Prosser Memorial Health

Board of Commissioners

Board Packet

February 23, 2023

Vision
Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser Memorial Health

Mission: Prosser Memorial Health will improve the health of our greater community.

Values
Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

BOARD OF COMMISSIONERS
THURSDAY, February 23, 2023
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: Mac McGrath, Project Manager, Bouten
Nick Gonzalez, Bouten Construction
Kurt Broeckelmann, bcDG
Paul Kramer, Project Director, NV5
Adam Trumbour, Senior Project Manager, NV5

I. CALL TO ORDER
A. Pledge of Allegiance

II. PUBLIC COMMENT

III. APPROVE AGENDA
Action Requested – Agenda

IV. CONSENT AGENDA
Action Requested – Consent Agenda
A. Board of Commissioners Meeting Minutes for January 26, 2023
B. Payroll and AP Vouchers # 170530 through # 171085 dated 01-18-23 through 02.15.23 in the amount of $6,674,692.70. Surplus Item Resolution # 1076: (3) Medical Beds, and (1) Pharmacy Balance.

V. MEDICAL STAFF DEVELOPMENT
A. Medical Staff Report and Credentialing **Dr. Wenger**
Action Requested – Advancement from Provisional
1. Advancement from Provisional
Jung "Joanne" Kim, MD – Locum Tenens privileges in Emergency Medicine effective March 1, 2023 through August 31, 2023.

2. New Appointment

Action Requested – New Appointment and Requested Clinical Privileges

Benjamin Passey, CRNA – Provisional/Advanced Practice Clinician staff with requested privileges in Anesthesia effective March 1, 2023, through August 31, 2023.

VI. SERVICES

A. Replacement Project Update

1. Design-DOH, WSDOT — **bcDG, NV5, Bouten**
2. City of Prosser-Development Agreement **(Attachment F)** — **NV5**
   Action Requested-Development Agreement
3. Construction **(Attachment C)** — **Bouten**
4. Schedule **(Attachment D)** — **Bouten**
5. Budget **(Attachment E)** — **NV5**

B. Capital Request- ERBE **(Attachment K)** — **Merry**

Action Requested-ERBE at a cost not to exceed $26,214

VII. FINANCIAL STEWARDSHIP

A. Review Financial Reports for January 2023 **(Attachment CC)** — **David**

Action Requested – Financial Reports

B. PMH Foundation Board Member-Lori Gardner — **Shannon**

Action Requested-Lori Gardner

C. PMH Foundation Operating Agreement **(Attachment DD)** — **Shannon**

Action Requested-PMH Foundation Operating Agreement

VIII. EMPLOYEE DEVELOPMENT

A. Review and Approve 2023 PMH Incentive Compensation Program **(Attachment X)** — **Craig**

Action Requested-2023 Incentive Compensation Program

B. International Association of Firefighters (IAFF)**(Attachment S)** — **Bryon**

Action Requested-IAFF Contract

IX. PATIENT LOYALTY

A. 2023 Patient Engagement Plan **(Attachment BB)** — **Merry**

Action Requested-2023 Patient Engagement Plan

X. QUALITY

A. Review and Approve 2023 Board Action Plan **(Attachment GG)** — **Craig**

Action Requested-2023 Board Action Plan

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

C. CEO/Operations Report — **Craig**

XI. EXECUTIVE SESSION

A. RCW 42.30.110 (l) 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

XII. RESUME REGULAR SESSION

XIII. SERVICES

A. Patient Financial Services Update **(Attachment MM) (Attachment NN)** **David**
Action Requested-Patient Financial Services

XIV. ADJOURN

PMH
Board of Commissioners
Work Plan – FY2023

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

Month	Goals & Objectives	Education
January	QUALITY: • Review/Approve 2023 Strategic Plan and 2023 Patient Care Scorecards • Sign Financial Disclosure and Conflict of Interest Statements • Approve 2023 Risk Management and Quality Assurance Plans • Select and Approve Board Officers • Review Board Committee structure and membership	EMPLOYEE DEVELOPMENT: • Review 2022 Employee Engagement Survey Results • Review 2022 Medical Staff Engagement Survey Results • Review PMH Wage scales QUALITY: • Review Board Self-Evaluation FINANCIAL STEWARDSHIP: • Review semi-annual financial performance report for PMH Clinics SERVICES: Replacement Facility Update • Regulatory Agency Updates

Month	Goals & Objectives	Education
		• Schedule • Budget
February	QUALITY: • Approve 2023 Board Action Plan EMPLOYEE DEVELOPMENT: • Approve 2023 Incentive Compensation Program	EMPLOYEE DEVELOPMENT: • Attend AHA Rural Health Governance Conference • Review 2023 Incentive Compensation Program • Review 2023 Employee Engagement Calendar PATIENT LOYALTY: • Patient Loyalty Summary report • Review Patient Engagement Plan SERVICES: Replacement Facility Update • Schedule • Budget
March	QUALITY: • Review/Approve Board Polices • Approve 2023 Corporate Compliance Plan • Approve 2023 Infection Prevention Control Plan MEDICAL STAFF DEVELOPMENT: • Support Providers' Day Celebration FINANCIAL STEWARDSHIP: • Accept 2022 Audit Report	PATIENT LOYALTY: • Review 2022 Utilization Review Performance QUALITY: • Review 2022 Corporate Compliance Report and 2023 Plan • Review 2022 Infection Prevention Summary and 2023 Plan EMPLOYEE DEVELOPMENT: • Review Employee Performance Report

Month	Goals & Objectives	Education
	PATIENT LOYALTY • Approve the 2023 Utilization Review Plan	MEDICAL STAFF DEVELOPMENT: • Review Business Plan for Specialty Clinic FINANCIAL STEWARDSHIP: • Presentation of the 2022 Audit Report by Auditors • Capital Campaign Update SERVICES: Replacement Facility Update • Schedule • Budget • Regulatory Agency Updates
April	QUALITY: • Approve 2023 Community Benefits Plan EMPLOYEE DEVELOPMENT • Conduct CEO Evaluation	SERVICES: Replacement Facility Update • Schedule • Budget QUALITY: • Strategic & Patient Care Score Cards • Review 2022 Community Benefits Report and 2023 Plan EMPLOYEE DEVELOPMENT: • Review 2022 Leadership Performance (LEM) • Review Employee Engagement Plan MEDICAL STAFF DEVELOPMENT: • Review 2022 FPPE/OPPE Summary PATIENT LOYALTY: • Call Center Update

Month	Goals & Objectives	Education
May	EMPLOYEE DEVELOPMENT: • Support Hospital Week Activities	SERVICES: • Replacement Facility Update · Schedule · Budget MEDICAL STAFF • Medical Staff Engagement Plan EMPLOYEE DEVELOPMENT: • Employee Retirement Update PATIENT LOYALTY: • Review Customer Service Program
June	QUALITY: • Review/Approve Board Polices • Approve 2022 CAH Annual Report FINANCIAL STEWARDSHIP: • Approve 2022 Cost Report	QUALITY: • Report 2023 Q1 Utilization Review • Review 2022 CAH Annual Report EMPLOYEE DEVELOPMENT: Review Medical Assistant Practice Council Progress SERVICES: • Marketing Update FINANCIAL STEWARDSHIP: • Accounting Software Update

Month	Goals & Objectives	Education
July	MEDICAL STAFF DEVELOPMENT: • Attend BOC, Medical Staff and Leadership Engagement Activity FINANCIAL STEWARDSHIP: • Approve Single Audit	SERVICES: • Replacement Facility Update · Schedule · Budget MEDICAL STAFF • Review PMH Clinic productivity QUALITY: • Quality Committee Report • Strategic & Patient Care Score Cards EMPLOYEE DEVELOPMENT: • Review New Employee Orientation & Onboarding process • Attend Leadership Car Wash and BBQ Tailgate party 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 · Schedule · Budget

Month	Goals & Objectives	Education
September	QUALITY: • Review/Approve Board Polices	EMPLOYEE DEVELOPMENT: • Review New Leader Onboarding process • Review Pre-employment screening program SERVICES: • Replacement Facility update · Schedule · Budget PATIENT LOYALTY: • Nurse Educator Update
October		QUALITY: • Conduct 2024 Strategic Planning • Strategic & Patient Care Score Cards EMPLOYMENT DEVELOPMENT: • Review Employee Benefit Changes for 2024 • Review 403(b) promotion campaign efforts of 2023 PATIENT LOYALTY: • Patient Loyalty Summary
November	FINANCIAL STEWARDSHIP: • Approve 2024 Property Tax Request for County Commissioners	QUALITY: • iVantage Update SERVICES: • Review draft 2024 Strategic Plan; 2024 Marketing and IT Plans; and Medical Staff Model/2024 Provider Recruitment Plan

Month	Goals & Objectives	Education

		• Replacement Facility Update
		  · Schedule
		  · Budget
		
		EMPLOYEE DEVELOPMENT:
		• Review Leadership & Exempt Wage scales for 2024
		• Review LDIs and status update on key Studer initiatives
		FINANCIAL STEWARDSHIP:
		• Review draft 2024 Budget

December	QUALITY: • Complete Board Self-Evaluations • Review/Approve Board Polices • Approve the 2024 Environment of Care Plan • Approve RHC Program SERVICES: • Approve 2024 Strategic Plan; 2024 Marketing and IT Plans; and Medical Staff Model/2024 Provider Recruitment Plan FINANCIAL STEWARDSHIP: • Approve 2024 Operating and Capital Budgets EMPLOYEE DEVELOPMENT: • Attend holiday celebration	QUALITY: • Review the 2023 Environment of Care results and 2024 Plan. • Review RHC Program.

Strategic Plan Scorecard

2023 - Strategic Plan Scorecard

Major Goal Areas & Indicators	2023 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2023 YTD	2022 Avg	2021 Avg
Patient Loyalty																
IP - "Would Recommend"	>92.5%	84.96%												84.96%	92.50%	93.10%
ED - "Would Recommend"	>85.8%	87.30%												87.30%	85.80%	84.00%
Acute Care - "Would Recommend"	>90.9%	81.06%												81.06%	90.90%	91.80%
OB - "Would Recommend"	>96.7%	93.52%												93.52%	96.70%	93.60%
Outpatient Surgery - "Would Recommend"	>96.1%	98.87%												98.87%	96.10%	96.60%
Clinic - "Would Recommend"	>92.6%	91.24%												91.24%	92.60%	91.00%
Outpatient - "Would Recommend"	>94.6%	94.19%												94.19%	94.60%	94.10%
Composite Score	>93.2%	92.62%												92.62%	93.20%	92.90%
Medical Staff Development																
Medical Staff Turnover	<7%	0%												0%	7%	12%
Prosser Specialty Clinic Visits	1,545	1,573												1,573	1,433	1,318
Benton City Clinic Visits	826	959												959	796	732
Prosser RHC Clinic Visits	775	1,039												1,039	1,155	1,227
Grandview Clinic Visits	919	1,083												1,083	960	778
Women's Health Center	609	683												683	597	602
*# of Active Medical Staff	>54	56												56	54	51
Employee Development																
403(B) Participation Rate	>98%	99%												99%	98%	98%
Average Recruitment Time (days)	<22	15												15	22	21
# of Open Positions (Vacancies)	<37	26												26	37	32
Hours of Overtime - Overtime/Total Hours Worked	<6.5%	6.6%												6.6%	6.50%	6.10%
Agency - Cost/Total Labor	<8.5%	8.2%												8.2%	8.50%	7.70%
Turnover Rate	<0.7%	0.3%												0.3%	0.70%	0.90%
Timely Evaluations	>86.70%	90.0%												90.0%	86.70%	71.80%
Education Hours/FTE	>1.12	0.73												0.73	1.12	1.05
New Hire (Tenure) < 1 year	<50%	0%												0%	0.50%	10%
* Lost Workdays due to On-the-Job Injuries	<7	12												12	7	19.49
Quality																
ED Encounters - Left Without Being Seen	<3.17%	2.76%												2.76%	3.17%	1.40%
*Falls with Injury	<2	0												0	2	3
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.08%	0.00%												0.00%	0.08%	0.00%
All-Cause Unplanned Readmissions within 30 Days	<5.63%	5.41%												5.41%	5.63%	6.10%
Diabetes Management - Outpatient A1C>9 or missing result	<21.67%	16.70%												16.70%	21.67%	21.88%
Services																
ED Visits	1,375	1,376												1,376	1,379	1,105
Inpatient Admissions	173	119												119	109	116
OB Deliveries	50	44												44	49	49
Surgeries and Endoscopies	313	350												350	278	179
Diagnostic Imaging Procedures	3,013	2,967												2,967	2,998	2,992
Lab Procedures	16,392	17,652												17,652	15,250	14,327
Adjusted Patient Days	2,530	1,857												1,857	2,195	1,697
Therapy Visits	1,415	1,581												1,581	1,466	1,453
Outpatient Special Procedures Visits	375	499												499	350	324
Financial Performance																
Net Days in Accounts Receivable	48	57												57	56	51
*Total Margin	6.12%	13.50%												13.50%	12.00%	18.40%
Net Operating Revenue/FTE	$20,705	$ 22,473												$ 22,473	$20,399	$20,682
Labor as % of net Revenue	55.30%	51.64%												51.64%	54.49%	57.00%
Operating Expense/FTE	$19,332	$ 19,543												$ 19,543	$17,866	$16,940
*Days Cash on Hand	126	145												145	163	155
Commercial %	31.60%	29.40%												29.40%	31.60%	29.00%
Total Labor Expense/Total Expense	59.10%	59.21%												59.21%	60.60%	61.00%

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

2023 - Patient Care Scorecard

Major Goal Areas & Indicators	2023 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2023 YTD	2022	2021
Quality																
Left Without Being Seen	<3.17%	2.76%												2.76%	3.17%	1.47%
Median Admit Decision Time to ED Departure Time for Admitted Patients	<54 min	61												61	54	60
Median Time from ED Arrival to Departure for Discharged ED Patients	<124 min	133												133	124	117
Severe Preeclamptic Mothers: Timely Treatment Rate	>68.75%	66.67%												66.67%	68.75%	N/A
All-Cause Unplanned 30 Day Inpatient Readmissions	<5.63%	5.41%												5.41%	5.63%	5.80%
Sepsis - Early Management Bundle	>96.67%	100.00%												100.00%	96.67%	94.40%
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.08%	0.00%												0.00%	0.08%	0%
Diabetes Management - Outpatient A1C>9 or missing result	<21.67%	16.67%												16.67%	21.67%	21.89%
Surgical Site Infection	<0.03%	0.00%												0.00%	0.03%	0.19%
Bar Code Scanning: Medication Compliance	>93.28%	91.55%												91.55%	93.28%	93.50%
Bar Code Scanning: Patient Compliance	>93.82%	91.06%												91.06%	93.82%	94.70%
*Overall Quality Performance Benchmark (INDEX Report)	>59.5	65												65	59.5	68.5
*Falls with Injury	<2	0.00%												0.00%	2	3

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

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser Memorial Health

Mission: Prosser Memorial Health will improve the health of our greater community.

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

BOARD WORK SESSION	**January 24, 2022**	**WHITEHEAD CONFERENCE ROOM**	
COMMISSIONERS PRESENT	**STAFF PRESENT**	**GUESTS**	**COMMUNITY MEMBERS**
• Dr. Steve Kenny • Keith Sattler-Teams • 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, CMO • Annie Parker, CCOO	• Adam Trumbour, Senior Project Manager, NV5 • Paul Kramer, Project Director, NV5 • Quinton Barrett, People Element • Mac McGrath, Project Manager, Bouten • Kurt Broeckelmann, bcDG	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. EMPLOYEE AND MEDICAL STAFF DEVELOPMENT	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Review 2022 Employee and Medical Staff Engagement Survey Results (**Attachment L)** & **(Attachment P)**	Quinton Barrett, from People Element, and Bryon Dirkes presented the results of the 2022 Employee and Medical Staff Engagement Surveys.	None.	NONE.
IV. SERVICES	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Replacement Facility Update			

1. Design	Adam, Kurt, and Craig provided the Board with updates regarding regulatory agency (DOH, USDA, City of Prosser) reviews; ongoing work with SVID to bury the existing overflow canal on hospital property; Washington DOT and the furniture fair.	None.	None.
2. Construction/ Schedule/Budget (Attachment F) (Attachment G) (Attachment H)	Paul, Adam, and Mac provided: a construction, schedule, and Budget update for the project.	None.	None.

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.

V. EXECUTIVE SESSION

A. RCW 42.30.110 (g) To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee.

V. RESUME SESSION

Open session resumed at 8:20 p.m.

VI. ADJOURN

There being no further business to attend to, Commissioner Kenny adjourned the meeting at 8:21p.m.

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser Memorial Health

Mission: Prosser Memorial Health will improve the health of our greater community.

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

BOARD MEETING	January 26, 2023,	WHITEHEAD CONFERENCE ROOM	
COMMISSIONERS PRESENT	**STAFF PRESENT**	**MEDICAL STAFF**	**GUESTS**
• Steve Kenny Ph.D. • Glenn Bestebreur-Teams • Susan Reams • Keith Sattler-Teams • 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 • Annie Parker, CCOO	• Dr. Jose Santa-Cruz	
AGENDA	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
I. Call to Order	The meeting was called to order by Commissioner Kenny at 6:07 p.m.		
A. Pledge of Allegiance			
II. Public Comment	None.	None.	None.
III. Approve Agenda	None.	Commissioner Reams made a Motion to approve the December 15, 2022, Agenda. The Motion was seconded by Commissioner McPartland and passed with 5 in favor, 0 opposed.	
IV. APPROVE CONSENT AGENDA **A. Board of Commissioners Meeting Minutes for December 15, 2022.**	None.	Commissioner McPartland made a Motion to approve the Consent Agenda. The Motion was seconded by Commissioner Reams and passed with 5 in favor, 0 opposed.	None.

B. Payroll & AP Vouchers #169603 through #170529 dated 12.08.22 through 01.17.23 in the amount of $10,754,384.21.			
V. MEDICAL STAFF DEVELOPMENT	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Medical Staff Report and Credentialing			None.
1. New Appointment	Dr. Santa-Cruz presented the following providers for **New Appointment:** **Gary Thomas, ARNP** – Provisional/Advanced Practice Clinician with requested privileges in Family Medicine effective February 1, 2023, through July 31, 2023. **Norman Hauk, PA-C** – Provisional/Advance Practice Clinician with requested privileges in Family Medicine effective February 1, 2023, through July 31, 2023.	A Motion to approve the New Appointment 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. • **Gary Thomas, ARNP** • **Norman Hauk, PA-C**	
1. Reappointment	Dr. Santa-Cruz presented the following providers for **Reappointment:** **Jessica Dingwall, MD** – Reappointment to Locum Tenens staff with requested privileges in Diagnostic Radiology effective February 1, 2023, through January 31, 2025. **Peter Park, ARNP -** Reappointment to Advanced Practice Clinician staff with requested privileges in	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 McPartland. The Motion passed with 7 in favor, 0 opposed.	None.

	Family Medicine effective February 1, 2023, through January 31, 2025. **Fareed Arif, MD** – Reappointment to Consulting staff with requested privileges in Nephrology effective February 1, 2023, through January 31, 2025.	• **Jessica Dingwall, MD** • **Peter Park, ARNP** • **Fareed Arif, MD**	
VI. FINANCIAL STEWARDSHIP	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Review Financial Reports for December 2022 **(Attachment T)**	David Rollins presented the December 2022 Financial Reports.	A Motion to accept the Financial Reports for December 2022, was made by Commissioner Reams, and seconded by Commissioner Bowden. The Motion passed with 7 in favor, 0 opposed.	None.
B. Review 2022 PMH Clinic Financials **(Attachment TT)**	David presented the 2022 PMH Clinic Financials.	None.	None.
C. Appoint New PMH Foundation Board Member- Belem Grey	The PMH Foundation Board recommended we appoint Belem Grey as a New Foundation Board Member.	A Motion to approve the New PMH Foundation Board Member- Belem Grey was made by Commissioner Reams and seconded by Commissioner McPartland. The Motion passed with 7 in favor, 0 opposed.	None.
VII. EMPLOYEE ENGAGEMENT	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
VII. EMPLOYEE ENGAGEMENT **A.** CPI Review **(Attachment II)**	Craig presented the CPI Salary adjustments for staff totaling $1,159,710 to be implemented in the 1st full pay period in February.	A Motion to approve CPI Adjustments as proposed was made by Commissioner Bowden and seconded by Commissioner Reams. The Motion passed with 7 in favor, 0 opposed.	**None.**
VIII. SERVICES	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Capital Request- ERCP Scopes	Craig presented the Capital Request- ERCP Scopes at a cost not to exceed $140,000 as budgeted.	A Motion to approve the Capital Request- ERCP Scopes at a cost not to exceed	None.

(Attachment TTT)		$140,000 was made by Commissioner Reams and seconded by Commissioner Dietrich. The Motion passed with 7 in favor, 0 opposed.	
IX. QUALITY	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
A. Review 2022 Quality Assurance Program Plans **(Attachment AA)**	Kristi reviewed the 2022 Quality Assurance Program Plan and presented the 2023 Quality Assurance Program Plan.	A Motion to approve the 2023 Quality Assurance Program Plan was made by Commissioner Reams and seconded by Commissioner Bowden. The Motion passed with 7 in favor, 0 opposed.	None.
B. Review 2022 Risk Management Program Plans **(Attachment BB)**	Kristi reviewed the 2022 Risk Management Program Plan and presented the 2023 Risk Management Program Plan.	A Motion to approve the 2023 Risk Management Program Plan was made by Commissioner Reams and seconded by Commissioner Bowden. The Motion passed with 7 in favor, 0 opposed.	
C. Board Officers **(Attachment GG) (Attachment HH)**	Board Officers for 2022 were reviewed: Steve Kenny, PH.D., President; Keith Sattler, Vice President; and Glenn Bestebreur, Secretary. All current officers indicated their willingness to continue in their current roles.	A Motion to approve the following Board Officers for 2023: Steve Kenny, PhD-President; Keith Sattler-Vice President; and Glenn Bestebreur was made by Commissioner Bowden and seconded by Commissioner Reams. The Motion passed with 7 in favor, 0 opposed.	None.
D. Board Committees and Membership **(Attachment HH)**	Craig presented the 2022 Board Committee Structure and membership.	A Motion to approve the 2023 Committee Structure and membership was made by Commissioner Dietrich and seconded by Commissioner Reams. The Motion passed with 7 in favor, 0 opposed.	None.
E. Legislative and Political Updates	Glenn Bestebreur gave a brief Legislative and Political Update.	None.	None.

F. CEO/Operations Report	Craig provided a brief Operations Report based upon his written report included in the January Board Packet.	None.	None.
There being no further regular business to attend to, Commissioner Kenny adjourned the regular business meeting at 7:10 p.m. The Board entered into Executive Session at 7:12 p.m. which was expected to last approximately 1 hour.			
X. EXECUTIVE SESSION			
A. RCW 42.30.110 (g) To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee.			
XI. RESUME SESSION			
Open Session resumed at 8:15 p.m.			
XII. ADJOURN			
There being no further business to attend to, Commissioner Kenny adjourned the meeting at 8:16 p.m.			

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser Memorial Health

Mission: Prosser Memorial Health will improve the health of our greater community.

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

JOINT CONFERENCE COMMITTEE	FEBRUARY 15, 2023	VINEYARD CONFERENCE ROOM

COMMITTEE MEMBERS PRESENT	NON-MEMBERS PRESENT
• Commissioner S. Reams • Commissioner S. Kenny • Dr. D. Carl • C. Marks, CEO • Dr. D. Weaver • Dr. B. Sollers	• 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 0700 am.		
APPROVAL OF MINUTES	Minutes for January 2023 were reviewed and approved by the Committee.	For informational purposes only.	Standing agenda item.
QUALITY			
2022 SPH Annual Assessment and 2023 SPH Program Plan	M. Fuller reported the SPH 2022 Annual Program Risk Assessment and 2023 SPH Goals. This is a State of WA RCW that a Safe Patient Handling Committee be established. At least half of the members are frontline nonmanagerial employees who provide direct patient care. There were ten patient handling injuries in 2022. Four injuries occurred while caring for a known combative patient. We want to ensure that we deliver consistent training on lifting equipment. We will be creating videos with our staff with our equipment.	Motion was approved and seconded. Approved.	No necessary follow up.

EOC/Safety Committee Update	K. Mellema shared the Safety & EOC Committee meeting minutes for January. All past due rounds have been given a clean slate and will start fresh this year. There was on safety recall on the 2016 F0350 Ford Truck/Ambulance. Two fire drills conducted on 11/30/2022 and again 12/22/2022. There were two falls at the Grandview Clinic with one workers compensation pending. The Physical Therapy clinic has a piece of equipment with a seat that is showing signs of wear and cracking. Education for leaders will be provided on the colored stickers used by BIOMED. Finally, Eric G. from WSHA attended the January Safety/EOC meeting.	For informational purposes only.	No necessary follow up.
The Chartis Group INDEX Report (iVantage)	K. Mellema shared the INDEX report from Fall 2022 and Winter 2023. PMH index rank for Fall 2022 was 13.3 and the index rank for Winter 2023 is 79.2 which indicated a significant increase in all of the pillars except for Outpatient Market Share.	For informational purposes only.	No necessary follow up.
PATIENT LOYALTY			
January 2023 Patient Satisfaction Data	M. Fuller reported that the Top Box score has been added to the Patient Loyalty Summary Report. In 2022, we exceeded our goal with the YTD (January 2023) is at 92.62%. The percentage rank 2022 has been added to the Summary Report as well. Top box is how our satisfaction data is publicly reported as overall favorability. The mean is an indicator of what we have done in a month and if it has it made an impact.	For informational purposes only.	Standing agenda item.
2023 Patient Engagement Plan	M. Fuller reported that the guiding principles of the plan are based on the Patient and Family Center Care (IPFCC) core concepts: Dignity and Respect, Information Sharing, Participation and Collaboration. Initiatives in 2023 will be focused reconnecting with our patients and community in the pandemic recovery period. We will continue to ensure timely information informs our patient care practice and we are providing education to our community. These initiatives are all included in the 2023 Strategic Plan under Patient Loyalty.	Plan has been recommended to the Board for review and approval.	Board of Commissioners
SERVICES			
Replacement Facility	C. Marks reported that we have had issues with communicating with the DOH for about two months. We were notified recently that our project has been handed off to another member of the DOH team which is the head of the whole department.	For informational purposes only.	No follow up necessary.

	We are working with the City of Prosser for a development agreement to delay any improvements to north Gap Road for the next 10 years until significant development occurs out there. This agreement will go before the Board for approval. WA DOT has a vision to put in a roundabout at the offramp on Gap Road. They want PMH to contribute $55,000 and when they decide to put in the roundabout, that $55,000 will be our contribution. A lot of dirt being moved on the property and the building pad is complete. The excavation team is working on putting in temporary roads and SVID will start to bury the canal next week which will take approximately a month. A fence will be put up around the site and construction trailers will be going in. Over the next month or two, they will be building a mock exterior of the hospital, including windows and materials that will be on the hospital. It gives us an opportunity to explore how the building will be put together and test water penetration.		
MEDICAL STAFF DEVELOPMENT			
Medical Staff Recruitment	Dr. Sollers reported that we have had a gap in care at the Prosser clinic. Dr. Rivero has started and will boost the Occupational Health program. PMH is actively looking at a family medicine candidate, but his residency is not complete until June 2023. We plan to recruit him, and he also was a previous employee of the hospital lab. There has been several ARNP candidates for primary care but there is a need for a physician at the Prosser clinic. The Dermatology clinic is growing and expanding with workstations for the MAs, office space and procedure room. There are changes in the Behavioral Health program. We do not have a nurse practitioner in the Benton City clinic, but we are currently recruiting.	For informational purposes only.	No follow up necessary.

	Dr. Higgs, orthopedic physician, will be starting in May. There is a potential outpatient Internal medicine candidate from tri-cities. We are also recruiting another pediatrician for the Prosser clinic. Dr. Dingwall is joining us in March. Dr. Barber is starting May 6th in the ED. Our biggest focus this coming year is supporting our providers appropriately.		
EMPLOYEE DEVELOPMENT			
Employee Engagement	C. Marks reported that we did the Super Bowl contest this year with 400 participants. Yesterday was Valentine's Day and we took around chocolate and flowers to staff. March Madness is around the corner.	For informational purposes only.	No follow up necessary.
AHA Rural Health Governance Conference	There are four Board members and Craig planning on attending the conference which is next week. There will not be a Board work session this month due to the conference.	For informational purposes only.	No follow up necessary.
FINANCIAL STEWARDSHIP			
Financial Performance – January 2023	C. Marks reported that we had a strong revenue month. We are significantly higher than last January.	For informational purposes only.	Standing agenda item.
Audits	C. Marks reported that we are undergoing two audits right now one with the state and one with DZA who is doing the financial audit.	For informational purposes only.	No necessary follow up.
ADJOURNMENT & NEXT SCHEDULED MEETING			
Meeting adjourned at 0807			
Next scheduled meeting March 22, 2023			

K. Mellema 2/15/2023

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser Memorial Health

Mission: Prosser Memorial Health will improve the health of our greater community.

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

FINANCE COMMITTEE MEETING
Monday – February 17, 2023,
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 – January 23, 2023, Minutes

II. FINANCIAL STEWARDSHIP

A. Review Financials –January 2023 **(Attachment CC)** **David**
Action Requested – January 2023 Financial Statements

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

C. Voucher Lists
Action Requested – Voucher List - Payroll and AP Vouchers # 170530 through #171085 **David**
Dated 01-18-23 through 02-15-23 in the amount of $6,674,692.70. Surplus Item Resolution # 1076: (3) Medical Beds, and (1) Pharmacy Balance.

D. Capital Request- ERBE **(Attachment K)** **David**
Action Requested-ERBE at a cost not to exceed $26,214.

E. ERP Update-Multiview **David**

III. ADJOURN

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

FINANCE COMMITTEE MEETING	January 23, 2023	VINEYARD CONFERENCE ROOM	
			GUESTS
~~• Keith Sattler~~ • Neilan McPartland • Brandon Bowden	• Craig Marks, CEO • David Rollins, CFO • Stephanie Titus, Director of Finance		
AGENDA	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
I. CALL TO ORDER	Neilan McPartland called the meeting to order at 7:46 a.m.		
II. APPROVE MINUTES		A motion to approve the Finance Committee Meeting Minutes for December 12, 2022, as presented was made by Neilan McPartland. The motion was seconded by Brandon Bowden and approved.	None.
III. FINANCIAL STEWARDSHIP **A.** Review Financials – December 2022 **(Attachment T)**	Net Income of $1,495,119 in December and Gross Charges were $24,525,174 which was 33% higher than budget for the month and 39% greater than the prior year. Net Operating Revenue came in at $8,796,771 (18% over budget).	A motion to recommend acceptance of the December 2022 Financial Statements as presented to the PMH Board of Commissioners was made	None.

	Expenses were $7,465,463 in December and 8% over budget. Surgeries were 307 vs 191 budget and ER visits were 1,636 vs 1,104 budget. Cash Flow was ($4,039) for the month and $4,497,795 YTD. AR were at a net 56 days overall.	by Brandon Bowden. The motion was seconded by Neilan McPartland and approved.	
B. Review Accounts Receivable and Cash Goal	AR was at 56 net days overall as Collections were $10,060,253 and greater than goal of $8,290,271 and greater than prior year total of $7,758,658. POS collections were $26,096 exceeding a budget of $15,000 but lower than prior year $27,972. POS collections YTD are $423,089 versus $180,000 budget and $227,060 prior year.	None.	None.
C. Voucher Lists Payroll and AP Vouchers #169603 through #170529 Dated 12.08.22 through 01.17.23 in the amount of $10,754,384.21.		A motion to recommend approval of the Voucher Lists #169603 through #170529 Dated 12.08.22 through 01.17.23 in the amount of $10,754,384.21. was made by Neilan McPartland, seconded by Brandon Bowden, and approved.	None.
D. Capital Request- ERCP Scopes **(Attachment TTT)**		A motion to recommend approval of the Capital Request- ERCP Scopes was made by Neilan McPartland, seconded by Brandon Bowden, and approved.	None.
IV. ADJOURN			
Having declared no further business, the meeting was adjourned at 7:53 am.			

MEMORANDUM

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

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

DATE: **February 2023**

RE: **CEO REPORT**

SERVICES

1. Replacement Facility Update

It's official, we have made it through the winter weather delays and our construction is now moving full speed ahead! This month we have focused on several design issues and are gradually shifting our focus to construction, the schedule, and our construction budget. Some of the recent activity on the project is contained in the Owner's Representative Monthly Progress Report **(Attachment A)**; minutes from our last (February 7th) Owners/Architects/Contractor (OAC) Meeting **(Attachment B)**; a monthly construction update from Bouten Construction **(Attachment C)**; a construction schedule from Bouten Construction **(Attachment D)**; and a Construction/Project Budget from NV5 **(Attachment E)**. There is no financing activity to report in February other than to say that we continue to work very closely with the USDA on the review of all payment vouchers for expenses related to the project.

A. Design

Last month I reported that despite daily attempts to contact the Washington Department of Health (DOH) regarding questions they raised about our project, we were unsuccessful. We continued to reach out daily this past month and recently learned that our project review has been handed over to a new (our third) DOH official. The official is John Williams, Executive Director of Construction Review Services at the Washington DOH. Mr. Williams has over 25 years of experience with healthcare design and regulation and is the leader of this department at the DOH. We look forward to working with Mr. Williams and his comments regarding our responses to issues previously identified. We now have a draft Development Agreement **(Attachment F)** with the City of Prosser to defer North Gap Road improvements until development in the area occurs (up to 10 years). Once the City approves the Agreement, the PMH Board will be asked to approve it, which we hope occurs in February. We also continue to wait for the Washington State Department of

Transportation (WSDOT) to approve our Intersection Control Evaluation (ICE) study and remediation plan for the intersection of North Gap Road and the I82 westbound on and off-ramps. We anticipate that WSDOT will require us to contribute approximately $55,000 to WSDOT for future improvements (a roundabout) they plan to make at the intersection. We will notify the Board when we sign the agreement with WSDOT, which the Board previously approved. Last fall we conducted a furniture fair at the hospital allowing PMH staff to see and try furniture preliminary selected for our project. Several pieces were not well liked and based on this feedback, Open Square (our furniture consultant) has identified several possible replacement pieces **(Attachment G)**. We plan to have several of these pieces shown again to our staff this fall. Stay tuned for when we will conduct a second Furniture Fair.

B. Construction/ Schedule/ Budget

In addition to their monthly report, Bouten Construction will also be providing us with bi-weekly construction updates. The first update **(Attachment H)** demonstrates the excavation progress being made on preparing the building pad, work on temporary roads and trailer locations, and the burying of utilities (water, sewer, electric). On February 20, Sunnyside Valley Irrigation District (SVID) plans to begin burying the overflow canal and plans to be done in approximately four weeks. Next week a security fence will be installed around the project to limit traffic on the site and protect the project as it is being constructed. Periodic tours of the site will be provided to the Board, staff, and Medical Staff when we reach construction milestones and there is something to see. Representatives from Bouten will be at the February Board Meeting to update the Board on all construction activities **(Attachment C)**; the construction schedule **(Attachment D)**; the deferred alternates and value engineering matrix **(Attachment I),** and the change order proposal log **(Attachment J)**. Representatives from NV5 will attend the February Board Meeting virtually and will present an updated construction/project budget with current expenditures **(Attachment E)**. Because there is not a Board Work Session in February, the replacement project updates will be given during the February Board Meeting.

2. Capital Acquisition-ERBE

The ERBE is an electrosurgical machine that uses Argon gas for the management of bleeding and polyp removal during GI procedures **(Attachment K)**. It prevents unnecessary damage to fragile tissue. Our current ERBE is used essentially every day now that we have two Gastroenterologists. It is connected to our current GI tower that permanently stays in the GI Suite. It should not be disconnected and moved from room to room. We are requesting another ERBE device because they are also critically important during ERCP's,

which are performed in the OR suite. The second ERBE will connect to our other Olympus tower to be used with Dr. McDonnell during ERCPs. It is important to note that in order to perform some procedures, the ERBE is not only essential, but also required. When planning for the addition of ERCPs at our facility, the need for an additional unit was not known. As a result, it was not included in our 2023 capital budget. It should also be noted that this piece of equipment will be used at our new facility. The Board will be asked at the February Board Meeting to approve the acquisition of an additional ERBE at a cost not to exceed $26,214.

Medical Staff Development

1. Medical Staff Recruitment

With the approval of the 2023 Medical Staff Recruitment Plan, we are aggressively pursuing candidates that will help meet the needs of the community we serve. To support this claim, we have successfully recruited six of the eleven providers identified in the plan. The remainder of the providers are predominantly in primary care (internal medicine, family practice, pediatrics). We are currently virtually interviewing several primary care providers and hope to have them visit in the near future. We have also extended contracts to several primary care physicians for their review. We are very optimistic about our ability to address the unmet primary care needs in the area for the coming years.

2. Medical Staff Leadership

2023 is the year of significant Medical Staff leadership changes at Prosser Memorial Health. Effective January 1st, 2023, Dr. David Carl became our new Chief of Staff and Dr. Jose Santa-Cruz became our new Vice Chief of Staff **(Attachment L)**. I would like to thank Dr. Jared Clifford outgoing Chief of Staff, for his outstanding leadership the past two years during some very challenging times. Thank you! In addition, we have several new providers assuming leadership positions including Dr. Steven Rode-Credentialing Committee Chair; Dr. David Barber-Emergency Department Committee Chair; Dr. Heidi Weaver-Perinatal/Pediatric Committee Chair; Dr. Coral Tieu-Surgery Committee Chair; and Dr. Suzanne Staudinger-Community Clinics Community Chair. Please join me in congratulating all of our new Medical Staff leaders! I have also included in the Board Packet our most recent pictorial of the PMH Medical Staff **(Attachment M)**. What an outstanding group!

3. Medical Staff Activity

A comprehensive list of Medical Staff Committee activities for the fourth quarter of 2022 is included in the Board packet for your review **(Attachment N)**. Some of the significant activities during the fourth quarter included ongoing internal and external quality chart reviews; the review of 33 new appointment and reappointment applications to the PMH Medical Staff; the development, and or, revision of numerous clinical policies; and the provision of ongoing clinical education. It should be noted that the PMH Medical Staff provided outstanding leadership and guidance throughout the busiest year in the history of PMH and are to be thanked for their commitment to our patients, staff and PMH. Finally, February 3 was National Women's Physicians Day, and we were pleased and proud to recognize our great providers **(Attachment O)**.

Employee Development

1. Employee Engagement

We began the New Year with several engagement activities. In January, we celebrated our tenured employees at the Years of Service Recognition event for our employees celebrating five years through thirty-five years of service. We munched on popcorn celebrating National Popcorn Day and held multiple sessions of on-site debriefs for the results of the Engagement Survey. We also held our Annual Super Bowl Squares Contest, which made the game a little more exciting as we watched to see if we would have winning numbers. In total, we had 400 PMH team members participate, which surpassed the 250 participants last year. Congratulations to the winners **(Attachment P)** and thank you to everyone that participated. On February 14, we celebrated Valentine's Day by distributing Valentine's chocolates and a Carnations to all staff, to help brighten everyone's day. As spring approaches, it is now time for everyone to start watching college basketball in preparation for the PMH March Madness Contest. Unfortunately, it does not currently look like the University of Washington, Washington State or the University of Minnesota will make the NCAA Tournament. Good luck and go Zags! I have also included our employee newsletter, The Pulse, in the Board packet **(Attachment Q)**. This month's newsletter highlights some of our employees that were recently recognized for their Years of Service in addition to our Aspire Award Winners, new providers, etc.

2. Employee Engagement Survey Follow-Up

Follow-up on the results of the 2022 Employee and Provider Engagement surveys are well underway. Human Resources, led by Bryon Dirkes, Chief Human Resources Officer, has been meeting with Prosser Memorial Health leaders to review and analyze their departmental engagement results and help the leader prepare and co-facilitate team-level action planning sessions. Following this review, each leader will identify the two to three most important work items to focus on and then create a personal action plan. Each team will also create a team plan. The goal in creating team action plans is to identify opportunities for team members to address the most important items while performing their daily work, not to create "extra" things to do. Once departmental action plans are created, each leader will enter their plans into the LEM using the 90-day plan feature and post the team plan on the department ASPIRE board. Over the next several months, department leaders will share plan updates with their one-up leader and monthly updates to the team and post on their ASPIRE board. Medical Staff meetings will be held at each location (clinics and hospital) to address Medical Staff results. Annie Parker, Chief Clinic Operations Officer, will first work with the Medical Directors of each location to review and analyze results and then hold provider meetings to discuss the results, identify the most important items and then prepare an action plan to address the identified opportunities for improvement. Again, the goal in creating action plans is to identify opportunities to address the most important items while performing daily work, coinciding with this activity. Human Resources will be working with leaders to identify best practices in employee engagement to support future leadership development opportunities and mentoring relationships where leaders with strengths in one or more engagement practices can partner with leaders focused on improvement in those areas. In addition, we are working with Huron to assist our leaders to demonstrate successful leadership traits everyday **(Attachment R)**.

3. IAFF Negotiations Update

Prosser Memorial Health has reached a tentative agreement with International Association of Firefighters (I.A.F.F), local I-24. The union represents 21 full-time and part-time EMTs and Paramedics after six negotiating sessions, the Union and Prosser Memorial Health leadership held mediation on January 5 and a second and final session on February 1, where a tentative agreement **(Attachment S)** was reached. The International Association of Firefighters union members will be voting on the agreement in the next few days to ratify the contract, at which time, the ratified agreement will be brought before the Board for approval. If the vote has not occurred before the February Board Meeting, the Board will be asked to approve the contract in March.

4. 2022 Incentive Compensation Program

This past year was challenging as we continued to grapple with the end of the pandemic and saw our volumes grow to levels PMH has never experienced. Throughout all of this, the PMH team performed well, as illustrated on our Pyramid of Success **(Attachment T),** where we exceeded four of our Pillar Goals for 2022. The current PMH Incentive Compensation Program rewards leaders and exempt staff (non-leadership) when PMH performs well, and most importantly exceeds budgeted financial expectations ("open the gate"). In 2022, PMH exceeded budgeted net income expectations by $5.5 million, with all COVID-19 relief funds removed from our income statement **(Attachment U)**. Per policy, up to 50% of the excess income ($2.76 million) can be used in the Incentive Compensation Program. Based on the overall 2022 hospital LEM score of 3.39 out of five **(Attachment V)** and the scores of individual departments (the average score was 3.64), PMH will pay approximately $388,679 of incentive compensation to the leaders and exempt (non-leadership) staff in April per policy **(Attachment W)**. Congratulations to everyone that earned incentive compensation in 2022.

5. 2023 Incentive Compensation

As I stated last year and I state again, my goal since I arrived at PMH has been to implement an Incentive Compensation Program for our entire Team, and I believe that it is time to do so. Our success in 2022 was not just because of the efforts of leaders and exempt staff, but because of the efforts of everyone. Recognizing this, I am proposing to the Board in February that all staff (excluding providers who already have incentive-based contracts) be included in the 2023 PMH Incentive Compensation Program **(Attachment X)**. This Program rewards our Team when PMH is successful as measured by our Pillar Goals. The better PMH does, the better our Team will do. The Program allows the Leadership Team to earn up to 15% incentive compensation and all other staff up to 5% incentive compensation each year. It should be noted, however, that the only way the Program pays anything is if PMH exceeds its budgeted net income or bottom line. This is referred to as "opening the gate". An individual's score is comprised of 50% from the overall hospital performance LEM score and 50% based on their specific department's LEM score. As an example, if this program had been in place in 2022, it would have paid approximately $1.35 million in incentive compensation to our Team and decreased our net income in 2022 by approximately $572,142. In my experience, this program has worked well to reward all staff for their contributions to the success of the organization and the organizations using it also thrived. If the Board approves the 2023 Incentive Compensation Program, it must be approved by our three unions before it can be implemented. If approved by everyone and we have a good year, the first incentive compensation checks will go out in April 2024. Since the program appears to be very complicated, we will conduct Open Forums to explain it to our entire team in the near future.

It should be noted that for all union staff, this system will not be used to determine their annual salary increases. They will continue to use their step system outlined in their contracts. Like previous years however, leaders and exempt (non-leadership) staff will use this system to calculate their annual pay increase by combining 80% of their LEM score and 20% of their Performance Appraisal Rating **(Attachment Y)**. This will result in an annual pay increase between 0% and 5%, depending upon an individual's performance **(Attachment Z)**. Based on previous years, this typically results in an average wage increase between 3.5% and 4.0% for leaders and exempt (non-leadership) staff.

6. 2023 Healthcare Workforce Scan

One of the most significant outcomes of the pandemic has been the increase in staff turnover and the overall shortage of healthcare workers across the country. As a result, the American Hospital Association (AHA) recently released a publication that helps define the challenge and explore possible solutions **(Attachment AA)**. Fortunately, PMH has been able to keep our turnover rate below 10% (8.4% in 2022), which far exceeds national averages. However, we must remain vigilant, and we are committed to continuing to enhance our engagement efforts throughout our organization.

Patient Loyalty

1. 2023 Patient Engagement Plan

The 2023 Patient Engagement Plan is being presented for Board approval this month **(Attachment BB)**. The guiding principles of the Institute of Patient-and-Family-Centered Care (IPFCC, 2018) help assess and direct our efforts: Dignity and Respect, Information Sharing, Participation, and Collaboration. We aim to deliver appropriate and timely care in partnership with the patient and their support system. The patient's perception of the care they receive is impacted by whether they felt we listened well, communicated in a way they could understand, and cared about them as we cared for them. Patient Satisfaction Survey results, patient comments, patient complaints, Service Recovery activity, and employee and provider feedback are all utilized to assess the successful implementation of our initiatives. We have identified 20initiatives for 2023, with several explicitly focusing on patient flow and improving access to care both in the hospital and across the clinics. The 2023 Plan is ambitious and comprehensive but will continue to expand as needs or new ideas are identified.

Financial Stewardship

1. Financial Performance- January

The best way to start the new year for any business is by having a strong financial performance in the first month of the year and I am pleased to report that PMH had a great start in January **(Attachment CC)**. Most of our patient volumes exceeded budget and prior year, and as a result, our gross revenue set a new monthly record ($25.5 million) exceeded budget by $3.0 million and exceeded last January by $8.5 million. It should be noted, however, that last January/February our Governor did restrict our ability to do routine outpatient surgeries, which negatively impacted our gross revenue. Our contractual allowances and deductions from revenue were in line with our increased revenue resulting in a net revenue of $9.46 million or 18% better than budget. Our operating expenses were 6% over budget, but understandable based on our increased volumes/revenue. This resulted in a very strong operating income of $1.2 million for January compared to our budgeted net income of $266,237. After adding in our non-operating income, our total net income was $1.28 million for a total margin of 13.5%. Outstanding! These results exceeded budget expectations as well as January 2022. It is a great way to start a new year. There is nothing to report regarding our year-to-date performance as it is the same as our January performance. In addition, we experienced a positive cash flow of $552,488 in January despite significant investments in our replacement facility project. As a result, our balance sheet remains strong with over $35 million in cash/investments, which positions us well as we begin a new year.

