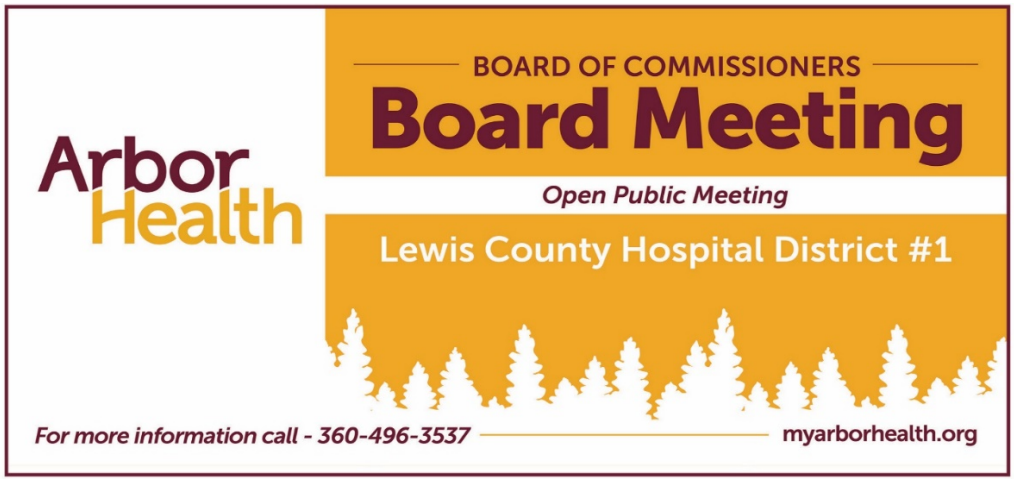
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

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

April 28, 2021 @ 3:30 PM
Join Zoom Meeting: https://myarborhealth.zoom.us/j/91876959512
Meeting ID: 918 7695 9512
One tap mobile: +12532158782,,91876959512#
Dial: +1 253 215 8782

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Agenda

Board Committee Reports

Consent Agenda

Old Business

New Business

Superintendent Report

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/91876959512
Meeting ID: 918 7695 9512
One tap mobile: +12532158782,,91876959512#
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** **Approval or Amendment of Agenda** **Conflict of Interest**		3:30 pm
Comments and Remarks • Commissioners • Audience		3:35 pm
Executive Session-*RCW 70.41.205 & RCW 70.41.200* • Medical Privileging-Janice Holmes • Quality Improvement Oversight Report-Commissioner Schumaker & Dexter Degoma		3:40 pm
Guest Speaker • C.H. (Skip) Houser, J.D., M.P.A. o *Principles of an Exceptional Public Hospital District Board*	5	4:00 pm
Department Spotlight • Revenue Cycle – Business Office, Health Information Management & Patient Access	26	5:00 pm
Board Committee Reports • Hospital Foundation Report-Committee Chair-Commissioner McMahan	29	5:05 pm
• Finance Committee Report-Committee Chair-Commissioner Coppock	31	5:10 pm
• Plant Planning Committee Report-Committee Chair-Secretary Herrin		5:15 pm
Consent Agenda *(Action)* • Approval of Minutes: o *Minutes of the March 31, 2021 Regular Board Meeting* o *Minutes of the April 7, 2021 Quality Improvement Oversight Committee Meeting* o *Minutes of the April 19, 2021 Plant Planning Committee Meeting* o *Minutes of the April 21, 2021 Finance Committee Meeting*	 33 39 42 45	5:20 pm
• Warrants & EFT's in the amount of $3,903,486.81 dated March 2021	48	
• Resolution 21-16-Approving 2021 QAPI Plan	50	

o *To approve the annual plan.*		
• Resolution 21-17-Approving 2021 Risk Management Plan o *To approve the annual plan.*	56	
• Resolution 21-18-Approving 2020 Critical Access Hospital Evaluation o *To approve annual evaluation-§485.641(a).*	66	
• Approve Documents Pending Board Ratification 4.28.21 o *To provide board oversight for document management in Lucidoc.*	84	
Old Business • Incident Command Update o *CNO/CQO Williamson will provide a verbal COVID 19 update.*		5:25 pm
Break		5:35 pm
New Business • Transitional Care Promotional Video o *To view the new marketing video.*		5:40 pm
• Board Bylaws o *To complete biennial review and discuss proposed edits.*	91	5:50 pm
• Redistricting o *To provide an update per RCW 70.44.042.*	109	6:10 pm
• Special Board Meeting-Prospective Commissioner Candidates Q & A o *To discuss the purpose of the meeting.*		6:15 pm
• Construction Budget Amendment o *To discuss options.*	110	6:25 pm
Superintendent Report	123	6:40 pm
Next Board Meeting Dates and Times • Regular Board Meeting-April 28, 2021 @ 3:30 PM (ZOOM) • Special Board Meeting-May 5, 2021 @ 6:00 PM (ZOOM) **Next Committee Meeting Dates and Times** • Arbor Health Foundation Meeting-May 11, 2021 • Compliance Committee Meeting-May 12, 2021 2:00 PM (ZOOM) • Finance Committee Meeting-May 19, 2021 @ 11:00 AM (ZOOM)		
Meeting Summary & Evaluation		6:50 pm
Adjournment		7:00 pm

Arbor Health Board Workshop
Public Hospital District No. 1 Lewis County

Principles of an Exceptional Public Hospital District Board

Commissioner's Workshop

Morton, Washington
April 28, 2021

C.H. (Skip) Houser, J.D., M.P.A.

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Arbor Health
Public Hospital District No. 1 Lewis County

Greetings and introductions

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Exceptional Board Principles
Governance Defined

Effective governance and creating an exceptional board requires clear relationships, authorities and responsibilities to guide strategic decisions through a set of cohesive polices and processes.

3

3

Exceptional Board Principles
Shared Responsibilities

- Determination as to responsibility for delivering the quality of services to the public/patients.
- Setting and following standards for operational excellence.
- Implementing policies and procedures.
- Safeguard compliance with regulations and policies

4

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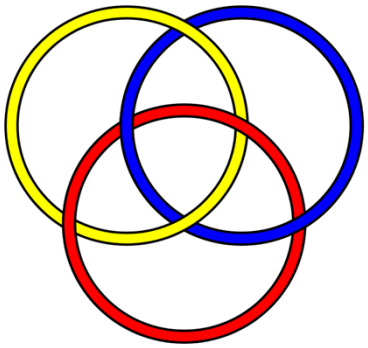
Exceptional Board Principles
Ambiguity, Roles, and Responsibilities

Steps to Overcome any Ambiguity in Roles and Responsibilities

- Recognition
- Communication
- Investigation
- Reconciliation



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12 Exceptional Board Principles
Constructive Partnership

1. **Constructive Partnership**

Exceptional boards govern in a constructive partnership with the Chief Executive Officer.

They build this through trust, candor respect and honest communication.

6

6

12 Exceptional Board Principles
Mission Statement

2. **Mission Statement**

Exceptional boards shape and uphold the mission and ensure congruence with decisions and organizational values.

"To foster trust and nurture a healthy community"

Arbor Health

7

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Arbor Health's
Vision Statement

Vision:

"To provide accessible quality healthcare "

8

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12 Exceptional Board Principles
Strategic Thinking

3. **Strategic Thinking**

Exceptional boards allocate time to what matters most and ensure the congruence between decisions and core values.

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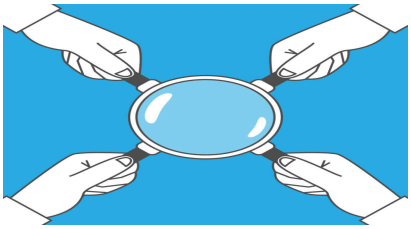
12 Exceptional Board Principles
Culture of Inquiry

4. **Culture of Inquiry**

Exceptional boards institutionalize a culture of inquiry, constructive debate, and engaged teamwork that leads to sound and shared decision making.



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Exceptional Board Culture

The problem is that most board cultures are developed by default, not design.

Got culture?

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12 Exceptional Board Principles
Independent-Mindedness

5. **Independent-Mindedness**

Exceptional boards are independent-minded. When making decisions on behalf of the organization, board members put the interests of the organization above those of the chief executive, themselves, or other interested parties.

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12 Exceptional Board Principles
Ethos of Transparency

6. **Ethos of Transparency**

Exceptional boards promote an ethos of transparency and ethical behaviors.

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12 Exceptional Board Principles
Compliance with Integrity

7. **Compliance with Integrity**

Exceptional boards govern with full recognition of the importance of their fiduciary responsibilities, developing a culture of compliance through appropriate mechanisms for active oversight.

14

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12 Exceptional Board Principles
Sustaining Resources

8. **Sustaining Resources**

Exceptional boards ensure that the organization's resources are balanced with its strategic priorities and capacities.

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12 Exceptional Board Principles
Results Oriented

9. **Results Oriented**

Exceptional boards track the organization's advancement towards its mission and evaluate the performance of major programs and services.

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Exceptional Board Principles
Board Evaluation

Exceptional Boards evaluate their progress and performance on a regular basis.

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12 Exceptional Board Principles
Intentional Board Practices

10. **Intentional Board Practices**

Exceptional boards make form follow function when it comes to their own operations. They invest in a structure and practices that transcend individuals and thoughtfully adjust them to respond to changing circumstances.

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12 Exceptional Board Principles
Continuous Learning

11. **Continuous Learning**

Exceptional boards embrace the qualities of a continuous learning organization, evaluating their own performance and assessing the value that they add to the organization.

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Continuous and Lifelong Learners

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12 Exceptional Board Principles
Revitalization

12. **Revitalization**

Exceptional boards revitalize themselves.

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Exceptional Board Principles
The Importance of Board Meetings

The time a board spends together is its most precious commodity.

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Exceptional Boards Principles
Elements of Effective Meetings

Governance researchers and experts examined what distinguishes good from great boards concluded that,

"Exceptional boards make meetings matter."

"They spend time wisely and productively."

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Exceptional Board Principles
Effective Board Meetings

The key ingredients to an effective board meeting is not the frequency or length, but rather the preparation and execution.

Meetings that focus on the board's time on critical organizational issues and facilitate thoughtful deliberation are more important than long reports and reviews.

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Exceptional Board Principles
Setting Priorities

Exceptional boards intentionally structure themselves to fulfill essential governance duties and prioritize organizational goals.

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Exceptional Board Principles
How to Sit on A Board Without Getting

How to Sit on A Board Without Getting Splinters

- Have a clear purpose and focused meeting agenda.
- Have an explicit decision-making process.
- Have information carefully summarized.
- Have proper review and preparation before the meeting.

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Exceptional Board Principles
Review of History

Those that fail to learn from history are doomed to repeat it.

Winston Churchill

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Exceptional Board Principles
Using Committees

Boards, at times may only be effective as the committees that support them.

Effective boards depend on the work of well structured and staffed committees that develop focused work plans supporting the board's strategic priorities.

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Exceptional Board Principles
Better Together

Individually there is little that we can do but together there is little that we cannot do.

John F. Kennedy

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Exceptional Board Principles
Elements of the Ineffective Board

Spending time on trivia

Short term bias

Reactive Stance

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Exceptional Board Principles
Characteristics of Ineffective Boards

Lack of Focus on "WIN"
(What's Important Now)

Continual Reviewing Reshaping and
Redoing (The 3 R's)

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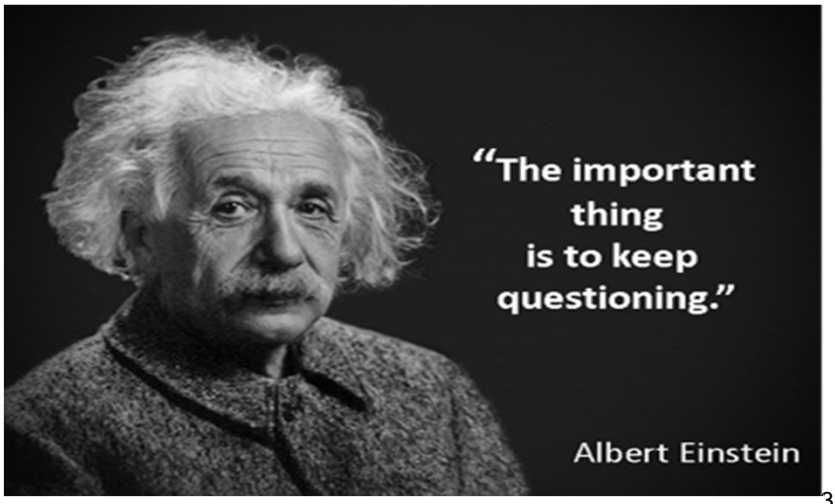
Exceptional Board Principles
Asking Questions Will Get You Answers



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Exceptional Board Principles
Are there any questions?

"The question is not what you look at,

but what you see"

-Henry David Thoreau

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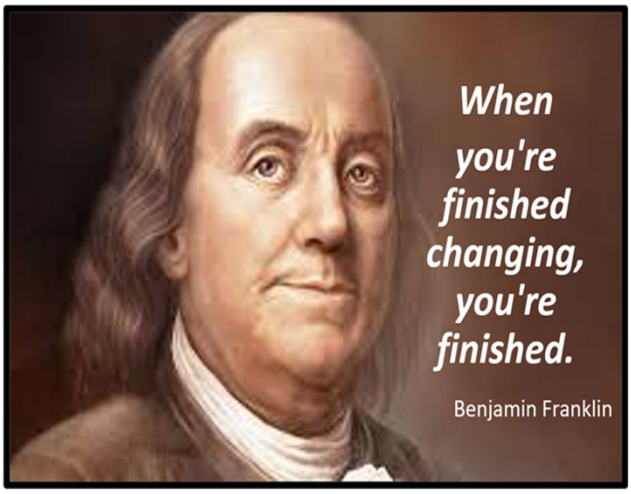
Exceptional Board Principles
Be Prepared to Change



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Exceptional Board Principles
Virtual Board Meetings

Meeting remotely and virtually has created challenges and opportunities.

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Exceptional Board Principles
Board Opportunities and Challenges

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Exceptional Board Principles
Seeking Answers in Trying Times

Certainty in times of Uncertainty

Where the strange is familiar
and the familiar is strange

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Exceptional Board Principles
Returning to Normal?

Returning to Normal?

An online research for “normal” provided 2,080,000,000 results with one definition stating that in general “normal” refers to a lack of significant deviation from average.

What is the new normal?

38

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Exceptional Board Principles
Creating the New Normal

The exceptional board must be prepared to provide leadership in creating the, “new normal”. The new normal will become the normal.

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Governance and Exceptional Board Principles
Summary

Boards must rise to meet the challenges and develop innovative and creative approaches while staying engaged throughout their term of service.

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Exceptional Board Principles
Questions and Answers

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THE END
THANK YOU

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2021 STRATEGIC GOALS-REVENUE CYCLE

Presented by Sherry Sofich; Revenue Cycle Director

Teams: Patient Access, Health Information Management and the Business Office

All three teams listed above comprise the key players of the "Revenue Cycle." The Revenue Cycle is defined as all administrative and clinical functions that contribute to the capture, management and collection of patient service revenue. This is called the "Life of a patient account from creation to payment."

THE TEAM

Patient access consist of 12 employees. They register patients, obtain authorizations and schedule imaging services. They also screen patient's for Covid symptoms

The Health Information team consists of 4 employees. They process medical record requests and code encounters

The Business office team consists of 9 employees. They bill and follow up on insurance claims, post payments and denials, complete the deposit, work with our collection agencies, process refunds and update the charge master

PATIENT EXPERIENCE

Although our focus is on obtaining the correct insurance information, registering patients accurately, getting an authorization, coding and billing and ultimately collecting money to pay for services, what we do behind the scene is create a positive patient experience throughout the entire revenue cycle

HOW DO WE MAKE IT POSITIVE?

For Patient Access, it starts with a smile, understanding the patients needs, grabbing a wheelchair, listening, registering patients correctly, helping the patient navigate through the process

Health Information Management-making sure the records get to where they need to go timely, coding the account correctly so it is adjudicated correctly and the patient doesn't get billed for something they shouldn't have to pay for.

For the business office, making sure the payments are posted correctly, the claim is billed timely and the patient is billed timely. Offering payment plans, discounts, charity care to help our uninsured patients. It is answering the phone timely, getting the patient answers and always being helpful.

GOALS

1. To build relationships and partnerships that prioritize community health needs.

Business Office/HIM

Goal: Partner with the insurance payer to address school needs/community youth programs

Benchmark: Two events in 2021

How? We were awarded a $7500 grant from the Dept of Health. We are hosting a youth fair in June. We will have counselors on site to help our youth navigate through these trying times. We will have prizes, food and fun.

Patient Access

Goal: Refer patients to the self pay biller to see if they qualify for Medicaid

Benchmark: Five patients per quarter and 20 per year.

How? Tracking this activity to see how many patients are referred.

Added action codes to track this activity. This started in March so we did not capture prior months.

Reviewing all self pay encounter for a 90 period to see if coverage was obtained. If so, moving the balance from SP and billing the insurance

Results: First quarter of 2021, 2 patients were referred to Medicaid.

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

Business Office/HIM

Goal: Increase conversion of bad debt to charity care

Benchmark: 50% Increase from last year. In 2020 we adjusted $133,685.

How? Proactively reach out to patients to see if they qualify.

Work with our early out vendor on propensity to pay

Results: First quarter of 2021, we adjusted $297,685 as charity care

Patient Access

Goal: Identify patients that qualify for charity care by using bill holds, and action codes to help the biller track these patients

Benchmark: We did not have a way to track this prior to 2nd quarter. We now have a process and will report the findings next quarter.

How? Handing out charity care applications when they arrive and are uninsured

Work with our early out vendor on propensity to pay

Using action codes to track this activity

Results: Will report this second quarter

3. To continue as stewards of public funds

Business Office/HIM

Goal: Decrease timely filing write-offs by 25%

Benchmark: 2020 we wrote off $108,072

How? * Cerner is helping us build work queues for claims approaching timely filing. It varies by payer and some only allow 90 days. They will auto bill if the claim is approaching the one year.

* Reviewing all self pay encounters for the last 90 days to see if the patient received retroactive Medicaid coverage.

* Self-pay inventory reconciliation being completed quarterly to assure that our early out vendor has all self pay accounts. We do not bill the patient if it is over one year.

Results: First quarter of 2021, we wrote off $22,688.

Patient Access

Goal: Increase point of service collections by 10% in the ER and 20% in outpatient services

Benchmark: Last year they collected $19,111 in the ER and $64,474 in OP Services. Total of $83,585.00

How? Being more proactive. Reading alerts. Learning new ways to ask for money. Offering prompt pay discounts

Results: Quarter 1 ER Collected $5,990.80 and OP Services Collected $45,754.53. Total collected first quarter 2021: $51,745.33

Arbor Health Foundation Meeting Minutes

Tuesday April 13, 2021

Online Zoom Meeting

Attendance: Ali Draper, Diane Markum, Caro Johnson, Betty Jurey, Lynn Bishop, Ann Marie Forsman, Jeaninne Walker, Leianne Everett, Wes McMahan, Gwen Turner, Linda Herrin

Excused: Pat Siesser, Paula Baker

Call to Order by President Ali Draper at 12:07pm

A motion was made and approved to accept Linda Herrin as a Hospital foundation Member. Ann Marie Forsman/Janine Walker

After discussion, a motion was made and approved to accept the March treasurers report. Ann Marie Forsman/Leianne Everett

The April minutes were approved with the correction of two board member names. Ann Marie Forsman/Wes McMahan

CEO Report: Leianne said that plans to use the Johnson & Johnson vaccine have been put on hold until more information is received. Arbor Health is exploring the possibility of developing a Care Clinic in Packwood. The Packwood community has seen a lot of change and growth and the Hospital Board has approved the process to collect information on this new project.

Leianne is looking for ways to improve community outreach and has approached Diane with the possibility of her transitioning into that role as she is an East Lewis County native and this is a natural offshoot. The position of Foundation Executive Director would be increased to .75 FTE. Conversations continue about how that might work. Diane stated that she would assist with the transition.

Directors Report:

Diane wanted to thank the many volunteers who continue to work on the Foundation Board and contribute to its success.

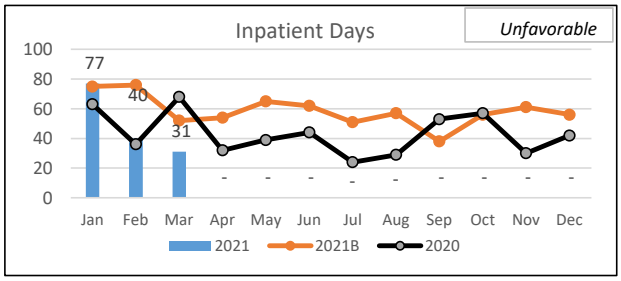
Old Business:

2021 magnetic calendars have been inserted in the New Movers Packets and distributed by Marc and Louise Fisher and Caro Johnson.

