Prosser Memorial Health

Board of Commissioners

Board Packet

October 27, 2022

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser Memorial Health

Mission: To improve the health of our community.

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

BOARD OF COMMISSIONERS – WORK SESSION
TUESDAY, October 25, 2022
6:00 PM - WHITEHEAD CONFERENCE ROOM
AGENDA

COMMISSIONERS:
Stephen Kenny, Ph.D.
Sharon Dietrich, M.D.
Glenn Bestebreur
Susan Reams
Keith Sattler
Brandon Bowden
Neilan McPartland

STAFF:
Craig Marks, CEO
Merry Fuller, CNO/COO
David Rollins, CFO
Shannon Hitchcock, CCO
Kristi Mellema, CQO
Bryon Dirkes, CHRO
Dr. Brian Sollers, CMO
Annie Parker, CCOO

GUESTS: Adam Trumbour, Senior Project Manager, NV5
Gary Hicks, Financial Advisor
Brandon Potts, Bouten Construction
Nick Gonzalez, Bouten Construction
Kurt Broeckelmann, bcDG

I. CALL TO ORDER

II. PUBLIC COMMENT

III. SERVICES

A. Replacement Facility Update

1. Design Updates

a. DOH/USDA/City of Prosser Reviews	**bcDG/NV5**
b. SVID (**Attachment D)**	**NV5**
c. Washington DOT	**bcDG**
d. Furniture Fair	**NV5**

2. Construction/Schedule/Budget

a. Contractor update	**Bouten/NV5**
b. Schedule **(Attachment C)**	**NV5/Bouten/bcDG**
c. Project Budget	**NV5**

3. Financing **Gary**

a. USDA **(Attachment F)**

b. Board Resolution #1073 **(Attachment G)** **Gary**

c. Construction Loan

B. Review Mission, Vision, Values & Standards of Behavior **(Attachment H**) **Craig**

C. 2023 Strategic Planning **(Attachment I)**

1. Patient Loyalty **Merry**
2. Medical Staff Development **Dr. Sollers/Annie**
3. Employee Development **Bryon**
4. Quality **Kristi**
5. Services **Shannon**
6. Financial Stewardship **David**

IV. ADJOURN

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BOARD OF COMMISSIONERS
THURSDAY, October 27, 2022
6:00 PM, WHITEHEAD CONFERENCE ROOM
AGENDA

COMMISSIONERS:
Stephen Kenny, Ph.D.
Sharon Dietrich, M.D.
Glenn Bestebreur
Susan Reams
Keith Sattler
Brandon Bowden
Neilan McPartland

STAFF:
Craig Marks, CEO
Merry Fuller, CNO/COO
David Rollins, CFO
Shannon Hitchcock, CCO
Kristi Mellema, CQO
Bryon Dirkes, CHRO
Dr. Brian Sollers, CMO
Annie Parker, CCOO

I. CALL TO ORDER
A. Pledge of Allegiance

II. PUBLIC COMMENT

III. APPROVE AGENDA
Action Requested – Agenda

IV. CONSENT AGENDA
A. Board of Commissioners Meeting Minutes for September 29, 2022.
B. **Payroll and AP Vouchers** #167840 through #168540 dated 09-22-22 through 10-19-22 in the amount of $6,270,447.64. Surplus Items Resolution #1072 (2) washers; (2) dryers; (2) Stryker Stretchers; and (1) Cast Cutter with Vacuum.
Action Requested – Consent Agenda

V. MEDICAL STAFF DEVELOPMENT
A. Medical Staff Report and Credentialing **Dr. Carl**
1. Advancement from Provisional
Elizabeth Karr, MD – Locum Tenens privileges in Emergency Medicine effective November 1, 2022, through April 30, 2024.

Juliet Dennis, MHNP – Advance Practice Clinician privileges in Mental Health effective November 1, 2022, through April 30, 2024.
Action Requested - Advancement from Provisional

2. **New Appointment**

Rachel Monick, MD – Provisional/Locum Tenens staff with requested privileges in Emergency Medicine effective November 1, 2022, through April 30, 2023.

Colton Rishor-Olney, MD – Provisional/Locum Tenens staff with requested privileges in Emergency Medicine effective November 1, 2022, through April 30, 2023.

Action Requested – New Appointment and Requested Clinic Privileges

3. **Reappointment**

Ketan Kale, MD – Reappointment to the Courtesy staff with requested privileges in Internal Medicine effective November 1, 2022, through October 31, 2024.

Tad White, MD – Reappointment to Courtesy staff with requested privileges in Family Medicine effective November 1, 2022, through October 31, 2024.

Fadi Akoum, MD – Reappointment to Consulting staff with requested privileges in Nephrology effective November 1, 2022, through October 31, 2024.

Katherine Cayetano, MD – Reappointment to Consulting staff with requested privileges in Pulmonology effective November 1, 2022, through October 31, 2024.

Naveen Rawat, MD – Reappointment to Consulting staff with requested privileges in Pulmonology effective November 1, 2022, through October 31, 2024.

Thomas Ballard, MD – Reappointment to Locum Tenens staff with requested privileges in Diagnostic Radiology effective November 1, 2022, through October 31,2024.

Randi Lindstrom, DO – Reappointment to Locum Tenens staff with requested privileges in Emergency Medicine effective November 1, 2022, through October 31, 2024.

Minal Bhanushali, MD – Reappointment to Telemedicine staff with requested privileges in Neurology effective November 1, 2022, through October 31, 2024.

James Jordan, MD – Reappointment to Telemedicine staff with requested privileges in Neurology effective November 1, 2022, through October 31, 2024.

Ravi S. Menon, MD – Reappointment to Telemedicine staff with requested privileges in Neurology effective November 1, 2022, through October 31, 2024.

Ravi Pande, MD – Reappointment to Telemedicine staff with requested privileges in Neurology effective November 1, 2022, through October 31, 2024.

Monjari Gillian, MD – Reappointment to Telemedicine staff with requested privileges in Diagnostic Radiology effective November 1, 2022, through October 31, 2024.

Jake Vrdoljak, MD – Reappointment to Telemedicine staff with requested privileges in Diagnostic Radiology effective November 1, 2022, through October 31, 2024.

Action Requested – Reappointment and Requested Clinical Privileges

VI. FINANCIAL STEWARDSHIP

A. Review Financial Reports for September 2022 & Investment Performance **David**
(Attachment Q) (Attachment U)
Action Requested – Financial Reports

B. Board Resolution # 1073-Replacement Facility Financing **(Attachment G)** **Craig/David**
Action Requested- Board Resolution # 1073 at a cost not to exceed $80,500,000.

C. Irrigation Canal Pipe-$75,000 (1240')
Action Requested-Purchase 1240' of irrigation canal pipe at a cost not to exceed $75,000. **Craig**

D. Modular Home Replacement **(Attachment V)** **David**
Action Requested- Modular Home Replacement at a cost not to exceed $79,654.

VII. QUALITY

A. Community Health Needs Assessment (CHNA) **(Attachment W)** **Kristi**
Action Requested-CHNA

B. Legislative and Political Updates **Commissioner Bestebreur**

C. CEO/Operations Report **Craig**

VIII. ADJOURN

PMH
Board of Commissioners
Work Plan – FY2022

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Month	Goals & Objectives	Education
January	QUALITY: • Review/Approve 2022 Strategic Plan and 2022 Patient Care Scorecards • Sign Financial Disclosure and Conflict of Interest Statements • Approve 2022 Risk Management and Quality Assurance Plans • Select and Approve Board Officers • Review Board Committee structure and membership SERVICES: • Approve acquisition of surgical equipment • Approve radiologist contracts • Approve Construction Loan	EMPLOYEE DEVELOPMENT: • Review 2021 Employee Engagement Survey Results • Review 2021 Medical Staff Engagement Survey Results QUALITY: • Review Board Self-Evaluation FINANCIAL STEWARDSHIP: • Review semi-annual financial performance report for PMH Clinics SERVICES: Replacement Facility Update • Construction Loan Schedule Update

Month	Goals & Objectives	Education
February	SERVICES: • Approve construction mini-MACC • Approve construction documents QUALITY: • Approve 2022 Board Action Plan EMPLOYEE DEVELOPMENT: • Review and Approve 2022 Leadership Incentive Compensation Program	EMPLOYEE DEVELOPMENT: • Attend AHA Governance Conference PATIENT LOYALTY: • Patient Loyalty Summary report • Review Patient Engagement Plan SERVICES: Replacement Facility Update: • Construction Documents • Mini-MACC • Schedule
March	QUALITY: • Review/Approve Board Polices • Approve 2022 Corporate Compliance Plan • Approve 2022 Infection Prevention Control Plan EMPLOYEE DEVELOPMENT • Review and Approve 2022 Leadership Incentive Compensation Program MEDICAL STAFF DEVELOPMENT: • Support Providers' Day Celebration FINANCIAL STEWARDSHIP: • Accept 2021 Audit Report SERVICES: • Approve the MACC / GMP for the new facility	PATIENT LOYALTY: • Review 2021 Utilization Review Performance QUALITY: • Review 2021 Corporate Compliance Report • Review 2021 Infection Prevention Summary EMPLOYEE DEVELOPMENT: • Review Employee Performance Report • Review the Communications Calendar FINANCIAL STEWARDSHIP: • Presentation of the 2021 Audit Report by Auditors • Capital Campaign Update

Month	Goals & Objectives	Education
	PATIENT LOYALTY • Approve the 2022 Utilization Review Plan	SERVICES: Replacement Facility Update • MCAA / GMP • USDA Update • Budget
April	QUALITY: • Approve 2022 Community Benefits Report EMPLOYEE DEVELOPMENT • Conduct CEO Evaluation SERVICES: • Approve the MACC / GMP for the new facility	SERVICES: Replacement Facility Update • MCAA / GMP • USDA Update • Budget QUALITY: • Strategic & Patient Care Score Cards • Review 2021 Community Benefits Report EMPLOYEE DEVELOPMENT: • Review 2021 Leadership Performance (LEM) • Review Employee Engagement Plan • Review the Communications Calendar MEDICAL STAFF DEVELOPMENT: • Review 2021 FPPE/OPPE Summary PATIENT LOYALTY: • Review Interpreter Services Plan • Call Center Update

Month	Goals & Objectives	Education
May	EMPLOYEE DEVELOPMENT: • Support Hospital Week	SERVICES: • Replacement Facility Update MEDICAL STAFF • Medical Staff Engagement Plan EMPLOYEE DEVELOPMENT: • Employee Retirement Update PATIENT LOYALTY: • Review Customer Service Program
June	QUALITY: • Review/Approve Board Polices • Approve 2021 CAH Annual Report FINANCIAL STEWARDSHIP: • Approve 2022 Cost Report	QUALITY: • Report 2022 Q1 Utilization Review EMPLOYEE DEVELOPMENT: • Review Leader Assessment and Development Program SERVICES: • Marketing Update • PMH Telehealth Update FINANCIAL STEWARDSHIP: • Accounting Software Update
July	MEDICAL STAFF DEVELOPMENT: • Attend BOC, Medical Staff and Leadership Engagement Activity FINANCIAL STEWARDSHIP: • Approve Single Audit	SERVICES: • Replacement Facility Update MEDICAL STAFF • Review PMH Clinic productivity QUALITY:

Month	Goals & Objectives	Education
		• Quality Committee Report • Strategic & Patient Care Score Cards • Board Judiciary Responsibilities EMPLOYEE DEVELOPMENT: • Human Resources Update • Review Leadership and Exempt Wage Scales FINANCIAL STEWARDSHIP: • Review Semi-Annual Financial Performance Report for PMH Clinics • Foundation Update
August	EMPLOYEE DEVELOPMENT: • Attend end of summer Engagement Activity for BOC, Medical Staff, and all staff	SERVICES: • Replacement Facility Update
September	QUALITY: • Review/Approve Board Polices	EMPLOYEE DEVELOPMENT: • Review Employee Benefit Changes • Review Leadership Development Activities SERVICES: • Replacement Facility update PATIENT LOYALTY: • Nurse Educator Update
October		QUALITY:

Month	Goals & Objectives	Education
		• Conduct 2023 Strategic Planning • Strategic & Patient Care Score Cards EMPLOYMENT DEVELOPMENT: • Review Leadership Accountability Resource Tools PATIENT LOYALTY: • Patient Loyalty Summary
November	FINANCIAL STEWARDSHIP: • Approve Property Tax Request for County Commissioners	QUALITY: • iVantage Update SERVICES: • Review draft 2023 Strategic Plan; 2023 Marketing and IT Plans; and Medical Staff Model/2023 Provider Recruitment Plan • Replacement Facility Update EMPLOYEE DEVELOPMENT: • Review Non-exempt (union) performance evaluation template FINANCIAL STEWARDSHIP: • Review draft 2023 Budget
December	QUALITY: • Complete Board Self-Evaluations • Review/Approve Board Polices • Approve the 2023 Environment of Care Plan	QUALITY: • Review the 2022 Environment of Care Plan

Month	Goals & Objectives	Education
	SERVICES: • Approve 2023 Strategic Plan; 2023 Marketing and IT Plans; and Medical Staff Model/2023 Provider Recruitment Plan FINANCIAL STEWARDSHIP: • Approve 2023 Operating and Capital Budgets • Banking relationship Selection EMPLOYEE DEVELOPMENT: • Attend holiday celebration	

Prosser Memorial Health

2022 - Patient Care Scorecard

Major Goal Areas & Indicators	2022 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2022 YTD	2021	2020
Quality																
Left Without Being Seen	<0.80%	2.02%	1.47%	0.88%	2.25%	2.97%	3.88%	2.89%	5.09%	4.40%				3.00%	1.47%	0.80%
Median Admit Decision Time to ED Departure Time for Admitted Patients	<44 min	53	56	51	51	45	51	53	63	53				53	60	70
Median Time from ED Arrival to Departure for Discharged ED Patients	<107 min	109	115	114	114	110	134	128	128	143				122	117	128
Severe Preeclamptic Mothers: Timely Treatment Rate	>90.00%	42.86%	57.14%	86.21%	60.00%	84.62%	90.91%	88.89%	100.00%	66.67%				70.59%	N/A	N/A
All-Cause Unplanned 30 Day Inpatient Readmissions	<2.70%	10.61%	2.74%	4.92%	3.77%	5.45%	9.09%	5.63%	6.45%	8.06%				6.22%	5.80%	3.80%
Sepsis - Early Management Bundle	>94.40%	100.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				96.43%	94.40%	72.73%
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.07%	0.00%	0.00%	0.57%	0.00%	0.00%	0.45%	0.00%	0.00%	0.00%				0.11%	0%	0.29%
Diabetes Management - Outpatient A1C>9 or missing result	<21.89%	22.40%	24.19%	24.53%	21.32%	22.32%	23.35%	26.83%	22.76%	20.98%				23.16%	21.89%	27.61%
Medication Reconciliation Completed	>90.00%	96.30%	94.74%	90.74%	92.00%	88.00%	85.00%	76.67%	81.67%	77.59%				86.76%	46%	47.15%
Turnaround time of 30 minutes or less for STAT testing	<30 min	22.0	21.0	21.0	21.0	19.0	19.0	18.0	19.0	19.0				19.9	38	37.5
Median Time to ECG for Patients Presenting to the ED with Chest Pain	< 6.3 min	5.0	3.0	5.0	5.0	4.0	4.0	5.0	3.0	4.0				4.2	6.3	7
Surgical Site Infection	<0.19%	0.00%	0.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				0.04%	0.19%	0.25%
Bar Code Scanning: Medication Compliance	>93.50%	94.91%	95.77%	95.43%	95.00%	94.54%	93.76%	91.55%	93.34%	92.50%				94.09%	93.50%	98.90%
Bar Code Scanning: Patient Compliance	>94.70%	96.42%	95.81%	96.17%	96.16%	95.95%	94.83%	92.35%	93.55%	92.87%				94.90%	94.70%	N/A
*Overall Quality Performance Benchmark (iVantage)	>61	61	61	36	36	36	36	36	36	36				36	61	53
*Falls with Injury	<2	-	-	-	-	-	1	-	-	-				1	3	2

Green at or above Goal (4)
Yellow within 10% of Goal (2)
Red More than 10% below Goal (0)

Prosser Memorial Health

2022 - Strategic Plan Scorecard

Major Goal Areas & Indicators	2022 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2022 YTD	2021 Avg	2020 Avg
Patient Loyalty																
IP - "Would Recommend"	>93.1%	94.8%	92.4%	91.7%	92.9%	90.5%	96.4%	79.2%	90.8%	90.3%				91.2%	93.1%	87.9%
ED - "Would Recommend"	>84.0%	83.9%	81.7%	76.4%	88.0%	88.8%	90.7%	67.7%	85.2%	91.3%				85.5%	84.0%	81.4%
Acute Care - "Would Recommend"	>91.8%	90.9%	94.4%	87.5%	94.4%	87.5%	91.7%	79.2%	85.0%	97.2%				89.5%	91.8%	84.1%
OB - "Would Recommend"	>93.6%	99.0%	100.0%	97.7%	100.0%	88.9%	100.0%	75.0%	100.0%	100.0%				94.7%	93.6%	92.3%
Outpatient Surgery - "Would Recommend"	>96.6%	100.0%	100.0%	97.2%	97.7%	94.4%	95.3%	98.5%	91.4%	95.2%				95.6%	96.6%	89.8%
Clinic - "Would Recommend"	>91.0%	92.8%	97.5%	91.7%	97.6%	91.8%	94.3%	86.8%	90.6%	92.5%				91.0%	91.0%	87.3%
Outpatient - "Would Recommend"	>94.1%	98.1%	96.1%	93.5%	96.0%	96.0%	94.8%	94.5%	90.6%	92.1%				94.6%	94.1%	88.1%
Composite Score	>92.9%	95.7%	95.2%	94.4%	94.1%	93.8%	93.7%	93.2%	94.0%	92.7%				92.7%	92.9%	N/A
Medical Staff Development																
Medical Staff Turnover	<10%	0%	0%	0%	0%	0%	4%	0%	1%	0%				5%	12%	0.2%
Prosser Specialty Clinic Visits	1,352	1,386	1,429	1,617	1,428	1,366	1,422	1,272	1,681	1,365				1,441	1,318	954
Benton City Clinic Visits	868	775	650	822	657	870	730	718	899	881				778	732	837
Prosser RHC Clinic Visits	1,291	1,063	1,111	1,206	1,106	1,211	1,122	1,152	1,398	1,138				1,167	1,227	1,226
Grandview Clinic Visits	969	1,055	833	1,021	873	986	960	904	1,065	1,107				978	778	589
Women's Health Center	679	508	600	660	533	611	708	554	648	569				599	602	601
*# of Active Medical Staff	>51	52	53	53	54	55	54	55	54	54				54	51	45
Employee Development																
403(B) Participation Rate	>98%	98%	98%	98%	98%	98%	98%	98%	99%	99%				98%	98%	46%
Average Recruitment Time (days)	<21	19	26	40	11	15	19	22	17.5	18				21	21	32
# of Open Positions (Vacancies)	<23	32	28	35	31	32	39	39	29	27				32	32	29
Hours of Overtime - Overtime/Total Hours Worked	<4.5%	6.8%	5.3%	4.9%	6.0%	6.3%	6.1%	8.2%	7.1%	7.1%				6.4%	6.1%	5.9%
Agency - Cost/Total Labor	<7.7%	6.2%	10.6%	6.9%	6.9%	5.7%	7.9%	7.7%	10.5%	8.9%				7.9%	7.7%	7.6%
Turnover Rate	<0.6%	0.6%	1.2%	0.9%	0.9%	0.9%	1.2%	0.6%	0.0%	0.6%				0.8%	0.9%	0.6%
Timely Evaluations	>71.8%	95.1%	85.0%	84.2%	93.0%	79.0%	80.0%	81.0%	78.0%	91.0%				85.1%	71.8%	70.2%
Education Hours/FTE	>2.15	0.64	1.33	1.39	0.95	0.68	0.75	0.44	1.05	1.68				0.99	1.05	1.22
New Hire (Tenure) < 1 year	<10%	0.6%	0.6%	0%	0.6%	0.3%	0.3%	1.4%	0.3%	1.1%				0.6%	10%	0%
* Lost Workdays due to On-the-Job Injuries	<10.25	11	7	7	0	0	6.3	13	15	8				7	19.49	10.25
Quality																
ED Encounters - Left Without Being Seen	<0.8%	2.0%	1.5%	0.9%	2.3%	3.0%	3.9%	2.9%	5.1%	4.4%				2.9%	1.4%	0.8%
*Falls with Injury	<2	0	0	0	0	0	1	0	0	0				0	3	2
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				0.00%	0.0%	0.3%
All-Cause Unplanned Readmissions within 30 Days	<2.7%	10.6%	2.7%	4.9%	3.7%	5.5%	9.1%	5.6%	6.5%	8.1%				6.3%	6.1%	3.8%
Diabetes Management - Outpatient A1C>9 or missing result	<21.88%	22.40%	24.19%	24.53%	21.32%	22.32%	23.35%	26.83%	22.76%	20.98%				23.19%	21.88%	27.61%
Services																
ED Visits	1,083	1,287	949	1,138	1,246	1,448	1,419	1,384	1,375	1,501				1,305	1,105	805
Inpatient Admissions	96	123	98	115	102	89	120	121	123	96				110	116	83
OB Deliveries	50	47	41	61	46	41	50	57	55	42				49	49	41
Surgeries and Endoscopies	187	162	170	268	274	288	337	284	331	301				268	179	101
Diagnostic Imaging Procedures	2,851	2,462	2,619	3,134	2,915	2,981	3,091	2,691	3,125	3,317				2,926	2,992	2,280
Lab Procedures	14,000	14,139	13,806	14,818	13,359	15,075	14,738	13,972	16,271	14,778				14,551	14,327	11,768
Adjusted Patient Days	1,900	1,627	1,819	2,016	1,838	2,127	2,461	2,502	2,545	2,500				2,159	1,697	1,393
Therapy Visits	1,651	1,225	1,391	1,542	1,339	1,420	1,701	1,540	1,817	1,448				1,491	1,453	1,314
Outpatient Special Procedures Visits	325	241	221	332	249	277	306	364	389	418				311	324	247
Financial Performance																
Net Days in Accounts Receivable	50	55	58	55	56	55	55	55	55	55				55	51	63
*Total Margin	6.90%	5.2%	13.6%	13.3%	11.2%	5.2%	16.8%	7.4%	23.6%	8.4%				12.1%	18.40%	4.50%
Net Operating Revenue/FTE	$ 19,431	$ 17,959	$ 18,695	$ 21,800	$ 19,651	$ 20,465	$ 21,737	$ 18,317	$ 23,184	$ 22,020				$ 20,425	$ 20,682	$ 17,191
Labor as % of net Revenue	56.30%	63.18%	52.36%	48.39%	62.85%	60.40%	50.97%	59.42%	45.01%	56.04%				55.40%	57.00%	61.30%
Operating Expense/FTE	$ 18,177	$ 17,959	$ 16,155	$ 17,591	$ 17,598	$ 19,469	$ 17,756	$ 17,086	$ 17,873	$ 19,609				$ 17,900	$ 16,940	$ 15,891
*Days Cash on Hand	109	142	150	154	150	148	152	154	161	163				161	155	183
Commercial %	28.60%	29.90%	30.90%	31.80%	31.70%	31.40%	31.60%	31.60%	31.30%	31.70%				31.70%	29.00%	29.00%
Total Labor Expense/Total Expense	60.20%	60.73%	60.33%	59.41%	62.99%	62.87%	60.43%	62.50%	58.03%	62.86%				61.13%	61.00%	61.30%

Green at or above Goal
Yellow within 10% of Goal
Red More than 10% below Goal
*Cumulative Total - goal is year end number

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Prosser Memorial Health

Mission: To improve the health of our community.

Values

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Promote Teamwork
Integrity
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Excellence

BOARD WORK SESSION	September 27, 2022		WHITEHEAD CONFERENCE ROOM
COMMISSIONERS PRESENT	**STAFF PRESENT**	**GUESTS**	**COMMUNITY MEMBERS**
• Dr. Steve Kenny • Keith Sattler • Glenn Bestebreur • Susan Reams • Brandon Bowden • Sharon Dietrich, M.D. • Neilan McPartland	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO • Shannon Hitchcock, CCO • Kristi Mellema, CCO • Bryon Dirkes, CHRO • Dr. Brian Sollers	• Paul Kramer, NV5 • Gary Hicks, Financial Advisor • Brandon Potts, Vice President-Bouten Construction	None.
AGENDA	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
I. CALL TO ORDER	The meeting was called to order by Commissioner Kenny at 6:00 p.m.	None.	None.
II. Public Comment		None.	None.
III. SERVICES	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Replacement Facility Update			
1. Design Updates **a. CN (Attachment D)** **b. SVID** **c. DOH/USDA/City of Prosser Reviews** **d. Furniture Fair**	Paul Kramer and Craig provided the Board with updates regarding the Certificate of Need (CN) granted by the Washington State Department of Health; ongoing work with SVID to bury the existing overflow canal on hospital property; regulatory agency (DOH, USDA, City of Prosser) reviews; and the scheduling of a furniture fair at PMH in November.	None.	None.

2. Construction/ Schedule/Budget **a. Value Engineering Update (Attachment E)** **b. Bouten MACC (Attachment F) (Attachment G)** **c. GC/CM Contract A133 (Attachment H)**	Brandon provided a Value Engineering update to the Board. He also presented the proposed Bouten MACC at a cost not to exceed $74,817,419 and the GC/CM contract- #A133.	None.	The Board will be asked to approve The Bouten MACC at a cost not to exceed $74,817,419 and the GC/CM contract with Bouten Construction A133, at the September Board Meeting.
d. Schedule (Attachment I) **e. Project Budget (Attachment J) (Attachment K)**	Paul reviewed a draft schedule and provided a budget for the project at a total cost not to exceed $112,048,033.	None.	The Board will be asked to approve the Project Budget at a total cost not to exceed $112,048,033. at the September Board Meeting.
3. Financing **a. USDA (Attachment L) (Attachment M)** **b. Construction Loan** **c. Equipment Lease**	Gary provided an update on all financing activities, including the USDA, construction loan and an equipment lease. Gary reviewed Board Resolution #1071- Project Financing.	None.	The Board will be asked to approve the Board Resolution #1071- Project Financing. at the September Board Meeting.
B. Capital Equipment Requests **1. Radiology Equipment for the Replacement Facility (Attachment N) (Attachment O)**	Merry Fuller and Craig Marks reviewed the capital equipment acquisition request- Radiology Equipment for the Replacement Facility- GE MRI and CT at a cost not to exceed $2,028,830.	None.	The Board will be asked to approve the capital equipment acquisition request- GE MRI and CT at a cost not to exceed $2,028,830 at the September Board Meeting.

There being no further regular business to attend to, Commissioner Kenny adjourned the regular business meeting at 7:28 p.m. The Board entered into Executive Session at 7:29 p.m. which was expected to last approximately 1 hour, with no action to be taken after the session.
IV. EXECUTIVE SESSION
A. RCW 42.30.110 (I) To consider proprietary or confidential nonpublished information related to the development, acquisition or implementation of state purchased health care services as provided in RCW 41.05.26
B. RCW 42.30.110 (g) To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee. Executive Session ended at 7:52 p.m.
V. RESUME SESSION
Open session resumed at 7:52 p.m.
VI. ADJOURN
There being no further business to attend to, Commissioner Kenny adjourned the meeting at 7:53 p.m.

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BOARD MEETING	September 29, 2022,	WHITEHEAD CONFERENCE ROOM	
COMMISSIONERS PRESENT	**STAFF PRESENT**	**MEDICAL STAFF**	**GUESTS**
• Steve Kenny Ph.D. • Glenn Bestebreur • Susan Reams • Keith Sattler • Sharon Dietrich, M.D. • Neilan McPartland • Brandon Bowden	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO • Shannon Hitchcock, CCO • Kristi Mellema, CCQO • Bryon Dirkes, CHRO	• Dr. Brian Sollers • Dr. Jared Clifford	• Bill Bouten

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
I. Call to Order	The meeting was called to order by Commissioner Kenny at 6:00 p.m.		
A. Pledge of Allegiance			
II. Public Comment	None.	None.	None.
III. Approve Agenda	None.	Commissioner Bestebreur made a Motion to approve the August 25, 2022, Agenda. The Motion was seconded by Commissioner Reams and passed with 6 in favor, 0 opposed.	None.
IV. APPROVE CONSENT AGENDA **A. Board of Commissioners Meeting Minutes for August 25, 2022.**	None.	Commissioner Sattler made a Motion to approve the Consent Agenda. The Motion was seconded by Commissioner Bestebreur and passed with 6 in favor, 0 opposed.	None.

B. Payroll & AP Vouchers #167133 through #167839 dated 08.18.22 through 09.21.22 in the amount of $7,808,752.65.			
V. MEDICAL STAFF DEVELOPMENT	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Medical Staff Report and Credentialing			None.
1. Advancement from Provisional	Dr. Jared Clifford presented the following providers for **Advancement from Provisional**: **Peter Himmel, MD** – Locum Tenens privileges in Emergency Medicine effective October 1, 2022, through March 31, 2024. **William Lou, MD** – Telemedicine Staff privileges in Neurology effective October 1, 2022, through March 31, 2024.	A Motion to approve the Advancement from Provisional Appointment and requested Clinical Privileges that were reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the following providers was made by Commissioner Reams and seconded by Commissioner Dietrich. The Motion passed with 7 in favor, 0 opposed. • **Peter Himmel, MD** • **William Lou, MD**	None.
2. New Appointments	Dr. Jared Clifford presented the following **New Appointments:** **Monroe Whitman lll, MD** – Provisional/Locum Tenens Staff with requested privileges in General Surgery effective October 1, 2022, through March 31, 2023.	A Motion to approve the New Appointments and requested Clinical Privileges that were reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the following providers was made by Commissioner Bestebreur and seconded by Commissioner Sattler. The Motion passed with 7 in favor, 0 opposed. • **Monroe Whitman lll, MD**	None.

	James Wallace, MD – Provisional/Locum Tenens Staff with requested privileges in Emergency Medicine effective October 1, 2022, through March 28, 2023. **Soo Young Kwon, MD** – Provisional/Telemedicine staff with requested privileges in Neurology effective October 1, 2022, through March 31, 2023	• **James Wallace, MD** • **Soo Young Kwon, MD**	
3. Reappointment	Dr. Jared Clifford presented the following providers for **Reappointment:** **Stephen Burton, MD** – Reappointment to the Telemedicine Staff with requested privileges in Neurology effective October 1, 2022, through September 31, 2024. **Aixa Espinosa-Morales, MD** – Reappointment to Telemedicine Staff with requested privileges in Neurology effective October 1, 2022, through September 31, 2024. **George Lopez, MD** – Reappointment to Telemedicine Staff with requested privileges in Neurology effective October 1, 2022, through September 31, 2024.	A Motion to approve the reappointment and requested Clinical Privileges that were reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the following provider was made by Commissioner Reams and seconded by Commissioner Dietrich. The Motion passed with 7 in favor, 0 opposed. • **Stephen Burton, MD** • **Aixa Espinosa-Morales, MD** • **George Lopez, MD**	

VI. SERVICES			
A. Bouten MACC (Maximum Allowable Construction Cost) (Attachment F) (Attachment G)	Craig Presented a Bouten MACC at a cost not to exceed $74,817,419.	A Motion to approve the Bouten MACC at a cost not to exceed $74,817,419 was made by Commissioner Bestebreur and seconded by Commissioner McPartland. The Motion passed with 7 in favor, 0 opposed.	**None.**
B. GC/CM Contract- Bouten Construction (Attachment H)	Craig Presented the PMH AIA General Contractor Construction Management (GC/CM) Contract A133 with Bouten Construction.	A Motion to approve the GC/CM Contract A133 with Bouten Construction was made by Commissioner Reams and seconded by Commissioner Bestebreur. The Motion passed with 7 in favor, 0 opposed.	**None.**
C. Contract Signing- MACC and GC/CM Contract	Craig presented Bill Bouten (President of Bouten Construction) to the Board. The MACC and GC/CM contract with Bouten Construction were signed by PMH CEO-Craig Marks and Bouten Construction President-Bill Bouten.	None.	**None.**
D. Radiology Equipment-GE MRI and CT (Attachment N) (Attachment O)	Merry presented a Capital Request for a General Electric MRI and CT at a total cost not to exceed $2,028,830.	A Motion to approve the Capital Request for a GE MRI and CT at a cost not to exceed $2,028,830 was made by Commissioner Reams and seconded by Commissioner Dietrich. The Motion passed with 7 in favor, 0 opposed.	**None.**
VII. FINANCIAL STEWARDSHIP	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Review Financial Reports for August 2022 (Attachment V)	David Rollins presented the August 2022 Financial Reports.	A Motion to accept the Financial Reports for August 2022, was made by Commissioner Dietrich, and seconded by Commissioner Reams. The Motion passed with 7 in favor, 0 opposed.	None.
B. Replacement Facility Project Budget (Attachment J) (Attachment K)	Craig presented a Replacement Facility Total Project cost not to exceed $112,048,033.	A Motion to approve the Replacement Facility Total Project cost not to exceed $112,048,033 was made by Commissioner Bestebreur and seconded by Commissioner Dietrich. The Motion passed with 7 in favor, 0 opposed.	None.

C. Board Resolution #1071 (Attachment M)	David presented Board Resolution #1071-Project Financing.	A Motion to approve the Board Resolution #1071-Project Financing was made by Commissioner Bestebreur and seconded by Commissioner Bowden. The Motion passed with 7 in favor, 0 opposed	None.
VIII. EMPLOYEE DEVELOPMENT			
A. Employee Inflation/Retention Incentive- 3.0% (excluding Leadership and Providers) (Attachment GG)	Craig presented an Employee Inflation Retention Incentive at a total cost not to exceed $556,182 (3.0%).	A Motion to approve the Employee Inflation Retention Incentive at a total cost not to exceed $556,182 (3.0%) was made by Commissioner Bestebreur and seconded by Commissioner Reams. The Motion passed with 7 in favor, 0 opposed.	
IX. QUALITY	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Legislative and Political Updates	Glenn Bestebreur gave a brief Legislative and Political Update.	None.	None.
B. CEO/Operations Report	Craig provided a brief Operations Report based upon his written report included in the September Board Packet. He also passed out the Strategic Planning Binders for 2023.	None.	None.
X. ADJOURN			
There being no further business to attend to, Commissioner Kenny adjourned the meeting at 7:03 p.m.			

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JOINT CONFERENCE COMMITTEE	OCTOBER 19, 2022	VINEYARD CONFERENCE ROOM

COMMITTEE MEMBERS PRESENT	NON-MEMBERS PRESENT
• Commissioner S. Reams • Commissioner S. Kenny • Commissioner Dr. S. Dietrich • C. Marks, CEO • Dr. D. Carl • Dr. B. Sollers • Dr. D. Weaver	• K. Mellema, CQO, CCO • M. Fuller, CNO/COO • Dr. S. Hashmi

AGENDA ITEM	DISCUSSION	RECOMMENDATION	FOLLOW-UP
CALL TO ORDER	Meeting was called to order by Commissioner Reams at 0707 am		
APPROVAL OF MINUTES	September 2022 minutes were reviewed and approved by the Committee.	For informational purposes only.	Standing agenda item.
QUALITY			
Strategic & Patient Care Scorecards	K. Mellema shared some September highlights from the Patient Care Scorecard: • All Cause Un-Planned 30-Day Readmissions – 8.06% • Sepsis (Early Management Bundle) – 100% • Healthcare Associated Infections – 0% • Diabetes Management (A1c >9) – 21% • STAT lab times – 19 minutes • ECG for Chest Pain patients – 4 minutes • Medication Barcode Scanning – 92.5% • Patient Barcode Scanning – 92.87% Strategic Plan Scorecard September highlights: • Prosser Specialty Clinic Visits – 1,365 • Women's Health Center Visits – 569 • 403(b) Participation Rate – 99%	For informational purposes only.	No necessary follow up.

	• Turnover Rate – 0.6% • Lost Workdays due to On-the-Job Injury – 16 days • ED Visits 1,501 • OB Deliveries - 42		
Community Health Needs Assessment (CHNA)	K. Mellema reported on the new 2022 Community Health Needs Assessment (CHNA). This is a CMS requirement for healthcare organizations that are not-for-profit. The 2022 CHNA was a collaboration between the Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Prosser Memorial Health, and Kadlec Regional Medical Center. The purpose of a CHNA is to help determine which critical health needs the community will focus on over the next three to five years. Quantitative and qualitative data was used to determine the significant health needs which were identified as being: • Behavioral Health • Housing and Homelessness • Access to Health • Community Partnership Development	For informational purposes only.	No necessary follow up.
PATIENT LOYALTY			
Patient Satisfaction Data	M. Fuller reported on the Patient Loyalty Summary Report: "Would Recommend". The Emergency Department was at 91.32% for September with a YTD of 85.52% which is over goal. Many of the survey comments for the Clinics continue to be around access. To help with this, the expanded Call Center will start November 1st, so when patients call the Clinic, they will get a live person. To compliment that, we will have a RN triage nurse. The clinic team is also working with a Studer customer service expert team that has come in and will be providing training and support for the staff. Acute Care is down a little bit based on increased volumes and the rotation of patients being moved to other rooms especially in the middle of the night which is a big patient dissatisfier. Terra and Maryanne have been working with the House Supervisors and charge nurse to be proactive and anticipate needs ahead of time to avoid moving patients as much as possible. Staffing has stabilized our increase in volumes.	For informational purposes only.	Standing agenda item.
iPad Donations	M. Fuller reported that there was a high-school student that started a Go-Fund me account to buy ten iPads with stands in response to patient isolation during the Covid pandemic. The intention is for hospitalized patients to be able to have the opportunity to virtually	For informational purposes only.	No necessary follow up.

	visit with their friends and families when visitors are not allowed. These ten iPads were donated to ten hospitals in Washington and PMH was a lucky recipient of one of the iPads on October 7th where there was a small gathering of staff for the presentation by the student and her family.		
SERVICES			
Replacement Facility Update	C. Marks reported that we continue to have meetings with the Department of Health (DOH). The call yesterday (10/18/22) was a clinical function meeting which gave us an understanding of what the DOH wants for us to complete in the Functional Plan in order for them to approve.	For informational purposes only.	Standing agenda item.
2023 Strategic Planning	C. Marks reported that we have had 10 Strategic planning sessions with employees and will do the same with the Board next week. There will be worksheets in the Board packet that can be used to jot down ideas. A draft Strategic Plan will be presented to the Board in November and a final copy in December.	For informational purposes only.	No follow up necessary.
MEDICAL STAFF DEVELOPMENT			
Medical Staff Recruitment	Dr. Hashmi reported that we are in negotiations with an orthopedic candidate who has extensive experience and is sports medicine trained. We recently had an interview with an internist from Tri-Cities but there is another internal medicine candidate coming November 1st who worked at Kadlec and moved to Indiana. There is a good candidate for radiology that is currently doing her fellowship at UW but will not complete until June. We have another radiologist (Dr. Russell) coming this week for a visit and had a third radiology candidate that contacted us from Joplin, Missouri. Dr. Sollers reported that a PA with dermatology training has signed a contract and will be working with Dr. Nylander. The ED now has a second ARNP that is full time this month. Dr. McDonnel (GI) will be starting with us in January. Finally, we have several psych ARNP candidates that we will start calling November 1st.	For informational purposes only.	No follow up necessary.
EMPLOYEE DEVELOPMENT			
Employee Engagement Activities	C. Marks reported that our next celebration is Halloween. We have pumpkins outside for the staff for the decorating contest. Also, the chili cook-off will happen on Halloween. Finally, the Holiday party is	For informational purposes only.	No follow up necessary.

	scheduled for December 10th, and it will be a casino night at the HAPO center in Pasco.		
Health Insurance Rates from 2023	C. Marks reported that health insurance costs are going up across the country, but we will not be increasing our rates. There maybe a slight increase for vision but that will be the only thing.	For informational purposes only.	No follow up necessary.
FINANCIAL STEWARDSHIP			
Financial Performance – September 2022	C. Marks reported that we exceeded budget at $742,013. Investment income took a hit despite having conservative investments. YTD we are at $8.5 million compared to last year which was $12.8 million which was due to Covid. If the Covid money is taken out of last year, we are far exceeding this year.	For informational purposes only.	Standing agenda item.
Modular Home Replacement	C. Marks reported that we will be replacing the modular home that burned down but a garage must be built on the property as well. We should get approximately $300,000-$400,000 once it is sold. This proposal will go before the Board this month for approval.	For informational purposes only.	Standing agenda item.
ADJOURNMENT & NEXT SCHEDULED MEETING			
Meeting adjourned at 0838			
Next scheduled meeting November 9, 2022			

K. Mellema 10/20/2022

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FINANCE COMMITTEE MEETING
Monday – October 24, 2022,
7:00 a.m. – Vineyard Conference Room
AGENDA

MEMBERS:
Keith Sattler
Neilan McPartland
Brandon Bowden

STAFF:
Craig Marks
David Rollins
Stephanie Titus

CALL TO ORDER

I. APPROVE MINUTES
Action Requested – September 26, 2022, Minutes

II. FINANCIAL STEWARDSHIP

A. Review Financials – September 2022 **(Attachment Q)** **David**
Action Requested – September 2022 Financial Statements

B. Review Accounts Receivable and Cash Goal **David**

C. Voucher Lists
Action Requested – Voucher List **-** Payroll and AP Vouchers # 167840 through #168540 **David**
Dated 09-22-22 through 10-19-22 in the amount of $6,270,447.64.
Surplus Item Resolution # 1072: (2) Commercial Washer Extractor (2) Commercial Dryer Extractors; (2) Stryker Stretchers; and (1) Cast Cutter with Vacuum.

D. Modular Home Replacement **(Attachment V)**
Action Requested-Modular Home Replacement driveway and garage at a cost not to exceed $79,654. **David**

III. ADJOURN

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FINANCE COMMITTEE MEETING	September 26, 2022	VINEYARD CONFERENCE ROOM	
			GUESTS
• Keith Sattler • Neilan McPartland • Brandon Bowden	• Craig Marks, CEO • David Rollins, CFO • Stephanie Titus, Director of Finance Operations		
AGENDA	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
I. CALL TO ORDER	Keith Sattler called the meeting to order at 7:09 a.m.		
II. APPROVE MINUTES		A motion to approve the Finance Committee Meeting Minutes for August 22, 2022, as presented was made by Neilan McPartland. The motion was seconded by Keith Sattler and approved.	None.
III. FINANCIAL STEWARDSHIP **A. Review Financials – August 2022 (Attachment V)**	David reported Net Income of $2,146,095 in August and Gross Charges were $23,458,145 which was 27% higher than budget for the month and 24% greater	A motion to recommend acceptance of the August 2022 Financial Statements as presented to the PMH Board	None.

	than the prior year. Net Operating Revenue came in at $9,104,983 (22% over budget). Expenses were $7,019,245 in August and 1% over budget. Surgeries were 331 vs 191 budget and ER visits were 1,375 vs 1,104 budget. Cash Flow was $1,536,782 for the month and $2,233,317 YTD. AR stayed at a net 55 days overall. Continued to discuss and show progress in Revenue Cycle to reduce Days in AR > 90.	of Commissioners was made by Neilan McPartland. The motion was seconded by Brandon Bowden and approved.	
B. Review Accounts Receivable and Cash Goal	AR stayed at 55 net days overall as Collections were a record $7,997,934 but goal still was aggressive at $9,419,613. POS collections were $35,308 exceeding a budget of $15,000 and prior year $4,720. POS collections YTD are $314,586 versus $120,000 budget and $132,394 prior year.	None.	None.
C. Voucher Lists **Payroll and AP Vouchers #167133 through #167839 Dated 08-18-22 through 09-21-22 in the amount of $7,808,752.65. Surplus Item Resolution # 1070: (4) Sleeper Sofas.**		A motion to recommend acceptance of the August 2022 Financial Statements as presented to the PMH Board of Commissioners was made by Neilan McPartland. The motion was seconded by Brandon Bowden and approved.	None.
IV. ADJOURN			
Having declared no further business, the meeting was adjourned at 7:48 am.			

MEMORANDUM

TO: **BOARD OF COMMISSIONERS**
PROSSER MEMORIAL HEALTH

FROM: **CRAIG J. MARKS, CEO**

DATE: **October 2022**

RE: **CEO REPORT**

SERVICES

1. Replacement Facility Update

Our replacement facility project was a significant area of focus in our 2022 Strategic Plan, and even though we have accomplished a lot, it will remain an area of focus in our 2023 Strategic Plan as we prepare to break ground. Our most recent project activities and plans are included in the October Owner's Representative (NV5) Project Report **(Attachment A)**; the minutes from our last project team meeting **(Attachment B)**; and the project schedule for the next four months **(Attachment C)**. To assist in compartmentalizing the project, I will continue to use the following areas: Design; Construction/ Schedule/ Budget; and Financing.

A. Design

The major focus of our design activity is meeting with the Washington Department of Health (DOH) to review our project drawings, operational plans, etc. We have been delayed in this process for several months as the result of staff turnover at the DOH. We have emphasized our desire, and need, to move quickly in an effort to keep our costs down as interest rates continue to rise. The DOH appears to be understanding of our concerns and has scheduled several meetings with us this week. Our ultimate goal is to receive and A2BC (Authorization to Begin Construction) from the DOH by mid-November. They have verbally indicated this is possible. They have also indicated that they will give us a foundation only permit by the end of this week. This would allow us to begin the construction sooner, however, the USDA may not allow this. We have asked them, but they have not responded to our question. We believe they will require us to have the A2BC from the DOH before they will give us a notice to proceed with the construction. Many members of the project team are involved in the DOH review process including clinical leaders from PMH. Currently the review is going well, and we hope to have an update for the Board at the October Board Work Session. Our Owner's Representatives continue to work with Sunnyside Valley Irrigation District (SVID) on burying the overflow irrigation canal running through the hospital property. The attached site plan **(Attachment D)** shows the current canal (green) and the proposed relocation site (orange). As we do more investigation, it may cost significantly more to move the canal (we are waiting on SVID for the cost of both options) and may involve more time and money to move the easements. We will discuss this

with the Board as we receive more information, but right now, it appears the best option is to bury the canal in its current location. The final significant design issue we are dealing with is obtaining written approval from the Washington Department of Transportation (WADOT) regarding our traffic study mitigation solution (a three-way stop at Gap Road and the I 82 westbound exit). They have verbally approved the solution, but we must have it in writing for the USDA.

B. Construction/Schedule/Budget

With the Board approval in September of the GC/CM contract and MACC with Bouten Construction, Bouten is in the process of communicating with each of the subcontractors that were the low bidders on our project. They are also hoping to conduct a construction team kick-off meeting with all contractors and owner before the end of October. The schedule for our project is in a state of flux as we continue to work with the DOH and the USDA. As we gather additional information in the coming week, we will share an updated schedule with the Board at the October Board Work Session. Based on what we know at this time, we anticipate breaking ground in late November or early December. There have been no changes to our budget which was approved in September, but I have included a recent article from Modern Healthcare about the increasing costs of hospital construction **(Attachment E)**. It is interesting that they wrote about the Moses Lake Project, but also that most hospital construction is moving forward despite the high inflation.

C. Financing

From a financing perspective we continue to receive good news as we have been officially approved for the additional $10 million loan and $1 million grant from the USDA **(Attachment F)**. We also have confirmation from Western Alliance Bank that they have approved our interim construction loan for $80.5 million. This loan and interest rate will not be approved until we get closer to construction. Gary Hicks will attend the October Board Work Session to discuss the construction loan and his recommendation regarding whether we should enter into a fixed or variable rate construction loan. Gary will also discuss Board Resolution #1073 **(Attachment G)** which authorizes David or me to sign the final loan documents.

2. 2023 Strategic Planning Update

We are off and running on our Strategic Planning Process for 2023. We have already conducted 10 employee forums throughout the organization and have several more scheduled before the end of October. The input we receive through this process is invaluable and will lead our development of our 2023 plan. This process not only helps us plan for the future, but it also helps us address immediate concerns and answer a variety of questions. We plan to complete the process in October and develop a draft plan for review by the Board in November. A portion of our October Board Work Session will be used to review our Mission, Vision, Values and Standards of Behavior **(Attachment H)** and to identify actions the Board would like to see in our 2023 Strategic Plan **(Attachment I)**. As you review the planning packet, please jot your thoughts down on the worksheets located at the back of the document and we will discuss them next week. The final 2023 PMH Strategic Plan will be presented to the Board for approval in December.

Patient Loyalty

1. Patient Satisfaction

For the first time since the beginning of 2022, our composite patient satisfactory score of 92.7% has slipped below our goal of 92.9% (2021 score) **(Attachment J)**. While most of our metrics are very close to our goal, we have seen an overall decline in our scores the past several months. While this trend can be explained by our higher volumes and lack of patient rooms, we are working on ways to deal with these challenges and maintain high patient satisfaction. It will certainly be easier in our new facility, but we must address this trend now. I am confident that our dedicated staff will identify solutions for these challenges and change our satisfaction trajectory upward so that by year-end we will once again be meeting our satisfaction goal and exceeding the expectations of those we serve.

2. Donation

A high school student, Raina Matthews, and her family delivered an iPad and stand for use by our patients on October 7th **(Attachment K)**. Raina was moved to action by the isolation of hospital patients during the Covid-19 pandemic and wanted to find a way to lessen the loneliness. She and her brother started a Go-Fund-me account to raise money for ten iPads with rolling stands to distribute to Washington Hospitals. The iPad will allow patients to connect with loved ones despite distance or risk of infection. A large group of PMH employees gathered in the Vineyard Conference Room to receive this gift and thank this inspirational young woman and her family.

Medical Staff Development

1. Medical Staff Recruitment

Last month I mentioned the increasing demand for providers and the small supply, which was supported in a recent Trustee Insights article **(Attachment L)**. Despite these challenges, our recruitment activity has increased, especially with providers reaching out to us as they pursue opportunities. We are currently recruiting for providers in radiology, orthopedic surgery, internal medicine, family practice, pediatrics, emergency medicine, and psychiatric nurse practitioners. We are currently in discussions with three radiologists, with two on-site visits already scheduled. We recently hosted Dr. Geoffrey Higgs-sports medicine orthopedic surgeon **(Attachment M)** and were very impressed with his experience and people skills. We are currently in negotiations with him and hope to have a signed contract by the end of October. We are also beginning a renewed recruitment effort in primary care (family practice, internal medicine and pediatrics) which we plan to carry into 2023. The statewide shortage of primary care providers must be addressed, or our emergency departments will continue to be overwhelmed. We have several primary care candidates that we will be interviewing in the coming weeks. We also continue to recruit emergency medicine providers and are pleased to welcome Ty Nielson, PA-C; Steve McPhee PA-C; Dr. Rishor-Olney; Dr. Monick; and Dr. Wallace; to our Emergency Medicine Team. I am also pleased to welcome Karmina Bowen-ARNP who is joining Dr. Nylander in the PMH Dermatology Center. Please join me in welcoming these providers to Prosser Memorial Health!

Employee Development

1. Employee Engagement

As a result of the hard work of our Employee Engagement Team, we will once again celebrate the Annual Halloween Extravaganza on October 31ST. This fun event will include a department and individual costume contest; a pumpkin decorating contest and pumpkin give-away; a chili cookoff; a distribution of caramel apples; and lunch from Between the Buns, served by the Administrative Team **(Attachment O)**. Good luck to everyone that dares to enter the contests! Planning is also underway for our Annual (now that COVID-19 is behind us!) Holiday Party which will be held December 10th at the HAPO Center in Pasco. Stay tuned for updates as sign-ups will begin soon. The October employee newsletter highlights some of the many activities and achievements at PMH in October **(Attachment P)**.

2. 2023 Benefits Update

The review of the 2023 Health & Welfare benefits renewal is complete. Our Broker, USI was successful in securing 2023 rates allowing Prosser Memorial Health to maintain the same healthcare rates as the current 2022 offerings. Leadership will now meet with the Insurance Advisory Committee (I.A.C.) made up of employees, directors, administrative staff and current insurance and retirement consultants (USI), to share information regarding the insurance plans for the upcoming year. It is noteworthy to mention that maintaining our current benefit rates that our employees pay is quite an unusual occurrence, especially with several very large medical claims in 2022 and overall inflation. This year's open enrollment process will be performed within UKG (our payroll / time & attendance system) allowing our employees to use existing information and requiring less data entry.

3. Leadership Development

The Prosser Memorial Health leadership team held this year's second Leadership Development Institute (LDI) on September 30th. The focus of the event was reviewing our Mission, Vision, Values and PMH Standards of Behaviors in preparation for our Strategic Plan review. After a robust discussion amongst the team, we affirmed the core elements of our guiding principles' while recognizing the need to include the word "Health", replacing "Hospital" in the Vision statement reflecting the growing reach and positive impact on our surrounding communities. Our Hospital, Clinics, growing partnerships, and expanding services, comprise this network of services that continues to propel Prosser Memorial Health forward.

The second half of the day of our LDI was spent in team competition testing our collective mettle throwing axes. It has been said, *"A picture (or few) is worth a thousand words" … so:*

Everyone eagerly participated, all reported having a good time together, and the winning team: (Brian Fischer; Craig Marks; Tami Schaff; Lindsay Mckie; and Sasha Thomasson) walked away with bragging rights, a souvenir axe (plastic, of course) and a camouflage hat to commemorate the momentous occasion.

Financial Stewardship

1. Financial Performance-September

September continued our year-to-date trend of strong volumes and financial performance again exceeding $20 million in gross charges **(Attachment Q)**. Most of our departmental volumes were better than budget which resulted in our gross revenue being $3.975 million (22%) better than projected. Our deductions from revenue were 60% of the gross charges for the month, which was on budget, however, our year-to-date adjustments remain high at 63% of gross charges compared to a budget of 60% as a result, our net revenue (the cash we expect to collect for services provided in September) is $8.8 million or $1.6 million (22%) better than budget. Our operating expenses for the month were over budget by 14% due to recognizing the Board approved Retention Inflation Incentive on the income statement which will be paid out in October. This resulted in a still favorable operating income of $962,242 and an operating margin of 10.9% both significantly better than budget. As is typical of each quarter end, we reflect a gain or loss on our investments which continue to be less favorable and resulted in requiring us to reflect a loss of $273,188. Therefore, after adding in our non-operating income, our net income for the month of September was $742,013 compared to our budgeted net income of $538,286. All in all, we performed well in September despite the current investment market and ability to provide additional compensation to our hard-working employees.

Year-to-date we are experiencing a similar story with strong growth (13% over budget) in revenue and volumes exceeding budget. Total operating expenses are now almost flat to budget only exceeding budget by $30,963 year-to-date. With volumes equally strong and showing an increase of 6% over the prior year, has resulted in an operating income of $9.1million and a net income of $8.6 million both 120% and 94%, respectively, over budget. Our payor mix continues to be solid and reflects our commercial market is growing compared to last year. September reflects our strongest commercial percentage yet for the year at 34.8%. September showed a strong cash flow of $1.1 million which is a reflection of our Business Office setting a record of $9.0 million in collections. Cash flow collections are $3.4 million year-to-date. This has resulted in the strengthening of our balance sheet to 163 days of cash compared to 148 days this time last year. We still are working towards our goal of lowering net days in accounts receivable as it remains at 55 days overall. Our team continues to work hard on this, but our strong financial performance makes it a tireless effort to keep up. In reflection, our success financially has been tremendous and without a doubt due to our dedicated staff and continued stellar performance serving our community and in all aspects of our Strategic Pillars.

2. Financial Challenges

We continue to hear and read about the financial challenges hospitals are facing in Washington **(Attachment R)** and across the country **(Attachment S)**. Significant lobbying is occurring in Olympia and Washington D.C. for financial relief for hospitals, but to date, no action has been taken. In my opinion, it is unlikely that there will be any relief in the near future as many, if not most hospitals and systems have very large reserves. If those reserves begin to be depleted, we may see action by Congress. Fortunately, we are performing well and are not dependent on any government assistance at this time.

3. PMH Clinics Quarterly Financial Performance

Through the third quarter of 2022 all clinics are continuing strong financial performance with a consolidated contribution margin of $3.6 million over budget **(Attachment T)**. Our clinic overall gross patient charges are exceeding budget by $5.9 million and we continue to be lean on expenses at 3% below budget. Revenue for all locations show strong results year-to-date as they compare to budget, mainly due to increased clinical visits for reasons other than COVID vaccinations and testing. All current providers are exceeding volumes as compared to last year and we continue to see a high demand for appointments. We continue to recruit for vacancies in our clinics. The Grandview Clinic is showing strong performance, exceeding budget expectations by 1% and showing growth over last year by 38%. The Benton City Clinic still struggles with hitting the 2022 budget without being fully staffed with providers, the current provider staff has grown volumes 16% in the current year over year-to-date last year. The Prosser Clinic is seeing a similar struggle in staffing providers; however, current providers are exceeding their budgeted volumes by 14% in comparison to year- to- date last year. In total, our clinics are 10% over last year's visit volumes. It is evident that our clinics continue to provide exceptional care to our growing community, and we continue to expand and recruit to meet and support the communities constantly growing health care needs to meet this demand. The PMH clinic network currently represents $79.3 million of gross revenue to Prosser Memorial Health.

4. PMH Investment Performance

As of September 30, 2022, the District has $16,494,969 in its investment portfolio which is managed by Time Value Investments. Investment earnings in 2022 have continued to be disappointing and have had to recognize another loss for third quarter as interest rates continue at historic lows. Rates have jumped up a bit post-September and we're now at the highest level we've seen since about mid-2007. Short-term investment rates are about 4.00-4.25% with 4.50% and higher in the 1–3-year range. From there, rates start to drop a bit, which reflects the uncertainty in the market about whether we'll have a recession (and therefore lower rates) sometime in the next year or two. Currently, we are sustaining all transferred funded depreciation incurred monthly under Board Designated Funds within the Funded Depreciation cash account and are opting not to roll anything into investments at this time. Upcoming, we have one bond maturing in October which will provide some offset to our losses. While we do have to continue to reflect our current market position quarterly, these are not impacting actual cash flow and the longer we hold on to our investments, the better our return will be. Aaron Bonck from Time Value Investments will present our current performance to the Board at the October Finance Committee **(Attachment U)**.

5. 2023 Budget Update

As we begin to collect information as part of our Strategic Planning Process, we have also begun to develop our operating and capital budgets for 2023. Our department leaders are currently projecting their volumes and expenses for next year, which has brought forward new challenges with high utilization, market instability, and inflation. By the end of October/early November, we will consolidate all department data and anticipate the total margin will be strong to meet or exceed our strategic goal of 6.0%. We will continue to work in correlation with our department leaders to identify additional opportunities for improvement (revenue growth and expense reduction), as needed, to meet our goals. In addition to working on our operating budget, we are also collecting capital acquisition requests from our Medical Staff and all PMH departments, and our clinics while being extremely cognizant of need versus want as we attempt to conserve our cash. A preliminary budget will be presented to the Finance Committee and the Board in November and the final 2023 operating and capital budgets will be presented to the Board for approval in December.

6. PMH Foundation Update

It is with great appreciation and gratitude; I am happy to announce that Bouten Construction has pledged $150,000 to the new hospital project; and Garrett Electric and Apollo Mechanical have pledged $75,000 each. The foundation is set to launch the public phase of the capital campaign for the new hospital project in November when we break ground at the new location.

7. Modular Home Replacement

On October 11, 2021, the modular home that Prosser Memorial Health owned, and was using for storage, caught fire and suffered a total loss of property and possessions. Travelers Insurance provided full replacement coverage per the PMH property insurance coverage and has issued reimbursement of $105,021 towards the value of this property less its calculated depreciated value and deductible of $10,000. The destroyed home was abated for asbestos and disposed of per state regulations. To place a new home on the site will require a new concrete slab that incorporates hooking up utilities (water, sewer, electricity.) The city code requires a paved driveway and a garage for a new or replacement home and insurance will not pay for this required upgrade. PMH identified three options that varied from $179,849 plus options to $222,829 plus options and is recommending a replacement home sold by Clayton Homes of Union Gap that is comparable in size and quality to the previous home **(Attachment V)**. It is a 3-bedroom, 2-bath, 1,512 sq ft home and will have a paved/asphalt driveway and a 2-car garage for approximately $365,506 once its completed. Its market value should be equal to or greater than this cost plus the value of the land upon which it resides. This home can then be utilized by PMH for temporary housing for travelers, locums, or new employees moving to Prosser, WA as its currently zoned as residential. At the

October Board Meeting, the Board will be asked to approve to build a new garage and driveway for approximately $79,654 for the aforementioned property and to coordinate with the Property Insurance Carrier to purchase and install the replacement modular home as described.

Quality

1. Community Health Needs Assessment

The development of a Community Health Needs Assessment (CHNA) is a governmental regulation (section 501(r)(3)(A)) as a not-for-profit organization. The CHNA helps determine which critical health needs the community will focus on over the next three to five years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin Counties. A full copy of the 2022 CHNA is in the October Board packet.

The CHNA steering committee began meeting weekly in January of 2022. The committee includes representatives of Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH). Quantitative and qualitative data were used to identify community needs through a mixed-methods approach. Qualitative data includes twenty-one interviews with working partners and community collaborators (partners), ten listening sessions, two behavioral health forums, two housing and homelessness forums, and two general forums. CHNA steering committee members met weekly in July and August 2022 to apply the prioritization criteria to the identified needs. The list below summarizes the significant health needs identified through the 2022 Community Health Needs Assessment process in no particular order **(Attachment W)**:

- **Behavioral Health** - The assessment identified significant needs for behavioral health response and prevention. Behavioral health, which encompasses mental health and substance use/misuse, was identified as a need in all areas of this CHNA.
- **Housing and Homelessness** - The assessment identified a low supply of affordable housing, low supply of multi-family units, low vacancy rates for rentals, and increased rental costs.
- **Access to Health** – The assessment identified a need for access to not only healthcare, but also access to community supports that enable health. Access to Health will include a focus on addressing barriers to medical care, including healthcare provider to patient ratios and linguistically appropriate, culturally responsive, and accessible care.
- **Community Partnership Development** – The assessment identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships

Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Kadlec Regional Medical Center, and Prosser Memorial Health, in collaboration with community partners will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs. The Board will be asked to approve this Plan at their October meeting.

2. Board Education

I'm pleased to report that the American Hospital Association is once again hosting its Annual Rural Health Care Leadership Conference in 2023 **(Attachment X)**. This year however, the conference will be held in San Antonio from February 19-22. The conference will be held at the JW Marriott and will feature noted speakers in health care, politics, management, etc. This is an excellent conference and an excellent way for Board members to interact with their peers regarding the challenges rural hospitals are facing. If you are interested in attending, please contact my office at your earliest convenience so that we can make a reservation for you.

3. Flu Vaccines

It is that time of year again! Flu shot season! We have scheduled three separate Employee Flu Vaccine Clinics: October 6th, October 14th and October 27th from 7-10 am in the Vineyard Conference room **(Attachment Y)**. Along with the flu shots, staff can do their annual N95 mask fitting and PAPR training. Employees that are unable to get their flu shot between 7-10 am on those three dates, can request their shot from the House Supervisor who has access to the vaccine at any time of the day or night. For those employees/volunteers who are 65 years and older, they can receive the Fluzone High-Dose vaccine because they are at higher risk of developing serious flu complications. Board members may receive a flu vaccine at the October Board Work Session (COVID-19 boosters are also available). Employee flu shots have been delivered to our primary care clinics where the clinical staff are able to administer to other staff members as needed. The ENT Clinic and the Specialty Clinic employees can receive their flu shots at the hospital. The Therapy Clinic already received their vaccine from our Employee Health staff last week. So far, we have approximately 113 employees that have received their flu vaccine with 10 declinations. Per our Employee Influenza Vaccination policy, the due date for vaccination is no later than October 31st.

4. October Board Meeting

The October Board Work Session will be used to give the Board updates and discuss several items including: a) a discussion of our replacement facility project by our project team; b) a discussion of a modular home replacement and c) a 2023 Strategic Planning discussion including a review of our Mission, Vision, Values and Standards of Behavior. The October Board Meeting will be routine with Medical Staff privileging, financial performance review and possible approval of financing for the replacement facility project (Board Resolution #1073), Community Health Needs Assessment and a Modular Home Replacement at a cost not to exceed $79,654. As a reminder the November Board Work Session and meeting will be held on November 15th and 17th and the December Board Work Session and meeting will be held on December 13TH and 15TH. These changes were all made to avoid conflicts with the upcoming holiday season.

If you have any questions regarding this report, or other hospital activities, please contact me at (269) 214-8185 (cell), (509) 786-6695 (office), or stop by and see me at the hospital.

Prosser Memorial Health Replacement Hospital

Owner Team Meeting Minutes

Meeting #	20221014	Date:	Meeting: Friday, October 14, 2022 Issued: Tuesday, October 18, 2022
Time & Location:	9:00amCT/8:00amMT/7:00amPT MS Teams Video Call	Prepared by:	Adam Trumbour – NV5
Attendees: ✓ = *Attended Meeting*	PMH Craig Marks Bryon Dirkes ✓ David Rollins Rey Rodriguez Merry Fuller ✓ Dr. Brian Sollers ✓ Phillip Braem NV5 Paul Kramer ✓ Adam Trumbour ✓ Braden Demmerly ✓ BCDG Kurt Broeckelmann ✓ Brooke Cinalli Hilary Beashore Lance White Finance Consult. Gary Hicks ✓ Bouten Brandon Potts ✓ Mac McGrath ✓ Sean Gossett Nick Gonzales		
	Attendees		

PMN = Post Meeting Note *For minutes from prior weeks, please reference previously issued minutes.*

No	Item	Date Due By	Ball in Court
1.	**GENERAL / ADMINISTRATION**		
1.1.	Project Goals, Objectives, & Strategies 24Jun22 – Adam to send to Hilary; may resolve on site.	IN PROGRESS	Team
1.2.	5Mar21 – Graham Team	CLOSED	
1.3.	5Mar21 – NV5 Transition	CLOSED	
1.4.	Contracting Realignment 7Oct – CLOSED NV5 to check with USDA on ability to sign contract now; PREVIOUS experience says contract was signed by USDA on Chelan project before A2BC.	IN PROGRESS	
2.	**SCHEDULE**		
2.1.	4-Month Look Ahead Schedule	INFO	
2.2.	In-Person Meetings – as noted at the end of meeting minutes.	INFO	
2.3.	Overall Project Schedule	INFO	
3.	**BUDGET**		
3.1.	Budget Development	INFO	
3.2.	Medical Equipment (Major and Minor) (moved to item 4.12)	INFO	
3.3.	DZA Feasibility Study	CLOSED	
3.4.	Financing 7Oct22 – PMH returned signed documents to USDA; additional funding is now secured, including separate construction loan. 14Oct22 – Critical path for now is USDA approval. Revised financing docs were circulated to PMH this week. No financing update meeting today.	INFO	
4.	**PROCUREMENT / OWNER-LED ACTIVITIES**		
4.1.	GC/CM RFP	CLOSED	

4.2.	Furniture & Demonstration Furniture 13May22 – OS to prepare final package for next week. OS is also researching the most reasonable procurement timeline (buy furniture upon construction commencement and pay for warehousing vs. risk of inflation year-to-year when purchasing later in the project timeline). Merry and Brian to discuss method for collecting information and feedback on additional demo furniture. Craig requests that Brian be the lead on feedback. Best approach would be a Furniture Fair Friday in a conference room to engage staff. NV5 to facilitate this. 3Jun22 – OpenSquare will present their furniture proposal to the team; need to determine a day/time. Need to include PMH Admin team—30 minutes during Thursday at 2PM – 4PM PT is preferable. PMN: Canceled. NV5 to reschedule with PMH and OpenSquare. 17Jun22 – PMH to provide an alternative meeting date/time. 24Jun22 – June 21 does not work for OpenSquare, try 7/28. 8Jul22 – Meeting scheduled for 7/28. 29Jul22 – OpenSquare presented their current furniture proposal to the team on July 28. NV5 to work with OpenSquare to plan a furniture fair with OpenSquare sometime before October. 19Aug22 – OpenSquare is working on this. NV5 will coordinate the dates in October via email. 14Oct22 – In progress.	INFO	NV5, OpenSquare
4.3.	Site Clearing	CLOSED	
4.4.	Geotechnical Engineer	CLOSED	
4.5.	Commissioning Agent	CLOSED	
4.6.	Security Design Consultant	CLOSED	
4.7.	New Facility Operational Meetings 04Mar22 – Team to commence meetings within the coming months.	INFO	NV5, Merry
4.8.	bcDG Contract	CLOSED	
4.9.	Landscape Consultant 11Mar22 – The Foundation would like to incorporate a donor patio/bricks, etc., and would like to know when the landscape contractor will be engaged. As of now, plan is to contract with them during April MACC process. Team to involve the Foundation thereafter. 22Apr22 – Graham received one bid for this work. (PMN) Graham indicates the bid was not compliant and therefore they did not accept it. 6May22 – Close out pending new contractor. 13May22 – PMH requests wildflower planting on fallow parts of the property, as part of the final site landscaping. 17Jun22 – Adam to send plan to Bouten. PMH needs a reasonably landscaped site but understands there might be potential to continue to enhance the landscaping once construction is complete. 5Aug22 – Bouten spoke with prospective landscaping, who recommended that any seeded areas also be irrigated. This is best addressed by the landscape design-build team once they are onboard as a subcontractor, though.	INFO	
4.10.	Telecommunications Provider 6May22 – PMH working on existing facility contract. USAC funding cannot apply until a facility is constructed, so PMH will proceed without USAC financing.	INFO	
4.11.	Flooding from Neighbor	CLOSED	NV5

4.12.	Medical Equipment (Major and Minor) 14Jan22 – We need to competitively bid all new equipment (lights/booms (Stryker), imaging). Note: lights from current ORs will be moved to new Procedure Rooms, for example. RBA advises against bidding the Steris system and Pyxis system. Need to provide specific dates for "required on site" for all equipment. 04Mar22 – NV5 to check in with RBA for next steps. 11Mar22 – NV5 is conducting a meeting with RBA on 3/17. 18Mar22 – Meeting was moved to 3/18. 8Apr22 – Next steps occur after MACC is approved. 6May22 – Adam to check with RBA on updated budget pricing. PMH may increase leased equipment by an additional $1.4MM. 13May22 – RBA will revisit their cost estimate and send to team for review. They will also review lease options to capture the additional $1.4MM in leasing PMH would like to pursue. 20May22 – NV5 to check on RBA progress. 3Jun22 – R&B sent a list of proposed leased equipment. NV5 to send to Steve, Dave, Merry, Craig. PMH is also working on reusing more imaging equipment vs. buying or leasing new. 17Jun22 – Adam to send to Gary. PMH team to review internally and determine which items are appropriate. NV5 to add this review to the on-site agenda for board week. 24Jun22 – NV5 to review lease list from David. 22Jul22 – RBA stresses the importance of executing procurement contracts this year to avoid unpredictable price increases.		
4.13.	Food Service Equipment 29Jul22 – NV5 will procure a FSE vendor once NTP date is set. 5Aug22 – Team reviewed FSE plans with Morrison, who provided minor comments.	INFO	
5.	**DESIGN / PERMITTING**		
5.1.	Annexation & Zoning	CLOSED	
5.2.	Certificate of Need	CLOSED	
5.3.	Water & Sewer (City)	CLOSED	
5.4.	City Permit Review 12Aug22 – NV5 to check with Nick re: building permit status now that MDNS is finalized. **PMN:** Nick is waiting for an "all clear" from the DoH before issuing a building permit. He will contact them ASAP to check on this. He also indicated that a foundation-only permit could be issued ahead of this, though we will need to check with USDA that they will allow us to break ground without a full-fledged building permit.	IN PROGRESS	NV5, PMH

5.5.	State Permit Review 19Aug22 – bcDG will talk to Kevin and communicate what Matthew set for expectations re building permit. 16Sept22 – bcDG and NV5 to reach out to Kevin at DoH to inquire about when to expect the A2BC form, which authorizes construction. Team stresses the need to understand where DoH is at in their process subsequent to Matthew's departure. 7Oct22 – Team met with Kevin Scarlett (DoH) on 10/4/22 to review the open comments. DoH anticipates that they could authorize an excavation and foundation permit as early as next week (week of 10/10), provided bcDG responds to those specific comments this week. DoH booked two meetings: 10/18 and 10/19, to review the remaining comments. PMH staff will need to attend, especially department heads. bcDG to coordinate this effort. NV5 to send PMH a shortlist of critical items that need their attention ASAP. 14Oct22 – Kevin has been out sick but talked through items with Lance. PMH team is working on the reports/studies/etc. identified as requirements in the DoH comments e.g. PHAMA, Water Mgmt Plan, ICRAs, etc. Merry will send her drafts to team EOD today 10/14 and then review them with Kevin during DoH meetings 10/18, 10/19. Merry, Paul, bcDG plan to meet Monday afternoon to prep for 10/18 call.	IN PROGRESS	bcDG, DoH, PMH
5.6.	Electric Service	CLOSED	
5.7.	Program Review	CLOSED	
5.8.	Nurse Server Mockup	CLOSED	
5.9.	NV5 DD Review	CLOSED	
5.10.	Design Progress Update 5Aug22 – Team intends to finalize the front-end specs the week of 8/8/2022. 12Aug22 – bcDG is working with Bouten on this. The last addendum is Friday, August 19. The front-end specs need to be completed before then, with time for Bouten to review and suggest edits if needed. bcDG to verify that all constructability comments were incorporated into the latest drawings, which will be issued as a bid addendum today. 19Aug22 – bcDG will need to revise the drawings to address USDA comments. TBD if this is issued as an addendum or conformed. 16Sept22 – bcDG will provide narratives to confirm accepted VE items before 9/21/22, later, they will issue revised design documents to incorporate all changes. 23Sept22 – Design team intends to issue a revised set or ASI by next week. 7Oct22 – Conformed set will be issued concurrent with submission to DoH in October. 14Oct22 – Team continues to work on detailed responses to DoH.	IN PROGRESS	bcDG, Graham

5.11.	<u>SVID coordination</u> 11Feb22 – NV5 to request SVID to complete all work, lateral and culverts included. 11Mar22 – Design for using irrigation water? Hilary to ask ECE. **PMN:** ECE can't provide this service. Graham will investigate working with the landscape contractor to provide this. 18Mar22 – SVID proposes to bury the ditch on PMH property as their preferred option. If SVID is going to underground the entire ditch, which is not PMH's preference, then PMH will not contribute to costs to underground the ditch. 8Apr22 – PMH wants at least a letter from PC to SVID. If the pipe is buried, can it be placed at perimeter and not through the middle of the site? 22Apr22 – Given the cost is less than installing concrete culverts, we should proceed with undergrounding; is along the perimeter better than diagonally through site? NV5 to work with SVID on this and the location of manholes. 6May22 – Adam to send Craig cost info and timing. 13May22 – SVID would charge an additional $30k for a perimeter routing. Team is leaning toward this option, as it clears the center of the site. NV5 to work with ECE and SVID on what this will entail (easement, especially). 3Jun22 – NV5 to maintain progress with SVID on rerouting. bcDG is working with ECE to address the neighboring subdivision's request to tap into the SVID overflow. NV5 to respond to the neighbor to let them know that we are likely rerouting the overflow. 22Jul22 – NV5 to check with SVID today on pricing. NV5 to forward update to PMH prior to board meeting. 29Jul22 – Relocated drainage route needs to be staked/surveyed in order to layout a new easement. NV5 coordinating surveying etc. SVID has notice to proceed for driveway work but needs to finalize the aforementioned reroute before scheduling the work. NV5 to double-check on putting overflow in same easement as supply. NV5 to ask why they need 30' (any legal reasons?). 12Aug22 – NV5 continues to contact the surveyor in an attempt to have the utilities staked per SVID's request. SVID indicated that the USBR will need to approved the ditch relocation, so NV5 is determining what that process entails and any schedule risks. The ditch may need to remain in its current location if the USBR process appears to be too lengthy. 19Aug22 – NV5 continues to work with SVID and USBR to reroute the overflow channel. This includes negotiating the easement locations and widths. 16Sept22 – NV5 to resend surveying proposal to PMH for approval. SVID indicates they will replace the supply pipe under our driveway after irrigation ceases on 10/24. NV5 to check on setting a formal date to lessen impacts on Bouten/construction team. 23sept22 – Staking complete. 7Oct22 – NV5 to speak with Ron today on progress of staking and timing of underground in existing location. SVID will relocate supply line at the end of October. 14Oct22 – SVID is potholing the relocation route today and hopes to provide a pricing update next week. NV5 will send the proposed easement plan to PMH as part of the board packet.	IN PROGRESS	NV5
5.12.	PAR Process	CLOSED	

5.13.	Traffic Study 5Aug22 – Will the final approval of the ICE push out the SEPA and building permit issuance dates? What is the anticipated duration of the ICE final approval by WSDOT? 12Aug22 – Per Steve Zetz email on 8/8, the MDNS incorporates the ICE as conditions for a Certificate of Occupancy, so we should not be held up on a building permit by the ICE. 16Sept22 – bcDG to check with TranspoGroup on final approval from the State DOT. 23Sept22 – No update from TranspoGroup; waiting on update from WADOT traffic office. 7Oct22 – ICE is with state for signatures and TranspoGroup does not anticipate any changes from WADOT.	IN PROGRESS	ECE/bcDG
5.14.	Helipad	CLOSED	
5.15.	Pneumatic Tube System	CLOSED	

5.16.	<u>USDA Review</u> 20May22 – USDA sent a summary of their status via email. They indicated they need the following prior to concurrence for construction: I show the following is needed prior to construction/bid: • Evidence of the BofA equipment lease $3.6MM secured • Evidence of Applicant contribution $17,300,000 deposited in the construction account. ($2.6M of the funds will be identified in the Out Lay Report as interim financing) • Submittal of evidence of required permits. • Approval by USDA of plans and drawings 100% • R-O-W documents need updated and submitted after permits are received. • Project Manager Resume • RFQ, RFQ short list, request for proposal, recommendation of Award, Executed Contract • Final Plans and specification for the project. • AIA contracts: USDA to complete review and approval of new contractor • Civil Rights Compliance Review and Limited English Proficiency review. • Non-Discrimination statement to be added as outlined in the Letter of Conditions • Posters to be posted and pictures submitted to USDA for concurrence • Certificate of Need to be submitted to USDA 17Jun22 – Gary understands we may need to convert to "Buy/Build America Act" (BABA) should we appeal to USDA for additional funding. As of now, this is not part of the design docs/specs, and converting to the Act would incur additional time and cost. Gary to check with USDA to understand the risk of this applying to our project. 29Jul22 – USDA has not indicated this is a requirement and has not answered this question directly. Other precedents indicate we are not bound to this, so we are proceeding as-is without BABA requirements. 12Aug22 – USDA sent comments to the team concerning contracts and design. The team is currently reviewing them, but they appear to be mostly clarifications; there did not seem to be comments mandating additions or deletions of scope. 19Aug22 – bcDG intends to respond to USDA comments the week of 8/29 7Oct22 – NV5 is coordinating with USDA to potentially proceed with excavation and foundation permit.	IN PROGRESS	NV5
5.17.	<u>Bulk Oxygen System</u> 6May22 – Adam to forward drawings as noted above. 20May22 – Oxygen farm is not likely to change due to VE. 17Jun22 – NV5 to facilitate meeting with Oxarc and design team. 22Jul22 – Hyperbaric is still in flux and would change system, so NV5 to request pricing from Oxarc once hyperbaric is resolved. 7Oct22 – Team to work to get full O2 farm drawings to comply with DoH comment. 14Oct22 – NV5 to circle back with bcDG and Oxarc on this.	IN PROGRESS	bcDG, NV5
5.18.	New Address	CLOSED	

5.19.	Lot Consolidation of Site	CLOSED	
5.20.	Benton County Noxious Weed Mitigation	CLOSED	
5.21.	Stormwater Permit (SWPPP) 29Jul22 – NV5 working with ECE on this. A newspaper ad was placed and now we are in the 30-day comment period before applying. We need SEPA approval date in order to apply. 12Aug22 – Adam to check on SEPA approval in order to proceed with SWPPP. 19Aug22 – SWPPP application is ready and needs to be signed by Bouten. NV5 to share all supporting info on SWPPP for Bouten to sign. 16Sept22 – Jason submitted to the state; we should have SWPPP approval by early October. 14Oct22 – Still in public comment period since we needed to re-advertise, with an anticipated receipt on 11/8/22.	IN PROGRESS	
6.	**PRE-CONSTRUCTION**		
6.1.	Value Engineering (VE) Process	CLOSED	
6.2.	ECCM/MCCM Procurement	CLOSED	
6.3.	Preconstruction Contract Amendment	CLOSED	
6.4.	CM Estimating	CLOSED	
6.5.	Early Procurement 7Oct22 – Chiller was released. Team working on AHU submittals (currently waiting on vendor for shop drawings). Bouten requests an early copy of the revised elevator spec ahead of conformed set date. 14Oct22 – AHUs submittal was approved from Henderson this week but need official copy from bcDG. Equipment needs to be released now to avoid price increase, so Bouten will release based on Henderson's notes.	IN PROGRESS	bcDG, Bouten
6.6.	MACC prep	CLOSED	
6.7.	Construction Commencement	CLOSED	
6.8.	Building Permit – See item 5.4 above.	IN PROGRESS	
6.9.	Graham Wind-Down	CLOSED	
6.10.	Groundbreaking Ceremony 7Oct22 – Team is looking at end of November for ceremony. Also need to plan USDA Preconstruction meeting. 14Oct22 – Bouten team is working with Shannon for groundbreaking materials (shovels, hardhats, etc.)	IN PROGRESS	Team
6.11.	Team Management 7Oct22 – Nick Gonzales will take a larger role in Project Management as the project transitions to the Construction phase.	INFO	
6.12.	Builder's Risk Insurance 14Oct22 – Bouten should have quotes next week. David Rollins to confirm he has gotten a quote from PMH insurance company.	INFO	Bouten, PMH

The above represents the writer's understanding of the items discussed and/or conclusions reached. It is requested that any questions, comments, omissions, and/or errors to these meeting minutes be directed in writing to this office within three (3) business days. Please contact NV5.

