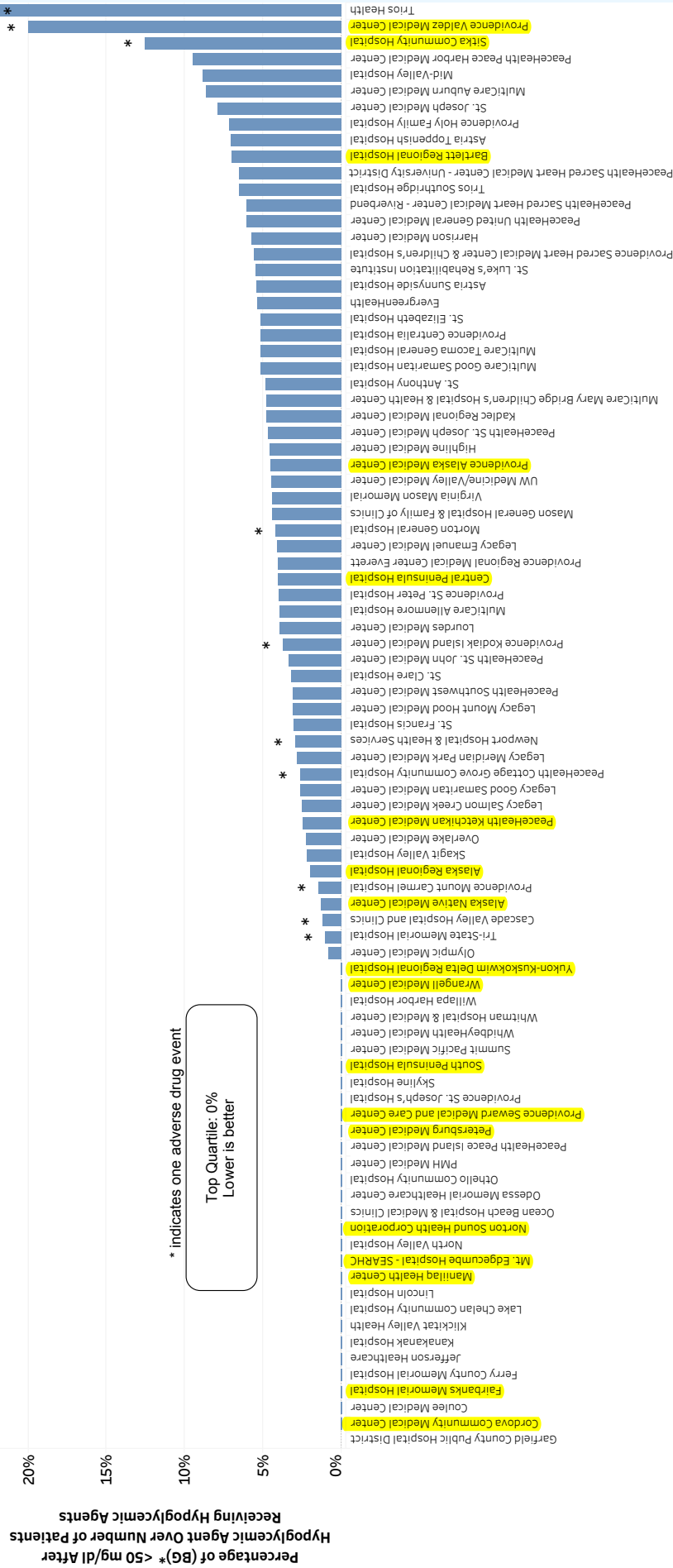
Washington State Hospital Association - for questions or support in improving results, please contact jennifer.G@wsaha.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Adverse Drug Events Hypoglycemic Agent: Option 1 2017 Q3 Distribution



Definition: Number of patient blood glucose (BG)* levels of <50 mg/dl after any hypoglycemic agent administration (patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) receiving hypoglycemic agents (oral & insulin).

Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System

Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsaha.org.

Partnership for Patients



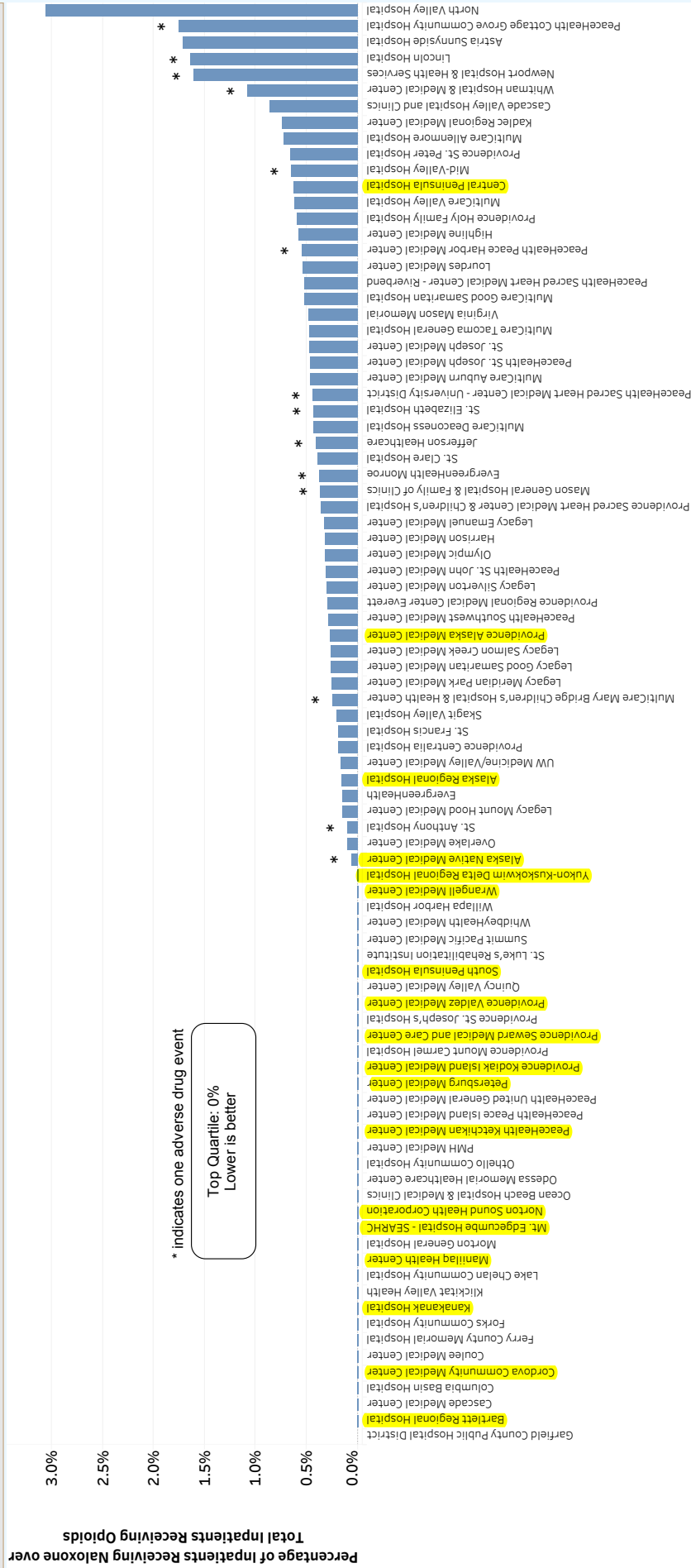
ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION



Washington State
Hospital Association

Patient Safety Comparison Report - January 2018 Release

Adverse Drug Events Opioids: Option 1 2017 Q3 Distribution



Definition: Number of patients (cared for in an inpatient area) who received naloxone after any opioid administration over number of patients (cared for in an inpatient area) receiving opioids. Exclusions: naloxone given in PACU and procedural areas, given (via IV infusion) for epidural-related itching symptoms all doses given in the ED or within 24 hours of admission for a diagnosis of suicide attempt, opiate abuse, dependence, poisoning, or overdose.

