



AGENDA
CCMC AUTHORITY BOARD OF DIRECTORS
CCMC CONFERENCE ROOM
June 22, 2017 at 6:00PM
REGULAR MEETING

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

Board of Directors

Kristin Carpenter exp. 3/20
April Horton exp. 3/19
Sally Bennett exp. 3/19
John Harvill exp. 3/18
Dorne Hawxhurst exp. 3/18

CCMC CEO

Scot Mitchell

OPENING

1. Call to Order
2. Roll Call – April Horton, Dorne Hawxhurst, John Harvill, Kristin Carpenter, Sally Bennett
3. Establishment of a Quorum

A. APPROVAL OF AGENDA

B. CONFLICT OF INTEREST

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

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

D. BOARD DEVELOPMENT

1. How to read Financial Statements

E. APPROVAL OF CONSENT CALENDAR

F. APPROVAL OF MINUTES

1. April 25, 2017 Board of Directors Regular Meeting Minutes Amended Pages 1-3
2. May 25, 2017 Board of Directors Regular Meeting Minutes Pages 4-5

G. REPORTS OF OFFICER and ADVISORS

1. CEO Report – Scot Mitchell, CEO Pages 6-8
2. Finance Report – Lee Holter, CFO Pages 9-28
3. Nursing Report - Helen McGaw, Interim CNO Pages 29-32

H. CORRESPONDENCE

1. Letter from David O'Brien owner of Cordova Drug Pages 33-37

I. ACTION ITEMS

1. Quality Improvement – 1st Quarter 2017 Patient Safety Pages 38-74
2. vRad Radiology Contract Page 75

J. DISCUSSION ITEMS

1. Update on Community Health Needs Assessment Pages 76-80

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

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

L. BOARD MEMBERS COMMENTS

M. EXECUTIVE SESSION

1. CEO Evaluation

N. ADJOURNMENT

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

Minutes
CCMC Authority – Board of Directors
CCMC Admin Conference Room
April 25, 2016 at 6:30pm
Regular Meeting

CALL TO ORDER AND ROLL CALL –

Scot Mitchell called the Board Meeting to order at 6:30pm.

Board members present: **April Horton, Dorne Hawxhurst, Sally Bennett and John Harvill.**

A quorum was established. 4 members present; 1 member absent.

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

A. APPROVAL OF AGENDA

M/Harvill S/Bennett “move to approve the agenda.”

4 yeas, 0 nays, 1 absent

Motion passed.

- B. CONFLICT OF INTEREST** ~ Sally Bennett stated that her husband works for the City and on some occasions that work filters over to the hospital. Scot Mitchell expressed that in and of itself he did not feel that that was a conflict.

Kristin Carpenter arrived at 6:35pm

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS

1. **Audience Participation** ~ None
2. **Guest Speaker** ~ None

D. BOARD DEVELOPMENT

1. Hospital Strength Index

Scot Mitchell provided a presentation, the information comes from a data company called iVantage. They look at various components, most of the data comes from cost reports. Most of this data actually comes from the 2015 cost report. The report shows that we are ranked at the 23rd percentile in the country based on our 2015 data. Our Inpatient Market Share shows we are ranked at the 43rd percentile and the Outpatient we're ranked in the 53rd percentile. From the Patient Satisfaction perspective they are saying that our hospital is ranked better than 2/3 of the hospitals in the country. Regarding our costs we are at the 3.8 percentile. Our Charges are in the upper quartile, Financial Stability we've moved up to the 2nd quartile. Our Inpatient and Outpatient Market Share were below the average in Alaska. But we're better off than the average CAH in the rest of the country. HCAPS we are much better than the average Alaska hospital when it comes to Patient Satisfaction and a little bit above the average hospital in the country. Regarding our Cost we barely fell behind the other CAH's in Alaska and that's because the cost of healthcare in Alaska is so much higher than the cost in the lower 48.

Next Meeting for Board Development the topic will be PERS

- E. APPROVAL OF CONSENT CALENDAR** ~ None

F. APPROVAL OF MINUTES

M/Horton S/Hawxhurst “move to approve the March 9, 2017 Regular HSB Meeting Minutes”.

5 yeas, 0 nay, 0 absent

Motion passed.

G. REPORT OF OFFICERS AND ADVISORS

1. **CEO's Report** ~ Scot Mitchell, CEO stated that his written report was in the packet. Congress is back in session talking about the repeal and replace of Obamacare. The plan is that they **1**

will vote on that this week. We have received notice today that our USAC grant (internet and telephone) is being cut by 7.5%. At a future meeting we're going to have to look at how to change our Radiology Department, which is computerized to a digital Radiology system by the end of September this year or we will have reduced reimbursement from Medicare. The cost of this CMS requirement will be approximately \$90,000. CCMC will be fully participating in the upcoming Terrorism Drill.

The Board requested a summary of the surveys and other regulatory events and their cycles that the organization is required to adhere to.

2. Finance Report ~ Lee Holter read a brief statement clarifying information provided at the last board meeting regarding Quality measures. The Financial Reports for February and March were presented. The ADC (Average Daily Census) is 3.8 for this year, most of our increase in income can be attributed to the Swing Bed which is \$564,000 over budget and \$442,000 over the prior year revenue. Deductions, and contractual allowances are up this year. Total Revenue is up \$373,000 over budget. Expenses in Wages and Benefits are below what we budgeted for. Our Professional Services is \$209,000 lower this year compared to last year.
3. Medical Director Report ~ Dr. Blackadar's Medical Director's Report was in the packet, some highlights from his report were that the Admits probably won't get much better than they were last year as we're not sending away a lot of people, we're admitting them. Clinic Visits are up. Dr. Blackadar requested that we increase clinic services by advertising those services better.
4. Nursing Report ~ Helen McGaw, Interim CNO is not able to be here to tonight, her written report is in the packet.

H. CORRESPONDENCE ~ None

I. ACTION ITEMS

1. Election of Officers

M/Bennett S/Harvill "I move to approve Kristin Carpenter as President, April Horton as Vice-President and Dorne Hawxhurst as Secretary of the CCMC Authority Board of Directors."

5 yeas, 0 nays, 0 absent

Motion passed.

2. Update CCMC Check Signers

M/Hawxhurst S/Harvill "I move to approve the Resolution of the CCMC Authority Board of Directors designating the representatives authorized for signing checks, non-check payroll tax payment, and cash transfers for Cordova Community Medical Center."

5 yeas, 0 nays, 0 absent

Motion passed.

3. 340B Retail Pharmacy

M/Harvill S/Horton "I move to approve the establishment of a 340B/Retail Pharmacy at CCMC, and authorize the expenditure of funds, as noted in the pro-forma budget presented by staff, to implement the 340B/Retail Pharmacy."

3 yeas, 1 nay, 1 abstain

Motion passed.

4. Conflict of Interest Policy

M/Harvill S/Horton "I move to approve the revised ADM 302, Conflict of Interest Policy as presented."

5 yeas, 0 nays, 0 absent

Motion passed.

5. City Distribution Request for PERS

M/Harvill S/Bennett "I move to approve recommending that the City of Cordova transfer \$240,500.00 to CCMC to covers the CCMC PERS payments that are currently in arrears."

4 yeas, 1 nay, 0 absent

Motion passed.

6. Delineation of Privileges for Dr. Mary Jo Groves

M/Horton S/Harvill "I move that the CCMC Authority Board of Directors grant one year Active Medical Staff Membership with the requested privileges to Mary Jo Groves, MD as requested, and recommended by the CCMC Medical Staff."

5 yeas, 0 nays, 0 absent

Motion passed.

7. Board Meeting Schedule –

The board agreed that going forward the regular meeting schedule will be the **4th Thursday of every month at 6:00pm**. The next regular meeting is scheduled for May 25th 2017.

J. DISCUSSION ITEMS ~ None

K. AUDIENCE PARTICIPATION ~ None

L. BOARD MEMBERS COMMENTS

Hawxhurst ~ None

Horton ~ As an outsider looking in, I would say that one of the major things that we have an issue with in this town is communication between people. No one watches the Scanner all the time, no one sits there and opens emails all the time. How can we better communicate to the public?

Harvill ~ My real comment is, what can we do to help you (Scot)? By that I mean, what can we do to promote or other things?

Bennett ~ None

Carpenter ~ None

M. ADJOURNMENT –

M/Bennett S/Horton "I move to adjourn the meeting."

Carpenter declared the meeting adjourned at 9:00pm

Prepared by: Faith Wheeler-Jeppson

Minutes
CCMC Authority – Board of Directors
CCMC Admin Conference Room
May 25, 2017 at 6:00pm
Regular Meeting

CALL TO ORDER AND ROLL CALL –

Kristin Carpenter called the Board Meeting to order at 6:00pm.

Board members present: **Dorne Hawxhurst, Kristin Carpenter, Sally Bennett and April Horton** (arrived at 6:17pm).

A quorum was established. 3 members present; 2 member absent.

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

A. APPROVAL OF AGENDA

M/Hawxhurst S/Bennett “move to approve the agenda.”

3 yeas, 0 nays, 2 absent

Motion passed.

B. CONFLICT OF INTEREST ~ None

April Horton arrived at 6:17pm

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS

1. **Audience Participation** ~ None

2. **Guest Speaker** ~ None

D. BOARD DEVELOPMENT

1. **Alaska Public Employees Retirement System**

Scot Mitchell provided a brief history on the PERS system as it relates to CCMC and its employees.

Next Meeting for Board Development the topic will be Financial Statements

E. APPROVAL OF CONSENT CALENDAR ~ None

F. APPROVAL OF MINUTES

M/Bennett S/Horton “move to approve the March 16, 2017 Regular Meeting Minutes, April 4, 2017 Worksession Meeting Minutes, and the April 25, 2017 Regular Meeting Minutes”.

4 yeas, 0 nay, 1 absent

Motion passed.

Hawxhurst asked that the vote on the motion be included in the minutes going forward.

Amended Minutes from the April 25, 2017 Regular Meeting will be brought back to the board for approval at the next meeting.

G. REPORT OF OFFICERS AND ADVISORS

1. CEO's Report ~ Scot Mitchell, CEO stated that his written report was in the packet. Clarification was provided to the Board regarding the 340B Program, and the AVEC contract. Additional information was given to the Board explaining more about the Electronic Medical Record and the Health information Exchange.

2. Finance Report ~ Lee Holter, CFO reported a few discrepancies in the Audit to the Board. In part, Meaningful Use revenue was not accounted for in the correct year, and Grant revenue has not been reported in a consistent manner for several years.
3. Nursing Report ~ Helen McGaw, Interim CNO provided an update to the Board on Long Term Care including that CMS has given us a 4 star rating. The facility will be providing clinical training as part of a CAN class for six students for the next 3 months. We're doing very well on everything patient care related.

H. CORRESPONDENCE ~ None

I. ACTION ITEMS

1. Delineation of Privileges – Dr. Michael Alexander

M/Bennett S/Hawxhurst "I move that the CCMC Authority Board of Directors grant one year Active Medical Staff Membership with requested tele-behavioral health privileges to Michael Alexander, MD as requested, and recommended by the CCMC Medical Staff."

4 years, 0 nays, 1 absent

Motion passed.

2. Revenue Cycle Changes

M/Bennett S/Horton "I move that the CCMC Authority Board of Directors authorize Scot Mitchell, CEO to sign a contract for revenue cycle services with AVEC Health Solutions."

4 years, 0 nays, 1 absent

Motion passed.

- J. DISCUSSION ITEMS ~ Quality Improvement – 4th Quarter 2016 Patient Safety Report**
Scot presented information from the 4th Quarter Patient Safety Report. Prior to Scot becoming the CEO, CCMC had not been doing any Quality Reporting, now we are reporting on almost all of the mandatory quality reporting metrics.

K. AUDIENCE PARTICIPATION ~ None

L. BOARD MEMBERS COMMENTS

Hawxhurst ~ None

Horton ~ None

Bennett ~ None

Carpenter ~ Thank you for the audit reporting

M. ADJOURNMENT –

M/Horton S/Bennett "I move to adjourn the meeting."

Carpenter declared the meeting adjourned at 8:15am

Prepared by: Faith Wheeler-Jeppson



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CEO Report to the CCMC Authority Board of Directors
June 22, 2017 Meeting
Scot Mitchell, CEO

The Big Picture

As I write this report, we are hearing that the Senate may introduce their version of a bill to repeal and replace the Affordable Care Act any day now. The process that the Senate has been using has been kept under wraps, so very little is known about their bill. The House passed the American Health Care Act a while back, but conventional wisdom says that the Senate bill will be considerably different from the House bill. There are several national hospital organizations that have already started reaching out to Senators to make sure they protect patients with their approach to healthcare reform. Once we know more about the Senate bill, I will let you know what the impact could be on CCMC.

The State Legislature has still not agreed on a budget for the coming year. If they are not able to approve a budget by the end of June, the State will be required to shutdown at least parts of the government services. At this time, we do not know which areas will be shut down and how they might impact CCMC. We have already started developing contingency plans for a potential shutdown. As we learn more about the State's actions over the next couple weeks, I'll let you know how they might impact CCMC.

Status Updates

- As approved by the board last month, we have started the process of transitioning to our new billing and coding company. AVEC Health Solutions has already started working on some of the older accounts that have not had any follow-up recently. They will start doing all of the coding on July 1st and all of the billing on September 1st.
- We have just started using the abaqis nursing home quality assurance program. This program will allow us to routinely assess our long term care residents to identify areas that might be at risk for non-compliance with CMS conditions of participation. The staff will then prioritize and conduct in-depth investigations into these areas and using the system develop performance improvement plans to help us provide the highest quality care possible while remaining in compliance with our conditions of participation. Examples of investigated areas include: abuse, dignity, nutrition, physical restraints, accidents, hydration, pain and pressure ulcers. The program also helps us to track the mandatory tasks that the facility must complete to stay in compliance.
- We have held two different sessions of our CAH Periodic Evaluation so far. We will need at least one more session to complete the process. This is an area that CCMC has been out of compliance with the CAH regulations for many years now. We are required to conduct this review annually. There are

many areas of focus that CMS mandates that we review. This review is covering 2016, and once the report is completed, I will bring it to the board for approval.

- On May 16, 2017 we had our annual physicist evaluation of all of our imaging equipment that emits radiation. The CT scanner, radiology equipment and portable x-ray machine are all within the accepted standards for those pieces of equipment.
- The Alaska Legislature has still not passed a 2018 budget. If they do not do so by June 30, 2017 the State of Alaska will have to shut down until a budget is passed. We have already started discussions internally on developing contingency plans for such an occurrence. We don't know for certain if payments from Medicaid for our long term care residents will stop in the event of a shutdown, but we are planning that they will. We do know there are other areas that will affect us, such as licensing of professional staff. All of our nurse staffing that will be coming on board in the next couple months already have their Alaska licenses, so we are good for that time frame.
- Our retail pharmacy project is moving forward nicely. We have started the recruitment process for a pharmacist and have one candidate coming onsite for an interview before the end of June. We have already started working with our supplier for the medications and over-the-counter items. Renovations to the new pharmacy area have started as well. We have had preliminary discussions with the software company that is providing the system to operate and manage the pharmacy and have scheduled the installation and training to take place the last week of August. We are planning for an opening in late September for the retail pharmacy.
- I have included two different First Quarter 2017 Patient Safety Reports from the Partnership for Patients quality improvement project that we participate in with the Alaska State Hospital and Nursing Home Association and the Washington State Hospital Association. As I mentioned last month, CCMC is now reporting our quality data to this project. Last year, CCMC was not reporting any quality data, so we have made some great strides in this area. We have also recently hired a permanent nurse into the Quality Improvement position which will help us as we continue to develop our quality improvement program. The first report compares the CAH hospitals in Alaska, while the second one compares all participating hospitals in Alaska and Washington. When compared to other hospitals, CCMC is doing better than the average CAH hospital in Alaska on several metrics. Our goals for moving forward with the quality improvement program will help us continue our processes for enhancing the care that we provide to our community.
- We recently participated in a demo of the CPSI EHR program, Evident. This is the second one that we've seen in our research for a new EHR system. We also have a demo of the Meditech system scheduled for July. We are expanding our search to consider a couple extra systems that we will review to make sure that we select the most appropriate EHR for our organization.
- We continue our recruitment efforts to help us meet our goal of solidifying the continuity of our employees. We have recently hired a permanent Physical Therapist, who will start on July 31, 2017. We have one CNO candidate coming onsite this week, with another candidate potentially coming for an onsite interview soon. We also have a Pharmacist candidate coming onsite for an interview the last week of June. Our new Quality Improvement nurse started on June 19th, and will also serve several other functions such as infection prevention, staff development, utilization review, case management and risk management. We are also recruiting staff nurses for the hospital and nursing home.
- We will be bringing a request to the board to change our radiology provider group. We have been using a company called RAPC for a while now, and the service has started suffering lately, making it more difficult for our physicians to receive the reports they need in a timely manner. We are proposing to contract with vRad to replace RAPC. The vRad agreement will help us improve our turnaround time for radiology reports, plus will also allow CCMC to bill the professional fee for

radiology reports. The RAPC contract that we've had allows them to bill for the professional fees instead of CCMC. The vRad contract will cost CCMC \$3,000 per month, but we estimate that we will be able to bill about \$6,000 per month in radiology professional fees, based on the volume we had in 2016.

- Last month I mentioned that we will need to convert our current computerized radiology equipment to digital radiology equipment in order to prevent penalties imposed by CMS. We had initially thought that the deadline was going to be in 2018, but we have subsequently found that the deadline is actually the end of September 2017. The best deal we have found for this conversion would cost CCMC about \$50,000. Due to the current cash flow issues we are having, we've decided that our best course of action will be to include the cost of this conversion in the 2018 capital budget, and absorb the 7% penalty for a few months until we are able to have the 2018 capital budget approved.
- I continue to have monthly meetings with representatives from the Native Village of Eyak and Ilanka Clinic. We are currently working on an MOU to resume collaborating on mental health services. I also had a recent conversation with the Tribal Council Chairman and Executive Director of NVE where we discussed the history of the local native population as well as opportunities for collaboration in the future.
- The IRS requires all not-for-profit hospitals to conduct a Community Health Needs Assessment every three years. CCMC completed one last year. A copy of the Implementation Plan that was approved by the former CCMC Health Services Board is included in the packet for this board meeting. The community effort developed the following main health strategies for CCMC:
 - Build collaborations with other health care providers.
 - Enhance communication and education.
 - Grow marketing of CCMC.
 - Develop the workforce.
 - Improve community buy-in.
 - Explore business developments.

I will provide an update on the status of our efforts on these strategies to the board at this meeting.



Monthly Financial Statements

April 2017

To the CCMC Health Services Board

April 2017 Financial Executive Summary

Pre-Audit

Statistics

Acute Care patient days decreased from 29 the prior month to 23 in April. Swingbed days increased by 2 for April from the 109 in March. Average Daily Census (ADC) remained the same for April at 4.5. The ER visits increased by 2 in April from March's 47 visits. PT procedures decreased by 98 modules in April which was 399 versus March which had 497. Lab tests increased in April because of the health fair in April with 304 tests compared to 284 in March. There were 164 registrations for lab tests during the Health Fair days. X-ray and CT tests were down in April at 29 and 14 compared to March which had 37 and 13. April clinic visits declined to 188 compared to 197 in March. Behavioral health visits went up from 71 in March to 90 for April.

Balance sheet

Please note that the financials presented are pre-audit and may be modified in the audit.

Cash decreased by \$135K from March to the end of April. The bulk of the change was in Construction in Progress Assets increased \$68K, AR increased \$45K and AP decreased \$21K, Day's cash on hand at the end of April 8.9 days versus March which had 14.

Net AR increased in April by \$45K from March which was at \$1,131K. Days in AR increased by 3.2 days to 74.7 days from March at 71.5 days. Payroll liabilities decreased (\$184K) from March to April down to \$311K.

The \$3.1 Mil Long Term debt amount accounts for funds received from the city, with \$918K received 2016.

Income Statement

Gross revenue for April was \$1,088K a increase of \$55K from March's gross revenue. Swing bed, long term care and behavioral health were above budget for the month of April. Behavioral health includes income of \$57K for Waivered disability income which is six months of Activity that was finally paid.

Contractual adjustments were \$171K in April a decrease of \$38k from March of \$209K, while Bad debt increased by \$88K from March.

April payroll decreased by \$20K from March. Payroll taxes and Benefits increased from March by \$20K for April due to higher self-insurance claims. Professional services increased by \$44K from March to April. Rents and Leases went down to \$11K for April from the March increase of late invoices

Overall expenses were higher in April by \$23K over March.

Year to Date

Please note that the financials presented are pre-audit and may be modified in the audit.

April Net Income was \$55,260 compared to March with a net income of \$50,260. Year to date net income is a positive \$310,064 compared to a budgeted loss of (\$257,006) and a Prior year loss of (\$879,848).

Activity and Projects

EHR

Work on E H R improvement continues, but is frustrating slow with setbacks. We are back on track with the internal system steering meeting and biweekly calls with Healthland technical support. There continue to be system problems, system work a rounds, and staff education issues to resolve.

The New EHR replacement process is moving forward and an RFP will be sent out. Management feels we need to move the process up as we have to test the whole year of 2018 for Meaningful Use stage 3, rather than the 90 day periods we have been able to do in the past. It would be better to test on one system for the year. We had our first system demo from

Budget

Business Line Statements/Departmental Statements

I am working on financial statements for our business lines, I.E., Sound Alternatives, Clinic, LTC in addition to the consolidated Hospital Financials. These individual financial statements would roll into the total CCMC financial statement you get each month. Also working to set up Departmental statements so managers can see their monthly departmental operation against budget.

Other items

The Audit for 2016 has been re-scheduled for the last week of April due to the change in Audit firms.

A charge master review has been scheduled for the third week of June, 2017, this will be a review of charge codes, proper use of CPT codes for billing compliance and a pricing review. Education will be provided to the department heads, administration and any board members who would like to attend the general session.

