Board of Commissioners

Strategic Planning Retreat

February 20, 2020

Pre-Reading Packet

2020 Strategic Planning Retreat
Thursday, February 20, 2020
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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
February 20, 2020 at 9:00 a.m.
Lewis County PUD, 240 7th Street, Morton, WA 98356

Mission Statement

The mission of Lewis County Hospital District No. 1, steward of public funds and trust, is to provide our highest level of compassionate, diligent and professional medical care.

Vision Statement

A caring team of people working together to lead our community toward better health.

Objectives

1. **Understand the healthcare landscape 2020 broadly and how it relates to the local healthcare landscape**
2. **Understand the Board of Commissioners' role as it relates to organizational strategic planning and other best practices**
3. **Review and refresh the organizations mission and vision**
4. **Establish organizational values**
5. **Establish organizational strategic priorities and key measures of success for 2020-2022**

AGENDA	LEAD	TIME
Call to Order **Conflict of Interest** **Reading of the Notice of the Special Meeting**	Board Chair Fritz	9:00 am
Welcome & Introductions	Superintendent Everett	9:05 am
Meeting Agenda, Objectives and Group Guideline	Karma Bass, Via Healthcare Consulting	9:10 am
The Evolution of America's Healthcare System and Key Imperatives for Today	Kara Witalis, Via Healthcare Consulting	9:20 am
Governance Rules of the Road: Best Practices for Board Effectiveness	Karma Bass	9:50 am
Break	Board Chair Fritz	10:30 am
Framing-Mission, Vision & Values	Kara Witalis	10:35 am
Arbor Health-Mission, Vision & Values	Facilitated Discussion, Karma Bass & Kara Witalis	10:55 am
Arbor Health-Where we are today? • 2017-2019 Strategic Plan Update • Environmental Scan • Market, Financial & Quality Assessment	Superintendent Everett	11:35 am

Break	Board Chair Fritz	12:05 pm
Framing-Strategies, Objectives & Action Plans	Kara Witalis	12:20 pm
Strategic Planning 2020-2022 • Strategies • Objectives • Action Plans	Facilitated Discussion, Karma Bass & Kara Witalis	12:40 pm
Next Steps & Closing Comments	Superintendent Everett	2:45 pm
Adjournment	Board Chair Fritz	3:00 pm

EMERGING ISSUES

Top 10 Trends to Watch (and Act Upon) in 2020

Seemingly routine trends will require more innovative and bold solutions, while ground-breaking changes may indicate “watchful waiting”

BY LAURA P. JACOBS

Beyond election-year dialogue, which will continue to place health care front and center, what should health care system trustees be watching in 2020? In some cases, what may seem routine trends will require more innovative and bold solutions, and some ground-breaking trends may indicate “watchful waiting.”

THE FUNDAMENTALS

Don’t be fooled if these seem “ordinary.” Solving the challenges that some of these ongoing trends present may require bold thinking and creative solutions to achieve the kind of impactful and sustainable results that this environment requires.

1 Economic Pressures

Trustee Talking Points

- Routine trends present challenges that may require more creative solutions to effect sustainable change.
- Fundamental trends include ongoing economic pressures, rising consumer expectations, an evolving workforce and continued movement toward value-based payment.
- Acceleration of telemedicine, virtual care and advances in biotechnology, diagnostic

equipment and analytic and digital tools have the potential for dramatic impact.

For many, the continual financial pressures created by expenses rising faster than revenues will be all-consuming. A slowing economy, or worse, a recession, could pose new challenges, including shifting payer mix to increased Medicaid or uninsured patients as well as deferred elective care. The continued growth of high-deductible health plans will require an attentive point-of-service collections process and a thoughtful pricing strategy.

With relentless capital needs for IT infrastructure and replacing/expanding facilities, a focus on margin improvement will be critical. Pharmacy cost management will be top of nmind, as the volatility of drug costs can create surprises in managing expenses. Taking a new look at ways to optimize human and capital resources through re-engineering care delivery and leveraging technology effectively will be necessary, as “the low-hanging fruit” of prior cost-reduction efforts has likely been plucked. A renewed focus on ways to reduce waste and unwarranted care variation through integrating data and analytics with lean processes and team engagement will require strong leadership. The call to make health care more affordable will be loud and continuous, as will the need to challenge traditional approaches and solutions to yield sustainable cost reduction that maintains or improves patient outcomes.

Trustees Should Discuss: Does current operating performance match the expectations built into your long-term financial plans and target bond ratings? That is, does your current cash flow generate the cash required to fund current and anticipated capital needs? If not, what actions are being taken to address costs and revenue growth? Have previous improvement efforts been sustained? How does the organization foster an environment that encourages new thinking and bold solutions that position it for future success?

2 Consumer Expectations

Rising consumer expectations of a multicultural/multigenerational demographic coupled with an aging population will continue to create both opportunities and threats to traditional health systems. Health care consumers seeking accessible, affordable and Amazon-like experiences will be attracted to the many new entrants that seek to fill that void. These will include technology-based companies, new primary care models, national providers of outpatient surgery and imaging, and hospital-at-home providers, all leveraging an ability to test new models of care, unencumbered by the politics and complex decision-making (and fixed costs) of a large hospital or health system.

As the population ages, keeping a watchful eye on Medicare payment policies as well as continuing to improve the coordination of care across the continuum for patients with complex, chronic conditions must be a priority for all health systems. Implementing strategies and working with other community organizations to address mental health and health issues caused by poverty and hunger or malnutrition also must receive attention from health system leaders; the overuse of emergency departments and overlong hospital stays are often due to these issues and can best be addressed through influencing social determinants of health.

Trustees Should Discuss: Who are the nontraditional competitors in your market and how is your organization addressing consumer expectations? How is the organization poised to succeed under Medicare payment models? How are care delivery models adapting to address patients with multiple chronic conditions? What community needs beyond medical care does your community health needs assessment identify -- e.g., housing, poverty, hunger, mental health — which your health system can address either directly or through community partners?

3 An Evolving Workforce

As a field that is primarily dependent on human resources to deliver services, attention must be paid to an evolving workforce. With high demand for physicians of many specialties, especially primary care, to serve in various roles across the health care sector beyond direct patient care, health systems will have to refresh recruitment approaches and evaluate retention strategies. This also holds true for most clinical and technology roles: Health systems must provide a workplace that is appealing to a multigenerational and multicultural workforce seeking flexible work hours, multiple venues for learning, competitive wages and benefits, and opportunities for advancement.

Union activity will continue to put pressure on organizations to engage employees in effective ways. This will put additional economic pressure on hospitals, so going beyond productivity monitoring will be required to assure individuals are working “at the top of their license” in efficient ways. Stress over concern that artificial intelligence (AI) will replace jobs must be replaced with strategies to effectively use AI to reduce the stress of boring, repetitive tasks. Effective change management leadership also will be paramount as “change fatigue” can impact morale, not to mention patient care, across the enterprise.

Trustees Should Discuss: Does your organization have a well-defined human resources strategy that incorporates all elements of the human capital value chain and their interrelationships: recruitment, performance management, compensation and benefits, learning systems, productivity management, leadership development? Does the strategy anticipate more changes in the future to the roles of care team members across the continuum — serving patients in their homes, through virtual technology, as well as in traditional settings? In what areas are vacancies (or overuse of agency or overtime pay) most severe, and what recruitment or retention strategies are being deployed to address the challenge? Has the health system played an active role in working with academic institutions and educational resources to promote the training of individuals at all skill levels in creative ways? What is your organization’s leadership development and succession plan?

SHIFTING SANDS

Market movement in the following areas is highly variable, depending on your state, region or town. But they remain highly impactful and require constant observation to avoid missing signs of rapid change.

4 Value-Based Payment

Despite some fits and starts, the ongoing march to value-based payment will continue through 2020 and beyond. While no payment mechanism has yet to become a panacea, most payers continue to move away from “vanilla” fee-for-service to an expectation that value be demonstrated by cost savings and improved quality. Medicare Advantage plans already cover 35 percent of individuals eligible for Medicare across the country, and enrollment continues to grow at a steady pace year over year. Many Medicaid plans are organized around HMO-like structures with defined provider networks and, in some cases, at-risk payment models.

Watch for increasing activity of employers in your market to contract directly with providers for certain specialty services (e.g., Amazon with City of Hope for cancer care) or to take risk for total cost of care. Payers such as UnitedHealth (through Optum) and many Blue Cross Blue Shield plans are developing their own provider networks. Health systems with a blind eye to changes in payer strategies run the risk of being marginalized.

All of these trends require increased collaboration and data sharing between physician organizations (either employed or affiliated groups) and hospitals — and physician leadership to drive the necessary changes in care models to effect value-based care delivery.

Trustees Should Discuss: What is the health system's payer strategy to address commercial, Medicare and Medicaid trends in your region? How is the organization fairing under the current value-based payment structures? How "healthy" are hospital-physician relationships to drive improvements in care across the continuum? What opportunities exist to work directly with employers both within and outside your community?

5 Regulatory Changes

Health care is one of the most highly regulated fields in the U.S., so keeping a pulse on federal and state regulatory changes is crucial. Current "hot buttons" revolve around price transparency (beyond just posting your charge master), site-neutral payments and drug costs. Nationwide shifts to single-payer or public options will receive a lot of talk but no action this election year. Site-neutral payments go beyond CMS policies: Many health plans (e.g., Anthem, United) have instituted payment policies requiring pre-authorization and potentially disallowing payment for certain surgical or imaging procedures in hospital-based settings.

Whether mandated or not, being ready for retail medicine by enabling technology and simplified pricing structures to provide consumers accurate information about their potential out-of-pocket costs will be a competitive advantage. Be alert to changes in state-specific Medicaid policies; shifts in coverage, payment models and rates can be severe depending on stresses on state budgets and the political climate.

Trustees Should Discuss: How is your organization prepared for pricing transparency? What is its strategy to respond to site-neutral payments for outpatient care? Does it have a competitive outpatient network — inclusive of outpatient surgery and imaging services? What do you anticipate at the state level in terms of regulatory changes or shifts in Medicaid policies?

6 Growth of Outpatient and Post-Acute Care

The growth of outpatient and post-acute care is not new, but it is receiving greater attention as competition heats up and financial performance is scrutinized. Virtually all health systems continue to grow their physician enterprise, either through acquisition of physician practices or through contracting in clinically integrated networks. But there is also a plethora of primary care and specialty care models that are either privately funded (e.g., Oak Street Health, One Medical) or sponsored by large public companies (CVS, Walmart) that are expanding rapidly across the country. This will put pressure on health systems to assure that their outpatient strategy is competitive in terms of patient service, affordability and care coordination, and provides facilities and other resources attractive to physicians and other clinicians.

Likewise, the high demand for post-acute care, given the aging of the population and push for "right care/right place" has fostered the expansion of a variety of post-acute providers and venues of care, including hospital care at home. Many health systems are finding that partnering with organizations that specialize in rehab, skilled nursing and home care is more feasible than operating their own post-acute services. But setting up service-level agreements and assuring smooth transitions of care still require the constant attention of health system leaders.

Trustees Should Discuss: How is your outpatient network poised to compete with the likes of CVS and Walmart? Is its financial performance sustainable, and how easy is it for prospective patients to access your services? Do you have a post-acute strategy that assures patients can move seamlessly across the continuum of care and receive care consistent with your health system's standards?

7 Health System Complexity

Health system complexity will continue to increase. Whether your organization is a single community hospital or a multihospital, multidimensional system serving multiple states, external trends demand that health systems operate effectively across the care continuum and across multiple functions. Your organization could play a role as a payer, technology/innovation accelerator, clinical research resource, educator and professional training site as well as a care provider in acute, post-acute, outpatient, virtual and retail care.

The sheer complexity of running the information technology or analytics function for many health systems is daunting, let alone the revenue cycle process for so many different care venues and payment models. This level of complexity demands new types of leaders and approaches to leadership. It also requires organizations to determine what they can and should do alone and where partners can bring expertise and focus. Even more importantly, hospitals and health systems must articulate a clear vision of the organization they aspire to be, and what they will (and will not) do to achieve that goal.

Trustees Should Discuss: Do our strategies and actions match our stated vision? What degree of transformation is required to get us there? Do we have the right leaders or leadership approach to get us there? Has organizational structure and function matured consistent with the size and scope of the health system? Is our governance structure and function geared to lead the current and future health care enterprise?

REVOLUTIONARY POTENTIAL

While not new, many of these trends are gaining traction quickly — how dramatic will the change be in your environment? Close monitoring and, in some cases, advancing the application of these disruptive elements warrant attention for organizations to remain relevant as the future unfolds.

8 Telemedicine and Virtual Care

Telemedicine and virtual care have come of age. They have moved from the pilot stage and use in select areas to being a key consideration for virtually every service — from primary care to intensive care. For many health systems, telemedicine and virtual care are still viewed as a care model in its infancy, but many of the new entrants leverage the convenience of telemedicine and virtual care to attract consumers and create loyalty. They also provide a critical linkage with many specialty services for rural providers.

For example, voice recognition in the hospital and home setting is growing and assisting patients with everything from adjusting the temperature in their hospital room to contacting their care manager from home. Wearables (think Apple watch) that track key health indicators (EKG) as well as using cell phone apps to manage chronic care and leverage behavior modification tools have been and will be widely promoted. The only holdup will be the pace at which payment models keep up with these digital and virtual advances.

Trustees Should Discuss: What is your health system's plan to adopt and scale the use of virtual technology? Has it gone beyond the pilot stage to being a routine way that care is delivered for appropriate services? How are wearable technologies or cell phone apps being incorporated into chronic care pathways — or when is the timing right for that?

9 Biotechnology and Clinical Advances

Trustee Takeaways

Biotechnology and clinical advances continue to incorporate precision health concepts. Many of the most advanced are primarily provided in academic medical centers (e.g., CAR T-cell therapy), but genomics is being applied in many settings to take population health to a new level. Diagnostic equipment is becoming more portable (hand-held devices) and increasingly incorporates AI (imaging equipment), which changes both the venue and role of clinicians in using the equipment.

With organizations like Apple and Google increasing their role in medical research, leveraging their powerful analytic engines, traditional clinical research organizations may either be challenged or will need to find new partners to accelerate research efforts.

Trustees Should Discuss: How do our medical staff approval processes and care pathways consider new therapies or diagnostic approaches? Do we have a strategy to work with academic medical centers to extend the reach of research and/or new therapies into the community setting? How are we considering genomics in our care delivery approaches? Have we set priorities to focus philanthropy on the most critical research efforts?

10 Advanced Analytic and Digital Tools

Blockchain, AI and other analytic and digital power have the potential to create new levels of efficiency in traditionally cumbersome processes — for example, in revenue cycle. But in many cases, these applications are just emerging and are still waiting to be unleashed in significant ways. At the same time, organizations that seize the power of some of these advanced digital tools could be the game changers in both reducing administrative costs and driving out waste.

Partnering with technology companies that are working on these applications could be an opportunity or a distraction for hospitals and health systems. Determining the organization's readiness to radically transform key functions will be critical, but in any case, leveraging the potential of advanced analytics in your organization is a first step. Most leaders acknowledge their current dilemma: being data rich and insight poor. Improving basic business intelligence across the organization is fundamental to understanding both current performance and shedding light on opportunities for redesign.

Board discussions in the year ahead should address both routine and disruptive trends.

- How does our organization foster an environment that encourages new thinking and bold solutions that position it for future success?
- What needs beyond medical care does our community health needs assessment identify — housing, poverty, hunger, mental health — which our health system can address either directly or through community partners?
- Does our organization have a well-defined human resources strategy that incorporates all elements of the human capital value chain and their interrelationships: recruitment, performance management, compensation and benefits, learning systems, productivity management, leadership development?
- How is our organization faring under current value-based payment structures?
- Is our organization prepared for pricing transparency?
- How is our outpatient network posed to compete with nontraditional competitors such as CVS and Walmart?
- In what ways are wearable technologies or cell phone apps being incorporated into chronic care pathways?
- Do our medical staff approval processes and care pathways consider new therapies or diagnostic approaches?

Trustees Should Discuss: How are we leveraging technology and analytics to (1) make business decisions; (2) drive clinical decisions; and (3) improve efficiencies? What are our plans to embrace AI within the organization? Should we be partnering with others to see how we could transform key functions like revenue cycle or population health management?

- How are we leveraging technology and analytics to make business decisions, drive clinical decisions and improve efficiencies?
- Is our governance structure and function geared to lead the current and future health care enterprise?

CONCLUSION

Health care remains a tornado of change due to the many demands from all stakeholders: Consumers demand change to make our services more accessible, less fragmented, more affordable; payers demand more efficiency, less waste, lower cost; our workforce demands greater flexibility, less stress, competitive pay…the list goes on. We can be daunted by the complexity and often conflicting changes expected of health care systems, or we can embrace many of the opportunities that will make health care better for consumers and providers of care. As the saying goes, “running away from the problem only increases the distance to the solution.” 2020 will be another year to seize the challenge and embrace change to improve health care.

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A ‘Twist’ On Top Ten Governance Trends For 2020

Michael Peregrine Contributor

Leadership Strategy

Challenges for corporate board members will only increase in 2020 GETTY

A twist, but hopefully not twisted . . . a slightly different take on developments likely to impact corporate governance in 2020. A list that doesn’t mention shareholder activism, cybersecurity, climate risks, nor SEC regulation. What follows are perspectives offered from a slightly higher altitude but still within sight of the tarmac.

Preparing for More Volatility. Directors will be expected to confront the tactical and strategic implications to their company of any potential political, social, economic

or regulatory volatility. Such uncertainty will be driven in part by the impeachment process, divided government and the 2020 elections, Other drivers may include questions concerning economic growth, trade conflict, income inequality, inflation and, more generally, continued societal fragmentation. To address these challenges will require directors to exercise more engagement, heightened attentiveness and close interaction with management.

Emphasis on Board Refreshment. Board composition will be impacted by the use of more extensive refreshment practices intended to foster the achievement of turnover and diversity goals. This, in recognition of data indicating that director tenure continues to be very extensive; that board vacancies are rare and when they do occur the seat is often taken by an experienced director. Term limits, performance evaluations and retirement requirements will see wider application. More consideration will be given to electing directors with no prior public company board experience.

Corporate Accountability Returns. The organizational commitment to a culture of ethics and corporate accountability will require greater involvement of, and support from, the board. The financial and reputational cost of organizational malfeasance will become more clear to leadership from new corporate fraud scandals, consumer safety and product design crises, legislative scrutiny, public focus on whistleblower protocols and increased regulatory enforcement activity. Director codes of ethics will be refined and given higher organizational prominence. The value of organizational rectitude will receive greater board recognition.

Re-Examining Purpose. Boards will re-examine the scope of their corporation's purpose and the related interests of a broader class of stakeholders. Boardroom dialogue will gradually move beyond the basic question of whether there is an obligation to address the relationship between stakeholders and purpose, to the question of how best to address such a relationship. The company's 2020 governance agenda must provide the board enough time to resolve very practical questions on more meaningful engagement with stakeholder interests and concepts of social responsibility.

Emphasis on Business Judgment Rule. Evolving judicial interpretation of the *Caremark* standard for director risk oversight will prompt greater board emphasis on satisfying the business judgment rule. This is particularly the case with respect to the risk management program. Special, documented and more informed board effort should be made to engage vigorously with management on key corporate risk factors. Committee charters should more clearly address risk monitoring duties. Senior executives should acknowledge board oversight responsibilities and adopt greater sensitivity to the corporate risk profile.

A Closer Focus on Innovation. Organizational innovation and disruption-related initiatives will receive closer board scrutiny with respect to feasibility, mission relatedness and conflicts of interest. The spectacular demise of several prominent unicorn ventures, regulatory scrutiny of high-profile data and technology ventures and uncertainty of the application of AI systems will combine to increase fiduciary caution. The pace with which innovation and related initiatives are pursued will be more measured. The company's innovation development process, and the portfolio and compensation of its innovation executives, will receive greater board oversight.

Improving Gender Equality. As part of workforce culture oversight, boards will pursue more detailed initiatives to advance women and improve gender equality within the organization. Gains in women representation in corporate governance and executive leadership will be solidified, and extended to women of color. Greater efforts will be made to address gender diversity at lower levels of management, with boards addressing what McKinsey calls the "broken rung" in the advancement pipeline. Governance will increase its commitment to a more inclusive workforce culture.

Greater Emphasis on Human Capital. The substantial recent uptick in CEO termination will prompt boards to enhance their search and succession activity and to increase their focus on talent development. Shortcomings in succession and executive development practices exposed by crisis or otherwise will be corrected by more formal processes for developing successor candidates for key leadership positions. Directors will more fully confront the engagement required for effective executive succession

planning. Greater oversight will be applied to assure linkage between strategic planning and workforce talent pools.

Pushing Change with Compliance Programs. Board oversight of compliance mechanisms will be grounded in a more integrated, coordinated and sophisticated approach across the organization. Boards will encourage the recalibration of organizational compliance efforts to be more responsive to factors such as corporate growth, global footprint, evolving leadership duties and implementation of formal enterprise risk functions. Directors will push compliance structures away from once-sacrosanct silos towards more collaborative internal arrangements, while preserving critical reporting relationships. Management-level compliance complacency will not be tolerated.

Retooling Structure and Process. Increasing competitive pressures and focus on stakeholder interests will lead boards to consider significant changes to board structure and decision-making practices. As the National Association of Corporate Directors has recommended, boards will seek to meet the demands of a different operating reality by reshaping thought processes and operational approaches. They will begin to modernize their expertise and behaviors in order to improve the corporation's competitiveness. This may lead to new perspectives on board composition and efficient boardroom processes.

MISSION

- The mission of Lewis County Hospital District No. 1,
- steward of public funds and trust,
- is to provide our highest level of compassionate, diligent and professional medical care.

VISION

- A caring team of people
- working together
- to lead our community
- toward better health.

VALUES - ACTQI

- **A**chievement - successful
- **C**reativity/innovation – thinking outside the box
- **T**eamwork – working together
- **Q**uality – everything right every time
- **I**ntegrity – doing the right thing when no one is looking

2017 Strategic Map

Lewis County Public Hospital District #1, dba Morton General Hospital (MGH) held a strategic planning retreat on October 24 and 25, 2016. The deliverables for the retreat included:

- Consensus on service delivery gaps within the District boundaries.
- Consensus on infrastructure and operational needs.
- Common understanding of payment reform, rural delivery and desired MGH response.
- Consensus on, and prioritization of, strategic planning initiatives for 2017-2019.

The retreat opened with a review of the District's 2015 strategic path. A discussion of key issues from the perspective of leadership and medical staff and was followed by an in-depth presentation by the national consultant that has been engaged by the Washington State Hospital Association to help define and develop a reimbursement system that will assure stability in Washington's most rural and smallest hospitals. After the presentation of local market data, a robust conversation pursued regarding opportunities, challenges, vision, priorities and potential strategies. At the closure of the retreat, there was broad consensus that MGH must remain focused and that realizing these initiatives will benefit District residents and position MGH well for the future.

