BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

It is our mission to deliver quality healthcare to the residents of and visitors to BigBearValley through the most effective use of available resources.

VISION

To be the premier provider of emergency medical and healthcare services in our BigBearValley.

BOARD OF DIRECTORS BUSINESS MEETING AGENDA

Wednesday, March 14, 2018 @ 1:00 p.m. – Hospital Conference Room

41870 Garstin Drive, Big Bear Lake, CA 92315

(Closed Session will be held upon adjournment of Open Session as noted below. Open Session will reconvene @ approximately 3:00 p.m. –Hospital Conference Room 41870 Garstin Drive, Big Bear Lake, CA 92315)

Copies of staff reports or other written documentation relating to each item of business referred to on this agenda are on file in the Chief Executive Officer's Office and are available for public inspection or purchase at 10 cents per page with advance written notice. In compliance with the Americans with Disabilities Act and Government Code Section 54954.2, if you need special assistance to participate in a District meeting or other services offered by the District, please contact Administration (909) 878-8214. Notification at least 48 hours prior to the meeting or time when services are needed will assist the District staff in assuring that reasonable arrangements can be made to provide accessibility to the meeting or service. **DOCUMENTS RELATED TO OPEN SESSION AGENDAS (SB 343)** -- Any public record, relating to an open session agenda item, that is distributed within 72 hours prior to the meeting is available for public inspection at the public counter located in the Administration Office, located at 41870 Garstin Drive, Big Bear Lake, CA 92315. For questions regarding any agenda item, contact Administration at (909) 878-8214.

OPEN SESSION

1. **CALL TO ORDER** — **Rob Robbins, President**

2. **PUBLIC FORUM FOR CLOSED SESSION**
   This is the opportunity for members of the public to address the Board on Closed Session items.
   (Government Code Section 54954.3, there will be a three (3) minute limit per speaker. Any report or data required at this time must be requested in writing, signed and turned in to Administration. Please state your name and city of residence.)

3. **ADJOURN TO CLOSED SESSION***

CLOSED SESSION

1. **CHIEF OF STAFF REPORT/QUALITY IMPROVEMENT: *Pursuant to Health & Safety Code Section 32155**
   (1) Chief of Staff Report

2. **HOSPITAL QUALITY/RISK/COMPLIANCE REPORTS: *Pursuant to Health & Safety Code Section 32155**
   (1) Risk / Compliance Management Report
   (2) QI Management Report

3. **TRADE SECRETS: Pursuant to Health and Safety Code Section 32106, and Civil Code Section 3426.1**
   (1) B.E. Smith Service Agreement

OPEN SESSION

1. **CALL TO ORDER** — **Rob Robbins, President**

2. **ROLL CALL** — **Shelly Egerer, Executive Assistant**

3. **FLAG SALUTE**

4. **ADOPTION OF AGENDA***

5. **RESULTS OF CLOSED SESSION** — **Rob Robbins, President**

6. PUBLIC FORUM FOR OPEN SESSION

This is the opportunity for persons to speak on items of interest to the public within subject matter jurisdiction of the District, but which are not on the agenda. Any person may, in addition to this public forum, address the Board regarding any item listed on the Board agenda at the time the item is being considered by the Board of Directors. *(Government Code Section 54954.3, there will be a three (3) minute limit per speaker. Any report or data required at this time must be requested in writing, signed and turned in to Administration. Please state your name and city of residence.)*

PUBLIC RESPONSE IS ENCOURAGED AFTER MOTION, SECOND AND PRIOR TO VOTE ON ANY ACTION ITEM

7. DIRECTORS' COMMENTS

8. INFORMATION REPORTS

A. Foundation Report — **Holly Elmer, Foundation President**

B. Auxiliary Report — **Gail Dick, Auxiliary President**

9. CONSENT AGENDA*

Notice to the Public:

Background information has been provided to the Board on all matters listed under the Consent Agenda, and the items are considered to be routine by the Board. All items under the Consent Agenda are normally approved by one (1) motion. If discussion is requested by any Board Member on any item; that item will be removed from the Consent Agenda if separate action other than that as stated is required.

A. February 13, 2018 Special Board of Directors Meeting Minutes: Shelly Egerer, Executive Assistant
B. February 14, 2018 Board of Directors Meeting Minutes: Shelly Egerer, Executive Assistant
C. February 2018 Planning & Facilities Report: Michael Mursick, Plant Director
D. February 2018 Human Resource Report: Erin Wilson, Human Resource Director
E. February 2018 Infection Control Report: Heather Loose, Infection Preventionist
F. 2017 Family Health Center / Rural Health Clinic Annual Evaluation
G. 2017 Annual Critical Access Hospital Evaluation
H. Policies and Procedures:
  (1) Americans with Disabilities Act
  (2) Confidential Information
  (3) Education Assistance
  (4) Employment Reference Checks
  (5) ID and Facility Access Badges
  (6) Dress Code
I. Board of Directors; Committee Meeting Minutes:
  (1) January 22, 2018 Special Planning & Facilities Committee Meeting Minutes
  (2) January 23, 2018 Special Planning & Facilities Committee Meeting Minutes

10. OLD BUSINESS*

- None

11. NEW BUSINESS*

A. Discussion and Potential Approval of the B. E. Smith Service Agreement

B. Discussion and Presentation of Critical Access Hospital Mock Survey: Presented by Carol Tuminaro w/QHR

C. Discussion and Presentation of the QHR IT Assessment Report

D. Discussion and Presentation of the Critical Access Hospital 2017 Impact Report

12. ACTION ITEMS*

A. <u>Acceptance of QHR Report</u>

Ron Vigus, Regional VP QHR

(1) March 2018 QHR Report

B. <u>Acceptance of CNO Report</u>

Kerri Jex, Chief Nursing Officer

(1) February 2018 CNO Report

C. <u>Acceptance of the CEO Report</u>

John Friel, Chief Executive Officer

(1) February 2018 CEO Report

(2) Board & Committee Meeting Date (s) 2018 Calendar

D. <u>Acceptance of the Finance Report & CFO Report</u>

Garth Hamblin, Chief Financial Officer

(1) January 2018 Financials

(2) February 2018 CFO Report

13. ADJOURNMENT* *** Denotes Possible Action Items**

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
SPECIAL BUSINESS BOARD MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, Ca. 92315
February 13, 2018

PRESENT:	Rob Robbins, President	Donna Nicely, Treasurer
	Gail McCarthy, 1st Vice President	John Friel, CEO
	Jack Roberts, 2nd Vice President	Shelly Egerer, Executive Assistant

ABSENT: None

STAFF: Garth Hamblin Kerri Jex

OTHER: None

COMMUNITYMEMBERS: Joseph Kelly Peter Boss, M.D. Ryan Orr
Robert Prince

OPEN SESSION

1. **CALL TO ORDER:**
   President Robbins called the meeting to order at 12:30 p.m.

2. **ROLL CALL:**
   Rob Robbins, Gail McCarthy, Jack Roberts and Donna Nicely were present. Also present was John Friel, CEO and Shelly Egerer, Executive Assistant.

3. **FLAG SALUTE**
   Board Member Roberts led the flag salute, all present participated.

4. **ADOPTION OF AGENDA:**
   President Robbins called for a motion to adopt the agenda as presented. Motion by Board Member Nicely to adopt the agenda as presented. Second by Board Member McCarthy to adopt the agenda as presented. President Robbins called for the vote. A vote in favor of the motion was 4/0.
   - Board Member Nicely- yes
   - President Robbins- yes
   - Board Member McCarthy- yes
   - Board Member Roberts - yes

5. **PUBLIC FORUM FOR OPEN SESSION**
   President Robbins opened the Hearing Section for Public Comment on Open Session items at 12:30 p.m. Hearing no request to make public comment, President Robbins closed Public Forum for Open Session at 12:30 p.m.

6. **DIRECTORS COMMENTS:**
   - None

7. **OLD BUSINESS***
   - None

8. **NEW BUSINESS:**

A. **Discussion, Interview, and Potential Approval of Bear Valley Community Healthcare District, Board of Director Candidate/Appointment:**

- President Robbins thanked all candidates for submitting their questionnaire and provided briefing on the interview process.

- Dr. Boss:
  - Retired physician, worked in the Hospital ER
  - Would like to expand the ER, improve/expand services, telemedicine
  - Has been a large part of the Hospital past and would like to be part of the Hospital's future
  - Is not opposed to evening or afternoon Board Meetings
  - Team player

- Robert Prince:
  - Community member with his wife and two daughters
  - Would like to expand services
  - Improve technology services
  - Feels community should be able to attend Board Meetings; not opposed to early evening meetings. Transparency is important.
  - Education conferences are important
  - Being a good advocate for the Hospital in public is important

- Ryan Orr:
  - Expand ancillary services
  - Upgrade Hospital equipment and resources
  - Board Member should be a Champion in the community
  - Work together collaboratively
  - Has knowledge of the Brown Act
  - No conflict with schedule to attend Board Meetings

- President Robbins stated that he was very impressed with all three candidates' questionnaire and interview's. President Robbins thanked the candidates for their time and willingness to support the Hospital.

Board Member Nicely motioned to approve Peter Boss, MD as the appointed Board Member. Second by Board Member McCarthy to approve Peter Boss, MD as the appointed Board Member. President Robbins called for the vote. A vote in favor of the motion was unanimously approved 4/0.

- Board Member Nicely- yes
- President Robbins- yes
- Board Member McCarthy- yes
- Board Member Roberts - yes

President Robbins swore Peter Boss, MD in with Oath of office.

9. **ADJOURNMENT**

President Robbins called for a motion to adjourn the meeting at 1:45 p.m. Motion by Board Member Roberts to adjourn. Second by Board Member Nicely to adjourn. President Robbins called for the vote. A vote in favor of the motion was unanimously approved 4/0.

- Board Member Nicely- yes
- President Robbins- yes

- Board Member McCarthy- yes
- Board Member Roberts - yes

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BUSINESS BOARD MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, Ca. 92315
February 14, 2018

PRESENT:	Rob Robbins, President		Donna Nicely, Treasurer
	Gail McCarthy, 1st Vice President		John Friel, CEO
	Jack Roberts, 2nd Vice President		Shelly Egerer, Ex. Assist.
	Peter Boss, MD, Secretary		
ABSENT:	Holly Elmer, Foundation	Gail Dick, Auxiliary	Kerri Jex
STAFF:	Garth Hamblin	Mary Norman	Sheri Mursick
	Steven Knapik, DO		
OTHER:	Ron Vigus, VP		
COMMUNITY MEMBERS:	None		

OPEN SESSION

1. **CALL TO ORDER:**
   President Robbins called the meeting to order at 1:00 p.m.

CLOSED SESSION

1. **PUBLIC FORUM FOR CLOSED SESSION:**
   President Robbins opened the Hearing Section for Public Comment on Closed Session items at 1:00 p.m. Hearing no request to make public comment. President Robbins closed Public Forum for Closed Session at 1:00 p.m.

2. **ADJOURNED TO CLOSED SESSION:**
   President Robbins motioned to adjourn to Closed Session at 1:00 p.m. Second by Board Member Nicely to adjourn to Closed Session. President Robbins called for a vote. A vote in favor of the motion was 5/0.
   - Board Member Boss - yes
   - Board Member Nicely- yes
   - President Robbins - yes
   - Board Member McCarthy - yes
   - Board Member Roberts - yes

RECONVENE TO OPEN SESSION

1. **CALL TO ORDER:**
   President Robbins called the meeting to Open Session at 3:00 p.m.

2. **ROLL CALL:**
Rob Robbins, Gail McCarthy, Jack Roberts, Peter Boss, MD and Donna Nicely were present. Also present were John Friel, CEO and Shelly Egerer, Executive Assistant.

3. **FLAG SALUTE:**
Board Member Boss led the flag salute all present participated.

4. **ADOPTION OF AGENDA:**
President Robbins called for a motion to adopt the agenda as presented. Motion by Board Member Nicely to adopt the agenda as presented. Second by Board Member McCarthy to adopt the agenda as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.
   - Board Member Boss - yes
   - Board Member Nicely- yes
   - President Robbins - yes
   - Board Member McCarthy - yes
   - Board Member Roberts - yes

5. **RESULTS OF CLOSED SESSION:**
President Robbins reported that the following action was taken in Closed Session:
The following reports were approved.

   - The Board of Directors unanimously approved to direct senior staff to execute a compensation package for former OPEIU employees consisting of an annual 3% pay raise effective February 1, 2018 and that a merit based grid system is to be implemented no later than June 1, 2018. In addition, $603.00 per month will be contributed to their health plan.

   - Chief of Staff Report:
     - Request for Initial Appointment:
       - Juan Estes, MD - Renaissance Radiology

     - Request for Reappointment:
       - Bohdan Olesnicky, MD – Emergency/Internal Medicine
       - Richard Baumgartner, MD – Family Practice
       - Michael Lalezerian, MD – Renaissance Radiology
       - James Port, MD - Renaissance Radiology
       - Gilbert Melin, MD – Renaissance Radiology
       - Ian Tseng, MD - Renaissance Radiology
       - Kellie Greenblatt, MD - Renaissance Radiology
       - Lara Eisenberg, MD - Renaissance Radiology
       - Matthew Carr, MD - Renaissance Radiology
       - Bruce Matthews, MD - Renaissance Radiology
       - Eric Wallace, MD – Renaissance Radiology
       - Cindy Sirois, MD – Renaissance Radiology
       - Joseph Roco, DO – Renaissance Radiology

     - Voluntary Resignation:
       - Shari Muir, MD – Tele Psychiatry

- Allan Churukian, MD – Emergency Medicine
- Jenifer Luman, MD – Emergency Medicine

- Risk Report

- QI Report

President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy-yes
- Board Member Roberts - yes

6. PUBLIC FORUM FOR OPEN SESSION:

President Robbins opened the Hearing Section for Public Comment on Open Session items at 3:02 p.m. Hearing no request to make Public Comment. President Robbins closed Public Forum for Open Session at 3:02 p.m.

7. DIRECTORS COMMENTS

- President Robbins reported the Board was pleased to have Peter Boss, MD as the newest Board Member and welcomed Board Member Boss.

8. INFORMATION REPORTS:

A. Foundation Report:

- Ms. Elmer was not in attendance.
- Mr. Friel reported that the Foundation has sought legal counsel advice for the Foundation Bylaws to ensure they are accurate as a 50C3.

B. Auxiliary Report:

- Ms. Dick was not in attendance to provide a report.

9. CONSENT AGENDA:

A. January 10, 2018 Special Board of Directors Meeting Minutes: Shelly Egerer, Executive Assistant

B. January 2018 Planning & Facilities Report: Michael Mursick, Plant Manager

C. January 2018 Human Resource Report: Erin Wilson, Human Resource Director

D. January 2018 Infection Control Report: Heather Loose, Infection Preventionist

E. Policies and Procedures:

(1) Laboratory Department / Blood Bank
(2) Laboratory Department/ Administration
(3) Laboratory Department / Microbiology
(4) Laboratory Department / Phlebotomy
(5) Skilled Nursing Facility
(6) Fire Watch
(7) Use of District Vehicles & Mobile Equipment
(8) Standardized Procedures For the Nurse Practitioners

F. Board of Directors; Committee Meeting Minutes:

(1) November 16, 2017 Finance Committee Meeting Minutes

President Robbins called for a motion to approve the Consent Calendar as presented. Motion by Board Member McCarthy to approve the Consent Calendar. Second by Board Member Nicely to approve the Consent Calendar as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely - yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

10. OLD BUSINESS:

- **None**

11. NEW BUSINESS*

A. Discussion and Potential Approval of the Following Service Agreements:

(1) William White, M.D. First Amendment to Clinic Service Agreement

(2) Paula Lebby, M.D. Clinic Service Agreement

President Robbins called for a motion to approve the William White, MD, First Amendment to Clinic Service Agreement and Paula Lebby, M.D. Clinic Service Agreement as presented. Motion by Board Member Nicely to approve the William White, MD, First Amendment to Clinic Service Agreement and Paula Lebby, M.D. Clinic Service Agreement as presented. Second by Board Member McCarthy approve the William White, MD, First Amendment to Clinic Service Agreement and Paula Lebby, M.D. Clinic Service Agreement as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely - yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

B. Discussion and Potential Approval of the Annual BVCHD Board of Directors Self Evaluation:

- President Robbins stated that the evaluation needs to be reviewed and approved at a Board Retreat to be scheduled at a later date. Administration is to arrange the retreat.

President Robbins called for a motion to review the Annual Board Self-Assessment at a Board Retreat to be scheduled. Motion by Board Member Nicely to review the Annual Board Self-Assessment at a Board Retreat to be scheduled. Second by Board Member Roberts to review the Annual Board Self-Assessment at a Board Retreat to be scheduled. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins- yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

C. Discussion and Potential Approval of the Assignment of Committee Members to the Following Committees:

- President Robbins appointed the following Board Members to the committees as listed below: Board Member Boss to the Finance and Hospital Affiliation and appointed himself to the Human Resource Committee.
  (1) Finance Committee
  (2) Human Resource Committee
  (3) Hospital Affiliation Committee

President Robbins called for a motion to approve Board Member Boss to the Finance Committee, the Hospital Affiliation Committee and President Robbins to the HR Committee. Motion by Board Member Nicely to approve Board Member Boss to the Finance Committee, the Hospital Affiliation Committee and President Robbins to the HR Committee. Second by Board Member Roberts to approve Board Member Boss to the Finance Committee, the Hospital Affiliation Committee and President Robbins to the HR Committee. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins- yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

12. ACTION ITEMS*

A. Quorum Health Resource Report:

(1) February 2018 QHR Report:

- Mr. Vigus reported the following information:
  - IT Assessment completed; final version will be provided to the Board of Directors at the March Board Meeting.
  - Board of Trustee Conference is scheduled for August.
  - A schedule of webinars are included in the QHR Report.

(2) Annual Benefit Report:

- Mr. Vigus reported the following information:
  - Implemented orthopedic services at the clinic
  - Maintained SNF 5 Star Rating
  - HPG discounts
  - Opened dental program at RHC
  - Cash on hand 216

President Robbins motioned to approve the QHR Report & the Annual Benefit Report as presented. Second by Board Member Roberts to approve the QHR Report & the Annual Benefit Report Update as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins- yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

B. CNO Report:

(1) January 2018 CNO Report:

- Ms. Mursick provided the following information on behalf of Ms. Jex:
  - SNF remains at 5 Star
  - ER remodel scheduled for Spring
  - QHR will be on site in March to conduct the CAH Mock Survey
  - Orthopedic services continue

President Robbins called for a motion to approve the CNO Report as presented. Motion by Board Member Nicely to approve the CNO Report as presented. Second by Board Member Roberts to approve the CNO Report as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins- yes
- Board Member McCarthy - yes
- Board Member Roberts – yes

C. Acceptance of the CEO Report:

(1) January 2017 CEO Report:

- Mr. Friel reported the following information:
  - We have 2 additional applications for the HIM position
  - Repairs will begin on the two new bathrooms this weekend.
  - I am continuing to work with CA Architects and Moon & Mayors to schedule tours of ER's and hospitals

President Robbins motioned to approve the CEO Report as presented. Second by Board Member Nicely to approve the CEO Report as presented. President Robbins called for the vote. A vote in favor was unanimously approved 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

D. Acceptance of the Finance Report:

(1) December 2017 Financials:

- Mr. Hamblin reported the following information:
  - Surplus of $185,190
  - Expenses still up
  - Acute Days over budget
  - ER visits increased - 1200 visits for the month
  - FTE's continue under budget
  - Strong cash
  - Operations are challenging but we are doing ok
  - Salary & wages are above budget;
    - Increased staff in ER
    - Radiology is also higher in budget
  - FHC exceeding budget

- RHC is looking at how to improve operations and increase patient visits
- Dental visits close to budget
- Purchased services in December are the Interim Laboratory Manager and Interim HIM Manager
- USDA is a long-term debt – principal payment is being paid

(2) CFO Report:

- Mr. Hamblin reported the following information:
  - Working on a schedule for the review of Revenue Cycle; QHR will be on site; front end process, review Trubridge work, potential to bring billing in house
  - HIM Manager application received, also posted on California Health Information Association web-site.

President Robbins called for a motion to approve the December 2017 Finance Report and the CFO Report as presented. Motion by Board Member Nicely to approve the December 2017 Finance Report and the CFO Report as presented. Second by Board Member Roberts to approve the December 2017 Finance Report and the CFO Report as presented. President Robbins called for the vote. A vote in favor was unanimously approved 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins- yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

13. ADJOURNMENT:

Board Member Nicely motioned to adjourn the meeting at 4:20 p.m. Second by Board Member Roberts to adjourn. President Robbins called for the vote. A vote in favor of the motion was unanimously approved 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins- yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

Bear Valley Community Healthcare District
Construction Projects 2018

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Hospital Front Lobby Door Replacement	Replace the old non function door with new door and hardware	Lyman Doors	Door has been ordered and should be installed in February	
Physical Therapy Exterior/Enterior Painting	Started this approved capital project to repair worn exterior conditions and paint to match all facilities	Kenny's Painting	In Progress	
Public Restroom/Acute Kitchen Plumbing Repair	Remove the concrete in areas to access damaged plumbing.	Pride Plumbing/Facilities	In Progress should be complete by third week of February	
Fire Riser	Installed new Fire Riser and Nitrogen Generator in Boiler room	SimplexGrinell	Complete	
Medgas Panel	Installed new MedGas Panel to meet code requirements. Old Panel was failing and unsupported.	FS Medical	Complete	
Employee Door Replacement	Door has failed.	Lyman Doors	Complete	
Pyxis Replacement	Pyxis equipment is in place and seismic anchors will be installed soon.	Facilities	In Progress	
ASHRE 188 Risk Management Plan for Legionellosis	New Mandate for Hospitals	Forensic Analytical Consulting Services Inc.	In Progress	

Bear Valley Community Healthcare District
Construction Projects 2018

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Hospital- Medical Air Compressor	Compressors is failing and no longer meets code requirments	FS Medical	Waiting on contracts	
Hospital- Fire Door Repairs	During our latest inspection most of our doors were identified as having deficiencies	Facilities	Will have to evaluate major repairs and include in Capital Budget	

Bear Valley Community Healthcare District
Potential Equipment Requirements

Department / Project	Details	Vendor and all associated costs	Comments	Date Council
Facilities- New SnowPlow for truck	Facilities would like to purchase a new plow with modern controls	N/A	Will include in next years Capital Budget	

Bear Valley Community Healthcare District
Repairs Maintenance

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Pharmacy cupboards & Sink	Removed non compliate cupboards and installed	Facilities	Complete	
Conference Room Lighting	Wired the lights so that they can be reduced	Ludeke Electric	Complete	
ER Safe	Installed new safe in ER for patient belongings	Facilites	Complete	
Hot Water Heater Repair In Central Plant	Old regulator failed and flooded the Mezzanine, new regulator installed	Facilities	Complete	
Boiler # 1 Motor Replacement	Replaced motor that had failing bairings	RF MacDonald	Complete	
HVAC Coil Repairs & Cleaning	Cleaned the condenser coils at all facilities that have never been cleaned or serviced. This will have dramatic improvements on efficiency & energy cost	ACS/Facilities	Complete	
RHC Heater Service & Repair	Serviced heating system and replaced grounded motor	Facilites	Complete	

Bear Valley Community Healthcare District
Repairs Maintenance

FHC Odor Issues	Found the bathroom vent for all bathrooms was installed in front of HVAC air intake. Installed carbon filters and odor eaters in HVAC to prevent future smells	Facilities	Complete	
FHC Boiler Repair	Replace failed modulating valve on boiler loop	ACS	Complete	

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

HR Monthly Report
February 2018

STAFFING	**Active:** 216 **New Hires:** 2 **Terms:** 2 **Open Positions:**
EMPLOYEE PERFORMANCE EVALUATIONS	**DELINQUENT:** 30 days: 2 60 days: 4 90 days: 0 90+ days: 0 **MOVING FORWARD:** Enforce Delinquent Evaluation Policy and continue monitoring ongoing annual evaluations.
WORK COMP	**NEW CLAIMS:** 0 **OPEN:** 11 Indemnity (Wage Replacement, attempts to make the employee financially whole) - 4 Future Medical Care – 6 Medical Only - 1 **MOVING FORWARD:** Quarterly claims review.
FILE AUDIT/ LICENSING	**FIVE FILE AUDIT:** One missing Meal and Rest Period One missing Work Comp Fraud One missing Handbook Acknowledgment One license expired (employee removed from schedule) All items returned from previous month **MOVING FORWARD:** Obtain required items, continue file audit.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Infection Prevention Monthly Report

February 2018

TOPIC	UPDATE	ACTION/FOLLOW UP
1. Regulatory	▪ Continue to receive updates from APIC. ▪ Continue NHSN surveillance reporting. • No Hospital acquired infections this month. ▪ Completion of CMR reports to Public Health per Title 17 and CDPH regulations. • No reportable diseases this month.	▪ Review ICP regulations. ▪ Continue Monthly Reporting Plan submissions.
2. Construction	• Seismic mounts for the pyxis are in progress.. • Sprinkler plumbing repair completed.	▪ Work with Maintenance and contractors to ensure compliance.
3. QI	▪ Continue to work towards increased compliance with Hand Hygiene. o Compliance at 59% for February. o Nurse managers are conducting surveillance during nursing rounds. This is helping get a more accurate reporting.	▪ Continue monitoring hand hygiene compliance.
4. Outbreaks/	▪ Community Health Report	

Surveillance	○ 3 cases of MRSA in outpatients. ○ 1 C-difficile infection for December. The report is provided in the middle of the next month so reporting will be a month behind. ▪ Public Health Report ○ Influenza still widespread across California.	▪ Informational
5. Policy Updates	▪ None	▪ Proposed changes to be presented at next P&T committee meeting.
6. Safety/Product	▪ None	▪ Continue to monitor compliance with approved cleaning procedures.
7. Antibiotic Stewardship	▪ Continue to monitor antibiotic usage hospital-wide.	▪ Informational.
8. Education	▪ ICP continues to attend the APIC meetings in Ontario.	▪ ICP to share information at appropriate committees.
9. Informational	▪ Legionella Water Plan • Project is ongoing..	▪ Informational
Heather Loose, BSN, RN	*Infection Preventionist*	*Date: March 5, 2018*

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Family Health Center/ Rural Health Clinic
Annual Evaluation for 2017

A review of Bear Valley Community Family Health Center (FHC) and Rural Health Clinic (RHC) was conducted for the calendar year 2017 as required by the Center for Medicare and Medicaid Services (CMS) Conditions of Participation for Rural Health Centers. This annual report is submitted to you for review and acceptance.

The information for the review was completed by an interdisciplinary team whose members consist of Sheri Mursick, Director of Outpatient Services/QI; Joanne Merrill, Special Programs Coordinator; Shelly Navarro, Clerical Assistant II; Dr. Knapik, Medical Director; Mary Norman Compliance/Risk Manager; Nicole Wheeler, Medical Staff Coordinator and Michael Mursick, Physical Plant Director . The report was reviewed by the Administrative Team and by the Medical Staff Executive Committee.

CLINIC OVERVIEW

Services, Providers and Volume

In 2017 we focused on improving access to care by expanding services offered at the Family Health Center and re-opening the Rural Health Clinic located in Big Bear City. Services offered at the RHC include medical and dental services. Several services lines have been evaluated to add additional availability to improve access to care such as chiropractic and mental health. The clinic has also enhanced the OB/GYN program by re-establishing the Comprehensive Perinatal Services Program (CPSP). Additional providers include Jim Skoien, Acupuncture; Lori Menendyan, LCSW; and Dr. Noble, Dentist.

The outpatient service volume shows an increase of 28% in 2017 which can be attributed to the additional service lines, programs and opening of the Rural Health Clinic.