2. Audits

We are currently in the process of having two audits completed at PMH. The first is our annual State of Washington Accountability Audits which focuses on accounts payable, payroll, accounts receivable, cash receipting, IT security, etc. as they relate to following applicable state laws and regulations, to ensure that we provide adequate controls over the safeguarding of public resources. This audit is wrapping up and the exit conference will be held on February 22 or 23. The second audit is our financial audit, which is being conducted by Dingus, Zarecor and Associates (DZA). DZA is currently progressing on the audit (remotely) and plan to present their findings to the Board at the March Board Work Session.

3. PMH Foundation Update

Planning is underway for Bottles, Brews, Barbecues June 9 & 10th! The event steering committee, as well as subcommittees, are meeting regularly to divide up the ideas and the tasks to be done to ensure we have another great event! Early bird ticket sales will go live on the Foundation's website: https://www.prosserhealth.foundation. Shannon is working directly with the Foundation Board of Directors to identify capital campaign donors and schedule meetings to go over the project and our campaign goals.

We are now accepting applications for the Auxiliary Scholarship Fund. These are available for seniors in Prosser, Grandview, and the Kiona-Benton School Districts who are interested in pursuing degrees in healthcare. The application can be found on our foundation website: https://www.prosserhealth.foundation. This month the Foundation will ask the Board of Commissioners to approve Lori Gardner joining the Foundation Board. Lori and her husband Chris live in Sunnyside and are very active in the community. Lori also owns French Vanilla Market and has been our gift shop vendor for almost two years. The Foundation Board will ask the Board of Commissioners to approve the updated Operating Agreement between the Hospital and the Foundation **(Attachment DD)**. The State Auditors have requested this document be updated as it has been four years since we last reviewed it.

QUALITY

1. Chartis (iVantage)2023 Performance Summary

The Chartis Group (aka iVantage) publishes the Top 100 Critical Access Hospital list every year. We have contracted with The Chartis Group for the last three years to help drive our own improvement by utilizing their benchmarks from the Top 100 Hospitals. The INDEX reports are published three times a year, Fall, Winter, and Spring. Our last report from 2022 was received December 9 which showed that our Index Rank was 13.3 out of a 100 **(Attachment EE)**. Our highest Index Rank so far has been 27.6 in the Fall of 2021. It's important to note that the data that is used to create these reports comes from publicly reported data to CMS and is anywhere from one to two years old. With that being said, I am happy to report that we received our Winter 2023 Index report this week **(Attachment FF)** and our Index Rank is 79.2!!!!! This is finally a data driven representation of the hard work that has been going on throughout our organization. There was a huge increase in our Finance Pillar from 29 in Fall 2022 to 81 in Winter 2023; Inpatient Market Share went from 33 to 53; just to name a few. Our most recent ranking of 79.2 puts us in the top quartile of all Critical Access Hospitals in the Country. We have made huge gains and it's all thanks to the leadership of our organization, providers, and staff! They go above and beyond every day to

deliver excellent care to our patients and it's great to see that hard work being reflected in this report. Job well done!!!

2. 2023 Board Action Plan

In December, the Board completed a self-evaluation, which was discussed at the January Board Meeting. Based on the discussion, I drafted a 2023 Board Action Plan to address the greatest opportunities for improvement identified during the evaluation process **(Attachment GG)**. These opportunities include Board education; continuing to build and maintain strong relationships with our Medical Staff and Leadership Team; etc. The Board will be asked to review the Plan and approve it at the February Board Meeting.

3. COVID-19 Update

It has been a long time since I have written about the COVID-19 pandemic, but the Biden Administration recently informed Congress that it will end the COVID-19 National and Public Health Emergencies (PHE) on May 11, 2023. This signals an end to the pandemic crisis era and an unwinding of federal flexibilities that reshaped the nation's healthcare system. In response, the American Hospital Association (AHA) did two things. First, they developed a Special Bulletin **(Attachment HH)** which outlines several changes that may affect hospital operations and key dates for when certain waivers will expire **(Attachment HH)**. Second, they sent a letter to the Department of Health and Human Services Secretary Xavier Becerra urging the department to take several actions to stabilize the healthcare delivery system, support the healthcare workforce, and remove unnecessary administrative and regulatory burdens **(Attachment II)**. We do not believe that the ending of the PHE will have any material effect on PMH, and we anxiously await our Governor's response, which may have more of an impact on us (e.g., the requirement to wear masks in all hospitals in the State of Washington). Stay tuned….

4. Board Education

A priority for our Board, as indicated in the 2023 Board Action Plan, is the ongoing education of our Commissioners. To that end, we will attempt to notify the Board of conferences they may want to attend. Next week four commissioners and I will attend the 36th Annual AHA Rural Healthcare Leadership Conference in San Antonio. Additional upcoming conferences include: the 2023 AHA Annual Membership Meeting in Washington D.C.- April 23-25 **(Attachment JJ)**; and the Washington Rural Hospital Leadership Conference in Lake Chelan-June 27-28 **(Attachment KK)**. If you are interested in attending these conferences, please contact Rosemary (786-6651).

5. AHA 2022 National Healthcare Governance Report

American Hospital Association (AHA) has periodically surveyed the nation's hospitals and health systems since 2005 to get a picture of how they are governed **(Attachment LL)**. This picture looks at nine areas that the AHA deems significant ranging from diversity to selection. In total 933 hospitals participated in the survey including PMH. This Report is only being presented for information.

6. February Board Meeting

A reminder that we do not have a Board Work Session in February, only the regular Board Meeting on February 23. At the Board Meeting the Board will receive an update on our replacement facility project that will address design, construction, schedule, and budget topics. The Board will be asked to approve: a Development Agreement with the City of Prosser; the acquisition of an ERBE at a cost not to exceed $26,214; a new PMH Foundation Board Member- Lori Gardner; a PMH Foundation Operating Agreement; the 2023 Patient Engagement Plan; a 2023 PMH Incentive Compensation Program; the IAFF Contract; and the 2023 Board Action Plan. The Board will also go into Executive Session and is expected to take action after the session.

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

NV5

Prosser Public Hospital District
Prosser Memorial Health Replacement Hospital
Progress Report

DATE: **February 15, 2023**

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
Introba (f/k/a Ross & Barruzzini)	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. Benton Public Utility District (BPUD), Developer's Agreement to provide electric utility service to the replacement hospital. A similar agreement was previously executed December 21, 2021, but it expired after one year without any utility construction activity due to the delay in the overall project construction commencement. PMH Administration signed the revised development agreement on February 8, 2023, which then enabled Bouten to schedule BPUD for electric utility construction efforts.
   b. Agreements, contracts and/or amendments *in process this period*:
      i. City of Prosser – Voluntary Agreement for Deferral of Frontage and Street Improvements. The project team has been working to finalize the Deferral Agreement with the City of Prosser, with Perkins Coie leading the charge on these efforts. Attorney Megan Lin, of Perkins Coie, returned the latest draft to the City on February 8 and does not expect disagreement from the City as we work to finalize the agreement. A copy of this agreement accompanies this month's board report. Once Megan and the project team feel the negotiations have culminated, the agreement will be finalized for PMH's approval and execution.

B. Site Development and Coordination
   a. Sunnyside Valley Irrigation District (SVID) – As noted in previous board reports, the project team is proceeding with moving the SVID overflow canal underground in its current location. SVID and Bouten Construction continue their coordination efforts regarding new utilities that will cross the ditch and the undergrounding of the ditch itself. While previously, SVID intended to start the undergrounding work the week of January 23, 2023, they currently anticipate commencing the work on February 27 and completing the work in March, 2023.

C. Design – Building
   a. bcDG continues in earnest to finalize its review with the Washington State Department of Health. The latest challenge from the Department is the indefinite leave of this project's

reviewer. As of early February, the project has been reassigned to John Williams, who is the head of this portion of the Department. John has been involved with the project since the earliest review meetings in 2021, which will hopefully allow him to efficiently close out the remaining review items on the project.

D. Permitting
   a. Local and state authorities having jurisdiction have permitted the project for construction.
   b. The project team continues to wait for a final signed copy of the Intersection Control and Evaluation (ICE) report that the project team sent to the Washington State Department of Transportation (WSDOT) in May. bcDG's traffic consultant, TranspoGroup, understands that WSDOT has completed their review and has no further comments, but that getting physical signatures is taking longer than anticipated. The project team hopes to receive a signed copy of the ICE by the end of this month.

E. Construction
   a. Please see construction phase reports issued by Bouten Construction and included in this month's Board Packet. In general:
      i. Construction is proceeding in earnest, with continued focus on preparing the soil for the placement of the building pad. Bouten encountered issues with soil performance at various points throughout the sitework efforts this month, though these issues were not atypical for this type of work. PMH's Geotechnical Engineer, GPI, was on site to advise Bouten on how to resolve the soil performance issues, which were generally related to moisture content and compaction. Approaches to resolve these issues included swapping previously placed soil with soil that performed within limits; scratching the soil and letting it dry out; adjusting compaction techniques to arrive at design specifications. From all reports provided by GPI, these issues were resolved, and the placed soil appears to meet design criteria.
      ii. Underground utility installation commenced, specifically for the water, sewer and power infrastructure. Bouten's team encountered small outcroppings of bedrock during this process, which is again somewhat typical for the type of construction and the findings of the preliminary soil study (geotechnical report). Bouten's team therefore expended additional effort to break up the bedrock and remove it. The spoils of these efforts will be spread as fill on the western portion of the site, where Bouten's forces have been "mining" soils in support of the building pad construction. Costs for this additional work will be accommodated via the "Rock Removal" allowance in the MACC, which was specifically created during the GMP/MACC process for such purposes. The project team is working with Bouten to quantify the material removed and establish a cost for this work. The construction team has since moved beyond this area and have not encountered further bedrock.
      iii. The construction team also encountered groundwater during the utility trench construction, which GPI noted in their field reports. The consensus from the field team is that water was leaching from the irrigation canal and following cracks in the soil to the excavation location. They've since moved beyond this area and have not encountered further water.

F. Operations / Activation
   a. The project team is restarting a regular pattern of monthly operations meetings, intended to plan and provide training for the operational shift and move process that will occur when PMH transitions to the new facility in 2024. This effort is led by NV5's Paul Kramer and Kim Cunningham, NV5's Transition Coordinator, who are facilitating the meetings. The team will also be working with Introba to coordinate and conduct final equipment review and coordination meetings supporting this overall effort.

b. The Operations and Transition team will continue to develop the 'Functional Program Document', as requested and required by the Department of Health, to act as an 'Owner's Manual' for this process.

III. PROCUREMENT:

A. Upcoming project team members to procure include:
   a. Art Consultant, 2023.
   b. Signage Design and Fabrication vendor, 2023.

IV. SCHEDULE:

See summary project schedule, attached herewith.

V. BUDGET

A. Attached to this report is a copy of NV5's current budget for the project, including a list of all costs incurred since the last board meeting.
B. NV5 and PMH are working to submit the next Outlay Report (#2) to USDA, which will document USDA's concurrence with current project expenditures. This should be complete by the week of the board meeting.
C. The project team has not processed any change orders to the MACC, and as such the overall contract value remains unchanged. The project team has worked with PMH to process Allowance Usage Authorizations (AUA), Contingency Usage Authorizations (CUA), and potential Change Order Proposals (COP) which cover the following changes and associated costs:
   a. AUA 001: $100,000 in costs to cover the builder's risk insurance premium. The remaining
   b. CUA 001: $2,685.81 in costs to build a larger construction drive entrance for better control of soil and rock track out of the site.
   c. CUA 002: $23,364.07 in costs related to Building Pad Snow Removal and Freezing Temperatures. This is only a portion of the costs for weather impacts, the other portion will be processed as a change order.
   d. COP 007: $14,412 in costs to cover Building Information Modeling (BIM) efforts for integration of the building's pneumatic tube system.

VI. PROJECT CHALLENGES / RISKS:

A. **Construction** – Now that the project is in the Construction phase, some potential risks to successful project completion are as follows:
   a. **Weather.** As construction activities continue through the remainder of the winter season, the project site and the works are vulnerable to weather extremes, including excessive precipitation and extreme cold. For the month spanning the January and February board work sessions, weather was generally cooperative and the construction team has not made further delay claims due to weather. The risk remains until warmer, drier weather in spring and summer.
   b. **Excavation and site development.** While PMH engaged a geotechnical engineer to survey the soils within the project area and inform the design process, there remains a risk of encountering foreign debris under the surface (such as agricultural debris, trash and other discarded materials, polluted soils, etc.), and unforeseen rock.
   c. **SVID construction.** While SVID intends to complete the irrigation ditch undergrounding work in early February 2023, it is not possible to hold them accountable for timely construction as they are essentially a public utility. If SVID delays this work by several months or more, this would in turn prevent Bouten from completing their sitework (roads and parking lots, for example) as planned. While the likelihood of this occurring appears remote based on SVID's previous performance, the risk remains until the undergrounding effort is complete.

d. **Lead times.** Throughout the pre-construction phase, the project team has attempted to identify risk to project completion due to extended lead times for equipment and materials. Fortunately, this disruption in the industry appears to be waning; however, the team will continue to monitor this risk, plan as reasonably as possible, and keep the PMH Board informed of schedule or costs impacts due to this phenomenon.

B. **Imaging Department final design.** bcDESIGNGROUP is finalizing the design of the imaging department, as noted in previous board reports. The cost for constructing these areas will be covered by an allowance in the amount of $1,000,000 that was created for this purpose during the MACC process. The true cost of this buildout will be understood once bcDG issues their design drawings and Bouten is able to provide a proposal for the work. The project team will review this with PMH prior to proceeding with the construction of the imaging suite.

C. **Design Coordination.** As we enter the construction phase of the project, any imperfections in the design documents will be identified by the general contractor as they arise, and the design team will assist the general contractor with developing a solution. This is a normal part of the construction process, as no design is 100% perfect, and to that end we've carried a contingency to cover these unforeseen issues. The project team feels strongly that they've created a well-coordinated design and associated document set, which should create very few coordination issues; however, there is always a risk of a large unforeseen design issue that could consume a large portion of contingency. The project team will endeavor to keep PMH informed of these issues as they arise and resolve.

D. **Traffic Study** – The project team continues to wait for the State to sign off on the Intersection Control Evaluation (ICE) study that PMH's consultant, TranspoGroup, completed earlier this summer. This is the last step in approving the traffic mitigation measures identified by the project team and the City of Prosser. The team is hopeful that the WSDOT will return a signed copy this month. Ahead of this milestone, the team understands that the State has approved the Hospital's proposal to install a 4-way stop at N Gap Road and the I-82 westbound on/off ramps, though WSDOT requested PMH to pay a fee in lieu of the improvements, since WSDOT is in fact slated to construct a traffic circle in that intersection in the near future.

E. **Road Improvement Deferral Agreement –** As noted in this report, the project team is working to finalize the deferral agreement for improvements to North Gap Road. The team is advocating for the best interests of PMH and the community, but as this is a negotiated process, the City could require any number of scenarios, including: construction of a portion of the road improvements concurrent with the building construction; payment now in lieu of construction; future payment in lieu of construction; future construction concurrent with road improvements to the north and south of PMH's parcel. The project team is hopeful for the latter, and will keep the Board informed of any developments.

VII. NEXT STEPS:

A. Continue to manage and monitor the Construction Phase.

VIII. ATTACHMENTS:

A. NV5 Master Budget – Project Summary Report dated 2/15/2023
B. Bouten Construction Master Construction Schedule, summary format, dated 1/27/2023

Bouten Construction Company
1060 Jadwin Ave.
Suite 300
Richland , Washington 99352
P: (509) 943-7677
F: (509) 943-7877

Project: K-825 PMH REPLACEMENT HOSPITAL
200 Prosser Health Drive
Prosser, Washington 99350

OAC Meeting Minutes: Meeting #4

Meeting Date	Feb 7, 2023	**Meeting Time**	10:00 AM - 11:00 AM Pacific Time (US & Canada)
Meeting Location	Whitehead Conference Room, Prosser Memorial Hospital	**Video Conferencing Link**	https://teams.microsoft.com/l/meetup-join/19%3ameeting_YjJmZjU1Y2YtMWRiOS00MWUzLTkyYWMtOWFhYjI1ZWFjMjRi%40thread.v2/0?context=%7b%22Tid%22%3a%2231860f8f-210d-4c34-8de6-95c92e3f2a92%22%2c%22Oid%22%3a%229856971a-524a-4d39-9d27-e09a28da3541%22%7d
Overview	Owner, Architect and Bouten Team status meeting during construction.		
Notes			
Attachments	2023.02.06 - K825 6 Week Look Ahead Schedule.pdf, 2023.02.06 - K825 OAC Meeting 04 Agenda.pdf, 2023.02.06 - K825 Open Submittal Log.pdf, 2023.02.06 - K825 Open RFI Log.pdf, 2023.02.06 - K825 Open Change Logs.pdf		

Scheduled Attendees

Name	Phone Number
Hilary Beashore (BCDESIGNGROUP, LLC)	P: (913) 232-2123 ext. 806
Lance White (BCDESIGNGROUP, LLC)	P: (913) 232-2123
Heather Dunton (BOUTEN CONSTRUCTION COMPANY)	P: (509) 943-7677
Nick Gonzales (BOUTEN CONSTRUCTION COMPANY)	P: (509) 535-3531
Craig Niemela (BOUTEN CONSTRUCTION COMPANY)	P: (509) 535-3531
Rich Zoller (BOUTEN CONSTRUCTION COMPANY)	P: (509) 943-7677
Braden Demmerly (NV5)	P: (303) 220-6400
Adam Trumbour (NV5)	P: (303) 220-6400
Craig Marks (PROSSER MEMORIAL HEALTH)	P: (509) 786-6695

Name	Phone Number
Kurt Broeckelmann (BCDESIGNGROUP, LLC)	P: (913) 232-2123
Joshua Belt (BOUTEN CONSTRUCTION COMPANY)	P: (509) 713-0586
Blake Ellingsen (BOUTEN CONSTRUCTION COMPANY)	P: (509) 535-3531
Mac McGrath (BOUTEN CONSTRUCTION COMPANY)	P: (509) 943-7677
Cody Shepherd (BOUTEN CONSTRUCTION COMPANY)	P: (509) 943-7677
Gary Hicks (G.L. HICKS FINANCIAL, LLC)	P: (801) 225-0731
Paul Kramer (NV5)	P: (303) 220-6400
Merry Fuller (PROSSER MEMORIAL HEALTH)	P: (509) 786-6695
David Rollins (PROSSER MEMORIAL HEALTH)	P: (509) 786-6695

Attendees

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
1.1	1	Attendees - Unscheduled			Low	Open

Official Documented Meeting Minutes

- No additional this week.

Safety

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
2.1	1	Project Safety Update	Joshua Belt (BOUTEN CONSTRUCTION COMPANY)		Medium	Open

Official Documented Meeting Minutes

- Full PPE gear at all times while on site.
- Heavy machinery operating and open trenching going on. Please make eye contact with the equipment operators and be aware of your surroundings.
- Extremely muddy at this time, making it slick on site.
- Paul to make a one-page announcement for PMH team regarding staying off site from now on.
- Temporary fence beginning next week.
- scheduled site visits will be established.

Schedule

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
3.1	1	Schedule Review/Construction Phasing	Joshua Belt (BOUTEN CONSTRUCTION COMPANY)		High	Open

Description
Review the current 6 week look ahead schedule.

Official Documented Meeting Minutes

- Josh reviewed the 6-week High level look ahead schedule.
- Excavation going on for sewer pipes and deep utilities.
- Electricians will be starting next week.
- Temp roads should be started by end of this week.
- Site fencing will be starting next week. With temp fencing will come more signage regarding the site.
- Temp power is on schedule for March 15th.
- SVID crossing should start installation today or tomorrow.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
3.2	1	Lead Time Impacts	Cody Shepherd (BOUTEN CONSTRUCTION COMPANY) Blake Ellingsen (BOUTEN CONSTRUCTION COMPANY)		High	Open

Official Documented Meeting Minutes

- The Generators are in resubmittal process. Tracking 18-month lead time once released.
- Door frames and hardware are in review. Lance to schedule a meeting with NV5, PMH and BCC to discuss. Lance should receive comments back by the end of this week.
- Switch gear is approved and pending confirmation of order date to establish projected delivery date.
- Have not secured additional storage at this time, Mac will make contact with the Port of Benton to discuss.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
3.3	1	Design Team Site Visits	Mac McGrath (BOUTEN CONSTRUCTION COMPANY)		Low	Open

Official Documented Meeting Minutes

- No current update.

Previous Meeting Minutes
Jan 24, 2023

- BCC received the quantity of site visits and will put them on the schedule to help track.

Submittals

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
4.1	1	Submittal Log	Blake Ellingsen (BOUTEN CONSTRUCTION COMPANY) Cody Shepherd (BOUTEN CONSTRUCTION COMPANY)		Medium	Open

Description
Review the current open submittal log and high priority items.

Official Documented Meeting Minutes

- High Priority
  - 05 3100 Steel decking shop drawings, these are currently with Lance. Should be returned by the end of the day.
  - All Exterior finish submittals are currently with Lance, pending trip to Prosser for Kurt/Brooke.
  - 22 4000 Plumbing fixtures, overdue at this time and needs reviewed.
  - 26 2413 Service Entrance Terminal Cabinet, overdue at this time and needs reviewed.
  - 26 5100 Interior lighting, these are currently with Lance.
  - Design team is working on interior changes due to Sheet Vinyl manufacturer going out of business.
  - Substitution requests related to roof curb and dampers were approved verbally in the meeting by Paul and Craig.

RFI's

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
5.1	1	RFI's	Blake Ellingsen (BOUTEN CONSTRUCTION COMPANY) Cody Shepherd (BOUTEN CONSTRUCTION COMPANY)		Medium	Open

Description
Review the current open RFI log.

Official Documented Meeting Minutes

- High Priority RFI's
  - RFI 011 - Whirlpool Bath Manufacturer - Paul sent comments back from the owner. Lance sent cleaning requirements back late last week.
  - RFI 027 - Kitchen Item #74 Scope Confirmation (trench drain in the kitchen). - Paul sent comments back from the owner.

- RFI 028 - Permanent Power Routing - We have confirmed that the fiber will be going in with power. Just need updated drawings, this does impact our SVID crossing.
- RFI 043 - Area E and F Duct Chase Clarifications - these are overdue, need to get incorporated into our BIM meetings.
- RFI 051 - Kitchen Panels NLIK and NK1KWall Adjustments - these are overdue, need to get incorporated into our BIM meetings.
- RFI 058 - Med Air Compressor Location Confirmation. - need these returned so we can order the medvac and med pump.
- RFI 060 - Sink location confirmation - This affects the underground work.

- PR02 is pending - RFI's are staying open until the PR comes out. Many responses are tied to this PR and may be approaching impact.

Budget

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
6.1	1	Open Changes	Mac McGrath (BOUTEN CONSTRUCTION COMPANY)		Medium	Open

Official Documented Meeting Minutes

- Team has started a weekly meeting to review all open changes.
- Owner changes
  - COP 001 - working with trade partners for updated pricing.
  - COP 003 - received comments back and are working through those.
  - COP 005 - pricing is pending per the revised RFI and Big D's pricing.
  - COP 006 - Weather delay costs - still showing as worst-case scenario, that price is most likely cut in half.
  - COP 007 - Pneumatic Tub BIM, received a verbal approval. Awaiting owner signature on official COP.
  - COP 008 - Mac responded and returned to Lance. Lance sent this back to Joe and is awaiting his answers.
  - COP 009 - Builders risk, just waiting on final confirmation that the invoice sent is there one and only.
  - POTENTIAL - Kitchen tile and epoxy - in Paul and Adam's court setting up a meeting with PMH and kitchen service providers.
- TIME SENSITIVE - Recessed slab water proofing - Getting pricing from Fowler to install waterproofing per RFI. Once pricing is received, we will need to have a review meeting for immediate direction.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
6.2	1	Builder's Risk	Mac McGrath (BOUTEN CONSTRUCTION COMPANY)	Feb 17, 2023	Medium	Open

Official Documented Meeting Minutes

- No current update.

Previous Meeting Minutes
Jan 24, 2023

- Mac to forward a copy of the policy to PMH for record when available.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
6.3	1	SVID Pipe Payment	Mac McGrath (BOUTEN CONSTRUCTION COMPANY)	Jan 31, 2023	Low	Open

Description
Tracking of payment to Big D's from PMH.

Official Documented Meeting Minutes

- Working through payment issue with Big D's and PMH.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
6.5	1	Deferred Alternates Decisions	Mac McGrath (BOUTEN CONSTRUCTION COMPANY)	Feb 28, 2023	Low	Open

Description
Drop dead dates for deferred alternates before schedule impact.

Official Documented Meeting Minutes

- BCC and PMH had a meeting on 2/7 and Mac will send an updated log. Mac will coordinate with Lance to go over 2 or 3 items that were discussed directly for issuance of PR.
- Team will set up a biweekly or monthly meeting to review for future.

AHJ's

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
7.1	1	City of Prosser			Low	Open

Description
Open items with City of Prosser.

Official Documented Meeting Minutes

- Water/Sewer connection permit application was issued. Cody will confirm the city's questions have been answered and update the team if needed.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
7.2	1	DOH	Lance White (BCDESIGNGROUP, LLC)		Low	Open

Description
Open items with DOH

Official Documented Meeting Minutes

- Lance is not getting any response from DOH at this time.
- BCDG will be calling John Williams this week to make contact.
- No current hold on PR-02 related to DOH.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
7.3	1	USDA	Adam Trumbour (NV5) Gary Hicks (G.L. HICKS FINANCIAL, LLC)		Low	Open

Description
Open items with USDA

Official Documented Meeting Minutes

- Adam and Gary working with Marty to confirm change order process and pay apps.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
7.4	4	BPUD	Adam Trumbour (NV5)	Mar 1, 2023		Open

Official Documented Meeting Minutes

- PMH is processing BPUD fees and developer agreement.

Design Documents and Revisions

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
8.1	1	ASI's / PR's	Lance White (BCDESIGNGROUP, LLC)	Feb 3, 2023	Low	Open

Official Documented Meeting Minutes

- PR 2 - is getting close to release.
- Final drawings for the Imaging Department - Lance sent the revised plan to GE a couple of weeks back. Lance to follow up and check status.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
8.2	1	Constructability Review		Feb 10, 2023	Medium	Open

Official Documented Meeting Minutes

- Still in BCC court tracking for end of this week.

Contract/Documentation

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
9.1	1	Pay Applications	Adam Trumbour (NV5)	Jan 31, 2023	High	Open

Official Documented Meeting Minutes

- Pay App 01 - Adam has received the update and is routing for approval now.
- Pay App 02 - Adam has received the update and is routing for approval now.
- Pay App 03 - Mac sent out a draft, comments will be back this week.

Owner Coordination

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
10.1	1	Owner Scope and Equipment	Lance White (BCDESIGNGROUP, LLC) Adam Trumbour (NV5)	Feb 28, 2023	Low	Open

Official Documented Meeting Minutes

- Kick off meeting was held on 1/24.
- Ross & Baruzzini has changed their name to Introba - they are getting a list pulled together of the equipment. BCC did not receive a list of Architecturally significant equipment. Adam to send to Mac but notes nothing has changed significantly from the drawings. BCC will start incorporating with the schedule, related to FS equipment or central sterile regarding floor sinks.
- Team to set up reoccurring owner scope meetings.
- Introba working on procurement schedule and potental spend scheule.

No.	Mtg Origin	Title	Assignment	Due Date	Priority	Status
10.2	1	Food Service Equipment	Adam Trumbour (NV5) Mac McGrath (BOUTEN CONSTRUCTION COMPANY)	Jan 31, 2023	Low	Closed

Official Documented Meeting Minutes

- Will close this item and track in 10.1.

Field Observations & Miscellaneous

PROSSER MEMORIAL HEALTH REPLACEMENT HOSPITAL

Construction Progress Report 02: 02.15.23

Project Overview:

Dry warm weather through mid-January allowed field activities placing fill material for the building pad to resume. The project schedule is back on track and no additional weather/soil delays are anticipated through February.

The delay through January has allowed submittal review and procurement related to steel embeds, anchor bolts, and rebar to be completed and eliminate setbacks as these items are typically received "Just in Time". Procurement and planning efforts continue on strong for the remainder of the project with the release of orders on key electrical and mechanical equipment which have the longest lead times of any on the project, currently up to 18 months, and will be monitored for impacts until received onsite.

Design efforts for the Imaging Department and other Agency changes continue tracking for completion. Owner furnished scopes and equipment conducted a kickoff meeting at the end of January and will continue on with regular check-ins through installation.

Subcontractor Buyout:

Total trades to be bought out: 34
Trades bought to date: 32
Value of buyout: $61,950,882 of $62,541,367

Submittal Log:

Total submittals required: 761
Total submittals in for review: 39
Total submittals approved: 149
Total submittals currently marked for revision: 5

Change Order and Contingency Use:

One allowance use authorization was submitted and approved this month totaling $100,000.

One contractor contingency use authorization has been submitted this month totaling $23,365. A number of potential contingency uses are under evaluation and projected at $106,000. The GCCM Contingency Balance is $2,226,307. The projected GCCM contingency balance is approximately 2.83% of the original construction contract value.

No owner change order requests have been approved this month. Four change order requests are currently under review totaling $107,275. A number of potential change orders are under evaluation and projected at $894,000.

Preliminary approval to add pneumatic tube system have been given and pricing is being finalized.

Unresolved Issues:

Issuance of PR02

RFI's (Outstanding)

16 (13 High Priority and Overdue)

Schedule Variance:

Data date: 01/27/2023
Critical milestones this month: None
Percent of critical milestones hit: N/A (0 of 0 To Date, 0 of 30 Total)
Schedule variance in days: 50 working days, final duration to be resolved in change order
Reason for variance: USDA approval to proceed and weather/soil condition delays

Summary Report for Progress Schedule: (dated—February 1, 2023):

The current schedule update remains consistent with the best case scenario schedule reviewed in mid-January. Additional schedule validation has occurred with multiple pull plan meetings for sitework and building super structure. Pull plan meetings will continue and occur approximately 60 days prior to the start of each major area or new scope of work.

The building pad continued on 1/23/23 with minor continued delays incurred throughout the next two weeks as unsuitable soil was removed and replaced. Approximately 1/30/23 Bouten directed Apollo, who needed two weeks notice, to mobilize for the underground plumbing. Layout and mobilization for plumbing occurred late the week of 2/6/23 with excavation and installation for deep plumbing mains in Area B.2 started on 2/13/23. Underground plumbing and electrical will continue for the next 3-4 weeks before the start of foundations.

The current schedule update reflects a new substantial completion date of 1/23/25 which will be validated during the delay review and incorporated as the new contract substantial completion date upon resolution.

Progress Photos


Big D's work the building pad


Big D's compaction of pad


Big D's processing soils


Big D's installs site sewer


Big D's hammers bedrock


Big D's backfilling site sewer


Apollo bedding sewer trench


Apollo installs deep sewer main


Big D's excavates deep sewer

Project Risks and Outstanding Questions:

- Weather/soil delay on the building pad. (Pending)
- Deferred alternates and added scope determinations.
- Trade partner manpower availability due to the delay adjustment in the schedule.
- Design team and owner response and approval times.

Permit Status:

Permit 1: Grading Permit Closed

Permit 2: Building Permit Approved

Permit 3: DOH A2BC issued. Permit will remain open until construction completion.

Permit 4: FAA Helipad pending.

BOUTEN CONSTRUCTION COMPANY

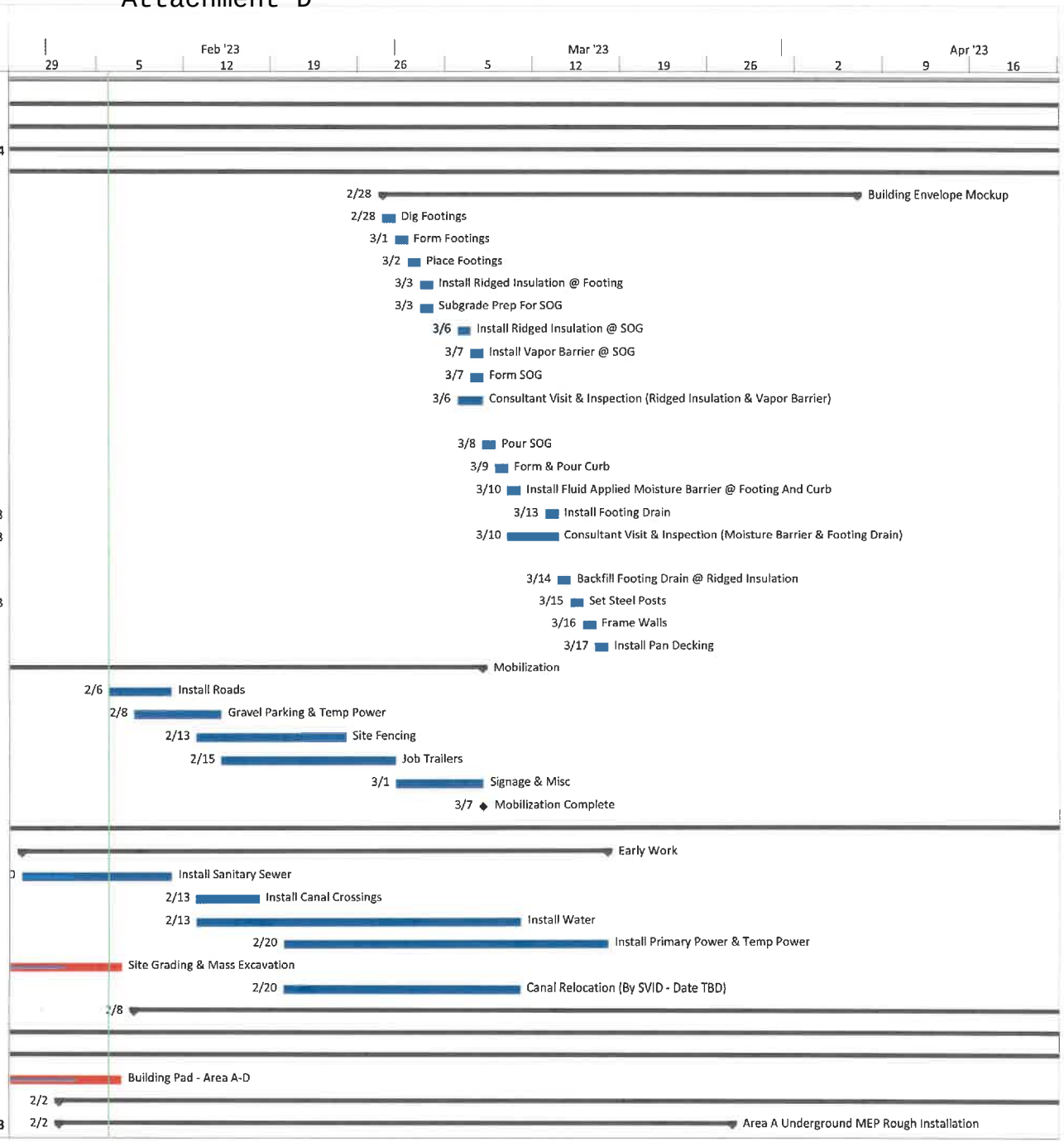
PMH REPLACEMENT HOSPITAL
Prosser Memorial Health

Data Date: Fri 2/3/23

6 WEEK LOOK AHEAD SCHEDULE

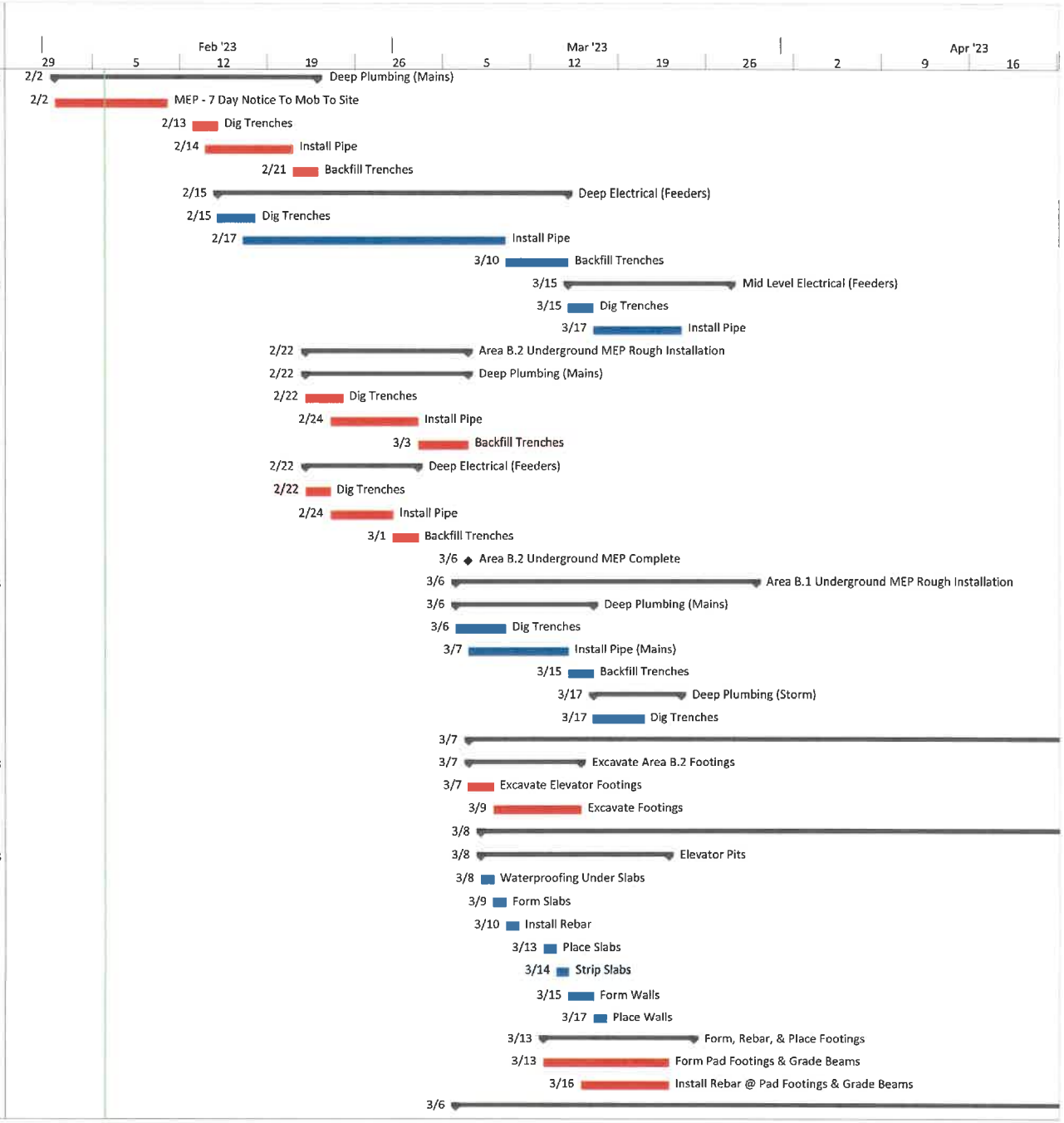
Attachment D

ID	Task Name	Dur	Start	Finish
0	**PMH HOSPITAL REPLACEMENT**	**686 day**	**Mon 8/1/22**	**Fri 4/11/25**
1	**Project Milestones**	**656 days**	**Mon 9/12/22**	**Fri 4/11/25**
37	**Preconstruction**	**451 days**	**Mon 8/1/22**	**Wed 5/8/24**
276	**Pull Plan Meetings**	**352 days**	**Wed 12/28/2**	**Wed 5/15/24**
293	**Construction**	**626 days**	**Tue 10/25/22**	**Fri 4/11/25**
297	**Building Envelope Mockup**	**28 days**	**Tue 2/28/23**	**Thu 4/6/23**
298	Dig Footings	1 day	Tue 2/28/23	Tue 2/28/23
299	Form Footings	1 day	Wed 3/1/23	Wed 3/1/23
300	Place Footings	1 day	Thu 3/2/23	Thu 3/2/23
301	Install Ridged Insulation @ Footing	1 day	Fri 3/3/23	Fri 3/3/23
302	Subgrade Prep For SOG	1 day	Fri 3/3/23	Fri 3/3/23
303	Install Ridged Insulation @ SOG	1 day	Mon 3/6/23	Mon 3/6/23
304	Install Vapor Barrier @ SOG	1 day	Tue 3/7/23	Tue 3/7/23
305	Form SOG	1 day	Tue 3/7/23	Tue 3/7/23
306	**Consultant Visit & Inspection (Ridged Insulation & Vapor Barrier)**	2 days	Mon 3/6/23	Tue 3/7/23
307	Pour SOG	1 day	Wed 3/8/23	Wed 3/8/23
308	Form & Pour Curb	1 day	Thu 3/9/23	Thu 3/9/23
309	Install Fluid Applied Moisture Barrier @ Footing And C	1 day	Fri 3/10/23	Fri 3/10/23
310	Install Footing Drain	1 day	Mon 3/13/23	Mon 3/13/23
311	**Consultant Visit & Inspection (Moisture Barrier & Footing Drain)**	2 days	Fri 3/10/23	Mon 3/13/23
312	Backfill Footing Drain @ Ridged Insulation	1 day	Tue 3/14/23	Tue 3/14/23
313	Set Steel Posts	1 day	Wed 3/15/23	Wed 3/15/23
314	Frame Walls	1 day	Thu 3/16/23	Thu 3/16/23
315	Install Pan Decking	1 day	Fri 3/17/23	Fri 3/17/23
330	**Mobilization**	**92 days**	**Tue 10/25/22**	**Tue 3/7/23**
334	Install Roads	5 days	Mon 2/6/23	Fri 2/10/23
335	Gravel Parking & Temp Power	5 days	Wed 2/8/23	Tue 2/14/23
336	Site Fencing	10 days	Mon 2/13/23	Fri 2/24/23
337	Job Trailers	10 days	Wed 2/15/23	Tue 2/28/23
338	Signage & Misc	5 days	Wed 3/1/23	Tue 3/7/23
339	*Mobilization Complete*	*0 days*	*Tue 3/7/23*	*Tue 3/7/23*
340	**Site Work & Utilities**	**126 days**	**Wed 11/30/2**	**Fri 5/26/23**
344	**Early Work**	**35 days**	**Mon 1/30/23**	**Fri 3/17/23**
345	Install Sanitary Sewer	10 days	Mon 1/30/23	Fri 2/10/23
346	Install Canal Crossings	5 days	Mon 2/13/23	Fri 2/17/23
347	Install Water	20 days	Mon 2/13/23	Fri 3/10/23
348	Install Primary Power & Temp Power	20 days	Mon 2/20/23	Fri 3/17/23
350	Site Grading & Mass Excavation	11 days	Mon 1/23/23	Mon 2/6/23
351	Canal Relocation (By SVID - Date TBD)	15 days	Mon 2/20/23	Fri 3/10/23
352	**Site Utilities (Intial Install)**	**78 days**	**Wed 2/8/23**	**Fri 5/26/23**
385	**Foundations**	**138 days**	**Fri 1/27/23**	**Thu 8/10/23**
386	**Excavation & Underground**	**90 days**	**Fri 1/27/23**	**Fri 6/2/23**
387	Building Pad - Area A-D	7 days	Fri 1/27/23	Mon 2/6/23
388	**Underground MEP**	**74 days**	**Thu 2/2/23**	**Tue 5/16/23**
389	**Area A Underground MEP Rough Installation**	**38 days**	**Thu 2/2/23**	**Mon 3/27/23**



6 WEEK LOOK AHEAD SCHEDULE

ID	Task Name	Dur	Start	Finish
390	**Deep Plumbing (Mains)**	**15 days**	**Thu 2/2/23**	**Wed 2/22/23**
391	MEP - 7 Day Notice To Mob To Site	7 days	Thu 2/2/23	Fri 2/10/23
392	Dig Trenches	2 days	Mon 2/13/23	Tue 2/14/23
393	Install Pipe	5 days	Tue 2/14/23	Mon 2/20/23
394	Backfill Trenches	2 days	Tue 2/21/23	Wed 2/22/23
395	**Deep Electrical (Feeders)**	**20 days**	**Wed 2/15/23**	**Tue 3/14/23**
396	Dig Trenches	3 days	Wed 2/15/23	Fri 2/17/23
397	Install Pipe	15 days	Fri 2/17/23	Thu 3/9/23
398	Backfill Trenches	3 days	Fri 3/10/23	Tue 3/14/23
399	**Mid Level Electrical (Feeders)**	**9 days**	**Wed 3/15/23**	**Mon 3/27/23**
400	Dig Trenches	2 days	Wed 3/15/23	Thu 3/16/23
401	Install Pipe	5 days	Fri 3/17/23	Thu 3/23/23
404	**Area B.2 Underground MEP Rough Installation**	**9 days**	**Wed 2/22/23**	**Mon 3/6/23**
405	**Deep Plumbing (Mains)**	**9 days**	**Wed 2/22/23**	**Mon 3/6/23**
406	Dig Trenches	3 days	Wed 2/22/23	Fri 2/24/23
407	Install Pipe	5 days	Fri 2/24/23	Thu 3/2/23
408	Backfill Trenches	2 days	Fri 3/3/23	Mon 3/6/23
409	**Deep Electrical (Feeders)**	**7 days**	**Wed 2/22/23**	**Thu 3/2/23**
410	Dig Trenches	2 days	Wed 2/22/23	Thu 2/23/23
411	Install Pipe	3 days	Fri 2/24/23	Tue 2/28/23
412	Backfill Trenches	2 days	Wed 3/1/23	Thu 3/2/23
413	*Area B.2 Underground MEP Complete*	*0 days*	*Mon 3/6/23*	*Mon 3/6/23*
414	**Area B.1 Underground MEP Rough Installation**	**18 days**	**Mon 3/6/23**	**Wed 3/29/23**
415	**Deep Plumbing (Mains)**	**9 days**	**Mon 3/6/23**	**Thu 3/16/23**
416	Dig Trenches	4 days	Mon 3/6/23	Thu 3/9/23
417	Install Pipe (Mains)	6 days	Tue 3/7/23	Tue 3/14/23
418	Backfill Trenches	2 days	Wed 3/15/23	Thu 3/16/23
419	**Deep Plumbing (Storm)**	**5 days**	**Fri 3/17/23**	**Thu 3/23/23**
420	Dig Trenches	2 days	Fri 3/17/23	Mon 3/20/23
452	**Excavate Footings**	**63 days**	**Tue 3/7/23**	**Fri 6/2/23**
453	**Excavate Area B.2 Footings**	**7 days**	**Tue 3/7/23**	**Wed 3/15/23**
454	Excavate Elevator Footings	2 days	Tue 3/7/23	Wed 3/8/23
455	Excavate Footings	5 days	Thu 3/9/23	Wed 3/15/23
462	**Area B.2 Foundations & Slab On Grade**	**42 days**	**Wed 3/8/23**	**Thu 5/4/23**
463	**Elevator Pits**	**11 days**	**Wed 3/8/23**	**Wed 3/22/23**
464	Waterproofing Under Slabs	1 day	Wed 3/8/23	Wed 3/8/23
465	Form Slabs	1 day	Thu 3/9/23	Thu 3/9/23
466	Install Rebar	1 day	Fri 3/10/23	Fri 3/10/23
467	Place Slabs	1 day	Mon 3/13/23	Mon 3/13/23
468	Strip Slabs	1 day	Tue 3/14/23	Tue 3/14/23
469	Form Walls	2 days	Wed 3/15/23	Thu 3/16/23
470	Place Walls	1 day	Fri 3/17/23	Fri 3/17/23
473	**Form, Rebar, & Place Footings**	**10 days**	**Mon 3/13/23**	**Fri 3/24/23**
474	Form Pad Footings & Grade Beams	8 days	Mon 3/13/23	Wed 3/22/23
475	Install Rebar @ Pad Footings & Grade Beams	5 days	Thu 3/16/23	Wed 3/22/23
1674	**Site Work**	**362 days**	**Mon 3/6/23**	**Mon 8/5/24**