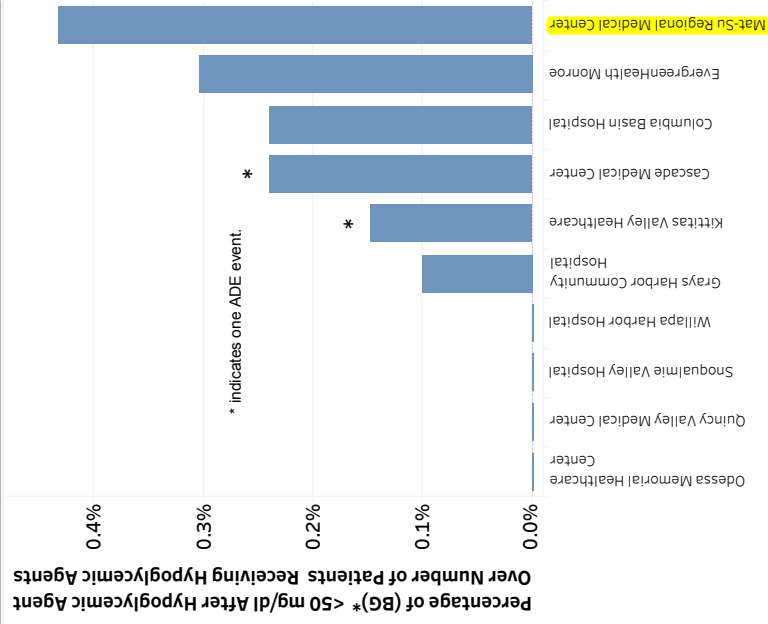
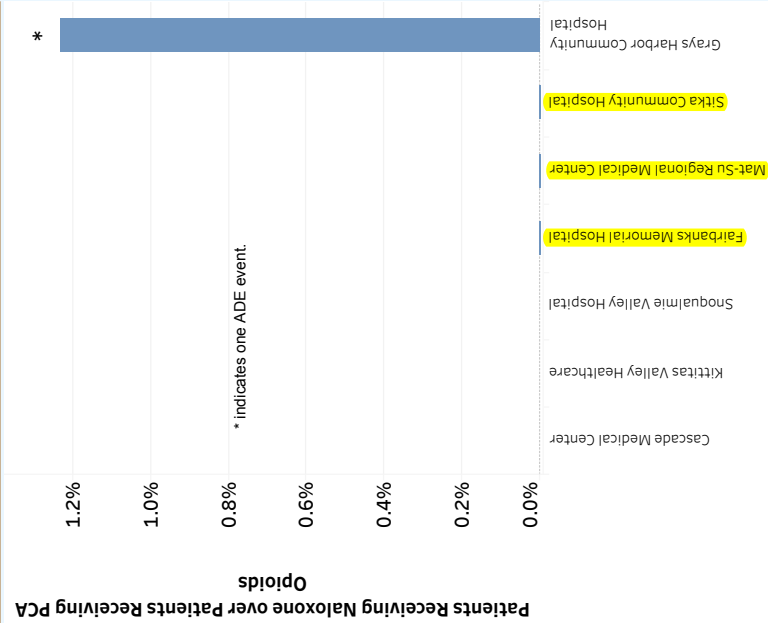
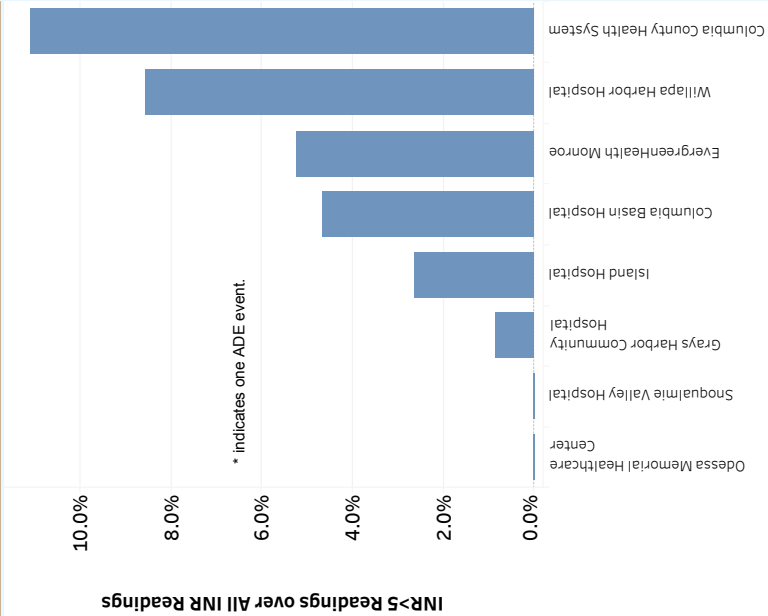
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System

Washington State Hospital Association - for questions or support in improving results, please contact Jennifer.G@wsaha.org.

Adverse Drug Events Anticoagulants
Option 2

Adverse Drug Events Opioids
Option 2

Adverse Drug Events Hypoglycemic Agent
Option 2



Anticoagulants ADE #2 Description:Total number of INR>5 readings (for patients cared for in an inpatient area) over total number of INR readings (for patients cared for in an inpatient area).

Opioid ADE #2 Description:Total number of patients (cared for in an inpatient area) receiving naloxone after PCA administration over total patient days (cared for in an inpatient area) receiving PCA opioids.

Hypoglycemic ADE #2 Description:Total number of BG (blood glucose) levels of <50 mg/dl (for patients cared for in an inpatient area) per 1,000 total patient days (excluding healthy newborns and ED readings).
Data Source (All): Washington State Hospital Association (WSHA) Quality Benchmarking System (QBS)

Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wshta.org.

Partnership for Patients

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION



Patient Safety Comparison Report - January 2018 Release

Inpatient Falls with Injury Rate (NQF 0202)

2017 Q3 Distribution



Definition: National Database of Nursing Quality Indicators/Collaborative Alliance for Nursing Outcomes (CALNOC) and NQF 0202: number of falls with an injury level of minor or greater per 1,000 patient days.

Date Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS) and CALNOC

Washington State Hospital Association - for questions or support in improving results, please contact Jennifer.G@wsa.org.

