SOUTHERN COOS HOSPITAL & HEALTH CENTER

Board of Directors Regular Meeting

September 28, 2023 6:00 p.m.

AGENDA

Executive Session Under 192.660(2)(c) to consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 Licensing of facilities and health maintenance organizations. No decisions shall be made in Executive Session.

I. Executive Session Call to Order
   1. Quality & Patient Safety Report
   2. Risk & Compliance Report
   3. Medical Staff Report

II. Call to Order Open Session – To begin at approximately 6:30pm
   1. Roll Call – Is Quorum Present?
   2. Agenda Additions or Corrections and Motion to Approve
   3. Reports from Executive Session
      a. Quality & Patient Safety Report
      b. Risk & Compliance Report
      c. Medical Staff Physician Credentialing & Privileging Report
   4. **Motion to Approve or Not Approve Reports from Executive Session** **(action)**
   5. Public Input

III. Consent Agenda
   1. Meeting Minutes
      a. Regular Meeting–08/24/23 1
      b. Executive Session–08/24/23 (provided in Executive Session)
      c. Special Meeting-09/21/23 6
   2. Monthly Counsel Invoice Robert S. Miller III - #... August 31, 2023 9
   3. **Motion to Approve or Not Approve Consent Agenda** **(action)**

IV. Staff Reports
   1. CEO Report 10
   2. Multi-Specialty Clinic Report 12
   3. CNO Report 15
   4. CFO Report 20
   5. CIO Report 21
   6. SCHD Foundation Report 22
   7. Strategic Plan Report (under separate cover)

V. Monthly Financial Statements: Review
   1. Month End Narrative 24
   2. Month End Statements for Period Ending August 31, 2023 26

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VI. Old Business

1. New Policies for Review & Approval (withdrawn from August agenda)
   a. 170.001 Safety Management Program 44
   b. 170.002 Authority of Safety Officer 54
2. Quality Assurance & Performance Improvement Plan-DNV Revision 55
3. **Motions to Approve or Not Approve Above Old Business (action)**

VII. New Business

1. FY23 Election of Officers-Board of Directors
2. Recommendation to Discontinue Employee Retention Bonuses
3. Plastic Surgery Hand & Wrist Business Plan (under separate cover)
4. Healthcare Collaborative Group-Facility Master Plan Presentation
   - Brian Kunkle, President (under separate cover)
5. **Motions to Approve or Not Approve Above New Business (action)**

VIII. Open Discussion & Adjournment

Southern Coos Health District
Board of Directors Meeting
Open Session Minutes
August 24, 2023

I. Executive Session Call to Order 6:00 p.m. Executive Session Under ORS 192.660(2)(c) to consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 Licensing of facilities and health maintenance organizations. No decisions shall be made in Executive Session.

II. Open Session Call to Order 6:30 p.m.

1. Roll Call – Quorum established; one member absent: Brent Bischoff, Board Chairman; Mary Schamehorn, Secretary; Norbert Johnson, Treasurer; Tom Bedell, Director. **Absent:** Pam Hansen, Director. **Administration:** Raymond Hino, CEO; Jeremiah Dodrill, CFO; Scott McEachern, CIO; Dawn Gray, Clinic Manager; Philip Keizer, MD, Chief of Staff. **Absent:** Cori Valet, CNO. **Others present:** Michael Snyder, MedSurg RN Manager; Robert S. Miller, III, Legal Counsel; Kim Russell, Executive Assistant. **Press:** None.

2. Agenda Additions or Corrections

No changes to the agenda.

Mary Schamehorn **moved to approve** the agenda as presented. Tom Bedell **seconded** the motion. **All in favor. Motion passed.**

3. Motions from Executive Session

a. Quality & Patient Safety Report. Presented in Executive Session by Sharon Bischoff, Quality RN.

b. Risk & Compliance Report presented in Executive Session by Barbara Snyder, Risk & Compliance.

c. Medical Staff Report Physician Credentialing & Privileging Report presented in Executive Session by Dr. PJ Keizer, MD, Chief of Staff.

i. <u>2-Year Privileges – New</u>
James Woods, MD – Provisional – Emergency Medicine

ii. <u>2-Year Privileges – Reappointments</u>
Douglas Crane, MD – Active – Internal Medicine

iii. <u>Direct Radiology Appointments & Reappointments – After Hours Reading Radiology</u>
None.

iv. <u>Medical Staff Status Change</u>
Basil Pittenger, MD – Internal Medicine – Privileges to Expire 08.31.23

Adam Kawalek, MD – Emergency Medicine – From Courtesy to Active

d. Medical Staff Delineation of Privileges-Emergency Privileges-Nurse Practitioner presented in Executive Session by PJ Keizer, MD, Chief of Staff.

Norbert Johnson **moved to accept** the Quality & Patient Safety Report, the Risk & Compliance Report, Medical Staff Credentialing and Privileging Report and the Delineation of Privileges as presented in Executive Session. Tom Bedell **seconded** the motion. **All in favor. Motion passed.**

4. Public Input

None.

III. Consent Agenda

1. Meeting Minutes

a. Regular Meeting–07/27/23
b. Executive Session–07/27/23 (provided in Executive Session)

2. Monthly Counsel Invoice Robert S. Miller III – #1332 July 31, 2023

Norbert Johnson **moved** to approve the Consent Agenda. Mary Schamehorn **seconded** the motion. **All in favor. Motion passed.**

IV. Staff Reports

1. CEO Report

Ray Hino, CEO, presented a summary of his monthly report for the prior month. **Covid-19:** Effective August 8 the mandate for healthcare workers to be vaccinated against Covid-19 will end and in accordance with DNV recommendations, mandatory masking for non-vaccinated staff when engaged in direct patient care, has been rescinded at this time. **DNV Survey:** The anticipated but unannounced DNV survey took place August 1-2 resulting in 11 non-conformities to be corrected in 60 days, with the plan of correction due August 26, 10 days following receipt of survey results. We received many compliments from the DNV surveyors on the quality of our staff and the quality of patient care provided to our patients. Before the next survey, it is our goal to move to ISO 9000 standards. (ISO 9000 is defined as a set of international standards on quality management and quality assurance developed to help organizations effectively document the quality system elements needed to maintain an efficient quality system. They are not specific to any one industry and can be applied to organizations of any size.) **Dietary Department Construction Project:** The previously reported Dietary Department plumbing repair and construction project concluded after 27 days. During that time, July 18-August 13, Dietary staff worked in restricted space while continuing to serve our patients. We would like to give a special thank you to the City of Bandon and Avery Richards for allowing us to use the

commercial dishwashing facilities at the Community Center and to our Dietari and Engineering staff for the extra effort and assistance. **Surgery Services:** The month of July had the highest volume of procedures in the last 12 months. An offer has been made for a half-time orthopedic surgeon as surgeon recruitment continues. **Emergency Physician Services:** Southern Coos has been staffing our emergency department by direct contracting with ER physicians who have worked here in the past. Special thanks to doctors Marriott, Mankowski and Kawalek, who have been covering the majority of the shifts for the past 2 months. We are also happy to welcome back local ER physician Dr. Jim Woods. **Sports Physical Clinic:** On August 11, Doctors Bonnie Wong and Noel Pense completed 35 sports physicals in the Bandon High School gym for students from Bandon, Port Orford and Myrtle Point. We are pleased to have offered this service at no charge with a canned food donation for the local food bank.

2. Clinic Report

Dawn Gray, Clinic Manager, presented the Clinic Report for the month, very pleased to share that clinic operations performed above budget for the month of July. She anticipates we will see continued improvement in the numbers of patients seen but the next two months may be lower, due to one physician being out for 2 weeks and as Vincent Tyson, FNP, moves to another assignment in September. We will then be onboarding Amy Hinshaw, FNP, returning to work for Southern Coos, in October. The Chronic Care Management kickoff was a success, with 3-5 patients served this month. Long term, this will result in increased revenues after a first-year loss.

3. CNO Report

Cori Valet, CNO, is out of office. Mike Snyder, MedSurg RN Manager, provided a summary of hospital clinical operations from the CNO Report for the month of July including current staffing report, noting the number of contract RNs is lower as we work to eliminate use. Nursing held another Skills Days event covering high risk, low volume important clinical skills that was well attended. These are scheduled quarterly. Emergency Department volumes have increased. The new Laboratory analyzer instrument is in place and live. We are pleased to welcome our new Surgical Services manager, Colleen Lorenz, an Oregon RN with Oregon license.

4. CFO Report

Jeremiah Dodrill, CFO, provided a summary of Finance Department operations for the month of July. **Audit & Cost Report:** The Finance Department has been working on the Moss-Adams financial audit and with CLA (Clifton, Larsen, Allen CPAs) on the Cost Report. Final FY23 audit report to be presented to the Board this fall. **Projects:** The team is also working with CLA on the long-range financial plan baseline per the Strategic Plan and total cost of ownership studies for the EMR/ERP (Electronic Medical Record/ Enterprise Resource Planning) in preparation for the special board presentation in September. The Facility Master Planning kickoff meeting will be August 31, a multi-phase process with RFP selection process and assessment. **Discussion:** Oregon's limited bed capacity was discussed. Critical Access Hospital designation is limited to 25 bed maximum.

5. CIO Report

Scott McEachern, CIO, provided a summary of his July report on Information Systems, Health Information Management, and Marketing. **Information Systems:** Cyber Security chart and stats reviewed. This topic remains a priority with email security awareness training for all staff and patch management. (Patch management is the process of applying updates to software, drivers, and firmware to protect against vulnerabilities. Effective patch management also helps ensure the best operating performance of systems, boosting productivity.) **Clinical Informatics**: Work continues in support of Quality Department reporting in Merit-Based Incentive Program (MIPS), Medicare Beneficiary Quality Improvement Program (MBQIP) and Medicare Promoting Interoperability Program (formerly Meaningful Use), CMS Framework for Health Equity, and OHA data tracking and reporting, as well as the Laboratory new analyzer project kickoff and new physician onboarding. **EMR/ERP Selection Process (Electronic Medical Record/Enterprise/Enterprise Resource Planning):** A special public meeting is planned to be held in September to present system recommendations, a total cost of ownership model, and outline a funding proposal. At this time, two finalist EPIC Community Connect vendors and two Enterprise Resource Planning vendors have provided demonstrations and reference checks are being completed. Mr. McEachern thanked staff for their participation. The process and timeline with a goal to have a final recommendation and report before the Board of Directors in October.

6. SCHD Foundation Report

Mr. McEachern, SCH Foundation Executive Director, recapped the July Foundation report. There is great momentum for the upcoming annual fundraiser, the Golf for Health Classic, to be held on September 16. Aging Well in Bandon event has been moved to May 2024.

7. Strategic Plan Report

Ray Hino, CEO, presented an update on progress of Strategic Plan initiatives. The strategic plan software issue has been resolved and the Executive Team has been able to update their progress. The compensation plan project, required to be in compliance with Salary Equity Law, is near completion with rollout in September. Mr. Hino thanked Carrie Okey, HR Director, for her work and efforts at transparency and communication with board and staff. Quality initiatives are all near completion. Mr. Hino is reviewing two vendors to provide a long-term board education plan. Disaster preparedness activities are planned. Board indemnification is complete. The finance team is making progress on long-term financial plan goals. **Discussion:** An employee recognition platform has been in place this last year; performance discipline will be administered through coaching and corrective action, and Administration is open to incorporating a merit component. Administration confirmed that it is time to begin preparation of a new strategic plan with discussion to include exploration of becoming a Level 4 Trauma Center.

V. Monthly Financial Statements

of July, including a review of Gross Revenue and Volumes, Deductions from Revenue, Labor Expenses, Professional Fees, Purchased Services, and Supplies. Lower volumes and an average daily patient census of 6.4, below the budgeted expectation of 9.3, resulted in an operating loss for the month of ($307,000). Days in Accounts Receivable increased to 50.6. Days of Cash on Hand closed at 117.7. Provider productivity goals and efficiencies are in progress. Congratulations to Dawn Gray, Multi-Specialty Clinic Manager, and her team, for exceeding budgeted expectations with Total Operating Revenue of $80,587, above budgeted expectation of $65,901. **Discussion:** Competitive bidding is performed for purchases. Marketing will begin for orthopedic surgery when credentialing and privileging of surgeon is complete.

VI. New Business

1. New Policies for Review & Approval

a. 170.001 Safety Management Program
b. 170.002 Authority of Safety Officer

These policies will be forwarded to the September agenda.

VII. Open Discussion and Adjournment

A date was selected for a special meeting to be held on September 21 at 6:00 p.m. to hear results of the RFP process and evaluation for EMR/ERP (Electronic Medical Record/Enterprise/Enterprise Resource Planning). No decision will be made at the special meeting. The next regular meeting will be held Thursday, September 28, 2023, with Executive Session at 6:00 p.m. and Open Session to immediately follow at approximately 6:30 p.m. Meetings are again open to the public in the main conference room of the hospital at 900 11th Street SE, Bandon, Oregon.

At 7:52 p.m. the meeting adjourned.

Brent Bischoff, Chairman *9-28-2023*

Mary Schamehorn, Secretary *9-28-2023*

Southern Coos Health District
Board of Directors Special Meeting
September 21, 2023

I. Call to Order 6:00 p.m.

1. Roll Call – Brent Bischoff, Board Chairman; Mary Schamehorn, Secretary; Norbert Johnson, Treasurer; Tom Bedell, and Pam Hansen, Directors. **Administration:** Raymond Hino, CEO; Jeremiah Dodrill, CFO; Scott McEachern, CIO; Dawn Gray, Clinic Manager; Philip Keizer, MD, Chief of Staff. Cori Valet, CNO. **Others present:** Madelaine Yue, Experis; Matthew Borchardt, CLA; Kim Russell, Executive Assistant. **Press:** None.

2. Agenda Additions or Corrections

Tom Bedell **moved to approve** the agenda as presented. Mary Schamehorn **seconded** the motion. **All in favor. Motion passed.**

3. Public Input

Mr. Bischoff welcomed the public in attendance, requesting a limit of 1-2 minutes per person. Public input was received in person, hearing from Dawn Gray, Clinic Manager who read a letter from clinic provider, Paul Preslar, DO, in favor of Epic Systems; Sharon Bischoff, Quality RN, shared concerns regarding increasing Quality reporting demands and system capability. Cori Valet, CNO, read two letters from RNs; one not in favor of Epic, as not an intuitive solution, and another in favor of Epic, both from previous experience. Colleen Lorenz, Surgical Services Manager, spoke in favor of the Epic Systems product as a great tool for use in the Operating Room. Trevor Jurgenson, Information Systems Manager and HIPAA Security Officer spoke in favor of Epic product in terms of HIPAA privacy and security compliance. Jeff Weymouth, IT Systems Analyst, presented a letter to the board to be forwarded and will be included in these minutes (see page 3).

II. ERP & EMR Vendor Recommendation, Total Cost of Ownership, and Financing Model – Presentation

Ray Hino welcomed and thanked the team of presenters and the board for their time and consideration. The presentation opened with Scott McEachern, CIO and Jeremiah Dodrill, CFO providing overviews. A Powerpoint presentation was provided with vendor selection criteria and results presented by Madelaine Yue, VP Solution Delivery, Experis Health Solutions. Total cost of ownership financial information was presented by Matthew Borchardt of Clifton Larson Allen, CPA firm, including forecasted revenue and expenses. Two EMR vendors have been identified for comparison review: Providence/Tegria and Oregon California Health Information Network (OCHIN,) both Epic Community Connect Programs. Two potential ERP vendors identified for evaluation are Sage Intacct and Premier, Inc. SCHD board members asked questions regarding business and revenue assumptions against

proposed expenses. Additional information gathering is still in process to be presented in the coming month with possible additional project funding, final financial report and recommendation to be presented in October. A copy of the Powerpoint presentation, as well as the meeting recording, are available by request from Southern Coos Administration Office at 541-329-1031.

III. Open Discussion and Adjournment

Board members thanked Madelaine, Matthew, Scott and Jeremiah, the finance team, and all staff who participated in the thorough process that included system demonstrations, the RFP (Request for Proposal) review processs, and financial analysis.

At 8:25 p.m. the meeting adjourned.

Brent Bischoff, Chairman *9-28-2023*

Mary Schamehorn, Secretary *9-28-2023*

Attachment 1 of 1: Public Input Letter from Jeff Weymouth, IT Systems Analyst

Attachment 1 of 1

Sep 21, 2023

Dear SCHHC Board of Directors,

Because the similarities between the OCHIN and Tegria implementations of EPIC are numerous, I will focus on the differences purely from an I.T. Standpoint.

Tegria's installation works off Providence Hospital's platform. All of their community partners run the same configuration and hardware making their help desk very efficient because every location is the same. If a community partner location doesn't fit into the "Hospital Platform Box" the location is required to reconfigure their workflows to conform to the platform.

The supported hardware list therefore is short, every facility has the same thing. Their workstations are within two generations of current offerings, their desktop scanners are top-of-the-line, and their label printers are all current models. I feel that the hardware requirements will continually be updated as the existing product meets EOL (End Of Life) and is replaced with a newer model.

There may initially be a larger financial outlay to replace serviceable equipment that is outside the scope of Tegrias equipment list, as well as shortening our workstation and equipment refresh schedule, for workstations and laptops, by at least two years.

Ochin has no native configuration to duplicate at every location so their equipment list is broader and more in line with our existing hardware and refresh practices. It is also more customizable according to their Community Partners needs. We have seen by our association with CCHC, that Ochin EPIC has a robust Clinic module not offered with Tegria.

Since Ochin does not have a standard implementation, support potentially may suffer as the help desk must be familiar with the unique configuration of the partners facility.

With many of our patients also receiving care from neighboring facilities that have already implemented EPIC or Cerner, Evident's patient portal demonstrates to them the shortcomings in the system we currently use and causes them to question if this is the facility in which they wish to receive care.

As a Hospital and a Health Center, I feel the Ochin implementation has a slight advantage over the Providence/Tegria one-size-fits-all approach, but I want to emphasize, that there is no bad choice - either implementation will benefit SCHHC.

The choice to do nothing and stay with Evident, or a bifurcated implementation that does not include both the clinic and the hospital would be a mistake as Evident's shortcomings are numerous, not up to date with current industry standards, and in some cases non-compliant.

Jeff Weymouth
Systems Analyst

INVOICE

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Southern Coos Hospital & Health Center

Bill to
Southern Coos Hospital & Health Center
900 11th Street SE
Bandon, OR 97411 USA

Ship to
Southern Coos Hospital & Health Center
900 11th Street SE
Bandon, OR 97411 USA

Invoice details
Invoice no.: 1366
Terms: Net 60
Invoice date: 09/07/2023
Due date: 11/06/2023

	Product or service		Amount
1.	**Attorney** Service date: 08/24/2023 Board Executive Session & General Meeting	2.5 units × $250.00	$625.00

Total **$625.00**

Ways to pay

Pay invoice

CEO Report

oard of Directors
E, CEO
f Directors, September 2023

COVID Update

The SCHHC Covid-19 Committee continues to meet every 2 weeks. Here are recent updates from the Committee:

- Due to the fact that effective as of August 8, 2023, the Public Health Emergency for COVID-19 has ended, and all Federal and State mandates for mandatory masking and vaccinations of health care workers have ended, Southern Coos Hospital has eliminated all mandatory requirements. However, we have seen an increase in employee infections in the past month. As a result, we have notified employees that we recommend (but are not mandating) that masks be worn when employees are in close contact with other employees and patients. Also, we are requiring that employees that are living with a COVID-19 positive individual, must mask while at work.

- The patient care trailer, equipped with a negative pressure room, that was ordered with COVID funds earlier this year, is due to be delivered to SCHHC before the end of this month.

- This year we have decided to expand our Annual Drive Through Flu Vaccination Clinic to include an option for COVID vaccinations as well. This is an Annual Flu Vaccine Clinic is an annual event that SCHHC is able to claim as a Community Benefit Expense.

DNV

- On September 11, 2023 we received notification from DNV that our Plan of Corrective Action, submitted in response to our survey on August 1 and August 2, has been accepted and approved. The next actions that are required of SCHHC to retain our accreditation is to submit a report of objective evidence of correction for our 5 NC-1 non-conformities no later than December 11, 2023. Congratulations, once again, to our entire Southern Coos team, and particularly to our Quality team for spearheading our preparation efforts.

Surgery

- On September 22, I sent Dr. Michael Ivanitsky a contract proposal to work as a 0.5 FTE orthopedic surgeon for Southern Coos Hospital & Health Center. We are coordinating our contract offer with Lower Umpqua Hospital, who is also offering a 0.5 FTE employment position to Dr. Ivanitsky. He has previously informed both hospitals that he is agreeable to such a sharing arrangement. We are looking forward to working with him at Southern Coos Hospital and bringing his orthopedic surgical service to our patients.

- This month we are bringing a business plan and a proposal to bring an additional surgery service onboard at Southern Coos Hospital. We have a tremendous opportunity to offer a specialty service in hand surgery and plastic surgery. This will be presented under new business this month.

Emergency Physician Coverage

- We are continuing to provide Emergency Physician coverage for our Emergency Department by direct contracting with physicians. Each month more physicians are coming on board, which is making it easier. We also use a Locum Tenens company, Medicus, to fill gaps in coverage. Through Medicus, we have brought in highly experienced physicians, and in some instances, highly experienced Nurse Practitioners as well. We have used Nurse Practitioners in the Emergency Department at Southern Coos Hospital in the past. Although it has been awhile. The State of Oregon allows Nurse Practitioners to work independently in hospital emergency rooms. Our Medical Staff Bylaws, permit it as well. The Nurse Practitioner that was brought in, under the Medicus contract, has done extremely well and we plan to continue using her.

Meetings with New Health Care Center Administrators

- Earlier this month, I met with Eddie Larsen, the new CEO for Coast Community Health Center (CCHC). Eddie has been onboard for about 6 weeks now. His most recent position, before coming to Bandon, was as the CEO for a Federally Qualified Health Center (FQHC) in Coeur d'Alene, Idaho. Previous to that, he was in Roseburg, Oregon. He comes to CCHC with a wealth of experience in FQHC operations, and appears to be a great addition to CCHC and to our community. We have agreed to begin meeting 2 times each month to facilitate a collaborative relationship between our 2 facilities.

- On September 13, I also met with John Reeves III, the Director for the Confederated Tribes of Coos County's new Health Clinic in Coos Bay. John also has a wealth of experience in Indian Health Services hospitals and clinics. He is charged with opening a new clinic in Empire, Oregon. They expect to be open in the First Quarter of 2024. John and I also found many opportunities for collaboration between our 2 facilities. As I was touring him in our hospital, he met our Managers for Medical Imaging, Laboratory and our Clinic. We offer appointments for tests and services that are very competitive with medical facilities in Coos Bay. I believe that we will be able to become a referral center for the new clinic. I am looking forward to continued meetings with Mr. Reeves as well.

Leadership Academy

- On August 28, we completed the first 12 months of the Southern Coos Hospital Leadership Academy for our Leadership Team. During the 12 months, we held monthly educational sessions on topics including: budgeting, personnel management, compliance, customer satisfaction and more. I am very pleased that we have been able to bring this level of training to our leadership. We plan to continue the leadership academy series into another 12 months, and add additional leaders that we are developing in our organization.

Multi-Specialty Clinic Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: Dawn Gray, Clinic Manager
Re: Multi-Specialty Clinic Report for SCHD Board of Directors Meeting – September 28, 2023

Provider News – August

August proved to be a remarkable month in the clinic despite Dr. Preslar being out for 2 weeks. Clinic registrations saw a notable 12% increase, and our primary care providers boosted their daily patient visits to an average of 8.4. It is worth mentioning that Dr. Pense saw one patient on a day when he was serving as a Hospitalist, although he did not have any scheduled clinic days throughout the month of August.

Upon review of the Clinic Income Summary for August, I have observed a loss of $59,757 despite having an increase in clinic registrations. A deeper dive revealed there is approximately $36k in late charges that will be realized in September's financials. I would like to emphasize that the year-to-date loss remains below our budgeted projections, and we are consistently seeing improvements in provider productivity with each passing month. It's worth noting that we anticipate a decline in clinic registrations for September following Vincent Tyson's departure on September 8th.

August 2023 Clinic Stats

Provider	Days in Clinic	Patients Scheduled	CXL'D	No Show	Total Seen	Average Seen	No Show Rate	Cancelation Rate	Total Telehealth	Total New Pts
Bonnie Wong, DO	16	119	8	5	106	6.6	4%	7%	0	40
Olixn Adams, DO	4	61	8	4	49	12.3	7%	13%	8	2
Noel Pense, DO	0	1	0	0	1	#DIV/0!	0%	0%	0	0
Paul Preslar, DO	8	91	12	4	75	9.4	4%	13%	0	34
Shane Matsui, LCSW	20	110	30	1	79	4.0	1%	27%	10	0
Vincent Tyson, FNP	20	186	11	5	170	8.5	3%	6%	4	1
Outpatient Services	23	253	13	9	231	10.0	4%	5%	0	0
Schmelzer	9	52	2	0	50	5.6	0%	4%	0	12
Totals	**100**	**873**	**84**	**28**	**761**	**7.6**	**3%**	**10%**	**22**	**89**
Total telehealth	**22**				530	Clinic Registrations				

In addition to the provider stats provided above, the specialist stats are:

- Dr. Qadir, Nephrologist, did not see patients in August.
- Dr. Webster, ENT/Dermatology, was in clinic one day and saw 20 patients.

Clinic Report – August

- In August, we successfully billed for two Chronic Care Management (CCM) patients, encompassing one regular CCM case and one complex CCM case with a higher reimbursement rate. Complex CCM accounts for both the time spent and the provider consultation, offering a more comprehensive level of care. Regrettably, our Care Coordinator Specialist has tendered her resignation, having received a job offer she couldn't refuse. We are actively recruiting for her replacement while ensuring uninterrupted CCM services for the two patients she had previously enrolled.
- The No Show rate decreased to 3% for the month of August.

- Advanced Health requires us to report Timeliness of Care metrics quarterly. Below is the report I submitted to Advance Health for Quarter 2:

Facility: Southern Coos Hospital & Health Center **Time frame: March-June 2023 (Qtr 2)**	**Values**
# of appointment cancellations- # of appointment cancellations by provider, provider's office, or member. – Totals by quarter	182 - this is the total for all our patients as our EMR is unable to sort by insurance type. We are working with Evident report writers to develop one
Appointment waiting time: Average time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment of services. -Totals by quarter	Unfortunately, our system does not have the capabilities to report this
# of appointments rescheduled- # of appointments rescheduled by provider, provider's office, or member. – Totals by quarter	73 - this is the total for all our patients as our EMR is unable to sort by insurance type. We are working with Evident report writers to develop one
Re-Scheduled Appointment Waiting Time: Average time from cancellation of initial appointment to the date of the re-scheduled appointment. -Totals by quarter	Unfortunately, our system does not have the capabilities to report this
Third Next Available Appointment (TNAA) – Totals by quarter- an instruction sheet and template (if needed) has been provided as an attachment. (please provide if currently being captured)	See attached spreadsheet

- Our NRC survey scores for the month of August have remained virtually unchanged. We did have two negative comments along with 20 positive ones. The negative comments had to do with access to care and provider interaction. Some of the positive comments were:
  - Dr. Preslar is a welcomed addition to Southern Coos. He is a fantastic doctor.
  - Staff friendly, professional, very competent. Recommend Dr. Wong to several other patients of the DO clinic.
  - It was very comfortable. My new doctor, Dr. Wong, was very good and she listened to you.
  - I'm always treated with respect when I visit this office. Everyone working in this office are all very professional.
  - Dr. Preslar was very, very good. Listened to everything that I had to say. Telling me exactly what the problems were and I couldn't think of a better doctor to have in the area here. Thank you very much.