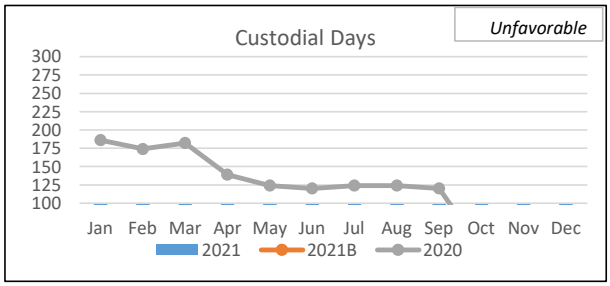
Meeting adjourned 12:46

Lewis County Hospital District No. 1
Board Financial Summary
March 31, 2021

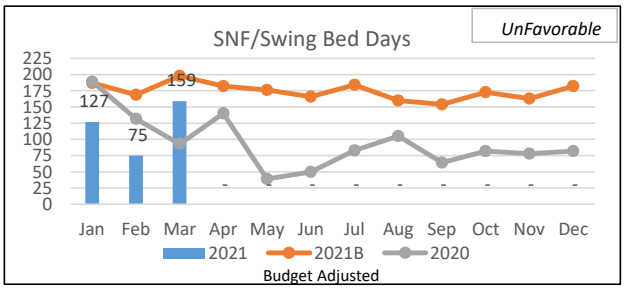
Growth



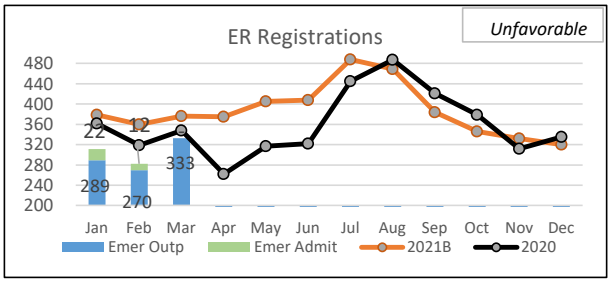
YTD: 148.00 Budget: 203.00 Pr Yr: 167.00



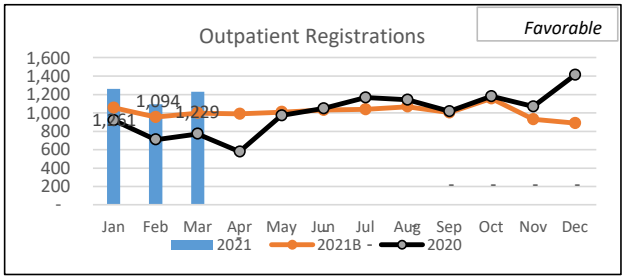
YTD: 0 Budget: 0 Pr Yr: 0



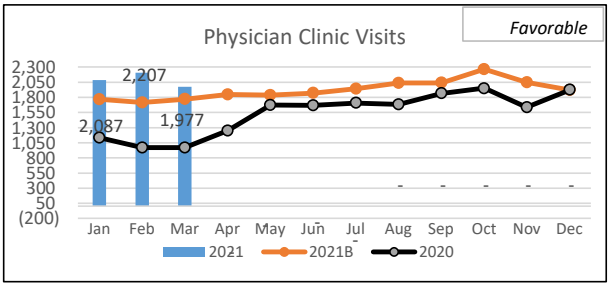
YTD: 361 Budget: 554 Pr Yr: 414



YTD: 892 Bud: 1115 Pr Yr: 1029

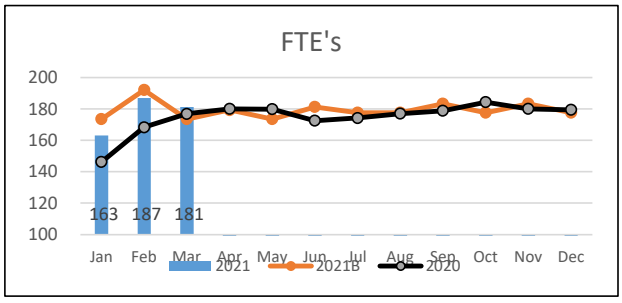


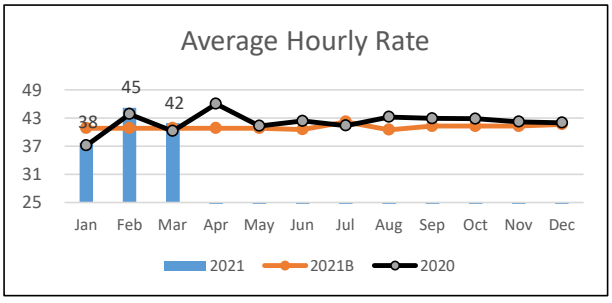
YTD: 3,584 Bud: 3,009 Pr Yr: 2,401

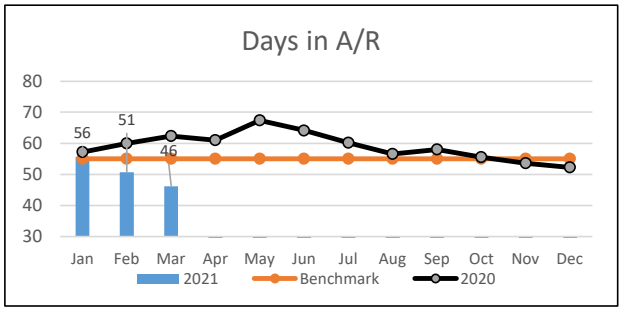


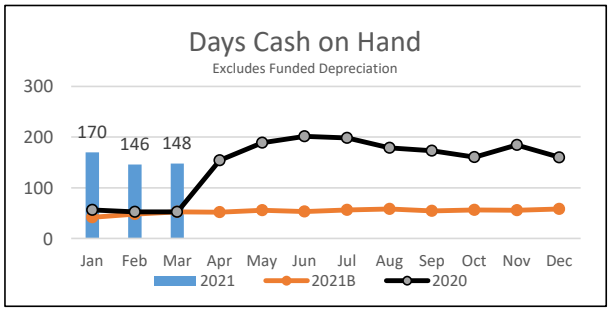
YTD: 6,271 Bud: 5,258 Pr Yr: 3,074

People and Operational Aspects









CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
March 31, 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 ☒ Don Roberts, Pharmacy ☒ Larry Sinkula, Surgical Services Director ☒ Shannon Kelly, CHRO ☒ Julie Taylor, Ancillary Services Director ☒ Skip Houser, Attorney ☒ David Crouch, Interim Maintenance Manager	

	☒ Dr. Mark Hansen, Chief of Staff	
Approval or Amendment of Agenda		Commissioner Coppock made a motion to approve the agenda. Commissioner Schumaker 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 Schumaker and Commissioner McMahan commended Superintendent Everett for exploring a clinic opportunity in Packwood, WA. Board Chair Frady noted that an article was published in the East County Journal informing the District there are three open positions for the upcoming Commissioner election. Audience: Packwood Resident Van Anderson shared an upcoming opportunity for partnership with the White Pass Historical Society Mountain Festival 5K and 10K.	Action Item-CHRO Kelly will follow up with Van Anderson to get contact information for the Mountain Festival.
Executive Session- RCW 70.41.205 & 70.41.200	Executive Session began at 3:40 p.m. for 20 minutes to discuss Medical Privileging and the Quality Improvement Oversight Report. The Board returned to open session at 4:00 p.m. No decisions were made in Executive Session. New Appointments- 1. Marc Koenig, MD 2. Philip Lowe, MD 3. Jennifer McEvoy, MD 4. Garland McQuinn, MD 5. Mark Pfeger, MD 6. Harold Prow, MD 7. Kinjal Desai, MD Reappointments- 1. Natasha Arora, MD 2. Scott Werden, MD 3. Ross Parker, MD 4. Tremont Parrino, MD 5. Colin Poon, MD 6. Amar Purandare, MD	Secretary Herrin made a motion to approve the Medical Privileging as presented and Commissioner McMahan seconded. The motion passed unanimously.

	7. Kevin Roscoe, MD 8. Charles Shen, MD 9. Navneet Singha, MD 10. David Stagnone, MD 11. Lloyd Stambaugh, MD 12. Benjamin Atkinson, MD 13. Aixa Espinosa Morales, MD 14. Bruce Geryk, MD 15. Yi Mao, MD 16. Elizabeth Walz, MD	
Guest Speaker-C.H. (Skip) Houser, J.D., M.P.A. • OPMA, PRA & COVID-19 Workshop	Skip provided training on the Open Public Meetings Act (OPMA) and Public Records Act (PRA). As a result of COVID-19, both the OPMA and PRA have been impacted by Proclamation 20-28.	
Department Spotlight	Deferring to the April Board Meeting.	
Board Committee Reports • Hospital Foundation Report	Commissioner McMahan shared the Arbor Health Foundation has tentatively scheduled their annual events for the Fall of 2021. Foundation Director Markham announced the Foundation awarded two employee scholarships.	
• Finance Committee Report	Commissioner Coppock highlighted the following from the March Finance Committee Meeting: 1. There are four resolutions in the consent agenda that the Finance Committee is recommending approval on. 2. Radia and South Sound Radiology have elected to go out of network with United Healthcare, which impacts the image read costs for patients. Arbor Health continues to be in network with Radia and United Healthcare. Superintendent Everett is posting a letter to patients to notify them of the upcoming changes as of April 1st, 2021, as a good faith attempt to notify patients.	
Consent Agenda	Board Chair Frady announced the consent agenda items for consideration of approval: 1. Approval of Minutes a. February 24, 2021 Regular Board Meeting b. March 3, 2021 Quality Improvement Oversight Committee Meeting c. March 24, 2021 Finance Committee Meeting 2. Warrants & EFT's in the amount of $4,408,382.25 dated February 2021	Secretary Herrin made a motion to approve the Consent Agenda and Commissioner Coppock seconded. The motion passed unanimously.

	3. Resolution 21-09-Declaring to Surplus or Dispose of Certain Property 4. Resolution 21-10-Approving Budget Amendment-Morton Clinic Computer Archive 5. Resolution 21-11-Approving Budget Amendment-Endoscopy Equipment Lease 6. Resolution 21-12-Approving Budget Amendment-Lab Equipment 7. Resolution 21-13-Approving Engaging Intrinium for SEIM Tool 8. Approve Documents Pending Board Ratification 03.31.21	
Old Business • Incident Command Update	CNO/CQO Williamson highlighted the following: 1. Clinics are actively engaged in the vaccine efforts. 2. Outreach efforts to reach the vulnerable population continues to be a focus. Marketing/Communications Manager Markham is well networked in the District and will be joining these efforts. 3. Lewis County is 21.53% vaccinated with 1st dose and 11.72% are fully vaccinated. 4. New eligibility tiers opened-1B Tier 3 and Tier 4. 5. Vaccine allocation in Washington continues to improve each week. 6. SARS-CoV-2 Variants are Circulating in WA State and the vaccine effectiveness is a concern.	
• PDC Filing Reminder	Board Chair Frady reminded the Board to complete their WA Public Disclosure Commission (PDC) by April 15, 2021.	Action Item-The Board will complete their PDC by April 15, 2021.
Break	Board Chair Frady called for a 5-minute break at 5:35 p.m. The Board returned to open session at 5:40 p.m.	
New Business • Resolution 21-14-Approving Budget Amendment-Foundation Director	Superintendent Everett reiterated the importance of community outreach as mentioned during the vaccine discussion. The District needs to develop opportunities and create and/or nurture partnerships within the District to reach our constituents. Currently, Marketing/Communications Manager Markham splits her time between the Hospital and the Foundation. Given the increased focus on community outreach needs this will no longer be feasible. Superintendent Everett proposed moving Marketing/Communications Manager Markham out of	Secretary Herrin made a motion to approve RES 21-14. Commissioner McMahan seconded and the motion passed unanimously.

	this role and adding a .75 FTE Arbor Health Foundation Director. Marketing/Communications Manager Markham will coach and support this role during the transition.	
Superintendent Report	Superintendent Everett shared the following: 1. Working with the Rural Collaborative on a shared Compliance Officer. Until the position is filled, Ancillary Services Director Taylor has been appointed as the Interim and will be supporting urgent needs and preparing for the May Meeting. Due to a compliance webinar and a Rural Collaborative Meeting, we are requesting to move the May 12th Meeting from noon to 2 p.m. 2. Presenting the At-Risk Compensation for the Superintendent to document the criteria for eligibility. Reiterated the importance of having this program in place to assist in recruitment and retention of key positions. There are increased expectations for roles which explains the variance in percentages. The At-Risk Compensation will start accruing next month for 2021 and it will be added to the budget process going forward if approved. a. Board Chair Frady proposed approving a resolution to memorialize the agreed upon 2021 Methodology. b. The Commissioners requested an updated budget reflecting the approved budget amendments, as well as the anticipated costs associated to approving the At-Risk Compensation program. 3. Proposing to pivot from a mobile clinic model to opening a Packwood Primary Care Clinic. This option will alleviate transportation burdens to the east end of the District, as well as potentially offer rehabilitation services and telehealth to patients. The next step would include completing a feasibility study. a. The Board fully supports moving forward with a feasibility study on a Packwood Clinic. 4. Proposing to cancel the April Plant Planning Meeting and will plan to reschedule once the RFP's come back for the rehab of Morton Clinic.	Action Item- Executive Assistant Garcia will move the upcoming May 12th Compliance Meeting to 2 pm. Commissioner McMahan made a motion to approve RES 21-15. Secretary Herrin seconded, Commissioner Schumaker abstained and the motion passed. Action Item- Superintendent Everett and CFO Boggess will present an updated budget with amendments at the April Finance Committee Meeting. Action Item- Superintendent Everett and CFO Boggess will do a feasibility study on a clinic in Packwood.
Meeting Summary & Evaluation	Superintendent Everett highlighted the decisions made and action items.	

Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourn the meeting at 6:22 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Quality Improvement Oversight Committee Meeting
April 7, 2020 at 7:00 a.m.
Zoom

AGENDA	DISCUSSION	ACTION
Call to Order Roll Call	Commissioner McMahan called the meeting to order at 7:00 a.m. Commissioner(s) Present in Person or via Zoom: ☒ Wes McMahan ☒ Chris Schumaker Committee Member(s) Present in Person or via Zoom ☒: ☐ Leianne Everett, Superintendent ☒ Dexter Degoma, Interim Quality Manager ☒ Sara Williamson, CNO/CQO ☒ Julie Taylor, Ancillary Services Director ☒ Richard Boggess, CFO ☒ Julie Allen, Quality Data Analyst ☒ David Crouch, Interim Facilities Director ☒ Lynn Bishop, Community Member ☒ Don Roberts, Pharmacist ☒ Shana Garcia, Executive Assistant ☒ Amanda Seals, Employee Health ☒ Dr. Mark Hansen, Chief of Staff ☒ Dr. Kevin McCurry, CMO ☒ David Crouch, Interim Facilities Manager ☒ Emily Mock, Life Center NW ☒ Korri Shimizu, Life Center NW	
Approval or Amendment of the Agenda		Commissioner McMahan made a motion to approve the agenda and Ancillary Commissioner Schumaker seconded. The motion passed unanimously.
Conflicts of Interest	The Committee noted no conflicts of interest.	
Guest Speaker • LifeCenter Northwest-Organ	Korri Shimizu reported the following: 1. There were two timely referrals and one missed referral. Recommended training for staff on the importance of the program, as well as timeliness.	Action Item-Interim Quality Manager Degoma will introduce Korri to our new Clinical Educator Hauser to do education on this

Procurement Annual Report	2. Arbor Health does not have an Organ, Tissue and Cornea Donation Policy on file with LifeCenter NW. 3. Arbor Health has a gap in data for 2019 & 2020 Death Record List. Commissioner McMahan recommended promoting a local story with an organ recipient to motivate the staff.	LifeCenter NW and timely referrals. Action Item- Interim Quality Manager Degoma will connect with Korri on a sample Organ, Tissue and Cornea Donation policy, as well as more information on Determination of Brain Death.
Consent Agenda	1. Approval of the following: a. Quality Improvement Oversight (QIO) Committee Meeting 03/03/21 b. Safe Patient Handling Committee Meeting 03/11/21 c. Environment of Care (EOC) Committee Meeting 03/17/21 2. Approval of the following Plans, Policies and Procedures in Lucidoc. a. Annual CAH Evaluation b. Emergency Preparedness Management Plan 2021 3. After the packet was released the following to manuals were added for approval by the Infection Prevention Committee: a. Epidemiology Manual b. Infection Prevention Manual	CFO Boggess made a motion to approve the consent agenda and Interim Facilities Director Crouch seconded. The motion passed unanimously. CNO/CQO Williamson made a motion to approve the Epidemiology Manual and Infection Prevention Manual. Commissioner Schumaker seconded and the motion passed unanimously.
Old Business • DNV Accreditation Update	Interim Quality Manager Degoma noted departments continue to prepare for the survey. Improvements include: 1. Ensuring clinical practices are reflected in policies and procedures. 2. Rolling out the 2021 Annual Skills and Competency Fair to all employees. 3. Engaging key leadership positions in Nursing and Facilities. 4. Reviewing competency requirements are integrated. 5. Ensuring the QAPI is brought to current federal and accreditation standards. 6. Continually improving infection prevention practices with COVID-19 awareness.	

	7. Engaging Greeley to review Medical Staff Rules and Regulations. Interim Quality Manager Degoma noted expectations for the DNV Survey and will schedule meetings in the next couple weeks with those that need additional information.	Action Item-Executive Assistant Garcia will schedule a meeting with Board Chair Frady, Commissioner Schumaker and the Quality Team.
• COVID-19 Update	CNO/CQO Williamson highlighted the following: 1. WA State is starting to experience a slight spike in COVID-19 cases due to the variants circulating. 2. The Roadmap to Recovery is transitioning from the disillusionment phase to reconstruction phase. 3. The District can only offer Moderna and Janssen vaccines, so we are unable to vaccinate 16- and 17-year old's. 4. The WA State Demand vs. Supply is almost 100,000 less than expected. 5. As part of the District's outreach efforts, we are planning a Packwood Vaccine Clinic for April 19th, 2021.	
New Business • Antimicrobial Stewardship	Pharmacist Roberts highlighted the following: 1. The Hospital participates in an antibiotic stewardship program. 2. In 2020, the pharmacy department is now driving the program and in the process of completing the seven elements set out by the CDC. 3. Antibiotic use is regularly reported to the Pharmacy & Therapeutic Committee now. 4. Reviewed goals for 2021 and by implementing a couple of them it will assist in working through identified barriers.	
Appendix	Interim Quality Manager Degoma noted this is an evolving calendar and the committee will keep it up to date.	
Meeting Summary & Evaluation	Interim Quality Manager Degoma highlighted the decisions made and action items. Commissioner McMahan requested an update regarding Workplace Safety at the June QIO Meeting.	Action Item- Interim Quality Manager Degoma will have Amanda Health in Employee Health provide an update on Workplace Safety.
Adjournment	Commissioner McMahan adjourned the meeting at 8:00 am.	

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Plant Planning Committee Meeting
April 19, 2021 at 7:00 a.m.
Zoom

AGENDA	DISCUSSION	ACTION
Call to Order **Roll Call**	Secretary Herrin called the meeting to order at 7:00 a.m. **Commissioners Present:** ☒ Tom Herrin, Secretary ☒ Chris Schumaker, Commissioner **Others Present:** ☒ Richard Boggess, CFO ☒ David Crouch, Interim Facilities Manager ☒ Shana Garcia, Executive Assistant ☒ Leianne Everett, Superintendent ☒ Sara Williamson, CNO/CQO	
Approval or Amendment of Agenda	None noted.	
Conflicts of Interest	None noted.	
Consent Agenda • **Review of Plant Planning Minutes-January 18, 2021**	The minutes were approved at the last Regular Board Meeting on January 27, 2021 and the committee did not have any additional edits.	
Old Business • **Emergency Power/OR HVAC Project Update**	CFO Boggess highlighted the following: 1. Schedule payments to Wood Harbinger and McKinstry related to the Project 2. On-budget and schedule with McKinstry. No significant changes orders identified. 3. There are no anticipated delays.	

• **Morton Clinic Repair Update**	CFO Boggess highlighted the following: 1. Anticipated four bid responses and only received two: DAE and McKinstry. Should we receive others, they will be considered until we award the bid. The average is about $1,000,000. 2. The bid scope was to replace flooring, drywall, painting and all of the cabinetry impacted by the event. Cosmetic changes beyond Line-of-sight would be the hospitals responsibility. 3. Hospital Deductible is $10,000. 4. The project costs are inflated due to the current market conditions and working conditions due to COVID. 5. Planning to proceed forward with the lowest bid.	
New Business • **Change of Scope of Emergency Power Project**	CFO Boggess highlighted the following related to changing the scope of the Project 1. Original project scope provided for added emergency lighting in patient rooms. 2. A review of the current wiring has determined that it is compliant with building code at time of completion; however, changes in code have placed it in non-conformance with today's codes. This is a hidden condition and unexpected at the inception of the project. Working on the panel will require bringing it to current code, which will expand the scope of work for McKinstry. 3. An alternative plan to achieve the same outcome of expanded emergency power was developed by Wood Harbinger and Hospital leadership. This plan calls for the intercepting the electric feeds prior to the panels and adding more Automatic Transfer switches. This will allow for greater utilization of the emergency power that is available. Current utilization of emergency power is below 30% of available generator capacity. Increasing the load above 30% would reduce operational testing required of Arbor Health today. 4. The cost estimate to move this direction is as follows: a. Architect and Engineering – $15,383 b. Estimate of Equipment - $101,867 c. Estimate of Construction – $100,000 Total of $217,250.	

	The Plant Planning Committee supports the change order and will inform the Board at the April Regular Board Meeting.	
Adjournment	Secretary Herrin motioned to adjourn at 7:27 a.m.	

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
April 21, 2021 at 12:00 p.m.
Conference Room 1 & Via Zoom

AGENDA	DISCUSSION	ACTION
Call to Order	Commissioner Coppock called the meeting to order via Zoom at 12:02 p.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 ☒ Char Hancock, Clinic Manager ☒ Sherry Sofich, Revenue Cycle Director	
Approval or Amendment of Agenda	Commissioner Coppock requested a correction to the Consent Agenda to amend the February Financials to the March Financials. CFO Boggess requested to amend the agenda by adding At Risk Compensation and 2021 Budget Amendments to New Business.	Secretary Herrin made a motion to approve the amended agenda and Community Member Fisher 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 –March 24, 2021 2. Revenue Cycle Update 3. Board Oversight Activities 4. Financial Statements-~~February~~ March	Secretary Herrin made a motion to approve the consent agenda as amended and Community Member Fisher seconded. The motion passed unanimously.

Old Business • **Financial Department Spotlight-Revenue Cycle & Morton Clinic**	Revenue Cycle Director Sofich and Clinic Manager Hancock provided departmental updates which include current state, challenges, opportunities, and financial position to date.	
• **Disaster Funding Update**	CFO Boggess noted there is no update regarding the PPP loan and monies will be recognized in 2021. The Provider Relief Fund Portal is still not open to report revenues and cost information. Auditors agree with our computation and recognizing the entire amount of Provider Relief Funds as lost revenue under current guidance. The District expects to receive from Insurance Carrier $95,238 for business interruption cost.	
New Business • **At-Risk Compensation**	CFO Boggess presented the At-Risk Compensation at the following: 1. 75% Accrual=$238,281 2. 100% Accrual=$317,708 Administration is proposing we accrue at 75% for 2021 to be paid out in first quarter of 2022. The Finance Committee supported this proposal and Superintendent Everett will share additional information at the April Regular Board Meeting.	
• **2021 Budget Amendments**	CFO Boggess presented the 2021 budget with approved amendments to date: RES 21-04, RES 21-10, RES 21-11 and RES 21-14. Net Income is now at $88,155 and does not factor in the implications of the cost report.	
• **Health Insurance Performance**	CFO Boggess shared the District's plan experience in quarter one is unfavorable to budget by 39%. Utilization stats exceed all comparisons with three claims exceeding the shock claim threshold of $40,000.	
• **Financial Audit Update**	CFO Boggess shared the District engaged Dingus, Zarecor & Associates for the 2020 audit. There are 3 items of risk with this year's audit: valuation of Accounts Receivable, Cost Report settlement calculation and COVID event transactions. Overall, Administration is expecting a favorable outcome to the audit. DZA will report at the May Finance Committee Meeting and Regular Board Meeting on the 2020 Audit Results.	
• **Capital Update**	CFO Boggess shared that during construction, we have identified a hidden condition the project of expanding emergency power to patient rooms. The	Action Item-Executive Assistant Garcia will include a resolution in

	team has reviewed an option to achieve the outcome. Expanding the project scope and cost is the best alternative to make sure we improve the plant. Due to the expanded scope, the costs will increase by an estimated $220,000. The Plant Planning Committee supports the scope of the project. Resolution 20-39 approves an initial project cost of $2,400,560 and this would amount would need additional approval. The Finance Committee supported the change order and will recommend approval of a resolution at the April Regular Board Meeting.	the Board Packet in April for the approval of the purchase of Emergency Power Change Order.
Meeting Summary & Evaluation	Superintendent Everett 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 1:08 pm.	