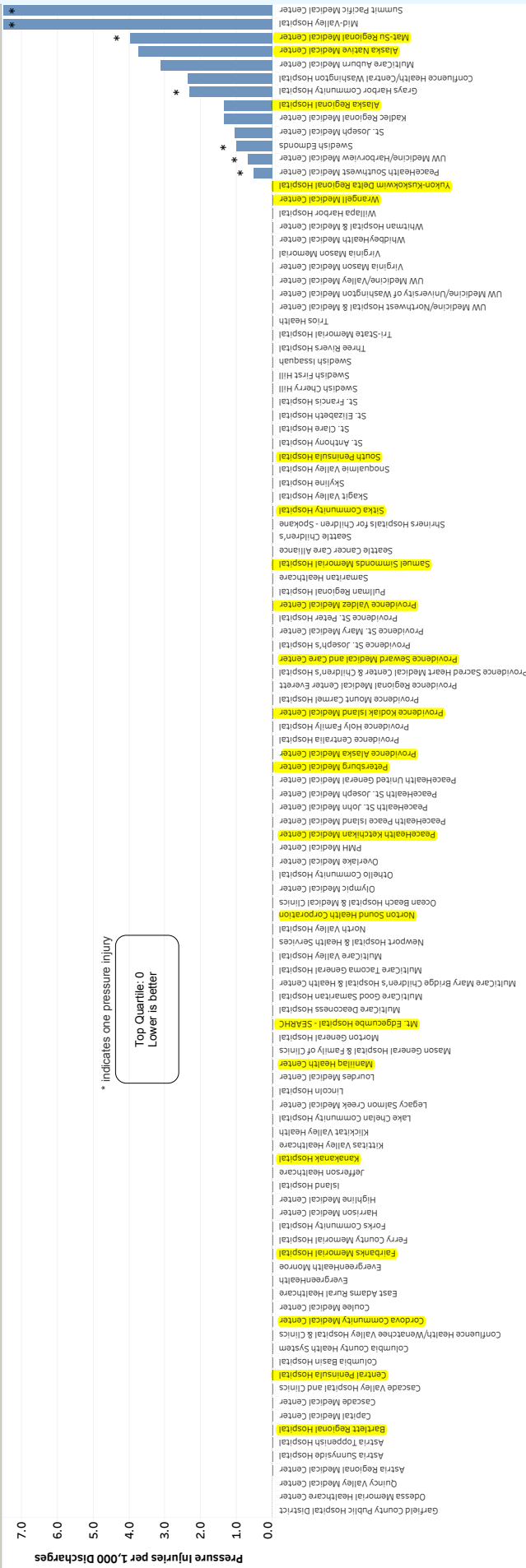
Decision Support

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Hospital-Acquired Pressure Injuries Rate (AHRQ PSI-03) 2017 Q3 Distribution



Definition: AHRQ PSI-03, number of pressure injuries stage III, IV, or unstageable per 1,000 medical and surgical discharges.
Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS)

Washington State Hospital Association - for questions or support in improving results, please contact jennifer56@wsha.org.

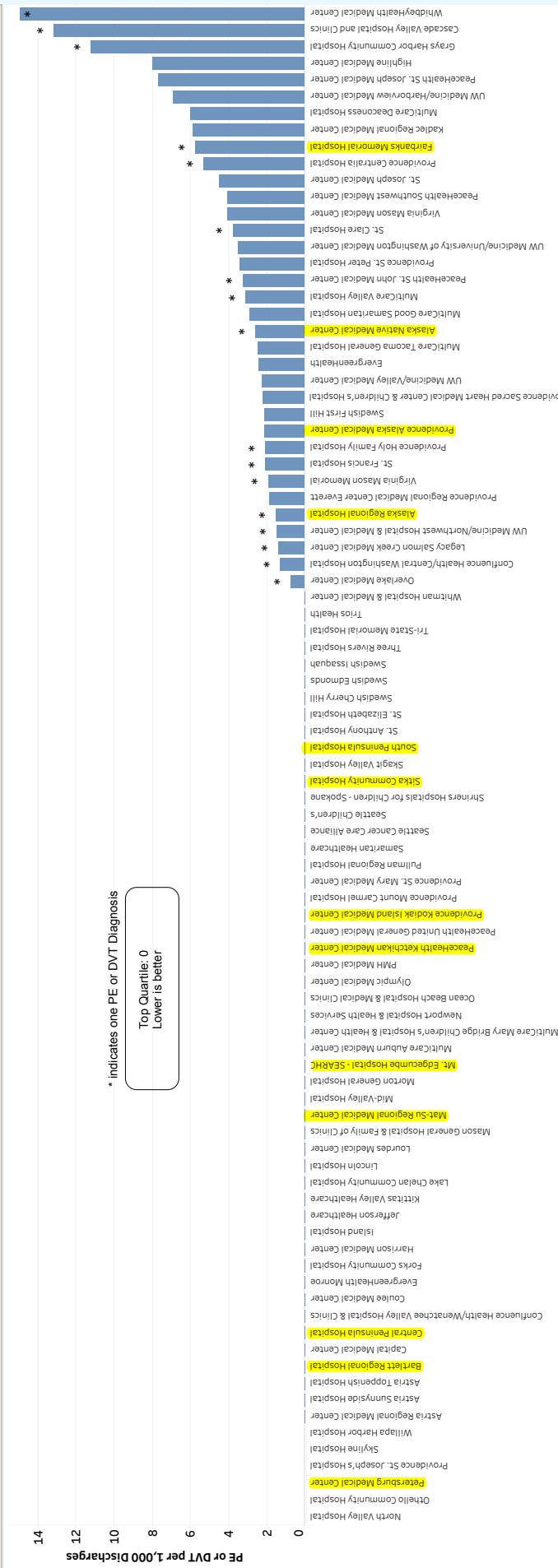
Decision Support

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Venous Thromboembolism: Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate (AHRQ PSI-12) 2017 Q3 Distribution



Definition: AHRQ PSI-12, number of PE or DVT discharges per 1,000 surgical discharges.

Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS)

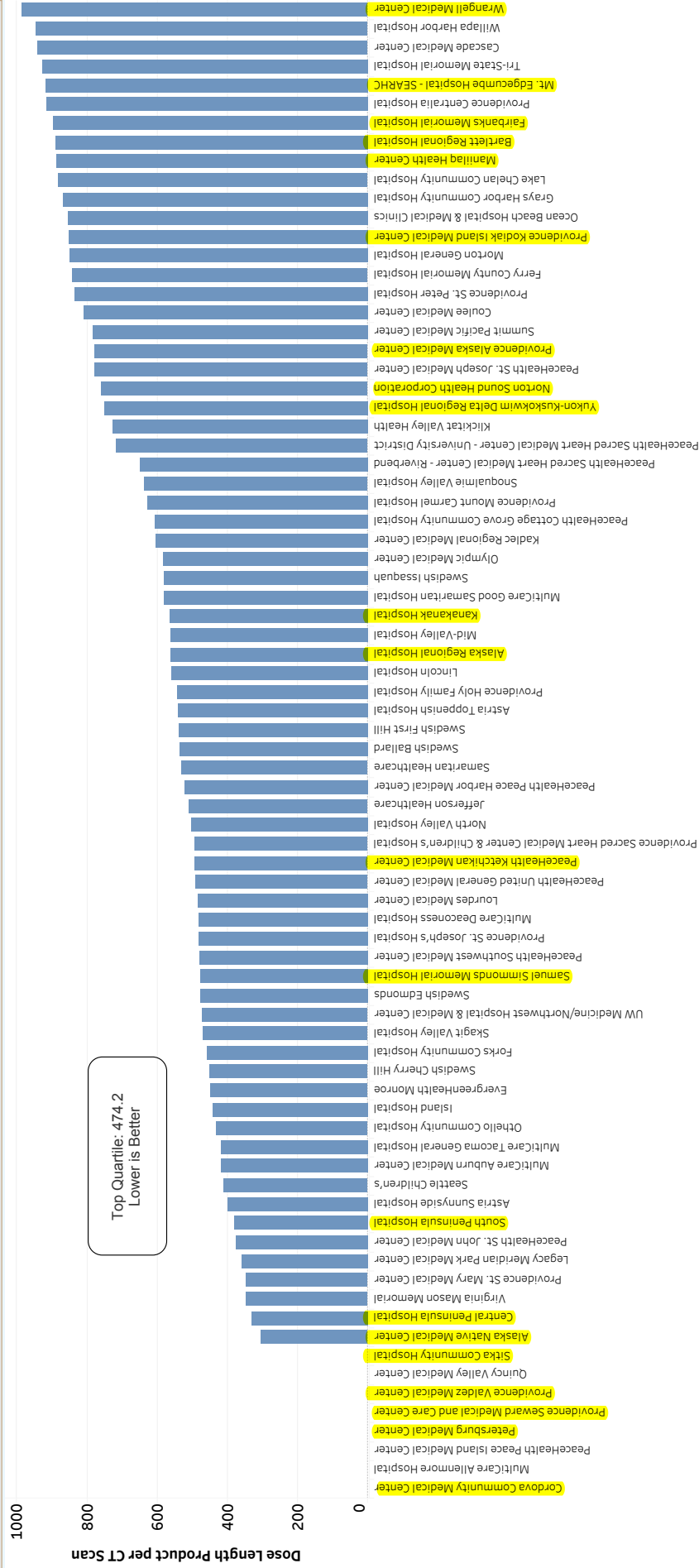
Washington State Hospital Association - for questions or support in improving results, please contact JeniferC@wsaha.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Undue Exposure to Radiation: Radiology Dosage Per Pediatric Head CT 2017 Q3 Distribution