August 2023 Results	Asked about medications		Care provider courtesy and respect		Care providers explain things		Care providers listened		Easy to get appt		Felt safe and secure		Human Understanding		NPS: Facility would recommend		Providers knew medical history	
Provider Name	Score	n-size	Score	n-size	Score	n-size	Score	n-size	Score	n-size	Score	n-size	Score	n-size	Score	n-size	Score	n-size
Tyson, Vincent (1003245457)	72.7	22	70.8	24	62.5	24	62.5	24	54.2	24	8303	24	59.1	22	72.7	22	33.3	24
Preslar, Paul (1437141793)	88.2	17	82.4	17	58.8	17	76.5	17	41.2	17	76.5	17	68.8	16	60	15	52.9	17
Wong, Bonnie (1437404415)	100	9	100	9	77.8	9	88.9	9	33.3	9	100	9	87.5	8	100	8	33.3	9
Schmelzer, Victoria (1417312893)	100	7	100	7	100	7	100	7	42.9	7	100	7	57.1	7	100	7	100	7
Adams, Olixn (1306006143)	100	3	100	3	100	3	100	3	66.7	3	100	3	100	1	100	1	66.7	3
Grand Total	**86.2**	**58**	**83.3**	**60**	**70**	**60**	**76.7**	**60**	**46.7**	**60**	**86.7**	**60**	**66.7**	**54**	**77.4**	**53**	**48.3**	**60**

- The report below outlines our current status in relation to the PCPCH quality measures we are tracking. I would like to highlight that we are improving and meeting our goals in 2 of the 3 measures. Hypertension control will be the focus of our first clinic PDSA (Plan, Do, Study, Act) quality improvement project that will kick off next month.

Southern Coos Multi-Specialty Clinic eCQM Performance Report for 2023						
Measure	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**	**As of 9/1/2023**	**Goals***
CMS122v11: Diabetes HbA1C Poor Control (>9) (lower is better)	25.0%	25.3%			22.4%	23%
CMS165v11: Controlling High Blood Pressure	46.5%	47.6%			48.6%	67%
CMS138v11: Tobacco Use: Screening and Cessation Intervention	90.1%	88.9%			88.6%	82%
***Goals set according to PCPCH Benchmarks**						
Green represents goal achieved						
Yellow represents ≤ 5 of goal						
Red represents > 5 under goal						

Clinic Provider Income Summary

All Providers

For The Budget Year 2024

	ACT JUL	BUD JUL	ACT AUG	BUD AUG	ACT YTD	Current Budget YTD FY24 Budget	Variance
Provider Productivity Metrics							
Clinic Days	72	54	77	34	149	111	37
Total Visits	475	364	508	162	1005	763	242
Visits/Day	6.6	6.7	6.6	4.8	6.8	6.9	(0.1)
Total RVU	1,061.83	815.78	1,077.97	406.25	2,139.80	1,732.07	407.73
RVU/Visit	2.24	2.24	2.12	2.51	2.13	2.27	(0.14)
RVU/Clinic Day	14.85	15.07	14.00	12.09	14.41	15.57	(1.16)
Gross Revenue/Visit	381.78	395.56	391.75	452.40	378.46	404.24	(25.78)
Gross Revenue/RVU	170.79	176.55	184.61	180.46	177.75	178.00	(0.24)
Net Rev/RVU	75.89	80.78	80.63	93.46	78.28	81.50	(3.22)
Expense/RVU	111.21	157.82	136.06	163.07	123.73	147.46	(23.73)
Diff	(35.32)	(77.04)	(55.44)	(69.61)	(45.45)	(65.96)	20.51
Net Rev/Day	1,127.08	1,217.39	1,128.78	1,130.29	1,127.96	1,269.17	(141.21)
Expense/Day	1,651.58	2,378.40	1,904.84	1,972.11	1,782.90	2,296.37	(513.47)
Diff	(524.50)	(1,161.01)	(776.07)	(841.82)	(654.94)	(1,027.20)	372.26
Patient Revenue							
Outpatient							
Total Patient Revenue	181,345	144,030	199,009	73,313	380,354	308,303	72,051
Deductions From Revenue							
Total Deductions From Revenue (Note A)	100,759	78,129	112,093	35,344	212,852	167,140	45,712
Net Patient Revenue	**80,587**	**65,901**	**86,916**	**37,969**	**167,502**	**141,163**	**26,339**
Total Operating Revenue	**80,587**	**65,901**	**86,916**	**37,969**	**167,502**	**141,163**	**26,339**
Operating Expenses							
Salaries & Wages	61,877	70,820	86,051	36,851	147,928	141,640	6,288
Benefits	3,426	8,703	6,338	5,454	9,764	16,682	(6,918)
Medical Supplies	0	496	0	567	0	1,064	(1,064)
Other Supplies	746	132	36	132	782	265	517
Other Expenses	2,500	2,225	1,667	559	4,167	4,451	(284)
Allocation Expense	49,539	46,373	52,526	22,683	102,065	91,312	10,753
Total Operating Expenses	118,088	128,750	146,673	66,247	264,761	255,414	9,347
					687		
Excess of Operating Rev Over Exp	**(37,501)**	**(62,849)**	**(59,757)**	**(28,278)**	**(97,259)**	**(114,251)**	**16,992**
Total Non-Operating Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Excess of Revenue Over Expenses	**(37,501)**	**(62,849)**	**(59,757)**	**(28,278)**	**(97,259)**	**(114,251)**	**16,992**

Note A - Average Collection Rate = 41% of Gross Charges, therefore the Deduction Rate is 59% of Gross Charges

Chief Nursing Officer Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: Cori Valet, RN, BSN, Chief Nursing Officer
Re: CNO Report for SCHD Board of Directors Meeting – September 28, 2023

Clinical Department Staffing- August 2023

- **Medical-Surgical Department –**
  - One per diem RN transitioned into a full-time position.
  - Three full-time CNAI/II positions vacant.
  - Four full-time nurse positions vacant.
  - Four contract RNs utilized to cover vacancies, vacation requests, and medical leave.
- **Emergency Department –**
  - One full-time RN vacancy due to termination.
  - One full-time LPN float position vacant (float between MS and ED).
  - One contract RN utilized.
- **Surgical Services –**
  - Colleen Lorenz has filled the permanent Surgical Services Manager position.
    - Colleen comes to Southern Coos Hospital with 32 years of experience, including 19 years in surgical leadership roles. She is experienced in all aspects of surgical nursing as well as sterile processing. She is excited to be in a management position that allows for both management and direct patient care interaction.
  - Current vacancies include: One full-time Circulating RN, one full-time and one per diem surgical technologist. One full-time surgical technologist starting in September.
  - One contract RN utilized.
- **Medical Imaging –**
  - Three full-time Radiology Technologist positions vacant.
  - Three Contract Radiology Technologists utilized in August.
- **Laboratory –**
  - One full time Medical Lab Technologist/Scientist position vacant.
  - One Contract Medical Lab Technologists continues to be utilized to fill the need.
- **Pharmacy –**
  - Fully staffed.
- **Respiratory Therapy –**
  - One Full time respiratory therapist position vacant.
  - Vacancies have been covered by existing respiratory therapists as well as the department manager.

Clinical Department FTE Statistics for August 2023

	Current Month								
	FTE			Contract			Total		
	Actual	Budget	Diff	Actual	Budget	Diff	Actual	Budget	Diff
Med Surg	**25.80**	**25.77**	**0.03**	**4.34**	**3.61**	**0.73**	**30.14**	**29.38**	**0.76**
Manager	1.00	1.01	-0.01	-	-	0.00	1.00	1.01	-0.01
CNA I	3.13	1.72	1.41	-	-	0.00	3.13	1.72	1.41
CNA II	4.46	3.77	0.69	-	-	0.00	4.46	3.77	0.69
Patient Activities Coordir	-	1.00	-1.00	-	-	0.00	-	1.00	-1.00
Charge Nurse	3.72	3.54	0.18	-	-	0.00	3.72	3.54	0.18
RN	8.95	10.99	-2.04	4.34	3.61	0.73	13.29	14.60	-1.32
LPN	2.68	2.56	0.12	-	-	0.00	2.68	2.56	0.12
Telemetry Tech	1.85	1.18	0.67	-	-	0.00	1.85	1.18	0.67
Swing Bed	**0.96**	**1.01**	**-0.05**	**-**	**-**	**0.00**	**0.96**	**1.01**	**-0.05**
Case Manager	0.96	1.00	-0.04	-	-	0.00	0.96	1.00	-0.04
LPN	-	0.01	-0.01	-	-	0.00	-	0.01	-0.01
Emergency Room	**12.13**	**12.12**	**0.01**	**0.16**	**0.90**	**-0.75**	**12.29**	**13.02**	**-0.73**
Manager	1.00	1.00	0.00	-	-	0.00	1.00	1.00	0.00
CNA II	1.42	2.49	-1.07	-	-	0.00	1.42	2.49	-1.07
LPN	3.29	2.39	0.90	-	-	0.00	3.29	2.39	0.90
RN	6.41	6.24	0.17	0.16	0.90	0.75	6.57	7.14	-0.57
Surgical Services	**3.13**	**5.60**	**-2.47**	**1.21**	**-**	**1.21**	**4.33**	**5.60**	**-1.27**
Director	0.03	1.00	-0.97	-	-	0.00	0.03	1.00	-0.97
Manager	1.00	-	1.00	-	-	0.00	1.00	-	1.00
RN	0.10	-	0.10	-	-	0.00	0.10	-	0.10
Surgical Nurse	1.07	3.00	-1.93	1.21	-	1.21	2.28	3.00	-0.72
Surgical Tech	0.92	1.60	-0.68	-	-	0.00	0.92	1.60	-0.68
Radiology	**3.52**	**3.05**	**0.47**	**2.75**	**1.81**	**0.95**	**6.27**	**4.86**	**1.41**
Manager	1.00	1.00	0.00	-	-	0.00	1.00	1.00	0.00
Coordinator	0.85	0.75	0.10	-	-	0.00	0.85	0.75	0.10
Medical Imaging Admin	0.98	1.00	-0.02	-	-	0.00	0.98	1.00	-0.02
Rad Tech IV	0.69	0.30	0.39	2.75	1.81	0.95	3.44	2.11	1.33
Ultrasound	**1.43**	**1.94**	**-0.51**	**-**	**-**	**0.00**	**1.43**	**1.94**	**-0.51**
Ultrasound Tech II	0.74	1.64	-0.90	-	-	0.00	0.74	1.64	-0.90
Ultrasound Tech IV	0.69	0.30	0.39	-	-	0.00	0.69	0.30	0.39
Mammography	**0.27**	**1.63**	**-1.36**	**-**	**-**	**0.00**	**0.27**	**1.63**	**-1.36**
Mammo Tech	0.27	1.63	-1.36	-	-	0.00	0.27	1.63	-1.36
Cat Scan	**2.06**	**0.06**	**2.00**	**-**	**-**	**0.00**	**2.06**	**0.06**	**2.00**
Rad Tech II	1.00	-	1.00	-	-	0.00	1.00	-	1.00
Ct/Rad Tech Reg	1.06	0.06	1.00	-	-	0.00	1.06	0.06	1.00
MRI	**1.04**	**0.99**	**0.05**	**-**	**-**	**0.00**	**1.04**	**0.99**	**0.05**
Rad Tech IV	1.04	0.99	0.05	-	-	0.00	1.04	0.99	0.05
Lab	**8.19**	**9.53**	**-1.34**	**1.01**	**1.81**	**-0.79**	**9.20**	**11.34**	**-2.14**
Manager	1.00	1.00	0.00	-	-	0.00	1.00	1.00	0.00
Assistant I	-	0.99	-0.99	-	-	0.00	-	0.99	-0.99
Assistant II	2.83	3.01	-0.18	-	-	0.00	2.83	3.01	-0.18
Assistant III	1.01	0.99	0.02	-	-	0.00	1.01	0.99	0.02
CNA II	0.56	-	0.56	-	-	0.00	0.56	-	0.56
Medical Lab Tech Lead	1.08	1.00	0.08	-	-	0.00	1.08	1.00	0.08
Medical Lab Scientist	0.60	0.55	0.05	-	-	0.00	0.60	0.55	0.05
Medical Lab Tech	1.09	1.99	-0.90	1.01	1.81	-0.79	2.10	3.80	-1.69
Pharmacy	**1.81**	**1.90**	**-0.09**	**-**	**-**	**0.00**	**1.81**	**1.90**	**-0.09**
Pharmacist	0.48	0.60	-0.12	-	-	0.00	0.48	0.60	-0.12
RN	1.33	1.30	0.03	-	-	0.00	1.33	1.30	0.03
Respiratory	**5.94**	**6.00**	**-0.06**	**-**	**-**	**0.00**	**5.94**	**6.00**	**-0.06**
Manager	1.00	1.00	0.00	-	-	0.00	1.00	1.00	0.00
Respiratory Therapist	4.94	5.00	-0.06	-	-	0.00	4.94	5.00	-0.06
Total Difference	**66.25**	**69.60**	**-3.35**	**9.47**	**8.13**	**1.34**	**75.72**	**77.73**	**-2.01**

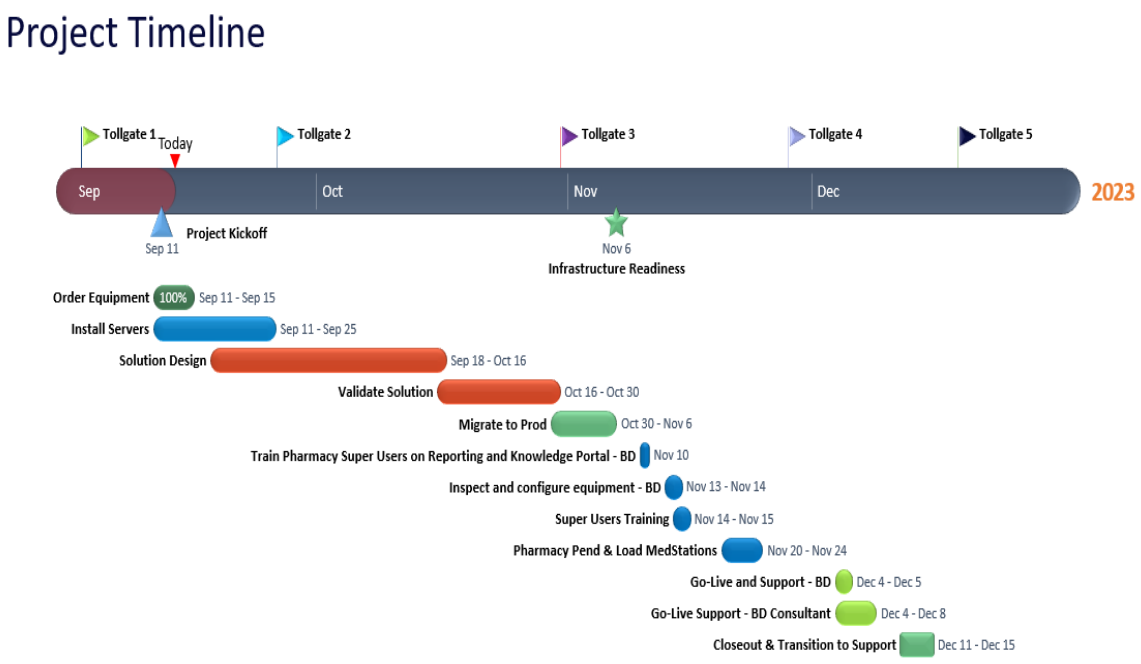
Laboratory Services –

- New Dimension Chemistry Instrument fully installed within the Laboratory Department.
- 89% of testing performed in August 2023 occurred in-house at SCHHC.

TEST SITE	#TESTS	#TEST ORDER CHOICES	%WORKLOAD
BAY AREA HOSPITAL	19	10	0.01
COQUILLE VALLEY HOSP	201	19	5.54
NATIONAL LABS	2	1	0.06
QUEST DIAGNOSTICS	180	95	4.96
SCHHC	3229	98	88.93
TOTAL	3631	223	

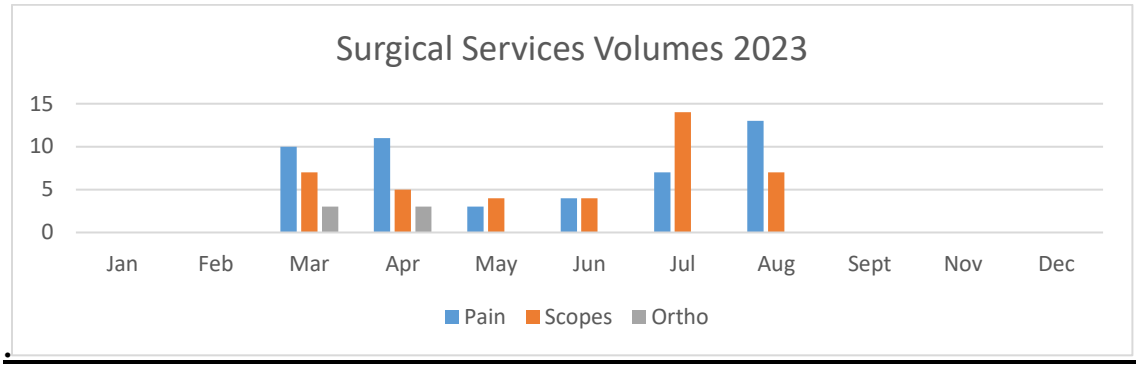
Pharmacy –

- New BD Pyxis ES (medication dispensing system) implementation planning has begun.
- Project plan is to Go-Live the week of December 4, 2023.



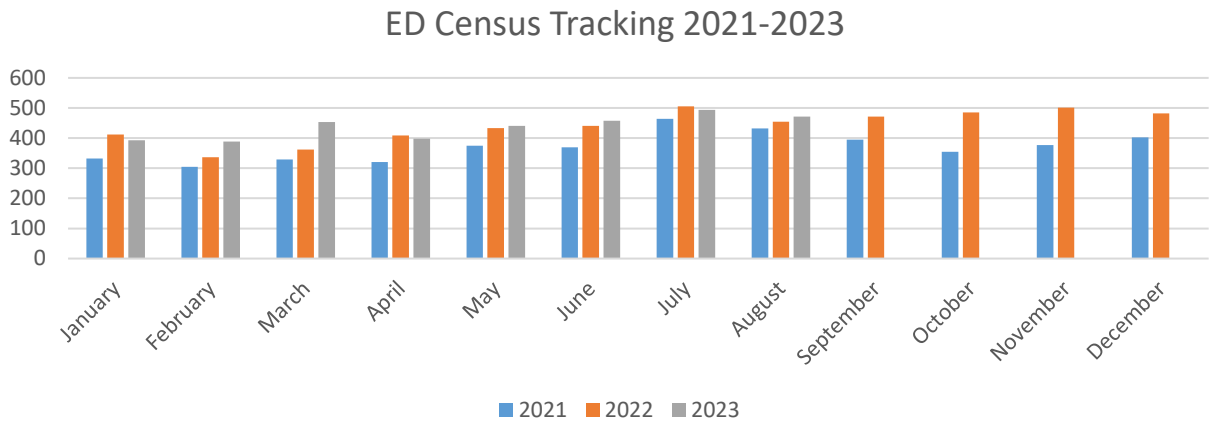
Surgical Services –

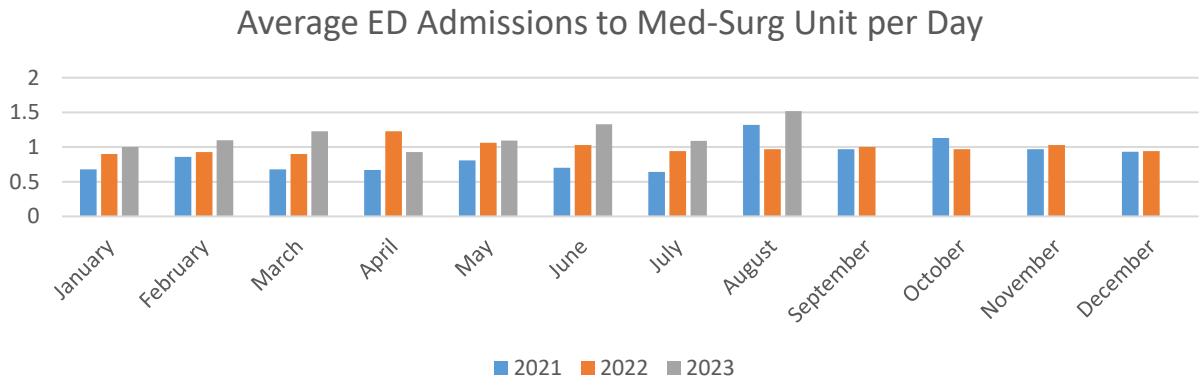
- Operating room light installation complete.
- Orthopedic surgical cases remain at zero/month utilizing South Coast Orthopaedic Associates (SCOA) providers.
- Two new surgeons have been approached to initiate services at SCHHC.

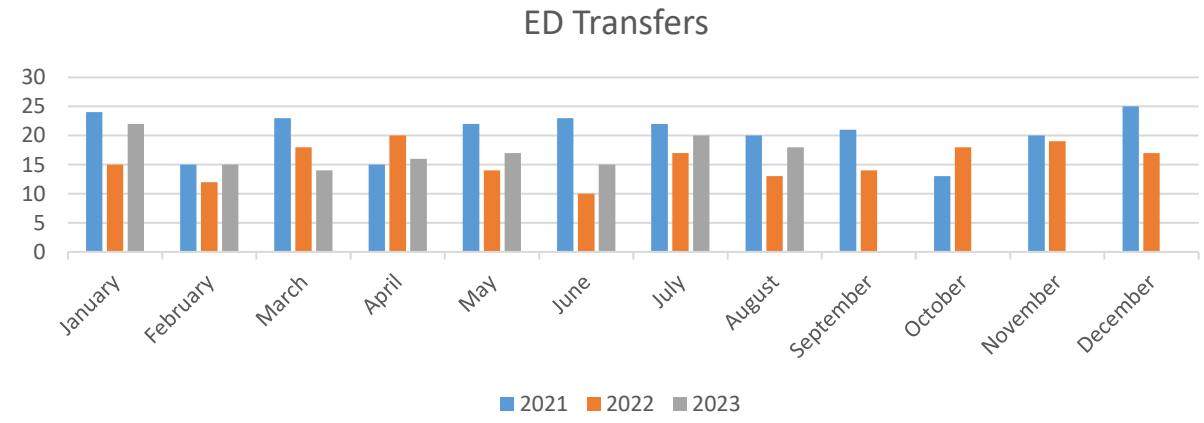


Emergency Department –

- Pediatric trauma "simulation-based' team training – August 11, 2023
    - Through a grant offered by the Oregon office of rural health a coordinated simulation training event occurred between Reach and Southern Coos Hospital to provide practice to both organizations on how to respond to and treat a pediatric trauma patient from initial notification in the field all the way through initial scene response, transport to the emergency department, patient treatment and transfer to a higher level of care.
    - Live video of the training was obtained and provided for ongoing educational opportunities.
    - Training involved emergency medical services (REACH), respiratory therapy, laboratory personnel, medical imaging technologists, emergency department nurses, the attending emergency department physician, engineering services and information services.


ED Census Tracking 2021-2023
600
500
400
300
200
100
0
January
February
March
April
May
June
July
August
September
October
November
December
2021
2022
2023


Average ED Admissions to Med-Surg Unit per Day
2
1.5
1
0.5
0
January
February
March
April
May
June
July
August
September
October
November
December
2021
2022
2023


ED Transfers
30
25
20
15
10
5
0
January
February
March
April
May
June
July
August
September
October
November
December
2021
2022
2023

Chief Financial Officer Report

To: Board of Directors and Southern Coos Management
From: Jeremiah Dodrill, CFO
Re: CFO Report for Board of Directors Meeting – September 28, 2023

Moss Adams 2023 FYE Audit and CLA 2023 FYE Cost Report

Moss Adams has completed its fieldwork portion of the audit of the district's financial statements for the fiscal year ended June 30, 2023. We are still on track for the completion of the audit by the end of October. CliftonLarsonAllen (CLA) is also finalizing the hospital's Medicare Cost Report. This should be completed by the end of September. The preparation of the Medicare Cost Report is an essential component of the proper revenue recognition and resulting financial results for the audit. We anticipate reviewing the results of these processes during the October District Board Meeting.

Implementation of GASB 96,

The Government Accounting Standards Board previously issued GASB 96, Subscription-Based Information Technology Arrangements (SBITAs), which is applicable to the District's financial statements for the fiscal year ended June 30, 2023. This pronouncement requires that SBITAs be accounted for in a similar manner to leases under GASB 87. When a government entity enters into a SBITA, they recognize the subscription asset and a related subscription liability on financial statements. The value of these is determined by calculating the present value of subscription payments that are due over the term of the SBITA and discounted by a discount rate. The government entity should then amortize these assets in a systematic and rational manner over the subscription term, further reducing the subscription liability by payments made during the term. The accounting and finance team is working with Moss Adams to evaluate all of our SBITAs and ensure the proper implementation under this accounting standard.

Master Facility Plan Development

SCHCH has contracted with the Healthcare Collaborative Group to help us create a Master Facility Plan. The Healthcare Collaborative Group is a highly reputable firm that specializes in various aspects of hospital facilities planning, project management, design and operations and has numerous large and small hospital clients within Oregon and Washington. Joe Kunkel will present the project plan and be available for any questions or considerations during the Board meeting on September 28, 2023.

Chief Information Officer Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: Scott McEachern, Chief Information Officer
Re: CIO Report for SCHD Board of Directors, September 28, 2023

Cybersecurity

Email Protection Provided by Mimecast	**June 2023**	**July 2023**	**August 2023**
Spam Blocked/Number of Emails	357/67462	747/44139	646/92876
Impersonation Attacks	746	732	867
Malware Detected and Quarantined	10	4	8
Links Clicked/Number Unsafe	253/4	387/0	431/0
Malicious Attachments	0 files	0	0
Internet Traffic Monitored by Critical Insight	June 2023	July 2023	August 2023
Number of Records Ingested (in millions)	497.5	514.2	540.5
Investigations	4	3	4
Reported Investigations	0	2	0
High Priority Investigations	0	0	0
Patch Management - Vulnerability Scans	June 2023	July 2023	August 2023
Critical	20	9	7
High	36	22	18
Medium	1679	1629	1545
Low	150	149	145
Info	14657	14535	14508

EMR/ERP Selection Process

Management presented a detailed update to the EMR/ERP selection process at the special SCHD Board Meeting on September 21, 2023. The SCHD Board has received an updated copy of the presentation. Management is continuing to work toward a final presentation to the board in October. We are working on the following outstanding items:

1. Build the project financing and funding model
    a. Advanced Health grant ?
    b. Negotiate best financing arrangement
2. Perform Revenue Cycle Management Structure and Operational Assessment
    a. Including an order of magnitude estimate for RCM services
3. Analyze growth initiatives for risk, success rate, and staff capacity

Southern Coos Health Foundation Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: Scott McEachern, Executive Director, SCHF
Re: SCH Foundation Report for SCHD Board of Directors, September 28, 2023

Events Update

Golf for Health Classic

The 16th Annual Golf for Health Classic was a rousing success. There were 114 golfers, plus numerous volunteers, Foundation board members and staff who helped with the event. Thanks to all. We even had a retired PGA award-winning golfer in our midst: Bob Gilder, who came with his son Bryan from Corvallis. He added a touch of excitement and class to the event. SCHHC Dietary Manager Rita Hamilton's food was excellent.