Quality and Process Improvement

As the FHC and RHC are departments of the Healthcare District, they take an active role in the District-wide QI Program. Clinic staff were members of the Medication Error Reduction Program (MERP), workplace violence workgroup, patient advocacy workgroup, Regulatory/QI subcommittee and Risk/QI subcommittee. QI goals set forth in 2017 were reflective of the need of the facility at the time. While some of the goals supported organizational wide improvement, other goals were department specific. The following was the department QI focus for 201

GOALS	ACCOMPLISHMENTS
Review and improve compliance with overall FHC/RHC coding and regulatory compliance.	QHR conducted a coding and compliance review. Specific accomplishments included: • Revision of the clinic charge master • Development of a matrix to be used as a quick reference for services/insurance coverage and authorization • Educated staff and providers regarding Medicare Annual Wellness Visit requirements • Clerical Assistant II attended AAPC Conference • Providers are in process of becoming Medi-Cal approved providers • Implemented Nurse Practitioner Practice Agreements • Clinic charts are now part of the District-Wide chart review process
Improve patient safety.	Improvements include: • Adding patient photo to pain management charts to ensure patient identification. • Installed emergency alarms in tele-med room, Medi-Cal Eligibility office and provider room • Posted Clinic formulary on the Pyxis. • Assigned nursing staff to attend MERP meetings. • Installed new Pyxis machine. • Revised prescription pad monitoring process. • Implemented daily huddles
Improve customer satisfaction	• Continue to evaluate frontline processes to improve patient appointment scheduling and check-in process. • Implemented Qualitick customer satisfaction survey.
Enhance PRIME Pain Management program.	• Added acupuncture, increased chiropractor availability, increased mental health availability. • Weekly group therapy sessions included introduction to alternative therapies such as Reiki, meditation, counseling, sleep coaching, etc.
Increase access to care	• Recruited additional providers to clinic.

	• Addition of specialty providers based on established wait lists for current specialty services. • Ensured consistency with Tavoca (automated appointment reminder system). • Opened the Rural Health Clinic in Big Bear City. • Partnered with The Center for Oral Health to provide dental services. • Expanded mental health services. • Conducted Community Immunization Fair. • Conducted flu shot clinic.

Policies and Procedures Summary

Clinic policies are reviewed by key clinic staff and providers. Policies are then submitted for review by the Clinical Policy and Procedures committee and Medical Executive Committee (MEC). Policies are then submitted to the governing board for final approval.

Policies are available to all staff members electronically in Policy Tech as well as printed in a binder which is kept in the Director of Outpatient Service's office.

Standardized procedures were developed to guide the mid-level providers. The standardized procedures were reviewed and signed by the clinic provider staff. In addition to the standardized procedures, provider staff have access to the Nurse Practitioner Acute Care Protocols for Emergency Departments, Urgent Care Centers and Family Practices manual.

Credentialing and Peer Review

Clinic providers are credentialed through Medical Staff. BVCHD has an ongoing Peer Review process which is reported/discussed at the Medical Executive Committee (MEC) meeting. The Chief of Staff keeps the board informed of any issue pertaining to Peer Review.

Medical Record Review

Chart audits are conducted on an on-going basis to ensure continuity of care, evidence of best practice and adherence to policies and procedures. Chart reviews are performed using an interdisciplinary approach and reviewed by the Clinic Medical Director.

The clinical record review includes but is not limited to the following components:

- Presence of demographic data
- Problem list is complete

- Allergies are documented
- Complete Past Medical History and Social History are documented
- History of Present Illness (HPI) is documented
- Pertinent Review of Systems (ROS) and Physical Exam (PE) are documented
- Ancillary tests ordered are appropriate
- Prescriptions are appropriate
- Treatment plan is appropriate
- Evidence of appropriate consults
- Continuity of care is evident between providers
- Documentation of patient education
- Recommendation for follow up is appropriate

Review of Services

The Family Health Center is comprised of a total of fifteen (15) treatment rooms. The rooms are equipped with equipment and supplies necessary to perform patient exams. Designated rooms at the clinic are suited for pediatric visits, chiropractic visits, telemedicine and OB visits.

The Rural Health Clinic is comprised of a total of three (3) exam rooms and a dental suite with two (2) dental chairs. The rooms are equipped with equipment and supplies necessary to perform patient exams. Designated areas are assigned for dental exams and procedures.

It is the responsibility of the providers to determine if the patient is appropriate for treatment at the clinic or requires referral for higher level of care. The Family Health Center provides care to pediatric, adolescent, adult and geriatric patients. The Rural Health Clinic provides care to adult and geriatric patients. Children not needing immunizations may be seen at the RHC.

Primary care services are provided at the Clinics. Conditions managed include but are not limited to:

- Routine medical exams/well adult exams
- Routine pediatric exams/well child exams-FHC only
- Pulmonary disorders-not requiring tertiary care
- Cardiac disorders-not requiring tertiary care
- Neurological Disorders-not requiring tertiary care
- Renal disorders-not requiring tertiary care
- Infectious processes-not requiring tertiary care
- Endocrine and Metabolic disorders-not requiring tertiary care
- Oncological conditions-not requiring tertiary care
- Disorders of pediatric patients not requiring tertiary care
- Gynecological Disorders-not requiring tertiary care
- Low-risk obstetrics/pre-natal monitoring
- Mental Health- not requiring tertiary care-FHC only
- Dental exams-RHC only

Specialty services offered at the clinic:

- Tele-Behavioral Health
- Orthopedics
- Chiropractic Care
- OB/GYN
- Chronic Pain Management
- Dental services

By routinely reviewing the most common diagnoses and referrals to specialty care, determination can be made regarding addition or expansion of services. The following are the most common diagnoses as determined by ICD-10 coding from patient charts. Reference Evident/CPSI Top 10 ICD-10 Diagnosis report.

THE TOP 10 DIAGNOSES SEEN AT THE CLINIC IN 2017:

- Essential hypertension
- Well child exam
- Chronic pain syndrome
- Low back pain
- Major depressive disorder
- Acute upper respiratory infection
- Encounter for dental examination and cleaning
- Accretions on teeth
- Encounter for supervision of normal pregnancy
- Cervicalgia

Due to the challenges patients have with access to care and transportation, efforts are made to maintain services at the clinic for higher level of care/specialty care whenever possible. The referral process can often be lengthy depending on the requested specialty, patient insurance and patient transportation limitations. The following list demonstrates the most frequent referrals to specialty care outside the clinic.

THE MOST FREQUENT REFERRALS TO SPECIALTY CARE:

- Cardiology
- Gastroenterology
- Neurology
- Orthopedics
- Dermatology
- Sleep Study
- ENT
- Ophthalmology
- Urology
- General Surgery

Section 2: Review of Services

Each service line/program affecting patient health and safety, including contract services, were evaluated based on activity, patient/client satisfaction if available and clinical outcomes.

1. Primary Care Services
   The Rural Health Clinic (RHC) program is intended to increase access to primary care services for Medicaid and Medicare patients in rural communities. An RHC is required to use a team approach of physicians working with mid-level providers to provide services. A nurse practitioner, a physician assistant, or certified nurse-midwife must be available to furnish patient care services at least 50 percent of the time the clinic operates. RHCs are required to provide outpatient primary care services and basic laboratory services.

   To be in compliance with the above federal guidelines, the Family Health Center ensures a mid-level provider is scheduled during operating hours Monday-Saturday. The Rural Health Clinic has a primary care mid-level provider available 20 hours/week. Currently, there are three full-time and five part-time primary care providers to cover both clinics. The providers see patients of all ages and conditions. When indicated, patients who require higher level of care are referred to a physician or specialist at the clinic. If the service is not available or exceeds the capability of the clinic, patients are referred to specialists "off" the mountain. Referrals are tracked to ensure follow-up and continuity of care. Efforts have been made to recruit in the areas of high referral rates.

   Access to care is an important aspect of the clinic. Appointments are made based on patient's reason for visit and the estimated time needed to provide quality care to the patient. New patient appointments and procedures are typically given 40 minute appointments. Established patient appointments are generally 20 minutes. Productivity is monitored on a monthly basis and feedback is provided to both provider and nursing staff.

   Dr. Knapik is the Medical Director for both clinics. He meets regularly with clinic providers, nursing and front office staff to provide guidance and feedback. He is present two half days/week at the clinic to provide patient care and is available to staff when needed to assist with concerns/issues. He conducts on-going chart and peer review for clinic providers.

   Provider recruitment is an on-going process. Recruitment is a combined effort of using local resources, recruiting agencies and advertisement.

2. Pediatrics
   The clinic is a primary source of healthcare to children in the Big Bear Valley. Routine Well child exam was one of the top reasons for visit in 2017. The well child exam evaluates the child's behavioral and physical development, assesses immunization status, and provides an opportunity to educate regarding health and community resources. The Vaccines for Children is a crucial aspect of the pediatric program. An effort was made in 2017, for all providers to assess and encourage immunizations at all pediatric visits.

3. OB/GYN
   The clinic has three part-time providers who are dedicated to women's health. Routine/low risk OB patients are seen at the clinic through their pregnancy. The nursing staff assists patients with planning their delivery at a hospital of their choice. The OB/GYN staff work in collaboration with the Mom and Dad's Project on the Comprehensive Perinatal Services Program (CPSP). The CPSP program allows for eligible patients to receive, in addition to routine obstetric care, orientation, initial and follow-up assessments, individualized care plan development, case coordination as well as comprehensive nutrition, health education and psychosocial interventions and referrals from a multidisciplinary team.

4. Telehealth/Behavioral Health
   Telehealth continues to be a successful program at the clinic. Behavioral health services currently is available 5 days per week. Clinical Therapists are scheduled via telehealth Monday-Thursday and a Psychiatrist on Fridays. Through the PRIME project, a Licensed Clinical Social Worker is available, on site, Mon-Fri for patient counseling and group therapy.

5. Chiropractic/Acupuncture (Alternative Therapies)
   This service line has also seen growth in 2017 with the addition of a second chiropractor in late 2016 and an Acupuncturist in 2017. Chiropractic and acupuncture services have been a helpful adjunctive therapy to patients in the Chronic Pain Program.

6. Orthopedics
   Orthopedics was one of the top referral sources in 2015 and 2016. Referrals often had a wait time of 6-8 weeks to see the specialist. The clinic now has an orthopedist one half day/week. The addition of this service at the clinic allows patients to stay in Big Bear and are generally seen within 2 weeks of the referral.

Review of Programs

7. PRIME Non-Malignant Chronic Pain Management:
   The program consists of a multidisciplinary team that provides care management and coordination using evidence based guidelines for prescribing to meet the needs of the chronic pain population in our district. Dr. Knapik is the physician champion and has helped coordinate the program. A Licensed Clinical Social Worker assists patient's transition and adjust to treatment plans and provide support and therapy when needed. Community partners and internal resources meet on a regular basis to discuss treatment guidelines, program successes and opportunities for improvement. This project has been a catalyst in creating continuity of care between providers, staff and patients. The FHC has implemented a monthly interdisciplinary care plan meeting to develop and discuss comprehensive treatment plans for non-malignant chronic pain management patients. This program has afforded the Family Health Center the opportunity to expand services to increase access to multi-modal alternative therapies such as chiropractic services, mental health services, acupuncture, support groups, laser therapy and orthopedics. This in turn has resulted in increased patient volumes.

Program status and benchmark reporting are discussed at clinic staff meetings and QI Committee. Mandatory reporting to DHCS is done at set intervals (mid-year and year end reporting). The DHCS PRIME Team completed a comprehensive administrative and clinical review of the BVCHD PRIME DY 12 Year-End Report and found no deficiencies. The maximum allowable payment for DY 12 was received.

8. Vaccines for Children (VFC):
   The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. CDC buys vaccines at a discount and distributes them to state health departments which in turn distribute them at no charge to those clinics registered as VFC providers. This program has been instrumental in the success of the pediatric program at the clinic.

9. Reach Out and Read:
   The 'Reach Out and Read' program is a grant funded program. The program is in partnership between the FHC and the Mom & Dad project. The goal is to have providers encourage parents to read aloud every day to their children. Providers "prescribe" developmentally-appropriate books for ages 6 months- 5 years at their WCE visit. All providers should participate in referring pediatrics for ASQ screening. This is an autism screening program. The goal is to reach all children when they leave their WCE and place a book in their hand, appropriate to their reading level.

10. Comprehensive Perinatal Services Program (CPSP):
    The FHC is working in collaboration with the Mom and Dad's Program on the CPSP Program to offer evaluations and education weekly. The Comprehensive Perinatal Services Program provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education.

    The San Bernardino County of Public Health Family Services section performed a Quality Assurance visit in August 2017. The review allowed for a customized counseling and provided the opportunity to identify factors that may improve the delivery of CPSP services. Only minor recommendations were made at the time of the review and all of the recommendations have been addressed.

The Annual Evaluation is used to review the clinical services and programs offered at the Family Health Center and Rural Health Clinic. From this evaluation, opportunities may be identified to further improve the care and services the FHC/RHC provides to the community.

Goals for 2018 include but are not limited to:

- Continue to recruit providers in all areas.
- Explore possibility of expanding telehealth program to include new service lines.
- Ensure mechanisms are in place to maintain clinic compliance with Rural Health Center regulations and coding/billing practices.
- Standardize front office procedures to improve patient flow, improve access to care and compliance with appointments.
- Increase volumes in all service lines through the Strategic Marketing Plan.
- Promote patient safety
- Implement and support Just Culture
- Increase community outreach through education programs, participation in health fair and community events.

In summary, clinic leadership, core staff and the administrative team have worked to address key elements of the Community Needs Assessment which highlighted the need for improved access to healthcare and enhanced pain management services. In this effort, the Family Health Center and Rural Health Clinic have made progress in provider recruitment and retention which has not only improved access but added much needed specialty services to our patients. Additionally, the PRIME Project has afforded the opportunity to develop a pain management program that has incorporated standardized pain management protocols and offer alternative therapies to this population.

In consideration of the Strategic Plan, Community Needs Assessment, Strategic Marketing Plan and cumulative patient feedback, the clinic will continue to grow to meet the needs of the community and strive to meet the goals set forth for 2018.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

To: Governing Board

From: Administrative Team & Regulatory/ QI Subcommittee

Re: Annual Critical Access Hospital Evaluation for 2017

Date: 3/2/2018

A review of Bear Valley Community Hospital was conducted for the calendar year 2017 as required by the Center for Medicare and Medicaid Services (CMS) Conditions of Participation for Critical Access hospitals. This annual report is submitted to the Board of Directors for review and acceptance.

The information for the review was completed by the Regulatory/QI Subcommittee. Members consist of Mary Norman, Compliance/Risk Officer, Sheri Mursick, QI, Kerri Jex, CNO, Patti Tondorf, Interim HIM Director, Heather Loose, Infection Preventionist, Heidi Markus, ED Director, and April Early, Clinical Informaticisit. The report was reviewed by the Administrative Team and by the Medical Staff Executive Committee.

EXECUTIVE SUMMARY

Services, Providers and Volume

In 2017 BVCHD added orthopedic services in the clinic as well as limited orthopedic surgical services as well as improved access to care by expanding services offered at the Family Health Center and re-opening the Rural Health Clinic located in Big Bear City. Services offered at the RHC include medical and dental services. Several services lines have been evaluated to add additional availability to improve access to care such as chiropractic and mental health. The clinic has also enhanced the OB/GYN program by re-establishing the Comprehensive Perinatal Services Program (CPSP). Additional providers include Jim Skoien, Acupuncture; Lori Menendyan, LCSW; and Dr. Noble, Dentist.

The outpatient service volume shows an increase of 28% in 2017 which can be attributed to the additional service lines, programs and opening of the Rural Health Clinic.

The ER experienced a 1.01% growth patient volume this year, inpatient admissions slightly decreased with 457 admissions as opposed to 468in the prior year. Swing admissions increased and observation admissions decreased. The Distinct Part Skilled Nursing Unit showed volume

increase, ending 2017 with a census of 19 residents.

The average length of stay on the Acute Inpatient Unit was 2.9 days, falling below the CAH requirement of 96 hours. More detailed information is included in the main report.

Quality and Process Improvement

In 2017, the Board continued to appoint a member to be an active participant on the QI Committee. In the beginning of the year the committee evaluated the 2016 focus areas which supported the Strategic Plan in the areas of Service, Safety and Compliance and set objectives and goals for the 2017 QI Plan. The committee found it important to engage staff members, managers, administrative leaders and Board members to work collaboratively on key concepts of the Strategic Plan and Community Needs Assessment. The QI Committee agreed upon the formation of the following work/focus groups: Patient Experience, Patient Advisory Council, BETA HEART, SNF QAPI, Metrics/Quality Measures, Harm Events and TeamSTEPPS. A "champion" was assigned to each of the work groups. The workgroups met on a regular basis to review performance data, identify areas in need of improvement and carry out and monitor improvement efforts. The champions of the workgroups met monthly at the QI Committee for collaboration and to discuss action plans and progress made. Quarterly, department managers attended the QI Committee for review and discussion of dashboards and focus group updates.

Work groups were developed to address specific target areas. Each work group developed objectives and action plans.

- Patient Experience- The purpose of this group will be to identify areas in which improvement activities can be focused to improve patient experience and promote a culture of customer service.
- Patient advisory- The goal of this group is to formalize a patient advisory council. Working with patients and families as advisors at the organizational level is a critical part of patient and family engagement. The council will approach opportunities to improve quality, safety and patient satisfaction. Patient and family advisors are valuable partners in efforts to reduce medical errors and improve the safety and quality of health care.
- TeamSTEPPS- TeamSTEPPS is an evidence based framework developed by Department of Defense's Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality and supported by Beta Healthcare. The program is used to improve teamwork and communication to improve patient safety. The goal of this workgroup is to identify trainers and implement the TeamSTEPPS philosophy and tools throughout the organization with an emphasis on the nursing units.

- BETA HEART- The BETA HEART program is a holistic approach to reduce patient harm.

  The overall goals of the program are to develop an empathic and clinically appropriate process that supports healing of both the patient and clinician after an adverse event; ensure accountability for the development of reliable systems that support the provision of safe care; provide a mechanism for early, ethical resolution when harm occurs as a result of medical error or inappropriate care; and instill trust in all clinicians and patients.

- Harm Events- The Risk Sub-Committee meets weekly to review information and monitor any issues that may require focus. The committee monitored trends with variance reports as well as looked at individual events for opportunities for improvement.

- Metrics/Quality Measures- Standardized data such as core measures, clinical quality measures and infection control data is reported routinely to outside entities such as NHSN, MBQIP, QHR and Cal HIIN. The purpose of this work group is to review data and identify areas in need of improvement. Data is reviewed by the Regulatory Committee.

- SNF QAPI (Quality Assurance Performance Improvement)-The SNF reviews and reports quality data as it applies to the overall star rating. CMS formalized the QAPI process specifically for skilled nursing facilities beginning in November 2017. The focus of this workgroup will be to establish the QAPI program according to CMS guidelines, identify areas of improvement and implement performance improvement plans (PIPs).

2017 QI Program Accomplishments:

TARGET AREA	ACCOMPLISHMENT
Patient Experience	• Cameras were installed in the lab hallway to better see the patients that are waiting. • Privacy curtain installed in the lab to improve patient privacy. • Outpatient registration area redesign to improve face to face communication between patients and registration clerks. • Participated with the phone system upgrade to include an automated attendant.

Patient Family Advisory Council (PFAC)	• Reviewed and made recommendations for signage around the facility. • The PFAC was provided with a questionnaire regarding dress code. The council's recommendations were incorporated into the revised Dress Code policy. • Increasing Qualitick response rates were discussed. • ER communication and visitor policy discussed. • PFAC was involved in choosing the new flooring for the ER. • Suggestion boxes have been placed in the front lobby and Clinic waiting room. • Essential oils placed throughout the hospital.
TeamSTEPPS	• Train the Trainer course completed February 16 & 17, 2017 • Workgroup participated in Beta Healthcare TeamSTEPPS webinar series. • Communication tools (SBAR and IPASS) were discussed at the nursing skills fair. • TeamSTEPPS training done at nursing staff meetings. • TeamSTEPPS training has been incorporated into hospital orientation. • Full training and rollout to ER staff planned for beginning of 2018 to comply with Beta Tier II requirements.
Beta HEART	• BETA provided a presentation on BETA HEART and Just Culture to members of the Board and management in April 2017. • The group decided to opt-in to the 2018 rollout of the Beta HEART program. Beta will be on site 1/5/18 to perform a gap analysis.

	• Patient Safety Culture survey conducted. • BVCHD enrolled in the Beta Healthcare Just Culture program. • District policies were evaluated to ensure Just Culture concepts were incorporated. • Just Culture policy was developed. • Just Culture train the trainer class was completed. • Roll-out of Just Culture training scheduled for 2018.
Harm Events	• QI/Risk sub-committee identified trend with medication errors/near misses. • MERP committee including pharmacy, nursing and front line staff was reinstated to identify areas of improvement, develop action plans and monitoring.
Metrics/Quality Measures	• Metrics/Quality Measures have been reported at nursing staff meetings, informing staff what is reported to MBQIP. • Patient Transfer Communication: Focus is on contacting the receiving facility before the patient leaves the sending facility. Implementation of T-system in the Emergency Department has increased compliance with documentation. • Cal HIIN conducted a site visit in June 2017, they are a part of Health Services Advisory Group (HSAG). The visit was focused on education and review of the measures/metrics. Discussion regarding low volumes and the challenges of being a small facility when comparing to national standards which are measured in "per 1,000 bed days". Cal HIIN to review possible alternative ways to provide the information so that reporting is relevant to our facility.

	• The eCQM was submitted and accepted. Electronic submission of the quality measures is one step necessary for Meaningful Use Attestation. The Meaningful Use attestation was submitted on Friday, March 3rd; confirmation of submission was received.
SNF Quality Assurance Performance Improvement (QAPI)	• SNF QAPI plan developed and implemented. • Performance improvement plans (PIPs) identified and implemented. • Successful CDPH survey December 2017.

BVCHD participates in MB QIP (Medicare Beneficiary Quality Improvement Project), which is a grant funded program through Health Resources and Services Administration, Office of Rural Health Policy (ORHP). Participating CAH's report on specific sets of annual measures determined by ORHP which will provide benchmarks and identify best practices and prepares the hospital for future public reporting requirements.

Policies and Procedures Summary

Policies were reviewed by the Policies and Procedure committee which included Sheri Mursick, Mary Norman, Kerri Jex, Kathleen Yerratt, Heidi Markus, Sherry Greenaway, and the Manager of the department policies being reviewed. Appropriate medical staff committees (P&T/IC, UR, IDCP) reviewed/approved policies prior to submission to the Medical Executive Committee (MEC). Policies were submitted to the governing board for approval.

Credentialing and Peer Review

BVCHD has an ongoing Peer Review process which is reported/discussed at the Medical Executive Committee (MEC) meeting. The Chief of Staff keeps the board informed of any issue pertaining to Peer Review. BVCHD's strategic partner Quorum Health Resources assisted in providing support for external peer review cases.

Medical Record Review

Documentation reviews were conducted by Health Information Management (HIM) and findings were reported to Med Executive Committee (MEC). Internal chart review process was expanded this year to include formalized meetings and standardization of documentation for chart reviews. The committee was chaired by Patricia Tandorf, Interim Director of Health Information Management. Members of the committee included Garth Hamblin, Chief Financial Officer, Stacey Black, Business Office, Valarie Reardon, Coder, Mary Norman, Risk/ Compliance

Officer, Kerri Jex, CNO, & rotating department managers.

Review of Services

Each clinical service impacting health and safety, including contract services, was evaluated and information is provided to the medical executive committee for their input.

The Emergency Department

The Emergency Department is licensed for 7 beds and sees approximately 11,000 patients per year. Average volumes increase seasonally with the opening of 2 ski resorts located within Big Bear Lake. The ED employs approximately 25 licensed nurses, and 8 Emergency Medical Technicians. A physician is on site 24 hours a day and midlevel coverage is available weekends and most holidays. Traditionally orthopedic coverage is contracted for weekends throughout the winter season.
The availability of life support equipment and skilled, competent staff to initiate emergency interventions is consistent in the Emergency Department on a 24 hour, seven day a week basis. Clinical functions (diagnostic, therapeutic or preventative) available in the Emergency Department include but are not limited to:

- Cardiac monitoring
- Ventilatory support
- Thrombolytic therapy
- Temporary pacing
- Electrical cardio version
- Cardiopulmonary resuscitation
- Hemodynamic support
- Treatment and report of assault/abuse
- Moderate sedation
- Lumbar punctures
- Splinting
- Gastric lavage

Acute/ Observation Services

The Acute Med/Surg/Tele Department is comprised of a total of nine (9) beds. The rooms have cardiac monitoring capabilities. There is a central telemetry monitor station located by the Acute and Emergency Department nurses station. The Emergency Department staff provides continuous monitoring of the telemetry monitor. Room 20 is designed for isolation. It is equipped with negative airflow and an anteroom.

The following types of patients requiring admission to the Med/Surg/Tele Department includes

but are not limited to:

- Pulmonary disorders
- Cardiac disorders
- Neurological Disorders
- Renal disorders
- GI and Nutritional Disorders
- Orthopedic conditions
- Surgical conditions
- Medical disorders
- Infectious processes
- Endocrine and Metabolic disorders
- Oncological conditions
- Disorders of pediatric patients not requiring tertiary care
- Gynecological Disorders

Therapies include but are not limited to IV therapy, pain management, respiratory therapy and nutritional support. Monitoring includes but is not limited to telemetry, non-invasive vital signs, pulse oximetry, and blood glucose monitoring.

Swing Beds

The Swing Bed Program is a specifically designed program for short-term stays to assist patients in recovery and rehabilitation. Patients are cared for by personnel whose training has been directed toward meeting the physical, spiritual, cultural, emotional, and safety needs of patient's while respecting patient's rights. Our mission is to provide competent, compassion care to the patients of our hospital.

Patients can be admitted to BVCHD Swing Bed Program for rehabilitation following surgery or qualifying illness. This could be in the form of a transfer from another hospital or from our own Acute Care Services.

The Swing Bed Program is integrated with the Acute Care Services. On average, most patients are in the Swing Bed Program for 2-6 weeks.
Patients admitted to the Swing Bed Program are usually in the need, but not limited to, one or more of the following services:

- Physical Therapy
- Orthopedic rehabilitation
- Wound care
- IV antibiotics (that cannot be provided on an outpatient basis)

Skilled Nursing

The Skilled Nursing Facility-Distinct Part provides a home setting for residents of the Big Bear Valley. Our residents are cared for by personnel whose training has been directed toward

meeting the physical, spiritual, cultural, emotional, and safety needs of each individual resident, while respecting their rights. It is the goal of the Skilled Nursing Facility staff to provide our residents with professional competent and compassionate care.

The Skilled Nursing Facility-Distinct Part consists of 21 licensed beds 20 of which are semi-private and 1 private. Nursing care is provided to the residents 24 hours/day, 7 days/week by licensed staff. Visiting hours are designed to meet the needs of the residents and families. Special visiting provisions may be arranged at the discretion of the nursing staff in collaboration with the Director of Nursing or designee.

Therapies may include but are not limited to pain management, physical therapy, respiratory therapy and nutritional support. Monitoring may include to non-invasive vital signs, pulse oximetry, and blood glucose monitoring. If the level of care exceeds the scope and complexity of the Skilled Nursing facility, the Director of Nursing and Case Manager, in collaboration with the IDCP committee, shall make arrangements for transfer to appropriate level of care

The Family Health Center is comprised of a total of fifteen (15) treatment rooms. The rooms are equipped with equipment and supplies necessary to perform patient exams. Designated rooms at the clinic are suited for pediatric visits, chiropractic visits, telemedicine and OB visits.