Definition: Total dose length product (DLP) for all head CTs divided by number of head CTs for pediatric patients.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

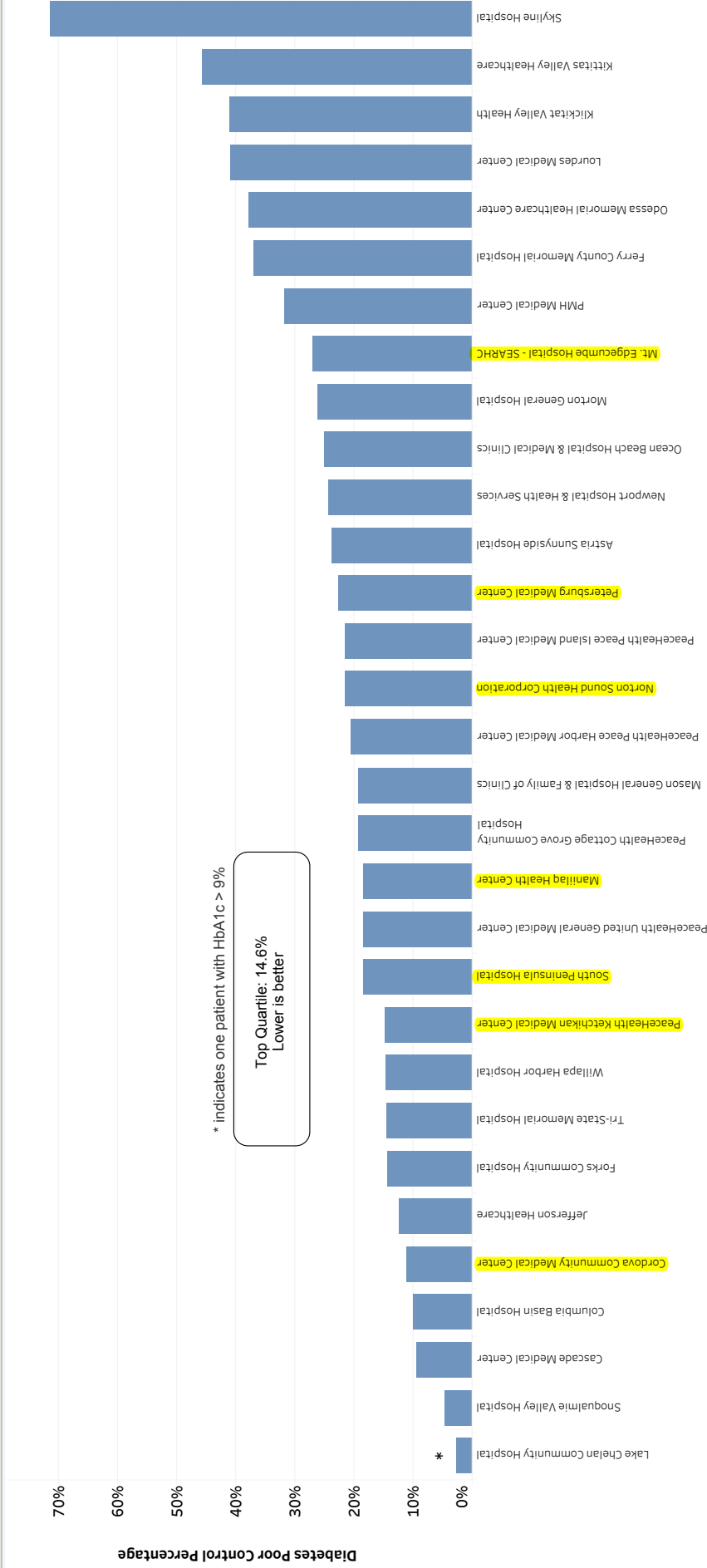
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsaha.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Population Health: Diabetic Care (Critical Access Hospitals Only) 2017 Q3 Distribution



Definition: Number of patients with HbA1c levels > 9% per all diabetes patients.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

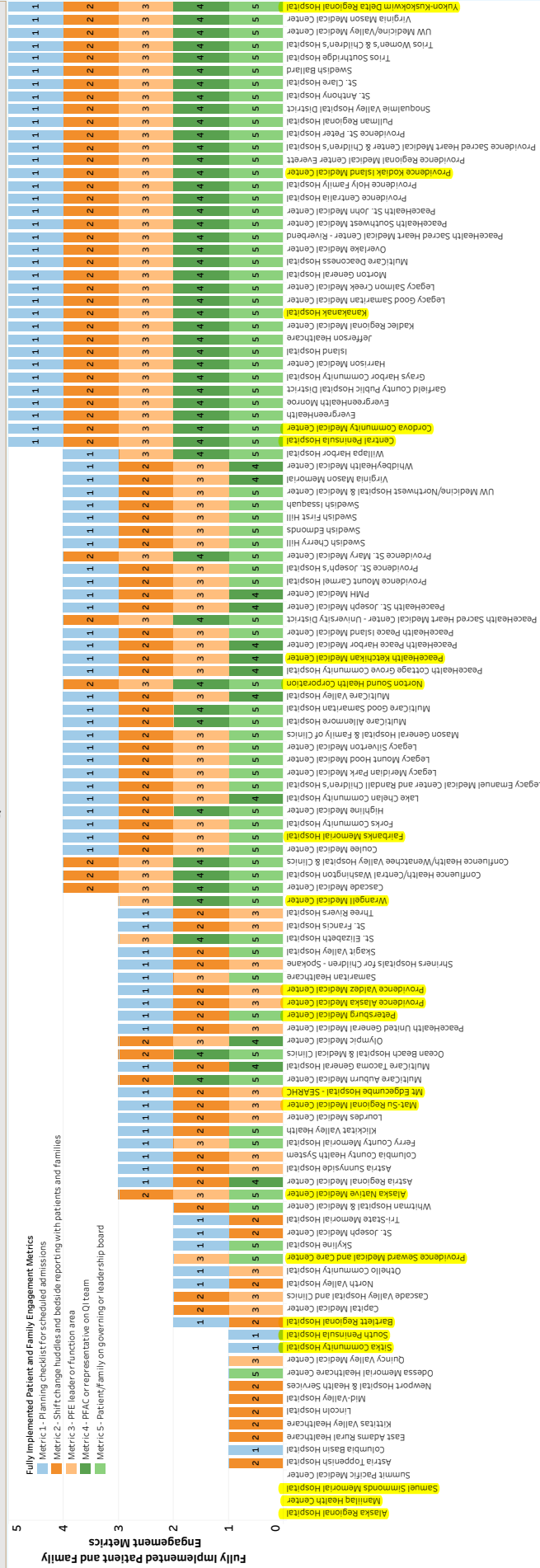
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsaha.org.

