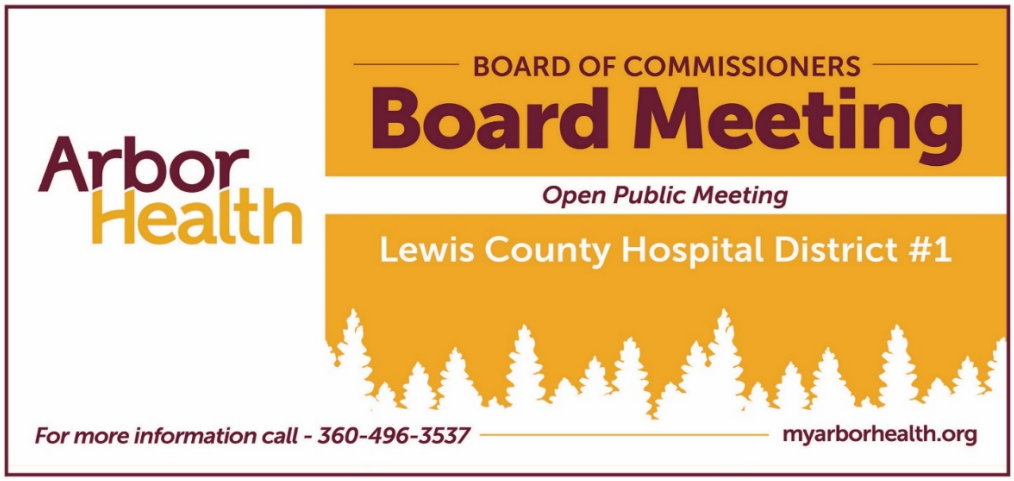
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

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

September 30, 2020 @ 3:30 PM

Join Zoom Meeting: https://myarborhealth.zoom.us/j/94449252973
Meeting ID: 944 4925 2973
One tap mobile: +12532158782,,94449252973#
Dial: +1 253 215 8782

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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
September 30, 2020 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/94449252973
Meeting ID: 944 4925 2973
One tap mobile: +12532158782,,94449252973# US
Dial:+1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	PAGE	TIME
Call to Order **Approval or Amendment of Agenda** **Conflict of Interest**		3:30 pm
New Business • Read Timely Filed Bids • Announce Apparent Low Bidder • Announce Date the Contract will be Awarded		3:35 pm
Comments and Remarks • Commissioners • Audience		3:50 pm
Guest Speaker • Washington Rural Health Collaborative o Elya Prystowsky, Executive Director	5	4:00 pm
Executive Session-*RCW 70.41.205* • Medical Privileging-Janice Holmes		4:30 pm
Break		4:50 pm
Department Spotlight • Pharmacy Department o *To strategically discuss the department's current and future state.*	26	5:00 pm
Board Committee Reports • Hospital Foundation Report-Committee Chair-Commissioner McMahan	28	5:15 pm
• Finance Committee Report-Committee Chair-Commissioner Herrin	30	5:20 pm
• Compliance Committee Report-Committee Chair-Commissioner McMahan		5:25 pm
Consent Agenda – *(Action items included below)* • [ ] Passed [ ] Denied [ ] Deferred		5:30 pm
• Minutes of the August 26, 2020 Regular Board Meeting *(Action)*	32	
• Minutes of the September 16, 2020 Compliance Committee Meeting *(Action)*	38	
• Minutes of the September 23, 2020 Finance Committee Meeting *(Action)*	40	

• Warrants & EFT's in the amount of $3,930,631.51 dated August 2020 *(Action)*	43	
• Resolution 20-37-Approving the Capital Purchase of LED Lighting *(Action)* o *To approve the purchase of LED replacement lighting for the District.*	45	
• Resolution 20-38-Approving the Engagement with Centralia College *(Action)* o *To approve the sponsorship of $75,000 to the college for marketing and recruitment purposes.*	48	
• Approve Documents Pending Board Ratification 9.30.20 *(Action)* o *To provide board oversight for document management in Lucidoc.*	51	
Old Business • OPMA & PRA Training Certificates o *To complete the public officials training-RCW 42.30.205 & 42.56.150.*		5:35 pm
New Business • Board Education o Consent Agenda ▪ *To discuss the propose of utilizing the consent agenda for routine meeting business.* o An Introduction to Quality ▪ *iProtean* o Philanthropy ▪ *iProtean*	 56 57 65	5:40 pm
• Diversity Training o *To finalize the details for the Professional Conduct in the Workplace training.*		5:50 pm
• Draft 2021 Operating Budget o *To present the proposed 2021 budget. The public hearing will be on November 11, 2020 and notice will be published two consecutive weeks prior to the meeting to notify the District.*	74	5:55 pm
• Board Policies & Procedures o Electronic Signatures (NEW) o Annual Adoption of the Compliance Plan o Annual CEO/Superintendent Evaluation o Board E-Mail Communication	 76 78 80 82	6:15 pm
• Change to Employee Benefits o *To discuss changes to employee benefits to reduce costs.*		6:25 pm
Superintendent Report	85	6:35 pm
Next Board Meeting Dates and Times • Special Board Meeting-October 7, 2020 @ 3:30 PM (ZOOM)-Executive Session-Review Bids • Special Board Meeting-October 13, 2020 @ 3:30 PM (ZOOM)-Select Contractor • Special Board Meeting-October 28, 2020 @ 1:00 PM (ZOOM)-Diversity Training & Budget • Regular Board Meeting-November 11, 2020 @ 3:30 PM (ZOOM) **Next Committee Meeting Dates and Times** • QIO Committee Meeting-October 14, 2020 @ 7:00 AM (ZOOM) • Plant Planning Committee Meeting-October 15, 2020 @ 7:00 AM (ZOOM) • Finance Committee Meeting-October 21, 2020 @ 12:00 PM (ZOOM)		
Meeting Summary & Evaluation		
Adjournment		6:50 pm

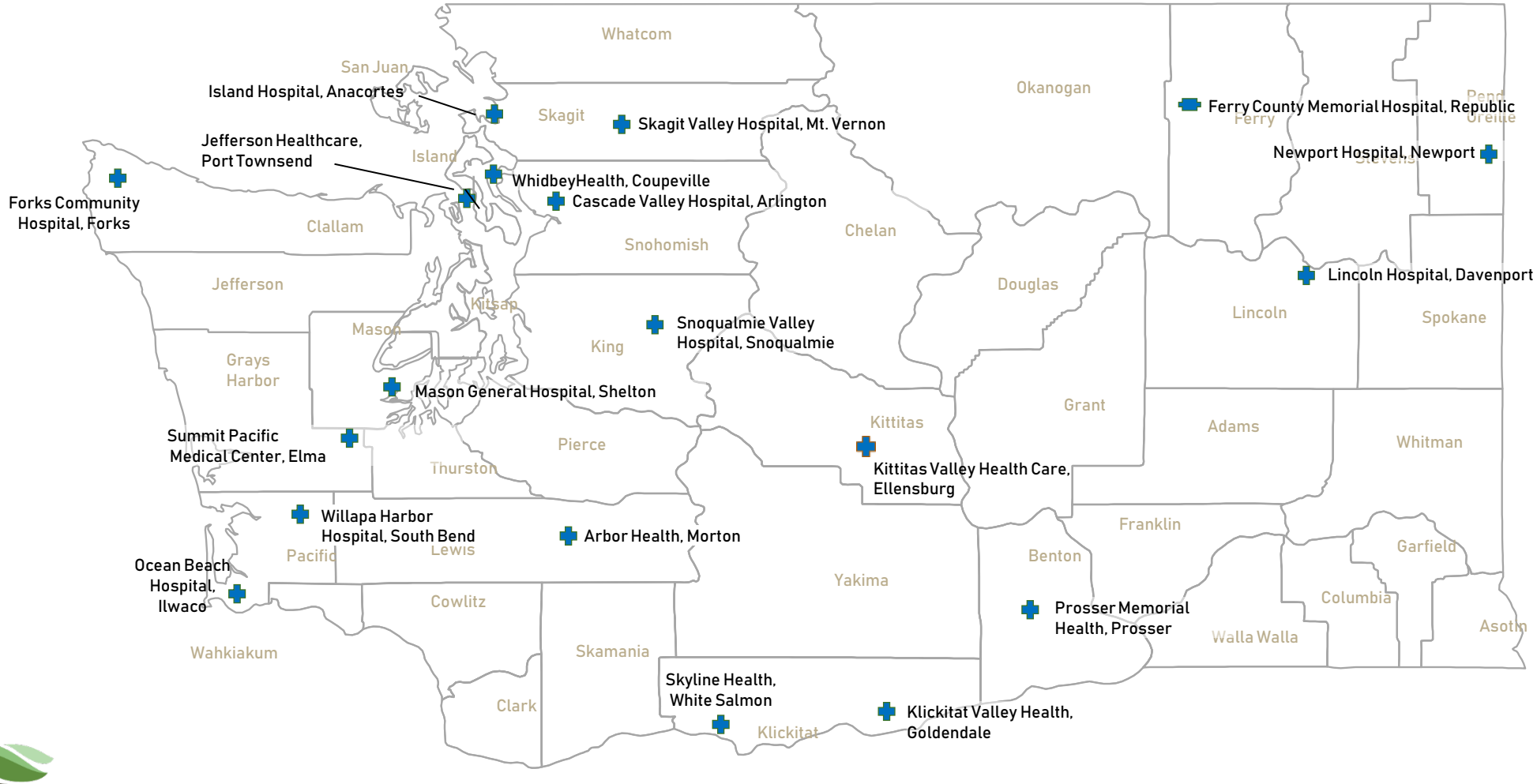
Washington Rural Health Collaborative

Arbor Health, Morton Hospital

Hospital Board of Commissioners

September 30, 2020

We Are…19 Members / 16 Counties



Washington Rural Health Collaborative

The Collaborative Board Continues its Legacy as Pioneers in Rural Washington Healthcare

Our Board

1. Julie Petersen, CEO & Chair – Kittitas Valley Healthcare
2. Josh Martin, CEO & Vice Chair – Summit Pacific Medical Center
3. Tom Wilbur, CEO & Secretary/Treasurer – Newport Hospital & Health Services
4. Eric Moll, CEO – Mason General Hospital & Family of Clinics
5. Robb Kimmes, CEO – Skyline Health
6. Leslie Hiebert, CEO – Klickitat Valley Health
7. Tim Cournyer, outgoing CEO – Forks Community Hospital
8. Heidi Anderson, incoming CEO – Forks Community Hospital
9. Mike Glenn, CEO – Jefferson Healthcare
10. Tyson Lacy, CEO – Lincoln Hospital and North Basin Clinics
11. **Leianne Everett, CEO – Arbor Health, Morton Hospital**
12. Larry Cohen, CEO – Ocean Beach Hospital
13. Craig Marks, CEO – Prosser Memorial Health
14. Kim Witkop, MD, Interim CEO – Snoqualmie Valley Hospital
15. Ron Telles, CEO – WhidbeyHealth Medical Center
16. Matthew Kempton, CEO – Willapa Harbor Hospital

Independence through Interdependence

Working together to preserve and enhance access to sustainable, high-quality healthcare in rural communities.

Problem Statement

The healthcare system has transformed into a highly complex, constantly changing industry.

Individual rural health systems struggle to recruit the talent, support, and infrastructure needed to thrive in this environment.

Without innovation, advocacy, collaboration and flexibility, rural hospitals face significant threats to their ability to meet changing community needs.

About the Collaborative

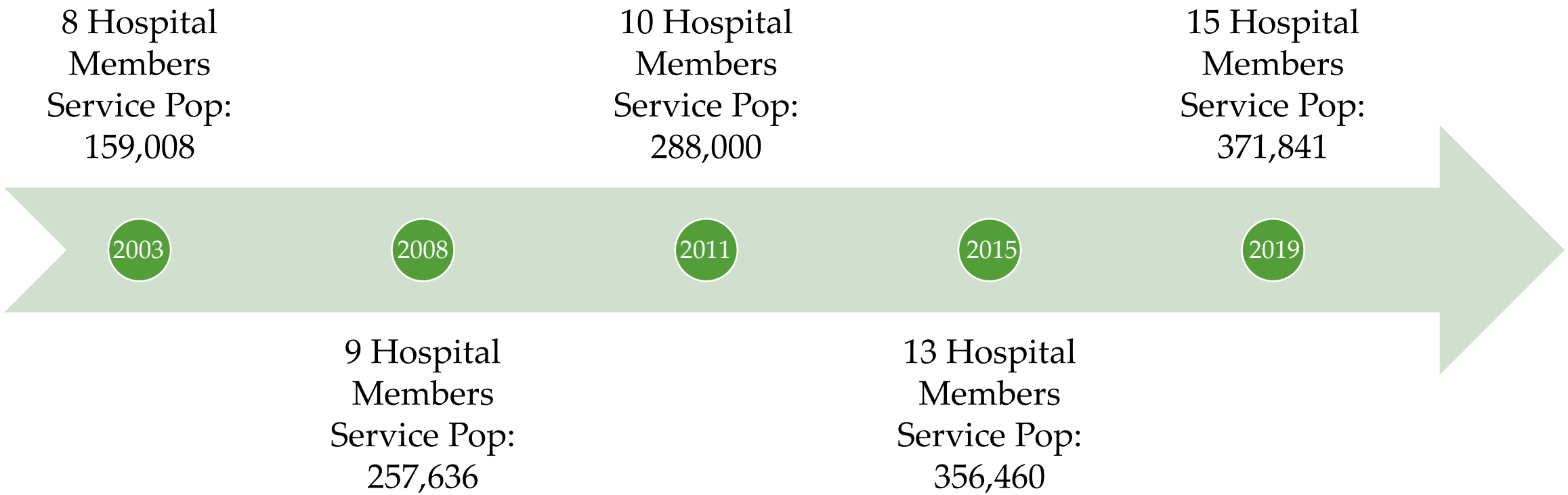
PURPOSE

To support Collaborative members to better serve their communities.
To overcome the challenges of rural healthcare.
To take advantage of the opportunities that a collective provides.
To speak with one rural voice.

MISSION

We defend, create and design the future of rural health care through collective strategy and action.

Collaborative History



Goals and Objectives Through 2023

Clinical Quality and Service	Offer products and services which enable members to achieve and sustain Quadruple AIM goals.
Financial Resilience and Growth	The Collaborative is financially sustainable. Collaborative members benefit financially due to Collaborative services and offerings.
Creativity	As the foundation for the defense and promotion of rural healthcare, begin the development and execution of a multi-year plan providing a springboard to a broader, more formal rural health network.

What are we up to?

Clinical Quality and Service

- HRSA Quality Improvement Grant
- Value-Based Care Readiness Program

Financial Resiliency and Growth

- Joints Contracts
- Group Purchasing

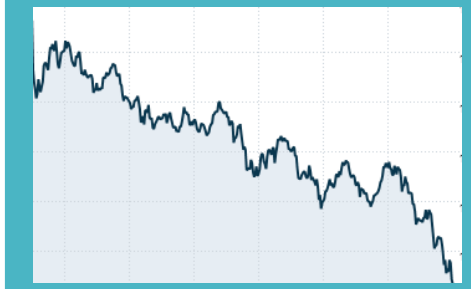
Creativity

- NWMHP ACO
- WA Rural Health Network LLC

2019 Year At-A-Glance

Metric	2019
Total patients served per day	4,009
Inpatient discharges	10,941
Clinic visits	580,346
Outpatient visits	739,948
Average daily census	143
Available beds	357
Full time employees	4,266
Provider FTEs	482
Emergency room visits	143,130
Net patient services revenue	$764,196,045
Charity care	$17,472,881
Combined district population	371,841

Financial Benefit to Membership



Shared Services, Shared Programs and Preferred Member Pricing

To reduce costs, standardize processes and remove redundancies, a key component of the Collaborative goes beyond just centralization or consolidation. Shared services and programs are operated like a business while also delivering services to our members lower costs as compared to external models.