Master Budget

Attachment E

Project Summary Report
Replacement Hospital

Prosser Memorial Health

Generated Feb 15, 2023 by budget4cast.com

Budget Code	Original Budget	Reallocations	Current Budget	Committed Costs	Approved Changes	Non-Forecasted Invoices	Requested Changes	Uncommitted Costs	Estimated Costs at Completion	Projected Over/(Under)	Previous Costs to Date	Current Draw Total	Total Costs to Date	% Complete	Balance to Finish
	A	B	A+B	C	D	E	F	G	C+D+E+F+G	(C+D+E+F+G) - (A+B)	H	I	H+I	(H+I) / (C+D+E+F+G)	(C+D+E+F+G) - (H+I)
Project Total	**112,048,033.00**	**0.00**	**112,048,033.00**	**87,752,483.68**	**222,769.52**	**2,622,061.14**	**1,608,108.18**	**15,826,045.42**	**108,031,467.94**	**(4,016,565.06)**	**8,962,940.40**	**1,641,271.29**	**10,604,211.69**	**10.00%**	**97,427,256.25**
1.00.00. Soft Costs	8,274,447.50	(7,500.00)	8,266,947.50	5,740,045.94	(2,230.48)	714,869.96	1,608,108.18	715,124.44	8,775,918.04	508,970.54	6,127,083.45	18,047.82	6,145,131.27	70.00%	2,630,786.77
1.01.00 - A/E Team Basic Services	3,965,132.00	(53,340.85)	3,911,791.15	2,777,774.00	(33,708.00)	0.00	1,593,446.25	0.00	4,337,512.25	425,721.10	3,117,796.19	0.00	3,117,796.19	72.00%	1,219,716.06
1.01.01. Basic Design Services Value	3,828,282.00	(19,632.85)	3,808,649.15	2,640,924.00	0.00	0.00	1,593,446.25	0.00	4,234,370.25	425,721.10	3,039,154.19	0.00	3,039,154.19	72.00%	1,195,216.06
1.01.02. Supplemental - Food Service Design	12,800.00	1,292.00	14,092.00	12,800.00	1,292.00	0.00	0.00	0.00	14,092.00	0.00	14,092.00	0.00	14,092.00	100.00%	0.00
1.01.03. Supplemental - Traffic Study	12,000.00	24,500.00	36,500.00	12,000.00	24,500.00	0.00	0.00	0.00	36,500.00	0.00	12,000.00	0.00	12,000.00	33.00%	24,500.00
1.01.04. Supplemental - Estimating	109,650.00	(59,500.00)	50,150.00	109,650.00	(59,500.00)	0.00	0.00	0.00	50,150.00	0.00	50,150.00	0.00	50,150.00	100.00%	0.00
1.01.05. Supplemental - Survey	2,400.00	0.00	2,400.00	2,400.00	0.00	0.00	0.00	0.00	2,400.00	0.00	2,400.00	0.00	2,400.00	100.00%	0.00
1.02.00 - Other Consultant Services	622,606.58	72,452.22	695,058.80	393,550.00	21,143.63	144,778.59	0.00	135,586.58	695,058.80	0.00	487,134.79	0.00	487,134.79	70.00%	207,924.01
1.02.01. Pre-Design Architecture Services	0.00	41,340.85	41,340.85	0.00	0.00	41,340.85	0.00	0.00	41,340.85	0.00	41,340.85	0.00	41,340.85	100.00%	0.00
1.02.02. Environmental Engineer	20,000.00	0.00	20,000.00	20,000.00	0.00	0.00	0.00	0.00	20,000.00	0.00	20,000.00	0.00	20,000.00	100.00%	0.00
1.02.03. Graphics & Signage	35,000.00	0.00	35,000.00	0.00	0.00	0.00	0.00	35,000.00	35,000.00	0.00	0.00	0.00	0.00	0.00%	35,000.00
1.02.04. Artwork Consultant	20,000.00	0.00	20,000.00	0.00	0.00	0.00	0.00	20,000.00	20,000.00	0.00	0.00	0.00	0.00	0.00%	20,000.00
1.02.05. Medical Equipment Planner	132,080.00	0.00	132,080.00	120,560.00	11,520.00	0.00	0.00	0.00	132,080.00	0.00	121,276.57	0.00	121,276.57	92.00%	10,803.43
1.02.06. Radiation Shielding Physicist	15,000.00	0.00	15,000.00	1,900.00	0.00	0.00	0.00	13,100.00	15,000.00	0.00	0.00	0.00	0.00	0.00%	15,000.00
1.02.07. Commissioning Agent	120,000.00	0.00	120,000.00	91,538.00	0.00	0.00	0.00	28,462.00	120,000.00	0.00	19,681.50	0.00	19,681.50	16.00%	100,318.50
1.02.08. IT/AV Security Systems Consultant	148,426.58	0.00	148,426.58	109,402.00	0.00	0.00	0.00	39,024.58	148,426.58	0.00	111,824.50	0.00	111,824.50	75.00%	36,602.08
1.02.09. Materials Management Consultant	8,600.00	0.00	8,600.00	8,600.00	0.00	0.00	0.00	0.00	8,600.00	0.00	8,600.00	0.00	8,600.00	100.00%	0.00
1.02.10. Mock-up Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
1.02.11. Appraisal Consultant	18,500.00	0.00	18,500.00	18,500.00	0.00	0.00	0.00	0.00	18,500.00	0.00	28,300.00	0.00	28,300.00	153.00%	(9,800.00)
1.02.12. CON Application Consultant — Health Facilities	25,000.00	7,673.63	32,673.63	23,050.00	9,623.63	0.00	0.00	0.00	32,673.63	0.00	32,673.63	0.00	32,673.63	100.00%	0.00
1.02.13. CON Legal & Filing Fees	80,000.00	11,437.74	91,437.74	0.00	0.00	91,437.74	0.00	0.00	91,437.74	0.00	91,437.74	0.00	91,437.74	100.00%	0.00
1.02.14. Miscellaneous Consultant Allowance	0.00	12,000.00	12,000.00	0.00	0.00	12,000.00	0.00	0.00	12,000.00	0.00	12,000.00	0.00	12,000.00	100.00%	0.00
1.03.00 - Reimbursable Expenses	198,257.00	0.00	198,257.00	0.00	0.00	94,608.64	0.00	103,648.36	198,257.00	0.00	94,608.64	0.00	94,608.64	48.00%	103,648.36

Budget Code	Original Budget	Reallocations	Current Budget	Committed Costs	Approved Changes	Non-Forecasted Invoices	Requested Changes	Uncommitted Costs	Estimated Costs at Completion	Projected Over/(Under)	Previous Costs to Date	Current Draw Total	Total Costs to Date	% Complete	Balance to Finish
	A	B	A+B	C	D	E	F	G	C+D+E+F+G	(C+D+E+F+G) - (A+B)	H	I	H+I	(H+I) / (C+D+E+F+G)	(C+D+E+F+G) - (H+I)
Project Total	**112,048,033.00**	**0.00**	**112,048,033.00**	**87,752,483.68**	**222,769.52**	**2,622,061.14**	**1,608,108.18**	**15,826,045.42**	**108,031,467.94**	**(4,016,565.06)**	**8,962,940.40**	**1,641,271.29**	**10,604,211.69**	**10.00%**	**97,427,256.25**
1.03.01. A-E Team Reimbursables	198,257.00	0.00	198,257.00	0.00	0.00	94,608.64	0.00	103,648.36	198,257.00	0.00	94,608.64	0.00	94,608.64	48.00%	103,648.36
1.04.00 - Agency and Permit Fees	509,561.82	(17,500.00)	492,061.82	214,442.30	14,661.93	238,497.33	14,661.93	53,564.49	535,827.98	43,766.16	401,379.05	0.00	401,379.05	75.00%	134,448.93
1.04.01. A.H.J. Plan Review Fees — City of Prosser	199,915.08	0.00	199,915.08	0.00	0.00	199,915.08	0.00	0.00	199,915.08	0.00	199,915.08	0.00	199,915.08	100.00%	0.00
1.04.02. Inspection Fees (if seperate from Plan review)	60,911.74	0.00	60,911.74	0.00	0.00	7,347.25	0.00	53,564.49	60,911.74	0.00	7,347.25	0.00	7,347.25	12.00%	53,564.49
1.04.03. State of Washington Project Review Fees	38,735.00	(7,500.00)	31,235.00	0.00	0.00	31,235.00	0.00	0.00	31,235.00	0.00	31,235.00	0.00	31,235.00	100.00%	0.00
1.04.04. Notice of Commencement	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
1.04.05. Department of Health / CON Fees	10,000.00	(10,000.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
1.04.06. Utility Assessment Fees — Electric, Internet and SVID	200,000.00	0.00	200,000.00	214,442.30	14,661.93	0.00	14,661.93	0.00	243,766.16	43,766.16	162,881.72	0.00	162,881.72	67.00%	80,884.44
1.05.00. - Testing and Inspection Fees	200,000.00	0.00	200,000.00	111,998.00	1,500.00	0.00	0.00	86,502.00	200,000.00	0.00	18,200.00	0.00	18,200.00	9.00%	181,800.00
1.05.01. Geotechnical Study & Soils Testing	30,000.00	(4,980.00)	25,020.00	16,700.00	1,500.00	0.00	0.00	6,820.00	25,020.00	0.00	18,200.00	0.00	18,200.00	73.00%	6,820.00
1.05.02. Materials Testing & Inspection	150,000.00	0.00	150,000.00	95,298.00	0.00	0.00	0.00	54,702.00	150,000.00	0.00	0.00	0.00	0.00	0.00%	150,000.00
1.05.03. Air Balance Testing	20,000.00	4,980.00	24,980.00	0.00	0.00	0.00	0.00	24,980.00	24,980.00	0.00	0.00	0.00	0.00	0.00%	24,980.00
1.06.00. - Project Management Fees and Expenses	2,346,454.10	(4,476.04)	2,341,978.06	2,235,885.10	(5,828.04)	79,312.99	0.00	32,387.01	2,341,757.06	(221.00)	1,846,370.39	15,573.26	1,861,943.65	80.00%	479,813.41
1.06.01. Out-Sourced Services — NV5	1,117,000.00	0.00	1,117,000.00	1,116,779.00	0.00	0.00	0.00	0.00	1,116,779.00	(221.00)	655,601.10	13,751.50	669,352.60	60.00%	447,426.40
1.06.02. Out-Sourced Services Expenses — NV5	111,700.00	0.00	111,700.00	0.00	0.00	79,312.99	0.00	32,387.01	111,700.00	0.00	77,491.23	1,821.76	79,312.99	71.00%	32,387.01
1.06.03. RCW 39.10 Consultant	15,000.00	(4,476.04)	10,523.96	16,352.00	(5,828.04)	0.00	0.00	0.00	10,523.96	0.00	10,523.96	0.00	10,523.96	100.00%	0.00
1.06.04. CM Pre-Construction Services — Graham + Bouten Precon	1,102,754.10	0.00	1,102,754.10	1,102,754.10	0.00	0.00	0.00	0.00	1,102,754.10	0.00	1,102,754.10	0.00	1,102,754.10	100.00%	0.00
1.08.00. - Other Owner Responsibilities	432,436.00	(4,635.33)	427,800.67	6,396.54	0.00	157,672.41	0.00	303,436.00	467,504.95	39,704.28	161,594.39	2,474.56	164,068.95	35.00%	303,436.00
1.08.01. Project Specific Legal Fees	100,000.00	0.00	100,000.00	0.00	0.00	154,133.83	0.00	0.00	154,133.83	54,133.83	151,659.27	2,474.56	154,133.83	100.00%	0.00
1.08.02. Temporary Utilities	53,436.00	0.00	53,436.00	0.00	0.00	0.00	0.00	53,436.00	53,436.00	0.00	0.00	0.00	0.00	0.00%	53,436.00
1.08.03. Document Reproduction	10,000.00	0.00	10,000.00	0.00	0.00	27.37	0.00	0.00	27.37	(9,972.63)	27.37	0.00	27.37	100.00%	0.00
1.08.04. Moving Costs	200,000.00	0.00	200,000.00	0.00	0.00	0.00	0.00	200,000.00	200,000.00	0.00	0.00	0.00	0.00	0.00%	200,000.00
1.08.05. Operations 'Start-Up' & Supplies	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
1.08.06. Clinical Cleaning / Final 'White Glove' Cleaning	50,000.00	0.00	50,000.00	0.00	0.00	0.00	0.00	50,000.00	50,000.00	0.00	0.00	0.00	0.00	0.00%	50,000.00
1.08.07. Staff Training	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00

Budget Code	Original Budget	Reallocations	Current Budget	Committed Costs	Approved Changes	Non-Forecasted Invoices	Requested Changes	Uncommitted Costs	Estimated Costs at Completion	Projected Over/(Under)	Previous Costs to Date	Current Draw Total	Total Costs to Date	% Complete	Balance to Finish
	A	B	A+B	C	D	E	F	G	C+D+E+F+G	(C+D+E+F+G) - (A+B)	H	I	H+I	(H+I) / (C+D+E+F+G)	(C+D+E+F+G) - (H+I)
Project Total	**112,048,033.00**	**0.00**	**112,048,033.00**	**87,752,483.68**	**222,769.52**	**2,622,061.14**	**1,608,108.18**	**15,826,045.42**	**108,031,467.94**	**(4,016,565.06)**	**8,962,940.40**	**1,641,271.29**	**10,604,211.69**	**10.00%**	**97,427,256.25**
1.08.08. Community Events / Public Relations	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
1.08.09. Owner Reimbursable Expenses	14,000.00	(2,740.52)	11,259.48	6,396.54	0.00	406.02	0.00	0.00	6,802.56	(4,456.92)	6,802.56	0.00	6,802.56	100.00%	0.00
1.08.10. Procurement Advertisements	5,000.00	(1,894.81)	3,105.19	0.00	0.00	3,105.19	0.00	0.00	3,105.19	0.00	3,105.19	0.00	3,105.19	100.00%	0.00
2.00.00. Hard Costs	92,682,542.50	7,500.00	92,690,042.50	81,542,437.74	0.00	1,766,441.18	0.00	9,381,672.98	92,690,551.90	509.40	1,857,710.82	1,623,223.47	3,480,934.29	4.00%	89,209,617.61
2.01.00. - Real Estate	1,725,619.18	0.00	1,725,619.18	0.00	0.00	1,725,619.18	0.00	0.00	1,725,619.18	0.00	1,725,619.18	0.00	1,725,619.18	100.00%	0.00
2.01.01. Property Cost	1,718,119.18	0.00	1,718,119.18	0.00	0.00	1,718,119.18	0.00	0.00	1,718,119.18	0.00	1,718,119.18	0.00	1,718,119.18	100.00%	0.00
2.01.02. Brokerage / Transaction Fees	7,500.00	0.00	7,500.00	0.00	0.00	7,500.00	0.00	0.00	7,500.00	0.00	7,500.00	0.00	7,500.00	100.00%	0.00
2.02.00. - Due-Diligence	25,375.00	12,765.60	38,140.60	0.00	0.00	38,650.00	0.00	0.00	38,650.00	509.40	38,650.00	0.00	38,650.00	100.00%	0.00
2.02.01. Environmental Studies	18,875.00	19,265.60	38,140.60	0.00	0.00	38,650.00	0.00	0.00	38,650.00	509.40	38,650.00	0.00	38,650.00	100.00%	0.00
2.02.02. Title Research / Support	6,500.00	(6,500.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.02.03. Civil Engineering Fees	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.03.00. - Site Improvements & Utilities	60,000.00	(5,265.60)	54,734.40	52,562.40	0.00	2,172.00	0.00	0.00	54,734.40	0.00	52,562.40	0.00	52,562.40	96.00%	2,172.00
2.03.01 Engineering Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.03.02 Tree Clearing for Geotech & Survey Work	60,000.00	(5,265.60)	54,734.40	52,562.40	0.00	2,172.00	0.00	0.00	54,734.40	0.00	52,562.40	0.00	52,562.40	96.00%	2,172.00
2.03.03 Temporary Conditions	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.04.00. - Construction by GC	81,320,048.32	0.00	81,320,048.32	81,320,048.32	0.00	0.00	0.00	0.00	81,320,048.32	0.00	0.00	1,623,223.47	1,623,223.47	2.00%	79,696,824.85
2.04.01. Construction GMP / MACC by Bouten	81,320,048.32	0.00	81,320,048.32	81,320,048.32	0.00	0.00	0.00	0.00	81,320,048.32	0.00	0.00	1,623,223.47	1,623,223.47	2.00%	79,696,824.85
2.06.00. - Medical/Clinical Equipment Costs	7,000,000.00	0.00	7,000,000.00	117,270.00	0.00	0.00	0.00	6,882,730.00	7,000,000.00	0.00	20,381.30	0.00	20,381.30	0.00%	6,979,618.70
2.06.01. Medical/Clinical Equipment	5,352,356.00	0.00	5,352,356.00	0.00	0.00	0.00	0.00	5,352,356.00	5,352,356.00	0.00	0.00	0.00	0.00	0.00%	5,352,356.00
2.06.02. Planning, Procurement, S&H, Tax, Storage, Installation	1,647,644.00	0.00	1,647,644.00	117,270.00	0.00	0.00	0.00	1,530,374.00	1,647,644.00	0.00	20,381.30	0.00	20,381.30	1.00%	1,627,262.70
2.07.00. - Signage, Graphics, Artwork	640,000.00	0.00	640,000.00	0.00	0.00	0.00	0.00	640,000.00	640,000.00	0.00	0.00	0.00	0.00	0.00%	640,000.00
2.07.01. Interior Wayfinding, Signage & Graphics	90,000.00	0.00	90,000.00	0.00	0.00	0.00	0.00	90,000.00	90,000.00	0.00	0.00	0.00	0.00	0.00%	90,000.00
2.07.02. Exterior Signage	300,000.00	0.00	300,000.00	0.00	0.00	0.00	0.00	300,000.00	300,000.00	0.00	0.00	0.00	0.00	0.00%	300,000.00
2.07.03. Original Artwork	150,000.00	0.00	150,000.00	0.00	0.00	0.00	0.00	150,000.00	150,000.00	0.00	0.00	0.00	0.00	0.00%	150,000.00
2.07.04. General Artwork	100,000.00	0.00	100,000.00	0.00	0.00	0.00	0.00	100,000.00	100,000.00	0.00	0.00	0.00	0.00	0.00%	100,000.00
2.08.00. - IT & Telecommunications Direct Costs	430,000.00	0.00	430,000.00	0.00	0.00	0.00	0.00	430,000.00	430,000.00	0.00	0.00	0.00	0.00	0.00%	430,000.00

Budget Code	Original Budget	Reallocations	Current Budget	Committed Costs	Approved Changes	Non-Forecasted Invoices	Requested Changes	Uncommitted Costs	Estimated Costs at Completion	Projected Over/(Under)	Previous Costs to Date	Current Draw Total	Total Costs to Date	% Complete	Balance to Finish
	A	B	A+B	C	D	E	F	G	C+D+E+F+G	(C+D+E+F+G) - (A+B)	H	I	H+I	(H+I) / (C+D+E+F+G)	(C+D+E+F+G) - (H+I)
Project Total	**112,048,033.00**	**0.00**	**112,048,033.00**	**87,752,483.68**	**222,769.52**	**2,622,061.14**	**1,608,108.18**	**15,826,045.42**	**108,031,467.94**	**(4,016,565.06)**	**8,962,940.40**	**1,641,271.29**	**10,604,211.69**	**10.00%**	**97,427,256.25**
2.08.01. Desktop Hardware and Services	20,000.00	0.00	20,000.00	0.00	0.00	0.00	0.00	20,000.00	20,000.00	0.00	0.00	0.00	0.00	0.00%	20,000.00
2.08.02. Telephone Hardware and Services	60,000.00	0.00	60,000.00	0.00	0.00	0.00	0.00	60,000.00	60,000.00	0.00	0.00	0.00	0.00	0.00%	60,000.00
2.08.03. TV's and Cabling	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.08.04. Network Hardware and Services	170,000.00	0.00	170,000.00	0.00	0.00	0.00	0.00	170,000.00	170,000.00	0.00	0.00	0.00	0.00	0.00%	170,000.00
2.08.05. Wireless Hardware and Services	180,000.00	0.00	180,000.00	0.00	0.00	0.00	0.00	180,000.00	180,000.00	0.00	0.00	0.00	0.00	0.00%	180,000.00
2.09.00. - IT & Telecommunications Indirect Costs	**21,500.00**	**0.00**	**21,500.00**	**0.00**	**0.00**	**0.00**	**0.00**	**21,500.00**	**21,500.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00%**	**21,500.00**
2.09.01. Freight / Shipping	10,750.00	0.00	10,750.00	0.00	0.00	0.00	0.00	10,750.00	10,750.00	0.00	0.00	0.00	0.00	0.00%	10,750.00
2.09.02. Project Management Service Fees	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.09.03. Installation	10,750.00	0.00	10,750.00	0.00	0.00	0.00	0.00	10,750.00	10,750.00	0.00	0.00	0.00	0.00	0.00%	10,750.00
2.10.00. - Communications & Non-Clinical Equipment	**755,000.00**	**0.00**	**755,000.00**	**0.00**	**0.00**	**0.00**	**0.00**	**755,000.00**	**755,000.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00%**	**755,000.00**
2.10.01. Kitchen Equipment	600,000.00	0.00	600,000.00	0.00	0.00	0.00	0.00	600,000.00	600,000.00	0.00	0.00	0.00	0.00	0.00%	600,000.00
2.10.02. Patient / Staff Television & Cable	75,000.00	0.00	75,000.00	0.00	0.00	0.00	0.00	75,000.00	75,000.00	0.00	0.00	0.00	0.00	0.00%	75,000.00
2.10.03. Security Equipment	70,000.00	0.00	70,000.00	0.00	0.00	0.00	0.00	70,000.00	70,000.00	0.00	0.00	0.00	0.00	0.00%	70,000.00
2.10.04. Time & Attendance Clock System	10,000.00	0.00	10,000.00	0.00	0.00	0.00	0.00	10,000.00	10,000.00	0.00	0.00	0.00	0.00	0.00%	10,000.00
2.11.00. - Furniture	**705,000.00**	**0.00**	**705,000.00**	**52,557.02**	**0.00**	**0.00**	**0.00**	**652,442.98**	**705,000.00**	**0.00**	**20,497.94**	**0.00**	**20,497.94**	**3.00%**	**684,502.06**
2.11.01. Furniture Selection and Layout	52,557.02	0.00	52,557.02	52,557.02	0.00	0.00	0.00	0.00	52,557.02	0.00	20,497.94	0.00	20,497.94	39.00%	32,059.08
2.11.02. Furniture Material Cost	652,442.98	0.00	652,442.98	0.00	0.00	0.00	0.00	652,442.98	652,442.98	0.00	0.00	0.00	0.00	0.00%	652,442.98
2.11.03. Temporary Storage	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.11.04. Freight / Shipping	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
2.11.05. Installation	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%	0.00
3.00.00. Contingency & Financing	**11,091,043.00**	**0.00**	**11,091,043.00**	**470,000.00**	**225,000.00**	**140,750.00**	**0.00**	**5,729,248.00**	**6,564,998.00**	**(4,526,045.00)**	**978,146.13**	**0.00**	**978,146.13**	**15.00%**	**5,586,851.87**
3.01.00. Owner Project Contingency	**4,526,045.00**	**0.00**	**4,526,045.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(4,526,045.00)**	**0.00**	**0.00**	**0.00**	**0.00%**	**0.00**
3.01.01. Original / Approved Value	4,526,045.00	0.00	4,526,045.00	0.00	0.00	0.00	0.00	0.00	0.00	(4,526,045.00)	0.00	0.00	0.00	0.00%	0.00
3.02.00. Financing	**6,564,998.00**	**0.00**	**6,564,998.00**	**470,000.00**	**225,000.00**	**140,750.00**	**0.00**	**5,729,248.00**	**6,564,998.00**	**0.00**	**978,146.13**	**0.00**	**978,146.13**	**15.00%**	**5,586,851.87**
3.02.01. Financing — Capitalized Interest	5,175,998.00	0.00	5,175,998.00	0.00	0.00	0.00	0.00	5,175,998.00	5,175,998.00	0.00	0.00	0.00	0.00	0.00%	5,175,998.00
3.02.02. Cost of Issuance & Finance Consultant	1,389,000.00	0.00	1,389,000.00	470,000.00	225,000.00	140,750.00	0.00	553,250.00	1,389,000.00	0.00	978,146.13	0.00	978,146.13	70.00%	410,853.87
Project Total	**112,048,033.00**	**0.00**	**112,048,033.00**	**87,752,483.68**	**222,769.52**	**2,622,061.14**	**1,608,108.18**	**15,826,045.42**	**108,031,467.94**	**-4,016,565.06**	**8,962,940.40**	**1,641,271.29**	**10,604,211.69**	**10.00%**	**97,427,256.25**

Costs incurred since January 16, 2023

Actual Costs Report
Replacement Hospital

Prosser Memorial Health

Generated Feb 15, 2023 by budget4cast.com

Displaying 13 entries based on your filters
Total: 1,689,873.76

Invoice Date	Vendor	Budget Code	Invoice Number	Disbursement Register Number	Description	Amount	Retainage %	Retainage Amount	Payment Date	Lien Waiver
Bouten Construction Co.										
02/13/23	Bouten Construction Co.	2.04.01. Construction GMP / MACC by Bouten	3	1002.00		627,510.44	0.00	0.00		Yes
02/08/23	Bouten Construction Co.	2.04.01. Construction GMP / MACC by Bouten	1	1002.00		747,856.54	0.00	0.00		Yes
02/08/23	Bouten Construction Co.	2.04.01. Construction GMP / MACC by Bouten	2	1002.00		247,856.49	0.00	0.00		Yes
					BOUTEN CONSTRUCTION CO. SUBTOTAL:	1,623,223.47		0.00		
BPUD										
12/15/23	BPUD	1.04.06. Utility Assessment Fees Electric, Internet and SV...	20221215	0.00		14,661.93	0.00	0.00	02/09/23	
					BPUD SUBTOTAL:	14,661.93		0.00		
Henderson										
01/22/23	Henderson	1.02.08. IT/AV Security Systems Consultant	0531005	39.00		4,023.00	0.00	0.00		
01/19/23	Henderson	1.02.08. IT/AV Security Systems Consultant	0531947	39.00		2,011.50	0.00	0.00	02/09/23	
					HENDERSON SUBTOTAL:	6,034.50		0.00		
Introba (Ross & Baruzzini)										
02/06/23	Introba (Ross & Baruzzini)	2.06.02. Planning, Procurement, S&H, Tax, Storage, Installation	55394	39.00		3,218.10	0.00	0.00		
02/06/23	Introba (Ross & Baruzzini)	1.02.05. Medical Equipment Planner	55395	39.00		5,760.00	0.00	0.00		
					INTROBA (ROSS & BARUZZINI) SUBTOTAL:	8,978.10		0.00		
NV5										
02/15/23	NV5	1.06.01. Out-Sourced Services NV5	315548	1002.00		13,751.50	0.00	0.00		
02/15/23	NV5	1.06.02. Out-Sourced Services Expenses NV5	315548	1002.00		1,821.76	0.00	0.00		

Invoice Date	Vendor	Budget Code	Invoice Number	Disbursement Register Number	Description	Amount	Retainage %	Retainage Amount	Payment Date	Lien Waiver
01/24/23	NV5	1.06.01. Out-Sourced Services NV5	311744	39.00		15,850.00	0.00	0.00	02/09/23	
01/24/23	NV5	1.06.02. Out-Sourced Services Expenses NV5	311744	39.00		3,077.94	0.00	0.00	02/09/23	
					NV5 SUBTOTAL:	34,501.20		0.00		
Perkins Coie										
02/07/23	Perkins Coie	1.08.01. Project Specific Legal Fees	6759799	1002.00		2,474.56	0.00	0.00		
					PERKINS COIE SUBTOTAL:	2,474.56		0.00		
					Total:	1,689,873.76		0.00		

Attachment F

VOLUNTARY AGREEMENT FOR DEFERRAL OF FRONTAGE AND STREET IMPROVEMENTS

THIS AGREEMENT ("Agreement") is made and entered into as of _____, 2023 by and between the City of Prosser, a Washington municipal corporation (the "City"), and Prosser Public Hospital District, d/b/a Prosser Memorial Health, a Washington municipal corporation ("PMH") (together, the "Parties").

RECITALS

WHEREAS, PMH is the owner of certain real property located at 200 Prosser Health Drive (Benton County Tax Parcel No. 135942000017000) in the City of Prosser, Washington, as more specifically described on **Exhibit A** attached hereto and incorporated herein by reference (the "Property");

WHEREAS, PMH proposes to construct a new 25-bed critical access hospital on the Property (the "Development") and the City has issued a final Mitigated Determination of Non-Significance ("MDNS", attached hereto as **Exhibit B**) under the Washington State Environmental Policy Act, Chapter 43.21C RCW, finding that the Development does not have a probable significant adverse impact on the environment provided certain identified mitigation measures are complete prior to the issuance of the final occupancy certificate.

WHEREAS, Mitigation Measure No. 2 in the MDNS requires PMH to either improve Gap Road fronting the Property to the City's standards for major collectors, ST-1, or to enter into an agreement with the City for deferral of such frontage improvements.

WHEREAS, Prosser Municipal Code ("PMC") Section 15.04.090(A) provides that the City cannot issue a building permit unless frontage improvements are made in accordance with the City's Standard Specifications.

WHEREAS, pursuant to RCW 82.02.020 and as contemplated by the MDNS and PMC Section 15.04.090(A), PMH and City agree to enter into this voluntary agreement for deferral of such frontage improvements under the terms and conditions set forth herein.

AGREEMENT

FOR AND IN CONSIDERATION OF and subject to the terms and conditions hereafter set forth, the City and the PMH agree as follows:

1. **Initial Frontage Improvements Prior to Certificate of Occupancy.** PMH agrees to construct entrance improvements as designed and shown on the construction drawings reviewed and approved by the City during the building permit review process before PMH may obtain an occupancy permit for any structure constructed on the Property (the "Initial Frontage Improvements").

Entrance improvements also include construction of all-way stop as identified in the Transportation Impact Analysis prepared by TranspoGroup, dated January 2022 and approved by City on February 22, 2022 ("Stop Improvements"). Alternatively, the Mayor of City and PMH are authorized to enter into an agreement with the Washington State Department of Transportation ("WSDOT") setting forth the requirements and timing of the Stop Improvements, or a functionally equivalent improvement, or a fee-in-lieu of mitigation, which would satisfy Mitigation Measure No. 2 in the MDNS.

Commented [LM(1]: Need to finalize after further discussion with WSDOT. Our understanding is WSDOT wants fee-in-lieu. Whatever changes are made, should be consistent in revised MDNS.

2. **Deferred Frontage Improvements**. The City defers requiring installation of the following improvements for the term of this Agreement, (the "Deferred Frontage Improvements"). Deferred Frontage Improvements are the improvements required by Mitigation Measure No. 2 in the MDNS, which must be delivered in accordance with the PMC in effect on the date of this Agreement (unless PMH elects to have the then-current standards govern the Deferred Frontage Improvements), except those specifically identified as Initial Frontage Improvements in Paragraph 1 of this Agreement.

Commented [LM(2]: Discussed appending the current provisions of the code that applies.

Specifically, unless already provided as an Initial Frontage Improvement, Deferred Frontage Improvements will include those shown in Mitigation Measure No. 2 of the MDNS; frontage does not include intersections. However, in lieu of sidewalk improvements, PMH may enter into an easement agreement to allow for the public use of an ADA-compliant walking trail adjacent to Gap Road. Such easement agreement must allow for the connection of future pedestrian improvements which would accommodate ADA-compliant travel from the south of the Property to the north property line of the Property.

All permits and approvals shall be conditioned upon and consistent with the terms and conditions of this Agreement.

Notwithstanding anything in this Agreement, PMH agrees to complete planning, design and construction of the Deferred Frontage Improvements at the earliest of the following events:

(a) Within 365 calendar days from when the City provides notice to PMH that permits have been filed for construction of (i) half street improvements on the opposite side of the portion of N. Gap Road fronting the Property; or (ii) street and frontage improvements planned by the Washington State Department of Transportation near and around the intersection of N. Gap Road and Highway 82 and the surrounding on-ramps; or (iii) half street improvements for the abutting property to the north along N. Gap Road, such that each of these improvements are beyond the conceptual phase; or

(b) Ten (10) years from the date of recording this Agreement.

3. **Latecomer**. Nothing in the Agreement forecloses PMH's rights to pursue a joint development agreement with other developments along the same street frontage or a latecomer agreement pursuant to PMC 12.50.020, which states:

> Any developer utilizing private funds to acquire public right-of-way and/or install street improvements on public right-of-way may apply to the city to establish a "latecomer agreement" for recovery of a pro rata share of the cost of acquiring public right-of-way and/or constructing said public improvements from other parties that subsequently develop their property and that will later derive a benefit from said improvements. The city administrator is authorized to accept applications for the establishment by contract of an assessment reimbursement area as provided by state law, provided such application substantially conforms to the requirements of this chapter. No latecomer agreement shall extend for a period longer than fifteen years from the date of final acceptance by the city. The city council shall have discretion to authorize or not to authorize latecomer agreements on a case-by-case basis.

4. **Dedication of Right-of-Way**. If design of the Deferred Frontage Improvements show that additional street right-of-way or public sidewalk and utility easements are necessary to accommodate the installation of the Deferred Frontage Improvements that abut the Property, PMH agrees to dedicate or convey the same to City.

5. **LID Formation**. PMH waives any and all rights to protest the formation by the City of a local improvement district, road improvement district, transportation benefit district, or other similar type of district to construct the above-described Deferred Frontage Improvements along Gap Road, insofar as said improvement district includes the Property within its boundaries. PMH grants and conveys to the City a right to exercise any and all rights held by PMH, its heirs, assignees, transferees or successors in interest, including any purchaser, mortgage holder, lien holder or other person who may claim an interest in the Property, to take any action needed to approve formation of said improvement district on behalf of the Property. This special, limited power of attorney shall terminate automatically upon creation of any improvement district contemplated in this section. PMH retains the right to protest the amount and method of assessment, consistent with the requirements of state law, including Chapter 35.44 RCW.

6. **Term**. This Agreement shall terminate ten (10) years from the date of recording or upon complete construction of the Deferred Frontage Improvements, in accordance with paragraph 2. The termination of this agreement shall not terminate ongoing maintenance obligations required by the PMC for public improvements.

7. **Agreement Voluntary**. PMH and the City agree that this Agreement is voluntary in all respects and is intended to implement Mitigation Measure 2 in City's MDNS in accord with the requirements of RCW 82.02.020.

8. **City to Make No Additional Demand.** The City agrees that PMH's compliance with the terms set forth in this Agreement satisfies Mitigation Measure 2 in City's MDNS for the Development. The City agrees to make no further demand on PMH with respect to frontage improvements for the Development, except as expressly provided in this Agreement, provided that the City reserves the right to re-evaluate the impacts and required mitigation in the event that the Development is expanded or modified in any way that increases the traffic generated by the Development.

9. **Entire Agreement; Modifications**. This Agreement supersedes all prior discussions and agreements between the Parties with respect to the frontage improvements required for the Development and Mitigation Measure 2 in City's MDNS. This Agreement contains the sole and entire understanding between the Parties and may be amended only by the execution of a written amendment by the Parties.

10. **Additional Acts**. From and after the date of this Agreement, each Party, at the request of the other Party, shall make, execute and deliver or obtain and deliver all instruments and documents, and shall do or cause to be done all such other acts, that either Party may reasonably require in order to effectuate the provisions and the intention of this Agreement.

11. **Governing Law**. This Agreement, and the rights and obligations of the Parties hereunder, shall be governed by and construed in accordance with the laws of the State of Washington.

12. **Severability**. If any provision or portion of this Agreement is held by any court of competent jurisdiction to be invalid or unenforceable, such holdings shall not affect the remainder hereof, and the remaining provisions shall continue in full force and effect to the same extent as would have been the case had such invalid or unenforceable provision or portion never been a part hereof, except to the extent the rights and obligations of the Parties have been materially altered by such unenforceability.

13. **Authority**. Each of the undersigned acknowledges that he/she has the authority to enter into this Agreement on behalf of the entity parties to this Agreement, and the undersigned further acknowledge that they have the authority to bind the entity to the terms of the Agreement.

14. **Notices**. All notices or other communications required or permitted hereunder shall be in writing, and shall be personally delivered or sent by registered or certified mail, postage prepaid, return receipt requested, or electronic mail, shall be deemed received upon (i) if personally delivered, the date of delivery to the address of the person to receive such notice, (ii) if mailed, three (3) business days after the date of posting by the United States post office, (iii) if delivered by overnight delivery, one (1) business

day after mailing, and (iv) if given by electronic mail, when sent. Any notice, request, demand, direction or other communication sent by electronic mail must be confirmed by letter mailed or delivered within three (3) business days of such electronic mail notice in accordance with subsection (i), (ii) or (iii).

To City:	City of Prosser 1002 Dudley Ave P.O. Box 1639 Prosser, WA 99350
To PMH:	Prosser Public Hospital District No. 1 d/b/a Prosser Memorial Health 723 Memorial Prosser, WA 99350
	With copy to:
	Andrew L. Greene Perkins Coie LLP 1201 Third Avenue, Suite 4900 Seattle, WA 98101

15. **Counterparts**. This Agreement may be executed in several counterparts, each of which shall be deemed an original, and all such counterparts together shall constitute one and the same agreement.

16. **Recording**. This Agreement shall inure to the benefit of and be binding upon the Parties hereto, their heirs, successors, administrators, executors and permitted assigns. This Agreement shall be recorded in the office of the Benton County Auditor and the obligations herein shall be covenants running with the land described on Exhibit A and shall be binding upon and inure to the benefit of all future owners thereof.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date first above written.

City of Prosser:

By: _____
Randy Taylor, Mayor

ATTEST:

By: _____
RACHEL SHAW, City Clerk

Approved as to form:

_____
HOWARD SAXTON, City Attorney

STATE OF WASHINGTON)
) ss.
COUNTY OF BENTON)

On this ____ day of _____, 2022, before me personally appeared Randy Taylor, to me known to be the Mayor of the CITY OF PROSSER, and acknowledged said instrument to be the free and voluntary act and deed of said limited liability company, for the uses and purposes therein mentioned, and on oath stated that he was authorized to execute said instrument.

In Witness Whereof I have hereunto set my hand and affixed my official seal the day and year first above written.

_____
Signature

_____
Print Name
NOTARY PUBLIC in and for the State of Washington, residing at _____.
My commission expires _____.

Prosser Public Hospital District d/b/a Prosser Memorial Health:

By: _____

Approved as to form:

_____
Andrew L. Greene, Attorney for PMH

STATE OF WASHINGTON)
) ss.
COUNTY OF BENTON)

On this ____ day of October, 2022, before me personally appeared _____, to me known to be the_____of PROSSER PUBLIC HOSPITAL DISTRICT D/B/A PROSSER MEMORIAL HOSPITAL, and acknowledged said instrument to be the free and voluntary act and deed of said limited liability company, for the uses and purposes therein mentioned, and on oath stated that he was authorized to execute said instrument.

In Witness Whereof I have hereunto set my hand and affixed my official seal the day and year first above written.

_____
Signature

_____
Print Name
NOTARY PUBLIC in and for the State of Washington, residing at _____.
My commission expires _____.

EXHIBIT A
LEGAL DESCRIPTION OF PROPERTY

Real property in the County of Benton, State of Washington, described as follows:

THE NORTH HALF OF THE SOUTHWEST QUARTER OF THE NORTHWEST QUARTER OF SECTION 35, TOWNSHIP 9 NORTH, RANGE 24 EAST W.M., BENTON COUNTY, WASHINGTON TOGETHER WITH THE SOUTHWEST QUARTER OF THE SOUTHWEST QUARTER OF THE NORTHWEST QUARTER OF SECTION 35, TOWNSHIP 9 NORTH, RANGE 24 EAST W.M., BENTON COUNTY, WASHINGTON, EXCEPT SOUTH 20 FEET THEREOF LESS STATE ROUTE NO. 82 TOGETHER WITH THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF THE NORTHWEST QUARTER AND THE SOUTH 20 FEET OF THE SOUTHWEST QUARTER OF THE SOUTHWEST QUARTER OF THE NORTHWEST QUARTER OF SECTION 35, TOWNSHIP 9 NORTH, RANGE 24 EAST W.M., BENTON COUNTY, WASHINGTON. EXCEPTING THEREFROM ANY PORTION LYING WITHIN STATE INTERSTATE 82, RIGHT OF WAY.

Attachment G

Prosser
Memorial Health

Furniture Alternate Options

opensquare

Dietary| Seating and Tables

Notes:

They like the configuration and layout.

Need a combination of styles to balance space.

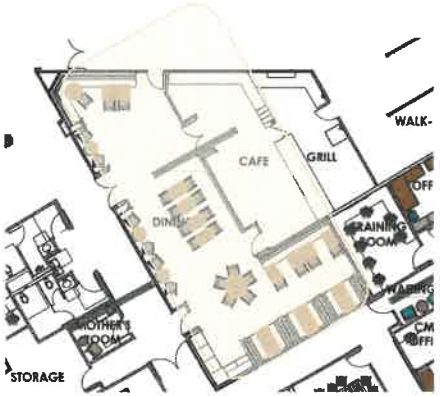
Would like to see something other than the Kasura and Kelly.

Products Used:

OFS Kasura Chairs

OFS Nineteen Tables

OFS Kelly Chair



Previous Selection:

Kwalu Novara

Kwalu Sciara Stool

This stool and the coordinating dining chair received mostly negative feedback. The comments mostly involved the accessibility. Users felt it was too constricting for a majority of users.

All products in the West Elm Health Collection were designed for workplace performance, modified specifically for the unique needs of the healthcare environment, and manufactured to withstand the wear and tear that products encounter in both environments.

West Elm Slope Chair and Stool

- Upholstered in Healthcare appropriate fabric options
- Metal Base
- Armless

West Elm Sterling Chair

- Upholstered in Healthcare appropriate fabric options
- Metal Base or Wood Base
- With or without Arms

Dietary| Seating and Tables

Notes:

They like the configuration and layout.

Need a combination of styles to balance space.

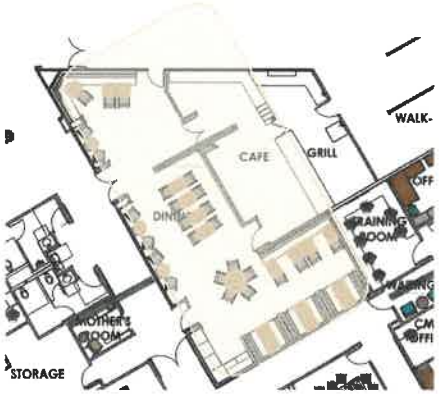
Would like to see something other than the Kasura and Yelly

Products Used:

OFS Kasura Chairs

OFS Nineteen Tables

OFS Yelly Chair



Previous Selection:

Kwalu Novara

Kwalu Sciara Stool

This stool and the coordinating dining chair received mostly negative feedback. The comments mostly involved the accessibility. Users felt it was too constricting for a majority of users.

Enea Lottus is a flexible, multi-height collection of chairs and tables that integrates simply and cleanly with any space. Sculpted for comfort with just the right flex, the elegant shell of the Lottus chair can be used alone or customized with a colored insert or upholstered cushion.

Coalesse Enea Lottus

- 12 Polypropylene Seat Shell Colors
- Option Upholstered Seat Cushion
- Armless, Loop Arm or Cantilevered Arm (shown at left)
- Stool Option
- Stackable

Dietary| Seating and Tables

Notes:

They like the configuration and layout

Need a combination of styles to balance space

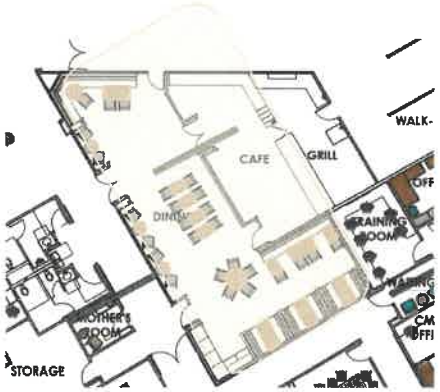
Would like to see something other than the Kasura and Yelly

Products Used:

OFS Kasura Chairs

OFS Nineteen Tables

OFS Yelly Chair



Previous Selection:

Kwalu Novara

Kwalu Sciara Stool

This stool and the coordinating dining chair received mostly negative feedback. The comments mostly involved the accessibility. Users felt it was too constricting for a majority of users.

Enea Altzo943 brings residential warmth and soul to the Workplace | with elevated design and elegant detail that complement many styles. Enea Altzo943 combines the clean curves of a precision-molded seat shell with the sculptural refinement of solid oak legs.

Coalesse Enea Altzo

- 12 Polypropylene Seat Shell Colors
- Option Upholstered Seat Cushion
- Armless
- Stool Option
- Solid Oak Leg

Dietary| Seating and Tables

Notes:

They like the configuration and layout

Need a combination of styles to balance space

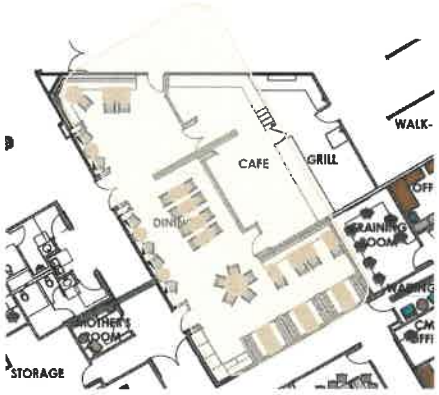
Would like to see something other than the Kasura and Yelly.

Products Used:

OFS Kasura Chairs

OFS Nineteen Tables

OFS Yelly Chair



Previous Selection:

Kwalu Novara

Kwalu Sciara Stool

This stool and the coordinating dining chair received mostly negative feedback. The comments mostly involved the accessibility. Users felt it was too constricting for a majority of users.

Kwalu Pinetta Dining Chair

Sophisticated styling and supreme quality define Kwalu's Pinetta Chair. Modern tapered arms provide spacious comfort and ingress/egress support. Elegant and versatile, this chair boasts a stunning show frame back and piping on the seat cushion. It is also available with a handgrip, which is optional. Casters are optional on the Pinetta and may be added to the front legs only.

Kwalu Madrid Bar Stool

Chic and minimalist, the pre-molded seat of the Madrid Bar Stool has no separation, retains its shape, is smooth and comfortable. The seat fits inside the stool frame, made of easily cleaned Classic Kwalu material with stretchers on all sides. The Madrid is suitable for use at bars, counters, and high tables.

