AGENDA
COMMUNITY HEALTH SERVICES BOARD
Cordova Center – Community Room A&B
August 11, 2016 at 7:00PM
REGULAR MEETING

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

Health Service Board

President:
David Allison
Term expires 03/19

Vice-President:
Tim Joyce
Term expires 03/17

Secretary:
Tom Bailer
term expires 03/17

Board members:
James Burton
term expires 03/19
Joshua Hallquist
term expires 03/18
Robert Beedle
term expires 03/18
James Wiese
Term expires 03/19

Administrator/CEO
Scot Mitchell

OPENING

1. Call to Order
2. Roll Call – David Allison, Tim Joyce, James Burton, Tom Bailer, Josh Hallquist, Robert Beedle and James Wiese.
3. Establishment of a Quorum

A. APPROVAL OF AGENDA

B. CONFLICT OF INTEREST

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS

1. Audience Comments (limited to 3 minutes per speaker).
   Speaker must give name and agenda item to which they are addressing.
2. Guest Speaker

D. APPROVAL OF CONSENT CALENDAR

E. APPROVAL OF MINUTES

1.

F. REPORTS OF OFFICER and ADVISORS

1. President's Report –
2. Administrator's Report - Attached
3. Finance Report – Will report at the meeting
4. Medical Director's Report - None
5. Sound Alternatives Report – Attached
6. Nursing Report - Attached
7. QHR Report – Quorum Monthly Updates

G. CORRESPONDENCE

H. ACTION ITEMS

I. DISCUSSION ITEMS

1. **Requested HSB Policy Update**
2. **Cash Distribution Request**
3. **CCMC Check Signer Availability**

J. 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.

K. BOARD MEMBERS COMMENTS

L. EXECUTIVE SESSION

1. **Review CCMC Legal Issue**

M. ADJOURNMENT

*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.

Cordova Community
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CEO Report to the HSB
August 11, 2016 Meeting
Scot Mitchell, CEO

Finances

Our financial struggles are continuing, but we are making progress on improving this situation. As you are well aware, hospital billing and collections are very complex processes with many moving parts. We are actively working on numerous areas to find the activities that are not working correctly and to conduct root cause analyses to develop solutions to fix them as soon as possible. Below are some of the key areas we are working now:

- Revenue cycle process maps are being developed to allow us to determine our current procedures.
- Policies are being reviewed to make sure they are accurate and appropriate.
- We are starting to collect benchmarking data to determine our current performance levels, and will be used to create new performance expectations and goals. My plan is to have a new format for presenting this data to the HSB soon.
- Our outsourced coder conducted a billing error analysis of the second quarter 2016 bills and found that we had errors on over 50% of those bills. An improvement plan is being implemented to reduce the errors.
- There are multiple issues with the Healthland Centriq system, and we are working with them to get those addressed.
- We are revamping our Revenue Cycle Team to work on the issues that have already been identified, as well as researching other issues for improvement. Our outsourced coders and billing company have been added to this team. Dan Hobbs, QHRs Senior Revenue Cycle Consultant has also been helping us with this process.
- Advanced Beneficiary Notices (ABN) have not been utilized for quite some time now. If we do not have an ABN signed by a Medicare beneficiary prior to receiving services and Medicare later denies the claim we cannot bill the patient for that service. This has been corrected.
- There were a large number of reference labs that were not getting billed, we found about $30,000 of those from the second quarter of 2016. A lab bill reconciliation process has been developed to capture those charges upfront, and we are going back to rebill the missed charges.
- Last month we had a financial and operational assessment conducted by a contact that I had worked with in the past. I should be receiving the final report on this assessment, with additional recommendations soon.

- We have changed a few processes to allow our coding company staff to access certain areas of our Centriq system. This allows them to better track and catch errors that will improve coding accuracy and increase charges.

We still have a long way to go on our finances, but we are making progress. Staff has been very eager to help with the reviews and also developing new solutions to improve our processes. This will be a long term effort to become more effective and efficient in the revenue cycle processes.

As was mentioned at last month's meeting, CCMC will need to request cash from the City to assist with the extra pay day in September. We will request $266,000 to cover the first pay day next month since our normal LTC payment will be received after that pay day. We normally use the LTC payment to cover payroll expenses. In addition to the payroll expenses, we will use some of the funds to cover three PERS payments that are in arrears.

