
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

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

November 11, 2020 @ 3:30 PM

Join Zoom Meeting: <https://myarborhealth.zoom.us/j/97594596868>

Meeting ID: 975 9459 6868

One tap mobile: +12532158782,,97594596868#

Dial: +1 253 215 8782



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Old Business

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Superintendent Report



**LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
November 11, 2020 at 3:30 p.m.
ZOOM**

<https://myarborhealth.zoom.us/j/97594596868>

Meeting ID: 975 9459 6868

One tap mobile: +12532158782,,97594596868#

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Mission Statement

To foster trust and nurture a healthy community.

Vision Statement

To provide accessible, quality healthcare.

AGENDA	PAGE	TIME
Call to Order		
Approval or Amendment of Agenda		
Conflict of Interest		3:30 pm
Comments and Remarks		3:35 pm
<ul style="list-style-type: none"> Commissioners Audience 		
Executive Session-RCW 70.41.205 & RCW 70.41.200		3:45 pm
<ul style="list-style-type: none"> Medical Privileging-Janice Holmes Quality Improvement Oversight Report-Commissioner McMahan & Dexter Degoma 		
Guest Speaker	5	4:30 pm
<ul style="list-style-type: none"> Washington State Hospital Association <ul style="list-style-type: none"> Cassie Sauer, President and Chief Executive Officer & Zosia Stanley, Associate General Counsel 		
Break		5:15 pm
Department Spotlight		5:20 pm
<ul style="list-style-type: none"> <i>Deferring to the December meeting.</i> 		
Board Committee Reports		
<ul style="list-style-type: none"> Hospital Foundation Report-Committee Chair-Commissioner McMahan 	31	5:20 pm
<ul style="list-style-type: none"> Finance Committee Report-Committee Chair-Commissioner Herrin 	32	5:25 pm
Consent Agenda – (Action items included below)		
<ul style="list-style-type: none"> <input type="checkbox"/> Passed <input type="checkbox"/> Denied <input type="checkbox"/> Deferred 		
<ul style="list-style-type: none"> Minutes of the September 30, 2020 Regular Board Meeting (<i>Action</i>) 	35	5:30 pm
<ul style="list-style-type: none"> Minutes of the October 7, 2020 Special Board Meeting (<i>Action</i>) 	42	
<ul style="list-style-type: none"> Minutes of the October 13, 2020 Special Board Meeting (<i>Action</i>) 	44	
<ul style="list-style-type: none"> Minutes of the October 14, 2020 Quality Improvement Oversight Committee Meeting (<i>Action</i>) 	46	
<ul style="list-style-type: none"> Minutes of the October 21, 2020 Finance Committee Meeting (<i>Action</i>) 	49	
<ul style="list-style-type: none"> Minutes of the October 28, 2020 Special Board Meeting (<i>Action</i>) 	52	

<ul style="list-style-type: none"> Warrants & EFT's in the amount of \$3,980,538.39 dated September 2020 <i>(Action)</i> 	55	
<ul style="list-style-type: none"> Resolution 20-43-Approving the Clinical/Non-Clinical Contracted Services Evaluation Matrix <i>(Action)</i> <ul style="list-style-type: none"> To approve the contracted services that have been evaluated to date. This matrix will be presented at the meeting. 	57	
<ul style="list-style-type: none"> Resolution 20-44-Declaring to Surplus or Dispose of Certain Property <i>(Action)</i> <ul style="list-style-type: none"> To approve liquidation of items beyond their useful life. 	58	
<ul style="list-style-type: none"> Approve Documents Pending Board Ratification 11.11.20 <i>(Action)</i> <ul style="list-style-type: none"> To provide board oversight for document management in Lucidoc. 	60	
Old Business		
<ul style="list-style-type: none"> Resolution 20-45-Approving the 2021 Proposed Tax Levies RCW 84.55.120 <i>(Action)</i> <ul style="list-style-type: none"> To discuss the consideration of possible increases in property tax revenues. Back up documentation will be provided upon receipt from Lewis County. 	63	5:35 pm
<ul style="list-style-type: none"> Resolution 20-46-Adopting the Lewis County Hospital District No. 1 2021 Budget <i>(Action)</i> <ul style="list-style-type: none"> To adopt the proposed budget for 2021. 	65	5:45 pm
<ul style="list-style-type: none"> Department Specific Measures <ul style="list-style-type: none"> The Board will bring back questions or recommendations. 	67	
New Business		5:55 pm
<ul style="list-style-type: none"> Board Education <ul style="list-style-type: none"> Board Mindsets to Drive Value <ul style="list-style-type: none"> iProtean Driving a Sustained Culture of Quality <ul style="list-style-type: none"> iProtean 	78 89	
<ul style="list-style-type: none"> 2021 Board Meeting Schedule <ul style="list-style-type: none"> To review the upcoming board meeting schedule for 2021. 	99	6:05 pm
<ul style="list-style-type: none"> Resolution 20-47-Approving the Fire District No. 4 Agreement <i>(Action)</i> <ul style="list-style-type: none"> To approve new operating expense. 	102	6:15 pm
<ul style="list-style-type: none"> Board Policies & Procedures <ul style="list-style-type: none"> Board Meeting Teleconference Board Mobile Device Management Board Self-Evaluation <ul style="list-style-type: none"> Commissioners to complete by December 16, 2020 Regular Board Meeting. Board Spending Authority 	106 108 110 115	6:25 pm
Superintendent Report		
<ul style="list-style-type: none"> Superintendent Everett will provide a verbal report. 	117	6:45 pm
Next Board Meeting Dates and Times		
<ul style="list-style-type: none"> Regular Board Meeting-December 16, 2020 @ 3:30 PM (ZOOM) 		
Next Committee Meeting Dates and Times		
<ul style="list-style-type: none"> QIO Committee Meeting-December 2, 2020 @ 7:00 AM (ZOOM) Plant Planning Committee Meeting-October 15, 2020 @ 7:00 AM (ZOOM) Finance Committee Meeting-November 18, 2020 @ 12:00 PM (ZOOM) Finance Committee Meeting-December 16, 2020 @ 12:00 PM (ZOOM) Compliance Committee Meeting-December 30, 2020 @ 12:00 PM (ZOOM) 		
Meeting Summary & Evaluation		
Adjournment		7:00 pm



Washington State
Hospital Association



WSHA and Arbor Health

Working Together for the Future of Health Care

Cassie Sauer, President and CEO

Zosia Stanley, Associate General Counsel

About WSHA





WSHA's Mission:

The Washington State Hospital Association (WSHA) advocates for and provides value to members in achieving their missions.

WSHA's Vision:

WSHA will be the trusted voice and indispensable resource that leads, challenges and assists hospitals and health systems to improve the health of the communities they serve.



WSHA Values

Service

We provide servant leadership to our members and each other.

Collaboration

We use the power of the collective to achieve WSHA's mission and vision.

Integrity

We operate with transparency and accountability.

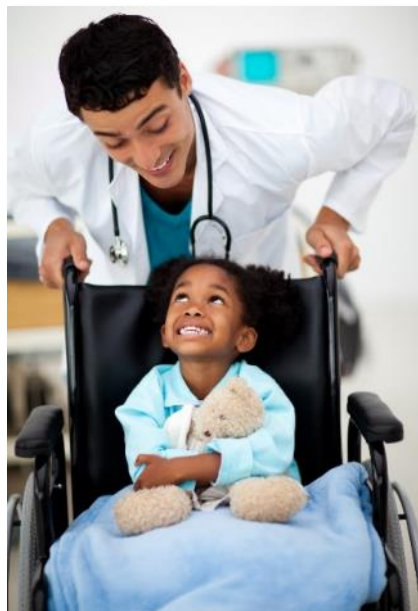
Innovation

We are dynamic and seek modern solutions.

Government Affairs



Safety & Quality



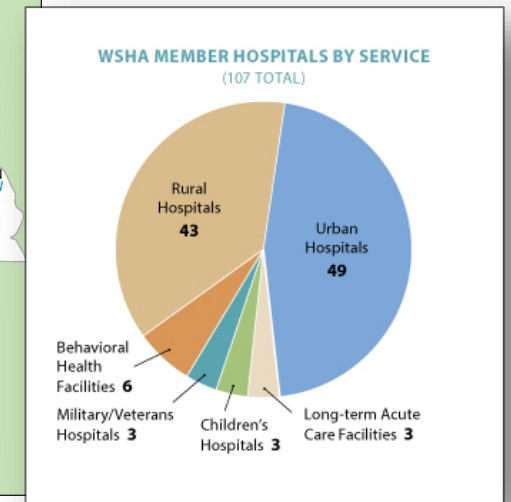
Coordinated Action on Major Issues



Power in Unity

Data Analytics







WSHA Senior Leadership Team



Cassie Sauer
President & CEO



Taya Briley
EVP & General Counsel



Eric Lewis
CFO



Jonathan Bennett
VP, Data Analytics & IT



Darcy Jaffe
SVP, Safety & Quality



Jacqueline Barton True
VP, Rural Health Programs



Chelene Whiteaker
SVP, Gov't Affairs



Beth Zborowski
SVP, Mem Engagement & Comms

How to Use WSHA

- Source for essential information
- Help answer key questions
- Networking at meetings and events
- Governance education for hospital governing boards
- Opportunities to influence legislation and regulations
- Opportunities for statewide leadership roles through committees and task forces
- Partnership with other organizations
- Events and education

Key WSHA Services

Government Affairs

Governance Education

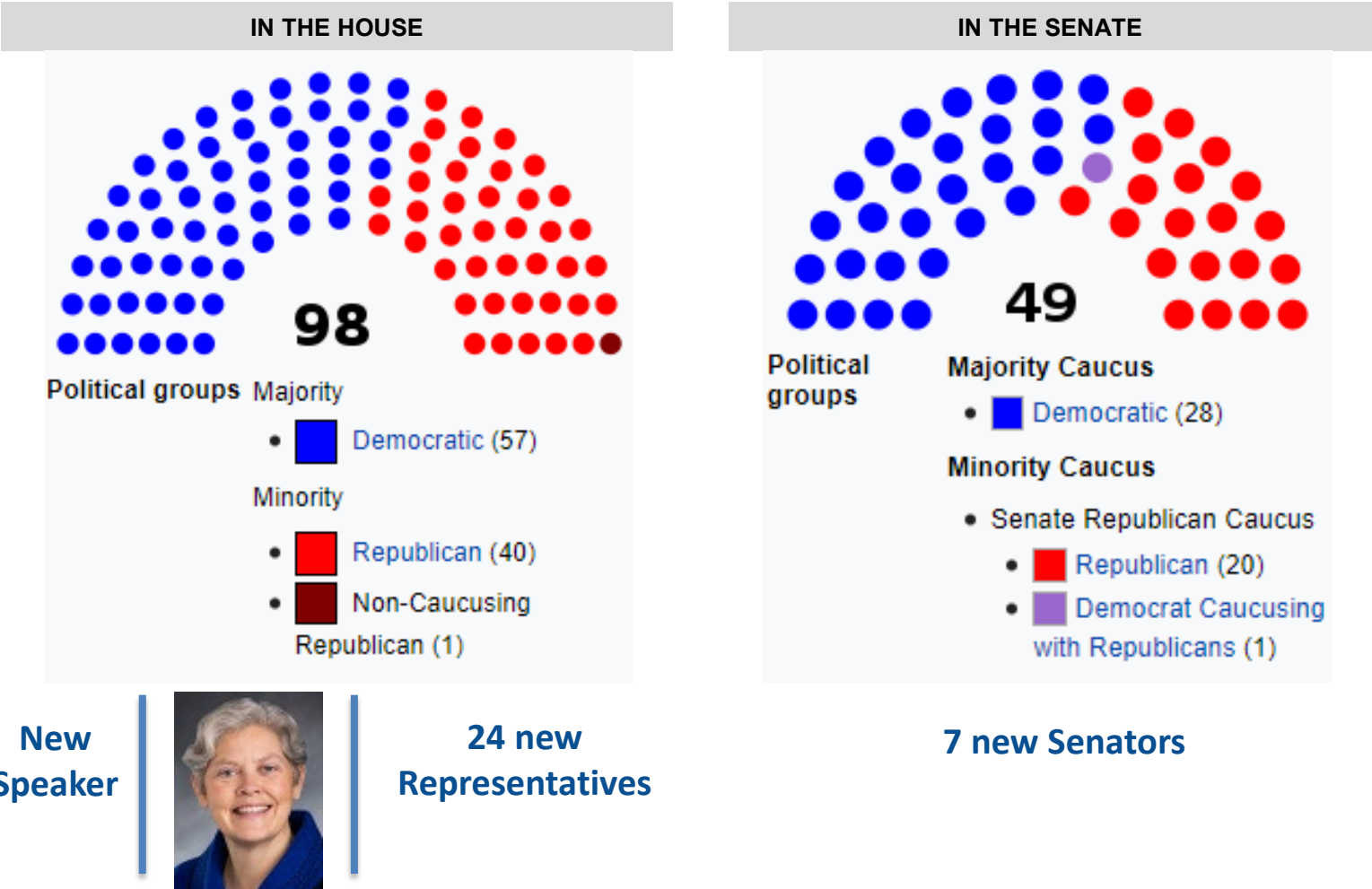
Safety and Quality

Washington Hospital Services



Legislative Framework

1. Ensure patients have access to care during and after hospitalization.
2. Ensure hospitals can be stable institutions serving their communities, long into the future.
3. Maintain flexibility for hospital operations while preventing burdensome and costly new regulations.



What Comes Next

- Massive budget shortfall
 - Will the feds help? How much?
 - Cuts, revenues, or combination?
- Special session in November? Never?
- Regular session – January 2021
- How to meet and advocate?



Two important tools:
Increase engagement!



HOSPITALS for a
HEALTHY FUTURE
PAC



Get Creative with Advocacy

- You are an expert right now
- Offer to be on a legislator's town hall
 - Connect with the legislator
 - Share key information with the community
 - Generate support for the hospital
- Bring legislators to see COVID changes
 - Drive through testing
 - PPE donning and doffing
 - Laboratory



Governance Education Program

- Content delivered virtually and in-person
- Recordings of courses available on demand
- Washington-specific content
- Certification available to those completing at least 12 credit hours
- Open to all health care leaders and board members



Visit www.wsha.org/governance for more information

Safety & Quality Program

Infections ★ Catheter
Associated Urinary Tract
Infections ★ Central Line
Associated Blood Stream
Infections ★ Surgical Site
Infections ★ Sepsis ★ C. Diff
Ventilator Acquired Conditions
Nursing and Staff Care ★ Falls
★ Pressure Ulcers ★ Venous

Thromboembolism ★ Worker
Safety ★ **Safe Delivery Roadmap**
★ Early Elective Deliveries ★
Episiotomy C-Section Rate ★
Inductions ★ **Medications** ★
Antibiotic Stewardship ★
Anticoagulants Hyperglycemic
Opioid ★ **General Care** ★
Behavioral Health

Washington Hospital Services Business Lines



Unemployment & Worker's Compensation Claims Management



LEAD Academy



External peer review



Industry Partner vendor program



PNW Pop and Business Intelligence

COVID

Current Status

Epidemiologic Curves

Cumulative Counts

Demographics

Testing

COVID-like Illness Hospitalizations



EPIDEMIOLOGIC CURVES

Data as of October 25, 2020 11:59PM PT

Select an Option

Confirmed Cases

Hospitalizations

Deaths

Select County



All



Tabular View

Click on Tabular View
to see and download
the data.

COVID-19 in Washington State

Confirmed Cases and Deaths by Illness Onset Date, and Hospitalizations by Admission Date

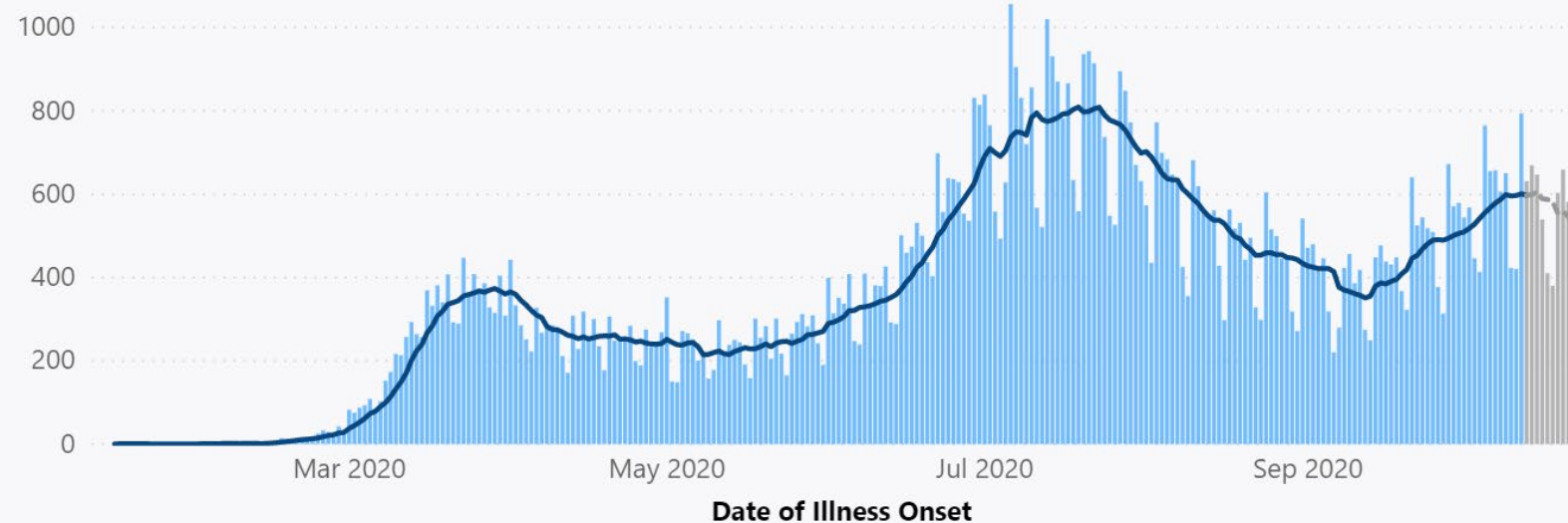
This chart shows the progression of the COVID-19 outbreak in Washington by cases, hospitalizations and deaths over time and is known as an epidemiologic curve. The epidemiologic curve is the curve referred to in the phrase, "flatten the curve."

[Learn More](#)



Confirmed Case Counts

● Confirmed Cases ● Data incomplete for recent dates — Confirmed Cases (7 day rolling avg.) — Incomplete data (7 day rolling avg.)



359 of 103,500 confirmed cases do not have an assigned county. Illnesses from the last 13 days may not yet be reported.

