



AGENDA
CCMC AUTHORITY BOARD OF DIRECTORS
CCMC CONFERENCE ROOM
September 28, 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
VACANT exp. 3/18
Dorne Hawxhurst exp. 3/18

CCMC CEO

Scot Mitchell

OPENING:

A. Call to Order

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

B. APPROVAL OF AGENDA

C. CONFLICT OF INTEREST

D. 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

E. BOARD DEVELOPMENT

1. Contractual Allowances

F. APPROVAL OF CONSENT CALENDAR

G. APPROVAL OF MINUTES

1. 7-27-2017 Regular Meeting Minutes Pages 1-3

H. REPORTS OF OFFICER and ADVISORS

1. CEO Report – Scot Mitchell, CEO Pages 4-6
2. Finance Report – Lee Holter, CFO Pages 7-29
3. Nursing Report – Tammy Pokorney, CNO Pages 30-55

I. CORRESPONDENCE

1. Letter from Mrs. Diana Rubio Page 56

J. ACTION ITEMS

1. 2016 CAH Periodic Evaluation – Annual report Pages 57-74

K. DISCUSSION ITEMS

1. CCMC Authority Board Vacancy

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

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

M. BOARD MEMBERS COMMENTS

N. EXECUTIVE SESSION

O. ADJOURNMENT

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

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

Minutes
CCMC Authority – Board of Directors
CCMC Admin Conference Room
July 27, 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: **April Horton, Dorne Hawxhurst, Kristin Carpenter, and Sally Bennett (telephonically).**

A quorum was established. 4 members present.

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

A. APPROVAL OF AGENDA

Carpenter “move to approve the agenda as presented.”

B. CONFLICT OF INTEREST ~ None

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS

1. Audience Participation ~ None

2. Guest Speaker ~ None

D. BOARD DEVELOPMENT

1. Balance Sheet

Lee Holter provided definitions of the individual sections listed on the Balance Sheet.

2. Hospital Scorecard

Scot Mitchell provided a handout at the meeting with the Financial Indicators listed, from those he and the CFO chose as the top indicators to reflect on the Scorecard. The indicators that was chosen under Utilization were, Hospital Patient Days, Long Term Care Patient Days, and Adjusted Patient Days (Hospital only). The indicators under Labor were, Full Time Equivalents (FTE's), Labor Cost per Manhour, Paid Manhours per Adjusted Patient Day, and Percent of Overtime. The Liquidity Ratio indicators chosen were Days Total Cash on Hand, Days in Accounts Receivable (Gross), and Average Payment Period. Operating Margin was chosen under Profitability Ratios. Activity Ratios indicator chosen was Average Age of Plant.

The Board will review the handout provided and discuss further at the next meeting.

E. APPROVAL OF CONSENT CALENDAR ~ None

F. APPROVAL OF MINUTES

M/Hawxhurst S/Bennett “move to approve the June 22, 2017 Regular Meeting Minutes as amended”.

4 yeas, 0 nay

Motion passed.

G. REPORT OF OFFICERS AND ADVISORS

1. **Board President Report** ~ Kristin Carpenter reported that she had helped work on the Agenda, and that there would be an Executive Session this evening.
2. **CEO's Report** ~ Scot Mitchell, CEO stated that his written report was in the packet. A few additional items, healthcare reform has a lot going on today and tomorrow, once we have a little more information he will let you know. Scot reported on the Contract approval process, after speaking to the Attorney we should not put the full contract in the board packet as there is proprietary and confidential information in those. What we can do is provide a memo and contract review with pertinent information. Lastly, we had a Mock Survey that finished up today, he will provide more detailed information when we get the report back.
3. **Finance Report** ~ Lee Holter, CFO reported out that the Days Cash has increased and we've seen a drop in Days in AR. On page 14, he pointed out that our Income was flat on Acute Care, year to date we are below budget for Acute Care. Long Term Care is the same as last year, and the Clinic has increased. In the Expense section we are below budget, we're below budget on Total Expenses. Wages have increased, that should continue to decrease the amount for Professional Services.
4. **Nursing Report** ~ Helen McGaw, LTC DON provided a written report in the packet on Long Term Care and the Nursing Department. she pulled the report from ABAQIS, and we are doing very well. We're continuing to work really hard on the survey readiness for the Long Term Care Survey. We have just hired another local C.N.A.

H. CORRESPONDENCE

1. A letter was written in response to David O'Brien's letter to the Board at the June Board meeting. That letter was hand delivered to David O'Brien at the meeting.

I. ACTION ITEMS

1. Employee Compensation Philosophy

M/Horton S/Bennett "I move that the CCMC Authority Board of Directors approves the Cordova Community Medical Center Compensation Philosophy as amended."

4 yeas, 0 nays

Motion passed.

J. DISCUSSION ITEMS

1. Board Vacancy Process

After discussions the Board came to the consensus that we can advertise in the paper, and on the CCMC Facebook page to solicit letters of interest.

K. AUDIENCE PARTICIPATION

David O'Brien spoke in opposition to the Board's decision to move forward with CCMC opening a 340B Pharmacy.

L. BOARD MEMBERS COMMENTS

Carpenter ~ Thank you to Scot for putting together the Compensation Philosophy and the Scorecard.

Hawxhurst ~ None

Bennett ~ None

Horton ~ None

M. EXECUTIVE SESSION

1. Discuss confidential information regarding a CCMC project.

M/Horton S/Hawxhurst “I move to go into Executive Session for matters, immediate knowledge of which would clearly have an adverse effect upon the finances of CCMC.”

Went into Executive Session at 7:20pm

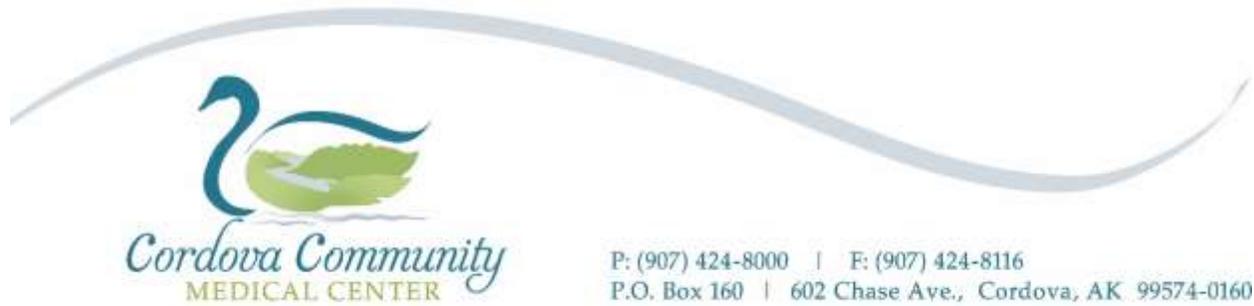
Came out of Executive Session at 7:54pm

N. ADJOURNMENT

M/Horton S/Hawxhurst “I move to adjourn the meeting.”

Carpenter declared the meeting adjourned at 7:55pm.

Prepared by: Faith Wheeler-Jeppson



CEO Report to the CCMC Authority Board of Directors
September 28, 2017 Meeting
Scot Mitchell, CEO

The Big Picture

Just when we thought it might be safe to be in the healthcare business, Congress revives its attempt to repeal and replace the Affordable Care Act (ACA). Congress failed to come up with enough votes to pass the Better Care Reconciliation Act (BCRA), which would have allowed for a partial repeal of the Affordable Care Act (ACA), earlier this summer. This attempt has come about very quickly, and the word is that the Senate will schedule a vote on the new Graham-Cassidy-Heller-Johnson bill within the next week, since they have a September 30th deadline to utilize the budget reconciliation process for these changes.

The new bill will repeal the ACA's individual and employer mandate, which is estimated to result in 14 million fewer insured individuals within the first year of passage. It would also repeal the ACA's Medicaid expansion, federal Basic Health Program and Health Insurance Marketplace subsidies. This bill would not provide any stability to the insurance market. States with small populations, like Alaska, would not fair very well under the proposed block grant program. The block grant program would provide flexibility to States, but if they don't have the capacity to implement these changes, it's not very helpful.

Status Updates

- We have been making some headway in our efforts to recruit and retain quality staff. Tammy Pokorney is our new permanent Chief Nursing Officer. Tammy recently retired from the military after a 24 year career there. Dolly Dryer is back for a temporary time as the Long Term Care Director of Nursing. Dolly is replacing Helen McGaw, whose agreement ended recently. Dolly has served several terms in nursing leadership at CCMC. Emily Rogers is our new permanent Physical Therapist. Emily and her family moved to Cordova from Fairbanks. Heidi Voss, pharmacist, joined CCMC earlier this month, and has already made a lot happen on the new retail pharmacy project. Lykia Lorenz has accepted the Executive Director position for Sound Alternatives. Lykia will spend part of her time providing clinical services to clients and part of her time on leadership. We have interviewed a Tele-Psychiatrist for Sound Alternatives and hope to have that position filled soon.
- I have enclosed the 2016 Critical Access Hospital Periodic Evaluation for board approval at this meeting. This is a required Condition of Participation for the CAH program. We convened a team of staff members to work on this evaluation earlier this year. Utilizing the information from these team meetings and other sources such as committee meetings, financial statements, utilization statistics, etc. I drafted the report. The draft report was then provided to the entire Leadership Team, including

the Medical Staff for review and comment. The report was then presented to the Quality Management Committee, which has recommended that the Board approve the report. The Centers for Medicare and Medicaid Services (CMS) requires the Board to approve this report every year.

- We had a mock CAH survey the last week of July. As expected, there are several areas that we need to continue working on. There were no major issues, but we do need to put some additional emphasis on developing a better education program for our staff on the swing bed program, as well as getting our competencies updated for all departments. We have had a Survey Readiness Team in place for a few months now, and this group is working on the issues found during the mock survey.
- On August 1, 2017, we had an onsite audit from the Universal Services program. We receive significant grant funding from them to help cover the costs of our internet and telephone services. We don't expect any issues with the audit as it seems that they are more interested in learning why these services cost so much in Alaska. The FCC recently allowed telecommunication providers in Alaska to assist their customers by eliminating the 7.5% reduction from USAC funds this year. We are in communication with ACS to make this happen. This will help us to the tune of around \$5,000 per month.
- As you know, we have been having some discussions with the local pharmacy in regards to the retail pharmacy that CCMC will be opening later this fall. We have received a proposal from Mr. O'Brien in regards to possibly purchasing some of his inventory and pharmacy files, along with some additional data that we requested. Our consultants are helping us evaluate the proposal and data, and we should have a response to Mr. O'Brien very soon. The renovation work is ongoing for the pharmacy location. Heidi Voss hit the ground running. We have received our State Pharmacy license from the Board of Pharmacy. We are also submitting applications for several other licenses and certifications that we must have before we can open the pharmacy. Our plans are to have the pharmacy opened by the end of October.
- We have recently brought on an Information technology firm to help us conduct a High Level Security Assessment of our IT system. This project will include an assessment to identify exposures and business practices within CCMC that incur unacceptable levels of risk to sensitive business information and electronic Protected Health Information, or are non-compliant with current information security best practices. An external vulnerability scan will be performed to identify weaknesses in systems accessible directly from the Internet. An on-site Wi-Fi security and signal propagation assessment will be performed to identify all Wi-Fi access points and map their approximate signal propagation.
- I recently signed an MOU with Ilanka Community Health Center to allow our behavioral health staff from Sound Alternatives to provide services to their patients. This is a service that had been provided a few years ago, so we are working with them again to help improve the quality of care provided to the residents of Cordova.
- I have been having some discussions with representatives from the Alaska State Hospital and Nursing Home Association about a strategy that could potentially allow CCMC to change the status of our long term care services that would allow us to include some of the costs from the LTC unit to our hospital cost report. I made this change in my last hospital that allowed us to receive a fairly significant increase in cash with little change to the operations of the LTC unit. We are still researching how it might impact CCMC if we were to pursue this option. I will keep you updated as we continue our due diligence process.
- The audit of the 2016 financial statements is almost complete. We are hoping to schedule the presentation of the audit to the Board at the October meeting. There were several reasons for the delay this year, and we will be able to explain these in more detail when the auditors present their findings next month.

- Staff has been very diligently working on improving the efficiency of CCMC's operations. We have reduced staffing levels in areas where we were over-staffed. We are still researching additional staffing improvement changes. We are working on a few other ways to improve our efficiency. For example, we have purchased an online system that will allow us to have all of our policies online, along with a more streamlined methodology for reviewing and approving them as required by CMS conditions of participation. We have also decided to utilize the ADP payroll system. This system will reduce the amount of time our payroll staff and managers spend preparing and approving payroll every two weeks. It will also provide all employees with much more detail and accessibility to their payroll and personnel information. Both of these systems should go live before the end of November.
- We have been having some discussions with staff from the State Department of Behavioral Health about improving our Sound Alternatives division. They are onsite this week, and I should have more details on their suggestions within a couple weeks. With Lykia coming onboard next month, we are excited about implementing new opportunities to improve and expand the behavioral health services provided to the people of Cordova.



Monthly Financial Statements

July 2017

To the CCMC Health Services Board

July 2017 Financial Executive Summary

Pre-Audit

The audit is expected to be completed any day. I keep checking. Due to the settlement of the 2015 Cost report which was revised on Monday, August 14th this is a subsequent event entry that needs to be included.

Statistics

Acute Care patient days for July were an amazing 49, the highest we had this year and far exceeded any month in the last three years. Swingbed days jumped to 114 for July compared to 90 for June. Average Daily Census (ADC) increased by 2.2 days over 3.1 in June.

July saw increase of 20 ER visits over June which had 55 visits. PT procedures increased by 47 modules to 343 in July versus June which had 296. Lab tests saw a large increase up to 435 in July compared to 283 in June. X-ray tests were also up by 9 tests for July from the 63 in June, while CT tests increased by 8 in July compared to 14 in June. July clinic visits slipped down by 22 from the 239 in June. Behavioral Health shed 15 visits from the 100 they had in June

Balance sheet

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

Cash stayed up but decreased by \$66K in July versus June's cash balance of \$525K. Day's cash on hand at the end of July was 16.8 days compared to 19.2 days at the end of June.

Net AR jumped up to \$1,741K an increase of \$308K over June. Days in AR rose to 83.3 days, back up as the busy month increased AR, there was an increase of 9 days from 74.1 days in June. I have included the most recent slide showing AVEC's progress on AR by week.

Construction in Progress decreased by \$9K in July as an ultrasound machine acquired last year was paid for and depreciation started.

Accounts payable stayed flat at \$916K from June to July. Payroll liabilities had a \$22K increase over June to \$339K for July.

There was no increase in debt to the city in July. Only minor changes in the other amount of debt for July.

Income Statement

Gross revenue increased in July to \$1,170K, July was a very good month for CCMC with all service lines seeing increases for July except Behavioral health. A wonderful month!

Contractual adjustments increased in July due to the increased revenue and the mix between the payers. Bad debt increased by \$61K in July due to accounts being identified by AVEC as uncollectable and the bad debt accrual for July. I have included the most recent slide showing AVEC's progress on AR by week.

Grant revenue was up in July due to receipts of a \$67K Behavioral Health grant, a small \$2K grant for Developmental Disabilities, and \$22K in grant funds for senior meals and the ride.

Payroll in July increased by \$45K from June to \$353K for July, a combination of one more day for July, Vacations occurring, with staff replacing those gone and a couple of payouts for staff who left in July. Payroll taxes and Benefits decreased by \$2K from June to July. Professional services saw a drop of \$12K in July vs June. Supplies expense fell by \$14K during July compared to June which had \$64,539, next month supplies expense will raise as we replace supplies used during July. Rents and Leases increased as we made deposits to consolidate housing. Administration continues to work on reducing fixed housing costs for travelers. Utilities were up as there was a late invoice for electricity in June. Maintenance and repair expenses continued to be in the \$6K range as summer maintenance projects continue in progress.

Overall expenses were up by \$26K in July over June. Because of the excellent revenue for July and expenses staying in line, CCMC had a positive operating profit of \$204.

Year to Date

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

YTD revenue for seven months of operation is \$769K over budget and exceeds last year by \$1,354,408. A good indication of having two doctors who are stable and a nursing force which for the most part is stable and the community gaining confidence in the providers.

YTD net income for July, our seventh month, was \$274,394 and increase of \$282K from June. It is encouraging though, that YTD expenses remain below budget and lower than last year's YTD expenses. This of course will reduce our reimbursement from Medicare, due to increased Medicaid swingbed and lower expenses.

Activity and Projects

EHR

Work on E H R improvement is suspended after viewing 3 systems and then deciding that we could not get a new system installed in 2017 and need to stick with one system through 2018 so that we meet meaningful use Stage 3 criteria to avoid reimbursement penalties on future revenue.

System problems are occurring with revenue being generated in a departments and the billing system trying to transfer the revenue to another department. I was able to celebrate some success with Healthland, in that they acknowledged that I was correct—that combining bills should not shift revenue

between departments. They will fix the problem, however not any time soon, it will be next year, (I am not holding my breath)--if then.

Budget

I will be working with managers and Administration to get a 2018 budget to the board later this year. The managers will be actively involved with their department's budget. Depending on their level of experience, I may have to actively assist them, but this is a good way to develop buy in on meeting operational goals.

Business Line Statements/Departmental Statements

This is a work in progress that keeps getting delayed. 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 report for 2016 is expected soon.

A charge master review has been completed during June, great education was done for department managers and for revenue cycle staff. The completed report was received the week of August 7th. Various prices were increased based on the pricing recommendations in the report. Further analysis and implementation of the recommendations will be done in the coming weeks.

AR billing, coding and Collections

AVEC staff continue working old open claims as well as coding new claims, they have started assuming some of the billing roles previously done by our current biller. We adjust processes internally to accommodate the changes and provide direction to them on how to use the Healthland system. Overall they are steadily bringing down the old outstanding claims and collecting new claims in a timely manner.

