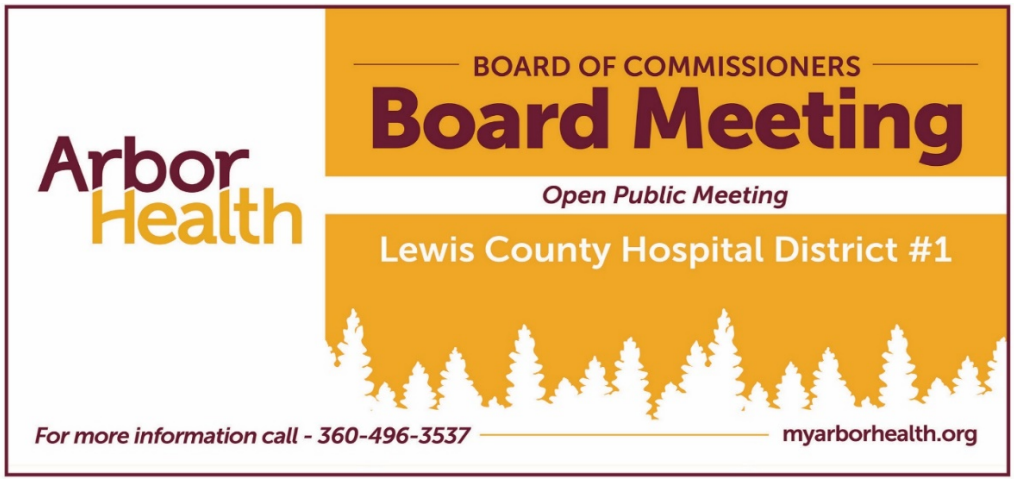
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

Board Chair – Trish Frady, Secretary – Tom Herrin,
Commissioner – Craig Coppock,
Commissioner – Wes McMahan & Commissioner-Chris Schumaker

August 26, 2020 @ 3:30 PM
Join Zoom Meeting: https://myarborhealth.zoom.us/j/94824041361
Meeting ID: 948 2404 1361
One tap mobile: +12532158782,,94824041361#
Dial: +1 253 215 8782

TABLE OF CONTENTS

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
August 26, 2020 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/94824041361
Meeting ID: 948 2404 1361
One tap mobile: +12532158782,,94824041361#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	PAGE	TIME
Call to Order **Approval or Amendment of Agenda** **Conflict of Interest**		3:30 pm
Comments and Remarks • Commissioners • Audience		3:35 pm
Executive Session-*RCW 70.41.205* • Medical Privileging-Janice Holmes		3:40 pm
Break		4:00 pm
Guest Speaker • Parker Smith & Feek o Jim Chesemore, Sr. Vice President & Principal	5	4:05 pm
Department Spotlight • Arbor Health Foundation o *To strategically discuss the foundation's current and future state.*	30	4:45 pm
Board Committee Reports • Hospital Foundation Report-Committee Chair-Commissioner McMahan	36	5:00 pm
• Finance Committee Report-Committee Chair-Commissioner Herrin	40	5:05 pm
Consent Agenda – *(Action items included below)* • [ ] Passed [ ] Denied [ ] Deferred		5:10 pm
• Minutes of the July 29, 2020 Regular Board Meeting *(Action)*	42	
• Minutes of the August 10, 2020 Special Board Meeting *(Action)*	51	
• Minutes of the August 14, 2020 Special Board Meeting *(Action)*	53	
• Minutes of the August 22, 2020 Finance Committee Meeting *(Action)*	55	
• Warrants & EFT's in the amount of $3,799,135.79 dated July 2020 *(Action)*	58	
• Resolution 20-33-Approving the 2020 Quality Assessment Performance Improvement Plan *(Action)* o *To approve the annual plan.*	60	

• Resolution 20-34-Approving the 2020 Risk Management Plan *(Action)* o *To approve the annual plan.*	95	
• Resolution 20-35-Approving the 2019 Critical Access Hospital Evaluation *(Action)* o *To approve annual evaluation-§485.641(a).*	108	
• Resolution 20-36-Approving the Medicare CMS Payment *(Action)* o *To approve the settlement payment to Medicare for the fiscal year 2019.*	126	
• Approve Documents Pending Board Ratification 8.26.20 *(Action)* o *To provide board oversight for document management in Lucidoc.*	129	
Old Business • OPMA & PRA Training Certificates o *To complete the public officials training-RCW 42.30.205 & 42.56.150.*		5:15 pm
• Post COVID Sustainability of Custodial Program o *To propose discontinuing the custodial care program.*		5:20 pm
New Business • Board Education o Electronic Signatures Process Feedback o Strategic Issues for Boards ▪ *iProtean* o Strategic Planning ▪ *iProtean*	 132 133 143	5:40 pm
• Board Policies & Procedures o *Quality Improvement Oversight Information* o *Records Retention* o *Superintendent Succession Plan*	 151 153 155	5:55 pm
Superintendent Report	165	6:00 pm
Executive Session-*RCW 42.30.110(1)(g)* • To discuss the performance of a public employee.		6:15 pm
Next Board Meeting Dates and Times • Regular Board Meeting-September 30, 2020 @ 3:30 PM (ZOOM) **Next Committee Meeting Dates and Times** • Compliance Committee Meeting-September 16, 2020 @ 12:00 PM (ZOOM) • Finance Committee Meeting-September 23, 2020 @ 12:00 PM (ZOOM) • Quality Improvement Oversight Committee Meeting-September 30, 2020 @ 7:00 AM (ZOOM)		
Adjournment		6:45 pm

ARBOR HEALTH

JIM CHESEMORE – PARKER, SMITH & FEEK, INC.

AGENDA

Discuss Medical Malpractice insurance market history and current conditions

Overview of Employment Practices Liability rural hospital current issues

Overview of your Directors and Officers Liability policy

History of Medical Practice Market

Competition among insurance carriers is critical to premium stability. If there is no competition, premiums will rise at a far greater pace than losses – as insurance company actuaries always forecast greater losses than typically occur.

The **hard** and **soft** insurance market cycles are a story of both increasing claims and loss of competition.

History of Medical Practice Market

In the late 1970s and early 1980s, the US insurance market went through a **medical malpractice insurance crisis**. Policy premiums weren't high enough to keep up with skyrocketing claims payouts, and many insurance carriers went under (bankrupt) or left the market segment. After recovering from that crisis (and another smaller one in the 1990s), the market has remained relatively stable, with periods known as a "soft market" – where premium rates decrease – or a "hard market" – where rates increase. But nothing as dramatic to this point – as was seen in the 1970s and 1980s

What did healthcare entities do then? What specifically initiated the crises?

History of Medical Practice Market

Combined Loss Ratio:

During the 70's and early 80s crises – insurance companies suffered combined loss ratios year-over-year of over 110%. What does that mean?

For every $1 of premium collected - insurance companies lose 10 cents.

1986 Risk Retention Act was passed by the Federal Government

History of Medical Practice Market

What did the 1986 Risk Retention Act do for healthcare entities?

For many hospitals and providers, obtaining medical malpractice during this period was either impossible (they went with NO insurance) or they paid very high prices. During the 99th Congress, the Committee on Commerce, Science, and Transportation conducted numerous hearings to examine the availability and cost of liability insurance. As a result, the United States Congress revised the Products Liability Risk Retention Act of 1981 through the Risk Retention Amendments of 1986. The final Act, which was signed into law by President Reagan on October 27, 1986, is known as the Liability Risk Retention Act of 1986. **This act allowed for the creation of new insurance programs – most notably for Med Mal**

History of Medical Practice Market

For Arbor Health and for Washington State – this 1986 Risk Retention Act helped create the Washington Hospital Insurance Fund – which eventually became the Washington Casualty Company.

Arbor Health (and most rural public district hospitals in Washington State) had no other choice but to join the Washington Hospital Insurance Fund/ Washington Casualty to obtain Medical Malpractice Insurance. You can still see the retroactive dates of these rural hospital policies show 1986!

History of Medical Practice Market

What else did the 1986 Risk Retention Act do for Arbor Health?

In 2015 the WRHC decided to form what is called a **Risk Purchasing Group**. RPG's were created into law with the 1986 Risk Retention Act and allow for "common" type entities (but with no ownership ties) to come together to purchase insurance as a group TO LEVERAGE premium volume with prospective insurance carriers – that individual rural hospitals cannot on their own. **This helped WRHC members save $516,000 in combined premium in 2015**.

History of Medical Practice Market

In California, a Tort Reform CAP State, two of their largest medical malpractice insurance companies – BETA and CHI – started in 1986 as a result of the 1986 Risk Retention Act. Both companies are Risk Retention Group's and are by far the largest writers of rural hospital medical malpractice in California today.

PS&F brought both of these insurance companies to Oregon, Alaska, and Washington in 2015 to help foster greater competition in the Northwest.

History of Medical Practice Market

By the 1990s – the Medical Malpractice insurance market had settled down and the industry saw over 30 new insurance companies jump into the market. This allowed for greater competition – which meant improved premiums for rural hospitals. Many states enacted Tort Reform/CAPS as well – helping to curb large claims for insurance companies. Colorado, Wyoming, and California had very good Tort Reform for medical malpractice – Washington State never enacted any Tort reform legislation.

By 2000 – Washington Casualty Company had 91% market share of the rural hospitals in Washington State. However, with no Tort Reform, Washington Casualty's combined ratios climbed to over 135% by 2000. Yikes!

And then 911 happened……

History of Medical Practice Market

Nationally, not enough states passed Tort Reform legislation and many of those insurance companies who were writing Medical Malpractice also saw their combined loss ratios escalate – many well above 110%!

After 911 many of the reinsurance (I will explain reinsurance) insurance companies who supported these medical malpractice insurance companies – pulled back and/or raised premiums dramatically. St. Paul Insurance company, who had nearly 30% of the US market share for medical malpractice exited the business.

The Washington State OIC declared Washington Casualty bankrupt and took over the company to tried rehabilitation. WCC sold to another insurance carrier.

History of Medical Practice Market

Arbor Health (and most other rural hospitals) stayed with Washington Casualty Company through their receivership and after their sale to a National Insurance Company – Coverys. Arbor Health and many other rural hospitals saw their premiums increase during this period.

Since 2010, however, the Medical Malpractice market in Washington State improved and new insurance carriers entered the market place. Competition among insurance carriers intensified and premiums stabilized. Arbor enjoyed a nice premium reduction in 2015 by moving into a WRHC Group Insurance program with Physicians Insurance and has seen stable premiums through it's current 2020 renewal.

What is happening today?

Since 2015 – the national medical malpractice market has begun to worsen once again. Claims frequency and severity is deteriorating rapidly. A recent analysis found the average cost of a medical malpractice claim in the U.S. has risen by 50% since 2009. What's more, payouts of above $5 million have increased sharply since just 2015.

The medical malpractice insurance market is also being impacted by changes within the healthcare industry itself. In its March 2019 review of the segment, A.M. Best noted the consolidation of physician groups, growing presence of private equity and hospital employment of physicians are shrinking the premium base for medical malpractice.

2019

Today, after more than a decade of soft-market pricing, there are indicators that the medical malpractice segment is quickly transitioning back to a hard market. According to the Medical Liability Monitor Annual Rate Survey, more than 25% of medical malpractice insurance premium rates increased in 2019 – the first time that's happened since 2001. Arbor Health's move into a Group Insurance program helped stave off premium increases for now. Progressive thinking on the WRHC's part!

Chubb/ACE announced in late 2019 that it would no longer write medical malpractice in certain "tough" jurisdictions. Three of those were in Washington State. King County, Pierce County, and Snohomish County.

2019

In Washington State, medical malpractice insurance companies saw large claims/settlements soar – with four claims settling for over $30M! One of those was a claim at a rural hospital in Jefferson County.

Coverys posted a 113% combined ratio in 2019 in Washington State

Physicians Insurance posted a 109% combined ratio in 2019 in Washington State

And then…….

2020

In early 2020, NORCAL – one of the top medical malpractice insurance companies announced they were selling the company due to deteriorating combined loss ratios. NORCAL posted a 5 year combined loss ratio of over 140%.

In July – Zurich announced that after 30 years of writing medical malpractice in the US – they were exiting the business and canceling all policies. Combined ratio for the past 5 years was over 127%.

In August – QBE announced they were exiting the US medical malpractice segment. QBE did not disclose their combined ratio.

FUTURE

White it is impossible to know what 2021 means for medical malpractice rates for Arbor Health – certainly we believe there will be pressure by all medical malpractice insurance companies to raise rates. Arbor Health's peers (not in the WRHC Group Program) did see premium increases in 2019 and 2020.

What can the WRHC members do?

.Continue working to improve risk management practices and lower incidents

.Look at possible small deductibles or SIR's to assume some risk but keep premiums in check

Employment Practices Liability Issues

If rising medical malpractices liability claims was not enough for rural hospitals, there has been a huge spike in the number of EPL incidents and a huge increase in settlements/jury awards.

Why?

Employment Practices Liability Issues

As we move into 2020, headlines continue to dominate the employee-related insurance marketplace. While the trend of allegations from #MeToo, the movement focused on sexual harassment in the workplace, and #timesup, the movement focused on equality in the workplace, are keeping pace with 2019, we are seeing headlines highlighting new legislation and rules passed by more than 20 state governments. These new laws protect alleged victims and invigorate more plaintiff-friendly judges and juries, leading to a continued trend of increased defense costs, settlements and judgements, and the promise of more to come as plaintiffs' firms test out new laws and rules.

Employment Practices Liability Issues

Top Employment Practices Liability (EPL) insurers such as AIG, Chubb, CNA and Travelers are seeing claims frequency and severity continue to trend upward, putting upward pressure on premiums and retentions for EPL in 2020. Overall, we anticipate that most insureds will experience rate pressure in the range of 5–15% in addition to premium increase in response to increases in employee count, the number-one exposure for EPL premium rating.

Physicians Insurance, the insurance for the WRHC EPL Group Program – saw three EPL settlements in excess of $1.5M!

Employment Practices Liability Issues

What else is happening?

Insurance Companies who once would take an EPL matter to trial and had found success with juries – are now hesitant to take nearly any EPL case to court. This is pressuring settlement amounts and insurance companies have lost leverage.

D&O Policy Basics

Reminder:

For Arbor Health – due to prior D and O claims/incidents – Physicians Insurance was the only insurance company who would write the Board's exposure back in 2016.

D&O Policy Basics

Remember that other insurance policies such as the general liability, automobile liability, and errors and omissions all include directors and officers under the definition of who is an insured. **Why then is a D&O policy necessary?**

- Emerging risks not covered in your standard insurance policies
- Regulatory exposures (state and federal)
- Bankruptcy
- Mergers and acquisitions (allegations against the board do not trigger standard insurance policies)
- Shareholder/policy holder lawsuits (derivative or other)
- Indemnification not allowed under the company's corporate bylaws

D&O Policy Basics

The traditional D&O insurance policies have three insuring agreements, denominated Side A, Side B, and Side C.

- The Side A coverage provides insurance when the insured organization is unable due to insolvency or legal prohibition to indemnify the company's directors and officers (for example, in bankruptcy or in a shareholders' derivative lawsuit – or a matter denied in the corporate bylaws). **NO deductible applies to this section. Why?**

- The Side B coverage provides reimbursement to the corporation when it is indemnifying its directors and officers. Almost all D&O lawsuits trigger this section of the policy first because the company can and does indemnify and defend the D&Os. **Nearly all policies have a retention on this policy section. Why?**

- The Side C coverage protects the insured organization itself (the "entity") for its own separate legal liabilities. In public company D&O insurance policies, the Side C entity coverage is limited to corporate liabilities under the securities laws. **Nearly all policies have a retention on this policy section. Why?**

Thank You

Q&A

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

MEMORANDUM

To: Board of Commissioners

From: Leianne Everett, Superintendent/CEO

CC:

Date: August 12, 2020

Re: Strategic Department Spotlight – Arbor Health Foundation

The Arbor Health Foundation has existed since 1994 with the sole purpose of supporting our hospital district. The Foundation raises funds for the purpose through a multitude of avenues, such as auctions, donations and bequeathments. The accompanying Income Statements demonstrate a positive net income for 2018 and 2019.

Our Gift Shop is another source of income for our Foundation. Throughout the calendar year, the revenues and expenses are recorded on the Hospital District's general ledger. In the first quarter of the following calendar year, the Gift Shop's net profit is calculated and distributed to the Foundation's general fund. The 2018 and 2019 Gift Shop Income Statements are provided to demonstrate the Gift Shop's profitability; however, the degree of profitability is variable from one year to the next.

Since our Foundation exists only to support the hospital district, that support has come to Arbor Health in many forms. Below is a list of contributions the Foundation as made:

- Equipment and Event Donations from 2013-2019 -- $180,703
- Scholarships to Employees from 2013-2019 -- $100,192
- Employee Appreciation Grocery Gift Cards -- $26,200
- Long-Term Care Activities Funding -- $16,000
- Miscellaneous Community Contributions -- $3,700

The interdependence between Arbor Health and Arbor Health Foundation exemplifies our core value of "one team, one mission."

Arbor Health | FOUNDATION

521 Adams Avenue, Morton, WA 98356 | 360-496-3610
Mailing Address: P.O. Box 1132, Morton, WA 98356

"We celebrate our past contributions to Arbor Health—and we strive to do even more."

Last Seven Year's Equipment and Event Expenditures $326,795.00

Pulmonary Diagnostic Equipment	$7,800.00
Lucas 3, automated CPR machine	15,307.00
Bariatric Wheelchairs	3,400.00
Contributed toward Operating Room HVAC	4,410.00
3-Dimensional Mammography Machine	87,000.00
ED Ultra Sound Machine	20,000.00
Vein Viewer for ED	16,014.00
Laboratory Microscope	5,664.00
New Hospital Bed	11,208.00
10 Blood Pressure Cuffs—Randle Clinics	300.00
Two Vital Sign Monitors	7,200.00
Staff Rejuvenation & Self Care Fairs	2,400.00
	$180,703.00

Scholarships, 2013-2019~ $100,192.00

2013	$ 15,159.00
2014	10,606.00
2015	7,604.00
2016	3,800.00
2017	30,017.00
2018	22,053.00
2019	10,953.00
Total	**$100,192.00**

A small sample of the recepients:

Julie Allen, Darian Atkinson, Shyla Barnett, Megan Christensen, Debra Cole, LeeAnn Evans, Katelin Forrest, Laura Glass, Ashley Hancock, Amra Harmansen, Pamela Hays, Colleen Littlejohn, Diane Markham, Ali Pickett, Makaylyn Rhodes, Sara Riley, Colleen Smith, Tory Spears, Faith Thompson and Carey Young.

Continued on side 2

Community Contributions:

Prescription Discharge Fund for patients unable to purchase prescriptions upon discharge	$1,000.00
Ambulance crew refreshments	200.00
Street-side community digital sign	2,500.00
	$3,700.00

Employee Appreciation Christmas Grocery Cards:

2013	$ 3,800.00
2014	4,350.00
2015	3,585.00
2016	3,750.00
2017	3,800.00
2018	3,150.00
2019	3,765.00
Total Dollars Gifted to Employees	**$26,200.00**

Long Term Care Activities Funding Budget

$2,000 budgeted per year for LTC activities/entertainment/travel

2013	$ 2,000.00
2014	2,000.00
2014	2,000.00
2015	2,000.00
2016	2,000.00
2017	2,000.00
2018	2,000.00
2019	2,000.00
	$16,000.00

Direct Payment Authorization

I (we) hereby authorize the Arbor Health Foundation to electronically debit my (our) account (and if necessary, electronically credit my (our) account to correct erroneous debits) as follows:

☐ Checking Account or ☐ Savings Account (select one) at the depository financial institution named below ("DEPOSITORY"). I (we) agree that ACH transactions I (we) authorize comply with all applicable law.

Depository Name: _____

Routing Number: _____ Account Number _____

Date(s) and/or frequency of debit(s): _____

Amount of Debit(s): _____

I (we) understand that this Authorization will remain in full force and effect until I notify the Arbor Health Foundation in writing that I wish to revoke this Authorization. I understand that the Arbor Health Foundation requires at least 10 days prior notice in order to cancel this Authorization.

Name (s) _____

Address _____

Address continued _____

Telephone _____ email_____

Date _____ Signature(s) _____

_____

Arbor Health Foundation
521 Adams Ave.
P.O. Box 1132
Morton, WA 98356

email: dmarkham@MyArborHealth.org

You can be a 15-Minute Philanthropist!

Over the past five years, the ELC Hospital Foundation has contributed just under $250,000.00 to Morton General Hospital, the hospital-owned clinics, their employees and the community.

We strive to do even more in the next five years!

You can play a part in this success with a small twice-monthly or monthly donation. For those of us who are paid twice monthly, donating what you earn in 15 minutes per payperiod will make you a 15-Minute Philanthropist. Of course, the amount doesn't have to equal 15 minutes, other amounts qualify as well.

This small donation will almost go unnoticed by most of us—but when combined together with others', it will add up to an impressive amount of money that will, in turn, be used for the benefit of our patients and employees. The majority of the hospital foundation's funds are used to purchase medical equipment and provide educational scholarships for district-wide staff.

All it takes from you is a signature and this donation will be automatically deducted from employees' paychecks or automatic deductions from non-employee checking accounts. (This is also payable by check for those who are not employed by Lewis County Hospital District No. 1)

Hourly rate of pay ÷ 60 (minutes) x 15 (minutes) = $_____ per pay period
(Example, if you make $15 per hour: 15 ÷ 60 x 15 = $3.75 per payday)

Other amount of your choosing $_____ per pay period

_____

Printed Name

_____

Signature Date

Mailing address (for tax receipt) _____

(Donations through employee payroll deductions are reserved for the employee scholarship fund for one year before being eligible for use in equipment purchases, etc.)

BOARD COMMITTEE REPORTS

Arbor Health Hospital Foundation
Virtual Meeting Agenda
July 14, 2020 at noon

Before the meeting started, Wes shared some thoughts about the seriousness of the virus.

Call to Order: 11 present, with excused absences for Pat and Caro, But Pat was able to be present after all.

Approval of June minutes was held over until next month, due to unavailability

Treasurer's report: Geri read her report, and it will be attached to these minutes. Chris moved, Pat seconded, and motion to approve was passed.

Administrator's report:

Richard

1. explained the hospital's readiness for the virus, with PPE adequate and available .Hospital finance is ok, but lighter than usual.
2. Ct and x-ray equipment ready to be replaced soon.
3.the emergency power project is coming soon.
4. Brandy___is the new clinic manager in Randle.
5.Julie Allen is moving to the Quality team.
6. We have a new pharmacist

Executive Director's report:

Diane said that there was $8100 in the scholarship fund, and there had been no applications.

Old Business:

* Welcome Packet is proceeding, with bags, shopping lists, calendars, brochures, hand sanitizer, and chapsticks. Ali, Diane, and Leanne will each include a letter.
* Bylaws amendment mostly just cosmetic corrections, but Diane wanted to explain why she recommended that she be the chair instead of the vice president having that responsibility.

Gwen moved, Geri seconded, and motion passed to amend the bylaws.

New Business:

*Pandemic Fundraising-combining two events in one; Discussed on-line auction. Diane

has been in touch with some other charities on how they were able to do it. Diane is asking us to think about what we can each provide for the auction . She feels that experiences are the biggest draw, like hotel stays or trips. There is no date yet set for the auction,
*Possible bake sale at the Farmers' Market. E-mail Ali if you are interested. So far, Jeannine, Pat, and Lynn.
*Why not a pot luck picnic for our August meeting??

Arbor Health Foundation Meeting Minutes

Tuesday August 11, 2020

Online Zoom Meeting

Attendance: Ali Draper, Diane Markum, Caro Johnson, Ann Marie Fosman, Wes McMahan, Jeannine Walker, Betty Jurey

Guest: Sara Williamson

Excused: Leianne Everett, Lynn Bishop, Shelley Riggs, Stephanie Poffile-Rudd, Chris Preheim

Call to Order by President Ali Draper at 12:00pm

President Ali Draper read the mission statement

Sara Williamson, Chief Nursing/Quality Officer for Arbor Health introduced herself. She shared the need for recruitment and retention of nurses and staff. One of the challenges is the shortage of local housing. The hospital hopes to recruit two new doctors by next year. Brenda Childress is the new client manager for the Mossyrock and Randle clinics. The hospital is working on a new accreditation program, striving for a higher level of practices and performances. The ER is pursuing a new stroke certification, with a goal to reduce the time needed to manage stroke care.

June 2020 minutes approved: Ann Marie Forsman, Wes McMahan

July 2020 minutes approved: Caro Johnson, Janine Walker

Treasurers Report was reviewed and approved: Caro Johnson, Janine Walker

Directors Report, Diane Markum:

Loren and Myrna Davison will be moving out of the area and Diane will order a new clock in appreciation of their service to the foundation. In addition, Betty

Jurey was awarded a gratitude gift for her service and commitment to the gift shop.

Old Business: A discussion was held regarding the possibility of having a booth at the Farmers Market to allow more interaction with the community. Janine Walker and Caro Johnson will get information about the schedule and determine if it is feasible this year.

The theme for the annual auction is "Mask-carde". Included this year will be normal auction items as well as reserve items for the live auction which will be held on Oct 3. Pre-sale dinners will be available for pick-up, to maintain the historic character of the dinner auction.

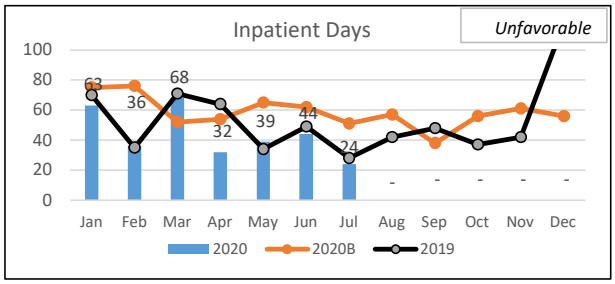
Welcome Packets are almost ready and volunteers are needed to stuff the bags. The packets will be distributed to East Lewis County Realtors to given to new residents.

