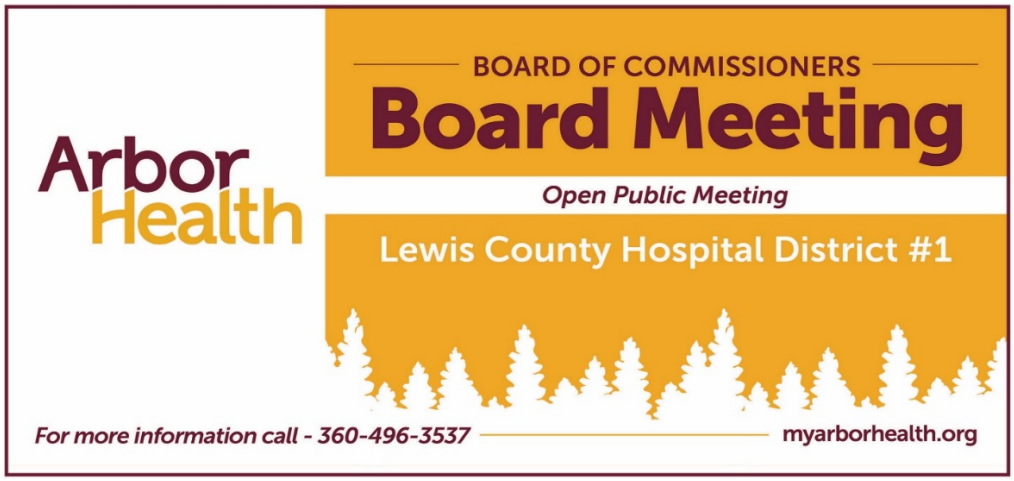
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

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

December 15, 2021 @ 3:30 PM
Join Zoom Meeting: https://myarborhealth.zoom.us/j/94428106689
Meeting ID: 944 2810 6689
One tap mobile: +12532158782,,94428106689#
Dial: +1 253 215 8782

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
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Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

TABLE OF CONTENTS

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
December 15, 2021 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/94428106689
Meeting ID: 944 2810 6689
One tap mobile: +12532158782,,94428106689#
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 **Roll Call** **Reading of the Mission & Vision Statement** **Approval or Amendment of Agenda** **Conflicts of Interest**		3:30 pm
Oath of Office *(Action)* • Assumption of Office-Craig Coppock, Kim Olive & Laura Richardson		3:35 pm
Comments and Remarks • Commissioners • Audience		3:45 pm
Executive Session-*RCW 70.41.20, RCW 42.30.110 (i) & RCW 70.41.200* • Medical Privileging-Medical Staff Coordinator Holmes • To discuss with legal counsel representing the agency matters relating to agency enforcement actions, or to discuss with legal counsel representing the agency litigation or potential litigation to which the agency, the governing body, or a member acting in an official capacity is or is likely to become, a party, which public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the agency. • Quality Improvement Oversight Report-Commissioner Schumaker & CNO/CQO Williamson	5	3:50 pm
Department Spotlight • *To resume in January 2022.*		
Board Committee Reports • Hospital Foundation Report-Committee Chair-Commissioner McMahan	7	4:20 pm
• Finance Committee Report-Committee Chair-Commissioner Coppock	9	4:25 pm
• Quality Improvement Oversight Report-Committee Chair-Commissioner Schumaker *(Action)* o *To revisit the frequency of the QIO Meeting per DNV/ISO 9001*	13	

recommendations.		
Consent Agenda *(Action)* • Approval of Minutes: o *November 10, 2021 Regular Board Meeting* o *November 10, 2021 Special Board Meeting* o *November 17, 2021 Finance Committee Meeting* o *November 29, 2021 Special Board Meeting* o *December 1, 2021 Quality Improvement Oversight Committee Meeting*	 28 33 36 39 42	4:30 pm
• Warrants & EFT's in the amount of $3,881,175.96 dated November 2021	47	
• Approve Documents Pending Board Ratification 12.15.21 (*To be provided at the meeting.)* o *To provide board oversight for document management in Lucidoc.*	49	
• Resolution 21-40-Declaring to Surplus or Dispose of Certain Property o *To approve liquidation of items beyond their useful life.*	51	
• Resolution 21-41-Approving the DZA Financial Audit, Single Audit for Cares Act Funding and Cost Report Annual Engagement *(Action)* o *To approve the engagement with DZA.*	53	
• Resolution 21-42-Approving DNV Accreditation Appointment *(Action)* o *To reappoint Infection Preventionist for 2022. (DNV NIAHO IC.1, SR.2a)*	65	
Old Business • Incident Command Update o *CNO/CQO Williamson will provide a verbal COVID 19 update, which will include Proclamation 21-14.*		4:35 pm
• Board Self-Evaluation o *To discuss as a Board the evaluations completed for 2021.*	68	4:40 pm
• Commissioner Compensation for Meetings and Other Services o *To revisit the approved policy and procedure.*	71	4:55 pm
New Business • Resolution 21-43-Approving the Purchase of the Network Redesign *(Action)* o *To approve a 2022 operating expense that is above the Superintendent's purchasing authority.*	74	5:00 pm
• Resolution 21-44-Approving the Second 2021 Retention Bonus Methodology *(Action)* o *To approve a one-time retention bonus methodology for staff.*	77	5:10 pm
• New Third Party Administrator for Flexible Spending Account & Health Reimbursement Arrangement Plans o To discuss and present for approval the plans in January 2022.	80	5:15 pm
• 2022 Organization of the Board & New Commissioner Orientation o *To present and discuss committee assignments and orientation in January 2022.*	81	5:20 pm
Superintendent Report • 2022 Departmental Strategic Measures DRAFT	83	5:30 pm
Meeting Summary & Evaluation		5:40 pm
Next Board Meeting Dates and Times • Regular Board Meeting-January 26, 2022 @ 3:30 PM (ZOOM) **Next Committee Meeting Dates and Times** • Finance Committee Meeting-December 22, 2021 @ 12:00 PM (ZOOM) • Finance Committee Meeting-January 19, 2022 @ 12:00 PM (ZOOM)		
Adjournment		5:45 pm

MEDICAL STAFF PRIVILEGING

The below providers are requesting appointment to the Arbor Health Medical Staff. All files have been reviewed for Quality Data, active state license, any malpractice claims, current liability insurance, peer references, all hospital affiliations, work history, National Practitioner Data Bank reports, sanctions reports, Department of Health complaints, Washington State Patrol background check and have been reviewed by the credentialing and medical executive committees including the starred items below. The credentialing and medical executive committees have recommended the following for approval.

INITIAL APPOINTMENTS-5

Radia

- Lauren Fetty, MD (Consulting Radiology Privileges)
- Alice Josafat, MD (Consulting Radiology Privileges)
- Kambrie Kato, MD (Consulting Radiology Privileges)
- John McGown, MD (Consulting Radiology Privileges)
- Ross Ondersma, MD (Consulting Radiology Privileges)

REAPPOINTMENTS-6

Arbor Health

- Kevin McCurry, MD (Emergency/Family Medicine Privileges)
- Amy Nielsen, CRNA (Anesthesia Privileges)

PeaceHealth Pathology

- Helen Kim, MD (Consulting Pathology Privileges)

Radia

- Matthew Stein, MD (Consulting Radiology Privileges)

Telestroke/Neurology Consulting Privileges

- Mimi Lee, MD (Consulting Telestroke/Neurology Privileges)
- James Wang, MD (Consulting Telestroke/Neurology Privileges)

✪-notates files with items to note.

COMMITTEE REPORTS

Arbor Health | FOUNDATION

521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Arbor Health Foundation Meeting
October 12, 2021
ZOOM

Mission Statement

To raise funds and provide services that will support the viability and long-term goals of the Lewis County Hospital District No. 1. This includes, but is not limited to, taking a leadership role in maintaining and improving community pride and confidence in all aspects of the hospital's health care system.

Attendance: Ali Draper, Jessica Scogin, Caro Johnson, Linda Herrin, Christine Brower, Ann Marie Forsman, Martha Wright, Jeannine Walker, Wes McMahan, Betty Jurey, Gerri Maize, Marc Fisher, Julie Taylor, Gwen Turner

Excused: Lynn Bishop

Call to Order by President Ali Draper at 12:07pm

October 2021 Treasurers report was approved. Gwen Turner/Jeannine Walker

October 2021 minutes were approved. Gwen Turner/Jeannine Walker

Administrators Report- Julie Taylor
The number of Covid cases has plateaued and the hospital only has one covid patient now. A booster clinic was held last week in Packwood and Morton and good feedback was received.

Directors Report:
Jessica reported on the storyteller's conference that she recently attended in San Diego. It was helpful in teaching non-profits be successful in their fund-raising efforts.

Old Business:

Arbor Health | FOUNDATION
521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

New Business:

Bank Housekeeping

The following motion was made:

Arbor Health Foundation requests the following changes to the bank accounts at Key Bank and Security State Bank. Add Jessica Scogin to all Arbor Health accounts.

Arbor Health Foundation Officers and signers on the bank accounts are to be assigned as follows:
Jessica Scogin, Executive Director
Virginia Ali Draper, President
Marc Fisher, Vice President - ***Remove Martha Wright, per vote on 11/9/21***
Caro Johnson, Secretary
Gerri Maize, Treasurer

Online banking rights are to be granted to Jessica Scogin, Virginia Ali Draper and Gerri Maize.

Motion approved Gwen Turner/Wes McMahan

A committee is being formed to work on the 2022 Foundation Budget and volunteers are welcome.

Election for 2022 officer will be addressed at the December meeting.

The foundation will have a Christmas sale in the board room Nov 30 & Dec 1, 2021 10-6pm. The sale is open to employees and patience's with procedures.

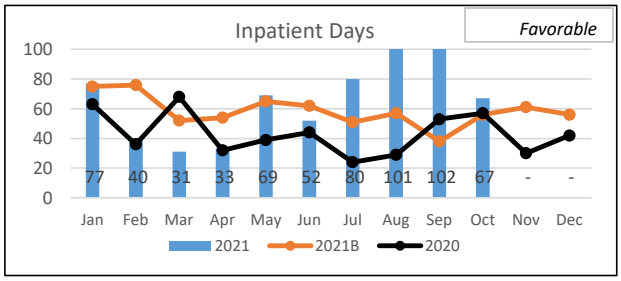
The foundation will have a booth at the Friends of Morton Park Bazar scheduled Nov 19, 20, 21 at the Lyle Building. The table fee is $30 and the vendor permit is $5.

Jessica Scogin showed a video that she made that featured the 15 Minute Philanthropist Program which allows employees and others to donate to the scholarship fund.

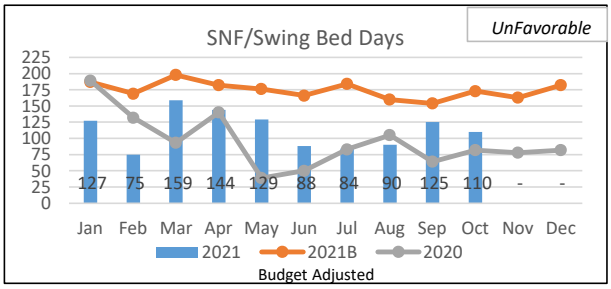
Meeting adjourned 12:54

Lewis County Hospital District No. 1
Board Financial Summary
October 31, 2021

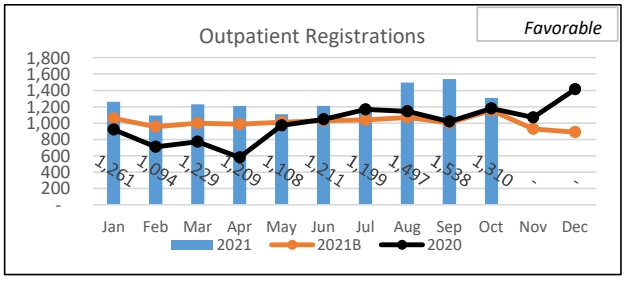
Growth



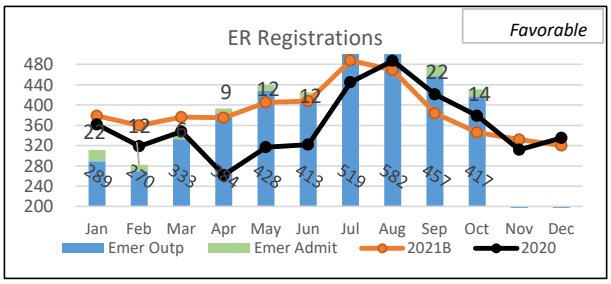
YTD: 652.00 Budget: 586.00 Pr Yr: 445.00