Partnership for Patients



Patient Safety Comparison Report - January 2018 Release

Patient and Family Engagement 2017 Q4 Distribution



Definition: Implementation of Five Key Metrics for Patient and Family Engagement.
Data Source: Survey Monkey

Washington State Hospital Association - for questions or support in improving results, please contact janifer5@wsaha.org.

Decision Support

28

Reducing Healthcare-Acquired Conditions in Nursing Homes

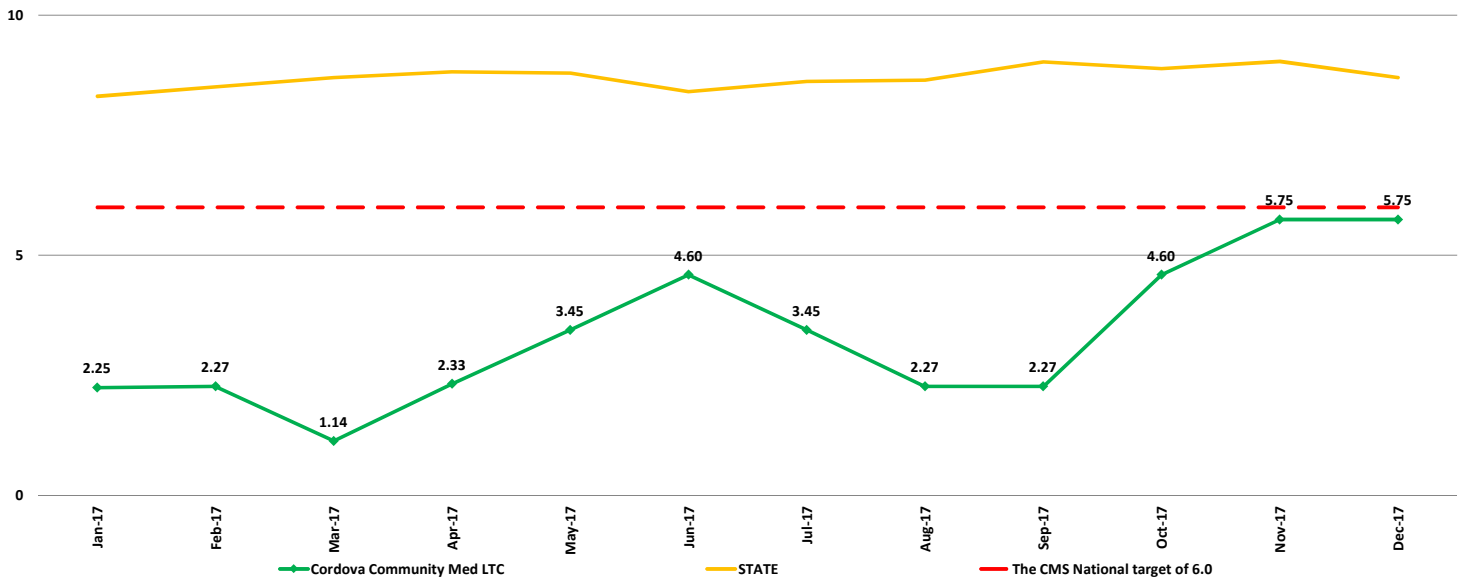
Proxy Composite Score Report, Data through December 2017

Cordova Community Med LTC

Your Facility's Current Score 5.75

Your State's Current Score 8.70

Proxy-Composite Score for your nursing center over time

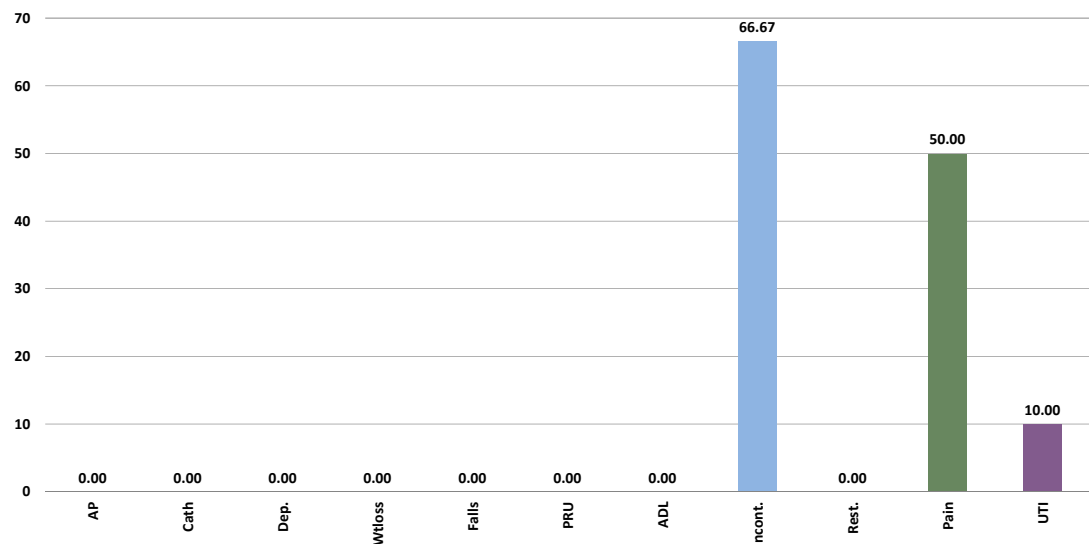


Month	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	AVG
Numerator	2	2	1	2	3	4	3	2	2	4	5	5	2.9
Denominator	89	88	88	86	87	87	87	88	88	87	87	87	87.4
Composite Rate	2.25	2.27	1.14	2.33	3.45	4.60	3.45	2.27	2.27	4.60	5.75	5.75	3.34

Proportion of the proxy-composite score from each measure for the most current time frame.

Proportion of the Proxy-Composite score from each measure: The **Proxy-composite Score** is comprised of 11 National Quality Forum-Endorsed long-stay quality measures. Which one(s) are driving your score? Look for the measure(s) with the highest percentages. Lower is better.