WARRANT & EFT LISTING NO. 2021-03

RECORD OF CLAIMS ALLOWED BY THE BOARD OF LEWIS COUNTY COMMISSIONERS

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

CERTIFICATION

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

Signed:

Richard Boggess, CFO

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

$3,903,486.81 this 28th day

of April 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 ***$3,903,486.81*** dated ***March 1, 2021 –March 31, 2021.***

Routine A/P Runs

Warrant No.	Date	Amount	Description
120419 - 120432	1-Mar-2021	187,631.42	CHECK RUN
120554 - 120555	1-Mar-2021	1,672.94	CHECK RUN
120556 - 120572	8-Mar-2021	727,138.74	CHECK RUN
120573 - 120628	5-Mar-2021	445,823.21	CHECK RUN
120629	4-Mar-2021	3,303.94	CHECK RUN
120630	8-Mar-2021	2,597.50	CHECK RUN
120631	9-Mar-2021	2,015.00	CHECK RUN
120632 - 120700	12-Mar-2021	151,803.44	CHECK RUN
120701 - 120716	15-Mar-2021	139,854.87	CHECK RUN
120717 - 120722	22-Mar-2021	30,624.57	CHECK RUN
120723 - 120757	19-Mar-2021	100,797.19	CHECK RUN
120758 - 120813	26-Mar-2021	13,948.71	CHECK RUN
120814 - 120826	29-Mar-2021	200,595.58	CHECK RUN
120827 - 120890	26-Mar-2021	184,182.50	CHECK RUN
120891 - 120896	31-Mar-2021	553,503.30	CHECK RUN
120897	15-Mar-2021	7,847.12	CHECK RUN
120898	26-Mar-2021	22,148.82	CHECK RUN
120899	29-Mar-2021	691.94	CHECK RUN
120900	31-Mar-2021	981.00	CHECK RUN
Total - Check Runs		$ 2,777,161.79	

Error Corrections - in Check Register Order

Warrant No.	DATE VOIDED	Amount	Description
120185	25-Mar-2021	(2,400.00)	VOID COLLABORATIVE PAID
120048	12-Mar-2021	(10.03)	VOIDED
119811	24-Mar-2021	(142.64)	VOIDED
TOTAL - VOIDED CHECKS		$ (2,552.67)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$ 2,774,609.12

Eft	Date	Amount	Description
1090	2-Mar-2021	12.26	MCKESSON
	5-Mar-2021	420,982.95	PAYROLL
1137	5-Mar-2021	163,969.35	PAYROLL TAXES
1091	9-Mar-2021	16.34	MCKESSON
1092	16-Mar-2021	49.47	MCKESSON
	19-Mar-2021	395,428.19	PAYROLL
1138	19-Mar-2021	148,242.50	PAYROLL TAXES
1093	23-Mar-2021	166.57	MCKESSON
1094	30-Mar-2021	10.06	MCKESSON
TOTAL EFTS AT SECURITY STATE BANK		$ 1,128,877.69	

TOTAL CHECKS, EFT'S, &TRANSFERS	$ 3,903,486.81

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE 2021
QUALITY ASSESSMENT PERFORMANCE
IMPROVEMENT PLAN RESOLUTION NO. 21-16

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

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

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

Approving the 2021 Quality Assessment Performance Improvement (QAPI) Plan.

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 28th day of April 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

DocID:	19683
Revision:	0
Status:	Pending Committee Approval
Department:	Quality
Manual(s):	

Plan : QAPI and Patient Safety Plan

QAPI and Patient Safety Plan

INTRODUCTION

Lewis County Hospital District No. 1 dba Arbor Health (Arbor Health) is located in eastern Lewis County, Washington surrounded by several National Forests and very close to Mt. Rainier National Park. The District operates Arbor Health, a 25-bed, 501c(3) Critical Access Hospital (CAH) providing a range of services including inpatient care, 24-hour emergency services, primary and specialty care, laboratory, pharmacy, diagnostic imaging, surgery, physical therapy and sleep lab. The purpose of a public hospital district under RCW 70.44 includes, among other factors, to provide hospital services and other health care services for the residents of the District and others.

PURPOSE

The purpose of the Quality Assessment, Performance Improvement (QAPI) and Patient Safety Plan is to provide a formal mechanism by which Arbor Health utilizes objective measures to monitor and evaluate the quality of services provided to patients. Quality and Patient Safety are defined broadly to include care that strives to be safe, effective, patient-centered, timely, efficient, and equitable. The plan facilitates a multidisciplinary, systematic performance improvement approach to identify and pursue opportunities to improve patient outcomes and reduce the risks associated with patient safety in a manner that embraces the mission, vision, and values of Arbor Health.

MISSION, VISION , VALUES

OUR MISSION

To foster trust and nurture a healthy community.

OUR VISION

To provide accessible quality healthcare.

OUR CORE VALUES

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

OBJECTIVE

- Continue to build the comprehensive resource infrastructure (i.e., human capital, data collection, analysis, process improvement, outcome assessment, software, education and training)
- To provide a framework for integrating quality, safety, and service into performance improvement opportunities, implementing actions, and evaluating results based on the aspirational goals of always providing care that is safe, effective, patient-centered, timely, efficient, and equitable.
- To encourage an environment that supports safety, encourages non-punitive reporting, addresses maintenance and improvement in patient safety issues in every department throughout the facility, and establishes mechanisms for the disclosure of information related to errors.
- To focus and coordinate the organization-wide performance improvement, patient safety, and patient experience initiatives based on sound metrics, state of the art analysis, and contemporary improvement methods.
- To facilitate communication, reporting, and documentation of all quality, patient safety, and patient experience activities to professional staff, administration, and appropriate governing members.
- To maximize effective organizational and clinical decision making.
- Promote teamwork and group responsibility in identifying and implementing opportunities for improvement.
- To utilize tools and approaches that capitalize on knowledge regarding holistic approaches to improving quality and safety systems, including those developed outside of health care.
- To enhance the integration of medical staff physicians into meaningful patient safety, patient experience, and quality initiatives.

STRUCTURE AND LEADERSHIP

Key employees are responsible for the development and implementation of the QAPI and Patient Safety Plan. These individuals, Arbor Health's Superintendent/Chief Executive Officer, Chief Nursing and Quality Officer, Chief Financial Officer, and Chief Human Resources Officers are joined by the hospital Chief Medical Officer and Chief of Staff to fully represent the spectrum of hospital services. These leaders work directly and openly to improve quality by setting priorities, modeling core values, promoting a learning atmosphere, acting on recommendations, and allocating resources for improvement. These individuals are supported by a structure of formal and informal committees or work groups where the components of the program are defined, implemented, refined, and monitored. These groups are comprised of attending physicians, staff, management, and members of the Board of Commissioners and are represented via a reporting process to the Quality Improvement Oversight Committee for QAPI and patient safety reporting. The Quality Improvement Oversight Committee which in turn reports to the Board of Commissioners.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROCESS

A. PRIORITIZATION OF AREAS FOR MEASUREMENT

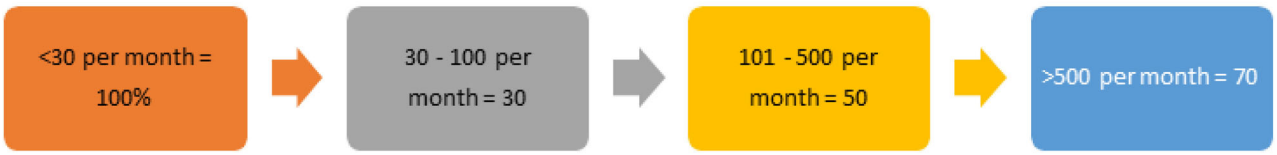
The process for identifying priorities for measurement requires input and discussion with senior leadership, departments, and services from all areas involved with quality performance measurement and improvement. Priorities are identified based on leadership objectives, regulatory requirements, opportunities identified in external benchmark projects, opportunities identified through analysis of patient safety event reports and opportunities identified through sentinel events, standard of care findings or "Sentinel Event Alerts." These objectives or topics are then displayed in a matrix to better understand which areas of importance and relevance they cross (high risk, high volume, problem prone, mission, internal and external customer satisfaction, clinical outcome, safety, and regulatory).

B. DEVELOPING MEASURE SPECIFICATIONS

Work groups or committees define the metrics (indicators, goals, and benchmarks) for each topic. Representatives from all involved services collaboratively develop quality performance measure specifications based on the opportunities identified to be studied. Team members are identified with the help of clinical and administrative leadership. Work groups develop written measurement specifications, along with data abstraction tools when necessary.

C. GATHERING DATA

Data is then gathered on a pre-determined timeframe (weekly, monthly, quarterly). Regular reporting of data requires continued attention from teams. A designated person will be assigned and held accountable for gathering data and having the information available when due. Sampling sizes are determined based on recognized, statistically significant sample sizes of:



Real time data are collected as possible.

D. ANALYZING AND REPORTING DATA

The work groups discuss data analysis and determine what initiatives must be implemented to attain the desired outcome. Analysis usually involves multiple iterations and analysis to examine different aspects of the quality issue. Whenever possible and appropriate, statistical control methods, trending, and/or comparison with published benchmarks are used to analyze quality and safety measures.

E. IMPLEMENTATION OF ACTIONS AND DISSEMINATION OF INFORMATION

Implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Communication of quality and safety information is the responsibility of clinical and administrative leadership. This information is reported to the Quality Management Department, and throughout the organization, using the Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequent as necessary, the performance is presented at the Quality Improvement Oversight Committee with minutes and then presented to the Board of Commissioners.

QAPI MODEL

Arbor Health has adopted the Plan, Do, Study, and Act (PDSA) methodology for quality assessment and improvement. The PDSA model is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a process.

P = Plan: Identify a goal or purpose, formulate a theory, define success metrics and put a plan into action.

D = Do: Implement the components of the plan

S = Study: Monitor outcomes to test the validity of the plan for signs of progress or success or problems and areas for improvement

A = Act: Integrate the learning generated by the process, adjust the goal or change interventional methods if necessary.

Additional Performance Improvement Methodologies

In addition to the PI methodology outlined above, other tools, techniques and methods are used to achieve improvement based on project goals and/or the nature of the problem under evaluation. Examples include Lean and Six Sigma via the Performance Improvement Program.

PATIENT SAFETY FOCUS

As a patient safety focused organization, Arbor Health has been developed to promote and support practices and policies for providing quality patient care and minimizing adverse incidents in patient care and safety. This program will assist to reduce/prevent risk exposures to the patients, employees, medical staff, and visitors in our facility, maintain equipment, and conserve hospital property. The Patient Safety and performance improvement systems are mutually compatible and interdependent.

Periodically, Arbor Health will survey clinical staff and physicians regarding the Culture of Patient Safety at the hospital. The results from this survey provide hospital leadership with an understanding of the safety culture at the hospital which is the product of the individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Action plans are developed and implemented at the hospital and department/unit level to enhance the culture of safety in order to improve the quality and safety of care provided and improve the reporting of events to enrich the safety culture at the hospital and clinics.

ANNUAL EVALUATION

Arbor Health and the Board of Commissioners shall review the effectiveness of the Quality Assurance Performance Improvement and Patient Safety Plan at least annually in alignment with the calendar year. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Arbor Health and the Board of Commissioners also evaluate annually their contributions to the performance improvement and patient safety activities at Arbor Health. An annual report is submitted to the Board of Commissioners incorporated in the plan.

Approvals

- **Committees:** (Not yet approved) Quality Improvement Oversight Committee, (Pending ratification) Board of Commissioners,
- **Signers:**

Original Effective Date:

Revision Date:

Review Date:

Attachments:
(REFERENCED BY THIS DOCUMENT)

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE 2021
RISK MANAGEMENT PLAN RESOLUTION NO. 21-17

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

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

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

Approving the 2021 Risk Management Plan.

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 28th day of April 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

DocID:	19754
Revision:	0
Status:	Pending Committee Approval
Department:	Quality
Manual(s):	

Plan : Risk Management Plan

Risk Management Plan

OUR ORGANIZATION

Lewis County Hospital District No. 1 dba Arbor Health (Arbor Health) is located in eastern Lewis County, Washington surrounded by several National Forests and very close to Mt. Rainier National Park. The District operates Arbor Health, a 25-bed, 501c(3) Critical Access Hospital (CAH) providing a range of services including inpatient care, 24-hour emergency services, primary and specialty care, laboratory, pharmacy, diagnostic imaging, surgery, physical therapy and sleep lab. The purpose of a public hospital district under RCW 70.44 includes, among other factors, to provide hospital services and other health care services for the residents of the District and others.

PURPOSE

The purpose of this plan is to describe Arbor Health's method to identify, prevent and reduce the occurrences which put people and the organization at risk for harm and financial loss. All departments and clinics participate in patient safety and loss prevention activities.

MISSION, VISION , VALUES

OUR MISSION

To foster trust and nurture a healthy community.

OUR VISION

To provide accessible quality healthcare.

OUR CORE VALUES

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

STRUCTURE AND LEADERSHIP

The Board of Commissioners provides oversight and direction for the Risk Management Plan. The members of the Board receive at least semi-annual reports on risk management activities. They also receive orientation in issues necessary to meet their responsibilities in risk management oversight. Risk management activities are delegated to the Superintendent/Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Nursing/Quality Officer (CNO/CQO), Chief Medical Officer (CMO), and Compliance Officer who have overall responsibility for the implementation and operation of the Risk Management Plan.

PLAN COMPONENTS

Risk management is a planned and systematic process to reduce and/or eliminate the probability that losses will occur at Lewis County Hospital District No. 1 dba Arbor Health. It consists of three distinct interrelated areas:

1. **Risk identification and loss prevention:**

These activities include the identification and correction of situations or problems which could potentially result in events or incidents of liability for the District, its employees, physicians and other health care providers.

2. **Loss reduction:**

Loss reduction includes those steps taken after an event or incident occurs to minimize the adverse impact on the patient, the District, or its staff.

3. **Risk financing:**

This involves the mechanisms utilized to ensure adequate financial resources are available to cover any potential liability situation.

POSITION AND COMMITTEE RESPONSIBILITIES

To be most effective in the healthcare setting, risk management involves the participation of every employee. The following positions and committees perform specific activities related to risk identification and loss prevention, loss reduction, and risk financing functions.

A. RISK MANAGEMENT

Risk Management is a coordinated system-wide process which identifies, prevents, or minimizes events that may present potential liability to our patients, visitors, volunteers, and staff. The Risk Management Department strives to attain the ultimate goals of a safe environment and quality patient care. While conducting event investigations, the Risk Management Department makes the determination for what tools will be used to complete the investigation, including what regulatory reporting is required (i.e. Serious Event, Root Cause Analysis and/or Failure Mode and Effects Analysis). The Risk Management Department also provides a wide variety of education to minimize exposure to the facility and its employees. Topics include but are not limited to Disclosure, Documentation and Informed Consent. The Risk

Management Department is available to all physicians, staff/employees for consultations, advice and help in dealing with difficult patient/visitor issues.

B. SUPERINTENDENT/CHIEF EXECUTIVE OFFICER (CEO)

In conjunction with the Chief Medical Officer and Chief Nursing/Quality Officer, this position reviews and manages the flow of information pertaining to the Risk Management Plan. The Superintendent/CEO procures adequate liability insurance coverage at reasonable premiums to cover losses. The District participates in professional and general liability insurance programs that provide coverage for medical malpractice and other types of negligence claims. The Superintendent/CEO also effectively negotiates and uses indemnity provisions in District contracts to transfer liability risks to other parties whenever possible. When necessary, legal advice is sought to advise the facility's administration, clinical and other staff in an attempt to minimize risk and loss and to assure that the organization and its policies, procedures and practices remain in compliance with applicable state and federal laws, rules and regulations. The Superintendent/CEO serves as the focal point of coordination for activities concerning risk management, relying upon input from each of the positions/areas outlined in this plan. The Superintendent/CEO procures and administers the District's malpractice insurance policies.

C. CHIEF FINANCIAL OFFICER (CFO)

Directs and coordinates district activities concerned with the financial administration, general accounting, patient business services, data processing, admission, medical records, health care review, resident activities, and statistical reporting. Provides necessary data and information for risk management purposes as required.

D. CHIEF NURSING AND QUALITY OFFICER (CNO/CQO)

In conjunction with the Superintendent/CEO and CMO, this position reviews and manages the flow of information pertaining to
the Risk Management Plan. Directs the following activities related to evaluating the quality of care provided and reports areas of potential risk to the Superintendent/CEO, QI Oversight Committee, Board of Commissioners, other appropriate staff or regulatory agency, for corrective action and improvement purposes:

- Quality Improvement Oversight Committee
- Quality Council
- Infection Prevention Committee (in conjunction with the Infection Preventionist and Epidemiologist)
- Environment of Care Committee
- Life Safety Committee
- Safety Committee
- Safe Patient Handling Committee (in conjunction with Safe Patient Handling Coordinator)
- Critical Access Hospital Evaluation (in conjunction with the Superintendent/CEO and CFO)
- Plans of Correction and Progress Reports for DOH surveys (in conjunction with the Superintendent/CEO and CFO)
- Complaints
- Quality Management Memos (incident reports)
- Adverse Events
- Restraint use
- Quality Assurance Performance Improvement (QAPI) Plan
- Risk Management Plan (in conjunction with the Superintendent/CEO and CMO)
- Peer Review
- Ongoing Professional Practice Evaluation (in conjunction with the Credentials Coordinator)
- Patient Satisfaction
- Hospital Inpatient and Outpatient Quality Reporting to Center for Medicare and Medicaid Services (CMS)
- Washington Rural Healthcare Collaborative (WRHC) quality measures
- Nursing documentation review quality Assurance Performance Improvement (QAPI) for District owned Rural clinics
- Rural Health Clinic annual program evaluations
- Washington Rural Healthcare Collaborative (WRHC) quality measures
- Nursing documentation review

- WSHA quality measures & projects
- Washington Department of Health Medicare Beneficiary quality Improvement program (MBQIP)
- Quality Improvement and risk management education

The CNO/CQO directs Nursing Services, Case Management, Surgical/Sterile Processing/Outpatient Services, Emergency Room, Wound Care, Nurse education, quality, Infection Prevention, Laboratory, and Imaging regarding issues related to quality and safety of clinical practice. This includes continual design and implementation of strategies to improve patient Care which are in alignment with research evidence based medicine. All areas perform risk management duties that help support safe operation of clinical units and coordinate with other departments, such as Central Supply, clinics and Anesthesiology. They insure supplies, Surgical materials and special equipment are Sterile and ordered in advance. They also insure data regarding Surgical Care, Infection Prevention, trauma, utilization, and other measures are made available to The quality Manager and/or CNO/CQO. This data is aggregated into trending information for risk analysis and assessment by The quality Manager and CNO/CQO.

The CNO/CQO serves on The Quality Improvement Oversight Committee and provides information regarding risk management activities. This Committee also receives reports from the Quality Manager on Quality Improvement Assurance and Improvement activities, medical staff peer reviews, on- going professional practice evaluations, hospital quality dashboard reports, progress on patient safety measures, employee satisfaction, patient satisfaction, and other quality initiatives. The Quality Improvement Oversight Committee reports quarterly to the Board of Commissioners.

E. CLINICAL INFORMATICS TEAM

The Nursing Informatics Team is nursing's primary resource for designing, building, and maintaining of the electronic health record (EHR), as well as training nursing staff on its use. The team also modifies and tests clinical applications for efficiency and effectiveness and identifies and communicates areas of potential risk to the Clinical Informatics Supervisor. In conjunction with the Clinical Informatics Supervisor, assures the clinical documentation system effectively supports and enhances the clinical process. The Clinical Informatics Supervisor directs the Coordinator and works with the Cerner team to develop and implement EHR updates or changes. The Supervisor coordinates the collection and analysis of metrics that relate to benefits realization and the return on investment in the clinical information system. This position analyzes data and makes changes in coordination with other departments. The EHR is a legal document that can be used by an injured patient in legal proceedings or in other legal matters.

F. COMPLIANCE OFFICER

The Compliance Officer is responsible for:

- Updating the Compliance Program Plan and assuring a system for prompt response to Compliance issues
- Communicating to staff the compliance hotline number and other means for reporting non-compliance
- Distributing the hospital's Standards of Conduct
- Investigating reported improprieties and/or non-compliance
- Reviewing/updating compliance policies and procedures
- Auditing departments on a routine basis to prevent, detect, and correct non-compliance
- Reporting progress on issues or concerns to the Administrator
- Providing the Board of Commissioners with periodic reports
- Providing effective education and training regarding Compliance and its purpose

G. CHIEF HUMAN RESOURCES OFFICER

In conjunction with the Credentialing Coordinator, Credentials Committee, Medical Executive Committee, and Board of Commissioners, is responsible for required credentialing and privileging of the facility's medical staff to ensure licensing and competency for the protection of patients at Arbor Health. The Chief Human Resources Officer, in coordination with Department Directors and/or Managers, is also responsible for ensuring current licensure and competency of all staff. This position directs the following policies and activities:

- Industrial Accident – Incident Claim policy
- Personnel Policy and Procedures Manual
- Group health insurance plans (health, dental, life, disability) for employees
- Pension plan for employees with the pension consultant
- Assistance to managers on employment issues in accordance with policies and union contracts

- Pre-Employment Drug Testing policy
- Sexual Harassment policy
- Labor negotiation sessions and preparatory work including salary reviews
- Collection of pertinent information and maintenance of files on arbitration sessions with employees
- Comprehensive orientation and training for new employees
- RELIAS training for employees by department
- Education Steering Committee – determines the annual planning cycle to assure that requirements are addressed, burden of education pushed at end of year is reduced, educational topics align with strategic plan, quality metrics are achieved, current organizational tactics are covered, tools and applications are reviewed and optimized.