Of course there have been some complaints to CCMC about their persistence in trying to collect payments on claims. Each time I am made aware of the issue, I provide the senior leadership of AVEC with feedback so they can adjust the process.

Respectfully submitted

Lee Holter
CFO

Cordova Community Medical Center
Balance Sheet

ASSETS	<u>7/31/2017</u>	<u>6/30/2017</u>	<u>7/31/2016</u>
Current Assets			
Cash	459,491	525,509	43,498
Net Account Receivable	1,741,321	1,433,362	1,440,458
Third Party Receivable	-	-	0
Other Receivables	6,398	6,398	100,481
Prepaid Expenses	55,689	24,672	26,943
Inventory	122,849	122,221	177,512
Total Current Assets	2,385,747	2,112,162	1,788,891
Property, Plant & Equipment			
Land	122,010	122,010	122,010
Buildings	7,006,763	7,006,763	7,006,763
Equipment	6,772,980	6,763,922	6,536,226
Construction in Progress	1,171,030	1,180,088	1,060,094
Subtotal PP&E	15,072,783	15,072,783	14,725,093
Less Accumulated Depreciation	(10,470,767)	(10,422,921)	(9,898,504)
Total Property & Equipment	4,602,015	4,649,861	4,826,589
Other Assets			
PERS Deferred Outflow	929,979	929,979	929,979
Total Other Assets	929,979	929,979	929,979
Total Assets	7,917,741	7,692,003	7,545,459
LIABILITIES AND FUND BALANCE			
Current Liabilities			
Accounts Payable	916,140	916,015	862,820
Payroll & Related Liabilities	339,586	317,376	549,160
Third Party Settlement Payment	0	0	0
Interest & Other Payables	11,816	11,808	345
Long Term Debt-- City	3,477,563	3,477,563	2,834,976
Other Current Long Term Debt	99,800	102,507	225,217
Total Current Liabilities	4,844,906	4,825,270	4,472,519
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	9,948,794	9,929,158	9,576,407
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	274,393	69,579	(727,169)
Total Net Position	(2,032,341)	(2,237,155)	(2,030,948)
Total Liabilities & Net Position	7,917,741	7,692,003	7,545,459

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

TOTAL	0 - 30	31 - 60	61 - 90	91 - 120	121+	Totals	Jul Days In AR
Gross A/R	185,639	55,686	28,412	20,863	183,057	473,657	16.7%
Commercial	162,063	14,969	47,836	7,149	101,969	333,985	11.8%
Medicare	219,043	74,648	66,270	136,961	110,571	607,492	21.4%
Medicaid	282,666	1,056	1,126	1,126	57,822	343,796	12.1%
Long Term Care	61,354	17,458	12,016	7,251	37,674	135,753	4.8%
Other Govt payers	-	751	1,242	65,347	252,021	319,361	11.3%
Extended Pymt Terms	184,407	46,316	98,863	43,569	99,789	472,944	16.7%
Private Pay	30,678	18,904	7,283	9,398	80,285	146,549	5.2%
Work Comp	1,125,849	229,788	263,049	291,664	923,188	2,833,538	100.0%
Totals	39.7%	8.1%	9.3%	10.3%	32.6%	100.0%	83.3
						<u>(98,322)</u>	Credit Balances

CORDOVA - ATB Weekly Comparison

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08142017

Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	329	254	180	137	199	254	199
Balance	\$283,341.87	\$178,789.89	\$67,460.23	\$101,113.38	\$116,284.81	\$169,144.63	\$96,618.19
AR %	28%	18%	7%	10%	11%	17%	10%
0 to 90 days AR % - 52%				90 + days AR % - 48%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08072017

Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	297	220	173	138	212	260	191
Balance	\$263,787.12	\$129,933.07	\$81,453.63	\$95,735.20	\$115,942.33	\$172,958.35	\$93,177.18
AR %	28%	14%	9%	10%	12%	18%	10%
0 to 90 days AR % - 50%				90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07312017

Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	285	276	143	134	200	266	189
Balance	\$238,829.90	\$131,952.18	\$87,804.69	\$78,458.54	\$109,898.03	\$178,027.51	\$92,181.02
AR %	26%	14%	10%	9%	12%	19%	10%
0 to 90 days AR % - 50%				90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07242017

Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	330	276	153	140	199	264	180
Balance	\$241,487.70	\$134,515.50	\$98,254.60	\$76,511.56	\$119,582.19	\$185,246.71	\$85,874.55
AR %	26%	14%	10%	8%	13%	20%	9%
0 to 90 days AR % - 50%				90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07172017

Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	321	246	158	123	204	272	179
Balance	\$233,047.46	\$136,041.18	\$111,685.67	\$52,043.30	\$143,808.28	\$171,921.47	\$89,879.21
AR %	25%	14%	12%	6%	15%	18%	10%
0 to 90 days AR % - 51%				90 + days AR % - 49%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07102017

Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	261	253	157	119	194	290	163
Balance	\$161,435.68	\$119,009.72	\$111,588.67	\$67,289.17	\$123,063.88	\$179,174.75	\$81,966.90
AR %	19%	14%	13%	8%	15%	21%	10%

	0 to 90 days AR % - 46%	90 + days AR % - 54%
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AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07032017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	287	241	171	126	174	308	152
Balance	\$158,402.75	\$171,984.46	\$119,115.33	\$82,499.78	\$124,412.41	\$169,894.68	\$77,005.96
AR %	18%	19%	13%	9%	14%	19%	9%
	0 to 90 days AR % - 50%			90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06262017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	284	236	177	146	166	341	181
Balance	\$194,397.30	\$140,058.70	\$125,250.26	\$88,857.41	\$131,910.05	\$182,499.31	\$79,870.87
AR %	21%	15%	13%	9%	14%	19%	8%
	0 to 90 days AR % - 49%			90 + days AR % - 51%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06192017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	267	236	175	156	153	351	179
Balance	\$165,205.39	\$171,098.47	\$205,909.53	\$101,031.72	\$123,858.03	\$187,394.41	\$71,235.45
AR %	16%	17%	20%	10%	12%	18%	7%
	0 to 90 days AR % - 53%			90 + days AR % - 47%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06092017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	250	259	189	163	154	361	193
Balance	\$153,011.67	\$192,763.53	\$222,889.32	\$105,800.41	\$123,286.52	\$193,886.77	\$74,063.02
AR %	14%	18%	21%	10%	12%	18%	7%
	0 to 90 days AR % - 53%			90 + days AR % - 47%			



Monthly Financial Statements

AUGUST 2017

To the CCMC Health Services Board

August 2017 Financial Executive Summary

Pre-Audit

The Audit is complete, as of this writing I am expecting the completed reports in the next week. I have entered the adjusting entries on the August Financials.

Statistics

Acute Care patient days dropped down in August from 49 in July to 12 in August. Swingbed days increased by 10 to 124 for August compared to 114 for July. Average Daily Census (ADC) fell back to 4.4 days in August versus 5.3 in July.

There were 68 ER Visits in August versus 75 in July. PT procedures dropped off in August to 136 versus 343 in July. Lab tests were down by 25 tests, with August having 410 tests versus 425 July. X-ray tests dropped to 57 in August compared to 72 in July, while CT tests were 15 compared to 22 in July. August clinic visits were up by 67 visits in August compared to 217 in July. Behavioral Health increased by 24 visits in August compared to 85 in July.

Balance sheet

Audit adjusting entries have been are reflected in the August Balance sheet.

Cash increased by \$41K in August versus July's cash balance of \$459K. Day's cash on hand at the end of August was 18.2 days compared to 16.8 days at the end of July.

Net AR dropped \$350K in August when compared to July. We are seeing constant improvement in AR due to the collect efforts by AVEC. Days in AR decreased to 80.1 days, versus 83.3 in July. I have included the most recent slide showing AVEC's progress on AR by week.

Construction in Progress dropped by \$1,060,085 due a prior period entry the Auditors did 2015.

Due to a change in the PERS Deferred out flow expected for 2017 that account was increased by \$288,809 by the auditors.

Accounts payable dropped by (\$180K) in August from July's amount of \$916,140. Payroll liabilities had a slight increase of \$3K increase over July, which had \$339,586.

There was no increase in debt to the city in July. Only minor changes in the other amount of debt for July.

The deferred inflow of PERS was reduced by \$12K by the auditors and the big change of an additional \$1,893K in the Long Term Pension liabilities by the auditors. Ufda. (useful Norwegian term with lots of different meanings).

Income Statement

Gross revenue dropped by \$48K in August to \$1,123K, a good month but not as good as July was. The biggest decrease was in Acute care a decrease of \$56K.

Contractual adjustments increased in August due to the increased revenue and the mix between the payers. Bad debt decreased by \$53K in August due to accounts being shifted to collections.

Grant revenue decreased in August from July's amount of \$91K down to \$39K for August.

Payroll in August decreased by \$4K from July to \$347K for August.

Payroll taxes and Benefits stayed flat from July to August. Professional services saw a drop of \$10K in August vs July. Supplies expense increased by \$30K in August as there is about a 30 day lag in replenishing supplies after a month with high activity. Rents and Leases increased in August vs July. Maintenance and repair expenses Increase by \$4K in August versus July, as summer maintenance projects continue in progress.

There were an increases in Travel and recruitment and relocation for August as several candidates for the behavioral directorship were here and the new CNO stated in August.

Overall expenses were up by \$53K in August compared to July. We had \$6K operating loss for August.

Year to Date

Please note that the financials reflect the completed Audit.

YTD revenue for eight months of operation is \$1,009K over budget and exceeds last year by \$1,696,929. A good indication of having two doctors who are stable and a nursing force which for the most part is stable and the community gaining confidence in the providers.

YTD net income for August, was \$269728 a decrease of \$6K from July. It is encouraging though, that YTD expenses remain below budget and lower than last year's YTD expenses. This of course will reduce our reimbursement from Medicare, due to increased Medicaid swingbed and lower expenses.

Activity and Projects

EHR

Work on E H R improvement is suspended after viewing 3 systems and then deciding that we could not get a new system installed in 2017 and need to stick with one system through 2018 so that we meet meaningful use Stage 3 criteria to avoid reimbursement penalties on future revenue. CMS has now decided to only require 90 testing in 2018.

System problems are occurring with revenue being generated in a departments and the billing system trying to transfer the revenue to another department. I was able to celebrate some success with Healthland, in that they acknowledged that I was correct—that combining bills should not shift revenue between departments. They will fix the problem, however not any time soon, it will be next year, (I am not holding my breath)--if then.

Budget

I will be working with managers and Administration to get a 2018 budget to the board later this year. The managers will be actively involved with their department's budget. Depending on their level of experience, I may have to actively assist them, but this is a good way to develop buy in on meeting operational goals.

Business Line Statements/Departmental Statements

This is a work in progress that keeps getting delayed. 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.

AR billing, coding and Collections

AVEC staff continue working old open claims as well as coding new claims, they have started assuming some of the billing roles previously done by our current biller. We adjust processes internally to accommodate the changes and provide direction to them on how to use the Healthland system. Overall they are steadily bringing down the old outstanding claims and collecting new claims in a timely manner.

Of course there have been some complaints to CCMC about their persistence in trying to collect payments on claims. Each time I am made aware of the issue, I provide the senior leadership of AVEC with feedback so they can adjust the process.

Respectfully submitted

Lee Holter
CFO

Cordova Community Medical Center
Balance Sheet

ASSETS	<u>8/31/2017</u>	<u>7/31/2017</u>	<u>8/31/2016</u>
Current Assets			
Cash	500,882	459,491	795,336
Net Account Receivable	1,391,718	1,741,321	1,105,172
Third Party Receivable	-	-	0
Other Receivables	83,394	6,398	100,481
Prepaid Expenses	47,869	55,689	12,588
Inventory	128,472	122,849	181,187
Total Current Assets	<u>2,152,334</u>	<u>2,385,747</u>	<u>2,194,763</u>
Property, Plant & Equipment			
Land	122,010	122,010	122,010
Buildings	7,006,762	7,006,763	7,006,763
Equipment	6,772,970	6,772,980	6,759,816
Construction in Progress	110,945	1,171,030	1,060,094
Subtotal PP&E	<u>14,012,687</u>	<u>15,072,783</u>	<u>14,948,682</u>
Less Accumulated Depreciation	(10,518,613)	(10,470,767)	(9,966,125)
Total Property & Equipment	<u>3,494,074</u>	<u>4,602,015</u>	<u>4,982,557</u>
Other Assets			
PERS Deferred Outflow	1,218,788	929,979	929,979
Total Other Assets	<u>1,218,788</u>	<u>929,979</u>	<u>929,979</u>
Total Assets	<u><u>6,865,196</u></u>	<u><u>7,917,741</u></u>	<u><u>8,107,300</u></u>
LIABILITIES AND FUND BALANCE			
Current Liabilities			
Accounts Payable	735,603	916,140	872,913
Payroll & Related Liabilities	342,329	339,586	606,535
Third Party Settlement Payment	0	0	0
Interest & Other Payables	14,183	11,816	353
Long Term Debt-- City	3,477,563	3,477,563	3,100,976
Other Current Long Term Debt	45,896	99,800	141,972
Total Current Liabilities	<u>4,615,575</u>	<u>4,844,906</u>	<u>4,722,749</u>
Long Term Liabilities			
2015 Net Pension Liability	6,907,864	5,015,100	5,015,100
Total Long Term Liabilities	<u>6,907,864</u>	<u>5,015,100</u>	<u>5,015,100</u>
Deferred Inflows of Resources			
Pension Deferred Inflow	77,000	88,788	88,788
Total Deferred Inflows	<u>77,000</u>	<u>88,788</u>	<u>88,788</u>
Total Liabilities	<u>11,600,439</u>	<u>9,948,794</u>	<u>9,826,637</u>
Net Position			
Unrestricted Fund Balance	2,460,523	2,769,541	2,769,539
Temporary Restricted Fund Balance	13,035	13,035	13,035
Prior Year Retained Earnings	(7,479,816)	(5,089,310)	(4,086,354)
Current Year Net Income	269,727	275,681	(415,558)
Total Net Position	<u>(4,736,531)</u>	<u>(2,031,053)</u>	<u>(1,719,338)</u>
Total Liabilities & Net Position	<u><u>6,865,195</u></u>	<u><u>7,917,741.39</u></u>	<u><u>8,107,300</u></u>

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

TOTAL	0 - 30	31 - 60	61 - 90	91 - 120	121+	Totals	Aug Days In AR
Gross A/R	<u>138,790</u>	<u>100,736</u>	<u>42,514</u>	<u>20,274</u>	<u>145,082</u>	<u>447,396</u>	16.1%
Commercial	109,739	79,760	10,311	39,456	78,368	317,633	11.4%
Medicare	176,471	53,811	136,042	4,793	128,993	500,109	18.0%
Medicaid	281,675	2,922	2,385	1,126	59,147	347,255	12.5%
Long Term Care	41,800	14,968	15,642	3,407	15,977	91,794	3.3%
Other Govt payers	-	63,702	9,869	82,116	353,701	509,388	18.3%
Extended Pymt Terms	178,299	67,044	29,354	15,971	76,804	367,472	13.2%
Private Pay	56,052	36,786	17,509	7,283	77,862	195,492	7.0%
Work Comp	982,825	419,729	263,626	174,426	935,934	2,776,540	100.0%
Totals	35.4%	15.1%	9.5%	6.3%	33.7%	100.0%	
						<u>(98,322)</u>	Credit Balances

Cordova Community Medical Center
Income Statement

	August 2017				Year To Date				
	Actual	Budget	Variance	Prior Yr	Variance	Budget	Actual	Variance	Prior Yr
REVENUE									
Acute	64,463	100,387	(35,924)	59,114	5,349	1,073,291	692,021	(381,270)	495,305
Swing Bed	254,204	27,562	226,642	3,954	250,250	222,663	1,793,602	1,570,939	580,555
Long Term Care	376,178	360,592	15,586	361,200	14,977	2,879,506	2,925,410	45,904	2,819,505
Clinic	138,445	95,447	42,998	87,231	51,215	643,299	775,484	132,185	590,773
Outpatients	256,164	254,207	1,957	244,209	11,956	1,971,367	1,802,556	(168,811)	1,694,163
Behavioral Health	33,660	45,933	(12,273)	26,175	7,485	453,068	263,564	(189,504)	375,406
Patient Services Total	1,123,115	884,128	238,987	781,882	341,233	7,243,194	8,252,636	1,009,442	6,555,707
DEDUCTIONS									
Charity	5,707	13,713	(8,006)	41,530	(35,823)	111,989	5,788	(106,201)	184,590
Contractual Adjustments	253,612	128,109	125,503	(20,605)	274,217	1,046,229	1,733,415	687,186	1,120,180
Bad Debt	64,496	25,137	39,359	(17,801)	82,298	205,288	545,850	340,562	288,019
Deductions Total	323,815	166,959	156,856	3,123	320,692	1,363,506	2,285,052	921,546	1,592,789
COST RECOVERIES									
Grants	38,727	28,061	10,666	303,024	(264,297)	321,293	252,778	(68,515)	389,989
In-Kind Contributions	93,754	66,582	27,172	321,114	(227,359)	762,361	738,060	(24,301)	1,002,131
Other Revenue	8,055	10,596	(2,541)	(10,053)	18,108	121,326	380,808	259,482	625,524
Cost Recoveries Total	140,537	105,239	35,298	614,085	(473,548)	1,204,980	1,371,646	166,666	2,017,644
TOTAL REVENUES	939,837	822,408	117,429	1,392,844	(453,007)	7,084,668	7,339,231	254,563	6,980,563
EXPENSES									
Wages	347,344	321,772	25,572	285,095	62,250	2,735,062	2,654,913	(80,149)	2,289,393
Taxes & Benefits	147,937	163,873	(15,936)	281,387	(133,450)	1,392,921	1,200,960	(191,961)	1,455,793
Professional Services	128,636	147,799	(19,163)	215,156	(86,520)	1,184,692	1,110,769	(73,923)	1,664,833
Minor Equipment	118	2,307	(2,189)	647	(529)	18,456	24,698	6,242	26,119
Supplies	69,002	35,348	33,654	40,123	28,880	278,121	392,628	114,507	277,059
Repairs & Maintenance	10,595	2,204	8,391	31,312	(20,717)	17,632	52,832	35,200	59,721
Rents & Leases	17,109	9,142	7,967	16,921	188	73,136	95,256	22,120	122,224
Utilities	104,666	100,019	4,647	126,206	(21,540)	812,882	849,885	37,003	817,983
Travel & Training	22,148	3,748	18,400	6,750	15,398	29,954	58,351	28,397	31,822
Insurances	21,027	17,959	3,068	14,355	6,672	144,826	130,800	(14,026)	126,551
Recruit & Relocate	11,847	4,167	7,680	509	11,339	33,336	38,340	5,004	53,640
Depreciation	47,846	43,750	4,096	67,621	(19,775)	350,000	367,193	17,193	365,227
Other Expenses	17,526	12,224	5,302	(4,846)	22,372	97,792	93,391	(4,401)	105,756
TOTAL EXPENSES	945,802	864,312	81,490	1,081,234	(135,432)	7,168,810	7,070,018	(98,792)	7,396,120
OPERATING INCOME	(5,965)	(41,904)	35,939	311,611	(317,575)	(84,142)	269,213	353,355	(415,558)
Restricted Contributions	10				515				
NET INCOME	(5,955)	(41,904)	35,949	311,611	(317,565)	(84,142)	269,728	353,870	(415,558)

