CLALLAM COUNTY
PUBLIC HOSPITAL DISTRICT NO. 2

BOARD OF COMMISSIONERS BUSINESS MEETING

LINKLETTER HALL
6:00 P.M.

June 17, 2026

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MEDICAL CENTER

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Board of Commissioners Meeting

Wednesday, June 17, 2026
Linkletter Hall
6:00 pm
www.olympicmedical.org/virtual-board-meeting

Working together to provide excellence in healthcare.

CALL TO ORDER
A. Pledge of Allegiance
B. Roll Call
C. Approve Agenda

CONSENT AGENDA
A. Minutes from June 3, 2026 (pgs. 41 - 46)
B. Joint Conference Committee Summary from June 9, 2026 (pg. 47)

PATIENT STORY – Scott Kennedy, MD, Chief Medical Officer

PUBLIC COMMENT
A. Public and virtual

KAUFMAN HALL REPORT – John Bauerlein, Managing Director, Kaufman Hall
(pgs. 3 - 26)

MEDICAL STAFF RECOMMENDATIONS – Colin Wolslegel, DO, Chief of Staff
A. Medical Staff Credentials Report for May 2026 (pgs. 27 - 28)

QUALITY UPDATE – Rhonda Bowen, Infection Prevention Control Program Manager
A. Hand Hygiene and Infection Rates (pgs. 29 - 33)

FINANCE UPDATE – Dennis Stillman, Interim Chief Financial Officer
A. Finance Update (pgs. 34 - 38)

ADMINISTRATOR'S REPORT – Mark Gregson, Interim Chief Executive Officer
A. Operations Update (pgs. 39 – 40)

OLD BUSINESS

NEW BUSINESS

OTHER

ADJOURN

OMC Performance Improvement Assessment Findings & Recommendations

Olympic Medical Center Board Report

June 17, 2026

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Executive Summary Workstream Findings & Recommendations

- Priority Areas:
  - Physician Enterprise & Service Line Review
  - Workforce Productivity
  - Clinical Documentation Integrity – Inpatient, Outpatient, & Professional Fee
  - Non-Labor / Supply Chain
  - Compliance
- Additional Areas:
  - Pharmacy
  - Revenue Cycle
  - Patient Status / Length Of Stay
  - Corporate & Shared Services
  - Information Technology
  - Real Estate

Today's Presentation and Other Assessment Considerations

Report Materials & Today's Discussion

- The purpose of the document is to provide a high-level executive summary of the performance improvement assessment conducted for Olympic Medical Center
- The assessment scope included only Olympic Medical Center performance as a stand-alone health system
- The workstream teams collaborated with their respective Olympic Medical Center key stakeholders, workstream leads and the Executive Sponsors to review all analyses, findings, recommendations, and financial opportunities
- The assessment findings and recommendations were developed not only through analyses, but also through stakeholder interviews and onsite visits to develop a balanced set of findings and recommendations
- All findings and financial opportunities are subject to change. However, they have been vetted by various Olympic Medical Center leadership prior to today's discussion

Performance Improvement Opportunity Overview

Estimated financial impact *(based on mid-point of analyses)*

Total Income Statement (P&L)		Total Balance Sheet	
$ 29.2 million *Revenue and Expense Opportunity*	• *Physician Enterprise accounts for 33% of total impact ($9.6M)[1]* • *Labor productivity accounts for 28% of total impact ($8.2M)* • *Combined CDI opportunity ($5.1M) accounts for 17% of impact* • *Non-labor improvements account for 8% of total impact ($2.5M)*	**$ 57.0 million** *Cash Opportunity*	• *$ 55M: monetization of 4 owned real estate assets* • *$ 1.9M: revenue cycle initiatives; POS collections and DNFB* • *$ 0.1M: Pharmacy inventory level adjustment*

1. Certain improvement opportunities may require additional costs and investment to achieve benefit that are not currently factored into the improvement opportunities, among others these include downstream revenue and real estate monetization

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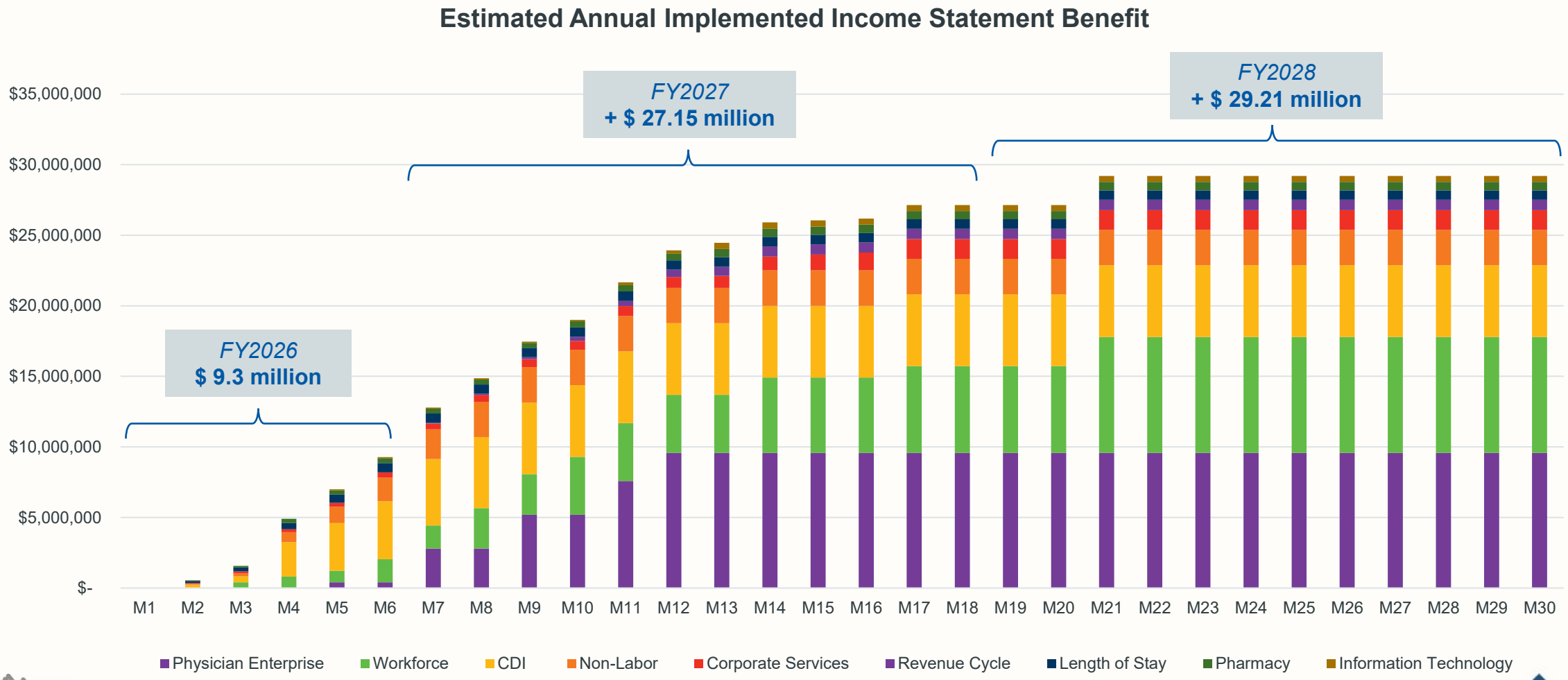
Performance Improvement Opportunity
Estimated Income Statement (P&L) Impact Timing



(1) Assumes implementation start date of July 1, 2026; projected benefit includes necessary Assessment Team initiative ramp-up and design support
(2) Analysis is based on mid-point financial opportunities

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Priority Areas

Physician Enterprise | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total Patient Access Benefit	Total Potential Downstream Revenue Benefit
	$1.0 - $2.2 *Midpoint: $1.6*	**$4.9 - $11.2** *Midpoint: $8.0*

	Key Summary Findings
Financial Performance	• Existing financial reporting limited for OMP. More robust financial reporting required for long-term OMP performance management. • Need to examine revenue and expense allocation to understand physician enterprise subsidy
Provider Performance	• Provider productivity is below 50th percentile in care team and provider modeling. Template governance and management opportunity exists to further drive productivity aims. • Recent closure of services indicates need for service line planning.
Patient Access	• New patients experience longer wait times compared to industry norms – with low realized schedule utilization across services. • Key patient access technology and reporting are unavailable – which limits patient access performance.
Change Management	• Standardized approach to patient access needed for advancement. Strategic centralized services are necessary to increase efficiency. • Responsiveness needed to improve physician engagement and build clinical leadership to support transformation.
Medical Group Infrastructure	• Opportunities exist for operational and financial improvement through leadership allocation, committee structure and centralized functions. • Review of MOB plant infrastructure needed for optimization and service requirements..

