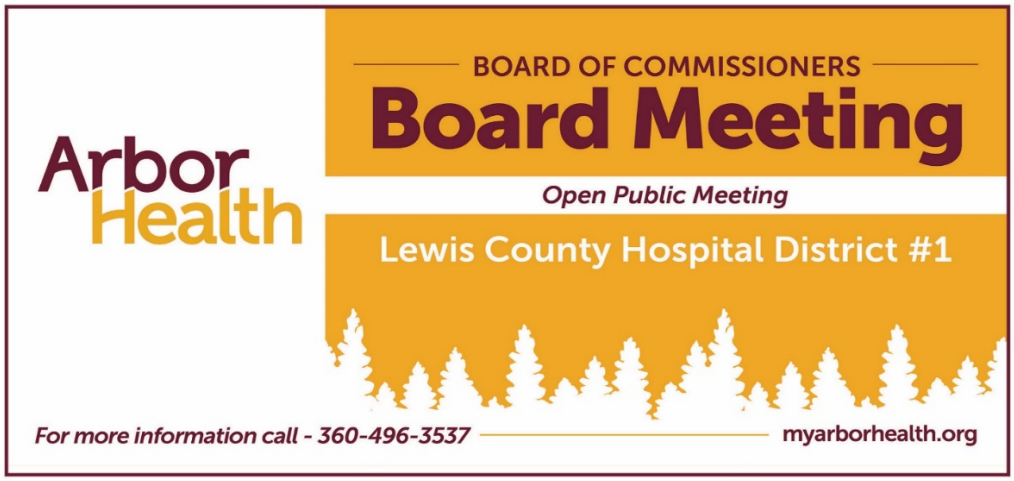
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

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

May 26, 2021 @ 3:30 PM
Join Zoom Meeting: https://myarborhealth.zoom.us/j/96969118735
Meeting ID: 969 6911 8735
One tap mobile: +12532158782,,96969118735#
Dial: +1 253 215 8782

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
May 26, 2021 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/96969118735
Meeting ID: 969 6911 8735
One tap mobile: +12532158782,,96969118735#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	PAGE	TIME
Call to Order **Roll Call** **Reading of the Mission & Vision Statement** **Approval or Amendment of Agenda** **Conflicts of Interest**		3:30 pm
Comments and Remarks • Commissioners • Audience		3:35 pm
Executive Session-*RCW 70.41.205* • Medical Privileging-Janice Holmes		3:40 pm
Guest Speaker • Tom Dingus, Partner, Dingus, Zarecor and Associates o *2020 Independent Financial & Internal Control Auditor Report*	5	3:45 pm
Department Spotlight • Morton Clinic	58	4:45 pm
Board Committee Reports • Hospital Foundation Report-Committee Chair-Commissioner McMahan	68	4:55 pm
• Finance Committee Report-Committee Chair-Commissioner Coppock	70	5:00 pm
• Compliance Committee Report-Committee Chair- Commissioner McMahan		5:05 pm
Consent Agenda *(Action)* • Approval of Minutes: o *Minutes of the April 28, 2021 Regular Board Meeting* o *Minutes of the May 5, 2021 Special Board Meeting* o *Minutes of the May 12, 2021 Compliance Committee Meeting* o *Minutes of the May 19, 2021 Finance Committee Meeting*	 72 79 81 85	5:10 pm
• Warrants & EFT's in the amount of $5,351,318.51 dated April 2021	89	
• Resolution 21-20-Approving the Medical Staff Bylaws o *To approve the Medical Staff Bylaws.*	91	

• Resolution 21-21-Approving the Medical Staff Rules & Regulations o *To approve the Medical Staff Rules & Regulations.*	161	
• Resolution 21-22-Approving the Purchase of the Cerner Pharmacy Clinical Surveillance Software o *To approve the purchase of the software.*	192	
• Approve Documents Pending Board Ratification 5.26.21 o *To provide board oversight for document management in Lucidoc.*	195	
Old Business • Incident Command Update o *CNO/CQO Williamson will provide a verbal COVID 19 update.*		5:15 pm
Break		5:25 pm
New Business • Board Bylaws o *To review the proposed edits on the bylaws.*	200	5:30 pm
• Resolution 21-23-Approving the Budget Amendment-Podiatrist o *To approve the budget amendment for the new service line of podiatry.*	217	5:45 pm
• Special Board Meeting-Commissioner Candidate Governance Education Webinar o *To invite declared candidates to the AWPHD webinar and Public Comment for Q & A.*		6:10 pm
Superintendent Report • Packwood Clinic • Emergency Power		6:15 pm
Meeting Summary & Evaluation		6:25 pm
Next Board Meeting Dates and Times • Special Board Meeting-June 2, 2021 @ 6:00 PM (ZOOM) • Regular Board Meeting-July 28, 2021 @ 3:30 PM (ZOOM) **Next Committee Meeting Dates and Times** • QIO Committee Meeting-June 2, 2021 7:00 AM (ZOOM) • Arbor Health Foundation Meeting-June 8, 2021 (ZOOM) • Finance Committee Meeting-June 30, 2021 @ 12:00 PM (ZOOM)		
Adjournment		6:30 pm

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Board of Commissioners
Lewis County Public Hospital District No. 1
doing business as Arbor Health
Morton, Washington

We have audited the financial statements of Lewis County Public Hospital District No. 1 doing business as Arbor Health (the District) for the year ended December 31, 2020. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated December 1, 2020. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in Note 1 to the financial statements. No new accounting policies were adopted, and the application of existing policies was not changed during the year ended December 31, 2020. We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the District's financial statements were management's estimate of the allowance for uncollectible accounts and contractual adjustments, estimated third-party payor settlements, and the liability for employee health insurance claims incurred but not reported.

- Management's estimate of the allowance for estimated uncollectible accounts and contractual adjustments is based on experience, third-party contractual history, and any unusual circumstances.
- Management's estimate for third-party settlements is based on interim payments, the District's expenses, and patient statistical data.
- Management's estimate of the CARES Act Provider Relief Fund revenue is based on lost revenues and COVID-19 qualifying expenses based on current guidance.

We evaluated the key factors and assumptions used to develop these estimates in determining that they are reasonable in relation to the financial statements taken as a whole.

The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

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Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

Management has determined that the exclusion of the East Lewis County Hospital Foundation from the financial statements is immaterial to the financial statements taken as a whole. The Foundation total assets at December 31, 2020, were approximately $70,000.

Disagreements with Management

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditors' report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated March 5, 2021.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the District's financial statements or a determination of the type of auditors' opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the District's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

The financial statements have been prepared assuming the District will continue as a going concern. As discussed in Note 14 to the financial statements, the COVID-19 pandemic has created economic uncertainties which may negatively impact the District's financial position. These uncertainties could cause substantial doubt of the District's ability to continue as a going concern. Management's plans regarding those matters are also described in Note 14. The financial statements do not include any adjustments that might be necessary if the District is unable to continue as a going concern.

We have considered management's plans and have concluded that substantial doubt of the District's ability to continue as a going concern has been alleviated. Management's use of the going concern basis of accounting is appropriate and the related disclosures are adequate. Our report is not modified with respect to this matter.

Other Matters

We applied certain limited procedures to the management's discussion and analysis which is required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

Restriction on Use

This information is intended solely for the use of Board of Commissioners and management of Lewis County Public Hospital District No. 1 doing business as Arbor Health and is not intended to be, and should not be, used by anyone other than these specified parties.

Dingus, Zarecor and Associates PLLC

Spokane Valley, Washington
May 5, 2021

Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Basic Financial Statements and
Independent Auditors' Reports

December 31, 2020 and 2019

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Lewis County Public Hospital District No. 1
doing business as Arbor Health
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DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT

Board of Commissioners
Lewis County Public Hospital District No. 1
doing business as Arbor Health
Morton, Washington

Report on the Financial Statements

We have audited the accompanying financial statements of Lewis County Public Hospital District No. 1 doing business as Arbor Health (the District) as of and for the years ended December 31, 2020 and 2019, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of December 31, 2020 and 2019, and the changes in its financial position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 14 to the financial statements, the COVID-19 pandemic has created economic uncertainties which may negatively impact the District's financial position. Management's evaluation of the events and conditions and management's plans to mitigate these matters are also described in Note 14. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 7 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 5, 2021, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters for the year ended December 31, 2020. We issued a similar report for the year ended December 31, 2019, dated April 27, 2020, which has not been included with the 2020 financial and compliance report. The purpose of those reports is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing for each year, and not to provide an opinion on the effectiveness of the District's internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
May 5, 2021

Lewis County Public Hospital District No. 1
doing business as Arbor Health
Management's Discussion and Analysis
Years Ended December 31, 2020 and 2019

Our discussion and analysis of Lewis County Public Hospital District No. 1 doing business as Arbor Health's (the District) financial performance provides an overview of the District's financial activities for the years ended December 31, 2020 and 2019. Please read it in conjunction with the District's financial statements, which begin on page 8.

Financial Highlights

- The District's net position increased by $853,548, or 9 percent, in 2020 and increased by $484,811, or 5 percent, in 2019.
- The District reported operating loss of $5,024,600 in 2020 and operating loss of $938,901 in 2019. Operating losses increased by $4,085,699 in 2020 and increased by $155,031 in 2019.
- Nonoperating revenues and expenses increased by $4,454,436, or 323 percent, in 2020 compared to 2019. Nonoperating revenues and expenses increased by $82,442, or 6 percent, in 2019 compared to 2018.

Using This Annual Report

The District's financial statements consist of three statements—a Statement of Net Position; a Statement of Revenues, Expenses, and Changes in Net Position; and a Statement of Cash Flows. These financial statements and related notes provide information about the activities of the District, including resources held by the District but restricted for specific purposes by contributors, grantors, or enabling legislation.

The Statement of Net Position and Statement of Revenues, Expenses, and Changes in Net Position

Our analysis of the District finances begins on page 4. One of the most important questions asked about the District's finances is, "Is the District as a whole better or worse off as a result of the year's activities?" The Statement of Net Position and the Statement of Revenues, Expenses, and Changes in Net Position report information about the District's resources and its activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when the cash is received or paid.

These two statements report the District's net position and changes in it. You can think of the District's net position—the difference between assets and liabilities—as a way to measure the District's financial health, or financial position. Over time, increases or decreases in the District's net position can help indicate whether its financial health is improving or deteriorating. You will need to consider other nonfinancial factors, however, such as changes in the District's patient base and measures of the quality of service it provides to the community, as well as the local economic factors, to assess the overall health of the District.

The Statement of Cash Flows

The final required statement is the Statement of Cash Flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operations, investing, and financing activities. It provides answers to such questions as "Where did cash come from?" "What was cash used for?" and "What was the change in cash balance during the reporting period?"

The District's Net Position

The District's net position is the difference between its assets and liabilities reported in the Statement of Net Position, on page 8. The District's net position decreased by $853,548, or 9 percent, in 2020 and increased by $484,811, or 5 percent, in 2019, as shown in Table 1.

A significant component of the change in the District's assets is the decline in capital assets. This is mostly attributed to the lack of capital spending across the District. The District plans for major renovation in support areas in 2021 and onward. Current assets have increased by 95 percent, mainly in cash as the District participated in various programs related to the COVID-19 pandemic. Changes in the Medicare program receivable, while sizeable, are standard experiences in the critical access hospital program.

Table 1: Assets, Liabilities, and Net Position

	2020	2019	2018
Assets			
Current assets	**$ 18,722,830**	$ 9,580,133	$ 8,896,608
Capital assets, net	**8,916,298**	9,469,416	10,823,038
Other noncurrent assets	**3,205,817**	1,339,891	1,282,355
Total assets	**$ 30,844,945**	$ 20,389,440	$ 21,002,001
Liabilities			
Current liabilities	**$ 9,988,546**	$ 3,881,409	$ 3,870,342
Noncurrent liabilities	**10,700,770**	7,205,950	8,314,389
Total liabilities	**20,689,316**	11,087,359	12,184,731
Net position			
Net investment in capital assets	**1,726,015**	1,180,609	785,695
Restricted for debt service	**836,344**	761,618	717,044
Unrestricted	**7,593,270**	7,359,854	7,314,531
Total net position	**10,155,629**	9,302,081	8,817,270
Total liabilities, deferred inflow of resources, and net position	**$ 30,844,945**	$ 20,389,440	$ 21,002,001

Operating Results and Changes in The District's Net Position

In 2020, the District's net position increased by $853,548, or 9 percent, as shown in Table 2. This increase is made up of very different components, compared with the increase in net position for 2019 of $484,811, and is discussed below.

Table 2: Operating Results and Changes in Net Position

	2020	2019
Operating revenues		
Net patient revenue, net of provision for bad debts	**$ 25,997,099**	$ 26,965,225
Electronic health records incentive payment (payback)	**-**	-
Grants and other	**527,328**	545,587
Total operating revenues	**26,524,427**	27,510,812
Operating expenses		
Salaries and benefits	**18,721,892**	16,760,671
Supplies	**2,124,331**	1,895,561
Depreciation and amortization	**1,736,150**	1,780,460
Other	**8,966,654**	8,013,021
Total operating expenses	**31,549,027**	28,449,713
Operating loss	**(5,024,600)**	(938,901)
Nonoperating revenues (expenses)		
CARES Act Provider Relief Fund	**3,711,316**	-
COVID-19 grants	**637,152**	-
Taxation	**1,792,600**	1,609,987
Interest income	**62,875**	131,170
Interest expense	**(425,819)**	(428,642)
Other	**100,024**	111,197
Total nonoperating revenues, net	**5,878,148**	1,423,712
Change in net position	**853,548**	484,811
Net position, beginning of year	**9,302,081**	8,817,270
Net position, end of year	**$ 10,155,629**	$ 9,302,081

Analysis of Financial Position, Results of Operations, Nonoperating Activities, and Cash Flows

The first component of the overall change in the District's net assets is its operating loss—the difference between net patient service revenues and the expenses incurred to perform those services. In 2020 and 2019, the District reported an operating loss. Operating losses increased by $4,085,699, or 435 percent, from 2019 to 2020, and increased by $155,031, or 20 percent, from 2018 to 2019.

The District experienced a decline in most service lines due to the COVID-19 pandemic, as illustrated in the table below.

	2020	2019	Variance	Variance %
Admissions				
Medical/surgical	**154**	190	(36)	-19%
Skilled nursing	**76**	96	(20)	-21%
Patient Days				
Medical/surgical	**517**	631	(114)	-18%
Skilled nursing	**1,137**	1,366	(229)	-17%
Custodial	**1,330**	2,723	(1,393)	-51%
Outpatient Utilization				
Outpatient registrations	**11,991**	10,580	1,411	13%
Observation registrations	**212**	218	(6)	-3%
Emergency registrations	**4,159**	4,721	(562)	-12%
Physician clinics	**18,434**	13,197	5,237	40%

The District acquired a local physician practice in 2020 in an effort to maintain stability in the primary care market. The District continues to experience turnover in staffing and has moved to staffing with out-of-market staffing contracts, thereby increasing its professional fee cost in 2020. Employee benefit cost continues to grow with an aging workforce.

The primary components of these changes in operating losses are:

- A decrease in inpatient and skilled nursing days of 17 percent.
- A decline in emergency department visit of 12 percent.
- An increase in physician clinic visit and referral outpatient utilization in laboratory and radiological encounters.
- Increase in salaries and benefits expense of $1,961,221 or 12 percent, from 2019 to 2020, and an increase of $603,040, or 4 percent, from 2018 to 2019.
- To maintain appropriate staffing levels and expertise, the District is utilizing out-of-market staffing resources as the local labor market does not support the staffing requirements. Staff recruitment is a high priority for the District and significant effort is being made recruiting staff to the area.

Capital Assets

At the end of 2020, the District had $8,916,298 invested in capital assets, net of accumulated depreciation, as detailed in Note 4 to the financial statements.

Debt

At year end, the District had $10,700,770 in revenue notes, mortgage loans, and capital lease obligations outstanding. The District issued new debt of $2,000,000 in 2020. The District's formal debt issuances—revenue notes—cannot be issued without approval of the District's Board of Commissioners.

Currently Known Facts, Decisions, and Conditions

There are no known changes in the community, industry, or state programs that can be quantified at this time.

Contacting the District's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the District's finances and to show the District's accountability for the money it receives. If you have questions about this report or need additional information, contact the administration department at Arbor Health, PO Box 1138, Morton, Washington 98356.

Lewis County Public Hospital District No. 1
doing business as Arbor Health
Statements of Net Position
December 31, 2020 and 2019

ASSETS	2020	2019
Current assets		
Cash and cash equivalents	**$ 13,907,557**	$ 4,690,387
Receivables:		
Patient accounts	**3,284,901**	3,814,638
Estimated third-party payor settlements	**454,668**	374,592
Taxes	**25,177**	30,141
Taxes restricted for debt service	**25,445**	29,897
Other	**450,314**	112,724
Inventories	**312,750**	257,648
Prepaid expenses and other	**262,018**	270,106
Total current assets	**18,722,830**	9,580,133
Noncurrent assets		
Cash and cash equivalents, limited as to use for capital acquisitions	**395,614**	608,170
Cash and cash equivalents, restricted for debt service	**810,899**	731,721
Cash and cash equivalents, restricted for capital acquisitions	**1,999,304**	-
Capital assets, net	**8,916,298**	9,469,416
Total noncurrent assets	**12,122,115**	10,809,307
Total assets	**$ 30,844,945**	$ 20,389,440

See accompanying notes to basic financial statements.

Lewis County Public Hospital District No. 1
doing business as Arbor Health
Statements of Net Position (Continued)
December 31, 2020 and 2019

LIABILITIES AND NET POSITION	2020	2019
Current liabilities		
Accounts payable	**$ 583,616**	$ 579,821
Accrued compensation and related liabilities	**1,798,286**	1,446,790
Estimated third-party payor settlements	**-**	577,252
Electronic health records incentive payback	**194,689**	194,689
Current maturities of long-term debt	**1,316,175**	1,005,000
Current portion of capital lease obligations	**-**	77,857
Unearned CARES Act Provider Relief Funds	**773,947**	-
Medicare accelerated payments	**5,321,833**	-
Total current liabilities	**9,988,546**	3,881,409
Noncurrent liabilities		
Long-term debt, less current maturities	**7,850,170**	7,205,950
Paycheck Protection Program loan	**2,850,600**	-
Total noncurrent liabilities	**10,700,770**	7,205,950
Total liabilities	**20,689,316**	11,087,359
Net position		
Net investment in capital assets	**1,726,015**	1,180,609
Restricted for debt service	**836,344**	761,618
Unrestricted	**7,593,270**	7,359,854
Total net position	**10,155,629**	9,302,081
Total liabilities and net position	**$ 30,844,945**	$ 20,389,440

See accompanying notes to basic financial statements.

Lewis County Public Hospital District No. 1
doing business as Arbor Health
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2020 and 2019

	2020	2019
Operating revenues		
Net patient revenue	**$ 25,997,099**	$ 26,965,225
Grants	**223,208**	127,329
Other	**304,120**	418,258
Total operating revenues	**26,524,427**	27,510,812
Operating expenses		
Salaries and wages	**14,792,381**	13,291,870
Employee benefits	**3,929,511**	3,468,801
Professional fees	**4,112,182**	3,631,231
Supplies	**2,124,331**	1,895,561
Utilities	**487,739**	386,128
Purchased services	**2,382,917**	1,965,280
Leases and rentals	**223,328**	128,090
Repairs and maintenance	**434,407**	389,054
Depreciation and amortization	**1,736,150**	1,780,460
Insurance	**214,206**	199,590
Other	**1,111,875**	1,313,648
Total operating expenses	**31,549,027**	28,449,713
Operating loss	**(5,024,600)**	(938,901)
Nonoperating revenues (expenses)		
CARES Act Provider Relief Fund	**3,711,316**	-
COVID-19 grants	**637,152**	-
Taxation for maintenance and operations	**981,433**	803,187
Taxation for bond principal and interest	**811,167**	806,800
Contributions	**4,299**	16,692
Build America Bond subsidy	**95,725**	92,146
Gain on sale of assets	**-**	2,359
Interest income	**62,875**	131,170
Interest expense	**(425,819)**	(428,642)
Total nonoperating revenues, net	**5,878,148**	1,423,712
Change in net position	**853,548**	484,811
Net position, beginning of year	**9,302,081**	8,817,270
Net position, end of year	**$ 10,155,629**	$ 9,302,081

See accompanying notes to basic financial statements.

Lewis County Public Hospital District No. 1
doing business as Arbor Health
Statements of Cash Flows
Years Ended December 31, 2020 and 2019

	2020	2019
Increase (Decrease) in Cash and Cash Equivalents		
Cash flows from operating activities		
Cash received from patient services	**$ 25,869,508**	$ 27,848,738
Cash received from grants	**223,208**	127,329
Cash received from other revenue	**304,120**	418,258
Cash paid to and on behalf of employees	**(18,669,767)**	(16,780,812)
Cash paid to suppliers and contractors	**(11,123,383)**	(9,782,468)
Net cash provided by (used in) operating activities	**(3,396,314)**	1,831,045
Cash flows from noncapital financing activities		
Proceeds from CARES Act Provider Relief Fund	**4,485,263**	-
Proceeds from COVID-19 grants	**637,152**	-
Proceeds from Medicare accelerated payments	**5,321,833**	-
Proceeds from Paycheck Protection Program	**2,850,600**	-
Cash received from taxation for maintenance and operations	**986,397**	803,093
Contributions received	**4,299**	16,692
Net cash provided by noncapital financing activities	**14,285,544**	819,785
Cash flows from capital and related financing activities		
Cash received from taxation for bond principal and interest	**815,619**	805,776
Interest paid	**(441,486)**	(455,500)
Principal payments on long-term debt	**(1,028,938)**	(1,636,780)
Proceeds from issuance of long-term debt	**2,000,000**	-
Principal payments on capital leases	**(77,857)**	(84,899)
Payments for purchase of capital assets	**(1,183,032)**	(426,838)
Proceeds from the sale of capital assets	**-**	2,359
Cash received from Build America Bonds subsidy	**46,685**	92,146
Net cash provided by (used in) capital and related financing activities	**130,991**	(1,703,736)
Cash flows from investing activities		
Interest received	**62,875**	131,170
Net increase in cash and cash equivalents	**11,083,096**	1,078,264
Cash and cash equivalents, beginning of year	**6,030,278**	4,952,014
Cash and cash equivalents, end of year	**$ 17,113,374**	$ 6,030,278

See accompanying notes to basic financial statements.

Lewis County Public Hospital District No. 1
doing business as Arbor Health
Statements of Cash Flows (Continued)
Years Ended December 31, 2020 and 2019

		2020		2019
Reconciliation of Cash and Cash Equivalents to the Statements of Net Position				
Cash and cash equivalents	**$**	**13,907,557**	$	4,690,387
Cash and cash equivalents, limited as to use for capital acquisitions		**395,614**		608,170
Cash and cash equivalents, restricted for debt service		**810,899**		731,721
Cash and cash equivalents, restricted for capital acquisitions		**1,999,304**		-
Total cash and cash equivalents	**$**	**17,113,374**	$	6,030,278
Reconciliation of Operating Loss to Net Cash Provided by (Used in) Operating Activities				
Operating loss	**$**	**(5,024,600)**	$	(938,901)
Adjustments to reconcile operating loss to net cash provided by (used in) operating activities				
Depreciation and amortization		**1,736,150**		1,780,460
Provision for bad debts		**521,292**		824,575
(Increase) decrease in current assets:				
Receivables:				
Patient accounts, net		**8,445**		(1,292,067)
Estimated third-party payor settlements		**(80,076)**		773,753
Other		**(288,550)**		(20,180)
Inventories		**(55,102)**		43,442
Prepaid expenses and other		**8,088**		8,798
Increase (decrease) in current liabilities:				
Accounts payable		**3,795**		75,647
Accrued compensation and related liabilities		**351,496**		(1,734)
Estimated third-party payor settlements		**(577,252)**		577,252
Net cash provided by (used in) operating activities	**$**	**(3,396,314)**	$	1,831,045

See accompanying notes to basic financial statements.

1. Reporting Entity and Summary of Significant Accounting Policies:

a. Reporting Entity:

Lewis County Public Hospital District No. 1 owns and operates Arbor Health (the District), a licensed 25-bed critical access hospital in Morton, Washington, and rural health clinics in Randle, Mossyrock and Morton, Washington. The District provides healthcare services to patients in eastern Lewis County, Washington. The services provided include acute care, emergency room, skilled swing-bed care services, physicians' clinic, and the related ancillary services (surgery, laboratory, imaging, therapy, etc.) associated with those services.

The District operates under the laws of the state of Washington relating to Washington municipal corporations. As organized, the District is exempt from the payment of federal income taxes. The Board of Commissioners consists of five community members elected to six-year terms.

Arbor Health Foundation (the Foundation), is a separate entity, and was organized to assist the District in raising donated funds. The resources and operations were determined not to be significant to the District and, therefore, the Foundation is not reported as a component unit of the District in the accompanying financial statements.

b. Summary of Significant Accounting Policies:

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise fund accounting – The District's accounting policies conform to accounting principles generally accepted in the United States of America as applicable to proprietary funds of governments. The District uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus.

Cash and cash equivalents – All cash receipts are deposited directly to the District's depository accounts at banks. Periodically, these funds are transferred to the operating accounts held by the Lewis County Treasurer (County Treasurer). The County Treasurer acts as the District's treasurer. Warrants are issued against the cash placed with the County Treasurer, and the warrants are redeemed from a commercial bank by the County Treasurer. The County Treasurer invests cash in interest-bearing investments at the direction of the District. For purposes of the statements of cash flows, the District considers all cash and cash investments with original maturity dates of less than 90 days as cash and cash equivalents.

Inventories – Inventories are stated at cost on the first-in, first-out method. Inventories consist of pharmaceutical, medical-surgical, and other supplies used in the District's operation.

Assets restricted or limited as to use – Assets restricted or limited as to use include assets set aside by the Board of Commissioners for future capital improvements over which the Board retains control and could subsequently use for other purposes, and assets set aside for repayment of principal and interest on bond indebtedness and capital acquisitions.

1. Reporting Entity and Summary of Significant Accounting Policies (continued):

b. Summary of Significant Accounting Policies (continued):

Bond premiums and discounts – The straight-line method is used to amortize the bond premiums and discounts over the period the related obligation is outstanding, which approximates the effective interest method.

Capital assets – The District capitalizes assets whose costs exceed $5,000 and with estimated useful lives of at least one year; lesser amounts are expensed. The capital assets are reported at historical cost. Contributed capital assets are reported at their estimated fair value at the time of their donation. When such assets are disposed of, the related costs and accumulated depreciation or amortization is removed from the accounts and the resulting gain or loss is classified in nonoperating revenues or expenses.

Compensated absences – Compensated absences consist of absences for which employees will be paid, such as vacation and sick leave. The District records unpaid leave for compensated absences as an expense and liability when incurred. Accrued vacation, which may be accumulated up to 360 hours, is payable upon resignation, retirement, or death. There is no limit to the amount of sick leave employees may accumulate; however, it is not payable to the employees upon conclusion of their employment under any circumstance. In 2018, the District began providing paid sick leave, in accordance with Washington State law, to all non-benefited employees.

Net position – Net position of the District is classified into three components. *Net investment in capital assets* consists of capital assets, net of accumulated depreciation, reduced by current balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net position* is the net position that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District. *Unrestricted net position* is the remaining net position that does not meet the definition of *net investment in capital assets* or *restricted*.

Operating revenues and expenses – The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions, including grants for specific operating activities associated with providing healthcare services—the District's principal activity. Nonexchange revenues, including taxes and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs. All other revenue and expenses not meeting these definitions are reported as nonoperating revenues and expenses, such as interest.

Restricted resources – When the District has both restricted and unrestricted resources available to finance a particular program, it is the District's policy to use restricted resources before unrestricted resources.

1. Reporting Entity and Summary of Significant Accounting Policies (continued):

b. Summary of Significant Accounting Policies (continued):

Grants and contributions – From time to time, the District receives grants from the state of Washington and others as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts restricted to capital acquisitions are reported after nonoperating revenues and expenses. Grants that are for specific projects, or purposes related to the District's operating activities, are reported as operating revenue. Grants that are used to subsidize operating deficits are reported as nonoperating revenue. Contributions, except for capital contributions, are reported as nonoperating revenue.

Subsequent events – Subsequent events have been reviewed through May 5, 2021, the date on which the financial statements were available to be issued.

Upcoming accounting standard pronouncements – In July 2017, the Governmental Accounting Standards Board (GASB) issued Statement No. 87, *Leases*, which increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases previously classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this statement, a lessee is required to recognize a lease liability and an intangible asset representing the lessee's right to use the leased asset, thereby enhancing the relevance and consistency of information about governments' leasing activities. The new guidance is effective for the District's year ending December 31, 2022, although earlier application is encouraged. The District has not elected to implement this statement early; however, management is still evaluating the impact, if any, of this statement in the year of adoption.

In June 2018, the GASB issued Statement No. 89, *Accounting for Interest Cost Incurred Before the End of a Construction Period*. The objectives of this statement are (1) to enhance the relevance and comparability of information about capital assets and the cost of borrowing for a reporting period and (2) to simplify accounting for interest cost incurred before the end of a construction period. The statement is effective for the District's year ending December 31, 2021. Management is currently evaluating the effect this statement will have on the financial statements and related disclosures.

2. Bank Deposits and Investments:

The Revised Code of Washington, Chapter 39, authorizes municipal governments to invest their funds in a variety of investments including federal, state, and local government certificates, notes, or bonds; the Washington State Local Government Investment Pool; savings accounts in qualified public depositories; and certain other investments. Amounts invested in the Washington State Local Government Investment Pool at December 31, 2020 and 2019, were approximately $12,682,000 and $4,915,000, respectively. The Washington State Local Government Investment Pool consists of investments in federal, state, and local government certificates and savings accounts in qualified public depositories.

Custodial credit risk – The risk that, in the event of a failure of the counterparty, the District will not be able to recover that value of the deposits or investments that are in the possession of an outside party. All District deposits are entirely covered by the Federal Deposit Insurance Corporation (FDIC) or by collateral held in a multiple-financial institution collateral pool administered by the Washington Public Deposit Protection Commission, and all investments are insured, registered, or held by the District's agent in the District's name at qualified public depositories. The District's investment policy does not contain policy requirements that would limit the exposure to custodial risk for investments.

Credit risk – The risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is typically measured by the assignment of a rating by a nationally recognized statistical rating organization. The District does not have a policy specifically requiring or limiting investments of this type.

Concentration of credit risk – The inability to recover the value of deposits, investments, or collateral securities in the possession of an outside party caused by a lack of diversification (investments acquired from a single issuer). The District does not have a policy limiting the amount it may invest in any one issuer or multiple issuers.

Interest rate risk – The possibility that an interest rate change could adversely affect an investment's fair value. The District does not have a policy specifically managing its exposure to fair value losses arising from changing interest rates.

3. Patient Accounts Receivable:

Patient accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of accounts receivable, the District analyzes its past history and identifies trends for each of its patient payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which include both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts.

The District's allowance for uncollectible accounts for self-pay patients has declined in comparison to the prior year due to increased collection efforts of self-pay accounts receivable balances. The District does not maintain a material allowance for uncollectible accounts from third-party payors, nor did it have significant writeoffs from third-party payors.