The Friday night reception was also well-received and went smoothly. Everyone seems to agree this is an event to continue.

GFHC TOTALS		
SPONSORSHIPS	**$ 67,000.00**	FINAL
CASH	**$ 2,080.00**	FINAL
CREDIT CARD	**$ 2,730.00**	FINAL
AUCTION	**$ 6,000.00**	ESTIMATE
TOTAL RAISED	**$ 77,810.00**	ESTIMATE

Alix McGinley, Amy Moss Strong, Scott McEachern, Joseph Bain and Sean Suppes will meet for a debrief on the event soon. If anyone has ideas, suggestions or comments, please let us know.

Aging Well in Bandon

May 2024, is the month set for Aging Well in Bandon. We have not set a specific day yet. The organizing committee plans to meet Sept. 28 to discuss details of the event and how to narrow down the many possible topics and presenters.

The format will be like Women's Health Day and will run from 9 a.m. to 3 p.m. at the Bandon Community Center, with coffee and a continental breakfast in the morning and lunch provided.

It will be a free event for the community featuring keynote speaker Morningstar Holmes and other presenters on topics pertinent to seniors.

Sponsors will be sought to help with expenses for the event.

SCHF Quarterly Art Show

The current show, "Glorious Water" is being taken down on Sept. 24. We sold 14 pieces of art from that show, with several of those including donations to the Foundation.

The next show's theme is "A Walk in the Woods" and runs October through December. The call to artists for that show has been sent out. The opening Art Show reception will be held on Sunday, Oct. 9, from 1-3 p.m. in the hospital lobby, with live music and refreshments.

Monthly Financial Statements

To: Board of Directors and Southern Coos Management
From: Jeremiah Dodrill, CFO
Re: August 2023 Month End Financial Results – September 28, 2023

Gross Revenue and Volumes – Gross revenues for June of $4,095,000 were lower than budgeted expectations of $4,407,000. OP gross revenues of $2,966,000 were lower than a budget of $3,303,000. Respiratory Therapy, Imaging and ER volumes exceeded budgeted expectations while Surgical, Lab and Clinic volumes fell below budget expectations. IP and Swing Bed volumes and revenues of $1,129,000 were higher than a budget of $1,104,000 for the month with an Average Daily Census (ADC) of 6.4 below budgeted expectations of 9.3. Lower swing bed volumes were offset by higher IP acute patient volumes and revenue.

Deductions from Revenue – Revenue deductions at $1,842,000 or 45.0% of gross revenue were higher than the budget of 38.1% due primarily to higher aging of accounts receivable as well as the cleanup of several higher value aged accounts that resulted in higher than normal contractual adjustments posted during the month of August. The Medicare cost report settlement estimate for the month of August is a receivable of $24k.

Total Operating Revenues of $2,253,000 were lower than the budget of $2,737,000 in August.

Labor Expenses were $1,617,000 in August compared to a budget of $1,765,000. Salaries and Benefits were lower than budget due to forecasted wage increases not yet realized. Contract staffing for radiology, surgery, lab, and the clinic remain in use; however, budget assumptions anticipated the continued use of contract staffing.

Professional Fees and Purchased Services combined were $531,000 which was higher than the budget of $514,000 due largely in part to higher-than-expected ER provider expenses in August.

Medical Supplies, Drugs and Other Supplies combined at $201,000 were higher compared to budgeted expectations of $184,000 due largely to the purchase of several specialty drugs used in the clinic.

Operating Expenses – Total operating expenses of $2,607,000 for the month were lower compared to a budget of $2,714,000.

Operating Income / Loss – Operating loss for August was ($353,000) compared to a budgeted gain of $22,000 due primarily to lower than anticipated volumes throughout many OP clinical areas, in particular in the surgery department which still being reconstituted.

Decrease in Net Position was $(202,000) compared to a budgeted increase in the amount of $121,000.

Days Cash on Hand for August was 114.5 days, down from July at 117.7. Cash was affected by the payment of the Medicare interim cost settlement and an increase in A/R days outstanding which was 51.0 in August up from 50.6 in July.

Supplemental Discussion of YTD Financial Results

The disappointing financial results for the first two months are primarily attributable to a couple factors.

OP Revenues

First, and most significant, is the lower overall OP volumes and revenues in the first two months have decreased expected profitability. In particular, the surgical services department has had no surgical procedures. The 82 cases represented in the volume graphs have been exclusively endoscopies and pain procedures, which have significantly lower charges than surgical procedures. Additionally, anesthesia volumes and revenues are significantly under budget as well. Year-to-date, the surgical department (including anesthesia) has booked $82k in gross charges compared to the budgeted expectations of $582k, representing a ($500k) variance. This has resulted in approximately ($200k) in reduced net revenues.

SCHHC is currently finalizing negotiations with Dr. Ivaniski, an orthopedic surgeon to bring cases to the OR. Additionally, executive leadership is pursuing an opportunity to contract with a highly productive plastic surgeon and hand specialist as a full-time surgical provider to help bolster surgical volumes and improve the overall financial viability of SCHHC's surgical services service line.

ED Physician Coverage

Since the termination of the OPYS physician contract to staff the emergency department, SCHHC has used several independent contractor physician providers to cover the ED shifts at a higher hourly rate. Over the first two months, ED provider coverage cost ($66k) more than the budget which was based on the OPYS contracted rate. Provider costs are not allowable costs on the Medicare cost report and thus these additional costs are not partially offset by higher Medicare reimbursements.

The higher rates were initially agreed to with these providers to ensure coverage during urgent transition in physician coverage model when OPYS was unable to secure coverage for several shifts in June, precipitating the termination of that agreement. Executive leadership is working to convert many of the current ED physicians to more sustainable contracted rates.

Southern Coos Hospital & Health Center

Volume and Key Performance Ratios
For The Period Ending August 2023

		Month						Year to Date				
		Actual	Budget	Prior Year	Variance to Bud	Variance to Prior		Actual	Budget	Prior Year	Variance to Bud	Variance to Prior
Volume Summary	IP Days	149	125	125	19.7%	19.2%		250	243	244	2.9%	2.5%
	Swing Bed Days	71	170	69	-58.2%	2.9%		168	340	185	-50.6%	-9.2%
	Total Inpatient Days	220	294	194	-25.3%	13.4%		418	583	429	-28.3%	-2.6%
	Avg Daily Census	7.1	9.5	6.3	-25.3%	13.4%		6.7	9.4	6.9	-28.3%	-2.6%
	Avg Length of Stay - IP	3.6	4.0	4.0	-9.5%	-9.9%		3.5	4.0	4.0	-11.6%	-12.0%
	Avg Length of Stay - SWB	6.5	24.3	9.9	-73.4%	-34.5%		9.3	17.9	9.7	-47.8%	-4.1%
	ED Registrations	452	460	443	-1.7%	2.0%		932	975	940	-4.5%	-0.9%
	Clinic Registrations	484	454	483	6.6%	0.2%		919	908	893	1.2%	2.9%
	Ancillary Registrations	1,130	1,025	1,025	10.2%	10.2%		2,073	1,902	1,902	9.0%	9.0%
	Total OP Registrations	2,066	1,939	1,951	6.6%	5.9%		3,924	3,785	3,735	3.7%	5.1%
Key Income Statement Ratios	Gross IP Rev/IP Day	6,961	8,339	7,526	-16.5%	-7.5%		7,310	8,900	7,895	-17.9%	-7.4%
	Gross SWB Rev/SWB Day	1,289	385	849	234.9%	51.9%		1,105	528	855	109.4%	29.3%
	Gross OP Rev/Total OP Registrations	1,436	1,704	1,414	-15.7%	1.5%		1,489	1,688	1,407	-11.8%	5.8%
	Collection Rate	55.0%	61.9%	63.6%	-11.1%	-13.4%		57.9%	61.9%	64.5%	-6.4%	-10.2%
	Compensation Ratio	71.8%	64.5%	63.9%	11.3%	12.4%		72.5%	65.1%	63.9%	11.3%	13.3%
	OP EBIDA Margin $	(255,908)	116,339	38,504	-320.0%	-764.6%		(470,286)	181,397	165,369	-359.3%	-384.4%
	OP EBIDA Margin %	-11.4%	4.3%	1.6%	-367.2%	-804.7%		-10.3%	3.3%	3.5%	-409.3%	-396.1%
	Total Margin	-9.0%	4.4%	3.8%	-302.7%	-333.7%		-8.9%	3.5%	5.3%	-351.7%	-267.8%
Key Liquidity Ratios	Days Cash on Hand	114.5	80.0	140.8	43.1%	-18.7%						
	AR Days Outstanding	51	50	45	2.0%	13.3%						

Southern Coos Hospital & Health Center

Data Dictionary

Volume Summary	IP Days	Total Inpatient Days Per Midnight Census
	Swing Bed Days	Total Swing Bed Days per Midnight Census
	Total Bed Days	Total Days per Midnight Census
	Avg Daily Census	Total Bed Days / # of Days in period (Mo or YTD)
	Avg Length of Stay - IP	Total Inpatient Days / # of IP Discharges
	Avg Length of Stay - SWB	Total Swing Bed Days / # of SWB Discharges
	ED Registrations	Number of ED patient visits
	Clinic Registrations	Number of Clinic patient visits
	Ancillary Registrations	Total number of all other OP patient visits
	Total OP Registrations	Total number of OP patient visits

Key Income Statement Ratios	Gross IP Rev/IP Day	Avg. gross patient charges per IP patient day
	Gross SWB Rev/SWB Day	Avg. gross patient charges per SWB patient day
	Gross OP Rev/Total OP Registrations	Avg. gross patient charges per OP visit
	Collection Rate	Net patient revenue / total patient charges
	Compensation Ratio	Total Labor Expenses / Total Operating Revenues
	OP EBIDA Margin $	Operating Margin + Depreciation + Amortization
	OP EBIDA Margin %	Operating EBIDA / Total Operating Revenues
	Total Margin (%)	Total Margin / Total Operating Revenues

Key Liquidity Ratios	Days Cash on Hand	Total unrestricted cash / Daily OP Cash requirements
	AR Days Outstanding	Gross AR / Avg. Daily Revenues

Southern Coos Hospital & Health Center

Summary Statements of Revenues, Expenses, and Changes in Net Position
For The Period Ending August 31, 2023

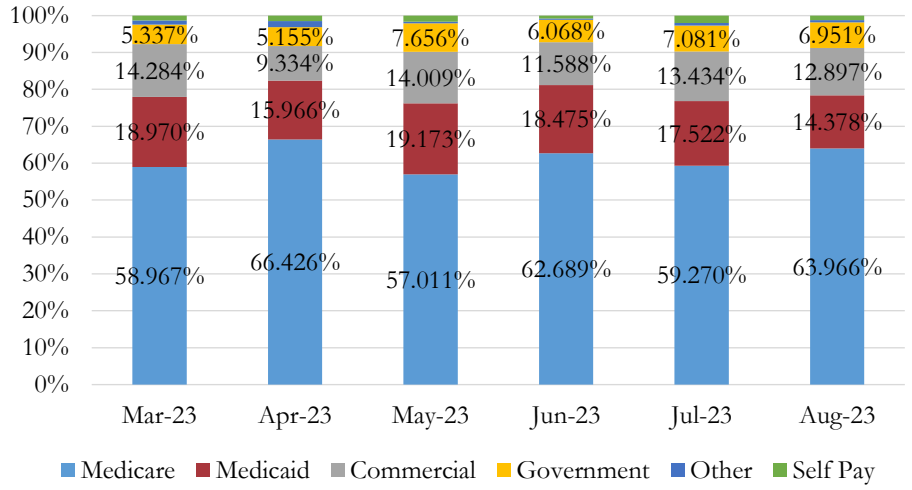
	Current Month - Aug-2023					Year To Date - Aug-2023				
	Aug-2023 Actual	Aug-2023 Budget	Variance	Var %	Aug-2022 Actual	Aug-2023 Actual	Aug-2023 Budget	Variance	Var %	Aug-2022 Actual
Patient Revenue										
Inpatient	1,128,762	1,103,769	24,993	2.3%	999,294	2,012,951	2,342,430	(329,479)	(14.1%)	2,084,425
Outpatient	2,966,388	3,302,991	(336,603)	(10.2%)	2,759,677	5,841,252	6,390,153	(548,901)	(8.6%)	5,256,173
Total Patient Revenue	**4,095,150**	**4,406,760**	**(311,610)**	**(7.1%)**	**3,758,971**	**7,854,203**	**8,732,583**	**(878,380)**	**(10.1%)**	**7,340,598**
Deductions From Revenue										
Total Deductions	**1,841,841**	**1,680,529**	**(161,311)**	**(9.6%)**	**1,369,751**	**3,307,871**	**3,330,376**	**22,505**	**0.7%**	**2,607,497**
Revenue Deductions %	*45.0%*	*38.1%*			*36.4%*	*42.1%*	*38.1%*			*35.5%*
Net Patient Revenue	**2,253,309**	**2,726,231**	**(472,922)**	**(17.3%)**	**2,389,221**	**4,546,332**	**5,402,207**	**(855,875)**	**(15.8%)**	**4,733,100**
Other Operating Revenue	20	10,449	(10,429)	(99.8%)	10	65	20,898	(20,833)	(99.7%)	15
Total Operating Revenue	**2,253,329**	**2,736,680**	**(483,350)**	**(17.7%)**	**2,389,231**	**4,546,397**	**5,423,105**	**(876,708)**	**(16.2%)**	**4,733,115**
Operating Expenses										
Total Labor Expenses	1,617,389	1,765,384	147,995	8.4%	1,525,575	3,294,889	3,532,242	237,353	6.7%	3,026,551
Total Other Operating Expenses	989,402	948,827	(40,575)	(4.3%)	876,217	1,912,034	1,897,206	(14,828)	(0.8%)	1,643,627
Total Operating Expenses	**2,606,791**	**2,714,212**	**107,420**	**4.0%**	**2,401,792**	**5,206,923**	**5,429,448**	**222,525**	**4.1%**	**4,670,178**
Operating Income / (Loss)	**(353,462)**	**22,468**	**(375,930)**	**(1673.2%)**	**(12,561)**	**(660,526)**	**(6,344)**	**(654,182)**	**10312.3%**	**62,937**
Net Non-Operating Revenues	**151,003**	**98,838**	**52,165**	**52.8%**	**104,430**	**256,738**	**197,677**	**59,061**	**29.9%**	**187,569**
Change in Net Position	**(202,459)**	**121,307**	**(323,765)**	**(266.9%)**	**91,869**	**(403,788)**	**191,333**	**(595,121)**	**(311.0%)**	**250,506**
Collection Rate %	**55.0%**	**61.9%**	**(11.1%)**	**(11.1%)**	**63.6%**	**57.9%**	**61.9%**	**(6.4%)**	**(6.4%)**	**64.5%**
Compensation Ratio %	**71.8%**	**64.5%**	**11.3%**	**11.3%**	**63.9%**	**72.5%**	**65.1%**	**11.3%**	**11.3%**	**63.9%**
OP EBIDA Margin $	**(255,908)**	**116,339**	**(372,247)**	**(320.0%)**	**38,504**	**(470,286)**	**181,397**	**(651,683)**	**(359.3%)**	**165,369**
OP EBIDA Margin %	**(11.4%)**	**4.3%**	**(15.6%)**	**(367.2%)**	**1.6%**	**(10.3%)**	**3.3%**	**(13.7%)**	**(409.3%)**	**3.5%**
Total Margin (%)	**(9.0%)**	**4.4%**	**(13.4%)**	**(302.7%)**	**3.8%**	**(8.9%)**	**3.5%**	**(12.4%)**	**(351.7%)**	**5.3%**

Volume and Key Performance Ratios
For The Period Ending August 2023

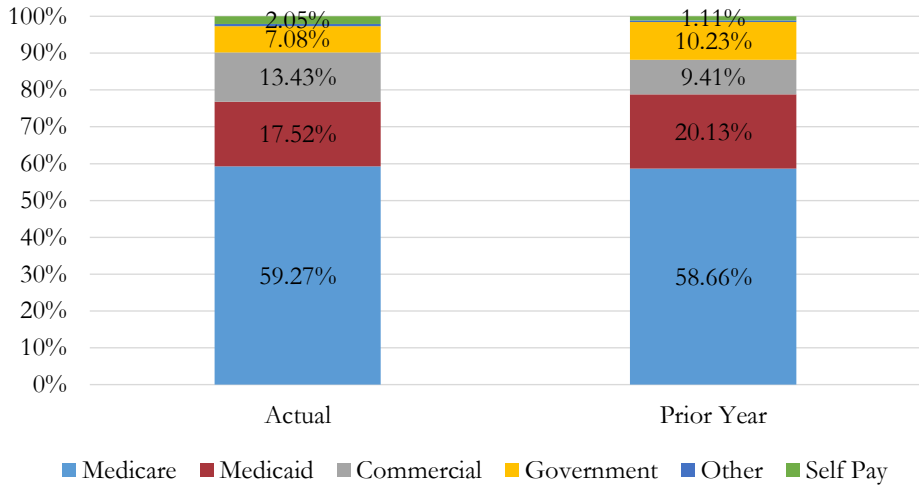
		Month					Year to Date				
		Actual	Budget	Prior Year	Variance to Bud	Variance to Prior Year	Actual	Budget	Prior Year	Variance to Bud	Variance to Prior Year
Payor Mix - Gross Charges	Medicare	63.97%	58.34%	58.34%	9.6%	9.6%	61.72%	58.66%	58.66%	5.2%	5.2%
	Medicaid	14.38%	17.23%	17.23%	-16.5%	-16.5%	15.88%	20.13%	20.13%	-21.1%	-21.1%
	Commercial	12.90%	14.48%	14.48%	-10.9%	-10.9%	13.15%	9.41%	9.41%	39.7%	39.7%
	Government	6.95%	8.78%	8.78%	-20.8%	-20.8%	7.01%	10.23%	10.23%	-31.4%	-31.4%
	Other	0.54%	0.30%	0.30%	80.4%	80.4%	0.59%	0.46%	0.46%	29.0%	29.0%
	Self Pay	1.27%	0.88%	0.88%	44.4%	44.4%	1.64%	1.11%	1.11%	48.4%	48.4%
	Total	**100.00%**	**100.00%**	**100.00%**			**100.00%**	**100.00%**	**100.00%**		

		Month			Variance %		Year To Date			Variance %	
		FY23 Actual	FY23 Budget	FY22 Prior Year	To Budget	To Prior Year	FY23 Actual	FY23 Budget	FY22 Prior Year	To Budget	To Prior Year
Patient Volumes	In Patient Days	149	125	125	19.7%	19.2%	250	243	244	2.9%	2.5%
	Swing Bed Days	71	170	69	-58.2%	2.9%	168	340	185	-50.6%	-9.2%
	Total Patient Days	**220**	**294**	**194**	**-25.3%**	**13.4%**	**418**	**583**	**429**	**-28.3%**	**-2.6%**
	Emergency Visits	452	460	443	-1.7%	2.0%	932	975	940	-4.5%	-0.9%
	Radiology Procedures	959	995	895	-3.6%	7.2%	1,766	1,842	1,656	-4.1%	6.6%
	Laboratory Tests	3,631	4,129	3,651	-12.1%	-0.5%	6,989	8,105	7,167	-13.8%	-2.5%
	Respiratory Visits	851	465	535	82.7%	59.0%	1,349	920	1,056	46.7%	27.7%
	Surgeries and Endoscopies	21	29	24	-27.6%	-12.5%	41	29	35	41.4%	17.1%
	Specialty Clinic Visits	21	207	206	-89.8%	-89.8%	219	343	342	-36.2%	-36.0%
	Primary Care Clinic	530	399	508	33.0%	4.3%	1,005	763	928	31.8%	8.3%

All Patients Payor Mix



Year to Date Payor Mix



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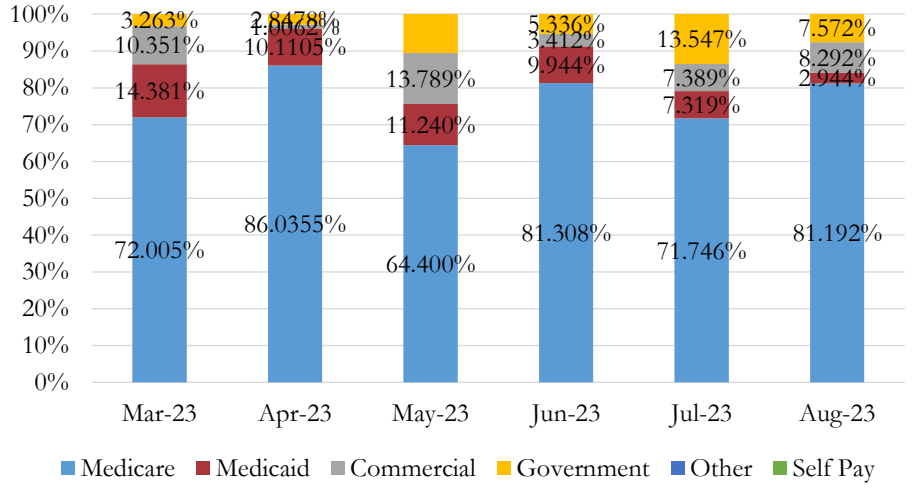
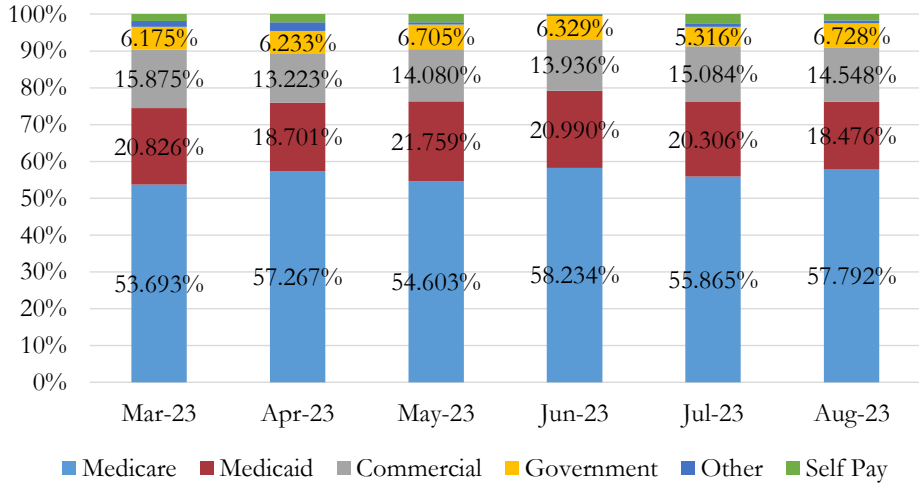
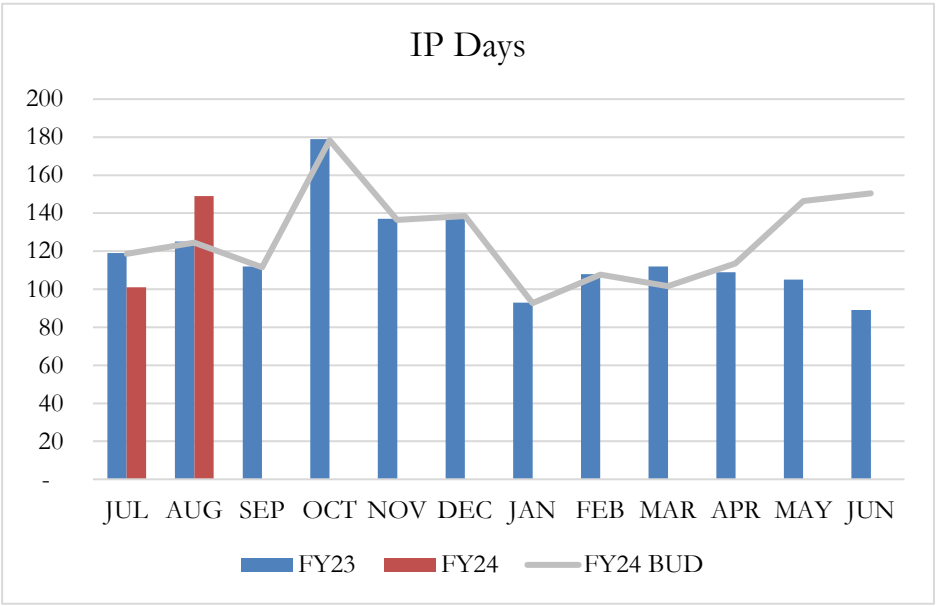
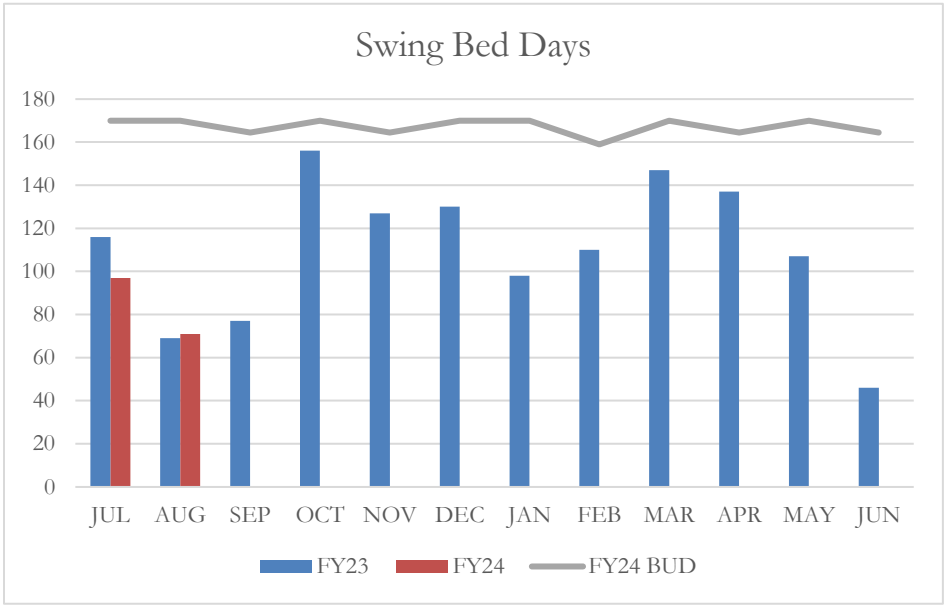
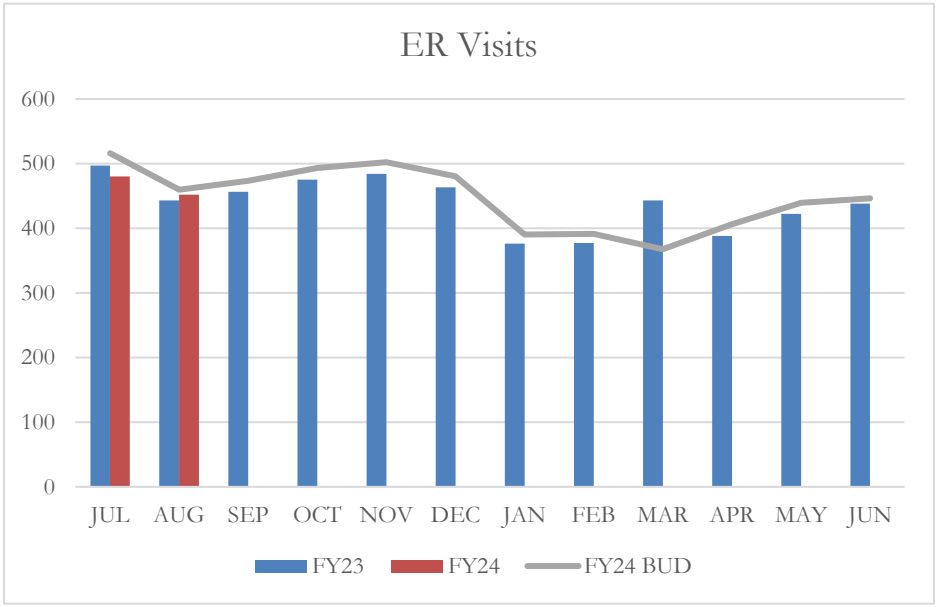