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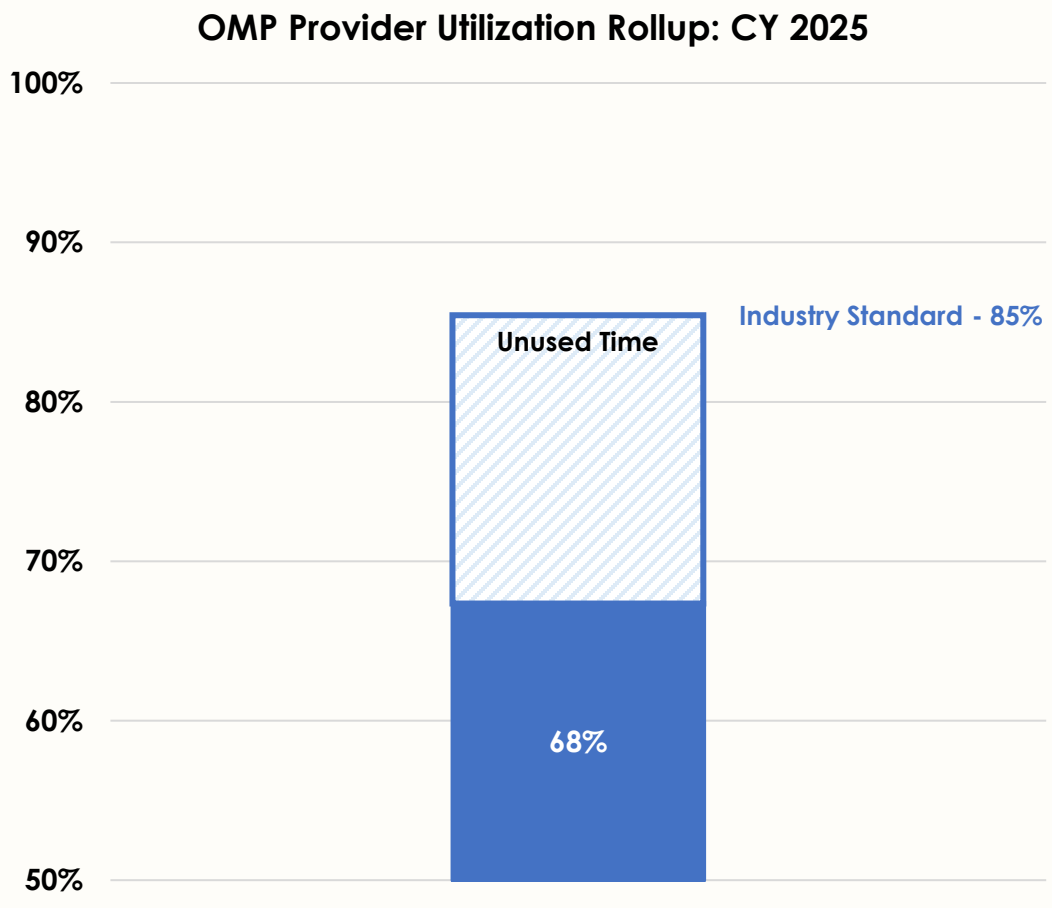
30% of scheduled visits are not being utilized in current state; OMP has the opportunity to unlock $2.4M-$5.6M in net revenue opportunity through improved patient access initiatives, with additional downstream revenue opportunity ($4.8M-$11.2M)



Visit Gap to Utilization Target	×	Net Revenue per Visit[4, 5] $152	=	Dollar Amount of Net Revenue Gap (NPSR)

	Provider Utilization Target	Incremental Patient Visits[2]	Net Revenue[3]		
			Low[4]	Mid[4]	High[4]
OMP	85%	36,791	$2.4M	$4.0M	$5.6M
OMC Downstream Revenue (2x OMP Net Revenue)			*$4.8M*	*$8.0M*	*$11.2M*

Highlights

- Current state realized utilization is 67.5% across OMP – with 80% of services evaluated below 75%.
- Realized utilization to be improved through targeted patient access initiatives, including:
  - Template management and governance
  - Pre-appointment engagement and processes
  - Centralized scheduling services and standards

1. Data Source: OMC PE-06 Patient Access File – visit volume data from 12 months (January 2025 – December 2025) ; Walk-in Clinic excluded due to lack of visit data provided
2. Calculation based on current state realized utilization (arrived visits versus scheduled visits), and visit variance (improvement) based on increasing utilization to outlined thresholds
3. Net Revenue per Visit used based on benchmark Median (Multispecialty with Primary and Specialty Care), due to outlier $/wRVU value for OMP Financial documents provided
4. Dollar amount of NPSR Gap based on Visit gap times Net Revenue per Visit value, discounted for other expenses ; Low (75% Utilization) ; Mid (80% Utilization) ; High (85% Utilization) targets identified
5. Calculation figures are rounded

Correlation between **low productivity and long new patient waits** indicate template and access optimization opportunity

OMP Access Scheduling & Metrics[1] By Cohort (January 2025 – December 2025)

Department	Total Appointments[1]	Provider Productivity (Care Team % Tile)[2]	Realized Utilization %[3]	No Show Rate[1]	New Patient %[4]	New Patient Days Waiting[4]
Primary Care	52,095	35	69.5%	3.5%	2.7%	53.0
Hematology/Oncology	39,817	78	65.6%	1.4%	*	*
Orthopedics	36,811	30	71.4%	3.0%	16.5%	33.5
Pediatrics	20,802	17	75.7%	3.8%	1.4%	35.0
Pulmonology	12,838	85	59.9%	3.1%	12.1%	44.4
Gastroenterology	11,935	83	63.7%	4.0%	30.2%	26.4
Cardiology	11,858	31	50.7%	1.9%	10.6%	90.6
OB/GYN	10,874	34	65.6%	2.8%	14.9%	23.9
Urology	8,120	11	64.2%	2.6%	19.4%	80.0
General Surgery	5,147	18	77.2%	1.4%	38.7%	9.2
Overall	**210,297**	**33**	**67.5%**	**2.8%**	**9.2%**	**40.7**

Below Performance Standard[5]	Above Performance Standard[5]

Observations

- **New Patient Days Waiting is significantly higher than benchmark** across specialties – when paired with low provider productivity, there is an opportunity to evaluate new patient scheduling and intake protocols
- **New Patient %** is worse than benchmark for most cohorts, suggesting that it is difficult for new patients to be seen quickly, when coupled with the long waiting time
- **Evaluating poor realized utilization rate** is paramount to addressing patient access concerns – as it creates difficulty meeting access and performance goals

1. OMC PE-06 Patient Access File – visit volume data from 12 months (January 2025 – December 2025)
2. Productivity data from PE-04 Provider Productivity file: 12 months (January 2025 – December 2025) for 73 Total Providers ; Benchmarked Against benchmark 2025 (2024 Data) Provider Productivity and Compensation Benchmarks
3. Realized Utilization calculated based on Patient Visit status "Completed" divided by total appointments ; No Show rate based on "No Show" appointment status ; appointment statuses to be further reviewed with OMP leadership.
4. New Patient % Calculated based on visit types i) "AC New" ; ii) "CC New" ; iii)' "CC New OB" ; New Patient days waiting calculated based on variance between Appointment "Date Made" and Appointment "Date Seen" fields
5. Performance Standards: 1) Provider Productivity >65th % tile ; 2) Realized Utilization >85% ; 3) New Patient % >15% ; 4) New Patient Wait Time <7 days
6. Excluded departments included: i) Urgent Care based on limited access strategy approach (20,279 annualized visits) ii) Limited new patient data for Hematology/Oncology

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Strategic summary & future considerations

OMC maintains a strong local market position within a geographically isolated rural market, with patients demonstrating a clear preference to remain local when services and access are available

Long-term market growth is expected to remain modest, reinforcing the importance of retaining appropriate care locally through operational improvement, access optimization, and targeted clinical collaboration

Current outmigration of approximately 48% appears to be driven less by broad competitive displacement and more by access limitations, operational constraints, and selected specialty coverage gap

Future opportunity exists to strengthen local care delivery through focused collaboration, specialty support, telehealth expansion, and improved referral pathways; however, the **immediate priority should remain operational reliability and access improvement**

Strategic opportunity is concentrated in strengthening local retention through improved access, operational reliability, and clinically aligned collaboration

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Workforce | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$3.1 - $13.8 *Midpoint: $8.2*	**$0**

	Key Summary Findings
Observations	• Current productivity tracking is largely monthly and retrospective, limiting timely management action. • Limited real-time dashboards and inconsistent reporting structures reduce visibility into department and service-line performance. • Some departments use productivity metrics that do not fully reflect actual workload, such as Sterile Processing using adjusted patient days instead of trays processed or loads sterilized. • Staffing request and approval processes lack a consistent, data-driven governance model
Recommendations	• Establish a standardized labor productivity framework with consistent metrics, benchmarks, and reporting cadence. • Implement real-time dashboards to improve operational visibility, accountability, and decision-making. • Align productivity measures to department-specific workload drivers, including revised units of service for Sterile Processing. • Separate reporting for key service lines, such as inpatient and outpatient Imaging, to improve benchmarking and performance management. • Create a structured, data-driven governance process for staffing requests and approvals, incorporating productivity benchmarks and labor agreement considerations.