Current Status

Epidemiologic Curves

Cumulative Counts

Demographics

Testing

COVID-like Illness Hospitalizations



COVID-LIKE ILLNESS HOSPITALIZATIONS

Data as of October 25, 2020 11:59PM PT

Select an Option

Sex

Age Group

Select an Option

- ☐ 0-19
- ☐ 20-39
- ☐ 40-59
- ☐ 60-79
- ☐ 80+
- ☐ All

COVID-19 in Washington State COVID-like Illness Hospitalizations

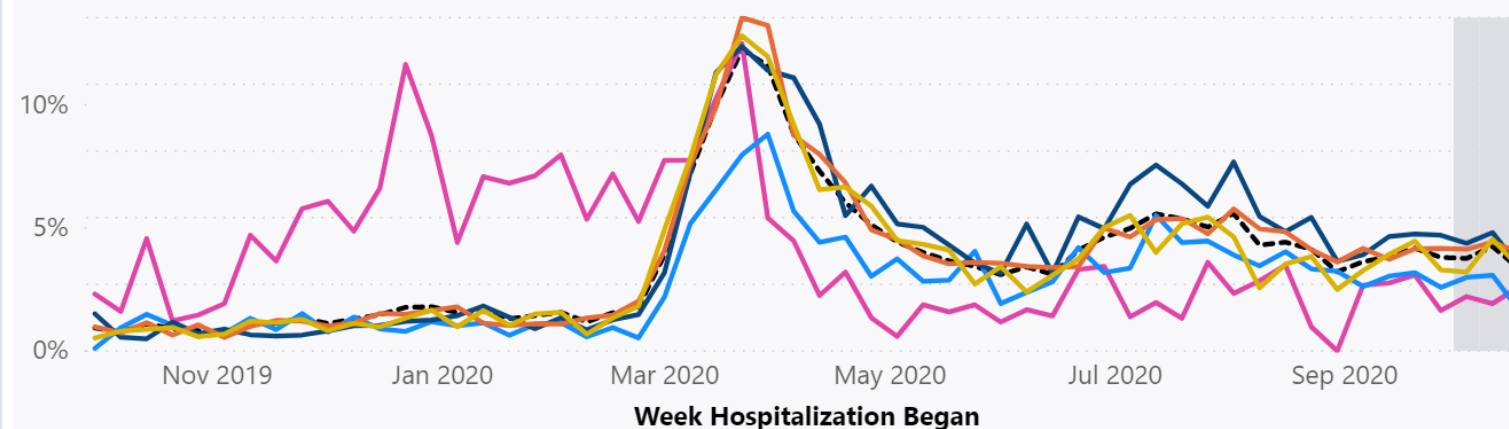
COVID-like illness hospitalizations (CLI) are not exact counts of people hospitalized with a COVID diagnosis. Since these data do not rely on a diagnosis, they provide near-real time trends of the outbreak.

[Learn More](#)



CLI-hospitalization percentage by Date and Age Group

● Hospitalizations from the last 2 weeks may not yet be reported ● All ● 0-19 ● 20-39 ● 40-59 ● 60-79 ● 80+



5,398 total emergency inpatient admissions reported for the last full week. The chart shows a large percentage of hospitalizations among children with fever and respiratory illness (i.e. COVID-like illness).



[Learn More](#)

PPE is Essential . . . And Controversial

- PPE is crucial to our ability to continue necessary services
- Shortages will continue
- Governor wants to “separate discussions about worker protection from supply chain”
- Science is evolving



Strategies on COVID-Related Financial Health

- Advocating for state and federal money for hospitals
- CARES Act
- Next wave of federal funding
- FEMA consultant
- Some hospitals furloughing
- Help us help ourselves!
- Goal: COVID is routine and normal work for the health system

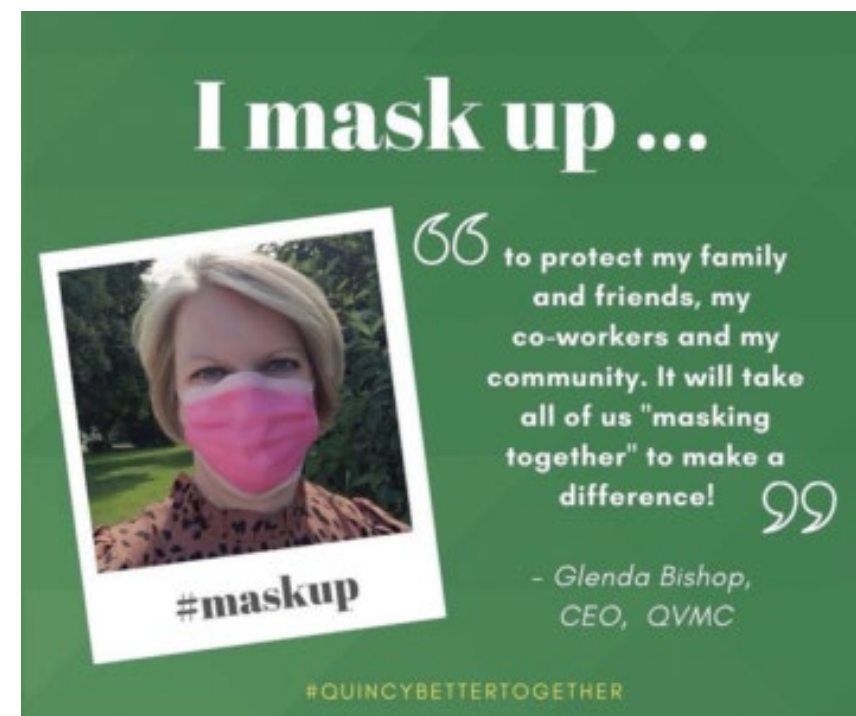
Key Steps to Exit

- Plenty of PPE
- Universal masking
- Widespread testing
- Contact tracing
- Safe places to self-isolate
- Antibody testing (is there real immunity?)
- Better treatment (there's plenty of Remdesivir, antibodies coming)
- Vaccine (coming soon?)

Encourage People to Mask Up and Social Distance! Repeatedly!

“What we need is hospital leaders standing shoulder to shoulder with local elected and other local community leaders getting folks to wear face coverings.”

-John Wiesman, Secretary of Health





Thank you for your leadership! Questions?



BOARD COMMITTEE REPORTS

Arbor Health Foundation Meeting Minutes

Tuesday October 13, 2020

Online Zoom Meeting

Attendance: Ali Draper, Diane Markum, Caro Johnson, Ann Marie Fosman, Wes McMahan, Jeannine Walker, Betty Jurey, Leianne Everett, Marc Fisher, Louise Fisher, Chris Preheim

Guest: Christine Brower

Excused: Lynn Bishop, Shelley Riggs, Stephanie Poffile

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

President Ali Draper read the mission statement

August minutes were reviewed and approved. Chris Preheim/Betty Jurey
September minutes and treasurers report were tabled.

Directors Report: Diane Markum: A scholarship was awarded to LeeAnn Evans in the amount of \$1400. She is pursuing a Bachelor of Nursing Degree. The grant for non-profit's that Diane had applied for was not awarded.

Old Business: Diane reported that the goal for the auction was \$30,000 and we raised \$29,053, a very big success for our first on-line auction. \$14,375 was from sponsorships and \$3160 was earmarked for the Fund-A-Need for the CT Scan. John Carter will be given a gratitude gift for his help with IT. Ninety people registered for the auction and 155 gifts were donated.

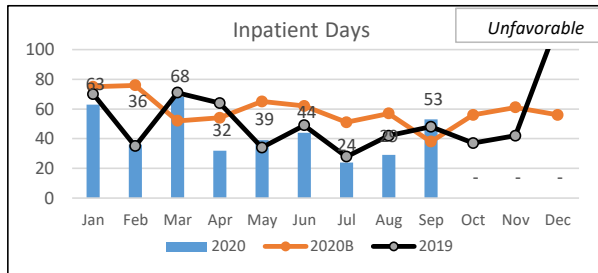
CEO Report: Leanne reported that installation of the CT scan will start next week. There has been considerable success in recruiting providers for future needs. The Hospital Board voted to discontinue the Custodial Care program, and the single patient remaining is looking to relocate.

Meeting adjourned 12:37

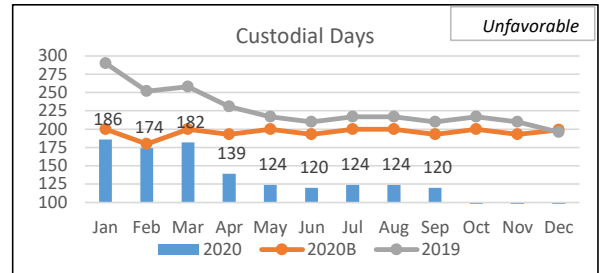
Lewis County Hospital District No. 1 Board Financial Summary

September 30, 2020

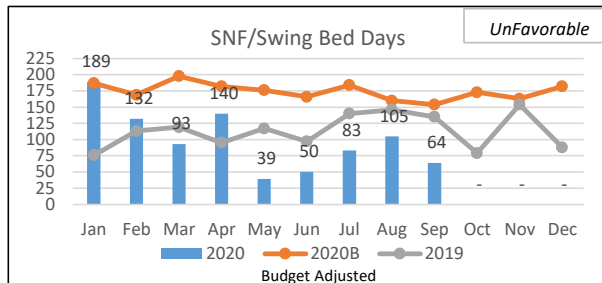
Growth



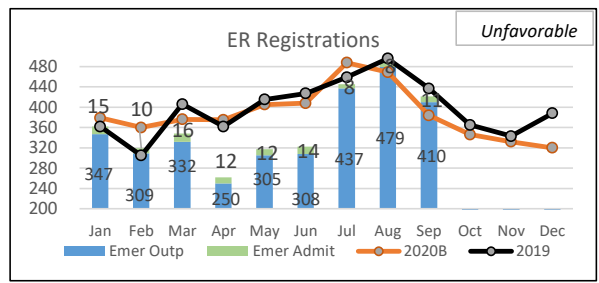
YTD: 388.00 Budget: 530.00 Pr Yr: 441.00



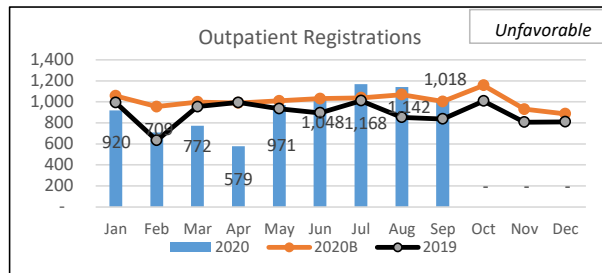
YTD: 1,293 Budget: 1,759 Pr Yr: 2,102



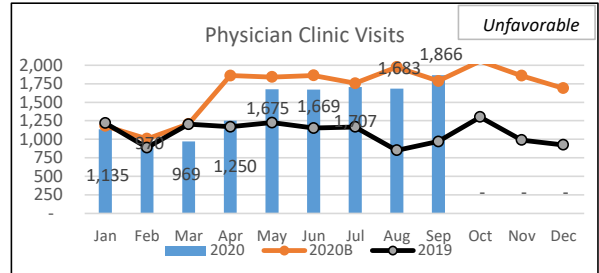
YTD: 895 Budget: 1,576 Pr Yr: 1,038



YTD: 3177 Bud: 3644 Pr Yr: 3669

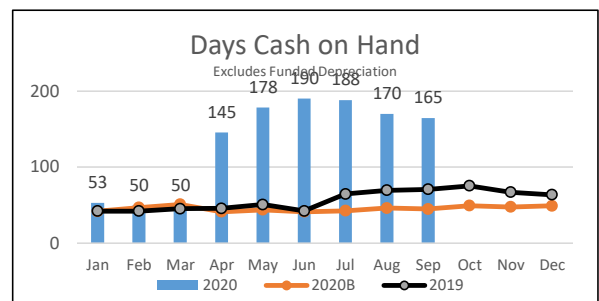
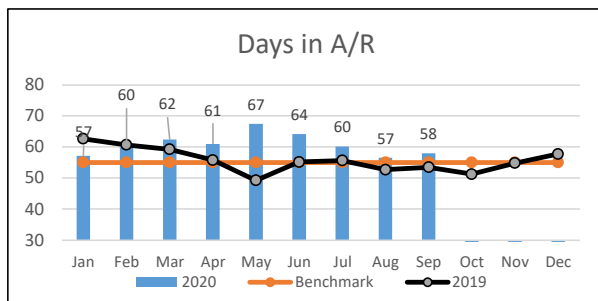
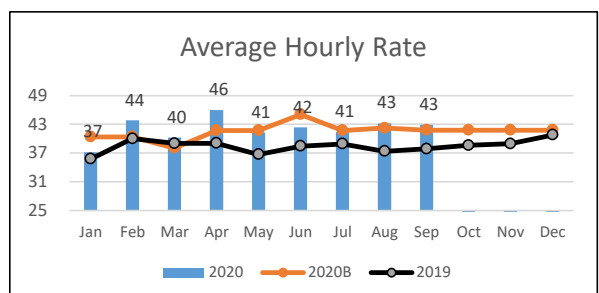
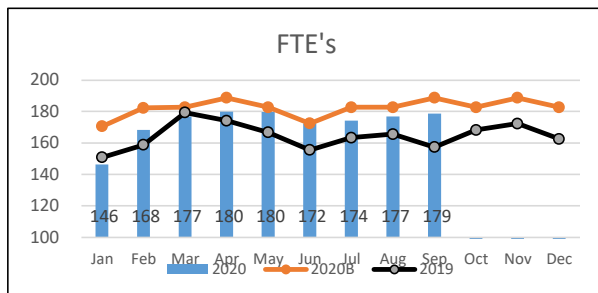


YTD: 8,327 Bud: 9,146 Pr Yr: 8,105



YTD: 12,924 Bud: 14,476 Pr Yr: 9,839

People and Operational Aspects



PROFITABILITY INDICATORS
OPERATING MARGIN-YTD

Definition: measures the control of operating expenses relative to operating revenue. In a hospital, Operating = patient care. This ratio reflects to overall performance of the core business.

Formula: Operating Income / Net Operation Revenue inclusive of Deductions, Charity & Bad Debt

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Arbor Health		(0.03)	(0.22)	(0.05)	(0.16)	(0.01)	0.02	(0.05)	(0.02)	(0.99)	-	-	-
2020 Target		(0.04)	(0.26)	0.00	(0.23)	(0.05)	(0.13)	(0.05)	0.07	(0.07)	(0.05)	(0.07)	(0.07)
Collaborative Member 1	Snoqualmie \	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Collaborative Member 2	Mason	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78	3.78
Collaborative Member 3	Skyline	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)	(4.19)
2017 Washington CAH Median (n=38)		(0.37)	(0.37)	(0.37)	(0.37)	(0.37)	(0.37)	(0.37)	(0.37)	(0.37)	(0.37)	(0.37)	(0.37)
2017 U.S. CAH Median (n=1,313)		0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27

LIQUIDITY INDICATORS
CURRENT RATIO

Definition: measures the number of times short-term obligations can be paid using short-term assets.

Formula: Current Assets / Current Liabilities

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Arbor Health		2.65	2.45	2.47	2.04	2.02	2.05	2.14	2.19	2.07	-	-	-
2020 Target		-	-	-	-	-	-	-	-	-	-	-	-
Collaborative Member 1	Mason	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40
Collaborative Member 2	Summit Pa	4.10	4.10	4.10	4.10	4.10	4.10	4.10	4.10	4.10	4.10	4.10	4.10
2017 Washington CAH Median (n=38)		3.46	3.46	3.46	3.46	3.46	3.46	3.46	3.46	3.46	3.46	3.46	3.46
2017 U.S. CAH Median (n=1,313)		2.54	2.54	2.54	2.54	2.54	2.54	2.54	2.54	2.54	2.54	2.54	2.54

CAPITAL STRUCTURE INDICATORS
DEBT SERVICE COVERAGE RATIO

Definition: measures the ability to pay obligations related to long-term debt. This is a key indicator of a facilities ability to take on additional debt. This is not a monthly indicator

Formula: (Net Income + Deprec + Int Exp) / ((Current Portion LTD / periods) + Interest in Period)

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Arbor Health Mthly		196%	-93%	166%	-53%	257%	299%	168%	236%	-825%	0%	0%	0%
Arbor Health YTD		163%	146%	147%	136%	143%	153%	154%	159%	112%	0%	0%	0%
2020 Target		-	-	-	-	-	-	-	-	-	-	-	-
Collaborative Member 1	Snoqualmie	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49
Collaborative Member 2	Mason	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00
2017 Washington CAH Median (n=38)		3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41
2017 U.S. CAH Median (n=1,313)		3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74

Capitalization Ratio -- LTD to Cap Ratio

Definition: measures the percentage of total capital that is debt

Formula: (Cur LTD + Long Term Debt) / (Cur LTD + LTD + Fund Balance)

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Arbor Health		48%	49%	49%	56%	59%	59%	58%	58%	61%	0%	0%	0%
2020 Target		-	-	-	-	-	-	-	-	-	-	-	-
Collaborative Member 1	Snoqualmie	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
Collaborative Member 2	Mason	0.46	0.46	0.46	0.46	0.46	0.46	0.46	0.46	0.46	0.46	0.46	0.46
2017 Washington CAH Median (n=38)		3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41	3.41
2017 U.S. CAH Median (n=1,313)		3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74

Cash to Debt Ratio

Definition: measures the ability to support its debt obligations from its operating cash flows. This is a debt coverage ratio. A YTD or Year End calculation is best for review

Formula: Operating Cash Flows from Cash Flow Statement / Total Debt

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Arbor Health		(0.42)	(0.51)	(0.41)	0.39	(0.37)	0.93	(0.30)	(0.36)	(0.26)	-	-	-
Arbor Health YTD		0.23	0.17	0.13	0.10	0.05	0.10	0.09	0.06	0.05	-	-	-
2020 Target		-	-	-	-	-	-	-	-	-	-	-	-
Collaborative Member 1		-	-	-	-	-	-	-	-	-	-	-	-
Collaborative Member 2		3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74	3.74

CONSENT AGENDA



**LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
September 30, 2020 at 3:30 p.m.
ZOOM**

<https://myarborhealth.zoom.us/j/94824041361>

Meeting ID: 948 2404 1361

One tap mobile: +12532158782,,94824041361#

Dial: +1 253 215 8782

Mission Statement

To foster trust and nurture a healthy community.

Vision Statement

To provide accessible, quality healthcare.

