Arbor Health

Strategic Planning Retreat

Tiller Arts Center

Morton, Washington

April 18, 2023

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Arbor Health - Board of Commissioners
2023 Strategic Planning Retreat
Tuesday, April 18, 2023

https://myarborhealth.zoom.us/j/84780282761
Meeting ID: 847 8028 2761
Dial: +1 253 215 8782

PROPOSED Objectives

- Provide an overview of the current healthcare landscape nationally and how it relates to the local healthcare landscape
- Facilitate a discussion regarding the role of the Board of Commissioners as it relates to organizational strategic planning and other best practices
- Review and affirm the organization's mission, vision, and values
- Establish organizational strategic priorities and goals for 2023-2025

PROPOSED Agenda 8:00 am – 4:15 pm

Time	**Topic**	**Lead**
8:00 am	Breakfast	
8:30 am	Call to Order and Opening Remarks	Tom Herrin, Board Chair
8:35 am	Welcome and Introductions	Michael Lieb, Interim CEO
8:45 am	Meeting Agenda, Objectives, and Group Guidelines	Erica Osborne, Via Healthcare Consulting
9:00 am	National and Regional Industry Trends	Linda Summers, Via Healthcare Consulting
9:30 am	*Energy Break*	All
9:45 am	Arbor Health State of the Union – Where We Are Today	Mike Lieb, Interim CEO
10:15 am	Governance Best Practices for Board Effectiveness	Erica Osborne, Via
11:15 am	The Board's Role in Strategic Planning	Erica Osborne, Via
11:45 am	*Lunch*	All
12:30 pm	Mission, Vision, and Values	Linda Summers, Via
1:00 pm	Strategic Planning 2023-2025 • Strategic Assessment Summary • Identification of Strategic Themes	Facilitated Discussion, Erica Osborne and Linda Summers
2:30 pm	*Break*	
2:45pm	Strategic Planning 2023-2025, *CONT.* • Small Group Work: Prioritization of Key Strategic Goals	Facilitated Discussion, Erica Osborne and Linda Summers
4:00 pm	Next Steps and Closing Comments	Michael Lieb, Interim CEO
4:15 pm	Close of Meeting	Tom Herrin, Board Chair

Version 4-10-2023

Strategic Planning Retreat
April 18, 2023

Via Healthcare Consulting

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Session Objectives

- Provide overview of current healthcare landscape
- Discuss the role of the Board and other best practices
- Review the organization's mission, vision, and values
- Identify organizational strategic priorities

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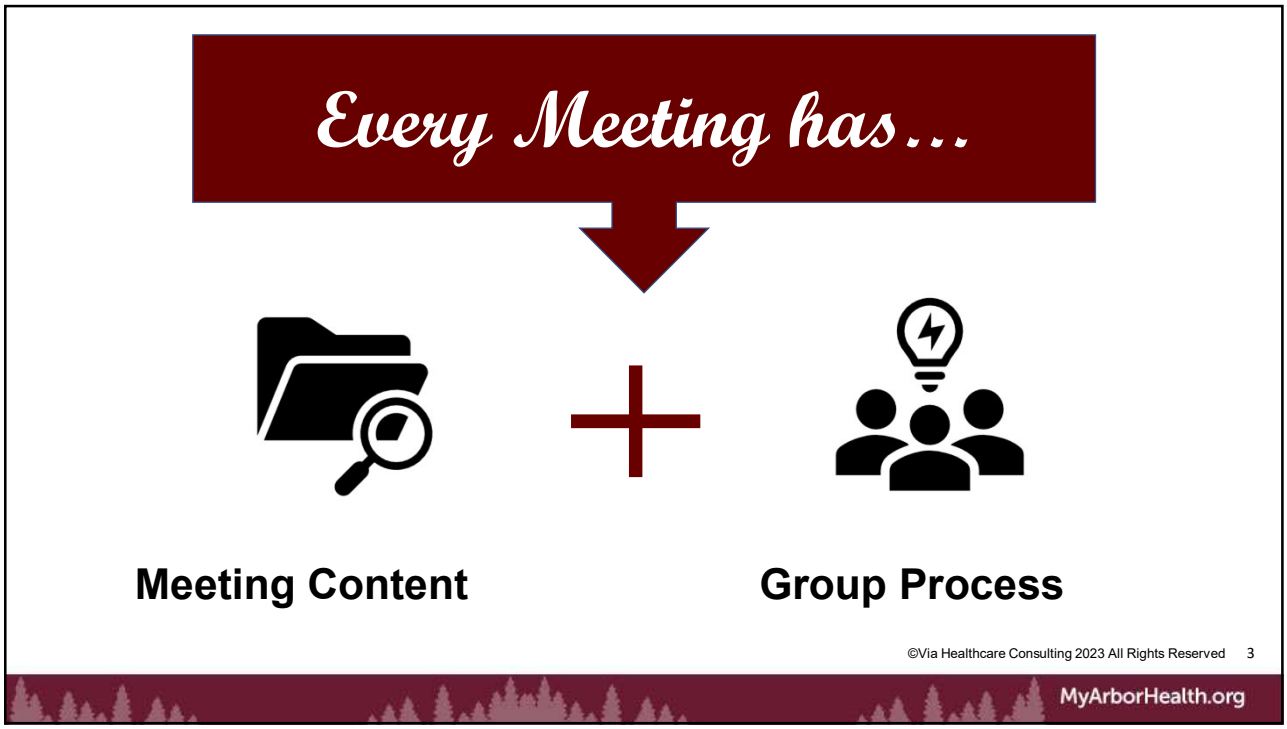
Every Meeting has…
Meeting Content
Group Process
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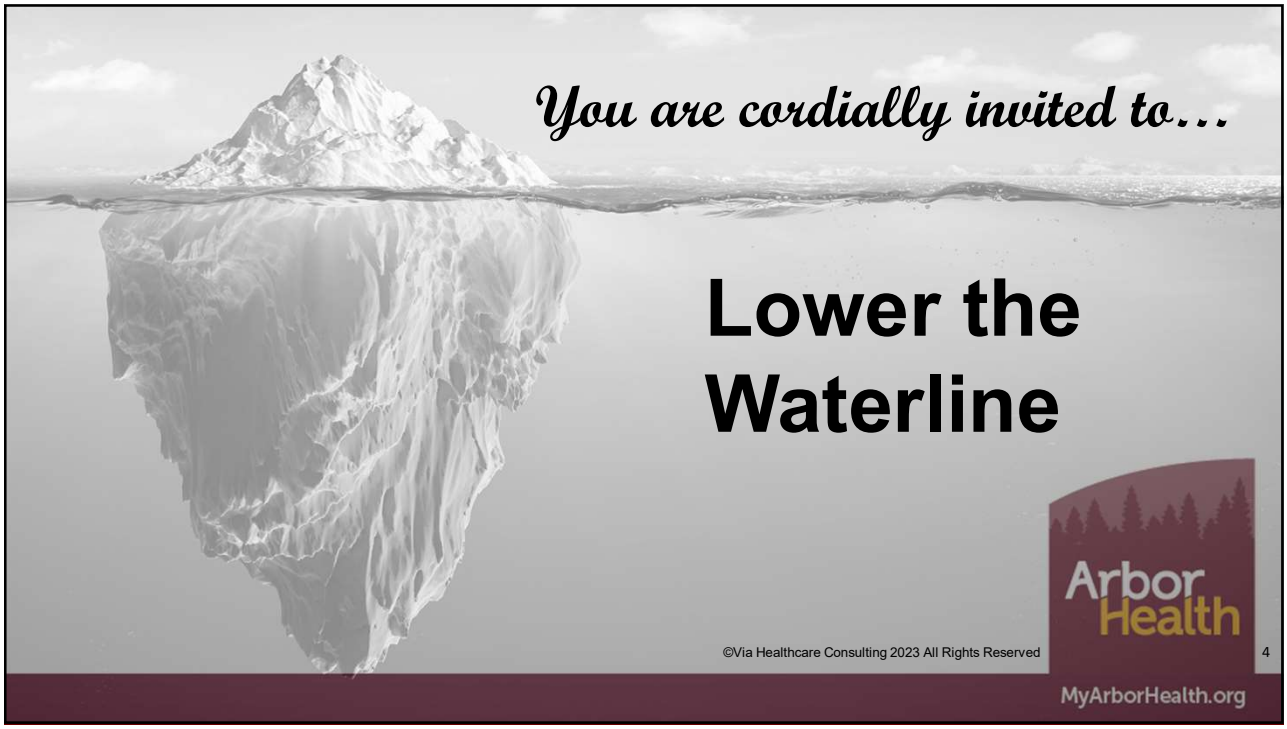
You are cordially invited to…
Lower the Waterline
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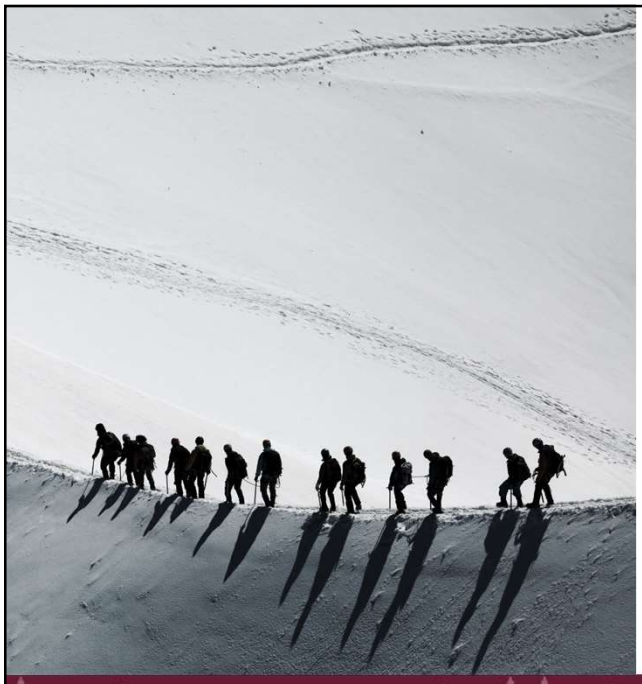

Group Guidelines

- "Lower the water line"
- Be honest *and* kind
- Declare "devil's advocate"
- Avoid side conversations
- Be fully engaged
- Use modified consensus decision-making
- Ensure all actions are assigned
- Utilize a parking lot

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National and Regional Industry Overview

Arbor Health

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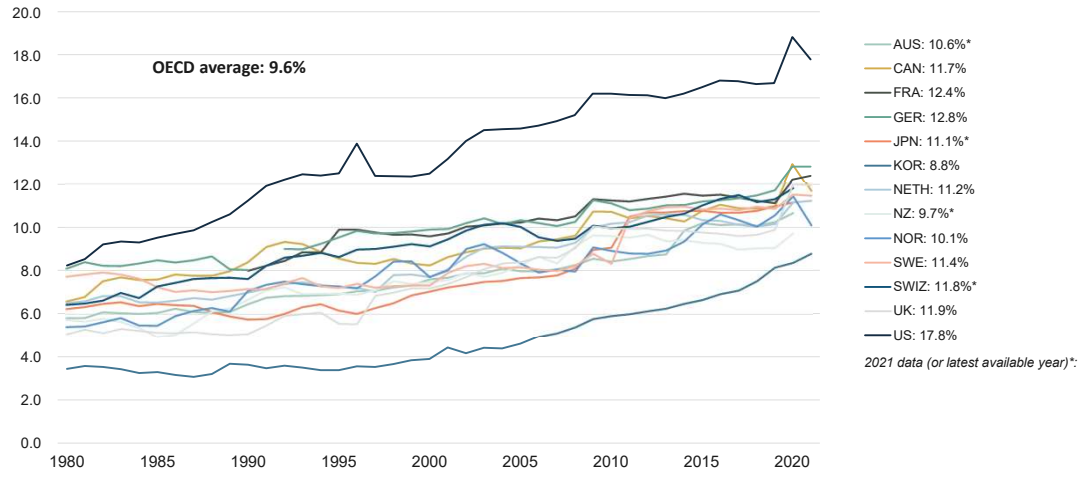
The U.S. is a world outlier when it comes to health care spending.

Percent of GDP spent on health, 1980–2021*



Notes: * 2020 data. Current expenditures on health for all functions by all providers for all financing schemes. Data points reflect share of gross domestic product. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP = gross domestic product. OECD average reflects the average of 38 OECD member countries, including ones not shown here. Data: OECD Health Statistics 2022.

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The Commonwealth Fund

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74

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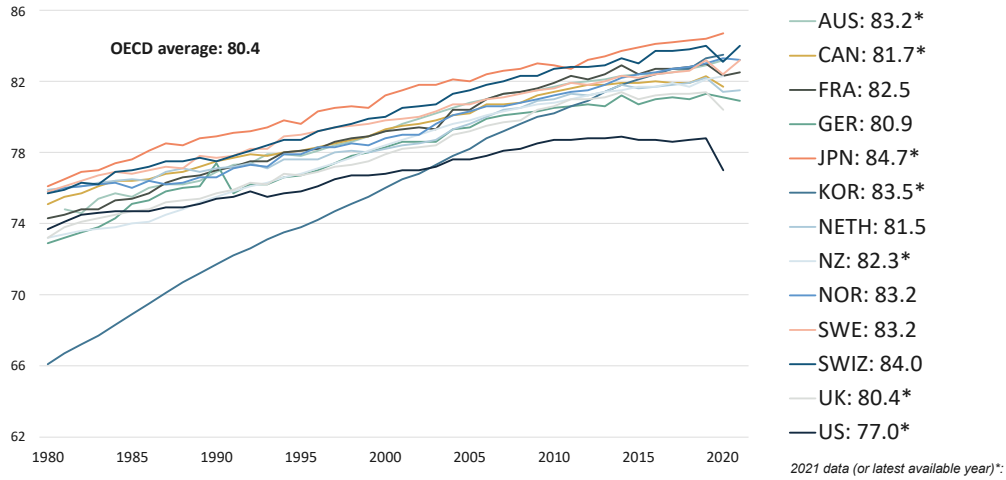
U.S. life expectancy at birth is three years lower than the OECD average.

Years expected to live, 1980–2021*



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The Commonwealth Fund

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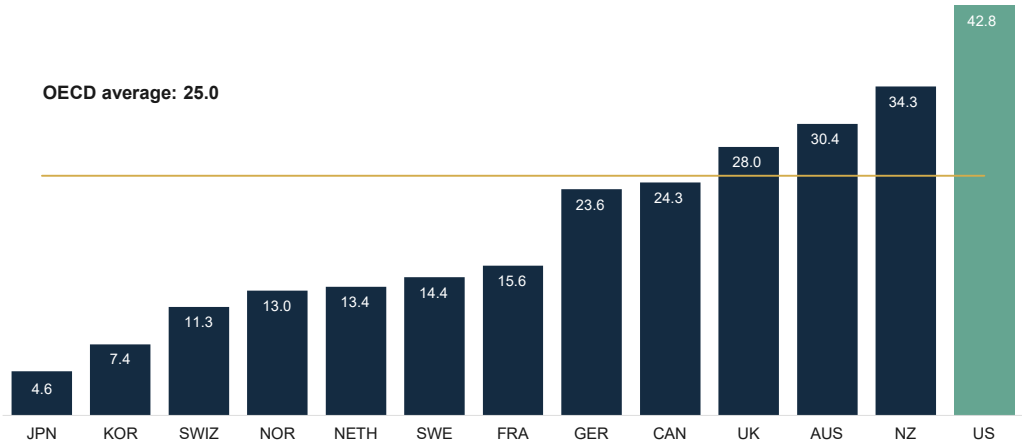
The U.S. obesity rate is nearly double the OECD average.

Percent of total population that is obese



Notes: Obese defined as body-mass index of 30 kg/m² or more. Data reflect rates based on measurements of height and weight, except NETH, NOR, SWE, SWIZ, for which data are self-reported. (Self-reported rates tend to be lower than measured rates.) 2021 data for NZ; 2020 data for KOR, NETH, and SWE; 2019 data for CAN, JPN, NOR, UK, and US; 2017 data for AUS, FRA, and SWIZ; 2012 data for GER. OECD average reflects the average of 23 OECD member countries, including ones not shown here, which provide data on obesity rates. Data: OECD Health Statistics 2022.

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The Commonwealth Fund

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74

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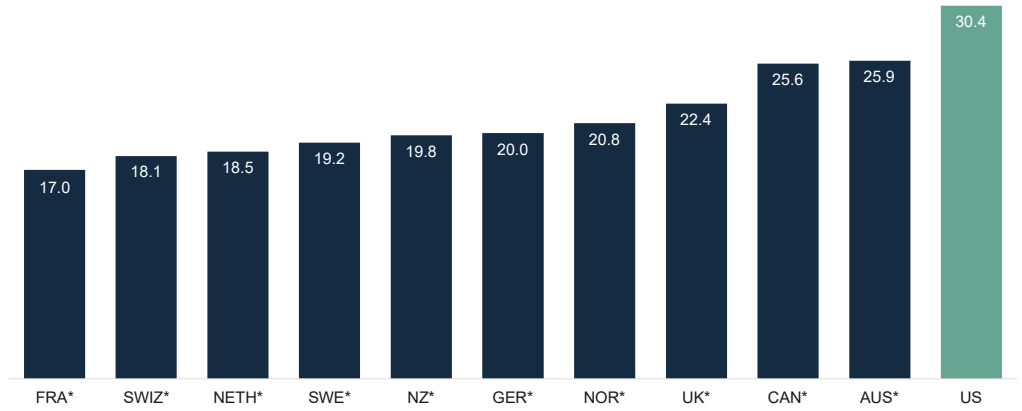
Adults in the U.S. are the most likely to have multiple chronic conditions.

Percent of adults age 18 and older who have multiple chronic conditions



Notes: Chronic disease burden defined as adults age 18 years and older who have ever been told by a doctor that they have two or more of the following chronic conditions: asthma or chronic lung disease; cancer; depression, anxiety or other mental health condition; diabetes; heart disease, including heart attack; or hypertension/high blood pressure. Data reflect 11 countries which take part in the Commonwealth Fund's International Health Policy Survey. * Statistically significant differences compared to US or comparator bar at p<.05 level. Data: Commonwealth Fund International Health Policy Survey, 2020.

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The Commonwealth Fund

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74

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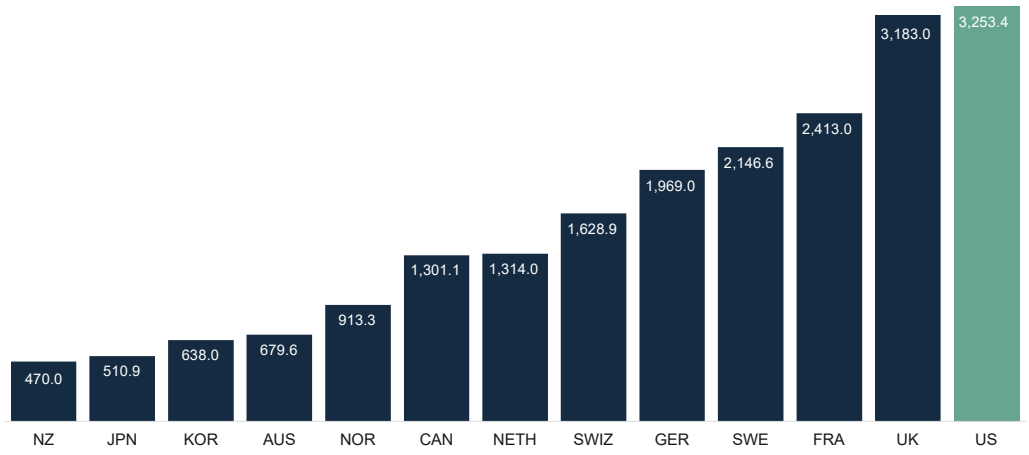
The U.S. has the highest rate of death because of COVID-19.

Deaths per 1 million because of COVID-19



Notes: Rate per 1 million people who have died from COVID-19 since January 22, 2020. Available data as of January 18, 2023. Data: Our World in Data.

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The Commonwealth Fund

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74

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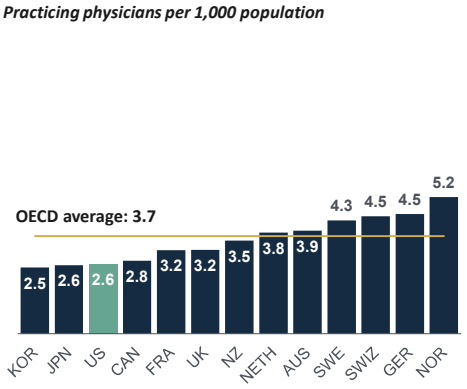
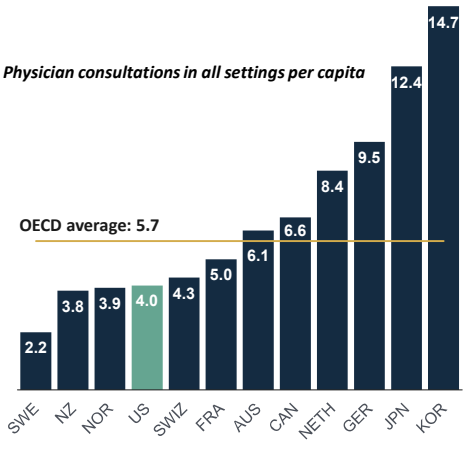
The U.S. has among the lowest rates of physician visits and practicing physicians.