OP Payor Mix




IP Days
200
180
160
140
120
100
80
60
40
20
-
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD


Swing Bed Days
180
160
140
120
100
80
60
40
20
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD


ER Visits
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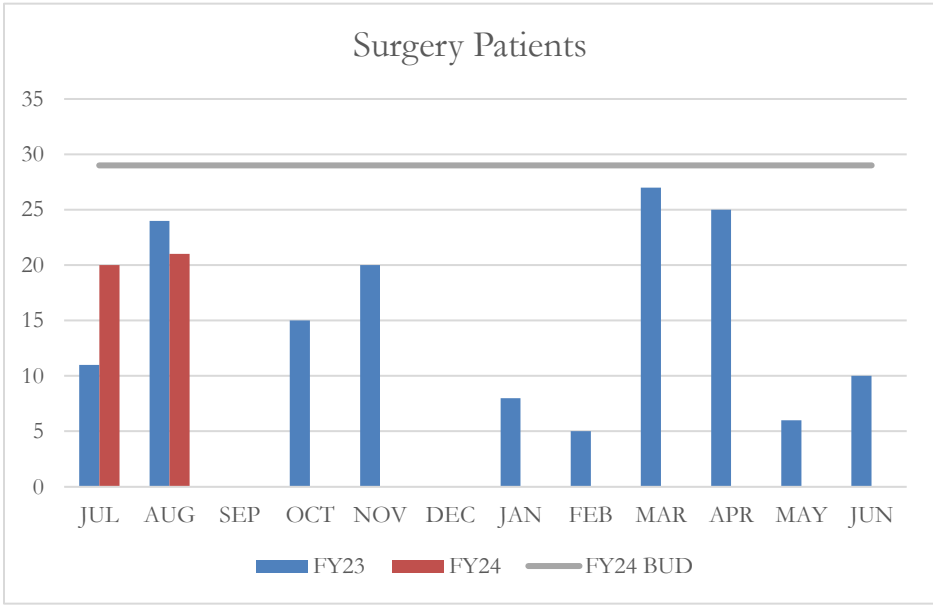
500
400
300
200
100
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD


Surgery Patients
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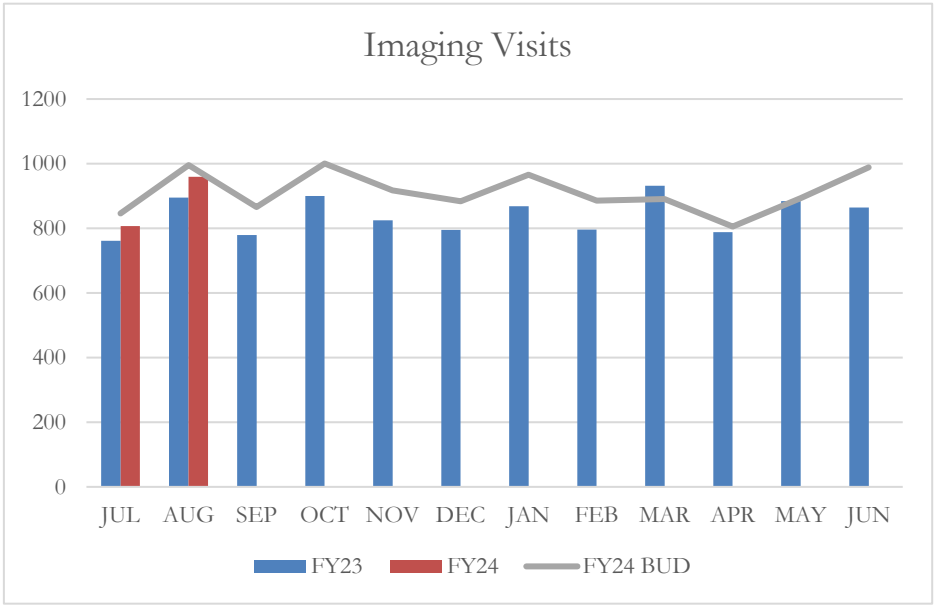
30
25
20
15
10
5
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD


Imaging Visits
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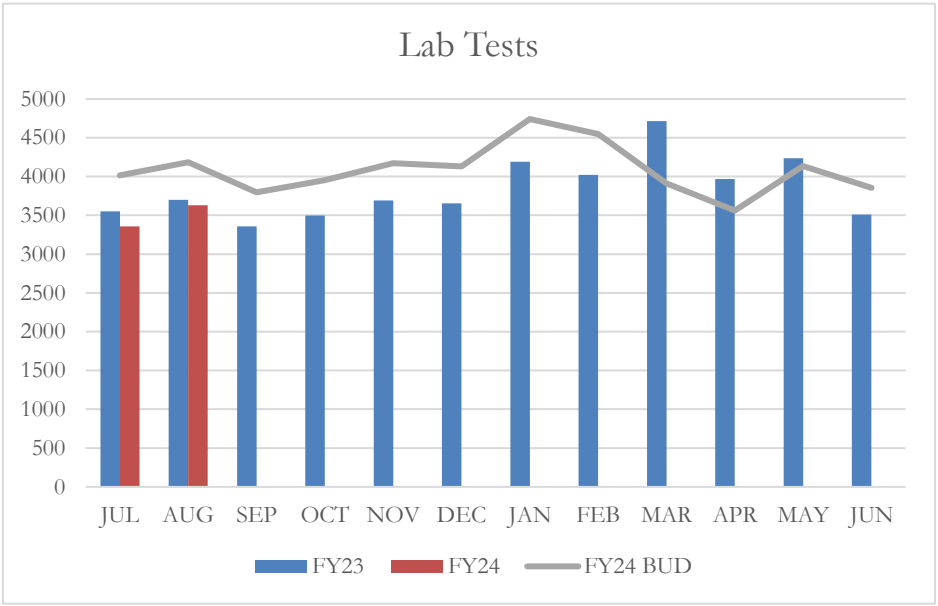
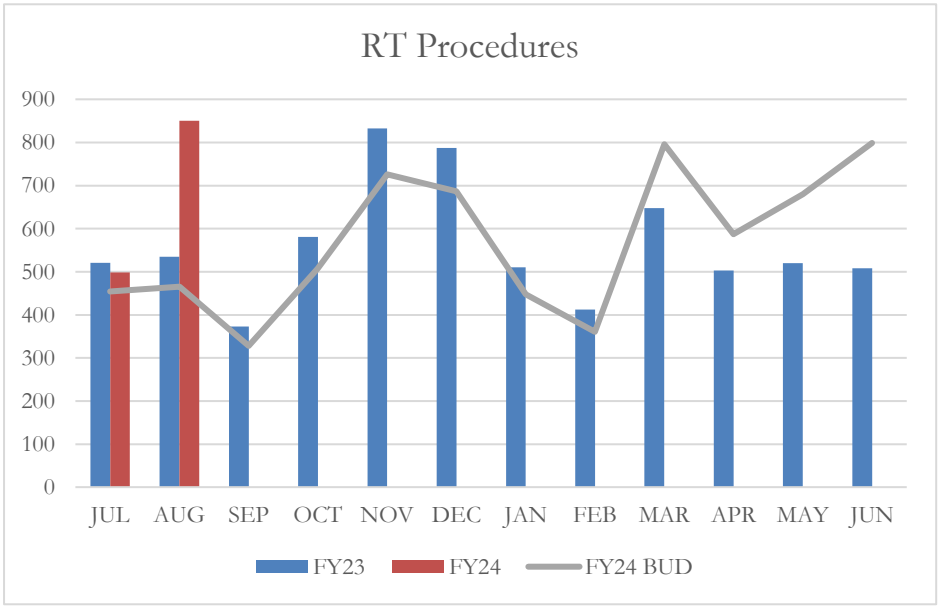
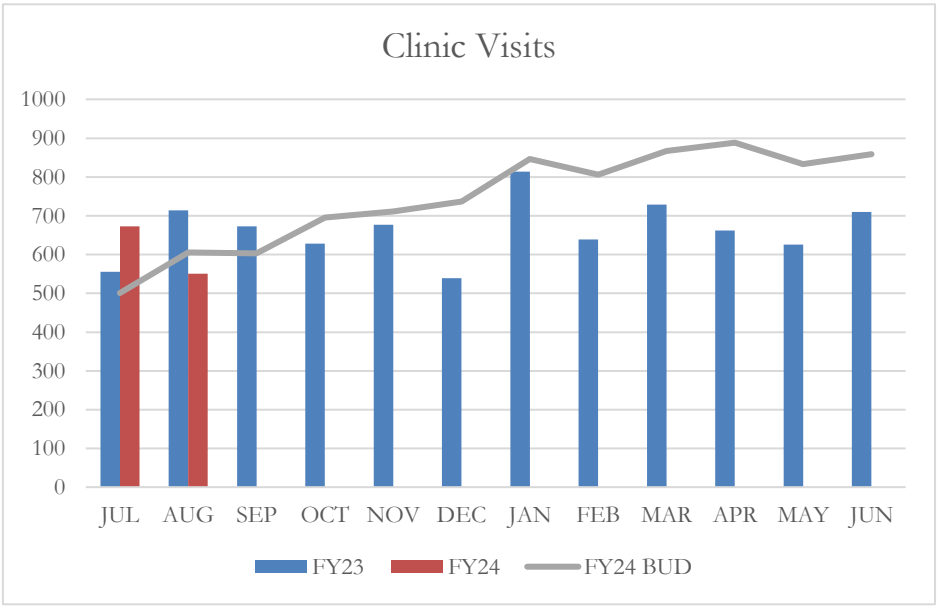
1000
800
600
400
200
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD


Lab Tests
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD


RT Procedures
900
800
700
600
500
400
300
200
100
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD


Clinic Visits
1000
900
800
700
600
500
400
300
200
100
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY23 FY24 FY24 BUD

Southern Coos Hospital & Health Center

Balance Sheet

For The Period Ending August 2023

	Balance as of August 2023	Balance as of June 2023	Change	Balance as of June 2022
Assets				
Current Assets				
Cash - Operating	7,225,468.21	7,581,927.08	(356,458.87)	6,600,541.83
Covid-19 Relief Funds	1,201,335.24	1,201,335.24	-	1,201,335.24
Medicare Accelerated Payments	-	-	-	3,041,478.77
Investments - Unrestricted	1,106,897.40	1,776,534.33	(669,636.93)	1,452,638.94
Investments - Restricted	9,488.28	9,488.28	-	9,488.28
Investment - USDA Restricted	233,704.60	233,704.60	-	233,704.60
Investment - Board Designated	1,972,783.35	1,972,783.35	-	1,972,783.35
Cash and Cash Equivalents	11,749,677.08	12,775,772.88	(1,026,095.80)	14,511,971.01
Patient Accounts Receivable	6,484,635.09	5,628,111.59	856,523.50	5,990,969.06
Allowance for Uncollectibles	(3,370,145.84)	(2,814,432.57)	(555,713.27)	(2,793,124.67)
Net Patient Accounts Receivable	**3,114,489.25**	**2,813,679.02**	**300,810.23**	**3,197,844.39**
Other Receivables	204,463.03	62,192.15	142,270.88	492,152.62
Inventory	305,238.19	260,325.95	44,912.24	163,374.84
Prepaid Expense	443,518.03	368,189.59	75,328.44	479,232.28
Property Tax Receivable	(1.00)	-	(1.00)	-
Total Current Assets	**15,817,385.58**	**16,280,159.59**	**(462,774.01)**	**18,844,575.14**
Property, Plant and Equipment				
Land	461,527.29	461,527.29	-	461,527.29
Property and Equipment:	19,599,169.33	19,307,837.73	291,331.60	17,205,487.52
Less: Accumulated Depreciation	(14,044,744.98)	(13,854,504.94)	(190,240.04)	(12,886,836.80)
Construction In Progress	21,072.68	281,976.83	(260,904.15)	67,081.39
Net PP&E	**6,037,024.32**	**6,196,836.91**	**(159,812.59)**	**4,847,259.40**
Total Assets	21,854,409.90	22,476,996.50	(622,586.60)	23,691,834.54

Southern Coos Hospital & Health Center

Balance Sheet

For The Period Ending August 2023

	Balance as of August 2023	Balance as of June 2023	Change	Balance as of June 2022
Liabilities and Net Assets				
Current Liabilities				
Accounts Payable	819,471.65	1,278,833.75	(459,362.10)	772,657.47
Accrued Payroll and Benefits	1,386,113.56	1,145,490.46	240,623.10	1,195,908.26
Interest and Other Payable	990,592.21	927,690.61	62,901.60	712,471.25
Current Portion of Long Term Debt	599,413.61	595,124.05	4,289.56	246,328.10
Medicare Accelerated Fund	-	-	-	3,041,479.14
Provider Relief Funds	1,201,335.24	1,201,335.24	-	1,201,335.24
Current Liabilities	**4,996,926.27**	**5,148,474.11**	**(151,547.84)**	**7,170,179.46**
Long-Term Debt	5,218,355.61	5,281,316.72	(62,961.11)	4,236,980.73
Less Current Portion of Long-Term Debt	(599,413.61)	(595,124.05)	(4,289.56)	(246,328.10)
Total Long-Term Debt, net	4,618,942.00	4,686,192.67	(67,250.67)	3,990,652.63
Total Liabilities	9,615,868.27	9,834,666.78	(218,798.51)	11,160,832.09
Net Assets:				
Fund Balance	12,642,329.72	12,531,002.45	111,327.27	12,706,270.36
Change in Net Position	(403,788.09)	111,327.27	(515,115.36)	(175,267.91)
Total Net Assets	**12,238,541.63**	**12,642,329.72**	**(403,788.09)**	**12,531,002.45**
Total Liabilities & Net Assets	21,854,409.90	22,476,996.50	(622,586.60)	23,691,834.54

Southern Coos Hospital & Health Center

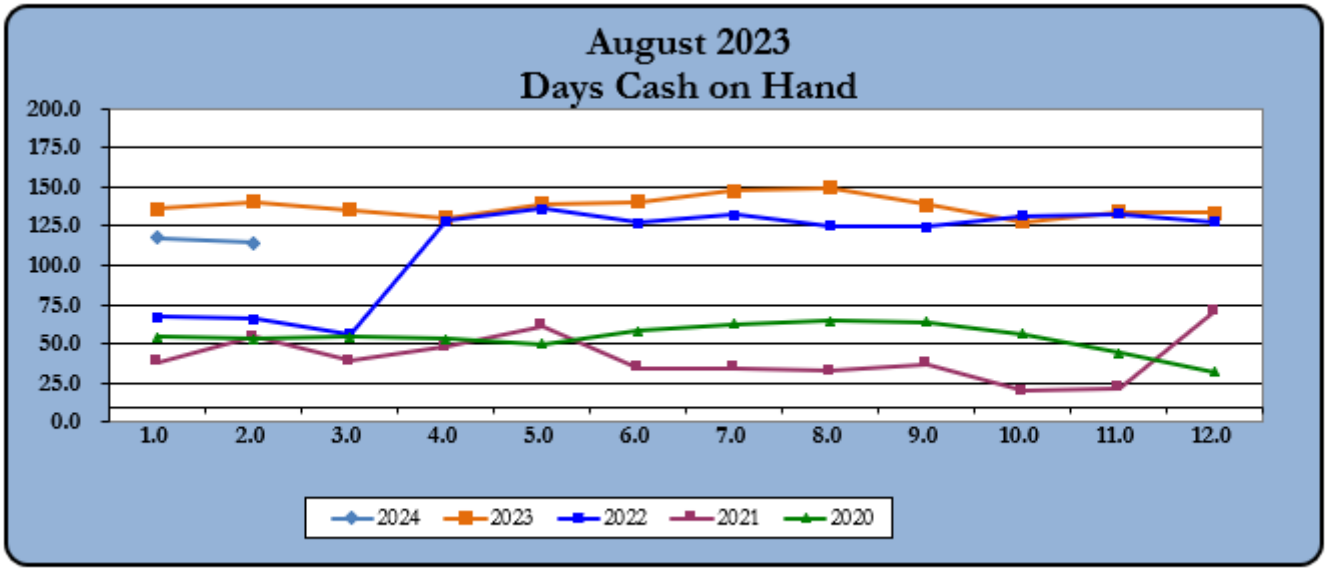
Summary Statements of Revenues, Expenses, and Changes in Net Position
For The Period Ending August 31, 2023

	Current Month - Aug-2023					Year To Date - Aug-2023				
	Aug-2023 Actual	Aug-2023 Budget	Variance	Var %	Aug-2022 Actual	Aug-2023 Actual	Aug-2023 Budget	Variance	Var %	Aug-2022 Actual
Patient Revenue										
Inpatient	1,128,762	1,103,769	24,993	2.3%	999,294	2,012,951	2,342,430	(329,479)	(14.1%)	2,084,425
Outpatient	2,966,388	3,302,991	(336,603)	(10.2%)	2,759,677	5,841,252	6,390,153	(548,901)	(8.6%)	5,256,173
Total Patient Revenue	**4,095,150**	**4,406,760**	**(311,610)**	**(7.1%)**	**3,758,971**	**7,854,203**	**8,732,583**	**(878,380)**	**(10.1%)**	**7,340,598**
Deductions From Revenue										
Total Deductions	**1,841,841**	**1,680,529**	**(161,311)**	**(9.6%)**	**1,369,751**	**3,307,871**	**3,330,376**	**22,505**	**0.7%**	**2,607,497**
Revenue Deductions %	*45.0%*	*38.1%*			*36.4%*	*42.1%*	*38.1%*			*35.5%*
Net Patient Revenue	**2,253,309**	**2,726,231**	**(472,922)**	**(17.3%)**	**2,389,221**	**4,546,332**	**5,402,207**	**(855,875)**	**(15.8%)**	**4,733,100**
Other Operating Revenue	20	10,449	(10,429)	(99.8%)	10	65	20,898	(20,833)	(99.7%)	15
Total Operating Revenue	**2,253,329**	**2,736,680**	**(483,350)**	**(17.7%)**	**2,389,231**	**4,546,397**	**5,423,105**	**(876,708)**	**(16.2%)**	**4,733,115**
Operating Expenses										
Salaries & Wages	1,105,312	1,247,676	142,365	11.4%	1,120,072	2,191,226	2,495,352	304,126	12.2%	2,182,108
Contract Labor	283,570	201,843	(81,727)	(40.5%)	147,125	515,907	403,685	(112,221)	(27.8%)	319,421
Benefits	228,508	315,865	87,357	27.7%	258,378	587,756	633,205	45,448	7.2%	525,022
Total Labor Expenses	1,617,389	1,765,384	147,995	8.4%	1,525,575	3,294,889	3,532,242	237,353	6.7%	3,026,551
Professional Fees	271,895	227,544	(44,351)	(19.5%)	213,296	546,168	455,088	(91,079)	(20.0%)	426,807
Purchased Services	259,262	286,301	27,039	9.4%	248,283	537,219	572,602	35,383	6.2%	467,445
Drugs & Pharmaceuticals	57,011	51,697	(5,314)	(10.3%)	34,457	148,687	103,394	(45,293)	(43.8%)	85,805
Medical Supplies	18,874	30,908	12,034	38.9%	36,336	35,817	61,366	25,549	41.6%	57,194
Other Supplies	125,366	101,085	(24,281)	(24.0%)	102,139	210,968	202,170	(8,798)	(4.4%)	161,402
Lease and Rental	1,100	-	(1,100)	0.0%	-	1,100	-	(1,100)	0.0%	-
Maintenance & Repairs	21,338	22,954	1,616	7.0%	23,985	50,463	45,909	(4,554)	(9.9%)	39,228
Other Expenses	92,112	86,413	(5,699)	(6.6%)	116,561	102,500	172,826	70,326	40.7%	203,844
Utilities	25,030	26,508	1,478	5.6%	28,785	49,153	53,015	3,862	7.3%	56,979
Insurance	19,860	21,547	1,688	7.8%	21,309	39,720	43,095	3,375	7.8%	42,490
Interest	-	-	-	0.0%	-	-	-	-	0.0%	-
Depreciation & Amortization	97,554	93,870	(3,683)	(3.9%)	51,065	190,240	187,741	(2,499)	(1.3%)	102,432
Total Operating Expenses	**2,606,791**	**2,714,212**	**107,420**	**4.0%**	**2,401,792**	**5,206,923**	**5,429,448**	**222,525**	**4.1%**	**4,670,178**
Operating Income / (Loss)	**(353,462)**	**22,468**	**(375,930)**	**(1673.2%)**	**(12,561)**	**(660,526)**	**(6,344)**	**(654,182)**	**10312.3%**	**62,937**
Non-Operating										
Property Taxes	89,427	91,439	(2,012)	(2.2%)	85,155	178,853	182,878	(4,024)	(2.2%)	170,310
Non-Operating Revenue	46,708	9,361	37,346	398.9%	19,661	49,655	18,723	30,932	165.2%	21,026
Interest Expense	(25,964)	(27,066)	1,103	(4.1%)	(14,784)	(52,161)	(54,133)	1,971	(3.6%)	(29,568)
Investment Income	40,833	25,104	15,728	62.7%	14,398	80,391	50,209	30,182	60.1%	25,801
Total Non-Operating	**151,003**	**98,838**	**52,165**	**52.8%**	**104,430**	**256,738**	**197,677**	**59,061**	**29.9%**	**187,569**
Change in Net Position	**(202,459)**	**121,307**	**(323,765)**	**(266.9%)**	**91,869**	**(403,788)**	**191,333**	**(595,121)**	**(311.0%)**	**250,506**

Southern Coos Hospital & Health Center

Income Statement
For The Period Ending August 2023
Comparison to Prior Months

	Current FY 2024					
	Mar-2023	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023
Patient Revenue						
Inpatient	770,755	1,059,282	930,031	716,725	884,189	1,128,762
Outpatient	2,112,993	2,203,623	2,697,349	2,622,888	2,874,864	2,966,388
Total Patient Revenue	**2,883,748**	**3,262,905**	**3,627,380**	**3,339,613**	**3,759,053**	**4,095,150**
Deductions From Revenue						
Charity Services	7,542	31,130	13,282	17,127	19,129	18,966
Contractual Allowances	1,225,657	845,438	1,174,490	835,800	1,385,666	1,612,254
Other Discounts	89,674	133,715	108,031	73,668	73,845	219,681
Bad Debt	8,834	(15,545)	(11,848)	(14,250)	(12,609)	(9,061)
Total Deductions	**1,331,707**	**994,738**	**1,283,955**	**912,345**	**1,466,030**	**1,841,841**
Net Patient Revenue	**1,552,041**	**2,268,167**	**2,343,425**	**2,427,269**	**2,293,023**	**2,253,309**
Other Operating Revenue	24,522	20	30	2,602	45	20
Total Operating Revenue	**1,576,563**	**2,268,187**	**2,343,455**	**2,429,870**	**2,293,068**	**2,253,329**
Operating Expenses						
Salaries & Wages	782,802	970,914	1,060,706	1,062,583	1,085,914	1,105,312
Benefits	222,327	306,730	307,709	298,364	359,248	228,508
Contract Labor	159,628	292,771	342,212	299,433	232,337	283,570
Professional Fees	207,963	223,611	237,823	220,118	274,273	271,895
Purchased Services	195,355	270,586	188,932	256,460	277,956	259,262
Medical Supplies	21,583	33,478	23,619	21,424	16,943	18,874
Drugs & Pharmaceuticals	54,653	46,573	51,603	(43,674)	91,675	57,011
Other Supplies	94,916	83,905	96,111	83,627	85,602	125,366
Depreciation & Amortization	56,703	84,554	83,150	103,106	92,686	97,554
Lease and Rental	4,003	-	-	-	-	1,100
Maintenance & Repairs	15,871	30,385	18,155	16,725	29,124	21,338
Utilities	4,955	28,406	26,595	27,031	24,123	25,030
Insurance	8,573	21,213	21,213	69,103	19,860	19,860
Other Expenses	102,474	73,022	77,722	136,092	10,388	92,112
Total Operating Expenses	**1,931,808**	**2,466,149**	**2,535,548**	**2,550,391**	**2,600,131**	**2,606,791**
Excess of Revenue Over Expenses from Operations	**(355,245)**	**(197,962)**	**(192,094)**	**(120,521)**	**(307,064)**	**(353,462)**
Non-Operating						
Unrestricted Contributions	84,424	89,427	89,427	89,427	89,427	89,427
Other NonOperating Revenue\Expense	96,349	48,382	23,280	38,423	2,948	46,708
Investment Income	5,006	34,857	37,326	37,699	39,558	40,833
Total Non-Operating	**185,779**	**172,666**	**150,032**	**165,549**	**131,932**	**176,967**
Interest Expense	(15,828)	(22,385)	(23,623)	(27,735)	(26,198)	(25,964)
Excess of Revenue Over Expenses	**(185,294)**	**(47,681)**	**(65,685)**	**17,292**	**(201,329)**	**(202,459)**



Calculation: Total Unrestricted Cash on Hand / Daily Operating Cash Needs

Definition: This ratio quantifies the amount of cash on hand in terms of how many "days" an organization can survive with existing cash reserves.