Next Online Meeting

Date: Friday, October 21, 2022, at 9:00am CT / 8:00am MT / 7:00am PT; via Teams

Upcoming In-Person Meetings

October 25 – Team arrives in Prosser midday
October 25 – Board Work Session
October 26 – Team Kickoff Meeting

Prosser Memorial Health

NV5

Prosser Public Hospital District
Prosser Memorial Health Replacement Hospital
Progress Report

DATE: October 18, 2022

I. PROJECT TEAM:

Prosser Memorial Health (PMH)	Owner
NV5	Owner's Representative
bcDesignGroup (bcDG)	Architect/Design Team
Henderson Engineering	Security, Low Voltage, Audiovisual Design
Gary Hicks Financial, LLC	USDA Application Consultant
Perkins Coie	General Counsel
R&B | Genesis (Mitchell)	Medical Equipment Planner
GeoProfessional Innovation	Geotechnical Engineering Services and Construction Materials Testing & Inspection Services
CBRE|Heery	Commissioning Agent
OpenSquare	Furniture Vendor
Bouten Construction	General Contractor as Construction Manager

II. PROGRESS:

A. Contracts – The following is a status of professional services agreements:
   a. Agreements, contracts and/or amendments *executed this period*:
      i. Bouten Construction, Contract for Construction Management services (A133 and A201) and the Guaranteed Maximum Price Amendment ("MACC").
   b. Agreements, contracts and/or amendments *in process this period*:
      i. None.

B. Site Development and Coordination
   a. Sunnyside Valley Irrigation District (SVID) – The project team continues its coordination efforts with SVID to relocate the existing irrigation overflow channel so that it is underground and routed along the western boundary of PMH's property. NV5 and PMH have engaged Rogers Surveying to stake the existing utilities, so that SVID can plan a feasible route. The final route will need to be approved by the US Bureau of Reclamation, so NV5 is gathering the data on what this process entails. In the event the USBR process is too lengthy, the contingency plan would be to run the channel underground in the ditch's current routing through the middle of PMH's property which would maintain the existing easement.

C. Design – Building
   a. bcDG has being working to resolve any remaining permit comments, which includes drawing revisions.
   b. bcDG will issue a final "conformed set" of drawings once all permitting items have been resolved. This work is anticipated to be complete before the start of construction.

D. Permitting
   a. State DOH Plan Review
      i. DoH reviewed the 100% Construction Documents and distributed their comments to the team on April 4, some of which cannot be resolved until final inspections are complete after construction. The design team issued comment responses to the

DoH on June 30, 2022 and continues to follow up to reach a resolution. Matthew Campbell was the lead representative from the DoH on this project, but he has left the Department and was replaced by Kevin Scarlett. The team is working to manage this change and minimize any risk to the current review process. The DoH did assure PMH, however, that their review process should not preclude the Team from breaking ground on the project. All comments must be resolved prior to receiving a license to operate as a healthcare facility.

ii. The State Department of Health granted concurrence for an excavation and foundation permit on October 18, 2022. The City of Prosser will process this permit within the coming days. USDA requires a full concurrence (A2BC) from the Dept of Health prior to granting their concurrence for construction, though, so PMH may not issue any notice to proceed to Bouten ahead of A2BC – despite having the excavation and foundation permit. Primarily, this is because any work completed by Bouten ahead of USDA concurrence would be at PMH's financial risk, as USDA would not commit any funds for these efforts prior to A2BC.

iii. The Department admits that they are short staffed and that they are doing their best to meet an unprecedented demand for new hospitals within the state. The project team is concerned that the Department will continue to move slowly in its review process, but nevertheless the team continues to push for timely response to submitted content.

iv. The team met with the Dept of Health on October 18 and 19, 2022 to review the project and will work to resolve any comments in a timely manner.

b. City

i. On April 20, the City building inspector indicated that they would issue a building permit once DoH (see item (II.D.b.), above) issued their concurrence for construction. The City should provide an excavation and foundation permit as noted in item (D.a.ii.), above.

E. USDA Approval

a. USDA has previously indicated that they need the Washington State Department of Health's A2BC prior to issuing their concurrence for construction. The project team is in discussions to determine if there is any leeway in having obtained the foundation permit as noted above.

F. Pre-Construction

a. Bouten Construction is working on the procurement of long-lead items, such as the new building's air handling units (Roof Top Units, or RTUs), so as to minimize their impact to the overall duration of construction, and to avoid potential future price escalation.

b. Bouten is awaiting Notice to Proceed with construction from PMH prior to commencing any work on site. This will not be issued until USDA has given their concurrence for construction, as noted in item (E.) above.

G. Operations / Activation

a. The project team intends to reconvene monthly operations meetings later in 2022. The meetings are intended to plan and strategize for the operational shift that will occur when PMH moves from their existing facility to the new facility in 2024.

b. NV5 and PMH are working on a structure and objectives for these operations meetings prior to commencing the meeting cadence.

III. PROCUREMENT:

A. Upcoming project team members to procure include:

a. Art Consultant, 2023.

b. Signage Design and Fabrication vendor, 2023.

Prosser Memorial Health

NV5

IV. SCHEDULE:

See 4-month look ahead schedule, attached herewith.

A. Washington State Department of Health Review – Ongoing thru October 2022
B. USDA Contracts and Design Review – Ongoing thru October 2022
C. Notice to Proceed (NTP) with Construction – October 2022

V. BUDGET

A. NV5 continues to update the master project budget subsequent to contract approvals and invoicing. It remains unchanged from the version shared with the board at the special meeting on September 8.

VI. PROJECT CHALLENGES / RISKS:

A. **USDA** – As noted in previous reports, Gary Hicks Financial and Health Facilities Planning & Development are providing guidance to the project team for the USDA application process. The project is currently in contract review and design review with local and regional USDA representatives, which is a necessary step in order for USDA to provide final funding approval and concurrence for construction. The USDA will likely need 2 – 3 weeks to review all final documents once they are submitted, the foremost being the A2BC from the Dept of Health.

B. **Construction Cost(s)** – As noted in previous reports, the project team continues to experience volatile cost variability and increases in the market for materials and labor. The team has mitigated this by facilitating a MACC / GMP which generally locks in pricing. Any changes to project scope or duration will be subject to additional cost volatility exposure.

C. **Traffic Study** – The City of Prosser indicated that per their development regulations PMH may be required to improve Gap Road in the immediate vicinity of the property in order to accommodate future traffic loads. The extents and scale of the improvements were determined by the outcomes of the City's and PMH's traffic studies. On behalf of PMH, the Project Team continues to advocate that any road improvements due to the Hospital construction, and therefore paid for by the project, should be minimal. Perkins Coie is reviewing the matter and will continue to advise PMH. In addition, the City indicated on May 2, 2022 that PMH will need to comply with WSDOT's requirement that an Intersection Control Evaluation (ICE) study be completed. bcDG is leading this effort with their subconsultant, Transpo Group. The study is complete and as of July 26, 2022, it is with WSDOT for approval, which could take 4 months or more. The finalized MDNS incorporates the ICE as a requirement for the building to be occupied (Certificate of Occupancy). The team is working to minimize any improvement requirements identified through the MDNS and ICE processes.

D. **State Department of Health Review** – The Washington State Department of Health, as noted in item II.D.b. above, is experiencing staffing issues which is currently hampering our ability to receive final approval for construction. With the departure of two staff members, the Department appears to be short-staffed. The project team is working to understand the Department's timeline for completing their review and is advocating for timely completion. This process is currently the most critical to the project schedule.

VII. NEXT STEPS:

A. Obtain Final Permits and Approvals for Construction (October – November 2022)

VIII. ATTACHMENTS:

A. 4-month look ahead schedule

Prosser Memorial Health
Replacement Hospital

Prosser Memorial Health

4 Month Outlook

OCTOBER 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
25	26	27	28	29	30	01
02	03	04	05	06	07 PROJECT TEAM MEETING; BLDG RESPONDS TO DoH	08
09	10	11	12	13	14 PROJECT TEAM MEETING	15
16	17 BOUTEN INTERNAL SUBCONTRACTOR KICKOFF	18 DoH REVIEW MEETINGS; DoH AUTH FOR EXCAVATION & FOUNDATION PERMIT	19	20 CITY GRANTS EXCAVATION & FOUNDATION PERMIT	21 PROJECT TEAM MEETING	22
23	24 OWNER/ARCHITECT/CONTRACTOR KICKOFF; MOBILIZATION	25 BOARD WORKSESSION	26 TEAM KICKOFF MEETING	27 BOARD MEETING	28 BLDG ISSUES CONFORMED SET	29
30	31	01	02	03	04	05

NOVEMBER 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
30	31	01	02	03	04 PROJECT TEAM MEETING	05
06	07	08	09	10	11 PROJECT TEAM MEETING	12
13	14	15 BOARD WORKSESSION	16 DoH PROVIDES ATRC	17 CITY ISSUES BUILDING PERMIT; BOARD MEETING	18	19
20	21 USDA PROVIDES CONCURRENCE FOR CONSTRUCTION	22	23	24 THANKSGIVING	25	26
27	28 GROUNDBREAKING?? - TBD	29 USDA PRECON MEETING; CONSTRUCTION START (TENTATIVE)	30	01	02	03
04	05	06	07	08	09	10

LEGEND

- IN PERSON MEETING NV5 & BCDG ON SITE UNLESS OTHERWISE NOTED
- ONLINE MEETING
- DELIVERABLE
- PMH MEETING NO ATTENDANCE BY PROJECT TEAM
- HOLIDAY
- FOR BOARD APPROVAL

Prosser Memorial Health
Replacement Hospital

Prosser Memorial Health

4 Month Outlook

DECEMBER 2022

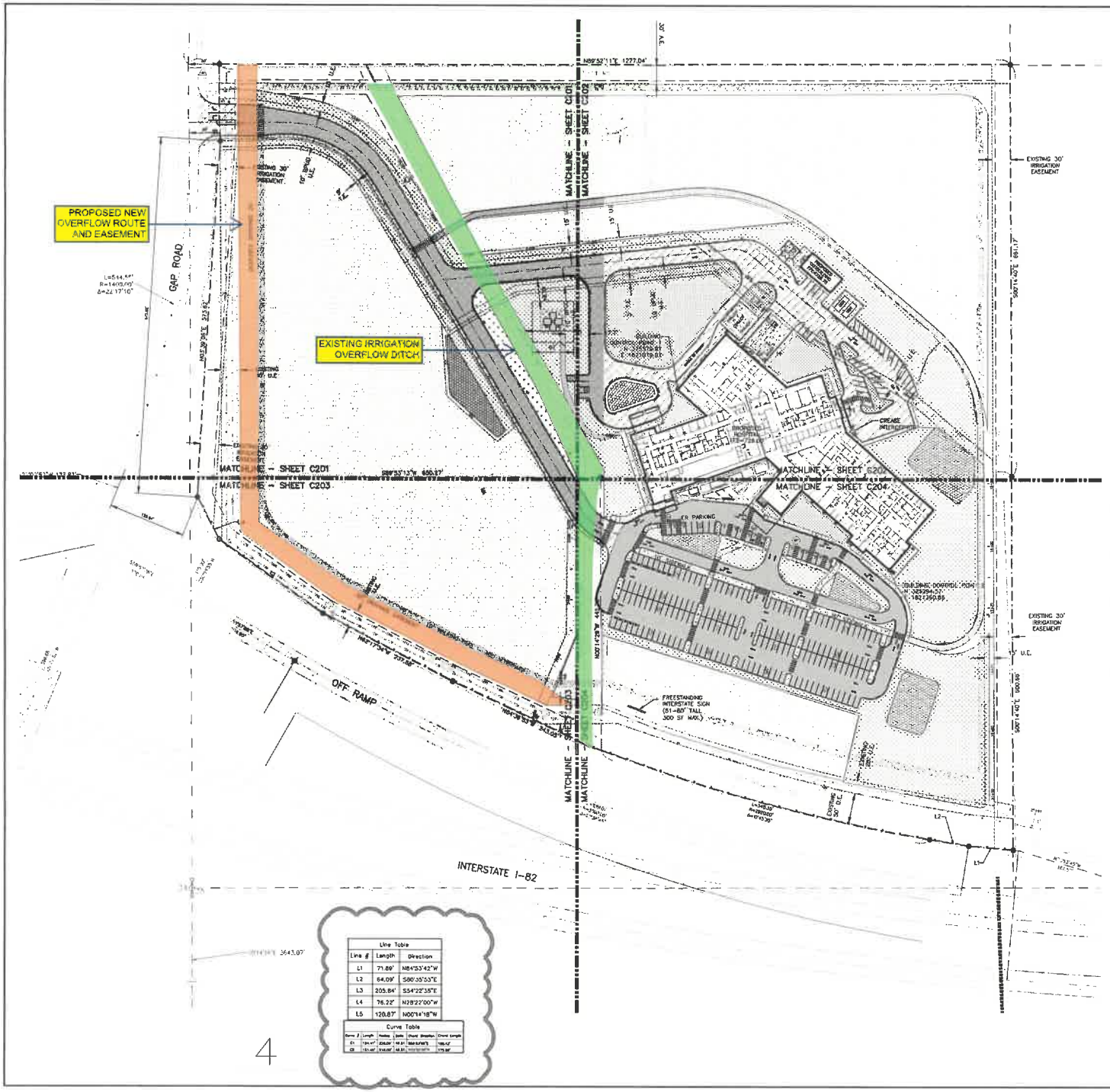
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
27	28	29	30	01	02 PROJECT TEAM MEETING	03
04	05	06	07	08	09 PROJECT TEAM MEETING	10
11	12	13	14	15	16 PROJECT TEAM MEETING	17
18	19	20 BOARD WORKSESSION	21	22 BOARD MEETING	23	24
25	26 CHRISTMAS (OBS)	27	28	29	30	31
01	02	03	04	05	06	07

JANUARY 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
01	02 NEW YEAR'S DAY (OBS)	03	04	05	06 PROJECT TEAM MEETING	07
08	09	10	11	12	13 PROJECT TEAM MEETING	14
15	16	17	18	19	20 PROJECT TEAM MEETING	21
22	23	24 BOARD WORKSESSION	25	26 BOARD MEETING	27	28
29	30	31	01	02	03	04
05	06	07	08	09	10	11

Items to be rescheduled:
NEW FACILITY OPERATIONAL MEETING (NV5-Led)
NEW FACILITY OPERATIONAL MEETING (Merry-Led)

Attachment D



north

60 0 60

SCALE 1" = 60'

LEGEND

PROPERTY LINE
EXISTING CONTOUR
EXISTING FENCE
EXISTING ASPHALT
EXISTING POWER POLE
EXISTING OVERHEAD POWER
EXISTING EASEMENT
EXISTING CENTERLINE
PROPOSED EASEMENT LINE
PROPOSED ACCESS EASEMENT
PROPOSED UTILITY EASEMENT
PROPOSED STANDARD ASPHALT SECTION
PROPOSED HEAVY ASPHALT SECTION
PROPOSED CONCRETE
PROPOSED WALKING TRAIL
PROPOSED SOD
PROPOSED HYDROSEEDING
PROPOSED DRAIN ROCK
AREAS NOT DISTURBED
BUILDING CONTROL POINT
ELECTRIC VEHICLE PARKING
ELECTRIC VEHICLE CHARGING PEDESTAL
PROPOSED CHAIN LINK FENCING
PROPOSED 6' WOOD PRIVACY FENCING
PROPOSED FIRE LANE STRIPING

A.E.
U.E.

ENGINEER:

EXPEDIENT CIVIL ENGINEERING, PLLC
9200 SUITS US DR, STE. B
BELLA VISTA, AR 72714

DEVELOPER:

PROSSER PUBLIC HOSPITAL DISTRICT
723 MEMORIAL STREET
PROSSER, WA 99350

ZONING:

CG - GENERAL COMMERCIAL

CURRENT COUNTY SETBACKS:

FRONT (GAP ROAD FRONTAGE): 25'
SIDE: 25'
REAR: 25'

PROPOSED GENERAL COMMERCIAL ZONING SETBACKS:

FRONT (GAP ROAD FRONTAGE): 0
SIDE: 0'
REAR: 0'

PARKING REQUIREMENTS:

1. INPATIENT ADMISSIONS - 1 SPACE PER 5 HOSPITAL BEDS
   VISITORS - 1 SPACE PER BED
   HOSPITAL STAFF - 1 SPACE PER 2 EMPLOYEES
   OUTPATIENTS - 3 SPACES PER EXAM OR PROCEDURE ROOM
   EMERGENCY PATIENTS - 1 SPACE PER 4 AVERAGE DAILY EMERGENCY VISITS
2. NUMBER OF PARKING SPACES REQUIRED - 171 SPACES
3. NUMBER OF STANDARD PARKING SPACES PROVIDED - 209 SPACES
4. NUMBER OF HANDICAP SPACES PROVIDED - 16 SPACES
5. TOTAL SPACES PROVIDED - 225 SPACES
6. NUMBER OF ELECTRIC VEHICLE SPACES REQUIRED - 10% OR 23 SPACES
7. TOTAL NUMBER OF ELECTRIC VEHICLES PROVIDED - 23 SPACES

bcDESIGNGROUP
11181 W 110th Street Suite 100
Overland Park, KS 66210
913.232.2123

Project Team:

HENDERSON ENGINEERS
8345 LENEXA DR., STE 300, LENEXA, KS 66214
913.712.0658

BOB D. CAMPBELL & COMPANY
4330 BELLEVIEW, KANSAS CITY, MO 64111
816.531.4144

EXPEDIENT CIVIL ENGINEERING, PLLC
9200 SUITS US DR, BELLA VISTA, AR 72714
479.344.0238

Project Title:
PROSSER MEMORIAL HEALTH
REPLACEMENT HOSPITAL - SITE, FOOTINGS, FOUNDATIONS & CONCRETE COLUMNS DOCUMENTS

I-82 and GAP ROAD, PROSSER WA, 99350

Issue Date: 12/13/2021

No.	Issue	Date
1	Addendum 1	1/14/2022
2	Addendum 2	2/4/2022
3	Addendum 3	4/4/2022
4	Addendum 4 - REVERSAL	7/7/2022

SITE PLAN & VEGETATIVE COVERINGS

Drawn by: AL

Project Number: 2008.1

C200

100% CONSTRUCTION DOCUMENTS

Hospitals contend with construction challenges

Economic, supply chain and labor issues have created a trifecta of obstacles for health care construction projects

Image from Getty Images

Like a lot of hospitals, Samaritan Healthcare in Moses Lake, Wash., postponed construction plans when COVID-19 hit in 2020. And when the economy began rebounding, the facility resumed plans for its $157 million facility to replace the original structure built in 1947.

Because the original building was landlocked, the hospital needed a larger, new facility at a new location with room to grow. Samaritan secured funding and finalized designs for the new 160,000-square-foot facility in 2019. After two years of a turbulent economy, Joe Kunkel, a consultant on the project, began updating plans to reflect the current construction market. The news was not good. In spring 2022, inflation hit a 40-year high.

Related Article

Engineering department reports skyrocketing lead times

"Inflation has hit health care construction hard, and that's consistent with what I am seeing with my clients across the board," says Kunkel, owner of The Healthcare Collaborative Group, Portland, Ore. "Supply and workforce shortages were already huge challenges in a rural area like Moses Lake. Inflation intensifies all the other challenges with supply and worker shortages."

Samaritan Healthcare will not break ground this summer as anticipated and is evaluating next steps on the project. But planning is difficult with supply and labor fluctuations and long lead times. Kunkel has been waiting almost two years for an electric generator and a year for an air handler. "It puts you in the position of having to make decisions early, knowing designs may need to change accordingly."

And, at time of this publication, inflation continues to escalate. Kunkel estimates that rates are rising 2% a month.

Theresa Sullivan, chief executive officer at Samaritan Hospital, says this economy is unlike any she's seen in her 30 years in health care. "We have gone through difficulties in health care, but I don't think I've seen so many challenges at the same time in our economy at this level," Sullivan says.

Supply and worker shortages

Nevertheless, construction teams are getting projects done. They are developing workarounds, finding creative ways to cut costs, substituting materials and products, and relying heavily on procurement. Teams are doing as much work in preconstruction as possible. They are ordering early and locking in prices. Teams are doing more work in-house. And more than ever, CEOs, designers, architects, engineers, contractors and laborers are working cohesively to save time, money and steps wherever possible.

But obstacles are significant. Existing workforce shortages exacerbated during COVID-19 haven't leveled off. Hospitals resuming construction post-COVID-19 are creating a high demand for materials. Supply chain interruptions, triggered in part by labor shortages, are causing major delays and cost overruns. And health care is competing with other industries for the same workers and supplies — another cost driver. The rise in fuel costs is driving up the cost of shipping worldwide. As of August, the U.S. rate of inflation was 9.1%.

With so many variables, hospitals are approaching construction and renovations from various angles.

"We are actually seeing a strong rebound in procurement nationwide for the health care sector with more opportunities for larger health care construction projects emerging," says Mark Howell, senior vice president at Skanska USA in Seattle. "At the same time, we are also seeing health care projects being paused and pushed out as organizations work to recover from the pandemic financially."

And whether planning current or long-term projects, hospitals are taking the economic hit today. Projects planned for two or three years down the road are often bid with today's exorbitant prices. Most suppliers are also only guaranteeing prices for shorter windows of time, so there is a need to lock prices and contracts in place now.

Hospitals are turning to experts to navigate the turbulent economic waters, says Dan Squiers, senior vice president and health care market lead at JLL, Orange County, Calif. "Hospitals are reaching out to firms like us to understand how escalating inflation will impact projects," he says. "More are open to prepurchasing materials that have long lead times. They are starting to budget projects that may not happen for a year or more."

According to 2022 data from the Associated General Contractors of America (AGC), the cost of construction materials jumped more than 20% from January 2021 to January 2022. In the last year, the cost of steel has increased 12%, paint has increased 20% and concrete has gone up 20%, according to Dan Haupt, CHFM, CHC, director of the health care division at AG|CM Inc., a construction management and estimating firm in Texas.

"Concrete prices cannot be guaranteed past one week," Haupt says. "Or even daily. Sometimes the price is given on the day of the pour."

Prices are driven by shortages in materials like copper, steel, concrete, lumber, glass, paint and roofing materials. There is a global shortage of computer microchips critical to electronic equipment like HVAC direct digital controls, creating lengthy lead times. "Air conditioning equipment is being delayed up to 14 months with cost increases of 12% to 15%," says Haupt. "Some electrical equipment is sitting on ships up to four months waiting for access to ports."

Even a missing part — no matter how small — can cause big setbacks. Waiting for roof fasteners can hold up an entire project. Previously easy-to-access materials are causing logjams.

"The shortage in electrical equipment is undoubtedly a huge issue, but basic materials are causing delays as well," says Randy Keiser, national health care director at Turner Construction Co. "In one case, we had all the other necessary materials, but we couldn't get the paint. It's the first time I've ever had a job put on hold because of paint! And the problem is not just with manufacturers, it's with their suppliers. Shortages start downstream."

Products made outside of the U.S. are harder to get overall. And rising fuel costs are impacting projects across the board, says Mark Kenneday, director of strategy and market development for health care at Gordian, a Greenville, S.C.-based provider of insights, technology and comprehensive services for all phases of the building life cycle. "It may sound like inflation is an over-the-table kind of index, but it impacts certain commodities more than others. Right now, you can't say there's a 9% inflation rate for oil and gas, because the rate is much higher for those industries," says Kenneday, a past president of the American Society for Health Care Engineering (ASHE).

Labor shortages are a huge problem. Manufacturers are lacking workers to make supplies, driving up prices. Contractors short of skilled trade workers are passing the cost onto hospitals. "My organization is experiencing a 15% to 25% increase in outsourced labor costs, and a 10% to 30% increase in contract renewals," says Michael Huff, CHFM, CHC, CHCPE, CPMM, CRCST, CHL, facility manager at Baylor Scott & White Medical Center, Temple, Texas.

Workforce shortages also fluctuate based on geography, says ASHE President Shadie (Shay) R. Rankhorn Jr., SASHE, CHFM, CHC. "In rural areas, it is harder to find qualified contractors who aren't already booked out for several months to a year or who don't want to leave urban areas for tighter-margin projects in rural areas."

Budget and schedule headaches

Not surprisingly, many health care construction projects are over budget and behind schedule. Haupt has seen preconstruction costs for projects skyrocket in cities like San Antonio, Houston and Dallas. In the past year, the preconstruction estimated cost of $52 million for a 50-bed rural hospital in South Texas has increased by 17%. The $150 million preconstruction cost of a 250-bed acute care hospital increased by 15%, Haupt says.

Even small projects are running up big price tags. A pharmacy project at Pennsylvania Hospital for Penn Medicine in Philadelphia ended up doubling its cost due to supply chain issues and time and space constraints, says Jeff O'Neill, who was senior director of facilities at Pennsylvania Hospital at the time of the project. The renovation was required to comply with USP General Chapter <800>, which regulates the safe handling of hazardous drugs.

The project was designed in 2019 but delayed in 2020 by COVID-19. When construction was set to launch, supplies were short and lead times were long. The wait for the air handlers alone was 12 to 16 weeks. Because of pandemic requirements and the size of the space, only limited trade personnel could work together in the space, extending the schedule and overhead costs. Ultimately, the project ended up costing approximately $4,000 per square foot for a total of $2 million — double the original projected cost.

"With a larger project, a $1 million increase wouldn't be unusual, but increasing a small project by $1 million and such a high percentage increase really gets the attention of the C-suite," O'Neill says. "Obviously, the dollar per square foot figure is alarming, but that is not always an accurate measure. The small area, combined with the higher-cost air systems, skews the dollar-per-square-foot metric."

In the past two years, the University of Maryland Medical System, headquartered in Baltimore, designed three free-standing medical facilities ranging from $30 to $60 million. While the projects were challenging and there were some delays, for the most part they finished on time and within budget, says Darryl Mealy, vice president of construction and facilities planning. But the economy is unpredictable. "We bid a job last year and then rebid it this spring and in about 15 months the cost of the project increased by 13%. That's almost 1% a month," he says.

At Brattleboro Memorial Hospital in Vermont, the team purchased materials for a three-operating room replacement and medical office space before COVID-19 but faced cost hikes down the line, according to Rob Prohaska, CHFM, director of plant services.

"There is only so much buying in advance that can be expected," Prohaska says. "We had large mechanical equipment committed through purchase orders. However, as the project progressed, material costs escalated for materials like ductwork and wire. So, we granted one-time material cost escalations to electrical and mechanical contracts."

Collaboration is crucial

Hospitals in their second year of a turbulent economy are relying on creativity, innovation and hard work to finish projects rife with challenges. Kenneday recommends a collaborative project delivery approach that involves the entire construction team in planning from day one. The one-team, one-contract approach helps to avoid changes — and cost overruns — down the road.

Big-picture approach

Amid skyrocketing inflation and post-COVID-19 setbacks, health care leaders are cautious about predicting the future. But they believe construction demand will not taper off anytime soon.

"We are seeing a high demand for bed tower expansions, cancer centers, women's and children's hospitals, replacement hospitals, ambulatory surgery centers and facility infrastructure upgrades," Howell says. "This is partly driven by pent-up demand for facilities after two-plus years of pandemic impacts and health care clients wanting to build now to lock in prices and get ahead of further cost escalation."

Adds O'Neill: "I've never seen costs go down once they are up, but the market is still hot enough that construction will continue growing in health care."

While this is a challenging time in health care construction, hospitals can learn from their experiences, Keiser says. One major takeaway: hospitals can't expect a supply chain to run perfectly. And as hard as it might be, hospitals need to maintain a big-picture approach to design at a time when day-to-day decisions are so urgent.

"Hospitals we are designing today are much more complex," Keiser says. "We need to build hospitals that are COVID-19-resistant, environmentally sustainable and that meet continually changing regulations. While we have major concerns about getting equipment like air handlers, we still need to keep the bigger picture in mind."

Beth Burmahl *is a freelance writer based in Carbon Cliff, Ill., and a regular* Health Facilities Management *contributor.*

"In a collaborative delivery model, all team members are sitting at the table from the beginning," Kenneday says. "The contractor has a good idea of what they can and can't buy or build, and can tell the design team up front. This way, a contractor won't step in several months into the project and tell the team certain materials aren't available. Or, if an architect suggests a change at a time when materials aren't available or are too costly, it can slow the project down and increase costs. Those situations are avoided through a collaborative project delivery process."

Mike Bruskin, vice president and chief procurement officer at Turner Construction Co., says these unsteady financial times call for cohesive teamwork to avoid the back and forth that can cause serious setbacks.

"We have to work together with trade partners and designers to expedite the review and approval process," says Bruskin. "We recommend shop drawings and submittals be reviewed collaboratively, changes be made at the review table, and returned at least 'Approved as noted' because 'Revise and resubmit' often results in losing our place in the manufacturing line. Bottom line: release early, ensure it is approved and maintain the production slot."

And hospitals are finding ways to cut through lengthy supply lead times, including tracking down supply and material alternatives.

"Clients are asking us to analyze alternative material sources and options to mitigate supply chain and cost impacts to the budgets," Howell says. During construction of the UNC Health surgical tower in Chapel Hill, N.C., the mechanical subcontractor notified the team that under-slab CPVC pipe wouldn't be available in time to reach a scheduled milestone. The Skanska USA team turned to a longtime supplier to provide an alternative source in time to meet the deadline.

Some hospitals are relying on custom manufacturers to get materials quicker. Teams are expanding options for products and materials to work around shortages, Bruskin says. "If a designer is married to just one idea, I guarantee there will be problems," he says.

Preparing for potential delays in advance was central to the recent construction of an outreach clinic by Iowa Specialty Hospitals & Clinics, Clarion, Iowa.

"We planned to have everything on-site before the project started, which really helped us meet our goals," says Steve Simonin, president and CEO. "We did experience delays and shortages with some projects, including doors, but we got as many materials as possible on-site before we started." Webster Clinic, one of 11 outreach clinics in the hospital's system, opened in spring 2022 on time and within budget.

Finally, some teams are improvising solutions on the fly. O'Neill's team installed temporary wood doors while waiting for the specified high-impact doors. On one construction job, Keiser says they brought in a temporary generator to keep the project on schedule until the final products arrived. "We are creating a lot of workarounds to keep projects moving," Keiser says. "We work extremely hard to track down materials. Supply chain issues have not derailed us, they have just made things tougher."

Attachment F

United States Department of Agriculture
Rural Development
Community Programs – State Office Olympia

October 5, 2022

Prosser Public Hospital District, DBA Prosser Mem. Health
Attn: Craig Marks, CEO
723 Memorial Street
Prosser, WA 99350

Reference: Prosser Public Hospital District, DBA Prosser Mem. Health
USDA RD CF Loan $10,000,000
USDA RD CF Emergency Rural Health Care (ERHC) Grant $1,000,000

Dear Mr. Marks:

We are pleased to announce that your request for a USDA RD CF Loan of $10,000,000, and a USDA RD CF Emergency Rural Health Care (ERHC) Grant of $1,000,000 has been approved. We have received official notification from our Finance Office those funds have been set aside for this project.

For your official records, we are providing you with a copy of Form RD 1940-1, "Request for Obligation of Funds". Please continue to comply with the requirements outlined in our Letter of Conditions. Rural Development is pleased for the opportunity to assist your community. If you have any questions, please contact Marti Canatsey, Community Programs Specialist, at (509) 367-8570.

Sincerely,

Koni Reynolds

Koni Reynolds
Community Programs Director

cc: Marti Canatsey, Community Programs Specialist, Yakima Area Office
Attachment (1)
Form RD 1940-1 (Request for Obligations of Funds)

Attachment G

PROSSER PUBLIC HOSPITAL DISTRICT
BENTON COUNTY, WASHINGTON

RESOLUTION NO. 1073

A RESOLUTION of the Board of Commissioners of Prosser Public Hospital District, Benton County, Washington, amending and restating Resolution No. 1062, as previously amended by Resolution No. 1067, providing for the issuance, sale and delivery of one or more series of hospital revenue bond anticipation notes in the aggregate principal amount of not to exceed $80,500,000 to provide funds to finance a new hospital and other medical buildings and improvements; fixing or setting parameters with respect to certain terms and covenants of the note(s); appointing the District's representative to approve the final terms of the note(s); and providing for other related matters.

Adopted: October 27, 2022

Prepared by:
Foster Garvey P.C.
1111 Third Avenue, Suite 3000
Seattle, Washington
(206) 447-4400

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**The cover page, table of contents and section headings of this Resolution are for convenience of reference only, and shall not be used to resolve any question of interpretation of this Resolution.*

PROSSER PUBLIC HOSPITAL DISTRICT
BENTON COUNTY, WASHINGTON

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WHEREAS, Prosser Public Hospital District, Benton County, Washington (the "District") has been duly established covering a portion of Benton County, Washington, for the purpose of owning and operating hospitals and other health care facilities and providing hospital services and other health care services for the residents of the District and other persons pursuant to the provisions of Chapter 70.44 RCW; and

WHEREAS, the District owns and operates Prosser Memorial Health, including Prosser Memorial Hospital and other District facilities (the "District Facilities"); and

WHEREAS, pursuant to chapters 35.41, 39.46 and 70.44 RCW, the District is authorized to conduct proceedings and to issue revenue bonds for the purpose of accomplishing the Project (as defined in Section 1 of this Resolution); and

WHEREAS, USDA (as defined in Section 1 of this Resolution) has provided the District with a Letter of Conditions-Community Facilities Program dated September 2, 2021, as amended on March 29, 2022, and on September 27, 2022, offering to make loans to the District, evidenced by nine hospital revenue bonds in the maximum principal amounts of $9,975,000, $8,975,000, $8,520,000, $7,515,000, $9,515,000, $9,000,000, $4,000,000, $7,000,000 and $3,000,000 and by two limited tax general obligation bonds in the maximum principal amounts of $7,975,000 and $5,025,000 to pay a portion of the costs of carrying out the Project (as defined in Section 1 of this Resolution). Chapter 70.44.110 RCW authorizes public hospital districts to issue short-term obligations in anticipation of the receipt of bond proceeds; and

WHEREAS, USDA (as defined in Section 1 of this Resolution) has also provided the District with an Emergency Health Care Grant Letter of Conditions dated September 27, 2022, offering to provide a grant in the maximum principal amount of $1,000,000 to pay a portion of the costs of carrying out the Project (as defined in Section 1 of this Resolution); and

WHEREAS, it is advisable for the District to construct and equip the Project (as defined in Section 1 of this Resolution and as further described in Section 2 of this Resolution); the Commission has estimated that the total costs of the Project will be approximately $112,048,033;

and it is advisable for the District to provide funds for defraying a portion of the cost of the Project from the proceeds of the sale of one or more hospital revenue bond anticipation notes pending the issuance of the revenue and limited tax general obligation bonds; and

WHEREAS, the Commission (as defined in Section 1 of this Resolution) deems it to be in the best interests of the District to borrow money and issue one or more hospital revenue bond anticipation notes payable from Net Revenue (as defined in Section 1 of this Resolution) pending the issuance of the revenue and limited tax general obligation bonds under the terms set forth in this Resolution; NOW, THEREFORE,

BE IT RESOLVED BY THE COMMISSION OF PROSSER PUBLIC HOSPITAL DISTRICT, BENTON COUNTY, WASHINGTON, as follows:

Section 1. Definitions. As used in this Resolution, the following capitalized terms shall have the following meanings:

"*Annual Debt Service*" means, for any Fiscal Year, all amounts required to be paid in respect of interest on and principal of the Revenue Note and all other long-term debt secured by a pledge of the Net Revenue of the District (excluding interest payments paid from capitalized interest deposited in the Interest Account and principal payments paid from proceeds of the Revenue Bonds and the LTGO Bonds or other obligations issued by the District).

"*Authorized Denomination*" means $0.01 and any integral multiple thereof.

"*Chief Executive Officer*" means the Chief Executive Officer of the District or such other officer of the District who may in the future perform the duties of that office, if any.

"*Chief Financial Officer*" means the Chief Financial Officer of the District or such other officer of the District who may in the future perform the duties of that office, if any.

"*Code*" means the United States Internal Revenue Code of 1986, as amended, and applicable rules and regulations promulgated thereunder.

"*Commission*" means the Board of Commissioners of the District, acting as the legislative authority of the District, as duly and regularly constituted from time to time.

"*Construction Account*" means the account created by Section 9 of this Resolution for the purpose of paying costs of the Project.

"*Costs of Issuance Subaccount*" means the subaccount of that name created within the Construction Account by Section 12 of this Resolution from which money will be used to pay the costs associated with issuance of the Revenue Note, the equipment lease obligations, the Revenue Bonds and the LTGO Bonds.

"*Coverage Requirement*" means 125% of the Net Income Available for Debt Service divided by the sum of all Annual Debt Service.

"*Days Cash on Hand*" means as of the date of calculation, the District's [unrestricted cash and cash equivalents + marketable securities and investments + board designated cash and investments for capital acquisitions] x 365 / [net operating expenses – depreciation and amortization expense – any other non-cash expenses].

"*Designated Representative*" means the Chief Financial Officer, or the Chief Executive Officer in the absence of the Chief Financial Officer, of the District appointed in Section 4 of this Resolution to serve as the District's designated representative in accordance with RCW 39.46.040(2).

"*District*" means Prosser Public Hospital District, Benton County, Washington, a municipal corporation of the State of Washington duly organized pursuant to the provisions of Chapter 70.44 RCW.

"*District Facilities*" means Prosser Memorial Hospital located in Prosser, Washington, and all other health care facilities now owned or hereafter acquired by the District.

"*Draws*" shall have the meaning given such term in Section 5 of this Resolution.

"*Final Terms*" means the terms and conditions for the sale of the Revenue Note including the principal amount, date or dates, interest rate or rates (or mechanism for determining interest rate or rates), and other terms or covenants.

"*Fiscal Year*" means the fiscal year of the District, as such fiscal year may change, currently, the calendar year.

"*Government Obligations*" has the meaning given in RCW 39.53.010, as now in effect or as may hereafter be amended.

"*Gross Revenue of the District*" means the proceeds of all operating and nonoperating revenues derived by the District at any time from any source, including any proceeds on deposit in any general or special fund maintained by the District, but excluding (i) all grants, donations and trust funds, including investment income earned thereon, which have been specifically restricted to a particular purpose inconsistent with the payment of expenses or debt service on any indebtedness incurred by the District, (ii) income derived from investments irrevocably pledged to the payment of any defeased bonds payable from Gross Revenue of the District, (iii) investment income earned on money in any fund or account created or maintained solely for the purpose of complying with the arbitrage rebate provisions of the Code, and (iv) all proceeds of tax levies, including any investment income earned thereon, all as determined in accordance with generally accepted accounting principles.

"*Hospital Consultant*" means any regionally recognized hospital consultant or consultants or any regionally recognized firm of certified public accountants with experience in the preparation of feasibility studies for use in connection with the financing of hospitals or evaluation of hospital operations selected by the District.

"*Interest Account*" means the account of that name created by Section 12 of this Resolution in the Note Fund from which money will be used to pay the interest on the Revenue Note.

"*Interest Payment Date*" means the first day of each month beginning with the month subsequent to closing of the Revenue Note.

"*Interest Rate*" means the rate or rates as determined by the Designated Representative and agreed to by the Purchaser.

"*Letter of Conditions*" means the letter from USDA to the District dated September 2, 2021, as amended by USDA on March 29, 2022, and on September 27, 2022, in response to the supplemental applications for additional funding submitted by the District to USDA, establishing the conditions under which USDA would loan money to the District to finance the Project and/or to repay the Revenue Note.

"*Liquidity Requirement*" means 60 Days Cash on Hand.

"*LTGO Bonds*" means the taxable limited tax general obligation bonds in one or more series authorized to be issued by Section 3 of this Resolution.

"*Maturity Date*" means December 1, 2024, or such other date as determined by the Designated Representative and agreed to by the Purchaser. The Maturity Date may be extended by the Registered Owner upon a request by the District at least three months prior to the original Maturity Date.

"*Net Income Available for Debt Service*" means:

(i) The excess of the operating and nonoperating revenue derived by the District from any source over all expenses and other proper charges incurred by the District plus: interest expenses on all indebtedness of the District; amortization expense of the District; and depreciation expense of the District; and less: proceeds of tax levies allocated to pay debt service on general obligation debt and all grants, donations, and trust funds, including investment income earned thereon, which have been specifically restricted to a particular purpose inconsistent with the payment of Operating and Maintenance Expenses; income derived from investments irrevocably pledged to the payment of any defeased bonds payable from Gross Revenue of the District; and investment income earned on money in any fund or account created or maintained solely for the purpose of complying with the arbitrage rebate provisions of the Code.

(ii) For purposes of paragraph (i), above, such calculation shall be made in accordance with generally accepted accounting principles and shall exclude: profits or losses resulting from the sale or other disposition, not in the ordinary course of business, of investments or fixed or capital assets; profits or losses resulting from the early extinguishment of debt; the net proceeds of insurance (other than business interruption insurance); and other extraordinary items.

"*Net Revenue*" means the Gross Revenue of the District less Operating and Maintenance Expenses incurred by the District.

"*Note Fund*" means the Revenue Note Fund, 2022 created by Section 12 of this Resolution for the purpose of paying the principal of and interest on the Revenue Note.

"*Note Purchase Offer*" means the final offer to purchase the Revenue Note from the Purchaser, setting forth certain terms and conditions of the issuance, sale and delivery of the Revenue Note, which offer is authorized to be accepted or ratified by the Designated Representative on behalf of the District, if consistent with this Resolution.

"*Note Register*" means the books or records maintained by the Note Registrar for the purpose of identifying ownership of the Revenue Note.

"*Note Registrar*" means the Chief Financial Officer, or any successor note registrar selected by the District for the Revenue Note.

"*Operating and Maintenance Expenses*" means all the operating expenses and other proper charges incurred by the District, as applicable; in each case, as determined in accordance with generally accepted accounting principles, but excluding interest, depreciation, and amortization expenses.

"*Permitted Investments*" means any lawful investments for public hospital districts under State law.

"*President*" means the President of the Commission (including the Vice President of the Commission in case of the President's absence or disability), or any presiding officer or titular head of the Commission, or any successor to the functions of the President.

"*Principal Account*" means the account of that name created by Section 12 of this Resolution in the Note Fund from which money will be used to pay the principal of the Revenue Note.

"*Project*" means the construction of a new 25-bed critical access hospital offering clinical and support services, construction of an education center and medical office building to be attached to the hospital, construction of a maintenance support building, construction of a helipad, and other capital purposes, as deemed necessary and advisable by the District. Incidental costs incurred in connection with carrying out and accomplishing the Project, consistent with RCW 39.46.070, may be included as costs of the Project. The Project includes acquisition, construction and installation of all necessary furniture, equipment, apparatus, accessories, fixtures, and appurtenances.

"*Purchaser*" means Western Alliance Business Trust, a Delaware statutory trust, or such other corporation, firm, association, partnership, trust, bank, financial institution or other legal entity or group of entities selected by the Designated Representative to serve as purchaser of the Revenue Note.

"*RCW*" means the Revised Code of Washington.

"*Record Date*" means the Note Registrar's close of business on the 15th day of the month preceding an interest payment date. With respect to prepayment of the Revenue Note prior to its maturity, the Record Date shall mean the Note Registrar's close of business on the date on which the Note Registrar sends the notice of prepayment as required by the Purchaser.

"*Registered Owner*" means, with respect to the Revenue Note, the person in whose name the Revenue Note is registered on the Note Register.

"*Resolution*" means this Resolution, as originally approved by the Commission or as it may from time to time be supplemented, modified or amended.

"*Revenue Bonds*" means the taxable hospital revenue bonds in one or more series authorized to be issued by Section 3 of this Resolution.

"*Revenue Note*" means the Hospital Revenue Bond Anticipation Note, 2022 (Non-Revolving Line of Credit) authorized by this Resolution pursuant to USDA requirements, to pay the costs of the Project pending receipt of Revenue Bond and LTGO Bond proceeds. The Revenue Note may be issued as a single note, or with multiple maturities.

"*Secretary*" means the Secretary of the Commission, or other officer of the District who is the custodian of the records and proceedings of the Commission, or any successor to the functions of the Secretary.

"*State*" means the State of Washington.

"*USDA*" means the United States of America, acting through the United States Department of Agriculture, Community Facilities Program in Rural Housing Service, an agency in Rural Development.

Section 2 The Project. The District hereby specifies, adopts and authorizes a plan for the Prosser Memorial Hospital replacement project and other capital purposes, as deemed necessary and advisable by the District (the "Project"). The total cost of the Project is estimated to be approximately $112,048,033. The Commission may make such changes prior to or during the actual construction of the Project where, in its judgment, it appears advisable.

Section 3 Authorization of the Revenue Bonds and LTGO Bonds. For the purpose of paying a part of the costs of the Project and retiring the Revenue Note, the District shall issue the Revenue Bonds and LTGO Bonds in the maximum aggregate principal amount of $80,500,000. The District irrevocably pledges to take all actions required to issue the Revenue Bonds and LTGO Bonds in compliance with the conditions specified in the Letter of Conditions. The Revenue Bonds shall be special obligations of the District payable from Net Revenue. The Revenue Bonds shall not be general obligations of the District. The District's full faith, credit and resources are not pledged for the payment of the Revenue Bonds. The general indebtedness to be incurred through the issuance of the LTGO Bonds shall be within the limit of up to 3/4% of the value of the taxable property within the District permitted without a vote of the qualified voters therein. The LTGO Bonds shall be general obligations of the District and the full faith, credit and resources of the District are pledged irrevocably for the prompt payment of the principal of and interest on the LTGO Bonds and such pledge shall be enforceable in mandamus against the District.

Section 4. Authorization and Description of the Revenue Note; Appointment of Designated Representative. The Chief Financial Officer, or the Chief Executive Officer in the absence of the Chief Financial Officer, is appointed as the Designated Representative of the District and is authorized and directed to approve the Final Terms of the Revenue Note, with such

additional terms and covenants as the Designated Representative deems advisable, within the following parameters.

(a) The aggregate principal amount of the Revenue Note shall not exceed $80,500,000.

(b) The Revenue Note shall bear interest at a rate or rates per annum as acceptable to the Designated Representative and the Purchaser.

(c) The Revenue Note shall be dated as of its date of delivery to the Purchaser, which date may not be later than December 31, 2023.

(d) Interest will be payable monthly on each Interest Payment Date. Interest will be computed on the basis of a year comprised of 360 days consisting of 12 months with 30 days in a month. Principal will be due and payable on the Maturity Date.

(e) The Revenue Note shall mature on the Maturity Date.

(f) The Revenue Note will be subject to prepayment in whole, or in part, on any date on or after November 1, 2023, at the option of the Designated Representative.

(g) The purchase price for the Revenue Note will be at par. The Purchaser may charge an upfront fee for the Revenue Note and the District will pay directly for expenses incurred by the Purchaser in connection with the preparation and execution of the Revenue Note, including the Purchaser's legal counsel fee in an amount not to exceed $20,000.

The Designated Representative may accept such additional terms, conditions and covenants as the Designated Representative determines are in the best interests of the District, consistent with this Resolution.

In determining the final principal amount, date of the Revenue Note, the Interest Rate, the Designated Representative, in consultation with other District officials, staff and advisors, shall take into account those factors that, in their judgment, will result in the most favorable terms on the Revenue Note to its maturity, including, but not limited to current financial market conditions and current interest rates for obligations comparable to the Revenue Note.

Section 5. Draws on the Revenue Note. Upon satisfaction of applicable requirements of the USDA, the District may make incremental draws on the Revenue Note (the "Draws") on the last business day of each month up to and including such final date, as determined by the Designated Representative and agreed to by the Purchaser and USDA, for the purpose of providing the funds with which to pay costs of the Project. Draws may be in any dollar amount as determined by the Designated Representative and agreed to by the Purchaser and USDA. No Draw may exceed the total amount of the costs to be paid from such Draw, and the proceeds of each Draw shall be used immediately to pay those costs. Draws shall be recorded on the Draw Record attached to the Revenue Note, or in such other form as the Designated Representative and the Registered Owner may agree. The District shall submit to the Registered Owner, with each request for a Draw, a draw certificate as provided by the Purchaser, an outlay report, and written approval from USDA for the release of funds, not less than ten days prior to the requested disbursement

date (unless the Registered Owner consents to honor a Draw request on less than ten days' advance notice).

The Commission has determined it to be in the best interest of the District that the Designated Representative be and hereby are severally authorized to make Draws in the amounts and at the times as such officials may determine hereafter in accordance with the terms and provisions set forth herein.

Each Draw shall bear interest at the Interest Rate and shall accrue interest from the date of that Draw on the principal amount of the Draw outstanding. Interest on the Revenue Note shall be payable on each Interest Payment Date. Principal of the Revenue Note is payable on the Maturity Date or, if earlier, the date of prepayment. If the Revenue Note is not paid when properly presented for payment on the Maturity Date or date of prepayment, the District shall be obligated to pay interest on the Revenue Note at the Interest Rate from and after its maturity or prepayment date until the Revenue Note, both principal and interest, is paid in full or until sufficient money for that payment in full is on deposit in the Note Fund, and the District has given the Registered Owner notice that such money is available to make such delinquent payment.

Section 6. Note Registrar; Registration and Transfer of the Revenue Note.

(a) *Registration of the Revenue Note*. The Revenue Note shall be issued only in registered form as to both principal and interest and the ownership of the Revenue Note shall be recorded on the Note Register.

(b) *Note Registrar; Duties*. The District's Chief Financial Officer is the initial Note Registrar for the Revenue Note. The Note Registrar shall keep, or cause to be kept, sufficient books for the registration and transfer of the Revenue Note, which shall be open to inspection by the District at all times. The Note Registrar is authorized, on behalf of the District, to authenticate and deliver the Revenue Note transferred or exchanged in accordance with the provisions of the Revenue Note and this Resolution, to serve as the District's paying agent for the Revenue Note and to carry out all of the Note Registrar's powers and duties under this Resolution. The Note Registrar shall be responsible for its representations contained in the Note Registrar's Certificate of Authentication on the Revenue Note. The Note Registrar may become an Owner with the same rights it would have if it were not the Note Registrar and, to the extent permitted by law, may act as depository for and permit any of its officers or directors to act as members of, or in any other capacity with respect to, any committee formed to protect the rights of Owners.

(c) *Note Register; Transfer and Exchange*. The Note Register shall contain the name and mailing address of each Registered Owner and the principal amount and number of the Revenue Note held by each Registered Owner. The Revenue Note surrendered to the Note Registrar may be exchanged for a Revenue Note in any Authorized Denomination of an equal aggregate principal amount and of the same series, interest rate and maturity. The Revenue Note may be transferred only if endorsed in the manner provided thereon and surrendered to the Note Registrar. Any exchange or transfer shall be without cost to the Owner or transferee. The Note Registrar shall not be obligated to exchange the Revenue Note or transfer registered ownership during the period between the applicable Record Date and the next upcoming interest payment or prepayment date.

Section 7. Form and Execution of the Revenue Note.

(a) *Form of the Revenue Note; Signatures*. The Revenue Note shall be prepared in a form consistent with the provisions of this Resolution and State law. The Revenue Note shall be signed by the President, or Vice President if the President is unavailable, and Secretary, either or both of whose signatures may be manual or in facsimile. If any officer whose manual or facsimile signature appears on the Revenue Note ceases to be an officer of the District authorized to sign bonds before the Revenue Note bearing their manual or facsimile signature is authenticated by the Note Registrar, or issued or delivered by the District, the Revenue Note nevertheless may be authenticated, issued and delivered and, when authenticated, issued and delivered, shall be as binding on the District as though that person had continued to be an officer of the District authorized to sign bonds. The Revenue Note also may be signed on behalf of the District by any person who, on the actual date of signing of the Revenue Note, is an officer of the District authorized to sign bonds, although they did not hold the required office on its date of issuance.

(b) *Authentication.* Only a Revenue Note bearing a Certificate of Authentication in substantially the following form, manually signed by the Note Registrar, shall be valid or obligatory for any purpose or entitled to the benefits of this Resolution: "Certificate of Authentication. This Note is the fully registered Prosser Public Hospital District, Benton County, Washington, Hospital Revenue Bond Anticipation Note, 2022, described in the Note Resolution." The authorized signing of a Certificate of Authentication shall be conclusive evidence that the Revenue Note so authenticated has been duly executed, authenticated and delivered and is entitled to the benefits of this Resolution.

Section 8. Payment of the Revenue Note. Principal of and interest on the Revenue Note shall be payable in lawful money of the United States of America. Interest on the Revenue Note is payable by electronic transfer on the interest payment date, or by check or draft of the Note Registrar mailed on the interest payment date to the Registered Owner at the address appearing on the Note Register on the Record Date. However, the District is not required to make electronic transfers except pursuant to a request by a Registered Owner in writing received on or prior to the Record Date and at the sole expense of the Registered Owner. Principal of the Revenue Note is payable upon presentation and surrender of the Revenue Note by the Registered Owner to the Note Registrar. The Revenue Note is not subject to acceleration under any circumstances.

Section 9. Construction Account; Disposition of Revenue Note Proceeds; Costs of Issuance Subaccount.

(a) *Construction Account*. A special account to be known and designated as the Construction Account, 2022 (the "Construction Account") is hereby created by the District to be held by U.S. Bank National Association ("U.S. Bank") pursuant to a Blocked Account Control Agreement between the District and U.S. Bank. The principal proceeds received as a result of Draws on the Revenue Note shall be paid into the Construction Account and used to pay costs of the Project. In addition, on or before the date of initial delivery of the Revenue Note to the Purchaser, the District shall deposit into the Construction Account from its own funds an amount to be determined by the Designated Representative in accordance with the Letter of Conditions, which shall be used to pay the interest on the Revenue Note as it comes due. Interest earnings on

Draws and other amounts deposited in the Construction Account, if any, shall be retained in the Construction Account and used to pay costs of the Project.

(b) *Costs of Issuance Subaccount*. A subaccount within the Construction Account to be known and designated as the Costs of Issuance Subaccount is hereby created by the District. The Costs of Issuance Subaccount shall be funded by the District on or before the date of initial delivery of the Revenue Note to the Purchaser in an amount determined by the Designated Representative and not objected to by USDA. All money in the Costs of Issuance Subaccount may be kept in cash or may be invested in Permitted Investments maturing in sufficient amounts at such times as shall be necessary to pay costs associated with the issuance of the Revenue Note, the Revenue Bonds and the LTGO Bonds. All net earnings on money and investments in the Costs of Issuance Subaccount shall be deposited in the Costs of Issuance Subaccount. If the District fails to set aside and pay into the Costs of Issuance Subaccount the amount determined above, the Purchaser may bring an action against the District to compel the setting aside and payment of such money. Upon the repayment of the Revenue Note, all monies remaining in the Costs of Issuance Subaccount will be transferred to a similar account(s) or fund(s) for the payment of costs associated with issuing of the equipment lease obligations, the Revenue Bonds and the LTGO Bonds.

Section 10. Prepayment. The Revenue Note may be prepaid from proceeds of the Revenue Bonds and the LTGO Bonds, or from other legally available funds on any date at par on or after November 1, 2023, at the option of the District on terms acceptable to the Designated Representative.

Section 11. Failure To Pay the Revenue Note. If the principal of the Revenue Note is not paid when the Revenue Note is properly presented at its maturity or date fixed for prepayment, the District shall be obligated to pay interest on the Revenue Note at the same rate provided in the Revenue Note from and after its maturity or date fixed for prepayment until the Revenue Note, both principal and interest, is paid in full or until sufficient money for its payment in full is on deposit in the Note Fund, or in a trust account established to refund or defease the Revenue Note, and the Revenue Note has been called for payment by giving notice of that call to the Registered Owner.

Section 12. Note Fund; Pledge of Revenue Bond and LTGO Bond Proceeds; Payment Source and Lien Position of the Revenue Note.

(a) *Note Fund*. A special fund to be known and designated as the Revenue Note Fund, 2022 (the "Note Fund") is hereby created by the District. The Note Fund shall be divided into a Principal Account and an Interest Account. So long as any Parity Bonds are Outstanding and payable from the Note Fund, the District shall set aside and pay into the respective accounts of the Note Fund out of the Net Revenue, the proceeds of the Revenue Bonds and LTGO Bonds and the Construction Account, fixed amounts without regard to any fixed proportion, namely:

(1) Into the Interest Account such amounts necessary, together with other money on deposit therein, to pay interest next due on the Revenue Note; and

(2) Into the Principal Account such amounts necessary, together with other money on deposit therein, to pay the principal of the Revenue Note on the Maturity Date or date of prepayment.

All money in the Interest Account and the Principal Account may be kept in cash or may be invested in Permitted Investments maturing in sufficient amounts at such times as shall be necessary to pay the principal of and interest on the Revenue Note. All net earnings on money and investments in the accounts in the Note Fund shall be deposited in the Note Fund, except any earnings which are subject to a federal tax or rebate requirement may be withdrawn from the Note Fund for deposit in a separate fund or account for that purpose. If the District fails to set aside and pay into the Note Fund the amounts determined above and as set forth herein, the Registered Owner may bring an action against the District to compel the setting aside and payment of such money.

(b) *Pledge of Revenue Bond and LTGO Bond Proceeds*. The District irrevocably pledges to redeem the Revenue Note on the Maturity Date or date of prepayment from the proceeds of the Revenue Bonds and LTGO Bonds, or from Net Revenue.

(c) *Payment Source and Lien Position*. The Revenue Note is payable solely out of all Net Revenue of the District and the proceeds of the Revenue Bonds and LTGO Bonds, and shall not be a general obligation of the District. All Net Revenue of the District is pledged to the payments required to be made into the Note Fund, and the Revenue Note shall constitute a lien and charge upon such Net Revenue of the District prior and superior to any other charges whatsoever, other than the District's Master Conditional Sales Agreement by and between Banc of America Public Capital Corp and the District, which has a lien on Net Revenue on a parity with the Revenue Note.

Section 13. Tax Covenants.

(a) *Preservation of Tax Exemption for Interest on the Revenue Note*. The District covenants that it will take all actions necessary to prevent interest on the Revenue Note from being included in gross income for federal income tax purposes, and it will neither take any action nor make or permit any use of proceeds of the Revenue Note or other funds of the District treated as proceeds of the Revenue Note that will cause interest on the Revenue Note to be included in gross income for federal income tax purposes. The District also covenants that it will, to the extent the arbitrage rebate requirements of Section 148 of the Code are applicable to the Revenue Note, take all actions necessary to comply (or to be treated as having complied) with those requirements in connection with the Revenue Note.

(b) *Post-Issuance Compliance*. The Chief Financial Officer is authorized and directed to review and update the District's written procedures to facilitate compliance by the District with the covenants in this Resolution and the applicable requirements of the Code that must be satisfied after the date of issuance of the Revenue Note to prevent interest on the Revenue Note from being included in gross income for federal tax purposes.

Section 14. Refunding or Defeasance of the Revenue Note. The District may issue refunding bonds pursuant to State law or use money available from any other lawful source to

carry out a refunding or defeasance plan, which may include (a) paying when due the principal of and interest on any or all of the Revenue Note (the "defeased Revenue Note"); (b) redeeming the defeased Revenue Note prior to its maturity; and (c) paying the costs of the refunding or defeasance. If the District sets aside in a special trust fund or escrow account irrevocably pledged to that prepayment or defeasance (the "trust account"), money and/or Government Obligations maturing at a time or times and bearing interest in amounts sufficient to redeem, refund or defease the Revenue Note in accordance with its terms, then all right and interest of the Owners of the defeased Revenue Note in the covenants of this Resolution and in the funds and accounts obligated to the payment of the defeased Revenue Note shall cease and become void. Thereafter, the Owners of defeased Revenue Note shall have the right to receive payment of the principal of and interest on the defeased Revenue Note solely from the trust account and the defeased Revenue Note shall be deemed no longer outstanding. In that event, the District may apply money remaining in any fund or account (other than the trust account) established for the payment or prepayment of the defeased Revenue Note to any lawful purpose.

Unless otherwise specified by the District in a refunding or defeasance plan, notice of refunding or defeasance shall be given, and selection of the Revenue Note for any partial refunding or defeasance shall be conducted, in the manner prescribed in this Resolution for the prepayment of the Revenue Note.

Section 15. Covenants. The District covenants and agrees with the Registered Owner of the Revenue Note, for so long as the Revenue Note remains outstanding, beginning with the Fiscal Year in which the Revenue Note is issued, to maintain compliance with the Coverage Requirement and Liquidity Requirement. If the financial reports of the District to be provided to the Registered Owner as described in Section 18 (a), disclose that the Coverage Requirement or the Liquidity Requirement is not being met, the District shall retain a Hospital Consultant for the purpose of making recommendations with respect to rates, fees, charges and operations of the District with a view to restoring compliance with the Coverage Requirement or the Liquidity Requirement, as applicable, which such report shall be provided to the Registered Owner. The District, to the extent feasible and lawful, shall follow the reasonable recommendations of such Hospital Consultant. If and so long as the District complies in all material respects with the recommendations of such Hospital Consultant, and so long as Net Income Available for Debt Service is at least equal to Annual Debt Service on all outstanding debt secured by the Net Revenue of the District in any Fiscal Year for which the Hospital Consultant's recommendations are made and any subsequent Fiscal Year for which such recommendations are renewed, the Coverage Requirement and the Liquidity Requirement, as applicable, shall be deemed satisfied, and the failure of the District to comply with this covenant shall not be deemed an event of default under the Revenue Note.

Section 16. Future Debt. The District covenants and agrees that for so long as the Purchaser is the Registered Owner and the Revenue Note is outstanding it will not hereafter issue any additional debt (except refunding revenue obligations that reduce the District's Annual Debt Service and up to $5,000,000 in equipment lease obligations included in the District's plan of finance included in the Letter of Conditions) or other debt or obligations which shall constitute a lien and charge against the Net Revenue prior, on a parity with or subordinate to the lien and charge against the same for payments required to be made for the Revenue Note without the prior written consent of the Purchaser, so long as the Purchaser is the Registered Owner, and USDA.

Section 17. Sale of the Revenue Note. The Designated Representative is authorized to review and accept the Note Purchase Offer on behalf of the District, so long as the terms provided therein are consistent with the terms of this Resolution.

Section 18. Reporting Requirements. For as long as the Revenue Note is outstanding, the District shall provide (a) its audited annual financial reports within nine months after the end of the District's Fiscal Year, (b) its approved annual operating budget within one month of its adoption, (c) its interim financial information on a quarterly basis within 45 days after the end of each fiscal quarter, beginning with the quarter in which the Revenue Note is delivered to the Purchaser, (d) monthly construction progress reports on or around the 15th day of each month, or on such other date(s) as agreed to by the District, the Registered Owner and USDA, and (e) such other information that the Registered Owner may reasonably request from time to time.

Section 19. Defaults and Remedies. In connection with the Revenue Note, if any of the following "Events of Default" occur, the District will work with the Registered Owner to cure such default:

(a) *Events of Default.* The following shall constitute "Events of Default" with respect to the Revenue Note:

(i) If a default is made in the payment of the interest on or principal of the Revenue Note when the same shall become due and payable; or

(ii) If the District defaults in the observance and performance of any other of the covenants, conditions and agreements on the part of the District set forth in this Resolution or any covenants, conditions or agreements on the part of the District, which default continues, and is not cured, for a period of more than 60 days after the Registered Owner has made written demand on the District to cure such failure; or

(iii) If the District files a petition in bankruptcy or is placed in receivership under any state or federal bankruptcy or insolvency law.

(b) *Suits at Law or in Equity.* Upon the happening of an Event of Default and during the continuance thereof, the Registered Owner may take such steps and institute such suits, actions or other proceedings, all as it may deem appropriate for the protection and enforcement of its rights to collect any amounts due and owing to or from the District, or to obtain other appropriate relief, and may enforce the specific performance of any covenant, agreement or condition contained in this Resolution.

Nothing contained in this Section 19 shall, in any event or under any circumstance, be deemed to authorize the acceleration of maturity of principal on the Revenue Note, and the remedy of acceleration is expressly denied to the Registered Owner of the Revenue Note under any circumstances including, without limitation, upon the occurrence and continuance of an Event of Default.

Section 20. Supplemental and Amendatory Resolutions. The District may supplement or amend this Resolution for any one or more of the following purposes without the consent of any Registered Owner of the Revenue Note:

(a) To add covenants and agreements that do not materially adversely affect the interests of a Registered Owner, or to surrender any right or power reserved to or conferred upon the District.

(b) To cure any ambiguities, or to cure, correct or supplement any defective provision contained in this Resolution in a manner that does not materially adversely affect the interest of the Registered Owner of the Revenue Note.

Section 21. Amending and Restating Resolutions Nos. 1062 and 1067. This Resolution hereby amends and restates Resolution No. 1062, as previously amended by Resolution No. 1067, to update the amount of the Revenue Note, update the total cost of the Project and authorize U.S. Bank to hold certain accounts of the District created pursuant to this Resolution.

Section 22. General Authorization and Ratification. The Commission, Chief Executive Officer, Chief Financial Officer and other appropriate officers of the District are severally authorized to take such actions and to execute such documents as in their judgment may be necessary or desirable to carry out the transactions contemplated in connection with this Resolution, and to do everything necessary for the prompt delivery of the Revenue Note to the Purchaser thereof and for the proper application, use and investment of the proceeds of the sale thereof), and all actions heretofore taken in furtherance thereof and not inconsistent with the provisions of this Resolution are hereby ratified and confirmed in all respects. If any one or more of the covenants or agreements provided in this Resolution to be performed on the part of the District shall be declared by any court of competent jurisdiction to be contrary to law, then such covenant or covenants, agreement or agreements, shall be null and void and shall be separable from the remaining covenants and agreements in this Resolution and shall in no way affect the validity of the other provisions of this Resolution or of the Revenue Note.

Section 23. Severability. The provisions of this Resolution are declared to be separate and severable. If a court of competent jurisdiction, all appeals having been exhausted or all appeal periods having run, finds any provision of this Resolution to be invalid or unenforceable as to any person or circumstance, such offending provision shall, if feasible, be deemed to be modified to be within the limits of enforceability or validity. However, if the offending provision cannot be so modified, it shall be null and void with respect to the particular person or circumstance, and all other provisions of this Resolution in all other respects, and the offending provision with respect to all other persons and all other circumstances, shall remain valid and enforceable.

Section 24. Counterparts. This Resolution may be executed in several counterparts each of which shall be regarded as an original (with the same effect as if the signatures thereto and hereto were upon the same document) and all of which shall constitute one and the same document.

Section 25. Effective Date of Resolution. This Resolution shall become effective immediately upon its adoption.

ADOPTED and APPROVED by the Commission of Prosser Public Hospital District, Benton County, Washington, at a regular meeting thereof, notice of which was provide pursuant to law, the 27th day of October, 2022, the following Commissioners being present and voting.

President and Commissioner

Vice President and Commissioner

Commissioner

Commissioner

Commissioner

Commissioner

Secretary and Commissioner

CERTIFICATION

I, the undersigned, Secretary of the Board of Commissioners (the "Commission") of Prosser Public Hospital District, Benton County, Washington (the "District"), hereby certify as follows:

1. The attached copy of Resolution No. 1073 (the "Resolution") is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Commission held on October 27, 2022, as that resolution appears on the minute book of the District; and the Resolution is now in full force and effect.

2. That such meeting was duly convened, held and included an opportunity for public comment, in all respects in accordance with law; due and proper notice of such meeting was given; that a legal quorum was present throughout the meeting; and a majority of the members of the Commission of the District voted in the proper manner for the adoption of the Resolution.

3. That all other requirements and proceedings incident to the proper adoption of the Resolution have been duly fulfilled, carried out and otherwise observed, and that I am authorized to execute this Certificate.

Dated: October 27, 2022.

PROSSER PUBLIC HOSPITAL DISTRICT,
BENTON COUNTY, WASHINGTON

_____

Secretary, Board of Commissioners

Attachment H

DRAFT

Mission, Vision, Values & Standards of Behavior

A S P I R E

Accountability Service Promote Teamwork Integrity Respect Excellence

Prosser Memorial Health

This is how we care.

Our Mission

Prosser Memorial Health will improve the health of our community.

Our Vision

FY 2022-2025
Prosser Memorial Hospital will become one of the top 100 Critical Access Hospitals in the country through the achievement of the following Pillars of Excellence.

Pillars of Excellence

1. Patient Loyalty Pillar: PMH will provide outstanding customer service, aspiring to treat those we serve the way they want to be treated.

GOAL: PMH will achieve a patient satisfaction rate of 95% or higher.

2. Medical Staff Development Pillar: PMH will respond to Medical Staff concerns and needs in a timely manner, pursue initiatives in collaboration with our Medical Staff and ensure the availability of the appropriate providers for those we serve.

GOAL: PMH will achieve and maintain an annual Medical Staff satisfaction rate of 90% or higher.

3. Employee Development Pillar: PMH will encourage and provide for the ongoing development of our employees. We will provide an atmosphere that values our employees and promotes:

- Open communication.
- Competitive wages and benefits.
- Selection and retention of effective, caring personnel.
- Utilization and development of talent throughout the organization.
- On-going education.
- Employee recognition.

GOAL: PMH will achieve and maintain an annual employee satisfaction rate of 90% or higher.

4. Quality Pillar: PMH will develop and maintain a system of continuous improvement which is incorporated into the daily work of every employee and Medical Staff member.

GOAL: Achieve an iVantage score of 49 or higher.

5. Services Pillar: PMH will develop and maintain appropriate facilities, technology and services to meet the needs of those we serve, that includes building a replacement facility.

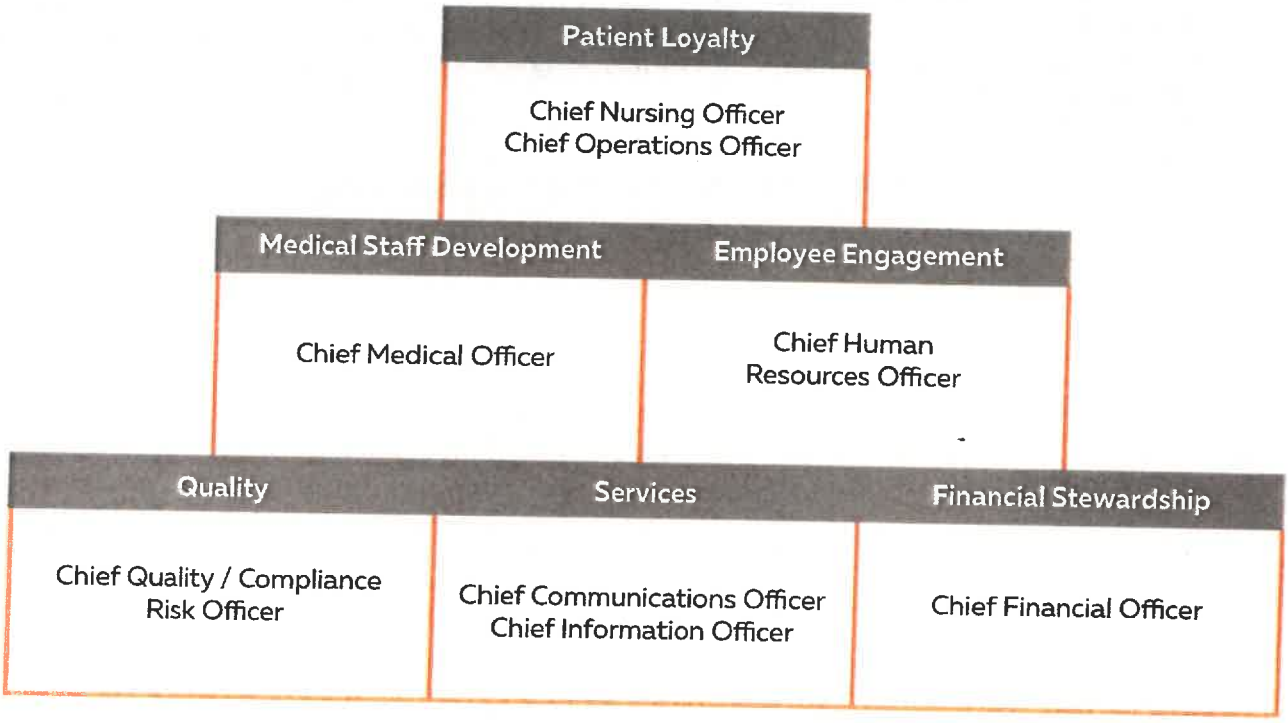
GOAL: PMH will achieve a 50% market share of our greater community for those services we provide.

6. Financial Stewardship Pillar: PMH will continue to strengthen its financial stewardship position to enhance the ability to develop new services, obtain needed technology, modernize facilities, recruit physicians and ultimately ensure long-term viability.

GOAL: PMH will achieve an annual total margin of 6% or more.