Practicing physicians per 1,000 population



Physician consultations in all settings per capita



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The Commonwealth Fund

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74

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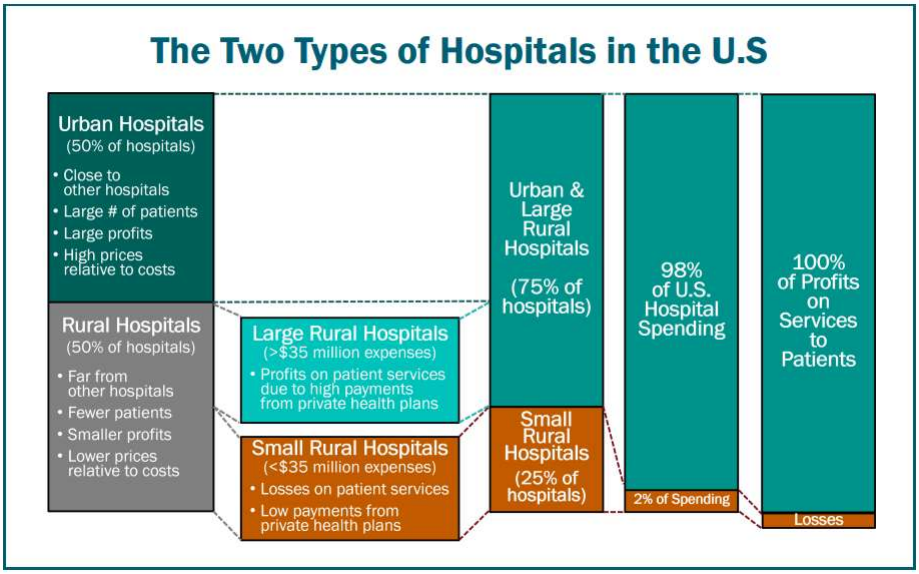
The Importance of Rural Hospitals



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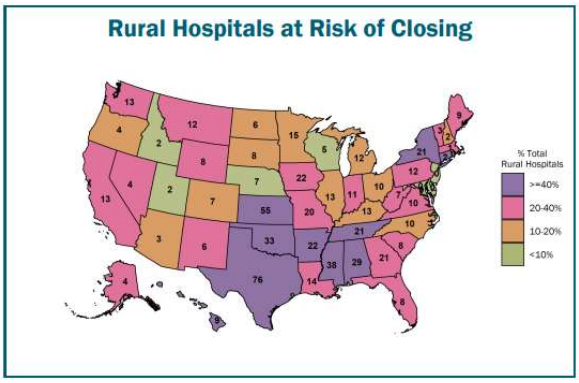
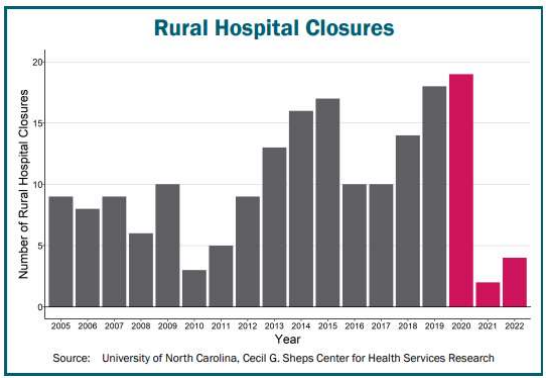
Rural hospitals are at risk…





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Key Drivers of the Current State

Labor Challenges

Revenue and Demand

Cash Flow Compression

Balance Sheet Flexibility

Length and Depth of a Recession

Governmental Funding and Policy

Event Risks

S&P U.S. Not-for-Profit Acute Health Care Outlook 2023, Modern Healthcare January 5, 2023

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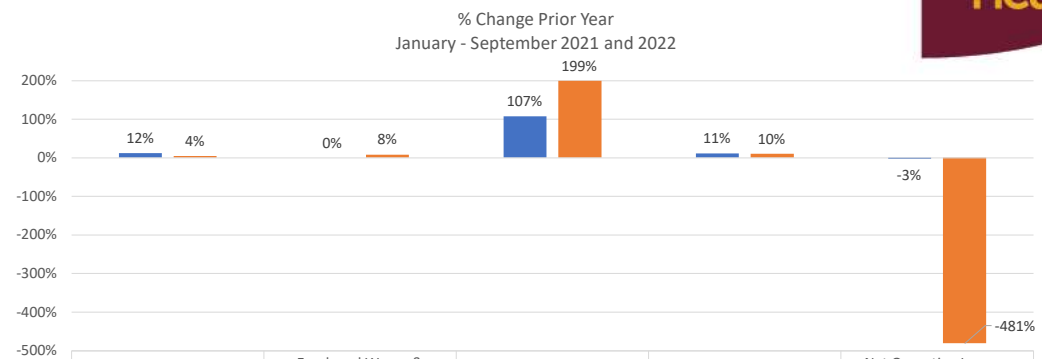
Arbor Health Financials vs. Washington Statewide Hospital Financials



	Total Operating Revenue	Employed Wages & Benefit Costs	Agency Traveler Costs	Total Operating Expenses	Net Operating Income (Loss)
Arbor health	12%	0%	107%	11%	-3%
WSHA	4%	8%	199%	10%	-481%

Source: WSHA - https://www.wsha.org/articles/financial-woes-threaten-patient-access-to-health-care-services-across-washington

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Where We Are Today

Progress since last Strategic Plan

April 18, 2023

Mike Lieb, FACHE, Interim CEO/Superintendent

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2020 Adopted Strategies

1. Build external relationships and partnerships that prioritize our community health needs.

2. Create a culture focused on safety, patient satisfaction, employee engagement, and excellent outcomes.

3. Be stalwart stewards of the public fund and trust.

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Progress Since 2020

Strategy # 1:

Build external relationships and partnerships that prioritize our community health needs.

- Community Outreach and partnerships
  - Health Fairs
  - Wellness Week
  - Drive Through Covid and Flu Vaccination Clinics
  - Concussion Management Program with Local School Districts
  - Foundation Events

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Progress Since 2020

Strategy # 2:

Create a culture focused on safety, patient satisfaction, employee engagement, and excellent outcomes.

- New Services

  Rapid Care Clinic

- New Providers

Dr. Fritz – Internal Medicine, 2020	Dr. Acosta – Family Medicine, 2021
Dr. Williams – Orthopedics, 2021	Dr. Peresco – Podiatry, 2021
Dr. Podbilski – Family Medicine, 2021	Carolyn Price, LICSW, 2021

Progress Since 2020

Strategy # 3:
Be stalwart stewards of the public fund and trust.

New and Enhanced Accreditation's	New Equipment or tools
DNV – Critical Access Accreditation	PCR Molecular Testing – Laboratory
DNV – Stroke Readiness Accreditation	Rapid Care Clinic
AASM – Sleep Lab Accreditation	Packwood Clinic (soon…)
WSHA – Sleep Lab Center of Excellence	

Covid Related Funds

Paycheck Protection Program (PPP)	$2,850,000
Medicare Accelerated Payment	$5,322,000 (repaid)
Provider Relief Funds (PRF – total)	$4,461,000
Additional grants and funds for Covid	

Office of Washington State Auditor 3-year review

Progress Since 2020

Strategy # 1: Selected Measures

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2022 YTD
NON-CLINICAL							
Administration: Open a primary care clinic in Packwood, WA by 12/31/2022		Open by 12/31/2022	In-progress	LOI signed	In-progress	April 2023 Opening	In-progress
Clinical Informatics: Successful implementation of Cerner/WAIIS immunization interface that meets DOH minimum data transmission thresholds.		Pass/Fail	Pass	Pass	Pass	Pass	Pass
Communications: Partner with vendors and community groups to host an overall wellness week, including a health fair	1	1 Event Annually	Event planned for Aug 27	Event planned for Aug 27	Wellness Week & Health Expo	Pass	Pass
Billing/HIM: Partner with Insurance Payor to address school needs/community youth programs	1	1 coordinated event/year	In-progress	5/16/2022 - Wellness event held for Morton Elementary 5th & 6th graders	Complete	Complete	Complete
Human Resources: Attend at least two local high school and college job fairs	1	2	2	1	0	2	5
Employee Health: Develop a community weight loss challenge that culminates in a 5k/10k/Half Marathon	1	1	Aug-22	Aug-22	5K	Complete	Complete
Patient Access: Increase the number of patients referred to the Self Pay Biller to see if they qualify for Medicaid by 100%	20	40	8	34	23	25	90
Quality and Risk: Improve grievance process compliance for *written acknowledgement letters* within 10 days of grievance by year end	70%	95%	100%	100%	100%	100%	100%
Clinical Education: Connect with Local RN and NAC programs 3 times/year for new graduates wanting Critical Access experience.	0	3	0	1	3	1	5

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Progress Since 2020

Strategy # 1: Selected Measures

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2022 YTD
CLINICAL							
Acute Care: Minimum of 1 community STEMI/Heart Attach event and 1 social media cardiac care message/newsletter article per quarter	0	1/4	9	2	5	4	20
Case Management: Ensure *5 Wishes Advance Directives* are provided to 70% of patients with no current advance directive	30%	70%	95%	94%	100%	100%	97%
Emergency Department: Minimum of 1 community STROKE education event and 3 EMS STROKE education events	0	1/3	1	5	2	4	12
Imaging: Develop & implement a Low Dose Lung Screening program by the end of 2022		Pass/Fail	In-progress	In-progress	In-progress	Implemented	Pass
Infection Control: Participate in 3 external events promoting IC to the community		3	0	0	1	2	3
Respiratory Therapy: Develop & implement 1 social media message/quarter re: pulmonary disease	0	1/qtr	0	1	1	7	9
Pharmacy: 50% of patients discharged during pharmacy hours on a new medication will be counseled by a pharmacist		≥ 50%	41%	56%	59%	47%	49%
Wellness: Create a community wide wellness plan that incorporates 2 additional partnerships with providers, employers, and community based entities focusing on overall health of our community by identifying target chronic illnesses and needs.	2	4	In-progress	Partnered with MAAL, Hampton Lumber & Mossyrock for Independence Day 5K/8K	Investigating 4th partnership	Lunch & Learn at Senior Centers	4
Rehab Services: Increase focus on student athletic performance & injury management.	0.75	2	In-progress	Training on ImPACT underway	ImPact is functioning	Program to assist with coach training & inservice given prior to football season at MWP	2
Surgical Services: Facilitate awareness of and local access to outpatient Infusion Care by developing marketing literature and outreach resulting in ≥ 20% increase in Same Day Surgery encounters	400	480	84	100	100	101	385
Swing Beds: Acute patients transferred out of District with subsequent skilled needs are readmitted to Arbor Health for local care	21	28 patients/year	21	21	10	14	66
Wound Care: Increase outpatient wound care visits by 10%	550	605	92	140	157	68	457

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Progress Since 2020

Strategy # 1: Selected Measures

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2022 YTD
NON-CLINICAL							
CLINICS							
Morton: Develop 2 community engagement events at clinic per year.	3	2/year	0	0	2	0	2
Mossyrock: Develop 2 community engagement events at clinic per year.	3	2/year	0	0	2	0	2
Randle: Develop 2 community engagement events at clinic per year.	3	2/year	0	0	2	0	2
Specialty: Develop 2 community engagement events at clinic per year.	3	2/year	0	0	2	0	2

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Progress Since 2020

Strategy # 2: Selected Measures

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

METRIC	BASELINE	TARGET	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2022 YTD
NON-CLINICAL							
Administration: Conduct one physician satisfaction or engagement survey with comparative data by 12/31/22.		Pass/Fail	In development	In development	In development	Failed	Failed
Clinical Informatics: Standardize drug protocols by increasing the number of Cerner order sets for P&T approved drug protocols and eliminate other versions	1	6 new protocols	0	1	0	0	1
Compliance: Resolve compliance and HIPAA events within 15 business days	25	15	2.6	4.1	1.9	2.5	2.8
Environmental Services: Decrease the percentage of overdue and incomplete work orders	28%	≤ 15%	19%	17%	23%	16%	18%
Billing/HIM: Track the number of Financial Assistance applications provided, returned & approved. Increase the number of applications provided by 10%	286	315	122	114	157	111	504
Human Resources: Conduct a minimum of 2 employee engagement surveys.	1	2	May-22	1	0	1	2
Foundation: Increase the number of staff members using the 15-Minute Philanthropist program by 20%	46	55.2	46	43	39	67	67
Patient Access: Identify patients that qualify for charity care by using bill holds allowing billers to track and follow-up with patients.	63	69	122	114	157	111	504
Quality and Risk: Initiate ISO 9001 by development and implementation of Quality Management System, completion of pre-assessment/gap analysis, and initiation of an ISO implementation action plan		Pass/Fail	In Progress	15 Leaders ISO trained; P&P workgroup started	Audit training & P&P Workgroup underway	Pass	Pass
Clinical Education: Stage annual competency completions each quarter to improve learning and content retention (Surgery, Acute, ED, and RT staff)		100%	20%	41%	50%	100%	52%

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Progress Since 2020

Strategy # 2: Selected Measures

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

METRIC	BASELINE	TARGET	2022 Q1	Q2	Q3	Q4	YTD
CLINICAL							
Acute Care: Increase documented patient education related to admission diagnosis within 4 hours of admission to 80% by year end (#IP admissions/# of IP with education started w/in 4 hours)	50%	≥ 80%	90%	100%	100%	100%	97%
Dietary/Nutrition: Increase number of participants in healthy cooking demonstrations for public by 50%	16	24	0	0	0	0	0
Emergency Department: Improve ED Moderate Sedation monitoring documentation to DNV standards	50%	≥ 95%	50%	100%	90%	100%	87%
Imaging: Decrease stroke/CT report turnaround to ≤ 15 Minutes	20 minutes	≤ 15 minutes	18	17	14.50	13.00	15.63
Infection Control: Increase hand hygiene compliance	87%	≥ 90%	79%	90%	72%	83%	81%
Laboratory: Decrease rate of reference lab rejected samples	0.70%	≤ 0.5%	0.65%	0.90%	0.64%	1.10%	1.00%
Respiratory Therapy: Recruit RT to core level of 60 hours/week of coverage (without traveler staff) by year end	24 hours/week	Pass/Fail	24/week	76/week	64/week	64/week	Pass
Pharmacy: Intervene on new antibiotic starts to improve monitoring of antibiotic therapy to expedite the best drug therapy for our patients	0	15/qtr	9	15	13	19	56 of 60
Pulmonary Rehab: Reopen Pulmonary Rehab prog. by year end	0	Pass/Fail	Fail	Fail	Fail	Fail	Fail
Wellness: Create 2 additional programs that provide and improve overall patient outcomes.	2	4	Medical Nutrition Therapy	Enhanced Fitness	Wellness Week	Community Connection Website	4
Rehab Services: Overall patient outcomes will be at least 90% of expected outcomes based on FOTO risk adjusted predictions	0%	≥ 90%	99%	85%	73%	78%	87%
Surgical Services: Improve preop H&P compliance to DNV stds.	50%	≥ 90%	60%	59%	92%	100%	69%
Swing Beds: Improve rate of Skilled Swing Bed Comprehensive Assessments completed	30%	≥ 90%	76%	100%	100%	100%	90%
Wound Care: 25% of all venous leg ulcer patients will achieve healed status or 50% reduction within 90 calendar days of starting therapy	18% (12/65)	25%	100%	0%	100%	100%	92%

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Progress Since 2020

Strategy # 2: Selected Measures

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

METRIC	BASELINE	TARGET	2022 Q1	Q2	Q3	Q4	YTD
CLINICS							
Morton: Increase annual wellness visits by 25%	189	236	68	75	78	73	294
Mossyrock: Increase annual wellness visits by 25%	112	140	34	46	29	34	143
Randle: Increase annual wellness visits by 25%	75	94	43	32	38	19	132
Specialty: Improve patient education and awareness by 50% of all patients seen their after visit summary (# of patients receiving after visit summary/total number of patients seen)	0	≥ 50%	45%	66%	81%	67%	64%

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Progress Since 2020

Strategy # 3: Selected Measures

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2022 YTD
NON-CLINICAL							
Administration: Decrease Non-RN interim staffing costs by 10% or greater (excludes Medefis)	$ 1,485,937	$ 1,337,343	$ 413,905	$ 348,683	$ 574,516	$ 815,863	$ 2,152,967
Clinical Informatics: Reduce encounters with missed charges secondary to admitting order errors by 20%	25	20	0	0	0	1	1
Compliance: Audit work plan for implementation, follow-through, and outcomes reported to Compliance Cmte.		100%	10%	32%	15%	14%	70%
Communications: Increase number of annual wellness visits by 10% through the use of effective marketing	375	413	151	125	145	126	547
Environmental Services: Decrease overtime by 25% by optimizing staffing schedules.	$ 9,305	$ 6,979	$ 2,007	$ 2,063	$ 4,243	$ 3,993	$ 12,306
Finance: Pay external vendors timely and per schedule, reducing variation/errors	80%	85%	81%	77%	84%	85%	81%
Billing/HIM: Decrease timely filing write-offs by 25%	$ 91,691	$ 68,768	$ 15,824	$ 12,233	$ 52,496	$ 12,045	$ 92,598
Human Resources: Hospital wide annual education will be completed by December 31, 2022	89%	95%	11%	22%	65%	32%	97%
Foundation: Establish a monthly donor program in the community minimize the reliance on fund raising events		Pass/Fail	In Progress	In Progress	In Progress	Amazon Smile, Roots & Wings Grant	Complete
Information Technology: Implement an IT asset tracking system that meets compliance requirement		Pass/Fail	In Progress	Implementation is progressing	Complete	Complete	Complete
Employee Health: Submit 100% of eligible claims to LNIs Stay-at-Work Program	80%	100%	100%	100%	100%	100%	100%
Patient Access: Increase point-of-service collections by 10% in ER and 10% in OP Services.	$ 20,261 $ 156,376	$ 22,287 $ 172,014	$ 2,157 $ 36,985	$ 3,744 $ 36,002	$ 7,683 $ 41,038	$ 9,799 $ 48,143	$ 23,383 $ 162,168
Quality and Risk: Increase Medication Error reporting by 10% to minimize unknown/unreported litigation risk	68	75	27	14	15	13	69
Clinical Education: 20% reduction in TNCC costs by implementing e-Learning challenge course	$458/RN	$366/RN	$300/RN	No TNCC	No TNCC	$325/RN	$311/RN
Supply Chain: All assets/capital purchases undergo asset purchase process/structure lead by Materials team.	50%	75%	50%		100%	100%	83%

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Progress Since 2020

Strategy # 3: Selected Measures

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2022 YTD
CLINICAL							
Acute Care: 30% reduction in lost revenue due to *Did Not Meet Inpatient Criteria* denials.	$ 113,984	$ 79,789	$ 82,309	$ -	$ 10,941	$ 83,995	$ 177,245
Case Management: 15% reduction in Code 44s	50	43	1	3	2	16	22
Dietary/Nutrition: Decrease department turnover by 40%	3	2	0	2	2	1	5
Emergency Department: Implement review process to manage ED Diversions in 2022 to 4.75% or less.	5%, 431 hrs annualized	≤4.75% or ≤416 hours	2%	4%	10%	3%	4.73%
Imaging: Reduce agency staffing costs by 10%	$ 114,990	$ 103,491	$ 68,965	$ 77,355	$ 152,813	$ (11,008)	$ 288,125
Infection Control: Update & distribute the hospital Antibiogram quarterly		4	1	1	1	1	4
Laboratory: 10% reduction in lab test write-offs due to lack of medical necessity or ABN	$ 85,000	$ 76,500	$ 22,566	$ 33,105	$ 23,079	$ 23,666	$ 102,416
Respiratory Therapy: Reopen outpatient PFT, EKG & Stress Test Services by year end	0	Pass/Fail	In Progress	Open	Pass	Pass	Pass
Pharmacy: Conduct med Inventory for usage and reduce inventory by 5% and increase safety per ISMP guidelines.	$ 146,874	$ 139,531	Q1 Inventory not valued	Q2 Inventory not valued	Q3 Inventory not valued	$ 127,211	$ 127,211
Pulmonary Rehab: Reopen Pulmonary Rehabilitation therapy (pending COVID guidelines) by year end	0	Pass/Fail	Fail	Fail	Fail	Fail	Fail
Wellness: Promote a wellness program that is an efficient use of funds and demonstrates a commitment to reducing healthcare cost overall in the community.		Pass/Fail	In Progress	In Progress	Thorbeckes talks continue	Enhanced Fitness	Pass
Rehab Services: Decrease our cancel/no show rate to reduce non-productive time and improve patient outcomes.	13%	≤ 12%	11%	13%	15%	17%	14%
Surgical Services: Increase surgical procedures by 30%	320	416	92	107	106	119	424
Swing Beds: All Weekday Swing Bed referrals will have a next business day response re: admission eligibility	40%	80%	100%	72%	100%	100%	93%
Wound Care: Increase biologic tissue (Sterishield & Epifix) administration for chronic wounds by 30%	60	78	25	36	36	9	106

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Progress Since 2020

Strategy # 3: Selected Measures

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2022				
			Q1	Q2	Q3	Q4	YTD
CLINICS							
Morton: Increase telehealth visits by 25%	187	234	59	58	69	74	260
Mossyrock: Increase telehealth visits by 25%	166	208	63	63	59	49	234
Randle: Increase telehealth visits by 25%	328	410	123	104	82	170	479
Specialty: Market and grow telehealth visits by 25%	120	150	25	29	34	21	109

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Questions?

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Legally-Mandated Fiduciary Duties

- Duty of Care
- Duty of Obedience
- Duty of Loyalty

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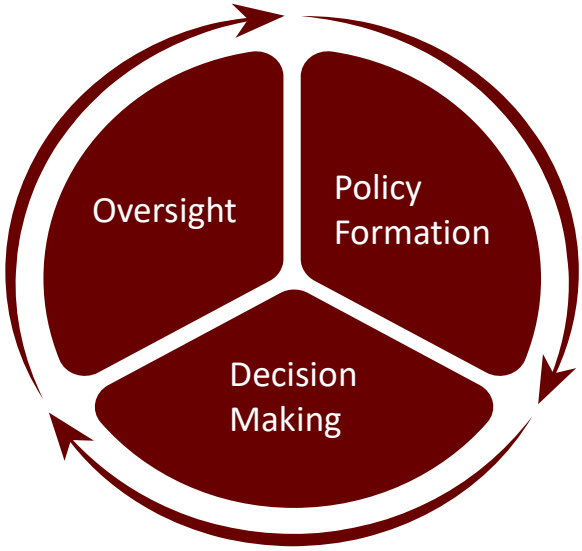
The Board's Role



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Three Important Notes

- Boards only have authority when meeting as a board (not as individuals or sub-sets)
- Boards must speak with one voice
- The Board's primary contact – and only employee – is the Superintendent /CEO

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The Board's Responsibilities

Oversight areas include:

- ☑ Quality
- ☑ Finance
- ☑ Strategy
- ☑ Superintendent and/or CEO
- ☑ Community benefit
- ☑ Governance effectiveness

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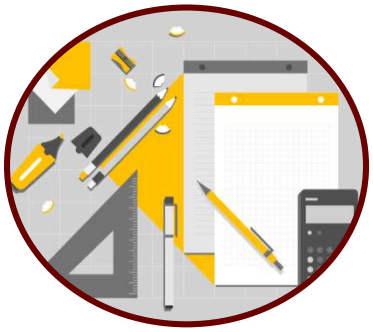
Governance vs. Management

The board handles *the <u>what</u>*

Management* handles *the <u>how</u>



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Questions to Clarify

1. Is it big?
2. Is it about the future?
3. Is it core to the mission?
4. High-level policy decision needed?
5. Is a red flag waving?
6. Is a watchdog watching?
7. CEO wants/needs board's support?