AGENDA TOPIC	CONCLUSION	ACTION ITEMS
Call to Order	<p>Board Chair Frady called the meeting to order via Zoom at 3:30 p.m.</p> <p>Commissioners present:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Trish Frady, Board Chair<input checked="" type="checkbox"/> Tom Herrin, Secretary<input checked="" type="checkbox"/> Craig Coppock<input checked="" type="checkbox"/> Wes McMahan<input checked="" type="checkbox"/> Chris Schumaker <p>Others present:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Leianne Everett, Superintendent<input checked="" type="checkbox"/> Shana Garcia, Executive Assistant<input checked="" type="checkbox"/> Sara Williamson, CNO/CQO<input checked="" type="checkbox"/> Roy Anderson, Compliance Officer<input checked="" type="checkbox"/> Janice Holmes, Medical Staff Coordinator<input checked="" type="checkbox"/> Diane Markham, Marketing/Communication Manager & Foundation Executive Director<input checked="" type="checkbox"/> Richard Boggess, CFO<input checked="" type="checkbox"/> Buddy Rose, Reporter<input checked="" type="checkbox"/> Elee Fairhart, Morton Resident<input checked="" type="checkbox"/> Elya Prystowsky, WRHC Executive Director<input checked="" type="checkbox"/> Don Roberts, Pharmacist<input checked="" type="checkbox"/> Larry Sinkula, Surgical Services Director<input checked="" type="checkbox"/> Shannon Kelly, CHRO<input checked="" type="checkbox"/> Julie Taylor, Ancillary Services Director<input checked="" type="checkbox"/> Jeffrey Wasson, Resident's Family Member	



	<input checked="" type="checkbox"/> Jenny Knudsen, Rognlin's Inc. <input checked="" type="checkbox"/> Deann Schlumpf, Resident's Family Member <input checked="" type="checkbox"/> Kurt Moyer, Pacific Tech <input checked="" type="checkbox"/> Marcus Gdula, McKinstry <input checked="" type="checkbox"/> MW <input checked="" type="checkbox"/> June Merchur, Wood Harbinger <input checked="" type="checkbox"/> Sharon Wedam, Morton Resident <input checked="" type="checkbox"/> Nancy Brown, Wood Harbinger <input checked="" type="checkbox"/> 360.414.8084, Pacific Tech <input checked="" type="checkbox"/> Van Anderson, Packwood Resident <input checked="" type="checkbox"/> Pam Hayes, HUC	
Approval or Amendment of Agenda		Commissioner Coppock made a motion to approve the agenda. Secretary Herrin seconded and the motion passed unanimously.
Conflicts of Interest	Board Chair Frady asked the board to state any conflicts of interest with today's agenda.	None noted.
New Business	<p>CFO Boggess stated the Board received three timely submitted bids today by noon from McKinstry, Pacific Tech Construction and Rognlin's, Inc.</p> <p>CFO Boggess opened the three bids and noted:</p> <ol style="list-style-type: none"> 1. Rognlin's, Inc.'s total bid \$2,495,000. 2. McKinstry's total bid-\$2,400,560. 3. Pacific Tech Construction's total bid-\$2,798,576. <p>CFO Boggess announced the apparent low bidder is McKinstry's at \$2,400,560.</p> <p>Superintendent Everett announced the contract will be awarded on October 13, 2020 at 3:30 PM during a Special Board Meeting.</p>	
Comments and Remarks	<p>Commissioners: Commissioner Schumaker shared his concerns regarding the District's reaction to the closure of the custodial care program.</p> <p>Commissioner McMahan apologized to the District that he was unaware of the concerns expressed. Board Chair Frady appreciated the concerns expressed by the District and reiterated that this was not an easy decision. She</p>	



	<p>thanked the staff for their commitment to the residents and their families during this transition.</p> <p>Audience: Jeffrey Wasson expressed concerns regarding the closure of the custodial care program and requested the Board reconsider putting a hold on their decision.</p> <p>DeAnn Schlumpf expressed concern regarding not being informed of the meetings or on the decision of where her family member was going to be placed.</p> <p>Elee Fairhart requested more information regarding the recent move towards an ACO contract.</p> <p>Superintendent Everett acknowledged the District has agreed to participate in an ACO; however, we are awaiting approval. This is quality driven and we have not agreed on the measures with Physicians of Southwest Washington. The goal of ACO's is to improve health while lowering the cost of care. Patients continue to choose their preferred provider. CMS is encouraging ACO models in rural healthcare.</p>	
Guest Speaker-WRHC, Elya Prystowsky, Executive Director	Elya Prystowsky with the Washington Rural Health Collaborative provided an overview of the benefits to Arbor Health's membership in the collaborative. She shared that as a collaborative we collectively speak with a larger voice. The membership provides a financial benefit through shared services and purchasing agreements.	
Executive Session- RCW 70.41.205	<p>Executive Session began at 4:20 p.m. for 20 minutes to discuss Medical Privileging. The Board returned to open session at 4:40 p.m. No decisions were made in Executive Session.</p> <p>New Appointments</p> <ol style="list-style-type: none"> 1. Stephen Burton, MD (Providence- Telestroke Privileges) 2. Nathan Cade, MD Active (Emergency Medicine) 3. Ruben Krishnananthan, MD Consulting (Radiology Privileges) 4. George Lopez, MD (Providence- Telestroke Privileges) 5. Aixa D. Espinosa Morales, MD (Providence- Telestroke Privileges) 6. Ravi Pande, MD (Providence- Telestroke Privileges) 	Secretary Herrin made a motion to approve the Medical Privileging as presented and Commissioner Coppock seconded. The motion passed unanimously.



	<ol style="list-style-type: none"> 7. Rizwani Kalani, MD (Providence- Telestroke Privileges) 8. Jianming Song, MD Active (Emergency Medicine) <p>Reappointments</p> <ol style="list-style-type: none"> 1. Kristine Andrade, MD Consulting (Radia-Radiology Privileges) 2. David Atkins, MD Consulting (Radia-Radiology Privileges) 3. Jennifer Montoure, ARNP Active (Family Medicine) 	
Break	Board Chair Frady called for a 5-minute break at 4:45 p.m. The Board returned to open session at 4:50 p.m.	
Department Spotlight <ul style="list-style-type: none"> • Don Roberts 	Pharmacist Roberts provided an overview of the Pharmacy. He comes with a wealth of experience and reiterated his primary responsibility is to partner with the clinical team in providing the best care to our patients. He believes the DNV Accreditation is important and is working to have the Pharmacy ready.	
Board Committee Reports <ul style="list-style-type: none"> • Hospital Foundation Report 	<p>Commissioner McMahan announced the auction is this weekend and commended the Foundation Volunteers for their efforts during this unusual year.</p> <p>Diane Markham encouraged everyone attend and noted the Fund-A-Need this year is the CT Scanner. The fundraising goal is \$30,000 and the Live Auction will be on YouTube on Saturday, October 3, 2020.</p>	
<ul style="list-style-type: none"> • Finance Committee Report 	<p>Commissioner Herrin highlighted the following:</p> <ol style="list-style-type: none"> 1. Utilities were higher due to a billing process change but should line up next month with YTD budget. 2. Benefits were higher due to increased utilization but will continue to account for it. 3. Revenue was down by 45%. 4. Overall, costs were higher than budgeted, making it an unfavorable month. 5. Requesting board approval on two Resolutions: <ol style="list-style-type: none"> a. LED Lighting b. Centralia College 6. CARES Act monies are going to cause a budget shift. The methodology for recognizing lost revenue has to change based on clearer guidance. 7. Continuing to pursue the Mobile Health Clinic. This will be brought to the full board in November for discussion. 	



<ul style="list-style-type: none"> Compliance Committee Report 	<p>Commissioner McMahan reiterated the action items that the Board needs to complete:</p> <ol style="list-style-type: none"> Complete and return Conflicts of Interest forms to Compliance Officer Anderson. Review the Regulatory Summary in Lucidoc. 	
Consent Agenda	<p>Board Chair Frady announced the following in consent agenda up for approval:</p> <ol style="list-style-type: none"> Minutes of the August 26, 2020 Regular Board Meeting (<i>Action</i>) Minutes of the September 16, 2020 Compliance Committee Meeting (<i>Action</i>) Minutes of the September 23, 2020 Finance Committee Meeting (<i>Action</i>) Warrants & EFT's in the amount of \$3,930,631.51 dated August 2020 (<i>Action</i>) Resolution 20-37-Approving the Capital Purchase of LED Lighting (<i>Action</i>) Resolution 20-38-Approving the Engagement with Centralia College (<i>Action</i>) Approve Documents Pending Board Ratification 9.30.20 (<i>Action</i>) 	<p>Secretary Herrin made a motion to approve the Consent Agenda and Commissioner Schumaker seconded. The motion passed unanimously.</p>
Old Business <ul style="list-style-type: none"> OPMA & PRA Training Certificates 	Nothing noted.	
New Business <ul style="list-style-type: none"> Board Education 	Board Chair Frady shared the design behind a consent agenda. The Board agreed the consent agenda is helpful and agreed to continue to vote on the consent agenda for resolution purposes to memorialize the decisions made.	
<ul style="list-style-type: none"> Diversity Training 	Board Chair Frady announced the training will be during a Special Board Meeting on October 28 th at 2:30 pm. The Leadership Team and directors of the organization will be joining in too.	
<ul style="list-style-type: none"> Draft 2021 Operating Budget 	Superintendent Everett noted the budget is in development. The operating budget was presented at the October 21, 2020 Finance Committee Meeting and will be presented to the Board again at a Special Board Meeting on October 28, 2020.	
<ul style="list-style-type: none"> Board Policies & Procedures 	<p>The Board supported adding the new policy for Electronic Signatures.</p> <p>The Board supported marking the following three policies and procedures as reviewed.</p> <ol style="list-style-type: none"> Annual Adoption of the Compliance Plan Annual CEO/Superintendent Evaluation Board E-Mail Communication 	<p>Secretary Herrin made a motion to add the new policy/procedure and to mark the policies and procedures as reviewed and Commissioner McMahan seconded. The</p>



		<p>motion passed unanimously.</p> <p>Action Item-Executive Assistant Garcia will create and publish the new policy in Lucidoc.</p> <p>Action Item-Executive Assistant Garcia will mark the three policies and procedures as reviewed.</p>
<ul style="list-style-type: none"> Change to Employee Benefits 	<p>CHRO Kelly noted in 2017 the Board delegated fiduciary authority to the retirement plan committee that meets quarterly. As a member of the Collaborative we can pool our assets in the retirement plan to reduce fees and access new investments. The Committee has agreed to transition to Nationwide.</p> <p>CHRO Kelly shared the next step will be for the Committee to share the details at the October 21, 2020 Finance Committee Meeting and will finally bring a resolution to the Board to adopt the new plan document.</p>	<p>Action Item-CHRO Kelly will research if employees will have to move money when moving platforms.</p>
Superintendent Report	<p>Superintendent Everett updated the following:</p> <ol style="list-style-type: none"> 1. The closure of Custodial Care is on track and placement of residents is going well. 2. The Flu Shot Clinic has been a success and a great service to the community. 3. The upcoming WSHA Fall Virtual Conference is in progress and we need to know if the Board wants to participate. <p>Superintendent Everett presented the Department Specific Measures that align with the three Strategic Goals. She highlighted a few different areas to demonstrate how the data will be measured. She requested the Board review the format, data presented and bring feedback to the November 11, 2020 Regular Board Meeting to ensure she is meeting the Board's expectations.</p>	<p>Action Item-The Board needs to notify Executive Assistant Garcia by Friday, October 2, 2020 if you would like to enroll in the conference.</p> <p>Action Item-Superintendent Everett will assign OR as a departmental update in early 2021.</p> <p>Action Item-The Board will review the Department Specific Measures and bring back questions or recommendations to the November 11, 2020 Regular Board Meeting.</p>



Meeting Summary & Evaluation	Superintendent Everett highlighted the action items. Commissioner McMahan shared we could have given more time and more opportunities for the District to give input on the Custodial Care program.	
Adjournment	Secretary Herrin moved and Commissioner McMahan seconded to adjourn the meeting at 6:57 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Secretary

Date



**LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
October 7, 2020 at 3:30 p.m.
ZOOM**

<https://myarborhealth.zoom.us/j/96185682451>

Meeting ID: 961 8568 2451

One tap mobile: +12532158782,,96185682451#

Dial by your location: +1 253 215 8782

Mission Statement

To foster trust and nurture a healthy community.

Vision Statement

To provide accessible, quality healthcare.

AGENDA	DISCUSSION/CONCLUSION	RECOMMENDATIONS/ ACTION/FOLLOW-UP
Call to Order	Board Chair Frady called the meeting via Zoom to order at 3:30 p.m. Commissioners present: <input checked="" type="checkbox"/> Trish Frady, Board Chair <input checked="" type="checkbox"/> Tom Herrin, Secretary <input checked="" type="checkbox"/> Craig Coppock <input checked="" type="checkbox"/> Wes McMahan <input type="checkbox"/> Chris Schumaker Others present: <input checked="" type="checkbox"/> Leianne Everett, Superintendent <input checked="" type="checkbox"/> Shana Garcia, Executive Assistant <input checked="" type="checkbox"/> Richard Boggess, CFO	
Reading of the Notice of the Special Meeting	Board Chair Frady read the special board meeting notice. Board Chair Frady noted the chat function was disabled and the meeting was not recorded.	
Executive Session • <i>RCW 42.30.110(1)(d)</i>	Executive Session began at 3:32 pm for 18 minutes to discuss negotiations on the performance of a publicly bid contract (<i>RCW 42.30.110(1)(d)</i>). The Board returned to open session at 3:50 p.m. No decisions were made in Executive Session.	
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourned at 3:51 p.m. The motion passed unanimously.	



Respectfully submitted,

Tom Herrin, Board Secretary

Date



**LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
October 13, 2020 at 3:30 p.m.
ZOOM**

<https://myarborhealth.zoom.us/j/93060233335>

Meeting ID: 930 6023 3335

One tap mobile: +12532158782,,93060233335#

Dial:+1 253 215 8782

Mission Statement

To foster trust and nurture a healthy community.

Vision Statement

To provide accessible, quality healthcare.

AGENDA	DISCUSSION/CONCLUSION	RECOMMENDATIONS/ ACTION/FOLLOW-UP
Call to Order	<p>Board Chair Frady called the meeting via Zoom to order at 3:32 p.m.</p> <p>Commissioners present:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Trish Frady, Board Chair<input checked="" type="checkbox"/> Tom Herrin, Secretary<input checked="" type="checkbox"/> Craig Coppock<input checked="" type="checkbox"/> Wes McMahan<input checked="" type="checkbox"/> Chris Schumaker <p>Others present:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Leianne Everett, Superintendent<input checked="" type="checkbox"/> Shana Garcia, Executive Assistant<input checked="" type="checkbox"/> Richard Boggess, CFO<input checked="" type="checkbox"/> Roy Anderson, Compliance Officer<input checked="" type="checkbox"/> Anas Sadkhi, Interim Maintenance Manager<input checked="" type="checkbox"/> June Mechure, Wood Harbinger<input checked="" type="checkbox"/> Nancy Brown, Wood Harbinger<input checked="" type="checkbox"/> Jeri Whitnell, Imaging Manager<input checked="" type="checkbox"/> Julie Taylor, Ancillary Services Director<input checked="" type="checkbox"/> Larry Sinkula, Surgical Services Director<input checked="" type="checkbox"/> Mark Gdula, McKinstry	
Reading of the Notice of the Special Meeting	<p>Board Chair Frady read the special board meeting notice.</p> <p>Board Chair Frady noted the chat function was disabled and the meeting was not recorded.</p>	



Executive Session <ul style="list-style-type: none">RCW 42.30.110(1)(d)	Executive Session began at 3:35 pm for 10 minutes to discuss negotiations on the performance of a publicly bid contract (RCW 42.30.110(1)(d)). The Board returned to open session at 3:45 p.m. No decisions were made in Executive Session.	
New Business <ul style="list-style-type: none">Resolution 20-39- Approving the Base Bid Plus Allowance from Contractor for the Generator/OR HVAC Project & Authorizing the Superintendent to Execute a Contract (Action)		
Action		Secretary Herrin made a motion to approve Resolution 20-39 awarding the bid to McKinstry and Commissioner Coppock seconded. The motion passed unanimously.
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourned at 3:48 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Board Secretary

Date



LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Quality Improvement Oversight Committee Meeting
October 14, 2020 at 7:00 a.m.
Conference Room 1 & 2 & Zoom

AGENDA	DISCUSSION	ACTION
Call to Order	<p>Commissioner McMahan called the meeting to order at 7:01 a.m.</p> <p>Commissioner(s) Present in Person or via Zoom:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Wes McMahan <input checked="" type="checkbox"/> Chris Schumaker <p>Committee Member(s) Present in Person or via Zoom:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Leianne Everett, Superintendent <input checked="" type="checkbox"/> Dexter Degoma, Interim Quality Manager <input checked="" type="checkbox"/> Roy Anderson, Compliance Officer <input checked="" type="checkbox"/> Sara Williamson, CNO/CQO <input checked="" type="checkbox"/> Lynn Bishop, Patient Experience Representative <input checked="" type="checkbox"/> Dr. Kevin McCurry, CMO <input checked="" type="checkbox"/> Julie Taylor, Ancillary Services Director <input checked="" type="checkbox"/> Amanda Seals, Employee Health & Wellness <input checked="" type="checkbox"/> Michelle Matchett, Administrative Assistant <p>Committee Member(s) Absent:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Char Hancock, Clinic Manager <input type="checkbox"/> Shana Garcia, Executive Assistant <input type="checkbox"/> Dr. Tom Anderson, Chief of Staff <input type="checkbox"/> Edwin Meelhuysen, Rehabilitation Services Director 	
Approval or Amendment of the Agenda	The Committee did not have any amendments of the agenda and approved it as is.	
Conflicts of Interest	The Committee noted no conflicts of interest.	None noted.
Consent Agenda	Commissioner Schumaker addressed concerns on page eight of the QIO Packet in the July 22, 2020 QIO Committee Meeting Minutes. He disagreed with the minutes and noted they do not accurately reflect his concerns with discontinuing the Custodial Care Program. Commissioner McMahan agreed that the statement could be misconstrued, but he did not feel that the minutes necessarily reflected that they were in agreement	

Confidential Information: prepared for quality assurance functions and protected under RCW 4.24.250, 70.41.200 and other state and federal statutes.