Strategic Initiatives

Three strategic initiatives were selected for 2017-2019:

- **Position and market the District's primary care clinics as the entry point for health care in the community. Meet the needs of District residents for accessible and available primary care and also grow our services by:**
    - Adding services including care coordination and behavioral health
    - Coordinating seamlessly with the hospital and more regional resources to assure timely and quality care transitions
    - Improving processes to increase productivity, and by
    - Developing additional access points and adding extended hours, walk-in hours and perhaps urgent care.

- **Engage employees and providers in creating a culture focused on safety, patient satisfaction and outcomes**. Engage staff to assure that we operate with a single voice and a shared culture *every touch, every time*, and that the District's services are viewed as a single entity—not as a separate clinic and hospital.

- **Continue to develop the infrastructure to support transition from volume to value:** The District anticipates that its reimbursement will increasingly be based on patient outcomes. Our challenge is to maintain at least 1% margin from operations, while investing in the efficiencies, analytics and processes that will assure our ability to participate in value-based care.

Vision Statement

Morton General Hospital and Clinics is a vital community resource dedicated to the Health of our community. It is facing an industry in transformation and will focus on caring for the well-being of all citizens who seek health and wellness from us.

We are an exceptional quality focused organization, who strives daily to insure excellence, safety and compassionate patient care.

We strive to empower and engage our team mates to focus on the purpose of caring for the health of our community.

We are financially solid and investing in the future of healthcare though improvement and technology. We are committed to partner with our communities and others to transform healthcare and wellness for East Lewis County.

Identified Needs/Gaps and Opportunities

Needs and Gaps

- Staff engagement, training on culture and value to volume
- View hospital and clinic as a single hospital
- Clinic transformation
- Make the clinics "a pillar of strength"—and potentially add more ancillary services
- More health education classes
- Geriatric programming
- Transportation

Opportunities

- Non-traditional service line development, i.e. gym and school-based services
- More convenient access for primary care and after-hours
- Home Health
- Telemedicine
- Pharmacy
- Clinic processes to improve productivity and patient satisfaction
- Behavioral health

Key Data Informing the Strategic Plan

- The District's population has declined by 1.6% since 2010. Today the population is 10,368 and nearly 23% are 65+, making the District one of the oldest communities in the State. The 65+ population is projected to grow by another 12% over the next 5 years, while total population will grow by less than 2%.

- More than 85% of MGH's inpatients in 2016 resided within the District. MGH's highest market share is within Morton itself (39%).

- In 2010, MGH enjoyed a 28% market share of the District (discharges). In 2016, it was 22%. Out-migration is spread to many communities along the I-5 corridor.

- In the District, 10 diagnoses account for about 36% of all inpatient hospitalizations. The two largest—OB and joints—are services not offered by MGH.

- National data suggests that the largest gross need for physicians in the District is for primary care. Assuming 100% of residents stayed locally for care, the community can also support a full time cardiologist, ophthalmologist, general surgeon, pulmonologist, OB/GYN, orthopedist, and oncologist.

Why Did We Not Focus on All of the Gaps?

During discussion attendees agreed that MGH needed to focus its priorities in areas that support access to care for District residents and that assure that the culture of the organization is prepared for value-based care. A majority of the identified gaps lent themselves nicely to initiatives focused on primary care, organizational culture and efficiencies to position MGH for the value-based reimbursement world. While not all of these are specifically called out in the strategic initiatives, it is highly likely that they will ultimately be incorporated.

For example, transportation, education, home health, behavioral health and more telemedicine gaps and opportunities could ultimately be placed under the primary care strategic initiative.

In the short term, and while areas of high interest, others including non-traditional service line strategies to support the community's health and developing or advocating for a local pharmacy alternative were deemed were not selected for immediate prioritization.

Discussion Group Themes

A series of 6 focus groups were conducted locally in late September. A total of 50 community members participated in the six groups, which were held throughout East Lewis County in Packwood, Randle, Morton and Mossyrock. Five themes emerged and are summarized below

#1: There were very positive perceptions of many Hospital services, and appreciation for recent improvements. ED was the exception; and there was great interest in ED alternatives. There were very positive perceptions of many Hospital services, and appreciation for recent improvements. ED was the exception; and there was great interest in ED alternatives.

#2: Local primary care is good: Many painted a positive picture about local primary care providers. Comments about improvements of the physical plant at Randle and the addition of a provider, (but most thought that wait times are still too long at that location) were frequent.

#3: The local pharmacy is a cause of great dissatisfaction. Attendees were highly dissatisfied by the current retail pharmacy in Morton. Many stated that travelling out of area for a prescription is faster than waiting for the local pharmacy to fill a prescription.

#4: Staff compassion overall and several programs are "standouts" from the perspective of attendees. Nursing staff, the PT program, the District's Healthy Aging Program and the cafeteria all rated exceptionally high.

#5: Urgent care, behavioral health and charges for services were identified as gaps. Other identified service gaps included home health, dietary counseling, OB (at least prenatal support) and community-based exercise options.

MEMORANDUM

To: Board of Commissioners

From: Leianne Everett, Superintendent

CC:

Date: 02/01/2020

Re: 2017-2019 Strategic Plan Update

In October 2016, we adopted three strategic priorities to pursue in 2017-2019. Below are the three priorities and Administration's work to fulfill those initiatives. I have also included areas of concern that can/will drive priorities into 2020.

- Position the market and District's primary care clinics as the entry point for health care in the community. Meet the needs of District residents for accessible and available primary care and also grow our services….*Post retreat, Administration expanded on the narrow interpretation of primary care to include basic hospital services as well.*
    - Added Case Management in February 2018. Due to the success and increasing awareness of need, we expanded the hours in 2019,
    - We have been unable to fill our Care Coordinator position(s),
    - Tele-behavioral health services for adults were added to our Rural Health Clinics in January 2019. 576 tele-behavioral health visits were provided 2019. We are currently working to add behavioral health services for adolescents in 2020,
    - Added a Behavioral Health Counselor in 2019. This position is providing crisis support throughout the organization to patients, as well as employees. Our Counselor also works closely with Case Management to safely discharge patients with appropriate services,
    - Engaged Allevant to support the growth of our skilled swingbed program in October 2018. We experienced a 378% growth in our swingbed days in 2019 vs 2016,
        - Established and continually nurture professional relationships with referring facilities,
    - Supplemented Dr. Park-Hwong's women's health services with a 0.5 midlevel provider to improve access within our district,
    - Converted our Sleep Lab to an accredited Sleep Clinic in May, 2018. We added a 0.5 FTE midlevel provider to increase access to sleep study services. In 2020, we will change accreditation bodies to allow us to expand into home sleep studies, thus capturing a new market,

- Redesigned Rehabilitation Services department by replacing a shared management model with a single manager, added full-time occupational therapy and added full-time speech therapy. We are currently working to add pediatric/adolescent services in 2020.
- **Remaining area(s) of concern**: Improving RHC provider access/production,

- Engage employees and providers in creating a culture focused on safety, patient satisfaction and outcomes. Engage staff to ensure we operate with a single voice and a shared culture every touch, every time, and that the District's services are viewed as a single entity – not as a separate clinics and hospital.
  - Conducted a Culture of Safety Survey in April 2018,
  - Conducted an Employee Engagement Survey in September 2019,
  - Adopted the parent name of Arbor Health in January 2019 to unify geographic locations into a single entity,
    - Updated and improved website,
    - Improved and increased social media presence,
    - Updated and increased billboard advertising,
    - Increased and improved print advertising and brochures,
  - Implemented several communication tools throughout the organization to improve teamwork. These tools are always evolving to meet the organizational needs.
    - Daily: Safety Huddles, Interdisciplinary Huddles and Administration Stand-ups
    - Weekly: Interdisciplinary Rounding
    - Bi-weekly: Manager Huddles, Manager Development
  - Restructured the Quality Department in April, 2018 (Generation 2.0). This restructure focused on data transparency, process improvement and regulatory compliance. In 2020, we are working on a Generation 3.0 with our Quality Department.
  - Restructured nurse leader model, retiring the DNS position and replacing with 24/7/365 House Supervisors,
  - **Remaining area(s) of concern**: Shifting our narrative to a patient centered perspective, rebuilding our complaint process and moving into DNV accreditation.
- Continue to develop the infrastructure to support transition from volume to value. The District anticipates that its reimbursement will increasingly be based on patient outcomes. Our challenge is to maintain at least 1% margin from operations, while investing in the

efficiencies, analytics and processes that will ensure our ability to participate in value-based care.

- Entered into value-based reimbursement contracts
  - Amerigroup – a Managed Medicaid three-year contract that aggregates our volumes with three other low volume hospitals. We have received $3.00 per member per month (PMPM), as well as almost $14,000 in 2018 and 2019 combined. We have not experienced shared savings and this contract is not expected to renew after 2020.
  - United Health Care – this Medicare Advantage program focuses on preventative care and has resulted in almost $12,000 thus far.
- Engaged in grant work with Washington Rural Healthcare Access Preservation and Cascade Pacific Action Alliance to supplement behavioral health program,
  - WRHAP – this is a multi-payor program. We have received over $123,000 thus far. This program supplements our tele-behavioral health programs in our rural health clinics.
  - CPAA – this is a Medicaid Transformation project that also supplements our tele-behavioral health programs. This has produced over $215,000 thus far.

MEMORANDUM

To: Board of Commissioners

From: Leianne Everett, Superintendent

CC:

Date: 02/01/2020

Re: Stakeholder Input

From October 2019 through December 2019, interviews and focus groups were conducted to collect stakeholder concerns and priorities into our strategic planning work. The following groups were solicited:

- **Commissioners** – Individual interviews were conducted with all current commissioners. Their comments are aggregated in the accompanying *Strengths-Weaknesses-Opportunities-Threats (SWOT) Analysis* and the *Strategic Priorities Summary*.
- **Key Medical Staff** – Individual interviews were conducted with seven providers. Their comments are aggregated in the accompanying *SWOT Analysis* and the *Strategic Priorities Summary*.
- **Leadership** -- Individual interviews were conducted with all members of the leadership team. Their comments are aggregated in the accompanying *SWOT Analysis* and the *Strategic Priorities Summary*.
- **Managers** -- Individual interviews were conducted with all members of the management team. Their comments are aggregated in the accompanying *SWOT Analysis* and the *Strategic Priorities Summary*.
- **Employees** – Three focus group meetings were held within the Hospital. 5 employees attended. Their aggregated responses are provided in an *Employee Report*.
- **Community** – Three community focus groups met at the Hospital. 5 community members attended. Their aggregated responses are provided in an *Community Report.*
- **Key Community Leaders** – Four individuals were interviewed. Their aggregated responses are provided in an *External Stakeholder Report.*
- **Healthcare Leaders** -- One executive from Providence and one executive from PeaceHealth were interviewed. Their aggregated responses are provided in an *External Stakeholder Report.*

Strengths

1. Influence on the community
2. Less layer of leadership
3. Focus on community
4. Proven positive track record with current administration
5. Clinics and hospital seem close knit
6. IHI training modules
7. Transparent staff
8. Critical Access Hospital (CAH) status
9. Unified and experienced leadership team
10. Supportive community
11. Transitional and skilled nursing care
12. Great CEO/CFO – leadership team is on the same page
13. Dedicated staff
14. Employees that care about the community and work together
15. History and community pride
16. Foundation
17. Personal attention to patients
18. Provider/patient relationships
19. Payroll number and size
20. Close physician relationship with CEO and administration
21. Emergency facilities
22. Strong leadership team
23. Personal care

Weakness

1. Leaders wear more than one hat
2. Benefits are weak and expensive
3. Lack of communication (silos)
4. Not enough volume to warrant specialists
5. Management turnover (recent)
6. Position recruitment
7. Aging equipment (e.g. CT/Xray)
8. Labor pool
9. Communication – from top down
10. Divide between administration and “front line”
11. Small community politics and personal agendas
12. Putting up with lower standards because of “fear to replace”
13. Not enough expectations on people because of “potential and lose staff”
14. Recruitment and retention
15. Underlying culture of entitlement of tenured staff
16. Too much upper management
17. Monetary draw for recruitment
18. Difficult to retain staff
19. Current Cerner capabilities
20. High lab costs
21. Lack of support for “out of the box” ideas
22. Inability for Bariatric care
23. Alignment of goals across staff

Opportunities

1. Potential growth for clinics
2. Hospitalist program should be grown
3. ICU beds
4. Women's health
5. Community health outreach
6. Urgent/After-hours care facility
7. Bone density/DEXA scans
8. Home health assistance
9. Acquire Morton Medical
10. Critical Access Hospital status
11. Wellness center (e.g. pool, rehabilitation, yoga, education)
12. Increase care coordination capabilities
13. Increase service lines
14. Serving diversity of cultures
15. Growing aging population
16. Motivating employees to take ownership
17. Better quality of services offered
18. Improve reputation of hospital
19. Increase outpatient admissions
20. Smoother process for interfacility transfers
21. Better outpatient services
22. In facility pharmacy
23. Mental health resources
24. Telehealth

Threats

1. Competitive wages
2. Community turning on hospital/losing support
3. Preparation for natural disaster fallout
4. Staff and patient security (e.g. active shooter, combative patient, cyber security)
5. Out migration of patients/services
6. Lack of specialty care
7. Market encroachment
8. Board change over
9. Payment system could be adjusted in a negative way
10. Medical billing or HIPAA error
11. Local economy (logging restrictions)
12. Medicare population (e.g. payment models, change to value-based care, data requirements become an over taxing process)
13. Federal/State regulations

Major Strategic Issues

1. Communication
2. Staffing shortage
3. Volatile job market
4. Population changes (e.g. lower incomes)
5. Recruitment of providers
6. Networking/collaboration (e.g. Providence)
7. Reduce number of travelers/interims
8. More community outreach for annual checkups and preventative care
9. More action groups
10. New or expansion of Randle clinic
11. Capital improvement
12. Accreditation
13. Retention of staff and stability of leadership
14. Staff training
15. Service line opportunities/improvements
16. Address public health
17. Viable financial model
18. Equitable access for entire district
19. After hours services
20. More skilled staff
21. Financial counselor
22. CIO or IT leadership
22. Increased marketing presence/exposure
23. Established and reliable primary care
24. Less travelers
25. More primary care providers
26. Increase reputation of patient care
27. Physician/Nursing burnout
28. Burden of EHR abilities
29. Better clinic-to-clinic or clinic-hospital integration

Vision

1. More affordable services for employees
2. Hospital subsidized childcare
3. Continue to grow cafeteria services
4. Engage more commercial payers
5. Care coordinator for each clinic
6. Grow behavioral and hospitalist programs
7. Packwood clinic or expansion of Randall clinic
8. More outside referrals
9. Use less paper
10. Consistent quality/improvement of service lines
11. More health-orientated activities and community education
12. Physical rehabilitation/Sports Medicine
13. Heart healthy cafeteria options
14. Improve billing and collection process(es)
15. Leadership and Board involvement with community activities
16. Wellness education (e.g. smoking cessation, diabetes, et. al.)
17. Use of Cerner to build care management
18. Nocturnist program
19. Develop/increase relationship with local schools
20. Grow wound/rehab/stroke services
21. Bariatric program
22. Surgical services
23. Develop relationships with referral centers
24. Safety culture and onboarding program
25. 80% market share of offered services
26. Podiatrist
27. Visiting specialists
28. MOI with WSU/UW medical school (e.g. rotations)
29. Develop working relationship with Veterans Administration (VA)
30. Telehealth
31. ED physician office
32. MSW for clinics
33. Better provider integration with Arbor Health

Outcomes and Goals

1. Radiology equipment upgrades
2. Care management program with tools in Cerner
3. Focus on relationship with frontline staff
4. More staff education
5. Less employee turnover
6. Community health education center
7. Address pharmacy outpatient issues
8. Increase EBITA margin
9. Increase telehealth offerings/program
10. More providers and stable well-trained nursing staff
11. Affordable laboratory services for patients from outside clinics
12. Increased market share for service lines provided by Arbor Health

Strategic Expectations

1. SMART Goals and clear quantifiable metrics
2. Preparation for the future
3. Measurable goals
4. Short, medium and long-term goals
5. “Listen” to the data, wants and needs of the community
6. Meet government requirements
7. Staff training and education to buy into the “big picture”
8. Increased relationship/understanding of leadership team and board
9. Use of the strategic plan
10. Goal alignment throughout organization
11. Increased fiscal solvency

Employee Report

Q1. What are the 3-5 most critical strategic Issues / questions facing the Hospital over the next three to five years?

1. Communication
2. Shorthanded staff

Q2. What Is your view of what the Hospital should look like in the next 3 to 5 years?

1. More comfortable seating in the ED
2. Better lighting
3. More consistent temperatures throughout the buildings
4. A way for the front desk staff to be more informed on upcoming events
    a. People approach them asking where certain meetings
    b. Front desk should be introduced to new employees for security reasons
5. Keep some Long-Term Care beds
6. Employees should be rewarded for extra training/ certifications
7. Better succession planning
8. More affordable services even for employees
9. Urgent care or after hour clinic services
10. Hospital subsidized childcare
11. Improve HRG system
12. Continue to grow cafeteria services
    a. Employees and the community really appreciate its affordable service
    b. It's a water hole for the community and Hospital staff to interact

Q3. What are the top 2-3 priorities for next 12-24 months?

1. Patient care
2. Employee Safety
3. Communication
    a. Celebrate the "Wins"
4. Less activities that require employee donations

Open Comments

1. Staff feels there is a disconnect between employees and administration.
    a. i.e. Adopt a Family
        i. Organization pays a "fair wage" but some employees are going through things that make it difficult to live off that
    b. Employees feel that administration does not know what they are going through
2. The mission and vision of Arbor Health needs to be displayed and communicated more often

Community Report

Q1. Most critical challenges facing community over the next 3-5 years

1. Volatile and small job market
    a. Logging
2. Population is changing to more lower income homes

Q2. How can the Hospital help your community meet these challenges? What can the Hospital do to help your community become more successful and achieve Its goals?

1. Engage more commercial payers
2. More preventative care
3. Partner with local business owners to provide a building that can be used for wellness classes or seminars
    a. Yoga, Pilates, Zumba etc.
4. Community has mixed feelings about Hospital offering service lines that directly compete with local business

Q3. Are there new or different ways in which the Hospital and your community can partner? If so, how could the Hospital be of value?

1. More education on pricing and insurance

Open Comment

1. More education on CAH billing model. Do we have to bill clinic patients at critical care rates? Show that if the patient wants to travel they can get a lab done cheaper somewhere else.
2. Keep open door policy
    a. Being able to speak to administration helps community members understand

External Stakeholder Report

Q1. In your opinion, what are the most critical challenges facing healthcare over the next 3-5 years?

1. Our aging population. Some form of healthcare for the aging population
2. Sustaining healthcare; concerned about the cost of healthcare
3. Be transparent about the cost of healthcare
4. Streamline billing
5. Cost of healthcare
6. Improve access to healthcare
7. Melding of mental health and substance abuse into healthcare. How will this look as we move into managed care
8. Stay closely connected to policy makers
9. On-going lack of community resources to address behavioral health concerns
10. Lack of patient beds and services
11. Increasing dementia and behavioral health patients with no placement opportunity
12. 10,000 people/day reaching Medicare eligibility (increased service demand)
13. Legislators focus on urban healthcare and not rural
14. Workforce shortages – lack of experience, increasing compensation

Q2. How can Arbor Health help your organization meet these challenges?

1. Transparency-Unfolds into a trust issue. Change to Arbor Health was not transparent enough. Small communities are resistant. Be educational and transparent
2. Be prudent on spending
3. Be open and transparent
4. Tell your story better
5. Advocate for improved broadband
6. Improved communication at patient handoffs
7. Integrated care plans
8. Access

Q3. Are there ways in which Arbor Health and your organization can partner to accomplish some of your organizational goals?

1. Yes, community involvement. Hospital is an economic force so sustainability
2. Emergency preparedness
3. Do primary care well. ER has a good reputation
4. Our swing bed patients get better care and more attention because of our lower nurse to patient ratios
5. Be present in the community, i.e., community cleanup day (more communities than just Morton support your hospital)
6. Presence – publicize, sponsor things, be more proactively visible
7. Offer things like CPR classes to community for free
8. Partner on bringing community health and wellness classes
9. Do events in senior centers, community halls, stores, libraries

Q4. Overall, what is your impression of Arbor Health as an organization?

1. Have not used services. Increase technology abilities/better up-to-date services, custodial program
2. Front desk is great; MRI is great
3. Build confidence in what you do and understand what you cannot do
4. Improved over last 40 years. Aesthetics of the facility. Never hear anything bad about staff
5. Partner with organizations to educate locals and keep them in the community

Q5. What if any unmet healthcare needs are there in our region?

1. Labor and delivery
2. Rape kits and training
3. Mental health
4. Substance Abuse
5. Diabetes

Q6. Are there ways in which Arbor Health and your organization can partner to address those un-met healthcare needs?

1. Community Health Workers

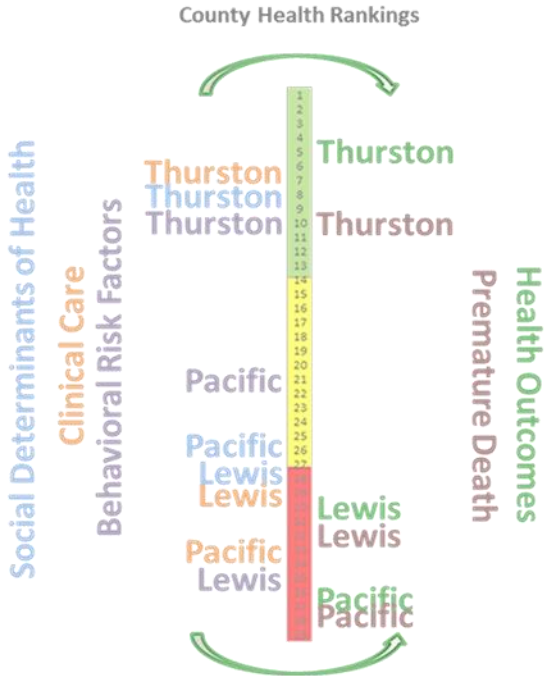
Q7. What strategic opportunities do you think Arbor Health could/should pursue over the next three years?

1. Moving in right direction with ambulance
2. Grants-create value through Medicaid Transformation monies before they go away
3. Programs for the elderly, aging and mental health
4. Pop-up services. Bring services to locations that do not get services due to time and distance
5. Lack of a strong social media presence
6. Expand primary care and swing bed to meet increasing demand

Q8. Do you have any other insights/ideas that you would like to share regarding the Hospital and its strategic planning process?