Dietary| Seating and Tables

Notes:

They like the configuration and layout.

Need a combination of styles to balance space

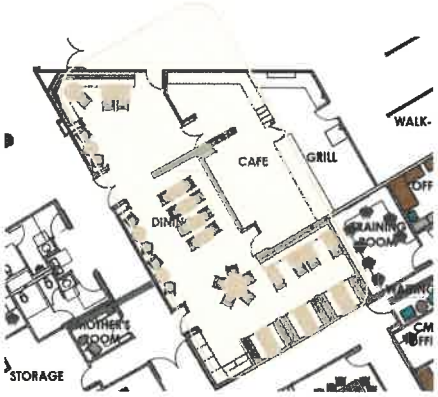
Would like to see something other than the Kasura and Yelly.

Products Used:

OFS Kasura Chairs

OFS Nineteen Tables

OFS Yelly Chair



Previous Selection:

Kwalu Novara

Kwalu Sciara Stool

This stool and the coordinating dining chair received mostly negative feedback. The comments mostly involved the accessibility. Users felt it was too constricting for a majority of users.

Blu Dot Dibs Chair

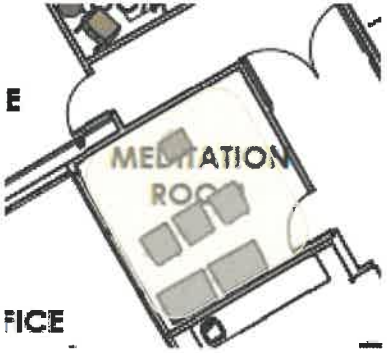
- Solid Beech Wood Leg
- Beech Veneer
- Plastic Glides
- 3 Wood Finishes

Steelcase Player Chair

- Upholstered in Healthcare appropriate fabric options
- Metal Frame
- With or Without Arms
- Stool Options

Meditation Room| Seating

Previous Selection:



Feedback on this chair was not favorable. Comfortability was the biggest concern

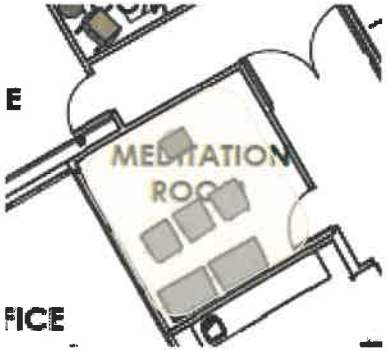
The beautiful Biella Lounge collection is purposely designed to create comfort on all sides. The angled back extends past the upholstered frame to support the neck and back of the user. The collection base with slightly splayed tapered legs in Kwalu classi finish is a nod to mid-century style. Biella's attached bolstered pillows are removable f easy cleaning. The Biella Collection includes a lounge, loveseat and sofa.

Kwalu Biella Chair and Love Seat

- Durable Finish
- Steel Reinforced
- Concealed Cleanout
- Chair, Love Seat, and Sofa options
- Also being used in waiting areas

Meditation Room| Seating

Previous Selection:



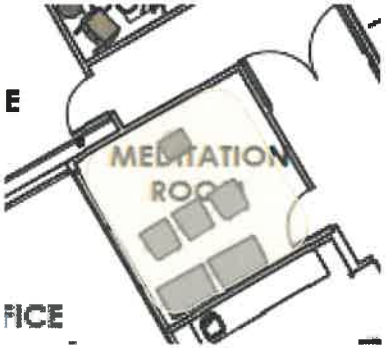
Feedback on this chair was not favorable. Comfortability was the biggest concern

Embold Chair and Love Seat

- 2 Different Chair Width Available
- Love Seats and sofas
- Bariatric Seating
- Headrest Option
- Wood or Metal Frame
- Matches Patient Room Seating

Meditation Room| Seating

Previous Selection:



Feedback on this chair was not favorable. Comfortability was the biggest concern

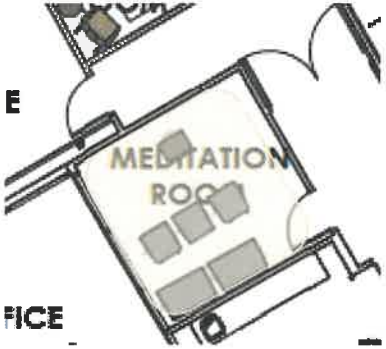
The Rule of Three series takes its name from the ancient belief that whatever energ object puts out, it is returned threefold. With its distinct arm styles, playful spirit, decidedly mod styling, and light and airy frame structure; the Rule of Three series exudes a positive radiance sure to bring good fortune to any space.

Carolina Rule of Three Lounge

- Upholstered or wood arms
- Love Seat and Chair Options
- Will match Exam room seating

Meditation Room| Seating

Previous Selection:



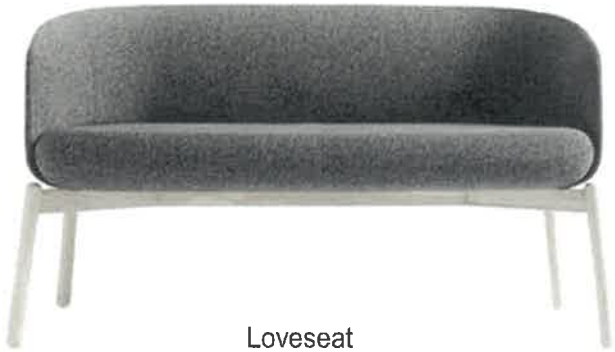
Feedback on this chair was not favorable. Comfortability was the biggest concern

Nest Low Wood is a soft and comfortable lounge option with a tight Nordic expressior The soft curves and fluid intersection of the seat and the backrest underlines the qual of the design and production method. It serves all kinds of modern spaces and provid a subtle yet distinct expression of Nordic quality and design. Nest Low Wood is part c the Nest series that comprises chairs, sofas and tables in two heights, enabling the creation of dynamic and flexible spaces.

Hightower Nest Low

Single Seat

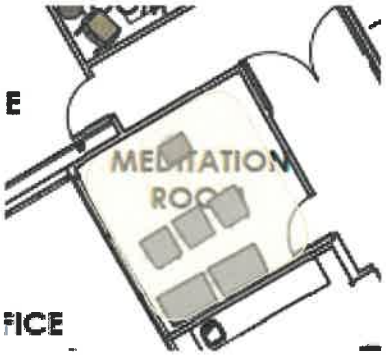
- Several upholstery options
- Wood base



Loveseat

Meditation Room| Seating

Previous Selection:



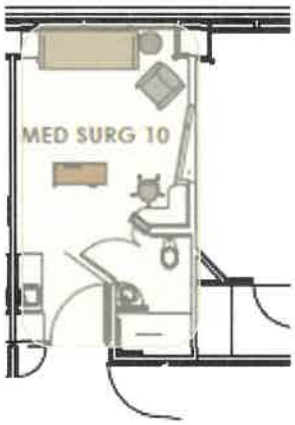
Feedback on this chair was not favorable. Comfortability was the biggest concern

A modern reshaping of the mid-century archetype, the Spire collection exemplifies clean, uncluttered design through soft geometric forms and proportions. Spire feature a low-profile seat that is expertly sculpted with an open angle, inviting users to relax. The silhouette of the chair provides a consistent aesthetic from guest, barstool, executive and lounge seating.

Darran Spire Lounge Chair

- Contoured plywood frame with a outer shell
- 3 base options: wood, metal blade, or swivel with casters
- Guest, Lounge and Bar height chairs available in ash or walnut solid wood frame
- Chairs available with or without upholstered arms

Patient Room| Physician Stool



Previous Selection:

We heard a few mixed reviews on this one.
Positives- users like the continuous ring along the seat bottom for height adjustability.
Negatives- users were mixed on the plastic back. Overall, they did not love the height of the stool or the footring for the most part.
*we did explain that the stool came in a shorter height and that seemed to be a positive for most.

Stance Physician Stool

Features
- Molded seat foam
- Polished die-cast aluminum base
- 2" hooded twin-wheel casters
- No tools required for assembly

Options
- Higher-height cylinder
- Auto-lock and soft-wheel casters
- Aluminum base with toe caps
- Stationary glide
- Moisture barrier

BOULTEN CONSTRUCTION COMPANY

Project Update

Prosser Memorial Health - Replacement Hospital

GeoProfessional Innovation on site inspecting the placement and conditions of the structural fill for the building pad.

Bid D's starting on grading the site for temporary roads and trailer locations.

Big D's installing the sanitary sewer line.

Big D's installing the sanitary sewer line.

UPCOMING CONSTRUCTION

- Big D's will finish the installation of the sanitary sewer
- Big D's will continue working on installation of the deep utilities, such as plumbing and electrical
- Frontier Fence Company will be on site starting week of February 13 to install temporary fencing to secure the site

Prosser Memorial Health

bcDESIGNGROUP

REPORT NO. 01
1/30/2023 - 2/10/2023
Craftsperson count: 16

Attachment I

PMH REPLACEMENT HOSPITAL
PROSSER MEMORIAL HEALTH
Prosser, Washington

Deferred Alternates & VE Matrix
January 23, 2023

ITEM	DESCRIPTION	DECISION BY	STATUS	AMOUNT	NOTES
1	BP10-01a: Column Cover Cladding (Paint Finish)				
	Provide wood-grain painted finish at the column covers. Current VE accepted as mono-color paint.	03/15/23	Pending	$ 20,425	Decision would be needed at time of approved submittal for no cost increase. Bouten is confirming drop dead date with trade partner, this date could be open to additional cost.
2	BP13-03: Solid Surface Countertop (Manufacturer)				
	Provide solid surface countertop type SS-3 Wilsonart per original plans and specs. Current VE accepted as Corian Group 2.	03/15/23	Pending	$ 17,709	Decision would be needed at time of approved submittal for no cost increase. Bouten is confirming drop dead date with trade partner, this date could be open to additional cost.
3	BP24-01b: Wall Protection (Option B)				
	Provide wall protection at all storage rooms per original plans and specs. Current VE accepted is no wall protection at storage rooms except at Materials Management storage room.	04/01/23	Pending	$ 37,449	Decision would be needed at time of approved submittal for no cost increase. Bouten is confirming drop dead date with trade partner, this date could be open to additional cost.
4	BP27-01: Pneumatic Tube System				
	Provide Pneumatic Tube System per original plans & specs.	04/30/23	Pending	$ 376,612	Decision date allows for lead time on equipment to align with start of MEP rough-in in Area A for no schedule impact. Pricing is open to additional costs. Decision date could occur later but has potential to impact schedule and costs. Amount shown includes allowance for adding back in electrical that was removed in PR-01 but was not part of the original VE. BIM for system is currently being added via change order.
5	BP33-01: Landscaping Allowance				
	Provide landscape design based on Basis of Design documents. Current VE accepted for landscape design based on $200,000 budget.	09/30/23	Pending	$ 351,067	Tracking to September decision date on increased budget.PMH can increase value at any increment desired.
6	Bid Alternate 2: Pre-Engineered Metal Building				
	Provide PEMB storage building per original plans and specs.	12/01/23	Pending	$ 491,600	Pricing is open to additional cost. Decision date is to avoid any schedule impacts to substantial completion date.
7	Bid Alternate 3: Helipad				
	Provide Helipad per plans and specs.	03/01/23	Pending	$ 77,435	3/1 date is for underground as currently shown on the schedule.
8	Bid Alternate 6: Revise 3Form Dimensional Panels to Revised AF5				
	Provide revised AF5 Vescom Tongo in lieu of specified product.	03/15/23	Pending	$ (128,165)	Decision would be needed at time of approved submittal for no cost increase. This credit had been discussed with the helipad add as an offsetting cost for initial USDA delay with Paul Kramer.
9	Bid Alternate 17: Oncology Buildout				
	Provide oncology buildout per original plans and specs.	06/30/23	Pending	$ 501,544	Decision date allows for lead time on equipment to align with start of MEP rough-in for no schedule impact. Pricing may be open to additional costs. Decision date could occur later but has potential to impact schedule and costs.

BOUTEN
CONSTRUCTION COMPANY

PMH REPLACEMENT HOSPITAL
PROSSER MEMORIAL HEALTH
Prosser, Washington

Deferred Alternates & VE Matrix
January 23, 2023

ITEM	DESCRIPTION	DECISION BY	STATUS	AMOUNT	NOTES
10	Owner Scope: Kitchen Equipment Contractor				
	Provide KEC through Bouten.	06/25/23	Pending	TBD	Underground to be installed per plan. Decision date allows 10 weeks for contracts/submittals and 6 weeks bidding for approved shops on equipment to align with start of MEP overhead/wall rough-in for no schedule impact. Pricing may be open to additional costs. Decision date could occur later but has potential to impact schedule and costs. Decision dates apply whether OFOI or CFCI. Current RFI outstanding for cart wash trench drain, needs resolution ASAP.
			Amount Approved	**$ -**	**All amounts include WSST.**

Attachment J

BOUTEN CONSTRUCTION COMPANY

CHANGE ORDER PROPOSAL LOG

PROSSER MEMORIAL HEALTH REPLACEMENT HOSPITAL

CONFIDENTIAL

Bouten Risk Contingency	$2,252,358
Contingency Adjustments	0
Approved CUA's	26,051
Current Contingency Balance	$2,226,307
Pending CUA [2]	30,000
Projected Contingency Balance	$2,196,307

Owner Contingency	$0
Contingency Adjustments	0
Approved COP's	0
Current Contingency Balance	$0
Pending COP's [2&8]	1,160,819
Projected Contingency Balance	($1,160,819)

Allowances	$1,290,000
Allowance Adjustments	0
Approved AUA's	0
Current Allowance Balance	$1,290,000
Pending AUA's [2]	122,880
Projected Allowance Balance	$1,167,120

Item #	Description	Reference Document	Date Initiated	Source	Change Type	BCDG Notified (Y/N)	Proceeding (Y/N)	ROM [1]	Submitted Cost	Approved Cost	Approval Status	Last Responsible Day	Comments
BOUTEN RISK CONTINGENCY													
CUA-001	Construction Entrance							$ -	$ 2,686	$ 2,686	Approved		
CUA-002	Building Pad Snow Removal & Freezing Temperatures							$ 30,000	$ 23,365	$ 23,365	Approved		
CUA-003	Canal Crossing & Workarounds							$ 30,000					
CUA-004													
CUA-005													
CUA-006													
CUA-007													
CUA-008													
CUA-009													
CUA-010													
Potential													
	Totals: BOUTEN RISK CONTINGENCY							**$ 75,000**	**$ 26,051**	**$ 26,051**			
OWNER CONTINGENCY													
COP-001	PR 01 Conformed Drawings	PR 01	09/30/22	BCDG	4	Y	N	$ 425,000					Pending RFI Response
COP-002	SVID Pipe Material	Work Session	10/25/22	Owner	4	Y	N	$ 67,000	$ 66,592	$ -	Cancelled	-	Big D's to provide and direct bill PMH in lieu of COP.
COP-003	Storm & Sanitary Sewer Changes	RFI 005	10/24/22	BCC	4	Y	N	$ -	$ 56,945				Submitted 1/10, In Bouten court to revise per comments
COP-004	Storefront Door Hardware	RFI 010	11/03/22	BCC	4	Y	N	$ -	$ -	$ -	Cancelled		No cost due to revised RFI response.
COP-005	PUD Reroute	RFI 028	11/03/22	PUD	1	Y	N	$ 40,000					Pending Trade Partner Response to revised RFI.
COP-006	Weather Delay Costs	Letter	12/05/22	BCC	7	Y	Y	$ 467,410					Pending Delay Completion & Cost Gathering
COP-007	Pneumatic Tube BIM	Friday Meeting	12/02/22	Owner	4	Y	N	$ 14,675	$ 14,412				Submitted 1/10, Pending PMH Signature.
COP-008	AHU-03 Humidifier Clarification	RFI 019	12/06/22	BCC	5	Y	N	$ 8,500	$ 9,147				Submitted 1/12, In Bouten court to respond to comments
COP-009	Builder's Risk Adjustment	Email	10/25/22	BCC	7	N	Y	$ 45,000					Pending Carrier confirmation of final premium.
Potential	Pneumatic Tube ($347,840)	Friday Meeting	12/02/22	Owner	4	Y	N						Pending Owner Decision
Potential	Kitchen Tile to Epoxy	Email	10/31/22	Owner	1	Y	N	$ 17,105					Submitted ROM 11/18, NV5 to schedule review meeting
Potential	Kitchen Equipment Contractor	Email	11/18/22	Owner	1	Y	N						Pending Owner Decision, Look at Jan/Feb 2023.
Potential	Misc Earthwork Changes	Multiple RFI's	12/16/22	BCC	4	Y	N	$ 5,000					Pending Bouten Review
Potential	Recessed Slab Waterproofing	RFI 041	12/19/22	BCC	4	Y	N	$ 60,000					Pending BCC/PMH/NV5 Discussion
Potential	Elevator Rails & Beam	RFI 042	12/19/22	BCC	4	Y	N	$ 20,800					Pending Trade Partner Response & Bouten Review
Potential													
	Totals: OWNER CONTINGENCY							**$ 1,170,490**	**$ 147,096**	**$ -**			
ALLOWANCES													
AUA-001	Builders Risk Premium	COP-009	01/12/23	BCC	7	N	Y	$ 100,000	$ 100,000				Sent 1/31
AUA-002	VE Allowance	GMP	09/27/22	BCDG	1	Y	Y						
AUA-003	Bedrock at Sewer	GMP	01/31/23	BCC	3	Y	Y	$ 22,880					Tracking CY onsite as encountered.
AUA-004													
AUA-005													
	Totals: ALLOWANCES							**$ 122,880**	**$ 100,000**	**$ -**			

BOUTEN CONSTRUCTION COMPANY

CHANGE ORDER PROPOSAL LOG

PROSSER MEMORIAL HEALTH REPLACEMENT HOSPITAL

CONFIDENTIAL

Bouten Risk Contingency	$2,252,358
Contingency Adjustments	0
Approved CUA's	26,051
Current Contingency Balance	$2,226,307
Pending CUA [2]	30,000
Projected Contingency Balance	$2,196,307

Owner Contingency	$0
Contingency Adjustments	0
Approved COP's	0
Current Contingency Balance	$0
Pending COP's [2&8]	1,160,819
Projected Contingency Balance	($1,160,819)

Allowances	$1,290,000
Allowance Adjustments	0
Approved AUA's	0
Current Allowance Balance	$1,290,000
Pending AUA's [2]	122,880
Projected Allowance Balance	$1,167,120

Item #	Description	Reference Document	Date Initiated	Source	Change Type	BCDG Notified (Y/N)	Proceeding (Y/N)	ROM [1]	Submitted Cost	Approved Cost	Approval Status	Last Responsible Day	Comments

SUMMARY OF CHANGE TYPE DISTRIBUTION

		BOUTEN RISK CONTINGENCY			OWNER CONTINGENCY			ALLOWANCES		
Change Type	Description	Total	Contract Value [6]	%	Total	Value	%	Total	Value	%
1	Owner Directed Change	$ -	$ 74,811,452	0.00%	$ 57,105	$74,811,452	0.08%	$ -	$ 1,290,000	0.00%
2	AHJ or Code Driven Change	-	74,811,452	0.00%	-	74,811,452	0.00%	-	1,290,000	0.00%
3	Unforeseen Condition	-	74,811,452	0.00%	-	74,811,452	0.00%	22,880	1,290,000	1.77%
4	Arch, Struct, or Civil	-	46,953,551	0.00%	582,157	46,953,551	1.24%	-	1,290,000	0.00%
5	Mechanical	-	12,997,825	0.00%	9,147	12,997,825	0.07%	-	-	0.00%
6	Electrical	-	14,860,076	0.00%	-	14,860,076	0.00%	-	-	0.00%
7	General Contractor	-	74,811,452	0.00%	512,410	74,811,452	0.68%	100,000	1,290,000	0.00%
	Totals: PMH REPLACEMENT HOSPITAL	**-**	**74,811,452**	**0.00%**	**1,160,819**	**74,811,452**	**1.55%**	**122,880**	**1,290,000**	**9.53%**

SUMMARY OF CONTINGENCY BALANCES

		BOUTEN RISK CONTINGENCY			OWNER CONTINGENCY			ALLOWANCES		
Item #	Description	Total	Contract Value [6]	%	Total	Value	%	Total	Value	%
1	Original Contingency Balance	$2,252,358	$ 74,811,452	3.01%	$0	$74,811,452	0.00%	$1,290,000	$74,811,452	1.72%
2	Revised Contingency Balance	2,252,358	74,811,452	3.01%	0	74,811,452	0.00%	1,290,000	$74,811,452	1.72%
3	Pending Changes	30,000	74,811,452	0.04%	1,160,819	74,811,452	1.55%	122,880	$74,811,452	0.16%
4	Projected Contingency Balance	2,196,307	74,811,453	2.94%	(1,160,819)	74,811,452	-1.55%	1,167,120	$74,811,452	1.56%
5	Percentage of Contingency Used - Approved	26,051	$2,252,358	1.16%	#REF!	$0	#REF!	-	$1,290,000	0.00%
6	Percentage of Contingency Used - Approved & Projected	56,051	$2,252,358	2.49%	#REF!	$0	#REF!	122,880	$1,290,000	9.53%

Notes:

1. ROM - Rough order of magnitude cost
2. Pending totals include total ROM and submitted costs. ROM costs are only included if final pricing has not yet been submitted.
3. Costs will be tracked as a ROM until COP is submitted to the Owner. Costs will then be tracked as submitted costs until approved (or disapproved) by Owner.
4. Pricing listed herein is original contract price and DOES NOT include Washington State sales tax unless otherwise noted.
5. Pricing listed herein DOES NOT include design fees unless otherwise noted
6. Contract values in Change Type Distribution table exclude Washington State sales tax.
7. Owner Contingency beginning balance consists of the MACC negotiation reduction.
8. Individual COP's include estimated Washington State sales tax. Sales tax is not part of the contract and will be removed from the COP value for the formal change orders.

Last Responsible Day Legend:

Tracking — Approval required date > two weeks out

Critical — Approval required within two weeks or less

Approval required immediately or is overdue

Hold — Approval on hold

Attachment K

Prosser Memorial Health

CAPITAL BUDGET REQUEST FORM

Date: 02/1/2023

Requesting Department: Surgical Services **Cost Center**: 702 **Project Lead: Sara Dawson**

Budgeted: ☐ Yes ☒ No Amount $ 21,839 + tax and shipping

Priority: ☐ Urgent ☒ Essential ☐ Replacement ☐ Desirable

Type of purchase: ☒ Purchase ☐ Capital Lease ☐ Operating Lease

Brief Description: The ERBE is an electrosurgical machine that uses Argon gas for the management of bleeding and Polyp removal during GI procedures. It prevents unnecessary tissue damage to the colon tissue. It also enables the physician to take out large polyps that would normally need to be removed with a surgical procedure.

STATEMENT OF NEED: It is critical for the ability for Dr. McDonnell to perform ERCPs, specifically sphincterotomies. We need to purchase another one in order to use it on the second Olympus to where Dr. McDonnell will be using the ERCP scopes in the surgical suite.

Utilization: ☐ Times per day ☐ Times per week ☒ Times per month ☐ Times per year

Utilization Comments:

Supply Chain Review: NA

Equipment environmental needs or construction needs: N/A

Biomedical and Periodic Maintenance: 1yr Service contract

IT Support Required: None

Please explain estimated revenue and/or savings: We will gain revenue by doing ERCPs

Cost associated with the capital item, where applicable: No associated costs with purchase.

Prosser
Memorial Health

Proposed financing: Purchase.

Items	Option A	Option B	Option C
Cost of capital item	21839.80		
Removal of old equipment	NA		
Maintenance contracts (By warranty x monthly $ of contract)	2495.00		
Start-up supplies + first year	N/A		
Training Costs	N/A		
Installation	N/A		
Site Preparation/Construction	N/A		
Shipping	unknown		
Tax (8.6%)	1878.22		
TOTAL COST OF PURCHASE	26,213.02		
Payback Period			
Return on Investment %			
Net Present Value			
Other			

Additional or reduction of FTE's needed to operate equipment: None

Impact	Departments impacted by this purchase	Departmental Collaboration: *(Are the Departments with Max or Min impact supportive and prepared for this purchase? What actions are planned for successful implementation across all impacted departments?)*
Max	**NA**	
Mod		
Min		**Already trained**

Staff Training Plan	
Who needs training?	**N/A**
Who will provide training?	

Prosser
Memorial Health

Proposed financing: Purchase.

Items	Option A	Option B	Option C
Cost of capital item	21839.80		
Removal of old equipment	NA		
Maintenance contracts (By warranty x monthly $ of contract)	2495.00		
Start-up supplies + first year	N/A		
Training Costs	N/A		
Installation	N/A		
Site Preparation/Construction	N/A		
Shipping	unknown		
Tax (8.6%)	1878.22		
TOTAL COST OF PURCHASE	26,213.02		
Payback Period			
Return on Investment %			
Net Present Value			
Other			

Additional or reduction of FTE's needed to operate equipment: None

Impact	Departments impacted by this purchase	Departmental Collaboration: *(Are the Departments with Max or Min impact supportive and prepared for this purchase? What actions are planned for successful implementation across all impacted departments?)*
Max	**NA**	
Mod		
Min		**Already trained**

Staff Training Plan	
Who needs training?	**N/A**
Who will provide training?	

Prosser Memorial Health

How will training be implemented?	
How will training be tracked?	
Will this be added to new hire orientation?	**NA**
Is a competency assessment indicated?	**No.**
What current P&P will require revision or development?	**No.**
Where will equipment manuals/instructions be kept for easy access 24/7?	**On sharepoint.**
Other	**Staff are already trained.**

Other Comments:

SIGNATURE PAGE: Please make sure all signatures are obtained before submitting for CEO/CFO for approval. Please ensure all documents are complete, signed, and ready for review the Monday of Board Packet Week (3rd Monday of the Month).

Department Director: _____ Date: 2-6-2023

Supply Chain Director: _____ Date: 02-06-2023

Maintenance Director: _____ Date: 2.6.23

Chief Information Officer: _____ Date: 2-9-23

Chief Nursing Officer: _____ Date: 2/9/23

Chief Financial Officer: _____ Date: 2/9/23

Chief Executive Officer: _____ Date: _____

To the Board of Commissioners for Approval (if applicable) Date of Board Approval: _____

erbe

"QUOTATION"
VIO® 3/APC® 3

Customer Contact Name: Malissa Garcia; mgarcia@prosserhealth.org
Facility Name: Prosser Health - PREMIER
Sales Representative: Alexis Goranson (206) 304-1891; alexis.goranson@erbe-usa.com
Date: 01/26/23 *Quote valid for (60) sixty days*

Description	Part #	Qty	Price	Extended Price
Erbe VIO® 3 Electrosurgical Unit	10160-000	1	$ 20,095.00	$ 20,095.00
Two-pedal foot switch; VIO® 3; ReMode; bracket; middle piece	20189-353	1	$ 1,235.00	$ 1,235.00
Monopolar cable MO 3 Pin; OD 3mm socket;L 4.5m	20192-135	2	$ 154.90	$ 309.80
Subtotal (capital):				**$ 21,639.80**
Estimated Shipping Cost (special freight):				**$ 200.00**
Invoiced Grand Total (without trade-in credit):				**$ 21,839.80**
Grand Total:				**$ 21,839.80**
				(plus applicable tax)
VIO® 3 (1 year per unit)		1	$ 2,495.00	$ 2,495.00
*		1	**$ 1,996.00**	**$ 1,996.00**

Extended Warranty:
***20% discount to be applied if extended warranty is purchased at time of system purchase**

"By receipt of this Quotation, you agree that this Quotation and its contents are of a confidential nature, and that you will hold and treat in the strictest confidence, and that you will not disclose this information or any of its contents to any other entity without the prior written authorization of Erbe USA"

Warranty: 2 years parts and labor VIO® Generator
1 year parts and labor APC® 3
Terms: Net 30 Days
Delivery: FOB Marietta, GA - Freight to be added as a separate line item

For more information or to place an order contact:

customerservice@erbe-usa.com
800-778-ERBE
ıwest Parkway, Marietta, GA 30067 FAX: 770-955-2577

Attachment L

Prosser Memorial Health Announces Dr. David Carl as New Chief of Staff

Prosser - Prosser Memorial Health is proud to announce Dr. David Carl as the new Chief of Staff starting January 2023. Dr. Carl, MD, leads Benton City Clinic's Pediatrics department and previously held the position of Vice Chief of Staff. He is certified by the American Board of Pediatrics, among many other professional certifications and associations.

"I am excited for the opportunity to lead Prosser Memorial Health during the time of growth. As always, our focus is on our patients and delivering high quality, affordable healthcare to our community," said Dr. David Carl.

Outgoing Chief of Staff, Dr. Jared Clifford, Podiatric surgeon at Prosser's Orthopedic Center, held the two-year position from 2021 to 2023. Grandview Clinic provider Dr. Jose Santa-Cruz, MD, will serve as the new Vice Chief of Staff. For more information, contact Chief Communications Officer Shannon Hitchcock in Prosser Memorial Health's Community Relations office at 509.786.6601.

Attachment M

Prosser
Memorial Health

OUR PROVIDERS

Jayme Thompson
DO
Family Medicine
Prosser Clinic
509.786.1576

Jacobo Rivero
MD, FAAFP
Occupational Medicine
Prosser Clinic
509.786.1576

Heather S. Morse
PMHNP-BC
Psychiatric & Mental Health
Prosser Clinic
509.786.1576

Teresa Charvet
PA-C
Women's Health
Prosser Clinic
509.786.1576
Prosser Women's Health Center
509.786.0031

Zach Garland
ARNP
Family Medicine
Prosser Clinic
509.786.1576
Prosser Wound & Infusion Care Center
509.786.6639

Nicola Nylander
MD
Dermatologist
Dermatology Center
509.588.4555

Karmina Bowen
ARNP
Certified Nurse Practitioner
Dermatology Center
509.588.4555

Steve Peters
MS, MHP, FS, LMHCA
Licensed Mental Health Therapist
Benton City Clinic
509.588.4075

Jessica Luther
ARNP
Nurse Practitioner
Benton City Clinic
509.588.4075

Suzanne Staudinger
MD
Family Medicine
Benton City Clinic
509.588.4075

Jennifer Brindle
MD
Family Medicine
Benton City Clinic
509.588.4075

David Carl
MD
Pediatrics
Benton City Clinic
509.588.4075

Brian Proctor
DO
Pediatrician
Grandview Clinic
509.203.1080

Erica Garza
ARNP
Family Medicine
Grandview Clinic
509.203.1080

Sarah Glover
ARNP
Family Medicine
Grandview Clinic
509.203.1080

Peter Park
ARNP
Family Medicine
Grandview Clinic
509.203.1080

Jose Santa-Cruz
MD
Family Medicine
Grandview Clinic
509.203.1080

Becky Morris
CNM-WHNP
Women's Health
Grandview Clinic
509.203.1080

Juliet Dennis
PMHNP-BC
Psychiatric & Mental Health
Grandview Clinic
509.203.1080

Tamera Schille
MD
Pediatrician
Yakima Valley Farm Workers Clinic*
509.882.3444

Mitchell L. Cohen
MD, AGAF, FACG
Gastroenterologist
Prosser Digestive Health Center
509.786.5599

W. Michael McDonnell
MD, FACP, AGAF, FAASLD
Gastroenterologist
Prosser Digestive Health Center
509.786.5599

Karan Bhatti
MD
Cardiologist
Prosser Heart Center
509.786.5599

Afton Dunham
ARNP
Nurse Practitioner
Prosser General Surgery Center
509.786.5599
Prosser Wound & Infusion Care Center
509.786.6639

Richard Unger
DO
General Surgeon
Prosser General Surgery Center
509.786.5599
Prosser Wound & Infusion Care Center
509.786.6639

Jared Clifford
DPM, FACFAS
Podiatric Surgeon
Prosser Orthopedic Center
509.786.5599

Thomas Halvorson
MD
Orthopedic Surgeon & Sports Medicine
Prosser Orthopedic Center
509.786.5599

Samuel J. Strebel
MD
Orthopedic Surgeon
Prosser Orthopedic Center
509.786.5599

Thomas Tieu
MD
Urologist
Prosser Urology Center
509.786.5599

Coral Tieu
MD
Allergy / ENT Specialist & Surgeon
Prosser Ear, Nose, & Throat Center
509.786.5599

Lori Lovato
Audiologist
Prosser Ear, Nose, & Throat Center
509.786.5599

Kevin Liebe
Audiologist
Prosser Ear, Nose, & Throat Center
509.786.5599

Robert Wenger
DO
Emergency Department
Hospital
509.786.2222

Lindsey Smith
DO
Emergency Department
Hospital
509.786.2222

Steven Rode
DO
Emergency Department
Hospital
509.786.2222

Wali Martin
MD
Emergency Department
Hospital
509.786.2222

James Wallace
MD
Emergency Department
Hospital
509.786.2222

Rachel Monick
MD
Emergency Department
Hospital
509.786.2222

Brian Sollers
DO
OB/GYN
Prosser Women's Health Center
509.786.0031

Heidi Weaver
MD
OB/GYN
Prosser Women's Health Center
509.786.0031

Bailey Padilla
CNM
Women's Health
Prosser Women's Health Center
509.786.0031
Benton City Clinic
509.588.4075

Ridhima Gupta
MD
OB/GYN
Yakima Valley Farm Workers Clinic*
509.882.4700

Derek Weaver
DO
Family Practice & Obstetrics
Weaver Family Medicine*
509.837.0070

Kevin Marsh
MD
Pediatric Hospitalist
Hospital
509.786.2222

Syed Hashmi
MD
Hospital Medicine
Hospital
509.786.2222

Caleb Haws
DO
Hospital Medicine
Hospital
509.786.2222

Shelli Collingham
MD
Hospital Medicine
Hospital
509.786.2222

Blake Roy
CRNA
Anesthesia
Hospital
509.786.2222

Ryan Steed
CRNA
Anesthesia
Hospital
509.786.2222

Robert Erwin
CRNA
Anesthesia
Hospital
509.786.2222

Ryan McDonald
CRNA
Anesthesia
Hospital
509.786.2222

Ben Passey
CRNA
Anesthesia
Hospital
509.786.2222

Thomas Ballard
MD
Diagnostic Imaging
Hospital
509.786.2222

*Affiliated Clinic

PMH Medical Staff Committees Report
November 2022 – January 2023

Medical Executive Committee: Dr. Clifford, Chair 2022, Dr. Carl, Chair 2023-2024

- The Committee met 4 times in the period.
- Quality reports included the Community Health Needs Assessment/Improvement Plan, Patient Scorecard, and RHC Clinic Survey results, as well as the quarterly Utilization Review Report.
- Required provider Certifications and related reminder notification system was reviewed.
- There were 6 New Appointments and 8 Reappointments to the Medical Staff approved and recommended to the Board during the period.

Medical Staff Quality Improvement Committee: Dr. Martin, Chair

- The Committee met 3 times during the period.
- Internal and external chart reviews were conducted on 41patient records during the period, including FPPE reviews.

Credentialing Committee: Dr. Martin, Chair 2022, Dr. Rode Chair 2023-2024

- The Credentialing Committee met three times in the period.
- There were 33 New Appointment/Reappointment applications reviewed by the Committee.

Emergency Department Committee: Dr. Wenger, Chair

- The Committee met two times in the period.
- ED Flow Project was presented. The project details how the patient flow proceeds safely and efficiently through the ED and prepares the department for patient volume surges.
- ED reported a record number 1665 patients November.
- The Insertion of External Pacemaker policy was approved by the Committee.
- The ED providers were made aware of the changes in the 2023 Coding and Billing Update.

Medicine / Pharmacy and Therapeutics Committees: Dr. Hashmi, Chair

- The Committee(s) met in November. The January meeting was rescheduled due to the ongoing DOH Survey.
- Acute Care Services Report metrics, Infection Control/Exposure Report, Reportable Diseases and Covid-19 updates were reviewed/discussed by the Committee.
- Medication Reconciliation Quality Improvement Project data reported for October: 98%
- DNP student project on Antimicrobial Stewardship was presented to the P&T Committee.
- Emergency Supply Kit Policy was approved for use. Kits placed in the clinics.
- The current Pharmacy & Therapeutics Dashboard data was reviewed.

Perinatal / Pediatric Committee: Dr. Carl, Chair 2022 and Dr. H. Weaver Chair 2023-2024

- The Committee met one time in the period.
- The following policy revisions were approved by the Committee: Care of the Substance Use Exposed Newborn Eat/ Sleep and Pharmacologic Treatment Guidelines; CordStat 13, and Bronchiolitis Protocol. The Pediatric Peripheral IV Policy to be approved online.
- VBAC/High Risk Reviews were discussed by the Committee; 5 approved, 1 pending additional information

Surgery Committee: Dr. Sollers, Chair 2022 and Dr. C. Tieu, Chair 2023-2024

- The Committee met in November and January.
- The Surgical Services Dashboard was presented. The November report had 2712 surgical cases/procedures to date. The 2023 Surgical Services Dashboard will report surgical procedures, colonoscopies and endoscopies separately.
- GI has its own identified quality markers and will have a separate report.
- Standardization of ED Communications with surgeons was discussed and informational topics reviewed for presentation to the ED Committee.
- A protocol for Drug Eluting Stents and Dual Antiplatelet Therapy for GI Procedures was approved, with a formal policy to be presented at the next meeting of the Committee.

Community Clinics Committee: Dr. Santa-Cruz, Chair 2022 and Dr. S. Staudinger Chair 2023-2024

- The Community Clinics Committee met in November and January.
- A report was provide on the Population Health nurse pilot program in the Prosser Clinic and Medicare Welcome and Wellness Exams. The goal is to have a nurse in each clinic to perform the Welcome to Medicare and Wellness program to patients.
- Grandview Clinic had its RHC Survey in January. There were identified policy deficiencies that were addressed and related policies were subsequently approved.

Attachment O

Prosser
Memorial Health

Experts in caring

Attachment P

To: Bryon Dirkes <bdirkes@prosserhealth.org>
Subject: FW: 2023 Superbowl Contest

Good Morning:

Are you good at sports predictions? Well, it's almost time for the 2023 Superbowl and for you to predict the winning team! We will be sending around the Football Squares sheets to sign-up.

The Superbowl will be played onSunday, February 12th

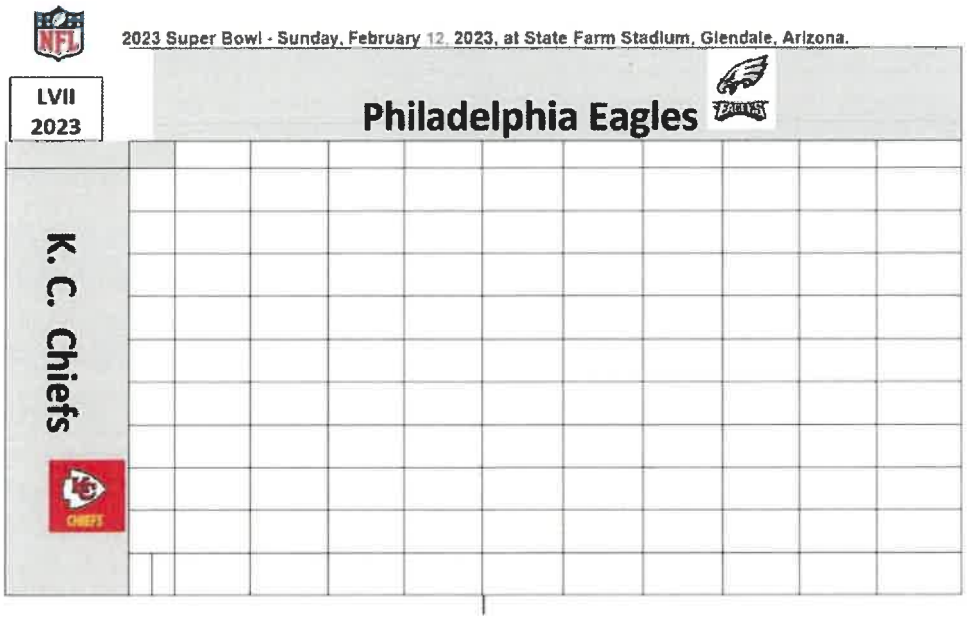
Prosser Memorial Health Superbowl Squares

What is it?

A chance to get engaged in a fun activity that brings us all together. It's also a great way to win great prizes by selecting the square that is picked after each quarter of the Superbowl game, based on the score at the end of each quarter during the Superbowl game.

How Do I Play?

Pick one open white square and***neatly print your first and last name: ONLY ONE square please!***



Where are the Sign-Up Sheets?

A Clinic sign-up sheet will be routed through the clinics beginning today!
The Hospital sign-up sheets will be routed to all departments beginning today!

What are the prizes this year?

First Quarter:
$25.00 Amazon Gift Card

Second Quarter:
$50.00 Prosser Memorial Health Logo Wear

Third Quarter:
$100.00 Visa Gift Card

Final:
Eight (8) Hours of Vacation Time

(winners must be PMH employees to qualify for the vacation/PTO prize)

Bryon Dirkes
Chief Human Resources Officer | Human Resources
PROSSER MEMORIAL HEALTH

Craig Marks

From: Crystal Blanco
Sent: Monday, February 13, 2023 11:26 AM
To: Crystal Blanco
Cc: !All Staff
Subject: 2023 Superbowl Contest

Importance: Low

Good morning:

What a game last night and below are our Superbowl Square Winners from Superbowl LVII!

First Quarter:

$25.00 Amazon Gift Card

Lonnie Montiel
Claudia Blackburn
Kaylee Swan
Darla Don

Second Quarter:

$50.00 Prosser Memorial Health Logo Wear

Isabel De La Cruz
Guadalupe Flores
Andrea Morena
Marisol Rojas

Third Quarter:

$100.00 Visa Gift Card

Maricela Rivera
Leticia (Geli) Copado-Trujillo
Stephanie Honey-Morrow
Tamara (Tammy) Pettis

Final

Eight (8) Hours of Vacation Time

Gus (Chompi) Davila
Jacquelyn (Jackie) Rodriguez
Christine Rivero
Amanda (Mandy) Hibbs

Congratulations to our winners. Human Resources will contact you with your prizes.

Have a great week!

