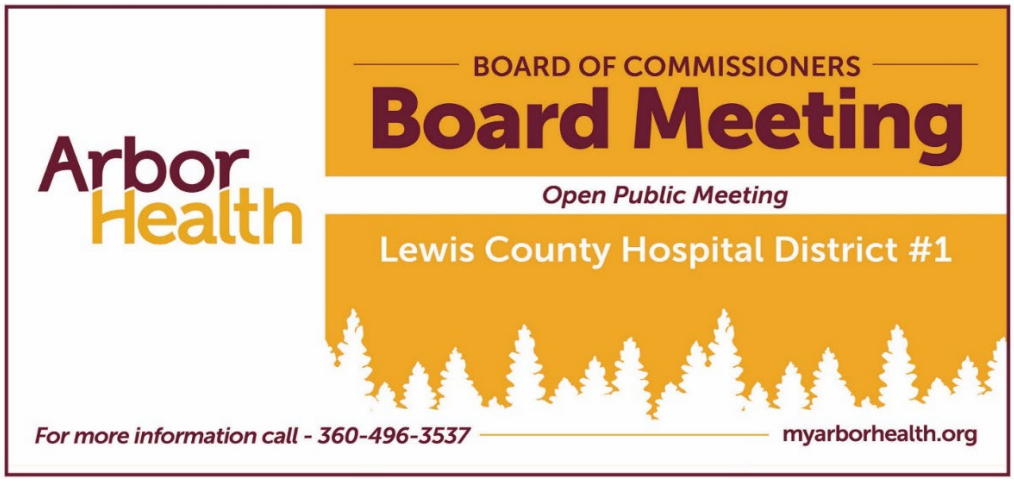
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

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

April 30, 2025 @ 3:30 PM

Conference Room 1 & 2 or Join Teams Meeting:

Meeting ID: 278 815 328 169

Passcode: 9uo7gX9H

Dial: +1.360.302.2717

Phone Conference ID: 705 103 053#

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Superintendent

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
April 30, 2025 at 3:30 p.m.
Conference Room 1 & 2 or via TEAMS
Meeting ID: 278 815 328 169
Passcode: 9uo7gX9H
Dial: +1.360.302.2717
Phone Conference ID: 705 103 053#

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	PAGE	TIME
Call to Order **Roll Call** **Excused/Unexcused Absences** **Reading of the Mission & Vision Statement** **Approval or Amendment of Agenda** **Conflicts of Interest**		3:30 pm
Comments and Remarks • Commissioners • Audience		3:35 pm
Executive Session- *RCW 70.41.200* • Medical Privileging-Chief of Staff Dr. Don Allison & Medical Staff Coordinator Barb Goble, Medical Staff Support Specialist Jill Elizaga	6	3:40 pm
Department Spotlight • *Laboratory-Laboratory Manager Janice Pendergast, COSO Julie Taylor*	8	3:45 pm
Board Committee Reports • Hospital Foundation Report-Committee Chair-Board Chair Herrin/Foundation Manager Jessica Scogin	16	4:00 pm
• Finance Committee Report- Committee Chair-Commissioner Anderson	18	4:05 pm
Consent Agenda *(Action)* • Approval of Minutes: o *March 26, 2025, Regular Board Meeting* o *April 14, 2025 Special Board Meeting* o *April 23, 2025, Finance Committee Meeting*	 27 34 36	4:15 pm
• Warrants & EFTs in the amount of $5,925,589 dated March 2025	42	
• Approve Documents Pending Board Ratification 04.30.25 o *To provide board oversight for document management in Lucidoc.*	44	
Old Business • Board Community Engagements		4:20 pm

○ *To monthly discuss the status of board engagements.* ○ *To review the public-input invite card*	46	
• Board Policy & Procedure Review ○ *Code of Ethics (Revision Recommendation) Compliance Officer Hargett*	47	
• Upcoming Commissioner Vacancies ○ *To discuss upcoming vacant positions; Commissioner #1-Morton & Position #5-At Large Position. The filing period is May 5th-9th.*	66	
New Business • Resolution 25-06-Adopting the Community Health Improvement Services (CHIS) Addendum ○ *To adopt the CHIS addendum which are the hospital activities related to improving community needs named in the hospital's Community Health Needs Assessment (CHNA). The annual CHIS addendum details these activities.*	101	4:25 pm
Superintendent Report • Board Educational Articles ○ Small-town America in crosshairs of Medicaid cuts ○ The cost of nurse turnover in 24 numbers | 2025 ○ Leak sheds light on plan for hospital alliance ○ WSHA & AWPHD Governance Education	107 112 115 117 121	4:35 pm
Meeting Summary & Evaluation		4:45 pm
Next Board Meeting Dates and Times • Regular Board Meeting-May 28, 2025 @ 3:30 PM (TEAMS & In Person) **Next Committee Meeting Dates and Times** • Compliance Committee Meeting-May 7, 2025 @ 12:00 PM (TEAMS) • Finance Committee Meeting-May 21, 2025 @ 12:00 PM (TEAMS) • Plant Planning Committee Meeting-May 28, 2025 @ 12:00 PM (TEAMS)		4:50 pm
Adjournment		4:55 pm

EXECUTIVE SESSION

MEDICAL STAFF PRIVILEGING

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

INITIAL APPOINTMENTS-4

Telestroke/Neurology Consulting Privileges

- Harsh Patel, MD

Arbor Health-Emergency Medicine Privileges

- Timothy Curlett, MD

Radiology Consulting Privileges

- Duard Enoch III, MD
- Austen Lawrence, DO

REAPPOINTMENTS-2

Telestroke/Neurology Consulting Privileges

- Sheila Smith, MD

Arbor Health-Sleep Medicine Privileges

- Jakdej Nikomborirak, MD

✪-notates files with items to note.

DEPARTMENT SPOTLIGHT

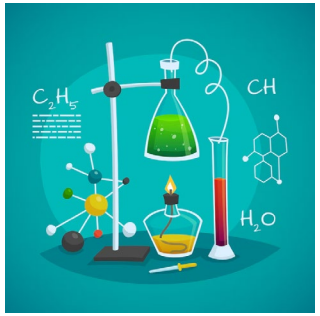
LABORATORY SERVICES

Julie Taylor, MSc., MLS (ASCP), FACHE

Janice Pendergast, MT (ASCP

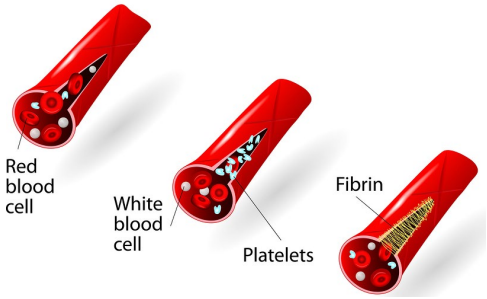
Departments

Chemistry

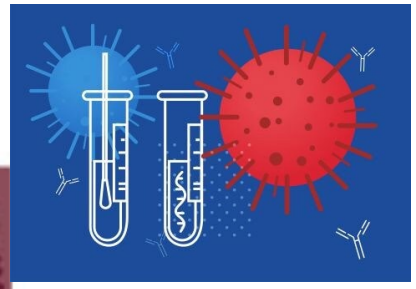


Hematology

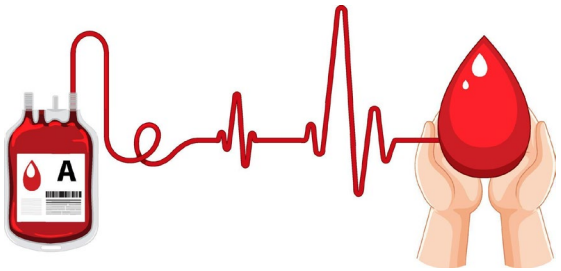
Coagulation



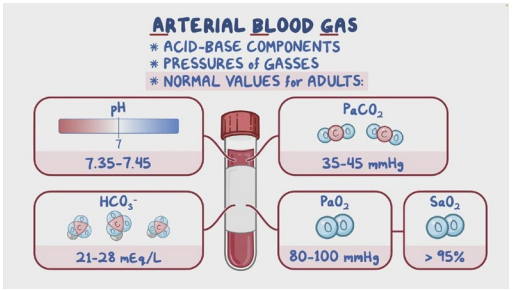
Serology



Blood Bank



Blood Gas



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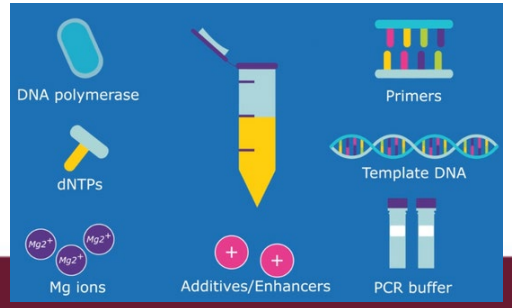
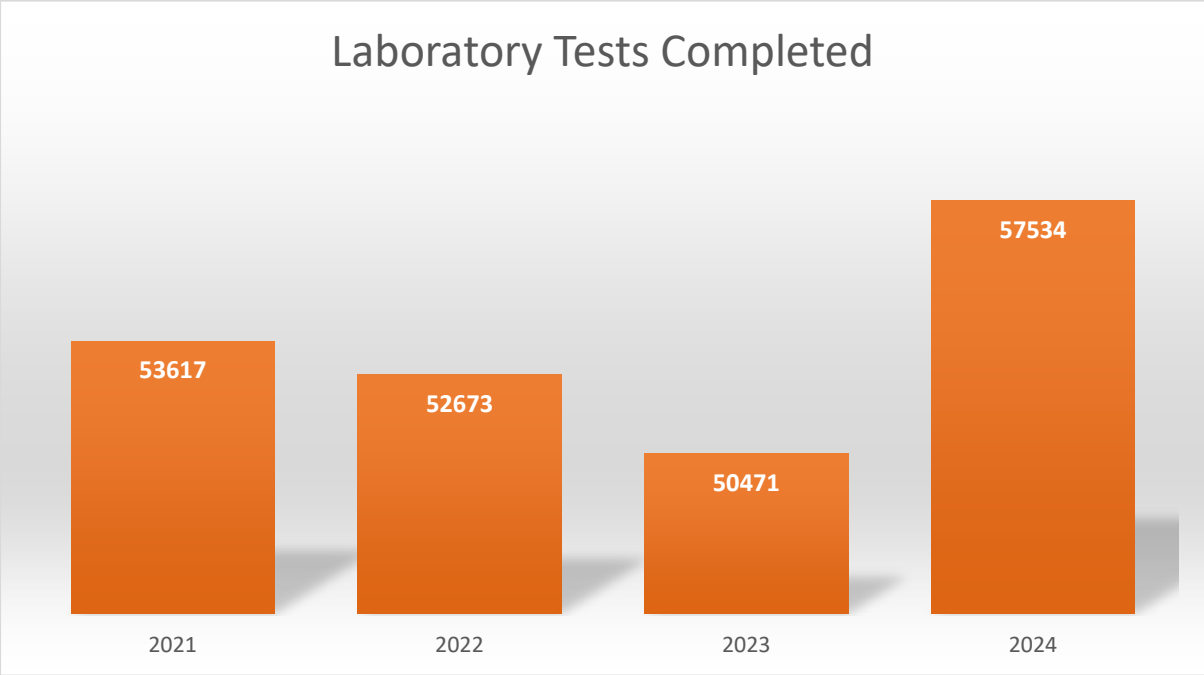
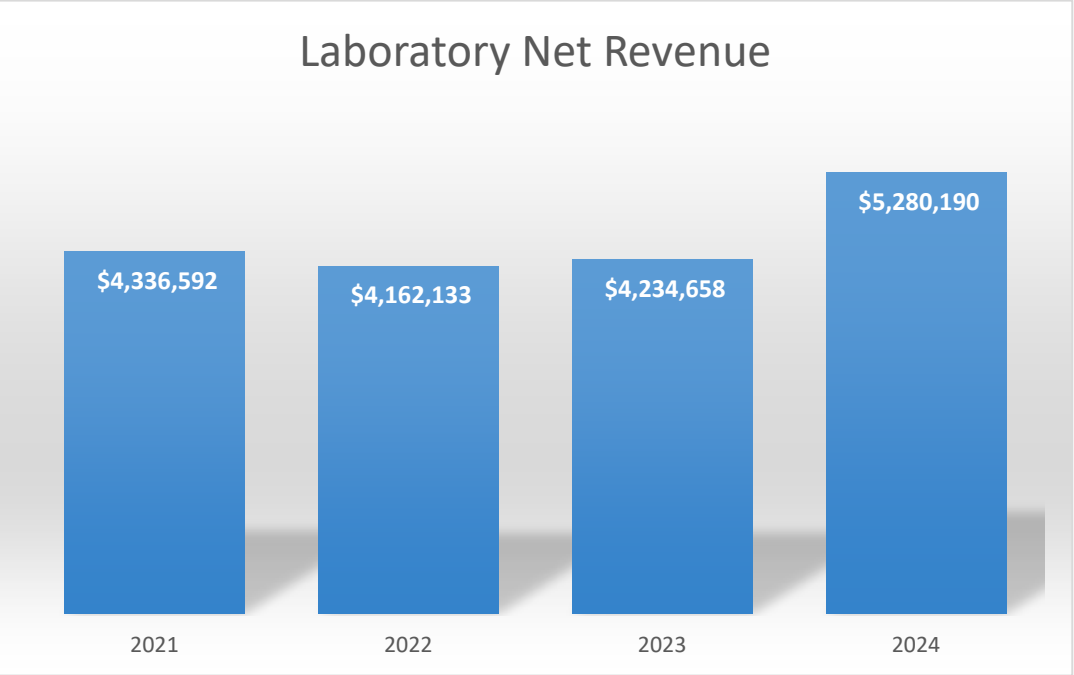


Arbor Health

Year over Year trending





Staffing

Workforce stabilization

Lab Manager recruitment

Janice Pendergast

20+ yrs at Swedish Medical Center

What patients are saying

Laboratory Department Care Team

- Great visit! Thank you!
- The nurses were outstanding.
- Overall great experience.
- The staff was very friendly and helpful. My overall experience has been great.

Laboratory Department Care Team

- No pain and minimal bruising from blood draw.
- A very friendly reception gal and the lab tech was super friendly and knowledgeable and did a really good job.
- I felt at ease.
- As always, the service at Arbor Health Clinic is outstanding.
- It's all good!
- All was very good!!

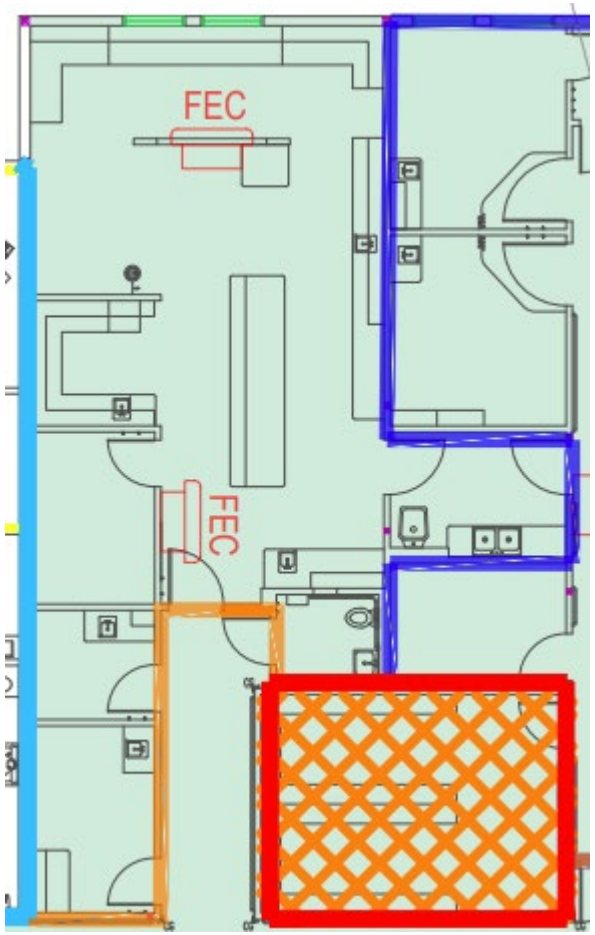
Laboratory Care Team

- Everything was great and hardly any wait time before I was seen.
- The lab technician was great and friendly and did my blood draw while making me feel very comfortable.
- The lab nurse was very friendly and professional

Future planning

Chemistry analyzers replacement

Space Planning



Questions?

COMMITTEE REPORTS

Arbor Health | FOUNDATION

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

Arbor Health Foundation meeting
4-8-2024- Hybrid

1. **Call to order**

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

- In attendance:
  - In Person: Char Hancock, Rob Mach, Marc Fisher, Paula Baker, Lenee Langham, Jeannie Walker, Tom Herrin, Shannon Kelly, Lynn Bishop, Martha Wright
  - Online: Julie Taylor, Martha Wright, Gwen Turner
- Excused absences:
  - Katelin Forrest, Louise Fisher, Christy Greiter

2. **Approval of March Treasurer's Report and Minutes** Fix the date for the next meeting to April 8, Shannon Kelly moves to approve the minutes and treasurer's report with the correction and Tom seconds. Motion approved.

3. **Administrators Report-** Rob Mach, strong financials for the first 3 months of the year. Some new equipment has been ordered and installed. All clinics will be getting new waiting room equipment. The front entrance carpet is going to be replaced soon. The new to Arbor Health rehabilitation equipment has been received from Providence after the closure of all of their outpatient rehab facilities. The equipment was surplused and given to Arbor Health.

4. **Executive Directors Report:**

- Report on Family Resource fair – 157 attendees (36 families). 49 passports returned, 43 resources on site. The paper did an article and published pictures of the event.
- Signup sheets – Please sign up for upcoming events.
- Thrive after 55 fair June 28th - looking for help from others with idea for participants.
-

5. **Old Business:**

- Blood pressure cuffs (10 physicians and advanced practice practitioners are asking for 10 each) , Motion from Tom to purchase 100 bp cuffs Shannon second, not to exceed $2500. Motion passes.
- 50/50 raffle update, there are no issues with increasing the number of tickets for the 50/50 raffle. We will update the number of tickets to 3000.

6. New Business: Char Hancock-sports physicals - Last years free sport physicals were completely successful. She is requesting we fund sports physicals again this year. Tom Herrin motioned we fund $1000 to sports physicals. Shannon Kelly second. Motion passes.

7. Next Meeting: May 13th

Good of the order please share.

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Finance Committee
From: Finance Department
Date: April 4, 2025
Subject: March Financial Statement Review

Volumes

The district's volume highlights show expected results for the month in Outpatient Registrations.

- Skilled Nursing volumes were less than budgeted expectations by 23 days or 24%.
- Emergency department volumes were less than budgeted expectations by 69 visits or 13%.

Income Statement

Results from Operations show net income of $164,646 for the month and $699,634 YTD. Net Operating Revenues were below budget by $95,356 for the month. Operating Expenses were below budgeted expectations by $166,835.

Revenue highlights
Month-to-date

- Inpatient revenues were unfavorable to budget by $307,429 or 35%.
- Outpatient revenues were favorable to budget by $507,716 or 12%.

Year-to-date

- Outpatient revenues were favorable to budget by 11% or $1,423,447.

Expense highlights
Month-to-date

- Benefits expense was less than budgeted expectations by $89,669.
    - Group Health insurance expense was less than expected by $116,679.

Year-to-date

- Supplies expense category was over budget by $143,940 or 18%.
    - This is primarily due to higher-than-expected DME expenses.

Mossyrock Clinic
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360-497-3333

Morton Hospital
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360-496-5112

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531 ADAMS AVENUE
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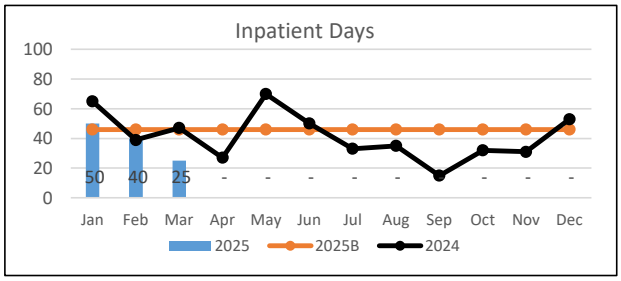
Balance Sheet

Highlights in the Balance sheet show cash decreasing and Accounts Receivable decreasing.

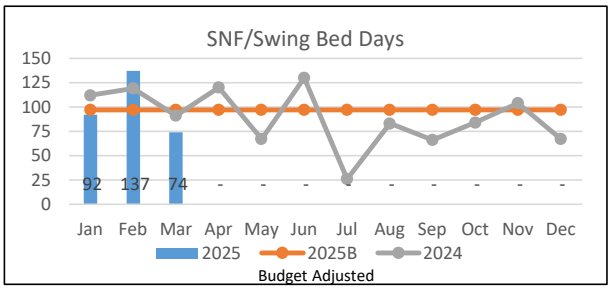
- Cash accounts decreased $650,187 to $4,642,045.
    - Days in cash increased from 38 days to 42 days.
- Accounts receivable decreased $375,602.
    - AR days decreased from 58 to 54 days.