Cordova Community Medical Center
Income Statement

	April 2017			Year To Date		
	Actual	Budget	Variance	Prior Yr	Variance	Variance
REVENUE						
Acute	62,594	200,268	(137,674)	105,351	(42,757)	165,310
Swing Bed	221,461	38,112	183,349	102,031	119,430	561,765
Long Term Care	362,883	349,168	13,715	340,716	22,167	31,434
Clinic	86,622	91,149	(4,527)	74,099	12,522	30,335
Outpatients	273,584	324,411	(50,827)	289,668	(16,085)	75,400
Behavioral Health	80,567	29,197	51,370	36,342	44,226	(31,595)
Patient Services Total	1,087,711	1,032,305	55,406	948,207	139,504	832,548
DEDUCTIONS						
Charity	129	15,835	(15,706)	136,016	(135,887)	(135,581)
Contractual Adjustments	171,493	147,937	23,556	203,942	(32,449)	200,167
Bad Debt	134,382	29,028	105,354	14,709	119,673	180,824
Deductions Total	306,005	192,800	113,205	354,668	(48,663)	245,210
COST RECOVERIES						
Grants	16,121	46,300	(30,179)	(99,474)	115,595	118,769
In-Kind Contributions	93,754	109,859	(16,105)	96,131	(2,376)	8,077
Other Revenue	24,618	17,484	7,134	(29,247)	53,865	376,118
Cost Recoveries Total	134,494	173,643	(39,149)	(32,590)	167,084	502,964
TOTAL REVENUES	916,200	1,013,148	(96,948)	560,949	355,251	1,090,402
EXPENSES						
Wages	323,920	321,772	2,148	302,026	21,894	184,716
Taxes & Benefits	148,115	163,873	(15,758)	121,894	26,221	(37,344)
Professional Services	161,278	145,371	15,907	193,580	(32,302)	(241,691)
Minor Equipment	61	2,307	(2,246)	196	(135)	(19,974)
Supplies	40,051	34,417	5,634	40,955	(905)	34,938
Repairs & Maintenance	974	2,204	(1,230)	8,002	(7,028)	11,078
Rents & Leases	11,558	9,142	2,416	5,894	5,664	3,426
Utilities	100,477	101,587	(1,110)	100,146	331	12,611
Travel & Training	4,636	3,742	894	3,853	783	5,536
Insurances	14,595	17,959	(3,364)	1,059	13,537	15,522
Recruit & Relocate	1,523	4,167	(2,644)	7,738	(6,215)	(38,381)
Depreciation	45,285	43,750	1,535	42,712	2,573	11,485
Other Expenses	8,468	12,224	(3,756)	28,695	(20,227)	(41,430)
TOTAL EXPENSES	860,940	862,515	(1,575)	856,751	4,189	(99,510)
OPERATING INCOME	55,260	150,633	(95,373)	(295,802)	351,062	1,189,912
Restricted Contributions						
NET INCOME	55,260	150,633	(95,373)	(295,802)	351,062	1,189,912

Cordova Community Medical Center Statistics

	31	28	31	31	30	31	30	31	30	31	30	31	30	31	30	31	30	31	Total	Average		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Cumulative		Monthly							
Hosp Acute+SWB Avg. Census	29																					
FY 2017 ADC	3.1	3.8	4.5	4.5	4.5																4.0	
FY 2016	0.8	1.9	1.6	2.0	1.6	2.2	1.2	0.3	0.7	1.1	0.5	1.1									1.3	
FY 2015	1.1	0.2	2.0	2.3	2.5	2.2	0.9	1.5	0.8	0.5	0.9	0.1									1.2	
Acute Admits																						
FY 2017	9	7	7	5																	28	7.0
FY 2016	6	8	3	8	9	5	7	5	6	10	6	8									81	6.8
FY 2015	1	1	4	6	5	2	5	1	5	5	3	1									39	3.3
Acute Patient Days																						
FY 2017	32	22	29	23																	106	26.5
FY 2016	16	15	18	22	26	20	11	10	18	22	15	17									210	17.5
FY 2015	2	3	7	8	16	3	10	2	11	6	7	2									77	6.4
SWB Admits																						
FY 2017	5	3	2	1																	11	2.8
FY 2016	2	2	0	2	1	3	1	0	1	2	1	2									17	1.4
FY 2015	1	1	3	3	2	0	0	3	1	1	0	0									15	1.3
SWB Patient Days																						
FY 2017	64	84	109	111																	368	92.0
FY 2016	10	40	32	37	24	46	25	0	3	11	1	17									246	20.5
FY 2015	31	3	55	60	60	62	18	45	12	10	19	0									375	31.3
CCMC LTC Admits																						
FY 2017	0	0	0	0																	0	0
FY 2016	1	0	0	0	0	0	2	0	0	0	0	0									3	0.3
FY 2015	0	0	0	1	1	2	1	2	2	1	0	0									10	0.8
CCMC LTD Resident Days																						
FY 2017	310	280	310	300																	1,200	300
FY 2016	310	290	310	297	310	298	292	310	300	310	300	310									3,637	303.1
FY 2015	310	280	308	287	307	300	274	273	388	309	300	310									3,646	304
CCMC LTC Avg. Census																						
FY 2017	10.0	10.0	10.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0									10.0	10.0
FY 2016	10.0	10.0	10.0	9.9	10.0	9.9	9.4	10.0	10.0	10.0	10.0	10.0									9.9	9.9
FY 2015	10.0	10.0	9.9	9.6	9.9	10.0	8.8	8.8	12.9	10.0	10.0	10.0									10.0	10.0
ER Visits																						
FY 2017	49	35	47	49																	180	45.0
FY 2016	52	45	52	52	59	79	85	74	51	55	37	53									694	57.8
FY 2015	23	46	49	40	104	73	104	97	47	56	37	39									715	59.6

Cordova Community Medical Center Statistics

	31	28	31	30	31	30	31	30	31	30	31	30	31	30	31	30	31	30	31	30	31	30	31	30	31	30	31	Cumulative Monthly	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec																	
Outpatient Registrations w/ER																													
FY 2017	120	111	138	293																								662	166
FY 2016									165	146	126	137																574	144
FY 2015																												0	0
PT Procedures																													
FY 2017	416	322	497	399																								1,634	409
FY 2016	319	344	349	401	326	396	291	324	489	346	407	415																4,407	367
FY 2015	224	197	280	347	321	224	319	345	216	170	296	269																3,208	267
OT Procedures																													
FY 2017	94	38	0	0																								132	33
FY 2016	105	107	51	139	124	53	31	26	36	62	66	111																911	76
FY 2015	24	55	95	67	108	65	35	107	90	99	115	128																988	82
Lab Tests																													
FY 2017	298	322	284	304																								1,208	302
FY 2016	304	363	324	350	374	399	318	314	319	340	272	219																3,896	325
FY 2015	440	350	533	266	486	311	411	328	359	363	291	367																4,505	375
X-Ray Procedures																													
FY 2017	47	43	37	29																								156	39
FY 2016	60	52	64	56	76	71	63	74	52	44	42	37																691	58
FY 2015	27	27	66	68	59	56	99	84	47	34	37	44																648	54
CT Procedures																													
FY 2017	7	7	13	14																								41	10
FY 2016									15	25	17	13																70	
FY 2015																												0	0
CCMC Clinic Visits																													
FY 2017	212	175	197	188																								772	193.0
FY 2016	178	197	170	203	222	191	205	231	343	227	203	223																2,593	216
FY 2015	141	151	157	196	204	190	224	270	164	194	131	160																2,182	182
Behavioral Hlth Visits																													
FY 2017	70	98	71	90																								329	82.3
FY 2016	94	100	103	104	89	75	58	39	56	47	80	122																967	81
FY 2015	94	90	73	97	37	68	112	49	106	70	71	76																943	79

Cordova Community Medical Center
Balance Sheet

ASSETS	<u>4/30/2017</u>	<u>3/31/2017</u>	<u>4/30/2016</u>
Current Assets			
Cash	236,918	371,694	128,255
Net Account Receivable	1,476,630	1,431,884	1,248,912
Third Party Receivable	-	-	0
Other Receivables	6,399	100,481	60,998
Prepaid Expenses	17,005	11,760	22,642
Inventory	136,369	133,542	185,039
Total Current Assets	<u>1,873,321</u>	<u>2,049,361</u>	<u>1,645,846</u>
Property, Plant & Equipment			
Land	122,010	122,010	122,010
Buildings	7,006,763	7,006,763	7,006,763
Equipment	6,763,922	6,759,816	6,526,416
Construction in Progress	1,141,582	1,077,323	1,060,094
Subtotal PP&E	15,034,276	14,965,911	14,715,283
Less Accumulated Depreciation	(10,332,560)	(10,287,275)	(9,770,553)
Total Property & Equipment	<u>4,701,716</u>	<u>4,678,636</u>	<u>4,944,730</u>
Other Assets			
PERS Deferred Outflow	929,979	929,979	929,979
Total Other Assets	<u>929,979</u>	<u>929,979</u>	<u>929,979</u>
Total Assets	<u>7,505,017</u>	<u>7,657,976</u>	<u>7,520,555</u>
LIABILITIES AND FUND BALANCE			
Current Liabilities			
Accounts Payable	875,507	854,777	1,687,950
Payroll & Related Liabilities	311,586	495,509	492,460
Third Party Settlement Payment	0	0	0
Interest & Other Payables	8,240	8,232	321
Long Term Debt-- City	3,093,127	3,100,976	2,182,460
Other Current Long Term Debt	107,840	114,108	237,104
Total Current Liabilities	<u>4,396,300</u>	<u>4,573,604</u>	<u>4,600,295</u>
Long Term Liabilities			
2015 Net Pension Liability	5,015,100	5,015,100	5,015,100
Total Long Term Liabilities	<u>5,015,100</u>	<u>5,015,100</u>	<u>5,015,100</u>
Deferred Inflows of Resources			
Pension Deferred Inflow	88,788	88,788	88,788
Total Deferred Inflows	<u>88,788</u>	<u>88,788</u>	<u>88,788</u>
Total Liabilities	<u>9,500,188</u>	<u>9,677,492</u>	<u>9,704,183</u>
Net Position			
Unrestricted Fund Balance	2,769,541	2,769,539	2,769,539
Temporary Restricted Fund Balance	13,035	13,035	13,035
Prior Year Retained Earnings	(5,089,310)	(5,056,893)	(4,086,354)
Current Year Net Income	311,191	254,804	(879,848)
Total Net Position	<u>(1,995,542)</u>	<u>(2,019,515)</u>	<u>(2,183,628)</u>
Total Liabilities & Net Position	<u>7,504,646</u>	<u>7,657,976</u>	<u>7,520,555</u>

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

TOTAL	0 - 30	31 - 60	61 - 90	91 - 120	121+	Totals	Apr Days In AR
Gross A/R	116,382	57,359	71,864	27,747	170,846	444,199	
Commercial	330,666	61,205	12,957	31,927	69,198	505,952	17.4%
Medicare	178,273	15,889	10,432	9,108	132,002	345,704	19.8%
Medicaid	274,581	25,192	1,117	1,118	61,195	363,204	13.6%
Long Term Care	34,556	20,027	27,794	28,014	44,420	154,811	14.2%
Other Govt payers	-	-	-	1,360	194,470	195,830	6.1%
Extended Pymt Terms	231,740	17,644	36,402	58,765	92,355	436,906	7.7%
Private Pay	15,619	4,537	13,485	11,767	58,051	103,459	17.1%
Work Comp	1,181,817	201,854	174,051	169,806	822,537	2,550,064	4.1%
Totals	46.3%	7.9%	6.8%	6.7%	32.3%	100.0%	100.0%
						88,568	Credit Balances

Cordova Community Medical Center
Income Statement

	April 2017			Year To Date			
	Actual	Budget	Variance	Prior Yr	Variance	Prior Yr	Variance
REVENUE							
Acute	62,594	200,268	(137,674)	105,351	(42,757)	241,194	165,310
Swing Bed	221,461	38,112	183,349	102,031	119,430	292,528	561,765
Long Term Care	362,883	349,168	13,715	340,716	22,167	1,401,935	31,434
Clinic	86,622	91,149	(4,527)	74,099	12,522	276,653	30,335
Outpatients	273,584	324,411	(50,827)	289,668	(16,085)	775,553	75,400
Behavioral Health	80,567	29,197	51,370	36,342	44,226	175,356	(31,595)
Patient Services Total	1,087,711	1,032,305	55,406	948,207	139,504	3,163,219	832,648
DEDUCTIONS							
Charity	129	15,835	(15,706)	136,016	(135,887)	135,710	(135,581)
Contractual Adjustments	171,493	147,937	23,556	203,942	(32,449)	699,728	200,167
Bad Debt	134,382	29,028	105,354	14,709	119,673	96,801	180,624
Deductions Total	306,005	192,800	113,205	354,668	(48,663)	932,239	245,210
COST RECOVERIES							
Grants	16,121	46,300	(30,179)	(99,474)	115,595	-	118,769
In-Kind Contributions	93,754	109,859	(16,105)	96,131	(2,376)	366,940	8,077
Other Revenue	24,618	17,484	7,134	(29,247)	53,865	(15,116)	376,118
Cost Recoveries Total	134,494	173,643	(39,149)	(32,590)	167,084	351,824	502,964
TOTAL REVENUES	916,200	1,013,148	(96,948)	560,949	355,251	2,582,804	1,090,402
EXPENSES							
Wages	323,920	321,772	2,148	302,026	21,894	1,130,638	184,716
Taxes & Benefits	148,115	163,873	(15,758)	121,894	26,221	637,492	(37,344)
Professional Services	161,278	145,371	15,907	193,580	(32,302)	746,215	(241,691)
Minor Equipment	61	2,307	(2,246)	196	(135)	24,316	(19,974)
Supplies	40,051	34,417	5,634	40,955	(905)	131,811	34,938
Repairs & Maintenance	974	2,204	(1,230)	8,002	(7,028)	11,361	11,078
Rents & Leases	11,558	9,142	2,416	5,894	5,664	41,051	3,426
Utilities	100,477	101,587	(1,110)	100,146	331	403,132	12,611
Travel & Training	4,636	3,742	894	3,853	783	9,470	5,536
Insurances	14,595	17,959	(3,364)	1,059	13,537	45,340	15,522
Recruit & Relocate	1,523	4,167	(2,644)	7,738	(6,215)	41,697	(38,381)
Depreciation	45,285	43,750	1,535	42,712	2,573	169,655	11,485
Other Expenses	8,468	12,224	(3,756)	28,695	(20,227)	70,472	(41,430)
TOTAL EXPENSES	860,940	862,515	(1,575)	856,751	4,189	3,462,652	(99,510)
OPERATING INCOME	55,260	150,633	(95,373)	(295,802)	351,062	(879,848)	1,189,912
Restricted Contributions							
NET INCOME	55,260	150,633	(95,373)	(295,802)	351,062	(879,848)	1,189,912

Financial Statement Scorecard

Cordova Community Medical Center

\$ in Whole Dollars unless otherwise noted	Apr-17		YTD 2017	
	Actual	Budget	Actual	Budget
Income/(Loss) from Operations	\$ 65,260	\$ 150,633	\$ 310,064	\$ (257,006)
Operating Margin	6.0%	-155.4%	8.4%	-7.6%
Operating EBIDA**	181.9%	-203.8%	177.1%	-83.3%
Total Operating Revenue	\$ -	\$ -	\$ -	\$ -
NPSR* per APD** (Whole \$) Combined				
NPSR* per APD** (Whole \$) Hospital Only			#REF!	
PSR per Clinic Visit	#DIV/0!	#REF!	#REF!	
Total Expenses	\$ 860,940	\$ 862,515	\$ 504,524	\$ 534,693
Expenses per APD** (Whole \$)			\$ 10,615	\$ 12,790
Expenses per APD** (Whole \$) Hospital Only'	#DIV/0!			
FTE's Per (APD)*** Adjusted Patient Day	-	-	#REF!	10.4
FTE's Per (APD)*** (Hospital only)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comp/Benefits as a % of NPSR	47.2%	47.9%	45.7%	47.5%
Total Comp/Benefits as a % of NPSR-HOSP	43.3%	44.9%	41.9%	44.6%
Total Comp as % of NPSR	36.0%	36.2%	33.5%	35.6%
Total Comp as % of NPSR-HOSP	33.4%	33.3%	30.8%	32.9%
Days of Total Cash	8.9	60		175
Days in A/R	74.7	65		60
Debt to Capitalization Ratio	0.0%	5.5%	0.0%	5.5%
Admissions			833	824
IP ER Visits (Admitted)			459	504
OP ER Visits			7,684	7,066
Total ER Visits	-	-	8,143	7,570
CCMC Clinic	188			
Total Physician Visits (includes ER)			11,126	12,416
Outpatient (non-ER) Visits			24,760	22,387
Total Outpatient Visits			32,444	29,453

Unfavorable compared to Budget or Prior Year

Favorable compared to Budget or Prior Year

- * NPSR = Net Patient Service Revenue
- ** EBIDA = Earnings Before Interest Depreciation and Amortization
- ***AOB = Adjusted Occupied Bed (takes into account Inpatient and Outpatient activi



Monthly Financial Statements

May 2017

To the CCMC Health Services Board

May 2017 Financial Executive Summary

Pre-Audit

Statistics

Acute Care patient days increased from 23 the prior month to 28 in May. Swingbed days remained at 111, the same for May as in April. Average Daily Census (ADC) remained the same for May at 4.5. The ER visits increased by 4 in May from April's 49 visits. PT procedures decreased by 72 modules in May which was 327 versus April which had 399. Lab tests increased in May by 14 tests. X-ray test went up by 13 tests for May while CT tests were down by 2 in May compared to April. May clinic visits increased by 60 visits compared to April which had 188 to 248 in May. Behavioral Health had 2 fewer visits in May than April.

Balance sheet

Please note that the financials presented are pre-audit and may be modified in the audit.

Cash decreased by \$21K from April to the end of May. Day's cash on hand at the end of April 8.9 days compared to May which had 9.4 an increase of .5.

Net AR increased in May by \$115K from April which was at \$1,476K. Days in AR increased by 3.8 days to 78.5 days from March at 74.7 days.

Accounts payable decreased by \$98K from April to May. Payroll liabilities had less than \$1K increase. Debt to the city increased by \$384,436 due to funds for PERS and the Medicare payment due to the cost report settlement.

Income Statement

Gross revenue for May was \$1,058K a decrease of \$30K from April Gross revenue of \$1,088. Decreases occurred in Outpatient and Behavioral health. The other services saw increases from April to May with the net effect be a reduction of \$30K for May.

Contractual adjustments increased in due to the outstanding balances for Medicare and Medicaid. In addition to calculation for contractual allowances for Self-pay there was and additional direct write off of \$102K for the difference in our charges for the labs done during the health fair and the cash collected. Bad debt decreased by \$110K from April to May, but is expected to rise as we get more aggressive on collects of older accounts.

May payroll increased by \$7K from May, primarily a factor in days of the month. Payroll taxes and Benefits increased from April to May by \$7K for May due to higher self-insurance claims. Professional services increased by \$31K from April to May. Supplies increased by \$24K in May from April. Rents and Leases increased by \$5K for May versus April. Utilities were up by \$21k over April. There increases in the categories of recruitment and other expenses for the month of May.

Overall expenses were higher in May by \$140K over April.

Year to Date

Please note that the financials presented are pre-audit and may be modified in the audit.

May YTD net income fell by (\$166K) from April's amount of \$311K to \$134K Net Income for May due to increased contractual's and expenses. Revenue remains above budget for YTD and Expenses below budget on a YTD basis.

Activity and Projects

EHR

Work on E H R improvement continues, but is frustrating slow with setbacks. We are back on track with the internal system steering meeting and biweekly calls with Healthland technical support. There continue to be system problems, system work a rounds, and staff education issues to resolve. System problems are occurring with revenue being generated in a departments and the billing system trying to transfer the revenue to another department. This has a detrimental effect tracking revenue properly for departments and filing the cost report. Temporally this has created an out of balance issue in the system which I have yet to resolve.

The New EHR replacement process is moving forward and an RFP will be sent out. Management feels we need to move the process up as we have to test the whole year of 2018 for Meaningful Use stage 3, rather than the 90 day periods we have been able to do in the past. It would be better to test on one system for the year. We had our first system demo from

Budget

Business Line Statements/Departmental Statements

I am working on financial statements for our business lines, I.E., Sound Alternatives, Clinic, LTC in addition to the consolidated Hospital Financials. These individual financial statements would roll into the total CCMC financial statement you get each month. Also working to set up Departmental statements so managers can see their monthly departmental operation against budget.

Other items

The Audit for 2016 has been mostly completed, there were some follow up issues I am trying to resolve this week.

A charge master review has been scheduled for the third week of June, 2017, this will be a review of charge codes, proper use of CPT codes for billing compliance and a pricing review. Education will be provided to the department heads, administration and any board members who would like to attend the general session.

Respectfully submitted

Lee Holter
CFO

Cordova Community Medical Center Statistics

	31	28	31	30	31	30	31	30	31	30	31	30	31	30	31	Total	Average
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec					
Hosp Acute+SWB Avg. Census		29															
FY 2017 ADC	3.1	3.8	4.5	4.5	4.5												4.1
FY 2016	0.8	1.9	1.6	2.0	1.6	2.2	1.2	0.3	0.7	1.1	0.5	1.1					1.3
FY 2015	1.1	0.2	2.0	2.3	2.5	2.2	0.9	1.5	0.8	0.5	0.9	0.1					1.2
Acute Admits																	
FY 2017	9	7	7	5	4											32	8.0
FY 2016	6	8	3	8	9	5	7	5	6	10	6	8				81	6.8
FY 2015	1	1	4	6	5	2	5	1	5	5	3	1				39	3.3
Acute Patient Days																	
FY 2017	32	22	29	23	28											134	33.5
FY 2016	16	15	18	22	26	20	11	10	18	22	15	17				210	17.5
FY 2015	2	3	7	8	16	3	10	2	11	6	7	2				77	6.4
SWB Admits																	
FY 2017	5	3	2	1	2											13	3.3
FY 2016	2	2	0	2	1	3	1	0	1	2	1	2				17	1.4
FY 2015	1	1	3	3	2	0	0	3	1	1	0	0				15	1.3
SWB Patient Days																	
FY 2017	64	84	109	111	111											479	119.8
FY 2016	10	40	32	37	24	46	25	0	3	11	1	17				246	20.5
FY 2015	31	3	55	60	60	62	18	45	12	10	19	0				375	31.3
CCMC LTC Admits																	
FY 2017	0	0	0	0	0											0	0
FY 2016	1	0	0	0	0	0	2	0	0	0	0	0				3	0.3
FY 2015	0	0	0	1	1	2	1	2	2	1	0	0				10	0.8
CCMC LTD Resident Days																	
FY 2017	310	280	310	300	310											1,510	378
FY 2016	310	290	310	297	310	298	292	310	300	310	300	310				3,637	303.1
FY 2015	310	280	308	287	307	300	274	273	388	309	300	310				3,646	304
CCMC LTC Avg. Census																	
FY 2017	10.0	10.0	10.0	10.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					12.5
FY 2016	10.0	10.0	10.0	9.9	10.0	9.9	9.4	10.0	10.0	10.0	10.0	10.0					9.9
FY 2015	10.0	10.0	9.9	9.6	9.9	10.0	8.8	8.8	12.9	10.0	10.0	10.0					10.0
ER Visits																	
FY 2017	49	35	47	49	53											233	58.3
FY 2016	52	45	52	52	59	79	85	74	51	55	37	53				694	57.8
FY 2015	23	46	49	40	104	73	104	97	47	56	37	39				715	59.6

Cordova Community Medical Center Statistics

	31	28	31	30	31	30	31	30	31	30	31	30	31	30	31	Cumulative Monthly	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec					
Outpatient Registrations w/ER																	
FY 2017	120	111	138	293												662	166
FY 2016									165	146	126	137				574	144
FY 2015																0	0
PT Procedures																	
FY 2017	416	322	497	399	327											1,961	490
FY 2016	319	344	349	401	326	396	291	324	489	346	407	415				4,407	367
FY 2015	224	197	280	347	321	224	319	345	216	170	296	269				3,208	267
OT Procedures																	
FY 2017	94	38	0	0	0											132	33
FY 2016	105	107	51	139	124	53	31	26	36	62	66	111				911	76
FY 2015	24	55	95	67	108	65	35	107	90	99	115	128				988	82
Lab Tests																	
FY 2017	298	322	284	304	318											1,526	382
FY 2016	304	363	324	350	374	399	318	314	319	340	272	219				3,896	325
FY 2015	440	350	533	266	486	311	411	328	359	363	291	367				4,505	375
X-Ray Procedures																	
FY 2017	47	43	37	29	42											198	50
FY 2016	60	52	64	56	76	71	63	74	52	44	42	37				691	58
FY 2015	27	27	66	68	59	56	99	84	47	34	37	44				648	54
CT Procedures																	
FY 2017	7	7	13	14	12											53	13
FY 2016									15	25	17	13				70	
FY 2015																0	0
CCMC Clinic Visits																	
FY 2017	212	175	197	188	248											1,020	255.0
FY 2016	178	197	170	203	222	191	205	231	343	227	203	223				2,593	216
FY 2015	141	151	157	196	204	190	224	270	164	194	131	160				2,182	182
Behavioral Hlth Visits																	
FY 2017	70	98	71	90	88											417	104.3
FY 2016	94	100	103	104	89	75	58	39	56	47	80	122				967	81
FY 2015	94	90	73	97	37	68	112	49	106	70	71	76				943	79