New Business: Dave Bunting from the White Pass Shopper donated beautiful flower to the front line workers at the hospital. In addition, he has donated $600 for the staff and front-line workers. Diane suggested that the foundation match his donation and order water bottles for all of the workers. Motion was made and approved. Caro Johnson/Janine Walker

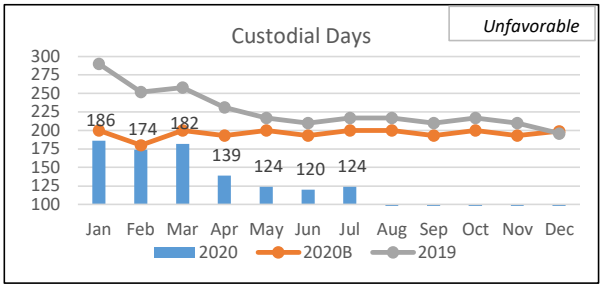
Meeting Adjourned 12:48

Lewis County Hospital District No. 1
Board Financial Summary
July 31, 2020

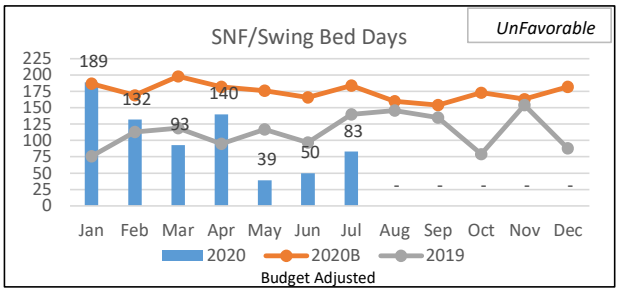
Growth



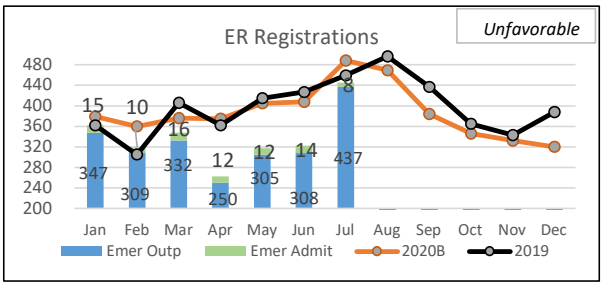
YTD: 306.00 Budget: 435.00 Pr Yr: 351.00



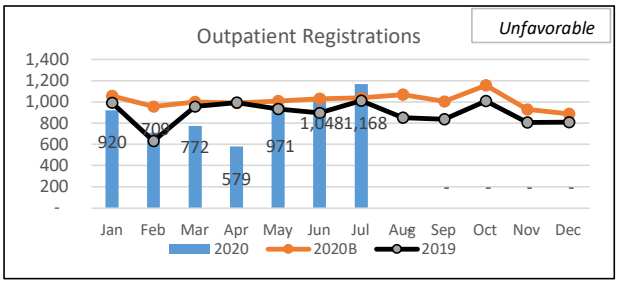
YTD: 1,049 Budget: 1,366 Pr Yr: 1,675



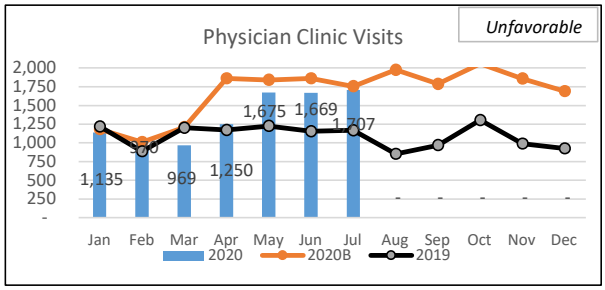
YTD: 726 Budget: 1,262 Pr Yr: 757



YTD: 2288 Bud: 2791 Pr Yr: 2736

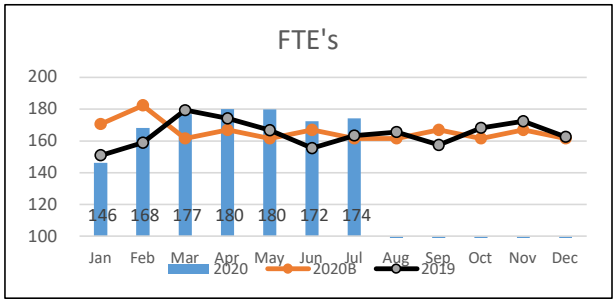


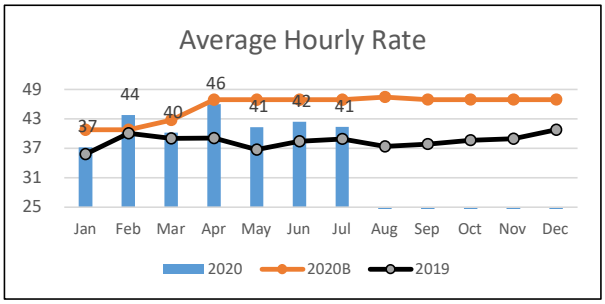
YTD: 6,167 Bud: 7,075 Pr Yr: 6,416

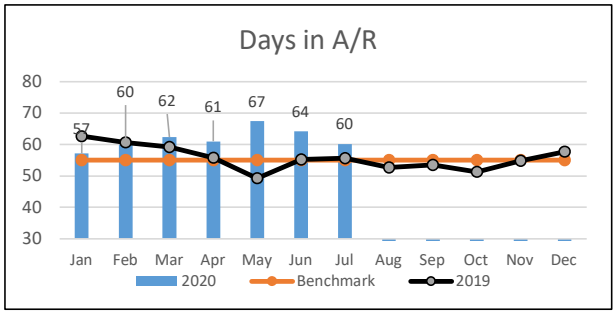


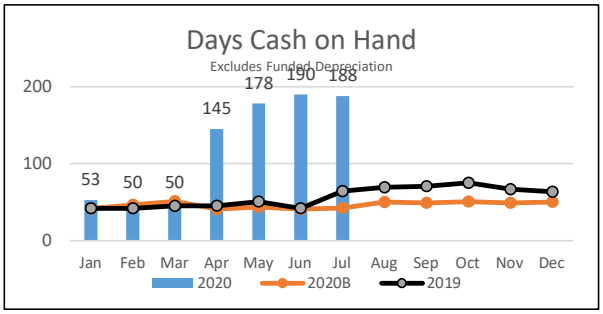
YTD: 9,375 Bud: 10,715 Pr Yr: 8,017

People and Operational Aspects









CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
July 29, 2020 at 3:00 p.m.
ZOOM
https://myarborhealth.zoom.us/j/99365012692
Meeting ID: 993 6501 2692
One tap mobile: +12532158782,,99365012692# US
Dial by your location: +1 253 215 8782 US

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA TOPIC	CONCLUSION	ACTION ITEMS
Call to Order	Board Chair Frady called the meeting to order via Zoom at 3:00 p.m. **Commissioners present:** ☒ Trish Frady, Board Chair ☒ Tom Herrin, Secretary ☒ Craig Coppock ☒ Wes McMahan ☒ Chris Schumaker **Others present:** ☒ Leianne Everett, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Sara Williamson, CNO/CQO ☒ Katelin Forrest, HR Generalist ☒ Janice Holmes, Medical Staff Coordinator ☒ Richard Boggess, CFO ☒ Buddy Rose, Reporter ☒ Roy Anderson, Compliance Officer ☒ Dexter Degoma, Interim Quality Manager ☒ Matthew Ellsworth, AWPHD-Executive Director	
Approval or Amendment of Agenda		Commissioner Coppock made a motion to approve the amended agenda. Secretary Herrin seconded and the motion passed unanimously.

Conflicts of Interest	Superintendent Everett asked the board to state any conflicts of interest with today's agenda.	None noted.
Comments and Remarks	Commissioners: Commissioner Schumaker noted he is impressed by the staff, operations, and processes here at Arbor Health and it has been an enjoyable experience. Commissioner Schumaker received a couple billing complaints requested status on the complaint cards. Superintendent Everett noted the cards have been ordered and we would email contact information for the Quality Management Office to address these constituents with concerns. Audience: Buddy Rose inquired if the District would like to inform the public via the newspaper regarding an update on the Generator/OR Construction Project. Superintendent Everett noted the District rejected all bids on July 24, 2020 and we are working with legal to reissue an invitation to bid.	Action Item-Executive Assistant Garcia will email contact information for the Quality Management Office to all commissioners.
Executive Session- RCW 70.41.205 & RCW 42.30.110 (1)(b), (c) • Medical Privileging- Katelin Forrest • To consider the minimum price at which real estate will be offered for sale or lease.	Executive Session began at 3:15 p.m. for forty-five minutes to discuss Medical Privileging and to consider the minimum price at which real estate will be offered for sale and lease. The Board returned to open session at 4:00 p.m. No decisions were made in Executive Session. **New Appointments** 1. Todd Garrett, CRNA- Active – (Arbor Health-Anesthesia) 2. Hartaj Girn, MD- Consulting- (Providence Medical Group-Cardiology) 3. Charles Rossow, MD- Consulting- (Providence Medical Group-Cardiology) **New Appointments (privileging by proxy with Mason General Hospital)** 1. Ryan Herde, MD- Consulting – (Radia – Radiology Privileges) 2. Jigish Patel, MD- Consulting- Radia-Radiology Privileges) 3. Xi Zhang, MD- Consulting – (Radia- Radiology Privileges)	Commissioner McMahan made a motion to approve the Medical Privileging as presented and Secretary Herrin seconded. The motion passed unanimously.

	New Appointments (privileging by proxy with Providence System) 1. Elizabeth Waltz, MD – Consulting – (Providence-Telestroke Privileges) 2. Madeline Tuong-Vi Nguyen, MD – Consulting – (Providence-Telestroke Privileges) **Reappointments** 1. Don Allison, MD - Active – (Arbor Health – Family Medicine) 2. Gopal Ghimire, MD- Consulting- (Providence Medical Group- Cardiology) 3. Devin Spera, MD - Active – (Arbor Health – Emergency Medicine) **Reappointments (privileging by proxy with Providence System)** 1. Syed Abbas, MD - Consulting – (Providence – Telestroke Privileges) 2. Abdelrahman Beltagy, MD - Consulting – (Providence – Telestroke Privileges) 3. Lindsey Frischmann, DO - Consulting – (Providence – Telestroke Privileges) 4. Christopher Fanale, MD - Consulting – (Providence – Telestroke Privileges) 5. Robert Lada, MD - Consulting – (Providence – Telestroke Privileges 6. Michael Marvi, MD - Consulting – (Providence – Telestroke Privileges 7. Tomoko Sampson, MD - Consulting – (Providence – Telestroke Privileges) 8. Tarvinder Singh, MD - Consulting – (Providence – Telestroke Privileges)	
Guest Speaker-AWPHD-Matthew Ellsworth, Executive Director	Executive Director Ellsworth provided an overview of the Association of Washington Public Hospital Districts (AWPHD) and how they support the District. AWPHD partners with WSHA on many topics; however, act independently too. Executive Director Ellsworth reiterated the importance of their roles as publicly elected officials. He recommended investing time in other community groups, as well as other special districts chairs as they are often experiencing the same challenges. Executive Director Ellsworth noted the topics AWPHD will be advocating for will be available by the end of this year or early next year.	

Executive Session-RCW 70.41.200 • QIO Committee	Executive Session began at 4:25 p.m. for thirty minutes to discuss Quality Improvement Oversight Committee. At 4:55 p.m. Board Chair Frady extended by five minutes. The Board returned to open session at 5:00 p.m. No decisions were made in Executive Session.	
Break	Board Chair Frady called for a five-minute break at 5:00 p.m. The Board returned to open session at 5:05 p.m.	
Department Spotlight • Emergency Department	CNO/CQO Williamson provided an overview of the Emergency Department.	
Board Committee Reports • Hospital Foundation Report	Commissioner McMahan commended the Hospital Foundation and all their efforts. COVID impacts all the Foundation events, so they are getting creative and joining the Farmer's Market in Morton, WA to raise awareness.	
• Finance Committee Report	CFO Boggess highlighted the following: 1. Volumes continue to trend below budget. 2. Outpatient volume is closer to target, as well as the clinic visits. This especially improved with acquiring Morton Clinic. 3. Days Cash on Hand continues to be strong at 190 days. The auditors have provided guidance on the funding received. The Board can expect that this number will trend down in third quarter due to the pay back to Medicare.	
Consent Agenda • Minutes of the June 10, 2020 Regular Board Meeting *(Action)* • Minutes of the June 29, 2020 Finance Committee Meeting *(Action)* • Minutes of the July 22, 2020 Quality Improvement Oversight Committee Meeting *(Action)* • Minutes of the July 22, 2020 Finance	Commissioner McMahan requested an edit to the June 10, 2020 Regular Board Meeting Minutes to include the action taken in New Business regarding Resolution 20-21 and 20-24. The Board agreed the sale price of the Elbe property will be equal to or greater than $218, 975 and the purchase price of the multi-family Morton rental property will be less than or equal to $346,600 plus closing costs.	Commissioner McMahan made a motion to approve the Consent Agenda with modifications to resolutions and June 10th, 2020 Minutes and Commissioner Coppock seconded. The motion passed unanimously.

Committee Meeting *(Action)* • Minutes of the June 25, 2020 Special Board Meeting *(Action)* • Minutes of the July 2, 2020 Special Board Meeting *(Action)* • Minutes of the July 9, 2020 Special Board Meeting *(Action)* • Minutes of the July 24, 2020 Special Board Meeting *(Action)* • Warrants & EFT's in the amount of $3,232,297.84 dated June 2020 *(Action)* • Resolution 20-27- Approving the Capital Sale of Property 54307 Mountain Highway East, Elbe, WA 98330 *(Action)* • Resolution 20-28- Approving the Capital Sale of Property 54307 Mountain Highway East, Elbe, WA 98330 *(Action)* • Resolution 20-27- Approving the Capital Sale of Property 54307 Mountain Highway East, Elbe, WA 98330 *(Action)* • Resolution 20-28- Approving the Capital Purchase of Property of 121		

Collar Avenue, Morton, WA 98356 *(Action)* • Resolution 20-29- Declaring to Surplus or Dispose of Certain Property *(Action)* • Approve Documents Pending Board Ratification 07.29.20 *(Action)*		
Old Business • RHC Visiting Nurse Services	Superintendent Everett has a Zoom Meeting scheduled this week to connect with DOH on this topic.	
New Business • Board & Committee Meetings	Board Chair Frady noted we have four new commissioners and proposed reviewing the remaining meeting times and dates through the end of the year. Commissioner McMahan proposed having QIO Committee Meetings every other month due to the increased focus on quality and going DNV. The Board agreed to leave the schedule as is for 2020 and readdress this topic in 2021. The Board agreed to moving the QIO Meetings from noon to 7 am. Commissioner Schumaker proposed moving the Regular Board Meetings from 3:00 pm to 3:30 pm. The Board agreed to moving the meeting time to 3:30 pm. Commissioner Herrin proposed moving Plant Planning Committee Meetings from Wednesdays to Thursdays and from 12 pm to 7 am. The Board agreed to moving the 12 pm meeting on October 14, 2020 to 7 am on October 15, 2020.	Action Item-Executive Assistant Garcia will update Committee meeting dates and times. Action Item-Executive Assistant Garcia will publish a legal updating the Regular Board Meetings to a start time of 3:30 pm.
• PSW ACO Discussion	Superintendent Everett highlighted the following on partnering with Physicians of Southwest WA (PSW) ACO: 1. PSW is considering the District as a potential partner. 2. ACO goals are to reduce costs and improve outcomes. 3. This partnership would potentially impact 600 lives in the Medicare Advantage. 4. PSW would provide Care Coordination Services.	Secretary Herrin made a motion to approve Resolution 20-30. Commissioner Schumaker seconded and the motion passed unanimously.

	5. If chosen, PSW is asking for a commitment from the District on or around August 15th. 6. This is an opportunity to learn and grow our population health skills.	
• Board Education	Board Chair Frady reviewed the orientation checklist and cheat sheets provided in the packet. Executive Assistant Garcia requested the four new commissioners to complete and return PRA and OPMA training certificates.	Action Item-Secretary Herrin and Commissioner McMahan, Schumaker and Coppock need to submit PRA & OPMA certificates upon completion to Executive Assistant Garcia to have on file in Kronos.
• Post COVID Sustainability of Custodial Program	Superintendent Everett highlighted the following on the sustainability of the custodial care program: 1. Providing custodial services in acute care setting has changed because of COVID-19. 2. Presented this to the Finance and Quality Improvement Oversight Committees for input. 3. The District is compliant with regulations; however, during a pandemic this is still a very fragile population. 4. Patient safety is a concern given the dilemma of staff crossover. 5. All four patients have signed waivers; however, this does not alleviate the District's risk. 6. The District has not been recruiting for the program and focused on transitional care. 7. There has been no waitlist since 2016. The Board deliberated the topic and agreed to host a Special Board Meeting on Monday, August 10, 2020 to discuss the sustainability of the custodial care program in public comment. This will give the District the opportunity to provide input. The Board and Superintendent Everett will draft an article to share the dilemma with the District. This will be shared in the Journal and on Facebook.	Action Item-Superintendent Everett will draft a newspaper article with Diane Markham regarding the upcoming Special Board Meeting to discuss the custodial care program.
Break	Board Chair Frady called for a five-minute break at 7:35 p.m. The Board returned to open session at 7:40 p.m.	
• Recruitment Update	Commissioner McMahan noted he has questions; however, he will ask later to save on time.	

• Annual Reviews	Commissioner Frady recommended the Commissioners review the evaluation and plans in preparation to approve at the next Regular Board Meeting on August 26, 2020. She proposed if the Commissioners have questions to route through the QIO Committee Chair Commissioner McMahan. Superintendent Everett reiterated between herself and Interim Quality Manager Degoma, they will be a resource to ensuring questions or concerns are addressed prior to approval.	
• Board Policies & Procedures	The Board supported marking the following three policies and procedures as reviewed. 1. Conflict of Policies 2. Distribution for Board and Committee Packets 3. Hospital Declaration of Personal Property as Surplus	Commissioner McMahan made a motion to mark the policies and procedures as reviewed and Commissioner Schumaker seconded. The motion passed unanimously. Action Item-Executive Assistant Garcia will mark the three policies and procedures as reviewed.
Superintendent Report	Superintendent Everett updated the following: 1. Researching the Mobile Clinic. The goal of this service line is to be affordable, accessible and limit exposure to patients. The District will need to subsidize this service line. Administration is reviewing options and will investigate grant dollars. It might be more viable to further explore the visiting nurse program. 2. Preparing an updated Organizational Chart and will be finalizing in preparation for surveys. 3. Drafting operational goals to accomplish the three board adopted strategies. 4. Operating under Incident Command during the COVID-19 pandemic. Commissioner McMahan thanked the Staff during these unprecedented times. Superintendent Everett announced next week the District is celebrating Jubilee Week even though the event was cancelled. Administration is hoping to celebrate the staff with activities, snacks and a 50/50 raffle.	Action Item-Superintendent Everett and CFO Boggess will continue to explore the mobile clinic model/visiting nurse program and funding options available to the District.

	Superintendent Everett noted a correction to the agenda that the next Finance Committee meeting is August 19th at 12 pm.	
Adjournment	Commissioner Coppock moved and Commissioner McMahan seconded to adjourn the meeting at 8:09 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
August 10, 2020 at 6 p.m.
ZOOM
https://myarborhealth.zoom.us/j/95981773957
Meeting ID: 959 8177 3957
One tap mobile: +12532158782,,95981773957#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION/CONCLUSION	RECOMMENDATIONS/ ACTION/FOLLOW-UP
Call to Order	Board Chair Frady called the meeting via Zoom to order at 6:01 p.m. **Commissioners present:** ☒ Trish Frady, Board Chair ☒ Tom Herrin, Secretary ☒ Craig Coppock ☒ Wes McMahan ☒ Chris Schumaker **Others present:** ☒ Leianne Everett, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO ☒ Roy Anderson, Compliance Officer ☒ Rhonda Krolczyk ☒ Judy Ramsey ☒ Reed Mettler ☒ Elee Fairhart ☒ Edwin Meelhuysen ☒ Dr. Kevin McCurry ☒ Owner ☒ Buddy Rose, Journalist ☒ Zora DeGrandpre ☒ Ali Draper ☒ Samuel Satterfield	

	☒ Mercy Macharia, Interim Pharmacist ☒ Raylene Sutter ☒ Karma Gacke, Activities Coordinator	
Reading of the Notice of the Special Meeting	Board Chair Frady read the special board meeting notice. Board Chair Frady noted the chat function was disabled and the meeting was not recorded.	
Comments & Remarks • Commissioner	Board Chair Frady provided an overview of why this program is at risk for discontinuing during COVID-19. The Board continues to have concerns delivering safe, quality care and service to this patient population.	
New Business • Sustainability of the Custodial Care Program		
Comments and Remarks • Audience	Board Chair Frady acknowledged receipt of a website message, as well as a phone call expressing concerns on this topic. There were five community members who provided public comment. The public expressed support for continuing the custodial care program. The Board thanked the District for their input and reiterated the importance of making the best decision for this fragile population.	
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourn at 6:41 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Board Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
August 14, 2020 at 7 a.m.
ZOOM
https://myarborhealth.zoom.us/j/91664667715
Meeting ID: 916 6466 7715
One tap mobile: +12532158782,,91664667715#
Dial:+1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION/CONCLUSION	RECOMMENDATIONS/ ACTION/FOLLOW-UP
Call to Order	Board Chair Frady called the meeting via Zoom to order at 7:00 a.m. **Commissioners present:** ☒ Trish Frady, Board Chair ☒ Tom Herrin, Secretary ☒ Craig Coppock ☒ Wes McMahan ☒ Chris Schumaker **Others present:** ☒ Leianne Everett, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO	
Reading of the Notice of the Special Meeting	Board Chair Frady read the special board meeting notice. Board Chair Frady noted the chat function was disabled and the meeting was not recorded.	
New Business • Resolution 20-31- Approving to Support Contract with ACO-PSW • Resolution 20-32- Approving the Capital Purchase of	Superintendent Everett highlighted the ACO requirements and shared an updated dollar amount to be paid in escrow if chosen to partner with PSW in their ACO. She received further documentation from CMS regarding the continued support for transformational care in rural communities.	

Flooring at Mossyrock Clinic	CFO Boggess discussed the solicited bids for replacing the flooring in the Mossyrock Clinic. He recommended the lowest bidder to the Board.	
Action		Secretary Herrin made a motion to approve Resolution 20-31 and Commissioner Craig seconded. The motion passed unanimously. Commissioner Coppock made a motion to approve Resolution 20-32 and Secretary Herrin seconded. The motion passed unanimously.
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourn at 7:21 a.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Board Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
August 19, 2020 at 12:00 p.m.
Conference Room 1 & Via Zoom

AGENDA	DISCUSSION	ACTION
Call to Order	Secretary Herrin called the meeting to order via Zoom at 12:00 p.m. **Commissioner(s) Present via Zoom:** ☒ Tom Herrin, Secretary ☒ Craig Coppock, Commissioner **Committee Member(s) Present in Person or via Zoom:** ☒ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO via Zoom ☒ Leianne Everett, Superintendent ☒ Marc Fisher, Community Member ☐ Clint Scogin, Controller ☒ Sara Williamson, CNO/CQO ☒ Diane Markham, Communications Manager	
Approval or Amendment of Agenda	Superintendent Everett requested to add an agenda item called Summary and Action Items to the end of the meeting.	Secretary Herrin made a motion to approve the amended agenda. Community Member Fisher seconded and the motion passed unanimously.
Conflicts of Interest	The Committee noted no conflicts of interest.	
Consent Agenda • **Review of Finance Minutes –July 20, 2020** • **Revenue Cycle Update** • **Board Oversight Activities** • **Cost Report Update** • **Financial Statements**		Commissioner Coppock made a motion to approve the consent agenda and Community Member Fisher seconded. The motion passed unanimously.

Old Business • **Financial Department Spotlight-Arbor Health Foundation**	Diane Markham highlighted how the Foundation advocates for the District. The Foundation has provided support through scholarships and purchasing medical equipment.	
• **July Capital Update**	CFO Boggess highlighted the upcoming capital projects yet to be accomplished in 2020 and the items that will likely be 2021 initiative.	
• **Disaster Funding Update**	CFO Boggess reviewed the Disaster Funding schedule. Regarding the PPP funds it appears that the District will have non-forgivable funds around $200,000. This is related to the cap on employees receiving only $15,385 in the PPP eight-week period. The interest rate will be favorable should the District elect not to refund the money and pay it back over time.	
New Business • **2021 Budget Planning**	CFO Boggess presented the 2021 volume assumptions for each major service lines. COVID-19 has reduced volumes in quarter two due to state mandates around elective procedures. In quarter three volumes are beginning to trend back towards target. We will use the 2020 targets except where there have been specific program changes to volumes such as Morton Clinic and Custodial Care program. COVID-19 has introduced new workflows that will need to be addressed in departmental budgets. The District needs to present the 2021 Budget to Lewis County in November. The plan is to complete the 2021 Budget by the September and October Finance Committee Meetings, present to the Board in September and adopt by resolution in November.	
• **2019 Cost Report Filing**	CFO Boggess noted the District has a payable to Medicare resulting for completion of the 2019 cost report in the amount of $178,918. This amount is accrued for on the Balance Sheet. CFO Boggess will present a resolution for payment at the Regular Board Meeting in the consent agenda. The Committee will recommend a resolution for payment to Medicare to the Board.	
• **WRHC Financial Comparative**	CFO Boggess reviewed the comparative data.	
Summary & Action Items		Secretary Herrin will propose approval of the Medicare Payment Resolution.

Adjournment	Commissioner Coppock made a motion to adjourn at 12:59 pm and CFO Boggess seconded. The motion passed unanimously.	

WARRANT & EFT LISTING NO. 2020-07

RECORD OF CLAIMS ALLOWED BY THE BOARD OF LEWIS COUNTY COMMISSIONERS

The following vouchers have been audited, charged to the proper account, and are within the budget appropriation.

CERTIFICATION

I, the undersigned, do hereby certify, under penalty of perjury, that the materials have been furnished, as described herein, and that the claim is a just, due and unpaid obligation against LEWIS COUNTY HOSPITAL DISTRICT NO. 1 and that I am authorized to authenticate and certify said claim.

Signed:

Richard Boggess, CFO

We, the undersigned Lewis County Hospital District No. 1 Commissioners, do hereby certify that the merchandise or services hereinafter specified has been received and that total Warrants and EFT's are approved for payment in the amount of

$3,799,135.79 this 26th day

of August 2020

Board Chair, Trish Frady

Commissioner, Craig Coppock

Secretary, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of ***$3,799,135.79*** dated ***July 1, 2020 –July 31, 2020.***

Routine A/P Runs

Warrant No.	Date	Amount	Description
117790 - 117797	2-Jul-2020	715,255.63	CHECK RUN
117798 - 117891	2-Jul-2020	276,553.65	CHECK RUN
117897 - 117900	10-Jul-2020	26,082.44	CHECK RUN
117901	6-Jul-2020	3,303.94	CHECK RUN
117902	7-Jul-2020	49.99	CHECK RUN
117903 - 117905	8-Jul-2020	8,050.97	CHECK RUN
117906 - 117962	10-Jul-2020	288,347.19	CHECK RUN
117963 - 117964	14-Jul-2020	10,366.15	CHECK RUN
117965 - 117970	17-Jul-2020	645,103.18	CHECK RUN
117971 - 118045	18-Jul-2020	185,419.77	CHECK RUN
118046 - 118049	24-Jul-2020	36,075.23	CHECK RUN
118050 - 118091	28-Jul-2020	300,677.91	CHECK RUN
118092 - 118103	28-Jul-2020	83,710.68	CHECK RUN
118112 - 118148	31-Jul-2020	114,557.74	CHECK RUN
118149 - 118150	31-Jul-2020	14,854.00	CHECK RUN
118151 - 118153	28-Jul-2020	20,175.08	CHECK RUN
118154	15-Jul-2020	20,117.36	CHECK RUN
118155	31-Jul-2020	980.98	CHECK RUN
Total - Check Runs		$ 2,749,681.89	

Error Corrections - in Check Register Order

Warrant No.	DATE VOIDED	Amount	Description
118094	30-Jul-2020	(90.00)	VOID
118101	28-Jul-2020	(82,819.80)	VOID
117830	13-Jul-2020	(586.52)	VOID
TOTAL - VOIDED CHECKS		$ (82,909.80)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$ 2,666,772.09

Eft	Date	Amount	Description
1056	7-Jul-2020	26.54	MCKESSON
1057	14-Jul-2020	142.56	MCKESSON
1058	21-Jul-2020	62.97	MCKESSON
1059	28-Jul-2020	138.06	MCKESSON
	10-Jul-2020	414,437.08	PAYROLL
1120	13-Jul-2020	154,070.87	PAYROLL TAX
	24-Jul-2020	413,431.01	PAYROLL
1121	24-Jul-2020	150,054.61	PAYROLL TAX
TOTAL EFTS AT SECURITY STATE BANK		$ 1,132,363.70	

TOTAL CHECKS AND EFT'S IN MULTIVIEW	$ 3,799,135.79

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE 2020
QUALITY ASSESSMENT PERFORMANCE
IMPROVEMENT PLAN RESOLUTION NO. 20-33

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

Approving the 2020 Quality Assessment Performance Improvement (QAPI) Plan.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of August 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

2020 QAPI and Patient Safety Plan and Evaluation

Table of Contents

OUR ORGANIZATION

Lewis County Public Hospital District No. 1 dba Arbor Health is located in eastern Lewis County, Washington surrounded by several National Forests and very close to Mt. Rainier National Park.

The District operates Arbor Health Morton Hospital, a 25-bed, 501c(3) Critical Access Hospital (CAH) providing a range of services including inpatient care, 24-hour emergency services, primary and specialty care, laboratory, pharmacy, diagnostic imaging, surgery, physical therapy and sleep lab.

The purpose of a public hospital district under RCW 70.44 includes, among other factors, to provide hospital services and other health care services for the residents of the District and others.

PURPOSE

The purpose of the Quality Assessment, Performance Improvement (QAPI) and Patient Safety Plan is to provide a formal mechanism by which Arbor Health utilizes objective measures to monitor and evaluate the quality of services provided to patients. Quality and Patient Safety are defined broadly to include care that strives to be safe, effective, patient-centered, timely, efficient, and equitable. The plan facilitates a multidisciplinary, systematic performance improvement approach to identify and pursue opportunities to improve patient outcomes and reduce the risks associated with patient safety in a manner that embraces the mission, vision, and values of Arbor Health.

MISSION, VISION, VALUES

Our Vision

To provide accessible, quality healthcare

Our Mission

To foster trust and nurture a healthy community

Core Values

- One team, one mission.
- Go out of your way, to brighten someone's day.
- Own it, embrace it.
- Care like crazy.
- Motivate, elevate, appreciate.
- Know the way, show the way, ease the way.
- Find joy along the way.

OBJECTIVE

Objectives of the CY 2020 QAPI and Patient Safety Plan are:

- Continue to build the comprehensive resource infrastructure (i.e., human capital, data collection, analysis, process improvement, outcome assessment, software, education and training)

- To provide a framework for integrating quality, safety, and service into performance improvement opportunities, implementing actions, and evaluating results based on the aspirational goals of always providing care that is safe, effective, patient-centered, timely, efficient, and equitable.

- To encourage an environment that supports safety, encourages non-punitive reporting, addresses maintenance and improvement in patient safety issues in every department throughout the facility, and establishes mechanisms for the disclosure of information related to errors.

- To focus and coordinate the organization-wide performance improvement, patient safety, and patient experience initiatives based on sound metrics, state of the art analysis, and contemporary improvement methods.

- To facilitate communication, reporting, and documentation of all quality, patient safety, and patient experience activities to professional staff, administration, and appropriate governing members.

- To maximize effective organizational and clinical decision making.

- Promote teamwork and group responsibility in identifying and implementing opportunities for improvement.

- To utilize tools and approaches that capitalize on knowledge regarding holistic approaches to improving quality and safety systems, including those developed outside of health care.

- To enhance the integration of medical staff physicians into meaningful patient safety, patient experience, and quality initiatives.