AVEC Collections

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	391	373	226	144	134	183	167
Balance	\$235,684.33	\$220,078.82	\$153,698.11	\$60,363.52	\$82,507.40	\$126,138.61	\$90,383.28
AR %	24%	23%	16%	6%	9%	13%	9%
0 to 90 days AR % - 63%				90 + days AR % - 37%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	385	358	210	144	139	196	172
Balance	\$202,675.94	\$224,140.06	\$156,776.28	\$47,239.85	\$89,293.80	\$132,166.57	\$90,414.98
AR %	21%	24%	17%	5%	9%	14%	10%
0 to 90 days AR % - 62%				90 + days AR % - 38%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 09052017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	364	356	202	149	144	234	182
Balance	\$253,257.13	\$262,871.17	\$116,951.33	\$89,207.19	\$96,126.67	\$166,794.32	\$96,332.42
AR %	23%	24%	11%	8%	9%	15%	9%
0 to 90 days AR % - 59%				90 + days AR % - 41%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08282017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	340	302	197	127	147	231	182
Balance	\$249,368.28	\$241,404.34	\$87,005.84	\$80,018.09	\$100,335.26	\$165,667.23	\$95,051.39
AR %	24%	24%	9%	8%	10%	16%	9%
0 to 90 days AR % - 57%				90 + days AR % - 43%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08212017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	344	265	183	132	156	222	174
Balance	\$268,619.79	\$208,559.83	\$80,714.83	\$95,995.72	\$104,707.18	\$147,054.42	\$90,141.25
AR %	27%	21%	8%	10%	11%	15%	9%
0 to 90 days AR % - 56%				90 + days AR % - 44%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08142017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	329	254	180	137	199	254	199
Balance	\$283,341.87	\$178,789.89	\$67,460.23	\$101,113.38	\$116,284.81	\$169,144.63	\$96,618.19
AR %	28%	18%	7%	10%	11%	17%	10%
0 to 90 days AR % - 52%				90 + days AR % - 48%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08072017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	297	220	173	138	212	260	191
Balance	\$263,787.12	\$129,933.07	\$81,453.63	\$95,735.20	\$115,942.33	\$172,958.35	\$93,177.18
AR %	28%	14%	9%	10%	12%	18%	10%
	0 to 90 days AR % - 50%			90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07312017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	285	276	143	134	200	266	189
Balance	\$238,829.90	\$131,952.18	\$87,804.69	\$78,458.54	\$109,898.03	\$178,027.51	\$92,181.02
AR %	26%	14%	10%	9%	12%	19%	10%
	0 to 90 days AR % - 50%			90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07242017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	330	276	153	140	199	264	180
Balance	\$241,487.70	\$134,515.50	\$98,254.60	\$76,511.56	\$119,582.19	\$185,246.71	\$85,874.55
AR %	26%	14%	10%	8%	13%	20%	9%
	0 to 90 days AR % - 50%			90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07172017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	321	246	158	123	204	272	179
Balance	\$233,047.46	\$136,041.18	\$111,685.67	\$52,043.30	\$143,808.28	\$171,921.47	\$89,879.21
AR %	25%	14%	12%	6%	15%	18%	10%
	0 to 90 days AR % - 51%			90 + days AR % - 49%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07102017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	261	253	157	119	194	290	163
Balance	\$161,435.68	\$119,009.72	\$111,588.67	\$67,289.17	\$123,063.88	\$179,174.75	\$81,966.90
AR %	19%	14%	13%	8%	15%	21%	10%
	0 to 90 days AR % - 46%			90 + days AR % - 54%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07032017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	287	241	171	126	174	308	152
Balance	\$158,402.75	\$171,984.46	\$119,115.33	\$82,499.78	\$124,412.41	\$169,894.68	\$77,005.96
AR %	18%	19%	13%	9%	14%	19%	9%
	0 to 90 days AR % - 50%			90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06262017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	284	236	177	146	166	341	181
Balance	\$194,397.30	\$140,058.70	\$125,250.26	\$88,857.41	\$131,910.05	\$182,499.31	\$79,870.87
AR %	21%	15%	13%	9%	14%	19%	8%

	0 to 90 days AR % - 49%	90 + days AR % - 51%
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AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06192017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	267	236	175	156	153	351	179
Balance	\$165,205.39	\$171,098.47	\$205,909.53	\$101,031.72	\$123,858.03	\$187,394.41	\$71,235.45
AR %	16%	17%	20%	10%	12%	18%	7%
	0 to 90 days AR % - 53%			90 + days AR % - 47%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06092017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	250	259	189	163	154	361	193
Balance	\$153,011.67	\$192,763.53	\$222,889.32	\$105,800.41	\$123,286.52	\$193,886.77	\$74,063.02
AR %	14%	18%	21%	10%	12%	18%	7%
	0 to 90 days AR % - 53%			90 + days AR % - 47%			



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

Date: September 20, 2017
To: CCMC Authority Board of Directors
From: Chief Nursing Officer, Tammy Pokorney, RN
RE: Nursing Report to Health Services Board

August 2017 Nursing Activity Update:

1. Caregiver openings –nursing positions are filled or allocated with offers for personnel. Nursing leadership is actively recruiting for permanent staffing to reduce the 3 travel billets on the professional nursing staff. A review of duties by position and job description continues with an estimated completion by 31 Oct 2017.
2. LTC census is 10 residents. Currently, we have 4 Swing beds occupied.
3. Priorities remain staff development, infection control, internal quality measures with quantifiable outcomes, and technology integration where applicable.
4. Attached is the quality report for:
 - a. Abaqis for Long Term Care.

Please let me know if there are any questions.

Tammy Pokorney
CNO

MBQIP Care Transitions Quality Report: Improving Care Through Emergency Department Transfer Communication (EDTC) Reporting Period: Second Quarter 2016 through First Quarter 2017 Discharges

MBQIP Quality Measures		Your Hospital Performance by				Your Hospital Performance Aggregate for All Four Quarters	State Current Quarter		National Current Quarter		
		2Q16	3Q16	4Q16	1Q17 Cordova		Average Current Quarter State	# CAHs with MBQIP MOU Submitting	90th Percentile*	Average Current Quarter National	# CAHs with MBQIP MOU
Total Medical Records Reviewed		N = 3	N = 12	N = 7	N = 8	N = 30	N = 174		N = 47636		
EDTC-1	Administrative Communication	100% (n=3)	0% (n=0)	100% (n=7)	88%	57%	95%	100%	95%	1170	100%
EDTC-2	Patient Information	100% (n=3)	100% (n=12)	100% (n=7)	0%	73%	94%	100%	95%	1170	100%
EDTC-3	Vital Signs	100% (n=3)	83% (n=10)	100% (n=7)	63%	83%	94%	100%	94%	1170	100%
EDTC-4	Medication Information	100% (n=3)	92% (n=11)	43% (n=3)	63%	73%	97%	100%	92%	1170	100%
EDTC-5	Practitioner Information	100% (n=3)	92% (n=11)	100% (n=7)	38%	80%	95%	100%	94%	1169	100%
EDTC-6	Nurse Information	100% (n=3)	83% (n=10)	29% (n=2)	50%	63%	87%	100%	89%	1170	100%
EDTC-7	Procedures and Tests	100% (n=3)	100% (n=12)	100% (n=7)	88%	97%	98%	100%	96%	1170	100%
All EDTC	Composite*	100% (n=3)	0% (n=0)	14% (n=1)	0%	13%	82%	100%	78%	1166	100%

N/A = the provider did not submit any data

D/E = the provider reported 0 records reviewed

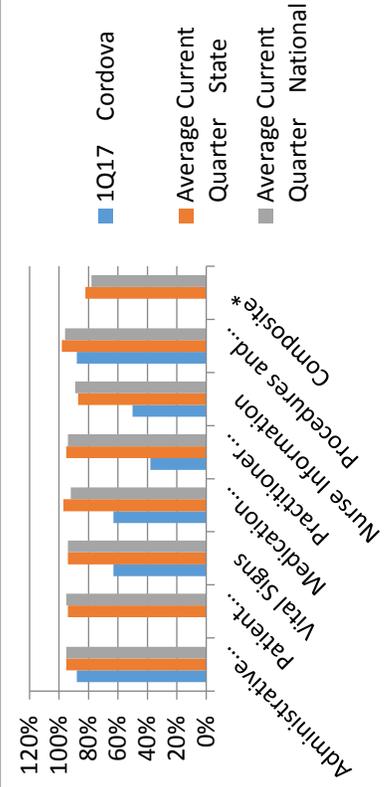
* The state and national roll-up for the All-

** The 90th percentile is the level of perfor-

perform at or better than the 90th percenti-

Please direct questions regarding your ME

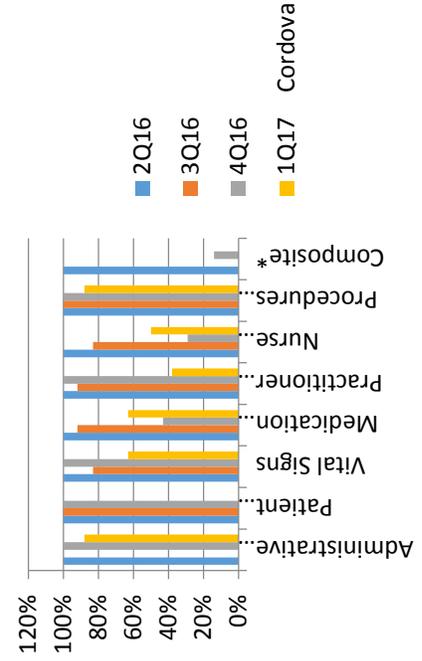
Flex Coordinator at: <https://www.ruralcent>



Cordova scored below state and national averages for 8 of 8 measures. Cordova shows variability in this set of measures, perhaps the process for medevacs is not known to all staff?

021307 - Cordova Community Medical Center

MBQIP Quality Measures	Your Hospital Performance by				Your Hospital Performance Aggregate for All Four Quarters	State Current Quarter			National Current Quarter		
	2Q16	3Q16	4Q16	1Q17 Cordova		Average Current Quarter State	# CAHs with MBQIP Submitting Data	90th Percentile*	Average Current Quarter National	# CAHs with MBQIP Submitting Data	90th Percentile**
	N = 3	N = 12	N = 7	N = 8		N = 174	N = 30	N = 47636			
Total Medical Records	N = 3	N = 12	N = 7	N = 8	N = 30	N = 174	N = 47636				
EDTC-1 Administrative Communication	100%	0%	100%	88%	57%	95%	95%	100%	1170	100%	
EDTC-2 Patient Information	100%	100%	100%	0%	73%	94%	95%	100%	1170	100%	
EDTC-3 Vital Signs	100%	83%	100%	63%	83%	94%	94%	100%	1170	100%	
EDTC-4 Medication Information	100%	92%	43%	63%	73%	97%	92%	100%	1170	100%	
EDTC-5 Practitioner Information	100%	92%	100%	38%	80%	95%	94%	100%	1169	100%	
EDTC-6 Nurse Information	100%	83%	29%	50%	63%	87%	89%	100%	1170	100%	
EDTC-7 Procedures and Tests	100%	100%	100%	88%	97%	98%	96%	100%	1170	100%	
All EDTC Composite*	100%	0%	14%	0%	13%	82%	78%	100%	1166	100%	



Cordova has done well on these measures in the past. Perhaps unfamiliarity with the measure is causing so much variability and an overall downturn in the measures for

Partnership for Patients



ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION



Washington State
Hospital Association

Cordova Community Medical Center

Patient Safety Trend Report

July 2017 Release



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Clostridium difficile Infection (CDI) Rate

Top Quartile Q1 2017: 0



Clostridium difficile Infections per 10,000 Patient Days

Number of Clostridium difficile Infections

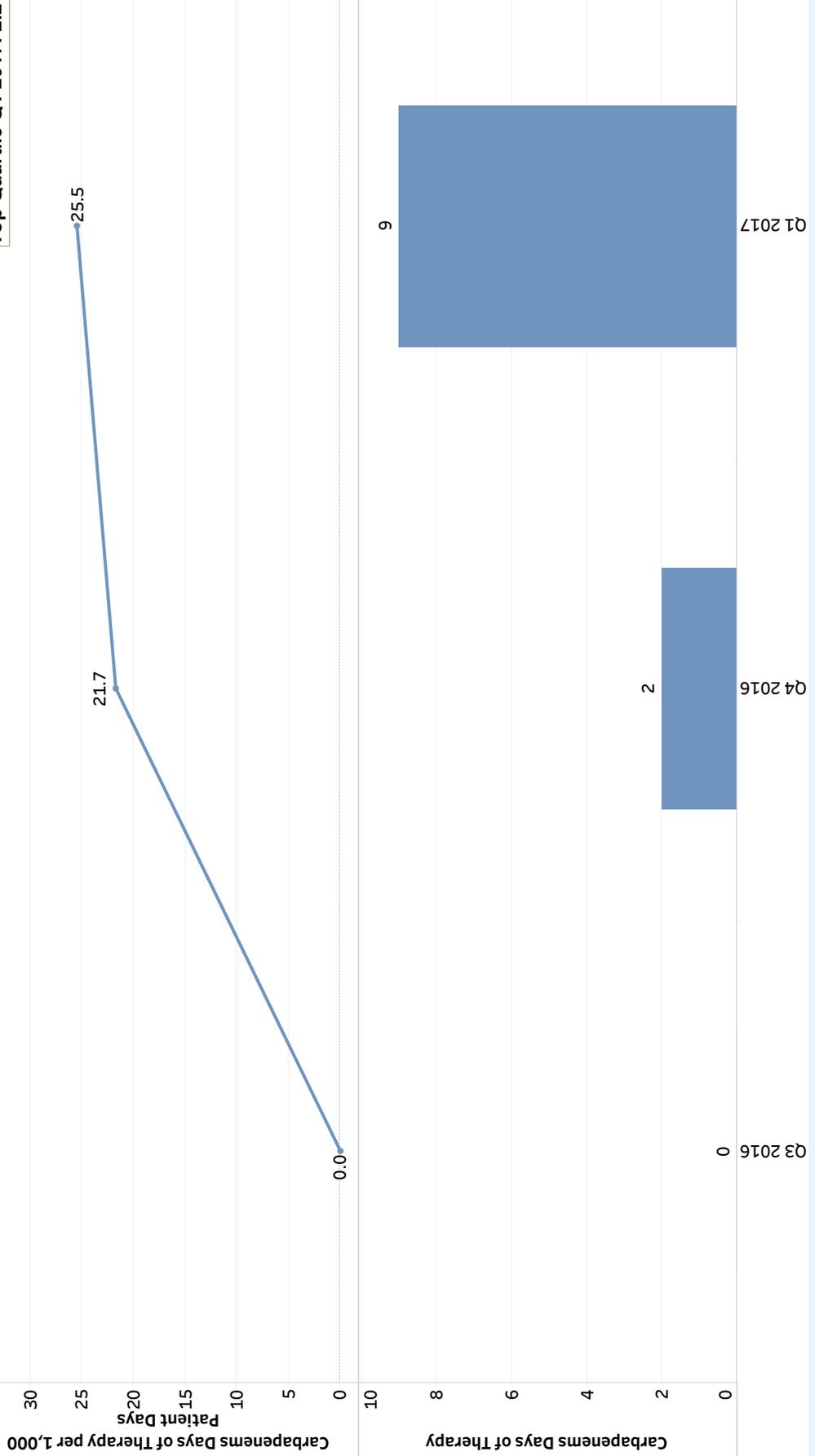
Definition: Facility CDI Healthcare Facility-Onset Incidence Rate = Number of all healthcare facility-onset (HO) Clostridium difficile infections (CDI) laboratory-identified (LabID) events per month in the facility / number of patient days for the facility x 10,000.
Data source: Centers for Disease Control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



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Antimicrobial Stewardship (ASP) Carbapenems Days-of-Therapy