Quality

We have been spending a lot of time reviewing our quality programs to see what areas we need to improve upon. Below are some of the highlights of what I've found so far:

- We have not had an operating Quality Improvement process for some time now. This is obviously a requirement for our conditions of participation as a CAH. I have asked our Leadership Team to start developing quality goals for each department of the hospital. We are also revamping our Quality Management Committee to address this deficiency.
- Randy Apodaca has agreed to lead our Quality Management Committee. Randy and I have spent some time discussing how we can get back to addressing our quality improvement requirements.
- CCMC has not reported any quality data since last year, with the exception of ED Transfer metrics that Mary Rios, Interim DON submitted at the end of July. I am working with staff and external resources to get this corrected.
- I have also asked the Leadership Team to research industry standards for benchmarking metrics in their areas. We will use these to help us start our internal benchmarking efforts.
- I have been reviewing the most recent CAH, LTC and Life Safety surveys and the Plans of Correction that were submitted to address the deficiencies found. The QMC committee will take on a review of each deficiency to make sure that we have corrected the problems, so we can be prepared for upcoming surveys.
- The Office of Civil Rights (OCR) announced a HIPAA Desk Audit process a couple weeks ago. CCMC was not selected for one of these audits, but I have asked our staff to utilize the OCR audit tool to conduct a self-audit of our HIPAA privacy practices. The QMC will also oversee this process.

Talent Management

One of the top concerns that the HSB has voiced to me has been securing consistent staffing. I have been looking at various components of our talent management activities. Below are some key issues so far:

- We are still having a very difficult time recruiting and retaining quality staff, most critically in nursing. We have been having discussions with three nurses who have expressed an interest in moving to Cordova. If these become a reality, it will be several months before they could be here.
- We have convened a Recruitment and Retention Committee made up of any employee that would like to participate. I have charged this group with coming up with strategies to help us with immediate staffing needs as well as intermediate and long-term strategies for recruiting and retaining quality healthcare professionals.
- I have used National Health Service Corps opportunities to help with tuition reimbursement for physicians and nurse in the past. CCMC has not used this program, but we are now researching this as an option.
- I held a "Lunch with the CEO" for employees on July 26th. We invited several employees from different departments to have lunch with me so I could give them an update on the various trends in national healthcare activities, along with how these affect CCMC and how we can respond to them. It also gave these employees an opportunity to ask questions of me.
- I am in the process of establishing a new performance management program for my direct reports that involves monthly Performance Management Interviews (PMIs) where we meet to go over their performance goals and address any issues they may have. This allows me the opportunity to stay on top of any performance issues, as well as making sure they have all the resources they need to meet the expectations established for them.

Quorum Health Resources

The HSB has directed Vice Chairperson Tim Joyce to serve as the liaison between the HSB and QHR to determine if CCMC is receiving enough value out of the relationship with QHR to continue the agreement. Tim and I have spoken about this several times since my arrival, and we are still evaluating this. CCMC had not received much from QHR prior to my arrival because there were few requests for assistance. I have spent a lot of time talking with Ron Vigus, RVP with QHR about the HSB's concerns. I have requested assistance in several areas from QHR, and will need some more time to fully evaluate the value, but here are some highlights of activity so far:

- As mentioned above, Dan Hobbs has been helping us with making our Revenue Cycle Team more effective so we can increase cash flow to the hospital. Dan has provided several documents and tools to help with the process, including benchmarking tools. He has also convened three separate webinars to meet with several of our team members to assist with the process. If we are successful in improving our RCM processes, this will be a very valuable benefit of the QHR agreement.
- QHR is performing a market basket analysis of our GPO program to see if their GPO might provide better pricing for our supplies, pharmaceuticals and food.
- We have received sample policies for Corporate Compliance, Quality Improvement and Risk Management programs.
- Sample productivity reporting mechanisms have been shared with us as well as financial and quality dashboards.

- The QHR education calendar for 2016 has been shared with all employees and the HSB. I also receive routine communication from them about education programs that I share with the appropriate staff and encourage them to participate in those programs. They also provide access to their library of trustee education resources that the HSB can take advantage of.
- I now have access to the QVantage program that will allow us to include our benchmarking metrics in the QHR system so we can compare our performance against other QHR affiliated hospitals. We are not using this system yet, but once we get our benchmarking data collated we may.
- We now hold Monthly Operational Review calls with several of the QHR staff, where we review our key issues and see if there are areas they can assist us with.
- We have been invited to attend a special webinar on physician credentials verification that is being scheduled.
- They did some research on pricing for an uninterruptable power supply for our CT scanner.
- All of the items mentioned above are included in the monthly fee.