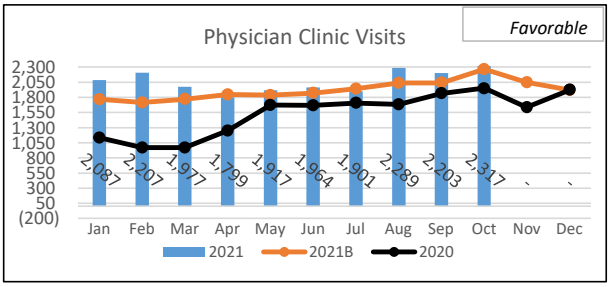
YTD: 1,131 Budget: 1,749 Pr Yr: 977



YTD: 12,656 Bud: 10,303 Pr Yr: 9,508

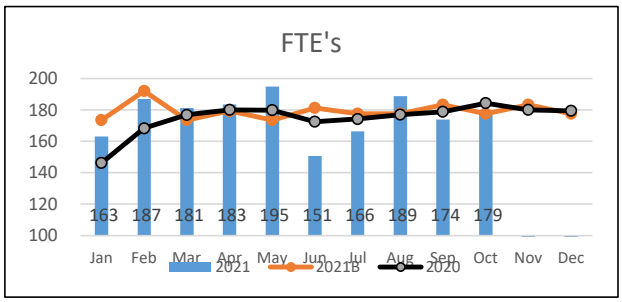


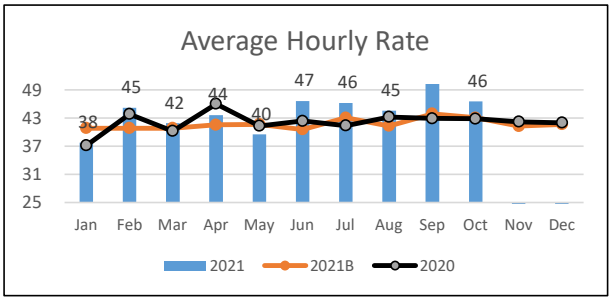
YTD: 4092 Bud: 3990 Pr Yr: 3662

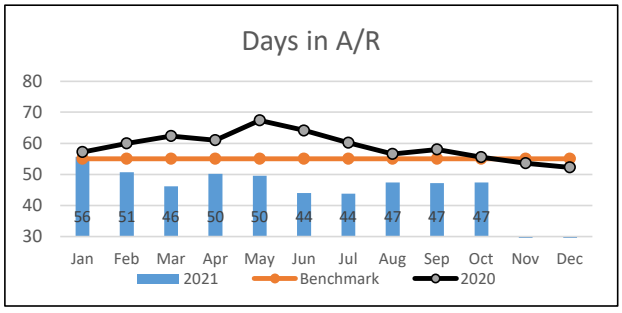


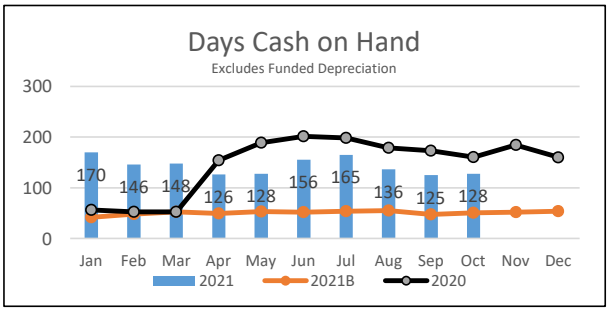
YTD: 20,661 Bud: 19,101 Pr Yr: 14,874

People and Operational Aspects









Lewis County Hospital District No. 1
Income Statement
October, 2021

CURRENT MONTH						YEAR TO DATE				
Pr Yr Month	% Var	$ Var	Budget	Actual		Actual	Budget	$ Var	% Var	Actual
671,277	-20%	(160,465)	821,855	661,390	Inpatient Revenue	7,058,193	8,269,249	(1,211,057)	-15%	6,375,565
2,509,587	-16%	(491,938)	3,167,525	2,675,587	Outpatient Revenue	27,617,270	31,710,863	(4,093,594)	-13%	25,005,046
385,094	-11%	(50,092)	465,386	415,294	Clinic Revenue	3,710,865	3,838,265	(127,400)	-3%	2,901,126
3,565,958	-16%	(702,495)	4,454,766	3,752,271	**Gross Patient Revenues**	**38,386,327**	43,818,377	(5,432,050)	-12%	34,281,737
1,069,874	36%	634,889	1,758,144	1,123,255	Contractual Allowances	13,576,117	16,668,303	3,092,186	19%	13,905,094
66,846	7%	2,318	33,092	30,774	Charity Care	339,347	341,211	1,865	1%	337,712
18,120	15%	8,096	55,536	47,441	Bad Debt	477,010	586,562	109,552	19%	90,218
1,154,840	35%	645,303	1,846,773	1,201,470	**Deductions from Revenue**	**14,392,474**	17,596,077	3,203,603	18%	14,333,024
2,411,118	**-2%**	**(57,192)**	**2,607,993**	**2,550,801**	**Net Patient Service Rev**	**23,993,854**	**26,222,300**	**(2,228,447)**	**-9%**	**19,948,713**
67.6%	-16.1%	-9.4%	58.5%	68.0%	**NPSR %**	62.5%	59.8%	-2.7%	-4.5%	58.2%
474,446	14%	10,007	73,806	83,813	Other Operating Revenue	1,280,412	738,055	542,357	73%	4,140,001
2,885,563	**-2%**	**(47,185)**	**2,681,799**	**2,634,613**	**Net Operating Revenue**	**25,274,265**	**26,960,355**	**(1,686,090)**	**-6%**	**24,088,714**
					Operating Expenses					
1,355,885	-7%	(91,130)	1,356,270	1,447,401	Total Productive Salaries	13,168,613	12,963,137	(205,476)	-2%	12,414,344
154,524	7%	13,986	198,315	184,329	Total Non Productive Salarie	2,180,443	1,983,150	(197,293)	-10%	1,824,926
1,510,408	-5%	(77,144)	1,554,585	1,631,729	Salaries & Wages	15,349,056	14,946,286	(402,769)	-3%	14,239,270
403,600	29%	106,700	370,168	263,468	Benefits	3,579,254	3,615,310	36,056	1%	3,223,095
158,083	29%	49,411	172,459	123,048	Professional Fees	1,182,956	1,652,342	469,386	28%	1,502,698
215,288	1%	2,659	196,674	194,015	Supplies	1,843,270	1,891,164	47,893	3%	1,686,730
303,715	5%	18,600	352,180	333,580	Purchase Services	3,480,514	3,689,741	209,227	6%	2,897,316
53,774	114%	34,378	30,052	(4,327)	Utilities	372,324	440,426	68,102	15%	434,656
23,261	-21%	(4,188)	19,623	23,811	Insurance	200,331	182,363	(17,969)	-10%	179,121
37,431	-118%	(47,685)	40,438	88,123	Other Expenses	454,813	424,436	(30,378)	-7%	474,457
2,705,559	3%	82,732	2,736,180	2,653,448	EBDITA Expenses	26,462,519	26,842,067	379,549	1%	24,637,343
180,004	-65%	35,546	(54,381)	(18,835)	**EBDITA**	(1,188,253)	118,288	(1,306,541)	-1105%	(548,629)
6.2%	65.0%	-1.3%	-2.0%	-0.7%	EBDITA %	-4.7%	0.4%	5.1%	1168.2%	-2.3%
					Capital Cost					
135,177	10%	11,077	115,902	104,826	Depreciation	1,027,092	1,096,850	69,759	6%	1,433,128
38,236	11%	4,387	39,802	35,415	Interest Cost	356,066	379,038	22,972	6%	364,899
2,878,972	3%	98,195	2,891,884	2,793,689	Operating Expenses	27,845,677	28,317,956	472,279	2%	26,435,370
6,592	-24%	51,010	(210,086)	(159,076)	**Operating Income / (Loss)**	(2,571,411)	(1,357,600)	(1,213,811)	89%	(2,346,655)
0.2%			-7.8%	-6.0%	Operating Margin %	-10.2%	-5.0%			-9.7%
					Non Operating Activity					
192,833	-3%	(4,085)	134,493	130,408	Non-Op Revenue	1,314,059	1,344,930	(30,871)	-2%	1,485,212
4,065	-439%	(7,549)	1,719	9,268	Non-Op Expenses	85,630	17,193	(68,437)	-398%	27,378
188,768	-9%	(11,634)	132,774	121,140	Net Non Operating Activity	1,228,429	1,327,736	(99,307)	-7%	1,457,834
195,359	-51%	39,376	(77,312)	(37,936)	**Net Income / (Loss)**	(1,342,982)	(29,864)	(1,313,118)	4397%	(888,822)
6.8%			-2.9%	-1.4%	Net Income Margin %	-5.3%	-0.1%			-3.7%

Lewis County Public Hospital District No. 1
Balance Sheet
October, 2021

	Current Month	Prior-Month	Prior-Year end	Incr/(Decr) From PrYr
Assets				
Current Assets:				
Cash	$ 11,099,098	12,946,912	13,907,559	(2,808,461)
Total Accounts Receivable	6,591,220	6,791,780	6,254,724	336,496
Reserve Allowances	(2,157,774)	(2,605,142)	(2,586,216)	428,443
Net Patient Accounts Receivable	4,433,446	4,186,638	3,668,507	764,939
Taxes Receivable	(179,564)	(305,462)	50,622	(230,186)
Estimated 3rd Party Receivables	54,132	54,132	1,087,432	(1,033,300)
Prepaid Expenses	261,883	283,228	262,018	(135)
Inventory	357,770	351,220	312,749	45,020
Funds in Trust	2,115,170	2,112,719	3,205,817	(1,090,647)
Other Current Assets	187,403	190,266	66,706	120,697
Total Current Assets	18,329,338	19,819,652	22,561,411	(4,232,073)
Property, Buildings and Equipment	34,517,304	34,495,885	31,221,772	3,295,532
Less Accumulated Depreciation	(22,950,652)	(22,844,521)	(22,305,474)	(645,178)
Net Property, Plant, & Equipment	11,566,652	11,651,364	8,916,298	2,650,355
Total Assets	$ 29,895,990	31,471,016	31,477,709	(1,581,719)
Liabilities				
Current Liabilities:				
Accounts Payable	902,007	2,009,408	583,624	318,383
Accrued Payroll and Related Liabilities	511,325	930,876	903,749	(392,424)
Accrued Vacation	883,292	869,348	894,536	(11,244)
Third Party Cost Settlement	5,814,069	5,844,789	6,149,286	(335,217)
Interest Payable	129,222	96,915	0	129,222
Current Maturities - Debt	1,316,175	1,316,175	1,316,175	0
Unearned Revenue	1,081,258	1,081,258	773,947	307,311
Other Payables	(8)	(8)	(8)	0
Current Liabilities	10,637,341	12,148,761	10,621,309	16,031
Total Notes Payable	4,318,774	4,343,138	4,560,487	(241,714)
Capital Lease	(0)	(0)	(0)	0
Net Bond Payable	6,127,229	6,128,534	6,140,283	(13,054)
Total Long Term Liabilities	10,446,003	10,471,672	10,700,771	(254,768)
Total Liabilities	21,083,344	22,620,433	21,322,080	(238,736)
General Fund Balance	10,155,629	10,155,629	10,155,629	0
Net Gain (Loss)	(1,342,982)	(1,305,046)	(0)	(1,342,982)
Fund Balance	8,812,646	8,850,582	10,155,629	(1,342,982)
Total Liabilities And Fund Balance	$ 29,895,990	31,471,016	31,477,709	(1,581,719)

Arbor Health
Cash Flow Statement
For the Month Ending October 2021

	MTD	YTD
Cash Flows from Operating Activites		
Net Income	(37,936)	(1,342,982)
Adjustments to reconcile net income to net cash provided by operating activities		
Decrease/(Increase) in Net Patient Accounts receivable	(248,989)	(764,938)
Decrease/(Increase) in Taxes receivable	(125,898)	230,186
Decrease/(Increase) in Est 3rd Party Receivable	0	1,033,300
Decrease/(Increase) in Prepaid expenses	21,345	135
Decrease/(Increase) in Inventories	(6,550)	(45,021)
Decrease in Other Current Assets	2,862	(120,697)
Increase/(Decrease) in Accrued payroll liabilities	(405,607)	(403,668)
Increase/(Decrease) in 3rd Party cost stlmt liabilities	(30,720)	(335,217)
Increase/(Decrease) in Accounts payable	(1,107,400)	625,695
Increase/(Decrease) in Interest payable	32,307	129,222
Depreciation expense	106,131	645,178
Net Cash Flow from Operations	(1,800,455)	(348,807)
Cash Flows from Investing Activities		
Cash paid for		
Purchases of Fixed assets	(21,419)	(3,295,532)
Net Cash Flow from (used) in Investing Activities	(21,419)	(3,295,532)
Cash Flows from Financing Activities		
Cash paid for		
Additions to long-term debt	0	0
Principal payments of long-term liabilities	(25,669)	(254,768)
Net Cash Flow from (used) in Financing Activities	(25,669)	(254,768)
Net Increase (Decrease) in Cash	(1,847,543)	(3,899,107)
Cash at Beginning of Period	$ 15,061,812	$ 17,113,376
Cash at End of Period	$ 13,214,269	$ 13,214,269

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MEMORANDUM

To: Board of Commissioners

From: Sara Williamson, CNO/CQO

Date: December 15, 2021

Re: Arbor Health Board *Quality Improvement Oversight Committee* and *Quality Council* (Quality Management Oversight function)

As we move forward on our 2022 *DNV NIAHO* and *ISO 9001* journey, we have identified opportunities to improve the quality improvement structure, initiatives, and members across our healthcare system to reduce data/reporting redundancy while ensuring interdisciplinary collaboration, system improvements, patient safety, and effective communication throughout the organization. Toward this goal, we propose changing the Quality Committee structure to allow for an operational and interdisciplinary *Quality Council* work group that communicates outcomes and assessments to the Board *Quality Improvement Oversight Committee*. See attachment for 2022 Quality Calendar for an overview for the quality committee information flow.

ISO 9001 Journey

- *What is ISO 9001*: ISO 9001 sets out the steps necessary to adopt a quality management system and is based on internationally recognized quality management principles set out by the International Standards Organization (ISO). Improving quality and enhancing patient safety through the implementation of a quality management system is the best way to provide patient centered care. ISO 9001 provides a model for a quality management system which focuses on the effectiveness of clinical, business and support processes to ensure high quality care is provided. The standard promotes the adoption of a process approach emphasizing the requirements, added value, process performance and effectiveness, and continual improvement through objective measurements.
- The ISO 9001 standard provides specific requirements for a quality management system that will enhance our ability to consistently deliver care that meets patient needs - as well as statutory and regulatory requirements.
- *Why ISO Certification*: Successful certification to ISO 9001 will demonstrate Arbor's ability to:
    - Ensure quality and safety in the treatment of patients.
    - Identify and manage risk to patients, staff and the organization.
    - Determine, manage, monitor and improve complex and interrelated processes.
    - Comply with relevant statutory and regulatory requirements.
    - Implement best practice routines and procedures.
    - Prevent incidents from occurring.
    - Identify areas of improvement and ensure continual enhancement of your quality management system.

  Perhaps the most important element of the standard however, is that it is not a one-off exercise. Regular reviews keep quality at the forefront with continuous improvement processes driving the way

our system evolves to better meet customer needs. ISO 9001 is one of the most widely used management tools in the world, with over 1 million organizations certified.

- *When ISO Certification*: To be achieved by 2024 (3 years from initial deemed NIAHO accreditation).
- *Initial Arbor Health ISO Implementation Steps*:
    - *Develop a Quality Management System (QMS)*: Design and implement the overall QMS system.
    - *Create a Quality Council*: Functions as the operational entity for system-wide quality improvement. It is an interdisciplinary committee that oversees the QMS with representation from Senior Leadership, Medical Staff, Nursing, Quality/ Risk Management, Physical Environment/Safety, Pharmacy Services, and Ancillary Services. This group will develop, implement, and maintain an effective, ongoing, system-wide, data-driven quality assessment and performance improvement (QAPI) program and maintain and demonstrate evidence of the effectiveness of its QAPI program.
    - The results of the *Quality Council* activities will be communicated to the Arbor Health *Board Quality Improvement Oversight Committee* as a part of the Quality Management Oversight process.

DNV GL HEALTHCARE

SAFEGUARDING HOSPITAL QUALITY

WHY TRADITIONAL ACCREDITATION IS UNDER ATTACK AND WHAT TO DO ABOUT IT

Safeguarding Hospital Quality: Why Traditional Accreditation is Under Attack and What to Do About It

Despite the efforts to improve the quality of care in hospitals and to prevent medical errors that were launched by the Institute of Medicine's "To Err is Human" report in the 1990's, patient safety remains at risk in American hospitals.[1] A Johns Hopkins University report recently announced that an estimated 250,000 patients die each year due to medical errors.[2] Some two million patients in the U.S. wind up with healthcare-associated infections every year, and nearly 90,000 die as a result.[3] And the Commonwealth Fund ranked the U.S. last among 11 countries for health outcomes, equity and quality.[4]

As a growing number of older Americans requires hospitalization, new bacteria develop and antibiotic resistance becomes more widespread, the dangers for hospitalized patients will grow.

In the midst of this infection epidemic, the traditional model of hospital accreditation – the process that is supposed to assure that hospitals are safe and delivering quality care - is under scrutiny. Legislators, the Centers for Medicare & Medicaid Services, and the *Wall Street Journal* are investigating incidents of hospitals with numerous quality problems that are still receiving accreditation and accepting and treating patients.[5]

This paper asks and answers the question: Is traditional accreditation enough, or do we need a new model for today's hospitals that will dramatically improve the quality of care and the safety that hospital patients should expect?

The Evolution of Hospital Accreditation

Although hospital surveys have been conducted in one form or another for the past century, and state licensing programs became commonplace after World War Two, it was not until the creation of the Medicare and Medicaid programs in the mid-1960s that there was a pressing need to certify hospitals to participate in government programs on a large scale.[6]

Starting in 1965, Medicaid and Medicare began pumping billions of dollars into the U.S. healthcare system. Standards for hospitals that could treat these patients were promulgated in the original Medicare legislation. Those original Conditions of Participation included the maintenance of clinical records, bylaws for medical staff, a 24-hour nursing service supervised by a registered nurse, utilization review planning, institutional planning, capital budgeting, and state licensure, among others.[7]

In the intervening decades, hospital surveys by a variety of organizations have become commonplace to ascertain that hospitals meet these standards and are able to receive payment for treating Medicare and Medicaid patients. Now, the 5,000 or so acute care facilities throughout

1. "Patient Safety in the U.S.A. Getting Better, But Concerns Remain." The Sentinel Watch. 30 June 2015. <https://www.americansentinel.edu/blog/2015/06/30/patient-safety-in-the-u-s-a-getting-better-but-concerns-remain/>. Accessed 4 March 2019.
2. Sipherd, Ray. "The Third-Leading Cause of Death in U.S. Most Doctors Don't Want You To Know About." *CNBC.* 22 February 2018. <https://www.cnbc.com/2018/02/22/medical-errors-third-leading-cause-of-death-in-america.html>. Accessed 4 March 2019.
3. Stone, Patricia W. "Economic Burden of Healthcare-Associated Infections: An American Perspective. *Expert Review of Pharmacoeconomics & Outcomes Research. October 2009, Vol. 9, Iss. 5, pp. 417-422. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2827870/>. Accessed 3 March 2019.*
4. Schneider, Eric. C., Sarnak, Dana O., et al."Mirror, Mirror 2017:International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care." The Commonwealth Fund. July 2017. <https://interactives.commonwealthfund.org/2017/july/mirror-mirror/>. Accessed 3 March 2019.
5. Macdonald, Ilene. "Grassley Urges Feds to find a way to Make Hospital Accreditation Reports Public." *Fierce Healthcare.* 20 September 2017. <https://www.fiercehealthcare.com/healthcare/grassley-urges-feds-to-find-a-way-to-make-hospital-accreditation-reports-public>. Accessed 3 March 2019.
6. Vatel, Boris. "The Government Inspector." *Journal of American Physicians and Surgeons*. Fall 2017, Vol. 22, Iss. 3, pp. 87-88. <http://www.jpands.org/vol22no3/vatel.pdf>. Accessed 28 December 2018.
7. McGeary, Michael G.H., "Medicare Conditions of Participation and Accreditation for Hospitals." Institute of Medicine. 1990. <https://www.ncbi.nlm.nih.gov/books/NBK235473/>. Accessed 28 December 2018.

the United States are accredited by a variety of private organizations or state government agencies.