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The Board's Role in Strategic Planning

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Strategic Planning: Key Board Responsibilities

- ☑ Become and stay engaged.
- ☑ Become and stay educated about strategic-level healthcare issues and trends.
- ☑ Ask tough questions on "the what."
- ☑ Ensure oversight; monitor management's progress toward implementation.

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Strategic Plan Structure

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The Strategic Planning Process

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What is the importance of the Mission, Vision, and Values?

Creates and clarifies

- Purpose
- Focus
- Stakeholder synergy
- Accountability

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The ***mission statement*** explains the organization's reason for existing.

It should be…

Inclusive	Specific
Concise	Memorable
Focused on *What* and *why*	Realistic
Action-oriented	Current

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Arbor Health Mission Statement

To foster trust and nurture a healthy community.

- *Does this still resonate?*
- *Does this adequately tell our patients and community stakeholders who we are and what we do?*
- *Is it memorable?*

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The ***vision statement*** conveys your community's hopes for the future.

It should be…

Inclusive	Realistic
Aspirational	Creative
Inspirational	Aligned

Arbor Health Vision Statement

To provide accessible, quality healthcare.

- *Does this still resonate?*
- *Does this adequately tell our patients and community stakeholders where we want to go?*
- *Is Arbor Health's value clearly communicated?*

The ***values*** convey core beliefs and guiding principles for the organization.

They should be…

- Descriptive of how we interact
- Applicable to everyone
- Clear and easily understood
- Timeless

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Arbor Health's Core Values

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

- *Are they connected to the mission?*
- *Do they truly describe the essence of Arbor Health?*
- *Do they reflect the Arbor Health's culture, commitment, and passion?*
- *Are they both internally and externally focused?*

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Arbor Health Strategic Assessment 2023

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Arbor Health CHNA Summary 2023 – 2025 (Hospital District)

Arbor Health

2010 – 2022 Demographics

- Total population growth – 6.6%
- Females aged 15 to 44 growth – 6.2%
- Hispanic population growth – 57%

Social Indicators

- Children (under 18) in poverty – 23.1%
- Vacant housing – 34.5%
- Unemployment rate – 7.0%

Health Behaviors

- Current smokers – 17%
- Drug overdose – 21 per 100k
- Teen birth rate – 28 per 1,000

Clinical Care

- Screened for breast cancer – 63%
- Flu vaccination – 48.5%
- Residents per PCP – 2,240:1
- Residents per Dentist – 1,520:1

Health Outcomes

- Adult Depressive Disorder – 27.8%
- Diabetes – 15.5%; Obesity – 25%
- Premature death – 7,600 per 100k

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External Stakeholder Perspectives

2023-2025 Community Health Needs Assessment Priorities:

- Workforce
- Access
- Behavioral Health
- Exercise & wellness programs
- Opportunities to support physical & mental health
- Prevent & manage chronic conditions
- Social determinants of health

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Board Member Perspectives

Key Strengths

- Engaged and committed workforce
- Clinic locations
- Rapid care clinic
- Emergency department
- Arbor Health Foundation
- Relationship with the Rural Health Collaborative

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Board Member Perspectives

Key Opportunities

- Youth community partnerships
- Health & wellness education
- Need for long-term care beds
- Elderly and prevention services
- Staff incentives
- Expand & fine-tune “Rapid Care” services
- Tell a better story
- Build a continuum of care with a strong prevention focus
- Consider low-cost services to attract new patients

Arbor Health Staff Perspectives

Key Strengths

- Internal teamwork & breaking down of silos
- Rapid care clinic
- Medical assistant apprentice program
- Open door leadership policy
- Personable care experience
- Information/social media presence
- Shorter wait times in emergency department
- Community service
- Increased access to services

Arbor Health Staff Perspectives

Key Opportunities

- Recruitment & retention of permanent staff
- Billing practices and processes
- Revenue recognition
- Same day appointment availability
- Equitable treatment of patients
- Discharge process
- Retail pharmacy
- Patient transportation
- Psychiatric telehealth services for the community
- Access to supplies

Community Listening Sessions

1. ***What services do you value that are currently offered by the District?***

- Imaging Services
- Mammography
- Laboratory Services
- Rapid Clinic – expansion desired
- *"Access is generally good"*
- *"Rehab dept. is strong"*

Community Listening Sessions

2. What services are currently not available that you would like to see offered locally?

- More same day availability (expanded hours)
- Diagnostic ultrasound
- Dermatology
- Childhood vaccinations offered at Rapid Care Clinic
- Instructions on how to access primary care
- Patient navigators
- Access to more information via patient portal
- Walk in availability in Packwood region
- Access to pharmacy services
- Improved coordination between regional emergency medical services and hospital

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Community Listening Sessions

3. What are the greatest unmet healthcare needs in the community?

- Mental health services – especially for young adults and children
- Chronic care
- Pediatrics
- Obstetric care
- Opioid management
- Veterans support
- Immigrant community support

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Arbor Health Strategic Planning 2023-2025

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Definition of “Strategic” Theme

- ✓ Longer-term timeframe
- ✓ Significant resource requirements
- ✓ Organization-wide growth
- ✓ Overarching issue focus
- ✓ Significant impact on groups of key stakeholders
- ✓ Affects organizational viability
- ✓ Directly impacts ability to achieve the mission
- ✓ Broader categories of action that more specific activities naturally fit within

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Proposed Strategic Themes

Financial Sustainability & Growth

Community Partnerships

Community Relations

Workforce Stabilization

Service & Quality

DRAFT

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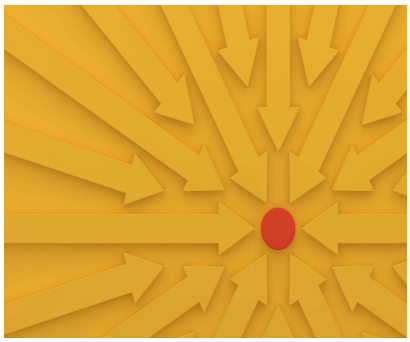
Definition of “Strategic” Goal



- ✓ Major area of priority over next 3 years
- ✓ Broad, tangible and descriptive
- ✓ Does not focus on the how, but rather what the results will look like
- ✓ Includes measurable indicators
- ✓ It is time based and achievable
- ✓ It is a stretch from where we are now

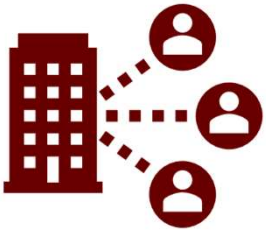
Financial Sustainability and Growth:

Utilize strategic and financially secure strategies to support growth and sustainability.

- ✓ Increase net revenues
- ✓ Define opportunities for growth and recapture outmigration
- ✓ Consider low-cost services to attract new patients
- ✓ Improve expense and supply management
- ✓ Improve collection processes and reduce denials
- ✓ Optimize utilization of Information Technology

Workforce Stabilization:

Recruit, retain, and engage highly qualified staff committed to delivering consistent, high-quality care and service to our communities.



- ✓ Focus on recruitment and retention of permanent employees
- ✓ Attract, develop, and retain strong talent and promote great careers
- ✓ Provide ongoing training opportunities for staff
- ✓ Identify ways to incentivize staff beyond compensation
- ✓ Partner with secondary schools and colleges to create or impact career pathways for our youth

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Community Partnerships:

Build and expand community partnerships; deliver programs that support physical and mental health of our community members.

- ✓ Continue to develop community partnerships especially around youth
- ✓ Provide health education at the community level
- ✓ Focus on wellness and prevention
- ✓ Partner with groups around the social determinants of health
- ✓ Ensure greater access to exercise and wellness programs/opportunities

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Service and Quality:

Improve access and quality of service so that our communities receive the appropriate level of care in a timely and equitable manner.

- ✓ Provide high quality healthcare experience
- ✓ Timely and improved access to services
- ✓ Increase behavioral health access points, services, and supports
- ✓ Improve discharge planning process
- ✓ Provide consistent positive experience of care
- ✓ Expand elderly care services
- ✓ Expand and fine-tune “Rapid Care” services

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Community Relations:

Foster greater trust and loyalty to Arbor Health within our communities by raising awareness of what the organization has to offer and what it does well.

- ✓ Identify new ways to engage the community to increase participation
- ✓ Continue to enhance Arbor Health’s social media presence
- ✓ Enhance and promote our value to the community
- ✓ Build a culture based on our values

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Group discussion

Please consider the following…

1. Do the strategic themes capture the most important areas for Arbor Health to focus on in the next three years? If not, what's missing?
2. Do the goals of each theme capture the targets and objectives? Is there anything that should be removed or anything that is missing?
3. What specific goals would you like to see prioritized:
   - Financial Stability and Sustainability
   - Workforce Stabilization
   - Community Partnerships
   - Access and Service
   - Community Relations

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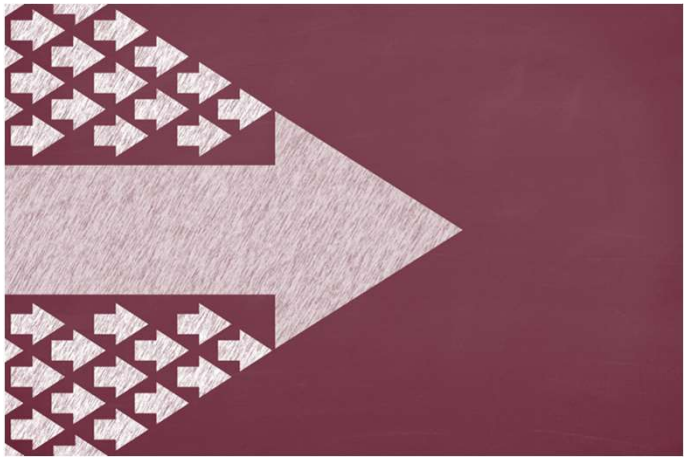

Arbor Health

Group Discussion Report Out

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Next Steps and Closing Comments

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Please take the time to complete the session evaluation before you leave.

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2023-2025 Community Health Needs Assessment Summary

Demographics

- 80% of Arbor Health's patients reside within Lewis County Public Hospital District No. 1 (District)
- District population – 11,000 (projected +4% by 2027)
- 30% of District residents are 65 or older (projected +14% by 2027)
- 8% of District residents are Hispanic (projected +17% by 2027)

Social Indicators Impacting Physical and Mental Health Outcomes

- Lewis County ranked 25th out of Washington's 39 counties in social and economic factors

Poverty and Income

- Significantly higher rates of children under 18 living in poverty in District (23% District vs. 16% County, 13% State)
- District median income of $53,125 vs. $54,970 County, $77,006 State

Educational Attainment

- Lower rates of educational attainment in the District vs. County and State
  - 46% of District population 25 and older report a high school diploma as highest educational attainment vs. 40% County, 30% State
  - 2.7% of District population 25 and older report having a master's degree vs. 13.9% State

Housing

- Nearly 1/3 of District and County homeowners pay >30% of their income on home costs.
- Of 35% vacant housing units, <4% are available for rent or sale

Unemployment

- District unemployment rate is 7% vs. 6.6% County, 4.9% State
- 24.2% of District residents report having three or more adverse childhood events (-12.4% between 2011 and 2021)

Other Social and Economic Factors

- More District children are living with single parents than County and State (34.1% District vs. 31.2% County, 25.4% State
- 15% of County residents report not having access to a reliable food source
- County households spend 30% of income on childcare costs vs. 27% State
- Violent crime rates are lower in the County (193 per 100,000 District vs. 294 per 100,000 State)

Health Behaviors that Strongly Impact Health

Alcohol and Tobacco Use

- Higher rates of current smokers in District and County (17% District/County vs. 13% State)
- 5% of District residents report heavy alcohol consumption vs. 3% County, 7% State

Opioids and Other Drugs

- Drug overdose deaths rate per 100,000 in the County were 21 compared to the State at 18

Other Health Behaviors

- 20% of District residents reported no physical activity outside of work vs. 22% County, 18% State
- 48% of County residents reported having access to exercise equipment vs. 80% State
- Significantly higher teen birth rate for females aged 15-19 in the County (28 per 1,000 County vs. 15 per 1,000 State

Clinical Care

Preventative Care

- Over 36% of women aged 40+ in the District have not received breast cancer screening vs. 27% State
- 22.9% of District residents have not had a checkup in the last year vs. 27.3% State

Immunizations

- 26.2% of County residents under 13 meet state immunization recommendations vs. 25.9% State
- Over 50% of District residents have not received a flu shot vs. 45.2% State

Health Care Provider Supply

- Lewis County has one primary-care physician per 2,240 residents vs. 1,180:1 State
- Lewis County has one dentist per 1,520 residents vs. 1,200:1 State

Health Outcomes

Physical and Mental Health Status

- 27.8% of District adults report having adult depressive disorder vs. 21.1% County
- 16.7% of District adults report poor mental health vs. 12% County, 12% State
- 67% of County youth report feeling anxious, 54% were unable to stop worrying, 39% felt sad or hopeless, and 23% considered suicide in the past year

Chronic Conditions

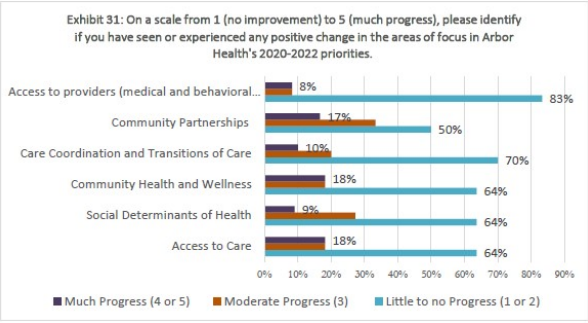
- The top five chronic conditions in Lewis County are – high cholesterol, high blood pressure, cancer, arthritis, and asthma (all of which have higher rates than the State)
- The District and County have higher rates of obesity and diabetes than the State

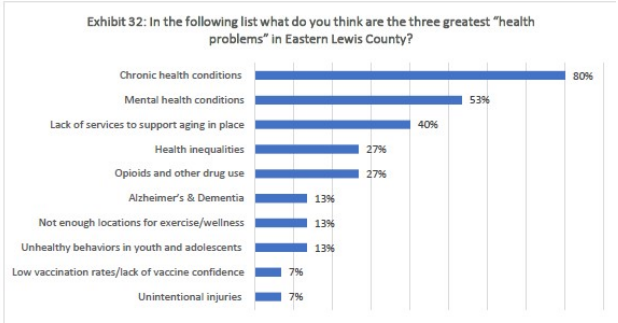
Length of Life

- The average life expectancy in Lewis County is 77.6 years of age vs. 80 years of age in the State
- The Lewis County premature death rate is 7,600 per 100,000 vs. 5,600 per 100,000 in the State

Community Health Priorities

2020 – 2022 CHNA Focus Areas and Outcomes





Selected 2023 – 2025 Community Priorities

- Recruitment and retention of a quality healthcare workforce.
- Better access to primary care.
- More behavioral health access points, services, and supports.
- More access to exercise and wellness programs/opportunities to support physical and mental health and prevent and manage chronic conditions.
- Partnering to address the social determinants of health (including housing, employment, and educational attainment).

Community Health Needs Assessment

2023 - 2025

Arbor Health

Morton Hospital
Mossyrock Clinic
Morton Clinic
Randle Clinic
Specialty Clinic

Adopted by the Lewis County Hospital District No. 1 Board of Commissioners, Wednesday, December 14, 2022

Table of Contents

Introduction and Brief History

More than 80 years ago, and as it was called then, Morton General Hospital opened as a privately-owned hospital to serve the health care needs of the hard-working settlers of East Lewis County. The goal was to care for those whose work in the timber industry helped build the Pacific Northwest. Over the decades to follow, the community grew, and in 1978, a public hospital district was formed to ensure the community a healthy future for generations to follow. Lewis County Public Hospital District No. 1 (a municipal corporation) then purchased the hospital.

In 1992, the hospital district constructed a 30-bed long-term care center addition to the hospital. The wing was later converted to serve as the hospital's inpatient rooms. A 1952 brick hospital structure served the community until 2006, when a new, modern facility was completed. The community celebrated the grand opening of the new hospital in January 2007. The new construction provided much-needed space for advancements in imaging and laboratory services.

The Lewis County Hospital District covers over 900 square miles and includes elevations as high as 4,500 feet. It extends east to White Pass, which is just southeast of Mt. Rainier National Park; west to Mayfield Lake, encompassing the towns of Mossyrock and Cinebar; and north to include the town of Mineral.

In January 2019, the District adopted a new parent name, Arbor Health (Arbor). This name change reflects the philosophy that our network of care is truly better when it works together, ensuring compassionate, professional health care right here in the community. With a canopy formed by trees and fall-themed colors of cranberry and gold, the Arbor name pays tribute to our timber industry and community history.

Arbor's Morton Hospital was designated as a Critical Access Hospital by meeting the federal and state designation requirements in the Washington State Rural Health Plan and the Medicare Conditions of Participation. Arbor operates three rural

Vision, Mission, Values

Our Vision:

To provide accessible, quality healthcare

Our Mission:

To foster trust and nurture a healthy community

Core Values:

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

Commitment to Quality Care:

Arbor Health is proud of the care we provide to our patients. Our goal is to provide the highest possible quality of care and continually improve our patient, staff, and physician satisfaction.

health clinics and several specialty clinics. More than 70% of our volume comes from outpatient and primary care volumes, and we provide a range of services, including behavioral health, respiratory and physical therapy, outpatient specialty care, diagnostic imaging, medical laboratory, and sleep medicine. Our Emergency Department, open 24/7, serves nearly 5,000 patients per year.

2020-2022 CHNA Priorities

Build external relationships and partnerships that prioritize unmet health needs, recognize the community's need and desire for more wellness services and address the impact of social determinants in health status.

Enhance health outcomes through recruitment and programs that increase access and support wellness, community health programming, coordinate whole person care, expand care coordination and transitions in care.

2020-2022 CHNA Update

Arbor's 2020-2022 CHNA and Implementation Plan priorities and strategies were adopted by the District's elected Board of Commissioners. They were selected after review of the collected data and feedback from community convenings. **Exhibit 1** details the priorities that were adopted and provides an update on key strategies implemented to address these priorities.

As with all health care facilities and communities across the nation, COVID-19 had a significant impact on Arbor's priorities during the 2020-2022 period, and that impact continues to date. At the time of this writing, there have been nearly 1.9 million total cases of COVID-19 in Washington State, and over 20,000 in Lewis County, resulting in almost 1,600 hospitalizations and nearly 300 deaths in the County.

Despite these challenges, Arbor has not only played a key leadership role in COVID mitigation, testing, and vaccinations, providing almost 6,000 vaccinations to date, but was also able to ensure access to quality care throughout our community despite the challenges posed by the pandemic. Due to Arbor's focus on COVID-19 response during 2020, the accomplishments highlighted in **Exhibit 1** focus largely on those made during 2021 and 2022.