Miscellaneous

- I will be attending the Alaska State Hospital and Nursing Home Association annual conference in Soldotna from August 30th through September 2nd. Then I will be taking a couple days of PTO after the conference. I will be returning to the office on September 7th. I will have phone and email contact and Stephen Sundby will be covering for me during this trip.
- I have been meeting with staff from the Native Village of Eyak and Ilanka Clinic to discuss opportunities for collaboration. We are working on ways to improve the relationship between the entities to make it easier for the patients that use both facilities along with the providers. We have already addressed some issues with sharing of medical information between the facilities and are also working on improving the process for transferring tribal members from CCMC to tertiary care hospitals.
- On August 23rd I will be conducting a "Lunch with the CEO" for some key stakeholders in the community. This will be similar to the same lunch I had with employees last month. I plan on alternating between employees and community leaders each month so we can work on improving our community relations. If you have any suggestions for people to invite to these events, please let me know.
- CCMC is due to conduct another Community Health Needs Assessment this year. This is one of the IRS requirements under the 501(r) regulations. I am working on getting quotes from vendors to help us with this process.
- After the July HSB meeting, Chairperson David Allison let me know that the HSB had asked for a draft policy to review on how HSB members should interact and communicate with hospital staff. I reached out to BHBC the day after last months' meeting and they are working on a draft policy to bring to the HSB for review.
- I have been working with the Leadership Team on an abbreviated strategic planning process to help me understand some of the key issues facing the hospital. We will continue this process and when appropriate, we will ask for a planning retreat with the HSB to review and update our strategic plan.
- The Fire, Safety and Disaster committee has been working on updating our disaster plan over the past several months. The plan has been updated and the committee is now working on additional training and drills for staff to bring everyone up-to-date on the new plan. I must say that I am very impressed with the work of Vivian Knop and this committee. CCMC has one of the most robust disaster plans that I have seen in smaller hospitals. The extra supplies and the response plans for the most likely events in this area are remarkable.

- Lee Bennett is working diligently in getting the budget process going. Previously the department managers were not involved in the budget process, but I want to involve them going forward. Once Lee has the financials closed out for June, he will also prepare responsibility reports for each department so the managers can see where they are for this year and work on preparing a budget for 2017. Our plan is to have the proposed 2017 operating and capital budgets to the HSB for approval at the October meeting. This will give the City enough time to include projected cash needs for CCMC in its 2017 budget.

QVIEW

JULY 2016

Quorum's Monthly Digest of the Business of Healthcare

OUT OF CONTROL

Prescription drug pricing is an increasingly high profile issue, with the stakes becoming greater for consumers, payers, and providers alike. *Modern Healthcare* reported that AARP's RxPrice Watch report found the combined average retail price of 622 prescription medicines widely used by seniors more than doubled over a 7 year period. Prices for those 622 widely used drugs — a mix of generic pills, brand-name drugs and high-priced "specialty drugs" for complex conditions — jumped 9.4 percent alone in 2013 — six times the general rate of inflation. This financial burden is amplified for some of those who are already in a disadvantaged state, such as those taking multiple medications, the elderly, and the uninsured. A 2015 Kaiser Family Foundation poll found that nearly half of all Americans are taking prescription drugs, and that a significant portion (24% of healthy patients, and 43% for those in especially poor health) found it difficult to keep up with payments.

A recent study of drug pricing cited by the *Associated Press* in a *New York Times* story found that from 2003 to 2014 the payments by commercial insurers for specialty prescription drugs climbed more than 300%. During this same period, the out of pocket costs for patients rose by 46%. Patients on individual insurance plans or ones provided through a smaller employer, tend to bear a greater percentage of these costs.

Through a series of high profile and egregious examples of price hikes, such as that reported by *Time* magazine about CEO Martin Shkreli, whose company purchased a low price (and life-saving) prescription drug and raised the price by over $736 per pill, the issue of drug prices has become the subject of congressional hearings. The CEO of Valeant was called before the Senate Special Committee on Aging, where the *New York Times* reports that he admitted "[…] it was a mistake to pursue, and in hindsight I regret pursuing, transactions where a central premise was a planned increase in the prices of the medicines." Political efforts to address the issue have gained some traction on the state level. In California, the *Sacramento Bee* is reporting on legislation being promoted that would require that drug makers send a notice in advance of significant price increases.