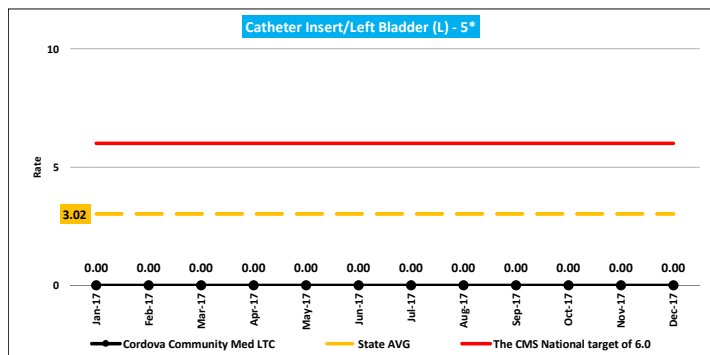
Data is from the MDS 3.0 and is presented over time in rolling 6 month time spans with the 'month' reflecting the end of the time period. For example, the data for the month of July is reflective of the time period of February 1 through July 31. The data for the proportions graph shown to the right and for your facility's current **Proxy-Composite score**, is the most recent 6 month time frame available at the time of the report.



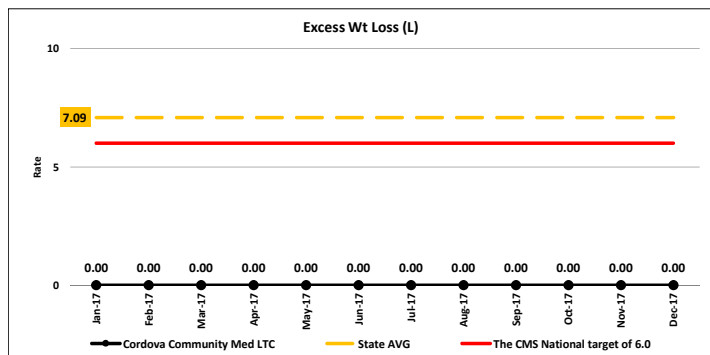
AP	Cath	Dep.	Wtloss	Falls	PRU	ADL	Incont.	Rest.	Pain	UTI
0	0	0	0	0	0	0	2	0	2	1
9	8	9	10	10	9	5	3	10	4	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	66.67	0.00	50.00	10.00

Cordova Community Med LTC

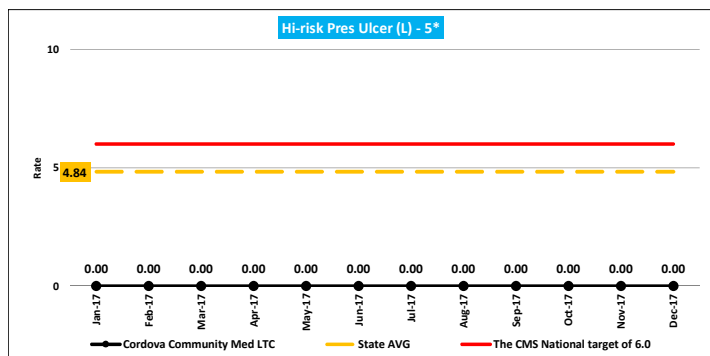
These graphs represent your facility's rates over time for each of the 11 long-stay quality measures that make up the Proxy-Composite score. Look for those measures with the higher scores to know where to focus your efforts - remember lower is better. Contact Mountain-Pacific Quality Health for any resources or assistance you might need to lower your scores.



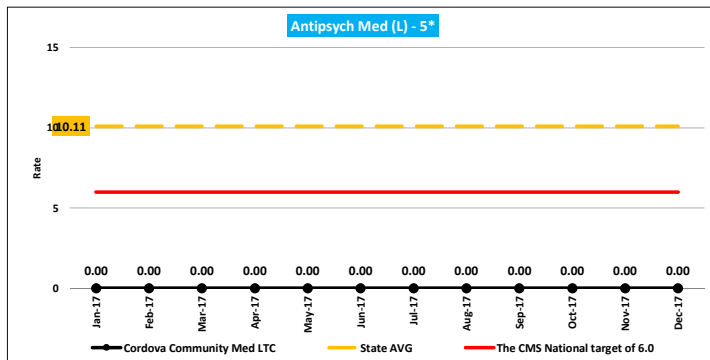
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	0	0	0
8	8	8	8	8	8	8	8	8	8	8	8
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



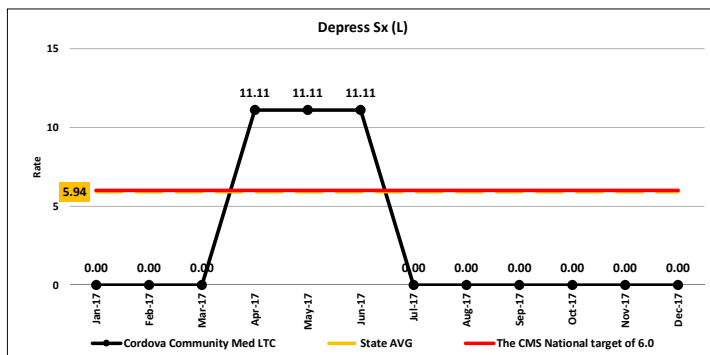
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	0	0	0
10	10	10	10	10	10	10	10	10	10	10	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



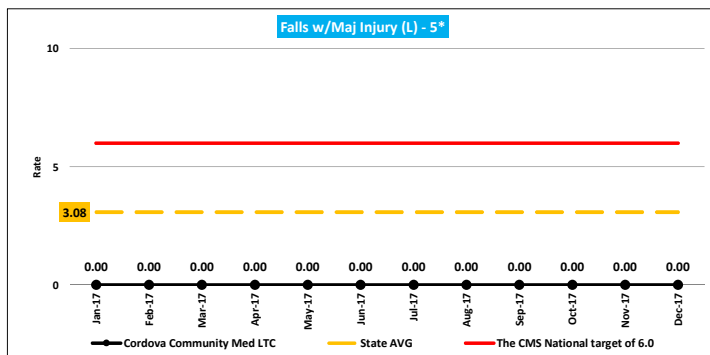
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	0	0	0
9	9	9	9	9	9	9	9	9	9	9	9
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



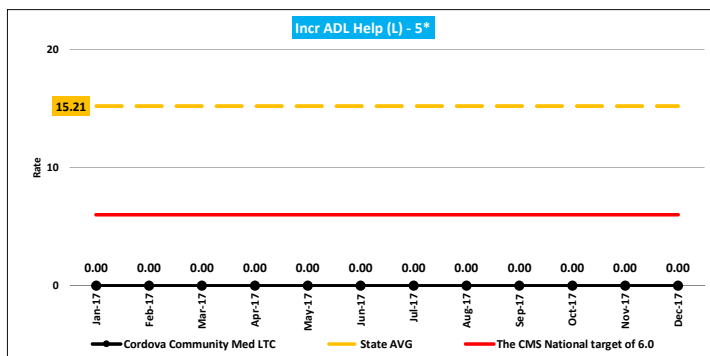
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	0	0	0
9	9	9	9	9	9	9	9	9	9	9	9
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