Top Quartile Q1 2017: 2.2

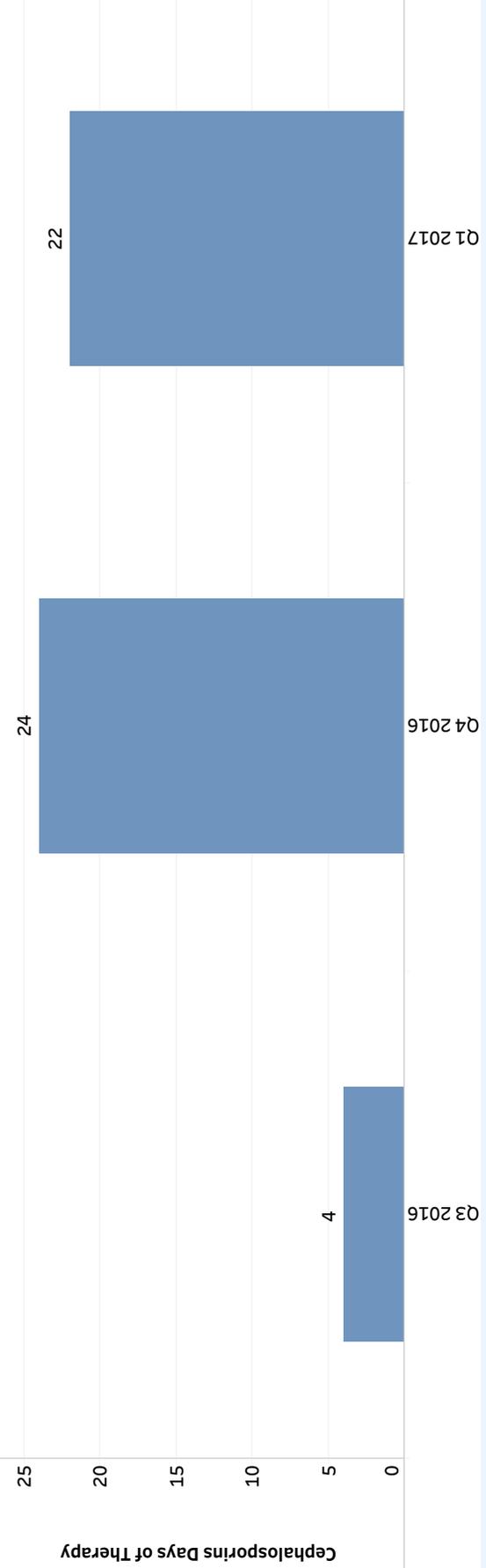
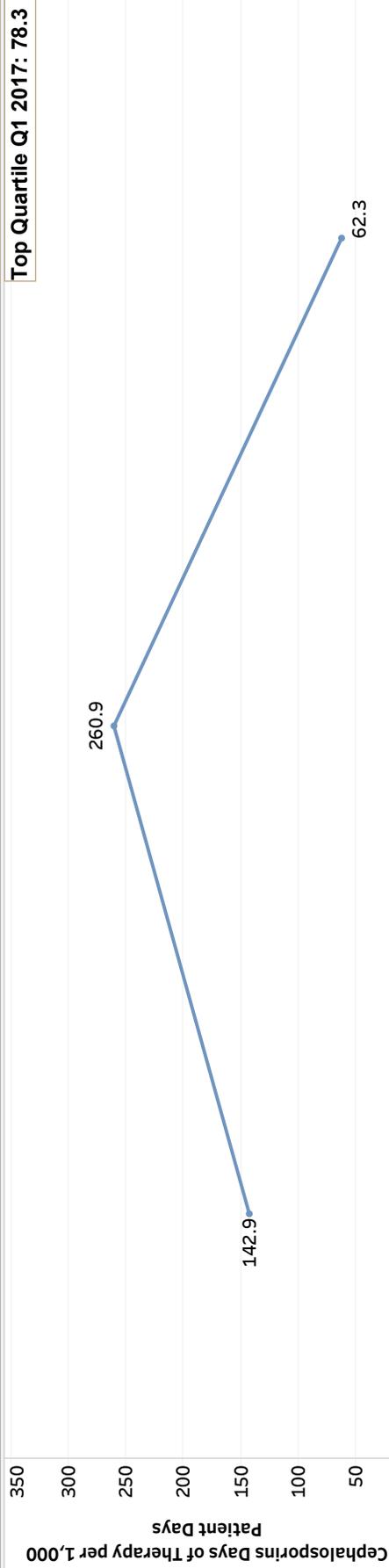


Definition: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Antimicrobial Stewardship (ASP) Cephalosporins Days-of-Therapy



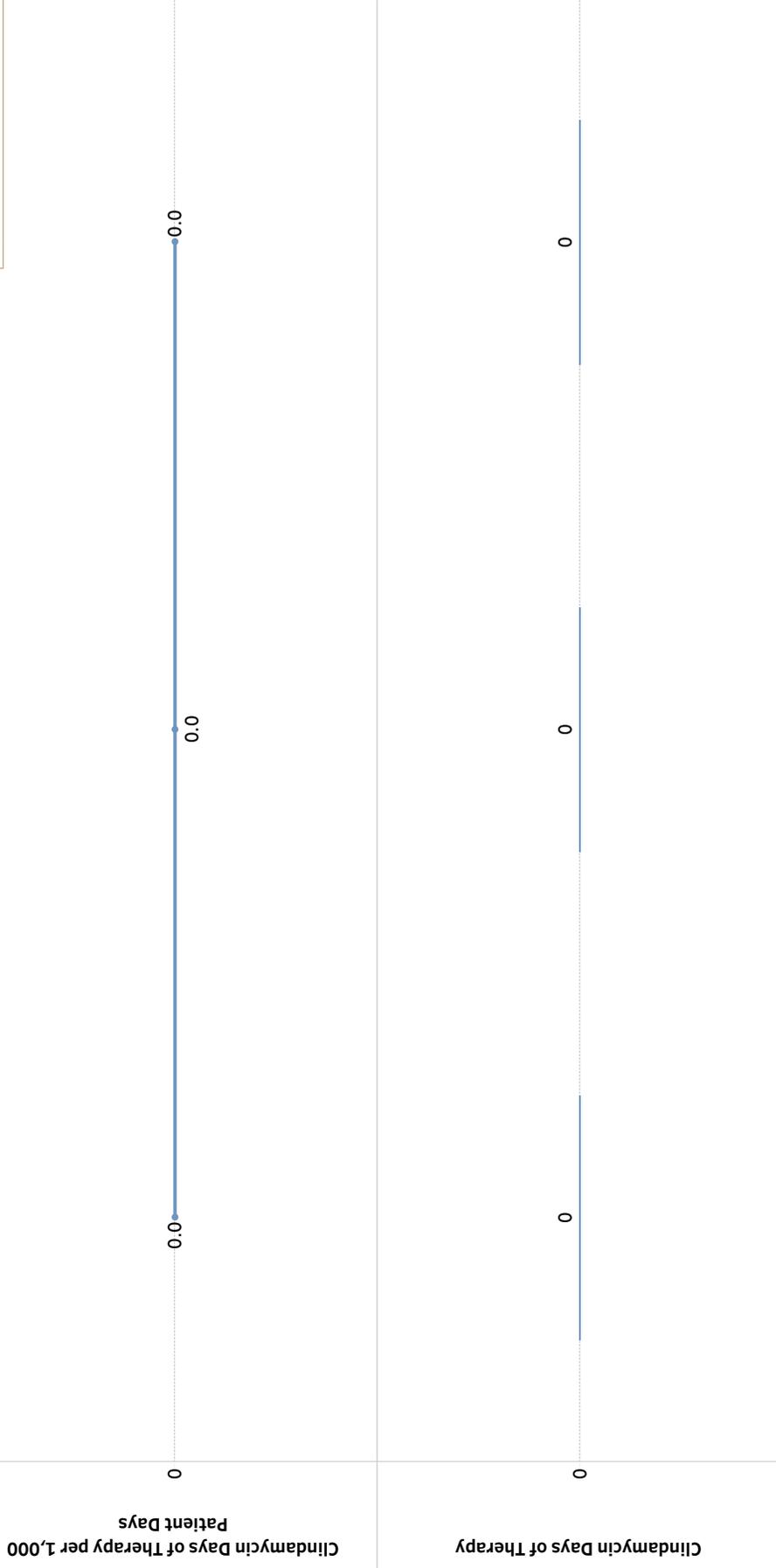
Definition: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Antimicrobial Stewardship (ASP) Clindamycin Days-of-Therapy

Top Quartile Q1 2017: 5.6



Clindamycin Days of Therapy

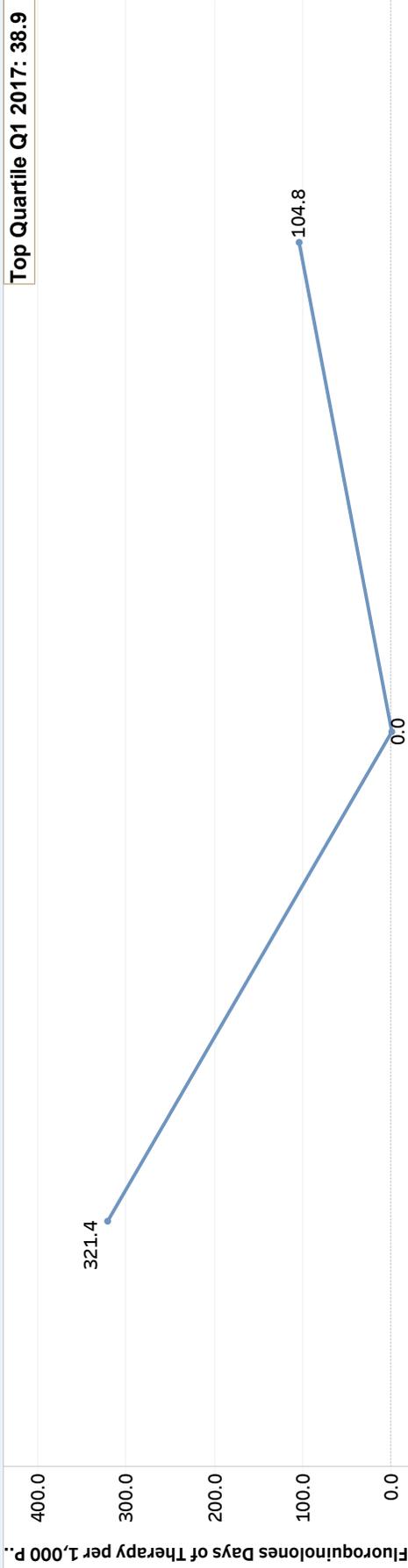
Definition: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Antimicrobial Stewardship (ASP) Fluoroquinolones Days-of-Therapy

Top Quartile Q1 2017: 38.9



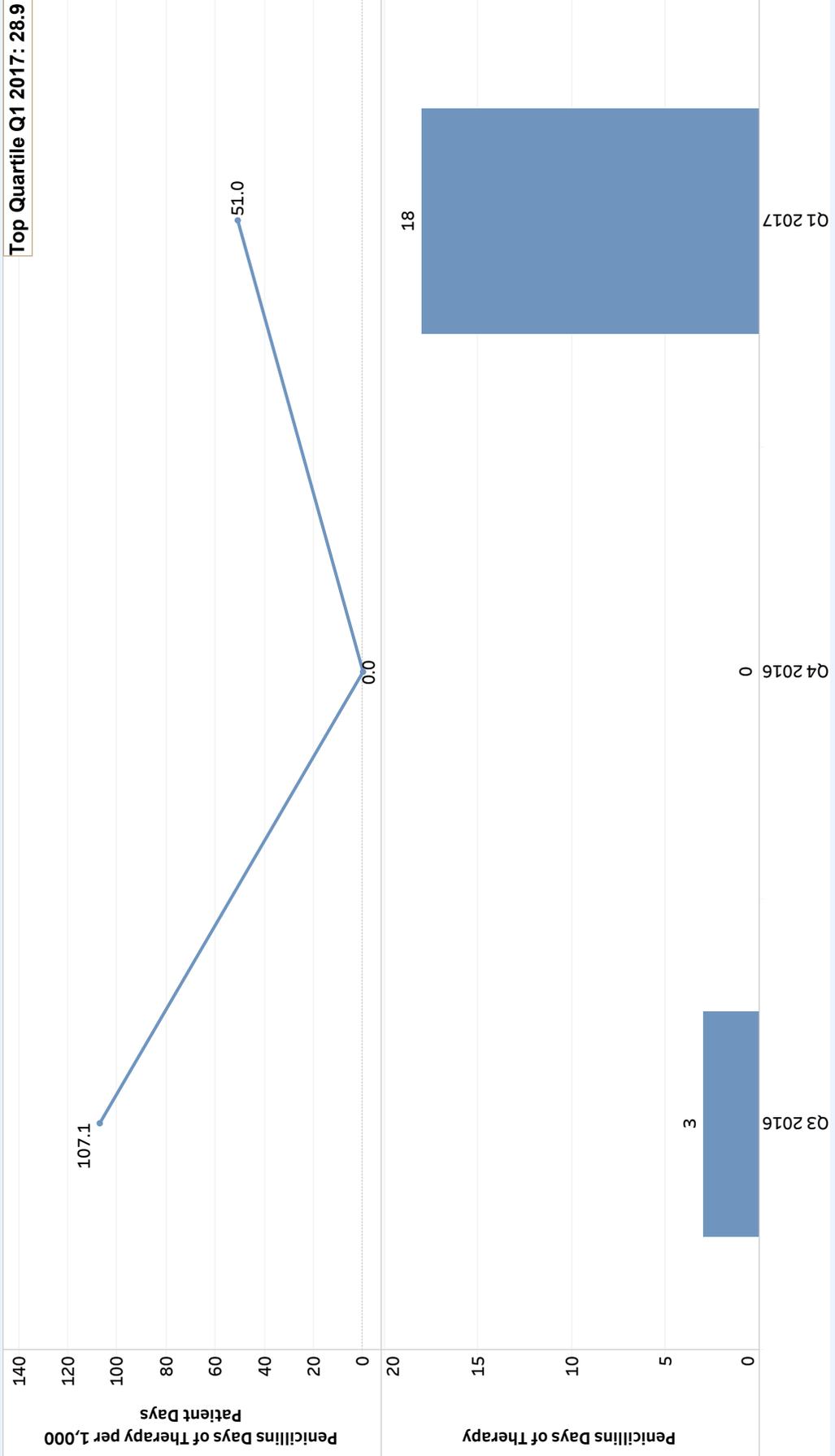
Definition: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Antimicrobial Stewardship (ASP) Penicillins Days-of-Therapy

Top Quartile Q1 2017: 28.9



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



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Severe Sepsis and Septic Shock Mortality Rate

Top Quartile Q1 2017: 2%



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



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Adverse Drug Events Anticoagulants: Option 1

Top Quartile Q1 2017: 0%

Number of Inpatients Receiving Warfarin

0.0%

Percentage of Events INR > 5 Over Total

INR Greater Than 5 Readings

0

0

0

0

0

Q3 2016

Q4 2016

Q1 2017

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.



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Adverse Drug Events Hypoglycemic Agent: Option 1

Top Quartile Q1 2017: 0%



(BG)* < 50 mg/dl After Hypoglycemic Agent Over Number of Patients Receiving Hypoglycemic Agents

Number of (BG)* < 50 mg/dl After Hypoglycemic Agent

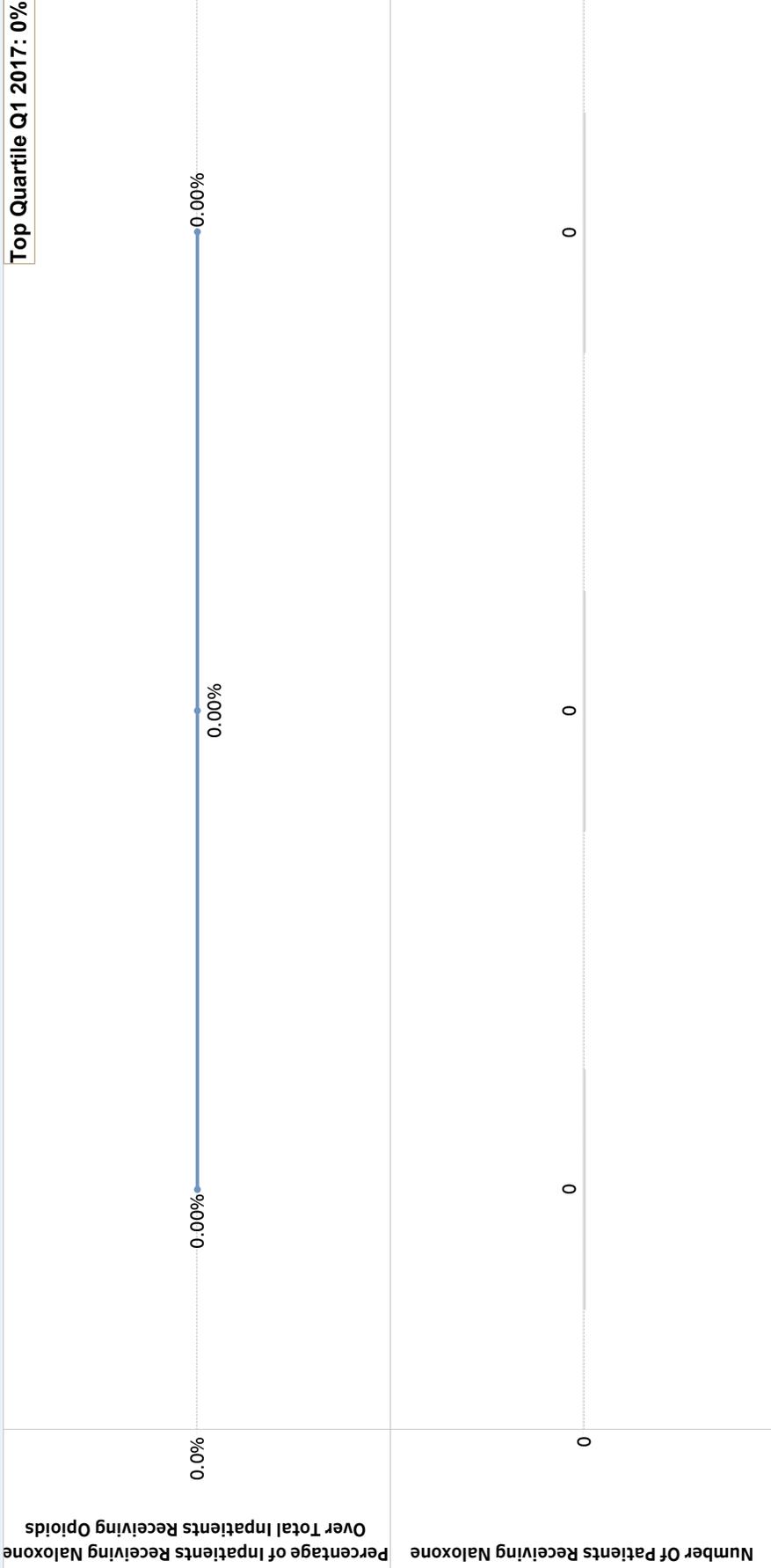
Definition: Number of patient blood glucose (BG)* levels of <50 mg/dl after any hypoglycemic agent administration (patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) receiving hypoglycemic agents (oral & insulin).
Data Source: Washington State Hospital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