Administrative Team

Pillar Champions



Our Values

ASPIRE to soar to a great height.

Accountability:
Take responsibility for our own behavior

Service:
Care enough to exceed the expectations of those we serve

Promote Teamwork:
Work together to achieve common goals

Integrity:
Do the right thing even when no one is watching

Respect:
Respect the inherent value and worth of each person

Excellence:
Exceed the expectations of those we serve

Our Shared Values & Standards of Behavior

Prosser
Memorial Health

Staff and Auxiliary

Prosser Memorial Health has a rich heritage of leadership in our community, consistently offering new and innovative services. While our Mission calls us to deliver compassionate, high-quality, affordable health services to our community, we also strive for excellence in every aspect of the way we care for our patients and their families. When we enhance our service excellence, we will establish a lifelong relationship with our patients and their families, securing our future and the next generation of quality health care.

These standards outline the behaviors necessary to achieve excellence in the way we work together as a team to serve our patients. We have the opportunity to practice excellence in every interaction we have with a patient, a family member, physician, visitor, or each other. In order to achieve and sustain service excellence, we request that each staff member read and incorporate these behaviors and follow these standards in their daily work lives. These expectations will be added to each job application and description as well as Medical Staff, Board member and auxiliary applications. All team members will be accountable for their customer service attitude and actions. Creating a workplace where everyone is willing to go the extra mile to show kindness and meet the needs of our patients, family members, physicians, and co-workers will be greatly beneficial to everyone.

Craig J. Marks, FACHE
CEO
Prosser Memorial Health

Introduction

Prosser Memorial Health strives to fulfill its Mission by expecting all staff to embrace our values and adopt our Standards of Behavior.

We believe each and every department and individual adds value to our organization and is accountable for its success.

We need to rejoice in the accomplishments of our coworkers, always recognizing them for a job well done.

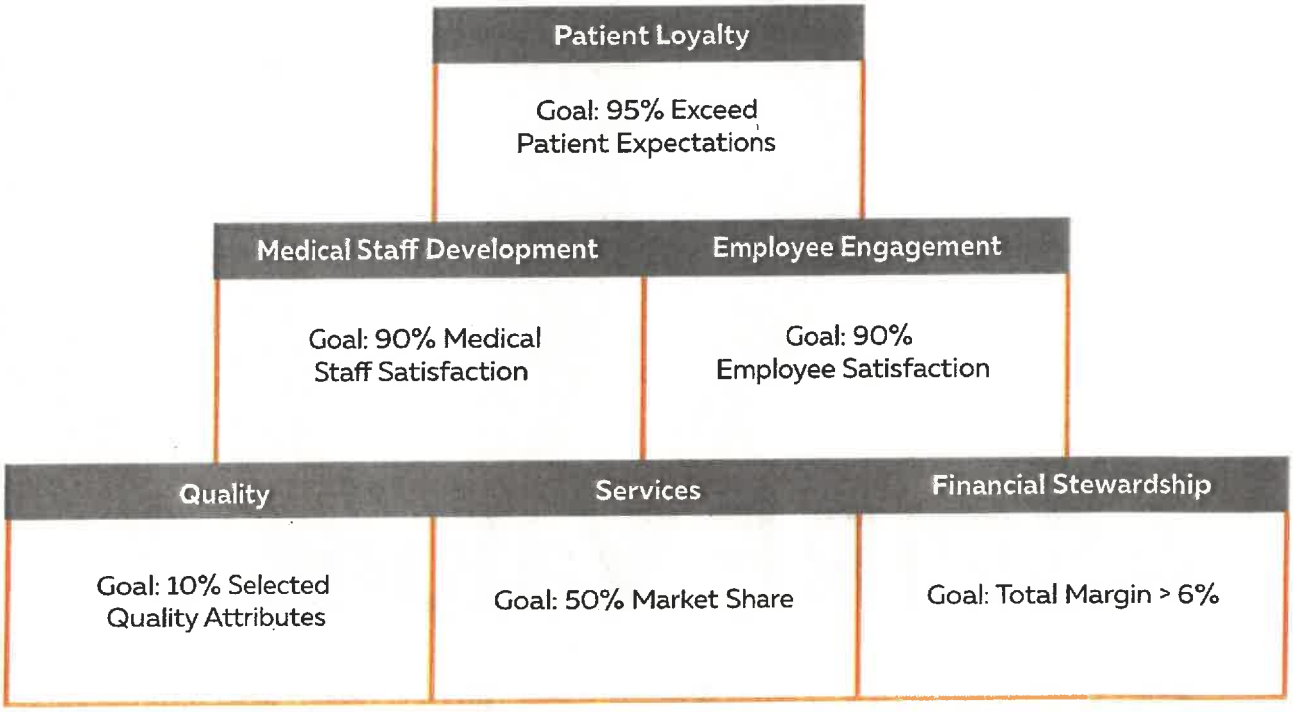
We believe that by consistently living and following these Values and Behaviors we will be proud of and take ownership with PMH, making our work enjoyable while exceeding the expectations of those we serve.

Our Values are to ASPIRE to soar to a great height.

A **Accountability:** Take responsibility for our own behavior
S **Service:** Care enough to exceed the expectations of those we serve
P **Promote Teamwork:** Work together to achieve common goals
I **Integrity:** Do the right thing even when no one is watching
R **Respect:** Respect the inherent value and worth of each person
E **Excellence:** Exceed the expectations of those we serve

Vision of Success FY2022 to 2025

We will become one of the top 100 Critical Access Hospitals in the country by living our ASPIRE Values and the achievement of the below Pillars of Excellence.



ASPIRE Values & Standards of Behavior

Prosser
Memorial Health

We Value ACCOUNTABILITY:

Take responsibility for our own behavior.

I WILL:

- Set a good example, project self-confidence, and not allow personal issues to interfere with the quality of my work.
- Anticipate and correct problems before they become complaints.
- Apologize to those we serve for problems or delays, do my best to make it right, initiate service recovery as warranted, and thank them for their understanding and patience.
- Seek out available education opportunities to improve my personal and professional skills so I can participate, learn, and grow.
- Avoid blaming others when problems occur by becoming part of the solution, and take responsibility for my own behavior.
- Take initiative to hold myself and others accountable for creating a positive environment.
- Take pride in what I do and my professional appearance, language and behavior.
- Own and resolve guest problems.

We Value SERVICE:

Care enough to exceed the expectations of those we serve.

I WILL:

- Immediately acknowledge everyone I meet, smile and, if possible, address them by name.
- Assist and/or escort those we serve to their destination or introduce them to someone who can help them.
- Contribute to the creation of a clean, safe environment for those we serve.
- Answer the phone with a smile in my voice and identify myself by name and department.
- Be professional, providing help in a friendly and compassionate manner.
- Seek out opportunities to promote a positive experience for our customers.
- Thank customers for choosing PMH.

A S P I R E

Accountability Service Promote Teamwork Integrity Respect Excellence

We Promote TEAMWORK

Work together to accomplish great things.

I WILL:

- Focus more on "we" and less on "me".
- Be open to new ideas and embrace change.
- Speak favorably about PMH, all departments, and coworkers, and go out of my way to make my team-members look good.
- Welcome new employees.
- Recognize and praise achievement.
- Communicate effectively.
- Have a positive, encouraging attitude when encountering co-workers.
- Seek partners in the community with common values and goals.

Accountability Service Promote Teamwork Integrity Respect Excellence

We Value INTEGRITY:

Do the right thing even when no one is watching.

I WILL:

- Do the right thing even when no one is watching.
- Be honest, trustworthy, responsible, and dependable.
- Be considerate of how I am perceived in my body language, eye contact, verbal tone, and writing style, realizing that this perception affects others and the outcome I am trying to achieve.
- Take ownership in positively representing PMH in and out of the workplace.
- Follow through with what I say.
- Take pride in what I do.
- Promote mutual respect and build community within PMH.
- Seek input from those impacted by decisions.
- Always wear my name badge.

A S P I R E

Accountability Service Promote Teamwork Integrity Respect Excellence

We Value RESPECT:

Treat others with Dignity.

I WILL:

- Protect everyone's privacy and confidentiality.
- Be aware and considerate of generational, physical, religious, financial and cultural diversity.
- Praise in public, coach in private.
- Recognize each person, situation and idea as significant.
- Not engage in gossip, inappropriate behavior or language.
- Treat others as they want to be treated.
- Provide services to the underserved and encourage others to do
- the same.
- Anticipate and provide for the needs of those we serve.
- Provide fairness and justice in internal policies and practices and external relationships.

Accountability Service Promote Teamwork Integrity Respect Excellence

We Value EXCELLENCE:

Exceed the expectations of those we serve.

I WILL:

- Participate in continuous improvement, recognizing that everything I do is a process that can be improved.
- Contribute to the creation of a just culture and not accept excuses, mediocrity, and carelessness.
- Do my best and remain positive.
- Use my time effectively.
- Anticipate and provide for the needs of those we serve.
- Provide compassionate and personalized service in a timely manner, and build strong relationships that create PMH guests for life.
- Strive to "raise the bar" in exceeding expectations.
- Promote effective use of resources.
- Ensure accountability for the development and use of resources in the present and their availability for the future.
- Always begin each day and each activity with quality in mind.
- Begin each customer interaction by considering their expectations and going beyond their expectations by providing care with compassion, integrity, respect and stewardship.

A S P I R E

Accountability Service Promote Teamwork Integrity Respect Excellence

Commitment to ASPIRE

Exceed the expectations of those we serve.

These Values and Standards of Behavior reflect the level of professionalism that we will demonstrate in providing services to our community.

These Values and Standards of Behavior have been developed by employees of Prosser Memorial Health to establish specific behaviors that all employees, medical staff, and volunteers are expected to model.

We believe that by adopting these Values and Standards of Behavior, those we serve will receive outstanding service, making PMH one of the finest hospitals in Washington.

I have read, understand, and agree to comply with the Prosser Memorial Health Values and Standards of Behavior.

_____	_____
Signature	Date
_____	_____
Print Name	Department

IX. Strategic Plan Worksheets

Review

FISCAL YEAR 2021-2024

Prosser Memorial Health

It is time to review our Mission, Vision, Values, and Standards of Behavior.
Please provide any input on changes you would like to see made in these areas.

Mission

Prosser Memorial Health will improve the health of our community.

Vision

Prosser Memorial Hospital will become one of the top 100 Critical Access Hospitals in the country through the achievement of the following Pillars of Excellence.

Values

ASPIRE to soar to a great height. (Accountability, Service, Care, Promote Teamwork, Integrity, Respect, Excellence)

Standards of Behavior

Our Vision

FISCAL YEAR 2021-2024

Prosser Memorial Health

To become one of the top 100 Critical Access Hospital in the country by achieving the goals set in our Six Pillars of Excellence.

1. Patient Loyalty Pillar: PMH will provide outstanding customer service, aspiring to treat those we serve the way they want to be treated.

GOAL: PMH will achieve a patient satisfaction rate of 95% or higher.

1. _____

_____

2. _____

_____

3. _____

_____

2. Medical Staff Development Pillar: PMH will respond to Medical Staff concerns and needs in a timely manner, pursue initiatives in collaboration with our Medical Staff and ensure the availability of the appropriate providers for those we serve.

GOAL: PMH will achieve and maintain an annual Medical Staff satisfaction rate of 90% or higher.

1. _____

_____

2. _____

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3. _____

_____

3. Employee Development Pillar: PMH will encourage and provide for the ongoing development of our employees. We will provide an atmosphere that values our employees and promotes:

- Open communication.
- Competitive wages and benefits.
- Selection and retention of effective, caring personnel.
- Utilization and development of talent throughout the organization.
- On-going education.
- Employee recognition.

GOAL: PMH will achieve and maintain an annual employee satisfaction rate of 90% or higher.

1. _____

_____

2. _____

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3. _____

_____

4. Quality Pillar: PMH will develop and maintain a system of continuous improvement which is incorporated into the daily work of every employee and Medical Staff member.

GOAL: Achieve an iVantage score of 49 or higher.

1. _____

_____

2. _____

_____

3. _____

_____

5. Services Pillar: PMH will develop and maintain appropriate facilities, technology and services to meet the needs of those we serve, that includes building a replacement facility.

GOAL: PMH will achieve a 50% market share of our greater community for those services we provide.

1. _____

_____

2. _____

_____

3. _____

_____

6. Financial Stewardship Pillar: PMH will continue to strengthen its financial stewardship position to enhance the ability to develop new services, obtain needed technology, modernize facilities, recruit physicians and ultimately ensure long-term viability.

GOAL: PMH will achieve an annual total margin of 6% or more.

1. _____

_____

2. _____

_____

3. _____

_____

Attachment J

Prosser Memorial Health

Patient Loyalty Summary Report: "Would Recommend" Mean

Data pulled: 10.17.22 mf

Survey Group	2022 Goal	Sept 2022	# Of Surveys	YTD 2022	# Of Surveys	% Rank	Patient Survey Comments
Emergency Depart.	>84.0%	91.32	31	85.52	240	65th	"Doctor was knowledgeable and had a great personality. I felt as if he was listening and was able to give me great advice." "The three nurses who attended me, two female and one male,...made me feel at ease and comforted."
HCAHPS-Inpatient	>93.1%	90.28	53	91.17	184	77th	"The food was good!" "The room was always clean and the personnel very kind."
Acute Care	>91.8%	97.22	9	89.54	98	64th	"Every nurse was the greatest. They showed that they gave their best for the patient and his wife. Thank you!" "All the doctors I met were wonderful. They worked hard to care for my husband."
Family Birthplace	>93.6%	100	6	94.67	62	88th	"Dr. Derick Weaver did an outstanding job." "Very attentive and friendly! Was able to have Madi deliver baby #2, just like she was there for baby #1. Appreciate all the nurses that helped and came to my room."
Out-Patient Surgery	>96.6%	95.19	26	95.6	125	20th	"The staff was great – All aspects professional and yet friendly." "Very good medical team. Thank you for excellent care!"
Clinic Network	>91.0%	92.54	57	90.98	640	12th	"Amazing teamwork with all staff very communicative with each other!" "Fantastic, everyone was professional friendly and supper helpful. I really appreciate you all so much. Thank you."
Out-Patient Services	>94.1%	92.13	54	94.56	418	50th	"I have never had a bad experience at this hospital!" "I have lab work done every month. I am always pleased with the way staff treats me."

	2022 Goal	YTD Score	Equation				*Composite score based on 2020 departmental revenue contributions
Composite Score	92.9%	**92.7%**	ED	0.13x	85.52	11.12	ED: 13%
			IP	0.16x	91.17	14.59	IP: 16% (Includes AC, OB)
			OR	0.23x	95.6	21.99	OP-Surgery: 23%
			Clinics	0.11x	90.98	10.01	Clinic: 11%
			OP	0.37x	94.56	34.99	Outpatient: 37%

Press Ganey_Facility Scorecard_(Specific service line)_Mean (Last month or YTD)_overall assessment Likelihood of Recommending_

Merry B Fuller, MSN, RN, FACHE CPHQ, CPHRM
Chief Nursing Officer/Chief Operating Officer
PROSSER MEMORIAL HEALTH
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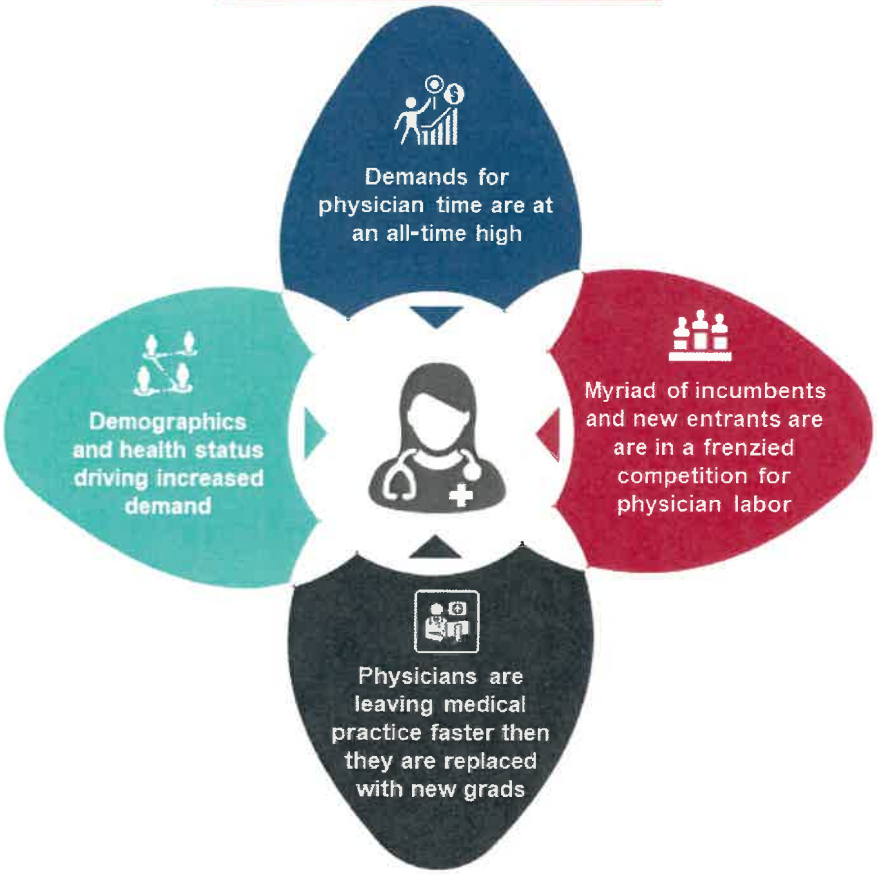
o: (509) 788 6038 | c: (509) 388-4334 | f: (509) 788 6013
mfuller@prosserhealth.org | www.prosserhealth.org

Prosser
Memorial Health

Trustee Insights

DOCTOR SHORTAGES



The effects of physician shortages are being compounded as competition for employing physicians has escalated to unprecedented levels. Health systems are competing with private equity investors, payers and new entrants to keep or attract new talent. Physicians are retiring or leaving the profession faster than they can be replaced with new providers. Increasing demands on physician time and a desire for work/life balance are creating a difficult landscape for physician employment. Organizations must act now to address the issues or risk being left with a shortage of doctors.

Where Have All the Doctors Gone?

Health Systems Must Learn to Better Compete for Physician Talent to Confront an Existential Threat

BY CHRIS SMEDLEY, SEMYON SHTULBERG AND ANDY ZISKIND

The COVID-19 pandemic painfully magnified the need for physicians, but the reality is that demand has been outpacing supply for many years. Now, compounding factors are exacerbating this shortage and intensifying the competition for physician talent to unprecedented levels.

A growing U.S. population is also becoming older and sicker. A majority of adults suffer from chronic illnesses, and more than a quarter are living with two or more comorbidities. Baby Boomers have entered the stage of life where they need more care. In response to these trends, CMS and CMMI are expanding opportunities for providers to take financial risk for the growing MA population by offering expanded reimbursement models, making physicians even more valuable and raising the stakes for retention of high-quality physicians and practices. The anticipated insolvency of the Medicare trust further accentuates the shift toward risk.

On the bright side, due to the Affordable Care Act and near record low unemployment, the past decade has seen an additional 40 million people obtain either private or public health insurance. The industry has responded by creating many new points of access in retail, digital and virtual settings. This too, has contributed to the need for more physicians.

The last several years have seen the acceleration of a steep change in the structure and alignment of

the U.S. health care system and providers. The impacts are being experienced by a variety of stakeholders – health systems, providers, owners, investors, payers, patients and many others.

Indeed, nearly everyone has witnessed or experienced some of the symptoms of these changes. Health care job turnover is at record levels, with many people changing roles, employers or leaving the field altogether.

Demand for Physicians is increasing...

Causes of increased demand

10.6%
U.S. population is projected to grow by 10.6% between 2019-34

50%
Over 50% of U.S. adults have at least 1 chronic condition...

27%
...over 27% of U.S. adults have multiple chronic conditions

42%
increase in insured Americans between 2011 and 2020

3,834
Medicare Advantage Plans available to Americans in 2022, more than in any other year

Burnout is reported by as many as half of physicians who are part of Generation X. Other cohorts find themselves less impacted by burnout but are still troubled by the commitment and sacrifices required by some aspects of their jobs. It is not unusual today to hear some health care providers lament the fact that they find the practice of medicine no longer fun or fulfilling. As many as four out of five physicians report no time to see additional patients or take on new duties. Health system revenue diversification strategies – which often require alternative care models and adoption of digital technologies – have increased the complexity of the physician role.

When looking at these symptoms, it is important to dig deeper into the underlying causes. Reports of physicians considering early retirement, complaining of burnout, feeling overwhelmed by competing priorities or failing to obtain a coveted medical school spot are not just anecdotal reflections. Data indicates that physicians are working fewer hours and spending nearly half of their office time at their desks rather than examination rooms. Through experience, we know that the corporate demands of health care are increasingly pulling physicians from the bedside to the boardroom, and the current rate of new graduates is not nearly enough to fill the spots of those retiring or leaving the profession.

Providers today have more employment options than ever before. While health systems are growing in scope of services and geographic reach, corporate, private equity and venture capital ownership of practices has increased dramatically. Non-traditional venues such as urgent care facilities, on-site clinics and retail clinics are rapidly expanding nationwide, with both new entrants (e.g., One Medical, Oak Street Health, VillageMD) and major corporations (e.g., Apple, Amazon, Walmart) all opening clinics of their own.

... while supply of physicians is growing slower than demand...

Contributing Factors to lower supply

> 40%
of physicians will be 65 years old or older within 10 years

78%
of physicians sometimes, often or always experience burnout

80%
of physicians report no time to see additional patients, take on new duties

Root causes of lower supply

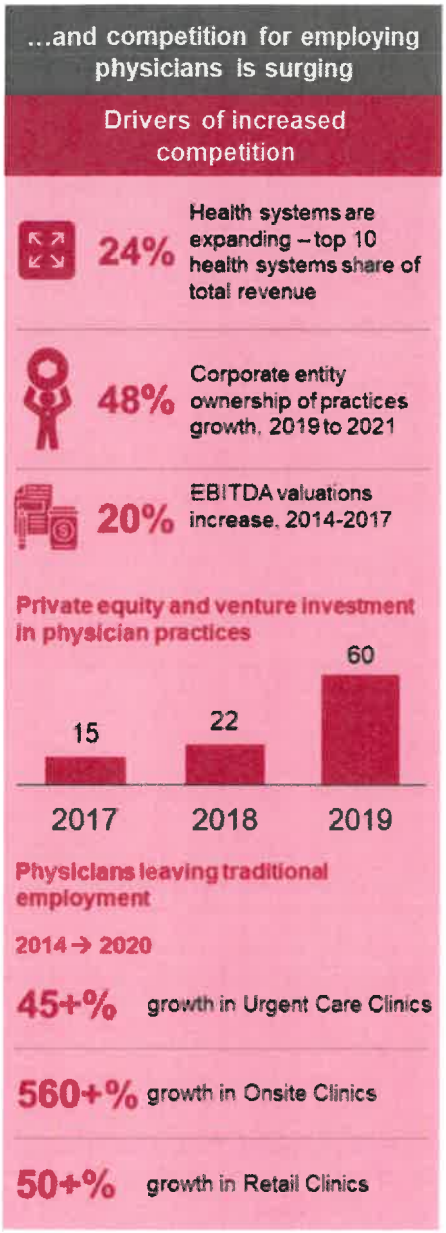
5.7% Physician hours worked decreased from 1996 to 2008

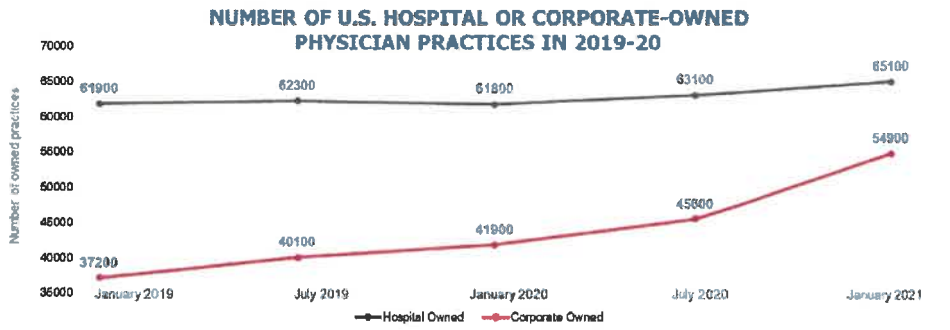
49% of physician office time is spent on EHR and desk work

Health system diversification strategies increase complexity of the physician role

New graduates and advanced practice providers not sufficient to meet demand

The new entrants are not just providing new points of delivery. They are also assuming risk as a foundational part of their business model, which allows for direct contracting and other non-traditional relationships. They are aggressively





recruiting providers in various subspecialties, including primary care. Payer entities and Optum are actively employing physicians, and the latter is now the largest employer of physicians in the country. At the same time, single specialty aggregators are aligning specialists and moving profitable services away from the health system facilities.

These new entrants are not bound by fair market value constraints of health systems. As a result, they can offer more lucrative practice purchase options. And many new entrants are actively "courting" physicians and practices, sometimes competing with one another as well as health systems. Providers are happy to entertain multiple offers and, in a contest of shiny new objects, health systems face an uphill battle.

Between 2019 and 2021, corporate ownership grew by 48% while hospital ownership grew just 5%, according to the IQVIA database. Corporate owners acquired more than 5 times as many practices during this period. This trend has allowed corporate owners of physician practices to reach levels of employment just short of hospitals. It is projected that they will likely surpass hospital systems in terms of owned practices in the near future.

If this trend continues, health systems and hospitals may soon find that they not only lack the physician complement needed to grow their services but may also be forced to reduce volumes and close locations due to a lack of physicians needed to serve their patients.

How can leadership teams of health systems manage through these issues?

A critical element to success is more effective alignment of leadership across the health system, especially between the physician organization and hospital, regarding key priorities and initiatives that address clinician needs and challenges. Creating and reinforcing an environment of engagement that recognizes the need for clinician voice in decision-making and management is essential to retain and attract the physician talent necessary in the current and future operating environment.

Do not assume you know what your physicians are thinking and needing. Ask yourself these three basic questions:

1. How can we focus on improving the quality of day-to-day practice? What can we do to reduce the administrative burden, reduce burnout and restore joy to the professional practice of medicine?

2. What can we do to strengthen the relationship between hospital and health system and physicians, ensuring that physicians have an

authentic voice in decision-making?

3. How do we proactively engage physicians now, so that we are not on the defensive once they have made the decision to leave?

It's critical to act now to preempt the disruptive forces working to dislodge traditional physician and health system relationships. Retention only gets harder once additional employment options are in play, and risks are compounded considering most health systems' need for growth. Health systems that are not already actively working on each of the choices above must start now or face disruption of their physician workforce in the future.

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

Behind the Scenes with Former New England Patriots Team Doctor Geoffrey Higgs

by Steven Ricker 8 years ago

The Expatriated Patriots Fan: Views and News from outside New England.

A little over a year ago, in late July 2013, I blew out my knee. My company has an onsite gym with a nice basketball court, and I play regularly. (Or did, and hope to again) Unfortunately I often play against guys half my age, right out of college even, and that might have lead

(https://musketfire.com/files/2014/09/ACLsurgery.jpg) My Knee after ACL surgery

me to push myself a bit. Anyway, whatever the cause, while playing, I hyper-extended my left knee while defending a fast break, and tore my ACL and meniscus.

I had surgery to replace my ACL (Anterior Cruciate Ligament, one of the major ligaments holding the knee together) that September and a touch up surgery on my meniscus in February of 2014.

I bring this up as it was what lead to this article in two ways. One way is that due to my decreased physical activity, I was looking for a way to fill up some of my time, and as a result I submitted a sample column to this website. No one was more surprised than I when it was accepted and I was allowed to become a contributor.

The other, and more important reason is that the injury caused me to have a number of meetings with my orthopedic surgeon, Dr. Geoffrey Higgs.

Dr Higgs is an accomplished physician and surgeon, an U.S Army veteran, and most importantly, (for the purposes of this article) a former team physician for the New England Patriots.

I discovered this because he had a small display case in one of his offices with a Patriots helmet, and a thank-you plaque from the team.

This was nice, both because I am a Patriots fan, and because I assumed the NFL would require only the best doctors for their team doctors. But I didn't think much of it until the announcement that the Patriots would be conducting joint practices with the Redskins. At that point, I realized this might be a great opportunity to find out how one becomes a physician for an NFL team, and share that info with the other fans at Musketfire.

***

Dr. Geoffrey Higgs, currently of Advanced Orthopaedics in Richmond Virginia was the Team Physician for the New England Patriots from 1998 to 2000, overlapping with Pete Carol's time in New England. But what did it take to get to that spot, and what is it like being a doctor for an NFL team?

Dr. Higgs's undergraduate degree is in Systems Engineering from the University of Virginia. After graduation, he even worked a year as an engineer, but ultimately decided that was not the career path for him.

In college, he had played football, and even now looks fit enough as though he could suit up and take the field as a linebacker. While playing though, he suffered a serious ankle injury, and had his ankle surgically repaired. It so happened that the doctor who did the surgery was the Team Physician for the Washington Redskins at the time. Dr. Higgs was so impressed with the doctor's competence, and his compassion in treating the injury, that it left him with a profound desire to emulate the man.

So, after concluding that engineering wasn't for him, he applied to Medical School and was accepted into Columbia University. After completing med school, he was accepted into a 6 year, academic orthopedic surgery residency program, also at Columbia.

To finance his way through medical school, Dr. Higgs utilized a military scholarship, where the U.S. Army covered tuition and books, as well as a $600 a month stipend, in return of service as a doctor in the U.S. Army Medical Corp after graduation. While this is a great way to cover educational costs and serve your country as well, the $600 a month stipend did not go far in New York City, as one might imagine. Living in squalid conditions in Harlem for most of med school, when he went to the University of California (San Diego) for a year to study with a prominent researcher of ligament and joint replacements he had to resort to living off peoples' couches for as long as they would have him.

(https://musketfire.com/files/2014/09/8-380x506.jpg) Dr Geoff Higgs
After his year in California, he returned to Columbia, where he was elected Chief Resident. He also received awards for Outstanding Physician and the Pediatric Orthopaedic Society of New York's Best Resident Research Award.

Also, while back at Columbia, a friend of Dr. Higgs (also a resident) got a position as a stadium physician at Yankee Stadium. Due to the workload, the friend recruited 3 other residents, including Dr. Higgs, to help him. This was Dr. Higgs first exposure to working with professional athletes. (And a chance to bring in some extra money to supplement his military stipend) Due to their work at Yankee Stadium, they were asked to assume a similar role at Madison Square Garden, home of the New York Nicks and the New York Rangers.

After completion of his residency, Dr. Higgs entered the U.S. Army and was stationed first in Korea, where he served as an Orthopedic Physician for all in country U.S forces. While there, continued his work in Sports medicine by working with various base teams, as well as covering the All World Taekwondo team. Additionally, all South Korean men have to server a two year term in either the military or police force when they turn 18. They are called Katusas and they get there medical care from the U.S, so Dr. Higgs assisted there as well.

From Korea, he was transferred to Germany for 3 years where he served as Assistant Chief of Orthopaedic Surgery at the U.S. Army Hospital in Heidelberg, German. From there, he was deployed to during the Bosnian war as Chief of Orthopaedic Surgery at the 67th U.S. Army Combat Support Hospital (Deployed) in Taszar, Hungary.

Dr. Higgs describes his time in the service as a great opportunity to serve the men and woman of the United States Armed Forces, and to have gained further experience in his field. While serving in the U.S. Army, Dr. Higgs received the Meritorious Service Medal and the Army Commendation Medal, and twice received the Overseas Service Medal.

Leaving the service as a Major, he next accepted a fellowship in Orthopaedic Sports Medicine and Shoulder Surgery at Harvard/Massachusetts General Hospital. While in the Boston area, Dr. Higgs developed relationships with many of the sports teams in the area, eventually serving as Team Physician for Harvard University Athletic Teams, the New England Patriots Professional Football Team, the Boston Bruins Professional Hockey Team, and the New England Revolution Professional Soccer Team.

But we are all football fans here, and it's the Patriots we want to hear most about...

***

It has been awhile since Dr. Higgs has worked with the Patriots, and he certainly could not discuss players by name anyway. But I was able to discuss with him some of the differences with working with professional athletes versus average patients, as well as what it is like to be a team doctor in general.

On working with Professional athletes, "Technically, in the operating room, it is the same. The operation is no different. However, there is a tremendous expectation from the athlete to return to full performance level. So there can be a psychological and emotional component to the care as well."

"Additionally, some injuries just will never allow recovery to previous performance level. For example, it's well documented that with rotator cuff injuries in throwing athletes, 40% never achieve the same level of performance."

One significant difference is the drive and time that pro athletes can put into their post-operative recoveries. It was well documented in the media that Robert Griffin spent 8 to 10 hours a day in rehab after his ACL repair. Dr. Higgs says very few nonprofessional athletes have the time, ability or support structure to put in that type of effort. As I consider my situation, where work, and insurance limited me to 6 hours a week (versus Griffin's 8 hours a day) I realize what a big difference that is.

Of course, some athletes are just tremendously genetically blessed as well. The doctor related to me a time with the Patriots where he performed arthroscopic surgery on both of a player's knees on a weekend. Three days later, he noticed that same player on the field, and said he had not cleared him to practice. So he went over and examined him. He said the player had almost no swelling, full range of motion, and his scars looked like they were 3 weeks old, not 3 days old. The player went on to play in an NFL game that weekend, one week after having surgery on both knees! Looking at my still limited knee a year after my ACL surgery (which granted, is much more severe than a "standard" scoping) I realize how blessed that player was.

As for what it is like being a team physician... "During the season, it is very demanding on your time. You have to check in every day, evaluate and diagnose injuries, and devise treatment plans." "Home games aren't so bad, but away games can be tough. You may travel with the team to say, a game at 4:05 in the afternoon in San Diego, have to take the red eye back, then see 40 patients the next day."

Plus, team physician isn't a position that pays very well according to Dr. Higgs. Doctors typically take these positions for "the love, enjoyment and thrill of the game he says, and for the privilege of association with world class athletes".

Much of the work load for a team doctor is simple sprains and strains I am told. However, there are obviously the occasional more severe injury, such as joint damage or ligament tears. Occasionally there are even catastrophic injuries to the head or neck requiring urgent treatment, and which can be really scary. Dr. Higgs was fortunate enough to not encounter any of these at the professional level, but unfortunately has had to treat some at the high school level, where he know volunteers his time. (And how fortunate is a high school to have a doctor of this caliber available in case of such an incident)

Of his time with the Patriots, Dr. Higgs says what impressed him most was seeing "From the ownership, the genuine love for and interest in the players that is purely generated out of thoughtfulness"

***

After completing his fellowship at Harvard and Mass General, Dr. Higgs had offers from both the University of Colorado and University of Oregon to be their Chief of Sports medicine. However, the pace of professional sports medicine was taking its toll, and in deference to his family, and after consulting with the family of a respected colleague, he chose to move back to Virginia and open up a private practice.

(https://musketfire.com/files/2014/09/Higgs1.jpg) Dr Geoff Higgs at the Washington Redskins Training camp

Now with Advanced Orthopaedics in Richmond Virginia, Dr. Higgs continues to stay active in sports medicine. In addition to treating aging athletes like this author, he volunteers a great deal of time for low income high school sports programs. Without his efforts, these schools would certainly not have medical care of this caliber available to them, maybe none at all at the games. He is also the Chief Team Physician for the Richmond Raiders Professional Arena Football Team, and has been the Chief Team Physician for each Professional Arena Football Team in Richmond including The Richmond Revolution, The Richmond Bandits and The Richmond Speed. He also serves as the team physician for Henrico High School and Highland Springs High School Athletic Programs, as a Team Physician for the Richmond Rhythm IBL Basketball team, as the Head Team Physician for the Virginia High School Football State Championships while they were played in Richmond, and as the Head Team Physician for the East West College Football All-Star Games.

And recently, with the transition of the Washington Redskins training camp to Richmond, he has re-affiliated with the NFL when asked to help provide medical coverage at their training camp.

(https://musketfire.com/files/2014/09/higgs2.jpg) Dr Higgs observes at Redskins Training camp in Richmond Va

They all have been fortunate to have access to such a highly trained physician, much as I have been fortunate as well. It is possible, likely even, that they, like I, had no idea of the years of work and training that goes into being a sports medicine doctor. I know all med school is hard, but until I had the chance to conduct this interview, I didn't realize the depth of effort and achievement represented by Dr. Higgs.

Richmond is very fortunate to have such a doctor serving its community. And so am I.

(https://musketfire.com/files/2014/09/Higgs.jpg) Dr. Geoff Higgs tends to Henrico defensive end who suffers from a concussion after a collision on the field.
Photo Credit Scott Elmquist

Shannon Hitchcock
Chief Communications Officer / E.D. of the Foundation | Community Relations
PROSSER MEMORIAL HEALTH

PROSSER MEMORIAL HEALTH EMPLOYEE NEWSLETTER

THE PULSE

Prosser Memorial Health

OCTOBER | 2022

News & Events

Wine Country Classic

Thank you to all of our sponsors and golfers for supporting the Prosser Memorial Health Foundation's 2nd Annual Wine Country Classic and the new hospital project!

WINE COUNTRY Classic
presented by Prosser Memorial Health

Thank You Sponsors!

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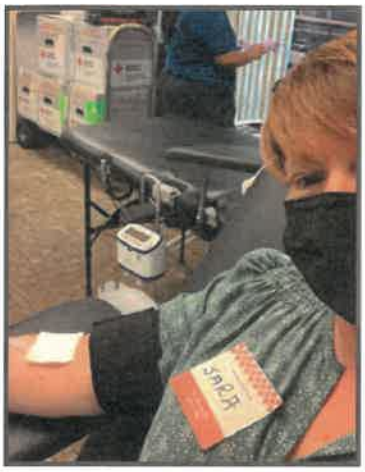
Prosser Boys & Girls Club 3rd Annual Dunk Tank Challenge

The Prosser Boys & Girls Club would like to thank you for an amazing event! Your support brought in more than $22,000 for local kids and teens. We're so grateful to have an amazing community behind us, and we appreciate our contestants and supporters for making the 3rd Annual Dunk Tank Challenge fun and successful!

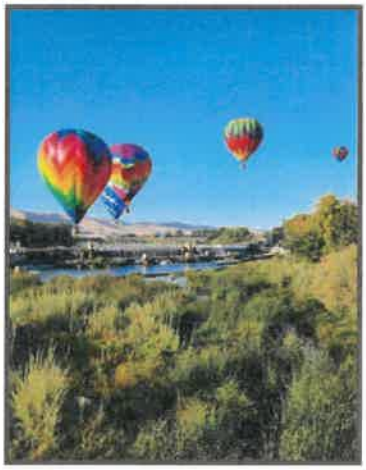
2022-2023 Health Occupations Class

Prosser High School seniors began their department rotations on October 4th. They have worked hard obtaining their BLS, first aid, infectious disease training and they are halfway through their Nursing Assistant training as well.



Blood Drive

Thank you to all PMH staff, friends, and families who came to donate at the blood drive!



Balloon Rally Winners

Lindsey Schutt, Family Birthplace RN & Patti Hoag, Medical Technologist won the Balloon Ride raffle and got to bring their husbands on their balloon ride!

Save the Date Staff Holiday Party

Stay tuned for more information regarding the staff holiday party on December 10!

News & Events

EMPLOYEE FORUM

2023 Strategic Plan

Please plan to attend one of the following employee forums* and provide us with your input into the 2023 Strategic Plan. All 12pm meetings will be provided lunch. For other meeting times, refreshments will be provided.

*Attendees at each forum will be put in a drawing for logo wear!

Monday, October 3
7 AM - 8 AM • Providers • Whitehead Conference Room
12 PM - 1 PM • Whitehead Conference Room

Tuesday, October 4
12 PM - 1 PM • Grandview Clinic
3 PM - 4 PM • Whitehead Conference Room

Wednesday, October 5
12 PM - 1 PM • Physical Therapy Gym
3 PM - 4 PM • Vineyard Conference Room

Tuesday, October 18
7 AM - 8 AM • Whitehead Conference Room
12 PM - 1 PM • Prosser Women's Health Center

Wednesday, October 19
12 PM - 1 PM • Prosser Clinic

Thursday, October 20
12 PM - 1 PM • Vineyard Conference Room

Tuesday, October 25
7 AM - 8 AM • Providers • Whitehead Conference Room
12 PM - 1 PM • Benton City Clinic

Breakfast is served.

Prosser Memorial Health

509.786.2222 | ProsserHealth.org


HALLOWEEN
FESTIVITIES
Monday, October 31
Lunch
Lunch will be served at the Loading Area near the Employee Entrance from 11:30am - 1:30pm. Between the Buns will cater lunch. Seating available in all conference rooms (Whitehead, Vineyard, Orchard).
Caramel Apples & Popcorn
Administration will be handing out caramel apples and kettle corn to all staff.
Blissful Bites
Blissful Bites will be serving in the loading area from 6:00am - 9:00am.
Busy Bean Café
Busy Bean Café will be offering free cider and hot chocolate all day.
Costume Contest
Submit your photo to IT and voting will be live after October 31st.
Chili Contest
If you would like to be a chili contest judge, please email Annie Tiemersma. All chili must be turned in by 9:00am. Chili judging begins 9:00am - 10:30am.
Pumpkin Decorating Contest
Turn in your pumpkin to the courtyard next to Patient Registration in the hospital. Submit a photo of your pumpkin to IT for voting.
Evening Staff
Dinner will be served in the Vineyard Conference room at 9:00pm. Caramel apples and kettle corn will also be available to pick up.
Prosser
Memorial Health
This is how we care.

News & Events

Employee

Flu Shots

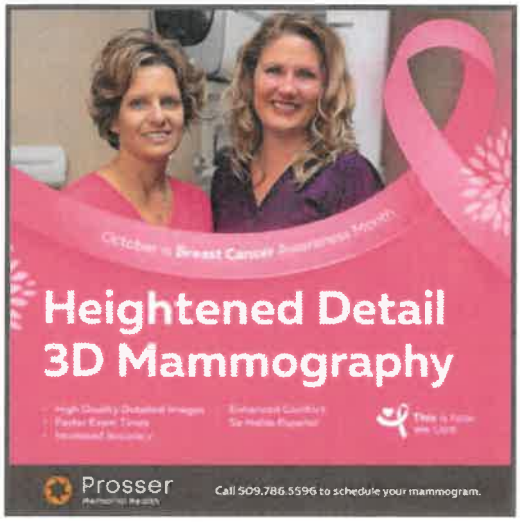
Vineyard Conference Room

October 6th, 14th, and 27th from 7-10am

N-95 mask fitting and PAPR training will occur at the same time.

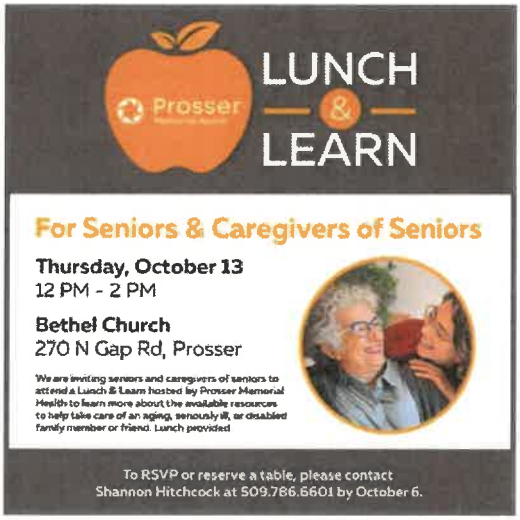
Prosser Memorial Health

This is how we care.



October is Breast Cancer Awareness Month

Employees can wear their pink t-shirts and jeans every Friday on October to support the Caren Mercer-Andreasen Women's Health Fund. Prosser Memorial Health offers Heightened Detail 3D Mammography which provides high-quality detailed images, faster exam times, increased accuracy, and enhanced comfort. Call 509.786.5596 to schedule your mammogram today!



Senior Lunch & Learn

Please join us on Thursday, October 13 from 12pm-2pm at Bethel Church for a seniors Lunch & Learn hosted by Prosser Memorial Health. Learn more about the available resources to help take care of an aging, seriously ill, or disabled family member or friend. Lunch Provided.

Diabetic Forum

Please join us on Tuesday, November 1 from 5:30pm-7:30pm at Bethel Church as our team of providers discuss diabetes wellness and care. Topics include: diet & nutrition, wound care, prevention, diabetic foot & nail care, and Hispanics with diabetes. This is a free community event. Diabetic friendly dinner and goodie bags provided.

ASPIRE Awards

Our ASPIRE program recognizes team members who demonstrate our core values of Accountability, Service, Promoting Teamwork, Integrity, Respect and Excellence.

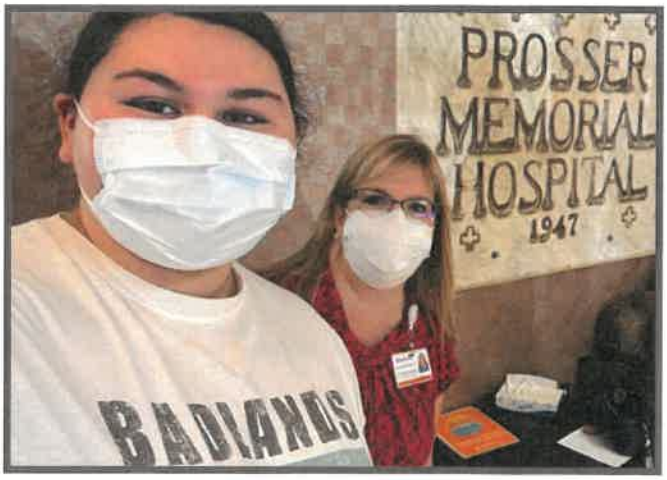
Maria Rivera

Congratulations to Maria Rivera, CNA in ACU, for receiving a Silver ASPIRE Award! Maria was nominated by a patient in the ACU who said, "It is apparent Maria knows her job and is excellent at it! In addition, she does her job with compassion and she takes the time to get to know you and proactively meet your needs. This embodies your values at Prosser Memorial Health. You are lucky to have her on staff!" We completely agree with you! On behalf of all of our patients, thank you Maria!

Welcome to the Team!

Left to right: Maria Herrera, Felix Garcia, Noemi Borrego, Gus Davila, James Mickelson, Rosie Molina, Ariana Garcia.

Scavenger Hunt



WELCOME TO THE TEAM

What have you enjoyed about Prosser Memorial Health so far?

Noemi Borrego
Grandview Clinic Patient Services Representative
Positive environment.

Gus Davila
Maintenance
All the events and the family atmosphere.

Ariana Garcia
Laboratory Assistant
Everyone here is very friendly and all about teamwork.

Felix Garcia
Admitting Patient Registrar
How friendly everyone is and how involved PMH is within the community.

Jim Mickelson
EMS Paramedic
The people and their good attitudes.

Rosalinda Molina
Community Relations/Busy Bean Barista
How everyone is so nice and helpful.

What is your favorite part of fall?

Noemi Borrego
Grandview Clinic Patient Services Representative
Favorite part of fall is the weather/colors and sweater weather.

Gus Davila
Maintenance
Chinook fishing.

Ariana Garcia
Laboratory Assistant
The weather change and fall decorations.

Felix Garcia
Admitting Patient Registrar
The fall leaves and my house smelling like pumpkin spice.

Jim Mickelson
EMS Paramedic
Hunting.

Rosalinda Molina
Community Relations/Busy Bean Barista
Pumpkin patches and cold weather.

Anniversaries

Happy Anniversary!

Thank you for being an essential part of Prosser Memorial Health's success.

Happy 1 Year

- **Aida De La Cruz**
  Laboratory Assistant II
- **Alysia Saenz Christensen**
  Prosser Clinic Patient Services Representative
- **Cassandra Hansen**
  EMS Technician - B
- **Christine Sheeres**
  Nursing Administration
  RN Resource Nurse
- **Elizabeth Davis**
  Emergency Department RN
- **Jessica Valdez**
  Laboratory Medical Technologist
- **Katie Fischer**
  Medical/Surgical RN
- **Lucerito Salcedo**
  Prosser Women's Health Center CMA
- **Maria Mendoza**
  Patient Registrar
- **Maria Uriostegui Figueroa**
  Prosser Specialty Clinic
  Patient Services Representative
- **Olivia Ramos**
  Patient Registrar
- **Trux French**
  Pharmacist

Happy 2 Years

- **Amanda Leighty**
  Surgical Technician
- **Neilan McPartland**
  Board Member
- **Kristen Redman**
  Medical/Surgical RN
- **Kyle Pettit**
  Diagnostic Imaging
  CT Technologist - R Eligible
- **Madeleine Nelson**
  Diagnostic Imaging
  CT Technologist - R Eligible
- **Maria Elena Gonzalez**
  Medical/Surgical Technician

Happy 3 Years

- **Alex Carballo-Martinez**
  Diagnostic Imaging MRI Technician
- **Dr. Heidi Weaver**
  Prosser Women's Health Center
- **Lindsay McKie**
  Pharmacist
- **Lucia Magana**
  Prosser Specialty Clinic CMA
- **Maria Padilla**
  Pharmacy Technician II

Happy 4 Years

- **Lyndsay Oswalt**
  Benton City Clinic CMA

Happy 5 Years

- **Jessenia Garcia**
  Prosser Clinic
  Patient Services Representative
- **Kaylee Swan**
  Patient Financial Services
  Collector/Cash Posting/Credit Balance

Happy 6 Years

- **Veronica Bonilla**
  Patient Financial Services
  Collector/Cash Posting/Credit Balance

Happy 7 Years

- **Andy Vanguardia**
  Maintenance Groundskeeper
- **Tonya Carreon**
  Nursing Administration
  RN Resource Nurse

Happy 8 Years

- **Michelle Morgan**
  Medical/Surgical RN

Happy 10 Years

- **Cynthia Alaniz**
  Laboratory Assistant II

Happy 11 Years

- **Sunshine Zavala**
  Surgical Services
  Environmental Services Technician

Happy 12 Years

- **Glenn Bestebreur**
  Board Member

Happy 14 Years

- **Nancy Sanchez**
  Patient Registrar

Happy 15 Years

- **Amanda Hibbs**
  Diagnostic Imaging
  CT Technologist - R
- **Jessica Chavez**
  Pharmacy Technician II

Happy 16 Years

- **Nora Newhouse**
  Human Resources
  Senior Generalist-Benefits

Happy 18 Years

- **Jessica Gonzalez**
  Patient Financial Services
  Collector/Cash Posting/Credit Balance

Happy 19 Years

- **Janie Gonzalez**
  Surgical Services CNA/Unit Secretary

Birthdays

Free 20oz Busy Bean Coffee on your birthday!

On your birthday, we just want to let you know that it is a great pleasure working with truly inspirational figures like yourselves. Thank you for all the incredible support you give towards Prosser Memorial Health. Happy Birthday to you all! #ThisIsHowWeCare

October 1
- **Cynthia Alaniz**
  Laboratory Assistant II

October 2
- **Noemi Borrego**
  Grandview Clinic
  Patient Services Representative

October 3
- **Andrea Moreno**
  Medical/Surgical Technician
- **Dr. Carolyn O'Conner**
  Prosser Clinic
- **Elizabeth Davis**
  Emergency Department RN
- **Annie Marie Tacadao**
  Laboratory Microbiologist

October 5
- **Rebecca Pettis**
  EMS Advanced EMT

October 6
- **Cindi Pineda**
  Dermatology Center CMA
- **Donna Tunning**
  IT Clinic Informatics Nurse
- **Melinda Hernandez Reyna**
  Medical/Surgical Technician

October 7
- **Dr. Brian Sollers**
  Prosser Women's Health Center
- **Jessica Valdez**
  Laboratory Medical Technologist

October 8
- **Sara Benitz**
  Employee Health RN Resource Nurse

October 9
- **Diana Ramirez**
  Patient Financial Services
  Revenue Integrity Analyst

October 10
- **Teresa Charvet**
  Prosser Clinic
- **Kimberly Winters**
  Health Information Management Certified Coder

October 11
- **Kyle Pettit**
  CT Technologist - R Eligible

October 13
- **Jennifer Kernan**
  Prosser Specialty Clinic
  Patient Services Representative
- **Berta Gonzalez**
  Grandview Clinic CMA

October 15
- **Sergio Merino**
  Surgical Services RN
- **Jonathan Friend**
  EMS Paramedic

October 16
- **Madeleine Nelson**
  CT Technologist - R Eligible
- **Rosalinda Molina**
  Busy Bean Barista

October 18
- **Rosemary Mendoza**
  Administration Executive Assistant
- **Ryan Austin**
  Information Technology System Analyst
- **Nicole Worley**
  Nursing Administration
  RN Resource Nurse

October 19
- **Maria Rivera**
  Medical/Surgical Technician
- **Maria Flores**
  Surgical Services RN Lead

October 20
- **Phillip Braem**
  Information Technology
  Chief Information Officer
- **Tina Salguero**
  Environmental Services Technician

October 22
- **Sara Dawson**
  Surgical Services Director

October 23
- **Hollis Ferritto**
  Prosser Specialty Clinic LPN Clinic
- **Diana Wilson**
  Prosser Specialty Clinic CMA
- **Dr. Steven Rode**
  Emergency Department

October 24
- **Maria Cardenas**
  Health Information Management Technician I
- **Juliet Dennis**
  Grandview Clinic
  Psychiatric Nurse Practitioner

October 27
- **Maria Rubalcaba**
  Patient Financial Services Biller
- **Rodelito Mallari**
  Laboratory Medical Technologist

October 28
- **Anna Atilano**
  Medical/Surgical RN
- **Samantha Santos**
  CT Technologist - R
- **Elizabeth Gonzalez**
  Family Birthplace RN

October 29
- **Mary Lee Dawsey**
  Accounting AP Clerk
- **Dr. Peter Himmel**
  Emergency Department

October 30
- **Stephanie Titus**
  Director/Foundation CFO/Finance Operations
- **Dr. Thomas Halvorson**
  Prosser Orthopedic Center
- **Veronica Huerta Monjes**
  Family Birthplace OB Technician

October 31
- **Katy Davis**
  Nursing Administration
  RN Resource Nurse
- **Ashley Kristofzski**
  Family Birthplace RN

Twenty 22 October

REACH

PAY YOURSELF FIRST!

The odds are that you won't win the lottery or receive a huge inheritance from a deceased relative that will relieve you from financial worries for the rest of your life. And, counting on Social Security to fund all your expenses in retirement may be much too optimistic as well. Social Security retirement payments are intended to cover only the most basic living expenses.

Focus on You

The reality is that you have to take matters into your own hands when it comes to preparing for your retirement. If you haven't thought much about it yet, you really should start focusing on your future retirement needs very soon. The earlier you begin planning, the better your chances of having the retirement you've dreamed about.

A good rule of thumb is that you will need 70% to 80% of your salary as retirement income if you hope to have a reasonably comfortable retirement. To help reach that goal, commit to saving a portion of your salary in a retirement plan each payday and keep on doing so for as long as you are employed. There is generally no substitute for regular contributions invested in a broad range of investments that can potentially grow tax-deferred over time.

Go on Autopilot

Making automatic paycheck contributions to a 401(k) or similar retirement savings plan helps simplify your financial life. You can't spend money you don't have and you don't have to go to the trouble of transferring funds electronically or writing a check. And you don't have to worry about where to invest each time you contribute to the plan. Your plan contributions are automatically invested for you in the investment options you selected from the retirement plan's investment menu.

It's a Good Habit

As you watch your retirement savings accumulate over time, you may be motivated to save even more for your future retirement. It may become second nature to seek out ways to reduce your discretionary spending so that you will have more money to set aside for your retirement. And whenever you receive a pay raise or a bonus, you may automatically think about saving a portion of it.

Growing Your Retirement Account

	You could have this much more saved after:			
If you increase plan contributions by:	5 years	10 years	20 years	40 years
$10/week	$3,023	$7,101	$20,020	$86,291
$15/week	$4,535	$10,652	$30,033	$129,447

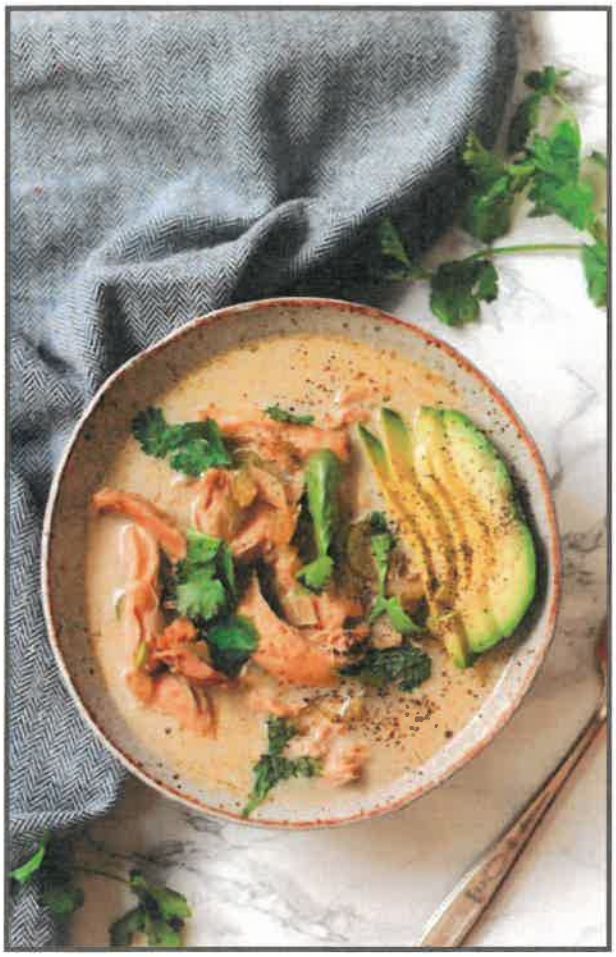
This is a hypothetical example used for illustrative purposes only. It assumes amounts are invested monthly, an average annual total return of 6%, and monthly compounding. It does not represent the result of any particular investment. Your results will be different. Amounts are rounded to the nearest dollar. Source: DST Retirement Solutions, LLC, an SS&C company.

Talk With a Financial Professional

If you want to learn more about what you can do to lay the groundwork for a financially secure retirement, why not tap into the expertise of an experienced financial professional?

If you have questions regarding your retirement plan, please contact Nora Newhouse in Human Resources, ext. 6688.

Paleo White Chicken Chili



Ingredients:

- 1 tbsp coconut oil
- 1 onion, diced
- 2 celery sticks, chopped
- 4 garlic cloves, minced
- 2 jalapeño peppers, seeded and membranes removed, diced
- 1½ lbs of skinless, boneless chicken thighs or breasts
- 1 tbsp ground cumin
- 2 tsp chili powder
- 1 tsp coriander
- 1 tsp dried oregano
- 1 tsp sea salt
- ⅛ tsp ground black pepper
- 4 cups of bone broth or chicken broth
- 1 4-oz can of diced green chili
- 1 14-oz can of full fat coconut milk,
- Optional garnish: cilantro, avocado slices, and/or more jalapeño slices

Instructions:

1. Heat coconut oil in a large pot over medium high heat.
2. Add onion, celery, garlic, and jalapeños and cook stirring for 5 minutes.
3. Push the veggies to the side then add the chicken with cumin, chili powder, coriander, oregano, sea salt, and black pepper.
4. Cook the chicken for 5 minutes until the chicken is browned on all sides.
5. Add the broth and diced green chili, and let the soup come to a boil.
6. Lower the heat to medium low, and let it simmer for 15 minutes.
7. Transfer the chicken to a bowl and use 2 forks to shred it completely.
8. Add the chicken back to the soup, then add in coconut milk.
9. Turn up the heat to medium high, then let the mixture come back to a boil.
10. Let it boil for 10 minutes until the soup is slightly reduced and thickened.
11. Take off heat and serve topped with your favorite garnish.

Prosser
Memorial Health

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Attachment Q

Prosser Memorial Health

Balance Sheet

September 30, 2022

Assets

	9/30/2022	8/31/2022	9/30/2021	12/31/2021
Cash & Temporary Investments	13,256,970	12,089,835	*8,071,500*	*9,316,646*
COVID Cash Holding	-	-	*1,473,753*	*1,546,716*
Gross Patient Accounts Receivable	39,883,272	40,568,933	*33,643,597*	*31,324,657*
Less Allowances for Uncollectible	(24,861,000)	(25,667,000)	*(20,971,000)*	*(19,716,000)*
Net Patient Receivables	15,022,272	14,901,933	*12,672,597*	*11,608,657*
Taxes Receivable	381,370	403,193	*306,233*	*23,641*
Receivable from 3rd Party Payor	368,741	256,224	*361,916*	*241,933*
Inventory	655,205	587,606	*295,184*	*570,651*
Prepaid Expenses	1,253,522	1,097,362	*1,084,529*	*1,152,815*
Other Current Assets	12,733	14,425	*18,999*	*4,746*
Total Current Assets	30,950,813	29,350,578	*24,284,711*	*24,465,805*
LEOFF Net Pension Asset	1,106,851	1,106,851		*1,106,851*
Whitehead Fund - LGIP	1,223,990	1,221,419	*1,214,579*	*1,214,855*
Funded Depreciation - Cash	2,998,912	2,773,430	*1,277,726*	*1,003,653*
Funded Depreciation - TVI	16,494,969	16,768,158	*16,791,856*	*17,537,681*
Bond Obligation Cash Reserve	767,546	767,546	*767,511*	*767,520*
USDA Debt Reserve Fund	-	-	-	-
Tax Exempt Lease Funds	-	-	-	-
Board Designated Assets	22,592,268	22,637,404	*20,051,672*	*21,630,560*
Land	478,396	478,396	*478,396*	*478,396*
Property Plant & Equipment	47,672,104	47,651,779	*43,993,911*	*46,165,427*
Construction In Progress	6,097,177	6,041,978	*5,062,205*	*4,226,277*
Accumulated Depreciation	(32,644,450)	(32,422,352)	*(30,062,775)*	*(30,725,767)*
Net Property Plant & Equipment	21,603,227	21,749,801	*19,471,737*	*20,144,333*
Investment & Other Non Current Assets	999,145	1,000,679	*1,028,577*	*1,023,805*
Land - Gap Road	1,745,440	1,745,440	*1,745,440*	*1,745,440*
Net Investments & Other Non Current Assets	2,744,585	2,746,119	*2,774,017*	*2,769,245*
Total Assets	**$ 77,890,893**	**$ 76,483,902**	***$ 66,582,137***	***$ 69,009,943***

Liabilities & Fund Balance

	9/30/2022	8/31/2022	9/30/2021	12/31/2021
Current Portion of Bonds Payable	883,627	882,266	*848,827*	*871,489*
Current Portion of USDA	-	-	-	-
Current Portion Capital Leases	253,990	252,836	*247,661*	*248,495*
Accounts Payable	2,375,205	2,496,957	*2,409,671*	*1,797,177*
Payroll & Related Liabilities	4,719,579	3,822,873	*3,316,547*	*3,410,607*
Cost Report Payable	442,014	425,494	*1,123,701*	*510,126*
Other Payables to 3rd Parties	1,346,364	1,346,364	*969,467*	*969,467*
Deferred LEOFF Pension	483,233	483,233	-	*483,233*
Deferred Tax Revenue	228,590	304,787	*215,493*	-
Deferred EHR Medicare Revenue	-	-	-	-
Deferred COVID Revenue	-	-	*1,473,753*	*1,546,716*
Accrued Interest Payable	74,517	56,235	*76,654*	*19,670*
Other Current Liabilities	-	-	-	-
Total Current Liabilities	10,807,119	10,071,045	*11,373,569*	*9,856,980*
Non Current Liabilities				
Bonds Payable net of CP	9,043,678	9,092,843	*9,883,566*	*9,482,042*
USDA Financing Payable net of CP	-	-	-	-
Capital Leases net of CP	414,572	436,502	*647,696*	*605,826*
Total Non Current Liabilities	9,458,250	9,529,345	*10,531,262*	*10,087,868*
Total Liabilities	20,265,369	19,600,390	*21,213,036*	*19,094,572*
Fund Balance				
Current YR Unrestricted Fund Balance	8,560,429	7,818,417	*12,791,117*	*16,487,111*
Prior YR Unrestricted Fund Balance	49,065,095	49,065,095	*32,577,984*	*32,577,984*
Restricted Fund Balance	-	-	-	-
Total Fund Balance	57,625,524	56,883,512	*45,369,101*	*49,065,095*
Total Liabilities & Fund Balance	**$ 77,890,893**	**$ 76,483,902**	***$ 66,582,137***	***$ 69,009,943***

Prosser Memorial Health

Statement of Operations
September 30, 2022

Month Ending Actual	Budget	Variance	%	Prior Year	%		Year to Date Actual	Budget	Variance	%	Prior Year	%
						Gross Patient Services Revenue						
$ 3,828,140	$ 3,852,992	$ (24,852)	-1%	$ *3,536,125*	8%	Inpatient	$ 33,556,878	$ 34,473,168	$ (916,290)	-3%	$ *31,455,559*	7%
18,380,184	14,380,840	3,999,344	28%	*13,294,650*	38%	Outpatient	151,234,004	128,667,033	22,566,971	18%	*115,519,276*	31%
22,208,324	18,233,832	3,974,492	22%	*16,830,775*	32%	**Total Gross Patient Services Revenue**	184,790,882	163,140,201	21,650,681	13%	*146,974,835*	26%
						Deductions from Revenue						
						Contractual Allowances						
4,138,002	3,745,499	(392,503)	-10%	*3,526,574*	17%	Medicare	38,801,459	33,511,410	(5,290,049)	-16%	*30,600,962*	27%
4,088,025	4,005,429	(82,596)	-2%	*3,880,351*	5%	Medicaid	39,271,078	35,837,035	(3,434,043)	-10%	*32,300,184*	22%
3,394,502	2,280,384	(1,114,118)	-49%	*2,028,743*	67%	Negotiated Rates	26,448,550	20,402,855	(6,045,695)	-30%	*18,579,554*	42%
1,110,368	356,770	(753,598)	-211%	*442,001*	151%	Other Adjustments	6,615,136	3,192,059	(3,423,077)	-107%	*2,552,398*	159%
12,730,897	10,388,082	(2,342,815)	-23%	*9,877,669*	29%	**Gross Contractual Allowances**	111,136,223	92,943,359	(18,192,864)	-20%	*84,033,098*	32%
358,727	303,175	(55,552)	-18%	*375,097*	-4%	Charity Care	3,450,317	2,712,538	(737,779)	-27%	*2,179,855*	58%
339,947	328,921	(11,026)	-3%	*114,155*	198%	Bad Debt	1,271,830	2,942,898	1,671,068	57%	*3,243,369*	-61%
13,429,571	11,020,178	(2,409,393)	-22%	*10,366,921*	30%	**Total Deductions From Revenue**	115,858,370	98,598,795	(17,259,575)	-18%	*89,456,322*	30%
8,778,753	7,213,654	1,565,099	22%	*6,463,854*	36%	**Net Patient Services Revenue**	68,932,512	64,541,406	4,391,106	7%	*57,518,513*	20%
-	126,814	(126,814)	-100%	*1,106,281*	-100%	COVID Net Revenue	1,785,036	1,141,326	643,710	56%	*8,363,759*	-79%
9,756	52,980	(43,224)	-82%	*16,804*	-42%	Other Operating Revenue	197,478	251,820	(54,342)	-22%	*169,012*	17%
8,788,509	**7,393,448**	**1,395,061**	**19%**	***7,586,939***	**16%**	**Net Revenue**	**70,915,026**	**65,934,552**	**4,980,474**	**8%**	***66,051,284***	**7%**
						Operating Expenses						
3,603,843	3,070,547	(533,296)	-17%	*3,349,881*	8%	Salaries	27,796,773	27,472,535	(324,238)	-1%	*24,549,898*	13%
877,804	794,022	(83,782)	-11%	*578,262*	52%	Benefits	7,063,438	7,104,205	40,767	1%	*5,904,699*	20%
438,176	285,002	(153,174)	-54%	*270,875*	62%	Purchased Labor	2,979,041	2,549,946	(429,095)	-17%	*2,554,863*	17%
4,919,823	4,149,571	(770,252)	-19%	*4,199,018*	17%	Sub-Total Labor Costs	37,839,252	37,126,686	(712,566)	-2%	*33,009,460*	15%
496,634	348,831	(147,803)	-42%	*368,393*	35%	Professional Fees - Physicians	3,837,876	3,139,481	(698,395)	-22%	*3,273,732*	17%
63,768	78,029	14,261	18%	*39,174*	63%	Professional Fees - Other	462,504	700,725	238,221	34%	*562,520*	-18%
1,244,844	1,208,942	(35,902)	-3%	*1,114,451*	12%	Supplies	10,365,887	10,930,473	564,586	5%	*8,907,850*	16%
41,073	47,475	6,402	13%	*44,629*	-8%	Purchased Services - Utilities	393,376	427,279	33,903	8%	*404,220*	-3%
441,901	452,325	10,424	2%	*400,511*	10%	Purchased Services - Other	3,493,507	4,070,929	577,422	14%	*2,743,402*	27%
171,163	161,302	(9,861)	-6%	*215,090*	-20%	Rentals & Leases	1,636,183	1,451,720	(184,463)	-13%	*1,647,626*	-1%
144,742	103,587	(41,155)	-40%	*120,304*	20%	Insurance License & Taxes	898,420	932,289	33,869	4%	*770,537*	17%
223,632	196,422	(27,210)	-14%	*186,122*	20%	Depreciation & Amortization	1,958,932	1,767,797	(191,135)	-11%	*1,631,593*	20%
78,687	141,593	62,906	44%	*96,773*	-19%	Other Operating Expenses	966,038	1,273,633	307,595	24%	*638,457*	51%
2,906,444	2,738,506	(167,938)	-6%	*2,585,447*	12%	Sub-Total Non-Labor Expenses	24,012,723	24,694,326	681,603	3%	*20,579,937*	17%
7,826,267	**6,888,077**	**(938,190)**	**-14%**	***6,784,465***	**15%**	**Total Operating Expenses**	**61,851,975**	**61,821,012**	**(30,963)**	**0%**	***53,589,397***	**15%**
962,242	**505,371**	**456,871**	**90%**	***802,474***	**20%**	**Operating Income (Loss)**	**9,063,051**	**4,113,540**	**4,949,511**	**120%**	***12,461,887***	**-27%**
						Non Operating Income						
77,946	76,314	1,632	2%	*71,831*	9%	Tax Revenue	708,392	686,822	21,570	3%	*658,808*	8%
(268,189)	2,935	(271,124)	-9238%	*2,347*	-11527%	Investment Income	(992,997)	26,411	(1,019,408)	-3860%	*(25,511)*	3792%
(29,986)	(46,681)	16,695	-36%	*(33,739)*	-11%	Interest Expense	(295,555)	(420,130)	124,575	-30%	*(321,354)*	-8%
-	347	(347)	-100%	-	0%	Other Non Operating Income (Expense)	77,538	3,125	74,413	2381%	*17,287*	349%
(220,229)	**32,915**	**(253,144)**	**-769%**	***40,439***	**-645%**	**Total Non Operating Income**	**(502,622)**	**296,228**	**(798,850)**	**-270%**	***329,230***	**-253%**
$ 742,013	**$ 538,286**	**$ 203,727**	**38%**	$ ***842,913***	**-12%**	**Net Income (Loss)**	**$ 8,560,429**	**$ 4,409,768**	**$ 4,150,661**	**94%**	$ ***12,791,117***	**-33%**

Prosser
Memorial Health

Statement of Operations 13-month Trend

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Gross Patient Services Revenue													
Inpatient	$ 3,536,125	$ 3,463,893	$ 3,043,354	$ 3,406,566	$ 3,605,247	$ 3,288,747	$ 3,726,370	$ 4,138,763	$ 3,310,749	$ 3,857,898	$ 3,644,634	$ 4,156,328	$ 3,828,140
Outpatient	13,294,650	12,964,572	13,593,213	14,195,193	13,346,293	14,047,763	17,199,727	16,039,568	17,523,148	18,638,990	16,756,514	19,301,817	18,380,184
Total Gross Patient Services Revenue	16,830,775	16,428,465	16,636,567	17,601,759	16,951,540	17,336,510	20,926,097	20,178,331	20,833,897	22,496,888	20,401,148	23,458,145	22,208,324
Deductions from Revenue	*38%*	*41%*	*39%*	*40%*	*38%*	*40%*	*38%*	*33%*	*38%*	*36%*	*35%*	*39%*	*40%*
Contractual Allowances													
Medicare	3,526,574	3,000,655	3,266,390	3,200,913	3,393,158	3,902,405	3,785,864	4,551,851	4,308,246	5,205,426	4,601,476	4,915,032	4,138,002
Medicaid	3,880,351	3,619,215	3,668,725	3,909,940	4,012,377	2,920,563	4,802,755	4,652,839	4,548,393	4,701,779	4,559,333	4,985,014	4,088,025
Negotiated Rates	2,028,743	2,278,447	2,412,022	2,549,312	2,379,307	2,584,862	2,978,601	2,714,651	2,834,178	3,257,683	2,888,068	3,416,698	3,394,502
Other Adjustments	442,001	648,306	368,145	398,392	199,926	624,993	626,880	1,328,948	654,495	818,520	652,908	598,097	1,110,368
Gross Contractual Allowances	9,877,669	9,546,623	9,715,282	10,058,557	9,984,768	10,032,823	12,194,100	13,248,289	12,345,312	13,983,408	12,701,785	13,914,841	12,730,897
Charity Care	375,097	285,889	296,306	599,602	341,961	354,814	452,226	343,536	438,650	521,022	351,581	287,801	358,727
Bad Debt	114,155	(144,638)	103,191	(114,798)	214,560	(24,155)	243,688	(92,400)	221,628	(133,838)	297,843	204,558	339,947
Total Deductions From Revenue	10,366,921	9,687,874	10,114,779	10,543,361	10,541,289	10,363,482	12,890,014	13,499,425	13,005,590	14,370,592	13,351,209	14,407,200	13,429,571
Net Patient Services Revenue	6,463,854	6,740,591	6,521,788	7,058,398	6,410,251	6,973,028	8,036,083	6,678,906	7,828,307	8,126,296	7,049,939	9,050,945	8,778,753
COVID Grant Revenue	1,106,281	337,283	1,496,853	25,046	455,985	107,900	50,843	712,772	52,506	249,375	107,208	38,580	-
Other Operating Revenue	16,804	206,955	19,922	28,650	118,972	(76,453)	23,220	50,187	23,821	15,152	27,206	15,458	9,756
Net Revenue	**7,586,939**	**7,284,829**	**8,038,563**	**7,112,094**	**6,985,208**	**7,004,475**	**8,110,146**	**7,441,865**	**7,904,634**	**8,390,823**	**7,184,353**	**9,104,983**	**8,788,509**
Operating Expenses	*65%*	*55%*	*59%*	*52%*	*63%*	*52%*	*48%*	*63%*	*60%*	*51%*	*59%*	*45%*	*56%*
Salaries	3,349,881	2,742,169	2,734,884	3,303,928	2,972,517	2,772,043	2,865,229	2,980,200	3,595,919	3,007,956	3,130,198	3,030,073	3,603,843
Benefits	578,262	832,824	685,761	68,030	827,743	492,813	753,577	929,136	864,394	805,166	737,393	614,207	877,804
Purchased Labor	270,875	152,018	427,135	310,891	250,000	386,545	269,484	288,146	267,672	328,737	321,151	429,131	438,176
Sub-Total Labor Costs	4,199,018	3,727,011	3,847,780	3,682,849	4,050,260	3,651,401	3,888,290	4,197,482	4,727,985	4,141,859	4,188,742	4,073,411	4,919,823
Professional Fees - Physicians	368,393	344,807	333,691	399,338	407,364	333,806	386,705	382,778	391,045	482,125	424,354	533,096	496,634
Professional Fees - Other	39,174	62,259	82,246	30,749	41,222	61,379	103,229	64,244	(26,169)	54,282	41,765	58,784	63,768
Supplies	1,114,451	1,255,438	877,373	1,080,455	1,134,236	1,003,996	1,100,475	961,608	1,416,520	1,182,777	1,122,439	1,198,991	1,244,844
Purchased Services - Utilities	44,629	34,396	26,701	33,590	49,802	23,513	49,904	37,431	33,429	46,709	53,512	58,004	41,073
Purchased Services - Other	400,511	277,356	423,787	458,116	335,478	381,919	365,468	382,103	477,295	319,531	330,670	459,142	441,901
Rentals & Leases	215,090	147,779	180,858	111,591	181,248	191,423	236,771	216,425	119,924	159,032	149,762	210,436	171,163
Insurance License & Taxes	120,304	90,770	97,105	92,103	99,053	87,858	87,811	101,813	94,344	112,234	87,476	83,089	144,742
Depreciation & Amortization	186,122	195,247	204,290	268,228	212,599	211,565	215,248	220,087	207,039	222,140	223,071	223,551	223,632
Other Operating Expenses	96,773	109,760	152,045	92,216	158,066	105,914	110,506	100,267	78,539	133,508	79,775	120,741	78,687
Sub-Total Non-Labor Expenses	2,585,447	2,517,812	2,378,096	2,566,386	2,619,068	2,401,373	2,656,117	2,466,756	2,791,966	2,712,338	2,512,824	2,945,834	2,906,444
Total Operating Expenses	**6,784,465**	**6,244,823**	**6,225,876**	**6,249,235**	**6,669,328**	**6,052,774**	**6,544,407**	**6,664,238**	**7,519,951**	**6,854,197**	**6,701,566**	**7,019,245**	**7,826,267**
Operating Income (Loss)	**802,474**	**1,040,006**	**1,812,687**	**862,859**	**315,880**	**951,701**	**1,565,739**	**777,627**	**384,683**	**1,536,626**	**482,787**	**2,085,738**	**962,242**
Non Operating Income													
Tax Revenue	71,831	73,342	71,831	73,097	74,817	80,262	88,426	77,100	74,594	80,517	78,534	76,197	77,946
Investment Income	2,347	11,834	(24,802)	(146,092)	476	476	(571,938)	11,722	8,769	(186,482)	2,158	10,012	(268,189)
Interest Expense	(33,739)	(32,265)	(32,361)	(20,143)	(31,143)	(60,844)	(21,572)	(30,723)	(39,532)	(21,447)	(30,255)	(30,052)	(29,986)
Other Non Operating Income (Expense)	-	-	-	6,000	-	81,261	14,920	(2,497)	(20,347)	-	-	4,200	-
Total Non Operating Income	**40,439**	**52,911**	**14,668**	**(87,138)**	**44,150**	**101,155**	**(490,164)**	**55,602**	**23,484**	**(127,412)**	**50,437**	**60,357**	**(220,229)**
Net Income (Loss)	**$ 842,913**	**$ 1,092,917**	**$ 1,827,355**	**$ 775,721**	**$ 360,030**	**$ 1,052,856**	**$ 1,075,575**	**$ 833,229**	**$ 408,167**	**$ 1,409,214**	**$ 533,224**	**$ 2,146,095**	**$ 742,013**
Total Margin	11.1%	14.9%	22.7%	11.0%	5.1%	14.8%	14.1%	11.1%	5.1%	17.1%	7.4%	23.4%	8.7%
Margin (Non Operating Income)	10.6%	14.3%	22.5%	12.1%	4.5%	13.6%	19.3%	10.4%	4.9%	18.3%	6.7%	22.9%	10.9%
Salaries as a % of Net Revenue	44.2%	37.6%	34.0%	46.5%	42.6%	39.6%	35.3%	40.0%	45.5%	35.8%	43.6%	33.3%	41.0%
Labor as a % of Net Revenue	55.3%	51.2%	47.9%	51.8%	58.0%	52.1%	47.9%	56.4%	59.8%	49.4%	58.3%	44.7%	56.0%
Operating Expense change from prior month	5%	-4%	-4%	-4%	3%	-7%	1%	3%	16%	6%	10%	8%	21%
Gross Revenue change from prior month	-11%	-13%	-12%	-7%	-10%	-8%	11%	7%	10%	19%	21%	24%	18%
Net Revenue change from prior month	-46%	-48%	-43%	-49%	-50%	-50%	-42%	-47%	-44%	-40%	9%	-35%	-37%