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Clinical Documentation Integrity (CDI) | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$4.4 - $5.9 *Midpoint: $5.1*	**$0**

	Key Summary Findings
Inpatient	• OMC's Medicare medical comorbidity and MCC rates rank in the bottom two quartiles versus regional peers, while low-acuity diagnoses are documented at disproportionately high rates — including among expired and hospice-discharge patients (April 2025–March 2026) • These trends indicate an opportunity to better capture patient acuity, severity of illness, and resource intensity through stronger documentation practices • Current CDI efforts are primarily focused on documentation validation, with an opportunity to expand proactive identification of additional MCCs and more appropriate principal diagnoses through a stronger "clinical detective" approach
Facility Outpatient CDI	• Align ED E/M level criteria more closely with actual resource utilization and peer/national benchmarks • Improve documentation and establish charge capture for phase II recovery services and principal illness navigation (PIN) services • Evaluate and enhance education on documentation and coding for IV administration services
Professional/Ambulatory CDI	• There is opportunity in E/M level distributions to better reflect patient acuity across OMC specialties as compared to regional reference points • Expanding into proactive CDI strategies, with comprehensive and advanced CDI education for OMC team (including Charge Review and Revenue Integrity teams) • Implementing a data-driven approach for provider reviews and education with targeted specialties and providers with highest opportunity for accurate E/M levelling and documentation best practices

Non-Labor | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$2.1 - $2.9 *Midpoint: $2.5*	**$0.1 - $0.1** *Midpoint: $0.1*

	Key Summary Findings
Clinical Supplies	• Vendor consolidation is evident across many supply categories but has not consistently driven leveraged enhanced pricing • Physician engagement is an opportunity and vital for improvement in vendor standardization, consolidation and pricing enhancements • Observed variation in vendor price performance within key product categories; internal product conversions may represent "quick win" opportunities
Purchased Services	• Multiple contracted service categories, including freight, clinical engineering, and linen, identified elevated spend drivers and contract structures warranting further review • Supply Chain & Inventory: office supplies, and laboratory purchasing identified opportunities to improve standardization, benchmark pricing alignment • Vendor Payment Processes: Significant spend currently flows through traditional and payment methods (ACH/Check), indicating opportunity streamline purchasing practices through virtual card and payment terms
Value Analysis Team (VAT)	• Currently, the VAT is less than adequate and has in most instances been absent • Olympic Medical Center must adopt and embrace a structured process for frontline users to evaluate and make decisions regarding product selection and usage • Must collaborate with physicians and executives early and often throughout the process for clinical initiatives • Guiding principles need to be surrounded by: Quality, Patient Outcomes, Effectiveness, Cost, Revenue, Product Availability, Education/Training, Safety and Regulatory Regulations, Research and New Innovations • An efficient and well-performing VAT is the primary mechanism for controlling the entry of products into the organization as well as standardization, evaluation, utilization, and communication with the goal of ensuring that patient quality of care is met
Food and Nutrition Services (FANS)	• Review of floor stock and requisition purchasing identified variability in product usage and ordering patterns across departments, indicating opportunity for formulary standardization and tighter inventory controls • Approximately $331K of floor stock and requisition costs per patient days are both above benchmark ranges, indicating opportunity to optimize/standardize across departments

Compliance, Risk, & Regulatory Environment | Overview and Methodology

Methodology

Methodology: Using the CMS Conditions of Participation as the primary framework, a two-day clinical and physical environment assessment was conducted on April 29–30, 2026, to evaluate the current state of regulatory compliance. The assessment included a targeted review of key priority areas and policies and procedures. Medical record documentation was reviewed for specific compliance requirements. The physical environment review included documentation as well as a building tour focused on critical systems.

Clinical Units: The Emergency Department, ICU, Telemetry, Labor & Delivery, Newborn Nursery, Medical Surgical 2 West Main, Endoscopy, OR, SPD, Diagnostic Imaging.

Physical environment: Main facility, 2 houses used by Security and Engineering, and the mobile MRI unit.

The Compliance Deficiency Action Report (CDAR) provides specific compliance deficiencies and recommendations where applicable. The report is organized by CMS Conditions of Participation categories.

- The organization's commitment to evaluating current practices and identifying opportunities to enhance patient care and operational effectiveness was evident throughout the engagement.
- The leadership and staff at Olympic Medical Center were highly engaged and collaborative. Discussions were thoughtful and productive, reflecting a shared commitment to continuous improvement and organizational progress towards regulatory compliance.

Compliance, Risk, & Regulatory Environment | High Priority Findings by Area of Focus

Focus Area	Key Issues / Policy / Process Breaches
Infection Control	[1] High Level Disinfection [2] Pre-treatment of surgical instruments [3] Glucometer contamination
Anesthesia	Deep sedation practices in the ED
Patient Rights	Restraint ordering, application, and monitoring
Nursing Practice	[1] Emergency equipment monitoring [2] Exceeding professional scope of practice (specific to deep sedation) [3] Medication errors (specific to titration orders)
Emergency Services	[1] *EMTALA – Medical Screening Exam breaches (penalties) [2] Central Log breaches
Physical Environment	[1] Water sources with biofilm and scale [2] Mobile MRI Unit – Unlocked and unattended [3] *NFPA guidelines specific to wiring (updates required) [4] *FGI guidelines specific to semi-critical space ceilings (porous) *Non-high priority issues requiring investment:* - **Furniture integrity, damaged walls, and rust on equipment* - **Medical gas valves requiring relocation in the ED trauma room* - **Plumbing pipe in the main corridor in the basement is a bump hazard requiring relocation (LS code)*

*indicates area with financial impact or required investment/capital needs

Additional Areas

Pharmacy | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$0.4 - $1.0 *Midpoint: $0.6*	**$0**

	Key Summary Findings
Formulary, Medication Utilization, and Cost Management	• Medication cost savings opportunities identified through transition to lower-cost medications and products, including biosimilars, intrauterine devices, and anti-infectives. • Medication inventory appears appropriate for the size of the hospital and cancer center, providing a buffer against drug shortages while limiting excess, expired, or wasted inventory. • Pharmacy team manages medication costs well and provides high-level of clinical pharmacy care despite recent reductions in acute care pharmacy staffing. • Incoming pharmacy director to evaluate the current pharmacy staffing model, including open positions, clinical pharmacy coverage needs, medication safety risks, employee workload, and the potential use of remote overnight pharmacist services to support safe and sustainable pharmacy operations
340B Drug Pricing Program	• Engage with nationally-recognized firm to reassess Medicare Cost Report DSH percentage • Evaluate collaboration with UW Medicine as a 340B contract pharmacy partner to provide infusion services with UW Medicine as the 340B covered entity purchaser of record. • Through the interview process with pharmacy and finance teams involved with the 340B program, they demonstrated a strong understanding of compliance requirements, program integrity principles, DSH calculation methodologies, and key reimbursement considerations • After being unenrolled from program, 340B team demonstrated strong program integrity by immediately halting the purchasing of 340B medications upon loss of eligibility status.
Patient Assistance Program	• OMC does not utilize outside vendor or software support for patient assistance program of medications • Patient navigators in OMC Cancer Center utilize Onco360 for specialty or self-administered medications when requested by patients unable to pay • Patient assistance provided for 80-100 patients for specialty and infusion annually currently, but total value not currently being tracked by patient navigation team

Revenue Cycle | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$0.5 - $0.8 *Midpoint: $0.6*	**$1.4 - $2.3** *Midpoint: $1.9*

	Key Summary Findings
Revenue Cycle Governance & Technology	• Standardize operational workflows, SOPs, training programs, and playbooks to reduce process variability and improve staff consistency • Develop centralized Revenue Cycle reporting and dashboard capabilities to provide integrated visibility into operational, financial, productivity, denial, AR, and POS collection performance • Continue to work with Providence to expand utilization of Epic functionality, automation, and AI-enabled tools to reduce manual workarounds, improve efficiency, and support scalable operations
Patient Access / Financial Clearance / POS Collections	• Establish a centralized Financial Clearance model with defined ownership for eligibility verification, authorization tracking, scheduling readiness, and patient financial engagement • Strengthen pre-service workflows through standardized authorization, eligibility, and escalation processes to reduce downstream denials and improve financial clearance completion rates • Standardize Point of Service collection expectations for copays, prior balances, deposits, and estimated patient responsibility with consistent scripting and accountability across all access points • Improve patient financial transparency and upfront collections through enhanced use of Epic estimates, eligibility tools, workflows, and outreach
DNFB / HIM & Coding / Denials Management	• Strengthen DNFB and charge lag management through standardized charge reconciliation processes, service-line accountability, escalation pathways, and enhanced operational visibility • Improve coding and HIM performance through enhanced productivity monitoring, coding quality oversight, documentation accuracy, and stronger integration between Coding, CDI, and clinical teams • Establish a formal Denials Prevention and Management governance structure with standardized denial categorization, root cause analysis, and cross-functional accountability across departments • Centralize appeals management and strengthen payer escalation, denial trending, and feedback loop processes to improve denial prevention, resolution timeliness, and operational transparency
AR Management / Bad Debt Optimization	• Expand high-dollar AR review processes and automation-driven prioritization strategies to improve follow-up efficiency, reduce aging accounts, and minimize write-off risk • Enhance pre-bad debt outreach and patient collectability strategies through proactive communication, propensity-to-pay tools, and improved coordination between collections and financial assistance teams

Patient Status and Length of Stay | *Executive Summary*
Recommendations

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$0.5 - $0.8 *Midpoint: $0.7*	**$0**