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Adverse Drug Events Opioids: Option 1

Top Quartile Q1 2017: 0%



Percentage of Inpatients Receiving Naloxone Over Total Inpatients Receiving Opioids

Number Of Patients Receiving Naloxone

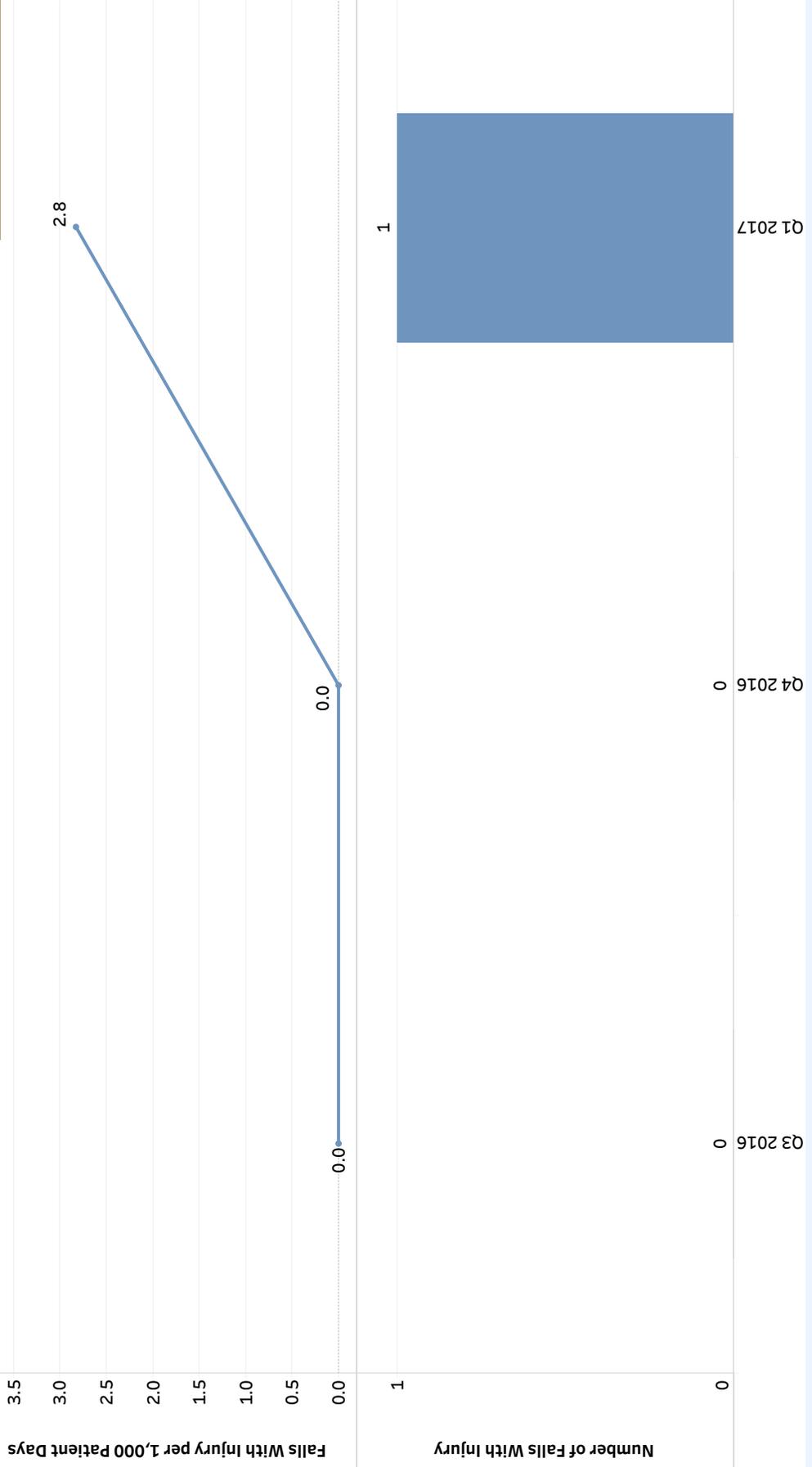
Definition: Number of patients (cared for in an inpatient area) who received naloxone after any opioid administration over number of patients (cared for in an inpatient area) receiving opioids. Exclusions: naloxone given in PACU and procedural areas, given (via IV infusion) for epidural-related itching 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.



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Inpatient Falls with Injury Rate (NQF 0202)

Top Quartile Q1 2017: 0



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

Partnership for Patients



ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION



Washington State Hospital Association

Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Hospital-Acquired Pressure Ulcers Rate (AHRQ PSI-03)

Top Quartile Q1 2017: 0



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 Jennifer.G@wsha.org.

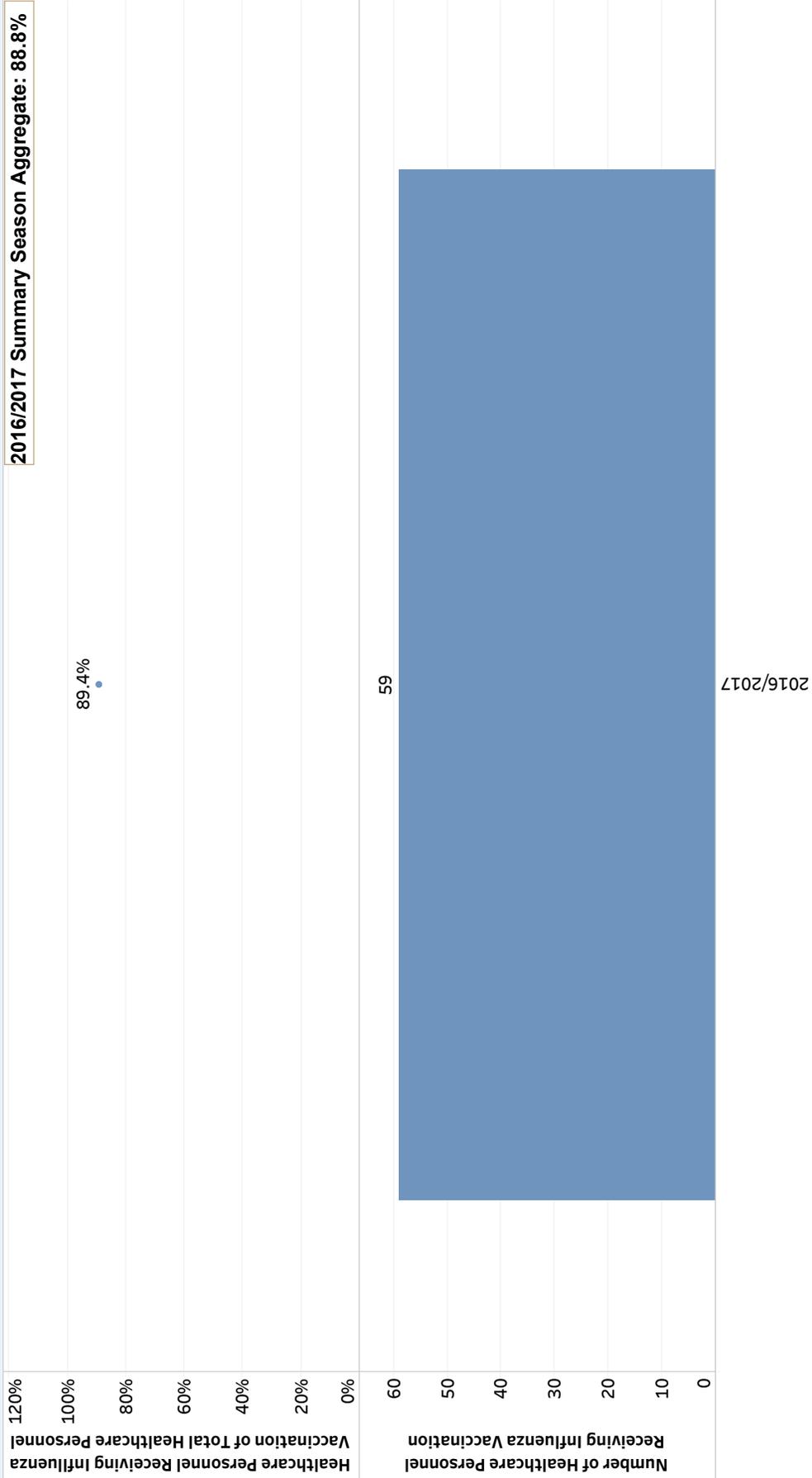
Decision Support



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Influenza Immunization of Healthcare Personnel

2016/2017 Summary Season Aggregate: 88.8%



Definition: Healthcare Personnel receiving influenza vaccine out of those who are physically present in the Healthcare facility for at least one working day between October 1st and March 31st of the following year (Excludes total number of Healthcare Personnel with contraindication).

Data Source: CDC NHSN.



Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Undue Exposure to Radiation: Radiology Dosage Per Pediatric Head CT

Top Quartile Q1 2017: 481.1

Dose Length Product (DLP) Ratio

0

Number of Pediatric CT Scans

0

Q3 2016

Q4 2016

Q1 2017

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).

Partnership for Patients



ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

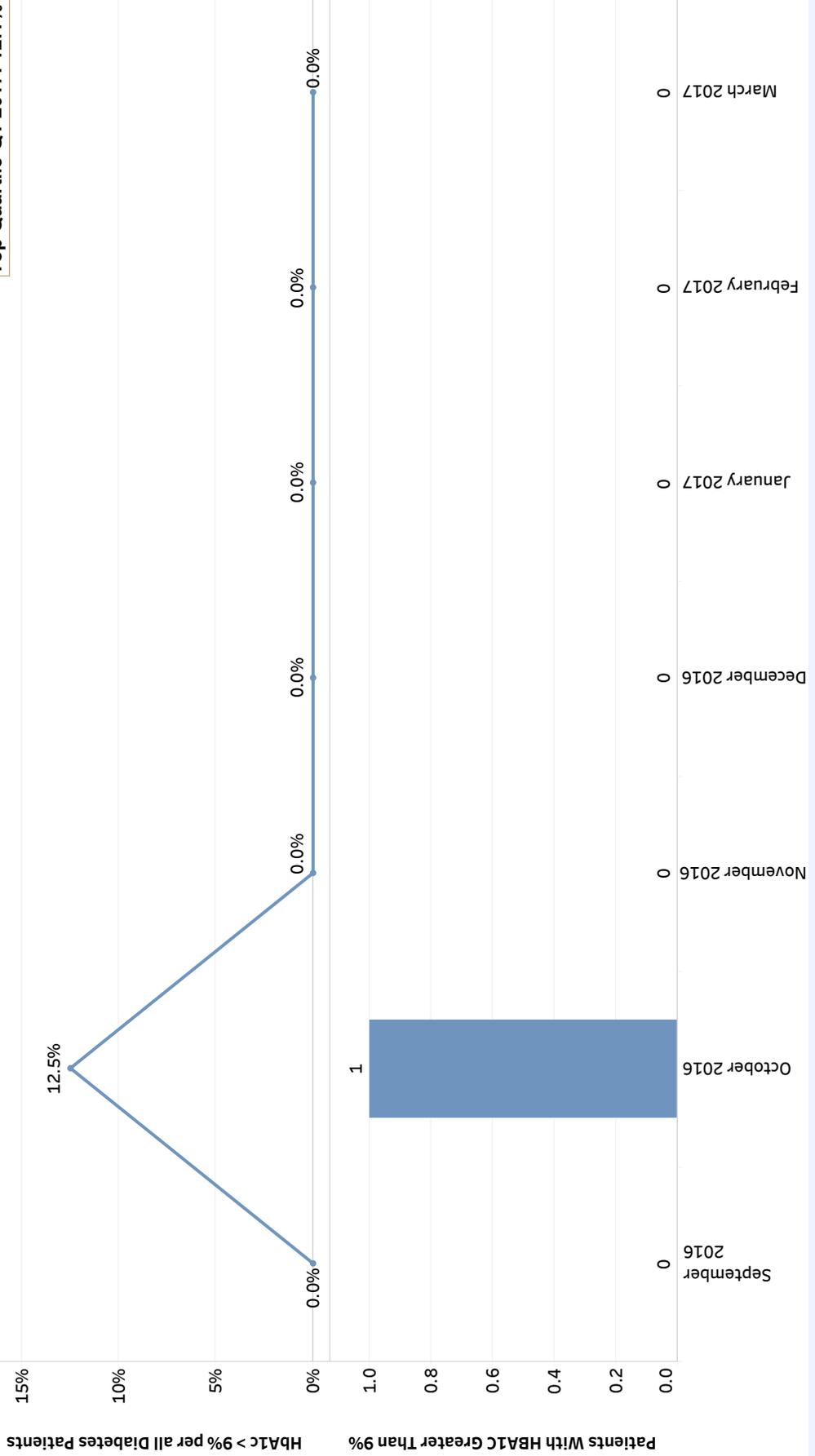


Washington State Hospital Association

Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

Population Health: Diabetic Care (Critical Access Hospitals Only)

Top Quartile Q1 2017: 12.1%



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 Jennifer.G@wsha.org.

Decision Support

Partnership for Patients



ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

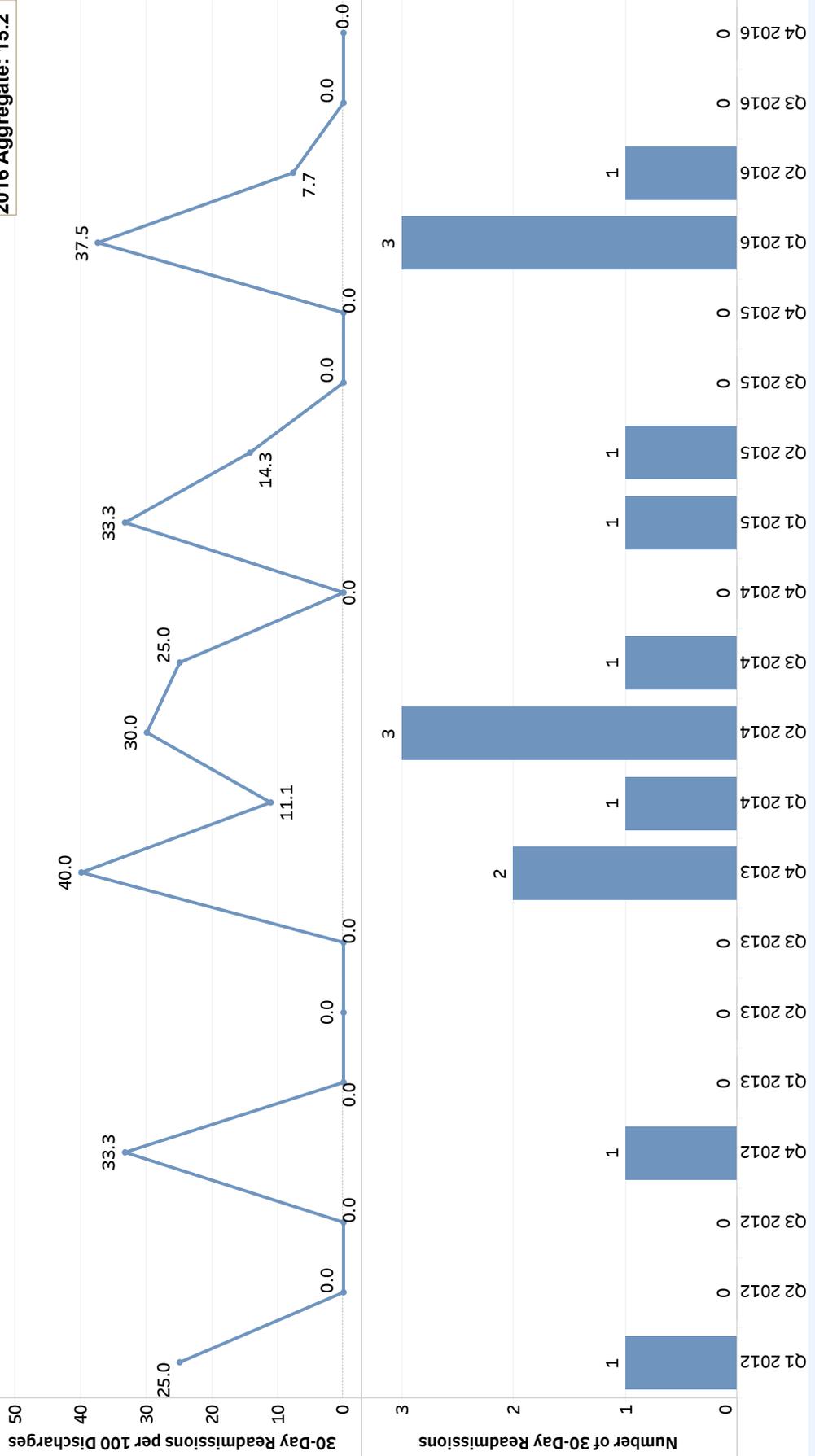


Washington State Hospital Association

Cordova Community Medical Center Patient Safety Trend Report - July 2017 Release

30-Day Medicare FFS Readmissions

2016 Aggregate: 15.2



Definition: Number of 30-Day Medicare FFS readmissions per 100 live discharges.
Data Source: Qualis Health and Mountain-Pacific Quality Health.