Exhibit 1:

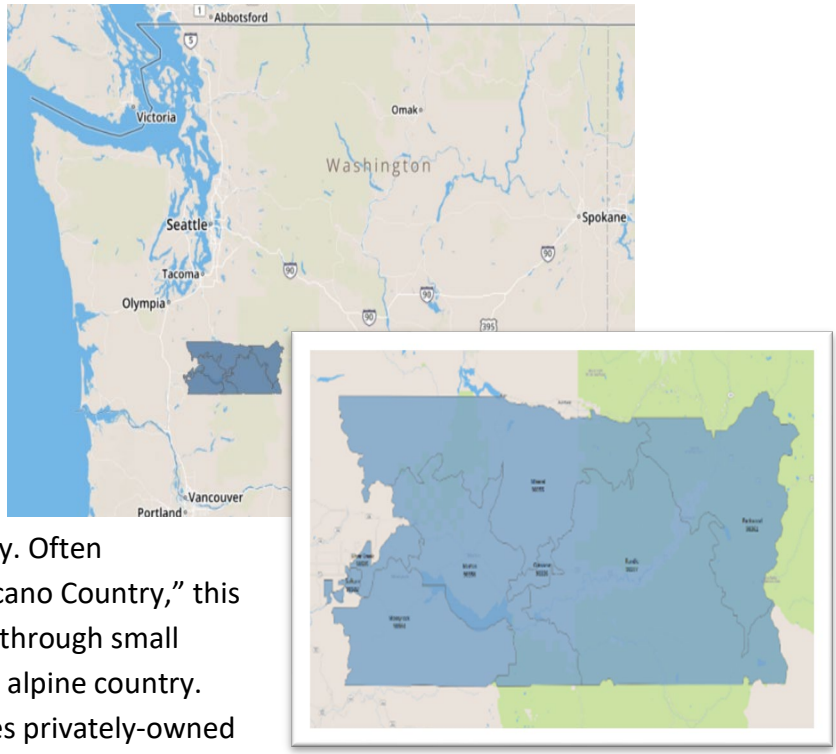
2020-2022 CHNA Priority Accomplishments

PRIORITY #1: Build Relationships and Partnerships That Prioritize Community Health Needs
Created a community-wide wellness plan through partnerships with providers, employers, and community-based entities focusing on the overall health of our community and identifying key chronic disease needs.
Provided 1,400 to-go meals to seniors in food-scarce homes.
Received Acute *Stroke Ready DNV* Stroke Certification in the Emergency Department in 2021.
Conducted eight community/EMS STROKE education events in 2022.
Increased mammography volume by 10% via external partners and targeted social media.
Promoted importance of infection control to the community every month via social media.
Established a medication disposal program for Morton, Mossyrock, and Randle.
Partnered with vendors and community groups to host live/virtual/drive-through health fairs each year.
Implemented immunization interface that meets DOH minimum data transmission thresholds.
Distributed community outreach messages every quarter re: Chest Pain/MI, Sepsis, COVID-19, Congestive Heart Failure, Pulmonary Disease, and Skilled Services.
Attended four local high school and college job fairs.
Created ImPACT concussion management and student athletic performance & injury management partnership with the schools' athletic programs.
Increased same-day surgery volumes by nearly 40% through targeted marketing and outreach.
Held three community engagement events at each of the Arbor Clinics each year.
Held one coordinated event each year with Insurance Payors to address school/community youth programs.
Increased number of patients referred for assistance with Medicaid eligibility by 200%.
Held a community weight loss challenge that culminated in a 5k/10k/Half Marathon each year.
Offered Critical Access Hospital experience for local RN and NAC program graduates four times/year.
PRIOIRTY #2: Enhance Health Outcomes Through Recruitment and Programs That Increase Access and Support Wellness
Established a new primary-care clinic in Packwood.
Increased the number of annual wellness visits in each of the clinics by over 20%.
Created five additional programs designed to improve overall patient outcomes.
Grew clinic telehealth visits by over 100% and specialty telehealth visits by nearly 300%.
Increased percentage of patients with documented patient education related to admission diagnosis within 4 hours of admission from 50% to 96%.
Implemented concurrent OPTUM admission review process for weekend admissions.
Decreased stroke/CT report turnaround to less than 15 minutes.
Over 50% of patients discharged on a new medication were counseled by a pharmacist in 2022.
Developed and implemented physician satisfaction/engagement survey.
Resolved compliance and HIPAA events within 15 business days.
Decreased the percentage of overdue and incomplete work orders from 28% to 19%.
Increased the number of financial assistance applications provided, returned, and approved by almost 40%.
Conducted employee engagement survey and increased employee engagement in events from 75% to 98%.
Increased the number of staff members participating in the 15-Minute Philanthropist program by 20%.
Monitored new antibiotic starts to improve monitoring of antibiotic therapy and other narrow therapeutic index drugs to facilitate the best drug therapy for our patients.
Reopened Pulmonary Rehab program.
86% of all venous leg ulcer patients achieved healed status (300% improvement) within 90 calendar days of starting therapy.
Increased documented skill-care assessments in Wound Care program to 84% from 68%.

Our Community and People

More than 80% of Arbor Health's patients reside within the boundaries of Lewis County Public Hospital District No. 1. The District encompasses 900 square miles and includes the communities of Morton, Randle, Mossyrock, Packwood, Glenoma, Silver Creek, Salkum, and Mineral. **Exhibit 2** depicts the boundaries of the District. Much of the District lies on the ancestral lands of the Cowlitz and Klickitat Native American Tribes.

Exhibit 2: District Map



Most of the District's communities are located along the White Pass Scenic Byway. Often referred to as the "The Playground of Volcano Country," this 124-mile U.S. Highway 12 corridor passes through small resource lands, river valleys, foothills, and alpine country. The region surrounding the byway includes privately-owned residential, agricultural, commercial, and forest land properties, as well as state parks, wildlife areas, power projects with associated recreation lands, the Gifford Pinchot and Okanogan-Wenatchee National Forests, Mount Rainier National Park, Mount St. Helens National Monument, and Mount Adams Wilderness Area. On a clear day, Mount Rainier, Mount St. Helens, and Mount Adams are all in full view.

The District's current population is approximately 11,000, as detailed in **Exhibit 3**. The District's population has increased by almost 7% between 2010 and 2022, and is expected to grow another 4% by 2027. Almost 30% of District residents are 65 or older, making the District one of the oldest communities in the State. The 65+ population is projected to grow by another 14% over the next five years. Approximately 8% of District residents are Hispanic, compared to 13% Statewide. Between 2010 and 2022, the District's Hispanic population grew by 57%, and is expected to grow another 17% by 2027.

Exhibit 3: District Demographics								
	2010	**% of Total Pop.**	**2022 Est.**	**% of Total Pop.**	**% Chg. 2010-2022**	**2027 Proj.**	**% of Total Pop.**	**% Chg. 2020-2027**
Total Population	10,287	100.0%	10,965	100.0%	6.6%	11,396	100.0%	3.9%
Pop. by Age								
0-17	1,844	17.9%	1,845	16.8%	0.1%	1,946	17.1%	5.5%
18-44	2,502	24.3%	2,758	25.2%	10.2%	2,850	25.0%	3.3%
45-64	3,636	35.3%	3,101	28.3%	-14.7%	2,897	25.4%	-6.6%
65-74	1,389	13.5%	2,110	19.2%	51.9%	2,500	21.9%	18.5%
75-84	714	6.9%	904	8.2%	26.6%	929	8.2%	2.8%
85+	202	2.0%	247	2.3%	22.3%	274	2.4%	10.9%
Total 0-64	7,982	77.6%	7,704	70.3%	-3.5%	7,693	67.5%	-0.1%
Total 65 +	2,305	22.4%	3,261	29.7%	41.5%	3,703	32.5%	13.6%
Hispanic	535	5.2%	840	7.7%	57.0%	985	8.6%	17.3%
AI/AN	160	1.6%	197	1.8%	22.7%	219	1.9%	11.5%
Fem. 15-44	1,379	13.4%	1,464	13.4%	6.2%	1,525	13.4%	4.2%
Source: Claritas 2022								

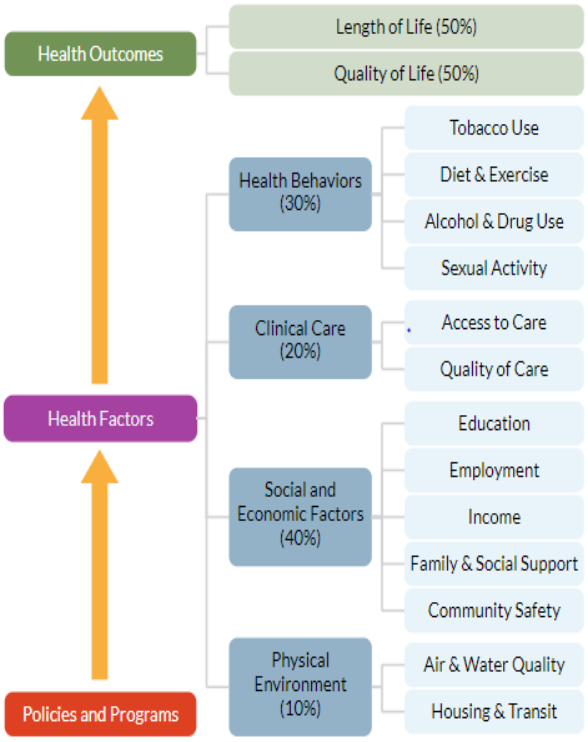
Methodology and Approach

The purpose of a public hospital district under RCW 70.44 is, among other things, *to provide hospital services and other health care services for the residents of the District and others*. Arbor sees the Community Health Needs Assessment (CHNA) process as a vital tool for understanding resident need and health care gaps. The intent is to use this CHNA for strategic and operational planning as we engage the community in various health improvement efforts. The voice of the community was important to this process and will be even more important as we move into development of the Implementation Plan.

Arbor organized this CHNA data collection and analysis consistent with the County Health Rankings (CHR) model developed by the Wisconsin Population Health Institute in collaboration with the Robert Wood Johnson Foundation (RWJF). This model recognizes that clinical care is only one element impacting a person's health. The RWJF publishes an annual report and health data for every county in the United States.

The model in **Exhibit 4** outlines a holistic view of population health, highlighting multiple factors and their relative contributions to health outcomes. This model delineates the underlying modifiable determinants of health that impact health outcomes (health factors) and groups them into four main categories (with associated weights): social and economic factors (40%), including indicators for community safety, education, employment, family and social support, and income; health behaviors (30%), which includes indicators for alcohol use, diet and exercise, sexual activity, and tobacco use; clinical care (20%), including access to and quality of care; physical environment (10%), consisting of air and water quality, housing, and transit.

Exhibit 4: RWJF CHR Health Model



Where data is available at the District level, we have incorporated it, and where not available, we have used Lewis County data as a proxy. Specific data sources used include:

- ALICE (Asset Limited, Income Constrained, Employed) Project
- American Community Survey, 2016-2020 (5-Year Estimates)
- Behavioral Risk Factor Surveillance System, 2016-2021
- DHHS, CDC, National Center for Chronic Disease Prevention and Health Promotion
- U.S. Census Bureau, 2021 Quick Facts
- University of Wisconsin, County Health Rankings & Roadmaps Program
- Washington Department of Health, All Deaths Dashboards, Chronic Disease Profiles, Social Determinants of Health Dashboard, Trauma Services, Immunization Data, Opioid Dashboard, Oral Health Profiles
- Washington HCA, Dental Data, and Apple Health (Medicaid) Reports
- Washington State Healthy Use Survey, 2021

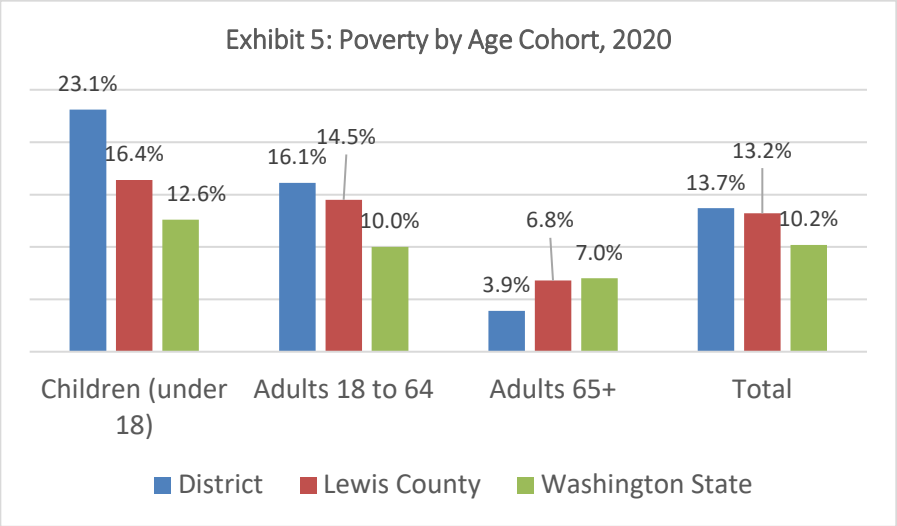
Health Factors and Outcomes in Lewis County

Social and Economic Factors – the Social Determinants of Health

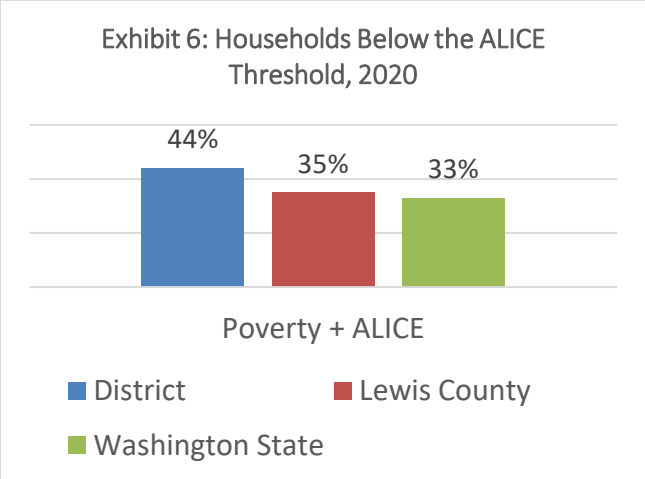
The social determinants of health—the conditions under which people are born, grow, live, work, and play—significantly influence the health of a community and its residents. These include indicators such as income and poverty levels, education level, unemployment, violent crime, and housing and childcare burdens. Lewis County is ranked 25th out of Washington's 39 counties related to social and economic factors.

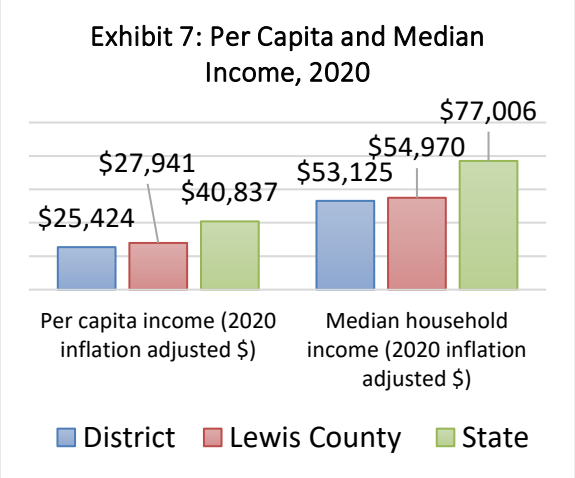
Poverty and Income

As seen in **Exhibit 5**, the District has significantly higher rates of children living in poverty (under 18 living in households earning below the Federal Poverty Level) than the County or State (23% compared to 16% and 13%, respectively).



With poverty being a critical predictor of poor mental and physical health outcomes, a 2020 United Ways of the Pacific Northwest report summarizes the status of ALICE families—an acronym that stands for Asset Limited, Income Constrained, Employed. These are working families that earn above the Federal Poverty Level (FPL), but do not earn enough to afford a basic household budget of housing, childcare, food, transportation, and health care.



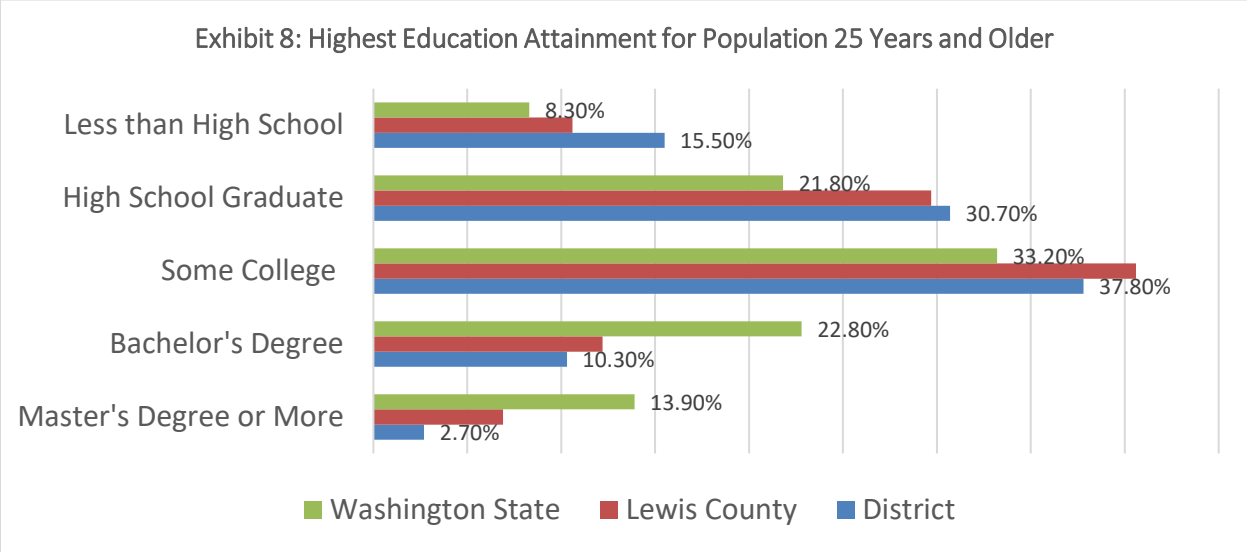


As identified in **Exhibit 6**, over 40% of households in the District are below the ALICE threshold, meaning they either make less than the FPL, or, if they earn above the FPL, it is still less than the basic cost of living for the area, and they struggle to make ends meet. This compares to 35% in the County and 33% Statewide. Per capita and median income are also slightly less in the District than in the County, but both are significantly less than the State. The per capita income in the District is $25,424, compared to $27,941 in the County and $40,837 in the State (**Exhibit7**).

Educational Attainment

Education is another significant social determinant that influences health over the course of a lifetime. Levels of educational attainment have been directly linked with important health outcomes. Adults with lower educational attainment are more likely to report worse health outcomes. For example, babies of mothers who did not graduate high school are twice as likely to die before their first birthday; and college graduates are expected to live at least five years longer than individuals who have not completed high school.

As identified in **Exhibit 8**, for almost half of the District population 25 years and older (46%), a high school diploma is their highest educational attainment. This compares to 40% in the County and 30% in the State. The percentage of the 25+ population that has some college or a bachelor's degree is also less in the District (48.1%, as compared to 52.8% in the County, and 56% in the State). Importantly, the State percentage of those with a master's degree is double that of the County, and five times that of the District.



Housing

The shortage of affordable housing limits a family's choice about where they live and often consigns lower-income families to potentially substandard housing in neighborhoods with higher rates of poverty and fewer accessible opportunities to improve health, including access to parks, bike paths, recreation centers, and community activities.

The Housing Affordability Index (HAI)—calculated and maintained by the Washington Center for Real Estate Research (WCRER) at the University of Washington—measures the ability of a middle-income family in 94 cities in the State with populations of 10,000 or more to make mortgage payments on a median price resale home. Critical to the notion of affordability, a household does not spend more than 25% of its income on principal and interest payments. It does the same for rentals, calculating the median income to afford an average-priced rental apartment without a family being overburdened. Renters are defined as being overburdened when rent exceeds 30% of gross household income.

Data from the American Community Survey in **Exhibit 9** demonstrates the lack of affordable housing in the District and County. Nearly one-third of District and County resident homeowners are paying more than 30% of their income on home ownership costs. Over 40% of renters in the District are paying more than the recommended 30% of income on rent.

Exhibit 9: Housing Affordability

Indicators	District	County	State
Residents paying more than 30% of income on homeownership costs	28.5%	30.8%	32.3%
Residents paying more than 30% of income on rent	40.9%	45.0%	45.2 %

Exhibit 10: Housing Availability

	District	County	State
Housing Units			
Occupied	65.5%	87.8%	92.2%
Vacant	34.5%	12.2%	7.8%
Vacant Housing Units			
For Rent	2.8%	7.8%	16.8%
For Sale Only	1.9%	6.0%	7.1%
Other Vacant	95.2%	86.2%	76.1%

Exhibit 10 further demonstrates the limited availability of housing in the District and County. While District-level data demonstrates that nearly 35% of housing units in the District are vacant, the vast majority of those are not actually available. Less than 4% of the vacant housing units in the District are available for rent or sale. The majority of vacant units fall into "other vacant," which includes units that have been sold but are not occupied yet; units for seasonal, recreational, or occasional use; units for migrant workers; those held for occupancy by a caretaker or janitor; and units held for personal reasons of the owner.

2-1-1 Counts

Washington 2-1-1 is the State's relatively new "go to" system for Washingtonians in need of accurate community health and human service information and referrals. 2-1-1- is a free, confidential community service and one-stop connection to local services such as utility assistance, food, housing, health care, childcare, after-school programs, elder care, crisis intervention, and more. The 2-1-1 data identifies social determinants of health and social needs trends in communities throughout Washington. The reports are designed to integrate with other data sets to provide a complete portrait of social determinants of health or social needs in a community.

As shown in **Exhibit 11**, with the exception of requests related to health care and COVID-19 (largely driven by COVID vaccination appointments), housing and shelter are the top reasons for calling the helpline and account for 20% of calls. Of those calls for housing and shelter, over half were for rent assistance (financial assistance for rent, mobile home lot fees, and other housing-related payments) and low-cost housing (programs that look for and provide housing, including subsidized housing, public housing, housing vouchers, and housing for people with special needs).

Exhibit 11: 2-1-1 Counts

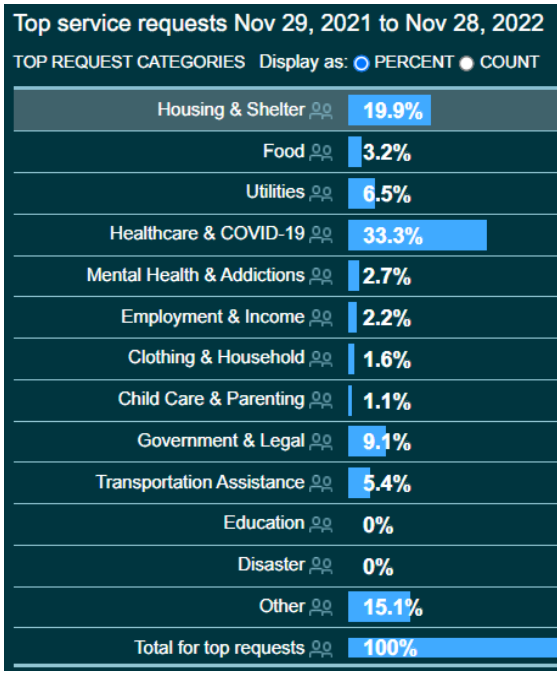
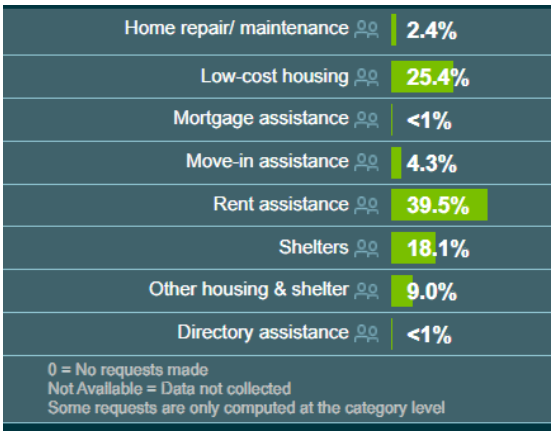


Exhibit 12: Top Housing & Shelter Requests



Unemployment

Unemployment can have negative health consequences. Those who are unemployed report feelings of depression, anxiety, low self-esteem, demoralization, worry, and physical pain. Unemployed individuals tend to suffer more from stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease, and arthritis. In addition, experiences such as perceived job insecurity, downsizing or workplace closure, and underemployment also have implications for physical and mental health. According to the American Community Survey (2020 data), while the District has slightly higher rates of unemployment (7.0%) than the County (6.6%), both are significantly higher than the State rate (4.9%).