It is the responsibility of the providers to determine if the patient is appropriate for treatment at the clinic or requires referral for higher level of care. The Family Health Center provides care to pediatric, adolescent, adult and geriatric patients.

Primary care services are provided at the Clinic. Conditions managed at the Family Health Center include but are not limited to:

- Routine medical exams/well adult exams
- Routine pediatric exams/well child exams
- Pulmonary disorders-not requiring tertiary care
- Cardiac disorders-not requiring tertiary care
- Neurological Disorders-not requiring tertiary care
- Renal disorders-not requiring tertiary care
- Infectious processes-not requiring tertiary care
- Endocrine and Metabolic disorders-not requiring tertiary care
- Oncological conditions-not requiring tertiary care
- Disorders of pediatric patients not requiring tertiary care
- Gynecological Disorders-not requiring tertiary care
- Low-risk obstetrics/pre-natal monitoring
- Mental Health- not requiring tertiary care

Physical Therapy

The Physical Therapy Department provides direct patient care to the in-patients and out-patients of Bear Valley Community Healthcare District. The category of "out-patients" includes the Skilled Nursing Facility (SNF) residents and patients who are coming for services from their

home.

Services are provided in a timely and professional manner, rendered with appropriate and effective treatments. Physical Therapy services are available at a minimum from 8:00 am to 5:00 pm Monday through Friday for in-patients and out-patients of all ages, from neonate to geriatrics, including Saturday, and holidays if determined PT is needed. In -patients are treated at bedside or in the hospital physical therapy department unless specific non-portable equipment is needed. Out-patients are seen in the Physical Therapy Department located across from the hospital. The Skilled Nursing Residents with be treated at bedside, the hallways for gait, hospital physical therapy department or brought to the Physical Therapy Building for care.

The Physical Therapy Department responds to requisitions for physical therapy by physicians. Due to the Direct Access Law in the state of California, a physical therapist can evaluate and treat for 12 visits without a physician's referral. Direct access occurs when a patient comes on their own to the department for care.

An initial assessment of the patient's functional ability, need for skilled therapy services, and their rehabilitation potential is made. With the initial assessment, a treatment plan of care (POC) is developed, and goals are set with the patient's needs in mind including home equipment needs or suggestions to the nursing staff in the care of the SNF residents (out-patients) and in-patients, or Swing Bed patients. The treatment plan is then initiated with continual reassessment of the patients' progress using appropriate research based testing.

In providing physical therapy services, the Physical Therapy Department administers physical therapy procedures and modalities to patients which include but are not limited to the following:

- Hydrocollater moist heat
- Ultrasound
- Myofascial Release
- Laser Therapy
- Soft tissue and joint mobilizations
- Electrical Stimulation
- Transcutaneous electrical nerve stimulation
- Cold packs
- Ice massage
- Cervical and Lumbar static traction
- Activities of daily living
- Functional activities training
- Gait training
- Therapeutic exercise
- Orthotic measuring and fitting
- Prosthetic training
- Paraffin bath
- Equipment needs

- Individual equipment ordering
- Patient/Family Education

The Physical Therapist has additional responsibilities as a consultant to the nursing staff and patients/residents of the SNF for wheelchair positioning, pain control issues, and evaluation of new patients/residents. The Physical Therapist attends the Interdisciplinary Care Plan (ICDP) meetings for the SNF residents, and Swing bed patients.

Respiratory Therapy

The Respiratory Therapy Department provides respiratory care to patients who have deficiencies and abnormalities of the cardio-pulmonary system.
The department is staffed by an in house or on-call Respiratory Therapist, licensed by the state of California, 24 hours a day, 7 days a week. Regular staffing hours are 7am – 7:30p.m. On-call hours are 7:30pm – 7am. On-call therapists are to be within 30 minutes of the facility

Services provided are safe, aseptic, preventative and restorative to neonate, pediatric, adolescent, adult and geriatric age groups.
Services include:

- Administration of pharmacological medications (via nebulization).
- Diagnostic and therapeutic agents necessary to provide treatment, disease prevention, pulmonary rehabilitation or a diagnostic regimen prescribed by a physician.
    - Administration of medical gases
    - Mechanical or physiological ventilatory support
    - Broncho-pulmonary hygiene
    - Cardio-pulmonary resuscitation
    - Maintenance of artificial airways
    - Collection and the analysis of arterial blood specimens
    - Collection of sputum specimens
    - Electrocardiogram
    - External cardiac ambulatory telemetry
    - Pulmonary function testing.
    - Smoking Cessation offered to patients and employees

Mom and Dad Project

The Bear Valley Community Hospital (BVCH) Mom and Dad Project serves as a local parenting Education and Resource Center. The program offers parenting classes beginning with Child Birth, and going all the way through parenting a teenager. The BVCH Mom and Dad Project offers Evidence Based Nurturing Parent Curriculum, including Nurturing Pre-Natal, Nurturing Father, Nurturing Teen Parents, and all other Nurturing Programs. We also offer Co-

Parenting/Blended Families – parenting intended for families who are trying to parent after a separation, divorce, or a new marriage.

The BVCH Mom and Dad Project also houses a Resource Center where referrals can be made for Doctor and Dental appointments, food stamps, transportation vouchers, help with applying for C4 Yourself, car seats, diapers, and many other services. The BVCH Mom and Dad Project is currently the only center in Big Bear to have WIC services available Monday's and Tuesday's in Big Bear.

Radiology

The Radiology department is staffed 24 hours a day, 7 days a week by an in house or on-call State Certified Radiologic Technologists. 60 Full time board certified Radiologists, are available 24 hours a day, 7 days a week. All diagnostic imaging studies are interpreted by a Radiologist.

Services are provided to all patients, including inpatient, outpatient and emergency.
Services provided include: general diagnostic x-ray, fluoroscopy, mammography, ultrasound and computed tomography. Services are provided for all ages, including neonate, pediatric, adult, and geriatric.

Surgical Services

The Surgical Services Department consists of one maintained operating suite, two bed PACU and outpatient surgical services. The Care Delivery System is team Nursing and total patient care. Currently limited procedures are performed in the OR including ophthalmic, pain management and orthopedic specialties.

Laboratory

The laboratory operates twenty-four (24) hours a day, seven (7) days a week. A licensed clinical laboratory scientist available twenty-four (24) hours a day. During the hours in-house staffing is not provided, pathologists and appropriate technologists will be available by telephone or pager and able to respond within thirty (30) minutes or less.

Diagnostic Services provided by the laboratory include:

- Blood Bank
- Coagulation
- General and Special Chemistry
- Hematology
- Microbiology
- Serology
- Urinalysis

Nutrition and Dietary Services

The Nutrition and Dietary Services Department (NDS) manages food system operations for provision of meals to meet the nutritional needs of patients, visitors, and staff. Our team works diligently to enhance the health and well-being of our patients/customers and to deliver quality meals featuring locally sourced and sustainable ingredients. NDS provides quality meals and services to the following:

- Skilled Nursing Facility
- Acute Wing
- Emergency Department
- Staff and Community Members
- Community Outreach- Meals on Wheels

The Director of NDS oversees the day to day operations for the food service department and staff and, as a Registered Dietitian assists residents and patients in developing and maintaining nutrition and healthy lifestyle behaviors to enhance health and quality of life. The NDS RD provides nutritional care and support for patients and residents which include:

- Medical Nutrition Therapy
    - Diabetes
    - Hypertension
    - Cardiovascular Disease
    - Renal
    - Hypercholesterolemia
    - Weight Loss
    - Weight Gain
    - Prenatal and Postnatal Nutrition
    - Food Allergies
- Nutrition Counseling and Nutrition Education
- Health Promotion
- Disease Prevention
- Development of Nutrition Policies and Procedures
- Approves and Oversees the Development of Therapeutic Menu Systems

- Assess the Nutrition Health Needs of the Patient
- Develops Nutrition Related Priorities, Goals and Objectives and Implementation of Nutrition

Recommendations

The Critical Access Hospital program continues to meet our needs from both a financial and clinical perspective. Based on a financial analysis by Quorum Health Resources, their report indicates that BVCHD received an estimated $1,199,903 more in payments from Medicare more as a CAH than would have been received as a PPS hospital. The district is in a favorable financial position moving forward.

As presented in the Strategic Plan, BVCHD is in the mountains but not isolated from state and national market forces impacting the fundamental economics of today's healthcare delivery system. BVCHD expects further decline in our inpatient census but have ample opportunity for substantial growth in our outpatient and post-acute care service lines.

In 2018 it is recommended that BVCHD continue to provide all current services and consider the following opportunities for improvement and expansion of services:

- Further expand services offered in associate with the chronic pain management program, utilizing funds provided by the PRIME Grant, including alternative therapies and inpatient medical stabilization.

- Investigate options for tele-psychiatry services in the ED, including participating in the San Bernardino County Innovations Grant program.

- Continue development of the role of the Patient and Family Advisory Committee within the District's current structure, including the exploration of options to allow for direct communication with the Board of Directors in order to comply with the CalHIIN Patient and Family Engagement metrics.

- Implement Just Culture program including training for all management and staff, as well as further developing the purpose and procedures for use of the "guide team".

- Work with BETA Healthcare Group to start the implementation of the HEART program with focus on the five domains which include: Culture of Safety, Rapid Event Detection, Investigation and Determination, Communication and Transparency, Care for the Caregiver, and Early Resolution.

- Revise and standardize Job descriptions, physical requirements for each job class and the

employee evaluation process.

- Continue expansion of adding contractual relationships with Health Insurance groups to ensure access to care for members of the Bear Valley Community.

- Work with contracted services to continue recruitment of Primary Care Providers for the Family Health Center.

- Consider expansion of the availability of dental services offered by the Center for Oral Health at the Rural Health Center.

- Develop relationships with community organizations by supporting community based programs and events.

- Pursue the development of an updated Community Needs Assessment.

MAIN REPORT
Section 1: Financial

Payor Mix	Current year 2017	Prior year 2016	% Change
Medicare	20.0	19.5	+1.02
Medicaid	39.4	37.9	+1.04
Other Third Party Payors	36.8	38.3	-.97
Charity Care	-	-	-
Other – Private Pay	3.8	4.3	-.88

*Data Source: 2016/2017 per Revenue by Financial Class

Section 2: Volume and Utilization of Services

1. Capacity

9 beds are available for inpatient, observation and swing bed patients, however, due to past census numbers we only staff for 5 beds. The patient census did exceed 5 patients during the last year during which times additional staff were brought in to accommodate the increased census.

2. Volume

Utilization of services was reviewed as outlined in the table below. Overall volume has increased in a few areas.

Volume	Current year 2017	Prior year 2016	% Change
Inpatient days	457	468	-.97
Swing Bed patient days	497	412	+1.21
Observation Admissions	51	94	-54
ER visits	11315	11,290	+1.01
Inpatient Surgeries	1	-	
Outpatient Surgeries	100	105	+.95
Outpatient visits	20,2762	20,261	+1.02
Medical Imaging Procedures	15,942	16,321	-.98
Laboratory Tests	162,520	163,262	-.99
Physical Therapy / Occupational Therapy Visits	5466	4502	+1.22

*Data Source: 2016/2017 Cost Report and Financial Statements

3. Average Length of Stay

The average length of stay for the year was 2.9 days. The average for all patients in a 12-month period is less than 96 hours in accordance with the CAH Conditions of Participation (COP) 485.620(b).

Average length of stay is tracked and reported to the Utilization Review Committee.

Average Length of Stay	**Current year 2017**	**Prior year 2016**	**% Change**
Inpatient average length of stay (days)	**2.9**	**3.2**	**-9.375%**
Number of patients (or %) with LOS of more than 96 hours	**10%**	**18%**	**-44.4%**
Swing Bed average length of stay (days)	**15.2**	**19**	**+20%**
Observation average length of stay (days)	**1.1**	**1.1**	**0%**
Emergency Department Visits	**11,623**	**11286**	**+2.986%**

*Data Source: CPSI/Evident Census Days Stay report

4. Medical Necessity Reviews

The Case Manager or the House Supervisor(s) screens every inpatient and observation patient to determine if provider documentation supports the level of care status. Staff utilizes Interqual criteria or the Two Midnight Rule for completing the initial screening. The Case Manager screens any Swing bed admission. Continued stay reviews are completed Monday – Friday by the Case Manager for payment authorization. Reports are submitted to the Utilization Review Committee for review and discussion.

5. Transfers

Transfers from the Emergency Department remained the same in 2017 as compared to 2016.

Based on data published by the Agency for Healthcare Research and Quality (AHRQ), in 2008 approximately 8.3% of Emergency Department visits in a rural hospital resulted in an inpatient admission, compared to 16% for non-rural hospital ED visits. Given that a CAH may offer fewer services than the average rural hospital and it is expected to achieve a 96-hour average length of stay or less, there is no expectation that every CAH is expected to admit 8% of its ED patients. This benchmark can however provide a useful starting point for assessing compliance.

Need for higher level of care as well as lack of specialists (General Surgery, Neurology, and Cardiac) comprise the majority of transfers. In 2017 the UR committee meeting reviewed transfers to determine if there is a reasonable proportionate relationship among the transfers and admissions to BVCHD. It is recommended that the UR committee further evaluate transfers this year to determine the number of transfers that could be admitted to BVCH if specialty services such as cardiology, neurology, orthopedics and surgery had been available.

Transfers	**Current year 2017**	**Prior year 2016**	**% Change**
Inpatient Transfers (147 patients, 18 transfers)	**8%**	**8%**	**0**
Emergency Department Transfers (11,623 patients, 903 transfers)	**13%**	**13%**	**0**

*Data Source: CPSI/Evident Transfer report

Section 3: Review of Nursing Services

Each patient care service affecting patient health and safety, including contract services, were evaluated based on activity (volume), patient/client/resident satisfaction if available and clinical outcomes. Each department is responsible for developing departmental indicators each year that reflect the scope and complexity of the department.

1. Acute /Swing Beds

   As is the current healthcare trend, Inpatient census has been declining. Medicare's Two Midnight rule has helped clarify the appropriate level of care upon admission. Observation services are still sporadic. UR reports show an upward trend in length of stay, this could possibly be attributed to the change in Hospitalist. It is recommended that UR continue to review length of stay and a team be generated to initiate daily care management rounds on all patients on the Acute and Swing units.

   Swing bed census is gradually growing now that staff is becoming more familiar with the criteria for utilization. The patients that have utilized our swing beds have expressed satisfaction with the care received and a few have converted to long term residents.

2. Emergency Department

   Volumes in the Emergency Department have consistently been seasonal. Peak volumes are experienced during the winter months. Seasonal staff is hired to accommodate the increase in patient volume. Dr. Pautz was contracted to provide coverage between Christmas and New Year's Day.

   Qualitick was utilized to provide immediate patient satisfaction feedback. Reports are shared at staff meetings, QI, MEC, and the BOD.

   An ED Flow action plan was implemented to initiate the use of the multi-purpose room as a fast track area for non-critical patients. Four patient recliners were placed in the MPR, curtain dividers were installed, supplies were evaluated and relocated and workstations were set up for the nurse, EMT and midlevel provider. The fast track room implementation has been successful as noted by patient satisfaction, increased patient privacy and staff engagement in the project.

   The ED received the Beta Quest for Zero Tier One award by achieving 100% compliance by nurses and physicians for training in "High Risk Chest Pain" diagnosis and treatment.

3. Surgical Services

   Surgical services expanded this year as Dr. Pautz was credentialed for orthopedic surgery. Dr. Tayani continued to perform cataract procedures once a month.

4. Long Term Care/Skilled Nursing Facility

The resident volume has increased due to marketing and outreach by Case Management and the SNF DON. We experienced a successful survey conducted by CDPH. Following the survey, the SNF DON, in collaboration with the Regulatory Committee, submitted a Plan of Correction.

Review of Ancillary Services

5. Respiratory Therapy/Cardiopulmonary

Respiratory Therapy continues to support the Nursing units by providing services related to the cardiopulmonary needs of the patients. No new services were added. A new blood gas analyzer was purchased to expand monitoring capabilities.

6. Medical Imaging

The Medical Imaging Department submitted a request for proposal for projects including a new mammography unit and a new CT scanner. Several credible bids were received and are in the process of being reviewed by Plant Maintenance, Administration and the Board of Directors. A new ultrasound machine (Toshiba Aplio 500) was purchased and put into service. The department also converted from Computed Radiography (CR) to Direct Capture Radiography (DR). New state of the art equipment installed in 2017, 80 slice Toshiba CT scanner, 3D Hologic Dimensions Mammogram machine, and Direct Capture Radiography in all X-ray rooms.

7. Laboratory

The laboratory purchased and installed a new automated Blood Culture Analyzer and a new Hematology Analyzer in 2017. Additional laboratory tests that were added include: Vitamin D and total Thyroxin. There was a change in leadership of the department in 2017, Gerald Consiglio resigned as Director and Pamela-Hargave Thomas was hired to manage the department.

8. Physical Therapy

Physical Therapy continued to see outpatients and support District wide services such as Swing beds, the SNF, and the PRIME program. The PT department expanded services with the purchase of a class 4 laser.

9. Outpatient Clinics

The Family Health Center currently, has three full-time and four part-time primary care providers. Dr. Knapik assumed the role of Clinic Medical Director in 2017. The clinic has three part-time providers who are dedicated to women's health. Routine/low risk OB patients are seen at the clinic through their pregnancy. The Telehealth/ Behavioral Health program

continues to be a success at the clinic. The Chiropractic service line has also seen growth in 2017 with the addition of another chiropractor. Chiropractic services has been a helpful adjunctive therapy to patients in the Chronic Pain Program. Orthopedics was one of the top referral sources in 2016 and 2017 and an Orthopedist was added to the clinic on half day per week. Referrals are tracked to ensure follow-up and continuity of care.

Provider recruitment continues to be an on-going process. Recruitment has consisted of a combined effort of using local resources, recruiting agencies and advertisement.

The clinic continues to support and build programs to serve the local community, notable projects from 2017 include PRIME- Chronic Pain Management, Vaccines for Children, Reach out and Read, and Comprehensive Perinatal Services Program (CPSP).

10. Dietary / Food Service

Dietary continues to contribute to patient care by providing meals specific to diet orders and patient needs. Nutricopia provided additional services and dietary consulting to improve quality of nutritional services. There was a change in leadership for the department and a new Dietician was hired to provide clinical services as well as manage the department. The "A" rating for food service by the county was maintained, a new stove was purchased, and the department partnered with Meatless Mondays to offer plant-based options that enhanced the menu.

Section 4: Additional Reports

Infection Control

BVCHD is committed to address detection, prevention and control of infections among patients and personnel. The goals of the Infection Prevention Program are to decrease the risk of infection to patients and personnel; monitor for occurrence of infection and implement appropriate control measures; identify and correct issues relating to infection prevention practices; limit unprotected exposure to pathogens throughout the hospital; minimize the risk associated with procedures, medical devices and medical equipment; and to maintain the compliance with State and Federal regulations pertaining to infection prevention.

The annual risk assessment and Infection Prevention Plan is based on the need for change and/or adjustments in the Infection Prevention Program determined by the patient population, demographics, services, procedures, diagnoses and current trends.

Service Assessment for January 2017-December 2017*

Clinical Area	Total Admissions	Total Days
Acute/Swing	158	624
Observation	69	76
Skilled Nursing Facility	27	7012
Emergency Department	11,620	N/A
Outpatient Surgery	145	N/A
Clinic	18,998	N/A
Physical Therapy	747	N/A
Total	31,764	7712

*Data source: CPSI/Evident Census Days Stay report

Top Ten Diagnosis 2017*

	Top 10 Inpatient Diagnosis	Top 10 ED Diagnosis
1	Chronic obstructive pulmonary disease, exac.	Other, chest pain
2	Pneumonia, unspecified organism	Syncope and collapse
3	Hypertensive heart disease with heart failure	Nausea with vomiting
4	Other pneumonia, unspecified organism	Concussion without loss of consciousness
5	Urinary tract infection	Acute nasopharyngitis (common cold)
6	Multiple Sclerosis	Acute cystitis without hematuria
7	Other Pulmonary embolism	Strain of muscle, fascia, tendon of lower back
8	Unspecified bacterial pneumonia	Streptococcal pharyngitis
9	Alcohol induce pancreatitis	Acute bronchitis
10	Sepsis, unspecified organism	Generalized anxiety disorder

*Data source: CPSI/Evident Top ICD10 Diagnosis reports

Infection Control Report-Occurrence Rate 2016 (all sources)

Top Organisms*	Total	%
Escherichia coli	234	45
Klebsiella pneumonia	48	9.1
Streptococcus agalactiae	33	6.3
Staphylococcus aureus	32	6.1
Staphylococcus epidermidis	23	6

*Other organisms had <3% prevalence rate.

NHSN Patient Safety Surveillance activities included:

- Device Associated Hospital Acquired Infection (HAI) Module
  - CLABSI
  - CAUTI
- Procedure –Associated HAI Module
  - Appendix surgery
  - Bile duct, liver or pancreatic surgery
  - Breast surgery
  - Gallbladder surgery
  - Colon surgery
  - Open reduction of fractures
  - Gastric surgery
  - Herniorraphy
  - Hip prosthesis
  - Knee prosthesis
  - Rectal surgery
  - Small bowel surgery
  - Spleen surgery
  - Exploratory abdominal surgery

- Multi-Drug Resistant Organism (MDRO) Module
  - Acinetibacter MDR
  - C.Diff
  - MRSA
  - VRE

There were no Healthcare Acquired Infections in 2017. There were 4 C-diff cases, community acquired. There were 18 cases of MRSA through ER and the clinic. There was 1 Surgical Site Infection on an open ankle fracture.

Healthcare Personnel Safety activities included:

Surveillance	Occurrence
Sharps injuries	3
Blood/body fluid exposure	2
Influenza vaccination- Employees	179 (89%)
Influenza vaccination- Providers (all credentialed) (#obtained from Nicole)	138
Influenza vaccination-Volunteers (#obtained from Shelly)	21

Seasonal influenza vaccine was offered to all employees, providers and volunteers at no cost. All employees, providers and volunteers were required to receive the vaccine, provider proof of

receiving the vaccine or sign a declination. Employees who declined the vaccine were mandated to wear masks while in patient care areas.

Hand Hygiene Compliance	YTD%
Staff and providers	80%

Education

Education activities focused on hand hygiene, respiratory etiquette, vaccinations. Infection prevention, PPE, blood borne pathogens exposure and hand hygiene are presented during new hire orientation and during annual re-orientation. Clinical leaders assisted in stressing the importance of hand hygiene to staff and participated in active surveillance.

Construction Projects

Facilities communicates with the Infection Preventionist for all construction projects. An Infection Control Risk Assessment (ICRA) is conducted on all projects. An Infection Prevention Construction Permit was issued for all projects for a Class III or higher. Use of proper barriers and airflow is a priority to maintain patient safety. CT and Mammo projects were completed this year, as well as new restrooms and renovation of Room 30.

Infection Prevention Plan 2018

Based upon the 2017 Infection Prevention Risk Assessment and Program Summary focus will continue to be on the following:

- NHSN required surveillance: MDRO, Device associated infections, hospital acquired infections.
- NHSN optional surveillance: Hand hygiene compliance, long term care surveillance, Antibiotic stewardship
- NHSN Healthcare Personnel Safety surveillance: Influenza vaccination.
- Transmission-based precaution training and compliance monitoring.
- Continuing education for staff regarding infection prevention.
- Environmental Services cleaning surveillance and education.
- Monitor for outbreaks.
- Identifying communicable diseases and complying with mandated reporting requirements.
- Work collaboratively with Employee Health to promote employee vaccinations; conduct surveillance of occupational exposures, injuries, and infections; identify emerging problems, monitor trends, and evaluate preventive measures.

Medication Management

Pharmacy and Nursing reviewed medication errors in 2017 and categorized the errors by the standard elements of performance. Medication errors and near misses were documented through the variance system. Medication incidents increased this year, partially due to the campaign to increase compliance in reporting errors and near misses by educating staff on non-punitive methods of investigation and process improvement for error reduction purposes. The top three elements of performance in relation to reported errors and near misses were found to be: Administration, Prescription Order Communication, and Dispensing. Nursing and Pharmacy will collaborate on a plan of action for process improvement and present a Medication Error Reduction Plan for 2018. The MERP will be presented to the Pharmacy and Therapeutics Committee and the Medical Staff.

Pharmacy experienced a change in leadership in 2017, the previous Director of Pharmacy resumed his position at BVCHD. Upon starting he met with nursing to discuss areas of concern and prioritized areas for improvement. A new Pyxis was installed this year and a new laminar hood was installed within the pharmacy.

The meaningful use measure for CPOE utilization has declined in 2017. Further investigation needs to be done in regards to CPOE requirements, physician and nurse training and overall functioning of the order entry process.

Emergency Preparedness Annual Program

Bear Valley Community Healthcare District has designed an Emergency Preparedness Program in order to maintain effective systems during natural disasters or other emergencies that may disrupt the organization's ability to provide care and treatment to the community. The goals of the Emergency Preparedness Program are to provide plans that may be implemented during times of disaster; increase availability of resources for the continuation of patient care during an emergency; establish actions to prepare for, mitigate, respond to, and recover from the effects of a disaster or emergency; and provide compliance with applicable codes and regulations.

The Annual Summary and Emergency Preparedness Plan is based on evaluation of BVCHD's All-hazards Emergency Operations Plan and the Hazard Vulnerability Analysis developed by the Emergency Preparedness Committee and approved by the Safety Committee. The need for change and/or adjustments in the Emergency Preparedness Program is determined by the annual HVA, patient population, demographics, and current trends.

Hazard Vulnerability Analysis for January 2017- December 2017:

BVCHD 2017 Hazard and Vulnerability Assessment Tool
Naturally Occurring Events

Event	PROBABILITY	SEVERITY = (MAGNITUDE - MITGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/ Mutual Aid staff and supplies	* Relative threat
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
Active Shooter	1	3	2	2	2	2	2	24%
Bomb Threat	1	2	3	3	1	1	3	24%
Building Move	0	0	0	0	0	0	0	0%
Chemical Exposure, External	1	1	1	2	1	1	2	15%
Civil Unrest	1	1	1	2	2	2	3	20%
Communication / Telephone Failure	3	1	1	3	3	2	3	56%
Dam Failure	1	2	1	1	2	1	1	15%
Drought	1	2	1	1	2	1	1	37%
Earthquake	3	3	3	3	2	2	2	72%
Epidemic	1	3	2	2	2	2	2	24%
Evacuation	3	1	2	2	1	1	1	44%
Explosion	1	3	3	3	3	3	2	31%
External Flood	1	2	2	2	2	2	2	22%
Fire	1	2	3	3	1	1	1	20%
Flood	1	1	2	2	3	2	2	22%
Forensic Admission	0	0	0	0	0	0	0	0%
Gas / Emissions Leak	2	1	0	1	3	2	3	37%
Generator Failure	2	1	0	2	1	2	2	30%
Hazmat Incident	1	2	2	2	2	2	1	20%
Hazmat Incident with Mass Casualties	1	2	2	2	2	2	2	22%

Hostage Situation	1	3	2	2	2	2	2	24%
Hurricane	0	0	0	0	0	0	0	0%
HVAC Failure	2	1	0	1	2	2	2	30%
Inclement Weather	3	2	1	1	2	2	2	56%
Infectious Disease Outbreak	1	2	0	1	2	2	2	17%
Internal Fire	2	2	3	2	2	2	1	27%
Internal Flood	1	1	2	2	3	2	3	24%
IT System Outage	2	1	1	3	3	2	2	44%
Landslide	2	1	0	0	2	2	2	26%
Large Internal Spill	1	1	1	1	3	3	2	20%
Mass Casualty Incident	1	3	1	1	2	2	2	20%
Natural Gas Disruption	1	1	0	1	2	2	1	13%
Natural Gas Failure	1	2	1	2	2	2	1	19%
Other								
Other Utility Failure	1	1	1	1	3	3	3	22%
Pandemic	1	3	0	2	2	2	2	20%
Patient Surge	2	1	0	2	2	2	2	33%
Picketing	1	0	0	1	1	2	1	9%
Planned Power Outages	1	0	0	1	2	2	3	15%
Power Outage	2	0	0	1	2	2	3	30%
Radiation Exposure	1	2	1	2	2	2	2	20%
Seasonal Influenza	2	1	0	0	1	1	2	19%
Sewer Failure	1	1	2	2	2	2	2	20%
Shelter in Place	2	1	1	1	2	3	3	41%
Strikes / Labor Action / Work Stoppage	1	1	0	2	2	1	3	17%
Suicide	1	3	1	1	2	2	3	22%
Supply Chain Shortage / Failure	2	1	1	2	2	2	2	37%
Suspicious Odor	1	1	1	1	3	2	2	19%
Suspicious Package/ Substance	1	2	2	2	2	2	1	20%

Temperature Extremes	3	1	1	1	2	2	1	44%
Terrorism	1	3	3	3	2	2	1	26%
Tornado	0	0	0	0	0	0	0	0%
Transportation Failure	2	1	1	1	2	3	2	37%
Trauma	1	3	1	1	3	2	2	22%
Tsunami	0	0	0	0	0	0	0	0%
VIP Situation	2	0	0	1	1	1	2	19%
Water Contamination	1	3	1	1	2	2	2	20%
Water Disruption	1	1	1	2	2	2	2	19%
Weapon	3	2	1	2	3	2	2	67%
Wildfire	3	2	2	2	2	2	3	72%
Workplace Violence/ Threat	2	2	2	2	3	2	1	44%

2017 Emergency Preparedness Program included:

Drills:

Telephone Outage:

The telephone outage was an actual even that provided the opportunity to practice emergency response plans. The business continuity policy was reviewed, an incident commander was chosen and HICS forms were used to document the incident.