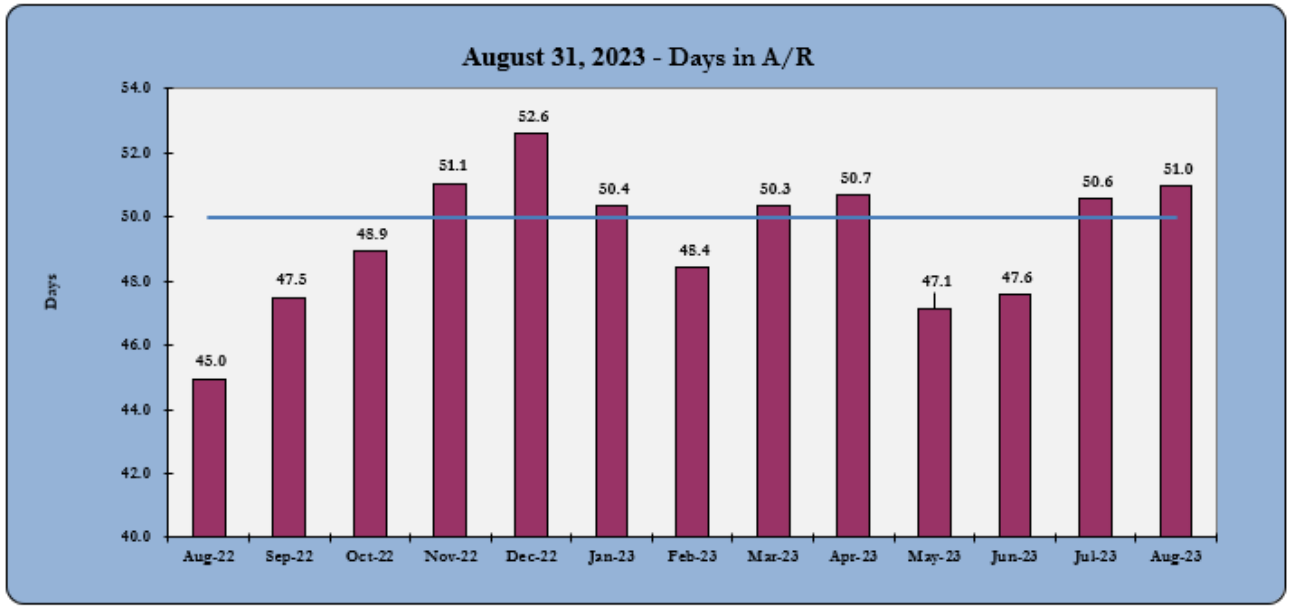
Desired Position: Upward trend, above the median

Year	Average
2024	116.1
2023	137.8
2022	113.0
2021	41.2
2020	54.0

Benchmark **80 Days**

How ratio is used: This ratio is frequently used by bankers, bondholders and analysts to gauge an organization's liquidity--and ability to meet short term obligations as they mature.

Fiscal	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2024	117.7	114.5										
2023	135.9	140.8	135.2	130.5	139.4	140.7	147.8	149.7	138.9	127.8	134.2	133.3
2022	67.2	66.2	56.6	128.6	136.1	127.4	132.1	125.1	124.6	131.5	132.8	127.5
2021	38.7	54.6	39.1	48.2	61.6	34.4	34.6	33.0	37.2	19.9	21.9	70.8
2020	54.3	53.4	54.2	53.3	50.3	58.3	62.6	64.9	63.8	56.4	44.0	32.0



Calculation: Gross Accounts Receivable / Average Daily Revenue

Definition: Considered a key "liquidity ratio" that calculates how quickly accounts are being paid.

Desired Position: Downward trend below the median, and below average.

Benchmark ***50***

How ratio is used: Used to determine timing required to collect accounts. Usually, organizations below the average Days in AR are likely to have higher levels of Days Cash on Hand.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A/R (Gross)	5,391,457	5,497,910	5,886,139	6,242,296	6,684,720	6,158,963	5,756,386	6,096,420	6,038,783	5,617,678	5,350,234	5,896,120	6,202,815
Days in AR	45.0	47.5	48.9	51.1	52.6	50.4	48.4	50.3	50.7	47.1	47.6	50.6	51.0

``	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
A/R (Gross)	5,391,457	5,497,910	5,886,139	6,242,296	6,684,720	6,158,963	5,756,386	6,096,420	6,038,783	5,617,678	5,350,234	5,896,120	6,202,815
Days in Month	31	30	31	30	31	31	28	31	30	31	30	31	31
Monthly Revenue	3,758,971	3,308,183	3,999,429	3,818,370	3,871,096	3,560,966	3,266,860	4,071,756	3,262,905	3,627,380	3,339,613	3,759,053	4,095,150
3 Mo Avg Daily Revenue	119,932	115,748	120,289	122,264	127,053	122,287	118,877	121,106	119,118	119,153	112,416	116,587	121,672
Days in AR	45.0	47.5	48.9	51.1	52.6	50.4	48.4	50.3	50.7	47.1	47.6	50.6	51.0

SOUTHERN COOS HOSPITAL & HEALTH CENTER
CAPTIAL PURCHASES SUMMARY

FY2024

Approved Projects:

Project Name	Department	Budgeted Amount	Total Spending	Amount Remaining	Date Completed
Non-Threshold Capital Purchases (<$15,000)					
New desk/workspace	ER	$ 14,500.00		$ 14,500.00	
Reclining Chairs	Radiology	$ 10,500.00		$ 10,500.00	
Desk Dividers	MedSurg	$ 10,000.00		$ 10,000.00	
Workstation Replacement	Information Systems	$ 10,000.00		$ 10,000.00	
Refrigerator Double Doors	Lab	$ 10,000.00		$ 10,000.00	
Bed Alarm System	Lab	$ 10,000.00		$ 10,000.00	
External automatic door near MRI	MedSurg	$ 10,000.00		$ 10,000.00	
Suction flow meters (19)	Radiology	$ 9,595.00		$ 9,595.00	
UHS Blanket Warming Unit	MedSurg	$ 7,500.00		$ 7,500.00	
Blanket Warmers	MedSurg	$ 7,335.00		$ 7,335.00	
Ultrasound Probe hockey stick	Radiology	$ 7,000.00		$ 7,000.00	
ID TipMaster	Radiology	$ 5,000.00		$ 5,000.00	
PAPR	Lab	$ 4,667.00		$ 4,667.00	
Door security	Radiology	$ 4,000.00		$ 4,000.00	
Not in Budget (<$15,000)					
		$ -		$ -	
		$ 120,097	**$ -**	**$ 120,097**	

SOUTHERN COOS HOSPITAL & HEALTH CENTER
CAPTIAL PURCHASES SUMMARY

FY2024

Approved Projects:

Project Name	Department	Budgeted Amount	Total Spending	Amount Remaining	Date Completed
Threshold Projects (>$15,000)					
Drug Dispensing System	Pharmacy	$ 170,000.00		$ 170,000.00	
Air Handler Fin replacement	Engineering	$ 70,000.00		$ 70,000.00	
AMSCO Washer	Surgery	$ 62,000.00		$ 62,000.00	
Construction for Washer	Surgery	$ 44,500.00		$ 44,500.00	
Gurney	ER	$ 43,700.00		$ 43,700.00	
Bariatric Bed	MedSurg	$ 35,000.00		$ 35,000.00	
Cardiac Monitors	MedSurg	$ 25,000.00		$ 25,000.00	
Outside Sign Upgrades	Engineering	$ 24,500.00		$ 24,500.00	
Ultrasound Probe Cardiac 3D X5-1	Radiology	$ 23,000.00		$ 23,000.00	
Wifi System Upgrade	Information Systems	$ 22,000.00		$ 22,000.00	
Security Camera System Expansion	Information Systems	$ 21,000.00		$ 21,000.00	
DataCenter Battery Backup Replacement	Information Systems	$ 20,000.00		$ 20,000.00	
BACT Alert 360 D Replacement	Lab	$ 20,000.00		$ 20,000.00	
Ultrasound Echo Bed	Radiology	$ 19,203.00		$ 19,203.00	
EKG Machine	ER	$ 15,000.00		$ 15,000.00	
Storage Server Replacement	Information Systems	$ 15,000.00		$ 15,000.00	
Not in Budget (>$15,000)					
		$ -		$ -	
		$ 629,903	**$ -**	**$ 629,903**	
Grand Total		**$ 750,000**	**$ -**	**$ 750,000**	

FY2024

Grant Funded Projects:

Project Name	Department	Budgeted Amount	Total Spending	Amount Remaining	Date Completed
		$ -		$ -	
		-		$ -	
		$ -	**$ -**	**$ -**	

Clinic Provider Income Summary
All Providers
For The Budget Year 2024

	ACT JUL	BUD JUL	ACT AUG	BUD AUG	ACT YTD	Current Budget YTD FY24 Budget	Variance
Provider Productivity Metrics							
Clinic Days	72	54	77	34	149	111	37
Total Visits	475	364	508	162	1005	763	242
Visits/Day	6.6	6.7	6.6	4.8	6.8	6.9	(0.1)
Total RVU	1,061.83	815.78	1,077.97	406.25	2,139.80	1,732.07	407.73
RVU/Visit	2.24	2.24	2.12	2.51	2.13	2.27	(0.14)
RVU/Clinic Day	14.85	15.07	14.00	12.09	14.41	15.57	(1.16)
Gross Revenue/Visit	381.78	395.56	391.75	452.40	378.46	404.24	(25.78)
Gross Revenue/RVU	170.79	176.55	184.61	180.46	177.75	178.00	(0.24)
Net Rev/RVU	75.89	80.78	80.63	93.46	78.28	81.50	(3.22)
Expense/RVU	111.21	157.82	136.06	163.07	123.73	147.46	(23.73)
Diff	(35.32)	(77.04)	(55.44)	(69.61)	(45.45)	(65.96)	20.51
Net Rev/Day	1,127.08	1,217.39	1,128.78	1,130.29	1,127.96	1,269.17	(141.21)
Expense/Day	1,651.58	2,378.40	1,904.84	1,972.11	1,782.90	2,296.37	(513.47)
Diff	(524.50)	(1,161.01)	(776.07)	(841.82)	(654.94)	(1,027.20)	372.26
Patient Revenue							
Outpatient							
Total Patient Revenue	181,345	144,030	199,009	73,313	380,354	308,303	72,051
Deductions From Revenue							
Total Deductions From Revenue (Note A)	100,759	78,129	112,093	35,344	212,852	167,140	45,712
Net Patient Revenue	**80,587**	**65,901**	**86,916**	**37,969**	**167,502**	**141,163**	**26,339**
Total Operating Revenue	**80,587**	**65,901**	**86,916**	**37,969**	**167,502**	**141,163**	**26,339**
Operating Expenses							
Salaries & Wages	61,877	70,820	86,051	36,851	147,928	141,640	6,288
Benefits	3,426	8,703	6,338	5,454	9,764	16,682	(6,918)
Medical Supplies	0	496	0	567	0	1,064	(1,064)
Other Supplies	746	132	36	132	782	265	517
Other Expenses	2,500	2,225	1,667	559	4,167	4,451	(284)
Allocation Expense	49,539	46,373	52,526	22,683	102,065	91,312	10,753
Total Operating Expenses	118,088	128,750	146,673	66,247	264,761	255,414	9,347
Excess of Operating Rev Over Exp	**(37,501)**	**(62,849)**	**(59,757)**	**(28,278)**	**(97,259)**	**(114,251)**	**16,992**
Total Non-Operating Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Excess of Revenue Over Expenses	**(37,501)**	**(62,849)**	**(59,757)**	**(28,278)**	**(97,259)**	**(114,251)**	**16,992**

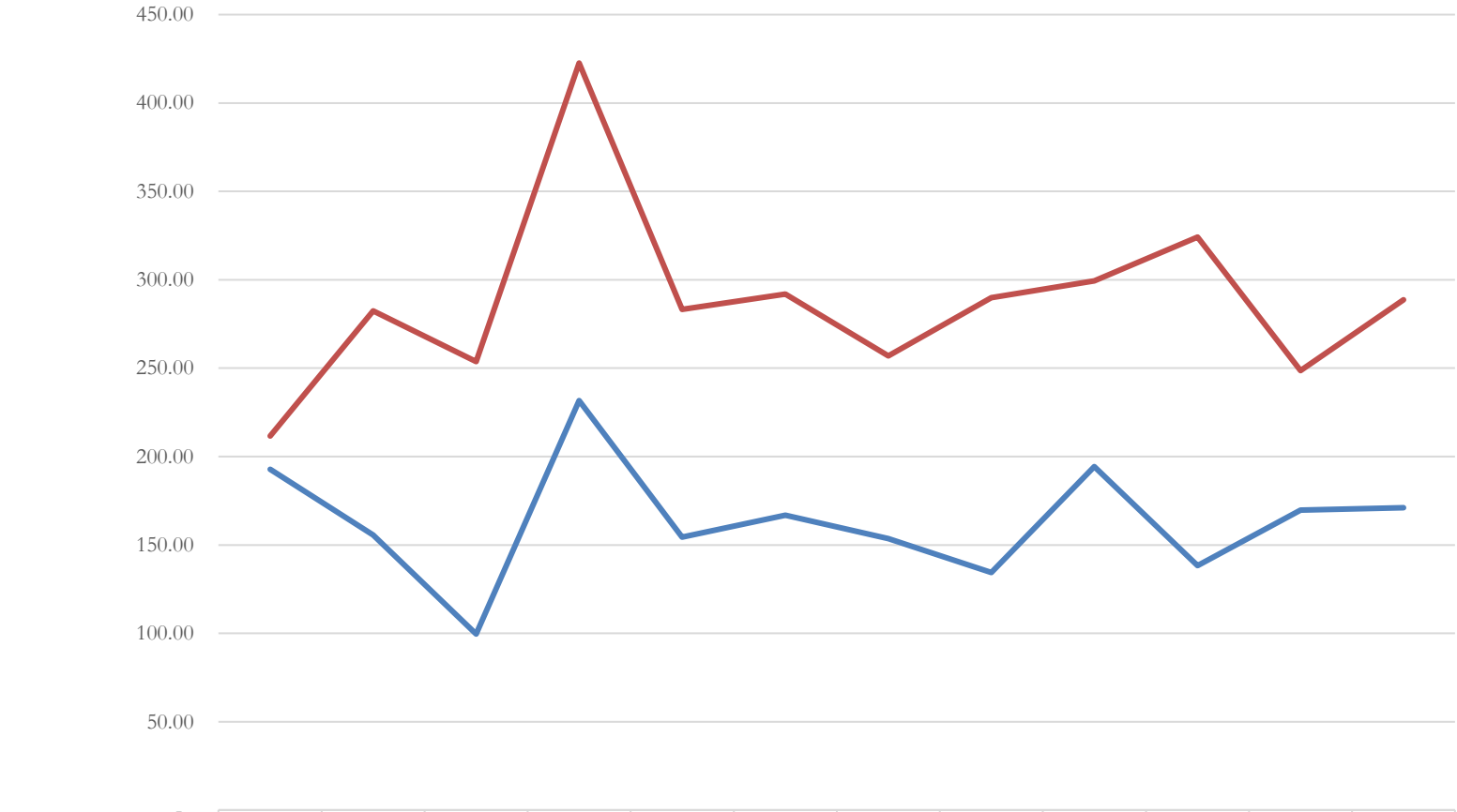
Note A - Average Collection Rate =41% of Gross Charges, therefore the Deduction Rate h is 59% of Gross

Southern Coos Hospital & Health Center

Summary Statements of Revenues, Expenses, and Changes in Net Position
For The Period Ending August 31, 2023

	Current Month - Aug-2023			Year To Date - Aug-2023		
	Hospital Actual	Clinic Providers Actual	Aug-2023 Actual	Hospital Actual	Clinic Providers Actual	Aug-2023 Actual
Patient Revenue						
Inpatient	1,128,762	-	1,128,762	2,012,951	-	2,012,951
Outpatient	2,767,379	199,009	2,966,388	5,460,898	380,354	5,841,252
Total Patient Revenue	**3,896,141**	**199,009**	**4,095,150**	**7,473,849**	**380,354**	**7,854,203**
Deductions From Revenue						
Total Deductions	**1,729,747**	**112,093**	**1,841,841**	**3,095,019**	**212,852**	**3,307,871**
Revenue Deductions %	*44.4%*	*56.3%*	*45.0%*	*41.4%*	*56.0%*	*42.1%*
Net Patient Revenue	**2,166,394**	**86,916**	**2,253,309**	**4,378,830**	**167,502**	**4,546,332**
Other Operating Revenue	20	-	20	65	-	65
Total Operating Revenue	**2,166,414**	**86,916**	**2,253,329**	**4,378,895**	**167,502**	**4,546,397**
Operating Expenses						
Total Labor Expenses	1,525,001	92,389	1,617,389	3,137,198	157,692	3,294,889
Total Other Operating Expenses	935,118	54,284	989,402	1,804,964	107,069	1,912,034
Total Operating Expenses	**2,460,119**	**146,673**	**2,606,791**	**4,942,162**	**264,761**	**5,206,923**
Operating Income / (Loss)	**(293,705)**	**(59,757)**	**(353,462)**	**(563,267)**	**(97,259)**	**(660,526)**
Net Non-Operating Revenues	**151,003**	**0**	**151,003**	**256,738**	**0**	**256,738**
Change in Net Position	**(142,702)**	**(59,757)**	**(202,459)**	**(306,529)**	**(97,259)**	**(403,788)**
Collection Rate %	**55.6%**	**43.7%**	**55.0%**	**58.6%**	**44.0%**	**57.9%**
Compensation Ratio %	**70.4%**	**106.3%**	**71.8%**	**71.6%**	**94.1%**	**72.5%**
OP EBIDA Margin $	**(196,151)**	**(59,757)**	**(255,908)**	**(373,027)**	**(97,259)**	**(470,286)**
OP EBIDA Margin %	**(9.1%)**	**(68.8%)**	**(11.4%)**	**(8.5%)**	**(58.1%)**	**(10.3%)**
Total Margin (%)	**(6.6%)**	**(68.8%)**	**(9.0%)**	**(7.0%)**	**(58.1%)**	**(8.9%)**

Net Revenue/Expense Per Clinic Visit - Clinic Combined



	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Net Rev/Visit	192.81	155.56	99.60	231.66	154.49	166.83	153.59	134.37	194.29	138.34	169.66	171.09
Expenses/Visit	211.57	282.40	253.68	422.57	283.33	291.97	257.00	289.88	299.36	324.20	248.61	288.73

DEPARTMENT:	Safety Management	NUMBER: 170.001	
SUBJECT:	Safety Management Program	PAGE: 1 of 10	
EFFECTIVE DATE:	Pending Approval	REPLACES POLICY DATED: N/A	
APPROVED BY:	Safety Committee, Policy & Procedure Committee, Quality & Patient Safety Committee, Board of Directors	DISTRIBUTION: Organization wide	

POLICY:

Southern Coos Hospital & Health Center (SCHHC) strives to provide quality patient care services that focus on the management of the environmental safety of patients, staff, and others through identification of safety risks and the planning and implementing of processes to minimize the likelihood of those risks.

SCOPE:

The scope of the Safety Management Plan shall define the processes which Southern Coos Hospital & Health Center utilizes to provide our patients, staff, and visitors with a physical environment free of hazards and manages activities proactively through risk assessment to reduce the risk of injuries to patients, staff and other individuals coming to the hospital.

OBJECTIVES:

The objective of this hospital's Safety Management Plan shall be to control known and potential safety hazards to our patients, staff, and visitors.

GOALS:

The goals of this hospital's Safety Management Plan shall include the following:

- Maintain a safe environment and conditions for patients, staff, and visitors.
- Reduce and control environmental hazards and risks of safety-related incidents by proactively evaluating systems in place and make the necessary changes through the Safety Committee, Performance Improvement Committee, administration, and departmental participation.
- Reduce and prevent accidents and injuries to patients, staff, and visitors.
- Provide education to all staff on the elements of the Safety Management Program.
- Inservice all staff on the use of and how to complete incident reports.
- Ensure safe work practices and conditions.

RESPONSIBILITY:

The Safety Officer and Safety Committee Chairperson shall be responsible for developing, implementing, monitoring, and managing the Safety Management Program.

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APPROVED BY:	Safety Committee, Policy & Procedure Committee, Quality & Patient Safety Committee, Board of Directors	DISTRIBUTION: Organization wide	

APPOINTING OF QUALIFIED INDIVIDUAL:

- The Chief Executive Officer shall appoint a qualified individual as the Safety Officer to oversee, monitor and evaluate safety activities; to manage the safety management program that measures and analyzes safety levels, reduces risks and hazards; and to help identify problem areas for correction.

- See Letter of Safety Officer Appointment (Policy #170.002).

IDENTIFYING AN INDIVIDUAL TO INTERVENE WHENEVER CONDITIONS POSE AN IMMEDIATE THREAT:

- The Administration has delegated to the Safety Committee through the Safety Officer and the Safety Committee Chairperson the authority to take action when hazardous conditions or potentially hazardous conditions exist.

- See Authority Policy.

SAFETY ISSUES SHALL BE EXAMINED BY APPROPRIATE REPRESENTATIVES:

- The Safety Committee shall include representation from administration and supervisory staff from clinical and support services. Nonsupervisory employees are encouraged to participate in the activities of the Safety Committee but may not be members. All members of the Safety Committee are appointed by the Chief Executive Officer of the hospital.

- The Safety Committee shall develop a valid audit procedure and carry out periodic audits of organizational performance against the Safety Management Plan.

RISK ASSESSMENTS WHICH PROACTIVELY EVALUATE THE IMPACT OF BUILDINGS, GROUNDS, EQUIPMENT, OCCUPANTS, AND INTERNAL PHYSICAL SYSTEMS ON PATIENT AND PUBLIC SAFETY:

- The risk assessment program shall be designed to proactively evaluate the risks that may have an impact on patient care, staff, and visitors as it relates to the safety of the buildings, grounds, equipment, occupants, internal physical systems, and the safe practices of hospital employees.

- The ongoing monitoring of performance regarding actual or potential risks in the environment of care shall be identified and communicated to the organization's leaders at least annually for consideration and possible inclusion in the hospital's priority for improvements.

- The Risk Assessment Program shall be carried out by using Risk Assessments, Incident/ Accident Reports, Investigation Policy, Hazard Surveillance Policy, Hazard Surveillance Inspections, Equipment and Utility Incident Reports, Security Incident Reports, and reports from various agencies such as insurance companies, state or county health agencies and fire agencies.

- See Risk Assessment Program Policy.

REPORTING AND INVESTIGATING ALL INCIDENTS OF PROPERTY DAMAGE, OCCUPATIONAL ILLNESS AND PATIENT, STAFF AND VISITOR INJURY:

- The Safety Committee shall review all summaries of property damage, occupational illness, accidents or injuries to patients, visitors and/or staff. Summary reports of incidents shall include evaluation of the incident, conclusions, recommendations, and actions taken.

- All staff shall receive education on what constitutes an incident and completing an incident report. An incident consists of:

- Property damage (hospital, patient, visitor, or staff including, damage, loss, etc.)

- Occupational illness (needlesticks, back injury, etc.)

- Unusual or dangerous occurrences (falls, equipment malfunctions, injuries, or accidents, etc.)

- The Safety Committee shall establish an incident reporting system:

- The department manager shall investigate all accidents and incidents. Serious accidents or an unusual frequency of accidents shall be investigated by the Safety Officer/ Safety Committee Chairperson. All incident reports shall be reviewed and studied by the Safety Officer to determine the cause. The Safety Officer shall make recommendations to the Safety Committee to prevent the reoccurrence of incidents.

- All incidents shall be aggregated on a quarterly basis and reported to the Safety Committee by the Safety Officer. The Safety Committee shall track and trend all incidents by type to determine if patterns exist. Once a pattern has been identified, a performance improvement project shall be developed to improve performance.

- See Safety Incident Report Protocol Policy, Staff Safety Incident Report Form, Staff Safety Incident Reports - Illness or Injury Policy, Incident Follow-Up Form.

IDENTIFIED RISKS:

- Any risks that are identified through proactive risk assessments, environmental tours, reporting mechanisms, etc., shall be evaluated, selected, and have procedures and controls put into place to reduce to the lowest possible point the adverse impact on the safety and health of patients, staff, and visitors of the hospital. For those cases, where appropriate and deemed necessary, the failure mode effects, and analysis process shall be undertaken.

- Risks identified shall include patient safety issues and employee safety, i.e., medication errors, patient falls, wrong site, wrong side surgery; visitor falls or injury, employee injury.

SAFETY POLICIES AND PROCEDURES:

- The Safety Committee shall develop written policies and procedures to enhance safety within the hospital and its grounds.

- All departments shall maintain individualized safety policies.

- All safety policies shall be reviewed annually. Any revision, updating or changes shall be submitted to the Safety Committee for approval.

- The ultimate responsibility for the development and maintenance of current department specific safety policies shall lie with the department managers, with the assistance of the Safety Officer, as appropriate.

- Representatives of the Safety Committee shall perform environmental tours of the hospital every six (6) months in patient care areas. Previously implemented activities to minimize or eliminate EOC risk(s) shall be evaluated and reported to the Safety Committee:

- Any deficiencies, hazards and unsafe practices shall be identified and reported to appropriate individuals/departments for resolution.

- Representatives of the Safety Committee shall conduct an annual environmental tour of all non-patient care areas:

- Previously implemented activities to minimize or eliminate EOC risks shall be evaluated.

- All deficiencies, hazards and unsafe practices shall be identified and reported to the appropriate individual/department for resolution.

HAZARD SURVEILLANCE INCLUDING RESPONSE TO PRODUCT RECALLS:

- An ongoing hazard surveillance program including response to product safety recalls shall be maintained and reported through the Safety Committee:
- Hazard Surveillance Inspection Surveys shall be conducted semiannually in each patient care department or service and annually in all other departments of the hospital by individuals with expertise in safety issues.
- All surveys shall be evaluated to determine if trends or patterns are present.
- A report shall be submitted to the Safety Committee identifying deficiencies, recommendations, actions taken and resolutions to the deficiencies following each survey.
- All product safety alerts, hazard notices and recalls shall be directed to the Chief Biomedical Engineer:
- In the event the notices are not directed to the Chief Biomedical Engineer, the notices shall be immediately rerouted to the Chief Biomedical Engineer.
- A Biomedical Engineer shall check the clinical equipment inventory to screen for equipment matches and shall evaluate the severity of the risk.
- In most cases, the notices may be addressed without removing equipment from service.
- In the event equipment must be removed from service, the equipment shall be replaced with a safe effective substitute.
- The Engineering Department shall impound equipment removed from use due to recall notices until it can be rendered safe.
- The Risk Manager shall report quarterly to the Safety Committee on any hazard notices and recalls affecting the hospital and all follow-up activities undertaken.

MAINTAINING AND SUPERVISING ALL GROUNDS AND EQUIPMENT:

- The Engineering Department Manager shall be responsible for supervising the activities of the ground's maintenance crew. The ground's maintenance crew shall maintain the property

according to the expectations of the hospital. Monitoring of equipment and preventive maintenance and inspection procedures, as well as education and training of users to protect against failure or user error, shall be monitored and maintained by the Engineering Department Manager.