	Key Summary Findings
Patient Status and Observation Management	• Provide Utilization Review/Case Management teams education workshops for status management and medical necessity outreach • Support expansion of Physician Advisor via internal resources through education and training • Establish formal pre-bill utilization management review processes for short stay cases and denials • Provide observation management education to ensure full care team is aware of how to prioritize observation patients • Improve medical necessity documentation to support appropriate level of care to prevent denials or provide additional support to appeal writers • Improve coordination between ED, hospitalists, and UM at the portal of entry • Enhance UM Committee as a forum to address medical necessity documentation and denials
Length of Stay	• Optimize and standardize current daily throughput meetings (MDRs) • Establish an afternoon central discharge escalation huddle, utilize assessment team's scripting, templates and training • Improve multidisciplinary communications for estimated discharge date (EDD), LOS and discharge barriers • Improve ED to inpatient handoff and boarding workflows • Strengthen home health coordination and preferred provider relationships; Implement "home-first" discharge pathways for appropriate patients; leading practice of 80+ % of patients going to home or home health • Optimize post acute placement strategies (Risk assessment tools, expedited authorizations, long length of stay committee, palliative care) • Improve Neurology care coordination to reduce clinical variation across high excess days DRGs

Reporting & Analytics	• Develop comprehensive patient status and length of stay dashboards to monitor performance
	  ➢ Patient Status: Observation rates at admission, observation rates at discharge, conversion rates, two midnight rates, peer to peer performance, etc.
	  ➢ Length of Stay: Volumes, LOS, GMLOS, O/E by unit, by provider, by specialty, by hour, etc.
	• Develop a dashboard to identify and track discharge barriers by type and department
	• Implement a data review process from executives to frontline line team members

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Corporate and Shared Services | *Executive Summary*
Recommendations

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$0 - $5.8 *Midpoint: $1.4*	**$0**

	Key Summary Findings
Expense Efficiency	• OMC shared services operate better than median performance compared to peers across all functions with the exception of Human Resources and Administration which drive 100% of the total expense variance at the mid-point ($1.4M) • The analysis suggests opportunities may be achieved through a combination of organizational redesign, process optimization, technology enablement, vendor rationalization, and selective workforce restructuring rather than across-the-board reductions
Productivity	• Variation between current performance and benchmark targets may reflect organizational complexity, legacy processes, decentralized responsibilities, or limited management infrastructure across support functions • The magnitude of opportunity across multiple departments may indicate broader structural and operational inefficiencies rather than isolated departmental performance issues • Given the relatively lean executive and director structure, some productivity variance may stem from limited strategic oversight, inconsistent operational governance, and insufficient management capacity to drive standardization and accountability
Span of Control	• Span of control is an additional lever to be reviewed when looking to capture savings shown in the expense analysis; while not a driver of savings, span of control contributes to cost savings by improving organizational efficiencies and lowers excess administrative expense • Limited director-level leadership may reduce opportunities for leadership development, succession planning, and management scalability as the organization grows • Functions with large staff populations and limited senior leadership coverage (e.g., Revenue Cycle, Information Technology, Supply Chain) may benefit from additional management layering to improve coaching, accountability, and operational consistency • The current structure may create uneven supervisory coverage across departments, leading to variability in employee support, performance management, and operational governance

Information Technology | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$0.3 - $0.6 *Midpoint: $0.4*	**TBD**

	Key Summary Findings
Vendor and platform spend is the primary savings lever	• 60% of IT spend is tied to software, maintenance, support, and subscriptions • 67% of IT spend is vendor-driven when consulting and purchased services are included • Contract volume and renewal exposure support a focused vendor governance effort
License, duplicate tool, and application rationalization provide direct savings	• Microsoft license right-sizing provides a visible near-term savings opportunity • Duplicate tools and workflow platforms create avoidable cost and support burden • The application portfolio is large enough to support rationalization
IT staffing appears lean, so savings should come from demand reduction	• Labor represents ~27.5% of IT spend, below the vendor-driven spend base • IT, Applications, and Clinical Informatics staffing appears lean relative to complexity • Savings should come from automation, reduced demand, and better governance.
Capital and cybersecurity are cost avoidance, not operating savings	• Infrastructure and security risks should be protected from broad cost cuts • External funding for network modernization creates capital cost avoidance • Deferred storage, identity, and monitoring needs require risk-based prioritization

Real Estate | *Executive Summary Recommendations*

Financial Opportunity *($ in millions)*	Total P&L Benefit	Total Balance Sheet Benefit
	$0	**$50 - $60** *Midpoint: $55*

	Key Summary Findings
Inventory	• The existing real estate Portfolio includes one acute-care hospital (67 beds, ~214K square feet) and an additional ~297K square feet across 31 Assets and 2 cities separate from the acute-care footprint
Strategic Opportunities for Real Estate Consideration	• Given the portfolio's limited leased footprint, resulting in fewer consolidation opportunities, the assessment focused on two primary value drivers: (i) optimizing vacancy and space utilization and (ii) evaluating monetization strategies to generate liquidity
Optimize Vacancy	• Recommend minimizing vacancy of existing owned Assets through third-party leasing, space optimization and/or consolidations
Generate Liquidity	• Identified specific existing owned assets that could be monetized. Based upon the inventory, market rents, and current capitalization rates, the estimated value of the four assets is approximately $55 million (via a sale / master leaseback strategy)

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Thank you.

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MEDICAL STAFF

CREDENTIALS REPORT – May 2026

The following are being recommended for approval by the Medical Executive committee. These recommendations are based upon a review of the (re)applicant's education, experience, demonstrated current professional competence, judgment, health status, documented results of clinical performance and the results of other quality review and monitoring studies. Other matters bearing on these recommendations include professional ethics, discharge of staff obligations, and compliance with applicable Medical Staff Bylaws and policies. No applicant shall be discriminated against, denied nor granted Medical Staff membership or clinical privileges on the basis of gender, age, sexual orientation, race, creed, ethnicity/national origin, on the basis of any other criterion lacking professional justification.

MEDICAL STAFF

Appointment to the Provisional AHP Staff:

1.	McCartt, Kyle, PA-C	Jamestown Family Health – Family Medicine
2.	Webb, Peter, PA-C	OMP Specialty Clinic - Cardiology
3.	Willy, Amanda, ARNP	OMP Wound Clinic

Appointment to the Provisional Active Staff:

1.	De La Cruz-Alcantara, Indhira, MD	Polyclinic

Reappointment to the Active Staff:

1.	Davis, Christine, MD	Sound – Emergency Medicine
2.	Monaghan, Linsey, MD	NOHN – Family Medicine
3.	Rush, Adam, MD	Sound – Emergency Medicine
4.	Wolslegel, Colin, DO	OMP - Gastroenterology

Appointment to the Telemedicine Staff:

1.	Akbari, Yasmin, MD	RADIA – Radiology
2.	Iles, Benjamin, DO	RADIA – Radiology
3.	Urdaneta Moncada, Alfonso, MD	RADIA – Radiology
4.	Tramontana, James, MD	RADIA – Radiology (Initial)
5.	Vigo, Harry, MD	Rural Physicians Group – Infectious Disease

Provisional Review Complete (FPPE):

1.	Schick, Karsten, ARNP	OMP - WIC

Resignations/Contract Terminations:

1.	Arca, Chris, MD	Providence Sleep – Effective 5/1/2026
2.	Brock, Brigit, MD	Swedish – Maternal Fetal Medicine Effective 04/30/2026
3.	Doherty, Michael, MD	Providence Sleep – Effective 5/1/2026
4.	Gerber-Gore, Paula, MD	Providence Sleep – Effective 5/1/2026
5.	Hensley, Holly, MD	Providence Sleep – Effective 5/1/2026
6.	Kaiboriboon, Kitty, MD	Providence Sleep – Effective 5/1/2026
7.	Ko, Pin-Yi, MD	Providence Sleep – Effective 5/1/2026
8.	Lacheney, Bethany, ARNP	Sound Emergency Medicine – Effective 4/8/2026
9.	Lee, Mimi, MD	Providence Neurology – Effective 4/10/2026
10.	Lekkala, Madhavi, MD	Providence Sleep – Effective 5/1/2026
11.	Macapinlac, Manuel, MD	OMCC – Effective 5/12/2026
12.	Morrow, Annie, ARNP	OMP – Effective 5/14/2026
13.	Pascual, Franchette, MD	Providence Sleep – Effective 5/1/2026

Approvals:
C&Q Committee: 05/19/2026
Medical Executive Committee: 05/25/2026
Board of Commissioners: 06/17/2026
Medical Staff: (For Information)

CREDENTIALS REPORT

14. Petrides, Michael MD	RADIA – Effective 5/1/2026
15. Phelps, Kara, MD	Incyte – Pathology – Effective 5/15/2026
16. Prince, Eric, MD	Providence Sleep – Effective 5/1/2026
17. Simon, Ednea, MD	Providence Sleep – Effective 5/1/2026
18. Smith, Steven, MD	Providence Sleep – Effective 5/1/2026
19. Spak, David, MD	RADIA – Effective 4/30/2026
20. Sparrow, Natasha, MD	Providence Sleep – Effective 5/1/2026
21. Yu, Derek, MD	Providence Sleep – Effective 5/1/2026

IPC is a team effort!

Continuously build knowledge

Know the evidence, know the why, know the regulatory requirements

Team support and participation are essential to practices that keep patients and staff from infection!