Prosser
Memorial Health

Statement of Cash Flows
September 30, 2022

CURRENT MONTH Actual	NET INCOME TO NET CASH BY OPERATIONS	YEAR TO DATE Actual
742,013	**NET INCOME (LOSS)**	**8,560,429**
223,632	Depreciation Expense	1,958,932
-	Amortization	-
-	Loss (Gain) on Sale of Assets	-
965,645	**TOTAL**	**10,519,361**
	WORKING CAPITAL	
(433,100)	Decrease (Increase) in Assets	(4,091,400)
736,074	Increase (Decrease) in Liabilities	950,139
1,268,619	**NET CASH PROVIDED BY OPERATIONS**	**7,378,100**
	CASH FLOWS FROM INVESTING ACTIVITIES	
(75,524)	Capital Purchasing	(3,377,577)
-	Proceeds on Capital Assets Sold	-
(71,096)	Investment Activity	(645,207)
(146,620)	**NET CASH USED BY INVESTING ACTIVITIES**	**(4,022,784)**
1,121,999	**NET CHANGE IN CASH**	**3,355,316**
	CASH BALANCE	
34,727,239	**BEGINNING**	**32,493,922**
35,849,238	**ENDING**	**35,849,238**
1,121,999	**NET CASH FLOW**	**3,355,316**

Prosser Memorial Health

Direct Cash Flow Statement

September 30, 2022

	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Year to Date 2022
CASH FLOWS FROM OPERATING														
PAYMENTS RECEIVED														
Commercial	3,130,632	3,153,931	2,875,267	3,330,492	2,870,461	2,644,488	3,345,808	3,083,155	3,080,772	3,456,092	3,664,670	3,459,009	3,952,203	29,556,658
Medicaid	2,103,782	1,687,063	1,529,067	1,709,233	1,527,015	1,438,583	1,933,332	1,793,945	1,717,575	1,999,159	1,776,093	1,922,625	2,251,936	16,360,263
Medicare	1,638,399	1,603,757	1,599,329	1,813,966	1,682,223	1,406,927	1,706,618	1,682,098	1,847,438	2,223,897	1,689,671	2,244,129	2,489,423	16,972,424
VA	56,988	52,706	66,281	119,229	83,053	37,616	94,447	100,585	74,713	18,848	46,441	74,217	46,243	576,163
Worker's Comp	109,063	145,456	130,592	154,764	154,456	80,761	125,210	100,871	123,467	196,392	274,009	213,343	196,405	1,464,914
Self Pay	163,813	108,110	129,044	97,535	65,480	93,400	120,387	66,663	98,505	69,161	123,196	84,611	65,184	786,587
Other Non Patient Payments	101,670	1,465,202	2,014,478	112,073	266,052	212,934	467,464	425,160	996,244	538,087	218,554	253,270	55,276	3,433,041
Cash Received (Patients, Insurance, Other)	**7,304,347**	**8,216,225**	**8,344,058**	**7,337,292**	**6,648,740**	**5,914,709**	**7,793,266**	**7,252,477**	**7,938,714**	**8,501,636**	**7,792,634**	**8,251,204**	**9,056,670**	**69,150,050**
Patient Refunds	(35,193)	(28,515)	(30,265)	(30,265)	(37,922)	(9,381)	(52,430)	(26,079)	(30,262)	(15,402)	(15,948)	(12,661)	(52,077)	(252,162)
AP Expenses	(3,276,658)	(3,837,948)	(3,398,633)	(1,628,648)	(3,425,965)	(2,483,587)	(4,162,503)	(4,176,244)	(4,332,217)	(3,764,079)	(3,055,432)	(3,345,398)	(3,856,458)	(32,601,883)
Settlement LumpSum Payments	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Payroll Expenses	(2,640,425)	(3,402,985)	(2,684,405)	(4,109,423)	(2,878,211)	(2,861,203)	(2,826,391)	(3,848,358)	(2,937,045)	(3,013,974)	(4,355,448)	(2,911,511)	(3,896,145)	(29,528,286)
Loan/Interest Expense	(114,934)	(57,467)	-	(456,436)	(57,467)	(57,467)	(57,467)	(57,467)	(57,467)	(224,627)	(54,467)	(54,467)	(54,467)	(675,363)
NET CASH PROVIDED BY OPERATING	**1,237,137**	**889,310**	**2,230,755**	**1,112,520**	**249,175**	**503,071**	**694,475**	**(855,671)**	**581,723**	**1,483,554**	**311,339**	**1,927,167**	**1,197,523**	**6,092,356**
CASH FLOWS FROM INVESTING ACTIVITIES														
Capital Purchasing	(421,857)	(175,878)	(772,834)	(386,876)	(641,743)	(216,418)	(134,128)	(249,106)	(371,445)	(658,291)	-	(390,385)	(75,524)	(2,737,040)
NET CASH USED BY INVESTING ACTIVITIES	**(421,857)**	**(175,878)**	**(772,834)**	**(386,876)**	**(641,743)**	**(216,418)**	**(134,128)**	**(249,106)**	**(371,445)**	**(658,291)**	-	**(390,385)**	**(75,524)**	**(2,737,040)**
NET CHANGE IN CASH	**815,280**	**713,432**	**1,457,921**	**725,644**	**(392,568)**	**286,653**	**560,347**	**(1,104,777)**	**210,278**	**825,263**	**311,339**	**1,536,782**	**1,121,999**	**3,355,316**
CASH BALANCE														
BEGINNING	**28,781,645**	**29,596,925**	**30,310,357**	**31,768,278**	**32,493,922**	**32,101,354**	**32,388,007**	**32,948,354**	**31,843,577**	**32,053,855**	**32,879,118**	**33,190,457**	**34,727,239**	**32,493,922**
ENDING	**29,596,925**	**30,310,357**	**31,768,278**	**32,493,922**	**32,101,354**	**32,388,007**	**32,948,354**	**31,843,577**	**32,053,855**	**32,879,118**	**33,190,457**	**34,727,239**	**35,849,238**	**35,849,238**
NET CASH FLOW	**815,280**	**713,432**	**1,457,921**	**725,644**	**(392,568)**	**286,653**	**560,347**	**(1,104,777)**	**210,278**	**825,263**	**311,339**	**1,536,782**	**1,121,999**	**3,355,316**

Prosser
Memorial Health

Key Operating Statistics
September 30, 2022

Month Ending Actual	Budget	Variance	%		Year to Date Actual	Budget	Variance	%	Prior Year	Change
				Key Volumes						
283	248	35	14%	Inpatient Acute Days	2,585	2,257	328	15%	2,632	-2%
148	148	0	0%	Inpatient Swing Days	931	1,346	(415)	-31%	682	37%
431	396	35	9%	**Total Inpatient Days**	3,516	3,603	(87)	-2%	3,314	6%
96	148	(52)	-35%	Inpatient Admissions	986	1,346	(360)	-27%	1,061	-7%
98	148	(50)	-34%	Inpatient Discharges	972	1,346	(374)	-28%	1,060	-8%
6	11	(5)	-47%	Swing Bed Discharges	53	103	(50)	-49%	60	-12%
2,500	1,874	627	33%	Adjusted Patient Days	19,362	17,050	2,312	14%	15,485	25%
14.37	13.20	1.17	9%	Average Daily Census	12.88	13.20	(0.32)	-2%	12.14	6%
569	700	(132)	-19%	Adjusted Discharges	5,353	6,371	(1,019)	-16%	4,953	8%
2.89	1.68	1.21	72%	Average Length of Stay - Hospital	2.66	1.68	0.98	59%	2.48	7%
14.00	13.04	0.96	7%	Average Length of Stay - Swing Bed	14.00	13.04	0.96	7%	11.37	23%
57%	53%	5%	9%	Acute Care Occupancy (25)	52%	53%	-1%	-2%	49%	6%
42	49	(7)	-15%	Deliveries	440	449	(9)	-2%	441	0%
199	120	79	66%	OR Surgical Procedures	1,597	1,093	504	46%	1,544	3%
102	65	37	*58%*	GI Procedures	818	589	*229*	*39%*		
1,501	1,068	433	40%	Emergency Dept Visits	11,747	9,723	2,024	21%	9,762	20%
14,778	13,808	970	7%	Laboratory Tests	130,956	125,655	5,301	4%	129,910	1%
3,317	2,812	505	18%	Radiology Exams	26,335	25,592	743	3%	27,111	-3%
1,365	1,334	31	2%	PMH Specialty Clinic	12,966	12,136	830	7%	11,711	11%
881	856	25	3%	PMH - Benton City Clinic Visits	7,002	7,791	(789)	-10%	6,835	2%
1,138	1,274	(136)	-11%	PMH - Prosser Clinic Visits	10,507	11,590	(1,083)	-9%	11,735	-10%
1,107	955	152	16%	PMH - Grandview Clinic Visits	8,804	8,695	109	1%	6,402	38%
569	670	(101)	-15%	PMH - Women's Health Clinic Visits	5,391	6,097	(706)	-12%	5,552	-3%
				LABOR FULL-TIME EQUIVALENT						
330.54	345.07	14.53	4%	Employed Staff FTE's	319.52	345.07	25.55	7%	268.89	19%
33.90	34.75	0.85	2%	Employed Provider FTE	33.87	34.75	0.88	3%	29.38	15%
364.44	379.82	15.38	4%	All Employee FTE's	353.39	379.82	26.43	7%	298.27	18%
311.63	303.86	(7.77)	-3%	Productive FTE's	308.61	303.86	(4.75)	-2%	262.17	18%
13.52	18.65	5.13	28%	Outsourced Therapy FTE's	14.00	18.65	4.65	25%	15.30	-8%
12.10	11.65	(0.45)	-4%	Contracted Staff FTE's	9.02	11.65	2.63	23%	7.52	20%
25.62	30.30	4.68		All Purchased Staff FTE's	23.02	30.30	7.28	24%	22.82	1%
9.05	12.00	2.95	25%	Contracted Provider FTE's	8.26	12.00	3.74	31%	7.05	17%
399.11	422.12	23.01	5%	All Labor FTE's	384.67	422.12	37.45	9%	328.14	17%

Prosser
Memorial Health

Financial Operations
September 30, 2022

	YTD 2021	YTD 2022	YTD Budget 2022
Utilization			
Admissions	1,061	986	1,346
Adjusted Admissions	4,957	5,430	6,371
Average Daily Census	9.6	9.5	8.3
Adjusted Occupied Beds	45.0	52.1	39.1
Average Length of Stay (days)	2.5	2.6	1.7
Outpatient Revenue %	78.6%	81.8%	78.9%
Total Yield (net patient revenue)	45.6%	23.1%	45.3%
Hospital Case Mix Index	0.99	0.99	1.00
Average Charge Per Patient Day	9,492	9,544	9,568
Financial Performance ($000)			
Net Patient Revenue	57,519	68,933	64,541
Total Operating Revenue	66,051	70,915	65,935
Total Operating Expense	53,589	61,852	61,821
Income (Loss) from Operations	12,462	9,063	4,114
Excess of Revenue Over Expenses	12,791	8,560	4,410
EBIDA (Operating Cash Flow)	14,093	11,022	5,881
Additions to Property, Plant, and Equipment	5,109	3,378	557
Balance Sheet ($000)			
Unrestricted Cash and Investments	9,545	13,257	16,686
Accounts Receivable (gross)	33,644	39,883	26,541
Net Fixed Assets	19,472	21,603	31,774
Current and Long-Term Liabilities (excluding LT debt)	11,374	10,807	7,884
Long-Term Debt	9,884	9,044	8,928
Total Liabilities	21,258	19,851	16,812
Net Worth	45,369	57,626	55,460

	YTD 2021	YTD 2022	YTD Budget 2022
Key Ratios			
Operating Margin (%)	18.9%	12.8%	6.2%
Total Margin (%)	19.4%	12.1%	6.7%
Operating EBIDA Margin (Operating Cash Flow)	21.3%	15.5%	8.9%
Average Expense per Adjusted Patient Days	3,461	3,195	3,626
Average Net Revenue per Adjusted Patient Days	3,715	3,560	3,785
Net Accounts Receivable (days)	57.82	54.65	53.60
Current Ratio (x)	2.14	2.86	3.80
Cash on Hand (days)	148	163	109
Cushion Ratio (x)	92.10	121.29	43.67
Return on Equity (%)	28.19%	14.86%	11.01%
Capital Spending Ratio	5.77	3.11	0.61
Average Age of Plant (Years)	13.82	12.50	10.52
Debt Service	11.67	7.52	6.55
Debt-to-Capitalization (%)	20%	16%	12.78%
Patient Revenue Sources by Gross Revenue (%)			
Medicare	32.2%	31.3%	32.2%
Medicaid	30.8%	30.6%	30.8%
Commercial Insurance	29.3%	31.7%	29.3%
Self-pay and Other	4.4%	2.9%	4.4%
Labor Metrics			
Productive FTE's (incl contract labor)	292.04	339.89	346.16
Total FTE's (incl contract labor)	328.14	384.67	422.12
Labor Cost (incl benefits) per FTE - Annualized	134,128	131,157	117,271
Labor Cost (incl benefits) as a % of Net Operating Revenue	50.0%	53.4%	56.3%
Net Operating Revenue per FTE - Annualized	268,387	245,804	208,265
Operating Expense per FTE - Annualized	217,750	214,390	195,272

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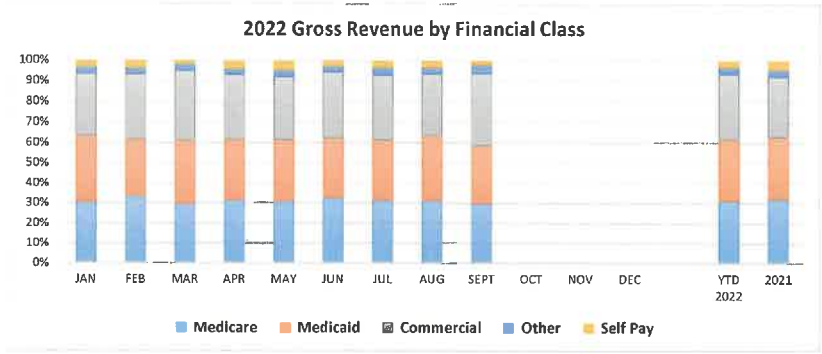
Prosser
Memorial Health

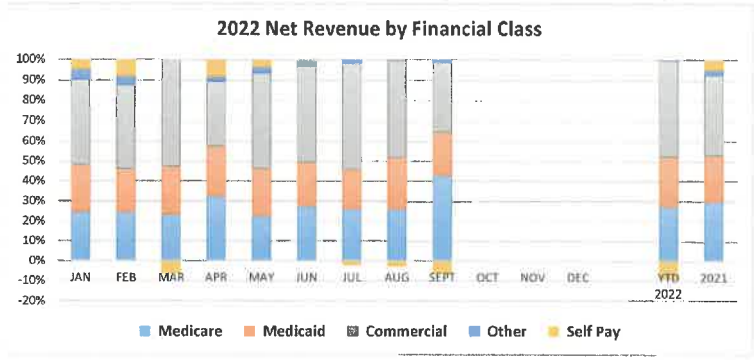
Revenue by Financial Class
September 30, 2022

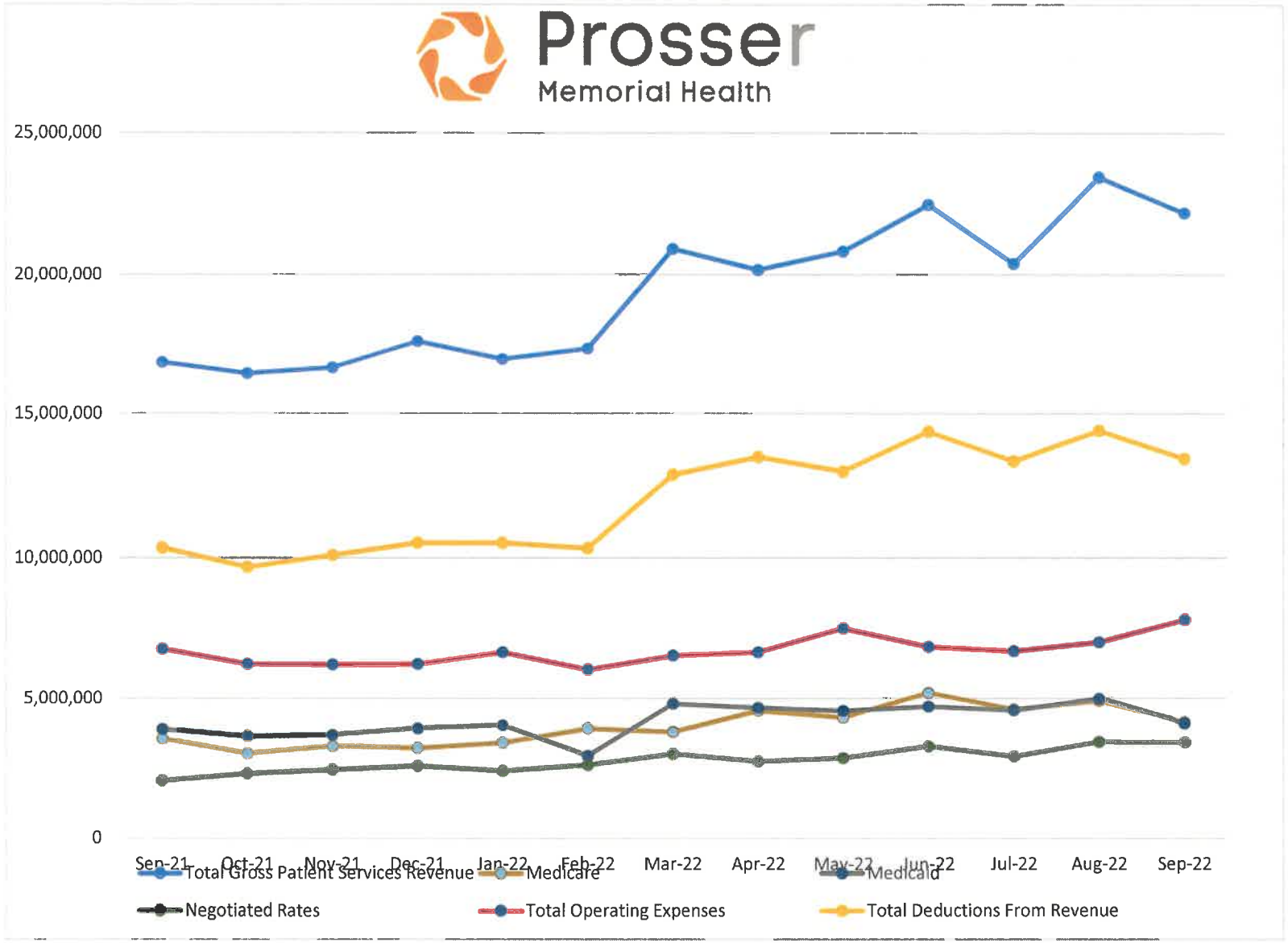
Month	Medicare	Medicaid	Commercial	Other	Self Pay	Total
JAN	30.6%	33.1%	29.9%	3.4%	3.0%	100.0%
FEB	33.6%	28.3%	31.5%	3.4%	3.2%	100.0%
MAR	29.6%	31.8%	33.6%	3.5%	1.5%	100.0%
APR	31.5%	30.2%	31.5%	2.9%	3.9%	100.0%
MAY	30.9%	30.8%	30.5%	3.4%	4.5%	100.0%
JUN	32.8%	29.7%	31.8%	3.0%	2.6%	100.0%
JUL	31.6%	29.9%	31.5%	4.0%	3.0%	100.0%
AUG	31.4%	32.4%	29.7%	3.5%	3.0%	100.0%
SEPT	29.8%	29.0%	34.8%	4.6%	1.8%	100.0%
OCT						
NOV						
DEC						
YTD 2022	31.3%	30.6%	31.7%	3.5%	2.9%	100.0%
2021	32.2%	30.8%	29.3%	3.3%	4.4%	100.0%



Net Revenue by Financial Class
September 30, 2022

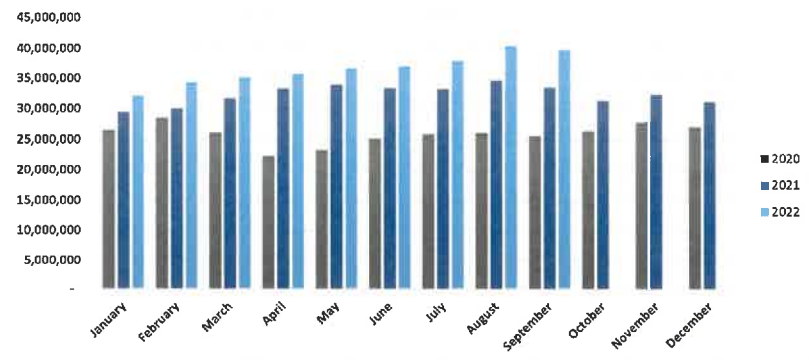
Month	Medicare	Medicaid	Commercial	Other	Self Pay	Total
JAN	24.9%	23.6%	42.0%	5.2%	4.3%	100.0%
FEB	24.7%	21.6%	41.5%	4.6%	7.6%	100.0%
MAR	23.6%	24.0%	54.5%	3.8%	-6.0%	100.0%
APR	32.6%	25.2%	31.8%	2.7%	7.7%	100.0%
MAY	22.7%	23.9%	47.1%	3.1%	3.3%	100.0%
JUN	27.6%	22.2%	46.8%	2.5%	0.8%	100.0%
JUL	26.3%	19.8%	52.1%	3.4%	-1.6%	100.0%
AUG	26.2%	25.9%	47.9%	2.4%	-2.4%	100.0%
SEPT	43.1%	21.8%	33.7%	7.4%	-6.0%	100.0%
OCT						
NOV						
DEC						
YTD 2022	27.5%	25.0%	47.5%	8.6%	-8.6%	100.0%
2021	29.8%	23.5%	39.5%	2.7%	4.5%	100.0%



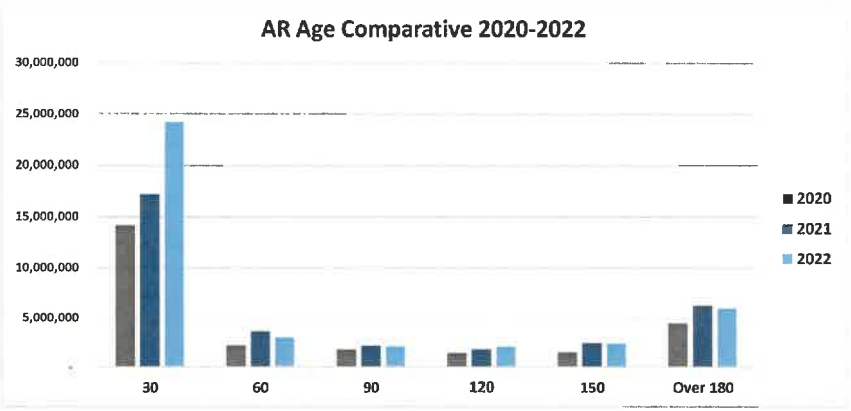

Prosser
Memorial Health
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
0
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Total Gross Patient Services Revenue
Medicare
Medicaid
Negotiated Rates
Total Operating Expenses
Total Deductions From Revenue

Prosser
Memorial Health

AR Balance Trend - 2020-2022



AR Age Comparative 2020-2022



AR Balance Trend

	2017	2018	2019	2020	2021	2022	% Change
January	13,660,199	16,931,510	19,428,531	26,540,403	29,542,976	32,260,939	*9%*
February	14,529,841	16,911,324	19,146,130	28,567,785	30,120,411	34,474,143	*14%*
March	15,115,376	14,989,166	19,513,147	26,130,696	31,816,016	35,287,961	*11%*
April	15,752,955	15,852,894	19,692,139	22,350,961	33,444,324	35,889,741	*7%*
May	15,131,907	16,812,980	19,455,887	23,319,876	34,107,637	36,813,211	*8%*
June	15,446,995	16,291,895	21,223,053	25,197,275	33,577,529	37,192,042	*11%*
July	15,918,959	15,979,415	20,206,074	25,943,825	33,378,224	38,080,535	*14%*
August	17,412,422	16,633,907	20,028,246	26,144,421	34,777,364	40,568,933	*17%*
September	**17,547,651**	**17,129,789**	**23,681,156**	**25,640,562**	**33,643,597**	**39,883,272**	**19%**
October	15,948,473	16,950,256	25,724,222	26,432,788	31,514,355		
November	16,292,336	17,374,013	25,655,024	27,862,474	32,541,479		
December	16,777,361	17,137,550	25,486,600	27,102,309	31,324,657		

AR Age Balance Comparative

	30	60	90	120	150	Over 180
2016	6,516,378	1,533,379	1,192,796	845,040	1,198,353	3,169,977
2017	8,485,080	2,326,733	1,239,497	1,126,649	1,319,407	3,050,285
2018	11,407,804	1,499,180	856,784	887,912	844,368	1,633,740
2019	14,686,419	2,050,648	1,390,503	1,195,111	1,602,547	2,755,927
2020	14,182,107	2,206,130	1,798,418	1,439,186	1,523,978	4,490,743
2021	17,232,998	3,669,536	2,177,756	1,825,705	2,462,740	6,274,862
2022	24,239,735	3,040,033	2,113,169	2,105,763	2,397,735	5,986,837

AR Percentage of Total Balance

2016	45%	11%	8%	6%	8%	22%
2017	48%	13%	7%	6%	8%	17%
2018	67%	9%	5%	5%	5%	10%
2019	62%	9%	6%	5%	7%	12%
2020	55%	9%	7%	6%	6%	18%
2021	51%	11%	6%	5%	7%	19%
2022	61%	8%	5%	5%	6%	15%

Prosser
Memorial Health

Lease Schedule
As of:
September 30, 2022

Building Rentals

Lease	Effective Date	Term Date	Auto Renew	Payment Amount		2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Total
Prosser Professional Center	May-17	April-32		20,687.55	RHC	253,240	255,698	260,838	263,369	263,369	268,663	271,270	276,722	282,174	287,790	45,020		3,222,270
Prosser Professional Center	May-17	April-32		9,583.00	Therapy	115,000	116,650	120,000	121,188	123,600	124,824	127,308	128,568	131,127	132,425	95,930		1,566,620
Prosser Family Fitness Pool	Jul-15	Jul-22		32,812.50	Therapy	73,625	16,000	16,000	16,000	16,000	8,000							408,125
Benton City Professional Center	May '12	2027		14,000.00	Family Med	168,000	168,000	168,000	168,000	168,000	56,000							1,232,000
Benton City Professional Center	May '12	2027		4,775.00	Pain Clinic	57,300	57,300	57,300	57,300	57,300	19,100							420,200
Yakima Valley Farmworkers	Oct-06	Oct-47		16,539.93	Spec Clinic	190,400	62,400	63,960	65,559	67,198	68,878	70,600	72,365	74,174	76,028	77,929	79,877	1,366,327
Chardonnay Building with Builder	Jun-13	Jun-28		9,082.00	OB/GYN	108,984	108,984	108,984	108,984	108,984	108,985	49,951						921,824
					Total Building Leases	966,549	785,032	795,082	800,400	804,451	654,449	519,129	477,656	487,475	496,244	218,880	79,877	9,137,366

A -
41770060 BUILDING RENTAL -PT
41770721 BUILDING RENTAL -ST
41770722 BUILDING RENTAL -OT

Leased Equipment

Lease	Effective Date	Term Date	Auto Renew	Payment Amount													Total
Stryker - Fee per Case agreeement	Mar-18	Mar-23		7,739.16		92,870	23,217										394,697
Biomerieux	Dec-19	Dec-24		798.70		9,584	9,584	8,786									47,922
Flex Financial (MAKO)	Oct-19	Oct-24		21,157.04		233,779	233,779	175,335									1,168,897
Karl Storz	Mar-21	Aug-23		5,838.37		70,060	46,707										175,151
Leaf	Sep-16	Sep-20	Renewed	7,807.00		93,684	93,684	93,684									336,000
Baxter - Infusion Pumps	Aug-17	Aug-22		193.80		1,550											6,202
Baxter - Spectrum SW	Aug-17	Aug-22		60.00		480											1,920
Quadient	Apr-20	Jul-25		282.00		3,384	3,384	3,384	1,974								17,766
					Total Equipment Leases	505,393	410,356	281,188	1,974	-	-	-	-	-			2,701,560
					Total Future Leases	1,471,942	1,195,388	1,076,270	802,374	804,451	654,449	519,129	477,656	487,475	496,244	218,880	79,877	11,838,926

Prosser
Memorial Health

Capital Expenditure Budget

GL #	DEPARTMENT	YEAR	DESCRIPTION	APPROVED COST	Anticipated by YE	Spent To Date	Purchase Date
60700	Med/Surg	**2022**	Sit to Stand Chair	10,000	Yes		
		2022	Blanket warmer	6,000	Yes		
		2022	Child Cribs (x2)	18,000	Yes		
		2022	Sleeper Sofa - Room 4	5,500	Yes		
		2022	Zoll Monitor	50,000	Yes		
70100	Family Birthplace	**2022**	Draeger Infant Warmer	13,224	Yes	14,298	8/1/2022
70200	Surgical Services	2021	Colonoscope Sterilizer	80,000	Yes	86,166	5/1/2022
		2022	Erbe	72,062	Yes	49,320	1/1/2022
		2022	Olympus Colonoscopes (x4)	185,038	Yes	185,038	11/24/2021
		2022	Stryker SPY-PHI (blood flow monitor)	115,000	Yes	121,951	6/1/2022
		2022	Megadyne Ace Blade	13,500	Yes		
		2022	Gastroscopes (x2)	46,000	Yes	50,662	7/1/2022
		2022	Flexible Uteroscope	15,500	Yes		
70700	Laboratory	2021	Nova Biomedical Stat Profile	13,227			
		2022	Chemistry Freezer	6,658	Yes	6,332	5/1/2022
		2022	RALS middleware interface	29,363			
		2022	Bugsy - EPIC module IC surveillance	90,000			
71400	Diagnostic Imaging	2021	TEE Service Line	132,234	Yes	31,480	*ongoing
		2022	i-STAT blood analyzer	11,868			
71800	Cardiopulmonary	**2022**	Philips V60 BiPAP Interface	43,322			
		2022	PFT Interface (Easy Pro)	15,000			
		2022	Hamilton Ventilator Interface	15,000	Yes	34,852	7/1/2022
72000	Physical Therapy	**2022**	Chattanooga Vectra GENSYS	5,736			
72300	Emergency Dept	**2022**	Stryker Stretchers (x3)	22,300	Yes		
		2022	ED EHR Module	10,000	Yes		
		2022	Metro Carts (x2)	15,000	Yes		
		2022	Altrix Unit	30,000	Yes		
		2022	Level 1 Unit	8,000	Yes		
		2022	Zoll Monitor	50,000	Yes		
72500	OSP	2021	Exam Chair	11,000			
		2021	Blanket Warmer	5,000			
		2022	New Patient Care divider curtains	7,000			
72600	Benton City	2021	Security Cameras	12,000			
		2022	Repainting of Building	38,622			
		2022	Remodel for Provider Office	7,020			
72630	Grandview	**2022**	Venue Go Ultrasound	44,890	Yes		
		2022	Cabinet and Desk Remodel	15,000	No		
72640	Women's Health	**2022**	Blanket Warmer	5,000	Yes		
		2022	Fluid Warmer	5,000	Yes		
72700	Specialty Clinic	**2022**	Medtronic Pill Capsule	17,889	Yes	16,019	1/1/2022
		2022	Provation Prof Fees Documenting SW	26,405	Yes	26,405	1/31/2022
		2022	Olympus Scopes	56,104			
84600	Environmental Services	**2022**	Carpet Shampooer	13,000			
		2022	Floor Scrubber	15,000			
85400	Information Technology	**2022**	Virtual Desktop Expansion	91,471			
		2022	Replacement Firewall	33,201	Yes	42,975	6/1/2022
		2022	Server Storage Archiving	14,000			
		2022	Interpretor Compliance HW/SW	20,000	Yes	24,998	*ongoing
85600	Scheduling Call Center	**2022**	Call Center Cubicle Set up	30,000		13,742	4/30/2022
87400	Employee Health	**2022**	@Net Health Agility	18,500			
			2022 Capital Items	**1,401,400**		*$ 65,339*	
			2021 Carryover Approved Capital Items	**212,234**		*$ 31,480*	
			TOTAL	**$ 1,613,634**		**$ 704,238**	
NON BUDGETED CAPITAL - BOARD APPROVED DURING 2022							
70200	Surgery	2022	Universal Driver (Stryker)			26,728	1/1/2022
70200	Surgery	2022	WM-DP# Mobile Workstation			70,539	2/1/2022
70200	Surgery	2022	Neptune 3 Rover			17,157	3/1/2022
70200	Surgery	2022	Electrosurgical Unit			12,588	9/1/2022
70200	Surgery	2022	Smartpump Dual Channel			7,738	9/1/2022
85100	Accounting	2021	Kronos			7,500	8/1/2022
85300	Patient Financial Svcs	2021	COVID Business Office Remodel			64,749	4/1/2022
85400	Information Technolo	2022	Cooling System			9,291	8/1/2022
						$ 216,290	
						$ 920,528	

Prosser Memorial Health

As of:

September 30, 2022

Capital Project Expenditures

Project Name	Budget	Jul-22	Aug-22	Sep-22
CIP - New Prosser Hospital		5,236,150	5,597,075	5,665,755
CIP - Gap Rd Land Improvement		118,571	118,571	118,571
	78,400,000	5,354,721	5,715,646	5,784,326
CIP - DI TEE Project	132,234	-	-	-
CIP - Dermatology Clinic	235,000	260,157	260,157	260,157
CIP - Beaker Lab System	788,596	-	-	-
CIP - Call Center	30,000	813	813	-
CIP - 1511 Meade Ave		12,378	12,378	12,378
CIP - PFS Office Remodel	35,328	-	-	-
Asset Clearing:				
TD100 System Additional Cost		2,216	2,216	2,216
Stryker Ceiling Exam Lights		-	-	-
Zoll Medical - Remote View X-series		5,000	5,000	5,000
Additional Cost to Firewall		209	209	209
16 Ipads (CDW Intrep Project)				
Core 2 (US)		20,431	20,431	20,431
Infant Resuscitative Warmer		14,298	-	-
Aquaplus Steamcleaner		12,459	12,459	12,459
Megadyne Elect gen/Smoke Evac			12,668	-
	81,093,614	5,682,682	6,041,977	6,097,176

Attachment R

Craig Marks

From: Beth Zborowski <BethZ@wsha.org>
Sent: Monday, October 03, 2022 2:48 PM
To: Craig Marks
Subject: WSHA 2Q Hospital Financial Survey Results
Attachments: image001.emz

Follow Up Flag: Follow up
Flag Status: Flagged

Hello excellent WSHA member CEOs, CFOs, Government Affairs and Public Relations teams,

We are preparing to release the results of WSHA's Q2 Financial Survey during a media briefing tomorrow morning. While the cumulative losses have grown since the Q1 press briefing in July, the narrative remains largely the same.

Included at the bottom of this email you will find a high-level summary of the survey results and updated talking points. We ask that you keep this information confidential until after WSHA's media briefing on Tuesday, October 4 at 9 a.m. If you are interested in listening in on the media briefing, you may register by visiting: https://wsha-org.zoom.us/meeting/register/tZItd--qqTIoGNx7YbSp1azHm8bfFXqGcc75

I want to thank the panelists who will join Cassie Sauer for the briefing, including:

- Mike Marsh, CEO, Overlake Medical Center
- Jacque Cabe, CFO, UW Medicine, Vice President for Medical Affairs, University of Washington at UW Medicine
- Diane Blake, CEO, Cascade Medical Center
- Alex Jackson, Chief Executive and Senior Vice President of the Inland Northwest Region for MultiCare Health System
- Eric Lewis, Chief Financial Officer, WSHA
- Chelene Whiteaker, SVP Government Affairs, WSHA

We hope you will use the included talking points to continue to tell your own hospital's story. We appreciate your partnership in advocating for sustainable access to vital hospital services.

Sincerely,
Beth Zborowski
Senior Vice President, Member Engagement and Communications
Washington State Hospital Association
Pronouns: she/her
Email: bethz@wsha.org | Phone: (206) 577-1807 | Cell: (208) 412-3886

Q2 2022 Financial Survey Results & Talking Points

Embargoed until 9:00 a.m. October 4, 2022

WSHA surveyed all acute care hospitals in Washington to compare their quarterly financial results from the second quarter of 2022 to the second quarter of 2021. The survey included all operations of their health system along with details on their COVID Relief, employee wages/benefits, and temporary labor expenses.

This survey represents all hospital systems and almost 97% of hospital beds across the state. Hospitals included in the survey employ more than 117,000 people. Hospitals and health systems also work with thousands of independent physicians, many through medical groups.

Washington State Hospitals Financials Six Months Ending June 30, 2022 and 2021			
Financial Metric	January - June 2022	January - June 2021	% Change Prior Year
Total Operating Revenue	$ 14,734,703,824	$ 14,161,794,360	4%
Employee Wages and Benefits	$ 7,623,979,677	$ 7,023,925,900	9%
Agency Traveler Costs	$ 1,021,583,579	$ 305,262,952	235%
Other Expenses	$ 7,251,800,249	$ 6,945,415,029	4%
Total Operating Expenses	$ 15,897,363,505	$ 14,274,603,881	11%
Net Operating Income (Loss)	$ (1,162,659,681)	$ (112,809,521)	931%
Operating Margin	-8%	-1%	
Net Non-Operating Revenues (Expenses)	$ (782,215,520)	$ 648,683,523	-221%
COVID Relief	$ 193,963,727	$ 327,178,439	-41%
Net Income (Loss)	$ (1,750,911,474)	$ 863,052,441	-303%
Net Income (Loss) Margin	-12%	6%	

Washington State Hospitals Financials 2nd Quarter (April - June)			
Financial Metric	April - June 2022	April - June 2021	% Change Prior Year
Total Operating Revenue	$ 7,572,927,018	$ 7,324,132,319	3%
Employee Wages and Benefits	$ 3,758,795,029	$ 3,510,682,318	7%
Agency Traveler Costs	$ 584,000,678	$ 159,567,409	266%
Other Expenses	$ 3,700,004,727	$ 3,532,351,067	5%
Total Operating Expenses	**$ 8,042,800,434**	**$ 7,202,600,793**	12%
Net Operating Income (Loss)	$ (469,873,416)	$ 121,531,526	-487%
Operating Margin	**-6%**	**2%**	
Net Non-Operating Revenues (Expenses)	$ (489,349,407)	$ 347,930,518	-241%
COVID Relief	$ 137,485,146	$ 211,063,397	-35%
Net Income (Loss)	**$ (821,737,677)**	$ 680,525,441	-221%
Net Income (Loss) Margin %	**-11%**	**9%**	

Financial Survey Results Talking Points

Key audiences: legislators, state agencies, hospital staff, community and business leaders, and media

Key Findings & Topline Messages:

- **Hospitals are critical community infrastructure.** Washingtonians rely on hospitals to be there to care for heart attacks, strokes, trauma, appendicitis, cancer, and other emergency and acute needs. Access to this specialized care is threatened by unsustainable financial losses.
- **Hospitals and health systems losses grew to $1.75 billion in the first six months of 2022 with almost $1.2 billion of this loss from operations.** This is a growth from previously reported operating losses of $693 million during the first quarter of 2022. We expect hospitals will face continued losses during the second six months of 2022 and into 2023.
- **These losses are not sustainable and are impacting hospital and health systems' capacity. There could be long-term impacts on availability of health care services to patients and communities**.
- **There are several factors contributing to hospital financial losses**, including:
    - Low Medicaid reimbursement as urban hospitals have not received a rate increase in more than 20 years.
    - High inflation resulting in drug, energy and supply costs increasing faster than payment rates
    - Labor shortages leading to higher costs of staffing, including increased labor contracts and traveling staff.
    - To recruit and retain staff, hospitals increased employee compensation by an average of 9% per employee in the first six months of 2022 compared to the prior year. This is for employed staff and does not include recent contract increases.
    - More complex patients whose care costs are much higher than reimbursement.
    - A large and increasing number of patients ready for discharge who are not able to secure placement in nursing homes or other post-acute care facilities.
    - Federal funding used to keep hospitals operating in 2020 and 2021 is almost all gone.
- Since the start of the pandemic, hospitals and health systems have worked to maintain access to health care services, however on-going losses cannot be sustained.

- Negative margins and a lack of reserves create capacity challenges and threaten the ability to sustain health care services. Without a small positive margin and/or reserves, hospitals and health systems struggle to:
    - Keep inpatient beds open – an already limited resource in Washington state, which has the fifth-lowest number of inpatient beds per capita in the country.
    - Increase wages to recruit and retain staff.
    - Reinvest in equipment, facilities or new services needed by the community.
    - Maintain critical community health services that do not generate revenue and are not core to the acute hospital care mission. Some examples include dental and behavioral health services, among others.
    - Pay principle on debt.
- Ongoing large financial losses will result in less access to health care for patients, as some hospitals are forced to close inpatient beds or units, or limit availability of certain services. Ultimately, continuation of these losses threatens hospitals with bankruptcy/closure.
- Hospitals are asking the state to address some of the factors driving these losses.

Detailed talking points

- ***Concerning and unsustainable trend:*** In aggregate for hospitals across the state, the net loss was approximately -$1.75 billion for the first six months of 2022, which represents a -12% total margin. Operating losses were approximately $1.2 billion for the same period. This means the cost of taking care of patients exceeded hospital reimbursement by $1.2 billion during the first six months of 2022! This shortfall is on-going and threatens patient care if not addressed. Consider sharing your organization's losses.

- ***Hospitals and health systems across Washington state have experienced negative margins and cash flow for the first six months of 2022 and anticipate massive losses to continue through the rest of the year and into 2023.*** This trend is unsustainable at a time when the cost of labor and supplies are increasing due to high inflation.
- These losses are inclusive of government COVID relief funds. Federal relief payments have ended and hospitals are no longer receiving additional funds.
- The causes of these unsustainable losses include the following:
    - Hospital reimbursement is growing much slower than inflation.
    - Hospitals cannot increase their prices to cover increasing costs of labor and supplies.
    - Hospital reimbursement for services is locked into fixed government fee schedules and contracts with insurance companies.
    - Between 60 and 80 percent of hospital patients are insured by government programs – Medicare and Medicaid. These programs significantly underpay hospitals compared to what it costs to provide services.
    - Medicaid paid 63 percent of the cost of care in 2020. Due to cost increases, some hospitals were paid as low as 42 percent of costs in the first six months of 2022. Most urban hospitals have not had a Medicaid rate increase in more than 20 years. Our state Medicaid payments are among the lowest in the country.
    - Medicare only increases reimbursements between 1 and 3 percent per year.
    - Costs to operate hospitals have increased significantly due to general inflation, labor shortages, drug costs and supply chain disruptions.
        - Labor shortages are massive, which are significantly increasing costs and making operations unstable. Hospitals have had to increase their workforce spending. Share your organization's experience with shortages and efforts you've taken to recruit and retain staff.
        - To meet high patient care needs, hospitals have increased their workforce with temporary labor by 133%. Hourly rates for these temporary workers have increased an astonishing 43%. The bottom line is temporary labor costs increased by an additional $716 million from 2021-2022. Share your temporary labor costs.
        - Inflation on needed supplies, drugs, energy, purchased services and other costs has been significant over the last 2 years.
    - The last COVID relief dollars were delivered to Washington hospitals/health systems in December 2021, with almost all funding used for COVID-related employee and supply expenses and lost revenues incurred in 2021 or earlier. Share the amount of federal relief received and how/when it was used.
    - Hospitals also had significant nonoperating investment losses in the first six months of 2022. Hospitals regularly and prudently invest reserves to earn interest on the funds while they wait for use, purchasing new equipment, funding new services or expanding physical space. Revenue from investments can also offset governmental payment shortfalls. In the first six months of 2022, even prudent investments, such as government bonds, lost money.
- Most of these losses are from large urban hospitals. Combined, urban and system hospitals lost $460 million from operations in the second quarter of 2022. This accounts for 98% percent of losses statewide.
- Almost 52 urban hospitals/systems had negative margins, totaling over $825 million in the second quarter of 2022.
- For independent rural hospitals, 24 out of 32 had negative operating margins in the second quarter of 2022.
- These financial challenges are happening at a national level, but Washington state's hospital losses are larger due to low Medicaid rates, more patients being ready for discharge but having no place to go, challenges with our behavioral health treatment system and a number of other factors.
- Hospitals in Washington state were also the first to be hit with the COVID-19 pandemic. They are continuing to treat patients with this illness, often at a loss.

- Hospitals are experiencing an elevated level of extremely sick patients across our state and the costs of treating these patients far exceeds reimbursement amounts. Therefore, the higher number of patients is resulting in larger losses.
    - One hospital shared examples of claims for Medicaid patients that received inpatient care for COVID-19. The sample included 12 patients with lengths of stay ranging from 11 to 63 days. For these cases, the combined actual cost of care was about $900,000, though Medicaid paid only $430,000. The hospital then had to bear the remaining cost of over a half-million dollars. Since there is no specific payment category for COVID yet, Medicare and Medicaid are currently paying 120% of the normal payment for respiratory admissions, such as pneumonia, far short of the increased complexity, length of stay and cost of care for these patients.
    - A children's hospital shared examples of a range of inpatient and outpatient claims, including both very complex cases, such as heart surgery, and more routine cases, such diabetes care. In most cases, the Medicaid payment was less than half the hospital's actual cost to provide the service. In one example involving surgery to a child with complications of autism and obesity, Medicaid only paid 12 percent of the hospital's actual cost to provide the care.
- Consider sharing your own organization's examples of underpayment.
    - Ongoing large financial losses will result in less access to health care for patients, as some hospitals will be forced to close inpatient units or limit availability of certain services. Ultimately, continuation of this threatens hospitals with bankruptcy/closure. Consider sharing how you foresee ongoing losses impacting care in your community.

There are actions the state can take to address the current financial crisis.

- The most immediate request from Washington's hospitals is to help address the difficult-to-discharge problem.
    - Between 10 and 20 percent of hospital patients statewide do not have a need for hospital-level care but are stuck in the hospital. Many of these patients are in the state's care.
    - These patients are not getting the support they need and occupy a tremendous amount of valuable hospital space: A patient in the hospital for 60 days displaces 20 normal-stay patients.
    - Caring for them with little or no payment is stressful to staff, financially devastating and impacts other patients. Specifically, in the short-term, we are asking the state to:
        - Fix the guardianship interpretation when a patient lacks capacity and needs long-term care in the Medicaid program. Not allowing family members to consent to long-term care placement is an equity issue;
        - Fund "bed-readiness" programs, in which hospitals pay for placement in long-term care. Hospitals cannot and should not be using precious resources for lifesaving and critical care for patients who can be served in long-term care.
        - Fund rapid response teams in long-term care to ensure they have adequate staffing to take patients needing discharge from acute care hospitals; and
        - Fund respite care for all patients with developmental disabilities who are living in hospitals.
- During the 2023 legislative session, our priorities will include:
        - Increasing Medicaid rates for hospitals.
        - Securing new funding to support post-acute care providers to ensure the state's health care system flows as it should, providing people with the access to care that they need in an appropriate setting. This will help them avoid becoming stuck in hospitals without the need for specialized care.
        - Support for behavioral health patients in crisis to allow intervention prior to an emergency department visit.

KaufmanHall

AUGUST 2022

National Hospital Flash Report

Real Data. Real Insight. Real Time.

Based on July Data from More Than 900 Hospitals

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Key Observations

Summary

U.S. hospitals and health systems are experiencing some of the worst margins since the beginning of the pandemic, and 2022 continues to be on pace to be the worst year of the pandemic in terms of financial performance. The gains hospitals saw in recent months reversed themselves in July, as lagging outpatient volumes shrunk revenues and expenses jumped up from June. Hospitals can no longer count on supplemental federal funding to buffer these mounting losses, as they did in previous pandemic years. The situation is so dire that on August 16 Fitch Ratings revised its sector outlook for U.S. not-for-profit hospitals and health systems to 'deteriorating.'

Margins

The median Kaufman Hall Year-To-Date (YTD) Operating Margin Index reflecting actual margins was -0.98% through July, unfortunately highlighting the continued losses hospitals have experienced this year. The median percent change in Operating Margin was -63.9% from last month and -73.6% from July 2021. The median percent change in Operating EBITDA Margin was -45.2% month-over-month, and -49% from July 2021.

Volumes

Outpatient volumes dipped in July, as more patients likely scheduled procedures in ambulatory settings instead of within hospital walls, a sign of a larger shift to outpatient settings. Operating Room Minutes dropped 10.3% from June and dipped 7.7% year-over-year (YOY). Length of Stay (LOS) rose 2% from June and was up 3.4% compared to July 2021, a sign that the patients coming into the hospital were sicker. Patient Days rose 2.8% from June to July but were down 2.6% from July 2021 levels. Adjusted Discharges dropped 2.8% month-over-month and were down by 4.2% compared to July 2021. Emergency Department (ED) Visits rose 2.6% from June to July and were up slightly YOY — by 0.7%.

Revenues

Volume reductions resulted in poor revenue performance in July. Gross Operating Revenue was down 3.6% from June and up 1.2% YOY. It is up 5.5% YTD. Outpatient (OP) Revenue dropped 4.8% from June levels but rose 0.6% YOY. It is up 7.1% YTD. Inpatient (IP) Revenue dropped 0.7% from the previous month and is down 1.5% from July 2021. It is up 3.6% YTD.

Expenses

Total Expenses dipped by just 0.4% from June to July and rose 7.6% from July 2021. Inflation and labor shortages contributed to total costs climbing 9.6% YTD. Labor Expense per Adjusted Discharge rose 3.5% from June and is up 13.9% YTD, a sign that the labor shortage is still going strong. Full-Time Employees Per Adjusted Occupied Bed (FTEs per AOB) is up 7.2% from June, possibly indicating increased hiring. Total Expense per Adjusted Discharge is up 2% from June.

Takeaways at a Glance

1. **Hospitals are experiencing some of the worst margins of the pandemic.**
   Seven months into 2022, organizations accrued enormous losses, but they lack the federal funds to offset the damage.

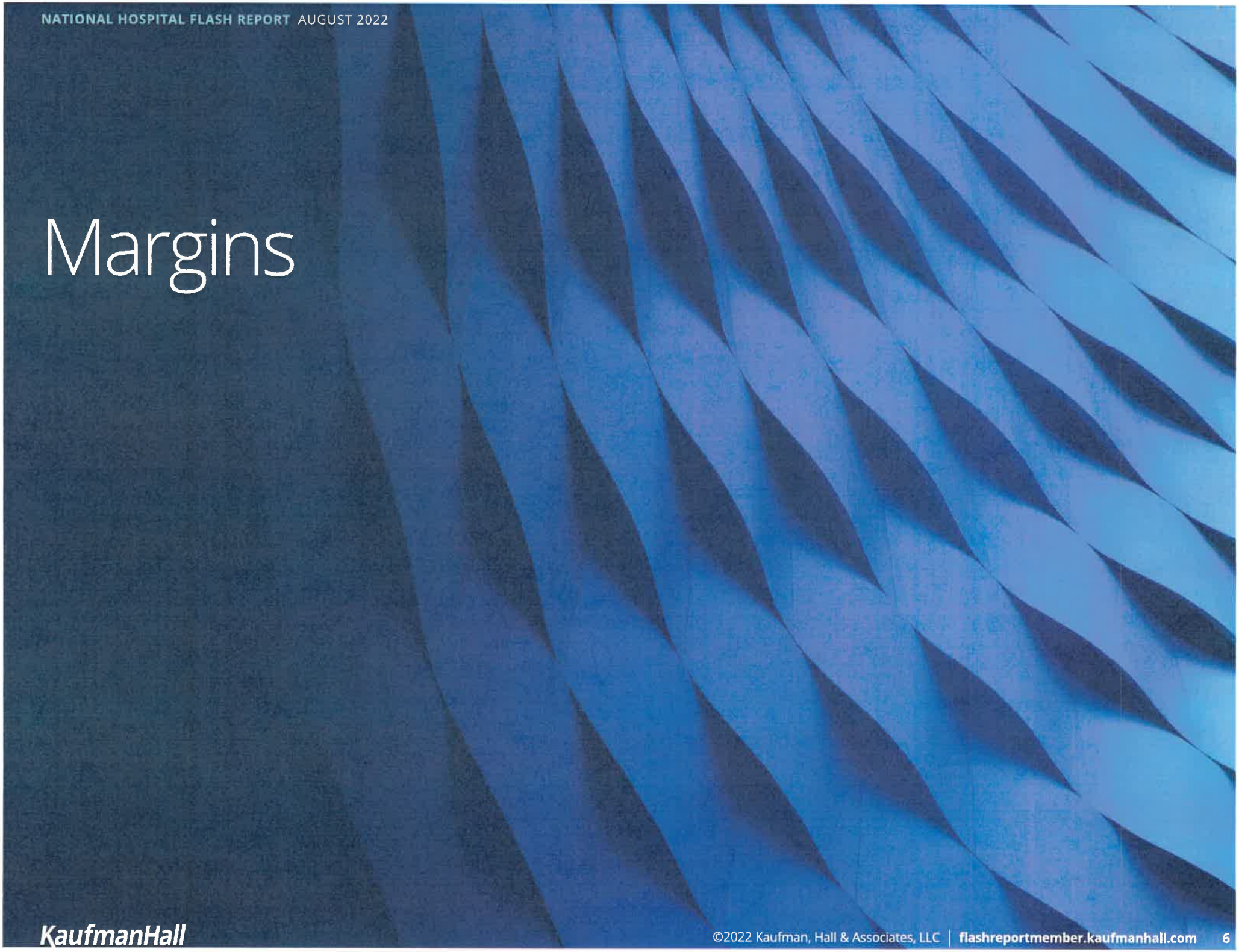
2. **Margins plummeted.**
   Although hospitals saw gradual improvement in recent months, July reversed any gains hospitals saw this year. As outpatient activity and revenue sank, labor expenses, which have remained well above pre-pandemic levels throughout 2022, rose.

3. **Labor expenses increased.**
   Although hospitals hired more aggressively, labor was still in high demand, and prices rose accordingly. Sicker patients stayed in the hospital longer, also driving up costs.

4. **Outpatient activity dropped.**
   The pent-up demand for outpatient procedures following the Omicron surge lessened, and the BA.5 subvariant's spread may have caused sick patients to stay home. An increasing number of patients continued to choose ambulatory centers over hospital settings for surgical procedures, a sign of a larger shift to ambulatory care and new ways of accessing care outside of the hospital.

5. **Organizations must continue to think strategically.**
   Despite the poor performance, leaders should not lose sight of long-term capital and strategic planning, despite the urgency of day-to-day pressures.

Margins

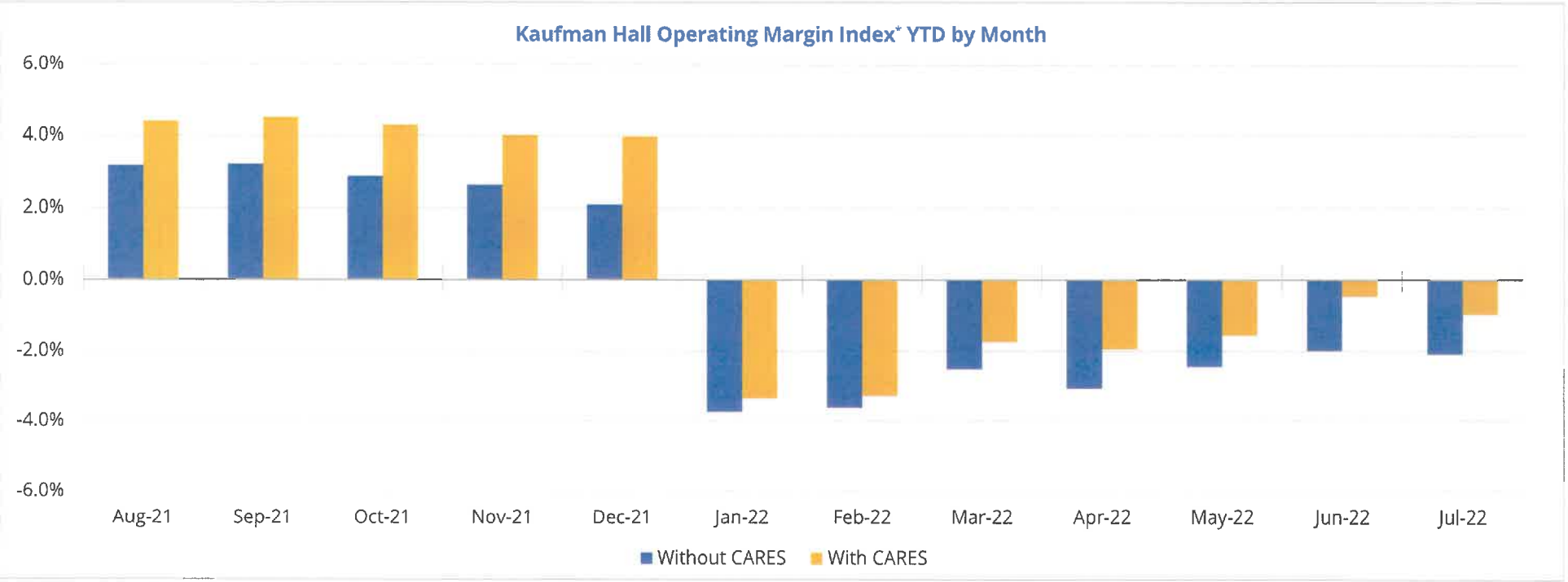


National Margin Results

MARGIN % CHANGE	Budget Variance	Month-Over-Month	Year-Over-Year	Year-Over-Year 2020
Operating EBITDA Margin Less CARES	-48.9%	-35.5%	-49.9%	-50.6%
Operating Margin Less CARES	-73.2%	-46.4%	-78.9%	-64.7%

Unless noted, figures are actuals and medians are expressed as percentage change

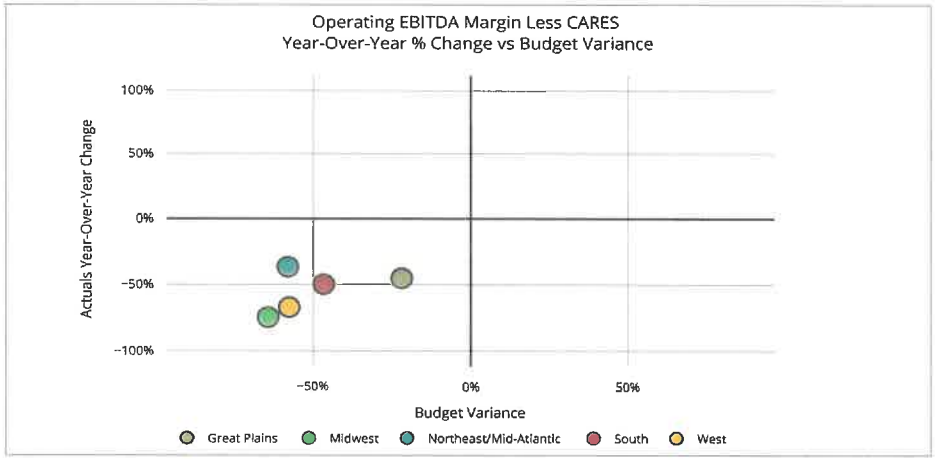
MARGIN ABSOLUTE CHANGE	Budget Variance	Month-Over-Month	Year-Over-Year	Year-Over-Year 2020
Operating EBITDA Margin Less CARES	541.59	455.39	682.65	706.03 bps
Operating Margin Less CARES	539.02	528.37	757.96	786.15 bps



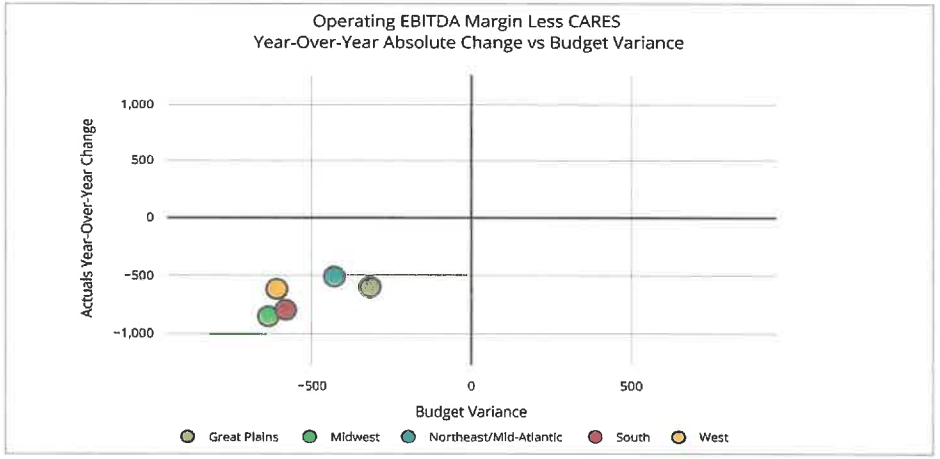
Source: *National Hospital Flash Report* (August 2022)

** Note: The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.*

EBITDA Margin by Region



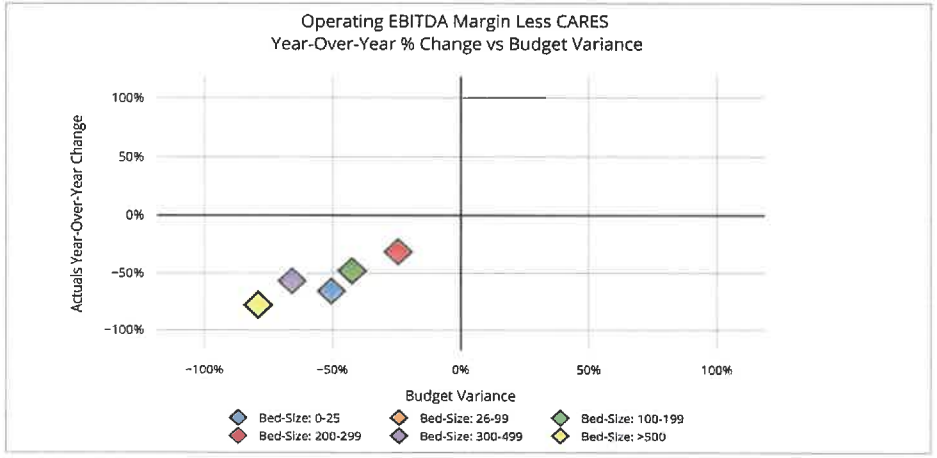
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



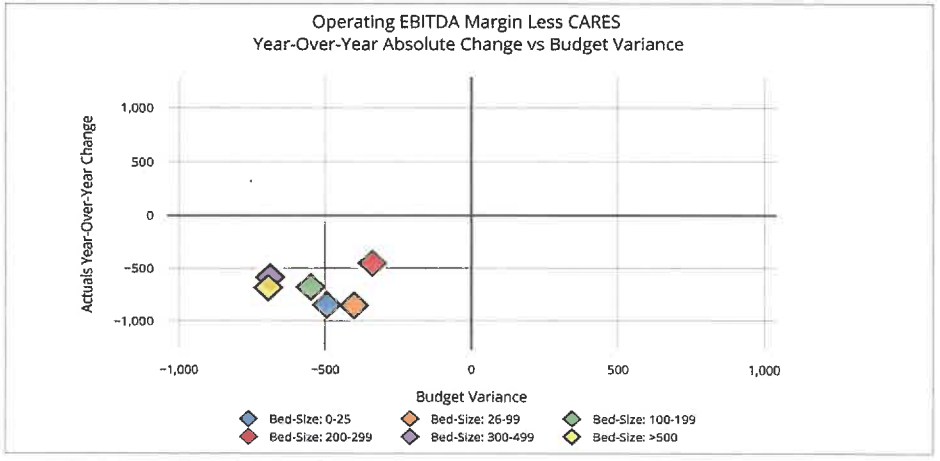
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

The median percent change in Operating EBITDA Margin (without CARES) declined year-over-year (YOY) for hospitals across all regions in July. Hospitals in the Midwest experienced the biggest decrease at -75% YOY, while hospitals in the Northeast/Mid-Atlantic decreased the least at -37% YOY.

EBITDA Margin by Bed Size



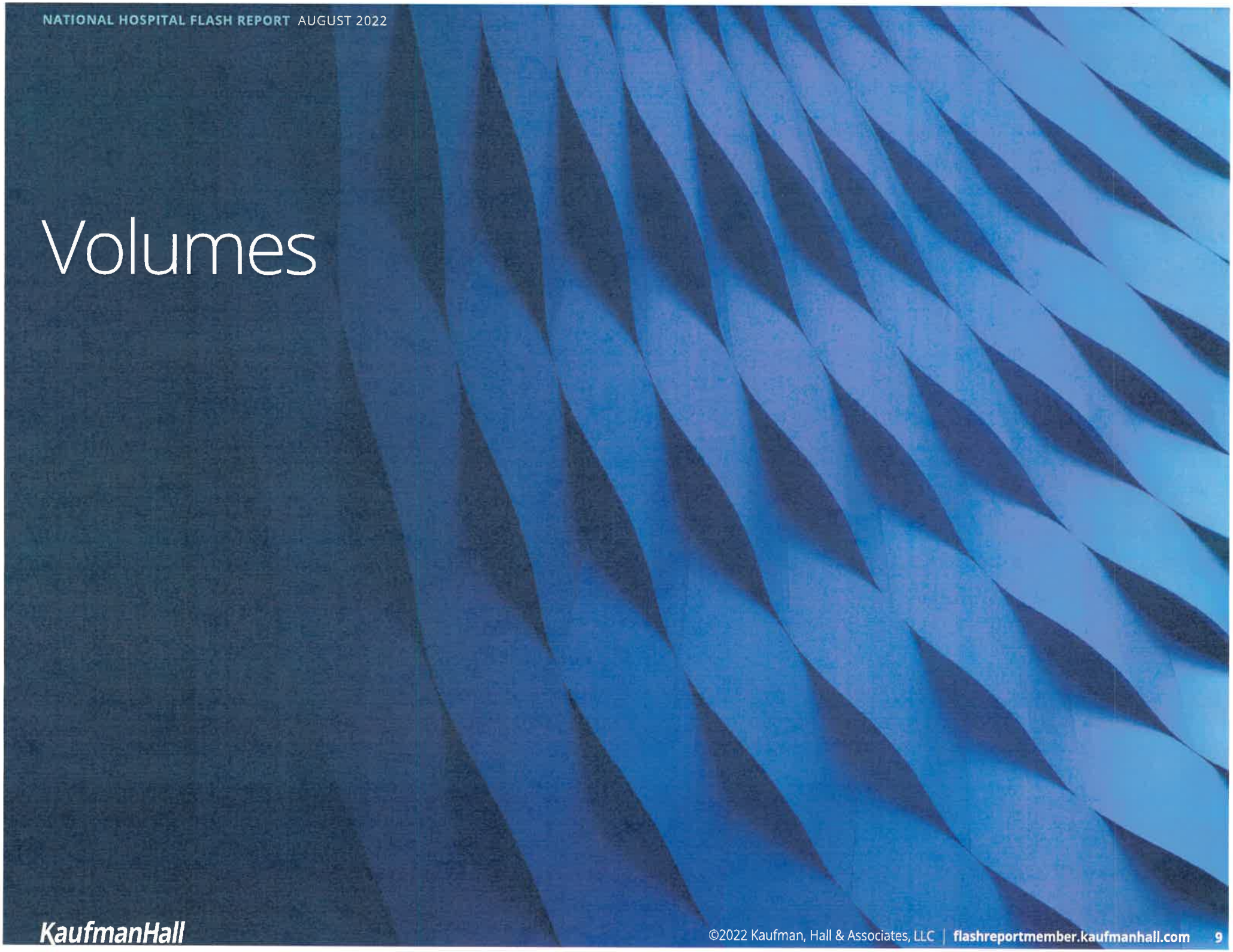
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



Source: Kaufman Hall *National Hospital Flash Report*, August 2022

The median percent change in Operating EBITDA Margin (less CARES) was down YOY in July for hospitals of all sizes. Hospitals with more than 500 beds had the biggest decline at -79% YOY. Hospitals with 200-299 beds had the smallest decline at -32% YOY.

Volumes

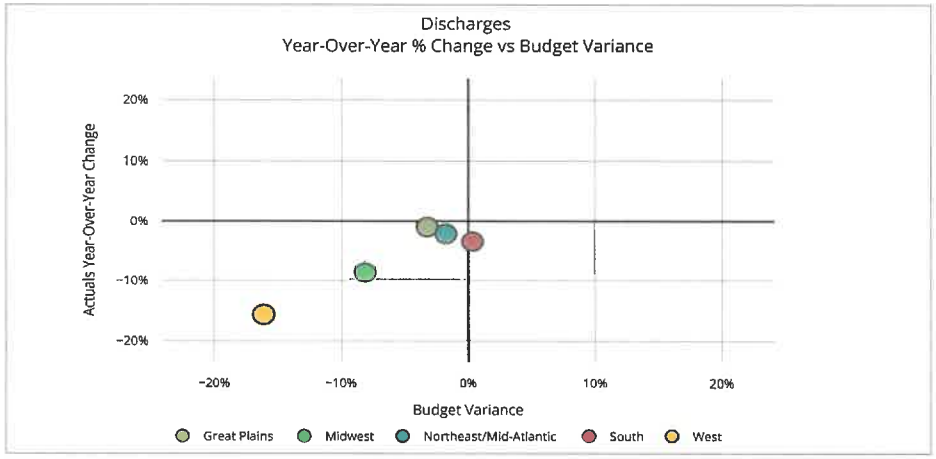


National Volume Results

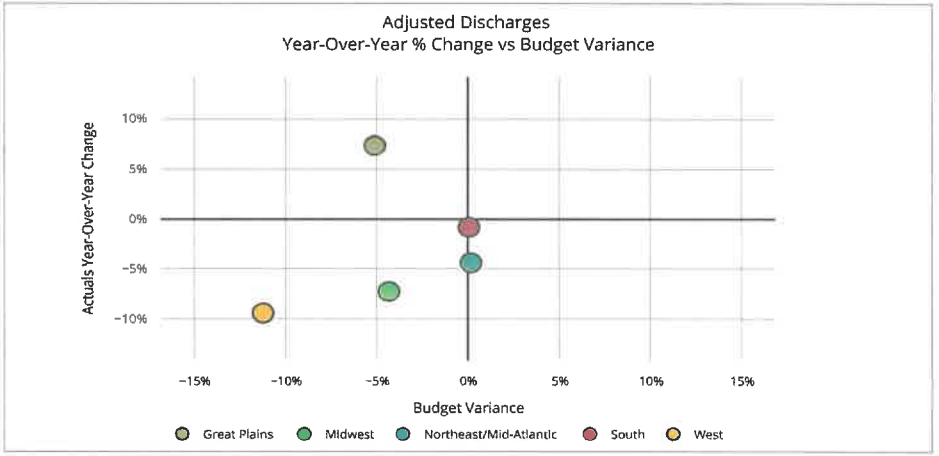
VOLUMES % CHANGE	Budget Variance	Month-Over-Month	Year-Over-Year	Year-Over-Year 2020
Discharges	-5.1%	0.7%	-5.8%	-3.5%
Adjusted Discharges	-2.3%	-2.8%	-4.2%	3.1%
Patient Days	-5.4%	2.8%	-2.6%	0.8%
Observation Patient Days as a Percent of Patient Day	6.8%	-6.5%	-0.7%	17.6%
Adjusted Patient Days	-0.1%	-0.2%	-2.4%	6.0%
Average Length of Stay	2.2%	2.0%	3.4%	3.4%
ED Visits	3.6%	2.6%	0.7%	13.2%
Operating Room Minutes	-7.7%	-10.3%	-7.7%	-11.2%

Unless noted, figures are actuals and medians are expressed as percentage change

Volume by Region



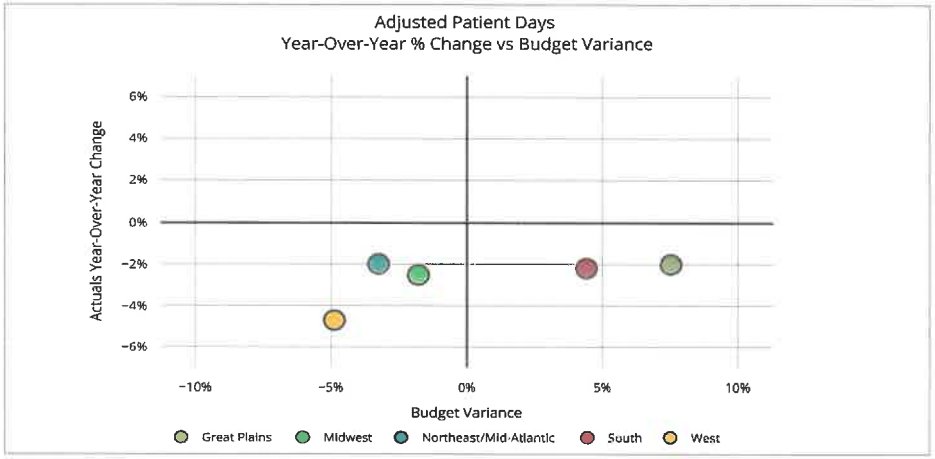
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



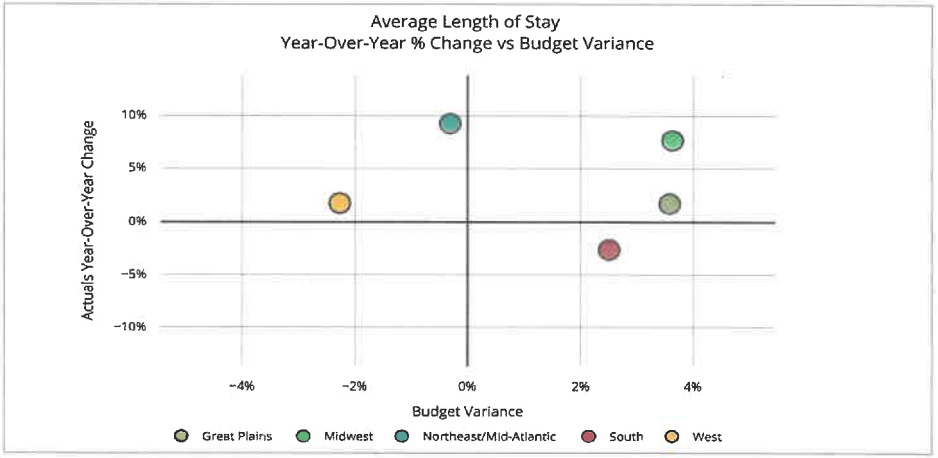
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Discharges declined YOY across all regions, with the West decreasing the most at -15.69%, and the Great Plains decreasing the least at -1.02% YOY. The Great Plains had the only increase in Adjusted Discharges, at 7.38%. The South's Adjusted Discharges held relatively flat at -0.84%. All other regions saw a decrease in Adjusted Discharges YOY, with the West region seeing the largest decrease at -9.42%.