Bryon

	Chiefs	Eagles
1st	7	7
2nd	14	24
3rd	21	27
Final	38	35

LVII
2023

Prosser
Memorial Health

Philadelphia Eagles

K.C Chiefs

	0	6	7	1	3	9	5	2	8	4
2	Shirley Menrieth	Kristal O.	Lindsay Mellie	Miriam Robles	Myra Wenn Gonzalez	Mari Rivera	Aubrey Wedale	Maureen Hildebrandt	Nicky	Brooke Goodpaster
3	Victoria Torrico	Rose H	Jay Boyle	Felix Garcia	Lucia Magana	Dorien Sanchez	Elisabeth Mora	Stephanie Pitzel	Judith Chavez	Jennifer Cantu
7	Madi Benjert	Sara M.	Kaylee Swan	Andrea Valle	Jessica Chavez	Kim Winter	Annie T.	Anna Mili	Guadalupe Manana	Alejandra Arteaga Martinez
4	Kelly Kimbrel	Brenda Flores	Tina	Angie Carter	Griselda Cruz	Kala Greene	Jasmin Zepeda	Amber Guthrie	Rebecca Hernandez	Andrea Morena
0	Brian Brindle	Lindsey Schutt	Jill Pagel	Rusti	Maria D. Cardenas	Cassi Cazares	Ivan Castellanos	Melissa Jeasen	Esmeralda Ornate	Elvia Gimlin
8	Lisa Lewis	Summer Landa	Courtney Mireles	Karla Greene	Gaylyn Concienne	Terra Palomarez	C. Rivero	Lynn Jedenchic	Sarah Gonzalez	Zaira Campuzano
1	Heather Lorenz	Jaya Raymond	Stephanie Flores	HAWS	Felicia Flores	Tina French	Christina Hurtado	Rosie Padilla	Irene Chavez	Miranda Wellner
5	Melinda M. Reyes	Manna Wheeler	Madeline Reed	RODE	Marneye Driesen	Bri Shenz	Katie Atkinson	Diana Wilson	Griselda Villalobos	Maria Persinger
6	Tammy Leighty	Lorie Serl	Dr. Hashmi	Elena Rodriguez	Veronica Huerta	Emily Berry	Sherry Ricard	Nanal Sanchez	Aimee Sarmiento	Shelly Morgan
9	Liz Gonzalez	Jomeca Escuyos	Monica Sanchez	Bailey Dilbert	Bonnie Bair	Shannon H.	Rosa Lopez	Olga Cuevas	Tabitha Breshears	Montessa

2023 Super Bowl - Sunday, February 12, 2023, at State Farm Stadium, Glendale, Arizona.

	Chiefs	Eagles
1st	7	7
2nd	14	24
3rd	21	27
Final	38	35

NFL LVII 2023

Prosser Memorial Health

Philadelphia Eagles

K.C Chiefs

	2	0	5	1	4	6	9	7	8	3
8	Rosie Sandoval	Laura Montanaro		Jennifer Trevino	Niemi Barrego	Nina Hanson (Louis)	Deb Bushnell	Peter Park	Steve Peters	Dr. Proctor
0	Dr. Staudinger	Dr Cam	Rocio Moran	Lucerito Salcedo	Imelda Herrera	David Portillo	Emmalee Mason	Cindi Pineda	Dr. Wallace	Vanessa Cisneros
3	Dr. Weaver	Lynnsay Oswalt	Baileys Padilla	Daisy Magana	Yolanda Campos	Grace Waters	Karmina Bowen	Brian Gese	Cecilia Barraza	Miranda Smith
1	Dr. Wenger	Zach Garland	Isabel Jimenez	Ophelia Gonzales	Jocelyn Martinez	Robert Mason	Steve McPhee	Geli Copado-Trujillo	Ariana Garcia	Dr. Martin
2	Erica Garza	Dr. Sellers	Kayla Hunt	Lucia Ramirez	Maisy Moats	Julie Martinez	Maria Cervantes	Anna Mendoza	Gabby Torres	Hope Ramirez
9	Rhonda Wild	Joe Alston	Ty Nelson	J. Joaquin	Rosa Torres	Jayne Thorsen	Dawn Bell	Toni Schaff	Peter Culp	Sarah Glover
7	Helen Burgard	Helen Blankenship	Richa Saem	Jessica Luther	Hideki Ruzow	Amanda Bazan	Michelle Crumby	Claudia Blackburn	Sofia Mendoza	Molly Schutt
4	Melodie Charwood	Alison Bunker	Nick Cobble	Stephanie Gonzalez	Lupita Lab PFM	Amy Doherty-Magallan	Ashley Kristofferson	Jenny Brindle	Sasha Thomasson	Stacie Olsen (ER)
6	Christi Doornink	Heather Morse	Maria Cristo	Dr Martin	Beth Phinney	Laura Sosa	Mariel Cerda	De Rivero	Teresa Chavez	Jenny Chavez
5	Dr. Nylander	Alexia Verduzco	Nichole Whitney	Becky Morris	Jose Santacruz	Esperanza Aviles	Juliette Dennis	Aida DeLaCruz	Jennifer Nunez	Erin Woody

2023 Super Bowl - Sunday, February 12, 2023, at State Farm Stadium, Glendale, Arizona.

	Chiefs	Eagles
1st	1	1
2nd	14	24
3rd	21	27
Final	38	35

NFL

LVII
2023

Prosser
Memorial Health

Philadelphia Eagles

K.C Chiefs

	6	5	3	0	1	4	8	2	7	9
0	Alison Campbell (ER)	Kim Crosby-Crosco		Adriana Trujillo	Samantha Garcia ext. 6124	Jen Kernan	Carolina Rueda	Jason Raver	Gussie Hughes	Jim Mickelson
8	Leticia Navarro		Gloria Zuniga	Hilda Campos	Ana Garcia	Mireya Diaz	Ruby Prieto	Dr. T. Tieu	Veronica	Nora
3	Rocky	Tim Shipley	Andy V.	Dr. Unger	Amy Enriquez	Paul Weisz	Cecilia Espinoza	Melissa Garcia	Mary Pat Hall	Neil Taylor
5	Jenny Hare	Lorie Sauls	Diana Ramirez	Gabriela Sanchez-Macias	Bryon Dirkes	Maria Davis	Phillip Braem	Stephanie Titus	Becca Pettis	Wendy Eller
1	Rachael Vargele	Liz Conklin	Afton Dunham	Maria Madrigal	Heath Anderson	Vida Sasso	mary castrejon	Dr. Cohen	Monica Pena	Coral Tieu
2	Tracy Van Mas	Maggie Munoz	Michelle Risk	Lynn Smith	Denise Guillen	Crystal Blanco	Maria Rubalcaba	Courtney Estell	Michael Smith	Shantel McGarvey
4	Maria Herrera (ER)	Savannah Capener	Billie Brown	Dr Clifford	MaryLee Dawsey	Rachel Carolina	Tom Norton	Ron Austin	Nigel Day	Katelyn Greene
9	Ashley Gunderson	Gaylin Griffiths	Rosa Rivera	Rita Galvan	Dr. Bhatti	Ethan Carter	Annie Parker	Dr. McDonnell	Monique Saenz	Bill Wilson
7	Kristi Shoman	JESSICA GONZALEZ	Denise Allen	Sandi mccall	Jasmin Figueroa	Wes Kessinger	Cristal Arreola	Jody Andringa	Leonie Montiel	Ingrid Mortensen
6	Hollie Wood	Cassie Hansen	Melanie M.	Brittney Derderian	Dr. Lindsey Smith	Rosa Merlin	Chantal Thornburg	Edith Naveras	Maria Meza	Suzanne Merkl

2023 Super Bowl - Sunday, February 12, 2023, at State Farm Stadium, Glendale, Arizona.

	Chiefs	Eagles
1st	7	7
2nd	14	24
3rd	21	27
Final	38	35

Prosser Memorial Health

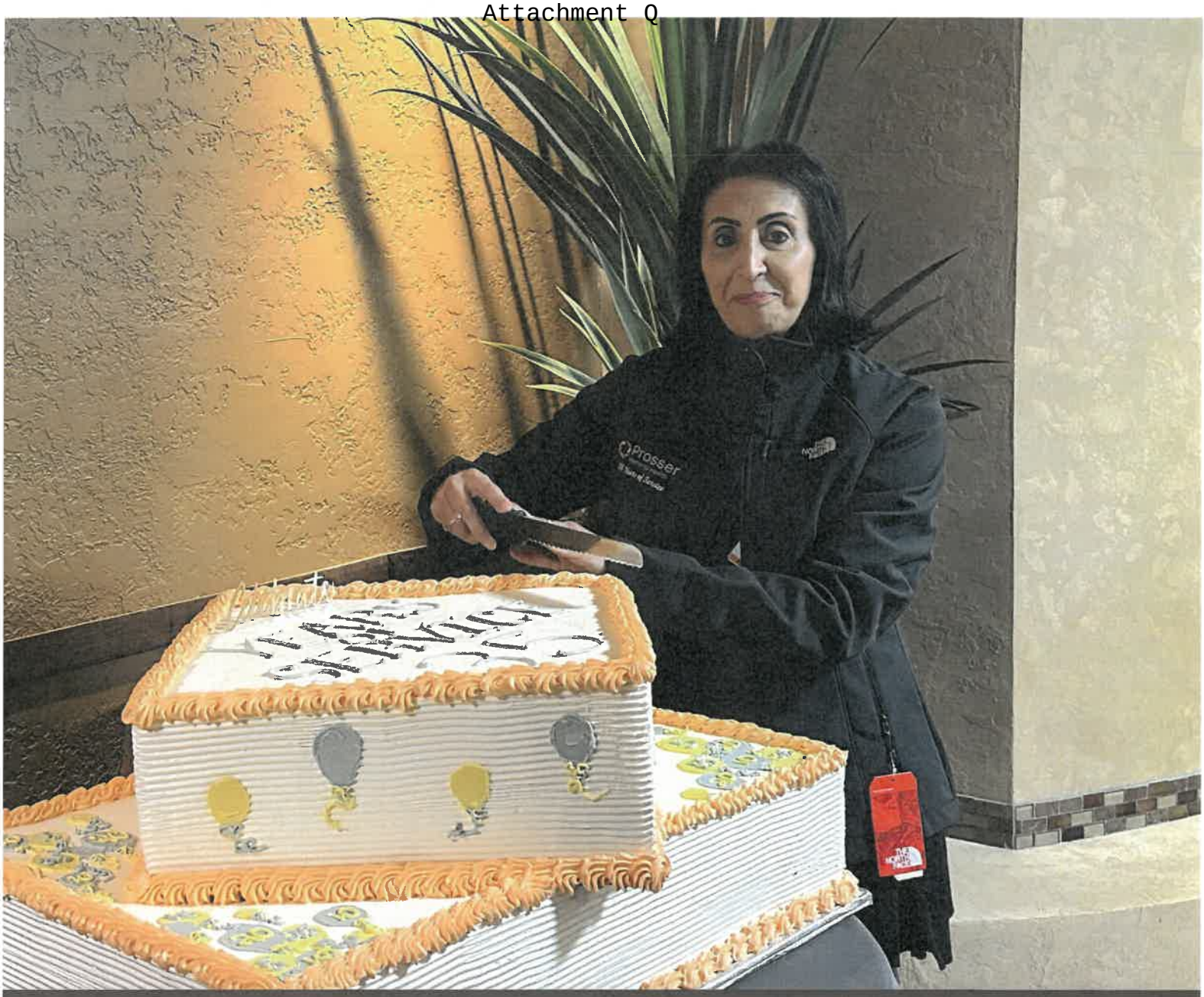
LVII 2023

Philadelphia Eagles

K.C Chiefs

	1	5	8	3	6	9	4	2	0	7
1	John Stalder	Sunshine Zavala	Briana Galarza	Juanita Dragulla	[illegible]	Cecilia Garcia	Tasha Sears	Brittney Balmes	Tricia McClure	Tamara Pettis
8	Chris Huston	Amanda Hibbs	Angela Garcia	Kari Mendoza	Merry Fuller	Tracy Lewis	[illegible] Flores	Kristi Mallema	[illegible]	Rosemary Mendoza
2	Rubi Rodriguez	Sophia Carrillo	Eileen Sheppard	[illegible] Takeuchi	Tanieka Sampson	Judy McCormick	Donna Haydon	A.C. Coleman	Michelle Arciga	Samantha Moncivaiz
9	Dorene Jones	Julie Gonzalez	DeAndre Hardy	Amanda Leighty	Jessica Valdez	Anna Iacadao	Kimberly Food Service	Bonnie A.	Cisco W.	Shawna Hagensicker
3	Isaiah M.	[illegible] Mikla	Blake Roy	Cheryl Stafford	Dave Stowman	Sierra Hilde	Meagan Bronkhorst	Rachel Boyle	Sarah Mora	Haley Seaton
6	Perla Salmeron.	Mardi Dixon	Gladys M.	Jacqueline Villanueva	Maggie Sanchez	Veronica Reyna	Alex Carballo	Roselina Pineda	Sergio Merino	Patti Hong
7	Jesse Hale	Shannon Magaña	Marlen Gonzalez	Miriah W.	Eric Heinlein	Celeste Olivas	Meghan Luther	Carline Vaux	Demi M.	Darla Don
5	Nancy Durbey	Maddy Nelson	Summer Washington	Maria Amezquita.	Nikole P.	Jaimie Smith	Lisa Reagor	Justin Herzog	Sam Strebel	Patty Lewis
0	Lisa Klette	Shelbie Stafford	[illegible] Mallin	Kyle Pettit	Esther Flores	Raquel McCraw	Kayla Schriner	Ashley Gunderson	Sara Dowa	Lanita Flores
4	Wellanie Bantle	[illegible]	[illegible]	Chris Wells	Brian Fechter	Amy Shook	Marisol Rojas	Olena	Marnaye D.	David Rollins

2023 Super Bowl - Sunday, February 12, 2023, at State Farm Stadium, Glendale, Arizona.



PROSSER MEMORIAL HEALTH EMPLOYEE NEWSLETTER

THE PULSE

Prosser
Memorial Health

FEBRUARY | 2023

News & Events

Years of Service Luncheon

On January 18th, we celebrated employees' years of service at Desert Wind Winery. Thank you for being outstanding professionals. We couldn't do it without you!

5 YEARS

10 YEARS

15 YEARS

20 YEARS

Congratulations Mary Castilleja for celebrating 35 years! Thank you for all that you do!

35 YEARS

Celebrating YEARS OF SERVICE

5 YEARS

- Brittney Balmes
- Rachel Boyle
- Brian Brindle
- Kayla Campbell
- Angela Carey
- Dr. David Carl
- Sara Dawson
- Courtney Estell
- Merry Fuller
- Jessenia Garcia
- Malissa Garcia
- Erica Garza
- Annabelle Hansen
- Peter Lewis
- Jessica Luther
- Sergio Merino
- Heather S. Morse
- Carolina Pineda-Perez
- Griselda Ponce-Verduzco
- Christine Rivero
- Dr. Jacobo Rivero
- Margarita Sanchez
- Kaylee Swan
- Christopher Wells
- ShaRhonda Wild

10 YEARS

- Cynthia Alaniz
- Felicia Flores
- Alan McLaughlin
- Mara Ripplinger

15 YEARS

- Crystal Blanco
- Jessica Chavez
- Mary Clark
- Dr. Jared Clifford
- Cecilia Garcia
- Angela Garcia
- Amanda Hibbs
- Christopher Huston
- Jennifer Kernan
- Susan Miklas
- Ernestina Salguero
- Jennifer Smith
- Jennifer Trevino
- Aurora Weddle

20 YEARS

- Sara Benitz
- Maria I. Cardenas
- Gaylin Griffitts
- Dorene Jones
- Rebecca Pettis

35 YEARS

- Mary Castilleja

Prosser Memorial Health

News & Events

Congratulations Dr. Cohen

Congratulations to our Gastroenterologist Dr. Mitchell Cohen, for receiving an award for "Excellence in Patient Healthcare" from Community Health of Central Washington. This award is in appreciation for his dedication and contribution to patient healthcare throughout our community! They stopped by our Digestive Health Center to personally present him with this award and to thank him and the PMH team for the excellent care their patients receive when they are referred to Dr. Cohen. Great job Dr. Cohen and team! You guys rock!

Congratulations Summer Landa!

Congratulations to Summer Landa, Respiratory Therapist, who is now a Neonatal Resuscitation Program Instructor!

Welcome Dr. McDonnell

Help us welcome gastroenterologist, Dr. W. Michael McDonnell to the Prosser Digestive Health Center. Dr. McDonnell made the move to Prosser Memorial Health on the recommendation of long-time colleague and friend, Dr. Mitchell Cohen.Dr. McDonnell is bringing Endoscopic Retrograde Cholangiopancreatography (ERCP) to Prosser Memorial, a service new to us and not currently offered in nearby healthcare facilities.

Welcome to the Team!

Top Left to Right: Dr. McDonnell, Courtney Mireles, Summer Washington, Julisa Gonzalez, Chantal Thornburg, Beth Davis
Bottom Left to Right: Madeline Reed, Heather Lorenz, Michelle Crumby

News & Events

Go Red for Women Luncheon

Save the date! The luncheon will be held Friday, February 3, 12pm at Desert Wind Winery. Tickets will be available for purchase at prosserhealth.foundation. Order your shirts and wine glasses now!

Blood Drive March 28

The blood drive will be held in the Vineyard Conference Room at Prosser Memorial Hospital from 9:00am - 3:00pm.

Visit https://www.redcrossblood.org/give and use code "PMH" to schedule a time. Community members welcome.

News & Events

Café Hours

Monday - Friday
Breakfast: 7:00am - 9:00am
Premade Burritos & Grab-N-Go's: 9:00am - 10:30am
Lunch: 10:30am - 2:00pm

Saturday and Sunday
Breakfast: 7:00am - 9:00am
Lunch: 11:00am - 1:00pm

Café Specials

Week of February 6
Chop Chop Salad, Hearth & Rye (sandwich bar), and Tavola

Week of February 13
Cheese Louise, Hearth & Rye, and Zen

Week of February 20
Drums & Flats, Hearth & Rye, and Happy Hen

Week of February 27
Verde, Hearth & Rye, and K-Steak

Mobile Order with InstaEat!

- Web Orders
  https://order.instaeat.com/2583
- Apple Devices Link
  https://apps.apple.com/us/app/instaeat/id1517007451
- Android Devices Link
  https://play.google.com/store/apps/details?id=com.tacitinnovations.instaeat&gl=US

ASPIRE Awards

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

Erica Garza

Congratulations to Erica Garza, ARNP, at our Grandview Clinic, for receiving a Gold ASPIRE Award! Erica came in on her day off to see a new patient who was having some very concerning symptoms. She did a thorough examination and then reached out to our hospitalists to ensure the best plan was being put into place for the patient. As a result of Erica's work and guidance, the patient was able to get the referrals she needed and got into see a spine surgeon quickly. The patient has now had the needed surgery and has her health back! We are immensely grateful to Erica for her part in making this happen. Thank you Erica for treating every patient like they are family!

Noemi Borrego

Congratulations to Noemi Borrego, Patient Services Representative at the Grandview Clinic, for receiving a Silver ASPIRE Award! Noemi was recognized for going above and beyond at our Diabetic Forum in November. We were able to use the headphones and translation system at Bethel Church for our Spanish speaking guests, but our translator had to cancel at the last minute. Noemi graciously agreed to jump in and do this, which entailed translating four presentations she had never seen before in real-time! This was quite a task as some of our presenters were speaking at a pretty fast clip. After the presentation one of the families using the translation equipment thanked us for providing such valuable information. They were able to make appointments to see Dr. Santa-Cruz before they left the event. Thank you Noemi! You truly went above and beyond and we were able to help our patients and our community in doing so.

Anniversaries

Happy Anniversary!

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

Happy 1 Year

- **Maria Diaz Sanchez**
  Emergency Services ED Tech
- **Alex Arnold**
  Emergency Services ARNP
- **James Mickelson**
  EMS Paramedic
- **Patricia Hoag**
  Laboratory Microbiologist

Happy 2 Years

- **Shawna Hagensicker**
  Surgical Services
  Central Sterilizing Technician

Happy 4 Years

- **Michelle Risk**
  Financial/Payroll Analyst
- **Nina Hanson**
  Prosser Clinic
  Population Health RN
- **Laura Montanaro**
  Diagnostic Imaging
  CT Technologist - R

Happy 5 Years

- **Miriah Webb**
  Diagnostic Imaging
  Echo Tech - R

Happy 6 Years

- **Merry Fuller**
  Nursing Administration
  Chief Nursing Officer
- **Brian Brindle**
  Diagnostic Imaging
  Echo Tech - R

Happy 8 Years

- **Wesley Kessinger**
  Emergency Services RN
- **Kale Guerin**
  EMS Paramedic
- **Jody Andringa**
  Emergency Services RN

Happy 9 Years

- **Hanna Wheeler**
  Family Birthplace RN
- **Eileen Sheppard**
  Surgical Services RN
- **Shantel McGarvey**
  Emergency Services RN

Happy 10 Years

- **Marta Meza**
  Patient Financial Services
  Financial Counselor

Happy 11 Years

- **Mara Ripplinger**
  Lab Assistant II

Happy 13 Years

- **Hope Ramirez**
  Benton City Clinic CMA

Happy 16 Years

- **Aurora Weddle**
  Diagnostic Imaging Director

Happy 18 Years

- **Gaylyn Concienne**
  Health Information Management
  Certified Coder

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

February 1

- **Jomeca Meildred Escuyos**
  Family Birthplace RN

February 3

- **Elisabeth Mora**
  Health Information Management
  Certified Coder

February 5

- **Roxane Snider**
  HR Generalist - Senior Recruiter

February 6

- **Deanna Bridger**
  Environmental Services Technician

February 7

- **Wellanie Bautista**
  Laboratory Microbiologist

February 8

- **Amanda Leighty**
  Surgical Services
  Surgical Technician

February 9

- **Mary Clark**
  Wound Care & Infusion Care Center
  Wound Care Nurse
- **Michelle Arciga**
  Nutrition Services Cook

February 10

- **Gabriela Guel**
  Family Birthplace RN

February 15

- **Shannon Hitchcock**
  Community Relations
  Chief Comms Officer/ E.D. of the Foundation/ Cmty. Relations
- **Ariana Garcia**
  Lab Assistant II

February 16

- **Rusti Wilson**
  Cardiopulmonary Director
- **Lindsey Smith**
  ER Physicians
  Physician Emergency
- **Erin Woody**
  Lab Assistant II

February 22

- **Tanieka Sampson**
  Surgical Services
  Surgical Technician

February 24

- **William Wilson**
  EMS EMT B2
- **Menalyn Herrero**
  Medical/Surgical RN
- **Isabel De La Cruz**
  Prosser Specialty Clinic CMA

February 25

- **Margarita Munoz-Costello**
  Medical Staff Coordinator

February 26

- **Maricela Rivera**
  Call Center Representative

February 28

- **Helen Burgard**
  Prosser Clinic CMA Float
- **Shirley Henrich**
  Medical/Surgical RN
- **Helen Burgard**
  OP Special Procedures RN

SHRINKING A MOUNTAIN OF DEBT, ONE PIECE AT A TIME

Debt is something you will probably have to deal with at some point. The size of that debt may range from owing the price of some new clothes to a mortgage on a house. Whatever the case, knowing how to handle personal debt is important in maintaining healthy finances over the long term.

Are You in Too Much Debt?

To evaluate your debt situation, start by asking yourself these questions:

- Is my credit card balance growing?
- Am I paying only the minimum on my bills or am I missing payments altogether?
- Do I spend over one-third of my income on paying off bills, loans, etc.?

All of these are warning signs that you may have taken on more debt than you can afford.

If you are juggling substantial debt, realize that you are not alone. The average overall debt held by U.S. households with any kind of debt was $96,371 in 2021, and as of September 2022, the average credit card balance among households with credit card debt was $9,260.[1,2]

How to Master Your Debt

Understand that while debt may initially seem like an unshrinkable mountain, it can be diminished one piece at a time. Gaining an overall understanding of your finances, including any debt you may hold, is probably the best way to do that.

The first step is to document your income. Look at your paychecks and assess how much money is coming in after taxes on both a monthly and an annual basis. Do the same for any other sources of income you may have.

The second step is to document your expenses. Ask yourself:

- How much do I spend monthly on necessary items such as rent, food, insurance, gas, and electricity?
- How much do I spend on optional items such as going to the movies, eating meals at restaurants, and buying expensive drinks at the coffee shop?

The third step is to document and understand your debt. For each loan and credit card, find out:

- What is the amount I owe?
- What is the interest rate?
- What is the payment schedule?

Use the information you've gathered to determine how much money you can dedicate to paying off your debt, as well as to project a timetable for doing so. From time to time, review your expenses to see if there are any new ways to allocate extra funds to reducing your debt. Also consider using cash instead of credit, as well as temporarily taking on some additional (perhaps seasonal) work, to help reduce your debt.

To tackle existing credit card debt, consider strategies such as paying off the card with the highest interest rate first, transferring your balance to a card with a lower interest rate, and paying more than the minimum amount. The last strategy is very important, since the less you pay off, the greater the interest will be and the longer it will take to pay off your balance in the long run.

It's Worth the Effort

Having too much debt can leave you cash strapped and unable to handle a financial emergency or make progress on saving for retirement and other financial goals. In fact, close to 30% of households surveyed by the Federal Reserve Board said they would not be able to cover an unexpected expense of $400 using cash, savings, or a credit card paid off at the next statement.[3] Outstanding credit card debt likely contributes to this dilemma, since many households would not have that much after accounting for what they owe on their credit cards.

You can avoid such pitfalls by analyzing your spending, controlling expenses, and establishing a plan to reduce -- and perhaps eliminate -- your debt. A financial professional can help you with your planning.

Source/Disclaimer:

[1]Bankrate, Average American debt 2021. November 22, 2022.

[2]Nerdwallet,"2022 American Household Credit Card Debt Study," Nerdwallet, December 8, 2022.

[3]Report on the Economic Well-Being of U.S. Households in 2020, Federal Reserve Board, July 2020.

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

Heart Healthy Caprese Avocado Toast

Servings: 4

Ingredients

- 2 ripe avocados
- 2 teaspoons fresh lemon juice
- Sea salt and black pepper, to taste
- 4 slices bread, toasted
- 4 ounces fresh mozzarella, sliced and cut into pieces, to fit the bread
- 1 cup grape tomatoes, halved
- 1/4 cup basil leaves, roughly chopped
- Balsamic glaze, for drizzling

Instructions

1. Cut the avocados in half, remove pit, and scoop the flesh into a small bowl. Add the lemon juice, sea salt, and black pepper, to taste. With a fork, mash the ingredients together, keeping the texture slightly chunky.
2. Spread the mashed avocado evenly onto toasted bread slices. Top with fresh mozzarella slices, tomatoes, and basil. Season with additional salt and pepper, if desired. Drizzle with balsamic glaze and serve immediately.

NOTES: You can use gluten-free, multi grain, or keto bread.

- **Calories: 329kcal**
- **Carbohydrates: 25g**
- **Protein: 12g**
- **Fat: 22g**
- **Saturated Fat: 6g**
- **Polyunsaturated Fat: 3g**
- **Monounsaturated Fat: 12g**
- **Trans Fat: 1g**
- **Cholesterol: 22mg**
- **Sodium: 332mg**
- **Potassium: 655mg**
- **Fiber: 8g**
- **Sugar: 4g**
- **Vitamin A: 729IU**
- **Vitamin C: 16mg**
- **Calcium: 200mg**
- **Iron: 2mg**

February Health Tips

There are dozens of ways to improve your health. You can eat nutritious food, maintain a healthy weight, take supplements, and exercise regularly. Another way to influence your health is to perform random acts of kindness. February 17th is Random Acts of Kindness Day. Studies have shown that random acts of kindness can provide the body with the following health benefits:

Acts Of Kindness

- **Increases Your Love Hormone**
  Performing and witnessing acts of kindness produces oxytocin, our 'love hormone.' Oxytocin increases our self-esteem and optimism, which is extra helpful when anxious or shy in a social situation.

- **Giving To Others Reduces Depression and Improves Your Sense of Well-Being**
  When we're depressed, it's hard to feel good about ourselves. We're quick to see our limitations and slow to remember our strengths. Helping others with random acts of kindness has been shown to make us feel better about ourselves and the world.

- **Helping Others Is Good for Our Heart**
  Performing acts of kindness lowers cortisol, our stress hormone. Helping others has been shown to protect against heart disease by reducing inflammation, especially C-Reactive protein.

- **A Helper's High**
  Studies have shown that putting the well-being of others before our own without expecting anything in return — or what is called being altruistic — stimulates the brain's reward centers. Those feel-good chemicals flood our system, producing a sort of "helper's high." For example, volunteering has been shown to minimize stress and improve depression, and that's not all. The same activity can also reduce the risk of cognitive impairment and even help us live longer. One reason for this, experts say, is because kindness contributes to our sense of community and belonging. And that, studies have found, is a pivotal contributor to a healthy, longer life.

- **Pain Reduction**
  Engaging in acts of kindness produces endorphins, the brain's natural painkiller. Giving to others has also been shown to instantly deactivate the area of the brain that reacts to painful stimuli. When performing an act of kindness, that area of the brain is turned off.

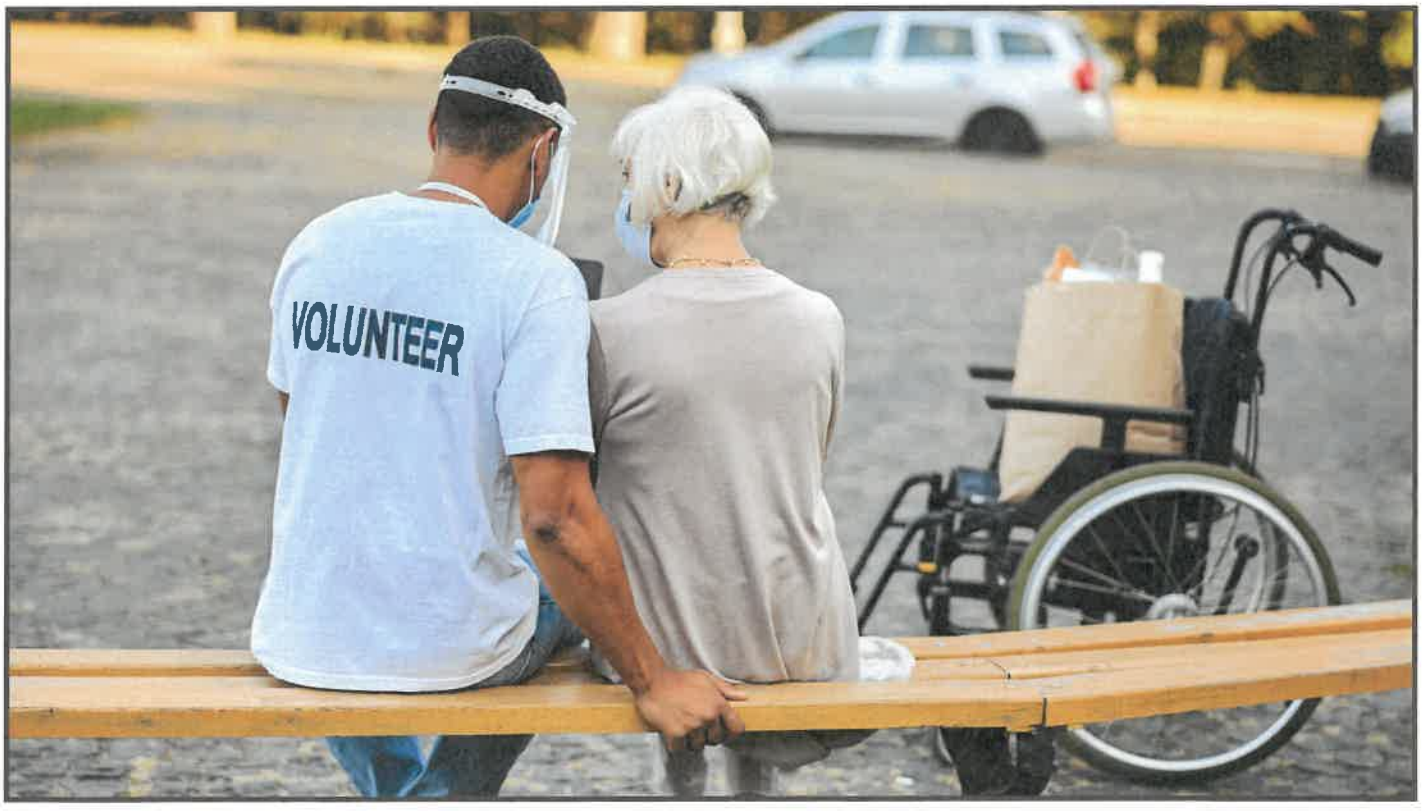
- **Lifespan**
  People who volunteer tend to experience fewer aches and pains. Giving helps to others protects overall health twice as much as aspirin protects against heart disease. People 55 and older who volunteer for two or more organizations have an impressive 44% lower likelihood of dying early, and that's after sorting out every other contributing factor, including physical health, exercise, gender, habits like smoking, marital status, and many more.

So, if you're convinced and want to jump right into being a kinder and more helpful person, here are a few ideas to get you started:

- While driving, make room for the car that wants to enter your lane.
- Let the person in line behind you at the supermarket go first.
- Give a genuine compliment to someone in the elevator with you.
- Do the same for your boss — they probably never get compliments!
- Let go of a grudge and tell that person you forgive them.
- Be there for a friend having a tough time. Don't try to fix it; just listen.
- Leave your mail carrier a thank you note.
- Pay for a meal or a cup of coffee for someone waiting in line behind you. Odds are, they will pay it forward.
- Reach out to a loved one. Check in with friends and family, just to let them know you're thinking about them. You could also send a postcard to a friend you haven't connected with in a while.
- Give an exhausted parent a break. Babysit for a parent who works from home, while their children are engaged in virtual learning. Being able to help the child, maybe making a snack, or even serving lunch can be tremendously helpful to a parent.

- Praise a local business. Leave a positive Google or Yelp review after a good experience at a local restaurant or store. This is especially helpful to them during the challenges of the pandemic.
- Donate your gently used clothing to a local shelter or safehouse. Towels and blankets can be especially welcome at animal shelters.
- Make time to volunteer. Food drives need helpers to arrange meal boxes and hand out at drive-up locations.
- Help a neighbor maintain their yard or driveway. Plow snow or mow the lawn of someone that could use the extra help.
- Bring in fresh fruits or vegetables to work to share with coworkers.

Remember, by performing acts of kindness(cheerfully), we are making the world a better place, but don't forget – any act of kindness you give to others is also a gift to yourself.



Prosser
Memorial Health

ProsserHealth.org

Attachment R

Issue 1

HARDWIRED RESULTS®

January 2023

Leadership Foundations

Ten Traits of Great Leadership

SELF-TEST:

How do you demonstrate these successful leadership traits?

GREAT LEADERS...

1. Know Themselves
2. Earn and Foster Trust
3. Are Curious and have a Growth Mindset
4. Are Bold and Brave in Their Actions
5. Set Clear Goals and Achieve Them
6. Lead Like an Entrepreneur
7. Spark Positivity
8. Know It's Not About Them
9. Insist on the Highest Standards
10. Lead the Change Journey

HURON

A Message From Huron

Happy New Year!

We are happy to announce that Huron is resuming our Hardwired Results® publication, which first debuted in 2004. The focus of this issue is on Leadership Foundations. - Ten Traits of Great Leadership.

As I reflect on the past three years of working through incredibly challenging times with healthcare leaders, there were wins and losses, successes and failures, laughter and tears, and through all of those, there was learning. Learning how to be more agile, make decisions faster, communicate better, and support our people through what may be some of the most difficult years of this generation. Leadership is hard. Whether you are a first-time leader, senior executive or somewhere in between, do you know what great leadership looks like?

At Huron, we believe defining leadership principles and enabling leaders to demonstrate these qualities is vital to overall success. In fact, organizations that define "what right looks like" and weave it into their culture gain alignment and momentum. These definitions of leadership become a guiding framework for hiring, orienting, and evaluating leader success. They are foundational, timeless and applicable to all areas.

If you haven't already done so, we challenge you to take the time to define what successful leadership looks like in your organization. If your organization does have leadership foundations in place, are your leaders held to this standard, and does it permeate your leadership culture?

Using what healthcare workers value in their workplace and what we know from our work with successful organizations around the country, Huron has defined ten foundational leadership characteristics. The foundational principles can be a guide for your organization as you define what excellence in leadership looks like for your organization.

Also, as part of this edition, we have also provided a self-assessment tool on the back pages. Use this to review and challenge your leadership readiness.

Now more than ever, your team needs a role model in leadership excellence, and while it is a challenging time to be in leadership, we are here to help. Thanks to each of you and the difference you make each and every day.

Yours in Service,

Tonia Breckenridge, MBA CP (SHRM) Managing

Director, Healthcare

Leadership Characteristics Defined

Defining Leadership in Your Organization

Imagine you signed up for a marathon. You show up early, ready for the run, only to find out there is no defined distance, no finish line, no rules, no path, no judges and none of those nice volunteers that staff the water cup stations along the way. You line up with the other confused runners to begin. The starting shot is fired, and everyone runs in different directions, tripping over each other as they look for the track. Ridiculous? Maybe. Yet sometimes, that is exactly how leaders feel as they take to the "leadership track."

Admittedly, there are those individuals who seem to be born with innate characteristics that make becoming an effective leader seemingly easier for them. But, as leadership scholar Warren Bennis says, "leaders are not born," to remind us that there are leadership characteristics that can be learned and refined.

So, how well has your organization defined the characteristics and skills expected of them? Do you have a sound guiding framework for leadership success? Do your leaders know "what right looks like"?

At Huron, we believe that defining leadership principles is critical, and investing in your leaders' development and enabling them to demonstrate these leadership qualities is vital to your organization's overall success.

When organizations clearly define and communicate leadership roles and expectations, it not only builds a solid foundation for leaders as they run the race, but it allows an opportunity for leaders to know upfront what is expected of them. They have insight into what they can expect to find in their peers and other leaders and what "winning" looks like. They can clearly see how to be a living expression of your culture, growth, and future success.

What does it take to be a great leader today?

Huron recently conducted a survey of 715 healthcare workers, including clinicians, nurses, staff, and leaders. We asked what these leaders value in their workplaces and their satisfaction with those factors. From this data, areas such as leadership excellence, Diversity, Equity and Inclusion, team rapport, as well as work-life balance, emerged as direct needs of our workforce today. (Huron's Healthcare Talent Research, 2022)

This new data provides excellent insight into what leaders should be aware of and where they should maintain and focus their efforts. After reviewing the data mentioned above, you might agree that some of the areas defined in this research would not have appeared on the list even a short time ago.

There may not be a formula or checklist to follow that instantly "makes you a great leader." However, Huron has studied and identified leadership foundations that we believe successful leaders consistently demonstrate.

The next pages will help define *ten leadership foundations that* successful healthcare leaders and organizations around the country demonstrate. It can be used as a guide to define what common characteristics great leaders have and need to lead, engage employees, strengthen cultures, and achieve goals today.

Leadership Foundations

Great Leaders . . .

1. Know Themselves

Leaders know that great leadership starts with themselves, knowing and appreciating their strengths and weaknesses, recognizing their biases, and understanding their impact on others at all times.

Great leaders have self-awareness. They know and appreciate their strengths and weaknesses and recognize their biases. They understand their role and the impact on others they lead. There are high expectations for what leaders say and do. They know that continuous improvement requires accepting feedback and putting it into action. This self-awareness, resilience and growth help them be their best selves for their colleagues and teams.

QUICK TIPS

KNOW THEMSELVES

- Use an assessment tool to gain insight into your unique personality and working styles. (MBS, Meyers Briggs, etc.)
- Use 360 feedback from your peers to help gain insight into your individual strengths and opportunities.
- Take time to self-reflect. Some biases are explicit and easy to identify. Others are implicit and require more introspection to identify.
- Seek out a coach or mentor to help in your personal development.
- Make sure you have an individual development plan for yourself. Great leaders are continually growing.

2. Earn and Foster Trust

Leaders listen first and bring empathy and their authentic selves to everything they do. They are okay with being vulnerable and embrace cultural differences to help those around them be their best.

One of a leader's most critical responsibilities is to foster an environment of trust.

Trust is the basis for most interactions we have. It's the reason we're willing to use our hard-earned paychecks to buy goods and services, devote our lives to another person in a relationship, or cast a vote for someone who will represent our interests. It is the reason we choose an organization or career or take on new jobs and roles. We all know what it feels like to have that trust broken. And we also know that once trust is lost, it is tough to regain.

Healthy organizations operate on trust. To reinforce the value of trust, think about what it is like when a team doesn't trust their leader, the team doesn't trust each other, or maybe the leader doesn't trust their team. Work might still get done, but with greater difficulty and outcomes that are not as reliable as in a workplace where trust is prevalent.

To build trust, great leaders are accessible and as transparent as possible, treating others as they want to be treated. They make it safe to succeed and to fail. They own their outcomes and are accountable for the team's successes and hardships. Leaders learn from mistakes, own up to those failures, and use those learnings to grow alongside their team.

Their behavior is genuine and authentic and encourages like behaviors in others. One thing is sure; leaders understand that our individual and collective differences add to the richness and success of our people, customers, and organization.

Leaders also understand that everything they do has a transactional and transformational component. A simple email might feel "transactional," but it can also be transformational depending on what's being communicated, such as reward and recognition. We don't shy away from that word as we fully understand the deep meaning of transformational. To be transformational as a leader is to bring sweeping and dramatic change.

HURON

While there is nothing wrong with wanting to be promoted or move up professionally, transformational leaders are more about what they give to their team rather than what they can get out of the situation. Unlike the leader who dramatically picks up trash or takes the time to talk to staff only when they're being watched, the authentic leader consistently demonstrates behaviors aligned with their values. Yes, even when no one is watching.

And authentic leaders support the success of others. Allowing people to succeed as their whole authentic self is one way to create psychological safety with your team. You will learn more about psychological safety in Foundation 5 - Focus on Employee Engagement.

QUICK TIPS

EARN & FOSTER TRUST

- Have a method to track your follow-up and that you do what you say you are going to do. Use a stoplight report to collect and communicate and rounding logs help to document interactions and ensure follow-up.
- Hardwire genuine reward and recognition into your huddle, staff meetings and your daily interactions.
- Be transparent with your team to create and build trust. Ask for help when needed.
- Be intentional to ask for other points of view that are different from your own.
- Admit when you don't have the answer. Consider how your team can help to solve.
- Following important communications, assess for gaps in understanding or misinterpretations.

3. Are Curious and Have a Growth Mindset

Leaders are students of the world. They are nimble learning machines that distill learning from every experience and want action and improvement.

If you've moved into a leadership position, you probably already know a lot. You've developed your skills and gained experience in your field. But there's always more to learn.

Great leaders have a growth mindset — they're on a constant quest for knowledge and personal development. Leaders are continuous learners. They demonstrate a growth mindset; they are curious about better ways to do things, seek wisdom from others, and share learning whenever possible.

Creativity drives innovation and turns ideas into action. But they don't learn alone. Leaders encourage others to experiment and learn from positive experiences and failures. Leaders are adaptable and open to change. They purposefully lead others through complexity. And leaders are masters of appreciative inquiry. They ask thoughtful questions designed to elicit new thoughts and problem-solving. Listening to your team and customers and looking for the question behind the question is a foundational characteristic of the most effective leaders.

Dr. Carol Dweck, a leading expert on motivation and achievement goal theory, and her team of researchers found employees of companies with a growth mindset are: "47% likelier to see their colleagues as trustworthy; 34% likelier to feel a strong sense of ownership and commitment to the company; 65% likelier to say that the company supports risk-taking; and 49% likelier to say that the company fosters innovation."

As we look to create a growth mindset, consider how often we rush to judgment. Our minds want to create meaning, constantly making assumptions and judgments while looking for patterns. This is not inherently bad – it can keep us safe. But beware that judgment can tend to block our curiosity.

A leader's growth mindset has incredible potential. Strive toward creativity, motivation, empathy, ambition, self-improvement and higher performance. It's one of the essentials that makes a leader great.

QUICK TIPS

ARE CURIOUS & HAVE A GROWTH MINDSET

- Make curiosity part of the conversations that you have with your staff. Add these discussions into huddles and staff meetings.
- When someone brings you a problem, ask them for their ideas. If they don't know, ask them, "Well, if you did know, what would it be?".
- If you don't have an individual growth plan for yourself, develop one. If you do, share it with your team so they know how to support you and others.
- Encourage all employees to have a growth plan. Make it part of your employee rounds and 1:1 conversations.
- Reward and recognize those who demonstrate intellectual curiosity. Allow people to "fail forward" and be rewarded for being curious, taking a step and moving something forward.
- Always challenge ideas respectfully and ask questions without being negative.
- If you find flaws in an idea, ask yourself, "If this COULD work, what could that look like?"
- Run ideas past a trusted advisor that thinks differently than you for a new set of eyes.

HURON

4. Are Bold and Brave in Their Thinking and Actions

Leaders challenge others and are willing to be challenged themselves, testing the status quo and standing up for what they believe in. They know good ideas come from all around and recognizing diverse perspectives can be the foundation for positive disruptive ideas.

Madam C.J. Walker said, "*I had to make my living and my opportunity, but I made it! Don't sit down and wait for the opportunities to come. Get up and make them.*" Madam C.J. Walker was an African American entrepreneur, philanthropist, and political and social activist. She was born in 1867 and died in 1919. According to the Guinness Book of World Records, she was also recorded as the first female self-made millionaire in America.

Think long about the quote above. One could learn a lot from a woman such as Madam Walker regarding being bold and brave. Considering who she was and the times she walked this earth, it would be expected that she not only had to overcome great obstacles but also had to do so with the boldness and bravery most of us in the 21st century could only imagine.

Great leaders challenge others and are willing to be challenged themselves, testing the status quo and standing up for what they believe in. They know good ideas come from all around and recognizing diverse perspectives can be the foundation for disruptive ideas. Leaders hold difficult conversations, encouraging constructive conflict to get to the best outcome and leaving disagreement at the door once a decision is made. Leaders know they cannot control everything but can navigate anything, much like a skilled sailor. While we may not be able to control the wind or the waves, we can use our skills and experience to navigate through them.

QUICK TIPS

Bold and Brave in their Thinking and Actions

- Think of an example of when you or someone you know has demonstrated bold thinking and actions. Challenge yourself and think of a situation you're in now that may give you a chance to step up and be bold.
- Understand that opportunities to improve don't make you a bad leader. Think of someone safe you can ask for constructive feedback. Get comfortable with asking, "How could I do better?"
- Is there a difficult conversation that needs to happen? Practice before having a tough conversation. Find a colleague and roleplay a difficult conversation with them.

5. Set Clear Goals and Achieve Them

Leaders know that self-limiting beliefs are just that — beliefs and not reality — and have the confidence to pursue the impossible. They know success doesn't fall in their lap and are willing to roll up their sleeves to pursue it.

Yogi Berra once said, "If you don't know where you're going, you'll end up somewhere else."

Setting goals helps leaders stay focused on what truly matters. Getting specific about goals helps leaders prioritize their time to achieve the organization's purpose. It allows one to understand where they need to aim their efforts. They come to favor progress over perfection. Leaders with clear goals take calculated risks and encourage others to identify the best solution and reach the best outcome. Leaders motivate and rally others to rise to new challenges and turn ideas into reality.

QUICK TIPS

Set Clear Goals and Achieve Them

- Keep your goals in front of you and take action.. Even small tasks and actions build upon the last; before you know it, you've done something significant.
- Create weekly or monthly progress reports, graphs and visuals to help you see your progress.
- Establish goals that stretch you but give yourself and your team the grace of celebrating the "little wins." If the goal is to move from 2 to 5 in 12 months and you realize you're now at 3.5 after three months...that's a big deal. Celebrate!

6. Lead Like an Entrepreneur

Leaders take an owner's mindset — doing what's best for the enterprise and executing their roles like they own the business. They own and act like the CEO of their work within the business.

Leading requires ownership and an entrepreneurial spirit. It's like when we talk about someone with a charismatic presence or a great performer, we say, "They OWNED that room!" We never say, "They RENTED that room!".

Ownership speaks to the spirit of leadership. An entrepreneur is someone we think of that owns their "business." How would you treat your workplace if it was your name on the sign or billboard out front? What if your mom or grandfather founded it? Would that bring a different level of pride to your work?

Rich Bluni, Huron National Speaker and author, about his dad, Jack, and how they named a street after him on the grounds of the hospital. So, literally, at the hospital where Rich worked each day, there was a street sign with the last name he shares with his dad on it. For Rich, that was more than just a sign. It was a reminder that "this is my house!" as we like to say. There was a sense of ownership when Rich walked by that street every day for several years.

Pride and connection.

It's true that we will usually treat something that is "ours" or that we "own" differently than we treat something that is someone else's. If you've ever lent a tool or a baking dish to *a friend* who is a little less "particular" than you are and you either had to ask 100 times to get it back or, once you did, you spent 45 mins wiping the dried mud and burnt cheese off the object, you know what we mean.

Leaders and team members leading as entrepreneurs are typically easy to spot. They are relentlessly committed to going above and beyond basic expectations. They feel that when the "organization wins," they win. It's not "us versus them"; it's just . . . us. They recognize that when they work hard, outcomes are achieved more often. If they find an opportunity for improvement in their area, they use this entrepreneurial spirit to identify a solution. They don't only bring problems forward; they bring solutions. They're the ones that when they say a sentence like "There's a problem over at..." they follow it with "...and I think we should do this!". They aren't just filling a role. They know the organization trusts them to care for and oversee an important piece of the business.

Ronaldo recognized there was a problem. He studied it. Then, he dug into his mind for solutions. He had a vision for what "right" would look like; he got creative, asked for help and then took action. He didn't send an email to his manager or write a complaint to HR. Or just "accept it" until that magical "they" came along to fix it. No. He took ownership of the problem and fixed it without inconveniencing or disrupting anyone else. An owner of a business often doesn't have the luxury of "passing the buck." They get out the mop, toolbox, or laptop and get busy. It's THEIR business. They want it to succeed, and they do what it takes to make it happen.

QUICK TIPS

Lead Like an Entrepreneur

- Consider what would be different if you excelled in this leadership quality. Who would benefit?
- Is there something that you currently have given to your leader that you should consider owning yourself?
- Identify something that you should lead and own that perhaps you don't at this time. Write it down and own it. There is no losing, only learning.
- Identify individuals that you can empower to follow your lead. Create a team full of owners.

7. Spark Positivity

Great leaders build on success and create attractive and engaging work environments. Leaders allow their authentic selves to impact the way they lead others positively.

Leaders who spark positivity and reject negative thinking inspire those around them to be their best at work. Without inspiration, people find they have to work harder to get as far, and leaders have to pour even more energy into convincing people to follow them.

Do you know who can't stand positive people? Negative people. You know them. Whenever you ask them how their department is doing, they say things like: "Oh, you know how it is..." and go on to tell you how NOT good it is. I mean, we all love a little dry humor sometimes, but if every time you ask someone how they are, they roll their eyes and say: "I'm just living the dream!" after a while, you start to figure out they don't mean it. Sometimes, as a leader, you have to find ways to help bring people to the light. Sometimes even the most negative among us just need a little push in the right direction.

One could write an entire book about the power of positivity, and many have. Please don't confuse "positivity" with some insincere, fake smile or sugary stuff. We are talking about optimism, hopefulness and empathy. In healthcare, we see so much negativity because we deal with some tough things. We see pain, illness, suffering and death. It's when it is dark you need light. When you are cold, you need warmth, and when you are surrounded by things that the rest of the world would shield their eyes from running away in terror, you need a little dose of optimism. A lift of spirit or even just a reminder that in all this darkness and struggle, there is a time for a smile, a hug, a laugh, or a reminder that there is something we can

find to be grateful for. We've talked about how trust matters for leaders. They need to trust and be trusted.

Positivity is like a magnet and builds trust in a team. Successful leaders recognize employees and say, "thank you." They seek to encourage a positive, productive, and innovative organizational climate and they model that behavior by what they do and say and how they think. They are authentic and liberal in sharing the wins. Employees appreciate heartfelt, sincere, specific recognition from their leaders. It doesn't just make others feel good; it drives and reinforces behaviors that produce great results. Remember, no one at the end of their lives ever says: "I got too much praise from everyone...I wish people were more critical of me!" As a leader, you never know how one word of encouragement, one thank you note, or one question about "what are you grateful for?" can be exactly what is needed. Be that leader. A good time to start is now.