	<p>for the closure and it was not an issue. Commissioners Schumaker and McMahan agreed that they would like the draft minutes distributed within a week for review.</p> <p>The following in consent agenda is up for approval:</p> <ol style="list-style-type: none"> 1. Minutes of the July 22, 2020 Quality Improvement Oversight (QIO) Committee Meeting (<i>Action</i>) 2. Minutes of the August 20, 2020 Infection Prevention & Control Committee Meeting (<i>Action</i>) 3. Minutes of the September 29, 2020 Environment of Care (EOC) Committee Meeting (<i>Action</i>) 4. EOC Committee <ol style="list-style-type: none"> a. Documents presented in Lucidoc for approval. 	<p>Commissioner Schumaker made a motion to approve the consent agenda as presented and CNO/CQO Williamson seconded. The motion passed unanimously.</p>
<p>Old Business</p> <ul style="list-style-type: none"> • Action Item Follow Up 	<p>Interim Quality Manager Degoma highlighted the following:</p> <ol style="list-style-type: none"> 1. Addressed the follow up items from the Pre-August QIO Meetings and provided status updates. 2. Provided follow up to the Hand Hygiene Memo. Ancillary Services Director Taylor shared in the Infection Prevention and Control Plan hand hygiene compliance is addressed. Commissioner McMahan asked if there were barriers to hand hygiene. Ancillary Services Director Taylor noted that the only barrier she observed was if the employee had something in their hand. 	
<p>New Business</p> <ul style="list-style-type: none"> • Performance Improvement (PI) Projects 	<p>Interim Quality Manager Degoma highlighted the following:</p> <ol style="list-style-type: none"> 1. Deferring this presentation to December QIO to compile Q3 data. Interim Quality Director Degoma wants to make sure the committee understands that the reason is to continue to build the infrastructure. 2. Once a year, managers will attend a QIO meeting to present progress on their PI Project. 	<p>Action Item-Katelin Forrest and Amanda Seals will present PI Project-Employee Injury Management at the December QIO Meeting.</p>
<ul style="list-style-type: none"> • Survey Preparation Update (Degoma) 	<p>Interim Quality Manager Degoma highlighted the following on the upcoming surveys:</p> <ol style="list-style-type: none"> 1. Stroke Certification by DNV will be onsite October 19, 2020. 2. In November there will be an unannounced DNV hospital accreditation survey. 3. Mock surveys have occurred and will continue to be conducted in preparation for survey readiness. 	
<ul style="list-style-type: none"> • QAPI and Patient Safety Areas of Focus-2Q2020 (Degoma) 	<p>Interim Quality Manager Degoma highlighted the following on first quarter performance metrics:</p> <ol style="list-style-type: none"> 1. The patient experience scores have been completed for Q2. We are getting more responses returned, so the numbers are increasing. 2. Compliance Officer Anderson suggested a sub-committee to address any questions. Superintendent 	<p>Action Item-Commissioner McMahan will recommend</p>

	Everett would like to revisit in this topic in 2021 with the objective of having a QIO meeting every other month.	to Board Chair Frady to add an agenda item to the November Regular Board Meeting regarding QIO Meeting occurrences/subcommittee option.
<ul style="list-style-type: none"> Contract Evaluations 	<p>Interim Quality Manager Degoma presented the service contract evaluations. The following contracts have been reviewed and recommended for continuation of the contract services.</p> <p>Contract evaluation criteria includes:</p> <ol style="list-style-type: none"> 1. Compliance with applicable laws, regulations, organizational policies, and certifying agencies 2. Adherence to comparable standard of Arbor Health 3. Participation in quality improvement programs 4. Assurance of timely, safe, and efficient care <p>Contracts presented includes the following:</p> <ol style="list-style-type: none"> 1. PROVIDENCE HEALTH & SERVICES_WASHINGTON dba PROVIDENCE MEDICAL GROUP SOUTHWEST WASHINGTON 2. SOUTH SOUND RADIOLOGISTS, INC., P.S. and RADIA INC., P.S. 3. PEACEHEALTH d/b/a PEACEHEALTH ST. JOHN MEDICAL CENTER 4. LEGACY EMANUEL HOSPITAL & HEALTH CENTER and LEGACY GOOD SALMON CREEK HOSPITAL 5. PROVIDENCE HEALTH AND SERVICES d/b/a PROVIDENCE CENTRALIA HOSPITAL 6. UW MEDICINE – HARBORVIEW MEDICAL CENTER 7. MULTICARE HEALTH SYSTEM 	Action Item-Interim Quality Manager Degoma will provide an update at the December meeting.
Meeting Summary & Evaluation	Nothing noted.	
Adjournment	Superintendent Everett made a motion to adjourn at 8:10 a.m. and CNO/CQO Williamson seconded. The motion passed unanimously.	



LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
October 21, 2020 at 12:00 p.m.
Conference Room 1 & Via Zoom

AGENDA	DISCUSSION	ACTION
Call to Order	<p>Secretary Herrin called the meeting to order via Zoom at 12:00 p.m.</p> <p>Commissioner(s) Present in Person or via Zoom:</p> <p><input checked="" type="checkbox"/> Tom Herrin, Secretary</p> <p><input checked="" type="checkbox"/> Craig Coppock, Commissioner</p> <p>Committee Member(s) Present in Person or via Zoom:</p> <p><input checked="" type="checkbox"/> Shana Garcia, Executive Assistant</p> <p><input checked="" type="checkbox"/> Richard Boggess, CFO via Zoom</p> <p><input checked="" type="checkbox"/> Leianne Everett, Superintendent</p> <p><input checked="" type="checkbox"/> Marc Fisher, Community Member</p> <p><input checked="" type="checkbox"/> Clint Scogin, Controller</p> <p><input checked="" type="checkbox"/> Sara Williamson, CNO/CQO</p>	
Approval or Amendment of Agenda	None noted.	Superintendent Everett made a motion to approve the agenda. CFO Boggess seconded, and the motion passed unanimously.
Conflicts of Interest	The Committee noted no conflicts of interest.	
Consent Agenda <ul style="list-style-type: none"> • Review of Finance Minutes –September 23, 2020 • Revenue Cycle Update • Board Oversight Activities • Cost Report Update • Financial Statements 		Superintendent Everett made a motion to approve the consent agenda and CFO Boggess seconded. The motion passed unanimously.
Old Business	CFO Boggess highlighted an update on the restatement of care act monies in 2019 and	

<ul style="list-style-type: none"> • Disaster Funding Update 	extension for the Paycheck Protection Program (PPP).	
New Business <ul style="list-style-type: none"> • Transition of the Employee Retirement Program 	<p>CFO Boggess presented that the Retirement Plan Committee has elected to partner with the Washington Rural Health Collaborative (WRHC) to select a joint purchasing retirement plan service solution. By partnering with WRHC, the participants in the plan will save money by reducing costs through record keeping/administrative fees, advisor fees and investment product costs. Ultimately, the collaborative will add another level of oversight by moving in this direction. The goal was to find a service solution that provided a comprehensive retirement plan with recordkeeping, administration, education, and communication solutions. The WRHC selected Nationwide as the service solution, so plan participants at Mass Mutual will move to Nationwide, including ongoing contributions.</p> <p>The Finance Committee supported moving to the Board for approval via resolution.</p>	Action Item-Executive Assistant Garcia will prepare a resolution for the October 28 th Special Board Meeting to approve the new plan documents for Nationwide.
<ul style="list-style-type: none"> • Health Insurance Update 	<p>CFO Boggess provided a health insurance update. The District's plan experience through Quarter 3 has shown an increase in total claim costs compared to 2019 by 69%. Our plan utilization metrics exceed industry benchmarks by 20%. The advantage of having a self-insured model is we are not having to pay the profit margin if we used a third party. Administration has built this experience in the 2021 Budget</p>	
<ul style="list-style-type: none"> • Generator/OR HVAC Project Update 	CFO Boggess noted since we awarded the bid to McKinstry, Inc. We shared the signed resolution with them this week to move forward.	
<ul style="list-style-type: none"> • 2021 Operating Budget 	<p>CFO Boggess presented a draft 2021 budget. The volumes presented reflect 2020 projections with some additional assumptions such as the addition of Morton Clinic, new providers and reduced costs in agency labor. There were 4 alternative options focused on changing expense structure presented focused on changes in staffing, travel and purchased services reviewed.</p> <p>Administration is recommending a budget with a net income of 1.12% or \$358,116. This will allow management to move forward with the achieving the strategic plan and provide the healthcare the District needs. Administration will adjust as needed</p>	Action Item-Executive Assistant Garcia will prepare a resolution for the November 11, 2020 Regular Board Meeting to approve the 2021 Budget.

	<p>throughout the year given the volatile market during this pandemic.</p> <p>The Finance Committee supported moving to the Board for presentation on October 28, 2020 and for approval via resolution on November 11, 2020.</p>	
Adjournment	Secretary Herrin adjourned the meeting at 1:00 pm.	



**LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
October 28, 2020 at 2:30 p.m.
ZOOM**

<https://myarborhealth.zoom.us/j/93060233335>

Meeting ID: 930 6023 3335

One tap mobile: +12532158782,,93060233335#

Dial:+1 253 215 8782

Mission Statement

To foster trust and nurture a healthy community.

Vision Statement

To provide accessible, quality healthcare.

AGENDA	DISCUSSION/CONCLUSION	RECOMMENDATIONS/ ACTION/FOLLOW-UP
Call to Order	<p>Board Chair Frady called the meeting via Zoom to order at 2:30 p.m.</p> <p>Commissioners present:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Trish Frady, Board Chair<input checked="" type="checkbox"/> Tom Herrin, Secretary<input checked="" type="checkbox"/> Craig Coppock<input checked="" type="checkbox"/> Wes McMahan<input checked="" type="checkbox"/> Chris Schumaker <p>Others present:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Leianne Everett, Superintendent<input checked="" type="checkbox"/> Shana Garcia, Executive Assistant<input checked="" type="checkbox"/> Richard Boggess, CFO<input checked="" type="checkbox"/> Roy Anderson, Compliance Officer<input checked="" type="checkbox"/> Kevin Conger, Dietary Manager<input checked="" type="checkbox"/> Char Hancock, Clinic Manager<input checked="" type="checkbox"/> Maria, Physicians Insurance<input checked="" type="checkbox"/> Jeri Whitnell, Imaging Manager<input checked="" type="checkbox"/> Julie Taylor, Ancillary Services Director<input checked="" type="checkbox"/> Larry Sinkula, Surgical Services Director<input checked="" type="checkbox"/> Brandy Childress, Clinic Manager<input checked="" type="checkbox"/> Sara Williamson, CNO/CQO<input checked="" type="checkbox"/> Sherry Sofich, Revenue Cycle Director<input checked="" type="checkbox"/> Larry Sinkula, Surgical Director<input checked="" type="checkbox"/> Shelly Knicks, Physicians Insurance	



	<ul style="list-style-type: none"> ☑ Lauren Stoll, Physicians Insurance ☑ Justin Steiner, Legal ☑ Don Roberts, Pharmacist ☑ Dexter Degoma, Interim Quality Manager ☑ Alicia Johnson, Clinical Informatics Manager ☑ Clint Scogin, Controller ☑ Buddy Rose, Reporter ☑ Joyce Bailey, ED Director ☑ Edwin Meelhuysen, Rehabilitation Services Director ☑ Shannon Kelly, CHRO ☑ Janice Holmes, Medical Staff Coordinator ☑ Dr. Jeff Ford, Emergency Department 	
Reading of the Notice of the Special Meeting	<p>Board Chair Frady read the special board meeting notice. She noted a correction to the notice to replace 2020 budget with presenting the 2021 budget to match the agenda.</p> <p>Board Chair Frady noted the chat function was disabled and the meeting was not recorded.</p>	
New Business <ul style="list-style-type: none"> • Professional Conduct in the Workplace Training <ul style="list-style-type: none"> ○ Physicians Insurance 	Attorney Justin Steiner presented training on professional conduct in the workplace for the Board and the leadership team of the District.	
<ul style="list-style-type: none"> • Resolution 20-40- Approving to Amend the 403(b) Plan <i>(Action)</i> 	Superintendent Everett reminded the Board that she explained at the September Regular Board of Commissioners meeting that Mass Mutual is exiting the retirement market, thus, forcing us to change investment platforms. She restated that the Retirement Committee elected to pool Arbor Health's retirement funds with five other WRHC hospital's funds to reduce investment costs for the individual investor. As a result, Arbor Health is moving to Nationwide's platform in mid-December 2020. All assets will be transferred from Mass Mutual to Nationwide. There will be a blackout period of about three days to accomplish this transition. The plan documents presented tonight represent this change in investment platform.	Commissioner Coppock made a motion to approve Resolution 20-40 and Secretary Herrin seconded. The motion passed unanimously.
<ul style="list-style-type: none"> • Resolution 20-41- Approving the Medical Staff Rules & Regulations <i>(Action)</i> 	Superintendent Everett highlighted the Medical Staff is presenting their Rules and Regulations for approval, as Medical Executive Committee (MEC) approved them this morning.	Commissioner McMahan made a motion to approve Resolution 20-41 and Commissioner Schumaker



	<p>Dr. Ford noted the Rules and Regulations were revised to reflect current practice for fully credentialed medical staff. The Rules and Regulations are an industry standard and we would be regulatorily negligent without reviewed and approved bylaws and supporting rules and regulations.</p> <p>Superintendent Everett noted MEC will be sending their bylaws and rules and regulations to an external firm for legal review.</p>	seconded. The motion passed unanimously.
<ul style="list-style-type: none"> Resolution 20-42- Approving the Clinical/Non-Clinical Contracted Services Evaluation Matrix (<i>Action</i>) 	Superintendent Everett highlighted the management team is presenting an annual review matrix for clinical and non-clinical contracted services. This is a list of contracts that have been reviewed to date	Commissioner Coppock made a motion to approve Resolution 20-42 and Secretary Herrin seconded. The motion passed unanimously.
<ul style="list-style-type: none"> Draft 2021 Operating Budget 	Superintendent Everett and CFO Boggess presented the 2021 Operating Budget. Secretary Herrin highlighted that the Finance Committee is presenting this budget option as it allows the District to grow, retain and serve the residents.	Action Item-Executive Assistant Garcia will create a resolution to adopt the Operating Budget at the Regular Board Meeting on November 11, 2020.
<ul style="list-style-type: none"> Approve Documents Pending Board Ratification 10.28.20 	Superintendent Everett noted ratification of documents is usually presented in Consent Agenda; however, in preparation for the upcoming survey, the management team has been diligently reviewing and updating documents in Lucidoc to ensure our policies and procedures reflect current practice.	Commissioner Schumaker made a motion to ratify the documents presented and Commissioner Coppock seconded. The motion passed unanimously.
Adjournment	Secretary Herrin moved and Commissioner Schumaker seconded to adjourned at 4:17 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Board Secretary

Date

WARRANT & EFT LISTING NO. 2020-09

RECORD OF CLAIMS ALLOWED BY THE
BOARD OF LEWIS COUNTY
COMMISSIONERS

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

CERTIFICATION

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

Signed:

Richard Boggess, CFO

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

\$3,980,538.39 this 11th day

of November 2020

Board Chair, Trish Frady

Commissioner, Craig Coppock

Secretary, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of ***\$3,980,538.39*** dated ***September 1, 2020*** –
September 30, 2020.

Routine A/P Runs

Warrant No.	Date	Amount	Description
118446 - 118452	2-Sep-2020	674,952.87	CHECK RUN
118453	8-Sep-2020	8,820.00	CHECK RUN
118456 - 118491	4-Sep-2020	69,949.02	CHECK RUN
118494 - 118495	11-Sep-2020	612,730.03	CHECK RUN
118496	4-Sep-2020	3,303.94	CHECK RUN
118497	8-Sep-2020	2,597.48	CHECK RUN
118498 - 118502	14-Sep-2020	26,367.70	CHECK RUN
118503 - 118544	11-Sep-2020	85,621.09	CHECK RUN
118545 - 118555	21-Sep-2020	824,694.73	CHECK RUN
118556 - 118639	18-Sep-2020	192,560.32	CHECK RUN
118640	21-Sep-2020	5,000.00	CHECK RUN
118641	8-Sep-2020	4,486.52	CHECK RUN
118642	8-Sep-2020	9,602.95	CHECK RUN
118643	15-Sep-2020	10,516.07	CHECK RUN
118644 - 118647	28-Sep-2020	114,437.81	CHECK RUN
118648 - 118713	25-Sep-2020	182,123.38	CHECK RUN
118714 - 118720	25-Sep-2020	7,120.13	CHECK RUN
118721	28-Sep-2020	691.93	CHECK RUN
118746	30-Sep-2020	980.98	CHECK RUN
118747	29-Sep-2020	14,548.40	CHECK RUN
Total - Check Runs		\$ 2,851,105.35	

Error Corrections - in Check Register Order

Warrant No.	DATE VOIDED	Amount	Description
114912	12-Sep-2020	(712.32)	VOID
117569	28-Sep-2020	(199.96)	VOID
TOTAL - VOIDED CHECKS		\$ (912.28)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	\$ 2,850,193.07
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Eft	Date	Amount	Description
1064	1-Sep-2020	452.31	MCKESSON
	4-Sep-2020	417,312.77	TRANSFER TO SECURITY STATE
1065	8-Sep-2020	100.57	MCKESSON
1066	15-Sep-2020	457.09	MCKESSON
1124	4-Sep-2020	151,780.20	IRS
1125	18-Sep-2020	145,714.77	IRS
	18-Sep-2020	409,536.61	TRANSFER TO SECURITY STATE
1067	29-Sep-2020	1,751.84	MCKESSON
1068	22-Sep-2020	3,239.16	MCKESSON
TOTAL EFTS AT SECURITY STATE BANK		\$ 1,130,345.32	

TOTAL CHECKS, EFT'S, & TRANSFERS	\$ 3,980,538.39
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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
CLINICAL/NON-CLINICAL CONTRACTED
SERVICES EVALUATION MATRIX

RESOLUTION NO. 20-43

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

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

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

Approving the Clinical/Non-Clinical Contracted Services Performance Review Matrix.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 11th day of November 2020, the following commissioners being present and voting in favor of this resolution.

Trish Frady, Board Chair

Tom Herrin, Secretary

Craig Coppock, Commissioner

Wes McMahan, Commissioner

Chris Schumaker, Commissioner



LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION DECLARING TO
SURPLUS OR DISPOSE OF CERTAIN PROPERTY

RESOLUTION NO. 20-44

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

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

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

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

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 11th day of November 2020, the following commissioners being present and voting in favor of this resolution.

Trish Frady, Board Chair

Tom Herrin, Secretary

Craig Coppock, Commissioner

Wes McMahan, Commissioner

Chris Schumaker, Commissioner

DISPOSAL/SURPLUS PERSONAL PROPERTY

EXHIBIT A

DATE	DESCRIPTION	DEPARTMENT	PROPERTY #	DISPOSITION	REASON
10/2020	HP COMPUTER	IT	5913	DISPOSAL	OBSOLETE
10/2020	HP COMPUTER	IT	5838	DISPOSAL	OBSOLETE
10/2020	HP COMPUTER	IT	5942	DISPOSAL	OBSOLETE
10/2020	HP COMPUTER	IT	5871	DISPOSAL	OBSOLETE
10/2020	HP COMPUTER	IT	5581	DISPOSAL	OBSOLETE
10/2020	HP COMPUTER	IT	5608	DISPOSAL	OBSOLETE
10/2020	SURGERY CLINIC	IT	5658	DISPOSAL	OBSOLETE
10/2020	LABEL MAKER	MAINTENANCE	5866	DISPOSAL	BROKEN
10/2020	RUNG DOCTOR	FLOORS	5930	DISPOSAL	BROKEN

Documents Awaiting Board Ratification 11.11.20		
	LCHD No. 1's Policies, Procedures & Contracts:	Departments:
1	Approved Personnel in Food Preparation Area	Dietary Services
2	Authorization/Supervision	HIPAA Security
3	Canceling Appointments and Encounters	Patient Access
4	Casual Part-time Employees	Human Resources
5	Code of Conduct	Human Resources
6	Compensatory Time Off Policy	Human Resources
7	Contracts Management	Administration
8	Declaration of Responsibility of a Minor	Patient Access
9	Dr. Don Allison, MD	Employment Agreements
10	Dr. Stan Tran Employment Agreement	Employment Agreements
11	Emergency Call List for Essential Services Policy	Maintenance
12	Ergonomic Workstation Evaluation	Human Resources
13	Environmental Services Procedure Guide	Facility Support
14	FoxHire, LLC Client Services Agreement	Contracted Services
15	GE Government Finance, Inc. Equipment Schedule	Finance, Bonds, Lines of Credit
16	GE Government Finance, Inc. Master Agreement	Finance, Bonds, Lines of Credit
17	Guidelines for Ill Dietary Employees	Dietary Services
18	Information Access Management	HIPAA Security
19	L. Leianne Everett Contract 2019	Employment Agreements
20	MRI Service Agreement	Service Agreements
21	Mechanical Dishwashing	Dietary Services
22	Medical Record Pick Up Confirmation	Health Information Management
23	Medical Records Management	Health Information Management
24	Professional Services Employment Agreement - Todd Nelson, CRNA	Employment Agreements
25	Shanna Angel, Anesthesia Director compensation	Employment Agreements
26	Telelanguage Service Agreement	Professional Services Agreement

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

OLD BUSINESS

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 11/03/2020
Subject: 2021 Proposed Tax Levy

As regulated by RCW 84.55.120, we are discussing the 2021 Proposed Tax Levy in our open Board of Commissioners meeting on November 11, 2020. As in past years, we requested the statutorily provided 1% increase to our levy. The District is required to submit this information to Lewis County by November 15th, 2020 deadline.