Lewis County Hospital District No. 1
Board Financial Summary
March 31, 2025

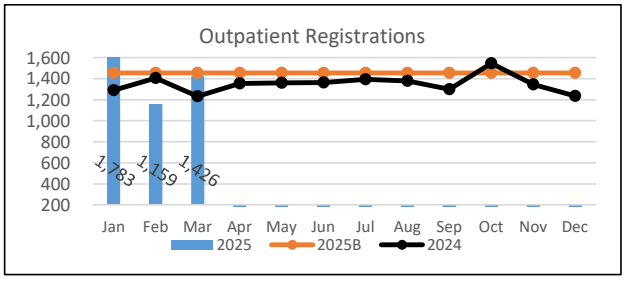
Growth



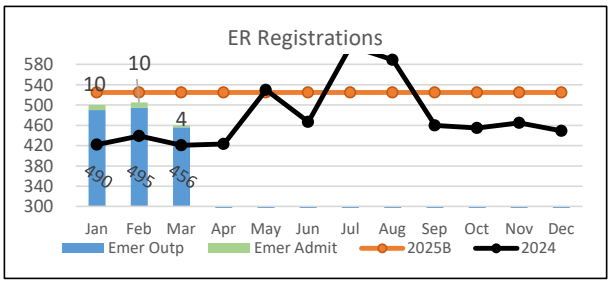
YTD: 115 Budget: 138 Pr Yr: 151



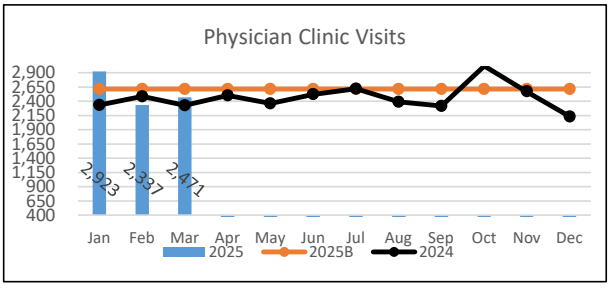
YTD: 303 Budget: 291 Pr Yr: 322



YTD: 4,368 Bud: 4,368 Pr Yr: 3,931

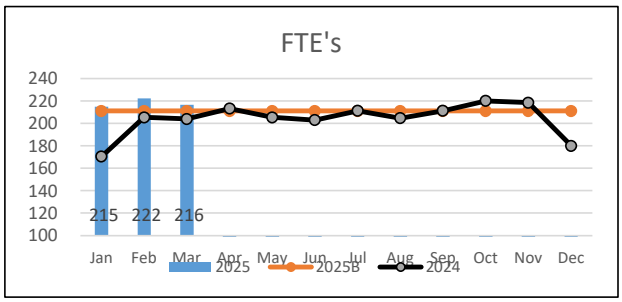


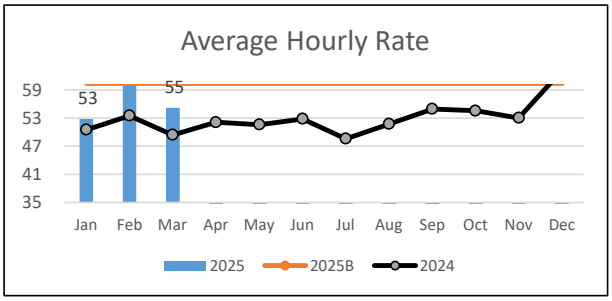
YTD: 1441 Bud: 1575 Pr Yr: 1282

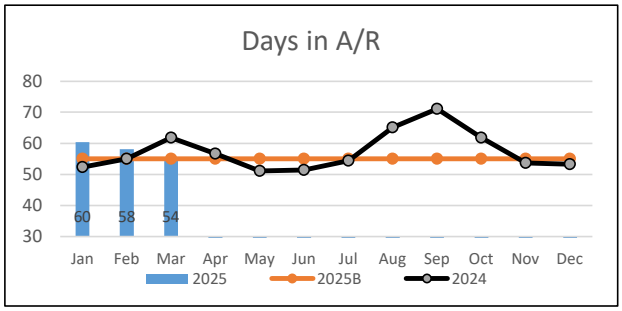


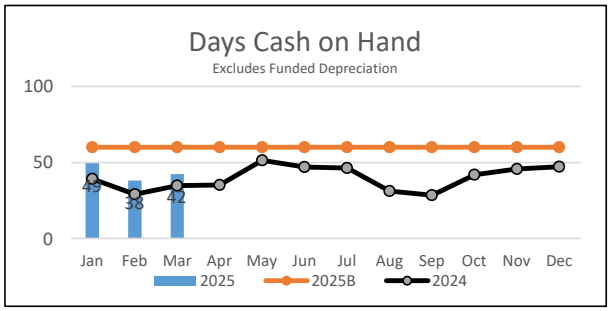
YTD: 7,731 Bud: 7,845 Pr Yr: 7,146

People and Operational Aspects









Lewis County Public Hospital District No. 1
Balance Sheet
March, 2025

	Current Month	Prior-Month	Prior-Year end	Incr/(Decr) From PrYr
Assets				
Current Assets:				
Cash	$ 4,642,045	5,292,232	6,170,247	(1,528,202)
Total Accounts Receivable	11,468,784	11,844,386	11,049,177	419,607
Reserve Allowances	(4,299,681)	(4,758,245)	(4,250,094)	(49,587)
Net Patient Accounts Receivable	7,169,103	7,086,141	6,799,083	370,020
Taxes Receivable	236,508	184,861	35,830	200,678
Prepaid Expenses	537,968	510,460	470,964	67,004
Inventory	248,048	243,788	238,552	9,496
Funds in Trust	1,928,995	1,921,614	1,913,639	15,355
Total Current Assets	14,762,667	15,239,095	15,628,316	(865,649)
Property, Buildings and Equipment	35,884,343	35,880,570	35,837,739	46,605
Accumulated Depreciation	(26,877,791)	(26,778,896)	(26,588,876)	(288,915)
Net Property, Plant, & Equipment	9,006,552	9,101,674	9,248,863	(242,311)
Right-of-use assets	904,159	924,944	1,168,907	(264,748)
Other Assets	2,496	2,551	2,661	(165)
Total Assets	$ 24,675,874	25,268,263	26,048,747	(1,372,873)
Liabilities				
Current Liabilities:				
Accounts Payable	532,585	1,357,599	1,291,094	(758,509)
Accrued Payroll and Related Liabilities	946,977	847,294	1,563,109	(616,132)
Accrued Vacation	1,032,694	963,473	984,338	48,355
Third Party Cost Settlement	(51,544)	18,142	598,945	(650,489)
Interest Payable	73,405	48,937	0	73,405
Current Maturities - Debt	950,221	950,221	950,221	0
Other Payables	4,632	4,712	4,842	(210)
Current Liabilities	3,488,970	4,190,378	5,392,551	(1,903,581)
Total Notes Payable	381,756	407,948	460,195	(78,439)
Lease Liability	807,437	836,872	897,925	(90,488)
Net Bond Payable	4,106,062	4,106,062	4,106,062	0
Total Long Term Liabilities	5,295,255	5,350,883	5,464,182	(168,926)
Total Liabilities	8,784,226	9,541,261	10,856,733	(2,072,507)
General Fund Balance	15,192,014	15,192,014	15,192,014	0
Net Gain (Loss)	699,634	534,988	0	699,634
Fund Balance	15,891,648	15,727,002	15,192,014	699,634
Total Liabilities And Fund Balance	$ 24,675,874	25,268,263	26,048,747	(1,372,873)

Lewis County Hospital District No. 1
Income Statement
March, 2025

CURRENT MONTH						YEAR TO DATE				
Pr Yr Month	% Var	$ Var	Budget	Actual		Actual	Budget	$ Var	% Var	Actual
779,036	-35%	(307,429)	891,070	583,641	Inpatient Revenue	2,674,876	2,674,584	292	0%	2,755,014
3,773,238	12%	507,716	4,335,745	4,843,461	Outpatient Revenue	14,382,523	12,959,076	1,423,447	11%	10,971,822
575,193	-8%	(56,804)	670,337	613,533	Clinic Revenue	1,875,685	2,011,011	(135,326)	-7%	1,741,162
5,127,467	2%	143,483	5,897,152	6,040,635	**Gross Patient Revenues**	**18,933,084**	17,644,671	1,288,413	7%	15,467,998
1,760,413	-6%	(139,072)	2,249,180	2,388,251	Contractual Allowances	7,095,368	6,780,893	(314,476)	-5%	6,224,947
119,119	-45%	(29,477)	65,521	94,998	Charity Care	269,793	200,927	(68,867)	-34%	225,078
11,825	-126%	(76,376)	60,484	136,860	Bad Debt	380,146	185,835	(194,311)	-105%	129,553
1,891,356	-10%	(244,925)	2,375,184	2,620,109	**Deductions from Revenue**	**7,745,308**	7,167,654	(577,653)	-8%	6,579,577
3,236,111	**-3%**	**(101,441)**	**3,521,968**	**3,420,526**	**Net Patient Service Rev**	**11,187,776**	**10,477,016**	**710,760**	**7%**	**8,888,420**
63.1%	5.2%	3.1%	59.7%	56.6%	**NPSR %**	59.1%	59.4%	0.3%	0.5%	57.5%
134,912	4%	6,085	154,489	160,574	Other Operating Revenue	383,392	463,467	(80,075)	-17%	290,074
3,371,023	**-3%**	**(95,356)**	**3,676,457**	**3,581,100**	**Net Operating Revenue**	**11,571,168**	**10,940,483**	**630,685**	**6%**	**9,178,494**
					Operating Expenses					
1,896,627	0%	(1,457)	2,244,926	2,246,383	Salaries & Wages	6,800,209	6,734,779	(65,430)	-1%	5,717,717
386,260	22%	89,669	411,453	321,784	Benefits	1,300,148	1,216,379	(83,769)	-7%	1,088,132
62,099	21%	11,843	56,157	44,314	Professional Fees	105,964	129,597	23,633	18%	157,796
217,285	-3%	(8,102)	269,256	277,358	Supplies	949,047	805,107	(143,940)	-18%	721,287
370,014	7%	28,484	404,894	376,409	Purchase Services	1,158,344	1,132,287	(26,056)	-2%	1,104,478
46,994	27%	10,644	39,897	29,253	Utilities	139,159	129,931	(9,228)	-7%	123,967
32,798	-5%	(1,588)	34,570	36,158	Insurance	108,150	103,710	(4,440)	-4%	98,339
43,998	30%	19,250	65,051	45,800	Other Expenses	149,856	207,845	57,988	28%	147,988
3,056,074	4%	148,744	3,526,202	3,377,459	EBDITA Expenses	10,710,877	10,459,634	(251,243)	-2%	9,159,704
314,949	36%	53,387	150,254	203,642	**EBDITA**	860,292	480,849	379,442	79%	18,790
9.3%	-39.1%	-1.6%	4.1%	5.7%	EBDITA %	7.4%	4.4%	-3.0%	-69.2%	0.2%
					Capital Cost					
124,842	7%	9,517	129,251	119,735	Depreciation	350,973	387,752	36,778	9%	363,591
30,603	23%	8,574	37,881	29,306	Interest Cost	88,791	116,043	27,252	23%	92,166
3,211,519	5%	166,835	3,693,334	3,526,499	Operating Expenses	11,150,642	10,963,429	(187,213)	-2%	9,615,461
159,504	-424%	71,478	(16,878)	54,601	**Operating Income/(Loss)**	420,527	(22,946)	443,473	-1933%	(436,968)
4.7%			-0.5%	1.5%	Operating Margin %	3.6%	-0.2%			-4.8%
(3,822)	0%	(22,959)	0	22,959	**Mcare/Mcaid Pr Yr**	22,959	0	(22,959)	0%	(3,822)
					Non Operating Activity					
88,374	10%	8,974	89,199	98,173	Non-Op Revenue	277,997	267,596	10,402	4%	246,451
4,883	-174%	(7,043)	4,044	11,087	Non-Op Expenses	21,849	12,133	(9,716)	-80%	14,587
83,491	2%	1,932	85,154	87,086	Net Non Operating Activity	256,148	255,463	686	0%	231,864
239,173	141%	96,369	68,277	164,646	**Net Income / (Loss)**	699,634	232,517	467,117	201%	(208,926)
7.1%			1.9%	4.6%	Net Income Margin %	6.0%	2.1%			-2.3%

Arbor Health

2025 Forecast

	2025 Budget	March Actual YTD	April-Dec Budget	2025 Forecast
Inpatient Revenues	10,669,498	2,674,876	8,002,124	10,677,000
Outpatient Revenues	51,975,806	14,382,523	38,981,855	53,364,378
Clinic Revenues	8,044,060	1,875,685	6,033,045	7,908,730
Gross patient Revenue	70,689,364	18,933,084	53,017,023	71,950,107
Deductions from Revenues	29,114,658	7,722,349	21,835,994	29,558,343
	41%	41%	41%	41%
Net Patient Revenues	41,574,706	11,210,735	31,181,030	42,391,765
Other Operating Revenue	1,853,867	383,392	1,390,400	1,773,792
Total Operating Revenues	43,428,573	11,594,127	32,571,430	44,165,557
Operating Expenses				
Salaries & Wages	26,979,068	6,800,209	20,234,301	27,034,510
Benefits	4,835,195	1,300,148	3,626,396	4,926,544
Professional Fees	462,943	105,964	347,207	453,171
Supplies	3,171,647	949,047	2,378,735	3,327,782
Purchase Services	4,684,720	1,158,344	3,513,540	4,671,884
Utilities	475,698	139,159	356,774	495,933
Insurance	414,839	108,150	311,129	419,279
Other Expenses	784,750	149,856	588,563	738,419
Depreciation	1,561,146	350,973	1,170,860	1,521,833
Interest Cost	456,589	88,791	342,442	431,233
Operating Expenses	43,826,595	11,150,641	32,869,946	44,020,587
Operating Income	(398,022)	443,486	(298,517)	144,970
	-1%	4%	-1%	0%
Non Operating Activity				
Non-Operating Income	1,021,848	256,148	766,386	1,022,534
	623,826	699,634	467,870	1,167,504

Arbor Health
Cash Flow Statement
For the Month Ending March 2025

	MTD	YTD
Cash Flows from Operating Activites		
Net Income	164,646	699,634
Adjustments to reconcile net income to net cash provided by operating activities		
Decrease/(Increase) in Net Patient Accounts receivable	(82,962)	(370,020)
Decrease/(Increase) in Taxes receivable	(51,647)	(200,678)
Decrease/(Increase) in Est 3rd Party Receivable	0	0
Decrease/(Increase) in Prepaid expenses	(27,508)	(67,003)
Decrease/(Increase) in Inventories	(4,260)	(9,496)
Decrease in Other Current Assets	0	0
Increase/(Decrease) in Accrued payroll liabilities	168,904	(567,776)
Increase/(Decrease) in 3rd Party cost stlmt liabilities	(69,686)	(650,489)
Increase/(Decrease) in Accounts payable	(825,094)	(758,721)
Increase/(Decrease) in Interest payable	24,468	73,405
Depreciation expense	98,895	288,915
Net Cash Flow from Operations	(604,244)	(1,562,229)
Cash Flows from Investing Activities		
Cash paid for		
Purchases of Fixed assets	(3,773)	(46,604)
Right-of-use assets	20,838	264,913
Net Cash Flow from (used) in Investing Activities	17,065	218,309
Cash Flows from Financing Activities		
Cash paid for		
Additions to long-term debt	0	0
Principal payments of long-term liabilities	(26,192)	(78,438)
Lease liabilities	(29,435)	(90,488)
Net Cash Flow from (used) in Financing Activities	(55,627)	(168,926)
Net Increase (Decrease) in Cash	(642,806)	(1,512,846)
Cash at Beginning of Period	$ 7,213,846	$ 8,083,886
Cash at End of Period	$ 6,571,040	$ 6,571,040

Arbor Health

Cash Forecast	Actual **January**	Actual **February**	Actual **March**	Forecast **April**	Forecast **May**	Forecast **June**	Forecast **July**	Forecast **August**	Forecast **September**	Forecast **October**	Forecast **November**	Forecast **December**
Planned Cash Reserves												
Total Cash Balance	8,083,887	7,441,734	7,213,845	6,571,040	6,702,465	6,833,890	6,965,315	7,096,740	7,228,165	7,359,590	7,491,015	7,622,440
Operating Reserves	(1,913,639)	(1,921,614)	(1,928,995)	(1,913,639)	(1,913,639)	(1,913,639)	(1,913,639)	(1,913,639)	(1,913,639)	(1,913,639)	(1,913,639)	(1,913,639)
Commitments and Contingencies	-											
Cash, Net of Reserves	6,170,248	5,520,120	5,284,850	4,657,401	4,788,826	4,920,251	5,051,676	5,183,101	5,314,526	5,445,951	5,577,376	5,708,801
Cash Receipts												
Patient Receipts - Run Rate	4,133,246	3,738,827	3,691,245	3,464,559	3,464,559	3,464,559	3,464,559	3,464,559	3,464,559	3,464,559	3,464,559	3,464,559
Non Operating	71,050	85,154	98,173	85,154	85,154	85,154	85,154	85,154	85,154	85,154	85,154	85,154
Other Operating Receipts	121,001	154,489	160,574	154,489	154,489	154,489	154,489	154,489	154,489	154,489	154,489	154,489
Total Cash Receipts	4,325,297	3,978,470	3,949,992	3,704,202	3,704,202	3,704,202	3,704,202	3,704,202	3,704,202	3,704,202	3,704,202	3,704,202
Cash Disbursements												
Payroll and Benefits	3,842,373	2,960,499	2,825,377	2,651,189	2,651,189	2,651,189	2,651,189	2,651,189	2,651,189	2,651,189	2,651,189	2,651,189
A/P -	1,067,126	1,391,754	1,728,805	830,382	830,382	830,382	830,382	830,382	830,382	830,382	830,382	830,382
Debt Coverage	57,867	55,434	55,627	38,050	38,050	38,050	38,050	38,050	38,050	38,050	38,050	38,050
Property, Plan, Equipment	84	(201,328)	(17,012)	53,156	53,156	53,156	53,156	53,156	53,156	53,156	53,156	53,156
Total Cash Disbursements	4,967,450	4,206,359	4,592,797	3,572,777	3,572,777	3,572,777	3,572,777	3,572,777	3,572,777	3,572,777	3,572,777	3,572,777
Net Change in Cash	**(642,153)**	**(227,889)**	**(642,805)**	**131,425**	**131,425**	**131,425**	**131,425**	**131,425**	**131,425**	**131,425**	**131,425**	**131,425**
Ending Cash Balance	**7,441,734**	**7,213,845**	**6,571,040**	**6,702,465**	**6,833,890**	**6,965,315**	**7,096,740**	**7,228,165**	**7,359,590**	**7,491,015**	**7,622,440**	**7,753,865**
Ending Cash Net Of Reserves	**5,528,095**	**5,292,231**	**4,642,045**	**4,788,826**	**4,920,251**	**5,051,676**	**5,183,101**	**5,314,526**	**5,445,951**	**5,577,376**	**5,708,801**	**5,840,226**

CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
March 26, 2025, at 3:30 p.m.
Conference Room 1 & 2 and via TEAMS
Meeting ID: 278 815 328 169
Passcode: 9uo7gX9H
Dial: +1.360.302.2717
Phone Conference ID: 705 103 053#

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order **Roll Call** **Unexcused/Excused Absences** **Reading the Mission & Vision Statements**	Board Chair Herrin called the meeting to order at 3:30 p.m. **Commissioners present:** ☒ Tom Herrin, Board Chair ☒ Wes McMahan, Secretary ☒ Craig Coppock ☒ Van Anderson ☒ Chris Schumaker **Others present:** ☒ Robert Mach, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Barbara Van Duren, CNO/CQO ☒ Colleen Littlejohn, ACNO ☒ Cheryl Cornwell, CFO ☐ Shannon Kelly, CHRO ☒ Julie Taylor, COSO ☐ Dr. Kevin McCurry, CMO ☐ Matthew Lindstrom, CFPO ☐ Spencer Hargett, Compliance Officer ☒ Barb Goble, Medical Staff Coordinator ☒ Dr. Don Allison, Chief of Staff			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	☒ Jessica Scogin, Foundation Manager ☒ Clint Scogin, Controller ☒ Robert Houser, Imaging Manager ☒ Buddy Rose, Journalist ☒ Diane Markham, Marketing & Communication Manager ☐ Julie Johnson, QMRC Manager ☐ Nicholas Tyler, Pharmacist ☐ Laura Glass, Patient Care Services Director Board Chair Herrin noted the chat function has been disabled and the meeting will not be recorded.			
Approval or Amendment of Agenda		Secretary McMahan made a motion to approve the agenda. Commissioner Coppock seconded, and the motion passed unanimously.		
Conflicts of Interest	Board Chair Herrin asked the attendees to state any conflicts of interest with today's agenda.	None.		
Comments and Remarks	Commissioners: Commissioner Anderson attended the Mineral Rural Fire District Meeting with Board Chair Herrin and CNO/CQO van Duren. Commissioner Anderson thanked both for joining in to be there to answer questions/concerns. Commissioner Anderson shared being incredibly grateful to CFO Cornwell and her service to the District while wishing her the best. Lastly, thank you to the IT Department for updating the TEAMS App for upcoming meetings. Commissioner Coppock also thanked CFO Cornwell for her time, especially with improving processes, revenue and financial health of the District. Audience: None.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Executive Session • RCW 70.41.200	Board Chair Herrin announced going into executive session at 3:35 p.m. for 10 minutes to discuss RCW 70.41.200-Medical Privileging and Quality Improvement Oversight Report. At 3:45 p.m. Board Chair Herrin extended Executive Session by 5 minutes. The Board returned to open session at 3:50 p.m. Board Chair Herrin noted no decisions were made in Executive Session. Initial Appointments: Telestroke/Neurology Consulting Privileges 1. Taylor Anderson, MD Reappointments: Telestroke/Neurology Consulting Privileges 1. Bruce Geryk, MD 2. Yi Mao, MD 3. Aixa Espinosa Morales, MD Radiology Consulting Privileges 4. James Hills, MD 5. Marc Koenig, MD 6. Phillip Lowe, MD 7. Jennifer McEvoy, MD 8. Garland McQuinn, MD 9. Hartley Sirkis, MD	Commissioner Coppock made a motion to approve the Medical Privileging as presented and Commissioner Anderson seconded. The motion passed unanimously.		
Department Spotlight • Imaging	Imaging Manager Houser shared insight into diagnostic imaging, its importance, common techniques and services provided. Provided updates on staffing and the challenge to fill positions, patient satisfaction, volumes and revenues. Celebrated accomplishments in 2023-2024, as well as noted projects in the pipeline. Imaging Manager Houser noted the biggest challenges are regulations,			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	staffing and cash to grow. The good news shows in the profit margin, additional services and additional opportunities shared in the work in progress.			
Board Committee Reports • Hospital Foundation Report	Board Chair Herrin highlighted the Foundation selected this year's fund-a-need, a Solo Step for the Rehabilitation Services Department. Also, the Foundation approved employee gym equipment for the hospital staff. Board Chair Herrin shared the Family Resource Fair was a huge success, 33 resource vendors and approximately 157 people attend. The Foundation is brainstorming a new event/resource fair idea for seniors.			
• Finance Committee Report	Commissioner Anderson highlighted the financial statistics for the month of February. Noting while it was a shorter month, volumes were favorable and shared variances to budget. Days in cash decreased but should recover. Expense variances were noted for salary and wages, but CFO Cornwell shared both benefits and supplies are recoverable expenses.			
Consent Agenda	Board Chair Herrin announced the consent agenda items for consideration of approval: 1. Approval of Minutes a. February 26, 2025, Regular Board Meeting b. March 12, 2025, QIO Committee Meeting c. March 19, 2025, Finance Committee Meeting 2. Warrants & EFTs in the amount of $4,568,072 dated February 2025 3. RES-25-05-Declaring to Surplus or Dispose of Personal Property	Commissioner Anderson made a motion to approve the Consent Agenda with the proposed edit to the QIO Meeting Minutes and Commissioner Schumaker seconded. The motion passed unanimously.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	4. Approve Documents Pending Board Ratification 03.26.25 Commissioner Anderson proposed editing the 031225 QIO Meeting Minutes by replacing .12 with 1.2 in the following sentence, "Commissioner Anderson noted again that the Grievance Rate is still incorrect for 2023 and should be 1.2 not .0012.	Edit QIO Meeting Minutes. Minutes, Resolutions and Warrants will be sent for electronic signatures.	Executive Assistant Garcia Executive Assistant Garcia	03.28.25 03.28.25
Old Business • Board Community Engagements	Commissioner Coppock shared patient feedback that they love the services offered here but requested the phone tree be reviewed. More specifically when a patient misses a call from Arbor Health that a patient can call the number back to cancel or reschedule appointments. Superintendent Mach shared this topic is in the works and being reviewed in a workgroup. Board Chair Herrin noted the biggest concerns/take-aways from the Mineral Rural Fire District Meeting was diversions and loving the Rapid Care Clinic with hopes of expanding hours. Commissioner Anderson plans to attend the April 23rd Mossyrock Fire District Meeting at 6 pm extended the invitation to join. Superintendent Mach closed with draft cards are being designed to share with the public to collect data.	Present Public Input Card.	Superintendent Mach	04.30.25
New Business • Upcoming Commissioner Vacancies	Board Chair Herrin shared the Board has two open vacancies, Commissioner Position #1 & #5. In past years the Board has been successful in building interest by hosting a Special Board Meeting to share what it means to be a commissioner, as well as answer any questions prior to candidates running for office. The Board has agreed to host a Special Board Meeting on Monday, April 14th at 6 pm. This way the Board can invite	Schedule Special Board Meeting.	Executive Assistant Garcia	Prior to 04.04.25