QUICK TIPS

Spark Positivity

- Add Celebrate Wins" as a standing agenda item to staff meetings and huddle agendas.
- Create a rounding calendar for your direct reports and start each round with some version of "What's Working Well?"
- Keep your own "gratitude list" in an accessible location. Review it on a regular cadence—schedule time for writing notes of appreciation every week.
- Keep supplies (cards, email addresses, home addresses, stamps) stocked. Don't let the absence of a stamp in your top desk drawer prevent you from making a positive impact on a colleague!

8. Know It's Not About Them

Leaders are human. They know that leadership and success are not about them but about the team. They know to be kind, decent and fair no matter what, showing others care and compassion.

Leaders lead people. So, in reality, no leader is successful on their own. Leadership is not an individual sport. If healthcare were a sport, it would definitely be a team sport. Leaders hire and develop the best, investing in others' development. Strong leaders surround themselves with different perspectives, new eyes, and diverse people with diverse styles and strengths. They do this because they want the best for the team.

In the book Good to Great, Jim Collins identified the characteristics of a Level 5 Leader. This leader builds enduring greatness through a combination of personal humility and professional will. Harvard Business Review's study of organizations that made the move from good to great revealed that every organization that met its criteria for greatness had a leader who possessed this quality.

What does it look like to lead with humility? When receiving praise, acknowledge it and then point to others on the team who made the accomplishment possible. When placed in the spotlight, bring others along who deserve recognition. Position others in a positive light.

Leaders also create space for others to grow beyond their capabilities, coaching and mentoring people to be their best. They intentionally foster individual growth and help people capitalize on their strengths. Leaders also communicate at all levels because they know that leadership and success are not about them but about the team.

Nelson Mandela summarizes this foundation well. He says, "It is better to lead from behind and to put others in front, especially when you celebrate victory when nice things occur. You take the front line when there is danger. Then people will appreciate your leadership."

Leaders lead from behind, listening more, recognizing others for a job well done, and creating moments that matter, especially when no one is watching. They are the ones who see the greatness and the potential in others and nurture it. They take joy in seeing others succeed.

QUICK TIPS

Know It's Not About Them

- Give recognition when due. When things are going well, take time to recognize others who are contributing.
- To grow your skill in a task, use the "see one, do one, teach one" methodology. Teaching allows someone to become more proficient and helps to validate behaviors as well.
- Invest in others by sharing your knowledge, experience and your learning. It makes others and YOU better.

HURON

9. Insist on the Highest Standards

Leaders are in the business of making something great. They hire and develop the best, investing in others' development.

Leaders insist on the highest standards of themselves and others. They set the bar high because they know their teams can exceed their expectations, modeling the behaviors they expect to see in others. Leaders deliver with the highest quality, always model positive behaviors and treat others respectfully. They do not shy away from performance conversations, re-recruiting high and solid performers and moving low performers up or out.

When considering your performance standards, commitment to excellence is an essential element. "Good is not good enough" is the attitude held by those who excel in their field.

QUICK TIPS

Insist on the Highest Standards

- Visibly demonstrate your commitment to the highest performance and hold others to that expectation. If you role model acceptance of sub-par performance, your team will follow.
- Recognize that you can only take your team members as far as you, yourself, have gone.
- Hold developmental conversations with each team member. Focus on the progress they have made on their individual development plan. Provide coaching to guide growth and elevate their performance.
- Create behavior standards that set the expectations. Make them high yet achievable.
- Coach to high standards in daily interactions. Coaching in the moment allows people to receive timely and valuable coaching.

10. Lead the Change Journey

Leaders know that even good and positive change requires intentional effort. They also understand the personal change journey and that adapting to change is a personal and individual choice. They can connect individuals to change and lead them and themselves through this journey.

Leaders across the industry are grappling with unprecedented disruption and change. There is a greater need than ever for agile and change-ready leaders.

It is important to remember that change happens at the individual and personal levels. Leaders must intentionally support individuals through their own personal change journey. This will enable them to be ready to learn and to work in new ways. Change will occur, not because they have to change but because they want to. It is also important for leaders to be aware of their own personal change journey, so they are ready to lead others effectively.

Leading through change can be challenging. Leaders will very likely see resistance to change because it's natural for us as humans to react this way. Resistance can be active or passive; understanding these is key if leaders effectively lead people through change.

QUICK TIPS

Lead the Change Journey

- Think about a change you are about to implement in your area. Look at the stages of the personal change journey and think about how you will address each to help people and yourself along the way.
- Get out of the office and talk to people. Use listening sessions to allow time to identify and discuss pockets of resistance. Listening sessions might include rounding conversations, focus groups, town hall meetings, team meetings, third-party interviews, online surveys and bulletin boards, to name just a few.
- Listen, be authentically interested, do what you say you will do, keep communication open, reward and recognize and be transparent as a leader.

HURON

In Summary

Leaders are in the business of making something great. They understand that great things don't happen in big grandiose moments but, as Vincent Van Gough said: "Great things are not done by impulse, but by a series of small things brought together." Considering an artist like Van Gogh, his paintings weren't done all at once. He had to take the brush to the canvas hundreds of thousands of times, changing color and angle, each little brush stroke building off the last to create his works. A sculpture by Michelangelo didn't happen by picking up a giant boulder of marble and striking it once, creating a masterpiece. No, the great master chiseled and chipped and worked on that stone, making each chip look more and more like the angel he envisioned to be inside that slab.

So, as you read through these Leadership Foundations, understand that you cannot "do it all" by next Tuesday! You're reading this to become a great leader and sometimes this will happen in the small steps you put into practice.

Minute by minute, day by day, like the artist touching the brush to the canvas one touch, one stroke at a time until before them, the great work takes shape. A great leader will always focus on delivering with the highest quality — no matter how small the task at hand because they know there is really no "small task," much like Michelangelo knew that there was no small chip in the marble. Each step brought him closer and closer to revealing something breathtaking that we still marvel at today.

Leaders foster inclusion in all they do, allowing individuals to speak their truth — even if they disagree, standing up for others, and empowering their teams to ask why and why not. Leadership takes bravery. It takes grit, as they say. A willingness to take chances. They remind us that we are on a journey together. As a matter of fact, the root word of "Leadership" is "Lead" from the Anglo-Saxon Old English word "Loedan," the causal form of "Lithan," which means "to travel." The "journey" part of leadership is literally built into the very root of the word.

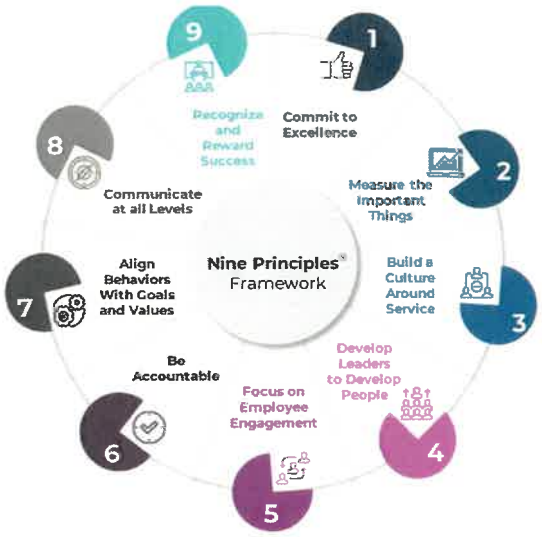
As you wrap your head around these timeless Leadership Foundations, embrace the journey. It's time to lean in, be curious, and enjoy your travels!

Huron announces New Upcoming Book *Summer 2023*

Over the years, at hundreds of organizations across the country, Huron has been both introducing and harvesting tools and techniques that improve and move organizations to higher levels.

With that in mind, Huron is pleased to announce its new and upcoming book, *Inspired Excellence* by best-selling author, Rich Bluni, RN. Grounded in our timeless Nine Principles® Framework of Excellence, Rich along with other healthcare experts offer fresh insights, evidence and strategies proven to drive your organization to success.

Email mstanzell@hcg.com to reserve your copy today!



Self Assessment

Questions to Ask Yourself

How do you rate in each defined leadership foundation? Answer these questions to help define areas in which you can grow as a leader.

1. Great Leaders... Know Themselves

Yes / No

- ☐ ☐ Do you know your strengths and opportunities?
- ☐ ☐ Do you recognize your biases?
- ☐ ☐ Do you have a personal development plan?

2. Great Leaders... Earn and Foster Trust

Yes / No

- ☐ ☐ How do you bring your genuine and authentic self to your team?
- ☐ ☐ Do you do what you say you are going to do?
- ☐ ☐ Do you intentionally put your biases aside and listen openly to others?
- ☐ ☐ Are you honest with yourself and your team about your limits and ask for help when needed?
- ☐ ☐ Are you transparent in your communication?

3. Great Leaders... Are Curious and Have a Growth Mindset

Yes / No

- ☐ ☐ How do you demonstrate a "growth mindset" for yourself and your team?
- ☐ ☐ Do you have an individual development/growth plan to grow as a leader?
- ☐ ☐ Have you challenged each direct report to create a professional development plan?
- ☐ ☐ Do you motivate and challenge others to be curious and improve their work?
- ☐ ☐ Do you embrace new ideas, or are you more likely to look for flaws first?

4. Great Leaders... Are Bold and Brave in Their Thinking and Actions

Yes / No

- ☐ ☐ Do you challenge yourself to be bold in your thinking and actions?
- ☐ ☐ Do you allow others to challenge you and encourage constructive conflict?
- ☐ ☐ When a difficult conversation is needed, do you lean in and get it done or avoid it as long as possible?

HURON

5. Great Leaders... Set Clear Goals and Achieve Them

Yes / No

- ☐ ☐ Do you have goals and desired outcomes set for yourself and your team?
- ☐ ☐ Do you have a method to check progress toward your goals?
- ☐ ☐ Do you celebrate progress and achieving milestones?

---

6. Great Leaders... Lead like an Entrepreneur

Yes / No

- ☐ ☐ Do you demonstrate ownership of your area or hope someone else will figure it out?
- ☐ ☐ Do you take responsibility for the losses as well as the wins?
- ☐ ☐ Do you identify as the "CEO" / "leader" of your area? Do you study an issue, have a vision for success, use your creativity and then take action? Are you stepping up to be the one who "turns the tables" on a problem?

---

7. Great Leaders... Spark Positivity

Yes / No

- ☐ ☐ Are you intentional in how you spark positivity in your area of responsibility? Do you model it? Share wins? Is it part of your day-to-day interactions?
- ☐ ☐ Do you reward and recognize your team frequently? Do you have thank you notes? If so, are your thank you notes at the bottom of your desk drawer or the top? (that's a coaching question we often ask the leaders we coach.)

---

8. Great Leaders... Know It's Not About Them

Yes / No

- ☐ ☐ Are you taking time to reflect on your performance and the efforts of others who have contributed to your success?
- ☐ ☐ Are you investing in developing others?

---

9. Great Leaders... Insist on the Highest Standards

Yes / No

- ☐ ☐ Do you know who your high, solid, and low performers are?
- ☐ ☐ Do you hold specific conversations with them to manage and elevate their performance?
- ☐ ☐ Does your team look to you for an example of the highest performance?

---

10. Great Leaders... Lead the Change Journey

Yes / No

- ☐ ☐ Do you know how people move through the personal change journey?
- ☐ ☐ Can you spot resistance to change and know how to address it?
- ☐ ☐ What are you doing to build a high-trust environment to help embrace change?

HURON

Attachment S

AGREEMENT

Style Definition: TOC 1

Between

PROSSER MEMORIAL HOSPITAL

and the

INTERNATIONAL ASSOCIATION OF FIREFIGHTERS, LOCAL I-24

EFFECTIVE January 1, ~~2020~~2023

UNTIL DECEMBER 31, ~~2022~~2026

DRAFT for Board of Commissioner Review

Table of Contents

PREAMBLE

This Agreement is made and entered into by and between Prosser Public Hospital District, Prosser, Washington, hereinafter referred to as the "Employer" and International Association of Firefighters, Local I-24 hereinafter referred to as the "Union" pursuant to a certification issued by the Public Employment Relations Commissioner, hereinafter referred to as "PERC". The purpose of this Agreement is to set forth wages, hours and working conditions for the bargaining unit.

ARTICLE 1 – RECOGNITION

1.1 Unit Description

The Employer hereby recognizes the Union as the exclusive bargaining representative for all regular full-time, fully compensated LEOFF eligible employees as defined by RCW 41.26.030(4e 1)(h) and RCW 18.71.200, excluding all other employees, and supervisory and confidential employees.

1.2 Communications and Notices

Any notices to be given hereunder by either party to the other except formal grievances, shall be effected in writing either by personal delivery or by first class mail as follows:

To the Employer	To the Union
CEO	President
Prosser Memorial Hospital	International Association of Firefighters
723 Memorial Street	Local I-24
Prosser, WA 99350	1305 Knight Street
	Richland, WA 99352

1.3 Regular Full-Time Employee

A regular full-time, fully compensated employee is one who is defined as LEOFF I eligible and works 1,950 or more hours in a calendar year and who has successfully completed the probationary period (one (1) year continuous employment).

1.4 Probationary Employee

A new or rehired employee hired to fill a regular full-time position as defined in Sections 1.1 and 1.3, and who has completed a probation period of not less than 90 (ninety) days of continuous employment. The probationary period may be extended for an additional ninety (90) days at the discretion of the Employer. During the probation period, the employee shall be on a trial basis and may be discharged without cause and without recourse. At the end of the probationary period, the employee will be notified whether regular status with the Employer has been granted.

ARTICLE 2 - RECOGNITION OF RIGHTS & FUNCTIONS OF MANAGEMENT

2.1 The Union recognizes the prerogative of the Employer to operate and manage its affairs in all respects in accordance with its responsibilities, lawful powers and legal authority except as expressly limited by the terms of this Agreement. All matters not expressly or clearly covered by the language of this Agreement or other addenda to this Agreement and/or Memoranda of Agreement, shall be administered for the duration of this Agreement by the Employer in accordance with such policies and/or procedures as the Employer, from time to time may determine.

2.2 Employer prerogatives and core management rights are inclusive of, but not limited to, the following:

1. The right to establish and modify reasonable work rules and procedures.

2. The right to schedule any and all work and overtime work, and the methods and process by which said work is to be performed in a manner most advantageous to the patients and consistent with the requirements of the public interest.

3. The right to hire, lay off and promote employees as deemed necessary by the Employer.

4. [illegible]

5. The right to make any and all determinations as to size and composition of the work force.

6. The parties understand and agree that incidental related duties connected with operations, not enumerated in job descriptions, shall nevertheless be performed by the employee when requested by the Employer.

7. The Employer shall have the right to take whatever actions the Employer deems necessary to carry out services in an emergency. The Employer shall be the sole determiner as to the existence of an emergency. An emergency shall be a sudden or unexpected happening or situation that calls for action without delay.

8. The Employer has the right to modify any and all operations and work requirements in order to more effectively and efficiently carry out services based on any and all new legislation, either national or state in origin, which may affect the Employer's ability to provide services on a cost-effective basis.

9. The Employer has the right to introduce new, improved and automatic methods and equipment to improve efficiency and reduce costs.

10. The Employer has the right to close or liquidate, combine, relocate, and reorganize divisions, offices, branches, operations, or facilities within the hospital. The decision to take such action is not subject to bargaining with the Union, however, the Employer agrees to meet with the Union to bargain Union identified impacts or effects of such action.

ARTICLE 3 – NON-DISCRIMINATION

3.1 The provisions of this Agreement shall be applied equally to all employees in the bargaining unit without discrimination as to race, color, religion (creed), genetic information, gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status. Neither PMH nor any bargaining unit employee shall in any way discriminate against any employee. All references to "employee" in this Agreement designates both sexes and whenever a particular gender is used, it shall be construed to include both male and female employees. The Union shall share equally with the Employer the responsibility for applying this provision of the Agreement.

3.2 The Employer, the Union, and its members agree not to interfere with the rights of employees to become members of the Union, and there shall be no discrimination, interference, restraint, threats or coercion against any employee because of Union membership or lack thereof or because of any employee's activity in any official capacity on behalf of the Union or for any other cause. The Union recognizes its responsibility as bargaining agent and agrees to represent all employees in the bargaining unit without discrimination, interference, restraint, threats or coercion.

3.3 When a new employee is hired in the bargaining unit, the Employer will give the name, address, and job classification of that employee to the Local Union President, or Secretary.

3.4 The Employer will give the new employee, at the time of hiring, a copy of the contract which will be supplied by the Union.

ARTICLE 4 - UNION RECOGNITION/DUES DEDUCTION

4.1 Employees may or may not join the Union. Employees electing to pay Union dues shall sign a dues deduction authorization form.

4.2 The Employer agrees to deduct twice each month Union dues from the pay of those

employees who individually request in writing that such deduction be made. The amounts to be deducted shall be certified to the Employer by the treasurer of Local I-24 and the aggregate deductions of all employees of Local I-24 shall be remitted, together with an itemized statement, to the International Association of Firefighters, Local I-24, 1305 Knight Street, Richland, Washington 99352, after such deductions are made. The Employer will also deduct with certification by the treasurer of Local I-24 and as supported by the individual's request in writing that such deduction be made, a one-time initiation fee as determined by the IAFF.

4.3 The Employer will coordinate pre-disciplinary, disciplinary action meetings, hearings and labor/management meetings. When an employee attends these meetings in the capacity of elected officer or shop steward of the Local, the employee will be granted time off with pay. Elected officers and shop stewards will receive the approval of their immediate supervisor to attend such meetings.

4.4 The Union shall designate its officers, delegates, and alternate delegates from among employees in the unit. The officers and delegates will not be recognized by PMH until the union has given PMH notice of the selection and their scope of authority. To the extent possible, the investigation of grievances or other business shall only be conducted during non-working times, in non-patient care areas and shall not interfere with the work of other employees, patient care or disturb patients or the normal operation of the Hospital. Meal and rest breaks are not considered working time.

Union indemnification: The Union shall defend, indemnify and hold harmless the Employer from, for and against any and all claims, lawsuits, complaints and/or grievances arising out of the provisions of this Article.

ARTICLE 5 – HOURS OF WORK

5.1 The Employer may schedule hours of work on the basis of eight (8), ten (10), twelve (12), or twenty-four (24) hours shifts. All hours worked in excess of forty (40) hours per week, Sunday through Sunday, shall be paid at one and one-half (1½) times the regular rate of pay. The Employer shall negotiate with the Union with respect to the impact of any decision, in the exercise of the Employer's discretion, regarding the change in work schedules of bargaining unit members. This includes, but is not limited to, changing from twenty-four (24) hour workdays to a lesser number of hours per day as set forth in this section.

5.2 Before the Employer changes the work schedule, as referred to in Section 5.1, the Employer shall first give the Union thirty (30) calendar days written notice and an offer to meet and negotiate the impact of the change. The notice and offer to negotiate shall not impede or alter the Employer's right to change the work schedule. The Employer agrees to continue bargaining the effects of such change, if any, are identified by the

Union.

5.3 The desired minimum staffing levels for any given 24-hour period is four (4) personnel with a minimum on-duty staffing will be four (4) personnel for the duration of this Agreement. Subject to the foregoing obligations in Sections 5.2, 5.4, and 5.7, the Employer will provide thirty (30) days' notice prior to any changes to a minimum staffing level effective this Section 5.3.

5.3.1 The parties agree that mandatory overtime will be initiated when the staff level falls below four (4) personnel. Further, the parties agree that when the staffing level falls to three (3) personnel, at the discretion of the Director, one shift lead all three (3) may be assigned to run (1) one for MED1 incidents and all three (3) shall respond on MED2 incidents or higher. In no instance will four (4) personnel be used as a single resource response.

5.3.2 Mandatory overtime will only be used to maintain the minimum of four (4) personnel on duty.

5.4 Overtime shall be governed by Prosser Memorial Hospital Policy Sec. 700.025 Overtime Approval

Shift Leads are required to obtain approval from the Director prior to the use of overtime. Employees who anticipate the need for overtime to complete the week's work must notify their supervisors in all cases and obtain approval prior to working hours that exceed beyond their normal schedule.

Procedure for offering Overtime

All per diem employees will be offered in seniority sequence according to shift prior to offering overtime to full time employees. Once all per diem employees have had an opportunity to accept or decline the work, then the shift lead may move on to offering the overtime to full time employees.

Mandatory Overtime

No employee may leave their post without the assistance of equal or higher class on site to take their place. At any time the employer may require employees to work extended hours. Consequences of Abandoning Post If any employee abandons their post without an employee of equal or higher class on site to take their place, they may be subject to disciplinary measures.

No employee shall be assigned work exceeding 72 consecutive hours. If an employee is assigned work beyond 72 consecutive hours, the employee shall be paid double time for all the work in excess of 72 consecutive hours.

5.5 The EMS Director shall not perform bargaining unit work except in cases where waiting for overtime personnel to respond would result in severe delay in patient care and treatment; or when no unit member is available; or to cover for employee time off for personal or professional activities.

5.6 [redacted]

ARTICLE 6 – WAGES

6.1 The types of employment and wages for all employees covered by this Agreement shall be listed in Appendix "A", attached hereto and by this reference incorporated herein.

ARTICLE 7 – HOLIDAYS

7.1 The following schedule of paid holidays shall be observed:

New Years Day	Thanksgiving Day
Memorial Day	Day after Thanksgiving
Independence Day	Christmas Day
Labor Day	Four (4) floating holidays to be taken in accordance with 7.5

If the holiday falls on an employee's day off, he shall be paid his regular rate of pay for that day. Full-time employees will receive eight (8) hours of pay and part-time employees will receive holiday pay prorated based on the number of regularly scheduled hours for the position. Probationary employees are eligible for the seven (7) set holidays on the same basis as other employees.

7.2 As a condition to payment for the above mentioned holidays, an employee must work the holiday if scheduled, the scheduled work day immediately preceding the holiday and the scheduled work day immediately following the holiday, unless excused by the Department Manager.

7.3 The Employer shall rotate holiday work to the best of its ability.

7.4 All employees covered under this Agreement who work a paid holiday~~, except floating, as defined in paragraph 12.1 above,~~ as referenced in paragraph 7.1 shall receive holiday pay at the regular rate of pay plus they shall be paid at the rate of time and one-half for hours actually worked on the holiday up to a maximum of eight (8) hours for regular

status employees. Holiday pay shall be paid on the scheduled shift where the majority of hours fall on the calendar date of the holiday.

7.5 Floating Holiday Hours: Full time eligible employees will be credited with thirty-two (32) hours for use as floating holiday hours on January 1 of each year. Probationary employees may not use floating holiday hours until completion of their probationary period. Floating holiday hours are not cumulative and must be taken during the year in which they are earned. Floating holiday hours may be used in one (1) hour increments.

ARTICLE 8 - SICK LEAVE

8.1 All regular employees as defined in Sections 1.1 and 1.3 above who have completed thirty (30) days of continuous service from their last day of hire shall be eligible for sick leave pay. Maximum accrual per month will not exceed eight (8) hours. Sick leave shall accrue based on the accrual factor (.04615) times the following hour types; inclusive of regular hours, low census hours, holidays, vacations, sick leave, overtime, funeral leave, call back, and in-service education up to a maximum of eighty (80) hours per pay period. Unused sick leave shall be accrued to a maximum of seven hundred twenty (720) hours. Sick leave credit is accrued by all regular part-time employees on a prorated basis. Part-time employees without benefits earn no sick leave benefits. Sick leave accrual for part-time employees is accrued in the same manner as described in vacation accrual for regular part-time employees.

8.2 Sick leave is accrued on the basis of eight (8) hours per month of continuous service.

Sickness shall be reported to the Department Director or designee within the department in the event the Department Manager is not available, or a designee with as much advance notice as possible but at least two (2) hours prior to the beginning of the employee's shift. Any employee who is off work due to illness in excess of three (3) work days, or less if sick leave abuse is an issue, will be required to provide a verification of illness from a medical practitioner acceptable to the hospital, as well as the medical practitioner's approval to return to work. The Employer has the right to require a second opinion from a medical practitioner directed and chosen by the Employer regarding the authenticity of sick leave usage and illness. A second opinion shall be at Employer expense.

Earned sick leave with pay may be taken for the following reasons:

A. Illness or injury which incapacitates the employee to the extent the employee is unable to perform the employee's work.

B. Doctor, dental, and optical appointments for treatment including laboratory work

associated with the actual appointments.

C Care for a child/children of the employee with a health condition that requires treatment or supervision. Child means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis (in place of) who is:

1. Under eighteen (18) years of age; or
2. Eighteen (18) years of age or older and incapable of self-care because of a mental or physical disability.

D. Care of a spouse, parent, parent-in-law, or grandparent of the employee who has a serious health condition or an emergency condition (Family Care Act RCW 49.12.270, WAC Chapter 296-130)

8.3 Sick leave may be accumulated up to a maximum of seven hundred twenty (720) hours. Employees with sick leave accumulated in excess of four hundred eighty (480) hours may exchange accumulated sick leave days for additional compensation at the rate of eight (8) hours at the employee's then regular hourly wage for each twenty-four (24) hours of accumulated sick leave in excess of four hundred eighty (480) hours. Employees may exchange sick leave hours for additional compensation one (1) time in any twelve (12) month period.

8.4 **Sick Leave Policy for Employees:** Sick leave is provided to employees as a protection against loss of income in the event of absence from work for medical reasons, including extended absence on account of illness or injury. Its use is restricted to health-related absences and employees are encouraged to accumulate sick leave to carry them through unforeseen and lengthy illness.

In accordance with the cooperative spirit of the Agreement, the Union and the Employer agree that they will work jointly to prevent misuse and/or abuse of sick leave. This means consultation with the appropriate Local President or designee in regard to a specific problem.

ARTICLE 9 – BEREAVEMENT LEAVE

9.1 Regular employees may take up to twenty-four (24) hours off their regularly scheduled hours at their hourly wage each calendar year in the event of death of an immediate family member. An additional sixteen (16) hours may be granted for a maximum of forty (40) hours when extensive travel (in excess of 300 miles one way) is required to attend a funeral. Time requested for bereavement leave must be taken within ten (10) calendar days of the death of a family member or the funeral of the family member.

9.2 Additional leave may be granted at the discretion of the Employer. The employee may choose to use accrued vacation, personal leave, or leave without pay

9.3 For the purpose of this article only, "immediate family" shall be defined as spouse, domestic partner, parent, grandparent, brother, sister, child, step-child, or grandchild of the employee, and the mother-in-law, father-in-law, son-in-law, daughter–in-law of the employee. PMH may request verification from the employee to confirm the basis for the leave.

ARTICLE 10 - VACATIONS

10.1 Vacations with pay shall be granted based on the following: Vacation hours shall accrue based on the continuing accrual factor in the appropriate category. Vacation accrual per pay period is determined by the number of hours worked by the regular part-time employee multiplied times the full-time employee's accrual factor and such amount shall not exceed the amount which could be accrued by a regular full-time employee. Part-time employees without benefits earn no vacation leave benefits. Hours applied toward vacation accrual shall include regular hours, low census hours, holidays, vacations, sick leave, overtime, in-service education, funeral leave and call back to a maximum of eighty (80) hours per pay period. Progression through the vacation schedule shall be based on years of service with the anniversary date being the set point.

~~2019~~ Schedule

1 yr. but less than 3 yrs.	.04615	96 hours per year
3 yrs. but less than 5 yrs.	.05769	120 hours per year
5 yrs. but less than 10 yrs.	.06538	136 hours per year
10 yrs. but less than 15 yrs.	.07692	160 hours per year
15 yrs. but less than 20 yrs.	.09231	192 hours per year
20 yrs. but less than 25 yrs.	.10385	216 hours per year

Accrued vacation may be used following completion of the probationary period. A maximum of fifteen (15) vacation days may be taken at one time.

10.2 Vacation pay shall be an amount equivalent to what the employee would have received had the employee been at work, including shift differential and excluding overtime and weekend premium.

10.3 Vacations will be requested in writing as far in advance as possible and shall be scheduled in accordance with Prosser Memorial Hospital Policy No. 730-0019.

10.4 The Employer reserves the right to make particular days/weeks unavailable for the taking of vacations so as to limit the number of employees who may take a vacation at any

particular time. In October of each year, employees will be eligible to cash out forty (40) hours of vacation time if employees have used a minimum of sixty (60) hours vacation time during the calendar year. Payment for this cash out would be in the first payroll of November. The cash out provision is subject to the employee making a request in writing and submitting it in a timely manner to the Department Manager.

10.5 Vacation time shall be accumulated during the probationary period; however, said vacation accruals may not be used until successful completion of six (6) months of service from the date of hire the probationary period. Vacation time may be allowed up to the limits of the amount earned. The employee must request, and said request is subject to prior approval from the Employer, before the employee can utilize said vacation time.

10.6 If an employee requests and receives approval to use vacation time after scheduled to work on the current posted work schedule, it shall be the responsibility of the Employee to find a replacement employee to work in their place.

10.7 Upon voluntary separation by resignation or retirement, provided the employee gives fourteen (14) calendar days written notification prior to separation, the employee shall receive compensation for up to two hundred (200) hours at the rates defined in Section 11.10.1. In case of involuntary separation by death, reduction in force, or termination the employee shall receive compensation for up to two hundred (200) hours at the rates defined in Section 11.10.1. Compensation will be paid at the employee's regular rate of pay.

ARTICLE 11 - LEAVES OF ABSENCE

11.1 Leave shall be granted to bargaining unit employees as set forth in the Agreement and the State of Washington Family Medical Leave Act and the Federal Family and Medical Leave Act and their amendments. The Employer shall comply with all other federal and state leave acts. The Employer and employees will comply with existing and any adopted FMLA or WFLA regulations and or interpretations.

11.2 Requests for paid or unpaid leave of absence shall be made to the Department Manager as far in advance as possible and must be requested in writing. A reply to grant or deny the request shall be given by the Employer within five (5) days following the request for leave.

In those cases where leaves are taken for illness or maternity reasons, a physician's written permission authorizing a return to full job responsibilities is required prior to the employee being allowed to start working.

11.3 **Military Leave:** Leave required in order for an employee to maintain status in a military

reserve of the United States shall be granted without pay, without loss of benefits accrued to the date such leave commences, and shall not be considered part of the employee's earned annual leave time. An employee who enlists or is drafted into the military service of the United States should be accorded those rights as set forth in the Uniformed Service Employment and Reemployment Rights Act and any other applicable federal and state law.

11.4 **Maternity Disability Leave:** In the case of pregnancy, an employee will be granted a leave of absence for the period of the employee's temporary disability caused by pregnancy or childbirth as verified by a qualified health care provider. The employee must inform her supervisor in advance of her intention to take leave and the approximate time expected to return to work.

Maternity leave policy and benefits at PMH Medical Center apply equally to married and unmarried women employees.

11.5 **Family and Medical Leave:** In accordance with the WFLA and FMLA policy, up to twelve (12) weeks (paid or unpaid) may be granted per twelve (12) month period for qualifying circumstances as determined by the Employer consistent with Federal and State laws. Twelve (12) month period means a rolling twelve (12) month period measured backward from the date leave is taken and continuous with each additional leave day taken. This shall be administered by the Employer. Employees are required to exhaust all accrued paid leave (i.e., vacation, sick leave, personal time, etc.) before becoming eligible for an unpaid leave of absence for family leave purposes. Employees using accrued leave during FMLA will continue to accrue vacation, sick leave and be paid for holidays if they occur during the paid leave. If the leave is unpaid, the employee will not accrue vacation, sick leave, nor be paid for holidays that occur during the unpaid leave nor will they accrue seniority. FMLA and all other leaves, whether paid or unpaid, shall run concurrently up to a maximum of twelve (12) weeks. When possible or foreseeable, requests for family and/or medical leave shall be submitted to the Employer a minimum of thirty (30) days prior to the date the leave is expected to commence. Violations of this provision shall be subject to the disciplinary process unless circumstances warranted a lesser notice.

11.6 Jury Duty: When an employee is absent from work in order to serve as a juror or report in person in response to a jury duty summons or subpoenaed by the Employer as a witness for hospital-related court appearances he they shall be granted pay for those days or portions of those days for which he is so such reasons absent from work during his their regularly scheduled work period, less the fee or other compensation paid him with respect to such jury duty. To receive pay for work time lost, an employee must notify his supervisor immediately upon being called for jury duty and must provide the Employer with satisfactory proof of the date(s) of the employee's service as a juror or appearance in court for that purpose or for jury duty examination and the compensation paid him therefor.

excluding transportation and subsistence allowance.

11.7 **Domestic Violence Leave:** Eligible employees shall be entitled to take reasonable unpaid leave for domestic violence, sexual assault or stalking that the employee has experienced, or for the use to care for and/or assist a family member who has experienced domestic violence, sexual assault or stalking. Leave under this provision shall be administered in accordance with RCW 49.76

11.8 **Education:** A leave of absence for educational purposes relating to the health care industry may be granted at the discretion of Administration for a period not to exceed one (1) year, provided there has been one (1) year of continuous employment.

11.9 In case of [illegible] leave of absence for health or maternity reasons, the leave is designed to provide a recuperative period of sufficient duration for the Employee to fully recover.

In taking a leave, the employee assumes some risk in job security. A leave of absence does not guarantee a job for employment at the completion of the leave; however, the Employer will make a good faith effort to fill the position vacated on a temporary basis. If the Employer has been able to maintain the position open through temporary employment, the employee on leave will be assured the job back. If the position is filled by a permanent employee, the employee on leave will revert to [illegible] status.

The employee is expected to return to full duties on the day after the leave expires or as scheduled, should a suitable opening be available.

ARTICLE 12 - RESERVATION OF PAID TIME OFF (PTO) PLAN

12.1 Articles x through 11 are subject to the reservation by the Employer to introduce and/or adopt a PTO policy, which may incorporate some or all of the leaves listed in Articles x through 11. In change to the current leave sections or favor of PTO policy is contemplated, the Employer will give the Union at least thirty (30) days notice and the opportunity to bargain a change to PTO.

ARTICLE ~~13~~12 - INDUSTRIAL INSURANCE

~~13.1~~12.1 For a period of absence from work due to injury or occupational disease resulting from employment, the employee shall file an application for workers' compensation in accordance with State Law.

~~13.2~~12.2 If the employee has accumulated sick leave credit, the Employer shall pay the difference between employee's loss compensation and employee's full regular salary unless the employee elects not to use employee's sick leave, provided that it is the responsibility of the Employer to make available a written explanation of such elective. Employees may request to use sick leave and, if needed, vacation leave to supplement time loss payments up to but not exceeding their normal pay.

~~13.3~~12.3 Should an employee receive workers' compensation for time loss and employee also receives sick leave compensation, the employee's sick leave accrual will be reduced by the total number of hours the employee was on sick leave minus the number of hours at employee's hourly rate for which employee is paid from a workers' compensation fund, on an hour for hour basis.

~~13.4~~12.4 Until eligibility for workmen's compensation is determined, the Employer may pay full sick leave, provided that the employee shall return any subsequent overpayment to the Employer.

~~13.5~~12.5 Should any employee apply for time loss compensation and the claim is then or later denied, sick leave and/or accrued vacation may be used for the absence.

~~13.6~~12.6 Nothing herein pertains to permanent disability award.

~~13.7~~12.7 If an employee has no sick leave accumulated or runs out of sick leave, the word "vacation" may be substituted for sick leave above.

ARTICLE ~~14~~13 - ACCIDENTS TO EMPLOYEES

~~14.1~~13.1 Accidents occurring while on duty will be reported to the supervisor Department Director, EMS Lead or Hospital House Supervisor immediately. The appropriate accident report must be completed by both the supervisor and employee and is then submitted to

ARTICLE ~~15~~14 - HOSPITAL PLANS

~~15.1~~14.1 The Employer agrees to make available health, dental, vision, life insurance, and AD&D plans for employee participation the first of the month following date of hire. subject to the following provisions:

~~15.2~~14.2 The Employer shall pay the percentages of premiums for the employee's coverage in the health, dental, vision, life insurance and AD&D plans set forth in Section 15.1. Should more than one insurance plan be available to the employee, the Employer will pay the percentage of the premium of the lowest premium plan subject to the provisions of

Section ~~15.1~~.

~~15.3~~14.3 The life insurance plan provides each employee life insurance during the period of employment.

~~15.4~~14.4 The Employer shall pay a percentage of the dental premium for the employee only in accordance with Section ~~15.1~~.

~~15.5~~14.5 The Employer shall provide a vision care plan for employees and pay a percentage of the monthly premium in accordance with Section ~~15.1~~. Plan participation is mandatory for bargaining unit members.

~~15.6~~14.6 Dependent coverages and Employer contributions are described in the open enrollment document consistent with Hospital policy.

~~15.7~~14.7 The hospital may, at its discretion, change or offer different insurance plans under this article for employee participation. The Employer reserves the right to modify insurance plans to stabilize premiums at current levels subject to providing the Union and employees sixty (60) days' notification prior to the implementation. Provisions of this section are not subject to the grievance procedure in this Agreement.

ARTICLE ~~16~~15 – SENIORITY

~~16.1~~15.1 No employee shall acquire any seniority until the employee has completed the probationary period. When an employee has completed the probationary period, seniority shall date from date of most recent hire; provided, however, employees who are laid off due to a reduction in force and are subsequently rehired within a twenty-four (24) month period shall be credited for all past service for seniority purposes.

~~16.2~~15.2 Seniority as herein defined shall mean length of continuous service within a classification in the Bargaining Unit, except for salary increases, where seniority shall mean length of service in grade and level.

~~16.3~~15.3 An employee shall lose all seniority rights and employment shall cease for any of the following reasons:

A. Voluntary resignation;

B. Discharge for just cause;

C. Failure to report for work at the end of an authorized leave of absence;

D. Failure to report for work recall from layoff in compliance with Section

E. Absence due to sickness, accidents or layoff for a period in excess of twenty-four (24) months.

ARTICLE ~~17~~16- LAYOFFS AND RECALL

~~17.1~~16.1 Seniority shall be the primary consideration within classifications for layoffs. When layoff becomes necessary the Employer will make every effort to provide the effected employees with not less than 30 calendar days' notice.

~~17.2~~16.2 Employees on layoff status shall be recalled prior to hiring of new employees for positions the laid off employee occupied. Laid off employees will be given preference for other positions for which they are qualified. Laid off employees will be recalled in inverse order of layoff (i.e., last person laid off is first recalled). An employee's right to recall shall be extinguished after a period of twenty-four (24) months. Laid off employees must keep the Employer advised of their current address. An offer of re-employment shall be in writing and sent by registered or certified mail to the employee. The employee shall be deemed to have received an offer within four (4) days after the Employer receives mailed confirmation of the re-employment offer. An employee so notified must indicate acceptance of recall within seven (7) calendar days from the confirmation date of the mailed notice. Failure to notify the employer of acceptance of the recall offer shall forfeit all recall rights of the employee under this Article.

~~17.3~~16.3 Employees recalled from layoff shall not lose previously accumulated seniority or time in service, and shall maintain the same rate of accrual for vacation and sick leave in effect when laid off. The employee must be re-employed within twenty-four (24) months to retain all call back rights and the employee must have completed their probationary period. However, employees shall not have vacation time or sick leave time reinstated where the employer as a result of the layoff has compensated the employee for said time.

ARTICLE ~~18~~17 - DISCIPLINE AND SEVERANCE

~~18.1~~17.1 [redacted]

[redacted]

~~18.2~~17.2 The Employer has the right to discipline any employee based on the following disciplinary actions:

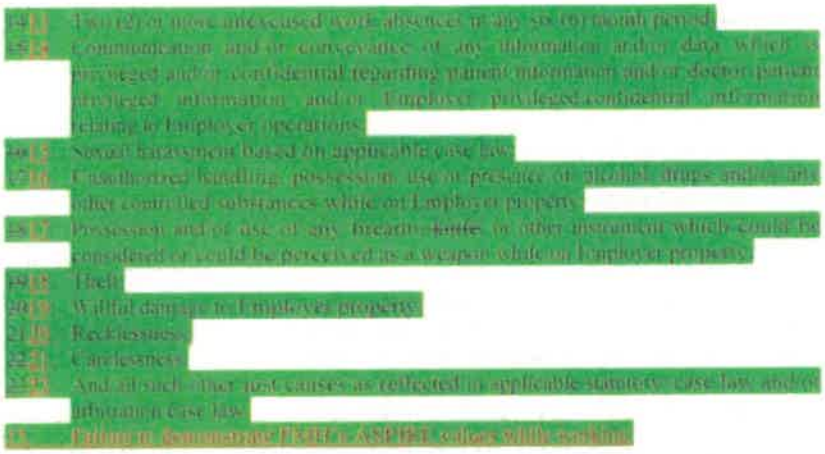
1. Oral reprimand
2. Written reprimand
3. Suspension without Pay
4. Discharge or Termination

It is important that standards of conduct be established for any organization and that employees who violate these standards be disciplined. In order to insure that discipline is administered fairly and consistently and in a timely manner, the Progressive Discipline process will be followed except for serious misconduct, which will warrant more serious discipline subject to the provisions within this Article.

The Employer has the right to implement the above disciplinary actions based upon the seriousness of the affected employee's conduct as determined by the Employer. The above enumerated disciplinary actions may be implemented without regard to the order indicated hereinabove. The Employer may determine the cause is of such a serious nature as to warrant a combination of disciplinary actions. Disciplinary actions do not have to be taken in order of increasing severity from oral reprimand to discharge based on the seriousness of the incident.

~~18.3~~17.3 Just Cause for the disciplinary action referenced [redacted] above is inclusive of but not limited to:

1. Neglect of duty (i.e., Violation of Patient Rights);
2. Insubordination (i.e., refusal or failure to obey supervisor in work related instructions or directives, etc.);
3. Conviction of a crime which may affect work performance;
4. Malfeasance or misfeasance of job requirements;
5. Misconduct;
6. Violation of published rules or regulations.;
7. Unauthorized use of equipment;
8. Abuse of sick leave (i.e., usage indicating a pattern or misrepresentation of illness);
9. Excessive Tardiness;
10. Excessive Absenteeism;
11. Falsification of reports and/or records;
12. Solicitation and/or acceptance of personal gifts or gratuities;
13. [redacted]



~~18.4~~17.4 The Employer has the right to implement progressive discipline without regard to whether or not causes for prior disciplinary actions are similar or the same.

~~18.5~~17.5 The Employer has the right to suspend without pay an employee for just cause for up to a maximum period of thirty (30) working calendar days for each cause.

~~18.6~~17.6 The Employer has the right to suspend without pay, discharge or terminate an employee for just cause, which the Employer believes to be of a serious nature. Prior to the implementation of a suspension without pay, discharge or termination, the Employer shall provide the Union or Shop Steward and the employee with a brief description of the causes and circumstances involved with the potential cause of action. The Union representative or Shop Steward and the employee will be provided an opportunity to present their perspective of the case(s) and/or circumstances prior to the Employer determining whether or not suspension without pay, discharge or termination is appropriate. The Union and employee's explanation shall occur at a pre-disciplinary action meeting to be established by the Employer. Thereafter, the Employer will investigate and make a determination as to whether or not suspension without pay, discharge or termination is appropriate.

~~18.7~~17.7 The Employer will provide copies of disciplinary action inclusive of written reprimands and suspension without pay to the Union representative. Notations of oral reprimands in the employee's personnel file shall be permitted and the employee will be informed of said notations. The notation will generally provide for the date, time and a brief description of the oral reprimand. All management personnel may initiate

disciplinary action subject to the provisions of this agreement.

~~18.8~~17.8 [redacted] files/references to disciplinary actions are subject to the following:

1. Oral reprimand shall remain in the employee's personnel file for a period of twelve (12) months from the date of the last infraction. If there exists another disciplinary action of an oral reprimand nature during the twelve (12) month period, both oral reprimands shall remain in the personnel file for twelve (12) months from the date of the latest oral reprimand.

2. Written reprimands shall remain in the personnel file for a period of twenty-four (24) months from the date of the last disciplinary action. If there exists another written reprimand within the twenty-four (24) month period, then all written reprimands will remain in the employee's personnel file for twenty-four (24) months from the latest written reprimand regardless of whether such reprimands are for similar or dissimilar causes. Reprimands relating to patient rights violations shall be maintained in the Personnel file for the applicable statutory time if greater than twenty-four (24) months (i.e., Statute of Limitations).

3. Suspensions without pay will remain in the employee's personnel file on a permanent basis.

4. Discharge or termination shall remain in the employee's personnel file permanently.

ARTICLE ~~19~~18 - GRIEVANCE PROCEDURE

~~19.1~~18.1 A grievance shall be defined as a dispute or disagreement involving the interpretation, application or alleged violation of a specific provision of this Collective Bargaining Agreement. Probationary employees may not file grievances regarding disciplinary action including termination.

~~19.2~~18.2 A grievance may be presented by the Union or the Employer in accordance with the provisions of this Article.

~~19.3~~18.3 The parties agree that the time limitations provided are essential to the prompt and orderly resolution of any grievance and that each will abide by the time limitations unless an extension of time is mutually agreed to in writing.

~~19.4~~18.4 No grievance shall be valid unless it is timely submitted at Step 1. If the grievance is not presented within fifteen (15) working days from its occurrence or knowledge of its occurrence, said grievance shall be waived and forever lost. For purposes of the essential

time limitation of fifteen (15) working days, this is to be defined as fifteen (15) working days, Monday through Friday.

~~19.5~~18.5 The grievance shall be in written form and shall include the following:

1. A specific statement of the grievance and relevant facts; and,
2. The specific provisions of the agreement allegedly violated; and,
3. The specific remedy sought.

~~19.6~~18.6 The grievance steps shall be as follows:

STEP 1:
The aggrieved employee or Union shall submit in writing within fifteen (15) working days of the occurrence of the employee's grievance to Employer. The Employer shall respond within fifteen (15) working days from the date of receipt of the grievance. If it is an Employer grievance, the Employer shall submit the grievance in writing within fifteen (15) working days of the occurrence to the Shop Steward. The Shop Steward shall respond within fifteen (15) working days of receipt of the Employer's grievance. If the grievance response is accepted, the grieving party will provide the other party with a close-out letter indicating acceptance of the response within [redacted] days of receipt. This process will be followed for all subsequent steps unless the response is not accepted which then the following will occur:

STEP 2:
If the grievance has not been satisfactorily resolved at Step 1, then the party initiating the grievance shall, within fifteen (15) working days of the due date of the response, file a written appeal to Step 2. If the grievance is one initiated by an employee or the Union, the appeal shall be to the Administrator or his designee within fifteen (15) working days of the Step 1 response. If the grievance is an Employer grievance, the Employer shall appeal the grievance in written form within fifteen (15) working days of the due date of the Shop Steward's response to the area representative of the Union. The response shall be due in writing within fifteen (15) working days of the date of receipt of the written appeal.

STEP 3:
If either party is dissatisfied with the response of the other party, the Union or the Employer may refer the grievance to final and binding arbitration. The Union or Employer may notify the other party in writing of submission to arbitration only if said notification is received by the other party within fifteen (15) working days from the date of the response in Step 2 or within fifteen (15) working days from the date of receipt of the timely response. Subject to timely notice, the parties will select an arbitrator to hear and determine the grievance. The parties will attempt to mutually agree upon a neutral arbitrator within the first fifteen (15) working days after submission to arbitration. If the

parties are unable to mutually agree, the parties shall request a list of eleven (11) names from the State Public Employment Relations Commission (PERC), or the American Arbitration Association (AAA). The parties shall attempt to agree on which service to use. If there is no agreement a coin toss will be used to determine which arbitration service to use. The Party initiating the Grievance shall call the heads or tails for the coin toss. The parties shall utilize the traditional striking of names methodology for selection of the neutral arbitrator. A coin will be flipped in order to determine who strikes the first name.