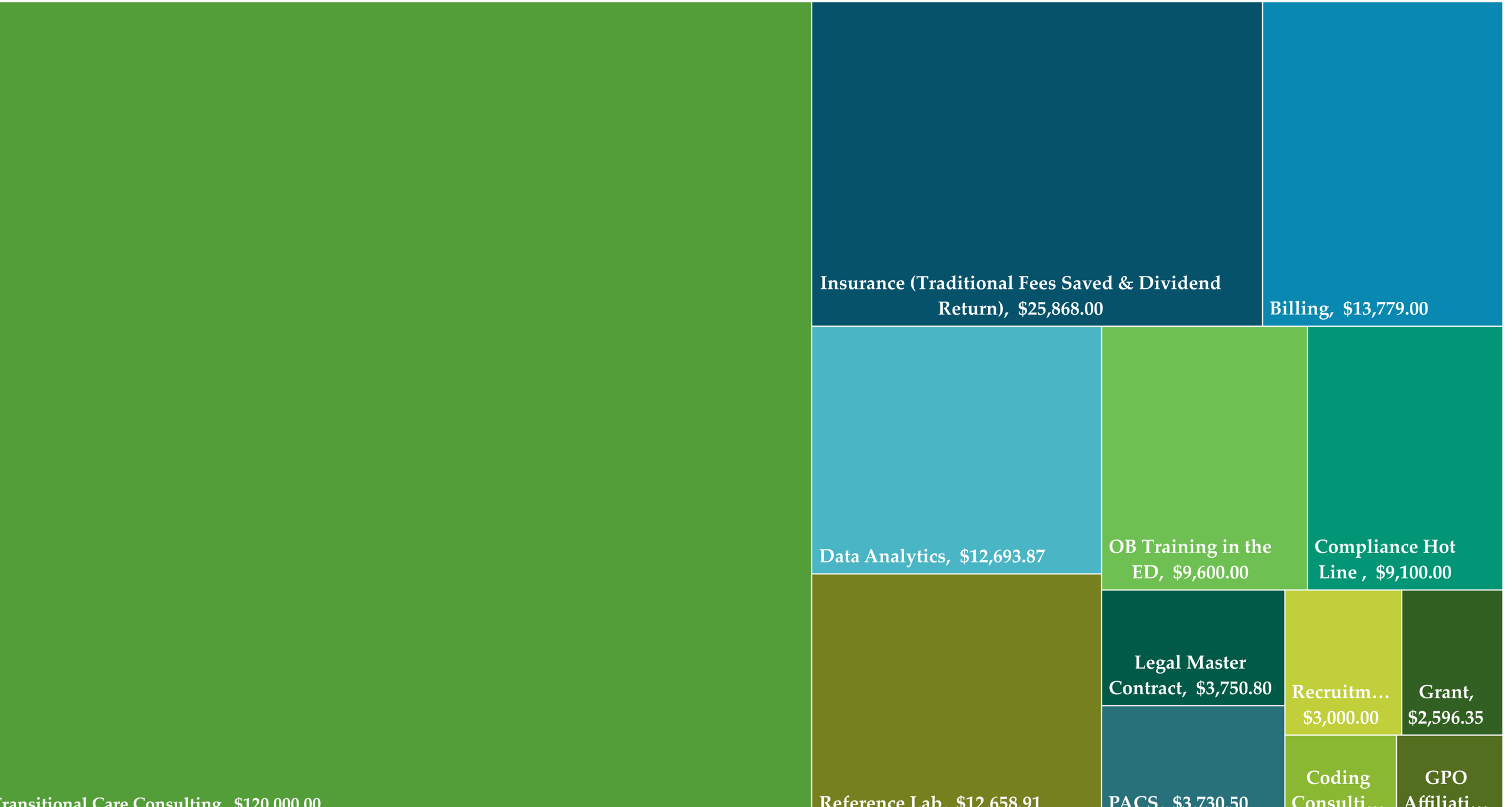
Alternative Payment Models through Value-Based Contracting

Healthcare reimbursement is evolving away from a per visit environment towards a community health and value-based approach. The Collaborative's Public Hospital District – Joint Operating Board (PHD-JOB) works together to negotiate value-based programs with health insurance companies.

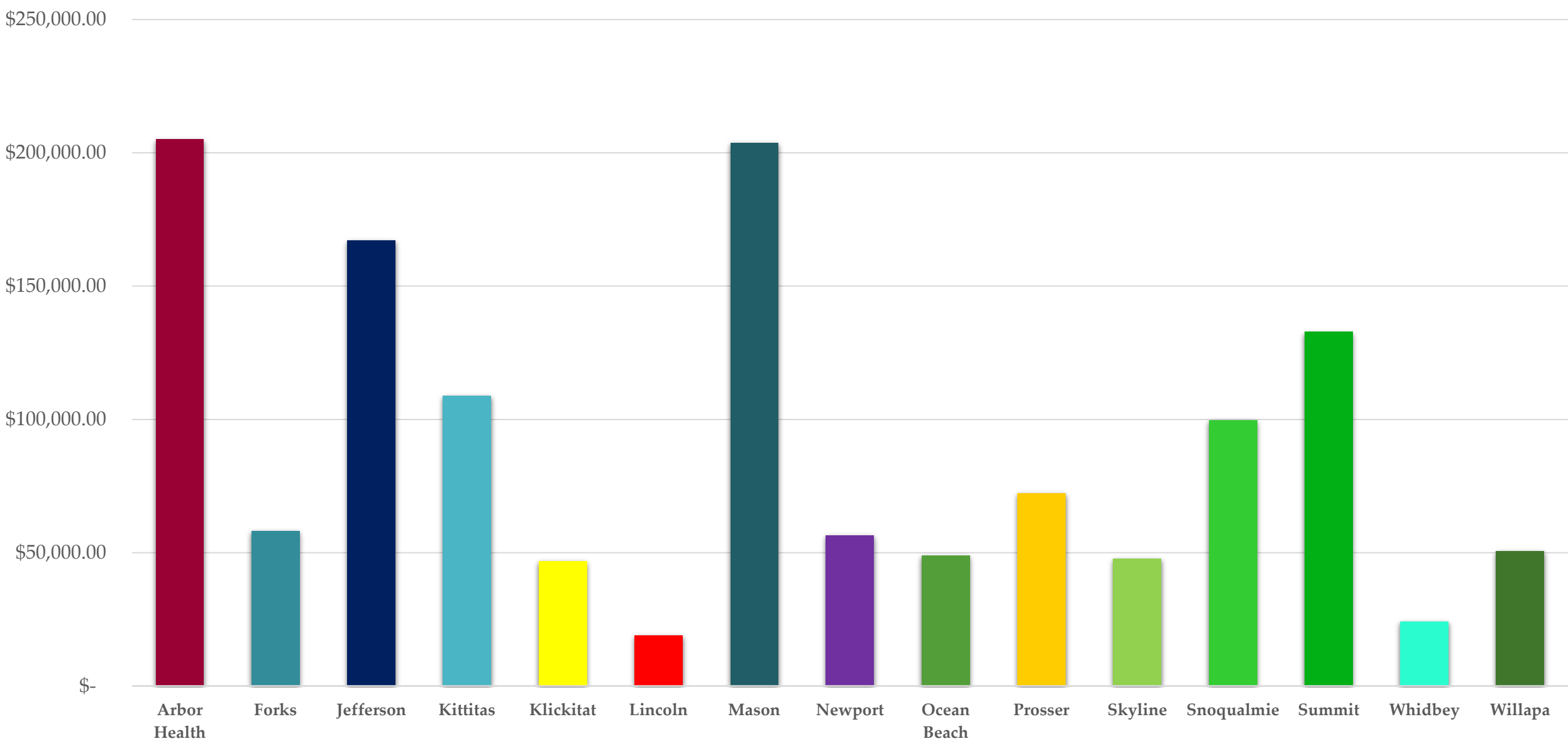
Public Hospital District-Joint Operating Board

- Focus on value-based contracts, shared savings arrangements, standardize contract language and revenue cycle issues
- Experienced staff to support with contract negotiation, implementation and ongoing management
- Cultivate strong relationships between members, payers, and service providers

ARBOR HEALTH RETURN ON INVESTMENT

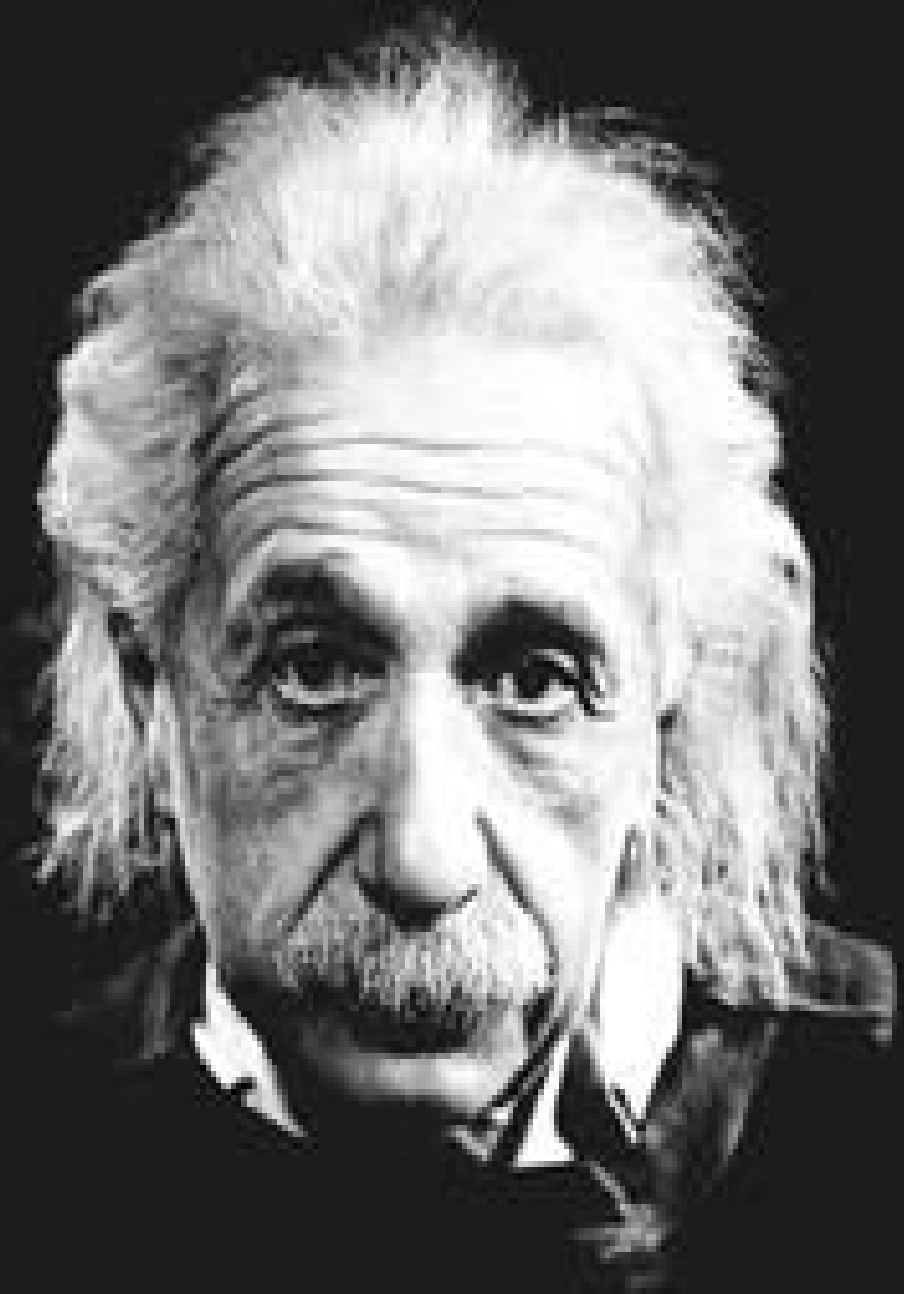


Total Net Savings by Member



"Not everything that counts can be counted, and not everything that can be counted counts."

-Albert Einstein



Benefits that cannot be counted

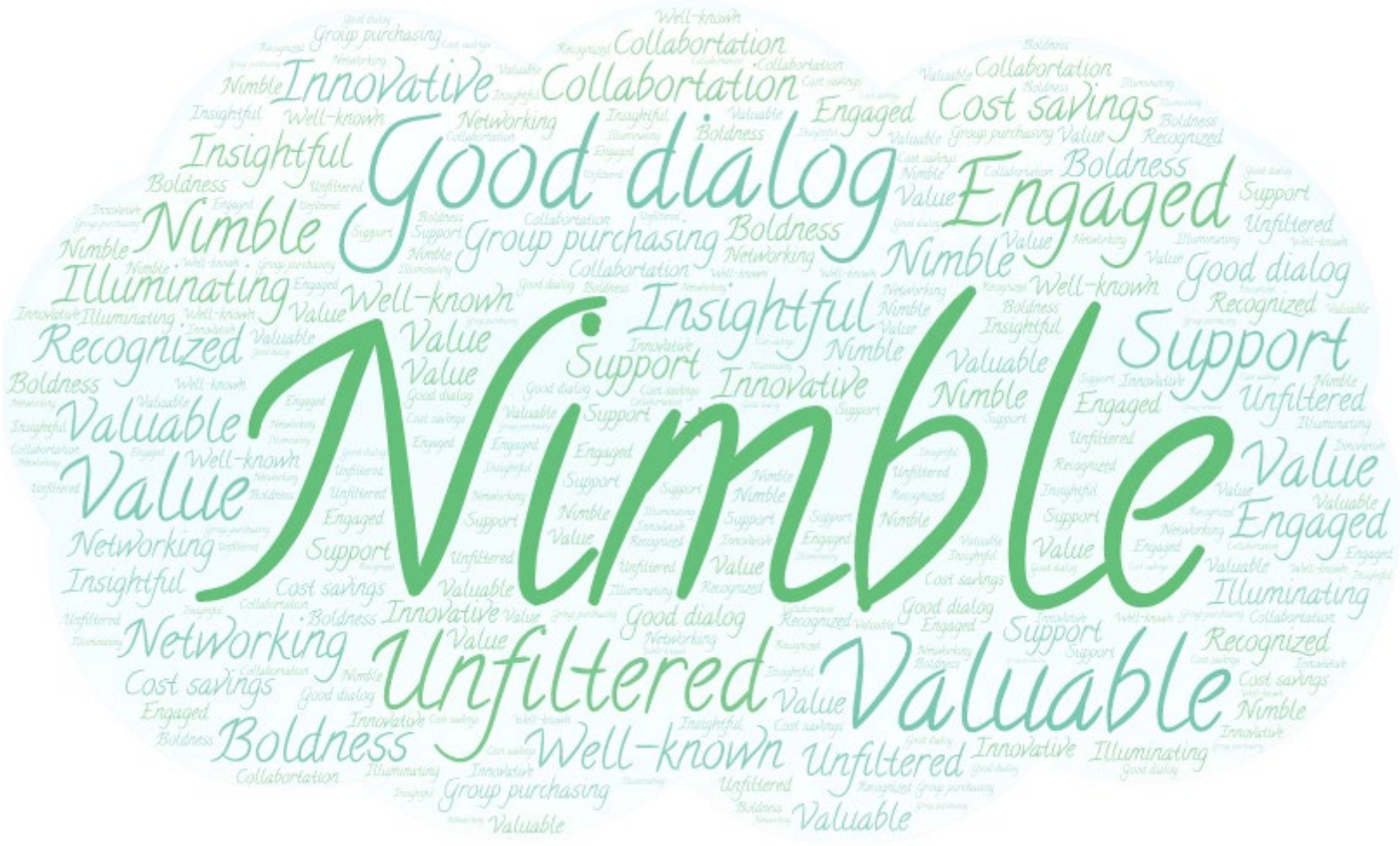
- Protection from the feeling of isolation from large hospital systems
- Rural hospitals share many of the same needs… and complaints
- There is so much talent among the CEOs
- We craft solutions together to very challenging problems
- We speak with a single rural health voice
- Networking. Networking. NETWORKING!!!!!

"The honest sharing between CEOs is the heartbeat of the Collaborative."