The *Washington Post* reports that hospitals across the country are employing a variety of strategies to help mitigate these costs, for the sake of both themselves and their patients. Administrators with University Hospitals of Cleveland have labeled drugs with a higher than average cost within their prescription system with dollar signs, in an effort to help ward physicians off costlier options. At the Indiana University Health System, physicians have begun to use less costly forms of commonly used medications. For instance, when the price of Vitamin K tablets spiked from a few dollars to over $60, doctors began to use the (comparably cheaper) injectable form mixed into a syrup, which could be administered orally.

Quorum Purchasing Advantage is working directly with your pharmacists on an initiative to reduce your hospital's pharmacy spend. For more information about these efforts, talk to your Quorum regional team.

References

Quotations in the text are drawn from the following sources:

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Article Posted on ModernHealthcare.com

Price hikes doubled average drug price over 7 years: AARP

By Associated Press | February 28, 2016

The average cost for a year's supply of a prescription drug doubled in just seven years to more than $11,000 — about three-quarters of the average annual Social Security benefit.

That's according to the latest study of price trends for widely used drugs conducted by AARP, the senior citizens advocacy group. It finds prices for existing drugs, driven entirely by manufacturer price hikes, have been rising more quickly since 2007 and likely will continue to do so.

AARP says its research shows drugmaker price hikes imposed one or more times a year are making prescription medicines increasingly unaffordable for retirees and many other patients. That's particularly true for people taking multiple drugs or needing long-term medication for chronic health problems, not to mention the uninsured.

An August poll by the Kaiser Family Foundation found 24 percent of Americans were having trouble paying for their medicines. That rose to 43 percent for those in poor health.

Retail prices for already-approved medicines often are increased 10 percent or more each year. That exacerbates the sting of six-figure prices for many newly launched drugs, plus exorbitant spikes in prices of some generic drugs with limited competition. Those trends have triggered multiple congressional investigations since last summer and made prescription drug prices a hot issue in the presidential race.

"Our concern with the prices we're seeing is that the overall trend is really accelerating," said Leigh Purvis, director of health services research in AARP's Public Policy Institute.

Drug prices doublng

AARP's latest RxPrice Watch report, being released Monday, found the average retail price among 622 prescription medicines widely used by seniors more than doubled from $5,571 in 2006 to an "incredible" $11,341 in 2013, Purvis said.

That's unaffordable for the many retirees with low incomes and limited savings, she added. In 2013, the average Social Security benefit was $15,526 and medium income for Medicare beneficiaries was $23,500.

Prices for those 622 widely used drugs — a mix of generic pills, brand-name drugs and

high-priced "specialty drugs" for complex conditions — jumped 9.4 percent alone in 2013, the most recent data AARP had. That jump was six times the 2013 general inflation rate and far above increases ranging from 3.6 percent to 7.6 percent between 2006 and 2012.

Specialty drugs for cancer, hepatitis C and rare diseases — many of them injected biologic drugs, which are produced inside cells rather than by mixing chemicals — drove the increase. The average widely used specialty drug cost $53,384 in 2013, 18 times the average annual cost for a brand-name drug ($2,960) and 189 times higher than the average price for a generic drug ($283).

Retirees hit hardest

Seniors are particularly hurt by the soaring drug prices, as Medicare plans generally require patients to share much more of the cost for their medicines than employer or other commercial insurance plans. For the priciest drugs, Medicare patients sometimes must pay half the cost, Purvis notes.

"This affects everyone," Purvis said, because even people who don't need prescription drugs are bearing part of the cost through higher insurance premiums and taxes that fund Medicare, the Veterans Administration and other government health programs.

Costlier generics

For years, patients and insurers were able to hold down their overall pharmacy bill through increasing use of cheap generic versions of off-patent brand-name drugs, and generics now account for seven in eight prescriptions dispensed in the U.S.

Generic prices normally decline over time as additional manufacturers enter the market, and average generic prices had been falling about 4 percent annually until they began rising in 2012, Purvis said.

Drugmaker mergers and low profit margins for generics have reduced the number of manufacturers of some generics so much that shortages of some are pushing prices up sharply. In addition, companies including Turing Pharmaceuticals andValeant Pharmaceuticals International have bought rights to some old generic drugs and jacked up their prices many times over.