The Issues Facing Hospitals and Hospital Patients

Hospitals are combating a variety of risks that can endanger patients. The 1996 Institute of Medicine report concluded that 98,000 Americans were dying in hospitals every year due to medical errors. A newer study in 2013 concluded an updated number is actually closer to 440,000 fatalities every year, which would make medical errors the third-leading cause of death in the United States.[8]

The authors of that study observe that not only was it probable the landmark IOM study under-counted deaths "it is...possible that the frequency of preventable and lethal patient harms has increased from 1984 to 2002–2008 because of the increased complexity of medical practice and technology, the increased incidence of antibiotic-resistant bacteria, overuse/misuse of medications, an aging population, and the movement of the medical industry toward higher productivity and expensive technology, which encourages rapid patient flow."

Along with the rise of antibiotic-resistant strains of diseases, deadly blood infections such as sepsis are increasing. Sepsis is linked to as many as 52 percent of deaths in U.S. hospitals.[9] Although the vast majority of sepsis cases are acquired outside of hospitalization, more than 20 percent of its victims are readmitted to the hospital within 30 days of discharge.[10] Meanwhile, the number of cases of sepsis are outpacing the growth of the U.S. population.[11]

Medical errors are the third-leading cause of death nationwide, or more than 250,000 per year, according to a 2016 study in the *British Medical Journal*.[12] Only cancer and heart disease claim more lives. Researchers at Johns Hopkins University have urged states to make modifications to death certificates to include a provision for reporting medical errors, as well as asking the Centers for Disease Control and Prevention to list medical errors as among its leading causes of death in the United States.[13]

Another serious issue is patient readmissions within 30 days of discharge from the hospital. Since the Medicare program began penalizing hospitals for excess readmissions as part of the Affordable Care Act in 2012, it has withheld nearly $2 billion from hospitals that failed to meet the standard, including $528 million in fiscal 2017.[14]

The costs regarding readmissions are not solely confined to penalties imposed by CMS. Readmissions cost the Medicare program $27 billion a year, of which $17 billion were related to what are considered avoidable costs. That does not include the costs of readmission for those enrolled in Medicaid, commercial plans, or who do not have insurance at all.[15]

8. "Hospital Errors are the Third Leading Cause of Death in U.S." The Leapfrog Group. 23 October 2013. <https://www.hospitalsafetygrade.org/newsroom/display/hospitalerrors-thirdleading-causeofdeathinus-improvementstooslow>. Accessed 3 March 2019.
9. "JAMA: Up to 50% of Hospital Deaths Linked to Sepsis." The Advisory Board. 21 May 2014. <https://www.advisory.com/daily-briefing/2014/05/21/jama-up-to-of-hospital-deaths-linked-to-sepsis>. Accessed 4 March 2019.
10. Chang, Dong W., Tseng, Chi-Hong and Shapiro, Martin F. "Rehospitalizations Following Sepsis: Common and Costly." *Critical Care Medicine.* October 2015, vol. 43, iss. 10, pp. 2,085-2,093.
11. Hajj, Jihane, Blaine, Natalie, et. al. "The 'Centrality of Sepsis': A Review on Incidence, Mortality, and Cost of Care." *Healthcare*. 30 July 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6164723/>. Accessed 4 March 2019.
12. Makary, Martin and Daniel, Michael. "Medical Error—The Third Leading Cause Of Death In The U.S." *BMJ*. 3 May 2016. <https://www.bmj.com/content/353/bmj.i2139>. Accessed 11 January 2019.
13. Allen, Marshall and Pierce, Olga. "Medical Errors Are No. 3 Cause Of U.S Deaths, Researchers Say." *NPR*. 3 May 2016. <https://www.npr.org/sections/health-shots/2016/05/03/476636183/death-certificates-undercount-toll-of-medical-errors>. Accessed 15 January 2019. LISTEN·3:47
14. "Hospital Readmissions Reduction Program Fact Sheet." The American Hospital Association. August 2016. <https://www.aha.org/system/files/2018-01/fs-readmissions.pdf>. Accessed 17 January 2019.
15. Kauffman, Bill. "Readmissions & Medicare: What's the Cost?" National Investment Center for Seniors Housing & Care. 23 March 2016. <https://www.nic.org/blog/readmissions-medicare-whats-the-cost/> Accessed 18 January 2019.

Meanwhile, the overall demographics of the U.S. population do not bode for an overall improvement in health anytime soon. The number of Americans over the age of 65 is projected to double by 2060, reaching nearly 100 million.[16] This aging population will put even more demands on America's hospitals and other medical providers.

In addition to the issues occurring within the hospital walls, these institutions are vastly expanding their services outside of those walls. Many large hospitals and healthcare systems have been acquiring medical groups in large numbers, transactions that tend to make care flow more complex. Meanwhile, the rise of telemedicine means that many hospitals are grappling with the care redesign and regulatory issues inherent in delivering services to offsite patient populations.

Is Accreditation Effective in Protecting Patients?

Accreditation of hospitals is extraordinarily important. All hospital patients -- whether inpatient or outpatient -- are putting their lives in the care of these institutions. Without a means that attest to the quality of care being provided, a hospital stay becomes a gamble in which patients are betting their health and their lives.

Nonetheless, despite the enormous complexity of these tasks and responsibilities, the accrediting process is
intended to ensure they provide care of the highest quality has often fallen short.

Accreditation these days is often systematic and, to some extent, ingrained. The most common forms of accreditation have not changed in years, if not decades. If a state agency is performing the accreditation during periods of lean budgets, it can be up to five years between surveys. Meanwhile, hospital staff can prepare for weeks, if not months, for a survey for accreditation. They often spend tens of thousands of dollars to get ready for the surveyors, not including the fees paid to accrediting bodies.

However, as with any process that is also mostly unchanged for decades, some practices have become hidebound. Surveyors trained to look for specific issues can become overzealous. They may issue "gotcha"-style warnings that have little to do with legitimate patient safety issues. It may be as picayune as a surveyor taking unattended papers off a nursing station desk and then claiming that patient records were not properly secured.

Moreover, when legitimate clinical or safety issues are discovered by surveyors, their proposed solutions can often be one-size-fits-all and overly proscriptive. This rigidity can often cause friction among hospital staff, particularly if the solution does not mesh well with its culture. It can also mean the proposed solution when implemented may not be effective.

Recent data and news reports tend to validate these concerns. A series of articles that appeared in the *Wall Street Journal* between September 2017 and December 2018 detailed numerous woes at hospitals certified by the Joint Commission, the largest accrediting body in the U.S. Among the issues that surfaced:

- A hospital in Massachusetts kept its accreditation despite being on the verge of being barred from participating in the Medicare program due to the deaths of two infants at the facility within a six-week period.[17]
- Thirty hospitals kept their accreditation even though the Centers for Medicare & Medicaid Services (CMS) had declared safety violations at their facility were so severe that patient lives were in danger.[18]

16. Mather, Mark. "Fact Sheet: Aging in the United States." Population Research Bureau. 13 January 2016. <https://www.prb.org/aging-unitedstates-fact-sheet/
17. Armour, Stephanie, "Hospital Watchdog Gives Seal of Approval, Even After Problems Emerge." *The Wall Street Journal*. 8 September 2017. <http://ezproxy.lapl.org/login?url=https://search-proquest-com.ezproxy.lapl.org/docview/1936595782?accountid=6749>. Accessed 6 January 2019.
18. Ibid.

- Mortality rates at hospitals accredited by the Joint Commission were no different than those accredited by state agencies, according to a study recently published in the *British Medical Journal*.[19]

"The wealthy, big hospitals that generally have more resources are more likely to be Joint Commission-accredited, and the thinking is that they have better outcomes," Ashish Jha, director of the Harvard Global Health Institute and an author of the study, told the *Wall Street Journal*. "What you find is that it doesn't have a big effect, and it really makes you worry. We've put a lot of faith and resources into accreditation."[20]

The coverage has drawn the attention of lawmakers and regulators in Washington, D.C. Sen. Charles Grassley, R-IA, chairman of the Senate Judiciary Committee, called for public disclosure of hospital inspection reports. The Energy and Commerce Committee in the U.S. House of Representatives also began a separate probe.[21] In December 2018, CMS announced it would examine whether it would continue to certify accreditation bodies that also operate consulting arms due to potential conflicts of interest.[22]

With an investigative spotlight cast on the work and business of accrediting bodies, what can be done to ensure that the process is not only fully functional, but ensures patient safety and a high quality of care? Is there a new model for accreditation that may be deployed?

Taking those specific issues into consideration, the process of accreditation, if possible, should not only ensure that hospitals and other healthcare facilities are safe for patients, but proactively encourage providers to improve the quality of care they provide between surveys. There is one accrediting company that can achieve that goal.

DNV GL Healthcare

DNV GL Healthcare was founded more than a decade ago with the intent of reinventing the healthcare accrediting process. Its founders - former hospital executives and hospital surveyors - had decided that the traditional, proscriptive process for accrediting was neither making hospital management happy nor patients safer. It eventually joined forces with DNV GL (Det Norske Veritas and Germanischer Lloyd), a Norwegian company with a century-and-a-half of certification and quality control experience, starting with Det Norske Veritas' decades of experience inspecting ships for insurance underwriting purposes. In the ensuing decades, DNV GL has become a global leader in certification and quality assurance in maritime shipping and the energy fields, and has more than 100,000 clients worldwide. The company consistently devotes five percent of its revenues to research and development.

DNV GL Healthcare focuses on promoting continuous quality improvement in American hospitals. One of the most significant ways DNV GL accomplishes this is through the annual surveys of hospitals, in contrast to The Joint Commission which surveys hospitals every three years. With limited resources, state agencies may survey even less frequently than that, particularly in times of lean budgets. The primary advantage conferred by annual surveys is that hospital staff are kept alert to opportunities to improve the healthcare services they are delivering, while not burdened by trying to meet an ultimatum set by another organization.

19. Armour, Stephanie. "Study Challenges Hospitals' Use of Accrediting Watchdogs." *The Wall Street Journal*. 18 October 2018. <http://ezproxy.lapl.org/login?url=https://search-proquest-com.ezproxy.lapl.org/docview/2121207968?accountid=6749>. Accessed 6 January 2019.
20. Ibid.
21. "E&C Chairmen Seek Information on CMS Oversight of Hospital Accreditors." American Hospital Association. 13 March 2018. <https://www.aha.org/news/headline/2018-03-13-ec-chairmen-seek-information-cms-oversight-hospital-accreditors>. Accessed 3 March 2019.
22. "CMS Seeks Public Comment on Accrediting Organizations and Conflicts of Interest." Centers for Medicare & Medicaid Services press release. 18 December 2018. <https://www.cms.gov/newsroom/press-releases/cms-seeks-public-comment-accrediting-organizations-and-conflicts-interest>. Accessed 3 March 2019.

"DNV GL Healthcare is a lot of work and a change in thought process," said Nicole Spence, manager of patient care services for Sentara Halifax Regional Hospital, a 192-bed facility in South Boston, Va. "But it is worth it."

ISO 9001 – The New Quality Model for Hospitals

Another significant component of DNV GL's focus on continuous quality improvement is the deployment of the ISO 9001 quality management system. ISO 9001 was originally developed for the manufacturing sector. DNV GL Healthcare adopted this highly respected system for the operation of hospitals. Any hospital that is accredited by DNV GL must become certified in the ISO 9001 processes within three years.

It would be difficult to overstate how important ISO 9001 is in the overall improvement in healthcare delivery. Although it sets specific standards and expectations, it is up to the individual institution to determine the route taken to meet specific goals. This flexibility allows individual healthcare institutions to set their own path toward improvement, one that meshes well with its management, culture and the preferences of its employees. If hospital staff wishes or needs to improve a process, they can do so without being disruptive to a healthcare institution's long-established processes, routines, and even corporate culture.

The primary advantage conferred by annual surveys and ISO 9001 is that hospital staff are kept alert to opportunities to improve the healthcare services they are delivering, while not burdened by trying to meet an ultimatum set by another organization.

These three differentiators – annual surveys, the ISO 9001 framework for continuous improvement, and customized quality improvement options for hospitals – have enabled the more than 500 DNV-GL accredited hospitals to achieve major improvements in quality.

Here Are Some of the Hospital Achievements:

CoxHealth

"The DNV GL accreditation process and ISO 9001 aligns with our strategy to integrate value-based payments and population health. Our partnership and implementation of an ISO 9001 quality management system process approach has created synergy and progression toward our goals," says Arlo Stallion, director of regulatory affairs and staff services at CoxHealth, a six-hospital system in Southwest Missouri.

As part of its continuous improvement efforts, CoxHealth focused on reducing patient readmissions. It integrated a tool into its electronic medical records system that gauged the risk of readmission for each patient, based on factors such as whether they had been hospitalized before and the number of prescription medications they were taking, among others. Particular attention was paid to patients who had five or more hospital admissions through the emergency room, a cohort that tends to have a significantly higher readmission rate than average. It was determined that many of these patients were seeking care through the ER due to dental pain, mental health, and social issues. The hospital put a care redesign team into place to study how it might be able to change familiar processes that might not represent the best clinical pathways for patients.

The solution: CoxHealth embedded social workers in the emergency department to assist with arranging a variety of community services to meet patient needs. It also established a Community Health Advanced Practice Paramedic Program (CHAPP) to conduct frequent home visits by specially trained paramedics to address the medical, behavioral and social needs of their patients.

The results: CoxHealth reduced its ED visits by 16%, and its readmission rates by about 15%.

Charleston Area Medical Center

West Virginians are particularly vulnerable to strokes. According to the American Heart Association and the American Stroke Association, nearly 69 percent of the state's residents are overweight or obese, a rate that is significantly higher than the national average. Partly as a result of an overly obese population, nearly 4 percent of West Virginians have had a stroke -- a percentage that is more than a third higher than the national average.

After two separate surveys with DNV GL Healthcare on its delivery of services to stroke patients, Charleston Area Medical Center in Charleston, West Virginia, was able to strengthen its program for stroke victims, including creating more timely interventions by its team of eight neurologists. It also hired an additional radiologist to more quickly interpret brain scans. As a result, the number of ischemic stroke patients who received PA within an hour of their stroke totaled 140 between April 2016 and April 2017 — compared to approximately 30 in the year prior to that period. Patients also swiftly received antithrombotics and anticoagulation therapy. After discharge, patients were prescribed cholesterol-reducing drugs and smoking cessation counseling if needed. The hospital also created a telestroke program, guaranteeing patients immediate care from a neurologist even if they are not at the CAMC facility.

As a result of these changes, in 2014 CAMC received the highest level of the Stroke Quality Achievement Award from the American Stroke Association. It also received this award in 2015 and 2016. In 2015, CAMC was the recipient of a Malcolm Baldrige National Quality Award.

We're a big supporter of DNV," said Barbara Covelli, CAMC's director of corporate compliance, "There's no better way to maintain accreditation and quality."

Nicklaus Children's Medical Center

Nicklaus Children's Medical Center in Miami, Florida has leveraged recent advances in technology to make its clinical operations more efficient and safer. It collaborated with a local firm, NESA Solutions, to dramatically speed up the supplying of its medical crash carts using radio frequency identification technology.

By having the digitally enabled cart communicate what supplies are needed rather than have staff conduct a thorough inventory, the carts can be restocked within minutes instead of hours.

And by using geofencing technology around the hospital's hand-washing areas, Nicklaus Children's is able to automatically determine who is washing their hands between procedures. This information allows the hospital to more effectively encourage staff to adopt the practice, thereby reducing hospital-acquired infections.