The increased levy was incorporated into the 2021 operating budget being presented tonight. The resolution to adopt the proposed levy is in conjunction with the resolution to adopt the 2021 operating budget. The tax dollars support the principle and interest payments of our past building projects.

As this memo is being constructed, information relating to our 2021 tax levy has not been provided by our County Assessor, Dianne Dorey.





LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE 2021
PROPOSED TAX LEVIES (RCW 84.55.120)

RESOLUTION NO. 20-45

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

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

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

Approving the 2021 Tax Levies which is the 1% increase of the 2020 rate as described in the county assessor resolution provided. (See attached from Department of Revenue.)

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 11th day of November 2020, the following commissioners being present and voting in favor of this resolution.

Trish Frady, Board Chair

Tom Herrin, Secretary

Craig Coppock, Commissioner

Wes McMahan, Commissioner

Chris Schumaker, Commissioner



LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION ADOPTING THE LEWIS
COUNTY HOSPITAL DISTRICT NO. 1
2021 BUDGET

RESOLUTION NO. 20-46

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

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

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

To adopt the proposed budget for the calendar year of 2021.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 11th day of November 2020, the following commissioners being present and voting in favor of this resolution.

Trish Frady, Board Chair

Tom Herrin, Secretary

Craig Coppock, Commissioner

Wes McMahan, Commissioner

Chris Schumaker, Commissioner

Lewis County Hospital District 1
Income Statement
Budget 2021 Presentation

	2021 Budget
Revenue	
Inpatient Revenue	\$ 9,893,672
Outpatient Revenue	36,487,290
Clinic Revenue	4,574,287
Gross Patient Revenue	50,955,249
Deductions from Revenue	19,866,456
Net Patient Revenue	31,088,793
NPSR % of Gross	61.0%
Other Operating Revenue	885,666
Total Operating Revenue	31,974,459
Operating Expense	
Salaries & Wages	17,639,195
Benefits	4,307,634
Professional Fees	1,977,010
Supplies	2,158,850
Purchase Services	4,256,292
Utilities	540,569
Insurance	205,439
Other Expense	505,562
Depreciation	1,133,886
Interest Expense	454,188
Total Operating Expense	33,178,625
Operating Income	(1,204,166)
Non Operating Income net of Expenses	1,593,284
Net Income	389,118
Net Income %	1.25%

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 11/03/2020
Subject: Department Specific Strategic Measures

You may remember that I handed out department specific strategic measures that align with our three strategic priorities at the October Regular Board Meeting. My ask of you was to review them and come to the November meeting with questions.

Because I continue to refine the measures with our management team, I have included the most current version of the reports for your review. Please remember the following as you are reflecting upon the information:

- This report will be finalized in December 2020 in preparation for use on January 1, 2021,
- Where applicable, the baselines will be reset to reflect 2020 data,
- Progress on the measures will be reported quarterly (March, July, September and December) at our Regular Board meetings,
- The final 2021 report will not be updated until Q1 2022.

I look forward to your comments as we operationalize the Board's strategic priorities for the District.



EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Develop a mobile clinic delivery model to address access issues such as cost and transportation.		Implement services by Q3-Q4 2021					
Clinical Informatics: Increase overall clinic portal enrollments to > 60%	44%	≥ 60%					
Communications: Partner with vendors and community groups to host a live/virtual/drive-through health fair.		1 Event Annually					
Environmental Services: Staff members will become CHEST (Certified Health Care Environmental Services Technician) certified within first year of employment	0	75%					
Facilities: Increase department employees engagement in employee events	0%	75%					
Finance: Increase vendor EFT utilization by 50%.	150/qtr	225/quarter					
Billing/HIM: Partner with Insurance Payor to address school needs/community youth programs		2 coordinated events/year					
Human Resources: 80% of chiefs, managers and directors will serve 24 hours/year of approved community service within the District.	0	101 hours/quarter					
Information Technology: Create a partnership with local internet vendors to develop wireless access for community needs (tower & connectivity)		Pass/Fail					
Employee Health: Develop a community weight loss challenge that culminates in a 5k/10k/Half Marathon		Pass/Fail					
Patient Access: Refer patients to the Self Pay Biller to see if they qualify for Medicaid.		5 patients/qtr, 20 patients/year					
Quality and Risk: Successful Critical Access Hospital DVN Certification		Pass/Fail					
Supply Chain: Create Cycle Count process to improve inventory accuracy.		75%					
CLINICAL							
Acute Care: Develop and implement 1 social media message or newsletter article per quarter re: Chest Pain/MI, Sepsis, Coronavirous, and CHF.	0	1/quarter, 4/year					

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
Case Management: Develop and implement 1 social media message or newsletter article per quarter re: skilled services	0	1/quarter, 4/year					
Dietary/Nutrition: Provide To Go meals to seniors in food scare homes	0	Number of Meals Served					
Emergency Department: Successful Acute Stroke Ready DNV Stroke Certification		Pass/Fail					
Imaging: Increase Mammography volume by 10% via external partners and social media		0					
Infection Control: Use social media to promote IC messaging once per month	0	3 messages per quarter					
Behavioral Health: Connect at least 24 unassigned clinic patients needing access to behavioral health to appropriate resources	0	6 patients per quarter					
Laboratory: Increase quality of blood cultures	70.50%	≥ 90%					
Respiratory Therapy: Develop and implement 3 social media messages/quarter re: pulmonary disease and diagnostic testing		3 messages per quarter					
Pharmacy: Establish a medication disposal program for Morton, Mossyrock and Randle		Minimum of 3 kiosks					
Pulmonary Rehab: Extend two smoking cessation classes per year to public		2 classes per year					
Wellness: Create a community wide wellness plan that incorporates 2 partnerships with providers, employers, and community based entities focusing on overall health of our community by identifying target chronic illnesses and needs.		2 partnerships					
Rehab Services: Create relationships with the schools for athletic program, including ImPACT concussion management, student athletic performance & injury management, and coach education programs.	0	1 athletic season of partnership with ImPACT					

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
Surgical Services: Facilitate awareness of and local access to outpatient Infusion Care by developing marketing literature and outreach to Lewis County clinics, home health, and Centralia, Longview and Tacoma hospitals' Case Management departments resulting in $\geq 20\%$ increase in Same Day Surgery encounters	266	≥ 319					
Anesthesia: Increase Ketamine clinic encounters	60	≥ 66					
Swing Beds: Acute patients transferred out of Arbor Health with subsequent skilled needs are readmitted to Arbor Health for local care		12 patients/year					
Wound Care: Refine and market Diabetic Foot/Toenail Care to increase visits	45	Greater than or equal to 20%					
CLINICS							
Morton: Develop 3 community engagement events at clinic per year.		3/year					
Mossyrock: Develop 3 community engagement events at clinic per year.		3/year					
Randle: Develop 3 community engagement events at clinic per year.		3/year					
Specialty: Develop 3 community engagement events at clinic per year.		3/year					

EXECUTIVE DASHBOARD

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

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Increase employees affirmative response to "My manager/supervisor has shown a genuine interest in my career" by 25%.	26%	33%					
Clinical Informatics: Increase Cerner Inpatient Admission Medication History completion	64%	≥ 80%					
Communications: Adopt mission/vision/values throughout organization		Kickoff 1 value per quarter					
Environmental Services: Increase compliance with "high touch" areas to ≥ 80%	57%	≥ 80%					
Facilities: Improve the average maintenance work order turnaround time by 5%.	tbd	#VALUE!					
Finance: Develop and implement a reliable timeline for processing accounts payable checkruns in Multiview		Zero deviations from scheduled runs each week					
Billing/HIM: Increase conversion of bad debt to charity care by 100%		Increase by 100%					
Human Resources: Conduct an employee engagement survey using an independent national vendor to establish baselines and comparatives.		Pass/Fail					
Information Technology: Develop 4 training seminars for staff and community on IT related topics	0	1 training/quarter					
Employee Health: Reduce reportable workplace injuries by 10% or more.	13	11.7					
Patient Access: Identify patients that qualify for charity care by using bill holds to flag encounters allowing biller to track and follow-up with patients.		20 patients per quarter, 80 patients per year					
Quality and Risk: Improve hospital wide HCAHPS Overall score to > 50%	46%	≥ 50%					
Supply Chain: Develop electronic non-stock ordering to reduce cost & time		Pass/Fail					
CLINICAL							
Acute Care: Handoffs and reports will be conducted using all elements of the SBAR model	0%	≥ 50%					

EXECUTIVE DASHBOARD

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

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
Case Management: Via cross training of Administrative House Supervisors to Admission Clinical Criteria, 80% of after hours/weekend admissions will be placed in the appropriate level of care		≥ 80%					
Dietary/Nutrition: Conduct healthy cooking demonstrations for public		One demonstration per quarter					
Emergency Department: Increase NIH Stroke Scale documentation on stroke patients (2020 = 50%)		≥ 80%					
Imaging: Decrease stroke/CT report turnaround to 15 minutes or less	43 minutes	≤ 15 minutes					
Infection Control: Increase hand hygiene compliance	74%	≥ 90%					
Behavioral Health: Reduce by 25% the number of EDIE patients with behavioral health concerns that are not care planned on EDIE system	24	≤ 18					
Laboratory: Decrease rate of reference lab rejected samples	0.88%	≤ 0.5%					
Respiratory Therapy: Compliance with the implementation of the COPD Gold Standard Care Map discharge criteria/bundle (reducing pulmonary related readmissions)		100%					
Pharmacy: Provide medication counseling at discharge	0%	60%					
Pulmonary Rehab: Increase unique patients secondary to implementation of COPD Gold Standard Care Map and clinic outreach for at risk pulmonary patients	28						
Wellness: Create 2 additional programs that are designed to engage the local community in health and wellness.		2 programs					
Rehab Services: Improve patient satisfaction score for progress during treatment	69%	≥ 80%					
Surgical Services: Increase return rate of internal Post-Operative Patient Experience Survey to greater than 90% (inclusive of endoscopy patients)	15%	≥ 90%					
Anesthesia: Increase overall rating of anesthesia provider on the Surgery Patient Satisfaction Survey	67%	≥ 90%					

EXECUTIVE DASHBOARD

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

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
Swing Beds: 90% or more patients will have an accurate documented admission skin care assessment (accurate = no skin issues or appropriate ulcer staging)		≥ 90%					
Wound Care: Increase initial nursing skin care assessments being documented in the skin care plan to ≥ 90%.		≥ 90%					
CLINICS							
Morton: Market and grow telehealth visits by 25%	504	630					
Mossyrock: Market and grow telehealth visits by 50%.	85	127.5					
Randle: Market and grow telehealth visits by 50%.	81	121.5					
Specialty: Market and grow telehealth visits by 50%.	31	46.5					

EXECUTIVE DASHBOARD

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Decrease interim staffing costs by 10% or greater.	\$ 1,604,585	\$ 1,444,127					
Clinical Informatics: Create a report that identifies patient care gaps for patients enrolled in United Health Care (UHC) Managed Care program to increase HEDIS Star Ranking to 4 Stars	2.25 Stars	4 Stars					
Communications: Establish measurements to evaluate marketing effectiveness.		Pass/Fail					
Environmental Services: Decrease overtime by 25% by optimizing staffing schedules.	\$ 4,893	\$ 3,670					
Facilities: 100% of critical PMs completed monthly.	95%	100%					
Finance: Pay external vendors timely and per schedule, reducing variation/errors (2020 = ??)							
Billing/HIM: Decrease timely filing write-offs (2020 = ??)		Decrease by 25% or greater					
Human Resources: Decrease employee turnover	20.60%	≤ 19%					
Information Technology: Reduce network downtime (2020 = ??)		Decrease by 50% or greater					
Employee Health: Decrease claims cost (national measure ?)							
Patient Access: Increase point-of-service collections by 10% in ER and 20% in OP Services.	\$ 1	\$ 1					
	\$ 1	\$ 1					
Quality and Risk: Reduce All Cause Readmissions by ≥ 20%	2.1	1.68					
Supply Chain: All assets/capital purchases undergo asset purchase process/structure lead by Materials team.	0%	100%					
CLINICAL							
Acute Care: ≥ 95% of acute admissions from ED will be placed in the appropriate level of care as per MCG		Greater than or equal to 95%					
Case Management: Implement weekly fax/email bed availability updates to primary referral sources to meet or exceed budgeted skilled swing admissions							
Dietary/Nutrition: Increase rebates from GPO food supplier (2020 = ??)		Increase by 20% or greater					

EXECUTIVE DASHBOARD

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
Emergency Department: Reduce Left Without Being Seen (LWOT) patients in ED by 10%	116	≤ 104					
Imaging: Minimize callback pay by utilizing a night shift radiology tech.	686 hours						
Infection Control: Decrease infectious disease readmissions within 30 days of hospital stay with same diagnosis.	6.75	1.99					
Behavioral Health: Reduce skilled patient avoidable days secondary lack of disposition or placement issues by 10%	50 days	45 days or less					
Laboratory: Decrease interim staffing costs by 20%	\$ 150,568	\$ 120,454.40					
Respiratory Therapy: Increase PFT tests secondary to implementation of COPD Gold Standard Care Map and clinic outreach for at risk pulmonary patients (2020 = ??)		Increase of 10% or greater					
Pharmacy: Utilize Senti7 to reduce drug costs		Decrease by 10% or greater					
Pulmonary Rehab: Transition Pulmonary Rehabilitation therapy to a group model (pending COVID guidelines) allowing for an increase in visits (2020 = ??)		Increase of 10% or greater					
Wellness: create a wellness program that is an efficient use of funds and demonstrates a commitment to reducing healthcare cost overall in the community.		Pass/Fail					
Rehab Services: Decrease our cancel/no show rate to reduce non-productive time and improve patient outcomes.	15%	Less than or equal to 12%					
Surgical Services: Develop/implement a tracking system for cost of open/not used/contaminated supplies resulting in a \$200/month reduction in surgical supply costs.		\$200/month reduction					
Anesthesia: Convert to single use vials for increased charge capture, reduced waste, and regulatory compliance (2020 = ??)							
Swing Beds: Implement weekly fax/email bed availability updates to primary referral sources to meet or exceed budgeted skilled admissions.	75	Greater than or equal to 75					
Wound Care: Develop and implement WOCN EPIFIX administration protocol for chronic wounds.	0	1+ encounters					
CLINICS							

EXECUTIVE DASHBOARD

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
<u>Morton</u> : Implement Chronic Care Management via Preventative Care Advisor.							
<u>Mossyrock</u> : Implement Chronic Care Management via Preventative Care Advisor.							
<u>Randle</u> : Implement Chronic Care Management via Preventative Care Advisor.							
<u>Specialty</u> :							

NEW BUSINESS



COURSE TRANSCRIPT: BOARD MINDSETS TO DRIVE VALUE

Expert Presenters:

Stephen Beeson, M.D.

Larry McEvoy, M.D.

Welcome to the advanced Quality course, Board Mindsets to Drive Value.

In this course, our experts will cover the leadership challenge, collaboration and engagement, simple rules for complex situations, building a different kind of organization, speeding up the speed of change, consistency and innovation, leadership leverage to create high value and working together.

1. THE LEADERSHIP CHALLENGE

STEPHEN BEESON IS CO-FOUNDER OF PRACTICING EXCELLENCE, A WEB-BASED LEARNING SYSTEM THAT ADVANCES PHYSICIAN EFFECTIVENESS. A BOARD-CERTIFIED FAMILY MEDICINE PHYSICIAN, HE HAS PROVIDED TOOLS TO HUNDREDS OF HOSPITALS FOR ENGAGING AND TRAINING PHYSICIANS.

Stephen Beeson: The bottom line for American health care is, quite frankly, despite intensive regulatory pressure, it's still a bit of a mess. Costs are still climbing; quality is sporadic; patient navigation through the system is complicated at best, unsafe at worst. We are called upon to lead a healthcare revolution, and I think all of us are challenged and overwhelmed by what lays in front of us.

LARRY MCEVOY IS CO-FOUNDER OF PRACTICING EXCELLENCE, A WEB-BASED LEARNING SYSTEM THAT ADVANCES PHYSICIAN EFFECTIVENESS. HE HAS EXTENSIVE EXPERIENCE AS AN EMERGENCY PHYSICIAN, PHYSICIAN EXECUTIVE AND THOUGHT LEADER.

Larry McEvoy: If we look around healthcare, it is easy to paint a pretty bleak picture. A huge percentage of our GDP goes to our healthcare costs. The health of our people is nothing spectacular by any metrics. We have big problems we can't seem to fix. And yet, we have spectacular pockets of clinical care. We have some spectacular technique. We have a huge group of very committed people who want to do things very well.

So you have to be asking yourself, if you're a board member, if you're a physician leader, if you're an executive, what the heck? How do we cook this up into something spectacular? I think it poses a real leadership challenge about translation. How do you paint a picture for all

the people in the organization about what is possible, about what can be done to put them in a position of collectively aspiring to what I can tell you they definitely aspire to on the ground?

Stephen Beeson: Our ability by which to frame this in a way that engages those who are responsible for delivering the care and driving the quality and protecting and preserving safety is really the mark of the next generation of leadership. Leadership has to be able to transition from, "We're doing this because the government says we need to and payers say we must," to frame it up in a way where physicians, staff, administrative leadership, board, unify together to get this done.

For board members, executive teams, physician executives, staff engagement and physician engagement are critical predictors for the capacity to get this work done. I think the call to action to get quality, safety, the patient experience—the markers of good hospital, bad hospital, good system, bad system—executed in tomorrow's reimbursement mechanism is about our capacity to engage those who are responsible for delivering care and to frame up our change efforts in a way that prompts them to say, "I'm in; let's roll."

2. COLLABORATION AND ENGAGEMENT

Larry McEvoy: Having been, over the course of my career, a clinician for many years, an executive, a CEO, I believe that the most important thing that leaders can do is to foster this idea of purpose and collaboration.

What as a board or as an executive or as a physician leader can you do to sponsor collaboration? First, stop thinking of collaboration as a coincidence or a result. Start thinking of collaboration as a practice. And start thinking about how to build practices that create the sort of things that you want.

In my time as an executive we actually had a methodology for driving collaboration. It wasn't related to topic. It wasn't related to infections or revenue cycle or registration or patient satisfaction or patient engagement. It was related to the very specific skill: how do we collaborate? If you're at that level of governance or leadership, getting really good at what collaboration is and how to build it is an essential skill, and so is learning to collaborate out in the open in front of other people.