Hand hygiene and glove use:

The big deal!

- 1.7-million people get a healthcare associated infection (HAI) every year in the U.S.
- 1 in 31 hospitalized patients has a HAI.
- 90,000 people die from these infections.
- HAIs are the most common complication of hospital care and a top 10 leading cause of death in the U.S.
- The most common way germs and infections are spread is by the hands of healthcare workers.
- Hand hygiene is the *most* effective way to prevent the transmission of germs and reduce HAIs.

History of Hand Hygiene Program at OMC

Stop draggin' your gloves around!

- Gloves do not replace the need for hand hygiene
- Change gloves with each different task – example: if you are providing patient care at the bedside and go to computer or touch anything in the room, then change your gloves before going back to the patient
- Hand hygiene should be done before putting on gloves and after taking gloves off

What's on your cell phone?

Studies show HAIs are transmitted from the hands of healthcare workers and use of their cell phones.

Bacteria such as MRSA or *E-coli* can live on cell phones for 6 hours and up to 28 days!

61% of Americans report using phones in restrooms.

What you can do:

- Review your cell phone's cleaning options. If compatible, use PDI Easy Screen 70% isopropyl alcohol wipes –rub with friction for 15 seconds.
- Strict adherence to hand hygiene and glove use.
- After you touch your phone, you must wash/sanitize your hands before you touch the patient or go on to another task.
- If you have gloves on when you touch your phone, you must remove them and wash/ sanitize your hands before touching a patient.

Goal: Implement Leapfrog Hand Hygiene Requirements

Opportunities:

- Increase in monthly observations
- Training – staff must be shown and do return demonstration at hire and annually
- System for monitoring dispensers, including product dispensed
- Leadership accountability

Healthcare Associated Infections

Centers for Medicare and Medicaid Required Reporting

Central Line Associated Blood Stream Infections
2026–0 to date
2025–1 med/surg patient
Days since last infection = **329**

Catheter Associated Urinary Tract Infections
2026–0 to date
2025–2 patients, 1 in ICU, 1 med/surg
Days since last infection = **505**

Methicillin Resistant Staphylococcus (MRSA) – positive blood cultures
2026–hospital onset = 0 to date
2025–hospital onset = 0

Clostridioides Difficile (C-diff)
2026–hospital onset = 0 to date
2025–hospital onset = 2

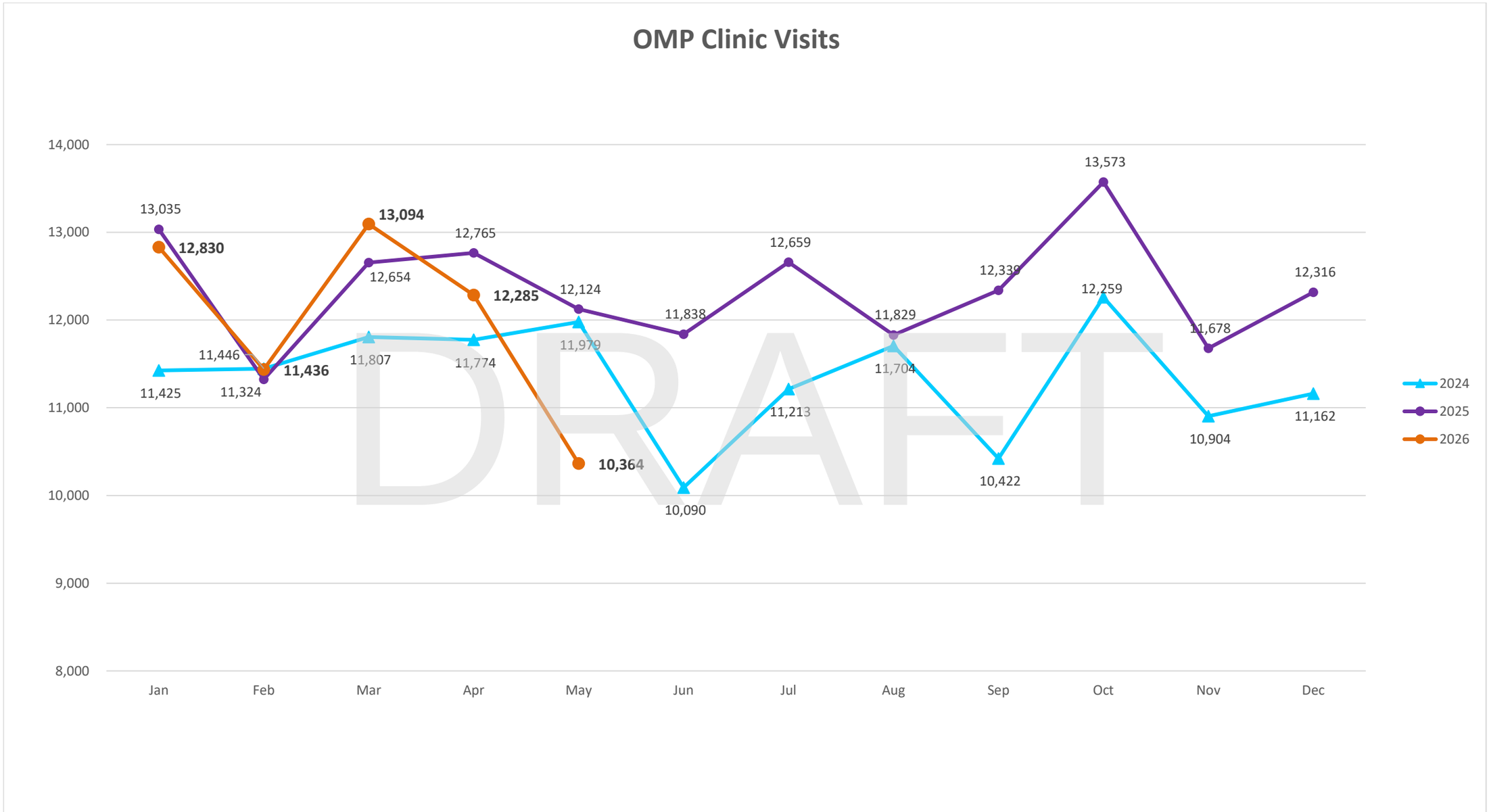
Surgical Site Infections:
- Colon Surgeries
  2026–0 to date
  2025–3 patients, 1 present on admission,
  2 superficial incisional infection
- Hysterectomies
  2026–0 to date
  2025–1 patient with a superficial incisional infection

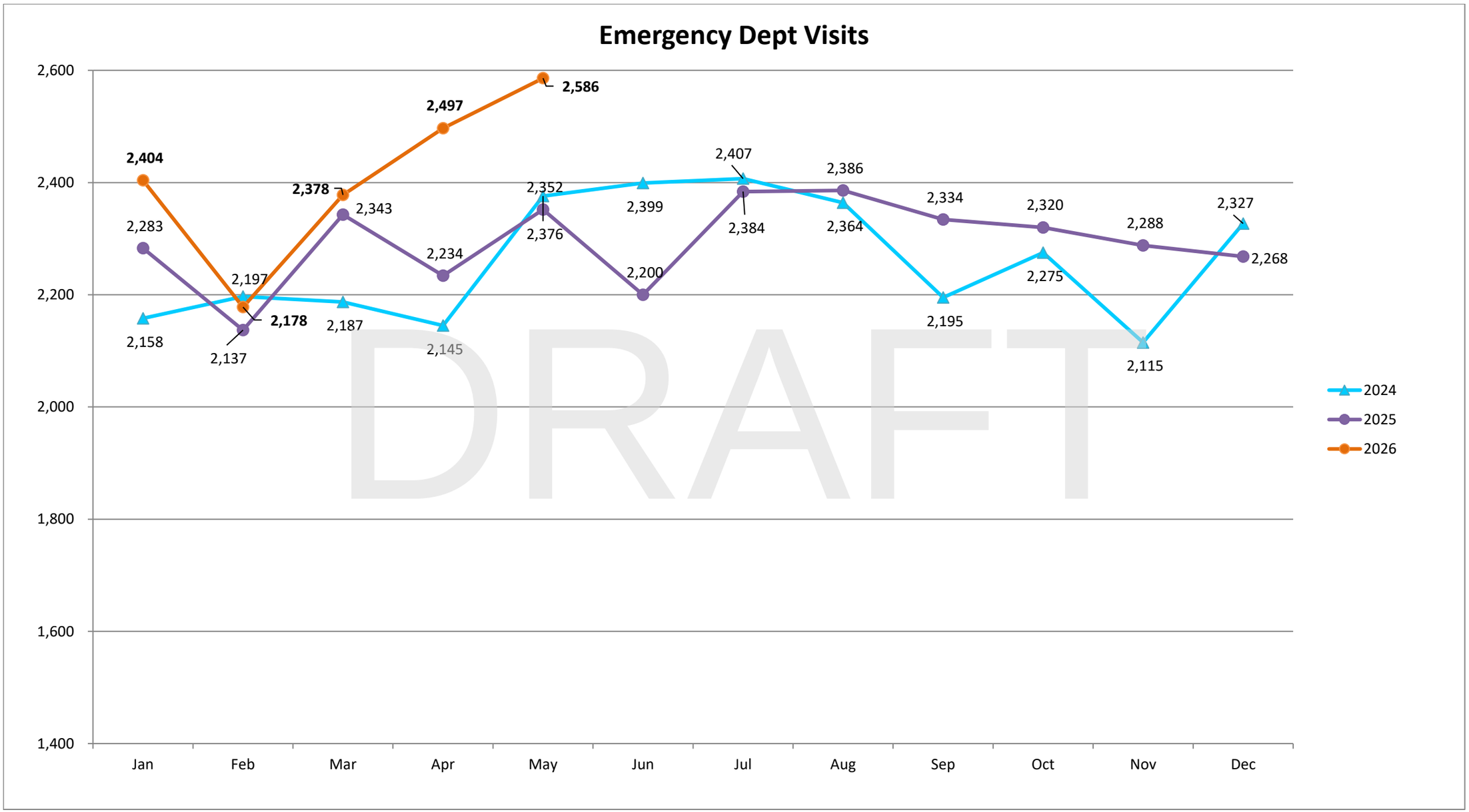
Thank you!