STRUCTURE AND LEADERSHIP

Key employees are responsible for the development and implementation of the QAPI and Patient Safety Plan. These individuals, Arbor Health's Chief Executive Officer and Superintendent, Chief Nursing and Quality Officer, Chief Financial Officer, and Director of Human Resources are joined by the hospital Chief Medical Officer and Chief of Staff to fully represent the spectrum of hospital services. These leaders work directly and openly to improve quality by setting priorities, modeling core values, promoting a learning atmosphere, acting on recommendations, and allocating resources for improvement. These individuals are supported by a structure of formal and informal committees or work groups where the components of the program are defined, implemented, refined, and monitored. These groups are comprised of attending physicians, staff, management, and members of the Board of Commissioners and are represented via a reporting process to the Quality Improvement Oversight Committee for QAPI and patient safety reporting. The Quality Improvement Oversight Committee which in turn reports to the Board of Commissioners.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROCESS

PRIORITIZATION OF AREAS FOR MEASUREMENT

The process for identifying priorities for measurement requires input and discussion with senior leadership, departments, and services from all areas involved with quality performance measurement and improvement. Priorities are identified based on leadership objectives, regulatory requirements, opportunities identified in external benchmark projects, opportunities identified through analysis of patient safety event reports and opportunities identified through sentinel events, standard of care findings or "Sentinel Event Alerts." These objectives or topics are then displayed in a matrix to better understand which areas of importance and relevance they cross (high risk, high volume, problem prone, mission, internal and external customer satisfaction, clinical outcome, safety, and regulatory).

DEVELOPING MEASURE SPECIFICATIONS

Work groups or committees define the metrics (indicators, goals, and benchmarks) for each topic. Representatives from all involved services collaboratively develop quality performance measure specifications based on the opportunities identified to be studied. Team members are identified with the help of clinical and administrative leadership. Work groups develop written measurement specifications, along with data abstraction tools when necessary.

GATHERING DATA

Data is then gathered on a pre-determined timeframe (weekly, monthly, quarterly). Regular reporting of data requires continued attention from teams. A designated person will be assigned and held accountable for gathering data and having the information available when due. Sampling sizes are determined based on recognized, statistically significant sample sizes of:

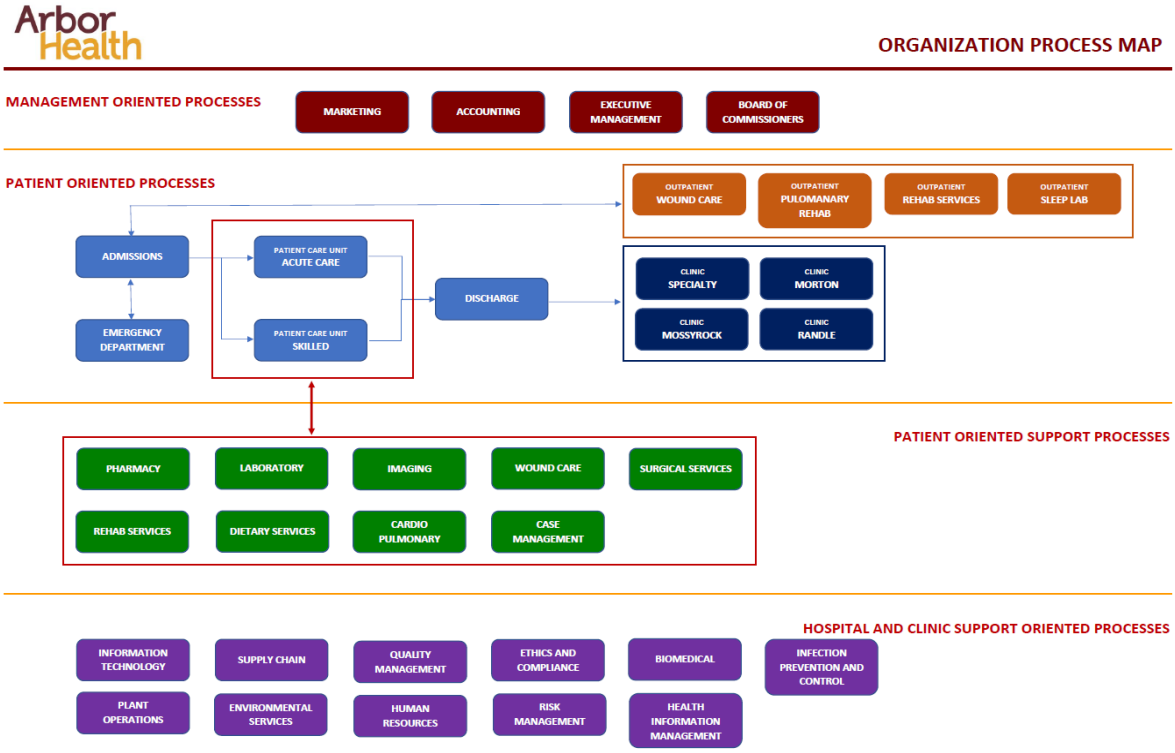
Real time data are collected as possible.

ANALYZING AND REPORTING DATA

The work groups discuss data analysis and determine what initiatives must be implemented to attain the desired outcome. Analysis usually involves multiple iterations and analysis to examine different aspects of the quality issue. Whenever possible and appropriate, statistical control methods, trending, and/or comparison with published benchmarks are used to analyze quality and safety measures.

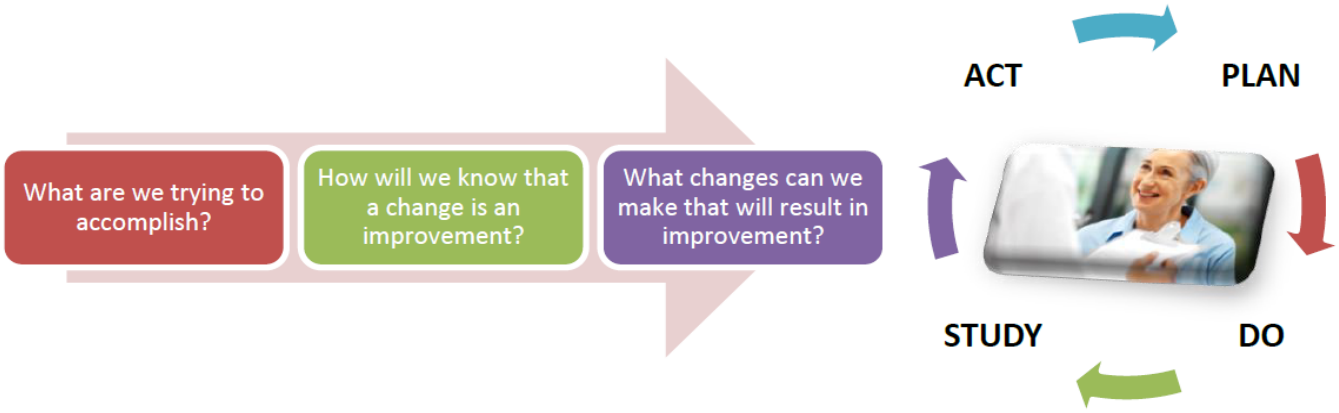
IMPLEMENTATION OF ACTIONS AND DISSEMINATION OF INFORMATION

Implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Communication of quality and safety information is the responsibility of clinical and administrative leadership. This information is reported to the Quality Management Department, and throughout the organization, using the Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequent as necessary, the performance is presented at the Quality Improvement Oversight Committee with minutes and then presented to the Board of Commissioners.



QAPI MODEL

Arbor Health has adopted the Plan, Do, Study, and Act (PDSA) methodology for quality assessment and improvement. The PDSA model is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a process.



P = Plan: Identify a goal or purpose, formulate a theory, define success metrics and put a plan into action.
D = Do: Implement the components of the plan
S = Study: Monitor outcomes to test the validity of the plan for signs of progress or success or problems and areas for improvement
A = Act: Integrate the learning generated by the process, adjust the goal or change interventional methods if necessary.

Additional Performance Improvement Methodologies
In addition to the PI methodology outlined above, other tools, techniques and methods are used to achieve improvement based on project goals and/or the nature of the problem under evaluation. Examples include Lean and Six Sigma via the Performance Improvement Program.

ANNUAL EVALUATION

Arbor Health Morton Hospital and the Board of Commissioners shall review the effectiveness of the Performance Improvement Plan at least annually in alignment with the calendar year. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Arbor Health and the Board of Commissioners also evaluate annually their contributions to the performance improvement and patient safety activities at Arbor Health. An annual report is submitted to the Board of Commissioners incorporated in the plan.

APPENDIX A

2020 Goals and Expectations

THE 2020 QAPI AND PATIENT SAFETY AREAS OF FOCUS

The QAPI and Patient Safety Plan is the framework for integration of departmental activities within the organization. Each department links to one of the main areas of focus identified for improvement. All departments develop annual objectives to address and support improvement of the care, treatment, service, and safety outcomes that align with Arbor Health's mission and annual QAPI and Patient Safety Areas of Focus. These objectives become the essence of the QAPI activities organization-wide.

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE

1. Reduction of hospital acquired infections with a goal of zero infections
2. Increase hand-hygiene compliance rate
3. Reduction of unassisted patient falls with a goal of zero falls
4. Reduction of the use of Restraints/Seclusions
5. Reduction of hospital acquired pressure injuries with a goal of zero injuries
6. Integration of the Patient Experience in Quality and Safety processes (HCAHPS)
7. Monitor trends in patient safety events through Arbor Health's event reporting system and implement actions to reduce harm
8. Conduct Annual Culture of Safety Survey
9. Conduct Annual Clinical Service Contract Quality Evaluations
10. Integration of PDSA through departmental improvements

B. IMPROVE RESOURCE UTILIZATION

1. Improve patient flow throughput
2. Reduce readmissions

C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS

1. Centers for Medicare/Medicaid Services (CMS) Core Measures / eCQM Measures
2. Quality Health Indicator (QHi) Project
3. Washington State Hospital Association Quality Benchmarking System (QBS)
4. Medicare Beneficiary Quality Improvement Project (MBQIP)

PATIENT SAFETY FOCUS

As a patient safety focused organization, Arbor Health has been developed to promote and support practices and policies for providing quality patient care and minimizing adverse incidents in patient care and safety. This program will assist to reduce/prevent risk exposures to the patients, employees, medical staff, and visitors in our facility, maintain equipment, and conserve hospital property. The Patient Safety and performance improvement systems are mutually compatible and interdependent.

Periodically, Arbor Health will survey clinical staff and physicians regarding the Culture of Patient Safety at the hospital. The results from this survey provide hospital leadership with an understanding of the safety culture at the hospital which is the product of the individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Action plans are developed and implemented at the hospital and department/unit level to enhance the culture of safety in order to improve the quality and safety of care provided and improve the reporting of events to enrich the safety culture at the hospital and clinics.

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE

METRIC	MEASUREMENT	2020 TARGET
Reduction of hospital acquired infections with a goal of zero infections		
CAUTI – Catheter Associated Urinary Tract Infection Infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney associated with the use of a foley catheter.	**Total # HAI Event(s)** **Rate per 1000 Pt. Days**	**5% Reduction from prior year** **Strive for "0" Events**
CDIFF - Clostridium difficile Infection of the large intestine (colon) caused by the bacteria Clostridium difficile.		
CLABSI – Central Line Associated Blood Stream Infection A primary laboratory confirmed bloodstream infection in a patient with a central line at the time of (or within 48-hours prior to) the onset of symptoms and the infection is not related to an infection from another site.		
MRSA - Methicillin-resistant staphylococcus aureus Infections caused by specific bacteria that are resistant to commonly used antibiotics.		
SSI – Surgical Site Infection Infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney.		
Reduction of hospital acquired infections with a goal of zero infections		
Hand Hygiene A simple yet effective way to prevent infections.	**Total Compliance /Opportunities by Visual Audits with a Goal of >90%**	**90%**
Reduction of hospital acquired infections with a goal of zero infections		
Unassisted Patient Fall A patient fall occurs when a patient falls or collapses and assistance from a healthcare provider does not occur. Unassisted falls are more likely than assisted falls to result in injury.	**Number of unassisted patient falls reported / (Acute Inpatient Days + Swing Bed Patient Days) x 100**	**5% Reduction from prior year** **Strive for "0" Events**
Reduction of the use of Restraints/Seclusions		
Restraints/Seclusion Use Episodes of seclusion and restraint, total time, and utilization rates were tracked. Seclusion and restraint are separate events, but they are documented as one occurrence.	**Measurement criteria based on CMS Condition of Participation standards**	**5% Reduction from prior year** **Strive for "0" Events**
Reduction of hospital acquired pressure injuries with a goal of zero injuries		
Hospital Acquired Pressure Ulcers Hospital-acquired pressure ulcers/injuries (HAPU/I) result in significant patient harm, including pain, expensive treatments, increased length of institutional stay and, in some patients, premature mortality. It is estimated each year more than 2.5 million patients in U.S. acute-care facilities suffer from pressure ulcer/injuries and 60,000 die from their complications3.	**ALL or None Bundle Compliance with HIIN Evaluation Measure**	**5% Reduction from prior year** **Strive for "0" Events**

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE

METRIC	MEASUREMENT	2020 TARGET
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)		
ARBOR HEALTH - MORTON HOSPITAL		
Global Rating Overall	**Rating of 9 – 10**	**≥50% Top Box**
Recommend the Hospital	**Definitely Yes**	
Communications with Nurses Overall	**Always**	
Nurses treat with courtesy/respect	**Always**	
Nurses listen carefully to you	**Always**	
Nurses explain in way you understand	**Always**	
Response of Hospital Staff Overall	**Always**	
Call Button help soon as wanted it	**Always**	
Help toileting soon as you wanted	**Always**	
Communication with Doctors Overall	**Always**	
Doctors treat with courtesy/respect	**Always**	
Doctors listen carefully to you	**Always**	
Doctors explain in way you understand	**Always**	
Hospital Environment Overall	**Always**	
Cleanliness of hospital environment	**Always**	
Quietness of hospital environment	**Always**	
Communication About Medicines Overall	**Always**	
Tell you what new medicine was for	**Always**	
Staff describe medicine side effect	**Always**	
Discharge Information Overall	**Yes**	
Staff talk about help when you left	**Yes**	
Information regarding symptoms/problems to look for	**Yes**	
Care Transitions Overall	**Strongly Agree**	
Hospital staff took preference into account	**Strongly Agree**	
Good understanding managing health	**Strongly Agree**	
Understood purpose of taking medications	**Strongly Agree**	
ARBOR HEALTH - EMERGENCY DEPARTMENT		
ED Overall	***Yes or Always***	**≥50% Top Box**
Standard Arrival		
Waiting time before noticed arrival		
Helpfulness of first person		
Comfort of waiting area		
Waiting time to treatment area		
Waiting time to see doctor		
ED Nursing		

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE		
METRIC	**MEASUREMENT**	**2020 TARGET**
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)		
ARBOR HEALTH - EMERGENCY DEPARTMENT		
Nurses courtesy	**Yes or Always**	**≥50% Top Box**
Nurse took time to listen		
Nurses attention to your needs		
Nurses informative re treatments		
Nurses concern for privacy		
ED Doctors		
Doctors courtesy		
Doctor took time to listen		
Doctor informative re treatment		
Doctors concern for comfort		
ED Tests		
Courtesy of person who took blood		
Concern blood draw comfort		
Waiting time for radiology test		
Courtesy of radiology staff		
Concern for comfort radiology test		
Family or Friends		
Courtesy shown family/friends		
Adequacy of info to family/friends		
Let family/friend be with you		
Personal/Insurance Info		
Courtesy during pers/insur info		
Privacy during pers/insur info		
Ease giving pers/insur info		
Personal Issues		
Informed about delays		
Staff cared about you as person		
How well pain was controlled		
Information about home care		
Overall Assessment		
Overall rating ER care		
Likelihood of recommending		

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE		
METRIC	**MEASUREMENT**	**2020 TARGET**
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)		
ARBOR HEALTH - CLINICS		
Clinic Overall	**Yes or Always**	**≥50% Top Box**
Standard Access		
Ease of scheduling appointments		
Ease of contacting		
Std Moving Through Your Visit		
Information about delays		
Wait time at clinic		
Clinic Nurse/ Assistant		
Concern of nurse/asst for problem		
How well nurse/asst listen		
Clinic Care Provider		
CP explanations of prob/condition		
CP concern for questions/worries		
CP efforts to include in decisions		
Likelihood of recommending CP		
CP discuss treatments		
Personal Issues		
How well staff protect safety		
Our concern for patients' privacy		
Std Overall Assessment		
Staff worked together care for you		
Likelihood of recommending		
Monitor trends in patient safety events through Arbor Health's event reporting system and implement actions to reduce harm		
Event Reporting Utilization Providing safe care to patients is a top priority, and Arbor Health rely heavily on the participation of the staff to enter patient safety concerns in order to gather data, identify trends and implement error reduction and prevention plans.	**Total number events entered**	**10% Increase from prior year**

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE		
METRIC	**MEASUREMENT**	**2020 TARGET**
Conduct Annual Culture of Safety Survey		
Annual Culture of Safety Survey As Arbor Health continually strive to improve patient safety and quality, hospital leadership increasingly recognizes the importance of establishing a culture of safety. Achieving such a culture requires leadership, physicians, and staff to understand their organizational values, beliefs, and norms about what is important and what attitudes and behaviors are expected and appropriate. The survey can be used to: - Raise staff awareness about patient safety, - Assess the current status of patient safety culture, - Identify strengths and areas for patient safety culture improvement, - Examine trends in patient safety culture change over time, - Evaluate the cultural impact of patient safety initiatives and interventions, and - Conduct comparisons within and across organizations.	**80% Staff Participation**	**80%**
Conduct Annual Clinical Service Contract Quality Evaluations		
Annual Clinical Service Contract Quality Evaluations According to CMS the hospital's governing body must ensure that contracted services comply with all applicable conditions of participation and standards. Any contract service that provides clinical care for patients presents a unique risk management challenge for a hospital and its medical staff. The best strategy to ensure that clinical services provided through a contract service do not increase potential risks to the hospital, the medical provider, or the patient is to review the service with a focus on risk management and risk prevention.	**100% Annual Compliance**	**100%**
Integration of PDSA through departmental improvements		
PDSA Integration PDSA is an analytical process that considers the process as is, analyzes it further, revises it as appropriate and then repeats the cycle for continuous improvement. The PDSA cycle includes internal and external customers into considers, as they can provide feedback about is the change plan works or not. The customer defines quality and hence it is appropriate to involve them in the process, to increase acceptance of the end product.	**Continuous Improvement from prior year**	**Department Specific**

B. IMPROVE RESOURCE UTILIZATION

METRIC	MEASUREMENT	2020 TARGET
Improve Patient Flow-Throughput		
Efficient patient flow will increase your healthcare facilities revenue and more importantly keep Arbor Health patients satisfied and safer. **PROPOSED STRATEGIES** - Align Reporting with Department Heads When you create a consistent reporting framework between your department heads, with your patients in mind, patient flow will become optimized. - Create a Culture of Accountability Hospital culture can impact patient care. Its values, mission and practices must be consistent with all employees. - Gain Executive Alliance and Integration for Improving Patient Flow Keeping in line with the findings above, the approach taken by senior managers and leaders does appear to matter. It can potentially add to the risk of harm when departments heads are not supportive of staff and hospital culture. - Explore Different Staffing Models Match capacity and demand. When the organization know its capacity constraints and demand patterns it can make changes to align with demand. When both are matched, delays in care can be reduced. - Use Technology to Improve Patient Care and Safety Patient flow is attainable when healthcare facilities have the right tools for collaboration and measurement. The high visibility with clinician-facing boards allows staff and patients real-time awareness with a HIPAA compliant waiting room whiteboard. - Instill the “Patient Flow Standard” and the 4 Hour Recommendation The 4-hour time frame referenced in the Standard is a guideline for hospitals to use as a reasonable goal in its boarding time - the time when a patient is held in the emergency department to the time they are admitted or transferred. - Train Staff on Time Management One of the most effective skills to have for healthcare professionals is time management. Understanding how to plan and control your time spent on daily tasks is crucial to patient safety. - Tying Maintenance and Operations to the Patient Experience Patient satisfaction is a top priority for health care facilities. Communicate more effectively between your departments - from maintenance, housekeeping and more. A patients' experience and satisfaction can depend largely on a task from the maintenance department. Think lighting, doors or broken equipment.		
Reduce Readmissions		
Readmission w/in 30 Days-All Cause Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions.	**Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions / Total inpatient discharges (excluding discharges due to death) x 100**	**20% Reduction from prior year**
% Return ER Visits w/in 72 hours Number of Emergency Department patients treated and released previously, then readmitted with the same or a similar diagnosis within 72 hours of initial release.	**(Number of ER patients returning with same or similar diagnosis to the ER within 72 hrs of their initial visit / Total ER visits) x 100**	

C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS		
METRIC	**MEASUREMENT**	**2020 TARGET**
Quality Health Indicator (QHi) Project *The Quality Health Indicator (QHi) Project is an economical, Web-based quality benchmarking program specifically designed, developed and driven by small rural hospitals and rural health clinics to compare selected quality measures with other similar hospitals and clinics.*		
CLINICAL QUALITY		
Healthcare Associated Infections per 100 Inpatient Days - BCBSKS CAH *Core Measure*	**[Number of Healthcare Associated Infections that occurred during the month / (Acute Inpatient Days + Swing Bed Patient Days)] x 100**	**5% Reduction from prior year Strive for "0" Events**
Unassisted Patient Falls per 100 Inpatient Days *Core Measure*	**[Number of unassisted patient falls reported / (Acute Inpatient Days + Swing Bed Patient Days)] x 100**	
Readmission within 30 days (All Cause) Rate- KHC HIIN & BCBSKS CAH & BCBSKS PPS *Core Measure*	**[Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions / Total inpatient discharges (excluding discharges due to death)] x 100**	**20% Reduction from prior year**
Percentage of Return ER Visits within 72 hours with same/similar diagnosis *Core Measure*	**(Number of ER patients returning with same or similar diagnosis to the ER within 72 hrs of their initial visit / Total ER visits) x 100**	
Total ED Transfers	***All of transfers from an ED to another healthcare facility***	**No Target**
EDTC-1 2020: Home Medications	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that Home Medications is documented and communicated to the receiving hospital in a timely manner***	**100%**
EDTC-2 2020: Allergies and/or Reactions	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that Allergies and/or Reactions is documented and communicated to the receiving hospital in a timely manner***	
EDTC-3 2020: Medications Administered in ED	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that Medications Administered in ED is documented and communicated to the receiving hospital in a timely manner***	

C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS		
METRIC	**MEASUREMENT**	**2020 TARGET**
Quality Health Indicator (QHi) Project *The Quality Health Indicator (QHi) Project is an economical, Web-based quality benchmarking program specifically designed, developed and driven by small rural hospitals and rural health clinics to compare selected quality measures with other similar hospitals and clinics.*		
CLINICAL QUALITY		
EDTC-4 2020: ED Provider Note	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that ED Provider Note is documented and communicated to the receiving hospital in a timely manner***	**100%**
EDTC-5 2020: Mental Status/Orientation Assessment	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that Mental Status/Orientation Assessment is documented and communicated to the receiving hospital in a timely manner***	
EDTC-6 2020: Reason for Transfer and/or Plan of Care	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that Reason for Transfer and/or Plan of Care is documented and communicated to the receiving hospital in a timely manner***	
EDTC-7 2020: Tests and/or Procedures Performed	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that Tests and/or Procedures Performed is documented and communicated to the receiving hospital in a timely manner***	
EDTC-8 2020: Tests and/or Procedure Results	***Number of patients transferred to another healthcare facility whose medical record documentation indicated that Tests and/or Procedure Results is documented and communicated to the receiving hospital in a timely manner***	
EDTC-All 2020: EDTC All or None Composite	***All EDTC elements were documented and communicated***	

C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS

METRIC	MEASUREMENT	2020 TARGET
Quality Health Indicator (QHi) Project *The Quality Health Indicator (QHi) Project is an economical, Web-based quality benchmarking program specifically designed, developed and driven by small rural hospitals and rural health clinics to compare selected quality measures with other similar hospitals and clinics.*		
CLINICAL QUALITY		
3-Hour Sepsis Bundle - BCBSKS CAH & BCBSKS PPS	***(Number of identified sepsis patients who receive all elements of the bundle / Number of identified inpatient and ED sepsis patients) x 100***	**95%**
Harm Events Related to Workplace Violence - KHC HIIN	***[Number of associated harm events related to workplace violence / Number of full-time equivalents (FTEs)] x 100***	**5% Reduction from prior year**
STROKE - Median Arrival Time to CT Performed	***Median of individual patients' time (in minutes) between hospital arrival and CT***	**≤ 45 minutes**
STROKE - Median Arrival Time to CT Interpretation	***Median of individual patients' time (in minutes) between hospital arrival and interpretation of CT***	**≤ 60 minutes**
STROKE - Median Arrival Time to Administration of Thrombolytic	***Median of individual patients' time (in minutes) between hospital arrival and receiving thrombolytic***	**≤ 75 minutes**
Washington State Hospital Association (WSHA) - QBS *Since 2005, WSHA's Patient Safety Program has provided a forum for urban and rural health care providers to share best practices and address issues of safety and quality, improving health care delivery and making care better and safer for all. The goal of this award-winning program is to help ensure the right care is delivered, at the right time, to every patient, every time* **.**		
ANTIMICROBIAL STEWARDSHIP *Antimicrobial stewardship. Antimicrobial stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.*		
Days of Therapy Fluoroquin Fluoroquinolones are medicines that kill bacteria or prevent their growth. Purpose Fluoroquinolones are antimicrobials, medicines used to treat infections caused by microorganisms. Physicians prescribe these drugs for bacterial infections in many parts of the body. For example, they are used to treat bone and joint infections, skin infections, urinary tract infections, inflammation of the prostate, serious ear infections, bronchitis , pneumonia, tuberculosis, some sexually transmitted diseases (STDs), and some infections that affect people with AIDS .	**(Total Number of Days of an acute Inpatients receiving Fluoroquin Therapy / Total acute patient days) x 1000**	**≤ 65.58** **20% Reduction from Baseline**

C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS		
METRIC	**MEASUREMENT**	**2020 TARGET**
Washington State Hospital Association (WSHA) - QBS *Since 2005, WSHA's Patient Safety Program has provided a forum for urban and rural health care providers to share best practices and address issues of safety and quality, improving health care delivery and making care better and safer for all. The goal of this award-winning program is to help ensure the right care is delivered, at the right time, to every patient, every time*		
ANTIMICROBIAL STEWARDSHIP *Antimicrobial stewardship. Antimicrobial stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.*		
Days of Therapy Clindamycin Clindamycin is used to treat certain types of bacterial infections, including infections of the lungs, skin, blood, female reproductive organs, and internal organs. Clindamycin is in a class of medications called lincomycin antibiotics. It works by slowing or stopping the growth of bacteria. Antibiotics such as clindamycin will not work for colds, flu, or other viral infections. Using antibiotics when they are not needed increases your risk of getting an infection later that resists antibiotic treatment.	**(Total Number of Days of an acute Inpatients receiving Clindamycin Therapy / Total acute patient days) x 1000**	**≤ 15.71** **20% Reduction from Baseline**
Days of Therapy Penicillin Penicillins are a group of antibacterial drugs that attack a wide range of bacteria. Drugs in the penicillin class work by indirectly bursting bacterial cell walls. They do this by acting directly on peptidoglycans, which play an essential structural role in bacterial cells. Peptidoglycans create a mesh-like structure around the plasma membrane of bacterial cells, which increases the strength of the cell walls and prevents external fluids and particles from entering the cell. When a bacterium multiplies, small holes open up in its cell walls as the cells divide. Newly-produced peptidoglycans then fill these holes to reconstruct the walls. Penicillins block the protein struts that link the peptidoglycans together. This prevents the bacterium from closing the holes in its cell walls. As the water concentration of the surrounding fluid is higher than that inside the bacterium, water rushes through the holes into the cell and the bacterium bursts.	**(Total Number of Days of an acute Inpatients receiving Penicillin Therapy / Total acute patient days) x 1000**	**≤ 89.06** **20% Reduction from Baseline**

C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS

METRIC	MEASUREMENT	2020 TARGET
Washington State Hospital Association (WSHA) - QBS *Since 2005, WSHA's Patient Safety Program has provided a forum for urban and rural health care providers to share best practices and address issues of safety and quality, improving health care delivery and making care better and safer for all. The goal of this award-winning program is to help ensure the right care is delivered, at the right time, to every patient, every time*		
ANTIMICROBIAL STEWARDSHIP *Antimicrobial stewardship. Antimicrobial stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.*		
Days of Therapy Cephalosporins Cephalosporins are bactericidal drugs, meaning they kill bacteria directly. They do this by interfering with how bacteria build their cell walls. Cephalosporins are grouped into five generations based on when the drugs were developed. In general, each generation is effective against certain types of bacteria.	**(Total Number of Days of an acute Inpatients receiving Cephalosporins Therapy / Total acute patient days) x 1000**	**≤ 90.02** **20% Reduction from Baseline**
Days of Therapy Carbapenems Carbapenems are beta-lactam antibiotics which have a broad spectrum of activity against many Gram-positive and Gram-negative aerobic and anaerobic organisms and are used for treating life-threatening serious infections not responding to standard antibiotic therapy.	**(Total Number of Days of an acute Inpatients receiving Carbapenems Therapy / Total acute patient days) x 1000**	**≤ 18.26** **20% Reduction from Baseline**
Overall	**(Total days of therapy for Fluoroquinolones + Total days of therapy for Clindamycin + Total days of therapy for Penicillins + Total days of therapy for Cephalosporins + Total days of therapy for Carbapenems / Total number of patient days) x 1000**	**≤ 278.63** **20% Reduction from Baseline**
ADVERSE DRUG REACTION (ADE) *An adverse drug reaction is a harmful reaction to a medicine given at the correct dose. The reaction can start soon after you take the medicine, or up to 2 weeks after you stop. An adverse drug reaction can cause serious conditions such toxic epidermal necrolysis (TEN) and anaphylaxis. TEN can cause severe skin damage. Anaphylaxis is a sudden, life-threatening reaction that needs immediate treatment. Ask your healthcare provider for more information on TEN, anaphylaxis, and other serious reactions.*		
ADE - Anticoagulant Safety - Option 1: INR>5 rate	**(Number of patient events with an INR>5 after any warfarin administration / Number of patients cared for in an inpatient area on warfarin)**	**≤ 1.97%** **20% Reduction from Baseline**