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	interested candidates to the April 30th Regular Board Meeting prior to filing the week of May 5th.			
Superintendent Report	Superintendent Mach highlighted the memo in the packet and added the following updates: 1. Legislative updates include: a. State insurance plans (PEBB & SEBB) there will be a rural carve out. b. Prepackaged prescriptions in the ED for patients to use in the first 24-48 hours. 2. Hired a locums at Morton Clinic who will backfill Dr. Fritz. 3. New patient menus are live, so patients can choose. Kudos to the whole team that made this happen. 4. Hired a new OR Coordinator Amy Hoejsi. 5. Acquired Rehabilitation Services equipment for free from Providence. 6. Collaborating with the new Randle Library on the reading path behind Randle Clinic. Plan to tell the AH story. CNO/CQO van Duren happily shared hiring more permanent nurses, as well as attending a luncheon on April 10th to meet new grads at Centralia College. Superintendent Mach thanks CFO Cornwell and the amazing job completed in the Finance Department. Appreciate the hard work and friendship, best of luck in the future.			
Meeting Summary & Evaluation	Superintendent Mach provided a meeting summary. Commissioner Anderson appreciated the meeting and seeing Secretary McMahan in person. Schedule ran longer due to technical			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	difficulties and the great department spotlight. Commissioner Schumaker thanked Commissioner Anderson for being the face of the Board in the community and good to see Secretary McMahan. Commissioner Coppock noted a good meeting, going to greatly miss CFO Cornwell and appreciate the good articles especially the Dr. Oz one. Secretary McMahan apologized for missing last month's meeting due to illness and plans to be more available with respiratory illness season behind us. Superintendent Mach noted the topics discussed today are the same issues being discussed at the Rural Collaborative. Specifically, hospitals want to grow, scared to spend money and how do we staff. Lastly, thank you Shana for your time as the Executive Assistant and please be patient as we transition the role to Misty Stephens. Board Chair Herrin appreciates the board coming together and feeling comfortable to share even when it may be uncomfortable.			
Adjournment		Commissioner Anderson moved, and Commissioner Coppock seconded to adjourn the meeting at 5:17 p.m. The motion passed unanimously.		

Respectfully submitted,

Wes McMahan, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
April 14, 2025, at 6:00 p.m.
Conference Rooms 1 & 2 &/or TEAMS
Meeting ID: 277 490 953 292
Passcode: n9yE3oW7
Dial: +1.360.302.2717
Phone Conference ID: 545 349 259#

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Excused/Unexcused Absences Reading the Mission & Vision Statements	Board Chair Herrin called the meeting to order at 6:00 p.m. **Commissioners present:** ☒ Tom Herrin, Board Chair ☒ Wes McMahan, Secretary ☒ Craig Coppock ☒ Van Anderson ☒ Chris Schumaker **Others present:** ☒ Misty Stephens, Executive Assistant ☒ Robert Mach, Superintendent ☒ Shana Garcia, Contract & Accreditation Manager			
Conflicts of Interest	Board Chair Herrin asked the Board to state any conflicts of interest with today's agenda.	None noted.		
Reading of the Notice of the Special Meeting	Board Chair Herrin read the special board meeting notice.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
To discuss Commissioner Position #1-Morton & Commissioner Position #5-At Large Position	Commissioner Herrin discussed a possible candidate pending clarification from the Elections Office in regards to holding two elective positions at the same time, along with verifying whether a candidate can be listed twice on the same ballot. The Board discussed the process if no one runs for office and if no one is elected. The Board reviewed the District Map and Board Member Job Description. Executive Assistant Stephens will create a candidate packet to share with interested constituents. The Board requested Marketing & Communications Manager Markham share the open commissioner positions on social media to peak interest in the upcoming vacancies.	Contact the Elections Office to clarify candidacy questions and provide information to the Board. Create candidate packets for distribution via email or by paper. Share Commissioner vacancies on social media weeks April 21st & 28th.	Executive Assistant Stephens and Contract & Accreditation Manager Garcia Executive Assistant Stephens Marketing & Communications Manager Markham	By end of week 04/18/25 By end of week 04/18/25 By end of week 04/18/25
Public Comment	Board Chair Herrin noted no community members present.	None noted.		
Adjournment	Commissioner Coppock moved, and Secretary McMahan seconded to adjourned at 7:00 p.m. The motion passed unanimously.			

Respectfully submitted,

Wes McMahan, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
April 23, 2025, at 12:00 p.m.
Via Teams

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Reading the Mission & Vision Statements Roll Call Excused/ Unexcused Absences	Commissioner Anderson called the meeting to order via Teams at 12:00 p.m. Commissioner(s) Present in Person or via Teams: ☒ Van Anderson, Commissioner ☒ Wes McMahan, Secretary Committee Member(s) Present in Person or via Zoom: ☒ Misty Stephens, Executive Assistant ☒ Shana Garcia, Contract & Accreditation Manager ☒ Robert Mach, Superintendent ☒ Marc Fisher, Community Member ☒ Clint Scogin, Controller ☒ Barbara van Duren, CNO/CQO ☒ Jessica Niedert, Business Office Manager ☒ Janice Cramer, Patient Access Manager ☒ Colleen Littlejohn, ACNO	Excused: Unexcused:		
Approval or Amendment of Agenda	Secretary McMahan requested to amend the agenda by adding Legislative Updates to CFO Financial Review under Old Business.	CNO/CQO van Duren made a motion to approve the amended agenda and Commissioner McMahan seconded.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
		The motion passed unanimously.		
Conflicts of Interest	Commissioner Anderson asked the Committee to state any conflicts of interest with today's amended agenda.	None noted.		
Consent Agenda	Commissioner Anderson announced the following in consent agenda up for approval: 1. Review of Finance Minutes –March 19, 2025 2. Board Oversight Activities 3. Review Warrants & EFT's in the amount of $5,925,589 dated March 2025 Superintendent Mach noted Warrants & EFT's were higher due to three payrolls in the month of March and Optum take back. The Finance Committee supports the Warrants and EFT's and will recommend approval at the Board level in Consent Agenda.	Superintendent Mach made a motion to approve the consent agenda and Secretary McMahan seconded. The motion passed unanimously. The Finance Committee supported requesting the Board's approval of the Warrants & EFT's at the Regular Board Meeting in Consent Agenda.	Executive Assistant Stephens	04.30.25 Regular Board Meeting
Old Business • CFO Financial Review	Superintendent Mach highlighted net income $164,646 for month, $699,634 YTD. Operating Revenue & Expenses below budget. Benefits expense was less than budget and Supplies expense was over budget. Balance Sheet shows Cash on Hand is up from 38 to 42 days and Accounts Receivable is decreased from 58 to 54 days. Inpatient days are down. Swing bed is strong. Controller Scogin noted Accounts Payable being elevated YTD due to the disputed Optum payment of half a million dollars because of the Arbor Health (AH) Contract and Rates being loaded incorrectly by Optum.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	Commissioner Anderson asked for clarification on Right of Use Assets. Controller Scogin responded these are operating leases recognized as debt. Secretary McMahan noted the Legislative updates indicate hospitals cannot report bad debt to credit reporting agencies. Billing Office Manager Niedert expressed concern that there will be no incentive for patients to pay their medical bills, which may negatively impact the District. Secretary McMahan agrees this has strong potential to affect the District. Superintendent Mach stated both Multicare & Providence were supportive of the bill. Once the law is enacted with interpretation the District will operationalize. Community Member Fisher noted an increase in Bad Debt. Billing Office Manager Niedert will review. Secretary McMahan appreciated CMO Dr. McCurry's Letter to the Editor as an effort to mitigate this topic.	Billing Office Manager Niedert will investigate contributing factors to the increase in Bad Debt.	Billing Office Manager Niedert	05.21.25 Finance Committee Meeting
• WIPFLI Financial Audit	Superintendent Mach noted WipFli audit and cost report should be completed by April 29th to be presented at the May 28th Regular Board Meeting. Secretary McMahan inquired as to whether an audit is done at the same time as an CFO exits. Superintendent Mach noted there will not be an additional audit; however, a mid-year Cost Report is routine.			
New Business • 2024 Self Insured Health Insurance	Controller Scogin reported normal upward trends at yearend as deductibles are met, and individuals are using their health benefits.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Quarter 4 Overview				
• 2025 Self Insured Health Insurance Quarter 1 Overview	Controller Scogin reported YTD the self-funded plan is tracking. Stop Loss Insurance recovered monies from prior months. The Benefit Expense is incurred in the month and the offset at a later date.			
• CFO Replacement	Superintendent Mach reported that once WipFli completes the financial audit and cost report, the District will engage a remote CFO.	Invite Remote CFO to upcoming meetings.	Executive Assistant Stephens	Tentatively 05.21.25 or 06.18.25 Finance Committee Meeting
• ERC Funds	Superintendent Mach reported excellent news, the ERC Funds were approved at $1,820,781 minus administrative fees. Cash on Hand should increase significantly. Commissioner Anderson asked if the District expects more funds in the future. Superintendent Mach noted no further ERC funds expected.			
• Washington Distressed Hospital Grant	Superintendent Mach reported qualifying to reapply for the WA Distressed Hospital Grant due to having less than 60 days of Cash on Hand. The District applied for an estimated $750k in hopes of continuing to serve the Medicaid population and offsetting the shortfall.	.		
• Capital Review	Nothing to report.			
• Surplus or Dispose of Personal Property	Nothing to report.			
Appendix	Superintendent Mach reported mixed messages from the State and Federal agencies around Medicaid. It is a waiting game now for federal approval. Superintendent Mach shared AH is using TRC to help navigate through Payer-Provider relations. Commissioner Anderson noted education funding is behind budget.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	Superintendent Mach reported that Skillsets was recently implemented and is open to all employees for education opportunities. Employees were notified and provided log-in information at the end of March. Community Member Fisher inquired as to the status of MRI. Superintendent Mach reported the project fell through due to state approval and reviewing other options. Commissioner Anderson references rental expenses high on rental properties. Superintendent Mach reported normal maintenance expenses. Commissioner Anderson references revenue by payer type, high on self-pay. CNO/CQO van Duren commented that patients come in as self-pay but then later are assisted with obtaining coverage. Patient Access Manager Cramer commented that patients come in but do not meet medical necessity to stay here but cannot be placed in which case cannot bill insurance.			
Meeting Summary & Evaluation	Superintendent Mach noted good meeting, thanked Controller Scogin, Billing Office Manager Niedert and Patient Access Manager Cramer for assisting in the meeting. Secretary McMahan stated a good meeting and that the District is going through cooky times and appreciates the questions and input throughout the meeting. Community Member Fisher stated being pleased with the meeting and would like to see a breakdown on the bond and current liabilities. Billing Office Manager Niedert noted great meeting, appreciates	Add a long-term debt schedule to next month's meeting.	Controller Scogin	05.21.25 Finance Committee Meeting

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	everyone's input and will research bad debt increase. Patient Access Manager Cramer stated nothing to add and appreciates being involved in these meetings to learn more. CNO/CQO van Duren appreciates Superintendent Mach for taking care of the team and the financial health of the organization. ACNO Littlejohn is grateful to be participating and learning ways to contribute to the meetings.			
Adjournment	Commissioner Anderson adjourned the meeting at 12:48 pm.			

WARRANT & EFT LISTING NO. 2025-03

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:

Robert Mach, Superintendent/CEO

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

$5,925,589 this 30th day

of April 2025

Board Chair, Tom Herrin

Secretary, Wes McMahan

Commissioner, Craig Coppock

Commissioner, Van Anderson

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of $5,925,589 dated March 1, 2025 – March 31, 2025.

ARBOR HEALTH WARRANT REGISTER SUMMARY
March 31, 2025

Routine A/P Check Runs

Warrant Number	Date	Amount	Description
Summary	2/1/2025-2/28/2025	1,400,804	System Checks
Summary	2/1/2025-2/28/2025	4,025,126	EFT payments
Total - Umpqua Bank		$ 5,425,930	

Warrant Number	Date	Amount	Description
1247	03/15/25	276,256	IRS
1248	03/28/25	213,796	IRS
4866-4871	03/31/25	9,608	BBP Admin
Total - Security State Bank		$ 499,660	

Total Checks/Warrants	$5,925,589

Error Corrections - in Check Register - Voids

Warrant No.	Date Voided	Amount	Description
138108	03/21/2025	1,945.00	Dept of Health
		0.00	
Total - Voided Checks		$ 1,945	

Documents Awaiting Board Ratification 04.30.25		
	LCHD No. 1's Policies, Procedures & Plans:	**Departments:**
1	Critical Access, Quality, Patient Safety & Risk Evaluation	Quality
In order to access the above documents you will need to log into Lucidoc. Once you have logged into Lucidoc, on the top toolbar click "My Meetings" and select the upcoming Board meeting date that's highlighted in green to see the agenda with documents needing to be 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

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Help shape the future of local healthcare.

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Arbor Health

DocID:	15804
Revision:	5
Status:	Official
Department:	Governing Body
Manual(s):	

Policy : Code of Ethics

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board of Commissioners will adopt and comply with this Code of Ethics.

Procedure:

Introduction

This Board of Commissioners Code of Ethics (Code) has been adopted by the Board of Commissioners (Board) of Lewis County Public Hospital District No. 1, Arbor Health of Lewis County, Washington (District) to promote honest and ethical conduct and compliance with applicable laws, rules and regulations by the members of the Board (Commissioners).

Applicability

This Code applies to each Commissioner.

How to Use the Code

This Code is a general guide to the Board's standards of conduct and regulatory compliance. This Code is not intended to cover every issue or situation Commissioners may face in their official capacity. This Code does not replace other more detailed policies and procedures adopted by the District, including but not limited to the District's Bylaws, the Lewis County Hospital District No. 1 Code of Ethics (to the extent applicable to Commissioners), and specific directives adopted from time to time by the Board.

It is essential that Commissioners thoroughly review this Code and make a commitment to uphold its requirements. Failure to read and/or acknowledge this Code does not exempt a Commissioner from his or her responsibility to comply with this Code, applicable laws, rules and regulations, and District policies and procedures.

None of the principles and practices outlined in the Code is intended to restrict any Commissioner from exercising its constitutional rights of free speech and should not be so construed. Furthermore, the exercise of such rights shall not subject any Commissioner to any sanctions under this Code, even if such exercise is otherwise inconsistent with a stated principle or practice of appropriate ethical conduct.

The Board does not intend to adopt any rule in this Code that violates existing law. If, as a result of changes in the law or otherwise, any provision of the Code is subsequently determined to violate applicable law, such provision

shall be construed in such a way as to eliminate such violation and, if no such construction of the applicable provision is possible, the provision shall be void.

Fundamental Responsibilities of Commissioners

The fundamental responsibility of each Commissioner is to promote the best interests of the public by overseeing the management of the District's business and community operations. In doing so, each Commissioner shall act in accordance with this Code, the District's other policies and procedures, and applicable laws, rules and regulations, including, but not limited to, Washington state law and the District's Bylaws. The Commissioners acknowledge that the purpose of Chapter 70.44 RCW, pursuant to which the District was formed, is to authorize the establishment of public hospital districts to own and operate hospitals and other health care facilities and to provide hospital and other health care services for the residents of such districts and other persons. The discharge of this responsibility requires the District to operate its hospital and other health care facilities in a competitive manner. Were it not to do so, the District could not compete with other private and public health care providers for patients, medical staff, executives and other critical operational support and would cease to be an economically viable entity notwithstanding the public support provided through tax levies against real property located within the District's boundaries.

Principles and Practices

1. In the performance of their official duties, Commissioners shall act ethically, in good faith, with integrity, with care, and in a manner they reasonably believe to be in the best interests of the public that is served by the District.

2. Commissioners shall not allow outside activities or personal financial or other interests to influence or appear to influence their ability to make objective decisions with respect to the District.

3. Commissioners shall conduct their official and personal affairs in such a manner as to give the clear impression that they cannot be improperly influenced in the performance of their official duties.

4. Commissioners in discharging their duties to the District shall use their best efforts to comply with all applicable laws, rules and regulations of federal, state and local governments and other regulatory agencies.

5. Commissioners shall not be beneficially interested, directly or indirectly, in any contract or transaction which may be made by, through or under the supervision of such Commissioner, in whole or in part, or which may be made for the benefit of their office, or accept, directly or indirectly, any compensation, gratuity or reward in connection with such contract or transaction from any other person beneficially interested therein, except to the extent permitted under applicable law. Should a Commissioner have a beneficial interest in any contract or transaction proposed for the District, such beneficial interest shall be disclosed to the Board, before the Board authorizes the District to enter into such contract or transaction. The existence of such conflict of interest shall be reflected in the official minutes of the Board. Any Commissioner having such a conflict of interest shall not vote when the matter is presented to the Board for approval. Moreover, such Commissioner shall not influence or attempt to influence any other Commissioner to enter into a contract or transaction in which such Commissioner has a beneficial interest.

6. At the time of a Commissioner's election, a Commissioner shall disclose in writing to the Board all personal or professional relationships that create, or have the appearance of creating, a conflict of interest with the District. Should any such personal or professional relationships arise in the future, the Commissioner shall promptly disclose such relationships to the Board.

7. Commissioners shall not use their position to secure special privileges or exemptions for themselves or others.

8. Commissioners may not, directly or indirectly, give or receive or agree to give or receive any compensation, gift, reward, or gratuity from a third party for the Commissioners' services to the District or as to any contract or transaction between the District and any other party.

9. Commissioners shall not receive any compensation, remuneration, payments or distributions from the District for their services as Commissioners, except as and only to the extent permitted by applicable law.

10. Commissioners shall not accept employment or engage in any business or professional activity that could reasonably be expected to place them in a conflict of interest with the District or require or induce them, by reason of their new employment or engagement, to disclose confidential information acquired by the Commissioners by the reason of their office.

11. To the extent Commissioners obtain confidential information by reason of their office, they will not disclose such confidential information to others unless authorized to do so by the Board. For purposes of this paragraph "confidential information" means information that the Commissioners are required to treat as confidential under applicable law (whether such law is derived from statutes, regulations, case law, the District's charter documents, or otherwise). Information regarding the District not deemed confidential under applicable law may be shared by the Commissioners with others.

12. If Commissioners receive frequent inquiries from individuals or other persons requesting the disclosure of confidential information, Commissioners shall bring that information to the attention of the other Commissioners to allow the Board to determine if it wishes to adopt preventive measures to further protect the Board and District's legitimate interest in controlling access to its confidential information.

13. Commissioners shall not simultaneously hold any other incompatible office or position, including, but not limited to, another office or position whose functions are inconsistent with the functions of a Commissioner for the District, or where the occupation of such other office or position is detrimental to the public interest.

14. Commissioners shall comply with all of the District's policies and procedures, including those applicable to District employees and medical staff generally, to the extent applicable to their services as Commissioners.

15. The Superintendent is, by statute, the District's chief administrative officer and, in such capacity, is responsible for the administration of the District. Accordingly, if Commissioners receive questions or concerns from employees, from members of the medical staff, or from the public concerning District operations, they shall promptly notify the Superintendent and it shall be the responsibility of the Superintendent (or the Superintendent's designee) to respond on behalf of the District. Similarly, if third parties, such as third party payors, employee groups, real estate developers, or others, communicate with Commissioners regarding existing or proposed business or other relationships with the District, such matters shall promptly be referred to the Superintendent to take whatever action the Superintendent deems appropriate. The Superintendent shall be accountable to the full Board for follow-up on such items.