Patient accounts receivable reported as current assets by the District consisted of the following amounts:

		2020		2019
Receivables from patients and their insurance carriers	**$**	**1,361,002**	$	1,309,205
Receivables from Medicare		**1,930,197**		2,518,631
Receivables from Medicaid		**322,683**		352,028
Receivables from 340b contract pharmacy		**66,706**		64,741
Total patient accounts receivable		**3,680,588**		4,244,605
Less allowance for uncollectible accounts		**395,687**		429,967
Patient accounts receivable, net	**$**	**3,284,901**	$	3,814,638

4. Capital Assets:

All capital assets other than land are depreciated or amortized (in the case of capital leases) by the straight-line method of depreciation using these asset lives:

Land improvements	8 to 25 years
Buildings and improvements	5 to 40 years
Equipment	3 to 25 years

Capital asset additions, retirements, transfers, and balances were as follows:

	Balance December 31, 2019	Additions	Retirements	Transfers	Balance December 31, 2020
Capital assets not being depreciated					
Land	$ 968,599	$ 30,000	$ -	$ -	**$ 998,599**
Construction in progress	405,798	367,101	-	(280,328)	**492,571**
Total capital assets not being depreciated	1,374,397	397,101	-	(280,328)	**1,491,170**
Capital assets being depreciated					
Land improvements	1,426,739	-	-	-	**1,426,739**
Buildings and improvements	17,053,317	382,804	-	-	**17,436,121**
Equipment	10,184,289	403,127	-	280,328	**10,867,744**
Total capital assets being depreciated	28,664,345	785,931	-	280,328	**29,730,604**
Less accumulated depreciation for					
Land improvements	(1,056,286)	(55,206)	-	-	**(1,111,492)**
Buildings and improvements	(11,796,925)	(662,494)	-	-	**(12,459,419)**
Equipment	(7,716,115)	(1,018,450)	-	-	**(8,734,565)**
Total accumulated depreciation	(20,569,326)	(1,736,150)	-	-	**(22,305,476)**
Total capital assets being depreciated, net	8,095,019	(950,219)	-	280,328	**7,425,128**
Capital assets, net	$ 9,469,416	$ (553,118)	$ -	$ -	**$ 8,916,298**

4. Capital Assets (continued):

	Balance December 31, 2018	Additions	Retirements	Transfers	Balance December 31, 2019
Capital assets not being depreciated					
Land	$ 968,599	$ -	$ -	$ -	**$ 968,599**
Construction in progress	159,091	313,982	(1,840)	(65,435)	**405,798**
Total capital assets not being depreciated	1,127,690	313,982	(1,840)	(65,435)	**1,374,397**
Capital assets being depreciated					
Land improvements	1,426,739	-	-	-	**1,426,739**
Buildings and improvements	16,987,243	20,570	-	45,504	**17,053,317**
Equipment	10,070,232	94,126	-	19,931	**10,184,289**
Total capital assets being depreciated	28,484,214	114,696	-	65,435	**28,664,345**
Less accumulated depreciation for					
Land improvements	(984,946)	(71,340)	-	-	**(1,056,286)**
Buildings and improvements	(11,098,569)	(698,356)	-	-	**(11,796,925)**
Equipment	(6,705,351)	(1,010,764)	-	-	**(7,716,115)**
Total accumulated depreciation	(18,788,866)	(1,780,460)	-	-	**(20,569,326)**
Total capital assets being depreciated, net	9,695,348	(1,665,764)	-	65,435	**8,095,019**
Capital assets, net	$ 10,823,038	$ (1,351,782)	$ (1,840)	$ -	**$ 9,469,416**

At December 31, 2020, construction in progress included the costs of two projects:

- The installation of a new IT servers, which had no additional costs and was completed in January 2021.
- An upgrade to the emergency power system and the heating, ventilation, and air conditioning (HVAC) system in the operating room. The project has an estimated cost to complete of approximately $2,205,000 and is expected to be completed in the July of 2021. This project is funded by the GE Government Finance, Inc., note payable described in Note 6.

5. Defined Contribution Retirement Plan:

The District has a tax-sheltered annuity (TSA) plan that is available to substantially all employees. The deferred compensation plan has been established by the District under Section 403(b) of the Internal Revenue Code and is administered by Nationwide. The name of the plan is Lewis County Hospital District No. 1 doing business as Arbor Health 403(b) Plan (the Plan). The Plan is a defined contribution plan funded from both employee and employer contributions that are deposited in employee-controlled accounts. Benefit terms, including contribution requirements, for the Plan are established and may be amended by the District. Employees may contribute to the TSA immediately upon employment. After employees have completed 12 months of service (1,000 hours in the preceding 12-month period), have attained age 18, and are in the eligible class, the District will make contributions to the employee's account. The District's contribution is on a matching basis at a rate to be determined annually by the District, and the District maintains sole discretion of how much, if any, it will make as an employer contribution. Employee and employer contributions are 100 percent vested at the time they are paid. Any forfeitures occurring during the plan year will be used to pay plan expenses and reduce the current-period contribution requirement. Pension expenses for the years ended December 31, 2020 and 2019, were approximately $524,000 and $485,000, respectively. Employee contributions to the Plan for the years ended December 31, 2020 and 2019, were approximately $798,000 and $780,000, respectively.

The District owed approximately $38,000 and $30,000 to the Plan at December 31, 2020 and 2019, respectively.

6. Long-term Debt and Capital Lease Obligations:

A schedule of changes in the District's long-term debt and capital lease obligations follows:

	Balance December 31, 2019	Additions	Reductions	Balance December 31, 2020	Amounts Due Within One Year
Long-term debt					
GE Government Finance, Inc note payable	$ -	$ 2,000,000	$ (23,938)	$ 1,976,062	$ 266,175
2005 LTGO bonds	1,205,000	-	(180,000)	1,025,000	185,000
2010 LTGO A bonds	505,000	-	(80,000)	425,000	85,000
2010 LTGO B bonds	4,130,000	-	-	4,130,000	-
2012 UTGO bonds	2,340,000	-	(745,000)	1,595,000	780,000
Bond premiums and discounts	30,950	-	(15,667)	15,283	-
Total long-term debt	8,210,950	2,000,000	(1,044,605)	9,166,345	1,316,175
Capital lease obligations					
Regents	37,586	-	(37,586)	-	-
De Lage (Cerner)	6,798	-	(6,798)	-	-
Everbank	33,473	-	(33,473)	-	-
Total capital lease obligations	77,857	-	(77,857)	-	-
Total long-term debt and capital lease obligations	**$ 8,288,807**	**$ 2,000,000**	**$ (1,122,462)**	**$ 9,166,345**	**$ 1,316,175**

	Balance December 31, 2018	Additions	Reductions	Balance December 31, 2019	Amounts Due Within One Year
Long-term debt					
Note payable to De Lage (Cerner)	$ 666,780	$ -	$ (666,780)	$ -	$ -
2005 LTGO bonds	1,375,000	-	(170,000)	1,205,000	180,000
2010 LTGO A bonds	585,000	-	(80,000)	505,000	80,000
2010 LTGO B bonds	4,130,000	-	-	4,130,000	-
2012 UTGO bonds	3,060,000	-	(720,000)	2,340,000	745,000
Bond premiums and discounts	57,808	-	(26,858)	30,950	-
Total long-term debt	9,874,588	-	(1,663,638)	8,210,950	1,005,000
Capital lease obligations					
Regents	74,137	-	(36,551)	37,586	37,586
De Lage (Cerner)	18,879	-	(12,081)	6,798	6,798
Everbank	69,740	-	(36,267)	33,473	33,473
Total capital lease obligations	162,756	-	(84,899)	77,857	77,857
Total long-term debt and capital lease obligations	**$ 10,037,344**	**$ -**	**$ (1,748,537)**	**$ 8,288,807**	**$ 1,082,857**

6. Long-term Debt and Capital Lease Obligations (continued):

Long-term debt – The terms and due dates of the District's long-term debt are as follows:

- GE Government Finance, Inc., note payable dated May 29, 2020 in the original amount of $2,000,000, for the upgrade to the emergency power system and the heating, ventilation, and air conditioning (HVAC) system in the operating room. The note is due in monthly installments of $27,471, including interest at 2.12 percent, through June 2027.
- Limited tax general obligation (LTGO) bonds dated February 18, 2005, in the original amount of $3,000,000; payable annually on December 1, with variable principal payments ranging from $185,000 to $225,000. Interest of 4.69 percent is payable semiannually through December 2025.
- LTGO series A bonds, dated October 28, 2010, in the original amount of $1,090,000, payable annually on December 1, with variable principal payments ranging from $85,000 to $95,000. Interest of 4 percent is payable semiannually through December 2025. The District issued the bonds for an addition and remodel to the hospital.
- LTGO series B bonds (federally taxable Revenue Build America Bonds), dated October 28, 2010, in the original amount of $4,130,000, payable annually on December 1, with variable principal payments starting in 2025, ranging from $25,000 to $495,000. Variable rate interest of 6.675 percent to 6.875 percent is payable semiannually through December 2035. The District issued the bonds for an addition and remodel to the hospital.
- Unlimited tax general obligation (UTGO) bonds (refunding), dated December 1, 2012, in the original amount of $7,265,000, payable annually on December 1, with variable principal payments ranging from $780,000 to $815,000. Variable rate interest of 2.25 percent to 2.75 percent is payable semiannually through December 2022. The District issued the bonds to refund the 2002 UTGO bonds.

All LTGO bonds are general obligations of the District and are secured by an irrevocable pledge of the District that it will have sufficient funds available to pay the bond principal and interest due by levying, each year, a maintenance and operations tax upon the taxable property within the District.

The UTGO bond is a direct and general obligation and is secured by an irrevocable pledge of the District that it will have sufficient funds available to pay the bond principal and interest due by levying each year a tax upon the taxable property within the District. Tax receipts limited for bond redemption and interest are used to pay the principal and interest each year.

6. Long-term Debt and Capital Lease Obligations (continued):

Capital lease obligations – All capital lease obligation we paid off by the district in 2020.

Aggregate annual principal and interest payments over the terms of long-term debt are as follows:

Years Ending	LTGO Bonds			UTGO Bonds		
December 31,	Principal	Interest	Totals	Principal	Interest	Totals
2021	$ 270,000	$ 354,274	$ 624,274	$ 780,000	$ 41,913	$ 821,913
2022	280,000	342,326	622,326	815,000	22,413	837,413
2023	295,000	330,143	625,143			-
2024	310,000	317,285	627,285	-	-	-
2025	320,000	303,752	623,752	-	-	-
2026-2030	1,830,000	1,169,722	2,999,722	-	-	-
2031-2035	2,275,000	482,969	2,757,969	-	-	-
	$ 5,580,000	**$ 3,300,471**	**$ 8,880,471**	**$ 1,595,000**	**$ 64,326**	**$ 1,659,326**

Years Ending	Other			Total Long-term Debt		
December 31,	Principal	Interest	Totals	Principal	Interest	Totals
2021	$ 266,175	$ 36,004	$ 302,179	$ 1,316,175	$ 432,191	$ 1,748,366
2022	296,319	33,331	329,650	1,391,319	398,070	1,789,389
2023	302,653	26,997	329,650	597,653	357,140	954,793
2024	309,122	20,528	329,650	619,122	337,813	956,935
2025	315,729	13,921	329,650	635,729	317,673	953,402
2026-2030	486,064	8,183	494,247	2,316,064	1,177,905	3,493,969
2031-2035	-	-	-	2,275,000	482,969	2,757,969
	$ 1,976,062	**$ 138,964**	**$ 2,115,026**	**$ 9,151,062**	**$ 3,503,761**	**$ 12,654,823**

7. Paycheck Protection Program Note Payable:

In April 2020, the District was granted a loan from North Cascades Bank, Division of Glacier Bank in the aggregate amount of $2,850,600, pursuant to the Paycheck Protection Program (PPP) under Division A, Title I of the Coronavirus Aid, Relief and Economic Security Act (CARES Act), which was enacted March 27, 2020.

The PPP loan, which was in the form of a Note dated April 23, 2020, matures on April 24, 2022, and bears interest at a rate of 1 percent per annum. The Note may be prepaid by the District at any time prior to maturity with no prepayment penalties. Funds from the loan may only be used for payroll costs, costs used to continue group health care benefits, mortgage payments, rent, utilities, and interest on other debt obligations incurred after February 15, 2020. The District used the entire loan amount for qualifying expenses. Under the terms of the PPP, certain amounts of the loan may be forgiven if they are used for qualifying expenses as described in the CARES Act. The District believes that its use of the loan proceeds will meet the conditions for forgiveness of the loan.

The Hospital applied for PPP loan forgiveness in November 2020. The loan forgiveness will be recorded as a Gain on Forgiveness of Paycheck Protection Program note payable in the statements of revenues, expenses, and changes in net position for the year ending December 31, 2021.

8. Net Patient Service Revenue:

The District recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients who do not qualify for charity care, the District recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the District's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the District records a significant provision for bad debts related to uninsured patients in the period the services are provided. The District's provisions for bad debts and writeoffs has decreased from prior years due to increased collection efforts. The District has not changed its charity care or uninsured discount policies during fiscal years 2020 or 2019. Patient service revenue, net of contractual adjustments and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

		2020		**2019**
Patient service revenue (net of contractual adjustments and discounts):				
Medicare	**$**	**17,382,035**	$	17,638,303
Medicaid		**4,035,270**		4,050,612
Other third-party payors		**4,029,429**		4,638,035
Patients		**1,146,365**		1,373,862
340b contract pharmacy		**338,405**		208,578
		26,931,504		27,909,390
Less:				
Charity care		**413,113**		119,590
Provision for bad debts		**521,292**		824,575
Net patient service revenue	**$**	**25,997,099**	$	26,965,225

8. Net Patient Service Revenue (continued):

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

- *Medicare* – The District has been designated a critical access hospital by Medicare and is reimbursed for most inpatient and outpatient services on a cost basis as defined and limited by the Medicare program. The rural health clinics are also paid under a cost reimbursement method. Nonrural health clinic physician services are reimbursed on a fee schedule. The District is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare administrative contractor.

- *Medicaid* – Reimbursement for most inpatient and outpatient services rendered to Medicaid program beneficiaries is reimbursed on a cost basis as defined by the state of Washington. The rural health clinics are paid under a prospective rate per encounter methodology. The District is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the District and review thereof by the Washington State Health Care Authority.

The District also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations governing Medicare, Medicaid, and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue decreased by approximately $10,000 in 2020, and increased by approximately $11,000 in 2019, due to differences between original estimates and final settlements or revised estimates.

The District provides charity care to patients who are financially unable to pay for the healthcare services they receive. The District's policy is not to pursue collection of amounts determined to qualify as charity care. Accordingly, the District does not report these amounts in net operating revenues or in the allowance for uncollectible accounts. The District determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries and wages, benefits, supplies, and other operating expenses, based on data from its costing system. The costs of caring for charity care patients for the years ended December 31, 2020 and 2019, were approximately $320,000 and $76,000, respectively. The District did not receive any gifts or grants to subsidize charity services during 2020 and 2019.

9. CARES Act Provider Relief Fund:

The District received $4,485,263 of funding from the CARES Act Provider Relief Fund. These funds are required to be used to reimburse the District for healthcare-related expenses or lost revenues that are attributable to coronavirus. The District has recorded these funds as unearned grant revenue until eligible expenses or lost revenues are recognized. During the year ended December 31, 2020, the District recognized $3,711,316 of grant revenue from these funds. The District had $773,947 remaining funds as of December 31, 2020, to use for healthcare-related expenses or lost revenues that are attributable to coronavirus in the next fiscal year.

10. Property Taxes:

The Lewis County Treasurer acts as an agent to collect property taxes levied in the County for all taxing authorities. Taxes are levied annually on January 1 on property values assessed as of the prior January 1 and are intended to finance the District's activities of the same calendar year. Assessed values are established by the Lewis County Assessor at 100 percent of fair market values. A revaluation of all property is required every four years.

Taxes are due in two equal amounts by April 30 and October 31. The assessed property is subject to lien on the levy date and taxes are considered delinquent after October 31. Collections are distributed monthly to the District by the County Treasurer.

The District is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general District purposes. Washington State Constitution and Washington State Law, RCW 84.55.010, limit the rate. The District may also levy taxes at a lower rate. Further amounts of tax need to be authorized by the vote of the residents of Lewis County.

Taxes estimated to be collectible are recorded as revenue in the year of the levy. Taxes levied for operations are recorded as nonoperating revenue. Since state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

The District's tax levies are comprised of the following:

2020

		Assessed Value		
	Levy Rate	Real and Personal	Timber	Total Levy Amount
Bond	0.4581	$ 1,259,765,626	$ 524,793,194	**$ 811,641**
Maintenance and operation	0.4770	$ 1,278,829,276	$ -	**$ 610,027**

2019

		Assessed Value		
	Levy Rate	Real and Personal	Timber	Total Levy Amount
Bond	0.5492	$ 1,117,672,972	$ 345,602,330	**$ 803,605**
Maintenance and operation	0.5313	$ 1,136,449,329	$ -	**$ 603,742**

11. Risk Management and Contingencies:

Risk management – The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Medical malpractice claims – The District has professional liability insurance coverage with Physicians Insurance. The policy provides protection on a "claims-made" basis whereby claims filed in the current year are covered by the current policy. If there are occurrences in the current year, these will only be covered in the year the claim is filed if claims-made coverage is obtained in that year or if the District purchases insurance to cover prior acts. The current professional liability insurance provides $1,000,000 per claim of primary coverage with an annual aggregate limit of $5,000,000. The policy has no deductible per claim.

The District also has excess professional liability insurance with Physicians Insurance on a "claims-made" basis. The excess malpractice insurance provides $4,000,000 per claim of primary coverage with an aggregate limit of $4,000,000. The policy has no deductible per claim.

No liability has been accrued for future coverage for acts, if any, occurring in this or prior years. Also, it is possible that claims exceed coverage available in any given year.

Self-insurance risk pools – The District has a self-insured unemployment plan for its employees. The District participates in the Public Hospital District Unemployment Trust, which is a risk transfer pool administered by the Washington State Hospital Association. The District recognized a $0 and $60,631 dividend from the Public Hospital District Unemployment Compensation Trust in 2020 and 2019, respectively, which was offset against unemployment expense. Payments by the District charged to unemployment expense prior to the dividend were approximately $53,000 and $60,000 in 2020 and 2019, respectively.

Industry regulations – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditations, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the District is in compliance with fraud and abuse statutes, as well as other applicable government laws and regulations. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

12. Medical Self-Insurance Plan:

The District partially self-insures the cost of employee healthcare benefits. The District self-insures the first $80,000 in claims per eligible participant. The District also purchases annual stop-loss insurance coverage for all claims in excess of $80,000 per participant. Accrued compensation and related liabilities on the statements of net position include an accrual for claims that have been incurred but not reported. Claim liabilities are re-evaluated periodically to take into consideration recently settled claims, frequency of claims, and other economic and social factors.

Changes in the District's incurred but not reported liability are as follows:

	2020	2019
Claim liability, beginning of year	**$ 70,000**	$ 69,141
Current year claims and changes in estimates	**2,111,945**	1,336,201
Claims payments	**(2,014,091)**	(1,335,342)
Claim liability, end of year	**$ 167,854**	$ 70,000

13. Concentration of Risks:

Patient accounts receivable – The District grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The majority of these patients are geographically concentrated in and around Lewis County.

The mix of receivables from patients was as follows:

	2020	2019
Medicare	**44 %**	49 %
Medicaid	**13**	16
Other third-party payors	**36**	28
Patients	**7**	7
	100 %	100 %

Physicians – The District is dependent on local physicians practicing in its service area to provide admissions and utilize hospital services on an outpatient basis. A decrease in the number of physicians providing these services or change in their utilization patterns may have an adverse effect on hospital operations.

Collective bargaining units – Effective July 1, 2018, the District renewed its contract with Carpenters' Industrial Council Local Union No. 2767. Approximately 45 percent of the District's employees are represented by the labor union under this collective bargaining agreement. The contract is effective through June 30, 2020. The contract was extended through June 30, 2021.

Effective July 8, 2019, the District renewed its contracts with Washington State Nurses Association for registered nurses and licensed practical nurses. Approximately 12 percent of the District's employees are represented by the labor union under these collective bargaining agreements. The contracts are effective through March 31, 2022.

14. COVID-19 Pandemic:

The COVID-19 pandemic has created economic uncertainties which may negatively impact the District's financial position. Beginning in March 2020, the District began experiencing significant declines in revenues due to the state of Washington temporarily suspending all elective surgeries and other elective procedures. In addition, the District has experienced declines in volumes of outpatient and ancillary services, such as radiology, laboratory, rehabilitation, respiratory, pulmonary, and clinic visits.

The District received government grants as described in Note 9 above, as part of the federal government's response to the pandemic.

Medicare sequestration has been suspended from May 1, 2020 through December 31, 2021, which will increase Medicare reimbursement by 2 percent.

The District also entered into the PPP loan described in Note 7 above, also a part of the federal government's response to the pandemic.

The District also received Medicare accelerated payments of $5,321,833 in April 2020. The Medicare accelerated payments will begin to be repaid within 1 year of issuance.

In addition to accepting funding from the CARES Act Provider Relief Fund and the other funding sources noted above, the District resumed the services that had been temporarily suspended. However, the pandemic continues to affect the District's operations. The ultimate COVID-19 pandemic effect on the District's financial position is unknown at this time.

15. Subsequent Event

The District incurred a capital lease obligation subsequent to year end for operating room equipment. The capital lease obligation is $542,530 with a 44-month term and a $13,307 monthly payment.

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Certified Public Accountants

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Commissioners
Lewis County Public Hospital District No. 1
doing business as Arbor Health
Morton, Washington

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Lewis County Public Hospital District No. 1 doing business as Arbor Health (the District) as of and for the year ended December 31, 2020, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents, and have issued our report thereon dated May 5, 2021.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

12015 East Main Avenue | Spokane Valley, WA 99206 | 509.242.0874 | www.dzacpa.com

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
May 5, 2021

Lewis County Public Hospital District No. 1
doing business as Arbor Health
Summary Schedule of Prior Year Audit Findings
Year Ended December 31, 2020

The audit for the year ended December 31, 2019, reported no audit findings, nor were there any unresolved findings from the periods ended December 31, 2018, or prior. Therefore, there are no matters to report in this schedule for the year ended December 31, 2020.

Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Financial Indicators

December 31, 2020

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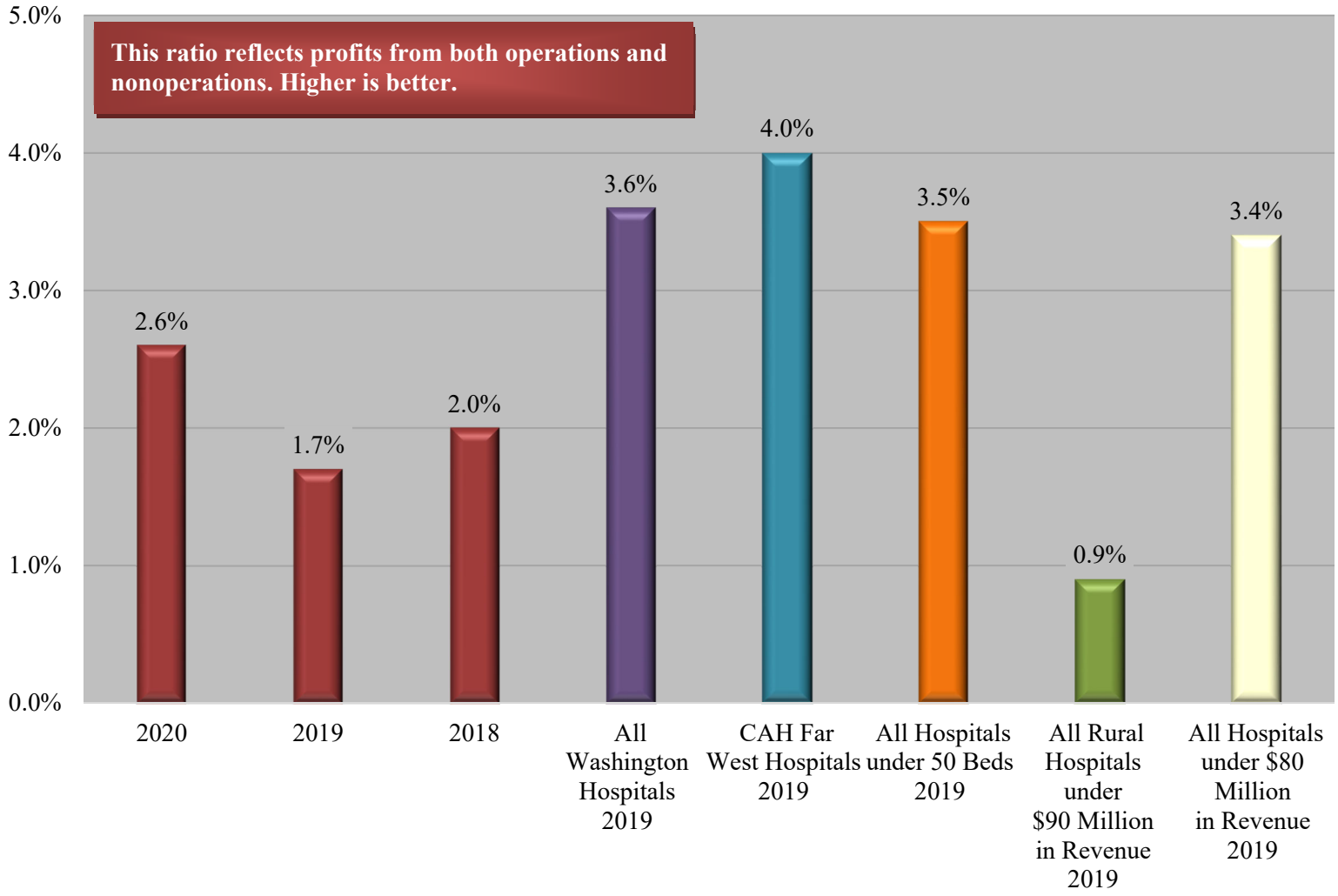
Certified Public Accountants

Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Total Margin

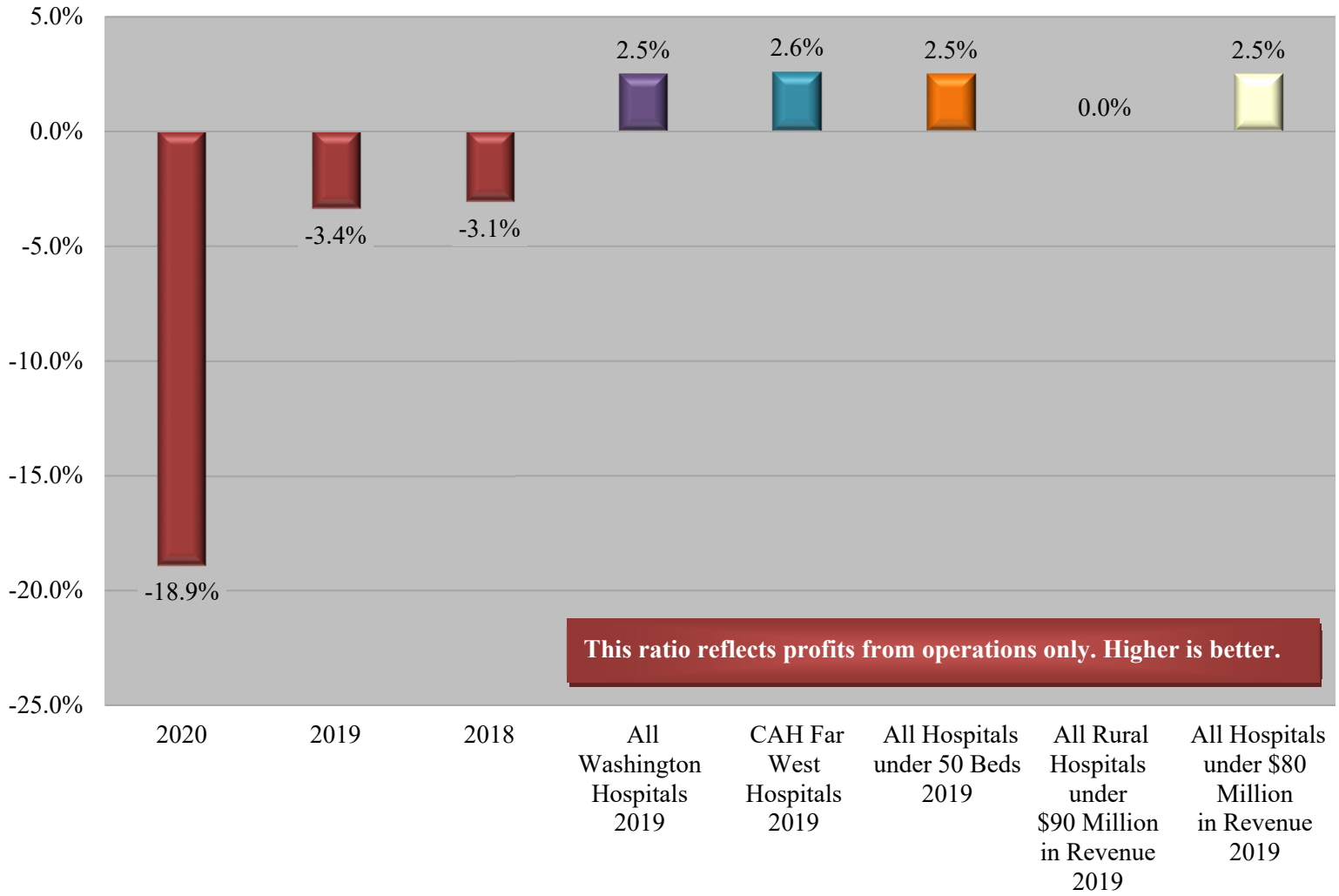
$$\frac{\text{Change in Net Position}}{\text{Total Revenues}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Operating Margin

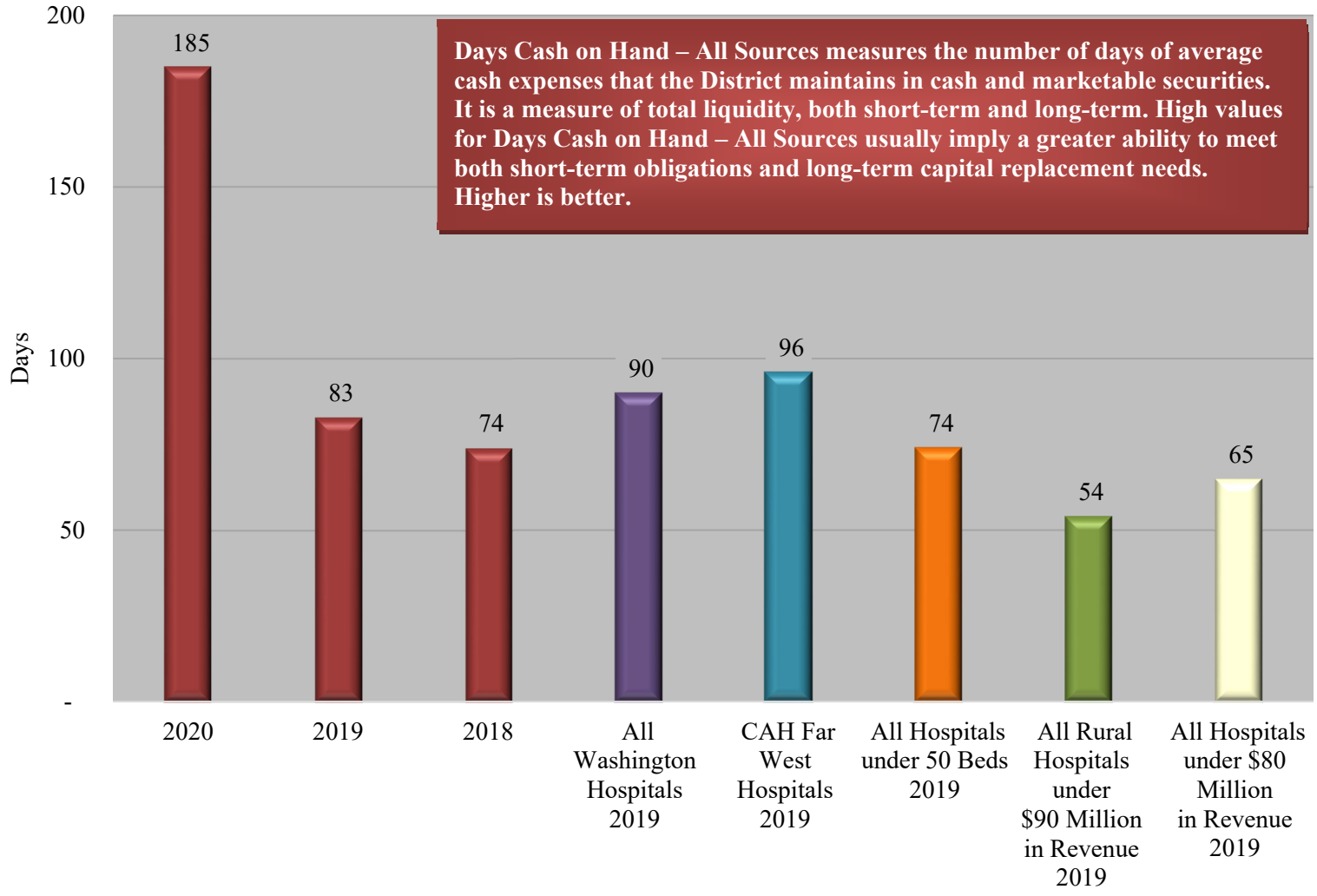
$$\frac{\text{Operating Income (Loss)}}{\text{Total Operating Revenues}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Days Cash on Hand – All Sources