1. Extensive waits in ER. 30 minutes or less is not true
2. Put pressure on Lewis County commissioners on how they have land development regulations to allow more homes i.e., smaller properties, to avoid raising taxes
3. Provide quarterly updates to the communities to get a "pulse"; "town halls,"
4. Look for input internally and externally
5. Partner with senior centers
6. East county is far less resourced that west county. Focus on value, build partnership regarding diabetes, obesity and tobacco use

Community Health Needs Assessment 2019



Community Feedback

Community Health Needs Assessment

Lewis County Community Health Services
DBA Valley View Health Center

Contents

Executive Summary

Lewis County Community Health Services, DBA Valley View Health Center (VVHC) is a Federally Qualified Health Center providing Primary Care, Dental, Behavioral Health and pharmaceutical services to residents of Southwest Washington since 2004. The Community Health Needs Assessment is completed every 3 years to guide our strategic plan and helps ground our activities to ensure we stay true to our charge as an FQHC and our mission to improve the health and well-being of residents of Lewis, Pacific and Thurston Counties in a patient centered atmosphere, respecting individual and cultural diversity.

Lewis and Pacific Counties are rural with limited public transportation options, severe shortages of health professionals, and are ranked in the bottom third of Washington State counties with respect to social determinants of health, behavioral risk factor, clinical care options and health outcomes. Thurston County is not classified as rural and ranks in the top third of Washington State counties with respect to social determinants of health, behavioral risk factor, clinical care options and health outcomes. However, there is a disparity between the Olympia-Lacey-Tumwater metro region and the rural parts of the county with respect to transportation and clinic care options.

Community feedback indicates the biggest concerns are access to care, especially local Primary Care and Specialist Provider shortages and transportation to health care; health care costs; quality of care; disease burden; lack of local social and support services, especially elder care; and substance use. The most desired local specialists include mental health/behavioral health, dental, Women's Health and Ophthalmology and Optometry.

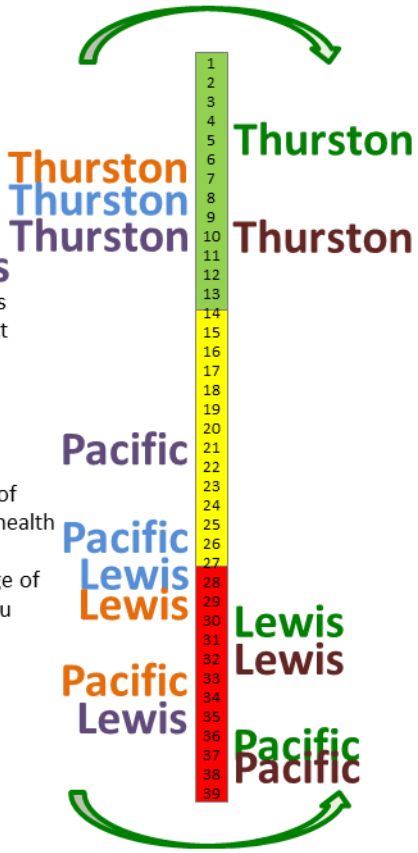
Key Findings: Health Ranking, Health Factors and Health Outcomes

County Health Rankings

Social Determinants of Health
Based on the conditions under which people are born, grow, live, work and play significantly influence the health of a community and its residents.

Behavioral Risk Factors
Based on those personal behaviors or patterns of behavior which strongly yet adversely affect heath thus increase the chance of developing a disease, disability or syndrome.

Clinical Care
Based on the number of uninsured, the ratio of primary care providers, dentists, and mental health providers per population, the number of preventable hospital stays, and the percentage of those getting mammography screening and flu vaccinations.

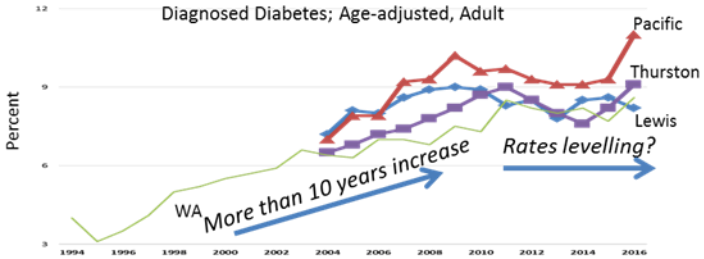


Health Outcomes
Based on how long people live and how healthy people feel while alive, rates of premature death, those with poor or fair health, the number of days with poor physical or mental health days, and the number of babies born with low birthweight.

Premature Death
Based on every death occurring before the age of 75 is premature and contributes to the total number of years of potential life lost.

% of population on Washington Apple Health

Lewis 34%
Pacific 32%
Thurston 23%
WA State 24%

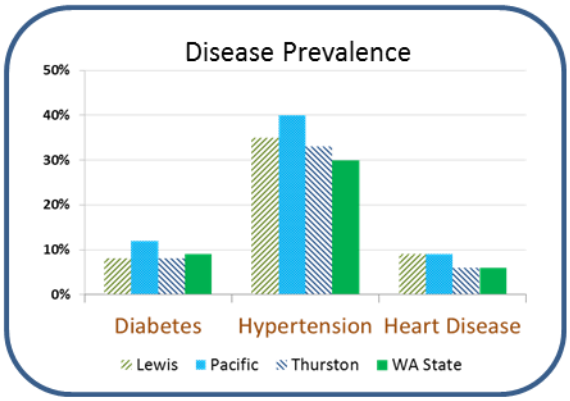


HealthCare Provider Shortage

1PCP for ~1,000 in Thurston, ~2,000 in Lewis, ~4,000 in Pacific — WA state And top US

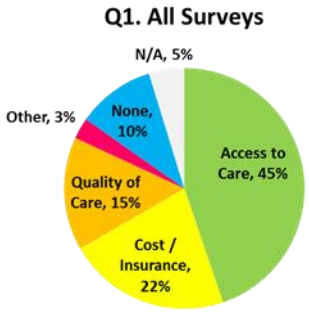
1 Dentist for
~1,500 Lewis, Thurston — WA State and top US
~3,000 Pacific

1 MHP for ~300-400
Lewis
Pacific
Thurston
WA State and top US

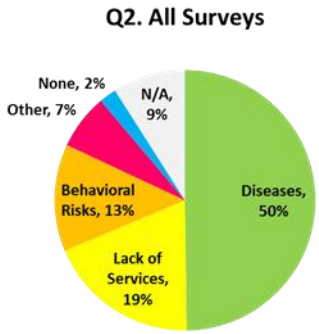


Key Findings: Community Themes and Strengths

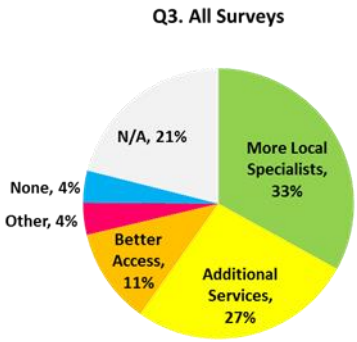
Biggest Challenge in Receiving Health Care:



Health Problems Seen in community:



Healthcare Service Wish:



Community Health Issues:

57% of surveyed community said lack of health-related services is biggest issue

#1 Substance Use Disorder Treatment
#2 Transportation to Health Care
#3 More Local Specialists Needed
#4 Elder/Shut-in/Home Care

#1 Mental Health
#2 Women's/OBGYN
#3 Dental
#4 Unspecified
#5 Primary Care (PCP)
#6 Ophthalmology/Optometry

VVHC Patients want:
#1 Dental
#2 Ophthalmology/Optometry
#3 Primary Care (PCP)
#4 Mental Health (MHP)
#5 Neurology
#6 Radiology

Detailed Contents

Community Health Needs Assessment Purpose

Lewis County Community Health Services, DBA Valley View Health Center (VVHC), as a Federally Qualified Health Centers (FQHC), is required to complete a Community Health Needs Assessment every 3 years. Beyond meeting a requirement, the assessment guides our strategic plan and helps ground our activities to ensure we stay true to our charge as an FQHC and our mission to improve the health and well-being of the community.

The assessment provides the means by which VVHC will remain responsive to the needs of our target population of low income, uninsured and medically under-served residents of Lewis, Pacific and Thurston Counties in a patient centered atmosphere, respecting individual and cultural diversity.

The assessment identifies the community characteristics of the VVHC service area as well as key health indicators and health disparities, which include morbidity, mortality, and access to care and various social determinants of health. This snapshot of our community is derived from publically available local, state and nationally recognized secondary data sources. The assessment is developed alongside community stakeholders. It summarizes community perceptions of health needs and issues, and frames strategies to address known and emergent health care issues. Community perception data comes from surveys and key informant interviews conducted by VVHC staff.

The assessment is organized by the 3 counties that VVHC primarily serves: Lewis, Pacific and Thurston. These 3 counties have different demographics, socioeconomics, and health measures. Strategies to address health care issues may need to be county-specific. The last assessment was completed in 2016. The latest available data is used for this current assessment and comparisons are made to 2016 when possible.

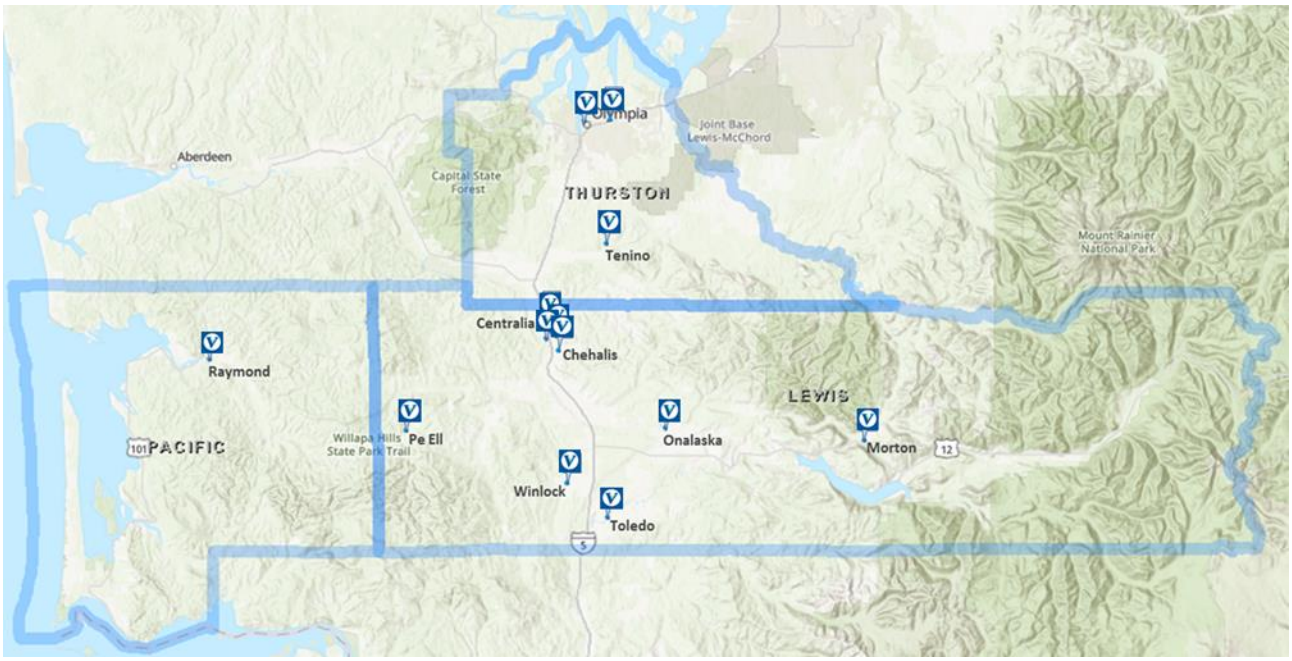
Acknowledgements

Valley View Health Center thanks the community members who assisted in this assessment by providing feedback through surveys and key informant interviews. Your time and thoughts are critical to understanding community health issues. Valley View Health Center also thanks our community partners and established community health forums.

VVHC Service Area

VVHC provides Primary Care, Dental, Behavioral Health and pharmaceutical services to residents of Southwest Washington since 2004. It originated out of discussions at the Lewis County Community Health Partnership for the need to reduce hospital emergency room visits from the uninsured. VVHC continues to grow and added three new clinic locations since the 2016 Community Needs Assessment for 13 current clinic sites. Nine of VVHC's clinics are located in Lewis County, one is in Pacific County and three are in Thurston County.

Over 75% of all VVHC patients reside in just 9 zip codes within the 3 counties. VVHC has clinics in 8 of the 9 zip code areas: Olympia (98501), Centralia (98531), Chehalis (98532), Onalaska (98570), Raymond (98577), Tenino (98589), Toledo (98591), and Winlock (98596). The 9th zip code area is located in Rochester (98579).



Valley View Health Center Clinic Locations

Lewis County Clinics

Valley View Chehalis Clinic - Medical, Dental & Behavioral Health
2690 NE Kresky Ave
Chehalis, WA 98532

Valley View Children's Dental
711 Harrison Ave
Centralia WA 98531

Valley View Health Center Centralia - Medical
2428 Reynolds Ave
Centralia WA 98531

Valley View Walk-in Clinic, Centralia - Medical
1800 Cooks Hill Road,
Suite G
Centralia, WA 98531

Valley View Health Center Morton - Dental Only
148 E Division
Morton, WA 98356

Valley View Health Center Onalaska - Medical and Behavioral Health
1810 Hwy 508
Onalaska, WA 98570

Valley View Health Center Pe Ell - Medical
402 N. Main Street
Pe Ell, WA 98572

Valley View Health Center Toledo - Medical and Behavioral Health
117 Ramsey Way
Toledo, WA 98591

Valley View Health Center Winlock - Medical and Behavioral Health
100 Cedar Lane
Winlock, WA 98596

Pacific County Clinic

Valley View Health Center Raymond - Medical, Dental & Behavioral Health
300 Ocean Avenue
Raymond, WA 98577

Thurston County Clinics

Valley View Health Center Olympia - Medical, Dental & Behavioral Health
3775 Martin Way E,
Suite A
Olympia WA 98506

Community Care Clinic Olympia - Medical
225 State Ave NE
Olympia WA 98501

Valley View Health Center Tenino - Medical and Behavioral Health
273 Sussex Ave E
Tenino, WA 98589

Lewis County

Characteristics

Lewis County is the 6th largest county in size in Washington State with a land area of 2,402 square miles. Lewis County is classified as rural with almost 60% of people living in unincorporated areas. Lewis County has 9 Cities/Towns: Centralia (population 17,170); Chehalis (pop. 7,535); Morton (pop. 1,125); Mossyrock (pop. 770), Napavine (pop. 1,980); Pe Ell (pop. 655); Toledo (pop. 720); Vader (pop. 625) and Winlock (1,340). VVHC has clinics located throughout the County in the cities of Centralia and Chehalis and the rural communities of Winlock, Tenino, Toledo, Onalaska, Morton and Pe Ell.

There are approximately 33 people per square mile in Lewis County and it ranks 22nd in population density for Washington State counties.[31] In comparison, the average population density for the whole state is almost 114 people per square mile. The 2019 estimated population of Lewis County is 79,480 and ranks 16th in population size for Washington State counties.[33] The Lewis County population has increased by 3.4% since 2016, whereas the state population increased by 5%. Over the next three years, it is estimated that the Washington State population will increase by approximately 15%.[32]

Lewis County is predominately White - not Hispanic (83%), compared to Washington State at 68%.[13] The Hispanic or Latino population (of any race) is 10% in Lewis County compared to Washington State at 13%.

The population is evenly divided between Female and Male, as is Washington State. Almost 22% of the total population is below 18 years of age, which is about the same as the state average. Over 21% of the population is 65 years of age or older. This is a notably larger aged population than the state average of 15% and National average of 16%. Lewis County also has a higher percentage of residents who are under 65 years of age with a disability (15%), compared to Washington State at 9%.

Transportation

Lewis County is the longest county in the State and takes roughly 2.5 hours to traverse by car from the farthest point East to the farthest point West, a distance of 120 miles on provincial roads. Lewis County has a limited number of major roads connecting it to other counties. Interstate 5 runs north to Thurston County and south to Cowlitz County. US Highway 12 runs east from Interstate 5 through the Cowlitz River Valley in the Cascade Mountains to Yakima County. State Route 7 runs North from US 12 to Pierce County and State Route 6 runs west from I5 through the coastal range to Pacific County. Within Lewis County, state routes and county roads primarily cover the Chehalis River Basin.

Public transportation is limited within Lewis County, especially in areas outlying areas. Twin Transit offers four fixed bus routes within Centralia and Chehalis. The bus stop closest to the main VVHC clinic on Kresky Avenue is located across a busy two lane street, making accessibility to the clinic difficult. Also, the total distance from the bus stop to the clinic entrance is 518 feet. The two Centralia Clinic locations reside along the main bus route. Twin Transit runs a Paratransit service for residents living within ¾ mile of the fixed bus routes, provided they have a referral from a health care professional certifying that services are necessary due to cognitive or physical impairments. There are 2 private taxi companies in Centralia and Chehalis.

L.E.W.I.S. Mountain Highway Transit provides transportation from the east end of Lewis County, specifically the cities of Packwood, Randall, Morton, Mossyrock and Onalaska, to the main cities of Centralia and Chehalis, roughly 75 miles one way. Passengers may request a stop at VVHC's main Chehalis Clinic.

There is no form of public transportation for those individuals living in the south end of the County which includes the cities of Winlock and Toledo.

In addition, transportation to and from medical and social service appointments is available to seniors, aged 60 or older, with no other means of transportation, through Lewis County Senior Transportation.

Public transportation from Centralia to Olympia includes a rural bus (Rural Transit – rT), bus (Greyhound) and train (Amtrak). Rural Transit has a route from Centralia to the communities of Grand Mound and Tenino, with connections to routes to Olympia. Thus to travel from Chehalis to Olympia for a specialty procedure, someone would have to take a Twin Transit bus from Chehalis to Centralia, transfer to an rT bus to Tenino, transfer to another rT route to Tumwater and transfer to an InterCity bus to downtown Olympia, and transfer to another Intercity route to West Olympia or East Olympia/Lacey.

Lewis County Public Health & Social Services provides free bus passes for those in need of transportation to health services. VVHC provides free bus passes to VVHC patients on a case by case basis. VVHC purchased an average of almost 100 bus passes per month in Lewis County to date in 2019. VVHC will also pay for taxi services in hardship cases.

Health Resource Availability in Lewis County

Designated Healthcare Professional Shortage Area

Lewis County is designated both a Health Professional Shortage Area (HPSA) and a Medically Underserved Population and is ranked 29th out of the 39 Washington counties for available clinical care services (Appendix 1 and Reference 24). This means there are fewer health care professionals than is optimal for the population size and characteristics. Within the VVHC service area, the shortage has increased since 2013.[6]

There is an unmet need for primary care and dental health services specifically for low income, homeless, and migrant farmworkers in Lewis County.[5] There is also a high need for Mental Health Services. There is only one Primary Care Physician for every 2,200 residents. This is twice that of Washington State as a whole where there is one Primary Care Physician for every 1,220 residents (Appendix 1). The ratios for Dentists (1 for every 1,450 residents) and Mental Health providers (1 for every 410 residents) are better, but both are still higher than Washington State average.[5]

Health Services

Health care providers serving the low-income population by accepting Apple Health (Medicaid), having a sliding fee scale or a reduced rate program are primarily Federally Qualified Health Centers (FQHC), Community Health Centers/Community Clinics, Rural Health Clinics, and Free Clinics.

VVHC is the only Federally Qualified Health Center (FQHC) with clinics in in Lewis County. Not surprisingly, VVHC has the largest share of the FQHC target population as patients in Lewis County.[7] Residents also travel to FQHC clinics in other counties, primarily Thurston and Cowlitz counties. Sea-Mar Community Health Center has the second largest share of patients in the communities of Centralia, and Onalaska. Cowlitz Family Health Center has the second largest share of patients in Chehalis, Toledo, and Winlock.

Lewis County has 9 Rural Health Clinics: 4 in Chehalis, 2 in Centralia, and 1 each in Randle, Morton and Mossyrock. There are 2 Community Health Centers/Community Clinics besides VVHC and 1 free clinic.

There is one immunization clinic serving children and approximately 10 providers in Lewis County other than VVHC that participate in the state Vaccines for Children Program, providing free vaccines to all children less than 6 years of age.[25] There are 4 Women's, Infants and Children (WIC) program clinics run by Lewis County Public Health & Social Services.

Lewis County has two hospitals, a regional Trauma Level 4 hospital in Centralia and a critical access Trauma Level 5 hospital in Morton.[19] The nearest Trauma Level 3 hospital is in Olympia and the nearest Trauma Level 2 hospitals are in Tacoma.

Behavioral Health Services

Behavioral health services (Substance Use Disorder and Mental Health) which accept Medicaid or have sliding fees are limited in Lewis County with are 7 providers in the Centralia-Chehalis area, 1 in Morton and 1 in Mossyrock.[26] VVHC provides behavioral health services at their Chehalis Clinic. VVHC also has an integrated care relationship with Cascade Mental Health to provide Primary Care to their patients at their facility in Centralia. According to a survey of licensed physicians from 2017-2019, only 4 psychiatrists have practice sites in Lewis County.[30]

Dental Services

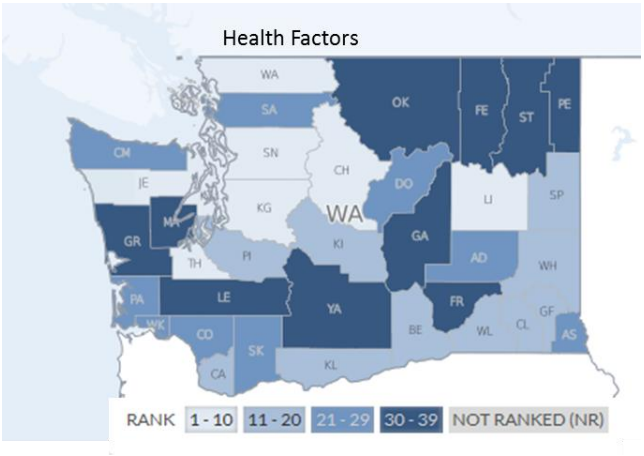
There are few dental providers in Lewis County specifically serving low-income populations by accepting Apple Health (Medicaid), having a sliding fee scale or a reduced rate program. The VVHC clinics in Centralia, Chehalis and Morton are the only dental clinics in Lewis County providing adult services to this population. There are 6 clinics, including 2 VVHC, participating in the Access to Baby & Child Dentistry (ABCD) program for children less than 6 years of age with parents or guardians enrolled in Apple Health.