Meanwhile, competition for biologic drugs is just beginning in the U.S., and those versions are only expected to cost 20 percent to 40 percent less than the original drug. Generic pills often cost about 85 percent less than the brand-name versions — if there are several generic versions available.

Cordova Community
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SOUND ALTERNATIVES
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Date: **August 11, 2016**
To: **Health Services Board**
From: **Stephen Sundby, Ph.D., Executive Director**
RE: **Sound Alternatives Report**

1. Sound Alternatives has stable staffing and has been fully staffed for almost three years.

2. Sound Alternatives is in the timeframe window for The Joint Commission (Accreditation) survey. The timeframe open on February 20, 2016 and extends for 18 months. The Joint Commission will survey sometime during that time period.

3. Sound Alternatives received the Notification of Grant Award for the Comprehensive Behavioral Health Treatment and Recovery (CBHTR) Grant and our Community Developmental Disabilities Grant.

    a. The Division of Behavioral Health *Compressive Behavioral Health Treatment & Recovery* Grant was reduced this year from $355,598 (FY16) to $333,574 (FY17) (please see attachment) as a result of the State of Alaska desire to shift from a "reliance on grants funded by General Funds (GF) dollars to program funding via Medicaid Dollars." This is a shift to a fee-for-service model using the reimbursement from Medicaid Expansion and third party funding resulting from the Affordable Care Act. There will be another reduction in the grant at the middle of this fiscal year (FY17). There will be continued reductions in grant funding in the near future as expressed below in an August 4, 2016 email from the Director of the Division of Behavioral Health.

        The Division appreciates the significant impact these reductions represent to the providers of community behavioral health services in almost every community and village in Alaska, and acknowledges the hard work that grantees must now undertake in order to begin to creatively address new business strategies in the face of continuing reductions in grant funding over the near future.

    I have been working with Sound Alternative's staff on a plan to address the continued reduction in grant funding that will occur in the near future. This has included reviewing all billing practices to insure that we are billing for all services provided; possible program expansion that would have a positive financial outcome; and at some point a require Reduction in Force (RIF) to remain financially viable.

    b. The Division of Seniors and Disabilities Service *Community Developmental Disabilities* Grant for Fiscal Year 2017 is funded at $49,988. This is the same amount as FY16. This grant covers primarily respite services for those with developmental disabilities.

4. Attached is a copy of the 4th Quarter/End of Year State of Alaska, Division of Behavioral Health, AKAIMS Report for Sound Alternatives.

SFY 2017 Treatment & Recovery Grantee Funding Summary Sheet

GRANTEE: *SOUND ALTERNATIVES (CORDOVA COMMUNITY MEDICAL CLINIC)*
Program: *CBHTR*
Grant #: *602-208-1751*

Statewide SFY 2017 Grant Funding Reductions:

a)	**Statewide System Proportional Reduction:** Allocated Proportionally Across All Eligible[1] Grant Funds	**$3,066,237**	
b)	Statewide Medicaid Expansion Population Payments (Payments made to grantees between 9-1-2015 to 5-31-2016)		**$6,997,523**
c)	**Statewide Medicaid Expansion Reduction:** Allocated Based on Agency Percentage of Total Medicaid Expansion Payments (excludes agencies that received Medicaid expansion payments but did not have grant funds eligible for this reduction)	**$2,713,416**	
d)	**Total Statewide Grant Funding Reduction (row a + c):**	**$5,779,653**	

Grantee SFY 2017 Grand Award Funding Summary:

e)	**SFY17 Starting Grant Amount:**		**$355,598**
f)	SFY17 Grant $$ Held Harmless from System Proportional Reduction:		$63,293
g)	SFY17 Grant $$ Subject to System Proportional Reduction:		$292,305
h)	**Amount of System Proportional Reduction to Grant:**	**$20,015**	
i)	SFY17 Grant $$ Held Harmless from Medicaid Expansion Reduction:		$167,854
j)	SFY17 Grant $$ Subject to Medicaid Expansion Reduction:		$187,744
k)	Agency Medicaid Expansion Payments Received:		$4,865
l)	Agency Total Amount of Medicaid Expansion Reduction [agency reduction is allocated across the agency's eligible grant(s)]:	$2,009	
m)	**Amount of Medicaid Expansion Reduction to Grant:**	**$2,009**	
n)	**SFY17 Total Grant Reduction (row h + m):**	**$22,024**	
o)	**SFY17 Total Adjusted Grant (row e – n):**		**$333,574**
p)	**Percent Reduction to the Starting Grant Amount (row n ÷e)**	**6.19%**	

[1] Please see the accompanying "Quick Reference Guide to the Grant Reduction Allocation Process" for what DBH defines as funds "eligible" for a reduction in either the proportional or the Medicaid expansion reduction process.