Great Shake Out:

BVCHD participated in the 2017 California Great Shake Out. The earthquake recording was played over the loud speaker. Employees, patients and visitors practiced the "duck, cover and hold on" response. Evaluators were sent to each department to observe the response, document findings, and share an earthquake preparedness video. After the "shaking" ceased, the evaluators asked their areas to provide evidence that the department has downtime forms available in case of computer outage. The evaluators also searched their areas for any hazards such as picture frames that could have fallen or shelves that were not secured to the wall. The findings were used to develop an After Action Report.

California Statewide Medical and Health Exercise:

This exercise was conducted at BVCHD as part of the San Bernardino County Department of Public Health, Preparedness and Response Program's exercise. This drill involved a full scale exercise in which two terrorist incidents were presented to staff, the House Supervisor and Administration Team coordinated to set up the Hospital Incident Command (HIC), roles were assigned to various directors and managers in the HIC, and the Emergency Department, Skilled Nursing Facility, and the Family Health Clinic (as an Alternate Care Site) were surged. Facilities staff set up the Surge Tent. An After Action Report was completed and submitted to the County as part of the Hospital Preparedness Planning grant requirements.

Holcomb Fire

This was an actual event that provided BVCHD with an opportunity to review and plan to implement the Skilled Nursing Facility Evacuation policy. While we never got to the point where we had to implement this policy, we did coordinate with area agencies, such as the Big Bear Fire Authority and Mountain Transit to plan for possible evacuation. The findings were used to develop an After Action Report and Improvement Plan.

Education

HazMat:

BVCHD trained 13 staff members in the appropriate procedures for hazardous material decontamination. The training took place over 3 days and the team practiced setting up the decontamination tent, and utilizing the decontamination suits.

The Emergency Preparedness Coordinator attended training at the Center for Domestic Preparedness in Anniston, Alabama. The training covered Hazmat Technician training. The course was 6 days long and included an opportunity to work in the hands-on full-suit training area for the last day. More Hazmat Decontamination trainings are planned for the spring.

HICS:

New managers were required to complete online courses including ICS 100, Introduction to Command System; ICS 700, National Incident Management System; and I-S 906 Workplace Security Awareness. New staff members were educated on hospital codes and basic disaster plans at BVCHD at new employee orientation.

Management staff was challenged with opportunities to exercise HICS structure, roles and forms during disaster drills and actual incidents.

Disaster Planning for California Hospitals:

The Emergency Preparedness Coordinator attended the Disaster Planning for California Hospitals Conference. Topics covered during the conference included California's earthquake risk, crisis standards of care, business continuity planning, hazard vulnerability analysis & incident tracking tools, & workplace violence prevention. The new CMS requirements for November 2017 were also covered.

Community Partnerships:

Hospital Planning Partners

The BVCHD Emergency Preparedness Coordinator serves on the Leadership team for the County Hospital Preparedness Planning Partners, as well as participates in all meetings and activities associated with the coalition. The HPP coalition meets quarterly to discuss disaster planning topics and provide education to hospitals throughout the county. HPP coordinates efforts with the County of San Bernardino Department of Public Health Preparedness and Response Program and Inland County Emergency Management Association.

Mountain Mutual Aid

A representative from BVCHD attended the Mountain Mutual Aid group. Mountain Mutual Aid meets quarterly to coordinate resources on the mountain, develop MOUs, and coordinate disaster planning efforts among key agencies involved in community response.

Health Emergency Local Planning Partners

A BVCHD representative attends the HELPP meetings in San Bernardino County. HELPP meets quarterly to disseminate information regarding health emergencies and arising health issues in the population.

BVCHD Emergency Preparedness Committee

The BVCHD Emergency Preparedness Committee meets at least 6 times per year to develop and revise Emergency Preparedness Policies, plan disaster drills, and assess preparedness issues within the facility. The Emergency Preparedness Committee reports to the Safety Committee and maintains authority and responsibility for the implementation and evaluation of the Emergency Management Plan.

Ski Resort/ Fire Department/ Hospital/ Sheriff/ County Dispatch

An annual meeting among key agencies on the mountain took place regarding issues that the community faces during the winter season including increased traffic, weather incidents, and increased population due to tourism and recreation. The agencies formulate plans to communicate and collaborate on issues as well as share data sets such as anticipated high volume days, staffing plans and contact information within their agency.

Review of Program Objectives:

The 2017 objectives for Emergency Preparedness were as follows:

- Plan and document a minimum of 4 disaster drills based on the 2016 HVA.
    - Participate in the California Statewide Drill, involving community collaboration
    - Participate in the Great Shakeout
    - Test surge capabilities and response
    - HICS structure and documentation
    - Decontamination training and certification
- Implement Disaster Tracking procedures in order to evaluate validity of HVA
- Inventory disaster equipment
    - Develop maintenance/ use logs
    - Assess equipment availability and needs
    - Train staff on disaster equipment access and use, including emergency oxygen supply
- Increase collaboration with outside agencies
    - Attend HP3/ HELPP meetings
    - Contribute to Mountain Mutual Aid collaborative

- Improve Disaster communication procedures
    - Continue testing and training on satellite phone use
    - Train management staff on GETS card use
    - Collaborate with Fire Department regarding purchase/ installation / training on updated HAM radio equipment
    - Train management staff regarding WebEOC use during external disasters
- Increase understanding of Hospital Incident Command structure and associated roles throughout the facility
    - Continue monitoring compliance with ICS 100, 700 & 906 for all staff
    - Provide additional training for management staff, with opportunity to practice hospital command procedures and documentation
- Update Emergency Management Plan and Procedures
    - Revise all policies in collaboration with the Emergency Preparedness Committee, Safety Committee and Policy & Procedure Committee
    - Ensure all policies complete the review and approval process including the BVCHD Board of Directors
    - Expand Continuity of Operations Procedures
- Ensure compliance with grant requirements and documentation
    - Meet with DPH regarding 2017 requirements
    - Submit all required documentation to DPH/ ICEMA
- Improve Workplace Violence policy
    - Review and update current policies and practices to comply with Cal-OSHA requirements
    - Report to OSHA as required per regulations
    - Develop and/or maintain mandated workplace violence logs
        - Expand Crisis Prevention Institute (CPI) training to all hospital staff that encounter patients
        - Review de-escalation skills with front line staff

Review of Program Effectiveness

Objective	Status
Plan and document a minimum of 4 disaster drills based on the 2017 HVA.	4 Disaster drills were documented in 2017
Implement Disaster Tracking procedures in order to evaluate validity of HVA	Actual events included power outages, internal flooding, wildfire, and phone outage
Inventory disaster equipment	Equipment was inventoried, multiple items found to be expired, will need a plan over the next several years to replace equipment and expand disaster recourses.
Increase collaboration with outside agencies	BVCH attended HELPP, served on the leadership committee for HP3, attended

	MMA, and attended the annual ski season preparedness meeting for local agencies
Improve Disaster communication procedures	Issued updated GETS cards to management and departments, purchased 800Mghz radio, bought new software for current radios, trained 1 additional HAM radio operator, collaborated with Fire Department and ICEMA regarding radio communication procedures and equipment
Increase understanding of Hospital Incident Command structure and associated roles throughout the facility	Drills utilizing HICS were completed. CDP training was attended by Emergency Preparedness Coordinator, recommendation for managers to attend CDP training.
Update Emergency Management Plan and Procedures	Emergency Preparedness committee reviewed policies and procedures in 2017. HazMat policy is still needing revision to reflect actual process. Manager attended HazMat training at CDP.
Ensure compliance with grant requirements and documentation	All grant documentation has been turned in. No grant money was issued at all from the county for 2017.
Improve Workplace Violence policy	New CPI training is being conducted, and is scheduled to continue throughout 2018.

Accomplishments

- Successfully completed 4 disaster drills including training for management staff on HICS
- Completed and submitted grant requirements to ICEMA
- Served on leadership committee for Hospital Preparedness Planning Partners Coalition
- Maintained/ developed relationships and partnerships with community stakeholders
- Inventoried Disaster Supplies
- Revised Emergency Preparedness Policies
- Developed Workplace Violence policy
- Updated GETS cards system for current Management Staff and hospital departments

Emergency Preparedness Objectives for 2017:

Based on the 2017 Emergency Preparedness Program Summary, focus will be on the following objectives in 2018:

- Plan and document a minimum of 4 disaster drills based on the 2018 HVA.
    - Participate in the California Statewide Drill, involving community collaboration
    - Participate in the Great Shakeout
    - Test surge capabilities and response
    - HICS structure and documentation
    - Decontamination training and certification

- Utilize Disaster Tracking procedures in order to evaluate validity of HVA
- Inventory disaster equipment
    - Develop multi-year plan to replace expired equipment
    - Train staff on disaster equipment access and use
    - Contact outside resources to obtain training on emergency oxygen supply
- Increase collaboration with outside agencies
    - Attend HP3/ HELPP meetings
    - Contribute to Mountain Mutual Aid collaborative
- Improve Disaster communication procedures
    - Initiate routine testing of satellite phone use
    - Re-train management staff on GETS card use
    - Collaborate with Fire Department regarding purchase/ installation / training on updated HAM radio equipment
    - Program all existing disaster radios
    - Train management staff regarding WebEOC use during external disasters

- Increase understanding of Hospital Incident Command structure and associated roles throughout the facility
    - Continue monitoring compliance with ICS 100, 700 & 906 for management staff
    - Provide additional training for management staff, with opportunity to practice hospital command procedures and documentation
    - Recommend all management staff attend training at CDP in Anniston
- Update Emergency Management Plan and Procedures
    - Revise all policies in collaboration with the Emergency Preparedness Committee, Safety Committee and Policy & Procedure Committee
    - Ensure all policies complete the review and approval process including the BVCHD Board of Directors
    - Expand Continuity of Operations Procedures
- Ensure compliance with grant requirements and documentation
    - Complete 2018 grant requirements
    - Submit all required documentation to DPH/ ICEMA
    - Finish leadership term on HP3 collaborative
- Continue with Workplace Violence Plan
    - Review and update current policies and practices to comply with Cal-OSHA & SB 1299 requirements
    - Report to OSHA as required per regulations
    - Develop and/or maintain mandated workplace violence logs
    - Continue implementation of training that complies with requirements as mandated by Cal-OSHA
    - Review Facility assessment to determine workplace violence risks and associated plan of correction

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
SPECIAL PLANNING & FACILITIES COMMITTEE
MEETING MINUTES
January 22, 2018

MEMBERS PRESENT:	Jack Roberts, 2nd Vice President	Shelly Egerer, Admin. Assistant
	Rob Robbins, President	Michael Mursick, Plant Manager
	John Friel, CEO	
STAFF:	Mary Norman	Garth Hamblin Colin Campbell
ABSENT:	Kerri Jex	
COMMUNITY MEMBERS:	None	

OPEN SESSION

1. **CALL TO ORDER**
   Board Member Roberts called the meeting to order at 3:00 p.m.

2. **ROLL CALL**
   Jack Roberts and Rob Robbins were present. Also present were John Friel, CEO, Mike Mursick, Plant Manager and Shelly Egerer, Executive Assistant.

3. **ADOPTION OF AGENDA***
   Board Member Roberts motioned to adopt the January 22, 2018 agenda as presented. Second by President Robbins to adopt the January 22, 2018 agenda as presented. Board Member Roberts called for the vote. A vote in favor of the motion was unanimously approved.
   - Board Member Roberts - yes
   - President Robbins - yes

CLOSED SESSION

1. **PUBLIC FORUM FOR CLOSED SESSION**
   Board Member Roberts opened the Hearing Section for Public Comment on Closed Session items at 3:00 p.m. Hearing no request to address the Planning & Facilities Committee, Board Member Roberts closed the Hearing Section at 3:01 p.m.

2. **ADJOURN TO CLOSED SESSION***
   Board Member Roberts motioned to adjourn to Closed Session at 3:01 pm. Second by President Robbins to adjourn to Closed Session. Board Member Roberts called for the vote. A vote in favor of the motion was unanimously approved.
   - Board Member Roberts - yes
   - President Robbins - yes

OPEN SESSION

1. **CALL TO ORDER:**
   Board Member Roberts called the meeting to order at 3:15 p.m.

2. **RESULTS OF CLOSED SESSION:**
   Board Member Roberts stated there was no reportable action taken in Closed Session.

3. **PUBLIC FORUM FOR OPEN SESSION:**
   Board Member Roberts opened the Hearing Section for Public Comment on Open Session items at 3:15 p.m. Hearing no request to address the Planning & Facilities Committee, Board Member Roberts closed the Hearing Section at 3:15 p.m.

4. **DIRECTOR'S COMMENTS:**
   - None

5. **APPROVAL OF MINUTES:**
   A. November 16, 2017

   Board Member Roberts motioned to approve the November 16, 2018 minutes as presented. Second by President Robbins to approve the November 16, 2018 minutes as presented. Board Member Roberts called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Roberts - yes
   - President Robbins - yes

6. **OLD BUSINESS***
   - None

7. **NEW BUSINESS***
   A. Discussion and Update on the Installation of a Marta Bench at Bear Valley Community Healthcare District:
   - Mr. Friel stated that the District was approached by a member of the Patient Advisory Committee to install the Marta Bench and we are trying to obtain information to see if this is feasible for the District and community.
   - Mr. Mursick reported that he spoke with the representative that install's the benches and stated that he will not install the bench if he could not have advertising installed; this is how the vendor makes his money. We are looking at additional options and cost to see if this is feasible for the District.
   - The Planning Committee suggested that Mr. Mursick contact Marta and find out information from them that we are not aware of and to find out a cost if the District installed. This item is to be brought back to the February Planning & Facilities Committee Meeting.

   Board Member Roberts reported there is no action required.

B. Discussion and Information on the Pharmacy USP 800 Mandate:

- Mr. Mursick stated that he brought this item to the Planning & Facilities Committee for information purposes on a project that is required to be completed by July. The purpose of the USP 800 is to develop standards for handling hazardous drugs and help promote patient safety. At this time, we do not have a cost on upgrading the Pharmacy to meet the requirements but the District will need to hire a vendor to assist the District in the project.
- Mr. Campbell reported that there are hazardous drugs used approximately twice a month and we need to be in compliance with the USP 800 Mandate. Sterile compounding should be completed by a Pharmacist but there are nurses who also complete this process.
- The Planning Committee requested that Mr. Mursick obtain cost and options, such as modular unit to ensure, we are in compliance by the July deadline. The committee also asked that this item be brought back to the February Planning & Facilities Committee with options and cost.

Board Member Roberts reported there is no action required.

C. Discussion and Information on BVCHD Providing Emergency/Triage Services at the Ski Resorts:

- Mr. Roberts stated that he asked for this item on the agenda; he would like Administration to determine if the District can provide services at both resorts.
  - Rent space at both resorts to provide triage services. This could determine some changes in the Facility Master Plan and open doors in the future for the District.
- The Planning Committee requested that Mr. Friel work with the nursing staff and if needed the management at both ski slopes to obtain information and a potential plan to be able to provide these services. This item is to be brought back to the February Planning & Facilities Committee.

Board Member Roberts reported there is no action required.

D. Discussion and Update on Master Plan/Design and Scheduling of Tours of Various Facilities:

- Mr. Friel reported that the Board agreed to two groups that we would like to move forward with. We have received information on the architect firms and would like to know what is the process that we are expected to do moving forward; is this item to stay at the Planning & Facilities Committee or should it be a full Board item. Both firms have provided some facilities to visit.
  - Ca architects suggested visiting the Long Beach Hospital.
  - Moon & Mayor recommended the Eisenhower Hospital and the expansion of ER.
- Board Member Roberts stated that he had to leave the meeting at 3:45 p.m. and asked that a Special Meeting be held on January 23 at 5:00 p.m.

Board Member Roberts reported there is no action required.

E. Discussion and Potential Recommendation to the Board of Directors the Following Policies & Procedures:

(1) Fire Watch

(2) Use of District Vehicles & Mobile Equipment

- Mr. Mursick asked the committee to provide a positive recommendation to the Board of Directors to approve the policies and procedures.
- President Robbins asked that the Use of District Vehicles & Mobile Equipment have verbiage added that written documentation of employees using the District's vehicles and mobile equipment will be in writing and placed in the employees HR file.

Board Member Roberts motioned to approve a positive recommendation to the Board of Directors of the Fire Watch and Use of District Vehicles & Mobile Equipment Policies and Procedures with verbiage added as suggested by the committee. Second by President Robbins to approve a positive recommendation to the Board of Directors of the Fire Watch and Use of District Vehicles & Mobile Equipment Policies and Procedures with verbiage added as suggested by the committee. Board Member Roberts called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Roberts - yes
- President Robbins - yes

8. PLANNING & FACILITIES*

A. Construction Project:

- Mr. Mursick reported the following:
  - Public & Staff Restrooms
  - Room # 30 Renovations
  - Medgas Panel
  - Pyxis Replacement
  - ASHRE 188 Risk Management Plan for Legionellosis
  - Medical Air Compressor
  - Fire Door Replacement

- Board Member Roberts asked that this item be placed on the Special Planning & Facilities Committee Meeting agenda for January 23.

B. Potential Equipment Requirements:

- Mr. Mursick reported the following:
  - New snow plow for District Vehicle.
  - Beginning to review next year's Capital Budget items and is going to be adding the replacement of the snow plow to the District vehicle; this will add to the budget approximately $6,000.00 for the plow and does not include installation.

C. Repairs Maintenance (FHC, RHC, PT, Hospital):

- Mr. Mursick reported the following:
  - Filters Replaced
  - Escutcheon Repairs

President Robbins motioned to approve, the Planning & Facilities Report item B & C as presented. Second by Board Member Roberts to approve, the Planning & Facilities Report items B & C as presented. Board Member Roberts called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Roberts - yes
- President Robbins - yes

9. **ADJOURNMENT***

President Robbins motioned to adjourn the meeting at 3:40 p.m. Second by Board Member Roberts to adjourn the meeting. Board Member Roberts adjourned the meeting.

- Board Member Roberts - yes
- President Robbins - yes

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
SPECIAL PLANNING & FACILITIES COMMITTEE
MEETING MINUTES
January 23, 2018

MEMBERS PRESENT:	Jack Roberts, 2nd Vice President Rob Robbins, President John Friel, CEO	Shelly Egerer, Exec. Assistant Michael Mursick, Plant Manager
STAFF:	Garth Hamblin	Mary Norman
ABSENT:	None	
OTHER:	None	
COMMUNITY MEMBERS:	None	

OPEN SESSION

1. **CALL TO ORDER**
   Board Member Roberts called the meeting to order at 5:00 p.m.

2. **ROLL CALL**
   Jack Roberts and Rob Robbins were present. Also present were John Friel, CEO, Mike Mursick, Plant Manager and Shelly Egerer, Executive Assistant.

3. **ADOPTION OF AGENDA***
   Board Member Roberts motioned to adopt the January 23, 2018 agenda as presented. Second by President Robbins to adopt the January 23, 2018 agenda as presented. Board Member Roberts called for the vote. A vote in favor of the motion was unanimously approved.
   - Board Member Roberts - yes
   - President Robbins - yes

4. **PUBLIC FORUM FOR OPEN SESSION:**
   Board Member Roberts opened the Hearing Section for Public Comment on Open Session items at 5:00 p.m. Hearing no request to address the Planning & Facilities Committee, Board Member Roberts closed the Hearing Section at 5:00 p.m.

5. **DIRECTOR'S COMMENTS:**
   - Board Member Roberts thanked staff for the flexibility to have an additional meeting on short notice and would like to have the February Planning & Facilities Committee Agenda include the discussion of changing time of the meeting.

6. **APPROVAL OF MINUTES:**
   - None

6. **OLD BUSINESS***
   A. **Discussion and Update on Master Plan/Design and Scheduling of Tours of Various Facilities:**
      - Mr. Friel stated that we have received two different proposals;
        - CA Architects are structured different and cost was higher than expected.
        - Moon & Mayors are also a great organization.
        - Both organizations would like to determine what the District needs are.
        - The Medical Staff has received updates on the process the Board is taking.
        - There is a potential need to ask the community to pass a bond, a feasibility study will need to be completed and ensure the community is supportive of the Hospital. Grants will also have to be looked into and completed to raise additional money to cover the cost of upgrading current facility or building a new facility.
        - Clarification on the estimates needs to be completed (Phase 1 and 2 is complete are we responsible to pay Phase 3).
        - The site visits will consist of the CEO, Board Members, CNO, ER Director, COS and the Maintenance Manager.
      - President Robbins feels that at this time the Planning Committee should have this item continue to be on the agenda until some items are accomplished; the Board should be informed of what the Planning Committee is discussing; this can be addressed in the CEO Board Report.
      - The committee feels that there is a difficult time in reviewing the documents provided by the architect companies. All resources need to be reviewed and we need to ensure the District is fiscally/financially responsible. The committee would like the CEO to recommend what architect group is best for the district. Mr. Hamblin is to determine the financial aspect of what the District can afford; we cannot put the District in a large amount of debt.

   Board Member Roberts reported no action required.

7. **NEW BUSINESS***
   - None

8. **PLANNING & FACILITIES***
   A. **Construction Project:**
      - Mr. Mursick reported the following:
        - Public & Staff Restrooms
          - Collapse in pipe and acute kitchen has an elbow that will need to be replaced, we will need to cut concrete and replace tile. This will take place on a Saturday and Sunday. Potential cost is $8,200 and the tile is not included.

        - Room # 30 Renovations is completed.
          - Committee would like to have a Rotary Mixer for the money raised and dedicated to the SNF rooms.
          - Lockers and cabinets would be approximately $2,100.00 to remodel the lockers and cabinets.

- Foundation is going to be conducting a donor function that will be conducted on March 19 and tours will be provided.

- Medgas Panel; replaced panel, there is still some work to complete.

- Pyxis Replacement is completed, brackets needs to be installed.

- ASHRE 188 Risk Management Plan for Legionellosis:
  - Organization came in, working on a plan and moving forward, this is mandated.

- Medical Air Compressor:
  - Purchased compressor, there is a process in order to install, this is an OSHPD Project. There are additional expenses that were not budgeted for.
  - Medical air is used in OR and some in RT.
  - Rented bottle that meets standards; this is to have a back up incase there is down time.

- Fire Door Replacement is continuing.
  - Maintenance has completed as many doors as they can, there is a potential that a vendor will need to be hired to assist in the replacement of the fire doors.

Board Member Robbins motioned to approve the Planning & Facilities Section A Report as presented. Second by Board Member Roberts to approve the Planning & Facilities Section A Report as presented. Board Member Roberts called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Roberts - yes
- President Robbins - yes

9. **ADJOURNMENT***

President Robbins motioned to adjourn the meeting at 5:55 p.m. Second by Board Member Roberts to adjourn the meeting. Board Member Roberts adjourned the meeting.

- President Robbins - yes
- Board Member Roberts- yes

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: BE Smith

Purpose of Contract: Interim SNF Director

Contract # / Effective Date / Term _____ / _____

Originating Dept. Name / Number: Admin

Department Manager **Signature:** _____ **Date:** _____

BAA: __Yes __No **W-9:** __Yes __No on file

Administrative Officer	**Signature:**		**Date:** 3/6/18
HIPAA/Privacy Officer (as appropriate)	**Signature**		**Date:**
Legal Counsel	**Signature:**	via email	**Date:** 3-6-18
Compliance Officer	**Signature:**		**Date:**
Chief Financial Officer	**Signature:**		**Date:** 6 MAR 2018
Chief Executive Officer	**Signature:**		**Date:** 3-6-18
Board of Directors When Applicable	**Signature**		**Date:**

1. **Final Signatures on Contract, BAA & W-9:** **Date:** _____
2. **Copy of Contract/BAA/W-9 forwarded to Department Manager:** **Date:** _____
3. **Copy of Contract/BAA/W-9 forwarded to Contractor (if applicable):** **Date:** _____
4. **Copy of Contract/BAA/W-9 scanned/emailed to Controller and Legal (if applicable):** **Date:** _____

Contract Cover Sheet

CONFIDENTIAL NOTICE:

B.E. SMITH
an AMN Healthcare company

B.E. SMITH INTERIM SERVICES AGREEMENT

This Agreement is established this day of February 26, 2018, between B.E. Smith Interim Services, Inc., ("Smith") and Bear Valley Community Healthcare District, Big Bear Lake, CA ("Client").

1. **Smith:**
   A) Agrees to provide to Client an Interim Leadership Professional ("Professional") for the following position: **Interim Director of Skilled Nursing Facility** ("Position").
   B) Agrees to present to Client a Professional Smith believes meets Client's requirements for Position.
   C) Upon acceptance of Professional by Client, Professional will be paid by Smith as an employee of Smith, and Smith assumes responsibility for such payment
   D) Professional will not be considered an employee of Client. Client will direct Professional only as to the ultimate outcome of the work to be performed.

2. **Client:**
   A) Agrees to pay to Smith five thousand five hundred dollars ($5,500) for each week or any part thereof for services rendered by Professional for up to one year, to be billed and paid once a month.
   B) Agrees to reimburse vendor or Smith directly for Professional's airfare, rental car and travel expenses to and from his/her home every two (2) weeks during this agreement. Specific travel schedules will be determined between Client and Smith Professional Services Consultant during the engagement start up meeting.
      a. Smith will arrange Professional's travel to and from home city for the engagement.
   C) Agrees to procure adequate lodging for Professional's use for the duration of this Agreement.
   D) Client will establish office location with appropriate internet/phone access for Interim Professional.
   E) Agrees to reimburse Smith for out of pocket expenses related to this engagement, including Smith's onsite visits.
   F) The minimum term of this Agreement is twelve (12) weeks (Term) beginning with the first full week that Professional works. This Agreement shall remain in effect until notice of termination is given by Client or by Smith.
   G) To terminate this agreement after the Term, Client shall provide to Smith at least three (3) weeks advance written notice (Notice Period) to terminate this Agreement. The termination will be effective as of the last Friday of the Notice Period.
   H) In the event Professional is accepted by Client, confirms a start date for Professional and Client cancels engagement prior to agreed upon start date, Client agrees to pay Smith a sum equivalent to one weekly fee as identified in 2A.
   I) Agrees Professional will function under Leadership Consultant Agreement until such time Professional obtains licensure in Client's state, if applicable.
   J) Beginning the first day of the second year fees will be increased by 6%.