- The Engineering Department shall conduct visual surveillance of the hospital's grounds on a daily basis. Surveillance activities shall include, but not be limited to:
    - Snow and ice, if applicable
    - Hazards including:
        - Rocks
        - Scraps of wood
        - Cans
        - Bottles
        - Sand
        - Refuse
        - Spills
        - Pavement failures
- Safety hazard reports shall be received by staff, the Safety Officer, or the Engineering Department, and shall be tracked, investigated, and repaired/corrected as needed.

PERFORMANCE STANDARDS:

- There shall be a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization-wide safety.
- The organizational Safety Committee shall develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment.
- Performance measures and outcomes shall be prioritized based upon high-risk, high volume, problem-prone situations and potential or actual sentinel event related occurrences.
- Criteria for performance improvement measurement and outcome indicator selection shall be based on the following:
- The measure can identify the events it was intended to identify.

- The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable.

- The measure has defined data elements and allowable values.

- The measure can detect changes in performance over time.

- The measure allows for comparison over time within the organization or between the organization and other entities.

- The data intended for collection are available.

- Results can be reported in a way that is useful to the organization and other interested stakeholders.

- The Safety Committee on an ongoing basis shall monitor performance regarding actual or potential risk related to one (1) or more of the following:

    - Staff knowledge and skills
    - Level of staff participation
    - Monitoring and inspection activities
    - Emergency and incident reporting
    - Inspection, preventive maintenance, and testing of safety equipment

- Other performance measures and outcomes shall be established by the Safety Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting shall be determined by the Safety Committee.

- To identify opportunities for improvement, the Safety Committee shall follow the organization's improvement methodology, the PDCA model. The basic steps to this model shall consistently be followed and include planning, designing, measuring, analyzing/assessing, improving, and evaluating effectiveness.

- Should the Safety Committee feel a team approach (other than the Safety Committee) is necessary for performance and process improvement to occur, the Safety/Environment of Care Committee shall follow the organization's performance improvement guidelines for improvement team member selection:

- Determination of team necessity shall be based on those priority issues listed (high-risk, volume and problem-prone situations and sentinel event occurrence).

- The Safety Committee shall review the necessity of team development, requesting team participation only in those instances where it is felt the Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter).

- Should team development be deemed necessary, primarily, team members shall be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified.

- The team shall be interdisciplinary, as appropriate to the subject to be improved.

- Performance improvement monitoring and outcome activities shall be presented to the Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome forwarded to the Organizational Performance Improvement Committee, Medical Executive Committee and Governing Body quarterly.

- The following performance measures are recommended:

    - Percent of staff able to demonstrate their knowledge of their role and expected participation in the safety program.

    - Percent of individuals receiving safety in-service within 30 days of scheduled

    - Percent of hazard surveillance rounds conducted on schedule (patient care six [6] months; other annually)

    - Number of safety incidents reported.

    - See Monitoring Activities Summary Format Policy, Safety Committee PI Monitoring and Evaluation Plan and Staff Safety Questionnaire.

INTEGRATION OF THE PATIENT SAFETY PROGRAM AND THE SAFETY MANAGEMENT PROGRAM:

- The monitoring, outcome and improvement activities that are defined in the Safety Management Program shall be integrated into the Quality & Patient Safety Program through frequent interactions between appropriate staff and participation on the appropriate oversight committees.

- The Safety Officer shall be an appointed member of the organization-wide Performance Improvement Committee.

- Members of the Safety Committee shall participate in root cause analyses, as appropriate.

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ORIENTATION PROGRAM THAT ADDRESSES GENERAL SAFETY PROCESSES, AREA-SPECIFIC SAFETY, SPECIFIC JOB-RELATED HAZARDS AND NEW EMPLOYEE ORIENTATION AND CONTINUING EDUCATION:

- The Safety Committee shall provide safety-related information through:
    - Orientation of new employees
    - Continuing education of all hospital employees
    - Safety information bulletin boards
- By developing a reference library of pertinent documents and publications dealing with all facets of hospital safety
- By recommending purchase of safety equipment and suggesting any necessary physical changes to improve safety conditions.
- The Safety Committee shall coordinate organization-wide educational activities in order to effect improvements in the safety of patients, visitors and staff:
    - All staff shall receive general safety orientation upon hire and annually thereafter.
    - The orientation shall include general hospital safety, patient safety, fire safety, emergency evacuation of patients, body mechanics/ergonomics, emergency management, medical equipment management, utility systems management, security management, hazardous materials and waste management, and infection prevention and control.
    - It is the responsibility of the department manager to train all employees on departmental specific safety procedures and job-related hazards.
- Educational programs shall be based on industry standards and literature review and are continually adapted to reflect organizational experience and the evaluation of effectiveness of training programs.

- A record of all in-service programs shall be maintained. Employees shall be evaluated on safety knowledge as part of the ongoing review of employee performance.

EVALUATION OF SAFETY MANAGEMENT PLAN'S OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

- The Safety Management Plan shall be reviewed every 12 months.
- The evaluation of the Safety Management Program shall include a review of the scope according to the current accrediting organization standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital.
- A comparison of the expectations and actual results of the program shall be evaluated to determine if the goals and objectives of the program were met.
- The overall performance of the program shall be reviewed by evaluating the results of performance improvement outcomes.
- The overall effectiveness of the program shall be evaluated by determining the degree that expectations were met.
- The performance and effectiveness of the Safety Management Program shall be reviewed by the Safety Committee, the Performance Improvement Committee and administration.
- Changes to the plan shall be incorporated into an updated Safety Management Plan by the Safety Officer, with approval from the Safety Committee.

DEPARTMENT:	Safety Management	NUMBER: 170.002	
SUBJECT:	Authority of Safety Officer	PAGE: 1 of 1	
EFFECTIVE DATE:	Pending Approval	REPLACES POLICY DATED: N/A	
APPROVED BY:	Safety Committee, Policy & Procedure Committee, Quality & Patient Safety Committee, Board of Directors	DISTRIBUTION: Organization wide	

POLICY:

- The Safety Officer shall be appointed by the Chief Executive Officer of Southern Coos Hospital & Health Center (SCHHC).

- Administration shall have delegated to the Safety Committee through the Safety Officer and the Safety Committee Chairperson, the authority to act when hazardous conditions or potentially hazardous conditions exist that could result in death, personal injury to individuals or damage to equipment or buildings.

- This delegated authority shall have been approved by the medical staff and Governing Body of the hospital.

- If, in order to resolve identified problems, it becomes necessary to undertake financial responsibility, verbal or written approval shall be obtained, if possible, from the Chief Executive Officer or his/her designee in his/her absence.

REQUIREMENTS AND QUALIFICATIONS:

- 5 years of experience as a Safety Officer or similar role
- Excellent knowledge of potentially hazardous materials or practices
- 2 years of experience in producing reports
- Experience with writing policies and procedures for health and safety
- Familiarity with conducting data analysis and reporting statistics
- Excellent organizational skills
- Critical thinker and problem-solving skills
- Team player
- Good time-management skills
- Excellent interpersonal and communication skills
- Certificate in occupational health and safety

DESIGNATION:

- Further, the Chief Executive Officer shall have designated:

  Jason Cook to be the Safety Officer.

Chief Executive Officer — Date: September 29, 2023

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PLAN

Fiscal Year 2023-2024

Southern Coos Hospital & Health Center

Quality Assurance and Performance Improvement Program

FY (Fiscal Year) 2024 (July 1, 2023 – June 30, 2024)

Formulated By: SCHHC (Southern Coos Hospital & Health Center) QAPI (Quality Assurance and Performance Improvement) Committee
Norbert Johnson, Board of Directors Liaison
Raymond Hino, CEO (Chief Executive Officer)
Noel Pense, DO, Quality and Patient Safety Medical Director
Phillip Keizer, MD, Medical Chief of Staff
Cori Valet, RN, BSN, CNO (Chief Nursing Officer)
Scott McEachern, CIO (Chief Information Officer)
Jeremiah Dodrill, CFO (Chief Financial Officer)
Barbara Snyder, RN, BSN, MBA, Quality, Risk, Compliance Officer
Sharon Bischoff, RN, BSN, Quality Coordinator

Approved By: Quality and Patient Safety Committee on 9/19/2023
Board of Directors on _____

Table of Contents

I. Mission, Vision, Values & Guiding Principles

a. Mission

Quality Healthcare with a Personal Touch

b. Vision

SCHHC will improve the health and viability of the community by working to be the best place for patients to receive care, for employees to work, and for providers to practice medicine.

c. Values: Strategic Plan Pillars

1. **People:** Improve employee experience and become an employer of choice.
2. **Service**: Build a culture of service excellence by providing a phenomenal experience for our customers (patients and each other).
3. **Quality**: Enhancing quality of care, improving patient safety, and ensuring our standards align with regulatory requirements.
4. **Growth:** Increase market share through enhancement of existing and development of new services.
5. **Finance:** Achieve profitability by increasing net revenue, controlling costs, maintaining an effective investment strategy, and streamlining the revenue.

d. Guiding Principles

1. **Facilitate change through experience.** Quality improvement theory and methodology is best learned through the experience of the Organization's patient care, duties, and responsibilities. By applying quality hands-on experience to the actual clinical environment, we may identify areas that are most important and create a platform for improvement throughout the organization.
2. **Define Quality and Get Agreement.** Obtaining agreement on the definition of quality in each situation or environment will allow a set goal and a framework for measuring and collecting data. Definitions of quality should include what is important to the patient and focus on Organizational safety, effectiveness, efficiency, and timeliness. Quality of care should be applicable to all patients and not vary based on gender, ethnicity, location, or socioeconomic status. Where national standards of quality are available, they will be adopted by SCHHC.
3. **Measure for Improvement, Not Accountability.** Data and specific measurements will be collected to monitor the process's progress. Continuous improvement decisions will be made based on data analysis and not rely on individual related work processes.
4. **Use a Quality Improvement Framework of PDCA (Plan Do Check Act) Cycle:** PDCA cycle is the backbone of quality improvement at SCHHC. The PDCA cycle is repeated to assure quality results are to the acceptable level desired.

1. **Plan:** Establish an objective; determine what questions need to be asked; what predictions need to be made; and what is needed to carry out the objective. The DNV Corrective Action Plan Form will be used in this stage.
2. **Do:** Carry out the plan, document the problems, unexpected observations, begin to collect and analyze data.
3. **Check.** Complete the analysis, compare the data to assumptions, and summarize learning. At this stage of the cycle, an internal review will be conducted to help analyze.
4. **Act**: Determine if the implementation worked, and what can be done differently in the next cycle to address the issue if it did not work. Once the implementation has succeeded, communicate it to other areas at SCHHC.

5. **Learn from variation of data.** This assists the Quality improvement team to accomplish goals in the PI process. Understanding statistical variation and causes of those specific variations will assist in the decision-making process. The use of statistical tools will be used in preparation for the hospital staff's understanding of Quality principles of the Six Sigma's DMAIC model of Performance Improvement.

II. Scope

The scope of the Organizational Quality Assurance and Performance Improvement Program encompasses measurement and the action taken to correct activities of the Medical Staff, Nursing and Ancillary or support services. Data will be collected from every department and service of the hospital. Processes and outcomes of care are designed, measured, and analyzed.

SCHHC is dedicated to meeting the needs of our patients in a manner which is consistent with our mission, vision, and strategic pillars. The Organizational Quality Assurance and Performance Improvement plan is designed to provide a systematic and organized program for promoting safe, quality patient care and services. Activities are interdisciplinary and collaborative to respond to the needs of the customer, patient, physician, employee, and community.

a. Integration of Care and Services

Through an interdisciplinary and integrated process, patient care and processes that affect patient care outcomes shall be continuously monitored and evaluated to promote optimal achievements, with appropriate accountability assumed by the Board of Directors, Medical Staff, Administration, and support personnel.

Our quality plan is focused around the five pillars from our Strategic Plan: people, service, quality, growth, and finance.

1. People

1. Utilize staff and the Quality and Patient Safety Committee to assist in determining ongoing departmental quality improvement objectives and goals.
2. To prepare and train staff in how to conduct internal reviews, to check processes for quality improvement.

2. **Service**

    1. Utilize patient satisfaction data to drive improved patient care. This will include managing Alerts in the NRC survey system.
    2. Utilizing the Clarity (Patient Events) reporting system to detect trends and concerns that need improvement. These events could also be considered for Performance Improvement Projects (PIP).

3. **Quality**

    1. Implementation of processes using the Plan Do Check Act (PDCA) approach.
    2. Development of a system where non-conformities found in the data are elevated to a corrective action plan.

4. **Growth**

    1. Develop an effective communication plan between staff, managers, department heads, executive leadership team, providers, and the Board of Directors.
    2. Support the new Hospital services, staff, physicians setting compliant standards for these entities.

5. **Finance**

    1. Develop and submit Quality measures to comply with regulatory agencies and programs that could result in positive payment adjustments for the facility.
    2. Monitor the Utilization Review Process to ensure healthcare services are being used appropriately, procedures and services are charged correctly, and medical services are efficiently utilized, through chart audits. This will assist in the preparation of SCHHC to adopt a value-based approach for future

b. Patient Safety Goals

The hospital will conduct a root cause analysis, and other investigations as appropriate, in response to a sentinel event, serious safety event, or significant near miss. The root cause analysis process involves an internal investigation and analysis of the sentinel event to reduce variations and prevent the event from recurring in the future.

i. Adopt the Joint Commission 2023 National Patient Safety Goals to help improve patient outcomes:

    1. Identify patients correctly.
        a. Use at least two ways to identify patients.
    2. Improve staff communication.
        a. Get important test results to the right staff or provider on time.

3. Use medicines safely.
    a. Ensure all medications are labeled.
    b. Take extra care with patients who take anticoagulants.
    c. Document and communicate correct information about a patient's medications.
    d. Reconcile patient medications, emphasizing bringing updated list at any visit.
    e. Give the patient written information about newly prescribed medications.
    f. Proper technique for mixing IV fluids and medications.
4. Use alarms safely.
    a. Prevent alarm fatigue.
    b. Ensure that alarms are heard and responded to on time.
5. Prevent infection.
    a. Use hand cleaning guidelines from the Center for Disease Control and Prevention.
    b. Support Infection control in hand washing initiative.
6. Identify patient safety risks.
    a. Reduce the risks of patient falls and screen patients for suicide.
    b. Support the Fall Prevention program.
7. Prevent mistakes in surgery.
    a. Ensure provider has obtained informed consent and verified with patient surgery.
    b. Follow standardized safety procedures for surgery and procedures.
    c. Ensure "time out" is being performed before any procedure or surgery.
8. Support the Restraints and Seclusion Committee as they develop processes, and staff training to ensure safe restraints and seclusion events are in accordance with policies (See Appendix A).
9. SCHHC Quality Department will support the SCHHC Engineering Department in the following areas:
    a. Improvement of the Life Safety Management system.
    b. Implementation of an Infection Control process.
    c. Life Safety Drill implementation and scheduling (See Appendix B.
    d. The SCHHC Engineering Department is responsible for the following areas:
        i. Establish an interdisciplinary team in developing a Hazard Vulnerability Assessment (to include a 96-hour plan)
        ii. Review and implementation of Emergency Management System to include the Hazard Vulnerably Assessment and periodic internal reviews of the Plan (See Appendix C).
        iii. Develop and implement a Medical Equipment Management System Policy. (passed on 8/8/2023 by the medical staff See Appendix D).

c. High Quality Goals

1. Provider Performance Data will be collected and prepared and used in recredentialing (See Appendix E).
    1. Antimicrobial Stewardship with Medical Staff support for data to be submitted as required to external entities in keeping with regulatory requirements.
    2. The Opioid Stewardship process will be created with Medical Staff support providing data submission requirements to external entities as required.

d. Utilization of Standards and Best Practices

1. SCHHC has chosen to work with DNV and pursue NIAHO (National Integrated Accreditation for Healthcare Organizations) accreditation. We will adopt NIAHO accreditation standards, work towards internal reviews, and toolkits for staff to utilize in PIP projects.
2. SCHHC will work toward mandatory CMS measures for CAH (CRITICAL ACCESS HOSPITAL) hospitals and develop voluntary measures as standards. We will use National and State Benchmarking to compare our hospital performance.
3. CDC (Centers for Disease Control) (Centers for Disease Control) guidelines will be reviewed for consideration for implementation, policy development, and for policy updates.
4. FDA (Food and Drug Administration) (Food and Drug Administration) guidelines. Develop policies and procedures as needed per current and future regulations.
5. Oregon Health Authority state regulations. Develop policies and procedures as needed per current and future regulations.

III. Guidelines for Governance and Leadership

Participation in Quality Improvement activity is the responsibility of Medical Staff, and everyone employed by or contracted staff with Southern Coos Hospital & Health Center. The organizational Quality Assurance & Performance Improvement Plan is reviewed and approved annually by the CEO and the Board of Directors.

The CEO and the Medical Staff in collaboration with the Board of Directors facilitate Quality Improvement by:

i. Authorizing the establishment of a committee structure to implement the Quality Assurance and Performance Improvement (QAPI) Program.
ii. Providing direction in setting performance improvement priorities based on our mission, vision, and strategic goals;
iii. Establishing an organizational culture that supports a commitment to quality and patient safety;
iv. Ensuring the quality program reflects the complexity of the hospital's organization and services;

v. Ensuring the quality program is focused on metrics related to improved health outcomes and the prevention and reduction of medical errors;
vi. Approving the Quality Assurance and Performance Improvement Plan (QAPI);
vii. Providing adequate resources, both material and staff, to accomplish the QAPI function;
viii. Receiving monthly reports of QAPI data from departments and services of the hospital including those provided through contracts;
ix. Reviewing, accepting, or rejecting periodic action plans based on findings, actions, and results of program activities regarding the effectiveness of organization-wide quality and safety activities;
x. Evaluating the effectiveness of the quality program annually, and if necessary, requiring modification to organizational structure and systems to improve outcomes;
xi. Requiring a process designed to assure that all individuals responsible for the treatment and/or care of patients, whether provided through internal mechanisms or contracted services, are competent;
xii. Specifying the detail and frequency of data collection.

a. Responsibilities and Accountability

1. Board of Directors

The Board of Directors shall be responsible for ensuring the provision of optimal quality care, safety, and organization-wide performance. The Board is accountable for the safety and quality of patient care provided in every department and service of the hospital.

The Board of Directors, which maintains overall responsibility, delegates patient safety, quality of patient care, and overall operations authority to the Hospital CEO. The Board of Directors considers and acts upon recommendations from Hospital Leadership and staff to develop, train, and implement QAPI.

2. Senior Leadership

1. Senior Leadership, consisting of the Chief Executive Officer (CEO), CNO (Chief Nursing Officer), CIO (Chief Information Officer), CFO (Chief Financial Officer), maintains the QAPI process through allocation of staff and resources necessary to fulfill the program requirements.
2. Administration also:
    a. Analyzes data and information in decision-making that supports patient safety and quality of care;
    b. Performs evaluations of clinically contracted services in collaboration with the respective department directors and reporting the results of the evaluation through the QAPI Committee structure to the Board and Medical Staff;
    c. Regularly evaluates the culture of safety and quality using valid and reliable tools;
    d. Ensures the participation of appropriate staff members of all departments and services in the Hospital through collaborative monitoring, evaluation of

patient outcomes, and essential functions to the QAPI Committee structure;

e. Ensures that appropriate corrective action is taken without undue delay for deficiencies discovered.

3. Chief of Staff, Quality Medical Director, and other Medical Staff Directors

1. The Chief of Staff, accountable to the CEO, has the primary authority for activities related to self-governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process. The Chief of Staff makes recommendations directly to the CEO based on the reports from medical staff committees, hospital departments, and other assigned groups.
2. The Medical Director of Quality provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, other credentialed practitioners, and privileged practitioners through the medical staff process. The Medical Director of Quality is actively involved in the measurement, assessment, and improvement of the following:
    a. The quality of Histories and Physicals.
    b. Medical assessment and treatment of patients.
    c. Appropriateness of clinical practice patterns including significant departures from established patterns of clinical practice.
    d. Unexpected Complications.
    e. Review Medication Use Monitoring.
    f. Accurate, timely, and legible completion of patient's medical records.
    g. Blood / Blood Component Usage Review.
    h. Operative / Invasive Procedure and Anesthesia.
    i. Review Risk Management / FMEA (Failure Mode and Effects Analysis).
    j. Sentinel/ Serious Safety Event.
    k. Patient Safety including safe opioid.
    l. Antibiotic Prescribing Practices.
    m. Utilization Management.
3. The Medical Staff, led by the Chief of Staff, reviews findings of the assurance process relevant to an individual's performance and Focused Professional Practice Evaluation (FPPE) and Professional Practice Evaluation (OPPE).
4. The Medical Staff is committed to developing and continuing to improve active involvement in the measurement, assurance, and improvement of data on individual credentialed practitioners from the aggregated data.
5. The Medical Staff shall conduct the following:
    a. Participate in developing specific indicators to systematically evaluate practitioner care. This may be accomplished by individual medical staff departments or medical staff committees approved by Medical Staff.
    b. Identify, analyze issues, opportunities, and recommend actions to Medical Staff Department Directors. Monitors the effect of the actions taken to

determine that any issue has been resolved.

c. Monitors the appropriateness of clinical practice patterns and significant departures from established standards of clinical practice;

d. Report medical staff quality information monthly to the Quality and Patient Safety Committee, Medical Staff Department Directors, Medical Staff and the Board of Director by written reports, summaries, or conclusions.

b. Resources for Quality Management System

When it is established that there is a need or opportunity to initiate a new service, extend product lines, occupy a new facility, or significantly change existing functions or processes, the design will be based upon the organization's mission, vision, and plans. The needs of the patients, staff, and all who use this service will be considered and up-to-date sources of information shall be used to design the process or service.

1. Designated Representative

1. The Quality Department is delegated by senior management as a management representative with senior leadership, to ensure the requirements of the Quality Management System are determined, implemented, and maintained. (See Quality and Patient Safety Meeting minutes of 8/15/2023).
2. The Quality and Risk Manager identifies conditions and events which could or have caused injury or loss; monitor resolution of risk-related problems; plan/provide appropriate education to employees, Medical Staff, and Board of Directors; and interact with the Medical Staff, Administration, Nursing and Clinical Services.
3. The Quality Department shall be responsible to support the organization's Quality Improvement principles, strategies, priorities, approach, and methodologies, which includes but is not limited to the following tasks:
    a. Working with the Medical Staff, all hospital departments/services, and staff to effectively measure, assess, analyze, and improve the quality and safety of care and services.
    b. Coordinate Quality Improvement orientation, education, and training.
    c. Facilitate and support Quality Improvement efforts.
    d. Coordinate survey preparations and facilitate a culture of continual survey readiness.
    e. Maintain the database for all QAPI activities including quality improvement initiatives, departmental quality measures, physician quality, credentialing, and peer review activities.
    f. Support Quality and Risk Manager to prepare an annual organization-wide evaluation of the Quality Program.
    g. Facilitate communication of quality improvement activities throughout the organization and the Quality and Patient Safety Committee to the Medical Staff and Board of Directors at least quarterly.
    h. Work closely with Risk Management to monitor or analyze any serious patient safety event and/or sentinel event and promote patient safety.
    i. Work with the Medical Chief of Staff, Executive Leadership, and Department Directors to select meaningful quality measures that address

patient quality or safety needs.

j. Provide reports using statistical tools & techniques to analyze and display data.

k. Compare internal data over time to identify any patterns, trends, or variations.

l. Compare data with external sources.

2. Plan for Developing Leadership in Quality

1. The Quality Department will research, develop, and implement a training program for Leadership on the Quality process. A plan for education will be developed and budgeted for the 2024-2025 fiscal year.
2. The Quality Department is responsible for training hospital staff in using Quality Tools and the Plan do Check Act process.
3. The Department Directors, Managers and Executive Team Members are accountable for the quality and patient safety during the performance of their staff for the care of service provided.
4. Executive Team Members, Department Directors or Managers will:
    a. Communicate and prioritize opportunities for improvement.
    b. Promote the development of standards of care and criteria to objectively measure the quality and safety of care/services rendered in their departments.
    c. Monitor, analyze and report the processes in their areas that affect patient care, safety, outcomes, and satisfaction.
    d. Design and redesign work processes to improve safety and quality.
    e. Participate in the evaluation of the performance of contracted services.
    f. Participate in quality improvement initiatives.
    g. Report QAPI data and actions taken as appropriate.
    h. Communicate the status of departmental quality, patient safety, and survey readiness initiatives regularly to departmental staff members.

3. Facility Wide Training

1. The Quality Department, with the Nursing and Human Resources departments, will research, develop, and implement a training plan for new employees in Quality Principles and processes. Included in this plan will be training for all staff annually in Quality principles, tools, and the Plan Do Check Act (PDCA) Process.
2. Quality Department representatives will introduce staff to Quality Assurance and Performance Improvement concepts and objectives during the new Employee orientation, department staff meetings, and in-services as needed. Employees are encouraged to participate in the team process.

4. Evaluation of Adequate Resources

The Quality Department will report the Results of quality improvement monitoring activities and the improvement action plans to Administration, the Board of Directors, and Medical Staff at least quarterly.

1. At least annually the allocation of resources to the Quality office will be evaluated.

5. **Sustainability of Quality Improvement Training**
    1. Educational meetings for hospital departments will be considered based on the identified specific needs of education for that department.
    2. Mandatory Training and documentation of that training for each employee will be kept by the Human Resources Department.

c. Leadership of the Quality Management System:

1. **Quality and patient Safety Committee**
    1. The Quality and Patient Safety Committee is a subcommittee of the Southern Coos Health District Board of Directors, per District by-laws.
    2. The Quality and Patient Safety Committee is the hospital-based multidisciplinary committee that coordinates organizational quality improvement activities and provides oversight to the Quality Management System. Membership includes: A Board of Director member, CEO, Executive Team, Medical Staff, Department Directors or Managers, Human Resources, Information Technology, and Department Supervisors.
    3. Quality and Patient Safety Committee meetings are scheduled monthly. Meeting activities include but are not limited to:
        a. Meeting agenda and departments reporting for the month will be emailed in advance to the committee members for review before the meeting
        b. Reviewing in-depth information and data regarding specific hospital departments or areas on an approved schedule;
        c. Reviewing quality data and process improvement efforts;
        d. Recommending improvement efforts for consideration by the Board of Directors;
        e. Reviewing and approving recommendations from the Policy Committee to present to the Board of Directors.
        f. Ensure the Patient Safety Program and Quality Assurance and Performance Improvement Program are integrated to ensure the flow of information to the appropriate areas for review, action, and/or follow-up.
        g. Hold accountability for the Quality and Risk Management programs to reduce the frequency and severity of adverse events, thus minimizing loss and contributing to Quality Improvement through risk identification, evaluation, control, and education.
2. **Coordination of the Quality Management System**
    1. **Meeting Schedule**
        a. Quality and Patient Safety Committee will meet monthly with an approved agenda and schedule of DNV NIAHO reporting departments and/or hospital standards (effective 10/3/2023), as follows:
            i. Monthly:
                1. SR.4a Threats to patient safety (e.g., falls, pt. identification, injuries);
                2. SR.4b Medication therapy/medication use; to include medication reconciliation, high-risk drugs, look alike- sound alike medications, and the use of dangerous abbreviations;
                3. SR.4c Operative and invasive procedures, to include wrong

site/wrong patient/wrong procedure surgery;

4. SR.4d Anesthesia/moderate sedation adverse events;
5. SR.4f Restraint use/seclusion, to include prolonged restraint (see PR.7 (SR.7));
6. SR.4i Utilization Management System;
    a. SR.4i (1) Readmissions; and,
    b. SR.4i (2) Aggregate findings and trends identified by the UR (Utilization Review) Committee (see UR chapter).
7. SR.4k Customer satisfaction, both clinical and support areas, including:
    a. SR.4k (1) Grievances;
8. SR.4m Unanticipated deaths;
9. SR.4n Adverse events/Near misses;
10. SR.4o Unplanned returns to surgery (as defined by SCHHC);
11. SR.4q Medical record delinquency;

ii. Quarterly:

1. SR.4e Blood and blood components-adverse events/usage;
2. SR.4g Effectiveness of pain management system;
3. SR.4h Infection prevention and control, including but not limited to:
    a. SR.4h (1) CMS required HAI (Hospital Acquired Infection) reporting; and,
    b. SR.4h (2) Antimicrobial stewardship.
4. SR.4j Patient flow issues, to include reporting of patients held in the Emergency Department or the PACU for extended periods of time (as defined by the organization);
5. SR.4l Discrepant pathology reports;
6. SR.4p Critical and/or pertinent processes, both clinical and supportive;
7. SR.4r Physical Environment Management Systems; and,
8. SR.4s Relevant data such as data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions, hospital acquired conditions, maternal morbidity, sepsis, and safe opioid practices.

iii. Scheduling may be modified based on need and according to policy 155.002 Performance Improvement (PI Measure Selection Criteria

2. Communication

a. Microsoft 360 applications will be used to communicate for all committees and projects. This will include the following.

i. TEAMS, with Channels, teams, and live events, allow communication

and collaboration across the organization. Through intranet resources.

ii. SharePoint is utilized for intranet and knowledge management and creating durable content on sites and pages targeted for specific Teams or committees.

iii. Outlook is used for mail, calendar tasks, contacts, and engagement analytics.