16. Commissioners shall fully cooperate with government investigators as required by applicable law. If a Commissioner encounters an investigator, or receives a subpoena, search warrant or other similar document, related to an investigation of the District, the Commissioner shall promptly give notice of such investigation to the Board.

17. Commissioners shall not destroy or alter any information or documents in anticipation of, or in response to, a request for documents by any applicable governmental agency or from a court of competent jurisdiction.

18. The Commissioners are expected to prepare for, participate in, and attend all Board meetings. They should commit the time necessary to review all Board materials. The same level of participation is expected with respect to all Board committees, if any, to which the Commissioners are assigned. For purposes of the foregoing, "attend" shall mean that the Commissioner arrives at the Board meeting (or, if applicable, the Board committee meeting) on time and stays until the conclusion of the meeting.

19. Commissioners are expected to engage in robust, active discussions of the issues submitted to the Board for consideration in order to arrive at the most carefully considered decisions for the District. With this in mind, Commissioners must study all relevant information (including materials in Board packages), articulate clearly their personal views, be prepared to argue for and support their positions, and, when appropriate, question and challenge the views of others. Such deliberations should be conducted in a respectful manner in line with customary standards of civility and decorum.

20. Commissioners when discussing District business, whether at Board meetings or elsewhere, are urged to adhere to the following standards: Commissioners should be respectful of the views of other Commissioners and executives, even if such views are contrary to the Commissioners' personal opinions; not divulge confidential information regarding the District's affairs; not purport to represent the views of the Board, unless authorized to do so by the Board; and not intentionally misrepresent, demean or belittle positions taken by other Commissioners or District executives and, where appropriate, take all reasonable steps to ensure that a balanced presentation of competing points of view is given so as to promote common understanding of (rather than to foster a spirit of divisiveness with respect to) the issues before the Board and the various competing points of view taken by other Commissioners and District executives. Nothing in this Code is intended to limit any Commissioner's constitutionally-protected rights of free speech, nor is this Code to be construed so as to impair the ability of Commissioners to participate in ceremonial, representational or informational functions in the pursuit of their official duties.

21. Commissioners are publicly-elected officials. As a consequence, if incumbent Commissioners choose to run for re-election, they will of necessity be involved in campaign-related activities during the tenure of their service on the Board. Nothing in this Code of Ethics is intended to deprive such individuals of, or to inhibit or limit the lawful exercise of, the right to engage in customary re-election activities, including but not limited to seeking and securing

endorsements, soliciting campaign contributions, distributing voter pamphlets and other campaign related materials, or making public appearances. They may solicit financial or other support for the community at large, hospital employees, medical staff members, nurses, and others, provided that the support comes from such persons when acting in their personal capacities, and not as representatives or employees of the District. All such support must be voluntary and may not be given or received with the expectation or understanding that the contributing individual will receive any consideration, privilege or benefit, directly or indirectly, from the District. Commissioners may not, claim, suggest or create the impression that their re-election is supported or endorsed by the District itself, nor may they use or gain access to the District financial resources to support their re-election campaign. They may however fully discharge their duties and responsibilities as Commissioners during the re-election campaign (as indeed they are obligated to do), and such activities are not wrongful.

22. Commissioners shall refrain from any illegal, unethical, or inappropriate conduct, whether or not specifically identified in this Code.

General Standards of Conduct

Commissioners' compliance with the principles and practices of this Code will be subject to the following guidelines:

1. Commissioners may not be considered in violation of the ethical guidelines of the Code as long as they have acted in good faith, and in a manner they believed to be consistent with their obligations under Code.

2. To the extent that Commissioners receive advice from the District's legal counsel (consisting of in-house counsel or legal counsel engaged by the District), Commissioners may rely upon such advice in discharging their duties to the District. If Commissioners have in good faith relied upon such advice in conducting the District's business, such reliance will constitute a defense to charges that actions based upon such reliance violated the provisions of the Code.

3. Absent evidence of bad faith, inadvertent violations of the Code that do not adversely affect the District in a material way and that do not create private benefits in favor of the Commissioner or related parties will not constitute grounds for disciplining a Commissioner.

Enforcement of Code

The Board is the body vested with the exclusive authority to enforce the provisions of the Code and to take disciplinary action against Commissioners for violations. As provided in Article VIII, the Board may, under certain circumstances, enlist the support of others to assist with fact finding and to make recommendations.

While members of the public may give the Board notice of alleged violations of the Code, they may not, except as qualified below, bring legal actions against Commissioners for alleged violations, whether such actions seek specific performance, damages or other forms of judicial relief. The Commissioners are not liable to members of the public for damages resulting for Code violations.

Notwithstanding the foregoing, if a Commissioner's misconduct constitutes official misconduct as to which a legal action may be brought by a member of the public, separate and apart from its constituting a violation of the Code, members of the public may pursue such matters, at law or in equity, in the same manner as they might otherwise have pursued such matters under then-existing law. Hence, as relates to members of the public, the Code does not, and is not intended to create, a basis for making claims or pursuing remedies that would not otherwise be available under existing law.

Reporting Procedures and Process

1. Any individual may advise the Board of an alleged violation of the Code by a Commissioner. To the extent feasible, any such notice should be given in writing and specify in reasonable detail the alleged misconduct.

2. The District will not take retribution or disciplinary action against any District employee who raises concerns or reports potential violations of the Code by a Commissioner, whether or not it is subsequently determined that there is a legal or factual basis to support such allegations. On the other hand, should members of the public allege official misconduct by Commissioners, and should such allegations not be supported either for factual or legal reasons, Commissioners may pursue such remedies as are available, at law or in equity, including but not limited to claims for libel or slander, against the parties wrongfully accusing the Commissioners of misconduct.

3. The Board shall review promptly, and in a prudent manner, allegations of Commissioner misconduct to determine whether there have been violations of the Code and what disciplinary action, if any, is appropriate. The processing of such allegations shall be under the direction of the Board Chair, acting with the advice of counsel, and being subject to the other guidelines provided for in this Article VIII. If the Board Chair is the subject of alleged misconduct, the responsibilities vested in the Board Chairman under the Code will pass to the next ranking officer (or, if none, the senior most member) of the Board who is not accused of the alleged Code violations.

4. The Board may, from time to time, adopt procedures for investigating, handling, and resolving allegations of misconduct, subject to adopting reasonable procedures for:

    a. gathering information regarding the alleged misconduct, including but not limited to, accepting written submissions, hearing testimony, conducting hearings, undertaking fact finding, and soliciting information from experts;

    b. the right of the accused to respond to the allegations and to be represented by counsel;

    c. the screening out of frivolous complaints; and

    d. the right of the public to observe such proceedings under the Open Public Meeting Act ("OPMA").

5. If the Board determines that a Commissioner has violated one or more of the provisions of the Code, the Board may give written or oral warnings, issue formal reprimands, publicly censure the Commissioner and/or relieve the commissioner of board committee assignments. Such disciplinary action shall be recorded in the minutes of the Board's meetings and, as directed by the Board, be published in local newspapers, the District's communications with residents, or through other media. In those instances where the misconduct is of a serious nature, the Board may, after receiving legal advice from counsel, initiate legal action in a court of competent jurisdiction to remove such Commissioner from office.

6. Subject to the following guidelines, the Board may appoint the Values, Ethics & Conflict of Interest committee to assist in fact-finding and/or making recommendations to the Board regarding allegations of Commissioner misconduct:

    a. It will be left to the discretion of the Board to determine whether such a panel should be convened and to determine the scope of the responsibility given to such panel. The Board shall consider all facts and circumstances in making such determinations, including but not limited to the seriousness of the allegations, the history of the alleged misconduct – whether constituting an isolated incident or pattern of misconduct, the publicity surrounding the activities, the level of public interest, and whether and to what extent the public's interest might be advanced by enlisting the support of others outside of the Board. The Board's determinations regarding such matters will be final and binding. It is not expected that such panels would be convened to handle frivolous complaints or allegations regarding inadvertent or minor violations of the Code.

    b. If the Board elects to solicit outside support in processing allegations of Code violations, the Board Chair, acting with the advice of legal counsel, shall appoint, on such basis as the Board Chair deems appropriate, the individuals to serve on the advisory panel, which participants may be drawn from public officials or members of the local business community (such as members of the chambers of commerce) from those municipalities whose geographic boundaries fall primarily within the boundaries of the District. The size of the panel will be determined by the Board Chair.

    c. The Board or, absent specific direction from the Board, the Board Chair will establish the specific fact-finding and advisory responsibilities of the panel.

    d. If such a panel is constituted, the panel's activities will be subject to the public access requirements of the OPMA, to the extent required by OPMA.

    e. The Board will, however, in all instances, retain ultimate decision making regarding whether the alleged misconduct constitutes a violation of the Code and whether and to what extent to take disciplinary action against any Commissioner found to be in violation of the Code.

7. To the extent that alleged misconduct constitutes a violation of law, separate and apart from a violation of the Code, such misconduct may be referred to the county prosecuting attorney for action.

Waiver

If a Commissioner believes that it is inappropriate to apply any of the provisions of this Code to such Commissioner, such Commissioner may submit to the Board a written request for a waiver from such provision. Such written request must be accompanied by a statement setting forth the reasons why the waiver should be granted under the circumstances. Such waiver shall be effective if approved by a majority vote of the Commissioners (excluding the requesting Commissioner). Furthermore, such waiver may be granted only if supported by legal advice from the District's in-house or outside legal advisors.

Review

The Board shall review this Code to ensure compliance with all applicable laws, rules and regulations, and to ensure that the Commissioners are held to the highest standards of conduct and ethics. In connection with such review, the Board should discuss what, if any, amendments or revisions are necessary to improve the effectiveness of this Code.

Amendments

This Code may be amended from time to time by the Board, if approved by a majority vote of all Commissioners, and any amendment must be disclosed as required by and in accordance with applicable laws, rules and regulations.

Affirmation

Each Commissioner is responsible for reviewing, understanding, acknowledging and personally upholding this Code and other policies and procedures. Each of the Commissioners shall certify that he or she has read, understands, is in compliance with and is not aware of any violations of this Code upon the initial adoption of this Code; upon the adoption of any amendments to this Code; upon a Commissioner's appointment, election or re-election to office; and at the beginning of each fiscal year. Each such certification shall be made by the execution of the Receipt and Acknowledgement attached hereto as Exhibit A.

EXHIBIT A

LEWIS COUNTY HOSPITAL DISTRICT NO. 1

Board of Commissioners Code of Ethics

Receipt and Acknowledgement

I understand that each Commissioner is responsible for reviewing, understanding, acknowledging and personally upholding the Board of Commissioners Code of Ethics (Code), and for familiarizing him or herself with the applicable detailed elements of other policies and procedures.

By executing this Receipt and Acknowledgement, I hereby acknowledge that:

1. I have received and read a copy of the Code;
2. I understand the contents of the Code;
3. I have familiarized myself with the applicable detailed elements of the Code of Ethics and other policies and procedures;
4. I affirm my commitment to and compliance with the standards and procedures set forth in the Code; and
5. I am not aware of any violations of the Code involving myself that occurred since the later of the adoption of the Code, the last time I executed and delivered a Receipt and Acknowledgement or the beginning of the last fiscal year that have not otherwise been reported in accordance with the procedures set forth in the Code.
6. I acknowledge that my execution of this Receipt and Acknowledgement has been requested by the Board of Commissioners as a part of the District's ongoing program to ensure compliance with the terms of the Code and that the District and the Board intended to rely upon the representations made herein.

Printed name: _____

Signature: _____

Date: _____

Document Owner:	Herrin, Tom
Collaborators:	
Approvals	
- Committees:	
- Signers:	
Original Effective Date:	07/17/2012
Revision Date:	[07/17/2012 Rev. 0], [07/17/2012 Rev. 1], [08/27/2015 Rev. 2], [08/27/2018 Rev. 3], [09/06/2019 Rev. 4], [01/19/2024 Rev. 5]
Review Date:	[11/08/2013 Rev. 1], [12/23/2014 Rev. 1], [06/20/2016 Rev. 2], [08/24/2017 Rev. 2], [07/21/2020 Rev. 4], [10/21/2022 Rev. 4]
Attachments: (REFERENCED BY THIS DOCUMENT)	
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	Compliance Plan

DocID:	16115
Revision:	6
Status:	Official
Department:	Human Resources
Manual(s):	Employee Reference Materials

Policy : Code of Conduct

Policy:

It is the policy of Lewis County Hospital District No. 1 (LCHD No. 1) to have each employee agree to abide by and sign the Code of Conduct Acknowledgement Form upon hire.

Mission

To foster trust and nurture a healthy community.

Vision

To provide every patient the best care and every employee the best place to work.

Core Values

One team, one mission.

Go out of your way, to brighten someone's day.

Own it, embrace it.

Care like crazy.

Motivate, elevate, appreciate.

Know the way, show the way, ease the way.

Find joy along the way.

PURPOSE OF CODE OF CONDUCT

LCHD No. 1 intends to maintain a patient care and business environment that is compliant with legal and regulatory requirements and that operates according to the highest ethical standards. We require members of LCHD No. 1's workforce to hold this same high standard as they care for patients and conduct their work activities at or for LCHD No. 1. This Code of Conduct sets out standards that have been adopted by LCHD No. 1, or that are established by laws and regulations that apply to LCHD No. 1. It has been designed to assure that every LCHD No. 1 workforce member will be aware of what is expected of them when they do their work. Many of the requirements summarized

in this Code of Conduct are addressed more fully in LCHD No. 1's policies, or in training and materials made available by the compliance program.

The standards discussed in this Code of Conduct apply to all of LCHD No. 1s workforce members, including LCHD No. 1's leaders, employees, medical staff members, credentialed practitioners, contracted service providers, volunteers and others who work at or for LCHD No. 1. Individuals subject to this Code of Conduct are required to:

1. Review the Code of Conduct.

2. Understand any Code requirements that impact their duties and responsibilities at LCHD No. 1

3. Conduct themselves in a manner that is consistent with standards and requirements outlined in this Code

4. Report any issues of suspected non-compliance with the Code of Conduct to their direct supervisor or the Compliance Officer so that the issues can be investigated and resolved

RESPONSIBILITY OF LEADERS

While all workforce members are obligated to follow the Code of Conduct, our leaders are charged with special responsibility. Our leaders are expected to model ethical and compliant behavior—to set an example that other workforce members can follow. LCHD No. 1 leaders are expected both to understand the Code requirements that apply in their areas of responsibility, and to know how to manage and lead so that LCHD No. 1's compliance and ethics goals are met. Leaders are expected to be kind, sensitive, thoughtful, and respectful, and to balance their other leadership responsibilities with LCHD No. 1's goals of ethical behavior and compliance with laws and regulations. It is part of their job to assure that ethical and compliant behavior is never sacrificed in the pursuit of other business objectives.

OUR CODE OF CONDUCT

LCHD No. 1 has adopted the following standards to further its purpose to conduct patient care and business activities in an ethical manner—one that is consistent with legal and regulatory requirements:

1. **PATIENT WELL BEING AND QUALITY OF CARE**

   a. We respect the dignity of each individual and will work to treat our patients and customers with consideration, courtesy and respect; to assure their comfort; and to recognize accept and respect their diversity.

   b. We will demonstrate sensitivity and responsiveness to our patients and their family members and domestic partners by listening attentively and patiently, and making an effort to fully understand and respond, as we are able, to their needs.

   c. We will inform patients about treatment alternatives and about the risks associated with each treatment.

   d. We will base care decisions on what is medically necessary and in the best interests of our patients.

   e. We will assure that patient care personnel are properly licensed, credentialed and experienced.

   f. We will support medical decision making by assuring that medical record documentation is legible, accurate, timely and complete, and will only amend or correct medical records in accordance with LCHD No. 1 policy.

   g. We will provide patients with the rights outlined in the conditions of participation for Medicare and Medicaid hospitals.

   h. We will work to create a care environment that supports patient safety and quality health care. Recognizing that errors and adverse events may occur, we will strive to create an atmosphere that encourages inquiry and appropriate disclosure, as well as one in which we learn, and apply lessons learned in developing systematic approaches to preventing error and harm.

   i. We will not distribute unauthorized materials and information, nor solicit our co-workers, customers or visitors for any purpose that has not been approved by LCHD No. 1.

2. EMTALA

a. We will provide a screening exam and stabilizing treatment to every person who comes to our LCHD No. 1 campus requesting examination and/or treatment for an emergency condition (including pregnant women who are in labor).

b. We will not delay a medical screening examination or stabilizing care in order to request patient financial information.

c. We will only transfer unstable emergency patients who request transfer or for whom we lack the capability or capacity to provide treatment, and only after we have provided necessary stabilizing care.

3. KICKBACK AND SELF-REFERRALS (STARK)

a. We will not offer, give, ask for, or accept anything that has economic value in exchange for referring, arranging for, purchasing or otherwise dealing in any items or services.

b. We will maintain our business and financial relationships with physicians in a manner that is consistent with the law.

4. GOVERNMENTAL LCHD NO. 1 REQUIREMENTS

a. We will conduct our activities for the benefit of our patients and of the communities that we serve. Our decisions will be based on what is good for LCHD No. 1 and will benefit our patients. Our business dealings will be conducted at arms-length.

b. We will not use LCHD No. 1 resources to support candidates for political office or to lobby for changes in the law.

c. We will not participate in political campaigns as representatives of LCHD No. 1, and will not make political contributions with LCHD No. 1 funds. We will not allow campaign activities for political candidates on LCHD No. 1 property.

5. BILLING AND CODING INTEGRITY

a. We will only bill insurers and government programs for items and services that have been properly ordered and have been provided to a patient, and that are supported by necessary medical record documentation. Items and service provided for patient convenience may be billed directly to the patient or customer if all required notices of non-coverage are provided as required by applicable law or regulation.

b. We will work to ensure that our billing and coding is accurate and in compliance with legal requirements.

c. We will promptly correct any discovered billing or coding error.

6. PRIVACY AND SECURITY OF INFORMATION

a. We will handle confidential information carefully, in accordance with legal requirements and LCHD No. 1 policies. We will only share such information with those who have a need and/or right to know.

b. We will treat confidential patient information with special care. We will only discuss or share protected patient information with those who have a right or need to know, only if necessary authorizations have been received, and only in a manner consistent with legal requirements. We will avoid discussing protected patient information in public areas.

7. CONFLICTS OF INTEREST

a. We will disclose any potential conflicts of interest as required by LCHD No. 1 policy, and will not participate in decision making when a conflict of interest exists.

b. We will not give or accept gifts or gratuities from business associates that might create an appearance of impropriety, or might improperly influence business decisions.

8. MAINTAINING A SAFE HEALTH CARE AND WORK ENVIRONMENT

a. We will not discriminate in hiring or employment matters against anyone on the basis of their race, color, national origin, sex, religion, age, sexual orientation, mental or physical disability, genetic information or veteran's status.

b. We will not engage in harassment of co-workers through unwelcome abusive or offensive conduct, whether verbal, physical or visual.

c. We will not use drugs or alcohol in an unauthorized or inappropriate manner in the workplace.

d. We will not engage in any violence or threats of violence in the workplace.

e. We will not use, carry, store or otherwise have in our possession any firearms or other weapons on LCHD No. 1 property.

f. We will not employ, grant privileges to or contract with persons or entities who we know are excluded from participating in Federal Health Care Programs, and will take prompt steps to suspend or terminate our relationship with any person or entity upon learning that they have been excluded.

9. RESEARCH

a. We will conduct all research activities in manner that is consistent with the highest ethical and moral standards, and in accordance with legal and regulatory requirements.

10. STEWARDSHIP OF LCHD NO. 1 PROPERTY AND INTERESTS

a. We are personally responsible and accountable for the proper expenditure of LCHD No. 1 funds, and the proper use of LCHD No. 1 property and equipment that is entrusted to us.

11. FINANCIAL REPORTING AND RECORD KEEPING

a. We will prepare and maintain all patients and business records and reports accurately and truthfully, following applicable standards for record keeping.

b. We will comply with financial reporting and accounting requirements that pertain to our business, including requirements pertaining to preparation and filing of cost reports with Medicare and other federal health care programs.

c. We will retain records for the periods required by law or LCHD No. 1 policy, and destroy records in a manner that ensures continued security of protected or confidential information.

12. REPORTING OBLIGATION AND NON-RETALIATION

a. We will report any concerns about possible non-compliance with this Code of Conduct, or with any LCHD No. 1 policy or legal or regulatory requirement that applies to LCHD No. 1, to a supervisor, to the Compliance Officer or to the compliance hotline.

b. We will not retaliate against anyone who in good faith reports a concern about possible non-compliance.

If you believe that you have seen or are aware of a situation that violates the requirements of this Code of Conduct, or of any policy or legal requirement, you are required by LCHD No. 1 policy and by this Code of Conduct to take appropriate steps to discuss or report your concern to LCHD No. 1 so that it can be investigated and, if necessary, appropriate steps can be taken to resolve it. You can meet your obligation to report in any of the following ways:

Discuss the concern with your immediate supervisor. When possible, the existing management structure and lines of authority should be utilized to resolve problems. Your supervisor, in turn, has an obligation to discuss possible serious compliance violations with LCHD No. 1's Compliance Officer.

Contact LCHD No. 1's Compliance Officer to discuss your concern. In some situations it may not be possible to discuss concerns directly with your supervisor—for instance, if a concern involves your supervisor it may not be comfortable or appropriate to discuss the concerns directly. It is always an appropriate alternative to contact LCHD No. 1's Compliance Officer to discuss your concerns. You may reach the Compliance Officer at 360-776-9853. Discussions with the Compliance Officer will be treated as confidential, and your identity will be protected to the extent allowed by law.

Call the compliance hotline. You can also use LCHD No. 1's compliance hotline to report your concern. The compliance hotline can be called toll free from anywhere in the United States at:**[866-474-2726]**. Reports to the hotline can be made anonymously and/or confidentially, and anonymity and/or confidentiality will be protected to the extent that the law allows.