K) In the event Professional or any candidate presented by Smith is subsequently hired, retained, contracted or otherwise engaged by Client within twelve (12) months after the later of (i) the presentation of the Professional by Smith or (ii) the termination of this Agreement, Client will pay to Smith a placement fee equal to:

1. Forty percent (40%) of the annual compensation to be paid to Professional or candidate if this event happens within the first six (6) months of this agreement.
2. Thirty-five percent (35%) of the annual compensation to be paid to Professional or candidate if it happens after the sixth (6^{th}) month.
3. This placement fee is due in full to Smith when the Professional or candidate is hired, retained, or otherwise engaged by Client.

L) All payments are due 30 days from date of invoice and shall accrue interest at the rate of one (1%) per month thereafter. Client is responsible for any costs of collection including reasonable attorney's fees and expenses incurred by Smith as a result of late or non-payments under this Agreement.

M) Consents to Smith's use of non-confidential information such as Client name and logos, in Smith's marketing materials such as newsletters, direct mail and website.

3. **Mutual Indemnification:**
To the maximum extent permitted by law, Client and Smith each agree to defend, indemnify and hold harmless the other party, its directors, officers and employees from and against any and all losses, claims, demands, costs, damages, liabilities, joint and several, and expenses of any nature (including attorney's fees) incurred by one party in connection with any and all claims, demands, actions, suits, arbitrations or proceedings in which the other party may be involved, caused by any act or omission of the indemnifying party to this agreement, its Professionals or employees. Nothing contained herein shall preclude an action between the parties to this agreement based on a breach of this Agreement.

4. **Insurance:**
Smith shall purchase and maintain during the duration of this Agreement and after the expiration of this Agreement as provided below, the following insurance coverage:
A) Professional liability covering all Professionals under this agreement in an amount no less than $1 million per incident, $3 million general aggregate. In the event such coverage is through a "claims made" policy and is either canceled, replaced or non-renewed, Smith shall obtain and maintain extended coverage ("tail") insurance covering occurrences during the effective period of this Agreement.
B) Workers' compensation and employer's liability coverage for Smith's legal and statutory obligations for damages due to bodily injuries either by accident or disease, occurring to Smith's Professionals, employees, agents or servants as a result of rendering services under this Agreement.
C) Unemployment Insurance as required by law for all employees.
D) Automobile liability insurance, covering Smith, its Professionals, agents, employees, or servants for property damage and bodily injury claims arising out of the ownership, maintenance, or use of vehicle, either owned, non-owned, or hired by or on behalf of Smith, its Professionals, agents, employees or servants. Minimum limits of liability for the above coverage shall be $1,000,000 per occurrence.
E) General liability covering Smith, its agents, employees, servants and Professionals for bodily injury, personal injury, or property damage claims arising out of the premises, products or activities of Smith in an amount no less than $1 million per incident, $3 million general aggregate.

5. **Professional Performance:**
If Client concludes that Professional assigned to Client by Smith is not performing in a satisfactory manner or that the Professional is otherwise not qualified for the position, said Professional shall not be permitted to continue working under this Agreement. Under such circumstances, Client will advise smith and Smith will immediately terminate Professional's assignment and ask Professional to leave Client's property. Under these circumstances, the minimum term and pre-termination notice requirements stated in Section 2 of this Agreement are not applicable.

6. **Confidential Information and HIPAA Compliance:**
All files, records and documents of Client or its subsidiaries or affiliates which comes into Smith's or Professional's possession shall remain the exclusive property of Client and shall be returned to Client upon completion of each Staff assignment under this Agreement. Smith and Professional shall at all time safeguard the integrity, security, and confidentiality of individually identifiable health information, as that term is defined in 42 U.S.C. Section 1320d(6)("Health Information"), to which the Professional has access by virtue of this Agreement. To accomplish this requirement, Smith shall maintain reasonable and appropriate administrative, technical and physical safeguards as specified in 42 U.S.C. Section 13620d-2(d)(2).

B.E. Smith, Inc., by
Adam Burns
Division Vice President
Date: 3/6/2018

Bear Valley Community Healthcare District, by
John Fried
Chief Executive Officer
Date: 3-8-18

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MEMO

Date: 01 March 2018

To: BVCHD Finance Committee

From: Garth M Hamblin, CFO

Subject: QHR IT Assessment for BVCHD

Recommended Action

Receive and Review QHR IT Assessment.

Background

In January 2018 Sharon Stewart, Vice President Technology Consulting of Quorum Health Resources was on-site to conduct an IT Assessment of BVCHD. Attached are an executive summary report and the full report. All board members have received these reports. The chairs of the Planning Committee and Finance Committee asked these reports be brought to their respective committees for review. We are planning that Sharon be available for the March 14 board meeting to present her findings.

Bear Valley IT Assessment

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

Executive Summary

February 2017

Sharon Stewart, MSHCAD, FACHE

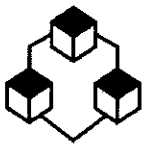
QUORUM | HEALTH RESOURCES®

Creating a Sustainable Future for Healthcare Organizations

AGENDA

- Story at a Glance
- People
- Operations & Infrastructure
- Projects
- Relationships
- Recommendations

STORY AT A GLANCE

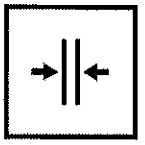


CURRENT STATE

- Major infrastructure upgrades completed
- Technical staffing meets day-to-day needs
- Core application supported by vendor

SUCCESSES

- No disabling security incidents
- Network upgrades in place reducing risk of future failures



GAPS

- Customer frustration with:
  - Scope of support
  - Transparency of request status

FINDINGS

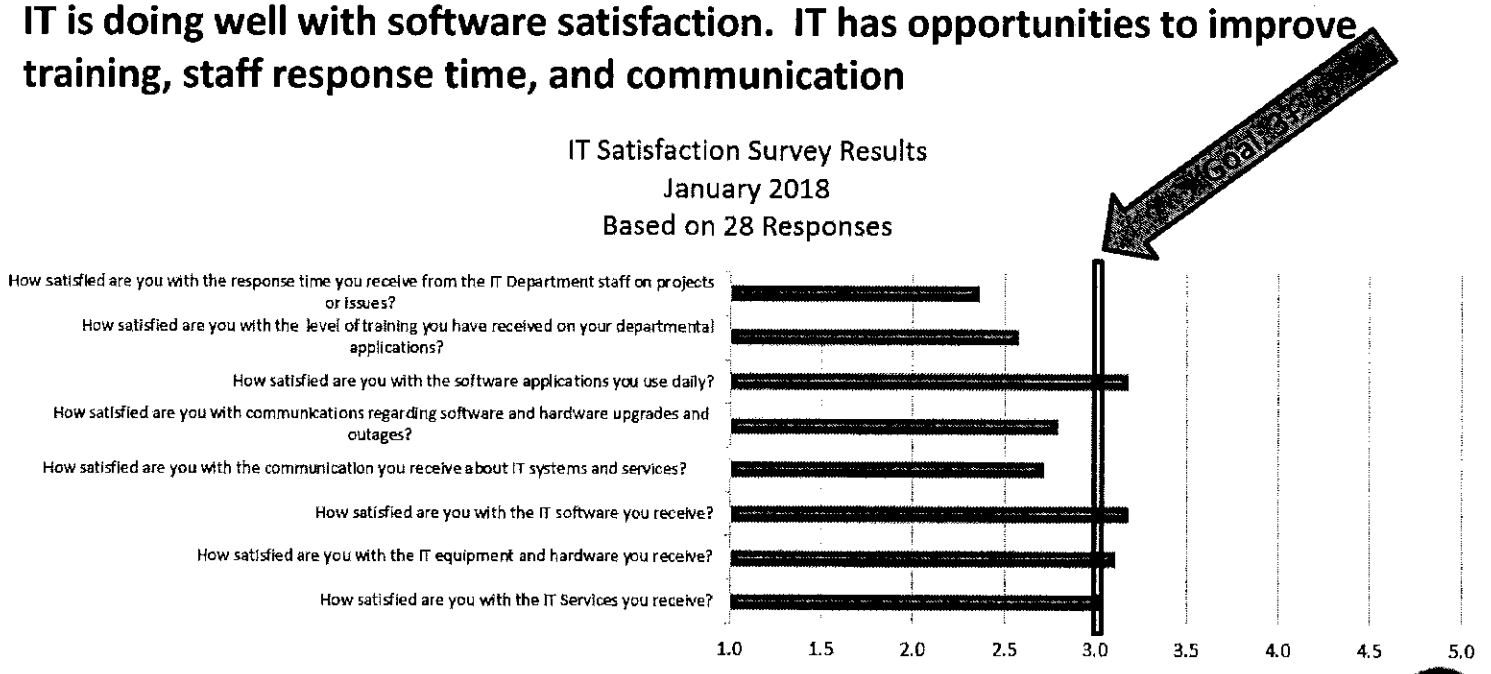
PEOPLE

The Bear Valley IT team is well-positioned for future success

- Bear Valley has strong skills on the current IT team
- Bear Valley could use part-time desktop support and greater support for core applications
- IT skill development is informal
- The IT Team reporting structure is consistent with best practices
- The IT staff budget is slightly lower than expected as a percentage of net revenue
- Bear Valley appropriately used outside resources for technical tasks when specialized skills and extra capacity were needed

SURVEY RESULTS

IT is doing well with software satisfaction. IT has opportunities to improve training, staff response time, and communication



OPERATIONS, IT INFRASTRUCTURE, AND CYBER-SECURITY

Bear Valley IT has overcome great challenges; made significant infrastructure improvements; and is ready to implement new best practices for cyber-security

- The Bear Valley IT team has deployed appropriate infrastructure improvements to protect the organization from future catastrophic events
- Current support processes are informal and lack the data needed to provide transparency to IT customers on the status of requests
- Bear Valley has had good success with cyber-security and has opportunities to continue this success with the improvements identified in the management action plan ("MAP")

PROJECTS

Bear Valley has completed many critical projects and is ready to formalize project scheduling and communication

- 32 major IT projects were completed in 2016 and 2017
- Few Bear Valley IT customers are aware of successes and plans for the future that support them
- IT is not always aware of hospital projects that require IT support in time to schedule appropriate resources

RELATIONSHIPS

IT internal relationships would improve with greater transparency; external relationships reflect strong and effective advocacy for the organization

- Creative, affordable solutions have been identified and deployed to meet key business needs (for example: dietary phones)
- IT vendors are regularly taken to task to provide the best solutions at the lowest prices
- The majority of stakeholders interviewed appreciate the support of the IT team and recognize that they have limited capacity to address issues


RECOMMENDATIONS

PEOPLE

- Continue with existing department structure, organization placement, and reporting relationships
- Hospitals do not typically have board committees for IT
- Identify a primary and secondary application support person for every user area, either from IT or operations. Convene this group monthly
- Identify a vendor or locally staff part-time help for desktop and password reset calls. Focus internal IT staff on critical projects
- Inventory skills, identify gaps, and implement formal development plans for each staff member
- Identify and vet vendors for supplemental staffing for projects and surges in demand. Vendors must be scheduled and managed by IT to ensure compliance with policies, procedures, and schedules

OPERATIONS, INFRASTRUCTURE, AND CYBER-SECURITY

- Implement a help desk ticketing system
- Maintain current success with cyber-security by utilizing best practices listed in the management action plan ("MAP")
- Report on risks with mitigation and remediation plans to leadership each quarter
- As budget permits, complete infrastructure projects and cleanup as outlined in the MAP

PROJECTS

- Provide transparency by reporting to hospital and clinic staff on IT project priorities, schedules, statuses, completions, and successes
- Engage IT early in purchase decisions when implementation will require IT work or ongoing support
- When requestors value faster project completion, allow the requestor to apply for access to IT-managed funding for outside assistance. Outside assistance must be selected, approved, and managed by IT

RELATIONSHIPS

- Internal
  - Repeat IT satisfaction survey every six months and use focus groups to target top areas for improvement
  - Implement quarterly IT Director rounding on department leaders
- External
  - Utilize CPSI optimization visits
  - Continue to negotiate skillfully and thoroughly with IT vendors
  - Challenge vendors to provide process improvement support at no cost


SUPPORTING
DOCUMENTATION

INTERVIEW LIST

- Sherry Greenaway, Admitting
- Donna Nicely, Board Member
- Fran Montoya, Case management
- John Friel, CEO
- Heidi Markus, Emergency
- Marlon Morgan, Environmental & Security
- Mike Mursick, Facilities
- Patricia Tondorf, Health information
- Courtney Bublitz, Imaging
- Angela Rodriguez, Imaging
- April Early, IT
- Jon Booth, IT
- Randle Weaver, IT
- Tim Hagerman, IT
- Pamela Hargrove-Thomas, Laboratory
- Dr. Knapik, Medical staff
- Kerrie Jex, Nursing
- Sheri Mursick, Outpatient services
- John McKinney, Physical Therapy
- Mary Norman, Risk & Compliance

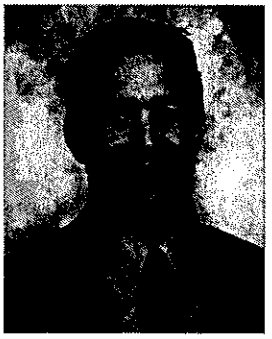
SUPPORTING DOCUMENTATION

- These items are available in separate files:
  - 2016-2017 project list
  - Organization structure
  - Application list
  - Equipment list
  - Network diagrams
  - Main building floor plan
  - Management action plan ("MAP")

CONTACT US

Sharon Stewart

Vice President
Technology Consulting
SStewart@qhr.com
817-657-8164



Shannon Williams

Vice President
PMO
SWilliams@qhr.com
479-879-7003

THANK YOU

Creating a Sustainable Future for Healthcare Organizations

QUORUM | HEALTH RESOURCES®

Bear Valley IT Assessment

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

February 2017

Sharon Stewart, MSHCAD, FACHE

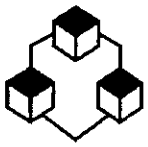
QUORUM | HEALTH RESOURCES®

Creating a Sustainable Future for Healthcare Organizations

AGENDA

- Story at a Glance
- People
- Operations & Infrastructure
- Projects
- Relationships
- Recommendations

STORY AT A GLANCE

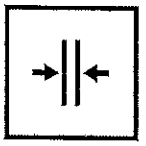


CURRENT STATE

- Major infrastructure upgrades completed
- Technical staffing meets day-to-day needs
- Core application supported by vendor

SUCCESSES

- No disabling security incidents
- Network upgrades in place reducing risk of future failures



GAPS

- Customer frustration with:
  - Scope of support
  - Transparency of request status

PEOPLE

Bear Valley has strong skills on the current IT team and is positioned well to add part-time desktop support and greater support for core applications

- The IT Director has deep knowledge and experience in infrastructure and system management
- The IT team knowledge of cybersecurity threats has prevented any major impacts to operations and safety
- The Clinical Informatics team member is making progress with providers
- Routine calls for user equipment deployment and support delay resolution of complex technical problems
- Three of four IT team members are not tasked or trained to provide user-level support for core CPSI applications

PEOPLE

IT skill development is informal

- Training on new systems and products is accomplished by observing the installation
- When software installations are managed remotely it is difficult for the IT team members to learn what they need to know to support the product effectively

PEOPLE

Bear Valley IT Team alignment is consistent with best practices, while budgeted capacity is somewhat under expected levels

- The IT Director reports to the Chief Financial Officer. This is a typical and appropriate structure
- Three IT team members have solid equipment and engineering skills; one IT team member has clinical application support skills
- The IT labor budget is slightly below expected levels based on percentage of net revenue

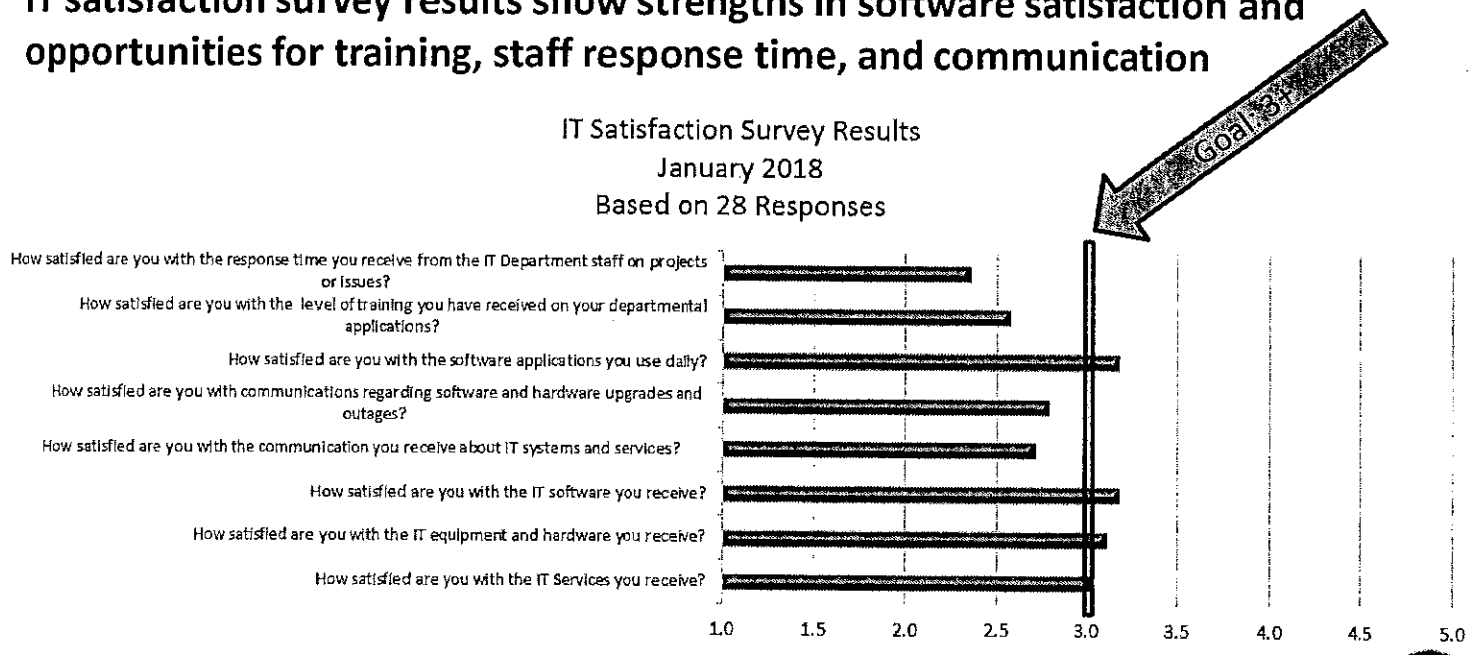
PEOPLE

Bear Valley appropriately used outside resources for technical tasks when specialized skills and extra capacity were needed

- Specialists perform cabling tasks as needed
- Phone system vendors provided assistance with new system implementation
- Evident (CPSI) provides billing and revenue cycle services
- Supplemental vendors have not been identified for:
  - Clinical systems support
  - Revenue cycle and accounting system support
  - Staff training and process improvement using information systems
  - Additional support for computers and printers ("desktop support")
  - [Shannon to provide description of technical engineering skills]

OPERATIONS AND INFRASTRUCTURE

IT satisfaction survey results show strengths in software satisfaction and opportunities for training, staff response time, and communication



OPERATIONS AND INFRASTRUCTURE

The Bear Valley IT team has deployed appropriate infrastructure improvements to protect the organization from future catastrophic events

- The infrastructure review included hardware, servers, network equipment, data closets, telecommunications equipment, and connections to external systems
- The telephone and email failures were unfortunate and inevitable given the organization's limited ability to invest in staff and equipment upgrades in earlier years
- Capital was approved to replace the phone system; the failure occurred before the new system could be installed
- Bear Valley was fortunate to have an experienced IT director on board when these issues occurred. Without his knowledge and skill, recovery may well have been slower and less successful
- A few key infrastructure investments – like badged server room doors and environmental controls – remain to be implemented

OPERATIONS AND INFRASTRUCTURE

Current support processes are informal and lack the data needed to provide transparency to IT customers on the status of requests

- The users contact IT team members directly for assistance
- Issues are addressed based on availability of IT team members and their schedules
- No formal partnership exists with IT customers to provide support for revenue cycle and financial applications
- Cybersecurity has been an area of great success. Additional investments will be required to stay secure and enable functionality needed for the organization to grow

OPERATIONS AND INFRASTRUCTURE: CYBER-SECURITY

Bear Valley has had good success with cyber-security and has opportunities to continue this success with specific improvements

- There is no policy on performing security audits
- At least one legacy system has an un-supported operating system – un-supported systems have vulnerabilities that cannot be patched
- There is no policy on laptop encryption; some laptops are not encrypted
- The Arcserve backup system may not be covered with a Business Associate Agreement
- Backups are not tested as often as they should be

PROJECTS

While major IT projects were completed in 2016 and 2017, most Bear Valley IT customers are unaware of successes and plans for the future that support them

- 32 major projects including circuits, wiring, servers, and desktop hardware were completed during 2016 and 2017 (See supporting documentation)
- The most impactful risk-reducing infrastructure upgrades are complete
- Ten significant infrastructure efforts remain on the books to be funded and scheduled in 2018 and beyond

PROJECTS

Projects that require IT support may not be on the IT plan

- The portfolio of IT projects is managed well but informally
- IT customers do not know where their requests sit on the project schedule
- Capital purchases made by hospital departments that require IT implementation and support work are not always reviewed by IT prior to the purchase. This can delay implementation when IT is unable to staff the installation quickly

RELATIONSHIPS

IT internal relationships would improve with greater transparency; external relationships reflect strong and effective advocacy for the organization

- Creative, affordable solutions have been identified and deployed to meet key business needs (for example: dietary phones)
- IT vendors are regularly taken to task to provide the best solutions at the lowest prices
- The majority of stakeholders interviewed appreciate the support of the IT team and recognize that they have limited capacity to address issues


RECOMMENDATIONS

PEOPLE

- Department structure
  - Continue with existing structure, organization placement, and reporting relationships
  - Current operational oversight is sufficient
  - Hospitals do not typically have board committees for IT
- Application support
  - Identify primary and secondary application support person for each user area, either in IT or operations
  - Assign IT resource for each non-IT person; measure, manage, and report on collaboration of these dyads and team
  - Support team should meet monthly to review reports and set priorities for improvements. Meeting should be agenda driven, with minutes distributed to organizational leadership
  - Insist on collaboration between all IT team members

PEOPLE

- Level 1 Support
  - Identify vendor or locally staff part-time help for desktop and password reset calls
  - Focus internal IT staff on critical projects
- On-call coverage
  - Post on-call schedules on intranet
  - Use documentation, team meetings, and cross-training to improve ability to resolve issues when first call is not to the "expert" or when the "expert" is unavailable

PEOPLE

- Implement formal development plans for each staff member
- Use training methods best suited to each learner
  - Classroom
  - Hands-on
  - Technical mentor (inside or outside the organization)
  - Self study

PEOPLE

- Identify and vet vendors for supplemental staffing for projects and surges in demand
  - Clinical systems support
  - Revenue cycle and accounting system support
  - Staff training and process improvement using information systems
  - "Desktop Support" for computers and printers
  - Level three network engineering and design
- Begin with an inventory of required skills
- On-demand staffing vendors should be scheduled and managed by IT to ensure compliance with policies, procedures, and schedules

OPERATIONS AND INFRASTRUCTURE

- Implement a help desk ticketing system to provide:
  - Data for process improvement
  - Data for budgeting
  - Data for skill-mix management
  - Transparency to customers by reporting:
    - Volume of requests
    - Responsiveness of support team
    - Number of requests resolved with one call ("first-call resolution rate")

OPERATIONS AND INFRASTRUCTURE: CYBER-SECURITY

- Maintain current success on protecting the organization by performing:
  - Formal risk assessment update each year
  - Risk assessment updates when equipment and systems are added
  - Outside risk assessment every three years
  - Vulnerability scan every quarter
  - Network penetration test at least every year and upon significant changes

OPERATIONS AND INFRASTRUCTURE: CYBER-SECURITY

- Implement a policy to perform a security audit every three months
  - QHR suggests you review three to five user accounts to ensure they have the appropriate security access; document users reviewed, findings, and provide a date stamp showing the status and if they have been corrected
- Add legacy system with un-supported operating system to risk assessment with highest priority for remediation
  - If this cannot be removed from the network, set up mitigation steps to help decrease the risk.
  - Have an annual risk acceptance form signed for this piece of equipment and track that on your annual risk assessment process
- Create a policy to encrypt all laptops, track these on the annual risk assessment
- Require Arcserve to sign a Business Associate Agreement, or find a vendor that will sign a BAA
- Create a procedure on how to perform a routine restore from the backup, including testing
  - Include restoring files from tape and checking their date stamp and file size. Ensure SQL backups are tested in the process, even if it is a dummy SQL Database.