Unemployment: 7.0% District

Unemployment: 6.6% Lewis County

Unemployment: 4.9% WA State

Adverse Childhood Experiences

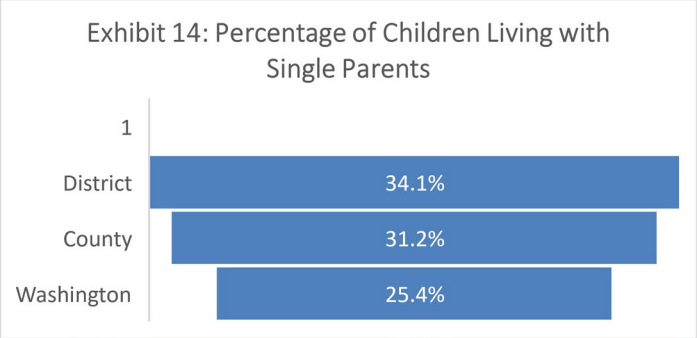
Exhibit 13: ACE Scores

	2011			2021		
ACE Score	**District**	**County**	**State**	**District**	**County**	**State**
1 to 2	22.0%	33.8%	35.6%	36.4%	32.0%	34.6%
3 to 5	31.7%	22.9%	19.7%	19.7%	24.7%	20.3%
6+	4.9%	5.5%	4.8%	4.5%	5.7%	5.7%
% 3+	36.6%	28.4%	24.5%	24.2%	30.4%	26.0%

Source: Washington Behavioral Risk Factor Surveillance System, 2011-2021.

Adverse Childhood Experiences, or ACEs, are traumatic events that occur in childhood and cause stress that changes a child's brain development. Exposure to ACEs has been shown to have adverse health and social outcomes in adulthood, including, but not limited to, depression, heart disease, COPD, risk for intimate partner violence, and alcohol and drug abuse. ACEs include emotional, physical, or sexual abuse; emotional or physical neglect; seeing intimate partner violence inflicted on one's parent; having mental illness or substance abuse in a household; enduring a parental separation or divorce; or having an incarcerated member of the household. **Exhibit 13** indicates that the percent of District residents who report having three or more ACEs has decreased since 2011 (24.2% in 2021 compared to 36.6% in 2011) and is now faring better than the County and is in line with the State (26%).

Other Social and Economic Factors



Adults and children in single-parent households are at risk for adverse health outcomes, including mental illness and unhealthy behaviors. Self-reported health has been shown to be worse among single mothers than for mothers living as couples, even when controlling for socioeconomic characteristics. Mortality risk is also higher among lone parents. Children in single-parent households are at greater risk of severe morbidity and all-cause mortality than their peers in two-parent households. The District's percentage of children living with single parents (34.1%) is higher than the County (31.2%) and significantly higher than the State (25.4%).

Exhibit 15 provides other County and State measures of social and economic factors that can impact physical and mental health outcomes. This data demonstrates that the County is faring far better than the State in terms of violent crime, but is faring worse in terms of food insecurity, with 15% of County residents not having access to a reliable source of food during the past year. Lewis County also has a lower Food Environment Index score (measure of factors that contribute to a healthy food environment) than the State (7.6 vs. 8.3). The County is faring worse in terms of childcare costs, with the average household spending 30% of its income on childcare for two children, compared to 27% in the State.

Exhibit 15: Other County and State Socioeconomic Characteristics

Metric	Definition	Lewis County	WA State
Violent Crime Rate per 100,000	Offenses that involve face-to-face confrontation	193	294
Food Insecurity	Did not have access to a reliable source of food during the past year	14%	10%
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best)	7.6	8.3
Childcare Cost Burden	Childcare costs for a household with two children as a percent of median household income	30%	27%

Source: 2022 County Health Rankings and Road Maps

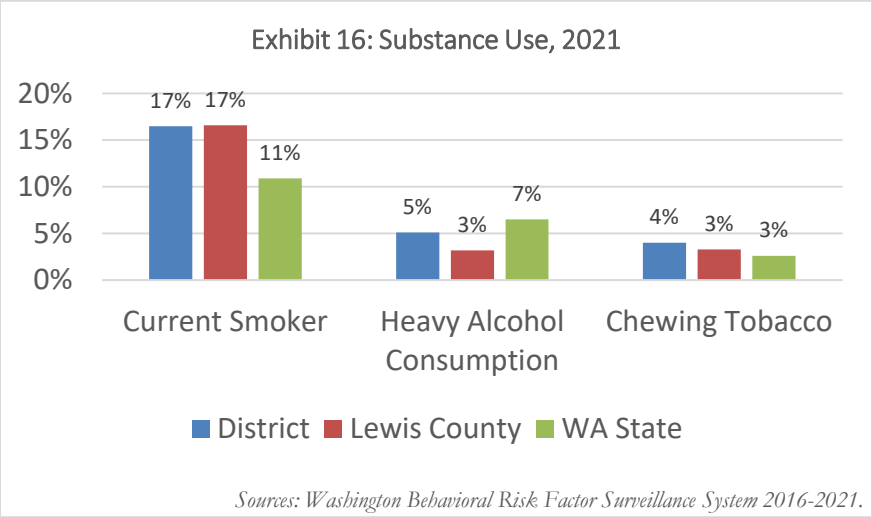
Better than WA State | Worse than WA State

Health Behaviors

Behavioral Risk Factors are those personal behaviors or patterns of behavior which strongly affect heath and increase the chance of developing a disease, disability, or syndrome if not managed or improved. Per RWJF's County Health Rankings, Lewis County is ranked 25th of the 39 Washington counties for Health Behaviors.

Alcohol and Tobacco Use

Smoking leads to disease and disability and harms nearly every organ of the body. Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Smoking also increases risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis.



As demonstrated in **Exhibit 16**, the percentage of adults who are current smokers in the District and County (both 17%) is higher than the State (13%).

Excessive drinking is also a risk factor for a number of adverse health outcomes, including alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes. Based on 2021 data, 5% of District residents reported heavy alcohol consumption. This was more than the County but less than the State rate.

Opioids and Other Drugs

Lewis County experienced more drug overdose deaths per 100,000 people in the 2018-2020 timeframe than Washington (21 per 100,000 compared to 18 per 100,000 statewide). Lewis County also experienced more drug-related hospitalizations than the State (110.7 vs. 81.5 per 100,000). Specific to opiates, Lewis County had a rate of 25 hospitalizations for all opiates per 100,000 people, compared to 20 Statewide.

Other Health Behaviors

Decreased physical activity has been related to several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. Sleep is also an important part of a healthy lifestyle, and a lack of sleep can have serious negative effects on one's own health, as well as the health of others. Ongoing sleep deficiency has been linked to chronic health conditions including heart disease, kidney disease, high blood pressure, and stroke, as well as psychiatric disorders such as depression and anxiety, risky behavior, and even suicide.

Exhibit 17: Health Behavior Measures

Access to Exercise:	Physical Inactivity:	Insufficient Sleep:
Lewis County: 48%	District: 20%	Lewis County: 33%
Washington: 79%	Lewis County: 22%	Washington: 32%
	Washington: 19%	

As identified in **Exhibit 17**, one in five District residents reports physical inactivity (no physical activity outside of work). The District fares slightly better (20%) than the County (22%) on this measure and slightly worse than the State (19%). Importantly, only 48% of Lewis County residents reported access to exercise opportunities (living close to a park or recreation facility), compared to almost 80% Statewide. Approximately one-third of Lewis County and Washington residents reported getting fewer than 7 hours of sleep per night, on average.

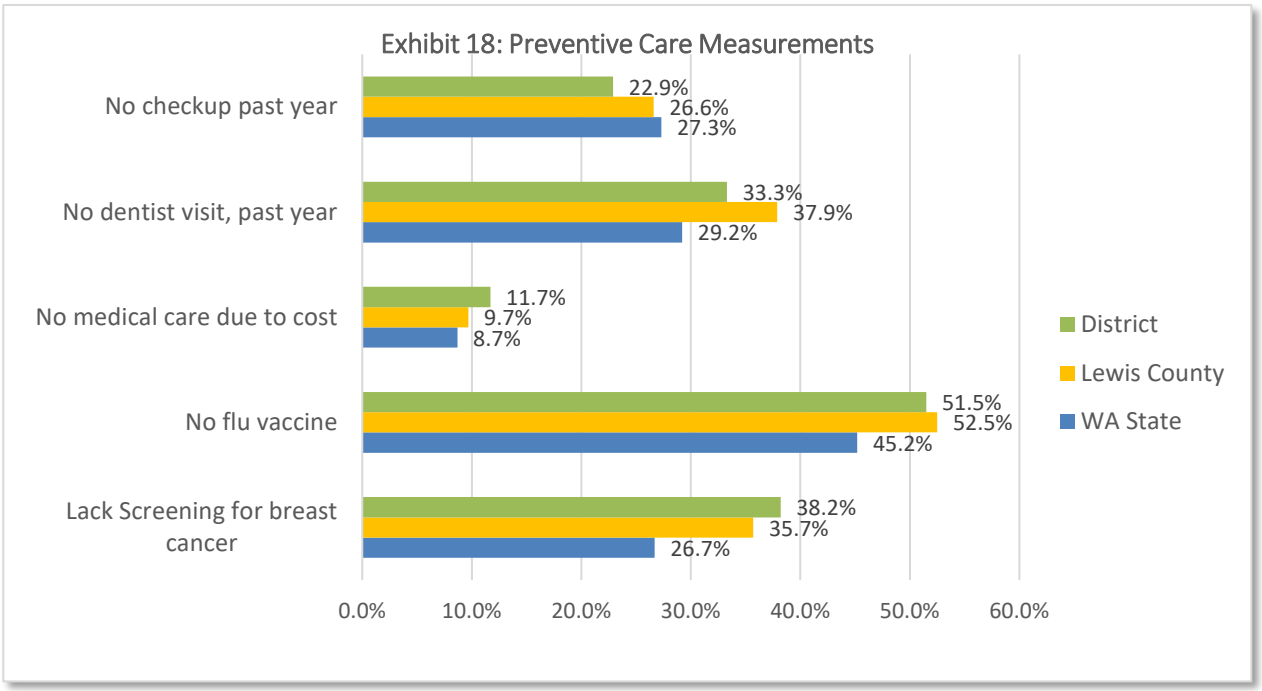
Early childbearing during teenage years has been associated with adverse health outcomes for the mother-child dyad, the impacts of which can extend to partners, other family members, and the community. Negative outcomes for children and mothers with early childbearing are best explained by social disadvantage and social adversity. Mothers who give birth during teen years face barriers to attaining an education at or above high school completion and face additional mental and physical stress as the result of chronic lack of community support. Young parents may struggle to find affordable, quality childcare and suitable transportation, further hampering options for education or employment. In Lewis County, the teen birth rate is significantly higher than the State, with 28 births per 1,000 females ages 15-19 in Lewis County, compared to 15 Statewide.

Clinical Care

Access to affordable, quality, and timely health care can help prevent diseases and detect issues sooner, enabling individuals to live longer, healthier lives. While part of a larger context, looking at clinical care helps us understand why some communities are healthier than others. Lewis County ranks 25th out of Washington's 39 counties for clinical care.

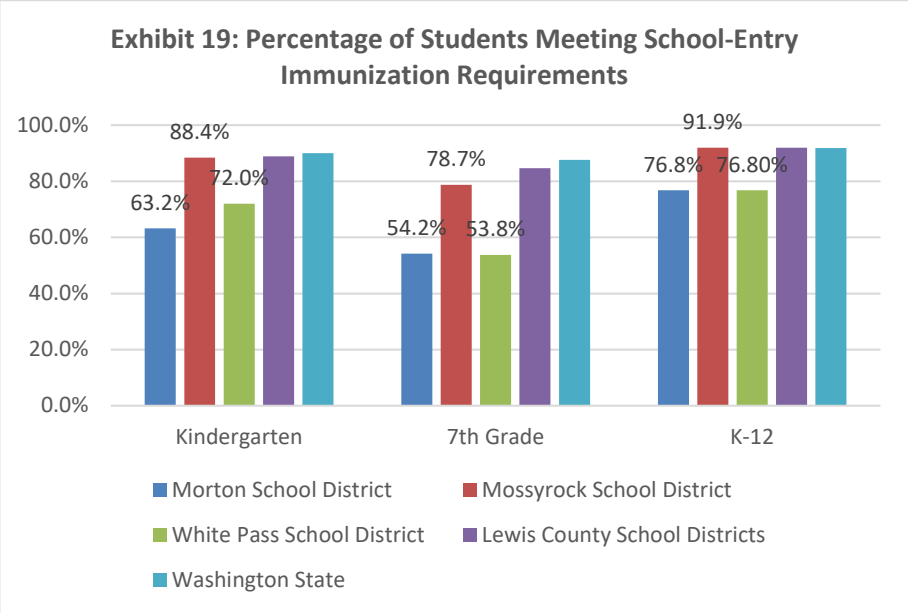
Preventive Care

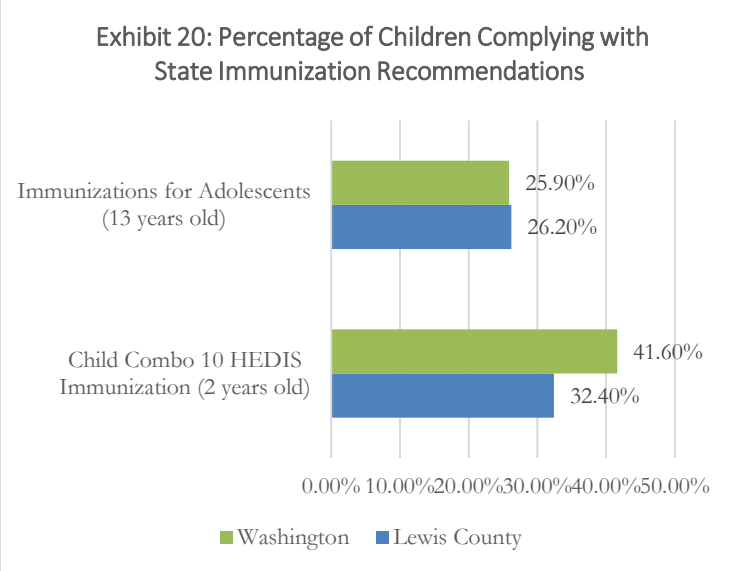
The District and Lewis County are doing worse than the State on all the measures of preventive care displayed in **Exhibit 18**, with the exception of getting a checkup in the past year. Over 36% of the District and County's women aged 40+ have not been screened for breast cancer, which is significantly more than the State rate of 27%. Importantly, over half of District and County residents have not received a flu shot, and more District residents report postponing needed medical care due to cost than the County or State rates. The District (22.9%) is doing better than the County (26.6%) or State (27.3%) in terms of having a checkup in the last year.



Immunizations

Receiving the appropriate vaccine on time is one of the best preventive health behaviors and one of the single most important ways parents can protect their children against serious diseases. While Lewis County School Districts overall and the Mossyrock School District within the Arbor Health community, are doing well overall in terms of meeting school-entry immunization requirements, Morton and White Pass School Districts are not faring as well as Mossyrock School District, and they have significantly lower rates of immunizations across all school-entry requirement measures than the County or State.



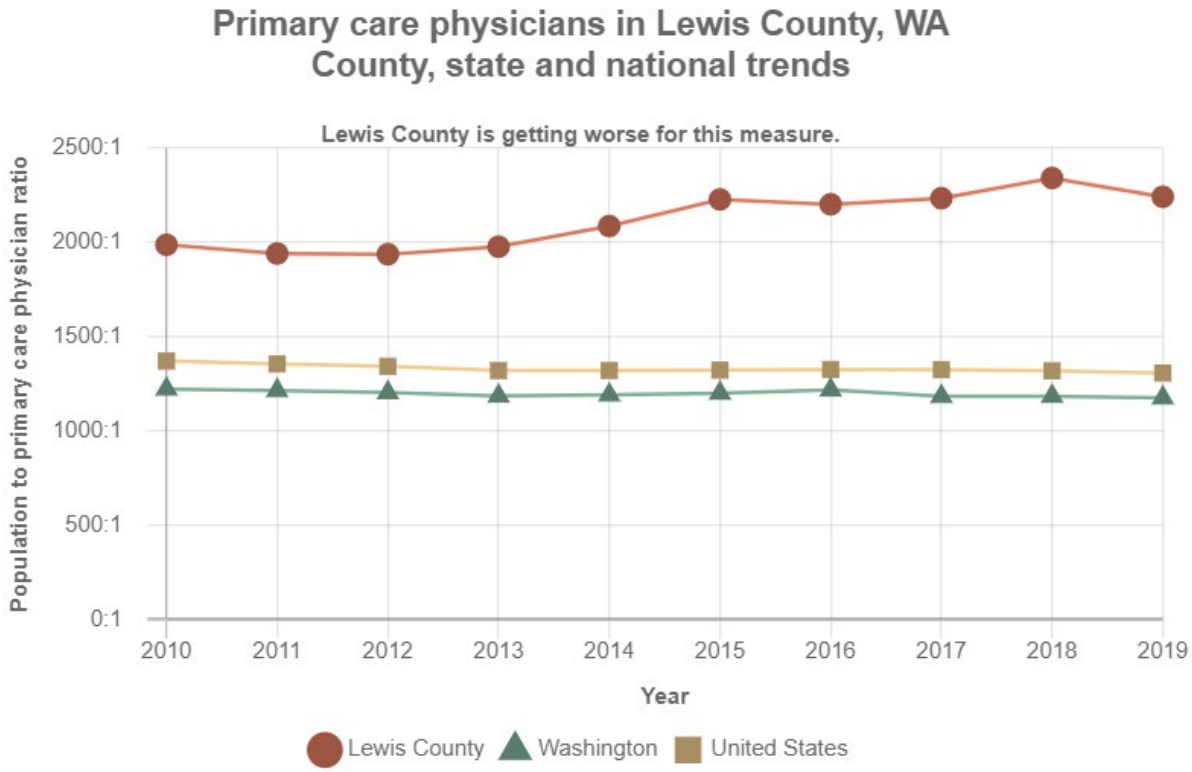


Lewis County is aligned with the State regarding the percentage of adolescents who received all of the recommended vaccinations by their 13th birthday, but the County fares significantly worse than the State for the percentage of children who received the recommended Combo 10 HEDIS vaccine series by their 2nd birthday (32.4% in Lewis County, compared to 41.6% Statewide).

Health Care Provider Supply

According to the American Medical Association's Area Health Resource File, there is one primary-care physician per 2,240 people in Lewis County. In the State, the number of people per primary-care physician is almost half that: one physician to 1,180 people. Importantly, the primary-care physician ratio has been getting worse in Lewis County over the last 10 years, as the State ratio has remained relatively flat (**Exhibit 21**).

Exhibit 21:



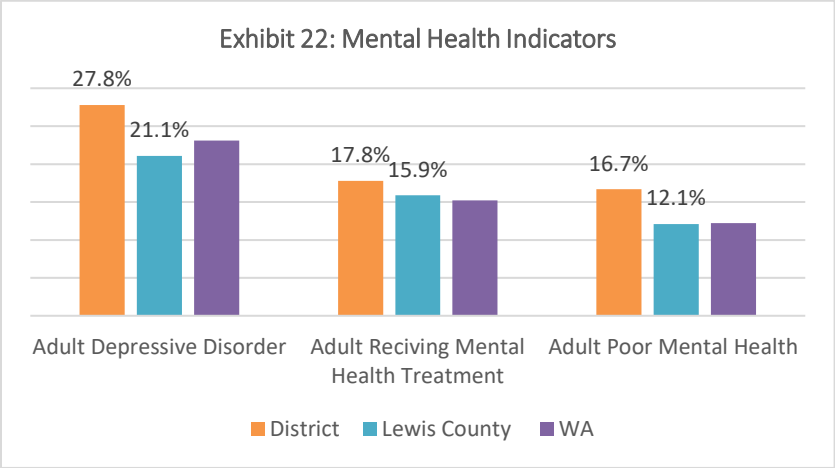
Lewis County's dentist-to-patient ratio is also worse than the State, with a ratio of 1,520:1 in Lewis County, compared to 1,200:1 in the State. The ratio of mental health providers to population in the County is in-line with the State (210:1 vs. 230:1).

Health Outcomes

Lewis County is ranked 30th of the 39 Washington counties for Health Outcomes. This is a picture of how long people live and how healthy people feel while alive. This ranking is based on the rates of premature death, those with poor or fair health, the number of days with poor physical or mental health days, and the number of babies born with low birthweight.