13. LCHD NO. 1'S POLICY AGAINST RETALIATION

a. LCHD No. 1's policies prohibit retaliation against anyone who in good faith reports a concern about possible or actual non-compliance. Every report of retaliation by LCHD No. 1 workforce members will be promptly investigated and if the investigation results in a finding that retaliation did occur, will result in discipline up to and including termination of the retaliating individual's employment or other relationship with LCHD No. 1.

14. FEDERAL AND WASHINGTON STATE FALSE CLAIMS LAWS

a. A Federal law known as the False Claims Act (FCA) prohibits knowing submission of false or fraudulent claims for reimbursement by any Federal government program, including Federally funded healthcare programs like Medicare and Medicaid. A person or organization can "knowingly" submit a false claim by (1) having actual knowledge that the claim is false, (2) ignoring information that suggests that a claim is not accurate, or (3) acting recklessly or not taking due care to assure that a claim is accurate and appropriate.

b. The False Claims Act provides for significant fines and penalties when it is violated. Treble damages, or three times the amount of any improper payments that result, can be assessed. In addition, a fine of between $5,500 and $11,000 can be imposed for every false or fraudulent claim. The government also has authority to require Medicare providers to enter into Corporate Integrity Agreements or to exclude providers from participation in Federal health care programs. In severe cases criminal prosecution is also possible. These severe results—combined with the Hospital's desire to operate an ethical business environment—are among the reasons that we have a compliance program, have adopted this Code of Conduct, and require every work force member to report concerns about possible violations so that we can find and resolve problems early.

c. Washington's State laws provide similar penalties for filing false or fraudulent claims. The Medical Care Public Assistance Statute requires repayment of improper payments with interest, and provides for treble damages and criminal fines of $25,000 for every false or fraudulent claim that is willfully filed with the Washington State Public Assistance Program (RCW 74.09). Washington's Health Care False Claims Act (RCW 48.80) makes it a felony to knowingly present a false or fraudulent claim to any government or private health care payor.

d. In addition to the protections provided by LCHD No. 1's policy that prohibits retaliation for good faith reports about compliance concerns, both Federal and Washington State law provide protections against retaliation for individuals who report fraud in good faith to the government. The Federal False Claims Act also allows an individual (a "relator") to file a civil law suit on behalf of the government to recover amount paid because of False Claims, and to share in any recovery that is made for the government as a result of the law suit.

15. BIAS INCIDENTS

a. A bias incident involves any discriminatory act against an individual or a group based on their age, religion, disability (physical or mental), race, ethnicity, national origin, sex, gender, gender identity, sexual orientation, marital status, veteran status, socioeconomic status, or any other identity.

b. If you encounter or suspect incidents of bias, you are encouraged to submit a QMM or if you wish to remain anonymous the compliance hotline can also be used. All events will be reviewed and followed up on as appropriate.

CONCLUSION

This Code of Conduct is a tool designed to communicate standards that apply to patient care and business activities at LCHD No. 1. The Code is intended to assure that every LCHD No. 1 workforce member understands the standards and can help LCHD No. 1 meet its obligation to comply. It is intended to help create and support a culture where, when problems do arise, they are identified quickly and resolved. Every LCHD No. 1 workforce member has an important role to play.

If you have questions about the Code of Conduct and what it requires, please talk to your supervisor or to the Compliance Officer. If we work together, we can ensure that LCHD No. 1 and patient care environment continue to be a workplace of which we can all be proud.

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Other Documents: (WHICH REFERENCE THIS DOCUMENT)	Compliance Plan

Chapter 42.23 RCW
CODE OF ETHICS FOR MUNICIPAL OFFICERS—CONTRACT INTERESTS

Sections

42.23.010 Declaration of purpose.
42.23.020 Definitions.
42.23.030 Interest in contracts prohibited—Exceptions.
42.23.040 Remote interests.
42.23.050 Prohibited contracts void—Penalties for violation of chapter.
42.23.060 Local charter controls chapter.
42.23.070 Prohibited acts.
42.23.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Cities, free passes, services prohibited: RCW 35.17.150.

County officers, general provisions: Chapter 36.16 RCW.

Ethics in public service act: Chapter 42.52 RCW.

Public employment, civil service: Title 41 RCW.

State officers, general provisions: Chapter 43.01 RCW.

RCW 42.23.010 Declaration of purpose. It is the purpose and intent of this chapter to revise and make uniform the laws of this state concerning the transaction of business by municipal officers, as defined in chapter 268, Laws of 1961, in conflict with the proper performance of their duties in the public interest; and to promote the efficiency of local government by prohibiting certain instances and areas of conflict while at the same time sanctioning, under sufficient controls, certain other instances and areas of conflict wherein the private interest of the municipal officer is deemed to be only remote, to the end that, without sacrificing necessary public responsibility and enforceability in areas of significant and clearly conflicting interests, the selection of municipal officers may be made from a wider group of responsible citizens of the communities which they are called upon to serve. [1961 c 268 s 2.]

RCW 42.23.020 Definitions. For the purpose of chapter 268, Laws of 1961:

(1) "Municipality" shall include all counties, cities, towns, districts, and other municipal corporations and quasi municipal corporations organized under the laws of the state of Washington;

(2) "Municipal officer" and "officer" shall each include all elected and appointed officers of a municipality, together with all deputies and assistants of such an officer, and all persons exercising or undertaking to exercise any of the powers or functions of a municipal officer;

(3) "Contract" shall include any contract, sale, lease or purchase;

(4) "Contracting party" shall include any person, partnership, association, cooperative, corporation, or other business entity which is a party to a contract with a municipality. [1961 c 268 s 3.]

RCW 42.23.030 Interest in contracts prohibited—Exceptions. No municipal officer shall be beneficially interested, directly or indirectly, in any contract which may be made by, through or under the supervision of such officer, in whole or in part, or which may be made for the benefit of his or her office, or accept, directly or indirectly, any compensation, gratuity or reward in connection with such contract from any other person beneficially interested therein. This section shall not apply in the following cases:

(1) The furnishing of electrical, water or other utility services by a municipality engaged in the business of furnishing such services, at the same rates and on the same terms as are available to the public generally;

(2) The designation of public depositaries for municipal funds;

(3) The publication of legal notices required by law to be published by any municipality, upon competitive bidding or at rates not higher than prescribed by law for members of the general public;

(4) The designation of a school director as clerk or as both clerk and purchasing agent of a school district;

(5) The employment of any person by a municipality for unskilled day labor at wages not exceeding $1,000 in any calendar month. The exception provided in this subsection does not apply to a county with a population of 125,000 or more, a city with a population of more than 1,500, an irrigation district encompassing more than 50,000 acres, or a first-class school district;

(6)(a) The letting of any other contract in which the total amount received under the contract or contracts by the municipal officer or the municipal officer's business does not exceed $3,000 in any calendar month.

(b) However, in the case of a particular officer of a second-class city or town, or a noncharter optional code city, or a member of any county fair board in a county which has not established a county purchasing department pursuant to RCW 36.32.240, the total amount of such contract or contracts authorized in this subsection (6) may exceed $3,000 in any calendar month but shall not exceed $36,000 in any calendar year.

(c)(i) In the case of a particular officer of a rural public hospital district, as defined in RCW 70.44.460, the total amount of such contract or contracts authorized in this subsection (6) may exceed $1,500 in any calendar month, but shall not exceed $24,000 in any calendar year.

(ii) At the beginning of each calendar year, beginning with the 2006 calendar year, the legislative authority of the rural public hospital district shall increase the calendar year limitation described in this subsection (6)(c) by an amount equal to the dollar amount for the previous calendar year multiplied by the change in the consumer price index as of the close of the 12-month period ending December 31st of that previous calendar year. If the new dollar amount established under this subsection is not a multiple of $10, the increase shall be rounded to the next lowest multiple of $10. As used in this subsection, "consumer price index" means the consumer price index compiled by the bureau of labor statistics, United States

department of labor for the state of Washington. If the bureau of labor statistics develops more than one consumer price index for areas within the state, the index covering the greatest number of people, covering areas exclusively within the boundaries of the state, and including all items shall be used.

(d) The exceptions provided in this subsection (6) do not apply to:

(i) A sale or lease by the municipality as the seller or lessor;

(ii) The letting of any contract by a county with a population of 125,000 or more, a city with a population of 5,000 or more, or an irrigation district encompassing more than 50,000 acres; or

(iii) Contracts for legal services, except for reimbursement of expenditures.

(e) The municipality shall maintain a list of all contracts that are awarded under this subsection (6). The list must be made available for public inspection and copying;

(7) The leasing by a port district as lessor of port district property to a municipal officer or to a contracting party in which a municipal officer may be beneficially interested, if in addition to all other legal requirements, a board of three disinterested appraisers and the superior court in the county where the property is situated finds that all terms and conditions of such lease are fair to the port district and are in the public interest. The appraisers must be appointed from members of the American Institute of Real Estate Appraisers by the presiding judge of the superior court;

(8) The letting of any employment contract for the driving of a school bus in a second-class school district if the terms of such contract are commensurate with the pay plan or collective bargaining agreement operating in the district;

(9) The letting of an employment contract as a substitute teacher or substitute educational aide to an officer of a second-class school district that has 300 or fewer full-time equivalent students, if the terms of the contract are commensurate with the pay plan or collective bargaining agreement operating in the district and the board of directors has found, consistent with the written policy under RCW 28A.330.240, that there is a shortage of substitute teachers in the school district;

(10) The letting of any employment contract to the spouse of an officer of a school district, when such contract is solely for employment as a substitute teacher for the school district. This exception applies only if the terms of the contract are commensurate with the pay plan or collective bargaining agreement applicable to all district employees and the board of directors has found, consistent with the written policy under RCW 28A.330.240, that there is a shortage of substitute teachers in the school district;

(11) The letting of any employment contract to the spouse of an officer of a school district if the spouse was under contract as a certificated or classified employee with the school district before the date in which the officer assumes office and the terms of the contract are commensurate with the pay plan or collective bargaining agreement operating in the district. However, in a second-class school district that has less than 200 full-time equivalent students enrolled at the start of the school year as defined in RCW 28A.150.203, the spouse is not required to be under contract as a certificated or classified employee before the date on which the officer assumes office;

(12) The authorization, approval, or ratification of any employment contract with the spouse of a public hospital district commissioner if: (a) The spouse was employed by the public hospital district before the date the commissioner was initially elected; (b) the terms of the contract are commensurate with the pay plan or collective bargaining agreement operating in the district for similar employees; (c) the interest of the commissioner is disclosed to the board of commissioners and noted in the official minutes or similar records of the public hospital district prior to the letting or continuation of the contract; and (d) and the commissioner does not vote on the authorization, approval, or ratification of the contract or any conditions in the contract.

A municipal officer may not vote in the authorization, approval, or ratification of a contract in which he or she is beneficially interested even though one of the exemptions allowing the awarding of such a contract applies. The interest of the municipal officer must be disclosed to the governing body of the municipality and noted in the official minutes or similar records of the municipality before the formation of the contract. [2023 c 153 s 1; 2020 c 69 s 1; 2007 c 298 s 1; 2006 c 121 s 1; 2005 c 114 s 1; 1999 c 261 s 2; 1997 c 98 s 1; 1996 c 246 s 1. Prior: 1994 c 81 s 77; 1994 c 20 s 1; 1993 c 308 s 1; 1991 c 363 s 120; 1990 c 33 s 573; 1989 c 263 s 1; 1983 1st ex.s. c 44 s 1; prior: 1980 c 39 s 1; 1979 ex.s. c 4 s 1; 1971 ex.s. c 242 s 1; 1961 c 268 s 4.]

Findings—Intent—1999 c 261: "The legislature finds that:

(1) The current statutes pertaining to municipal officers' beneficial interest in contracts are quite confusing and have resulted in some inadvertent violations of the law.

(2) The dollar thresholds for many of the exemptions have not been changed in over thirty-five years, and the restrictions apply to the total amount of the contract instead of the portion of the contract that pertains to the business operated by the municipal officer.

(3) The confusion existing over these current statutes discourages some municipalities from accessing some efficiencies available to them.

Therefore, it is the intent of the legislature to clarify the statutes pertaining to municipal officers and contracts and to enact reasonable protections against inappropriate conflicts of interest." [1999 c 261 s 1.]

Purpose—Captions not law—1991 c 363: See notes following RCW 2.32.180.

Purpose—Statutory references—Severability—1990 c 33: See RCW 28A.900.100 through 28A.900.102.

Severability—1989 c 263: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1989 c 263 s 3.]

Severability—1980 c 39: "If any provision of this amendatory act or its application to any person or circumstance is held invalid, the

remainder of the act or the application of the provision to other persons or circumstances is not affected." [1980 c 39 s 3.]

RCW 42.23.040 Remote interests. A municipal officer is not interested in a contract, within the meaning of RCW 42.23.030, if the officer has only a remote interest in the contract and the extent of the interest is disclosed to the governing body of the municipality of which the officer is an officer and noted in the official minutes or similar records of the municipality prior to the formation of the contract, and thereafter the governing body authorizes, approves, or ratifies the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote or votes of the officer having the remote interest. As used in this section "remote interest" means:

(1) That of a nonsalaried officer of a nonprofit corporation;

(2) That of an employee or agent of a contracting party where the compensation of such employee or agent consists entirely of fixed wages or salary;

(3) That of a landlord or tenant of a contracting party;

(4) That of a holder of less than one percent of the shares of a corporation or cooperative which is a contracting party.

None of the provisions of this section are applicable to any officer interested in a contract, even if the officer's interest is only remote, if the officer influences or attempts to influence any other officer of the municipality of which he or she is an officer to enter into the contract. [1999 c 261 s 3; 1961 c 268 s 5.]

Findings—Intent—1999 c 261: See note following RCW 42.23.030.

RCW 42.23.050 Prohibited contracts void—Penalties for violation of chapter. Any contract made in violation of the provisions of this chapter is void and the performance thereof, in full or in part, by a contracting party shall not be the basis of any claim against the municipality. Any officer violating the provisions of this chapter is liable to the municipality of which he or she is an officer for a penalty in the amount of five hundred dollars, in addition to such other civil or criminal liability or penalty as may otherwise be imposed upon the officer by law.

In addition to all other penalties, civil or criminal, the violation by any officer of the provisions of this chapter may be grounds for forfeiture of his or her office. [1999 c 261 s 4; 1961 c 268 s 6.]

Findings—Intent—1999 c 261: See note following RCW 42.23.030.

RCW 42.23.060 Local charter controls chapter. If any provision of this chapter conflicts with any provision of a city or county charter, or with any provision of a city-county charter, the charter shall control if it contains stricter requirements than this chapter. The provisions of this chapter shall be considered as minimum standards to be enforced by municipalities. [1999 c 261 s 5; 1961 c 268 s 16.]

Findings—Intent—1999 c 261: See note following RCW 42.23.030.

RCW 42.23.070 Prohibited acts. (1) No municipal officer may use his or her position to secure special privileges or exemptions for himself, herself, or others.

(2) No municipal officer may, directly or indirectly, give or receive or agree to receive any compensation, gift, reward, or gratuity from a source except the employing municipality, for a matter connected with or related to the officer's services as such an officer unless otherwise provided for by law.

(3) No municipal officer may accept employment or engage in business or professional activity that the officer might reasonably expect would require or induce him or her by reason of his or her official position to disclose confidential information acquired by reason of his or her official position.

(4) No municipal officer may disclose confidential information gained by reason of the officer's position, nor may the officer otherwise use such information for his or her personal gain or benefit. [1994 c 154 s 121.]

Effective date—1994 c 154: See RCW 42.52.904.

RCW 42.23.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 s 104.]

Arbor Health

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Packwood Clinic
13051 US HWY 12
360-496-3777

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

Dear community member,

Have you ever considered serving your community through public office? Now might be the perfect opportunity. Lewis County Hospital District No. 1, dba Arbor Health, has two hospital commissioner positions up for election. One position is open to Morton residents while the other, an at-large position, is open to any registered voter who resides within the hospital district boundaries.

If you have an interest in either position, you must declare your intent between May 5 through May 9 to become a candidate. For more information on the procedure for filing and a map of the hospital district, visit https://elections.lewiscountywa.gov/candidate-filing-information/ .

The hospital commissioner role

A hospital commissioner is a county-elected position with a six-year term. The position involves governance oversight of the hospital policies and standards. The commissioners review, discuss and collaborate with the Superintendent/Chief Executive Officer on the strategic direction of the Hospital District.

The Board of Commissioners conduct hospital district business monthly in meetings that are open to the public. Each commissioner also participates in two committees that meet either monthly or quarterly. While a background in management, business, finance or healthcare can be a benefit to a commissioner, it is not in any way required. Commissioner training and education is encouraged and provided for all board members. In fact, the Washington State Hospital Association (WSHA) supports new commissioners in understanding their governance role. WSHA sponsors educational opportunities, meetings and conferences throughout the year to give commissioners the opportunity for on-going education. The Association of Washington Public Hospital Districts (AWPHD) offers Commissioner Resources as well, visit Commissioner Resources | Association of Washington Public Hospital Districts.

By being a hospital commissioner, you can serve your community and help ensure that quality healthcare remains available to East Lewis County residents. While the commissioner position is not a paid position, stipends are available for meetings and education. Also, another benefit available to elected commissioners is the opportunity for healthcare insurance. To find out more about the insurance and stipends, contact Arbor Health Administration at 360-496-3770.

We encourage you to step up to this challenge.

Lewis County Hospital District No. 1
Job Description

Position: Board Commissioner (Elected)
Term: 6 Years

Primary Responsibility:

1. Commissioners are responsible for over-seeing the Hospital District's policies and organization with respect to the operation of the District, including the delivery of quality patient care. In fulfilling its obligation, the Board's role is to adopt the necessary general policies to achieve those ends and to delegate the day-to-day operational responsibility with respect to those policies to the Superintendent. Commissioners accomplish this purpose by majority vote. An individual commissioner is currently one-fifth of this body that has been given the above commission.

Expectations:

1. Have the motivation and ability to meet the time requirements associated with board membership;
2. Not serve as the advocate of narrow interests or interest groups;
3. Possess a high level of personal and professional integrity;
4. Actively participate in discussions/deliberations;
5. Support board policies and decisions once they are formulated even after voting against them.
6. Be willing to serve in a leadership role (as the board chair, board secretary or a committee chair);
7. Follow through on commitments to the district, the board, and other commissioners;
8. Be aware of potential legal liabilities associated with serving as a commissioner (Fiduciary duties);
9. Have no general conflicts of interest that would affect the ability to decide/act in the best interest of the organization or its owners;
10. Observe commission confidentiality;
11. Understand and be willing to advance organization's vision and key goals;
12. Attend and actively participate in board education/development programs;
13. Guard against diminishing the district's resources, either physical or medical, except as a last resort;
14. If unwilling/unable to fulfill these expectations, a commissioner should consider resigning. (The Commission, however, recognizes not only the high cost of training a person but also the fact that a myriad of dysfunctions can temporarily affect human beings. Resignation, therefore, is not encouraged except when no other avenue remains open. The Commission respects and deeply appreciates the efforts of all its members.)

Objectives:

1. To survey the hospital services and other health care facilities within and without our district with the goal of providing comprehensive services;
2. To construct, maintain and operate the hospital and other facilities;
3. To own or lease hospitals and other health care facilities and equipment which are located inside or outside of the boundaries of said district as commissioners shall deem proper for the benefit of the district;
4. To contract indebtedness or borrow money for corporate purposes that the district is authorized by law to provide;
5. To raise revenue by the levy of an annual tax on all taxable property within the district;
6. To enter contract to carry out any of the powers authorized by law;
7. To pay actual necessary travel expenses and living expenses incurred while in travel status for (a) qualified physicians or other health care practitioners (b) other qualified persons who are candidates for superintendent or other managerial and technical positions;
8. To employ superintendents, attorneys, and other technical or professional assistants and all other employees;
9. To make all contracts useful or necessary to carry out the lawful authority given to the district.

*For a complete list on Public Hospital Districts see Chapter 70.44 RCW.

Hospital District #1:
Commissioner Districts & Precincts with Population

Lewis County, Washington

2020 census data used to calculate population totals.
Silver Creek Precinct is only partly in Hospital District #1 with no appreciable population in the District.
A small part of Harmony Precinct with no appreciable population is outside of the District. Temple and Verndale precincts are split by the boundary between Commissioner Districts 1 & 3.