MDS 3.0 Report

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

Report Filter:

- Analysis Period End Date: **14-Aug-2017**
- Random Sample: **None**
- Resident Group(s): **Swing Beds LTC**

Residents included: 10

Accidents

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



Activities of Daily Living

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



Bed Mobility



Transfer



Locomotion on Unit



Locomotion off Unit



Dressing



Eating



Toileting



Behavioral and Emotional Status

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



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



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



Dental Status and Services

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

Broken Denture



No Natural Teeth



Abnormal mouth tissue



Obvious cavity



Inflamed, bleeding gums



Mouth, facial pain



Hearing and Vision

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



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



Hydration

Prevalence of Dehydration (Most Recent MDS) (QP015)



Dehydration



Volume Depletion



Infections (non-UTI related)

Wound Infection (Most Recent MDS) (QP061)



Nutrition

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



Physical Restraints

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



Trunk Restraint (In Bed)



Limb Restraint (In Bed)



Trunk Restraint (In Chair)



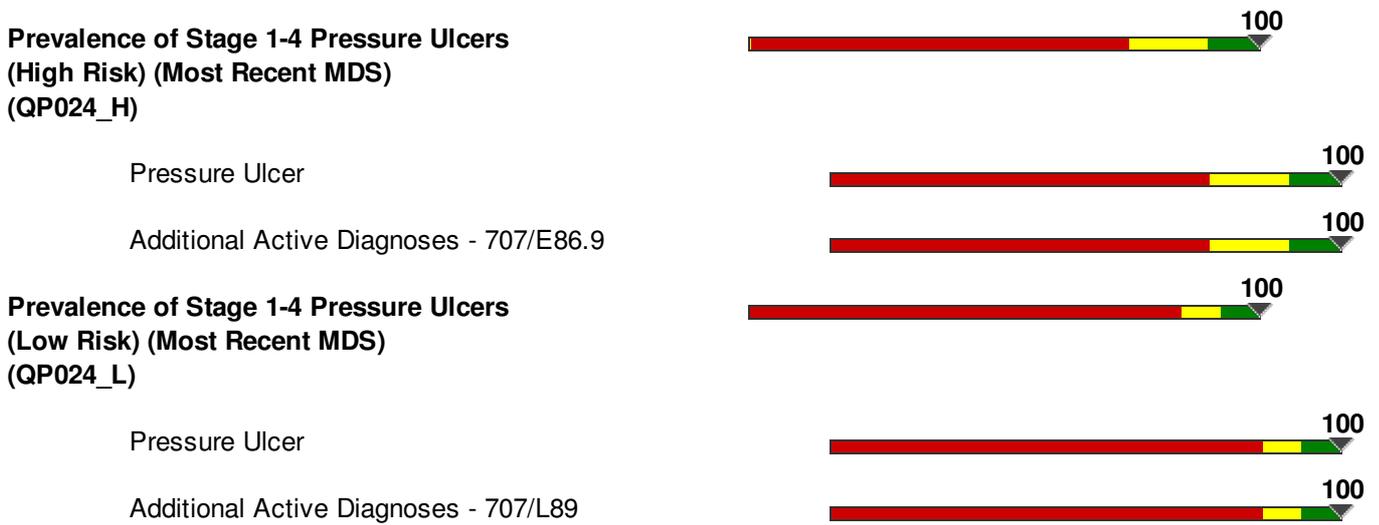
Limb Restraint (In Chair)



Chair Prevents Rising



Pressure Ulcers



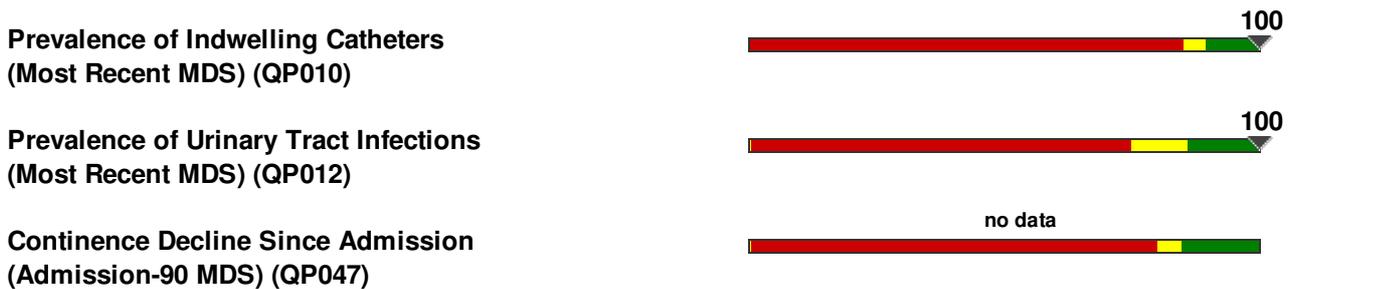
Range of Motion



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.

MDS 3.0 Report

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

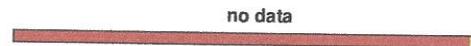
Report Filter:

- Analysis Period End Date: **20-Sep-2017**
- Random Sample: **None**
- Resident Group(s): **Swing Beds LTC**

Residents included: 10

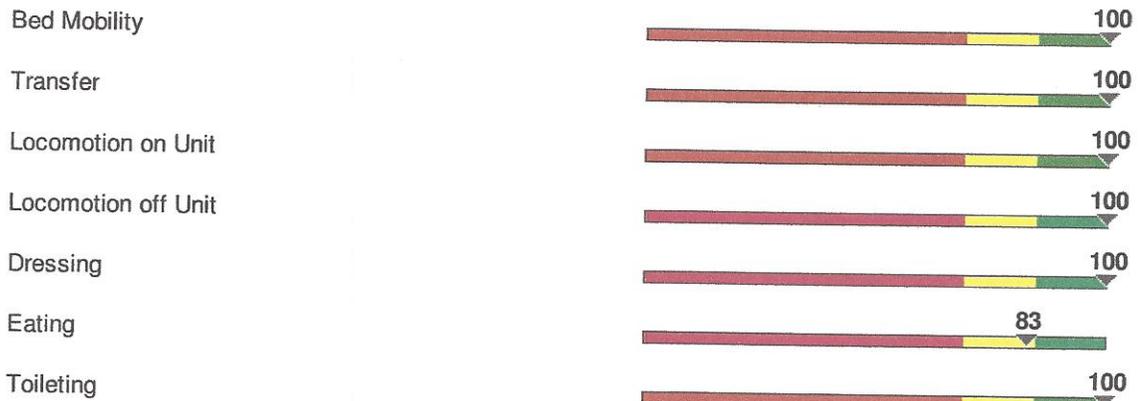
Accidents

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



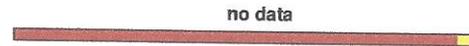
Activities of Daily Living

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

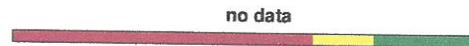


Behavioral and Emotional Status

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

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

Broken Denture

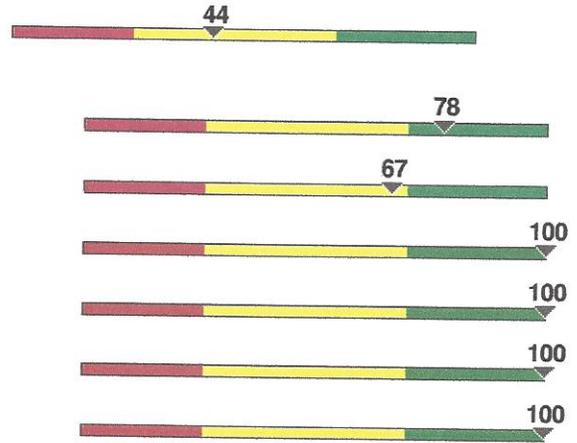
No Natural Teeth

Abnormal mouth tissue

Obvious cavity

Inflamed, bleeding gums

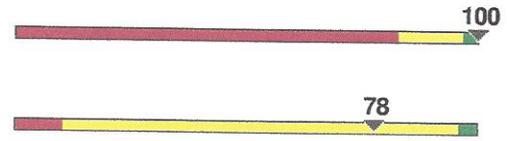
Mouth, facial pain



Hearing and Vision

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

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

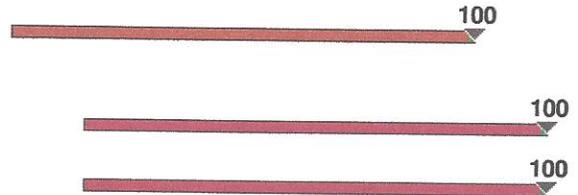


Hydration

Prevalence of Dehydration (Most Recent MDS) (QP015)

Dehydration

Volume Depletion



Infections (non-UTI related)

Wound Infection (Most Recent MDS) (QP061)



Nutrition

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



Physical Restraints

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

Trunk Restraint (In Bed)

Limb Restraint (In Bed)

Trunk Restraint (In Chair)

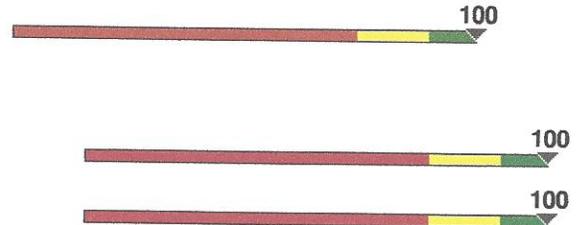
Limb Restraint (In Chair)

Chair Prevents Rising

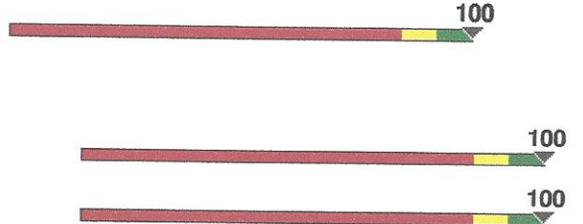


Pressure Ulcers

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

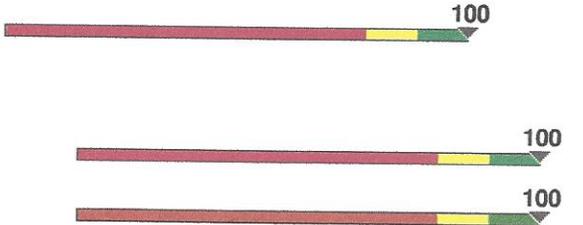


Prevalence of Stage 1-4 Pressure Ulcers (Low Risk) (Most Recent MDS) (QP024_L)



Range of Motion

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



Tube Feeding

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



Urinary Catheter, Incontinence and Infection

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



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



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



Residents With Flagged Assessments

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

Name	Identifier	Room Number	Assessment Date(s)
<i>Wandering</i>			
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)
<i>Bed Mobility</i>			
No residents were flagged for this care area.			
<i>Transfer</i>			
No residents were flagged for this care area.			

August 12, 2017

Diana M. Rubio
P.O. Box 1109
Cordova, AK. 99574

AUG 15 2017

CCMC Health Board
P.O. Box 160
Cordova, AK. 99574

Attention: Scott Mitchell, CEO

My 93 yr. old Mother, Aleen R. Brown, was admitted to CCMC on 12-16-2016 . It was determined it would be in her best interests to live in the nursing home. Chris Johnson, Giovanna and Barb Jewell have helped me apply several times and we see the light at the end of the tunnel. Randy sat down with me when Mom was admitted and explained that she had 28 days of therapy and another 90 days of which Medicare would pay. I explained that her supplemental insurance had been canceled. The trouble is, I was given other information from other people.

I would respectfully request that CCMC create a specific protocol/checklist for families who are admitting their loved ones to the nursing home; A checklist that is laid out so that there is no confusion. Adding a list of who to approach for what, what assistance is available, etc. It took more than six weeks to have a bath schedule arranged for my Mother. Nurse Nicole arranged that after many request to other nurses. I didn't know to go to Giovanna or Helen McGaw.

It took us 6-8 weeks to get Mom's menu sorted out, and to get distilled water for her C-Pap. She was falling because her bed was too high. Thank heavens for Helen McGaw. She arranged a lower bed for Mom, got her distilled water and obtained a sewing table for her. In short, she has done everything to make Mom adjust and be happy. Giovanna has also been kind and helpful.

I would like to put my two cents in on CCMC renewing Helen's contract. She is a real asset to the hospital and a great advocate for Seniors. Of Course, Chris Belgarde is beyond excellent also.

I hesitated to send this letter, because I am not being critical of my Mother's care and all of the kindness shown her. However, I feel that the more knowledge and/or help, the more beneficial it is to patients and CCMC. It would make everyone's life easier if we knew what to do.

Sincerely,

Diana Rubio

CC: Sally Bennett, Dorne Hawkhurst, John Harvill, April Horton and
Kristin Smith



Memorandum

To: CCMC Authority Board of Directors

From: Scot Mitchell, FACHE, CCMC CEO

Subject: 2016 CAH Periodic Evaluation – Annual Report

Date: August 16, 2017

Suggested Motion: “I move that the CCMC Authority Board of Directors approves the 2016 CAH Periodic Evaluation – Annual Report.”

To: Cordova Community Medical Center Authority Board of Directors
From: Scot Mitchell, FACHE, Chief Executive Officer
RE: Critical Access Hospital Periodic Evaluation for 2016
Date: July 12, 2017

A review of Cordova Community Medical Center was conducted for the calendar year 2016 as required by the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation for Critical Access Hospitals. This annual report is submitted to you for your review and approval. The information for this report was collected by the Leadership Team at CCMC. I have compiled the report and it has been reviewed by the Leadership Team, Quality Management Committee and the Medical Staff.

EXECUTIVE SUMMARY

2016 was another year of transition for CCMC. For many years now, the facility has been subject to a great deal of staff turnover, which has led to a significant lack of continuity of leadership within the facility. CCMC started seeing a change in this phenomena last year. Dr. Sanders joined Dr. Blackadar on the Medical Staff, so the organization now has two full-time local, board certified physicians. This is the first time in about 15 years that CCMC has had two full-time local physicians. As the new CEO started in June, a concerted effort was made to try to address the lack of full-time local staff. Numerous staff, especially in nursing were hired in 2016, which has reduced the reliance on temporary staff. The lack of leadership continuity is the most significant issue facing CCMC, without it you cannot adequately develop and implement improvement plans.

With the addition of the two new physicians over the past two years, CCMC has seen a continuity of the Medical Staff that has led to an increase in patient volumes and a reduction in transfers out of the facility. Our acute care patient days went up more than 150% while our emergency room visits are staying steady at about 2 per day. Clinic visits last year increased 9% over 2015.

The radiology department added Computed Tomography (CT) scanning services in 2016. This led to an increase in imaging procedures by 19%, as well as helped reduce the number of transfers out of CCMC. Our average length of stay was 57.8 hours, below the CAH requirement of 96 hours. More detailed information is included in the main report.

We started resurrecting our quality improvement program in 2016. Staff has developed and the board approved a QI plan for 2017, so we are now on the way to improving our quality program. CCMC also started submitting quality data in September 2016, participating in the Partnership for Patients program between the Alaska State Hospital and Nursing Home Association and the Washington State Hospital Association.

CCMC has a contract with the Healthcare Quality Service for external physician peer review. 100% of acute and observation admissions, transfers, blood transfusions and unexpected deaths are subject to internal physician peer review. CCMC has a contract with Partners in Health Network, an NCQA certified Credentials Verification Organization, to perform the primary source verification for the physician privileging.

As part of this evaluation, every clinical service impacting health and safety, including contracted services, were evaluated and reviewed by the Quality Management Committee. There was an issue noted in radiology services that has led to the process of changing radiology services providers in 2017.

The clinical policies review process was used, but not fully, to evaluate those policies. As a result most of the policies were reviewed and some changes were recommended and approved by the Health Services Board in 2016. A new process has now been implemented to improve this process.

Recommendation

The Critical Access Hospital program continues to meet the needs of CCMC from a clinical perspective, as well as a financial one. While still financially struggling, it would be very difficult to continue operations without the CAH designation. The clinical services provided by CCMC are appropriate for the needs of the community.

MAIN REPORT

Financial Review

Like a lot of critical access hospitals, CCMC has struggled financially for many years. There are several factors at play for our facility. The geographic isolation of Cordova, combined with small population limits the volume of utilization of services, but we are still required to provide certain services, which means having the staff, equipment and supplies for services that will never receive enough utilization to allow us to recover our fixed costs. The high cost of being located in Alaska also puts us at a disadvantage. It is extremely difficult to recruit and retain quality healthcare professionals in such a remote, frontier area. Despite these, and other factors, CCMC started making a dent in the financial issues in 2016.

The end of 2016 was improved over 2015 as it pertains to the balance sheet. Total current assets increased by more than 13% from the previous year. Accounts payable decreased by 38% compared to the prior year. Other changes included the addition of underfunding of the Public Employees Retirement System pension fund, which was finally determined by the State of Alaska under the GASB 68 accounting standard.

2016 total patient revenue increased more than one million dollars, or 12%. This is due to the addition of another full time physician to the medical staff. With two board certified local physicians, more patients were seen in the clinic and admitted to the hospital, as well as transfers out of CCMC were reduced significantly over 2015.

Wages and benefits increased by almost 8% in 2016 as compared to 2015. This was due to a focus on reducing the reliance on temporary staff in the latter half of 2016. The nursing staff in the hospital was 100% temporary when I started at the end of June, but we hired three permanent RNs before the end of the year.