"We chose to work with DNV GL Healthcare because they would be a true working partner with us, instead of an organization that just checked off the boxes to be sure we were compliant," said Jose Perdomo, Nicklaus Children's senior vice president of ethics and compliance and privacy officer. "We have always pushed the envelope on clinical excellence, and in fact we developed our own clinical excellence index to monitor 55 metrics required for quality care. Our previous accrediting organization did not give us any credit for this achievement. DNV GL Healthcare recognizes the progress we have made."

Other examples of hospital achievements include:

- CoxHealth also lowered c.diff rate infections by 63%
- Piedmont Healthcare System, Atlanta, reduced infection in half, benefiting patients AND saving nearly $2 million in cost avoidance
- Self Regional Healthcare, Greenwood, S.C., cut patient fall rates by half, protecting patients and saving $80,000

Independently conducted surveys of DNG GL-accredited hospitals verify the value of this new accreditation model.

Statement	Percent Agreed
Adoption of the DNV GL Healthcare certification helped us meet our performance objectives.	94%
Adoption of DNV GL Healthcare has helped us improve the treatment of our patients.	92%
Our DNV GL Healthcare accreditation has been embraced by the nursing staff.	93%
I would recommend DNV GL Healthcare accreditation to other healthcare professionals.	95%
The ISO 9000 component of DNV GL Healthcare accreditation was an important factor in the adoption process.	85%
The DNV GL Healthcare Surveyors' approach has encouraged us to identify and develop processes directly connected to our hospitals' goals.	93%
Processes are critical to the way that we manage healthcare in our hospitals.	99%
The key to good patient care is effective management of the processes.	92%

The same independent research team also verified that 30 day readmission rates for DNV GL are lower (15.243%) compared to 15.507% for the Joint Commission, a statistically significant difference.

While these significant achievements by hospitals accredited by DNV GL are impressive, the demands of the future will continue to create new challenges. Healthcare costs will continue to rise. Pressure is mounting on providers to deliver value-based care, particularly given that Centers for Medicare & Medicaid Services has recently cut the number of years participants can remain in accountable care organizations without risk. Both of those developments will also force providers to continue to reduce patient readmissions and demonstrate high quality metrics.

Meanwhile, as more healthcare costs are shifted over to individual patients, they will demand better care at a lower price.

Hospitals and other healthcare providers must respond to these ever-increasing demands. They can only be successful and meet their commitment to provide quality care for their communities if they have the tools and the guidance to improve the quality of care they deliver, every day. The path toward higher-quality, value-based care requires a new model for accreditation, one that can guide the future of healthcare delivery itself.

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DNV GL is one of the world's leading certification bodies. We help businesses manage risk and assure the performance of their organizations, products, people, facilities and supply chains through certification, verification, assessment, and training services. We combine technical, digital and industry expertise to empower companies' decisions and actions.

Within healthcare we help our customers achieve excellence by improving quality and patient safety through hospital accreditation, managing infection risk, management system certification and training.

With origins stretching back to 1864 and operations in more than 100 countries, our experts are dedicated to helping customers make the world safer, smarter and greener.

DNV GL HEALTHCARE

How ISO 9001 and its accrediting process helps achieve results

CoxHealth

A five-hospital system in Southwest Missouri, CoxHealth used ISO 9001 to tackle its issue with patients being readmitted to its facilities within 30 days of discharge. It's an issue that has led to the Medicare program imposing financial penalties on hospitals that do not improve.

CoxHealth found a surprise – its inpatient readmission issues really were connected with individuals who needed better outpatient care. Particular attention was given to patients who had five or more hospital admissions through the emergency room, a cohort that tends to have a significantly higher readmission rate than average. It was found that many of these patients were seeking care through the ER due to dental pain, mental health, and social issues. It was determined these patients were not receiving the right outpatient care to meet their ongoing healthcare needs.

CoxHealth began arranging for better care in the surrounding communities, including collaborations with federally qualified health clinics in order to provide more comprehensive primary care. It also embedded social workers in its emergency departments to better evaluate the needs of patients who showed up seeking care, ensuring they were sent to the right provider. Coxhealth also established a Community Health Advanced Practice Paramedic Program (CHAPP) to conduct frequent home visits by specially trained paramedics to address the medical, behavioral, and social needs of such patients. As a result, there was a 16 percent decrease in emergency room visits from these specific patients. Among those who received CHAPP services specifically, there was a 97 percent drop in ED visits while they were enrolled in the 12-week program.

"The DNV GL accreditation process and ISO 9001 aligns with our strategy to integrate value based payments and population health. Our partnership and implementation of an ISO 9001 Quality Management System process approach has created synergy and progression toward our goals," said Arlo Stallion, CoxHealth's System Director of Regulatory Affairs and Medical Staff Services.

Charleston Area Medical Center

The flagship facility for an 838-bed hospital system in West Virginia, Charleston Area Medical Center has had to confront one of the state's biggest healthcare problems: The high prevalence of strokes. A resident of the state is nearly 2.5 times as likely to suffer a stroke than a resident of Colorado, and twice as likely as a Minnesotan.

continued ⟶

Using ISO 9001 as a guide, Charleston was able to address the state's stroke issue by creating more timely interventions for patients suspected of suffering a stroke, including hiring an additional radiologist to speed imaging interpretations. Between April 2016 and April of last year, the number of ischemic stroke patients who received clot-busting drugs at Charleston Area Medical Center more than quadrupled compared to the same 2015-16 time period.

Charleston Area Medical Center received the highest level of the Stroke Quality Achievement Award from the American Stroke Association for the years 2014-16. In 2015, the hospital was the recipient of a Malcolm Baldrige National Quality Award.

Academic Research

Researchers at James Madison University in Virginia, Michigan State University and Miami University in Ohio have concluded that DNV GL's accreditation process is embraced by hospital nurses and physicians, helps hospitals better meet their performance objectives, and improve the hospital's relationship with their patients. The formal findings will be published later this year.

DNV GL-BUSINESS ASSURACE HEALTHCARE

DNV GL-Business Assurance is a world-leading certification body. We help businesses assure the performance of their organizations, products, people, facilities and supply chains through certification, verification, assessment, and training services. Within healthcare, we help our customers achieve excellence by improving quality and patient safety through hospital accreditation, managing infection risk, management system certification and training. The DNV GL Group operates in more than 100 countries. Our 13,500 professionals are dedicated to helping our customers make the world safer, smarter and greener.

ANNUAL QIO COMMITTEE AND QUALITY COUNCIL REPORTING SCHEDULE

JANUARY QUALITY COUNCIL	FEBRUARY QUALITY COUNCIL	FEBRUARY SPECIAL COMMITTEE MEETING	MARCH	APRIL QUALITY COUNCIL
▪ Department Specific PI Dashboard Q4 Update	▪ Department Specific PI Dashboard Q4 Update	▪ 2021 QAPI Evaluation ▪ 2022 QAPI Plan ▪ 2021 CAH Evaluation ▪ 2022 CAH Plan ▪ 2021 EOC Evaluation ▪ 2022 EOC Plan ▪ 2021 EOP Evaluation ▪ 2022 EOP Plan ▪ 2021 Infection Prevention Evaluation ▪ 2022 Infection Prevention Plan ▪ 2021 Antimicrobial Stewardship Evaluation ▪ 2022 Antimicrobial Stewardship Plan ▪ 2022 Staffing Matrix ▪ Annual Contract Evaluations ▪ 2022 Scope of Service ▪ Annual PI Data Review	▪ QAPI Dashboard ▪ Regulatory and Accreditation ▪ Environment of Care (EOC) ▪ Department Specific PI Summary	▪ Department Specific PI Dashboard Q1 Update

MAY QUALITY COUNCIL	JUNE	JULY QUALITY COUNCIL	AUGUST QUALITY COUNCIL
▪ Department Specific PI Dashboard Q1 Update	▪ QAPI Dashboard ▪ Regulatory and Accreditation ▪ Environment of Care (EOC) ▪ Department Specific PI Summary	▪ Department Specific PI Dashboard Q2 Update	▪ Department Specific PI Dashboard Q2 Update

SEPTEMBER	OCTOBER QUALITY COUNCIL	NOVEMBER QUALITY COUNCIL	DECEMBER
▪ QAPI Dashboard ▪ Regulatory and Accreditation ▪ Environment of Care (EOC) ▪ Department Specific PI Summary	▪ Department Specific PI Dashboard Q3 update	▪ Department Specific PI Dashboard Q3 Update	▪ QAPI Dashboard ▪ Regulatory and Accreditation ▪ Environment of Care (EOC) Department Specific PI Summary

CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
November 10, 2021 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/91570159415
Meeting ID: 915 7015 9415
One tap mobile: +12532158782,,91570159415#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Board Chair Frady called the meeting to order via Zoom at 3:30 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 ☒ Kathleen Arnold, Interim Pharmacist ☒ Robert Hirst, Interim Quality Manager ☒ Janice Cramer, Medical Staff Coordinator ☒ Richard Boggess, CFO ☒ Van Anderson, Packwood Community Member ☒ Larry Sinkula, Surgical Services Director			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	☒ Diane Markham, Marketing & Communications Manager ☒ Kim Olive, Human Resource Assistant ☒ Laura Richardson, Morton Community Member ☒ Buddy Rose, Reporter ☒ Spencer Hargett, Compliance Officer ☒ Shannon Kelly, CHRO			
Approval or Amendment of Agenda		Commissioner Coppock made a motion to approve the agenda. Commissioner McMahan seconded and the motion passed unanimously.		
Conflicts of Interest	Board Chair Frady asked the Board to state any conflicts of interest with today's agenda.	None noted.		
Comments and Remarks	Commissioners: Secretary Herrin, Commissioners Coppock and McMahan, as well as Board Chair Frady congratulated and welcomed Kim Olive and Laura Richardson to the 2022 Board of Commissioners. Commissioner McMahan thanked Marketing & Communications Manager Markham for the recent vaccine article in the newspaper. Audience: None note.			
Executive Session- RCW 70.41.205	Executive Session began at 3:39 p.m. for 5 minutes to discuss Medical Privileging. The Board returned to open session at 3:44 p.m. No decisions were made in Executive Session. Initial Appointments- <u>Arbor Health</u> 1. Esther Park-Hwang, MD (Gynological Medicine) Reappointments-	Commissioner McMahan made a motion to approve the Medical Privileging as presented and Commissioner Coppock seconded.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	Telestroke/Neurology Consulting Privileges 1. James Jordan, MD (Consulting Telestroke/Neurology Privileges) 2. Biggya Sapkota, MD (Consulting Telestroke/Neurology Privileges)	The motion passed unanimously.		
Department Spotlight	To resume in January 2022.			
Board Committee Reports • Compliance Committee Report	Commissioner McMahan provided a comprehensive update.			
Consent Agenda	Board Chair Frady announced the consent agenda items for consideration of approval: 1. Approval of Minutes a. October 27, 2021, Regular Board Meeting b. November 3, 2021, Compliance Committee Meeting 2. Warrants & EFT's in the amount of $4,948,905.16 dated October 2021 3. Approve Documents Pending Board Ratification 11.10.21	Secretary Herrin made a motion to approve the Consent Agenda and Commissioner McMahan seconded. The motion passed unanimously.		
Old Business • Incident Command Update	CNO/CQO Williamson highlighted the following: 1. Washington state's vaccination rate is 78.6% as of October 25, 2021. There has been progress with vaccinations, however, do not be surprised if the percentage declines given the denominator is larger by adding 5-11 year old's. Lewis County's vaccination rate is 46.6% as of November 9, 2021, so			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	compliance is behind the state. 2. While cases have plateaued for the time being, keep in mind the baseline is higher than a year ago. People need to remain diligent with the Delta+ variant on the horizon. 3. The 7-day rolling average is 30 cases per day in Lewis County. 4. The Federal Mandate will impact the District and we will work towards complying. 5. The Rapid PCR instrument is a testing option.			
• Proposed Budget	CFO Boggess noted there have been no changes and reported a net loss of $398,343. The proposed income statement does not include the full cost report impact. For comparison, the 2020 cost report adjustment had a positive impact of an approximately $900,000. This calculation is dependent on the mix of services that come through the door.			
New Business • 2022 Schedule	The board supported moving forward with the proposed 2022 schedule. Executive Assistant Garcia will publish the Regular Board Meeting schedule, along with populating calendar invites.	Publish 2022 schedules.	Executive Assistant Garcia	12.15.21 Regular Board Meeting
• Board Policy & Procedure Review	Board Self-Evaluation-Approved. Board Spending Authority-Approved. Electronic Signatures-Approved. The Board approved all three policies/procedures as presented. Commissioner McMahan requested to revisit commissioner compensation for education days in	Marked three documents as Reviewed in Lucidoc. Review the Commissioner Compensation for	Executive Assistant Garcia Executive Assistant Garcia	12.15.21 Regular Board Meeting 12.15.21 Regular Board Meeting

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	a month. The Board requested to review the policy at the 12.15.21 Regular Board Meeting.	Meetings and Other Services Policy and Procedure.		
• Board Self-Evaluation	Board Chair Frady requested the Board complete the Self-Evaluation and return completed assessments to Administration. The Board will review the results at the 12.15.21 Regular Board Meeting.	Complete Board Self-Evaluation and give to Executive Assistant Garcia.	Board of Commissioners	12.01.21
Superintendent Report	Superintendent Everett presented Quarter 3 Department Strategic Measures. Top priorities continue to be the Packwood Clinic, building the Swingbed Program, maintaining RT and Pulmonary Services and expanding our wellness footprint. Superintendent Everett noted for the goals where we did not achieve, we must remember we are still in a pandemic and use this as a learning opportunity as we set 2022 Strategic goals.			
Meeting Summary & Evaluation	Superintendent Everett highlighted the decisions made and action items.			
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourn the meeting at 4:47 p.m. The motion passed unanimously.			

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
November 10, 2021 at 6:00 p.m.
ZOOM
https://myarborhealth.zoom.us/j/87884485121
Meeting ID: 878 8448 5121
One tap mobile: +12532158782,,87884485121#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Board Chair Frady called the meeting to order via Zoom at 6:00 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 ☒ Richard Boggess, CFO ☒ Kim Olive, Human Resource Assistant ☒ Laura Richardson, Morton Community Member ☒ Buddy Rose, Reporter ☒ Spencer Hargett, Compliance Officer ☒ Shannon Kelly, CHRO			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Conflicts of Interest	Board Chair Frady asked the Board to state any conflicts of interest with today's agenda.	None noted.		
Reading of the Notice of the Special Meeting	Board Chair Frady read the special board meeting notice. Board Chair Frady noted the chat function has been disabled and the meeting will not be recorded.			
New Business • Present the 2022 Budget	CFO Boggess presented the 2022 budget.			
• Discuss Setting of the Property Tax Levy	CFO Boggess noted the following: 1. The UTGO Bond is a voter approved bond that will extinguish at the end of 2022. These monies are used for capital activity. a. The Board supported the District research replacing the bond, as it will be a continuation and taxes will remain the same. 2. The Maintenance & Operational Levy can be increased by the Board by 1% per year without restriction. The District is classified at a population <10,000 and will be reassessed with the new census in 2022. If the population exceeds 10,000, the District can only increase the levy by the rate of inflation. The highest lawful levy amount for 2021 is $670,604. As a reminder, this is a one-time increase and is reviewed annually. Administration presented three potential options: a. 1.00%=$637,863 b. 3.35%=$651,669 c. 6.25%=$670,608			
Public Comment	No comment.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourned at 6:27 p.m. The motion passed unanimously.			