Now, we like to think of boards and the way they're built and the way they're purposed as inherently collaborative bodies, and they should be. By the way, I don't think collaboration means we agree all the time. Many boards don't collaborate as well as they can. And actually, that's OK. But your path to collaboration has to involve an investment in a skill set: what does collaboration look like; what do we need to learn to do? Another part of it is to actually practice it out in front of each other. Don't be afraid to fail. You'll have times when you're trying to collaborate and you'll clunk into competition mode, or one-upsmanship mode.

I once had a board member say to me, and he was sort of half laughing at himself and the board and half laughing at me, “Are you calling me out?” And I sort of half laughed back, and said, “Well, yeah I am, but not because there's anything wrong with you. But if we keep going this way, we're going to slip into our competition mode.” You know, who's right, who's wrong. And instead we want to head toward collaboration mode.

This idea of learning how to collaborate well as a board or as an executive team is a skill that you have to make your own before you can ask other people to do it well. This is just a burden of leadership.

Stephen Beeson: The process and the concept of collaboration is a precursor to team participation and getting the work done. There are a couple of activities that I've found in all my years of doing this within my own organization and organizations from across the country. One is shared learning—being one of them. There is nothing like having board members, the executive team, the clinical team, the medical executive committee (MEC) together at an annual retreat, not only learning what strategies really work to create organizational agility and to survive the gauntlet in front of us right now, but doing it together and then having a meal afterwards. Board presence at physician retreats with the executive team is a really powerful gesture.

Physicians want to be responded to. There is nothing more frustrating to physicians than not having the tools and the equipment they need to be able to do their jobs clinically. Out-front executive leadership that rounds, visits, knows, participates with physicians sends a signal that physicians are partners, not customers, because that died about 15 years ago.

We as physicians are intensely reciprocal organisms. And we are going to treat leadership exactly the same way we are treated. When we're rounded on, provided the tools and equipment that we need to be able to do our jobs well, and when we feel there is a sense of leadership responsiveness, it not only provides us the tools and equipment we need to do our job, which is the first order point, it creates physician willingness and receptiveness to participate.

3. SIMPLE RULES FOR COMPLEX SITUATIONS

Larry McEvoy: Health care these days is unbelievably complex, and it is tempting in complex situations to come up with a lot of complicated rules. If you want an organization that can really adapt and be consistent in challenging times, in difficult circumstances, you will do that best if you have some simple rules that allow you to meet any challenge, and that allow you to diverge off those simple principles, in keeping with them, into specific responses.

Stephen Beeson: Great organizations run on very simple ways of doing things. I'll give you an example. I was working with a group that was trying to improve patients' perception of access—not actual access, but the patient satisfaction survey was "patients' perception of

access." So the members of the group came up with strategies by which to manage this. The idea was to have fresh magazines and fish tanks—because they are calming and soothing and doesn't make it seem as though you're waiting as long. So we talked about the scalability of those strategies; for example, how are you going to do that in the endoscopy suite? How are you going to do that in the GI suite? How are you going to do that in the OR? How are you going to do that with the hospitalist in early discharges?

We then talked about the idea of transitioning from tactical, complex rules and regulations to creating a retractile that we could diffuse as a simple message across the entire organization. It became, "Let's stop wasting the time of our patients," and we used that as our leadership call. The people in the front line will figure that out. They may decide to have fresh magazines and maybe even a fish tank. Or they may decide something else that is more appropriate for their environment.

We have to create simple rules that can apply everywhere. And those simple rules allow and empower and tap the talent of the team to figure it out. But they all knew, in this example, that they are going to stop wasting the time of their patients. And they are going to figure out how to do it locally.

Using a simple-rules approach regarding safety, the patient experience, is how all great organizations run.

Larry McEvoy: Are our simple rules built to drive performance, built to drive collaboration, built to drive adaptation, built to drive consistency, regardless of the topic? Should it work in revenue cycle? Yeah, it better. Should it work in terms of how we meet and greet patients? Yes, it better. Should it apply to how we deal with OR emergencies or failures or wrong site surgeries? Yes, it better.

This idea of leadership beginning to understand meeting complex challenges with simple rules that can be applied widely everywhere by everybody in a variety of ways specifically tailored to the situation is probably an unknown frontier for most of us. It has a name—complexity science. In chaotic environments, things self-organize and actually adapt very well; they organize themselves coherently. But I don't know that strategically we've applied this to organizations. I can say it resonates very well with clinical people. In the organizations I've been part of the simple rules approach has really put up some profound results.

4. BUILDING A DIFFERENT KIND OF ORGANIZATION

Stephen Beeson: For organizations that have the agility necessary to meet the demands being placed upon them right now, that agility does not arise from top-down leadership. Top-down leadership is important, but top-down's leadership capacity to create bottom-up change is a driver and predictor of whether the organization will be able to get the work done.

There are a couple of key elements to creating bottom-up change. One is a clear sense of common ground, where everybody understands the essence of what the organization wants to become. The common ground is not a regulatory pressure; the common ground is not value-based purchasing; the common ground is not what CMS says. The common ground is a deeply, mutually created aspiration for who we are, what we do, non-negotiable.

Another key element for creating a different kind of organization is the propensity and ability to tap the talent of the organization's team. For physicians in particular, nurses in particular, physician leadership in particular, to mandate and dictate doesn't work and creates a sort of behavior that has earned the physician reputation over the years of, "Oh, they're so difficult."

Physicians are deeply connected to what's best for patients. It is critical, it is vital for the executive team, board members, physician leadership, administrative leadership to be connected as a singular voice in terms of common ground, what we aspire to be. But unless they can tap the talent of the team and get those in the microsystems to lead their local environments, it will be really tough.

And so a different kind of organization is one that is deeply aspirational, run on common ground, that taps the talent of its team and becomes the sort of organization that is truly built around the patient, that doesn't just say that but does things in that way. Because the patient is the only thing that the board, the executive, MEC, nursing, physicians, groundskeeper, parking lot attendant, radiation tech, all have in common. You have such massive cultural and approach diversity, building your work truly around the patient is the one mechanism to unify people around a higher calling, bigger mission, than any one of us.

Larry McEvoy: When I say a different kind of organization, I mean to think of organizations as holding on to what we need, getting rid of waste and then bringing in new things. No person with cancer, no person whose aorta has just torn, or who needs to have a fingernail lifted to repair a laceration under it, none of them want the mechanic. None of them want the robot. If they want the robot it's because the doctor is using the robot and they trust the doctor and the OR team. What they really want is connection. They want to know that you are attentive to them as a person, technically, yes, but also personally, that you count to them.

SUMMARY

LEADERSHIP SHOULD ENGAGE STAFF AND PHYSICIANS TO SUCCESSFULLY GO THROUGH THE TRANSITION TO NEW DELIVERY SYSTEMS.

STAFF AND PHYSICIAN ENGAGEMENT ARE CRITICAL PREDICTORS FOR GETTING WORK DONE.

LEADERSHIP MUST FRAME THE CHANGE EFFORTS TO GET STAFF AND PHYSICIANS WILLING TO PARTICIPATE.

COLLABORATION IS NOT A COINCIDENCE OR A RESULT; IT IS A PRACTICE THAT REQUIRES A SKILL SET AND SHOULD BE PRACTICED IN FRONT OF OTHERS.

COLLABORATION AND ENGAGEMENT ARE ENHANCED BY:

- SHARED LEARNING (FOR EXAMPLE, PARTICIPATION IN RETREATS), AND
- TREATING PHYSICIANS AS PARTNERS

ORGANIZATIONS FUNCTION BETTER WHEN THEY USE SIMPLE RULES TO ADDRESS COMPLEX SITUATIONS. SIMPLE RULES:

- CAN BE APPLIED EVERYWHERE
- EMPOWER TEAMS, AND
- RESOLVE ISSUES LOCALLY

SIMPLE RULES SHOULD DRIVE PERFORMANCE, COLLABORATION, ADAPTATION AND CONSISTENCY.

LEADERSHIP SHOULD ENCOURAGE BOTTOM-UP CHANGE – IT'S A PREDICTOR AND DRIVER OF GETTING WORK DONE.

BOTTOM-UP CHANGE REQUIRES:

- A CLEAR SENSE OF COMMON GROUND, AND
- A MUTUALLY-CREATED ASPIRATION OF WHO WE ARE AND WHAT WE DO

LEADERSHIP SHOULD TAP THE TALENT OF ITS TEAM.

THE ORGANIZATION SHOULD BE TRULY BUILT AROUND THE PATIENT.

THE PATIENT IS THE ONE COMMONALITY THAT UNIFIES THE ENTIRE STAFF.

5. SPEEDING UP THE SPEED OF CHANGE

Larry McEvoy: If you are a board member, an executive, a physician leader, change is what you have to help sponsor. The question then becomes not whether change is possible, because I think all of us could look around and say it's inevitable. Change is ubiquitous, but somehow it's this big trick for us.

If you look at some of the learning going on right now in organizations and some of the neuroscience, what we really push back on are some of the things that are easily flipped in an organization if we lead a little bit differently. This is challenging. But none of you can change me. You can put stimulus around me; you can put pressure on me. But ultimately, I have to make a decision about how I want to respond. You say, well, so what?

So I think one element of change is putting people in a position of volition. I choose this. And the leadership art there is to put them in a position of understanding what they already value so that the change they make is consistent with who they are and where they want to go already, rather than twisting their ear and trying to get them to do something that doesn't

make sense to them. Because whenever you're in that position, even if they do it, some part of them is pushing back.

Stephen Beeson: The more demands placed on us as a leadership team, the more likely it is that we will grab the very method that slows the organization—which is the “bark the orders from on-high” and fail to tap the talent of the team in the clinical front line, and to create, “Oh, what's corporate doing now? What's administration doing now?” Then you find yourself as a leadership team pulling a bag of rocks. And despite the fact that you've yelled it really loud, and a lot of times, you find yourself getting blown off, you find people uninterested and, quite frankly, resentful. For a team of professionals deeply committed to the same thing, you just delivered it in the wrong way.

Larry McEvoy: Change is not just an event. Change is actually a physiological state, or readiness for change is a physiological state. There are reasons and ways to get into a learning or receptive state about change, to become curious, to become volitional and empowered, and to become intent about doing it well. If you can put people in a position of focusing on mastery, individually and together, on autonomy, which is not the opposite of collaboration, by the way, but you know what? I have the capacity to choose, and I will choose this thing. And if you can tie them to purpose—why do I want to do this; why do I want to be part of this; why is this a good thing—change comes quite a bit easier.

Often we put people in a position where they are stripped of their mastery—we have to refinance the bond; we have to hit our metrics; we have to get our scores; we have to get this contract. Now I'm not saying that the reason we are sending those signals is a bad idea. But the way that we send them can be geared toward helping people with mastery, autonomy and purpose in a way that facilitates their capacity to actually drive change, choose it, facilitate it and spread it. And it seems to me if you are at the board level, the executive level, you do not want to be dragging 500, 5,000, or 10,000 or 20,000 people when instead they could stand up and say, “You know what? We understand; we intend; we choose. Let's go.”

In order to govern, sponsor, lead an organization that can right now give more consistent care and right now, tomorrow, and next year continually change and adapt, the first step is to acknowledge that we are out of the era of, “We know where we're going, I'll tell you how to do it, now please march.” The next step is to acknowledge that we live now in a complex world that is changing. The way we have done things has some value; we are going to keep that, but we have to take a different approach. Publicly signaling that as a board, and not just asking other people to do it, but to say, “We are thinking about this, too,” is a very significant, brave and necessary signal.

6. CONSISTENCY AND INNOVATION

Stephen Beeson: The clinical variances occurring within healthcare organizations right now are killing patients and driving cost in a significant way. Our ability to embed clinical decision

support, clinical order sets, consistency and reliability, into the approach to clinical disease states is vital to reduce cost, improve safety, improve reliability and consistency. Everybody would do that. So how do you do that and create the chance to innovate?

Here is the common connection between the two: evidence is what guides us. That is how our organization runs. When we place our higher calling through adherence to evidence and clinical order sets, then patients and physicians and nursing have an opportunity to lead this locally.

Larry McEvoy: The challenge for physician leadership is that you are not shuffling papers anymore; you're not getting people through a Joint Commission review. Your job is to drive collaboration in two paradoxical and at times almost contradictory sounding directions—consistency and innovation. Physician leadership has to have the capacity to help physicians—because that's their constituency—and everyone who works with physicians to begin to get more consistent in our care, in our practices, in our culture, in our processes, our methodologies, metrics, the whole thing. And then to say, “How can we do it better? How can we innovate?” That is a tough challenge.

Here is an example. I'm in the emergency department at 2 a.m. and Mr. Jones comes in having a heart attack. This happens all the time every day around the country. What should I tell him? “We're really innovative here. We take care of each patient a little bit differently. We make it up on the fly and some great stuff comes out of that.” That is not reassuring to Mr. Jones, lying on his back about to go to the cath lab, right?

But think about this one: “You know what, Mr. Jones? I can tell you honestly, we value consistency. We take care of you the exact same way we take care of every other heart attack patient since 1972.” Well, that's not so good either.

So physician leadership's job is to balance both of these, but not from a point source of expertise, because frankly no one, no one, is good enough to know all of the things that should be going on in a complex healthcare organization right now, every second of the day. So the challenge underneath this consistency/innovation imperative is to help people begin to build collaborative microsystems that can work independently in the middle of the night and then also connect to each other at any hour of the day or night as they pass patients or information back and forth. And this collaborative ability to drive consistent high performance and to constantly adapt is a high skill; physician leaders need it in spades. It is a learnable skill, but it does challenge us out of our expert mindset—“I know this, I'll tell you what to do.”

So the challenge for leaders is to move themselves and by extension, other leaders and entire teams and entire organizations from, “I know this, I'll tell you what to do,” to “Wait a minute, a lot of stuff going on here.” How do we get more consistent in our performance and how do we continually adapt and change to get better, and how do we create skills to do that—processes, methodologies? And how do we create a culture and a mindset that allows us to do that continually, because that is how we begin to remodel care and remodel an organization over time.

7. LEADERSHIP LEVERAGE TO CREATE HIGH VALUE

Larry McEvoy: Leadership is not just about “who,” it’s about “how.” It is about mutual teaching and learning. What are we teaching and learning? One is certainly a skill set. If I want to sit down with someone and debrief what happened, there is a skill set to creating curiosity, understanding and safety in that conversation. Or I could just scream at somebody, “What happened here?!!” Right? That’s a skill thing.

The second thing is interactions. I can choose to be in front of five hundred people while they sit and do nothing and I say something. Or we can structure that interaction differently so there is a lot of teaching and learning going on per unit time. So that is this idea of interactions.

And then there is this idea of capacity. Network science is showing us that in an organization there is the overt conversation, the one that follows the org chart. But there are all sorts of other networks and structures by which information travels and sticks and holds. This is why culture eats strategy for lunch.

So when we talk about leadership leverage, we are talking about investing in skills and competency across a wide variety of people. But leadership leverage is not just skills. Leadership leverage is also the way leaders and others set up interactions throughout the organization so that teaching, learning, performance grows faster everywhere. And there is a skill set to setting up those interactions and multiplying them.

And then there is this idea of capacity. How can we take advantage of how things spread and grow in organizations to make sure that those skills and interactions spread and grow rapidly? There is probably another, higher order: how do we create networks and channels that actively pick up the movement of new ideas, new thinking, new performance?

So when I say leadership leverage that is what I mean. It goes far beyond being a good or bad leader and your direct impact, to how you think strategically as a leader or a person charged with developing leaders or leadership—how to grow skill, how to grow interactions, and how to grow capacity simultaneously at all levels. Because that is how you are going to really move an organization quickly as opposed to having a couple leaders over in the corner doing a good job and really struggling uphill and eventually getting worn out because you are not capacitating the whole system at the same time.

Stephen Beeson: When we talk about leadership leverage and the things that really create a big impact, one that comes to the forefront is that great leaders are remarkable storytellers. When we talk about the call to action for health care, there is nothing that connects teams more than what it is that we’re currently doing—the victories and the defeats—to mobilize and to access the decision-making apparatus in the human brain, to say, “We have to do this differently.”

There's a very well known quote: "He who has a compelling enough 'why' can overcome any 'how.'" As a board, as an executive team, we must be able to articulate in a compelling and connecting way the "why," because that is the role of the executive team, that is the role of the board, to be able to make the case for the community on the behalf of the organization and those you serve that we have go and we have go fast.

8. WORKING TOGETHER

Stephen Beeson: I have spent the last 19 years side-by-side with physicians in every environment that you can imagine. Physicians are frustrated with a lot of the changes that have occurred. They desperately seek to participate in something they are proud of. They want to do it with team members who do things well. They want to serve a higher calling and bigger mission.

The really effective boards, the really effective executive teams understand that, because physicians are now called upon to do a whole host of things that, quite frankly, we don't know how to do. Leading and transforming to a new patient-centered era, to deliver value in an era where fee-for-service has been the prevailing thing that all of us are so accustomed to, to run a safety huddle, to do a pre-procedure time-out, all these things are now parts of highly effective organizations, and physicians are now accountable for doing things that we don't necessarily know how to do.

So really great executive teams and board members will invest in physicians. And they will help them, educate them, develop their leadership teams. They will do it side-by-side with them; they'll learn together; they'll have happy hour after their board retreat where the physicians are participating and they develop relationships with them. This is not about accommodating specific physician turf because we can no longer subsidize a physician agenda; we can no longer subsidize a board agenda; we can no longer subsidize anything but how to deliver high-value, patient-centered, highly-coordinated, evidence-based, physician-led, really effective care. That is the formula that will allow you to survive the train that's coming at us right now.

SUMMARY

CHANGE CAN BE ACCELERATED BY:

- PUTTING STAFF IN A POSITION OF VOLITION
- ACKNOWLEDGING THE NEED FOR A NEW APPROACH
- SIGNALING THIS AS A BOARD

CONSISTENCY AND INNOVATION IN CLINICAL CARE ARE CONNECTED BY EVIDENCE.

PHYSICIANS MUST BALANCE BOTH CONSISTENCY AND INNOVATION. THIS REQUIRES COLLABORATIVE MICROSYSTEMS THAT CAN WORK INDEPENDENTLY WHEN NECESSARY.

THIS COLLABORATIVE ABILITY IS A LEARNABLE SKILL, BUT IT CHALLENGES PHYSICIANS TO WORK OUTSIDE THEIR “EXPERT” MINDSET.

LEADERSHIP IS ABOUT WHO, WHAT AND HOW. IT’S ABOUT MUTUAL TEACHING AND LEARNING THAT REQUIRES:

- SKILL SET – TO CREATE CURIOSITY, UNDERSTANDING AND SAFETY IN CONVERSATIONS
- INTERACTIONS – SO TEACHING, LEARNING AND PERFORMANCE GROWS QUICKLY EVERYWHERE
- CAPACITY – CAPITALIZING ON HOW THINGS SPREAD IN AN ORGANIZATION SO THEY SPREAD MORE QUICKLY

LEADERSHIP CAN ALSO CREATE HIGH VALUE BY CREATING NETWORKS AND CHANNELS TO ACTIVELY IDENTIFY THE MOVEMENT OF NEW IDEAS, NEW THINKING AND NEW PERFORMANCE.