Volume by Region (continued)

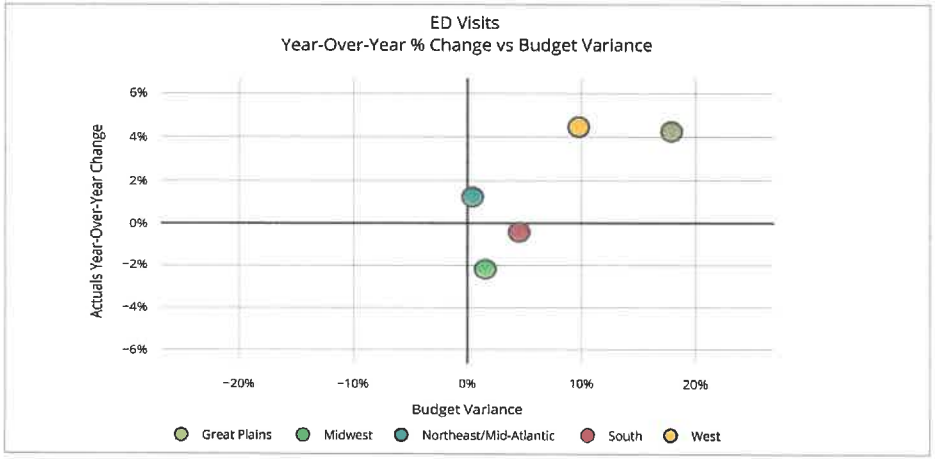


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

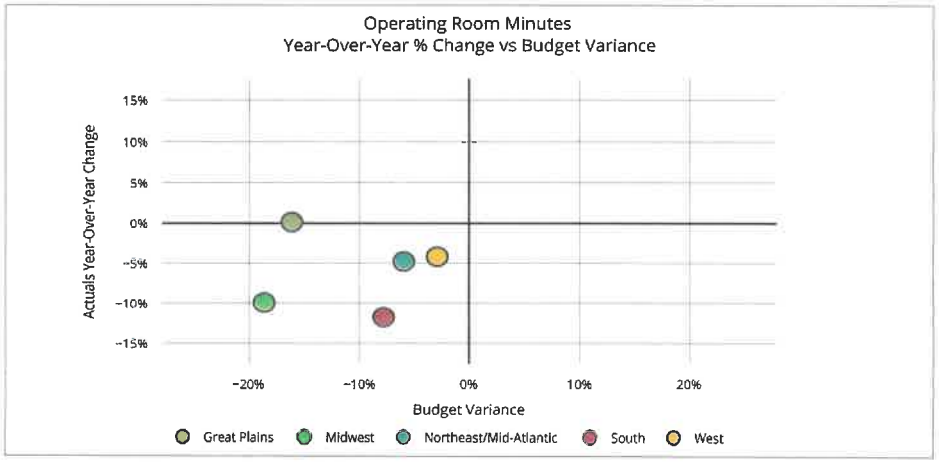


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Adjusted Patient Days decreased across all regions. The West saw the largest decrease in Adjusted Patient Days YOY at -4.69%. All regions rose YOY for Average Length of Stay (LOS), except for the South, which declined -2.65%. The Northeast/Mid-Atlantic region increased the most at 9.24% YOY.



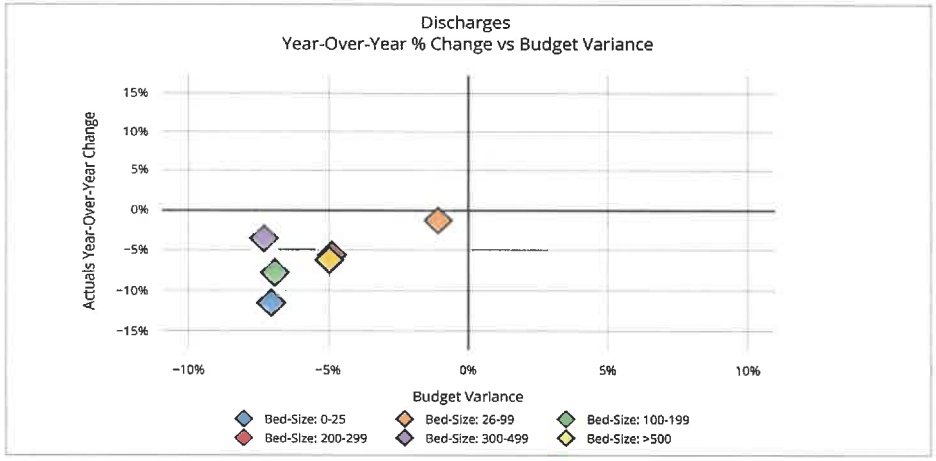
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



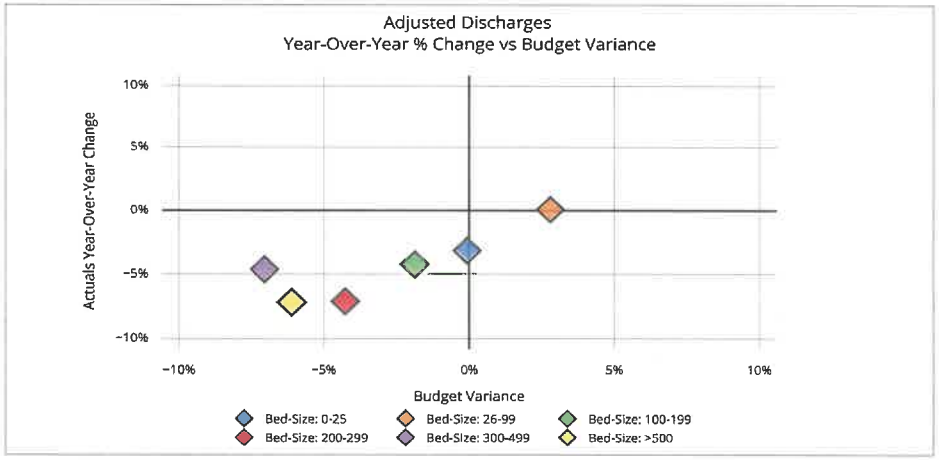
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Emergency Department (ED) Visits rose the most for the West region with an increase of 4.46% YOY. The South (-0.43%) and the Midwest (-2.19%) saw the only decreases YOY. Operating Room Minutes decreased YOY for all regions, except the Great Plains, which increased by just 0.14%. The South saw the greatest decline at -11.73%.

Volume by Bed Size

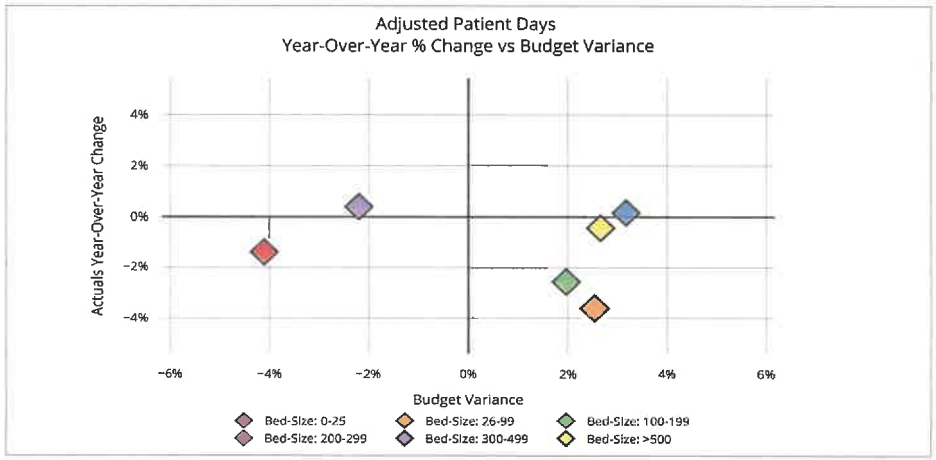


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

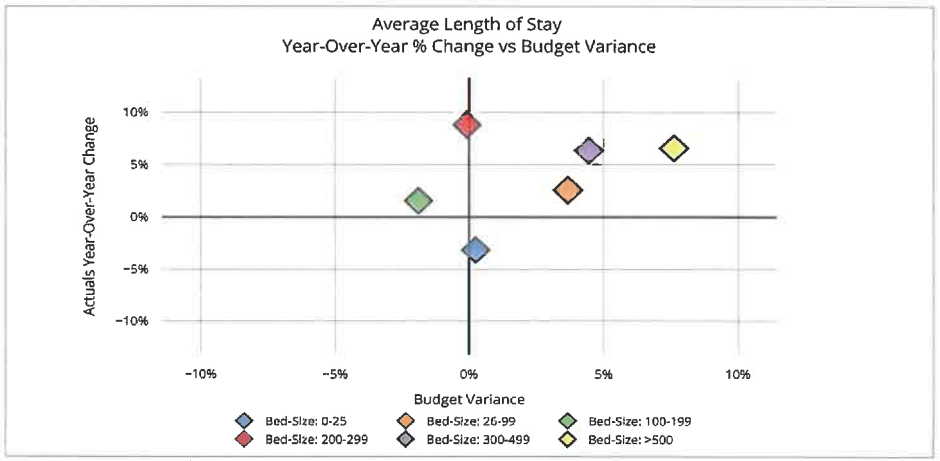


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Discharges declined YOY for all hospitals, and the bed-size cohort of 25 or fewer beds saw the largest decline of -11.54%. Adjusted Discharges declined YOY the most in the 200-299 and greater than 500 bed-size cohorts at -7.12% and -7.23%, respectively. Hospitals with 26-99 beds saw the only increase in Adjusted Discharges at 0.08%.



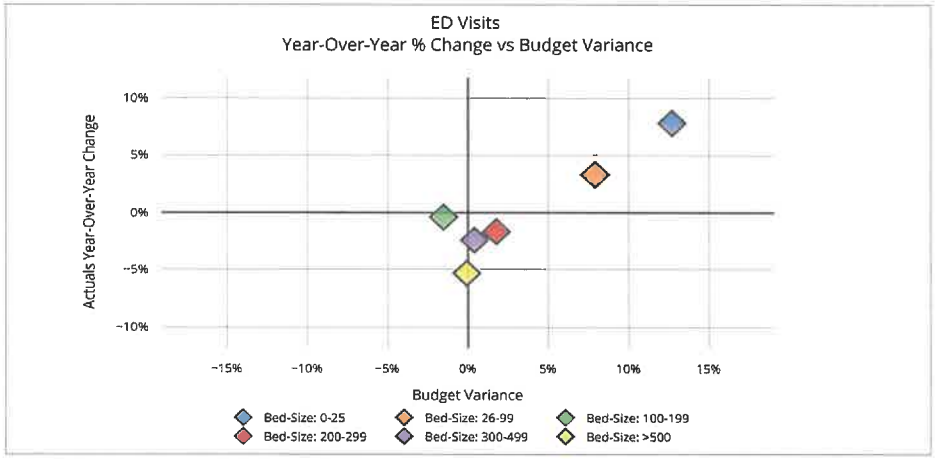
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



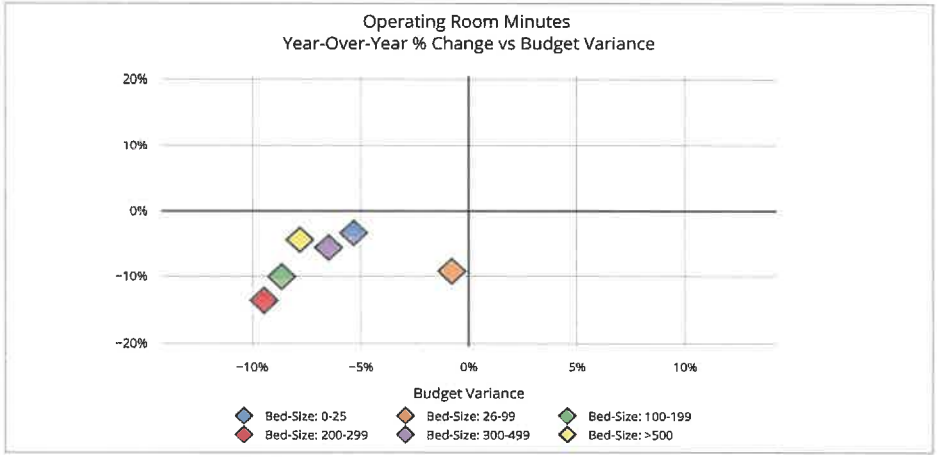
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Adjusted Patient Days increased YOY only slightly for hospitals with up to 25 beds at 0.16% and for bed-size 300-499 increasing at 0.36%. The remaining cohorts saw a decrease, with the hospital beds of 26-99 seeing the biggest decrease at -3.64%. Average LOS rose YOY for all cohorts, except those with 25 or fewer beds, which had a decrease of -3.16%. Hospitals with 200-299 beds had the largest YOY increase at 8.82%.

Volume by Bed Size (continued)



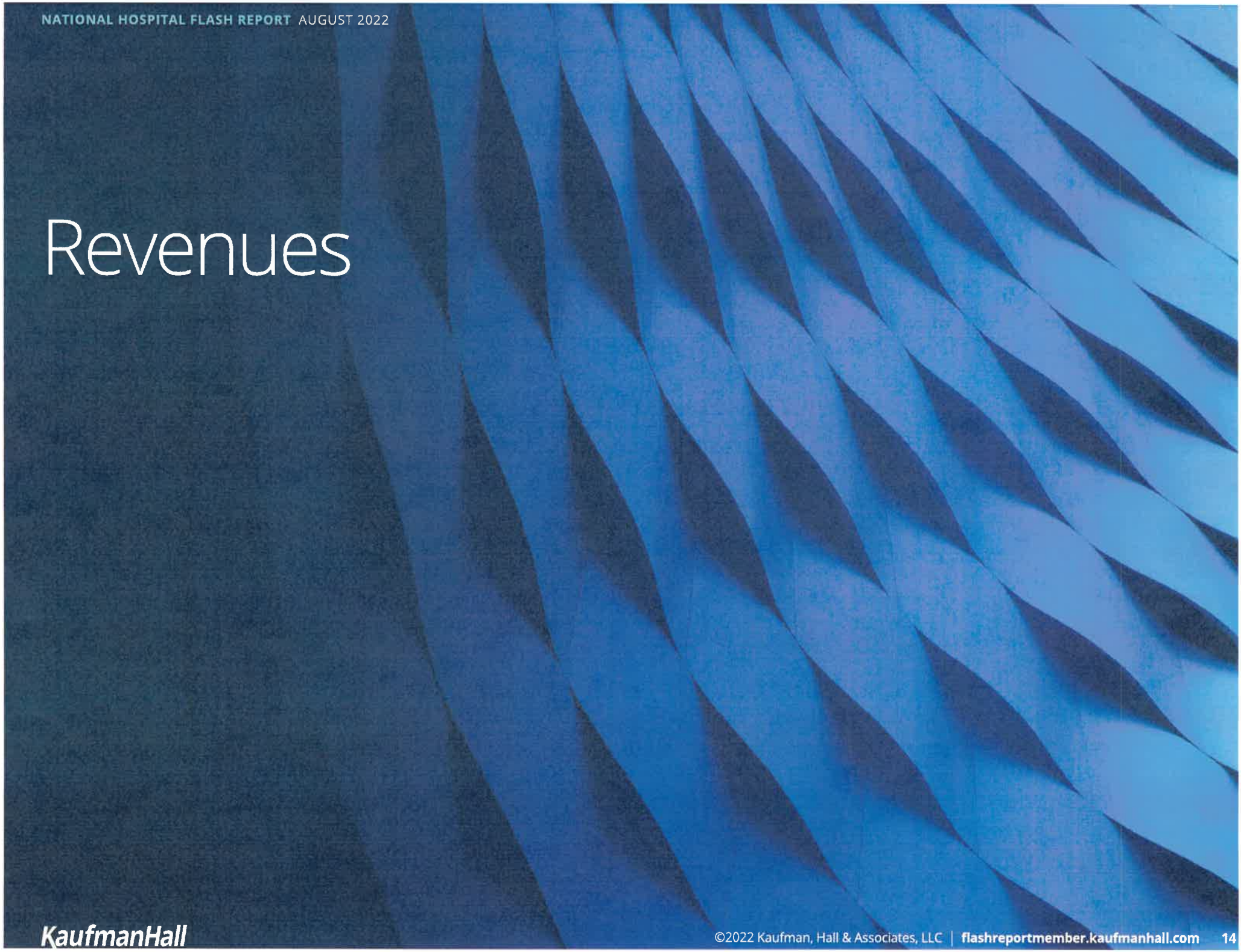
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



Source: Kaufman Hall *National Hospital Flash Report*, August 2022

ED visits dropped the most YOY for hospitals with 500 beds or more, at -5.35%. Both hospital cohorts with fewer than 100 beds saw increased ED Visits, with the largest increase of 7.85% for the cohort with 25 or fewer beds. Operating Room Minutes decreased for all bed-size cohorts, with hospitals with 200-299 beds decreasing the most at -13.64%. Operating Room Minutes decreased the least for hospitals with 25 or fewer beds, at -3.35%.

Revenues

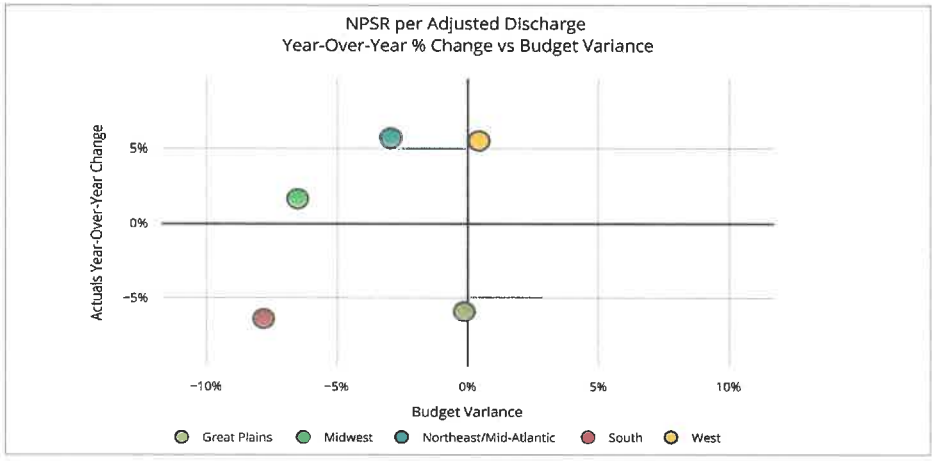


National Revenue Results

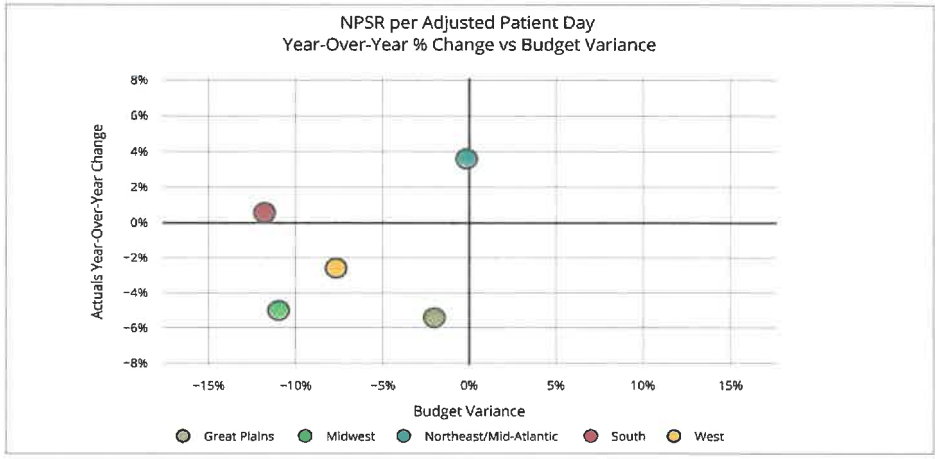
REVENUE % CHANGE	Budget Variance	Month-Over-Month	Year-Over-Year	Year-Over-Year 2020
Gross Operating Revenue Less CARES	-3.9%	-3.6%	1.2%	9.0%
IP Revenue	-8.3%	-0.7%	-1.5%	4.7%
OP Revenue	-2.1%	-4.8%	0.6%	12.7%
Bad Debt and Charity	-0.2%	6.1%	-4.7%	-1.3%
NPSR per Adjusted Discharge	-3.4%	-1.8%	-0.9%	1.8%
NPSR per Adjusted Patient Day	-8.2%	-4.1%	-0.1%	-1.2%
IP/OP Adjustment Factor	3.0%	-2.5%	1.3%	5.3%
Bad Debt and Charity as a % of Gross	2.9%	10.0%	-4.1%	-4.2%

Unless noted, figures are actuals and medians are expressed as percentage change

Revenue by Region



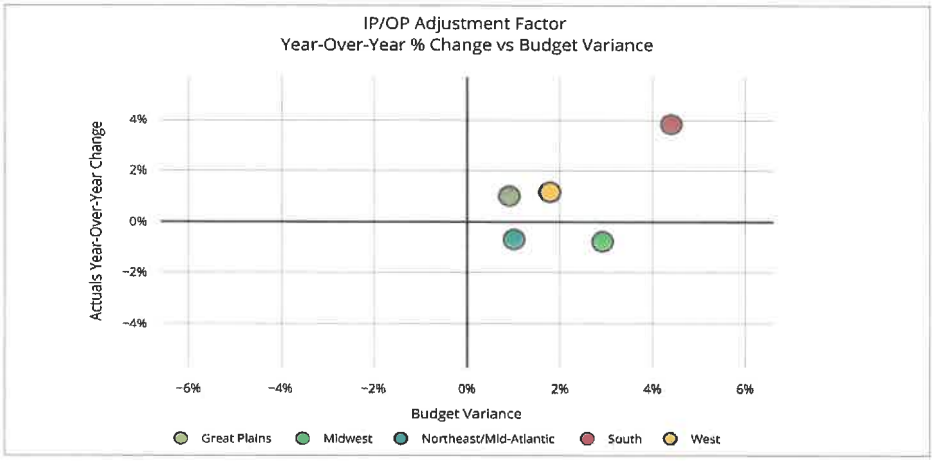
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



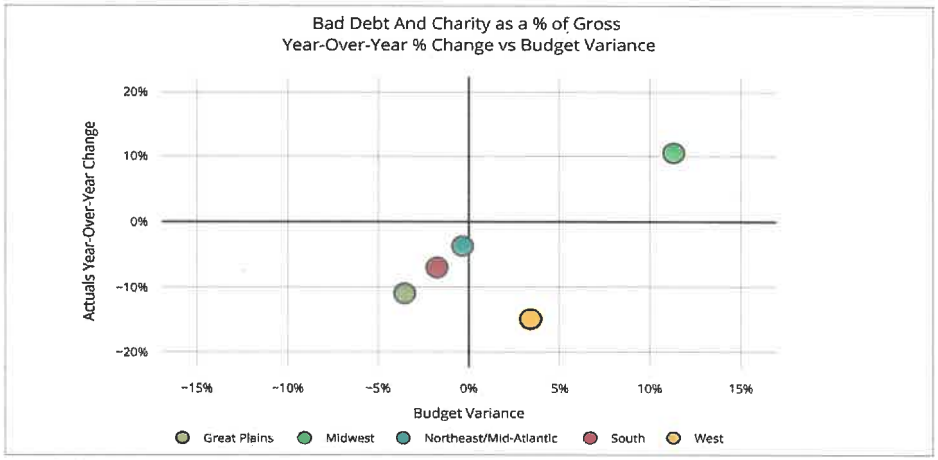
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Net Patient Service Revenue (NPSR) per Adjusted Discharge increased YOY in the West, Midwest and Northeast/Mid-Atlantic, with the Northeast/Mid-Atlantic increasing the most at 5.69%. The South experienced the greatest decline at -6.4%. NPSR per Adjusted Patient Day was down YOY in three of the five regions. The Great Plains saw the largest decrease of -5.42%. The Northeast/ Mid-Atlantic saw the largest increase at 3.59%.

Revenue by Region (continued)



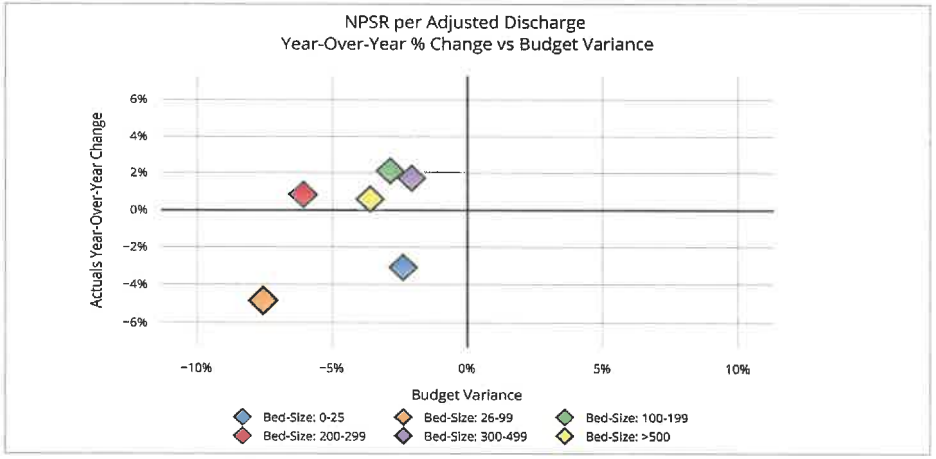
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



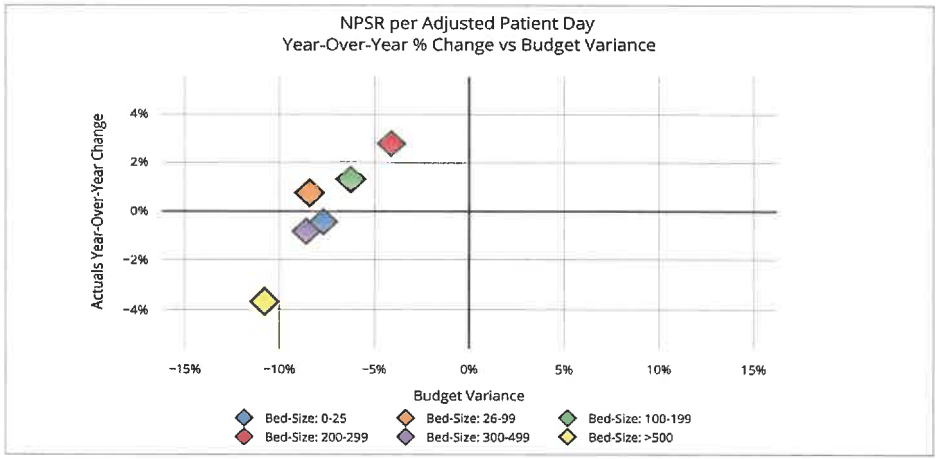
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

The Inpatient/Outpatient (IP/OP) Adjustment Factor increased YOY for three of five regions, with the highest increase in the South (3.84%). The Midwest and the Northeast/Mid-Atlantic saw the only YOY decreases at -0.78% and -0.69% respectively. Bad Debt and Charity as a Percent of Gross was down YOY for most regions, with the West seeing the largest decrease at -14.92%. The Midwest was the only region with an increase, at 10.5% YOY.

Revenue by Bed Size

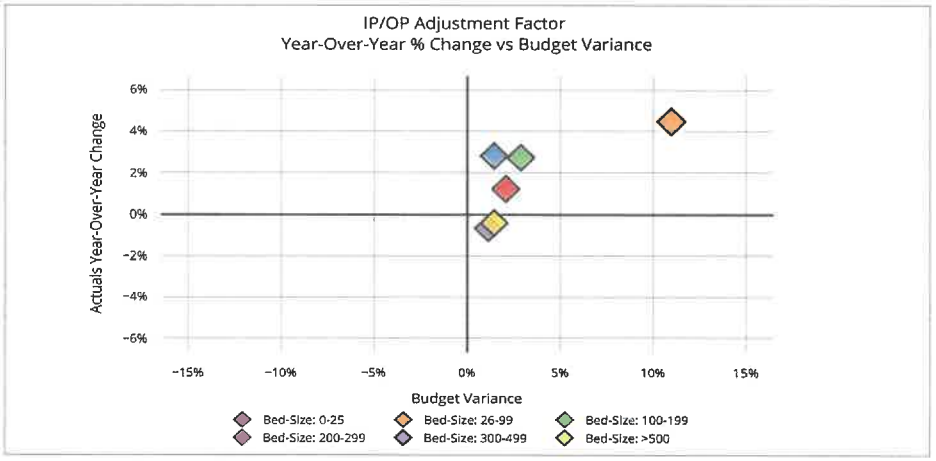


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

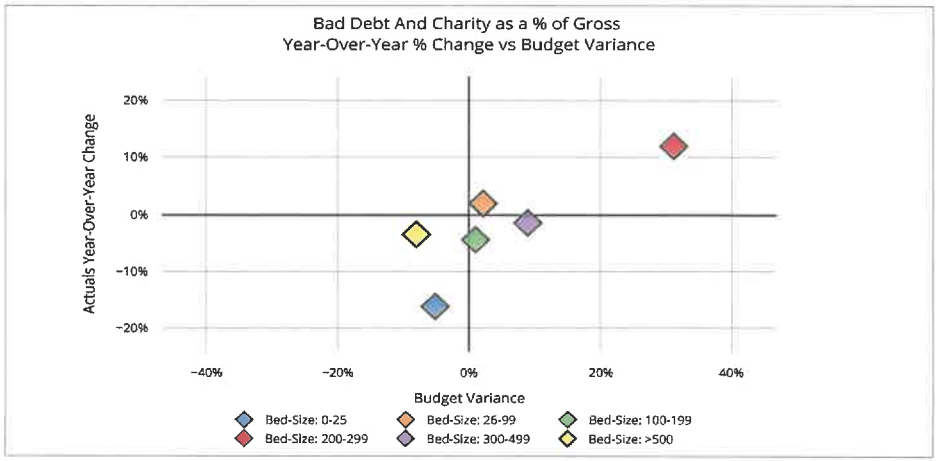


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

NPSR per Adjusted Discharge declined YOY the most for hospitals with 26-99 beds, at -4.87%. This metric increased among all hospitals with more than 99 beds, with the largest increase for hospitals with 100-199 beds at 2.1%. NPSR per Adjusted Patient Day was up YOY among half the hospital cohorts. The biggest increase was for the cohort of 200-299 beds at 2.8%. Hospitals with more than 500 beds experienced the biggest drop in this category at -3.71%.



Source: Kaufman Hall *National Hospital Flash Report*, August 2022



Source: Kaufman Hall *National Hospital Flash Report*, August 2022

The IP/OP Adjustment Factor increased YOY for all hospitals with fewer than 300 beds, the largest increase being for hospitals with 26-99 beds at 4.47%. Hospitals with 300-499 beds saw the greatest declines, at -0.66%. Bad Debt and Charity as a Percent of Gross was down YOY for most bed-size cohorts with the largest decrease for hospitals with 25 or fewer beds at -16.22%. The two cohorts that had an increase were bed sizes of 26-99 and 200-299, with the latter having the largest increase at 11.94%.

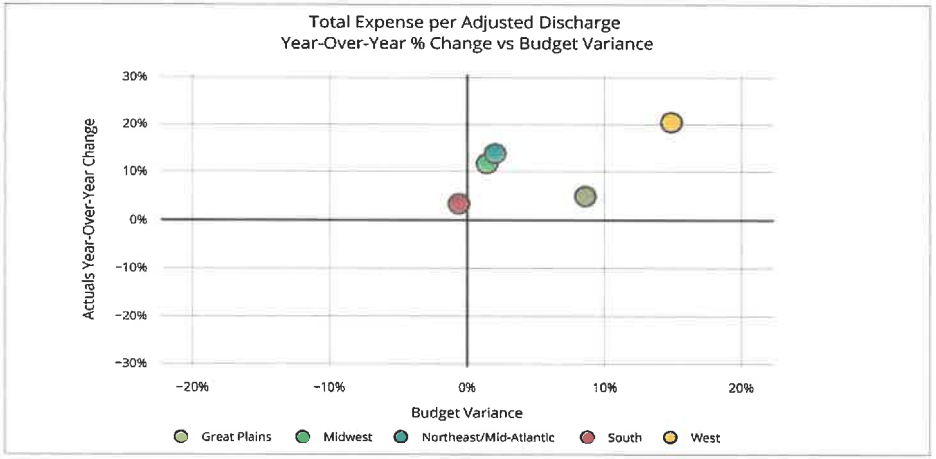
Expenses

National Expense Results

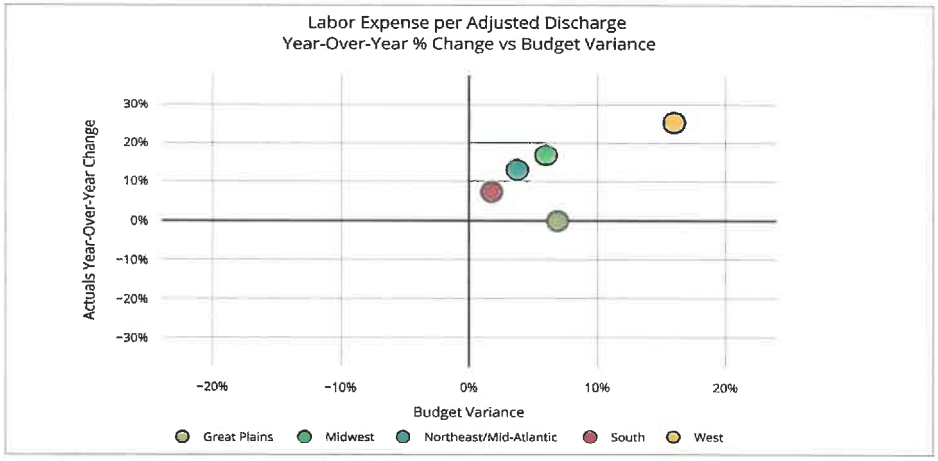
EXPENSES % CHANGE	Budget Variance	Month-Over-Month	Year-Over-Year	Year-Over-Year 2020
Total Expense	0.2%	-0.4%	7.6%	13.9%
Total Labor Expense	1.2%	0.8%	8.9%	16.4%
Total Non-Labor Expense	-1.3%	-1.7%	4.2%	10.3%
Supply Expense	-7.2%	-8.6%	-0.8%	5.5%
Drugs Expense	-9.6%	-4.7%	-3.3%	4.6%
Purchased Service Expense	1.3%	-2.4%	6.3%	11.0%
Total Expense per Adjusted Discharge	1.8%	2.0%	10.8%	9.1%
Labor Expense per Adjusted Discharge	5.8%	3.5%	13.5%	17.0%
FTEs per AOB	-2.9%	7.2%	1.2%	-4.6%
Non-Labor Expense per Adjusted Discharge	-0.5%	0.3%	6.4%	4.9%
Supply Expense per Adjusted Discharge	-4.0%	-4.8%	0.4%	2.4%
Drug Expense per Adjusted Discharge	-11.0%	-2.1%	2.5%	1.6%
Purchased Service Expense per Adjusted Discharge	3.9%	1.5%	6.2%	11.9%

Unless noted, figures are actuals and medians are expressed as percentage change

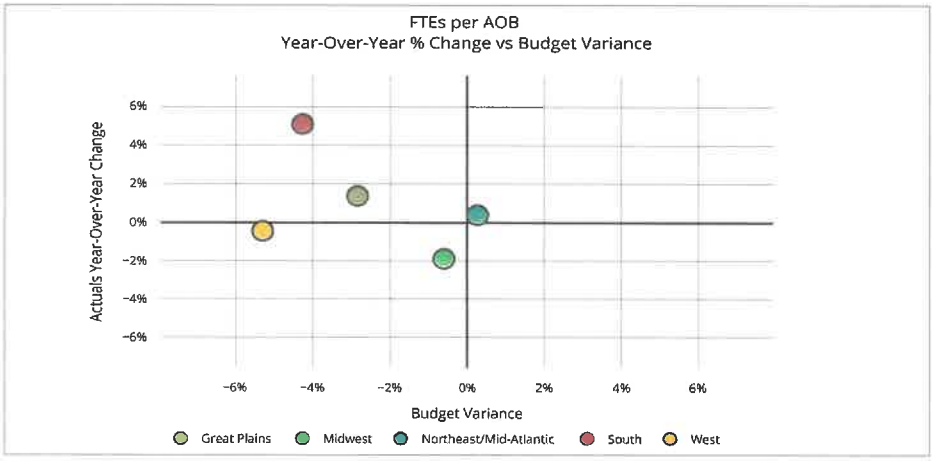
Expense by Region



Source: Kaufman Hall *National Hospital Flash Report*, August 2022



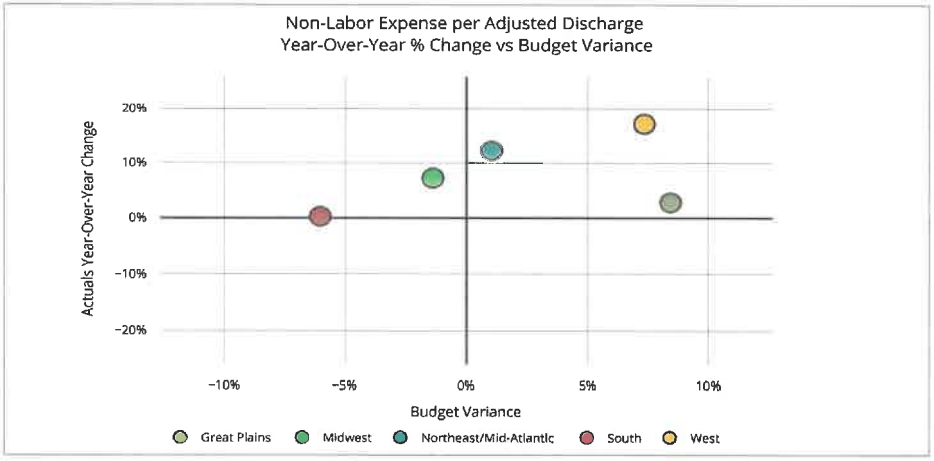
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



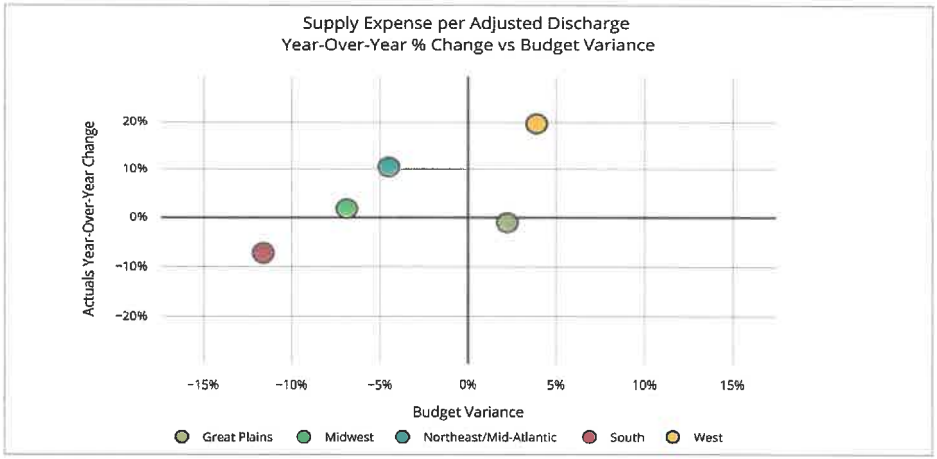
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Total Expense and Labor Expense per Adjusted Discharge rose YOY for all regions, except the Great Plains, where Labor Expense per Adjusted Discharge decreased slightly at -0.10%. The West had the biggest increase in Total Expense per Adjusted Discharge at 20.47% YOY, as well as the biggest increase in Labor Expense per Adjusted Discharge at 25.17%. Full-Time Equivalents (FTEs) per Adjusted Occupied Bed (AOB) declined the most for the Midwest region at -1.89% and increased the most for the South region at 5.1%. The Northeast/Mid-Atlantic and West hovered close to flat at 0.38% and -0.46%, respectively.

Expense by Region (continued)

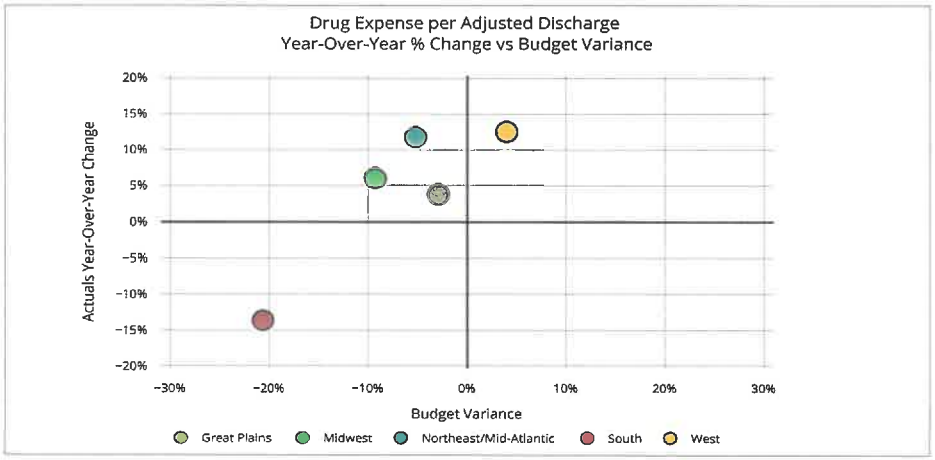


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

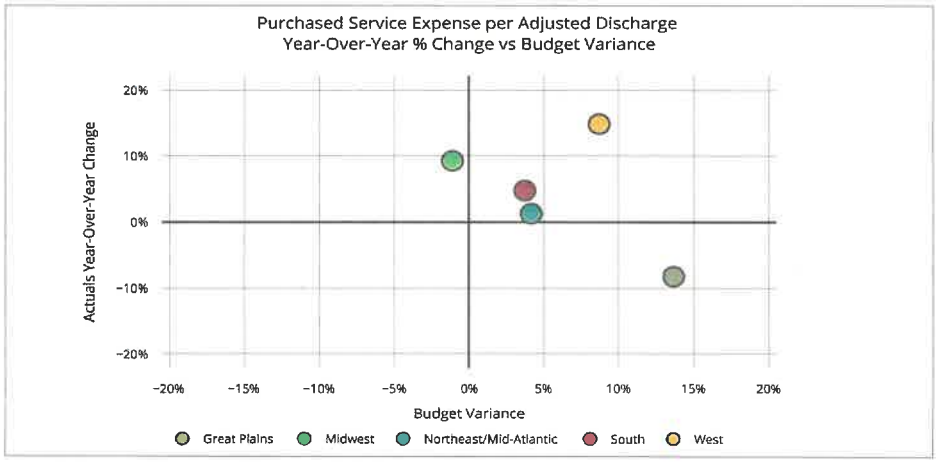


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Non-Labor Expense per Adjusted Discharge rose for all five regions YOY. The West had the biggest increase at 17.2%. The South region had the smallest increase at 0.22%. Supply Expense per Adjusted Discharge increased YOY for three regions, but not in the South nor the Great Plains. The West saw the largest increase at 19.62%, while the South experienced the biggest decline at -7.24% YOY.



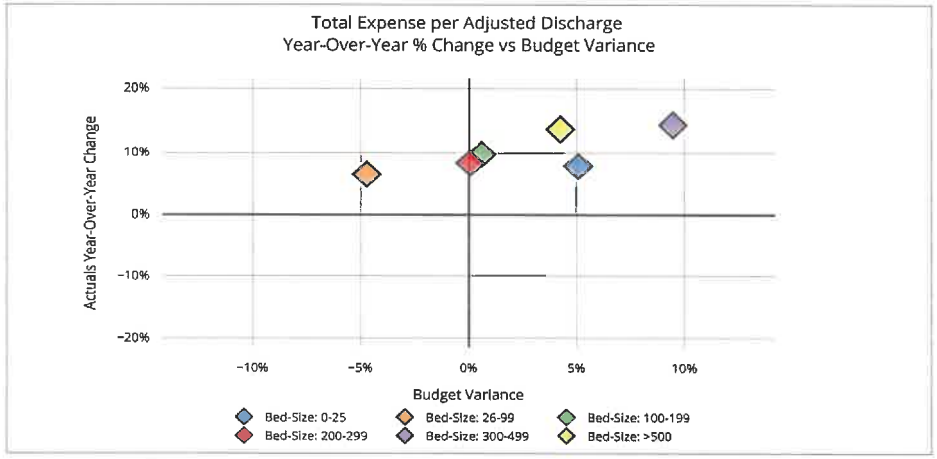
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



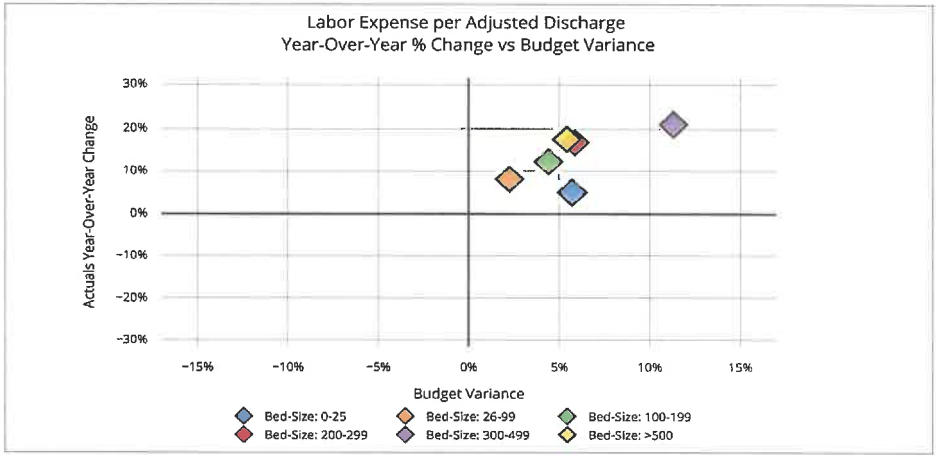
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Drug Expense per Adjusted Discharge rose across regions except the South, which declined -13.60%. The largest increases were in the West at 12.44%. Purchased Service Expense per Adjusted Discharge decreased YOY only for the Great Plains region at -8.25%. The West experienced the biggest increase, at 14.85%.

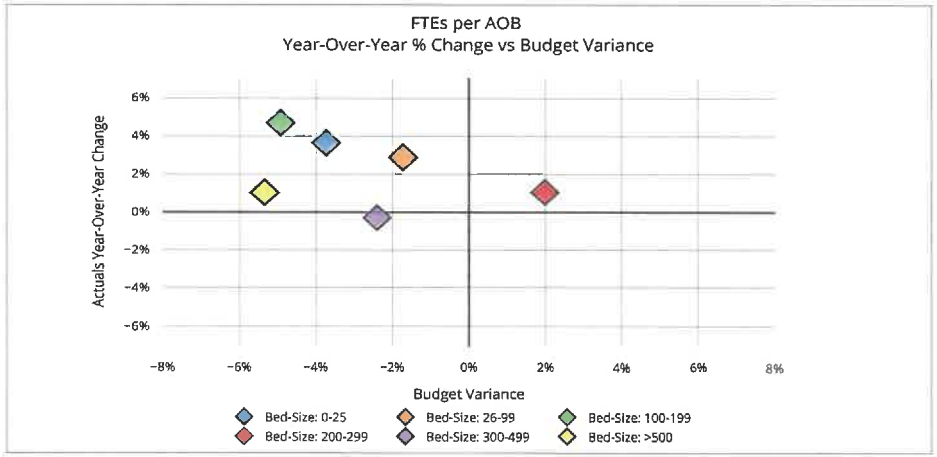
Expense by Bed Size



Source: Kaufman Hall *National Hospital Flash Report*, August 2022



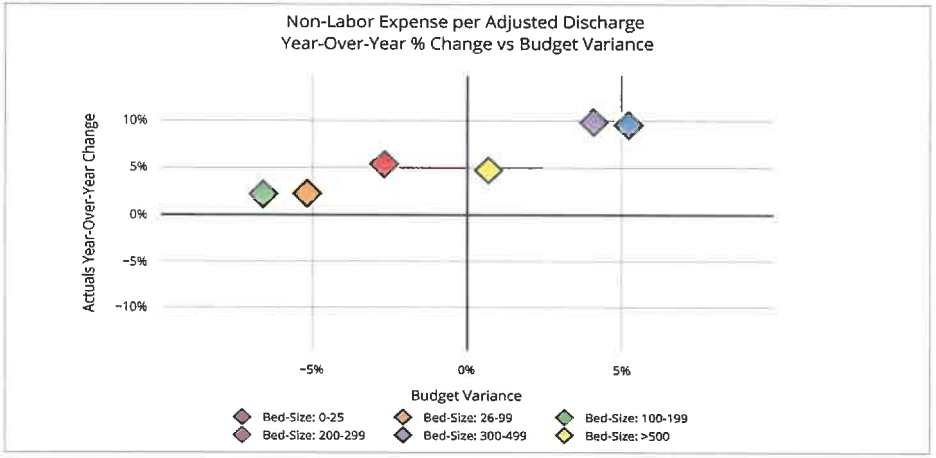
Source: Kaufman Hall *National Hospital Flash Report*, August 2022



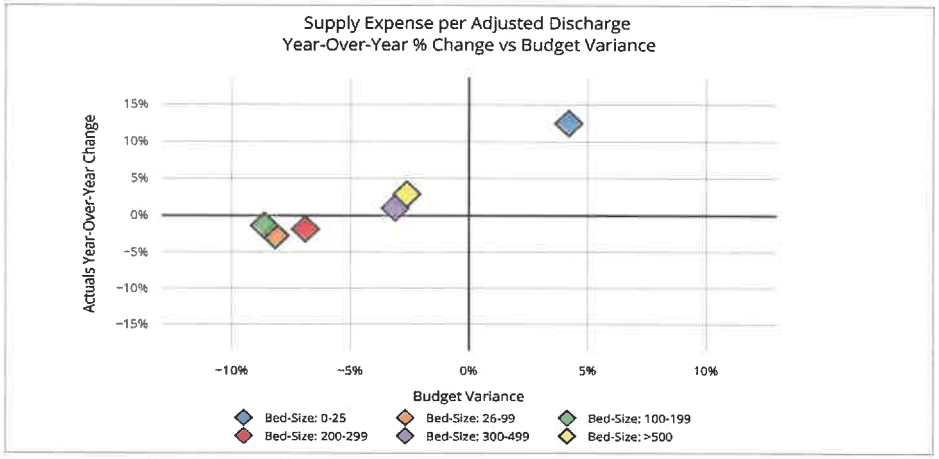
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Total Expense per Adjusted Discharge rose YOY for hospitals of all sizes. Hospitals with 300-499 beds increased the most at 14.38%. The smallest increase was in hospitals with 26-99 beds at 6.52%%. Labor Expense per Adjusted Discharge was also up for all cohorts, with hospitals of up to 25 beds increasing the least at 5.06% and hospitals with 300-499 beds increasing the most at 21.07% YOY. FTEs per AOB were up YOY for most bed-size cohorts, with hospitals of 100-199 beds increasing the most at 4.71%. The exception was for hospitals with 300-499 beds, which was close to flat at -0.32%.

Expense by Bed Size (continued)

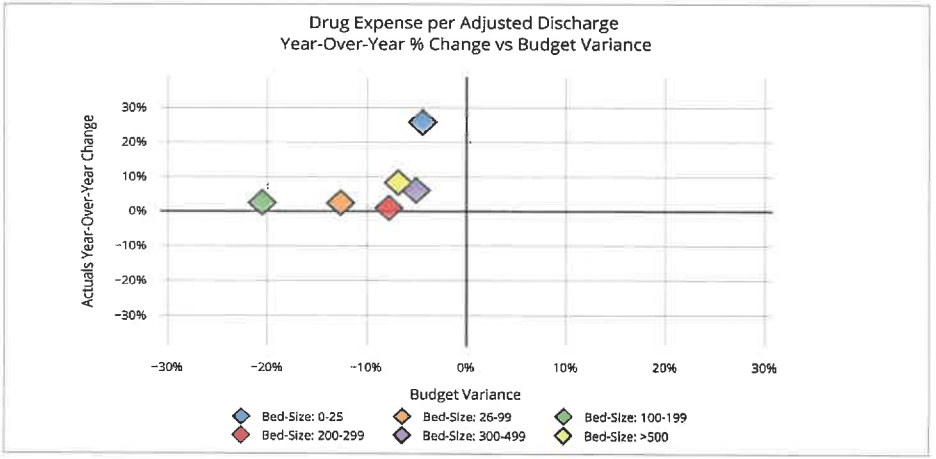


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

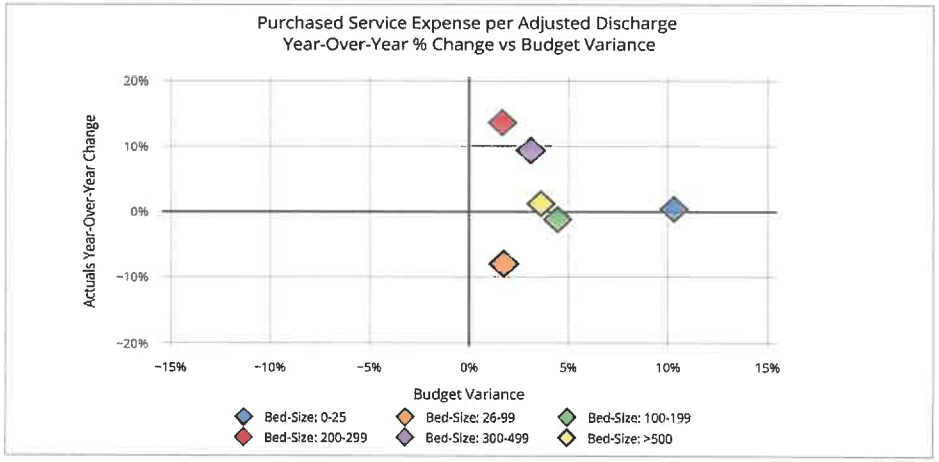


Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Non-Labor Expense per Adjusted Discharge increased YOY for all six cohorts. Hospitals with 300-499 beds had the biggest increase at 9.85% YOY. Hospitals with 26-99 and 100-199 beds had the smallest increases at 2.23% and 2.19% respectively. Supply Expense per Adjusted Discharge was up YOY for three of the six bed-size cohorts — those with greater than 300 and 25 or fewer beds. Hospitals with 25 or fewer beds had the greatest increase at 12.48%. Hospitals with 26-99 beds experienced the largest decline, at -2.74% YOY.



Source: Kaufman Hall *National Hospital Flash Report*, August 2022



Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Drug Expense per Adjusted Discharge was up for all cohorts and increased the most YOY for hospitals with 25 or fewer beds at 25.83%. Hospitals with 200-299 beds saw the smallest increase at 0.96%. Purchased Service Expense per Adjusted Discharge increased YOY for most bed-size cohorts with the 200-299 bed size cohort increasing the most at 13.71%. Hospitals with 26-99 beds saw the biggest decrease, at -8.05%.

Non-Operating

National Non-Operating Results

KHA Perspective

- The Federal Reserve enacted its second consecutive 75 basis point rate hike in July
- The fourth increase this year brought the benchmark rate to a range of 2.25%-2.50%, its highest since summer 2019
- Federal Reserve Chairman Jerome Powell noted that additional "unusually large" rate increases could be warranted as the Fed continues to balance broad price increases, robust job gains, and a slowing economy
- The Consumer Price Index (CPI) rose 8.5% in July from a year prior; the slowing pace from June was largely driven by a 7.7% drop in gasoline prices
- Nonfarm payrolls rose by 528,000 in July as unemployment ticked lower to 3.5%; the unemployment rate is now back to pre-pandemic levels and the economy has fully recovered all the jobs it lost during the COVID-19 shutdowns
- The S&P 500 was up 9.1% in July, bringing its YTD return to -13.3%; U.S. equities finished July on a positive note courtesy of strong earnings from technology and oil companies

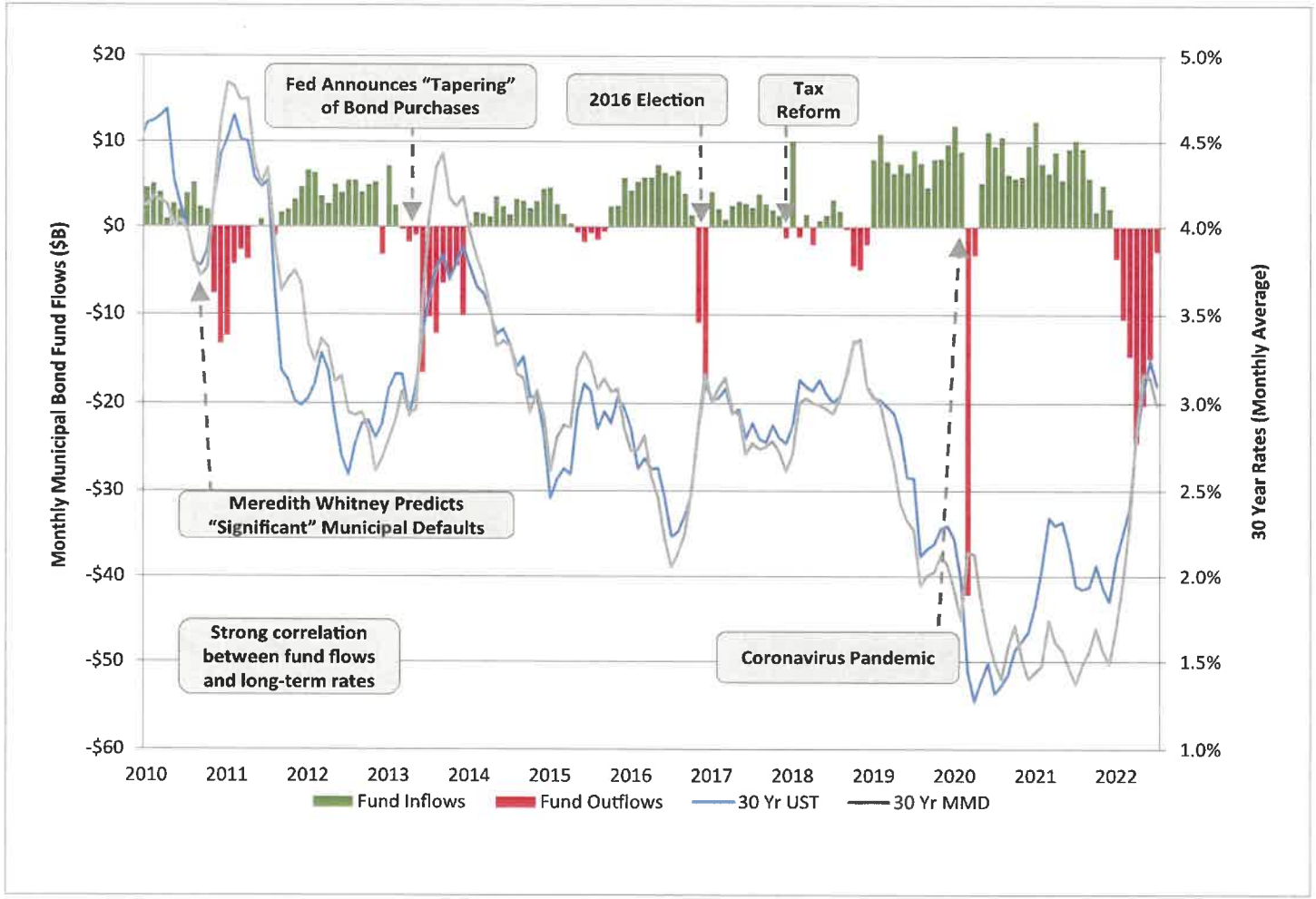
	July 2022	M-o-M Change	Y-o-Y Change
General			
GDP Growth*	-0.9%	n/a	n/a
Unemployment Rate	3.5%	-0.1%	-1.9%
Personal Consumption Expenditures (YoY)	4.8%	+0.1%	+1.2%
Liabilities			
1m LIBOR	2.36%	+58 bps	+227 bps
SIFMA	1.33%	+42 bps	+131 bps
30yr MMD	2.89%	-29 bps	+150 bps
30yr Treasury	2.96%	-22 bps	+107 bps
Assets			
60/40 Asset Allocation†	n/a	5.2%	-9.6%

* U.S. Bureau of Economic Analysis, Q2 2022 "Advance Estimate"

† 60/40 Asset Allocation assumes 30% S&P 500 Index, 20% MSCI World Index, 10% MSCI Emerging Markets Index, 40% Barclays US Aggregate Bond Index

Non-Operating Liabilities

Long Term – Monthly Municipal Bond Fund Flows with 30-Year U.S. Treasury and 30-Year MMD



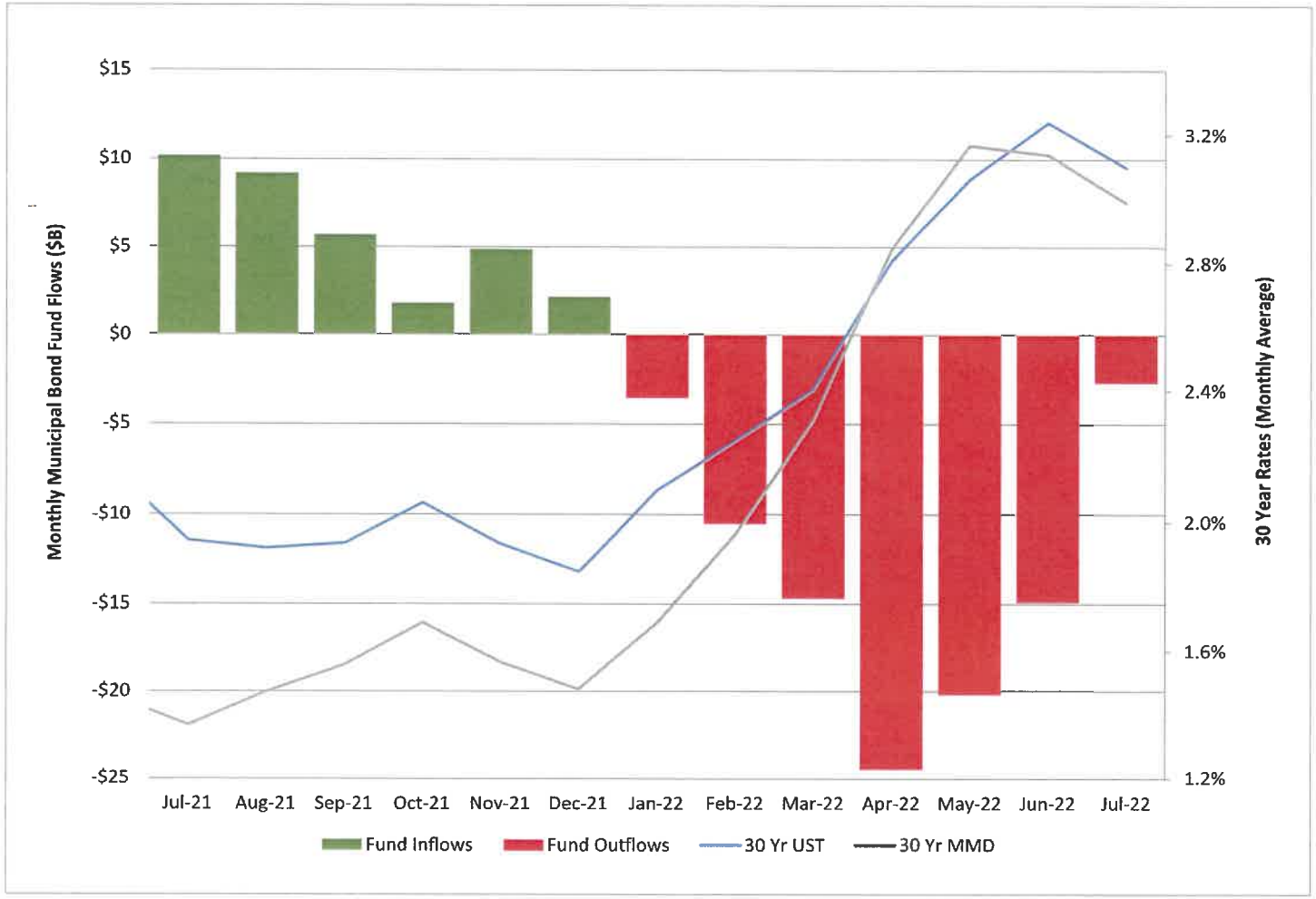
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Yields on the 30-year Treasury bond decreased 22 basis points in July to 2.96%. Comparatively, yields on the tax-exempt benchmark 30-year MMD rate dropped 29 basis points over the last month, down to 2.89% with Muni-UST ratios continuing to vary as the two benchmarks continue to show volatility. Muni supply continued to be muted as issuers maneuvered around the Fed's announcement. July saw $2.7 billion of outflows, the seventh straight month of negative flows. Some market participants believe the municipal market is showing greater signs of stability following June's $14.9B in outflows.

Taxable and tax-exempt debt capital markets, as approximated here by the '30-yr U.S. Treasury' and '30-yr MMD Index', are dependent upon macroeconomic conditions, including inflation expectations, GDP growth and investment opportunities elsewhere in the market. A key measure to track is bond fund flows, particularly in the more supply and demand sensitive tax-exempt market. Fund flows are monies moving into bond funds from new investment and principal and interest payments on existing and maturing holdings. Strong fund flows generally signal that investors have more cash to put to work, a boon to the demand. Fund inflows generally are moderate and consistent over time while fund outflows are typically large and sudden, as external events affect investor sentiment, resulting in quick position liquidation which can drive yields up considerably in a short amount of time.

Non-Operating Liabilities (continued)

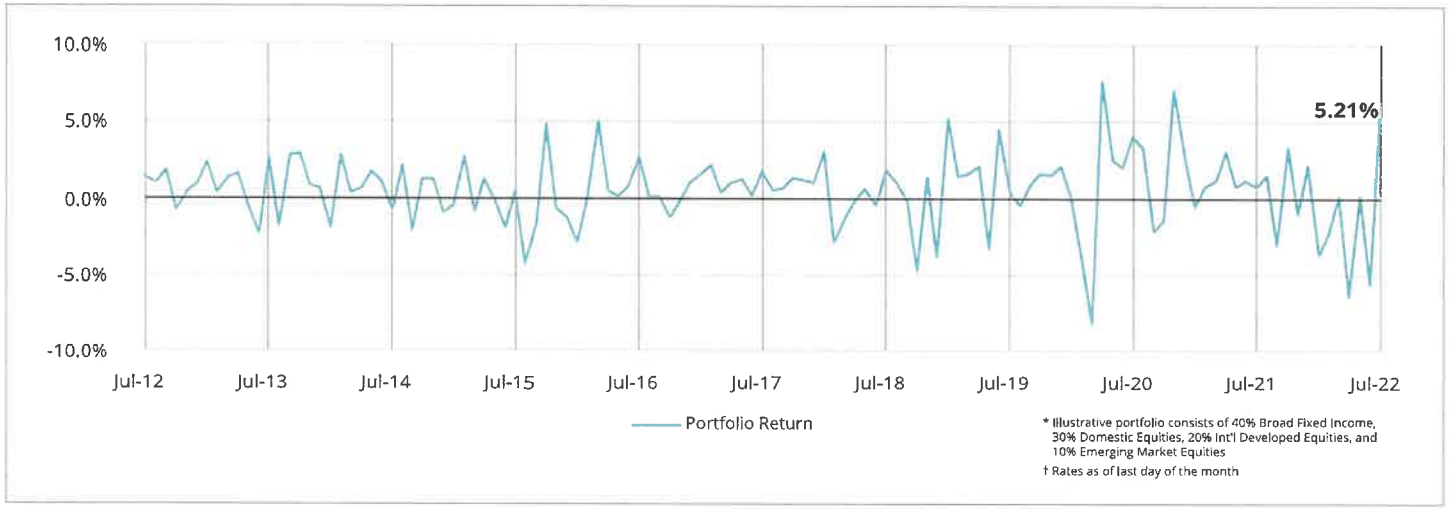
Last Twelve Months – Monthly Municipal Bond Fund Flows with 30-Year U.S. Treasury and 30-Year MMD



Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Non-Operating Assets

Long Term – Illustrative Investment Portfolio Returns, Month-over-Month Change



Source: Kaufman Hall *National Hospital Flash Report*, August 2022

Last Twelve Months – Illustrative Investment Portfolio Returns, Month-over-Month Change

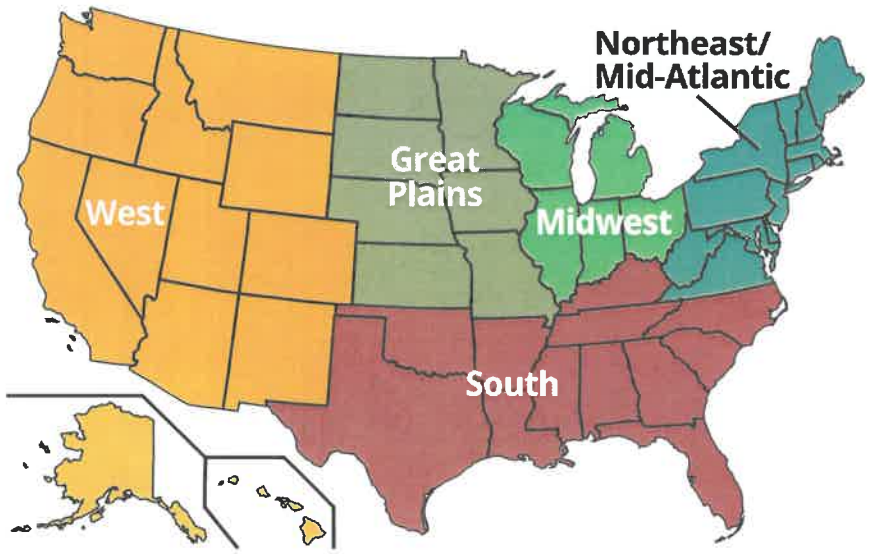
Source: Kaufman Hall *National Hospital Flash Report*, August 2022

The 60/40 blended asset portfolio ended July up 5.2%. The S&P 500 finished 9.1% higher, experiencing its best month since November 2020. The MSCI World Index and Barclays Aggregate Index both finished the month up 7.9% and 2.4% respectively, while the MSCI Emerging Markets index finished down 0.7%. The 60/40 portfolio is now down 9.6% year-over-year.

About the Data

The *National Hospital Flash Report* uses both actual and budget data over the last three years, sampled from more than 900 hospitals on a recurring monthly basis from Syntellis Performance Solutions. The sample of hospitals for this report is representative of all hospitals in the United States both geographically and by bed size. Additionally, hospitals of all types are represented, from large academic to small critical access. Advanced statistical techniques are used to standardize data, identify and handle outliers, and ensure statistical soundness prior to inclusion in the report. While this report presents data in the aggregate, Syntellis Performance Solutions also has real-time data down to individual department, jobcode, paytype, and account levels, which can be customized into peer groups for unparalleled comparisons to drive operational decisions and performance improvement initiatives.