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
November 17, 2021, at 12:00 p.m.
Via Zoom

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Commissioner Coppock called the meeting to order via Zoom at 12:00 p.m. Commissioner(s) Present in Person or via Zoom: ☒ Tom Herrin, Secretary ☒ Craig Coppock, Commissioner Committee Member(s) Present in Person or via Zoom: ☒ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO ☒ Leianne Everett, Superintendent ☒ Marc Fisher, Community Member ☐ Clint Scogin, Controller ☒ Sherry Sofich, Revenue Cycle Director ☒ Sara Williamson, CNO/CQO			
Approval or Amendment of Agenda	No amendments noted.	Secretary Herrin made a motion to approve the agenda and CFO Boggess seconded. The motion passed unanimously.		
Conflicts of Interest	Commissioner Coppock asked the Committee to state any conflicts of interest with today's agenda.	None noted.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Consent Agenda	Commissioner Coppock announced the following in consent agenda up for approval: 1. Review of Finance Minutes –October 20, 2021 2. Revenue Cycle Update 3. Board Oversight Activities 4. Financial Statements-October	Secretary Herrin made a motion to approve the consent agenda and Community Member Fisher seconded. The motion passed unanimously.		
Old Business • Financial Department Spotlight	Commissioner Coppock reminded the committee that the department spotlights will resume in January 2022.			
• Review 2022 Proposed Budget	Secretary Herrin inquired about 2022 capital items. CFO Boggess noted impact of capital transactions are reflected on the income statement under depreciation. The calculated amount is a rough estimate of the current deprecation schedule and construction in progress. The items listed on the capital list that are crossed out have been eliminated as a lease option was selected verses purchasing. CFO Boggess will recalculate depreciation to include "if" all 2021 were purchased, then what would deprecation be on the budget. CFO Boggess confirmed 340b monies are designated funds for ambulance costs. There is not enough funding to cover the costs, so there are additional costs to the District that flood into the cost report through Medicare/Medicaid programs. Commissioner Coppock requested in the tax levy presentation to include the associated dollar amount to the associated percentages. This will better explain the impact of the levy decision.	Recalculate depreciation to ensure it is not a huge difference from the current estimate. Update the table with the levy percentages to include dollar amounts.	CFO Boggess CFO Boggess	11.29.21 Special Board Meeting 11.29.21 Special Board Meeting
• Public Health Emergency	CFO Boggess provided status updates on the funding receiving			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Funding Update	during the pandemic. Moving forward unless there is action, we will remove them from the list and only report on an as needed basis.			
New Business • Decision to Engage the District External Auditor	CFO Boggess shared DZA continues to be a great partner and a trusted entity. CFO Boggess recommended the District reengage. While the District is not required to have an annual audit, it is an industry standard and best practice. By having the audited financial statements for the past five years and proving a positive track record, this will be helpful as we move forward for another bond.	The Finance Committee is recommending the engagement of Dingus, Zarecor and Associates to audit the financial statements for 2021. This recommendation requires a resolution to be presented at the next Regular Board Meeting.	Executive Assistant Garcia	12.15.21 Regular Board Meeting
• New Service Line Provider Activity	CFO Boggess shared to performance of the new services lines of orthopedics and podiatry. Initial numbers show clinic visit numbers are better than expected. A provider meeting is in the works to discuss both service lines and for our own providers to better understand the programs and referring to both providers.			
• Surplus or Dispose of Certain Property	CFO Boggess presented the list of the District's property that needs to be surplused or disposed of. The Finance Committee supported the surplusing and/or disposing of certain property and will recommend approval at the Board level in Consent Agenda.	The Finance Committee supported requesting the Board's approval of a resolution at the Regular Board Meeting.	Executive Assistant Garcia	12.15.21 Regular Board Meeting
Meeting Summary & Evaluation	CFO Boggess highlighted the decisions made and the action items that need to be taken to the entire board for approval.			
Adjournment	Commissioner Coppock adjourned the meeting at 12:48 pm.			

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
November 29, 2021 at 6:00 p.m.
ZOOM
https://myarborhealth.zoom.us/j/86773822704
Meeting ID: 867 7382 2704
One tap mobile: +12532158782,,86773822704#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Board Chair Frady called the meeting to order via Zoom at 6:00 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 ☒ Richard Boggess, CFO ☒ Buddy Rose, Reporter ☒ Julie Taylor, Ancillary Services Director ☒ Spencer Hargett, Compliance Officer ☒ Van Anderson, Packwood Resident			
Conflicts of Interest	Board Chair Frady asked the Board to state any conflicts of interest with today's agenda.	None noted.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Reading of the Notice of the Special Meeting	Board Chair Frady read the special board meeting notice. Board Chair Frady noted the chat function has been disabled and the meeting will not be recorded.			
New Business • Resolution 21-38-Approving the 2022 Proposed Tax Levies RCW 84.55.120	CFO Boggess revisited the information presented at the Public Hearing. The bond levy will conclude at the end of 2022. However, the District can ratify an increase up to 6.25%, using banked points from prior years, over the 2020 levy for the Maintenance and Operation (M & O) levy. One clarification was made, explaining that the Administrative Refund applies to the M & O levy, not the bond levy as previously presented. The M & O levy supports 1.7% of the operating expenses. Administration supports approving the banked amount of 6.25% to support the increasing needs of the District in a volatile healthcare industry during 2022. Commissioner Schumaker supported a 1% increase given the impact to the public and their increases to taxes. Secretary Herrin supported a 6.25% increase given the growing needs for capital and the overall increase in costs to deliver healthcare. Commissioner Coppock supported a 3.25% increase given it's middle of the road. Commissioner McMahan supported a 6.25% increase due to the rising cost of healthcare and the difficulty in recruiting and retaining staff. Keeping healthcare available to the District is a priority. Board Chair Frady shared recently a community member praised Arbor	Secretary Herrin made a motion to approve Resolution 21-38, the 2022 proposed tax levies, at 6.25%. Commissioner Coppock seconded. Commissioners Coppock and McMahan and Secretary Herrin voted yea and Commissioner Schumaker voted nay. The motion passed.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	Health and was so grateful to have healthcare in the District.			
• Resolution 21-39-Approving the 2022 Budget	CFO Boggess presented the 2022 budget, which included the 6.25% levy The Finance Committee requested depreciation be reviewed to ensure the assumptions reflect the District's current position. The 2022 Operating Budget projects a $371,183 Net Income loss.	Commissioner Coppock made a motion to approve Resolution 21-39-2022 Budget impacted by the 6.25 levy rate. Secretary Herrin seconded. The motion passed unanimously.		
Adjournment	Secretary Herrin moved and Commissioner McMahan seconded to adjourned at 6:48 p.m. The motion passed unanimously.			

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
QUALITY IMPROVEMENT OVERSIGHT MEETING
December 1, 2021 at 7:00 a.m.
ZOOM

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Commissioner Schumaker called the meeting to order via Zoom at 7:01 a.m. Present in Person or via ZOOM ☒: ☒ Wes McMahan, Commissioner ☒ Chris Schumaker, Commissioner ☒ Leianne Everett, Superintendent ☒ Bob Hirst, Interim Quality Manager ☒ Sara Williamson, CNO/CQO ☒ Julie Taylor, Ancillary Services Director ☒ Richard Boggess, CFO ☒ Julie Allen, Quality Data Analyst ☒ David Crouch, Interim Facilities Director ☒ Lynn Bishop, Community Member ☒ Kathleen Arnold, Pharmacist ☒ Shana Garcia, Executive Assistant ☒ Dr. Mark Hansen, Chief of Staff ☒ Dr. Kevin McCurry, CMO ☒ LeeAnn Evans, Inpatient and ED Services Director ☒ Kevin Conger, Dietary Manager ☒ Gary Preston, MA PhD CIC FSHEA			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Approval or Amendment of Agenda		Quality Data Analyst Allen made a motion to approve the agenda and Superintendent Everett seconded. The motion passed unanimously.		
Conflicts of Interest	The Committee noted none.			
Committee Reports • Environment of Care (EOC) • Pharmacy & Therapeutics (P & T) • Infection Prevention & Control (IP & C) • Utilization Review (UR) • Emergency Services, Stroke & Trauma (ES, S & T) • Staffing	1. Facilities Director Crouch reported EOC is compliant with DNV. While Facilities is 100% compliant with drills, there are identified barriers. A subcommittee has been formed to develop a plan to train staff on all shifts. The Committee recommended David Crouch be appointed as the Safety Officer. 2. Interim Pharmacist Arnold reported P & T has focused on alignment with the new WAC's, which includes updating policies and drug protocols to current best practices. Medication and patient scanning are at 88% accuracy. The new Surveillance program should improve the monitoring of medications. Antimicrobial Stewardship audits show providers are mindful when prescribing. A new Pain Management Policy and Order Set was approved by Medical Staff. 3. Ancillary Services Director Taylor reported IP & C remains focused on monitoring COVID cases and emphasized the vaccine and boosters which now includes ages 5+ . Antimicrobial Stewardship audits remain in process with monitoring drug appropriateness data.	The QIO Committee is recommending to reappointment Ancillary Services Director Taylor as the Infection Preventionist in 2022. This recommendation requires a resolution to be presented at the next Regular Board Meeting.	Executive Assistant Garcia	12.15.21 Regular Board Meeting

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	COVID PCR testing is now available and is primarily used for symptomatic patients, as well as for COVID testing for transfers, admits and pre-procedure testing. The hospital is in the contingency care phase and this is monitored at least monthly by the COVID multi-disciplinary committee. The Committee recommended Julie Taylor be reappointed as the Infection Preventionist for 2022 per DNV NIAHO IC.1, SR.2a. 4. CNO/CQO Williamson reported UR Q2 Metrics. An Optum implementation plan was discussed and a review is in place to follow up at the next meeting. A quick guide was included to keep everyone informed and aligned. 5. CNO/CQO Williamson reported Emergency Services reviewed a protocol, a new charter and the new legislation regarding 2SSB 5195 Opioid Overdose Reversal Medication-Prescribing. The Stroke Program reviewed the upcoming survey requirements which included the scope of services, quality metrics, EMS education and third quarter stroke metrics. 6. CNO/CQO Williamson reported Staffing Committee reviewed ADO's, identified committee membership changes and the need to review the staffing matrix at the next meeting.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Consent Agenda • Approval of Minutes.	Approval of the following: 1. June 9, 2021 Quality Improvement Oversight (QIO) Committee Meeting 2. June 16, 2021 Environment of Care (EOC) Committee Meeting 3. August 24, 2021 Environment of Care (EOC) Committee Meeting	Quality Data Analyst Allen made a motion to approve the consent agenda and CFO Boggess seconded. The motion passed unanimously.		
Old Business • 060921 Action Item Verbal Follow Up	Interim Quality Manager Hirst noted the action items are reflected in the updated dashboard.			
• Regulatory Update • *Hospital Accreditation DNV Survey-Corrective Action Plan* • *DNV Stroke Recertification Survey*	Interim Quality Manager Hirst highlighted the following: 1. The Hospital continues to monitor the findings from the May DNV survey. 2. The Hospital is preparing for the upcoming remote DNV Stroke recertification survey on December 3, 2021. The Hospital continues to experience low volumes on strokes with a high-risk diagnosis. This means extra due diligence is required to ensure appropriate care is delivered in the ED.			
New Business • Department Specific Performance Improvement Features	Dietary Manager Conger noted the department is meeting and maintaining goals to date. The barriers were identified which included ongoing training to employees and increased communication with providers/nursing regarding the intake charting.			
• QAPI Dashboard-2QTR2021 & 3QTR2021	Interim Quality Manager Hirst noted the following: a. Reviewed the top box scores which indicates a positive trend line for the Hospital, ED and Clinics. New goals will be established for 2022.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	b. Highlighted the measures through third quarter. c. Received more QMM's; however, this is a good increase. This increase keeps leadership and staff informed of the events occurring through the hospital to identify trends or near misses.			
• Arbor Health Board QIO Committee and Quality Council	CNO/CQO Williamson proposed improving the quality improvement structure as we move on our journey with DNV into ISO 9001. To achieve this goal, we want to add an operations and interdisciplinary Quality Council work group that communicates outcomes and assessments to the QIO Committee on a quarterly basis. Commissioners McMahan and Schumaker requested additional information to understand the new structure.	Request additional supporting documentation from DNV NIAHO and ISO 9001 that supports/requires this structure to meet the standards.	CNO/CQO Williamson	12.15.21 Regular Board Meeting
Meeting Summary & Evaluation	Commissioner Schumaker provide a summary.			
Adjournment	CNO/CQO Williamson moved and Superintendent Everett seconded to adjourn at 8:06 a.m. The motion passed unanimously.			

WARRANT & EFT LISTING NO. 2021-11

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

$3,881,175.96 this 15th day

of December 2021

Board Chair, Trish Frady

Commissioner, Craig Coppock

Secretary, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of $3,881,175.96 dated November 1, 2021 – November 30, 2021.

Routine A/P Runs

Warrant No.	Date	Amount	Description
123435 - 123445	1-Nov-21	223,435.00	CHECK RUN
123446	1-Nov-2021	981.00	CHECK RUN
123447 - 123448	2-Nov-2021	839.68	CHECK RUN
123449 - 123459	8-Nov-2021	655,491.20	CHECK RUN
123460 - 123518	5-Nov-2021	232,935.70	CHECK RUN
123519 - 123541	15-Nov-2021	286,471.90	CHECK RUN
123542 - 123600	12-Nov-2021	171,128.43	CHECK RUN
123601	1-Nov-2021	10,885.31	CHECK RUN
123602	1-Nov-2021	9,923.19	CHECK RUN
123603	1-Nov-2021	64.12	CHECK RUN
123604	1-Nov-2021	107.48	CHECK RUN
123605	9-Nov-2021	107.48	CHECK RUN
123606 - 123615	22-Nov-2021	646,220.43	CHECK RUN
123616 - 123671	19-Nov-2021	95,941.29	CHECK RUN
123672 - 123716	29-Nov-2021	118,732.47	CHECK RUN
123717 - 123729	30-Nov-2021	169,787.16	CHECK RUN
123730	30-Nov-2021	24.44	CHECK RUN
123731	23-Nov-2021	32.60	CHECK RUN
123732 - 123733	30-Nov-2021	22,609.03	CHECK RUN
TOTAL - CHECK RUNS		$ 2,645,717.91	

Error Corrections - in Check Register Order

Warrant No.	Date Voided	Amount	Description
123599	22-Nov-2021	918.93	VOID
123604	1-Nov-2021	107.48	VOID
TOTAL - VOIDED CHECKS		$ 1,026.41	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$	2,644,691.50

EFT	Date	Amount	Description
1156	12-Nov-2021	157,542.50	IRS / TAX
PAYROLL	12-Nov-2021	444,274.18	PAYROLL
1157	26-Nov-2021	168,877.66	IRS / TAX
PAYROLL	26-Nov-2021	465,790.12	PAYROLL
TOTAL EFT'S AT SECURITY STATE BANK		$ 1,236,484.46	

TOTAL CHECKS, EFT'S & TRANSFERS	$	3,881,175.96

Documents Awaiting Board Ratification 12.15.21		
	LCHD No. 1's Policies, Procedures & Plans:	Departments:
1	Account Adjustments	Business Office
2	CIC Local Union No. 2767	Union Contracts
3	Cleaning Equipment Brought Into The Operating Room	Surgery
4	Cleaning of Rigid Laparoscopes and Cystoscopes	Sterile Processing
5	Clinic Instruments (Cleaning & Transport)	Sterile Processing
6	Commissioner Compensation for Meetings and Other Services	Governing Body
7	Credit Card Use	Finance
8	Dietary Staff Specific Illness Management	Employee Health & Wellness
9	Documentation Requirements	Health Information Management
10	F13: Disposable Glove Use	Dietary Services
11	F2: Cutting Boards	Dietary Services
12	F3: Pest Control	Dietary Services
13	F6: Cleaning of Food and Non-Food Contact Surfaces	Dietary Services
14	G1: Dietary Technician Safety Guidelines	Dietary Services
15	GI Procedure Attire	Surgery
16	H4: Failure of Gas Supply	Dietary Services
17	H8: Patient Meal Times	Dietary Services
18	Health Reimbursement Arrangement (HRA)	Human Resources
19	Humidity Level in Surgery	Surgery
20	Implantable Traceability	Surgery
21	Modified International 10-20 Measurement Procedure	Sleep Center
22	Operating Room Visitors	Surgery
23	PACU Documentation	PACU
24	PACU Patient Transfer to Acute Care	PACU
25	Patient Packet	Sleep Center
26	Payment Posting	Business Office
27	Portion Control	Dietary Services
28	Pre Registration and Scheduling for Sleep Lab	Sleep Center
29	Preventing Fraud Waste and Abuse Anti-Rebating Statute (Chaper 19.68 RCW	Compliance
30	Prompt Pay Discount	Business Office

31	Protection of Personal Belongings during Sleep Study	Sleep Center
32	Registering Unidentified Emergency Room Patients	Patient Access
33	Rehabilitation Documentation Guidelines	Rehabilitation Services
34	Sterile Processing	Sterile Processing
35	Sterile Processing Traffic Control	Sterile Processing
36	Steris System 1e Process Monitoring	Sterile Processing
37	Steris System 1e Processor Operation	Sterile Processing
38	TB Exposure Plan	Employee Health & Wellness
39	Temporary Workforce Members	HIPAA Privacy

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 QIO meeting date that's highlighted in green to see the agenda with documents needing to be approved. 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.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION DECLARING TO
SURPLUS OR DISPOSE OF CERTAIN
PROPERTY

RESOLUTION NO. 21-40

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:

That the equipment and supplies listed on Exhibit A, attached hereto and by this reference incorporated herein, are hereby determined to be no longer required for hospital purposes. The Administrator is hereby authorized to surplus, dispose and/or trade in of said property upon such terms and conditions as are in the best interest of the District.