C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS

METRIC	MEASUREMENT	2020 TARGET
Washington State Hospital Association (WSHA) - QBS *Since 2005, WSHA's Patient Safety Program has provided a forum for urban and rural health care providers to share best practices and address issues of safety and quality, improving health care delivery and making care better and safer for all. The goal of this award-winning program is to help ensure the right care is delivered, at the right time, to every patient, every time*		
ADVERSE DRUG REACTION (ADE) *An adverse drug reaction is a harmful reaction to a medicine given at the correct dose. The reaction can start soon after you take the medicine, or up to 2 weeks after you stop. An adverse drug reaction can cause serious conditions such toxic epidermal necrolysis (TEN) and anaphylaxis. TEN can cause severe skin damage. Anaphylaxis is a sudden, life-threatening reaction that needs immediate treatment. Ask your healthcare provider for more information on TEN, anaphylaxis, and other serious reactions.*		
ADE - Glycemic Management - Option 1: BG<50 rate	**(Number of patient BG <50 mg/dl after any hypoglycemic agent administration / Number of patients receiving hypoglycemic agents)**	**≤ 4.04%** **20% Reduction from Baselin**
ADE - Anticoagulant Safety - Option 1: Naloxene rate	**(Number of patients who received naloxone / Number of patients receiving opioids)**	**≤ 0.351%** **20% Reduction from Baseline**
Screening for Clinical Depression and Follow-up Plan - QBS		
Percent of patients screened and follow-up plan documented	**(Number of Medicaid enrollees screened for depression and follow-up plan documented / Number of Medicaid enrollees who visited the hospital)**	**98%**

APPENDIX B

2019 Evaluation

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE

METRIC	MEASUREMENT	TARGET	2019
Reduction of hospital acquired infections with a goal of zero infections			
CAUTI	*Total # HAI Event(s) Rate per 1000 Pt. Days*	**0**	**1**
CDIFF		**0**	**0.2**
CLABSI		**0**	0
MRSA		**0**	0
SSI		**0**	0
Increase Hand Hygiene Compliance			
Hand Hygiene Rate	*Total Compliance/*	**95%**	**75.4**
Reduction of unassisted patient falls with a goal of zero falls			
Unassisted Patient	*Number of unassisted*	**0**	**0.21**
Reduction of the use of Restraints/Seclusions			
Restraints/Seclusion	*Measurement criteria*	**0**	No Data
Reduction of hospital acquired pressure injuries with a goal of zero injuries			
Hospital Acquired Pressure Ulcers Rate	*ALL or None Bundle Compliance with HIIN Evaluation Measure*	**100%**	No Data
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)			
ARBOR HEALTH - MORTON HOSPITAL			
Global Rating Overall	*Rating of 9 – 10*	**≥50% Top Box**	32
Recommend the Hospital	*Definitely Yes*		64
Communications with Nurses Overall	*Always*		42
Nurses treat with courtesy/respect	*Always*		6
Nurses listen carefully to you	*Always*		82
Nurses explain in way you understand	*Always*		44

METRIC	MEASUREMENT	TARGET	2019
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)			
Response of Hospital Staff Overall	*Always*	**≥50% Top Box**	58
Call Button help soon as wanted it	*Always*		45
Help toileting soon as you wanted	*Always*		70
Communication with Doctors Overall	*Always*		86
Doctors treat with courtesy/respect	*Always*		66
Doctors listen carefully to you	*Always*		
Doctors explain in way you understand	*Always*		99
Hospital Environment Overall	*Always*		28
Cleanliness of hospital environment	*Always*		85
Quietness of hospital environment	*Always*		7
Communication About Medicines Overall	*Always*		97
Tell you what new medicine was for	*Always*		92
Staff describe medicine side effect	*Always*		96
Discharge Information Overall	*Yes*		58
Staff talk about help when you left	*Yes*		55
Information regarding symptoms/problems to look for	*Yes*		60
Care Transitions Overall	*Strongly Agree*		53
Hospital staff took preference into account	*Strongly Agree*		14
Good understanding managing health	*Strongly Agree*		89
Understood purpose of taking medications	*Strongly Agree*		47

METRIC	MEASUREMENT	TARGET	2019
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)			
ARBOR HEALTH - EMERGENCY DEPARTMENT			
ED Overall	*Yes*	**≥50% Top Box**	58.6
Standard Arrival	*Yes*		52.4
Waiting time before noticed arrival	*Yes*		67.6
Helpfulness of first person	*Yes*		61.9
Comfort of waiting area	*Yes*		33.5
Waiting time to treatment area	*Yes*		52.7
Waiting time to see doctor	*Yes*		44.2
ED Nursing	*Yes*		66.7
Nurses courtesy	*Yes*		69.8
Nurse took time to listen	*Yes*		68.6
Nurses attention to your needs	*Yes*		66.3
Nurses informative re treatments	*Yes*		63.6
Nurses concern for privacy	*Yes*		65.3
ED Doctors	*Yes*		58.7
Doctors courtesy	*Yes*		60.7
Doctor took time to listen	*Yes*		61.3
Doctor informative re treatment	*Yes*		59
Doctors concern for comfort	*Yes*		53.9
ED Tests	*Yes*		56.4
Courtesy of person who took blood	*Yes*		55.4
Concern blood draw comfort	*Yes*		57.3

METRIC	MEASUREMENT	TARGET	2019
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)			
Waiting time for radiology test	*Yes*		47.2
Courtesy of radiology staff	*Yes*		65.9
Concern for comfort radiology test	*Yes*		56.5
Family or Friends	*Yes*		59.9
Courtesy shown family/friends	*Yes*		61.1
Adequacy of info to family/friends	*Yes*		55.6
Let family/friend be with you	*Yes*		62.9
Personal/Insurance Info	*Yes*		62.4
Courtesy during pers/insur info	*Yes*		67.5
Privacy during pers/insur info	*Yes*		61.7
Ease giving pers/insur info	*Yes*		57.7
Personal Issues	*Yes*		55.9
Informed about delays	*Yes*		53.5
Staff cared about you as person	*Yes*		60.5
How well pain was controlled	*Yes*		51
Information about home care	*Yes*		57.7
Overall Assessment	*Yes*		55
Overall rating ER care	*Yes*		57.5
Likelihood of recommending	*Yes*		52.5

METRIC	MEASUREMENT	TARGET	2019
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)			
ARBOR HEALTH - CLINICS			
MOSSYROCK			
Clinic Overall	*Yes*	**≥50% Top Box**	71
Standard Access	*Yes*		66.8
Ease of scheduling appointments	*Yes*		67.8
Ease of contacting	*Yes*		65.8
Std Moving Through Your Visit	*Yes*		56.2
Information about delays	*Yes*		57
Wait time at clinic	*Yes*		55.4
Clinic Nurse/	*Yes*		74.4
Concern of nurse/asst for problem	*Yes*		69.5
How well nurse/asst listen	*Yes*		79.3
Clinic Care Provider	*Yes*		75.6
CP explanations of prob/condition	*Yes*		76.1
CP concern for questions/worries	*Yes*		76.4
CP efforts to include in decisions	*Yes*		76.3
Likelihood of recommending CP	*Yes*		77.1
CP discuss treatments	*Yes*		72
Personal Issues	*Yes*		74.2
How well staff protect safety	*Yes*		72.4
Our concern for patients' privacy	*Yes*		70.6
Std Overall Assessment	*Yes*		73.1
Staff worked together care for you	*Yes*		75.2
Likelihood of recommending	*Yes*		71.1

METRIC	MEASUREMENT	TARGET	2019
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)			
ARBOR HEALTH - CLINICS			
RANDLE			
Clinic Overall	*Yes*	≥50% Top Box	71
Standard Access	*Yes*		66.8
Ease of scheduling appointments	*Yes*		67.8
Ease of contacting	*Yes*		65.8
Std Moving Through Your Visit	*Yes*		56.2
Information about delays	*Yes*		57
Wait time at clinic	*Yes*		55.4
Clinic Nurse/ Assistant	*Yes*		74.4
Concern of nurse/asst for problem	*Yes*		69.5
How well nurse/asst listen	*Yes*		79.3
Clinic Care Provider	*Yes*		75.6
CP explanations of prob/condition	*Yes*		76.1
CP concern for questions/worries	*Yes*		76.4
CP efforts to include in decisions	*Yes*		76.3
Likelihood of recommending CP	*Yes*		77.1
CP discuss treatments	*Yes*		72
Personal Issues	*Yes*		72.4
How well staff protect safety	*Yes*		74.2
Our concern for patients' privacy	*Yes*		70.6
Std Overall Assessment	*Yes*		73.1
Staff worked together care for you	*Yes*		75.2
Likelihood of recommending	*Yes*		71.1

METRIC	MEASUREMENT	TARGET	2019
Integration of the Patient Experience in Quality and Safety processes (HCAHPS)			
ARBOR HEALTH - CLINICS			
SPECIALTY			
Clinic Overall	*Yes*		71
Standard Access	*Yes*		66.8
Ease of scheduling appointments	*Yes*		67.8
Ease of contacting	*Yes*		65.8
Std Moving Through Your Visit	*Yes*		56.2
Information about delays	*Yes*		57
Wait time at clinic	*Yes*		55.4
Clinic Nurse/ Assistant	*Yes*		74.4
Concern of nurse/asst for problem	*Yes*		69.5
How well nurse/asst listen	*Yes*		79.3
Clinic Care Provider	*Yes*		75.6
CP explanations of prob/condition	*Yes*	**≥50% Top Box**	76.1
CP concern for questions/worries	*Yes*		76.4
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Likelihood of recommending	*Yes*		71.1

METRIC	MEASUREMENT	TARGET	2019
Monitor trends in patient safety events through Arbor Health's event reporting system and implement actions to reduce			
Event Reporting Utilization	*Total number events entered*	**10% Increase from prior year**	320
B. IMPROVE RESOURCE UTILIZATION			
Reduce Readmissions			
Readmission w/in 30 Days-All Cause	*Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions / Total inpatient discharges (excluding discharges due to death) x 100*	**20% Reduction from prior year**	**2.1**
% Return ER Visits w/in 72 hours	*(Number of ER patients returning with same or similar diagnosis to the ER within 72 hrs of their initial visit / Total ER visits) x 100*	**20% Reduction from prior year**	**2.4**
C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS			
Clinical Quality - QHi			
Total ED Transfers	*All of transfers from an ED to another healthcare facility*	**No Target**	186
Outpatient Emergency Department Transfer Communication (EDTC-SUB 1 Administrative Communication) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility prior to transfer / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	**95.2**

METRIC	MEASUREMENT	TARGET	2019
Clinical Quality - QHi			
Outpatient Emergency Department Transfer Communication (EDTC-SUB 2 Patient Information) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	**95.2**
Outpatient Emergency Department Transfer Communication (EDTC-SUB 3 Vital Signs) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	**97.8**
Outpatient Emergency Department Transfer Communication (EDTC-SUB 4 Medication Information) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	**95.2**

METRIC	MEASUREMENT	TARGET	2019
Clinical Quality - QHi			
Outpatient Emergency Department Transfer Communication (EDTC-SUB 5 Physician or Practitioner Generated Information) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	100.0
Outpatient Emergency Department Transfer Communication (EDTC-SUB 6 Nurse Generated Information) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	100.0
Outpatient Emergency Department Transfer Communication (EDTC-SUB 7 Procedures and Tests) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	98.4

METRIC	MEASUREMENT	TARGET	2019
Clinical Quality - QHi			
Outpatient Emergency Department Transfer Communication (All EDTC) - (KS MBQIP 2019-2020)	*(Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the relevant elements for each of the seven sub-measures were communicated to the receiving hospital within 60 minutes of discharge / All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility) x 100*	**100%**	86.6
3-Hour Sepsis Bundle - BCBSKS CAH & BCBSKS PPS	*(Number of identified sepsis patients who receive all elements of the bundle / Number of identified inpatient and ED sepsis patients) x 100*	**95%**	64%
Harm Events Related to Workplace Violence - KHC HIIN	*[Number of associated harm events related to workplace violence / Number of full-time equivalents (FTEs)] x 100*	**5% Reduction from prior year**	**0.41**
STROKE - Median Arrival Time to CT Performed	*Median of individual patients' time (in minutes) between hospital arrival and CT*	**≤ 45 minutes**	39.8
STROKE - Median Arrival Time to CT Interpretation	*Median of individual patients' time (in minutes) between hospital arrival and interpretation of CT*	**≤ 60 minutes**	**61.3**
STROKE - Median Arrival Time to Administration of Thrombolytic	*Median of individual patients' time (in minutes) between hospital arrival and receiving thrombolytic*	**≤ 75 minutes**	**75.5**
Antimicrobial Stewardship - QBS			
Fluoroquinolones	*(Total days of therapy for Fluoroquinolones / Total number of patient days) x 1000*	**≤ 65.58** 20% Reduction from Baseline	32.1

METRIC	MEASUREMENT	TARGET	2019
Antimicrobial Stewardship - QBS			
Clindamycin	*(Total days of therapy for Clindamycin / Total number of patient days) x 1000*	**≤ 15.71** 20% Reduction from Baseline	6.8
Penicillins	*(Total days of therapy for Penicillins / Total number of patient days) x 1000*	**≤ 89.06** 20% Reduction from Baseline	28.6
Cephalosporins	*(Total days of therapy for Cephalosporins / Total number of patient days) x 1000*	**≤ 90.02** 20% Reduction from Baseline	40.2
Carbapenems	*(Total days of therapy for Carbapenems / Total number of patient days) x 1000*	**≤ 18.26** 20% Reduction from Baseline	1.9
Overall	*(Total days of therapy for Fluoroquinolones + Total days of therapy for Clindamycin + Total days of therapy for Penicillins +*	**≤ 278.63** 20% Reduction from Baseline	109.6
Adverse Drug Events (ADE) - QBS			
ADE - Anticoagulant Safety - Option 1: INR>5 rate	*(Number of patient events with an INR>5 after any warfarin administration / Number of patients cared for in an inpatient area on warfarin)*	**≤ 1.97%** 20% Reduction from Baseline	0%
ADE - Glycemic Management - Option 1: BG<50 rate	*(Number of patient BG <50 mg/dl after any hypoglycemic agent administration / Number of patients receiving hypoglycemic agents)*	**≤ 4.04%** 20% Reduction from Baseline	0.82%
ADE - Anticoagulant Safety - Option 1: Naloxene rate	*(Number of patients who received naloxone / Number of patients receiving opioids)*	**≤ 0.351%** 20% Reduction from Baseline	0%

METRIC	MEASUREMENT	TARGET	2019
Screening for Clinical Depression and Follow-up Plan - QBS			
Percent of patients screened and follow-up plan documented	*(Number of Medicaid enrollees screened for depression and follow-up plan documented / Number of Medicaid enrollees who visited the hospital)*	**98%**	63.71%

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE 2020
RISK MANAGEMENT PLAN RESOLUTION NO. 20-34

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

Approving the 2020 Risk Management Plan.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of August 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

2020 RISK MANAGEMENT PLAN

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OUR ORGANIZATION

Lewis County Public Hospital District No. 1 dba Arbor Health is located in eastern Lewis County, Washington surrounded by several National Forests and very close to Mt. Rainier National Park.

The District operates Arbor Health Morton Hospital, a 25-bed, 501c(3) Critical Access Hospital (CAH) providing a range of services including inpatient care, 24-hour emergency services, primary and specialty care, laboratory, pharmacy, diagnostic imaging, surgery, physical therapy and sleep lab.

The purpose of a public hospital district under RCW 70.44 includes, among other factors, to provide hospital services and other health care services for the residents of the District and others.

PURPOSE

The purpose of this plan is to describe Arbor Health's method to identify, prevent and reduce the occurrences which put people and the organization at risk for harm and financial loss. All departments and clinics participate in patient safety and loss prevention activities.

MISSION, VISION, VALUES

Our Vision

To provide accessible, quality healthcare

Our Mission

To foster trust and nurture a healthy community

Core Values

- One team, one mission.
- Go out of your way, to brighten someone's day.
- Own it, embrace it.
- Care like crazy.
- Motivate, elevate, appreciate.
- Know the way, show the way, ease the way.
- Find joy along the way.

STRUCTURE AND LEADERSHIP

The Board of Commissioners provides oversight and direction for the Risk Management Plan. The members of the Board receive at least semi-annual reports on risk management activities. They also receive orientation in issues necessary to meet their responsibilities in risk management oversight.

Risk management activities are delegated to the President and Superintendent, Chief Financial Officer (CFO), Chief Nursing/Quality Officer (CNO/CQO), Chief Medical Officer (CMO), and Compliance Officer who have overall responsibility for the implementation and operation of the Risk Management Plan.

PLAN COMPONENTS

Risk management is a planned and systematic process to reduce and/or eliminate the probability that losses will occur at Hospital District No. 1 of Lewis County, dba Arbor Health. It consists of three distinct interrelated areas:

1. ***Risk identification and loss prevention:***
   These activities include the identification and correction of situations or problems which could potentially result in events or incidents of liability for the District, its employees, physicians and other health care providers.
2. ***Loss reduction:***
   Loss reduction includes those steps taken after an event or incident occurs to minimize the adverse impact on the patient, the District, or its staff.
3. ***Risk financing:***
   This involves the mechanisms utilized to ensure adequate financial resources are available to cover any potential liability situation.

POSITION AND COMMITTEE RESPONSIBILITIES

To be most effective in the healthcare setting, risk management involves the participation of every employee. The following positions and committees perform specific activities related to risk identification and loss prevention, loss reduction, and risk financing functions.

RISK MANAGEMENT

Risk Management is a coordinated system-wide process which identifies, prevents, or minimizes events that may present potential liability to our patients, visitors, volunteers, and staff. The Risk Management Department strives to attain the ultimate goals of a safe environment and quality patient care.

While conducting event investigations, the Risk Management Department makes the determination for what tools will be used to complete the investigation, including what regulatory reporting is required (i.e. Serious Event, Root Cause Analysis and/or Failure Mode and Effects Analysis).

The Risk Management Department also provides a wide variety of education to minimize exposure to the facility and its employees. Topics include but are not limited to Disclosure, Documentation and Informed Consent.

The Risk Management Department is available to all physicians, staff/employees for consultations, advice and help in dealing with difficult patient/visitor issues.

PRESIDENT AND SUPERINTENDENT

In conjunction with the Chief Medical Officer and Chief Nursing/Quality Officer, this position reviews and manages the flow of information pertaining to the Risk Management Plan.

The President and Superintendent procures adequate liability insurance coverage at reasonable premiums to cover losses. The District participates in professional and general liability insurance programs that provide coverage for medical malpractice and other types of negligence claims. The President and Superintendent also effectively negotiates and uses indemnity provisions in District contracts to transfer liability risks to other parties whenever possible.

When necessary, legal advice is sought to advise the facility's administration, clinical and other staff in an attempt to minimize risk and loss and to assure that the organization and its policies, procedures and practices remain in compliance with applicable state and federal laws, rules and regulations. The President and Superintendent serves as the focal point of coordination for activities concerning risk management, relying upon input from each of the positions/areas outlined in this plan.

The President and Superintendent procures and administers the District's malpractice insurance policies.

CHIEF FINANCIAL OFFICER (CFO)

Directs and coordinates district activities concerned with the financial administration, general accounting, patient business services, data processing, admission, medical records, health care review, resident activities, and statistical reporting. Provides necessary data and information for risk management purposes as required.

CHIEF NURSING AND QUALITY OFFICER (CNO/CQO)

In conjunction with the President and Superintendent and CMO, this position reviews and manages the flow of information pertaining to the Risk Management Plan.

Directs the following activities related to evaluating the quality of care provided and reports areas of potential risk to the President and Superintendent, QI Oversight Committee, Board of Commissioners, other appropriate staff or regulatory agency, for corrective action and improvement purposes:

- Quality Improvement Oversight Committee
- Quality Council
- Infection Prevention Committee (in conjunction with the Infection Prevention Nurse Coordinator and Epidemiologist)
- Environment of Care Committee
- Life Safety Committee
- Safety Committee
- Safe Patient Handling Committee (in conjunction with Safe Patient Handling Coordinator)
- Critical Access Hospital Evaluation (in conjunction with the President and Superintendent and CFO)
- Plans of Correction and Progress Reports for DOH surveys (in conjunction with the President and Superintendent and CFO)
- Complaints
- Quality Management Memos (incident reports)
- Adverse Events
- Restraint use
- Quality Assurance Performance Improvement (QAPI) Plan
- Risk Management Plan (in conjunction with the President and Superintendent and CMO)
- Peer Review
- Ongoing Professional Practice Evaluation (in conjunction with the Credentials Coordinator)
- Patient Satisfaction
- Hospital Inpatient and Outpatient Quality Reporting to Center for Medicare and Medicaid Services (CMS)

- Rural Health Clinic annual program evaluations
- Washington Rural Healthcare Collaborative (WRHC) quality measures
- Nursing documentation review quality Assurance Performance Improvement (QAPI) for District owned Rural clinics
- Rural Health Clinic annual program evaluations
- Washington Rural Healthcare Collaborative (WRHC) quality measures
- Nursing documentation review
- WSHA quality measures & projects
- Washington Department of Health Medicare Beneficiary quality Improvement program (MBQIP)
- Quality Improvement and risk management education

The CNO/CQO directs Nursing Services, Case management, Surgical/Sterile Processing/Outpatient Services, Emergency Room, Wound Care, Nurse education, quality, Infection Prevention, Laboratory, and Imaging regarding issues related to quality and safety of clinical practice. This includes continual design and implementation of strategies to improve patient Care which are in alignment with research evidence based medicine. All areas perform risk management duties that help support safe operation of clinical units and coordinate with other departments, such as Central Supply, clinics and Anesthesiology. They insure supplies, Surgical materials and special equipment are Sterile and ordered in advance. They also insure data regarding Surgical Care, Infection Prevention, trauma, utilization, and other measures are made available to The quality Manager and/or CNO/CQO. This data is aggregated into trending information for risk analysis and assessment by The quality Manager and CNO/CQO.

The CNO/CQO serves on The QI Oversight Committee and provides information regarding risk management activities. This Committee also receives reports from The quality Manager on quality Improvement Assurance and Improvement activities, medical staff peer reviews, on-going professional practice evaluations, hospital quality dashboard reports, progress on patient safety measures, employee satisfaction, patient satisfaction, and other quality initiatives. The QI Oversight Committee reports quarterly to The Board of Commissioners.

CLINICAL INFORMATICS TEAM

The Nursing Informatics Team is nursing's primary resource for designing, building, and maintaining of the electronic health record (EHR), as well as training nursing staff on its use. The team also modifies and tests clinical applications for efficiency and effectiveness and identifies and communicates areas of potential risk to the Clinical Informatics Supervisor. In conjunction with the Clinical Informatics Supervisor, assures the clinical documentation system effectively supports and enhances the clinical process.

The Clinical Informatics Supervisor directs the Coordinator and works with the Cerner team to develop and implement EHR updates or changes. The Supervisor coordinates the collection and analysis of metrics that relate to benefits realization and the return on investment in the clinical information system. This position analyzes data and makes changes in coordination with other departments. The EHR is a legal document that can be used by an injured patient in legal proceedings or in other legal matters.

COMPLIANCE AND HIPAA OFFICER

The Compliance Officer is responsible for:

- Updating the Compliance Program Plan and assuring a system for prompt response to Compliance issues
- Communicating to staff the compliance hotline number and other means for reporting non-compliance
- Distributing the hospital's Standards of Conduct
- Investigating reported improprieties and/or non-compliance
- Reviewing/updating compliance policies and procedures
- Auditing departments on a routine basis to prevent, detect, and correct non-compliance
- Reporting progress on issues or concerns to the Administrator
- Providing the Board of Commissioners with periodic reports
- Providing effective education and training regarding Compliance and its purpose

As HIPAA Officer this position conducts an assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of Patient Health Information (PHI) stored or held electronically by Arbor Health. The HIPAA Officer ensures HIPAA Privacy and Security requirements are implemented, followed and complaints are investigated and reported as appropriate. This position provides data and reports to the governing Board concerning the number of HIPPA/Privacy complaints, their disposition and other compliance issues.

HUMAN RESOURCES DIRECTOR

In conjunction with the Credentialing Coordinator, Credentials Committee, Medical Executive Committee, and Board of Commissioners, is responsible for required credentialing and privileging of the facility's medical staff to ensure licensing and competency for the protection of patients at Arbor Health. The Director of Human Resources, in coordination with Department Directors and/or Managers, is also responsible for ensuring current licensure and competency of all staff.
This position directs the following policies and activities:

- Industrial Accident – Incident Claim policy
- Personnel Policy and Procedures Manual
- Group health insurance plans (health, dental, life, disability) for employees
- Pension plan for employees with the pension consultant
- Assistance to managers on employment issues in accordance with policies and union contracts
- Pre-Employment Drug Testing policy
- Sexual Harassment policy
- Labor negotiation sessions and preparatory work including salary reviews
- Collection of pertinent information and maintenance of files on arbitration sessions with employees
- Comprehensive orientation and training for new employees
- SWANK training for employees by department
- Education Steering Committee – determines the annual planning cycle to assure that requirements are addressed, burden of education pushed at end of year is reduced, educational topics align with strategic plan, quality metrics are achieved, current organizational tactics are covered, tools and applications are reviewed and optimized.

FACILITIES MANAGER

The Facilities Manager is responsible for the overall physical facilities. This position chairs the Life Safety Committee which is also responsible for the organization's disaster preparedness. The Facilities Manager ensures that regular fire safety inspections and drills are done and that the appropriate scheduled inspection of all medical and other equipment is accomplished, as well as having all repairs/replacements done when necessary. The Facilities Manager has written procedures to follow in the cases of equipment/supply recall to assure that all equipment subject to recall is appropriately serviced, repaired, returned or otherwise removed from service when required for the safety of the patients, employees and/or others. The Facilities Manager reports quarterly on specific facility improvement indicators at EOC Committee.

The Facilities Manager is responsible for administering the following plans and related policies or procedures through the Safety and Life Safety Committees:

- Fire Safety Management Plan
  - Fire drills
- Emergency Preparedness Management Plan
  - Emergency preparedness drills (including NIMS)
- Medical Equipment Management Plan
  - Review medical equipment tests
- Utility Systems & Physical Environment Management Plan
  - Review preventative maintenance (inventory, performance, documentation)
- Security Management Plan
  - Security rounds

- Hazardous materials and Waste management (HMWM) Plan
  - Chemical hazard/SDS
- Code drills (Orange, Gray, Silver, Amber, White)

These plans and/or policies are a vital part of The organization's risk management Plan.

SAFETY OFFICER

The Safety Officer is chair of the Safety Committee, voted in annually by its members. The Safety Officer and Committee is responsible for the organization's Safety and Accident Prevention Plan and assures the following activities occur:

- EOC/Safety rounds
- PPE hazard assessment
- New product evaluations
- Review staff accidents
- Evaluate & update Safety & Accident Prevention Plan
- Review L&I accident claims and rates of injury
- Maintain Safety bulletin boards
- Post Washington Industrial Safety and Health Act (WISHA) Poster(s)
- Educate staff

MEDICAL STAFF

The Medical Staff is responsible for governing the medical practice at the hospital. The Chief of Staff chairs the Medical Executive Committee which receives information from the Chief Medical Officer, Credentials Committee, Quality Oversight Committee, Infection Prevention Committee, Pharmacy and Therapeutics Committee, Bylaws Committee, and Utilization Review/Medical Records/Tissue and Transfusion Committee. These committees assist the medical staff in identifying areas of risk and in providing information required to correct or decrease the risk. The Medical Executive Committee is responsible for addressing risk management issues as they relate to medical staff appointment, reappointment, privileging, peer review, competence, and intimidating and disruptive behavior.

The hospital is required by law to report to the Department of Health the termination or restriction of staff privileges of any licensed physician. In addition, physicians and hospitals are required by law to report to the Medical Quality Assurance Commission or other appropriate division of the Department of Health, any information that appears to show a physician is or may be unable to practice medicine with reasonable skill and safety. The Commission/division then makes its own investigation.

PHARMACIST

The Pharmacist chairs the Pharmacy and Therapeutics Committee which is a standing committee of the Medical Staff. The Pharmacy and Therapeutics Committee is responsible for evaluating available evidence regarding the relative safety, efficacy and effectiveness of therapeutic agents and devices used in the hospital and clinics to ensure their quality meets said standards. They continually revise the hospital formulary so it represents the best available for prophylaxis or management of disease and meets the needs of patients. The Pharmacist recommends quality control specifications, methods of distribution and control, and drug utilization reviews.