H. FACILITIES MANAGER

The Facilities Manager is responsible for the overall physical facilities. This position chairs the Life Safety Committee which is also responsible for the organization's disaster preparedness. The Facilities Manager ensures that regular fire safety inspections and drills are done and that the appropriate scheduled inspection of all medical and other equipment is accomplished, as well as having all repairs/replacements done when necessary. The Facilities Manager has written procedures to follow in the cases of equipment/supply recall to assure that all equipment subject to recall is appropriately serviced, repaired, returned or otherwise removed from service when required for the safety of the patients, employees and/or others. The Facilities Manager reports quarterly on specific facility improvement indicators at EOC Committee. The Facilities Manager is responsible for administering the following plans and related policies or procedures through the Safety and Life Safety Committees:

- Fire Safety Management Plan
- Fire drills
- Emergency Preparedness Management Plan
- Emergency preparedness drills (including NIMS)
- Medical Equipment Management Plan
- Review medical equipment tests
- Utility Systems & Physical Environment Management Plan
- Review preventative maintenance (inventory, performance, documentation)
- Security Management Plan
- Security rounds
- Hazardous materials and Waste management (HMWM) Plan
- Chemical hazard/SDS
- Code drills (Orange, Gray, Silver, Amber, White)
- These plans and/or policies are a vital part of he organization's risk management plan.

I. SAFETY OFFICER

The Safety Officer is chair of the Safety Committee, voted in annually by its members. The Safety Officer and Committee is responsible for the organization's Safety and Accident Prevention Plan and assures the following activities occur:

- EOC/Safety rounds
- PPE hazard assessment
- New product evaluations
- Review staff accidents
- Evaluate & update Safety & Accident Prevention Plan
- Review L&I accident claims and rates of injury
- Maintain Safety bulletin boards

- Post Washington Industrial Safety and Health Act (WISHA) Poster(s)
- Educate staff

J. MEDICAL STAFF

The Medical Staff is responsible for governing the medical practice at the hospital. The Chief of Staff chairs the Medical Executive Committee which receives information from the Chief Medical Officer, Credentials Committee, Quality Oversight Committee, Infection Prevention Committee, Pharmacy and Therapeutics Committee, Bylaws Committee, and Utilization Review/Medical Records/Tissue and Transfusion Committee. These committees assist the medical staff in identifying areas of risk and in providing information required to correct or decrease the risk. The Medical Executive Committee is responsible for addressing risk management issues as they relate to medical staff appointment, reappointment, privileging, peer review, competence, and intimidating and disruptive behavior. The hospital is required by law to report to the Department of Health the termination or restriction of staff privileges of any licensed physician. In addition, physicians and hospitals are required by law to report to the Medical Quality Assurance Commission or other appropriate division of the Department of Health, any information that appears to show a physician is or may be unable to practice medicine with reasonable skill and safety. The Commission/division then makes its own investigation.

K. PHARMACIST

The Pharmacist chairs the Pharmacy and Therapeutics Committee which is a standing committee of the Medical Staff. The Pharmacy and Therapeutics Committee is responsible for evaluating available evidence regarding the relative safety, efficacy and effectiveness of therapeutic agents and devices used in the hospital and clinics to ensure their quality meets said standards. They continually revise the hospital formulary so it represents the best available for prophylaxis or management of disease and meets the needs of patients. The Pharmacist recommends quality control specifications, methods of distribution and control, and drug utilization reviews. The Pharmacist routinely provides (among other responsibilities):

- Verification of orders versus MARS for accuracy of transcription
- Review of antibiotic use
- Unit dose dispensing for medication
- Techniques to enhance distinction between look-alike/sound alike drug names
- Assistance in the formulation and implementation of programs designed to meet the needs of the medical and nursing staff for complete and current knowledge related to drug practice
- Advise to medical staff in the selection of drugs
- Data/information to medical staff regarding drug usage, adverse drug reactions and medication errors
- Investigation of Quality Management Memos – Medication
- Help to medical staff to differentiate between similar therapeutic agents

L. INFECTION PREVENTION AND CONTROL

The Infection Preventionist provides advanced professional and clinical leadership on infection control and prevention matters and administers the Infection Control and Prevention Plan. This position, in conjunction with a contracted Epidemiologist, is responsible for the management of infectious disease identification, surveillance, prevention, control, investigation, consultation, research, education, and development and review of related policies and procedures. Additionally, this position directs the hospital and associated clinics in complying with related local, state, and federal guidelines, standards and regulations. This role is an integrated function of the organization-wide quality and patient safety program.

M. EMPLOYEE HEALTH

The Employee Health Nurse is also responsible for tracking and reporting staff exposure to infectious disease, actual infection, and immunization and tuberculosis screening and compliance. This position provides TB screening of each new employee and TB review/latent TB testing and immunization review of current employees on an annual basis. This position conducts evaluation of ill employees and helps determine need for work restrictions, therapy or referral, and need for communicable disease evaluation. The Employee Health Nurse, in conjunction with the Epidemiologist, also evaluates exposures to contagious disease, environmental hazards, and bioterror issues. This position takes appropriate corrective action including notification of public health authorities, dissemination of information, training or education, developing preventative measures, and improving communication to reduce/prevent future risk. Quarterly data on exposures, infections, and TB screening and compliance is provided to the Infection Control Committee which recommends corrective action and reports areas of potential risk to the Medical Executive Committee.

N. CLINICAL EDUCATION

Clinical Education helps plan, develop and implement clinical education and training. Appropriate education programs are developed as needed to address medical-legal and risk management related subjects. Education and in-services are also provided as the result of tracking and trending of patient care and safety measures data.

O. EMERGENCY DEPARTMENT

The RN Emergency Department Coordinator, in conjunction with the Emergency Department Medical Director, provides leadership, generates decisions and sets goals to assure the unit meets and exceeds the standards of care defined for the patient population. The RN Emergency Department Coordinator audits patient care and provides data that is aggregated into trending information for risk analysis and assessment of emergency care measures to the Trauma Quality Improvement Committee. This position also provides incident reports and findings to the Quality Manager and CNO/CQO. Serious Incidents may result in activation of the Adverse Event/Sentinel Event protocol and root cause analysis (RCA) process. The Quality Manager further defines, aggregates, trends, analyzes, and reports on incidents to the QI Oversight Committee.

P. CASE MANAGEMENT

The Case Manager works with the patient, family and medical providers to foster communications and effective, efficient care. This position coordinates patient transitions through the hospital. The Case Manager is responsible for regularly assessing the patient and working with the patient's medical team to chart the patient's progress and monitors that the plan of care is being carried out. The Case Manager makes sure the patient understands medical instructions and that the medical team understands the patient's needs and concerns. This position acts as the patient's advocate and the care team's representative, trying to make sure everyone works together for the benefit of the patient. The Case Manager is also responsible for Utilization Review and intervenes as appropriate when changes in status are indicated.

Q. SAFE PATIENT HANDLING COMMITTEE

The Safe Patient Handling Committee responsible to the Environment of Care Committee. The primary responsibility of the Safe Patient Handling Committee is to establish, implement and monitor the Safe Patient Handling Program. This program develops and implements strategies to control the risk of injury to patients and health care workers associated with the lifting, transferring, repositioning, or movement of a patient. The committee works in close conjunction with the Infection Prevention Nurse, Safety Committee and appropriate nursing leadership to carry out its responsibilities. Areas/issues of potential risk are reported to the EOC Committee for monitoring and further improvement purposes. Specific responsibilities of the Safe Patient Handling Committee are:

- Review all patient falls
- Review staff accidents related to patient handling
- Evaluate & update Safe Patient Handling Program/ Plan
- Code drills (Rapid Response)
- Educate staff

R. SUPPLY CHAIN MANAGEMENT

The Purchasing Clerk chairs the ad-hoc Product Evaluation Sub-Committee which is responsible to the Safety Committee. The Product Evaluation Sub-Committee evaluates new and replacement products for safety, effectiveness and cost. Members of this sub-committee include the Pharmacist, CNO/CQO, Infection Preventionist, Case Manager, Quality Manager, Chief Medical Officer, Controller, and other staff as necessary to ensure its findings are congruent with environment of care, life safety, infection prevention and control, medication management, and patient safety standards. It reports its findings to the appropriate director/manager/department, the Safety Committee and the Infection Prevention Committee, which reviews any issues of potential risk. The Purchasing Clerk monitors and updates the following policies and/or procedures to address special safety issues in emergency situations. These policies and/or plans are a vital part of the organization's Risk Management Plan:

- Safety Data Sheet (SDS) Management
- Medical Device Recalls and Hazard Notices

S. INFORMATION TECHNOLOGY

The Information Technology Manager conducts security and risk assessment of potential threats to District information systems. This position organizes an appropriate defense system and inserts controls intended to prevent accidental hazards, deter intentional acts, detect problems as early as possible, enhance damage recovery, and correct problems. This position is also responsible for providing awareness training (of security threats and potential problems and crimes) to staff and assessing the number and type of work orders received. These findings are aggregated and reported to the QI Committee and areas/issues of potential risk are reported to the CFO and President and Superintendent.

EVENT REPORTING

Employees/Physicians are the eyes and ears of the organization and have a responsibility to use sound patient safety practices in caring for our patients. All employees/physicians are responsible for patient safety. Every employee/physician has the following responsibilities when an untoward event occurs:

- First and foremost, take appropriate steps to care for the patient and minimize negative outcomes.
- Contact the patient's attending physician to report the incident and implement any therapy or treatment ordered.
- Implement steps to contain the risk to others, as appropriate.
- Enter an incident report in the electronic incident reporting system (ComplyTrack system).
- Take care of any family needs, as appropriate.
- Disclosure of the event by the appropriate care team to the patient/family.
- Documentation of the event and the disclosure in the medical record.

All members of the medical staff, house staff, and employees are required to report suspected and/or identified medical errors/events and should do so without the fear of reprisal/retaliation in relationship to their employment. A report of an event or hazard may be entered into the electronic event reporting system (ComplyTrack) with or without providing your name.

MANDATORY STATE REPORTING OF EVENTS

The State of Washington requires mandatory electronic reporting by all licensed health care facilities of any incident or event that may be
associated with or may be an actual patient safety concern; and requires an automatic disclosure to patients and their families. Events of interest to the Commonwealth are described as Incidents, Serious Events or Infrastructure Failures.
What is an Incident?
An incident is an event, occurrence, or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event.
What is a Serious Event?
A serious event is an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. The term does not include an incident.
What is an Infrastructure Failure?
An infrastructure failure is an undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety. The Quality Management Department in concert with Administration make all determinations as to what occurrences are reported to the state.

CULTURE OF PATIENT SAFETY

Periodically, Arbor Health will survey clinical staff and physicians regarding the Culture of Patient Safety at the hospital. The results from this survey provide hospital leadership with an understanding of the safety culture at the hospital which is the product of the individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Action plans are developed and implemented at the hospital and department/unit level to enhance the culture of safety in order to improve the quality and safety of care provided and improve the reporting of events to enrich the safety
culture at the hospital and clinics.

POTENTIAL LEGAL ACTION

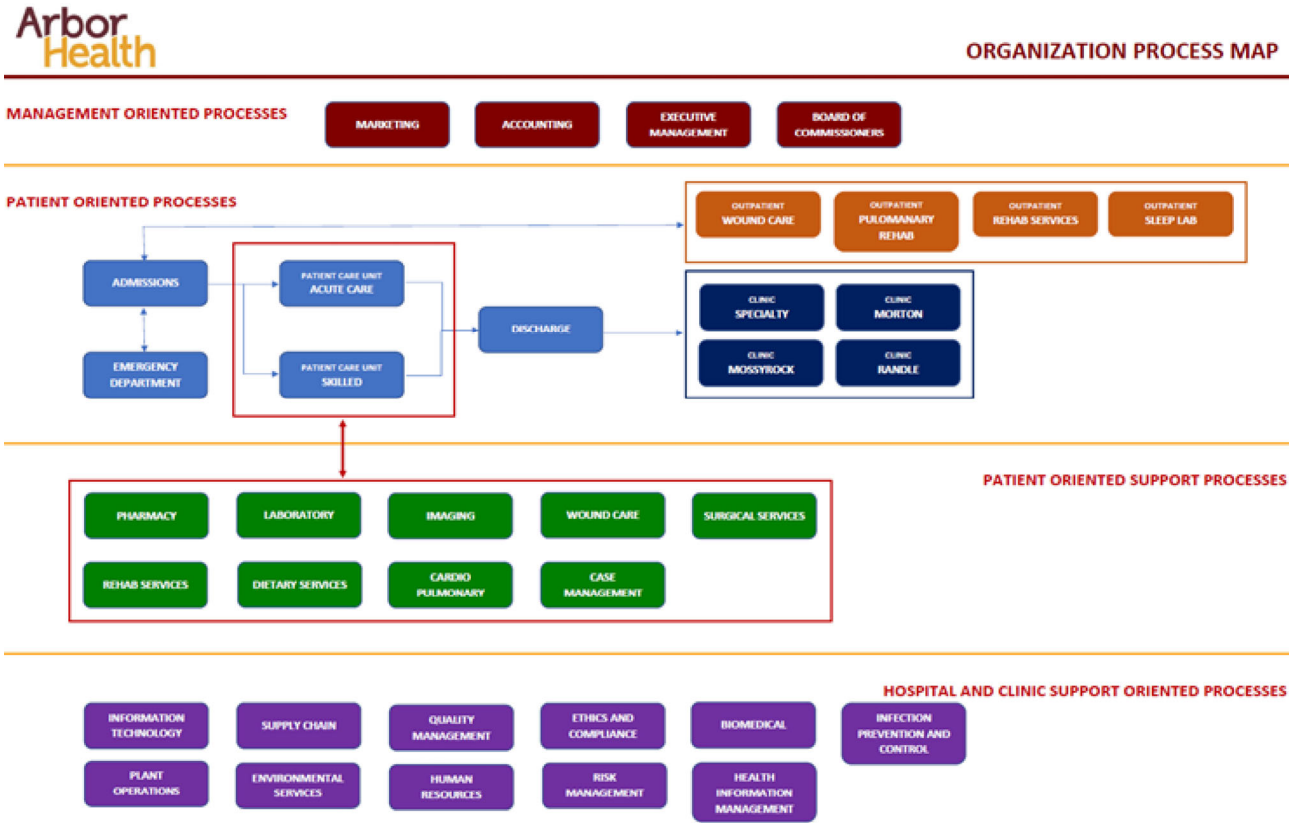
If any employee learns of an incident or complaint that may lead to legal action against the hospital or a staff member, that person should immediately notify the Compliance Officer, CEO, CFO, CMO, or CNO/CQO. Employees should not speak with attorneys or investigators who are not affiliated with the District regarding any matter involving the District unless specifically authorized to do so. Questions regarding whether a person is a hospital representative or for other guidance should be directed to the CEO.

ANNUAL EVALUATION

Arbor Health Morton Hospital and the Board of Commissioners shall review the Risk Management Plan at least annually in alignment with the calendar year. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Arbor Health and the Board of Commissioners also evaluate annually their contributions to the performance improvement and patient safety activities at Arbor Health.

IMPLEMENTATION OF ACTIONS AND DISSEMINATION OF INFORMATION

Implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Communication of quality and safety information is the responsibility of clinical and administrative leadership. This information is reported to the Quality Management Department, and throughout the organization, using the Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequent as necessary, the performance is presented at the Quality Improvement Oversight Committee with minutes and then presented to the Board of Commissioners.



Document Owner: Degoma, Dexter

Collaborators: Everett, Leianne
Williamson, Sara

Approvals

- Committees: (Not yet approved) Quality Improvement Oversight Committee, (Pending ratification) Board of Commissioners,

- Signers:

Original Effective Date:

Revision Date:

Review Date:

Attachments:
(REFERENCED BY THIS DOCUMENT)

Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE 2020
CRITICAL ACCESS HOSPITAL
EVALUATION

RESOLUTION NO. 21-18

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 2020 Critical Access Hospital Evaluation.

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 28th day of April 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

2020 CRITICAL ACCESS HOSPITAL PERIODIC EVALUATION

January 1, 2020 - December 31, 2020

Submitted for Review and Approval
March 3, 2021
Quality Improvement Oversight Committee

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OUR ORGANIZATION

Lewis County Public Hospital District No. 1 dba Arbor Health is located in eastern Lewis County, Washington surrounded by several National Forests and very close to Mt. Rainier National Park.

The District operates Arbor Health Morton Hospital, a 25-bed, 501c(3) Critical Access Hospital (CAH) providing a range of services including inpatient care, 24-hour emergency services, primary and specialty care, laboratory, pharmacy, diagnostic imaging, surgery, physical therapy and sleep lab.

The purpose of a public hospital district under RCW 70.44 includes, among other factors, to provide hospital services and other health care services for the residents of the District and others.

PURPOSE

The purpose of the Annual Critical Access Hospital (CAH) Evaluation is to provide a formal mechanism by which Arbor Health carries out a periodic evaluation of its total program periodically. The evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed. In alignment with the Centers for Medicare and Medicaid Services'(CMS) Condition of Participation (CoP) for CAH, this document describes and includes but not limited to the review of utilization of Arbor Health's services, outcomes from active and closed clinical records, and a report of key policies and procedures that were either newly developed, reviewed and updated.

MISSION, VISION, VALUES

Our Vision

To provide accessible, quality healthcare

Our Mission

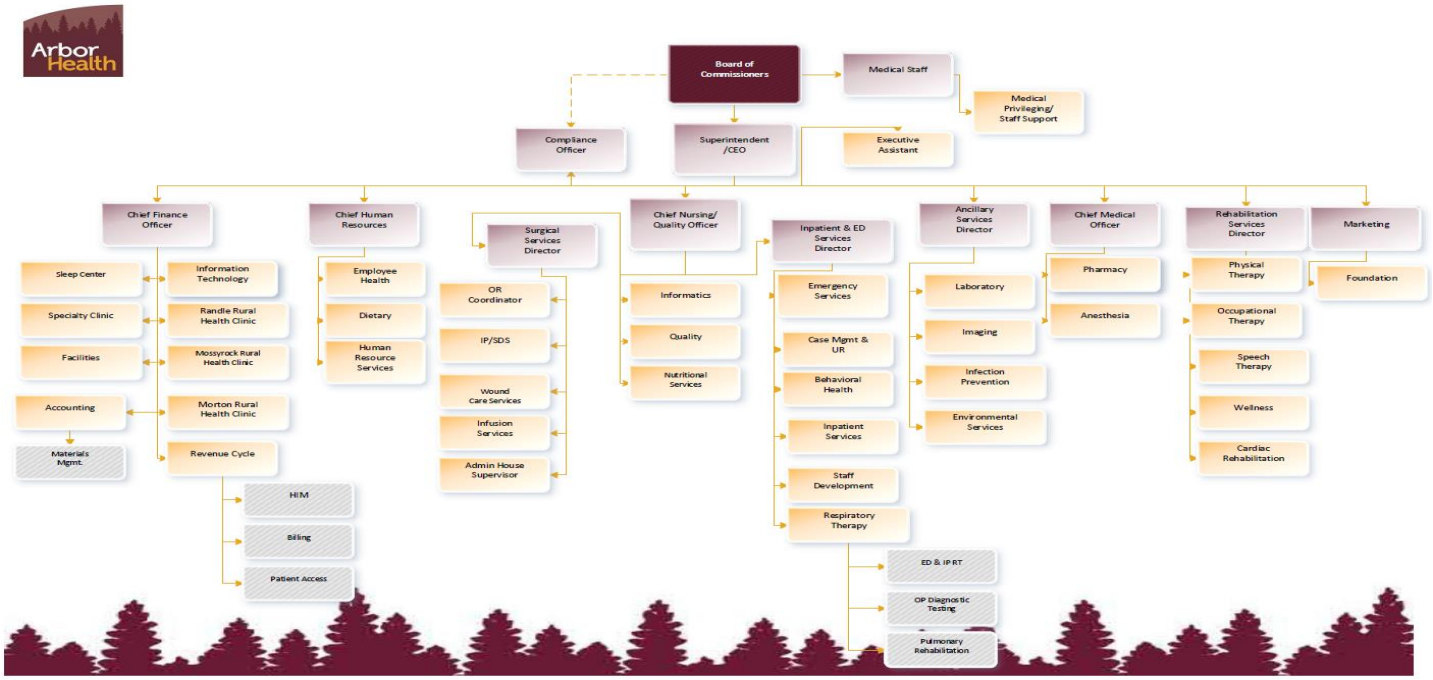
To foster trust and nurture a healthy community

Core Values

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

STRUCTURE AND LEADERSHIP

Key employees are responsible for the development, evaluation, and review of Arbor Health's Annual CAH Evaluation. These individuals, Arbor Health's President and Superintendent, Chief Clinical Officer, Chief Financial Officer, and Director of Human Resources are joined by the hospital Chief Medical Officer and Chief of Staff to fully represent the spectrum of hospital services. These leaders work directly and openly to improve quality by setting priorities, modeling core values, promoting a learning atmosphere, acting on recommendations, and allocating resources for improvement. These individuals are supported by a structure of formal and informal committees or work groups where the components of the program are defined, implemented, refined, and monitored. These groups are comprised of attending physicians, staff, management which in turn reports to the Board of Commissioners.