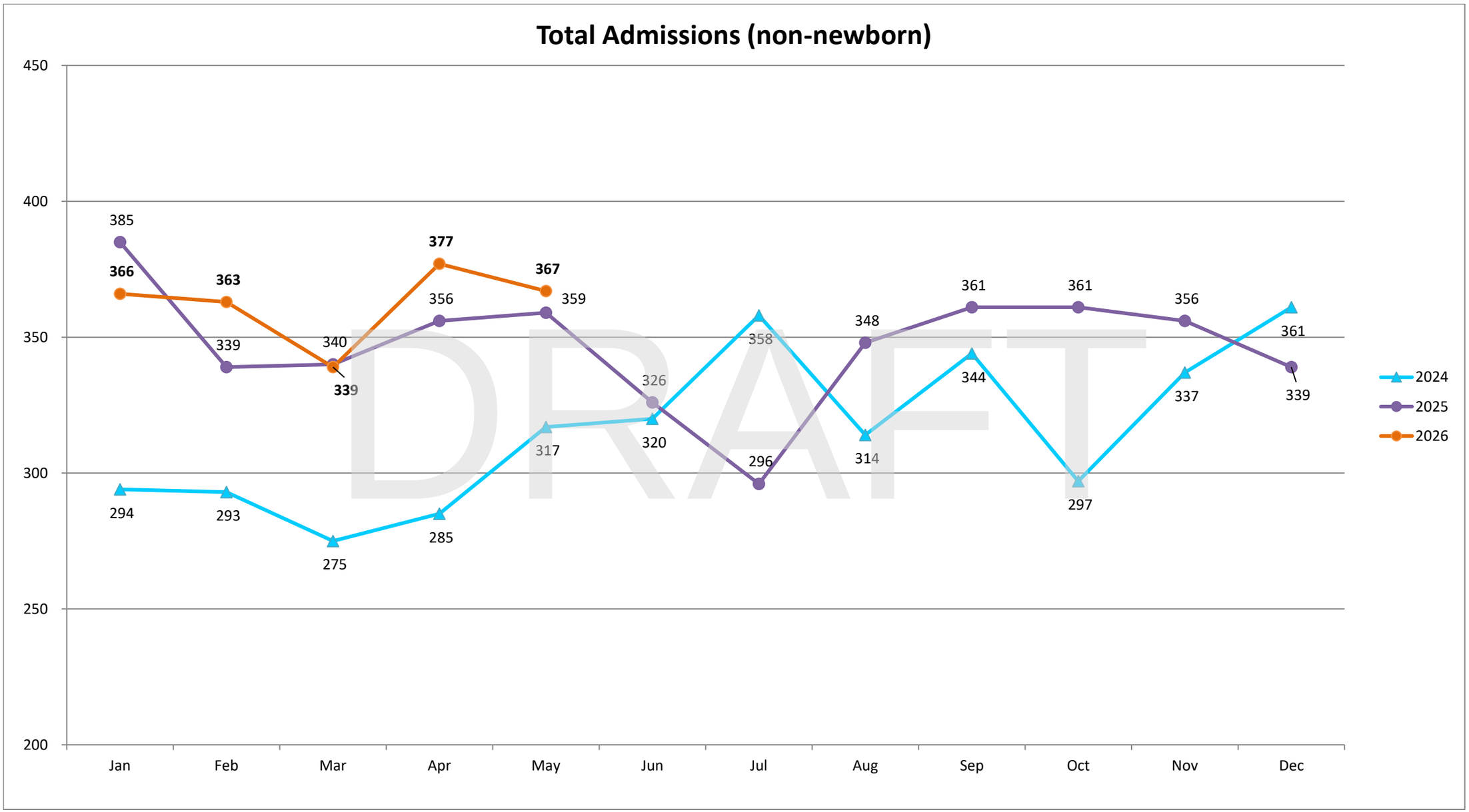
QUESTIONS?

Rhonda Bowen, MPH, CIC, CPPS, CPHQ
Manager, Infection Prevention and Control

rbowen@olympicmedical.org
360-461-7106


OMP Clinic Visits
14,000
13,000
12,000
11,000
10,000
9,000
8,000
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
13,035
12,830
11,446
11,324
11,436
11,425
13,094
12,654
11,807
12,765
12,285
11,774
12,124
11,979
10,364
10,090
11,838
12,659
11,213
11,829
11,704
12,339
10,422
13,573
12,259
11,678
10,904
12,316
11,162
2024
2025
2026
DRAFT


Emergency Dept Visits
2,600
2,400
2,200
2,000
1,800
1,600
1,400
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2,404
2,283
2,158
2,197
2,137
2,178
2,378
2,343
2,187
2,497
2,234
2,145
2,586
2,352
2,376
2,399
2,200
2,407
2,384
2,386
2,364
2,334
2,195
2,320
2,275
2,288
2,115
2,327
2,268
2024
2025
2026
DRAFT