Cordova Community Medical Center
Balance Sheet

ASSETS	<u>5/31/2017</u>	<u>4/30/2017</u>	<u>5/31/2016</u>
Current Assets			
Cash	258,051	236,918	682,720
Net Account Receivable	1,591,863	1,476,630	1,253,883
Third Party Receivable	-	-	0
Other Receivables	6,399	6,399	100,481
Prepaid Expenses	22,335	17,005	22,642
Inventory	135,538	136,369	198,405
Total Current Assets	2,014,185	1,873,321	2,258,131
Property, Plant & Equipment			
Land	122,010	122,010	122,010
Buildings	7,006,763	7,006,763	7,006,763
Equipment	6,763,922	6,763,922	6,526,416
Construction in Progress	1,166,982	1,141,582	1,060,094
Subtotal PP&E	15,059,676	15,034,276	14,715,283
Less Accumulated Depreciation	(10,377,845)	(10,332,560)	(9,813,266)
Total Property & Equipment	4,681,832	4,701,716	4,902,018
Other Assets			
PERS Deferred Outflow	929,979	929,979	929,979
Total Other Assets	929,979	929,979	929,979
Total Assets	7,625,996	7,505,017	8,090,127
LIABILITIES AND FUND BALANCE			
Current Liabilities			
Accounts Payable	777,218	875,507	1,722,567
Payroll & Related Liabilities	312,435	311,586	547,355
Third Party Settlement Payment	0	0	0
Interest & Other Payables	10,017	8,240	329
Long Term Debt-- City	3,477,563	3,093,127	2,182,460
Other Current Long Term Debt	105,176	107,840	234,167
Total Current Liabilities	4,682,410	4,396,300	4,686,878
Long Term Liabilities			
2015 Net Pension Liability	5,015,100	5,015,100	5,015,100
Total Long Term Liabilities	5,015,100	5,015,100	5,015,100
Deferred Inflows of Resources			
Pension Deferred Inflow	88,788	88,788	88,788
Total Deferred Inflows	88,788	88,788	88,788
Total Liabilities	9,786,298	9,500,188	9,790,766
Net Position			
Unrestricted Fund Balance	2,769,541	2,769,541	2,769,539
Temporary Restricted Fund Balance	13,035	13,035	13,035
Prior Year Retained Earnings	(5,089,310)	(5,089,310)	(4,086,354)
Current Year Net Income	145,530	311,191	(396,859)
Total Net Position	(2,161,203)	(1,995,542)	(1,700,639)
Total Liabilities & Net Position	7,625,094	7,504,646	8,090,127

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

	0 - 30	31 - 60	61 - 90	91 - 120	121+	Totals	May Days In AR
TOTAL							
Gross A/R							
Commercial	105,798	54,266	41,088	67,703	188,362	457,216	16.8%
Medicare	257,377	48,831	69,155	11,001	100,081	486,445	17.9%
Medicaid	153,275	135,964	150,078	16,344	115,530	571,190	21.0%
Long Term Care	283,325	32,165	25,192	1,117	62,314	404,113	14.9%
Other Govt payers	23,801	11,988	30,526	26,218	14,557	107,090	3.9%
Extended Pymt Terms	-	401	982	4,325	207,308	213,016	7.8%
Private Pay	81,458	102,389	82,384	23,252	90,374	379,857	14.0%
Work Comp	7,111	9,618	10,222	13,485	59,404	99,840	3.7%
Totals	912,144	395,621	409,626	163,445	837,930	2,718,767	100.0%
	33.5%	14.6%	15.1%	6.0%	30.8%	100.0%	
						88,568	Credit Balances

Cordova Community Medical Center
Income Statement

	May 2017				Year To Date				
	Actual	Budget	Variance	Prior Yr	Variance	Budget	Variance	Prior Yr	Variance
REVENUE									
Acute	90,590	219,216	(128,626)	71,754	18,836	736,846	(239,752)	312,948	184,145
Swing Bed	255,768	32,017	223,751	79,799	175,959	138,012	972,049	372,327	737,734
Long Term Care	376,773	357,896	18,877	367,647	9,127	1,818,304	(8,162)	1,769,581	40,560
Clinic	100,529	86,363	14,166	80,709	19,820	388,299	19,217	357,362	50,154
Outpatients	211,181	280,271	(69,090)	207,505	3,676	1,215,438	(153,304)	983,058	79,076
Behavioral Health	24,146	81,117	(56,971)	96,069	(71,923)	245,929	(78,022)	271,425	(103,518)
Patient Services Total	1,058,987	1,056,880	2,107	903,483	155,504	4,542,828	512,026	4,066,702	988,152
DEDUCTIONS									
Charity	26	16,325	(16,300)	494	(469)	70,034	(69,879)	136,204	(136,050)
Contractual Adjustments	300,773	152,512	148,261	165,999	134,774	654,275	546,393	865,727	334,941
Bad Debt	24,629	29,925	(5,296)	51,919	(27,290)	128,380	173,674	148,720	153,334
Deductions Total	325,428	198,762	126,666	218,413	107,015	852,689	650,187	1,150,651	352,225
COST RECOVERIES									
Grants	443	28,061	(27,618)	86,965	(86,522)	178,652	(59,440)	86,965	32,247
In-Kind Contributions	87,767	66,582	21,185	93,848	(6,081)	423,903	38,881	460,787	1,997
Other Revenue	14,311	10,596	3,715	573,519	(559,208)	67,462	307,851	588,403	(183,090)
Cost Recoveries Total	102,522	105,239	(2,717)	754,332	(651,810)	670,017	287,293	1,106,156	(148,846)
TOTAL REVENUES	836,081	963,357	(127,276)	1,439,403	(603,322)	4,360,156	149,131	4,022,207	487,081
EXPENSES									
Wages	330,715	321,772	8,943	274,076	56,639	1,769,746	(123,677)	1,404,714	241,355
Taxes & Benefits	155,255	163,873	(8,618)	181,711	(26,455)	901,302	(145,899)	819,202	(63,799)
Professional Services	192,819	192,775	44	267,456	(74,637)	727,468	(30,125)	1,013,671	(316,328)
Minor Equipment	9,734	2,307	7,427	412	9,322	11,535	2,541	24,728	(10,652)
Supplies	64,539	35,338	29,201	25,887	38,652	172,997	58,291	157,698	73,590
Repairs & Maintenance	7,056	2,204	4,852	1,465	5,591	11,020	18,475	12,826	16,669
Rents & Leases	16,501	9,142	7,359	19,546	(3,046)	45,710	15,267	60,597	380
Utilities	121,233	101,587	19,646	93,456	27,777	514,503	22,472	496,588	40,388
Travel & Training	6,321	3,748	2,573	2,840	3,481	18,716	2,611	12,310	9,016
Insurances	19,721	17,959	1,762	19,888	(167)	90,949	(10,366)	65,227	15,355
Recruit & Relocate	16,826	4,167	12,659	21,167	(4,341)	20,835	(693)	62,865	(42,723)
Depreciation	45,285	43,750	1,535	42,712	2,573	218,750	7,674	212,367	14,057
Other Expenses	16,162	12,224	3,938	5,799	10,364	61,120	(15,916)	76,271	(31,067)
TOTAL EXPENSES	1,002,166	910,846	91,320	956,414	45,753	4,564,651	(199,343)	4,419,065	(53,758)
OPERATING INCOME	(166,085)	52,511	(218,596)	482,989	(649,074)	(204,495)	348,474	(396,859)	540,838
Restricted Contributions									
NET INCOME	(166,085)	52,511	(218,596)	482,989	(649,074)	(204,495)	348,474	(396,859)	540,838

Financial Statement Scorecard

Cordova Community Medical Center

\$ in Whole Dollars unless otherwise noted	May-17		YTD 2017	
	Actual	Budget	Actual	Budget
Income/(Loss) from Operations	\$ (166,085)	\$ 52,511	\$ 143,979	\$ (204,495)
Operating Margin	-19.9%	-41.3%	3.2%	-4.7%
Operating EBIDA**	72.7%	-44.0%	122.8%	11.1%
Total Operating Revenue	\$ -	\$ -	\$ -	\$ -
NPSR* per APD** (Whole \$) Combined				
NPSR* per APD** (Whole \$) Hospital Only			#REF!	
PSR per Clinic Visit	#DIV/0!	#REF!	#REF!	
Total Expenses	\$ 1,002,166	\$ 910,846	\$ 697,343	\$ 727,468
Expenses per APD** (Whole \$)			\$ 10,615	\$ 12,790
Expenses per APD** (Whole \$) Hospital Only'	#DIV/0!			
FTE's Per (APD)*** Adjusted Patient Day	-		#REF!	10.4
FTE's Per (APD)*** (Hospital only)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comp/Benefits as a % of NPSR	47.2%	47.9%	45.7%	47.5%
Total Comp/Benefits as a % of NPSR-HOSP	43.3%	44.9%	41.9%	44.6%
Total Comp as % of NPSR	36.0%	36.2%	33.5%	35.6%
Total Comp as % of NPSR-HOSP	33.4%	33.3%	30.8%	32.9%
Days of Total Cash	9.4	60		175
Days in A/R	78.5	65		60
Debt to Capitalization Ratio	0.0%	5.5%	0.0%	5.5%
Admissions			833	824
IP ER Visits (Admitted)			459	504
OP ER Visits			7,684	7,066
Total ER Visits	-	-	8,143	7,570
CCMC Clinic	188			
Total Physician Visits (includes ER)			11,126	12,416
Outpatient (non-ER) Visits			24,760	22,387
Total Outpatient Visits			32,444	29,453

Unfavorable compared to Budget or Prior Year

Favorable compared to Budget or Prior Year

* NPSR

= Net Patient Service Revenue

** EBIDA

Earnings Before Interest Depreciation and Amortization

***AOB

= Adjusted Occupied Bed (takes into account Inpatient and Outpatient activi

Nursing Services
Monthly Report
June 19, 2017

We have started on our journey to build an objective, measurable Quality Assessment and Improvement Plan (QAPI). We will be using a system known as ABAQIS. The software for the program was developed by the physician who wrote the quality measurement tools and Long Term Care Survey Standards for CMS. The data used to measure our quality indicators comes from 1:1 interviews with residents and families, clinical records review, and clinical assessments submitted to CMS. By the end of June we will have all of our data entered and be able to generate reports showing our strengths and vulnerabilities. Then we review those areas against the CMS standards to identify priorities for our quality improvement plan. This tool not only structures our program but it prepares us for our annual survey by showing us exactly the same information and standards used by the surveyors.

MDS 3.0 Report

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

Report Filter:

- Analysis Period End Date: **19-Jun-2017**
- Random Sample: **None**
- Resident Group(s): **None**

Residents included: 10

Accidents

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



Activities of Daily Living

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



Bed Mobility



Transfer



Locomotion on Unit



Locomotion off Unit



Dressing



Eating



Toileting



Behavioral and Emotional Status

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



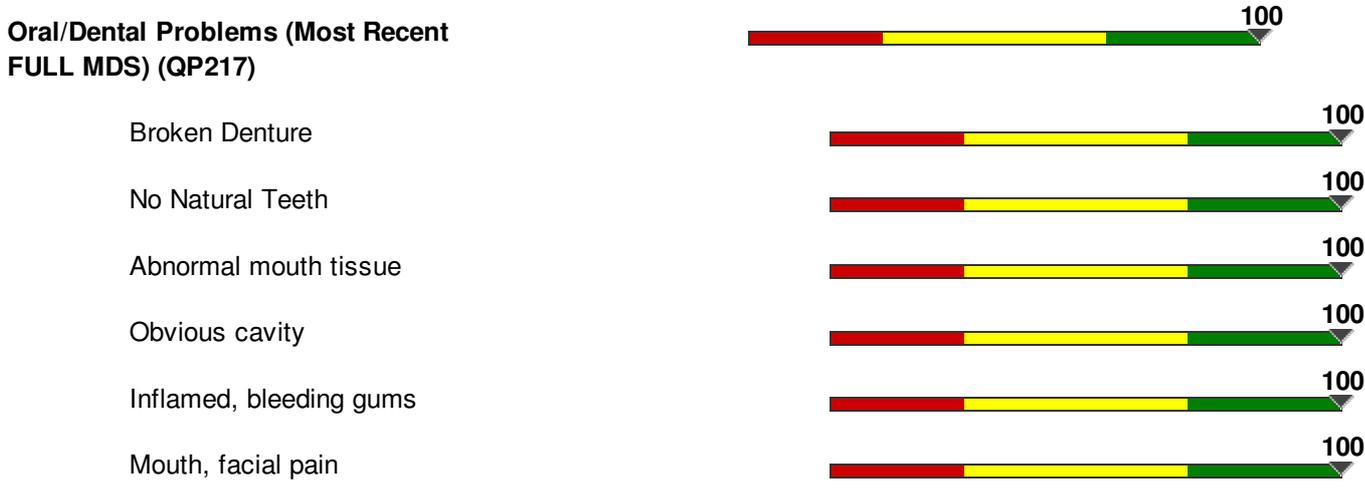
Increase in Resistance to Care (Admission-90 MDS) (QP106a)



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



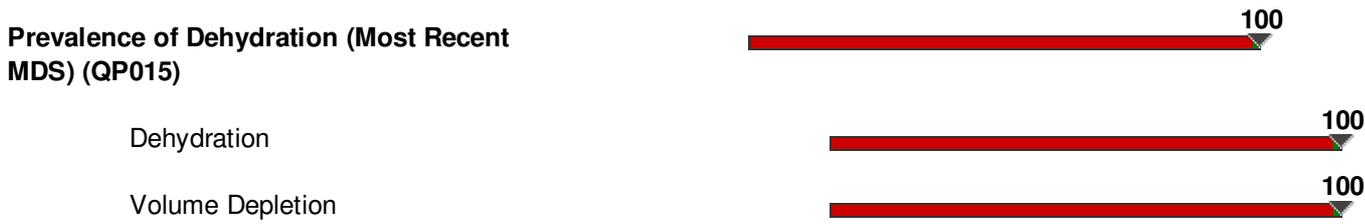
Dental Status and Services



Hearing and Vision



Hydration



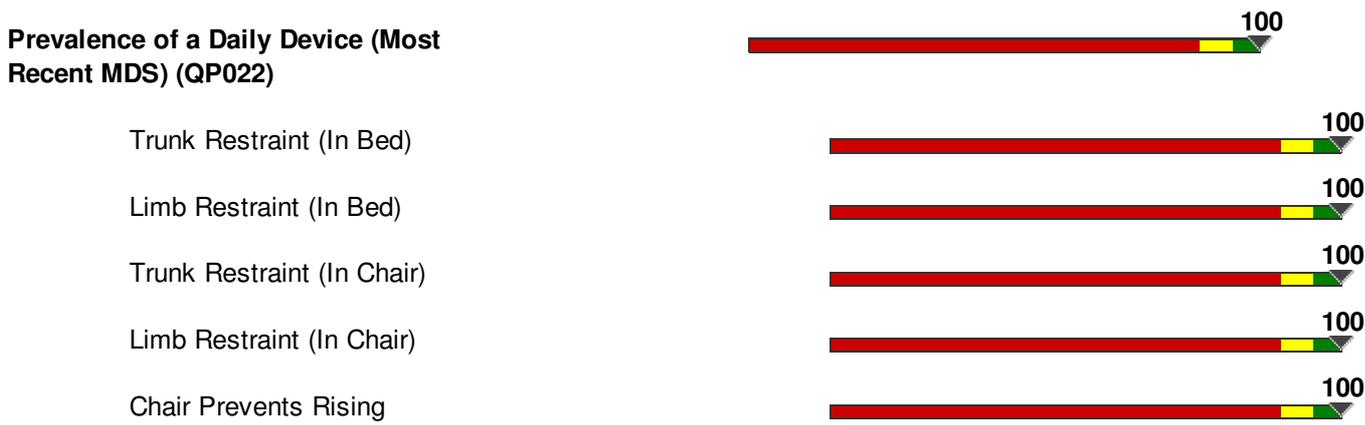
Infections (non-UTI related)



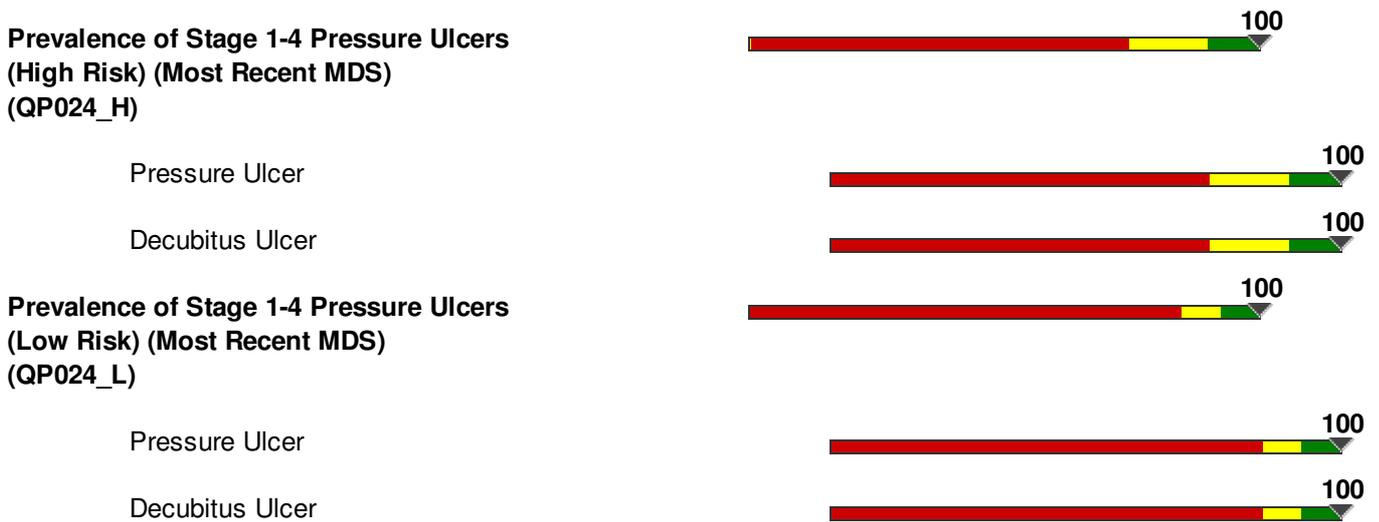
Nutrition



Physical Restraints



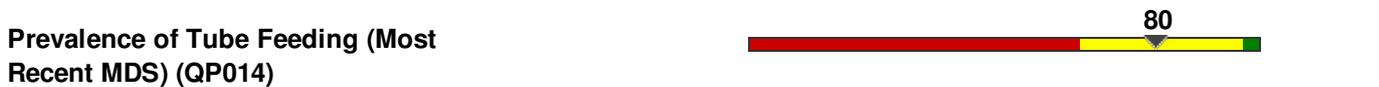
Pressure Ulcers



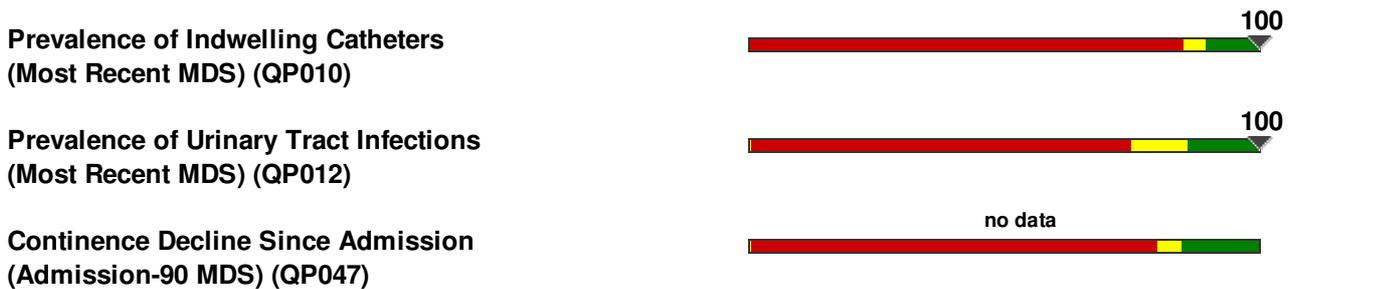
Range of Motion



Tube Feeding



Urinary Catheter, Incontinence and Infection



Residents With Flagged Assessments

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

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

Wandering

No residents were flagged for this care area.

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

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

Bed Mobility

No residents were flagged for this care area.

Transfer

No residents were flagged for this care area.

**Cordova Drug Co., Inc.
P.O. Box 220
516 First St.
Cordova, AK 99574
907-424-3246 Fax 907-424-3245
cordovadrug@ctcak.net**

June 18, 2017

**CCMC Authority Board of Directors
Cordova Community Medical Center**

Dear Board Members,

I would like to address you regarding a recent plan of action that you have taken. That is the plan to open a 340B pharmacy at CCMC.

The way I understand the 340B program is that it was formed in order to provide pharmacy services in areas that were underserved or that had a substantial population of impoverished residents that needed discounted healthcare, in this case, discounted prescriptions. When I told my broker of your plan he did a little research and here is his response:

I am missing something here, or just not understanding the situation in Cordova as far as 340B healthcare programs are concerned. With the demographics of Cordova being what they are (as copied herein), I don't see much room for 340B in terms of healthcare, unless there are residents (indigenous natives of Alaska, perhaps) outside the town who need Federally supported healthcare and prescriptions. Consider these statistics:

Cordova, Alaska

Males: 1,232 (55.4%)

Females: 994 (44.6%)

Median resident age: 49.7 years

Alaska median age: 33.3 years

Estimated median household income in 2015: \$86,827

Cordova: \$86,827

AK: \$73,355

Estimated per capita income in 2015: \$46,000.00

These seem to indicate a healthy financial picture in the town, and it is clearly a small town. Difficult to see where the 340B patient base will come from, and if there are any

people in the lower economic strata, how many could there be? If you are not filling 340B now, and there is no 340B pharmacy, there doesn't seem to be much of a need for one. Are you SURE they are opening a pharmacy? Most small hospitals (and other small 340B clinics) contract with local pharmacies to fill their Rx's, rather than open their own facility. Otherwise, the cost of staffing far outweighs any financial benefits that having their own pharmacy might provide.

These comments are from a man who has spent the last 20 years brokering deals for buying and selling independent pharmacies, some of which had 340B contracts, or existed in communities where 340B pharmacies operated.