Map of Regions



General Statistical Terms

- **Range:** The difference in value between the maximum and minimum values of a dataset
- **Average (Mean):** The average value of an entire dataset
- **Median:** The value that divides the dataset in half, the middle value
- **1st Quartile:** The value halfway between the smallest number and the median
- **3rd Quartile:** The value halfway between the median and the largest number

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Talk to us

Have a comment on the Kaufman Hall *National Hospital Flash Report*?
We want to hear from you. Please direct all questions or comments to
flashreports@kaufmanhall.com

Attachment T

Prosser Memorial Health

Physician Clinics Consolidated

Income Statement As Of: September 30, 2022

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior	Variance	% Var
Clinical Patient Revenue	22,990,014	17,113,052	5,876,962	34%	14,801,355	8,188,660	55%
Deductions From Revenue	(9,465,126)	(6,740,030)	(2,725,096)	40%	(6,329,337)	(3,135,789)	50%
Net Patient Revenue	**13,524,888**	**10,373,022**	**3,151,866**	**30%**	**8,472,018**	**5,052,870**	**60%**
Other Operating Revenue	-	-	-	**0%**	**1,028**	**(1,028)**	**-100%**
Provider Salaries	7,025,196	7,457,011	431,815	6%	6,211,763	813,434	13%
Clinical Support Salaries	2,500,029	2,533,900	33,871	1%	2,213,344	286,685	13%
Benefits	671,568	639,189	(32,379)	-5%	451,100	220,468	49%
Purchased Labor	30,693	25,682	5,012	20%	14,850	15,843	107%
Total Salaries and Benefits	10,227,486	10,655,782	438,319	4%	8,891,057	1,336,430	15%
Professional Fees	513,585	181,650	(331,935)	-183%	176,896	336,689	190%
Supplies	782,899	1,010,840	227,941	23%	654,348	128,551	20%
Utilities	45,074	58,650	13,576	23%	54,693	(9,619)	-18%
Purchased Services	239,706	227,703	(51,242)	-23%	205,932	33,774	16%
Rentals & Leases	676,214	683,716	24,515	4%	615,704	60,510	10%
Other Direct Expenses	77,746	188,507	(14,951)	-8%	98,367	(20,621)	-21%
Total Non Salary Expenses	2,335,224	2,351,066	15,842	1%	1,805,940	529,284	29%
Total Expenses	**12,562,710**	**13,006,848**	**444,138**	**3%**	**10,696,997**	**1,865,713**	**17%**
Contribution Margin	**962,178**	**(2,633,826)**	**3,596,003**	**-137%**	**(2,223,951)**	**3,186,129**	**-143%**
FTE's							
Provider Staff	32.54	29.10	(3.44)	-12%	24.44	(8.10)	-33%
Clinic Staff	69.09	70.54	1.45	2%	49.82	(19.27)	-39%
Contracted	1.12	1.20	0.08	6%	1.00	(0.12)	-12%
Total	102.75	100.84	(1.91)	-2%	75.26	(27.49)	-37%
Employed							
Hours Paid	138,210	135,510	(2,700)	-2%	118,811	(19,398)	-16%
Hours Worked	118,677	108,408	(10,269)	-9%	101,484	(17,193)	-17%
Contracted							
Hours	1,528	1,360	(168)	-12%	1,612	85	5%
Total Worked Hours	120,204	109,768	(10,436)	-10%	103,096	(17,108)	-17%
Unit of Service (UOS) Total Visits	46,397	47,679	(1,282)	-3%	42,301	4,096	10%
Productivity (Worked Hours / UOS)	2.59	2.30	0.29	13%	2.44	(0.15)	-6.3%
Avg Physician Productivity	*60,915*	*76.2%*			*50,835*	*83.2%*	*-8.5%*
Clinic Providers' PMH Gross Revenue	**$ 79,327,493**						

Prosser
Memorial Health

Prosser Family and Women's Health Clinic
Income Statement As Of: September 30, 2022
RURAL HEALTH CLINIC

	YTD Actual	YTD Budget	Variance	% Var	*YTD Prior*	*Variance*	*% Var*
Clinical Patient Revenue	6,515,533	5,518,904	996,629	18%	*5,144,279*	*1,371,254*	*27%*
Deductions From Revenue	(1,628,883)	(1,379,726)	(249,157)	18%	(1,286,070)	*(342,813)*	*27%*
Net Patient Revenue	**4,886,649**	**4,139,178**	**747,472**	**18%**	**3,858,209**	***1,028,440***	***27%***
Other Operating Revenue	-	-	-	**0%**	***1,028***	***(1,028)***	***-100%***
Provider Salaries	1,599,305	1,706,611	107,307	6%	*1,617,254*	*(17,949)*	*-1%*
Clinical Support Salaries	872,869	873,089	220	0%	*709,040*	*163,829*	*23%*
Benefits	175,407	184,234	8,827	5%	*139,288*	*36,119*	*26%*
Purchased Labor	-	-	-	0%	*14,850*	*(14,850)*	*-100%*
Total Salaries and Benefits	2,647,581	2,763,934	116,354	4%	*2,480,432*	*167,149*	*7%*
Professional Fees	159,251	121,125	(38,126)	-31%	*126,750*	*32,501*	*26%*
Supplies	217,151	261,147	43,996	17%	*275,291*	*(58,140)*	*-21%*
Utilities	20,362	20,550	188	1%	*19,938*	*424*	*2%*
Purchased Services	90,937	60,225	(30,712)	-51%	*81,402*	*9,535*	*12%*
Rentals & Leases	274,953	272,250	(2,703)	-1%	*273,966*	*987*	*0%*
Other Direct Expenses	14,811	47,835	33,024	69%	*34,928*	*(20,117)*	*-58%*
Total Non Salary Expenses	777,465	783,132	5,667	1%	*812,275*	*(34,810)*	*-4%*
Total Expenses	**3,425,046**	**3,547,067**	**122,021**	**3%**	***3,292,707***	***132,338***	***4%***
Contribution Margin	**1,461,604**	**592,111**	**869,492**	**147%**	***566,530***	***895,074***	***158%***
FTE's							
Provider Staff	8.94	8.00	(0.94)	-12%	*7.53*	*(1.41)*	*-19%*
Clinic Staff	24.55	22.25	(2.30)	-10%	*17.62*	*(6.93)*	*-39%*
Contracted	1.12	1.00	(0.12)	-12%	*1.00*	*(0.12)*	*-12%*
Total	34.62	31.25	(3.37)	-11%	*26.15*	*(8.47)*	*-32%*
Employed							
Hours Paid	45,549	41,140	(4,409)	-11%	*40,237*	*(5,312)*	*-13%*
Hours Worked	39,168	32,912	(6,256)	-19%	*33,899*	*(5,269)*	*-16%*
Contracted							
Hours	1,528	1,360	(168)	-12%	*1,612*	*85*	*5%*
Total Worked Hours	40,695	34,272	(6,423)	-19%	*35,511*	*(5,184)*	*-15%*
Unit of Service (UOS) Total Visits	15,898	17,736	(1,838)	-10%	*17,287*	*(1,389)*	*-8%*
Productivity (Worked Hours / UOS)	2.56	1.93	(0.63)	-32%	*2.05*	*(0.51)*	*-25%*

Prosser
Memorial Health

Benton City Clinic

Income Statement As Of: September 30, 2022

RURAL HEALTH CLINIC

	YTD Actual	YTD Budget	Variance	% Var	*YTD Prior*	*Variance*	*% Var*
Clinical Patient Revenue	2,277,993	1,980,575	297,417	15%	*1,690,414*	*587,579*	*35%*
Deductions From Revenue	(569,498)	(495,144)	(74,354)	15%	(422,604)	*(146,895)*	*35%*
Net Patient Revenue	**1,708,494**	**1,485,431**	**223,063**	**15%**	**1,267,811**	***440,684***	***35%***
Other Operating Revenue	-	-	-	**0%**	-	-	*0%*
Provider Salaries	663,944	808,759	144,815	18%	*727,058*	*(63,114)*	*-9%*
Clinical Support Salaries	460,720	449,032	(11,688)	-3%	*397,768*	*62,952*	*16%*
Benefits	93,275	103,791	10,516	10%	*75,363*	*17,912*	*24%*
Purchased Labor	-	-	-	0%	-	-	*0%*
Total Salaries and Benefits	1,217,939	1,361,582	143,643	11%	*1,200,189*	*17,750*	*1%*
Professional Fees	2,143	-	(2,143)	0%	*900*	*1,243*	*138%*
Supplies	129,416	121,063	(8,353)	-7%	*112,730*	*16,686*	*15%*
Utilities	6,925	8,700	1,775	20%	*7,943*	*(1,018)*	*-13%*
Purchased Services	40,660	39,750	(910)	-2%	*33,926*	*6,735*	*20%*
Rentals & Leases	126,863	145,575	18,712	13%	*147,655*	*(20,792)*	*-14%*
Other Direct Expenses	13,461	28,342	14,881	53%	*15,643*	*(2,182)*	*-14%*
Total Non Salary Expenses	319,468	343,430	23,962	7%	*318,796*	*672*	*0%*
Total Expenses	**1,537,407**	**1,705,012**	**167,604**	**10%**	***1,518,985***	***18,422***	***1%***
Contribution Margin	**171,087**	**(219,580)**	**390,667**	**-178%**	***(251,175)***	***422,262***	***-168%***
FTE's							
Provider Staff	4.51	5.00	0.49	10%	*4.69*	*0.18*	*4%*
Clinic Staff	11.38	13.00	1.62	12%	*9.21*	*(2.17)*	*-24%*
Contracted	-	-	-	0%	-	-	*0%*
Total	15.89	18.00	2.11	12%	*13.90*	*(1.99)*	*-14%*
Employed							
Hours Paid	21,616	24,480	2,864	12%	*22,230*	*614*	*3%*
Hours Worked	18,163	19,584	1,421	7%	*18,659*	*496*	*3%*
Contracted							
Hours	-	-	-	0%	-	-	*0%*
Total Worked Hours	18,163	19,584	1,421	7%	*18,659*	*496*	*3%*
Unit of Service (UOS) Total Visits	7,002	7,812	(810)	-10%	*6,835*	*167*	*2%*
Productivity (Worked Hours / UOS)	2.59	2.51	(0.09)	-3%	*2.73*	*0.14*	*5%*

Prosser
Memorial Health

Grandview Clinic

Income Statement As Of: September 30, 2022

RURAL HEALTH CLINIC

	YTD Actual	YTD Budget	Variance	% Var	*YTD Prior*	*Variance*	*% Var*
Clinical Patient Revenue	3,262,305	2,153,674	1,108,631	51%	*1,547,888*	*1,714,417*	*111%*
Deductions From Revenue	(815,576)	(538,419)	(277,158)	51%	(897,775)	*82,199*	*-9%*
Net Patient Revenue	**2,446,729**	**1,615,256**	**831,473**	**51%**	**650,113**	***1,796,616***	***276%***
Other Operating Revenue	-	-	-	**0%**	-	-	***0%***
Provider Salaries	988,147	867,226	(120,921)	-14%	*709,066*	*279,081*	*39%*
Clinical Support Salaries	376,658	507,664	131,006	26%	*365,823*	*10,835*	*3%*
Benefits	134,948	109,713	(25,235)	-23%	*72,772*	*62,176*	*85%*
Purchased Labor	-	-	-	0%	-	-	*0%*
Total Salaries and Benefits	1,499,753	1,484,603	(418,975)	-12%	*1,147,661*	*352,092*	*31%*
Professional Fees	-	32,400	32,400	100%	*27,781*	*(27,781)*	*-100%*
Supplies	112,787	142,051	29,264	21%	*111,219*	*1,568*	*1%*
Utilities	14,969	13,125	(1,844)	-14%	*12,653*	*2,316*	*18%*
Purchased Services	41,054	26,625	14,429	54%	*27,409*	*13,645*	*50%*
Rentals & Leases	106	450	(344)	-76%	*246*	*(140)*	*-57%*
Other Direct Expenses	14,081	26,775	(12,694)	-47%	*21,451*	*(7,370)*	*-34%*
Total Non Salary Expenses	182,998	241,426	(58,428)	-24%	*200,759*	*(17,761)*	*-9%*
Total Expenses	**1,682,751**	**1,726,029**	**43,278**	**3%**	**1,348,420**	***334,331***	***25%***
Contribution Margin	**763,978**	**(110,773)**	**874,751**	**-790%**	**(698,307)**	***1,462,285***	***-209%***
FTE's							
Provider Staff	7.98	5.90	(2.08)	-35%	*4.97*	*(3.01)*	*-61%*
Clinic Staff	12.02	14.60	2.58	18%	*8.89*	*(3.13)*	*-35%*
Contracted	-	-	-	0%	-	-	*0%*
Total	20.00	20.50	0.50	2%	*13.86*	*(6.14)*	*-44%*
Employed							
Hours Paid	27,202	27,880	678	2%	*22,183*	*(5,019)*	*-23%*
Hours Worked	23,422	22,304	(1,118)	-5%	*18,947*	*(4,475)*	*-24%*
Contracted							
Hours	-	-	-	0%	-	-	*0%*
Total Worked Hours	23,422	22,304	(1,118)	-5%	*18,947*	*(4,475)*	*-24%*
Unit of Service (UOS) Total Visits	8,804	8,719	85	1%	*6,402*	*2,402*	*38%*
Productivity (Worked Hours / UOS)	2.66	2.56	(0.10)	-4%	2.96	*0.30*	*10%*

Prosser
Memorial Health
Dermatology Clinic

Income Statement As Of: September 30, 2022

PROVIDER BASED CLINIC

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior	Variance	% Var
Clinical Patient Revenue	910,880	658,249	252,631	38%	38,615	872,265	2259%
Deductions From Revenue	(537,419)	(381,784)	(155,635)	41%	(22,397)	(515,023)	2300%
Net Patient Revenue	**373,461**	**276,465**	**96,996**	**35%**	**16,218**	**357,243**	**2203%**
Other Operating Revenue	-	-	-	**0%**	-	-	**0%**
Provider Salaries	333,173	334,980	1,807	1%	71,176	261,997	368%
Clinical Support Salaries	51,267	40,960	(10,307)	-25%	10,484	40,783	389%
Benefits	26,242	18,588	(7,654)	-41%	5,611	20,631	368%
Purchased Labor	-	-	-	0%	-	-	0%
Total Salaries and Benefits	410,682	394,528	(418,975)	-12%	87,271	323,411	371%
Professional Fees	-	-	-	0%	-	-	0%
Supplies	87,391	168,214	80,823	48%	2,569	84,822	3302%
Utilities	2,818	3,150	332	11%	-	2,818	0%
Purchased Services	4,339	32,175	(27,836)	-87%	11,698	(7,359)	-63%
Rentals & Leases	42,271	40,500	1,771	4%	-	42,271	0%
Other Direct Expenses	6	11,354	(11,347)	-100%	-	6	0%
Total Non Salary Expenses	136,825	255,392	(118,568)	-46%	14,267	122,558	859%
Total Expenses	**547,507**	**649,920**	**102,414**	**16%**	**101,538**	**445,969**	**439%**
Contribution Margin	**(174,046)**	**(373,456)**	**199,410**	**-53%**	**(85,320)**	**(88,726)**	**104%**
FTE's							
Provider Staff	0.99	1.00	0.01	1%	0.08	(0.91)	-1138%
Clinic Staff	1.90	3.20	1.30	41%	0.09	(1.81)	-2011%
Contracted	-	-	-	0%	-	-	0%
Total	2.89	4.20	1.31	31%	0.17	(2.72)	-1600%
Employed							
Hours Paid	3,928	5,712	1,784	31%	272	(3,656)	-1344%
Hours Worked	3,492	4,570	1,077	24%	264	(3,228)	-1223%
Contracted							
Hours	-	-	-	0%	-	-	0%
Total Worked Hours	3,492	4,570	1,077	24%	264	(3,228)	-1223%
Unit of Service (UOS) Total Visits	1,821	1,242	579	47%	66	1,755	2659%
Productivity (Worked Hours / UOS)	1.92	3.68	1.76	48%	4.00	2.08	52%

Prosser Memorial Health
Specialty Clinic

Income Statement As Of: September 30, 2022

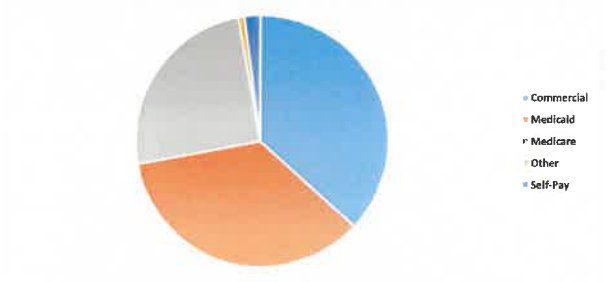
PROVIDER BASED CLINIC

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior	Variance	% Var
Clinical Patient Revenue	10,023,304	6,801,650	3,221,654	47%	6,380,159	3,643,145	57%
Deductions From Revenue	(5,913,749)	(3,944,957)	(1,968,792)	50%	(3,700,492)	(2,213,257)	60%
Net Patient Revenue	**4,109,555**	**2,856,693**	**1,252,862**	**44%**	**2,679,667**	**1,429,888**	**53%**
Other Operating Revenue	-	-	-	**0%**	-	-	**0%**
Provider Salaries	3,440,627	3,739,435	298,807	8%	3,087,209	353,419	11%
Clinical Support Salaries	738,515	663,155	(75,359)	-11%	730,229	8,285	1%
Benefits	241,696	222,863	(18,833)	-8%	158,066	83,630	53%
Purchased Labor	30,693	25,682	5,012	20%	-	30,693	0%
Total Salaries and Benefits	4,451,531	4,651,135	(418,975)	-12%	3,975,504	476,028	12%
Professional Fees	352,191	28,125	(324,066)	-1152%	21,465	330,726	1541%
Supplies	236,153	318,365	82,212	26%	152,540	83,614	55%
Utilities	-	13,125	13,125	100%	14,159	(14,159)	-100%
Purchased Services	62,716	68,928	(6,212)	-9%	51,498	11,218	22%
Rentals & Leases	232,021	224,941	7,080	3%	193,836	38,184	20%
Other Direct Expenses	35,388	74,202	(38,814)	-52%	26,345	9,043	34%
Total Non Salary Expenses	918,468	727,686	190,783	26%	459,843	458,626	100%
Total Expenses	**5,370,000**	**5,378,821**	**8,821**	**0%**	**4,435,346**	**934,653**	**21%**
Contribution Margin	**(1,260,445)**	**(2,522,128)**	**1,261,682**	**-50%**	**(1,755,680)**	**495,235**	**-28%**
FTE's							
Provider Staff	10.12	9.20	(0.92)	-10%	7.17	(2.95)	-41%
Clinic Staff	19.23	17.49	(1.74)	-10%	14.01	(5.22)	-37%
Contracted	-	0.20	0.20	100%	-	-	0%
Total	29.35	26.89	(2.46)	-9%	21.18	(8.17)	-39%
Employed							
Hours Paid	39,914	36,298	(3,616)	-10%	33,889	(6,025)	-18%
Hours Worked	34,432	29,039	(5,393)	-19%	29,715	(4,717)	-16%
Contracted							
Hours	-	-	-	0%	-	-	0%
Total Worked Hours	34,432	29,039	(5,393)	-19%	29,715	(4,717)	-16%
Unit of Service (UOS) Total Visits	12,872	12,170	703	6%	11,711	1,161	10%
Productivity (Worked Hours / UOS)	2.67	2.39	(0.29)	-12%	2.54	(0.14)	-5%

Prosser
Memorial Health

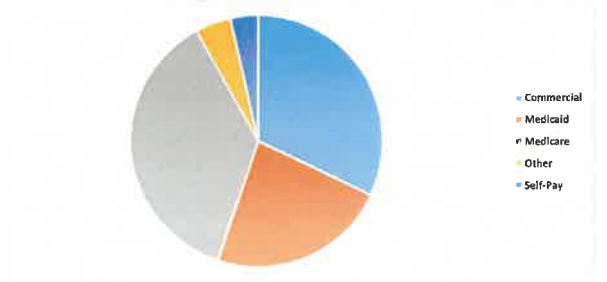
Revenue By Financial Class

Benton City Clinic



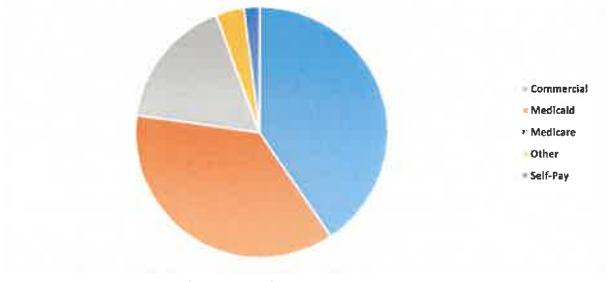
Revenue by Financial Class		
Commercial	840,612	37%
Medicaid	802,015	35%
Medicare	570,966	25%
Other	18,246	1%
Self-Pay	46,154	2%
Grand Total	**2,277,993**	

Specialty Clinic



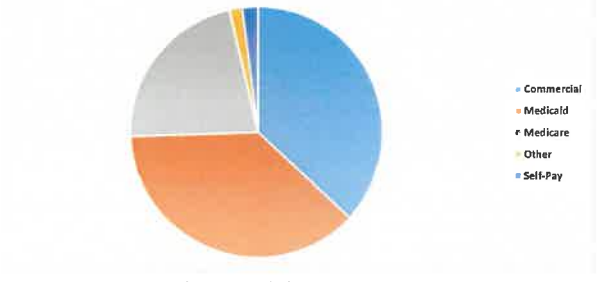
Revenue by Financial Class		
Commercial	3,218,075	32%
Medicaid	2,310,064	23%
Medicare	3,682,035	37%
Other	455,079	5%
Self-Pay	358,051	4%
Grand Total	**10,023,304**	

Prosser Clinic



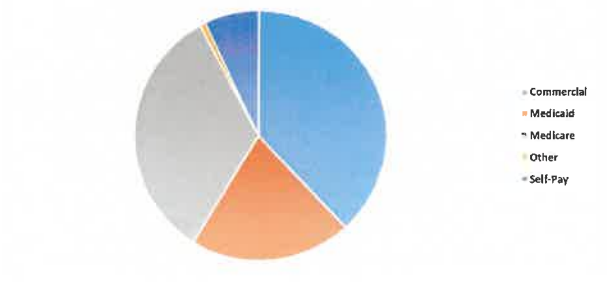
Revenue by Financial Class		
Commercial	2,647,914	41%
Medicaid	2,380,175	37%
Medicare	1,112,832	17%
Other	241,531	4%
Self-Pay	133,081	2%
Grand Total	**6,515,533**	

Grandview Clinic



Revenue by Financial Class		
Commercial	1,206,698	37%
Medicaid	1,222,070	37%
Medicare	712,459	22%
Other	54,048	2%
Self-Pay	67,030	2%
Grand Total	**3,262,305**	

Dermatology Clinic



Revenue by Financial Class		
Commercial	347,205	38%
Medicaid	188,445	21%
Medicare	303,340	33%
Other	6,951	1%
Self-Pay	64,939	7%
Grand Total	**910,880**	

Prosser
Memorial Health

CLINICAL PROVIDER VISITS BY MONTH

Benton City Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	2021 YTD
BRINDLE (BCC)	-	-	-	-	-	32	125	131	143				431	-
CARL	190	149	171	131	204	164	128	144	183				1,464	1,417
DUNHAM	-	-	-	-	-	-	-	-	-				-	7
LUTHER	209	204	236	116	260	120	179	27	230				1,581	1,594
MICROULIS	-	-	-	-	-	-	-	-	-				-	610
PADILLA	20	17	21	26	26	37	41	18	22				228	63
PETERS	52	54	64	55	67	40	54	82	73				541	56
SPOMER	-	32	70	85	69	86	45	12	-				399	-
STUADINGER	179	121	195	163	191	199	46	47	56				1,197	1,529
ZHMUROUSKI (BCC)	-	-	-	-	-	-	-	-	-				-	164
ZIRKER	-	-	-	-	-	-	-	-	-				-	1,073
TOTAL	650	577	757	576	817	678	618	461	707	-	-	-	5,410	6,513

Prosser Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	2021 YTD
BRINDLE (PC)	-	-	-	-	-	-	-	-	24				24	-
CHARVET (PC)	150	109	128	115	95	139	92	124	120				1,072	1,316
CHARVET (WH)	7	12	21	10	22	23	-	13	8				116	144
COOKS	126	129	142	140	135	129	134	156	95				1,186	-
DUNHAM	-	-	-	-	-	-	-	-	-				-	1,138
GARLAND	126	158	191	149	168	118	182	170	141				1,403	304
GILSTAD	25	50	39	36	18	-	-	-	-				168	-
GLOVER													-	128
HANNAN (NC)	16	14	18	20	19	8	24	23	23				165	-
MIN	-	-	-	-	-	-	-	-	-				-	1,173
P MORRIS (PC)	210	192	174	202	219	134	203	213	150				1,697	1,835
MORSE	203	178	229	102	131	121	177	211	167				1,519	1,717
OCONNOR	169	172	172	189	191	167	170	196	179				1,605	2,162
P MORRIS (WH)	14	3	-	1	9	-	-	-	-				27	364
PADILLA	179	141	173	158	250	212	120	189	178				1,600	1,158
PARK (PC)	-	-	-	-	-	-	-	-	-				-	18
PROCTOR (PC)	-	-	1	-	-	-	-	-	-				1	-
SOLLERS	168	251	297	163	139	254	242	196	211				1,921	2,175
THOMPSON	-	-	-	37	132	173	129	160	146				777	
WEAVER	138	192	167	198	186	208	190	241	164				1,684	1,689
ZHMUROUSKI (PC)	-	-	-	-	-	-	-	-	-				-	1,017
ZIRKER	-	-	-	-	-	-	-	-	-				-	25
TOTAL	1,531	1,601	1,752	1,520	1,714	1,686	1,663	1,892	1,606	-	-	-	14,941	16,338

Specialty Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	2021 YTD
BHATTI	208	223	145	225	248	252	191	236	215				1,943	1,837
CLIFFORD	220	238	310	181	202	286	194	303	271				2,205	2,084
COHEN	22	72	104	95	81	75	61	97	42				649	-
DUNHAM	169	152	153	137	98	100	129	112	111				1,161	502
GARLAND	-	-	-	10	10	17	16	17	10				80	-
HALVORSON	158	136	146	153	125	154	106	148	151				1,277	1,313
HUANG	-	-	-	-	-	-	-	-	-				-	54
LIEBE	31	40	44	28	48	32	29	53	30				335	-
LOVATO	16	26	23	19	13	18	20	21	22				178	-
STREBEL	128	100	134	131	144	115	109	168	146				1,175	1,100
TIEU CORAL	144	155	194	165	152	194	151	202	104				1,461	1,511
TIEU THOMAS	164	149	214	149	95	54	149	202	162				1,338	1,306
UNGER	37	40	38	30	49	33	25	39	26				317	844
TOTAL	1,297	1,331	1,505	1,323	1,265	1,330	1,180	1,598	1,290	-	-	-	12,119	10,551

Grandview Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	2021 YTD
DENNIS	-	-	-	-	23	44	41	71	95				274	-
GARZA	148	159	187	109	150	194	101	128	126				1,302	1,201
GLOVER	95	100	142	134	99	137	118	203	147				1,175	464
HANKS	136	120	128	141	150	106	136	130	92				1,139	1,150
PARK (GC)	56	97	116	116	132	100	86	77	74				854	714
PROCTOR (GC)	102	98	129	139	104	170	157	109	187				1,195	-
R MORRIS	82	53	71	60	85	64	86	77	74				652	416
SANTA-CRUZ	222	176	215	147	218	130	125	210	197				1,640	1,554
ZHMUROUSKI (GC)	-	-	-	-	-	-	-	-	-				-	348
TOTAL	841	803	988	846	961	945	850	1,005	992	-	-	-	7,957	5,847

Dermatology Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	
NYLANDER	161	183	202	205	188	256	219	199	204				1,817	66

Footnote: Information above only includes visits by provider, not clinic staff/nurse visits

Prosser
Memorial Health

CLINICAL PROVIDER REVENUE BY QUARTER

	Q1	Q2	Q3	Q4	TOTAL	*2021 YTD*
BHATTI	1,381,351	1,840,057	1,505,042		**4,726,450**	*4,113,873*
BRINDLE		24,549	326,458		**351,007**	*-*
CARL	345,201	239,763	217,835		**802,799**	*423,360*
CHARVET	305,068	197,115	168,928		**671,111**	*343,679*
CLIFFORD	1,575,784	992,811	1,699,536		**4,268,131**	*2,667,756*
COHEN	1,309,405	2,678,339	2,998,264		**6,986,008**	*-*
COOKS	378,931	228,925	213,083		**820,939**	*-*
DENNIS		27,831	81,619		**109,450**	
DUNHAM	307,630	296,312	341,317		**945,259**	*417,092*
GARLAND	421,446	238,499	360,972		**1,020,917**	*63,913*
GARZA	474,785	306,246	254,697		**1,035,728**	*364,228*
GILSTAD	142,533	53,457	1,243		**197,233**	*-*
GLOVER	244,127	200,783	275,953		**720,863**	*131,896*
HALVORSON	631,875	516,779	486,425		**1,635,079**	*1,540,861*
HANKS	179,056	186,530	158,839		**524,425**	*285,832*
HANNAN	83,093	51,159	65,676		**199,928**	*106,824*
HUANG	-	-	-		**-**	*327,275*
LIEBE	18,936	15,800	18,001		**52,737**	*33,780*
LOVATO	99	192	156		**447**	*5,135*
LUTHER	444,040	306,391	411,496		**1,161,927**	*464,979*
MICROULIS	480	-	-		**480**	*188,009*
MIN	9,547	-	-		**9,547**	*379,585*
R MORRIS	520,803	131,871	190,390		**843,064**	*310,455*
MORSE	197,871	122,052	184,852		**504,775**	*373,688*
NYLANDER	277,529	343,515	306,235		**927,279**	*38,334*
OCONNOR	763,116	545,538	533,196		**1,841,850**	*789,558*
P MORRIS	485,860	336,616	357,729		**1,180,205**	*521,832*
PADILLA	870,395	461,227	436,123		**1,767,745**	*507,627*
PARK	310	178,455	198,325		**377,090**	*140,621*
PETERS	36,332	33,468	44,305		**114,105**	*12,612*
PROCTOR	365,213	245,955	276,125		**887,293**	*3,887*
SANTA-CRUZ	548,945	340,503	343,150		**1,232,598**	*588,626*
SOLLERS	2,286,750	1,677,075	1,570,363		**5,534,188**	*3,612,033*
SPOMER	67,591	151,999	23,286		**242,876**	*-*
STAUDINGER	370,178	326,210	300,620		**997,008**	*413,355*
STREBEL	2,996,270	2,778,203	2,474,478		**8,248,951**	*5,726,922*
THOMPSON	-	212,625	304,484		**517,109**	*-*
TIEU CORAL	1,619,952	1,479,354	1,621,926		**4,721,232**	*3,899,695*
TIEU THOMAS	1,350,403	1,103,099	1,511,087		**3,964,589**	*3,775,429*
UNGER	5,093,169	5,350,563	4,336,799		**14,780,531**	*9,396,233*
WEAVER	1,672,515	1,468,658	1,245,530		**4,386,703**	*3,334,976*
ZHMUROUSKI	12,267	4,737	132		**17,136**	*502,039*
ZIRKER	184	403	114		**701**	*229,804*
TOTAL	**27,789,040**	**25,693,664**	**25,844,789**	**-**	**79,327,493**	***46,035,803***

Attachment U

PROSSER MEMORIAL HEALTH

Equity Contribution Strategy

INVESTMENTS 2022

	Acquired	Maturity	Rate	Instrument	Original Amount	Balance as of Month Ending 2021 December	Balance as of Month Ending 2022 September	YTD Impact	CASH-OUT ORDER	CUMULATIVE VALUE IN ORDER	CUMULATIVE IMPACT IN ORDER	Realized Loss	Maturity Value	Loss on Maturity Value
										TARGET FOR PMH EQUITY:	18,038,332			
A	10/2020	10/2022	0.19%	392213644	1,550,000	1,549,732	1,548,256	(1,476)	4	12,301,291	(1,476)	(1,744)	1,555,896	(7,639)
B	10/2020	09/2024	0.38%	392213432	1,000,991	984,011	923,409	(60,602)	8	18,038,332	(207,625)	(77,582)	1,008,513	(85,104)
C	11/2020	04/2025	0.45%	751007364	3,000,000	2,934,165	2,714,448	(219,717)	9	$ 20,752,780	$ (427,342)		3,068,110	
D	06/2021	10/2025	0.25%	392217501	4,645,909	4,590,058	4,212,471	(377,587)	11	27,248,004	(1,042,712)		4,696,449	
E	06/2021	10/2023	0.13%	392217502	1,991,250	1,980,234	1,916,406	(63,828)	7	17,114,923	(147,023)	(74,844)	1,997,063	(80,657)
F	10/2021	02/2026	0.55%	392219258	2,540,907	2,520,536	2,282,753	(237,783)	8	23,035,533	(665,125)		2,602,023	
G	10/2021	04/2024	0.38%	392219259	993,242	989,883	942,070	(47,813)	6	15,198,517	(83,195)	(51,172)	1,002,580	(60,510)
H	10/2021	04/2023	0.13%	392219260	1,992,812	1,989,062	1,955,156	(33,906)	5	14,256,447	(35,382)	(37,656)	1,996,550	(41,394)
					$ 17,715,111	$ 17,537,681	$ 16,494,969	$ (1,042,712)				(242,998)	17,927,183	(275,303)
								(207,625)						

OTHER INVESTMENTS & CASH AVAILABLE

OPERATING CASH TARGET REDUCTION			10,863,362	13,256,970	1	6,530,133	-
FUNDED DEPREC - CASH			1,003,653	2,998,912	2	9,529,045	-
WHITEHEAD FUND - LGIP			1,214,855	1,223,990	3	10,753,035	-
				$ 17,479,872			
UNRESTRICTED CASH AVAILABLE 9/30:				**$ 33,974,841**			
Forecasted Cash Increase by 12/31:				1,800,000			
				$ 35,774,841			

OTHER RESTRICTED INVESTMENTS

BOND OBLIGATION RESERVE FUND	1,106,851	1,106,851
LEOFF NET PENSION ASSET	767,520	767,546
		$ 1,874,397
TOTAL INVESTMENTS & CASH		**$ 37,649,238**

Project Cost	Total	USDA Loan	USDA Grant	Applicant	Operating Lease
land/right of way	1,725,375			1,725,375	
Project Inspection	200,000	200,000		-	
Fees, permits and other	632,235	18,500		613,735	
Professional Services	6,915,443			6,915,443	
Relocation Exp	200,000				
Construction	81,500,000	72,003,954		9,496,046	
Administrative	100,000			100,000	
Miscellaneous	132,437			132,437	
Bond Counsel/ Issuance	1,389,000			1,389,000	
Equipment	4,551,500	3,551,500	1,000,000	-	
Op. Lease FF&E	5,000,000				5,000,000
Interest	5,175,997			5,175,997	
Contingencies	4,526,046	4,526,046		-	
Total Project Costs	$ 112,048,033	$ 80,300,000	$ 1,000,000	$ 25,548,033	$ 5,000,000

PMH Spent to Date:	7,509,701
Remaining:	18,038,332
Construction Interest Account:	5,175,997
Construction Payables Account:	12,862,335
	18,038,332
Unrestricted Cash Balance 9/30:	$ 33,974,841
Forecast Unrestricted Cash Balance 12/31:	35,774,841
Less PMH Equity Obligation:	(18,038,332)
Unrestricted after Construction Accounts 12/31:	**$ 17,736,509**
Unrestricted Days of Cash 12/31:	79
Total Days of Cash including Restricted 12/31:	87

PMH has to allocate their Equity prior to any interim construction financing. PMH is forecasting the need to liquidate 5 instruments at The Notice to Proceed for $7,285,297 (cash-out order 4-8) along with $10,753,035 (cash-out order 1-3) in available cash as defined above.

The Investments listed above are numbered in preference of Cash-Out Order, their rolling cumulative value and their gain/(loss) upon liquidation of the instrument as of 9/30. PMH would liquidate all Cash Instruments and reduce Operating Cash first and then move up to Financial Investments and liquidate in Order indicated that minimizes the financial impact.

As of 9/30 the loss in FYE2022 on the cash-out instruments would be ($207,625) for a cumulative loss since original investment of ($242,998.) The Remaining Investment Losses recognized to date would eventually be recouped if the investments are held to maturity.

Attachment V

	Clayton Homes - Albany	Palm Harbor - Sunset Bay	Palm Harbor - California
Modular Home	$ 174,849	$ 212,153	$ 222,829
Options (HVAC/Heat Pump, etc...)	30,000	30,000	30,000
Excavation/Foundation	24,000	24,000	24,000
Entrance/Deck	5,400	5,400	5,400
Utilities	11,500	11,500	11,500
Driveway	18,000	18,000	18,000
Garage	34,000	34,000	34,000
Landscaping	7,500	7,500	7,500
Contingency	9,157	10,277	10,597
	305,249	342,553	353,229
Sales Tax	26,557	29,802	30,731
Permits/Fees/Engineering	8,700	8,700	8,700
	$ 340,506	$ 381,055	$ 392,660
Demolition	25,000	25,000	25,000
Grand Total	$ 365,506	$ 406,055	$ 417,660
Proceeds/Paid			
PMH	(12,378)	(12,378)	(12,378)
Travelers	105,021	105,021	105,021
Net:	$ 92,643	$ 92,643	$ 92,643
PMH portion			
Deductible	10,000	10,000	10,000
Garage & Driveway	64,677	64,677	64,677
Contingency	4,977	5,585	5,759
	$ 79,654	$ 80,262	$ 80,436

ALT. KITCHEN #1

ALT. KITCHEN #2

HOMES BUILT WITH YOU IN MIND

HouseSmart® is how we approach everything we do.

IN STOCK SALE PENDING

Preferred Plus CP561F Clayton

$220,000s* BEFORE OPTIONS

3 beds 2 baths 1,512 sq. ft.




*Images may show options not included in base price

REQUEST INFO

Attachment W

2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Benton & Franklin Counties, WA

This CHNA was conducted as a collaboration between Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Prosser Memorial Health, and Kadlec Regional Medical Center. To provide feedback on this CHNA or obtain a printed copy free of charge, email info@BFCHA.org.

CHNA STEERING COMMITTEE

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PUBLIC HEALTH
Prevent • Promote • Protect
BENTON-FRANKLIN HEALTH DISTRICT

Benton Franklin Community HEALTH ALLIANCE

KADLEC

Prosser Memorial Health

CONTENTS

EXECUTIVE SUMMARY

Purpose

The Community Health Needs Assessment (CHNA) helps determine which critical health needs the community will focus on over the next three to five years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin Counties.

Methods

The CHNA steering committee began meeting weekly in January of 2022. The committee includes representatives of Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH). Providence Community Health Investment staff provided invaluable technical assistance and qualitative data analysis.

Quantitative and qualitative data were used to identify community needs through a mixed-methods approach. Quantitative data sources include a community survey, Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), and the Healthy Youth Survey (HYS) as well as Centers for Disease Control and Prevention (CDC), Child Care Aware of America, County Health Rankings and Roadmaps, Washington State Department of Children, Youth & Families (WA DCYF), Washington Statistical Analysis Center (WA SAC), Washington Association of Sheriffs and Police Chiefs (WASPC), and Washington Tracking Network (WTN). Quantitative data is presented through a life course perspective.

Qualitative data includes twenty-one interviews with working partners and community collaborators (partners), ten listening sessions, two behavioral health forums, two housing and homelessness forums, and two general forums.

The COVID-19 pandemic impacted our nation and communities. The focus became one of crisis response that required the concentration of resources and resulted in pandemic-related challenges that impacted data collection causing data limitations and information gaps.

Results

CHNA steering committee members met weekly in July and August 2022 to apply the prioritization criteria to the identified needs. Criteria included worsening trend over time, disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities, community rates worse than state average, the opportunity to impact based on community partnerships, severity of the need and/or scale of need. The following Community Health Improvement Plan Guiding Concepts also informed the prioritization process: Equity, Life-course wellness, Health in All Policies (HiAP), Evidenced-based, and Collective Impact. The list below summarizes the significant health needs identified through the 2022 Community Health Needs Assessment process in no particular order:

BEHAVIORAL HEALTH

The 2019 Benton & Franklin Counties Community Health Needs Assessment (CHNA) identified that our community needed to better understand the behavioral health gaps and needs within the community. An assessment was completed in the spring of 2022 through a partnership with Eastern Washington University (EWU). The assessment identified significant needs for behavioral health response and prevention. Behavioral health, which encompasses mental health and substance use/misuse, was identified as a need in all areas of this CHNA. With the serious behavioral health workforce shortage, increase in need, and existing coalitions working towards solutions, our steering committee identified behavioral health as a priority area.

HOUSING AND HOMELESSNESS

The 2019 CHNA also identified that our community needed to better understand the housing and homelessness gaps and needs within the community. The assessment was completed in the spring of 2022 through a partnership with EWU. On housing, the assessment identified a low supply of affordable housing, low supply of multi-family units, low vacancy rates for rentals, and increased rental costs. Housing increases in Benton and Franklin Counties are not keeping up with population growth and demand. Regarding homelessness, the assessment identified a shortage of low-barrier housing options for residents experiencing homelessness. Additionally, there has been a greater than two-fold increase in the average number of days a person experiences homelessness in Benton and Franklin Counties. Stable housing has consistently been shown to improve both physical and mental health outcomes. For this reason and because the Benton and Franklin regions are experiencing rapid growth, a lack of affordable housing, a lack of low-barrier solutions to homelessness, and the complexity of solving these issues through effective community partnerships, our steering committee identified these issues as priorities for the upcoming Community Health Improvement Plan (CHIP).

ACCESS TO HEALTH

This 2022 CHNA identified a need for access to not only healthcare, but also access to community supports that enable health. It is understood that optimal health is influenced by access and quality of healthcare, health promoting behaviors, the physical environment, and socioeconomic factors. Access to Health will include a focus on addressing barriers to medical care, including healthcare provider to patient ratios and linguistically appropriate, culturally responsive, and accessible care. In addition, the steering committee broadened this priority to include needs identified in the CHNA, such as access to safe and nutritious food; transportation; safe, licensed, and affordable childcare; health education; chronic disease prevention; and resource awareness.

COMMUNITY PARTNERSHIP DEVELOPMENT

Benton and Franklin Counties are fortunate to have numerous community coalitions and committees aimed at improving and supporting community health. This region also has a business community which is quite supportive of promoting local health and social initiatives. However, this CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships.

These priorities were approved by the Kadlec Community Board on October 19, 2022; the Benton Franklin Health District on XX, 2022; the Benton-Franklin Health Alliance on XX; and Prosser Memorial Health on XX, 2022.

Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Kadlec Regional Medical Center, and Prosser Memorial Health, in collaboration with community partners will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs.

Kadlec will also develop its three-year CHIP to respond to these prioritized needs in collaboration with community partners. The 2023-2025 Kadlec CHIP will be approved and made publicly available no later than May 15, 2023.

Measuring Our Success: Results from the 2020 Benton & Franklin Counties CHIP

While striving to achieve the goals outlined in the 2020 CHIP, the COVID-19 pandemic impacted our community and the focus became one of crisis response. In spite of the pandemic, outcomes were achieved, and a few key outcomes are listed below:

- Benton-Franklin Health District, Kadlec Regional Medical Center, Prosser Memorial Health, the Hispanic Chamber of Commerce, and many other community partners came together to expand access to health care services related to the COVID-19 pandemic.
- In the spring of 2022, a sales tax in Benton and Franklin Counties went into effect, providing one penny per every $10 to go towards behavioral healthcare and access in the two counties.
- Columbia Basin Health Associates established primary care facilities in rural areas of north Franklin County. Prosser Memorial Health (PMH) hired multiple new providers in urgent/after-hours care, pediatrics, family practice, obstetrics and women's health, emergency medicine, and behavioral health. PMH also expanded clinic hours where appropriate.
- Benton-Franklin Health District established the Food Access and Security Coalition which began meeting in April of 2022.
- Benton-Franklin Health District contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a more comprehensive needs assessment regarding homelessness and behavioral health. The report was completed in June of 2022 completing two CHIP objectives and providing data to inform the 2022 CHNA and 2023 CHIP.

To read the Benton & Franklin Counties 2020 CHIP, click here.

Measuring Our Success: Results from the 2020-2022 Kadlec Regional Medical Center CHIP

The priorities identified in the 2019 Benton & Franklin Counties CHNA were behavioral health challenges, access and cost of health care, and social determinants of health. While striving to achieve the goals outlined in the 2020-2022 Kadlec CHIP, the COVID-19 pandemic impacted our community and therefore responding to COVID-19 became Kadlec's priority. A few key outcomes are listed below:

- Telemedicine services expanded rapidly in response to the pandemic, and 48,291 telemedicine visits were completed in 2020 and 37,260 telemedicine visits were completed in 2021.
- Kadlec established the Community Resource Desk (CRD), which is a free service that connects people with community resources they need, including establishing a primary care provider, dental care, medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and basic needs such as food, transportation, clothing, work, or housing aid. The CRD was instrumental in helping community members access COVID-19 vaccines and testing.
- Four of the eight of Kadlec's Family Medicine Residency program residents that graduated in 2022 are staying within Kadlec.
- Kadlec integrated behavioral health in primary care by embedding social workers in three clinics.
- Between January 2020 and September 2022, 669 people were trained in Mental Health First Aid and other mental health and suicide prevention programs.
- As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking Community Health Workers (CHW) were hired in 2021 to be frontline agents of change, helping to reduce health disparities in underserved communities, working alongside their clients as they navigate health care services and access resources.

To read the Kadlec Regional Medical Center 2020-2022 CHIP, click here.

INTRODUCTION

As a collaboration between Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH), this CHNA covers Benton and Franklin Counties.

Who We Are: Benton-Franklin Health District

The Benton-Franklin Health District (BFHD) has been serving the growing community of Benton and Franklin counties for over 75 years. Made up of more than one hundred dedicated staff members, BFHD serves the bi-county population of over 300,000 residents, thousands of visitors, and covers almost 3,000 square miles within its jurisdiction. BFHD is poised and ready to address current and emerging public health concerns. In addition to providing many services directly, BFHD works collaboratively with dozens of community partners and organizations to address health needs of people living, working, and visiting the bi-county region.

Mission BFHD provides all people in our community the opportunity to live full, productive lives by promoting healthy lifestyles, preventing disease and injury, advancing equity, and protecting our environment.

Vision BFHD is a proactive leader uniting knowledgeable staff and proven practices with strong partners and informed residents to form a resilient, healthy community where all of us can learn, work, play, and thrive to our greatest potential.

Values Excellence – Diversity – Communication and Collaboration – Integrity and Accountability – Effectiveness

Equity BFHD believes everyone in the community should have the opportunity to attain their highest level of health. BFHD values and serves all people regardless of age, race, ethnicity, gender identity, sexual orientation, religion, socioeconomic status, or physical and mental abilities.

Who We Are: Benton-Franklin Community Health Alliance

The Benton Franklin Community Health Alliance (BFCHA) began in 1993 as a task force of community leaders from Benton and Franklin Counties who believed that the community needed a cancer treatment facility, but that funding needs were too large for any one hospital to absorb alone. The hospitals worked together to finance and operate the Tri-Cities Cancer Center, which has become a world class cancer treatment facility associated with the Seattle Cancer Care Alliance. Today, BFCHA serves as a "neutral convener" bringing healthcare and community leaders together to address a variety of issues related to health and quality of life in Benton and Franklin Counties.

Who We Are: Kadlec Regional Medical Center

Our Mission Provide safe, compassionate care.
Our Vision Health for a better world.
Our Promise "Know me, care for me, ease my way."
Our Values Safety—Compassion—Respect—Integrity—Stewardship—Excellence—Collaboration

Kadlec Regional Medical Center (KRMC) is a not-for-profit serving residents in Southeast Washington and Northeast Oregon. Founded in 1944, KRMC is an acute-care hospital located in Richland, Washington. The hospital has 337 licensed beds and is approximately eleven acres in size.
More than 3600 employees work in the hospital, the freestanding Emergency Department, and in primary and specialty care clinics throughout the region. Kadlec is part of the family of mission-driven organizations that make up Providence, serving communities across a seven-state footprint.
Major programs and services offered to the community include the following: comprehensive, award-winning cardiac care program; neurosurgery and neurology; all-digital outpatient imaging center; pediatrics, rural and emergency care; telehealth services in partnership with clinics and hospitals in Southeast Washington and Northeast Oregon and is the region's only Level III Neonatal Intensive Care Unit. KRMC is a Level III Trauma Center.

Kadlec dedicates resources to improve the health and quality of life for the communities they serve. During 2021, Kadlec provided $63,900,000 in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Benton and Franklin Counties and beyond. Kadlec further demonstrates organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs.

[1] Per federal reporting and guidelines from the Catholic Health Association.

Who We Are: Prosser Memorial Health

For 75 years, Prosser Memorial Health has provided high-quality, compassionate, and comprehensive healthcare services to our communities. Service lines include: 24/7 Emergency Department; Orthopedics; Cardiology; Dermatology; General Surgery and ENT/Allergy; Gastroenterology; Urology; Obstetrics and Family Birthplace; Therapy Services; and Primary Care through our local clinics.

Prosser has also expanded their Community Health Programs to include a Community Paramedic Program which helps to provide care the vulnerable, promote health and wellness, and lower the cost of healthcare.

Prosser Memorial Health's Mission is to "improve the health of our community," and they further demonstrate this by offering the best quality medical care using their six organizational Values: Accountability, Services, Promote Teamwork, Integrity, Respect and Excellence.

Prosser's Chief Quality and Compliance Officer participated in this CHNA process.

Health Equity

We acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by striving to address the underlying causes of racial and economic inequities and health disparities. We believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

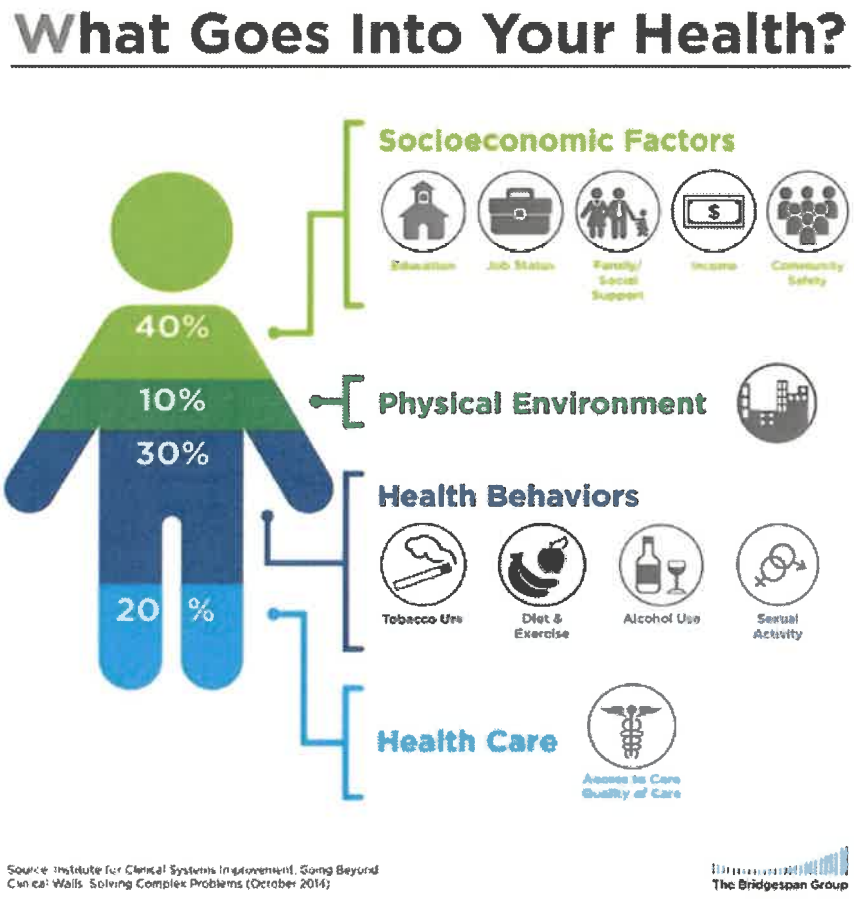


Figure 1. Factors contributing to overall health and well-being

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is a valuable tool we use to better understand health disparities and inequities within the communities we serve, as well as community strengths and assets (see Figure 2 for definition of terms[3]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

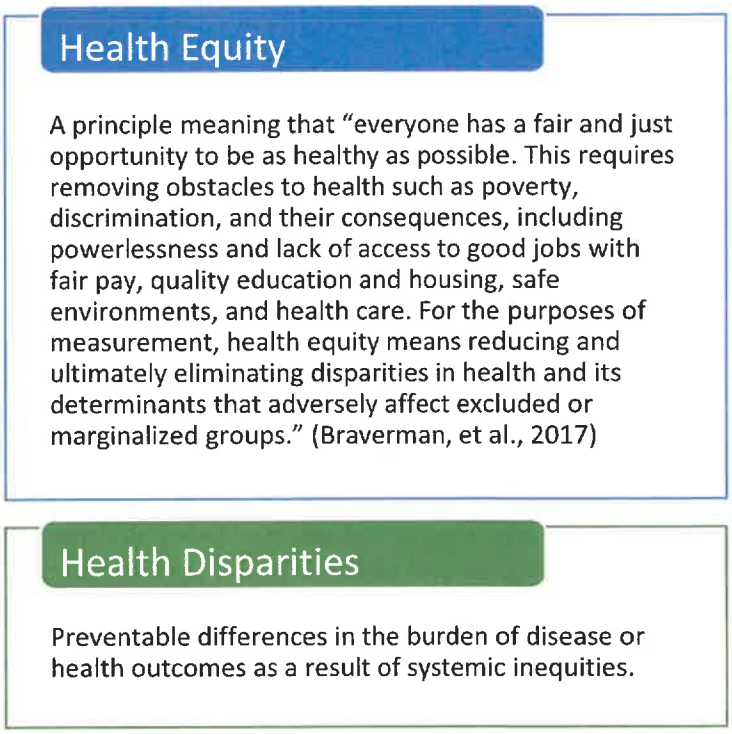


Figure 2. Definitions of key terms

Efforts taken to center equity in community engagement included interviewing stakeholders who represent organizations serving various demographic groups that are historically marginalized. Populations included were aging adults, people experiencing homelessness, Spanish-speaking communities, immigrants, and families of those living with disabilities. Listening sessions were designed to include participants from under-represented groups and included family members and caregivers of those living with disabilities, aging community members, veterans, and youth and adults experiencing homelessness. The community survey was distributed in English and Spanish.

When possible, data categories were broken down into more specific sub-groups to better identify unique differences. Restrictions in data sharing and small numbers limited the range of data available for disaggregation.

[3] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

OUR COMMUNITY

Description of Community Served

Benton and Franklin Counties are located in south central Washington just west of the confluence of the Columbia and Snake Rivers. Pasco is the county seat of Franklin County while Prosser, located 30 miles west, is the Benton County seat. Many county facilities are located in Kennewick. With a combined population of more than 300,000, the area is Washington's third largest metro area and among of the fastest growing. The area's three largest cities, Kennewick, Pasco, and Richland became known as the "Tri-Cities" not long after WWII. Other principal cities in Benton County are West Richland and Benton City. Outside of Pasco, Franklin County's small towns support some of the country's most productive farmland irrigated by the Columbia Basin Project. They include Eltopia, Basin City, Mesa, Connell, and Kahlotus. The rich agricultural opportunities provide residents with access to fresh and locally grown food. In fact, for five months of the year, there are farmers' markets open throughout the region nearly daily. Additionally, multiple local farms offer you-pick and roadside produce sales. With over 300 days of sunshine per year, multiple paved and natural trails, and numerous community parks, this region offers opportunities for outdoor recreation for all ages and ability levels in a high-desert climate.

Hospital systems serving Benton and Franklin Counties and beyond include Kadlec Regional Medical Center, Trios Health, Lourdes Health, and Prosser Memorial Health. Federally Qualified Health Centers serving the area are Miramar Health Centers, Tri-Cities Community Health, and Columbia Basin Health Association. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, Benton and Franklin Counties serve as the boundary for the service area.

Community Demographics

The tables below provide basic demographic and socioeconomic information about Benton and Franklin Counties and how they compare to Washington State.

POPULATION TOTALS

Table 1. Population Totals

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
2020 Total Population	205,700	96,760	302,460	7,656,200
Female Population	102,198	47,071	149,269	3,835,105
Male Population	103,502	49,689	153,191	3,821,095

Source: WA OFM, 2020

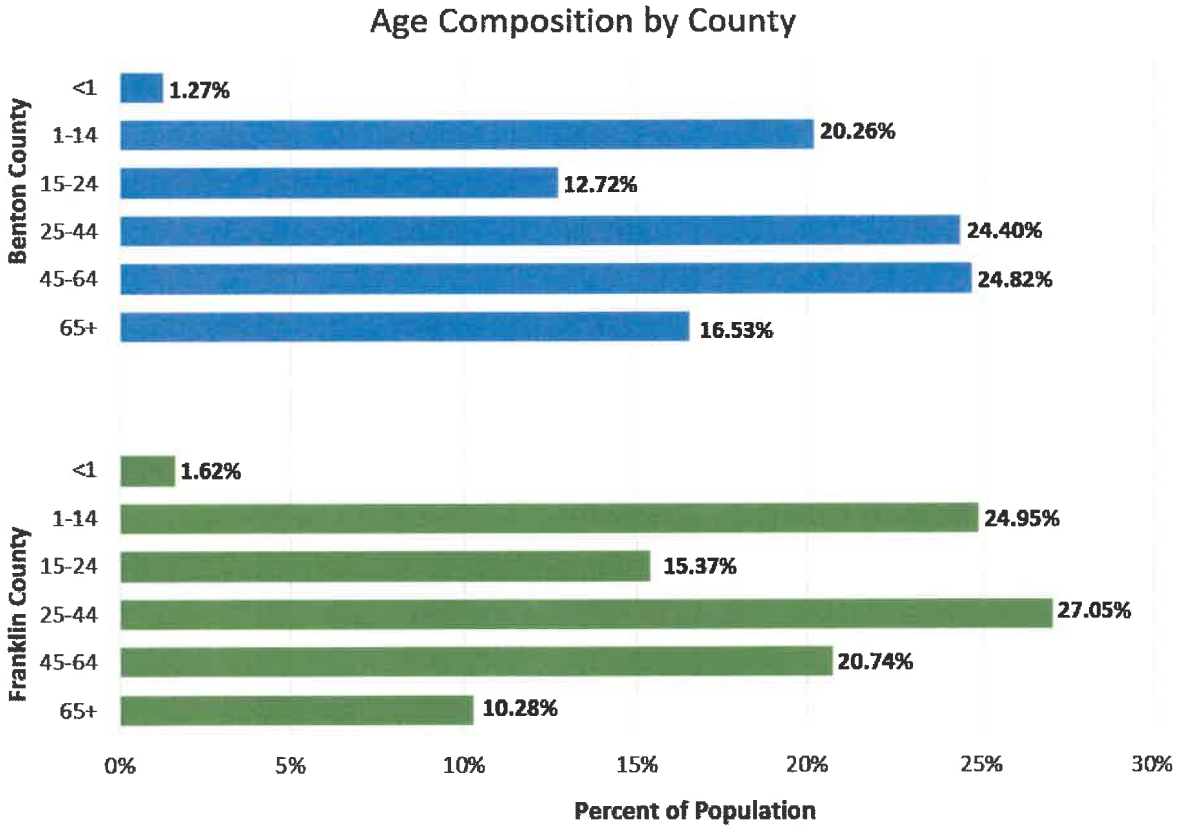
POPULATION BY AGE

Table 2. Population by Age

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Population that is <1 Years Old	1.27%	1.62%	1.38%	1.16%
Population that is 1-14 Years Old	20.26%	24.95%	21.76%	17.35%
Population that is 15-24 Years Old	12.72%	15.37%	13.57%	12.61%
Population that is 25-44 Years Old	24.40%	27.05%	25.25%	27.25%
Population that is 45-64 Years Old	24.82%	20.74%	23.52%	24.89%
Population that is 65+ Years Old	16.53%	10.28%	14.53%	16.74%

Source: WA OFM, 2020

Figure 3. Age Composition by County



Source: WA OFM, 2020

POPULATION BY RACE AND ETHNICITY

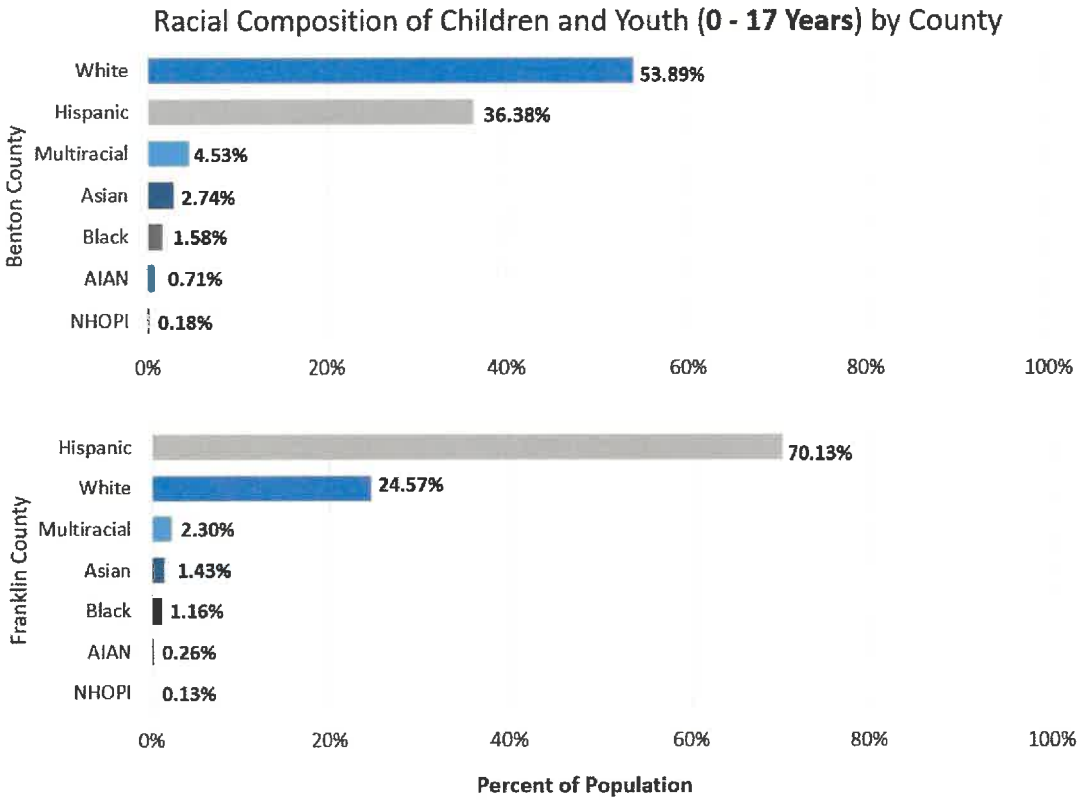
Table 3. Population by Race and Ethnicity

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Youth (0-17) who identify as American Indian & Alaska Native, Not Hispanic	0.71%	0.26%	0.55%	1.40%
Youth (0-17) who identify as Asian, not Hispanic	2.74%	1.43%	2.26%	8.22%
Youth (0-17) who identify as Black, not Hispanic	1.58%	1.16%	1.43%	4.45%
Youth (0-17) who identify as Hispanic	36.38%	70.13%	48.77%	22.71%
Youth (0-17) who identify as Multiracial, not Hispanic	4.53%	2.30%	3.71%	9.15%
Youth (0-17) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.18%	0.13%	0.16%	0.97%
Youth (0-17) who identify as White, not Hispanic	53.89%	24.57%	43.13%	53.10%
Adults (18-64) who identify as American Indian & Alaska Native, Not Hispanic	0.79%	0.56%	0.72%	1.28%
Adults (18-64) who identify as Asian, not Hispanic	3.62%	2.34%	3.21%	10.44%
Adults (18-64) who identify as Black, not Hispanic	1.50%	1.97%	1.65%	4.27%
Adults (18-64) who identify as Hispanic	21.96%	53.77%	32.17%	12.60%
Adults (18-64) who identify as Multiracial, not Hispanic	2.05%	1.36%	1.83%	3.51%
Adults (18-64) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.17%	0.18%	0.18%	0.77%
Adults (18-64) who identify as White, not Hispanic	69.90%	53.77%	60.25%	67.13%

Adults (65+) who identify as American Indian & Alaska Native, Not Hispanic	0.44%	0.36%	0.42%	0.89%
Adults (65+) who identify as Asian, not Hispanic	3.26%	2.90%	3.17%	7.09%
Adults (65+) who identify as Black, not Hispanic	0.67%	1.86%	0.94%	2.11%
Adults (65+) who identify as Hispanic	6.22%	24.07%	10.26%	3.71%
Adults (65+) who identify as Multiracial, not Hispanic	1.29%	.088%	1.20%	1.37%
Adults (65+) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.10%	0.04%	0.08%	0.27%
Adults (65+) who identify as White, not Hispanic	88.02%	69.88%	83.92%	84.56%

Source: WA OFM, 2020

Figure 4. Racial Composition of Children and Youth (0-17 Years) by County

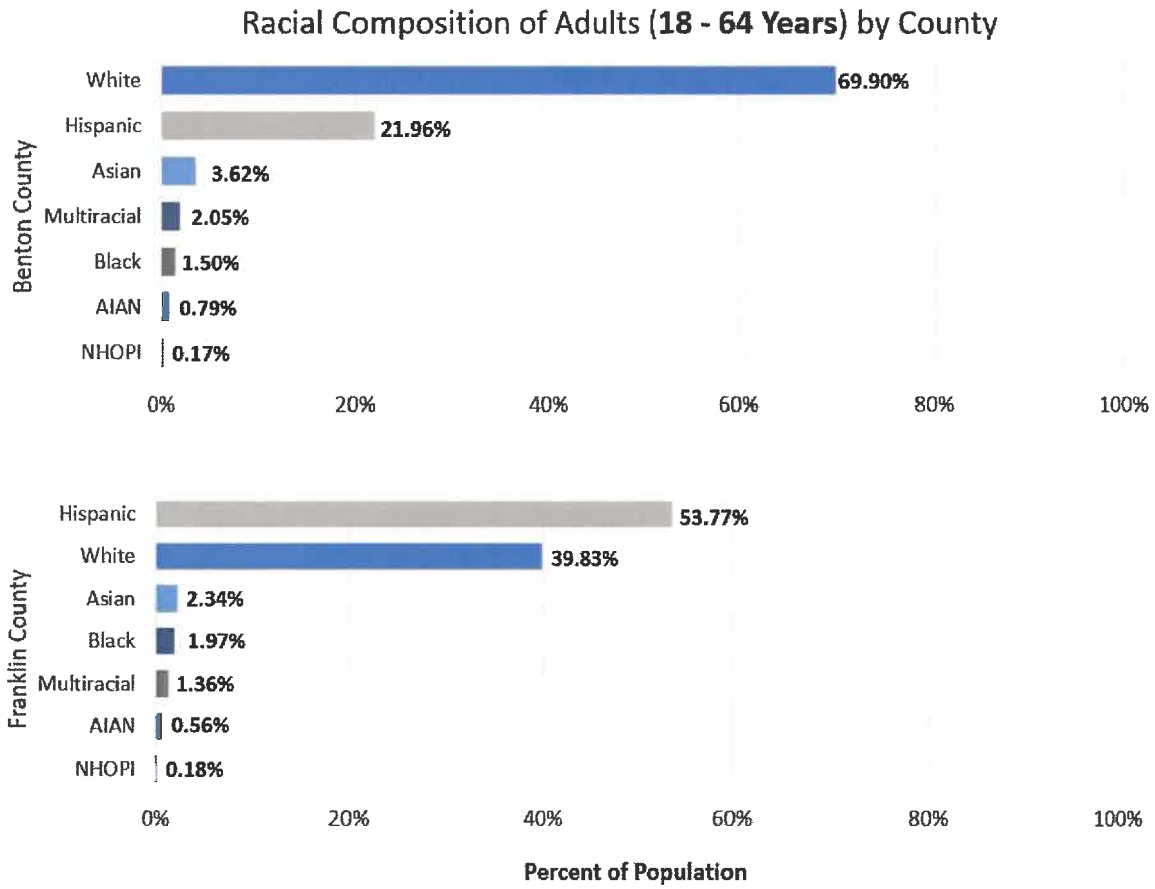


Source: WA OFM, 2020

AIAN—American Indian and Alaska Native

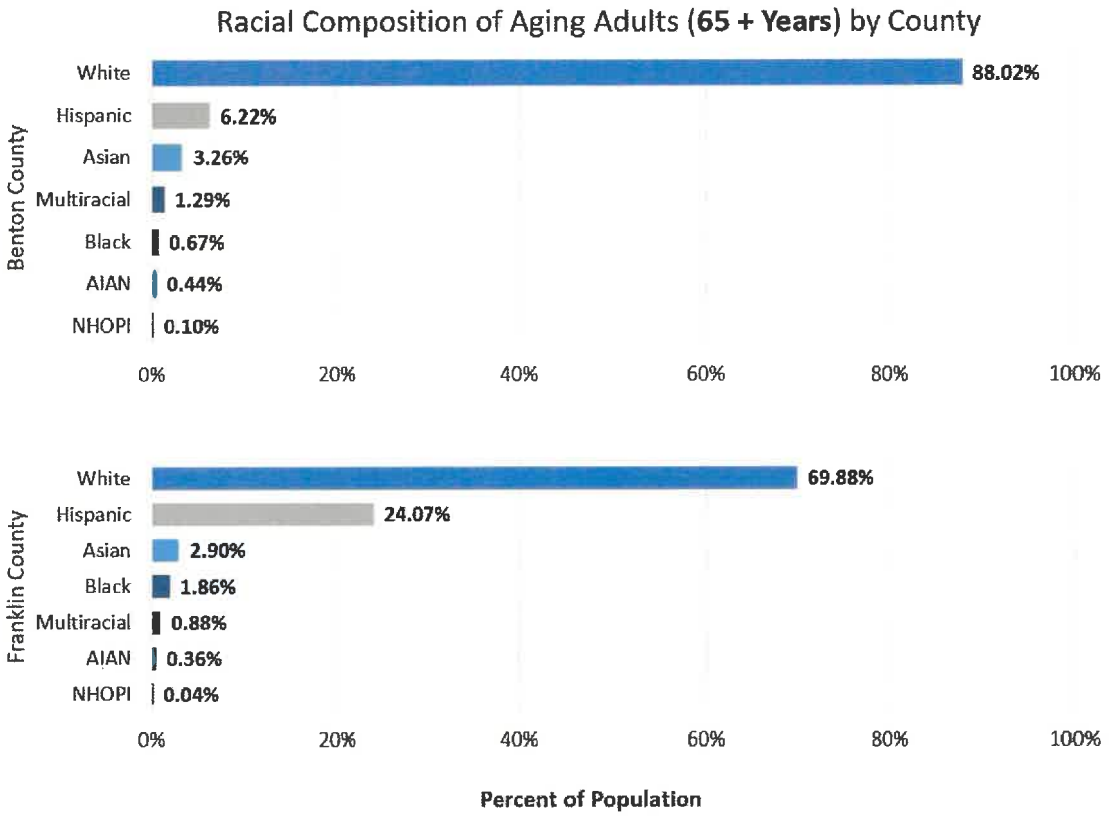
NHOPI—Native Hawaiian or Pacific Islander

Figure 3. Racial Composition of Adults (18-64 Years) by County



Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

Figure 6. Racial Composition of Older Adults (65+ Years) by County



Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

MEDIAN INCOME

Table 4. Median Household Income

Indicator	Benton County	Franklin County	Washington State
Median Household Income*	$72,847	$63,575	$80,319
Median Household Income (Preliminary Estimate)**	$75,882	$73,656	$81,998

**Source: WA OFM, 2019*
***Source: WA OFM, 2020*
BentonFranklinTrends.org, 2019—no owners paying 50%+ metric

HOUSING COST BURDEN

Table 5. Percent of Residents with Severe Housing Cost Burden

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Renters Paying 30%+ of Income on Shelter	44.1%	42.7%	43.7%	45.3%
Renters Paying 50%+ of Income on Shelter	20.7%	16.2%	19.4%	20.5%
Owners Paying 30%+ of Income on Shelter	15.5%	19.2%	16.5%	23%

INCOME BELOW FEDERAL POVERTY LEVEL (FPL)

Table 6. Percent of Residents with Income Below FPL by Age Group

Indicator	Benton County	Franklin County	Washington State
Total Residents Living Below FPL	10.2%	14.2%	10.2%
<5 Years	15.80%	15.20%	13.40%
5-17 Years	14.20%	20.60%	12.30%
18-34 Years	11.90%	12.80%	13.10%
35-64 Years	7.30%	11%	8.20%
65+ Years	7.10%	11.70%	7.50%

Source: US Census, 2020

INSURANCE ESTIMATES

Table 7. Residents Uninsured and Residents with Medicaid

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Percent Residents Uninsured*	7.1%	14.1%	9.3%	6.2%
Percent Residents with Medicaid**				23.98%
Percent Residents with Medicaid***	21.9%	36.1%	26.4%	19.8%

**US Census Bureau, 2020*
***Data.medicaid.gov, 2020*
****BentonFranklinTrends.org, 2019*

HEALTH PROFESSIONAL SHORTAGE AREA

Benton and Franklin Counties are designated by the Health Resources & Services Administration (HRSA) as Health Professional Shortage Areas (HPSA) having shortages of primary care, dental, and mental health providers meaning there are not enough providers for the population, service area, or facilities.

Franklin County is also designated by HRSA as a Medically Underserved Area (MUA) having too few primary care providers, high infant mortality, high poverty or a high elderly population.

Definitions and additional information can be on the HRSA website.

See Appendix 1 for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering community information, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited working partners, community collaborators, and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions.

Quantitative and qualitative data were used to identify community needs through a mixed-methods approach. Quantitative data sources include Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), and the Healthy Youth Survey (HYS) as well as Centers for Disease Control and Prevention (CDC), Child Care Aware of America, County Health Rankings and Roadmaps, Washington State Department of Children, Youth & Families (WA DCYF), Washington Statistical Analysis Center (WA SAC), Washington Association of Sheriffs and Police Chiefs (WASPC), and Washington Tracking Network (WTN). Quantitative data is presented through a life course perspective.

Qualitative data includes twenty-one interviews with working partners and community collaborators (partners) were conducted, ten listening sessions, a community survey, two behavioral health forums, two housing/homelessness forums, and two general forums. Partners interviewed and listening session participants represent members of medically underserved, low-income, and minority populations in the community.

Process for Gathering Comments on CHNA and Summary of Comments Received

The 2019 Benton & Franklin Counties CHNA, Kadlec Executive Summary, and the 2020-2022 Kadlec CHIP were made widely available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP) as well as through various channels with our community-based organization partners. Two requests for hard copies were made to Kadlec and copies were sent via United States Postal Service mail at no charge. No comments were received. The CHNA will be posted on Kadlec's website and remain there through two subsequent CHNA cycles.

HEALTH INDICATORS

The 2022 CHNA health indicators were primarily selected based on four factors: one or both Benton and Franklin Counties' values were significantly higher than Washington State's value; a significant disparity between Benton County and Franklin County was identified; there was a significant change from previous years in Benton or Franklin Counties; or the indicator was identified in the 2020 CHIP as a goal metric to measure.

Pregnancy, Birth & Sexual Health

PRENATAL CARE INITIATION

Table 8. First Prenatal Care Visit

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Pregnancies with First Prenatal Care Visit in the 1st Trimester	74.85%	76.36%	75.39%	81.82%
Pregnancies with First Prenatal Care Visit in the 2nd Trimester	17.61%	16%	17.03%	13.19%
Pregnancies with First Prenatal Care Visit in the 3rd Trimester	5.29%	4.71%	5.08%	4.38%
Pregnancies Receiving No Prenatal Care	2.25%	2.93%	2.19%	1.18%

Source: Community Health Assessment Tool (CHAT), 2020

BIRTH STATISTICS

Table 9. Birth Rates and Infant Mortality

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Birth Rate (per 1,000 Population)	12.09	15.26	13.10	10.85
Birth Rate (per 1,000 Population) to Women Aged 10-19 Years	12.15	14.33	12.95	8.7
Births with a Low Birthweight (<2500g)	6.31%	6.77%		6.71%
Infant Mortality Rate (per 1,000 Births)			6.56	4.49

Source: CHAT, 2020

YOUTH CONDOM USE

Table 10. Youth Condom Use

Indicator	Benton & Franklin Counties Combined	Washington State
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 8th Grade	34.54%	31.24%
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 10th Grade	62.25%	58.43%
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 12th Grade	62.91%	54.72%

Source: Healthy Youth Survey (HYS), 2021

Family & Community

CHILD CARE COSTS AND AVAILABILITY

Table 11. Child Care Cost and Need Met

Indicator	Benton County	Franklin County	Washington State
Average Child Care Cost per Child per Month	$894	$899	$1,044
Average Child Care Cost per Child per Month as Percentage of Median Household Income	17%	19%	18%
Estimated Percent Child Care Need met by Licensed Child Care (<35 Months)	11%	14%	17%
Estimated Percent Child Care Need met by Licensed Child Care (35 Months to School Aged)	25%	34%	53.30%

Source: Child Care Aware of America, 2021

YOUTH PHYSICAL AND VERBAL ABUSE

Table 12. Youth Surveyed Report Physical and Verbal Abuse

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 8th grade	30.70%	31.20%
Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 10th grade	33%	30.80%

Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 12th grade	32.10%	34%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 8th grade	15.80%	17.50%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 10th grade	20.90%	21.60%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 12th grade	19%	19.90%

Source: HYS, 2021

Activity, Nutrition & Weight

YOUTH PHYSICAL ACTIVITY

Table 13. Youth Physical Activity

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Reporting Not Meeting Physical Activity Recommendations – 6th Grade	82.40%	81.30%
Youth Reporting Not Meeting Physical Activity Recommendations – 8th Grade	78.20%	80.90%
Youth Reporting Not Meeting Physical Activity Recommendations – 10th Grade	76.70%	78%
Youth Reporting Not Meeting Physical Activity Recommendations – 12th Grade	77.80%	77.30%

Source: HYS, 2021

YOUTH BMI

Table 14. Youth BMI

Indicator	Benton & Franklin Counties Combined	Washington State
Youth in Top 15% BMI by Reported Height and Weight – 8th Grade	16.60%	17.30%
Youth in Top 15% BMI by Reported Height and Weight –10th Grade	18.10%	15.80%
Youth in Top 15% BMI by Reported Height and Weight – 12th Grade	17.70%	15.30%

Source: HYS, 2021

Access to Healthcare & Use of Preventative Services

ACCESS TO HEALTHCARE

Table 15. Access to Healthcare Resources

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Adults (18-64) Reporting Having Any Kind of Medical Coverage*	88.05%	68.54%	80.31%	88.45%
Adults (18-64) Reporting Having a Primary Care Provider*	77.22%	61.83%	71.10%	73.96%
Primary Care Provider to Population Ratio**	1430:1	4720:1		1180:1
Dentist to Population Ratio**	1390:1	2030:1		1200:1
Mental Health Providers to Population Ratio**	350:1	720:1		250:1

**Source: Behavioral Risk Factor Surveillance System (BRFSS), 2020*
***Source: County Health Rankings and Roadmaps, 2021*

Mental & Behavioral Health

ADULT AND YOUTH MENTAL HEALTH

Table 16. Adult and Youth Mental Health

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Adults Reporting Poor Mental Health for 14+ Days for the Last 30 Days*	13.38%	10.90%	12.63%	14.23%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 8th Grade**			35.80%	35.30%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 10th Grade*			41.60%	38.20%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 12th Grade*			48.60%	44.50%

**Source: BRFSS, 2020*
**Source: HYS, 2021*

YOUTH MENTAL HEALTH (SUICIDE)

Table 17. Youth Mental Health (Suicide)

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 8th Grade	18.80%	19.30%
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 10th Grade	20.40%	19.50%
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 12th Grade	21.30%	20.20%

Source: HYS, 2021

Substance Use

OPIOID STATISTICS

Table 18. Opioid Statistics

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Opioid Prescriptions per 100 Residents*	72.9	12.4		39.5
Opioid Overdose Hospitalization Rate (per 100,000 Population)**			14.18	14.47
Opioid Overdose Mortality Rate (per 100,000 Population)**			15.71	15.30

**Source: Center for Disease Control and Prevention (CDC), 2020*
***Source: CHAT, 2019*

YOUTH VAPING

Table 19. Youth Vaping

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Report Using E-Cigarettes in Past 30 Days – 6th Grade	3.80%	3.20%
Youth Report Using E-Cigarettes in Past 30 Days – 8th Grade	6.50%	5.10%

Youth Report Using E-Cigarettes in Past 30 Days – 10th Grade	9.40%	8%
Youth Report Using E-Cigarettes in Past 30 Days – 12th Grade	11.70%	15.50%

Source: HYS, 2021

Violence & Injury Prevention

CRIME STATISTICS

Table 20. Crime Statistics

Indicator	Benton County	Franklin County	Washington State
Violent Crime Rate per 1,000 Residents*			3.4
Rate of Reported Domestic Violence Offenses per 100,000 Residents**	875.55	635.59	774.39
Total youth (12-17) Arrest Rate per 10,000 Youth***	336.20	202.36	121.24

**Source: Washington Association of Sheriffs and Police Chiefs (WASPC), 2020*

***Source: WASPC, 2020*

**** Source: Washington Statistical Analysis Center (WA SAC), 2020*

INJURIES

Table 21. Injuries

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Hospitalization Rate per 100,000 Population Due to Falls for People Aged <65	129.74	60.31	106.57	118.65
Hospitalization Rate per 100,000 Population Due to Falls for People Aged 65+	2222.45	1627.43	2088.72	1789.26
Age-Adjusted Hospitalization Rate per 100,000 Population for Unintentional Injuries	654.4	536.53	624.41	574.36
Age-Adjusted Non-Fatal Intentional Self-Harm/Suicide Rate per 100,000 Population	53.59	23.26	43.85	49.83

Source: CHAT, 2019

YOUTH SEXUAL ASSAULT

Table 22. Youth Experiencing Sexual Assault

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 8th Grade	18.40%	20%
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 10th Grade	27.90%	24.80%
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 12th Grade	31.40%	27.20%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 8th Grade	9.30%	9.90%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 10th Grade	18.80%	13.80%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 12th Grade	19.50%	22%

Source: HYS, 2021

Chronic Illness

Table 23. Chronic Illness

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Age-Adjusted All Cancer Incidence Rate per 100,000 Population	343.95	321.14	336.23	474.59
Adults Reporting Having Ever Been Told They Had Coronary Heart Disease and/or a Heart Attack**	6.32%	4.84%	5.70%	4.61%
Adults Reporting Having Ever Been Told They Had Diabetes (Excludes Gestational and Pre-Diabetes)**	8.35%	8.72%	8%	8.02%
Age-Adjusted Hospitalization Rate per 100,000 Population Due to Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis*	112.23	94.64	107.26	60.66

** Source: CHAT, 2019*
*** Source: BRFSS, 2020*

Life Expectancy, Leading Causes of Death & Quality of Life

LIFE EXPECTANCY & YEARS OF POTENTIAL LIFE LOST

Table 24. Life Expectancy and Years of Potential Life Lost

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Life Expectancy	78.70	79.80	79.08	79.85
Years of Potential Life Lost**	4,402 Years	3,520 Years	4,106 Years	3,860 Years

Source: CHAT, 2020

***A cumulative estimation of the average time a person would have lived had they not died prematurely (before the age of 65)*

Table 25. Life Expectancy and Years of Potential Life Lost by County

County	Population	Years of Potential Life Lost (YPLL) Rate	Estimated Years Lost
Benton County	205,700	4,402 Years per 100,000 Population	9,055 Years
Franklin County	96,760	3,520 Years per 100,000 Population	3,406 Years

Table 26. Life Expectancy by Zip Code

Indicator	Life Expectancy Years
Benton City (99320)	78.41
Kennewick (99336)	74.59
Kennewick (99337)	79.75
Kennewick (99338)	85.77
Plymouth (99346)	67.68
Prosser (99350)	79.06

Richland (99352)	79.38
West Richland (99320)	80.30
Richland (99354)	80.14
Pasco (99301)	78.86
Connell (99326)	85.88
Eltopia (99330)	78.96
Mesa (99343)	89.91

Source: CHAT, 2020

LEADING CAUSES OF DEATH

Table 27. Leading Causes of Death

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Major Cardiovascular Diseases Mortality Rate per 100,000 Population	187.51	186.44	186.31	180.27
Malignant Neoplasms Mortality Rate per 100,000 Population	137.37	122.69	133.24	135.74
COVID-19 Mortality Rate per 100,000 Population	60.42	89.02	67.33	35.82
Alzheimer's Disease per 100,000 Population	67.56	42.42	62.26	41.71
Unintentional Injuries per 100,000 Population	52.40	42.22	49.50	51.42
Chronic Lower Respiratory Disease per 100,000 Population	32.05	37.57	33.40	28.89
Diabetes Mellitus per 100,000 Population	16.93	26.94	19.07	22.23
Chronic Liver Disease and Cirrhosis per 100,000 Population	14.30	15.26	13.90	14.12
Intentional Self-Harm (Suicide) per 100,000 Population*	18.22			15.39
Parkinson's Disease per 100,000 Population*	9.04			9.25

Source: CHAT, 2020

**To protect personal health information, rates from counts <10 will be suppressed. If counts are zero, "0" will be recorded.*

SUICIDE MORTALITY

Table 28. Age-Specific Suicide Mortality Rates by Age

Indicator	Benton & Franklin Counties Combined	Washington State
Population Aged 0-17	2.71	2.68
Population Aged 18-34	15.39	19.31
Population Aged 35-64	19.65	21.42
Population Aged 65+	25.27	20.25

Source: CHAT, 2016-2020
To protect personal health information, multiple years and large groups were combined.