Total Admissions (non-newborn)
450
400
350
300
250
200
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2024
2025
2026
385
339
339
356
359
326
296
348
361
361
356
339
366
363
340
377
367
294
293
275
285
317
320
358
314
344
297
337
361
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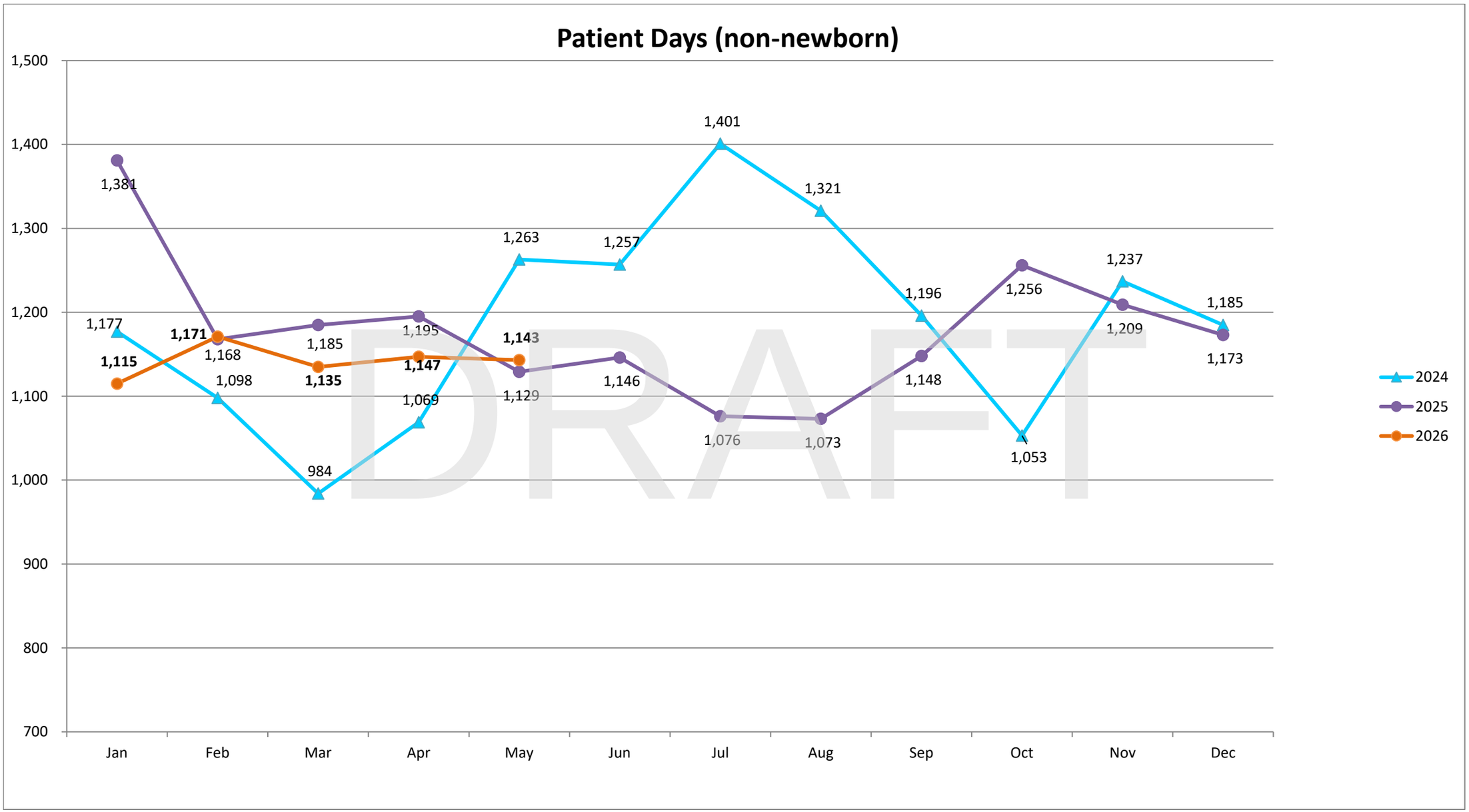
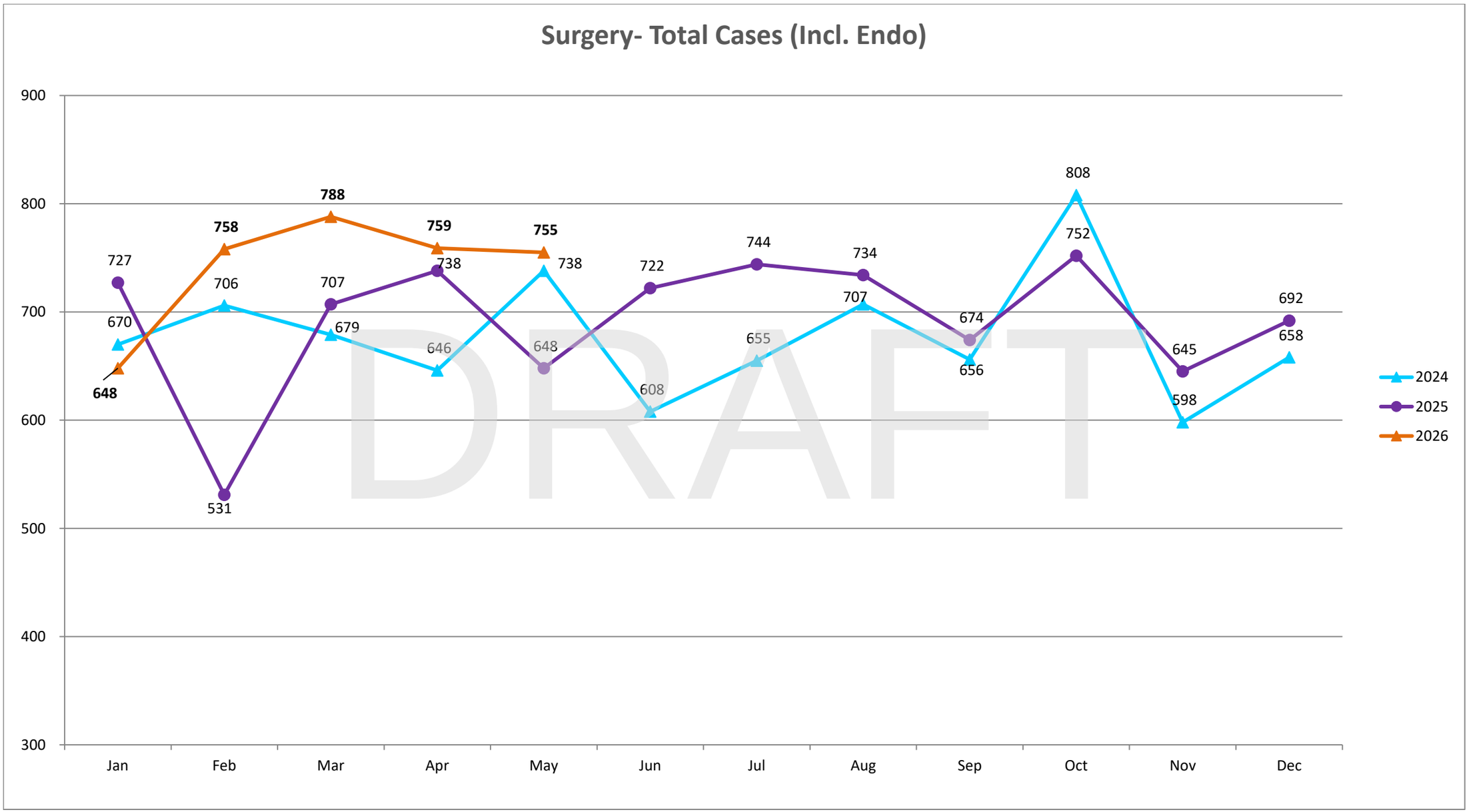

Patient Days (non-newborn)
1,500
1,400
1,300
1,200
1,100
1,000
900
800
700
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
1,381
1,177
1,098
984
1,069
1,263
1,257
1,401
1,321
1,196
1,053
1,237
1,185
1,115
1,171
1,168
1,135
1,147
1,143
1,129
1,146
1,076
1,073
1,148
1,256
1,209
1,173
1,185
1,195
2024
2025
2026
DRAFT


Surgery- Total Cases (Incl. Endo)
900
800
700
600
500
400
300
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
727
670
706
679
646
738
608
655
707
656
752
598
658
531
707
738
722
744
734
674
808
645
692
648
758
788
759
755
2024
2025
2026
DRAFT

CEO Report to Board

June 17, 2026

Communication

Presented at the Sequim Chamber of Commerce last week.
Provider presentations scheduled monthly through September.
Dr Wolslegel presenting on June 18, therapeutic endoscopy.
Employee forums will be held next week.

University of Washington Partnership

Implementing UW Virtual Stroke Services at OMC.
Kaufman Hall assessment completed and presented.
Focus now will be on working with UW to determine structure of the partnership.

Surveys and Accreditation

The Department of Health survey findings were due to be sent to us last Friday.
Confirmed that it has not yet been sent for our response.
Preparing an action plan to submit upon confirmation of the findings.

Operations

Labor contract negotiations continuing with 2 union groups, both UFCW.
Access group has met. Determined data to collect and measure. Data is being collected and will be reviewed after July 1.

Olympic Medical Clinics & Physicians (OMP)

OMP all provider meeting will be held next week.
OMP leadership job applications have been reviewed, and interview process is beginning
Physician contract structure has been prepared. Currently obtaining provider leadership review and will be part of the all-provider meeting next week.

Recruiting for the following physician specialties

Pulmonology

Physician scheduled for interviewed.

Nurse Practitioner interviewed and preparing an agreement.

Cardiology

Physician interview scheduled.

Orthopedics

Additional call coverage in effect.

Physician position posted and are reviewing applications for potential interviews.

PA positions are posted and candidates being interviewed.

Urology

NP position posted and candidate scheduled for an interview.

OLYMPIC MEDICAL CENTER

Board of Commissioners
Board Meeting Minutes
June 3, 2026

The meeting of the Board of Commissioners of Olympic Medical Center was called to order in Linkletter Hall at 12:30 pm by Board President Phil Giuntoli. In attendance were Commissioners Phil Giuntoli, Thom Hightower, RN, Tom Oblak, Nancy Field, Penney Sanders, Carleen Bensen, MD, Gerald Stephanz, MD; Mark Gregson, Interim Chief Executive Officer; Scott Kennedy, MD, Chief Medical Officer; Helen Morrison, MN, RN, Interim Chief Nursing Officer; Heather Delplain, Admin Director Human Resources; Pattie Fischer, Executive Assistant to the CMO and CNO; Arielle Roberson, Executive Assistant to the ICFO and Risk Management; staff and public members. Allen Chen, MD, Chief Physician Officer was excused.

CALL TO ORDER

A. Pledge of Allegiance
B. Roll Call
C. Approved Agenda

MOTION: To approve the Agenda.
Motion carried unanimously.

CONSENT AGENDA

A. Minutes from May 20, 2026;
B. Bad Debt for the month of March 2026 in the amount of $32,414.37;
C. Bad Debt for the month of April 2026 in the amount of $150,890.78;
D. Vouchers from April 2026 in the amount of $14,709,407.88 covered by warrants 11335 to 11778 and electronic payments EFTP 87090 to EFTP 87146, EFTP 87148 to EFTP 87222, and EFTP 89061 to EFTP 89107, EFTP 89110 to EFTP 89184, EFTP 91061 to EFTP 91097 drawn on the General Fund;
E. Payroll for the period of April 12, 2026 through April 25, 2026 in the amount of $3,359,575.59 covered by direct deposits EFTP-089185 to EFTP-091015 drawn on the general fund.
F. Payroll for the period of April 26, 2026 through May 9, 2026 in the amount of $3,343,612.09 covered by direct deposits EFTP-091187 to EFTP-093013 drawn on the general fund.

MOTION: To approve the Consent Agenda.
Motion carried unanimously.

EXECUTIVE SESSION

At 12:33 pm, the meeting was moved to executive session for discussion with legal counsel regarding current or potential litigation (RCW 42.30.110(1)(i)). It was announced the meeting would be back in open session after 15 minutes at 12:48 pm.

At 1:00 pm, the executive session concluded, and the meeting was moved back into open session.

PATIENT STORY – Liz Uraga, Director, Quality Management Program

A patient who underwent surgery at Olympic Medical Center reported feeling taken care of through interactions over a multi-day stay with registration staff, CNAs, medical assistants, nurses, and providers. Special mention of Dr. Tatro, Dr. Maynard, Casey and Nathaniel Ingersoll for helping to assure the patient, manage pain and advise in healing. Truly appreciates Olympic Medical Center staff for providing patient-centered care.