3. **Documentation and Discussions**
    a. Microsoft TEAMS will provide conversations through posts and documentation will be kept in the Team folders for each team and channel in the file portion.
    b. Access can be limited with the control of "manage access" for viewing and editing purposes."
4. **Report to the Board of Directors**
    a. The Quality Department will report during the Executive Session at each monthly Board Meeting.

IV. Feedback, Data Systems, and Monitoring

a. Quality Improvement System

1. The PDCA (Plan, Do, Check, Act) model/process for performance improvement is utilized as the methodical approach to Quality Assurance and Performance Improvement initiatives.

b. Sources of Data

1. Each Department and/or Committee is responsible for collecting data and submitting it at the monthly or quarterly scheduled interval to the Quality Department.
2. Information Systems will help collect data, build reports, and assist individuals in data collection in the EMR (Electronic Medical Record).

c. Collection of Data

1. The staff collects, organizes, and analyzes data necessary to determine root causes, track performance, benchmarking, etc. Data is organized to facilitate comparison and trends.
2. The data collection is conducted promptly and efficiently. Statistical techniques and data displaying "tools" will be utilized. Tools may include charts and graphs, Run Charts, Histograms, Pareto Charts, Flow Charts, Cause and Effect diagrams (Fishbone Diagrams), Control Charts, etc. for the analysis of Information and Data.
3. The frequency of data collection and measurement is related to:
    1. The frequency of the event (affect a significant percentage of patients);
    2. Problem prone processes;
    3. The significance of the event or process monitored, such as
        a. What the leaders view as most important,

b. The extent to which the important aspect of care, processes, and outcomes monitored has been demonstrated to meet expectation or be problem free,

c. Customer satisfaction responses.

4. Priority issues and adverse events may require more detail and frequency of measurement activities.

5. Department Data reports are due by the seventh of each month to the Quality Department.

d. Review of Data and Comparison of Benchmarks

1. The monitoring and analysis process will include at least the following evaluations and will be referred to with the corresponding DNV NIAHO standards (effective 10/3/2023):
    1. SR.4a Threats to patient safety (e.g., falls, pt. identification, injuries);
    2. SR.4b Medication therapy/medication use; to include medication reconciliation, high risk drugs, look alike- sound alike medications, and the use of dangerous abbreviations;
    3. SR.4c Operative and invasive procedures, to include wrong site/wrong patient/wrong procedure surgery.
    4. SR.4d Anesthesia/moderate sedation adverse events;
    5. SR.4e Blood and blood components-adverse events/usage;
    6. SR.4f Restraint use/seclusion, to include prolonged restraint (see PR.7 (SR.7));
    7. SR.4g Effectiveness of pain management system;
    8. SR.4h Infection prevention and control, including but not limited to:
        a. SR.4h (1) CMS required HAI reporting; and,
        b. SR.4h (2) Antimicrobial stewardship.
    9. SR.4i Utilization Management System; SR (Standard Requirements).
        a. 4i (1) Readmissions; and,
        b. SR.4i (2) Aggregate findings and trends identified by the UR Committee (see UR chapter).
    10. SR.4j Patient flow issues, to include reporting of patients held in the Emergency Department or the PACU for extended periods of time (as defined by the organization);
    11. SR.4k Customer satisfaction, both clinical and support areas, including:
        a. SR.4k (1) Grievances;
    12. SR.4l Discrepant pathology reports;
    13. SR.4m Unanticipated deaths;
    14. SR.4n Adverse events/Near misses;
    15. SR.4o Unplanned returns to surgery (as defined by the organization);
    16. SR.4p Critical and/or pertinent processes, both clinical and supportive;
    17. SR.4q Medical record delinquency;
    18. SR.4r Physical Environment Management Systems; and,
    19. SR.4s Relevant data such as data submitted to or received from Medicare quality

reporting and quality performance programs including but not limited to data related to hospital readmissions, hospital acquired conditions, maternal morbidity, sepsis, and safe opioid practices.

2. Benchmarks may consist of an individual Department, State, National or Vendor averages or goals.

e. Display of Data

1. Data will be presented in an excel dashboard and updated monthly.
2. Charts, graphs, Run Charts, Histograms, Pareto Charts, Flow Charts, Cause and Effect diagrams (Fishbone Diagrams), Control Charts may be requested for analysis purposes or to increase the ease of data display.

V. Guidelines for Performance Improvement Projects (PIPs)

Quality Improvement activities will address both clinical and organizational services. These activities are designed to assess key functions of patient care. We will study, identify, and correct problems or improvement opportunities found during processes of patient care delivery.

a. Plan for Conducting PIPs

1. Potential PIPs Identified

1. Improvement opportunities are identified by departmental and organizational QI (Quality Improvement) activities, customer satisfaction surveys, sentinel/serious safety events, hospital/medical staff committees, opportunity for improvement forms and through formal and informal networking of all Employees.
2. Appropriate action will be recommended and implemented to eliminate or reduce variations identified or to improve quality of care. The Quality and Patient Safety Committee may refer to the specialized Performance Improvement groups to audit implementation of and compliance with the quality improvement process.
3. Policy 155.002 Performance Improvement (PI) Measure Selection Criteria may be utilized for identification purposes.

2. Criteria for Prioritization of PIPs

1. Priorities for Quality Improvement shall be established collaboratively by the Board, Administration, Medical Staff, and the Quality and Patient Safety Committee. The following criteria will be considered in establishing priorities:
    a. Mission, Vision, and Values.
    b. Strategic Plan, Community needs.
    c. Needs and expectations of patients and families and other customers.
    d. Input from Medical Staff and Employees.
    e. High Volume diagnoses/procedures/processes.
    f. High Risk diagnoses/procedures/processes.
    g. High-cost diagnoses/procedures/processes.
    h. Problem prone procedures/processes.
    i. Input from external sources (licensing, regulatory agencies.)

j. Clinical competency and training needs.
k. Resources required to make the improvement, both human and material.
l. Prioritization Matrix.

2. The Quality and Risk Manager will oversee the setting of priorities for quality improvement activities. Items/topics will be evaluated by the Quality and Patient Safety Committee. Quality improvement activities may be re-prioritized by the committee based on needs and resources. Issues may be reprioritized in response to sentinel/serious safety events identified, through quality indicators tracking and trending, unanticipated adverse occurrences affecting patients, changes in regulatory requirement, changes in patient population, in the physical environment, and/or changes in the expectations or needs of patients, staff or the community.

3. PIPs development

1. The effectiveness of any action taken is assessed and documented. Periodic monitoring of the results of correction action, including re-design of processes, will be conducted to make sure that any problems identified have been alleviated or eliminated and the improvement sustained. Any design/re-design initiative(s) will be evaluated for their effectiveness. If the specific department does not show improvement, new actions will be taken and, once again, the effectiveness will be assessed.

2. PDCA

a. The Plan-Do-Check (Study)-Act cycle worksheet from the Institute for Healthcare Improvement (IHI) will be utilized for writing down and testing the change for PIPs development.
    i. This should be used as an overall roadmap for the PIP and to track progress.
b. The PDCA cycle is shorthand for testing a change by developing a plan to test the change (Plan), The following should be included:
    i. During this phase, a Root Cause Analysis shall be performed.
    ii. Determination of measures and how the data will be collected.
    iii. An objective should be stated and be SMART (Specific, Measurable, Achievable, Realistic, and Time-specific).
    iv. Goals or metrics selected
    v. An outcome prediction should be identified.
    vi. Answering "who, what, when and where" in relation to the change.
    vii. A Failure Mode and Effects Analysis may be performed.
c. Carrying out the test (Do), Should include:
    i. Execution of the plan
    ii. Documentation of issues using the SBAR (Situation Background Assessment Recommendation) technique for communicating the situation, background, assessment (metrics), recommendations (change), and organize thoughts, and follow-through.
    iii. Any unexpected observations
d. Observing and learning from the consequences (Check or Study), The

following will be included in this phase.

i. An Internal Review will be conducted according to policy 155.009.

ii. Data should be collected, analyzed, and studied.

1. It is recommended that data is displayed in a run chart or control chart or an easily deciphered visual form that can be shared.

iii. Data should be compared to predictions.

iv. Summarization of learning will be documented.

e. Determining what modifications should be made to the test (Act). In this phase the following will be recorded.

4. **Process for Reporting PIPs**

1. PDCA cycle will be presented to the Quality and Patient Safety Committee with a summary of the PIP.
2. Review Policy 155.009, for the department's Quality presentation for each PIP report.

b. PIP Teams

1. Designation

1. Each team should have at least one member who has the following roles:

a. **Clinical Leadership.** Hospital staff member who has the authority to test, implement a change, and problem solve issues that arise in this process. This person understands how the change will affect the clinical care process. This person may be the "on-the-ground" staff member.

b. **Technical expertise.** This person has deep knowledge of the process or area of question. There may be more than one person needed depending on technical, clinical, and systems affected.

c. **Day-to-Day Leadership**. This individual is the lead of the team and ensures the completion of tasks. This person ensures that everyone has the resources needed to complete tasks.

d. **Project Sponsorship**. This person has executive authority and serves as the link to the team and the organization's senior management. This member assists the team in obtaining resources and overcoming barriers to implementing improvements.

e. Individuals may be selected from staff members and may include community involvement to share a patient's perspective.

f. Staff members that the team is outside their duties may be compensated according to duties assigned.

2. Characteristics

1. The Optimal size of a team is between five to eight individuals.
2. The QI team meets regularly to review performance data, identify areas in need of improvement, and carry out and monitor improvement efforts.
3. For these activities, the teams will use a variety of QI approaches and tools, including the Model for Improvement (MFI), Plan Do Study Act (PDCA) cycles, workflow mapping, assessments, audit and feedback, benchmarking, and best practices research.
4. The QI team should have a clearly identified "practice champion" who is committed

to the ideal and process of continuous improvement.

c. Documentation of PIPs

1. Documentation should be kept in TEAMS under the team's channel or group.
2. A data dashboard and or easy to decipher visual should be presented to the Quality and Patient Safety Committee.
3. Policy 155.009 will be utilized in the documentation and presentation of each PIP report and documentation.

VI. Systematic Analysis and Systematic Action

a. Corrective Action Plan (CAP)

1. Every PIP or Corrective Action Plan (CAP), a plan will be made for collecting and utilization of measures and data, including how to collect the data. Data may be quantitative or qualitative.
2. Qualitative data requires a rigorous process that delineates exactly where to look for the data and what needs to be captured.

b. Data Will be Verified and Corrected

1. This will help to identify data limitations and opportunities to improve the process or system.

c. Preliminary Data Analysis

1. The recommended questions should be addressed:
    1. How do these data compare with other organizations, or the benchmark chosen?
    2. What is the trend over time? Is it static, improving, or worsening?
    3. How is data likely to be interpreted or misinterpreted?
    4. Is there an opportunity for improvement?
    5. Who receives the data? For what purpose?

d. Further Study of Data

1. If warranted, the following may be employed.
    1. Variation analysis and statistical evaluation.
    2. A focused Retrospective review
    3. Process analysis

e. Decisions and Actions

1. Further action may be taken based on data and information.
2. This will be integrated int the PDCA cycle.

f. Continued Monitoring

1. Monitoring of performance improvement action and the following questions can be considered:
    1. Have the proposed changes been implemented? And to what extent?
    2. How could compliance with change be enhanced?
    3. What effects are the changes having on patient outcomes? Are these desirable effects?
    4. Are changes modified and tested further? Do we need longer time before drawing conclusions? Do the changes need to be ended due to ineffective results?

g. Communication

1. Communication is part of the above analysis and actions.
2. Effective communication will be used to provide information to appropriate staff so they can make decisions and act.

h. Unintended Consequences

1. Recognition and anticipation of the possible unintended consequences of guideline implementation is a critical step to harnessing all the benefits of quality improvement in practice.
2. During the PDCA cycle, during analysis and evaluation in the Check and Act portions of the cycle, unintended consequences will be looked at and addressed.
3. Potential failure modes and effects analysis (FMEA); failure modes, effects, and criticality analysis (FMECA) may be employed to look at ways, or modes that something may fail, and the consequences of the possible change. FMEA is used during design to prevent failures.

i. Root Cause Analysis

1. In response to a sentinel event occurrence, healthcare associated infection outbreak, or identification of undesirable patterns, trends or variations in its performance related to the safety or quality of care, the administrative team, or Risk and Quality Department shall appoint an event analysis team, who will conduct a root cause analysis.
2. Policy 155.006 Root Cause Analysis should be referred to and used, including the approved forms for Root Cause Analysis outlined in the policy.

j. Monitoring of Interventions for Sustained Improvement

1. The internal review process will help to monitor the check portion of PDCA cycle.
2. The internal review process policy 155.009 shall be utilized to monitor interventions in connection with the 155.002 Performance Improvement measure Selection Criteria policy.
3. The Quality Department and departmental staff involved in the measure will decide how to monitor ongoing goals, the frequency of follow-up of measures as needed or indicated. Once the data is statistically consistent and there is a reasonable assurance that the process is consistent, frequency may decrease to a 3, 6, 9, months and/ or yearly measurement.

VII. Communication

The Board of Directors, CEO, Executive Leadership Team, Department Managers and Directors, and Medical Staff leaders regularly communicate with each other on issues of patient safety and quality.

a. Committees and Reporting Procedure

1. The Quality and Patient Safety Committee (QPS (Quality and Patient Safety) (Quality and Patient Safety)) is a subcommittee of the Board of Directors By-Laws.
2. The Quality and Patient Safety Committee (QPS) has several subcommittees that report data, information, and projects to the Quality and Patient Safety Committee (QPS), and then to the Board of Directors.
3. Committees are as follow:
    1. Clinic Quality Committee
    2. Coding, & Documentation Tracking Committee
    3. Data Submission Committee
    4. DNV/CAH monthly regulatory outreach.
    5. EMR & CPSI Committee
    6. Grievance and Patient Events Committee
    7. Infection Control Committee
        a. COVID Committee
    8. NRC (Patient Satisfaction and Survey Committee)
    9. Patient Safety Falls Committee
    10. Patient Safety Restraints and Seclusion Committee

11. Pharmacy and Therapeutics in connection with Infection Control
12. Policy Committee
13. Safety Committee
    a. Emergency Preparedness
    b. Workplace Violence
14. Utilization Review Committee

b. Minutes & Follow-up

1. All minutes of meetings are maintained as defined in the Record Retention policy. (Policy #) Cumulative quality improvement activity reports are maintained for three years either in their original form, or electronically stored.
2. Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with Hospital Policy, State, and Federal Regulations governing the confidentiality of quality improvement work documents (Policy #)
3. Follow-up of action items will be discussed every month until resolved at the Quality and Patient Safety Committee.

VIII. Evaluation

a. Assessment of Quality Management System

1. The effectiveness of the Quality Assurance and Performance Improvement Program is evaluated annually and revised as necessary by Quality and Risk Manager. Any changes or revisions are presented first to the Executive Leadership, CEO, then the Board of Directors for approval.
2. The Center for Medicare & Medicaid Services Hospital QAPI worksheet will be used as a guide for the evaluation process.

b. Purpose of Evaluation

1. Evaluation of the QAPI program will help SCHHC to determine if a hospital's Quality Assessment and Performance Improvement (QAPI) program meets Medicare Conditions of Participation.

IX. Establishment of Plan

a. Time Frame

1. The Quality Assurance and Performance Improvement Plan (QAPI) will be evaluated and reviewed annually.
2. The evaluation of the plan shall begin three months prior to the last effective date of the QAPI.

b. QAPI Addendum Revisions

1. Addendums/revisions may be presented to the Quality and Patient Safety Committee and the Board of Directors for approval.
2. Updating the QAPI should be completed the month before the last effective date.
3. The QAPI should be presented to the Board of Directors by the month of the last effective date.

X. Appendix A

Cause that led to the nonconformity in restraints:

A. There has not been a comprehensive Quality Management System in place yet that operates with a continuous improvement lifecycle for non-conformities including patient rights/restraints. The data reported monthly and quarterly showed that the goals were not being met for restraints. However, there has not been a process (nor tools) to conduct formal analyses, such as failure modes and effects analyses, root cause analyses, and documented corrective action plans for continuous learning and improvement.

B. If there had been a failure modes and effects analyses for restraints, the Restraint and Seclusion Committee might have anticipated that there is inadequate ongoing restraint training for licensed independent practitioners as well as nursing staff members in the Emergency Department because of ongoing staffing changes. In this specific case, our hospital's providers were not using the pre-established order sets for restraints. In addition, our Electronic Health Record (Evident/CPSI) is not user friendly, so if a provider has never used this order set before, they might have a difficult time finding the order set in the system.

Organization Corrective Action Plan (CAP):

A. The Quality Assurance and Performance Improvement Plan (QAPI) will be revised to add restraints as a project for FY 2023 (ending June 2024). The QAPI will define roles and responsibilities for the Restraint and Seclusion committee members, forms and expectations for objectives, processes, and documentation. The QAPI revisions will be drafted with the QAPI committee members and presented for edits/approval to the September 2023 Medical Staff Meeting, Quality and Patient Safety Committee meeting, and Board Meeting. The monthly Quality dashboard will continue to illuminate restraint data which will be presented monthly at both the Quality and Patient Safety Committee meeting and monthly executive meeting of the Board of Directors. The data regarding restraint policy, education, and processes will have continuous analysis so that appropriate optimization of specific failing areas can be identified, elevated for action, and mitigated.

B. Information was provided to medical staff in attendance at the Medical Staff Committee meeting on 8/8/2023 regarding the use of order sets within the electronic health record. This information included a conversation outlining all of the required provider orders for restraint. A "quick sheet" for providers to have quick information regarding how to enter pre-established electronic restraint order sets will be developed in time to be presented to the September 12, 2023 Medical Staff Committee meeting.

A second option is being developed "on paper" for new doctors who are not able to navigate the electronic health record. This "on-paper" restraint/seclusion order set will be created and approved by medical staff for use as a secondary option for restraint orders in the event that entry directly into the electronic health record cannot be completed. This order set will be presented to the medical staff for approval September 12, 2023.

The restraint/seclusion face-to-face documentation sheet shall be updated by September 14, 2023 to include a notation at the top of the form that it is for Violent and/or Self-destructive patients.

The Restraint and Seclusion Committee will continue to meet monthly to review incidents of restraint use to identify non-conformities and implement a correction and monitoring plan. Next committee meeting scheduled for September 14, 2023.

Staff Training/Education Plan:

A Quality Essentials Toolkit training (Institute for Healthcare Improvement) is scheduled for September 7th, 2023 for all members of the Restraint and Seclusion Committee. This allows the members to actively learn and practice their restraint data analysis skills before the 9/14/23 Restraint and Seclusion meeting.

By 08/31/2023:

- An e-mail communication will be drafted and provided to all licensed independent practitioners who work in the emergency department, surgical department, and medical-surgical department to be provided that includes the restraint and seclusion policy, specific details regarding order requirements and instructions on how to utilize the order sets within the electronic medical record.
- A quick reference guide will be posted at each licensed independent practitioner's work station in the emergency department, sleep room, hospitalist office, and surgical manager office that outlines restraint/seclusion order requirements and how to access orders sets within the electronic medical record.

All nurses and licensed independent practitioners who work in the emergency department, surgical department, and medical-surgical departments will receive an email communication regarding the implementation of a paper restraint and seclusion order set once approved by the Medical Staff on 9/12/23.

All nurses will receive competency-based training regarding the entry of written orders into the electronic medical record by 9/12/23.

Person and/or Function responsible for implementation of Corrective Action Plan:	
Cori Valet, Chief Nursing Officer PJ Keizer, MD, Medical Chief of Staff	
Date for implementation of Corrective Action Plan:	
Date(s) CAP will begin	Corrective action plan initiated 07/26/2023 after non-conformity identified by SCHHC Restraint and Seclusion Committee on 7/11/2023.
Date(s) and actions taken since survey end date, prior to CAP submission	August 17, 2023 Restraint and Seclusion Committee members met to discuss non-conformities related to restraint order requirements. An analysis of failures was performed, and a plan of correction was created that included updating the face-to-face documentation form, creation of new paper restraint order forms, a new quick reference for providers to assist with electronic order entry, and training for staff and providers. August 21, 2023 a meeting occurred with members of the Restraint and Seclusion Committee as well as Quality oversight to discuss and develop a method of ongoing monitoring to include Quality oversight. August 21, 2023 paper restraint and seclusion order sets were created. August 22, 2023 the paper restraint and seclusion order sets were emailed to the Medical Staff Coordinator for inclusion on the Medical Staff Agenda as an action item for the September 12, 2023, meeting. August 22, 2023 the quick reference guides were laminated and posted at each provider workstation in units who may initiate restraint or seclusion. August 22, 2023 Email communication sent to all Emergency Department providers, Hospitalists, Surgical and Anesthesia providers, Respiratory Therapists, and Nursing Staff members of Restraint Order Requirements and available order sets for use within the electronic medical record.
Date(s) of Projected Completion / Compliance with the Standard Requirements	September 29th, 2023.
Organization method for follow-up:	
Method for monitoring or follow-up	Chart review by the CNO for 100% of incidents. The Chair of the Restraint and Seclusion committee will provide a

	written report monthly to the Quality oversight committee that includes: documentation of the process including incidents, quality improvement tools, and plan of action and resolution.
Frequency of monitoring	Each incident: Chief Nursing Officer (CNO) reviews each incident once it is immediately possible to review. The CNO checks the restraint incident against the restraint policies and procedures. Weekly: Restraints will be reviewed and evaluated in the Clarity (incident reporting) and Grievance Committee by the CNO, CEO, and Quality Office personnel within one week of the incident. Monthly: Restraint and Seclusion Committee meeting and review. Data from the restraint will be entered into the Quality Dashboard for review by the Quality and Patient Safety Committee along with the Board of Directors. Annually: QAPI objective (restraint) will be reviewed to evaluate whether the objective was met, and to evaluate the process for effectiveness.
Measures of effectiveness	Chart review demonstrates that 100% of charts reviewed are compliant with restraint policies and procedures.
Evidence of sustained compliance	100% sustained compliance for 12 months. Each month that drops below 100% will have a Root Cause Analysis and Corrective Action Plan (PDCA) completed and reported to the Quality oversight committee for review and recommendation.

XI. Appendix B

Cause that led to the nonconformity in Life Safety:

Finding #1: The policy and the permit process did not include a requirement for input from the Infection Control RN. NFPA standards are not correlated with the project management tasks in the Limble project management system, so there is not a "turnkey" method to ensure compliance with the NFPA standards.

Finding #2: There was not an effective process for scheduling or monitoring night shift fire drills. Monitoring processes are not fully in place and there was not an evaluation of effectiveness. There has not been a comprehensive Quality Management System in place yet that operates with a continuous improvement of the lifecycle for non-conformities including fire drills. The data reported quarterly showed that the goals were not being met for fire drills. However, there has not been a process (nor tools) to conduct formal analyses, such as failure modes and effects analyses, root cause analyses, and documented corrective action plans for continuous learning and improvement.

Finding #3: While installing a new project management system (Limble), the NFPA elements were not correlated in Limble with the project management items. In this case, it resulted in the kitchen Ansul fire sprinkler missing some of the required NFPA elements in the project management system. Limble was not fully utilized to its potential to become a repository for all of the requisite information.

Finding #4: While installing a new project management system, the NFPA elements were not correlated in Limble with the project management items. Limble was not fully utilized to its potential to become a repository for all of the requisite information. In this case, it resulted in the fire doors missing some of the required NFPA elements in the project management system.

Organization Corrective Action Plan (CAP):

Finding #1:

Containment: Added section for input from Infection Control Officer in existing Barrier Protection Plan Policy.

Containment Completion Date: Policy Updated 8/10/23 and sent to Policy Committee and approved on 8/22/23.

Corrective Action

(Process / System Changes):

The NFPA standards will be reviewed against policies to ensure standards are met on an annual basis. This will occur during the first two weeks of January each calendar year beginning in 2024.

Other Areas Affected: Hospital Wide-Fire barriers in all locations need to be reviewed before penetration.

Infection Prevention input required.

Finding #2:

Containment: Fire drill added to schedule to be completed for Third Quarter in October 2023 for both shifts. Fire drills are now scheduled for the 2nd Wednesday of the first quarter of each month, except for the third quarter. For the third quarter, the fire drills for both day and night shift are scheduled for Sept 13th, 2023. The following fire drills for day and night shift are scheduled for October 11, 2023, and January 10, 2024.

The Quality Assurance and Performance Improvement Plan (QAPI) will be revised to add life safety management as a project for FY 2023 (ending June 2024). The QAPI will define roles and responsibilities for individuals, forms and expectations for objectives, processes, and documentation. The QAPI revisions will be drafted with the QAPI committee members and presented for edits/approval to the September 2023 Medical Staff Meeting, Quality and Patient Safety Committee meeting, and Board Meeting. The quarterly Quality dashboard will continue to illuminate life safety data which will be presented quarterly at both the Quality and Patient Safety Committee meeting and monthly executive meeting of the Board of Directors. The data regarding life safety policy, education, and processes will have continuous analysis so that appropriate optimization of specific failing areas can be identified, elevated for action, and mitigated.