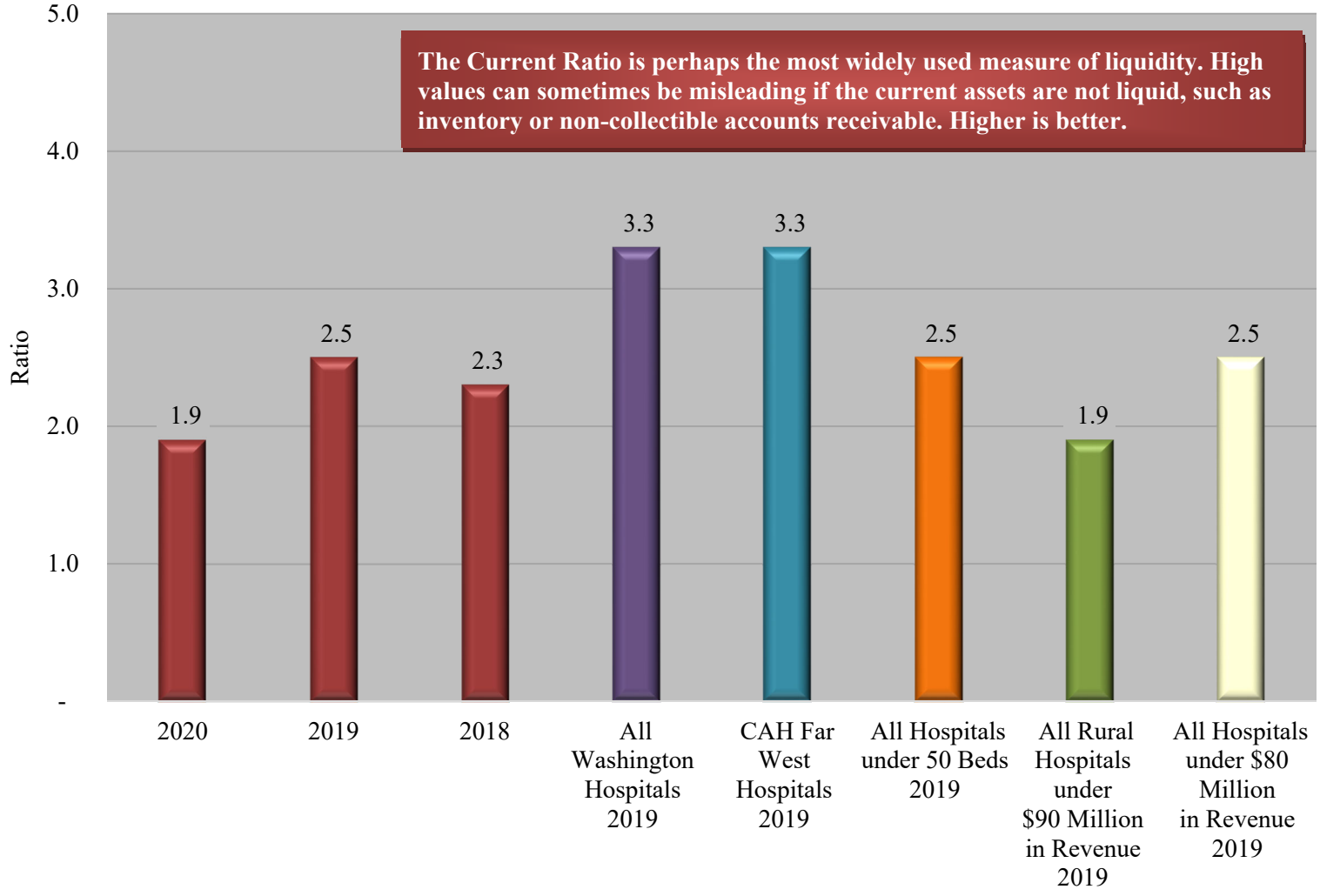
$$\frac{\text{Cash + Short-term Investments + Unrestricted Long-term Investments}}{\text{(Total Expenses - Depreciation) / 365}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Current Ratio

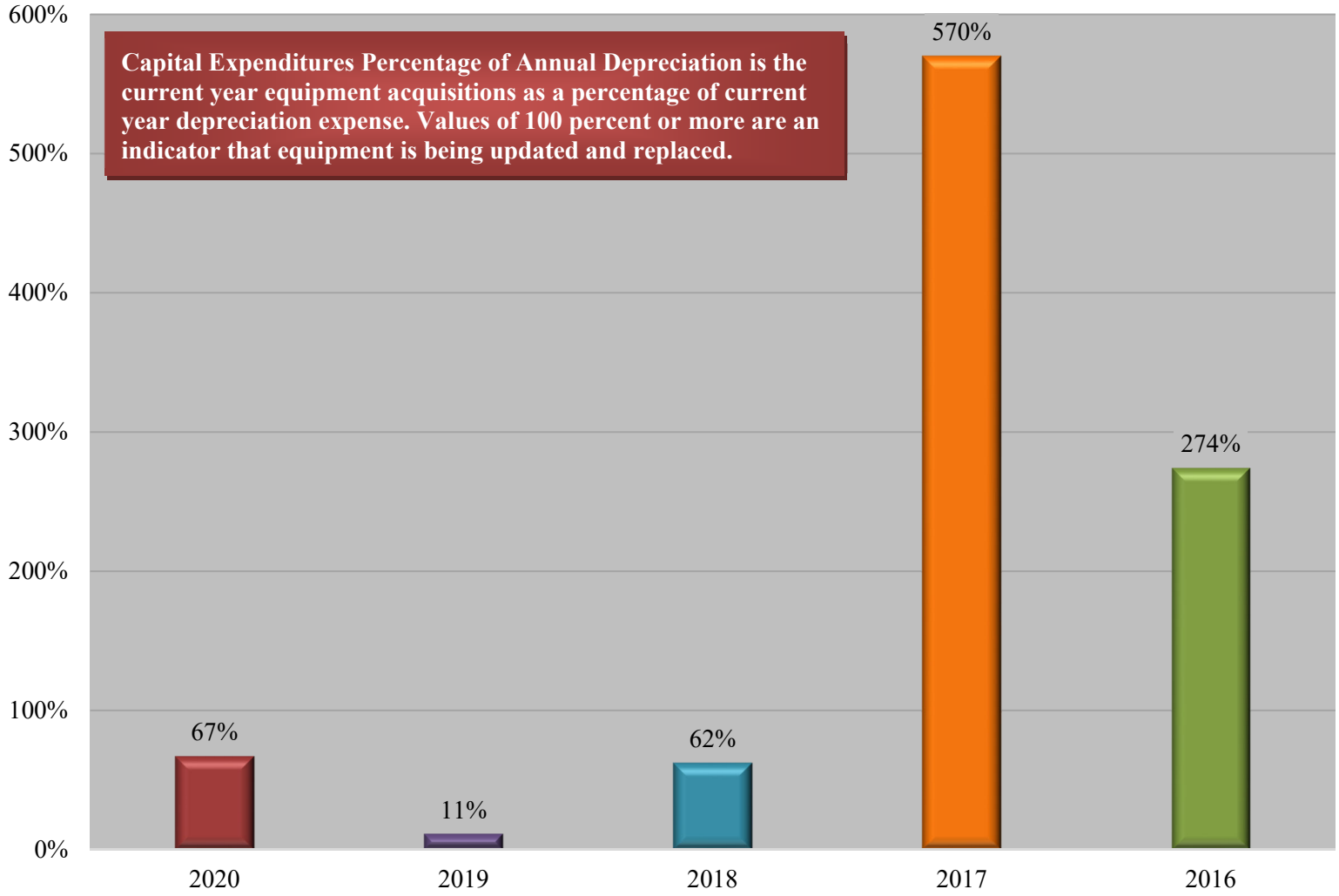
$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Capital Expenditures Percentage of Annual Depreciation

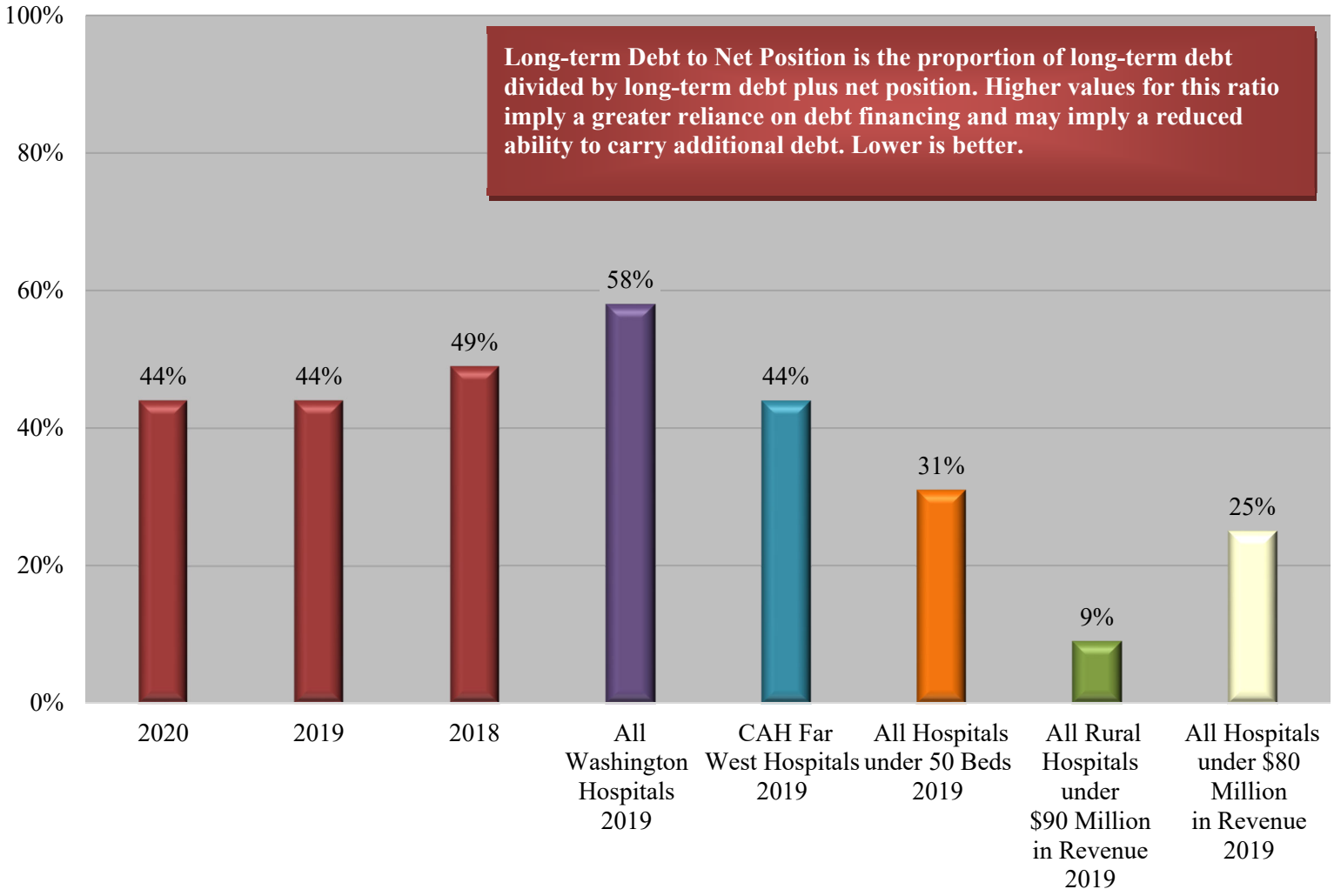
Equipment Capital Expenditures
Equipment Depreciation Expense



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Long-term Debt to Net Position

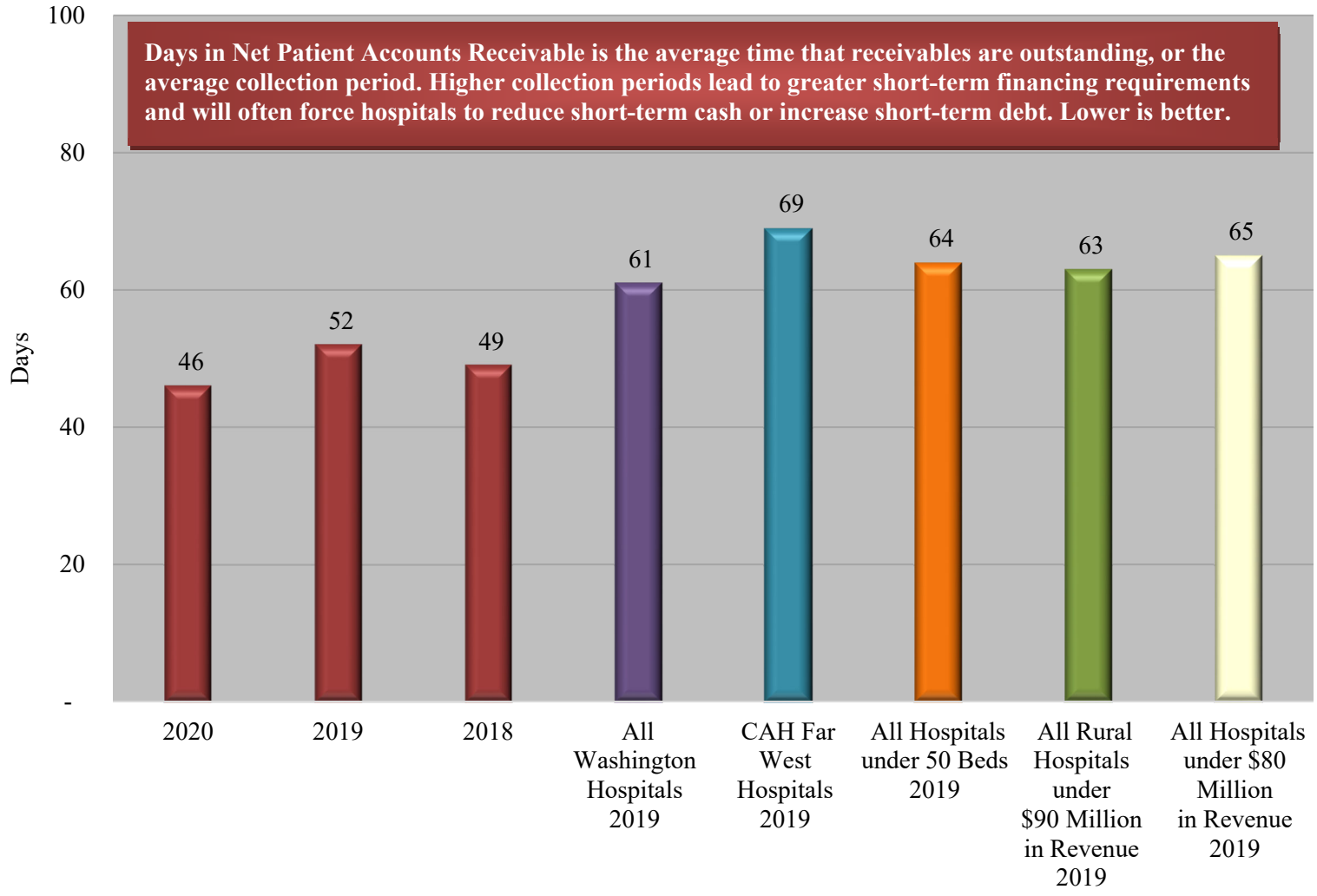
$$\frac{\text{Long-term Debt}}{\text{Long-term Debt + Net Position}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Days in Net Patient Accounts Receivable

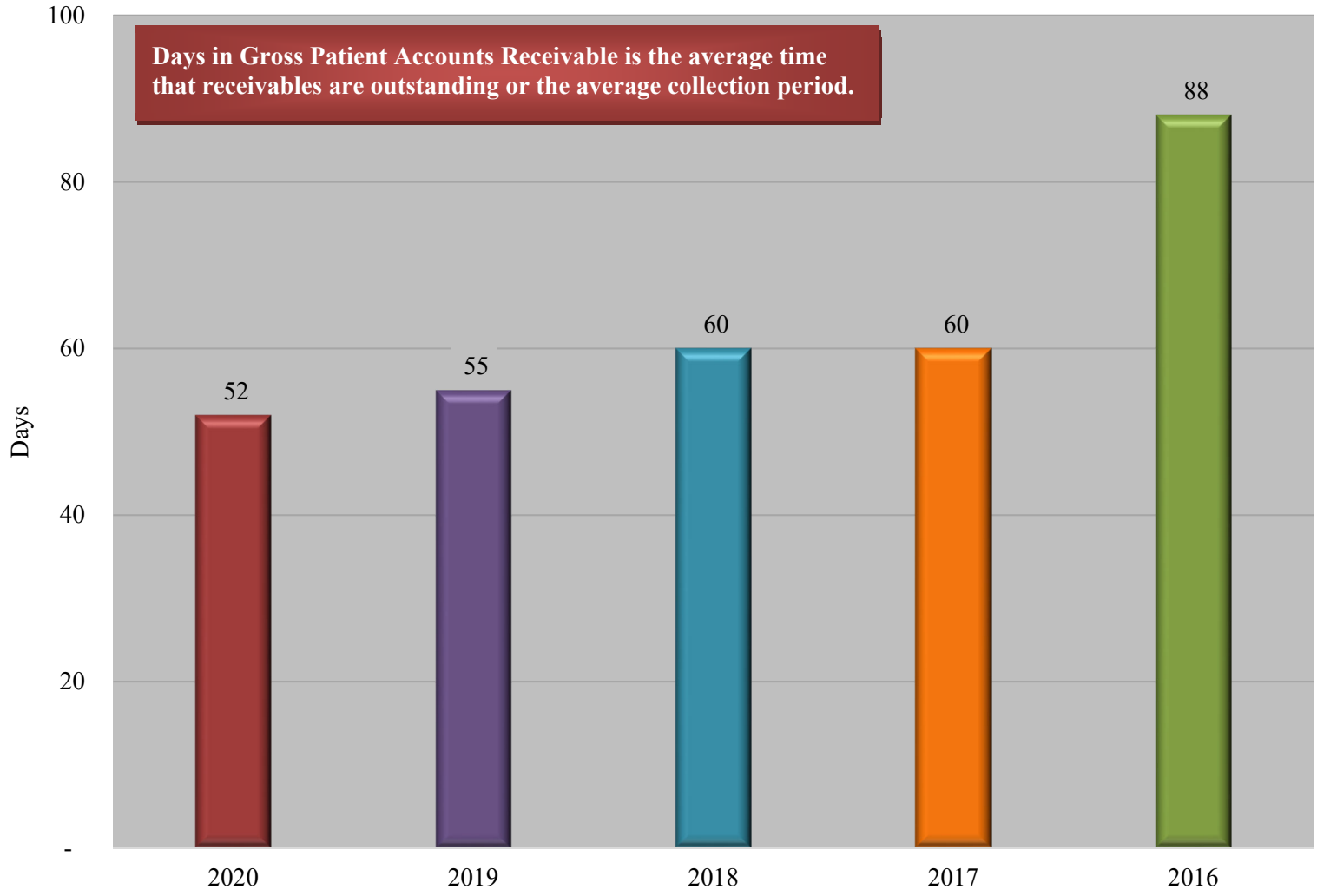
$$\frac{\text{Net Patient Accounts Receivable}}{\text{Net Patient Service Revenues / 365}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Days in Gross Patient Accounts Receivable

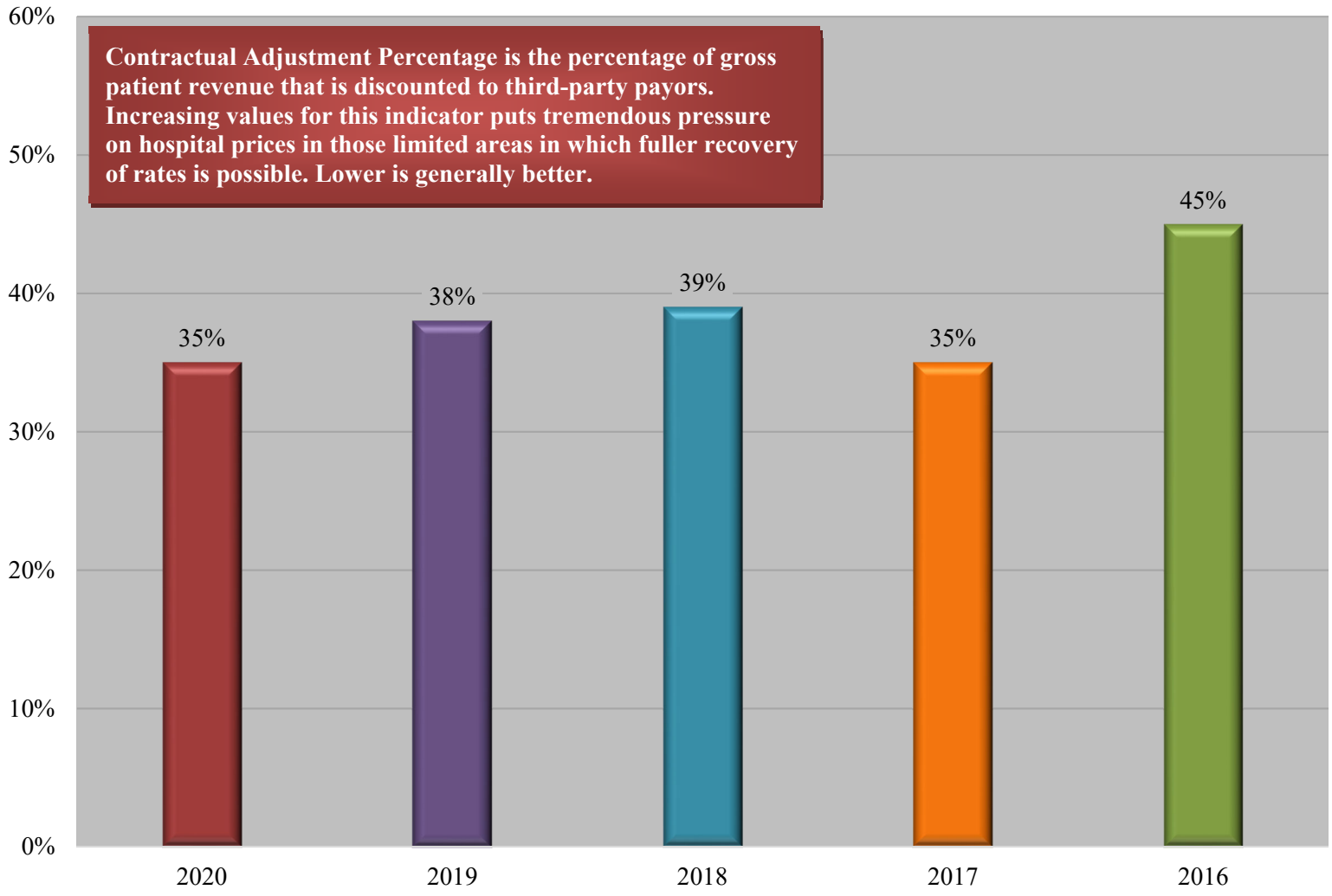
$$\frac{\text{Gross Patient Accounts Receivable}}{\text{Gross Patient Service Revenues / 365}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Contractual Adjustment Percentage

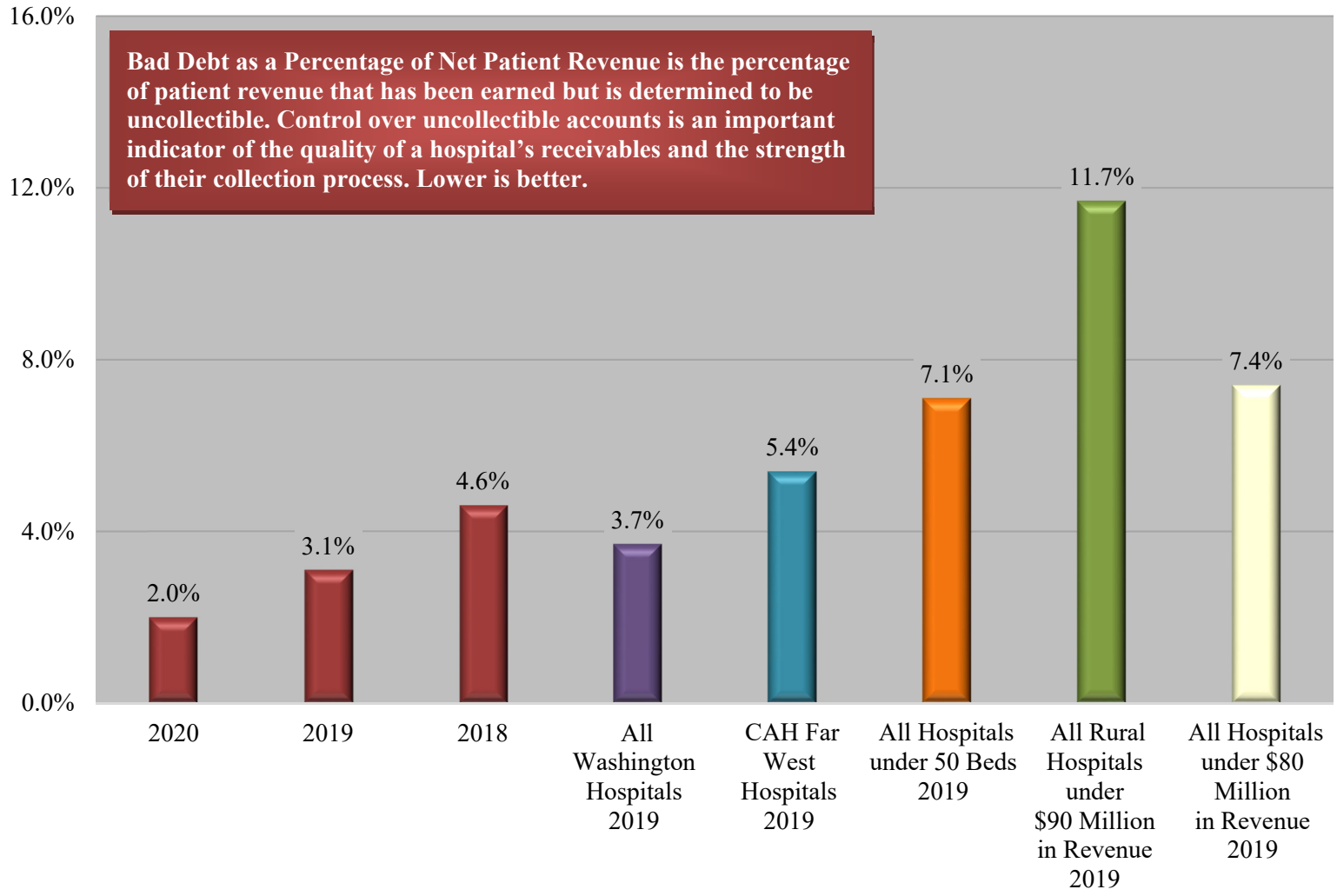
Contractual Adjustments
Gross Patient Revenues



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Bad Debt as a Percentage of Net Patient Revenue

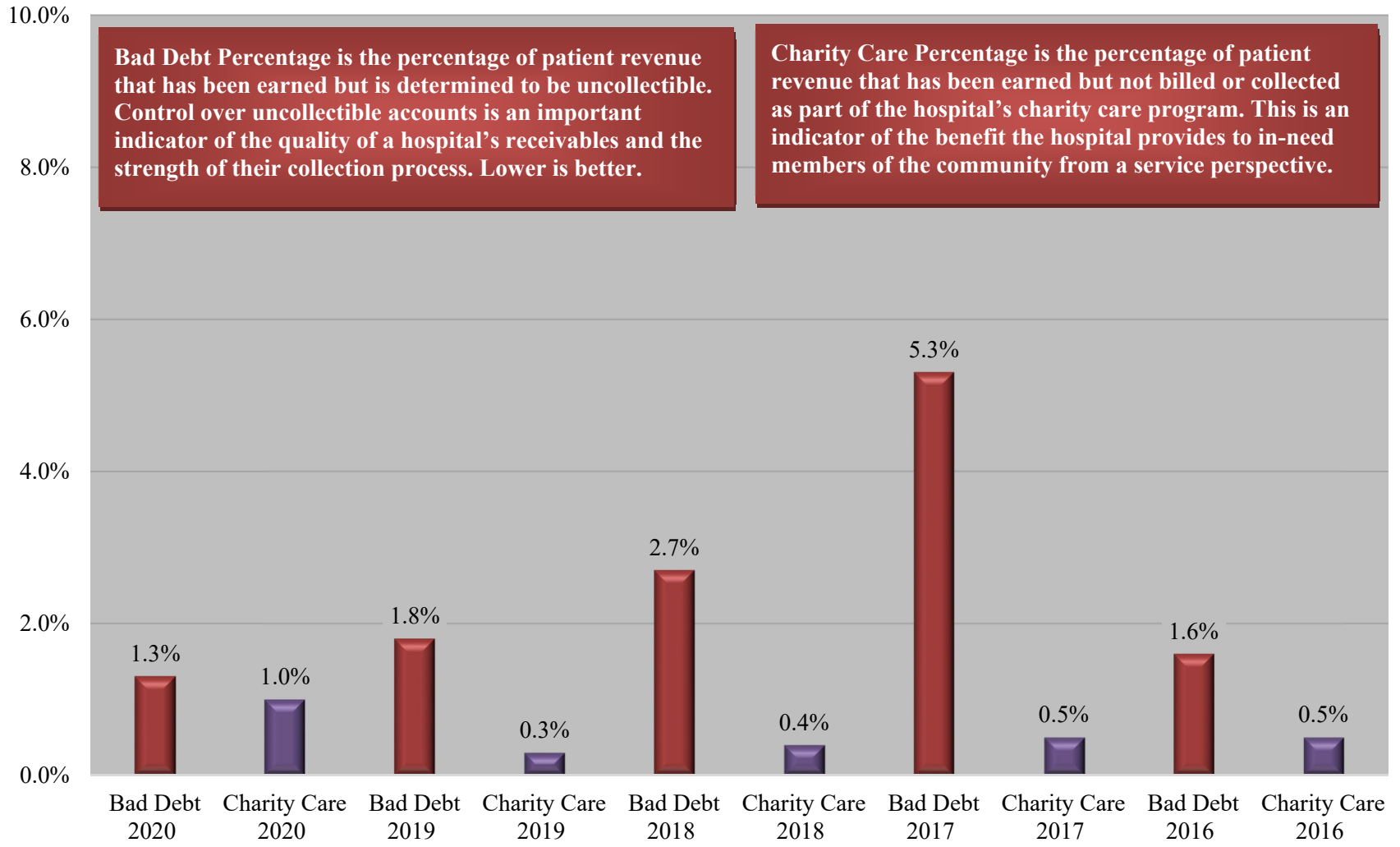
$$\frac{\text{Provision for Bad Debt}}{\text{Net Patient Revenues}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

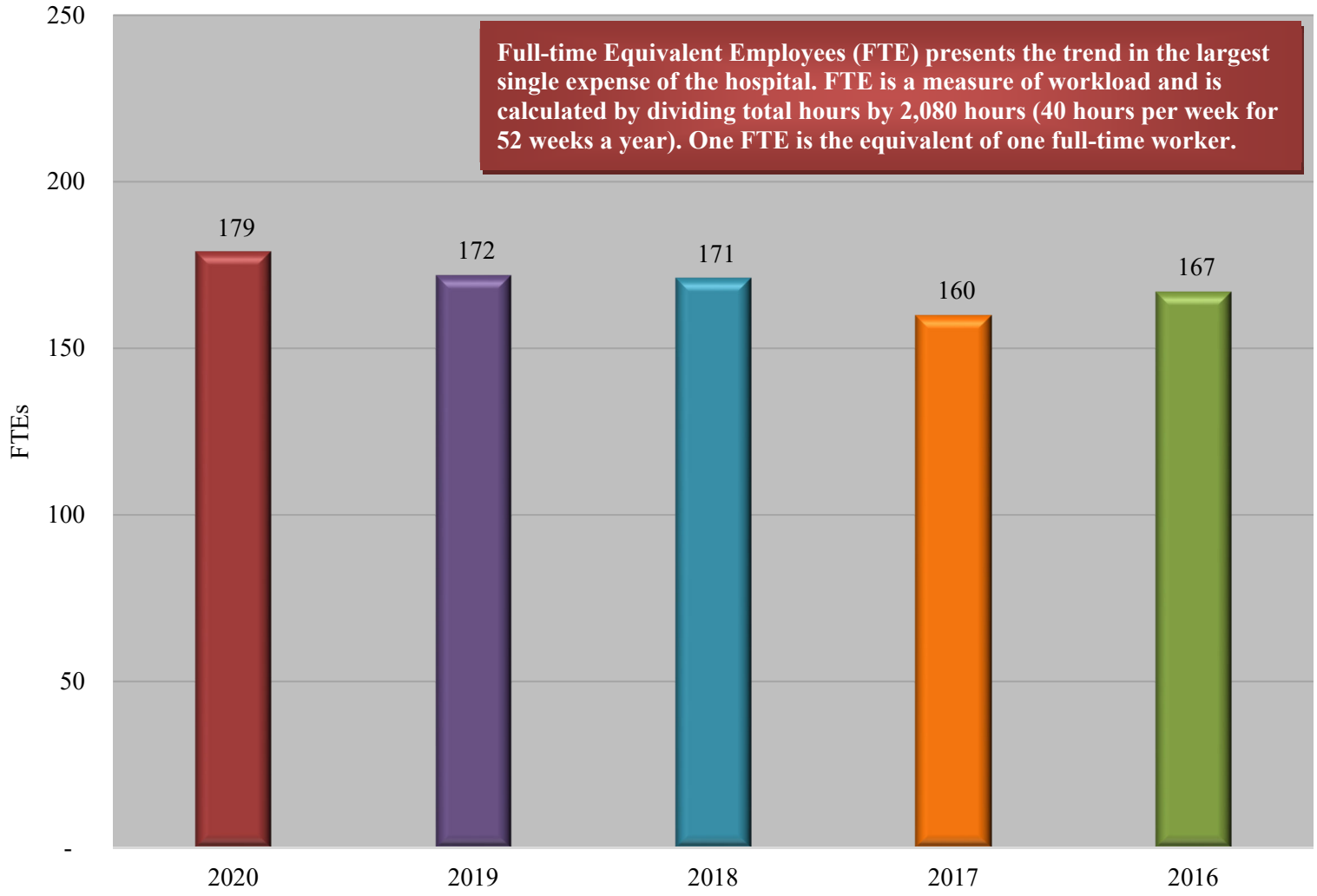
Bad Debt and Charity Care Percentage

Provision for Bad Debt / Gross Patient Revenue	Charity Care / Gross Patient Revenues