Other Agencies in Lewis County Serving Target Population

- Arbor Health (formerly Morton General Hospital and clinics)
- Cascade Mental Health
- CHOICE Regional Health Network
- Health and Hope Medical Outreach
- Lewis County Gospel Mission
- Lewis County Public Health & Social Services
- Northwest Pediatric Center
- Pope's Place (formerly Pope's Kids Place)
- Providence Centralia Women's Health Services
- Planned Parenthood
- Possibilities Women's Center
- Reliable Enterprises
- Union Gospel Mission

*Note: This is only a representation of available health-related services and not an exhaustive list.

Health Factors and Outcomes in Lewis County



Heath Factors include Social Determinants of Health and Behavioral Risk Factors interacting to result in Health Outcomes. Social determinants of health - the conditions under which people are born, grow, live, work and play - significantly influence the health of a community and its residents. Behavioral Risk Factors - those personal behaviors or patterns of behavior which strongly yet adversely affect heath - increase the chance of developing a disease, disability or syndrome. As summed up by the Washington State Department of Health, "Health and quality of life at all stages in life depend on the cumulative effects of behaviors and exposures earlier in life, and on social, genetic, and epigenetic effects that span generations".[17]

Social Determinants of Health

Lewis County is ranked 27th out of 39 Washington Counties for Social and Economic Factors (Appendix 1). These include education level, unemployment poverty levels, income inequality, income inequality, social associations, violent crime, injury deaths and children in single-parent households.

Lewis County high school education rates (87%) are lower than to the state (91%), but are about equal to National rates (87%).[13] The same percentage of females and males do not have a high school education. The rate for those with a Bachelor's degree or higher is about half of the state and National rates (15% Lewis County; 35% State; 31% US).

Almost 9% of people 5 years of age and older speak a language other than English at home.[13] This is about half the state and national average. In addition, just over 4% of those reporting speaking English less than well.[18] This is lower than the state average of almost 8%.

There are an estimated minimum of 450 homeless in Lewis County and 18% have severe housing problems (Appendix 1 and Reference 15). This compares to an estimated minimum of over 50,000 homeless in WA State and 18% of all residents are experiencing severe housing problems.

The primary labor markets of Lewis County include Government, Wholesale/Retail Trade, Health Care & Social Assistance, Manufacturing, and Accommodation & Food Services based on the percentage of labor employed in these industries.[33] Government, Health Care & Social Assistance, and manufacturing are the top 3 industries for the percentage of wages paid Lewis County is classified as an Economically Distressed Area, with an unemployment rate of almost 7% as of July 2019.[27] The unemployment rate has decreased since 2016, but is still higher than the state and National average of 4%. Slightly more males than females are unemployed, but it is not statistically significant.

The average annual wage in 2017 was $40,500, with a median hourly wage of $20.15. The per capita personal income in 2017 was $40,041, ranking Lewis County 28th out of 39 Washington State counties in this category. In comparison, per capita income in Washington State was $57,896 and the US average was $51,640.[27] The Lewis County income metrics and the county rankings have improved since 2016.

An estimated 15% of Lewis County residents live below the Federal Poverty Level (FPL), compared to the State at 11% and the Nation at 12%.[13] This population is eligible for the VVHC nominal fee if they are also uninsured. Over 22% of persons are living at or below 125% of FPL, which is above the state average of 16%.[18] This population is eligible for the VVHC sliding fee scale schedule rates if they are also uninsured or covered under Medicaid.

In addition, almost 33% percent of Lewis County residents find it difficult to meet basic needs based on 2016 data.[1] These households earn more than the FPL, but less than the basic cost of living for the county. About 18% of Lewis County residents report having food insecurity, similar to the state rate, and 23% are enrolled in SNAP, which is higher than the state rate.[17]

Roughly 34% of Lewis County residents are on Apple Health, which is higher than the state 24% enrollment.[29] Lewis County Apple Health enrollees include 14,884 adults and 12,412 children as of July 2019. Almost 9% of Lewis County residents less than 65 years of age are estimated to not have health insurance as of 2018.[13] This is currently higher than Washington State (7%), but lower than the United States (10%). The county uninsured rate has decreased since 2014 when it was 13%. Significantly more males (almost 12%) than females (almost 9%) do not have health insurance.

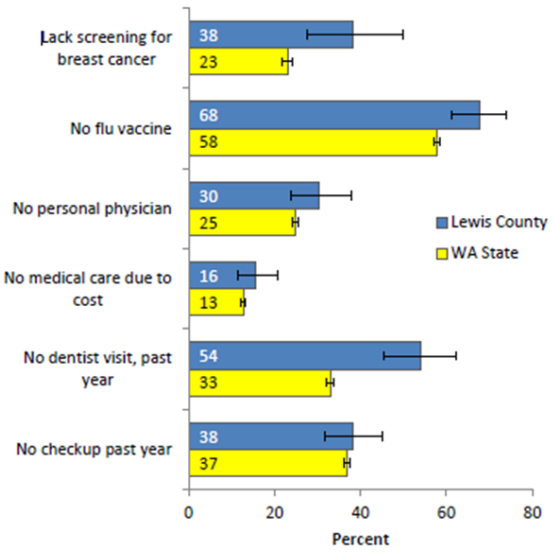
According to the Henry J. Kaiser Family Foundation, 48% of uninsured adults said the main reason they were uninsured was because the cost was too high, even under the Affordable Care Act.[10] Uninsured adults are less likely than adults with any kind of health coverage to receive preventive and screening services and less likely to receive these services on a timely basis.[11]

Behavioral Risk Factors

Lewis County is ranked 35th of the 39 Washington Counties for Health Behaviors (Appendix 1). Rates of adult smoking (17%), physical inactivity (22%), and alcohol-impaired driving deaths (38%) are all higher than the Washington State average. There is lower access to exercise opportunities (52%) than the state average. There are more teen births in Lewis County than the state average. The rate of excessive drinking (16%) is slightly lower than the state rate. The prevalence of sexually-transmitted infections is lower in Lewis County than the state average.

Preventive Care

Lewis County residents are doing worse than the state in seeking preventive health care. For example, 38% of residents have not been screened for breast cancer which is significantly more than the state average.[17] Whereas almost 70% of Lewis County residents get screened for colorectal cancer.[2] Over one-third of residents also did not get a medical checkup in the last year.[17]



Immunizations

Receiving the appropriate vaccine on time is one of the best preventive health behaviors and one of the single most important way parents can protect their children against serious diseases.[23] Lewis County school aged children are doing well for meeting school-

entry immunization requirements: 88% of kindergartners; 83% of 6th graders; and 91% for all grades K-12.[20] These rates are just slightly higher but statistically significant than the state average.

In comparison, only 34% of children in Lewis County are considered fully immunized using the HEDIS Combo 10 measure, compared to the state average of 45%[20] Only 16% of children 6 months-17 years old received influenza vaccine in 2018, compared to the state average of 25%. This is far below the Health People 2020 goal of 70%.[3] The adolescent HPV immunization rate is 45% for at least 1 dose, but only 26% are up-to-date with a complete series. These rates are only slightly lower than the state at 49% and 29%, respectively.

Oral Health

Poor oral health is widespread in Washington State and the United States and disproportionately affects low-income populations.[12] Most low-income adults and children in Washington State receive dental coverage through Apple Health. Federal law mandates that Medicaid programs cover dental services for children under the age of 21, but there are no requirements for adult coverage. This is reflected in the rates of those eligible for Apple Health receiving dental services.[28] In Lewis County, only 22% of those adults (21 years and older) received a dental service in 2018, compared to 54% of children (20 years of age and younger). These both are slightly lower than the state utilization rate.

Overall, 54% of Lewis County adult residents report not seeing a dentist in the past year for any reason, compared to the state average of 33%.[17] Lewis County is doing better on children's oral health indicators than Washington State as a whole based on 2016 measures.[22] For example, for children in Head Start/ECEAP, 33% had a tooth decay experience and 6% had untreated decay, compared with 45% and 25%, respectively in the state.

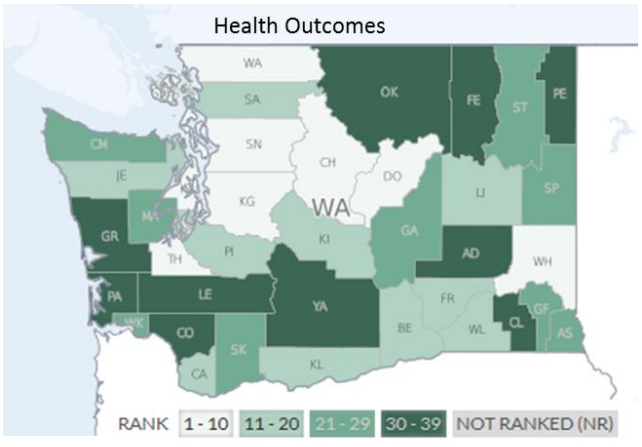
Opiate Use

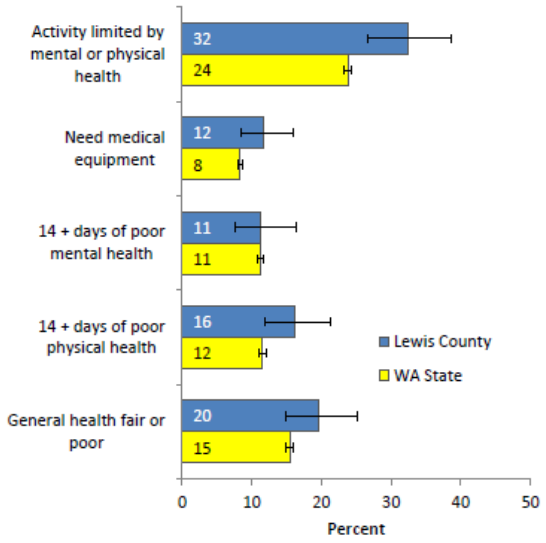
Lewis County had a rate of 36 publicly-funded first treatment admissions and 25 hospitalizations for all opiates per 100,000 people.[21] In the first quarter of 2019, the retail opioid prescription rate was 80 per 1,000 people.[21] This is higher than the state rate of 61 per 1,000. This rate has been declining in Lewis County and the state from a high in 2014-2015.

Prior to treating chronic pain patients, VVHC requires they sign a narcotic pain prescription contract, specifying patient rules and responsibilities. It is VVHC's policy to taper patients off opiate based pain medication. VVHC offers, on a case by case basis, alternative options to pain management that include a free membership to the local gym, medical massage or chiropractic treatments paid through charitable contributions.

Health Outcomes

Lewis County is ranked 30th of the 39 Washington Counties for Health Outcomes.[14] This is a picture of how long people live and how healthy people feel while alive. This ranking is based on the rates of premature death, those with poor or fair health, the number of days with poor physical or mental health days, and the number of babies born with low birth weight.





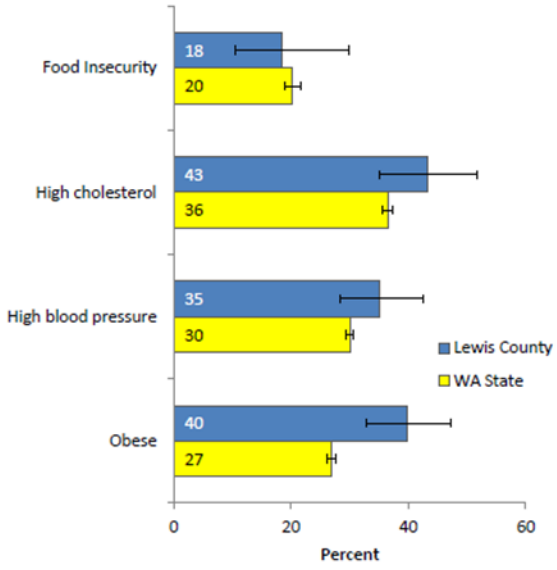
Social and Mental Health

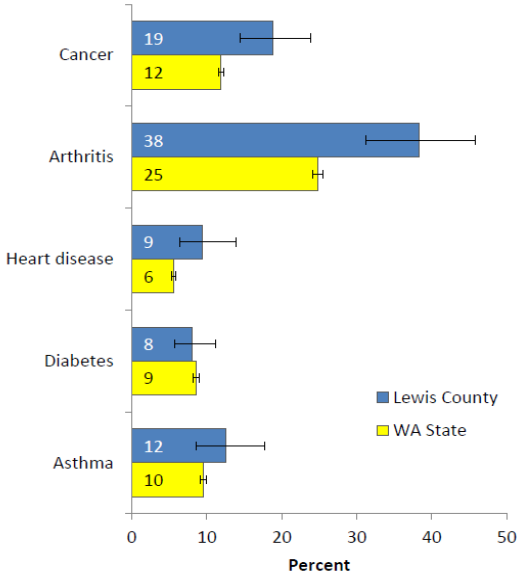
An estimated 20% of the US population has a diagnosable mental disorder in a given year, including 5 percent who have a serious mental illness such as schizophrenia or bipolar disorder.[9] Only 42% of those adults diagnosed with a mental illness received mental health services. According to the Washington State Healthy Youth Survey in 2016, 36% of Lewis County youth reported being depressed and 22% reporting having suicide ideation.[17] These are statistically the same rate as Washington State. Lewis County residents had an average of 4 poor mental health days per month and 13% of residents report frequent mental distress (Appendix 1 & 2).

Whether poor mental health leads to poor physical health, poor physical health leads to poor mental health, or both are caused by a common risk factor is not clear. More than 30% of surveyed Lewis County adults reported have their activities limited by mental or physical health and 20% reported their general health was fair or poor.[17]

Morbidity (Illness)

Lewis County adults have a higher or equal prevalence of cancer, arthritis, heart disease, and obesity than the state.[17] Asthma, high cholesterol, high blood pressure and diabetes prevalence is about the same as the state.

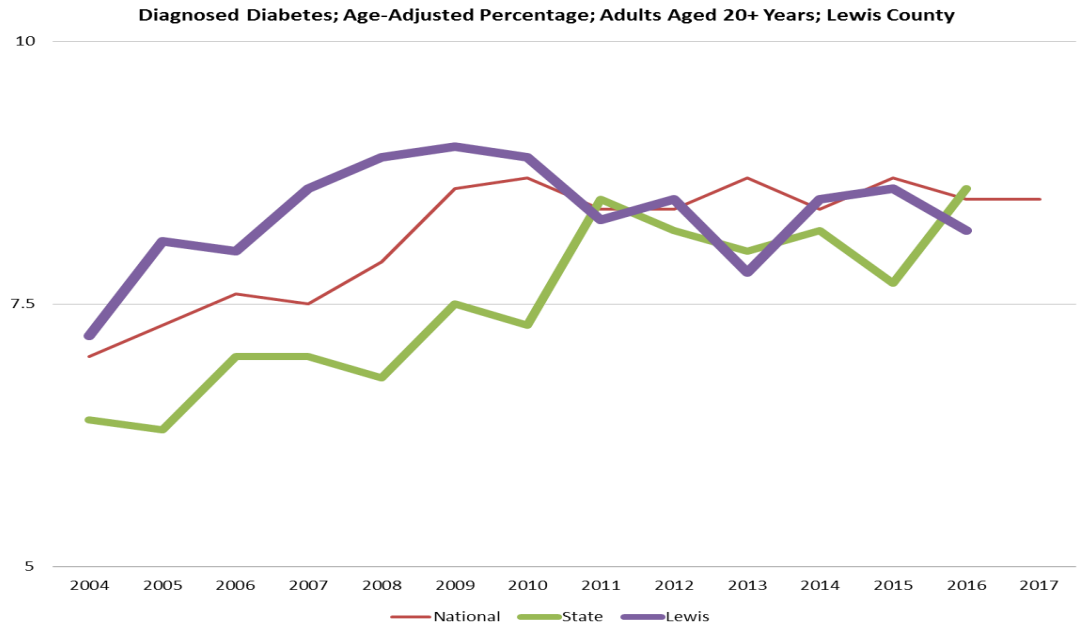




Specifically, the total number of diagnosed Diabetes Mellitus cases in adults (all types) may be leveling off, after dramatic increases from 4% in 1980 to 8.7% in 2010.[4] As of 2016, the prevalence of diabetes in Lewis County is just over 8%.[4] This is just below the state average, but is not statistically significant. Slightly more Lewis County females than males have diabetes, but it is not statistically significant.

As of 2017, at the national and state level, those aged 65 and older have the highest rates of diabetes about 20%, followed by those aged 45-64 at about 13%.[4] Nationally and at the state level, those with less than high school education have the highest rates at about 12-13%, followed by those with a high school education at about 10%. Nationally, Hispanics have the highest rate at over 12%, followed by Blacks at 11%, Asians at 9% and Whites at 8%. No age group, education or race/ethnicity data is available at the county level.

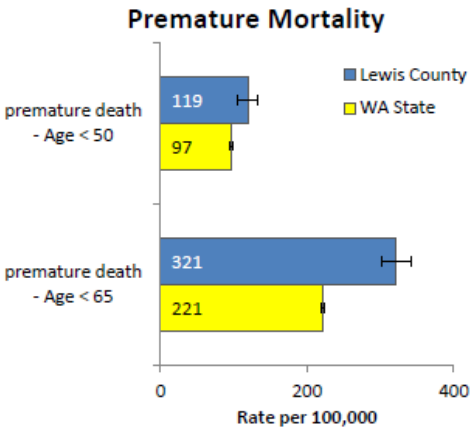
Statewide, the rate of newly diagnosed Diabetes Mellitus cases in adults has been decreasing over the past few years, while the mean age of diagnosis remains steady at about 52 years of age (regardless of gender, race/ethnicity or education level). Nationally, the incidence of new cases rose from a rate of 3.5 per 1,000 in 1980 to a high of 8.5 in 2010, and a decrease to 6.5 in 2017.[4] At the state level, the current incidence is 5.7 per 1,000.

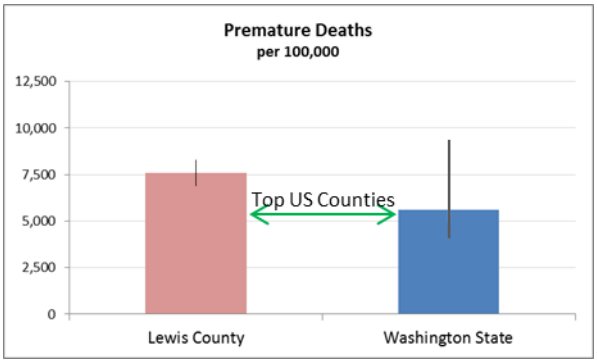


Mortality (Death)

Leading causes of death in an area provides insight to the health status of a population. A high rate of deaths due to preventable causes indicates heightened disease burden or an unmet need for health care services. Every death occurring before the age of 75 is considered premature and contributes to the total number of years of potential life lost.

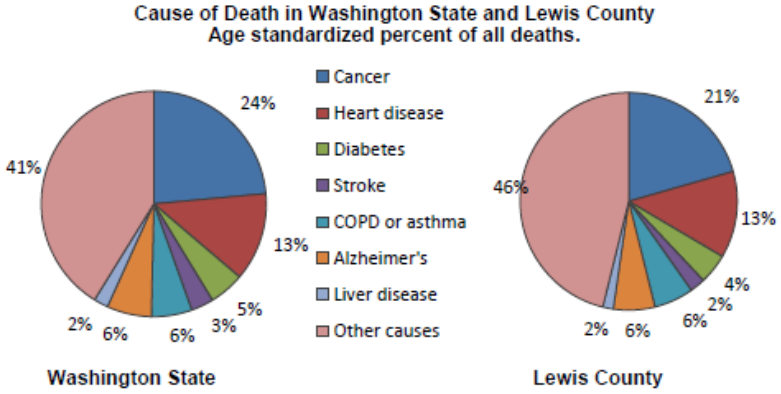
The average life expectancy of Lewis County residents is 77.6 years of age, lower than the Washington state average of 80 years of age (Appendix 2). Lewis County is also Ranked 32nd of the 39 Washington Counties with 7,600 premature deaths per 100,000 (Appendix 1). These rates have increased from 2016. In comparison, the Washington State average is 5,600 per 100,000 and the top healthiest US counties have rates of 5,400 per 100,000.[14] Specifically, there are significantly more premature deaths in Lewis County than the state average for those between 50-65 years of age.[17]

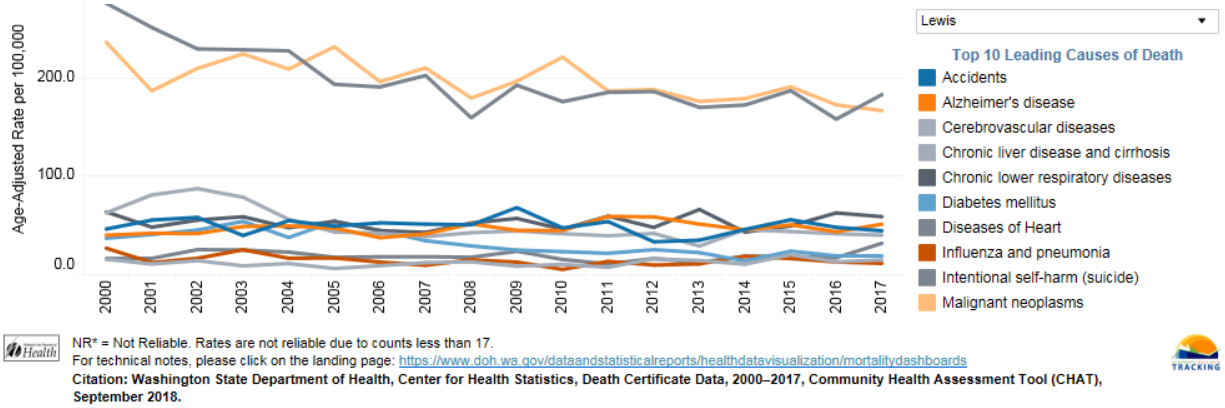




The leading causes of non-accident death in Lewis are malignant neoplasms (cancers) and major cardiovascular diseases.[16,17] This matches Washington State causes of death rates overall.

In general, death rates due to cancer have slowly decreased.[16] lung cancer (lung, bronchus, and trachea) is most prevalent followed by colorectal and pancreas cancer. Death rates due to heart disease were also slowly falling except for an increase from 2016-2017, primarily due to a significant increase in female deaths.



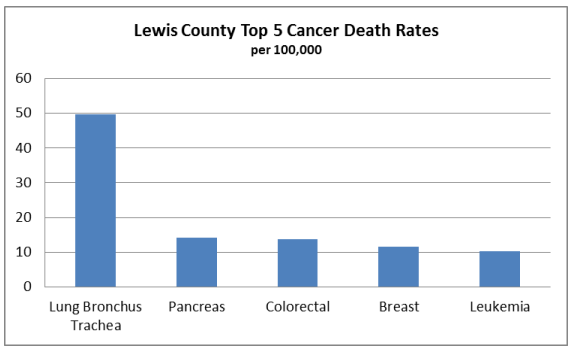


NR* = Not Reliable. Rates are not reliable due to counts less than 17.
For technical notes, please click on the landing page: https://www.doh.wa.gov/dataandstatisticalreports/healthdatavisualization/mortalitydashboards
Citation: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2000–2017, Community Health Assessment Tool (CHAT), September 2018.