A change in accounting methodology in 2016 resulted in our utilities expense showing a significant increase over the prior year as the USAC grant funds we receive had previously been shown as a reduction in costs was shifted to the other revenue category. This did not affect cash flow, but was strictly an accounting change. Depreciation expense increased 73% due to the project costs for adding the CT scanner was completed and the scanner is now in use.

A permanent Chief Financial Officer started in September 2016 and he has already made a positive impact on several areas such as revenue cycle management, accounting and electronic health record research.

Volume and Utilization of Services

Facility Capacity

Cordova Community Medical Center is licensed as a Critical Access Hospital by the State of Alaska for 23 beds. Ten of those beds are designated as long term care and the remaining 13 are dual licensed as acute care and swing bed. The emergency department has two beds, and does have the capability to expand when surge capacity is required. The laboratory was staffed with two full-time technicians. A laboratory director shared time with other departments. The imaging department had one full-time technician who also covered on-call almost entirely by himself. Our rehabilitation department had one Occupational Therapist and a Physical Therapist position that was covered by temporary staff for the entire year. The Occupational Therapist also provided services to children at the local school system.

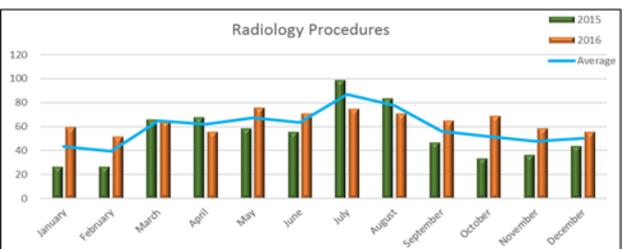
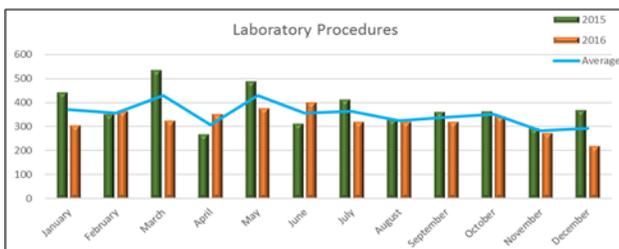
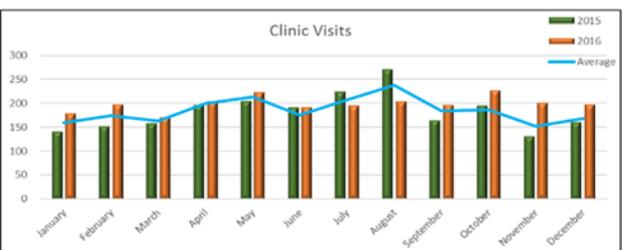
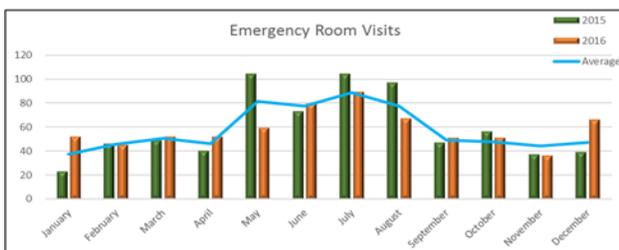
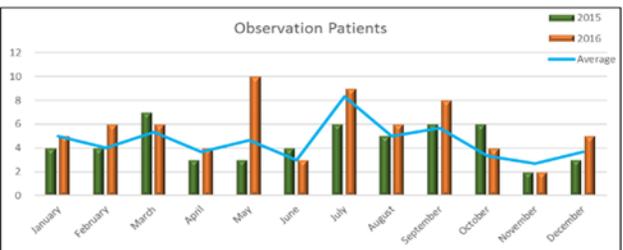
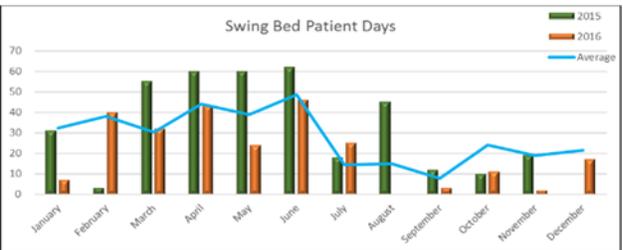
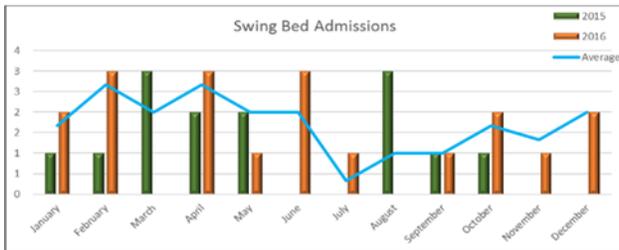
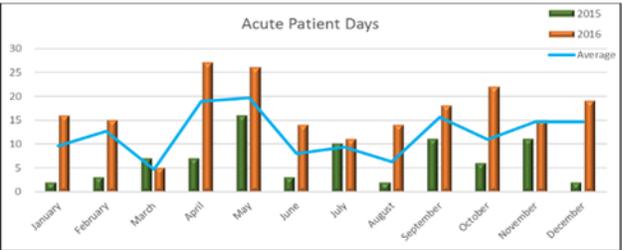
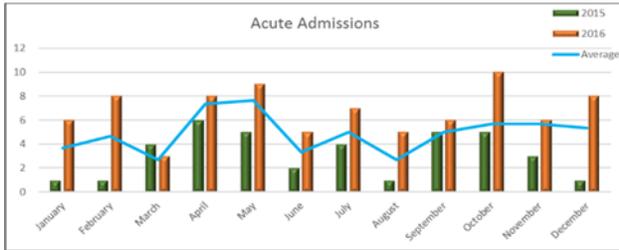
Our family medicine clinic started 2016 with one full-time, board certified family medicine physician who also covered call 24/7 for the emergency department. Dr. Hannah Sanders joined Dr. Sam Blackadar last spring, marking the first time in more than a decade that CCMC had two permanent, board certified full-time physicians who live in Cordova.

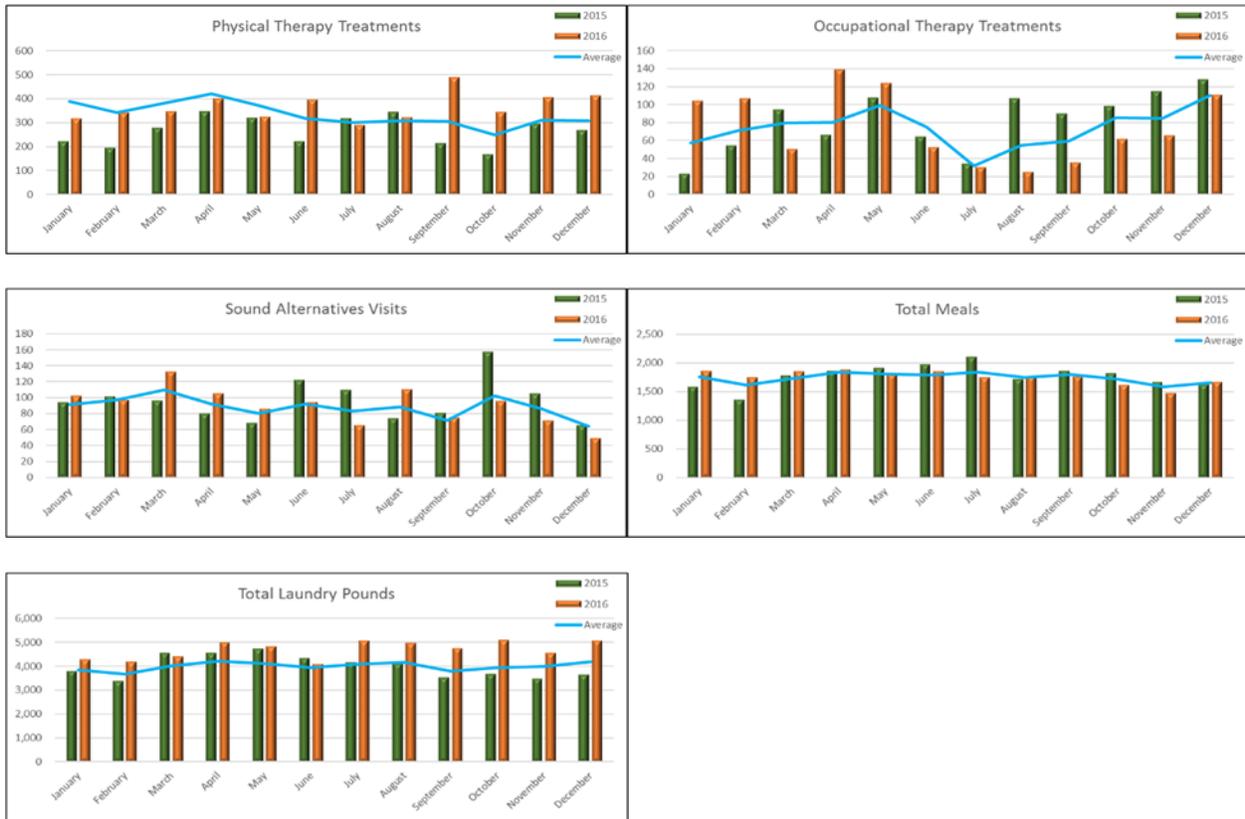
Volumes

CCMC saw both increase and decreases in utilization of services in 2016. With the addition of Dr. Sanders we continued to see increases that started when Dr. Blackadar joined the medical staff in 2015. For example, the number of acute care admissions more than doubled in 2016. Clinic visits increased 9% over the previous year. Although swing bed admissions increased by about one-third, the number of swing bed days actually dropped by about the same percentage, due to differences in rehabilitation therapy. Emergency room visits and laboratory procedures dropped from 2015 volumes. Radiology procedures increased 19% in 2016, partially due to the addition of CT services. Physical therapy volumes increased by more than one-third while occupational therapy volumes decreased by about 8%. The occupancy of our nursing home increased from 96.9% in 2015 to 99.5% in 2016. The number of behavioral health visits decreased 6%. The table and charts below show utilization volumes from various CCMC departments, as pulled from our electronic health record system. We believe these numbers to be fairly accurate, but due to issues with the system we suspect slight variances from actual.

Statistic	2015	2016	% Change
Acute Admissions	38	82	116% 
Acute Patient Days	80	202	153% 
Swing Bed Admissions	14	19	36% 
Swing Bed Patient Days	375	250	-33% 
Long Term Care Resident Days	3,546	3,650	3% 
Observation Patients	60	69	15% 
Emergency Room Visits	715	699	-2% 
Clinic Visits	2,182	2,377	9% 
Laboratory Procedures	4,505	3,901	-13% 

Radiology Procedures	648	774	19%	↑
Physical Therapy Billed Units	3,208	4,407	37%	↑
Occupational Therapy Billed Units	988	911	-8%	↓
Sound Alternatives Visits	1,152	1,081	-6%	↓
Total Meals Served	21,179	20,935	-1%	↓
Total Laundry Pounds	48,061	56,398	17%	↑





Average Length of Stay

In 2016 the acute care average length of stay for the 82 admissions was 57.8 hours, well under the 96 hour average required for the CAH conditions of participation. CCMC did have 16 acute care patients who had lengths of stay longer than the 96 hour average. In comparison, the acute care length of stay in 2015 was 50.4 hours for the 40 admissions. There were 4 patients that year with a length of stay longer than 96 hours.

Average Length of Stay	2015	2016	% Change
Acute care average length of stay (hours)	50.4	57.8	15%
Number of patients with LOS more than 96 hours	4	16	300%
Swing bed average length of stay (days)	26.8	13.2	-51%
Observation average length of stay	N/A	103.4	N/A

Transfers

With the addition of Dr. Blackadar and Dr. Sanders over the past two years, CCMC has seen a significant decrease in the number transfers out of our facility. Another positive impact on reducing transfers was seen when the CT scanner was installed in the winter of 2016. We had 51 transfers in 2015 and only 36 in 2016. When you consider the average costs of emergency transfers via airplane from Cordova, the reduction in 2016 saved local citizens about \$500,000. The Medical Staff reviews all transfers to determine the appropriateness of the transfers as well as to identify any potential issues with EMTALA

compliance. There were no instances of inappropriate transfers and no instances of lack of compliance with EMTALA regulations.

Transfers	2015	2016	% Change
Inpatient Transfers	1	6	500% 
Emergency Room Transfers	50	30	-40% 
Total Transfers	51	36	-29% 

Medical Record Review

Health Information Management Reviews

The HIM department reviews 100% of the patient records, both inpatient and outpatient as well as the clinic, as part of their routine monitoring program. These chart reviews include abstracting data from each episode of care to determine if required documentation is present. The following items are reviewed for inclusion in the patient charts: complete and accurate physician and nurse notes, lab results and imaging reports are scanned into the chart, all ordered medications are documented appropriately, other test results are scanned into the chart and any other information specific to the patient is included to make the chart complete and accurate. HIM also serves as a double check to make sure we are capturing all charges for services provided.

In 2016 the HIM department reviewed 4,629 patient episodes and abstracted the inpatient, outpatient and clinic charts for their review. The table below shows the top deficiencies and opportunities for improvement noted during the review.

Deficiency Area	Number of Charts with Deficiency
Order status	237
Incomplete or inaccurate documentation	213
Missing or inaccurate charges	127
Missing diagnosis	19

When a documentation deficiency is found during the chart review, the HIM department works with the appropriate provider, nurse or ancillary staff member to correct the problem. This process is completed shortly after the patient episode has occurred, which helps increase accuracy for future charts.

Medical Staff and Peer Review

The Medical Staff of CCMC has undergone significant changes over the past several years. The current Medical Staff has been actively involved in improving the many roles that the Medical Staff plays in the hospital, clinic and nursing home settings. For example in 2015 there was really no peer review process until Dr. Blackadar joined the staff and he instituted an internal review process and led the process to contracting with an outside peer review entity for cases that needed an external review. CCMC contracted with Healthcare Quality Service, based out of Seattle, Washington in October 2015 for external physician peer review services. There have been no cases sent to Healthcare Quality Service for peer review in 2015 or 2016.

The CCMC Medical Staff has implemented a process whereby they perform internal reviews of 100% of all of the following cases:

- Admissions to acute care
- Admissions to observation
- Transfers
- Blood transfusions
- Unexpected deaths

These internal reviews of the physician's cases are conducted by the other physician. For example in 2016, Dr. Blackadar reviewed a total of 48 cases where Dr. Sanders was the admitting physician in the above categories, while Dr. Sanders reviewed 35 of Dr. Blackadar's cases. The Medical Staff has also recently started utilizing locum tenens physicians to perform peer reviews when they are onsite. There were no instances of inappropriate care or adverse outcomes noted as part of these reviews.

Review of Services

Nursing Services

The CCMC Nursing Department provides nursing services for several areas, including acute care, swing bed, emergency room, observation and clinic. A Registered Nurse (RN) is on duty 24 hours a day, 7 days a week in the acute care department. An RN or Licensed Practical Nurse (LPN) is also available 24/7 in the nursing home as well. In addition, Certified Nursing Assistants are also scheduled on both the day and night shifts in the nursing home. All of the nursing staff is trained in Basic Life Support and the RN's are also trained in Advanced Cardiac Life Support, Pediatric Advanced Life Support and specialty training in trauma care.

In the acute care setting, the nurses provide skilled nursing services for those patients who are generally expected to stay less than 96 hours. The acute care status is generally what people think of when someone is admitted to the hospital. Swing bed care is a category whereby the status of the patient can 'swing' between acute care and skilled care. Observation bed services are available when a patient needs short term care and monitoring, while giving the physician an opportunity to determine if the patient needs to be admitted for a longer amount of time.

The CCMC long term care unit is licensed for 10 beds, which stayed full almost the entire year of 2016. Our nursing home provides restorative care that focuses on helping the residents maintain their functional abilities and preventing their physical decline. The nursing staff is trained in managing difficult behaviors, dementia and Alzheimer's disease along with the nuances of caring for the completely disabled.

The emergency room is available 24 hours a day, 7 days a week to provide care to those with serious illnesses and injuries. Initial assessment and stabilization is provided by a Registered Nurse, who contacts the physician to come to the ER to treat the patient. Our policies require our physicians to arrive in the emergency room within 30 minutes of being called. In reality, our physician response time is much quicker than 30 minutes.

The nursing department was active in 2016 in many improvement processes. Below is a brief overview of some of the nursing services accomplishments last year.

- Moved to evidence based nursing procedures by implementation of Lippincott Learning system
- Continued customization and recalibration of the electronic health record

- Completed an inventory and assessment of our medical equipment, prioritizing items for the budget
- All immunizations performed are being tracked on the Alaska VacTrak system
- Successfully developed a Plan of Correction for the nursing area deficiencies in the long term care surveys
- Staff participated in the Long Term Care Committee of the Alaska State Hospital and Nursing Home Association
- Started the preparation for the development of an action plan to meet the Phase 1 Conditions of Participation for the new federal long term care regulations
- In conjunction with the Medical Staff developed clinical protocols for conscious sedation

Clinic

CCMC operates a provider based family medicine clinic on the hospital campus. For many years, CCMC has been forced to rely on locum tenens physicians to cover short periods of time. This situation is not optimal for continuity of care for local patients. The past two years have seen major strides in improving the quality and continuity of care provided in the clinic. Dr. Sam Blackadar started a full time practice at the clinic in 2015. Dr. Hannah Sanders joined the practice in 2016. Having two full time, local physicians has led to much better consistency and quality care for our patients and the community. It has been almost 15 years since CCMC has had two local, full time physicians on staff.

Now that Cordova has two full time, board certified family medicine physicians who live here, we have started seeing an increase in patients utilizing the clinic. 2016 saw clinic visits increase by 9% to 2,377 visits. There were 2,182 clinic visits in 2015. Having full time physicians has also allowed us to add expand upon our services. The list below is a sample of some of the services provided in the clinic.