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

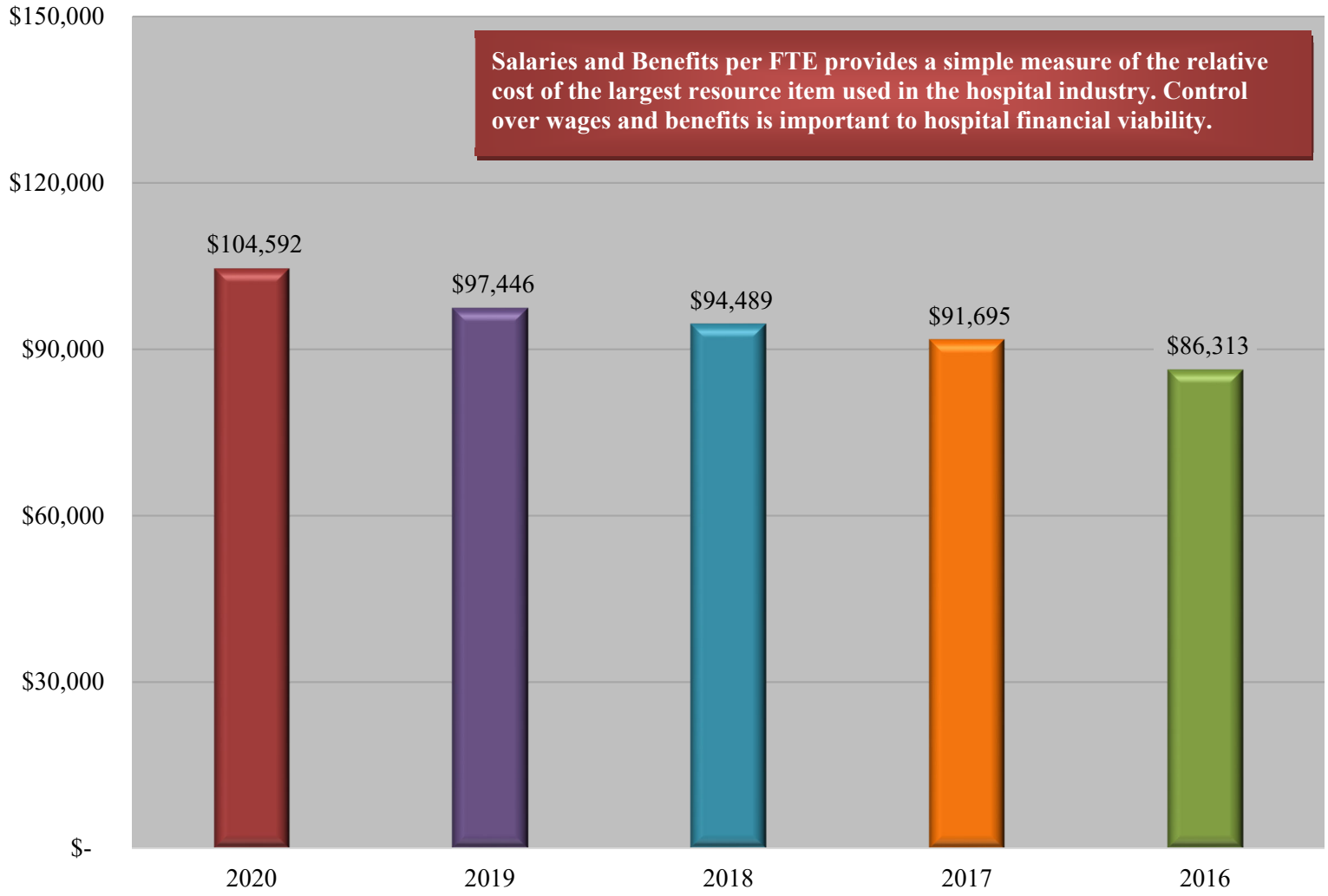
Full-time Equivalent Employees (FTE)



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Salaries and Benefits per FTE

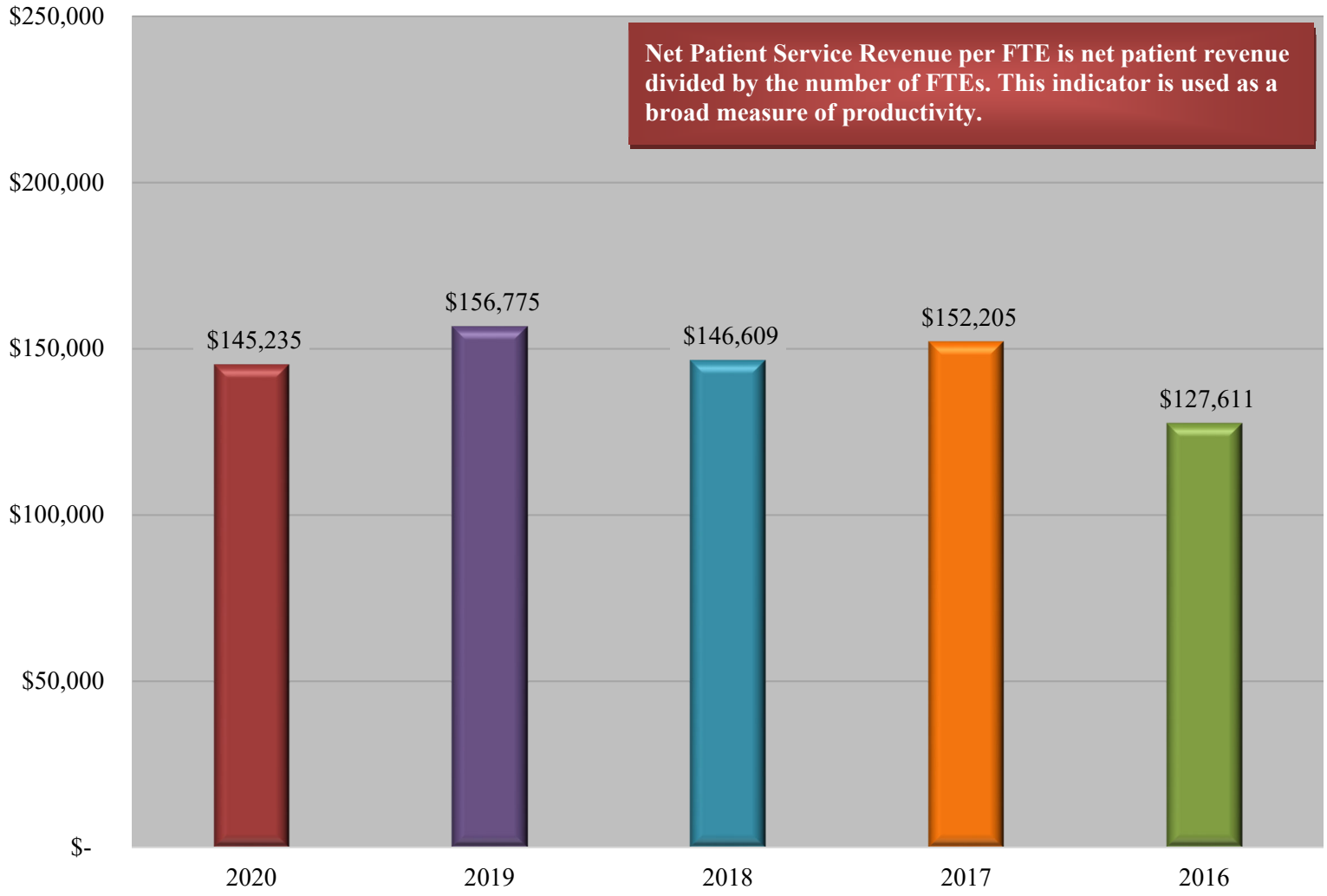
$$\frac{\text{Total Salaries + Total Benefits}}{\text{FTEs}}$$



Lewis County Public Hospital District No. 1
doing business as
Arbor Health

Net Patient Service Revenue per FTE

Net Patient Service Revenue
FTEs



Arbor Health Morton Clinic

531 Adams Avenue, Morton, WA

News, Goals and Achievements

- Water Damage
- Department Specific Strategic Goals
- Annual Wellness Visits
- Covid Vaccines-Outreach
- Sleep Clinic Outreach
- Additional Providers

Water Damage

•On February 14, 2021, Morton Clinic sustained water damage in 2/3 of the facility when a pipe burst in the ceiling.

•Restoration began the week of May 3rd. The photos are the source room on February 14th and May 10th.

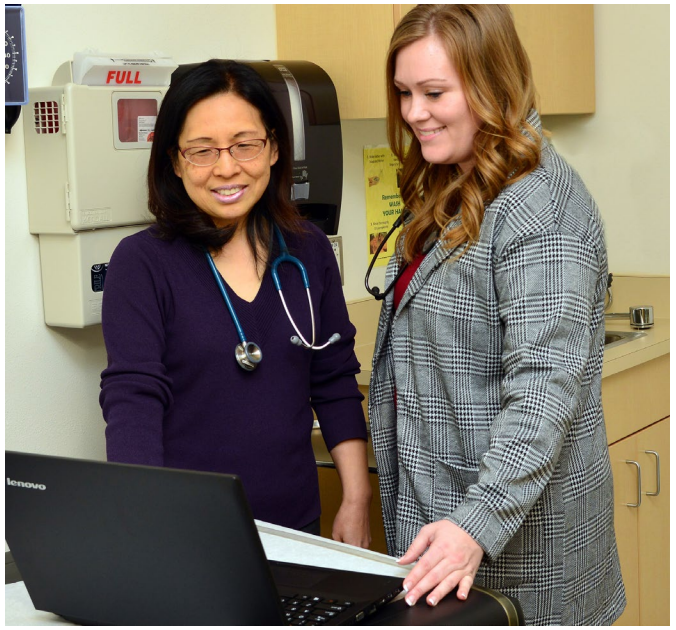
•It has been challenging for the providers and clinical staff to provide care in the current accommodations as there are 5 exam rooms to be shared by 4-6 providers. To improve patient access 3 providers will move into the portion of the clinic that is useable. Support staff will stay in the hospital for the time being. A temporary waiting area has been built for this purpose.

•This catastrophe is giving us the chance to upgrade some things that were difficult to do and maintain clinic access at the same time such as: insulating the the walls in between patient exam rooms, reconfiguring the front desk area to meet ADA codes and give access to those in wheelchairs, creating a nursing pool area for better teamwork and freeing up exam rooms that were being used for offices.

Strategic Goals

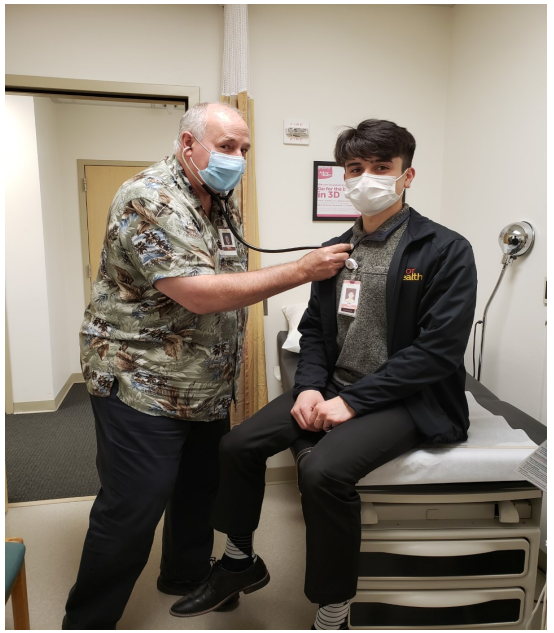
Develop 3 community engagement events at the Morton Clinic per year

Community engagement events will include a drive thru flu shot clinic, blood pressure check station at Jubilee, ongoing Covid vaccine clinics



Increase Telehealth visits by 25%

Virtual visits are here to stay, and we are assessing and encouraging patients to sign up! Poor internet connection in our rural community is a roadblock. Many of our older patients are technology resistant but our commitment to helping them create a patient portal account is a high priority.



Implement Chronic Care Management

Chronic Care Management-train and engage providers to use the tools available to engage and partner with patients for improved overall health

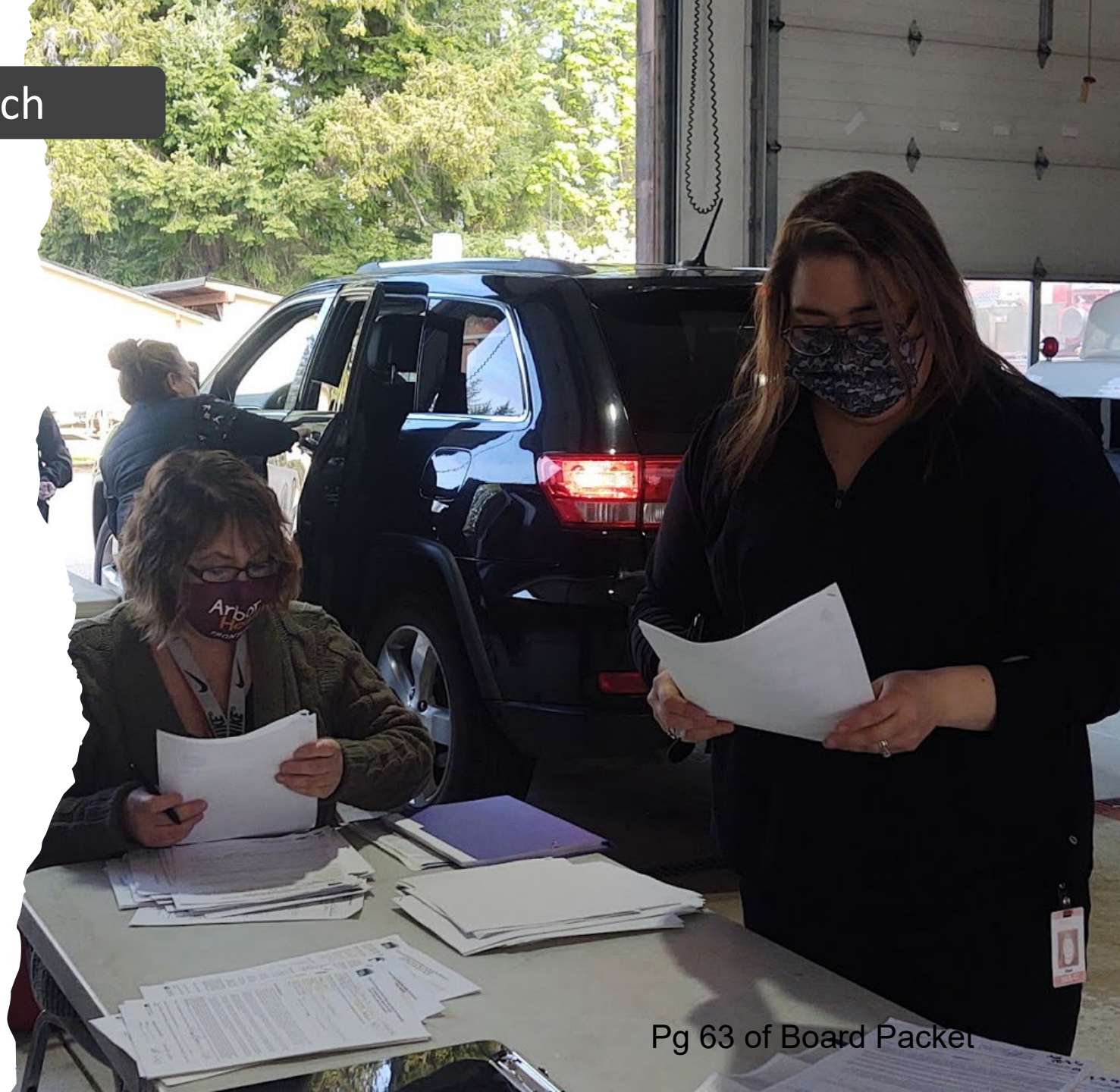
Annual Wellness Visits

Annual wellness visits (AWV) are yearly appointments to create or update a patient's personalized prevention plan and are an important part of our ACO and HMO contracts. A patient's personalized prevention plan helps prevent illness based on current health and risk factors. As primary care continues to move towards preventative care and away from acute care, our goal is to partner with the patient to improve their overall health and reduce their risk factors. Using the AWV to identify diagnoses and health issues sets the stage for preventative care.

COVID-19 Vaccines and Outreach

Demand for large/mass vaccine clinics has been significantly reduced. To decrease waste, we are currently keeping a list and scheduling when we have 10 people who wish to receive a vaccine. We are also keeping in close contact with the Randle and Mossyrock Clinics to pool demand.

Diane Markham is working with us to create new opportunities such as placing waiting lists at Colton Pharmacy and local food banks.



Sleep Clinic Outreach

- To increase sleep clinic and sleep lab referrals Dr. Jak has recorded a short video that explains the relationship of sleep habits with overall health. We will be sending the video to outside providers to encourage referrals to the Arbor Health Sleep Program.

- We continue to stress the importance of sleep with our Arbor Health providers and receive most referrals from them.

New Providers

Dr. Robert Williams, Orthopedics, will be joining the Morton Clinic in June of this year. He will be in office 3 days a month. Marketing efforts are generating calls to the clinic to be put on his schedule.

Senior leadership is looking at a full-time surgical podiatrist to compliment Dr. Williams and better serve our community.

Dr. Robert Williams

Desired Outcome

The common goal is to nurture a healthy community by providing accessible, quality healthcare. Future goals are realized by daily care and attention. The Morton Clinic providers and staff are working diligently each day to provide outstanding healthcare and customer service.

BOARD COMMITTEE REPORTS

Arbor Health Foundation Meeting Minutes

Tuesday May 11, 2021

Online Zoom Meeting

Attendance: Ali Draper, Diane Markham, Caro Johnson, Betty Jurey, Lynn Bishop, Ann Marie Forsman, Jeannine Walker, Wes McMahan, Gwen Turner, Linda Herrin, Shelley Riggs, Stephanie Poffile-Rudd

Guest: Julie Allen

Call to Order by President Ali Draper at 12:10pm

Julie Allen expressed her gratitude to the Board for the scholarships that she has received from the Foundation the past two years. She has obtained a Bachelor of Science Degree in Health Care Management and has been approved for graduation.

Minutes and Treasurers Report:

After discussion, a motion was made and approved to accept the April minutes and treasurers report. Ann Marie Forsman/Caro Johnson

Administrators Report-
Leianne was not present but Diane said that a successful vaccine event was held at the Packwood fire station.

Directors Report:
Diane showed a video which was made for marketing Transitional Care. The audio was not good so Diane will email the link to the Board members.

Old Business:

New Business:

The board would like to continue to support the area EMS crews by providing beverages and snacks. Diane will buy a refrigerator and Keurig machine to be put in the room used by crews. EMS Appreciation Week starts May 16, and it was suggested that a gift basket with snacks be purchased for each of the eight teams that use the Hospital. It would be distributed and used when volunteers have meetings or training. The Board agreed to support this project.

Wellness Week is planned for September and will include a 5k walk/run, educational events and health expo.

A discussion was held regarding memorials for Carol LaGra and Harold Cooper. The Board would like to look at ideas that can be used to honor their service to the foundation. Lynn Bishop will work with Pat Siesser and Jeannine Walker to find options for the memorials.

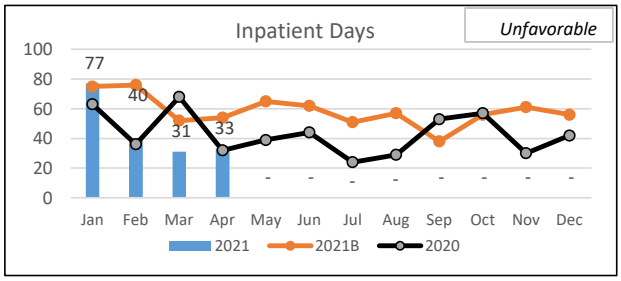
Events: Cap and Corks has been cancelled for this year but we are still moving forward with the Ladies Brunch and the Dinner Auction. Lynn is looking for volunteers to help with these projects.

Diane told the Board that the Arbor Health Foundation Director position will soon be advertised as a .75 FTE.

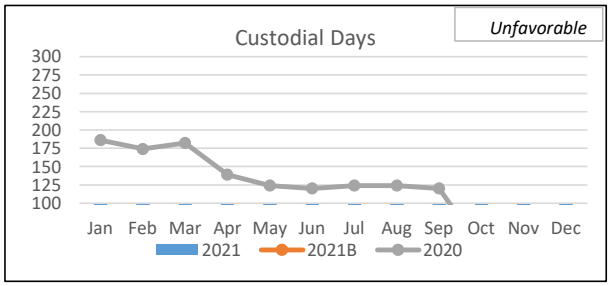
Meeting adjourned 12:42

Lewis County Hospital District No. 1
Board Financial Summary
April 30, 2021

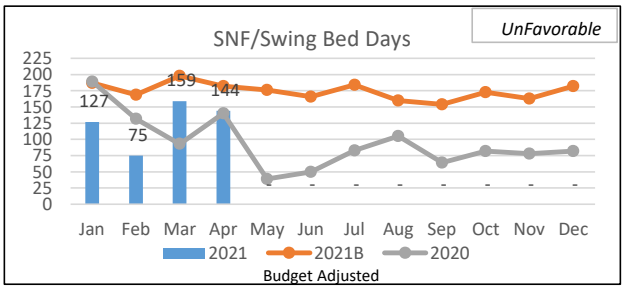
Growth



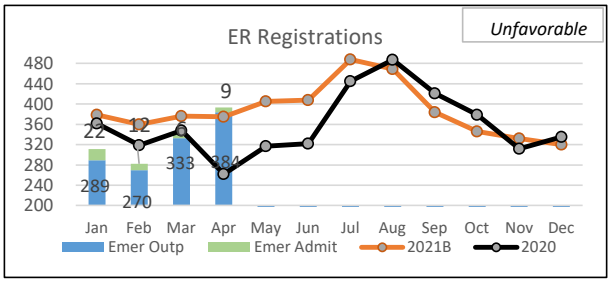
YTD: 181.00 Budget: 257.00 Pr Yr: 199.00



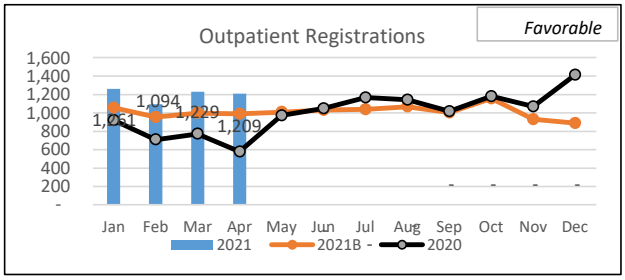
YTD: 0 Budget: 0 Pr Yr: 0



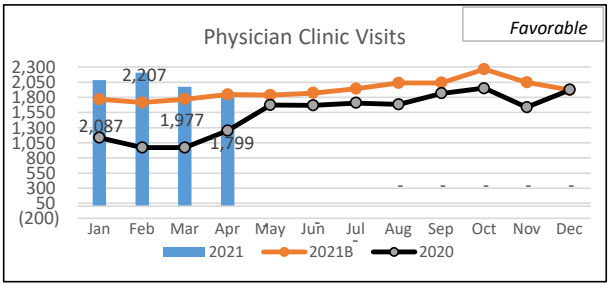
YTD: 505 Budget: 736 Pr Yr: 554



YTD: 1276 Bud: 1490 Pr Yr: 1291

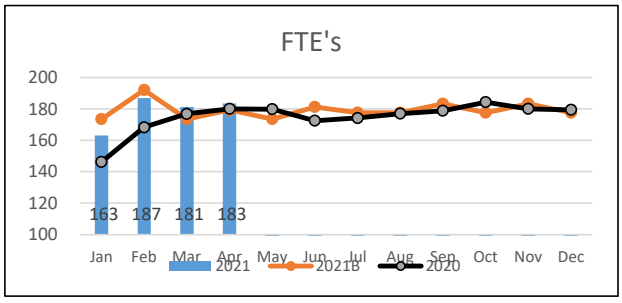


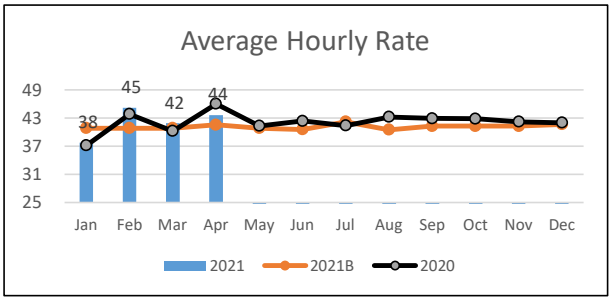
YTD: 4,793 Bud: 3,998 Pr Yr: 2,980

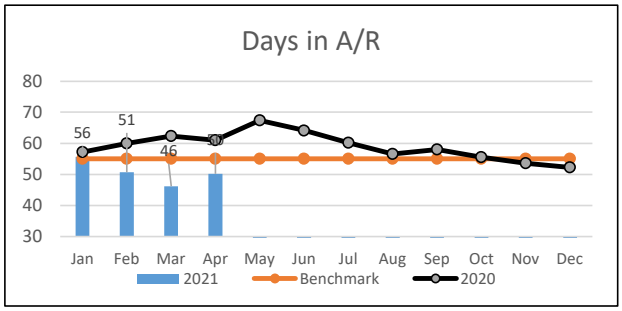


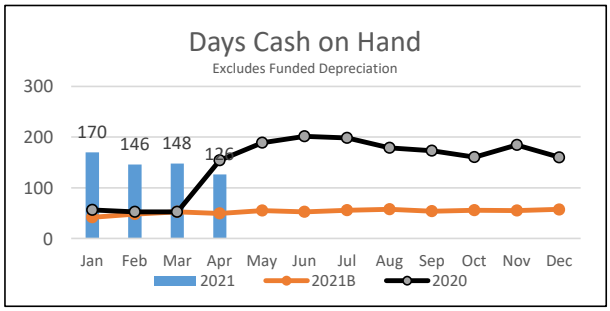
YTD: 8,070 Bud: 7,106 Pr Yr: 4,324

People and Operational Aspects









CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
April 28, 2021 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/96126789069
Meeting ID: 961 2678 9069
One tap mobile: +12532158782,,96126789069#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA TOPIC	CONCLUSION	ACTION ITEMS
Call to Order Roll Call	Board Chair Frady called the meeting to order via Zoom at 3:30 p.m. **Commissioners present:** ☒ Trish Frady, Board Chair ☒ Tom Herrin, Secretary ☒ Craig Coppock ☒ Wes McMahan ☒ Chris Schumaker **Others present:** ☒ Leianne Everett, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Sara Williamson, CNO/CQO ☒ Dexter Degoma, Interim Quality Manager ☒ Janice Holmes, Medical Staff Coordinator ☒ Diane Markham, Marketing/Communication Manager & Foundation Executive Director ☒ Richard Boggess, CFO ☒ Clint Scogin, Controller ☒ Van Anderson, Packwood Resident ☒ Sherry Sofich, Revenue Cycle Director ☒ Larry Sinkula, Surgical Services Director ☒ Shannon Kelly, CHRO ☒ Julie Taylor, Ancillary Services Director ☒ Skip Houser, Attorney ☒ David Crouch, Interim Maintenance Manager	

	☒ Buddy Rose, Lewis County Journal	
Approval or Amendment of Agenda	Superintendent Everett requested to add the EMTALA Policy to the list of documents being ratified via Lucidoc in the Consent Agenda.	Commissioner Schumaker made a motion to approve the amended agenda. Commissioner Coppock seconded and the motion passed unanimously.
Conflicts of Interest	Board Chair Frady asked the Board to state any conflicts of interest with today's agenda.	None noted.
Comments and Remarks	Commissioners: Commissioner McMahan thanked Executive Assistant Garcia and Interim Quality Manager Degoma for their efforts. Commissioner Schumaker provided comments captured as an attachment to the minutes. Audience: Packwood Resident Van Anderson recommended the District provide more data in the Annual Critical Access Hospital Evaluation with respect to history trends and patient satisfaction.	
Executive Session- RCW 70.41.205 & 70.41.200	Executive Session began at 3:50 p.m. for 20 minutes to discuss Medical Privileging and the Quality Improvement Oversight Report. The Board returned to open session at 4:10 p.m. No decisions were made in Executive Session. New Appointments- 1. Matthew Stein, MD (Consulting Radiology Privileges) 2. Hanbing Wang, MD (Consulting Telestroke Neurology Privileges) Reappointments- 1. Prabhakar Kesava, MD - (Consulting Radiology Privileges) 2. Jakdej Nikomboririak, MD (Consulting Sleep Medicine Privileges) 3. Sheila Smith, MD - (Telestroke Neurology Consulting Privileges) 4. Andrew Taylor, MD – (Consulting Radiology Privileges) 5. Ian Timms, MD - (Consulting Radiology Privileges) 6. Chrystel Venturini, MD - (Consulting Radiology Privileges)	Commissioner McMahan made a motion to approve the Medical Privileging as presented and Commissioner Coppock seconded. The motion passed unanimously.

	7. Evert-Jan Verschuyl, MD - (Consulting Radiology Privileges) 8. Pedro Vieco, MD - (Consulting Radiology Privileges) 9. Fang Zhu, MD - (Consulting Radiology Privileges)	
Guest Speaker-C.H. (Skip) Houser, J.D., M.P.A. • Principles of an Exceptional Public Hospital District Board	Guest Speaker Houser provided a presentation on the "Principles of an Exceptional Public Hospital District Board."	
Department Spotlight • Revenue Cycle	Revenue Cycle Director Sofich provide insight into her team; Business Office, Health Information Management and Patient Access as they go the extra mile to leave the patient with a positive experience. She highlighted each departments goals as it relates to the Board's Strategic Priorities.	
Board Committee Reports • Hospital Foundation Report	Commissioner McMahan shared the Arbor Health Foundation is going to miss Foundation Director Markham but support her journey with community outreach. Foundation Director Markham noted there is no movement at this time for the Foundation.	
• Finance Committee Report	Commissioner Coppock highlighted the April Finance Committee Meeting which included the following: 1. Supporting a 75% accrual rate for the At-Risk Compensation for Management Team. 2. Sharing the 2021 budget with amendments. 3. Experiencing an unfavorable health insurance performance in Q1 2021. 4. Expecting DZA to report at the May Finance Committee and Board Meeting. 5. Supporting the emergency power change order.	
• Plant Planning Committee Report	Secretary Herrin noted the Plant Planning Committee supports the scope change to include emergency power. He noted further discussion on this project will be addressed in new business, as new information will be shared.	
Consent Agenda	Board Chair Frady announced the consent agenda items for consideration of approval: 1. Approval of Minutes a. March 31, 2021 Regular Board Meeting b. April 7, 2021 Quality Improvement Oversight Committee Meeting	Secretary Herrin made a motion to approve the Consent Agenda and Commissioner Coppock seconded. The motion passed unanimously.

	c. April 19, 2021 Plant Planning Committee Meeting d. April 21, 2021 Finance Committee Meeting 2. Warrants & EFT's in the amount of $3,903,486.81 dated March 2021 3. Resolution 21-16-Approving 2021 QAPI Plan 4. Resolution 21-17-Approving 2021 Risk Management Plan 5. Resolution 21-18-Approving 2020 Critical Access Hospital Evaluation 6. Approve Documents Pending Board Ratification 04.28.21	
Old Business • Incident Command Update	CNO/CQO Williamson highlighted the following: 1. The outpatient infusion therapy Bamlanivimab is no longer effective given solo, as the variants are resistant. Further discussions on this topic will occur at the next Medical Staff Meeting. 2. The Janssen COVID-19 Vaccine resumed use in the United States as of April 23, 2021. 3. The District is doing vaccine outreach on May 3, 2021 at the Packwood Fire Department and Cascade Campground.	
Break	Board Chair Frady called for a 5-minute break at 5:45 p.m. The Board returned to open session at 5:50 p.m.	
New Business • Transitional Care Promotional Video	Marketing/Communications Manager Markham presented the most recent Transitional Care Promotional video.	
• Board Bylaws	Board Chair Frady shared the bylaws need to be reviewed biennially. The District had them reviewed two years ago by a consultant to ensure the RCW's were still accurate. Board Chair Frady requested the Commissioners review and email Executive Assistant Garcia any recommended edits by Friday, May 7, 2021. A redlined version will be presented at the May Regular Board Meeting for approval with recommended edits.	Action Item-The Board will email Executive Assistant Garcia proposed edits to the Board Bylaws by May 7, 2021.
• Redistricting	Superintendent Everett noted the delays in the census data release will postpone redistricting into 2022. Executive Assistant Garcia will add important dates related to redistricting to the Annual Calendar, which will be updated in the Board of Commissioner's Resource Manual.	Action Item-Executive Assistant Garcia will update the Annual Calendar to reflect Redistricting date requirements.
• Special Board Meeting-Prospective	Board Chair Frady shared the Board will do introductions, share the job description, and open for	

Commissioner Candidates Q & A	public comment for Q & A time for interested candidates.	
• Construction Budget Amendment	CFO Boggess presented Resolution 20-39 which approved the Generator/OR HVAC project for $2,400,560. The Plant Planning Committee supported moving forward with the change in scope to include the Emergency Power for the clinical areas. The Finance Committee supported moving forward with the additional funding requirements. CFO Boggess noted since both meetings additional information has surfaced improving the cost of expanding the scope. There are three scenarios: 1. Abandon the goal of adding emergency care areas and get a change order to reduce the scope. 2. Pursue the same scope with a change order of $18,012 for emergency lighting in the patient care area as planned. 3. Pursue a revised scope by expanding emergency power to Rehab Services, MOB, and patient care areas with an estimated cost of $122,250. The Board supported moving forward with option three with a cost of $122,250.	Secretary Herrin made a motion to approve Resolution 21-19- Approving OR/HVAC Budget Amendment for Emergency Power for $122,250. Commissioner McMahan seconded and the motion passed unanimously.
Superintendent Report	Superintendent Everett shared the following: 1. Recruitment continues to be ongoing. 2. Background on the At-Risk Compensation model was a directive from the previous board. To have a detailed and documented process, the bonus structure took time to develop. She reiterated this model will retain good people, decrease the costs of turnover, reduces risk and ultimately recruits the talent needed for the District. 3. Legislative bills continue to be ongoing. 4. The Q1 2021 Department Strategic Measure results were presented.	
Meeting Summary & Evaluation	Superintendent Everett highlighted the decisions made and action items.	
Adjournment	Secretary Herrin moved and Commissioner Schumaker seconded to adjourn the meeting at 6:48 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Secretary Date

Talking Points- C. Schumaker

Commissioner Comments

4/28/2021

Talking Points One-

2021 Strategic Goals-Revenue Cycle

Pg. 28 -Patient Access

Goal: Increase Point of Service collections by 10% in the ER and 20% in outpatient services

How: Being Proactive. Reading alerts. Learning new ways to ask for money. Offering prompt day discounts.