The death rate due to diagnosed Diabetes Mellitus (all types) has significantly decreased in Lewis County since 2005. It is 18 per 100,000, which is lower than the state rate of 21 per 100,000.[16] The death rate to due Alzheimer's has slowly increased in Lewis County and is 51 per 100,000. This is a little higher than the state rate of 45 per 100,000.[16]

Lewis County had an average annual opioid death rate of 8 per 100,000 population from 2013-2017.[21] This is just below the state rate of about 10 deaths per 100,000 persons and less than the national rate

of almost 15 deaths per 100,000 persons.[8] Overall, the prescription opioid death rate is declining, but is offset by the rise in heroin and synthetic opioid deaths.



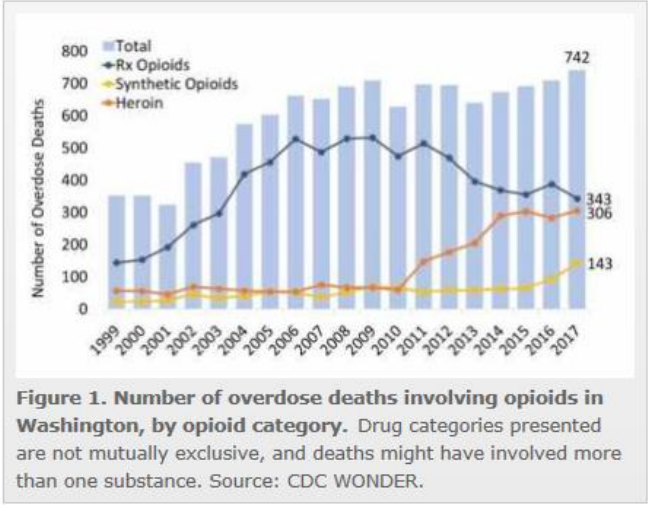
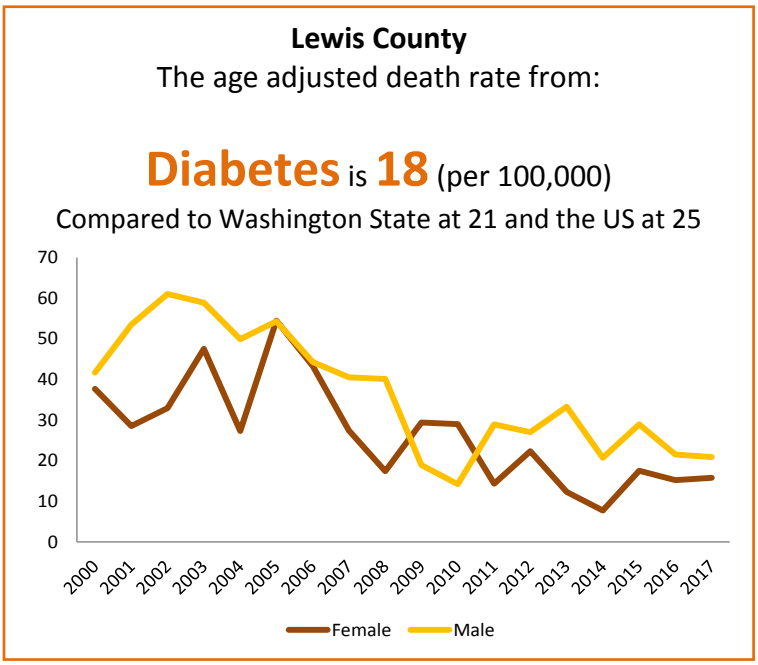


Figure 1. Number of overdose deaths involving opioids in Washington, by opioid category. Drug categories presented are not mutually exclusive, and deaths might have involved more than one substance. Source: CDC WONDER.



Pacific County

Characteristics

Pacific County is the 10th smallest county in size in Washington State with a land area of 932 square miles. Pacific County is classified as rural with almost 70% of people living in unincorporated areas. Pacific County has 4 Cities/Towns: Ilwaco (population 965); Long Beach (pop. 1,455); Raymond (pop. 2,885) and South Bend (pop. 1,625). VVHC has a clinic in Raymond.

There are approximately 23 people per square mile and Pacific County ranks 26th in population density for Washington State counties.[31] In comparison, the average population density for the whole state is almost 114 people per square mile. The 2019 estimated population of Pacific County is 21,640 and ranks 30th in population size for Washington State counties.[32] The Pacific County population has increased by 2 % since 2016, whereas the state population increased by 5%. Over the next three years, it is estimated that the Washington State population will increase by approximately 15%.[32]

Pacific County is predominately White - not Hispanic (82%), compared to Washington State at 68%.[13] The Hispanic or Latino population (of any race) is 10% in Pacific County compared to Washington State at 13%.

The population is evenly divided between Female and Male, as is Washington State. Just over 16% % of the total population is below 18 years of age, which is less than the state average of 22%. About 30% of the population is 65 years of age or older. This is a notably larger aged population than the state average of 15% and National average of 16%. Pacific County also has a much higher percentage of residents who are under 65 years of age with a disability (22 %), compared to Washington State at 9%.

Transportation

Pacific County is not particularly large in square miles but its geography limits the number of roads. US Highway 101 runs north and south along the coast, State Route 105 runs north into Grays Harbor County, State Route 6 runs east to Lewis County, and State Route 4 runs east to Wahkiakum County. Few county or secondary roads exist outside of the Long Beach, South Bend and Raymond communities.

Pacific Transit, serving the Peninsula and North Pacific County in Pacific County, also four fixed bus routes and a Dial-a-Ride Service. To qualify for Dial-a-Ride, individuals must be disabled and/or ADA certified, a senior 65 or older and located ¼ mile off the main bus route.

VVHC provides free bus passes to patients on a case by case basis. VVHC has not purchased bus passes for in Pacific County patients to date in 2019. VVHC will also pay for taxi services in hardship cases.

Health Resource Availability in Pacific County

Designated Healthcare Professional Shortage Area

Pacific County is designated both a Health Professional Shortage Area (HPSA) and a Medically Underserved Population and is ranked 33rd out of the 39 Washington counties for available clinical care services (Appendix 1 and Reference 24). This shortage is especially severe for dental services. This

means there are fewer health care professionals than is optimal for the population size and characteristics. Within the VVHC service area, the shortage has increased since 2013.[6]

There is an unmet need for primary care, dental and mental health services for all Pacific County.[5] There is only one Primary Care Physician for every 4,250 residents. This is four times that of Washington State as a whole where there is one Primary Care Physician for every 1,220 residents (Appendix 1). There is only 1 dentist for every 3,090 residents, which is 3 times the state average. There is 1 Mental Health provider for every 390 residents, which is similar to the state average.[5]

Health Services

Health care providers serving the low-income population by accepting Apple Health (Medicaid), having a sliding fee scale or a reduced rate program are primarily Federally Qualified Health Centers (FQHC), Community Health Centers/Community Clinics, Rural Health Clinics (RHC), Free Clinics and some private providers.

There are 2 Federally Qualified Health Centers (FQHC) with clinics in Pacific County: VVHC and Cowlitz Family Health Center. Cowlitz Family Health Center has the largest share of the FQHC target population as patients in Pacific County.[7] VVHC has the second largest share of all patients and the largest share in the communities Raymond and South Bend. Pacific County residents also travel to FQHC clinics in other counties, primarily Cowlitz County and Astoria Oregon.

Pacific County has 3 Rural Health Clinics: 2 in Ilwaco and 1 in Naselle. There are 2 Community Health Center/Community Clinics besides VVHC and there are no free clinics in Pacific County.

VVHC is the only one immunization clinic serving children and there are approximately 9 providers in Pacific County other than VVHC that participate in the state Vaccines for Children Program, providing free vaccines to all children less than 6 years of age.[25] There are 3 Women's, Infants and Children (WIC) program clinics in Pacific County. The Pacific County Health Department also runs the FIRST Steps and Maternal Support Services Programs.

Pacific County has two critical access hospitals, a Trauma Level 5 in South Bend and a Trauma Level 4 in Ilwaco.[19] The nearest Trauma Level 3 hospitals are in Aberdeen and Longview and the nearest Trauma Level 2 hospital is in Vancouver.

Behavioral Health Services

There are 2 clinics offering behavioral health services (Substance Use Disorder and Mental Health) and accepting Medicaid or have sliding fees in Pacific County.[26] According to a survey of licensed physicians from 2017-2019, there are psychiatrists with practice sites in Pacific County.[30]

Dental Services

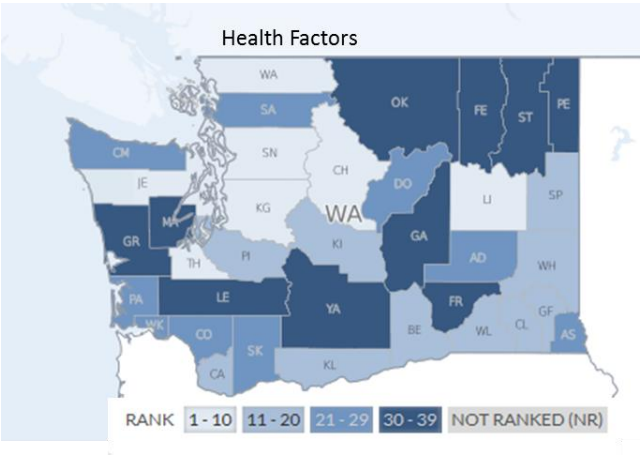
There are only two dental providers in Pacific County specifically serving low-income adults by accepting Apple Health (Medicaid), having a sliding fee scale or a reduced rate program. One is in Raymond in the north part of the county and one is in Ocean Park, out on the Long Beach peninsula. There is also only 1 clinic participating in the Access to Baby & Child Dentistry (ABCD) program for children less than 6 years of age with parents or guardians enrolled in Apple Health.

Other Agencies in Pacific County Serving Target Population

- CHOICE Regional Health Network
- Coastal Community Action Program
- Cowlitz Family Health Center
- Lifeline Connections
- Pacific County Health and Human Services
- Union Gospel Mission
- Willapa Behavioral Health
- Willapa Counseling Center
- Willapa Harbor Hospital

*Note: This is only a representation of available health-related services and not an exhaustive list.

Health Factors and Outcomes in Pacific County



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Social Determinants of Health

Pacific County is ranked 26th out of 39 Washington Counties for Social and Economic Factors (Appendix 1). These include education level, unemployment poverty levels, income inequality, income inequality, social associations, violent crime, injury deaths and children in single-parent households.

Pacific County high school education rates (88%) are lower than to the state (91%), but are equal to US rates.[13] More males (8%) than females (6%) do not have a high school education, but the difference is not statistically significant. The rate of those with a Bachelor's degree or higher is about half of the state and national rates (75% Pacific County; 35% State; 31% US).

About 11% of people 5 years of age and older speak a language other than English at home.[13] This is about half the state and national average. In addition, almost 5% of those older than 5 years of age report speaking English less than well.[18] This is lower than the state average of almost 8%.

There are an estimated minimum of 100 homeless in Pacific County and only 1% have severe housing problems (Appendix 1 and Reference 15). This compares to an estimated minimum of over 50,000 homeless in WA State and 18% of residents experiencing severe housing problems.

The primary labor markets of Pacific County include Government, Accommodation & Food Services, Manufacturing, Agriculture (Farming, Forestry, Fishing and Hunting), and Wholesale/Retail Trade

based on the percentage of labor employed in these industries.[34] Government, Manufacturing and Agriculture are the top 3 industries for the percentage of wages paid. Pacific County is classified as an Economically Distressed Area, with an average 3 year unemployment rate of about 7% as of July 2019.[27] The unemployment rate has decreased since the 2016 Needs Assessment, but is still higher than the state and National average of 4%. Significantly more males (9%) than females (3%) are unemployed.

The average annual wage in 2017 was $36,177, with a median hourly wage of $18.83.[27] The per capita personal income in 2017 was $40,150, ranking Pacific County 31st out of 39 Washington State counties in this category. In comparison, per capita income in Washington State was $57,896 and the US average was $51,640. The Pacific County income metrics and the county rankings have improved since 2016.

An estimated 17% of Pacific County residents live below the Federal Poverty Level (FPL), compared to the State at 11% and the Nation at 12%.[13] This population is eligible for the VVHC nominal fee if they are also uninsured. Almost 24% of persons are living at or below 125% of FPL, which is above the state average of 16%.[18] This population is eligible for the VVHC sliding fee scale schedule rates if they are also uninsured or covered under Medicaid.

In addition, almost 33% percent of Pacific County residents find it difficult to meet basic needs based on 2016 data.[1] These households earn more than the FPL, but less than the basic cost of living for the county. About one-third of Pacific County residents report having food insecurity and 23% are enrolled in SNAP, which is higher than the state rate.[17]

Roughly 32% of Pacific County residents are on Apple Health, which is higher than the state 24% enrollment.[29] Pacific County Apple Health enrollees include 4,295 adults and 6,935 children as of July 2019. This is higher than the state enrollment of 24% of total population. Almost 10% of Pacific County residents less than 65 years of age do not have health insurance as of 2018.[13] This is higher than both Washington State and the United States. The county uninsured rate has decreased since 2014 when it was 15-20%. Significantly more males (11%) than females (7%) do not have health insurance.[18]

Behavioral Risk Factors

Pacific County is ranked 21st of the 39 Washington Counties for Health Behaviors (Appendix 1). Rates of adult smoking (15%), physical inactivity (23%), and alcohol-impaired driving deaths (56%) are all higher than Washington State averages. There is lower access to exercise opportunities (66%) than the state average. There are more teen births in Pacific County than in Washington as a whole. The rate of excessive drinking (15%) is slightly lower than the state. The prevalence of sexually-transmitted infections in Pacific County is lower than the state average.

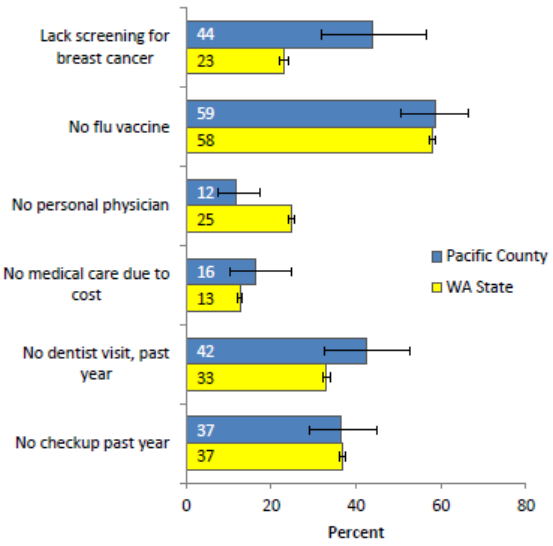
Preventive Care

Pacific County residents are doing worse than the state in seeking preventive health care. For example, 44% of residents have not been screen for breast cancer which is double the state average.[17] Less than 70% of Pacific County residents get screened for colorectal cancer.[2] Over one-third of residents also did not get a checkup in the last year.[17]

Immunizations

Pacific County school aged children are doing well for meeting school-entry immunization requirements: 85% of kindergartners; 87% of 6th graders; and 87% for all grades K-12.[20]

In comparison, only 19% of children in Pacific County are considered fully immunized using the HEDIS Combo 10 measure, compared to the state average of 45%.[20] Only 12% of children 6 months-17 years old received influenza vaccine in 2018, compared to the state average of 25%. This is far below the Healthy People 2020 goal of 70%.[3] The adolescent HPV immunization rate is 30% for at least 1 dose, but only 15% were up-to-date with a complete series. These rates are lower than the state at 49% and 29%, respectively.



Oral Health

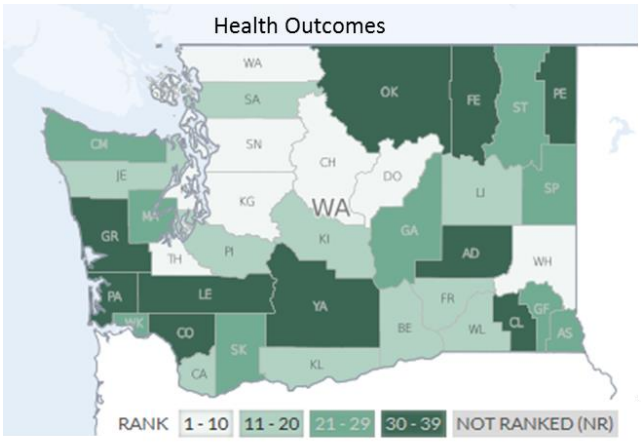
Overall, 42% of Pacific County adult residents report not seeing a dentist in the past year for any reason, compared to the state average of 33%.[17] Only 21% of Apple Health eligible adults (21 years and older) received a dental service in 2018, compared to 55% of eligible children (20 years of age and younger). These are slightly lower than the state as a whole.

Opiate Use

There is no recent data for opioid admissions or hospitalizations in Pacific County. In the first quarter of 2019, the retail opioid prescription rate was 69 per 1,000 people.[21] This is higher than the state rate of 61 per 1,000. This rate has been declining in Pacific County and the state from a high in 2014-2015.

Health Outcomes

Pacific County is ranked 37th of the 39 Washington Counties for Health Outcomes.[14] This is a picture of how long people live and how healthy people feel while alive. This ranking is based on the rates of premature death, those with poor or fair health, the number of days with poor physical or mental health days, and the number of babies born with low birth weight.



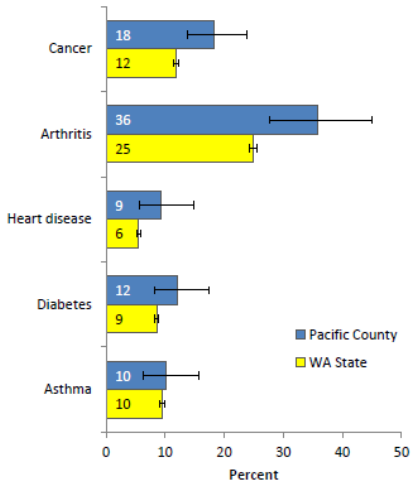
Social and Mental Health

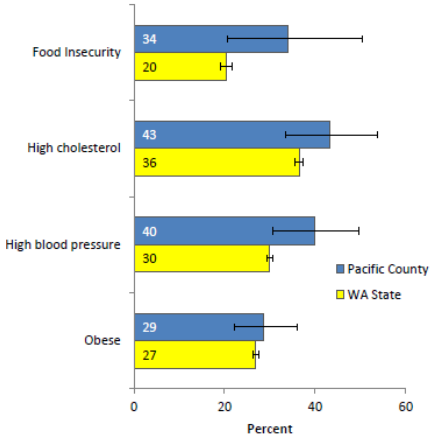
Almost one-third of Pacific County youth reported being depressed and almost 20% reporting having suicide ideation.[17] These are statistically the same rate as Washington State. Pacific County adults had an average of 4.5 poor mental health days per month and 14% of residents report frequent mental distress (Appendix 1 & 2). More than one-third of surveyed Pacific County adults reported have their activities limited by mental or physical health and 20% reported their general health was fair or poor.[17]

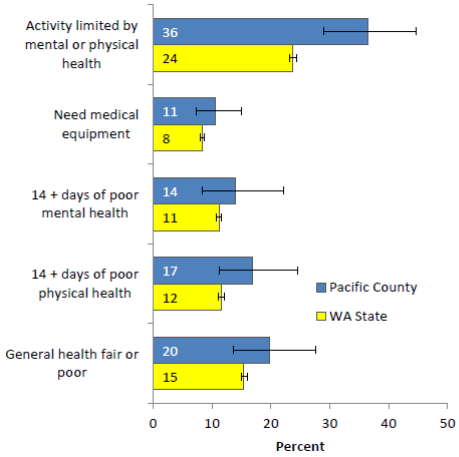
Morbidity (Illness)

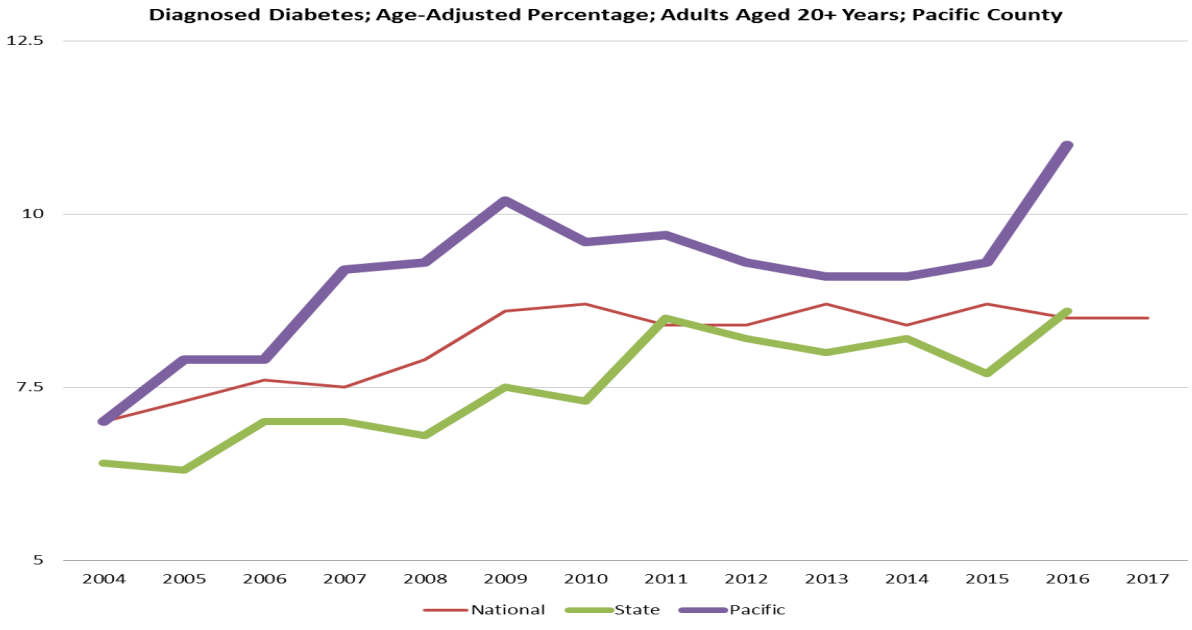
Pacific County adults have a statistically higher prevalence of cancer and arthritis than the state. Heart disease, diabetes, asthma, high cholesterol, high blood pressure and obesity prevalence is about the same as the state.[17]

Specifically, the total number of diagnosed Diabetes Mellitus (all types) in adults in Pacific County is just over 11%.[4] This is higher than the state average but not statistically significant. More Pacific County males than females have diabetes, but it is not statistically significant. For national and state trends of prevalence and incidence, see the section above, Lewis County *Morbidity (Illness)*.