Sound Alternatives

Quarterly Summary for FY 2016

Substance Abuse

1. Number of patients served within a quarter.	Q1	Q2	Q3	Q4	FYTD
Adult Substance Abuse: 12 - Adult - Out Patient - SA	8	5	9	5	16
Youth OP Substance Abuse: 10 - Youth & Family OP Substance Use Disorder Treatment - SA	1	0	2	2	3
Total	**9**	**5**	**11**	**7**	**19**

2. Number of patients enrolled into program type during the quarter.	Q1	Q2	Q3	Q4	FYTD
Adult Substance Abuse: 12 - Adult - Out Patient - SA	2	2	5	1	10
Youth OP Substance Abuse: 10 - Youth & Family OP Substance Use Disorder Treatment - SA	1	0	1	1	3
Total	**3**	**2**	**6**	**2**	**13**

3. Number of patients placed on a waitlist following an assessment.	Q1	Q2	Q3	Q4	FYTD
Total					

4. Number of patients on the waitlist currently receiving interim services.	Q1	Q2	Q3	Q4	FYTD
Total					

5A. Number of Injection Drug Users Admitted to Treatment.	Q1	Q2	Q3	Q4	FYTD
Adult Substance Abuse: 12 - Adult - Out Patient - SA	1	0	1	1	3
Total	**1**	**0**	**1**	**1**	**3**

5B Number of Injection Drug Users: Placed on waiting list, with interim services provided within 48 hours.	Q1	Q2	Q3	Q4	FYTD
Total					

6A Number of Pregnant Women: Admitted to Treatment.	Q1	Q2	Q3	Q4	FYTD
Total					

6B Number of Pregnant Women: Referred to Treatment elsewhere.	Q1	Q2	Q3	Q4	FYTD
Total					

7A Residential treatment programs total number of DBH bed days available.	Q1	Q2	Q3	Q4	FYTD
Total					

7B Residential Treatment Program ONLY: Number of bed days utilized this quarter.	Q1	Q2	Q3	Q4	FYTD

Total					

7C Residential Treatment Program ONLY: Number of children that accompanied their parent/guardian to treatment.	Q1	Q2	Q3	Q4	FYTD
Total					

8. Number of patients disenrolled from treatment programs (No disenrollments from MH Programs are counted).	Q1	Q2	Q3	Q4	FYTD
Adult Substance Abuse: 12 - Adult - Out Patient - SA	3	5	1	2	11
Youth OP Substance Abuse: 10 - Youth & Family OP Substance Use Disorder Treatment - SA	0	0	1	0	1
Total	**3**	**5**	**2**	**2**	**12**

9. Total Discharged during the quarter (SA/Dual clients only).	Q1	Q2	Q3	Q4	FYTD
Total	**2**	**4**	**2**	**2**	**10**

10. Number of patients discharged from treatment that received HIV/AIDS risk assessment, education, and risk reduction counseling.	Q1	Q2	Q3	Q4	FYTD
Total	**0**	**0**	**0**	**1**	**1**

11. Number of patients discharged from treatment that received Hepatitis C education this quarter.	Q1	Q2	Q3	Q4	FYTD
Total	**2**	**4**	**2**	**2**	**10**

12. Number of patients discharged from treatment that received TB education and/or referral for TB testing.	Q1	Q2	Q3	Q4	FYTD
Total	**2**	**4**	**2**	**2**	**10**

Emergency Services

1. Number of emergency phone contacts.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	0	0	1	1	2
Total	**0**	**0**	**1**	**1**	**2**

2. Number of emergency contacts seen drop-in / office.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	0	1	2	1	4
Total	**0**	**1**	**2**	**1**	**4**

3. Number of emergency contacts seen in home.	Q1	Q2	Q3	Q4	FYTD
Total					

4. Number of emergency contacts seen at hospital / on-call intervention.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	5	2	7	2	16
Total	**5**	**2**	**7**	**2**	**16**