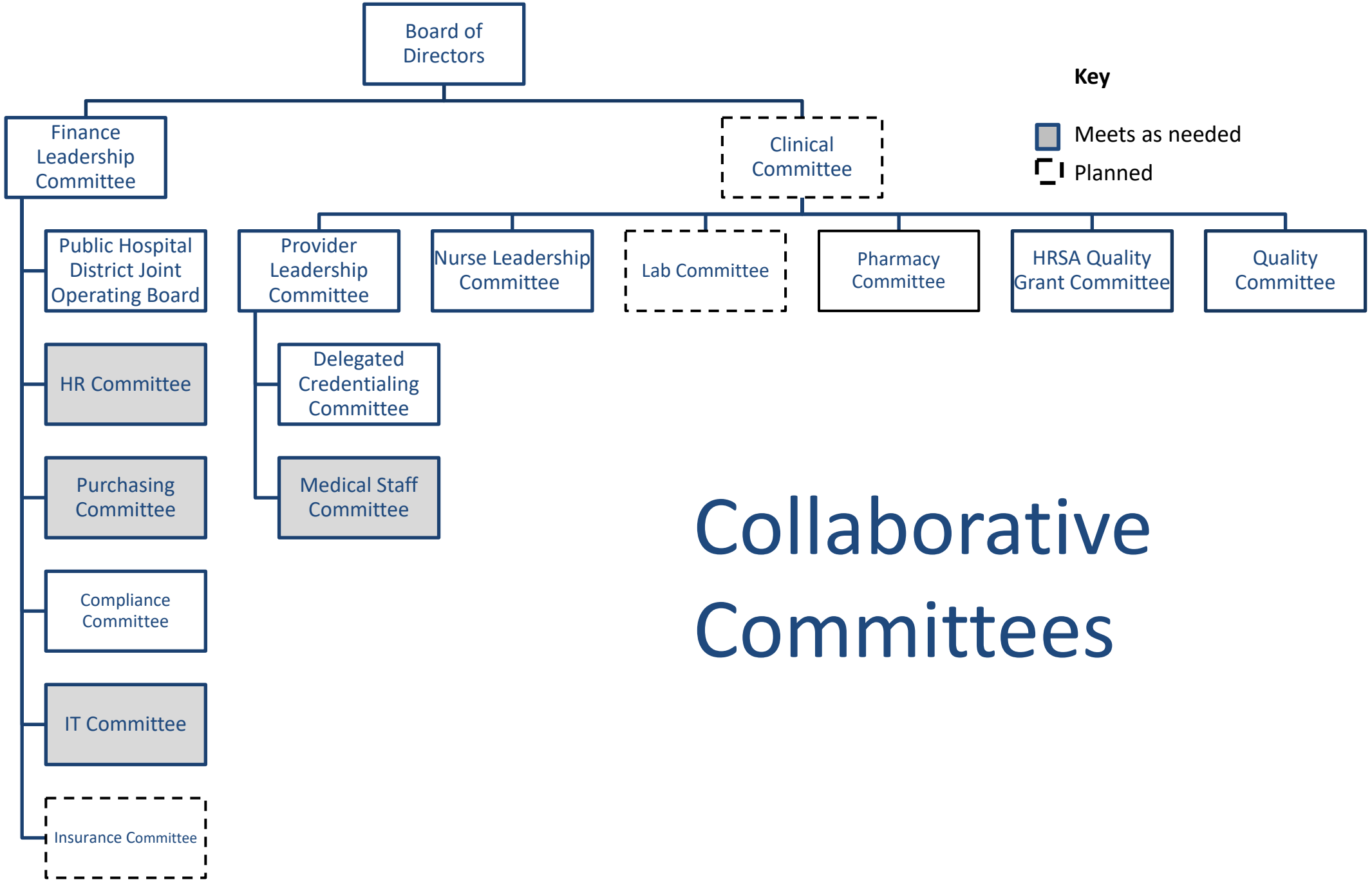
" Our bench is strong"

"Together we will survive. Individually, we will not."

"I need the comradery."


Nimble
Good dialog
Engaged
Unfiltered
Valuable
Innovative
Collaboration
Insightful
Support
Value
Networking
Boldness
Well-known
Recognized
Illuminating
Cost savings
Group purchasing

And it goes beyond the CEOs…



Collaborative Committees


Skyline Hospital

Arbor Health


Klickitat Valley Health


Klickitat Valley Health


Ocean Beach


Ocean Beach


Arbor Health


Kittitas Valley Healthcare


Summit Pacific Medical Center


Summit Pacific Medical Center


Prosser Memorial

Collaborative Team

Paul Kennelly,
Senior Director

Heather Muller,
Administrative Coordinator

Margaret Moore,
Financial and Business Analyst

Elya Prystowsky, PhD,
Executive Director

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

MEMORANDUM

To: Board of Commissioners

From: Don Roberts, B.A., B.S., R.Ph., SIDP

CC:

Date: September 23, 2020

Re: Strategic Department Spotlight – Pharmacy

I first want to say that I am extremely proud to be a new member of the team at Morton Hospital, Arbor Health. I am the quintessential Texan. I was born and raised in Texas and have lived most of my life in Texas. My great great grandfather, Oran Milo Roberts was the Governor of Texas in 1881, which qualifies me to be a member of the Sons of the Republic of Texas. I attended the University of Texas and played in the Longhorn Band and am still a member of the Alumni Band.

However, Morton is the most beautiful place I have ever lived. The people are warm and friendly and have made us feel at home. And the scenery is beautiful. When I interviewed with Leianne, she asked why I wanted to come to Morton. I asked her what the temperature was, and she said 66 degrees. I told her it was 102 degrees where I was and that was in May.

As the new Director of Pharmacy, I bring 50 years of pharmacy experience to the job. My hope is to make our pharmacy the leading hospital in the area.

Pharmacy has changed over the last 20 years. The education now requires 6 years and is focused mainly on clinical activity. It is the Pharmacist job to see that Physicians can make the best use of the pharmacy resources available. Pharmacist are now more patient centered and want to see that patients have a good understanding of the medications they are taking. We maintain a collegial relationship with our physicians and try to help them in any way possible. We have an in-depth knowledge of the law and do our best to see that the hospital and the clinics are prepared for any State inspections or accreditation surveyors.

We hope to add a robust Performance Improvement program to keep our level of performance high and patient safety at the top of our list. After an arduous 2 months to get a Washington license, I have now been the pharmacy the last two weeks assessing what we have and where I can make a difference. Accreditation requires a lot of work and we will do our best to see that the pharmacy meets all the criteria.

Thank you for the opportunity to serve this community. I would be glad to answer any questions you might have.

BOARD COMMITTEE REPORTS

Arbor Health Foundation Meeting Minutes

Tuesday Sept 8, 2020

Online Zoom Meeting

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

Guest: Julie Taylor

Excused: Jaylee Rose

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

President Ali Draper read the mission statement

Julie Taylor, Ancillary Services Director, reported that she supervises the imaging department and housekeeping and also keeps the infection control standards up to date. She ensures that rooms are cleaned and masks and social distancing are maintained. She said that Mossyrock school had made and donated 200 face shields.

August minutes were not attached and were tabled

Treasurers Report was summarized by Diane who said we have a balance of approximately $32,000 and have had no major financial changes. We do expect additional income and expenses because of the Dinner Auction.

Directors Report, Diane Markum: Welcome Packets have been distributed to area Real Estate offices and town halls. Diane has submitted a grant application to Lewis County Economic development for loss of income as a result of the pandemic. Three scholarship applications were approved for Julie Allen, Shelly Harbaugh and Deborah Cole, however the scholarship for Deborah Cole was cancelled due to the pandemic.

Old Business: A discussion was continued regarding the possibility of having a booth at the Farmers Market to allow more interaction with the community. After discussion is was agreed to consider this for next year.

Plans for the dinner auction are moving forward. Diane said director can still contribute baked goods as in past years. She can make certificates for them and the winners can contact the person doing the baking. Donations for the auction are coming in the meal is planned and the website will soon be up.

Ali Draper was given an award for Outstanding Service and Excellence for all of her work for the Foundation.

New Business: Foundation Shirts are available for new members and others who would like them. Prices are $16.25 and $18.25 and another order will be going in soon.

Wes McMahan outlined a new project called the Rose Program. Hospital employees could be recognized for superior care to patients. He will donate $1000 to start the program and will work with Diane to outline how it might work.

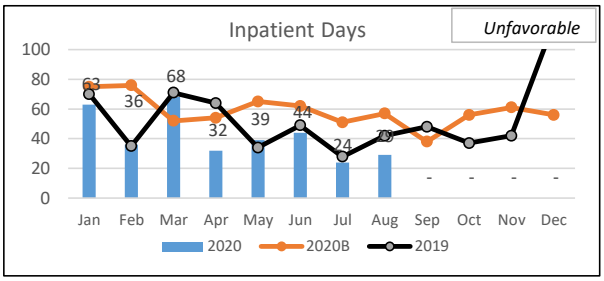
The Foundation has supported the "End of Life Fund" for out of town families that need assistance for the final care of their loved ones. The account now needs $1000 to refund the program. A motion was made to fund the account. Ann Marie/Caro

Diane briefed the Board on Prescription Program which provides assistance for prescriptions for hospital patients who cannot afford to purchase all of their prescriptions upon discharged. Arbor Health has a relationship with Colton's Pharmacy for reduced costs. This, in the end, is in support of the hospital as it reduces return trips to the ER.

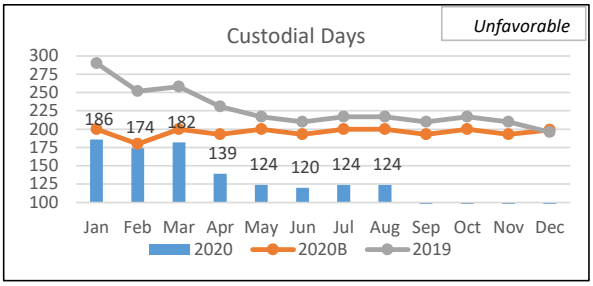
Meeting adjourned 12:45

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

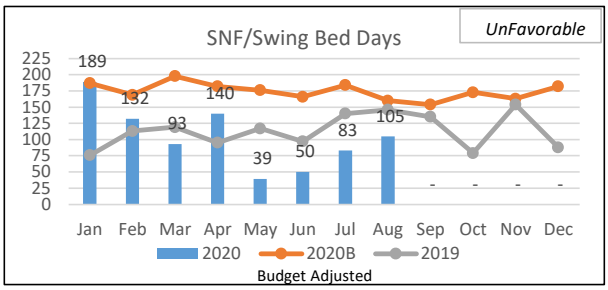
Growth



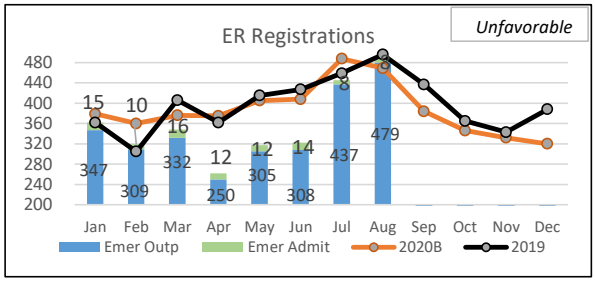
YTD: 335.00 Budget: 492.00 Pr Yr: 393.00



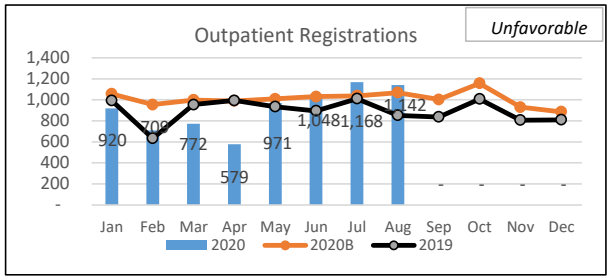
YTD: 1,173 Budget: 1,566 Pr Yr: 1,892



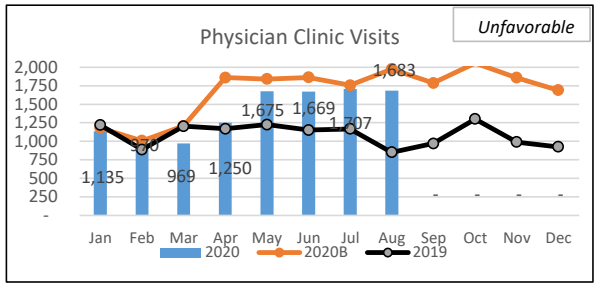
YTD: 831 Budget: 1,422 Pr Yr: 903



YTD: 2767 Bud: 3260 Pr Yr: 3232

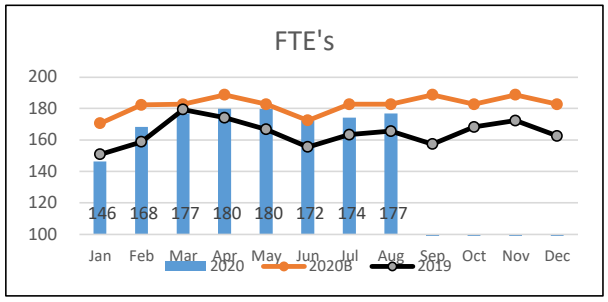


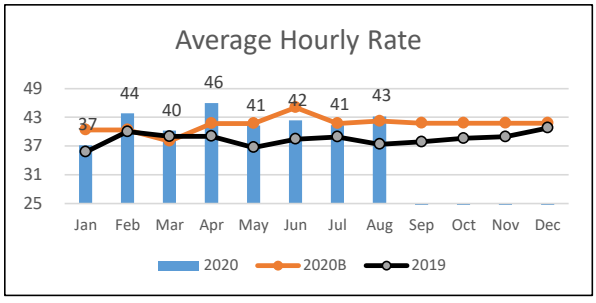
YTD: 7,309 Bud: 8,143 Pr Yr: 7,268

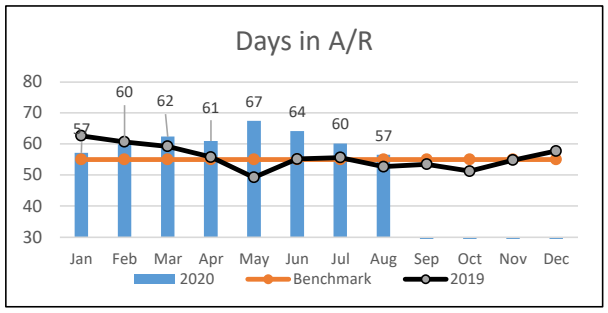


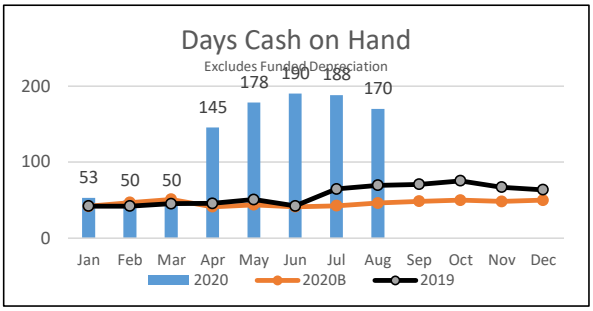
YTD: 11,058 Bud: 12,690 Pr Yr: 8,869

People and Operational Aspects









CONSENT AGENDA

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

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA TOPIC	CONCLUSION	ACTION ITEMS
Call to Order	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 ☒ Katelin Forrest, HR Generalist ☒ Janice Holmes, Medical Staff Coordinator ☒ Diane Markham, Marketing/Communication Manager & Foundation Executive Director ☒ Richard Boggess, CFO ☒ Buddy Rose, Reporter ☒ Joyce Bailey, Case Manager ☒ Dexter Degoma, Interim Quality Manager ☒ Jim Chesemore, Sr Vice President & Principal-PSF ☒ Don Roberts, Pharmacist ☒ Larry Sinkula, Surgical Services Director ☒ Shannon Kelly, CHR	

Approval or Amendment of Agenda	Superintendent Everett requested to add Meeting Date September 30th, 2020 and Diversity Training Discussion to New Business and Meeting Summary and Evaluation prior to adjournment.	Commissioner Schumaker made a motion to approve the amended agenda. Secretary Herrin 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: Commissioner McMahan commended the Board for hosting the Special Board Meeting to hear the District's opinion on discontinuing the Custodial Care Program. Commissioner Schumaker thanked the citizens that were in attendance and reiterated the importance of representing our constituents during these decisions. Audience: None noted.	
Executive Session- RCW 70.41.205	Executive Session began at 3:37 p.m. for 23 minutes to discuss Medical Privileging. The Board returned to open session at 4:00 p.m. No decisions were made in Executive Session. **New Appointments** 1. Montana Blackley, CRNA-Allied Health- (Arbor Health-Anesthesia Privileges) 2. Joseph Freeburg, MD-Consulting- (Providence-Telestroke Privileges) 3. Mimi Lee, MD-Consulting (Providence-Telestroke Privileges) 4. Harrison March, MD-Consulting- (Radia – Radiology Privileges) 5. Karolyn K Moody, DO – Active – (Arbor Health – Emergency Medicine) 6. Kishan Patel, MD-Consulting-(Providence-Telestroke Privileges) 7. Stanford Tran, MD – Active – (Arbor Health – Emergency Medicine) **Reappointments** 1. Mark Hansen, MD-Active- (Arbor Health-Emergency Medicine and Family Practice Privileges)	Commissioner McMahan made a motion to approve the Medical Privileging as presented and Commissioner Coppock seconded. The motion passed unanimously.