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 15th day of December 2021, 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

DISPOSAL/SURPLUS PERSONAL PROPERTY

EXHIBIT A

DATE	DESCRIPTION	DEPARTMENT	PROPERTY #	DISPOSITION	REASON
11/09/2021	Toaster	Dietary	5957	Surplus/Dispose	Broken

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE DZA
FINANCIAL AUDIT, SINGLE AUDIT
FOR CARES ACT FUNDING AND COST REPORT
ANNUAL ENGAGEMENT RESOLUTION NO. 21-41

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:

To approve the engagement with Dingus, Zarecor & Associates, PLLC for the financial audit, single audit for Cares Act Funding and cost report preparation for year ended December 2021. The gross fee for these services is $43,750 plus out-of-pocket costs i.e., shipping & travel. Standard hourly rates apply for unexpected circumstances.

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 15th day of December 2021, 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

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

November 5, 2021

Board of Commissioners
and Richard Boggess
Lewis County Public Hospital District No. 1
doing business as Arbor Health
521 Adams Street
Morton, Washington 98356

We are pleased to confirm our understanding of the services we are to provide Lewis County Public Hospital District No. 1 doing business as Arbor Health (the District) for the year ending December 31, 2021.

Audit Scope and Objectives

We will audit the financial statements of the District, which comprise the statement of net position as of December 31, 2021, the related statements of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the disclosures. Accounting standards generally accepted in the United States of America (GAAS) provide for certain required supplementary information (RSI), such as management's discussion and analysis (MD&A), to supplement the District's basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to the District's RSI in accordance with GAAS. These limited procedures will consist of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We will not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance. The following RSI is required by generally accepted accounting principles and will be subjected to certain limited procedures, but will not be audited:

- Management's Discussion and Analysis.

We have also been engaged to report on supplementary information other than RSI that accompanies the District's financial statements.

We will subject the following supplementary information to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS, and we will provide an opinion on it in relation to the financial statements as a whole, in a report combined with our auditors' report on the financial statements:

- Schedule of expenditures of federal awards.

The objectives of our audit are to obtain reasonable assurance as to whether the financial statements as a whole are free from material misstatement, whether due to fraud or error; issue an auditors' report that includes our opinion about whether your financial statements are fairly presented, in all material respects, in conformity with generally accepted accounting principles (GAAP) and report on the fairness of the supplementary information referred to in the second paragraph when considered in relation to the financial statements as a whole. Reasonable assurance is a high level of assurance but is not absolute assurance and therefor is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. Misstatements, including omissions, can arise from fraud or error and are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgement of a reasonable user made based on the financial statements. The objective also includes reporting on —

- Internal control over financial reporting and compliance with provisions of laws, regulations, contracts, and award agreements, noncompliance with which could have a material effect on the financial statements in accordance with *Government Auditing Standards*.
- Internal control over compliance related to major programs and an opinion (or disclaimer of opinion) on compliance with federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major program in accordance with the Single Audit Act Amendments of 1996 and Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance).

The *Government Auditing Standards* report on internal control over financial reporting and on compliance and other matters will include a paragraph that states (1) that the purpose of the report is solely to describe the scope of testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance, and (2) that the report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. The Uniform Guidance report on internal control over compliance will include a paragraph that states that the purpose of the report on internal control over compliance is solely to describe the scope of testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Both reports will state that the report is not suitable for any other purpose.

Our audit will be conducted in accordance with auditing standards generally accepted in the United States of America; the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; and the provisions of Uniform Guidance, and will include tests of accounting records, a determination of major programs in accordance with Uniform Guidance, and other procedures we consider necessary to enable us to express such opinions. We will issue written reports upon completion of our single audit. Our reports will be addressed to the governing board of the District.

Auditors' Responsibilities for the Audit of the Financial Statements

We will conduct our audit in accordance with GAAS and will include tests of your accounting records and other procedures we consider necessary to enable us to express such opinion. As part of an audit in accordance with GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

We will evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management. We will also evaluate the overall presentation of the financial statements, including the disclosures, and determine whether the financial statements represent the underlying transactions and events in a manner that achieves a fair presentation. We will plan and perform the audit to obtain reasonable rather than absolute assurance about whether the financial statements are free of material misstatement, whether from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the government or to acts by management or employees acting on behalf of the government. Because the determination of abuse is subjective, *Government Auditing Standards* do not expect auditors to provide reasonable assurance of detecting abuse.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is a risk that material misstatements or noncompliance may exist and not be detected by us, even though the audit is properly planned and performed in accordance with U.S. generally accepted auditing standards and *Government Auditing Standards*. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements or on major programs. However, we will inform the appropriate level of management of any material errors, any fraudulent financial reporting, or misappropriation of assets that come to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential, and of any material abuse that comes to our attention. We will include such matters in the reports required for a single audit. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors.

We will also conclude, based on the audit evidence obtained, whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the government's ability to continue as a going concern for a reasonable amount of time.

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, and may include direct confirmation of certain assets and liabilities by correspondence with selected individuals, funding sources, creditors, and financial institutions. We may request written representations from your attorneys as part of the engagement.

We may, from time to time and depending on the circumstances, use third-party service providers in serving your account. We may share confidential information about you with these service providers but remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your personal information. In addition, we will secure confidentiality agreements with all service providers to maintain the confidentiality of your information and we will take reasonable precautions to determine that they have appropriate procedures in place to prevent the unauthorized release of your confidential information to others. In the event that we are unable to secure and appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider. Furthermore, we will remain responsible for the work provided by any such third-party service providers.

Audit Procedures — Internal Control

We will obtain an understanding of the entity and its environment, including internal control relevant to the audit, sufficient to identify and asses the risks of material misstatement of the financial statements, whether due to error or fraud, and to design and perform audit procedures responsive to those risks and obtain evidence that is sufficient and appropriate to provide a basis for our opinions. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentation, or the override of internal control. An audit is not designed to provide assurance on internal control or to identify deficiencies in internal control. Accordingly, we will express no such opinion.

Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from illegal acts and other noncompliance matters that have a direct and material effect on the financial statements. Our tests, if performed, will be less in scope than would be necessary to render an opinion on internal control and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*.

As required by the Uniform Guidance, we will perform tests of controls over compliance to evaluate the effectiveness of the design and operation of controls that we consider relevant to preventing or detecting material noncompliance with compliance requirements applicable to each major federal award program. However, our tests will be less in scope than would be necessary to render an opinion on those controls and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to the Uniform Guidance.

An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. However, during the audit, we will communicate to management and those charged with governance internal control related matters that are required to be communicated under AICPA professional standards, *Government Auditing Standards*, and the Uniform Guidance.

Audit Procedures — Compliance

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we will perform tests of the District's compliance with provisions of applicable laws, regulations, contracts, and agreements, including grant agreements. However, the objective of those procedures will not be to provide an opinion on overall compliance and we will not express such an opinion in our report on compliance issued pursuant to *Government Auditing Standards*.

The Uniform Guidance requires that we also plan and perform the audit to obtain reasonable assurance about whether the auditee has complied with applicable laws and regulations and the terms and conditions of federal awards applicable to major programs. Our procedures will consist of tests of transactions and other applicable procedures described in the *OMB Compliance Supplement* for the types of compliance requirements that could have a direct and material effect on each of the District's major programs. The purpose of these procedures will be to express an opinion on the District's compliance with requirements applicable to each of its major programs in our report on compliance issued pursuant to the Uniform Guidance.

The auditors' procedures do not include testing compliance with laws and regulations in any jurisdiction related to Medicare and Medicaid antifraud and abuse. It is the responsibility of management of the entity, with the oversight of those charged with governance, to ensure that the entity's operations are conducted in accordance with the provisions of laws and regulations, including compliance with the provision of laws and regulations that determine the reported amounts and disclosures in the entity's financial statements.

Therefore, management's responsibilities for compliance with laws and regulations applicable to its operations, include, but are not limited to, those related to Medicare and Medicaid antifraud and abuse statutes.

With respect to cost reports that may be filed with a third party (such as federal and state regulatory agencies), the auditors have not been engaged to test in any way, or render any form of assurance on, the propriety or allowabililty of the specific costs to be claimed on, or charges to be reported in, a cost report. Management is responsible for the accuracy and propriety of all cost reports filled with Medicare, Medicaid, or other third parties.

Other Services

We will also prepare the District's Medicare cost report for the year ending December 31, 2021.

We will also assist in preparing the financial statements, schedule of expenditures of federal awards, and related notes of the District in conformity with U.S. generally accepted accounting principles and the Uniform Guidance based on information provided by you. These nonaudit services do not constitute an audit under *Government Auditing Standards* and such services will not be conducted in accordance with *Government Auditing Standards.* We will perform the services in accordance with applicable professional standards. The other services are limited to the financial statement, schedule of expenditures of federal awards, and related notes and services previously defined. We, in our sole professional judgment, reserve the right to refuse to perform any procedure or take any action that could be construed as assuming management responsibilities.

Responsibilities of Management for the Financial Statements

Our audit will be conducted on the basis that you acknowledge and understand your responsibility for designing, implementing, and maintaining internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error, including monitoring ongoing activities; for the selection and application of accounting principles; and for the preparation and fair presentation of the financial statements in conformity with accounting principles generally accepted in the United States of America.

Management is responsible for making all financial records and related information available to us and for the accuracy and completeness of that information, including information from outside of general and subsidiary ledgers. You are also responsible for providing us with (1) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, such as: records, documentation, identification of all related parties and all related-party relationships and transactions, and other matters; (2) access to personnel, accounts, books, records, supporting documentation, and other information as needed to perform an audit under the Uniform Guidance, (3) additional information that we may request for the purpose of the audit, and (4) unrestricted access to persons within the government from whom we determine it necessary to obtain audit evidence. At the conclusion of our audit, we will require certain written representations from you about the financial statements and related matters.

Your responsibilities include adjusting the financial statements to correct material misstatements and confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the government involving (1) management, (2) employees who have significant roles in internal control, and (3) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the government received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring that the government complies with applicable laws, regulations, contracts, agreements, and grants. Management is also responsible for taking timely and appropriate steps to remedy fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, or abuse that we report. Additionally, as required by the Uniform Guidance, it is management's responsibility to evaluate and monitor noncompliance with federal statutes, regulations, and the terms and conditions of federal awards; take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings; promptly follow up and take corrective action on reported audit findings; and prepare a summary schedule of prior audit findings and a separate corrective action plan. The summary schedule of prior audit findings should be available for our review at the beginning of audit fieldwork.

You are responsible for identifying all federal awards received and understanding and complying with the compliance requirements and for the preparation of the schedule of expenditures of federal awards (including notes and noncash assistance received) in conformity with the Uniform Guidance. You agree to include our report on the schedule of expenditures of federal awards in any document that contains and indicates that we have reported on the schedule of expenditures of federal awards. You also agree to include the audited financial statements with any presentation of the schedule of expenditures of federal awards that includes our report thereon OR make the audited financial statements readily available to intended users of the schedule of expenditures of federal awards no later than the date the schedule of expenditures of federal awards is issued with our report thereon. Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the schedule of expenditures of federal awards in accordance with the Uniform Guidance; (2) you believe the schedule of expenditures of federal awards, including its form and content, is stated fairly in accordance with the Uniform Guidance; (3) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the schedule of expenditures of federal awards.

You are also responsible for the preparation of the other supplementary information, which we have been engaged to report on, in conformity with U.S. generally accepted accounting principles. You agree to include our report on the supplementary information in any document that contains and indicates that we have reported on the supplementary information. You also agree to include the audited financial statements with any presentation of the supplementary information that includes our report thereon OR make the audited financial statements readily available to users of the supplementary information no later than the date the supplementary information is issued with our report thereon. Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the supplementary information in accordance with GAAP; (2) you believe the supplementary information, including its form and content, is fairly presented in accordance with GAAP; (3) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the supplementary information.

Management is responsible for establishing and maintaining a process for tracking the status of audit findings and recommendations. Management is also responsible for identifying and providing report copies of previous financial audits, attestation engagements, performance audits, or other studies related to the objectives discussed in the Audit Objectives section of this letter. This responsibility includes relaying to us corrective actions taken to address significant findings and recommendations resulting from those audits, attestation engagements, performance audits, or studies. You are also responsible for providing management's views on our current findings, conclusions, and recommendations, as well as your planned corrective actions, for the report, and for the timing and format for providing that information.

You agree to assume all management responsibilities relating to the financial statements, schedule of expenditures of federal awards, related notes, and any other nonaudit services we provide. You will be required to acknowledge in the management representation letter our assistance with preparation of the financial statements, schedule of expenditures of federal awards, and related notes, and that you have reviewed and approved the financial statements, schedule of expenditures of federal awards, and related notes prior to their issuance and have accepted responsibility for them. Further, you agree to oversee the nonaudit services by designating an individual, preferably from senior management, with suitable skill, knowledge, or experience; evaluate the adequacy and results of those services; and accept responsibility for them.

Preparation of Cost Reports and Consulting

We will prepare the District's Medicare cost report for the year ending December 31, 2021. We remind you that you have the final responsibility for the Medicare cost report and, therefore, you should review it carefully before you sign and file it. We make no representation that our services will identify any or all opportunities to maximize reimbursement.

All of the information included in the cost report is the representation of management. We direct your attention to the fact that management has the responsibility for the proper recording of the transactions in the books of account, for the safeguarding of assets, for the substantial accuracy of the cost report, and for identifying and ensuring the District complies with the laws and regulations applicable to its activities.

We will also provide Medicare and other reimbursement consulting services as requested throughout the year, including but not limited to review of Medicare rate settings and desk-review and audit adjustments.These services will be provided at our standard rates.

You are also responsible for management decisions and functions; for designating a senior management-level individual with suitable skill, knowledge, or experience to oversee the cost report preparation services we provide; and for evaluating the adequacy and results of those services and accepting responsibility for them.

Conformance with Section 952 of Public Law 96-499

Section 952 of P.L. 96-499 requires access by the Secretary of Health and Human Services and the U.S. Comptroller General to the books and records of subcontractors of Medicare providers. Absent the allowability of such access, the provider's cost for such services would not be allowable for Medicare reimbursement purposes if the contract value over 12 months is $10,000 or more. We would grant such access if this law is applicable to our services.

HIPAA Business Associate Agreement

You agree that you are solely responsible for the accuracy, completeness, and reliability of all data and information you provide us for our engagement. You agree to provide any requested information on or before the date we commence performance of the services. To protect the privacy and provide for the security of any protected health information, as such is defined by the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the regulations and policy guidances thereunder ("HIPAA"), we shall enter into a HIPAA Business Associate Agreement ("BAA").

Engagement Administration, Fees, and Other

We understand that your employees will prepare all cash, accounts receivable, or other confirmations we request and will locate any documents selected by us for testing.

At the conclusion of the engagement, we will complete the appropriate sections of the Data Collection Form that summarizes our audit findings. It is management's responsibility to electronically submit the reporting package (including financial statements, schedule of expenditures of federal awards, summary schedule of prior audit findings, auditors' reports, and corrective action plan) along with the Data Collection Form to the federal audit clearinghouse. We will coordinate with you the electronic submission and certification. The Data Collection Form and the reporting package must be submitted within the earlier of 30 calendar days after receipt of the auditors' reports or nine months after the end of the audit period.

We will provide copies of our reports to the District; however, management is responsible for distribution of the reports and the financial statements. Unless restricted by law or regulation, or containing privileged and confidential information, copies of our reports are to be made available for public inspection.