OPERATIONS AND INFRASTRUCTURE – AS BUDGET PERMITS

- Organize tools and remove the unnecessary materials from data closets and server rooms
- Replace fire suppression in the main server room – remove overhead water sprinkler
- Add badge lock to the equipment / storage closet in nursing area
- Provide cooling and temperature control for all data closets
- Remove old, unused cable in the ceilings
- Install conduit for the ceiling cables
- Eliminate technical barriers to use of the AT&T Fiber circuit purchased in a previous year

OPERATIONS AND INFRASTRUCTURE – AS BUDGET PERMITS

- Complete the cabling project to off-campus building
- Perform and document regular UPS tests
- Complete the migration to the Nutanix system
- Organize the cabling approach (may require different cable lengths and colors)
- Remove old, unused equipment from the data closets
- Add a remote access strategy to the project list

PROJECTS

- Provide transparency by reporting on IT project:
  - Priorities
  - Schedules
  - Status of ongoing projects
  - Completions / successes
- Post project schedules and statuses on Bear Valley intranet
- Engage IT early in purchase decisions when implementation will require IT work or ongoing support

PROJECTS

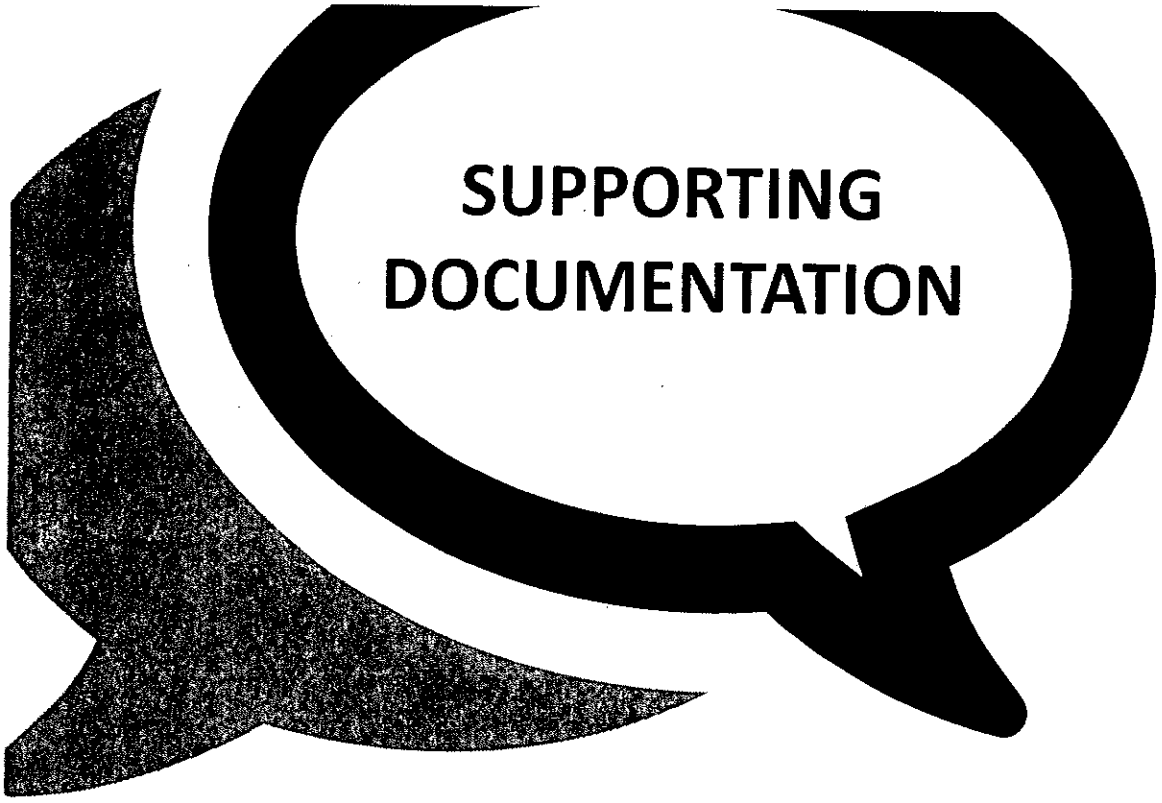
- Create a project to identify and document IT risks and include:
  - Likelihood of occurrence
  - Severity of impact
  - Cost of remediation
- Report Risks and the mitigation strategy for each one to senior leadership each quarter
  - When risk mitigation costs are too high, implement and audit compliance with policies to close the gaps

PROJECTS

- When requestors value faster project completion:
  - Allow the requestor to request access to IT-managed funding for outside assistance
  - Outside assistance must be selected, approved, and managed by IT
  - Budget must include capacity to audit work done by outside providers to ensure compliance with IT Policies & Procedures, particularly for security controls
  - A risk to mitigate: this strategy assumes unlimited IT Management capacity.
    - When volume of work expands more than 50%, add a part-time Project Management resource

RELATIONSHIPS

- Internal
  - Repeat IT satisfaction survey every six months and use focus groups to target top areas for improvement
  - Insist on strong collaboration between IT team members
  - Implement quarterly IT Director rounding on department leaders
- External
  - Utilize CPSI optimization visits
  - Continue to negotiate skillfully and thoroughly with IT vendors
  - Challenge vendors to provide process improvement support at no cost


SUPPORTING
DOCUMENTATION

INTERVIEW LIST

- Sherry Greenaway, Admitting
- Donna Nicely, Board Member
- Fran Montoya, Case management
- John Friel, CEO
- Heidi Markus, Emergency
- Marlon Morgan, Environmental & Security
- Mike Mursick, Facilities
- Patricia Tondorf, Health information
- Courtney Bublitz, Imaging
- Angela Rodriguez, Imaging
- April Early, IT
- Jon Booth, IT
- Randle Weaver, IT
- Tim Hagerman, IT
- Pamela Hargrove-Thomas, Laboratory
- Dr. Knapik, Medical staff
- Kerrie Jex, Nursing
- Sheri Mursick, Outpatient services
- John McKinney, Physical Therapy
- Mary Norman, Risk & Compliance

SUPPORTING DOCUMENTATION

- These items are available in separate files:
  - 2016-2017 project list
  - Organization structure
  - Application list
  - Equipment list
  - Network diagrams
  - Main building floor plan

SUPPORTING DOCUMENTATION

Notes For the Risk Assessment

Periodic Review and Updates to the Risk Assessment

The risk analysis process should be ongoing. In order for an entity to update and document its security measures "as needed," which the Rule requires, it should conduct continuous risk analysis to identify when updates are needed. (45 C.F.R. §§ 164.306(e) and 164.316(b)(2)(iii).) The Security Rule does not specify how frequently to perform risk analysis as part of a comprehensive risk management process. The frequency of performance will vary among covered entities. Some covered entities may perform these processes annually or as needed (e.g., bi-annual or every 3 years) depending on circumstances of their environment. A truly integrated risk analysis and management process is performed as new technologies and business operations are planned, thus reducing the effort required to address risks identified after implementation. For example, if the covered entity has experienced a security incident, has had change in ownership, turnover in key staff or management, is planning to incorporate new technology to make operations more efficient, the potential risk should be analyzed to ensure the e-PHI is reasonably and appropriately protected. If it is determined that existing security measures are not sufficient to protect against the risks associated with the evolving threats or vulnerabilities, a changing business environment, or the introduction of new technology, then the entity must determine if additional security measures are needed. Performing the risk analysis and adjusting risk management processes to address risks in a timely manner will allow the covered entity to reduce the associated risks to reasonable and appropriate levels.[1]

Link: https://www.pcisecuritystandards.org/documents/Penetration_Testing_Guidance_March_2015.pdf

	Vulnerability Scan	Penetration Test
Purpose	Identify, rank, and report vulnerabilities that, if exploited, may result in an intentional or unintentional compromise of a system.	Identify ways to exploit vulnerabilities to circumvent or defeat the security features of system components.
When	At least quarterly or after significant changes.	At least annually and upon significant changes. (Refer to Section 2.6 of this document for information on significant changes.)
How	Typically a variety of automated tools combined with manual verification of identified issues.	A manual process that may include the use of vulnerability scanning or other automated tools, resulting in a comprehensive report.

CONTACT US

Sharon Stewart

Vice President
Technology Consulting
SStewart@qhr.com
817-657-8164

Shannon Williams

Vice President
PMO
SWilliams@qhr.com
479-879-7003

THANK YOU

Creating a Sustainable Future for Healthcare Organizations

QUORUM | HEALTH RESOURCES®

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MEMO

Date: 01 March 2018

To: BVCHD Board

From: Garth M Hamblin, CFO

Subject: Impact Analysis of Conversion to PPS Reimbursement
FYE June 30, 2017

Recommended Action

Receive and Review "Impact Analysis of Conversion to PPS Reimbursement for FYE June 30, 2017".

Background

With the completion of reports and audits for our fiscal year ended June 30, 2017, David Perry, Associate Vice President Healthcare Finance and Reimbursement from Quorum Health Resources, completed the attached "Impact Analysis of Conversion to PPS Reimbursement for FYE June 30, 2017"

Since we were paid as a Critical Access Hospital in fiscal year 2017, the report analyzes the financial impact if we were to have been paid under the Perspective Payment System methodology. Page 6 of the report shows that we would have been paid $1,199,103 less as a PPS hospital than we were paid as a CAH hospital.

Bear Valley Community Hospital

Big Bear Lake, California

Impact Analysis of Conversion to PPS
Reimbursement FYE June 30, 2017

David Perry, Associate Vice President
Healthcare Finance & Reimbursement

QUORUM | HEALTH RESOURCES®

February 2018

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Project Objectives

The enclosed report presents Quorum Health Resource's analysis of the impact on Bear Valley Community Hospital (the "Hospital") if the Hospital were reimbursed for Medicare services under the Prospective Payment System ("PPS") methodology for FYE June 30, 2017.

The purpose of this analysis was to identify the potential impact of converting the Hospital from a Critical Access Hospital ("CAH") to a short term acute care hospital reimbursed under PPS. The analysis does not provide legal advice. Quorum did not audit the financial records. This analysis does not attest to any representations made by the Hospital, its agents, or its representatives.

The impact analysis of converting to PPS consisted of performing a review of the Hospital's cost report for FYE 6/30/16, and estimating the financial impact of converting the Hospital to the PPS reimbursement methodology for Medicare services.

Overview of Recommendation

Based on its analysis of the financial impact of converting to a PPS reimbursement methodology, Quorum recommends that the Hospital maintain its critical access status and that this analysis be prepared each year to ensure that the positive financial impact of CAH status remains.

MEDICARE INPATIENT REIMBURSEMENT IMPACT

As noted in the chart below, the financial impact of converting to the PPS reimbursement methodology for Medicare inpatient services was a reduction in reimbursement totaling approximately $160,000.

Hospital Specific Rate (updated to FY2018)	$9,167.75
Capital Rate (Federal Rate)	$536.93
Sum of Operating and Capital Rates	**$9,704.68**
Case Mix (per FY2014 Cost Report information)	.87
Medicare Reimbursement per discharge under PPS reimbursement	**$8,443.08**
Medicare Discharges for FY2017 Cost Report	64
Annual Reimbursement before Low Volume Adjustment	**$540,357**
Medicare Low Volume Adjustment	$135,089
Medicare PPS Inpatient Reimbursement	**$675,446**
Medicare Critical Access Hospital Reimbursement per the As Filed FY2017 Cost Report	$835,904
Inpatient Gain (Loss)	**($160,458)**

The PPS reimbursement rate is calculated using the sole community hospital specific rate. The Hospital was identified as a sole community hospital in FY2014 and receives the greater of the IPPS federal rate or the hospital specific rate. The FY2016 Inpatient reimbursement was calculated using the updated hospital specific rate.

The Low Volume adjustment represents additional Medicare reimbursement afforded to hospitals with less than 1,600 Medicare discharges. The Hospital's low volume percentage for the FY2014 cost report was 25% and would be the same percentage for FY2017.

The case mix used in the calculation is .87. This is based on the Medicare Provider and Statistical Report ("PSR") that was used to prepare the FY2014 Medicare Cost Report.

MEDICARE OUTPATIENT REIMBURSEMENT IMPACT

As noted in the chart below, the financial impact of converting to the PPS reimbursement methodology for Medicare outpatient services was a reduction in reimbursement totaling approximately $825,000.

	Outpatient Charges (excluding Therapies)	Therapy Charges
Medicare OP Charges	$6,778,034	$280,712
Estimated PPS Reimbursement	19%	15%
	$1,314,939	$42,107
Total PPS Reimbursement	$1,357,045	
CAH Reimbursement	$2,182,921	
Net Gain (Loss) Converting to PPS	**($825,876)**	

The outpatient reimbursement percentages were obtained from cost report information for the PPS Cost Report filed by the Hospital in FY2014.

The following item was not included in the calculations noted above as the data was not readily available. However, it should be noted that the nature of this item would only increase the loss identified.

As a critical access hospital, the Hospital is not subject to the 72-hour rule. This is a provision in the Medicare regulations that requires select Medicare outpatient revenues performed 72 hours prior to the inpatient admission to be included with the inpatient charges. This would reduce the amount of outpatient charges for Medicare patients for which the Hospital would bill. The amount of this "reduction" was not identified.

MEDICARE SWING BED REIMBURSEMENT IMPACT

As noted in the chart below, the financial impact of converting to the PPS reimbursement methodology for Medicare swing bed services was a reduction in reimbursement totaling more than $216,000.

SNF Reimbursement	$464.55
Swing Bed Patient Days	134*
Medicare PPS Reimbursement	$62,250
CAH Reimbursement	$278,280*
Gain (Loss) on Conversion to PPS	**($216,030)**
**Per 2017 Cost Report*	

Under PPS reimbursement, the swing bed services provided by the Hospital would be reimbursed using the RUG PPS methodology. We used the SNF's reimbursement rate from a hospital's SNF reimbursement for FY2016 from a hospital in the area.

Overall Medicare Reimbursement Impact

The financial impact of converting to the PPS reimbursement methodology for Medicare services that are currently paid on a cost basis for critical access hospitals was a reduction in reimbursement totaling approximately $1,200,000. We would not recommend that the Hospital consider converting to PPS at the present time, but do advise that this analysis be prepared annually to ensure that the critical access reimbursement methodology is still beneficial to the Hospital.

Inpatient Impact	($157,197)
Outpatient Impact	($825,876)
Swing Bed Impact	($216,030)
Total Medicare Impact	**($1,199,103)**

QUORUM | HEALTH RESOURCES®

Board Report

March 2018

Revenue Cycle Implementation

Dan Hobbs, QHR Revenue Cycle consultant, was onsite in February. He focused on Registration process improvement, TruBridge performance and evaluation of potential of inhouse billing and collections.

Contractual Allowances and Bad Debt Review

Our Hospital Finance and Reimbursement (HFR) consultants have begun the process to work with Garth to review the allowances in your financial statements for the contractual allowances made for third party reimbursement and bad debt reserves. The purpose of the analysis is to evaluate the accuracy of the Contractual allowances and Bad Debt reserve for all payors.

IT Assessment

Sharon Stewart, QHR IT consultant, has completed her IT Assessment. She will call in to the Board meeting to review the report.

Compensation Plan Development

We have provided examples of other hospitals' grid Compensation Plans for the Bear Valley team to use in developing its new plan.

Upcoming Education Events – March

03/01/18 Outpatient Clinical Documentation Improvement

March 1, 2018 10:30 - 11:30 am CST

03/02/18 Reimbursement & Regulatory Update: ACA

March 2, 2018 2:00 - 3:00 pm CST

03/08/18 Physician Services Webinar

March 8, 2018 10:30 - 11:30 am CST

03/13/18 - 03/15/18 IRS Billing & Collections Requirements 3-Part Series

Three-part webinar series presented March 13, 14, 15, 2018

03/13/18 Board Leadership Series Topic #3

March 13, 2018 12:00 - 1:00 pm CST

03/16/18 Making Your OR the Shop of Choice

March 16, 2018 10:30 - 11:30 am CST

QUORUM | HEALTH RESOURCES®

Other

- Ron Vigus is planning to attend the March Board meeting.

- **2018 Quorum Health Board Essentials Workshop**
  August 8, 2018 – Omni Hotel, Nashville, TN
  August 9-10, 2018 – Omni Hotel, Nashville, TN

Upcoming Projects

- CAH Mock Survey – March 2018
- Cost Report Review – following preparation of Cost Report
- Contractual Analysis and Bad Debt Review – March
- GPO Assessment – to be scheduled

Completed Projects

- Contractual Accounts and Bad Debt Analysis
- Financial Operations Review
- RHC Coding & Compliance Review
- Community Health Needs Assessment
- Chargemaster Review
- Compliance Assessment
- Compliance Implementation
- IT Assessment
- Revenue Cycle Assessment

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CNO Monthly Report

TOPIC	UPDATE	ACTION/FOLLOW UP
1. Regulatory Updates	▪ SNF Life Safety survey completed. 1 deficiency, POC has been submitted to CDPH and accepted. ▪ QHR will be onsite in March to complete a mock CAH Survey & Life Safety Survey ▪ CDPH onsite for visit on the SNF unit.	▪ Informational
2. Budget/Staffing	▪ Overtime, call offs assessed each shift ▪ Flexing of staff as warranted by census ▪ Departments working on budgets and capitol requests. ▪ Budget review meetings will be held with Department Manager, CFO, & Controller starting in April. ▪ Clinical Manager interviews conducted 3/1/18.	▪ Continue to monitor
3. Departmental Reports		
▪ Emergency Department	▪ ED Manager is working with Plant Maintenance on "ED remodel" project scheduled for spring 2018. ▪ Mercy helicopter now stationed at BB Airport . ▪ Clinical Informatics is working on an agreement with T system to update EHR to allow E-Prescribing. This will help with Meaningful Use metrics as well as compliance with new prescription requirements. ▪ Stroke committee has been established to improve standard of care and metrics for Stroke patients that present to the ED.	• Informational
▪ Acute	▪ Swing bed current census=1 ▪ 1 FT RN out on personal LOA ▪ Clinical Informatics is working on implementing E-Prescribing for inpatient unit. ▪ Census has increased due to increased Swing bed placement and admissions through the ED.	▪ Continue to monitor

▪ Skilled Nursing	▪ SNF remains at 5-star rating. ▪ Census is currently at 18 residents. ▪ New bathtub options are being reviewed for replacement tub. ▪ Hoyer lifts are being reviewed for purchase (budgeted expense). ▪ A bariatric bed for a resident is being reviewed for purchase (budgeted expense). ▪ Several SNF residents are scheduled to see the new podiatrist at the FHC. ▪ SNF DON currently on LOA.	▪ Continue to monitor ▪ Informational
▪ Surgical Services	▪ Surgical stats are attached. ▪ Orthopedic procedures are being done by Dr. Pautz one day per week.	▪ Monitor surgical services costs and FTEs
▪ Case Management	▪ DON and Eligibility Worker are working on referrals for SNF residents and Swing patients.. ▪ Case Management and Eligibility Services are working on alternative placement for a resident who needs a higher level of service. ▪ Case Management currently taking a class on Multiple Data Set (MDS) submission for the SNF unit.	▪ Continue to monitor
▪ Respiratory Therapy	▪ Working with Department Lead to revise job description to include management duties as necessary to run the Respiratory Department. ▪	▪ Informational
▪ Physical Therapy	▪ Director of PT attended PT annual PT Conference. ▪ Exterior and Interior painting projects are in process. ▪ PT Staff will be participating and representing BVCHD at the "Supergirl Snow Pro" snowboarding event at Bear Mountain March 17- 18.	▪ Continue to monitor
▪ Food and Nutritional Services	▪ 2 new staff hired and currently being trained. ▪ Meatless Monday program has been implemented (see attached memo from Registered Dietician).	▪ Informational

	▪ New Policy manual has been purchased, all polices will go through the review process upon implementation of the new manual.	
4. Infection Prevention	▪ Hand Hygiene monitoring continues. ▪ Infection Preventionist is rounding weekly to educate staff on hand hygiene and infection issues. ▪ Infection Preventionist is working with EVS to review cleaning logs and competencies. ▪ Infection Preventonist attended SB County Infection Control meeting.	▪ Informational
5. QAPI	▪ Working on Just Culture manager training. 4 training opportunities have been scheduled for managers to attend. The last management training will be held March 28th. Board members have been invited to Just Culture management training. ▪ Just Culture guide team met to discuss and recommend actions for an event on the SNF unit, new form was created and process in place for future event analysis. ▪ BETA HEART gap analysis workgroup met to discuss implementation of recommended actions from the gap analysis. The workgroup will focus on communication delivery and effective communication techniques. ▪ PFAC met 1/29/18, discussed Nurse leader rounding, ED wait room & environmental concerns, coffee with Jeff Schedule, PFAC project opportunities, and the BETA Heart program. ▪ The first "Smoke Free Big Bear" program (6 week smoking cessation course) with CARE grant funding ended. 8 participants graduated from the course, next course to start in April. ▪ SCORE survey will be open March 5-23rd for staff to take. Computers will be set up in the conference room for staff to utilize. Results of the survey will be debriefed in each department after data has been analyzed.	▪ Informational ▪ Continue process for Just Culture/ BETA Heart implementation ▪ Continue quarterly PFAC meetings ▪ Continue CARE grant program and reporting

6. Policy Updates	▪ Policies reviewed weekly by Policy and Procedure committee. ▪ Radiology and Administration policies being reviewed.	▪ Reviewed through P&P Committee
7. Safety/Product	▪ Workplace Violence training is being provided to all BVCHD staff. ▪ Saline shortage continues.	▪ Continue to monitor new regulation and compliance dates
8. Education	▪ BLS Classes scheduled monthly, ACLS & PALS scheduled quarterly ▪ Smoking Cessation classes being held as scheduled. ▪ Nursing skills orientation/ annual review of competency is being held quarterly for all clinical staff. ▪ Relias (online courses) training assigned through HR and department managers.	• Continue to monitor
9. Information Items/Concerns	▪ AttendedCalHIIN Patient and Family Engagement webinar. ▪ Attended CHA EMTALA webinar. ▪ Attended CHA CNO quarterly meeting. ▪ Nurse Leaders have been rounding daily to educate staff on current issues in the district and to encourage feedback on staff that need to be recognized for excellent performance. Staff feedback for this program has been positive.	▪ Informational
Respectfully Submitted by: *Kerri Jex, CNO*	*Date: March 2nd, 2018*	

NUTRITION AND DIETARY SERVICES

- Our staff of the BVCHD Nutrition and Dietary Service Department are excited to partner with Meatless Monday-

Meatless Monday is global movement with a simple message: once a week, cut the meat. Launched in 2003, Meatless Monday is a non-profit initiative of **The Monday Campaigns,** working in collaboration with the Center for a Livable Future (CLF) at the Johns Hopkins Bloomberg School of Public Health. The goal is to reduce meat consumption by 15% for our personal health and the health of the planet. Now entering its second decade, Meatless Monday is embraced in 36 countries, in 12 languages, demonstrating the universal appeal of an idea that is simple to understand and easy to do. In one recent preliminary study of more than 450,000 adults, those who followed a plant-based diet that was 70 percent plants had a 20 percent lower risk of dying from heart disease or stroke than those whose diets centered on meat and dairy. A Harvard study that tracked more than 120,000 people for 30 years found that those who ate the most red meat tended to die younger during the study period but that swapping just one daily serving of beef for nuts could cut the risk of dying early by as much as 19 percent.

Our Team hosted and catered a recent Lunch and Learn with AAUW featuring the nutritional benefit of local seasonal produce sourced within 75 miles of Big Bear Lake (Please see attached flyer)

We welcome two new team members:

Daniel Matheson and Brian McAlister-Floyd.

2018 Surgery Report

Jan-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA	4	Knee Injections
Critel - CRNA	5	LESI
Critel - CRNA	3	Trigger Point Injections
Critel - CRNA	1	Shoulder Injection
Critel - CRNA	1	Trigger Thumb Injection
Pautz - DO	3	ORIF Finger
Pautz - DO	1	ORIF Calcaneus
Pautz - DO	2	ORIF Radius
Pautz - DO	1	Acromioplasty, Rotator Cuff Repair
Pautz - DO	1	A-1 Pulley Release
Tayani	6	Cataracts
Total	28	
Feb-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA	1	B/L Shoulder Injection
Critel - CRNA	1	Trigger Point Injection
Critel - CRNA	1	Hip Injection
Pautz - DO	2	ORIF Scaphoid
Pautz - DO	1	Open Repair TFCC
Pautz - DO	1	Acromioplasty, Rotator Cuff Repair
Pautz - DO	1	Repair of AC Joint
Pautz - DO	1	Repair of Malunion Humerus
Pautz - DO	1	ORIF Radius
Tayani	0	Cataracts
Total	10	
Mar-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA		
Critel - CRNA		
Critel - CRNA		
Pautz - DO		
Pautz - DO		
Pautz - DO		
Pautz - DO		
Pautz - DO		
Tayani		
Total	0	
Apr-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA		
Critel - CRNA		
Critel - CRNA		
Critel - CRNA		
Pautz - DO		
Pautz - DO		

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CHIEF EXECUTIVE OFFICER REPORT
February 2018

CEO Information:
On January 31, 2018, the California Department of Public Health (CDPH) completed the Life Safety Survey. We have completed the Plan of Corrections and submitted it to CDPH and the POC has been accepted. (Attachment)

February 24, 2018 I was invited to speak at the Sugarloaf Home Owners Association Meeting and provided an update on the hospital and the success we have accomplished. This was well received.

The HIM Manager position is continuing to be posted. We are continuing the search to fill this position. We received several applications that are being vetted with the Management Team and the Interim HIM Manager.

There have been several employee meetings scheduled to inform staff of the recent change of the OPEIU being dissolved. Erin Wilson, Garth Hamblin and I are attending the meetings.

The new bathrooms have been fixed and are fully functioning.

I have been in contact with CA Architects and Moon & Mayors to schedule tours of facilities. At this time, we are in the process of working with Dignity Health to tour their facility in San Martin, CA. Staff; CEO, CNO & Plant/Maintenance Manager will be attending the tours. Any board members that would also like to participate will be kept apprised of the dates and times.

Marketing:
We are continuing to work with Mercy Air and BB Lake Fire Department to continue to promote the partnership with Mercy Air.

We will have booths at the Community Church for the Annual Easter Egg Hunt on March 24.

Employee Activities:
The District participated in the 7th Annual Polar Plunge on March 3rd at the Veterans Park. Several employees volunteered and there were approximately fifteen employees were braved the cold weather and plunged into the water.

Town Hall Meetings are being scheduled for April and May 2018.

Attachment (s):
QHR Board Minutes.
Patient thank you letter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING _____ B. WING _____	01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 31201 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 18	E000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Director of Nursing

(X6) DATE

Electronically Signed

02/13/2018

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING 02 - MAIN BUILDING 01 B. WING _____	01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 6/26/1991 K7 SURVEY UNDER: 2012 Existing STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V(111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care Facilities. Census = 18	K000		
K753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.	K753	As of 1/31/18, Bear Valley Community Healthcare District (BVCHD) Distinct Part SNF is in full compliance with tag 0753. The shower curtain observed during the survey as well as the hardware supporting the curtain were removed on 1/31/18 immediately following the exit interview. BVCHD DP SNF will be utilizing the existing door to the shower room to protect resident privacy instead of a shower curtain.	1/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/13/2018

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING 02 - MAIN BUILDING 01 B. WING _____	01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K753	Continued From page 1 o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their facility free of combustible decorations. This was evidenced by a curtain hanging fabric served as decoration that was not flame retardant. This could lead to an increased spread of fire and affected one of two smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.7.5.6 Combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not	K753		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING 02 - MAIN BUILDING 01 B. WING _____	01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K753	Continued From page 2 interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms, having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. Findings: During a tour of the facility and interview with the Director of Facilities on 1/31/18, the combustible decorations in the facility were observed. At 11:32 a.m., there was a shower curtain hanging in the corridor in front of the shower room door by Room 30. There was no tag found. When interviewed, the Director of Facilities stated that he was not sure if the shower curtain had been treated with flame retardant.	K753		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quorum Board Minutes

Addressing Changes in the Healthcare Landscape

Improving Patient Experience with Technology

February 2018

Amazon, Berkshire Hathaway and JPMorgan Chase recently announced plans to form an independent health care company for their U.S. employees. And while the details around how these efforts will impact the health care industry; a likely outcome is a continued emphasis on investing in and designing technology solutions to meet consumer demands.

This initiative is one of several non-traditional players entering the market. CVS's recent health deal to buy Aetna and Apple wanting consumers to store health records on their phones are just two examples of changes underway. Amazon founder and CEO Jeff Bezos said in a press release, "Hard as it might be, reducing healthcare's burden on the economy while improving outcomes for employees and their families would be worth the effort." Shannon Williams, vice president of project management for Quorum Health Resources explained, "If this internal solution increases quality, decreases costs and enhances the health of its employees, you can bet Medicare and Medicaid will be watching. Further, if the product expands outside of these companies, the initiative may impact the way the healthcare market is reimbursed for commercial insurance customers."

Hospitals can implement consumer-focused technology solutions to improve patient care and health while reducing cost from the most basic infrastructure to various points of care. Here are few ideas to leverage today's digital era and emphasis on technology:

1. Invest in Personal Health Record (PHR) software. If a hospital attested for Meaningful Use, it is already required to utilize PHRs. Before patients leave, registration staff should help patients get their accounts setup before they leave the office. Most PHRs allow consumers to access from a mobile phone as well.
2. Create education that is accessible online or through a mobile application. Today's consumers are known to research symptoms and self-diagnosis before calling their physician. Offering consumer education provides easy-to-access resources they need.

(Continued)

3. Launch an innovation team to routinely brainstorm how the hospital can increase consumer-facing offerings. Collaborate with nurses and staff who interact with consumers often. Listen to their needs and design a solution that meets those needs.

4. Implement innovative technology elements into your IT Strategic Plan. Such projects should also align with the latest requirements from payors.

5. Review your Electronic Health Record (EHR) solution to design an interface plan between systems, and other providers, which incorporates clinical data from disparate systems. This will ensure the right information is available to consumers through the PHR system.