The Pharmacist routinely provides (among other responsibilities):

- Verification of orders versus MARS for accuracy of transcription
- Review of antibiotic use
- Unit dose dispensing for medication
- Techniques to enhance distinction between look-alike/sound alike drug names
- Assistance in the formulation and implementation of programs designed to meet the needs of the medical and nursing staff for complete and current knowledge related to drug practice
- Advise to medical staff in the selection of drugs
- Data/information to medical staff regarding drug usage, adverse drug reactions and medication errors
- Investigation of Quality Management Memos – Medication
- Help to medical staff to differentiate between similar therapeutic agents

INFECTION PREVENTION AND CONTROL

The Infection Preventionist provides advanced professional and clinical leadership on infection control and prevention matters and administers the Infection Control and Prevention Plan. This position, in conjunction with a contracted Epidemiologist, is responsible for the management of infectious disease identification, surveillance, prevention, control, investigation, consultation, research, education, and development and review of related policies and procedures. Additionally, this position directs the hospital and associated clinics in complying with related local, state, and federal guidelines, standards and regulations. This role is an integrated function of the organization-wide quality and patient safety program.

EMPLOYEE HEALTH

The Employee Health Nurse is also responsible for tracking and reporting staff exposure to infectious disease, actual infection, and immunization and tuberculosis screening and compliance. This position provides TB screening of each new employee and TB review/latent TB testing and immunization review of current employees on an annual basis. This position conducts evaluation of ill employees and helps determine need for work restrictions, therapy or referral, and need for communicable disease evaluation. The Employee Health Nurse, in conjunction with the Epidemiologist, also evaluates exposures to contagious disease, environmental hazards, and bioterror issues. This position takes appropriate corrective action including notification of public health authorities, dissemination of information, training or education, developing preventative measures, and improving communication to reduce/prevent future risk. Quarterly data on exposures, infections, and TB screening and compliance is provided to the Infection Control Committee which recommends corrective action and reports areas of potential risk to the Medical Executive Committee.

CLINICAL EDUCATION

Clinical Education helps plan, develop and implement clinical education and training. Appropriate education programs are developed as needed to address medical-legal and risk management related subjects. Education and in-services are also provided as the result of tracking and trending of patient care and safety measures data.

EMERGENCY DEPARTMENT

The RN Emergency Department Coordinator, in conjunction with the Emergency Department Medical Director, provides leadership, generates decisions and sets goals to assure the unit meets and exceeds the standards of care defined for the patient population. The RN Emergency Department Coordinator audits patient care and provides data that is aggregated into trending information for risk analysis and assessment of emergency care measures to the Trauma Quality Improvement Committee. This position also provides incident reports and findings to the Quality Manager and CNO/CQO. Serious Incidents may result in activation of the Adverse Event/Sentinel Event protocol and root cause analysis (RCA) process. The Quality Manager further defines, aggregates, trends, analyzes, and reports on incidents to the QI Oversight Committee.

CASE MANAGEMENT

The Case Manager works with the patient, family and medical providers to foster communications and effective, efficient care. This position coordinates patient transitions through the hospital. The Case Manager is responsible for regularly assessing the patient and working with the patient's medical team to chart the patient's progress and monitors that the plan of care is being carried out. The Case Manager makes sure the patient understands medical instructions and that the medical team understands the patient's needs and concerns. This position acts as the patient's advocate and the care team's representative, trying to make sure everyone works together for the benefit of the patient.

The Case Manager is also responsible for Utilization Review and intervenes as appropriate when changes in status are indicated.

SAFE PATIENT HANDLING COMMITTEE

The Safe Patient Handling Committee responsible to the Environment of Care Committee. The primary responsibility of the Safe Patient Handling Committee is to establish, implement and monitor the Safe Patient Handling Program. This program develops and implements strategies to control the risk of injury to patients and health care workers associated with the lifting, transferring, repositioning, or movement of a patient. The committee works in close conjunction with the Infection Prevention Nurse, Safety Committee and appropriate nursing leadership to carry out its responsibilities. Areas/issues of potential risk are reported to the EOC Committee for monitoring and further improvement purposes.

Specific responsibilities of the Safe Patient Handling Committee are:
- Review all patient falls
- Review staff accidents related to patient handling
- Evaluate & update Safe Patient Handling Program/ Plan
- Code drills (Rapid Response)
- Educate staff

SUPPLY CHAIN MANAGEMENT

The Purchasing Clerk chairs the ad-hoc Product Evaluation Sub-Committee which is responsible to the Safety Committee. The Product Evaluation Sub-Committee evaluates new and replacement products for safety, effectiveness and cost. Members of this sub-committee include the Pharmacist, CNO/CQO, Infection Preventionist, Case Manager, Quality Manager, Chief Medical Officer, Controller, and other staff as necessary to ensure its findings are congruent with environment of care, life safety, infection prevention and control, medication management, and patient safety standards. It reports its findings to the appropriate director/manager/department, the Safety Committee and the Infection Prevention Committee, which reviews any issues of potential risk.

The Purchasing Clerk monitors and updates the following policies and/or procedures to address special safety issues in emergency situations. These policies and/or plans are a vital part of the organization's Risk Management Plan:
- Safety Data Sheet (SDS) Management
- Medical Device Recalls and Hazard Notices

INFORMATION TECHNOLOGY

The Information Technology Manager conducts security and risk assessment of potential threats to District information systems. This position organizes an appropriate defense system and inserts controls intended to prevent accidental hazards, deter intentional acts, detect problems as early as possible, enhance damage recovery, and correct problems. This position is also responsible for providing awareness training (of security threats and potential problems and crimes) to staff and assessing the number and type of work orders received. These findings are aggregated and reported to the QI Committee and areas/issues of potential risk are reported to the CFO and President and Superintendent.

EVENT REPORTING

Employees/Physicians are the eyes and ears of the organization and have a responsibility to use sound patient safety practices in caring for our patients. All employees/physicians are responsible for patient safety.

Every employee/physician has the following responsibilities when an untoward event occurs:
- First and foremost, take appropriate steps to care for the patient and minimize negative outcomes.
- Contact the patient's attending physician to report the incident and implement any therapy or treatment ordered.
- Implement steps to contain the risk to others, as appropriate.
- Enter an incident report in the electronic incident reporting system (ComplyTrack system).
- Take care of any family needs, as appropriate.
- Disclosure of the event by the appropriate care team to the patient/family.
- Documentation of the event and the disclosure in the medical record.

All members of the medical staff, house staff, and employees are required to report suspected and/or identified medical errors/events and should do so without the fear of reprisal/retaliation in relationship to their employment. A report of an event or hazard may be entered into the electronic event reporting system (ComplyTrack) with or without providing your name.

MANDATORY STATE REPORTING OF EVENTS

The State of Washington requires mandatory electronic reporting by all licensed health care facilities of any incident or event that may be associated with or may be an actual patient safety concern; and requires an automatic disclosure to patients and their families.

Events of interest to the Commonwealth are described as Incidents, Serious Events or Infrastructure Failures.

What is an Incident?
An incident is an event, occurrence, or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event.

What is a Serious Event?
A serious event is an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. The term does not include an incident.

What is an Infrastructure Failure?
An infrastructure failure is an undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.

The Quality Management Department in concert with Administration make all determinations as to what occurrences are reported to the state.
- The law requires that any health care worker who reasonably believes that a serious event has occurred with a patient shall immediately report the event according to their facility's patient safety plan and the incident reporting instructions listed above.

- In addition, if the facility discovers that a Licensed Health Care Provider has failed to report a serious event, then that facility may notify the licensing board of the failure to report by the licensed health care provider.

CULTURE OF PATIENT SAFETY

Periodically, Arbor Health will survey clinical staff and physicians regarding the Culture of Patient Safety at the hospital. The results from this survey provide hospital leadership with an understanding of the safety culture at the hospital which is the product of the individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Action plans are developed and implemented at the hospital and department/unit level to enhance the culture of safety in order to improve the quality and safety of care provided and improve the reporting of events to enrich the safety culture at the hospital and clinics.

POTENTIAL LEGAL ACTION

If any employee learns of an incident or complaint that may lead to legal action against the hospital or a staff member, that person should immediately notify the Compliance Officer, CEO, CFO, CMO, or CCO.

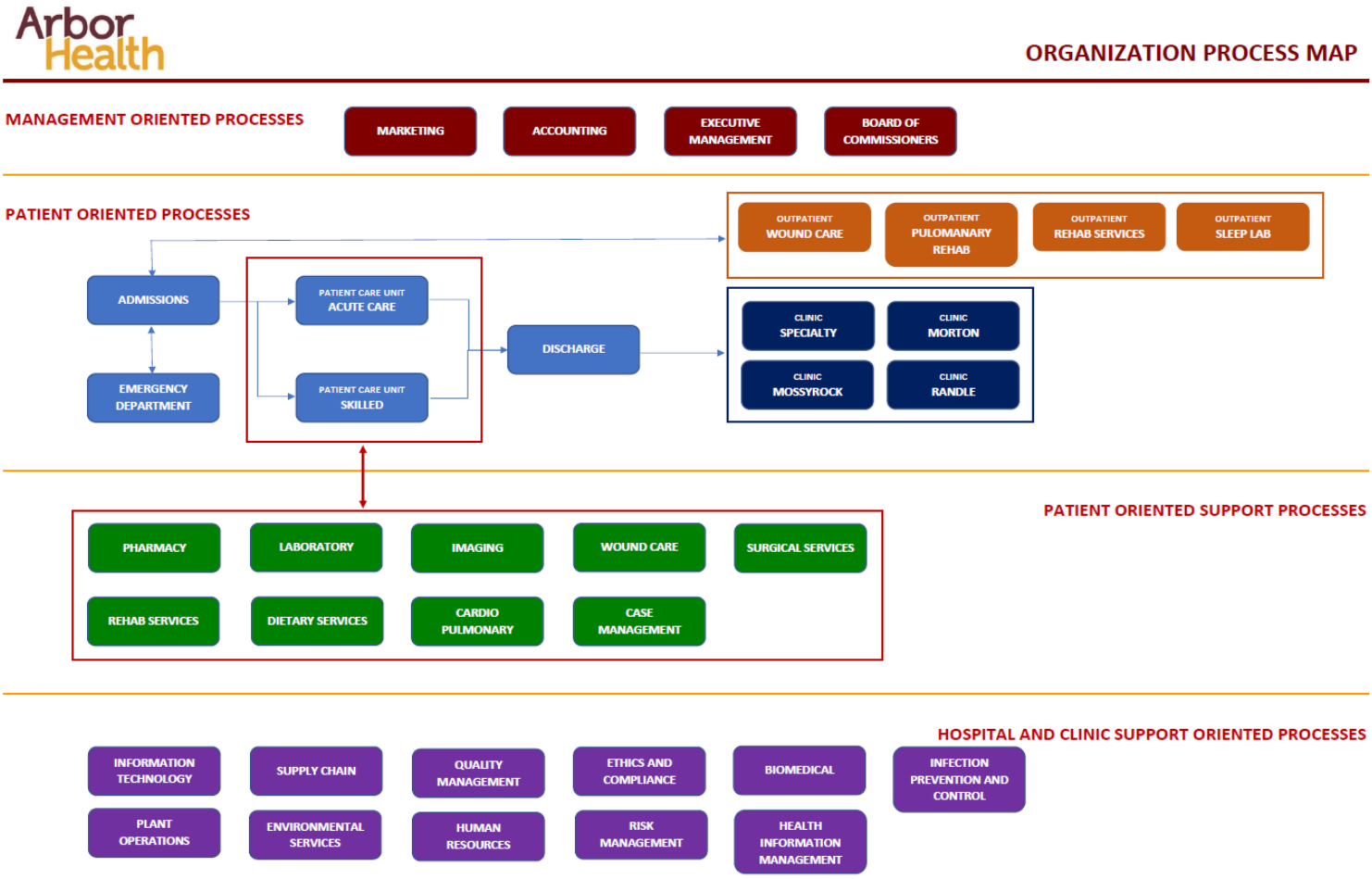
Employees should not speak with attorneys or investigators who are not affiliated with the District regarding any matter involving the District unless specifically authorized to do so. Questions regarding whether a person is a hospital representative or for other guidance should be directed to the CEO.

ANNUAL EVALUATION

Arbor Health Morton Hospital and the Board of Commissioners shall review the Risk Management Plan at least annually in alignment with the calendar year. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Arbor Health and the Board of Commissioners also evaluate annually their contributions to the performance improvement and patient safety activities at Arbor Health.

IMPLEMENTATION OF ACTIONS AND DISSEMINATION OF INFORMATION

Implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Communication of quality and safety information is the responsibility of clinical and administrative leadership. This information is reported to the Quality Management Department, and throughout the organization, using the Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequent as necessary, the performance is presented at the Quality Improvement Oversight Committee with minutes and then presented to the Board of Commissioners.



LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE 2019
CRITICAL ACCESS HOSPITAL
EVALUATION RESOLUTION NO. 20-35

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

Approving the 2019 Critical Access Hospital Evaluation.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of August 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

2020 CRITICAL ACCESS HOSPITAL PERIODIC EVALUATION

January 1, 2019 - December 31, 2019

Table of Contents

OUR ORGANIZATION

Lewis County Public Hospital District No. 1 dba Arbor Health is located in eastern Lewis County, Washington surrounded by several National Forests and very close to Mt. Rainier National Park.

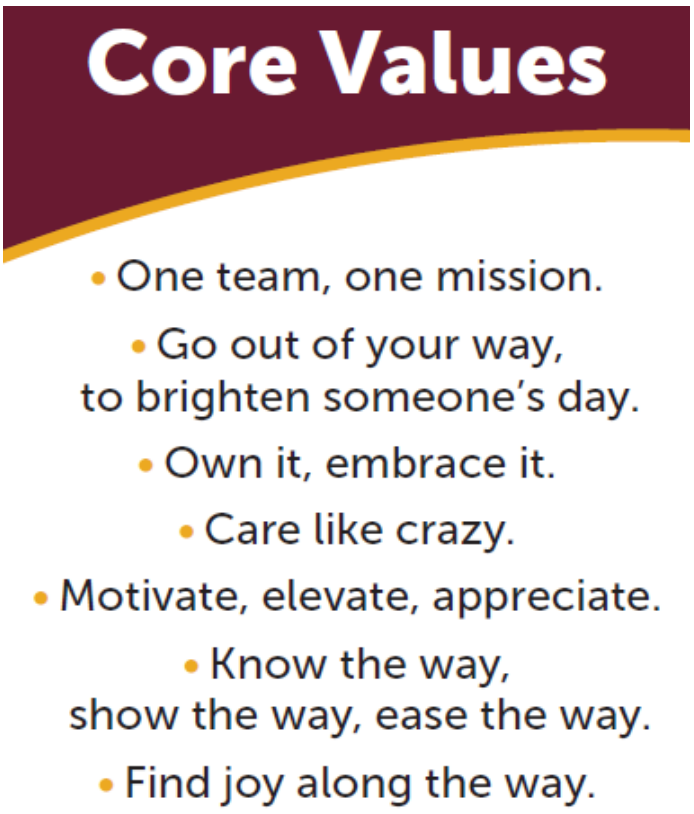
The District operates Arbor Health Morton Hospital, a 25-bed, 501c(3) Critical Access Hospital (CAH) providing a range of services including inpatient care, 24-hour emergency services, primary and specialty care, laboratory, pharmacy, diagnostic imaging, surgery, physical therapy and sleep lab.

The purpose of a public hospital district under RCW 70.44 includes, among other factors, to provide hospital services and other health care services for the residents of the District and others.

PURPOSE

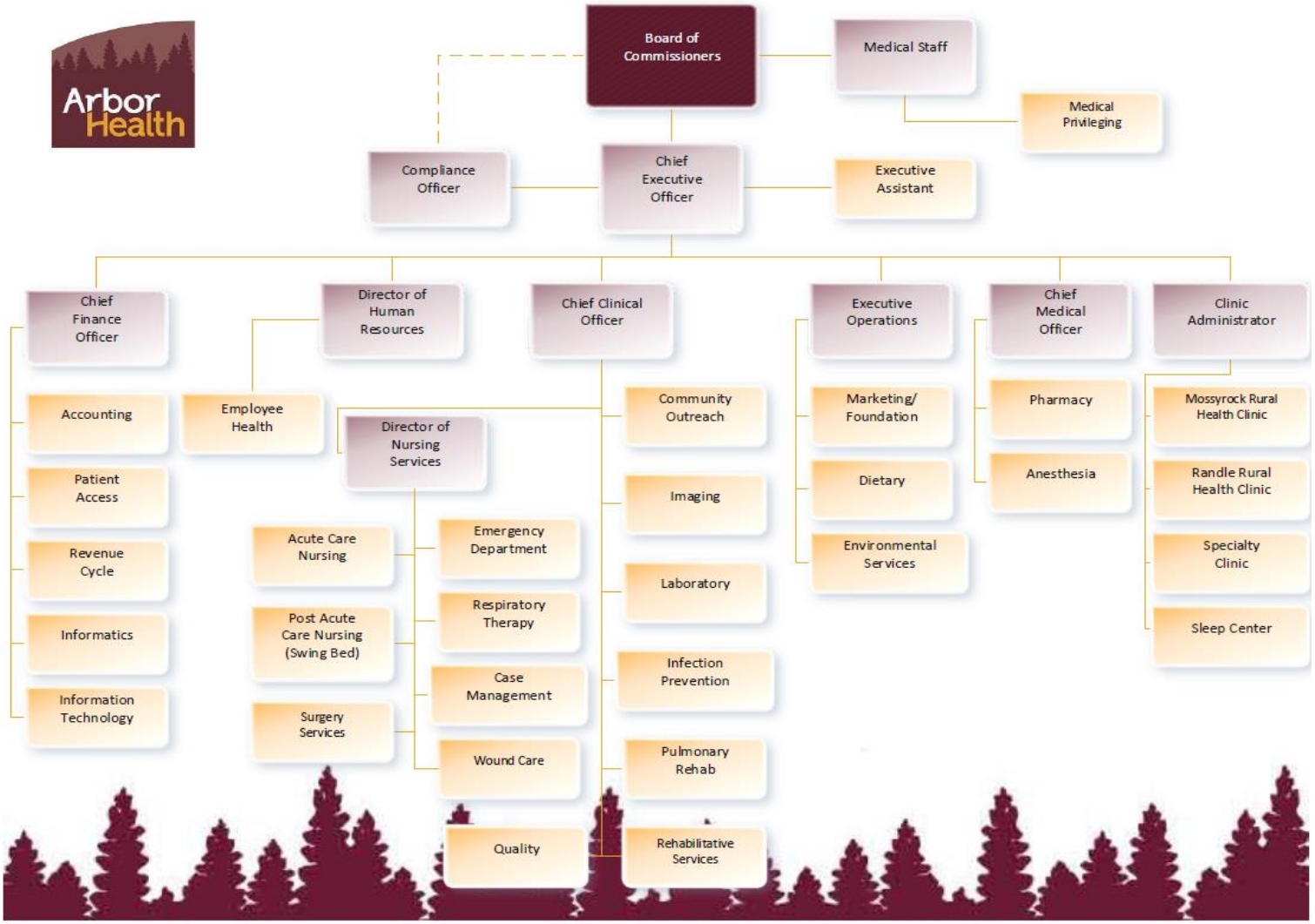
The purpose of the Annual Critical Access Hospital (CAH) Evaluation is to provide a formal mechanism by which Arbor Health carries out a periodic evaluation of its total program periodically. The evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed. In alignment with the Centers for Medicare and Medicaid Services'(CMS) Condition of Participation (CoP) for CAH, this document describes and includes but not limited to the review of utilization of Arbor Health's services, outcomes from active and closed clinical records, and a report of key policies and procedures that were either newly developed, reviewed and updated.

MISSION, VISION, VALUES



STRUCTURE AND LEADERSHIP

Key employees are responsible for the development, evaluation, and review of Arbor Health's Annual CAH Evaluation. These individuals, Arbor Health's President and Superintendent, Chief Clinical Officer, Chief Financial Officer, and Director of Human Resources are joined by the hospital Chief Medical Officer and Chief of Staff to fully represent the spectrum of hospital services. These leaders work directly and openly to improve quality by setting priorities, modeling core values, promoting a learning atmosphere, acting on recommendations, and allocating resources for improvement. These individuals are supported by a structure of formal and informal committees or work groups where the components of the program are defined, implemented, refined, and monitored. These groups are comprised of attending physicians, staff, management which in turn reports to the Board of Commissioners.



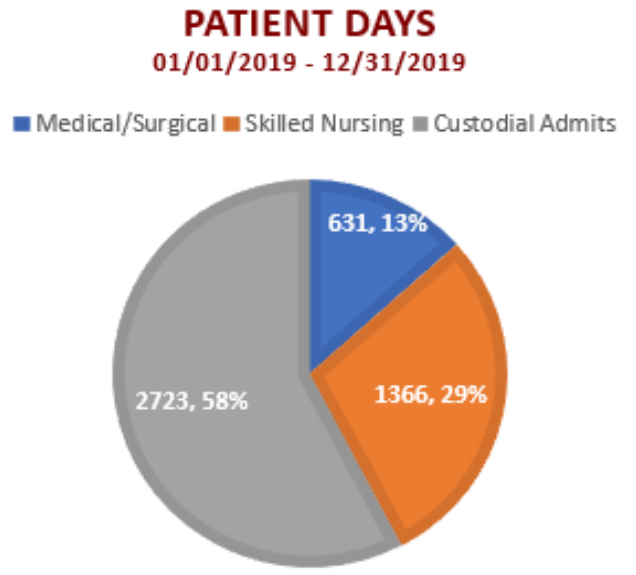
PROGRAM EVALUATION

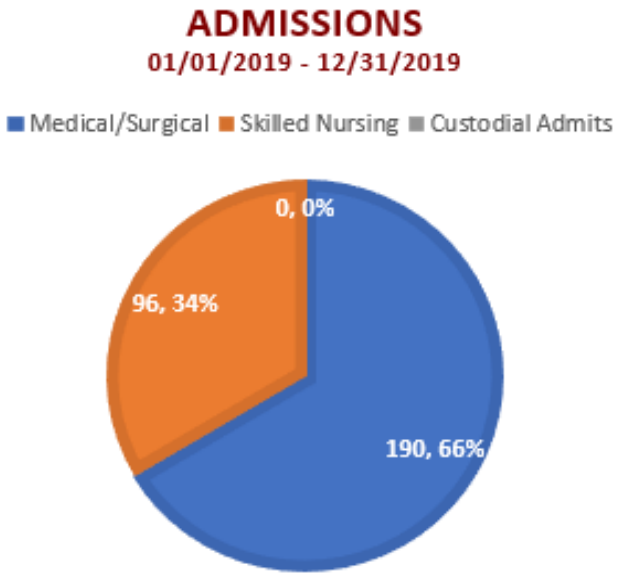
A. OUR SERVICES

- 24-hour, on-site ER Doctor
- Morton Clinic
- Mossyrock Clinic
- Randle Clinic
- Specialty Clinic
  - General Surgery
  - Women's Health
  - Sleep Medicine
- Surgery Clinic
- Wound Care Clinic
- Clinical Laboratory
- Consulting Specialists
- Diagnostic Imaging
  - CT Scan
  - 3-D Digital Mammography
  - Digital X-Ray
  - MRI
  - Nuclear Medicine
  - Ultrasound
- Behavioral Health
- Nutritional Services
- Outpatient Drug Therapy
- Physical Rehabilitation
  - Aqua Therapy
  - Occupational Therapy
  - Physical Therapy
  - Respiratory Services
  - Speech Therapy
- Sleep Lab
- Social Services