Containment Completion Date: 9/13/24

Corrective Action

(Process / System Changes): Quarterly 2nd Shift Fire drills will be run by the Plant Operations Manager or the assigned on-call engineering staff. Routine (quarterly) internal audit of completion and report of any findings to both the Safety Committee and the Quality and Patient Safety Committees.

Annual evaluation of NFPA life safety codes have been reviewed verified on August 22nd, 2023, by the Plant Operations Manager and these will be reviewed annually and correlated with policies and procedures each January to ensure all standards are met.

Finding #3:

Containment: Conducted inspection of the kitchen Ansul fire sprinkler system to complete NFPA 17A Code.

Containment Completion Date: 8/4/23

Corrective Action

(Process / System Changes): Added complete points of inspection to Maintenance Program. (Limble)

Implement a routine (monthly) internal audit of completion of all inspections and report of any findings to Safety Committee monthly. Additionally, the Safety Committee finding will be reported to Quality and Patient Safety Committee on a quarterly basis. The NFPA codes will be added to the Limble system and reviewed/updated annually (every January) so that the codes are able to be reconciled with the project task/assignment.

Finding #4:

Containment: Conducted full 13-point inspection of Fire Doors according to NFPA 80 standard.

Add full inspection list to Maintenance Program (Limble).

Containment Completion Date: 8/4/23

Corrective Action

(Process / System Changes): Added complete points of inspection to Maintenance Program (Limble). Adding NFPA standards to this inspection in the maintenance program (Limble) by 9/1/23.

There will be an annual internal audit of completion, and a report of any findings to the Safety committee in the month subsequent to the annual inspection. Additionally, any Safety Committee findings will be reported to the Quality and Patient Safety Committee on a quarterly basis. An annual evaluation of NFPA life safety codes will occur each January to ensure all standards are up to date in the Limble system.

Staff Training/Education Plan:

Finding #1: Staff training on proper use of Barrier Protection Policy and how to receive permits will occur by 9/1/23

With IT, Infection Control, Engineering, and all of these employees will receive a review of policy / requirements for any barrier penetration.

Finding #2: All members of the engineering staff will have training regarding NFPA Code to support Fire Drill requirements. The training program for engineering staff to perform drills will occur by 9/8/23

All Staff trained on fire drill procedures annually.

Finding #3: All members of the engineering staff will have training regarding how to find the NFPA Codes in the Limble system associated with the inspection work. The training program for engineering staff to locate NFPA Codes while performing inspections along with where/how to document inspections completed and frequency requirements will occur by 9/8/23.

Finding #4: All members of the engineering staff will have training regarding how to find the NFPA Codes in the Limble system associated with the inspection work. The training program for engineering staff to locate NFPA Codes while performing inspections along with where/how to document inspections completed and frequency requirements will occur by 9/8/23.

Person and/or Function responsible for implementation of Corrective Action Plan:	
Jason Cook, CHFM, Plant Operations Manager/Safety Officer.	
Date for implementation of Corrective Action Plan:	
Date(s) CAP will begin	**Finding #1: The** policy was updated 8/10/23 and sent to the Policy Committee and was approved on 8/22/23. **Finding #2: 8**/2/23 2nd Shift(night) Fire Drill was added to the Plant Operations Manager schedule for in-person training quarterly. **Finding #3: 8**/2/23, full inspection added to maintenance program. **Finding #4: 8**/2/23, full inspection added to maintenance program.
Date(s) and actions taken since survey end date, prior to CAP submission	**Finding #1:** 8/22/23, Added to Policy Committee Agenda for approval. **Finding #2:** 8/2/23 Fire Drill (day and night shift) added to calendar for 3rd quarter 2023. **Finding #3:** 8/4/23 Conducted full inspection to NFPA standard **Finding #4:** 8/4/23 Conducted full inspection to NFPA standard
Date(s) of Projected Completion / Compliance with the Standard Requirements	**Finding #1:** 8/22/23 **Finding #2:** 9/13/23 **Finding #3:** 9/8/23 **Finding #4**: 9/8/23
Organization method for follow-up:	
Method for monitoring or follow-up	**Finding #1**: Policy implemented and loaded into the MCN policy management program and will flag users for this policy to have annual review in the hospital's Policy Committee. **Finding #2:** Documentation of Fire Drill Sign in Sheet. After Action Performance Evaluation Sheet for each fire drill for each shift. **Finding #3:** Completion of fully up to date NFPA code checklist and PM (Preventative Maintenance) schedule to ensure that Limble checklist is properly correlated with NFPA standards. This will take place in January each year. **Finding #4:** Completion of fully up to date NFPA code checklist and PM schedule to ensure that Limble checklist is properly correlated with NFPA standards. This will take place in January each year.

Frequency of monitoring	**Finding #1:** Annually **Finding #2:** Quarterly. Routine (monthly) internal audit of completion and report of any findings to Safety Committee monthly. Additionally, the Safety Committee findings will be reported Quality and Patient Safety Committee on a quarterly basis. **Finding #3:** Annually. **Finding #4:** Annually.
Measures of effectiveness	**Finding #1:** 100% of the time, permits will show that there was input from the Infection Control RN. **Finding #2**: 100% of the time there will be fire drill documentation that indicates fire drills occurred on the day and night shift each quarter. Documentation will include Fire Drill Sign in Sheet and After-Action Performance Evaluation Sheet. **Finding #3:** 100% of the time the NFPA codes will be aligned with the work orders for timely and complete inspections; and the Limble system will show that the inspection was actually done according to those requirements. **Finding #**4: 100% of the time the NFPA codes will be aligned with the work orders for timely and complete inspections; and the Limble system will show that the inspection was actually done according to those requirements.
Evidence of sustained compliance	**Finding #1: Approved** permits will show evidence of infection control input and will be in place for any work penetrating barrier will be reviewed by the Safety Committee and Quality and Patient Safety Committee each quarter. Annual audit of NFPA codes for changes in code and/or environment will be completed to a goal of 100%. **Finding #2:** Documentation of Fire Drill Sign in Sheet and After-Action Performance Evaluation Sheet will be reviewed by Safety Committee quarterly and Quality and Patient Safety Committee quarterly. **Finding #3:** Checklist for the annual audit of NFPA codes for changes in code and/or environment will be reviewed in the first quarter by the Safety Committee and the Quality and Patient Safety Committee. Documentation of monthly checks completed and stored in the Maintenance Program will be reviewed in these committee meetings also. **Finding #4:** Checklist for annual audit of NFPA codes for changes in code and/or environment will be reviewed in the first quarter by the Safety Committee and the Quality and Patient Safety Committee. Documentation of monthly checks completed and stored in the Maintenance Program will be reviewed in these committee meetings also.

XII. Appendix C

Cause that led to the Emergency Management System nonconformity:

Finding #1: There has not been a comprehensive Quality Management System in place yet that operates with a continuous improvement lifecycle for non-conformities including when a plan such as an Emergency Management Plan is incomplete or lacking. The data reported quarterly showed that the goals were not being met for having this plan in place. However, there has not been a process (nor tools) to conduct formal analyses, such as failure modes and effects analyses, root cause analyses, and documented corrective action plans for continuous learning and improvement.
In this case, the Emergency Preparedness Committee is not fully developed and, and there has not been a focus on mitigation activities for physical environment/life safety 96-hour mitigation planning.

Finding #2: There hasn't been a process in place to put analyses and plans in place for the first time or for review for the physical environment. In this case, the hazardous vulnerable analysis (HVA) was not re-visited on an annual basis. This is a consequence of an Emergency Preparedness Committee that does not yet function optimally.

Organization Corrective Action Plan (CAP):

Finding #1:
Containment: A complete 96hr Sustainability shortfall Assessment will be done. The Quality Assurance and Performance Improvement Plan (QAPI) will be revised to add the Emergency Management Systems as a project for continuous improvement and refinement for FY 2023 (ending June 2024). The QAPI will define roles and responsibilities for individuals, forms and expectations for objectives, processes, and documentation. The QAPI revisions will be drafted with the QAPI committee members and presented for edits/approval to the September 2023 Medical Staff Meeting, Quality and Patient Safety Committee meeting, and Board Meeting. The quarterly Quality dashboard will continue to illuminate data which will be presented quarterly at both the Quality and Patient Safety Committee meeting and monthly executive meeting of the Board of Directors. The data regarding Emergency Management Systems education, and processes will have continuous analysis so that appropriate optimization of specific failing areas can be identified, elevated for action, and mitigated.

Containment Completion Date: 9/29/23
A meeting was held on 8/23/23 with the Emergency Preparedness Committee to update expectations and activities moving forward. During this meeting, a new form was implemented, and the assessment was completed (with documented conclusions) for the 96-hour sustainability evaluation and plan. The Emergency Preparedness Committee reviewed and approved the plan.

Corrective Action
(Process / System Changes):
A more effective Emergency Preparedness Committee will launch on 9/12/23. This committee is responsible for the development, implementation and maintenance of the emergency plan, emergency response procedures and related training in a building or facility. The key aspects of an effective Emergency Preparedness Committee will include a) buy-in from entire Executive leadership; b) a work plan for the year, including a comprehensive emergency preparedness plan that addresses the mitigation activities that are illuminated in a 96-hour sustainability shortfall report. The Committee will have an agenda, minutes, delegated task, action items, and methods for follow-up and escalation.

An annual evaluation of the 96-hour sustainability report/NFPA life safety standards will take place in September each year. This annual evaluation will be added to the maintenance program (Limble) and to the policy management program (MCN). Both programs have scheduling flags that alert the policy owner that annual reviews are due.

The Emergency Preparedness Committee will create an emergency mitigation plan for high risk "red" hazards identified in

the HVA (Hazard Vulnerability Assessment). Routine monitoring of mitigation plan (based on NFPA standards and/or internal standards) will be completed and documented in Limble and be part of the work plan for both the Emergency Preparedness Committee. Additionally, annual review of HVA will be completed with resulting changes in risk profile that will inform updates to the 96hr Sustainability shortfall Assessment.

Finding #2:

Containment: A complete HVA report for 2023 will be done. The Quality Assurance and Performance Improvement Plan (QAPI) will be revised to add the Emergency Management Systems as a project for continuous improvement and refinement for FY 2023 (ending June 2024). The QAPI will define roles and responsibilities for individuals, forms and expectations for objectives, processes, and documentation. The QAPI revisions will be drafted with the QAPI committee members and presented for edits/approval to the September 2023 Medical Staff Meeting, Quality and Patient Safety Committee meeting, and Board Meeting. The quarterly Quality dashboard will continue to illuminate data which will be presented quarterly at both the Quality and Patient Safety Committee meeting and monthly executive meeting of the Board of Directors. The data regarding Emergency Management Systems education, and processes will have continuous analysis so that appropriate optimization of specific failing areas can be identified, elevated for action, and mitigated.

Containment Completion Date: 9/29/23

A meeting was held on 8/23/23 with the Emergency Preparedness Committee to update expectations and activities moving forward.

Corrective Action
(Process / System Changes):

A more effective Emergency Preparedness Committee will launch on 9/12/23. This committee is responsible for the development, implementation and maintenance of the emergency plan, emergency response procedures and related training in a building or facility. The key aspects of an effective Emergency Preparedness Committee will include a) buy-in from entire Executive leadership; b) a work plan for the year, including a comprehensive emergency preparedness plan that addresses the mitigation activities that are illuminated in a 96-hour sustainability shortfall report. The Committee will have an agenda, minutes, delegated task, action items, and methods for follow-up and escalation.

An annual evaluation of the Hazard Vulnerability Assessment HVA will take place in September each year. This annual evaluation will be added to the maintenance program (Limble) and to the policy management program (MCN). Both programs have scheduling flags that alert the policy owner that annual reviews are due.

The Emergency Preparedness Committee will create an emergency mitigation plan for high risk "red" hazards identified in the HVA (Hazard Vulnerability Assessment). Routine monitoring of mitigation plan (based on NFPA standards and/or internal standards) will be completed and documented in Limble and be part of the work plan for both the Emergency Preparedness Committee. Additionally, an annual review of the HVA will be completed with resulting changes in risk profile that will inform updates to the Assessment.

Staff Training/Education Plan:

Finding #1: The Plant Operations Manager will be trained in completing assessments, non-conforming documentation, and effective planning before 9/12/23. The Emergency Preparedness Committee members will complete training by 9/12/23 so that the committee can be more effective in their work. There will be annual training updates for committee members.

Finding #2: The Plant Operations Manager will be trained in completing assessments, non-conforming documentation, and effective planning before 9/12/23. The Emergency Preparedness Committee members will complete training by 9/12/23 so that the committee can be more effective in their work. There will be annual training updates for committee members.

Person and/or Function responsible for implementation of Corrective Action Plan:

Jason Cook, CHFM, Plant Operations Manager/Safety Officer

Emergency Preparedness Committee members	
Date for implementation of Corrective Action Plan:	
Date(s) CAP will begin *Include the date(s) the organization began discussion and plans for action, typically within days of the survey end date or receipt of the report.*	**Finding #1**: 8/23/23 Meeting with Emergency Preparedness Committee occurred. **Finding #2**: 8/23/23 Meeting with Emergency Preparedness Committee occurred.
Date(s) and actions taken since survey end date, prior to CAP submission *If these dates <u>and</u> actions are included in the sections above, reply with "see above."*	**Finding #1**: "see above" **Finding #2**: "see above"
Date(s) of Projected Completion / Compliance with the Standard Requirements *These dates should be within 60 calendar days of survey end date** *For submission dates outside the 60 days, the response must detail interim actions taken, including staff communication, within the 60 days post survey.*	**Finding #1**: September 29th, 2023. **Finding #2**: September 29th, 2023.
Organization method for follow-up:	
Method for monitoring or follow-up *Select a method for monitoring effectiveness* *Example: Chart review, internal audits, etc.*	**Finding #1**: The hospital 96-hour sustainability shortfall report including mitigation activities will now be part of the 2023 -24 Quality Assurance and Performance Improvement (QAPI) plan which will be reviewed quarterly (November 2023) in the Quality and Patient Safety meetings. This 96-hour sustainability shortfall report will be reviewed specifically for mitigation activities, and this will be reported to the Board of Directors quarterly also. **Finding #2**: The Hazard Vulnerability Assessment will be added to the QAPI and will be reviewed quarterly in the Quality and Patient Safety meetings (November 2023). This Hazard Vulnerability Assessment will be reported to the Board of Directors quarterly.
Frequency of monitoring	**Finding #1**: Quarterly **Finding #2**: Quarterly
Measures of effectiveness	**Finding #1**: 100% of the 96hr Sustainability Shortfall Assessment items will have mitigation plans accompanying those items. **Finding #2**: The Hazard Vulnerability Assessment will be complete with 100% of high-risk hazards having a mitigation plan.
Evidence of sustained compliance	**Finding #1**: Documentation of Committee agendas, minutes, action plans, mitigation plans for shortfalls, will be stored in an orderly manner in the hospital drive. Emergency Preparedness, Quality and Patient Safety, and Board of Directors minutes will demonstrate that 100% of the 96hr Shortfall Assessment has been reviewed and has corresponding

	mitigation plans. **Finding #2**: Documentation of Committee agendas, minutes, action plans, mitigation plans for shortfalls, will be stored in an orderly manner in the hospital drive. Emergency Preparedness, Quality and Patient Safety and Board of Directors minutes will demonstrate that the Hazard Vulnerability Assessment has been reviewed and that 100% of the high-risk hazards have corresponding mitigation plans.

XIII. Appendix D

Cause that led to the Medical Equipment Management System nonconformity:

The Medical Equipment Management System is not fully in place. There has not been a Hospital Wide Policy nor a process for identifying / isolating / addressing equipment related to serious injury, illness, or death. Additionally, there has not been a process for continuous review of an incident reporting policy and process to ensure that it is effective. With every asset loaded in Limble (maintenance program), our activities in the maintenance program (Limble) have not been connected to policies and processes including code, policy, project management process, documentation, auditing and reviewing for effectiveness, or corrective action plans, as necessary.

Organization Corrective Action Plan (CAP):

The Quality Assurance and Performance Improvement Plan (QAPI) will be revised to add the Medical Equipment Management Systems as a project for continuous improvement and refinement for FY 2023 (ending June 2024). The QAPI will define roles and responsibilities for individuals, forms and expectations for objectives, processes, and documentation. The QAPI revisions will be drafted with the QAPI committee members and presented for edits/approval to the September 2023 Medical Staff Meeting, Quality and Patient Safety Committee meeting, and Board Meeting. The quarterly Quality dashboard will continue to illuminate data which will be presented quarterly at both the Quality and Patient Safety Committee meeting and monthly executive meeting of the Board of Directors. The data regarding Medical Equipment Management Systems education, and processes will have continuous analysis so that appropriate optimization of specific failing areas can be identified, elevated for action, and mitigated.

Containment:

Develop policy / process to identify / isolate medical equipment related to serious injury, illness, or death.

Completion of correct policy created was approved by the Policy Committee on 8/10/23. This policy is in compliance with the Safety Medical Devices Act.

Communication of the standard was sent to all Managers on 8/25/23.

Containment Completion Date: 9/29/23

Corrective Action
(Process / System Changes):

This policy will be uploaded to the MCN policy management program and HR Relias Training Program once all policy approvals have been finalized (9/29/23).

The Materials Management Manager will be the lead for knowledge and action regarding medical device failure reporting.

The Quality Assurance and Performance Improvement Plan (QAPI) will be revised to add the Medical Equipment Management Systems as a project for continuous improvement and refinement for FY 2023 (ending June 2024). The QAPI will define roles and responsibilities for individuals, forms and expectations for objectives, processes, and documentation. The QAPI revisions will be drafted with the QAPI committee members and presented for edits/approval to the September 2023 Medical Staff Meeting, Quality and Patient Safety Committee meeting, and Board Meeting. The quarterly Quality dashboard will continue to illuminate data which will be presented quarterly at both the Quality and Patient Safety Committee meeting and monthly executive meeting of the Board of Directors. The data regarding education, and processes will have continuous analysis so that appropriate optimization of specific failing areas can be identified, elevated for action, and mitigated.

Other Areas affected: Hospital Wide

Staff Training/Education Plan:

Training will be necessary hospital-wide:
Required Relias training (Relias is our hospital's HR based employee training system) on new policy relating to how equipment is to be identified / segregated when related to serious injury, illness, or death. All contract and employed service providers and per diem staff will be required to take this training by 9/29/23.

The Materials Management Manager will be the process lead and will train all managers by 9/29/23 regarding the new process, so that managers can support their employees in following the new policy and procedures.

Person and/or Function responsible for implementation of Corrective Action Plan:

Jonathan Yamasaki, Materials Management Manager
Jason Cook, CHFM, Plant Operations Manager/Safety Officer.

Date for implementation of Corrective Action Plan:–

Date(s) CAP will begin	The new medical equipment management policy was sent for approval to the Policy Committee on 8/10/23 and was approved during the 8/22/23 meeting. The Quality Assurance and Performance Improvement (QAPI) revisions will be drafted with the QAPI committee members and presented for edits/approval to the September 2023 Medical Staff Meeting (9/12/23), Quality and Patient Safety Committee meeting (9/19/23), and Board of Directors Meeting 9/28/23).
Date(s) and actions taken since survey end date, prior to CAP submission	"See above"
Date(s) of Projected Completion / Compliance with the Standard Requirements	9/29/23
Organization method for follow-up:	
Method for monitoring or follow-up	• Review of Relias training to ensure that training of all employees has been done. • Incidents will be reviewed to look for an increase in internal incident reporting for medical equipment through the newly established process. The Quality office will review and report all incidents for medical equipment reporting to the Quality and Patient Safety Committee. Process fidelity data will be retained also.

	• Review in quarterly Quality and Patient Safety meetings to look for training data, incident data, process data, and trends. • Variances will be elevated for additional corrective action planning.
Frequency of monitoring	Instantaneous – Relias training system will alert managers when employees fail to complete training on time. Monthly – Quality office review Quarterly – Safety Committee review of equipment failures. Quality and Patient Safety, and Board of Directors review of equipment failures.
Measures of effectiveness	100% of medical equipment failures will be reported and managed according to the hospital's established policies and procedures with input from the Materials Management Manager.
Evidence of sustained compliance	Quality data will demonstrate compliance and evaluations of the data will be present in the meeting minutes for the Safety Committee, Quality and Patient Safety Committee, and the Board of Directors.

XIV. Appendix E

Cause that led to the nonconformity:

Practitioner specific performance data collection has not been part of medical staff self-governance at Southern Coos Hospital and Health Center (SCHHC) historically, and consequently data on each provider has not been consistently collected. Additionally, data analytics in the hospital's electronic health record (EHR) is cumbersome, and so clinical data collection is very time consuming. Although SCHHC has begun to collect practitioner specific performance data, SCHHC has not yet created a comprehensive process or policy to guide data collection and review.

Organization Corrective Action Plan (CAP):

A policy and process will be put in place so that provider performance data will accompany every re-privileging application that goes for consideration to the Medical Staff and the Board of Directors.

Actions Taken:

May 9, 2023 - The RN (Registered Nurse) Quality Coordinator presented information to the Medical Staff regarding provider performance data collection and measurement. This was presented and adopted by the Medical Staff during the May 2023 Medical Staff Meeting.

May 10, 2023 - The SCHHC Quality Department created a spread sheet for each provider to track data collection for MS.10 (SR1) / (SR.1a)/ (SR.1b) / (SR.1c)/(SR.1d) / (SR.1d(1) / (SR.1d(2)/ (SR.1d(3)/(SR.1d(4))/ (SR.1d(5)/(SR.1d(6)/ SR.1d(7) / (SR.1d(7)(i) / (SR.1d(7)(ii)/(SR.1d(8)/ (SR.1d(9)/(SR.1d(10))/ (SR.1d(11)/(SR.1d(12)/ (SR.2).

May 25, 2023 – The Quality Department added Data on Blood Use to the spread sheets.

June 21, 2023 – A meeting took place with the IT department, Quality department, and the CEO to move forward with extracting data.

June 28, 2023 - Data extraction training was given to those staff who planned to assist with data extraction.

July 10, 2023 – The Quality and Risk Manager reached out to an outside vendor, Medi Solv, for assistance with data analytics.

June 13, 2023 -- The Quality Department added length of stay data, and readmissions data to spread sheets.

August 16, 2023 – The CEO and Executive Team met to assess the Quality Department Resources regarding data extraction.

August 17, 2023; Medical Staff Services evaluated the types of spread sheets needed for all providers.

August 17, 2023; Data extractor vendor, proposal received and will be considered over the next few weeks.

August 22, 2023; Created Microsoft Teams data channel per provider, and an Excel spreadsheet for tracking the data. Providers will be able to see their individual data on this site.

A policy will be created to provide guidance regarding provider performance data (process, criteria, and frequency for evaluating the clinical performance of providers with clinical privileges) and will be recommended for approval at the Policy Committee (September 19th, 2023), Medical Staff Committee (October 10th, 2023) and the Board of Directors (October 23rd, 2023).

By October 1st, 2023, a quality profile will be developed for each provider to be used for evaluation as a part of the appointment and reappointment process. This will be made available to providers in advance of the October 2023 Medical Staff Committee.

Starting November 7th, and continuing on the seventh of each month, performance data will be collected on each active working provider. The Quality office will ensure that this performance data is available to each provider by the third Monday of each month.

At time of reappointment, reappraisal and renewal of privileges, the provider performance data will be sent to the Medical Staff Executive Committee and made available also for Board of Directors review.

Other Areas Affected:

Medical Staff Services will bring data forward for reappointment, reappraisal, and renewal of privileges.
The Board of Directors will be provided with data to review for each reappointment, reappraisal, and renewal of privileges.
The Executive Team and hospital staff will ensure adequate resources will be devoted to the gathering of data.
HR and Employee Health will be required to share relevant data.
Utilization Review and Case management will be asked to send reports to the Quality office.
Laboratory be asked to send reports on blood use and ordering of labs.
The OR will be providing data on surgical patients.
HIM (Health Information Management) will be providing timely medical record data.
Anesthesia provides quality form to Quality each month for every surgery.
Risk and Compliance will be providing data from the patient event electronic system.
In short, every department will be affected to provide data for providers.

Staff Training/Education Plan:

Every department is expected to provide data to the Quality department, so training with each affected department will occur on an individual basis prior to November 1st, 2023.
Staff who submit data may need training on Excel spreadsheets and how to extract data from the electronic health record, and the process for submitting data to Quality. This will be accomplished by September 29, 2023.
Providers who access their files and data via Microsoft TEAMS will be provided educational tools by November 1st, 2023.

Person and/or Function responsible for implementation of Corrective Action Plan:

Raymond Hino, CEO
Philip J. Keizer, MD, Chief of Medical Staff
Michele Winchell, Medical Staff Services Coordinator
Sharon Bischoff RN, Quality Coordinator

Date for implementation of Corrective Action Plan:-

Date(s) CAP will begin *Include the date(s) the organization began discussion and plans for action, typically within days of the survey end date or receipt of the report.*	May 9, 2023, Discussion began in Medical Staff Meeting. See dates above. Provider performance data was introduced to the medical staff in this meeting (evident in the May 9th Minutes).
Date(s) and actions taken since survey end date, prior to CAP submission *If these dates and actions are included in the sections above, reply with "see above."*	August 16, 2023, Executive Team met to assess Quality Department Resources. August 17, 2023; Medical Staff Services evaluated spreadsheets needed for all providers. August 17, 2023; Data extractor vendor, proposal received and will be considered over the next few weeks.
Date(s) of Projected Completion / Compliance with the Standard Requirements *These dates should be within 60 calendar days of survey end date** *For submission dates outside the 60 days, the response must detail interim actions taken, including staff communication, within the 60 days post survey.*	The process is projected to be compliant with the standard by November 7, 2023. This is because of all of the policy approvals needed from the Policy Committee, Medical Staff, and Board of Directors as well as the development of practitioner specific quality performance data measures and national data benchmarks.

Organization method for follow-up:

Method for monitoring or follow-up *Select a method for monitoring effectiveness*	Each provider will have a spreadsheet (performance data tickler) managed by the Medical Staff Services Coordinator and this spreadsheet will have the dates when the performance data was sent to the Medical

Example: Chart review, internal audits, etc.	Staff Committee and the Board of Director.
Frequency of monitoring *Select a defined frequency to monitor effectiveness* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	The spreadsheet will be reviewed monthly by the Quality department to ensure that data is made available to the Medical Staff Executive Committee and the Board of Directors.
Measures of effectiveness *Select a measure/metric that measures effectiveness* *Example: Chart review demonstrating 100% of charts reviewed were compliant or no findings of nonconformance during audit.*	100% of reappointment privileges or addition of privileges will have appropriate performance data printed and included with the physical packet that goes to the Credentialing Committee, Medical Staff Executive Committee and Board of Directors.
Evidence of sustained compliance *Select a measure/metric that verifies sustained compliance* *Example: 100% compliance/conformity, including planned actions for any continued nonconformance identified during monitoring.*	Credentialing Committee, Medical Chief of Staff, and Board of Directors Chairman will sign off that they received performance data on the providers that are being considered before them 100% of the time.