	2. Lilith Judd, MD-Consulting- (Providence-Telestroke Privileges) Extending Dr. Quoc Ho's Medical Staff Appointment to March 31st, 2021.	Commissioner McMahan made a motion to approve extending Dr. Quoc Ho's appointment to 03.31.21 and Secretary Herrin seconded. The motion passed unanimously.
Break	Board Chair Frady called for a 3-minute break at 4:02 p.m. The Board returned to open session at 4:05 p.m.	
Guest Speaker	Jim Chesemore with Parker Smith & Feek (PSF) provided an overview of the District's three policies: Malpractice, Employment Practices Liability and Directors & Officers. Jim confirmed the District renewed policies on August 1, 2020 for the next year. Regarding coverage for patients at risk during COVID-19, the waivers are a first line of defense; however, the District has a duty to protect high risk patients, protect their exposure and mitigate care. The District has known risk by offering the Custodial Care Program. Jim shared the impact of COVID has potential to be carved out of the coverage and not be covered by the liability carriers in the future. Jim noted the District can engage Physicians Insurance (PI) risk management team to complete an assessment of the Hospital to identify opportunities for improvement. Superintendent Everett confirmed the District is continually collaborating with PI which includes the waiver the resident's signed.	
Department Spotlight • Diane Markham	Diane Markham provided an overview of the Arbor Health Foundation. Their mission is to invest in the District's employees and equipment through fundraising and events. Diane asked the Board to participate in the 15-Minute Philanthropist, which supports employee scholarships. The upcoming virtual Dinner Auction Maskarades will be online and is October 3, 2020. The Fund-A-Need this year is the CT Project. The Board's participation and attendance is highly encouraged.	

Board Committee Reports • Hospital Foundation Report	Commissioner McMahan commended Diane Markham and her efforts with the Arbor Health Foundation. He thanked Loren and Myrna Davidson for their service to the Foundation and to the White Pass Shopper for their donations to the front-line workers of the Hospital.	
• Finance Committee Report	CFO Boggess highlighted the following: 1. Volumes continue to be low in inpatient, custodial and swing bed areas. 2. ED, Outpatient and Clinic Visits are trending back up towards budget for 2020. 3. Days Cash on Hand is at 188 days, which was built up due to CARES Act monies. 4. Days in AR are trending lower and closer to target. 5. Recommending approval of Resolution 20-36 for a Medicare Payable that was accounted for on the Balance Sheet throughout the year.	
Consent Agenda	Superintendent Everett requested an edit on page two of the August 19, 2020 Finance Committee Meeting Minutes. She requested to edit the agenda item title from Summary & Action Items to Meeting Summary & Evaluation.	Commissioner Coppock made a motion to approve the Consent Agenda with the requested edits and Secretary Herrin seconded. The motion passed unanimously.
Break	Board Chair Frady called for a 3-minute break at 5:27 p.m. The Board returned to open session at 5:30 p.m.	
Old Business • OPMA & PRA Training Certificates	Board Chair Frady requested that all commissioners complete and return completed certificates to Executive Assistant Garcia by the September 30, 2020 Regular Board Meeting. Commissioner McMahan noted he completed the training in February and will not be providing a certificate to the District Office.	Action Item- Commissioner Coppock and Secretary Herrin will complete the OPMA & PRA Training and return certificates by 09.30.20.
• Post COVID Sustainability of Custodial Program	Board Chair Frady opened the floor for further discussion on the Sustainability of the Custodial Program. The Board deliberated the topic and remained focused on quality of care and the safety of our patients and the staff. Superintendent Everett reiterated it is the Board's discretion to discontinue a service line.	Secretary Herrin made a motion to discontinue the Custodial Care Program and Commissioner Coppock seconded. Board Chair Frady, Secretary Herrin and Commissioner Coppock voted yea and Commissioners Schumaker and McMahan

		voted nay. The motion passed. Action Item-The Board agreed to follow state guidelines during the transition period and placement of the residents. Action Item-Board Chair Frady and Superintendent Everett will collaborate on a statement for Buddy Rose, so the Board can provide the same message to the District.
New Business • Board Education	Board Chair Frady requested feedback on the proposed Electronic Signature process. The Board agreed that Executive Assistant Garcia will send text prompts if documents are sitting with anyone for an extended period. The Board requested a department update from IT in early 2021 and a Cyber Risk Plan, since Cyber Security is an important topic in this month's education.	Action Item-Superintendent Everett will assign IT as a departmental update in early 2021.
• September 30th Meeting Date	Board Chair Frady proposed moving QIO Meeting from September 30, 2020 to October 14, 2020 due to it being a Regular Board Meeting date. Commissioners McMahan and Schumaker agreed to the scheduling update.	Action Item-Executive Assistant Garcia will update the calendar by moving the September QIO Meeting to October 14, 2020 at 7 am.
• Diversity Training	Superintendent Everett suggested the Board participate in a 2- hour diversity training in the next sixty days. Board Chair Frady requested the Board email three to four days that would work to do this training by end of business this Friday, August 28, 2020.	Action Item-The Board will email three to four days regarding their availability for diversity training in the next 60 days.
• Board Policies & Procedures	The Board supported marking the following three policies and procedures as reviewed. 1. Quality Improvement Oversight Information 2. Records Retention 3. Superintendent Succession Plan	Commissioner Schumaker made a motion to mark the policies and procedures as reviewed and Secretary Herrin seconded. The motion passed unanimously.

		Action Item-Executive Assistant Garcia will mark the three policies and procedures as reviewed.
Superintendent Report	Superintendent Everett updated the following: 1. The District has been conditionally accepted into the ACO. 2. The District has delayed selling the Elbe Home until we have gained possession of the Morton Duplex Property.	
Executive Session- RCW 42.30.110(1)(g)	Executive Session began at 6:30 p.m. for 30 minutes to discuss the performance of a public employee. The Board returned to open session at 7:00 p.m. No decisions were made in Executive Session.	
Meeting Summary & Evaluation	The Board provided feedback on the meeting packet. Commissioner McMahan questioned the Consent Agenda and will email questions to Superintendent Everett.	Action Item-Commissioner McMahan will email questions to Superintendent Everett regarding items in the Consent Agenda.
Adjournment	Secretary Herrin moved and Commissioner Schumaker seconded to adjourn the meeting at 7:12 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Compliance Committee Meeting
September 16, 2020 at 12:00 p.m.
Conference Room 1 & Via Zoom

AGENDA	MINUTES	ACTION
Call to Order	Compliance Officer Anderson called the meeting to order at 12:00 p.m. **Board Commissioner Present(s):** ☒ Wes McMahan, Commissioner ☒ Craig Coppock, Commissioner **Present:** ☒Roy Anderson, Compliance Officer ☒Shana Garcia, Executive Assistant ☒ Sherry Sofich, Revenue Cycle Manager ☐ Leianne Everett, Superintendent ☒ Dexter Degoma, Interim Quality Manager ☒ Shannon Kelly, HR Director ☒ Richard Boggess, CFO ☒ Sara Williamson, CNO/CQO	
Approval or Amendment of Agenda	None noted.	
Conflicts of Interest	None noted.	
Consent Agenda • **Minutes of May 27, 2020 Compliance Committee Meeting**	The committee did not have any additional edits and accepted the minutes.	Action Item-Executive Assistant Garcia will adjust the meeting time to one hour going forward.
Old Business • **Compliance Review/Work Plan for 2020**	Compliance Officer Anderson shared the 2020 Work Plan, limited due to COVID.	
New Business • **Consultants**	Compliance Officer Anderson utilized the same consultants in second and third quarter regarding the needs of the District.	
• **Public Records Report**	Executive Assistant Garcia noted there was one new public record request in third quarter, but was dismissed. Since the one open request is an	

	in-person inspection of records, those have been suspended until October 1, 2020.	
• **Legal Regulatory** o **Hospital** o **Ambulatory**	Compliance Officer Anderson continues to monitor regulatory requirements due to COVID-19. Compliance Officer Anderson noted he does not have Conflict of Interest forms from Commissioners Coppock and Schumaker and will need them by September 30, 2020. The policy/procedure and form are in Lucidoc.	Action Item-Commissioners Coppock and Schumaker need to complete and return their Conflicts of Interest Disclosure Form to Compliance Officer Anderson by September 30, 2020.
• **Summary Report Compliance Items Review**	Compliance Officer Anderson focused on the following in second and third quarter: 1. Regulations for COVID-19 2. Review Case Management Role 3. Provider Paperwork 4. Medical Records 5. Record Retention PDSA 6. Custodial Care Waivers 7. New Construction 8. Board Minutes 9. Credit Card Policy These items were addressed further in the appendix summaries.	
• **Compliance Department Activity Report & Issues** o **Review/Follow Up Items** o **HIPPA Issues** o **Compliance Issues & Events** o **Hotline** o **Education-Board and Committee Specific**	Compliance Officer Anderson reported there were 57 HIPPA Events in 2020. Primarily email related. There was one reportable to the federal government as a willful disclosure of PHI. There were 37 Compliance Events in 2020. Compliance Officer Anderson noted there was no activity on the website or hotline and the preferred method continues to be in person or over the phone. Compliance Officer Anderson recommended the Board review the Compliance Regulatory Summary in Lucidoc on an annual basis.	Action Item-All Commissioners need to review the Compliance Regulatory Summary located in Lucidoc on an annual basis.
Appendix Summaries	Compliance Officer Anderson attached supporting documentation to the related Compliance Activities for the quarter.	
Next Meeting-December 30, 2020	The next meeting is scheduled for December 30, 2020.	
Adjournment	Commissioner McMahan adjourned the meeting at 12:40 p.m.	

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
September 23, 2020 at 12:00 p.m.
Conference Room 1 & Via Zoom

AGENDA	DISCUSSION	ACTION
Call to Order	Secretary Herrin called the meeting to order via Zoom at 12:02 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 via Zoom ☒ Leianne Everett, Superintendent ☒ Marc Fisher, Community Member ☒ Clint Scogin, Controller ☒ Sara Williamson, CNO/CQO ☒ Don Roberts, Pharmacist	
Approval or Amendment of Agenda	None noted.	Commissioner Coppock made a motion to approve the agenda. Superintendent Everett seconded
Conflicts of Interest	The Committee noted no conflicts of interest.	
Consent Agenda • **Review of Finance Minutes –August 19, 2020** • **Revenue Cycle Update** • **Board Oversight Activities** • **Cost Report Update** • **Financial Statements**	CFO Boggess requested to edit the August 19, 2020 Finance Committee Meeting Minutes on page two by removing complete and replacing with present. The plan is to ~~complete~~ present the 2021 Budget by the September and October Finance Committee Meetings, present to the Board in September and adopt by resolution in November.	Commissioner Coppock made a motion to approve the consent agenda as amended and Community Member Fisher seconded. The motion passed unanimously.
Old Business	Pharmacist Roberts noted the primary function of the pharmacy is to provide counsel to the clinical	

• **Financial Department Spotlight-Pharmacy**	team by providing appropriate medications in the most cost-effective manner. Pharmacist Roberts chairs the Pharmacy and Therapeutics Meeting which is where the formulary is determined. Superintendent Everett reviewed how the pharmacy staffing model has evolved in the past two years to not only support the clinical team, but to provide the best quality of care to our patients. In 2018 we had a 24/7/365 Pharmacist. in 2019 we changed the model by engaging contracted pharmacists and Medication Review for after hours and weekend remote coverage. As of June, we have hired a permanent pharmacist and continue to utilize after hours medication review. This is important to take into consideration while reviewing historical numbers.	
• **August Capital Update**	CFO Boggess highlighted the capital projects in progress or have been completed for 2020.	
• **Disaster Funding Update**	CFO Boggess reviewed the summary of the CARES Act funding. HHS has provided guidance related to reporting requirements and recognition of lost revenue. The lost revenue methodology will be current year vs. prior year volumes instead of current year vs. budgeted volumes. The District will need to recompute this estimate and adjust moving forward. The impact will be in the Other Operating Revenue line. The deadline to use the funds is June 2021. CFO Boggess reiterated the District volume expectations have not been realized due to the response to the COVID-19 pandemic.	
New Business • **Draft 2021 Operating Budget**	CFO Boggess presented the 2021 Operating Budget. The numbers presented are expected to change as the team refines the budget. An updated schedule will be provided at the Board meeting	
• **LED Lighting Plan**	CFO Boggess presented the LED Lighting Replacement project. The cost of the project is $202,858 and the District will receive a grant and a rebate, leaving the District funding approximately $91,346. The quality of lighting will improve. The organization will recognize a savings in reduced power consumption and replacement of bulbs and manpower to service the lights. The Finance Committee supported moving to the Board for approval via resolution.	Action Item-Executive Assistant Garcia will include a resolution in the Board Packet for the approval of the Capital Purchase of LED Lighting.

• **Centralia College Engagement**	CFO Boggess presented the Centralia College Sponsorships where the District will be branding our logo in the Allied Health Services room in the College. This engagement will be for $75,000 and can be remitted evenly over a five-year span. The District has an established relationship with the College and the hope is to recruit staff for clinical areas of the District. This is an investment in both marketing and recruitment. The recruitment is supported by our providing the College with clinical rotations for its students. The Finance Committee supported moving to the Board for approval via resolution.	Action Item-Executive Assistant Garcia will include a resolution in the Board Packet for the approval of the Centralia College Sponsorship.
• **Mobile Health Clinic**	CFO Boggess presented the Mobile Health Clinic (MHC) vision. The District is anticipating we can provide accessible and affordable healthcare by utilizing a MHC and having self-pay patients pay a $25 fee. It is recommended to find a grant to underwrite the startup costs of the program and to be prepared for an operating loss in the future. The District is anticipating the MHC will increase patient satisfaction and establish brand presence in the market. By moving to this delivery model, we will break down some of the barriers like distance and transportation issues. The goal would be to execute this program by third or fourth quarter of 2021. The Finance Committee supported bringing it to the November Board Meeting for a broader discussion.	
Adjournment	Secretary Herrin adjourned the meeting at 1:24 pm.	

WARRANT & EFT LISTING NO. 2020-08

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

$3,930,631.51 this 30th day

of September 2020

Board Chair, Trish Frady

Commissioner, Craig Coppock

Secretary, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of ***$3,930,631.51*** dated ***August 1, 2020 –August 31, 2020.***

Routine A/P Runs

Warrant No.	Date	Amount	Description
118370 - 118371	3-Aug-2020	15,680.79	CHECK RUN
118373	3-Aug-2020	80,520.55	CHECK RUN
118104 - 118111	3-Aug-2020	747,390.64	CHECK RUN
118372	4-Aug-2020	3,303.94	CHECK RUN
118492	5-Aug-2020	2,015.00	CHECK RUN
118374	7-Aug-2020	4,486.52	CHECK RUN
118160 - 118217	7-Aug-2020	110,346.64	CHECK RUN
118375	10-Aug-2020	2,597.48	CHECK RUN
118156 - 118159	10-Aug-2020	15,647.10	CHECK RUN
118218 - 118228	13-Aug-2020	793,633.78	CHECK RUN
118229 - 118306	14-Aug-2020	331,725.98	CHECK RUN
118314	21-Aug-2020	191,658.13	CHECK RUN
118307 - 118313	24-Aug-2020	54,822.83	CHECK RUN
118493	26-Aug-2020	21,858.66	CHECK RUN
118454	28-Aug-2020	691.93	CHECK RUN
118377 - 118445	28-Aug-2020	171,695.33	CHECK RUN
118376	28-Aug-2020	178,918.00	CHECK RUN
118455	31-Aug-2020	980.98	CHECK RUN
Total - Check Runs		$ 2,727,974.28	

Error Corrections - in Check Register Order

Warrant No.	DATE VOIDED	Amount	Description
118220	27-Aug-2020	(4,486.52)	VOID
118224	27-Aug-2020	(397.50)	VOID
TOTAL - VOIDED CHECKS		$ (4,884.02)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$ 2,723,090.26

Eft	Date	Amount	Description
1060	4-Aug-2020	469.43	MCKESSON
1122	7-Aug-2020	164,544.91	INTERNAL REVENUE
	7-Aug-2020	439,020.54	TRANSFER TO SECURITY STATE
1061	11-Aug-2020	72.96	MCKESSON
1062	18-Aug-2020	210.94	MCKESSON
	21-Aug-2020	439,707.46	TRANSFER TO SECURITY STATE
1123	24-Aug-2020	163,449.10	INTERNAL REVENUE
1063	25-Aug-2020	65.91	MCKESSON
TOTAL EFTS AT SECURITY STATE BANK		$ 1,207,541.25	

TOTAL CHECKS, EFT'S, &TRANSFERS	$ 3,930,631.51

DATE PREPARED: Tuesday, September 8, 2020

DATE SENT: Sep 24, 2020

PREPARED BY: Clint Scogin
Clint Scogin (Sep 24, 2020 12:44 PDT)

SUPERVISOR SIGNATURE: Richard Boggess

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
CAPITAL PURCHASE OF LED LIGHTING RESOLUTION NO. 20-37

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 LED Lighting for Morton Hospital, Morton Clinic, Mossyrock Clinic and Randle Clinic. The cost of the project includes consultant planning and design, installation, disposal cost and commissioning. Arbor Health has received grants from Trans Alta and Lewis County PUD to support this project. The purchase price is $207,585 plus contingency of 5%.