LEADERS SHOULD ARTICULATE WHY THINGS MUST CHANGE, NOT JUST HOW THEY WILL CHANGE.

EFFECTIVE LEADERS UNDERSTAND WHAT MOTIVATES PHYSICIANS, AND WILL INVEST IN THEM.

For additional information please go to www.iprotean.com



COURSE TRANSCRIPT: DRIVING A SUSTAINED CULTURE OF QUALITY: WHAT WORKS, WHAT DOESN'T?

Expert Presenters:

Stephen Beeson, M.D.

Larry McEvoy, M.D.

Welcome to the advanced Quality course, Driving a Sustained Culture of Quality: What Works, What Doesn't? In this course, our experts will cover: striving for a culture of high quality, the essential tenets of a culture of quality, what's new, the science, the intersection of quality and tools and modeling and design.

1. A CULTURE OF QUALITY

LARRY MCEVOY IS CO-FOUNDER OF PRACTICING EXCELLENCE, A WEB-BASED LEARNING SYSTEM THAT ADVANCES PHYSICIAN EFFECTIVENESS. HE HAS EXTENSIVE EXPERIENCE AS AN EMERGENCY PHYSICIAN, PHYSICIAN EXECUTIVE AND THOUGHT LEADER.

Larry McEvoy: We hear a lot in organizations, around organizations, out in the media, about quality—and we should. There is abundant evidence that clinical and overall quality in healthcare organizations is simply not robust enough for what we need. On the other hand, we pay a lot of attention to results and trends. And those are really helpful places to start.

Underneath the results and the metrics that boards review, there are processes and structures in organizations. Hopefully those are working well. But even if you have the right processes and structures—patient safety committee, for example, quality committee, quality huddles—underneath those structures and processes is culture.

What is culture? It's the way we think and act everywhere, all the time. Now, organizations are ecosystems; people don't act the same in every little pocket of those ecosystems. But one of the board's jobs, to really drive results, is to get down into the way people think and act everywhere, so it's consistent and it actually supports the work of the processes and structures.

I think we've gotten better looking at processes and structures and metrics and trends. But I think we're entering a new era of understanding that culture is not just a nicety. It's not just saying thank you to somebody, or going through the motions. Culture is really looking at the dynamics of how we interact so that we can work better and not just execute those processes and structures, but continually improve them and get better results.

A CFO friend of mine I used to work with had a great saying; he applied it to a lot of things but we'll apply it here: "You can't fatten a cow by weighing it every day." And so this whole idea of healthcare culture is not just making sure you have processes and structures in place and see if they're running every day. Don't just look at metrics every day or every month. Let's get underneath and find out what shifts those things.

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Stephen Beeson: How do we actually translate culture to actionable strategies and organizational outcomes? The process of cultivating a culture of safety is, number one, everybody knows about it. It goes from the boardroom to the executive suite to the medical directors and the administrative leaders, and they all act as facilitators of a common message of, "We are dedicated to the outcomes and the safety of the patients that we take care of together."

Number two is that those particular messages impact the moment-to-moment and day-to-day behaviors of those caring for patients at the motor end plate, which is at the bedside.

And number three, as a physician, physicians assume a leadership position, embrace, support and lead the effort by example, to leverage their influence with those who look to us for leadership, to get these things to happen in the endoscopy suite, in the O.R., in the cath lab, in the ED, in the family medicine clinic. Because if your physicians are not doing it, talking about and framing it, leading the effort by example, it's very hard to get that diffusion from the board level all the way down to the motor end plate, again, of health care where it actually occurs.

2. STRIVING FOR HIGH QUALITY

Larry McEvoy: What is a high performance culture that drives high quality? Well, it's easy to define what it's not, to begin with. Example, if I'm working in a clinical team, where nurses, techs, other physicians, patient and family, a clinical microsystem is going to function at a high level and create a quality result for one person any given day or night, I could consider myself the answer, and everyone else simply tools of my own mind. That's one way to look at it.

But that's not really an intelligent way to look at it. The nurses have a set of skills and a set of observations and things they pay attention to that are different from mine, but overlap with the patient's quality. So do the other physicians and the pharmacy tech and others involved in the patient's care. So that goes to one of the key aspects of a high performing quality culture, which is this idea of what we call "interdependence."

The Center for Creative Leadership defines a few different leadership mental models inherent in teams. One is called the dependent model, which is, I'm the doctor; I'm the expert. I know what's going on, and I will tell you what to do.

Another model is the idea of independent leadership; we are all experts of some kind. I do my thing and she does hers and he does his and it all works out.

And the third one is, wait a minute. The way we think and act is connected. What I do may have influence on you. The way I think may have influence on you. And together we want to be smarter on behalf of this patient, or all the patients, than we would be alone.

All three of those models are at play in organizations. There is a time when as an emergency physician, I really do know what the patient needs because of my experience, not the fact that I'm a better person. And nurses will say, hey, tell us what we need to do now. And I can say, let's do this, okay, great. It makes things better for everybody.

There's a time when one team sees a patient, does a nice hand-off, and another team takes over. They're acting independently after that interchange.

But if you really want things to get better, people have to be able to act interdependently, to see themselves as parts of a whole. That interdependent requirement means certain cultural attributes, behaviors and thoughts have to be in everybody's heads.

Consider listening as an example. Listening is really a key skill. One of the things that we all do very well is we pattern recognize. "I've seen a patient like this before; this guy must be the same way." But this is not always true. So, our pattern recognition capability is handy, but our ability to look at patterns and say, this one might be different, or we should start a new pattern, only can happen when people can freely speak and listen to each other.

So, listening is a skill, but underneath that is this idea of people really seeing each other as interdependent. The nurse who's been here two days may have some wisdom I, who have been here 30 years, don't. So that's a really key aspect.

Another aspect of a healthy quality culture is very rapid feedback loops. We can't improve quality by waiting six months to get a report from IT that's 44 pages deep, and has 9,000 fields per page. I'm not saying that isn't useful information, but rapid feedback loops are, "We just tried this or that with a patient, how did it work?" "Mrs. Jones, are you feeling cared for now? Are you feeling our attention is on you?" "Team, how did we just use this interaction, this case, this day in the clinic, to get a little bit better? How do we know we got a little bit better? What do we do next?"

So, these rapid feedback loops, this idea of interdependence and a public commitment to learning—not just, we're *going* to learn, but here is what we *are* learning—are really key things to drive a quality culture.

3. ESSENTIAL TENETS OF A CULTURE OF QUALITY

Stephen Beeson: The essential elements of a culture of quality are, first and foremost, a uniform understanding and agreement as to what that is—our dedication to continuous improvement. Another key element is clear goals that support the execution of it—accountabilities at the executive level and the leadership team to achieve it. Also, it is necessary to invest in talent management and leadership development to be able to carry forward the message, hold people accountable and diffuse the essential skills—everything from how to do safety huddles, to have difficult conversations, to reduce hierarchy—that create a speak-up culture. These are all elements and tenets of a culture of quality, culture of safety, and all framed within the idea of continuous improvement.

The very basic tenets of quality and safety have been long-standing pursuits. We have made a little bit of progress. But I think we still have a long way to go. And I think placing quality and safety at the first and foremost of our strategic efforts, from the board to the executive team, to the management teams, to the front line, is a vital and healthy shift, as long as we always remember that top-down mandate of quality and safety is really a paradox, because it doesn't occur by virtue of top down. It occurs by leadership teams facilitating a ground up understanding and shared purpose of the safety and quality of the organization.

Larry McEvoy: I'm going to give you a formula that describes for me a simple way to remember the tenets of a culture of quality. And that formula is: ML to the N.

M is motivation. Quality is something that should be omnipresent. In other words, people have to be motivated around it. If you ask most healthcare people, it doesn't matter if they're an executive or a finance person, or a physician, if they're a dermatologist or a surgeon, an ICU nurse, an ER nurse, a pharmacy tech, it doesn't matter, "Do you want to be really, really good at what you do?" Almost all of them say, "Yeah, sure we do." So, the gap isn't really in motivation initially, but once people get into organizations and are exposed to politics and policy and things that can't get done, plus all the tasks and distraction they have, it is really easy to get demotivated.

High quality is accomplished by very energized and motivated people who don't give up. And as a board, you want an army of really motivated people who don't give up on quality. They don't give up on Mrs. Jones in the middle of the night or on Tuesday morning. And they don't give up on it systemically.

So how do you sustain this kind of culture; how do you foster human motivation? We know more and more about this these days. There was a time when we said, "You know, you're lucky to have a job. Do your job well and get outta here and come back tomorrow," and that was considered good enough. In this information knowledge economy, we have a wide variety of folks from different demographics, different ideas of what a job means, of portability of work,

and where it also still takes a long time to create a good team and good technically skilled people: cardiologists, ICU nurses, family medicine, outpatient nurses, whatever it is. This idea of motivation is really a cornerstone that should concern every board. And it turns out we know some things about human motivation. There is great science on it and I think boards should find out about it.

Motivation boils down to the acronym MAP. Here, M means alternately mastery and meaning—helping people define and pursue what is important for them to be good at. This happens to be a great thing for quality.

A is autonomy, the ability to choose. It doesn't mean separateness or do what you want. It means the capacity to choose. And too many organizations are places where people have to do everything. You want to create environments where teams and individuals can choose how to design as much of their work as possible so they deliver high quality.

P is purpose. Too much healthcare is mechanical. It shouldn't be, but it is. There are lots of things to do and boxes to check. It is all very wearying.

People gravitate around mastery/meaning, autonomy and purpose; that is, connection to the patient, connection to their work and connection to why they want to be in health care. And this is a good thing; that's M—motivation.

L means having a learning mindset. People love to learn. We all get a little bored just going through the motions every day. The brain likes novelty; we know this from neuroscience. And we learn best when we're rewarded for taking on a challenge, for effort, even if the effort is not successful, and for getting ready to take on another challenge. So, this learning environment is something you want to have in every little interaction you have. If every time a nurse and a doctor, or a team, gets together to huddle, or a board gets together, and says, "How have we strengthened motivation here? How have we strengthened learning," you're in good shape.

Now N, the exponent N, means that the more times you can create collisions, where people are colliding and they're increasing their motivation and they're increasing learning, they're going to be involved and engaged. Every collision should be positive, motivating and should increase learning. If you keep colliding, you will get a return in the organization. So, people have to think culturally, how do we multiply collisions?

SUMMARY

CULTURE IS THE WAY WE THINK AND ACT EVERYWHERE, ALL THE TIME.

THE BOARD SHOULD ENSURE THAT:

- PEOPLE ACT CONSISTENTLY TO SUPPORT THE PROCESSES AND STRUCTURES THAT CONTRIBUTE TO HIGH QUALITY
- THE DYNAMICS OF INTERACTIONS IMPROVE EXECUTION OF PROCESSES AND STRUCTURES TO ACHIEVE BETTER RESULTS

TO ENCOURAGE AND SUPPORT A CULTURE OF QUALITY, THERE MUST BE A COMMON MESSAGE THAT AFFECTS THE BEHAVIORS OF CAREGIVERS, MOMENT-TO-MOMENT, DAY-TO-DAY. PHYSICIANS SHOULD SUPPORT AND LEAD THE EFFORT BY EXAMPLE.

CAREGIVERS SHOULD WORK INTERDEPENDENTLY AND EXHIBIT SHARED CULTURAL ATTRIBUTES AND BEHAVIORS INCLUDING LISTENING, RAPID FEEDBACK LOOPS AND A COMMITMENT TO LEARNING.

THE TENETS OF A QUALITY CULTURE INCLUDE:

- A UNIFORM UNDERSTANDING REGARDING DEDICATION TO CONTINUOUS IMPROVEMENT
- CLEAR GOALS
- ACCOUNTABILITY AT THE EXECUTIVE AND LEADERSHIP TEAM LEVELS, AND
- INVESTMENT IN TALENT MANAGEMENT AND LEADERSHIP DEVELOPMENT

MOTIVATION, LEARNING AND COLLISIONS ARE ESSENTIAL FOR A CULTURE OF QUALITY.

MASTERY, AUTONOMY AND PURPOSE ARE ALL PART OF MOTIVATION.

EVERY INTERACTION WITH OTHER CAREGIVERS OR STAFF SHOULD BE APPROACHED WITH A LEARNING MINDSET.

FINALLY, IT'S IMPORTANT THAT PEOPLE HAVE LOTS OF COLLISIONS WITH OTHERS; COLLISIONS SHOULD BE POSITIVE, INCREASE MOTIVATION AND ENCOURAGE LEARNING.

4. WHAT'S NEW HERE?

Stephen Beeson: The newness of attention towards quality and safety really isn't new at all. It seems to get additional emphasis with how health care is being paid for and how it is being incentivized through commercial payers and the government. But this is the first time we've had this degree of focus and accountability. It has gotten the attention of boards and leadership teams across this country because of immense regulatory pressure.

What is new is the transparency, the shared awareness of, quite frankly, the harm that healthcare systems are doing, the clinical variation and its potential impact on care outcomes, and the immense regulatory pressure that we all feel in getting this work done.

So, although the pursuit of quality and safety has been a longstanding tenet of healthcare systems everywhere, what is new is the immense pressure and the immense focus on healthcare leadership teams across the country. It is first and foremost on every agenda. We have to facilitate and build a culture of quality and safety so everybody knows and understands what needs to be done, with a shared common practice and approach, and bring all of this down to the clinical frontline, with subsequent outcomes we can prove. We have to prove that we have a commitment to quality and safety, and also that we have the objective measures that verify the execution of our vision.

5. THE SCIENCE BEHIND THIS

Larry McEvoy: If you're a healthcare leader, a board, and you're thinking about how to lead a cultural evolution, if you will, an epidemic of better quality thinking and acting, and yet as the board you can't be everywhere all the time, you got to say, "How do I master *that* math?" Two answers.

Number one is to actually model your own journey. Don't be a distant board that just sits there and stamps things. Let people see your own journey. "We were pretty results-oriented before and we're still after results. But we're learning more and more that a culture of quality means how we model our own behavior and how we sponsor that in others."

Modeling your own behavior as a board means public learning. "We went to a conference; here is what we learned. Oops, we didn't know that two years ago. Probably if we knew then what we know now, we would have done it this way."—"We as a board are curious. We're interested in not just being experts, but learners. And we're asking other people to learn publicly as well." This is a powerful, powerful signal from the board.

I think the other thing that boards can do really powerfully is investigate the architecture of epidemics and movements. Typically in organizations we have a ruling somewhere from a committee. We pass an edict and then we promulgate it with policies and emails and repetitive things. That's not necessarily the best way to get things going.

There is a whole body of science around how epidemics work and spread, and how networks influence people. I think it's worthwhile for the board to get interested and educated about network science—which is how the structure of networks can actually allow things to travel—complexity science—how in chaotic circumstances, things can self-organize and diffuse very rapidly—and neuroscience—how humans learn and participate. Now those are some heavy topics: complexity science, neuroscience and network science. The goal is to start to understand them in terms of simple practicalities; that is, understanding the networks in this organization and how influence moves. How can we tailor our quality culture to the neuroscience of human learning, human motivation, human contagion of passing things back and forth?

You know, gossip works for a reason. It's attractive and sticky and it moves. Quality should be that way as well. The board should consider how to work with executives and other leaders to understand how to create optimal collisions, and lots of them, so those collisions are sticky, they're attractive to people—"Wow, I want to look more at that"—and that those collisions travel and travel and travel. So, instead of asking people to come to a quality meeting, people are joining a quality movement they find energizing. They can see the results in micro, and they can also see the bloom spread across the organization as everyone begins to do this.

Stephen Beeson: The message of, "We must do the right and best things for the communities we serve," is a resonating, connecting, empowering message. The best leaders in terms of the ideas of new science and engaging people are using very purposeful messaging to be able to create purposeful shared mission as a mechanism to drive human behavioral change. And that's where I've seen some of the new science emerge in terms of the pursuit of quality and safety, and actually getting it to happen.

One thing I've seen in some of the healthy boards and executive teams is working within the paradox of establishing a culture of quality and reliability and diffusing this throughout the organization, while avoiding all that comes with a top-down regulatory mandate.

The emergence of new thinking and new science around this is that a top-down regulatory mandate is not the mechanism by which to create employee-physician-frontline worker engagement to embrace, support and do these things when nobody is looking. It sometimes disengages people from the very actions needed to achieve what the regulations are intended to do.

Some of the new progressive thinking is to realize we have to create a movement, a shared purpose, an intensely purposeful way of doing things that is built upon a simple guiding principle of safety, always—quality is our first and foremost strategic priority—and to create simple guiding principles that allow very complex organizations to rally around a shared common purpose as opposed to, "We are doing this because CMS says so."

6. THE INTERSECTION OF CULTURE AND TOOLS

Larry McEvoy: Now, some of you are watching this and saying, well, what about tools? Quality tools—PDSA cycles, the ability to think critically together, root cause analyses, sentinel event discussions, safety huddles—fantastic tools, fantastic. And organizations and teams need those tools. I'm simply saying that underneath the tools is the culture, the ways we interact. You can have a hammer sitting on the floor and it's a beautiful Sears Craftsman hammer, it's a great tool, and five people are looking at it, but it's the master craftsman who knows how to use that hammer. Tool-using is really culture. How do we use our tools? How do we interact with each other to create better results?

Stephen Beeson: Culture is an understanding, it's your constitution—it is a way of doing things. It's your shared purpose, it's your operating system, and it's really the first thing that you work on. If you begin to deploy tools and tactics in the absence of a shared understanding, shared purpose, common ground way of doing things, then the tools and the strategies can lose some of their context. But at the same time, if you have a cultural commitment, a common ground and a vision that doesn't diffuse out of a board room, and people don't have the tools and the tactics and the processes and clinical order sets and all the other things that make for a highly reliable healthcare system, then you never get the diffusion of organizational culture transcending to healthcare outcomes.

So, the two are links in a chain, and one begets the other. Frequently we bypass the cultural shared purpose step and we jump into the tactics by which to get it done, and people look at it out of context and will engage with it less vigorously than they do when there is a co-created, shared understanding: "This is what our legacy must be, and this is why safety and quality are vitally important for the type of care that we want to provide to our community."

7. MODELING AND DESIGN

Stephen Beeson: What are the leaders' actions, activities and attributes that facilitate people to mobilize around the shared common purpose? There are very common and consistent leadership attributes for organizations that have executed cultural change, particularly in the areas of quality and safety.

Number one is the authenticity of the message. When leaders speak through storytelling, they demonstrate their obsession with providing reliable, safe, kind and compassionate care. And they message it everywhere they go, whether it be a one-on-one conversation with a nurse on the floor, or whether it be at an annual retreat with all of their managers and all of their physician leaders gathered in a room, or whether it's in the boardroom. It is a consistent compass in everything they do, and it's a reflection, again, of their obsession with getting this work done. And the authenticity of the message just oozes out of them.

The power and the lever of an authentic well-messaging, passionate leader speaking on behalf of quality and safety is one of the modeling features that I think creates a big influence. And that diffusion around the right message can really spread to other leaders who begin to message similarly.

Another thing in terms of modeling is that leaders who are so committed to this are willing to defend it because it is truly non-negotiable.