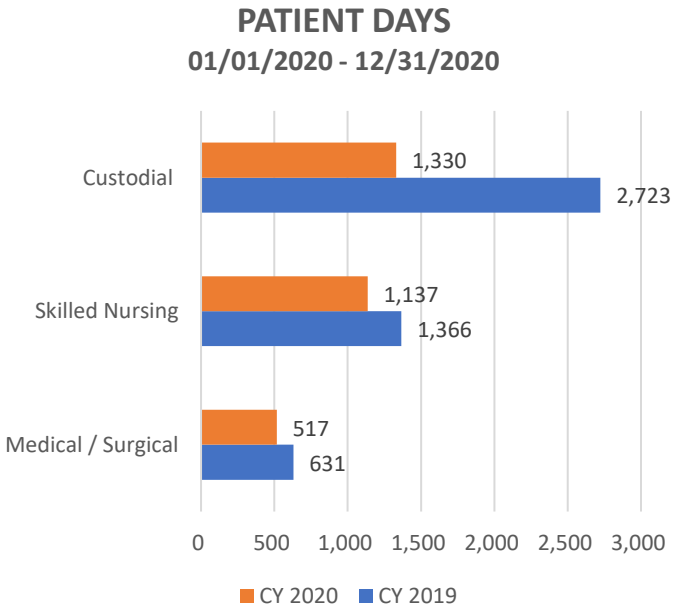
PROGRAM EVALUATION

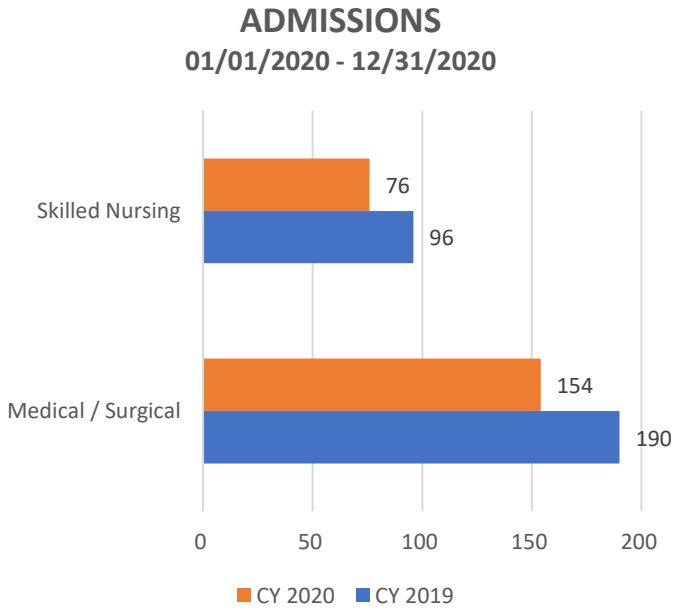
A. OUR SERVICES

- 24-hour, on-site ER Doctor
- Morton Clinic
- Mossyrock Clinic
- Randle Clinic
- Specialty Clinic
  - General Surgery
  - Women's Health
  - Sleep Medicine
- Wound Care Clinic
- Clinical Laboratory
- Consulting Specialists
- Diagnostic Imaging
  - CT Scan
  - 3-D Digital Mammography
  - Digital X-Ray
  - MRI
  - Nuclear Medicine
  - Ultrasound
- Behavioral Health
- Nutritional Services
- Outpatient Drug Therapy
- Physical Rehabilitation
  - Aqua Therapy
  - Occupational Therapy
  - Physical Therapy
  - Respiratory Services
  - Speech Therapy
- Sleep Lab
- Social Services

B. VOLUME AND UTILIZATION

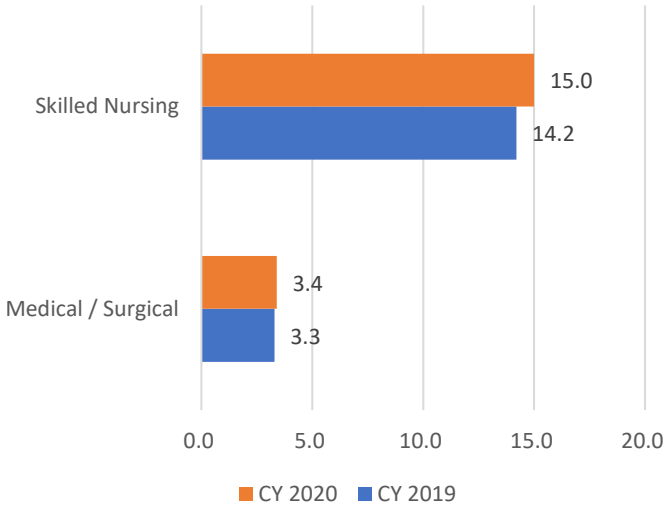
INPATIENT UTILIZATION



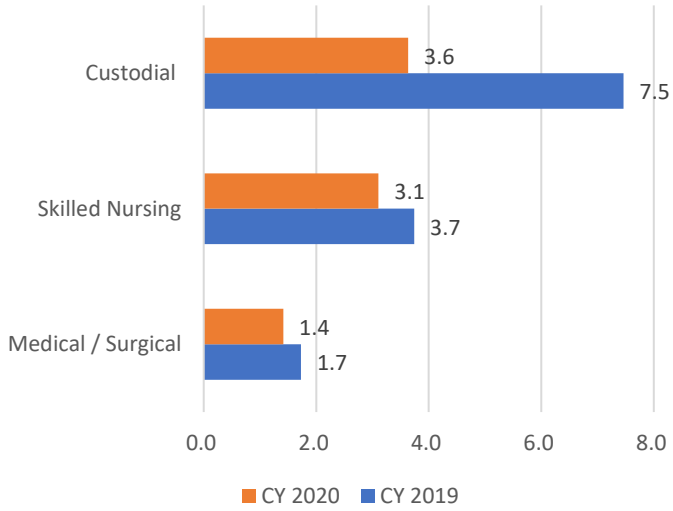


INPATIENT UTILIZATION *(Continued)*

LENGTH OF STAY
01/01/2020 - 12/31/2020

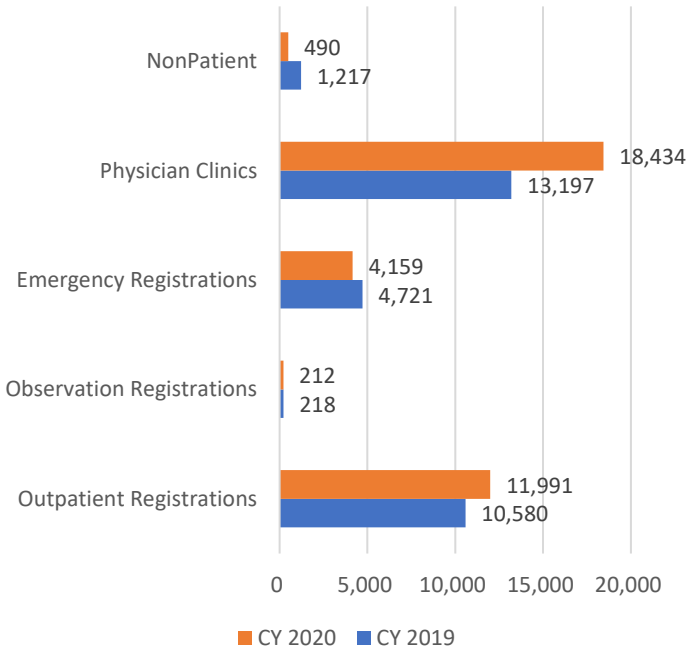


AVERAGE CENSUS
01/01/2020 - 12/31/2020

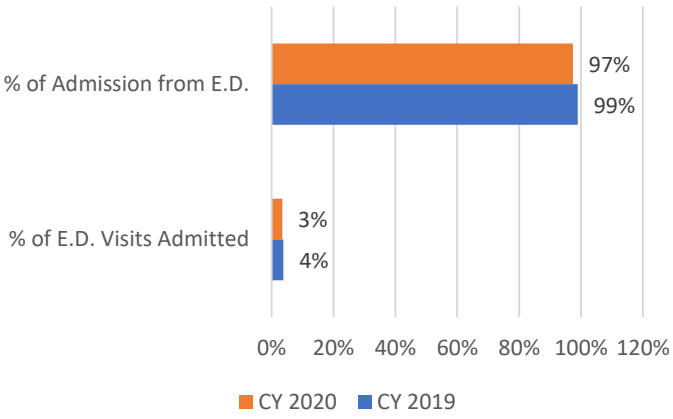


OUTPATIENT UTILIZATION

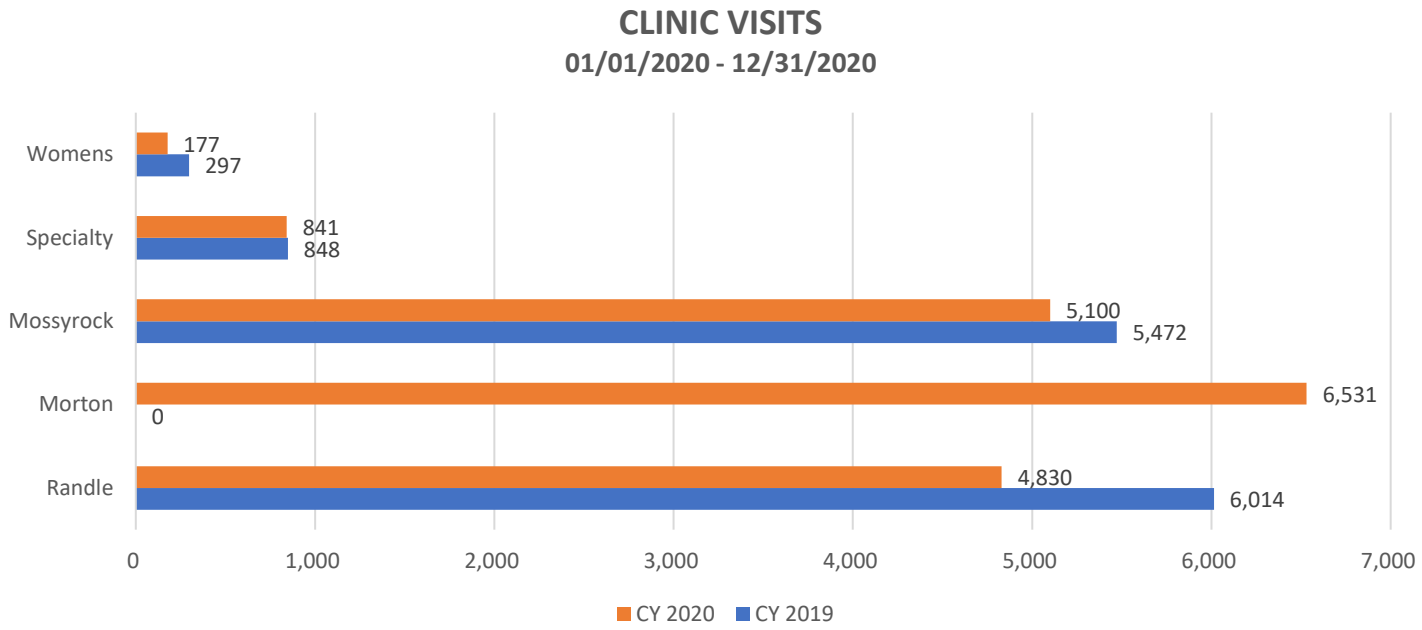
REGISTRATIONS
01/01/2020 - 12/31/2020



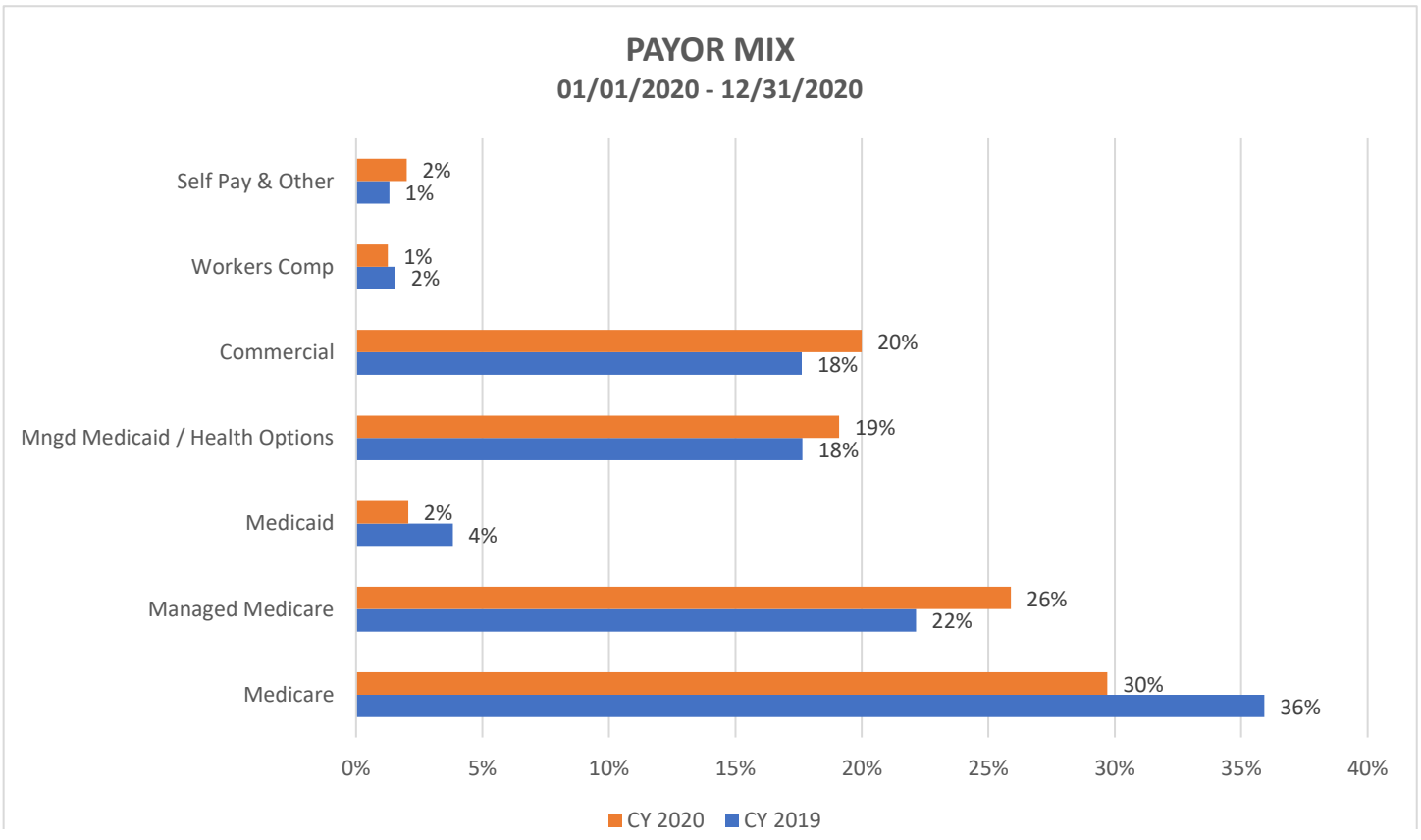
ED ADMISSIONS
01/01/2020 - 12/31/2020



CLINIC UTILIZATION



PAYOR MIX

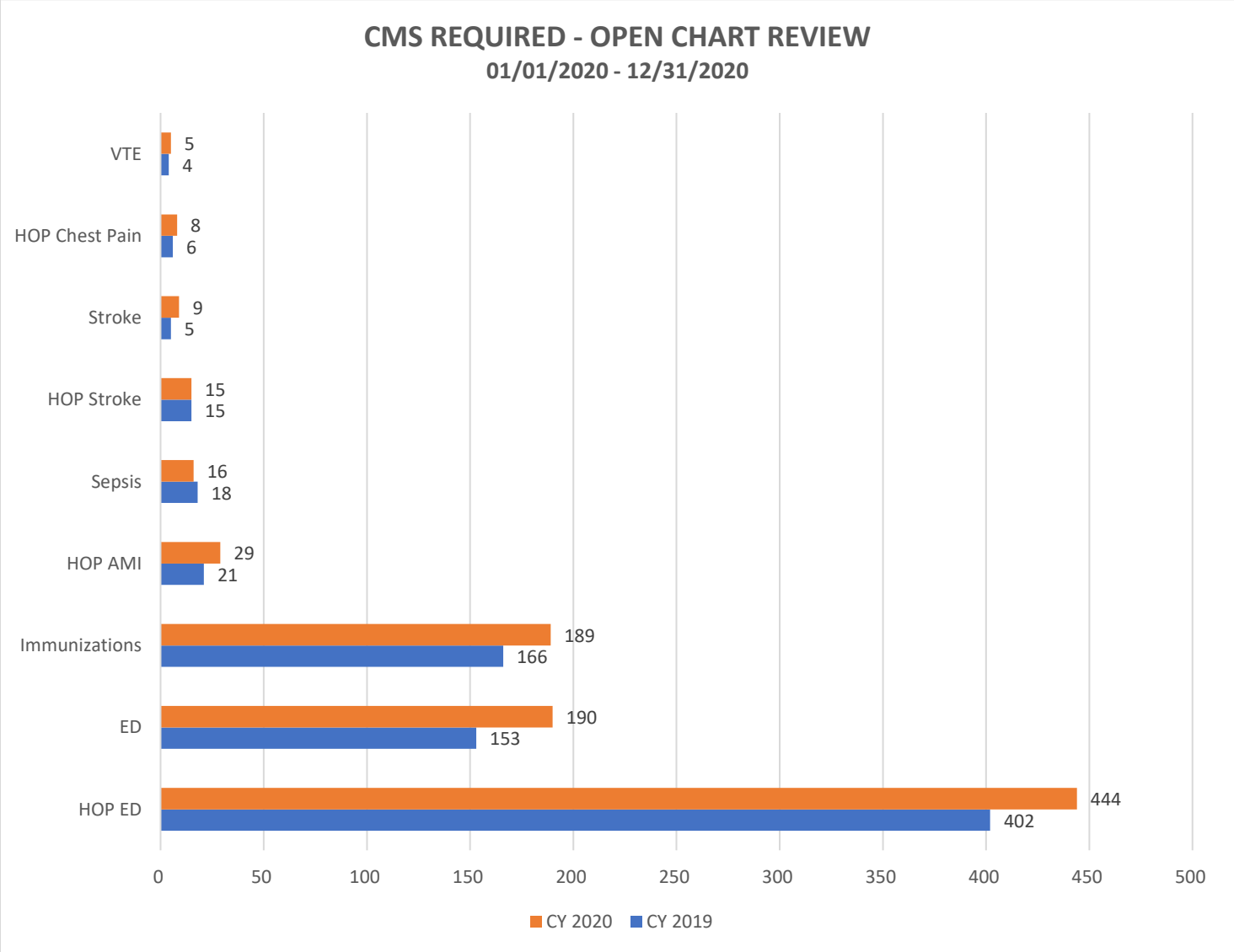


C. ACTIVE AND CLOSED MEDICAL RECORDS AUDIT

REVIEW PROCESS

In compliance with CAH regulation CFR 485.641(a) (1) (ii) a representative sample (at least 10%) of both active and closed clinical records were reviewed in in the past year. Records addressed included inpatient, emergency room, and ambulatory records. Both concurrent and retrospective reviews were conducted for completeness, accuracy, informed consent, medical necessity, and adherence to protocols and standards of care.

OPEN CHART REVIEW

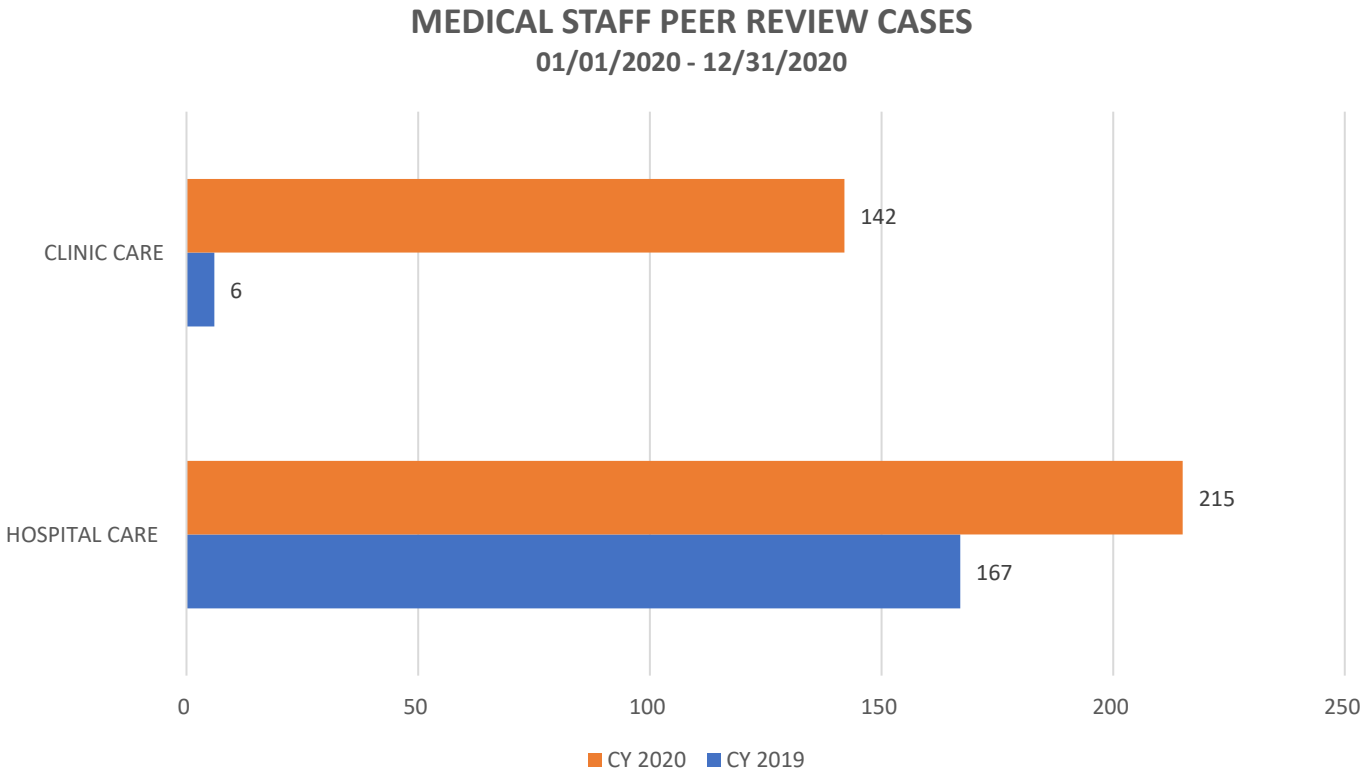


MEDICAL STAFF PEER REVIEW

Arbor Health performs Peer Review for both hospital cases and clinic encounters. Arbor Health uses an external Peer Review process for the hospital cases in agreement with the Washington Hospital Services, a Washington State Hospital Association company and an internal Peer Review process is conducted for clinic encounters. Active and closed clinical records undergo review according to criteria established by the Arbor Health Peer Review Committee. Additional cases review selections come through requests from Compliance, Utilization Review, Risk Management, Medical and/or Nursing staffs. Peer Review findings are discussed in executive session meetings of the Arbor Health Medical Staff. Findings are used in determination of clinical privileges, continued membership on Arbor Health's Medical Staff, or other corrective or remedial action as appropriate.