The arbitrator will meet and hear the matter at a date to be mutually agreed upon by and between the parties and the arbitrator. A decision shall be reached within a reasonable period of time after the arbitration proceedings and after post arbitration briefs are applicable.

The arbitrator shall not have the authority to add to, subtract from, alter, change or modify the terms and/or provisions of this agreement. The power of the arbitrator shall be limited to interpretation of or application of the terms of this agreement or to determine whether there has been a violation of the terms of this agreement by either the Employer or the Union. The arbitrator shall be jurisdictionally limited to deciding the issue raised at Step 1 of the grievance procedure. The arbitrator shall not have the authority to decide additions, variations and/or subsequent grievances beyond the matter raised in Step 1. The arbitrator shall not have the authority to award punitive damages. Each party shall pay one half (1/2) of the arbitrator's bill. Each party shall pay their own costs and attorney fees of the grievance/arbitration process.

ARTICLE ~~20~~19- JOB OPENING

~~20.1~~19.1 The Employer will post a notice about vacancies and/or new positions for a period of five calendar (5) days. This provision is not applicable to temporary, per diem, and seasonal positions, nor are these provisions applicable to vacancies and/or new positions, which require special training or qualifications

~~20.2~~19.2 The Employer has the right to make temporary appointments for up to three (3) consecutive months in order to address potential interruption of patient care, building maintenance requirements and/or work schedule. The appointments may be extended an additional three (3) months by mutual agreement between the employer and the union.

~~20.3~~19.3 If the Employer decides to fill a vacancy in an existing position, the Employer will give consideration to the advancement of existing employees subject to the Employer's assessment of the interested employees' qualifications and other relevant factors.

~~20.4~~19.4 If the Employer determines that a promotion should be implemented and that the promotion involves movement from a class in one grade to a class in a higher grade, the Employer will give consideration to eligible and interested employees' qualifications and other relevant criteria. If the Employer determines that there are no current, interested employees who have the qualifications, the Employer may advertise for outside applicants and select from outside applicants.

~~20.5~~19.5 [illegible]

ARTICLE ~~21~~20– PERFORMANCE OF DUTY – RULES AND REGULATIONS

~~21.1~~20.1 Nothing in this Agreement shall be construed to give an employee the right to strike and no employee shall strike or refuse to perform his assigned duties to the best of his ability during the term of this Agreement.

~~21.2~~20.2 The Union agrees that it will not condone or cause any strikes, slowdowns, mass sick call or any other form of work stoppage, or interference of normal operations of the Employer during the term of this Agreement.

~~21.3~~20.3 The Union agrees that its members shall comply in full with the Employer's Rules and Regulations, Policies and Guidelines, including those related to conduct and work performance.

~~21.4~~20.4 The Employer agrees that the Employer's Rules and Regulations, Policies and Procedures and Guidelines, promulgated after the effective date of this Agreement, which affect working conditions and performance, shall be posted on the Union bulletin boards. Any changes of Employer's Rules and Regulations Policies and Guidelines dealing with mandatory subjects of bargaining shall be negotiated per RCW 41.56. Notification to the Union shall be the posting, written or personal notification to a Union official. If no response is given by the Union to the Employer within fifteen (15) days of "notification" as described above, the posting shall be considered in effect and any right to bargain waived.

~~21.5~~20.5 [illegible]

Reference to this collective bargaining agreement:

Policy	Description
865-1000	Professional Appearance & Dress Policy
865-1006	Bulletin Boards
865-1008	Corrective Action Process
865-1011	Driving Record – Request for MV Abstract
865-1015	Employee Records
865-1042	Post-Offer Drug Testing
865-3002	Substance Abuse/Reasonable Suspicion Testing
865-3001	Tobacco Free Environment
865-3003	Weapons

ARTICLE 22[21] – GROOMING

22.1[21.1] Proper hygiene promotes professionalism within PMH and a favorable image to our residents. Members are expected to maintain the highest standards of personal cleanliness and present a neat, professional appearance at all times meeting Standards of Grooming (SOG's).

22.2[21.2] General Appearance

Such an appearance shall be as to foster and enhance efficient, effective and professional image and posture. All members shall adhere to the PMH Professional Appearance & Dress Policy or as governed by existing EMS SOGs.

22.3 Cleanliness

Members of the Department will be expected to maintain high standards of neatness and personal grooming at all times while on duty. Cleanliness is vital in all positions and is important for the sake of hygiene and appearance. All employees shall meet SOG's.

22.4 Jewelry and Piercing

Excessive jewelry, head or neck tattoos, or body piercing ornaments that are visible to the public while in uniform disrupt public trust and efficiency. If these objects create an employee or patient safety situation or barrier to care, Administration and Human Resources will make the final determination. Expansion rings, wedges and small earrings that do not dangle or otherwise imply offense and that do not pose a safety threat are permitted. Please refer to PMH Policy 865-1000. Any member who violates this policy shall be deemed to be "out of uniform" and subject to disciplinary action up to and including termination.

22.5 Hair

There are many hairstyles which are acceptable to the department. Hair must be neat and clean. The bulk or length of the hair must not interfere with the normal wearing of a standard uniform cap.

The hair on the top and sides of the head will be neatly arranged. Hair must never be of such bulk or length that it will jeopardize the personal safety of the EMT or in the performance of emergency operations.

Hair styles and bangs shall not obstruct vision or eye contact. Artificial hair coloring shall be in good taste and reflect a professional image. Hair styles, hair designs, brands, tails, multiple unnatural colors or other hair arrangements which may meet SOG's guidelines, but do not reflect a professional image of exams or safety concern, shall be strictly prohibited.

ARTICLE 23[22] - DRUG & ALCOHOL TESTING POLICY

23.1[22.1] Reporting to work under the influence of alcohol and or illegal drugs, or the use, sale or possession by an employee of illegal drugs is strictly prohibited and may result in disciplinary action, including termination.

PMH recognizes a need to provide an opportunity for employees to deal with alcohol related problems through employee assistance programs. Any employee who voluntarily seeks treatment for a personal alcohol problem or for a substance abuse disorder, not involving criminal conduct, may do so through employee assistance programs if offered by the employer, on their own choosing, in complete confidence and without jeopardizing the employee's employment with PMH.

Employees, in order to avoid disciplinary action for offenses, may not claim a substance abuse problem and seek treatment to avoid adverse disciplinary actions.

Such voluntary action must be done prior to any act or reasonable suspicion that would result in being ordered to submit to discovery testing and or disciplinary action.

It is understood between the parties that the disciplinary action referred to herein Article 22.1 of the Collective Bargaining Agreement may be termination from employment or through the commitment of such an act as described in this Article results in personal injury or death of a District employee or member of the general public, destruction of or damage to District equipment or property, destruction of or damage to public or private property.

Other such infractions as covered by this Article shall be dealt with in accordance with their merits.

23.2 Where a supervisory employee of the District has a reasonable suspicion to believe an employee is under the influence of alcohol or illegal drugs or is using illegal drugs the supervisory employee shall follow the *Reasonable Suspicion Testing Policy* governing Prosser Memorial Health Employees. employee in question will be asked to submit to discovery testing including breath tests, urinalysis and/or a blood screen to identify any involvement with alcohol or illegal drugs.

An employee who refuses to submit to discovery testing for alcohol and/or illegal drugs shall be presumed to be under the influence of alcohol or an illegal drug for the purpose of administering this Article.

23.3 For the purpose of administering this Article, the following definition of terms is provided:

Reasonable Suspicion

Reasonable Suspicion is based on specific objective facts and reasonable inferences from those facts in the light of experience that discovery testing will produce evidence of illegal drug use or improper alcohol use by that particular employee.

Under the influence. The following cutoff levels shall be used for the initial screening of specimens to determine whether they are negative for these drugs or classes of drugs. All cutoff concentrations are expressed in nanograms per milliliter (ng/mL).

DEPARTMENT OF TRANSPORTATION STANDARDS – 49 CFR PART 40 §40.87		
Type of Drug or Metabolite	Initial Test	Confirmation Test
Marijuana metabolites	50	
Delta-9-tetrahydrocannabinol-9-carboxylic acid (THC)		15
Cocaine metabolites	150	
Benzoylecgonine		100
Opiate metabolites, Codeine/Morphine	2000	
Codeine		2000

Formatted: Spanish (Spain)

Morphine		2000
6-Acetylmorphine	10	10
Phencyclidine (PCP)	25	25
Amphetamine – AMP/MAMP	500	
Amphetamine (AMP)		250
Methamphetamine (MAMP)		250 Blind specimen must also contain at least 100 ng/ml of amphetamine
Methylenedioxymethamphetamine (MDMA)	500	250
Methylenedioxyamphetamine (MDA)		250
Methylenedioxyethylamphetamine (MDEA)		250

Level of the positive result for ethyl alcohol (0.02 or if

Illegal Drugs – are defined as all forms of narcotics, depressants, stimulants, hallucinogens and cannabis which sale, purchase, transfer or unauthorized use or possession is prohibited by law. Marijuana is considered illegal and shall not be allowed to be consumed, inhaled or injected in any way and in possession of or under the influence while employed regardless of state or federal law allowing such consumption, inhaling, ingestion or under the influence.

Over-the-Counter Drugs – are those which are generally available without a prescription and are limited to those drugs which are capable of impairing the judgment of an employee to safely perform the employee's duties.

Prescription Drugs – are defined as those drugs which are used in the course of medical treatment and have been prescribed and authorized for use by a licensed practicing physician or dentist.

23.4 If an employee is required to submit to a drug test the following procedure shall be followed:

The employee shall be given an opportunity to confer with a Union representative if one is readily available and the employee has requested such a conference.

The employee shall be given an opportunity to explain the reason for the employee's condition, such as reaction to a prescribed drug, fatigue, exposure to toxic substances, or any other reasons known to employee to the best advantage. The District and Union representative may be present during the discussion.

The District may request urine and/or blood samples.

Urine and blood samples shall be collected at a local laboratory, hospital or medical facility. The District shall transport the employee to the collection site. The District and Union representative may be allowed to accompany the employee to the collection site and observe the bottling and sealing of the specimen. The employee shall not be observed by the District when the urine specimen is given.

All specimen containers and vials and bags used to transport the specimen shall be sealed to safeguard their integrity, in the presence of the District, employee and the Union representative and proper chain of custody procedures shall be followed.

The drug tests of the specimen shall be conducted by an authorized laboratory capable of accurately measuring such substances.

If a specimen tests positive in an immunoassay screen test, the result must be confirmed by a gas chromatography/mass spectrometry test. The specimen must show positive results on the GC/MS (gas chromatography/mass spectrometry) confirmation test to be considered positive.

At the employee's or the Union's option, a sample of the specimen may be requested and sent to a laboratory chosen by the Union for testing which meets state and federal laboratory requirements for drug/alcohol testing. The cost of this test will be paid by the Union or the employee. Failure to exercise this option may not be considered as evidence in an arbitration or other proceeding concerning the drug test or its consequence. The results of this second test shall be provided to the District.

The District, the employee and the Union shall be informed of the results of all tests, and provided with all documentation regarding the tests as soon as the test results are available to the Medical Review Office.

23.5 The Medical Review Office shall be chosen and agreed upon between the District and the Union. The role of the Medical Review Office will be to review, interpret and confirm positive test results and communicate the results as previously specified. The Medical Review Office shall review all pertinent medical records made available by the tested employee when a confirmed positive test could have resulted from legally prescribed medication.

23.6 If the results of the drug test are positive and support a conclusion that the employee used an illegal drug or reported to work while under the influence of alcohol, the employee may be subject to discipline including immediate discharge.

23.7 The employee has the right to challenge any discipline imposed in the same manner that the employee may grieve another bargaining unit action.

ARTICLE ~~24~~23 - SAVINGS CLAUSE

~~24.1~~23.1 If an Article or Section of the Agreement is held to be unlawful or unenforceable by a court of competent jurisdiction, such judicial decision shall apply only to the specific provision involved. The remainder of the Agreement shall not be affected thereby and the parties agree to enter into immediate negotiations for the purpose of arriving at a mutually satisfactory replacement for such an invalidated provision.

ARTICLE ~~25~~24 - TERM OF AGREEMENT

~~25.1~~24.1 This Agreement shall be effective (*date of signing*) except where otherwise indicated, and shall continue in full force and effect until the 31st day of December, 2028.

~~25.2~~24.2 All language changes shall be effective beginning from the date of signature by both parties prospectively.

~~25.3~~24.3 Negotiations between the parties shall commence at least five (5) months prior to the submission of the yearly budget to the board of the Employer consistent with RCW 41.56.440.

FOR THE UNION:

_____
President

Date ratified: _____

FOR THE EMPLOYER:

_____
Craig Marks, CEO

_____
Stephen Kenny, Ph.D., Chairman
Board of Commissioners

Date ratified: _____

ATTACHMENT A

	Base	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
EMT	$ 18.01	$ 18.64	$ 19.23	$ 19.97	$ 20.67	$ 21.39	$ 22.14	$ 22.91	$ 23.71	$ 24.54	$ 25.40	$ 26.29	$ 27.21	$ 28.17	$ 29.15	$ 30.17	$ 31.23	$ 32.32	$ 33.45
AEMT	$ 18.74	$ 19.40	$ 20.08	$ 20.78	$ 21.51	$ 22.26	$ 23.04	$ 23.85	$ 24.68	$ 25.53	$ 26.44	$ 27.37	$ 28.32	$ 29.31	$ 30.34	$ 31.40	$ 32.50	$ 33.64	$ 34.82
PM	$ 22.72	$ 23.51	$ 24.34	$ 25.19	$ 26.07	$ 26.98	$ 27.93	$ 28.90	$ 29.92	$ 30.96	$ 32.05	$ 33.17	$ 34.33	$ 35.53	$ 36.77	$ 38.06	$ 39.39	$ 40.77	$ 42.20

FF Wage Scale 1-1-2023 through 12-31-20

DRAFT for Board of Commissioner Review

Attachment T

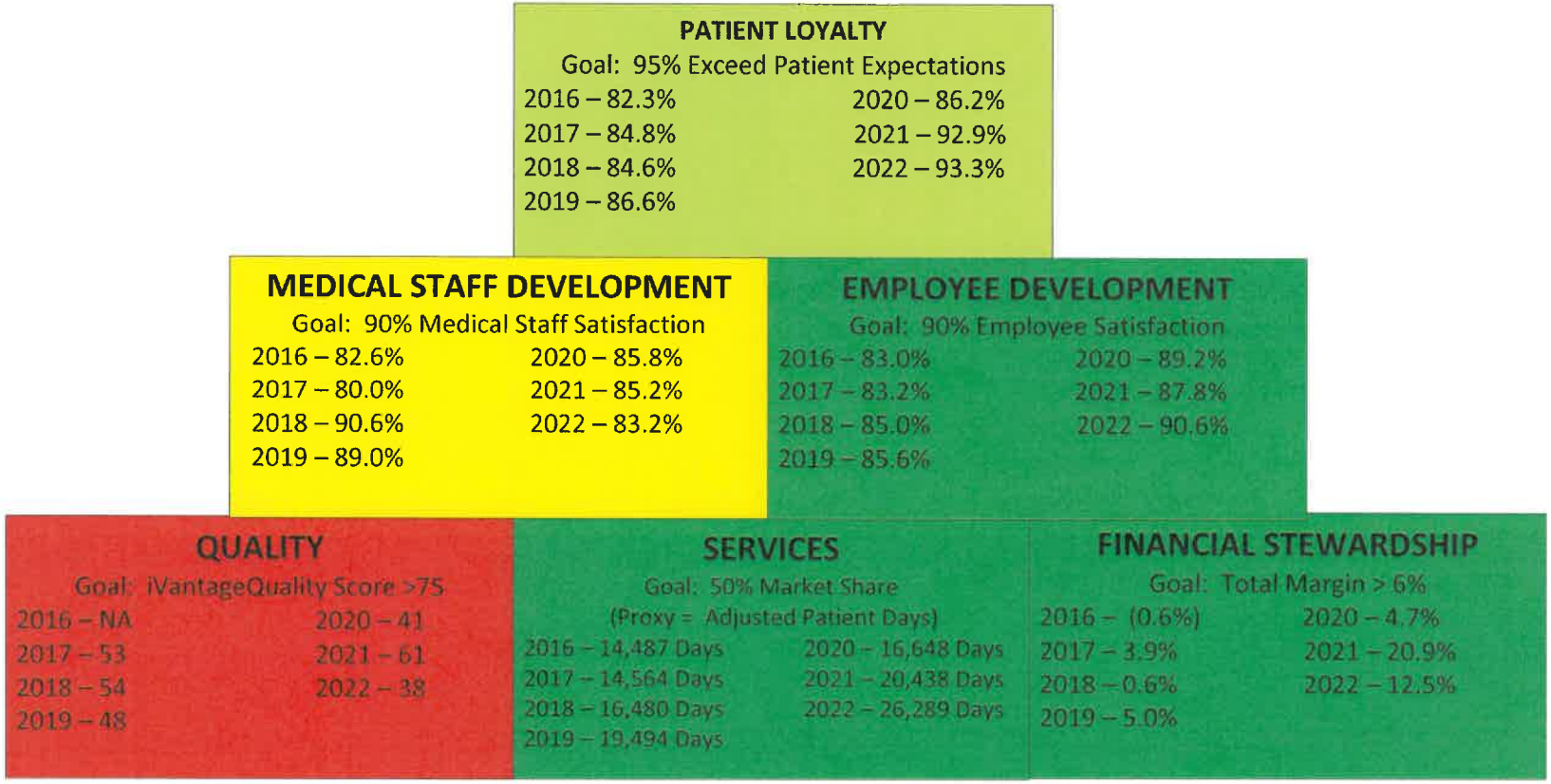
Prosser Memorial Health

Mission:

Prosser Memorial Health will improve the health of our greater community.

Vision of Success FY2016 to 2022

PMH will become one of the top 100 Critical Access Hospitals in the country through the achievement of our Pillars of Excellence.



Our Values

- ASPIRE -

***A**ccountability* ***S**ervice* ***P**romote Teamwork* ***I**ntegrity* ***R**espect* ***E**xcellence*

2023

1-11-23

Attachment U

Prosser Memorial Health

Pro Forma Statement of Operations *(less COVID Revenue)*
December 31, 2022

	Year to Date			
	Actual	Budget	Variance	%
Gross Patient Services Revenue				
Inpatient	$ 45,664,634	$ 46,310,005	$ (645,371)	-1%
Outpatient	209,759,013	172,846,632	36,912,381	21%
Total Gross Patient Services Revenue	255,423,647	219,156,637	36,267,010	17%
Deductions from Revenue				
Contractual Allowances				
Medicare	54,599,295	45,018,014	(9,581,281)	-21%
Medicaid	54,080,810	48,142,175	(5,938,635)	-12%
Negotiated Rates	38,430,589	27,408,456	(11,022,133)	-40%
Other Adjustments	8,477,293	4,288,096	(4,189,197)	-98%
Gross Contractual Allowances	155,587,987	124,856,741	(30,731,246)	-25%
Charity Care	4,347,939	3,643,925	(704,014)	-19%
Bad Debt	1,459,272	3,953,382	2,494,110	63%
Total Deductions From Revenue	161,395,198	132,454,048	(28,941,150)	-22%
Net Patient Services Revenue	94,028,449	86,702,589	7,325,860	8%
COVID Net Revenue	-	-	-	28%
Other Operating Revenue	250,345	462,574	(212,229)	-46%
Net Revenue	**94,278,794**	**87,165,163**	**7,113,631**	**8%**
Operating Expenses				
Salaries	37,450,106	36,905,609	(544,497)	-1%
Benefits	9,049,646	9,543,532	493,886	5%
Purchased Labor	4,310,091	3,425,505	(884,586)	-26%
Sub-Total Labor Costs	50,809,843	49,874,646	(935,197)	-2%
Professional Fees - Physicians	5,219,693	4,185,974	(1,033,719)	-25%
Professional Fees - Other	605,989	936,913	330,924	35%
Supplies	14,447,158	14,617,146	169,988	1%
Purchased Services - Utilities	515,536	569,705	54,169	10%
Purchased Services - Other	4,915,693	5,427,905	512,212	9%
Rentals & Leases	2,137,254	1,935,627	(201,627)	-10%
Insurance License & Taxes	1,256,143	1,243,052	(13,091)	-1%
Depreciation & Amortization	2,618,357	2,357,063	(261,294)	-11%
Other Operating Expenses	1,305,255	1,699,356	394,101	23%
Sub-Total Non-Labor Expenses	33,021,078	32,972,741	(48,337)	0%
Total Operating Expenses	**83,830,921**	**82,847,387**	**(983,534)**	**-1%**
Operating Income (Loss)	***10,447,873***	***4,317,776***	***6,130,097***	**142%**
Non Operating Income				
Tax Revenue	941,175	915,762	25,413	3%
Investment Income	(878,678)	35,214	(913,892)	-2595%
Interest Expense	(362,300)	(560,173)	197,873	-35%
Other Non Operating Income (Expense)	87,332	4,167	83,165	1996%
Total Non Operating Income	**(212,471)**	**394,970**	**(607,441)**	**-154%**
Net Income (Loss)	**$ 10,235,402**	**$ 4,712,746**	**$ 5,522,656**	**117%**
	10.9%	5.4%		

Attachment V

Annual Evaluation - 2022

Date: 02/15/2023

Name	Leader	Department	Division	Job Title	Year Ending
Marks, Craig		Administration		CEO	2022

Total Weight: 100/ 100

Overall Performance Score: 3.39

Pillar	Goal Name	Description	Rating Description	Result	Total Weight	Score	Weighted Score	Status
Patient Loyalty	PMH Patient Satisfaction Rate	Achieve a patient satisfaction score of 92.91% or higher (2021 – 92.90%) (Would Recommend – Weighted): Department Weights below: ED: 13% IP: 16% OP Surgery: 23% OP: 37% Clinic: 11%	Units : HCAHPS Percentage Higher is better 5 is 95 and above 4 is 93.91 to 94.99 3 is 92.91 to 93.9 2 is 88.91 to 92.9 1 is 88.9 and below	93.20 for Jan thru Dec	30%	3.28	0.98	
Medical Staff Engagement	PMH Medical Staff Satisfaction Rate	Achieve a Medical Staff satisfaction rate of 85.21% or higher (2021 – 85.20%). Strategic Programs Medical Staff survey – Question #12: I am satisfied with my current relationship with PMH.	Units : Percentage Higher is better 5 is 89.21 and above 4 is 87.21 to 89.2 3 is 85.21 to 87.2 2 is 83.2 to 85.2 1 is 83.19 and below	83.20 for Jan thru Dec	20%	2	0.4	
Employee Engagement	PMH Employee Satisfaction Rate	Achieve an annual employee satisfaction rate of 90% or higher (2021 – 87.80%). Strategic Program Employee Survey – Question #5: Overall, I am satisfied working at PMH.	Units : Percentage Higher is better 5 is 91.81 and above 4 is 89.81 to 91.8 3 is 87.81 to 89.8 2 is 85.81 to 87.8 1 is 85.8 and below	90.60 for Jan thru Dec	15%	4.39	0.66	
Employee Engagement	Complete timely performance evaluations of all dir	Complete timely performance evaluations of all direct reports at a rate 80% or higher.	Units : Percentage Higher is better 5 is 100 and above 4 is 90 to 99.99 3 is 80 to 89.99 2 is 70 to 79.99 1 is 69.99 and below	100 for Apr thru Apr	5%	5	0.25	
Quality	PMH Quality Goal	Achieve an annual average iVantage Score of 61 or higher. (2021 score was 61%)	Units : Percentage Higher is better 5 is 65 and above 4 is 63.1 to 64.9 3 is 61.1 to 63 2 is 59.1 to 61 1 is 59 and below	38 for Jan thru Dec	10%	1	0.1	
Services	PMH Services Goal	Achieve an Adjusted Patient Days Per Day calculation of 62.45 (2021 Budgeted – 22,796 / 365 = 62.45) or above.	Units : Days Higher is better 5 is 66.46 and above 4 is 64.46 to 66.45 3 is 62.46 to 64.45 2 is 62.45 to 62.45 1 is 62.44 and below	72.02 for Jan thru Dec	10%	5	0.5	
Finance	Financial Performance	Prosser Memorial Health will achieve a percentage variance of budgeted total margin for FY 2022 of 6.9% or greater (COVID funds are included). (annual total margin was 6.03% for 2021).	Units : Percentage Higher is better 5 is 8.9 and above 4 is 7.9 to 8.89 3 is 6.9 to 7.89 2 is 6.03 to 6.89 1 is 6.02 and below	12.50 for Jan thru Dec	10%	5	0.5	

Attachment W

Prosser Memorial Health

2022 Incentive Compensation Program

Draft Analysis as of 02.15.2023

EXEMPT - Leadership	Max Eligible	LEM Score	Bonus Percentage	Bonus
George Washington	21,001	3.81	76%	16,003
John Adams	1,187	3.58	72%	851
Thomas Jefferson	21,890	3.90	78%	15,861
James Madison	19,113	3.59	72%	13,724
James Monroe	23,400	3.68	74%	15,813
John Quincy Adams	21,881	3.43	69%	15,011
Andrew Jackson	15,572	3.58	72%	11,150
Martin Van Buren	29,088	3.67	73%	21,351
William Henry Harrison	21,310	3.93	79%	16,750
John Tyler	9,004	3.79	76%	6,826
James K. Polk	20,851	3.65	73%	15,222
Zachary Taylor	17,778	3.08	62%	10,952
Millard Filmore	19,381	3.92	78%	15,196
Franklin Pierce	22,801	3.64	73%	16,600
James Buchanan	22,202	3.39	68%	15,053
Abraham Lincoln	6,457	3.15	63%	4,069
Andrew Johnson	32,520	3.78	76%	24,585
Ulysses S. Grant	16,947	3.39	68%	11,491
Rutherford Birchard Hayes	12,858	3.39	68%	8,718
James A. Garfield	18,750	3.67	73%	13,763
Chester A. Arthur	19,990	4.01	80%	16,032
Grover Cleveland	21,659	3.69	74%	15,985
Benjamin Harrison	12,021	3.76	75%	13,650
William McKinley	20,464	3.78	76%	13,650
Theodore Roosevelt	17,285	3.54	71%	13,650
	427,660	3.62	72%	**$ 341,956**

EXEMPT Non-Leadership	Max Eligible	LEM Score	Bonus Percentage	Bonus
William H. Taft	681	3.69	74%	$ 503
Woodrow Wilson	3,843	3.81	76%	$ 2,929
Warren G. Harding	2,865	3.68	74%	$ 2,109
Calvin Coolidge	3,628	4.01	80%	$ 2,910
Herbert Hoover	2,627	3.93	79%	$ 2,065
Franklin D. Roosevelt	1,086	3.15	63%	$ 685
Harry S. Truman	3,027	3.39	68%	$ 2,053
Dwight D. Eisenhower	3,517	3.69	74%	$ 2,596
John F. Kennedy	4,404	3.39	68%	$ 2,986
Lyndon B. Johnson	3,858	3.68	74%	$ 2,840
Richard M. Nixon	2,565	3.93	79%	$ 2,017
Ronald Reagan	3,221	3.67	73%	$ 2,365
George H. W. Bush	3,853	3.69	74%	$ 2,844
William J. Clinton	3,106	3.39	68%	$ 2,107
George W. Bush	3,915	3.68	74%	$ 2,882
Barack Obama	2,980	3.93	79%	$ 2,342
Donald J. Trump	2,153	3.39	68%	$ 1,460
Joseph R. Biden	3,050	3.81	76%	$ 2,325
		3.66	73%	**$ 40,018**

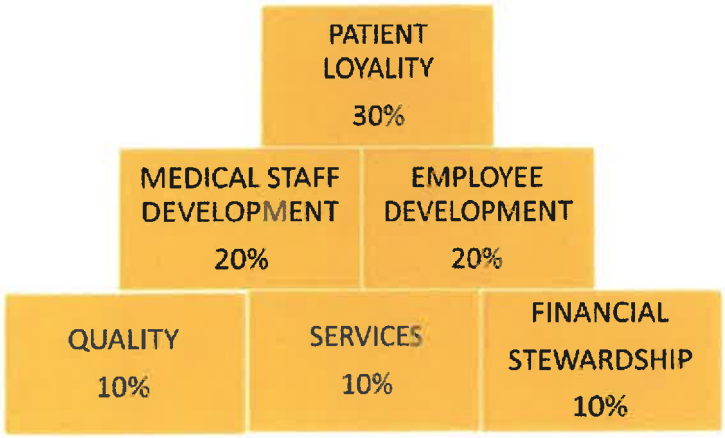
Grand Total: $ 381,974

Attachment X

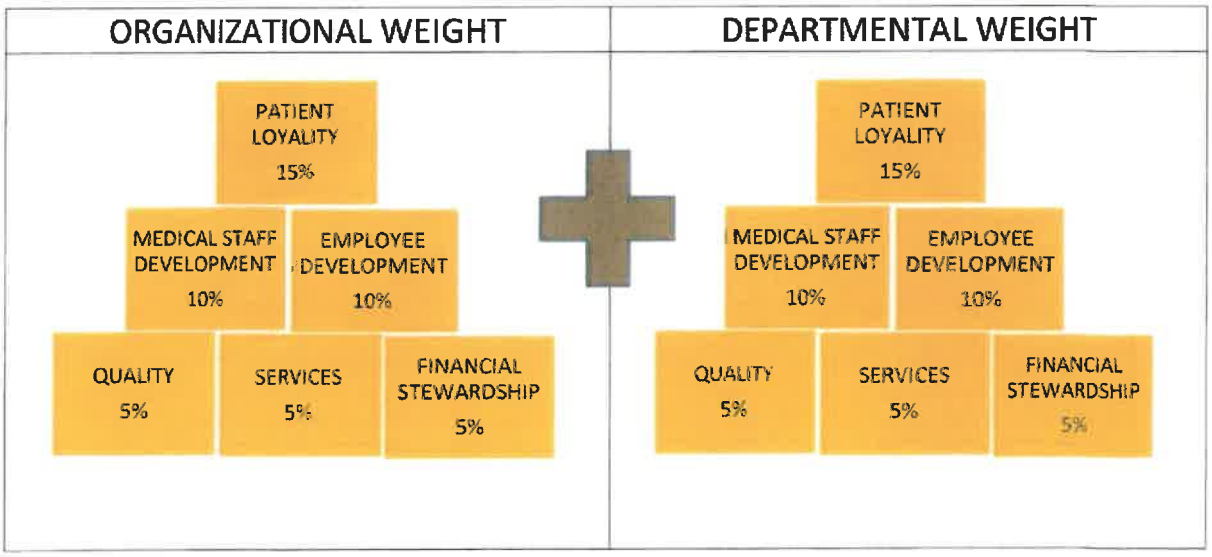
2023 PMH Incentive Compensation Program

FEBRUARY 23, 2023

2023 Prosser Memorial Health Organizational LEM Weighting Distribution:



Leadership Team and all PMH Employees (non-leadership & non-providers)
LEM Weighting Distribution:
50% Prosser Memorial Health Organizational LEM Goal Achievement
50% Department Specific LEM Goal Achievement



FY 2023 LEADERSHIP and all PMH Employees (non-leadership and non-providers)
INCENTIVE COMPENSATION PROGRAM
LEADERSHIP EVALUATION MANAGER (LEM)
February 23, 2023

- 100% of incentive compensation is at risk and earned based on the annual weighted average LEM score (no rounding).
  - LEM score of 5 would earn 100%
  - LEM score of 4 would earn 75%
  - LEM score of 3 would earn 50%
  - LEM score of 2 would earn 25%
  - LEM score of < 2 would earn 0%

- Door Opener
  - If the Budgeted Total Margin is met by Prosser Memorial Health (PMH), the door to awarding incentive compensation is opened. Then use the above formula.
  - Will not pay-out more than 50% of excess margin without Board of Commissioner approval.

- A percentage is based on Prosser Memorial Health achievement and a percentage may be based on individual achievements as defined below.

CEO	LEADERSHIP TEAM and all PMH Employees (non-leadership & non-providers)
100% is based on PMH achieving one or more goals and at the discretion of the Board of Commissioners.	50% is based on PMH achieving one or more goals. 50% is based on department LEM scores

Eligible individuals can earn either a percentage or both percentages depending on achievement.

PMH Leadership and Exempt (non-leadership)
Incentive Compensation Program
FY2023
16-Feb-23

Leadership Team (26)				Exempt (non-leadership) (18)			
% of Base Pay	LEM Score	Payout %	$$	% of Base Pay	LEM Score	Payout %	$$
15%	5	100%	$ 534,808	5%	5	100%	$ 66,005
11.25%	4	75%	$ 401,106	4.00%	4	75%	$ 52,804
7.50%	3	50%	$ 267,404	3.00%	3	50%	$ 39,603
3.75%	2	25%	$ 133,702	2.00%	2	25%	$ 26,402
0%	<2	0%	$ -	0%	<2	0%	$ -

Based on $3,565,385 Budget Salaries (2023) **Based on $1,320,092 Budget Salaries (2023)**

The actual overall performance score will be used in the calculation (no rounding). For example, a leader with an overall performance score of 3.5 will receive an incentive payment of 9.375% of their base annual salary. An Exempt non-leadership employee with an overall performance score of 3.5% will receive an incentive payment of 3.5% of their base annual salary.

Gate Opener = PMH must meet its Total Net Income Budget for 2023 = $6,209,240 (6.12%) AND the plan will not pay out more that 50% of excess margin without Board of Commissioner approval.

PMH Leadership and all PMH Employees (non-leadership and non-providers)
Incentive Compensation Program
FY2023
16-Feb-23

Leadership Team (26)				Exempt (non-leadership) (18)				All Non-Exempt (non-providers) (287)				Total
% of Base Pay	LEM Score	Payout %	$$	% of Base Pay	LEM Score	Payout %	$$	% of Base Pay	LEM Score	Payout %	$$	
15%	5	100%	$ 534,808	5%	5	100%	$ 66,005	5%	5	100%	$ 930,005	$ 1,530,818
11.25%	4	75%	$ 401,106	4.00%	4	75%	$ 49,504	4.00%	4	75%	$ 697,504	$ 1,148,114
7.50%	3	50%	$ 267,404	3.00%	3	50%	$ 33,003	3.00%	3	50%	$ 465,003	$ 765,409
3.75%	2	25%	$ 133,702	2.00%	2	25%	$ 16,501	2.00%	2	25%	$ 232,501	$ 382,705
0%	<2	0%	$ -	0%	<2	0%	$ -	0%	<2	0%	$ -	
Based on $3,450,100 Budget Salaries (2022)				**Based on $814,625 Budget Salaries (2022)**				**Based on $17,064,764 Budget Salaries (2022)**				

The actual overall performance score will be used in the calculation (no rounding). For example, a leader with an overall performance score of 3.5 will receive an incentive payment of 9.375% of their base annual salary. A non-leadership employee with an overall performance score of 3.5% will receive an incentive payment of 3.5% of their base annual salary.

Gate Opener = PMH must meet its Total Net Income (less COVID Relief Funds) Budget for 2022 = $6,209,240 (6.12%) AND the plan will not pay out more that 50% of excess margin without Board of Commissioner approval.

PMH Pay-for-Performance System
Leadership and Exempt (non-leadership) Staff
Annual Wage Program
2023

LEM Score	Review Score	% Wage Increase
5	4	4.8%
4	3.5	3.9%
3	3	3.0%
2	2.5	2.1%
< 2	< 2	0.0%

Wage Increase calculation = 80% of LEM Score + 20% Annual Review
Example: 4.0 LEM + 3.5 Annual Review = 3.9% Raise
((4.0.8)+(3.5*.2))/100 = .039 or 3.9%*

*** Average organization-wide pay increase approved by the Board of Commissioners in the Annual Operating Budget (2023 = 4.2%)**

SUBJECT:	All PMH Employees (Excluding providers) Incentive Compensation Policy	NO:	

Purpose: This document sets forth the Incentive Compensation Policy for Prosser Memorial Health. The purpose of this policy is to establish a uniform policy to award incentive compensation and to recognize successful participation in an incentive program for all Employees (Excluding Providers) at Prosser Memorial Health.

Policy:
An incentive is a lump sum payment granted to recognize accomplishment in relation to pre-established target goals and performance measures and criteria.

General:
An incentive is delivered through a formal, documented and approved plan based on a predetermined annual reward schedule. The plan criteria is beyond normal expectations with quantifiable measurements used to evaluate performance.

Payment of awards shall be made with the first full pay period of April after completion of the annual performance period and approximately thirty (30) days from the day submitted for approval to the CEO.

Incentives will be calculated on an annual basis beginning with the first month of the calendar year. The incentive pay shall be made through payroll and shall be reduced by customary and required withholdings.

The Prosser Memorial Health Board of Commissioners reserves the right to amend or terminate the program in whole or part at any time.

Eligibility:
a. New Employees (Excluding Providers) will have their incentive prorated based upon the total number of days they worked during the incentive calculation period.
b. The recipient must be an employee on the date that the payment is awarded
c. The recipient must be an employee on the last day of the predefined period for achieving the objectives.
d. Employees on a Performance Improvement Plan and/or Corrective Action Plan during the incentive period will have their incentive payment prorated based on the number of days the employee was on the performance improvement plan and/or Corrective Action Plan.
e. Employees on a Performance Improvement Plan and/or Corrective Action Plan at the time of payment will not receive a payment until they have successfully completed their Performance Improvement Plan and/or Corrective Action Plan.
f. Employees on extended leave during any of the predefined periods may have their incentive prorated based upon the number of months they worked during the incentive calculation period.

Definition:
Incentive: A pay plan that is designed to reward the accomplishment of specific results. An incentive payment is tied to expected results which are identified at the beginning of a performance cycle. An incentive plan is a nondiscretionary lump-sum payment in addition to an employee's base pay.

EXAMPLE

Leadership and Exempt (non-leadership) Annual Performance Appraisal

Employee Name	John Doe	Job Title	Parking Attendant
Department	Valet Service	Manager	Sally Diddet
Review Due Date	TBD	Date Completed	TBD

Instructions: Please rate the following questions with either Exceptional (5), Exceeds Standards (4), Meets Standards (3), Needs Improvement (2), Does Not Meet Standards (1). Comments are required for ratings of 5, 2, and 1.

Exceptional (5): Performance far exceeds expectations due to exceptionally high quality of work performed in all essential areas of responsibility, resulting in an overall quality of work that is superior; and either includes the completion of a major goal or project or making an exceptional or unique contribution in support of their department.

Exceeds Standards (4): Performance consistently exceeds expectations in all essential areas of responsibility and the quality of work overall is excellent. Annual goals are met.

Meets Standards (3): Performance consistently meets expectations in all essential areas of responsibility. Individual has full proficiency of skills applicable to the performance criteria, and quality, quantity, and results are consistently positive. Annual goals are met.

Improvement Needed (2): Performance is not consistently meeting expectations and fails to meet expectations in one or more essential areas of responsibility. A development plan to improve performance is required to accompany this appraisal including deliverables and timelines and monitored to measure progress.

Does Not Meet Standards (1): Performance is unacceptable and is below expectations in most essential areas of responsibility. Individual requires more than the typical amount of oversight and close supervision on this standard. As per Policy 865-1027, a Plan of Action (POA) is needed for items marked Does Not Meet Standards. A POA is an agreement between the leader and manager on actions to improve specific performance behaviors. The POA needs to accompany the performance appraisal. The individual's manager will monitor progress and submit a follow up report to attach to the performance appraisal no later than six (6) months following implementation. The individual must achieve a rating of at least "Meets Standards" to be eligible for a pay increase. Failure to perform at a "Meets Standards" level may result in corrective action up to and including termination from employment.

EXAMPLE

Job Duties -- Manages workload assignments as shown by appropriate prioritization of workload, is able to problem solve and work with minimal supervision, uses work resources appropriately, and completes work within established time frames. Stays current with professional standards, works effectively with new managers, technology and processes and maintains education, current licensure and/or certification as required.	**Rating** 4
Comments:	

Leadership Evaluation Manager (LEM) – Updates LEM on a consistent (e.g. monthly, quarterly) basis ensuring information is accurate and timely. Makes sure essential areas of responsibility and work performed tie back to Strategic Plan Pillars and LEM goals.	**Rating** 5
Comments:	

Education -- Participates in all mandatory education programs and required meetings. Leads and participates in committees as required. Able to describe his/her responsibilities related to general safety, disaster preparedness, and regulatory compliance.	**Rating** 5
Comments:	

Customer Service -- Demonstrates courtesy and ability to respond effectively to customers, staff, patients, public, volunteers, and physicians. Immediately acknowledges a customer's presence and is able to understand their needs. Displays a full knowledge and assists with the successful implementation of department service standards.	**Rating** 5
Comments:	

EXAMPLE

ASPIRE Values and Standards of Behavior – Consistently models ASPIRE Values of Accountability, Service, Promote Teamwork, Integrity, Respect and Excellence and demonstrates PMH organizational expectations of communication, initiative, time and priority management, HIPAA, and confidentiality.	**Rating** 4
Comments:	

Goal, Training, and Development – Identify *two* goals to build skills for the future. What training, support, action, or resources are needed to fulfill these skills? Consider the leader's present status and future potential for the organization. Please also note accomplishments of goals from the previous year. Provide a descriptive statement for each goal.
Comments:

Please answer the following questions with either Yes or No response.

Met and discussed performance appraisal with leader.	**☒Yes ☐No**
Job description reviewed and performance expectations discussed. Goals identified for the next evaluation cycle.	**☒Yes ☐No**
Individual LEM reviewed and discussed. Individual can articulate the importance of their work in relation to the strategic pillars and LEM goals.	**☒Yes ☐No**
Commitment to ASPIRE Acknowledgement signed and dated consistent with performance appraisal.	**☒Yes ☐No**
HealthStream In-Service Education training/education modules are current and on-track.	**☒Yes ☐No**
If applicable to position, annual competencies completed and forwarded to Human Resources.	**☒Yes ☐No**
Safety Manual and SDS Manual reviewed as required.	**☒Yes ☐No**

Overall Average Numerical Performance Appraisal Rating:	**Total Points** 23 **/ 5 =** 4.6

EXAMPLE

Comments:	

Average Performance Appraisal and Leadership Evaluation Manager (LEM) Score:	Performance Appraisal Rating 4.6 x .2 = .92 LEM Score 2.6 x .8 = 2.08 Combined Appraisal/LEM Score = 3.0
Comments	

Manager Signature: _____ **Date:** _____

Employee Signature: _____ **Date:** _____

Employee Comments:

PMH Pay-for-Performance System
Leadership and Exempt (non-leadership) Staff
Annual Wage Program
2023

LEM Score	Review Score	% Wage Increase
5	4	4.8%
4	3.5	3.9%
3	3	3.0%
2	2.5	2.1%
< 2	< 2	0.0%

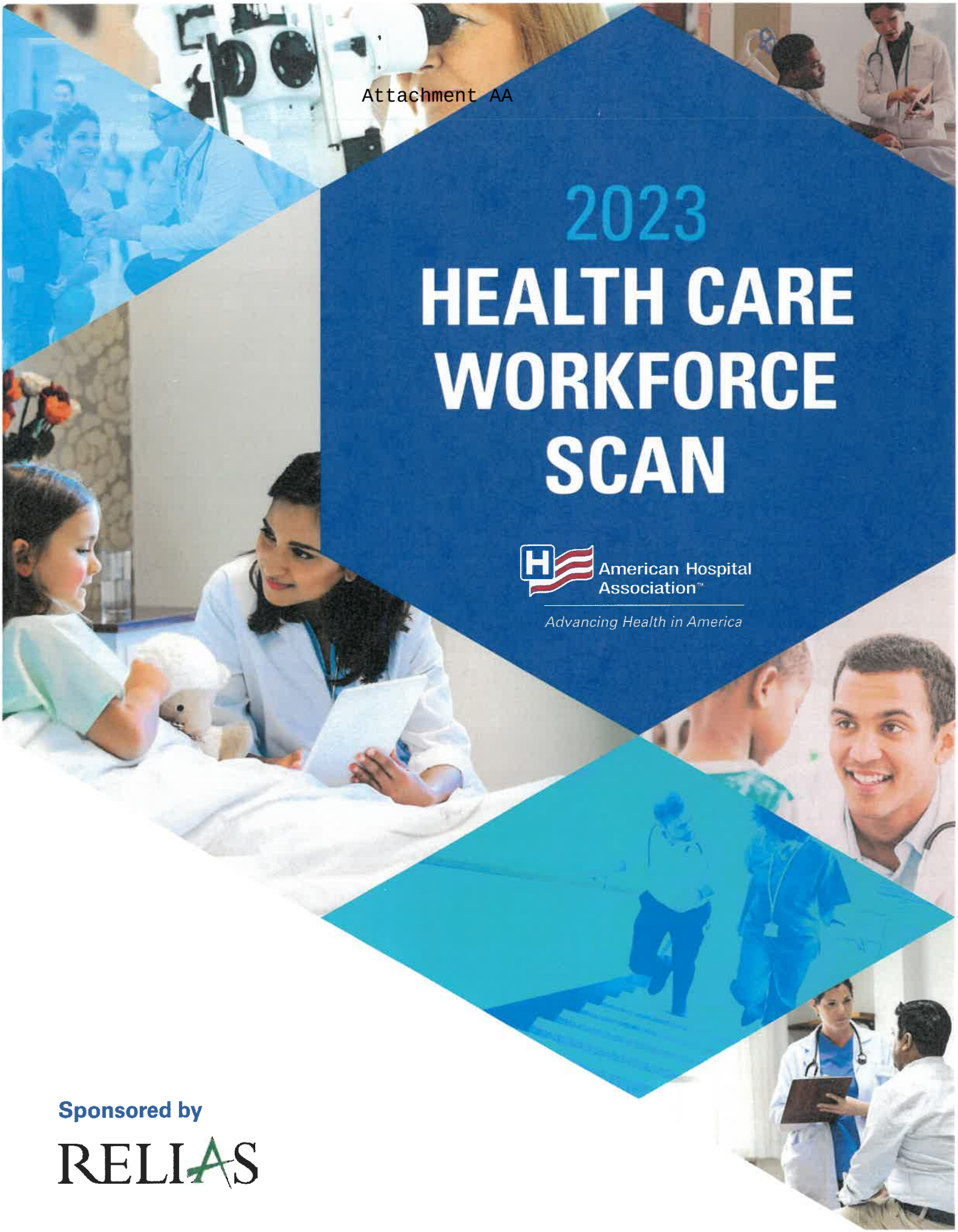
Wage Increase calculation = 80% of LEM Score + 20% Annual Review

Example: 4.0 LEM + 3.5 Annual Review = 3.9% Raise

((4.0.8)+(3.5*.2))/100 = .039 or 3.9%*

*** Average organization-wide pay increase approved by the Board of Commissioners in the Annual Operating Budget (2023 = 4.2%)**

Attachment AA



2023 HEALTH CARE WORKFORCE SCAN

American Hospital Association™

Advancing Health in America

Sponsored by

RELIAS

WELCOME

2023 American Hospital Association Health Care Workforce Scan

A strong and resilient workforce is the backbone of our hospitals and health systems. There is no higher priority than ensuring that we care for the caregiver, that we make our working environment safe, and that we foster the ability for individuals to have joy in their work.