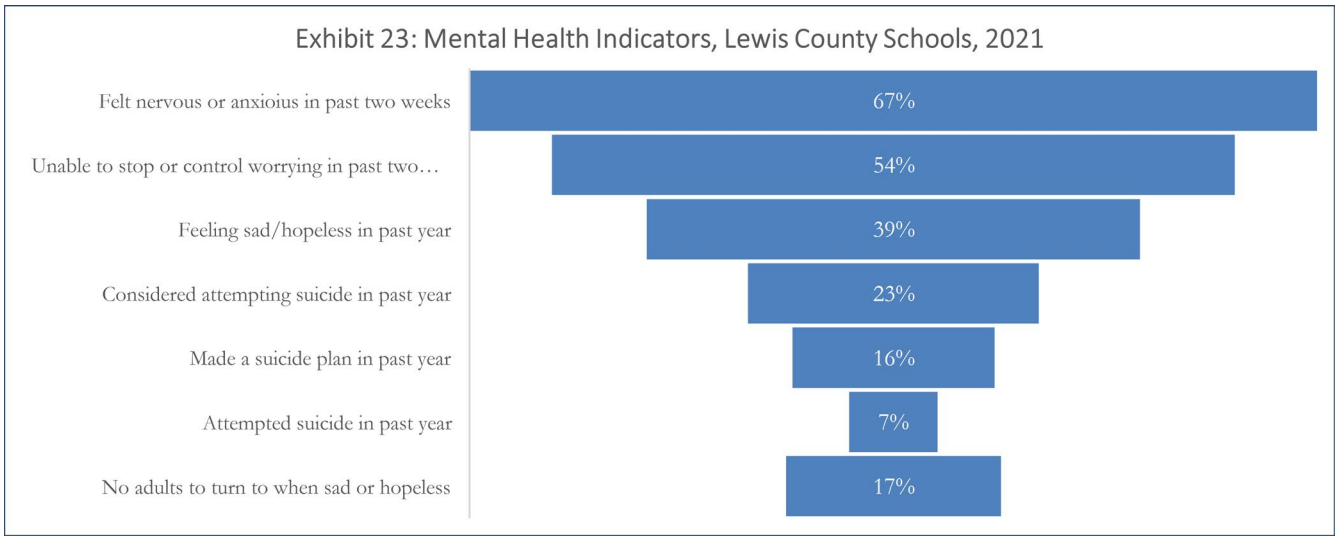
Physical and Mental Health Status

An estimated 20% of the U.S. population has a diagnosable mental disorder in any given year, including 5% who have a serious mental illness such as schizophrenia or bipolar disorder. Only 42% of those adults diagnosed with a mental illness receive mental health services.

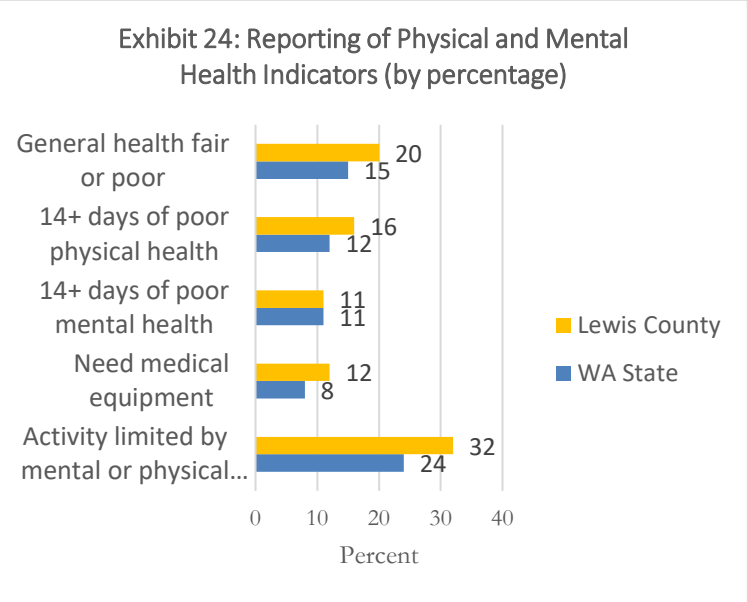


On key mental health indicators, the District is faring worse than the County and the State (**Exhibit 22**). The percentage of adults who reported being told they have a depressive disorder in the District is 30% higher than in the County. More adults in the District also report poor mental health (self-reported that their mental health was "not good" 14 or more days in the past 30 days); 17% in the District, 12% each in the County and State.

As identified in **Exhibit 23**, and according to the State's Healthy Youth Survey, 67% of Lewis County students felt nervous or anxious in the past week, 54% were unable to stop or control worrying in the past two weeks, 39% reported feeling sad or hopeless in the past year, and 23% considered suicide in the past year. These percentages are similar to the State's rates.

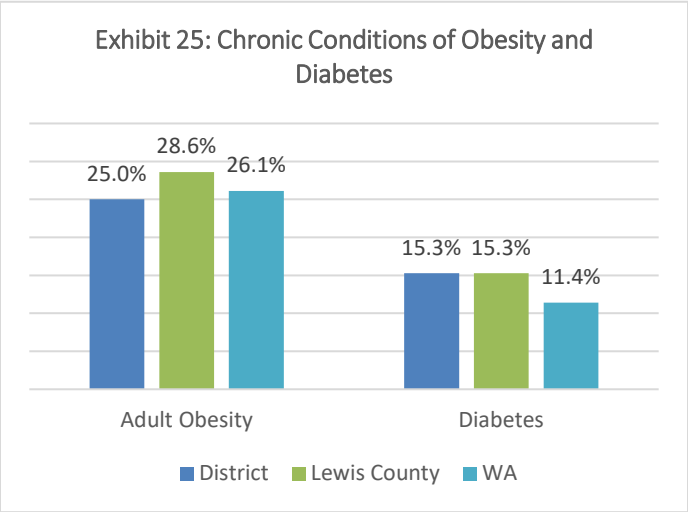


Whether poor mental health leads to poor physical health, poor physical health leads to poor mental health, or both are caused by a common risk factor is not clear. **Exhibit 24** demonstrates that Lewis County in general fares worse than the State on mental and physical health indicators. More than 30% of Lewis County adults surveyed reported have their activities limited by mental or physical health (compared to a State rate of 24%), and 20% reported their general health was fair or poor, with 16% reported having 14 or more poor physical health days in the last year.

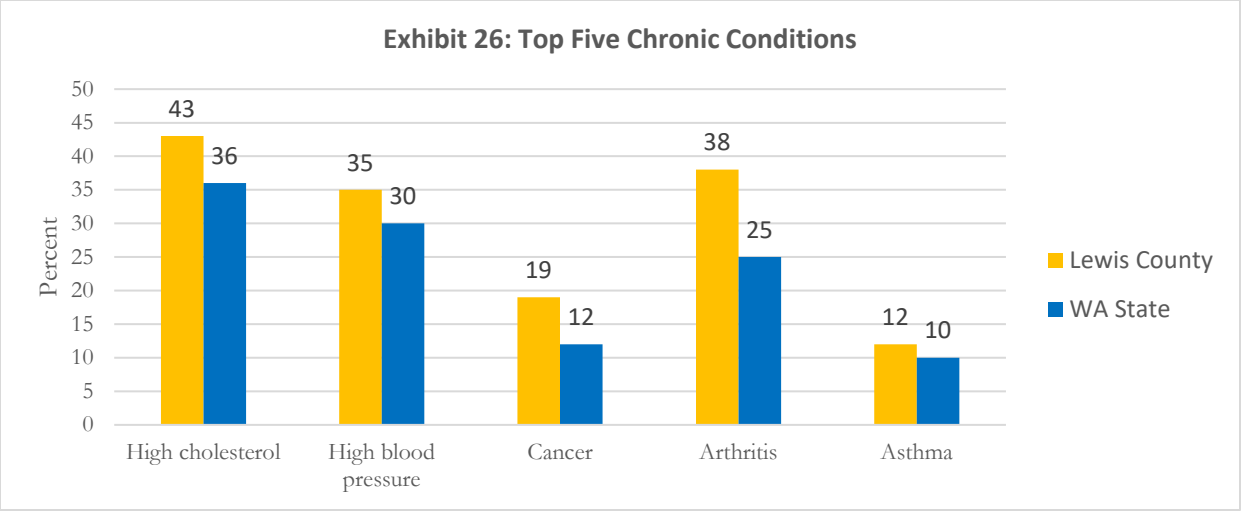


Chronic Conditions

Chronic diseases are broadly defined as conditions that last 1 year or more, require ongoing medical attention, and/or limit activities of daily living. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States.

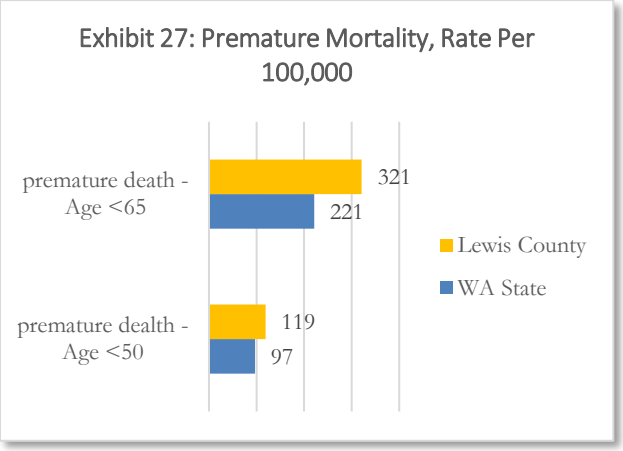


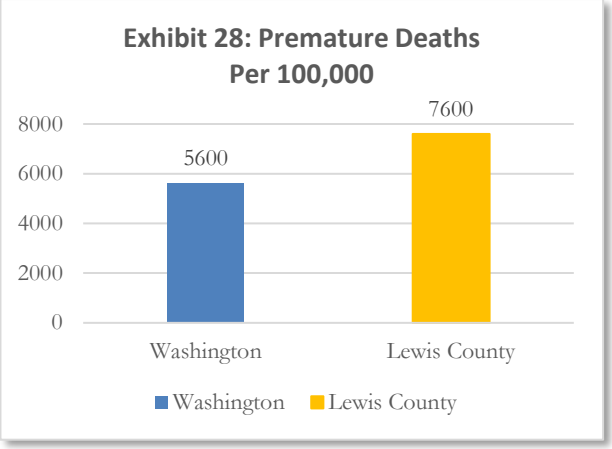
As identified in **Exhibit 25,** the prevalence of obesity in the District is less than in the County or State. However, the percentage of those with diabetes is higher in the District and in the County than Statewide. Of the chronic conditions listed in **Exhibit 26,** Lewis County adults have higher rates than the State across the board, including a significantly higher percentage of adults with high cholesterol, arthritis, and cancer.



Length of Life

Analyzing the leading causes of death in an area provides insight to the health status of a population. A high rate of deaths due to preventable causes indicates heightened disease burden or an unmet need for health care services. Every death occurring before the age of 75 is considered premature and contributes to the total number of years of potential life lost. The average life expectancy of Lewis County residents is 77.6 years of age, lower than the State average of 80 years. Lewis County is also ranked 32nd of the 39 Washington counties for



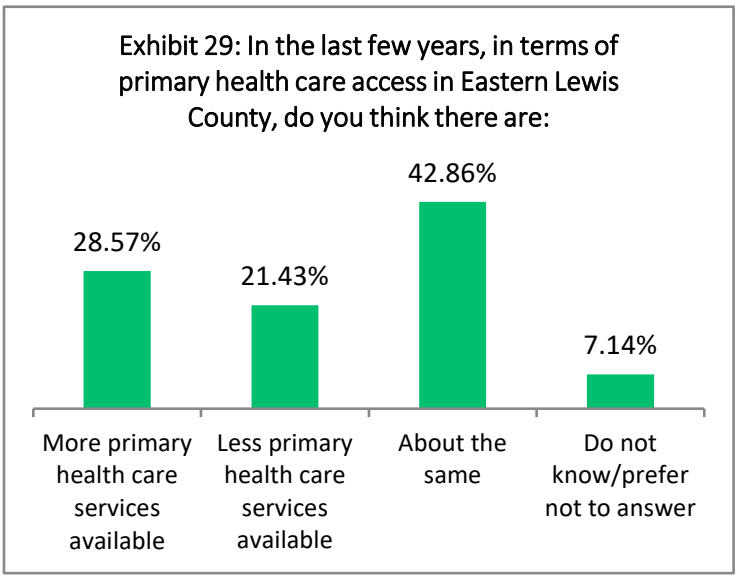


premature deaths, with 7,600 premature deaths per 100,000 residents. These rates have increased from 2016. In comparison, the State average is 5,600 per 100,000, and the top healthiest U.S. counties have rates of 5,400 per 100,000. Specifically, there are significantly more premature deaths in Lewis County than the State average for those between 50-65 years of age.

Community Convening

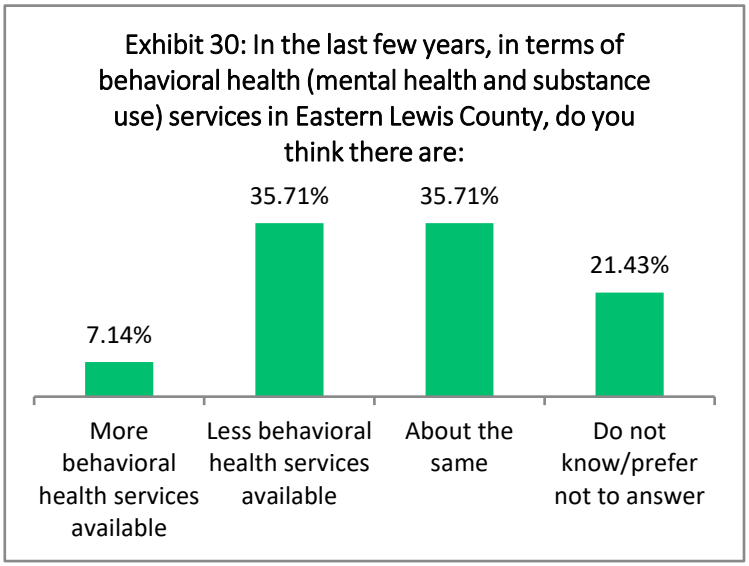
Arbor Health engaged community leaders to secure input regarding unmet health needs and priorities. In the Fall of 2022, Arbor Health surveyed key community leaders and health care providers including representatives from public health, physical and mental health providers, first responders, school districts, social service and civic agencies throughout Eastern Lewis County. 60% of all surveys were returned. Responses and themes are summarized below. Arbor Health has also begun a process of engaging staff and the broader community via a survey, which at the writing of this survey is still ongoing. The results will be used to inform and develop the specific implementation strategies.

The survey asked the community leaders to respond based upon what they have heard or experienced in the community; and wherever possible to share their insights and perspectives as a community leader/provider. Highlights and takeaways from the survey are provided below.



Primary Care and Behavioral Health Access

Respondents had mixed responses regarding **primary care access** with the most common response being *"about the same".* Seven percent did not know or preferred not to answer, and the remaining 50% were split between more or less. Importantly, none of the respondents thought wait time to see a primary care provider improved over the last few years; almost 60% thought wait times had worsened.



Community leaders reported that behavioral health services are faring worse in terms of access: only 7% felt that there were more services available today then there were a few years ago. 36% of respondents reported less behavioral health, and 21% reporting that that did not know or preferred not to answer.

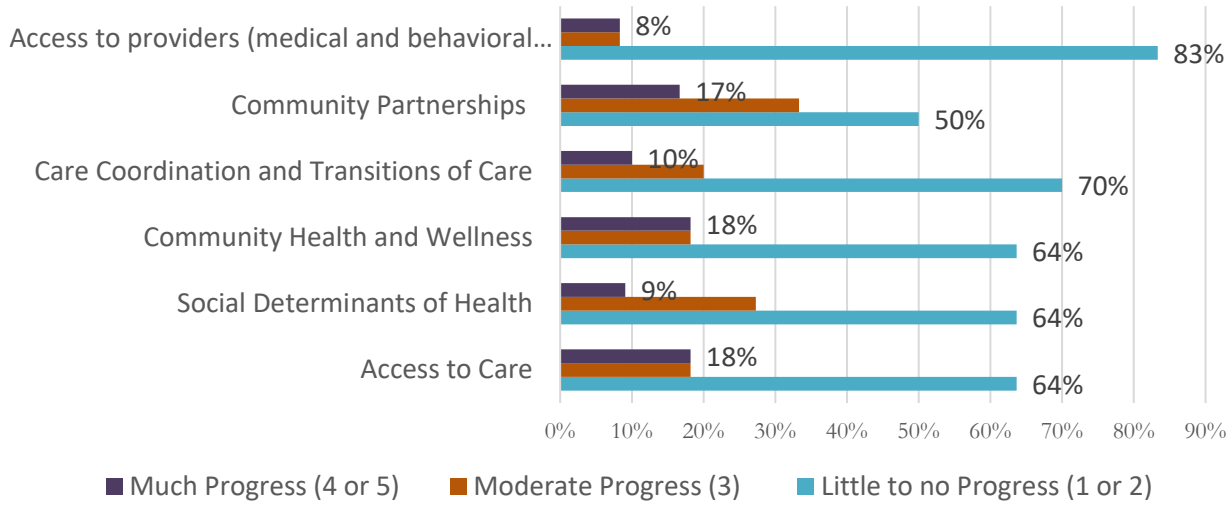
Community Health Priorities

The survey also queried for insight and perspective on Arbor Health's 2020-2022 focus areas from the CHNA priorities including: *Access to Care, Social Determinants of Health, Community Health and Wellness, Care Coordination and Transitions of Care, Community Partnerships, and Access to Providers (medical and behavioral health);* and also to respond to Arbor Health's two selected priorities, which include:

- Building external relationships and partnerships that prioritize unmet health needs, recognize the community's need and desire for more wellness services and address the impact of social determinants in health status.
- Enhancing health outcomes through recruitment and programs that increase access and support wellness, community health programming, coordinate whole person care, expand care coordination and transitions in care.

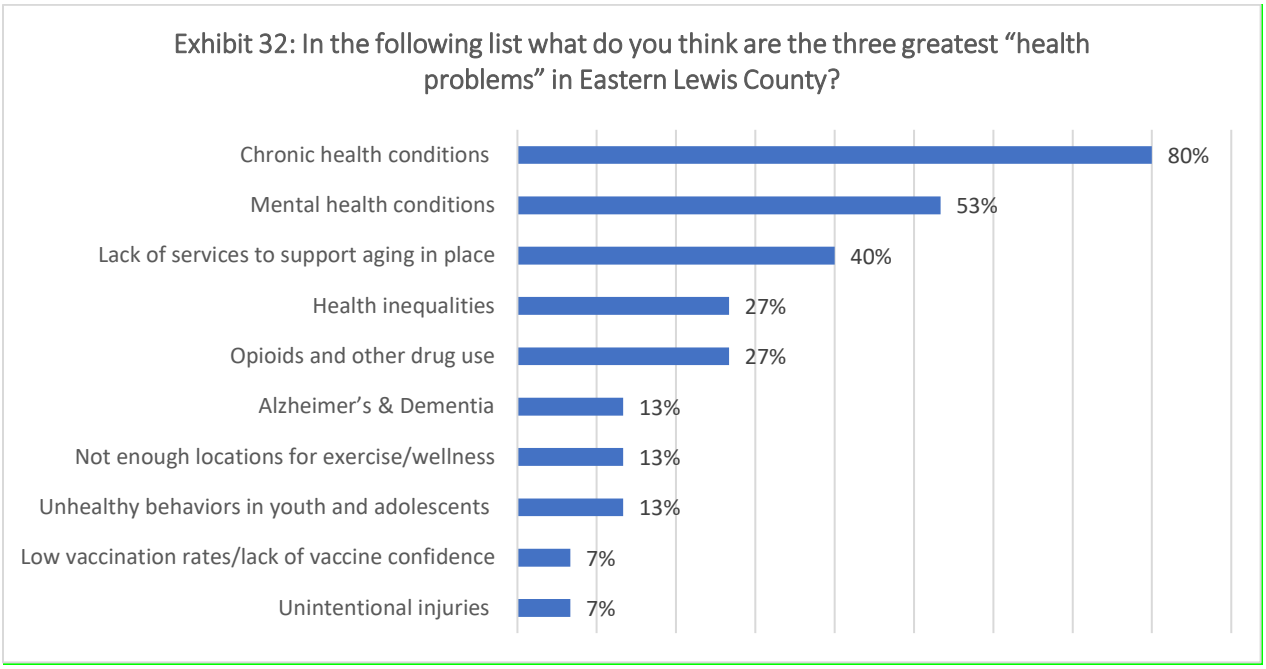
Exhibit 31 demonstrates that of those respondents that had an opinion, most community leader respondents had not seen or experienced positive change in the community related to the focus areas from the previous CHNA, with the exception of Community Partnerships wherein 50% reported moderate to much progress. 83% said they had seen little to no improvement related to access to medical and behavioral health providers. 70% had seen little to no improvement in care transitions and coordination.

Exhibit 31: On a scale from 1 (no improvement) to 5 (much progress), please identify if you have seen or experienced any positive change in the areas of focus in Arbor Health's 2020-2022 priorities.



Respondents were then asked to rate the overall health of East Lewis County: 64% ranked the county as somewhat healthy, 29% as unhealthy and 7% did not know or chose not to respond. Importantly, none of the community leaders rated the community as healthy or very healthy.

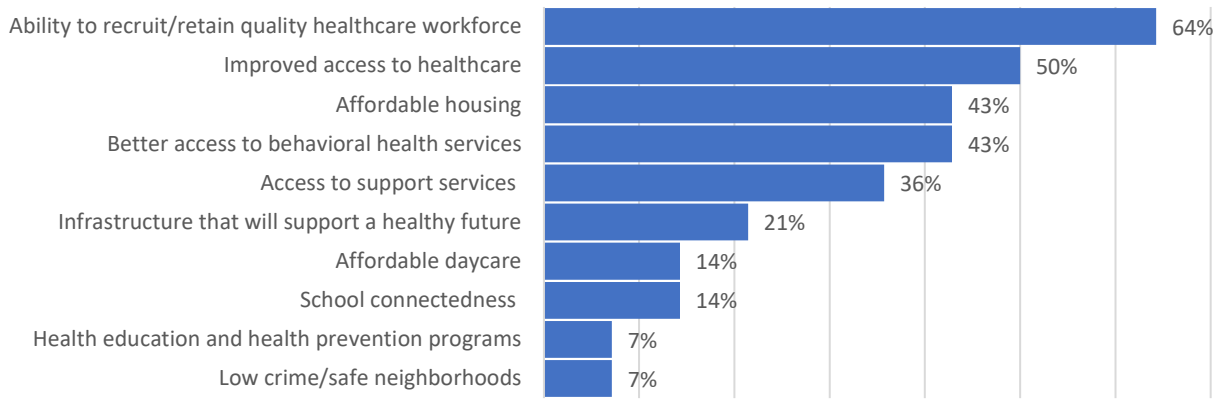
To understand the factors underlying respondent beliefs about the health of the community, they were also given a list of 14 health problems, and asked*, "what do you think are the three greatest 'health problems' in the community?"* **Exhibit 32** shows that chronic conditions were seen as the greatest health problem with 80% of respondents identifying chronic conditions as one of the top three health problems. Mental health conditions ranked number two (53%), and lack of services to support aging (40%) in place ranked number three.