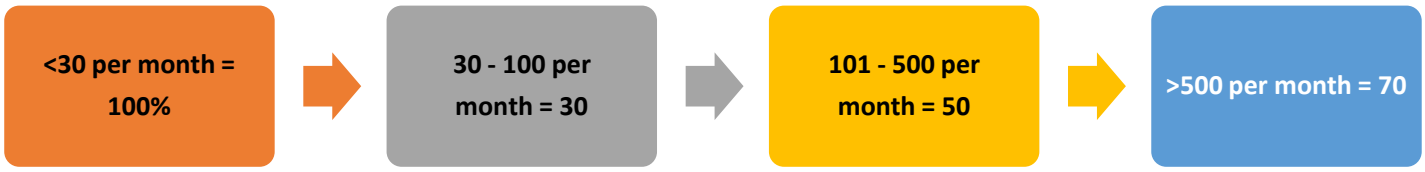
Indicators that trigger selection or consideration for Physician Peer Review include but not limited to:

-Unanticipated deaths, including patient suicide
-Unanticipated complications in patient condition and/or treatment that result in actual or potential prolongation of the patient's stay, and/or major permanent loss of function.
-Surgery on the wrong patient or wrong body part
-Surgical and/or anesthesia related complications including unexpected return to surgery
-Unplanned re-admission within seven days of discharge for same or similar diagnosis (excludes Swingbed admissions)
-Moderate to severe adverse drug reactions
-Blood utilizations
-Other cases requested by nurse managers, PI/Risk Manager, or medical staff



GATHERING DATA

Data is then gathered on a pre-determined timeframe (weekly, monthly, quarterly). Regular reporting of data requires continued attention from teams. A designated person will be assigned and held accountable for gathering data and having the information available when due. Sampling sizes are determined based on recognized, statistically significant sample sizes of:

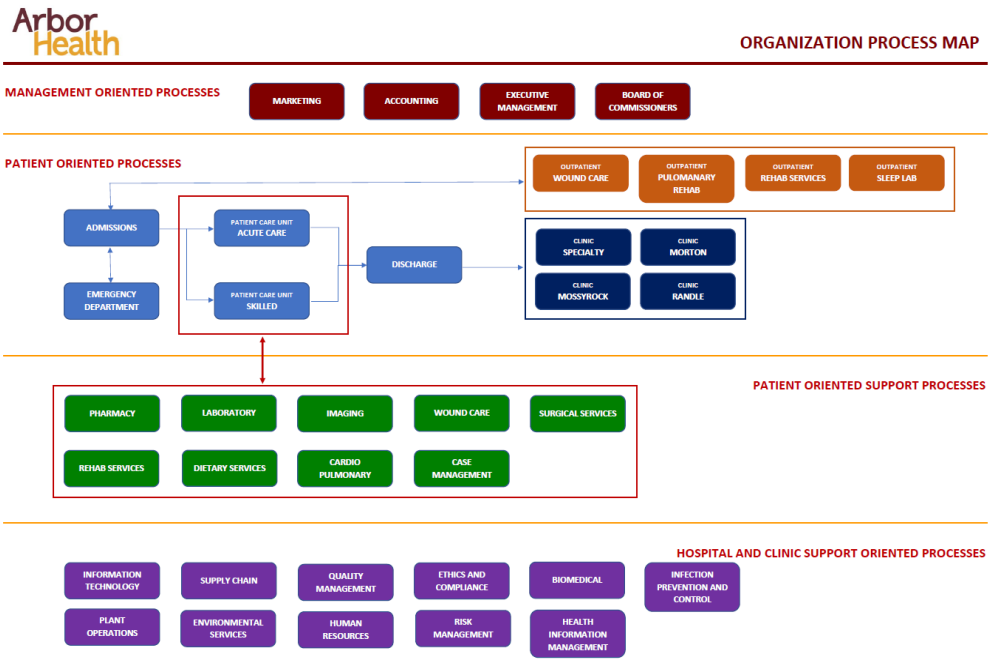


ANALYZING AND REPORTING DATA

The work groups discuss data analysis and determine what initiatives must be implemented to attain the desired outcome. Analysis usually involves multiple iterations and analysis to examine different aspects of the quality issue. Whenever possible and appropriate, statistical control methods, trending, and/or comparison with published benchmarks are used to analyze quality and safety measures.

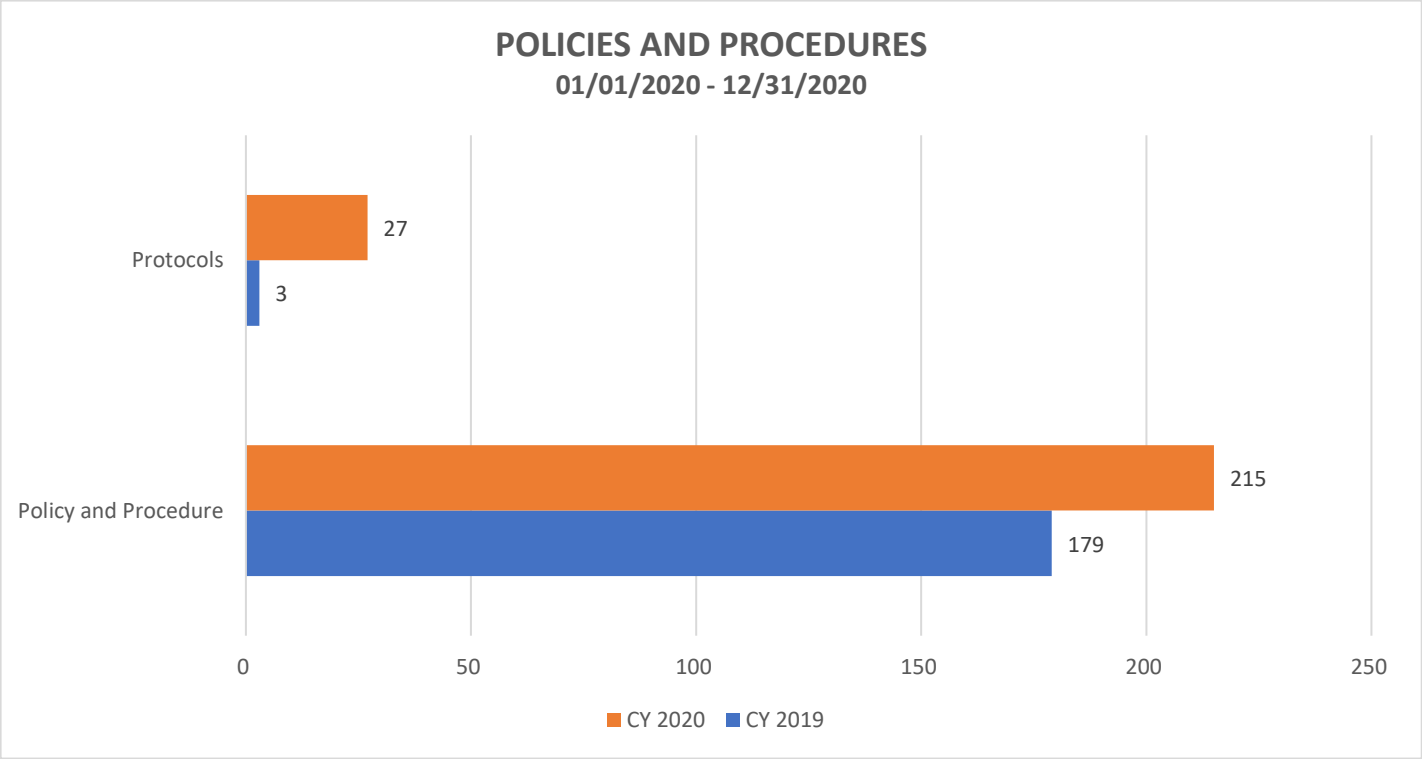
IMPLEMENTATION OF ACTIONS AND DISSEMINATION OF INFORMATION

Implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Communication of quality and safety information is the responsibility of clinical and administrative leadership. This information is reported to the Quality Management Department, and throughout the organization, using the Performance Improvement Quarterly report and/or other acceptable formats. Annually or more frequent as necessary, the performance is presented at the Quality Improvement Oversight Committee with minutes and then presented to the Board of Commissioners.



D. HEALTH CARE POLICIES

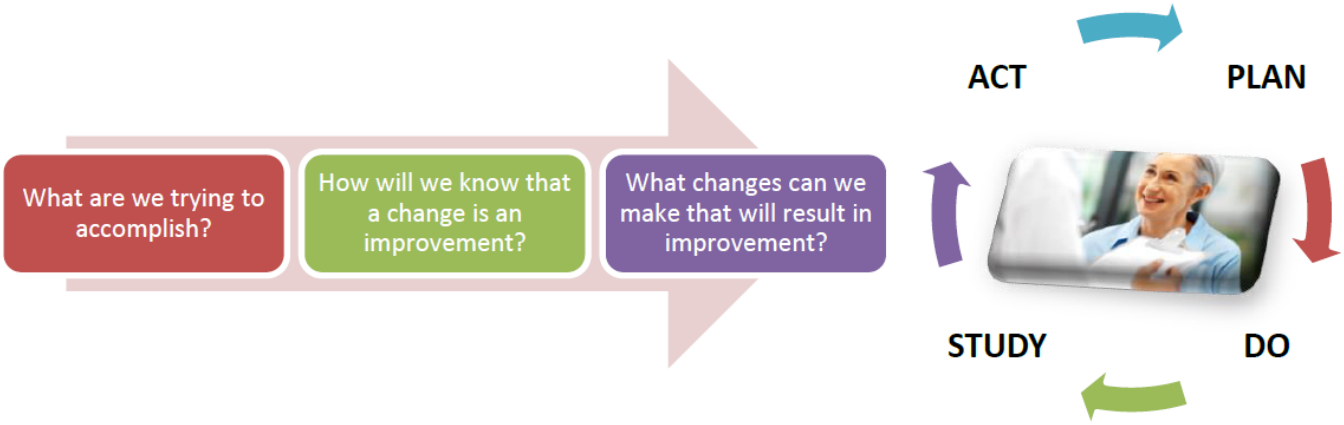
Patient care and administrative policies are added, reviewed, revised and/or deleted by action of the appropriate Arbor Health department or committee and approved by the Board of Commissioners. Policies are scheduled for review at least annually and whenever need for modification is recognized. Compliance with timely policy review is tracked by the applicable department director or manager and reported to the Policy and Procedure Review Committee.



E. QUALITY ASSURANCE

QAPI MODEL

Arbor Health has adopted the Plan, Do, Study, and Act (PDSA) methodology for quality assessment and improvement. The PDSA model is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a process.



P = Plan: Identify a goal or purpose, formulate a theory, define success metrics and put a plan into action.
D = Do: Implement the components of the plan
S = Study: Monitor outcomes to test the validity of the plan for signs of progress or success or problems and areas for improvement
A = Act: Integrate the learning generated by the process, adjust the goal or change interventional methods if necessary.

Additional Performance Improvement Methodologies

In addition to the PI methodology outlined above, other tools, techniques and methods are used to achieve improvement based on project goals and/or the nature of the problem under evaluation. Examples include Lean and Six Sigma via the Performance Improvement Program.

PRIORITIZATION OF AREAS FOR MEASUREMENT

The process for identifying priorities for measurement requires input and discussion with senior leadership, departments, and services from all areas involved with quality performance measurement and improvement. Priorities are identified based on leadership objectives, regulatory requirements, opportunities identified in external benchmark projects, opportunities identified through analysis of patient safety event reports and opportunities identified through sentinel events, standard of care findings or "Sentinel Event Alerts." These objectives or topics are then displayed in a matrix to better understand which areas of importance and relevance they cross (high risk, high volume, problem prone, mission, internal and external customer satisfaction, clinical outcome, safety, and regulatory).

DEVELOPING MEASURE SPECIFICATIONS

Work groups or committees define the metrics (indicators, goals, and benchmarks) for each topic. Representatives from all involved services collaboratively develop quality performance measure specifications based on the opportunities identified to be studied. Team members are identified with the help of clinical and administrative leadership. Work groups develop written measurement specifications, along with data abstraction tools when necessary.

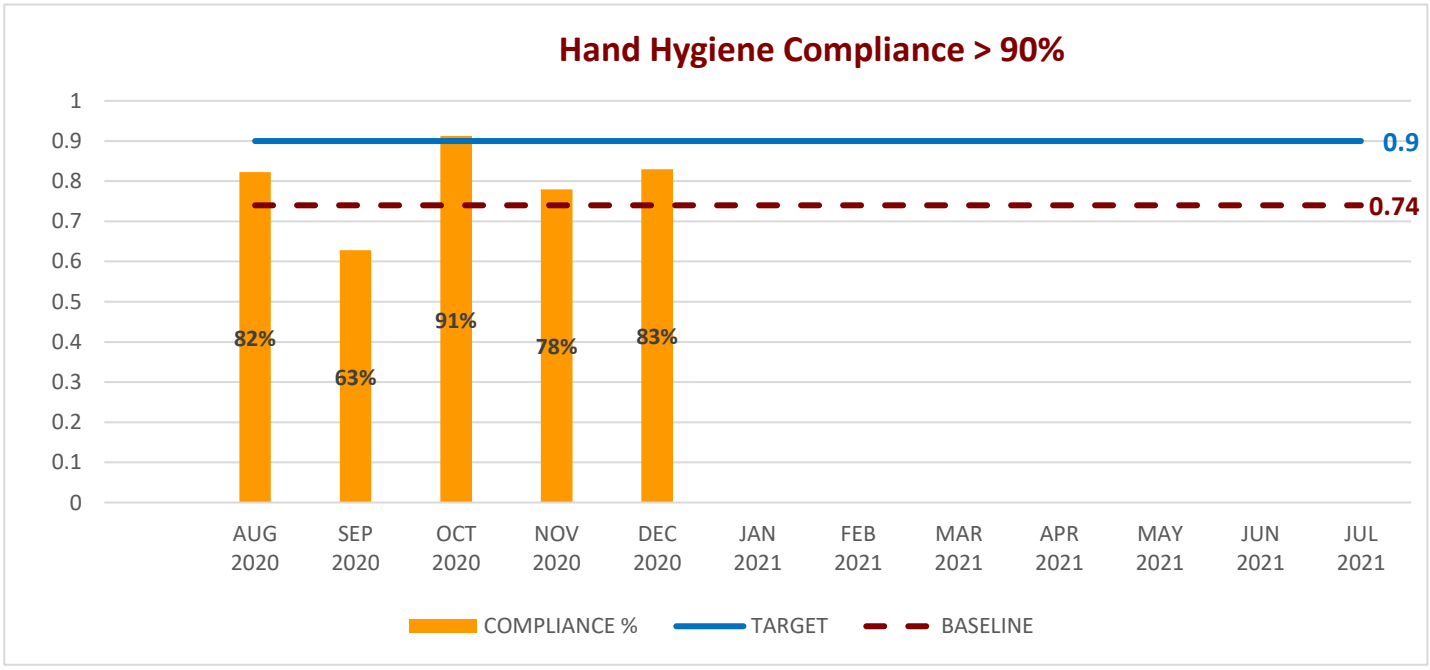
Reduce Readmissions	**MEASUREMENT**	**TARGET**	**2019**	**2020**	**TARGET MET**
Readmission w/in 30 Days-All Cause *Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions.*	*Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions / Total inpatient discharges (excluding discharges due to death) x 100*	**20% Reduction from prior year**	**2.1**	**6.15**	**NOT MET**
% Return ER Visits w/in 72 hours *Number of Emergency Department patients treated and released previously, then readmitted with the same or a similar diagnosis within 72 hours of initial release.*	*(Number of ER patients returning with same or similar diagnosis to the ER within 72 hrs of their initial visit / Total ER visits) x 100*		**2.4**	**1.135**	**MET**

Monitor trends in patient safety events through Arbor Health's event reporting system and implement actions to reduce harm	**MEASUREMENT**	**TARGET**	**2019**	**2020**	**TARGET MET**
Event Reporting Utilization *Providing safe care to patients is a top priority, and Arbor Health rely heavily on the participation of the staff to enter patient safety concerns in order to gather data, identify trends and implement error reduction and prevention plans.*	*Total number events entered*	**10% Increase from prior year**	**320**	**329**	**MET**

Reduction of unassited patient falls with a goal of zero falls	**MEASUREMENT**	**TARGET**	**2019**	**2020**	**TARGET MET**
Unassisted Patient Falls per 100 Inpatient Days *A patient fall occurs when a patient falls or collapses and assistance from a healthcare provider does not occur. Unassisted falls are more likely than assisted falls to result in injury.*	*[Number of unassisted patient falls reported / (Acute Inpatient Days + Swing Bed Patient Days)] x 100*	**5% Reduction from prior year Strive for "0" Events**	**0.21**	**0.19**	**MET**

F. INFECTION PREVENTION AND CONTROL

Reduction of hospital acquired infections with a goal of zero infections	MEASUREMENT	TARGET	2019	2020	TARGET MET
CAUTI – Catheter Associated Urinary Tract Infection Infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney associated with the use of a foley catheter.	*Total # HAI Event(s) Rate per 1000 Pt. Days*	5% Reduction from prior year Strive for "0" Events	1.0	0	MET
CDIFF - Clostridium difficile Infection of the large intestine (colon) caused by the bacteria Clostridium difficile.			0.2	0	MET
CLABSI – Central Line Associated Blood Stream Infection A primary laboratory confirmed bloodstream infection in a patient with a central line at the time of (or within 48-hours prior to) the onset of symptoms and the infection is not related to an infection from another site.			0	0	MET
MRSA - Methicillin-resistant staphylococcus aureus Infections caused by specific bacteria that are resistant to commonly used antibiotics.			0	0	MET
SSI – Surgical Site Infection Infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney.			0	0.22	NOT MET



G. PATIENT SATISFACTION

ARBOR HEALTH MORTON HOSPITAL

ARBOR HEALTH MORTON HOSPITAL					
METRIC	MEASUREMENT	TARGET	2019 Top Box	2020 Top Box	TARGET MET
Global Rating Overall	*Rating of 9 – 10*	≥50% Top Box	32.0	**58.3**	MET
Recommend the Hospital	*Definitely Yes*		64.0	**59.5**	MET
Communications with Nurses Overall	*Always*		42.0	**73.3**	MET
Nurses treat with courtesy/respect	*Always*		6.0	**79.4**	MET
Nurses listen carefully to you	*Always*		82.0	**80.6**	MET
Nurses explain in way you understand	*Always*		44.0	**60.1**	MET
Response of Hospital Staff Overall	*Always*		58.0	**70.7**	MET
Call Button help soon as wanted it	*Always*		45.0	**67.0**	MET
Help toileting soon as you wanted	*Always*		70.0	**74.4**	MET
Communication with Doctors Overall	*Always*		86.0	**67.9**	MET
Doctors treat with courtesy/respect	*Always*		66.0	**77.1**	MET
Doctors listen carefully to you	*Always*			**71.5**	MET
Doctors explain in way you understand	*Always*		99.0	**55.1**	MET
Hospital Environment Overall	*Always*		28.0	**62.9**	MET
Cleanliness of hospital environment	*Always*		85.0	**82.2**	MET
Quietness of hospital environment	*Always*		7.0	**43.6**	MET
Communication About Medicines Overall	*Always*		97.0	**48.5**	MET
Tell you what new medicine was for	*Always*		92.0	**60.0**	MET
Staff describe medicine side effect	*Always*		96.0	**37.5**	NOT MET
Discharge Information Overall	*Yes*		58.0	**81.7**	MET
Staff talk about help when you left	*Yes*		55.0	**77.8**	MET
Information regarding symptoms/problems to look for	*Yes*		60.0	**85.6**	MET
Care Transitions Overall	*Strongly Agree*		53.0	**43.2**	NOT MET
Hospital staff took preference into account	*Strongly Agree*		14.0	**36.6**	NOT MET
Good understanding managing health	*Strongly Agree*		89.0	**43.8**	NOT MET
Understood purpose of taking medications	*Strongly Agree*		47.0	**49.4**	NOT MET

ARBOR HEALTH EMERGENCY DEPARTMENT

ARBOR HEALTH EMERGENCY DEPARTMENT					
METRIC	MEASUREMENT	TARGET	2019 Top Box	2020 Top Box	TARGET MET
ED Overall	*Yes*		58.6	**74.6**	MET
Standard Arrival	*Yes*		52.4	**70.9**	MET
Waiting time before noticed arrival	*Yes*		67.6	**83.8**	MET
Helpfulness of first person	*Yes*		61.9	**81.2**	MET
Comfort of waiting area	*Yes*		33.5	**60.3**	MET
Waiting time to treatment area	*Yes*		52.7	**70.5**	MET
Waiting time to see doctor	*Yes*		44.2	**61.1**	MET
ED Nursing	*Yes*		66.7	**80.2**	MET
Nurses courtesy	*Yes*		69.8	**86.7**	MET
Nurse took time to listen	*Yes*		68.6	**78.9**	MET
Nurses attention to your needs	*Yes*		66.3	**78.5**	MET
Nurses informative re treatments	*Yes*		63.6	**77.4**	MET
Nurses concern for privacy	*Yes*		65.3	**79.3**	MET
ED Doctors	*Yes*		58.7	**70.1**	MET
Doctors courtesy	*Yes*		60.7	**69.8**	MET
Doctor took time to listen	*Yes*		61.3	**70.5**	MET
Doctor informative re treatment	*Yes*		59.0	**71.6**	MET
Doctors concern for comfort	*Yes*		53.9	**68.5**	MET
ED Tests	*Yes*		56.4	**79.1**	MET
Courtesy of person who took blood	*Yes*	***≥50%***	55.4	**83.4**	MET
Concern blood draw comfort	*Yes*	***Top Box***	57.3	**80.2**	MET
Waiting time for radiology test	*Yes*		47.2	**73.9**	MET
Courtesy of radiology staff	*Yes*		65.9	**86.0**	MET
Concern for comfort radiology test	*Yes*		56.5	**74.0**	MET
Family or Friends	*Yes*		59.9	**72.0**	MET
Courtesy shown family/friends	*Yes*		61.1	**74.7**	MET
Adequacy of info to family/friends	*Yes*		55.6	**72.6**	MET
Let family/friend be with you	*Yes*		62.9	**67.3**	MET
Personal/Insurance Info	*Yes*		62.4	**81.6**	MET
Courtesy during pers/insur info	*Yes*		67.5	**84.0**	MET
Privacy during pers/insur info	*Yes*		61.7	**81.3**	MET
Ease giving pers/insur info	*Yes*		57.7	**79.3**	MET
Personal Issues	*Yes*		55.9	**70.3**	MET
Informed about delays	*Yes*		53.5	**65.5**	MET
Staff cared about you as person	*Yes*		60.5	**79.1**	MET
How well pain was controlled	*Yes*		51.0	**68.8**	MET
Information about home care	*Yes*		57.7	**71.1**	MET
Overall Assessment	*Yes*		55.0	**73.2**	MET
Overall rating ER care	*Yes*		57.5	**75.7**	MET
Likelihood of recommending	*Yes*		52.5	**69.7**	MET

ARBOR HEALTH CLINICS

ARBOR HEALTH - ALL CLINICS					
METRIC	MEASUREMENT	TARGET	2019 Top Box	2020 Top Box	TARGET MET
Clinic Overall	*Yes*		71.0	**67.9**	MET
Standard Access	*Yes*		6638.0	**59.8**	MET
Ease of scheduling appointments	*Yes*		67.8	**60.1**	MET
Ease of contacting	*Yes*		65.8	**59.5**	MET
Std Moving Through Your Visit	*Yes*		56.2	**57.0**	MET
Information about delays	*Yes*		57.0	**58.7**	MET
Wait time at clinic	*Yes*		55.4	**55.6**	MET
Clinic Nurse/ Assistant	*Yes*		74.4	**74.0**	MET
Concern of nurse/asst for problem	*Yes*		69.5	**69.5**	MET
How well nurse/asst listen	*Yes*		79.3	**78.4**	MET
Clinic Care Provider	*Yes*	***≥50%***	75.6	**71.3**	MET
CP explanations of prob/condition	*Yes*	***Top Box***	76.1	**71.8**	MET
CP concern for questions/worries	*Yes*		76.4	**73.1**	MET
CP efforts to include in decisions	*Yes*		76.3	**72.1**	MET
Likelihood of recommending CP	*Yes*		77.1	**70.9**	MET
CP discuss treatments	*Yes*		72.0	**68.3**	MET
Personal Issues	*Yes*		72.4	**72.5**	MET
How well staff protect safety	*Yes*		74.2	**75.8**	MET
Our concern for patients' privacy	*Yes*		70.6	**69.1**	MET
Std Overall Assessment	*Yes*		73.1	**67.1**	MET
Staff worked together care for you	*Yes*		75.2	**69.0**	MET
Likelihood of recommending	*Yes*		71.1	**65.3**	MET

H. ANNUAL EVALUATION

Arbor Health Morton Hospital and the Board of Commissioners shall review the Critical Access Hospital Periodic Evaluation at least annually in alignment with the calendar year. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Arbor Health and the Board of Commissioners also evaluate annually their contributions to the performance improvement and patient safety activities at Arbor Health.