Response-

-Always maintain a compassionate approach towards bill collection.

-Be a partner and always look for positive approaches when seeking payments

-Recognize that most people don't understand medical billing-they don't understand why medical care cost so much. According to the website www.Meddata.com, the average deductible is $1,820 and average out-of-pocket maximum is $4,400. That equates to a 30-day paycheck for a middle-income wage earner and 90-day paycheck for a minimum wage earner.

-Always share how we can save people money.

Talking Points Two-

At-Risk Compensation – This is Performance Pay, not a fixed salary.

Meet certain Goals/Objectives = increased compensation

This is a necessity to stay competitive with competing medical institutions.

This directly effects the quality of care and services we can offer.

Pg. 125 Executive, Directors/Managers, Support

100% = 317,000 and 75%=238,00

Response-

-Census.gov (2019) stated the Median Household income of Lewis County is $53,400.

-The percentage of Lewis County residence living in poverty is 12.2%, or a family of four has an income of $26,500.

-Most wage earners in Lewis County are hourly or fixed salary.

-We are implementing a new pay structure for some Hospital Employees, which will significantly increase compensation.

-We have outstanding employees that are good at their job. This performance-based compensation will occur.

-We must be open and transparent with the community, concerning the need for performance-based compensation and why it is necessary that we offer it.

- I commend Superintendent Everett's commitment to fund the At-Risk Compensation through cost containment. We would be hard pressed to defend At-Risk Compensation funding by increasing the prices of patient care. How we operate should align with the community's capacity to support.

-We need to walk carefully with At-Risk Compensation. It can be controversial for publicly financed hospitals, where compensation is a budgeted item, and most funding is from the public purse. Using a basketball metaphor, do the quality performance metrics used for our At-Risk Compensation represent a "Lay-up" of clinical processes or a "Three-point shot" of clinical outcomes? We must have high standards and expectations to maintain the public trust in our new At-Risk Compensation program.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
May 27, 2020 at 6 p.m.
ZOOM
https://myarborhealth.zoom.us/j/99664919204
One tap mobile: +16699006833,,99664919204# US
Dial: +1 253 215 8782 US
Meeting ID: 996 6491 9204

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION/CONCLUSION	RECOMMENDATIONS/ ACTION/FOLLOW-UP
Call to Order	Board Chair Frady called the meeting via Zoom to order at 6:00 p.m. **Commissioners present:** ☒ Trish Frady, Board Chair ☒ Tom Herrin, Secretary ☒ Chris Schumaker ☒ Wes McMahan ☒ Craig Coppock **Others present:** ☒ Leianne Everett, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Van Anderson, Packwood Resident	
Reading of the Notice of the Special Meeting	Board Chair Frady read the special board meeting notice. Board Chair Frady noted the chat function has been disable and the meeting will not be recorded.	
New Business • Commissioner Position #2- Packwood, Randle & Glenoma Areas, Position #3- Mossyrock & Silver Creek Areas and	Board Chair Frady welcomed Packwood Resident Anderson. Board Chair Frady highlighted there are three positions open and when a candidate files the position is declared. The Board shared experiences to date on current positions held in the District.	

Position #4-At Large Position	Board Chair Frady noted the Commissioner Job Description was included in this meeting's packet for reference.	
Public Comment	Packwood Resident Anderson continues to be interested by actively attending meetings to become informed on district business. No additional questions asked. Board Chair Frady thanked Packwood Resident Anderson for attending and reiterated to file online or in person at the Lewis County Auditor's Office the week of May 17th-21st.	
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourned at 6:24 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Board Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Compliance Committee Meeting
December 30, 2020 at 12:00 p.m.
Via Zoom

AGENDA	MINUTES	ACTION
Call to Order Roll Call	Commissioner McMahan called the meeting to order at 12:00 p.m. **Board Commissioner Present(s):** ☒ Wes McMahan, Commissioner ☒ Craig Coppock, Commissioner Committee Member's Present: ☒Julie Taylor, Interim Compliance Officer ☒Shana Garcia, Executive Assistant ☒ Sherry Sofich, Revenue Cycle Manager ☒ Leianne Everett, Superintendent ☒ Dexter Degoma, Interim Quality Manager ☒ Shannon Kelly, HR Director ☒ Richard Boggess, CFO ☒ Sara Williamson, CNO/CQO ☒ Ashley Sofich, Shadowing	
Approval or Amendment of Agenda	Interim Compliance Officer Taylor requested to amend the agenda by adding a Regulatory Update to New Business.	Commissioner Coppock made a motion to approve the amended agenda and Superintendent Everett seconded. The motion passed unanimously.
Conflicts of Interest	None noted.	
Consent Agenda	Interim Compliance Officer Taylor announced the following in consent agenda up for approval: 1. Review of Compliance Minutes-12.30.20 2. Lucidoc P & P's: a. Care of Law Enforcement Patients b. Medicare Advance Beneficiary Notice Procedure (ABN) c. Patient Rights & Responsibilities-Swing Bed d. Patient Rights & Responsibilities	Commissioner Coppock made a motion to approve the consent agenda and CHRO Kelly seconded. The motion passed unanimously.

Old Business • Regulatory Readiness Update	CNO/CQO Williamson highlighted the department managers continue to prepare for the surveyors to come any day now. Management is in the process of implementing an additional tool within Lucidoc called the Accreditation Manager. The Accreditation Manager maintains the DNV Survey Standards and allows managers to organize their documentation requirements to meet the inspector's standards onsite or remotely. In 2020 especially, there was an increased trend that inspectors were doing only remote audits. This tool will prepare the District for future audits.	
• Compliance Program Update	Interim Compliance Officer Taylor highlighted the five identified priorities that are being addressed between Revenue Cycle Director Sofich and herself in 2021. Most recently, Interim Compliance Officer Taylor met with HIM and identified documentation opportunities that will be addressed with Informatics and was communicated to Medical Staff today.	
• Conflicts of Interest Compliance	Interim Compliance Officer Taylor report 100% compliance for the Board and the Management Team.	
• Compliance Committee Structure Update	Superintendent Everett noted the shared compliance role between three hospitals continues to be the model for the leadership of this committee. CHRO Kelly is collaborating on creating the joint job description, then it will be presented to the Superintendent/CEO group and finally we will start recruiting to fill the position. Superintendent Everett is proposing we continue to have quarterly meetings with governance attendance; however, the operational group will meet monthly to do the work outlined in Appendix A and the Compliance Work Plan. The Compliance Committee supported the new committee structure presented.	Action Item-Interim Compliance Officer Taylor and Executive Assistant Garcia will create a monthly meeting for the Compliance Operational Workgroup starting in June 2021.
• Records Retention Update	Superintendent Everett noted legal is reviewing the current policy. Annual training for the managers occurred in February with the Washington State Archives. The District engaged ArchiveSocial to manage social media records. There will be additional training scheduled for Q3 & Q4 2021.	

• Compliance Activity Report	Interim Compliance Officer Taylor reported the following report: 1. Q1 2021-HIPAA Events=8. All were investigated, closed and none are reportable. 2. Q1 2021-Compliance Events=14. 13 of those are carry over from 2020 and remain open due to COVID-19 pandemic. These will need to be investigated.	
New Business • DZA Audit of 501R	CFO Boggess noted in 2016, the District received an audit review for its 501 (c)(3) compliance. The District was unaware of our status, but quickly moved to address open items of compliance. In 2020, the District had DZA perform an audit which is a twostep process. The District will continue to build on the recommendations from the DZA Audit. Additional updates will be reported in Q2 2021.	
• Green Building Act	CFO Boggess noted the Green Building Act was passed in WA State in May 2019. There were three compliance deadlines based on the square footage size of the structure to review. The District is already addressing compliance by the following: 1. LED lighting to the Hospital. 2. Installing fuel efficient generators. 3. Adding the OR's own HVAC. The District needs a plan implement by 2028 to meet the Green Building Act.	
• Information Blocking Initiative	Revenue Cycle Director Sofich noted above the District complied as of April 5, 2021.	
• Public Records Act Audit Priority 2021	Superintendent Everett noted the District is working with legal on a new policy. The District has one public record request open as it is a physical inspection of records.	
• State of WA-Meaningful Use Audit	CFO Boggess noted in February 2021 the District received an email noting our inclusion in an audit of 2015 Meaningful Use. The District has responded. Meaningful Use monies were in effort to bring technology advancements to assist providers in communicating via EHR's.	
• Regulatory Update	CNO/CQO Williamson shared the Hospital had an unannounced survey on May 11, 2021 with the Department of Health regarding the Emergency Medical Treatment and Labor Act (EMTALA). The District had an awareness this was coming due to	

	unusual event that occurred two weeks ago in the ED. The Hospital had already started addressing identified opportunities related to EMTALA. Additional EMTALA Training for staff and providers will be in Q2 and Q3 2021. The District will expect a corrective action plan in the next couple weeks which will be brought to the next Compliance Committee Meeting.	
Appendix Summaries	Interim Compliance Officer Taylor created a 2021 Compliance Committee Action Schedule which will be a great tool during this transition period.	
Meeting Summary & Evaluation	Interim Compliance Officer Taylor summarized the meeting.	
Next Meeting-August 11, 2021	The next meeting is scheduled for August 11, 2021.	
Adjournment	Commissioner Coppock moved and Superintendent Everett seconded to adjourn meeting at 3:09 p.m. The motion passed unanimously.	

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
May 19, 2021 at 11:30 a.m.
Conference Room 1 & Via Zoom

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order	Commissioner Coppock called the meeting to order via Zoom at 11:00 a.m. **Commissioner(s) Present in Person or via Zoom:** ☒ Tom Herrin, Secretary ☒ Craig Coppock, Commissioner **Committee Member(s) Present in Person or via Zoom:** ☒ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO ☒ Leianne Everett, Superintendent ☒ Marc Fisher, Community Member ☒ Clint Scogin, Controller ☐ Sherry Sofich, Revenue Cycle Director ☒ Sara Williamson, CNO/CQO ☒ Don Roberts, Pharmacist			
Approval or Amendment of Agenda	CFO Boggess requested to adjust the order of New Business: 1. Cerner Pharmacy Clinical Surveillance Software 2. Podiatry Business Line 3. Capital Update 4. 2020 Financial Audit Presentation 5. Commissioner Email Discussion	Secretary Herrin made a motion to approve the amended agenda and Superintendent Everett seconded. The motion passed unanimously.		
Conflicts of Interest	None noted.			

Consent Agenda	Commissioner Coppock announced the following in consent agenda up for approval: 1. Review of Finance Minutes – April 21, 2021 2. Revenue Cycle Update 3. Board Oversight Activities 4. Financial Statements-April	Secretary Herrin made a motion to approve the consent agenda and CFO Boggess seconded. The motion passed unanimously.		
Old Business • **Financial Department Spotlight**	CFO Boggess deferred the department spotlight for Nursing, Acute/SNF to the July Finance Committee Meeting.		Sara Williamson & LeeAnn Evans	07.21.21 Finance Committee Meeting
• **Disaster Funding Update**	CFO Boggess noted all reporting requirements remain on hold pending HHS updates. There is another opportunity for RHC's to receive money soon.			
New Business • **Cerner Pharmacy Clinical Surveillance Software**	Pharmacist Roberts is proposing to purchase a pharmacy clinical surveillance software to deliver the most effective drug regimen and minimize errors. This process will speed up the process and increase accuracy. This program will automate the regulatory reporting requirements too. Three vendors were reviewed, but recommended Cerner as it already aligns with current EHR and the cost is the lowest at $47,600.	The Finance Committee supported requesting the Board's approval of a resolution at the Regular Board Meeting.	Shana Garcia	05.26.21 Board Meeting
• **Podiatry Business Line**	CFO Boggess presented a new service line opportunity of podiatry. The physician sought out Arbor Health and is very interested in providing services at Arbor Health by August of 2021. This service would be complimentary to the Orthopedist Dr. Williams who will be joining in Q3 2021. This program supports the Districts goals of expanding Operating Room (OR) services. CFO Boggess reviewed the major factors of the proforma including additional staff members in clinic and operating room, along with the need to purchase a mobile C-ARM (X-Ray) for the OR. A budget	The Finance Committee supported requesting the Board's approval of a resolution at the Regular Board Meeting. Resolution to include budget amendment and capital purchase of C-arm.	Shana Garcia	05.26.21 Board Meeting

	amendment would introduce a loss of $150,379 into the 2021 budget year. While this moves the hospital's 2021 budget into a loss position, the hospital is well positioned at this point to accommodate the short-term loss due to its cash position.			
• **2020 Financial Audit Presentation**	Tom Dingus from Dingus, Zarecor and Associates presented the 2020 Financial Audit and highlighted the following: 1. The audited financial statements with no findings. 2. Impact of the Cares Act dollars in offsetting volume declines and future impact of the PPP loan forgiveness. 3. In 2020, the District grew it's net position, more revenue than expenses and the days cash on hand. 4. The financial indicators, which displays the District's history in comparison to hospitals within Washington and nationally. 5. Future opportunity for growth should focus on surgery and rehab services departments.	The Finance Committee supported presenting the 2020 Financial Audit Reports to the Board.	Richard Boggess & Tom Dingus	05.26.21 Board Meeting
• **Capital Update**	CFO Boggess noted the construction project remains on schedule with the OR portion coming to completion at the end of the month. Presented the 5-year capital plan. Planning to do a master site plan by Q4 2021.			
• **Commissioner Email Discussion**	Commissioner Coppock and CFO Boggess shared Commissioner Schumaker's concerns and requests. The Committee noted the information requested is currently available in the finance packet and is available to Commissioners for their review 10-14 days prior to the Board meeting. The Board Bylaws allow committee assignments to change mid-year, so Secretary Herrin will	The Finance Committee will propose a committee assignment switch midyear.	Secretary Herrin & Board Chair Frady	05.26.21 Board Meeting

	discuss possibilities further with Board Chair Frady.			
Meeting Summary & Evaluation	CFO Boggess highlighted the decisions made and the action items that need to be taken to the entire board for approval.			
Adjournment	Commissioner Coppock adjourned the meeting at 12:33 pm.			

WARRANT & EFT LISTING NO. 2021-04

RECORD OF CLAIMS ALLOWED BY THE BOARD OF LEWIS COUNTY COMMISSIONERS

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

CERTIFICATION

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

Signed:

Richard Boggess, CFO

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

$5,351,318.51 this 26th day

of May 2021

Board Chair, Trish Frady

Commissioner, Craig Coppock

Secretary, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of ***$5,351,318.51*** dated ***April 1, 2021 –April 30, 2021.***

Routine A/P Runs

Warrant No.	Date	Amount	Description
120901 - 120915	5-Apr-2021	685,591.80	CHECK RUN
120916 - 120961	2-Apr-2021	590,964.51	CHECK RUN
120962	5-Apr-2021	3,303.94	CHECK RUN
120963	8-Apr-2021	2,597.50	CHECK RUN
120964 - 121031	9-Apr-2021	148,397.23	CHECK RUN
121032 - 121049	12-Apr-2021	163,218.11	CHECK RUN
121050 - 121061	19-Apr-2021	711,853.29	CHECK RUN
121062 - 121127	16-Apr-2021	678,234.68	CHECK RUN
121128 - 121183	23-Apr-2021	212,976.63	CHECK RUN
121184 - 121198	23-Apr-2021	178,255.72	CHECK RUN
121199 - 121200	26-Apr-2021	81,574.08	CHECK RUN
121201	27-Apr-2021	798.18	CHECK RUN
121202 - 121204	30-Apr-2021	16,342.85	CHECK RUN
116508	1-Apr-2021	241.98	MANUAL CHECK
119811	27-Apr-2021	142.64	MANUAL CHECK
121205	15-Apr-2021	12,555.13	CHECK RUN
121206 - 121255	30-Apr-2021	17,597.47	CHECK RUN
121256 - 121257	30-Apr-2021	158.17	CHECK RUN
121263 - 121299	30-Apr-2021	103,537.76	CHECK RUN
Total - Check Runs		$ 3,608,341.67	

Error Corrections - in Check Register Order

Warrant No.	Date Voided	Amount	Description
119915	9-Apr-21	(1,250.00)	VOID CHECK
120841	22-Apr-2021	(10,800.00)	VOID CHECK
120929	9-Apr-2021	(888.69)	VOID CHECK
TOTAL - VOIDED CHECKS		$ (12,938.69)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$ 3,595,402.98

Eft	Date	Amount	Description
1139	2-Apr-2021	157,894.53	IRS / TAX
	2-Apr-2021	410,549.23	PAYROLL
1095	6-Apr-2021	484.04	MCKESSON
	6-Apr-2021	1,089.35	KYLER BELL / PAYROLL
	15-Apr-2021	155,988.10	IRS / TAX
	16-Apr-2021	405,575.41	PAYROLL
1096	13-Apr-2021	2,473.90	MCKESSON
1097	20-Apr-2021	480.13	MCKESSON
1098	27-Apr-2021	194.80	MCKESSON
	30-Apr-2021	448,837.74	PAYROLL
1141	30-Apr-2021	172,348.30	IRS / TAX
TOTAL EFTS AT SECURITY STATE BANK		$ 1,755,915.53	

TOTAL CHECKS, EFT'S, &TRANSFERS	$ 5,351,318.51

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
MEDICAL STAFF BYLAWS RESOLUTION NO. 21-20

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

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

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

Approving the Medical Staff Bylaws.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of May 2021, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

Arbor Health Morton Hospital

MEDICAL STAFF BYLAWS

Part I: Governance

April 2021

Table of Contents

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Arbor Health Morton Hospital in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital Board of Commissioners.

1.2 Authority

Subject to applicable federal, state and local law, the authority and approval of the Board of Commissioners the medical staff will exercise such power on behalf of the hospital as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of the Arbor Health Morton Hospital. Henceforth, whenever the term "the hospital" is used, it shall mean Arbor Health Morton Hospital; and whenever the term "the Board" is used, it shall mean Board of Commissioners.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the medical staff of the hospital is a privilege that shall be extended only to professionally competent and qualified physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons,podiatrists, physician assistants (P.A.) and advanced practice registered nurses (certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives, and clinical nurse specialists) who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies of the medical staff and the hospital.

2.2 Qualifications for Membership

The qualifications for medical staff membership are delineated in Part III of these bylaws (Credentials Procedures Manual).

2.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, sex, gender identity or expression, sexual orientation, creed, color, age, military status, or marital status, race, gender, religion, disability unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the medical staff. The Board shall act on appointment and reappointment only after the medical staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) with the exception of temporary, emergency, and disaster privileges. Appointment and reappointment to the medical staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for medical staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III of these bylaws (Credentials Procedures Manual).

2.6 Medical Staff Members Responsibilities

2.6.1 Each staff member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by similarly situated medical professionals.

2.6.2 Each staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as may be required.

2.6.3 Each physician, consistent with his/her granted clinical privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each staff member must submit to any pertinent type of health evaluation as requested by the officers of the medical staff, the Administrator, and/or Service Chief when it objectively appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or credentials committee as part of an evaluation of the member's objective ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing physician health or impairment.

2.6.5 Each staff member must abide by the medical staff bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital.

2.6.6 Each staff member must provide evidence of professional liability coverage in the minimum amount of $1,000,000/$3,000,000. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member shall notify the Administrator or designee immediately of any and all malpractice claims threatened in writing or filed against the medical staff member, or when the staff member knows or reasonably knows of the facts giving rise to a probable claim.

2.6.7 Each staff member agrees to release from any liability, to the fullest extent permitted by law, all persons for their conduct, done in good faith, in connection with investigating and/or evaluating the quality of care provided by the medical staff member and his/ her credentials.

2.6.8 Each staff member shall prepare and complete in timely fashion, according to medical staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

c. The content of complete and focused history and physical examinations is delineated in the rules and regulations.

2.6.9 Each staff member will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with applicable federal and state laws and regulations, including but not limited to HIPAA, to conduct authorized research activities, or to perform medical staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by applicable law or the hospital or its representatives prior to disclosure.

2.6.10 Each staff member must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's clinical privileges.

2.6.11 Each medical staff leader shall disclose to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or hospital. Medical staff leadership will address the conflict of interest issues per the Medical Staff Conflict of Interest policy.

2.7 Medical Staff Member Rights

2.7.1 Each staff member in the Voting category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Service Chief or other appropriate medical staff leader(s), that practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.7.2 Each staff member in the Voting category has the right to initiate a recall election of a medical staff officer by following the procedure outlined in Section 4.7 of these bylaws, regarding removal and resignation from office.

2.7.3 Each staff member in the Voting category may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by twenty percent (20%) of the members of the Voting category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each staff member in the Voting category may initiate a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by twenty percent (20%) of the members of the Voting category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

2.7.5 Each staff member in the Voting category may call for a Service meeting by presenting a petition signed by two (2)of the members of the Service. Upon presentation of such a petition the Service Chief will schedule a Service meeting.

2.7.6 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.7 Any staff member has a right to a hearing/appeal pursuant to the conditions and procedures described in the medical staff's hearing and appeal plan (Part II of these bylaws).

2.8 Staff Dues

Annual medical staff dues, if any, shall be determined by the MEC. Failure of a medical staff member to pay dues shall be considered a voluntary resignation from the medical staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.9 Indemnification

2.9.1 Members of the medical staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and medical staff.

2.9.2 Subject to applicable law, the hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which he is made a party by reason of his having acted in an authorized official capacity and in good faith on behalf of the hospital or medical staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability were authorized and/or constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Voting Category

3.1.1 Qualifications

Members of this category must have served on the medical staff for at least one year, and

a. be involved in at least twenty-five (25) patient contacts per year (i.e., a patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient surgical procedure) at the hospital, or

b. have worked at least fifty (50) shifts per year, or

c. have attended at least four (4) meetings (of which must be at least one general medical staff meeting and at least one committee meeting) per year

In the event that a member of the voting category does not meet the qualifications for appointment or reappointment to the Voting category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the medical staff and hospital, the member may be appointed to another medical staff category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

a. Attend medical staff or Service meetings of which s/he is a member and any medical staff or hospital education programs;

b. Vote on all matters presented by the medical staff, Section, and committee(s) to which the member is appointed; and

c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

3.1.3 Responsibilities

Members of this category shall:

a. Contribute to the organizational and administrative affairs of the medical staff;

b. Actively participate as requested or required in activities and functions of the medical staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

c. Fulfill or comply with any applicable medical staff or hospital policies or procedures.

3.2 The Nonvoting Category

3.2.1 Qualifications

The nonvoting category is reserved for medical staff members who do not meet the eligibility requirements for the Voting category.

3.2.2 Prerogatives

Members of this category may:

a. Attend medical staff and Service meetings of which s/he is a member and any medical staff or hospital education programs; and

b. Serve on medical staff committees, other than the MEC, and may vote on matters that come before such committees.

c. Members of this category may not vote on matters before the entire medical staff of be an officer of the medical staff.

3.2.3 Responsibilities

Members of this category shall:

a. Have the same responsibilities as voting category members.

3.3 Honorary Recognition

The Honorary Category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Honorary Category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend medical staff and Service meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff

Officers of the medical staff shall consist of:

4.1.1 Chief of Staff;

4.1.2 Secretary; and

4.1.3 Immediate Past Chief of Staff

4.2 Qualifications of Officers

4.2.1 Officers must be members in good standing of the voting category and be actively involved in patient care in the hospital, indicate a willingness and ability to serve, have no pending adverse recommendations concerning or restrictions of medical staff appointment or clinical privileges, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. Qualifications for the positions of Chief of Staff also include the degree of MD, or DO. The medical staff nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2.2 Officers may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain his/her position is in the best interest of the hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

4.3 Election of Officers

4.3.1 The nominating committee shall offer at least one nominee for each available position. Nominations must be announced, and the names of the nominees distributed to all members of the active medical staff at least thirty (30) days prior to the election.

4.3.2 A petition signed by at least ten percent (10%) of the members of the active staff may add nominations to the ballot. The medical staff must submit such a petition to the Chief of Staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The nominating committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the ballot.

4.3.3 Officers shall be elected at least one (1) month prior to the expiration of the term of the current officers. Only members of the Voting category shall be eligible to vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes will be elected, subject to confirmation of the election by the Board. In the event of a tie vote, the medical staff support professional will make arrangements for a runoff vote(s) of the tied nominees until one candidate receives a greater number of votes.

4.4 Term of Office

All officers serve a term of one (1) year. They shall take office in the month of January. An individual may be reelected for (2) two successive terms.

4.5 Vacancies of Office

The MEC shall fill vacancies of office during the medical staff year, except the office of the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Secretary shall serve the remainder of the term.

4.6 Duties of Officers

4.6.1 Chief of Staff: The Chief of Staff shall represent the interests of the medical staff to the MEC and the Board. The Chief of Staff will fulfill the duties specified in Part IV of these bylaws (Organization and Functions Manual).

4.6.1.1. Responsibilities of the Chief of Staff

4.6.1.2. The Chief of Staff is the primary elected officer of the medical staff and is the medical staff's advocate and representative in its relationships to the Board and the administration of the hospital. The Chief of Staff, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules, regulations and policies. Specific responsibilities and authority are to:

4.6.1.3. Call and preside at all general and special meetings of the medical staff;

4.6.1.4. Serve as chair of the MEC and as ex officio member of all other medical staff committees without vote, and to participate as invited by the Administrator or the Board on hospital or Board committees;

4.6.1.5. Enforce medical staff bylaws, rules, regulations and medical staff/hospital policies;

4.6.1.6. Except as stated otherwise, appoint committee chairs and all members of medical staff standing and ad hoc committees; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees or to serve as medical staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

4.6.1.7. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;

4.6.1.8. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

4.6.1.9. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

4.6.1.10. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

4.6.1.11. Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

4.6.1.12. Attend Board meetings and Board committee meetings as invited by the Board;

4.6.1.13. Ensure that the decisions of the Board are communicated and carried out within the medical staff; and

4.6.1.14. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws.

4.6.2 Secretary: In the absence of the Chief of Staff, the Secretary shall assume all of the duties and have the authority of the Chief of Staff. The Secretary will collaborate with the hospital's medical staff office, assure maintenance of minutes, attend to correspondence, act as medical staff treasurer, and coordinate communication within the medical staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.6.3 Immediate Past Chief of Staff: This officer will serve as a consultant to the Chief of Staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.7 Removal and Resignation from Office

4.7.1 The medical staff may remove any officer if at least ten percent (33%) sign a petition advocating for such action. The petition must be followed by an affirmative vote by two thirds (2/3) of those active staff members casting ballot votes. Such vote must occur within forty-five (45) days after approval by the Medical Staff at a regular meeting of a motion proposing a vote on the question of removal and be subject to the concurrence of the Board via the Administrator.

a. Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements detrimental to the hospital, or its goals, or programs, or an automatic or precautionary suspension of clinical privileges that lasts more than thirty days. The Board will determine if the member has failed in his/her duties after consulting with the joint conference committee.

4.7.2 Resignation: Any elected officer may resign at any time by giving written notice to the MEC. Such resignation shall take effect on the date of receipt or any later time specified therein.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The medical staff shall be organized as a non-departmentalized staff. The MEC may recognize any group of practitioners who wish to organize themselves into a Service. Any Service, if organized, shall not be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the Service is making a formal recommendation to the MEC. A Service Chief will be elected by the Service. Services exist to perform any of the following activities:

a. Continuing education/discussion of patient care;

b. Grand rounds;

c. Discussion of policies and procedures related to the Service;

d. Discussion of equipment needs related to the Service;

e. Development of recommendations for the MEC related to the Service; and

f. Participation in the development of criteria for clinical privileges when requested by the credentials committee or MEC; or

g. Discussion of a specific issue at the request of a medical staff committee or the MEC.

5.1.2 The current Services that are organized by the medical staff and formally recognized by the MEC shall be listed Part IV of the bylaws (Organization and Functions Manual).

5.2 Qualifications, Selection, Term, and Removal of Service Chief

5.2.1 Each Service Chief shall serve a term of one (1) year commencing on January 1 and may be elected to serve successive terms. All Service Chiefs must be members of the voting medical staff, have relevant clinical privileges and be in good standing.

5.2.2 Service Chiefs shall be elected by majority vote of the voting members of the Service, subject to ratification by the MEC. Each Service shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC. If such procedures are not established, then the voting procedures set forth in Section 4.3.3 shall be used.

5.2.3 Service Chiefs may be removed from office by the MEC if two-thirds (2/3) of the voting members of the Service recommend such action, or, in the absence of such recommendation, the MEC may remove a Service Chief on its own by a two thirds (2/3) vote if any of the following occurs:

a. The Service Chief suffers an involuntary loss or significant limitation of practice privileges; or

b. The MEC determines that the Service Chief has failed to demonstrate to the satisfaction of the MEC or the entire medical staff if he or she choose that he or she is effectively carrying out the responsibilities of the position;

c. If a Service Chief is removed through this process, a new election will be held according to established Service procedure;

5.2.4 Service Chiefs will be removed from office automatically if the following occurs:

a. The Service Chief ceases to be a member in good standing of the medical staff.

5.3 Responsibilities of Service Chiefs

a. To oversee all clinically-related activities of the Service;

b. To oversee all administratively-related activities of the Service, unless otherwise provided by the hospital;

c. To provide ongoing surveillance of the performance of all individuals in the medical staff Service who have been granted clinical privileges;

d. To give input to the credentials committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff Service;

e. To give input to the credentials committee regarding the clinical privileges for each member of the Service and other licensed independent practitioners practicing with privileges within the scope of the Service ;

f. To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services;

g. To continually assess and improve of the quality of care, treatment, and services;

h. To maintain quality control programs as appropriate;

i. To ensure orient and continuously education of all persons in the Service; and

j. To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff department to provide patient care services.

5.4 Assignment to Service

The MEC will, after consideration of the recommendations of the Service Chief of the appropriate Service, recommend Service assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Service. Clinical privileges are independent of Service assignment.

Section 6. Committees

6.1 Designation and Substitution

There shall be a MEC and such other standing and ad hoc committees as established by the MEC and enumerated in Part IV of the bylaws (Organization and Functions Manual). Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the medical staff may be discharged by medical staff representation on such hospital committees as are established to perform such functions. The Chief of Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 MEC

6.2.1 Committee Membership:

a. Composition: The MEC shall be a standing committee consisting of the following voting members: the officers of the medical staff with the majority being physicians. The chair will be the Chief of Staff. The Administrator, Chief Nurse Executive, or designee, shall serve as an ex-officio, non-voting member of the MEC.

b. Removal from MEC: An officer who is removed from his/her position in accordance with Section 4.7 above will automatically lose his/her membership on the MEC.

6.2.2 Duties: The duties of the MEC, as delegated by the medical staff, shall be to:

a. Serve as the final decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions;

b. Coordinate the implementation of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, medical staff category, Service assignments, clinical privileges, and corrective action;

d. Report to the Board and to the medical staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance/quality improvement activities;

e. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and hospital management matters;

g. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;

h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

i. Review and act on reports from medical staff committees, Services, and other assigned activity groups;

j. Formulate and recommend to the Board medical staff rules, policies, and procedures;

k. Request evaluations of practitioners privileged through the medical staff process when there is an objective question about an applicant or member's ability to perform privileges requested or currently granted;

l. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;

n. Oversee that portion of the corporate compliance plan that pertains to the medical staff;

o. Hold medical staff leaders, committees, and Services accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws; and

q. The MEC is empowered to act for the organized medical staff between meetings of the organized medical staff.

6.2.3 Meetings: The MEC shall meet at least four (4) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 All meetings of the medical staff shall be held at a time determined by the MEC. Notice of any meeting shall be given to all medical staff members as set forth in these bylaws, as well as via appropriate media and posted conspicuously.