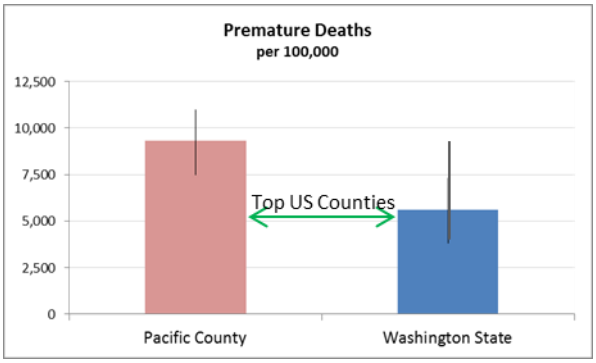






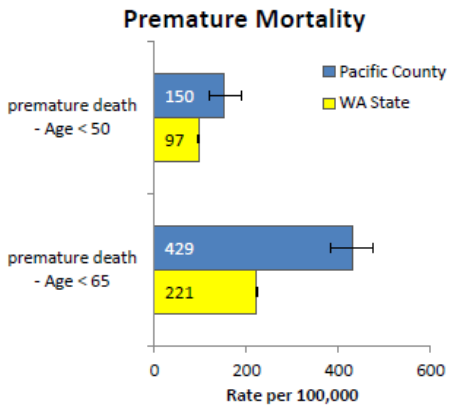
Mortality (Death)

Leading causes of death in an area provides insight to the health status of a population. A high rate of deaths due to preventable causes indicates heightened disease burden or an unmet need for health care services. Every death occurring before the age of 75 is considered premature and contributes to the total number of years of potential life lost.

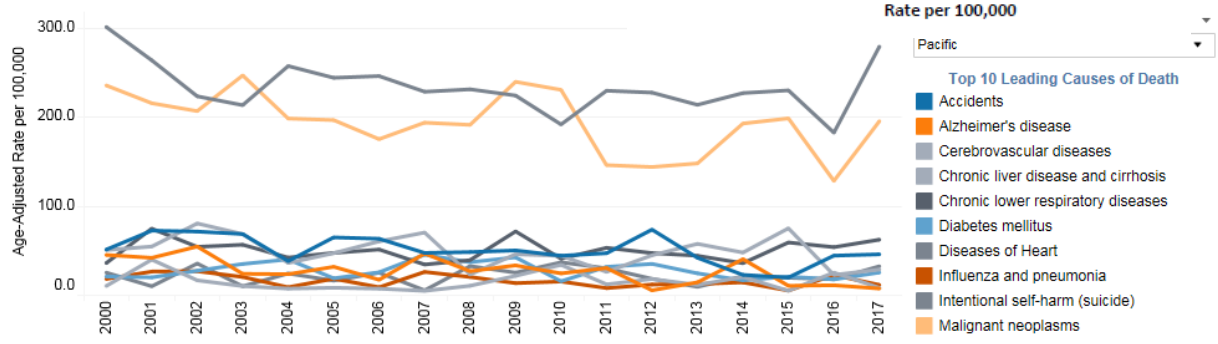


The average life expectancy of Pacific County residents is 76.4 years of age, lower than the Washington state average of 80 years of age (Appendix 2).

Pacific County is Ranked 37th of the 39 Washington Counties with 9,300 premature deaths per 100,000 (Appendix 1). These rates have increased from 2016. In comparison, the Washington State average is 5,600 per 100,000 and the top healthiest US counties have rates of 5,400 per 100,000.[14] Specifically, there is twice the rate of premature deaths in Pacific County than the state average for those between 50-65 years of age.[17]



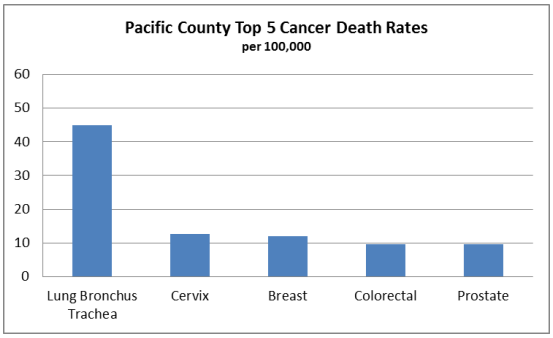
The leading causes of non-accident deaths in Pacific County are major cardiovascular diseases followed by malignant neoplasms (cancers). [16,17]



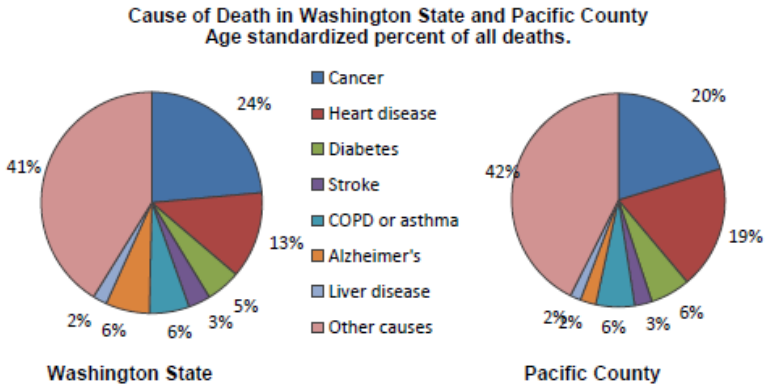
NR = Not Reliable. Rates are not reliable due to counts less than 17.
For more information, please click on the landing page: https://www.doh.wa.gov/dataandstatisticalreports/healthdatavisualization/mortalitydashboards
Citation: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2000–2017, Community Health Assessment Tool (CHAT), September 2018.

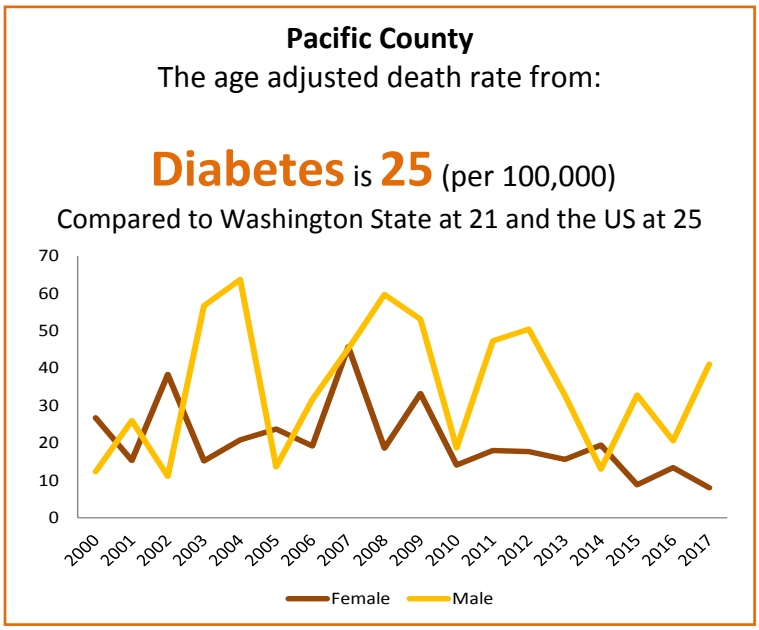
In general, death rates due to cancer have slowly decreased over the last 10 years, except for an increase from 2016-2017.[16] Additional years of data are needed to determine if this is a new trend.[16] Lung cancer (lung, bronchus, and trachea) is most prevalent followed by cervix, breast, colorectal and Prostate cancer. Death rates due to heart disease were slowly falling until a large increase from 2016-2017, primarily due to a significant increase in male deaths.

The death rate due to diagnosed Diabetes Mellitus has decreased since 2005 and is 25 per 100,000.[16] This is higher than the state rate and the same as the US average.[33] The death rate to due Alzheimer's has generally decreased in Pacific County and is 7 per 100,000. This is much lower than state rate of 45 per 100,000, but due to the small numbers of deaths, direct comparisons should be made with caution.



Pacific County had an average annual opioid death rate of 7 per 100,000 population from 2013-2017, but low counts make this rate unreliable. [21] The state rate is about 10 deaths per 100,000 persons and the national rate is almost 15 deaths per 100,000 persons.[8]





Thurston County

Characteristics

Thurston County is the 8th smallest counties in size in Washington State with a land area of 722 square miles. Thurston County is not classified a rural county with equal numbers of people living in unincorporated and incorporated areas. Thurston County has 7 cities/towns: Bucoda (population 580); Lacey (pop. 51,270); Olympia (pop. 52,770); Rainier (pop. 2,110); Tenino (pop. 1,840); Tumwater (pop. 24,060); and Yelm (pop. 9,135). VVHC has 2 clinics in Olympia and 1 clinic in Tenino.

There are approximately 396 people per square mile and Thurston County ranks 6th in population density for Washington State counties.[31] In comparison, the average population density for the whole state is 114 people per square mile. The 2019 estimated population of Thurston County is 285,800 and ranks 6th in population size for Washington State counties.[32] The Thurston County population has increased by almost 5% since 2016, which is the same as the state. Over the next three years, it is estimated that the Washington State population will increase by approximately 15%.[32]

Thurston County is predominately White - not Hispanic (75%), compared to Washington State at 68%.[13] The Hispanic or Latino population (of any race) is 9% in *Thurston* County compared to Washington State at 13%.

The population is evenly divided between Female and Male, as is Washington State. Almost 22% of the total population is below 18 years of age, which is about the same as the state average. About 17% of the population is 65 years of age or older. This is about the same as the state and national averages. Thurston County has the percentage of residents who are under 65 years of age with a disability as the state (9 %).

Transportation

Thurston County has US Intestate 5 running North-South, US Highway 101 running from I5 Northwest to Mason County, State Highway 8 running from 101 West to Grays Harbor County, State highway 507 running north –south from Pierce County to Lewis County, and US Highway 12 from I5 to Grays Harbor County. The municipalities of Olympia, Lacey and Tumwater and the immediate surrounding areas have numerous county and city roads.

Intercity Transit serves the greater Olympia-Lacey-Tumwater area with extensive routes. One route serves the rural community of Yelm and 2 routes have service to Tacoma. Multiple private taxi companies and the ride share companies Uber and Lyft serve the greater Olympia-Lacey-Tumwater area. Rural Transit (rT) has routes between Tumwater and the South County communities of Rainier, Tenino, Bucoda, Grand Mound, and Rochester.

VVHC provides free bus passes to patients on a case by case basis. VVHC purchased an average of 45 bus passes per month in Thurston County in 2019 to date. VVHC will also pay for taxi services in hardship cases.

Health Resource Availability in Thurston County

Designated Healthcare Professional Shortage Area

Thurston County is designated a Health Professional Shortage Area (HPSA) for specific populations and is ranked 7th out of the 39 Washington counties for available clinical care services[24] (Appendix 1). This means there are fewer health care professionals than is optimal for the population size and characteristics. But the shortage is mostly due to the lack of Primary Care in the outlying regions from the Olympia-Lacey-Tumwater metro area. Within the VVHC service area, the shortage has increased since 2013.[6]

There is an unmet need for primary care, dental and mental health services for some populations and areas in Thurston County, especially rural Thurston and specific low-income populations in Olympia and Lacey.[5] Overall, there is one Primary Care Physician for every 1,040, which is better than the one Primary Care Physician for every 1,220 residents (Appendix 1). The ratios for Dentists (1 for every 1,350 residents) and Mental Health providers (1 for every 350 residents) are both are higher than the State average.[5]

Health Services

Health care providers serving the low-income population by accepting Apple Health (Medicaid), having a sliding fee scale or a reduced rate program are primarily Federally Qualified Health Centers (FQHC), Community Health Centers, Rural Health Clinics (RHC) and Free Clinics.

There are 2 Federally Qualified Health Centers (FQHC): VVHC and Sea-Mar Community Health Center. Sea-Mar Community Health Center has the largest share of the FQHC target population as patients in Thurston County by a large margin.[7] VVHC has the largest share in the communities of Rochester, Tenino and Oakville, and the second largest share in Olympia, Lacey, and Rainier. Thurston County residents also travel to FQHC clinics in other counties, primarily Pierce County.

Thurston County has 2 Rural Health Clinics, both in Rochester. There are 4 Community Health Centers/Community Clinics besides VVHC and 3 free clinics.

There are 3 immunization clinics serving children and approximately 30 providers in Thurston County other than VVHC that participate in the state Vaccines for Children Program, providing free vaccines to all children less than 6 years of age.[25] There are 6 Women's, Infants and Children (WIC) program clinics in Thurston County.

Thurston County has two hospitals Providence St Peter (Trauma Level 3) and Capital Medical Center, an acute care facility.[19] The nearest Trauma Level 2 hospitals are in Tacoma.

Behavioral Health Services

There are a number of behavioral health services (Substance Use Disorder and Mental Health) which accept Medicaid or have sliding fees in Thurston County.[26] VVHC has an integrated care relationship with Behavioral Health resources to provide Primary Care and counseling services to their patients on their campus in Olympia. According to a survey of licensed physicians from 2017-2019, 21 psychiatrists have practice sites in Thurston County.[30]

Dental Services

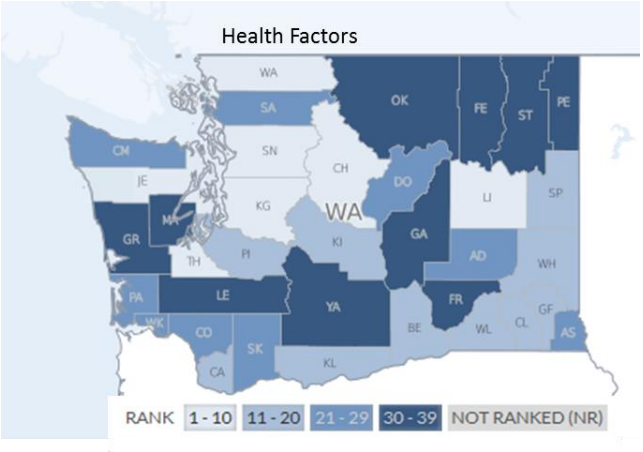
There are 4 dental clinics in Thurston County specifically serving low-income adults by accepting Apple Health (Medicaid), having a sliding fee scale or a reduced rate program. There are 15 clinics, including VVHC, participating in the Access to Baby & Child Dentistry (ABCD) program for children less than 6 years of age with parents or guardians enrolled in Apple Health.

Other Agencies in Thurston County Serving Target Population

- Behavioral Health Resources
- CHOICE Regional Health Network
- Family Support Center
- Northwest Pediatric Center
- Planned Parenthood
- Providence Health & Services Washington
- Sea-Mar Community Health Center
- Thurston County Public Health & Social Services Department
- Union Gospel Mission

*Note: This is only a representation of available health-related services and not an exhaustive list.

Health Factors and Outcomes in Thurston County



Heath Factors include Social Determinants of Health and Behavioral Risk Factors interacting to result in Health Outcomes. Social determinants of health - the conditions under which people are born, grow, live, work and play - significantly influence the health of a community and its residents. Behavioral Risk Factors - those personal behaviors or patterns of behavior which strongly yet adversely affect heath - increase the chance of developing a disease, disability or syndrome. As summed up by the Washington State Department of Health, "Health and quality of life at all stages in life depend on the cumulative effects of behaviors and exposures earlier in life, and on social, genetic, and epigenetic effects that span generations".[17]

Social Determinants of Health

Thurston County is ranked 8th out of 39 Washington Counties for Social and Economic Factors (Appendix 1). These include education level, unemployment poverty levels, income inequality, income inequality, social associations, violent crime, injury deaths and children in single-parent households.

Thurston County high school education rates at almost 94% are higher than the state and US rates.[13] Roughly the same percentage of females and males do not have a high school education. The rate of those with a Bachelor's degree or higher is about equal to the state average and higher than the national rates.

Over 11% of people 5 years of age and older speak a language other than English at home.[13] This is about half the state and national average. In addition, just over 4% of those older than 5 years of age report speaking English less than well.[18] This is lower than the state average of almost 8%.

There are an estimated minimum of 2,000 homeless in Thurston County and 17% of residents have severe housing problems (Appendix 1 and Reference 15). This compares to an estimated minimum of over 50,000 homeless in WA State and 18% of residents experiencing severe housing problems.

The primary labor markets of Thurston County include Government, Wholesale/Retail Trade, Health Care & Social Assistance, Accommodation & Food Services, and Administrative & Waste Services based on the percentage of labor employed in these industries.[35] Government, Wholesale/Retail Trade, Health Care & Social Assistance are the top 3 industries for the percentage of wages paid. The Thurston County unemployment rate is just over 5% as of July 2019.[27] This is just above the state and National average of 4%. Slightly more males than females are unemployed, but it is not statistically significant.

The average annual wage in 2017 was $49,176, with a median hourly wage of $20.15.[27] The per capita personal income in 2017 was $48,845, ranking Thurston County 11th out of 39 Washington State counties in this category. In comparison, per capita income in Washington State was $57,896 and the US average was $51,640.

Almost 11% of Thurston County residents live below the Federal Poverty Level (FPL), which is about the same as the State and National averages.[13] This population is eligible for the VVHC nominal fee if they are also uninsured. Almost 15% of persons are living at or below 125% of FPL, which is just below the state average.[18] This population is eligible for the VVHC sliding fee scale schedule rates if they are also uninsured or covered under Medicaid.

In addition, about 26% percent of Thurston County residents find it difficult to meet basic needs based on 2016 data.[1] These households earn more than the FPL, but less than the basic cost of living for the county. About 17% of Thurston County residents report having food insecurity and 14% are enrolled in SNAP, which are similar to state rates.[17]

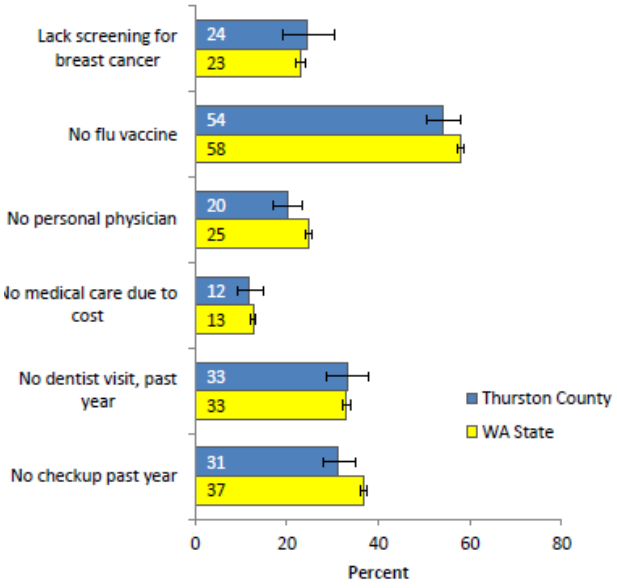
Roughly 23% of Thurston County residents are on Apple Health, which is about the same as the state enrollment.[29] Thurston County Apple Health enrollees include 37,622 adults and 27,884 children as of July 2019. About 6% of Thurston County residents less than 65 years of age are estimated to not have health insurance as of 2018.[13] This is lower than both Washington State and the United States. The county uninsured rate has decreased since 2014 when it was 9%. Significantly more males (8%) than females (6%) do not have health insurance.[18]

Behavioral Risk Factors

Thurston County is ranked 10th of the 39 Washington Counties for Health Behaviors (Appendix 1). Rates of adult smoking (13%), physical inactivity (15%), and alcohol-impaired driving deaths (25%) are all lower than the state average. There is lower access to exercise opportunities (73%) than the state average. There are slightly less teen births in Thurston County than the state average. The rate of excessive drinking (16%) and the prevalence of sexually-transmitted infections is about the same in Thurston County as state averages.

Preventive Care

Thurston County residents are doing about the same as the state average in seeking preventive health care. For example, about one-quarter of residents have not been screened for breast cancer and about one-third also did not get a medical checkup in the last year. Between 70-80% of Thurston County residents get screened for colorectal cancer.[2]



Immunizations

Thurston County school aged children are mostly doing well for meeting school-entry immunization requirements: 84% of kindergartners; 68% of 6th graders; and 83% for all grades K-12.[20] The 6th grade rate is much lower than the state average.

In comparison, only 39% of children in Thurston County are considered fully immunized using the HEDIS Combo 10 measure, compared to the state average of 45%.[20] Only 22% of children 6 months-17 years old received influenza vaccine in 2018, compared to the state average of 25%. This is far below the Health People 2020 goal of 70%.[3] The adolescent HPV immunization rate was 47% for at least 1 dose, while 26% are up-to-date with a complete series. These rates are only slightly lower than the state at 49% and 29%, respectively.

Oral Health

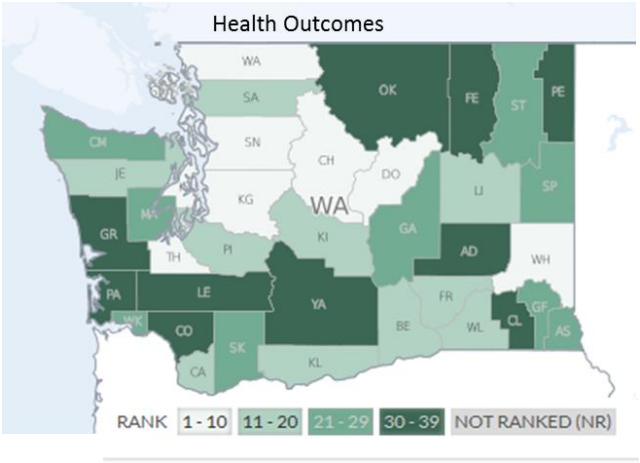
In Thurston County, about 20% of Apple Health eligible adults (21 years and older) received a dental service in 2018, compared to 47% of eligible children (20 years of age and younger). This is lower than the state utilization rate. Overall, about one-third of residents saw a dentist in the past year which is the same rate as the state.[17]

Opiate Use

Thurston County had a rate of 15 hospitalizations for all opiates per 100,000 people.[21] In the first quarter of 2019, the retail opioid prescription rate was 59 per 1,000 people.[21] This is higher than the state rate of 61 per 1,000. This rate has been declining in Lewis County and the state from a high in 2014-2015.

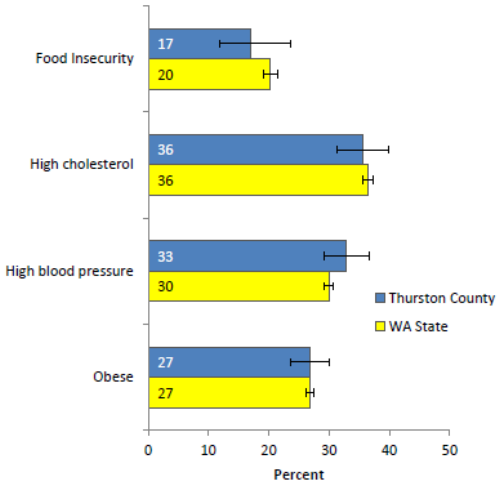
Health Outcomes

Thurston County is ranked 5th of the 39 Washington Counties for Health Outcomes.[14] This is a picture of how long people live and how healthy people feel while alive. This ranking is based on the rates of premature death, those with poor or fair health, the number of days with poor physical or mental health days, and the number of babies born with low birth weight.