As some of you may know Cordova Drug has been for sale for a couple of years now. Recently my broker received communication that another drugstore owner in Alaska was interested in procuring it. This could be the only chance that I have to sell. When I told my broker of your plans he said that that very well could remove the potential offer to buy from the table.

I must state that I am somewhat upset and insulted that CCMC would venture down this path without communicating with or consulting the person who has 35 plus years' experience running a drugstore in Cordova. As my broker mentioned above, we could have at least explored the idea of contracting with my business before you launched into this program.

I downloaded minutes from the City of Cordova website. Upon examination of your minutes from the April 20th meeting I was initially confused and still am. First of all, the minutes weren't complete because no board member comments or explanation of the handouts were included. I assumed that they would be in the minutes to be approved at your May 25th meeting, they weren't, at least not online. Anyway in Scott's statement in his proposal for the 340B Pharmacy in which he stated "The management of CCMC believing that the addition of a 340B Pharmacy is a beneficial business model to the hospital and the community." I don't know if there was any discussion about the potential impact on my business but because there was absolutely no communication between CCMC and me, I don't know why he would make such a statement.

Read on and you decide whether there really is any community benefit.

Following on with the numbers that were on the handouts in your board packet I noted some things that were hard to understand. First of all Start Up Costs did not include the \$25,000 that I think has already been paid to Transcend Rx, nor is there any mention of the initial cost of drug inventory. I also do not understand where the Savings on benefits comes from unless you are going to discontinue employee health insurance (or part of it) when you open the pharmacy. I also wonder about the savings on employee drug costs on health insurance. I assume that means that somehow every employee is going to become a patient of CCMC, which is the only way they can get their Rx's filled at the CCMC Pharmacy, and they are all going to get all of their prescriptions filled there, and it looks like it is going to happen almost overnight.

In the handouts following that in your board packet which give a projected financial timeline I see other things that I don't understand. The first is the number of prescriptions filled per day after month 12. In all the years I have been associated with Cordova Drug we have NEVER exceeded an annual average of more than 35 prescriptions per day. Of course in the summer it is higher but in the winter it is way lower. And that is with my pharmacy getting all of the prescription business that stays in town. I do not see how a pharmacy in Cordova that can only fill prescriptions for the patients of its own clinic can average more than about 20 per day. If that's the case your pharmacy would be stuck at the numbers for month six which would cause you to keep operating at a loss.

The other part I don't understand is the "Hospital portion of the pharmacist". Doesn't CCMC pay all of the expenses for the pharmacy, or is the pharmacy some new city entity whose existence is separate from everything else? If it isn't then the deduction for the hospital portion of the pharmacist still comes out of the CCMC budget, so how can it be a negative amount in these calculations?

The idea of another pharmacy in Cordova is not new. It has been extensively explored on two other occasions that I know of. Both times the idea of two pharmacies was abandoned because it did not make financial sense. That was back when pharmacies made a modest profit on prescriptions because the insurance companies reimbursed more at that time.

Now---to my business. If you should continue down this path I feel we will both starve. You--because I believe your projected profit numbers are woefully inflated.

Me--because of the structure of my business. It can only exist if all of the parts of it contribute to the whole. The pharmacy by itself would not survive because it doesn't even make enough profit to pay a pharmacist's salary, leave alone all the other overhead involved (benefits, technician, hardware, software, labels, bottles, bags, utilities, etc.) If one part of my business starts to fail the whole thing will collapse. The pharmacy part of my business provides the most revenue (cash flow) but the least amount of profit. The cash flow from the pharmacy provides the means for me to at least pay the bills even if I'm not getting much actual profit from it. As soon as that cash flow diminishes my ability to stay solvent, especially in the winter, also diminishes. This would cause me to lay off or eliminate employees, decrease payroll, and eventually force me to use my own personal assets to support the business. I have worked too long and too hard to do this.

I am ready to retire. If I can't sell my drugstore soon my wife and I have decided to sell it all and close the doors. Close the doors on a business that has served Cordova since 1908. It is the oldest existing drugstore in the state. Recently I had some hope of a sale, which would leave Cordova with a drugstore, but now I

fear that that opportunity may be dwindling if not already gone due to your actions.

You may think that if I close that some other Walgreens or Eagle or other will fill the gap. If the guy with 35 years of experience operating a drugstore in Cordova can't make it go then who else could? As I said before, the pharmacy by itself cannot support itself. The big chains aren't going to put a pharmacy in here that will just lose money. No existing business will put a pharmacy in that the rest of the business has to support. Possibly CCMC thinks it could then expand its own pharmacy to fill the gap. Then all of the customers that come in off the street that aren't 340B customers would have to be served with non 340B drugs. The CCMC pharmacy would then have to use all those supposed profits from the 340B program to pay all of the bills because of the low reimbursement from the insurance companies on those non 340B drugs. In other words it couldn't support its own pharmacy for the same reasons stated above.

The bottom line here is that someone should have explored the possibility of contracting with my business to offer 340B services to the community—that is if the plan was to serve the poor and underprivileged in the spirit of the program. If the plan was to try to use the profits to pay CCMC's bills, which seems to be the case, then your project may leave Cordova with NO pharmacy. Think of that—NO drugstore. No place for anyone from out of town to fill their prescriptions. No place for patients of Ilanka or the dentist to get their prescriptions. Not to mention the loss of the million dollars plus of revenue that pumps through my business every year, or the loss of some of the services my business provides.

It's hard for me to sleep at night thinking; I have worked my butt off for 40 years and built this business up only to have my retirement shattered because part of the municipality of Cordova engaged in a government subsidized program that directly competed with private business.

I am sorry that I could not read this to you in person, as I am at a long planned family reunion. I probably would have gotten too emotional anyway and made a mess of it. If nothing else I hope that this will cause you board members to question some of the numbers I have alluded to above, and to really question the source of the projected timeline data. If those numbers came from some communities Outside that are the same size as Cordova, question whether they served a large outlying area as well (which we don't have) or if they had an abundance of impoverished citizens, or if they existed far from any other clinic and pharmacy so they got all the business from everyone. Any one of these would have increased those projected numbers. Question whether any of these numbers correlated at all with the situation in the city of Cordova. Question all—I don't think those numbers are right myself.

I apologize for the length of this letter, but I feel that CCMC is traveling down the wrong path here and I am striving to leave Cordova with a functioning drugstore.

I have structured my business to provide pharmacy services to the citizens of Cordova even though that part of my business is not making much profit. I hope to pass it on to a new owner who can continue to provide this essential service.

I thank you for your time and consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "David A. O'Brien". The signature is fluid and cursive, with the first name "David" being the most prominent.

David A. O'Brien Owner

**cc: Cordova City Council
Gary Van Winkle MD Ilanka Health Center**



Memorandum

To: CCMC Authority Board of Directors

From: Scot Mitchell, FACHE, CCMC CEO

Subject: Quality Improvement – 1st Quarter 2017 Patient Safety

Date: June 19, 2017

Suggested Motion: “I move that the CCMC Authority Board of Directors approves the Quality Improvement – 1st Quarter 2017 Patient Safety Report.”

Partnership for Patients



ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION



Washington State
Hospital Association

Alaska Critical Access Hospital Patient Safety Report - May 2017 Release

Partnership for Patients



ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION



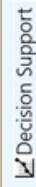
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Nursing Sensitive Measures 2017 Q1 Distribution



Alaska State Hospital and Nursing Home Association and Washington State Hospital Association - for questions or support in improving results, please contact patricia@ashnha.com or ericb@wsha.org.



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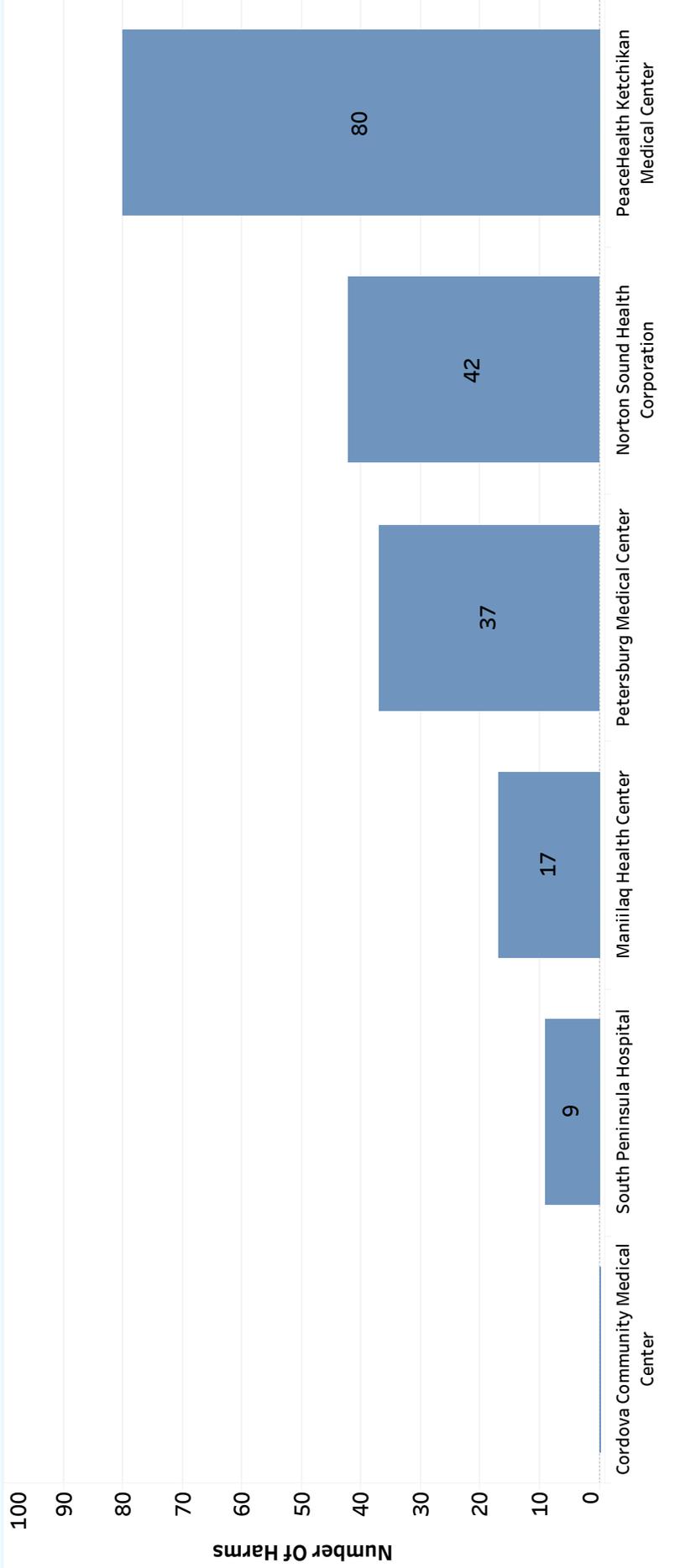
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Decision Support

Partnership for Patients



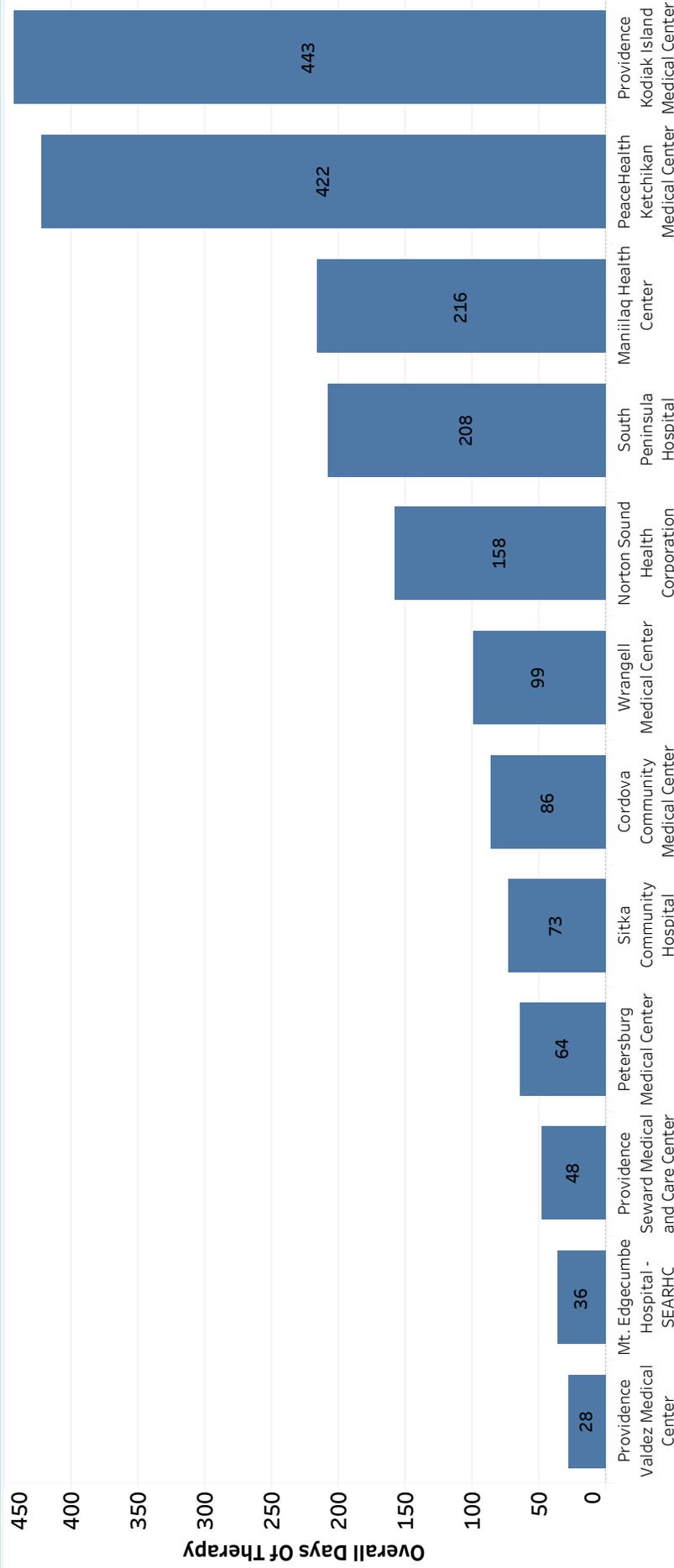
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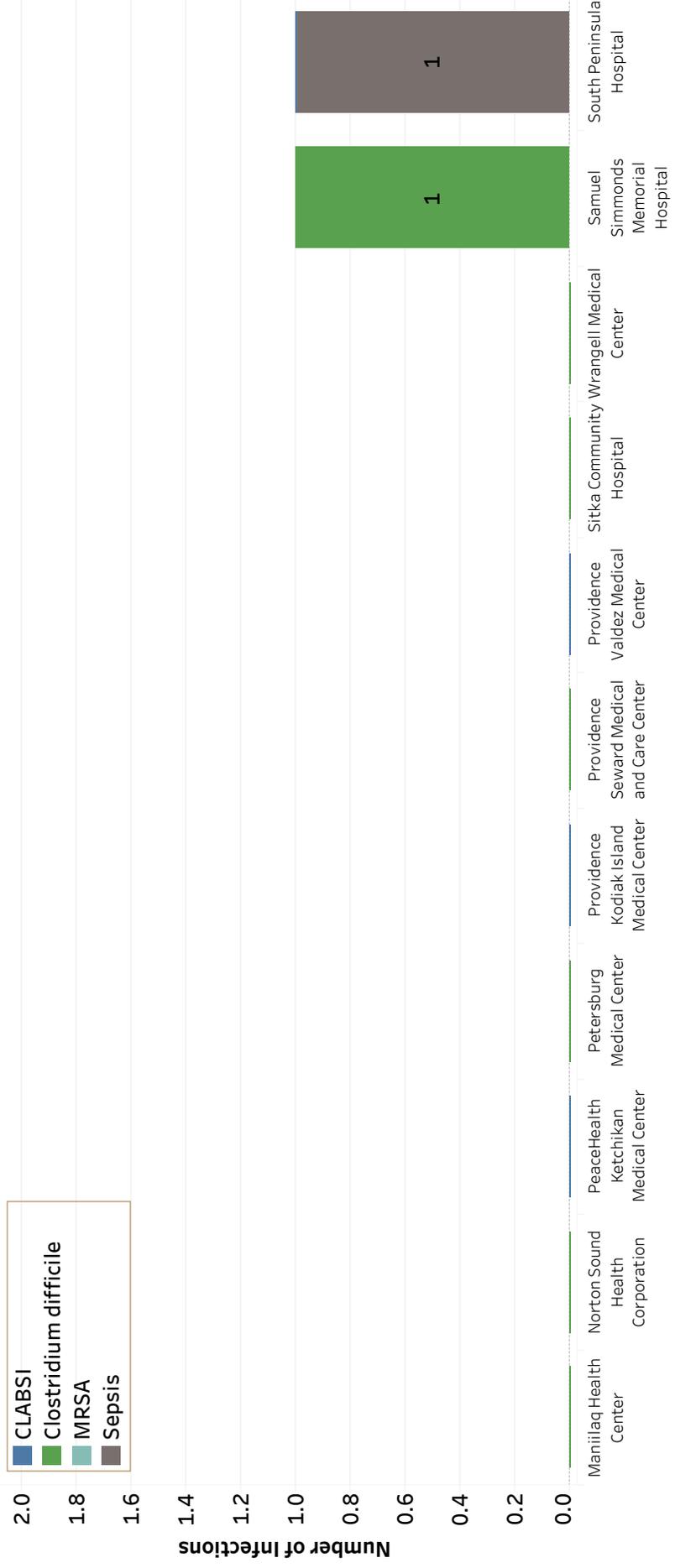
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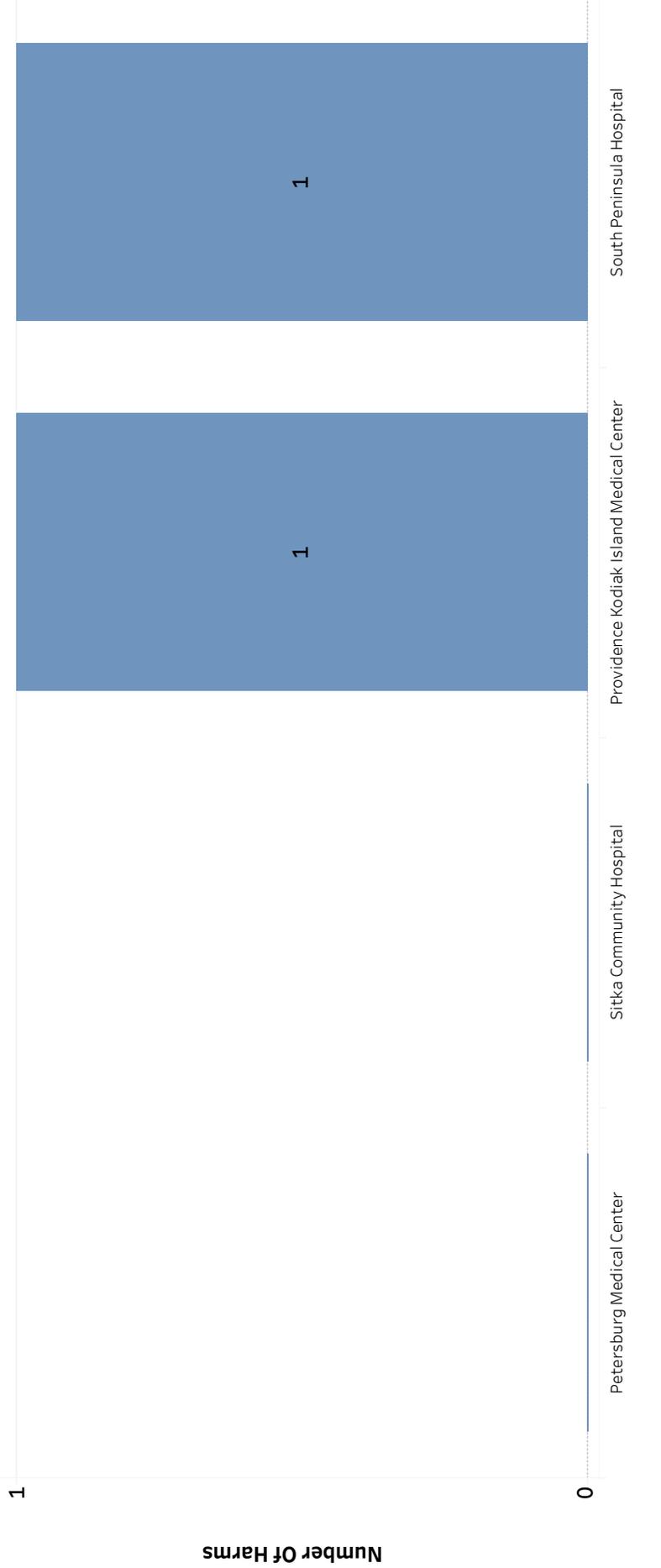
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Washington State Hospital Association

Alaska Critical Access Hospital Patient Safety Report - May 2017 Release

Venous Thromboembolism: Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) (AHRQ PSI-12) 2016 Q4 Distribution



Alaska State Hospital and Nursing Home Association and Washington State Hospital Association - for questions or support in improving results, please contact patricia@ashnha.com or ericb@wsha.org.

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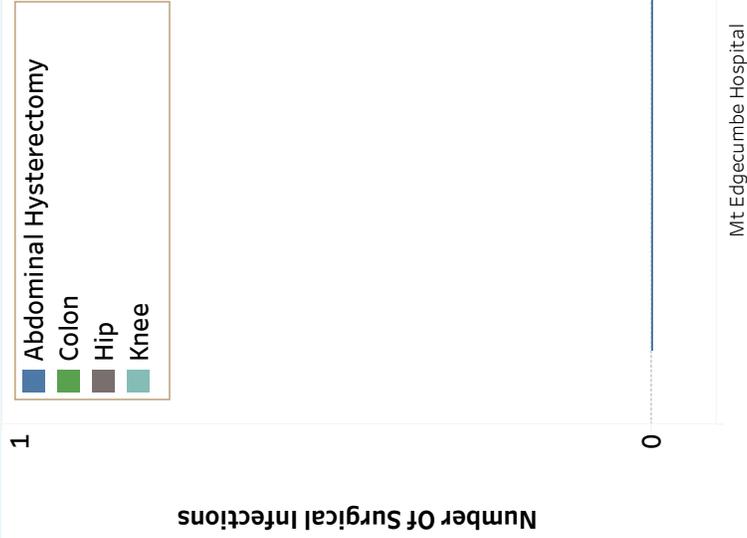
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Washington State Hospital Association

Alaska Critical Access Hospital Patient Safety Report - May 2017 Release

Surgical Site Infections 2017 Q1 Distribution



Alaska State Hospital and Nursing Home Association and Washington State Hospital Association - for questions or support in improving results, please contact patricia@ashmha.com or ericb@wsha.org.

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Patient Safety Comparison Report May 2017 Release

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Note: High outliers may exceed scale of graphs. Such cases will appear to be cutoff.

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



ASHNHA Member Agreement on Sharing Patient Safety Data

ASHNHA members have agreed to share patient safety data internally to support learning and collaboration. Initial data shared will be data submitted as part of the Partnership for Patients Hospital Improvement and Innovation Network. A monthly hospital comparison report will be generated by the Washington State Hospital Association. These graphs will include all hospitals in Alaska and Washington that are participating in the patient safety initiative.