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 30th day of September 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

Arbor Health

Washington Rural Health Collaborative

EQUIPMENT ASSESSMENT and REQUEST FORM

SECTION 1 - DEPARTMENT INFORMATION / ITEM REQUESTED

DEPT NAME: Plant Service — DEPT #:

DEPT DIRECTOR: Richard Boggess — PHONE EXT:

GENERAL DESCRIPTION OF ITEM: LED replacement light project at Hospital and Clinic.

REASON FOR PURCHASE (Choose all that apply)

☐ New ☑ Replacement ☐ Broken ☐ End of Life ☐ Quality of Care ☐ Safety ☐ Patient Satisfaction

☐ Increase Volume ☐ New Revenue ☑ Other (explain) Cost Savings and community partnership

Notes about reason for request, effect on department's operations, effect on other departments, and impact of purchase on revenues or volumes :

This lighting replacement project will reduce our operating cost related to lighting by 57%. It will replace our current t-8 fluorescent bulbs and ballast fixtures with more efficient LED lights. The life of the LED bulbs is projected to 7-10 years compared to LED and compact LED bulbs of 2 years. By replacing the bulbs AH will save future maintenance cost as well freeing staff to perform other activities. It is estimated that the will reduce our carbon footprint by 315,735.

DO WE HAVE ANY SIMILAR EQUIPMENT IN THE ORGANIZATION / WHICH DEPARTMENT? ☐ Yes - Provide dept # ☑ No

CAN THIS EQUIPMENT BE UTILIZED BY OTHER DEPARTMENTS? ☐ Yes - Provide dept # ☑ No

The lighting replacement project will impact virtually every area of the main campus and parking lot.

WERE (3) COMPETITIVE QUOTES OBTAINED? (Please attach) ☑ - Yes ☐ No - Please provide reason below

Only 1 vendor has provided this comprehensive type of service including planning, design and implementation service include building the relationship with the granting organization.

SUGGESTED VENDOR: ATS Building Solutions — PREFERRED MODEL #:

NAME/CONTACT OF VENDOR: Moe Salem

ESTIMATED PRICE $: $205,085

SOURCE OF ESTIMATED PRICE: ☑ Quote - (Attach all) ☐ Other - Explain

SECTION 2 – INFORMATION TECHNOLOGY, INFORMATICS, BIOMED AND FACILITIES

Will this purchase interface with our computer system? ☐ Yes - Provide Information below ☑ No ☐ Unsure -

There is not IT system interfaces

FACILITITES INVOLVEMENT	☑ Yes - Provide Information below	☐ No	☐ Unsure
BIOMED INVOLVEMENT	☐ Yes - Provide Information below	☑ No	☐ Unsure
CLINICAL INFORMATICS INVOLVEMENT	☐ Yes - Provide Information below	☑ No	☑ Unsure
IT INVOLVEMENT	☐ Yes - Provide Information below	☑ No	☐ Unsure

Explain and/or quantify any known involvement or expenses in these areas.

This is a turnkey project. The cost of the Hospital is $202,585 with a Grant from TransAlta for $101,139, covering 50% of the cost. There is a rebate from PUD for $10,100 upon completion. The hospital is responsible for the remaining amount of $91,346. In addition the hospital will perform the work for the Morton Clinic update. That cost is $2,500 with a rebate from PUD for $1,120.

EQUIPMENT ASSESSMENT TEAM EVALUATION SUMMARY

PROS	**Improve Hospital lighting - reducing maintenance cost**
CONS	Timing is bad due to COVID 19 uncertainty
CONSIDERATIONS	The Grant from TransAlta covering 50% of the cost and PUD rebates contributing to reduce cost. Project would need to complete prior to Emergency Power project in 2021
RECOMMENDATIONS	Recommend moving forward with project

ADDITIONAL ACQUISITION/ PREP COST $	$ -
ADDITIONAL PREP/ TRAINING HOURS	0

COMMENTS	

BASE EQUIPMENT PRICE - AS PROVIDED	$ 205,085.00
SUPPORT AND MAINTENANCE COSTS	
ADDITIONAL INSTALL OF SUPPORT COST	
TOTAL ADDITIONAL ASSOCIATED COST	
TOTAL MONTLY CONSUMABLES COST	
MISC EXPENSE	
MISC EXPENSE	
TOTAL NON- RECURRING EXPENSE	$ 205,085.00
TOTAL RECURRING EXPENSE	$ 205,085.00

****** FOR FINANCE DEPARTMENT USE ONLY ******

HOW ARE WE PAYING FOR THIS? 50% from Grant from Transalta and PUD. Remainder is Hospital Capital Budget

IS THIS BUDGETED ☐ Yes ☑ No

BUDGETED PURCHASE DATE 10/1/2020

DEPT FOR DEPRECIATION Plant Services

TYPE OF EQUIPMENT

☐ Building Improvement ☐ Capital Lease ☐ Building

☑ Major Moveable ☐ Fixed Equipment ☐ OTHER (explain)

****** APPROVALS ******

Chief Financial Officer _____ Date

Chief Executive Officer _____ Date

Board of Commissioner Chairperson _____
if > than $30,000 Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
ENGAGEMENT W/CENTRALIA COLLEGE RESOLUTION NO. 20-38

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 sponsorship of $75,000 to Centralia College for marketing and recruitment purposes.

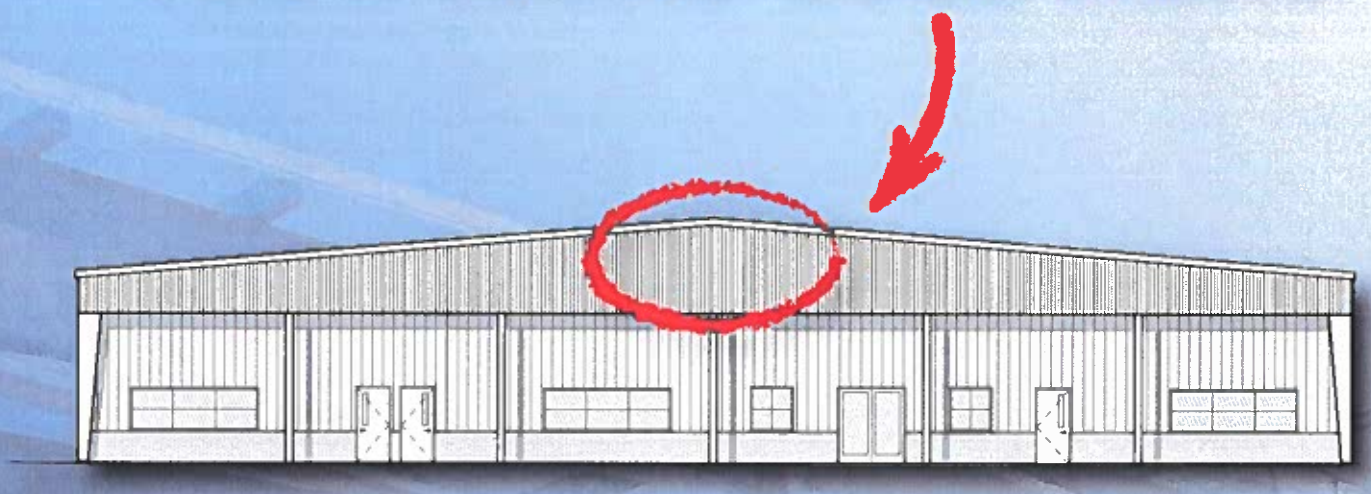
ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 30th day of September 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

YOUR NAME GOES HERE!



Make a permanent impression in our community.

Students and leaders from regional industry, our local communities and traditional college students will reference and benefit from the impact of this building - your name can be synonymous with that impact.

$250,000 permanent building rights.
Payment options available.

Let the community know you care.

Put your name in these rooms for students to see for generations.

Price is $75,000 per room or industrial area.
Payment options available.

	Approved Documents Pending Board Ratification 09.30.20	Department
	Arbor Health's Policies, Procedures & Contracts	
1	2010 A and B Bonds	Finance, Bonds, Lines of Credit
2	2012 Refunding Bond	Finance, Bonds, Lines of Credit
3	ASA CLASSIFICATION SYSTEM	Anesthesia Services
4	Acute Hyperkalemia Protocol	Pharmacy (Medication Management)
5	Adenosine Protocol	Pharmacy (Medication Management)
6	Agreement for Placement of Student Nurses Between Indiana State University & MGH	Affiliation Agreements
7	Autoclave Monitoring - Biological Testing and Chemical Indicators	Sterile Processing
8	Baylor University OTD Clinical Affiliation Agreement	Affiliation Agreements
9	Bowie Dick Test Verification	Sterile Processing
10	Britt Medical Search Agreement	Search Agreements
11	CHOICE Addendum A	Membership Agreement
12	CMC- Clinical Management Consultants	Search Agreements
13	Calcium Chloride / Gluconate Protocol	Pharmacy (Medication Management)
14	Care and Service of Order Transmission System-Telepharmacy	Pharmacy (Medication Management)
15	Cleaning Autoclavable Equipment Prior To Autoclaving	Sterile Processing
16	Cleaning Equipment Brought Into The Operating Room	Surgery
17	Cleaning of Rigid Laparoscopes and Cystoscopes	Sterile Processing
18	Clinic Instruments (Cleaning & Transport)	Sterile Processing
19	Controlled Substance for Acute Pain in the Emergency Department	Pharmacy (Medication Management)
20	Controlled Substances for Chronic Pain in the Emergency Department	Pharmacy (Medication Management)
21	Crash Cart Monitoring and Unit Inspections	Pharmacy (Medication Management)
22	Custodial Consult/Doctor Visits	Non-Skilled Swing
23	Dr. Devin Spera, MD	Professional Services Agreement

24	Dr. Esther Park-Hwang-Specialty Clinic	Employment Agreements
25	Dr. Jeff Ford-ED	Employment Agreements
26	Dr. Karolyn Moody, DO Physician Employment Agreement	Employment Agreements
27	Dr. Stan Tran Employment Agreement	Employment Agreements
28	Dr. Tom Anderson, M.D.	Employment Agreements
29	Electrosurgery Safety In the O.R.	Surgery
30	Evidence Based Clinical Practice	Department of Nursing
31	FoxHire, LLC Client Services Agreement	Contracted Services
32	GI Procedure Attire	Surgery
33	Gemini Diversified Services, Inc	Credentialing
34	Global Healthcare Services Search Agreement	Search Agreements
35	Heart & Soul Healthcare	Search Agreements
36	Imaging Downtime	Radiology/Medical Imaging
37	Implantable Traceability	Surgery
38	JT Consultant & Development, LLC Agreement & BAA	Service Agreements
39	Jeremy Lausch Sleep Studies Scoring	Contracted Services
40	Kaiser Foundation Health Plan of WA-Hospital	Kaiser
41	Kaiser Foundation Health Plan of WA-MMC	Kaiser
42	Ketone (Acetone) Test	Chemistry
43	LC PUD Dark Fiber Lease Agreement-Exhibit B	Information Technology Services Agreement
44	Lorazepam Drip Protocol	Pharmacy (Medication Management)
45	Lucidoc Document Control and Management	Administration
46	MGMA Data Dive Agreement	Information Technology Services Agreement
47	Managing Emergency Department Excess Volume	Department of Nursing
48	Operating Room Coverage	Surgery
49	PARA Pricing Transparency Tool	Contracts
50	Pacific Lutheran University Education Experience Agreement	Affiliation Agreements
51	Pacific Northwest University AAMC Uniform Clinical Training Affiliation Agreement	Affiliation Agreements
52	Patient Bill of Rights	Clinics
53	Patient Responsibilities	Clinics
54	Pharmacy Access Policy	Pharmacy (Medication Management)

55	Physicians Services for Custodial Care	Non-Skilled Swing
56	Quality Improvement Oversight Information	Governing Body (Board of Commissioners)
57	Radiation Safety In Surgery	Surgery
58	Rapid Response	Department of Nursing
59	Records Retention	Governing Body (Board of Commissioners)
60	Refrigerator Temperature Checks	Department of Nursing
61	Reporting of Alleged Abuse	Department of Nursing
62	Reproductive Health Care	DOH Policies & Procedures
63	Seattle Pacific University Educational Affiliation Agreement	Affiliation Agreements
64	Social Networking Policy	Human Resources
65	Sterile Processing Traffic Control	Sterile Processing
66	Steris System 1e Processor Operation	Sterile Processing
67	Superintendent Succession Plan	Governing Body (Board of Commissioners)
68	Surgical Attire	Surgery
69	Telecommuting	Human Resources
70	Timer Verification	QC/QA
71	Tonya Goodson, ARNP Employment Agreement	Employment Agreements
72	Travis Podbilski, DO Employement Agreement	Employment Agreements
73	Ultrasound Endovaginal	Radiology/Medical Imaging
74	Vancomycin per Pharmacy Protocol	Pharmacy (Medication Management)
75	Victoria Acosta, DO Employment Agreement	Employment Agreements
76	Visitors in the Emergency Department	Emergency Services
77	WA DOH Cares Act Contract HSP25231-0	Interagency Agreement
78	Zoledronic Acid (Reclast) Protocol	Pharmacy (Medication Management)

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

OLD BUSINESS

NEW BUSINESS

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 9/22/2020
Subject: Consent Agenda

Consent agendas are designed to allow boards to condense routine business actions into one agenda item. This allows the board to conduct business more effectively and more efficiently. To be effective, structure should be in place when using consent agendas.

- The Chair decides which items are placed into the consent agenda.
- The Consent Agenda is distributed with supporting documents in a timely manner to allow board members to read and review.
- Board members may ask for agenda items to be moved (or pulled) out of the Consent Agenda for regular discussion.
- The Chair may elect to address the matter immediately or move it to New Business or Old Business for regular discussion.
- Once no items are to be removed, the best practice is to read aloud the remaining consent agenda items.
- The Chair can move to adopt the Consent Agenda. Hearing no objections, the Chair can announce that the Consent Agenda is adopted without a vote being necessary.
- The minutes should include the full text of the resolutions, reports and recommendations adopted as part of the consent agenda.

Arbor Health purposely put the board sub-committee reports before the Consent Agenda. This was done because the sub-committee is the "working arm" of the full board, thus allowing governance work to be done during the Regular Board Meeting. Any resolutions that are recommended by a sub-committee will be placed in the Consent Agenda unless the resolution is expected to be controversial. Otherwise, the sub-committee minutes and verbal report is expected to provide enough information to the board members to allow for an expedited decision in the consent agenda.

COURSE TRANSCRIPT: INTRODUCTION TO QUALITY

Experts:
Barry Bader
Todd Sagin, M.D., J.D.
Brian Wong, M.D.

INTRODUCTION

WELCOME TO THE INTRODUCTION TO QUALITY.

IN THIS COURSE, OUR QUALITY EXPERTS COVER: THE HISTORY OF QUALITY; QUALITY AS A CORE RESPONSBILITY; PHYSICIAN CREDENTIALING; SIX AIMS THAT DEFINE QUALITY; THE IMPACT OF HEALTHCARE REFORM; AND THE QUALITY COMMITTEE.

BARRY BADER IS A CONSULTANT, SPEAKER AND FACILITATOR SPECIALIZING IN THE GOVERNANCE OF HOSPITALS AND HEALTH SYSTEMS INCLUDING BOARD RETREATS, GOVERNANCE ASSESSMENTS AND RESTRUCTURING AND REDESIGN INITIATIVES.

Barry Bader: Many board members come to their position as a director or a trustee very familiar with financial and business aspects of running an organization, and probably the least comfortable area—the one where they have the least confidence in their own abilities—is in overseeing the quality of care in the hospital and the quality of care delivered by physicians. What any board member of a healthcare organization needs to understand is their oversight responsibility for quality is absolutely as important as their responsibilities for finance, for business, for organizational integrity, as important as anything else that they may do. There is nothing more fundamental to board members' responsibility than their responsibility for the quality of care that is delivered in the organization.