Great leaders in terms of modeling are always gathering feedback. How can I become better in service to the mission of quality and safety? What can I do more effectively as a board member, as an executive team member, as a physician leader, as a manager, always gathering feedback from those providing care in terms of how they could be a better servant to the mission? When you're gathering feedback, you are continuously improving and you are also reducing the hierarchy that can sometimes obstruct the true essence of a quality and safety culture.

Leaders who have gotten this work done are immensely optimistic. They bring hope, belief, and optimism: "We can do this, we can get this done." If you look at the immense regulatory pressures we have in front of us, we can choose to be victims really easily. And those who are victims never get the work done. You can't be a victim and a transformative leader at the same time, so you have to pick which one you're going to be.

Those who have engineered transformative change are the ones who are hopeful, they have intense belief, they are gathering feedback, they are giving feedback and they have this authentic dedication to what they want to become. And with that, they create design. They enroll themselves in dyad leadership roles, where they are always connecting with each other, where there is lateral flow of information, where board members are rounding with the executive team in the clinical units, bringing visibility and authenticity, demonstrating that it's not just the board sitting in some remote retreat somewhere, but they're in there, they're talking with the people who are providing care.

Effective leaders develop a dedication and a focus to leadership development, knowing that the investment in the skills and the talents of their leadership teams is probably one of the most important they can make. They will design and budget for leadership development. In terms of design, they will create leader accountabilities, meaning, if we want to have a culture dedicated to quality and safety, these are the metrics that prove that. We will assess you, CEO, by virtue of your ability to execute on these metrics. And we'll hold you accountable for it, because the mission is so important.

SUMMARY

ALTHOUGH THE ATTENTION TO QUALITY ISN'T NEW, THE NEW MECHANISMS FOR PAYMENT AND INCENTIVES HAVE INCREASED THE DEGREE OF FOCUS AND ACCOUNTABILITY. EMPHASIS HAS BEEN PLACED ON TRANSPARENCY AND A SHARED AWARENESS OF THE CLINICAL IMPACT OF VARIATION. REGULATORY PRESSURE AND A FOCUS ON LEADERSHIP TEAMS HAVE INCREASED SIGNIFICANTLY.

BOARDS SHOULD BECOME FAMILIAR WITH HOW BEHAVIORS IN AN ORGANIZATION ARE INFLUENCED AND HOW THEY CAN CHANGE. THE BEST WAY TO DO THIS IS TO INVESTIGATE NETWORK SCIENCE, COMPLEXITY SCIENCE AND NEUROSCIENCE.

AN IMPORTANT THING TO KEEP IN MIND IS THAT REGULATORY, TOP-DOWN MANDATES ARE NOT EFFECTIVE MECHANISMS FOR ENCOURAGING EMPLOYEES AND PHYSICIANS TO EMBRACE CULTURAL CHANGE.

CULTURE AND THE USE OF TOOLS ARE LINKS IN A CHAIN. BOTH ARE REQUIRED TO CONTINUOUSLY IMPROVE CLINICAL OUTCOMES.

TO GET PEOPLE TO MOBILIZE AROUND A SHARED COMMON PURPOSE, THERE MUST BE:

- AN AUTHENTIC MESSAGE
- A WILLINGNESS TO DEFEND THAT MESSAGE
- A MECHANISM FOR GATHERING FEEDBACK, AND
- IMMENSE OPTIMISM

For additional information please go to www.iprotean.com

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 11/03/2020
Subject: 2021 Regular Board and Sub-Committee Proposed Schedules

The proposed 2021 **Regular Board Meeting** schedule is below. Historically, June meetings were cancelled due to Board participation in WSHA's annual educational event. November and December dates are adjusted to meet the annual operating budget deadline and holidays. All meetings will be held in Conference Rooms 1 and 2, if permitted, with Zoom to allow remote attendance.

- January 27, 2021 at 3:30 pm,
- February 24, 2021 at 3:30 pm,
- March 31, 2021 at 3:30 pm,
- April 28, 2021 at 3:30 pm,
- May 26, 2021 at 3:30 pm,
- July 28, 2021 at 3:30 pm,
- August 25, 2021 at 3:30 pm,
- September 29, 2021 at 3:30 pm,
- October 27, 2021 at 3:30 pm,
- November 10, 2021 at 3:30 pm,
- December 15, 2021 at 3:30 pm.

Our **Finance Committee** generally meets monthly, one week before the Regular Board meeting. While this committee currently meets at 12:00 pm, the time of day can be changed to meet the needs of the assigned commissioners. The proposed Finance Committee meeting dates are:

- January 20, 2021
- February 17, 2021,
- March 24, 2021,
- April 21, 2021,
- May 19, 2021,



- June 30, 2021,
- July 21, 2021,
- August 18, 2021,
- September 22, 2021,
- October 20, 2021,
- November 17, 2021,
- December 22, 2021.

Our **Compliance Committee** meets quarterly. Like the Finance Committee, this committee currently meets at 12:00 pm, however, the time of day can be changed to meet the needs of the assigned commissioners. The proposed Compliance Committee meeting dates are:

- February 10, 2021,
- May 12, 2021,
- August 11, 2021,
- November 3, 2021.

Our **Plant Planning Committee** is required to meet a minimum of one time per year. We typically hold these meetings on an as needed basis, often resorting to an ad hoc approach. We are proposing a quarterly schedule knowing that we may simply cancel these meetings if they are not needed. The proposed Plant Planning Committee meeting dates are:

- April 7, 2021,
- July 14, 2021,
- October 13, 2021.

Our **Foundation** meets monthly, primarily at 12:00 pm. If in person meetings are allowed in 2021, the Foundation will move some of the noon meetings to in-person dinner meetings for fellowship. The proposed Foundation meetings are:

- January 12, 2021,
- February 9, 2021,
- March 9, 2021,
- April 13, 2021,
- May 11, 2021,
- June 8, 2021,
- July 13, 2021,
- August 10, 2021,



- September 14, 2021,
- October 21, 2021,
- November 9, 2021,
- December 14, 2021.

New for 2021, our **Quality Improvement Oversight Committee** will move away from quarterly meetings. I am proposing that this committee meets twice per quarter resulting in eight meetings per year. The purpose of this meeting schedule is to allow for the regular work of the committee to be done in the first month of the quarter. This allows the committee to focus on quality and satisfaction measures in the third month of the quarter. This committee will need to continue to meet at 7:00 am for one hour as physician involvement in this meeting is required. The proposed Quality Improvement Oversight Committee dates are:

- January 13, 2021,
- March 3, 2021,
- April 7, 2021,
- June 2, 2021,
- July 7, 2021,
- September 8, 2021,
- October 6, 2021,
- December 1, 2021.

The final board sub-committee is the governance committee. This is an ad hoc committee that does not have a proposed schedule. However, the by-laws are due to be reviewed, amended if necessary and approved in 2021.



To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 11/03/2020
Subject: Approving Fire District No. 4 Agreement

Recently, Bill Reynolds approached me to discuss lost revenue Fire District #4 experiences given the number of parcels the District owns in Morton and our tax-exempt status. He presented a list of parcels, their assessed value (cumulatively \$11,008,400), and the lost revenue (\$5,961.80). This is an ask that I had never experienced in 20+ years of healthcare leadership experience.

To better understand Bill's request, I reached out to Washington State hospitals, as well as one of our attorneys. My research found that some, but not all, of the hospitals had been approached by their local fire district with a similar request. Some did enter into an agreement while others did not.

Our attorney was very familiar with these types of agreements, having drafted several for other clients. He explained that the law allows for fire districts to request financial support, but it does not require us to comply. However, several municipalities do enter into agreements out of a sense of community and being good citizens.

You are being presented with several options for discussion. The attached document was built upon Bill's information. His lost revenue calculation is represented in the column titled "Original Request."

- Version 1 removes all parcels that do not have structures but continues to include the hospital and MOB. This version is the most generous of the options I am proposing (\$5,886.09).
- Version 2 builds upon V.1 and further removes the hospital and MOB. This version is the most aggressive proposal (\$405.36).
- Version 3 is similar to V.2; however, it does add back 50% of the lost revenue associated with the hospital and MOB. This version was presented as a collegial option between V.1 and V.2 (\$3,153.15).



I want to reiterate that we are under no regulatory obligation to agree to any version presented. However, the Fire District does provide services to our hospital district. They do an annual walkthrough, and they respond to all fire alarms, including false alarms due to aging technology. Bill is expected to attend the regular board meeting to answer any questions you may have.

This expense is well within the scope of my spending authority. However, I thought it prudent to discuss a new, on-going operating expense that is not as black and white as most operating expenses. There will be a resolution to ratify your decision on this matter.



Properties Owned by Lewis County Hospital District No. 1

<u>Parcel</u>	<u>Address</u>	<u>Use/Description</u>	<u>Assessed Value \$</u>	<u>Original Request</u>	<u>V.1</u>	<u>V.2</u>	<u>V.3</u>
8551000000	277 5th Street	Lot behind red house	\$ 13,700.00	\$ 7.42	\$ 7.42	\$ 7.42	\$ 7.42
8552000000	488 Adams Ave	Red House	\$ 165,700.00	\$ 89.74	\$ 89.74	\$ 89.74	\$ 89.74
8531012000	430 Temple Ave	ED House	\$ 109,900.00	\$ 59.52	\$ 59.52	\$ 59.52	\$ 59.52
8583002000	522 Temple Ave	MOB Building	\$ 3,908,700.00	\$ 2,116.83	\$ 2,116.83	\$ 2,116.83	\$ 2,116.83
8594001000	501 Cottlers Lane	Garden Lot	\$ 27,500.00	\$ 14.89	\$ 14.89	\$ 14.89	\$ 14.89
8531008000	451 Temple Ave	Trailer House	\$ 61,400.00	\$ 33.25	\$ 33.25	\$ 33.25	\$ 33.25
8594000000	439 Cottlers Ln	Robbins Nest	\$ 118,600.00	\$ 64.23	\$ 64.23	\$ 64.23	\$ 64.23
8564004000	588 Adams Ave	MOB Building Lot	\$ 35,000.00	\$ 18.95	\$ 18.95	\$ 18.95	\$ 18.95
8564002000	522 Adams Ave	Parking Lot	\$ 20,000.00	\$ 10.83	\$ 10.83	\$ 10.83	\$ 10.83
8579000000	497 Adams Ave	Parking Lot	\$ 43,000.00	\$ 23.29	\$ 23.29	\$ 23.29	\$ 23.29
8579004000	541 Adams Ave	Main Hospital	\$ 6,149,000.00	\$ 3,330.10	\$ 3,330.10	\$ 3,330.10	\$ 3,330.10
8564001000	554 Adams Ave	Parking Lot	\$ 28,000.00	\$ 15.16	\$ 15.16	\$ 15.16	\$ 15.16
8531011000	450 Temple Ave	ED Parking Lot	\$ 35,000.00	\$ 18.95	\$ 18.95	\$ 18.95	\$ 18.95
8605051001	121A Collar Ave	Duplex	\$ 147,800.00	\$ 80.04	\$ 80.04	\$ 80.04	\$ 80.04
8605051002	121B Collar Ave	Duplex	\$ 145,100.00	\$ 78.58	\$ 78.58	\$ 78.58	\$ 78.58
				\$ 5,961.80	\$ 5,961.80	\$ 5,961.80	\$ 5,961.80
				\$ -	\$ 75.71	\$ 5,556.44	\$ 2,808.65
				\$ 5,961.80	\$ 5,886.09	\$ 405.36	\$ 3,153.15



LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE FIRE
DISTRICT NO. 4 AGREEMENT

RESOLUTION NO. 20-47

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

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

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

To approve a new operating expense of \$XXX.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 11th day of November 2020, the following commissioners being present and voting in favor of this resolution.

Trish Frady, Board Chair

Tom Herrin, Secretary

Craig Coppock, Commissioner

Wes McMahan, Commissioner

Chris Schumaker, Commissioner



DocID: 14518
Revision: 4
Status: Official
Department: Governing Body
 (Board of Commissioners)
Manual(s):

Policy & Procedure : Board Meeting Teleconference

Policy:

The Board of Commissioners of Lewis County Hospital District No. 1 shall create a board meeting teleconference policy.

Purpose:

This policy is to set guidelines for teleconference of board meetings for Board of Commissioners and the Superintendent.

Procedure:

Board members and/or the Superintendent of Lewis County Hospital District No. 1 may attend hospital board meetings via telecommunications within the following guidelines:

1. Board members and/or the Superintendent shall make arrangements to teleconference at least 24 hours prior to a regular or special meeting.
2. Teleconference will be permitted only when at least two board members are at the meeting place.
3. Board members and/or the Superintendent may attend up to four regular and two special meetings per year via teleconference.
4. Teleconferencing Commissioners are able to vote.
5. Commissioners must be able to hear and be heard.

Document Owner: Frady, Trish

Collaborators:

Approvals

- Committees: (12/19/2018) Board of Commissioners, (09/25/2019) Board of Commissioners,

- Signers:

Original Effective Date: 06/18/2010

Revision Date: [06/18/2010 Rev. 0], [08/28/2012 Rev. 1], [08/12/2014 Rev. 2],
[07/24/2015 Rev. 3], [11/27/2018 Rev. 4]

Review Date: [04/11/2011 Rev. 0], [05/31/2016 Rev. 3], [09/05/2019 Rev. 4]

Attachments:

(REFERENCED BY THIS DOCUMENT)

Other Documents:

(WHICH REFERENCE THIS DOCUMENT)

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at

<https://www.lucidoc.com/cgi/doc-gw.pl?ref=morton:14518>.



DocID: 17933
Revision: 0
Status: Official
Department: Governing Body
 (Board of Commissioners)
Manual(s):

Policy & Procedure : Board Mobile Device Management

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board of Commissioners shall not send or receive electronic communications during a board meeting concerning any matter pending before the board.

Procedure:

Commissioners should:

1. Not use electronic communication devices to review or access information regarding matters not in consideration before the board during a board meeting.
2. Only use the internet during meetings to access the board agenda packet information, board resource documents, including but not limited to board policies, the bylaws, Robert's Rules of Order or other research relevant to the discussion.
3. Make every effort to refrain from sending or receiving electronic communication of a personal nature during board meetings. It may sometimes be necessary to send or receive urgent/emergency family or business communications during meetings.

Document Owner: Frady, Trish

Collaborators:

Approvals

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

- **Signers:**

Original Effective Date: 12/05/2017

Revision Date: [12/05/2017 Rev. 0]

Review Date: [08/27/2018 Rev. 0], [09/05/2019 Rev. 0]

Attachments:

(REFERENCED BY THIS DOCUMENT)

Other Documents:

(WHICH REFERENCE THIS DOCUMENT)

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<https://www.lucidoc.com/cgi/doc-gw.pl?ref=morton:17933>.



DocID: 8610-104
Revision: 2
Status: Official
Department: Governing Body
 (Board of Commissioners)
Manual(s):

Policy & Procedure : Board Self-Evaluation

Policy:

It is the policy of Lewis County Hospital District No.1 that the Board of Commissioners will conduct an annual self-evaluation.

Purpose:

For the Board of Commissioners to set and review goals and expectations.

Procedure:

The Board of Commissioners will identify their areas of strengths and weaknesses ensuring their personal goals and hospital health system goals are compatible. They will do this by using one of the evaluation forms located in the binder marked **Board Self Evaluation** located in the Administration office.

Document Owner: Frady, Trish

Collaborators:

Approvals

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

Original Effective Date:

Revision Date: [07/05/2006 Rev. 1], [08/27/2018 Rev. 2]

Review Date: [07/09/2008 Rev. 1], [05/29/2009 Rev. 1], [03/21/2014 Rev. 1],
 [05/31/2016 Rev. 1], [09/05/2019 Rev. 2]

Attachments:

(REFERENCED BY THIS DOCUMENT)

Other Documents:

(WHICH REFERENCE THIS DOCUMENT)

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<https://www.lucidoc.com/cgi/doc-gw.pl?ref=morton:10652>.

Sample #1 — Board of Directors Full Board Evaluation

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

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

Sample #1 — Board of Directors Full Board Evaluation

Mission and Purpose

LOW				HIGH
1	2	3	4	5

1. Statements of the organization's mission are well understood and supported by the board.
2. Board meeting presentations and discussions consistently reference the organization's mission statement.
3. The board reviews the organization's performance in carrying out the stated mission on a regular basis.

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Governance / Partnership Alignment

1. The board exercises its governance role:
 - 1) Ensuring that the organization supports and upholds the mission statement, core values, statement of faith, vision statement, and partnership policies.
2. The board periodically reviews, and is familiar with, the organization's partnership core documents. (Note: This item applies when a ministry has partnered with other ministries.)
3. The board reviews its own performance and measures its own effectiveness in governance work.
4. The board is actively engaged in the board development processes.

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Board Organization

1. Information provided by staff is adequate to ensure effective board governance and decision-making.
2. The committee structure logically addresses the organization's areas of operation.
3. All committees have adequate agendas and minutes for each meeting.
4. All committees address issues of substance.

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Sample #1 — Board of Directors Full Board Evaluation

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



DocID: 18944
Revision: 0
Status: Official
Department: Governing Body
 (Board of Commissioners)
Manual(s):

Policy & Procedure : Board Spending Authority

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board Chair is responsible for the annual Board of Commissioners' budget. All district funds incurred by individual Commissioners must receive prior approval from the Board Chair, or delegate, before district funds can be committed.

Procedure:

Authority to Requisition

The Board Chair is responsible for Board of Commissioners related expenditures and is the only person authorized to commit district funds on behalf of the Board of Commissioners. The Board Chair may delegate authority to an alternative in his/her absence. This delegation should be submitted in writing to the CFO, detailing who is authorized, length of delegation, any restrictions (such as restricting delegation to types of expenses or maximum limits of delegation).

Types of Costs Incurred

1. **Commissioner Compensation:** Compensation is subject to "Commissioner Compensation for Meetings and Other Services" policy (DocID 15827). Time is reported and processed via the District's Kronos timekeeping system.
2. **General/Office Supplies:** A Purchase Requisition form will be used to request all general/office supplies for Commissioners. This form will be approved by the Board Chair, or delegate, prior to being submitted to the Purchasing Department for acquisition.
3. **Legal/Professional Services:** The Board Chair, or delegate, is the only person that can commit District funds towards legal/professional services. Individual commissioners engaging these services without prior approval will be individually responsible for the cost of the service.
4. **Education/Travel Expenses:** All Commissioner education and travel related expenses must be approved by the Board Chair prior to incurring any associated costs. Commissioners must comply with the "Travel Expense Reimbursement Policy" (DocID 16195) when submitting travel related expenses for reimbursement. The "Travel Reimbursement Form" must be completed and signed/dated. The form and supporting documentation must be submitted to the Board Chair, or delegate, for approval. Reimbursements are processed and paid via the District's

Kronos timekeeping system. Any expenses incurred without prior approval, non-reimbursable per policy or not addressed by the policy will be the responsibility of the individual Commissioner.

5. All Other Expenses: All other expenses must be approved by the Board Chair, delegate or full board, prior to being incurred. Without prior approval, Commissioners will be individually responsible for the expense.

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