Documents Awaiting Board Ratification 04.28.21		
	LCHD No. 1's Policies, Procedures & Contracts:	Departments:
1	A/B/D TYPING AND REVERSE GROUPING -GELCARD TEST METHOD	Blood Bank
2	ANNUAL REVIEW OF PROCEDURES AND POLICIES	Lab General Policies/Procedures
3	Accounts Payable Authorized Signers	Finance
4	Accounts Payable Processing Timing Policy	Finance
5	Additional Pay for Exempt Employees	Human Resources
6	Administrative Chain of Command	Administration
7	Amended Report	QC/QA
8	Annual CAH Evaluation	Quality
9	Attendance	Human Resources
10	Bankruptcy Accounts	Business Office
11	Blood Bank - Discarded/Wasted Blood Components	Blood Bank
12	Blood Bank - Serologic Centrifuge - Functional Calibration	Blood Bank
13	Bloodworks Northwest Blood Return and Paperwork	Blood Bank
14	Body Fluid Analysis	Hematology
15	Body Fluid pH testing	Chemistry
16	C. difficile Test	Serology
17	CEREBROSPINAL FLUID ANALYSIS	Hematology
18	COMPATIBILITY TESTING - TUBE METHOD	Blood Bank
19	CSF Cell Counts	Hematology
20	CT Dose Limitations (Exceeded Dosage)	Radiology/Medical Imaging
21	Chargeable Supplies	Materials Management
22	Checking RPMs for the Sorval Cell Washer	Blood Bank
23	Coding of Medical Records	Health Information Management
24	Continuing Education for the Imaging Department	Radiology/Medical Imaging
25	Contrast use by Cardiovascular Sonographers	Radiology/Medical Imaging
26	Credit Card Use	Finance

27	D-Dimer	Coagulation
28	Darren Freeman, ARNP Employment Agreement	Employment Agreements
29	Disposal Of Surplus Personal Property	Finance
30	EDTA-Dependent Pseudothrombocytopeni	Hematology
31	Echocardiograms	Radiology/Medical Imaging
32	Education & Competency's	Human Resources
33	Electronic Time and Attendance Standards	Human Resources
34	Epidemiology Manual	Infection Prevention & Control
35	Fecal Leukocytes	Hematology
36	Fecal Occult Blood Test	Serology
37	Fixed Asset and Capital Purchase Policy	Finance
38	Fresh Frozen Plasma (FFP)	Blood Bank
39	General Principles of Ultrasound	Radiology/Medical Imaging
40	Glucose Tolerance Test	Chemistry
41	H8: Labor Shortage/Surge in Census	Dietary Services
42	HIV Ag/Ab Combo	Serology
43	Imaging Department Staffing Plan	Radiology/Medical Imaging
44	Imaging Service Requests	Radiology/Medical Imaging
45	Imaging Staff Availability and Reporting Timeline	Radiology/Medical Imaging
46	Indigent Services	Business Office
47	Individualized Quality Control Plan (IQCP)	QC/QA
48	Infection Prevention Manual	Infection Prevention & Control
49	Laboratory Delegation of Duties	Lab General Policies/Procedures
50	Laboratory Quality Control	QC/QA
51	Laboratory Quality Management Program	Lab General Policies/Procedures
52	Laboratory Sample Collection	Lab General Policies/Procedures
53	Laboratory Thermometer Verification	QC/QA
54	Legal Blood Alcohol	Lab General Policies/Procedures
55	Legal Drug Testing Collection	Lab General Policies/Procedures
56	Lipemic CBC - HGB Correction	Hematology
57	Look Back Policy for Transfusion Recipients	Blood Bank
58	Lucidoc Document Control and Management	Administration
59	MALARIA-Thick and Thin Smears	Hematology
60	MTS DISPENSER CALIBRATION & CLEANING	Blood Bank

61	Medefis Master Agreement for Regular Fulltime Staffing Services	Professional Services Agreement
62	Medicare Collection Agency Administrative Cost	Business Office
63	Methamphetamine Differentiation	Serology
64	Millipore Water System	QC/QA
65	Mono Test	Serology
66	Ordering of Imaging Studies	Radiology/Medical Imaging
67	PREWARMING TECHNIQUE FOR ANTIBODY SCREEN	Blood Bank
68	PTT	Coagulation
69	Paid Sick Leave - Casual Part Time Employees	Human Resources
70	Paid Time Off	Human Resources
71	Pathologists Review: Guidelines for Peripheral Smear Pathologist Review	Hematology
72	Patient Weight Limitations per Imaging Equipment Manufacturers	Radiology/Medical Imaging
73	Personnel Records	Human Resources
74	Pipette Calibration	Lab General Policies/Procedures
75	Placing Orders,Labeling and Collection of Lab Specimens	Lab General Policies/Procedures
76	Portable X-Ray Unit	Radiology/Medical Imaging
77	RH TESTING FOR D - TUBE METHOD	Blood Bank
78	Radiation Physicist Services	Radiology/Medical Imaging
79	Relocatable Power Tap's/ Power Strips	Maintenance
80	Reportable Ranges	Laboratory
81	Reporting Critical Value Results	Lab General Policies/Procedures
82	Respiratory Syncytial Virus Antigen	Serology
83	Sedimentation Rate (ESR)	Hematology
84	Sign out protocol for blood componenets	Blood Bank
85	Sorall Cellwasher: Operation and Quality Control	Blood Bank
86	Specimen Rejection : Guidelines	Lab General Policies/Procedures
87	Sperm Count - Post Vasectomy	Hematology
88	Staff Licenses and Certifications	Human Resources
89	Storage of Blood Components - Loss of Monitored Refrigeration	Blood Bank
90	Strep A Test	Serology

91	Suspected Drug - Seeking Behavior	Emergency Services
92	Suspended Charges	Business Office
93	Temperature and Humidity Monitoring	Lab General Policies/Procedures
94	Transfusion-Associated Infections-Reporting	Blood Bank
95	Triage	Emergency Services
96	Triage Patient Flow and Privacy	Emergency Services
97	Ultrasound Breast	Radiology/Medical Imaging
98	Ultrasound Gynecological	Radiology/Medical Imaging
99	Ultrasound Obstetrical	Radiology/Medical Imaging
100	Ultrasound Testicular	Radiology/Medical Imaging
101	Urinalysis Microscopic Examination and Reporting	Urinalysis
102	Urinalysis criteria for Microscopic exam/Culture	Urinalysis
103	Utilizing Manufacturer Defined Chemistry Procedures	Chemistry
104	Verifying Ongoing Competency in the Laboratory	Lab General Policies/Procedures
105	Waived Testing - Personnel	Point of Care Testing
106	Waived and Point of Care Testing	Point of Care Testing
107	Washington Public Health Lab: Specimen Collection and Submisson	Lab General Policies/Procedures
108	Wet Prep /KOH reporting	Microbiology
109	X-Ray Ankle	Radiology/Medical Imaging
110	Xray Acromioclavicular Articulation	Radiology/Medical Imaging
111	Xray Cervical Spine	Radiology/Medical Imaging
112	Xray Clavicle	Radiology/Medical Imaging
113	Xray Elbow	Radiology/Medical Imaging
114	Xray Fingers	Radiology/Medical Imaging
115	Xray Foot	Radiology/Medical Imaging
116	Xray Forearm	Radiology/Medical Imaging
117	Xray Hand	Radiology/Medical Imaging
118	Xray Hip	Radiology/Medical Imaging
119	Xray Knee	Radiology/Medical Imaging
120	Xray Lumbosacral Spine	Radiology/Medical Imaging
121	Xray Os Calcis (Heel) (Calcaneus)	Radiology/Medical Imaging
122	Xray Pelvis	Radiology/Medical Imaging
123	Xray Ribs	Radiology/Medical Imaging
124	Xray Sacroiliac Joints	Radiology/Medical Imaging
125	Xray Scoliosis Study	Radiology/Medical Imaging
126	Xray Shoulder	Radiology/Medical Imaging
127	Xray Sternoclavicular Joints	Radiology/Medical Imaging

128	Xray Sternum	Radiology/Medical Imaging
129	Xray Thoracic Spine	Radiology/Medical Imaging
130	Xray Thoraco-Lumbar Spine	Radiology/Medical Imaging
131	Xray Tibia-Fibula	Radiology/Medical Imaging
132	Xray Toes	Radiology/Medical Imaging
133	Xray Wrist	Radiology/Medical Imaging

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OLD BUSINESS

NEW BUSINESS

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING AMENDED
BOARD BYLAWS

RESOLUTION NO. 19-18

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 amended board bylaws. Revised the logo and Section 3.6.

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 31st day of July 2019, the following commissioners being present and voting in favor of this resolution.

Shelly Fritz, Board Chair

Marc Fisher, Commissioner

Kenton Smith, Secretary

Trish Frady, Commissioner

Judy Ramsey, Commissioner

APPROVED BY THE COMMISSION OF PHD #1 MUNICIPAL SEAL

AMENDED AND RESTATED BYLAWS OF LEWIS COUNTY HOSPITAL DISTRICT NO. 1

(Revision date – 07/31/19)

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 at 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 chairperson, and 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.

2.1 Chairperson. The chairperson 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 a proper book for that purpose. In the absence of the chairperson, the secretary or his/her designee may preside at board meetings. RCW 42.30.035.

2.3 Absence of Chairperson and Secretary. If neither the chairperson nor the secretary is present, a designee will be appointed by the chairperson

2.4 Officer Vacancy. If a vacancy occurs in the office of either the chairperson 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 of commissioners, 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 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 chairperson of the board 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 mail to each member of the governing body. Notice of the special meeting shall be completed by the following: delivered to each local newspaper of general circulation and to each local radio or television station which has on file with the governing body a written request to be notified of such special meeting or of all special meetings; posted on the board's website, prominently displayed at the main entrance of the principal location 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 mail at least twenty-four hours before the time of such meeting as specified in the notice. The call and notice shall specify the time and place of the special meeting and the business to be transacted. The board shall not take final disposition on any other matter at such meetings. Such written 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 mail. 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 circulation in the county. 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 chairperson may provide for a meeting site other than the regular meeting site and the 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
- Reading the Mission & Vision Statements
- Approval or Amendment of Agenda
- Conflicts of Interest
- Department Updates as Necessary
- Introduction of any guest as necessary
- Comments and Remarks
- Executive Session as Necessary
- Board Committee Reports
    - Financial Committee
    - Quality Improvement Oversight Committee
    - Plant Planning Committee
    - Strategic Planning Committee
    - Governance Committee
    - Hospital Foundation Report
    - Resolution Review Committee
    - Compliance Committee
- 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
- Next Meeting Dates and Times
- Adjournment

b. **Special Meetings**

- Call to Order
- Reading of the Notice of Special Meeting
- Executive Session or Sessions as Necessary
- Consideration of Matters Stated in the Notice
- Action
- 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 a book or books kept for such purposes. 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).

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).

Before convening in executive session, the chairperson of the board 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 chairperson of the board or of a designee RCW 42.30.110(2).

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 of commissioners. 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 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 chairperson shall recommend to the board a commissioner as chairperson 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; 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; quality manager; chief of medical staff; secretary of medical staff; chief clinical officer; director of nursing services; and such other members as the committee chair deems appropriate. The quality improvement oversight committee shall meet quarterly and as needed.

Plant Planning: Two commissioners; superintendent; environmental services manager; 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 one time each year and 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 and such other members as the committee chair deems appropriate. The Compliance Committee shall meet one time each year and as needed.

Values, Ethics or Conflict of Interest: An 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 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

(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 hospital and 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 and administrative officer of the hospital and of the district. In direct charge with full authority to act, as representative of the Board, and subject to its policies, he or she shall be responsible for the efficient administration of all affairs of the Hospital and the District. RCW 70.44.080.

In the performance of his or her duties prescribed by law, all of which shall be faithfully discharged, and not by way of limitation of his or her 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 hospital and 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;

(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 hospital and the district along with any special reports that may be requested by the board;

(xii) Prepare the agenda for and attend all meetings of the board at which s/he may 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 on his or her 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 hospital and 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 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 him 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

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.

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.

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 31st day of July, 2019

Board Chair

Board Secretary

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: 4/21/2021
Subject: Redistricting

Because the composition of our board of commissioners provides for commissioner districts, we are required to adjust commissioner district boundaries every ten years after census data is released to ensure each district has roughly the same population. This is called redistricting.

The release of the 2020 census data was delayed. This means that redistricting cannot happen this year and will have no impact on the November 2021 election. However, redistricting will impact the November 2023 election.

Below are key dates to be aware of that impact our public hospital district. These dates will be added to the Board calendar to ensure compliance to the redistricting requirements.

- 9/30/2021-Census data to be released to Washington State.
- 11/15/2021-Washington State Redistricting Commission to release information to public hospital district.
- 8/15/2022-Public hospital district has 8 months to complete redistricting plan.

Incidentally, RCW 70.44.042 allows public hospital district boards to eliminate commissioner districts via resolution. This would default all commissioner positions to At-Large. If the Board of Commissioners are interested in this, we would need to take action at the April 28th meeting to be in effect for the November 2021 election. Actions taken after April 28th would not be effective until the November 2023 election.

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MEMORANDUM

To: Board of Commissioners

From: Richard Boggess, CFO

Date: April 21, 2021

Re: Construction Budget Amendment

The construction project remains on schedule. One of the objectives of the project was to provide additional emergency lighting within the facility. We have identified a hidden condition that was not identified at the onset of the project. The following is the amount approved by Resolution 20-39.

McKinstry Base Bid	$2,310,560
Allowance - Infection Control	$90,000
Resolution 20-39 Total	$2,400,560

Upon further inspection of the electric panels feeding patient rooms, we identified that modifying these panels would require us to update certain panels to meet 2012 electric code related to grounds and neutrals. Doing this work would result in a change order from McKinstry and additional work in patient care area. We have asked them to stop work on this particular aspect of the project pending further research. They have provided 3 options to address this issue, each option is looking at different panels to update. The least expense option is for $18,011.97 and only addresses the condition on one panel of the many panels that have the same condition. Other options range as high of $66,000 and still only address the condition in the differing panels while leaving remaining panels condition of "existing non-conforming."

A different idea has been presented to address this situation and expand overall emergency power capability beyond lights in patient rooms. It would add the Rehab, MOB and Patient Care wing to the emergency power line. This is accomplished by adding an emergency power automatic transfer switch to the line feeding the various panels and leaving the panels in place as "existing – nonconforming." This approach also reduces future operating cost by eliminating annual load bank requirements that costs between $3,000-5,000. L&I has indicated that this work is beyond the scope of the current permit. However, they are not opposed to issuing a new permit to facilitate this work. Wood Harbinger has provided rough estimates of this approach:

Wood Harbinger A&E fees	$15,383
Estimated Equipment from A&E schedule	$88,566
Licensing/Permitting Cost Estimate	$5,000
Estimated Construction Cost from A&E	$13,301
Total:	$122,250

Finance and Plant Planning Committees have discussed the project. Plant Planning is supportive of moving forward with the additional work subject to understanding the contingency dollars available in the project. The project does have an "allowance" for infection control as identified above, but not a specific contingency fund. It is the recommendation of the Finance Committee that the Board of Commissioners approve expanding the scope of the project at a projected cost of $220,000 after having reviewed and discussed the "allowance." After the Finance Committee Meeting, we got further clarification on the estimate provided by Wood Harbinger. It does include an estimated labor cost that we thought McKinstry would provide and as such is inclusive of labor cost except for permitting. McKinstry has not confirmed the cost to date.

The above discussion is summarized into the following three options:

1) Abandon the goal of adding emergency lighting in care areas and get a change order for reducing the scope of work. It is unknown at this point but estimated at $7,000 to $10,000.
2) (SAME SCOPE) Move forward with a change order of $18,012 for this work to achieve emergency lighting in the patient care area as planned.
3) (REVISED SCOPE) Expand the scope of work to add 1 ATS expanding emergency power to the Rehab Services, MOB and patient care areas. Estimated cost is $122,250. Change order of ($7,000-$10,000) as offset. For a net of around $112,000.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE BASE BID
PLUS ALLOWANCE FROM CONTRACTOR
FOR THE GENERATOR/OR HVAC PROJECT
& AUTHORIZING THE SUPERINTENDENT
TO EXECUTE A CONTRACT

RESOLUTION NO. 20-39

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:

Awarding the contract to McKinstry as the qualified bidder and approving the Base Bid Plus Allowance of $2,400,560 for the Generator/OR HVAC Project. Authorizing the Superintendent to execute a contract with the successful bidder.

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 13th day of October 2020, the following commissioners being present and voting in favor of this resolution.

P Frady
P Frady (Oct 19, 2020 07:04 PDT)
Trish Frady, Board Chair

Tom Herrin
Tom Herrin (Oct 15, 2020 15:14 PDT)
Tom Herrin, Secretary

Craig Coppock
Craig Coppock (Oct 16, 2020 14:08 PDT)
Craig Coppock, Commissioner

Wes McMahan
Wes McMahan (Oct 16, 2020 08:13 PDT)
Wes McMahan, Commissioner

Chris Schumaker (Oct 19, 2020 05:57 PDT)
Chris Schumaker, Commissioner

Arbor Health Emergency Generators Replacement

Lewis County Hospital District No. 1

General Contracting & MEP Services

MORTON, WASHINGTON

SEPTEMBER 30, 2020

Copy

FOR THE LIFE OF YOUR BUILDING

McKinstry
For The Life Of Your Building
5005 3rd AVE. S. • SEATTLE, WA 98134 • 206.762.3311 • mckinstry.com

September 30, 2020

Leianne Everett

Arbor Health Morton Hospital
521 Adams St.
Morton, WA 98356

Re: Lewis County Hospital District No. 1 Arbor Health Emergency Generator Replacement

Dear Ms. Everett,

Thank you for the opportunity to propose our mechanical and electrical services for the Arbor Health project. We believe that our integrated approach, healthcare campus experience, and logistics capabilities position us as the superior choice for your M&E project partner.

INTEGRATED MECHANICAL & ELECTRICAL

To drive the highest value project for all parties involved, McKinstry's team believes in collaboration, consistent and frequent communication and forming long-term partnerships throughout our projects. We believe the Arbor Health project offers a unique delivery opportunity that will drive out waste, streamline planning, and provide a single point of accountability for M&E construction. By combining engineers, detailers, and tradespeople under one roof, we are able to work more efficiently, collaborate more effectively, and communicate proactively—all of which harness real cost and schedule savings. Our integrated approach will eliminate scope gaps between mechanical and electrical trades, streamline constructability and sequencing, and mitigate risk and silos present in traditional delivery methods.

HEALTHCARE CAMPUS EXPERIENCE

With hundreds of healthcare projects completed in the last five years alone, McKinstry has extensive and in-depth experience in hospitals and medical centers, medical office spaces, and critical environments. The proposed team understands the complexities and high level of detail needed to deliver the project successfully while maintaining standards of care for Arbor Health patients. Each has been a part of complicated campus projects that involve critical tie-ins and shutdowns in active healthcare environments. Furthermore, they hold quality, cleanliness, patient-safety, and operational efficiency to the highest regard. We hope this provides the confidence and peace of mind in our team's capabilities and expertise to deliver this project.

It is our commitment to you to be a proactive project partner in guaranteeing overall project success. Please don't hesitate to reach out with further questions or clarifications.

Sincerely,

Dan Ronco | Project Executive
206.423.4178 | DanielR@mckinstry.com

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Section

1

Bid Form

DOCUMENT 00 41 00

BID FORM

PROJECT IDENTIFICATION: EMERGENCY GENERATOR REPLACEMENT/OR HEAT PUMP ADDITION
Lewis County Hospital District No. 1
Arbor Health Morton Hospital
521 Adams Street
Morton, WA 98356
Project No.: 18039.01
Date Issued: September 1, 2020

BID TO: Lewis County Hospital Distinct No. 1
Arbor Health Morton Hospital
Administrative Office
521 Adams Street
Morton, WA 98356
Attn: Leianne Everett, CEO, Arbor Health Morton Hospital

BID FROM:
Legal Name of Bidder McKinstry Co., LLC
Street Address 5005 3rd Ave S
City, State, and Zip Code Seattle, WA 98134
Telephone No. 206.762.3311

1. The undersigned BIDDER agrees, if this Bid is accepted, to enter into an agreement with OWNER, in the form included in the Bidding Documents, to perform and furnish the Work as specified or indicated in the Bidding Documents for the Bid Price and within the Bid Times indicated in this Bid and in accordance with the other terms and conditions of the Contract Documents.