See Appendix 1: Quantitative Data

COMMUNITY INPUT

Interviews and Listening Sessions

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Benton-Franklin CHNA steering committee members conducted 21 interviews with working partners and community collaborators (partners) including 33 participants. They also conducted 10 listening sessions with a total of 67 community members. Interviews and listening sessions were conducted between March and May 2022. Below is a high-level summary of the findings of these sessions; **full details on the protocols, findings, and attendees are available in Appendix 2.**

VISION FOR A HEALTHY COMMUNITY

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The primary theme shared was "community engagement and connection" and participants noted the importance of people working together towards common goals, having meaningful conversations, and volunteering. The following is a list of all the themes that emerged:

- Community engagement and connection
- Easy access to health care, including mental health services, for everyone
- Safety
- Diversity, inclusion, and respect
- Opportunities for recreation and a healthy lifestyle
- Economic security, including affordable housing and employment

COMMUNITY STRENGTHS

While a CHNA is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist, including the following identified by partners:

Community engagement and willingness to help

Partners identified the greatest strength of Benton and Franklin Counties as the community engagement and people's willingness to show up to help one another. They shared that people care for one another, support one another, welcome new folks to the community, and volunteer to meet the needs of others. People care deeply about the community and many people have remained in the community for many years and are giving back.

A spirit of collaboration and partnership

Partners spoke to a strong spirit of collaboration and partnership in Benton and Franklin Counties. There is a lot of commitment to working together to make meaningful change towards shared goals. They shared examples of collaborations between law enforcement agencies, nonprofits, faith-based organizations, health care, government, emergency response teams, and community members.

Strong network of community organizations to meet needs

Partners shared there are many local organizations to meet people's health and Social Determinant of Health needs. There are multiple hospitals, clinics, urgent care centers, and specialists in the community to give patients options. There are strong school districts which are connected to many of the families and serve as a trusted partner. The Hanford site employs many people.

Diversity of cultures and community knowledge

Partners shared the people of Benton and Franklin Counties are a strength. There are many cultures represented in the communities and opportunities to build relationships with people of different backgrounds.

COMMUNITY NEEDS

Listening session participants discussed a variety of needs, but the four most common were **mental health, homelessness and housing instability, access to health care services, and substance use/misuse.** Mental health was the most frequently discussed need. Long wait times for appointments, provider turnover, and insurance barriers prevent people from accessing timely, high-quality mental health, primary care, and specialty care. Groups that may experience additional barriers to responsive care include young people, older adults, Spanish-speaking people, veterans, and people with developmental disabilities. Participants discussed the importance of more culturally responsive health care services, and providers with empathy for patients' situations. Participants were concerned about the high cost of housing and lack of affordable housing in the area. Substance use/misuse was also identified as a community challenge and the lack of detox services was frequently identified as a gap.

Other needs discussed in detail by listening session participants include **community resources, safety, transportation, and family support and resources.**

Mental health	Mental health was overwhelmingly identified as the most pressing community need. Most partners spoke to needing more mental health treatment services, including mental health counselors and facilities at all clinical levels. Specifically, they noted a need for improved crisis services and pediatric inpatient services. Contributing to the community needs are workforce challenges, noting high burnout, testing and supervision barriers, and low wages for entry level roles as contributors. Transportation can be especially challenging for people living in more rural parts of the counties when accessing mental health supports. Language is also a barrier for people whose primary language is not English. Partners were particularly concerned about young people, including youth in foster care, noting that mental health needs have only increased during the COVID-19 pandemic. They noted seeing an increase in anxiety, depression, and social isolation, as well as an increase in behavioral issues with students, potentially connected to a lack of stability during the pandemic. People with developmental disabilities have few options for accessing behavior support specific to their needs locally, noting a need to provide more intentional support for this group and their caregivers. Partners spoke to the COVID-19 pandemic as exacerbating mental health needs for everyone and contributing to a lot of stress for families, and a lack of connection for many people, including older adults. Health care providers also experienced increased stress and mental health needs during the pandemic. Telehealth services improved access for some people but created challenges for others, particularly people with a developmental disability or people lacking access to or comfort with technology.
Substance use/misuse	Partners highly prioritized substance use/misuse because of how it affects whole families and communities. They shared there are not enough substance use disorder (SUD) treatment services in the community, although there are many great efforts underway, including the Recovery Center, to meet the need. There is specifically a need for inpatient SUD treatment services and a detox center for withdrawal management. Partners emphasized how critical it is to have a detox center within the community. There is insufficient behavioral health workforce to meet the need, potentially due to low wages for people without advanced degrees and burnout in the field. Partners identified young people, older adults, and people experiencing homelessness as groups that may not receive the support needed in accessing support for substance use/misuse issues. During the COVID-19 pandemic, partners have seen substance use/misuse increase for both adults and young people.

Access to health care services	Partners shared that while there are many health care services in the two counties, there is still a need for more primary care providers and specialists to reduce wait times. Access to preventive care is especially important for ensuring people receive timely and appropriate care, avoiding unnecessary calls to EMS or avoidable ED visits. In addition to preventive care, partners spoke to a need for improved discharge planning, including medication management, particularly for people experiencing homelessness. For people needing a skilled nursing facility or hospice, there are also limited options in the community. Partners shared it can be challenging to recruit health care professionals from outside of the area, particularly with the high cost of housing. The health care system can be challenging for people to navigate, particularly for older adults, people whose primary language is not English, and people with a disability. Transportation was highlighted as a primary barrier for people, particularly if they live in a rural area or have mobility issues. Other barriers include cost of care, language, childcare, and appointment times during work hours. Partners highlighted the following populations as experiencing additional barriers to care: people with developmental disabilities, older adults, young people, the Latino/a community, and people experiencing homelessness. Due to the COVID-19 pandemic, some people delayed preventive health care services or were not able to access the health care services they needed. Telehealth improved access for some patients but is challenging for those without access to or comfort with technology. COVID-19 vaccine disinformation and the politicization of public health practices put additional strain on the health care system and providers. Positively, the pandemic created more opportunities for education and outreach with communities, and increased awareness of the role of health care and public health in the community.
Homelessness and housing instability	Partners prioritized homelessness and housing instability because of its connection to so many other needs and because of the importance of people first being stably housed before addressing their other needs. They described homelessness as a symptom of other issues and noted concern for folks not just living unsheltered, but also those living in their cars or RVs, couch surfing, and moving frequently. They spoke to needing more homelessness services in the community to address hygiene issues and care coordination needs. They emphasized a need for more housing in general, but in particular low-barrier permanent supportive housing, transitional housing, and workforce housing. Partners emphasized the importance of taking a Housing First approach. The high cost of housing and low housing stock have made finding affordable housing a challenge for many people in the community, both wanting to buy and rent homes. They spoke to very low vacancy rates, leading to competition for rentals, increases in rent, and overcrowding. For people with low incomes, a behavioral health condition, or any negative rental history, finding affordable, stable housing can be more challenging. Older adults and families with children with special needs also lack housing that meets their needs, including skilled nursing facilities.

The following needs were frequently prioritized, but with lower priority by partners. They represent the **medium-priority health-related needs,** based on community input:

Economic insecurity, education, and job skills	Partners discussed the need for more financial stability for many families, ensuring there are living wage jobs, job skill trainings, and investments in education. With high cost of housing, families may spend a substantial portion of their income on rent, especially for seasonal and agricultural workers. To address these needs, partners advocated for more equitable funding of public education and support for higher education, increased job skill training particularly for students in more rural districts, and support for skilled work training. Partners identified single parents with a special needs child, seasonal workers, and the Latino/a community as being disproportionately affected by economic insecurity. The pandemic affected businesses and workers, particularly in the service and hospitality industries.
Affordable childcare and preschools	Partners emphasized affordable and flexible childcare as crucial for stable families and a strong workforce. Without addressing this need, people will not be able to participate fully in the workforce and there will continue to be staffing challenges. There is very little affordable childcare in the community and limited free preschool spots. For families working non-traditional hours, finding flexible childcare can be very difficult. For families with a child with a disability, there is very little childcare that can meet the child's needs. This prevents parents from working. The pandemic highlighted how important childcare is for keeping people staffed and for businesses being able to recruit and retain employees.
Food insecurity	Many partners shared that the community is working to ensure people have access to food, although the food options may not always be the healthiest and programs may not address what is causing food insecurity. They shared that food pantries often provide non-perishable foods, which are often not as nutritional as fresh foods. Fresh and healthy foods can be challenging for families with low incomes to afford. Families new to the United States may not be familiar with reading the food labels and identifying healthy foods for their children. Workers on the Hanford site have little access to food on-site besides what they bring. The pandemic exacerbated food insecurity more many people. While there have been additional supports to provide food to families, partners noted there are often a lot of cars lined up waiting to receive food assistance at events, underscoring the need.
Community safety	Partners shared that while they do not think Benton and Franklin Counties overall are unsafe, they are concerned about increased community violence and neighborhoods where residents do not feel safe. This might contribute to people not feeling comfortable accessing parks or recreation. Partners spoke to seeing a large increase in gun violence in 2021, as well as people manifesting anger and stress into violence. They emphasized that addressing community safety needs to be a collaboration between law enforcement and the community.

Community Survey

Benton-Franklin Health District contracted with Zencity, a well-respected community input and insights platform, to conduct a community health survey. The survey was conducted in English and Spanish, respondents were recruited via the internet, and was fielded from March 17-April 11, 2022. The sample survey of Benton and Franklin Counties adults, 18+ was 657. The data was weighted to represent the population in Benton and Franklin Counties. Key findings:

- Just over half the respondents (54%) are satisfied with the quality of life.
- Around half the respondents rate their physical, mental, and dental health as good.
- Fifty-seven percent of respondents reported getting all the health care they needed with no delay, 73% reported getting all the mental health care they need, and 67% responded that they got all the dental health care they needed. Cost and not having a regular provider were leading reasons for not getting enough care.
- Respondents feel that a healthy community is one in which health care and services are accessible to all. They think mental health services are the most important thing the community needs.
- Four groups consistently reported lower quality of life, lower overall health, and less access to health care than other groups: respondents aged 18-34, Hispanic/Latino/a respondents living in Franklin County, and respondents with low incomes.

See Appendix 1: Community Survey

Trends in Behavioral Health

The Institute for Public Policy & Economic Analysis completed "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties." A survey of mental health providers was conducted and two behavioral health forums were held in person in May of 2022. Forum participants included representatives from community service and non-profit organizations, health care, businesses, government agencies, community members. Relevant data was shared and participant input sought to help identify current needs and gaps in community behavioral health.

KEY FINDINGS FROM THE BEHAVIORAL HEALTH FORUMS

- Significant workforce shortages, more services, more providers, more coordination across organizations and broader social supports are important behavioral health needs in the community today.

KEY FINDINGS FROM THE DATA PRESENTATION

- In adults and youth data alike, rates of mental health issues, substance use/misuse, and the need for treatment is undeniable. If left untreated, many of these issues can lead to higher rates of thoughts of suicide and reliance on substances.
- Suicide rates for the total population have increased slightly over past 25 years while youth suicides and attempts have likely grown over past 20 years. Depression in adults and youth alike

are rising, and the rate of prescribing depression medication is growing, at least among the Medicaid population.

- On a positive note, there has been a steep drop in alcohol and marijuana usage in 10th graders, and rates of binge drinking in adults have slightly decreased.
- Opioid prescribing has declined steeply over past few years, although the lethality of the drugs appears to have climbed.
- Community protective factors declined to 50% in Benton County in 2021, which is 10% lower than WA benchmark. These are conditions or attributes in communities that promote the health and well-being of children, ultimately leading to the development of healthy young adults in the community. These factors include access to economic and financial resources, safe and stable housing, safe childcare, along with medical care and mental health services. On the other hand, school and family protective factors have shown overall increases through 2010-2021 in Benton County and WA.

KEY FINDINGS FROM THE SURVEY OF MENTAL HEALTH PROVIDERS

- Issues with insurance companies significantly impair the ability of providers to care for their patients. For example, having access to other Medicaid insurance carriers like Amerigroup and Molina, along with greater accessibility to medications from insurance companies, were mentioned. Additionally, some providers had specific concerns that some mental health issues are not being recognized by insurance companies for treatment. When insurance companies are willing to work with providers, there are delays in reimbursements and complications with filing paperwork.
- Survey respondents expressed a strong desire for more coordination across organizations to help reduce significant wait times they are currently experiencing.

Click here for "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties."

Trends in the Continuum of Housing

The Institute for Public Policy & Economic Analysis completed "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

A survey of housing providers was conducted and two housing and homelessness forums were held in person in May of 2022. Forum participants included representatives from community service and non-profit organizations, health care, businesses, government agencies, community members. Relevant data was shared, and participant input sought to help identify current needs and gaps in the continuum of housing availability for residents with low incomes and experiencing homelessness.

KEY FINDINGS FROM THE HOUSING AND HOMELESSNESS FORUMS

According to the participants at the forums, the four greatest needs in helping to reduce challenges for residents with low incomes and experiencing homelessness to secure housing include:

(1) Removing barriers,
(2) Greater availability of housing options,
(3) Need for more coordination, and
(4) Need for stronger social supports.

KEY FINDINGS FROM THE REVIEW OF THE DATA

- A review of the housing data indicates that total housing units have not been meeting population demand, but there are efforts to build up units, specifically multi-family units.
- Increasing rental rates are a challenge for renters because the growth rate of household income is about one-third of the growth rate of rent.
- The greater Tri-Cities (Kennewick, Pasco, Richland, West Richland, and surrounding towns) has consistently been in a very tight market for rental housing, as the vacancy rate is below 2% for most years from 2016 to 2021.
- Persons experiencing homelessness and unstable housing are growing in Tri-Cities, whereas the WA number is decreasing. There are currently almost 4,000 people in the Homeless Management Information System (HMIS) system in the greater Tri-Cities. The length of days someone is homeless in the greater Tri-Cities has nearly doubled and the rate of those returning to homelessness is still increasing.

KEY FINDINGS FROM THE SURVEY OF HOUSING OPTIONS

- The most significant obstacles facing housing facilities that serve residents with low incomes and experiencing homelessness are lack of financial resources, drug use, and workforce challenges. Relations with neighbors and ability to attract potential clients are ranked lower.

Click here for "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

Community Forums

Two general forums were convened in July to share qualitative and quantitative data with community members and to ask them to identify additional community health needs that may be present in Benton and Franklin Counties. The first general forum was held in person on July 12, 2022, with 41 participants, and the second was held virtually on July 14, 2022, with 35 participants. They were asked to consider the following:

- What is going well?
- What are the most significant community health issues?

- What is most concerning to you?
- What do you think this community is ready, able, willing to work on?
- What else would you like to know?

Forum participants believe that there is a willingness to collaborate and find solutions as a community, that people care and are willing and invested in creating a better community. An increase in the number of Community Health Workers and the impact they are making was noted. Participants want to know the results of the current CHIP, how programs are funded, and who the champions are for each major challenge. The one-tenth of one percent local sales tax that went into effect in April of 2022 for chemical dependency or mental health purposes was noted as a positive development for future program funding. The need for increased awareness of community resources was noted especially for youth. There is an interest in improving transportation as it can be a barrier to accessing healthcare. Childcare costs and the nursing shortage were identified as priorities. Top priorities identified include behavioral health, access to care, workforce, and housing. Participants believe that the community is ready, willing, and able to work on mental health, substance use and abuse, access to healthcare, and housing and homelessness.

Challenges in Obtaining Community Input

The COVID-19 pandemic continues to present barriers and challenges to collecting community input. Rather than being held in person, partner interviews were held virtually presenting technological challenges for some participants and decreasing the opportunities for in person, interpersonal communication. Technology presented challenges in one listening session and participation was limited for the in person older adult listening session, likely due to the pandemic. While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

CHNA steering committee members reviewed the qualitative and quantitative data independently, in steering committee meetings, and by participating in the three community forums. Committee members met weekly in July and August 2022 to apply the prioritization criteria to the identified needs and reached consensus through discussion and debate. Prioritization criteria included worsening trend over time, disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities, community rates worse than state average, the opportunity to impact based on community partnerships, severity of the need and/or scale of need. The following Community Health Improvement Plan Guiding Concepts also informed the prioritization process: Equity, Life-course wellness, Health in All Policies (HiAP), Evidenced-based, and Collective Impact.

See Appendix 3: Community Health Improvement Plan Guiding Concepts

2022 Priority Needs

The list below summarizes the significant health needs identified through the 2022 Community Health Needs Assessment process in no particular order:

BEHAVIORAL HEALTH

The 2019 Benton & Franklin Counties Community Health Needs Assessment (CHNA) identified that our community needed to better understand the behavioral health gaps and needs within the community. The 2020 Benton & Franklin Counties Community Health Improvement Plan (CHIP) included an objective (BH 2.1.1) to complete a comprehensive behavioral health needs assessment. The assessment was completed in the spring of 2022 through a partnership with Eastern Washington University (EWU). The assessment identified significant needs for behavioral health response and prevention. In fact, in all areas of the CHNA, behavioral health was identified as a need. Behavioral health includes mental health and substance use/misuse. With the serious behavioral health workforce shortage, increase in need, and existing coalitions working towards solutions, our steering committee identified behavioral health as a priority area.

HOUSING AND HOMELESSNESS

The 2019 CHNA identified that our community needed to better understand the housing and homelessness gaps and needs within the community. The 2020 Benton & Franklin Counties Community Health Improvement Plan (CHIP) included an objective (SDOH 2.1.1) to complete a comprehensive housing and homelessness needs assessment. The assessment was completed in the spring of 2022 through a partnership with EWU. On housing, the assessment identified a low supply of affordable housing, low supply of multi-family units, low vacancy rates for rentals, and increased rental costs. Housing increases in Benton and Franklin Counties are not keeping up with population growth and

demand. Regarding homelessness, the assessment identified a shortage of low-barrier housing options for residents experiencing homelessness. Additionally, there has been a greater than two-fold increase in the average number of days a person experiences homelessness in Benton and Franklin Counties. Stable housing has consistently been shown to improve both physical and mental health outcomes. For this reason and because the Benton and Franklin regions are experiencing rapid growth, a lack of affordable housing, a lack of low-barrier solutions to homelessness, and the complexity of solving these issues through effective community partnerships, our steering committee identified these issues as priorities for the upcoming CHIP.

ACCESS TO HEALTH

The 2019 CHNA identified a need for access to not only healthcare, but also access to community supports that enable health. It is understood that optimal health is influenced by access and quality of healthcare, health promoting behaviors, the physical environment, and socioeconomic factors. Access to Health will include a focus on addressing barriers to medical care, including healthcare provider to patient ratios and linguistically appropriate, culturally responsive, and accessible care. In addition, the steering committee broadened this priority to include needs identified in the CHNA, such as access to safe and nutritious food; transportation; safe, licensed, and affordable childcare; health education; chronic disease prevention; and resource awareness.

COMMUNITY PARTNERSHIP DEVELOPMENT

Benton and Franklin Counties are fortunate to have numerous community coalitions and committees aimed at improving and supporting community health. This region also has a business community which is quite supportive of promoting local health and social initiatives. However, the CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Benton-Franklin Health District, Trios Health, Lourdes Health, Prosser Memorial Health, Miramar Health Center, and Tri-Cities Community Health. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. As noted in the Community Partnership Development priority section above, the CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources and expanding the work of community health improvement to non-traditional partnerships to address the needs identified in this CHNA.

See table on page 101 in Appendix 2, "Organizations and Initiatives Addressing Community Needs in Benton and Franklin Counties."

EVALUATION OF 2020 BENTON & FRANKLIN COUNTIES CHIP IMPACT

Table 29. Outcomes from BFHD 2020 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Social Determinants of Health	Housing and Homelessness Community Health Needs Assessment	Complete a comprehensive housing and homelessness assessment.	BFHD contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a comprehensive housing and homelessness needs assessment. The assessment included analysis of data, a survey of housing providers, and two community forums attended by over 60 participants. The assessment meets a 2020 CHIP objective, and the results are incorporated in this 2022 CHNA.
Social Determinants of Health	Built for Zero (BFZ) Model	BFZ is an initiative that utilizes real-time, by-name data to secure housing resources and target them for the greatest possible reduction in homelessness.	Built for Zero presentation was made at the Housing Continuum of Care Task Force meeting in April of 2022 to introduce the model to community partners.
Social Determinants of Health	People have access to nutritious foods	Establish a Food Access Coalition.	BFHD and BFCHA formed an Access and Security Coalition (FASC) that started meeting in March of 2022.
Social Determinants of Health	Health and social determinants of health are considered and evaluated in community-level initiatives and agency-wide policies.	Apply for and attend the Washington Walkability/Movability Action Institute with interdisciplinary team.	BFHD partnered with BFCOG and Benton-Franklin Transit (BFT) to submit a proposal to attend the Washington Walkability/Movability Action Institute (WA WAI). The WA WAI is a multi-day, multi-disciplinary course focused on equitable policies, systems, and environmental interventions to enhance active transportation opportunities. The team from BFHD, BFCOG, and BFT were joined by representatives from the City of Pasco and Southeast Washington Aging & Long-Term Care (SEWALTC). The team will continue to meet, expand, and receive support from the faculty at the

			National Association of Chronic Disease Directors and the Centers for Disease Control and Prevention (CDC).
Access and Cost of All Healthcare	Health Equity and Access Team (HEAT)	HEAT serves to innovate on ways to increase the provider/population ratio and expand resources to the community.	HEAT has connected with TRIDEC, the Chamber of Commerce and Hispanic Chamber of Commerce, and Visit Tri-Cities on recruitment and retention of providers in primary care.
Access and Cost of All Healthcare	COVID-19 Response	Coordinated and comprehensive infectious disease management	BFHD, Kadlec, PMH, the Hispanic Chamber of Commerce, and many other community partners came together to expand COVID-19 testing and vaccination sites. In addition, BFHD provided community COVID-19 surveillance, served to educate the public about COVID-19 risks and precautions, provided recommendations to businesses, schools, and healthcare organizations, and worked with Washington State Department of Health for a state-wide, coordinated response.
Access and Cost of All Healthcare	Clinical expansion	Expansion of access through increased regional clinical capacity	To expand into rural communities, Columbia Basin Health Associates established primary care facilities in rural areas of north Franklin County. PMH hired multiple new providers in urgent/after-hours care, pediatrics, family practice, obstetrics and women's health, emergency medicine, and behavioral health. PMH also expanded clinic hours where appropriate. Kadlec Clinic hired numerous specialty providers, family medicine physicians, and primary care Nurse Practitioners (NP).
Access and Cost of All Healthcare	Data sharing	Coordinated sharing of community health data	Kadlec and PMH are engaged in data sharing with the coordinated use of MyChart, by Epic.
Access and Cost of All Healthcare	Resource connection	Community Resource Desk (CRD)	Kadlec established the CRD in October of 2020. It is a free service that connects people with community resources including establishing a primary care provider, dental care,

			medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and basic needs such as food, transportation, clothing, work, or housing aid. By connecting people with resources, a barrier to access is removed.
Behavioral Health Challenges	Tax policy	Sales tax revenue for behavioral health	In the spring of 2022, a sales tax in Benton and Franklin Counties went into effect, providing one penny per every $10 to go towards behavioral healthcare and access in the two counties. This is sustainable funding that will result in about $1.4 million annually to address the needs identified. Work is being done to establish the plan for prioritizing the spending towards the greatest need.
Behavioral Health Challenges	Washington Youth Safety and Wellbeing Taskforce	Advocacy, testimony, and representation	Another policy-level activity related to behavioral health support was BFCHA's involvement in advocating and testifying on the Washington Youth Safety and Wellbeing Taskforce, which recommended a statewide Tip Line. The Tip Line, which is expected to come online in the 2022-23 school year, will be a resource for anyone to call with a tip related to a risk of harm to self or others, including suicide, domestic violence, or other risks. BFCHA has printed and distributed more than 50,000 credit-card size Mental Health Resource handouts in English and Spanish. These are distributed through schools, health fairs, and other venues.
Behavioral Health Challenges	Positive Messaging	Messages to reinforce resilience and positive thinking	Key Connection, the Behavioral Health Committee of BFCHA, BFHD, Educational Service District (ESD) 123, Kadlec, and school districts partnered to develop positive messaging signs to support youth mental health and resilience. BFHD supported a Mental Health Mondays campaign and hosted Trauma Informed Training for school staff to increase awareness of behavioral health issues and provide tools for educators. Greater Columbia

			Accountable Community of Health (GCACH) established "Practice the Pause" campaign, which has run several times during the COVID-19 pandemic and is undergoing a refresh to branding and content for continued use. Partners who provide community education on behavioral health issues and/or suicide prevention include Catholic Charities, Lutheran Social, ESD123, the National Alliance on Mental Illness (NAMI), and Kadlec.
Behavioral Health Challenges	Means Restrictions	Firearm lock boxes and education	Kadlec partnered with Ranch & Home retailer to provide 500 free firearm lock boxes and safe storage education as a means of preventing suicide. The project was funded by Kadlec Foundation.
Behavioral Health Challenges	Behavioral Health Needs Assessment	Comprehensive community-wide assessment of behavioral health needs	BFHD contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a comprehensive behavioral health needs assessment. The assessment included analysis of data, a survey of behavioral health providers, and two community forums attended by over 35 participants. The assessment meets a 2020 CHIP objective and the results are incorporated in this 2022 CHNA.

EVALUATION OF 2020-2022 KADLEC REGIONAL MEDICAL CENTER CHIP IMPACT

This report evaluates the impact of the 2020-2022 Kadlec Community Health Improvement Plan (CHIP). Kadlec responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 30. Outcomes from Kadlec 2020-2022 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Behavioral Health Challenges	Integrated Behavioral Health	Behavioral health integrated in primary care clinics	Three social workers are embedded in three Kadlec Clinics.
Behavioral Health Challenges	Mental Health First Aid	Community education programs	Between January 2020 and September 2022, 669 people were trained in Mental Health First Aid and other mental health and suicide prevention programs.
Behavioral Health Challenges	Positive Messaging Campaign	Messages to reinforce resilience and positive thinking	Kadlec, Key Connection, the Behavioral Health Committee of BFCHA, BFHD, ESD 123, and school districts partnered to develop positive messaging signs to support youth mental health and resilience. Kadlec housed, coordinated, and distributed signs throughout the community.
Behavioral Health Challenges	Means Restrictions	Firearm lock boxes and education	Kadlec partnered with Ranch & Home retailer to provide 500 free firearm lock boxes and safe storage education as a means of preventing suicide. The project was funded by Kadlec Foundation.
Access and Cost of Health Care	Telemedicine Services	Expand telemedicine services	Expanded telemedicine services completed 48,291 telemedicine visits in 2020 and 37,260 telemedicine visits in 2021.
Access and Cost of Health Care	Family Medicine Residency program		Kadlec's Family Medicine Residency program residents graduated in 2022 with four of the eight staying within Kadlec.
Access and Cost of Health Care	Healthy Ages	Provide Medicare education and consultations	Between January 2020 and August 2022, 1079 people participated in Medicare education programs and/or consultations.

Access and Cost of Health Care	Community Outreach	Community Health Workers (CHW)	As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking CHWs joined the Population Health team in 2021.
Access and Cost of Health Care	Medication Assistance Program (MAP)	Medication assistance to Kadlec patients who qualify	MAP started in March of 2020. In 2021, 161 patients were served.
Access and Cost of Health Care	Community Resource Desk (CRD)	Awareness of, and access to, community resources	Kadlec established the CRD in October of 2020. It is a free service that connects people with community resources including establishing a primary care provider, dental care, medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and transportation.
Social Determinants of Health (SDOH)	Community Resource Desk (CRD)	Awareness of, and access to, community resources	The CRD connects people with community resources to meet basic needs such as food, transportation, clothing, work, or housing aid.
Social Determinants of Health	Community Outreach	Community Health Workers	As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking CHWs joined the Population Health team in 2021.
Social Determinants of Health	Built for Zero (BFZ) Model	BFZ is an initiative that utilizes real-time, by-name data to secure housing resources and target them for the greatest possible reduction in homelessness.	BFZ presentation was made at the Housing Continuum of Care Task Force meeting in April of 2022 to introduce the model to community partners.

Addressing Identified Needs

The Community Health Improvement Plan developed for Benton and Franklin Counties will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing plans to address the health needs. If the need will not be addressed or have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions that will be taken, but also the anticipated impact of these actions and the resources needed to address the need.

Because partnership is important when addressing health needs, the Benton and Franklin Counties CHIP will describe any planned collaborations between BFHD, BFCHA, Kadlec and community-based organizations in addressing the health need.

In addition to the Benton and Franklin Counties CHIP that will be developed, Kadlec will develop a Kadlec CHIP that will be approved and made publicly available no later than May 15, 2023.

2022 CHNA GOVERNANCE APPROVAL

Kadlec Regional Medical Center

Reza Kaleel — Date
Chief Executive, Providence Southeast Washington

Ted Samsell, MD — Date
Community Board Chair

Orest Holubec — Date
Executive Vice President, Chief Communication and
Community Engagement Officer, Providence

Benton-Franklin Health District

Jason Zacarria — Date
District Administrator

Benton-Franklin Community Health Alliance

Kirk Williamson — Date
Program Manager

Prosser Memorial Health

Craig J. Marks — Date
Chief Executive Officer

To request a printed paper copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email info@BFCHA.org.

APPENDICES

Appendix 1: Quantitative Data

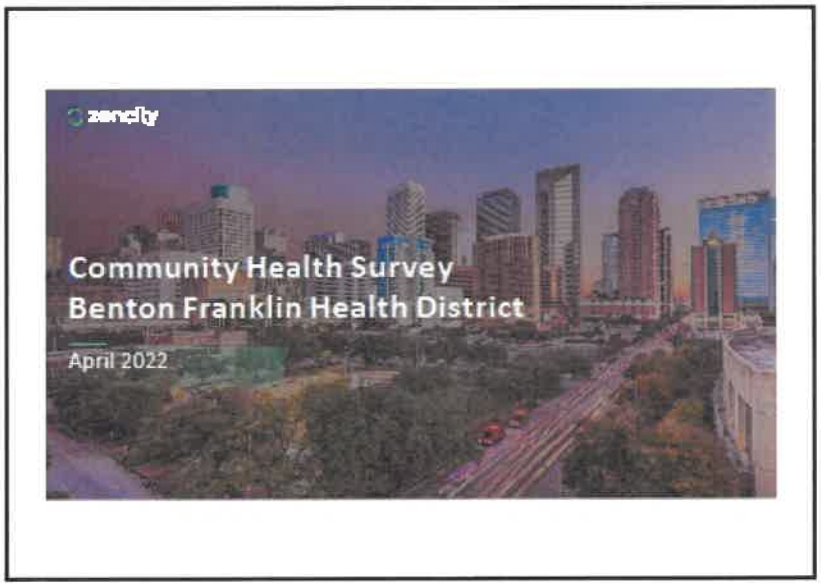
Appendix 2: Community Input

Appendix 3: Community Health Improvement Plan Guiding Concepts

Appendix 4: Community Health Needs Assessment Steering Committee

Appendix 1: Quantitative Data

PRIMARY DATA COLLECTION SURVEY RESULTS



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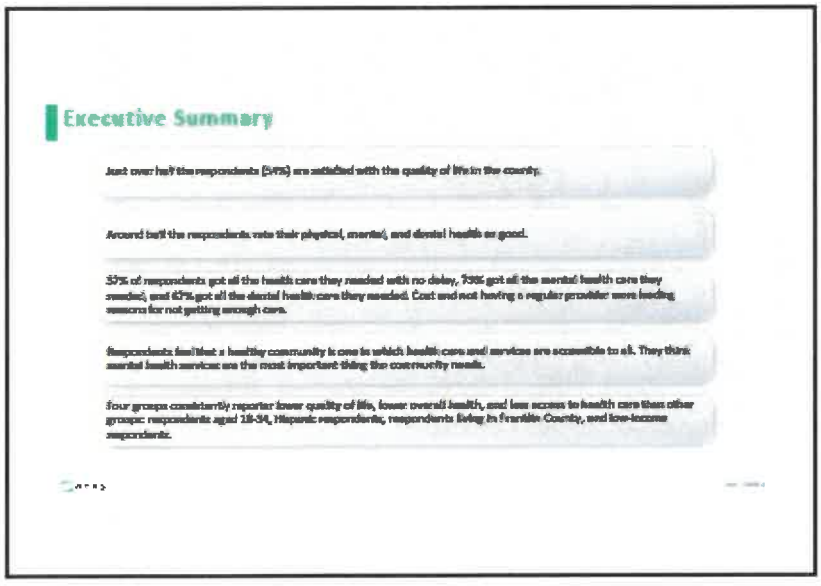

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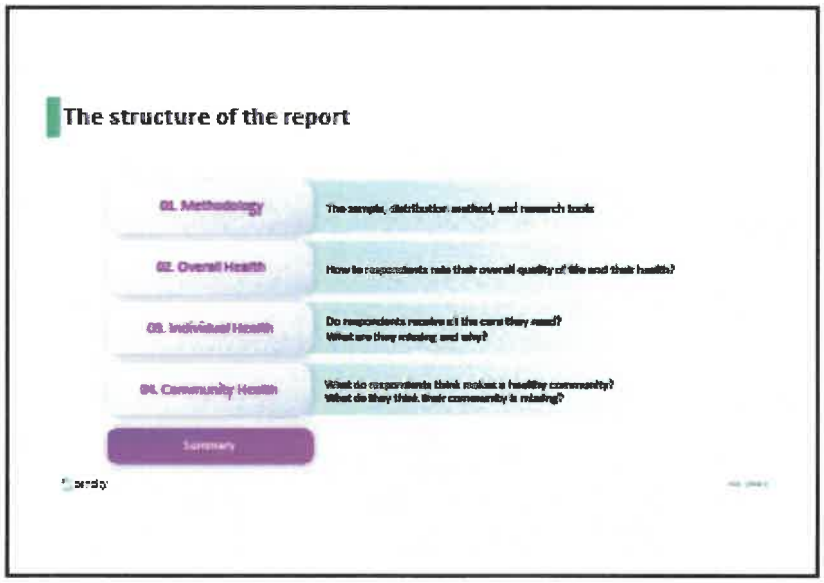
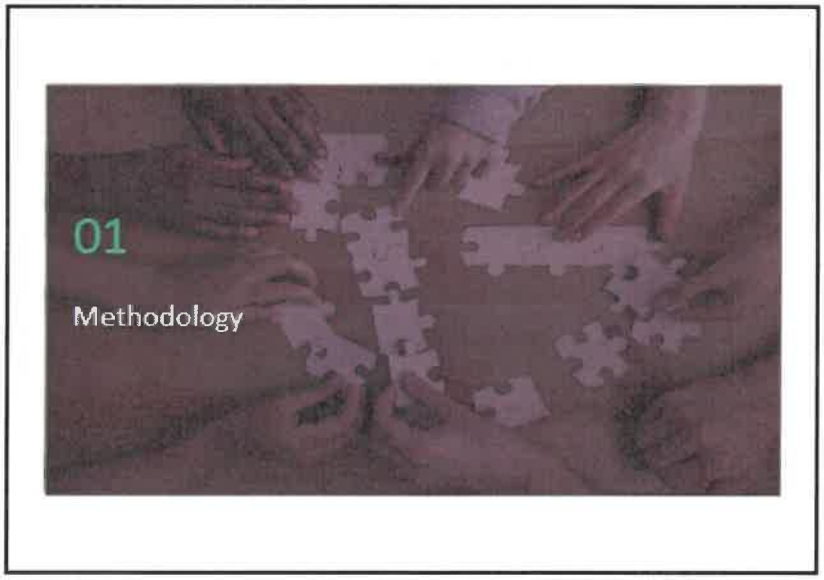

The structure of the report
01. Methodology
The sample, distribution method, and research tools
02. Overall Health
How to respondents rate their overall quality of life and their health?
03. Individual Health
Do respondents receive all the care they need?
What are they missing and why?
04. Community Health
What do respondents think makes a healthy community?
What do they think their community is missing?
Summary

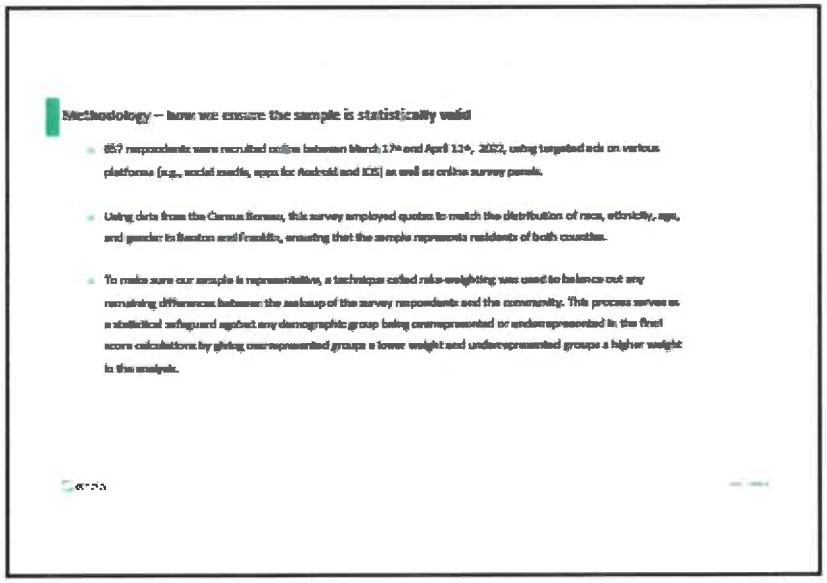
3


01
Methodology

4


Methodology
657 sample survey of Benton and Franklin adults, 18+
Respondents recruited via Internet
Fielded March 17th–April 11th, 2022
Survey was conducted in English and Spanish
Data was weighted to represent the population in Benton and Franklin Counties

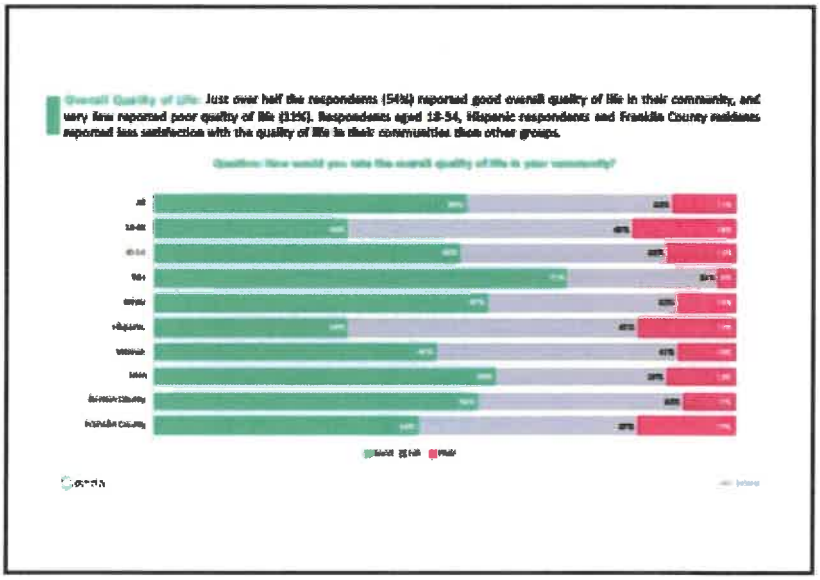
5


Methodology – how we ensure the sample is statistically valid
657 respondents were recruited online between March 17th and April 11th, 2022, using targeted ads on various platforms (e.g., social media, apps for Android and iOS) as well as online survey panels.
Using data from the Census Bureau, this survey employed quotas to match the distribution of race, ethnicity, age, and gender in Benton and Franklin, ensuring that the sample represents residents of both counties.
To make sure our sample is representative, a technique called rake-weighting was used to balance out any remaining differences between the makeup of the survey respondents and the community. This process serves as a statistical safeguard against any demographic group being overrepresented or underrepresented in the final score calculations by giving overrepresented groups a lower weight and underrepresented groups a higher weight in the analysis.

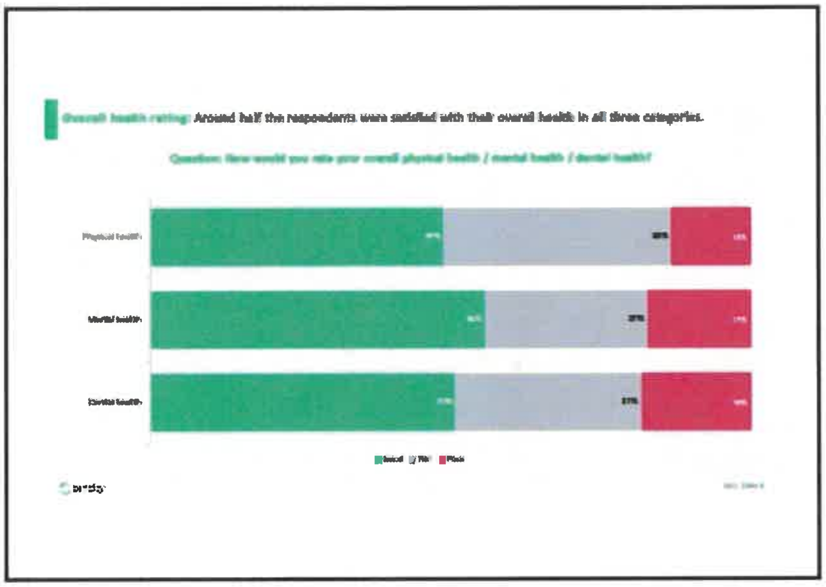
6


02
Overall Health

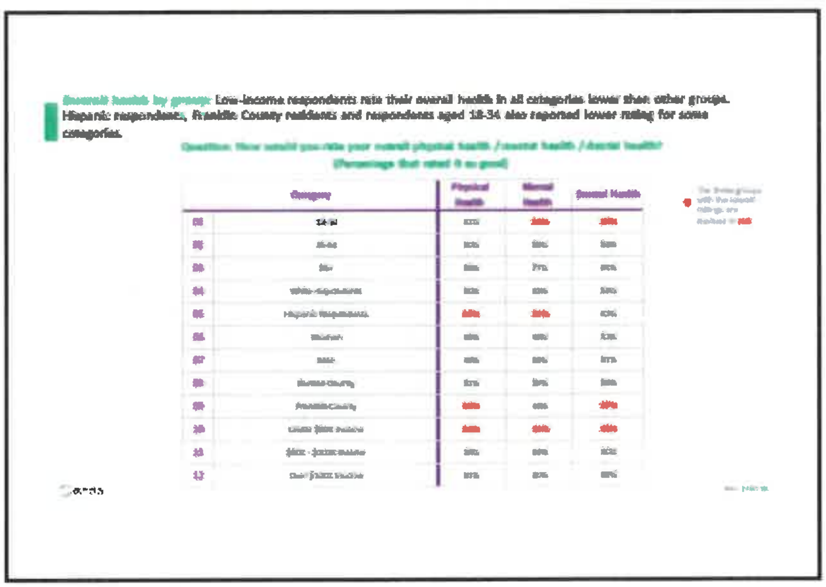
7


Overall Quality of Life: Just over half the respondents (54%) reported good overall quality of life in their community, and very few reported poor quality of life (11%). Respondents aged 18-34, Hispanic respondents and Franklin County residents reported less satisfaction with the quality of life in their communities than other groups.

8


Overall health rating: Around half the respondents were satisfied with their overall health in all three categories.
Question: How would you rate your overall physical health / mental health / dental health?
Physical health
Mental health
Dental health

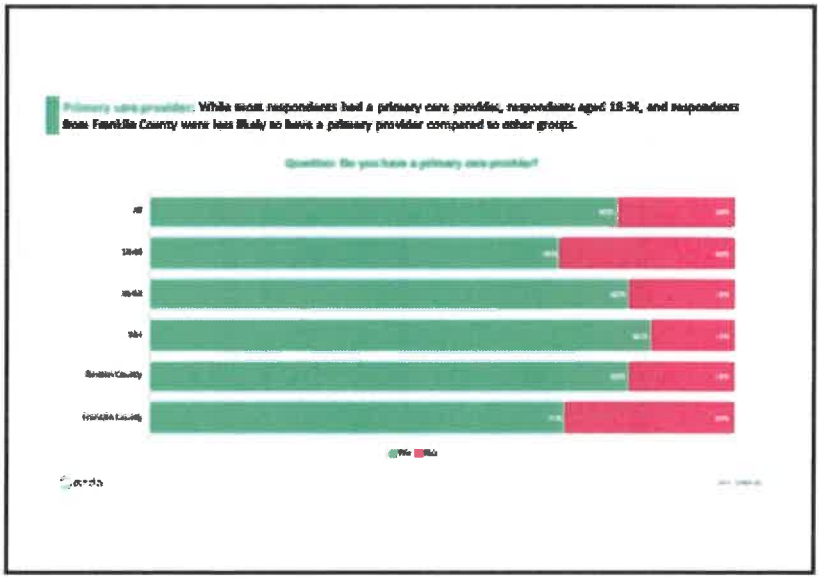
9


Overall health by groups: Low-income respondents rate their overall health in all categories lower than other groups. Hispanic respondents, Franklin County residents and respondents aged 18-34 also reported lower rating for some categories.
Category
Physical Health
Mental Health
Dental Health

10

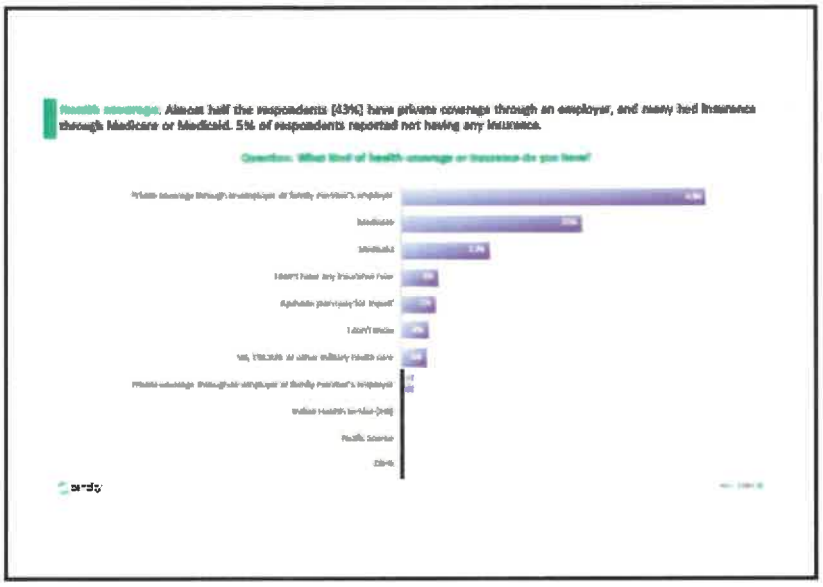

03
Individual Health

11


Primary care provider: While most respondents had a primary care provider, respondents aged 18-34, and respondents from Franklin County were less likely to have a primary provider compared to other groups.
Question: Do you have a primary care provider?

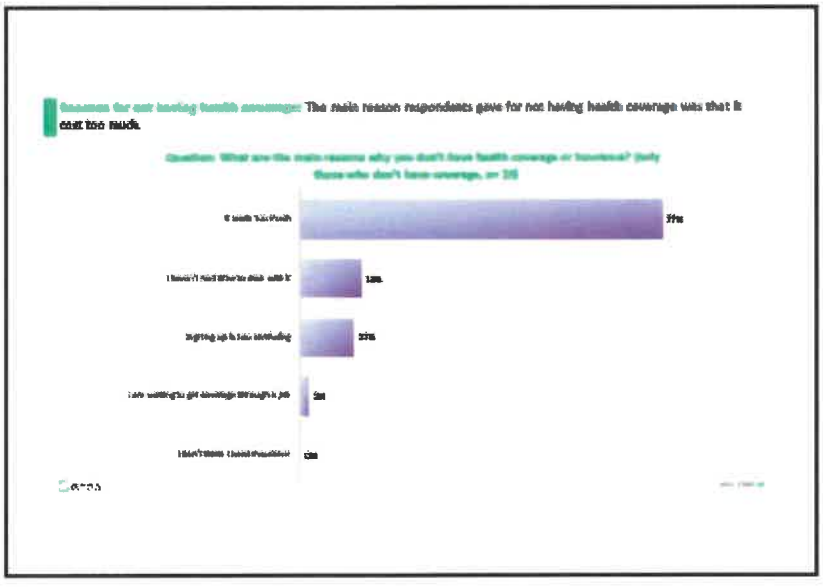
12

Health coverage. Almost half the respondents (43%) have private coverage through an employer, and many had insurance through Medicare or Medicaid. 5% of respondents reported not having any insurance.



13

Reasons for not having health coverage: The main reason respondents gave for not having health coverage was that it cost too much.



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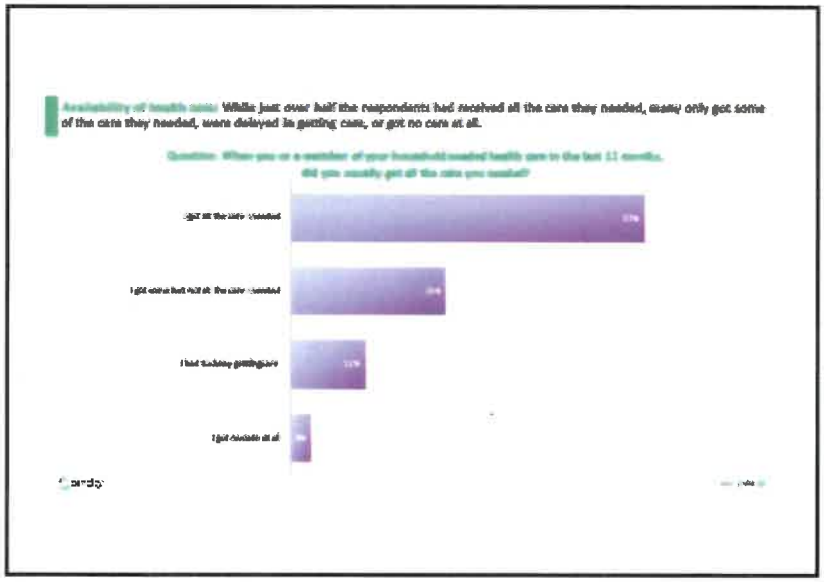
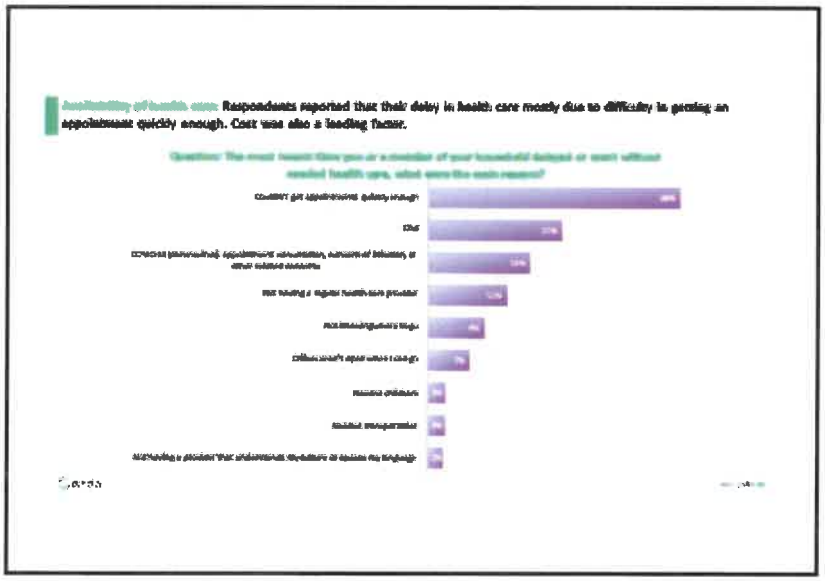
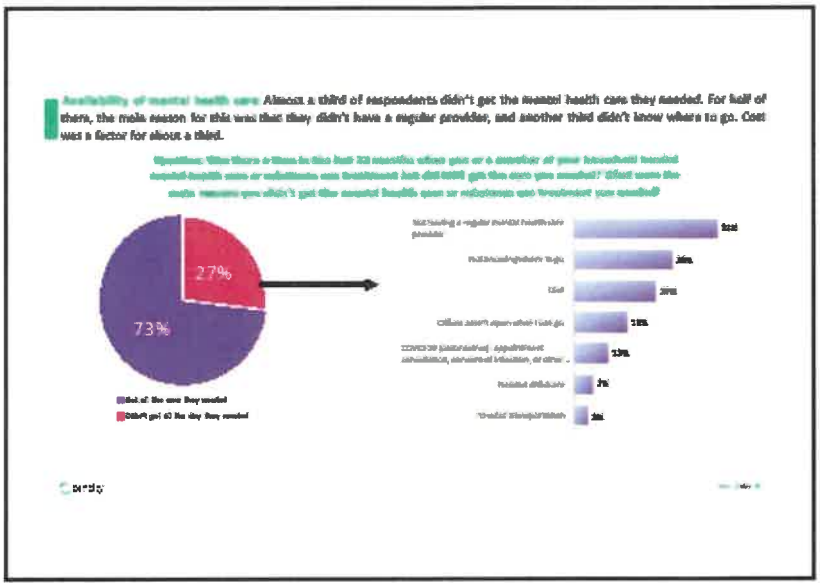

Availability of health care: While just over half the respondents had received all the care they needed, many only got some of the care they needed, were delayed in getting care, or got no care at all.

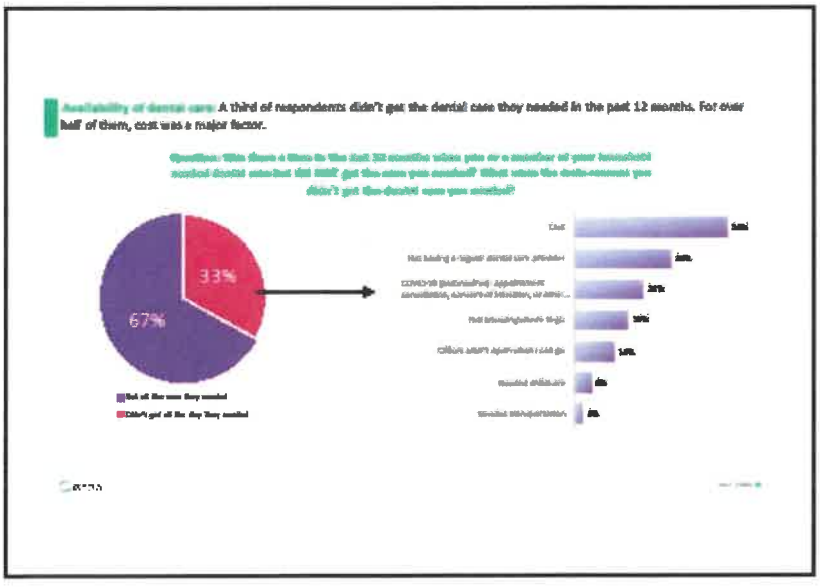
15


Availability of health care: Respondents reported that their delay in health care mostly due to difficulty in getting an appointment quickly enough. Cost was also a leading factor.

16

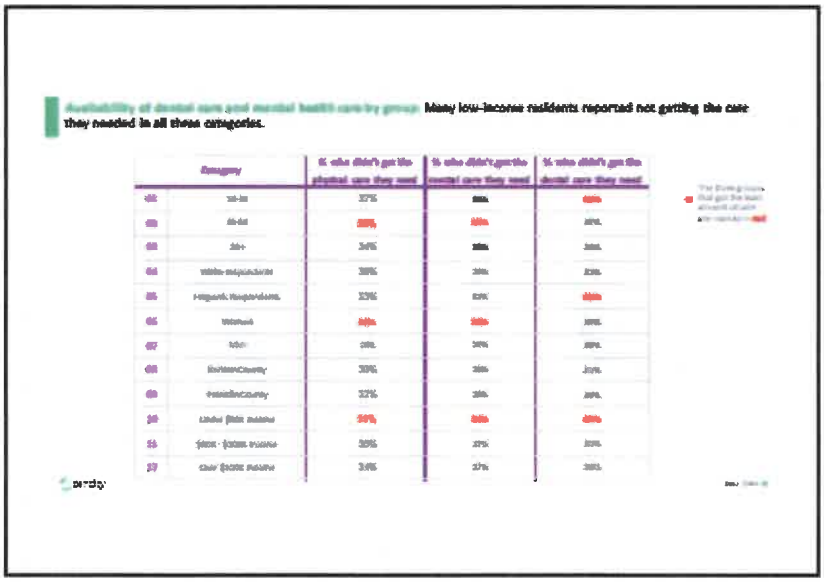

Availability of mental health care: Almost a third of respondents didn't get the mental health care they needed. For half of them, the main reason for this was that they didn't have a regular provider, and another third didn't know where to go. Cost was a factor for about a third.
27%
73%

17


Availability of dental care: A third of respondents didn't get the dental care they needed in the past 12 months. For over half of them, cost was a major factor.
33%
67%

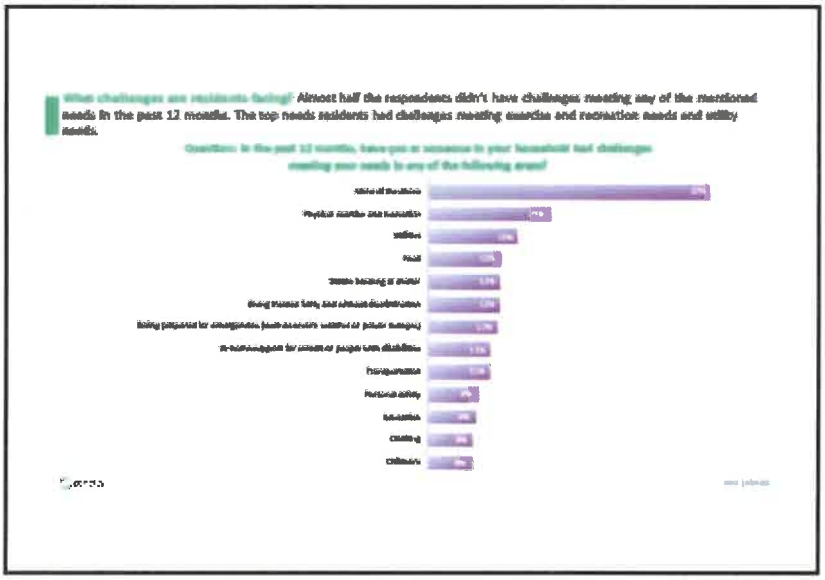
18

Availability of dental care and mental health care by group: Many low-income residents reported not getting the care they needed in all these categories.



19

What challenges are residents facing? Almost half the respondents didn't have challenges meeting any of the mentioned needs in the past 12 months. The top needs residents had challenges meeting: exercise and recreation needs and utility needs.



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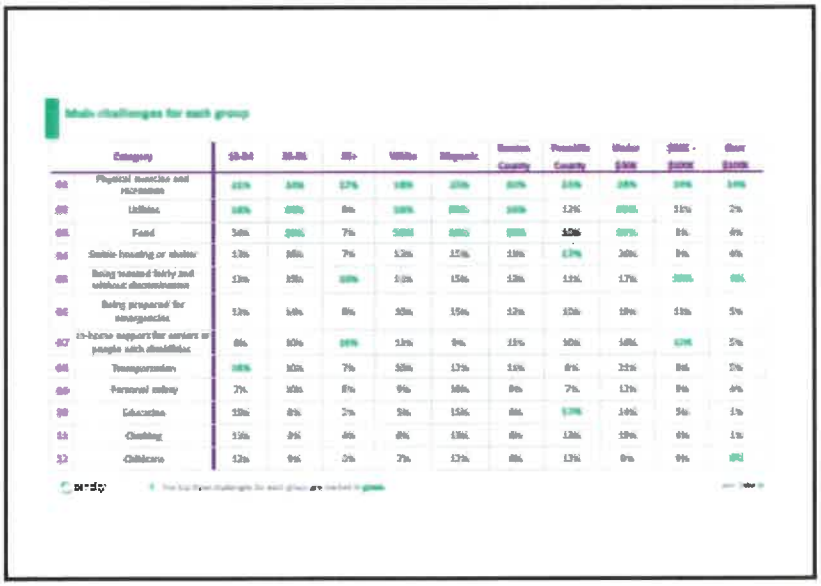

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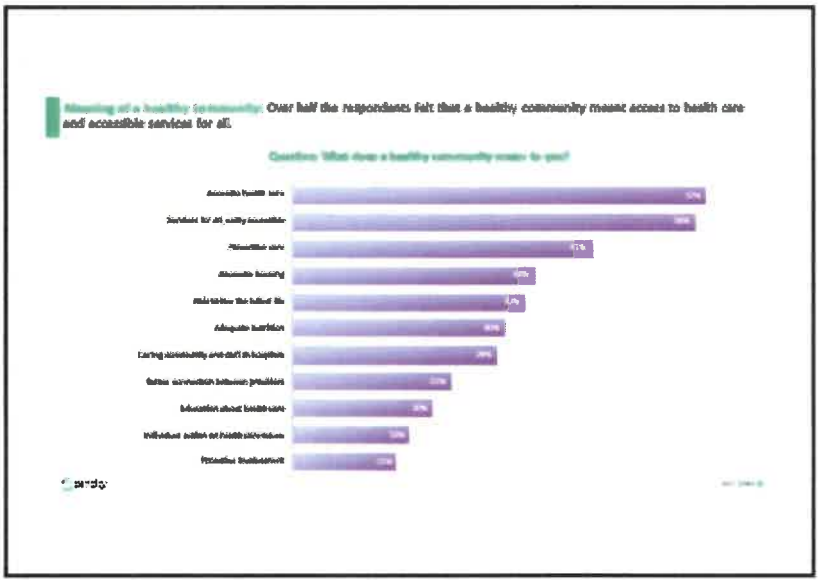
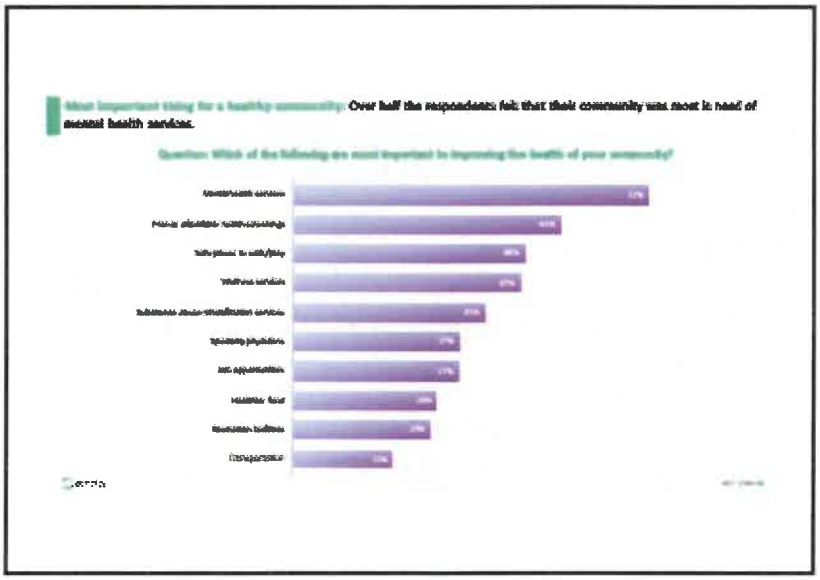
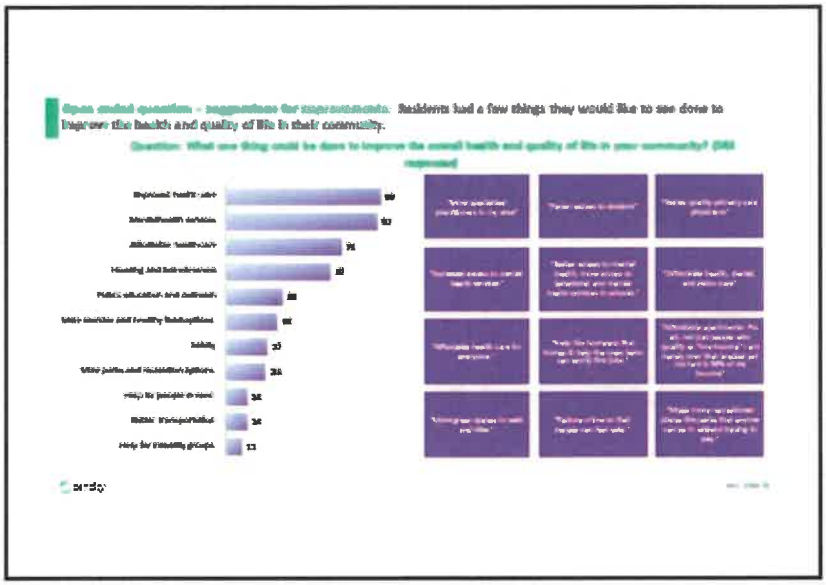

Meaning of a healthy community: Over half the respondents felt that a healthy community means access to health care and accessible services for all.
Question: What does a healthy community mean to you?

23


Most important thing for a healthy community: Over half the respondents felt that their community was most in need of mental health services.
Question: Which of the following are most important to improving the health of your community?