B. VOLUME AND UTILIZATION

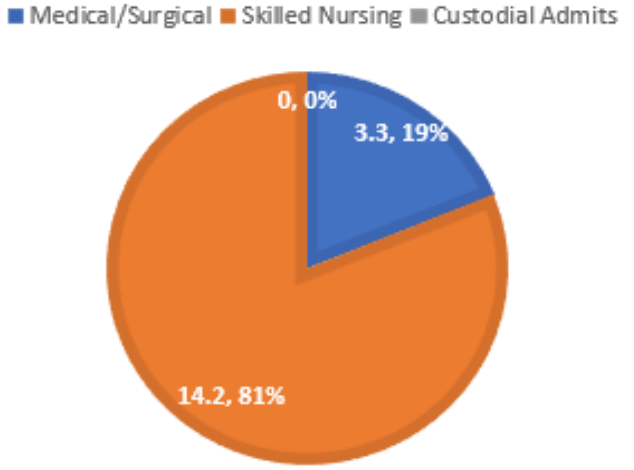
INPATIENT UTILIZATION



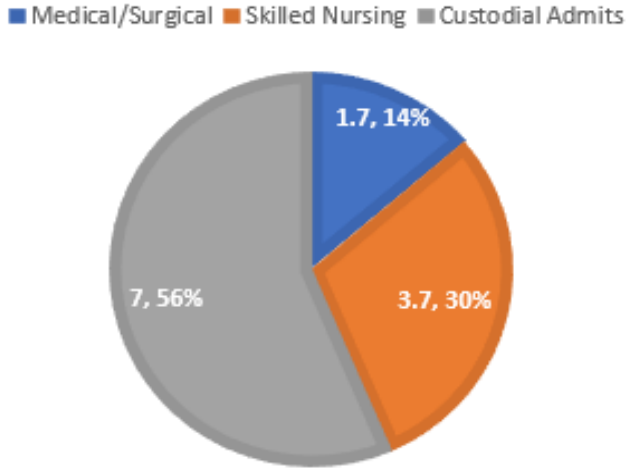


INPATIENT UTILIZATION *(Continued)*

LENGTH OF STAY
01/01/2019 - 12/31/2019

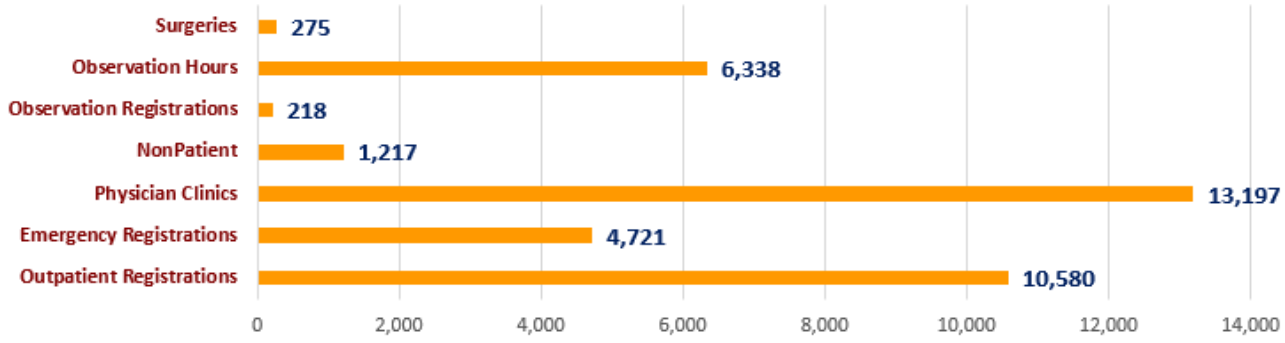


AVERAGE CENSUS
01/01/2019 - 12/31/2019

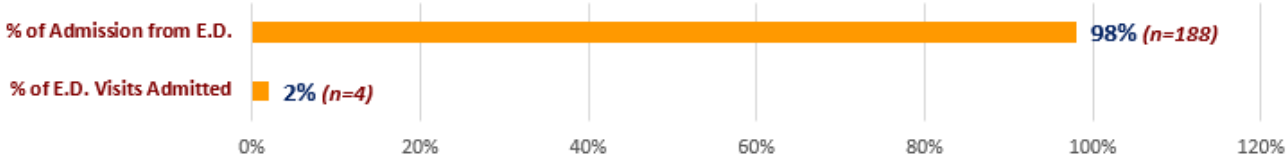


OUTPATIENT UTILIZATION

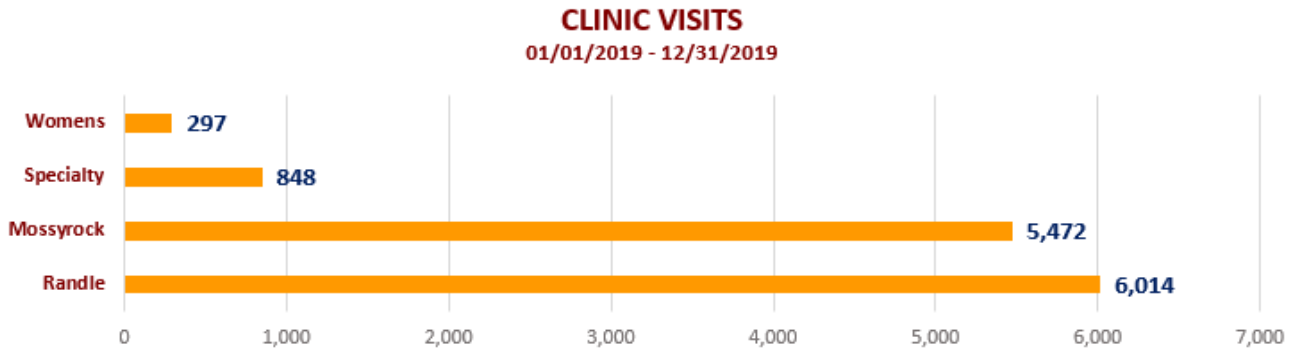
REGISTRATIONS
01/01/2019 - 12-31/2019



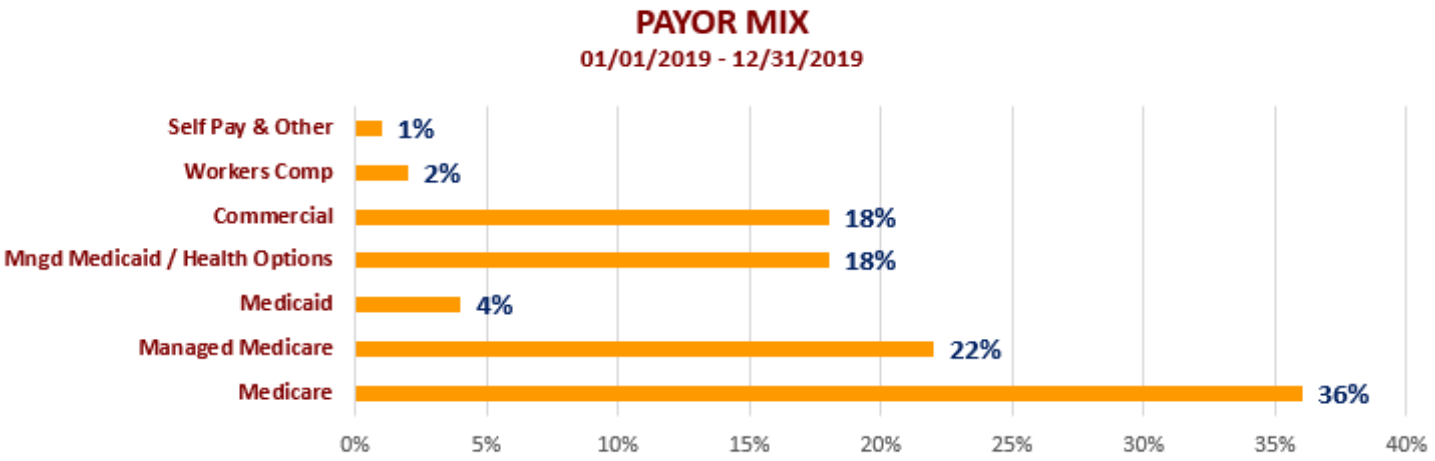
ED SERVICES
01/01/2019 - 12/31/2019



CLINIC UTILIZATION



PAYOR MIX

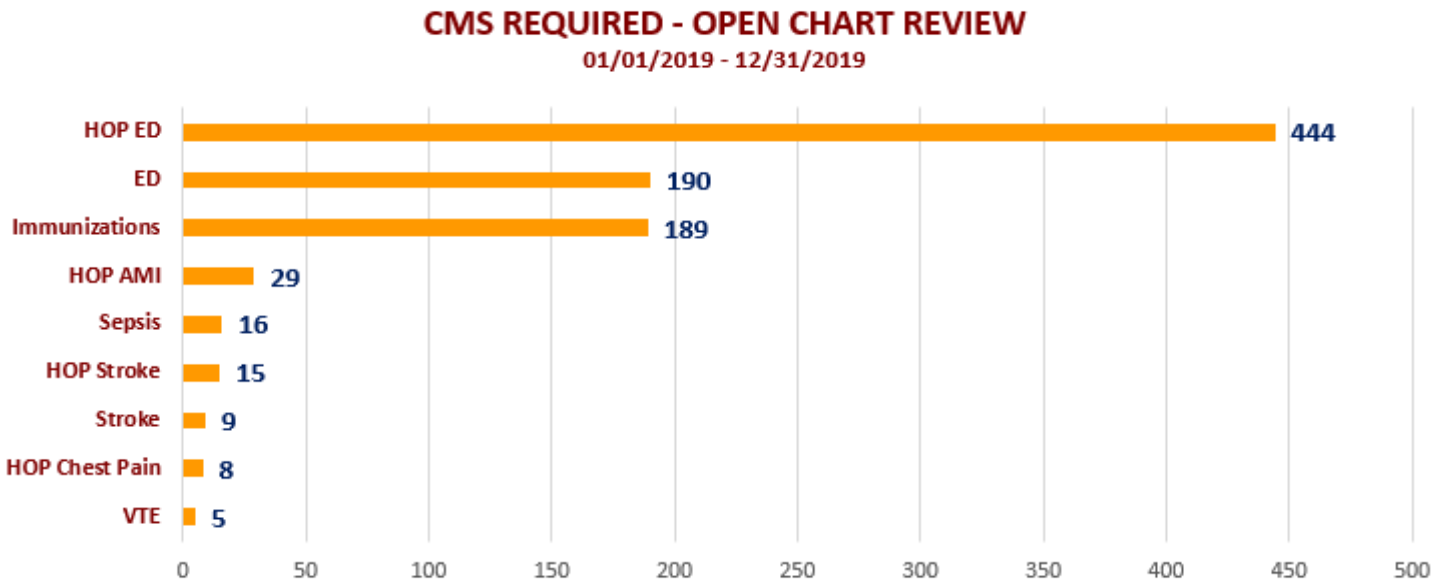


C. ACTIVE AND CLOSED MEDICAL RECORDS AUDIT

REVIEW PROCESS

In compliance with CAH regulation CFR 485.641(a) (1) (ii) a representative sample (at least 10%) of both active and closed clinical records were reviewed in in the past year. Records addressed included inpatient, emergency room, and ambulatory records. Both concurrent and retrospective reviews were conducted for completeness, accuracy, informed consent, medical necessity, and adherence to protocols and standards of care.

OPEN CHART REVIEW



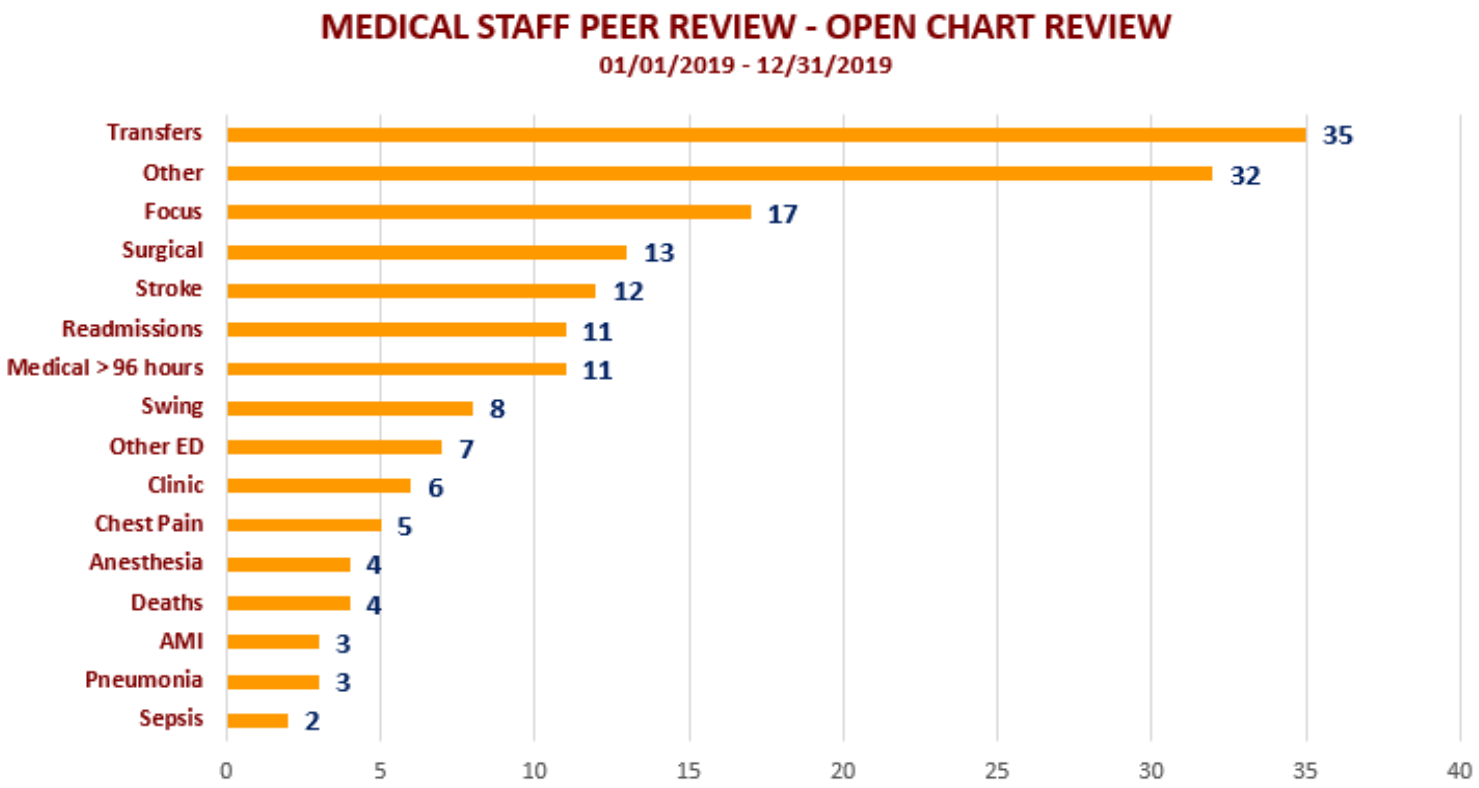
MEDICAL STAFF PEER REVIEW

Arbor Health performs Peer Review for both hospital cases and clinic encounters. Arbor Health uses an external Peer Review process for the hospital cases in agreement with the Washington Hospital Services, a Washington State Hospital Association company and an internal Peer Review process is conducted for clinic encounters. Active and closed clinical records undergo review according to criteria established by the Arbor Health Peer Review Committee. Additional cases review selections come through requests from Compliance, Utilization Review, Risk Management, Medical and/or Nursing staffs. Peer Review findings are discussed in executive session meetings of the Arbor Health Medical Staff. Findings are used in determination of clinical privileges, continued membership on Arbor Health's Medical Staff, or other corrective or remedial action as appropriate.

Indicators that trigger selection or consideration for Physician Peer Review include but not limited to:

-Unanticipated deaths, including patient suicide
-Unanticipated complications in patient condition and/or treatment that result in actual or potential prolongation of the patient's stay, and/or major permanent loss of function.
-Surgery on the wrong patient or wrong body part
-Surgical and/or anesthesia related complications including unexpected return to surgery
-Unplanned re-admission within seven days of discharge for same or similar diagnosis (excludes Swingbed admissions)
-Moderate to severe adverse drug reactions
-Blood utilizations
-Other cases requested by nurse managers, PI/Risk Manager, or medical staff

MEDICAL STAFF PEER REVIEW *(Continued)*



GATHERING DATA

Data is then gathered on a pre-determined timeframe (weekly, monthly, quarterly). Regular reporting of data requires continued attention from teams. A designated person will be assigned and held accountable for gathering data and having the information available when due. Sampling sizes are determined based on recognized, statistically significant sample sizes of:

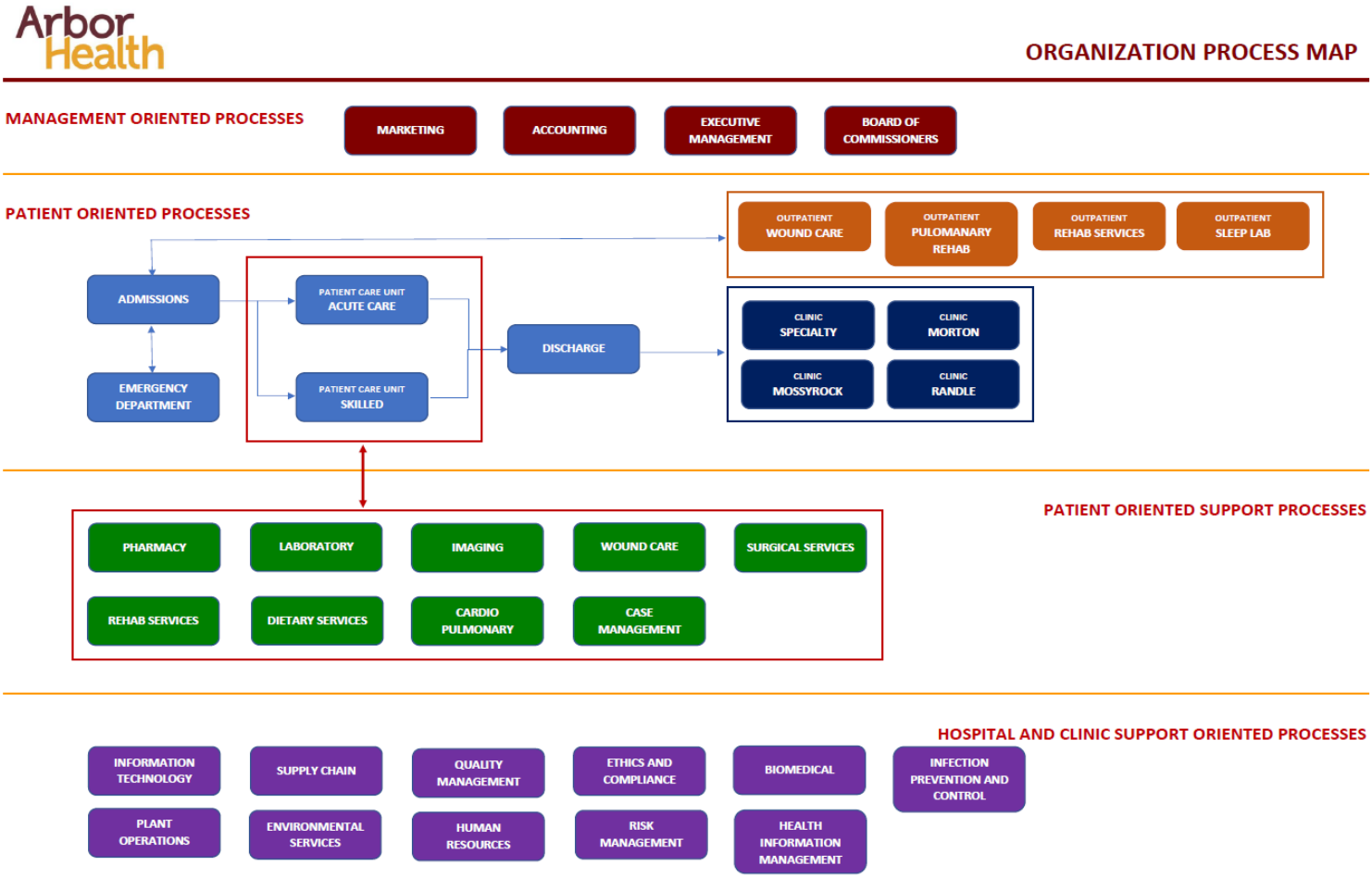
<30 per month = 100% → **30 - 100 per month = 30** → **101 - 500 per month = 50** → **>500 per month = 70**

ANALYZING AND REPORTING DATA

The work groups discuss data analysis and determine what initiatives must be implemented to attain the desired outcome. Analysis usually involves multiple iterations and analysis to examine different aspects of the quality issue. Whenever possible and appropriate, statistical control methods, trending, and/or comparison with published benchmarks are used to analyze quality and safety measures.

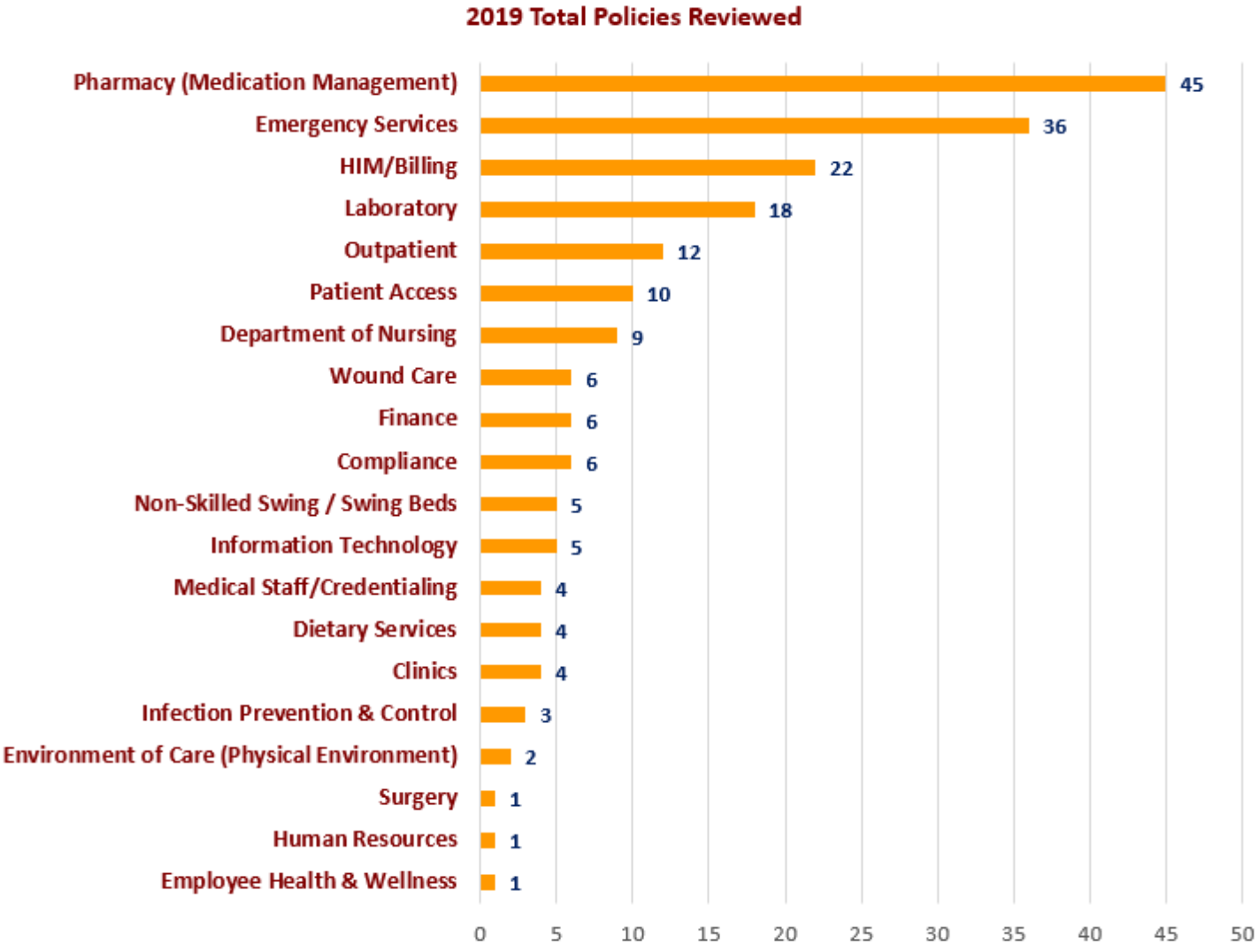
IMPLEMENTATION OF ACTIONS AND DISSEMINATION OF INFORMATION

Implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Communication of quality and safety information is the responsibility of clinical and administrative leadership. This information is reported to the Quality Management Department, and throughout the organization, using the Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequent as necessary, the performance is presented at the Quality Improvement Oversight Committee with minutes and then presented to the Board of Commissioners.



D. HEALTH CARE POLICIES

Patient care and administrative policies are added, reviewed, revised and/or deleted by action of the appropriate Arbor Health department or committee and approved by the Board of Commissioners. Policies are scheduled for review at least annually and whenever need for modification is recognized. Compliance with timely policy review is tracked by the applicable department director or manager and reported to the Policy and Procedure Review Committee.



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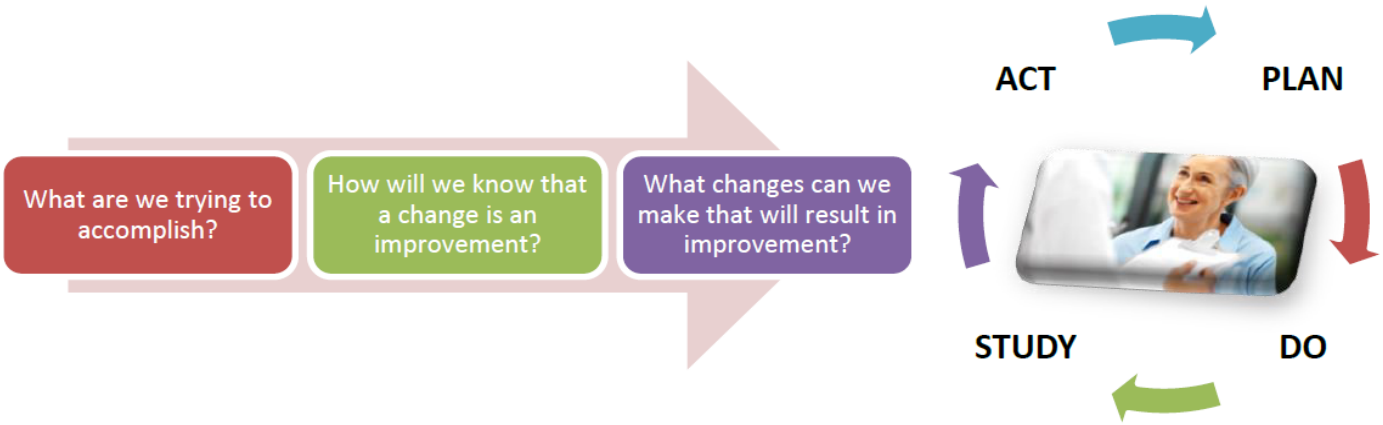
E. QUALITY ASSURANCE

QAPI MODEL

Arbor Health has adopted the Plan, Do, Study, and Act (PDSA) methodology for quality assessment and improvement. The PDSA model is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a process.



P = Plan: Identify a goal or purpose, formulate a theory, define success metrics and put a plan into action.
D = Do: Implement the components of the plan
S = Study: Monitor outcomes to test the validity of the plan for signs of progress or success or problems and areas for improvement
A = Act: Integrate the learning generated by the process, adjust the goal or change interventional methods if necessary.

Additional Performance Improvement Methodologies

In addition to the PI methodology outlined above, other tools, techniques and methods are used to achieve improvement based on project goals and/or the nature of the problem under evaluation. Examples include Lean and Six Sigma via the Performance Improvement Program.

PRIORITIZATION OF AREAS FOR MEASUREMENT

The process for identifying priorities for measurement requires input and discussion with senior leadership, departments, and services from all areas involved with quality performance measurement and improvement. Priorities are identified based on leadership objectives, regulatory requirements, opportunities identified in external benchmark projects, opportunities identified through analysis of patient safety event reports and opportunities identified through sentinel events, standard of care findings or "Sentinel Event Alerts." These objectives or topics are then displayed in a matrix to better understand which areas of importance and relevance they cross (high risk, high volume, problem prone, mission, internal and external customer satisfaction, clinical outcome, safety, and regulatory).

DEVELOPING MEASURE SPECIFICATIONS

Work groups or committees define the metrics (indicators, goals, and benchmarks) for each topic. Representatives from all involved services collaboratively develop quality performance measure specifications based on the opportunities identified to be studied. Team members are identified with the help of clinical and administrative leadership. Work groups develop written measurement specifications, along with data abstraction tools when necessary.

Reduction of unassisted patient falls with a goal of zero falls	Measurement	2017	2018	2019
▪ **Unassisted Patient Fall** *A patient fall occurs when a patient falls or collapses and assistance from a healthcare provider does not occur. Unassisted falls are more likely than assisted falls to result in injury.*	Number of unassisted patient falls reported / (Acute Inpatient Days + Swing Bed Patient Days) x 100	0.06	0.13	0.21

Monitor trends in patient safety events through Arbor Health's event reporting system and implement actions to reduce harm	Measurement	2017	2018	2019
▪ **Event Reporting Utilization** *Providing safe care to patients is a top priority, and Arbor Health rely heavily on the participation of the staff to enter patient safety concerns in order to gather data, identify trends and implement error reduction and prevention plans.*	Total number events entered	No Data	311	320

Reduce readmissions	Measurement	2017	2018	2019
▪ **Readmission w/in 30 Days-All Cause** *Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions.*	Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions / Total inpatient discharges (excluding discharges due to death) x 100	2.5	2.4	2.1
▪ **% Return ER Visits w/in 72 hours** *Number of Emergency Department patients treated and released previously, then readmitted with the same or a similar diagnosis within 72 hours of initial release.*	(Number of ER patients returning with same or similar diagnosis to the ER within 72 hrs of their initial visit / Total ER visits) x 100	2.5	2.4	2.4

F. INFECTION PREVENTION AND CONTROL

Reduction of hospital acquired infections with a goal of zero infections	Measurement	2017	2018	2019
▪ **CAUTI – Catheter Associated Urinary Tract Infection** *Infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney associated with the use of a foley catheter.*	Total # HAI Event(s) **Rate per 1000 Pt. Days**	0 **0**	0 **0**	1 **1.0**
▪ **CDIFF - Clostridium difficile** *Infection of the large intestine (colon) caused by the bacteria Clostridium difficile.*	Total # HAI Event(s) **Rate per 1000 Pt. Days**	1 **0.1**	0 **0**	1 **0.2**
▪ **CLABSI – Central Line Associated Blood Stream Infection** *A primary laboratory confirmed bloodstream infection in a patient with a central line at the time of (or within 48-hours prior to) the onset of symptoms and the infection is not related to an infection from another site.*	Total # HAI Event(s) **Rate per 1000 Pt. Days**	0 **0**	0 **0**	0 **0**
▪ **MRSA - Methicillin-resistant staphylococcus aureus** *Infections caused by specific bacteria that are resistant to commonly used antibiotics.*	Total # HAI Event(s) **Rate per 1000 Pt. Days**	1 **0.1**	0 **0**	0 **0**
▪ **SSI – Surgical Site Infection** *Infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney.*	Total # HAI Event(s) **Rate per 1000 Pt. Days**	1 **0.1**	0 **0**	0 **0**

Increase hand-hygiene compliance rate	Measurement	2017	2018	2019
▪ **Hand Hygiene** *A simple yet effective way to prevent infections.*	Total Compliance /Opportunities by Visual Audits with a Goal of >95%	94%	83%	75.4%

G. PATIENT SATISFACTION

ARBOR HEALTH MORTON HOSPITAL

ARBOR HEALTH MORTON HOSPITAL HCAHPS Initiative	Arbor Health Top Box % 2020 Goal	CAH National Top Box %	Arbor Health Top Box % 2019
Global Hospital Rating 0-10	**≥50**	**77.2**	**32**
Recommend the Hospital	**≥50**	**74.7**	**64**
Communication with Nurses	≥50	83.5	42
Nurses treat with courtesy /respect	≥50	90.4	6
Nurses listen carefully to you	≥50	81.4	82
Nurses explain in way you understand	≥50	78.7	44
Response of Hospital Staff	≥50	74.4	58
Call button help soon as wanted it	≥50	72.9	45
Help toileting soon as you wanted	≥50	77.2	70
Communication with Doctors	**≥50**	**83.8**	**86**
Doctors treat with courtesy/respect	**≥50**	**89.7**	**66**
Doctors expl in way you understand	**≥50**	**79.2**	**99**
Doctors listen carefully to you	≥50	82.6	
Hospital Environment	**≥50**	**73.2**	**28**
Cleanliness of hospital environment	≥50	81.2	85
Quietness of hospital environment	**≥50**	**65**	**7**
Communication about Medicines	≥50	67.8	97
Tell you what new medicine was for	**≥50**	**80.3**	**92**
Staff describe medicine side effect	≥50	55.6	96
Discharge Information	≥50	**89.3**	58
Staff talk about help when you left	≥50	88.4	55
Info re symptoms/prob to look for	≥50	**90.4**	60
Care Transitions	≥50	54.9	53
Hosp staff took pref into account	≥50	49.5	14
Good understanding managing health	**≥50**	**53.9**	**89**
Understood purpose of taking meds	≥50	61.7	47

ARBOR HEALTH EMERGENCY DEPARTMENT

ARBOR HEALTH EMERGENCY DEPARTMENT HCAHPS Initiative	Arbor Health Top Box % 2020 Goal	Arbor Health Top Box % 2019
ED Overall	≥50	58.6
Standard Arrival	≥50	52.4
Waiting time before noticed arrival	≥50	67.6
Helpfulness of first person	≥50	61.9
Comfort of waiting area	**≥50**	**33.5**
Waiting time to treatment area	≥50	52.7
Waiting time to see doctor	**≥50**	**44.2**
ED Nursing	≥50	66.7
Nurses courtesy	≥50	69.8
Nurse took time to listen	≥50	68.6
Nurses attention to your needs	≥50	66.3
Nurses informative re treatments	≥50	63.6
Nurses concern for privacy	≥50	65.3
ED Doctors	≥50	58.7
Doctors courtesy	≥50	60.7
Doctor took time to listen	≥50	61.3
Doctor informative re treatment	≥50	59
Doctors concern for comfort	≥50	53.9
ED Tests	≥50	56.4
Courtesy of person who took blood	≥50	55.4
Concern blood draw comfort	≥50	57.3
Waiting time for radiology test	≥50	47.2
Courtesy of radiology staff	≥50	65.9
Concern for comfort radiology test	≥50	56.5
Family or Friends	≥50	59.9
Courtesy shown family/friends	≥50	61.1
Adequacy of info to family/friends	≥50	55.6
Let family/friend be with you	≥50	62.9
Personal/Insurance Info	≥50	62.4
Courtesy during pers/insur info	≥50	67.5
Privacy during pers/insur info	≥50	61.7
Ease giving pers/insur info	≥50	57.7
Personal Issues	≥50	55.9
Informed about delays	**≥50**	**53.5**
Staff cared about you as person	≥50	60.5
How well pain was controlled	≥50	51
Information about home care	≥50	57.7
Overall Assessment	≥50	55
Overall rating ER care	≥50	57.5
Likelihood of recommending	≥50	52.5