These reports will go to quality directors, CEOs, CNOs, CMOs and ASHNHA Patient Safety Committee members. The reports will show Washington and Alaska hospitals on the same the chart. If desired an Alaska specific report will also be available

As part of sharing data there is agreement among ASHNHA members that we do not compete on safety in Alaska. We want safe care and no harm for all patients at all facilities. Sharing of data is to drive improvement and support learning and collaboration.

The key principle in sharing the data is that Alaska hospitals do not compete on patient safety and will not use this data for competitive purposes. This agreement is shared with everyone who receives the reports so they understand the purpose of the data sharing.

To help people understand what this means here are a couple of examples:

- Hospital A will not run advertising that says “Our CAUTI rate is lower than Hospital B.”
- Hospital C will not promote a services saying “come to our hospital it is safer in surgical site infections than Hospital D.”
- Hospitals CAN use the data to brag about their own results, such as “Hospital A has not had a CAUTI in 9 months” or “Hospital C has not had a surgical site infection in x months” or “Hospital B is collaborating with other Alaska hospitals to improve patient safety and we are showing significant improvements in ___ area.”

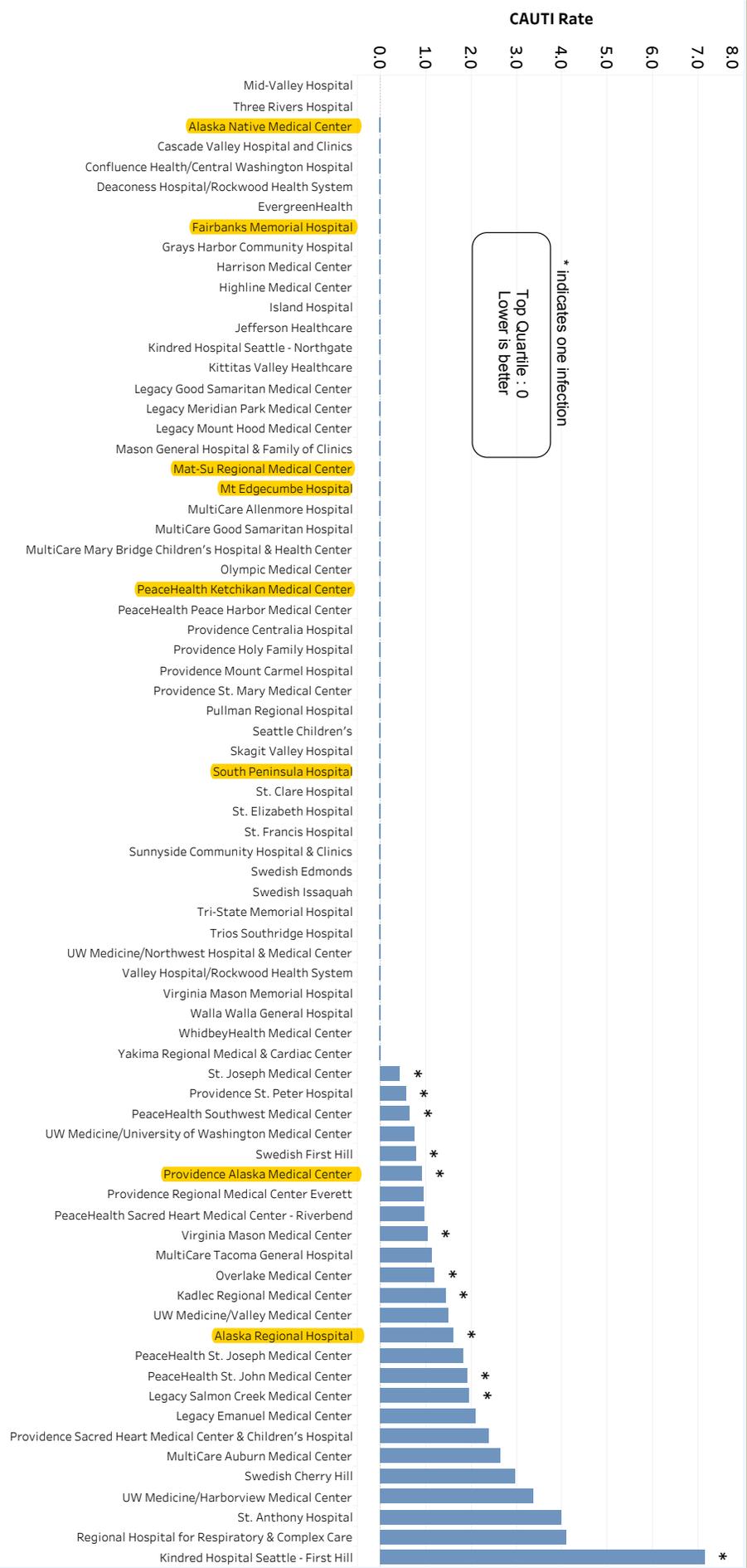
The ASHNHA Patient Safety Committee and Executive Committee have discussed and understand this agreement and will support others at their facility in using the data in appropriate ways to improve care and increase opportunities to learn and collaboration to make care as safe as possible in Alaska.

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Catheter Associated Urinary Tract Infection (CAUTI) ICU Rate 2017 Q1 Distribution



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

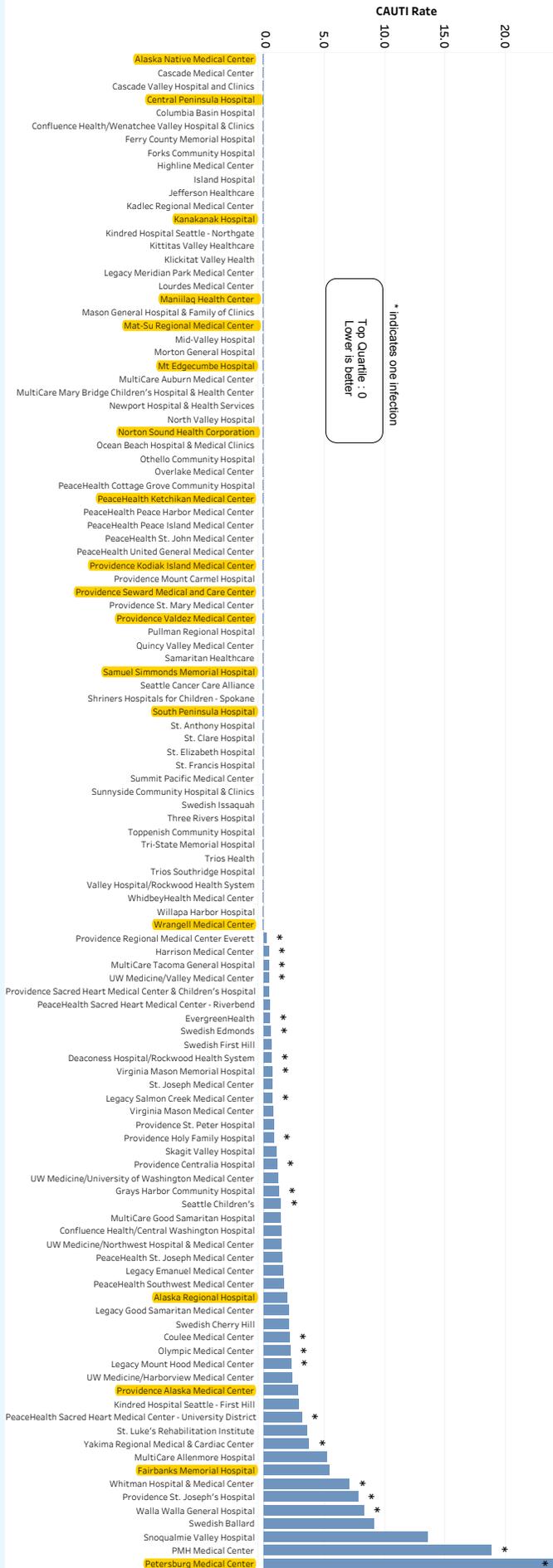
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsna.org.

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Catheter Associated Urinary Tract Infection (CAUTI) Non-CU Rate 2017 Q1 Distribution



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

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

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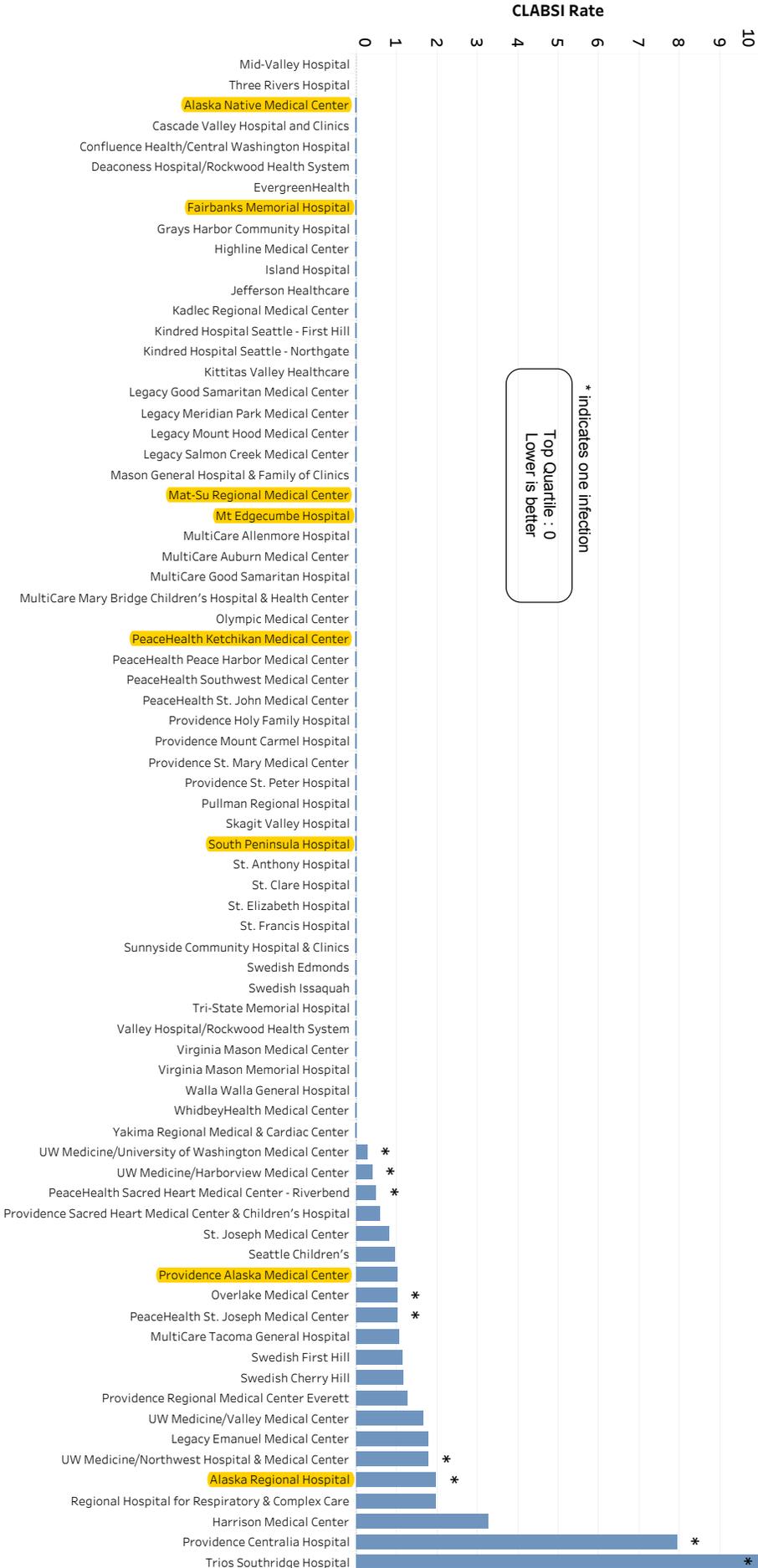
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Central Line Associated Bloodstream Infections (CLABSI) ICU Rate 2017 Q1 Distribution



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

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

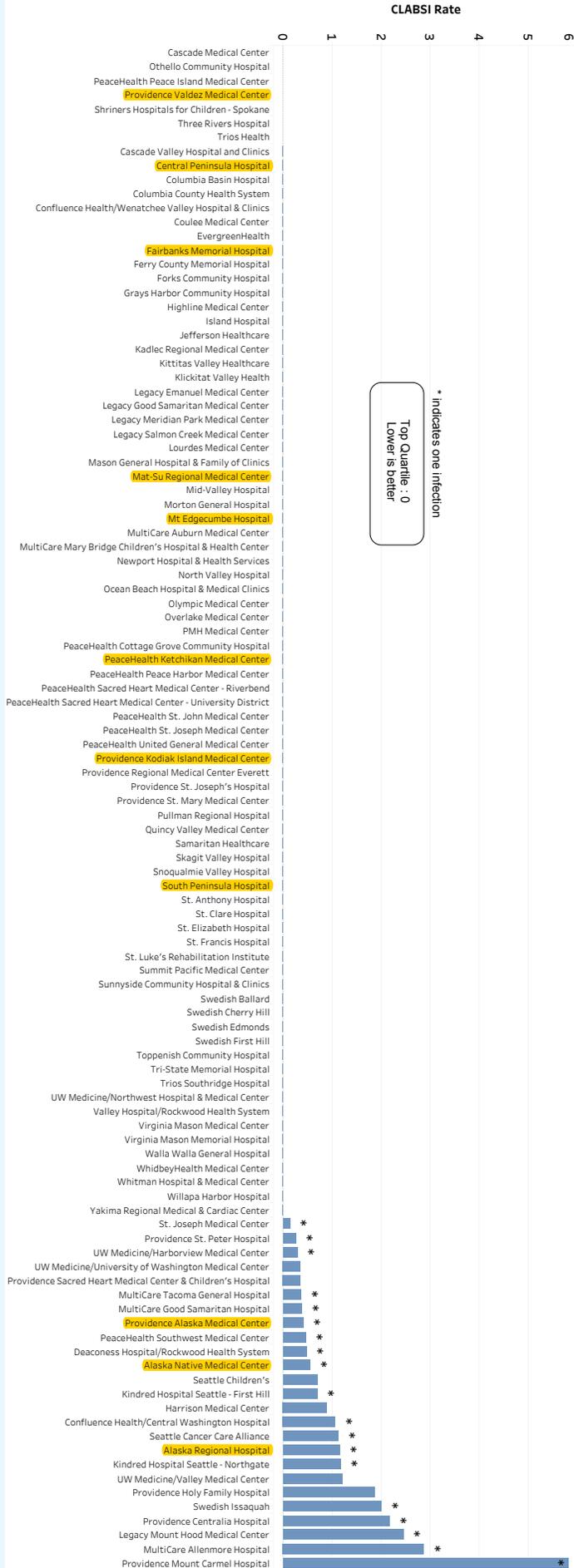


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Central Line Associated Bloodstream Infections (CLABSI) Non-ICU Rate 2017 Q1 Distribution



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

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

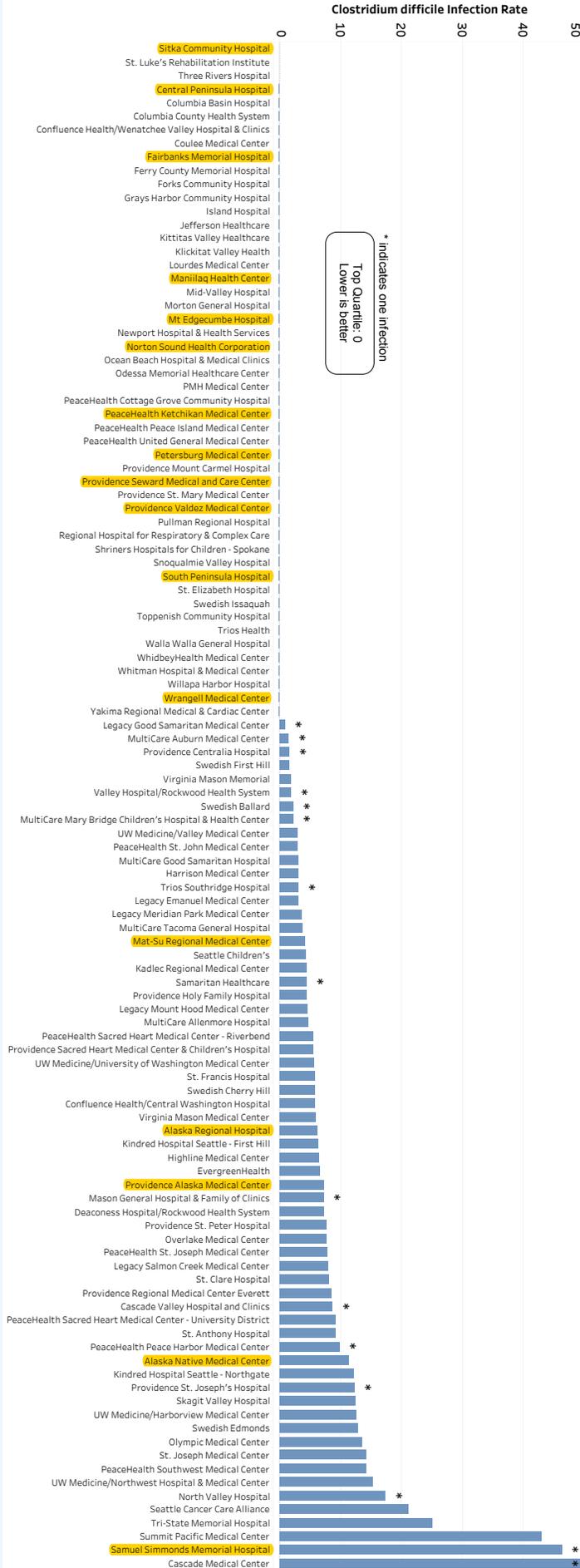
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Clostridium difficile Infection (CDI) Rate 2017 Q1 Distribution



Definition: Facility CDI Healthcare Facility-Onset Incidence Rate = Number of all healthcare facility-onset (HO) Clostridium difficile infections (CDI) laboratory-identified (LabID) events per month in the facility / number of patient days for the facility x 10,000.

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

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

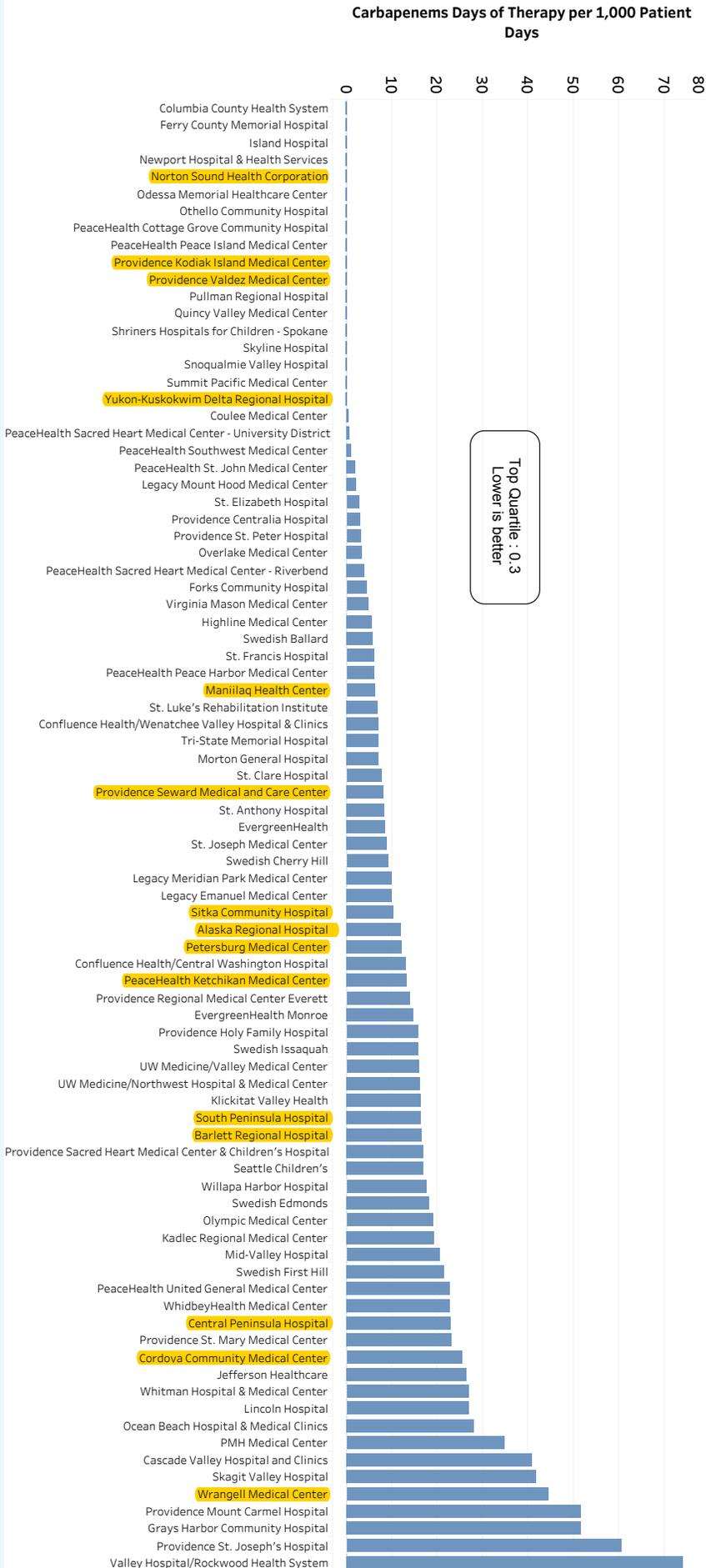


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Antimicrobial Stewardship (ASP) Carbapenems Days-of-Therapy 2017 Q1 Distribution