Social and Mental Health

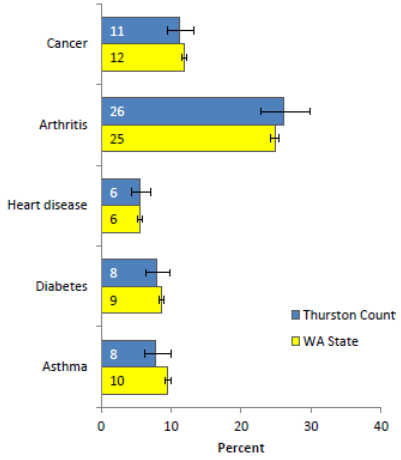
Almost 40% of Thurston County youth reported being depressed and 24% reporting having suicide ideation.[17] These are statistically the same rate as Washington State. Thurston County adults reported having an average of 3.6 poor mental health days per month and 11% of residents report frequent mental distress (Appendix 1 & 2). One-quarter of surveyed Thurston County adults reported have their activities limited by mental or physical health and 14% reported their general health was fair or poor.[17]

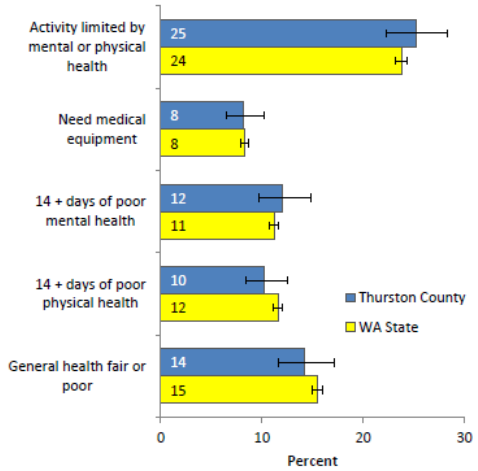


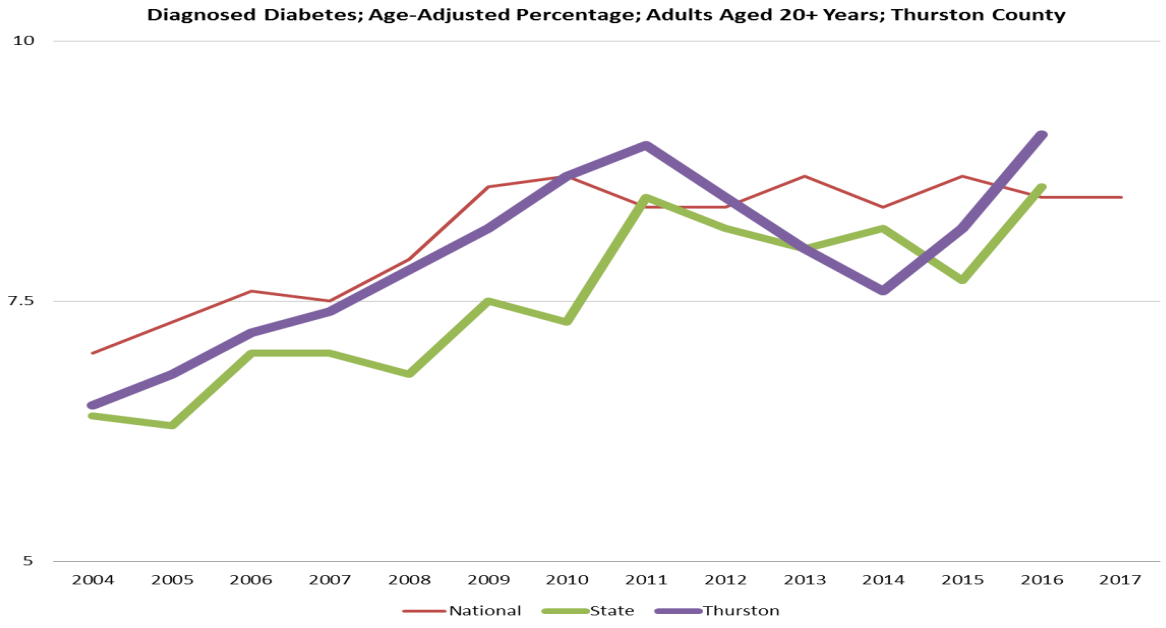
Morbidity (Illness)

Thurston County adults have the same prevalence of cancer, arthritis, heart disease, diabetes, asthma, high cholesterol, high pressure and obesity as the state.[17]

Specifically, the total number of diagnosed Diabetes Mellitus (all types) in adults in Thurston County is just over 9%.[4] This is about the same rate as the state average. More Thurston County males than females have diabetes, but it is not statistically significant. For national and state trends of prevalence and incidence, see the section above, Lewis County *Morbidity (Illness)*.

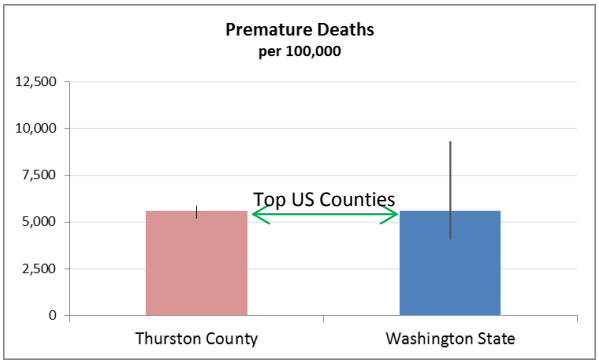






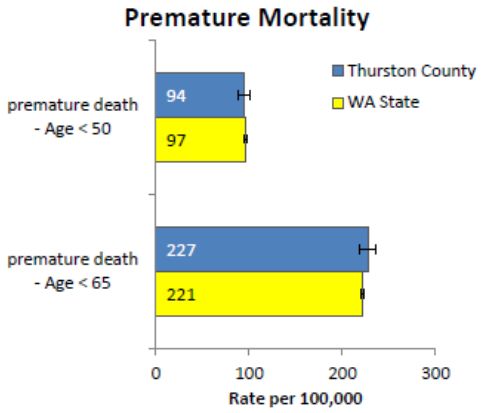
Mortality (Death)

Leading causes of death in an area provides insight to the health status of a population. A high rate of deaths due to preventable causes indicates heightened disease burden or an unmet need for health care services. Every death occurring before the age of 75 is considered premature and contributes to the total number of years of potential life lost.

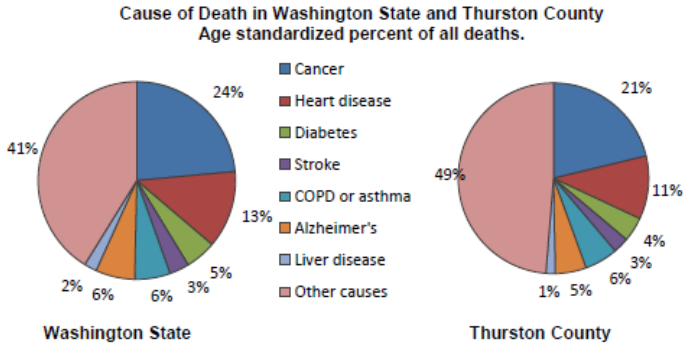


The average life expectancy of Thurston County residents is 80.3 years of age, the same as the state average (Appendix 2).

Thurston County is Ranked 10th of the 39 Washington Counties with 5,600 premature deaths per 100,000 (Appendix 1). These rates are similar to the Washington State average and the top healthiest US counties.[14]



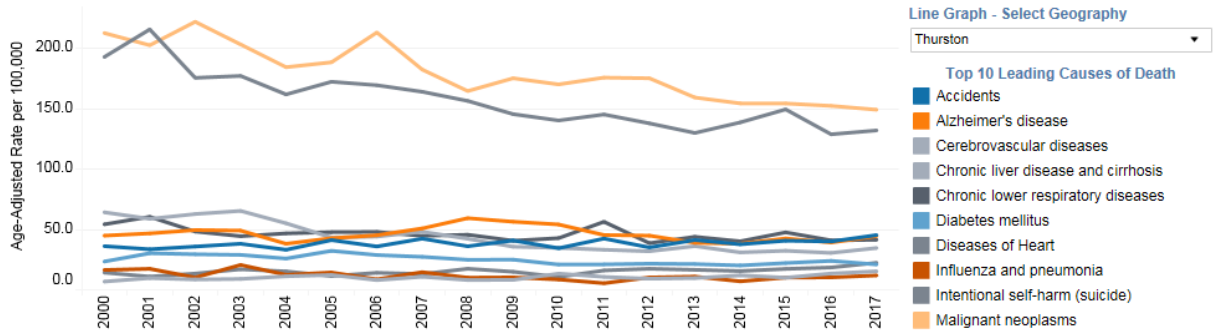
The leading cause of non-accident deaths in Thurston County are malignant neoplasms (cancers) followed by major cardiovascular diseases. [16,17] This is similar to the state.



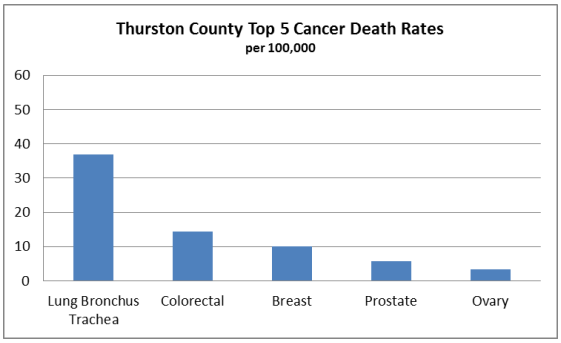
In general, death rates due to cancer have slowly decreased with a slight increase from 2016-2017 for males.[16] Additional years of data are needed to determine if this is a new trend.[16] Lung cancer (lung, bronchus, and trachea) is the most prevalent followed by colorectal and breast cancer. Death rates due to heart disease were also slowly falling except for an increase from 2016-2017, primarily due to a slight increase in female deaths.

The death rate to diagnosed Diabetes Mellitus has not changed much since 2010 and is 21 per 100,000, which is about the same as the state rate. The death rate to due Alzheimer's has generally stayed steady and is 44 per 100,000, which is lower than the state rate, but higher than the US average.[16]

Thurston County had an average annual opioid death rate of 7 per 100,000 population from 2013-2017.[21] This is below both the state and national rates.[8]



NR = Not Reliable. Rates are not reliable due to counts less than 17.
For more information, please click on the landing page: https://www.doh.wa.gov/dataandstatisticalreports/healthdatavisualization/mortalitydashboards
Citation: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2000–2017, Community Health Assessment Tool (CHAT), September 2018.

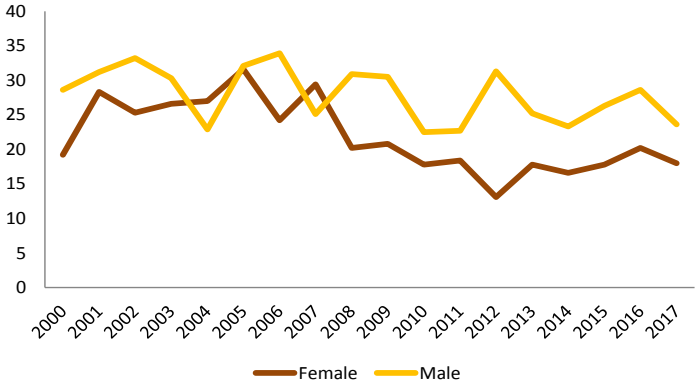


Thurston County

The age adjusted death rate from

Diabetes is **21** (per 100,000)

Compared to Washington State at 21 and the US at 25



Community Themes and Strengths (Input From The Community)

Community feedback on perceptions of health issues and healthcare needs was solicited through surveys, in-person "voting" and key informant interviews.

Methods

Surveys were distributed to select venues and available in clinic lobbies and online from July-October 2019. Short presentations were given at 9 venues in Lewis County including 2 Senior Centers, 4 Service Clubs, a low-income apartment building, a hosted movie night and a meeting with local Fire Department officials. Surveys were shared by front desk staff at the Chehalis, Centralia, and Tenino clinics. The online survey was announced via the VVHC Facebook page and the Chehalis Chamber of Commerce listserv. The surveys included 3 questions: 1) What is the biggest challenge you face when trying to use health care services; 2) What types of health problems do you see most often in our community; and 3) What is the health care service that you wish was offered in our community? The surveys also collect the respondent's zip code, age and whether they were a VVHC patient. The survey was available in both English and Spanish.

In-person "voting" was done at 3 community events In Centralia, Tenino, and Willapa. Attendees were asked to "vote" for their top 3 health issues if they had $300.00 to spend on the issues.

Key informant interviews were conducted by the VVHC leadership with select community leaders and stakeholders. The interviews included 10 questions based on the MAPP Community Assessment Access Project by the Robert Wood Johnson Foundation to guide the conversation.

Qualitative methods were used to analyze the results. For the surveys and "voting", the answers were coded to identify main themes and sub-themes within each theme. A total of three themes per question were selected for ease of grasp. Theme and sub-theme answers were counted. On the surveys, some answers did not fit into themes or sub-themes so were coded as "Other". These included nonsensical answers and answers not related to the question. Some respondents also had answers of "None", "Not Sure" and some questions were not answered. The answer "none" means the respondent indicated everything was fine and did not have a biggest challenge, problem, or desired service. Some respondents included multiple answers per question. Each answer was recorded. Thus, theme and sub-theme totals are greater than the total number of surveys.

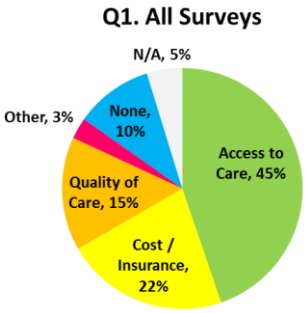
Survey Results

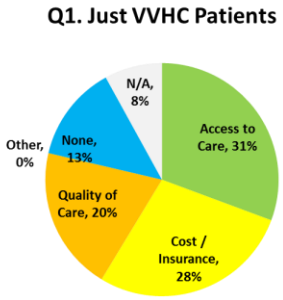
A total of 197 surveys were completed in-person or online. Three surveys were completed in Spanish. About 1/3rd of respondents self-identified as current or former VVHC patients, 2/3^{rds} were not patients and almost 7% did not identify as a patient or not.

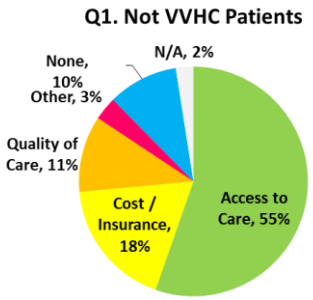
Question 1 - What is the biggest challenge you face when trying to use health care services?
The main themes were:

- Access to Care
- Cost
- Quality of Care

Of the 210 total answers: 45% were Access to Care, 22% were Cost or Insurance, 15% were Quality of Care, 3% were "Other", 10% were "None", and 5% did not answer. VVHC patients were about evenly split between the top 3 themes: Access, Cost and Quality.







The Access to Care sub-themes were:

- Appointment Scheduling (33% of theme answers)
- Primary Care Provider Shortage (28%)
- Specialist Provider Shortage (13%)
- Transportation (9%)
- Personal & Work Related (7%)
- Days and Hours of Operation of Clinics (5%)
- Lack of Non-traditional Provider (1%)

Appointment scheduling included delays and not getting appointments in timely manner. Primary care provider shortage included not enough providers and providers not accepting new patients. Transportation included insufficient transportation options and long travel times. Personal & Work-related included not being able to find the time for medical appointments and not being able to take time off work for appointments.

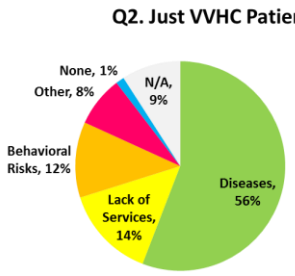
The Cost sub-themes were "Cost" (58%) and Insurance (42%). "Cost" included "cost", "money", concern about not all costs being covered by insurance and concern for out-of-pocket expenses. Insurance included "insurance", concern about insurance plans not being accepted by providers, lack of providers accepting Medicare and Medicaid plans and not having insurance.

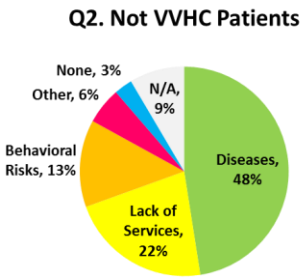
The top Quality of Care sub-theme was Good Customer Service (86%). This included slow response times when waiting for clinic return calls and referrals, inability or difficulty contacting nurses and providers, long telephone hold times, desire for compassionate and caring staff and providers, "good" providers who listen and want to help and trust. Other Quality of Care sub-themes included the provider visit restricted to one topic, not being able to have the same provider, respect for Native Americans and foreign born, lack of translation services and paperwork.

Question 2 - What types of health problems do you see most often in our community?
The main themes were:

- Diseases
- Lack of Local Services
- Behavioral Risk Factors.

Of the 223 total answers: 50% were Diseases; 19% were Lack of Services; 13% were Behavioral Risk Factors; 7% were "Other"; 2% were "None" and 9% did not answer. Some respondents appear to have answered per the intent of the question of what *community* issues they were aware of, while others appear to have answered with personal ailments. VVHC patient and non-patients answers were similar, except more non-VVHC patients selected Lack of Services.





The answers under the "Disease" theme were a list of acute and chronic diseases. The Diseases sub-themes were:

- Mental/Behavioral Health (22%)
- Bariatric-related, including acid reflux, obesity and weight (17%)
- Diabetes (12%)
- Respiratory-related, including Allergies, Asthma, Colds, Flu, and Ear Nose & Throat (11%)
- Addiction and dependency (7%)
- Cardiovascular, including high blood pressure (7%)
- Musculoskeletal, including back and joint injuries and chronic pain (6%)
- Dental (5%)
- Cancer (4%)
- Basic Health, including preventive care, age-related and unspecified chronic diseases (4%)

Other diseases answers included Infectious Disease, STD, UTI, vision/eye, autism, dementia, and failure to thrive.

The Lack of Local Services sub-themes were:

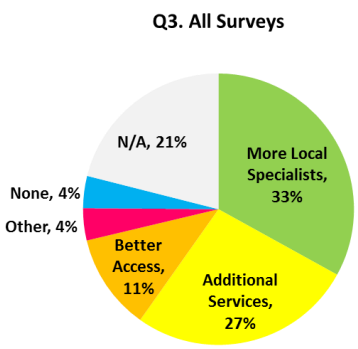
- Access to Care, including general basic health care (24%)
- Elder care, including shut-ins and home care (20%)
- EMT/Emergency services, including trauma care and using ED/emergency services as primary care provider and transportation (15%)
- Lack of Mental Health/Behavioral Health services (13%)
- Indigent Care, including underserved (11%)
- Transportation to Healthcare (6%)
- Pregnancy Prevention (4%)

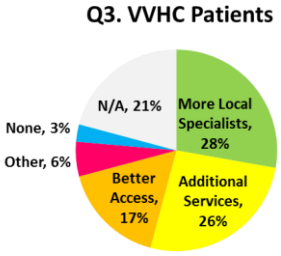
Other lack of local services answers included dental, health education, unspecified local specialists, and unspecified maternal & child health services.

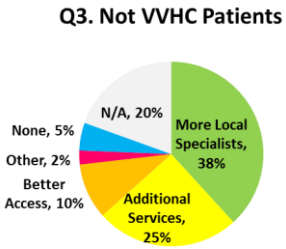
The top Behavioral Risk Factor sub-themes were Substance Use, including alcohol, drugs and smoking (71%), followed by not seeking preventive care (16%), and poor diet (3%). Other answers included stress and lack of exercise.

Question 3 - What is the health care service that you wish was offered in our community?
The main themes were:

- More Local Specialists
- Additional Services
- Better Access







Of the 209 total answers: 33% were for More Local Specialists; 27% were Additional Services; 11% were for Better Access; 4% "Other"; 4% were "None"; and 21% did not answer or answered Not Sure. VVHC patients and non-patients answers were similar, except fewer VVHC patients answered more local specialists and more VVHC patients answered Better Access.

The top desire for Local Specialists sub-themes were:

- Mental/Behavioral Health, including counseling, trauma, and screening (26%)
- Dental, including additional dentists, emergency services and dentures (17%)
- Primary Care/Internal Medicine, including more options, quality care and less provider "churn" (13%)
- Unspecified Local Specialists (7%)
- Dermatology (6%)
- Ophthalmology and Optometry (6%)
- Alternative Medicine, including Holistic/Naturopaths (5%)
- Cardiovascular, including cardiac specialist and heart screening (5%)
- Women's Health and OB/GYN (4%)
- Urology (4%)

Other desired local specialists included Neurology and Traumatic Brain Injury, Endocrinology, Allergy, Obesity, and radiology.

The top desired Services sub-themes were:

- Substance Use and Rehabilitation (17%)
- Community Health Workers, including paramedicine, PAs, mobile health services, and alternatives to the ED (15%)
- Elder Care, including shut-in and home care (13%)
- Physical Therapy, Occupational Therapy, and Chiropractic (11%)
- Shelters and homeless services (9%)
- Exercise facilities and options (6%)

Other desired local services included blood testing, chemotherapy, health education, especially nutrition, hearing aids, Hospice, family planning/pregnancy prevention/terminations, inpatient physical rehabilitation, navigators (additional resources and help with switching insurance coverage), pain center, preventive care, speech therapy and tribal physicians.

The top desired Access sub-themes were evenly split between Transportation, including shuttles and more options (30%), more Urgent Care / Walk-in options, including more hours and days open (30%), and better healthcare access for the under-insured & uninsured, including free clinics and more affordable care to all (30%). Other access sub-themes were healthy food, nurse helpline, veterans/VA contracted clinics.

"Voting" Results

A total of 141 participants "voted" for their top 3 community health issues resulting in a total of 423 votes. The themes were:

- Mental Health & Family Counseling (33%)
- Substance Abuse (18%)
- Transportation to Healthcare (15%)
- Women's Health (9%)
- Local Specialty Care (8%)
- Access to Healthy Food (5%)
- Dentistry (5%)
- Housing & Homelessness (4%)

Other votes were for after-school programs, employment, family values, health insurance for all, higher prosecution for sex crimes, indoor children's play area and senior services.