HISTORY OF QUALITY

TODD SAGIN IS BOTH A PHYSICIAN EXECUTIVE AND AN ATTORNEY, AND IS RECOGNIZED ACROSS THE NATION FOR HIS WORK WITH HOSPITAL BOARDS, MEDICAL STAFFS AND PHYSICIAN ORGANIZATIONS.

Todd Sagin: When we consider the history of quality improvement efforts in hospitals, it is helpful to go all the way back to the early 20th century. That was a time when hospitals were just starting to be meaningful places in which to receive care. In fact, before that you had less than a 50/50 chance of surviving the encounter.

In the late 20th century, there were quality improvement activities taking place in other parts of the American economy that we began to import into healthcare. These went under names like Total Quality Assurance and Continuous Quality Improvement. In 1999, the healthcare industry was shocked when the Institute of Medicine issued a report suggesting that we have maybe as many as 100,000 preventable deaths in our hospitals every year. This was just stunning information. And it has since been substantiated by a wealth of studies and research.

In the wake up that initial report by the IOM, we saw a plethora of quality initiatives taking place in American hospitals and healthcare institutions. Many professional societies have created coalitions to sponsor them. There has been a ton of research and an explosion of academics that are focused on quality improvement.

Despite all those activities, the advancement of patient safety has been slow in our hospitals, and one of the pieces that is considered critical and, perhaps, missing from much of this time period I'm talking about is board leadership. Boards were focused on finance, they were focused on philanthropy, capital development, but they weren't focused on quality. And so over the past decade we have made a huge effort in our institutions to get our boards to take a leadership position with regard to patient safety and quality.

QUALITY AS A CORE RESPONSIBILITY

Bader: One of the reasons that boards have such a hard time with quality is they approach it almost as if it were "how do we combat world hunger." The issue is so large and it is, in some ways, so foreign to what their backgrounds are that the task can seem overwhelming.

If you look at the fundamental roles of a board: boards plan, they establish goals, they oversee performance, they make major decisions and they connect to the community or to the stakeholders of the organization. Take that as an overlay and put that on the board's quality responsibilities, and suddenly this very difficult responsibility becomes much more manageable.

So the first thing that a board has to do is to plan, and to plan, it needs to have a basic understanding of what is healthcare, what is this organization. How does it go about doing what it does? How do we deliver patient care every day? And then, what is our plan for measuring and improving the quality of care? What are the major things that we are going to work on and improve and why have we chosen to do that? That is the planning and goal-setting aspect of the board quality responsibility and it is typically done on an annual and ongoing basis.

The second task is oversight. Oversight is a combination of metrics and engaged conversations. The metrics are the key measures of quality, of clinical quality outcomes as well as process, the measures of how well we are providing access to the community, how easy it is for patients to

get appointments, how satisfied they are with their care and the experience that they have. All of those are among the key measures of quality.

But simply looking at a set of numbers or charts on paper is not a board overseeing quality. To do that there has to be an engaged conversation between and among board members and senior management and clinical leaders of the organization to understand what is behind the numbers.

Periodically a board may be called upon to make some significant decision that relates to quality. It may be making an investment in some quality-related information technology. On occasion the board may also be asked to make a very hard decision relating to the credentials of a physician. Those are examples of the decision-making responsibility of the board.

Finally there's that connection to the community, the diplomatic role as it relates to quality. Hospitals are often their own worst salesmen to the community about what a fantastic job they are doing, not just at delivering quality but also in assuring quality. For many years it was industry that competed for the Malcolm Baldrige National Quality award. Now there is a healthcare award, and hospitals and health systems are now among the leaders in this country in applying continuous improvement techniques, Six Sigma techniques to clinical care and making dramatic improvements in clinical care. That's done by clinicians and managers, but it is done with the leadership and commitment of the board.

Sagin: Historically we have relied on the medical staff to make sure that there was high quality care delivered in our hospitals, and if the board was able to assure that there was a high quality, competent medical staff, that was considered adequate. The board didn't really need to look beyond the credentials of the physicians when it thought about quality of care.

However, over the last ten to fifteen years, we have become concerned that that alone has not raised the bar for quality in our institutions. And that there is more that is necessary to change the culture of our institutions and the systematic processes in our institutions to assure that safer care, higher quality care is actually achieved.

It is the board's responsibility to make sure these things happen. This is critical to the mission of the institution, and the board has to take a leadership role. In fact, many people feel that it is because boards have not been out front providing such a leadership role that we haven't made more progress. Physicians, for example, typically focus on care for their individual patients. They tend not to be focused on the broader institution and how it functions to assure safe care. Without the board prodding them and leading the way and setting benchmarks and expectations, it is hard for the rest of the institution to rally around the significant changes that are necessary to instill a culture of quality in our hospitals.

PHYSICIAN CREDENTIALING

Bader: Today what is the board's responsibility with regard to the quality of the medical staff and particularly with regard to the initial credentialing of physicians, their appointment and initial privileges to the staff and their periodic reappointment, at least every two years? There are some hospitals that have a small medical staff—five, ten, twenty, thirty physician members—and theoretically, the board could get into great detail reviewing the backgrounds of each and every one of them. On the other hand, there are hospitals that have hundreds of physicians on their medical staff. There is no way that the board could get into detail on all of them. In either situation, regardless of whether a medical staff is very small or very large, a board should not try to do detailed review of the qualifications on every single doctor.

The board's job in the area of credentialing oversight, as it is with finance, is to know that there is an effective mechanism in place. For credentialing, that means that the board is satisfied that the medical staff has a very thorough process of gathering all essential information about a physician's background; training; their current performance; their malpractice suits; whether they've had any difficulties elsewhere; their behavioral competency; and how well they work with others, which is absolutely critical to quality patient care. The board should be satisfied that the medical staff has a good, thorough, effective process for looking at all of that on each individual physician, and that their recommendations when they come to the board to appoint a physician, reappoint a physician, grant privileges for this procedure or not for that procedure, are based on a sound and thorough and diligent review.

SUMMARY

QUALITY IS A CORE RESPONSIBILITY OF THE BOARD.

THE BOARD OVERSEES THE PLANNING AND GOAL SETTING OF THE QUALITY IMPROVEMENT PROCESS, MAKING SIGNIFICANT DECISIONS AND ENSURING THE ORGANIZATION HAS A QUALITY FOCUS AS IT CONNECTS WITH THE COMMUNITY.

PHYSICIAN CREDENTIALING IS ONE WAY A BOARD ENSURES THE ORGANIZATION IS COMMITTED TO QUALITY. THERE MUST BE AN EFFECTIVE MECHANISM IN PLACE, AND IT MUST BE FOLLOWED, TO CREDENTIAL AND PRIVILEGE PHYSICIANS PRACTICING IN THE HOSPITAL.

SIX AIMS OF QUALITY

BRIAN WONG, PHYSICIAN AND CHIEF EXECUTIVE OFFICER OF THE BEDSIDE TRUST, ASSISTS ALL LEVELS OF HEALTHCARE PROVIDER ORGANIZATIONS TO BECOME ADEPT AT RECOGNIZING AND CURING THEIR OWN FOUNDATIONAL PROBLEMS—PRIMARILY BY CONNECTING LEADERSHIP PRACTICES TO PATIENT-CENTERED CARE.

Brian Wong: The IOM report, *To Err is Human,* was followed about two years later by a second work that was called *Crossing the Quality Chasm*. It laid out the chasm that exists between our current state and this ideal state, and they thought that the divide was so great that they just literally said it's a chasm, there is almost no way to bridge it.

And so rather than address the solution, they identified six aims. These are known as the Six Aims of the Institute of Medicine. They've been broadly adopted as a goal for American healthcare today.

The acronym for the Six Aims spells out the word STEEEP, with three Es. S is safe; T is timely; the three Es are efficient, effective, and equitable; and P stands for patient centered. These six aims have become the backbone of how we assess and measure quality. That is to say, healthcare must be safe. It must be timely. It must be efficient. It must be effective. It must be equitable, and it must be patient centered. So that's almost the formation of a quality dashboard for a healthcare organization.

You might ask yourself as far as these six aims, is that really in the domain of the board, is that what the board should be focused on? Isn't that what the doctors do? Didn't this report really originate from the medical profession? Shouldn't it be their responsibility? And the short answer is yes, and it also comes back to the board because the board is the ultimate authority. The board delegates responsibility to the medical staff, through the medical staff organization, through the medical executive committee, through a department structure, to look at quality, but the board is responsible for how it performs in quality.

You must have a working knowledge of what matters in healthcare, what's being measured, how we are doing. That's really your ultimate responsibility—to oversee the performance of the organization.

And within the six aims of the IOM, those six things, is everything a board should care about. That is why you exist as a board, as a fiduciary, to be responsible on behalf of patients, to make sure those six things are taken care of. That is the quality agenda, but I would argue that is also the board's agenda. If those things function well, you should have a well functioning hospital that also does well financially.

QUALITY AND HEALTH REFORM

Bader: The healthcare system is in the midst of not merely change, but many people believe transformation in the way that we pay for medical care and, as a result, in the way that we deliver medical care. We have predominantly had in this country a fee-for-service-based system. Generally, insurers as third parties and government as the provider for the elderly and the poor paid individual fees to doctors, paid fees to hospitals for visits and procedures. And while there certainly are benefits to a fee-based system, one of the financial incentives [under a fee-based system] is to reward volume—the more you do, the more you are paid. And perversely, if a patient goes into the hospital and they suffer an adverse occurrence, or they develop a hospital acquired infection, perversely and traditionally hospitals and doctors would provide more services to help them get better and they would get paid more.

This system is one that we as a country cannot afford any longer and so no matter what happens in Congress and in state capitals with some specific pieces of healthcare reform legislation, there is a general consensus that we are going to be changing from a payment system that has been volume driven by fee-for-service payments to a system that will be value driven. Hospitals, physicians and other providers along the continuum of care are going to be paid more based on value; that is, how efficiently they are able to provide high quality outcomes and excellent patient service and excellent patient experience.

So, we are more likely to see insurance carriers and government take populations of patients with certain kinds of medical conditions and provide a global budget to a network of hospitals, physicians and other providers to be able to provide care. We're going to change from paying for volume to paying for value.

That is going to fundamentally, over time, affect the work of the hospital and health system governing board and their quality committee. How might that change? Well, value based care is going to be heavily driven by best practices for treating these particular kinds of patients. So the board and the quality committee will be looking very much at are we embracing best practices and how well are we following best practices.

They will also want to raise the culture question, are we flexible as we apply best practices so we never lose sight of the needs of individual patients? And do we provide sufficient discretion for physicians to, when justified, deviate from a protocol? The last thing we want is cookbook medicine. What we want is patient-focused care. Boards are going to be looking more at that; quality committees will look more at that.

Wong: I think there's an old conventional wisdom that many supported which was low cost equals low quality, and the paradigm shift that must occur is that we have to reduce waste and improve quality, and both must happen. There is an incredible amount of duplication and waste that exists in our healthcare, so I would like to look at the overall cost equation, not so much do less care, but do less redundant care, do less harmful care, do less care that's unnecessary and that's how you take cost out. When you do those things, those are fundamental key drivers to improving quality, because how can you say something is quality if it's redundant or wasteful or inefficient or any of those things? So we have to get ourselves in a conversation that says both must occur and neither is mutually exclusive. That is to say, low cost does not equal low quality and, in fact, in the future, the way we may measure this is to say that high quality and low cost must occur together.

Bader: Many boards ask how can they possibly establish specific targets for quality when it is the area in which they feel the least confident of their knowledge and background. A board should not be coming up with quality targets on its own. It should be looking to its administrative and medical staff leadership to recommend quality goals and targets. But the board should not be blindly approving those, any more that it would blindly approve a target for a bond rating or for the operating margin or for the return on investment in the financial area. A board ought to be asking, how do these goals compare with national patient safety

goals, with quality goals, how in fact does our patient safety and our quality compare? Are we among the leaders, are we in the vast middle, or are we among the laggards? Where did we come up with these numbers to set our goals? Why have we chosen the goals that we have chosen? Board members should be well equipped to be able to ask those questions and evaluate the answers.

SUMMARY
THE INSTITUTE OF MEDICINE RELEASED TWO SEMINAL REPORTS ON QUALITY IN THE LATE 1990S AND EARLY 2000S. THESE REPORTS ENERGIZED HOSPITALS IN THEIR QUALITY IMPROVEMENT EFFORTS.
THE IOM IDENTIFIED SIX QUALITY AIMS: SAFE, TIMELY, EFFICIENT, EFFECTIVE, EQUITABLE AND PATIENT-CENTERED.
AS A RESULT OF THESE REPORTS, BOARDS SAW THEIR ROLE IN QUALITY EMPHASIZED AND MORE CLEARLY DEFINED.
UNDER HEALTH REFORM, THE FOCUS IS ON VALUE – BOTH IN TERMS OF COST AND QUALITY.
HOSPITALS AND PHYSICIANS WILL GET PAID BASED ON EFFICIENCY IN DELIVERING CARE, AND ALSO THE QUALITY OF THAT CARE. THE NEW SYSTEM WILL BE DRIVEN BY "BEST PRACTICES," AND WILL REQUIRE A PATIENT-FOCUSED APPROACH. ONE OF THE OVERALL GOALS IS TO HAVE LESS REDUNDANT CARE.

THE QUALITY COMMITTEE

Bader: We are used to seeing boards have finance committees. Traditionally, hospital and health system boards did not have quality committees, but if quality is as important a responsibility as finance, and if there is a need for the board to really understand how quality is being assessed and assured and how physicians are being recommended for appointment or disciplinary action, there is a need for a committee that can develop a fuller understanding to do the hard work and to bring well-documented recommendations to the board. That is the work of a quality committee.

Who should be on a quality committee? The answer, of course, will differ among hospitals. Generally, it is a mix of several physicians who have a strong interest in quality and who would be willing to challenge the recommendations and thinking of their own peers on the medical staff in order to make sure that the medical staff's own credentialing and quality review processes are meeting the expectations of the hospital's mission and commitment to the community.

Second, there should be members of the governing board who could also be physician members of the governing board, but at least some should be non-physicians. They should be community members who have the skills and the background, not necessarily in healthcare quality, but in management, in leadership, in law, to be able to understand complex medical information and to be able to ask hard and fair questions of the information that they are seeing.

Third, the executive leadership of the hospital should be on that committee. The chief executive officer, sometimes the chief operating officer, almost always the chief nursing officer and if there is a physician chief—a chief medical officer—that individual should be there, not

necessarily as a voting member of the committee but as a primary staff member to the committee.

Wong: The quality committee in my opinion is the most important committee of all because it goes to the heart of the matter. It goes to why we're in this business, which is to take care of patients, ergo improve quality and reduce harm to the patients to whom we are providing care.

The reason there is value in a board quality committee is you have dedicated expertise, dedicated focus on that one subject, just as you have dedicated experts on an audit committee or strategic planning committee or a finance committee. This requires some dedicated effort, and I think all board members probably need to take a turn on the quality committee to understand how it works, what is being asked and how it conducts itself.

It meets as a separate committee at a separate time from the board so that you can feel you're digging deeper; understanding quality; understanding what's being done; how it's being done; and how you can influence what the hospital's agenda is in quality and shaping it so that it meets with the board's overall objectives.

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

COURSE TRANSCRIPT: PHILANTHROPY

INTRODUCTION

WELCOME TO THE MISSION AND STRATEGY COURSE: PHILANTHROPY.

IN THIS COURSE, OUR EXPERTS WILL COVER: THE IMPORTANCE OF PHILANTHROPY FOR TODAY'S HOSPITALS; DIFFERENT FUND DEVELOPMENT MODELS; THE ROLE OF TRUSTEES; THE ROLE OF PHYSICIANS; FUNDRAISING STRATEGIES; RESTRICTED VERSUS UNRESTRICTED FUNDS; AND HOW TAX REFORM AND HEALTHCARE REFORM MAY AFFECT YOUR ORGANIZATION'S PHILANTHROPIC EFFORTS.

1. OVERVIEW

WILLIAM MCGINLY IS PRESIDENT AND CHIEF EXECUTIVE OFFICER OF THE ASSOCIATION FOR HEALTHCARE PHILANTHROPY, AN ORGANIZATION DEVOTED TO FUNDRAISING, PUBLIC RELATIONS AND MARKETING FOR NON-PROFIT HEALTH CARE PROVIDERS.

William McGinly: If you really consider all that not-for-profit hospitals have been, and we go back to the turn of the last century, what you find is that hospitals started off as almshouses. Medicine in a hospital was totally dependent upon philanthropy—the giving nature of a community—to provide care for those who could not afford it.