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

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

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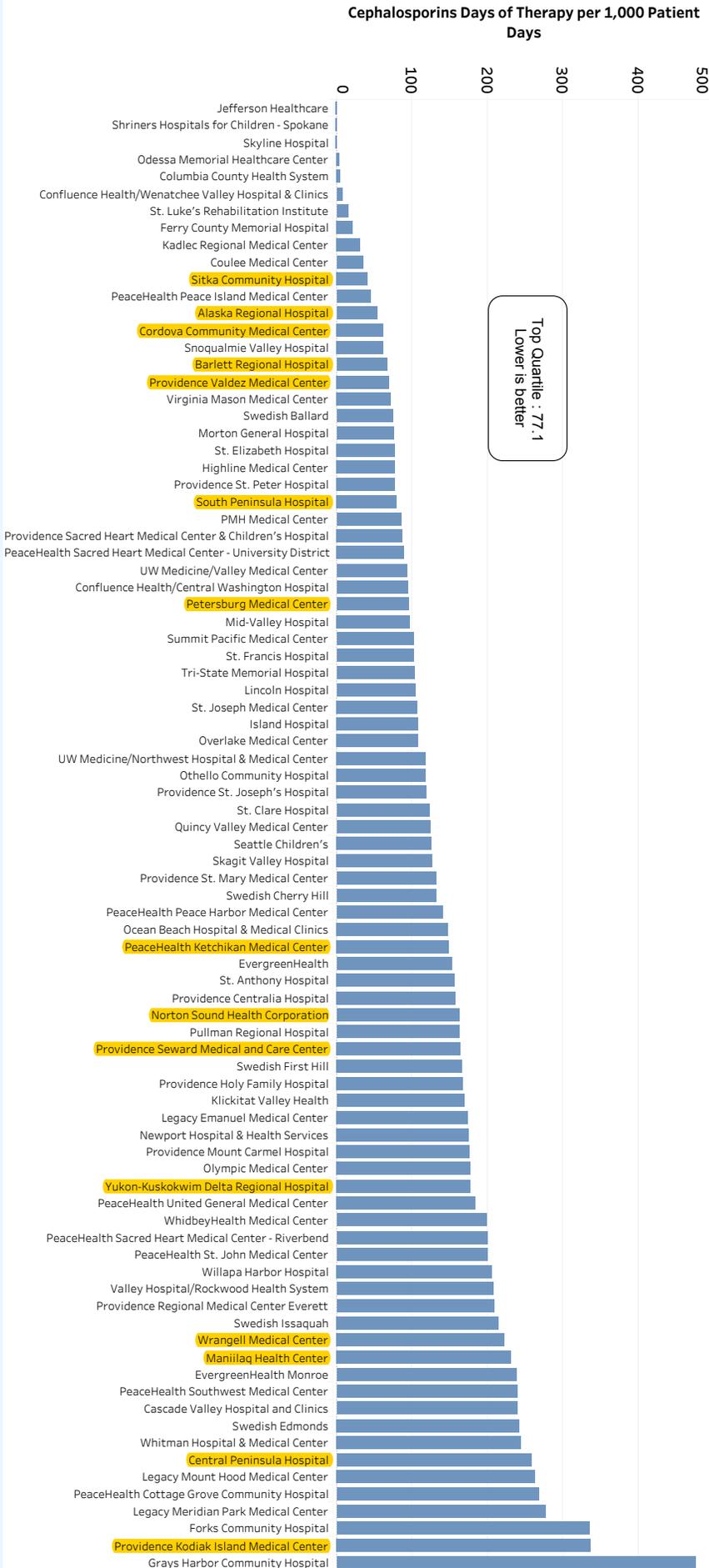
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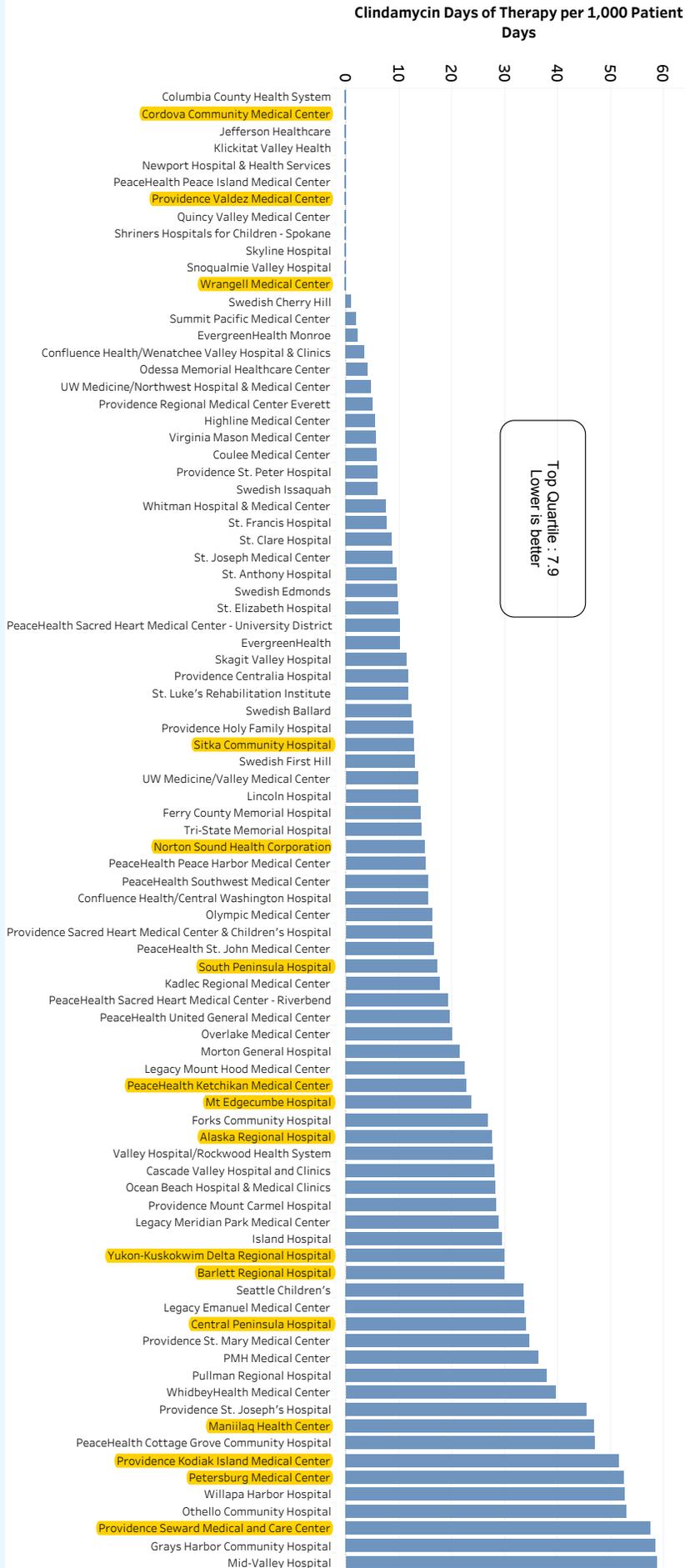
Antimicrobial Stewardship (ASP) Cephalosporins Days-of-Therapy 2017 Q1 Distribution



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

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

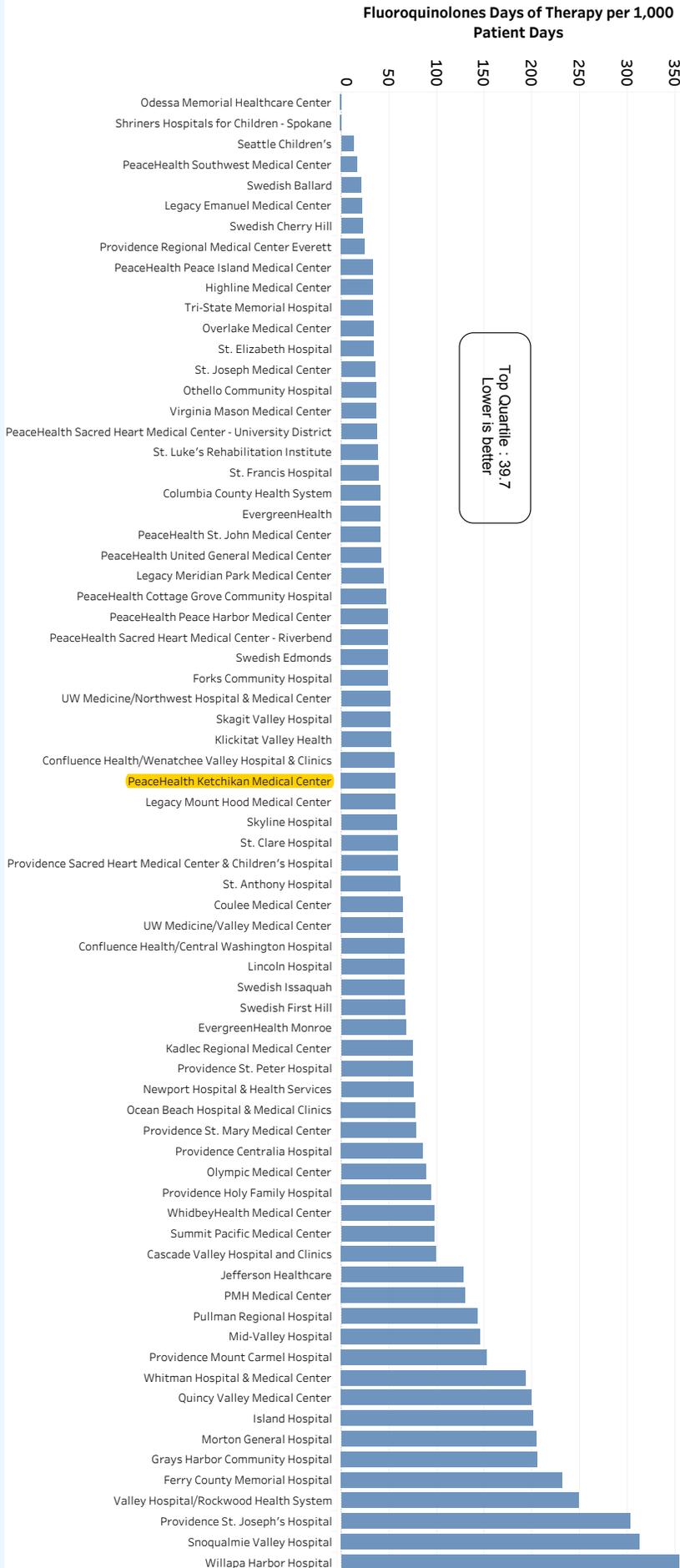
Antimicrobial Stewardship (ASP) Clindamycin Days-of-Therapy 2017 Q1 Distribution



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

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

Antimicrobial Stewardship (ASP) Fluoroquinolones Days-of-Therapy 2017 Q1 Distribution



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

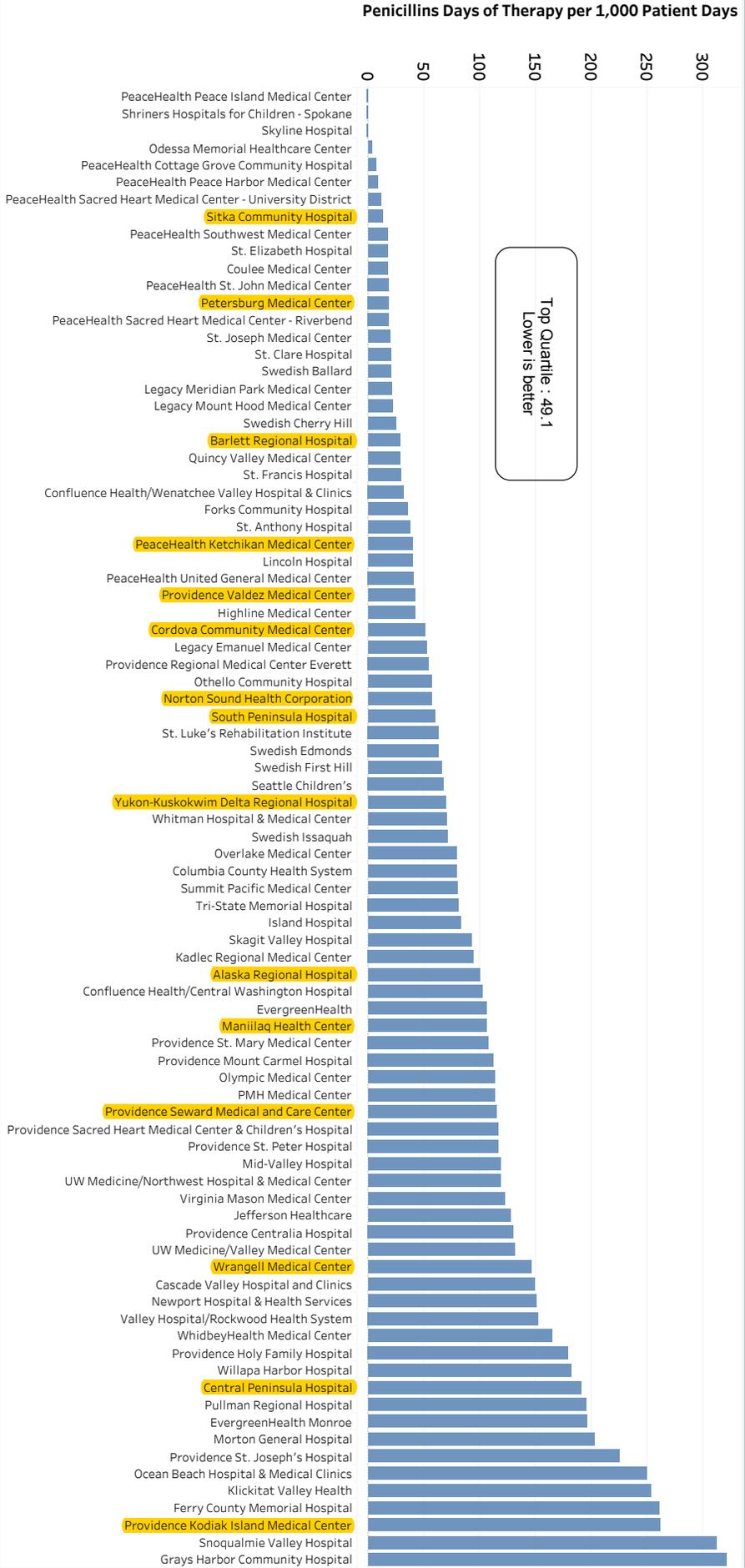
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsaha.org

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Antimicrobial Stewardship (ASP) Penicillins Days-of-Therapy 2017 Q1 Distribution

Antimicrobial Stewardship (ASP) Penicillins Days-of-Therapy
2017 Q1 Distribution



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

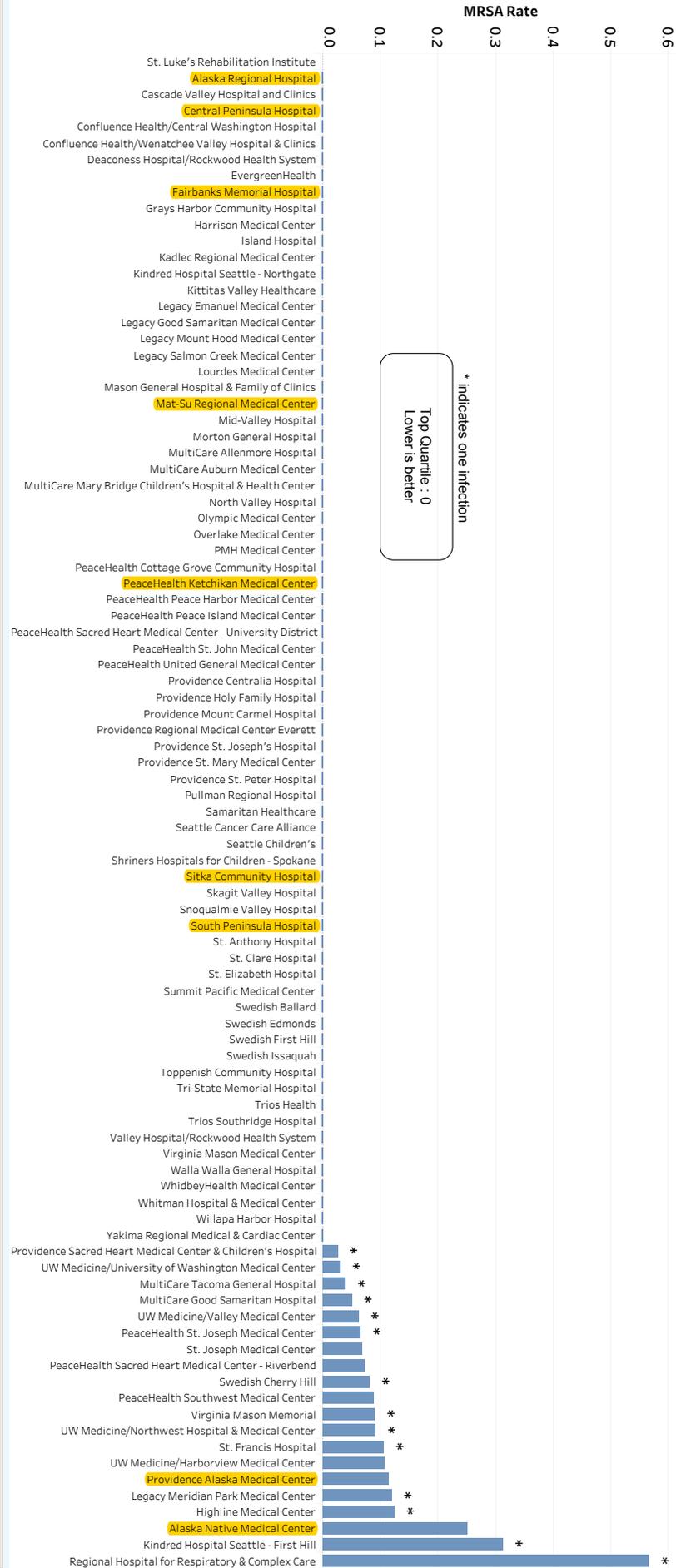
Washington State Hospital Association - for questions or support in improving results, please contact JenniferC@wsaha.org

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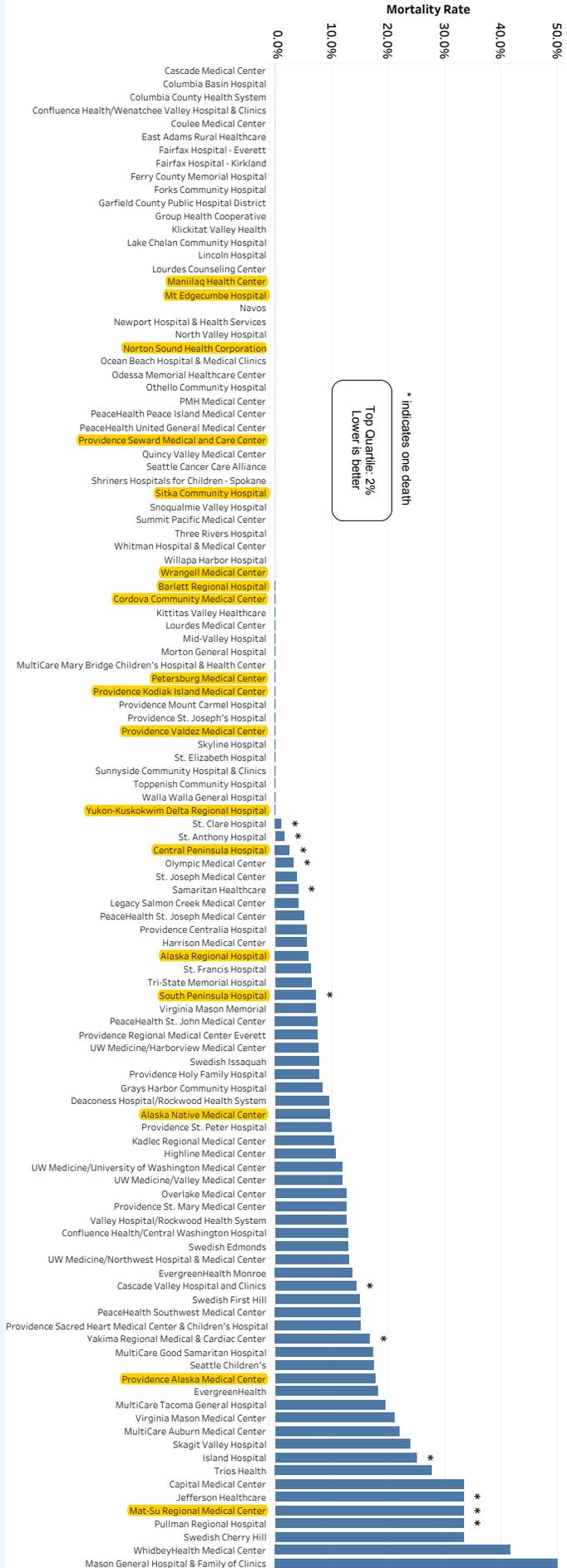
Methicillin-Resistant Staphylococcus Aureus (MRSA) 2017 Q1 Distribution



Definition: MRSA Blood Incident LabID Rate is the number of MRSA Blood Incident LabID Count per 1,000 patient days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN)

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

Severe Sepsis and Septic Shock Mortality Rate
2017 Q1 Distribution



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

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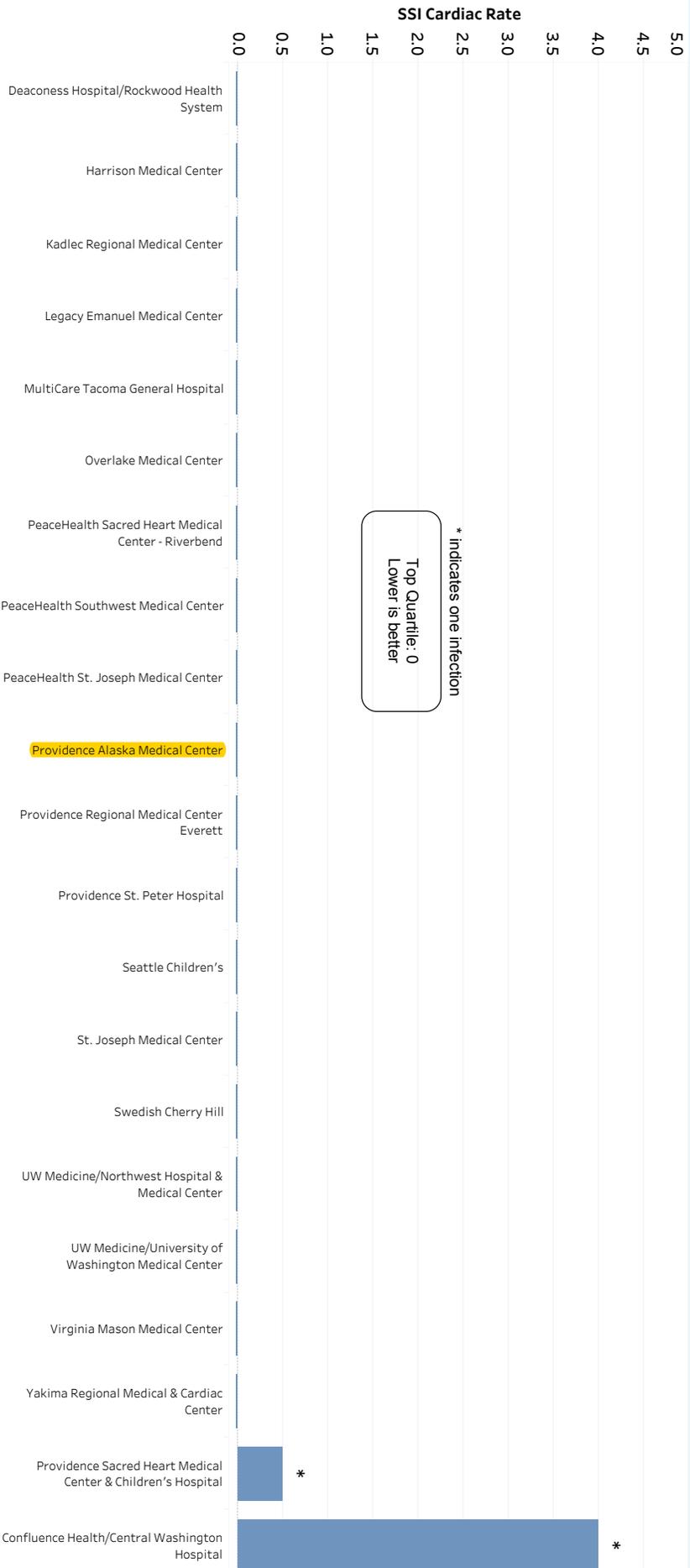
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Surgical Site Infection (Cardiac) Rate 2017 Q1 Distribution



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

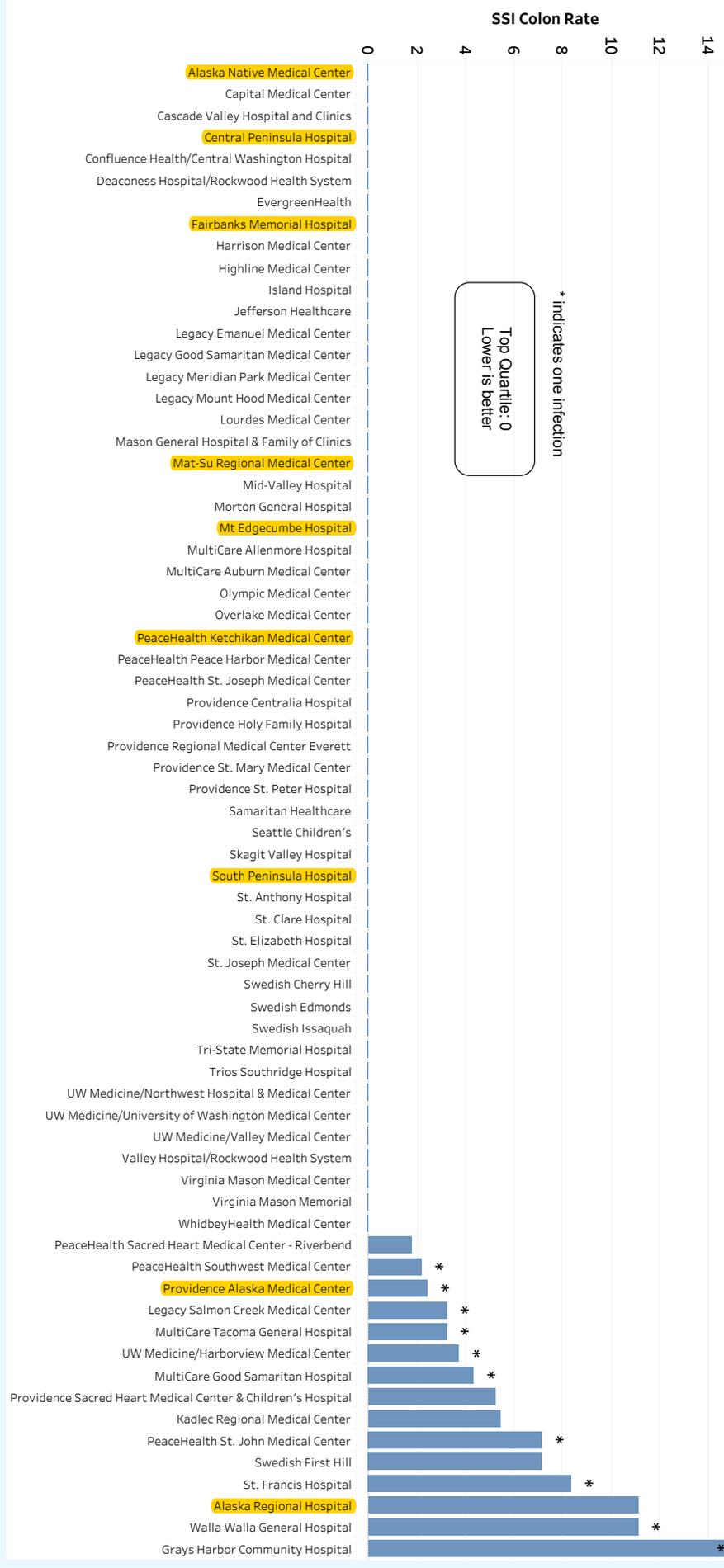
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsha.org.