Key-Informant Interview Results

Discussions with select community leaders yielded similar concerns with health-related issues as the surveys. Namely, access to healthcare is a barrier. This includes a shortage of local Primary Care and Specialty Providers, and transportation to healthcare. Lack of elder care and mental/behavioral health and Substance Use Disorder providers and services is also a concern. Other concerns included the pervasiveness of people using the emergency medic system as their primary care provider and for transportation. Notable developments include approximately 13 primary care providers leaving practice in Lewis County in 2019. This increases the barriers to access because 1) there are fewer providers and 2) the existing providers have an increase in patient loads which delays getting appointments and referrals.

> *"There seems to be a poor understanding of where to go for primary and mental healthcare"*

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Appendix 1

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

2019 Rankings	Washington State	Lewis County	Pacific County	Thurston County
Health Outcomes		30	37	5
Length of Life		32	37	10
Premature death	5,600	7,600	9,300	5,600
Quality of Life		24	38	6
Poor or fair health	14%	14%	18%	12%
Poor physical health days	3.7	4.1	4.4	3.3
Poor mental health days	3.8	4.0	4.5	3.6
Low birthweight	6%	7%	8%	6%
Health Factors		32	27	6
Health Behaviors		35	21	10
Adult smoking	14%	17%	15%	13%
Adult obesity	28%	34%	31%	30%
Food environment index	8.1	7.3	6.8	7.7
Physical inactivity	16%	22%	23%	15%
Access to exercise opportunities	87%	52%	66%	73%
Excessive drinking	18%	16%	15%	17%
Alcohol-impaired driving deaths	33%	38%	56%	25%
Sexually transmitted infections	435.9	332.1	244.6	432.2
Teen births	20	33	32	18
Clinical Care		29	33	7
Uninsured	7%	8%	10%	6%
Primary care physicians	1,220:1	2,200:1	4,250:1	1,040:1
Dentists	1,240:1	1,450:1	3,090:1	1,350:1
Mental health providers	310:1	410:1	390:1	350:1
Preventable hospital stays	2,914	3,353	3,402	2,733
Mammography screening	39%	33%	37%	34%
Flu vaccinations	44%	32%	38%	44%
Social & Economic Factors		27	26	8
High school graduation	79%	84%	89%	85%
Some college	70%	56%	54%	71%
Unemployment	4.8%	6.6%	7.0%	5.0%
Children in poverty	14%	21%	25%	13%
Income inequality	4.5	4.3	4.7	3.9
Children in single-parent households	28%	34%	30%	29%
Social associations	8.7	9.5	15.1	9.2
Violent crime	294	193	157	237
Injury deaths	64	82	85	68
Physical Environment		31	14	30
Air pollution - particulate matter	7.4	6.8	6.2	7.2
Drinking water violations		Yes	Yes	Yes
Severe housing problems	18%	18%	1%	17%
Driving alone to work	72%	78%	7%	80%
Long commute - driving alone	36%	36%	23%	32%

Note: Blank values reflect unreliable or missing data
Source: https://www.countyhealthrankings.org/app/washington/2019/compare/snapshot?counties=53_041%2053_049%2053_067
Accessed 9/20/2019

Appendix 2

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

Compare Counties 2019 Additional Measures	Washington State	Lewis County	Pacific County	Thurston County
Length of Life				
Life expectancy	80.3	77.6	76.4	80.3
Premature age-adjusted mortality	290	380	420	290
Child mortality	40	60	70	40
Infant mortality	4	7		5
Quality of Life				
Frequent physical distress	11%	12%	13%	10%
Frequent mental distress	12%	13%	14%	11%
Diabetes prevalence	9%	11%	13%	9%
HIV prevalence	208	69	179	119
Health Behaviors				
Food insecurity	12%	15%	15%	13%
Limited access to healthy foods	6%	8%	13%	7%
Drug overdose deaths	15	15	22	12
Motor vehicle crash deaths	8	13	12	7
Insufficient sleep	31%	32%	30%	29%
Clinical Care				
Uninsured adults	8%	10%	11%	7%
Uninsured children	3%	3%	4%	3%
Other primary care providers	1,171:1	1,043:1	2,703:1	1,293:1
Social & Economic Factors				
Disconnected youth	7%	8%		8%
Median household income	$70,900	$50,100	$45,500	$71,400
Children eligible for free or reduced price lunch	44%	59%	60%	38%
Residential segregation - Black/White	59	69		43
Residential segregation - non-white/white	38	25	26	23
Homicides	3	3		2
Firearm fatalities	10	13	14	11
Physical Environment				
Homeownership	63%	69%	76%	64%
Severe housing cost burden	14%	14%	13%	14%
Demographics				
Population	7,405,743	78,200	21,626	280,588
% below 18 years of age	22.2%	21.6%	16.4%	21.6%
% 65 and older	15.1%	20.7%	29.7%	16.7%
% Non-Hispanic African American	3.8%	0.7%	0.9%	3.1%
% American Indian and Alaskan Native	1.9%	2.0%	2.9%	1.8%
% Asian	8.9%	1.2%	2.2%	6.1%
% Native Hawaiian/Other Pacific Islander	0.8%	0.2%	0.2%	1.0%
% Hispanic	12.7%	10.1%	9.7%	9.0%
% Non-Hispanic white	68.7%	83.6%	81.8%	75.1%
% not proficient in English	4%	2%	3%	2%
% Females	50.0%	50.0%	49.9%	51.1%
% Rural	16.0%	60.7%	64.8%	21.0%

Note: Blank values reflect unreliable or missing data
Source: https://www.countyhealthrankings.org/app/washington/2019/compare/additional?counties=53_041%2053_049%2053_067.
Accessed 9/20/2019

MEMORANDUM

To: Board of Commissioners

From: Leianne Everett, Superintendent

CC:

Date: 02/01/2020

Re: Hospital District Primary and Secondary Markets and Key Statistics

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Arbor Health's primary and secondary service markets are defined by the following communities:

Primary Service Market (PSM) (zip code):

Packwood (98361)

Randle (98377)

Glenoma (98336)

Morton (98356)

Mossyrock (98564)

Mineral (98355)

Secondary Service Market (SSM) (zip code):

Ashford (98304)

Elbe (98330)

Silver Creek (98585)

Salkum (98582)

The primary and secondary service markets encompass approximately 11,700 lives, of which:

1. 65+ years old: 21.8% in 2010, 28.2% in 2019, projected to be 31.1% by 2024
2. 65+ years old: 28.2% for Arbor Health, vs. 20.5% for WRHAP Hospitals, vs. 18.7% CAH Average
3. 65+ year olds are projected to increase by another 13.4% by 2024,
4. PSM has experienced modest growth that is projected to continue, however growth is in the 65+ population,
5. SSM, while smaller than the PSM, is growing more rapidly whose population is slightly younger

Additional information about our PSM and SSM, unrelated to size, follows:

- Average Household Income:

	2019
Washington State	$ 101,633
Lewis County	$66,954
Primary Service Market	$60,401
Secondary Service Market	$69,500
PSM + SSM	$62,132

1. 22% of PSM + SSM live with a household income of less than $25,000
2. 23% of PSM household live with a household income of less than $25,000
3. 20% of SSM households live with a household income of less than $25,000

- Ethnicity:

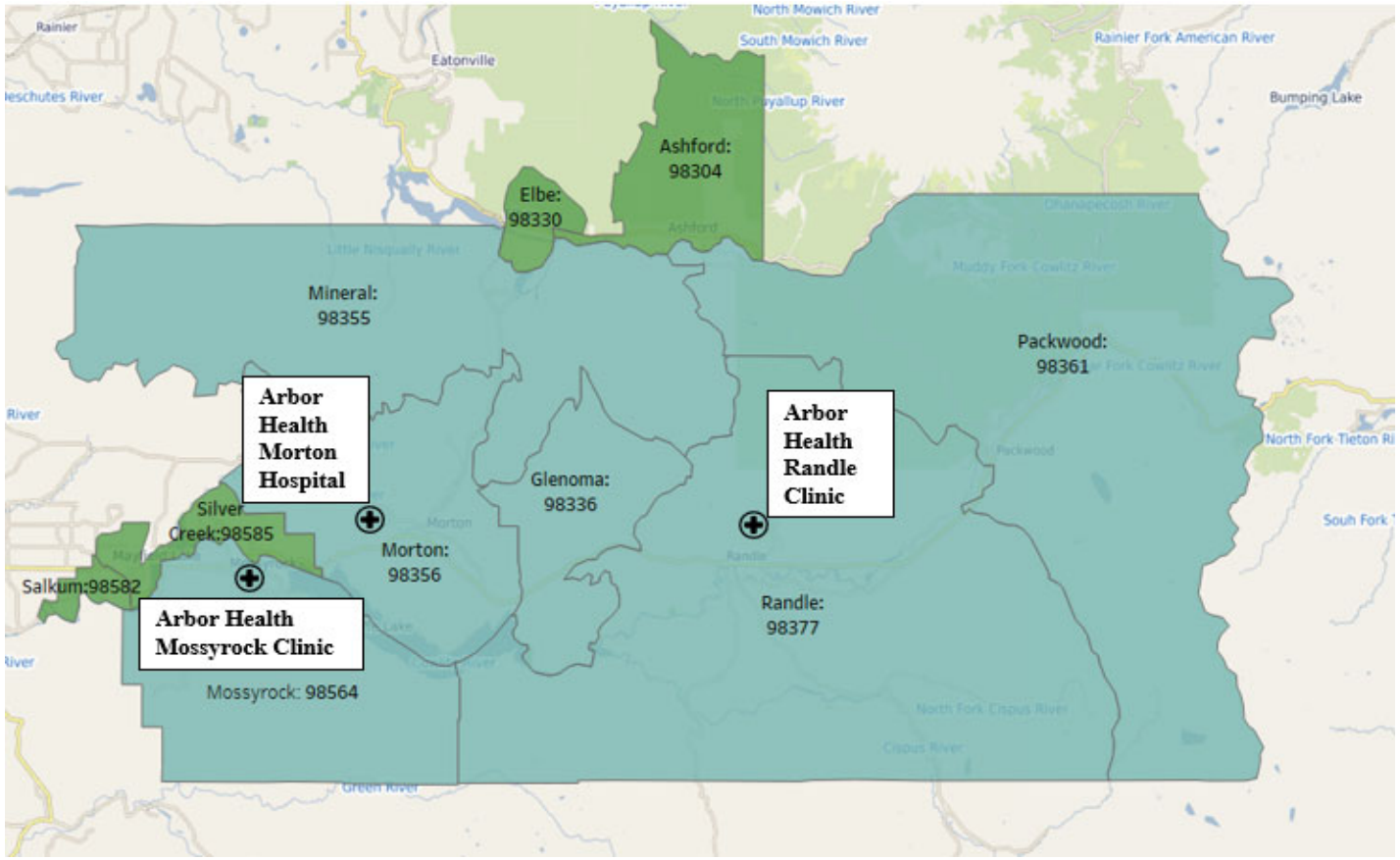
	White Alone	Hispanic	American Indian/Alaska Native	Other
WA State	64%	13%	1.3%	21.7%
Lewis County	77%	11%	1.4%	10.6%
Primary Service Market	83.8%	6.7%	1.7%	7.8%
Secondary Service Market	83.6%	6.7%	1.4%	8.3%
PSM + SSM	84%	7%	1.7%	7.3%

1. In our PSM, White Alone is projected to decline slightly by 2024, while Hispanics are projected to increase by 18.3%,
2. In our SSM, White Alone is projected to increase by 3.4% by 2024 and Hispanics are projected to increase by 17.8%,

- Health Indicators

Metric	PSM +SSM	Lewis County	WA State
Binge Drinking	8.2%	8.8%	12.2%
Current Smoker	17.2%	17.1%	11.6%
Obese, bmi > 30	28.4%	31.3%	25.7%
14+ days of poor mental health	9.7%	11.1%	10.0%
Told you have diabetes	8.3%	12.4%	11.4%
Told you have high blood pressure	51.9%	45.7%	36.5%
Told you have high cholesterol	40.7%	40.8%	35.4%
Told you have asthma	13.2%	14.9%	14.9%
Told you have COPD	11.9%	10.0%	7.1%
Told you have arthritis	50.0%	42.9%	33.7%
Depression	20.9%	22.5%	22.1%
Told you had a stroke	6.7%	5.3%	4.0%
Told you had angina/coronary heart disease	8.2%	6.5%	4.8%

As defined by Arbor Health, the PSM is the large teal area and the SSM includes the green areas.



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MEMORANDUM

To: Board of Commissioners

From: Leianne Everett, Superintendent

CC:

Date: 02/01/2020

Re: Arbor Health Inpatient Market Share by Service Line

Health Facilities Planning & Development provided Arbor Health with inpatient market data by service line for years 2014 through 2018. Their information is summarized below:

- **Primary Service Market**
  - Resident hospitalizations increased by 15% in 2018 vs. 2014,
  - Top inpatient services lines were general medicine (19%), orthopedics (13%), cardiology (24%), gastroenterology (14%) and general surgery (6%),
  - **Arbor Health's** share of this market decreased by 8% in 2018 vs. 2014,
  - **Arbor Health's** largest share of this market is in oncology (38%), gastroenterology (36%), general medicine (29%) and cardiology (23%),
- **Secondary Service Market**
  - Resident hospitalizations increased by 16% in 2018 vs. 2014,
  - Top inpatient services lines were general medicine (2%), orthopedics (14%), cardiology (65%), gastroenterology (92%) and general surgery (31%),
  - **Arbor Health's** share of this market increased by 0.5% in 2018 vs. 2014,
  - **Arbor Health's** largest share of this market is in oncology (11.1%), gastroenterology (12.0%), general medicine (10.9%) and neurosciences (8.3%),
- **Combined Service Markets**
  - Resident hospitalizations increased by 15% in 2018 vs. 2014,
  - Top inpatient services lines were general medicine (16%), orthopedics (13%), cardiology (34%), gastroenterology (26%) and general surgery (11%),
  - **Arbor Health's** share of this market decreased by 6.3% in 2018 vs. 2014,
  - **Arbor Health's** largest share of this market is in oncology (30.3%), gastroenterology (30.4%), general medicine (25.1%), cardiology (16.8%) and neurosciences (11.8%).

MEMORANDUM

To: Board of Commissioners

From: Leianne Everett, Superintendent

CC:

Date: 02/01/2020

Re: Arbor Health Utilization Statistics

Arbor Health has experienced volume increases in all pertinent areas across the health system from 2016-2019.

Service	Change	Change %
Inpatient	-1,083	-65.2%
Swing	4,681	377.8%
Total	3,598	124.0%
Outpatient	2,809	28.0%
Emergency	148	3.2%
Clinic	1,165	9.5%

In addition to volume, other changes can be extrapolated from the analyses. For example:

- **Inpatient Days**
    - Medicare Advantage days increased despite the overall decline in inpatient days,
    - Self Pay days markedly declined in 2017 vs. 2016 and continued modest declines through 2019,
- **Skilled & Non-Skilled Swingbed Days**
    - Medicaid and Medicaid HMO days dramatically increased by 2019,
    - Blue Cross experienced measurable growth as well,

- **Outpatient Encounters**
    - Medicare volumes are shifting away from traditional Medicare to Medicare Advantage plans,
    - Medicaid HMO plans, Client Billings and Self Pay all experienced growing volumes,
    - Commercial and Blue Cross volumes had modest volume increases,
- **Emergency Room Encounters**
    - Medicare volumes are shifting away from traditional Medicare to Medicare Advantage plans,
    - Commercial Insurance, Workers Comp and Self Pay all experienced volume growth,
- **Professional/Clinic Encounters**
    - 2017 and 2018 volumes experienced growth but provider turnover is reflected in the declining volumes in 2019,
    - Medicare volumes are shifting away from traditional Medicare to Medicare Advantage plans,
    - Commercial Insurance volumes improved during this period,
    - Self Pay experienced modest growth.

Arbor Health
Balance Sheet
2015 through 2019

	2015	2016	2017	2018	2019
Assets	audited	audited	audited	audited	unaudited
Current Assets:					
Cash	$ 2,747,525	$ 3,882,763	$ 5,072,454	$ 3,669,662	$ 4,690,389
Total Accounts Receivable	6,070,249	9,907,339	6,808,267	7,194,873	6,827,483
Reserve Allowances	(3,007,027)	(5,948,042)	(4,557,792)	(3,756,600)	(2,967,894)
Net Patient Accounts Receivable	3,063,222	3,959,297	2,250,476	3,438,273	3,859,589
Taxes Receivable	100,558	78,906	64,402	58,920	59,634
Estimated 3rd Party Receivables	-	-	955,483	1,480,508	338,030
Prepaid Expenses	249,347	416,468	246,595	278,903	270,106
Inventory	128,841	160,452	191,211	301,089	263,318
Funds in Trust	1,731,204	1,198,701	1,221,466	1,282,344	1,339,891
Other Current Assets	44,147	(1,817)	546	1,416	67,771
Total Current Assets	**8,060,844**	**9,694,771**	**10,002,633**	**10,511,117**	**10,888,729**
Property, Buildings and Equipment	28,407,041	28,993,708	29,699,104	29,611,905	30,038,742
Less Accumulated Depreciation	(14,468,518)	(15,716,642)	(17,649,620)	(18,788,866)	(20,569,325)
Net Property, Plant, & Equipment	13,938,523	13,277,066	12,049,484	10,823,038	9,469,417
Other Assets	215,713	63,926	0	0	0
Total Assets	**$ 22,215,080**	**$ 23,035,762**	**$ 22,052,117**	**$ 21,334,155**	**$ 20,358,145**

	2015	2016	2017	2018	2019
Liabilities	audited	audited	audited	audited	unaudited
Current Liabilities:					
Accounts Payable	$ 238,017	$ 401,341	$ 365,542	$ 503,666	$ 460,881
Accrued Payroll and Related Liabilities	1,070,622	349,399	410,695	540,121	547,546
Accrued Vacation		770,262	809,311	908,404	899,148
Third Party Cost Settlement	-	1,557,486	500,964	526,853	1,366,241
Interest Payable	(276)	0	0	0	0
Current Maturities - Debt	1,132,826	1,677,492	1,650,760	1,722,955	1,080,932
Unearned Revenue		-	-	-	-
Other Payables	10,192	228	865	506	213
Current Liabilities	2,451,381	4,756,208	3,738,138	4,202,504	4,354,961
Total Notes Payable		1,318,880	666,777	0	(0)
Capital Lease		248,654	163,858	76,582	0
Net Bond Payable		10,153,942	9,223,475	8,237,809	7,207,875
Total Long Term Liabilities	13,314,813	11,721,476	10,054,110	8,314,391	7,207,875
Total Liabilities	**15,766,194**	**16,477,683**	**13,792,248**	**12,516,895**	**11,562,836**
General Fund Balance	6,712,689	6,558,079	8,259,869	8,817,260	8,817,260
Net Gain (Loss)	(263,803)	0	(0)	(0)	(21,950)
Fund Balance	**6,448,886**	**6,558,079**	**8,259,869**	**8,817,260**	**8,795,310**
Total Liabilities And Fund Balance	**$ 22,215,080**	**$ 23,035,762**	**$ 22,052,117**	**$ 21,334,155**	**$ 20,358,145**

Arbor Health
Income Statement
2015 through 2019

	2015	2016	2017	2018	2019
	audited	audited	audited	audited	unaudited
Inpatient Revenenues	$ 6,982,704	$ 8,697,171	$ 8,731,578	$ 8,592,937	$ 10,068,927
Outpatient Revenues	24,219,180	29,241,237	30,034,464	31,570,468	32,486,170
Clinic Revenues	2,415,413	2,584,166	2,770,526	2,854,926	2,584,549
Total Gross Patient Revenues	33,617,297	40,522,574	41,536,569	43,018,331	45,139,645
Contractual Allowances	10,333,213	17,041,013	14,184,273	15,555,512	17,288,084
Bad Debt	1,539,666	667,234	2,219,821	1,152,550	824,572
Charity Care	95,921	190,823	221,214	154,969	119,590
Other Adjustments	-	1,294,775	753,201	1,095,808	821,833
Total Deductions From Revenue	11,968,800	19,193,845	17,378,509	17,958,840	19,054,079
Net Patient Revenues	**21,648,497**	**21,328,729**	**24,158,060**	**25,059,491**	**26,085,566**
Other Operating Revenue	659,066	552,777	376,774	512,958	879,741
Total Operating Revenue	**22,307,563**	**21,881,506**	**24,534,834**	**25,572,449**	**26,965,308**
Operating Expenses					
Salaries And Benefits	14,820,154	14,425,701	14,939,808	16,989,746	18,189,246
Professional Fees	2,042,003	1,777,869	2,064,214	1,745,271	2,093,601
Supplies	1,782,942	1,461,496	1,541,643	2,117,454	1,887,611
Purchases Services	2,636,185	2,624,986	2,478,066	2,720,081	3,259,453
Utilities		394,074	421,353	411,363	417,883
Insurance Expense	204,098	201,630	212,475	180,577	199,589
Depreciation and Amortization	1,601,939	1,962,969	1,981,238	1,810,679	1,754,163
Interest Expense	627,185	628,887	576,414	516,679	455,499
Other Expense	432,143	272,166	410,065	267,755	491,045
Total Operating Expenses	24,146,649	23,749,777	24,625,276	26,759,606	28,748,090
Income (Loss) From Operations	**(1,839,086)**	**(1,868,271)**	**(90,442)**	**(1,187,157)**	**(1,782,782)**
Non-Operating Revenue/Expense	1,575,285	1,633,719	1,792,233	1,744,548	1,760,832
Net Gain (Loss)	**$ (263,801)**	**$ (234,552)**	**$ 1,701,790**	**$ 557,391**	**$ (21,950)**

A. IMPROVE PATIENT SAFETY, QUALITY, AND SERVICE
1. Reduction of hospital acquired infections with a goal of zero infections
2. Increase hand-hygiene compliance rate
3. Reduction of unassisted patient falls with a goal of zero falls
4. Reduction of the use of Restraints/Seclusions
5. Reduction of hospital acquired pressure injuries with a goal of zero injuries
6. Integration of the Patient Experience in Quality and Safety processes (HCAHPS)
7. Monitor trends in patient safety events through Arbor Health's event reporting system and implement actions to reduce harm
8. Conduct Annual Culture of Safety Survey
9. Conduct Annual Clinical Service Contract Quality Evaluations
10. Integration of PDSA through departmental improvements
B. IMPROVE RESOURCE UTILIZATION
1. Improve patient flow throughput
2. Reduce readmissions
C. MONITOR EXTERNAL REGULATORY, ACCREDITATION, AND COLLABORATIVE INDICATORS
1. Quality Health Indicator (QHi) Project
2. Washington State Hospital Association Quality Benchmarking
3. Medicare Beneficiary Quality Improvement Project (MBQIP)