7.1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the Medical Staff

a. The Chief of Staff may call a special meeting of the medical staff at any time. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

b. Written or electronic notice stating the time, place, and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Services

Committees and Services may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Services

A special meeting of any committee or Service may be called by the committee chair or Service Chief thereof or by the Chief of Staff.

7.4 Quorum

7.4.1 Medical Staff Meetings: Those present and eligible medical staff members voting on an issue.

7.4.2 MEC and Credentials Committee: A quorum will exist when 50% of the members are present.

7.4.3 Service meetings or medical staff committees other than those listed in 7.4.2 above: Those present and eligible medical staff members voting on an issue.

7.5 Attendance Requirements

7.5.1 Members of the medical staff are encouraged to attend meetings of the medical staff. MEC and credentials committee members must attend 50% of committee meetings or they will be replaced.

a. Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable Service Chief or committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practioner's membership on the medical staff and privileges at the hospital. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

b. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the Administrator

The Administrator is an ex-officio member, without vote, of all medical staff committees to encourage participation of management to assist the medical staff. The committee may go into executive session, with medical staff members only, when desired.

7.7 Robert's Rules of Order

Medical staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest edition of Robert's Rules of Order shall determine procedure.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Service or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Service

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Service. Such recommendation will then be forwarded to the MEC for action.

7.10 Rights of Ex officio Members

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote or be counted in determining the existence of a quorum.

7.11 Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or other designated committee. A permanent file of the minutes of each meeting shall be maintained in accordance with applicable law, including but not limited to chapter 42.56 RCW..

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to a joint conference committee composed of the officers of the medical staff and an equal number of members of the Board for review and recommendation to the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 The chair of the Board or the Chief of Staff may call for a joint conference as described above at any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.

8.1.3 Any conflict between the medical staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of Part I of these bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The medical staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws and rules & regulations shall be effective when approved by the Board. The medical staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by twenty percent (20%) of the members of the voting category.

Each voting member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All voting members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff if the medical staff receives sixty-six percent (66%) of the votes cast by those voting.

Amendments so adopted shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations and Policies

9.3.1 The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws, which may be compiled and organized in a rules, regulations and/or policies manual.

9.3.2 Proposed amendments to the rules, regulations and policy manual may be originated by the MEC.

9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.4 In addition to the process described in 9.3.3 above, the organized medical staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy. This is in the manner set forth in Section 2.7.4. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

9.3.5 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital Administrator. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.

Arbor Health Morton Hospital

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

August ___, 2014

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Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Criteria for Initiation

These bylaws encourage, but do not require, medical staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial intervention efforts may include but are not limited to the following:

a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

c. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following collegial intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation the MEC will authorize an investigation to determine whether sufficient evidence exists to support such a recommendation.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted by a medical staff officer, committee chair, Service chief, Administrator or hospital board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC initiates the request, it shall appropriately document its reasons.

2.2 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the medical staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the Administrator. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The investigating body shall notify the practitioner in question that the investigation is being conducted and an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.1 An external peer review consultant should be considered when:

a. Litigation is reasonably likely;

b. The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;

c. There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

2.3 MEC Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file and taking all steps necessary to restore the practitioner to the same or similar position she/he was in prior to the investigation.

b. Deferring action for a reasonable time when circumstances warrant;

c. Issuing letters of admonition, censure, reprimand, or warning.

d. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

g. Recommending suspension, revocation, or probation of medical staff membership; or

h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, that recommendation shall be transmitted in writing to the board. The recommendation of the MEC shall be forwarded to the Board unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following instances, the practitioner's privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The Chief of Staff with the approval of the Administrator may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty (60) days, the practitioner shall be obligated to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

3.1.1 Licensure

a. **Revocation and suspension**: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

b. **Restriction**: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation**: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

3.1.2 Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a practitioner is excluded, preculeded or barred from Medicare, Medicaid, Tricare, or other federal or state governmental programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.3 Controlled substances

a. **DEA certificate**: Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. **Probation**: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.4 **Medical record completion requirements**: A practitioner will be considered to have voluntarily suspended the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This supenspention of privileges shall not apply to patients admitted or already scheduled at the time of supspention, to emergency patients, or to imminent deliveries. The suspended privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.5 **Professional liability insurance**: Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic suspention of a practitioner's clinical privileges. If within 60 calendar days of the suspention the practitioner does not provide evidence of required professional liability insurance (including coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.6 **Medical Staff dues/special assessments**: Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic suspesnment of a practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the medical staff.

3.1.7 **Felony conviction**: A practitioner who has been convicted of or entered a pleas of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, theft, violence, or a charge involving moral turpitude in any jurisdiction shall automatically suspend medical staff membership and privileges. Such suspention shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

3.1.8 **Failure to satisfy the special appearance requirement**: A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically suspend all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the medical staff.

3.1.9 **Failure to participate in an evaluation**: A practitioner who fails to participate in an evaluation of his/her qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically suspended all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the medical staff.

3.1.10 **Failure to Execute Release and/or Provide Documents**: A practitioner who fails to execute a general or specific release and/or provide documents when requested by the Chief of Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically suspend all privileges. If the release is executed and/or documents provided within thirty (30) calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.11 **MEC Deliberation**: As soon as practicable after action is taken or warranted as described in Sections 3.1.1 through Section 3.1.11, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in the Section 2.3 above.

3.2 Precautionary (Summary) Restriction or Suspension

3.2.1 **Criteria for Initiation**: A precautionary restriction or suspension may be imposed when the medical staff feels that it needs to immediate action be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when MEC and/or the Administrator determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution. Under such circumstances the MEC or the Board or any two of the following Administrator or designee, Chief of Staff or designee, or Service Chief may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at the hospital.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the Administrator, and the board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the Chief of Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.2.2 **MEC action**: As soon as feasible but no later than 14 calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

3.2.3 **Procedural rights**: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described in Section 2, the member shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for medical staff appointment or physicians or dentists eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following actions when the basis for such action is related to clinical competence or professional conduct:

a. Denial of medical staff appointment or reappointment;

b. Revocation of medical staff appointment;

c. Denial or restriction of requested clinical privileges;

d. Involuntary reduction or revocation of clinical privileges;

e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed for more than fourteen (14) calendar days; or

f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

a. Issuance of a letter of guidance, warning, or reprimand;

b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on privileges;

c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

e. Notice to appear for a special meeting under the provisions of these bylaws;

f. Automatic relinquishment or voluntary resignation of appointment or privileges;

g. Imposition of a precautionary suspension that does not exceed fourteen (14) calendar days;

h. Denial of a request for leave of absence, or for an extension of a leave;

i. Determination that an application is incomplete or untimely;

j. Determination that an application will not be processed due to misstatement or omission;

k. Decision not to expedite an application;

l. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;

o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

p. Termination of any contract with or employment by hospital;

q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any regulatory agency standards on competency evaluation;

r. Any recommendation voluntarily accepted by the practitioner;

s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

t. Change in assigned staff category;

u. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;

z. Grant of conditional appointment or appointment for a limited duration; or

aa. Appointment or reappointment for duration of less than twenty-four (24) months.

4.3 Notice of Recommendation

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to these bylaws entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no later than five (5) calendar days) be given written notice by the Administrator delivered either in person or by certified mail, return receipt requested. This notice shall contain:

a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);

b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;

c. Notice that the recommendation, if finally adopted by the board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

d. A copy of Sections 4.4 to 6.6 of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

Such individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Administrator or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final board action.

4.5 Notice of Hearing and Statement of Reasons

The Administrator shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

a. The time, place and date of the hearing;

b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the MEC, (or the Board), at the hearing;

c. The names of the hearing panel members and presiding officer or hearing officer, if known; and

d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the hearing panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer (or hearing panel chair), be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer (or hearing panel chair) shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

a. When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. This panel will be appointed by a joint decision of the Administrator and the Chief of Staff. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel so long as such individual can serve in a fair and unbiased capacity. Hearing panel members need not be members of the hospital medical staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

b. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

c. The Administrator or designee shall notify in writing the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object within five (5) days of receipt of notice, if at all, to appointment of any member(s). Any objection to any member of the hearing panel, chair or, to the hearing officer shall be made in writing to the Administrator, who, in conjunction with the Chief of Staff, shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the Administrator and the Chief of Staff.

5.2 Hearing Panel Chairperson or Presiding Officer

5.2.1 In lieu of a hearing panel chair, the Administrator, acting for the Board and after considering the recommendations of the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no previous history with either the hospital or the practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the Administrator to serve as the presiding officer and shall be entitled to one vote.

5.2.3 The presiding officer (or hearing panel chair) shall do the following:

a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and

h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

As an alternative to the hearing panel described in Section 5.1 of these bylaws, the Administrator, acting for the Board and in conjunction with the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.

The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the "hearing panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal "discovery" in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

b. Reports of experts relied upon by the MEC;

c. Copies of redacted relevant committee minutes;

d. Copies of any other documents relied upon by the MEC or the Board;

e. No information regarding other practitioners shall be requested, provided or considered; and

f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

6.1.2 Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

6.1.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Washington.

6.5 Rights of the Practitioner and the Hospital

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To call and examine witnesses to the extent available;

b. To introduce exhibits;

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

d. To have representation by counsel who may be present at the hearing, the role of counsel determined at the pre-hearing conference. It will be either to:

Advise his or her client;

Participate in resolving procedural matters; or to

Argue the case for his/her client.

Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing; and

e. To submit a written statement at the close of the hearing.

6.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

6.5.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Burden of Proof

It is the burden of the MEC (or Board of Commissioners) to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all medical staff and hospital policies.

6.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed, following the close of the hearing.

6.9 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.10 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer or the Administrator on a showing of good cause.

6.11 Persons to be Present

Attendance at the hearing shall be restricted to those individuals necessary to or involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or Administrator.

6.12 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

6.13 Basis of Recommendation

The hearing panel shall recommend in favor of whichever side demonstrates the preponderance of evidence.

6.14 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the Administrator who shall forward it, along with all supporting documentation, to the Board for further action. The Administrator shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment.

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, either the practitioner subject to the hearing or the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the Administrator or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the board.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

a. The Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel shall not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, a record of this procedure, similar to that done for the hearing panel, will be made.

c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

d. The Board may deliberate in a closed or executive session, provided any final action by the Board shall be conducted in a public meeting. The Board may affirm, modify or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the credentials committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to an applicant, or to revoke or terminate the medical staff appointment and/or clinical privileges of a current member, that individual may not apply within five (5) years for medical staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

7.7 Fair hearing and appeal for those with privileges without medical staff membership and who are not physicians or dentists

Podiatrists and psychologists are not entitled to the medical staff hearing and appeals procedures set forth in the medical staff bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner shall have the right to meet personally with the Service Chief and the Chief of Staff to discuss the recommendation. The practitioner must request such a meeting in writing to the Administrator within 10 working days from the date of receipt of such notice. At the meeting, the practitioner must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a medical staff hearing and none of the procedural rules set forth in the medical staff bylaws with respect to hearings shall apply. Findings from this review will be forwarded to the affected practitioner, the MEC and the Board.

The practitioner may request an appeal in writing to the Administrator within 10 days of receipt of the findings of the review. Two members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner. A representative from the medical staff leadership may be present. The decision of the appeal will be forwarded to the Board for final decision. The practitioner will be notified within 10 days of the final decision of the Board.

Arbor Health Morton Hospital

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

August ___, 2014

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Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the medical staff credentials committee shall consist of at least three (3) members of the voting medical staff. The Chief of Staff will appoint the chair and other members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite members such as representatives from hospital administration and the Board.

1.2 Meetings

The medical staff credentials committee shall meet on call of the chair or Chief of Staff.

1.3 Responsibilities

1.3.1 To review and recommend action on all applications and reapplications for membership on the medical staff including assignments of medical staff category;

1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners;

1.3.3 To recommend eligibility criteria for the granting of medical staff membership and privileges;

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

1.3.5 To review, and where appropriate take action on, reports that are referred to it from other medical staff committees, medical staff or hospital leaders; and

1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the Administrator or designee.

1.4.2 Individual practitioners may review their credentials file under the following circumstances:

Practitioner may review their credentials file only upon written request. Review of such files will be conducted in the presence of the medical staff service professional, medical staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from or copied from the file. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

2.1 No practitioner shall be entitled to membership on the medical staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.2 The following qualifications must be met by all applicants for medical staff appointment, reappointment or clinical privileges:

2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, optometry or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.2 Have a current unrestricted on initial appointment state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Washington;

2.2.3 Have a record that is free from current Medicare/Medicaid exclusion or preclusion and not be on the Office Inspector General List of Excluded Individuals/Entities;

2.2.4 Have a record that is free of felony convictions related to violence, drug offenses, theft or healthcare fraud or abuse within the last five (5) years;

2.2.5 A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within (5) five years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association;

2.2.5.1. A practitioner who fails to become board certified in compliance with these bylaws or medical staff credentialing policies will be reviewed by the MEC to determine if action should be taken.

2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.7 Oromaxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;

2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine;

2.2.9 A psychologist must have a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate to the area of clinical practice;

2.2.10 Possess a current, valid, unrestricted on initial appointment drug enforcement administration (DEA) number if applicable;

2.2.11 Have appropriate written and verbal communication skills;

2.2.12 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

b. A history of consistently acting in a professional, appropriate and collegial manner with others in previous clinical and professional settings.

2.3 The following qualifications must also be met by all applicants requesting clinical privileges:

2.3.1 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

2.3.2 When objectively necessary, provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of medical staff membership and the specific privileges requested by and granted to the applicant;

2.3.3 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

2.3.4 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

2.3.5 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved medical staff development plan;

2.3.6 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

2.4 Exceptions

2.4.1 All practitioners who are current medical staff members and/or hold privileges as of [date of Board approval] and who have met prior qualifications for membership and/or privileges shall be exempt from requirements regarding residency completion and board certification.

2.4.2 Only the Board may create additional exceptions to the above Section 2.2 after consultation with the MEC.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for appointment to the medical staff and requests for clinical privileges will be forwarded to the medical staff office. Upon receipt of the request, the medical staff office will provide the applicant an application package, which will include a complete set of the medical staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted medical staff membership or privileges (if such expectations have been adopted by the medical staff).

A completed application includes, at a minimum:

a. A completed, signed, and dated application form;

b. A completed privilege delineation form if requesting privileges;

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;

d. All applicable fees;

e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card;

f. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;

g. Relevant practitioner-specific data as compared to aggregate data, when available; and

h. Morbidity and mortality data, when available.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing for an application determined to be incomplete.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the medical staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application the Administrator, in collaboration with the medical staff office, will determine if the requirements of sections 2.2 and 2.3 are met. In the event the requirements of sections 2.2 and 2.3 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the medical staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.

3.1.4 Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

3.1.5 Upon receipt of a completed application, the medical staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office will collect relevant additional information which may include:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, (if any) for the practitioner's lifetime;

b. Documentation of the applicant's past clinical work experience;

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office will verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

d. Information from the AMA or AOA Physician Profile and the Office Inspector General list of Excluded Individuals/Entities;

e. Information from professional training programs including residency and fellowship programs;

f. Information from the National Practitioner Data Bank (NPDB); in addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

g. Other information about adverse credentialing and privileging decisions;

h. One or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges;

i. Information from a lifetime criminal background check.

j. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges; and

k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available.

Note: In the event there is undue delay in obtaining required information, the medical staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five (45) calendar days will be deemed a withdrawal of the application.

3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization and Acknowledgement

The applicant must complete and sign the application form. By signing this application the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any material inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

3.2.2 Consents to appear for any requested interviews in regard to his/her application.

3.2.3 Authorizes the hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consents to hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested;

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

c. Professional and ethical qualifications;

d. Professional liability actions including currently pending claims involving the applicant; and

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

3.2.6 Authorizes the hospital medical staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits or challenges against any medical staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

3.2.7 Acknowledges that the applicant has had access to the medical staff bylaws, including all rules, regulations, policies and procedures of the medical staff and agrees to abide by their provisions.

Notwithstanding section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, s/he shall reimburse the hospital and any member of the medical staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

3.2.8 Agrees to provide accurate answers to the application questions and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's medical staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

a. Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

b. Has your license to practice or registration in any state ever been relinquished, denied, challenged, limited, suspended, or revoked, whether voluntarily or involuntarily?

c. Have you ever been asked to surrender your professional license?

d. Have you ever been suspended, sanctioned, excluded or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TriCare, or Medicaid)?

e. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

f. Has your DEA certificate ever been relinquished, limited, denied, suspended, or revoked?

g. Is your DEA certificate currently being challenged?

h. Have you ever been named as a defendant in any criminal proceedings or been arrested or charged with a crime?

i. Has your employment, medical staff membership, or clinical privileges ever been reduced, suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily?

j. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a hospital's or health facility's Board made a decision on such application for appointment, reappointment, or clinical privileges?

k. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?

l. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions (e.g. sexual harassment)?

m. Have you ever been the subject of focused individual monitoring at any hospital or health care facility other than to confirm competency immediately following an initial grant of a privilege(s)?

n. If you are not currently board certified please answer n. through r. below (if board certified skip to s below):

o. Have you ever been examined by any specialty board, but failed to pass the examination? Please provide details.

p. If not certified, have you applied for the certification exam?

q. Have you ever been accepted to take the certification exam?

r. If yes, what dates are you scheduled to take the certification exam?

s. Have any professional liability claims or suits ever been filed against you or are any presently pending?

t. Have any judgments or settlements been made against you in professional liability cases? (If yes, please provide a short synopsis of the allegations and outcome of the case).

u. Have you ever been refused or denied coverage, had coverage cancelled, or had specific privileges excluded by a malpractice liability carrier?

v. Have you ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement)?

w. Are you currently taking any substances or medications which could impair your ability to safely perform the privileges which you are requesting in this application?

x. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions (e.g. sexual harassment)?

y. Have you ever been terminated from employment or from a group practice?

3.3 Application Evaluation

3.3.1 Applicant Interview

a. All applicants for appointment to the medical staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Service Chief, MEC or Board. The interview may take place in person, by telephone or videoconferencing at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate medical staff performance expectations.

b. Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

3.3.2 Service Chief Action

a. Completed applications are presented to the Service Chief for review, and input to the credentials committee/MEC. If an application is presented to the Service Chief, the Service Chief will review the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Service Chief may obtain input if necessary, from an appropriate subject matter expert. If a Service Chief believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment.

b. The Service Chief forwards to the medical staff credentials committee the following:

Input whether to approve the applicant's request to membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

Input regarding defining those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

Comments supporting the input in 3.3.2 b above.

3.3.3 Medical Staff Credentials Committee Action

The medical staff credentials committee reviews the application and forwards the following to the MEC:

a. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

Comments supporting the recommendations in 3.3.3 b above.

3.3.4 MEC Action

The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

c. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

d. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

Comments supporting the recommendations in 3.3.4 above.

3.3.5 Board Action:

e. The Board reviews the application and votes for one of the following actions:

The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;

If the board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.6 **Notice of final decision**: Notice of the Board's final decision shall be given, through the Administrator to the MEC and to the chair of each Service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Service to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.3.7 **Time periods for processing**: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Competency Evaluation

All initially requested privileges shall be subject to a period of focused competency evaluation. The Service Chief with the approval of the MEC will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The credentials committee will also establish the duration for such focused competency evaluation and triggers that indicate the need for performance monitoring.

The medical staff will also engage in ongoing competency evaluation to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. Ongoing competency evaluation shall be undertaken as part of the medical staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to focused competency evaluation when issues affecting the provision of safe, high quality patient care are identified through the ongoing process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 5. Reappointment

5.1 Criteria for Reappointment

5.1.1 It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section 5.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing medical staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning focused professional practice evaluation. A suitable peer shall substitute for the Service Chief in the evaluation of current competency of the Service Chief, and recommend appropriate action to the credentials committee.

5.2 Information Collection and Verification

5.2.1 **From appointee**: On or before four (4) months prior to the date of expiration of a medical staff appointment or grant of privileges, a representative from the medical staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the medical staff office:

a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;

b. Information concerning continuing training and education internal and external to the hospital during the preceding period; and

c. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

5.2.2 From internal and/or external sources: The medical staff office collects and verifies information regarding each staff appointee's professional and collegial activities to include those items listed in Section 3.2.8.

5.2.3 The following information is also collected and verified:

a. A summary of clinical activity at this hospital for each appointee due for reappointment;

b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

c. Attestation of any required hours of continuing medical education activity per state licensure requirements;

d. Service on medical staff, Service, and hospital committees;

e. Timely and accurate completion of medical records;

f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;

g. Any significant gaps in employment or practice since the previous appointment or reappointment;

h. Verification of current licensure;

i. National Practitioner Data Bank query;

j. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges; and

k. Malpractice history for the past two (2) years, which is verified by the medical staff office with the practitioner's malpractice carrier(s).

5.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

5.3 Evaluation of Application for Reappointment of Membership and/or Privileges

5.3.1 The reappointment application will be reviewed and acted upon as described in Sections 3.3.2 through 3.3.5 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the medical staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment".

Section 6. Clinical Privileges

6.1 Exercise of privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be podiatrists, dentists, oral and maxillofacial surgeons, physicians serving short locum tenens positions, telemedicine physicians, or house staff such as residents moonlighting in the hospital, or others deemed appropriate by the MEC and Board.

6.2 Requests

When applicable, each application for appointment or reappointment to the medical staff must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

6.3 Basis for Privileges Determination

6.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

6.3.2 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

6.3.3 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

6.4 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Dentists and oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an appropriate training and demonstrated current competence.

6.5 Special conditions for physician assistants

Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Allied health practitioners (AHPs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. All records must have review and/or cosigning done by a physician as well as all history and physical exams must be cosigned by a physician. The privileges of these AHPs shall terminate immediately, without right to due process, in the event that the employment of the AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the AHP with a physician member of the medical staff organization is terminated for any reason.

6.6 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. Podiatrists may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an appropriate training and demonstrated current competence

6.7 Special Conditions for Residents or Fellows in Training

6.7.1 Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Chief of Staff in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

6.7.2 The physician under whom the resident or fellow is training must communicate periodically with the MEC and the Board about the performance of his/her residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

6.8 Special Conditions for the Aging Practitioner

At the age of 65 practitioners shall be required to undergo proctoring of his/her clinical performance as part of the assessment of his/her capacity to perform the requested privileges. Such proctoring may be required in the absence of any previous performance concerns. The scope and duration of the proctoring shall be determined by the MEC upon recommendation of the Service Chief and credentials committee. In addition to the proctoring, a practitioner may be required to complete a biennial examination that addresses their physical and mental capacity to perform the privileges requested. The physical and mental exams are to be conducted by a physician acceptable to the credentials committee, and the outcome shall be documented on the approved form and submitted to the credentials committee by the date requested. The physical exam is a "fitness to work" evaluation and must indicate that the practitioner has no physical or mental problem that may interfere with the safe and effective provision of care permitted under the privileges granted.

6.9 Telemedicine Privileges

6.9.1 Requests for telemedicine privileges at the hospital that includes patient care, treatment, and services will be processed only by fully credentialing and privileging the practitioner through the usual mechanisms of the medical staff.

6.9.2 When telemedicine services are furnished to the Hospital's patients through an agreement with a **distant-site telemedicine entity**, the governing body of this Hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the Hospital's governing body ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with requirements stated above, permit the Hospital to comply with all applicable Conditions of Participation for the contracted services. The Hospital's governing body shall also ensure, through its written agreement with the distant-site telemedicine entity, that all of the following provisions are met:

a. The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards stated in 42 CFR Section 485.616(c)(1)

b. The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services. The distant-site provides the Hospital with a current list of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity

c. The individual distant-site physician or practitioner holds a license issues or recognized by the state in which the Hospital is located

d. With respect to a distant-site physician or practitioner, who holds current privileges at the Hospital, the Hospital as evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information shall include all adverse events that result from the telemedicine services provides by the distant-site physician or practitioner to the Hospital's patients, and all complaints the Hospital has received about the distant-stie physician or practitioner.

e. The distant-site telemedicine entity may or may not be a Medicare-participating provider or supplier. This is at the discretion of the Hospital to require this as a condition of the agreement with the distant-site entity.

6.9.3 When telemedicine services are furnished to the Hospital patients through an agreement with a **distant-site hospital**, the governing body of the Hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the Hospital's governing body ensures, through it's written agreement with the distant-site hospital, that all of the following provisions are met:

a. The distant-site hospital providing the telemedicine services is a Medicare-participating hospital

b. The individual distant-site physician or practitioner is privileges at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital

c. The individual distant-site physician or practitioner holds a license issues or recognized by the state in which the Hospital is located

d. With respect to a distant-site physician or practitioner, who holds current privileges at the Hospital, the Hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and send the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information shall include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the Hospital's patients and all complaints the Hospital has received about the distant-site physician or practitioner

6.9.4 The Hospital will define and apply criteria for determining the privileges to be granted to individual practitioners and a procedures for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the Hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to these requirements.

6.10 Temporary Privileges

The Administrator, acting on behalf of the Board and based on the recommendation of either a member of the MEC, the Chief of Staff or the Chief Medical Officer, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

6.10.1 Important Patient Care, Treatment or Service Need: Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days, while the full credentials information is verified and approved. When granting such privileges, the organized medical staff verifies primary verification of education, demonstration of current competence, primary verification of state professional licenses, receipt of professional references (including current competence), and receipt of database profiles from AMA, AOA, NPDB, and OIG Medicare/Medicaid exclusions.

6.10.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the hospital: current licensure; education training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required; malpractice history; one positive reference specific to the applicant's competence from an appropriate medical peer; ability to perform the privileges requested; a query to the Office of Inspector General list of Excluded Individuals/Entities, and results from a query to the National Practitioner Data Bank.

6.10.3 Applicants are ineligible for temporary privileges if they have had:

a. Successful challenge to licensure or registration;

b. Subjection to involuntary termination of medical staff membership at another organization; or

c. Subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

6.10.4 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

6.10.5 Termination of temporary privileges: The Administrator, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may effect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Administrator or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

6.10.6 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

6.10.7 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of Service affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.10.8 Disaster Privileges:

a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the Administrator and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

   A current picture hospital ID card that clearly identifies professional designation;

   A current license to practice;

   Primary source verification of the license;

   Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

   Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

   Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

b. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

c. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

d. The practitioner with disaster privileges must be appropriately identified (i.e., badging).

e. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

f. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for modification of appointment status or privileges

A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category, Service assignment, or clinical privileges by submitting a written request to the medical staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the medical staff office, to the credentials committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate Service Chief or Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of administrative remedies

Every practitioner agrees that s/he will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

7.5 Reporting requirements

The Administrator or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes and any State reporting requirements. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the medical staff and/or patient care responsibilities longer than 30 days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the Chief of Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Chief of Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these bylaws. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Section 9. Practitioners Providing Contracted Services

9.1 Licensed Independent Practitioners

When the hospital contracts for care services with licensed independent practitioners (LIP) who provide readings of images, tracings or specimens through a telemedicine mechanism, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

9.2 Exclusivity policy

Whenever hospital policy specifies that certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the hospital and qualified practitioners, then other practitioners must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

9.3 Qualifications

A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

The terms of the medical staff bylaws will govern disciplinary action taken by or recommended by the MEC.

9.4 Effect of contract or employment expiration or termination

The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

Section 10. Medical Administrative Officers

10.1 A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

10.2 Each medical administrative officer must achieve and maintain medical staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

10.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

10.3.1 Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.

10.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.

10.3.3 A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
MEDICAL STAFF RULES & REGULATIONS RESOLUTION NO. 21-21

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

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

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

Approving the Medical Staff Rules & Regulations 2021.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of May 2021, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

LEWIS COUNTY HOSPITAL DISTRICT NO. 1

MEDICAL STAFF RULES AND REGULATIONS

Contents

MEDICAL STAFF RULES & REGULATIONS

I. ADMISSION AND DISCHARGE OF PATIENTS

1. Lewis County Hospital District No. 1 shall accept patients for care and treatment on the basis of medical need except those patients who cannot be properly cared for by the facilities of this Hospital.

2. Only a member of the Medical Staff who has admitting privileges may admit a patient to the Hospital.

3. A general consent form, signed by, or on behalf of, every patient admitted to the Hospital must be obtained at the time of admission except where an emergency exists. The attending physician must inform the patient of the nature of, and risk inherent in any special diagnostic, treatment, or surgical procedures, as well as complications and alternative treatments. A signed authorization for consent for such procedures shall be part of the patient's permanent medical records.

4. A physician must be responsible for the care of a patient in the hospital and must co-sign the history and physical examination. The attending physician shall be responsible for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the relatives of the patient. Whenever these responsibilities are transferred to another Staff Member, a note covering the transfer of responsibility shall be entered in the medical record.

5. Each physician must assure timely, adequate professional care for his/her patients in the Hospital, being available or having available an eligible alternative practitioner with whom prior arrangements have been made and who has appropriate clinical privileges at the Hospital. It is the responsibility of the Physician or his/her alternate to be available at all times. In the event that the responsible Physician or their alternate cannot be reached, the Medical Director will be notified and may initiate care of the patient.

6. In accordance with 42 C.F.R. § 485.620(b), admissions with a length of stay in excess of 96 hours will be monitored and, on a case,-by-case basis patients will be discharged or transferred in order for the Hospital to remain in compliance with requirements for Critical Access Hospitals.

7. All orders for admission and discharge, care or treatment shall be in writing. A telephone order shall be considered to be in writing if dictated to a nurse and signed by the physician within forty-eight (48) hours. Verbal diagnostic and therapeutic orders are accepted and transcribed by the RN, PT, and RT. Such orders are authenticated by the Practitioner issuing the order within forty-eight (48) hours.

8. All Practitioners with admitting privileges shall be governed by the Medical Staff Bylaws, Rules and Regulations.

9. The admitting Practitioner shall provide all information within his/her knowledge as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatsoever.

10. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

11. Patients who are admitted to the Hospital shall be discharged only on written order of the attending physician or designee. Should the patient leave the Hospital against the advice of the attending physician or without proper discharge, a notation of the incident shall be made in the patient's medical record.

12. A patient who leaves the Hospital of his/her own volition shall be requested to sign a form releasing the Hospital and the attending physician from any responsibility.

13. In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable amount of time.

14. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. In the event of patient death, the coroner will always be contacted. An autopsy can be encouraged by the attending physician but is at the discretion of the coroner. An autopsy may be performed only with a written consent, signed in accordance with state law or in accordance with state mandate. The coroner or his/her designee shall perform all autopsies. Provisional anatomic diagnoses shall be recorded on the medical record within twenty-four (24) hours and the complete protocol should be made a part of the record within four (4) weeks.

15. The attending Practitioner shall comply with the Utilization Management Plan and the hospital's plan to improve performance.

II. CONSULTATIONS

1. It is the responsibility of the Practitioner to seek consultations when indicated. The consultant must be qualified to give an opinion in this service. The consultant's findings and opinions shall be recorded, signed, and become a part of the medical record. The patient may request additional professional opinions, which may not be unreasonably denied.

2. The attending physician is primarily responsible for requesting consultations when indicated and for calling the qualified consultant. Requests for consultations shall be noted in the medical record.

3. When the nurse responsible for patient care believes that any aspect of that patient's care places the patient in jeopardy and is unable to have his/her concerns alleviated by direct discussions with the responsible physician, the nurse will take his/her concerns through the following people in order listed until his/her concerns are alleviated or until remedial action has been taken:

    a. Immediate Nursing Director or Administrative Nurse Supervisor
    b. Chief of Staff
    c. Chief Nursing Officer
    d. Administrator on Call

    Before another physician is contacted, the nurse has the ethical obligation to inform the responsible physician that another physician is going to be contacted.

4. Any qualified Practitioner or Allied Health Professional with clinical privileges in the Hospital may be called for consultation within his/her area of expertise.

5. The nursing staff shall have access to privileges granted to Practitioners and Allied Health Professionals. A copy of these privileges are located in Lucidoc.

6. Except in emergency, consultation with a member of the Active Medical Staff shall be required in:

    a. All major cases in which the patient is at risk.

    b. Cases in which, according to the judgment of the physician:

- ❖ The diagnosis is questionable.
- ❖ There is doubt as to the best therapeutic measures to be utilized.

c. In cases involving criminal action.

The consultant shall make and sign a record of his/her findings and recommendations in every such case.

7. Consultations are recommended at least for the following conditions:

   a. When a patient is not a good risk for operation or treatment.
   b. On all patients, especially critically ill, where the diagnosis is obscure after ordinary diagnostic procedures have been completed or where there is doubt as to the best therapeutic measures to be utilized.
   c. In unusually complicated situations, where specific skills of other Practitioners may be needed.
   d. In instances in which a patient exhibits severe psychiatric symptoms.
   e. When requested by the patient or his/her family.

III. EMERGENCY SERVICES

1. Emergency Services shall be provided twenty-four (24) hours each day. The Emergency Services shall have an elected Medical Director of Emergency Services.

2. The Emergency Department shall be covered by qualified members of the Medical Staff. The Medical Director of Emergency Services shall arrange for Emergency Department coverage schedule. The schedule shall be prepared in advance and be posted at the Hospital reception desk and nurses' station. Changes in the schedule shall be coordinated with the Director of Emergency Services.