Projection: Lambert Conformal Conic
Datum: 1983 North American Datum
State Plane South Zone

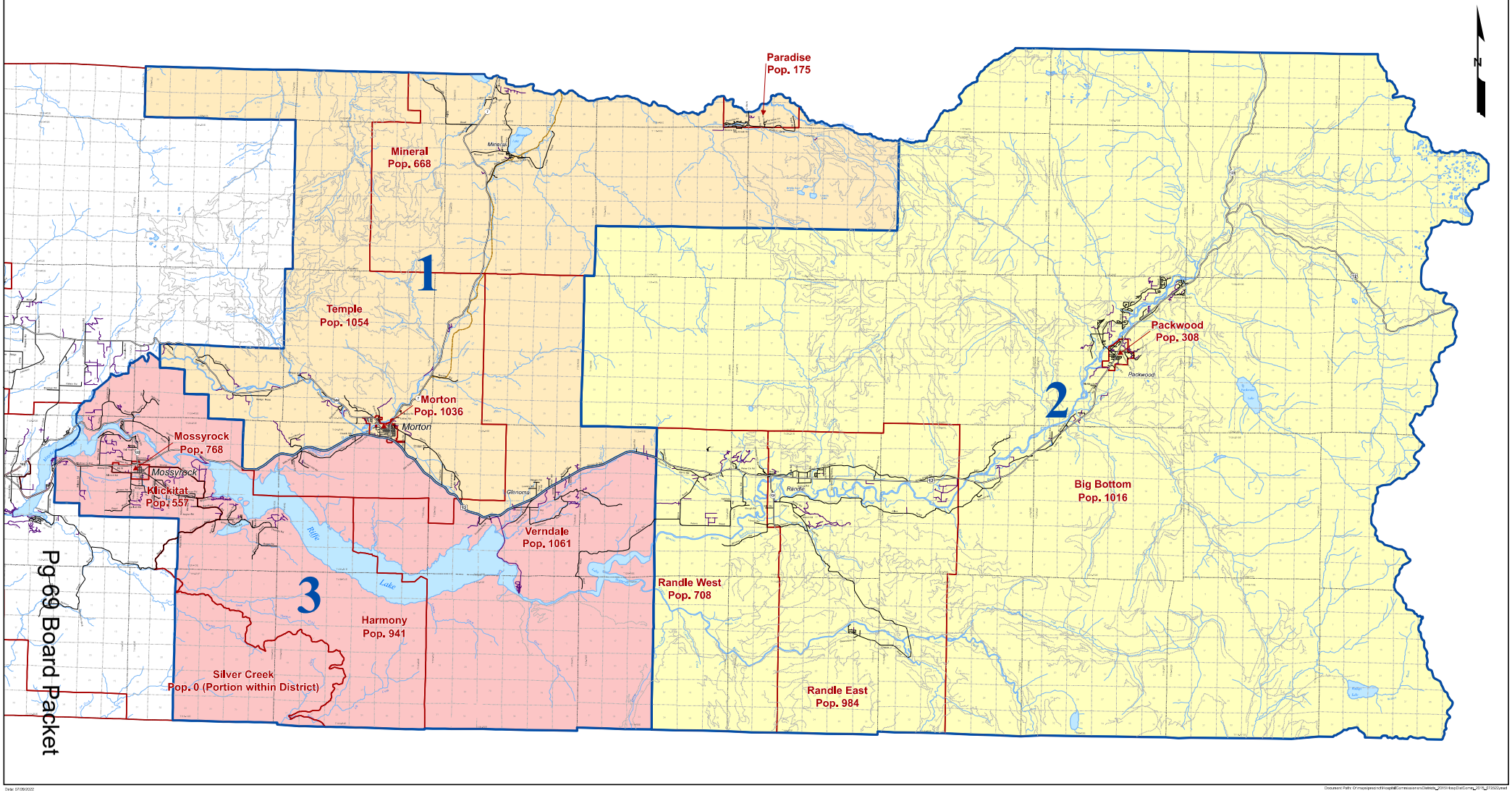
Hospital District #1

Commissioner District 1 Population = 3,148

Commissioner District 2 Population = 3,016

Commissioner District 3 Population = 3,112

Total Population = 9,276



MRSC
Empowering local governments

Running for Local Elected Office

This page provides an overview of the process for seeking local elected office in Washington State, including required qualifications, the filing process, primary and general elections, financial disclosures, political advertisements, and more.

IMPORTANT: Filing week has changed! Beginning in 2024, the candidate filing period has been moved up about one week and now starts the first Monday in May (see RCW 29A.24.050). The candidate filing week for 2025 will be May 5-9.

What this page covers: This page focuses on running for local governing body or executive positions such as city councilmember, mayor, county commissioner, county auditor, sheriff, fire district commissioner, school board director, etc.

What this page does *not* cover: This page does not address unique requirements to run for judicial offices or temporary elected positions such as political party precinct officers or charter review board members.

It also does not address elections in conservation districts, districts that require property ownership to vote (such as irrigation districts, diking/drainage districts, or weed control districts), or proposed new districts/new cities.

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Overview

There are thousands of local government elected positions in Washington State encompassing a wide range of functions and job duties in cities, towns, counties, and many types of special purpose districts. These elected positions are crucial to providing leadership and oversight for local governments, and any qualified individual can run for these offices.

Below is a summary of the various types of elected positions.

Cities and Towns

Washington has 281 cities and towns, all of which have a specific classification (first class, second class, code city, town, or unclassified) and form of government (mayor-council or council-manager) under state law.

All cities and towns are governed by an elected city council. In mayor-council cities and towns, voters also elect a mayor who serves as the city's chief administrative officer. Council-manager cities, on the other hand, designate one councilmember to serve as a ceremonial mayor – usually selected by the other councilmembers – and hire a professional city manager.

To see the classification and form of government of any city or town, refer to MRSC's Washington City and Town Profiles.

City and town officials are generally elected in odd-numbered years (RCW 29A.04.330). All city and town offices are nonpartisan (RCW 29A.52.231), meaning no party affiliations will be listed on the ballot. A "full" or "regular" term for most city officials is four years.

> **Charter cities:** There are 10 first class cities – Aberdeen, Bellingham, Bremerton, Everett, Richland, Seattle, Spokane, Tacoma, Vancouver, and Yakima – and one home rule charter code city (Kelso) that may have slightly different election provisions.
>
> In addition, one unclassified city (Waitsburg) continues to operate under its original territorial charter and conducts its own independent elections. In these cities, be sure to consult the election provisions in the city charter.

Counties

There are 39 counties in Washington, most of which are governed by an elected board of county commissioners. Several home rule charter counties have county councils instead.

Each county also has a number of other independently elected county positions, typically including an assessor, auditor, county clerk (superior court), prosecuting attorney, sheriff, treasurer, and sometimes a coroner. For more information on these different offices and their general duties, see our page County Elected and Appointed Officials.

Unlike cities, towns, and special purpose districts, most county offices are partisan, meaning that each candidate will self-identify a party affiliation that will be listed on the ballot (RCW 29A.04.110). However, the candidate does not have to be endorsed by the party or have any formal affiliation with a party, and candidates may also choose to express no party preference.

Most county officials are elected during even-numbered years (see RCW 29A.04.321 and RCW 36.16.010), except for certain home rule counties or filling certain unexpired terms resulting from a vacancy. A "full" or "regular" term for county officials is typically four years (see RCW 36.16.020 and RCW 36.32.030).

> **Home rule charter counties:** There are seven home rule charter counties – Clallam, Clark, King, Pierce, San Juan, Snohomish, and Whatcom – that may be governed by a county council instead of a board of commissioners and have adopted somewhat different election provisions by charter, such as designating additional elected positions, making certain offices nonpartisan, or holding regular elections in odd-numbered years. In these counties, be sure to consult the election provisions in the county charter.

"Special Purpose Districts" – Fire Districts, Ports, Public Hospitals, Schools, Utility Districts, Etc.

In addition to Washington's cities, towns, and counties, there are hundreds of special purpose districts that perform specialized functions.

"Special purpose district" is a generic term that broadly encompasses many different government types. While there are varying definitions, MRSC uses the term broadly to refer to any local government that is not a city, town, or county. This includes:

- Cemetery districts
- Fire protection districts and regional fire authorities
- Park and recreation districts
- Port districts
- Public hospital districts (PHDs)
- Public utility districts (PUDs)
- School districts
- Water-sewer districts
- And many others

Most of these special purpose districts are governed by elected commissioners or directors, although some districts (such as library districts or transit districts) are governed by appointed officials or trustees instead.

Most special purpose district officials are elected in odd-numbered years (RCW 29A.04.330), although there are exceptions for districts where property ownership is required to vote as well as PUDs and conservation districts.

All special purpose district offices are nonpartisan, meaning no party affiliations will be listed on the ballot (RCW 29A.52.231). The length of a "full" or "regular" term for special purpose district officials is typically four or six years, depending on the agency type.

> **Unique provisions:** There are unique election provisions for conservation districts (chapter 89.08 RCW) and districts requiring property ownership to vote, such as irrigation districts (chapter 87.03 RCW), various diking, drainage, or flood control "special districts" (Title 85 RCW), or weed control districts (chapter 17.04 RCW). These unique provisions are not discussed on this page, so consult the relevant laws for those jurisdiction types.

Who Can Run for Office?

In order to hold *any* elective public office in Washington State, a person must meet the qualifications in RCW 42.04.020 and RCW 29A.24.075 and be an "elector" (as defined in the Washington State Constitution, Article VI, Section 1) of the city, county, or special purpose district in which they are running for office.

To summarize these various requirements: at the time a candidate *files their declaration of candidacy with the county elections office* – typically in early May – the candidate must:

- Be a United States citizen,
- Be 18 years of age or older,
- Be a registered voter within the jurisdiction/district they seek to represent (all candidates should make sure their voter registration information is up-to-date),
- Be a resident of the state, county, and precinct for at least 30 days before they file the declaration of candidacy, and
- Not be currently incarcerated for a felony (see below).

Some offices may have additional requirements in state law or local charter, so consult your local government and county elections office to confirm the requirements.

For instance, in optional municipal code cities, each candidate must be a city resident for at least one year to hold office. See RCW 35A.12.030 (mayor-council code cities) and RCW 35A.13.020 (council-manager code cities). MRSC takes the position that this means one year before the date of the general election. See, generally, *In re Contested Election of Schoessler*, 140 Wn.2d 368 (2000).

Meanwhile, any candidate for the position of county prosecuting attorney must also be admitted as an attorney in the State of Washington (see RCW 36.27.010).

Felony Convictions

If a person has been *disqualified from voting* due to a felony conviction, they are not eligible to run for office. See the Washington State Constitution Article VI, Section 1 and Section 3.

Specifically, this applies to all persons convicted of an "infamous crime" as defined in RCW 29A.04.079, which means "a crime punishable by death in the state penitentiary or imprisonment in a state or federal correctional facility," but not including adjudication in juvenile court or convictions for misdemeanors or gross misdemeanors.

However, a convicted felon's voting rights are automatically restored once the person is no longer incarcerated. See RCW 29A.08.520.

To summarize, convicted felons may *not* run for office while they are incarcerated for a felony, but they *may* run for office once they are no longer incarcerated for the felony.

However, an elected official must forfeit their office if they are convicted of a felony *while in office*. See RCW 42.12.010(5).

Which Offices Are Up for Election?

At least two weeks before the candidate filing period each year, and often significantly earlier, each county elections office will post a list of all positions that are scheduled to be voted upon this year (see WAC 434-215-005).

For each position, these postings typically include the name of the incumbent, the term length and type, whether the position is partisan or nonpartisan, and any associated filing fee.

Term Length and Type

It is important to understand the different term lengths and types (see RCW 29A.24.020) for positions that will be on the ballot for each election:

- **"Regular" or "full" term:** This is a regularly scheduled election and the normal length of time an elected official serves in the office. For city and county positions, this is typically four years. However, there are a few positions with shorter terms – for instance, some elected positions in certain first class cities (according to city charter) and council position seven in second-class cities (see RCW 35.23.051). For special purpose districts, the regular term length is typically four or six years depending on the agency type and applicable state laws.
- **"Unexpired" term:** This means the office was *not* originally scheduled to be on the ballot this year, but the person who was elected to the position left before the end of their regular term, creating a vacancy. While the position may have been temporarily filled by appointment, it must appear again on the general election ballot and the winner will serve the remainder of the original full term. As a result, this "unexpired" term will be shorter than the regular/full term.
- **"Short and full" term:** This means that the office *was* originally scheduled to be on the ballot this year, but the person who was elected to the position left before the end of their regular term, creating a vacancy. While the position may have been temporarily filled by appointment, it will appear on the general election ballot as originally scheduled. The winner will technically serve two terms – a "short" term that starts immediately after the election certification and ends December 31, and then the subsequent "full" term starting on January 1. See RCW 29A.04.169.

Term limits: There are no term limits in state law for local elected officials, and many local governments lack the legal authority to impose term limits. However, some charter cities, charter counties, or optional municipal code cities do have the authority to voluntarily adopt term limits (see AGO 1991 No. 22), so elected officials within such jurisdictions should consult their local rules.

Elected Official Salaries

Many elected officials are eligible to receive some sort of salary or compensation for their service, but the amounts vary depending on the type of agency, the applicable state laws, and local policies.

Some officials are paid a fixed salary regardless of the number of hours or days worked, while others are paid on a per diem or per-meeting basis, and some are not paid anything other than expense reimbursements. County officials are generally paid more than city or special purpose district officials. Elected officials also *might* be eligible to receive benefits in certain cases.

For more information on this topic, see our page on Salaries, Compensation, and Benefits for Local Elected Officials.

Holding Multiple Government Offices

Washington does not have a "resign to run" law, so any current government employee or official can run for local elected office as long as they are otherwise eligible to hold office.

However, if a candidate who already holds another office wins the election, there are potential conflicts of interest that might require the individual to give up one of their positions.

State law prohibits holding certain positions simultaneously. For instance, a public hospital district commissioner cannot also be an employee of the same public hospital district (RCW 70.44.040(3)). In this example, the hospital employee could *run* for the position of hospital commissioner while still on staff, but if the employee *won* the election they would have to resign their staff position to assume the elected office.

There are similar prohibitions, with limited exceptions, for optional municipal code cities – see RCW 35A.12.030 for mayor-council code cities and RCW 35A.13.020 for council-manager code cities.

Other statutes or local charters/codes may provide additional restrictions on dual office-holding, so always consult the state laws and local rules applicable to your jurisdiction(s).

In addition, the common law (court-made) doctrine of incompatible offices says that the same person may not hold two or more "public offices" simultaneously if those offices would be considered "incompatible" with one another – for instance, if one position is subordinate to the other or if there

would be a conflict of interest between the two positions. For more information on this topic, see our page on Incompatible Offices.

Even if the offices are compatible, there could be potential financial conflicts of interest – for instance, if the official is in a position to vote on a collective bargaining agreement that would cover their position as a paid employee. There could also be blurred lines of authority if, for instance, a city employee who reports to an elected mayor was elected to city council. The jurisdiction's attorney may need to provide legal advice depending on the facts of the situation.

> **Appearing On the Same Ballot More than Once.** A candidate's name may not appear more than once on the same ballot (RCW 29A.36.201). If a candidate is interested in two offices that would both be on the same ballot, the candidate must choose just one of those positions to file for and run for that office. The only exceptions are for precinct committee officers or temporary elected positions such as charter review board members or freeholders.

Prohibited Use of Public Facilities

Current government officials or employees who are running for office or seeking reelection must be careful to keep their election activities separate from their work activities and may not use "public facilities" (such as a work computer, printer, vehicle, or company time) to support their election campaign.

For more information, see our page on Use of Public Facilities in Election Campaigns.

Conflicts of Interest

State law prohibits local elected officials from having financial conflicts of interest, with limited exceptions.

For instance, an elected official on a governing body (city council, board of commissioners/directors, etc.) generally may not have a financial interest in a contract with their own agency, since the governing body has the authority to approve such contracts and the official has a personal financial stake in the decision. This applies to collective bargaining agreements as well as private contracts.

Violations can result in civil penalties, voiding of a contract, and possible forfeiture of office.

Even if the official does not vote on the contract or has recused themselves, a conflict of interest still exists. Unless there is a qualifying exception, the only ways to avoid the conflict of interest are either to resign from office and proceed with the contract on a private basis, or to remain in office but forgo the contract.

Some agencies have also adopted their own local codes of ethics that are stricter than state law.

Any candidate who has a financial interest in a contract with a local government, has a spouse or dependent with a financial interest in such a contract, or who might be interested in such a contract in the future, should review the relevant laws/policies and carefully consider the impact of the conflict before seeking office within that government.

For more information on these topics, see our pages on Ethics and Conflicts of Interest and Local Codes of Ethics.

Filing the Declaration of Candidacy

To run for office, an individual must file a declaration of candidacy with the county filing officer during the filing period and submit the required filing fee or petition, if applicable.

The filing officer is typically the county auditor or, for some counties, the head of the elections office; for simplicity's sake, we will refer to the filing officers and their departments as the "county elections office."

> **Important:** A summary of the filing process is below, but always refer to the candidate filing guide produced by your county elections office which will contain the specific requirements for your county.
>
> Candidates might be required to file with the state Public Disclosure Commission (PDC), as described later, *before* filing the declaration of candidacy with the county elections office if they have already publicly stated that they are running for office or engaged in certain other campaign-related activities.

Regular Filing Period and Declaration of Candidacy

The regular candidate filing period lasts for five days, beginning at 8:00 AM the first Monday in May and ending at 5:00 PM on Friday of the same week (RCW 29A.24.050).

Each candidate must complete the declaration of candidacy form (RCW 29A.24.031) provided by their county elections office. Candidate filings are typically submitted online, but they may also be submitted in-person (see RCW 29A.24.040) or by mail (RCW 29A.24.081).

Each candidate will also be asked, either during the filing process or shortly thereafter, to provide information for the local voters' pamphlets that will be mailed to voters shortly before the primary and general elections – such as a brief biography, candidate statement, and photo. See RCW 29A.32.241-.250. The deadline for candidate submissions is typically right after the filing deadline. Candidates are strongly encouraged to submit this information as it provides a chance for voters to get to know them better and make an informed decision.

> **Candidate names and nicknames.** For their first name, a candidate is allowed to use a nickname by which they are commonly known, but the last name must be the last name under which the candidate is registered to vote. Candidates may *not* include a nickname designed intentionally to mislead voters, and they may *not* include a nickname that indicates a present or past occupation/military rank, a position on a policy issue, or the candidate's political affiliation. See RCW 29A.24.060.
>
> If a person files a declaration of candidacy using a false name or a name similar to an existing candidate with the intent to confuse and mislead the voters, they may be charged with a felony under RCW 29A.84.320. If two or more candidates genuinely have very similar names that might confuse voters, the filing officer may include additional information to distinguish between the candidates (see WAC 434-215-060).

Filing Fees

The filing fee for each office depends on the salary or compensation for that office; see RCW 29A.24.091. Your county elections office will list the filing fee for each office, but here is a summary of how the fees are calculated. (Write-in filing fees are slightly different, as discussed later.)

Annual salary for the office	Filing fee
No annual salary, or compensation is on per-meeting or per diem basis	No fee
$1,000 or less per year	$10
More than $1,000 per year	1% of annual salary

Any candidate who lacks sufficient assets or income to pay the filing fee may file a petition instead; see RCW 29A.24.091(4). The petition must follow the format and requirements prescribed by RCW 29A.24.101 and contain the signatures of registered voters within the jurisdiction. The number of signatures must be at least as great as the number of dollars of the filing fee. For instance, if the filing fee is $120, the candidate may submit a petition with at least 120 valid signatures instead.

Withdrawing

Any candidate who filed for office during the regular candidate filing period may withdraw their declaration of candidacy no later than 5:00 PM on the Monday following the last day of the regular filing period (RCW 29A.24.131).

The candidate must submit a signed request that their name not be printed on the ballot; the filing fee is non-refundable.

> **Withdrawing after the official withdrawal deadline:** Any candidate who unofficially "withdraws" after the withdrawal deadline will still appear on the respective primary or general election ballot, unless a court orders their removal.
>
> If a candidate who unofficially withdrew after the withdrawal deadline is one of the top two vote-getters in the primary election, they will still advance to the general election. If the candidate receives the most votes at the general election, they will be considered elected to office.
>
> If the candidate has changed their mind and again wishes to serve, they could assume office if otherwise qualified. If the candidate still does not wish to serve, they may either assume office and then resign, creating a vacancy, or they could refuse to assume the office, in which case the

governing body could declare the seat vacant and then fill it by appointment.

If No One Files – Special Filing Period

If the withdrawal deadline has passed and no one has filed for a particular office, there is a "void in candidacy" for the office. See RCW 29A.24.141. A void in candidacy also occurs if the only candidates who filed have either died or been disqualified.

When such a void occurs before the primary election, the filing officer must open a special filing period for three normal business days and provide notice to the public and the news media within the county (see RCW 29A.24.181). Any candidates who file during the special filing period will appear on the general election ballot, and no primary will be held. The candidate receiving the most votes in the general election will be declared the winner.

There is no withdrawal period for candidates who file during a special filing period.

If the special filing period has passed and *still* no one has filed for office, or if the void occurs after the primary election, a "lapsed election" occurs. See RCW 29A.24.191-.220. The position is considered stricken from the ballot, no write-in votes will be counted, and the incumbent will "hold over" or remain in office for another term. If the incumbent does not wish to serve another term, they may resign and create a vacancy that will be filled by appointment.

Financial Disclosures and PDC Reporting

Within two weeks of "becoming a candidate," most candidates for local office must file a C-1 candidate registration form with the state Public Disclosure Commission (PDC), as well as an F-1 personal financial affairs statement, in accordance with chapter 42.17A RCW (which will be reorganized as Title 29B beginning January 1, 2026).

There are certain exemptions – for instance, candidates seeking election in small jurisdictions usually do not have to file financial disclosures. See RCW 42.17A.135 and the PDC guidance on Who Files the F-1 Report.

Important: You might be required to file PDC reports *before* you file a declaration of candidacy with the county elections office. For PDC purposes, you become a "candidate" (as defined in RCW 42.17A.005) and trigger reporting requirements the first time you:

- Receive contributions or make campaign-related expenditures,
- Reserve advertising space or facilities to promote your candidacy,
- Authorize someone else to do any of those activities,
- Publicly state that you are seeking office, or
- File the declaration of candidacy with the county elections office.

It is important to be aware of the exact date that your candidacy begins. To avoid triggering the reporting requirements inadvertently or earlier than intended, a person exploring whether to run should say that they are "thinking about running" for office.

In addition, candidates who are required to file with the PDC must report their campaign contributions and expenses using either "mini reporting" or "full reporting" depending on the amount of money they intend to raise or spend. Candidates who are required to file an F-1 statement will also be required to file annual F-1 statements during their time in office, if they are elected.

The PDC is the agency responsible for campaign finance rules and for investigating potential campaign violations. Candidates who violate the financial disclosure requirements can face penalties ranging from civil fines to, if a court finds that the violation probably affected the election outcome, the voiding of the election itself (see RCW 42.17A.750).

For more information, carefully review the PDC resources for candidates, which includes training videos and live online classes.

Political Advertisements and Campaign Signs

Any political advertisements must identify the ad sponsor(s), although the requirements vary depending on the type of ad. For more information, see the PDC webpage on Sponsor ID: What to Include.

Many political candidates use social media to help spread the word. Candidates for local office, including incumbents seeking reelection, should

use a personal social media account rather than an official account for all campaign-related activities. However, if the official is elected to office, they may then want to refrain from using personal social media accounts for work-related matters to reduce potential First Amendment or public records liability.

Temporary campaign signs must comply with local and state sign regulations. Campaign signs are generally permitted within the local right-of-way, especially if the area has served as a traditional public forum. (For example, in an area where "for sale" signs, advertisements, or notices of lost animals have been allowed.)