ARBOR HEALTH CLINICS

ARBOR HEALTH CLINICS HCAHPS Initiative	Arbor Health Top Box % 2020 Goal	Arbor Health Top Box % 2019
Clinic Overall	≥50	71
Standard Access	≥50	66.8
Ease of scheduling appointments	≥50	67.8
Ease of contacting	≥50	65.8
Std Moving Through Your Visit	≥50	56.2
Information about delays	**≥50**	**57**
Wait time at clinic	≥50	55.4
Clinic Nurse/Assistant	≥50	74.4
Concern of nurse/asst for problem	≥50	69.5
How well nurse/asst listen	≥50	79.3
Clinic Care Provider	≥50	75.6
CP explanations of prob/condition	≥50	76.1
CP concern for questions/worries	≥50	76.4
CP efforts to include in decisions	≥50	76.3
Likelihood of recommending CP	≥50	77.1
CP discuss treatments	≥50	72
Personal Issues	≥50	72.4
How well staff protect safety	≥50	74.2
Our concern for patients' privacy	≥50	70.6
Std Overall Assessment	≥50	73.1
Staff worked together care for you	≥50	75.2
Likelihood of recommending	≥50	71.1

H. ANNUAL EVALUATION

Arbor Health Morton Hospital and the Board of Commissioners shall review the Critical Access Hospital Periodic Evaluation at least annually in alignment with the calendar year. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Arbor Health and the Board of Commissioners also evaluate annually their contributions to the performance improvement and patient safety activities at Arbor Health.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
MEDICARE CMS PAYMENT RESOLUTION NO. 20-36

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

Approving the 2019 Medicare CMS Payment of $178,918.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of August 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

LEWIS COUNTY
PUBLIC HOSPITAL DISTRICT NO. 1
doing business as
ARBOR HEALTH

(Primary Provider Number 50-1319)

Form CMS-2552-10
Hospital and Hospital Health Care Complex Cost Report

December 31, 2019

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 50-1319	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/1/2020 6:10 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/1/2020 Time: 6:10 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ARBOR HEALTH MORTON HOSPITAL (50-1319) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

Encryption Information

ECR: Date: 6/1/2020 Time: 6:10 am
pf4bhrhhiQe:UiN67PCB9PsOMg98O0
CptW5OOiCWFs2hq.axMlK:Q.Wk78FO
.BwxO7BYAIO3c2lk

PI: Date: 6/1/2020 Time: 6:10 am
dtbQyN546s6ar.t8O1WU:pU1mlDC9O
u:VFzOPVUpfoOfw:4FEI9eW0AQ91R:
7oTYODUN:JOOARmp

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-104,468	14,875	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-248,801	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		84,005		0	10.00
10.01	RURAL HEALTH CLINIC II	0		75,471		0	10.01
200.00	Total	0	-353,269	174,351	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Part A	$	(353,269)
Part B	$	174,351
Amount due Arbor Health/(CMS)	$	(178,918)

	Approved Documents Pending Board Ratification 08.26.20	Department
	Arbor Health's Policies, Procedures & Contracts	
1	Chart Analysis	Health Information Management
2	Coding Ethics and Guidelines	Health Information Management
3	Collection Assignment Policy	Finance
4	Conflict of Policies	Governing Body (Board of Commissioners)
5	Distribution for Board and Committee I	Governing Body (Board of Commissioners)
6	Dr. Kevin McCurry, MD	Professional Services Agreement
7	Emergency Bag	Clinics
8	Employee Disclosure Requirements	Human Resources
9	Employee Problem Resolution & Comp	Human Resources
10	Foundation Volunteer Code of Ethics	Hospital Foundation
11	Hospital Declaration Of Personal Prope	Governing Body (Board of Commissioners)
12	Interpreter Access	Patient Access
13	Lost & Found	Patient Access
14	Refunds	Business Office
15	Registering Deceased Persons Upon Ar	Patient Access
16	Risk Analysis	HIPAA Security
17	Rural Health Clinics Nondiscrimination	Rural Health Clinics
18	Security Awareness Training	HIPAA Security
19	Workplace Injuries	Human Resources

In order to access the above documents you will need to log into Lucidoc. Once you have logged into Lucidoc, on the top toolbar click "My Meetings" and select the upcoming board meeting date that's highlighted in green to see the agenda with documents needing to be ratified. You are able to view the documents once in the agenda. If the date is highlighted in yellow that means the agenda has not been released yet.

OLD BUSINESS

NEW BUSINESS

Shana Garcia

From: Shana Garcia
Sent: Friday, August 14, 2020 7:52 AM
To: Commissioner Frady; Commissioner Coppock; Commissioner Schumaker; Commissioner McMahan; Commissioner Herrin
Cc: Leianne Everett; Shana Garcia; Richard Boggess
Subject: Electronic Signatures Process

Hi All,

As we continue to utilize electronic signatures I have developed a process to ensure we are all on the same page. Please see below:

1. Board approves minutes, resolutions and/or warrant listings. Within 24 to 48 hours Executive Assistant will email via Adobe Pro for signatures. Due to unforeseen circumstances, if Administration is unable to meet this timeline a communication will be emailed to the Board.
2. The order of signatures will be as follows:
    a. Secretary Herrin
    b. Commissioner McMahan
    c. Commissioner Coppock
    d. Commissioner Schumaker
    e. Board Chair Frady
    f. Superintendent Everett or CFO Boggess (as required.)
3. Once the documents have been assigned for signature, Executive Assistant will email everyone to know which documents will be coming through.
4. Commissioners will be expected to sign within 24 to 48 hours. Due to unforeseen circumstances, if a commissioner is unable to meet this timeline a communication will be emailed to the Board Chair and Executive Assistant on the expected timeline of completion.

Thank you all and have a great weekend!

Shana Garcia
Executive Assistant
Public Records Officer
360-496-3537 Office
360-496-3511 Fax
sgarcia@myarborhealth.org

Arbor Health | 521 Adams Avenue | P.O. Box 1138 | Morton, WA 98356

COURSE TRANSCRIPT: STRATEGIC ISSUES FOR BOARDS

Expert Presenters:
Seth Edwards
Martin Liutermoza

WELCOME TO THE ADVANCED MISSION & STRATEGY COURSE, STRATEGIC ISSUES FOR BOARDS. THE COURSE FEATURES AN EXPERT ON CYBERSECURITY AND ANOTHER EXPERT ON MACRA—THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT.

THE MATERIAL COVERED IN THIS CYBER SECURITY PORTION OF THE COURSE INCLUDES IT SECURITY AND ENTERPRISE RISK MANAGEMENT, PILLARS OF DEFENSE AGAINST CYBER ATTACKS, ORGANIZATION VULNERABILITIES, AND PREVENTING, PREPARING FOR AND MITIGATING CYBER ATTACKS.

THE MACRA PORTION OF THE COURSE INCLUDES MACRA DEFINITION AND GOALS, HOW MACRA WORKS, THE MERIT-BASED INCENTIVE PAYMENT SYSTEM VS. THE ADVANCED ALTERNATIVE PAYMENT MODEL TRACK AND WHY MACRA IS A BOARD CONSIDERATION.

CYBERSECURITY

1. IT SECURITY & ENTERPRISE RISK MANAGEMENT

MARTIN LIUTERMOZA IS THE GLOBAL HEAD OF INFORMATION SECURITY ENGINEERING AND THE GLOBAL SECURITY OPERATIONS CENTER AT NASDAQ WHERE HE LEADS THE EFFORT ON INFORMATION SECURITY FOR NASDAQ-OWNED COMPANIES.

Martin Liutermoza: Information security is a piece of the overall Global Risk Management Program. There are three layers of defense against cyber attacks within an organization: Information security, internal audit and group risk management. They complement each other in many ways. The information security group has a large swath of IT-related issues to cover. The internal audit group will help information security find the gaps they may be missing. And then group risk management also has a complementary function in things like disaster recovery and cybersecurity-related events that could happen within a disaster recovery event.

The board gets involved with information security right from the beginning. We need to have a charter that is blessed by the board. We need to have a three- to five-year strategic plan that's blessed by the board. We need to make sure that that plan is being executed in a timely manner as detailed within the plan. The Chief Information Security Officer (CISO) needs to

report to the board that his information security team is meeting that plan, and also that the other two layers of defense are complementing what the information security team is doing.

The board should understand that information security is cyclical and in that cyclical approach the group risk team and the information security team and, to a lesser extent, internal audit will identify the risks within the company and help to remediate the various issues that still need to mature. Never is an information security program completely mature. New attacks come out on a daily basis. So it's always cyclical and on a yearly basis the board and information security and group risk probably would need to sit down, understand what their risk profile is and where they want to take the information security team into the next year.

Information security teams will vary in size by the organization's risk. The number that's kicked around in the industry the most is that an organization should spend 1 to 3 percent of its total tech budget, and that will help you decide where your information security personnel should be in terms of breadth and scope.

2. PILLARS OF DEFENSE

The pillars of defense we should define are governance, which is the pillar that the board sees the most. Information security, internal audit and group risk management (most likely through the CISO) will provide provide metrics, draft charters and the three-year, the five-year plan for the board to approve.

Other pillars of defense include the application security team and the engineering team that will design protections in monitoring equipment across the network. There also is a security operation center, and this is very important. The security operations center is something that is very hard to operate and maintain, and this may be a place where organizations may look to outsource. As a hospital you are going to have some requirement to monitor your security posture on a 24 by 7 basis. And that gets much easier as you have a third party helping you with that, or doing that as a whole.

Another pillar is the compliance team, and the compliance pillar will help you determine what the posture of your security is within your network. What does your security hygiene look like? Security hygiene is: are my servers and my systems being patched? Are they configured in a very set way? And are the metrics that are produced going to the proper places? So the metrics that are produced by the compliance team will be sent to the information security team, and then reported up to the board.

In summary, the pillars of defense are:

- Governance
- Application security team
- Engineering team

- Security operations center
- Compliance Team

3. VULNERABILITIES

The exposures that a hospital has are called the attack surface. An attack surface may be a server facing the internet. An attack surface may be a desktop computer that has email access. It may be a desktop computer that is not physically controlled but can be accessed by someone who is not part of the organization.

So you have to worry about everything. You can't just focus on one thing. An organization that does focus on one aspect of security is bound to overlook something and eventually pay the price. Everybody is used to the hackers that are trying to come in and attack a webserver. There are lots of ways to do that, but a lot of times the attackers now find it easier to use a technique like phishing.

Phishing is a technique where an email is sent to an organization and it looks like it could have come from somebody within the organization. It can be very tricky. The user clicks on a link, is asked to enter some user credentials, user names, passwords, and those then are compromised. Alternatively, if someone can get a USB key into a computer that is not fully physically controlled, that is an easy way for an attacker to gain a foothold within the network.

Data breaches can affect patient safety because there are a lot of medical devices that did not take security into account. If you have a data breach within your facility, there is a good probability that the machines that are connected to that network could also be compromised. There would have to be some sort of malicious user, obviously, who would look to do this, but that user could take control of any number of machines and adversely affect a patient's health.

Any device that you put on a network is going to be vulnerable to some sort of cyber attack. So, we talked about phishing and we talked about those types of vulnerabilities. If you have your hospital devices on the same networks as computers that have internet access such as email or web surfing, you stand a great degree of risk of having one of those devices compromised.

4. PREVENTING/PREPARING FOR ATTACKS

It is important that you deploy your resources for security in overlapping types of architectures. By that I mean you will have an internet facing firewall. Behind the firewall now you will have a web application firewall, which is specific to preventing attacks from web applications. Behind that you have the web server and on the web server you have protection mechanisms called white listing. You should always know what software is on your server at any given point in time. That prevents attackers from being able to place vicious software on a server and

maintaining what we call persistence. So if I'm able to put software on your server, I can maintain persistence, but that persistence also requires a command and control channel. That command and control channel needs to go back out to the internet somehow. If you can control that back channel out to the internet, typically using a proxy server and, again, more white listing on where that server can talk back out to, then you can control that type of access. There are ways for you to monitor what the attacker is doing. And some of those are monitoring how much data is going out the door. And that's very important as well. So we monitor things like net flows. We monitor packet captures for any command and control channels that may be going up on another channel besides the normal proxy server.

On the internal side, we have phishing campaigns to train our users. You can't do everything on a technical basis; you have to train your users as well. And then you have your basic controls that you've always known about and you've always had. For example, everybody has anti-virus on their system. That is still an important layer within the network and that overlaps with things like white listing. If you have those layers you are much less likely to be compromised.

The more landmines that you can put within your network, the more likely one of those attackers is to trip over one of those landmines. That gives your security monitoring team an opportunity to catch those malicious users before they do serious damage.

For a hospital to prepare for a cyber attack requires a multi pronged process and it is driven by the board. We talked about the board approving a charter, the board approving a three- to five-year cyber plan. From there you also have to have incident response plans. How was an incident handled?-What run books do you have for various incidents and when they occur? That will all affect how quickly you can recover from any specific incident.

One organizational structure that I've seen for vetting technical risk within an organization is to have a tech risk committee. That tech risk committee generally is senior management and it reports to the audit committee. That really is the highest level of managing your security risk. So, if the bubble is up there, and the law is set down, so to speak, you really have a good handle on your risk.

Applying cyber security-related components to disaster recovery is important. One example for that would be someone comes into my database, corrupts my entire database, how do I recover from that? It's not just maybe a table or two tables, it's an entire terabyte worth of data. So running drills would be a component of how quickly you can recover. And constant vigilance is the theme that really needs to happen across the organization. Security is not just one person's responsibility; it's not one group's responsibility. It has to come from the top that security is everybody's responsibility.

5. MITIGATING ATTACKS

One thing people often ask is how do I mitigate the damage if I am compromised? There are a number of ways that you can do that, and one of the obvious ones is to have good backups of all your data, and to test those backups. For example, consider the recent emergence of ransom ware. Ransom ware is when an attacker will infect your computer, infect your server, and encrypt all the data on that server or on that computer. Your chances of decrypting that data are slim to none, and the only guaranteed way of getting out of that situation is to have a good backup.

There is the security monitoring piece. If you can catch the attacker before he has a chance to get his tools into your network, that means you have to have a very good security monitoring program. You can go ahead and block the attacker fairly quickly. And that's the reason your security group should be focusing on tools, tactics and procedures because our attackers develop new tactics and procedures and tools on a daily, yearly basis. So we need to continually understand those and actively search for those within our networks.

Recovering from a doomsday scenario and how that's communicated to the organization, possibly to customers, and possibly to the public, is a very difficult thing. It needs to be thought about by senior management, and planned out, and some sort of run book created. It has to be a compilation of your legal department, your information security department and senior management, and it can change any given point in time. You may think that the level of severity of the attack is very low, and five minutes later it could be medium. And five minutes later you find it's a doomsday scenario. Everybody has to be available, has to be able to adjust and to understand his or her responsibilities.

Summary

The Layers of Defense for an organization Against Cyber Attacks Include structures and mechanisms for:

- Information security
- Internal audit, and
- Group risk management

The Board's role in cybersecurity includes approving the security charter and the three-to five-year plan presented by the Chief Information Security Officer as well as board-level oversight of information security activities.

The Board needs to understand that information security is cyclical and that the information security program is never completely "mature."

The pillars of defense against cyber attacks include:

- the Board
- The application security team
- The engineering team
- A security operations center
- the compliance team

THE ORGANIZATION'S "ATTACK SURFACE" PRESENTS A SIGNIFICANT VULNERABILITY AND SHOULD BE MANAGED TO ENSURE SECURE USE OF DESKTOP COMPUTERS AND THE WEBSERVER.

PATIENT SAFETY CAN BE COMPROMISED THROUGH USE OF MEDICAL DEVICES THAT DO NOT HAVE ADEQUATE SECURITY FEATURES OR WORK THROUGH THE ORGANIZATION'S NETWORK.

OVERLAPPING ARCHITECTURES CAN HELP PREVENT ATTACKS. THESE INCLUDE AN INTERNET FACING FIREWALL, A WEB APPLICATION FIREWALL, WEB SERVER WITH WHITE LISTING AND DESIGNING A BACK CHANNEL CONTROL TO THE INTERNET.

THE ORGANIZATION SHOULD CONDUCT PHISHING CAMPAIGNS AND OTHER SECURITY EXERCISES TO TRAIN USERS.

OTHER MITIGATING STEPS INCLUDE DATA BACKUP (AND TESTING), SECURITY MONITORING AND A COMPREHENSIVE COMMUNICATION PLAN IN THE EVENT OF A DISABLING CYBER ATTACK.

MACRA

WE NOW MOVE TO THE SECOND PART OF THE COURSE, THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT, FEATURING SETH EDWARDS.

6. MACRA: DEFINITION & GOALS

SETH EDWARDS HEADS THE POPULATION HEALTH MANAGEMENT COLLABORATIVE AT PREMIER, INC., PROVIDING A BROAD ARRAY OF STRATEGIC AND OPERATIONAL SERVICES SURROUNDING POPULATION HEALTH MANAGEMENT FOR HOSPITALS AND HEALTH SYSTEMS.

Seth Edwards: MACRA legislation was passed in 2015. It "evolves" the way physicians are being reimbursed, and moving towards value-based reimbursement for them. It stands for the Medicare Access and Chip Reauthorization Act of 2015, and has created new programs called the Quality Payment Program that enacts the legislation through a regulation.

The goal of MACRA and the Quality Payment Program is to bend the cost curve**.** We as a country spend a large amount of money on health care—close to 20 percent of our gross domestic product—and CMS is looking for different models to reimburse clinicians and other parts of the healthcare system to do exactly that, to bend the cost curve. It has established value-based reimbursement models to address cost, efficiency, quality of care and the use of information technology to really drive improvements in the way that care is being delivered so that we can work towards reducing the cost.

7. HOW MACRA WORKS

MACRA creates two different tracks for clinicians to participate in Medicare. One is called the Merit-Based Incentive Payment System, or MIPS as health policy wonks have taken to call it. The second is the Advanced Alternative Payment Model track. And each of these tracks has different incentives to address the goals we talked about earlier.

MIPS judges clinicians across four different categories: quality, cost, improvement activities and meaningful use, or now what's called the advancing care information category. CMS will create a composite score, and then compare clinicians to others within the program. Depending upon how well clinicians perform, they will get an upward or downward adjustment to their payment.

Under the Advanced Alternative Payment Model track, CMS is trying to create different delivery models—so things like accountable care organizations, or bundled payments, or things along those lines—that are really working to align incentives across a continuum and will work to drive the triple aim of improving quality and reducing costs, while improving patients' experience of care.

CMS created an initial projection when it released the proposed rules related to the Quality Payment Program. Essentially what it projects is that smaller practices, those of a hundred eligible clinicians or fewer, will receive the brunt of the penalties for these programs. For solo practitioners, CMS projects about 97 percent will receive some type of negative downward payment adjustment. For those practices at 25 eligible clinicians or fewer, it projects about 90 percent will have some type of negative payment adjustment. With that said, CMS also heard a lot of feedback from stakeholders that this program is very, very challenging, and so it created what it is calling a transitional year where there are lower thresholds for participation.

When CMS is measuring clinicians, it looks at performance across the year. For that first year under MIPS, it is a 90-day span across each of those four categories. For the Advanced Alternative Payment model track, it is performance across the entire performance year. So performance measurement depends on whether you are in the MIPS or AAPM track. Remember, it's not just one patient at a time. CMS will aggregate your performance across a performance period to provide you with the scores for those various measures.

In order to prepare for MACRA, there are a number of considerations that require thoughtful analysis. The first step is to do an assessment to understand how well positioned you are, both under MIPS as well as for potential to move into an Advanced Alternative Payment Model. There are a number of reports out there you can use to do this. There are reports from CMS called The Quality Resource and Utilization Reports, or QRURs, that provide great insights into the quality of care that's provided, as well as the cost associated with that care for individual clinicians as well as for practices as a whole. We highly suggest looking at that, understanding how well you're set to perform, and identifying from that various opportunities you may want to work on improving.

After that, we highly suggest developing a strategic plan to determine how you are going to move forward, whether it's staying in MIPS for a couple of years and then moving towards an Advanced Alternative Payment Model track, or whether it's staying in MIPS over the long run. And that should be tied not only to a MACRA strategy, but to a broader strategy related to other payment changes and delivery system reforms that are coming, or that you perceive to be coming from the new administration.

We are seeing a number of strategies in the market to put in place the foundation to begin to be successful under MACRA. A lot of it is related to driving clinically integrated networks and using them to share resources across different provider groups, so that you're not just going in alone. Being successful in this model requires quite a bit of investment, not only of money, but also of resources and time on behalf of each practice. And so, finding ways to be able to work together through clinically integrated networks, or through assistance from a health system or other provider types, is really critical and something that we're seeing a lot of organizations pursuing. It not only helps with MIPS, but it also lays a foundation that you can build upon to move into an Advanced Alternative Payment Model in the future. So if you want to use a clinically integrated network as a vehicle to move towards an ACO or a bundled payment model, you will have a lot of the infrastructure in place to be able to do so.

8. MIPS vs AAPMs

There are inherent advantages and disadvantages between being in a MIPS and an Advanced Alternative Payment Model. And it really depends on where your organization is currently, and where you're planning to head in the future in terms of a population health strategy. MIPS puts your reimbursement at risk, starting at 4 percent, going up to 9 percent, depending upon how well you perform. If you feel like you are a high quality, high performing provider, being in MIPS can provide you with a lot of opportunities to get an upward adjustment that can be much greater than what you would get under the Advanced Alternative Payment Model.

Conversely, if you pursue an Advanced Alternative Payment Model, you get a guaranteed 5 percent bonus, assuming you meet the requirements to be considered an Advanced Alternative Payment Model. So there is certainty in that model, but you can't get above the 5 percent.

So there is a kind of weighing of the options. Do you believe you will perform better under MIPS and have a potential for a higher upward adjustment? Or do you like the certainty of being in the Advanced Alternative Payment Model and getting a guaranteed 5 percent bonus?

On top of that, to be able to qualify as an Advanced Alternative Payment Model, there is a requirement that the participants take more than nominal financial risk for losses. You're at risk outside of MACRA for any losses above an expected expenditure amount. So you have a potential to have to write CMS a check back, even though you have a guaranteed 5 percent bonus through MACRA. And oftentimes that 5 percent bonus is not going to cover the amount of exposure that you have to take on under an Advanced Alternative Payment Model.

It is really a difficult consideration. Do you want to be in MIPS and have a risk for 4 percent upward or downward adjustment, up to 9 percent? Or do you want to be in an Advanced Alternative Payment Model, get the guarantee of 5 percent bonus, but then have a potential to have to write CMS a check back if you spend more than you're expected to?

Lots of organizations are considering the strategy and are thinking through which option is the best. Lots of them are looking at MIPS as a great opportunity, not only to have a higher upside but also to really start to figure out ways to integrate and work with independent clinicians across their market. For a lot of organizations, that is the right way to go, particularly if you are not ready to move into two-sided risk models and don't have the actuarial experience and the understanding around how to manage a population.

Conversely, there are some organizations out there who have been working in two-sided risk for quite a while, have a great understanding of how to manage a population, are looking for that certainty for not only themselves, but also for the other clinicians with whom they work to be able to get a 5 percent bonus. So again, I really think it goes back to, where are you as an organization, and how prepared are you to move into a two-sided model.

If you are in an ACO, you don’t necessarily qualify for an Advanced Alternative Payment Model automatically. In fact, it requires three statutorily defined items for the model to count. You have to use certified electronic health record technology. You have to have quality measures that impact the payment of shared savings. And you have to have more than nominal financial risk for losses. But the majority of Medicare ACO participants are actually in one-sided models. It's called the Medicare Shares Savings Program Track 1 where you share the savings with CMS, but you do not have to pay back any losses that you may incur. And that would qualify as a MIPS APM. So you wouldn't be an Advanced Alternative Payment Model, you would still be a part of MIPS and have the opportunity for the upward and downward adjustments we talked about previously.

9. THE BOARD

As a board member, MACRA is a really important consideration because it has an impact on your long-term viability as a health system—not only looking at how you support your employee clinicians, should you have some, but then also how you're engaging with independent clinicians within your marketplace. MACRA sets up a dynamic where there are incentives to align with clinicians, to be able to help them, but then it also puts in place a need to align with clinicians ahead of other organizations, what we're calling “disrupters” coming into the market, who could potentially set up an accountable care organization with the clinicians, leave the health system out of it and then you're viewed as a cost center.

It's going to have a major impact on how you're going to work with clinicians in the future, as well as how you're going to continue to evolve with the new payment models. Because as

we've seen, there is no new money coming into health care, and so working with clinicians, moving towards population health models that will help you be successful under value-based reimbursement, is going to be a key critical differentiator for your health system going forward.

SUMMARY

THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 WAS ENACTED TO BEND THE COST CURVE BY MOVING CLINICIANS TO VALUE-BASED REIMBURSEMENT MODELS.

MACRA HAS TWO TRACKS: THE MERIT-BASED INCENTIVE PAYMENT SYSTEM, CALLED MIPS, AND ADVANCED ALTERNATIVE PAYMENT MODELS, CALLED AAPMS.
EACH TRACK HAS DIFFERENT INCENTIVES.

UNDER MIPS, CLINICIANS ARE EVALUATED ACROSS FOUR CATEGORIES: QUALITY, COST, IMPROVEMENT ACTIVITIES AND MEANINGFUL USE (NOW CALLED "ADVANCING CARE INFORMATION")

- CLINICIANS ARE GIVEN A COMPOSITE SCORE AND THIS IS COMPARED WITH OTHER CLINICIANS IN THE PROGRAM
- PERFORMANCE IS EVALUATED FOR A 90-DAY SPAN FOR EACH CATEGORY
- THE RESULT IS AN UPWARD OR DOWNWARD ADJUSTMENT TO PAYMENT, FROM 4 PERCENT IN THE TRANSITION YEAR TO 9 PERCENT WHEN FULLY IMPLEMENTED

UNDER AAPMS, THE OBJECTIVE IS TO CREATE DIFFERENT DELIVERY MODELS AND THEN ALIGN INCENTIVES ACROSS A CONTINUUM.

- PERFORMANCE IS MEASURED ACROSS AN ENTIRE YEAR
- CLINICIANS ARE GUARANTEED A 5 PERCENT BONUS IF REQUIREMENTS ARE MET
- THERE IS ADDITIONAL RISK OUTSIDE MACRA FOR LOSSES GENERATED ABOVE THE EXPECTED EXPENDITURES

CLINICALLY INTEGRATED NETWORKS PLAY A KEY ROLE IN THE ORGANIZATION'S SUCCESS UNDER MACRA.

MACRA AFFECTS THE LONG-TERM VIABILITY OF THE ORGANIZATION. FOR EXAMPLE, IT AFFECTS:

- HOW THE ORGANIZATION WILL WORK WITH ITS CLINICIANS IN THE FUTURE, AND
- HOW THE ORGANIZATION CAN POSITION ITSELF AS THE INDUSTRY IMPLEMENTS NEW PAYMENT MODELS

For additional information please go to www.iprotean.com

COURSE TRANSCRIPT: STRATEGIC PLANNING

Expert Presenters:
Marian Jennings
Jeff Bauer

WELCOME TO THE MISSION AND STRATEGY COURSE "STRATEGIC PLANNING."

IN THIS COURSE, OUR EXPERTS WILL COVER: THE STRATEGIC PLANNING PROCESS; THE ROLE OF THE BOARD IN THAT PROCESS; SHORT- AND LONG-TERM STRATEGIC PLANNING; FINANCIAL ANALYSIS; THE IMPORTANCE OF SETTING PRIORITIES; PLAN INTEGRATION; AND IMPLEMENTING THE PLAN.

1. STRATEGIC PLANNING PROCESS

MARIAN JENNINGS IS A CONSULTANT SPECIALIZING IN STRATEGIC AND FINANCIAL PLANNING, AND SYSTEM PLANNING AND DEVELOPMENT.

Jennings: I always think of a strategic planning process as having three phases. The first phase is really to create a common foundation of understanding of where we are. The second phase is to determine a clear future direction, sometimes called the desired future state. How we would like our organization to be positioned, what do we want to be like in three to five years. And then the third phase is the implementation phase.

If I think about the first phase, creating a common foundation of understanding, what that entails is both a quantitative assessment and a qualitative assessment. The quantitative assessment would actually look at data—data about our market, about trends, about our competitive positioning, about demographics and what we expect will happen in terms of our market, our own internal indicators, our utilization, our medical staff profile, a whole array of information that is objective—that will help make sure that everyone involved in the planning process has clarity from a factual perspective about where we're starting.

That quantitative information needs to be complemented by qualitative information. Qualitative information is really opinions. They are not facts, but they are incredibly important. These may be the opinions of your physician leaders; these may be opinions of your board leaders; these may be opinions of your community at large; these may be opinions of your patients and how satisfied they are with the hospital services. All of those are valuable inputs to say this is how we perceive this organization as it is today, and this is what we would hope for this organization in the future. So that qualitative input and the factual quantitative data actually serve as a very critical foundation for any good strategic planning process.