- Comprehensive family medicine
- Routine health prevention
- Coordinated disease management including diabetes, heart disease, pulmonary and rheumatologic conditions
- Comprehensive women's healthcare
- Family planning
- Prenatal care
- Well child checkups
- Adult and pediatric vaccines
- Merchant Marine/Coast Guard physicals
- Sports physicals and school entry physicals
- Non-operative orthopedics
- Dermatologic conditions including skin exams and removal or biopsy of suspicious lesions
- Quarterly visits from a Pediatrician

Laboratory

The Cordova Community Medical Center laboratory is a Clinical Laboratory Improvement Amendments (CLIA) certified, moderate complexity laboratory. We perform numerous test in-house such as chemistry, hematology, urinalysis and coagulation. We can also perform several screening and kit tests such as influenza, respiratory syncytial virus, streptococcus, etc. CCMC laboratory offers chain of custody

collection and processing of drug screening specimens for employers and healthcare providers. In 2016 the laboratory conducted about 3,900 tests, with about 1,100 of those being reference tests sent to Quest.

Radiology

Cordova Community Medical Center has maintained x-ray and ultrasound equipment for use in providing diagnostic imaging services. Computed Tomography (CT or CAT scan) services were launched in February 2016, which added a much needed modality to the diagnostic imaging services repertoire. Not only did the CT services help enhance the quality of care to the community we serve, it was also a significant component in helping to reduce the number of transfers from CCMC to other hospitals outside Cordova. We performed 590 x-rays last year with an average of 5 minutes per exam. The new CT was used to perform 184 CT scans, with an average exam time of 15 minutes.

Rehabilitation

In 2016, the CCMC Rehabilitation department included physical therapy and occupational therapy services. Occupational Therapy was provided by a permanent OT, who was also the director of the Rehabilitation department. Physical Therapy was provided by temporary staff that was available full time throughout the entire year. Physical therapy billed units increased 37% from 3,208 in 2015 to 4,407 in 2016. Occupational therapy billed units dropped from 988 in 2015 to 911 in 2016.

Behavioral Health

Sound Alternatives exists to help improve the quality of life for all local residents, particularly those with mental or emotional problems, substance abuse and addiction problems and/or developmental disability limitations. We do this by promoting health and well-being, fostering self-sufficiency and empowering all individuals toward a more productive community contribution. In 2016 Sound Alternatives had six staff members. Below is an overview of the services provided by Sound Alternatives staff.

- Comprehensive intake assessment for mental health and substance abuse
- Individual outpatient psychotherapy for children, youth and adults
- Family therapy
- Psychiatric evaluations
- Provide 24/7 on-call crisis intervention
- Functional assessments
- Referral to other providers as necessary
- Outreach services
- EAP counseling to CCMC employees
- Consultation for hospital staff and community agencies as requested
- Rehabilitation treatment for substance abuse
- Respite care for developmental disabilities
- Residential habilitation/in-home support
- Case management
- Disability awareness and training
- Medicaid travel
- Tele-psychiatry for medication evaluation and management

The total volume of visits to Sound Alternatives dropped to 1,081 in 2016, down about 6% from the 1,152 in 2015. These numbers are still higher than the 944 visits in 2014.

Dietary

The Dietary department is responsible for providing the nutritional meals to all our LTC residents and acute care patients. We currently utilize a five week cycle of menus and offer substitutions and menu options for every meal to honor individual preferences of our residents and patients. Each resident receives an annual Medical Nutrition Therapy assessment and quarterly care plan updates. Special diets and individual preferences are followed. CCMC employs a Certified Dietary Manager and contracts with a Registered Dietician. Monthly Interdisciplinary Team meetings are held to review resident and patient progress and care plans. On a quarterly basis the residents and/or a family member are invited to care conferences where they are given the opportunity to ask questions of their care givers and give their opinions and suggestions on food services.

CCMC has partnered with the State of Alaska Nutrition, Transportation and Support grant program for more than 20 years. This program provides congregate and home delivered meals and transportation is offered to eligible seniors Monday through Friday. This program functions with the guidance of an elected senior council, and the congregate meals are provided in the CCMC cafeteria. The meals and transportation are provided for a suggested donation, but there is no mandatory payment from the recipients.

The total meals served in 2016 dropped slightly to 20,935 compared to 21,179 in 2015. LTC resident meals increased 5% from the previous year due to an increase in resident days. Acute care meals saw a 35% increase over 2015 due to the increase in acute care patients. Swing bed meals dropped 27%, coinciding with the decrease in swing bed days. Congregate meals dropped 25% from 5,616 to 4,233 in 2016, and home delivered meals also dropped 25% to 2,778 compared to 3,772. The number of rides dropped about 8% from 2,248 in 2015 to 2,071 in 2016.

Social Services

CCMC hired a new Medical Social Worker/Admissions and Discharge Planner in February 2016. There had been an incumbent in this position previously, so it was not a new position. The Social Services department carries out the following broad categories of duties for CCMC: work with other health care entities to facilitate transfers to our facility; completes long term care and swing bed authorizations and re-authorizations when due; assess and document bi-psycho-social assessments of patients and residents; discuss discharge plans with patients and families; facilitates interdisciplinary team meetings and quarterly care conferences; helps arrange for the safe discharge of patients and residents. These are just a few of the social services duties performed.

Review of Contract Services

Pharmacist

CCMC currently has contracted with a Consultant Pharmacist, Adam Baxter, RPh. Mr. Baxter comes onsite to CCMC on a quarterly basis which coincides with the quarterly care conferences for the long term care residents. During his visits, the Pharmacy and Therapeutics (P&T) Committee also meets. He completes medication reviews each month while off site, so we do not incur travel expenses. The P&T Committee

conducted a yearly evaluation of pharmacy services and found the service from Mr. Baxter was meeting the needs of our facility.

Dietician

Renee Legan, RD, is the contracted Dietician for CCMC. She comes onsite quarterly to coincide with the LTC resident care conferences. During her onsite visits, she meets with and conducts chart reviews of all residents and current patients. Renee analyzes data and recommends dietary adjustments and attends the care conferences. Throughout the year, Renee reviews and approves all nutritional assessments and care plans. She is available for consultation, reviews and assists in menu planning and creating dietary spreadsheets for all five cycles of weekly menus. Renee also assists in reviewing and drafting Dietary policies and procedures and is part of a team designated to improve the residents dining experience.

Reference Laboratory

The CCMC laboratory has been using Quest Diagnostics as our main reference lab for several years now. Quest performs the majority of our reference lab tests. Specimens are transported via Alaska Airlines Goldstreak service to Quest. In 2016, the medical staff expressed concerns about the turnaround time for receiving results of cultures sent to Quest for review. As a result of the analysis of this issue, it was found that we can receive faster turnaround times on cultures by using Providence Anchorage Medical Center instead of Quest. There are several factors at play in this issue, so staff is using the quickest method to get these results returned so the physicians can use that information in their care plans for patients.

Blood Bank Services

Blood Bank of Alaska provides blood products for CCMC. We receive four units of O negative blood every two weeks. These units are kept in the laboratory for use in case of an emergency transfusion. If the units are not used before the next shipment is received, the original units are returned to Blood Bank of Alaska so we will always have four fresh units of blood on stock. Blood Bank of Alaska also provides processing and transport of blood products in the event a CCMC patient requires a transfusion of type specific, cross matched blood. The services received from Blood Bank of Alaska have been sufficient to meet the needs of our patients.

Radiology

Radiology Associates, PC (RAPC) has been the contracted radiology service for several years now. They read all of the images produced in our radiology department. RAPC provides their services via telemedicine only, and do not provide onsite medical services. Over the past year or so, we have seen some issues with a lack of providing us with quality improvement reports as well as some credentialing issues. With the concerns about RAPC service, we have been conducting research into switching our radiology professional services to a different group. Based on recent discussions, we expect that this change will take place prior to the end of 2017.

Pediatrics Specialty Clinic

Dr. Susan Beesley is certified by the American Board of Pediatrics and provides care to the children of Cordova on a quarterly basis in the CCMC clinic. Dr. Beesley provides comprehensive pediatric care in a

very busy schedule that fills up weeks in advance of her visits. There have been no changes in her practice from 2015 to 2016.

Medication Management

Medication management is an important component of the care plan for our patients. CCMC takes a multi-disciplinary approach to medication management that involves the Medical Staff, Nursing Staff, Pharmacy and Therapeutics Committee and the consulting pharmacist. Both formal and informal communication strategies are utilized to review medication therapy for our patients, and any one of the above groups can escalate concerns about any medication issues.

Quality Improvement

The past few years have been difficult for CCMC when it comes to the lack of continuity with senior leadership positions. The excessive turnover has made it very challenging for the facility to develop and implement an effective quality improvement program. With a new CEO starting mid-year of 2016, the facility embarked on a course of action to restore a systemic quality improvement process. This led to the Health Services Board approving a 2017 Continuous Quality Improvement Plan in December of 2016. Prior to this time, there was really no coordinated quality improvement program over the past few years.

The CCMC Quality Management Committee (QMC) is tasked with the responsibility to oversee this plan. Below are the specific responsibilities as outlined in the approved plan.

- Ensuring that the review functions for each department and sub-committee are completed
- Ensuring that the quality plan is reviewed and acted upon appropriately and includes:
 - Review of long term care and critical access hospital regulatory updates
 - Review of life safety regulatory updates
 - Provide a summary report to the QMC on a quarterly basis
- Prioritizing and reviewing issues referred to the QMC
- Ensuring that data obtained through QI activities are analyzed, recommendations made and appropriate follow-up of problem resolution is done
- Covering utilization review
- Ensuring completion of periodic evaluation functions to meet Conditions of Participation requirements as a critical access hospital

In 2015 CCMC did not complete quality data submission for the Physician Quality Reporting System (PQRS). This will result in a penalty on some future Medicare reimbursements. We did submit PQRS quality data for both Drs. Blackadar and Sanders for 2016, in the areas of hemoglobin A1C control in diabetic patients, tobacco use in adults and documentation of current medications. As a result of this data submission, Drs. Blackadar and Sanders will not be subject to the reimbursement penalty in 2018.

Infection Control

The same issues resulting from the lack of continuity in senior leadership that affected the quality improvement process also impacted the infection control program. Accountability for the infection control program has been the responsibility of the Director of Nursing. While there has been minimal activity in this area in 2016, CCMC has recently hired a nurse who will have infection control as one of her

essential responsibilities. The Infection Control Committee is responsible for staff training and monitoring the infection control system facility wide.

Policy Review

CCMC has utilized the Quality Management Committee (QMC) as the main method for reviewing and approving policies. The members of the QMC are the Chief Executive Officer, Medical Director, Director of Nursing, Department Managers and the Chief Financial Officer. The individual departments are responsible for reviewing current policies and writing new policies as needed. Once the policies are reviewed by the Department Managers, they are brought to the QMC for final review. New policies followed the same procedure and were then taken to the Health Services Board for final approval.

Again, the lack of continuity in staffing has led to less than perfect performance in this area. The following departments did complete the full review of their policies in 2016: Administration, Dietary, Health Information Management, Infection Control, Materials Management, Pharmacy, Radiology, Senior Services, Social Services and Sterile Processing. The Long Term Care and Nursing departments completed a partial review of their policies. In order to address this area of need, in early 2017 CCMC developed a new more streamlined methodology for the annual policy review process, and has recently adopted a new online process for writing policies utilizing the MCN Healthcare system.

Organizational Plans

Quality Improvement

The quality improvement plan utilizes the following sub-committees to help complete its functions: Fire/Safety/Disaster, Infection Control, Medical Staff, Pharmacy and Therapeutics, Quality Improvement and Utilization Review. As mentioned previously, there was no approved quality improvement plan in 2015 and 2016, but the Board did approve a plan for 2017 in December of 2016. The approved plan for 2017 includes 39 different quality improvement projects between the hospital, nursing home and clinic.

Infection Control

CCMC has had an infection control plan in place for some time now, but minimal activity has occurred in recent years due to the excessive turnover in the senior leadership at the hospital. This has historically been the responsibility of the Director of Nursing, and that position has been one of the ones that has had the most turnover.

Corporate Compliance

The Corporate Compliance program exists to make sure that CCMC is obeying all federal, state and local laws that apply to our facility. In particular, the program helps us do the best we can to prevent fraud, waste or abuse at our facility. When a compliance issue is reported, an initial investigation is started, all of the supporting information is gathered and then the details are reported to the Chief Executive Officer. The CEO will review the complaint and if an employee is involved, the employee related information will be shared with the department manager for resolution. When the matter is resolved, the method of resolution is documented and the issue is closed. In 2016, there were two reported potential compliance issues, both of which were resolved appropriately. This is a reduction from the three issues reported in 2015.

Disaster

The CCMC Emergency Management Plan was reviewed and approved with limited changes by the Fire/Safety/Disaster Committee in 2016. After this approval, copies of the previous plan were replaced with the updated version and distributed throughout the facility. Work was started in 2016 on developing a presentation to be used for educating staff on the various components of the plan. This presentation was completed in 2017. The Fire/Safety/Disaster Committee held quarterly meetings in 2016. Three CCMC staff members attended the Hale Borealis statewide emergency management conference last fall in Anchorage. CCMC participated in the statewide earthquake exercise in the spring of 2016.

Survey Readiness

Critical Access Hospital

The State of Alaska, Department of Health and Social Services performed an unannounced standard CAH survey September 7-18, 2015. Several deficiencies were found, and the DHSS accepted the written Plan of Correction on November 2, 2015.

Long Term Care

The State of Alaska, Department of Health and Social Services performed an unannounced standard LTC survey February 16-19, 2015. Several deficiencies were found and the DHSS accepted the written Plan of Correction.

The DHSS performed an unannounced LTC survey on January 4-8, 2016. Several deficiencies were found, and the DHSS accepted the written Plan of Correction on February 16, 2016.

The DHSS conducted another unannounced LTC survey on November 7-11, 2016. Several deficiencies were found, and the DHSS accepted the written Plan of Correction on January 12, 2017.

Life Safety

The State of Alaska, Department of Health and Social Services conducted a standard unannounced life safety code survey in conjunction with each of the LTC and CAH surveys mentioned above. Several deficiencies were found during each of these surveys, and written Plans of Correction were submitted and accepted by DHSS, the most recent one was accepted on January 12, 2017.

Mock Survey

CCMC has not had a mock survey for several years. We did have Long Term Care and Life Safety surveys in 2016, and our last Critical Access Hospital survey was in 2015. We do have a CAH mock survey scheduled for July 2017.

Continuous Survey Readiness

Several CCMC committees included various components of survey readiness as part of their committee work, but the facility did not have a formal program in 2015 nor 2016 outside of the committee actions.

A formal survey readiness team was seated in early 2017, and is now actively working on preparing for future CAH, LTC and life safety code surveys.

Evaluation Participants

The following staff members participated and provided data and information in the CAH Periodic Evaluation of Cordova Community Medical Center for 2016.

- Charles Blackadar, MD, Medical Director
- Hannah Sanders, MD, Chief of Staff
- Scot Mitchell, Chief Executive Officer
- Lee Holter, Chief Financial Officer
- Helen McGaw, RN, Interim Chief Nursing Officer/LTC Director of Nursing
- Carmen Nourie, Laboratory Manager
- Kevin Byrd, Radiology Manager
- Vivian Knop, Materials Manager/Pharmacy Technician
- Faith Wheeler-Jeppson, Compliance Officer
- Chasity Brand, HIM Manager
- Holly Rikkola, HIM
- Kim Wilson, HR Coordinator
- Susan Banks, Dietary Manager
- Giovanna Atkins, Social Worker
- Brian Butler, Facilities Manager

Applicable CAH Conditions of Participation

- **C-0331 §485.641(a) Standard: Periodic Evaluation**
 - The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of:
- **C-0332 §485.641(a)(1)(i)**
 - The utilization of CAH services, including at least the number of patients served and the volume of services.
- **C-033 §485.641(a)(1)(ii)**
 - A representative sample of both active and closed records. A representative sample of both active and closed records means not less than 10% of both active and closed patient records.
- **C-0334 §485.641(a)(1)(iii)**
 - The CAH's health care policies.
 - C-0272 §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional health care staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners or clinical nurse specialists, if they are on staff.
 - C-0272 §485.635(a)(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.
- **C-0335 §485.641(a)(2)**
 - The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.

- **C-0336 §485.641(b) Standard: Quality Assurance**
 - The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. An effective quality assurance program means a QA program that includes:
 - Ongoing monitoring and data collection
 - Problem prevention, identification and data analysis
 - Identification of corrective actions
 - Implementation of corrective actions
 - Evaluation of corrective actions, and
 - Measures to improve quality on a continuous basis
- **C-0337 §485.641(b)(1)**
 - All patient care services and other services affecting patient health and safety, are evaluated.
- **C-0338 §485.641(b)(2)**
 - Nosocomial infections and medication therapy are evaluated.
- **C-0339 §485.641(b)(3)**
 - The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH.
- **C-0340 §485.641(b)(4)**
 - The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by:
 - One hospital that is a member of the network, when applicable
 - One QIO or equivalent entity
 - One other appropriate and qualified entity identified in the State rural health care plan
 - In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and distant-site hospital, the distant-site hospital, or
 - In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (b)(4)(i) through (iii) of this section.
- **C-0341 §485.641(b)(5)(i)**
 - The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective actions if necessary.
- **C-0342 §485.641(b)(5)(ii)**
 - The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.
- **C-0343 §485.641(b)(5)(iii)**
 - The CAH documents the outcome of all remedial action.

**Cordova Community Medical Center
Critical Access Hospital Periodic Evaluation for 2016
Approvals**

Quality Management Committee:

Kelly Kedzierski, RN, Committee Chair

Date

Medical Director:

Sam Blackadar, MD

Date

Chief Executive Officer:

Scot Mitchell, FACHE

Date

Cordova Community Medical Center Authority Board of Directors:

Kristin Carpenter, Board Chair

Date