ELIZABETH MILLS IS A SENIOR COUNSEL IN THE CHICAGO OFFICE OF PROSKAUER, AN INTERNATIONAL LAW FIRM, AND A MEMBER OF THE FIRM'S HEALTH CARE DEPARTMENT, FOCUSING ON HEALTH CARE ORGANIZATIONS AND TAX EXEMPTION ISSUES FOR NOT-FOR-PROFIT ORGANIZATIONS.

Elizabeth Mills: Many years ago, hospitals were funded primarily by gifts from the public. There weren't other sources of payment for medical services except for those relatively wealthy individuals who were able to pay for their services. Today, that is not the case. We have many sources of payment for hospital services: Medicare, Medicaid, private insurance, many other types of programs. So philanthropy accounts for only a very small part of hospital revenues today. That doesn't mean it's not important.

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

Marian Jennings: We will see a resurgence of the importance of philanthropy for hospital financial viability and, specifically, for major projects for the hospital. When hospitals first

started as non-profit organizations they often had benefactors. We then got into the world of complex payment—Medicare and Blue Cross and many different insurance companies—and we started relying appropriately on those who used our services to pay for the hospital and allowed us to flourish. But in the world we are facing, with cutbacks on payment from the federal and state level, Blue Cross plans, other private insurance plans, many organizations will not be able to generate internally or through borrowing sufficient capital to meet their needs for growth and development to invest in new technology, to put in that new information system, to go to a more modern emergency room. They will have to rely on philanthropy.

LISA GOLDSTEIN IS SENIOR VICE PRESIDENT AND TEAM LEADER OF NOT-FOR-PROFIT HEALTHCARE RATINGS WITH MOODY'S INVESTORS SERVICE.

Lisa Goldstein: There are three primary ways not-for-profits can fund their capital strategy. Let's say a hospital wants to build a new patient tower or it wants to buy new high-end equipment for patient care. The three major avenues or ways to fund that capital would be debt; for example, tax-exempt bonds on the market to fund the new tower. It could be from cash flow—basically you take your earnings from your operations and you use it to fund the capital, so you earn it the old fashioned way through cash flow. Finally, the third would be through fundraising and through philanthropic efforts.

Many hospitals have a fundraising division or a fundraising arm that launches campaigns for hospitals, or they have annual ongoing giving programs to the not-for-profit hospitals. That is distinctly different from the for-profit hospitals. Usually people don't give, donor wise, to for-profit hospitals—because they are for-profit. They are not a 501(c)(3).

So 501(c)(3) not-for-profit hospitals have that third leg of fundraising, and depending on the size of the hospital and the sophistication of the hospital, the fundraising division can be very sophisticated and well developed. So fundraising is a very viable method or vehicle for funding capital needs.

McGinly: Two years ago in the United States, our members raised approximately $8.6 billion in philanthropic support. That is only a day or two of the overall cost of healthcare delivery in our country. But it is making a crucial difference—location by location, community by community—depending on the needs of that community and the programs, the equipment, the availability, the access to care.

You will find, too, that in almost every building project in a not-for-profit hospital, there is an element or proportion of philanthropy that is contributing to providing service through the physical plant, through the equipment, through the nurse training, through physician training and a variety of other programs as we meet the needs of various communities.

2. FUND DEVELOPMENT MODELS

McGinly: The models for fund development and philanthropy have evolved over the years. In the 60s, hospitals really were not terribly active in philanthropy. The focus was more on the business operation of the hospital, covering the cost. Hospitals provided a service, added a profit and a third party paid. Those were wonderful times, at least financially.

During that same period of time, when Medicare and Medicaid came in, [the government] said, "Oh well, if you are raising money, if you have philanthropic support, we are going to reduce the Medicare and Medicaid reimbursement we give you by whatever amount you raise." So, as we are all human beings and want to make things work to our advantage, many hospitals established foundations to keep that money separate and apart so that it would not present the opportunity for an offset in their operations.

About 72 percent of not-for-profit hospitals operate in what is a foundation mode: an institutionally related foundation that has links and controls tied to the hospital. Money is separate and apart. It is invested by a group of people who serve on a board, who are devoted to the fundraising, not the operation of the hospital. So that makes it exclusive. Having a board allows us to attract significant people in the community to serve. But the separate part of it is very advantageous and very comforting to an awful lot of donors.

The second part is simply a hospital that has a philanthropy department within the hospital. The hospital, a 501(c)(3), can give charitable receipts for donations and it operates quite nicely. It depends on the size of the hospital.

A third structure we have is one that introduces a system level program. In the late 90s, many hospitals went into a system approach—mergers, acquisitions. For the most part, you have a foundation or a hospital fundraising committee in each hospital [in the system] because fundraising is local and people want to know where their money is going. But the system level is yet another level in the ownership of all these deliverables. An awfully lot of back office work, annual fund, mailings are coordinated through [the system]. Those are primarily the three structures we see today.

Mills: The corporate relationship of the separate foundation to the hospital is something that varies widely as well. If you are in a health system, both the foundation and the hospital may be controlled by the parent organization, so the hospital and foundation are brother-sister organizations. In other cases, the foundation may be a subsidiary of the hospital. In other cases, it may have no formal governance relationship to the hospital whatsoever, yet it still exists to serve the needs of the hospital.

Many hospitals have a separate fundraising foundation that is separately incorporated. It has its own tax exemption. It files its own Form 990 and it has the same reporting duties to the

public. It has its own board, and its purpose in life is to raise money for hospital purposes and to hold that money if it is not needed immediately.

If the hospital has a development department and not a separate foundation, then as board members, you are responsible for that function as well as the operation of the hospital. If there is a separate foundation, those board members, who may include many of the same people as the hospital board, are responsible for that function. But in either case, the mission is the same, which is to support hospital activities.

McGinly: The relationship between the two boards, the hospital board of trustees and the foundation board of trustees, is a crucial one.

The hospital board is clearly responsible for providing for the management and the operation of the hospital itself, and all of the intricacies that go into delivering care. The relationship between the two boards is very crucial on a communication level. What we often find is that the CEO of the hospital serves *ex officio* on the foundation board. The chair of the hospital board serves *ex officio* on the foundation board. The chairman of the foundation board also will serve *ex officio*—perhaps—on the hospital board. So there is communication about what the hospital is doing and what it is planning to do, and how the foundation can raise dollars to support those activities. If there is no communication, there's a real issue there.

One of the key things is to see that the CEO of the hospital is serving on that foundation board as well. That is a primary communication level. Then we get into the roles and responsibilities and things that the CEO of the hospital can do to support and work the elements of the fundraising because the community really wants to see the top person. It wants to know that he or she is committed to this. And we have seen better success and higher performance out of foundations when the hospital CEO is actively engaged.

SUMMARY

THERE IS A GROWING NEED FOR PHILANTHROPIC SUPPORT FOR HOSPITALS AND HEALTH SYSTEMS. MEDICARE AND MEDICAID PAYMENT RATES CONTINUE TO PLUNGE, BUT HOSPITALS HAVE INCREASED NEEDS FOR CAPITAL AND IT INVESTMENTS.

TYPICALLY, HOSPITALS ORGANIZE THEIR FUND DEVELOPMENTS EITHER THROUGH A SEPARATE FOUNDATION OR THROUGH A HOSPITAL FUND DEVELOPMENT DEPARTMENT.

A FOUNDATION IS A SEPARATE ENTITY WITH ITS OWN BOARD. IT HAS ITS OWN TAX EXEMPTION AND FILES ITS OWN 990. ITS MISSION IS TO SUPPORT THE HOSPITAL'S ACTIVITIES AND PROGRAMS.

IF THE HOSPITAL HAS A FUND DEVELOPMENT DEPARTMENT, THEN THE HOSPITAL BOARD IS ULTIMATELY RESPONSBLE FOR FUNDRAISING.

IF THERE IS A FOUNDATION, COMMUNICATION BETWEEN THE TWO BOARDS IS ESSENTIAL. THIS CAN BE ENHANCED BY OVERLAPPING BOARD MEMBERSHIP, BUT THE CRITICAL FACTOR IS CEO INVOLVEMENT AND ENGAGEMENT.

3. ROLE OF THE TRUSTEES

McGinly: The hospital trustees' interaction with the foundation can come in the form of several things. Certainly members of both boards should be active in actually providing financial support to the foundation, so we want to make givers, donors out of all the trustees on the hospital side and the foundation side. About six percent of all donations come from the board members of both the hospital and the foundation.

It is important to recognize that the foundation needs to identify people who may have an interest in the hospital in supporting it philanthropically, and the contacts that hospital trustees have in the community often times will surface people who are interested. Again, the hospital trustees' primary responsibility is providing for the operation of the hospital, but these secondary things are also important in helping to elevate and increase and grow philanthropy. The foundation board is doing that 100 percent of the time.

Also, there is a role for the hospital trustee in reaching out to the community, explaining what the hospital is doing. It is not all about programs and delivery of service. It is about mission. And if the hospital trustees are focused on the mission—why we exist, what we are doing, how we are making a difference, how we are saving lives, how we are changing lives—that is also wonderfully supportive of philanthropy.

Mills: As a board member, you are representing the hospital to the community and you are always in that role even when you are not sitting at a hospital board meeting. So you can play as active or as backseat a role as is comfortable for you in philanthropy. But you do have a great deal of opportunity to help to influence people to give to the hospital. It's your hospital. You should be proud of it and tell people what great things it does.

McGinly: Hospital trustees play roles in philanthropy that I bet they don't even realize. They are very visible in the community, they are well known, and if their message when they are talking about the hospital focuses on the mission of the hospital, that helps. Referring friends or acquaintances or business people to the foundation provides a tremendous opportunity. Those introductions are key. Often we don't think about that. Perhaps hospital trustees don't see that opportunity unless we build a culture of philanthropy, an awareness of philanthropy across the board.

4. ROLE OF PHYSICIANS

McGinly: We all know that physicians are crucial to healthcare delivery. They are the leaders in our hospitals; patients associate them with the care that is delivered in the hospital, and they can have a crucial role in the philanthropic process. Identifying people, referring potential donors to the foundation is a crucial role, and also being donors themselves. Now, sometimes people will refer to the physicians, "Oh my heavens, they're already giving by virtue of time that they donate and their expertise." But the fact is physicians are human beings just like anyone

else. You have to embrace them. You have to bring them into the process. In addition to being leaders on the hospital side, we find some physicians really get excited about taking a leadership role in the philanthropic effort—whether it ties back to specific programs they have an interest in or for the overall health of the hospital.

5. FUNDRAISING STRATEGIES

McGinly: Many organizations that are just starting out as well as some that have been in the business for a long period of time may primarily rely on special events and an annual campaign, which they run once a year. We find that about two thirds of the staff time and the resources that we have will go into those two activities. Those activities—the special events, the annual campaign—while we are investing a lot and the expenses are pretty high, the return is much lower in cash. But those events and the annual campaign are providing an awfully lot of benefit for us.

In the annual campaign, often times we are identifying small donors who are interested in the hospital, and we have to become more sophisticated in how we examine people who are responding during the annual campaign. When you have requested a $50 donation or $100 donation and somebody consistently comes back with $500, you want to talk to that person. There is something more there than just, "Oh, I want to be a part of this." That person wants to be a bigger part of it. Special events, again, have the benefit of drawing an awfully lot of people into the hospital. They also elevate awareness of the hospital.

So we see high performers that run a capital campaign, and when they finish the capital campaign and they have had great success, they don't just give a sigh of relief and walk away. They begin an ongoing major gift campaign, because through the capital effort they have identified people who have given large dollar amounts and, again, those people want to be more involved. So now you have a program that is the annual campaign—hopefully, you are running it more than once a year. You have special events. You have a capital campaign that you are considering, and major gifts. And with that group, too, you also then roll into the planned giving effort. You are reaching out to different segments of the community in ways they can give. It is that broader sense or that broader array of programs that has an appeal to different segments in your community.

As a not-for-profit, we have a lot of education to do with the public. We know from research that members of the public at large don't understand the difference between a for-profit and a not-for-profit. The confusion about for-profit and not-for-profit is crucial, and it is out there in communities throughout the United States. We have to generate an understanding that the not-for-profit has to have profits as well. The difference is that we reinvest those profits in the enterprise, in the community, so that we are building and strengthening what we are able to offer through the bottom line and philanthropy. So our responsibility in educating a community is crucial because philanthropy is very local. People want to be reassured that their dollars are having an impact. We see that now more than ever.

6. RESTRICTED V. UNRESTRICTED FUNDS

McGinly: Part of the responsibility for all hospital board members is to understand the appeal for restricted funds and unrestricted funds. Of course, the donor is the person who is expressing or putting in place the restriction that he or she want on funds and directing them to specific projects.

Very clearly, always when you have a capital campaign, those funds are restricted. You are raising dollars for a specific purpose, whether it is capital improvement, renovations, or additions, and it is restricted to the elements that are a part of that capital campaign. Now, again, the capital campaign is an intense effort over an extended period of time—two, three, four, five years where pledges are a part of that—but what we're saying to the donor is, "Yes, those funds you are giving are going to that restricted, particular program."

Unrestricted funds—which many of us like to have in the business—can be used for the greatest need, or we can move those funds around and support things in the hospital that we know are essential for delivering care. So you will find unrestricted funds that go into community benefit programs and charity care. We know that right now in hospitals 10.6 percent of the dollars raised are going to support community benefit programs that, for example, deal with obesity programs, deal with prenatal care, or go to clinics that we put out in the community to provide care. Another approximately 7.3 percent is going to provide charity care. That is part of the goal; that is part of the mission of a not-for-profit hospital. That is why we exist. We have to take all people that come in the door. That is part of our responsibility.

Jennings: Philanthropy actually fits in the allocation of resources or determining where you are going to put your money in two ways. It is a source of funding, just like debt is a source of funding or generating cash flow from operations is a source of funding. And it is a very critical source of funds for the organization that essentially expands your financial capability and allows you to have a longer list of priorities for action. Having said that, it is very important that philanthropy or a particular donor's preference doesn't drive what goes to the top of your list. I sometimes will see that a hospital has a potential donor and that person is very generous and is very interested in making a particular gift. But for the benefit of the community, the dollars might be better spent elsewhere. So I think it takes some self-discipline to work with that donor and to try to explain why your perspective on what would be the best and highest use of the investment for the community's benefit might be in a different area from what he or she originally had been thinking.

SUMMARY

HOSPITAL AND FOUNDATION BOARD MEMBERS USUALLY ARE MAJOR DONORS TO THE HOSPITAL, BUT THEY HAVE ADDITIONAL ROLES: THEY IDENTIFY POTENTIAL DONORS AND THEY ALSO SERVE AS THE HOSPITAL'S AMBASSADORS TO THE COMMUNITY – LETTING PEOPLE KNOW ABOUT ITS MISSION AND SERVICE. PHYSICIANS ALSO CAN TAKE A LEADERSHIP ROLE IN THE HOSPITAL'S FUNDRAISING EFFORTS BY REFERRING POTENTIAL DONORS.

MOST HOSPITALS RELY ON SPECIAL EVENTS AND AN ANNUAL CAMPAIGN – AND THESE ARE NECESSARY TO BUILD AWARENESS OF THE HOSPITAL AND ALSO TO IDENTIFY SMALL DONORS. HIGH PERFORMING ORGANIZATIONS CONDUCT MULTIPLE MAJOR GIFT CAMPAIGNS EACH YEAR.
THE CAPITAL CAMPAIGN ALWAYS GENERATES RESTRICTED FUNDS – THAT IS, FUNDS THAT MUST BE USED FOR THAT PROJECT. AND AT TIMES, DONORS WILL GIVE MONEY THEY WANT USED FOR A SPECIFIC PROGRAM.
THESE ARE "RESTRICTED" FUNDS. THE HOSPITAL ALSO RECEIVES FUNDS FROM DONORS THAT CAN APPLY TO THE GREATEST AREA OF NEED; FOR EXAMPLE, FOR COMMUNITY BENEFIT OR CHARITY CARE. THESE ARE "UNRESTRICTED" FUNDS.
THE HOSPITAL SHOULD WORK WITH DONORS TO EXPLAIN ITS PERSPECTIVE ON THE BEST USE OF DONATIONS.

7. TAX REFORM AND HEALTHCARE REFORM

McGinly: Tax reform is an area that both hospital trustees and foundation trustees need to be aware of and they need to keep a constant focus on what is happening. One element that we see occurring consistently is the proposal to reduce the deductibility of gifts from 33 or 35 percent to 28. We find that this proposal will have a broad impact across all not-for-profit arenas. We know that people will give to a hospital or the charity of their choice based on their interests and their experience. They are not going to give because of the tax deduction, but they will give more [when donations are tax deductible] because that is an incentive the government is providing. We have estimated that reducing that deductibility in the healthcare arena may result in a loss of nearly a billion dollars.