3. Every patient who comes to the Hospital on whose behalf a request is made for examination or treatment for a medical condition will be provided a medical screening examination by a physician, using the resources routinely available to the Hospital, to determine whether the individual has an emergency medical condition. If it is determined that the individual has an Emergency Medical Condition, the physician will provide the individual with such further medical examination and treatment, within the capacity of Lewis County Hospital District No. 1, as required to stabilize the medical condition, or to arrange for an appropriate transfer of the individual to another medical facility according to established transfer policies and procedures.

4. Patients requiring admission to the Hospital for an acute Emergency Medical Condition shall be attended by the physician on call.

5. The purpose of the on-call list is to ensure that the Emergency Department is prospectively aware of which physicians are available to provide further treatment necessary to stabilize individuals with emergency medical conditions. If physicians regularly provide a service to the public, the service should be available through on-call coverage.

6. Active staff members of those specialties determined by the Medical Executive Committee are required to participate in the Emergency Department call rotation to cover the service deemed most appropriate. It is expected that members of any given specialty will divide that responsibility in a fair and equitable fashion. In instances where adequate call coverage cannot be achieved by as there are not enough specialists to adequately cover call, the Medical Executive Committee shall determine and impose a reasonable call schedule. If for any reason a physician cannot fulfill on-call duties, it is the physician's responsibility to arrange for an alternate physician and to notify the Emergency Department.

7. It is expected that pages or phone calls to the on-call physician be returned promptly. If there is no response within 30 minutes, attempts may be made to reach another physician within the practice. If unsuccessful, the chief of the respective department will be contacted, followed by the Chief of Staff.

8. Any individual who has been offered, but refuses, a medical screening examination, and any individual who has been offered, but refuses, stabilizing treatment or transfer, shall be asked to sign form(s) acknowledging that they have refused such examination, treatment or transfer. In any event, the refusal shall be documented.

9. No patient may be admitted to the Hospital from the Emergency Department without being evaluated by qualified medical personnel and admitted by a Practitioner with Medical Staff privileges.

10. An appropriate medical record shall be kept for every patient receiving emergency or outpatient services and shall be incorporated into the patient's Hospital record. It is the Practitioner's responsibility to complete the outpatient or emergency room record.

11. There shall be an appropriate system of Peer Review for the care of patients treated in the emergency department.

12. When an admitted patient enters into an acute emergency state and the patient's physician is not available, the Emergency Department physician

shall care for the patient according to his/her own judgment until the patient's physician is available. The physician shall document a summary of the medical care rendered and report to the patient's physician.

13. The emergency room nurse shall have access to privileges granted to Practitioners and Allied Health Professionals. A copy of these privileges are located in Lucidoc.

14. All X-ray, laboratory, and EKG reports shall immediately follow the patient to the nursing floor. Any abnormal findings shall be relayed to the attending physician promptly.

15. A detailed policy and procedure manual for the emergency room is available in Lucidoc for use by the attending physician and nursing staff. A review of this manual shall be acknowledged annually.

IV. GENERAL CONDUCT OF CARE

1. A general consent form, signed by, or on behalf of, every patient admitted to the Hospital must be obtained at the time of admission. A specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure shall be obtained. Written, signed, informed, surgical consent shall be obtained by the physician, prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully desirable before the emergency operative procedure is undertaken if time permits. Should a second operation be required during the patient's stay in the Hospital, a second consent specifically worded should be obtained. If two (2) or more specific procedures are to be carried out at the same time and this is known in advance, they shall be described and consented to on the same form.

2. The practitioner's orders must be in writing. All medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

3. All orders for treatment shall be written/electronic. An order shall be considered written/electronic if dictated to a registered nurse or other authorized person and signed by the attending physician. An admitting

diagnosis shall be recorded in the medical record at the time of the patient's admission.

4. All drugs and medications administered to patients shall be accepted and generally listed in the Hospital formulary or other publications acceptable to the Pharmacy and Therapeutics Committee.

5. Automatic stop orders for narcotics, antibiotics, barbiturates, hypnotics, steroids, tranquilizers and IV therapy shall prevail at 72 hours unless otherwise specified. The nursing staff shall inform the Practitioner of impending expirations of orders. All orders on anti-coagulants and oxytoxics preparations shall be written with specific doses and times to be given.

V. GENERAL PROVISIONS

1. Only Practitioners who have submitted proper credentials and have been duly appointed to membership, on the Medical Staff and Allied Health Professionals who have submitted proper credentials and have been granted privileges may treat patients.

2. Standing orders shall be formulated by conference between the Medical Staff members, nursing and pharmacy. They may be changed only after conference with the Medical Staff. These orders shall be followed in so far as proper treatment of the patient will allow and when specific orders are not written by the attending Practitioner, they shall constitute the orders for treatment. All protocol orders shall be reviewed annually.

3. All X-rays taken shall be interpreted by the Hospital contracted Telemedicine Consulting Radiology group who will submit written, signed reports. The original report of the radiologist is to be affixed to the patient's chart.

4. All electrocardiograms taken shall be interpreted by the attending physician and will be read by the Hospital contracted Telemedicine Consulting Cardiology group. The original report is to be affixed to the patient's chart.

5. All records, X-rays and other documents concerning the patient's care for treatment shall be the property of the Hospital and shall not be removed or electronically transmitted without a court order, subpoena, the permission of the Administrator, or on medical request by the patient. Records may be removed or electronically transmitted from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken or transmitted without permission of the Administrator. In case of readmission of a patient, all previous records shall be available for the use of the attending

Practitioner. This shall apply whether the same Practitioner attends the patient or not. Unauthorized use of charts from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.

6. Copies of the medical records shall be provided for insurance review or on request of peer review or governmental agencies as deemed appropriate.

7. All Hospital records are subject to medical audit as may be required by the Hospital.

8. The Chief of Staff is the spokesperson for the Medical Staff and shall represent the opinion, advice and consent to the Administration and the Governing Body when appropriate.

9. Principles of medical ethics as adopted and amended by the American Medical Association, the American Osteopathic Association, the American Dental Association, and the American Podiatric Medical Association shall govern the professional conduct of the members of the Medical Staff.

10. The Medical Staff, with consultation from the Administrator and the Governing Body, shall designate those physicians who perform specialty Hospital-based services to the Hospital including, but not limited to, clinical and anatomical pathology, radiology, electrocardiogram reading and other consulting services.

VI. MEDICAL RECORDS

1. The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. The record shall be pertinent and current and sufficiently detailed and organized to enable the practitioner responsible for the patient to provide continuing care to the patient, determine later what the patient's condition was at a specific time and review the diagnostic and therapeutics performed and the patient's response to treatment. This record shall include identification data, complaint, past medical history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, and autopsy report if performed.

2. A complete admission history and physical examination shall be recorded. This report shall include the chief complaint, details of present illness,

relevant past, social and family histories, inventory of body systems, comprehensive current physical assessment and a statement of the course of action planned for the patient while in the Hospital. When recording an outpatient assessment details of present illness is necessary.

3. A history and physical must be present on the chart or dictated prior to surgery or any potentially hazardous diagnostic procedure with a covering admit note on the chart. A lack of a current history and physical shall cause the surgery or any potentially hazardous diagnostic procedure to be cancelled unless the attending physician states in the medical record that such delay would be detrimental to the patient. However, the history and physical shall be recorded promptly after the surgery has been completed.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of test and treatment. Progress notes shall be recorded daily.

5. Operative reports shall include:
    a. name and hospital identification number of the patient,
    b. date and times of the surgery,
    c. the name of the surgeon(s) who performed the procedure and any assistants and a description of their tasks,
    d. the pre-operative and post-operative diagnoses,
    e. the name of the procedure performed,
    f. the type of anesthesia administered,
    g. description of techniques, findings, and tissues removed or altered,
    h. complications, if any,
    i. any estimated blood loss, and
    j. any prosthetic devices, transplants, grafts, or tissues implanted).

    Operative reports shall be dictated or written in the medical record immediately after surgery and contain:
    a. The surgeon and assistants;
    b. Pre-operative and post-operative diagnosis;
    c. Procedures performed;
    d. Specimens removed;
    e. Estimated blood loss (specify N/A if no blood loss);
    f. Complications (if any encountered);
    g. Type of anesthesia administered; and,
    h. Grafts or implants (may indicate where in chart for detail, if any).

6. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations, so verified on the record, be recorded prior to the operation.

7. All clinical entries in the patient's medical record shall be accurately dated and authenticated. Authentication means to establish authorship by written/electronic signature and identifiable initials. A legend of signatures and initials will be maintained on file in the medical record department.

8. Symbols and abbreviations may be used only if they are not on the list of unapproved abbreviations. An official record of unapproved abbreviations should be kept on file in Lucidoc.

9. Final diagnosis and complications must be documented without unapproved abbreviations, symbols and acronyms and shall be dated and signed by the responsible Practitioner in a timely manner.

10. A discharge clinical summary shall be documented all medical records. Conclusions at the termination of hospitalization shall be recorded in a discharge summary on all patients hospitalized over twenty-four (24) hours or a short stay form in the case of patients who require less than twenty-four (24) hours of hospitalization. In all instances, the content of the medical record shall be sufficient justify the diagnosis and warrant the treatment and end result. The responsible Practitioner shall authenticate all summaries. The discharge summary shall include the provisional diagnosis or reason(s) for admission, the principal and secondary diagnoses, and clinical résumé. The clinical résumé concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed, and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, are recorded, using acceptable disease and operative terminology.

11. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and/or audits consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

12. A medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Chief of Staff in accordance with Medical Records Department policy.

13. All medical records shall be completed on a timely basis. The patient's medical record shall be completed within seventy-two (72) hours of discharge of the patient, including the final diagnosis, and dictated discharge summary. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart shall be available in the medical records department for thirty (30) days after discharge. If three or more records remain incomplete sixty (60) days after the essential reports have been received and placed on record, they shall be considered delinquent, and the Administrator shall notify the Practitioner by letter that his/her privileges to admit patients or provide any other professional services shall be automatically suspended five (5) days after written notice. The suspension shall remain in effect until all records have been completed. Charts that accumulate during vacation time or because of personal or family hardships shall be exempt until the physician has returned to normal practice. The suspension shall not be applied capriciously, and reasonable efforts of progress shall be considered by the Administrator. The admitting department, nursing station and other affected departments shall be notified of any suspension of privileges. Any Practitioner with privileges suspended three (3) or more times in one calendar year shall be addressed by the Medical Executive Committee of the medical staff. Approval of these Rules and Regulations by the Governing Body shall be deemed to confer such power to suspend privileges upon the Administrator and no notice of such action need be furnished the Governing Body, nor is any additional action required of them.

14. The Practitioner may continue to treat their patients who were admitted prior to suspension. In the event of an emergency where the life of the patient may be endangered, a suspended Practitioner will be allowed to admit the patient regardless of suspension of privileges.

15. Information and certifications required by the third-party payors and other reviewing agencies is considered part of the patient's medical record and is subject to the completion by the Practitioner on a timely basis.

16. Incomplete charts of patients whose attending Practitioners have permanently moved away or are unable to complete the charts because of incapacitating illness or death shall be handled according to Medical Record Department policy.

17. Progress notes shall be documented given a pertinent chronological report of the patient's course in the Hospital and reflect any change in condition and the

results of treatment. Pertinent progress notes are also made by individuals so authorized by the medical staff.

18. The history and physical documented by an Allied Health Professional must be authenticated and cosigned by the Practitioner responsible for the patient.

VII. OUTPATIENT SURGERY

1. Adequate accommodations for patients who require interim nursing care during medical or surgical treatment an/or diagnostic procedures on a short stay basis will be provided.

2. Scheduling of short stay and outpatient surgery shall be the responsibility of the attending Practitioner in conjunction with the surgery scheduler.

3. The admission and discharge of patient's outpatient surgery shall be in accordance with Medical Staff Rules and Regulations, Section I.

4. Services of all departments of the Hospital shall be available to the patient as ordered by the attending Practitioner and be rendered on a scheduled basis, except for emergencies.

5. A permanent medical record of the patient's care and treatment shall be kept in accordance with the criteria established by the Medical Records Department.

VIII. PATIENT TRANSFERS

1. Policies, rules and regulations governing patient transfers shall be the responsibility of the Medical Staff and can be found in Lucidoc.

IX. SURGICAL CARE

1. Policies, rules and regulations governing the use of the Operating Room will be the responsibility of the Surgical Department. The Surgical Department will adopt and revise such rules as are necessary to insure the proper utilization of the operating room and the provision of high-quality care. Medical staff members using the Operating Room will abide by such rules.

2. A qualified anesthetist shall examine each patient before surgery to evaluate the risk of anesthesia and shall evaluate each patient prior to discharge for proper anesthesia recovery. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post anesthetic follow-up of

the patient's condition. A post-anesthesia note, which must be done within forty-eight (48) hours of discontinuation of anesthesia and must include:

a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
b. Cardiovascular function, including pulse rate and blood pressure;
c. Mental status;
d. Temperature;
e. Pain;
f. Nausea and vomiting; and,
g. Postoperative hydration. Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary).

3. All tissues requiring histopathological evaluation, removed at operation, shall be sent to a pathologist who shall make such examination, as he/she may consider necessary to arrive at a pathological diagnosis. Identification, including pertinent information relative to the case, shall accompany the specimen. The pathologist's report shall be made a part of the patient's medical record.

4. Elective surgery cases shall be admitted the day of surgery. Short stay cases, with laboratory and admitting procedures previously completed, may be admitted by 6 AM on the day of the surgery.

5. The operating surgeon shall have a qualified assistant at all major operations consisting of removal of a major appendage, radical breast, or entering a closed body cavity.

6. Sterilization procedures may be performed only with proper patient consent in accordance with applicable law and when deemed to be in the best interest of the patient by the attending physician.

7. It is the responsibility of the surgeon to be in the operating room and ready to commence at the time scheduled.

8. Female patients of childbearing capabilities undergoing any surgical procedure must have a pregnancy test within seven (7) days prior to surgery.

9. The operating surgeon or his/her designee shall be responsible for post operative orders and care unless the operating surgeon has designated in the medical record, a physician to assume responsibility for specific portions of postoperative care.

10. For all cases performed by a board-eligible or board-certified surgeon or surgical specialist, the necessity for and the type of assistant shall be at the discretion of the operating surgeon.

X. CONDUCT

1. Policies, rules and regulations governing Medical Staff conduct will be the responsibility of the Medical Staff. Conduct policies will include:
    a. Drug and Alcohol Impairment Free Policy
    b. Impairment
    c. Rehabilitation and Reinstatement
    d. Disruptive Conduct
    e. Anti-Harassment

XI. ORGANIZATION AND FUNCTIONS

1.1 Organization of the Medical Staff

The medical staff shall be organized as a non-departmentalized staff including the Services of Emergency Medicine, Primary Care and Surgery. A Service Chief shall head each Service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the MEC having ultimate responsibility. The MEC may create committees to perform certain prescribed functions. The medical staff officers, Service Chiefs, and hospital and medical staff committee chairs, are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports as appropriate to the appropriate Service or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

The medical staff, acting as a whole or through committee, is responsible for the following activities:

1.3.1 Governance, direction, coordination, and action

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members when warranted;

d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the medical staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and Board; and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:

Medical assessment and treatment of patients

Use of medications

Use of blood and blood components

Operative and other procedures

Education of patients and families

Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations

Appropriateness of clinical practice patterns

Significant departures from established pattern of clinical performance

Use of developed criteria for autopsies

Sentinel event data

Patient safety data

Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient

Findings of the assessment process relevant to individual performance; and

d. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.3.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the medical staff's and administration's approach to and methods of performance improvement;

b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and

d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Credentials review (see Part III: Credentials Procedures Manual)

1.3.5 Information Management

a. Review and evaluate medical records to determine that they:

Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

b. Develop, review, enforce, and maintain surveillance over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, and recommend methods of enforcement thereof and changes therein; and

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.6 Emergency Preparedness

Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

1.3.7 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.3.8 Bylaws review

a. Conduct periodic review of the medical staff bylaw, rules, regulations and policies; and

b. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations and policies.

1.3.9 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; and

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 Infection Control Oversight

a. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

b. Develop and approve policies describing the type and scope of surveillance activities including:

Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections;

Review of prevalence and incidence studies, as appropriate; and

Collection of additional data as needed.

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and

h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.11 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by the Joint Commission;

f. Perform practitioner analysis related to medication use;

g. Approve policies and procedures related to the Joint Commission Provision of Care, Treatment, and Services Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

h. Develop and measure indicators for the following elements of the patient treatment functions:

Prescribing/ordering of medications;

Preparing and dispensing of medications;

Administrating medications; and

Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications; and

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 Practitioner Health

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental or, physical conditions or similar problems affecting the practitioner's competency. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;

b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

c. Notify the impaired practitioner's Service Chief and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the Practitioner Health Committee does not alter the primary responsibility of the department chair for clinical performance within that chair's department;

d. Create opportunities for referral (including self referral) while maintaining confidentiality to the greatest extent possible; and

a. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

1.3.13 Utilization Management

a. Study recommendations from medical staff members, quality assessment coordinators and others to identify problems in utilization and the review program;

b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

c. Forward all unjustified cases in any review category to the appropriate clinical department or committee for review and action;

d. Review case-mix financial data and any other internal/external statistical data;

e. Upon review of any data, conduct further studies, perform education or refer the data to the medical staff Medical Executive Committee for their review and action;

f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, medical staff, and administration in matters of privileged communication and legal release of information.

1.4 Responsibilities of Service Chiefs

a. To oversee all clinically-related activities of the Service;

b. To oversee all administratively-related activities of the Service, unless otherwise provided by the hospital;

c. To provide ongoing surveillance of the performance of all individuals in the medical staff Service who have been granted clinical privileges;

d. To give input to the credentials committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff Service;

e. To give input to the credentials committee regarding the clinical privileges for each member of the Service and other licensed independent practitioners practicing with privileges within the scope of the Service ;

f. To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services;

g. To continually assess and improve of the quality of care, treatment, and services;

h. To maintain quality control programs as appropriate;

i. To ensure orient and continuously education of all persons in the Service; and

j. To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff department to provide patient care services.

1.5 Responsibilities of the Chief of Staff

1.5.1 The Chief of Staff is the primary elected officer of the medical staff and is the medical staff's advocate and representative in its relationships to the Board and the administration of the hospital. The Chief of Staff, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules, regulations and policies. Specific responsibilities and authority are to:

b. Call and preside at all general and special meetings of the medical staff;

c. Serve as chair of the MEC and as ex officio member of all other medical staff committees without vote, and to participate as invited by the Administrator or the Board on hospital or Board committees;

d. Enforce medical staff bylaws, rules, regulations and medical staff/hospital policies;

e. Except as stated otherwise, appoint committee chairs and all members of medical staff standing and ad hoc committees; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees or to serve as medical staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

f. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;

g. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

h. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

i. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

j. Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

k. Attend Board meetings and Board committee meetings as invited by the Board;

l. Ensure that the decisions of the Board are communicated and carried out within the medical staff; and

m. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws.

2.1 General language governing committees

The following shall be the standing committees of the medical staff: Medical Executive Committee and Credentials Committee. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The Chief of Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the Chief of Staff when establishing the committee. The Chief of Staff and the Administrator, or their designees, are ex officio members of all standing and ad hoc committees.

Medical staff members may be assigned to hospital committees. Any action taken at a hospital committee that affects the practice of those with privileges must have that action approved by the Medical Executive Committee.

Committee members may be removed from the committee by the Chief of Staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

2.2 MEC (medical staff committee)

Description of the MEC is in Part I: Governance; Section 6.2. The MEC also oversees the peer review function as performed by outside authority

2.3 Credentials Committee (medical staff committee)

Description of the credentials committee is in Part III: Credentials Procedures Manual; Section 1.

2.4 Pharmacy and Therapeutics Committee (hospital committee)

i. Composition: The pharmacy and therapeutics committee shall consist of at least one (1) medical staff member. The Administrator shall appoint the hospital representatives to the committee.

ii. Responsibilities: The committee shall be responsible for those functions described in section 1.3.11 above.

2.5 Infection Control Committee (hospital committee)

iii. Composition: The infection control committee shall consist of at least one (1) practitioner who serves as a liaison to the committee. The Administrator shall appoint the hospital representatives to the committee.

iv. Responsibilities: The committee shall be responsible for those functions described in section 1.3.10 above.

2.6 Bylaws Committee (medical staff ad hoc committee)

v. Composition: The bylaws committee shall consist of at least one (1) member of the medical staff.

vi. Responsibilities: The committee shall be responsible for those functions described in section 1.3.8 above.

2.7 Utilization Review/Medical Records and Tissue and Transfusion Committee (hospital committee)

vii. Composition: The utilization review/medical records and tissue and transfusion committee shall consist of at least one (1) medical staff member. The Administrator shall appoint the hospital representatives to the committee.

viii. Responsibilities: The committee shall be responsible for those functions described in sections 1.3.5 and 1.3.13 above.

2.8 Ethics Committee (hospital committee)

2.8.1 Composition: The ethics committee shall consist of at least two (2) medical staff members. The Administrator shall appoint the hospital representatives to the committee.

2.8.2 Responsibilities/Purpose: This committee shall be responsible for those functions described in section 1.3.1.h above.

2.9 Practitioner Health Committee (medical staff ad hoc committee)

2.9.1 Composition: The Medical Executive Committee serves as this committee.

2.9.2 Responsibilities: This committee shall be responsible for those functions described in section 1.3.12 above.

2.10 Nominating Committee (medical staff ad hoc committee)

2.10.1 Composition: The Medical Executive Committee serves as this committee.

2.10.2 Responsibilities: The committee shall provide an annual slate of nominees for the elected medical staff positions.

3.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or medical staff unless done in a willful and wanton manner. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

3.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

a. Applications for appointment/affiliation, clinical privileges, or specified services;

b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

e. Quality assessment and performance improvement/peer review activities;

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities; and

i. Other hospital, committee, department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

When requested by the Chief of Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the medical staff requested to perform a board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the provider under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case-by-case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

ADOPTION

These Medical Staff Rules and Regulations have been adopted by the Active Medical Staff of Lewis County Hospital District No. 1 on May 15, 2021 and shall become effective when approved by the Board of Commissioners:

mark hansen
mark hansen (May 17, 2021 11:34 PDT)

Chief of Staff: Mark Hansen, MD — May 17, 2021 — Date

Kevin McCurry, MD (May 17, 2021 11:39 PDT)

Secretary: Kevin McCurry, MD — May 17, 2021 — Date

Leianne Everett
Leianne Everett (May 17, 2021 11:41 PDT)

Chief Executive Officer: Leianne Everett — May 17, 2021 — Date

Medical Staff Rules Regulations 2021

Final Audit Report 2021-05-17

Created:	2021-05-12
By:	Shana Garcia (Sgarcia@mortongeneral.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAQ9N5JTQI5L0wkN5eVP30ksikC2mkIcdS

"Medical Staff Rules Regulations 2021" History

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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
PURCHASE OF THE CERNER PHARMACY
CLINICAL SURVEILLANCE SOFTWARE RESOLUTION NO. 21-22

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

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

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

Approving the purchase of the Cerner Pharmacy Clinical Surveillance Software.

The purchase price is $47,600.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of May 2021, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

MEMORANDUM

To: Finance Committee

From: Don Roberts, Pharmacist

Date: May 6, 2021

Re: Cerner *Pharmacy Clinical Surveillance* Software

Congruent with best practices as defined by the America Society of Health System Pharmacists, the Clinical Pharmacist is tasked with surveying all patients' medical records for potential problems with medications. With a goal to deliver the most effective drug regimen and minimize error, these comprehensive reviews function to ensure not only the correct dose and route but to also assess for

- food/drug interactions,
- drug/drug interactions,
- allergies,
- drug appropriateness to lab and microbiology findings,
- drug dosing appropriate to clinical and lab findings,
- congruence with antibiotic stewardship metrics and evidence-based guidelines, and
- alignment with a patient's home medication regimen.

Patient assessment/reassessment data in a hospital setting is very fluid and dynamic and based on multiple ongoing clinical interventions, some or all these data can shift significantly within a day, an hour, or minutes. Errors, oversights, or delays in aligning these dynamic data elements, can result in medical complications, prolonged hospitalizations, and/or loss of life or limb. Manual management of these variables is not only labor intensive but is rife for potential error.

The Cerner *Pharmacy Surveillance Program* facilitates this process with greater speed and accuracy as it resides within our Cerner electronic medical record (EMR). Through various software algorithms between Cerner's integrated pharmacy, medication, laboratory, and nursing modules, the *Pharmacy Surveillance Program* rapidly analyzes data with a high level of accuracy that far exceeds that of a manual review.

The *Pharmacy Surveillance Program* further provides a catalogue of rules from which the pharmacist can choose to target specific areas of need in detecting problems. The program then searches for similar problems throughout the entire patient population based on these evidence-based rules. It also provides a real time collaboration between nursing, pharmacy, lab, and medicine resulting in more timely multidisciplinary treatment interventions.

Additionally, it automates regulatory reporting requirements such that the reports are more accurate and timelier.

Three vendors were reviewed to meet this service requirement. Following is pricing structure for each vendor:

	CareFusion	Cerner	Wolters Kluwer
Setup cost	$0	$44,180	0
Monthly	$4,234	$57	$2,600
Term of Contract	60 months	monthly	60 months
5-year cost of usage/ownership	$254,040	$47,600	$156,000

Documents Awaiting Board Ratification 05.26.21		
	LCHD No. 1's Policies, Procedures & Contracts:	Departments:
1	ADP Master Services Agreement-Employee Engagement	Information Technology Services Agreement
2	ANESTHESIA APPARATUS CHECKOUT RECOMMENDATIONS	Anesthesia Services
3	ANESTHESIA RESPONSIBILITIES IN PACU	Anesthesia Services
4	Admission of Bariatric Patient	Department of Nursing
5	Admission to Skilled Swing Bed after Discharge from Inpatient	Skilled Swing
6	Adverse Events	Quality
7	Assessment Of The Emergency Department Patient	Emergency Preparedness
8	Bedside Shift Report	Department of Nursing
9	C013: Trayline/Taste/Temperature Record	Nutrition Services
10	C019: Nourishments, Patient Specific	Nutrition Services
11	C10: Tray Identification/Delivery/Pick-Up	Nutrition Services
12	C12: Nursing Unit Stock	Nutrition Services
13	C20: Test Tray Evaluation	Nutrition Services
14	CBC: Pre-Warm Technique for Cold Agglutinin	Hematology
15	COMPLETION OF ANESTHESIA RECORD SHEET	Anesthesia Services
16	CT Contrast Injection Procedure	Radiology/Medical Imaging
17	Cardiac Arrest - Code Blue	Department of Nursing
18	Care and Condition of Patient in OR	Surgery
19	Care of Law Enforcement Patients	Department of Nursing
20	Circulating Nurse Responsibilities	Surgery
21	Coroner's Cases	Case Management
22	Critical Results Notification	Radiology/Medical Imaging
23	D1 A:Nutrition Care Manual Review	Nutrition Services
24	DUTIES AND RESPONSIBILITIES OF CERTIFIED REGISTERED NURSE ANESTHETIST (C.R.N.A.)	Anesthesia Services
25	Darren Freeman, ARNP Employment Agreement	Professional Services Agreement

26	Diagnostic Contrast Reaction Care	Radiology/Medical Imaging
27	Discharge Criteria - Surgery	Surgery
28	Discharge Planning Skilled Patient	Non-Skilled Swing
29	Disclosure of Medical Errors or Events	Quality
30	Dr. Robert Williams - JT Consulting	Professional Services Agreement
31	EMERGENCY DEPARTMENT INFORMATION EXCHANGE	Emergency Services
32	Emergency Uncrossmatched Blood	Blood Bank
33	End of Life Care	DOH Policies & Procedures
34	Environmental Services Department Procedure Guide	Facility Support
35	Gastric Occult Blood And pH POC Testing	Department of Nursing
36	Hemoccult Point Of Care Testing	Department of Nursing
37	Incident Reporting (AKA Quality Management Memo (QMM))	Quality
38	Information Blocking of Electronic Health Information	Health Information Management
39	Interdisciplinary Team Rounds	Case Management
40	Job Descriptions/Performance Evaluations	Human Resources
41	Laboratory Chemical Hygiene Plan	Lab General Policies/Procedures
42	Lake Washington Institute of Technology Affiliation Agreement	Affiliation Agreements
43	Mammography EQUIP QA Program	Radiology/Medical Imaging
44	Medical Staff Conduct Policy	Medical Staff
45	Medicare Advance Beneficiary Notice Procedure (ABN)	Compliance
46	Nuclear Medicine Linens and Patient Waste	Radiology/Medical Imaging
47	Nurse Initiated Protocol - Fever Management	Emergency Services
48	Operating/Procedure Room Guidelines For Imaging Services	Radiology/Medical Imaging
49	Organ And Tissue Donation	Case Management
50	PNWU Clinical Internship Agreement-School of Physical Therapy	Affiliation Agreements
51	Patient Health Education	Clinics
52	Patient Personal Belongings	Department of Nursing

53	Patient Rights & Responsiblities-Swing Bed	Swing Beds
54	Patient Rights and Responsibilities	Department of Nursing
55	Patient Teaching	Department of Nursing
56	Patient Transfer Policy	Medical Staff
57	Peer Review for Medical Staff	Medical Staff
58	Polysomnology Staff	Sleep Center
59	Post Anesthesia Care Unit (PACU)	PACU
60	Post-Operative Complications, Physician Availability	Medical Staff
61	Pregnancy Urine POC Testing	Department of Nursing
62	Recruitment, Selection and Onboarding	Human Resources
63	Reporting of Alleged Abuse	Department of Nursing
64	Safe Place for Newborns/Abandonment of Newborns	Emergency Services
65	Skilled Comprehensive Care Plan	Non-Skilled Swing
66	Stocking & Cleaning of Anesthesia Machine	Anesthesia Services
67	Suture Removal	Emergency Services
68	Transfusion Reaction Investigation	Blood Bank
69	Trauma Audit	Emergency Services
70	Urinalysis by Clinitek Status	Department of Nursing
71	Visitation Policy Notice	Administration
72	hCG Test for serum/urine	Serology

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

OLD BUSINESS

NEW BUSINESS

AMENDED AND RESTATED BYLAWS OF
LEWIS COUNTY HOSPITAL DISTRICT NO. 1
(Revision date – 05/26/21)

MORTON, WASHINGTON

ARTICLE I

FORMATION AND PURPOSE

This public hospital district (the "District"), a municipal corporation, was created in 1978 to provide hospital services for the residents of the District and other persons. The activities of the District shall be conducted in conformity with the Constitution and laws of the State of Washington, including RCW 70.44 and RCW 42.30, as now in effect and hereafter amended. These bylaws are adopted to further the lawful purposes of the District, which include providing quality hospital and other health care services appropriate to the needs of the population served, and to facilitate the governing of the District's hospital, clinics, emergency care, swing beds and other health care facilities, which shall be operated in compliance with applicable law and regulations. These bylaws shall be reviewed by the District at least once every two years and revised as appropriate.

ARTICLE II

BOARD OF COMMISSIONERS

Section 1. Qualification and Election. No person shall be eligible to be elected to the office of public hospital district commissioner unless he or she is a registered voter residing within the boundaries of the district and, if applicable, within the commissioner district from which he or she is elected. All district commissioners shall be elected and serve, whether from a particular commissioner district or at large, in the manner and for the term prescribed by law. All members of the board of commissioners (the "Board" or the "Commission"), whether elected or appointed, shall be required to take an oath of office in the form prescribed by the laws of the State of Washington relating to public officials. RCW 29A.04.133; RCW 70.44.040(2).

Section 2. Organization and Offices of the Board of Commissioners. The Board shall by its first regular meeting in each calendar year organize by the election of, from its own members, a president, who shall be referred to as the Chair, and the Secretary, such election to be by a majority vote of the commissioners in each case. The terms of both officers shall be for one year. RCW 70.44.050.

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2.1 Board Chair. The Board Chair shall act as the presiding officer at meetings of the Board.

2.2 Secretary. The Secretary shall prepare, or cause to be prepared, minutes of all regular and special meetings of the board, shall sign the same and shall keep or cause them to be kept in document management system for that purpose. In the absence of the Board Chair, the Secretary or designee may preside at board meetings. RCW 42.30.035.

2.3 Absence of Chairperson and Secretary. If neither the Board Chair nor the Secretary are present, a designee will be appointed by the Board Chair.

2.4 Officer Vacancy. If a vacancy occurs in the office of either the Board Chair or the Secretary, an election of officers shall take place at the next regular meeting of the board to fill the unexpired term created by the vacancy.

2.5 Commissioner Vacancy. A vacant commissioner position may be filled by the board appointing a new member in the manner prescribed by law. RCW 42.12.070; RCW 70.44.045.

2.6 Forfeiture. A commissioner shall forfeit his or her office by non-attendance at meetings of the commission for 60 days, unless excused by the commission or as otherwise provided in RCW 42.12.010. RCW 70.44.045.

Section 3. Meetings of the Board of Commissioners.