The audit documentation for this engagement is the property of Dingus, Zarecor & Associates PLLC and constitutes confidential information. However, subject to applicable laws and regulations, audit documentation and appropriate individuals will be made available upon request and in a timely manner to the Washington State Auditor's Office cognizant or oversight agency for the audit or its designee, a federal agency providing direct or indirect funding, or the U.S. Government Accountability Office for purposes of a quality review of the audit, to resolve audit findings, or to carry out oversight responsibilities. We will notify you of any such request. If requested, access to such audit documentation will be provided under the supervision of Dingus, Zarecor & Associates PLLC personnel. Furthermore, upon request, we may provide copies of selected audit documentation to the aforementioned parties. These parties may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

The audit documentation for this engagement will be retained for a minimum of seven years after the report release date or for any additional period requested by a regulatory agency. If we are aware that a federal awarding agency, pass-through entity, or auditee is contesting an audit finding, we will contact the party(ies) contesting the audit finding for guidance prior to destroying the audit documentation.

We expect to begin our audit in approximately March 2022 and to issue our reports no later than May 2022. Tom Dingus is the engagement partner and is responsible for supervising the engagement and signing the reports or authorizing another individual to sign them.

Our fee for these services will be at our standard hourly rates plus out-of-pocket costs (shipping and travel) except that we agree that our gross fee, excluding expenses, will be as follows:

Audit	$25,000
Preparation of Medicare cost report	$11,250

Our fee for the Single Audit required for the CARES Act Provider Relief Fund is $7,500.

Our standard hourly rates vary according to the degree of responsibility involved and the experience level of the personnel assigned to your audit. Our invoices for these fees will be rendered each month as work progresses and are payable on presentation. In accordance with our firm policies, work may be suspended if your account becomes 60 days or more overdue and may not be resumed until your account is paid in full. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report(s). You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket costs through the date of termination. The above fee is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. If significant additional time is necessary, we will discuss it with you and arrive at a new fee estimate before we incur the additional costs.

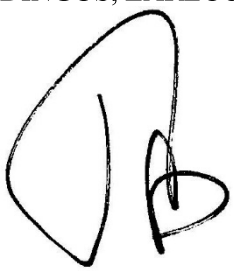
You have requested that we provide you with a copy of our most recent external peer review report and any subsequent reports received during the contract period. Accordingly, our 2019 peer review report accompanies this letter.

Reporting

We will issue a written report upon completion of our audit of Lewis County Public Hospital District No. 1 doing business as Arbor Health's financial statements. Our report will be addressed to Identify parties, such as "management and those charged with governance" of Lewis County Public Hospital District No. 1 doing business as Arbor Health. Circumstances may arise in which our report may differ from its expected form and content based on the results of our audit. Depending on the nature of these circumstances, it may be necessary for us to modify our opinions, add a separate section, or add an emphasis-of-matter or other-matter paragraph to our auditors' report, or if necessary, withdraw from this engagement. If our opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed opinions, we may decline to express an opinion or withdraw from this engagement.

We appreciate the opportunity to be of service to Lewis County Public Hospital District No. 1 doing business as Arbor Health and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please print and sign a copy and return to us.

DINGUS, ZARECOR & ASSOCIATES PLLC



Tom Dingus, CPA
Owner

RESPONSE:

This letter correctly sets forth the understanding of Lewis County Public Hospital District No. 1 doing business as Arbor Health.

Management signature: _____

Title: _____

Date: _____

Governance signature:

_____

Title:

_____

Date:

_____

Arnett Carbis Toothman llp
CPAs & Advisors

actcpas.com

101 Washington Street East
P.O. Box 2629
Charleston, WV 25329
304.346.0441 office | 304.346.8333 fax
800.642.3601

REPORT ON THE FIRM'S SYSTEM OF QUALITY CONTROL

July 14, 2020

To the Owners of
Dingus, Zarecor & Associates, PLLC
and the Peer Review Committee of the Washington Society of Certified Public Accountants

We have reviewed the system of quality control for the accounting and auditing practice of Dingus, Zarecor & Associates, PLLC (the firm), in effect for the year ended November 30, 2019. Our peer review was conducted in accordance with the Standards for Performing and Reporting on Peer Reviews established by the Peer Review Board of the American Institute of Certified Public Accountants (Standards).

A summary of the nature, objectives, scope, limitations of, and the procedures performed in a System Review as described in the Standards may be found at www.aicpa.org/prsummary. The summary also includes an explanation of how engagements identified as not performed or reported in conformity with applicable professional standards, if any, are evaluated by a peer reviewer to determine a peer review rating.

Firm's Responsibility

The firm is responsible for designing a system of quality control and complying with it to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. The firm is also responsible for evaluating actions to promptly remediate engagements deemed as not performed or reported in conformity with professional standards, when appropriate, and for remediating weaknesses in its system of quality control, if any.

Peer Reviewer's Responsibility

Our responsibility is to express an opinion on the design of the system of quality control and the firm's compliance therewith based on our review.

Required Selections and Considerations

Engagements selected for review included engagements performed under *Government Auditing Standards*, including compliance audits under the Single Audit Act; and audits of employee benefit plans.

As a part of our peer review, we considered reviews by regulatory entities as communicated by the firm, if applicable, in determining the nature and extent of our procedures.

Opinion

In our opinion, the system of quality control for the accounting and auditing practice of Dingus, Zarecor & Associates, PLLC, in effect for the year ended November 30, 2019, has been suitably designed and complied with to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Firms can receive a rating of *pass*, *pass with deficiency(ies)* or *fail*. Dingus, Zarecor & Associates, PLLC, has received a peer review rating of *pass*.

ARNETT CARBIS TOOTHMAN LLP

Arnett Carbis Toothman LLP

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING DNV
ACCREDITATION APPOINTMENT RESOLUTION NO. 21-42

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:

To reappoint Infection Preventionist Julie Taylor for 2022. (DNV NIAHO IC.1, SR. 2a)

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 15th day of December 2021, 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

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: Dr. Gary Preston, Epidemiologist & Leianne Everett, Superintendent
Date: 12/15/2021
Subject: Approving Infection Preventionist Appointment

In preparation for our ongoing DNV accreditation, I am asking you, via a motion of the Infection Control Committee, to approve the following appointment:

1. Julie Taylor to serve as Arbor Health's Infection Preventionist. This appointment is to fulfill DNV's NIAHO accreditation requirement IC.1,SR.2a *(an individual(s) who is qualified through education, training, experience or certification in infection prevention, is appointed by the governing body as the infection control professional(s) responsible for the Infection Prevention and Control Program).*

OLD BUSINESS

Sample #1 — Board of Directors Full Board Evaluation

December 2021

Scores are based on the compilation of returned evaluations.

Rankings go from 1 = Low/Disagree up to 5 = High/Agree

Board Activity

		LOW 1	2	3	4	HIGH 5	
1.	The board operates under a set of policies, procedures, and guidelines with which all members are familiar.				X		80%
2.	The Executive Committee reports to the board on all actions taken.				X		86%
3.	There are standing committees of the board that meet regularly and report to the board.					X	100%
4.	Board meetings are well attended, with near full turnout at each meeting.					X	100%
5.	Each board member has at least one committee assignment.				X		95%
6.	Nomination and appointment of board members follow clearly established procedures using known criteria.					X	100%
7.	Newly elected board members receive adequate orientation to their role and what is expected of them.				X		95%
8.	Each board meeting includes an opportunity for learning about the organization's activities.					X	100%
9.	The board follows its policy that defines term limits for board members.					X	100%
10.	The board fully understands and is supportive of the strategic planning process ~~of the ministry~~.				X		85%
11.	Board members receive meeting agendas and supporting materials in time for adequate advance review.					X	100%
12.	The board adequately oversees the financial performance and fiduciary accountability of the organization.					X	100%
13.	The board receives regular financial updates and takes necessary steps to ensure the operations of the organization are sound.					X	100%
14.	The board regularly reviews and evaluates the performance of the CEO.					X	100%
15.	The board actively engages in discussion around significant issues.				X		95%
16.	The board chair effectively and appropriately leads and facilitates the board meetings and the policy and governance work of the board.				X		95%

Sample #1 — Board of Directors Full Board Evaluation

December 2021

		LOW 1	2	3	4	HIGH 5	
	Mission and Purpose						
1.	Statements of the organization's mission are well understood and supported by the board.					X	100%
2.	Board meeting presentations and discussions consistently reference the organization's mission statement.					X	100%
3.	The board reviews the organization's performance in carrying out the stated mission on a regular basis.				X		95%
	Governance / Partnership Alignment						
1.	The board exercises its governance role: 1) Ensuring that the organization supports and upholds the mission statement, core values, statement of faith, vision statement, and partnership policies.				X		95%
2.	The board periodically reviews, and is familiar with, the organization's partnership core documents. (Note: This item applies when a ministry has partnered with other ministries.) Remove?						—
3.	The board reviews its own performance and measures its own effectiveness in governance work.					X	100%
4.	The board is actively engaged in the board development processes.				X		80%
	Board Organization						
1.	Information provided by staff is adequate to ensure effective board governance and decision-making.				X		90%
2.	The committee structure logically addresses the organization's areas of operation.					X	100%
3.	All committees have adequate agendas and minutes for each meeting.					X	100%
4.	All committees address issues of substance.					X	100%

Please make any other comments about the work and effectiveness of our boards:

Comments:

We have respect for each other and share a common goal of having Arbor Health be a medical facility we can be proud of.

We'er getting better each month!

I feel this board has worked together during some unprecedented times; communication, meetings and supportive learning regarding roles has been different and challenging. I have missed the face to face interaction and collaboration with fellow board members.

That being said I believe it takes some extra effort and responsibly on the part of each commissioner to be diligent and stay informed.

* Trust and allow the work to be done at committee levels, if you have questions take it to the chair of that committee.
* Be prepared, read your packet.
* Be responsible to know your meeting dates and times.
* Check your email regularly.
* We are a team, discussion and disagreement are part of the process but once a decision has been made we serve our community and our administrative leaders by standing in support and speaking with one voice.

DocID:	15827
Revision:	2
Status:	In preparation
Department:	Governing Body
Manual(s):	

Policy : Commissioner Compensation for Meetings and Other Services

Policy:

The Board created a policy for Commissioner Compensation for meetings and other services.

Purpose:

The purpose is to provide understanding in the compensation for Commissioners services rendered to the District.

Procedure:

A Lewis County Hospital District No. 1 Commissioner will be compensated, under RCW.70.44.050, for the following meetings and services:

1. Each commissioner shall document their time with a (1) in the time and attendance system for each day or portion of a day spent in attendance doing official district business.
2. All regular, special and adhoc meetings of the Board.
3. All committee meetings of committees set forth in the Hospital District By-laws.
4. All administration meetings requiring commissioner participation, ie. audits, consultants.
5. Educational meetings will be paid for any day meetings held and one travel stipend day per conference. Educational meetings approved by the Board Chair.
6. A day of board educational training per month, ie. iProtean. Provision of a certificate required.
7. A meeting per month either in person or remotely to set either Special or Regular board meeting agenda(s) with Superintendent and/or Executive Assistant.
8. A maximum of two meetings per month either in person or remotely between the Board Chair and the Superintendent to conduct hospital business.
9. Any day of service to the District not included in this policy may be compensated with approval of the Board.

Document Owner:	Frady, Trish
Collaborators:	
Approvals	

- **Committees:**
- **Signers:**

Original Effective Date:	06/13/2012
Revision Date:	[06/13/2012 Rev. 0], [06/26/2018 Rev. 1]
Review Date:	[11/08/2013 Rev. 0], [12/23/2014 Rev. 0], [07/24/2015 Rev. 0], [08/02/2016 Rev. 0], [08/24/2017 Rev. 0], [07/21/2020 Rev. 1]

Attachments:
(REFERENCED BY THIS DOCUMENT)

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

NEW BUSINESS

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
PURCHASE OF THE NETWORK REDESIGN RESOLUTION NO. 21-43

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 purchase of the Network Redesign. This is a 2022 operating expense that is above the Superintendent's purchasing authority.

The purchase price is $93,000.

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 15th day of December 2021, 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

Arbor Health

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Mossyrock Clinic
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Morton Hospital
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Morton Clinic
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360-496-5145

MEMORANDUM

To: Board of Commissioners

From: Richard Boggess, CFO

Date: December 1, 2021

Re: Network Redesign Project

It is the practice of Arbor Health (AH) to conduct periodic security and network reviews and address issues and findings. In Q4 of 2021, we completed the review provided by Sensato, a business partner of the Washington State Hospital Association. The results of the survey were presented to the Compliance Committee on November 11, 2021. The survey identifies items of risk to be addressed in the IT workplan for the upcoming year. Some items are easy fixes such as policy changes. Other items are larger projects requiring outside expertise. One such project is the network segmentation of the AH network. The following is the specific finding and associated table of analysis:

Cybersecurity Capability Maturity Model Evaluation Report C2M2 STRUCTURE

Finding	Priority	Recommendation
Network Segmentation	Critical	Currently Arbor Health's network is flat with IT and OT devices managed on one network. It is recommended that a plan to segment the network be developed and implemented as soon as possible.

3. Establish and Maintain Cybersecurity Architecture

MIL1	a.	A strategy to architecturally isolate the organization's IT systems from OT systems is implemented, at least in an Ad Hoc manner	PI
MIL2	b.	A cybersecurity architecture is in place to enable segmentation, isolation, and other requirements that support the cybersecurity strategy	NI
	c.	Architectural segmentation and isolation is maintained according to a documented plan	NI
MIL3	d.	Cybersecurity architecture is updated at an organization-defined frequency to keep it current	PI

Currently, the AH network is defined as flat, allowing actors to move/communicate across the entire network regardless of role. AH needs to move to a network containing multiple subnets and reduce the broadcast domain based on locations/sites. Traffic will then be segmented and managed by the firewalls. This will allow for increased security and reduces the noise on the network due to more efficient routing and design. This work is complicated by the number of cloud-based vendors used by AH. Specifically, Cerner's reach within our organization is very detailed and will be a complicating factor. For example, a printer located in the Mossyrock

clinic is defined within the Cerner build by IP address and the IP address(es) will change. Changing our network structure will require coordination with Cerner, and all healthcare partners and vendors to ensure continuity of care.

AH will collaborate with its current IT partner, Intrinium, d/b/a Torchlight, to accomplish this work. The scope of work will cover the following elements: 1) Design of the new IP scheme, 2) Create new networks on the AH equipment, 3) Coordinate changes with healthcare partners, 4) Implement the segmentation, 5) Decommission the old network and close old VLANs. In addition, there could be some professional services from Cerner to ensure seamless operation on their side. We estimate that the timeframe will be around 20 weeks at this point in time. Total Project costs of $93,000 are expected as follows: Intrinium – $78,000 on a firm quote, Cerner – $15,000 estimated. These costs are planned in the 2022 operating budget.

Normally we would route this request through committees such as Compliance and Finance for the review, oversight, and education as part of the process. Given the scope of work, vendor timelines and the desire to ensure business and patient safety, we have advanced this project to the earliest possible decision point. Normal timing would have placed approval at the board level in late January. Vendor timelines are the most crucial element here and currently Cerner is scheduling projects in late Q2 of 2022. Intrinium will be prepared to start planning in January 2022. As stated, these funds were planned in the 2022 operating budget. However, the project costs exceed the Superintendent's purchasing authority. We ask for Board support via resolution to initiate this project.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE SECOND 2021
RETENTION BONUS METHODOLOGY RESOLUTION NO. 21-44

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 a one-time retention bonus methodology for staff. Option selected???

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 15th day of December 2021, 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

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 12/09/2021
Subject: Second 2021 Retention Bonus Methodology

In July, Administration presented, and the Board approved a retention bonus. This is being proposed again because the healthcare industry continues to experience staffing shortages and volatility. Other Washington critical access hospitals are using multiple retention bonuses to reward staff for their continued services to their respective districts.

Staffing issues are reducing services to our district now. We previously closed our Pulmonary Rehab program and are now facing the loss of mammography and general ultrasound. There has been no ability to supplement these staffing gaps with contracted providers. To ensure we do not lose staff unnecessarily, we are creating a more robust retention program, of which retention bonuses are only one component. I expect to bring this program, with costs, to you at the January 2022 Regular Board meeting.

As with the previous retention bonus, our proposal is:

- Award $1,000 to employees that were paid for 1,800+ hours during a defined 12-month period.
- Award $500 to employees that were paid for 1,799 – 1,200 hours during a defined 12-month period.
- Award $250 to employees that were paid for 401 – 1,199 hours during a defined 12-month period.