All of these factors further emphasize the importance of investing in system integration and consumer-focused technology. As consumer technology companies continue to enter into the health care market, hospitals should continue to focus on technology that enhances the consumer experience. To discuss your IT Strategic Plan, EHR solution or how your hospital can enhance the consumer experience through technology capabilities, please reach out to your regional vice president.

Heard in the News

Read more about this topic here:

New York Times

Harvard Business Review

NPR

VOX

Clyde E. Weinman

424 Belmont Drive
Big Bear City, California 923124
Cellular: 909.671.9430
Email mcweinman3649@gmail.com

Bear Valley Community Health District
Bear Valley Community Hospital
Mr. John Friel, Chief Executive Officer
41870 Garstin Drive
Big Bear Lake, California 92315

February 22, 2018

Re: Emergency Medical Aid for Clyde E. Weinman

Dear Mr. Friel,

This past week I had an emergency that warranted emergency medical treatment and was taken by ambulance to your "emergency room." From the moment I arrived I was received by a very energetic staff diligently working in my best interests, with my health being their primary concern. I was attended to almost immediately and every staff member was caring, concerned and compassionate in their treatment.

I would like to especially thank Michelle Valenzuela, LVN the nurse that was assigned to monitor my care. Her compassion and caring attitude that she exhibited during my ten hour staff was never ending. She catered to all my needs in an utmost professional manner and made me feel not only comfortable but continued to reassure me that I was receiving top quality medical attention. Her comforting words and prompt action brought an early resolve to a potentially devastating outcome. To this I will forever be grateful.

I thank the entire staff in the emergency room that day for their dedication and hard work.

Cordially,

Clyde E. Weinman

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MEMO

Date: February 09, 2018

To: Board of Directors

From: John Friel, CEO

Re: Board of Directors Board Meeting & Committee Meetings

Recommendation:
The Board of Directors approve the Board and Committee Meeting 2018 Calendar as presented.

Background:
BVCHD District Bylaws state that the Board Meeting Calendar is to be approved on an annual basis by the Board of Directors. Administration is providing the Board Meeting Calendar and the Committee Meeting Calendar for approval.

BOARD / COMMITTEE
MEETING DATES 2018

BUSINESS BOARD MEETING/ President - Rob Robbins
Monthly Public Meeting ▼ 2nd Wednesday of the Month ▼ Closed Session at 1:00 pm ▼ Open Session at 3:00 pm

1/10/18	2/14/18	3/14/28/	4/11/18	5/9/18	6/13/18	7/11/18	8/8/18	9/12/18	10/10/18	11/14/18	12/12/18

PLANNING & FACILITIES MEETING/ Chair -Jack Roberts; Vice Chair - Rob Robbins
Monthly Public Meeting ▼ 4th Thursday of the Month ▼ 5:00 pm

1/25/18	2/22/18	3/22/18	4/26/18	5/24/18	6/28/18	7/26/18	8/23/18	9/27/18	10/25/18	11/22/18	12/27/18

FINANCE MEETING / Chair - Donna Nicely: Vice Chair - Peter Boss, MD
Monthly Public Meeting ▼ First Tuesday of the Month ▼ 1:00 pm

1/3/18	2/6/18	3/6/18	4/3/18	5/8/18	6/5/18	7/3/18	8/7/18	9/4/18	10/2/18	11/6/18	12/4/18

HUMAN RESOURCES MEETING/ Chair - Gail McCarthy ; Vice Chair - President Robbins
Bi-Monthly Public Meeting ▼ Last Monday of Every Other Month ▼ 12:00 pm

1/29/18	3/26/18	5/28/18	7/30/18	9/24/18	11/26/18

* Indicates change in scheduling

Updated 3/5/2018 - SUBJECT TO CHANGE

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

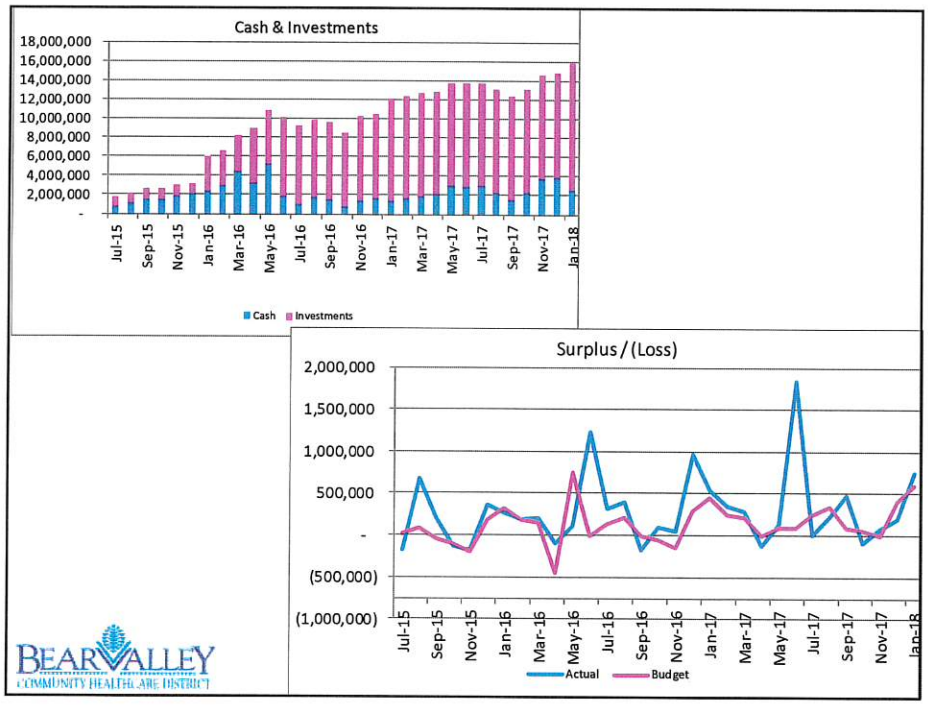
Finance Report

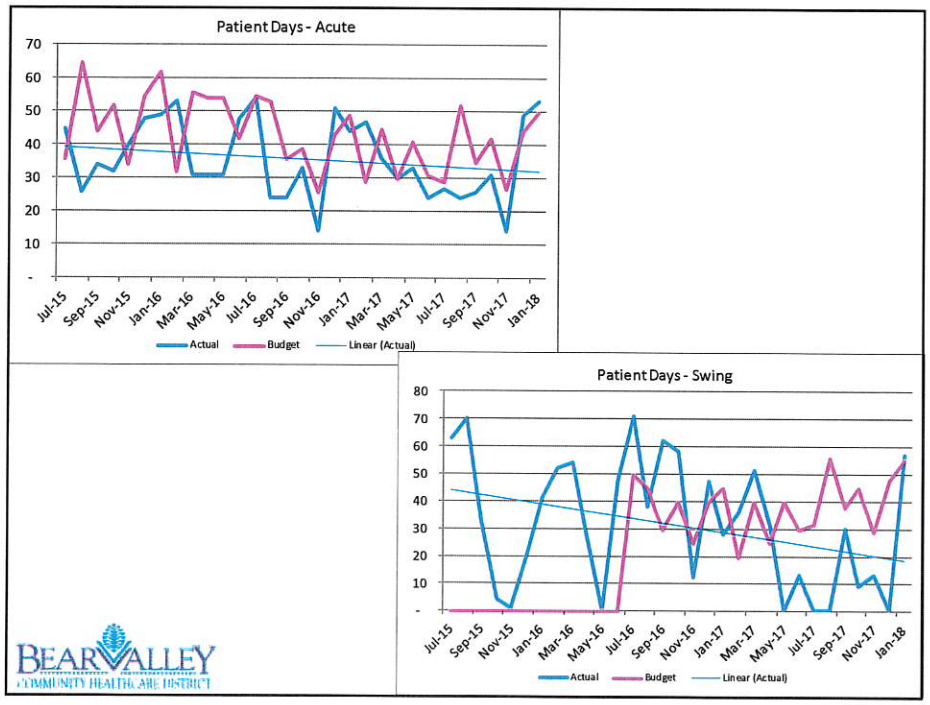
January 2018 Results

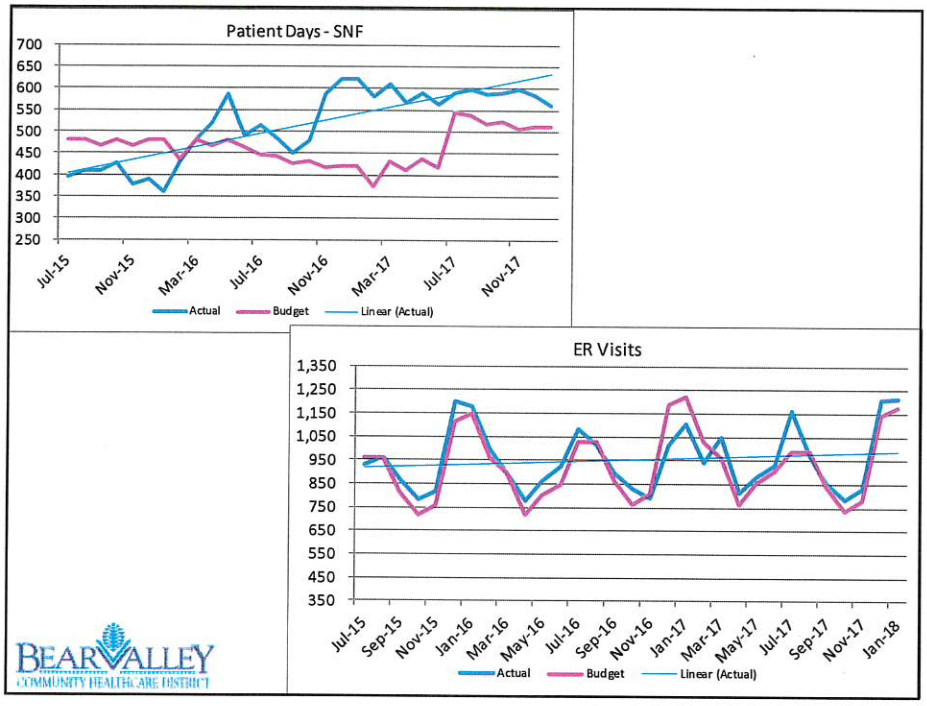
Summary for January 2018

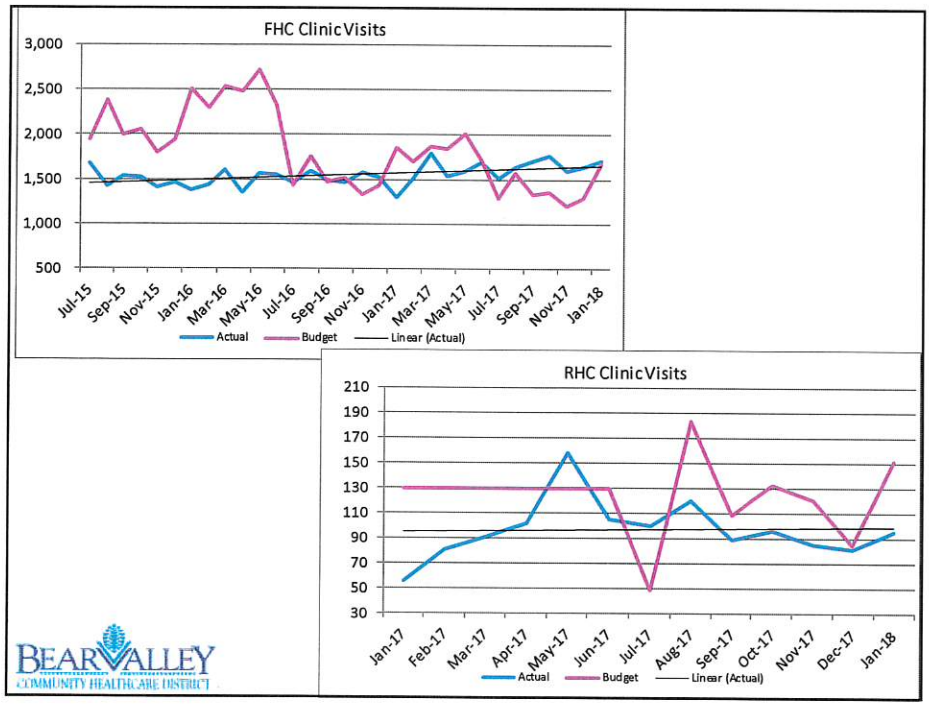
- Cash on Hand - $2,490,708
  Investments - $13,452,520
- Days Cash on hand, including investments with LAIF – 254
- Surplus of $739,240 for the month compared to budgeted surplus of $608,402.
- Total Patient Revenue over Budget by 3.4% for the month
- Net Revenue was 7.4% higher than budget.
- Total Expenses 1.8% more than budget

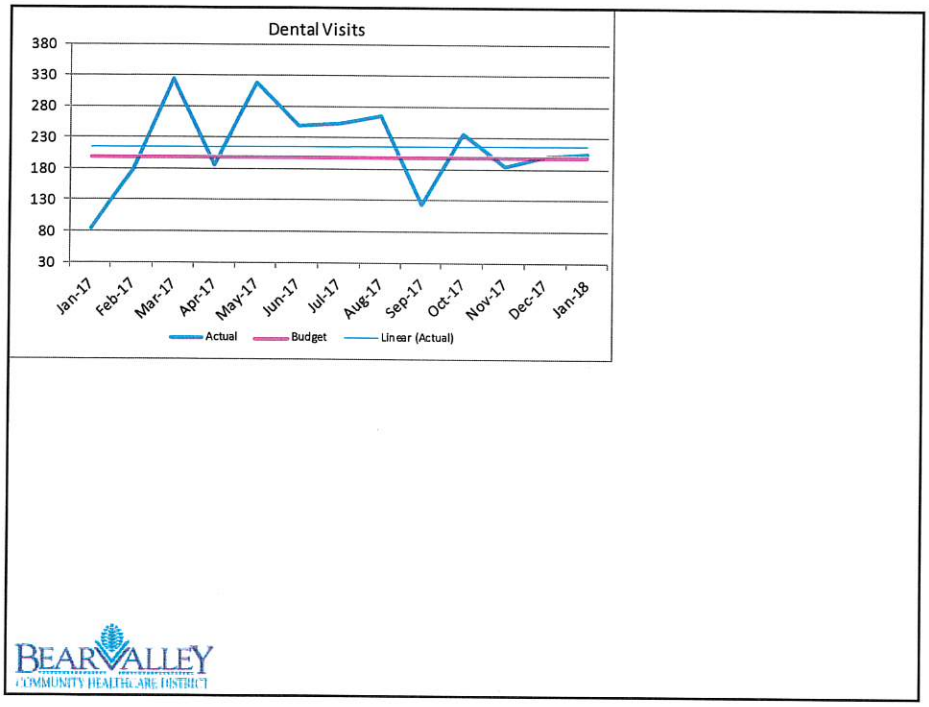
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

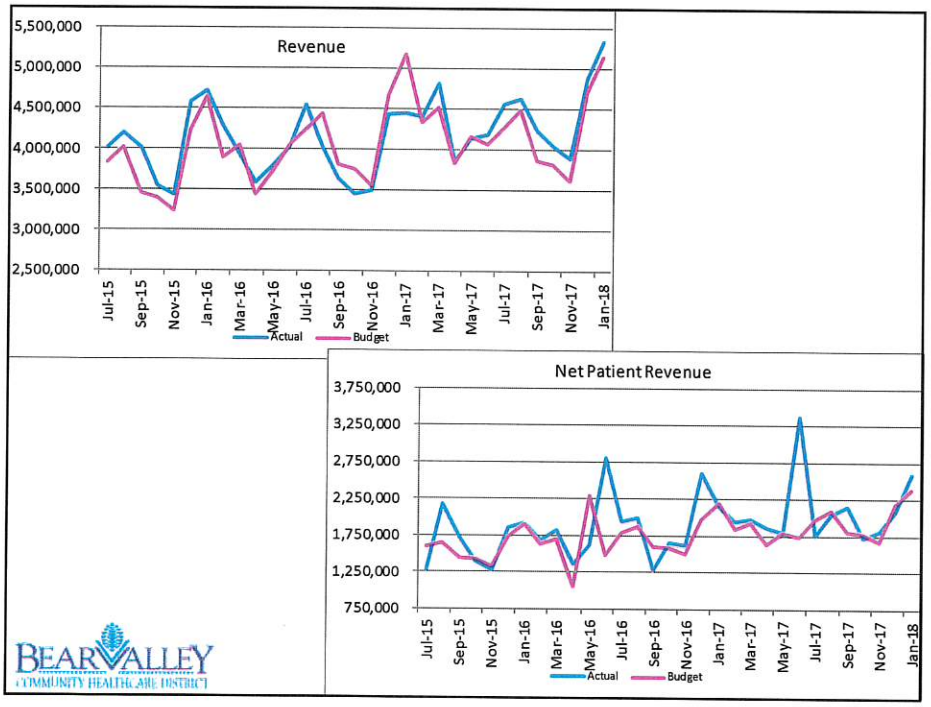

Cash & Investments
18,000,000
16,000,000
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
-
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Cash
Investments
Surplus / (Loss)
2,000,000
1,500,000
1,000,000
500,000
-
(500,000)
(1,000,000)
Actual
Budget
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

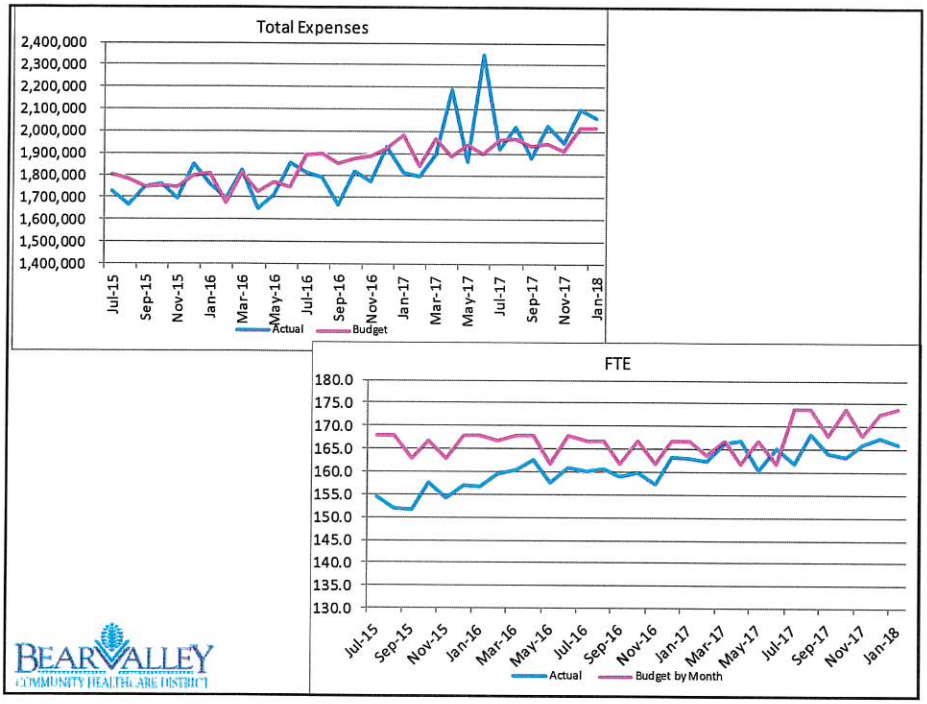

Patient Days - Acute
70
60
50
40
30
20
10
-
Actual
Budget
Linear (Actual)
Patient Days - Swing
80
70
60
50
40
30
20
10
-
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

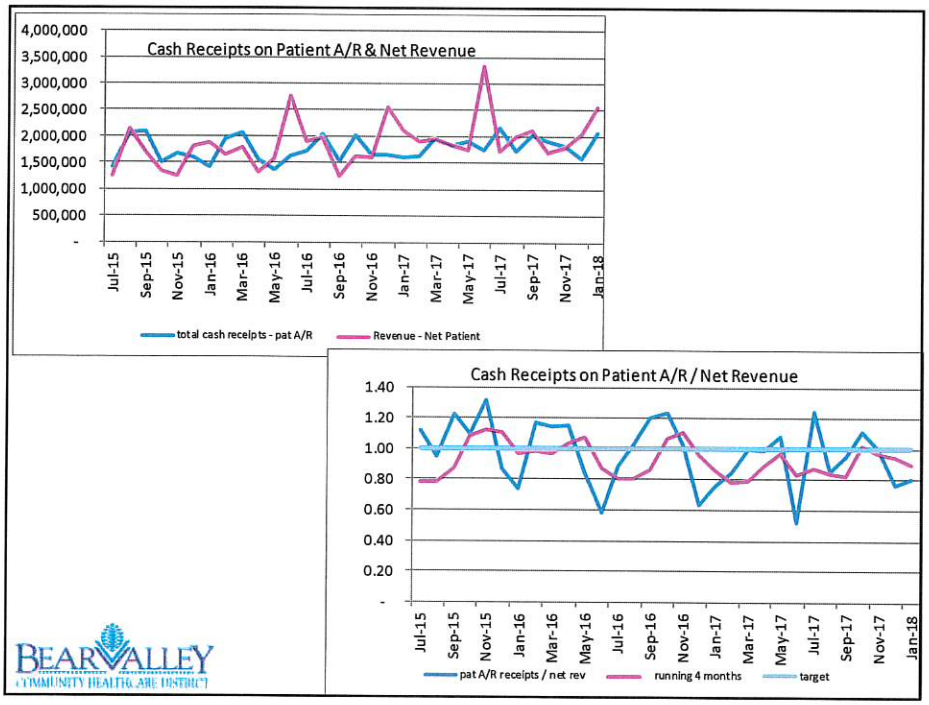

Patient Days - SNF
700
650
600
550
500
450
400
350
300
250
Jul-15
Nov-15
Mar-16
Jul-16
Nov-16
Mar-17
Jul-17
Nov-17
Actual
Budget
Linear (Actual)
ER Visits
1,350
1,250
1,150
1,050
950
850
750
650
550
450
350
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

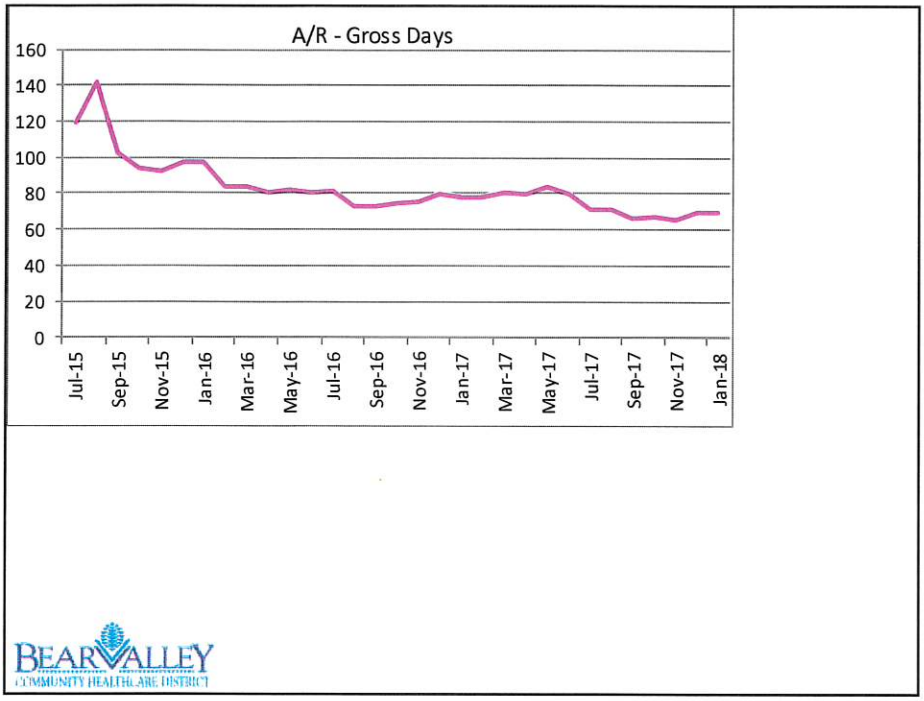

FHC Clinic Visits
3,000
2,500
2,000
1,500
1,000
500
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Actual
Budget
Linear (Actual)
RHC Clinic Visits
210
190
170
150
130
110
90
70
50
30
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Dental Visits
380
330
280
230
180
130
80
30
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Revenue
5,500,000
5,000,000
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Actual
Budget
Net Patient Revenue
3,750,000
3,250,000
2,750,000
2,250,000
1,750,000
1,250,000
750,000
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Actual
Budget
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Total Expenses
2,400,000
2,300,000
2,200,000
2,100,000
2,000,000
1,900,000
1,800,000
1,700,000
1,600,000
1,500,000
1,400,000
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Actual
Budget
FTE
180.0
175.0
170.0
165.0
160.0
155.0
150.0
145.0
140.0
135.0
130.0
Actual
Budget by Month
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
Cash Receipts on Patient A/R & Net Revenue
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
total cash receipts - pat A/R
Revenue - Net Patient
Cash Receipts on Patient A/R / Net Revenue
1.40
1.20
1.00
0.80
0.60
0.40
0.20
-
pat A/R receipts / net rev
running 4 months
target
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


A/R - Gross Days
160
140
120
100
80
60
40
20
0
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

January 2018 Financial Results

For the month . . .

Total Patient Revenue of $5,324,283 for January was 3.4% over budget. Inpatient revenue was 18.6% over budget. Both acute patient days and swing patient days were over budget. Outpatient revenue was 5.5% over budget. Revenue for all clinic departments combined was 44.9% over budget. Emergency room revenue was 1.6% under budget even with ER visits slightly over budget. Skilled nursing facility revenue was within 1% of the budgeted amount.

Deductions from Revenue of $2,753,071 were within 1% of budget.

Total operating Revenue of $2,606,549 was 6.6% over budget.

Total Operating Expenses of $2,058,598 were 1.8% higher than budget.

Our Surplus for the month of January 2018 was $739,240. This was 21.5% higher than budget.

Our Operating Cash and Investments total $15,943,228 as of the end of January 2018. Total days cash on hand are 254.

Key Statistics

Patient days in both acute and swing beds were both over budget for the month. SNF days of 560, and average daily census of 18.06, were over budget. Emergency room visits of 1,209 were 2.7% over budget.

Through the first seven months of our Fiscal Year . . .

Patient revenue is 5.3% over budget, total revenue deductions are 9.1% more than budget, total expenses are 1.3% higher than budget, and our surplus of $1,625,134 is $176,924 lower than budget.

Acute and Swing patient days continue to run significantly lower than budgeted. SNF days are 12% over budget. ER Visits are 5.1% over budget. FTE continue to be under budget.