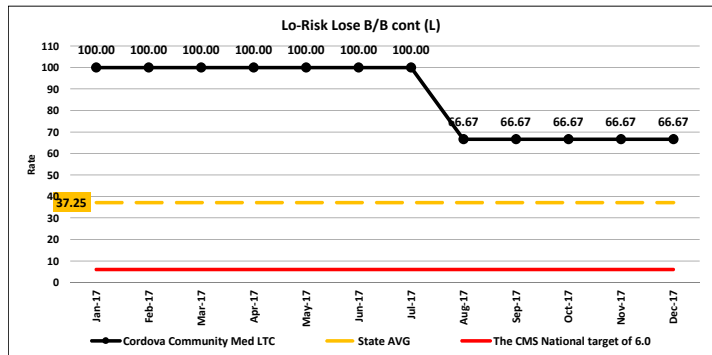
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	1	1	1	0	0	0	0	0	0
9	9	9	9	9	9	9	9	9	9	9	9
0.00	0.00	0.00	11.11	11.11	11.11	0.00	0.00	0.00	0.00	0.00	0.00



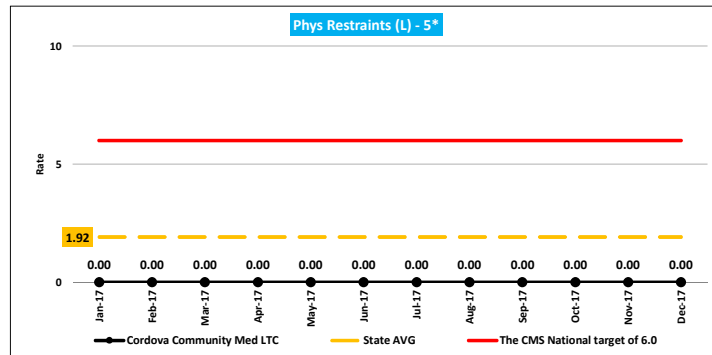
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	0	0	0
10	10	10	10	10	10	10	10	10	10	10	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



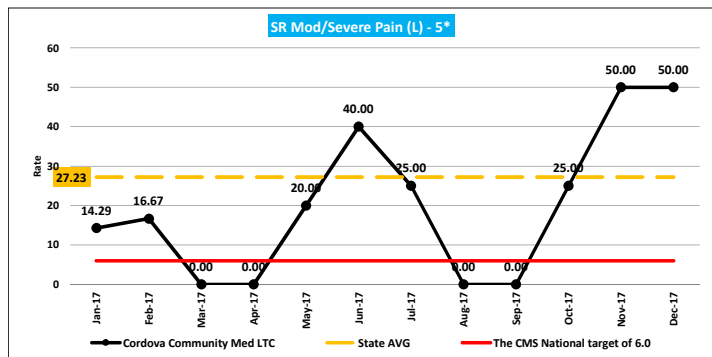
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	0	0	0
6	6	6	6	6	6	6	6	6	5	5	5
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



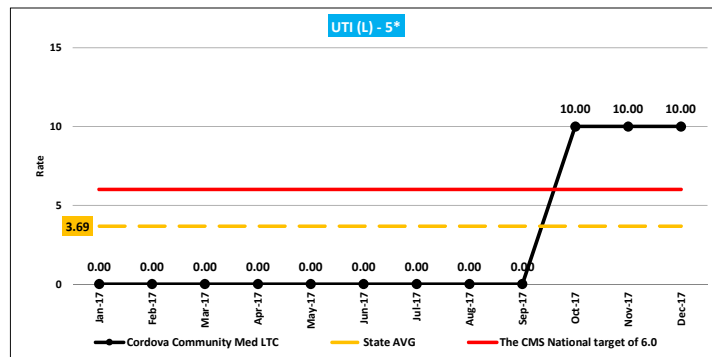
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
1	1	1	1	1	1	2	2	2	2	2	2
1	1	1	1	1	1	2	3	3	3	3	3
100.00	100.00	100.00	100.00	100.00	100.00	100.00	66.67	66.67	66.67	66.67	66.67



Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



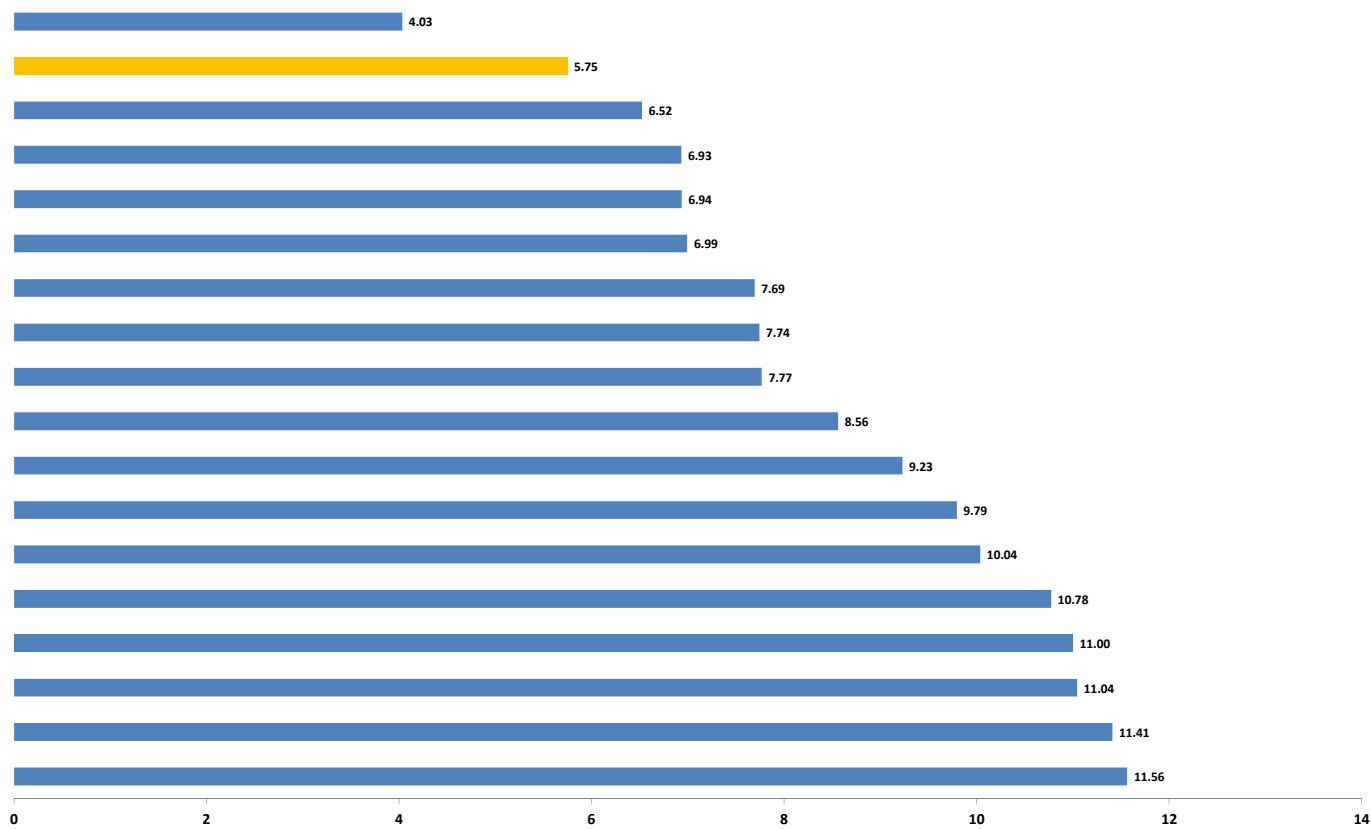
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
1	1	0	0	1	2	1	0	0	1	2	2
7	6	6	4	5	5	4	4	4	4	4	4
14.29	16.67	0.00	0.00	20.00	40.00	25.00	0.00	0.00	25.00	50.00	50.00



Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
0	0	0	0	0	0	0	0	0	1	1	1
0	0	0	0	0	0	0	0	0	10	10	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10.00	10.00	10.00

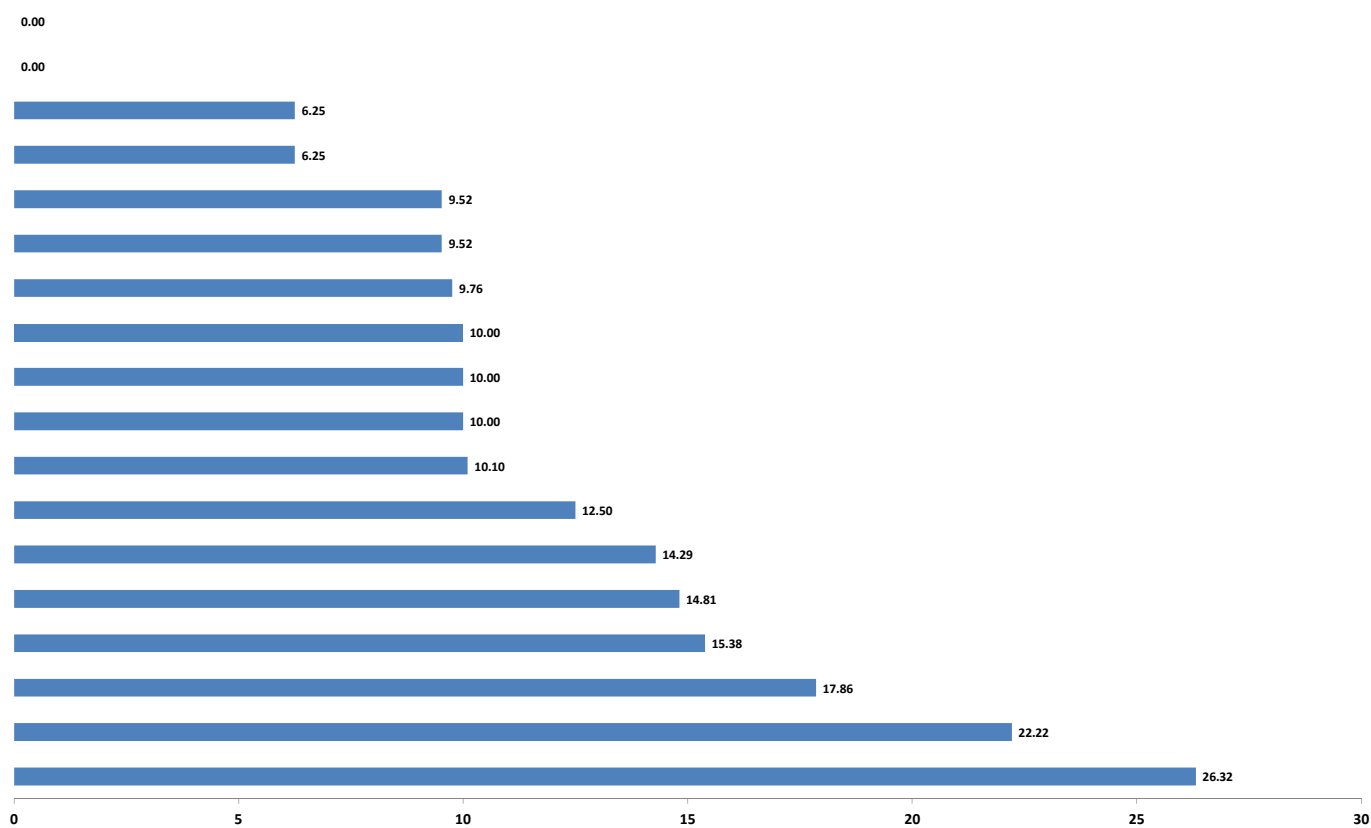
Cordova Community Med LTC

This ranking shows your facility's current Proxy-Composite score in relation to all of the nursing facilities in your state:



Cordova Community Med LTC

This ranking shows your facility's current Anti-Psychotic Medication score in relation to all of the nursing facilities in your state:





To: CCMC Authority Board of Directors
From: Kelly Kedzierski, RN
RE: February 2018 Quality Improvement Report

Quality Improvement

CCMC uses national benchmarks provided by national associations, clinical organizations, and federal and state provided databases such as WSHA Partnership for Patients.

The organization will continue to monitor progress toward goals by comparing its results to these benchmarks and its historical performance.

- Currently we are meeting on a monthly basis.
- The last Quality meeting was held on January 17, 2018 where we discussed -
 - 2018 Quality Plan
 - QAPI Self-Assessment
 - Facility Assessment
 - PIP updates and reports
- To ensure that we are in compliance with all of the Plans of Corrections from our recent Surveys. Each department manager brings their documentation for all of the committee members to view. This gives the committee the data we need so we are able to evaluate our progress toward each quality goal.

Infection Control

- The infection control committee has been having monthly meetings to ensure that we are keeping track of the infection control needs throughout the hospital as well as addressing concerns that could potentially affect the community.
- There was a meeting called to order on January 9th in regards to the relatively severe flu season throughout the nation.

At this meeting Dr. Blackadar discussed-

- The need to be prepared in the event of an influenza outbreak.

- Supply levels of oral and IV antivirals.
 - Inventory of Influenza Vaccinations
 - Adequate oxygen supply
- Hand Hygiene is ongoing.
- Staff Flu Vaccination is at 100%

- Per the CDC's acting director Dr. Anne Schuchat- "Influenza activity is still on the rise over all."



SOUND ALTERNATIVES

P: (907) 424-8300 | F: (907) 424-8645

P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

13 Feb 2018

Subject: Sound Alternatives Report to CCMC Authority Board of Directors

- This past quarter was spent getting familiar with Sound Alternatives and its programs and evaluating its current state of operations.
- To gain a better understanding of the current state of the Sound Alternatives program subject matter experts in behavioral health Medicaid, policy, electronic health records, and finance were requested.
- Champney Consulting was brought on board to review the Developmental Disability (DD) services program.
- Rider Consulting was brought on board with the assistance of the Alaska Behavioral Health Trust Authority for technical assistance to review/evaluate Sound Alternatives
- Several deficiencies were identified, with the most significant being the electronic health record (EHR)/billing that does not include outpatient behavioral health nor does the one recently purchased
- Several services being provided are not being billed due to current billing system, potential to increase revenue once resolved
- Only have one clinician meeting the state's clinical documentation requirements. This clinician received a 100% on the record review.
- Staff requires training in clinical documentation, billing, patients' rights, infection control, HIPAA and emergency preparedness just to name a few.
- In the initial reviewing phase of the consultants recommendations a few courses of actions have been identified, currently awaiting approval to implement improvement plan to address deficiencies found during their assessment.
- Sound Alternatives is currently under 2 plan of corrections one for the Developmental Disability program and the other for Behavioral Health
- Determining if Sound Alternatives will fully integrate with CCMC meaning one EHR/billing system

Lykia Lorenz, LCSW, BCD

Executive Director, Sound Alternatives
Cordova Community Medical Center