While only 13% of respondents suggested that the lack of options and places for exercise and wellness is a problem, Arbor Health notes that data tells us that the two highest rated problems, chronic health and behavioral health, are both improved by access to exercise and wellness programming.

Community Leader respondents were then provided a list of factors and were asked to "*Identify the top three most important factors that will improve the health and quality of life in Eastern Lewis County?"* **Exhibit 33** shows that over 60% of respondents identified the ability to recruit and retain a quality healthcare workforce as one of the top three factors for improving health and quality of life in the community. Improved access to healthcare (50%), better access to behavioral health services (43%), and affordable housing (43%) were also identified as top factors.

Exhibit 33: the top three most important factors that will improve the health and quality of life in Eastern Lewis County?



In addition to ranking the recruitment and retention of a quality healthcare workforce as the top priority, when asked to rank the importance of focusing on workforce development and retention in comparison to other healthcare needs in Eastern Lewis County, 50% of respondents thought it was somewhat important, 29% thought it was important, and 21% thought it was critically important. No respondent said that a focus on workforce was not important.

Some of the same themes identified as health problems above were similarly reflected in an open-ended question where respondents were asked "*Are you aware of any populations in East Lewis County that are less healthy or are experiencing greater disparities*?" Groups identified with inequities, included:

- Mental health patients
- Patients with chronic medical issues
- Low-income
- Elderly
- Fractured families/single parent households

Community leader respondents were also asked to respond to an open-ended question which read *"Is there anything else you would like to add about the health of your community?"* Exhibit 34 identifies that these responses were largely focused on the availability, accessibility and affordability of health care services and providers. Respondents also recognized the impact of social determinants including community connectedness, employment, and affordable housing.

Selected 2023-2025 Community Priorities:

The results of the community engagement process and data in this CHNA support a focus on:

- Recruitment and retention of a quality healthcare workforce
- Better access to primary care
- More behavioral health access points, services and supports
- More access to exercise and wellness programs/opportunities to support physical and mental health and prevent and manage chronic conditions.
- Partnering to address the social determinants of health (including housing, employment, and educational attainment).

Exhibit 34: Is there anything else you would like to add about the health of your community?
Need more affordable healthcare.
The changing community: with more vacation rentals, fewer neighbors in community to check in on one another.
Severe lack of resources for the treatment of the mental health population.
Nursing and physician shortages
Grateful for Packwood Clinic opening.
Would like to see more employment and affordable housing opportunities.
Need more timely appointments and responses from clinics.
Poor health due to inability to access health care.

Implementation Plan

Over the next several months, Arbor Health will drill down on the needs and priorities identified in this CHNA through further engagement with and input from the community, which will culminate in the development of an Implementation Plan. Specifically, Arbor Health will complete the general community surveying (and we expect to have in excess of 200 community surveys and targeted follow-up interviews that will guide this work) and then work with its community partners, as well as our staff and Board to validate the selected priorities, determine which priorities Arbor Health has the expertise, funding and resources to address, which Arbor Health can support other organizations in the community in leading, and then ultimately developing specific Implementation Plan strategies for addressing the selected priorities.

Once this community engagement and Implementation Plan process is complete, the Plan will be presented to the Board; adopted and appended to this CHNA. Consistent with IRS rules it will also be widely disseminated. More importantly, it will serve as Arbor Health's guidance for the next three years in implementing community health improvement efforts.

Board of Commissioners 2023 Strategic Planning Retreat
Board Member Interview Summary

I. Arbor Health's current strengths:

- The workforce is committed and engaged within the community (4)
- The geographic location of clinics (2)
- Opening of the rapid care clinic (2)
- The emergency department
- The Arbor Health Foundation
- Relationship with the Rural Health Collaborative

II. Arbor Health's most significant weaknesses or challenges:

- Staffing recruitment, retention, and engagement (5)
- Fiscal health of the organization (though members recognize this is a national issue) (3)
- Lack of trust of Arbor Health within the community (3)
- Poor communication especially around out-processing of patients (2)
- Increased expenses such as the reliance on travelers and employee benefits (2)
- The change in senior leadership (2)
- Ability of the system to keep up with the influx of people moving into the area
- Access to care and long wait times

III. Arbor Health's greatest opportunities in the next 2-3 years:

- Continue to develop community partnerships especially around youth, i.e., physical therapy services in sports to bring younger patients in and relationships with schools and colleges to grow our own employees (4)
- Provide health and wellness education at the community level, i.e., diabetes care, mental health and substance use, parenting classes (4)
- Re-open hospital's long-term care (LTC) program or a new free-standing LTC facility (3)
- Focus on services for the elderly as well as overall preventive services (2)
- Identify ways to incentivize staff beyond compensation i.e., daycare services, educational opportunities (2)
- Expand and fine-tune the "Rapid Care" services in Morton (2)
- Advertise what Arbor Health has to offer – do a better job telling the story of what it has to offer and what it does well (2)
- Build out a continuum of care that has a strong preventive focus
- Add services that have little infrastructure costs associated with them to attract new patients, i.e., chiropractic services

IV. Most serious external threats to Arbor Health:

- Inability to recruit or retain qualified staff (4)
- Workforce retention (3)
- Financial health (2)
- Reliance on travelers
- Reduction in efficiency due to low staffing levels and burnout
- Aging population
- Out migration of patients to competitors
- Mental health

V. 3 most critical issues that can/must be addressed in the new 3-year strategic plan:

- Improve financial health to ensure long-term sustainability
- Workforce stabilization
- Build and expand community partnerships to improve population health and ensure health equity
- Develop the community's trust and loyalty to Arbor Health to prevent out migration and ensure long-term viability

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

The Two Different Types of Hospitals in the U.S.

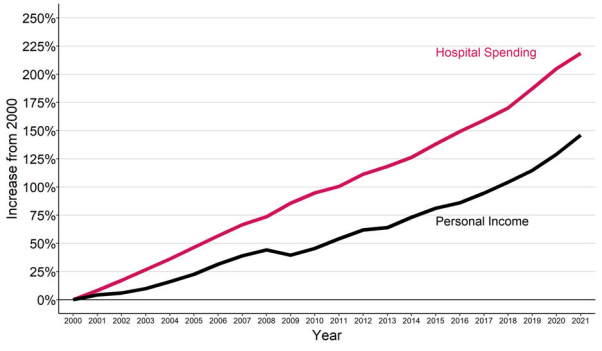
The Need to Control Hospital Spending Without Harming Patients

Hospitals are an essential part of the healthcare system. Although far more care is being delivered in patients' homes, physicians' offices, and ambulatory surgery centers today than in the past, there are many types of services that cannot be safely delivered in any setting other than a hospital.

Moreover, it is important for every community to have adequate hospital capacity available when it is needed. During the coronavirus pandemic, hospitals unexpectedly needed to provide care for tens of thousands of patients with COVID-19. Some communities were forced to erect temporary hospitals or inpatient units in order to ensure there would be adequate capacity to treat all patients who needed care.

However, hospitals are also very expensive. The United States spends more than $1.3 trillion each year on hospital services. More than one-third (37%) of total healthcare spending goes to hospitals, a far larger share than any other healthcare sector. Over the past two decades, national spending on hospital services tripled, more than the increase in total healthcare spending and far more than the growth in personal income. Hospital spending is expected to increase even faster now due to inflation, supply chain problems, and staff shortages.

Cumulative Growth in National Hospital Spending and Personal Income, 2000-2021



Sources: CMS National Healthcare Expenditure Accounts, BEA Personal Income Data

Because hospitals represent such a large portion of total healthcare spending, it will be almost impossible to make health care or health insurance more affordable unless methods are found to control the growth in spending on hospital care. However, this must also be done in a way that preserves the ability of all citizens to obtain high-quality hospital care in a timely fashion.

As the country searches for policies that will control or reduce hospital spending while maintaining access to quality care, it is essential to recognize that the nation's hospitals fall into two very different categories: (1) small rural hospitals, and (2) urban and larger rural hospitals. These two groups of hospitals differ dramatically in terms of both the amount they contribute to healthcare spending growth and the size of the financial challenges they face in delivering healthcare to the communities they serve.

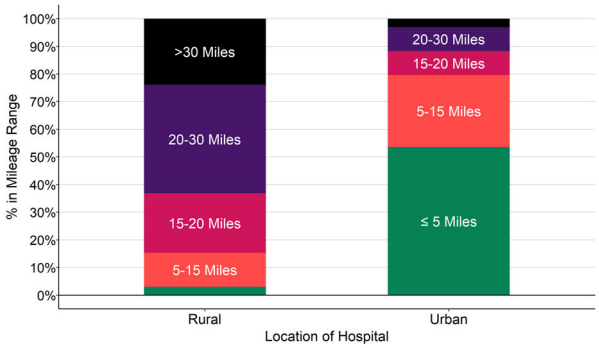
How Rural Hospitals Differ From Urban Hospitals

Almost one-half of the nation's short-term general hospitals are located in rural areas. Rural hospitals differ from urban hospitals both in terms of their size and their distance from other hospitals:

Most rural hospitals are the only source of hospital care in their community. Most cities and urban areas have multiple hospitals that patients can use, but most rural communities have only one hospital that is easily accessible, if they have a hospital at all.

- The majority of urban hospitals are less than 5 miles away from another hospital, and 80% are within a 15 mile drive from another hospital.
- In contrast, almost two-thirds of rural hospitals are more than 20 miles away from the next closest hospital, and one-fourth are 30 miles or more away.

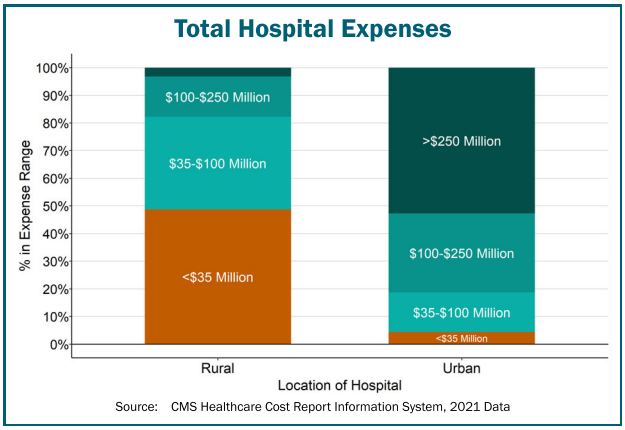
Driving Distance to Closest Alternative Hospital



Sources: CMS Provider of Services data, Google Maps

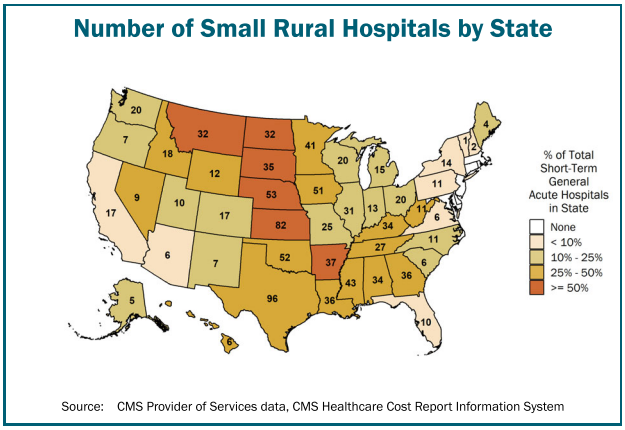
Most rural hospitals are much smaller than urban hospitals. Although there are some large hospitals located in communities that are classified as rural, most rural hospitals are much smaller than most urban hospitals. The size of a hospital has traditionally been defined in terms of the number of inpatient beds it is licensed to operate, but most of the services that hospitals deliver today are ambulatory care services, not inpatient care. Consequently, a hospital's total annual expenses is a better measure of its relative size than the number of inpatient beds:

- Most urban hospitals have over 200 inpatient beds, whereas most rural hospitals have 25 or fewer beds.
- One-half of urban hospitals have expenses of more than $250 million, whereas only 2% of rural hospitals are that large.
- One-half of rural hospitals have total expenses of less than $35 million, compared to only 4% of urban hospitals.



Six Differences Between *Small* Rural Hospitals and Other Hospitals

Small rural hospitals – those with annual expenses below the median for rural hospitals ($35 million in 2020-2021) – deliver many of the same kinds of essential services as larger hospitals do. They have emergency services available around the clock, they provide basic laboratory tests and imaging studies, and they provide inpatient care and outpatient care for a wide range of health problems. However, they face far greater financial challenges in delivering essential healthcare services than both urban hospitals and larger rural hospitals.



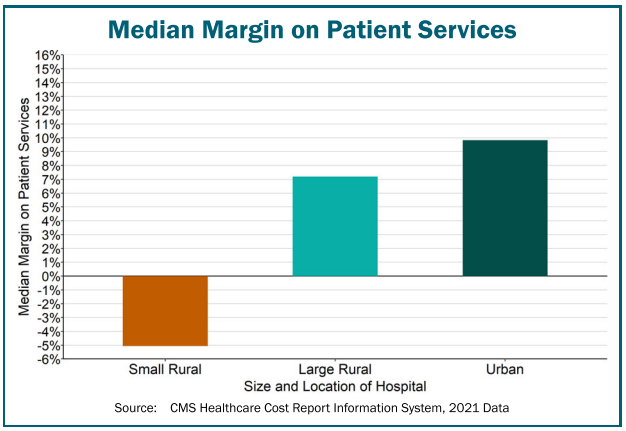
There are over 1,000 small rural hospitals in the country, representing one-fourth of the nation's total short-term general acute hospitals. Most states (44) have at least one small rural hospital; in 21 states, at least one-fourth of all the hospitals in the state are small rural hospitals, and in 6 of those states, 50% or more of the hospitals are small rural hospitals. Small rural hospitals are the principal source of healthcare for the residents and workers in many of the nation's agricultural areas and ranchlands, which require large amounts of land for crops and animals but have relatively few residents per square mile. In many cases, these hospitals are also the only source of primary care for the communities they serve.

There are six major differences between small rural hospitals and other hospitals that must be considered in establishing policies and payments for hospital services:

1. Losses on Patient Services

Most small rural hospitals lose money delivering services to patients, while most urban hospitals and larger rural hospitals make profits on patient services. The primary source of revenues for most hospitals is the payments for services they receive from health insurance plans. Most small rural hospitals are paid less for services by insurance plans than the cost of delivering those services. In contrast, most larger rural hospitals and urban hospitals have been paid more – often significantly more – than it costs them to deliver services to patients.

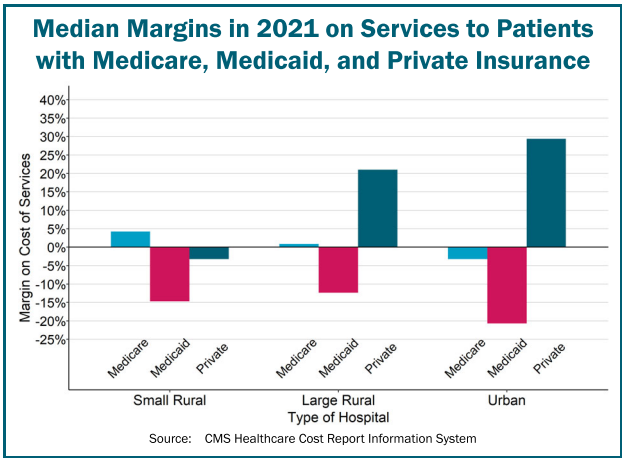
- Two-thirds of small rural hospitals lose money delivering patient services. In 2021, the median margin on patient services for small rural hospitals was -5%, i.e., at the majority of the hospitals, payments were 5% or more below what it cost them to deliver the services. These hospitals experienced similar losses prior to the pandemic.
- In 2021, the median margin on patient services for larger rural hospitals was +7% and at urban hospitals it was +10%, i.e., the larger hospitals were paid significantly more than it cost them to deliver their services. Although margins decreased after the pandemic, most urban and large rural hospitals continued to receive more in payments than it cost to deliver services.



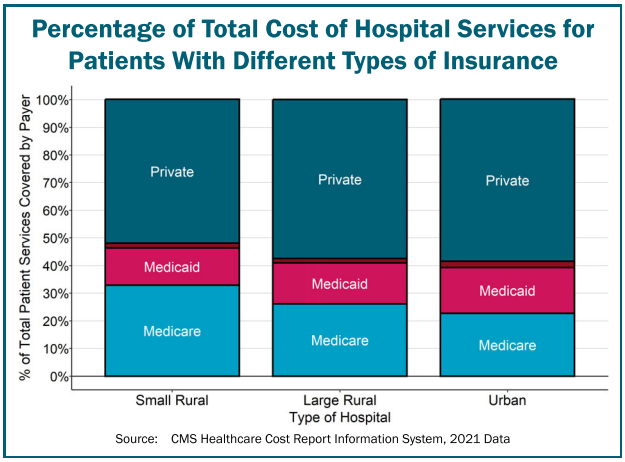
2. Inadequate Private Insurance Payments

Small rural hospitals lose money on patient services because of inadequate payments from private insurance plans, whereas urban hospitals and larger rural hospitals make large profits on services to patients with private insurance. Most hospitals lose money on Medicaid and uninsured patients. However, while large hospitals can offset these losses with the profits they make on patients who have private insurance, small rural hospitals cannot.

- The majority (55%) of small rural hospitals lose money on services delivered to patients with private insurance (including Medicare Advantage plans). In 2021, the median margin at small rural hospitals for patients with private insurance was -3.6%. 40% of small rural hospitals lost more than 10% on services delivered to these patients.
- In contrast, most urban hospitals and large rural hospitals make high profits on services to patients with private insurance. In 2021, the median profit on patients with private insurance was +21% at large rural hospitals and +29% at urban hospitals. One-fourth of urban hospitals made profits of over 50% on services to patients with private insurance.



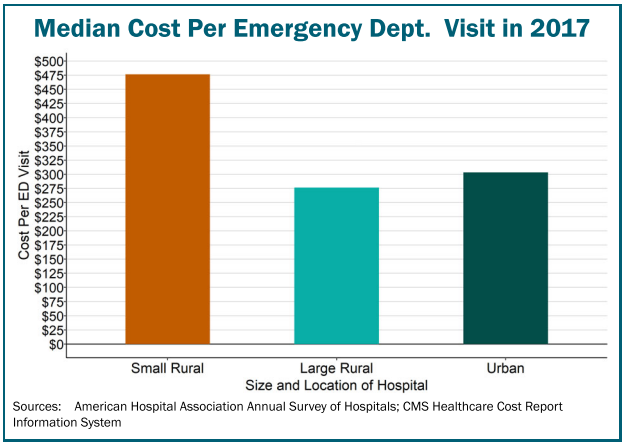
- A common myth about small rural hospitals is that almost all of their patients are on Medicare or Medicaid or are uninsured. In fact, on average, more than half of the services at small rural hospitals are delivered to patients with private insurance, only slightly lower than the percentage in urban hospitals. As a result, low margins or losses on patients with private insurance, combined with losses on Medicaid and uninsured patients, cause small rural hospitals to have large overall losses on patient services.



3. Higher Cost of Delivering Services

Small rural hospitals need higher payments for essential services than larger hospitals because it costs more to deliver those services in communities with smaller populations. The average cost of an emergency room visit, inpatient day, laboratory test, or imaging study is inherently higher in a small rural hospital than at a larger hospital because there is a minimum level of staffing and equipment required to make sure these "standby" services are available on a 24/7 basis regardless of how many patients actually need to use them on any given day. For example, a hospital Emergency Department (ED) has to have at least one physician available around the clock in order to respond to injuries and medical emergencies quickly and effectively, regardless of how many patients actually have an emergency. The communities served by small rural hospitals have fewer ED visits because they have fewer residents, but the minimum cost of staffing the ED will be the same (or even higher if it costs more to recruit physicians and nurses to the rural community), so the average cost per visit will be higher. Consequently, payments that are high enough to cover the average cost per service at larger hospitals will fail to cover the costs of the same services at small rural hospitals.

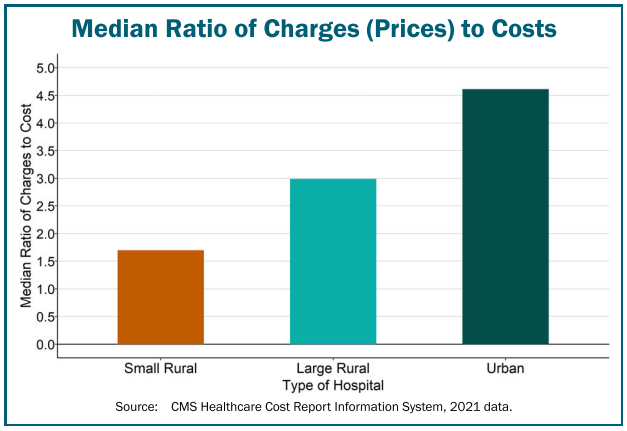
- In 2017, the median small rural hospital had fewer than 4,000 ED visits per year (about 10 visits per day). In contrast, the median was over 16,000 ED visits per year at larger rural hospitals and over 42,000 visits at urban hospitals (10 times as many as the median small rural hospital).
- Because of the smaller number of visits, the median small rural hospital had an average cost per ED visit of $476 in 2017, 60-70% higher than the $276 cost per ED visit at the median large rural hospital and the $304 cost per ED visit at the median urban hospital.



4. Lower Charges Relative to Costs

Small rural hospitals charge less relative to their costs than urban and larger rural hospitals, which contributes to losses from private insurance plans. The prices that any hospital charges for its services have to be high enough to cover the costs of delivering the services and also high enough to offset the losses on services delivered to those patients who do not have insurance, who cannot pay the cost-sharing amounts required by their insurance, or who have an insurance plan that pays less than the cost of services. However, many hospitals charge far more than is necessary to cover their costs.