Once that foundation is in place, the question is now what. And to think about the future, there are really a couple of things that I think are extremely important. One is to take the time as an organization to articulate your assumptions about the future. Now what do I mean by that? There are no facts about the future. Particularly with what is going on right now in healthcare—will reform stay, are they going to overturn reform and what's going to happen to Medicare—there is so much uncertainty about the future that no one knows for sure. But a good plan is based upon a set of assumptions about how we anticipate, in our local market, our environment unfolding. So please spend the time to be clear about your assumptions about the future.

An important part of the plan needs to then be that third phase which is what I call implementation. And typically the implementation phase has two components. They are linked together. One component is the development of detailed action plans over the next two to three years of who needs to do what, when and how. And couple that with a strategic financial plan, which is saying what are the resources that we would require in order to implement the plan? What are the capital resources, what are the operating investments we need to make? You need to ensure that implementation of your plan will be feasible; it will not be something that you can't afford to do. And secondly, that if you actually implement the plan as identified, it will sustain and enhance the financial performance of the organization.

JEFFREY BAUER IS A HEALTH FUTURIST AND MEDICAL ECONOMIST WHO CONSULTS WITH HOSPITALS ON DELIVERY SYSTEMS AND MULTI-STAKEHOLDER PARTNERSHIPS.

Bauer: The strategic plan must, regardless of the methods it uses, have some quantifiable goals that will be met at a specific point in time. So if it's a two year plan or a five year plan, it will look that far into the future and say two years out we will have this market share or two years out we will be well underway in establishing our patient-centered medical home or have our telemedicine plan up and running; five years from now we will have affiliated ourselves with a major payer network. There are lots and lots of different possibilities.

I think you have to do something to define the ways you are going to measure yourself, so a strategic plan isn't just generalities—and sad to say, I see this rather often, "We're going to provide the best possible healthcare for the community"—it is rather, two years from now or five years from now we will be known for three areas of clinical service; we will be in the top 25 percent of all hospitals nationally for our care in these four clinical areas.

The second aspect of a strategic planning process that to me is critical is that it be a written document. And then number three that to me is critically important is it must be an ongoing process. The realm of possibilities is constantly expanding; the environments in which you work are constantly changing. So have objectives, have them written down and keep fine-tuning it [the plan]. The idea of a fixed plan is absolutely out the window. The only way you are going to survive in the 21st century is to have a perpetual strategic planning process.

2. ROLE OF THE BOARD

Jennings: The board can play a variety of roles in terms of its day to day involvement in the strategic planning process but, ultimately, it always maintains and retains the authority and responsibility to approve the strategic plan in full, so that never changes. Whether the board uses a strategic planning committee of board members, whether it serves as a planning committee of the whole, whether it asks management to develop the first pass of the strategic plan that then will go to the board or to the planning committee, those decisions are up to you.

But what is not up to you is your need to be clear with management about your expectations of the process. For example, if you are in my camp, you would say that one of your expectations is that this process will result in a plan that has clear-cut metrics or measures of success that we as a board can use to monitor progress.

So if you are going to say we want to be an outstanding healthcare organization, we as a board would agree on what that means, and we would say this year, next year, the year after, how far toward that goal have we reached.

Secondly, you would establish a parameter with management that whatever you do in your strategic plan must be affordable and must improve the financial position of the hospital longer term.

Finally, the board needs to be clear with management that all planning that is being undertaken—whether it's a quality plan, or it's an information technology plan, or it's a plan for our philanthropy and our fundraising campaign, or it's a plan for our master facility—all of those plans need to be organized within the context of the overall strategic plan and must be incorporated into a strategic financial plan.

3. SHORT- AND LONG-TERM STRATEGIC PLANNING

Jennings: When an organization is thinking about its strategic financial plan, I typically would recommend that they look at it in two components, which would dovetail. The first is short term. What are the steps we need to take immediately? And the other is the long term. How do we want to be positioned in three to five years? There's a great tendency to establish goals from three to five years out and not demand the rigor to improve performance in the short run. It's like hoping that in year three or four, somehow some miracle is going to happen and it will be easier for us to accomplish our long-term objectives. That miracle is not something we should be counting on. What you need to do in the short run is improve short-term financial performance and I will give you one specific. It's not very popular, but you need to at least break even on Medicare today.

If you believe that you want to be financially viable in the long term, and we know that Medicare is going to continuously cut payments, you need to find a way to at least break even

on Medicare today if you actually want to be financially viable in the future. So that is an illustrative example of a short-term, focused activity that you would say is a short-term financial strategy. That will not be sufficient for long term.

For long term you actually need to do such basic building blocks as establish a targeted bond rating and agree on how you're going to get there. Establish targets for days cash on hand and develop an approach that is going to take you multiyear to perhaps get to your desired days cash on hand target. Establish the rigor of integrating strategic and financial planning; do it in a new way in the future than how you may have in the past.

Things have changed. It used to be in the past that if a credit worthy organization had a good project, one that showed a return on investment, it could find the sources of funding that it required. Looking into the future, this will be different, and this is a new world for us. We are likely to have more good projects in front of us than we can afford to finance. It is extremely important, therefore, that you have a process to determine the priority of those projects so that you are not making decisions chronologically until you run out of money, in which case you just realize that maybe your most important project is one you no longer can afford to do.

4. FINANCIAL ANALYSIS

Jennings: Whenever we are developing financial forecasts or forecasts of how our strategy will be implemented, the timing, the effectiveness of the strategy, it's very useful to think about developing “what if” or sensitivity analyses. A sensitivity analysis is one where you change an assumption and then you say what would be the impact on the organization if this assumption came to be.

So let's say you are building an ambulatory facility and it is part of your strategic plan. You have developed a financial plan as part of that, all seems to be working fine and you want to say to yourself, “Well, what if?” What if we couldn't get a contract to provide services to a certain group of patients? What if we had a payment cut of 10 percent? What if this service actually moves out of the outpatient surgery center and into the home or the office setting in the next five years? Using sensitivity analysis allows the organization to understand the potential risks and the financial impact of those risks.

It may be that you would do a “what if” scenario and you would say based upon this “what if,” we would still go forward. It doesn't change our decision. Or you might say, boy this “what if” scenario would have meant we wouldn't have gone forward. The question then becomes, can you as an organization do anything to influence the likelihood of that scenario taking place? You might not be able to influence whether new medical technology breakthroughs come into play that would eliminate the need for the service you're offering. But you might be able to do something in terms of your relationships with your physicians, or your competitors or the community, or the payers, that would increase the likelihood that your desired future would unfold and that this alternative “what if” scenario would not take place.

SUMMARY

THERE ARE THREE DISTINCT PHASES IN THE STRATEGIC PLANNING PROCESS:

PHASE 1 INVOLVES ESTABLISHING A COMMON FOUNDATION FOR THE PLANNING DISCUSSIONS, AND IT REQUIRES COLLECTING BOTH QUANTITATIVE AND QUALITATIVE DATA.

IN PHASE 2, THE BOARD AND MANAGEMENT MUST ARTICULATE THEIR ASSUMPTIONS ABOUT THE FUTURE.

PHASE 3 IS IMPLEMENTATION, AND IT INCLUDES THE DEVELOPMENT OF A DETAILED ACTION PLAN IN CONJUNCTION WITH A STRATEGIC FINANCIAL PLAN.

THE STRATEGIC PLAN SHOULD BE SET FORTH IN A WRITTEN DOCUMENT THAT INCLUDES QUANTIFIABLE GOALS.

THE BOARD HAS A KEY ROLE IN DEVELOPING THE STRATEGIC PLAN. FIRST, IT SHOULD BE CLEAR WITH MANAGEMENT ABOUT ITS EXPECTIONS. IT SHOULD SET PARAMETERS FOR AFFORDABILITY AND IMPROVING THE HOSPITAL'S FINANCIAL POSITION.

AND IT MUST MAKE SURE THAT ALL OTHER PLANS – FOR EXAMPLE, QUALITY, INFORMATION TECHNOLOGY, FUNDRAISING, MASTER FACILITY – ARE ORGANIZED WITHIN THE CONTEXT OF THE STRATEGIC PLAN AND INCORPORATED INTO THE STRATEGIC FINANCIAL PLAN.

FINALLY, WHEN DEVELOPING FINANCIAL FORECASTS FOR STRATEGIC PLAN INITIATIVES, THE BOARD AND MANAGEMENT SHOULD CONDUCT SENSITIVITY ANALYSES ON PROPOSED PROJECTS. THESE ARE "WHAT IF" SCENARIOS THAT SERVE AS ONE MORE AID WHEN PREDICTING A PROJECT'S POTENTIAL FOR SUCCESS.

5. SETTING PRIORITIES

Jennings: You would legitimately say in the for profit environment okay, what we want to do is we want to invest in those products and services that generate the highest return for our shareholders. And if something is lower return, get rid of it, and redeploy the resources into something that generates a higher return. Yippee, we're done.

However, our mission calls us to do something different. Our mission calls us to serve the community. Not only is that a practical reality, it's also a legal requirement, and a fiduciary responsibility.

So what are the kinds of criteria that you would want to use in your hospital setting in order to set priority between and among competing programs and services? I would argue that you probably need to look at four or five components.

The first would be mission compatibility. How close to your mission is a service or a program? It's easier to answer this question if you have a clear mission than if you have an extremely general mission that would say, well, everything is close. But I'll give you a for instance. Let's say that your mission calls you to meet the healthcare needs of the community and let's say that we're looking at a service for which you're the only provider in your community, versus a service where every hospital in town offers a program. Yours is good, so is theirs. Which one of those two would you say is closer to meeting the needs of your mission? I would argue the former because if you closed it down, there would be nothing available to local residents—as

opposed to the latter because if you closed it down, they would still have multiple alternatives. So mission is one category.

The second category would be how attractive is the market. That has to do with the size of the market. Is it a growing market, is it a fragmented market where we think we could actually increase our share, or is it a market dominated by a competitor so it would be very difficult for us to grow? Is it a market where, looking at the demographics of our population, we see that they are going to need more of this service five years down the road than they have in the past?

A great example today is something like orthopedics versus obstetrics. In many markets around the country, the number of women of childbearing age is declining. The number of births is declining. On the other hand the baby boomers have lots of joints that need to get replaced. If you could put one more dollar in, and that was your only criterion, you'd probably want to allocate it to a growing need rather than a shrinking need.

The third category in addition to mission and market attractiveness would be quality. Honestly, if I have a service that already is a high quality service, that would count in terms of how I was going to allocate resources. So are you trying to allocate resources to bring up the lowest quality service you have, or build upon and promote a service for which you already have a high quality ranking?

The fourth, and this is often unspoken but we need to get it right on the table, is physician support for a program or service. Do you have a physician champion; do you have a physician leader; do you have someone who has real passion to grow the service?

And last, and I say this last not because it is least important, but because it needs to be in the context of mission and market attractiveness and quality and physician leadership, is the financial performance.

Now, you may look at those five criteria, those five buckets, and say they're not all weighted equally, and I would agree.

Most organizations would weight the financial criteria at least 30, maybe 40 percent of the total score with the notion being that we have to maintain the financial integrity of the organization and, therefore, we have to give considerable weight to finance. But they're not going to make it 100 percent of the score. They're not going to say the only thing that matters to us is which of these services makes the most money. That really is not your fiduciary role. Your role is a balancing role and by using this kind of framework, management will actually do the underlying assessment, but you should be involved in saying, yes, these criteria resonate with us. That then becomes the basis for the board to say now that we have this information about the relative potential and performance of our various products and services and service lines, which ones do we think should be at the top of the list for further investment?

6. PLAN INTEGRATION

Jennings: I sometimes get the question, what's the best way to do planning? What I would typically recommend is that you establish an overall strategic planning process, and as you get to articulating the quality agenda, the philanthropic agenda, you actually create task forces or teams of people who will flesh out that aspect of the overall strategic direction in greater detail but, importantly, bring it back to the strategic planning committee—or the board if it's serving as the overall strategic planning committee—where all of that can be put together in an integrated fashion.

Every activity, every investment is competing for resources with every other investment. It's not like there's a quality silo, and there's an IT silo, and there's a developing-our-people silo and there's a growth silo. All of those are going to be calling on the same set of resources from the organization. So having the strategic planning committee or the board as a whole actually drive the overall process, be clear about what you expect from any of these task forces or specific groups that might be taking on a piece of the strategic planning development, and then help them see how this will come together for the entire strategic plan and in an integrated strategic financial plan, that's a very critical role.

I sometimes think it's very valuable, if you have a strategic planning committee, to have the strategic planning committee and the finance committee meet together when the finance committee is reviewing the budget or establishing the budget parameters for the upcoming fiscal year. Get those two groups of people in the same room at the same time, talking not only about the strategy for next year, but the financial requirements and the budget for next year and making sure at that specific level that they are dovetailing.

SUMMARY

WHEN SETTING PRIORITIES BETWEEN AND AMONG COMPETING PROGRAMS – ALL OF WHICH REQUIRE SIGNIFICANT RESOURCES – EXAMINE THOSE PROGRAMS USING THE FOLLOWING CRITERIA: MISSION COMPATABILITY, MARKET ATTRACTIVENESS, QUALITY, PHYSICIAN SUPPORT AND FINANCIAL PERFORMANCE.

THEN ASSIGN A WEIGHT TO EACH OF THOSE COMPONENTS. THIS ALLOWS A MORE SYSTEMATIC APPROACH TO PROGRAM ASSESSMENT.

THE MOST EFFECTIVE WAY TO UNDERTAKE THE STRATEGIC PLANNING PROCESS IS TO ESTABLISH TASK FORCES OR TEAMS THAT FOCUS ON THE DETAILS OF ONE ASPECT OF THE PLAN AND THEN REPORT THEIR FINDINGS AND RECOMMENDATIONS TO THE BOARD STRATEGIC PLANNING COMMITTEE. THIS COMMITTEE IS RESPONSBILE FOR ASSESSING AND INTEGRATING THE VARIOUS COMPONENTS INTO THE STRATEGIC PLAN.

7. IMPLEMENTING THE PLAN

Jennings: Let's assume that you have finally completed the strategic plan and the strategic financial plan and you feel comfortable about the direction of the organization and you believe that it's affordable and it's going to work from a financial perspective, all for the good. How do you know as a board that the organization is actually implementing its plan? Often I see that

there's a tendency for board members to want to get involved with all of the hows—well, how are we going to do this and exactly when are we going to do that and now tell me again who's going to be in charge of the third thing? I don't see that as the role of the board. I think that's the role of management. You hire management to execute and implement, and that's what execution and implementation is all about.

However, it is the role of the board to say I need to know that we're on track, if we're ahead of schedule, if we're behind schedule or are we pretty much okay? Or do we need to redirect some of our activities because something in our environment has changed? So the best way I see for the board to do that is that, in the planning process, the organization would establish clear measures of success or milestones. So I'll give you an example. If I am going on a trip, I need to know what my destination is. Once I know my destination, I need to then say, well how am I doing getting there? So if my trip is to San Diego and I'm starting in Philadelphia and I've got my car, so I've got my car tuned up, I've got my organization tuned up to be able to get me to my destination, how far should I get at the end of a day on my trip, or how far should you get as an organization in six months or in twelve months, or in two years?

One of the values of using the milestone or the metric approach where the board can be doing routine monitoring of performance against where you want to be long term is to identify where you need to reconsider. Sometimes, we're doing the right things; we're just not doing enough of them, or fast enough. Sometimes, we may not be doing the right things to get where we need to get. What I would see the role of the board is to ask the question, "I see that we wanted to be this far along. I see that we're half way there. I'm wondering whether that is because our objective has changed, has something happened in the market, what we wanted to do is no longer relevant? Is it is more difficult to accomplish than what we had anticipated, or whether we're really not devoting the resources, or we don't have the right skill set in place to accomplish the task?" That is the appropriate board question of management. If you, as a board, are clear on your strategic direction long term, unless something about that has changed, or your measure wasn't a good measure, you are going to need to know that you are making timely progress to that long-term objective.

For additional information please go to www.iprotean.net.

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Policy : Quality Improvement Oversight Information

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board of Commissioners in accordance with RCW 70.41.200, and as hereafter are amended, implement the District's Quality Improvement Oversight Program.

The District's Quality Improvement Oversight Program will have as its basis the minimum requirements found in the above reference statute. The Board of Commissioners will welcome and support reasonable enlargement of the scope of coverage of this program beyond the minimum requirements under law. The Board of Commissioners will adopt the District's Quality Improvement Oversight Program by resolution at a regular board meeting.

In accordance with the bylaws of this District and as they are hereafter amended, two hospital district commissioners are appointed to the Quality Improvement Oversight Committee.

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Policy : Records Retention

Policy:

It is the policy of Lewis County Hospital District No. 1 that in accordance with RCW 40.14 and as hereafter amended, the Board of Commissioners of Lewis County Hospital District No.1 commissions the protection of public records, documents and publications.

There shall be a designated records officer to supervise the District's records program.
The Records Officer shall:

1. Coordinate and maintain all aspects of the records management program as that program is approved by the Board of Commissioners.
2. Manage the inventory in accordance with procedures prescribed by the "Public Hospital Districts General Records Retention Schedule". The Districts records program will meet the Washington State Local Records Committee recommendations and the Board of Commissioners' policy.
3. Consult with any other personnel responsible for the maintenance of specific records within this organization regarding records retention and transfer recommendations and requirements.
4. Analyze records inventory data, examine and compare internal department inventories for duplication of records and recommend to the Superintendent maximum retentions for all copies commensurate with legal, financial and administrative needs.
5. Review the District's records program at least annually to insure that they are complete and current.

The Superintendent shall give an annual District Record Management report to the Board of Commissioners.

Document Owner:	Frady, Trish
Collaborators:	
Approvals	
- Committees:	(12/19/2018) Board of Commissioners,
- Signers:	
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Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

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Manual(s):	

Policy : Superintendent Succession Plan

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board of Commissioners shall follow the Superintendent Succession Plan.

Purpose:

This policy is to set guidelines for the replacement of the Superintendent.

Procedure:

PHASE ONE: Appointment of Emergency Superintendent/Short Term Superintendent Succession Plan

At the first indication that Lewis County Hospital District No. 1 has or soon will have a vacancy in the Superintendent position, the Chair of the Board of Commissioners will call for a special meeting of the Board of Commissioners within 48 hours.

1. One of the purposes shall be to demonstrate board leadership.
2. Another purpose shall be to review Phase One and Two of the Superintendent Succession Plan and to establish a course of action.
3. The Board will take the following steps:
    a. The Board will follow Phase One of the Superintendent Succession Plan. This meeting may last for as long as thirty days. Each part of this emergency meeting will be a continuance of the original emergency meeting. This meeting does not end until thirty days have passed or until adjourned.*
    b. To fulfill an immediate need, the Board will appoint an Emergency Superintendent from the Administrative Team. The length of his/her appointment will be determined by the Board of Commissioners.
    c. Before adjournment the Board shall prepare a statement, addressed to the following: Medical Staff, Employed Staff and the Public, containing the subject matter of this meeting and the Board's collective position.

d. As soon as business of Phase One is completed, this Phase One special meeting will be adjourned.

* *Note: This emergency meeting may continue for as long as 30 days and from time to time the Chair of the Board may put this meeting into continuance as conditions require.*

PHASE TWO: Interim Superintendent Succession Plan

Phase Two begins on the 1st day after the last special meeting held in Phase One. All Phase Two meetings will be special or regular meetings. The Superintendent will be hired after two regular board meetings.

1. For the purpose of Phase II the board will appoint an ad hoc committee that will be commissioned to make recommendations of candidates for the position of interim superintendent of Lewis County Hospital District No. 1 to the Board as a whole.
    a. The Committee shall consist of two current Board members.
    b. The Committee chairperson is determined by the by-laws of Lewis County Hospital District No. 1. (See Section 7 of by-laws.)
    c. The Committee can and should use whatever resources are available to compile a comprehensive list of candidates (See Addendum I.)
2. The ad hoc committee will return a list of candidates for interim superintendent within 60 days of the adjournment of the emergency special meeting of the Board.
3. Upon receiving the list of candidates, the Board will begin the process of appointing the Interim Superintendent.

PHASE THREE: Long Term Superintendent Succession Plan

All Phase Three meetings may occur in regular or special meetings with the exception of meetings dealing with the hiring of a Superintendent, which must be addressed in two regular meetings.

1. The Board of Commissioners will establish a search committee. The two commissioners appointed to the Committee by the Board of Commissioners will determine administrative position 3.
    a. It will consist of 2 commissioners and 3 administrative employees.
        i. One administrative employee from nursing.
        ii. One administrative employee from financing.
        iii. One administrative employee from any other administrative position.
        iv. The CMO and/or the chief of the medical staff.
    b. The committee chairperson is determined by the by-laws of Lewis County Hospital District No. 1. (See Section 7 of by-laws.)
    c. The mission of the advisory committee shall be to bring the names in rank order of the qualified candidates to the Board as soon as possible but no later than 270 days.
2. The search committee will recommend to the Board a minimum of three and a maximum of five candidates. The Board will review and evaluate the listing of candidates from the search committee and select the top three.
3. The Board of Commissioners will select a candidate from the recommended group, negotiate a contract and hire the Superintendent for Lewis County Hospital District No. 1.

Superintendent SUCCESSION ADDENDUM

Section 1 Board considerations before requesting a cover letter and resume.

1. Board Environment
2. Financial Operations
3. Possible New Programs and Clinics
4. Changing Health Care
5. Internal Talent
6. Salary expectations based on market comparison
7. Future needs of the District
8. Invested Interest in Community

Section 2 Suggested Qualifications for Superintendent

SUGGESTED INTERIM Superintendent QUALIFICATIONS

1. Is respected
2. Is able to follow established procedure
3. Allows managers to manage
4. Does not attempt to initiate big changes
5. Possesses BA/BS Degree
6. Possesses appropriate credentials

SUGGESTED QUALIFICATIONS FOR Superintendent

1. Bachelor or Masters Degree preferred in Health Care, Administration, Nursing and/or Finance
2. Strong Background in Healthcare Finance
3. Demonstrated Leadership in Quality Improvement
4. Highly motivated goal-oriented leader
5. Decision maker who demonstrates vision in Rural Health Care
6. Minimum 3 years experience in Rural Health Care preferred
7. Leadership skills supported by management abilities
8. Able to network or willing to network in health care
9. Visionary (Research-based)
10. Willing to belong to collaborative and to attend conferences
11. Willing to take vacations

12. Willing to participate in employee events and award programs
13. Capable of functioning as team member
14. Keeps board informed
15. Computer Savy
16. Able to establish and enhance working relationships with physicians
17. Able to increase market share
18. Make yourself available to community organizations such as the city council, chamber of commerce
19. Encourage managers to attend conferences
20. Develop, update, and maintain current strategic plan

Section 3 Suggested Area Promotional Plan

Include a list of local realtors and their numbers to potential candidates.

Morton is not in the middle of nowhere, it is in the middle of EVERYWHERE! Easy access to:

Seattle	**Portland**
Space Needle	Pioneer Square
Pike Place Market	Portland Saturday Market
Seattle Seahawks	Portland Trailblazers
Seattle Mariners	Rose Garden Events
Woodland Park Zoo	Oregon Zoo
Seattle Aquarium	Oregon Museum of Science and Industry (OMSI)
Museum of Flight	Lloyd Center (Ice Skating)
Pacific Ocean	**Ski Areas**
Long Beach Peninsula	White Pass Ski Area
Ocean Shores	Crystal Mountain Resort
Pacific Beach	The Summit at Snoqualmie
Westport	Mt. Hood
Astoria	Mt. Bachelor
Seaside	
Recreation	**Airports**
Boating	Portland International
Water Skiing	Seatac International
Fishing (Lakes, streams, and ocean)	
Hunting	
Hiking and Mountain Climbing	
Mt. Rainer	
Mt. St. Helens	

Strategically recruit spouses also. Insure that spouses of potential candidates that are visiting our hospital feel welcome too. Somebody should be available (Foundation member or staff, etc) to have lunch with and/or visit them to address concerns and questions they may have about our area. Match these people up as best as we can with potential similar interests. This could be an avenue for others to be involved.

WSHA should be able to advise regarding what appeals to potential candidates as far as salary expectations and other things in general.

Section 4 Suggested Board Statements

Phase 1 Emergency Plan

Statement to: Hospital Staff and Medical Staff(via letters and "Hospital Happenings"paper)

The Hospital Board met on _____ to consider the temporary leave of absence for _____, Superintendent of Morton General Hospital and Lewis County Hospital District No. 1. Until further notice all Superintendent decisions, contracts, and hospital business will be administered by_____. (The board will immediately begin a search for an interim Superintendent. This search will be guided by the Phase 1, emergency phase, of the Superintendent succession plan.)

Statement to: Public (via newspaper and web site)

Due to (various introductory statements). The board met on _____and appointed _____as temporary Superintendent for all operations of Morton General Hospital and Lewis County Hospital District No. 1. The Board has begun a search for an interim Superintendent. This search will be guided by the Phase 1, emergency phase, of the Superintendent Succession Plan.

Phase 2 Resignation or Retirement Plan

Statement to: Hospital, Medical Staff and Public via memo, letter and/or newspaper

The Board met on _____and accepted the (resignation or retirement) of Superintendent _____ as of _____. The Board has begun the search for a replacement Superintendent. This replacement search will be guided by the Superintendent Succession Plan. Until the beginning date of the new Superintendent, all operations will be managed by _____.

Section 5 Resources

1. Washington State Hospital Association
2. Washington Rural Health Collaborative
3. AWPHD President
4. Search Firm (strongly recommended)
    a. Korn and Ferry, Mark Collins
    b. Witt Keiffer
    c. Quorum

Include area promotional brochures from surrounding Chambers of Commerce, local newspaper visitor guides and event listings, and Lewis County tourism information should be distributed to potential candidates.

Section 3 Area Promotional Plan and Candidate Recruitment

Document Owner:	Frady, Trish
Collaborators:	
Approvals	
- Committees:	(09/26/2018) Board of Commissioners,
- Signers:	
Original Effective Date:	01/27/2011
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Review Date:	[11/08/2013 Rev. 0], [06/20/2016 Rev. 2], [08/24/2017 Rev. 2]
Attachments: (REFERENCED BY THIS DOCUMENT)	
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	

SUPERINTENDENT REPORT

SUPERINTENDENT'S REPORT August 2020

Mission: *To foster trust and nurture a healthy community*
Vision: *To provide accessible, quality healthcare*

	Opportunity	CY 2020 Progress	Status	Associated Documentation
Informational	Population Health	Verbal update will be provided on acceptance into PSW's NWMomentum Health Partners ACO		*None*
Compliance	2021 Operational Budget	Timeline provided to communicate regulatory compliance to submitting 2021 Operating Budget to Board of Commissioners and County Clerk		08/18/2020 2021 Operating Budget Memo
Informational	Property Acquisition & Disposition	Verbal update will be provided on the purchase and disposition of property		*None*
Informational	Construction Re-bid Timeline	Construction bid timeline provided to communicate Board involvement		*08/18/2020 Construction Bid Timeline*
Strategic	Recruitment	Recruitment of key positions provided		08/18/2020 Recruitment Update

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 8/18/2020
Subject: 2021 Operating Budget

RCW 70.44.060(6) requires that the Superintendent prepare an operating budget for the District and present it to the Board of Commissioners by November 1st annually. The following:

- Draft 2021 Operating Budget
  - Present at the September 23, 2020 Finance Committee meeting,
  - Present at the September 30, 2020 Regular Board of Commissioners meeting,
- Final 2021 Operating Budget (*RCW 70.44.060(6))* and Proposed Tax Levy *(RCW 84.65.120)*
  - Present at the October 21st Finance Committee meeting,
  - Board notices will run on two consecutive weeks (10/28/2020 and 11/4/2020) in district media,
  - Present at Regular Board of Commissioners meeting to be adopted via resolution on November 11, 2020,
- Certification to the County
  - District budgets and levy requests must be filed with the county clerk on or before November 30, 2020 to comply with *RCW 84.52.020.*

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 8/18/2020
Subject: Construction Bid Timeline

Please note the dates of interest associated with the Generator/OR HVAC construction project. Events that need or require Commissioner involvement are highlighted in yellow.

- September 1, 2020: Bid Advertisement
- **September 3 or 4, 2020 at 12:00 pm**: Pre-Bid Conference - Optional participation by Commissioners on Plant Planning Committee
- **September 8, 2020 from 9:00 am to 3:00 pm**: Site Visit by Appointment
- **September 17, 2020**: Substitution Requests Due
- **September 17, 2020**: Questions Due
- **September 23, 2020**: Addendums Issued By
- **September 30, 2020 at 12:00 pm**: Bids Due
- **September 30, 2020 at 3:30 pm**: Bids Open and Apparent Low Bidder announced at Regular Board Meeting
- **October 13, 2020 at 3:30 pm**: Award bid to most responsible bidder

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 8/18/2020
Subject: Recruitment Update

Arbor Health has been very fortunate to have successfully recruited several key positions. The following positions have been recently filled:

- Mossyrock Clinic Physician –Victoria Acosta, D.O. will begin treating patients in August 2021. She is finishing her residency in Tacoma, WA. Dr. Acosta has served as Chief Resident and is a native Washingtonian.
- Facilities Manager – Our new Facilities Manager has an illness in the family that prevents him from joining our team. He is providing consultative services while we look to fill the position.