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Surgical Site Infection (Colon) Rate 2017 Q1 Distribution



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

Data Source: CDC NHSN.

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Surgical Site Infection (Hip and Knee) Rate 2017 Q1 Distribution



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

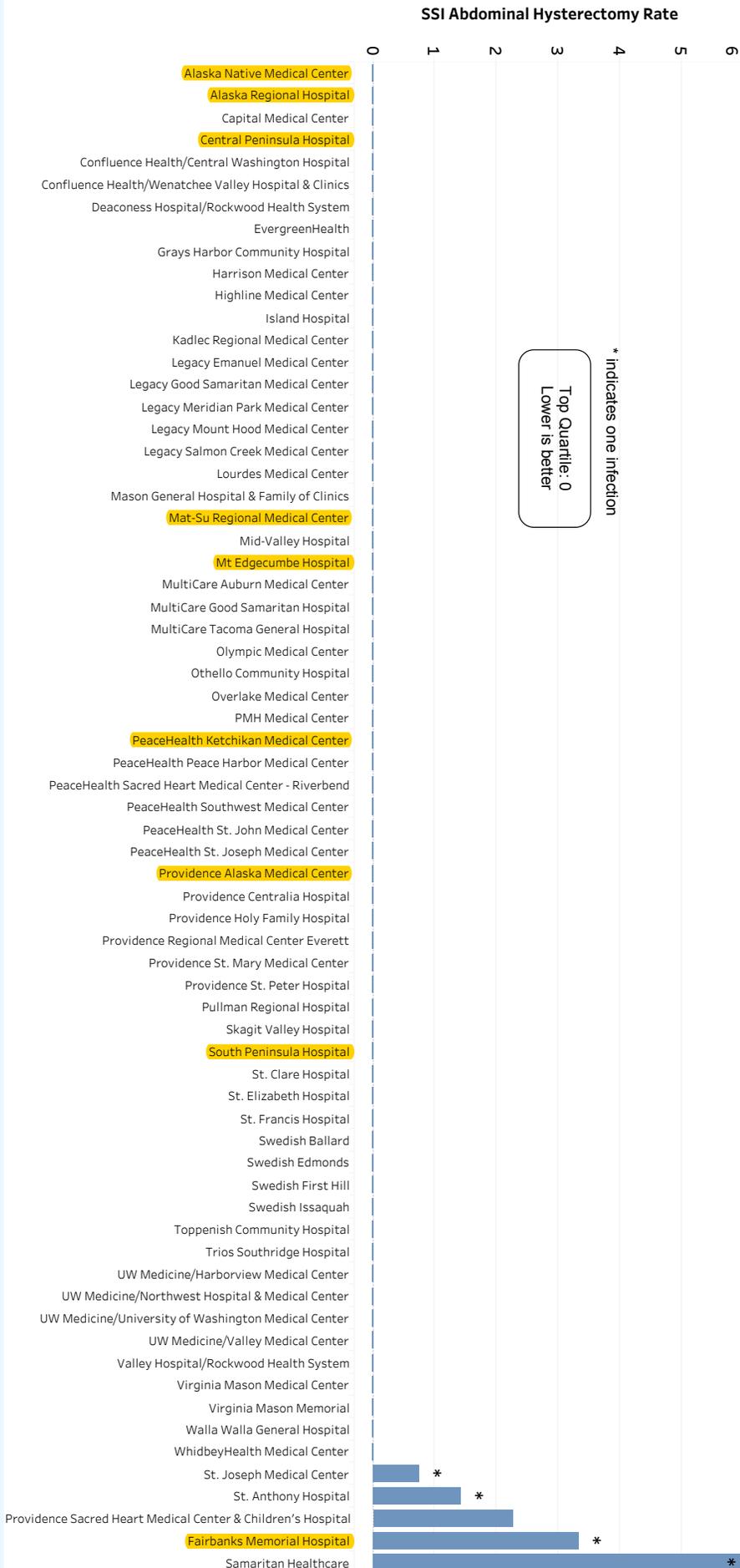
Washington State Hospital Association - for questions or support in improving results, please contact JenniferC@wsha.org.

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Surgical Site Infection (Abdominal Hysterectomy) Rate 2017 Q1 Distribution



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

Data Source: CDC NHSN.

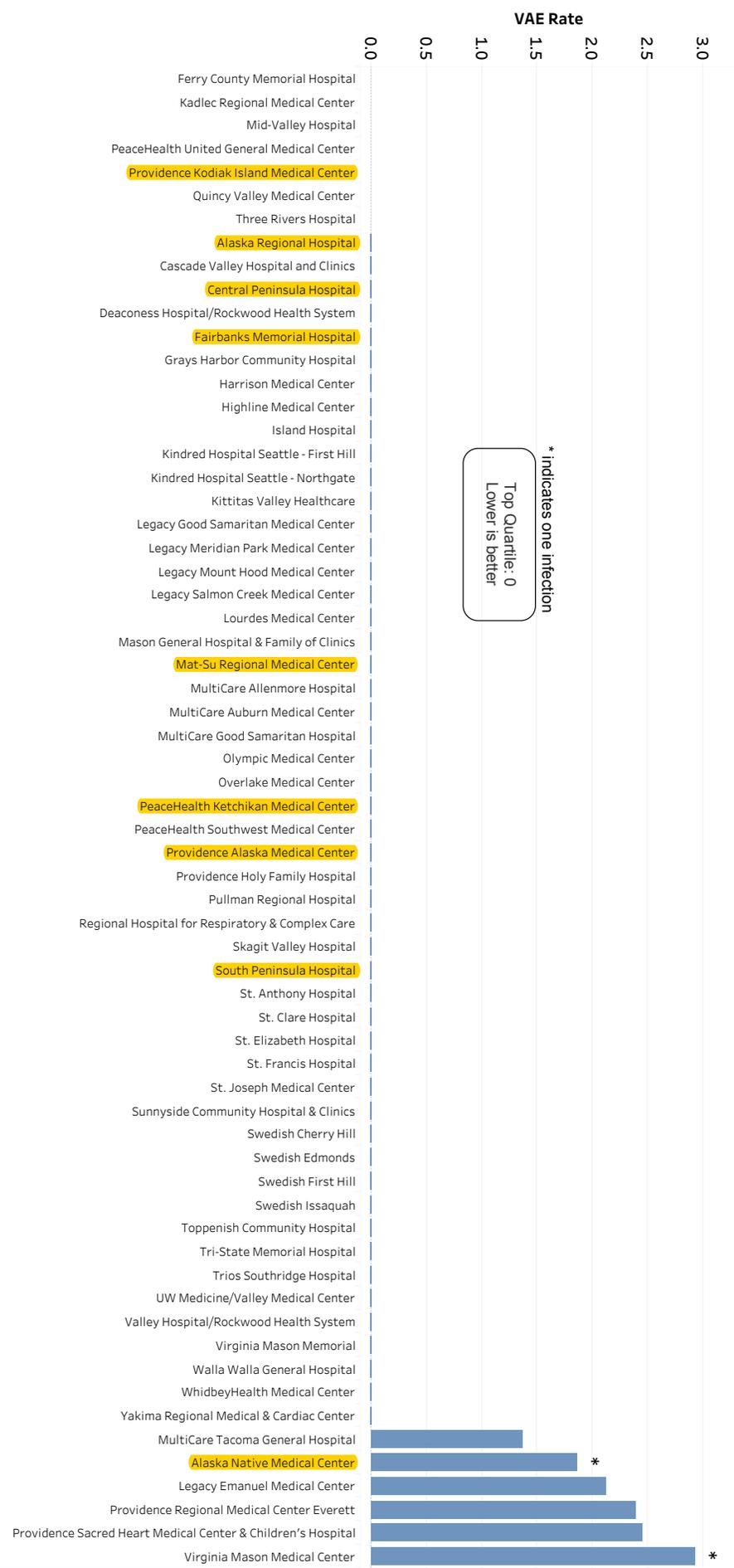
Washington State Hospital Association - for questions or support in improving results, please contact: JenniferG@wsha.org.

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Ventilator Associated Events (VAE): Infection-Related Ventilator-Associated Complications IVAC 2017 Q1 Distribution



* Indicates one infection
Top Quartile: 0
Lower is better

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

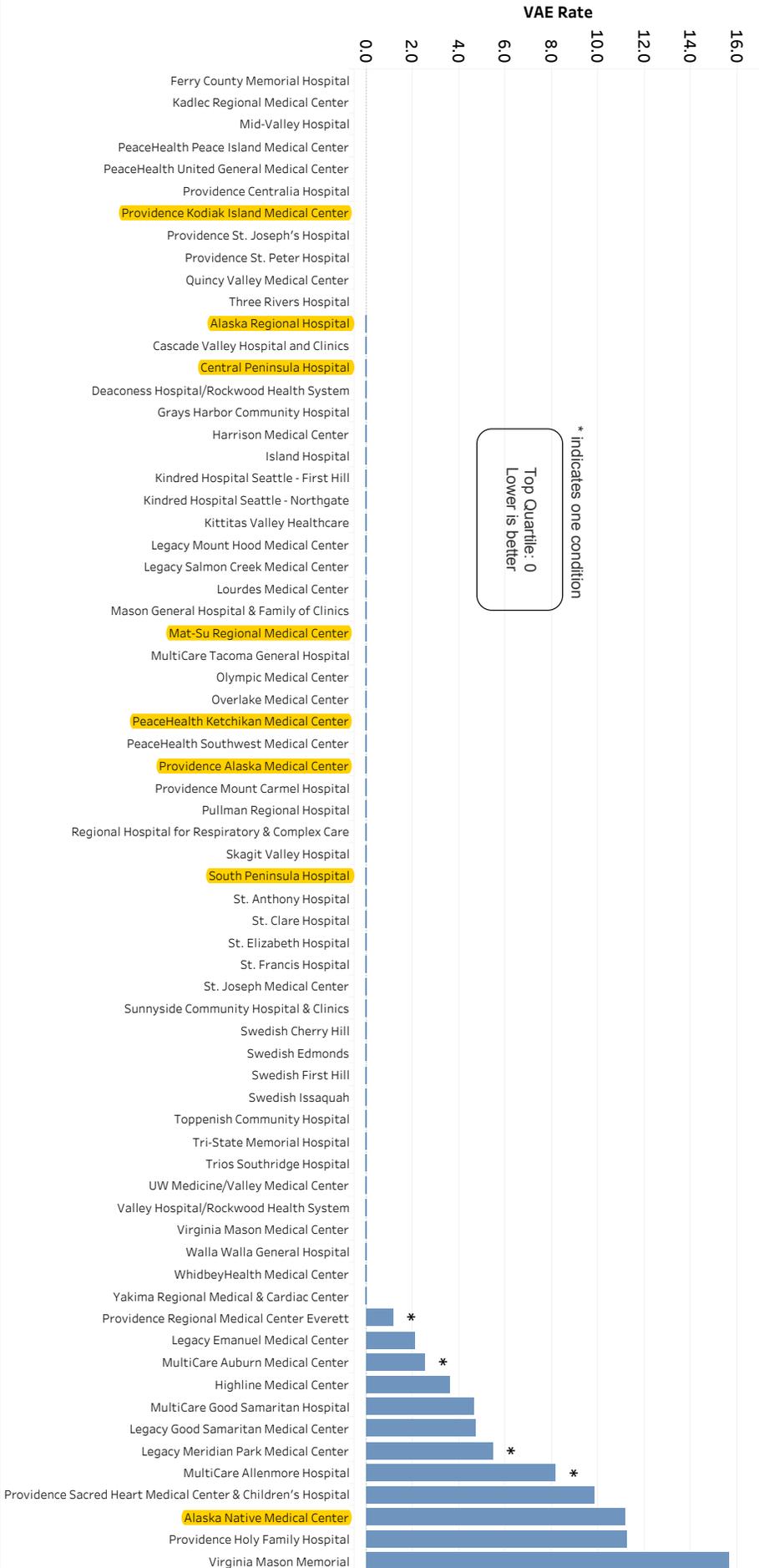
Washington State Hospital Association - for questions or support in improving results, please contact JenniferG@wsha.org.

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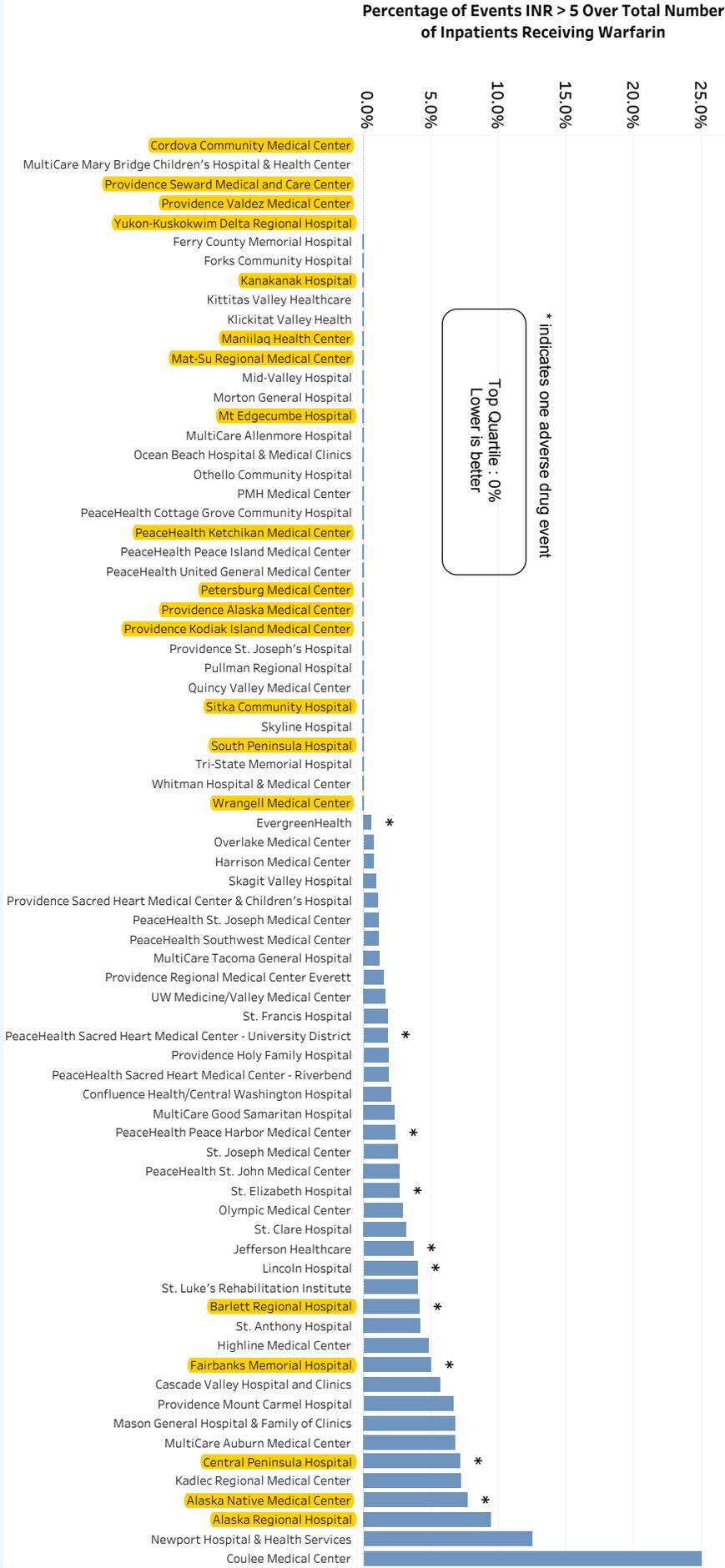
Ventilator Associated Events (VAE) : Ventilator-Associated Condition VAC 2017 Q1 Distribution



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

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

Adverse Drug Events Anticoagulants: Option 1 2017 Q1 Distribution



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

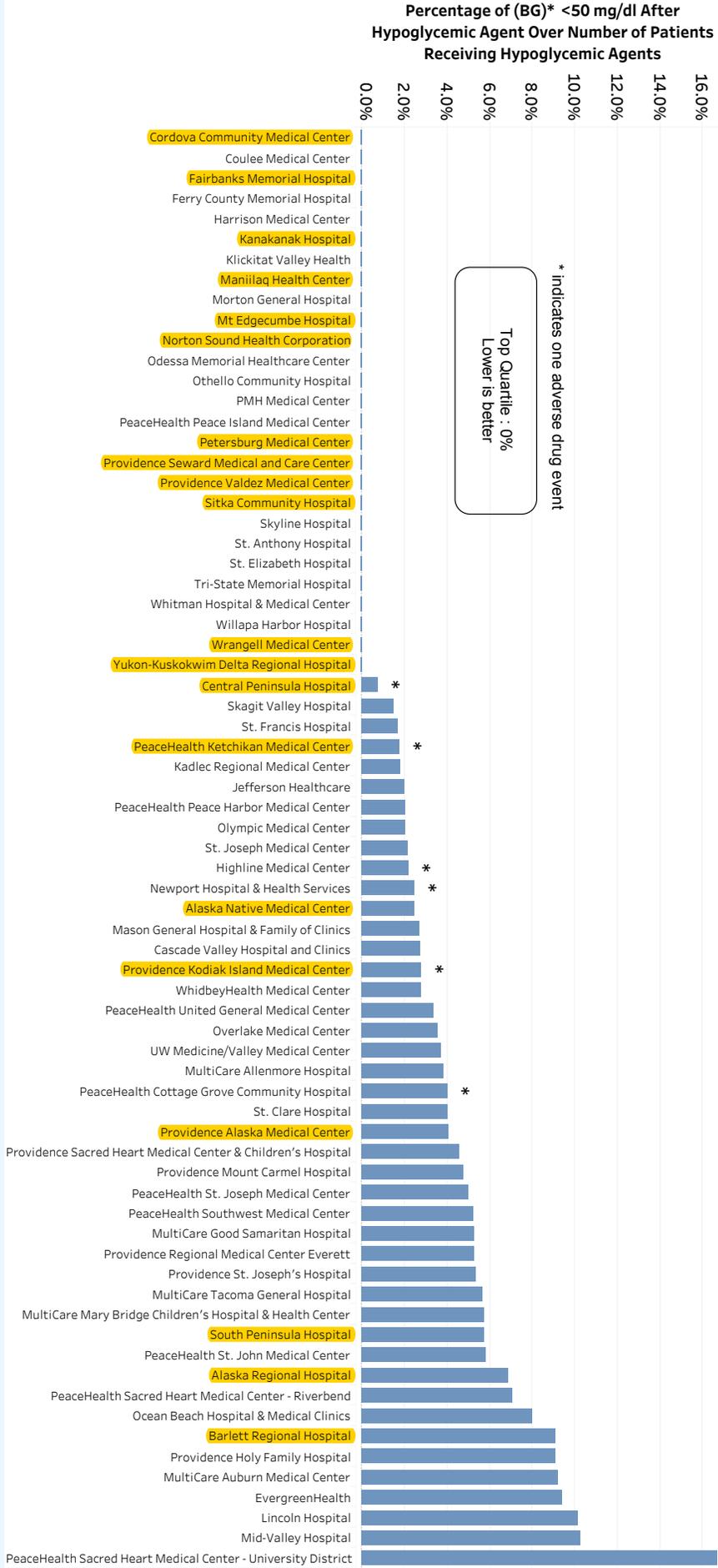
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System

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Adverse Drug Events Hypoglycemic Agent: Option 1 2017 Q1 Distribution



Definition: Number of patient blood glucose (BG)* levels of <50 mg/dl after any hypoglycemic agent administration (patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) receiving hypoglycemic agents (oral & insulin).
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System