PUBLIC COMMENT

A. Dr. Cynthia "Cindy" West spoke regarding the pediatric service line at Olympic Medical Physicians. Expressed concern that the clinic is currently operating in an unsustainable way due to two provider positions not being filled, which has increased the clinical burden on the remaining pediatric providers. The work of pediatric providers spans from on-call to consults to hospital care and to clinic work with a variety of diagnoses and situations which are further compounded by challenges from being in a rural location.
B. Amy Miller, PA-C with the Children's Clinic brought forth concern that the providers are in a fragile state due to being overburdened. Questioned whether OMC could provide obstetric services without adequate pediatric support. Does not feel that the pediatric service line has been given the support it needs to continue to function well; specifically people, equipment and support.
C. Michelle Turner, ARNP has been a longtime provider to children in the community and is grieved to see the culture within the service line become toxic due to uncertainty. Reports that many providers are looking for other opportunities.
D. Public member Sharon Litwin recently came to the hospital for five-days straight to see a friend who was a patient. Appreciated the care given to her friend, though concerned about conversations she had with staff who voiced they were understaffed. Did not understand why the Board has executive sessions as scheduled. Would like to continue to have reports on the progress of hiring a chief executive officer.

QUALITY UPDATE – Liz Uraga, Director, Quality Management Program and Cheryl Sifford, Director, Olympic Medical Home Health

Olympic Medical Home Health Presentation

- Home Health's mission is to assist and coordinate care for patients to continue to recuperate at home with skilled nursing.
- Recently had a survey follow-up with no new findings.
- Home Health provides care from Diamond Point to Neah Bay.
- Home Health works with all local providers, even going to assisted living facilities to take care of patients who have been cared for at the hospital.
- Briefly discussed end of life care (hospice), which Home Health does not currently provide.

Requested Update on OMP Patient Access Process Improvement Project

- Increased provider productivity as seen on Finance report.
- Focused project of access to care with OMP clinics.
- Working on gathering and validating data so that stakeholders can make informed goals and decisions.
- Stakeholders will be making recommendation(s) to Quality Management Oversight Committee (QMOC).
- MGMA data has been purchased to assist with best practices and metrics.

Culture of Safety Presentation

- Culture of Safety Press Ganey Survey was offered to staff from March 9 – April 13, 2026.
- OMC had a 62% response rate which is 10% higher than Press Ganey's national average of 52% response rate.
- OMC's Prevention and Reporting metric improved from 2023 in the course of this survey.
- Plan to lean into OMC's strength, specifically compassion.
    - *YouTube video (Press Ganey Associates LLC – The Nursing Advantage: Delivering Compassionate, Connected Care) was not able to be shown.*
- Press Ganey reports that the perception of safety impacts outcomes in quality, efficiency, patient experience and workforce engagement.
- Compassion in Action Strategic Plan includes Compassionate Connected Care, Trauma Informed Care, Team STEPPS and Rounding.
    - Challenged department leaders to have teams choose an improvement strategy to implement.

QMOC Overview Presentation

- Important to keep committees confidential to encourage and maintain involvement, see and address issues.
- All Quality Committees report up to Quality Management Oversight Committee (QMOC).

BOARD COMMITTEE REPORTS

Joint Conference Committee

- Board of Commissioners bylaws now require that summaries or minutes are included in Board packets.
- Commissioners Field and Bensen were interested in having the Joint Conference Committee be involved in provider compensation.
    - *Tabled motion*.

PPS vs. CAH Committee

- Committee looking at prospective pay system (PPS) vs. critical access hospital (CAH) for OMC.
- Interested in looking at a comparison of 10-years.
- There may be alternate reimbursement systems available to OMC in the future.
- Advocacy with representatives at both the state and national level will be important.
- Rural hospitals across the nation are under significant financial stress.

FINANCE UPDATE – Dennis Stillman, Interim Chief Financial Officer

Board Finance Committee Report

- EBIDA strong performance of 10.9%.
- Mr. Stillman utilized a whiteboard to show April finances to Commissioners.
- OMC is in a slightly better position at this time than it had budgeted for.
- OMC is working to fill positions. Recently ~40 requests to hire were approved.
  - Filling positions may take time and is a process.
- Discussion ensued around productivity, 340B, legislation, Medicaid changes, supporting patients and staffing.

MOTION: To approve the surplusing $9,095 worth of assets.
Motion carried unanimously.

INTERIM CEO UPDATE – Mark Gregson, Interim Chief Executive Officer

Provider Employment Agreements

- Amanda Willy, ARNP, has been working as an RN in the Wound Clinic and has extensive experience. Recently obtained her ARNP licensure.

MOTION: To approve the employment agreement with Amanda Willy, ARNP, for work at the Wound Clinic at the annual salary of $112,778 as presented.
Motion carried unanimously.

- Will be credentialed after her contract is approved.
- Introduction of Mitzi Hazard, Director of Rehabilitative Services
- Introduction of Randy Holeman, Director of Diagnostic Imaging
- Introduction of Anthony Shiepko, Director of Materials Management
- Introduction of Charles Ho, Director of Pharmacy

Operations and Quality Update

- Community presentations continue.
- Employee forums to occur in June.
- UW virtual services continue to be formalized
- Kaufman Hall assessment is now complete. A summary report will be given to the Board and the Business Meeting on June 17, 2026.
- Recruiting continues.
  - Have had interviews with solid candidates for the Chief Ambulatory Services Officer position.

Dashboard

- Discussed Sound Physicians data and contract.
- Commissioners requested fine-tuning metrics in the Dashboard to better understand data.

Department of Health Survey

- Department of Health (DOH) Survey took place last week. OMC was cleared from findings from September 2025. There was one item regarding documentation of suicide ideation patients in the Emergency Department that had to be addressed immediately.

- OMC has had multiple surveys; state survey seems to have a different standard.
- There may be findings from this latest survey from DOH.

OTHER

A. WittKieffer Recruitment

- Governance Committee to meet with WittKieffer to discuss recruitment efforts of chief executive officer permanent hire.

B. Statement

- Commissioner Stephanz made apology statement to the public and staff in attendance concerning slow movement to address concerns brought forth to the Board.
  - Those concerns range from the perception of the difficulty to communicate with hospital administration, lack of transparency, poor employee morale, job security, failure to address service line needs for timely and effective patient care, lack of understanding of the challenges of practicing in a rural area, providers intending to leave employment, perception of undermining of physician leadership, and belief that the Board of Commissioners is not seeing the full picture.
  - Commissioner Stephanz assured those in attendance that steps are being taken by the Board to exert its influence in addressing concerns and that resolutions will take time.

MOTION: The Interim CEO will direct the OMC Finance Committee to evaluate different models of ensuring the continuity of Pediatric Services to the citizens of Clallam County and OMC, and present recommendations to the Board of Commissioners. This will include the immediate recruitment of one or more providers.

- Discussion ensued regarding the best way and time to address pediatric service line concerns.

MOTION with amendment: The Interim CEO will direct the OMC Finance Committee to evaluate different models of ensuring the continuity of Pediatric Services to the citizens of Clallam County and OMC.

- Discussion ensued regarding the expectation of Kaufman Hall report to give complete assessment of all service lines to bear weight in decision making.

Motion with amendment carried unanimously.

- Commissioners identified motion with amendment as a strategic initiative.
- Commissioner Hightower requested that Mr. Gregson give an update to the Board in a month with his assessment of working with the Pediatric Service line.

MOTION: In light of current gaps of administrative structure at OMP, the Joint Conference Committee will address the delay in completing provider contracts since October 2025.

- Commissioner Field expressed the importance of having infrastructure in place to help providers address compensation concerns.
- Discussion ensued regarding the need for contracts and the importance of assuring providers they are valued and compensated fairly while making fiscal decisions with data from Kaufman Hall report.

3 in favor; 4 opposed. Motion defeated.

ADJOURN

There being no further business, the meeting was adjourned at 3:14pm.

APPROVED AND ADOPTED this 17th day of June, 2026.

ATTEST:

	_____ President
_____ Secretary	_____ Commissioner
_____ Commissioner	_____ Commissioner
_____ Commissioner	_____ Commissioner

OLYMPIC MEDICAL CENTER

Joint Conference Committee

DATE: June 9, 2026
TIME: 4:30 pm
LOCATION: Wendel Conference Room
MEMBERS: Commissioners Phil Giuntoli, Nancy Field, and Carleen Bension, MD, Chair
Interim Chief Executive Officer Mark Gregson
Georgia Heisterkamp, MD
Sheena Plamoottil, MD, Chief of Surgery
Jennifer Swanson, MD, Chief of Medicine

Discussion Summary
The Committee convened to continue discussion of agenda items from previous meeting as time did not allow completion of the agenda. - Ongoing discussion regarding scheduling difficulties in endoscopy. - The Provider Survey was reviewed and approved to be sent to all OMP providers, Hospitalists, ED physicians, and Anesthesia providers. - Exit interviews were discussed. - Provider compensation was reviewed. - Joint Conference Committee will be meeting on a monthly basis for the short term.