However, campaign signs are not allowed within the state highway right-of-way. In addition, placing campaign signs on private property or in the parking strip abutting private property requires the property owner's permission.

For more information about political advertising and campaign signs, see the PDC's Political Advertising Guide, which recommends checking with the local public works department for guidance on where campaign signs can be placed, when they can be installed, and when they must be removed.

If a political sign has been legally placed, no one may remove or deface the sign without authorization, and defacement or improper removal is a misdemeanor (RCW 29A.84.040).

During the 18-day voting period, no campaign-related activities are allowed within 25 feet of ballot drop boxes. There is a similar prohibition on campaign-related activities inside of or within 100 feet of entrances to voting centers and student engagement hubs (RCW 29A.84.510).

Candidates are allowed by law to purchase voter data from their county elections office to be used for political purposes (RCW 29A.08.720).

The Primary Election

Depending on the office and how many people file, a primary election *might* be held on the first Tuesday in August (RCW 29A.04.311) to narrow the field to the top two candidates. As noted earlier, no primary will be held following a special filing period.

Partisan Primaries

For partisan county offices, a primary election will be held for each "full" or "regular" term office, even if only one or two candidates have filed.

If more than two candidates file, the top two vote-getters in the primary will advance to the general election, regardless of political party.

If only one or two candidates file, the same candidate(s) will appear again on the general election ballot. However, no primary will be held for an *unexpired* partisan position (caused by a vacancy) if there is only one candidate who has filed for the position. That candidate would only appear on the general election ballot.

See RCW 29A.52.112.

Nonpartisan Primaries

If the candidate withdrawal deadline has passed and there are only one or two candidates who have filed for a particular nonpartisan office, there will be no primary election for that office and the candidate(s) will advance directly to the general election. See RCW 29A.52.220.

In addition, no primary election is held for park and recreation districts or cemetery districts, regardless of how many candidates file for the office. Instead, all candidates will appear on the general election ballot. See RCW 29A.52.220(2).

Primary Election Procedures

The order in which the candidates appear on the ballot (and in the voters' pamphlet) will be determined randomly by lot, which must be conducted publicly and may be witnessed by the media and by any candidate (RCW 29A.26.131).

Ballots are mailed to voters at least 18 days before the primary, with longer timelines for service members and overseas voters (RCW 29A.40.070). The first election results will be released shortly after the polls close at 8 PM on Election Day, with the results updated each day afterward as more ballots are received and tabulated.

Each county canvassing board must certify the election results 14 days after the primary (RCW 29A.60.190). The top two candidates will advance to the general election, and any defeated candidates must wrap up their campaigns and file any necessary reports with the PDC. See the PDC resources for After the Election and Wrapping Up a Candidacy.

If the third-place candidate is especially close to the second-place candidate, the election may go to a mandatory recount, or one of the candidates may request a recount, as discussed on our page Local Elections Administration.

The General Election

The general election is held the first Tuesday after the first Monday in November (RCW 29A.04.321).

If a primary election was held for a given position, the top two candidates will be listed on the general election ballot, with the candidate who received the most votes in the primary listed first (RCW 29A.36.170).

If no primary election was held, all the candidates will be listed on the general election ballot, with the order of appearance determined randomly by lot (see RCW 29A.36.170, 29A.52.220, and 29A.36.131).

Ballots are mailed to voters at least 18 days before the general election, with longer timelines for service members and overseas voters (RCW 29A.40.070). The first election results will be released shortly after the polls close at 8 PM on Election Day, with the results updated each day afterward as more ballots are received and tabulated.

Each county canvassing board must certify the election results 21 days after the general election (RCW 29A.60.190). If the election is especially close, it may go to a mandatory recount, or one of the candidates may request a recount, as discussed on our page Local Elections Administration.

Write-In Candidates

Instead of voting for the candidate(s) printed on the ballot in a primary or general election, any voter may write in the name of a different person, even if that person has not filed for office and is not an official candidate. Some candidates may even organize a write-in campaign if they missed the filing deadline.

However, for write-in votes to be counted, the person whose name is written in must declare their candidacy and pay the required write-in filing fees, if any, no later than 8 PM on Election Day.

The write-in filing fee for each office depends on the salary or compensation for that office as well as when the candidate files; see RCW 29A.24.091. Your county elections office can tell you what the write-in filing fee is for any office, but below is a summary of how write-in fees are calculated.

Annual salary for the office	Write-in filing fee if filing more than 18 days before election	Write-in filing fee if filing 18 days or less before election
No annual salary, or compensation is on per-meeting or per diem basis	No fee	No fee
$1,000 or less per year	No fee	$25
More than $1,000 per year	No fee	1% of annual salary

A person may only file as a write-in candidate for one position on the ballot, and they may not file a write-in campaign if their name already appears elsewhere on the ballot, unless the only office for which they are listed is precinct committee officer or a temporary elected position such as charter review board member or freeholder.

In addition, a candidate who filed for the primary election (either during the regular candidate filing or as a write-in candidate), but failed to advance to the general election, may not file as a write-in candidate for the same position at the general election.

See RCW 29A.60.021 and RCW 29A.24.311-.320.

After the General Election

After the election, all candidates must wrap up their campaigns and file any necessary reports with the PDC. See the PDC resources for After the Election and Wrapping Up a Candidacy.

The winning candidate will begin transitioning from campaign mode to their new governance role. Many newly elected officials will have a few weeks to prepare before taking office on January 1, but some officials will take office almost immediately after the election results are certified in late November.

To assume office, the official must post the required bonds (if any) and take the oath of office, as described on our page Official Bonds and Oaths of Office.

While not required, it is courteous for a losing candidate to concede to the winning candidate and congratulate them, which encourages civility and helps strengthen our country's longstanding democratic traditions. Similarly, the winning candidate should be gracious toward the losing candidate(s).

Recommended Resources

Below are additional resources for local elective candidates or potential candidates to review:

- **WA Secretary of State:** County Elections Offices in Washington State – Provides contact information for elections offices in all 39 counties, which in turn provide detailed candidate filing guides
- **Public Disclosure Commission:** For Candidates – Information on financial disclosure registration and reporting
- **Association of Washington Cities:** So You Want to Be an Elected Official – Overview of the roles and responsibilities of city and town elected officials

Last Modified: March 20, 2025

Individual Board Member Role as Community Ambassador

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

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

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

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

Employment Matters

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

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

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

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

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

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

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

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

Quality of Care or Service Concerns

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

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

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

Communication of Information

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

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

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

What You Should Do – General Guidelines

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

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

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

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

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

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

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

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

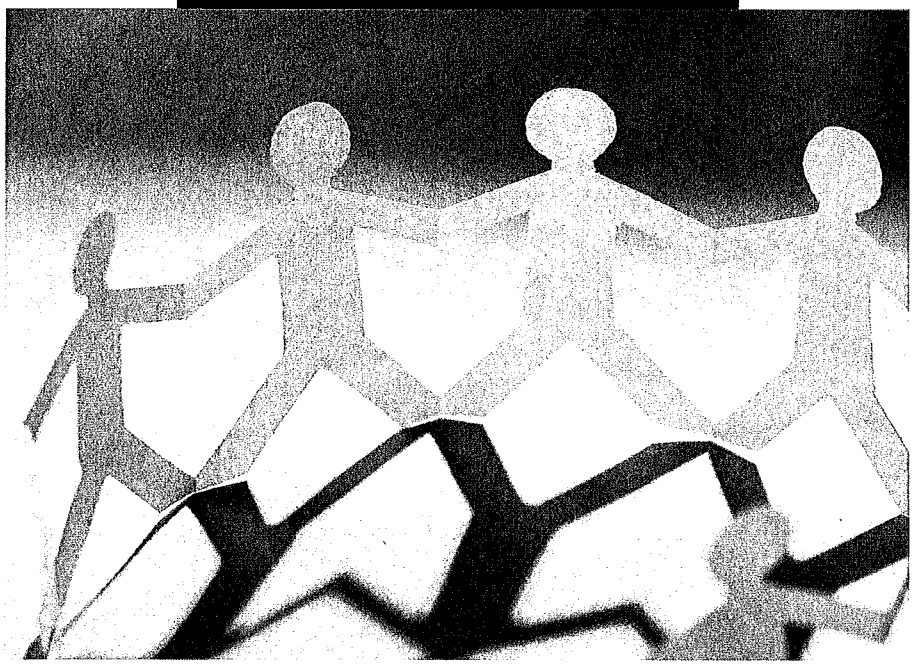
Ambassador as Trust Builder

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

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

Trustee Insights

TRANSFORMING GOVERNANCE



The Ever-important Role of Hospital Community Boards

Forward-thinking governance can lead to a renewed focus on nonprofit hospitals' mission

BY KARA WITALIS

Community governance is more critical today than ever before considering recent, often fast-moving trends and changes in the U.S. health care market. Today's health care system is being reshaped by the mega forces of consolidation, payment reform, the impacts of social determinants of health, and public scrutiny, perception and expectation, to name just a few. Nonprofit hospitals and health systems that double down on strong community governance not only have increased likelihood of staying true to their mission, but also have distinct strategic advantages over those that do not.

The Origin of the Community Board

Nonprofit hospitals — those that meet Section 501(c)3 requirements of the Internal Revenue Service code — are exempt from federal, state or local taxes and receive other preferential treatment and benefits. The idea is that any profits (or savings derived by not having to pay taxes, for example) will be reinvested into the community to further the charitable purpose.

In 1969, with the passage of Rev. Rul. 69-545, 1969-2 C.B. 117, the IRS provided greater clarity for tax-exempt status qualification for hospitals. It is with this ruling that the role and importance of the community board was made clear and became law.

First, the ruling clarifies the charitable purpose of hospitals as "the promotion of health for a class of persons sufficiently large enough to constitute benefit for the community as a whole." Additionally, the ruling outlines six factors of community benefit that hospitals can provide to obtain and maintain a tax exemption.

1. Operate an emergency room open to all, regardless of the patient's ability to pay.

2. Maintain a board of directors drawn from the community. A hospital board of directors comprised of independent civic leaders helps to ensure that the hospital serves public, rather than private, interests and, therefore, operates for the benefit of the community.

3. Maintain an open medical staff policy (i.e., not restrict medical staff privileges to a limited group of physicians).

American Hospital Association™
Advancing Health in America

4. Provide hospital care to all patients able to pay, including those who do so through Medicare and Medicaid.

5. Use surplus funds to improve facilities, equipment and patient care.

6. Use surplus funds to advance medical training, education and research.

The role of the community board is, therefore, to ensure that the tax-exempt health care organization operates in a manner consistent with its charitable purpose and benefits the community as a whole rather than private interests.

Community Benefit Standard

Enacted in 2010, the Patient Protection and Affordable Care Act adds four additional requirements that tax-exempt hospitals must meet to maintain their tax-exempt status.

1. Conduct a community health needs assessment every three years and develop an implementation plan for how it will address those needs.

2. Develop, maintain and broadly publicize charity care and financial assistance policies.

3. Set a limit on charges. A tax-exempt hospital cannot charge individuals eligible for financial assistance more for medical services than they do patients with insurance.

4. Set billing and collection limits. A tax-exempt hospital may not take extraordinary collection actions against an individual, such as filing a lawsuit, before the hospital determines whether that individual is eligible for financial assistance.

Together with the six factors in the 1969 ruling, these are commonly referred to as the community benefit standard.

To collect information about tax-exempt hospitals and enforce their compliance with the requirements, the IRS requires (as of 2008) that tax-exempt hospitals report on community benefit activities by content category in the IRS tax form 990 and Schedule H.

Greater Need for Community Governance

These tax-filing requirements (IRS tax form 990 and Schedule H) have led to greater transparency into the provision of community benefit. Using the all-in IRS definition of community benefit, the American Hospital Association reports that, on average, system-affiliated hospitals provide 10-14% of their total annual expenditures on community benefit activities, nearly half of which goes for financial assistance for patients and absorbing losses from Medicaid and other means-tested government program underpayments. Using data from filings with the IRS, the AHA showed that tax-exempt hospitals provided more than $110 billion in total benefits to their communities in filings for fiscal year 2019. This is roughly four times the $28 billion estimated value that the nation's tax-exempt hospitals collectively receive in tax-exemption, as reported in an updated analysis conducted by the Kaiser Family Foundation.

But greater transparency has also led to heightened public and regulatory scrutiny. Fierce and ongoing debate persists about whether the IRS' definition of community benefit (set out in the tax form 990 and Schedule H) is the right definition, and whether or to what extent tax-exempt hospitals are adequately meeting the letter and the spirit of the tax-exemption laws. Policy advocacy groups, news journalists and others continue to raise the question of whether tax-exempt hospitals are doing right by the laws and by their communities. The debate is arguable on both sides, but in today's world, perception is reality.

This scrutiny is coming at a time of other significant changes in the market. For example, today more than 50% of all tax-exempt community hospitals are part of a consoli-

Strategic Advantages of Strong Community Governance

Now more than ever, the community board's approach to improving community health is a mission and strategic imperative. In addition to ensuring that providing health care services to the community is fulfilled, effective and forward thinking, community health governance leads to:

- Increased organizational integrity, image and public trust.
- Protection from public scrutiny and potential regulatory intrusion.
- An enhanced voice in local community health issues.
- Better use of precious resources with targeted investments to address local community needs.
- A greater willingness by the public to donate funds and services.

dated system. Within system governance, the community board is often far removed from the health system's strategic decision-making table, forcing a delta between local community need and strategic decisions — all the more reason for strong, effective local community governance to ensure that local needs are not lost in the size and scale of consolidated systems.

What's more, the Affordable Care Act's promotion of population health, primarily through new payment mechanisms, shifts the financial incentive away from a volume-based, fee-for-service payment system to a system based on value. This fundamental change in how hospitals are paid for services creates a strategic imperative to expand the notion of community benefit beyond the IRS standard to include population health more broadly. Indeed, the 1969 IRS ruling requires hospitals to do just that: "the promotion of health for a class of persons sufficiently large enough to constitute benefit for the community as a whole." Payment reform makes this explicit.

The movement toward population health, coupled with the inequities in the nation's health care delivery system unmasked through the COVID-19 pandemic, has raised awareness of the impact of social determinants of health on patient, population and community health. Social determinants of health are the non-medical factors that influence health outcomes.

To address health care disparities in hospital inpatient care and beyond, the Centers for Medicare & Medicaid Services is adopting health equity-focused measures in the

Key Roles of the Hospital Community Board

- **Adhere to the mission.** The mission is the reason that the organization exists. Everything done by the organization should tie back to the organization's purpose and mission.
- **Advocate for your community's health needs.** Community board members are the voice of the community in the boardroom. They represent and prioritize the needs of the community. To do this well, board members are encouraged to solicit and incorporate diverse perspectives from the community as a whole, particularly historically marginalized communities.
- **Understand how your organization provides community benefit and addresses your community's health care needs.** Regarding the IRS regulations, there are three notable issues. First, there is no federal minimum amount of spending on community benefit activities that is required by tax-exempt hospitals. In other words, these organizations are required to report spending, but the dollar value may be zero. Second, the reported spending on community benefit activities does not have to be tied to priority heath issues identified in the community health needs assessment. Third, not all states' laws pertaining to community benefit provision and reporting are equal.

  That said, policy hawks are advocating for regulators to require certain spending levels in community health improvements and for those investments to be directly tied to community health needs. Forward thinking leaders of tax-exempt hospitals are tracking community benefit spending (through IRS form 990 and Schedule H) year-over-year, establishing investment targets above baseline and connecting community benefit activities to the needs identified in the CHNA and plans.
- **Be a spokesperson for the organization.** Health care organizations and executives are tasked with making difficult decisions to balance the needs of the community with financial sustainability. Community board members can support the organization by being a spokesperson for the organization when needed.
- **Build constructive relationships in the community.** Hospitals are frequently regarded as the primary health care service provider in their community. Still, it is helpful to engage with other organizations that may be better suited to address certain needs. There is a myriad of organizations with which hospitals can partner to drive better community health — public health agencies, schools, churches, local markets, public parks and recreation departments, law enforcement, social services agencies, civic associations, food banks, housing services and shelters.
- **Hold management and the board accountable.** Conducting routine board self-evaluation helps foster continuous improvement in performance and drives change when necessary. Through this process board members gain a better understanding of their roles and responsibilities, tend to be more engaged in the work and often have a more collaborative relationship with both their management and each other.

Inpatient Quality Reporting Program. These measures include capturing specific hospital activities to address health inequity in strategic planning, data collection and analysis, quality improvement and leadership engagement. Additionally, hospitals are now required to screen inpatients for health-related social needs like food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. CMS states, "By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes."

With such significant change — and the renewed emphasis on community health — strong and effective local community governance can serve as the center of gravity in health care.

Re-valuing Community Governance

The community board has never been more important than it is today. In the new era of health care, strong community governance should strive to meet the letter of the laws and justify tax-exempt status. At the same time, community governance should also strive to meet the spirit of the laws in which health care programs, services and investments collectively raise the level of health for everyone in the community, particularly the poor and vulnerable.

The time is now to take a more contemporary approach to community governance that reflects today's realities. Community boards need to view community health and benefits more broadly and to think more boldly about how health care fulfills the mission and addresses the underlying causes of health problems in our local communities.

Questions for Discussion

Use these questions to prompt discussion at your next board meeting.

- What are the health challenges of the citizens of our community, particularly the poor and most vulnerable? Do our reports provide overall health data, or do we receive stratified data that provides insight on individuals or groups that may be "left behind"?
- In what ways are we actively using the community health needs assessment to drive our actions and investments to improve community health?
- What partners can help address our needs? How does the organization identify and evaluate community organizations that could serve as potential partners?
- What is our annual spending on community benefit activities (i.e., IRS form 990 and Schedule H tax filings)? How does our spending compare to the national average? What more can be done?
- What is needed to increase the health system's capacity to change toward value-based models?

Kara Witalis (kwitalis@viahcc.com) is principal at Via Healthcare Consulting, based in Carlsbad, Calif.

Please note that the views of authors do not always reflect the views of the AHA.

Governance & Executive Education

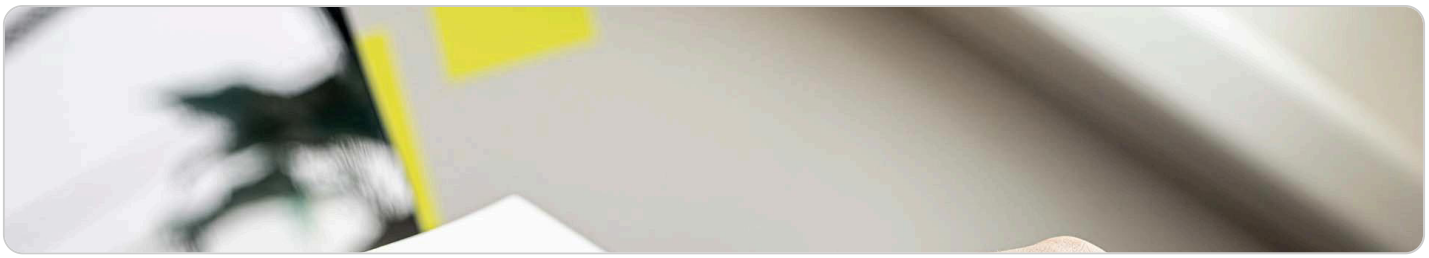
WSHA in partnership with AWPHD (http://www.awphd.org) offers an Executive Education and Governance Certification program to increase knowledge and understanding of hospital governance in Washington State, and assist Executive and board leadership in assessing and enhancing board effectiveness. Members who participate in these learning opportunities can earn their Health Care Governance certification.

The WSHA and AWPHD Governance Education Portal (https://governanceeducation-wsha.talentlms.com/) is your centralized hub to access courses and your personal learner profile. For more information on how to create an account and how to login please email govedu@wsha.org (mailto:govedu@wsha.org).

The following 2025 courses are open for registration through the Governance Education Portal:

Navigating the Impacts of State and Federal Policy Decisions
March 24 | 10:00 – 11:00 am
presented by Cassie Sauer, Cathy Bambrick & Bertha Ortega

Hospital Finances 201
May 21 | 12:00 – 1:00 pm
presented by Andrew Busz & Eric Lewis



Curriculum

Learn more about the content offered through webinars and at WSHA/AWPHD events.

(/events-resources/governance-education/education-curriculum/)

Certification

Health Care governance certification is just 12 credit hours away.

(/events-resources/governance-education/board-certification/)

Credit Hours

How to earn credit hours towards your WSHA health care governance certification.

(/events-resources/log-hours/)

Affiliates

Washington Hospital Services (http://www.wahospitalservices.com) Association of Washington Public Hospital Districts (http://www.awphd.org)

Contact Us

Washington State Hospital Association
999 Third Avenue
Suite 1400
Seattle, WA 98104

Map / Directions (/about/getting-to-wsha-map-and-directions/)

206.281.7211 phone
206.283.6122 fax

info@wsha.org (mailto:info@wsha.org)

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Contact (/contact)

(https://www.facebook.com/WAHospitals) (https://www.twitter.com/WAHospitals)

NEW BUSINESS

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION ADOPTING THE
COMMUNITY HEALTH IMPROVEMENT
SERVICES (CHIS) ADDENDUM RESOLUTION NO. 25-06

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 CHIS addendum which are the hospital activities related to improving community needs named in the hospital's CHNA. The annual CHIS addendum details these activities.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 30th day of April 2025, the following commissioners being present and voting in favor of this resolution.

_____
Tom Herrin, Board Chair

_____
Wes McMahan, Secretary

_____
Van Anderson, Commissioner

_____
Craig Coppock, Commissioner

_____
Chris Schumaker, Commissioner

Annual Community Health Improvement Services Addendum

Hospital Name:	Lewis County District Hospital No. 1
License #:	600293024
Fiscal Yearend (Ex.6/30/2023):	Dec. 31, 2024

Washington State Department of HEALTH
DOH 346-131 July 2022)

4A-K) See sheet labeled "Instructions for Completion" for instructions to complete addendum. Insert additional lines as needed.