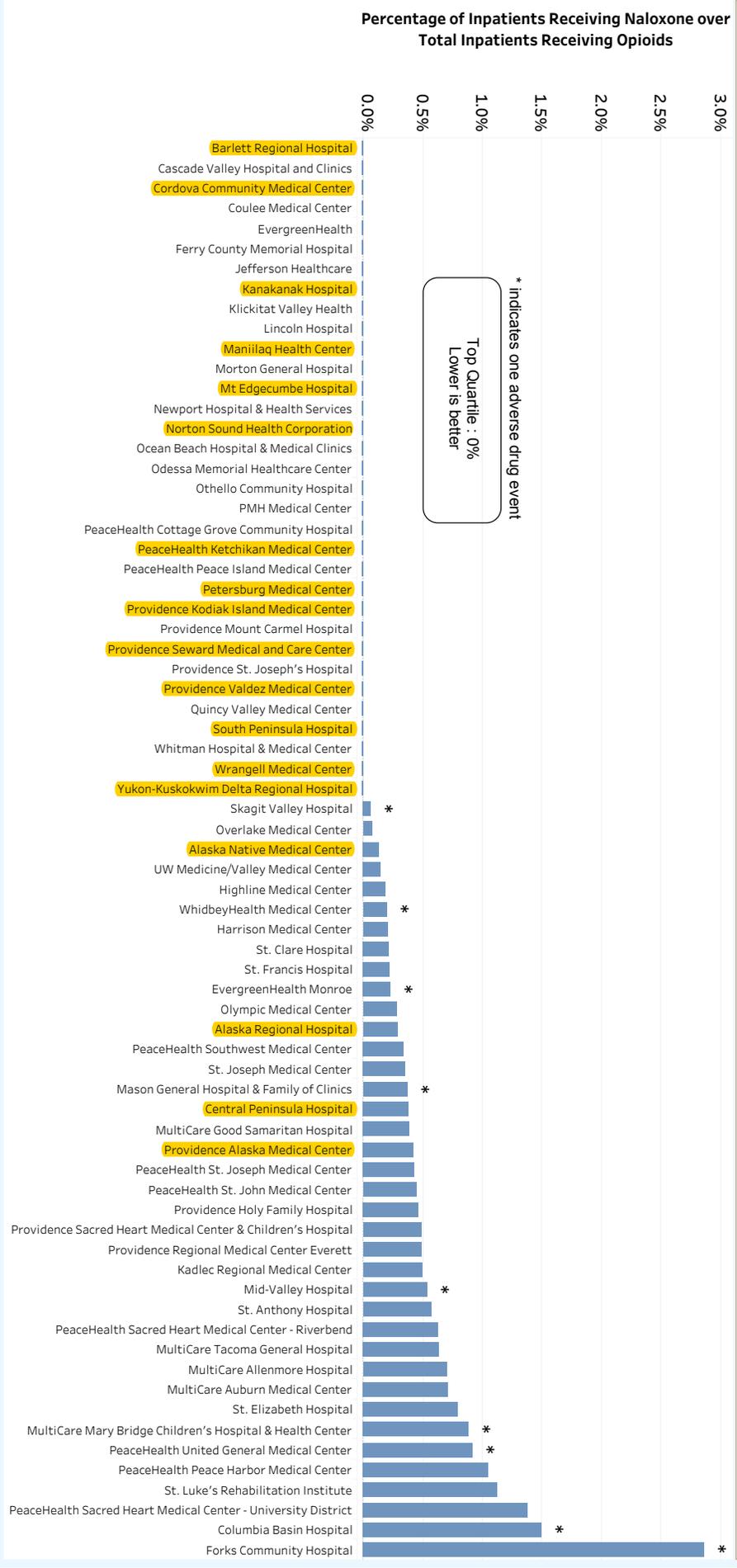
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Adverse Drug Events Opioids: Option 1 2017 Q1 Distribution

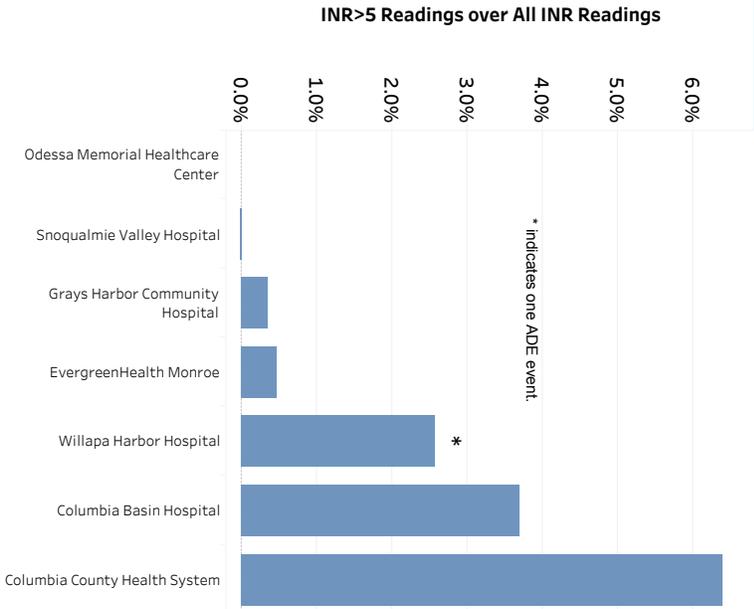


Definition: Number of patients (cared for in an inpatient area) who received naloxone after any opioid administration over number of patients (cared for in an inpatient area) receiving opioids. Exclusions: naloxone given in PACU and procedural areas, given (via IV infusion) for epidural-related itching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

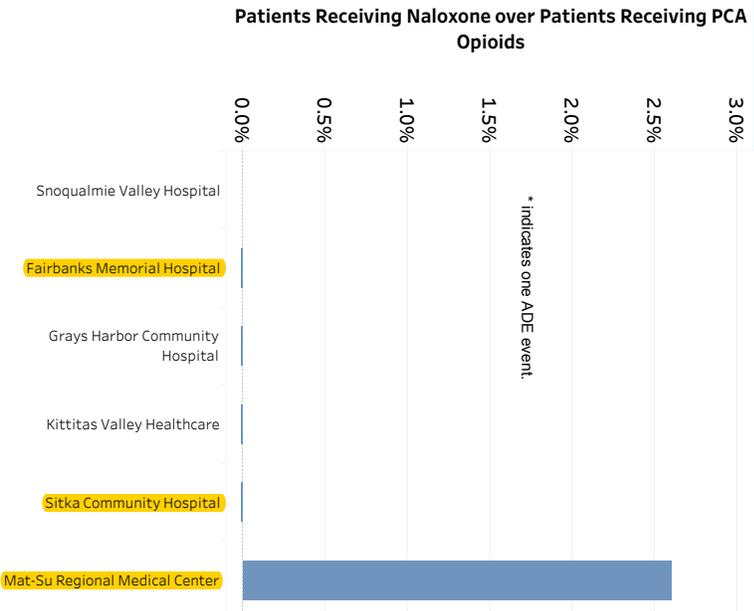
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System

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

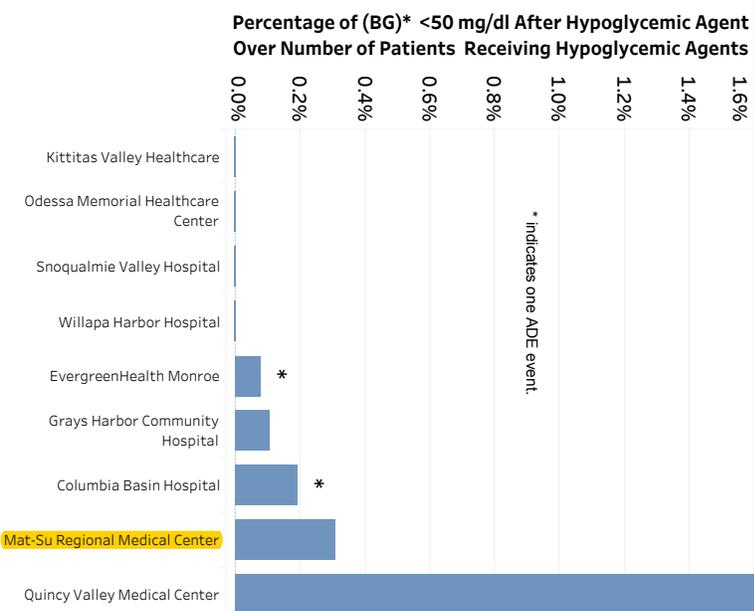
Adverse Drug Events Anticoagulants Option 2



Adverse Drug Events Opioids Option 2



Adverse Drug Events Hypoglycemic Agent Option 2



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

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

Hypoglycemic ADE #2 Description: Total number of BG (blood glucose) levels of <50 mg/dl (for patients cared for in an inpatient area) per 1,000 total patient days (excluding healthy newborns and ED readings).

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

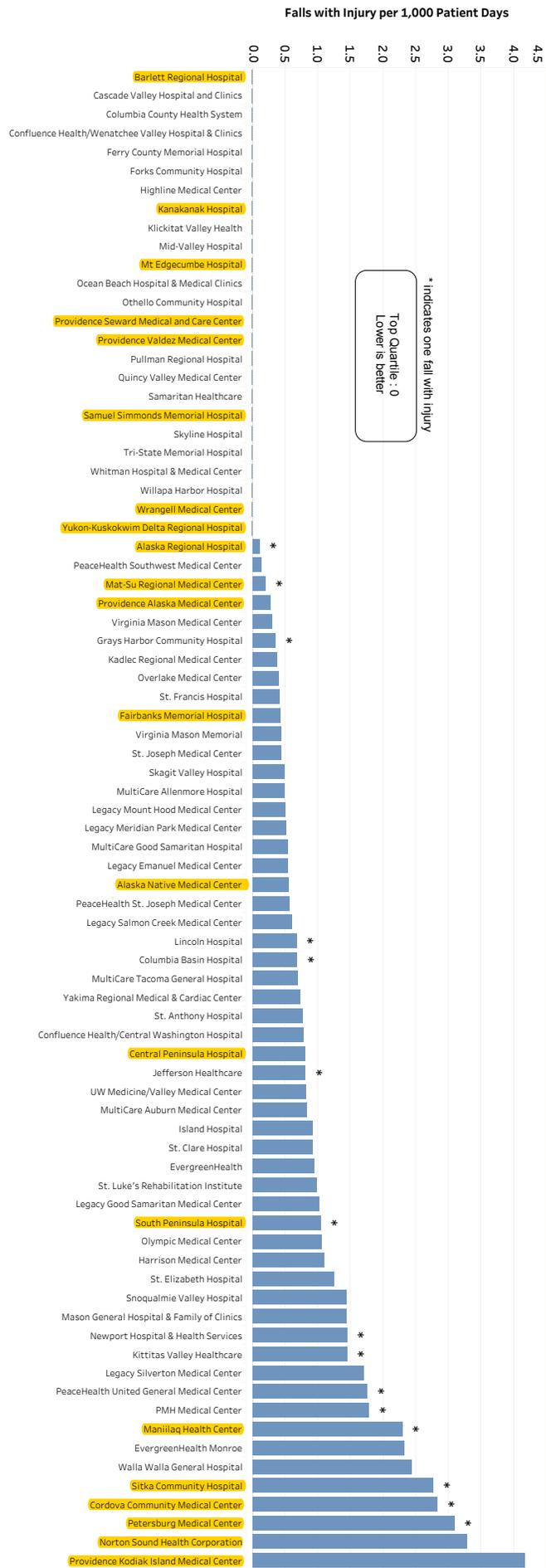
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 Inpatient Falls with Injury Rate (NQF 0202)
 2017 Q1 Distribution



Definition: National Database of Nursing Quality Indicators/Collaborative Alliance for Nursing Outcomes (CALNQI) and NQF 0202, number of falls with an injury level of minor or greater per 1,000 patient days.
Data Source: Washington State Hospital Associations (WSHA) Quality Benchmarking System (QBS) and CALNOC

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

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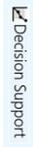
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Hospital-Acquired Pressure Ulcers Rate (AHRQ PSI-03) 2016 Q4 Distribution

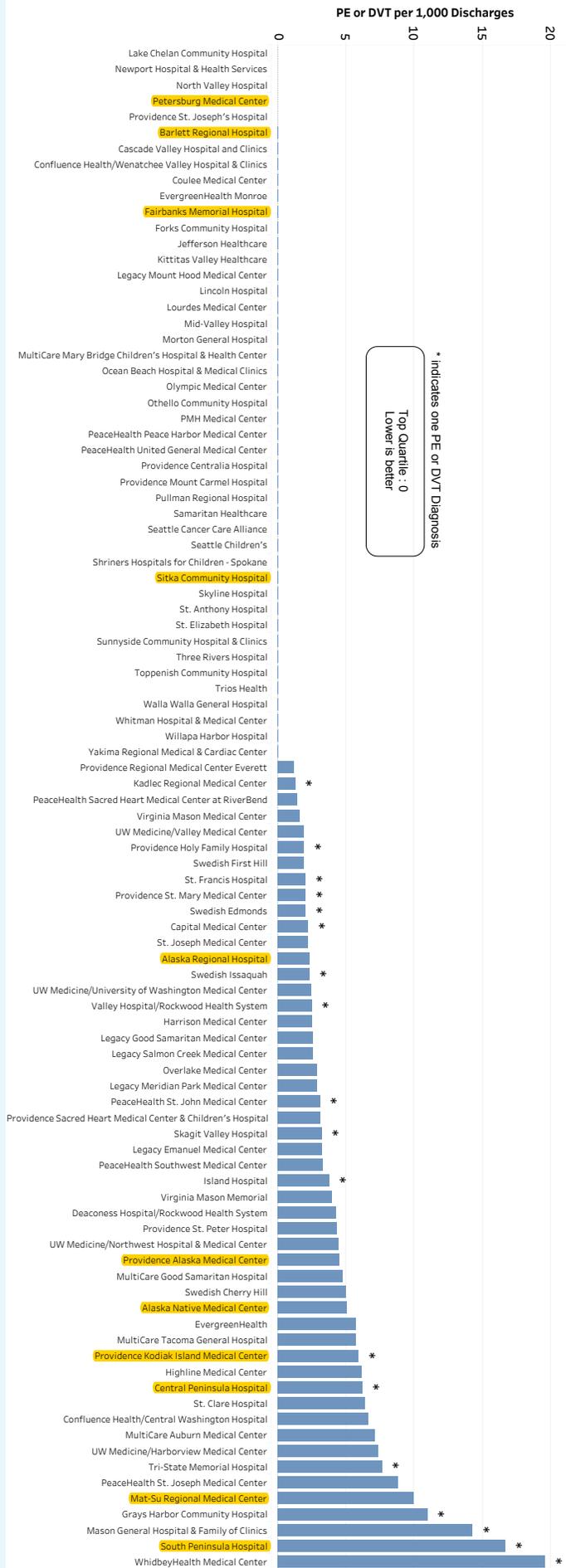


Definition: AHRQ PSI-03, number of pressure ulcers stage III, IV, or unstageable per 1,000 medical and surgical discharges.
 Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS)

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



Venous Thromboembolism: Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate (AHRQ PSI-12)
2016 Q4 Distribution



Definition: AHRQ PSI-12, number of PE or DVT discharges per 1,000 surgical discharges.
Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS)

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

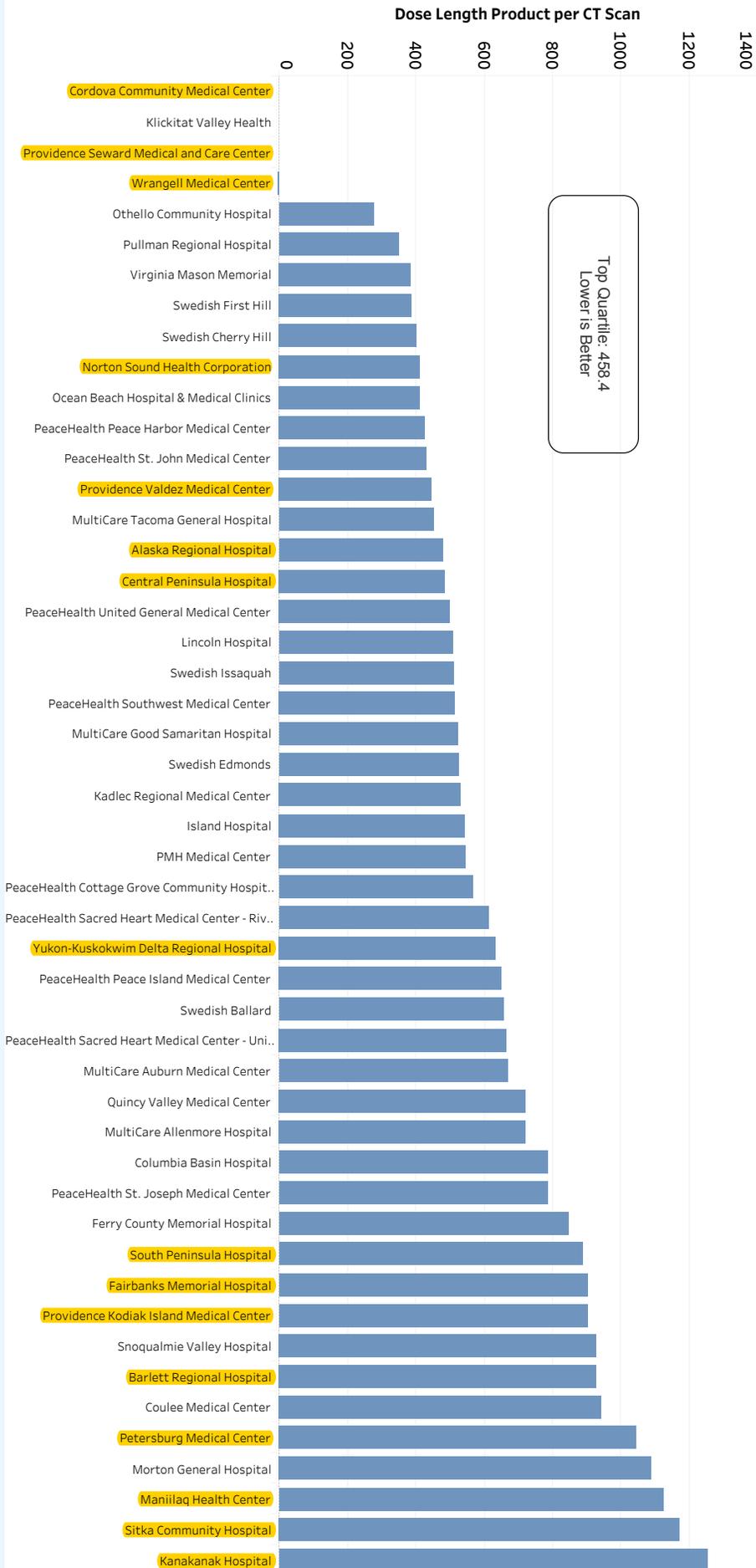
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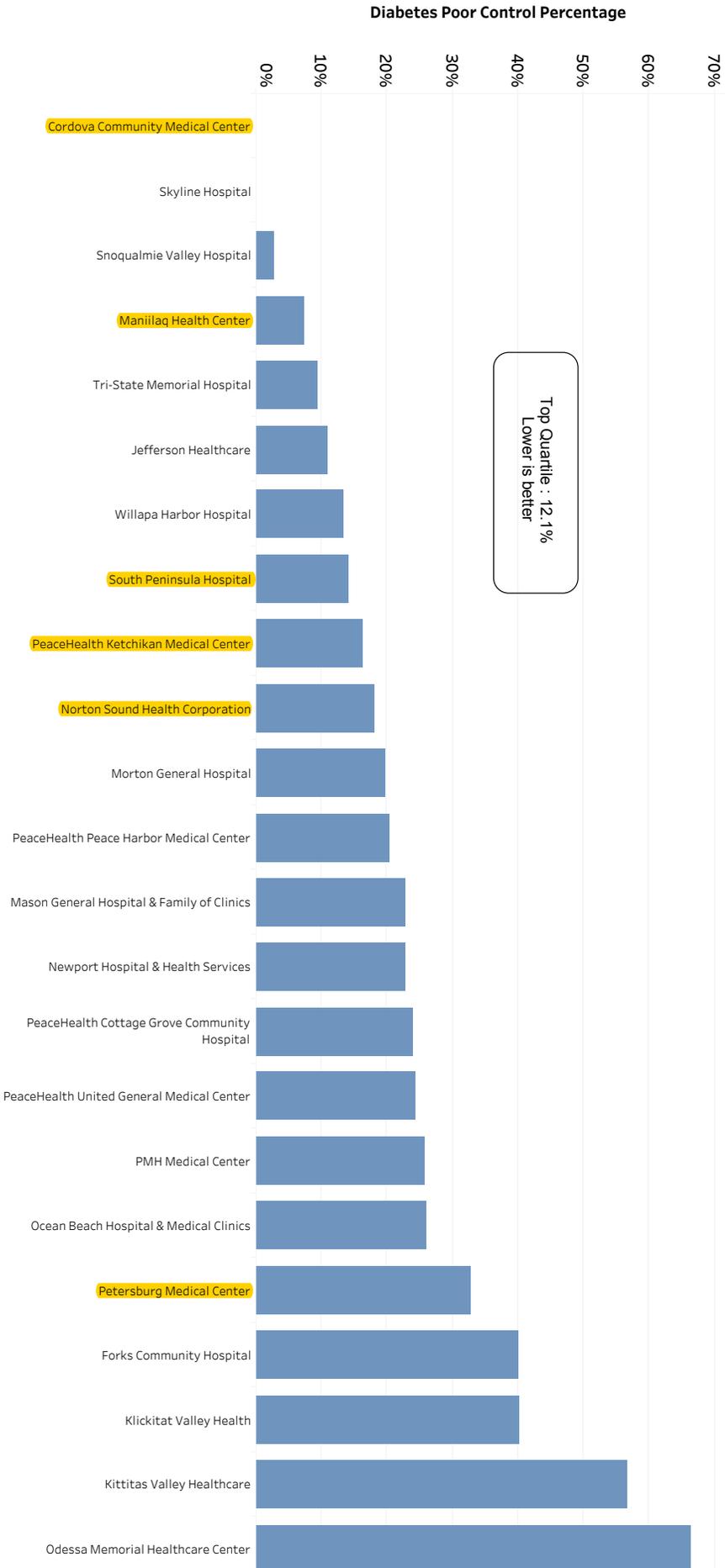
Undue Exposure to Radiation: Radiology Dosage Per Pediatric Head CT 2017 Q1 Distribution



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

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

Population Health: Diabetic Care (Critical Access Hospitals Only) 2017 Q1 Distribution



Definition: Number of patients with HbA1c levels > 9% per all diabetes patients.

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

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



Memorandum

To: CCMC Authority Board of Directors
From: Scot Mitchell, FACHE, CCMC CEO
Subject: vRad Contract
Date: June 19, 2017

Suggested Motion: “I move that the CCMC Authority Board of Directors authorize Scot Mitchell, CEO to sign a contract for \$3000 per month for professional radiology services with vRad.”

Community Health Needs Assessment Establishing Health Priorities Reporting Document

Introduction

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

Description of Community Served

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

Input from Broad Interests

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

Prioritized Health Needs

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

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

Cordova Community Medical Center
January 18, 2017

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

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

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

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

Cordova Community Medical Center
January 18, 2017

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

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

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

Dissemination

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

Implementation Strategy

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

Resolution to Approve Community Health Needs Assessment Implementation Plan

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

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

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

Upon vote taken, the following voted:

For:

Against:

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

 _____
Health Service Board

02/09/2017

 _____
CCMC CEO

9 Feb 2017