3.1 All Meetings. All meetings of the Board shall be open and public in compliance with the Open Meetings Act, Chapter 42.30 RCW, and all persons shall be permitted to attend any meeting of the Board, except as otherwise provided by law. RCW 42.30.030. In the event that any meeting is interrupted by a group or groups of persons so as to render the orderly conduct of such meeting unfeasible, and order cannot be restored by the removal of individuals who are interrupting the meeting, the board may order the meeting room cleared and continue in session or may adjourn the meeting and reconvene at another location selected by majority vote of the board. In such a session, final disposition may be taken only on matters appearing on the agenda. Representatives of the press or other news media, except those participating in the disturbance, shall be allowed to attend any session held pursuant to this section. Nothing in this section shall prohibit the board from establishing a procedure for readmitting an individual or individuals not responsible for disturbing the orderly conduct of the meeting. RCW 42.30.050.

3.2 Regular Meetings. The Board shall provide the time for holding regular meetings by resolution. Unless otherwise provided for by law, meetings of the board need

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not be held within the boundaries of the district. If at any time any regular meeting falls on a holiday, such regular meeting shall be held on the next business day or as determined by a vote of the Board. RCW 42.30.070. For the purposes of this section "regular" meetings shall mean recurring meetings held in accordance with a periodic schedule declared by resolution of the Board from time to time. The Board must make the agenda of each regular meeting of the governing body available online no later than twenty-four hours in advance of the published start time of the meeting. RCW 42.30.077.

3.3 Special Meetings. A special meeting may be called at any time by the Board Chair or by a majority of the members of the Board by delivering written notice personally, face to face, by phone, by mail, by fax, or by electronic communication to each member of the governing body. Notice of the special meeting shall be completed by any of the following: emailed to newspapers of general circulation of the District or to local radio or television station which are on file with the governing body a request to be notified of such special meeting or of all special meetings; posted on the Board's website, displayed on hospital or clinic readerboards and the meeting site if not at the principal location. Such notice must be delivered personally, by mail, by fax, by phone or by electronic communication at least twenty-four hours before the time of such meeting as specified in the notice. The notice shall specify the time,place of the special meeting either in person or virtual and the business to be transacted. The Board shall not take final disposition on any other matter at such meetings. Such notice may be dispensed with as to any member who at or prior to the time the meeting convenes files with the Secretary a written waiver of notice. Such waiver may be given by fax or electronic communication. Such written notice may also be dispensed with (i) as to any member who is actually present at the meeting at the time it convenes or (ii) as to any member who, prior to the time the meeting convenes, receives notice of the meeting by email and files a written consent to receive meeting notices by email. RCW 42.30.080.

3.4 Budget Hearing. The Superintendent shall prepare a proposed budget for the ensuing year and file the same in the records of the commission on or before the first day of November. Notice of the date and time of the budget hearing must be published for at least two consecutive weeks at least one time each week in a newspaper printed and of general circulationof the District. On or before the 15th day of November of each year, the board shall hold a public hearing on the district's proposed budget for the following year at which hearing any taxpayer may appear and be heard against the whole or any part of the proposed budget. Upon conclusion of the hearing, the commission shall, by resolution, adopt the budget as finally determined and fix the final amount of expenditures for the ensuing year. RCW 70.44.060 (6).

3.5 Emergency Meetings. If by reason of fire, flood, earthquake or other emergency, there is a need for expedited action by the Board to meet the emergency, the Board Chair may provide for a meeting site other than the regular meeting site and the

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notice requirements of these bylaws shall be suspended during such emergency. RCW 42.30.070. The meeting notices required by these bylaws and chapter 42.30 RCW may be dispensed with in the event a special meeting is called to deal with an emergency involving injury or damage to persons or property or the likelihood of such injury or damage, when time requirements of such notice would make notice impractical and increase the likelihood of such injury or damage. RCW 42.30.080.

3.6 The Order of Business. Meetings of the commission shall be as follows:

a. **Regular Meetings**

- Call to Order
- Roll Call
- Reading the Mission & Vision Statements
- Approval or Amendment of Agenda
- Conflicts of Interest
- Comments and RemarksExecutive Session as necessary
- Guest Speaker as necessaryDepartment Updates as necessary
- Board Committee Reports
- Consent Agenda – The Consent Agenda may include minutes of regular and special board meetings, minutes of board committees, and monthly warrants. Any board member or the Superintendent may request an item be removed from the consent agenda and placed as a separate item.
- Old Business
- New Business
- Superintendent's Report
- Executive Session as Necessary
- Meeting Summary & Evaluation
- Next Meeting Dates and Times
- Adjournment

b. **Special Meetings**

- Call to Order
- Roll Call
- Reading the Mission & Vision Statements
- Conflicts of Interest
- Reading of the Notice of Special Meeting
- Executive Session or Sessions as necessary
- Public Comment as necessary
- Consideration of Matters Stated in the Notice

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Moved up [1]: <#>Executive Session as Necessary¶

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Quality Improvement Oversight Committee¶
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Strategic Planning Committee¶
Governance Committee¶
Hospital Foundation Report¶
Resolution Review Committee¶
Compliance Committee¶

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- Action as necessary
- Adjournment

Section 4. Action by the Board. "Action" means the transaction of the official business of the Board including but not limited to receipt of public testimony, deliberations, discussions, considerations, reviews, evaluations, and final actions. "Final action" means a collective positive or negative decision, or an actual vote by a majority of the members of the board sitting as a body or entity, upon a motion or resolution. RCW 42.30.020(3). All proceedings of the Board shall be by motion or resolution recorded in the District's document management system. RCW 70.44.050. Minutes of all regular and special meetings, except executive sessions thereof, shall be promptly recorded and shall be open to public inspection. RCW 42.32.030. The Board shall not adopt any motion, resolution, rule, regulation, or directive, except in a meeting open to the public and then only at a meeting, the date of which is fixed by law or rule, or at a meeting of which notice has been given. Any action taken at meetings failing to comply with the provisions of this section shall be null and void. RCW 42.30.060(1). The Board shall not vote by secret ballot. Any vote taken in violation of this section shall be null and void and shall be considered an "action" within the meaning of this section and the Open Public Meetings Act, Chapter 42.30 RCW. RCW 42.30.060(2).

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It shall not be a violation of the requirements of the Open Public Meetings Act, Chapter 42.30 RCW, or these bylaws for a majority of the members of the board to travel together or gather for purposes other than a "regular meeting" or a "special meeting" as these terms are defined in the Open Public Meetings Act, Chapter 42.30 RCW, and these bylaws; provided, that they take no "action" as defined in this in the Open Public Meetings Act, Chapter 42.30 RCW, and these bylaws. RCW 42.30.070.

Section 5. Executive Sessions. Nothing contained in these bylaws may be construed to prevent the Board from holding an executive session during a regular or special meeting. RCW 42.30.110(1).

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Before convening in executive session, the Board Chair shall publicly announce the purpose for excluding the public from the meeting place, and the time when the executive session will be concluded. The executive session may be extended to a stated later time by announcement of the Board Chair or of a designee. RCW 42.30.110(2).

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An executive session may be held only for one or more of the purposes identified below or as otherwise permitted by RCW 42.30.110(1) or other applicable law:

a. To consider matters affecting national security;
b. To consider, if in compliance with any required data security breach disclosure under RCW 19.255.010 and 42.56.590, and with legal counsel available,

information regarding the infrastructure and security of computer and telecommunications networks, security and service recovery plans, security risk assessments and security test results to extent that they identify specific system vulnerabilities, and other information that if made public may increase the risk to the confidentiality, integrity, or availability of agency security or to information technology infrastructure or assets;

c. To consider the selection of a site or the acquisition of real estate by lease or purchase when public knowledge regarding such consideration would cause a likelihood of increased price;

d. To consider the minimum price at which real estate will be offered for sale or lease when public knowledge regarding such consideration would cause a likelihood of decreased price. However, final action selling or leasing public property shall be taken in a meeting open to the public;

e. To review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs;

f. To receive and evaluate complaints or charges brought against a public officer or employee. However, upon the request of such officer or employee, a public hearing or a meeting open to the public shall be conducted upon such complaint or charge;

g. To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee. However, subject to RCW 42.30.140(4), discussion by a governing body of salaries, wages, and other conditions of employment to be generally applied within the agency shall occur in a meeting open to the public, and when a governing body elects to take final action hiring, setting the salary of an individual employee or class of employees, or discharging or disciplining an employee, that action shall be taken in a meeting open to the public;

h. To evaluate the qualifications of a candidate for appointment to elective office. However, any interview of such candidate and final action appointing a candidate to elective office shall be in a meeting open to the public;

i. To discuss, with legal counsel representing the district, litigation or potential litigation to which the district, the board, or a member acting in an official capacity is, or is likely to become, a party, when public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the district; provided, however, this exception does not permit the board to hold an executive

session solely because an attorney representing the district is present. For purposes of this exception, "potential litigation" means matters protected by RPC 1.6 or RCW 5.60.060(2)(a) concerning: (A) litigation that has been specifically threatened to which the district, the board, or a member acting in an official capacity is, or is likely to become, a party; (B) litigation that the district reasonably believes may be commenced by or against the district, the board, or a member acting in an official capacity; or C) litigation or legal risks of a proposed action or current practice that the district has identified when public discussion of the litigation or legal risks is likely to result in an adverse legal or financial consequence to the district;

j. To conduct meetings, proceedings, and deliberations of the board, its staff or agents, concerning the granting, denial, revocation, restriction, or other consideration of the status of the clinical or staff privileges of a physician or other health care provider as that term is defined in RCW 7.70.020, if such other providers at the discretion of the board is considered for such privileges;
provided that the final action of the board as to the denial, revocation, or restriction of clinical or staff privileges of a physician or other health care provider as defined in RCW 7.70.020 shall be done in public session. RCW 42.30.110; RCW 70.44.062; and;

k. To conduct collective bargaining sessions with employee organizations, including contract negotiations, grievance meetings, and discussions relating to the interpretation or application of a labor agreement; or to conduct that portion of a meeting during which the governing body is planning or adopting the strategy or position to be taken by the governing body during the course of any collective bargaining, professional negotiations, or grievance or mediation proceedings, or reviewing the proposals made in the negotiations or proceedings while in progress.

l. To review the report or the activities of a quality improvement committee established under RCW 70.41.200.

Section 6. Quorum. A majority of the persons holding the office of district commissioner shall constitute a quorum of the Board for the transaction of business, but no resolution shall be adopted without a majority vote of the whole Board. RCW 70.44.050.

Section 7. Committees and Representatives. The Board may from time to time act as a committee of the whole or appoint such other committees, as it may deem necessary or advisable in the conduct of its affairs. The Board may from time to time

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choose to change committee appointments as needed. The activities of any committees so appointed shall be conducted lawfully and be recorded in written minutes. The Board Chair shall recommend to the board a commissioner as Board Chair of such committees to serve for terms not to exceed one year. The Superintendent will appoint an administrative staff person to support each board committee. Committees of the Board shall meet periodically as provided in these bylaws or as provided by resolution of the Board.

7.1 Board Committees. The designation, membership and meeting schedule of the standing committees of the Board shall be as follows:

Finance Committee: Two commissioners; Superintendent; CFO; CNO/CQO and such other members as the committee chair deems appropriate. The finance committee shall meet monthly and as needed.

Quality Improvement Oversight Committee: Two commissioners; Superintendent; CNO/CQO, Quality Manager; CMO; Chief of M Staff; Ancillary Services Director; , Nursing Leadership; Facilities Director; and such other members as the committee chair deems appropriate. The QIO committee shall meet minimally quarterly or as needed.

Plant Planning: Two commissioners; Superintendent; Facilities Director; CFO; CNO/CQO and such other members as the committee chair deems appropriate. The Plant Planning Committee shall meet one time each year and as needed.

Strategic Planning Retreat: All members of the Board; Superintendent; and such other members as the Board deems appropriate. The whole board will have a Strategic Planning Retreat every three years, unless otherwise advised by the Strategic Planning Committee. The whole board will meet once a year to have a focused discussion about the current Strategic and Implementation Plans and the committee's recommendations. Such meeting(s) shall be conducted as a Special Meeting of the Board in compliance with these Bylaws and Chapter 42.30 RCW.

Strategic Planning Committee: Two commissioners; Superintendent; community member guests; and such other members as the Board deems appropriate. The Strategic Planning Committee shall meet as needed.

Governance Committee: Two commissioners; Superintendent; and such other members as the committee chair deems appropriate. The Governance Committee shall meet biannually and as needed.

Compliance Committee: Two commissioners; Compliance Officer; Superintendent; CFO; CNO/CQO; Revenue Cycle Director; CHRO; and such other

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members as the committee chair deems appropriate. The Compliance Committee shall meet minimally one time each year and as needed.

Values, Ethics or Conflict of Interest: Other adhoc committee will be appointed by the Board and meet as needed.

The Board may volunteer district constituents for membership on committees based upon experience, willingness, and ability to contribute to the committee objectives. Committees shall act within board approved job descriptions.

7.2 Board Representatives. The designation and reporting schedule of the representatives of the board shall be as follows:

State Legislative Representative: One commissioner; and such other members as the board deems appropriate. The representative to the state shall report to the board only as needed.

Foundation: One commissioner. The representative to the Foundation shall report to the board as needed.

Section 8. Powers and Duties of the Board or Commission. The Board shall be the governing body to which the Superintendent, other district employees and the medical staff ultimately are responsible to for all facilities, services and activities of the District, including the condition of the physical plant. While the authority of the Board may be delegated to the Superintendent and the Medical Staff by resolution, any delegation of authority by the Board may be rescinded in its sole discretion, as provided for by law. RCW 70.44.090 (a)

All of the powers authorized in Chapter 70.44 RCW may be exercised by the board in the performance of its duties prescribed therein. Among other things, the Board shall strive to:

(i) Adopt and review bylaws, at least once every two years, that address legal accountabilities and responsibilities;

(ii) Determine the policies of the district and the purposes of the hospital and other district health care facilities and services in proper relation to community needs;

(iii) Establish a program for the ongoing management of a hospital quality improvement program and malpractice prevention program, including medical staff sanction and grievance procedures and information collection and reporting procedures. The quality

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improvement program will review the services rendered in the hospital and other district health care facilities and other services in order to improve the quality of medical care of patients and to prevent medical malpractice;

(iv) Exercise proper care and judgment in the selection of a qualified superintendent who shall be responsible for implementing policies adopted by the board;

(v) Promote planning and coordinate professional interests with administrative, financial, and community needs, the policies of the district, and the purposes of the hospital and other district health care facilities and services;

(vi) Provide for the periodic evaluation of the Superintendent;

(vii) Provide for the periodic evaluation of the Board and its members;

(viii) Provide facilities, equipment, and personnel to meet the needs of patients within the purposes of the hospital and other district health care facilities and services and consistent with present and future community needs;

(ix) Establish and appoint a medical staff;

(x) Assure that an appropriate standard of professional care is maintained, requiring the medical staff of the hospital to be accountable to the board;

(xi) Assure that the medical staff possess appropriate current qualifications, and determine, in its discretion, which kinds of health care providers shall be considered for clinical privileges or medical staff membership;

(xii) Approve bylaws, rules, and regulations as adopted by the medical staff before they become effective;

(xiii) Provide for the sound administration and application of public funds, adopting annual budgets for the district and the Hospital at the times and in the manner required by law; and

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(xiv) Maintain accurate records of district finances and all related activities.

RCW 70.41.200

Section 9. Avoidance of Conflicts of Interest. District commissioners, being aware of the fiduciary nature of their positions, shall avoid actions and relationships that result in a conflict between their private financial interests and their public responsibilities. Commissioners shall not violate the conflict of interest provisions of these Bylaws, Chapter 42.20 RCW, Chapter 42.23 RCW or any other applicable law.

Recognizing that even the appearance of impropriety should be avoided, no commissioner shall:

(i) Be beneficially interested in or otherwise expect to profit from, directly or indirectly, any contract, sale, lease, or purchase made by the district, except as specifically permitted under RCW 42.23.030 or RCW 42.23.040, as now in effect or hereafter amended, or under other applicable law;

(ii) Accept, directly or indirectly, any compensation, gratuity, favor, or award from any party seeking to do business with the District, or in connection with any contract made by the District, other than (a) compensation and reimbursement for expenses as provided by law, or (b) compensation in connection with contracts permitted under RCW 42.23.030, as now in effect or hereafter amended, or under other applicable law;

(iii) Employ, use, or appropriate any district employee, money, or property for his private benefit;

(iv) Hold any office, engage in any employment, or occupy any position, public or private, which could create conflicts between the duties, interests, and opportunities inherent in such office, employment, or position and the commissioner's public responsibilities as a member of the board;

(v) Reveal or divulge to any other party unless authorized by the board, any confidential information received in the performance of his duties as a commissioner, nor use such information for personal gain.

Any commissioner, upon discovering or suspecting that he has or may have a conflict of interest contrary to the policies and standards set forth in this section, shall promptly report the same to the board. In such cases, a commissioner shall take such action as may be required to comply with the provisions of these bylaws and applicable law, including, if required, abstaining from voting on the matter.

ARTICLE III

OTHER OFFICERS

Section 1. Superintendent.

1.1 Appointment. The Board shall select and appoint as Superintendent a competent and experienced hospital administrator who shall be its direct representative in the management of the District. The Superintendent shall be appointed for an indefinite term, removable at the will of the Board, and shall receive such compensation as the Board shall establish by resolution. The appointment or removal of the Superintendent shall be by resolution of the Board, introduced at a regular meeting and adopted at a subsequent regular meeting by majority vote. RCW 70.44.070.

1.2 Powers and Duties. The Superintendent shall be the Chief Executive Officer of the District. In direct charge with full authority to act, as representative of the Board, and subject to its policies, shall be responsible for the efficient administration of all affairs of the District. RCW 70.44.080.

In the performance of the duties prescribed by law, all of which shall be faithfully discharged, and not by way of limitation of authority, the Superintendent shall:

(i) Carry out the orders of the Board and see that all the laws of the state pertaining to matters within the functions of the district are duly enforced;

(ii) Perfect and submit to the board for approval a plan of organization for the personnel concerned with the operation of the District, which shall be reviewed annually;

(iii) Prepare annually a budget or budgets showing anticipated receipts and expenditures for the ensuing fiscal year which shall be submitted to the Board to allow timely filing and hearing thereon before adoption as required by law;

(iv) Select, employ, control, and discharge all other employees;

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(v) Assure that all building, equipment, and other facilities are maintained in good repair;

(vi) Furnish periodic recommendations to the Board with respect to the acquisition, development, and extension of desirable health care facilities, equipment, and services, including estimates for the above;

(vii) Supervise all business affairs including the disbursement of funds, recording of financial transactions, collection of accounts, and purchase and issue of supplies;

(viii) Certify to the Board all the bills, allowances and payrolls, including claims due contractors;

(ix) Recommend to the Board a range of salaries to be paid to district employees;

(x) Cooperate with the Medical Staff and secure like cooperation on the part of all those concerned with rendering professional services;

(xi) Submit regularly to the Board reports regarding the health care services and financial activities of the District along with any special reports that may be requested by the Board;

(xii) Prepare the agenda and attend all meetings of the Board to participate in the discussion of matters being considered;

(xiii) Execute on behalf of the District all contracts, agreements, and other documents and papers that he may be authorized by resolution of the Board to sign;

(xiv) Undertake own initiative the performance of such other duties, consistent with law and the policies of the board, as may be in the best interest of the District.

RCW 70.44.090.

Section 2. Treasurer. The Board shall appoint a person having experience in financial or fiscal matters as the Treasurer for the District. The Board shall require the

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Treasurer to obtain a surety bond, with a surety company authorized to do business in the state of Washington, in an amount under the terms and conditions which the Board by resolution from time to time finds will protect the District against loss. The premium on any such bond shall be paid by the District. All district funds shall be paid to the Treasurer and shall be disbursed by only on warrants issued by an auditor appointed by the commission, upon orders or vouchers approved by it. The Treasurer shall maintain such special funds as may be created by the commission, into which he shall place all money as the commission may, by resolution, direct. If the Treasurer of the District is some other person, all funds shall be deposited in such bank or banks authorized to do business in this state as the commission by resolution shall designate, and with surety bond to the District or securities in lieu thereof of the kind, no less in amount, as provided in RCW 36.48.020 for deposit of county funds. Such surety bond or securities in lieu thereof shall be filed or deposited with the treasurer of the district, and approved by resolution of the commission. RCW 70.44.171.

Section 3. Auditor. The Board shall appoint as auditor of the District a person experienced in accounting and business practices. The Auditor shall report in the performance of his duties directly to the Superintendent. The Auditor shall draw, sign, and issue all warrants for the disbursement of funds of the District upon the orders of, or vouchers approved by, the commission; and shall be responsible in the performance of such other duties relating to business affairs of the district including the recording of financial transactions, collection of accounts, and the routine purchase and issue of supplies, as are assigned by the Superintendent. RCW 70.44.171.

ARTICLE IV

MEDICAL STAFF

Section 1. Appointment and Organization. The Board shall appoint the members of the Medical Staff of the Hospital biennially after considering recommendations duly submitted in accordance with the medical staff bylaws; provided that all initial appointments shall be provisional and that all appointments to the provisional medical staff shall be for a period of six (6) months. A single reappointment to the provisional medical staff may be permitted for another three-month period. Such bylaws, rules and regulations governing the appointment, organization, liability insurance coverage and activities of the medical staff, including procedures for the granting, denial, reduction, or termination of staff privileges and the identification of the kinds of health care providers eligible to be considered for such privileges or medical staff membership, shall be subject to approval and revision or modification by the board. The board shall assure that the requirements of due process of law are observed. RCW 70.43.010

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Section 2. Powers and Duties. Each person admitted to the hospital shall be under the care of a member of the medical staff possessing clinical privileges, such medical staff also shall have authority and responsibility in the manner prescribed by its bylaws, rules and regulations to:

(i) Evaluate the professional competence of medical staff members and applications for clinical privileges;

(ii) Make recommendations to the board concerning initial medical staff appointments, reappointments, and the granting, denial, reduction, or termination of clinical privileges;

(iii) Establish procedures designed to promote the achievement and maintenance of an appropriate standard of ethical and professional practice, and the efficient use of district resources;

(iv) Participate in and offer recommendations in the development of policies relative to the effective use of existing facilities, and provision for the improvement or extension thereof where appropriate, to assure adequate patient care, responsive to the needs of the population served now and in the future;

(v) Supervise a medical education program in the hospital and render such other services as the board may consider desirable to enhance the standards of medical practice in the hospital;

(vi) Be accountable to the board for the proper discharge of the duties set forth in this section.

Section 3. Professional Liability Insurance Coverage. All practitioners who are granted medical staff privileges to practice within the hospital shall maintain liability insurance with limits of one million dollars per occurrence and three million dollars annual aggregate. Proof of coverage shall be the responsibility of the practitioner. The practitioner shall give the hospital thirty (30) days prior written notice of cancellation or termination of any such policy. The practitioner's insurance company must be: a) acceptable to the district, and b) licensed to underwrite malpractice insurance in the State of Washington. These policy limits will be reviewed by the board annually and revised as appropriate.

ARTICLE V

INDEMNIFICATION AND INSURANCE

Section 1. Indemnification. The District shall indemnify and hold harmless to the full extent permitted by applicable law each person who was or is made a party to or is threatened to be made a party to, or is involved (including, without limitation, as a witness) in an actual or threatened action, suit or other proceeding, whether civil, criminal, administrative or investigative by reason of the fact that he or she is or was a commissioner, officer, employee or agent of the district, or having been such a commissioner, officer, employee or agent, he or she is or was serving at the request of the district as a director, officer, employee, agent, trustee or in any other capacity of another corporation or of a partnership, joint venture, trust or other enterprise, including service with respect to employee benefit plans, whether the basis of such proceeding is alleged action or omission in an official capacity or in any other capacity while serving as a commissioner, officer, employee, agent, trustee or any other capacity, against all expense, liability, and loss (including, without limitation, attorneys' fees, judgments, fines, ERISA excise taxes or penalties in amounts to be paid in settlement) actually or reasonably incurred or suffered by such person in connection therewith. Such indemnification shall continue as to a person who has ceased to be a commissioner, officer, employee or agent of the district and shall inure to the benefit of his or her heirs, and personal representatives.

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Section 2. Insurance. The District may purchase and maintain insurance, at its expense, to protect itself and any commissioner, officer, employee, agent or trustee of the District or another corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss to the full extent permitted by applicable law.

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ARTICLE VI

CONSTRUCTION AND CONVENTIONS

Section 1. Gender and Number. As used in these bylaws, personal pronouns shall be interpreted to refer to persons of either gender and relative words whenever applicable to more than one person shall be read as if written in the plural.

Section 2. Titles, Headings and Captions. The titles, headings, and captions appearing in these bylaws are used and intended for convenience of description or reference only and shall not be construed or interpreted to limit, restrict, or define the scope or effect of any provision.

Section 3. Severability. If any provision of these bylaws or its application to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of these bylaws or the application of the provision to other persons or circumstances shall not be affected.

ARTICLE VII

AMENDMENT

These bylaws may be amended by resolution of the Board introduced at a regular meeting and adopted at a subsequent regular meeting.

ADOPTED this _____day of _____, 2021

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Board Chair

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Board Secretary

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Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 5/16/2021
Subject: Podiatry Service Line

A podiatry service line has been on our governance wish list since I arrived in 2016. In fact, our district once benefitted from podiatry services from Dr. Dujela of Washington Orthopedic Services. This Board of Commissioners may remember that I have noted in prior months' updates that I was in negotiations with a podiatrist.

Originally, I was negotiating with a non-surgical podiatrist. That negotiation has been paused due to the interest of and in a surgical podiatrist. As of this writing, the surgical podiatrist is interested in contracting as a full-time provider for Arbor Health. Both parties are awaiting the ratification of a budget amendment to sign the contract. Patients would begin seeing this podiatrist as of September 1, 2021.

Richard submitted a Podiatric Pro Forma to the Finance Committee on 5/19/2021, which is being recommended to the Board of Commissioners for approval. This pro forma assumes modest services in the first six months with volume growth of 5-10% per month thereafter. In addition to clinic revenues, incidental radiology and surgery revenues are projected because of this service line addition.

Podiatric services are expected to be self-sustaining by month 8, in 2022. My ask of you is to approve a budget amendment of ($150,379.00) for calendar year 2021. These early months absorb the start-up costs of the service line, setting the service up for a sustainable 2022. I believe that this service line will benefit our diabetic population, our residents with difficult to heal leg and foot wounds, as well as residents experiencing foot and ankle trauma.

Our CPA firm has historically advised that one difference between surviving and thriving critical access hospitals is robust outpatient services. I implore you to seriously consider the benefit that adding podiatric services brings to our patients and to our District.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE BUDGET AMENDMENT-PODIATRIST

RESOLUTION NO. 21-23

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

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

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

Approving the budget amendment to add a Podiatrist not included in the District 2020 Budget by RES 20-48 on November 30, 2020.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of May 2021, the following commissioners being present and voting in favor of this resolution.

_____ _____

Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____

Craig Coppock, Commissioner Wes McMahan, Commissioner

_____

Chris Schumaker, Commissioner

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
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360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

Lewis County Hospital District No. 1 (d/b/a Arbor Health)

2021 BUDGET AMENDMENT REQUEST FORM

When requesting a Budget Amendment, this form MUST be completed and filed with the CFO Office to be placed on the next agenda of the Board of Hospital Commissioners.

RECOMMENDATION:
Move forward with the starting of the Podiatry line of business.

JUSTIFICATION:
This will allow Arbor Health to employer a physician in a new service line outside of the budgeting process. This program has the ability of increasing volumes in clinic, radiology, MRI, and surgical activities.

BUDGET CONSIDERATION:
Load months 1-4 of the attached Podiatry Pro Forma representing an organization increased loss of $(150,379).

Submitted by Richard Boggess, CFO Date March 24, 2021

For Accounting Use:

On this _____ day of _____, 2021 the following budget request has been approved thus amending the 2021 Operating Budget as follows:

Arbor Health Podiatry Program Proforma			BUDGET AMENDMENT PERIOD												Budget Amendment
	Yr 1	Yr 2	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	
Gross Patient Revenue	**1,847,961**	**2,874,924**	2,751	51,804	103,608	168,432	173,082	177,732	182,382	189,822	192,612	197,262	201,912	206,562	326,595
Deductions	**1,237,732**	**1,865,187**	1,644	35,514	71,028	114,272	116,951	119,629	122,308	126,696	128,405	131,084	133,762	136,441	222,458
Net Patient Revenue	**610,230**	**1,009,737**	1,107	16,290	32,580	54,160	56,132	58,103	60,075	63,127	64,207	66,179	68,150	70,122	104,137
Bad Debt	**92,398**	**154,074**	138	2,590	5,180	8,422	8,654	8,887	9,119	9,491	9,631	9,863	10,096	10,328	16,330
Total Operating Revenue	**517,832**	**855,663**	970	13,700	27,400	45,738	47,477	49,216	50,955	53,635	54,576	56,315	58,054	59,793	87,808
Salaries	**490,067**	**482,114**	65,607	35,584	39,396	38,125	39,396	38,125	39,396	38,125	39,396	39,396	38,125	39,396	178,711
Benefits	**90,232**	**88,767**	10,867	6,809	7,324	7,153	7,324	7,153	7,324	7,153	7,324	7,324	7,153	7,324	32,153
Total Wages & Benefits	**580,299**	**570,881**	76,473	42,393	46,720	45,278	46,720	45,278	46,720	45,278	46,720	46,720	45,278	46,720	210,864
Professional Fees	**1,500**	**1,500**	125	125	125	125	125	125	125	125	125	125	125	125	500
Supplies	**16,812**	**15,311**	8,922	1,211	321	542	582	621	661	724	748	787	827	866	10,996
Purchased Service	**6,367**	**5,366**	1,100	100	517	517	517	517	517	517	517	517	517	517	2,233
Rent & Leases	**0**	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Insurance	**14,000**	**14,000**	1,167	1,167	1,167	1,167	1,167	1,167	1,167	1,167	1,167	1,167	1,167	1,167	4,667
Utilities	**780**	**819**	65	65	65	65	65	65	65	65	65	65	65	65	260
Travel	**5,000**	**5,000**	417	417	417	417	417	417	417	417	417	417	417	417	1,667
Depreciation/Amortiztaion	**9,000**	**9,000**	750	750	750	750	750	750	750	750	750	750	750	750	3,000
Other Expenses	**12,000**	**3,000**	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	4,000
Total Operating Expenses	**645,758**	**624,877**	**90,018**	**47,227**	**51,082**	**49,860**	**51,342**	**49,939**	**51,421**	**50,042**	**51,508**	**51,548**	**50,145**	**51,627**	**238,186**
Net Operating Income	**(127,926)**	**230,785**	(89,048)	(33,527)	(23,682)	(4,122)	(3,865)	(723)	(466)	3,594	3,068	4,768	7,910	8,167	(150,379)
Contribution Margin	-24.7%	27.0%	-9182.1%	-244.7%	-86.4%	-9.0%	-8.1%	-1.5%	-0.9%	6.7%	5.6%	8.5%	13.6%	13.7%	-171.3%
Departmental UOS															
Office Visits	**736**	**1,590**	4	25	50	97	105	113	121	133	138	146	154	162	649
Total Operating Revenue / UOS	703.81	538.15	223.14	546.90	546.90	470.56	451.84	435.74	421.73	401.99	395.05	385.66	377.22	369.61	135.30
Salaries & Emp Ben / UOS	788.72	359.04	17,595.21	1,692.32	932.54	465.82	444.64	400.87	386.68	339.35	338.19	319.95	294.20	288.80	324.92
Supplies / UOS	22.85	9.63	2,052.74	48.33	6.41	5.58	5.54	5.50	5.47	5.43	5.41	5.39	5.37	5.35	16.94
Total Operating Expense / UOS	877.69	393.00	20,711.70	1,885.29	1,019.59	512.96	488.62	442.14	425.58	375.06	372.84	353.01	325.83	319.13	367.02

Lewis County Hospital District #1
2021 Budget Amendment Discussion
Calendar Year 2021

	Approved Budget as Amended	Podiatry Budget	Proposed Amended Budget
Total Gross Patient Revenues	52,080,934	326,595	52,407,529
Total Deductions From Revenue	20,589,957	222,458	20,812,415
Net Patient Revenues	**31,490,977**	**104,137**	**31,595,114**
Other Operating Revenue	885,666	0	885,666
Total Operating Revenue	32,376,643	87,808	32,464,451
Operating Expenses			
Salaries & Compensation	17,912,727	178,711	18,091,438
Benefits	4,331,020	32,153	4,363,173
Professional Fees	1,977,010	500	1,977,510
Supplies	2,254,815	10,996	2,265,811
Purchases Services	4,498,928	3,900	4,502,828
Utilities	540,569	260	540,829
Insurance Expense	216,939	4,667	221,606
Depreciation and Amortization	1,179,560	3,000	1,182,560
Interest Expense	458,640	0	458,640
Other Expense	511,562	4,000	515,562
Total Operating Expenses	33,881,770	238,187	34,119,957
Income (Loss) From Operations	(1,505,129)	(150,379)	(1,655,508)
Non-Operating Revenue/Expense	1,593,284	0	1,593,284
Net Gain (Loss)	88,155	(150,379)	(62,224)

SUPERINTENDENT REPORT