Bear Valley Community Healthcare District
Financial Statements January 31, 2018

Financial Highlights—Hospital

STATEMENT OF OPERATIONS

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 16/17	FY 17/18		VARIANCE		FY 16/17	FY 17/18		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
1	Total patient revenue	4,455,083	5,324,283	5,151,692	172,591	3.4%	28,060,245	31,540,094	29,964,971	1,575,123	5.3%
2	Total revenue deductions	2,319,996	2,753,071	2,758,045	(4,974)	-0.2%	14,902,821	17,503,763	16,042,254	1,461,509	9.1%
3	% Deductions	52%	52%	54%			53%	55%	54%		
4	Net Patient Revenue	2,135,087	2,571,212	2,393,647	177,565	7.4%	13,157,424	14,036,332	13,922,717	113,615	0.8%
5	% Net to Gross	48%	48%	46%			47%	45%	46%		
6	Other Revenue	20,052	35,338	51,981	(16,643)	-32.0%	184,960	195,987	363,073	(167,086)	-46.0%
7	Total Operating Revenue	2,155,139	2,606,549	2,445,628	160,921	6.6%	13,342,384	14,232,319	14,285,790	(53,471)	-0.4%
8	Total Expenses	1,806,823	2,058,598	2,022,973	35,625	1.8%	12,563,149	13,964,226	13,783,961	180,265	1.3%
9	% Expenses	41%	39%	39%			45%	44%	46%		
10	Surplus (Loss) from Operations	348,316	547,951	422,655	125,296	-29.6%	779,235	268,093	501,829	(233,736)	46.6%
11	% Operating margin	8%	10%	8%			3%	1%	2%		
12	Total Non-operating	182,545	191,288	185,747	5,541	3.0%	1,406,419	1,357,040	1,300,229	56,811	4.4%
13	Surplus/(Loss)	530,861	739,240	608,402	130,838	-21.5%	2,185,654	1,625,134	1,802,058	(176,924)	9.8%
14	% Total margin	12%	14%	12%			8%	5%	6%		

BALANCE SHEET

		A	B	C	D	E
		January	January	December		
		FY 16/17	FY 17/18	FY 17/18	VARIANCE	
					Amount	%
15	Gross Accounts Receivables	10,667,961	10,762,136	9,769,429	992,707	10.2%
16	Net Accounts Receivables	4,010,921	4,194,077	3,660,830	533,247	14.6%
17	% Net AR to Gross AR	38%	39%	37%		
18	Days Gross AR	79	70	70	0	0.1%
19	Cash Collections	1,610,604	2,062,073	1,567,959	494,114	31.5%
21	Investments	10,852,271	13,452,520	10,952,520	2,500,000	22.8%
22	Cash on hand	1,318,907	2,490,708	3,884,817	(1,394,109)	-35.9%
23	Total Cash & Invest	12,171,178	15,943,228	14,837,337	1,105,891	7.5%
24	Days Cash & Invest	213	254	237	17	7.1%
	Total Cash and Investments	12,171,178	15,943,228			
	Increase Current Year vs. Prior Year		3,772,050			

Bear Valley Community Healthcare District
Financial Statements January 31, 2018

Statement of Operations

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 15/16	FY 16/17		VARIANCE		FY 15/16	FY 16/17		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
	Gross Patient Revenue										
1	Inpatient	253,809	368,022	310,242	57,780	18.6%	1,607,063	1,136,117	1,748,905	(612,788)	-35.0%
2	Outpatient	709,709	1,077,117	1,021,007	56,110	5.5%	5,860,751	7,119,057	6,311,391	807,666	12.8%
3	Clinic Revenue	179,676	370,318	255,589	114,729	44.9%	1,282,025	2,487,753	1,546,035	941,718	60.9%
4	Emergency Room	3,031,377	3,260,191	3,314,181	(53,990)	-1.6%	17,628,173	18,972,029	18,623,788	348,241	1.9%
5	Skilled Nursing Facility	280,512	248,635	250,673	(2,038)	-0.8%	1,682,233	1,825,139	1,734,852	90,287	5.2%
6	**Total patient revenue**	**4,455,083**	**5,324,283**	**5,151,692**	**172,591**	**3.4%**	**28,060,245**	**31,540,094**	**29,964,971**	**1,575,123**	**5.3%**
	Revenue Deductions										
7	Contractual Allow	2,011,049	2,429,042	2,524,663	(95,621)	-3.8%	12,396,710	15,339,391	14,684,775	654,616	4.5%
8	Contractual Allow PY	26,000	(3)	-	(3)	#DIV/0!	(21,958)	(30)	-	(30)	#DIV/0!
9	Charity Care	6,876	7,644	11,033	(3,389)	-30.7%	68,591	39,972	64,172	(24,200)	-37.7%
10	Administrative	1,844	1,974	9,667	(7,694)	-79.6%	61,250	299,617	56,230	243,387	432.8%
11	Policy Discount	5,867	13,595	7,874	5,721	72.7%	41,983	75,644	45,802	29,842	65.2%
12	Employee Discount	2,869	6,231	4,284	1,947	45.4%	20,542	36,397	24,919	11,478	46.1%
13	Bad Debts	173,950	201,297	200,524	773	0.4%	1,061,408	828,636	1,166,356	(337,720)	-29.0%
14	Denials	266,959	93,291	-	93,291	#DIV/0!	1,274,295	884,135	-	884,135	#DIV/0!
15	**Total revenue deductions**	**2,319,996**	**2,753,071**	**2,758,045**	**(4,974)**	**-0.2%**	**14,902,821**	**17,503,763**	**16,042,254**	**1,461,509**	**9.1%**
16	**Net Patient Revenue**	**2,135,087**	**2,571,212**	**2,393,647**	**177,565**	**7.4%**	**13,157,424**	**14,036,332**	**13,922,717**	**113,615**	**0.8%**
							-				
	gross revenue including Prior Year	40.2%	40.2%		40.2%		40.2%	447.4%	447.4%	0.0%	
	Contractual Allowances as a percent to gross revenue WO PY and Other CA	39.2%	39.2%		39.2%		39.2%	437.2%	437.2%	0.0%	
17	**Other Revenue**	20,052	35,338	51,981	(16,643)	-32.0%	184,960	195,987	363,073	(167,086)	-46.0%
18	**Total Operating Revenue**	**2,155,139**	**2,606,549**	**2,445,628**	**160,921**	**6.6%**	**13,342,384**	**14,232,319**	**14,285,790**	**(53,471)**	**-0.4%**
	Expenses										
19	Salaries	783,621	849,855	825,362	24,493	3.0%	5,339,660	5,697,972	5,723,794	(25,822)	-0.5%
20	Employee Benefits	284,842	315,442	330,888	(15,446)	-4.7%	2,009,493	2,126,741	2,266,487	(139,746)	-6.2%
21	Registry	-	-	-	-	#DIV/0!	33,285	16,028	-	16,028	#DIV/0!
22	Salaries and Benefits	**1,068,463**	**1,165,297**	**1,156,250**	**9,047**	0.8%	**7,382,438**	**7,840,741**	**7,990,281**	**(149,540)**	-1.9%
23	Professional fees	159,841	173,264	168,392	4,872	2.9%	1,023,632	1,163,446	1,121,974	41,472	3.7%
24	Supplies	111,924	172,497	139,806	32,691	23.4%	855,790	921,749	878,576	43,173	4.9%
25	Utilities	47,547	41,326	48,076	(6,750)	-14.0%	310,906	290,434	321,797	(31,363)	-9.7%
26	Repairs and Maintenance	25,834	32,513	22,668	9,845	43.4%	149,841	206,670	158,470	48,200	30.4%
27	Purchased Services	248,557	308,903	312,447	(3,544)	-1.1%	1,864,301	2,388,600	2,088,100	300,500	14.4%
28	Insurance	25,014	25,912	25,917	(5)	0.0%	175,285	182,140	181,419	721	0.4%
29	Depreciation	50,869	82,710	75,000	7,710	10.3%	329,907	465,907	525,000	(59,093)	-11.3%
30	Rental and Leases	17,329	14,242	16,297	(2,055)	-12.6%	127,384	191,011	114,079	76,932	67.4%
32	Dues and Subscriptions	4,316	2,710	5,046	(2,336)	-46.3%	30,593	34,291	35,320	(1,029)	-2.9%
33	Other Expense.	47,129	39,225	53,074	(13,849)	-26.1%	313,072	279,236	368,945	(89,709)	-24.3%
34	**Total Expenses**	**1,806,823**	**2,058,598**	**2,022,973**	**35,625**	**1.8%**	**12,563,149**	**13,964,226**	**13,783,961**	**180,265**	**1.3%**
35	**Surplus (Loss) from Operations**	**348,316**	**547,951**	**422,655**	**125,296**	**-29.6%**	**779,235**	**268,093**	**501,829**	**(233,736)**	**46.6%**
36	**Non-Operating Income**										
37	Tax Revenue	189,917	186,047	186,047	-	0.0%	1,329,419	1,302,329	1,302,329	-	0.0%
38	Other non-operating	-	12,000	3,283	8,717	265.5%	89,352	42,247	22,981	19,266	83.8%
	Interest Income	496	1,071	4,167	(3,096)	-74.3%	42,952	67,476	29,169	38,307	131.3%
	Interest Expense	(7,868)	(7,830)	(7,750)	(80)	1.0%	(55,304)	(55,012)	(54,250)	(762)	1.4%
39	**Total Non-operating**	**182,545**	**191,288**	**185,747**	**5,541**	**3.0%**	**1,406,419**	**1,357,040**	**1,300,229**	**56,811**	**4.4%**
40	**Surplus/(Loss)**	**530,861**	**739,240**	**608,402**	**130,838**	**-21.5%**	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Bear Valley Community Healthcare District
Financial Statements

Current Year Trending Statement of Operations

A Statement of Operations—CURRENT YEAR 2018

		1	2	3	4	5	6	7	8	9	10	11	12	
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	YTD
	Gross Patient Revenue													
1	Inpatient	95,787	98,514	150,843	142,719	77,702	202,529	368,022						1,136,117
2	Outpatient	868,939	1,205,964	1,063,953	1,047,978	997,359	857,747	1,077,117						7,119,057
3	Clinic	347,893	369,602	339,870	391,164	329,577	339,330	370,318						2,487,753
4	Emergency Room	2,985,253	2,686,263	2,407,574	2,203,306	2,221,976	3,207,446	3,260,191						18,972,029
5	Skilled Nursing Facility	261,793	265,487	262,653	261,572	265,920	259,078	248,635						1,625,139
6	**Total patient revenue**	**4,559,665**	**4,625,850**	**4,224,893**	**4,046,739**	**3,892,534**	**4,866,130**	**5,324,283**	-	-	-	-	-	**31,540,094**
	Revenue Deductions C/A	0.56	0.47	0.47	0.47	0.44	0.53	0.46	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.49
7	Contractual Allow	2,548,409	2,192,333	1,994,911	1,909,156	1,696,412	2,569,127	2,429,042						15,339,391
8	Contractual Allow PY	-	463	1,249	(1,739)	-	-	(3)						(30)
9	Charity Care	7,675	12,842	-	-	9,999	1,812	7,644						39,972
10	Administrative	(746)	114,668	169,442	10,431	2,860	989	1,974						299,617
11	Policy Discount	11,532	11,940	7,202	10,680	10,915	9,781	13,595						75,644
12	Employee Discount	4,711	9,099	3,938	4,084	4,131	4,202	6,231						36,397
13	Bad Debts	(59,348)	69,295	45,428	236,304	205,433	130,228	201,297						828,636
14	Denials	307,852	190,797	(129,516)	169,768	162,874	89,070	93,291						884,135
15	**Total revenue deductions**	**2,820,085**	**2,601,437**	**2,092,654**	**2,338,683**	**2,092,624**	**2,805,209**	**2,753,071**	-	-	-	-	-	**17,503,763**
		0.62	0.56	0.50	0.58	0.54	0.58	0.52	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
16	**Net Patient Revenue**	**1,739,580**	**2,024,413**	**2,132,239**	**1,708,056**	**1,799,911**	**2,060,921**	**2,571,212**	-	-	-	-	-	**14,036,332**
	net / tot pat rev	38.2%	43.8%	50.5%	42.2%	46.2%	42.4%	48.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	44.5%
17	**Other Revenue**	7,162	35,245	20,043	45,312	35,896	16,992	35,338						195,987
18	**Total Operating Revenue**	**1,746,742**	**2,059,658**	**2,152,282**	**1,753,369**	**1,835,807**	**2,077,912**	**2,606,549**	-	-	-	-	-	**14,232,319**
	Expenses													
19	Salaries	800,028	842,003	802,366	798,066	721,536	884,119	849,855						5,697,972
20	Employee Benefits	286,721	318,469	300,954	292,526	296,309	316,321	315,442						2,126,741
21	Registry	12,718	-	-	-	-	3,310	-						16,028
22	Salaries and Benefits	**1,099,467**	**1,160,472**	**1,103,320**	**1,090,592**	**1,017,845**	**1,203,749**	**1,165,297**	-	-	-	-	-	**7,840,741**
23	Professional fees	163,392	159,614	149,941	191,107	168,319	157,808	173,264						1,163,446
24	Supplies	130,715	136,046	101,350	139,091	134,939	107,112	172,497						921,749
25	Utilities	42,342	42,209	43,009	40,689	40,990	39,869	41,326						290,434
26	Repairs and Maintenance	22,461	19,239	35,825	30,007	38,216	28,409	32,513						206,670
27	Purchased Services	302,014	346,148	281,012	373,876	381,162	395,485	308,903						2,388,600
28	Insurance	25,762	25,762	25,762	25,835	25,762	27,345	25,912						182,140
29	Depreciation	48,568	49,162	58,815	61,486	82,456	82,710	82,710						465,907
30	Rental and Leases	46,445	39,979	35,360	23,454	15,317	16,214	14,242						191,011
32	Dues and Subscriptions	5,518	5,427	5,725	5,181	4,523	5,207	2,710						34,291
33	Other Expense.	36,147	35,255	43,441	47,022	39,491	38,655	39,225						279,236
34	**Total Expenses**	**1,922,831**	**2,019,314**	**1,883,559**	**2,028,341**	**1,949,020**	**2,102,562**	**2,058,598**	-	-	-	-	-	**13,964,226**
35	**Surplus (Loss) from Operations**	**(176,089)**	**40,344**	**268,723**	**(274,973)**	**(113,213)**	**(24,650)**	**547,951**	-	-	-	-	-	**268,093**
36	**Non-Operating Income**													
37	Tax Revenue	186,047	186,047	186,047	186,047	186,047	186,047	186,047						1,302,329
38	Other non-operating		10,247	(130)	130	20,000	-	12,000						42,247
	Interest Income	1,906	626	30,375	693	965	31,840	1,071						67,476
	Interest Expense	(7,717)	(7,902)	(8,002)	(7,752)	(7,763)	(8,047)	(7,830)						(55,012)
39	**Total Non-operating**	**180,236**	**189,018**	**208,290**	**179,118**	**199,249**	**209,840**	**191,288**	-	-	-	-	-	**1,357,040**
40	**Surplus/(Loss)**	**4,147**	**229,362**	**477,013**	**(95,854)**	**86,036**	**185,190**	**739,240**	-	-	-	-	-	**1,625,134**

Input Trend Stmt Ops

2017-18 Actual BS

BALANCE SHEET
(Reflects 6/30/17 Y/E audit adjustments)

	July	Aug	Sept	Oct	Nov	Dec	Jan	PY BS June
ASSETS:								
Current Assets								
Cash and Cash Equivalents (Includes CD's)	2,926,360	2,290,992	1,483,027	2,187,881	3,733,239	3,884,817	2,490,708	2,858,405
Gross Patient Accounts Receivable	10,084,033	10,529,969	9,819,853	9,516,577	8,883,930	9,771,838	10,764,545	10,749,524
Less: Reserves for Allowances & Bad Debt	6,481,129	6,632,089	5,818,066	5,954,203	5,590,675	6,111,008	6,570,468	6,824,943
Net Patient Accounts Receivable	3,602,904	3,897,880	4,001,787	3,562,374	3,293,255	3,660,830	4,194,077	3,924,581
Tax Revenue Receivable	2,232,569	2,232,569	2,232,569	2,232,569	1,944,288	970,958	827,168	56,787
Other Receivables	88,537	55,474	750,144	324,224	-1,218,923	-1,160,647	-1,793,802	107,830
Inventories	217,948	220,580	221,025	226,011	222,712	222,388	229,341	212,805
Prepaid Expenses	330,877	339,259	336,340	352,943	342,699	313,470	295,570	192,216
Due From Third Party Payers	0							
Due From Affiliates/Related Organizations	0							
Other Current Assets	0							
Total Current Assets	9,399,195	9,036,754	9,024,893	8,886,002	8,317,270	7,891,816	6,243,062	7,352,624
Assets Whose Use is Limited								
Investments	10,894,184	10,894,184	10,921,640	10,921,640	10,921,640	10,952,520	13,452,520	10,894,184
Other Limited Use Assets	144,375	144,375	144,375	144,375	144,375	144,375	144,375	144,375
Total Limited Use Assets	11,038,559	11,038,559	11,066,015	11,066,015	11,066,015	11,096,895	13,596,895	11,038,559
Property, Plant, and Equipment								
Land and Land Improvements	547,472	570,615	570,615	570,615	570,615	570,615	570,615	547,472
Building and Building Improvements	9,657,088	9,659,388	9,686,383	9,696,603	9,699,157	9,699,804	9,737,717	9,657,088
Equipment	9,625,066	9,694,652	10,189,492	10,232,207	11,486,278	11,504,275	11,516,840	9,614,476
Construction In Progress	1,058,659	1,101,848	753,103	1,356,225	146,485	146,485	146,485	532,158
Capitalized Interest	0							
Gross Property, Plant, and Equipment	20,888,285	21,026,502	21,199,592	21,855,650	21,902,534	21,921,179	21,971,657	20,351,194
Less: Accumulated Depreciation	12,764,979	12,814,141	12,872,956	12,934,442	13,016,899	13,099,608	13,182,318	12,716,411
Net Property, Plant, and Equipment	8,123,306	8,212,362	8,326,636	8,921,208	8,885,636	8,821,571	8,789,339	7,634,783
TOTAL UNRESTRICTED ASSETS	28,561,060	28,287,674	28,417,544	28,873,224	28,268,920	27,810,282	28,629,297	26,025,966
Restricted Assets	0	0	0	0	0	0	0	0
TOTAL ASSETS	28,561,060	28,287,674	28,417,544	28,873,224	28,268,920	27,810,282	28,629,297	26,025,966

2017-18 Actual BS

BALANCE SHEET
(Reflects 6/30/17 Y/E audit adjustments)

	July	Aug	Sept	Oct	Nov	Dec	Jan	PY BS June
LIABILITIES:								
Current Liabilities								
Accounts Payable	1,382,046	985,885	792,559	1,431,694	876,176	956,102	943,576	1,055,031
Notes and Loans Payable								
Accrued Payroll	775,117	846,351	884,291	975,116	996,448	697,894	802,910	684,799
Patient Refunds Payable								
Due to Third Party Payers (Settlements)	709,007	709,470	695,980	695,980	718,109	552,505	718,109	649,537
Advances From Third Party Payers								
Current Portion of Def Rev - Txs,	2,046,518	1,860,471	1,674,424	1,488,377	1,302,330	1,151,283	965,236	-4
Current Portion - LT Debt	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000
Current Portion of AB915								
Other Current Liabilities (Accrued Interest & Accrued Other)	15,243	23,005	30,785	38,407	46,169	7,621	15,350	7,621
Total Current Liabilities	4,962,931	4,460,183	4,113,039	4,664,574	3,974,233	3,400,405	3,480,181	2,431,984
Long Term Debt								
USDA Loan	2,930,000	2,930,000	2,930,000	2,930,000	2,930,000	2,895,000	2,895,000	2,965,000
Leases Payable	0	0	0	0	0	0	0	0
Less: Current Portion Of Long Term Debt	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000
Total Long Term Debt (Net of Current)	2,930,000	2,930,000	2,930,000	2,930,000	2,930,000	2,860,000	2,860,000	2,930,000
Other Long Term Liabilities								
Deferred Revenue	0	0	0	0	0	0	0	0
Other	0	0	0	0	0			
Total Other Long Term Liabilities	0	0	0	0	0	0	0	0
TOTAL LIABILITIES	7,892,931	7,390,183	7,043,039	7,594,574	6,904,233	6,260,405	6,340,181	5,361,984
Fund Balance								
Unrestricted Fund Balance	20,663,982	20,663,983	20,663,982	20,663,982	20,663,982	20,663,982	20,663,982	16,251,126
Temporarily Restricted Fund Balance	0	0				0		
Equity Transfer from FRHG	0	0				0		
Net Revenue/(Expenses)	4,147	233,510	710,523	614,668	700,705	885,895	1,625,134	4,412,856
TOTAL FUND BALANCE	20,668,129	20,897,491	21,374,505	21,278,650	21,364,687	21,549,877	22,289,116	20,663,982
TOTAL LIABILITIES & FUND BALANCE	28,561,060	28,287,674	28,417,544	28,873,224	28,268,920	27,810,282	28,629,297	26,025,966

Units of Service

For the period ending: January 31, 2018

31 215

Bear Valley Community Hospital

Current Month							Year-To-Date					
Jan-18		Jan-17	Actual -Budget		Act.-Act.		Jan-18		Jan-17	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
53	50	44	3	5.3%	20.5%	Med Surg Patient Days	224	279	244	(55)	-19.7%	-8.2%
57	55	28	2	4.3%	103.6%	Swing Patient Days	109	303	316	(194)	-64.0%	-65.5%
560	515	620	45	8.7%	-9.7%	SNF Patient Days	4,101	3,673	3,758	428	11.7%	9.1%
670	**620**	**692**	**50**	**8.1%**	**-3.2%**	**Total Patient Days**	**4,434**	**4,255**	**4,318**	**179**	**4.2%**	**2.7%**
14	15	13	(1)	-6.7%	7.7%	Acute Admissions	89	105	94	(16)	-15.2%	-5.3%
17	15	14	2	13.3%	21.4%	Acute Discharges	92	105	100	(13)	-12.4%	-8.0%
3.1	-	3.1	3.1	#DIV/0!	-0.8%	Acute Average Length of Stay	2.4	-	2.4	2.4	#DIV/0!	-0.2%
1.7	1.6	1.4	0.1	5.3%	20.5%	Acute Average Daily Census	1.0	1	1.1	(0.3)	-19.7%	-8.2%
19.9	18.4	20.9	1.5	8.3%	-4.8%	SNF/Swing Avg Daily Census	19.6	18	18.9	1.1	5.9%	3.3%
21.6	**20.0**	**22.3**	**1.6**	**8.1%**	**-3.2%**	**Total Avg. Daily Census**	**20.6**	**20**	**20.1**	**0.8**	**4.2%**	**2.7%**
48%	**44%**	**50%**	**4%**	**8.1%**	**-3.2%**	**% Occupancy**	**46%**	**44%**	**45%**	**2%**	**4.2%**	**2.7%**
12	15	12	(3)	-20.0%	0.0%	Emergency Room Admitted	78	105	79	(27)	-25.7%	-1.3%
1,197	1,000	1,091	197	19.7%	9.7%	Emergency Room Discharged	6,918	7,000	6,639	(82)	-1.2%	4.2%
1,209	**1,177**	**1,103**	**32**	**2.7%**	**9.6%**	**Emergency Room Total**	**6,996**	**6,655**	**6,718**	**341**	**5.1%**	**4.1%**
39	**38**	**36**	**1**	**2.7%**	**9.6%**	**ER visits per calendar day**	**33**	**31**	**31**	**2**	**5.1%**	**4.1%**
86%	**100%**	**92%**	**33%**	**33.3%**	**-7.1%**	**% Admits from ER**	**88%**	**100%**	**84%**	**59%**	**59.3%**	**4.3%**
-	-	-	-	0.0%	#DIV/0!	Surgical Procedures I/P	2	-	-	2	0.0%	#DIV/0!
14	16	5	(2)	-12.5%	180.0%	Surgical Procedures O/P	96	141	40	(45)	-31.9%	140.0%
14	**16**	**5**	**(2)**	**-12.5%**	**180.0%**	**TOTAL Procedures**	**98**	**141**	**40**	**(43)**	**-30.5%**	**145.0%**
987	**295**	**642**	**692**	**234.6%**	**53.7%**	**Surgical Minutes Total**	**7,258**	**2,047**	**2,047**	**5,211**	**254.6%**	**254.6%**

Units of Service

For the period ending: January 31, 2018

Bear Valley Community Hospital

Current Month							Year-To-Date					
Jan-18		Jan-17	Actual -Budget		Act.-Act.		Jan-18		Jan-17	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
6,539	6,234	5,296	305	4.9%	23.5%	Lab Procedures	43,656	39,923	41,257	3,733	9.4%	5.8%
1,210	1,006	1,084	204	20.3%	11.6%	X-Ray Procedures	5,385	5,199	5,627	186	3.6%	-4.3%
298	360	300	(62)	-17.2%	-0.7%	C.T. Scan Procedures	1,852	1,841	1,812	11	0.6%	2.2%
260	197	157	63	32.0%	65.6%	Ultrasound Procedures	1,605	1,355	1,419	250	18.5%	13.1%
63	50	31	13	26.0%	103.2%	Mammography Procedures	465	350	317	115	32.9%	46.7%
472	269	338	203	75.5%	39.6%	EKG Procedures	2,192	1,781	1,824	411	23.1%	20.2%
257	153	179	104	68.0%	43.6%	Respiratory Procedures	954	705	733	249	35.3%	30.2%
1,365	1,536	1,300	(171)	-11.1%	5.0%	Physical Therapy Procedures	9,579	10,906	12,107	(1,327)	-12.2%	-20.9%
1,803	1,826	1,352	(23)	-1.3%	33.4%	Primary Care Clinic Visits	12,212	10,589	10,456	1,623	15.3%	16.8%
240	200	85	40	20.0%	182.4%	Specialty Clinic Visits	1,500	1,400	85	100	7.1%	1664.7%
2,043	**2,026**	**1,437**	**17**	**0.8%**	**42.2%**	**Clinic**	**13,712**	**11,989**	**10,541**	**1,723**	**14.4%**	**30.1%**
79	**78**	**55**	**1**	**0.8%**	**42.2%**	**Clinic visits per work day**	**75**	**66**	**58**	**9**	**14.4%**	**30.1%**
19.1%	20.00%	16.60%	-0.90%	-4.50%	15.06%	% Medicare Revenue	19.63%	20.00%	20.60%	-0.37%	-1.86%	-4.72%
34.70%	37.00%	35.10%	-2.30%	-6.22%	-1.14%	% Medi-Cal Revenue	39.41%	37.00%	38.33%	2.41%	6.53%	2.83%
40.20%	38.00%	42.10%	2.20%	5.79%	-4.51%	% Insurance Revenue	36.24%	38.00%	36.91%	-1.76%	-4.62%	-1.82%
6.00%	5.00%	6.20%	1.00%	20.00%	-3.23%	% Self-Pay Revenue	4.71%	5.00%	4.16%	-0.29%	-5.71%	13.40%
145.6	155.00	144.0	(9.4)	-6.1%	1.1%	Productive FTE's	144.55	153.57	141.8	(9.0)	-5.9%	1.9%
165.9	174.00	162.8	(8.1)	-4.7%	1.9%	Total FTE's	165.06	172.14	160.3	(7.1)	-4.1%	3.0%

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CFO REPORT for

March 6, 2018, Finance Committee and March 14, 2018, Board meetings

QHR Revenue Cycle Review

Dan Hobbs of QHR was with us on February 20, 21, and 22. Focus of the review was on the three areas outlined -

Patient Access Services, front-end, processes

review of TruBridge performance

consideration of bringing PFS/Billing processes in-house

We are working to follow up with information and clarifications to complete his review and report.

HIM Manager Update

Over the past week and a half we have received a number of applications through Indeed. We have interview 3 by phone and will look to invite 2 to come and meet with us in person.

FY 2019 (July 1, 2018 through June 30, 2019) Budget Preparation Schedule

I have attached the FY 2019 budget preparation plan / schedule.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

FY 2019 (July 1, 2018 through June 30, 2019)
BUDGET PREPARATION CALENDAR

Mar 09, 2018	Capital Budget Requests due to Accounting
Mar 02, 2018	Budget Packets / Details to Managers
Mar 23, 2018	Manager budgets due to Accounting
Apr 06, 2018	Finish input & review of budgets by Accounting
Apr 09 through 13, 2018	meetings with Managers
April 16 through 20, 2018 – Budget Review by Admin Team	
May 01, 2018	Preliminary Budget reviewed with Finance Committee
May 2018	additional review by Finance Committee as needed for final review, recommendation
June 05, 2018	Finance Committee review of Budget for Submission to full Board of Directors for approval
June 13, 2018	Board of Directors approval of FY 2019 Budget including 3 year Capital Budget Plan