5. Number of emergency contacts seen in community.	Q1	Q2	Q3	Q4	FYTD
Total					

6. Number of emergency contacts seen Emergency Outreach Intervention.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	0	0	1	0	1
Total	**0**	**0**	**1**	**0**	**1**

7. Number of emergency contacts seen by appointment.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	0	0	4	0	4
Total	**0**	**0**	**4**	**0**	**4**

8. Number of emergency contacts seen Community Service Patrol.	Q1	Q2	Q3	Q4	FYTD
Total					

9. Number of emergency contacts seen under "other" circumstances.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	0	0	1	0	1
Total	**0**	**0**	**1**	**0**	**1**

Special Populations

1. Number of individuals screening positive for a Co-occurring Disorder.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	6	4	6	6	22
Total	**6**	**4**	**6**	**6**	**22**

2. Number of individuals screening positive for a Traumatic Brain Injury.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives	7	4	2	7	20
Total	**7**	**4**	**2**	**7**	**20**

Mental Health Enrollment

1. Number of SED youth served in the quarter.	Q1	Q2	Q3	Q4	FYTD
General Mental Health: Other	0	0	1	1	1
SED Youth MH: 09 - OP Svcs for HRC in EC & Youth with SED & Families	6	6	7	6	9
Total	**6**	**6**	**8**	**7**	**10**

2. Number of SED youth enrolled at agency.	Q1	Q2	Q3	Q4	FYTD
General Mental Health: Other	0	0	1	0	1
SED Youth MH: 09 - OP Svcs for HRC in EC & Youth with SED & Families	1	2	2	1	6
Total	**1**	**2**	**3**	**1**	**7**

3. Number of youth (other than SED) served in the quarter.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives: General Mental Health: Other	3	3	1	2	4
Total	**3**	**3**	**1**	**2**	**4**

4. Number of youth (other than SED) enrolled at agency.	Q1	Q2	Q3	Q4	FYTD
General Mental Health: Other	1	0	0	1	2
Total	**1**	**0**	**0**	**1**	**2**

5. Number of SMI Adults served in the quarter.	Q1	Q2	Q3	Q4	FYTD
General Mental Health: Other	3	0	0	0	3
SMI Adult MH: 11 - Outpatient Treatment for Adults with Serious Mental Illness - MH	10	9	10	15	16
Total	**13**	**9**	**10**	**15**	**19**

6. Number of SMI adults enrolled at agency.	Q1	Q2	Q3	Q4	FYTD
General Mental Health: Other	2	0	0	0	2
SMI Adult MH: 11 - Outpatient Treatment for Adults with Serious Mental Illness - MH	3	0	2	4	9
Total	**5**	**0**	**2**	**4**	**11**

7. Number of adults (other than SMI) served in the quarter.	Q1	Q2	Q3	Q4	FYTD
Sound Alternatives: General Mental Health: Other	15	16	19	12	27
Sound Alternatives: SMI Adult MH: 11 - Outpatient Treatment for Adults with Serious Mental Illness - MH	1	1	1	0	1
Total	**16**	**17**	**20**	**12**	**28**

8. Number of adults (other than SMI) enrolled at agency.	Q1	Q2	Q3	Q4	FYTD
General Mental Health: Other	6	5	4	3	17
Total	**6**	**5**	**4**	**3**	**17**

Cordova Community
MEDICAL CENTER

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

Date: August 5, 2016
To: Health Services Board
From: Director of Nursing, Mary Rios, BSN
RE: Nursing Report to Health Services Board

August 2016 Nursing Activity Update:

1. Caregiver openings - Nursing is now at 100% traveler nurses and two traveler nursing aides due to start. Nursing leadership actively working on finding replacement for those whose contract are near completion and innovative ideas to help recruit nurses. Hospital openings posted in US military publication for those leaving activity duty. "Shuttle" pick up and drop off of travelers. Housing is a challenge currently.

2. LTC census was down to 9 residents. We accepted our 10th resident last week and are excited to have him in the medical center.

3. We enhanced the documentation checklist and report to help ensure we are meeting all criteria for our patients seen in the emergency department that are going to be transferred to another facility for a higher level of care. This data is submitted to the State quarterly as a performance improvement initiative for "ED Transfer Communication Quality Measure or EDTC". With the change in process we now have a summary report that includes all key points that are monitored. This drastically decreases the number of documents that we print and copy for each transfer.

That is all we have currently. Let me know if there are any questions.

Thanks,
Mary Rios