To be eligible, the employee must be employed on 12/15/2020, as well as the payment date. Previously, 196 employees received a retention bonus, resulting in $211,849 cost to the District.

You may also remember that the bonuses were grossed up to account for payroll taxes to the employee. It was the Board's intent to ensure that each employee received the full cash benefit of the bonus. While this approach resulted in a fair and

equitable application, it also resulted in the Finance team having to calculate the unique bonus amount 196 times. While Administration is hopeful that this generosity will be considered as you discuss a second retention bonus for 2021, Finance is advocating for a less manual approach. For example, one could assume that the average tax bracket is 15% for our employees. That would mean that the Finance team would pay out the three bonus amounts grossed up by 15% (i.e., $1,000 + 10% gross up = $1,100.00). The grossed-up bonus would be processed against the employees' individual claimed tax brackets. For employees with a higher tax bracket, their net pay would be less than the employees with a lower tax bracket. Using Finance's recommendation, the fair and equitable approach applies to the process but not to the net amount paid to the employee.

Because Administration has a conflict of interest with this proposal, no recommendation is forthcoming. Administration is simply providing options for consideration in the effort to reward the employees that opted to continue to work at Arbor Health while peers that elected to move between employers were financially rewarded for their willingness to change employers.

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To: Board of Commissioners
From: Shannon Kelly, CHRO
Date: 12/07/2021
Subject: New Third Party Administrator of Flexible Spending Account and HRA Reimbursement Arrangement Plans

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Arbor Health have used Northwest Marketing Resources (NMR) to administer our Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA) for many years. NMR has been great to work with but recently made the decision to provide customers with a better customer service experience and improved customer service through technology. They made the decision to partner with a local third-party administrator (TPA), who will take over our FSA and HRA accounts.

TPSC Benefits, in Tacoma, WA, is a TPA that NMR has worked with for years in other capacities. TPSC will offer additional services for our employees that they do not currently have. These additional services include online access to their account, a mobile app, debit card and more.

We will be bringing a resolution and plan documents to the January meeting for your approval. The plans are effective January 1, 2022.

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To: Board of Commissioners
From: Leianne Everett, Superintendent/CEO
Date: 12/07/2021
Subject: 2022 Organization of the Board & New Commissioner Orientation

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On January 26, 2022, we will have our first Regular Board Meeting for 2022. At that time, we will have two new commissioners. This will require the Board to elect a new board chair, secretary and assign committee members for 2022. Until those actions can occur, Secretary Herrin and Commissioner Coppock will attend the only committee meeting that will occur prior to the Regular Board Meeting – Finance Committee on January 19th. Furthermore, we plan to have Secretary Herrin lead the January 26th Regular Board Meeting until officers are elected.

Until then, Executive Assistant Garcia and I will begin orienting the new commissioners. This will be consistent with the orientation we provided prior new commissioners. Also, in keeping with past practice, we will be looking to assign the new commissioners a Commissioner Buddy. This Buddy will be available to the new commissioners for questions they may have throughout the year. This process is not structured as it is intended to function as a "lifeline" if the new commissioner deems it needed and necessary.

Finally, given that it looks like COVID is here to stay for the foreseeable future, I plan to resurrect the quarterly 1:1 meetings that I historically had with commissioners. Historically, I had lunch once per quarter with the commissioners to hear what is working well, what is not, and to discuss opportunities for improvement. These lunches were cancelled when we went into Incident Command. Although we are still under Incident Command, I think we can find ways, i.e., TEAMS or ZOOM, to re-establish these important meetings.

SUPERINTENDENT REPORT

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To: Board of Commissioners
From: Leianne Everett, Superintendent/CEO
Date: 12/09/2021
Subject: 2022 Department Strategic Measures - DRAFT

As we bring 2021 to a close, the managers and I have been working on their 2022 Department Strategic Measures. You may remember that these department measures are aligned with the Board of Commissioner's strategic priorities.

The priorities spring from a three-year strategic plan that was established in early 2020 to guide our effort for the following three years. 2022 will be the third and final year for these priorities. At the end of 2022, we will hold our next Strategic Planning Retreat to establish a new three-year plan with new priorities.

The presented measures remain in draft as we continue to negotiate and fine tune the department measures for next year. Some measures are being replaced with new departmental goals. Some measures carry forward for various reasons. Most measures will not have a baseline yet as 2021 remains incomplete.

We have added a couple of departments for 2022 (Compliance & Foundation). These additions represent the expansion of this model throughout the organization. Because 2021 was the inaugural year, we continue to expand, refine, a mature this process.

Please watch for a more complete version to be presented at the January 2022 Regular Board of Commissioners meeting. Thereafter, progress on the 2022 measures will be presented after the close of each quarter.

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Develop a primary care clinic in Packwood, WA		**Open by 12/31/2022**					
Clinical Informatics: Successful implementation of Cerner/WAIIS immunization interface that meets DOH minimum data transmission thresholds.							
Compliance: Provide responses to compliance questions from all departments within 2 business days of receipt.	**2**	**2**					
Communications: Partner with vendors and community groups to host an overall wellness week, including a health fair	**1**	**1 Event Annually**					
Environmental Services: Staff members will become CHEST (Certified Health Care Environmental Services Technician) certified within first year of employment		**75%**					
Facilities: Increase department employees engagement in employee events		**75%**					
Finance: Increase vendor invoice EFT utilization by 15%.	**1**	**1.15**					
Billing/HIM: Partner with Insurance Payor to address school needs/community youth programs	**1**	**1 coordinated event/year**					
Human Resources: Attend at least two local high school and college job fairs	**1**	**2**					
Foundation: Increase the number of Gift Shop Volunteers to 11	**7**	**11**					
Information Technology: Network uptime should be 99.7% or greater		**≥ 99.7%**					
Employee Health: Develop a community weight loss challenge that culminates in a 5k/10k/Half Marathon	**1**	**1**					
Patient Access: Refer patients to the Self Pay Biller to see if they qualify for Medicaid.		**5 patients/qtr, 20 patients/year**					
Quality and Risk: Improve grievance process compliance for written acknowledgement letters within 10 days of grievance		**≤ 10 days**					
Supply Chain: Create Cycle Count process to improve inventory accuracy.	**65%**	**85%**					
CLINICAL							
Acute Care: Develop and implement 1 social media message or newsletter article per quarter re: Chest Pain/MI, Sepsis, Cornonavirous, and CHF.							
Case Management: Develop and implement 1 social media message or newsletter article per quarter re: skilled services							

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022				
			Q1	Q2	Q3	Q4	YTD
Dietary/Nutrition: Increase numbe of To Go meals to seniors in food scarce homes by 1%	1	1.01					
Emergency Department: Minimum of 1 community STROKE education event and 3 EMS STROKE education events		1/3					
Imaging: Develop & implement a Low Dose Lung Screening program by the end of 2022		Pass/Fail					
Infection Control: Participate in 3 external events promoting IC to the community		3					
Laboratory: Develop a process to notify providers of all hospital patient preliminary culture results		85%					
Respiratory Therapy: Extend 2 smoking cessation classes per year to public	0	2					
Pharmacy: Establish a medication disposal program for Morton, Mossyrock and Randle		Minimum of 3 kiosks					
Pulmonary Rehab: Extend two smoking cessation classes per year to public	0	2 classes per year					
Wellness: Create a community wide wellness plan that incorporates 2 additional partnerships with providers, employers, and community based entities focusing on overall health of our community by identifying target chronic illnesses and needs.	2	4					
Rehab Services: Increase focus on student athletic performance & injury management.	0.75	2					
Surgical Services: Facilitate awareness of and local access to outpatient Infusion Care by developing marketing literature and outreach to Lewis County clinics, home health, and Centralia, Longview and Tacoma hospitals' Case Management departments resulting in ≥ 20% increase in Same Day Surgery encounters	1	1					
Anesthesia:							
Swing Beds: Acute patients transferred out of District with subsequent skilled needs are readmitted to Arbor Health for local care		28 patients/year					
Wound Care: Increase outpatient wound care visits by 10%	1	1.1					
CLINICS							
Morton: Develop 3 community engagement events at clinic per year.		3/year					

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022				
			Q1	Q2	Q3	Q4	YTD
Mossyrock: Develop 3 community engagement events at clinic per year.		3/year					
Randle: Develop 3 community engagement events at clinic per year.		3/year					
Specialty: Develop 3 community engagement events at clinic per year.		3/year					

EXECUTIVE DASHBOARD

TO CREATE A CULTURE FOCUSED ON SAFETY, PATIENT SATISFACTION, EMPLOYEE ENGAGEMENT AND EXCELLENT OUTCOMES

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration:							
Clinical Informatics: Standardize drug protocols by increasing the number of Cerner order sets for P&T approved drug protocols and, as indicated, eliminate access to any other versions beyond P&T approved protocols	1	6					
Compliance: Resolve compliance and HIPAA events within 15 business days	25	15					
Communications: Increase our Google Business Profile reviews by 25%	76	95					
Environmental Services: Increase compliance with "high touch" areas to ≥ 80%	57%	≥ 80%					
Facilities: Improve the average maintenance work order turnaround time by 5%.	11	10.45					
Finance: Financial information will be available for end-users by the 6th working day for 11 of 12 months		11					
Billing/HIM: Track the number of Financial Assistance applications provided, returned & approved.	1	1					
Human Resources: Conduct a minimum of 2 employee engagement surveys.	1	2					
Foundation: Increase the number of staff members participating in the 15-Minute Philanthropist program by 20%	48	57.6					
Information Technology: All Worxhub tickets, including weekend tickets, are acknowledged within an average of 2 days of input & calculated quarterly.		≤ 2 days					
Employee Health: Complete RCAs on 90% of all reportable workplace injuries	0%	90%					
Patient Access: Identify patients that qualify for charity care by using bill holds to flag encounters allowing biller to track and follow-up with patients.	1	1					
Quality and Risk: Initiate ISO 9001 as evidenced by development/implementation of Quality Management System, completion of organization pre-assessment/gap analysis, and initiation of an ISO implementation action plan/calendar		Pass/Fail					
Supply Chain: Implement & maintain a housewide monthly product out-date process		95%					
CLINICAL							
Acute Care: Increase documented patient education related to admission diagnosis within 4 hours of admission (#IP with education started w/in 4 hours)							
Case Management: Implement concurrent OPTUM admission review process for weekend admissions (# of OPTUM reviews sent/# weekend admissions)	0.00%	≥ 60%					
Dietary/Nutrition: Increase number of participants in healthy cooking demonstrations for public by 20%	1	1.2					
Emergency Department: Improve ED Moderate Sedation monitoring documentation to DNV standards (# of sedation patients/# of sedation documentation compliance with all elements of requirement)		≥ 95%					

Imaging: Decrease stroke/CT report turnaround to 15 minutes or less	**43 minutes**	**≤ 15 minutes**
Infection Control: Increase hand hygiene compliance	**74%**	**≥ 90%**
Laboratory: Decrease rate of reference lab rejected samples	**0.88%**	**≤ 0.5%**
Respiratory Therapy: Recruit Respiratory Therapist, market to referral sources, and reopen Pulmonary Rehab program		**Pass/Fail**
Pharmacy: Provide medication counseling at discharge		**60%**
Pulmonary Rehab: Recruit Respiratory Therapists, market to referral sources, and reopen Pulmonary Rehab program		**Pass/Fail**
Wellness: Create 2 additional programs that are designed to engage the local community in health and wellness.	**2**	**4**
Rehab Services: Overall patient outcomes will be at least 90% of expected outcomes based on FOTO risk adjusted predictions	**0%**	**≥ 90%**
Patient Satisfaction will be 90% net promotor score from FOTO	**0%**	**≥ 90%**
Surgical Services:		
Anesthesia: Anesthesia PRE- and POST-OP charting accuracy to DNV standards greater than 95%		**≥ 95%**
Swing Beds: Improve rate of Skilled Swing Bed Comprehensive Assessments completed weekly (# of Skilled Swing Bed Comprehensive Assessments completed/# of Skilled Swing Bed patients on Wednesday)		**≥ 90%**
Wound Care: Venous Leg Ulcer outcome measure		
CLINICS		
Morton: Increase annual wellness visits by 25%	**1**	**1**
Mossyrock: Increase annual wellness visits by 25%	**1**	**1**
Randle: Increase annual wellness visits by 25%	**1**	**1**
Specialty: Market and grow telehealth visits by 50%.	**31**	**62**

EXECUTIVE DASHBOARD

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2021 Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Decrease interim staffing costs by 10% or greater.	$ 2,368,626	$ 2,131,763					
Clinical Informatics: Through training and workflow changes, reduce the number of encounters with missed charges secondary to admitting order errors by 20%	1	0.8					
Compliance: Audit work plan for implementation, follow-through, and outcomes reported to Compliance Committee		100%					
Communications: Increase number of annual wellness visits by 10% through the use of effective marketing messaging	1	1					
Environmental Services: Decrease overtime by 25% by optimizing staffing schedules.	$ 4,893	$ 3,670					
Facilities: 100% of critical PMs completed monthly.	95%	100%					
Finance: Pay external vendors timely and per schedule, reducing variation/errors	70%	85%					
Billing/HIM: Decrease timely filing write-offs by 25%	$ 1	$ 1					
Human Resources: All performance evaluations will be completed within 30 days of the due date	81%	100%					
Foundation: Establish a monthly donor program in the community to ease in the process of obtaining philanthropic donations to minimize the reliance on fund raising via events		Pass/Fail					
Information Technology: Implement an IT asset tracking system that meets compliance requirement & supports the District in tracking IT devices.		Pass/Fail					
Employee Health: Submit 10% of eligible claims to LNIs Stay-at-Work Program	80%	100%					
Patient Access: Increase point-of-service collections by 10% in ER and 10% in OP Services.	$ 1	$ 1					
	$ 1	$ 1					
Quality and Risk: Increase Medication Error reporting by 10% to minimize unknown/unreported litigation risk	68	74.8					
Supply Chain: All assets/capital purchases undergo asset purchase process/structure lead by Materials team.		75%					
CLINICAL							
Acute Care: 30% reduction in lost revenue due to *Did Not Meet Inpatient Criteria* denials.	$ 90,000	$ 63,000					
Case Management: 10% reduction in Code 44s	1	0.9					
Dietary/Nutrition: Decrease department turnover by 40%		0					
Emergency Department: Implement review process to manage ED Diversions to less than 5%	1	≤ 5%					
Imaging: Redesign staffing model & recruit employees in order to offer all available services		Pass/Fail					
Infection Control: Partner with Pharmacy to utilize Cerner Pharmacy surveillance program to reduce antibiotic usage in inappropriate situations							
Laboratory: Reduce lab test write-offs due to lack of medical necessity or ABN		> 10%					

Respiratory Therapy: Recruit Respiratory Therapists, market to referral source, and reopen outpatient PFT, EKG & Stress Test Services		**Pass/Fail**
Pharmacy: Utilize Sentri7 to reduce drug costs		**Decrease by 10% or greater**
Pulmonary Rehab: Recruit Respiratory Therapists, market to referral sources, and reopen Pulmonary Rehab in a group model (pending COVID guidelines) by end of 2022	**0**	**Pass/Fail**
Wellness: create a wellness program that is an efficient use of funds and demonstrates a commitment to reducing healthcare cost overall in the community. This may be done through outsourcing to share costs, etc..		**Pass/Fail**
Rehab Services: Decrease our cancel/no show rate to reduce non-productive time and improve patient outcomes.	**13%**	**≤ 12%**
Surgical Services: Increase surgical procedures by 10%	**1**	**1.1**
Anesthesia: Initiate peripheral nerve block competency resulting in new revenue (ortho)		**$ 10,800**
Swing Beds: Implement referral development and weekly fax/email bed availability updates to primary referral sources to achieve a return to budgeted skilled admissions	**1**	**1793**
Wound Care: Increase WOCN EPIFIX administration for chronic wounds by 30%	**1**	**1.3**
CLINICS		
Morton: 99.5% of all charts are completed according to medical staff guidelines		**≥ 99.5%**
Mossyrock: 99.5% of all charts are completed according to medical staff guidelines		**≥ 99.5%**
Randle: 99.5% of all charts are completed according to medical staff guidelines		**≥ 99.5%**
Specialty: 99.5% of all charts are completed according to medical staff guidelines		**≥ 99.5%**