24

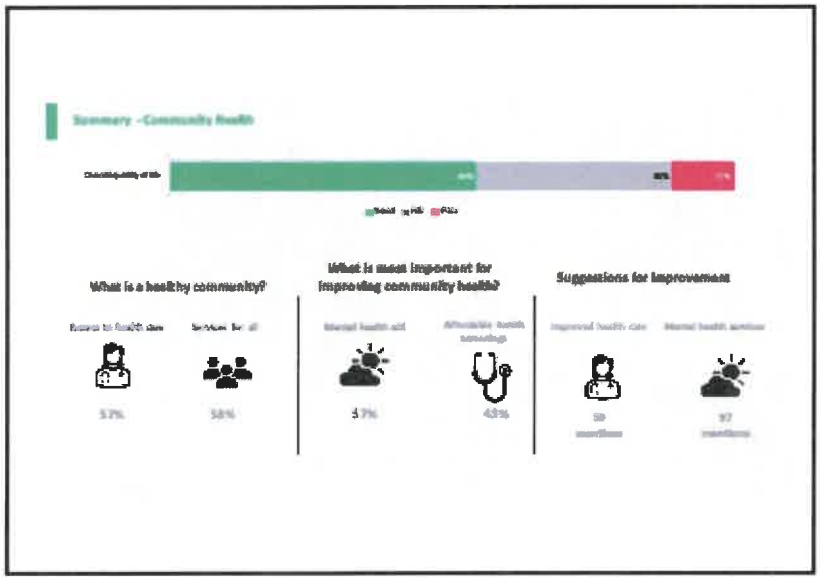


25

26


Summary - Individual Health
Physical health
Mental health
Dental health
Physical health
28%
Difficulty getting appointments
38%
Cost
21%
Mental health
27%
Not having a regular provider
31%
Not knowing where to go
35%
Dental health
33%
Cost
54%
Not having a regular provider
34%

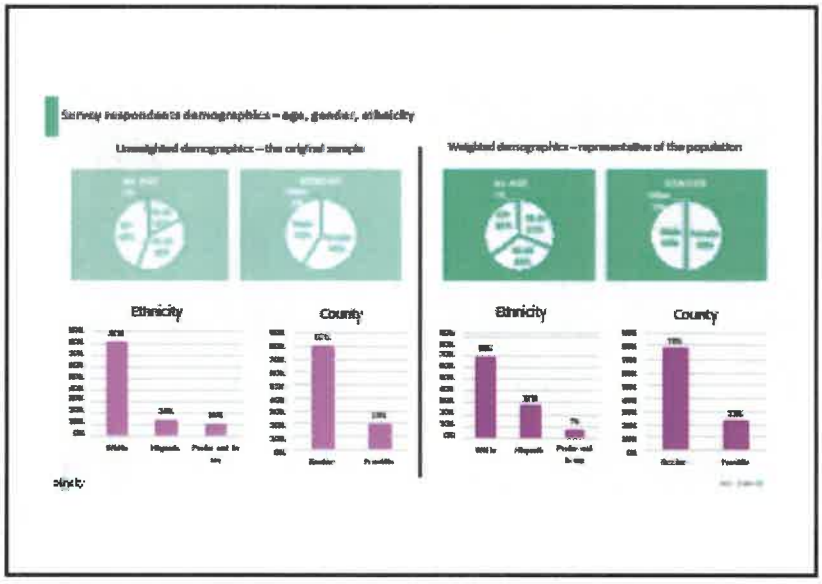
27


Summary -Community Health
What is a healthy community?
What is most important for improving community health?
Suggestions for Improvement
57%
58%
47%
43%

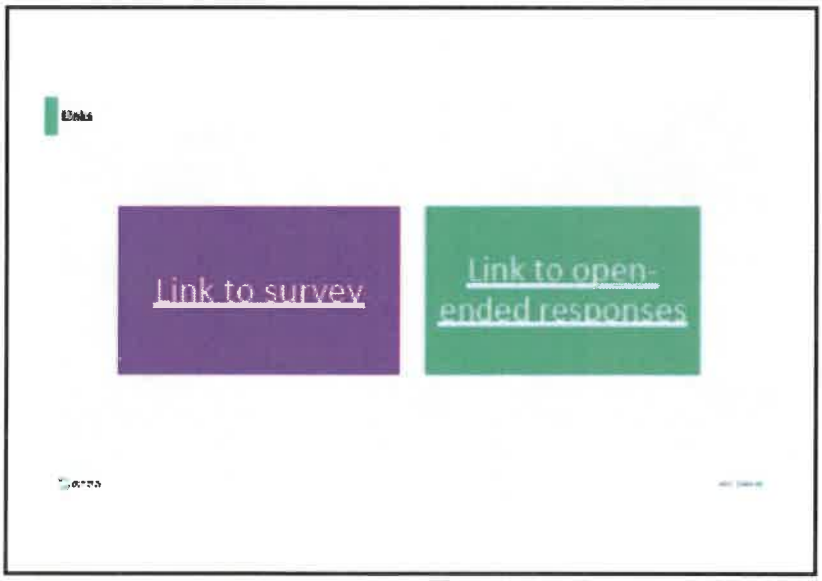
28

29

30


Survey respondents demographics – age, gender, ethnicity
Unweighted demographics – the original sample
Weighted demographics – representative of the population
Ethnicity
County
Ethnicity
County

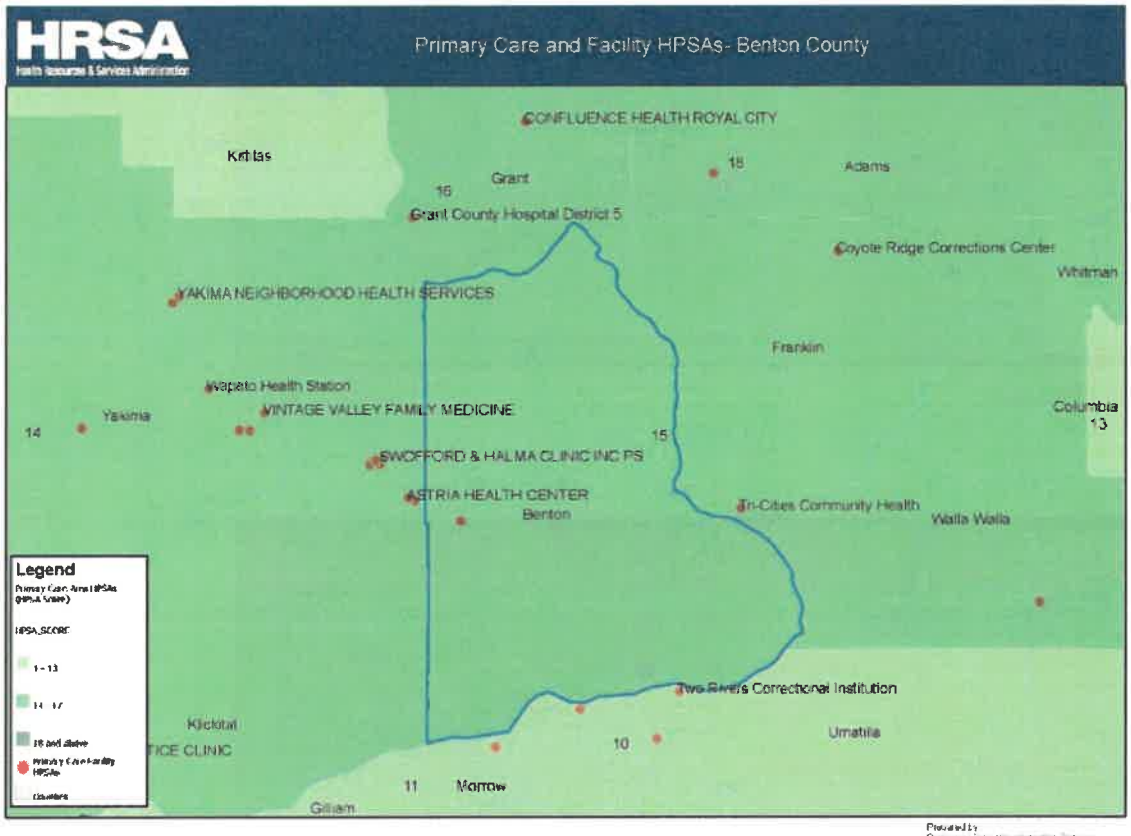
31

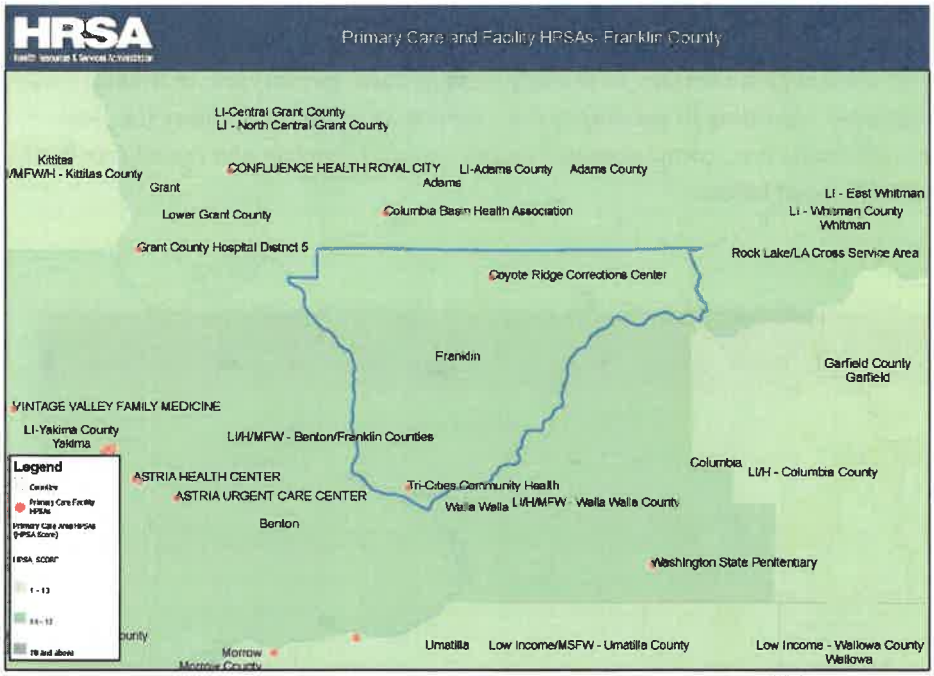

Links
Link to survey
Link to open-ended responses

32

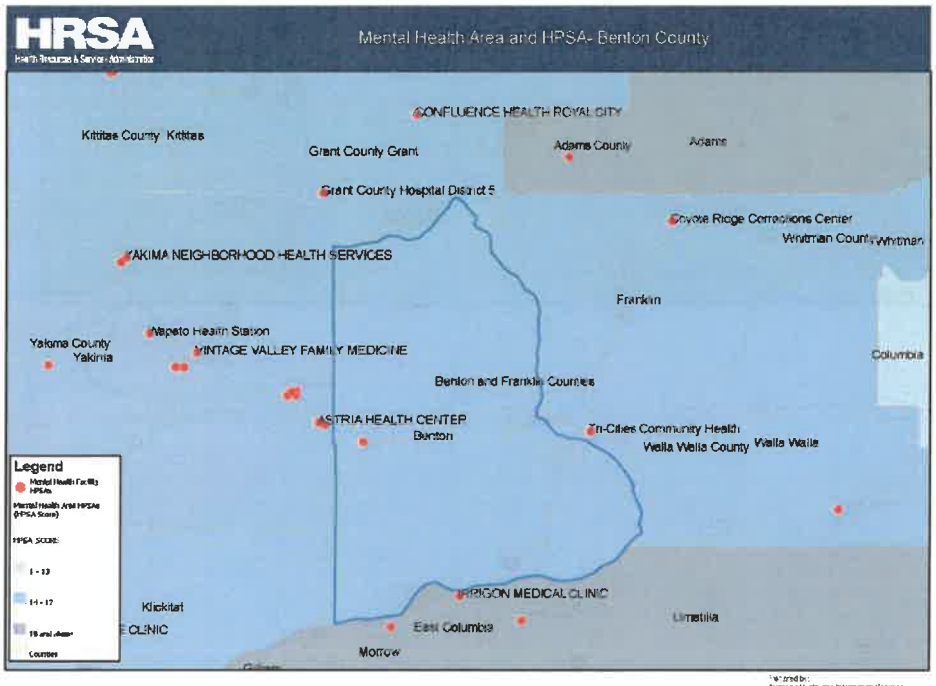
HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Benton and Franklin Counties are HPSAs as depicted on the maps below.





data.HRSA.gov



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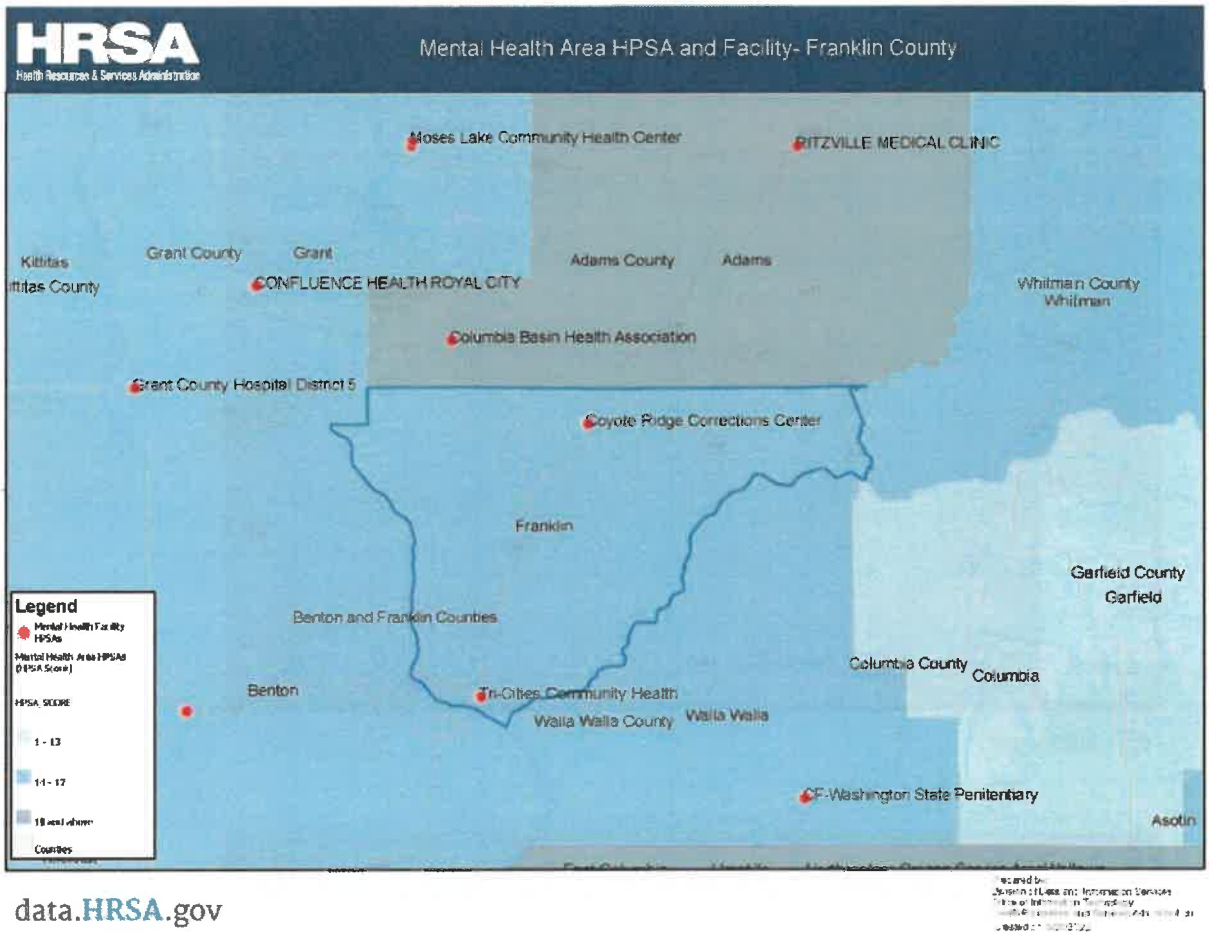

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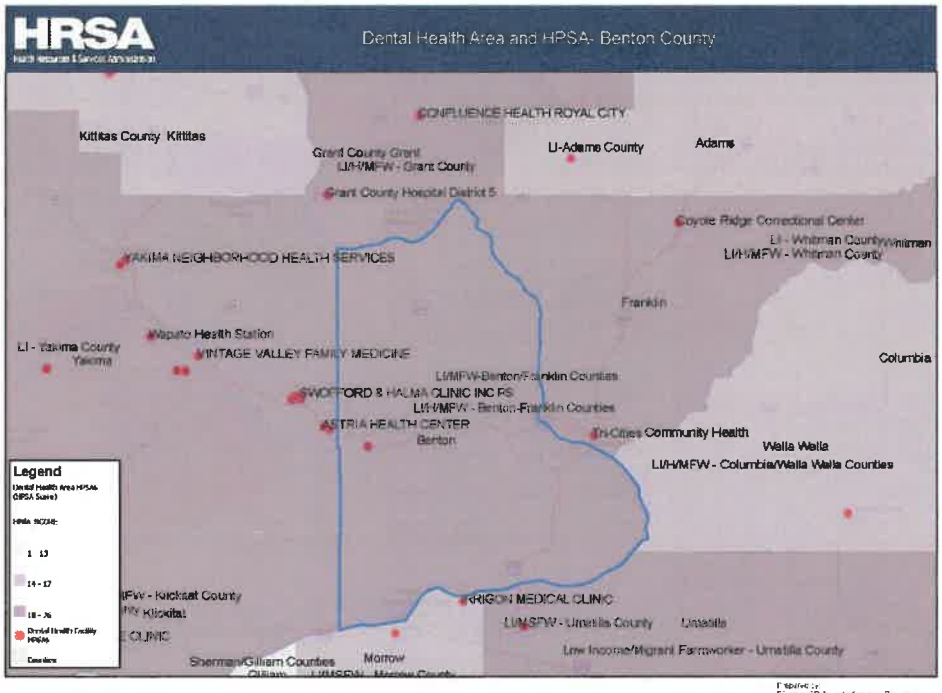

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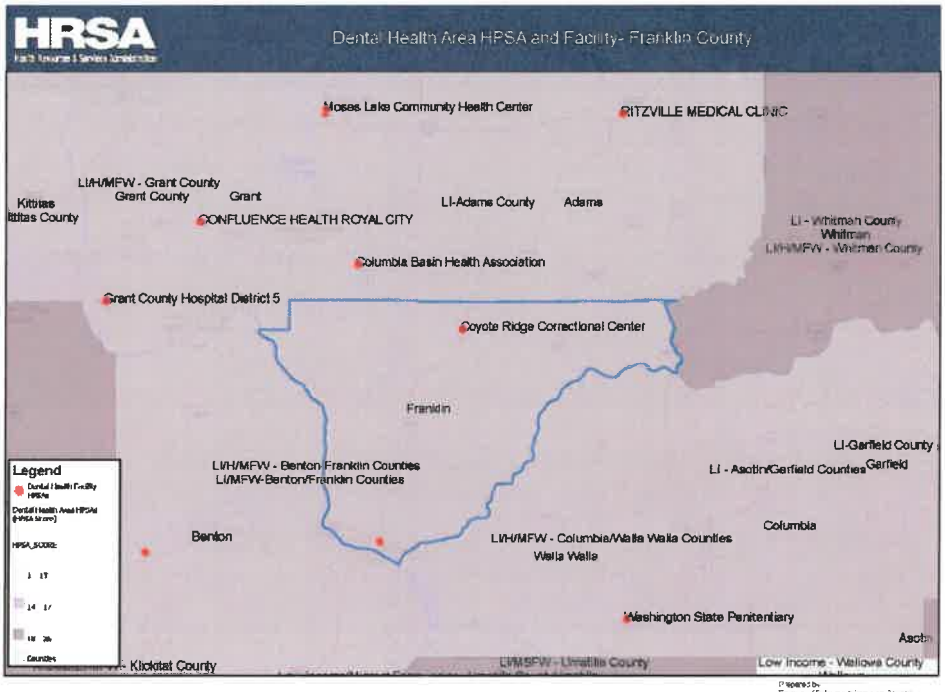
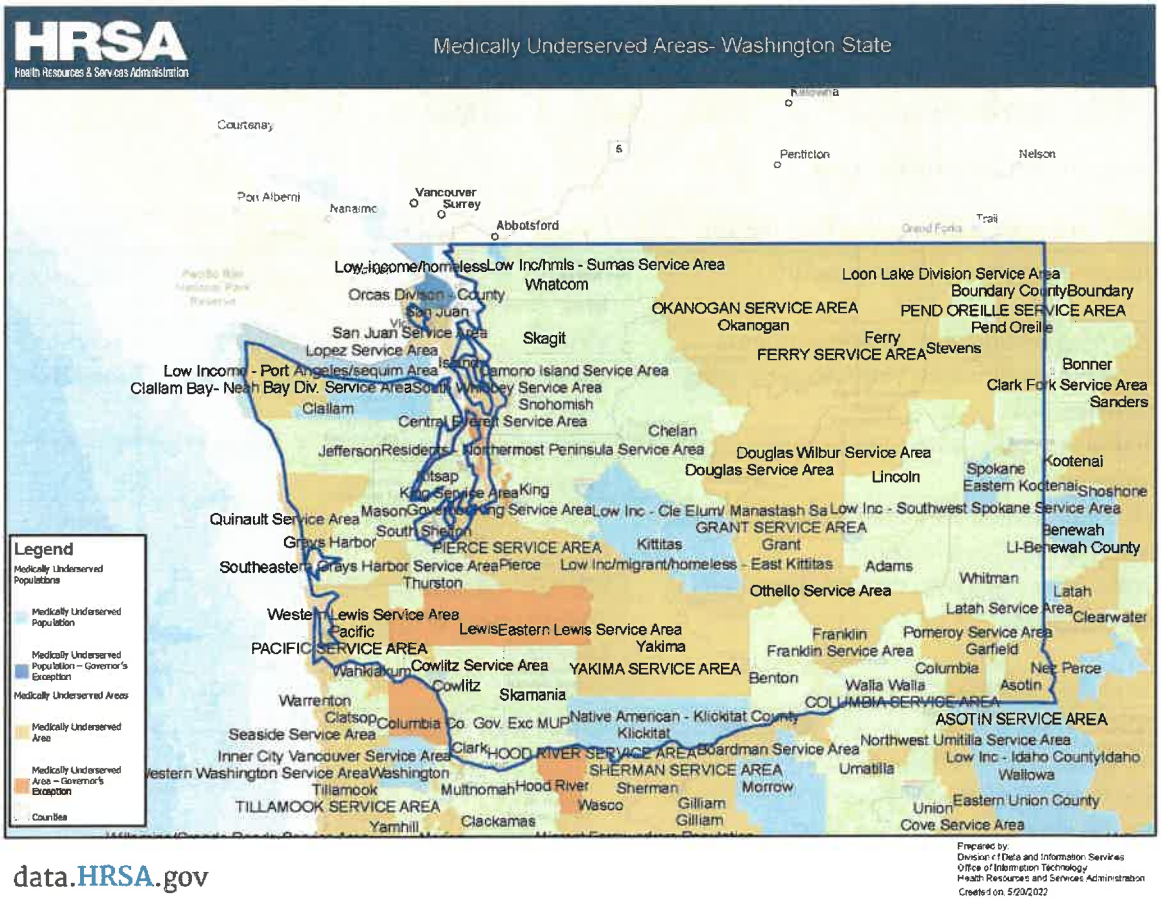


data.HRSA.gov

MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. The following map depicts Franklin County as a MUA. Benton County and Franklin County are not identified as having MUPs.



Appendix 2: Community Input

INTRODUCTION

Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The Benton-Franklin CHNA Collaborative conducted 21 interviews with working partners and community collaborators (partners), including 33 participants. Partners are defined as people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. They also conducted 10 listening sessions with 67 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

The Benton-Franklin CHNA Collaborative completed 10 listening sessions that included a total of 67 participants. The sessions took place between March 30 and May 26, 2022.

Table_Apx 1: Community Input

Community Input Type and Population	Location of Session	Date	Language
Listening session with older adults	Senior Life Resources/ Meal on Wheels	5/11/2022	English
Listening session with college students	Virtual	5/4/2022	English
Listening session with youth experiencing homelessness	Virtual with My Friends' Place	4/6/2022	English
Listening session with men experiencing homelessness	Tri-City Union Gospel Mission	3/30/2022	English
Listening session with Spanish-speaking men experiencing homelessness	Tri-City Union Gospel Mission	3/30/2022	Spanish
Listening session with women experiencing homelessness	Women's Shelter of the Tri-City Union Gospel Mission	3/30/2022	English
Listening session with veterans	Virtual	5/5/2022	English
Listening session with people whose family members are or were living with mental illness and SUD as well as people living with mental illness	Virtual with NAMI	5/26/2022	English
Listening session with parents of students in the Migrant Program	Kennewick School District Admin Building	5/12/2022	Spanish
Listening session with parents of children and adults with developmental disabilities	The Arc of Tri-Cities	5/19/2022	English

The collaborative conducted 21 partner interviews including 33 participants overall between March and April 2022. Partners were selected based on their knowledge of the community and engagement in work that directly serves people experiencing health disparities and social inequities. The Benton-Franklin CHNA Collaborative aimed to engage partners from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives.

Table_Apx 2. Key Community Partner Participants

#	Organization	Name	Title	Sector
1	Arc of Tri-Cities	Donna Tracy	Program Manager	Intellectual and developmental disabilities
	Arc of Tri-Cities	Melissa Brooks, RN	Parent to Parent Coordinator	
2	Benton County Department of Human Services	Kyle Sullivan	Manager	Developmental disabilities, community resources, emergency services, housing, veteran's resources
3	Boys and Girls Clubs of Benton and Franklin Counties	Brian Ace	Executive Director	Education, preschool, childcare
4	Columbia Basin College	Dr. Rebekah Woods, JD, PhD	President	Education, college, health care workforce development
	Columbia Basin College	Douglas Hughes, MAE-CI, CSFA, CST, CRCST	Dean: School of Health Sciences	
5	Community Health Plan of Washington City of Pasco	Blanche Barajas	Outreach Specialist Mayor	Health insurance City government
	Pasco Fire Department/ EMS	Ben Shearer	Community Risk Reduction Specialist	Emergency services
6	Family Learning Center	Teresa Roosendaal	Executive Director	Education, ESL, refugee services
7	Greater Columbia Behavioral Health Youth Suicide Prevention Coalition	Cameron Fordmeir	Regional Administrator for the Substance Use Disorder Recovery Navigator Program Chair	Mental health, substance use/misuse
8	HPMC Occupational Medical Services	Karen Phillips, MD	Site Occupational Medical Director	Occupational medicine, environmental safety, Hanford workers
	HPMC Occupational Medical Services	Audrey Wright	Health Education Specialist	

9	Kennewick Police Department	Chris Guerrero	Kennewick Police Chief	Law enforcement, emergency services
10	Kennewick School District	Brian Leavitt	K-12 Student Services Director	Education
	Kennewick School District	Alyssa St. Hilaire	Director of Federal Programs	
	Kennewick School District	Traci Pierce	Superintendent	
	Kennewick School District	Robyn Chastain	Executive Director, Communications and Public Relations	
11	Kiona-Benton City School District	Pete Peterson	Superintendent	Education
12	Lourdes Health	Joan White-Wagoner	CEO	Health care
	Trios Health	John Solheim	CEO	
13	North Franklin School District	Jim Jacobs	Superintendent	Education
14	Prosser Memorial Health	Craig Marks	CEO	Health care
	Prosser Memorial Health	Kristi Mellema	Chief Safety Officer	
15	Senior Life Resources Northwest	Grant Baynes	Executive Director	Senior supportive care services, older adults
16	Tri-Cities Hispanic Chamber of Commerce Heritage University	Martin Valadez	Executive Director Regional Director Tri-Cities Campus	Commerce, Latino/a community Education, university
17	Tri-City Development Council (TRIDEC)	Karl Dye	CEO	Economic development, business, tourism
	Visit Tri-Cities	Michael Novakovich	CEO	
18	Tri-City Union Gospel Mission	Susan Campbell, RN	Tri-City Union Gospel Mission Volunteer	Homelessness
19	Two Rivers Health District, Kennewick Public Hospital District	Gary Long	President	Health care
	Two Rivers Health District, Kennewick Public Hospital District	Wanda Briggs	Commissioner	
20	United Way of Benton and Franklin Counties	Dr. LoAnn Ayers	President and CEO	Community resources, food security, education
	United Way of Benton and Franklin Counties	Paul Klein	Director of Community Impact	
21	Yakima Valley Farm Workers Clinics (locally known as Miramar)	Micheal Young	Vice President of Operations East	Community health center, health care

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions (see Listening Session Questions for the full list of questions):

- Community members' definitions of health and well-being
- The community needs
- The community strengths

For the partner interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2022 CHNAs (see Partner Interview Questions for the full list of questions):

- The community served by the partner's organization
- The community strengths
- Prioritization of unmet health related needs in the community, including social determinants of health
- The COVID-19 pandemic's effects on community needs
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations

Training

The facilitation guides provided instructions on how to conduct a partner interview and listening session, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a partner interview and listening session and were provided question guides.

Data Collection

Partner interviews were conducted virtually and recorded with the participant's permission. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The partner names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of partner, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4)

unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "food insecurity" can occur often with the code "obesity." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions, although rather than recordings, notes were used. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision of a Health Community

Listening session participants were asked to share their vision of a health community. The following themes emerged:

- **Community engagement and connection:** In a healthy community there is a sense of engagement and willingness to work together to help one another. People are working together towards common goals, having meaningful conversations, and volunteering. They work to build community and put in the effort to care for one another, including keeping one another safe from COVID-19.
- **Easy access to health care, including mental health services, for everyone**: Community members shared that in a healthy community everyone has access to health care services, including mental health care. No one is turned away and people are treated with compassion. They shared people should be able to get the care they need in a timely manner and care should be patient centered.
- **Safety**: Many community members spoke to the importance of feeling safe in their community. Part of feeling safe is addressing crime and substance use on the streets. Some members also thought having a good police presence indicates a healthy community.
- **Diversity, inclusion, and respect**: Community members spoke to the importance of all people being accepted and having a united community. They shared that a healthy community is diverse and welcoming of people. Specifically people with disabilities are able to engage meaningfully and safely in the community.

- **Opportunities for recreation and a healthy lifestyle**: Community members shared people should have opportunities for recreation and a physically, spiritually, and emotionally healthy lifestyle. They can exercise and eat healthy food, as well as care for their spirituality. Their physical environment, including the water and air, also promotes health.
- **Economic security, including affordable housing and employment:** In a healthy community everyone has access to affordable housing, employment opportunities, and education.

Community Needs

High priority community needs identified from listening sessions

- **Mental health:** Mental health was the most frequently discussed need by community members. Their primary concern was how challenging it can be to find a mental health provider accepting new patients and covered by one's insurance. Long wait times, potentially caused by staffing shortages, means many people have unmet mental health needs. There is also a need for improved services for people in crisis, such as mobile outreach—a service which has been discontinued. The following populations were identified as having unmet needs:
    - Veterans: There are a lack of local providers who take VA patients. It can be challenging for veterans to get mental health services until in crisis.
    - Spanish-speaking people: There is a need for more mental health services in Spanish, including group therapy in Spanish.
    - Young people: It can be very challenging for young people to access mental health appointments. There is a lack of inpatient facilities for young people, meaning they often have to travel to other parts of the state far from their families. Participants spoke to the importance of more screening for mental health needs and teaching coping skills in schools.
    - Older adults: To address social isolation, there is a need for more prosocial activities for older adults. It is also important the community foster opportunities to demonstrate that older adults matter and belong.
- **Homelessness and housing instability:** Participants shared housing is expensive and there is a lack of affordable and low-income housing. Applying to rent an apartment is time intensive and requires resources. Participants noted additional challenges for the following populations:
    - Young people: Young people often need a cosigner to rent an apartment, which is challenging for those without support. There is a need for more resources for young people looking for housing.
    - People with developmental disabilities: There is a need for more independent housing for people with developmental disabilities. It is currently a crisis-driven housing system.
    - Older adults: To remain in their homes, older adults often need support, including help with upkeep and safety checks. The rising cost of housing can be challenging for older adults, noting a need for discounts.
- **Access to health care services:** Participants were particularly concerned about challenges accessing timely and affordable primary and specialty care because of long wait times and

provider turnover. Patients with Medicaid or those uninsured have fewer options for care. Everyone should have access to health care insurance. They discussed the need for more culturally responsive health care services, and providers with empathy for patients' situations. They shared there are specific challenges in accessing responsive and timely care for the following groups:

  - Young people, including those estranged from guardians, experiencing houselessness, and/or identifying as LGBTQIA+: Young people estranged from a guardian cannot access crucial health care services due to lack of parental consent. There is a need for providers to be more aware of the "Mature Minor" law. Young people, particularly those experiencing homelessness or identifying as LGBTQIA+, spoke to not always receiving respectful care and feeling judged by providers. There is a need for LGBTQIA+ specific health resources, including Hormone Replacement Therapy, and for providers to be better educated on how to provide respectful and competent care to this group.
  - People with developmental disabilities: Participants spoke to the need for more local providers with training in treating people with developmental disabilities. There is a need for more accommodations at hospitals and healthcare facilities to support these families.
  - Veterans: There is a need for improved continuity of care for veterans being discharged from the VA. The nearest permanent VA medical facilities are in Walla Walla, Yakima, and Spokane.

- **Substance use/misuse:** Participants were particularly concerned about the lack of detox services in the community, noting the need for a detox center locally. They were also concerned about their perception of increased substance use/misuse by people on the street and living unhoused.

Medium priority community needs identified from listening sessions

- **Community resources:** Participants shared there needs to be more communication about available programs and resources in the community, through a variety of channels. They mentioned the importance of not only sharing information online but through additional methods. This may require more intentional outreach.
- **Safety:** Community members spoke to concerns about an increase in crime and concerns about safety. In particular, they were worried about theft, people carrying weapons close to schools, substance use in public, and gangs. They noted wanting to see faster response times from first responders and some participants shared wanting to see better police engagement in the community.
- **Transportation:** Participants shared transportation can be especially challenging for older adults and people with disabilities. They shared the current process for accessing transportation services is invasive and time intensive, with long wait times. They noted transportation is a barrier to getting to health care appointments and other resources. They shared wanting to see free bus passes and transportation services that do not require long applications.

- **Economic security, including job training and educational opportunities:** Participants discussed wanting more investment in educational opportunities for adults, as well as college resources for high school students. They noted a need for job training, particularly for Spanish-speaking adults, and more temporary job placement for veterans being discharged.

While less frequently discussed, participants also talked about needs related to **parenting and family support**, including affordable childcare and before/after school care, as well as help purchasing necessities for children, like diapers. Participants also discussed **racism, discrimination, and lack of inclusion.** Participants shared they experience racism when seeking job opportunities and discrimination contributed to people being turned away from care. They want to see more inclusion for people with developmental disabilities and marginalized groups, including people experiencing homelessness.

Community Assets

The following table includes programs, initiatives, or other resources that participants noted are working well for them.

Area of Need	Program, Initiative, or Other Resource
Access to health care	Grace Clinic
Community resources and information	2-1-1 Department of Social & Health Services iMPACT! Compassion Center JustServe Local churches providing food, clothing, and other resources
Disability services and inclusion	Benton Franklin Parent Coalition Children's Developmental Center Down Syndrome Association of the Mid-Columbia, particularly playdates for all ages The Arc of Tri-Cities, particularly the Spanish program for parents and resource list on website Special Olympics
Domestic violence, assault, and trafficking	Mirror Ministries Support, Advocacy & Resource Center (SARC)
Education	Migrant Education Program
Economic	Goodwill Industries employment services Grace Kitchen WorkSource
Food security	Food banks Meals on Wheels

Housing and homelessness	Housing Resource Center Safe Harbor's My Friends' Place Tri-City Union Gospel Mission
LGBTQIA+ resources	The Q Card Project
Mental health	Clubhouse International Mental Health Court Parents and Children Together (PACT) Practice the Pause program
Recreation	Fitness center and walking paths at the Columbia Basin College Parks and green spaces
Substance use/misuse	Oxford House Tri-Cities—Transitional Housing
Transportation	Dial-a-Ride Free public transportation and bus passes
Veterans	Columbia Basin Veterans Center Benton County Veterans Therapeutic Court Sport therapy programs and recreational therapy programs for veterans (social situation with free activities)

FINDINGS FROM PARTNER INTERVIEWS

Community Strengths

The interviewer asked partners to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Community engagement and willingness to help

Partners identified the greatest strength of Benton and Franklin Counties as the community engagement and people's willingness to show up to help one another. They shared that people care for one another, support one another, welcome new folks to the community, and volunteer to meet the needs of others. People care deeply about the community and many people have remained in the community for many years and are giving back. For example, at the start of COVID-19, community members donated soap and cleaning supplies to health care facilities. Another example is the active, grassroots network of parents coming together to help children with developmental disabilities. The passage of the one-tenth of 1% sales tax for behavioral health needs demonstrates the community's commitment to ensuring people can access the services needed.

> *"We have a community that cares and wants to improve the conditions and the lives of the children, youth, and their families in our community. I see a lot of things, a lot of great things going on. This is not a community that stands by and watches passively, this is a community that rolls up its sleeves and gets to work."—Community Partner*

> *"It's a community that rises up to help one another."—Community Partner*

To leverage this strength, partners recommended reaching out to community members to share what the community needs are and how they can get involved in solutions. Another example is to create a model that ensures volunteers provide support where it is needed most to create collective impact. This would involve community agencies working together to identify how to leverage volunteers to make the greatest impact.

> *"The biggest asset anybody have (sic) isn't money, it's their time. How they could get engaged with different things would be huge, because that's why it's called a community and people getting involved in things."—Community Partner*

A spirit of collaboration and partnership

Partners spoke to a strong spirit of collaboration and partnership in Benton and Franklin Counties. There is a lot of commitment to working together to make meaningful change and working towards shared goals. They shared examples of collaborations between law enforcement agencies, nonprofits, faith-based organizations, health care, government, emergency response teams, and community members. The COVID-19 pandemic has been an example of organizations coming together to respond to a crisis.

> *"I think the willingness to collaborate and to really talk about what's going on in the community, that is a strength of this community, but I see it in the nature of my job in talking to a lot of people. I see it over and over again that the will is there, but there are often gaps in communication. Even though people are really trying, it's not for lack of trying or for a lack of goodwill, but people don't know what other people are doing or other organizations are doing."—Community Partner*

Partners emphasized this strength can be leveraged to align priorities and goals between organizations, creating shared efforts and avoiding territorialism. Partners recommended leveraging this strength by focusing on local organizations to meet community needs, rather than outside sources. They also recommended bringing in community members to participate in collaboratives and continuing to create opportunities for more communication. This communication can help identify available capacity to address challenges and services that can meet needs.

> *"I'll start by saying I think the greatest strength in the Tri-Cities is the collaborative nature of all the different entities that put their specific agendas aside and they absolutely want to work together with partners to do what's best for the community as a whole."—Community Partner*

Strong network of community organizations to meet needs

Partners shared there are many local organizations to meet people's health and social determinant of health needs. There are multiple hospitals, clinics, urgent care centers, and specialists in the community to give patients options. There are strong school districts which are connected to many of the families and serve as a trusted partner. The Hanford site employs many people.

To leverage this network of organizations partners suggest facilitating more coordinated responses to ensure they are not operating in silos. They also suggested more communication between health care systems and collaborating on creative ways to recruit health care professionals to the community. The schools and many community-based organizations have trust built with community members and can

help share information, particularly during challenging times like the COVID-19 pandemic. Services can also be co-located at schools which can serve as a trusted site for families.

Diversity of cultures and community knowledge

Partners shared the people of Benton and Franklin Counties are a strength. There are many cultures represented in the communities and opportunities to build relationships with people of different backgrounds. This strength can be leveraged by ensuring community-building events celebrate the diversity in the community. In conversations about how to address needs, community members affected by those needs should be included in the decision making.

> *"Are we paying attention to those community events that can highlight some of the diversity in our community? Are there such things? Very few. Celebrate the different cultures."—Community Partner*

High Priority Unmet Health-Related Needs

Partners were asked to identify their top five health-related needs in the community. Four needs were prioritized by most partners and with high priority. Four additional needs were categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs.

Partners were most concerned about the following health-related needs:

1. Mental health
2. Substance use/misuse
3. Access to health care services
4. Homelessness and housing instability

Mental health

Mental health was overwhelmingly identified as the most pressing community need. Partners frequently spoke to mental health as a foundational need connected to many other needs and important for well-being. They noted mental health needs to be addressed in conjunction with substance use/misuse challenges. They also see mental health challenges as connected to community violence, with anger and stress manifesting in the form of violence. Racism and discrimination also affect people's mental health and feeling of belonging.

> *"How are we making people know and understand that they are welcome here that this is a place that wants them to be part of the community and that cares about them?"—Community Stakeholder*

Community partners spoke to the following needs related to mental health services:

- **More mental health treatment services:** This includes mental health counselors and facilities at all clinical levels. They noted it can be challenging to find providers locally.

"Of course, mental health is on everybody's mind. Just isn't enough [services] available."— Community Stakeholder

- **Improved crisis services:** Partners shared crisis response is often overwhelmed. They would like more crisis response professionals who can go to schools or other locations in the community when there is a crisis.
- **Pediatric inpatient services:** There is a need for more pediatric psychiatry facilities and inpatient services.
- **A focus on early identification and early intervention**: Partners shared they want to see a new model of responding to mental health challenges that focuses on early identification and intervention of needs in response to early signs of emotional and mental health challenges.

"We just don't seem to have the resources as a nation and as a community to address mental health, both in its most tragic outcomes, meaning those that really need to find some sort of residency to help deal with that, but I think, also, in trying to understand the mental health precursors. How someone may start on this end of the spectrum."— Community Stakeholder

Contributing to the community needs are system challenges and access barriers including the following:

- **Workforce challenges:** Recruiting and retaining qualified mental health professionals is difficult. The challenging nature of the work and low wages for entry level roles contribute to burnout. This work can be draining, particularly without good support and supervision. The testing and supervision requirements for licensure can also be a barrier for professionals. There is a need to build up the workforce by opening up pathways for existing health care professionals to become mental health professionals. Partners also suggested mental health organizations work together to meet community needs by each providing one piece of the needed services, rather than competing to provide the same services and recruit the same people.

"You're working with the most vulnerable people, situations, and scenarios, and when you help somebody they go off living productive lives and you don't hear from them. Individuals that don't have a good outcome, whether it's perceived or actual, you'll hear a lot about it. When you do good it's not really emphasized unless you have good leadership who reminds you and does those supervisions and debriefings and remind you of the purpose and why you're there. Otherwise, you're just hearing the bad all day long and you're seeing the bad and it's reinforced. It can be draining and there can be high burnout in that field." – Community stakeholder

- **Transportation**: Transportation to services can be especially difficult for people living in more rural areas, including North Franklin County. Other areas, such as Benton City have no mental health services locally. Within the Tri-Cities, people may have to travel quite a distance between different services and appointments, meaning people may have to prioritize some services over others.

- **Language and culture:** There are limited mental health services in Spanish, Russian, and other primary languages spoken in the area.

Partners names the following populations as having additional mental health needs:

- **Young people**: Mental health needs for young people have only increased due to the COVID-19 pandemic. Partners noted seeing an increase in anxiety, depression, and social isolation. They were also concerned about youth suicide. They were concerned about bullying and social media negatively affecting youth mental health. They noted seeing an increase in behavioral issues with students, potentially connected to a lack of stability during the pandemic.
- **Young people in foster care**: Accessing quality mental health treatment and having treatment options can be more challenging for young people in foster care.
- **People with developmental disabilities:** Partners shared people with developmental disabilities have few options for accessing behavior support specific to their needs locally, noting a need to provide more intentional support for this group and their caregivers. Some of these support needs include building social skills, support for families in crisis, and providers with knowledge and training to support people with developmental disabilities. Washington State mandates insurance cover behavioral services for individuals with autism, but it is challenging to find providers. There is a need for more provider education and improved disability inclusion.

  "[People with developmental disabilities] require more of a behavior mechanisms and new structure, we just don't have the services here in the Tri-Cities."—Community Partner

- **Older adults:** Ensuring older adults feel cared for and valued in the community is important. There is a need for improved social connections for older adults experiencing social isolation.
- **Hanford workforce:** Accessing mental health services may be challenging for some of the workforce at Hanford.

Partners spoke to the COVID-19 pandemic as exacerbating mental health needs for everyone and contributing to a lot of stress for families, and a lack of connection for many people, including older adults. While there has been more stress for people, it has been more socially acceptable to talk about that stress.

> *"People talking more about their stress because it was something that more people felt comfortable because more people were openly discussing it. It might have always been something but now, it was in your face and okay to talk about. The mental health really took an upswing in need and verbalized need during the pandemic."—Community Partner*

The pandemic has contributed to a lack of connection for many people, including older adults, making it more difficult for people to feel connected and build relationships.

> *"If I was looking for a glaring gap, mental health services for students, parents, families, the community as a whole, that's probably our number one issue right now and along with that, almost those clinical-level mental health services but also just counseling in general."—Community Partner*

The pandemic has negatively affected the mental health of young people. A lack of stability and access to caring adults for some children during the pandemic contributed to increased behavioral needs. Partners spoke to schools experiencing challenges with students re-adjusting to being in person and dealing with the resulting mental health and behavioral needs.

> *"The youth that most needed stability during the last two years and access to caring adults to advocate for them, probably had the least access as we dealt with isolation in school shutdown. I think that's been for sure negatively impact due to COVID."—Community Partner*

Partners have seen increased anxiety in young people and exacerbated mental health needs for school-age children, particularly in areas where there may not be the resources in schools to address the needs.

> *"I honestly believe in and can attest with my job and the kids we serve and staff we serve, because of COVID, there's been an increase in anxiety. There's been a clear shift in need from physical to mental health and maybe seeking some stability around that becomes quite a priority."—Community Partner*

> *"I think what it has done is it's exacerbated the need for mental health, especially among our school-aged kids, and we do not have the same level of resources given our rural atmosphere that some of the other school districts may have access to. There's no doubt that the pandemic has exacerbated that, though, in a big way."—Community Partner*

Health care providers also experienced increased stress and mental health needs during the pandemic. Some of the mental health workforce moved to telehealth positions where they can be compensated at a higher rate.

Telehealth services improved access for some people but created challenges for others, particularly people with a developmental disability or people lacking access to or comfort with technology.

Substance use/misuse

Partners highly prioritized substance use/misuse because of how it affects whole families and communities. They shared substance use/misuse is a huge issue in the community. They emphasized the importance of addressing mental health and substance use/misuse together, as these issues can be co-occurring.

> *"[A] substance use disorder always affects the children. It creates a feeling of uncertainty and unsafety in the home, there's a desire to find stability elsewhere. There also comes with that a sense of dependence and being able to take care of the parents and others in the home."—Community Partner*

They shared there are not enough substance use disorder (SUD) treatment services in the community, although there are many great efforts underway, including the Recovery Center, to meet the need. Partners were especially excited about these efforts although shared the following needs:

- **A detox center for withdrawal management:** Partners emphasized how critical it is to have a detox center within the community. Without these services, people who need medically

supervised detox either end up in jail or have to seek services in Yakima or Spokane. Traveling outside the area is challenging for the individual and their support system. Patients ready for treatment need to have immediate access to an assessment to ensure they have timely access to treatment when they are engaged.

- **Inpatient SUD treatment services:** The Recovery Center should help address this need.

> *"It's I think a shame, a crime and shame that you have somebody in the community as big as ours, that if they need inpatient drug or alcohol treatment, that they can't have access to that locally, that they have to go out of the community for that. That will be something that we address with [the recovery center]."—Community Partner*

Addressing the substance use/misuse needs in the community is a huge challenge without the appropriate treatment options locally. They shared there needs to be a unified approach with warm handoffs between services.

> *"The mental health and substance use disorders issues that we're dealing with right now are huge and I strongly believe we're not going to rest our way out of this problem."—Community Partner*

There is insufficient behavioral health workforce to meet the need, potentially due to low wages for people without advanced degrees and burnout in the field. There can also be high burnout in the field considering negative outcomes are often most emphasized. Good support and quality supervision are crucial to supporting this workforce.

> *"You're working with the most vulnerable people, situations, and scenarios, and when you help somebody they go off living productive lives and you don't hear from them. Individuals that don't have a good outcome, whether it's perceived or actual, you'll hear a lot about it. When you do good it's not really emphasized unless you have good leadership who reminds you and does those supervisions and debriefings and remind you of the purpose and why you're there. Otherwise, you're just hearing the bad all day long and you're seeing the bad and it's reinforced. It can be draining and there can be high burnout in that field." – Community Partner*

Partners identified the following groups that may not receive the support needed in accessing support for substance use/misuse issues:

- **Young people:** Partners were concerned about substance use/misuse starting in middle and high school.
- **Older adults:** Their needs may be overlooked or ignored because of their age.
- **People experiencing homelessness:** Partners were concerned about substance use/misuse on the streets, potentially affecting community safety.

During the COVID-19 pandemic, partners have seen substance use/misuse increase for both adults and young people.

Access to health care services

Partners shared that while there are many health care services in the two counties, there is still a need for more primary care providers and specialists to reduce wait times. Partners report patients can wait months to see a primary care provider. People without one may be forced to use their ED for health care needs. Partners also reports it can be challenging finding enough primary care physicians for all the Hanford staff.

> *"Not having enough primary care providers in the area or having long waits for individuals who need basic healthcare needs. Then it would be also the transportation to where unfortunately there's some communities that wait to see a doctor until are actually in pain or they wait it out. Usually at that point, you may need to call an ambulance, the ER. — Community Partner*

There are also long wait times to see specialists, including for endocrinology, gastroenterology, oncology, etc. People travel from other areas to receive specialty care locally, which can increase demand. Partners report a desperate shortage of specialists, meaning patients wait three or four months to get an appointment and many specialists are overwhelmed with demand.

> *"Most specialty care just cannot wait three, four, or five months to get in, and that's where we end up a lot. We have patients who are able, that often go outside the community to larger markets like Seattle or Portland or Spokane, but it's often problematic there as well."—Community Partner*

In addition to more primary care providers and specialty providers, partners spoke to the following needs to improve access to care:

- **Improved training and recruitment:** Partners shared it can be challenging to recruit health care professionals from outside of the area, particularly with the high cost of housing. It is also important to ensure people within the community stay and provide services. Local training programs, like Columbia Basin College, are limited by a finite number of clinical placements. Training programs cannot grow without new practices or expanded hospitals. The COVID-19 vaccine mandate has also meant some providers have left.
- **Discharge planning and medication management:** Improved discharge planning to ensure patients can fill their prescriptions is important for all patients, but especially people experiencing homelessness.
- **Post-acute care:** For people needing a skilled nursing facility or hospice, there are also limited options in the community.
- **Health education, including family planning support:** Health education should be provided in a culturally sensitive way.

Access to preventive care is especially important for ensuring people receive timely and appropriate care, avoiding unnecessary calls to EMS or avoidable ED visits. Because of policies, EMS and the Fire Department are only reimbursed if they transport a patient to the hospital, but sometimes treating and not transporting is the best option. Another challenge is that EMS and the Fire Department have to bring

patients to the Emergency Department for jail booking clearance. This can be unnecessary from a medical perspective and potentially not the best use of resources. There is opportunity for better collaboration and policy change to address some of these systems.

> *"Trying to encourage our lawmakers, Congress, and legislation to think about those things that we need to redesign those systems to take care of people."—Community Partner*

The health care system can be challenging for people to navigate due to the following barriers:

- **Technology and health literacy:** Technology and online forms may be difficult for people to navigate if they lack a computer or comfort with technology. Technology can create additional barriers for older adults, people whose primary language is not English, and people with a disability. There is a need for more support for people experiencing barriers to care, rather than leaving people to figure it out on their own.

  "I think the world of electronics is alienating a lot of people... I personally love it, but if you have a language barrier, a disability, your hearing, your vision, bottom line, it's not accessible to you."—Community Partner

- **Transportation**: This was highlighted as a primary barrier for people, particularly if they live in a rural area or have mobility issues. Public transportation can be difficult for people needing to take multiple buses to get to appointments. Tri-Cities is very spread out, meaning patients may have to travel between different providers and appointments. Reliable transportation can be crucial for ensuring people with chronic conditions and people experiencing homelessness receive preventive and timely care.

  "We're so spread out, nobody can just go one place and be served. You have to bounce all over the different appointments in three cities, and we don't have the transportation structure that I think other cities may have."—Community Partner

- **Cost of care**: People with low incomes or lacking insurance may not be able to afford the cost of care.

  "There's a broad population of people who, for whatever reason, don't have the ability to pay for their medical care and are not on some sort of state supplemental plan."—Community Partner

- **Language**: Ensuring all materials are translated into Spanish, Russian, and other primary languages of patients is important for improving access.
- **Childcare**: A lack of childcare can make it more difficult for parents to go to their appointments.
- **Appointment times during work hours: T**here is a need for extended clinic hours and weekend hours to ensure people can see their provider without missing work. This is also relevant for Hanford site workers.

Partners highlighted the following populations as experiencing additional barriers to care:

- **People with developmental disabilities:** Care needs to be adapted to meet the needs of people with developmental disabilities. Partners suggested finding creative solutions to working with patients is important.

  "I think that's one thing too is our providers are pretty stretched in our community and so the ability to be creative tends to get diminished. I don't know if we just don't have enough providers."—Community Partner

- **Older adults:** Technology and transportation can be barriers to care for older adults and they may need support in navigating the health care system. Health care workers that provide home visits may be able to support discharge planning and ensure older adults are safe in their home.

  "[Older adults] either don't get on, or if they're able to get on Zoom somehow, they don't interact to the same degree with that. I think we've just got to broaden out our communication styles and simplify them for those groups that need that done for them."—Community Partner

- **Young people**: School have identified a need for improved home hygiene related to things like lice, bed bugs, etc. Accessing appointments with pediatricians is difficult.

  "As a parent, it's been really difficult even in my own personal life and then also having and seeing this echoed broadly in the community and hearing stories from our students, how difficult it is to get kids into the doctor, or to do so in a way that's timely or to get feedback about just the care that they're receiving because the clinics are so inundated."—Community Partner

- **The Latino/a community:** Partners were concerned about the Latino/a community having access to preventive care if patients lack a primary care provider and insurance. Due to social inequities and disinformation about the COVID-19 vaccine, the Latino/a community was disproportionately affected by COVID-19. This underscores the importance of building trust with this community.
- **People experiencing homelessness:** This population may need additional resources to support accessing care, including transportation resources.

Due to the COVID-19 pandemic, some people delayed preventive health care services or were not able to access the health care services they needed. As people return to care, there are long-wait times for appointments and delays, leading to unmet health needs. Some patients had surgeries delayed or canceled and others had medications lapse.

"I think this last year and particularly this year since January, we've seen a lot of unmet health things where, what, maybe a diabetic hadn't come in as regularly as they were because we couldn't get them in or they were scared to come out or they had just declined to get service during that time. The amount of unmet needs went up during COVID because

so much of our healthcare capacity was directed and siloed toward COVID care."—Community Partner

Partners agreed telehealth improved access for some patients but is challenging for those without access to or comfort with technology. They shared it should not fully replace in-person care considering the importance of those face-to-face interactions. Families without internet access or technology were isolated at the start of the pandemic.

COVID-19 vaccine disinformation and the politicization of public health practices put additional strain on the health care system and providers. Partners emphasized the lessons learned about the importance of building trust with the community, particularly specific populations that have been historically marginalized. While health care providers are generally seen as experts, some experienced distrust by patients related to COVID-19 vaccine information.

"As a general rule, patients have a high respect for providers and nurses and medical staff and tend to look for them for expertise and direction, and I think that the pandemic, because of [vaccine disinformation and the politicizing of COVID], has really influenced patients into rejecting or questioning things that they would have typically just naturally accepted."—Community Partner

Positively, the pandemic created more opportunities for education and outreach with communities, and increased awareness of the role of health care and public health in the community.

"I guess it just goes back to my previous statement about awareness and let's say education. Because it's really more awareness and to get people to buy in and understand why public health and its role within healthcare, in general, is important to us."—Community Partner

Through vaccine outreach and engagement with Community Health Workers, partners learned the importance of providing vaccine clinics outside of work hours and ensuring they are offered at places where people already go, like grocery stores. Having bilingual folks working and being very consistent with timing helps build trust.

"Consistency, finding out what works for them, making it easy. How do you lower the barriers [to the COVID-19 vaccine]? How do you make it easier for them and comfortable for them?"—Community Partner

Partners also saw that providing isolation and quarantine space at local motels for people living unsheltered worked well.

Homelessness and housing instability

Partners prioritized homelessness and housing instability because of its connection to so many other needs and because of the importance of people first being stably housed before addressing their other needs.

"Yes, food in their stomach, those essential needs truly are essential because it starts there. It starts with a good night's sleep, it starts with being warm in the winter, it starts with having access to appropriate meals, and then the rest of that stuff can work itself out."—Community Partner

They described homelessness as a symptom of other issues, including mental health, substance use/misuse, access to health care, economic security, and more.

"I guess, circling back around to my main theme is that homelessness is a symptom. It's a symptom of issues that have occurred probably over time that we really need to keep focusing in my view on the upstream, which is mental health, substance use disorder, healthcare. Even financial planning when it comes to major medical needs because that's, healthcare is one of the big issues in bankruptcy, and bankruptcy then leading to loss of a home." – Community Partner

Partners shared homelessness and housing instability is growing and it includes people in a variety of living situations, including folks not just living unsheltered, but also those living in their cars or RVs, couch surfing, and moving frequently.

"We're seeing folks who are living out of their cars and not just the typical, what people associate homelessness with, someone living in a tent or living under an overpass type of scenario. We have people living in their cars, living in motor homes, moving from spot to spot."—Community Partner

This means people in different situations may need different levels of support and different types of services.

"When I looked at the homeless as a population, it truly is not a homogenous group, there are many reasons why people become homeless and the needs of the homeless as we addressed them, really we need strategies that meet their specific needs."—Community Partner

They spoke to needing more housing in general and more services including the following:

- **Homelessness services:** More hygiene services for students, care coordination and navigation for folks experiencing chronic homelessness, and more street-based care to meet folks where they are needed to improve the health and well-being of folks experiencing homelessness.
- **Low-barrier permanent supportive housing:** This type of housing with on-site services is particularly important for ensuring folks in recovery or with a substance use disorder remain stably housed. Partners emphasized the importance of taking a Housing First approach.

"In Benton County, we need to develop permanent supportive housing options. It works. Again, it's an initial investment, but in the long run from a quality of life, from a humanistic standpoint, and from the people that don't care about that, they just care about where their taxpayer dollars goes, it saves taxpayer dollars in the end too, with these ancillary services."—Community Partner

- **Transitional housing:** Providing housing for 6-12 months with supportive staff will help people re-engage in the community and build skills to live independently.
- **Workforce housing**: There needs to be housing available for folks who are recruited for jobs in the community. A lack of affordable housing units in the community makes it challenging to attract workforce to the area and some workers find themselves living in RVs because they cannot find housing.

The high cost of housing and low housing stock have made finding affordable housing a challenge for many people in the community, both wanting to buy and rent homes. Partners were concerned about young people and young families being able to find an affordable home. The market is competitive and expensive, meaning young people are priced out of buying their first home and building equity.

> *"I sit there and I think when a young family, they're both working but not making a huge salary and they maybe have a kid or two, I don't know how they're going to be able to purchase a home or even in a lot of situations, rent. When we start talking about affordable housing, affordable for young families, but then again, we just simply don't have enough units for people that are at the poverty level too."—Community Partner*

People are willing to pay above fair market rent, meaning landlords are able to charge high prices for apartments. Partners are seeing landlords increase rent by $400 or $600 a month, burdening people and leading to spending tradeoffs. This high cost of rent also contributes to overcrowding as families double up in apartments.

> *"They have to spend too much money on their housing to be able to afford some of the other things that they need in life."—Community Partner*

They spoke to very low vacancy rates, leading to competition for rentals and increases in rental prices. This can make it more challenging for people with any criminal history or a poor credit score to find housing. While there are efforts to develop new housing locally, it tends to be for people with higher incomes and therefore, is not meeting the unmet need.

> *"Our vacancy rate in Benton and Franklin Counties is below 1%. There just aren't units to put [people] in."—Community Partner*

> *"I never thought that we'd be in this situation where our housing stock, availability, whatever you want to call it is in such bad shape."—Community Partner*

For people with low incomes, a behavioral health condition, or any negative rental history, finding affordable, stable housing can be more challenging. People's incomes have not increased at the same rate as the cost of housing, meaning those who work in seasonal roles may have more difficulty finding affordable, stable housing.

> *"I think the overarching concern we hear from people is affordable housing. If we're trying to attract the young workforce to our community, there's certainly challenges related to that. When we look at a lot of the hospitality workers, particularly the people that haven't worked their way into managerial roles, the incomes that they make, housing becomes a challenge."—Community Partner*

There are no skilled nursing facilities locally and older adults living on a fixed income may be more likely to be unstably housed. Families with children with special needs may also have difficulty finding housing that accommodates and meets their needs.

The COVID-19 eviction moratoriums benefited some renters, but also created frustration for landlords falling behind on their mortgage. There is a strong need for rental assistance for people unable to pay back the rent they owe.

Medium Priority Unmet Health-Related Needs

Four additional needs were often prioritized by partners:

5. Economic insecurity, education, and job skills
6. Affordable childcare and preschools
7. Food insecurity
8. Community safety

Economic insecurity, education, and job skills

Partners discussed the need for more financial stability for many families, ensuring there are living wage jobs, job skill trainings, and investments in education. Economic security is connected to a lot of other needs, including housing and access to other resources.

With the high cost of housing, families may spend a substantial portion of their income on rent, especially for seasonal and agricultural workers. To address these needs, partners advocated for the following:

- **More equitable funding of public education and support for higher education:** The way public education is currently funded contributes to the opportunity gap. Higher-income schools receive more funding than lower-incomes schools, which creates economic inequities later.
- **Increased job skill training, particularly for students in more rural districts:** There are fewer opportunities for high school students to access business internships, apprenticeships, etc. than there used to be. Transportation can be a barrier for some students.
- **Support for skilled work training**: Some high schools are cutting classes related to skilled work, such as metalworking and mechanics. Partners noted the importance of having programs to train plumbers, electricians, construction workers, etc. which are in demand.

> *"We need skilled workers. We don't need everyone to go to a four-year college, I'm sorry. We need plumbers, we need electricians, we need construction people and those are all really good-paying jobs."—Community Partner*

They emphasized the importance of supporting educational opportunities so that people can do work that is meaningful to them and something they feel good about accomplishing.

> *"I think it would be nice if we look at how do we help people evolve or improve the stability of that socio-economic situation over the course of their lives and, at a minimum, generationally."—Community Partner*

High inflation and challenges with workforce employment were identified as challenges for the local economy. Business owners are having difficulty filling positions, affecting their ability to meet demands and stay open.

Partners identified the following populations as being disproportionately affected by economic insecurity:

- **People with developmental disabilities and their caregivers:** Finding childcare for children with special needs is very challenging, meaning these parents are often unable to work full time jobs. This is especially difficult for single parents of a child with a developmental disability or other special need. There are also limited opportunities for people with developmental disabilities to develop job-related skills.

"Most kids with developmental disabilities are staying [in school] until 21 because the world looks pretty bleak for them in a lot of opportunities."—Community Partner

- **Seasonal workers:** Due to the nature of the work, seasonal workers may receive variable income throughout the year.
- **The Latino/a community:** Partners spoke to the importance of supporting the Latino/a community in accessing educational opportunities and addressing inequities in access to education. For some, there may be a lack of understanding about the return on investment for higher education.

"I don't think there's enough individuals from the Latino community that are going on to higher education. There's more and more... There's still so many people that don't go on and really educating them and their parents about the importance of higher education."—Community Partner

The COVID-19 pandemic affected businesses and workers, particularly in the service and hospitality industries. Some small businesses and restaurants closed when people were staying home, leading to workers in the service sector losing their jobs. Schools are also facing many challenges meeting the needs of their students and can benefit from additional resources.

Affordable childcare and preschools

Partners emphasized affordable and flexible childcare as crucial for stable families and a strong workforce. Without addressing this need, people will not be able to participate fully in the workforce and there will continue to be staffing challenges. Many employers are reporting that childcare is a factor in their difficulty recruiting workers.

"That's affordable childcare and preschools. It's having a dramatic effect on our workforce and our ability for meeting the needs of our clients because we just can't, we could hire 100 people today and still be short. It's that bad. I think a lot of it is because of that inability to have their kids look after in an affordable place. We don't get to use their talent."—Community Partner

Childcare is also crucial for allowing caregivers to access other services, including health care.

There is very little affordable childcare in the community and limited free preschool spots, meaning the cost is a barrier for many families. The Early Childhood Education and Assistance Program (ECEAP), or Washington's free pre-kindergarten program, gets full quickly.

> *"I've heard multiple times that it's almost impossible to find affordable childcare in this community."—Community Partner*

For families working non-traditional hours, finding flexible childcare can be very difficult. Some parents may only need childcare on certain days or specific hours, particularly if they work an early or late shift. It also needs to be easily accessible for people living in rural areas.

> *"Is childcare available for nontraditional work shifts? What does it look like if you work Tuesday, Wednesdays, and Thursdays, but not any other days? The way the model is structured, you have to pay for your slot. That becomes really problematic."—Community Partner*

For families with a child with a disability, there is very little childcare that can meet the child's needs. Even children eligible for benefits through the Developmental Disability Administration (DDA) experience challenge finding childcare providers with the capacity and knowledge to support the child. Children with a disability but who are unable to qualify for the DDA will have even more difficulty. This prevents parents from working and can be especially challenging for single parents who may have no choice but to care for their child instead of working. This puts families in very challenging positions where they are not able to meet their basic needs because the parent(s) cannot work without safe childcare.

The pandemic highlighted how important childcare is for keeping people staffed and for businesses being able to recruit and retain employees.

> *"Affordable childcare and preschools, just from a workforce development standpoint, this pandemic brought a lot of interesting things to the forefront and the care of children and the flexibility that we have to provide to our teams so that we can continue to keep them employed and doing the great work that they do, but also taking care of their families. This has really found itself on the map in a pretty significant way."—Community Partner*

While challenging before the COVID-19 pandemic, staffing for childcare centers only became more difficult. Some staff had to resign to care for their own children and there is generally high turnover.

> *"Oh, and whether it's pandemic-related or not, I couldn't tell you, but staffing for us has been a challenge, just like everybody. I haven't been able to find qualified [childcare] staff that'll stay the course and be there long enough to make a meaningful difference. It's a challenge."—Community Partner*

Childcare centers had to drastically reduce enrollment based on COVID-19 guidelines, meaning they could serve fewer children. Some centers changed how they provide services and are not returning to their pre-pandemic enrollment numbers.

Food insecurity

Many partners shared that the community is working to ensure people have access to food, although the food options may not always be the healthiest and programs may not address what is causing food insecurity. People may not be able to access these food resources if they lack transportation.

They shared that food pantries often provide non-perishable foods, which are often not as nutritional as fresh foods. School lunches provided by the districts may not always be the healthiest either. Cost may be a factor.

> *"Once again, because you're dealing with a lot of donated food especially non-perishables, it's not necessarily going to be the healthiest choice, and so I think there's real disconnect between healthy options for families and what is easily and readily available. I think that's problematic in the long run."—Community Partner*

Fresh and healthy foods can be challenging for families with low incomes to afford. Families new to the United States may not be familiar with reading the food labels and identifying healthy foods for their children. For example, families may assume a lot of the foods like breakfast cereals are healthy options, but they can have a lot of sugar.

> *"At Christmas time, a lot of schools think it's a good thing to send kids home with a box or a number of boxes of cereal to eat over Christmas break. If those kids didn't have that cereal, they think that that's going to promote their health. You know what? They're used to eating rice and beans or something equivalent to that for breakfast or rice and vegetables. I think that's a healthier choice than sugar cereal."—Community Partner*

Workers on the Hanford site have little access to food on-site besides what they bring.

The pandemic exacerbated food insecurity for many people. While there have been additional supports to provide food to families, partners noted there are often a lot of cars lined up waiting to receive food assistance at events, underscoring the need. Partners emphasized the importance of ensuring all families that need help are receiving it, since the need only seems to have worsened in the past few years.

> *"It's a challenge we face in our nation, we subsidize the least healthy food. It makes it very difficult to be able to afford healthy fruits, vegetables, appropriate proteins, so on so forth."—Community partner*

Community safety

Partners shared that while they do not think Benton and Franklin Counties overall are unsafe, they are concerned about increased community violence and neighborhoods where residents do not feel safe. This might contribute to people not feeling comfortable accessing parks or recreation, which affects chronic conditions, mental health, and overall wellness.

"I think I will actually say community violence, lack of feeling of safety. I want to be clear to articulate that I don't think this is a broad community issue. I do think they're isolated neighborhoods within our community where this is a real challenge and does not get the focus that it should based on who does or does not live in those neighborhoods."—Community Partner

In neighborhoods with higher crime rates, residents feel more insecurity. Not all neighborhoods get the same level of attention to ensure safety.

Partners spoke to seeing a large increase in gun violence in 2021. The increase in gun violence is measured by an increase in shots fired for a variety of reasons.

"When I talk about gun violence, I'm talking shots-fired calls, whether it was directed at somebody or shots-fired in the air that we responded to, so that whole gamut. We saw a huge increase in that, and to pin it down to something specific, it's happening nationwide. There's huge increase across the nation."—Community Partner

Gun violence needs to be addressed locally as a community, as well as a country.

"I personally think that as a country, we need to do something about gun violence."—Community Partner

Partners are also seeing people manifesting anger and stress into violence, potentially due to the effects of the pandemic.

"There just seems to be, again, I don't know if it's COVID related, but anger and stress that's manifesting itself into ways that we're seeing in the community that are unusual."—Community Partner

They emphasized that addressing community safety needs to be a collaboration between law enforcement and the community. This requires building relationships between law enforcement and the community and also having the resources to move people into safe situations if they are affecting public safety.

"Public safety isn't about police or fire doing something specific. It is that collaboration when somebody feels safe to leave their doors unlocked like we used to. All of that. It can't be done alone. We tell our folks, every contact matters. Every single contact, when you're dealing with somebody, you can make a difference, because the majority of the time, you're dealing with really good people who are having a really bad day."—Community Partner

Community Partner Identified Assets

Partners were asked to identify one or two community initiatives or programs that they believe are currently meeting community needs.

Table_Apx 3. Organizations and Initiatives Addressing Community Needs in Benton and Franklin Counties

Community Need	Community Organization/Initiative
Access to Health Care	• Benton Franklin Community Health Alliance: Brings together representation from various groups in the health care community to promote conversation and collective problem-solving. • Camp Trios for children with Type 1 diabetes • Columbia Basin Health Association • Community Health Worker/ Promotores programs: They have the ability to go into people's homes to understand their specific needs and situation and provide more in-depth case management. • Free vaccinations for children in schools • Grace Clinic: Provides free medical, dental, and mental health services to people without insurance. Many partners emphasized how crucial this clinic is for ensuring everyone has access to health care services. • Nurse-Family Partnership at the Health Department: Brings health care services to people who need it most, rather than expecting people to seek out or travel to services. It is a good example of a community-based intervention. • Tri-Cities Community Health: In partnership with the National Alliance for Hispanic Health, provides the Diabetes Prevention Program for Latino/a individuals in Pasco. • Yakima Farmworkers Clinic: Provides health care services to communities with barriers accessing health care services.
Behavioral Health	• One-tenth of one percent sales tax for mental health that passed in Benton and Franklin Counties: Invests in an inpatient and outpatient treatment program. • Benton Franklin Behavioral Health Advisory Committee: This committee is currently in progress and will make recommendations on programs or services that will be funded by the one-tenth of one percent sales tax for mental health. • The Recovery Coalition: Brings a lot of awareness to behavioral health needs in the community and current gaps in services. • Wraparound with Intensive Services (WISe) Program: Wraparound services to help children, youth, and their families with intensive mental health care. • The Recovery Center: The current efforts underway to establish a drug and alcohol treatment center with mental health services is seen as great progress to meet a dire need. • Comprehensive Healthcare: Embedded therapists in Kennewick School District provides on-site mental health support in schools. This ensures there is no need to wait for outside referrals and minimizes a lot of barriers to care.
Education	• Communities in Schools: Provides resources to families and students, building trust and support to help students be successful.

Food Insecurity	• Churches providing food • Meals on Wheels: Partnering with Pasco Fire so that they can provide food baskets or frozen meals if a family has an urgent need for food. During the pandemic Meals on Wheels has adapted to meet people's needs, providing drive-through pick-up options and more flexibility with combinations of hot and frozen meals. • Salvation Army Food Bank: Provides food distribution twice a week. • Second Harvest: Works to ensure food is distributed at community events and is easily accessible. Food distributions at schools are also helpful.
Health and Social Services	• Coalition for a Healthy Benton City: Works with school districts to increase community connectedness and address substance use/misuse. • Mustangs for Mustangs: Provides emergency assistance for anyone in Prosser, along with their immediate families. Their services are related to personal safety, utility assistance, food security, transportation, housing, and medical needs. • Safe Kids Benton-Franklin: Evidence-based programs to help parents and caregivers prevent childhood injuries.
Housing and Homelessness	• Elijah Family Homes: Provides stable housing for families seeking recovery and safety from substance use/misuse, abuse, and poverty. The program invests in families long-term to help them gain self-sufficiency. • Pasco Haven: A 60-unit housing project in Pasco that provides mental health support and health care services.
Senior Services	• Prosser Senior Community Center
Services for People with Developmental Disabilities	• The Arc: Provides a space where children with developmental disabilities can feel included and part of a community through programs like the summer camp and Special Olympics. These programs create spaces for friendship and belonging. • Tri-Cities Community Health: Includes providers who have completed the Center of Excellence Training to be able to diagnose children with autism.

Community Partners: Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Partners shared the following opportunities:

Engage in partnership opportunities based on shared community priorities

Community based organizations in Benton and Franklin Counties are working towards addressing similar needs. Partners emphasized rallying around these needs, acknowledging the primary issues in the community, and partnering to solve them. Partnering allows for more creative solutions to addressing challenging problems and opportunity for sharing resources. They described a need for strategic collaboration.

"Collaboration is wonderful. I think that strategic collaboration is even more useful. Collaboration can lead to outcomes or it can lead to conversations that don't lead to much else."—Community Partner

Partners recommended measuring progress towards goals and communicating frequently to keep everyone aligned.

"Those are the suggestions that I always have. Stay local, keep the facts in mind, get the emotions or all of your biases out of the way and let's speak to what needs to be done and how to do that appropriately."—Community Partner

Partners identified the following shared priorities where sectors could better align to address complex challenges:

- Addressing behavioral health staffing challenges: Partners shared organizations may compete to recruit the same people or provide the same services. They advocated for a system that works together to collectively meet the needs of the community, with different organizations each providing a sub-set of services. Together, multiple organizations will meet the full needs of the community, layering different services, rather than competing for the same services. This means all organizations do not need to try to do everything but can be strategic with how they leverage resources.

  "There are so many things that we could layer that don't have to be done by one agency or have to be done by all agencies. We can start layering the services that we don't have rather than competing for the same resources."—Community Partner

- Homelessness and health care: There is opportunity for more communication about post-discharge care and supporting the needs of patients experiencing homelessness. Finding solutions to barriers to care, including transportation, requires partnership. One opportunity is to create volunteer opportunities for nurses to work with people living unsheltered to give nurses a better understanding of community health work and the specific needs of this population.

De-siloed and whole person care

Patients have multiple needs and should have their needs addressed holistically. When people seek services in a health care setting, providers need to be considering what other services they need and how they can be connected. Unfortunately, patients can be passed between services without a lot of follow up or support. Warm hand offs may ensure people have support in those transitions. The COVID-19 pandemic made some communication and care coordination between organizations more difficult. Case conferencing on shared patients may help improve linkages.

"I just feel that in general, organizations just really need to collaborate to be more open and not so jealous of the services that they offer, but really look at it in the aspect of we're helping one person. What do they need? Do they need clothing? Do they need

transportation? Do they need health insurance? Just really be the connector of all the service."—Community Partner

Provide community-based services to ease access

Partners emphasized the benefits of bringing needed services to people. They shared home visits can be especially helpful for older adults who may have difficulty getting to care. Providing care in the home can be a preventive measure rather than waiting until people have emergent needs. Community Health Workers or Promotores can provide case management and personalized care in the community. Co-located services in schools or places where families already go can also reduce barriers. These services aim to reach out to people and meet them where they are, not expecting them to overcome barriers on their own.

"I think healthcare as a whole needs to be redesigned, if we're going to reach out to those disadvantaged people, we need to quit expecting them to overcome those barriers and do that."—Community Partner

Leverage convenors to promote action

Partners would like to see more effective collaboration that moves beyond conversations and leads to community improvement. This requires dedicated funding and leadership to keep work moving. Neutral convenors can pull together competing systems to foster dialogue and promote community solutions. They can also support including community members and patients to gain insight. This can also reduce competition and help the community think strategically about how to leverage resources.

"Whatever the issue is, youth mental health or access to healthy food, or neighborhood safety, whatever the case is, you can pick the issue, but how do we find a way to convene people that care, but also to have action associated with it so you're not just spending time talking about the problem, but instead, you're trying to implement a solution. I think that would be the big suggestion I would have is to find conveners that are willing to bring together resources and people to try to solve bigger issues across boundaries and across scope."—Community Partner

Build trust and relationships between organizations

Trust between organizations is the foundation for making progress towards community goals. Particularly in times of challenge and crisis, there has to be strong trust and communication. Opportunities for relationship building are between the police departments and the Emergency Departments at local hospitals. Additionally, the local health systems could continue to communicate to ensure they are collectively meeting the health needs of residents. Building relationships allows organizations to learn about others' strengths and opportunities to learn from one another.

LIMITATIONS

While partners and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a partner. Multiple interviewers conducted the session, which may affect the consistency in how the questions were asked. Multiple note-takers affected the consistency and quality of notes across the different listening sessions.

Some listening sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

PARTNER INTERVIEW QUESTIONS

1. Please state your name, title, and organization as you would like them included in the report.
2. How would you define the community that your organization serves?
3. While a Community Health Needs Assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization serves.
4. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health.
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. What suggestions do you have for how we can leverage community strengths to address these community needs?
8. Please identify one or two community health initiatives or programs that you see currently meeting the needs of the community.
9. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
10. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to health care services		Gun violence
	Access to dental care		HIV/AIDS

	Access to safe, reliable, affordable transportation		Homelessness/lack of safe, affordable housing
	Affordable childcare and preschools		Job skills training
	Aging problems		Lack of community involvement and engagement
	Bullying in schools		Mental health concerns and treatment access
	Community violence; lack of feeling of safety		Obesity and chronic conditions
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g. climate change, fires/smoke, pollution)		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Few community-building events (e.g. arts and cultural events)		Substance Use Disorders and treatment access
	Food insecurity		Other:

LISTENING SESSION QUESTIONS

1. What makes a health community? How can you tell when your community is healthy?
2. What's needed? What more could be done to help your community be healthy?
3. What's working? What are the resources that currently help your community be healthy?
4. Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

Click here for "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties."

Click here for "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

Appendix 3: Community Health Improvement Plan Guiding Concepts

Community Health Improvement Plan (CHIP) Guiding Concepts

Equity: As defined by the U.S. Department of Health and Human Services, health equity is the attainment of the highest level of health for all people. Population-level factors, such as the physical, built, social, and policy environments, can have a greater impact on health outcomes than individual-level factors. The root causes of health inequity can be directly linked to a failure to address these population-level factors. In addition, linkages between science, policy, and practice are critical to achieving health equity.
https://www.cdc.gov/minorityhealth/publications/health_equity/index.html#:~:text=As%20defined%20by%20the%20U.S.,outcomes%20than%20individual%2Dlevel%20factors.

Life-course wellness: Reducing health disparities requires an understanding of the mechanisms that generate disparities. Life course approaches to health disparities leverage theories that explain how socially patterned physical, environmental, and socioeconomic exposures at different stages of human development shape health within and across generations and can therefore offer substantial insight into the etiology of health disparities.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6356123/

Health in All Policies (HiAP): is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. https://www.cdc.gov/policy/hiap/index.html

Evidence-based: The interventions, policies, and community supports listed in the CHIP will be evidence-based. They will be disease prevention approaches that have the potential to impact public health. Resources from the National Institutes of Health list agencies and organizations with their own process to identify what is evidence-based but often a systematic review or a meta-analysis is used to evaluate the body of evidence in a given field.
https://prevention.nih.gov/research-priorities/dissemination-implementation/evidence-based-practices-programs

Collective Impact: Collective Impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change. The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. https://www.chathamcountync.gov/Home/ShowDocument?id=38860

Appendix 4: Community Health Needs Assessment Steering Committee

Table_Apx 4. Community Health Needs Assessment Committee Members

Name	Title	Organization	Sector
Sean Domagalski, RN, BSN, MHA	Performance Manager	Benton-Franklin Health District	Public Health
Kelly Harnish, MPH, MCHES	Public Health Educator, Community Health Improvement Plan Coordinator	Benton-Franklin Health District	Public Health
Karen Hayes, MA	Community Health Investment Manager	Kadlec Regional Medical Center/Providence	Hospital
Pernell Hodges	Epidemiologist	Benton-Franklin Health District	Public Health
Hazel Kwak, BHSC, NCMA	Community Health Investment Coordinator	Kadlec Regional Medical Center/Providence	Hospital
Kristi Mellema, BSN, RN	Chief Quality and Compliance Officer	Prosser Memorial Health	Hospital
Amy Person, MD	Health Officer	Benton-Franklin Health District	Public Health
Carla Prock, RN, BSN	Senior Manager, Healthy People & Communities	Benton-Franklin Health District	Public Health
Christy Wang, BSN, RN, MPH	Epidemiologist	Benton-Franklin Health District	Public Health
Kirk Williamson	Program Manager	Benton-Franklin Health Alliance	Public Health

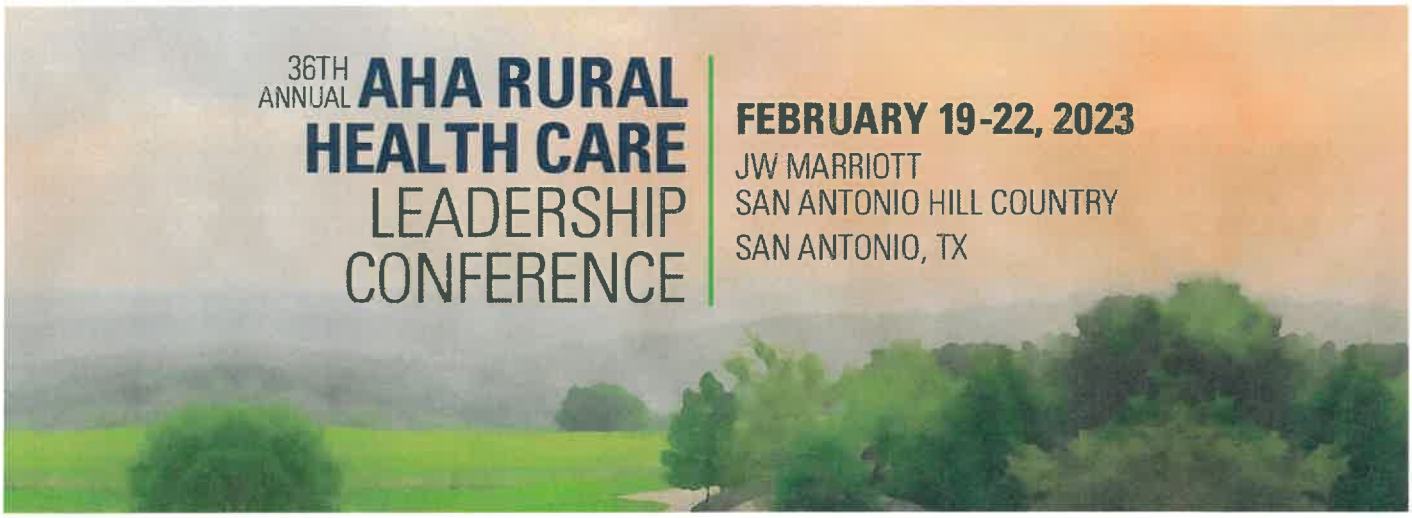
Attachment X

Craig Marks

From: Sarah Reusch from the American Hospital Association <marketing-noreply@aha.org>
Sent: Thursday, October 06, 2022 7:31 AM
To: Craig Marks
Subject: See you in San Antonio! New location for the 2023 AHA Rural Health Care Leadership Conference

Follow Up Flag: Follow up
Flag Status: Flagged

American Hospital Association™
Advancing Health in America



REGISTRATION NOW OPEN

Early Bird Savings Ends December 9, 2022

Join the American Hospital Association for the **2023 AHA Rural Health Care Leadership Conference**, February 19-22, in San Antonio.

The conference brings together top practitioners and thinkers to share strategies and resources to tackle operational, financial, and environmental rural health challenges while presenting innovative approaches to transform care delivery and business practices.

Join leaders from rural hospitals and health care systems with a strong presence in rural communities, rural health clinics, associations, and community health organizations for two and a half days of education, networking, and collaboration. Previous participants have included administrators, trustees, physician executives, nursing administrators, public health officials, and community leaders.

RESERVE YOUR SPOT >>

FEATURED PLENARIES

The Power of Leaving Your Comfort Zone
Michael Easter, author of *The Comfort Crisis: Embrace Discomfort to Reclaim Your Wild, Happy Healthy Self*

Leading Through Uncertainty
Nadja West, *First African American Army Surgeon General and Former Commanding General*, U.S. Army Medical Command

Powering Through the Super Storm: The Rural Governance Challenge
Jamie Orlikoff, *President*, Orlikoff & Associates, Inc., *National Advisor on Governance and Leadership* to the American Hospital Association, and *health care governance expert*

Washington Update
Lisa Kidder Hrbrosky, *Senior Vice President, Legislative and Political Affairs*, American Hospital Association, **Travis Robey**, *Vice President, Political Affairs,* American Hospital Association, and **Shannon Wu, PhD**, *Senior Associate Director of Payment Policy*, American Hospital Association

VIEW SCHEDULE >>

REGISTRATION

Early bird savings end December 9, 2022.

Bring your team! Register four and the fifth attend for free!

RESERVE YOUR SPOT >>

SPECIAL OFFER FOR AHA MEMBERS

Interested in receiving complimentary registration?

The **Hosted Buyer Forum** offers a private showcase for hospital and health system leaders interested in connecting with solution providers addressing key hospital issues. Approved applicants are given complimentary registration to the conference. After the Forum is complete participants are encouraged to join the Associate and Sponsor Reception for beverages, appetizers, and networking. **Learn more.**

Employee Flu Shots

Vineyard Conference Room

October 6th, 14th, and 27th from 7-10am

N-95 mask fitting and PAPR training will occur at the same time.

Prosser Memorial Health

This is how we care.