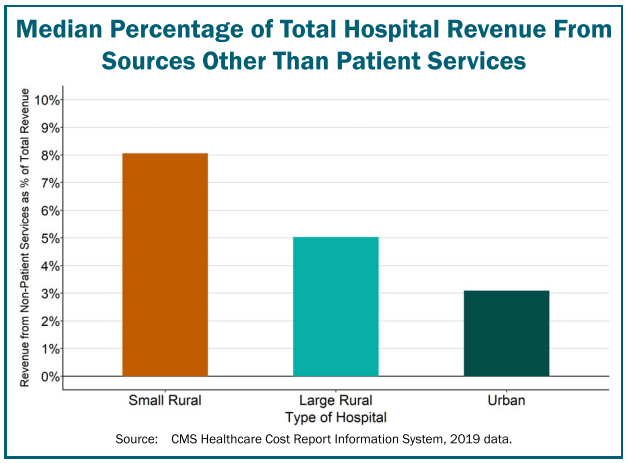
- Most urban hospitals charge more than four times as much as it costs them to deliver services. As a result, they can provide large discounts to private insurance plans and still make significant profits on their services. In 2021, the median urban hospital charged 4.6 times what it cost to deliver services, more than double the markup at small rural hospitals, and the median large rural hospital charged amounts that were 3 times its costs. One-fourth of urban hospitals charged prices more than 6 times what it cost them to deliver services.
- In contrast, at most small rural hospitals, their charges are less than twice what it costs them to deliver their services. In 2021, the median small rural hospital charged only 1.7 times what it cost to deliver services. As a result, small rural hospitals suffer financially when they are forced to provide large discounts to health insurance plans.



5. Dependence on Government Funding

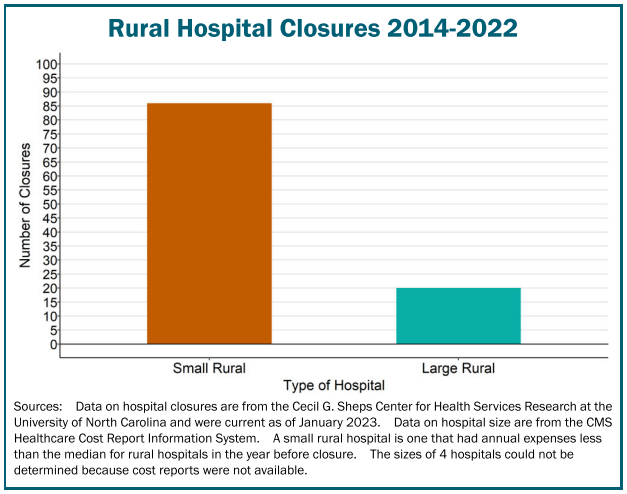
Losses on patient services make small rural hospitals more dependent on local tax levies, government subsidies, and other sources of income than urban hospitals and larger rural hospitals. If a hospital isn't paid enough by health insurance plans to cover the costs of delivering services to patients, the hospital has to find other sources of revenue in order to continue operating. Many small rural hospitals depend on local tax revenues, state grants, or profits on other activities in order to make up the losses on the services they deliver to patients.

- Prior to the pandemic, most small rural hospitals received more than 8% of their total revenues from sources other than payments for services to patients, and one-fourth received more than 15% of their revenues that way.
- In contrast, most larger rural hospitals received less than 5% of their revenues from sources and activities other than patient services, and most urban hospitals received less than 3% of their revenues that way.
- More than 40% of small rural hospitals are able to receive local and state tax revenues because they are government-owned or are operated by public hospital districts, compared to only 26% of larger rural hospitals and fewer than 11% of urban hospitals.



6. Greater Likelihood of Closure

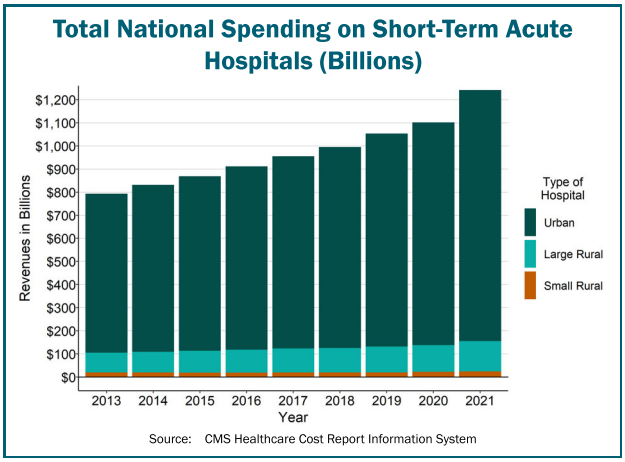
Small rural hospitals are more likely to close due to inadequate revenues. If a hospital does not receive sufficient revenues from insurance payments or government funding to cover its costs over multiple years, it will ultimately be forced to close. Over 100 rural hospitals have closed in the past decade, and nearly 80% of these closures have been small rural hospitals. Many more small rural hospitals would likely have been forced to close during the pandemic had it not been for the large federal grants they received. Since these grants were only temporary and small hospitals experienced significant increases in costs during the pandemic, more small rural hospitals may have to close in the near future unless better ways of paying them are implemented.



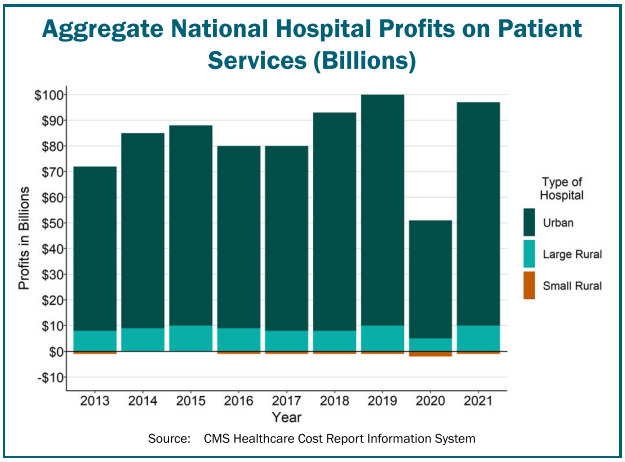
Efforts to Control Healthcare Spending Need to Differentiate Small Rural Hospitals and Larger Hospitals

Clearly, there are very significant differences between small rural hospitals and larger hospitals (both urban and rural). These differences have important implications for designing policies that control or reduce spending on hospital services while ensuring access to essential health services for citizens in all parts of the country:

- Little in the way of savings can be achieved by reducing payments to small rural hospitals. Although small rural hospitals represent 25% of the short-term general hospitals in the country, they only receive 2% of national spending on hospital services, and they account for less than 3% of the significant increase in national hospital spending that has occurred in recent years. Revenues at small rural hospitals increased by a total of $12 billion nationally from 2013 to 2021, compared to an increase of $400 billion at urban hospitals. Even a large reduction in spending on services at small rural hospitals would have only a minuscule impact on total national healthcare spending.



- Reducing payments to small rural hospitals will accelerate closures and reduce access to services for rural communities. Policies and programs designed to reduce spending on hospitals by cutting payments for hospital services or reducing utilization of hospital services will have a far more negative impact on small rural hospitals than larger hospitals, because profit margins at most small rural hospitals are already low or negative. Even a small reduction in revenues at small rural hospitals could force more of them to close. Although revenues decreased for most hospitals in 2020 due to the coronavirus pandemic, the majority of urban hospitals and large rural hospitals remained profitable, whereas an even higher proportion of small rural hospitals lost money on patient services. Many small rural hospitals were only able to continue operating because the special federal assistance provided to hospitals during the pandemic enabled them to offset these losses. In 2021, profits increased at urban and large rural hospitals, but most small rural hospitals continued to lose money.



Rural Hospitals Need Better Payments from Both Private and Public Payers

The data show that there is little to be gained by reducing spending on small rural hospitals and much to be lost by doing so. Conversely, providing adequate payments to small rural hospitals could preserve access to essential healthcare services for rural communities with minimal impact on overall healthcare spending. The losses on patient services at all of the small rural hospitals in the country could be eliminated for less than $2 billion per year – that is less than two-tenths of one percent of current national spending on all hospitals.

Unfortunately, Medicare payment policies are making things worse for small rural hospitals rather than better:

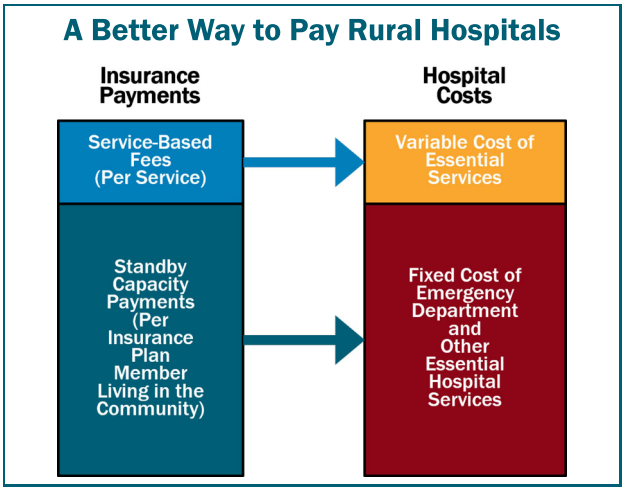
- **Cuts in Payments to Critical Access Hospitals.** Although Medicare payments under the Inpatient Prospective Payment System (IPPS) are being increased in 2023 by the highest amount in 25 years, most small rural hospitals will not benefit from this. Over 80% of small rural hospitals are designated as Critical Access Hospitals, which are not paid under IPPS. Medicare payments to Critical Access Hospitals have actually been reduced because of the return of sequestration reductions. Medicare now pays Critical Access Hospitals only 99% of what it costs the hospitals to deliver services, which means that most small rural hospitals will be guaranteed to lose money on services they deliver to Medicare beneficiaries.
- **Reducing Access to Inpatient Care.** A new federal Rural Emergency Hospital program has been promoted as a way of preventing rural hospital closures. However, it would require closing the hospital's inpatient unit, thereby eliminating a service that proved to be essential in most communities during the pandemic. In addition, the payments for the hospital's outpatient services would no longer be based on the cost of delivering hospital services in rural areas.
- **Creating Budgets That Are Smaller Than What It Costs to Deliver Care.** The Center for Medicare and Medicaid Innovation (CMMI) has proposed creating "global budgets" as a way of helping small rural hospitals. However, CMMI's demonstration program to test this concept (called the CHART Model) would cut the amount of Medicare revenue the hospitals have received in the past, and their payments in the future would no longer be based on the actual increases in the costs of delivering services in rural areas.

Moreover, while most proposals for helping small rural hospitals have focused on changing payments under Original Medicare, the primary cause of financial losses at small rural hospitals has been inadequate payments from private health insurance plans (including both employer-sponsored insurance and Medicare Advantage plans). As a result, even if Medicare payments for small rural hospitals were increased, it would not be enough to prevent rural hospital closures unless there are also significant increases in payments from private health insurance plans and state Medicaid programs.

Creating A Better Way of Paying Small Rural Hospitals

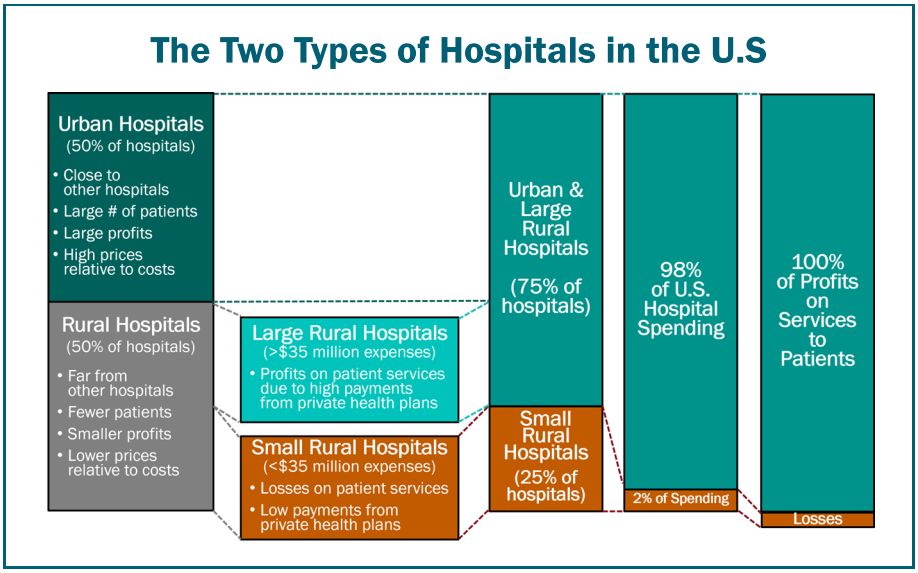
The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers use to pay for services. Small rural hospitals are paid for delivering individual services to patients, but there is no payment at all for what residents of a rural community would likely view as one of the most important services of all – the availability of physicians, nurses, and equipment to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

A hospital's ability to deliver a service on short notice is often referred to as "standby capacity," because a minimum level of personnel and equipment must be standing by in case a patient needs the service, even if it turns out that no patient actually does need it. The coronavirus pandemic made many people aware for the first time that current payment systems do not ensure that hospitals have enough standby capacity to handle unexpectedly large increases in the number of patients who need hospital care. While large hospitals can pay for the costs of standby capacity using the profits they make on delivering services, small rural hospitals do not have that ability.



Community fire departments aren't supported by high fees charged for fighting fires, and small rural hospitals shouldn't be supported through high fees paid by people who are ill or injured. In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive ***Standby Capacity Payments*** from both private and public payers in addition to being paid Service-Based Fees when individual services are delivered. The Standby Capacity Payment would support the fixed costs of essential services at the hospital, and Service-Based Fees would only need to cover the variable costs of those services.

More details on how to design and implement this approach are described in the Center for Healthcare Quality and Payment Reform's report *A Better Way to Pay Rural Hospitals*. Citizens, businesses, local governments, state government, and the federal government must all take action to ensure that every payer provides adequate and appropriate payments for small rural hospitals before more rural communities lose access to essential healthcare services.



Individual Board Member Role as Community Ambassador

Serving in the role of a hospital board member is an honor and a responsibility. Community members are appointed or elected to support the organization and to provide the required oversight to ensure the vision, mission, and values of the organization are being met.

In addition to their official duties involved in oversight, Individual board members need to be prepared for the inevitable situation of being approached by someone in the community seeking assistance in resolving a concern or issue, or information regarding the organization's operations.

It is quite common, in fact, for members of the community to approach their local hospital board member with concerns, questions and requests for assistance. In the case of hospital districts where board members are elected commissioners, there is an even greater potential for community members as constituents to feel they have direct access to the board as a way to resolve their personal issues.

Carefully navigating these interactions is what is often described as acting as a community ambassador. Board members should be prepared for this and know how to respond in a way that acknowledges the request, while at the same time "does no harm." This briefing is created to help board members respond to common scenarios.

Employment Matters

It's an uncomfortable reality that not all healthcare employees will be satisfied with their job at all times. While most hospitals and health systems aim to be the employer of choice in their community, the organization will not be able to address all employees concerns or issues perfectly. Delivering high quality healthcare services is a demanding and stressful job. Board members should be prepared for this reality and balance their compassion for the hospital employees who might approach them with an understanding that the organization is highly responsive and works hard to take care of its own. It may also be good to know that there are many resources available to help employees work through issues that arise during their employment at the hospital.

Hospital board members are elected to represent the communities the hospital serves. That means board members are often the first people employees or family members turn to when something at the hospital doesn't meet their expectations.

First, board members should learn to recognize what constitutes a personnel or employee matter. Common personnel or human resources (HR) issue includes discussion of an employee or potential employee's:

- Hiring or decision not to hire
- Termination or disciplinary actions
- Salary, benefits, hours, schedules, shifts
- Working conditions/environment
- Conflict between an employee and his/her boss or other employees/managers
- Conflict or concerns between or among employees
- Concerns regarding the CEO's conduct

If you are approached about any these issues, recognize that you've stepped into a potentially dangerous area. Because the laws regarding employee and personnel matters are quite complex and specific, it would be wise for a board member to understand the optimal steps to take to direct the individual to the proper channels. All board members, particularly new ones, want to learn as much as they can and be helpful, but this can make them vulnerable to providing inappropriate assistance to any employee, nurse,

or physician who has a problem or personal request. What some new board members don't immediately realize is that individual board members have no authority. It's only when meeting as a whole board that authority exists. So rather than getting involved with individual requests, a board members should let the employee seeking assistance know the board won't take action except when the matter comes to the board through the proper channels.

Generally speaking, most organizations refer employee matters to a human resources designee, for example the vice president of human resources or chief human resources officer. Unless, of course, the concern raised is regarding that particular human resources individual, in which case the matter should be referred to the CEO.

In most organizations, the board's only employee is the CEO. If an employee raises a concern regarding the CEO's conduct, the employee should be referred to the board chair. In support of the CEO, general complaints regarding CEO decisions should be responded to by voicing support of the CEO and a reminder that individual board members have no authority in or responsibility for the CEO's or organizations decisions. That authority and responsibility rests with the full board.

Quality of Care or Service Concerns

The hospital's primary mission is to provide quality healthcare to the communities it serves. Members of the board have a responsibility to participate in the oversight to ensure that care is being delivered as it should and that the medical staff providers are competent and qualified. Most board members will readily admit that health care is a complex industry requiring significant investment of member time and energy to understand and meaningfully participate in the oversight of that care.

Quality of care and care delivery issues, however, do occur and board members want to do their part to support the organization's opportunities to improve care and care delivery. Communicating that message of care and concern is the role of the board member; getting involved or attempting to handle an issue regarding quality is not.

Any healthcare organization strives to provide high quality care and service to the patients and families it serves. There will inevitably be situations where patients or families will bring a concern or complaint regarding the care they received to a board member. Organizations typically designate a department or specific personnel to manage quality and service concerns; these may be a patient advocate, patient representatives, or ombudsman. A leading practice is to provide board members with a card that can be given to community members with this department's contact information. This practice supports the organization's proactive commitment to addressing care concerns.

Communication of Information

Because of a board member's high-level role within the organization, you may find yourself in the sometimes uncomfortable position of knowing information that it is not yet appropriate to share. This may perhaps include information about staffing and operational plans at the hospital that may impact the employees. If an issue is still under discussions and hasn't yet been released through official hospital channels, a board member has an obligation to keep it confidential.

Learning when to share information is a true skill that takes some time to learn. Confidential information must be left in the boardroom; discussion likewise should not be taken outside the boardroom when it's not appropriate. It is crucial that members not share this information because the right information shared in the wrong way can be as damaging as sharing the wrong information.

Media requests should be directed to the organization's public relations department or to the CEO. Once again, individual board members should refrain from speaking to the media as a representative of the board unless asked to specifically serve in the that role. As a general rule of thumb, requests for interviews should be granted with reserved right to review the information for accuracy before release to the public.

What You Should Do – General Guidelines

In any of the above-described situations, "active listening" skills can help. The following are a few steps board members can take when asked for assistance.

- **Listen to understand.** Listening to someone's request for assistance or concern is a kind and compassionate way to respond. Board members should practice active listening when approached with an issue about the hospital by an employee, patient, patient's family member, or a community member. Active listening includes facing the person, making eye contact, and allowing them to tell their story and vent their emotions without interruption or defensiveness.

- **Express empathy.** Expressing understanding of someone's concern lets that person know that someone is listening and is concerned about the situation. However, expressing empathy is not the same as becoming involved; it is telling the person "I can understand why you're upset," or "I can understand why you're frustrated."

- **Acknowledge emotions or experience without laying blame.** Acknowledging someone's experience and the challenges it has caused for that person is not the same as blaming the hospital or its managers for that difficult situation. When spoken with sincerity, a blameless apology conveys a sense of caring and concern to the employee, patient, or family member. An appropriate response for a board member is: "I'm sorry this happened;" or "I'm sorry you are experiencing this difficulty."

- **Direct those seeking assistance to the appropriate channel.** Employees bring hospital-related problems to board members because they trust them, and they believe the board member can do something to fix those problems. Rather than getting involved with individual requests, board members should let the employee know the board doesn't get involved in hospital issues unless the issue comes to the full board through the proper channels. Board members should be prepared by knowing the proper channels for specific concerns and providing contact information for that channel.

- **Express thanks.** Thanking an employee for taking time to share a complaint or entrusting a board member with the concern is another step in letting the employee know the concern is being taken seriously. A board member should communicate that the employee is important, and that he or she cares about how the hospital treats its employees and cares for patients and the organization's perception in the community.

- **Proceed with caution.** Most of all, board members should not encourage employees or physicians to bring their private complaints and concerns to board members, and they should not make private promises to employees or physicians. Again, requests should be directed to the organization's appropriate channels for resolution, typically the human resources designee or the CEO. When an employee or physician is told: "I'll look into this and get back to you," there can be very serious consequences because it undermines the hospital's staff and leadership and tells the person with the compliant that it's fine to try to get around the appropriate channels. When someone asks for help,

however, a board member does have a responsibility to listen. If the problem seems real and part of a developing trend, the matter should be discussed privately with the board chairman or the CEO, but the board member has an equal responsibility not to show any special attention to any specific request for assistance. When people ask for help, that request should be acknowledged, there should be an expression of empathy without a suggestion of blame, and finally them know the proper route to follow.

Ambassador as Trust Builder

Board members are the hospital's ambassadors in its communities. When a community member's expectations are not met, board members should demonstrate compassion, help direct the community member employee on where in the organization to go to get a concern addressed. Perhaps most importantly, if trust has been punctured, the board member should help rebuild that trust with the community member or employee. This role is an important part of helping the hospital fulfill its strategic theme of being a valued community asset.

As with the physician's dictum, the role of a board member is to first do no harm. It is always best to error on the side of caution. Actively showing compassion and empathy, while not becoming involved individually or putting the organization in a difficult position is the best course of action. With proper attention to leading practice and clear guidelines, your community will respect the processes and consistently with which all board members conduct themselves.