	A. Type of Activity:	B. Method in which the activity was delivered:	C. How the activity relates to an identified community need in the community health needs assessment:	D. The target population for the activity:	E. Strategies to reach the target population:
1	Reduction in Wait Times to new patients	In Person	Improve Access to Primary Care	East Lewis County Residents	Website, Quarterly Newsletter Circulations, Social Media, Newspaper Circulation of the District for Lewis County, Clinic Visits
2	Recuitment and retention of a quality healthcare workfroce	In Person	Realize a Healthier East Lewis County	Healthcare workers	Website, Social Media, Online advertising on job websites (ie 3Rnet), Hard copy advertising at Arbor Health locations
3	Complete school-based sports physicals	In Person	Increase % of population reporting access to exercise	Secondary school aged residents of East Lewis county	Partnership with school district athletics department, Flyers disributed by school districts, Social Media

	F. Identified outcome metrics:	G. The cost to the hospital to provide the activity:	H. The methodology used to calculate the hospital's costs:	I. The total number of people served by the activity:	J. List entities that administered the community health improvement service, if other than the hospital:
1	Reduction in Wait Times to new patients	FT Salaried $390,000	Salary Position	222	None
2	Reduction in turnover as well as open positions to fill	$417,500	Comp project/Conexus	302	None
3	Increase in sports physicals completed	No additional costs to perform this task; completed by existing staff	NA	180	None

	A. Type of Activity:	B. Method in which the activity was delivered:	C. How the activity relates to an identified community need in the community health needs assessment:	D. The target population for the activity:	E. Strategies to reach the target population:
4	Promote access to flu vaccines	In Person	Improve Access to Preventitive Services	East Lewis County Residents	Drive through vaccine days in multiple locations throughout the hospital district, Website, Social Media, Newspaper Circulation of the District for Lewis County, Flyers posted in the community, Clinic Visits
5	Phreesia	Virtual + In Person	Ensure consistent use of Best Practice Assessment Tools for Mental Health	East Lewis County Residents with internet access and/or cell phones	Clinic Visits, Patient Outreach by Clinical Staff
6	Patient Point	Virtual + In Person	Realize a Healthier East Lewis County Through Educational Tools	East Lewis County Residents	Social Media, Word of Mouth from Clinic Staff, Clinic Visits
7	Family Resource Fair	In Person	Increase % of patients compliant with Well Child Checks	East Lewis County Residents with families of young children	Website, Social Media, Newspaper Circulation of the District for Lewis County, Flyers posted in the community, Flyers sent home by School Districts
8	Additional bus stops up to Packwood	In Person	Improve Access to Preventitive Services	East Lewis County Residents	Website, Quarterly Newsletter Circulations, Social Media, Newspaper Circulation of the District for Lewis County

	F. Identified outcome metrics:	G. The cost to the hospital to provide the activity:	H. The methodology used to calculate the hospital's costs:	I. The total number of people served by the activity:	J. List entities that administered the community health improvement service, if other than the hospital:
4	Increase the number of flu vaccines provided	$12,175	Cost/Vaccine dose	615	None
5	Increase compliance rate for completition of PHQ-2	$60,240	Service costs per contract	2580	None
6	No specific metrics pulled. Prompts educational engagement.	No cost to organization	NA	10,319	None
7	Increase in pediatric patients seeking care in hospital district	$500	Venue rental, advertising	178	None
8	Increase in ridership on Brown Line	No cost to organization	NA	4260	Lewis County Transit

SUPERINTENDENT REPORT

Arbor Health

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Packwood Clinic
13051 US HWY 12
360-496-3777

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioner

From: Superintendent Mach

Date: 04.30.25

Re: April Superintendent Report

- Strong March financials.
- Completed negotiations with WSNA and Ratified by Nurses.
- Finished Kitchen hood project.
- Installed new Mossyrock clinic sign.
- Working on project to replace entry way flooring.
- Received ERC funds after 2 years wait.
- Participated in Providence Centralia CHNA, broached the idea of doing our CHNA with Providence in 3 years.
- Presented Q1 Service awards on 4/2.
- Hosted Skyline health on 4/17 for site visit to help them maximizing radiology workflow.
- Engaged WIPFLI to provide Remote CFO coverage (Sarah Paul).
- DOH is going forward with this years distressed hospital grant which we will apply for.
- Installed new water fountain for lobby.
- Have engaged WIPFLI to do Medical claims audit that is required by state as a government agency running a self-funded plan and we have never done.
- Published letter from Dr. McCurry in the paper for our patients about potential Medicaid cuts.
- Misty Stephens has started as our new Executive administrative assistant
- Working on an offer to a new CRNA to replace Todd when he retires later this year.
- Transportation Tuesday's is getting off the ground.
- Working with Randle Library to have walking path behind our clinic.
- We added new educational offerings for all our employees through Skillset
- Starting 3 days of MRI service and switching Nuclear medicine vendor to current MRI vendor.
- Purchased timing system for running events we sponsor.
- Redesigned Human resources space, giving them additional space.

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2025 Goals	December	January	February	March	April	May	June	July	August	September	October	November
Financial Stability and Growth												
End the fiscal year of the hospital with a positive operating margin of at least 3% or better.		5.90%	5.80%	6.00%								
Workforce Stabilization												
Voluntary resignations under 12%		1.19%	1.18%	1.18%								
Service and Quality												
Patient satisfaction ranking likelihood of recommending all departments combined ≥ 70%												
Community Relations and Partnerships												
Sponsor at least 4 community events and the CEO attends at least 12 community events annually (2 per district and 4 at large events)	Christmas parade, Centralia College advisory meeting	Gave presentation to East Lewis County Chamber on Hospital happenings		Barb Attended Mineral FD meeting,sponsored Family Fair								

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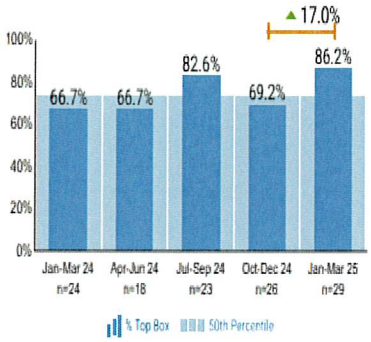
Likelihood of Recommending

Morton, WA- HCA... ius MASTER / Jan-Mar 25 / WOULD RECOMMEND / All Areas

HCAHPS

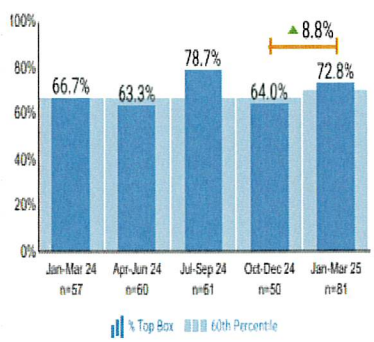


Morton, WA- ...ehab (web) / Jan-Mar 25 / Likelihood of Recommending / All Areas

Rehabilitation

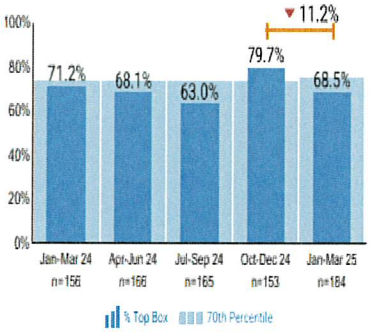
Morton, WA- ...Care (web) / Jan-Mar 25 / Likelihood of Recommending / All Areas

Rapid Care



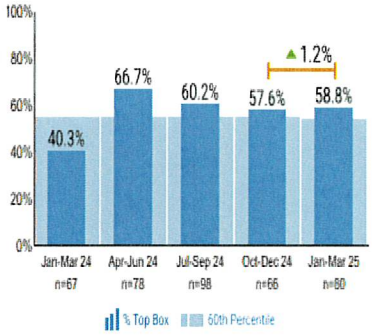
Morton, WA- ...ient (web) / Jan-Mar 25 / Likelihood of Recommending / All Areas

Outpatient Services



Morton, WA - ED (web) / Jan-Mar 25 / Likelihood of Recommending / All Areas

Emergency Departmen



March 2025, Digital Marketing Report

Website Analytics

Total website views: 27,075

Top three pages:

- Patient portal, 3,437 views
- Morton Hospital location, 2,221 views
- Provider Directory with 1,591 views

Top 5 Service Pages:

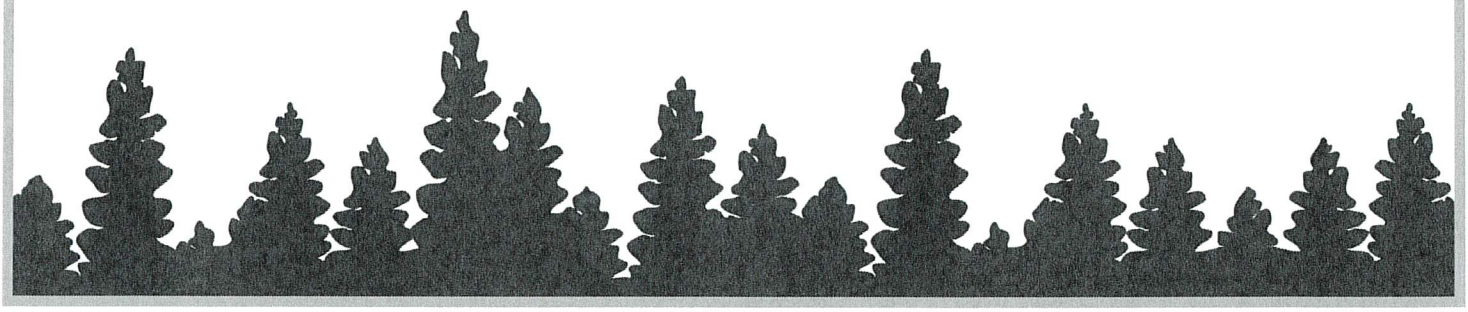
- Foot & Ankle, 528 (Running a pay-per-click digital campaign.)
- Rapid Care Clinic, 223 views
- Mammography, 188 views
- Rehab, 166 views
- Cardiology, 142 views

Google Report:

- Overall cumulative ratings for all profiles (providers and facilitites) 4.5
- Morton Clinic, 3.6
- Morton Hospital, 4.2
- Mossyrock Clinic, 3.6
- Packwood Clinic, 5.0
- Randle Clinic, 3.7
- Rapid Care Clinic, 4.7
- Rehab Services Clinic, 5.0

Community Support

- Packwood Mtn Festival 5K



Arbor Health

Kevin McCurry, MD

Chief Medical Officer, Arbor Health

Morton, Washington

April 7, 2025

Dear East Lewis County Neighbor,

We understand that recent discussions about federal funding for Medicaid may have left you feeling uncertain about your healthcare coverage. At Arbor Health, we want to reassure you that no matter what the future holds, your health remains our top priority. We are here to support you and ensure that you continue to receive the care you need.

We strongly encourage you to keep up with your regular check-ups, treatments, and preventive care. Delaying care can lead to more serious health issues that may require expensive emergency room visits or hospitalization. Our goal is to help you stay healthy and avoid unnecessary medical crises.

If you are concerned about medical costs, please know that Arbor Health offers generous financial assistance programs to help with your bills. We are committed to making healthcare accessible to everyone, regardless of financial circumstances. Our team is available to discuss your options and work with you to ensure that cost is not a barrier to your care.

Your health matters to us, and we want to continue being your trusted healthcare provider. Please don't hesitate to schedule your appointments, refill prescriptions, or reach out to us with any concerns. If you have questions about financial assistance or need help navigating your options, our staff is ready to assist you.

Thank you for trusting Arbor Health with your care. We are honored to serve you and will continue to stand by you during these uncertain times. We are one team with one mission and that is to care for you like crazy.

Sincerely,

Kevin McCurry, MD

CMO

Arbor Health

BECKER'S
HOSPITAL REVIEW

Financial Management

Small-town America in crosshairs of Medicaid cuts

Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals 1 hour ago

Members of Congress will say their fiscal 2025 budget blueprint doesn't call out Medicaid by name. That might be true, but it's arguing semantics: To leave Medicare unscathed, as members of Congress vow, the House budget plan's $880 billion cut to federal health spending almost certainly must come from Medicaid — there's nowhere else to find it.

Just as certain: a cut that deep would be disastrous for working families and children in small-town America, where Medicaid means health, productivity, and financial stability.

It also would devastate our safety net and the essential hospitals at its core. Americans who face financial challenges — who just need a hand up — depend on essential hospitals, and these hospitals depend on Medicaid to keep the lights on. If you cut Medicaid to the bone, you put health care and jobs at risk for millions of Americans.

Many of those people live in rural communities. We know non-elderly adults and children in small towns and rural areas are more likely than urban dwellers to rely on Medicaid and the Children's Health Insurance Program (CHIP). In Arkansas, Louisiana, Washington, West Virginia, and nearly a dozen other states, at least one-fifth of non-elderly adults in small towns and rural communities depend on Medicaid.

Medicaid cuts as deep as those in the House plan also would fall hard on children. In Arizona, Arkansas, Florida, Louisiana, New Mexico, and South Carolina, at least half of children in small towns and rural areas depend on Medicaid or CHIP.

Supporters of cuts claim people won't lose benefits or that work requirements and other eligibility constraints would ensure that only those who truly "deserve" Medicaid have access to it. But ask anyone kicked off Medicaid if their benefits went untouched. Also, lost in the eligibility debate is the simple fact that nearly two-thirds of adult Medicaid beneficiaries already have jobs.

This isn't surprising when you consider that among companies with three or more workers, only about half offered health benefits to at least some of their workers in 2023. The is particularly true among firms with just three to nine workers, with only 39% offering health benefits.

So, in communities where mom-and-pop shops dominate — again, often rural areas — Medicaid is often the only game in town for low-income workers. Cutting federal Medicaid funding leaves states holding the bag, forcing them into tough decisions on eligibility and services. That can mean loss of coverage for people who have nowhere else to turn and lead to medical debt, bankruptcies, and work days lost to untreated medical conditions.

But the economic consequences of an $880 billion cut to Medicaid ripple far beyond the local diner. Essential hospitals — about a quarter serve rural areas — often are a community's largest employer. Further, they breathe economic life into communities in a multitude of ways beyond the jobs they provide. In 2022, essential hospitals supported $283 billion in economic activity and 6.7 million jobs nationwide — much of it in low-income communities that need both the most.

All this leads to a perverse outcome for the proposed Medicaid cuts: sicker communities and higher health care costs. Further, as Americans lose access to needed care, job losses and tumbling economic activity (and the tax revenue that goes with it) follow. Small-town America and its children stand to feel the most pain when this happens.

Worse, the hospitals these communities depend on will have fewer resources to give them the safety net they'll need. Essential hospitals rely heavily on Medicaid; it's about half their payer mix. Even then, Medicaid payments fall well short of essential hospitals' costs. So, they rely on a patchwork of other federal, state, and local support to fill the gap. But there is no patch for an $880 billion funding cut.

We need to invest in the safety net, rural communities, and these hospitals — not pull the rug out from under them with unprecedented Medicaid and CHIP cuts. Small towns and their hospitals are looking to Congress to do right by working families and all Americans by protecting the health care they need.

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Financial Management

The cost of nurse turnover in 24 numbers | 2025

By: **Molly Gamble** 3 days ago

Nurse shortages and mounting labor costs are among health system CEOs' top concerns, and a new survey puts numbers to the financial risks hospitals face from nurse vacancies and churn.

The 2025 NSI National Health Care Retention & RN Staffing Report features input from 450 hospitals in 37 states on registered nurse turnover, retention, vacancy rates, recruitment metrics and staffing strategies.

It found the average cost of turnover for one staff RN grew from January through December 2024 to $61,110, among other dollar figures and statistics that are helpful to understand the financial implications of one of healthcare's most persistent labor disruptions.

Here are 24 numbers that illustrate the cost of nurse turnover, according to the most recent edition of the report, which is available in full here.

1. The turnover rate for staff RNs decreased by **2.4%** in 2024 from the year prior, resulting in a national average of **16.4%**. Given varying bed size, RN turnover can range from **5.2%** to **36.4%**.

2. The average cost of turnover for a staff RN increased by **8.6%** in the past year to **$61,110**, with a range of **$49,500** to **$72,700**. This is up from the average cost of turnover for an RN in 2023, which was **$56,300**.

3. Each percent change in RN turnover stands to cost or save the average hospital **$289,000** per year.

4. The RN vacancy rate sat at **9.6%** nationally in 2024, down **0.3%** from the year prior. This marks an improvement, as hospitals hired approximately **98,000** RNs for a 2024 add rate of **5.6%**.

5. The average time to recruit an experienced RN ranged from **62** to **103** days in 2024, with the average sitting at **83** days — **three** days quicker than the year prior.

7. Every region represented in the report recorded a modest decrease to RN turnover in 2024. The South Central region saw the high end of the average (**18%**) while the North East region saw the low end (**14.6%**).

8. Over the past five years, RNs in step down, telemetry and emergency services were most mobile with a cumulative turnover rate between **113%** and **121%**. "Essentially, these departments will turn over their entire RN staff in less than four and a half years," the report states.

9. RNs in pediatrics and surgical services were less mobile in that five-year timeframe, exiting at rates of **77.2%** and **77.1%**, respectively.

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The Leader

Wednesday, April 9, 2025

Leak sheds light on plan for hospital alliance

(/uploads/original/20250401-152802-26d-IMG_9624.jpg)

lefferson Healthcare along Sheridan Street in Port Townsend.

.EADER PHOTO BY ALEX FRICK

'osted Wednesday, April 9, 2025 3:00 am

3y James Robinson

\n effort to create a new regional health alliance between Jefferson Healthcare and Olympic Medical Center ıppears to be moving forward, with leaked project planning documents describing particulars of how an alliance night ultimately play out.

The project documents, acquired by The Leader, followed comments made by Jefferson Healthcare Commissioner Matt Ready at the March 26 meeting where he accused his co-commissioners of meeting secretly with OMC epresentatives to merge the two organizations.

Called Project Driftwood, the Jefferson Healthcare proposal calls for the formation of the Peninsula Health Alliance, effectively a not-for-profit alliance which project documents say would allow Jefferson Healthcare and Olympic Medical Center in Port Angeles to remain independent, while improving and expanding clinical ɔrograms, creating operating efficiencies and economies of scale and the ability to improve and expand clinical ɔrograms.

The plan, according to Project Driftwood documents, calls for a 12-member "super board" — with seven board nembers from Olympic Medical Center and five from Jefferson Healthcare. According to the plan, all currently elected commissioners would sit on the super board and the super board would govern the regional health ılliance while individual boards would remain responsible for governance of their own organizations.

The proposal calls for a three-year phased-in leadership approach, with an appointed executive director planned for the first year. Project documents propose that Jefferson Healthcare Chief Executive Officer, Mike Glenn, would serve as the alliance's first executive director.

"Frankly, many of the opportunities embedded in this model have been deliberated for years," according to Project Driftwood documents. "Olympic Medical Center and Jefferson Healthcare have been strong partners for decades. We share the same governance, leadership and medical group models, electronic medical record and perhaps most importantly, commitment to excellence cultures."

Project Driftwood is the outgrowth of an OMC decision announced in December 2024 to hire Juniper Advisory Group to guide them through a process to decide if they need a partner, and if so, who that partner should be. Roughly 20 organizations were invited to submit proposals, including Jefferson Healthcare.

"We are still in the preliminary stages of the exploration process,"said Bobby Stone, director of marketing and communications for Olympic Medical Center. "We received inquiries from several interested parties and are engaged in a due diligence process to learn more about these organizations. We are bound to confidentiality about who these interested parties are."

A key player at Jefferson Healthcare also noted the non disclosure agreement as reason for their silence.

But no one from the organization has made public mention of the plan to submit a proposal and the other commissioners have remained quiet about Project Driftwood.

"A subset of Jefferson commissioners were involved or consulted during the drafting phase," Ready said in a previous interview. "I was not. I only became aware of the proposal during the executive session on February 5. The full board has never voted to authorize the proposal or the direction of the negotiations. Much of the process has taken place out of public view, contrary to the principles of public hospital governance."

Kolff said in the meeting that "all of our actions have been legal according to our legal counsel." He also stated that Ready was "in violation of the board's ethics policy."

Emails provided by Ready show correspondence between Jefferson Healthcare Commissioner Kees Kolff and Jefferson Healthcare top executives, discussing the merger plan, and Kolff's efforts to draft language and an organizational chart.

"Thanks for the conversation with Mike about this exciting possible alliance the other day, and thanks for the opportunity to share some ideas for edits on the organizational chart and the governance comments that go along with that," Kolff wrote to Pranav Sharma, head of strategic planning, marketing and communication for Jefferson Healthcare. "I have attached a reworded narrative. There were too many edits to make 'show changes' useful," the email stated. It was copied to Mike Glenn, Shannon Groff and commissioners.

At the March 26 commissioners' meeting Ready made his concerns public and alleged that members of the board had been negotiating secretly with representatives of OMC. Ready further alleged that members of the commission had violated open meeting laws and abused the use of executive session.

When asked about the use of executive session to discuss the possible alliance, Jefferson Healthcare Commissioner Jill Buhler Rienstra did not respond to requests for comment. According to Kolff, Buhler Rienstra is out of town this week, and he was traveling and not able to provide a complete comment by presstime.

Should Olympic Medical Center continue its evaluation of the Jefferson Healthcare's proposal, the next step would involve representatives from Jefferson Healthcare visiting OMC facilities for a site visit and further discussions. Olympic Medical Center project documents indicate the agency would make a decision in April or May on whether OMC will pursue a partnership.

The OMC decision to seek a partner comes amidst myriad financial challenges, including federal cuts and halts to Medicaid reimbursements.

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PHOTOS: Creative signs, heartfelt emotion stretch for half a mile (/stories/creative-signs-heartfelt-emotion-stretch-for-half-a-mile,204223)

Arbor Health

Care like crazy

From: Governance Education <govedu@wsha.org>
Sent: Tuesday, April 15, 2025 7:59 PM
To: Shana Garcia <sgarcia@myarborhealth.org>
Subject: New WSHA & AWPHD Governance Education Shorts

[EXTERNAL] - This message is from an outside sender: STOP, LOOK and THINK!

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