What you have to remember is that this isn't a benefit for those who are making the gift. It is a benefit for those who are receiving services. If I'm giving less at one level, there will be fewer dollars available to support the services of the needy and those programs that are essential in communities, and that is the key element. So I would suggest as a hospital executive, as a hospital board member and a foundation board member, you keep your eye on the ball about what is going on with tax reform. Let's not introduce disincentives for donors. Let's keep it positive.

Healthcare reform is presenting a lot of challenges for healthcare and philanthropy as well. The positive about this is that the intentions of healthcare reform are really primarily to cover a lot more people—32 million more Americans. As this has rolled out and as it has gone through Congress, it has introduced a lot of change and uncertainty in the minds of people who have healthcare and who, of course, are interested in what the quality of healthcare is like in their community. But it has also introduced uncertainty in the minds of donors about the changes that are going to take place. How will it be different? How will it affect me? Will the hospital in my community still be there? Will it be delivering care the way it is now? Is what I'm supporting now through my philanthropy going to grow? Is that crucial to the community? How will that affect us?

So the uncertainty in the minds of some donors about what is coming next is creating a pause, if you will, and some internal thinking on their part: "Do I continue to support at the level that I

was? Do I look at new ways to support this?" And often times during that pause, philanthropy is reduced or it slows down. Or if I am involved in supporting a hospital and I have pledges due, I may extend them until I figure out what is going to happen and how it will impact me.

Mills: Some people will say that because we now have healthcare reform we won't have any uninsured people, any people who need financial assistance and we won't need philanthropy. I think we can all foresee that that is not precisely what is going to happen. We will still have those who can't afford insurance, still have those who don't buy insurance and those who aren't required to buy insurance, as well as undocumented persons who may not be able to obtain insurance. So there will always be a role for hospital philanthropy, both to serve the people who can't pay and to enhance hospital services.

In addition, the health reform act has many exciting opportunities for demonstration projects, for trying new ways of doing things. And some of these require that in addition to getting government money that you put up some of your own money as well. So that is another role for philanthropy, specifically in relation to the health reform process.

For more information, please go to www.iprotean.com.

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 9/22/2020
Subject: 2021 Operating Budget

The 2021 Operating Budget is still in development. A version was presented to the Finance Committee on 9/23/2020. At that time, a verbal update was provided on changes that had been made after the packet went to print.

Accompanying this memorandum is a snapshot of a more recent iteration. Richard suggested that this version is about 85% complete with changes being made daily. The biggest takeaway is that we continue to use the 2020 Budget as our baseline for volumes. We are adding or subtracting known changes, such as the acquisition of Morton Clinic and the discontinuing of our interim pharmacist services.

On October 21, 2020, the proposed 2021 Budget will be presented to the Finance Committee. We will then present the budget at the Special Board Meeting scheduled for October 28, 2020. This will comply with RCW 70.44.060(6) requiring me to file a proposed budget by November 1.

After two weeks of public notices, we will present the 2021 Operating Budget for adoption by the Board (via resolution) on November 11, 2020. At this same public meeting, we will discuss the setting of property tax levies as tax revenue are part of our 2021 Operating Budget. This action will comply with RCW 84.5.120.

Lewis County Hospital District 1

Income Statement

Budget 2021 Presentation

DRAFT - September 22 2020

	2019 Actual	2020 Budget	August YTD Budget	August Act YTD	Forecast Act + Rem Bud	8 Annualized	Material Issues	Projected 2020	2021 Budget	$ Incr (Decr)	% Incr (Dcrs)
Revenue											
Inpatient Revenue	10,068,927	11,230,770	7,552,693	5,014,254	8,692,331	7,521,381		7,521,381	10,795,201	3,273,820	44%
Outpatient Revenue	32,486,170	36,231,613	24,504,994	19,765,679	31,492,298	29,648,519	300,000	29,948,519	36,596,386	6,947,868	23%
Clinic Revenue	2,584,549	4,045,136	2,567,658	2,181,044	3,658,522	3,271,566		3,271,566	2,954,969	(316,597)	-10%
Gross Patient Revenue	45,139,646	51,507,519	34,625,345	26,960,977	43,843,151	40,441,466		40,741,466	50,346,556	9,905,091	24%
Deductions from Revenue	18,428,509	21,050,544	14,389,213	11,155,074	17,816,405	16,732,611		16,732,611	20,138,622	3,406,011	20%
Net Patient Revenue	26,711,137	30,456,975	20,236,132	15,805,903	26,026,746	23,708,855		24,008,855	30,207,934	6,499,079	27%
NPSR % of Gross	59%	59%	58%	59%	59%	58.6%		58.9%	60.0%		
Other Operating Revenue	879,741	852,851	568,550	4,057,029	4,341,330	6,085,544		6,085,544	502,965	(5,582,579)	-92%
Total Operating Revenue	27,590,878	31,309,826	20,804,682	19,862,932	30,368,076	29,794,398		30,094,398	30,710,899	916,501	3%
Operating Expense											
Salaries & Wages	14,806,725	18,160,177	11,971,499	11,261,754	17,450,432	16,892,631	100,000	16,992,631	17,533,207	540,576	3%
Benefits	3,468,802	3,976,369	2,628,840	2,481,924	3,829,453	3,722,886	250,000	3,972,886	4,254,576	281,690	8%
Professional Fees	2,117,301	2,226,182	1,504,090	1,215,337	1,937,429	1,823,006		1,823,006	1,841,265	18,260	1%
Supplies	1,893,282	2,104,191	1,397,966	1,316,291	2,022,516	1,974,437		1,974,437	2,100,209	125,773	6%
Purchase Services	3,268,295	3,609,521	2,416,229	2,310,401	3,503,693	3,465,602		3,465,602	4,259,091	793,490	23%
Utilities	417,883	488,424	324,295	313,575	477,704	470,363		470,363	548,296	77,934	17%
Insurance	199,589	217,842	143,633	134,729	208,938	202,094		202,094	214,785	12,692	6%
Other Expense	491,618	784,660	565,771	400,348	619,237	600,522		600,522	506,732	(93,790)	-16%
Total Operating Expense	26,663,495	31,567,366	20,952,323	19,434,359	30,049,402	29,151,539		29,501,539	31,258,161	1,756,623	6%
EBDITA	927,383	(257,540)	(147,641)	428,573	318,674	642,860		592,860	(547,262)	(1,190,122)	-185%
	3%	-1%	-1%	2%	1%	2%			-2%		
Capital Cost											
Depreciation	1,753,600	1,738,517	1,158,596	1,167,639	1,747,560	1,751,459		1,751,459	1,001,742	(749,717)	-43%
Interest Expense	455,499	416,446	277,631	288,491	427,306	432,737		432,737	454,188	21,452	5%
Operating Income	(1,281,716)	(2,412,503)	(1,583,868)	(1,027,557)	(1,856,192)	(1,541,336)		(1,591,336)	(2,003,192)	(461,857)	30%
Non Operating Income	1,766,528	1,606,614	1,071,076	1,127,405	1,662,943	1,691,108		1,691,108	1,645,205	(45,903)	-3%
Net Income	484,812	(805,889)	(512,792)	99,848	(193,249)	149,772		99,772	(357,987)	(507,759)	-339%
	2%	-3%	-3%	1%	-1%	1%		0%	-1%		

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 9/22/2020
Subject: Electronic Signatures

Local agencies have been authorized to use electronic signatures (e-signatures) since 2016. This authorization received a reboot in June 2020. However, Arbor Health only elected to utilize e-signatures in 2020 out of necessity during the pandemic.

In August, we drafted and discussed a process for e-signatures. I am now proposing policy and procedure language to formalize the process. This policy will govern the way e-signatures are created, generated, sent, communicated, received, and stored. Please find the proposed policy language below:

Policy: It is the policy of Lewis County Hospital District No. 1 to utilize electronic signatures for board commissioners to officially authorize board business, such as board of commissioner minutes, resolutions and warrants listings.

Procedure:

1. Board action is taken, such as approving minutes, resolutions, and warrants listing.
2. Within two business days, the Executive Assistant will generate and email documents to be signed by commissioners in Adobe Pro. Only commissioner district email addresses will be used in this process.
3. The order of signers will be as follows:
    a. Secretary Herrin
    b. Commissioner McMahan
    c. Commissioner Coppock
    d. Commissioner Schumaker
    e. Board Chair Frady
    f. Superintendent, as required
    g. CFO, as required

4. Once the documents have been distributed via email, the Executive Assistant will send an email to signers alerting them of a document needing signed.
5. Commissioners are expected to sign the document within 48 hours of receipt.
6. Signed documents will be stored in the Board of Commissioners designated sections of Lucidoc.

My ask of you is to propose changes to the draft policy and procedure provided. Once we have reached agreement, I will need a motion to approve/ratify the policy and procedure as presented or amended. After the meeting, we will publish the approved policy in Lucidoc.

DocID:	17952
Revision:	0
Status:	Official
Department:	Governing Body (Board of Commissioners)
Manual(s):	

Policy & Procedure : Annual Adoption of the Compliance Plan

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board of Commissioners commissions the implementation of the District's Compliance Plan in accordance with the Office of Inspector General Compliance Program Guidance.

The District's Compliance Plan will have as its basis the minimum requirements found in the appertaining documents of the Federal Office of the Investigative General, CFR42 Vol. 5 Sub Chapters G Port 482 COP and the Office of Inspector General Compliance Program Guidance.

The Board of Commissioners encourages and supports thoughtful and applicable expansion of the scope and coverage of this program beyond the minimum requirements under the law.

Procedure:

1. In accordance with the Compliance Plan of this District, and as here-after amended, two Board of Commissioners are appointed to the Compliance Committee.
2. The Director of Compliance will present the Compliance Plan annually to the Compliance Committee for review and comment.
3. The Board of Commissioners will adopt the District's Compliance Plan by resolution at a regularly scheduled board meeting.

Document Owner:	Frady, Trish
Collaborators:	
Approvals	
- Committees:	(09/25/2019) Board of Commissioners,
- Signers:	

Original Effective Date:	12/05/2017
Revision Date:	[12/05/2017 Rev. 0]
Review Date:	[09/07/2018 Rev. 0], [09/05/2019 Rev. 0]
Attachments: (REFERENCED BY THIS DOCUMENT)	
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	

DocID:	8610-103
Revision:	3
Status:	Official
Department:	Governing Body (Board of Commissioners)
Manual(s):	

Policy & Procedure : Annual CEO/Superintendent Evaluation

Policy:

The Board of Commissioners of Lewis County Hospital District No. 1 will conduct an evaluation of the CEO/Superintendent no less than annually, but may call for an evaluation at anytime.

Purpose:

For the Board of Commissioners of Lewis County Hospital District No. 1 and the CEO/Superintendent to set and review expectations of the CEO/Superintendent.

Procedure:

The Board of Commissioners and the CEO/Superintendent will identify the CEO/Superintendent areas of strengths and weaknesses ensuring that the CEO/Superintendent professional goals and hospital health systems goals are compatible. This will be done by the Board of Commissioners completing the CEO/Superintendent Evaluation.

Document Owner:	Frady, Trish
Collaborators:	
Approvals	
- Committees:	(07/25/2018) Board of Commissioners, (09/25/2019) Board of Commissioners,
- Signers:	
Original Effective Date:	
Revision Date:	[07/05/2006 Rev. 1], [05/31/2016 Rev. 2], [06/26/2018 Rev. 3]
Review Date:	[07/09/2008 Rev. 1], [05/29/2009 Rev. 1], [04/06/2010 Rev. 1], [04/11/2011 Rev. 1], [11/08/2013 Rev. 1], [12/23/2014 Rev. 1], [09/05/2019 Rev. 3]
	CEO/Superintendent Evaluation

Attachments:
(REFERENCED BY THIS DOCUMENT)

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

DocID:	14114
Revision:	6
Status:	Official
Department:	Governing Body (Board of Commissioners)
Manual(s):	

Policy & Procedure : Board E-Mail Communication

Purpose:

The following communication policy is adopted to enhance and improve communications by and between Board members and Administration.

Policy:

The Board of Commissioners of Lewis County Hospital District No.1 shall maintain a district email communication policy.

Procedure:

1. All email to and from board members shall be subject to Arbor Health's Electronic Mail Usage Policy, Document ID: 10115.
2. All board members will refrain from including any response or opinion in emails that may be construed as a serial board meeting.
3. All board member emails will be maintained on the district servers for the duration required by the Public Records Act.

Document Owner:	Frady, Trish
Collaborators:	

Approvals

- **Committees:** (09/25/2019) Board of Commissioners,
- **Signers:**

Original Effective Date: 09/25/2009

Revision Date: [09/25/2009 Rev. 0], [04/22/2010 Rev. 1], [01/04/2012 Rev. 2], [01/19/2012 Rev. 3], [01/20/2012 Rev. 4], [10/17/2012 Rev. 5], [09/06/2019 Rev. 6]

Review Date: [04/11/2011 Rev. 1], [12/23/2014 Rev. 5], [05/31/2016 Rev. 5], [08/27/2018 Rev. 5]

Attachments:
(REFERENCED BY THIS DOCUMENT)

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

SUPERINTENDENT REPORT

SUPERINTENDENT'S REPORT September 2020

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

	Opportunity	CY 2020 Progress	Status	Associated Documentation
Informational	ACO	Update provided on acceptance into PSW's NWMomentum Health Partners ACO		*09/22/2020 ACO Update Memo*
Informational	Custodial Program	Verbal update will be provided on the disposition of the four residents		*None*
Informational	Property Acquisition & Disposition	Update provided on the purchase and disposition of property		*09/22/2020 Property Acquisition Memo*
Informational	Population Health	Update on COVID-19's impact on flu season & Commissioner flu shots		*09/22/2020 Population Health Memo*
Education	WSHA Fall Virtual Meeting	Due to COVID-19, WSHA's fall conference will be virtual		09/22/2020 WSHA Fall Virtual Conference Memo

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 9/22/2020
Subject: ACO Update

We are still being considered for acceptance into Physicians of Southwest Washington's (PSW) Northwest Momentum Health Partners Accountable Care Organization (NWMHP ACO). Emails have been sent from NWMHP to our providers informing them that they are being enrolled into an ACO. This notification fulfills a CMS requirement and is a great sign that our entry is being seriously considered.

We have been provided the quality measures against which our success will be measured. The metrics will be as follows:

- Patient/Caregiver Experience – 10 measures
- Care Coordination/Patient Safety – 4 measures
- Preventative Health – 6 measures
- Clinical At-Risk Population – 1 depression measure, 1 diabetes measure and 1 hypertension measure

Our family practice provider contracts have quality measures tied to their bonus compensation. Their 2021 compensation will be updated to reflect performance on the ACO metrics.

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 9/22/2020
Subject: Property Acquisition

We continue to move forward with acquiring the Collar Avenue duplexes. A purchase and sale agreement has been signed by both parties and earnest monies have been deposited.

The attorney has initiated a title search and the sellers have initiated relocation efforts on behalf of the tenants. The purchase is still on track for a mid-October close after the tenants have vacated the property.

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 9/22/2020
Subject: Population Health

As we enter the fall months, we have a growing concern about how COVID-19 will impact influenza season. While many questions remain unanswered, we have decided to move flu shots outside of the clinic walls. We will be holding Drive-Through Flu Shot Clinics from 10:00 am – 5:30 pm on the following dates:

- September 25, 2020 in Morton
- September 29. 2020 in Mossyrock
- September 30, 2020 in Randle

However, as a commissioner, you will be able to receive your flu shot through Employee Health. Please contact Amanda Seals, CMA at aseals@myarborhealth.org or 360-496-3582 to schedule your vaccine at your convenience. Amanda will graciously meet you at your automobile to administer the shot.

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 9/22/2020
Subject: WSHA Fall Virtual Conference

Washington State Hospital Association (WSHA) will be holding their 2020 Fall Annual Meeting virtually through a series of presentations. The first event was held on September 16th; however, there are four more dates in which you can participate.

- October 7, 2020, 10:00-11:00 am: Mara Liasson, Keynote Presentation
- October 7, 2020, 11:30 am – 1:00 pm: WSHA Legislative Update & Discussion
- October 28, 2020, 10:00-11:30 am: WSHA Peer Exchange-Lesson Learned from COVID-19 Response
- November 11, 2020, 10:00-11:30 am: Carvell Wallace, Keynote Presentation
- December 2, 2020, 10:00 – 11:30 am: Don Berwick, Keynote Presentation

Please let Shana Garcia know by noon on Friday, October 2, 2020 if you would like to be enrolled in the conference.