2. In submitting this Bid, BIDDER represents, as more fully set forth in the Agreement, that:

   a. This Bid will remain subject to acceptance for 60 days after the day of Bid opening;
   b. The Owner has the right to reject this Bid;
   c. BIDDER accepts the provisions of the Instructions to Bidders regarding disposition of Bid Security;
   d. The BIDDER shall deliver the required performance and payment bonds to the Owner not later than three days following the date of execution of the Contract;
   e. BIDDER has examined copies of all the Bidding Documents;
   f. BIDDER is familiar with federal, state, and local laws and regulations;
   g. BIDDER has correlated the information known to BIDDER, and information and observations obtained from visits to the site, drawings identified in the Bidding Documents, and additional examinations, investigations, explorations, texts, and data with the Bidding Documents;
   h. This Bid is genuine and not made in the interest of or on behalf of an undisclosed person, firm, or corporation and is not submitted in conformity with an agreement or rules of a group, association, organization or corporation; BIDDER has not directly or indirectly induced or solicited another Bidder to submit a false or sham Bid; BIDDER has not solicited or induced a person, firm, or corporation to refrain from bidding; and BIDDER has not sought by collusion to obtain for itself an advantage over another BIDDER or over OWNER;

i. BIDDER has read and understands the provisions for liquidated damages set forth in the form of Agreement between the Owner and Contractor; and
j. BIDDER has received the following Addenda, receipt of which is hereby acknowledged:

Date	Number
09/09/2020	Addendum #1
09/18/2020	Addendum #2

3. BIDDER will complete the Work in accordance with the Contract Documents for the following price which does not include Washington State and local sales tax except as designated in Article 4 of the Instructions to Bidders. This price is hereby designated as the Base Bid and does not include Allowance No. 1.

LUMP-SUM BASE BID PRICE Two million three hundred ten thousand five hundred sixty dollars (Use Words) ($ 2,310,560.00 (Use Figures))

The Lump-Sum Base Bid Price is further broken down into price per portion of the Work as follows:

Description of Portion of the Work	Price Per Portion of the Work
Emergency Generator Replacement and Electrical Infrastructure Rework	One million nine hundred eight thousand twenty-seven dollars (Use Words) ($ 1,908,027.00 (Use Figures))
OR Heat Pump Addition	Four hundred two thousand five hundred thirty-three dollars (Use Words) ($ 402,533.00) (Use Figures)

ALLOWANCE

The following allowance is in addition to the Base Bid amount and shall be added to the Base Bid to obtain the Total Bid amount. See Section 01 21 00-Allowances for additional information.

Allowance No.1: Ninety thousand dollars ($90,000) for infection control and prevention measures as specified in Section 01 35 33-Infection Control Procedures.

TOTAL BID (BASE BID PLUS ALLOWANCE) Two million four hundred thousand five hundred sixty dollars (Use Words) ($ 2,400,560.00 (Use Figures))

4. BIDDER agrees that Substantial Completion and Final Completion for portions of the Work for the OR Heat Pump Addition will be within the 31 continuous calendar day period described in Article 1.09-Work Restrictions of Section 01 10 00-Summary. BIDDER agrees that Substantial Completion of the entire Work will be within 180 calendar days from the execution of the contract. BIDDER agrees that Final Completion of the entire Work will be within 210 calendar days from the execution of the contract.

5. Bidders states the bidder is not on Medicare OIG exclusion list.

6. The following documents are attached to and made a condition of this Bid:

a. Required Bid Security in the form of AIA Document A310-2010 in the amount of 5 percent of the Bid.
b. A Bidder's qualification statement in the form of AIA Document A305-1986.

c. A List of Subcontractors in the form of AIA Document G705-2001.
d. Preliminary construction schedule.

SUBMITTED BY:

Legal Name Of Bidder Dan Ronco on behalf of McKinstry Co., LLC

By (signature) Dan Ronco

Title Director of Electrical Construction

Date 09/29/2020

State of Washington Contractor's License No. MCKINCL942DN

The Bidder represented by the above signature is a:

Sole Proprietor	_____
Partnership	_____
Corporation	_____
Other Legal Entity	X LLC

If Bidder is a partnership, give full names of all partners. N/A

If Bidder is a corporation, the State in which the Bidder is incorporated is the State of N/A.

Business Address: 5005 3rd Ave S
Seattle, WA 98134

Phone Number: 206.762.3311

Provide corporate seal if a corporation.

END OF DOCUMENT

RES-20-39

Final Audit Report 2020-10-19

Created:	2020-10-15
By:	Shana Garcia (Sgarcia@mortongeneral.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAaR5uGy_h_nikyN75JkVX8VFzZoJg7pn_

"RES-20-39" History

Document created by Shana Garcia (Sgarcia@mortongeneral.org)
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2020-10-15 - 8:15:15 PM GMT

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Document e-signed by P Frady (commissionerfrady@myarborhealth.org)
Signature Date: 2020-10-19 - 2:04:52 PM GMT - Time Source: server- IP address: 70.41.80.238

Agreement completed.
2020-10-19 - 2:04:52 PM GMT

SUPERINTENDENT REPORT

SUPERINTENDENT'S REPORT April 2021

Mission: *To foster trust and nurture a healthy community*
Vision: *To provide accessible, quality healthcare*

	Opportunity	CY 2021 Progress	Status	Associated Documentation
Informational	Recruitment	Update on ongoing recruitment efforts for selected positions	on-going	*04212021 Recruitment Memo*
Informational	At-Risk Compensation	At-Risk Compensation model cost is summarized with two accrual options presented.	on-going	*04212021 At-Risk Compensation Memo*
Informational	Legislative Update	Providing an update on legislative bills alive at 4/14/2021.	on-going	*04212021 Legislative Update Memo*
Strategic	Q1 Department Strategic Measures	Providing Q1 update on progress to completion of Q1 Department Strategic Measures	Complete with quarterly updates	*04212021 Q1 2021 Department Strategic Measures*

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 4/21/2021
Subject: Recruitment

Below is a recruitment update on selected positions:

- Facilities Director – Negotiating with a qualified candidate to fill this position currently held by an interim,
- Surgical Podiatrist – interviewing an interested provider,
- Non-surgical Podiatrist – negotiating,
- Certified OT Assistant – starting the recruitment process for a per diem due to increased volume,
- Randle Clinic Physician – We are securing an interim provider to provide services between Dr. Ho's departure and Dr. Podbilski's arrival.
- Quality Manager - currently being filled by an interim, no new qualified candidates to review,
- Massage Therapist – actively recruiting to fill this upcoming vacancy.

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 4/21/2021
Subject: At-Risk Compensation

As requested at the March Regular Board of Commissioners meeting, I am bringing forward the cost implication of the At-Risk Compensation for all executives, directors and managers. The information presented below represents two scenarios: 1) full financial exposure and 2) a more probable outcome of 75% of possible At-Risk compensation earned.

Group	100% Earned	75% Earned
Executive	$ 130,699	$ 98,024
Clinical Directors/Managers	$ 106,803	$ 80,102
Support	$ 80,207	$ 60,155
Total	$ 317,708	$ 238,281

I am recommending that our Finance team begin accruing the 75% earned scenario in the April 2021 month-end close. This will be "trued up" in Q1 2022, resulting in a client prepared audit entry to ensure the actual earned amount is recorded in the 2021 audited financial statement that will be used to prepare the cost report.

No resolution for a budget amendment will be forthcoming. My intent to fund the At-Risk Compensation will be through cost containment. An example of cost containment is the sharing of a Compliance Officer with two other Collaborative facilities.

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 4/21/2021
Subject: Legislative Update

As of April 14, 2021, the following WSHA priority bills have passed both chambers:

- SHB 1095: B&O Tax Exemption for COVID-19 Emergency Grants – signed into law by Governor Inslee (WSHA supported)
- ESHB 1196: Concerning audio-only telemedicine – I advocated for during January Hospital Advocacy Days (WSHA supported)
- SSB 5271: Providing liability protections for health care providers and facilities that recognized the evolving standards of care during COVID-19 (WSHA supported)
- ESSB 5178: Establishing timely consideration of waivers of select state health care laws to enable timely response by the health care system during a governor-declared statewide state of emergency (WSHA supported)
- SSB 5140: Miscarriage management (WSHA opposed)
- ESSB 5190: Providing health care workers with presumptive benefits during a public health emergency (WSHA monitored)
- 2SSB 5195: Concerning prescribing opioid overdose reversal medication (WSHA supported)
- E2SSB 5377: Public option – (WSHA monitored)
- E2SHB 1152: Supporting measures to create comprehensive public health districts (WSHA monitored)
- E2SHB 1272: Concerning health system transparency (WSHA monitored)
- ESSB 5115: Establishing health emergency labor standards (WSHA monitored)

A full list of healthcare bills can be found at https://www.wsha.org/articles/bills-that-have-passed-both-chambers-nurse-licensure-compact-to-get-work-session/

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To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 4/21/2021
Subject: Q1 2021 Department Strategic Measures

Strategy 1: To build relationships and partnerships that prioritize community health needs:

- Achieved goal: 14 of 33, or 42%
- Goal in progress: 7 of 33, or 21%
- Did not achieve goal: 12 of 33, or 37%

Strategy 2: To create a culture focused on safety, patient satisfaction, employee engagement and excellent outcomes:

- Achieved goal: 16 of 33, or 48%
- Goal in progress: 4 of 33, or 13%
- Did not achieve goal: 13 of 33, or 39%

Strategy 3: To continue as stewards of public funds:

- Achieved goal: 9 of 33, or 27%
- Goal in progress: 9 of 33, or 27%
- Did not achieve goal: 16 of 33, or 49%

Overall Progress:

- Achieved goal: 39 of 99, or 39%
- Goal in progress: 20 of 99, or 20%
- Did not achieve goal: 41 of 99, or 42%

Starting April 2021, the department featured in the *Department Spotlight* agenda item will be discussing their progress toward accomplishing their strategic goals.

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Develop a primary care clinic in Packwood, WA		Open by 12/31/2021	In-progress				
Clinical Informatics: Increase overall clinic portal enrollments to > 60%	44%	≥ 60%	31%				
Communications: Partner with vendors and community groups to host a live/virtual/drive-through health fair.		1 Event Annually	0				
Environmental Services: Staff members will become CHEST (Certified Health Care Environmental Services Technician) certified within first year of employment		75%	0%				
Facilities: Increase department employees engagement in employee events		75%	100%				
Finance: Increase vendor invoice EFT utilization by 50%.	150/qtr	225/quarter	209				
Billing/HIM: Partner with Insurance Payor to address school needs/community youth programs		2 coordinated events/year	June event in-progress				
Human Resources: 80% of chiefs, managers and directors will serve 24 hours/year of approved community service within the District.		101 hours/quarter	121				
Information Technology: Create a partnership with local internet vendors to develop wireless access for community needs		Pass/Fail	0				
Employee Health: Develop a community weight loss challenge that culminates in a 5k/10k/Half Marathon		Pass/Fail	In-progress				
Patient Access: Refer patients to the Self Pay Biller to see if they qualify for Medicaid.		5 patients/qtr, 20 patients/year	2/5				
Quality and Risk: Successful *Critical Access Hospital* DVN Certificiation		Pass/Fail	Survey scheduled for May 2021				
Supply Chain: Create Cycle Count process to improve inventory accuracy.	65%	75%	65%				
CLINICAL							
Acute Care: Develop and implement 1 social media message or newsletter article per quarter re: Chest Pain/MI, Sepsis, Cornonavirous, and CHF.		1/quarter, 4/year	6				
Case Management: Develop and implement 1 social media message or newsletter article per quarter re: skilled services		1/quarter, 4/year	10				

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
Dietary/Nutrition: Provide To Go meals to seniors in food scarce homes		Number of Meals Served	630 (avg 10/day)				
Emergency Department: Successful Acute *Stroke Ready* DNV Stroke Certification		Pass/Fail	Pass				
Imaging: Increase Mammography volume by 10% via external partners and social media	1382	1520.2	364/380				
Infection Control: Use social media to promote IC messaging once per month		3 messages per quarter	1 video & multiple posts				
Laboratory: Increase quality of blood cultures	70.50%	≥ 90%	100%				
Respiratory Therapy: Develop and implement 1 social media messages/quarter re: pulmonary disease and diagnostic testing		1 messages per quarter	0				
Pharmacy: Establish a medication disposal program for Morton, Mossyrock and Randle		Minimum of 3 kiosks	In-progress				
Pulmonary Rehab: Extend two smoking cessation classes per year to public		2 classes per year	0				
Wellness: Create a community wide wellness plan that incorporates 2 partnerships with providers, employers, and community based entities focusing on overall health of our community by identifying target chronic illnesses and needs.		2 partnerships	Partnered with UW & Enhanced Fitness for remote senior exercise program study				
Rehab Services: Create relationships with the schools for athletic program, including ImPACT concussion management, student athletic performance & injury management, and coach education programs.		1 athletic season of partnership with ImPACT	ImPACT is scheduled for August				
Surgical Services: Facilitate awareness of and local access to outpatient Infusion Care by developing marketing literature and outreach to Lewis County clinics, home health, and Centralia, Longview and Tacoma hospitals' Case Management departments resulting in ≥ 20% increase in Same Day Surgery encounters	333	400	103/100				
Anesthesia: Increase Ketamine clinic encounters by 15%	56	64.4	14/16.1				

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
Swing Beds: Acute patients transferred out of District with subsequent skilled needs are readmitted to Arbor Health for local care		12 patients/year	5				
Wound Care: Refine and market Diabetic Foot/Toenail Care to increase visits by 20%	45	54	3/13.5				
CLINICS							
Morton: Develop 3 community engagement events at clinic per year.		3/year	COVID Clinics				
Mossyrock: Develop 3 community engagement events at clinic per year.		3/year	COVID Clinics				
Randle: Develop 3 community engagement events at clinic per year.		3/year	COVID Clinics				
Specialty: Develop 3 community engagement events at clinic per year.		3/year	0				

EXECUTIVE DASHBOARD

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

METRIC	BASELINE	TARGET	2021 Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Increase employees affirmative response to "My manager/supervisor has shown a genuine interest in my career" by 25%.	26%	33%	In-progress				
Clinical Informatics: Increase Cerner Physician Inpatient Admission Medication History completion	64%	≥ 80%	29.0%				
Communications: Adopt mission/vision/values throughout organization		Kickoff 1 value per quarter	One team, one mission				
Environmental Services: Increase compliance with "high touch" areas to ≥ 80%	57%	≥ 80%	97%				
Facilities: Improve the average maintenance work order turnaround time by 5%.	11	10.45	11.6				
Finance: Develop and implement a reliable timeline for processing accounts payable checkruns in Multiview	Process on Friday of each week	90% of all check runs are processed weekly on Fridays	77.0%				
Billing/HIM: Increase conversion of bad debt to charity care by 100%	$ 133,685	$ 267,370	$ 297,685				
Human Resources: Conduct an employee engagement survey using an independent national vendor to establish baselines and comparatives.		Pass/Fail	In-progress				
Information Technology: Develop 4 training seminars for staff and community on IT related topics		1 training/quarter	0				
Employee Health: Reduce reportable workplace injuries by 10% or more.	13	11.7	0				
Patient Access: Identify patients that qualify for charity care by using bill holds to flag encounters allowing biller to track and follow-up with patients.		20 patients per quarter, 80 patients per year	0				
Quality and Risk: Improve hospital wide HCAHPS Overall score to ≥ 70%	58%	≥ 70%	98.0%				
Supply Chain: Implement & maintain a housewide monthly product out-date process		11 out of 12 months	3				
CLINICAL							
Acute Care: Improve HCAHPS *Communication About Medications* Overall top box score to ≥ 60%	48.5%	≥ 60%	81.6%				
Case Management: Improve HCAHPS *Care Transitions Overall* top box score to ≥ 50%	43.20%	≥ 50%	74.4%				
Dietary/Nutrition: Conduct healthy cooking demonstrations for public		One demonstration per quarter	Minestrone				
Emergency Department: Decrease average door to tPA ≤ 60 minutes for stroke patients	114	≥ 60	60				
Imaging: Decrease stroke/CT report turnaround to 15 minutes or less	43 minutes	≤ 15 minutes	14.3				
Infection Control: Increase hand hygiene compliance	74%	≥ 90%	88%				
Laboratory: Decrease rate of reference lab rejected samples	0.88%	≤ 0.5%	0.7%				
Respiratory Therapy: Implement COPD Gold Standard Care Map discharge criteria/bundle on acute/skilled respiratory patients		≥ 90%	0.0%				
Pharmacy: Provide medication counseling at discharge		60%	0.0%				

Pulmonary Rehab: Increase annual unique patients secondary to implementation of COPD Gold Standard Care Map and clinic outreach for at risk pulmonary patients	28	32	0
Wellness: Create 2 additional programs that are designed to engage the local community in health and wellness.		2 programs	Continue senior exercise program once study with UW is complete
Rehab Services: Improve patient satisfaction score for progress during treatment	69%	≥ 80%	69.0%
Surgical Services: Increase return rate of internal Post-Operative Patient Experience Survey to greater than 90% (inclusive of endoscopy patients)	15%	≥ 90%	17.0%
Anesthesia: Increase overall rating of anesthesia provider on the Surgery Patient Satisfaction Survey	67%	≥ 90%	80.0%
Swing Beds: Skilled patient with a Braden Score < 12 will have a Wound Care consultation	75%	≥ 90%	66.0%
Wound Care: Increase documented skil care assessments (must capture all 8 assessment elements)	68%	≥ 80%	82.1%
CLINICS			
Morton: Market and grow telehealth visits by 25%	504	630	24/157.5
Mossyrock: Market and grow telehealth visits by 50%.	85	128	41/32
Randle: Market and grow telehealth visits by 50%.	81	122	83/30.5
Specialty: Market and grow telehealth visits by 50%.	31	62	18/16

EXECUTIVE DASHBOARD

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2021 Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Decrease interim staffing costs by 10% or greater.	$ 2,368,626	**$ 2,131,763**	**$ 506,207**				
Clinical Informatics: Create a report that identifies patient care gaps for patients enrolled in United Health Care (UHC) Managed Care program to increase HEDIS Star Ranking to 3 Stars	2.25 Stars	**3 Stars**	**2.22**				
Communications: Increase Sleep Studies by 10% through the use of effective marketing messaging	69	**76**	**0**				
Environmental Services: Decrease overtime by 25% by optimizing staffing schedules.	$ 4,893	$ 3,670	**$ 2,853**				
Facilities: 100% of critical PMs completed monthly.	95%	**100%**	**100%**				
Finance: Pay external vendors timely and per schedule, reducing variation/errors	70%	**80%**	**75%**				
Billing/HIM: Decrease timely filing write-offs by 25%	$ 108,072	**$ 81,054**	**$ 22,688**				
Human Resources: Decrease employee turnover (without retirement)	20.60%	**< 19%**	**3.98%**				
Information Technology: Reduce controllable network downtime hours within organizational control by 50%	33	**17**	**6/4.25**				
Employee Health: Decrease claims costs using Experience Factor as metric (updated annually)	1.3075	**$ 1.18**	**In-progress**				
Patient Access: Increase point-of-service collections by 10% in ER and 20% in OP Services.	$ 19,111	**$ 21,022**	**$ 5,991**				
	$ 64,474	**$ 70,921**	**$ 45,755**				
Quality and Risk: Reduce *All Cause Readmissions* by > 20%	2.8	**2.24**	**1.9**				
Supply Chain: All assets/capital purchases undergo asset purchase process/structure lead by Materials team.		**75%**	**66%**				
CLINICAL							
Acute Care: 30% reduction in lost revenue due to *Did Not Meet Inpatient Criteria* denials.	$ 90,000	**$ 63,000**	**$ -**				
Case Management: 50% reduction in lost revenue due to *No Authorization* Skilled patient denials	$ 176,000	**$ 88,000**	**$ -**				
Dietary/Nutrition: Increase rebates from GPO food supplier by 20%	$ 3,852	**$ 4,622**					
Emergency Department: Reduce annual Left Without Being Seen (LWOT) patients in ED by 10%	116	**104**	**27/26**				
Imaging: Reduce callback hours worked by 10% by utilizing a night shift radiology tech.	**686**	**617**	**120/154.25**				
Infection Control: Decrease infectious disease readmissions within 30 days of hospital stay with same diagnosis.	6.75	**2**	**3.6**				
Laboratory: Decrease interim staffing costs by 20%	$ 150,568	**$ 120,454.40**	**$ -**				

Respiratory Therapy: Increase PFT test volume secondary to implementation of COPD Gold Standard Care Map and clinic outreach for at risk pulmonary patients to 12		**12**	**0**
Pharmacy: Utilize Sentri7 to reduce drug costs		**Decrease by 10% or greater**	**Evaluating products**
Pulmonary Rehab: Transition Pulmonary Rehabilitation therapy to a group model (pending COVID guidelines) allowing for a 100% increase in visits	128	**256**	**0**
Wellness: create a wellness program that is an efficient use of funds and demonstrates a commitment to reducing healthcare cost overall in the community.		**Pass/Fail**	**In development**
Rehab Services: Decrease our cancel/no show rate to reduce non-productive time and improve patient outcomes.	15%	**Less than or equal to 12%**	**11%**
Surgical Services: Develop/implement new ortho service line		**20 cases**	**0**
Anesthesia: Acquire peripheral nerve block competency resulting in new revenue (ortho)		**$ 10,800**	**$ -**
Swing Beds: Implement weekly fax/email bed availability updates to primary referral sources to return to budgeted skilled admissions	76	**140**	**22/35**
Wound Care: Develop and implement WOCN EPIFIX administration protocol for chronic wounds to achieve a 20% increase.	21	**25.2**	**5**
CLINICS			
Morton: Implement Chronic Care Management via Preventative Care Advisor.			**In-progress**
Mossyrock: Implement Chronic Care Management via Preventative Care Advisor.			**In-progress**
Randle: Implement Chronic Care Management via Preventative Care Advisor.			**In-progress**
Specialty: Hospital & clinic chart notes complete within 48 housrs of visit	95%	**≥ 90%**	**99.3%**