COVID-19 has shone a bright light on the selfless dedication of the people in whose hands we put our health and well-being. But this has come at a steep price: Health care workers have been at the tip of the spear of the growing stress, trauma and burnout we've seen around the globe.

While health care workforce challenges are not new, the pandemic has greatly exacerbated them. This national emergency demands bold, immediate action from public and private sector leaders.

A key pillar of AHA's 2022-2024 Strategic Plan is Addressing Workforce Challenges in the Now, Near and Far. The AHA Board of Trustees' Task Force on Workforce, which was formed at the start of this year, has been leading a number of efforts designed to rescue our current workforce and assure the future supply of needed health care professionals.

As part of this work, we are excited to share with you the AHA's 2023 Health Care Workforce Scan. Based on a review of the latest reports, studies and other data sources, this Workforce Scan provides an annual snapshot of America's health care employment, as well as insights and information to help lead your organization forward.

Health care is a truly noble profession, a calling that can change and save lives. While none of the actions in this report will yield an instant remedy, we hope that these provide a clear, actionable path forward to advance the health of the people and communities you serve.

Wright L. Lassiter III
AHA Board Chair

Rick Pollack
AHA President and CEO

Tackling Workforce Challenges

We have always dealt with workforce challenges, but this time the demographics are different. In many ways, we're dealing with a perfect storm. The aging population is increasing demand for health care services. Yet the labor force participation rate has dropped to 62.1% from pre-pandemic levels of 63.4%, creating a record number of job openings[1] and more Americans are nearing retirement age than entering working age. Our educational pathways are not where they need to be to replace people retiring or leaving the field. Last, but certainly very far from least, health care workers are exhausted from dealing with COVID-19 for two-plus years.

The magnitude, duration and pace of change during the pandemic have amplified the stress health care workers already face. Through all their emotional, physical and financial challenges, health care workers across the board have continued to put high-quality, compassionate patient care at the center of all they do. In these extraordinary times, they need extraordinary support.

I'm honored to chair The AHA Workforce Task Force, comprised of nurse, physician and executive leaders. Our goal is to provide tools, data, best practices and strategies to strengthen the health care workforce right now, in the near future and over the long term. This workforce scan offers valuable insights and practical recommendations to help you think – and act – innovatively to support, retain and recruit staff.

The good news is that we know health care is incredibly meaningful and joyful work for those who choose this path. We must continue to develop bold new ways to support our current staff and ensure we attract the workers we need to meet the health care demands of today – and tomorrow.

Ronald C. Werft
Chair, AHA Board
Task Force on Workforce
President and CEO, Cottage Health

TABLE OF CONTENTS

Better Patient Care, Happier Employees

Solutions To Improve Your Healthcare Organization

At Relias, we're passionate about helping healthcare workers thrive through personalized learning, accredited courses, and talent solutions. We help drive positive outcomes, ranging from improved nurse retention to clinical performance.

We love data. Here's some of ours –

11,000 clients

across the continuum of care

81% increase in nurse retention
in two years within a healthcare system comprised of six hospitals

~3,000 acute courses

1,700+ certified or accredited courses

140 clinical assessments across 40 specialties – all with in-house, personalized course creation

6.5 fewer days of post-hire orientation
within a healthcare system comprised of 17 hospitals and over 600 newly-licensed nurses

26% reduction in obstetrical hemorrhages
requiring four or more units of PRBCs and reduced deliveries requiring activation of a massive transfusion protocol (MTC) by 50%

GET STARTED

Get started with a personalized product demo, customized to meet your organization's needs.

Fundamental Factors Shaping the Future Workforce

Our key findings at a glance:

Workforce shortages are not disappearing any time soon.

The pandemic exacerbated existing shortages of health care workers in all roles, from clinicians to environmental and food services to admissions and scheduling. These shortages will persist well beyond the pandemic given today's highly competitive labor market.

Whether you call it the Great Resignation, the Great Reshuffle or the Great Attrition, all sectors of the economy – health care included – have been affected by massive worker turnover.

Record numbers of people are leaving their current jobs for new ones, new fields or new pursuits outside the job market altogether.

Health care workers are amazing, but they're human.

Despite all the difficulties, trauma and challenges they have faced, millions continue to show up and believe in their ability to make a difference in patients' lives. Their mental and physical well-being requires tangible help and support from their leaders, and respect from the communities they serve.

Massive disruption in health care has an upside.

The incredible challenges have also created unique opportunities to accelerate change and improve the way care is delivered, whether through technology, new care delivery approaches or multidisciplinary team models.

All health care stakeholders need to work together.

Ensuring the health and safety of the health care workforce – and the health and safety of the patients they care for – requires commitment at the individual, organizational and community level.

Looking Ahead in Health Care

As the health care landscape continues to shift, workforce planning strategies must also readjust. Trends to watch include:

Inflation + increased costs of caring = continuing financial challenges.[2,3,4,5,6]

An analysis prepared by Kaufman, Hall & Associates, LLC and released in September 2022 by the AHA shows that hospitals and health systems continue to face intense pressure on staff and resources while also dealing with rising expenses for supplies, drugs and equipment, as well as for the workforce. Left unaddressed, these financial challenges have the potential to jeopardize access to essential health care services for patients.

The trends are expected to continue through the end of 2022, with losses in the billions of dollars for hospitals and health systems, resulting in the most financially difficult year for the field since the beginning of the COVID-19 pandemic in 2020.

The first half of 2022 has severely tested hospitals and health systems due to the impacts of COVID-19 surges, increased expenses and a lack of COVID-19 relief funding. As a result, even the most optimistic projections for the entirety of 2022 indicate margins will be down 37% compared to pre-pandemic levels, with more than half of hospitals operating in the red. Under a pessimistic scenario for the rest of 2022, margins could be down as much as 133% compared to pre-pandemic levels, with over two-thirds of hospitals operating in the red.

Hospital and health system expenses are expected to increase by nearly $135 billion in 2022 over 2021 levels with a large component of that deriving from expenses related to retaining and supporting the workforce. Employed labor expenses are projected to rise by $57 billion more than last year and contract labor by $29 billion. In fact, contract labor expenses alone are nearly 500% higher than pre-pandemic levels, which has played a significant role in driving expense growth for hospitals. The remaining $49 billion in added expenses in 2022 include those for supplies, drugs and equipment, which have all experienced significant growth from pre-pandemic levels.

These significant financial challenges for 2022 add to a report the AHA released in April that examined the tremendous growth in a variety of input costs for hospitals and health systems, including expenses for workforce, drugs, supplies and equipment, as well as the impact of skyrocketing economy-wide inflation. Notably, that report showed that hospital labor expenses per patient were up 19.1% over pre-pandemic levels in 2019.

At the same time, deferred care during the pandemic has led to increased patient acuity in America's hospitals — which means the people hospitals see are much sicker than in the past — and that means they are more expensive to treat.

Technology is crucial to reshaping health care delivery.[7,8]

Technology offers powerful potential to change and improve health care delivery. Thirty-six percent of consumers own a wearable health

device or use a smartphone to track wellness, and nearly 60% believe the data are useful and should be collected by their physicians. Remote monitoring sensors and capabilities also support the ability of hospitals to bring appropriate care to patients in alternative settings, such as through hospital-at-home programs. But increasing health care worker tech literacy and adoption requires making time in their busy schedules for training and also ensuring that it fits seamlessly into their workflow.

Telehealth has been such a huge hit with patients and providers alike during the pandemic that it's no longer a question of if it will continue to be used, but of how much and when. Eighty-five percent of physicians say telehealth has increased timeliness of care, 75% say it allowed them to deliver high-quality care and more than 70% are motivated to use it more. This interest spurred the American Medical Association to create a "Return on Health" framework to help physicians optimize virtual care in terms of financial ROI; patient, physician and caregiver satisfaction; and access and health equity.

Expanded digital access to health care is critical, especially as provider shortages continue. This highlights the urgency of bringing reliable and affordable high-speed broadband service to all Americans. The U.S. Census estimates that nearly 14% of urban households and more than 19% of rural ones do not have a broadband subscription.

Attracting and retaining talent and optimizing productivity in a hybrid work environment also will depend heavily on technology, as well as on cultivating the leadership skills necessary to manage a hybrid workforce. Health care organizations project 37% of their employees will be hybrid or remote going forward, and half report that they are changing their hiring policies to source talent — and allow those hires to work — from any geographic region.

Hospitals are rethinking leadership roles and responsibilities.[9,10,11]

Leadership development and key competencies will play an even more critical role as health care organizations seek to strengthen resilience and thrive in a fast-changing environment. Whether addressing an increased role for technology, leading a remote team or rethinking care models to adapt to different team configurations, essential leadership qualities include vision/strategy, communication skills, agility and integrity. Leadership roles in telehealth, quality/safety, behavioral health and patient experience are growing more important, and positions such as Chief of Telehealth or Distance Care Delivery, Chief Wellness Officer, Chief Nursing Informatics Officer and Director of Innovation are being created or relied on more heavily.

Throughout the pandemic, nurses have demonstrated valuable leadership. They have taken on broader roles and more nontraditional ones, such as greater responsibility related to discharge planning, coordination of care services and care transition. Hospitals that continue to encourage greater leadership opportunities by evaluating nursing skill sets and creating more flexible, meaningful career pathways will be better prepared to meet future crises — and also support ever-critical nurse retention.

The patient/clinician relationship is evolving.[12]

Consumerism and access to information is driving change in health care and redefining the way patients and clinicians relate. Fifty-six percent of clinicians believe that over the past 10 years, patients have become more empowered to manage their own medical conditions. Similar numbers predict that with the aid of technology, access to health data and greater control over their own medical records, patients will better manage their own health as informed members of their care team.

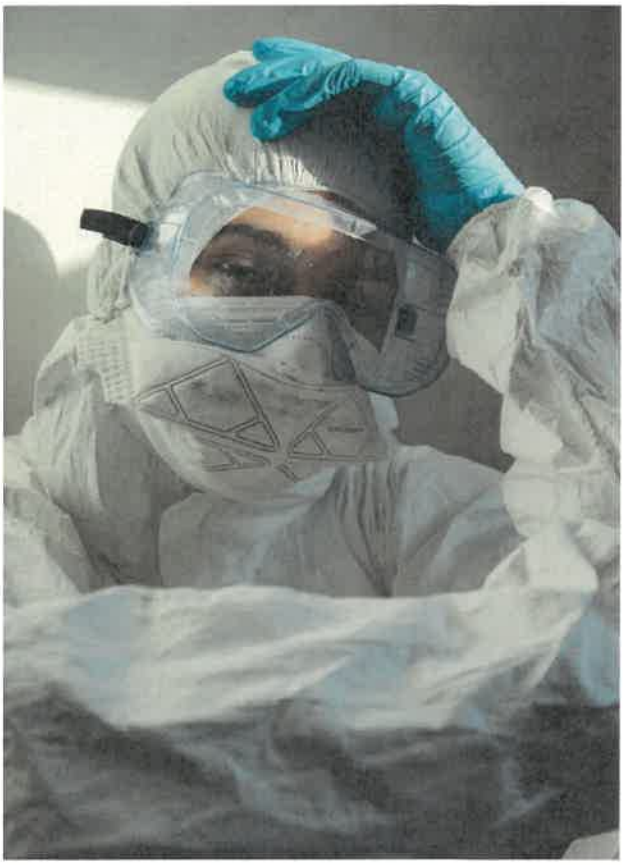
More than 60% of clinicians believe that over the next decade, they will work more collaboratively with their patients, taking advantage of health data and clinical insights to inform decision-making. They will also be increasingly likely to emphasize a preventive approach for patient mental and physical well-being, supporting individuals' efforts to stay healthy rather than focusing primarily on treating illness.

This will make soft skills such as listening, being empathic and communicating effectively, both in person and digitally, increasingly important for clinicians. The ability to express compassion through a screen must go hand-in-hand with digital knowledge and the ability to optimize digital tools.

The COVID-19 pandemic has exacerbated existing challenges — and created new ones.[13,14,15,16,17]

Health care workforce shortages certainly predate COVID-19, but the pandemic has intensified the issue, with as many as 47% of health care workers planning to leave their jobs by 2025. COVID-19 also created a heightened demand for specialist care to support long-haul patients and chronic COVID-impacted conditions.

In addition, some patients who postponed or skipped routine screenings or delayed care during the pandemic now require more complex care. For example, cancers typically caught earlier are now presenting in later stages. A 22% increase in health care utilization related to musculoskeletal conditions is predicted due to deferred care and postponed elective surgeries



such as joint replacement. Deferred care is also expected to make treating cardiovascular disease a more substantial burden.

Burnout — part of the stress injury continuum which also includes compassion fatigue, moral distress, anxiety, depression, post-traumatic stress disorder (PTSD) and other conditions — is another long-standing issue exacerbated by the pandemic. More than 60% of front-line health care workers reported that pandemic-related worry or stress negatively impacted their mental health. Thirteen percent received mental health services or medications and another 20% thought they might need mental health services but didn't seek care for reasons ranging from fear of stigma to lack of access.

The increased need for better and expanded access to sustained support for clinicians is mirrored by the need to increase access to behavioral health services in the broader population, in which visits are expected to increase by 50%.

The pandemic also amplified health equity challenges, with COVID disproportionately affecting marginalized communities. Meanwhile, the increasing reliance on digital health care highlights the need to reduce barriers to taking advantage of these options.

Last but far from least, the pandemic underscored the importance of taking concrete steps today to ensure that hospitals and health systems will be prepared to respond to the emergencies and pandemics of tomorrow.

WORKFORCE CORE CHALLENGE #1:
Reconnect Clinicians to Purpose

Most health care workers choose their profession because they passionately desire to help people by restoring or improving their health. Reconnecting to purpose and rediscovering the "why" is key to helping workers move forward as we continue to emerge from the COVID-19 pandemic – and seek to use the lessons learned to change health care for the better in our communities.

As part of efforts to successfully recruit and retain a qualified, dedicated and diverse workforce, hospitals and health systems must create environments that consistently support meaningful work and nurture relationship-building with colleagues, patients and families. Maximizing patient care time while minimizing administrative tasks is essential to reinspiring workers to find the joy, satisfaction and meaning they value so highly.

WHY Purpose Matters

Nursing vacancy rates and turnover are sky-high.[18,19]

Registered nursing remains a top growth occupation, projected to grow 7% through 2029. However, the 2021 RN vacancy rate was just shy of 10%, a point higher than the previous year, and turnover for staff RNs rose 2.8% to 18.7%. Average turnover costs for a bedside RN range from $28,400 to $51,400, costing hospitals on average between $3.6 million and $6.5 million annually. Feeding their "why" through onboarding, engagement and mission-driven culture plays a key role in improving RN retention.

Healthy, engaged workers are essential to high-quality care.[20,21,22]

Burnout-related turnover costs have been estimated at $9 billion for nurses and $2.6 billion to $6.3 billion for physicians, without factoring in the impact on other health workers spanning the continuum of care. Beyond the financial impact for hospitals, the negative consequences of burnout on workers' emotional and physical well-being can affect the time, energy and compassion they have to devote

to patient care. COVID-related stress is only one of many factors that may contribute to burnout. All health care workers have reported symptoms of anxiety, depression, PTSD, compassion fatigue and moral distress.

Workers seek meaningful work aligned with their priorities.[23]

For many workers, the pandemic was a wake-up call to realign priorities and explore new opportunities. In today's tight labor market, hospitals compete for talent not only with other hospitals but with other health care organizations and employers in a broad spectrum of industries, many of whom can offer more flexibility and desirable remote or hybrid work options — but not necessarily the same powerful opportunity to make a difference in people's lives that health care can.

HOW to Fortify Purpose

Create and model a culture that reflects mission-driven values.[24]

Meaningful work that makes a difference in people's lives and health continues to be a powerful pull, underscoring the need to cultivate alignment between organizational mission and individual calling. Cultures aligned with mission-driven values should strive to be inclusive, empowering, responsive, collaborative and trust-inspiring. For Parkview Health in Fort Wayne, Indiana, establishing a shared governance model has been effective in demonstrating its commitment to a "workplace culture of ownership" that helps individuals feel listened to and valued. Leaders must also focus on reinforcing joy, pride and satisfaction as well as model them in their own behavior. Demonstrate daily through behavior and policy that every employee is committed to caring for patients, neighbors and community members, and each other.

Find out what really matters to employees.[25,26,27,28,29]

Research shows that 80% of people leave their jobs because they don't feel appreciated. Consistently asking employees about their core needs — through onboarding, surveys, town halls, rounding, team huddles or other avenues — offers the best path to providing recognition and a work environment they value. Not feeling listened to or supported at work ranks right up there with insufficient staffing, insufficient pay and the emotional toll among reasons nurses list for leaving. Understanding that different constituencies, whether generations or job roles, have different needs is also important. Consider regular "stay" interviews to gain insight into what excites physicians, nurses and other employees when they come to work, what future they see for themselves at your organization, what changes they would like to see and other meaningful information.

Make strengthening satisfaction a key strategy.[30,31,32,33,34]

Reduce burnout and improve retention by demonstrating commitment to workplace practices that strengthen employee satisfaction including:

- Safe work environments.
- Safe reporting structures.
- Competitive compensation.
- Better career guidance.
- Appropriate staffing levels.
- Confidence that supervisors and leaders have their backs.
- Healthy work/life synergy.
- Flexible scheduling.
- Relevant upskilling/professional development.
- Shared decision-making.

Nurture a willingness to embrace self-care.[35]

Clinicians need to realize that taking care of themselves is as important as taking care of their patients. To overcome reluctance to seek out appropriate care for physical and mental health, encouragement must start at the top and cascade throughout all leadership levels. Acknowledge the pressure and stress workers face. Develop educational programs, provide a menu of self-care resources that address a variety of needs and ensure practical, real-time access to support services.

Emphasize commitment to patient-centric care.[36,37]

Put patient outcomes and wellness at the center of models of care. Integrate technology in ways that support better, more efficient care and increase opportunities for direct patient interaction.

WHAT to Think About Going Forward:

- **Do you provide frequent, regular opportunities for your employees to express concerns and identify needs, and then respond to these needs by investing in solutions?**
- **How effectively — and publicly — do you express gratitude for your team members' commitment to deliver quality care, and advocate for them in your community?**
- **What steps can you take to expand autonomy and clinician empowerment?**
- **How can you move to a shared governance model that welcomes diverse voices at the table?**
- **Have you considered incentives for self-care, such as making mental health a competency or including it in performance appraisals?**
- **Have you identified an accountable executive team leader to spearhead and measure well-being efforts?**

WORKFORCE CORE CHALLENGE #2:
Provide Support, Training and Technology Clinicians Need to Thrive in Multiple Care Delivery Environments

The pandemic has accelerated changes in the ways care is delivered, with a wider acceptance of virtual in addition to in-person options. The settings where care is delivered also continue to expand, whether it's where patients live, in outpatient clinics, in community facilities or in hospitals. The ability to succeed in, and transition seamlessly between, a wide variety of care environments requires new skills and technologies, new flexibility in the workforce and innovative strategies for workforce management.

WHY Support, Training and Technology Matter

New staffing models take on new importance.[38,39]

Optimizing available staff resources to maintain high-quality care delivery demands planning and creativity. Nearly 40% of nurse leaders identified adoption of new staffing models as the top advancement that should be maintained beyond the pandemic. Some clinicians also anticipate that tomorrow's multidisciplinary care teams will include data analysts, IT specialists and digital quality control experts to help leverage data-driven insights to improve care.

Different environments demand different skill sets.[40,41]

Nearly half of clinicians surveyed believe that in the next 10 years, most health care will be provided in a patient's home rather than a health care setting and 63% anticipate doing most of their consultations virtually. In a hospital-at-home model, staff members need to be comfortable working one-on-one and making decisions without a support team in the same physical space. Successfully caring for patients via telehealth requires the ability to convey soft skills like empathy through a computer or a smaller

mobile device. Interdisciplinary community-based care models require all care team members to collaborate, communicate and be resilient in order to make holistic patient assessments and develop and implement comprehensive care plans.

Soft skills go hand in hand with technology literacy.[42]

As the focus shifts to providing care tailored to the patient's location and preferred method, clinicians need to be agile enough to move seamlessly between care delivery models and able to adapt to different types of patient relationships. Eighty-two percent of clinicians say soft skills such as listening, being empathetic and communicating effectively are becoming increasingly important. They also predict that over the next decade technology literacy will become their most valuable capability, ranking higher than clinical knowledge. As a result, they are eager for training in using digital health technologies to deliver remote patient care as well as in how to use data effectively to improve patient care.

More care options, more access, fewer disparities.[43,44,45]

Reshaping health care delivery and expanding access to care are key to reducing health care disparities. Safely and effectively bringing care to patients wherever they are can improve outcomes and build a more equitable health care system. Expanding care from traditional hospitals and clinics to patients' homes, community centers and other dispersed locations can improve access to treatment for underserved or highly vulnerable people. Identifying and tackling digital inequities is also key to narrowing care inequities since access to telehealth and other digital communication technologies is increasingly critical to efforts to improve health literacy, empower and engage patients, and support self-management.

HOW to Address This Challenge

Go virtual.[46]

Eighteen months after implementing an innovative virtual nurse approach to staffing, MercyOne in Des Moines, Iowa, has seen improvements in patient safety, quality and satisfaction; better communication among the patient, family and care team; increased clinician satisfaction and higher productivity. Using two-way videoconferencing technology located in the patient's room, the virtual nurse assists bedside nurses in monitoring, communicating and conducting discharge planning.

Make technology an ally.[47,48,49]

Technology offers powerful potential to automate repetitive tasks and support teams, and integrating it is vital to optimizing clinical productivity and improving satisfaction. Ambient intelligence, virtual assistant solutions, voice-to-text apps and natural language processing can reduce the time clinicians spend entering data into electronic health records, freeing time for direct patient care. Artificial intelligence (AI) tools can mine big data for valuable diagnostic and treatment support.

Making the most of technology requires:

» Continuous training so the care team keeps pace with digital advances.
» Time and support to practice and master new technology and digital capabilities.
» Person-centered digital design.
» Regulatory standards to ensure safety, security and quality.
» Providing the right information and right tools at the right time to support clinical decision-making.

Institute innovative care delivery models.[50]

High-tech and high-touch both play key roles in quality care and should be consistently integrated into holistic delivery models. Hybrid options integrate virtual and in-person treatment, while the Partners for Nursing Staffing think tank recommends a tribrid approach that incorporates three components: on-site care, IT integration of patient monitoring equipment, and ambulatory access and virtual/remote care delivery. When piloting new models, build in continuous measurement to track quality of patient and staff experience, outcomes and resource management.

Promote agility with cross-functional professional development.[51]

Build confidence, deepen expertise and sharpen leadership skills by providing ample opportunities for cross-functional, interdisciplinary training across departments, organizations and care settings. This can streamline ad hoc or crisis redeployment, improve efficiency and, most importantly, enhance patient care. Investing in simulations, rotation and mentorship programs, and specialization fellowships encourages maintenance of existing skills and mastery of additional ones, but small, incremental enhancements to existing training offerings can also deliver results.

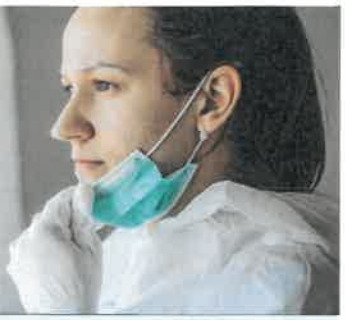
Build interest early in health care opportunities.[52]

Spark interest and broaden skill sets by enhancing access to nursing and health care competency-building in high school. Offer test preparation support and undergraduate scholarships to help attract people interested in a variety of health care roles.

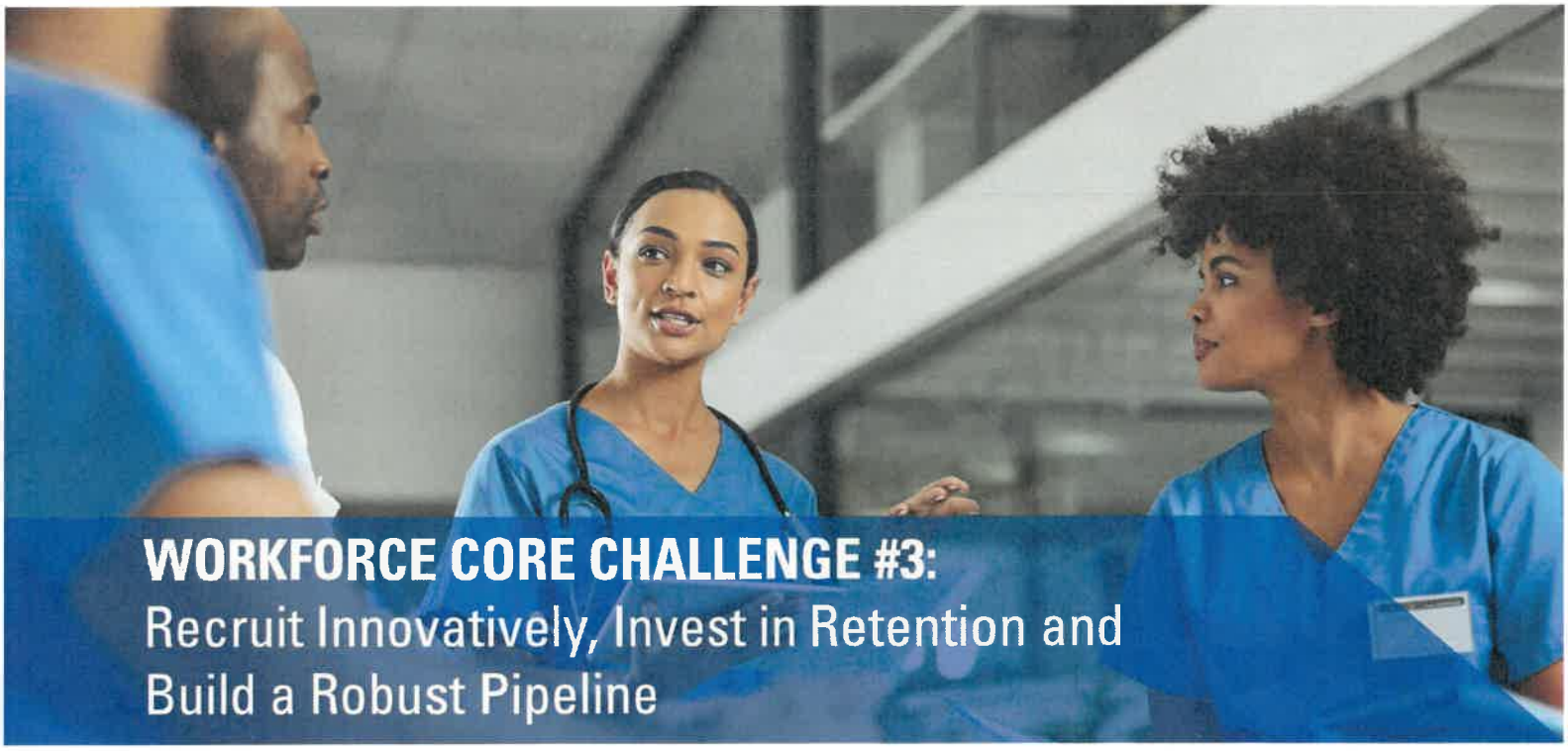
Collaborate with clinical professional training programs to incorporate required skill sets into the curricula.[53,54,55,56]

Physician and nurse education needs to keep pace with advances and changes in health care, including how to confidently use new technologies, work effectively in multidisciplinary teams, and cultivate soft skills such as listening, being empathic and communicating well. Medical education should include visits to patients' homes and other nonhospital care settings, training on incorporating patient and family perspectives into care, and narrative self-reflection to support empathic care. Fifty-three percent of nursing school administrators and 42% of nurses believe there should be a great emphasis on leadership skill development in nursing school. Embedding it into the nursing school experience starts preparing nurses early to feel empowered to make sure they have a voice at the decision-making table. Nursing schools also need to prepare students to better understand social determinants of health and expand community-based learning experiences that enable them to care knowledgeably for people with diverse life experiences and cultural values.

WHAT to Think About Going Forward:



- Are you investing time in gaining a clear understanding of current workload, workflows and team composition before exploring technology solutions?
- How can you expand career pathways to provide growth opportunities for health care workers at all levels of their careers?
- How effectively are you using existing and emerging technologies, including intelligent automation and AI, to enable clinicians to focus more on patient care and less on administrative tasks?
- Should clinicians be compensated differently for participation in different care delivery models, and how?
- How can technology be used to create remote opportunities, such as through expanded telehealth, for positions that currently are primarily in-person care?
- How regularly do your managers provide information and clarity on advancement opportunities, upskilling workshops and career mobility requirements?



WORKFORCE CORE CHALLENGE #3:
Recruit Innovatively, Invest in Retention and Build a Robust Pipeline

To ensure high-quality patient care now and in the future, health care workforce recruitment and retention must be top priorities in the short term. At the same time, developing a robust pipeline is critical to creating a sustainable long-term solution.

WHY These Efforts Matter

Shortages aren't shrinking.[57,58,59,60]

The pandemic exacerbated existing health care worker shortages. More than a third of nurses surveyed say they are likely to leave their job by year-end 2022, and nearly a third of those plan to leave the field altogether or retire. The Wisconsin Council on Medical Education and Workforce projects that by 2035, the state could be short nearly 16,000 nurses. In New York state, hospitals and nursing homes are grappling with high vacancy rates in all health care roles (19% on average), but most significantly among RN (25%) and entry-level clinical positions. In Massachusetts, nearly 14% of nursing jobs at acute care hospitals are open, double the amount in 2019.

Satisfaction levels need bolstering.[61,62,63,64,65,66]

Physician burnout increased to 47% in 2021, up from 42% in 2020. More than half describe the impact of burnout on their lives as strong to severe. Forty-four percent of nurses planning to quit their jobs blame burnout and a high-stress environment. Only 22% of millennial nurses, who were the least satisfied pre-pandemic, currently report being satisfied. They blame their dissatisfaction on burnout and disappointing compensation. Forty percent of RNs say that COVID-19 negatively impacted their career satisfaction, and one-quarter say they would not choose to be an RN if they could do it all over again. The well-being of nurse leaders is also a concern, with one-quarter reporting that they are not emotionally healthy. That includes 17% of chief nursing officers and certified nurse educators, a 143% increase in only six months.

Competition for labor is intense.[67,68]

Many nurses continue to trade staff positions for highly paid travel nursing contracts, while others head to different facilities that offer generous signing bonuses. Staffing costs are skyrocketing, especially in small rural hospitals that often find it hard to attract workers. Median hourly hospital pay was nearly 15% higher in the first quarter of 2022 compared with that of the previous year. Larger health systems like CoxHealth are not immune to recruitment and retention challenges either. Last year the system spent $25.5 million on raises to 6,500 employees, and it has also been working on strengthening its pipeline by adding 150 more students to its affiliated nursing school class.

Young nurses are exiting in droves.[69,70]

Between 2019 and 2022, the U.S. nursing workforce dropped 1.8% — more than 100,000 people. This decline, the largest decrease in 40 years, was fueled primarily by the exodus of RNs younger than 35 leaving hospital-based jobs. Their numbers fell by 4% compared with a 0.5% drop for nurses 35 to 49 and a 1% decline for those 50 and older. This could have concerning long-term implications, especially when coupled with the fact that baccalaureate- and higher-degree nursing programs denied admission to a record 91,000 applicants for the 2021-22 academic year — more than 10,000 more than the previous year.

Turnover is costly.[71,72]

The average turnover rate for staff RNs was 18.7% in 2020, up 2.8% points from the previous year. In fact since 2016, hospitals have turned over about 90% of their workforce on average, and 83% of their RNs. This doesn't come cheap, with the cost of turnover for a bedside RN ranging from $28,400 to $51,700, adding up to annual losses of $3.6 million to $6.5 million. For each percentage change in RN turnover, the average hospital can save or lose $270,800 per year. Physician turnover costs are also high. Lost revenue can exceed $1 million if a specialist position is vacant, and recruitment costs can add $250,000 or more per physician for sourcing, relocation and a sign-on bonus.

HOW to Achieve These Objectives

Collaborate to expand training options.[73,74]

Partner with schools, community organizations and other health care organizations to create apprenticeships, earn-while-you-learn programs, and other on-the-job training opportunities.

» Mary Washington Healthcare in Virginia partners with Germanna Community College to create an Earn While You Learn program, onboarding two cohorts of as many as 60 students each year. Nursing students work 12-20 hours a week using a clinical rotation model. The program now includes an additional nursing school as well as mentor models for nursing assistants and is considering an apprenticeship model for other clinical roles such as surgical technologists.

» Participants in the Jump Start program at MercyOne in Iowa receive a monthly stipend while they finish nursing school, and MercyOne covers the cost of board exams and licensing fees. After RN licensure, the nurses begin work at MercyOne.

» Project Firstline is the Centers for Disease Control and Prevention's national training collaborative for health care infection prevention and control. As part of this program, the AHA is partnering with the League for Innovation in the Community College to provide comprehensive infection control education and practice for nursing and allied health students.

» Freeman Health System in Missouri partners with Crowder College to provide an opportunity for education and employment through a 16-week paid Certified Medical Assistant apprentice program.

Recruit internationally.[75,76]

Over the next three years, Sanford Health in Sioux Falls, South Dakota, plans to hire more than 700 internationally trained nurses to work in its health system. Sanford covers housing during the initial transition period and also has instituted a program to help the nurses get acculturated to their new communities. Louisiana-based Ochsner Health is offering employment to eight Ukrainian nurses and will assist their families in settling in the U.S. in the pilot phase of CGFNS International's "Passport2Liberty initiative." To avoid creating shortages in nurses' home countries, it's important to ensure that efforts are not draining needed clinicians from their ranks.

Launch nursing programs.[77, 78]

Nearly 60 schools and hospitals across the country have partnered to start or expand nursing programs in 2022. Programs run the gamut from accelerated BSN programs and virtual nursing programs, to brand-new nursing schools and licensed practical nursing programs. For example, BHSH System in Michigan is providing $20 million to Oakland University — $10 million to grants for nursing students and $10 million to support infrastructure expansion and faculty hiring. Students who receive a grant must commit to work for BHSH for two years following graduation.

The more flexible, the better.[79,80,81,82]

Build flexibility into jobs whenever possible, and provide the technology support that enables remote work, including for roles traditionally handled in person. Modernize staffing models and offer more shift options with variable start times, durations, locations and sharing opportunities. Integrate app-enabled capabilities to support self-scheduling, work-from-home opportunities and schedule flexibility.

For example, Pittsburgh-based Allegheny Health Network's (AHN's) mobile internal staffing model offers nurses and technicians in selected roles the opportunity to rotate to AHN hospitals throughout the state. AHN also has options for employees who prefer to work weekends or night shifts. Yale New Haven Hospital (YNHH) developed an alternative staffing model that uses a variety of licensed and nonlicensed nursing team members to support critical care registered nurses. YNHH leaders also created flex shifts, including four-hour support role shifts, for nurses whose schedules could not accommodate a traditional-length shift.

Up investment in upskilling.[83,84,85,86]

More than half of health care workers say they are interested in upskilling. Education and upskilling programs can reduce financial barriers to choosing a health care career and advancing professionally:

» UCHealth in Colorado plans to invest $50 million in its new Ascend leadership program to help current and prospective employees earn clinical certification, participate in foundational learning programs such as English language and college prep, and earn degrees in areas such as social work and behavioral health. Newly hired employees will also be able to earn a high school diploma or GED.

» Along with three educational partners, the University Medical Center of El Paso (Texas) will pay up to $5,000 annually for two years for employees to earn a degree in nursing, respiratory, imaging or other hard-to-fill fields. Employees maintain full-time employment status and compensation while working part-time. Under another new program, the hospital is offering eligible employees pursuing a health care degree up to $5,250 a year in student loan-repayment assistance.

» To fill the scores of medical assistant openings, in Nashville, Tennessee, Vanderbilt University Medical Center partnered with Nashville State Community College to train current employees, including truck drivers and environmental services staff. During the training, workers continue to receive their full salary plus tuition reimbursement. They are also training high school students to receive medical assistant certification.

» In Pennsylvania, Geisinger's Nursing Scholars Program awards $40,000 in financial support to each employee who is pursuing a nursing career and makes a five-year commitment to work as an inpatient nurse. The program is open to any employee who has worked with Geisinger for at least a year and is not already a registered nurse or provider.

Engage in smart onboarding.[87]

Robust onboarding improves retention by helping to ensure clinician well-being and engagement from Day 1. This plays a vital role, because the first year of employment often determines whether or not employees build loyalty. Key points to consider include:

» Robust content. Help new hires understand your organization's processes and priorities, and the value of their roles.

» Career pathways. Provide information and organization resources about professional development and advancement.

» Mentoring. Trusted one-on-one relationships support network-building, cultural assimilation and a sense of belonging.

Advocate for change.[88]

The AHA is urging Congress to prioritize funding, policies and actions that support the health care workforce needs today and tomorrow. These include:

» Lifting the cap on Medicare-funded residency slots.

» Increasing funding for direct and indirect graduate medical education.

» Increasing support for nursing schools and faculty.

» Offering loan forgiveness and reimbursement.

» Fast-tracking visas for health care workers.

Be intentionally inclusive.[89]

Support the efforts of medical, nursing and allied health profession schools to further expand recruitment and support of diverse students. Intentionally integrate diversity, equity and inclusion ideals into leadership practices, operations, strategic planning and decision-making. Create psychological safety in your workforce and on care teams to attract and retain diverse talent.

Provide nontraditional support.[90]

If affordable or rental housing is in short supply, consider purchasing housing for workers, building affordable units near the hospital, or offering housing grants:

» St. Luke's Wood River, located in a popular Idaho tourist area, is building 12 single-family homes that will be long-term rentals for employees.
» Bozeman Health in Montana has invested in 100 units in a future workforce housing complex to provide employees with affordable rentals.
» Northwell Health, Johns Hopkins, Cleveland Clinic and BJC Healthcare are among employers offering grants or forgivable loans that can be used for associated housing costs.

Work with local community groups such as the Chamber of Commerce, Realtors, Kiwanis and school organizations to identify appropriate job opportunities for spouses or partners of potential hires. Partner with community groups to find affordable child care, or consider providing it on-site with flexible hours.

Recruit for cultural as well as competency fit.[91,92]

Prescreen candidates honestly about the pros and cons of your community to ensure that it matches their lifestyle as well as professional expectations. Nearly half of administrators say that their physician-retention program actually starts during recruitment, in particular with taking care to hire for both clinical and cultural fit.

Respect the power of the dollar.[93,94,95,96,97]

Pay increases are always welcome, but boosting employees' paychecks in other ways also can go a long way toward reinforcing retention. These include:

» Incentive pay for mentoring or leading preceptor classes.

» Relocation expense assistance for allied health and support staff as well as medical professionals.

» Offering flexible benefits such as child care and elder care resources and the opportunity for employees to choose the ones that best fit their specific needs.

» Benefits that help employees eliminate student loan debt more quickly.

» Retention bonuses for home- and community-based employees.

» Raise minimum wage for nonpatient-facing staff.

Turn to in-house staffing agencies.[98, 99]

Internal staffing agencies offer nurses and other clinicians the premium pay and flexibility of external travel agencies, with the benefit of staying within a single health care system. Develop a workforce pool that can be allocated to the areas of highest need across departments and geographic destinations. Jefferson Health in Philadelphia created a Nursing SEAL (service, excellence, advocacy and leadership) Team, which deploys participating RNs to acute care locations based on anticipated staffing needs.

WHAT to Think About Going Forward

- **How can you revamp current onboarding practices to amplify effectiveness?**
- **What opportunities can you provide to increase shadow experiences for clinical positions?**
- **What local universities, community colleges and/or online educational platforms can you partner with to attract high school students to health care careers?**
- **What new career pathways can you create by expanding upskilling and professional development training?**
- **In what ways can you increase scheduling flexibility to better meet workers' life-balance objectives?**
- **How can you best prepare to ensure high-quality patient care in the face of continuing labor shortages?**

Health Care Workforce Scan

Ask the Experts

How does workplace culture impact what's happening today in terms of resignations or attrition?

Donald. J. Parker
President, behavioral health care transformation services, Hackensack Meridian Health

In our post-pandemic recovery stage, health care leaders' Servant Leadership practices become even more important as we face the daunting task of future-proofing our beleaguered work force and increasing individual system and organizational resilience. Listening more to our staff and colleagues and more intently allows us to feel real empathy for the toll COVID has exacted on our health care workforce.

There is nothing like a natural disaster like COVID to create an extensive era of change. That "silver lining" effect can be multiplied when leaders make clear and convincing commitments to the growth of their teammates. Investment in development and education at every level of the organization makes the recovery journey a speedier one.

What can leaders do to create the right culture to meet the needs of staff?

Ronald C. Werft
President and CEO, Cottage Health; chair, AHA Board Task Force on Workforce

Ensuring a supportive and engaging workplace culture may well be our most important leadership responsibility and our most valuable recruitment and retention asset. It requires a multipronged approach to staff engagement, a willingness to listen and act, shared decision-making, frequent and transparent communication, and consistency across the organization. Leaders must model the culture they aspire to, prioritize support for the workforce and hold their teams accountable to the organization's values. Plans should include acknowledging and providing solutions to addressing wellness, workplace violence and the trauma which has unfolded over the past three years.

How has the cumulative stress from two-plus years of dealing with the pandemic impacted staff overall? How are clinicians being impacted?

Mary Mather
CEO, UofL Health–Peace Hospital

In addition to an already stressful environment in health care, the pandemic has certainly exacerbated health care workers' emotional and mental health. Essentially, we are managing the effects of trauma. I think in addition to the moral distress some clinicians are faced with, some clinicians are also beginning to cultivate self-awareness and gaining a deeper understanding of themselves. We are defining and aligning our values, which we hope will lead to intentional and purposeful living, making work and life more meaningful. When these values don't align, I believe employees will seek other agencies or professions to fulfill this purpose. Thus, the Great Resignation.

How do we address the sense of divide that seems to exist today, where what's best for the organization may not be in alignment with what workers feel is best for them (particularly in nursing, where we seem to be seeing more push for collective bargaining)?

Erik Martin, DNP, R.N., CENP
Vice president patient care services and chief nursing officer, Norton Children's Hospital

The core of our business is caring for people and now, more than ever, this has to include self-care. In order to provide excellent, high-quality and safe care to patients, our team members must prioritize their own mental, emotional, and physical health and safety. When individual decisions misalign with business decisions, it's essential for us (leaders) to recalibrate and focus on what brought us all together and why we're in health care. At the heart of it, we're all showing up every day to improve the health and well-being of the communities we serve.

To what extent can the challenges around staffing be addressed through care model redesign, and/or introducing new technology or optimizing current technology?

Claire Zangerle, DNP, MBA, R.N., NEA-BC, FAONL, FAAN
Chief nurse executive, Allegheny Health Network

There isn't one factor driving the staffing challenges in the current health care environment. As such, there is not one solution, but many that are, in some cases, interrelated. Further, solutions will reflect some of the broader influences impacting health care, such as consumerism, concerns about affordability and access to care. The various approaches necessary to address the staffing challenges require a sense of urgency that focuses on a realignment of current resources — realignment around new care models that support top of license work and utilizing technologies that increase sufficiency and reduce task burden. Each organization's approach to redesigning care delivery and integrating technology need to be customized to fit the needs and culture of their workforce, all while maintaining safe and high-quality care delivery to the communities they serve.

What innovative approaches or solutions have you seen hospitals and health systems taking lately to address workforce shortages?

Robyn Begley, DNP, R.N.
CEO, American Organization of Nurse Leaders; senior vice president, workforce and chief nursing officer, American Hospital Association

Flexibility and technology. Health leaders are asking their workforce what they want rather than developing solutions as to what they think employees want. Rather than a one-size-fits-all approach, they are offering flexibility. For decades, nurses have worked primarily 12-hour shifts. Some health care workers are able to work part-time or weekends only. Hospitals and health systems are asking nurses when they can work and are creating innovative weekend programs. We have seen this in the past with other staffing shortages. Many systems have considered what jobs or tasks can be done outside of the hospital and allow their health care workers to perform these duties remotely, either from home or remote locations.

Flexibility and technology are also key to being able to provide safe and effective care for our patients. Health care workers are increasingly using technology such as patient wearables to assist in care. We've seen very promising patient outcomes with the hospital-at-home program, which allows patients to remain in their home while still receiving acute-level care. Another technology, telesitter, allow patients more privacy and rest but also allows a nurse to check on multiple patients at once without interrupting the patient's sleep.

What opportunities are there to help existing staff to expand their value by developing or expanding their skills in areas like working with artificial intelligence, machine learning systems or virtual reality (VR)?

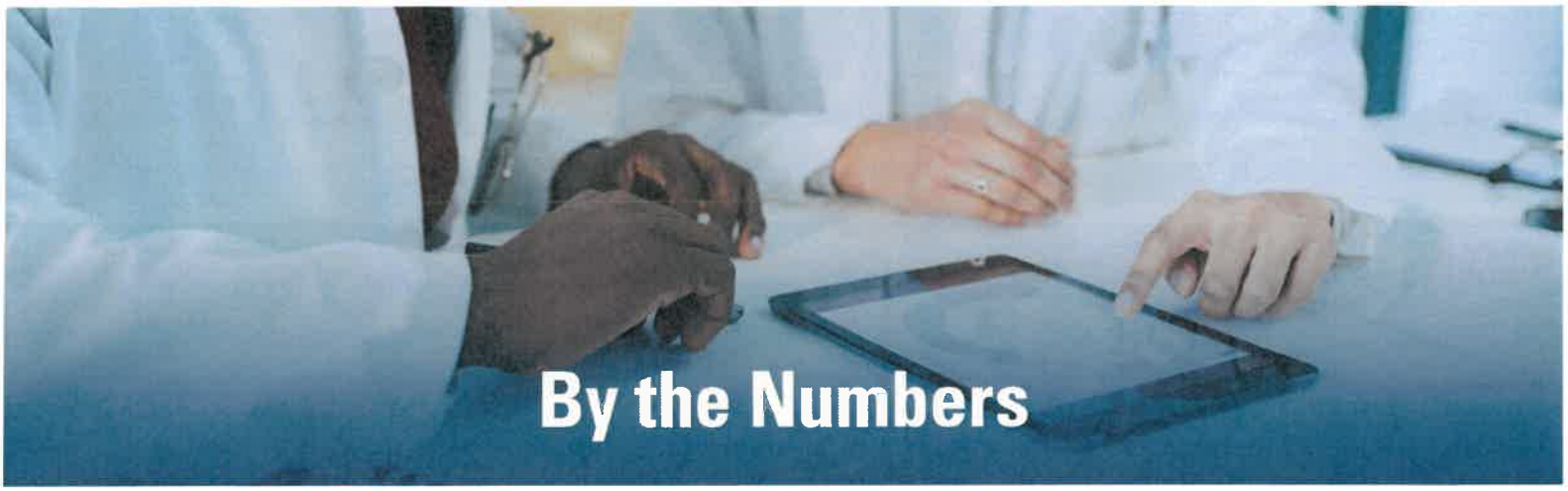
Felicia Sadler, MJ, BSN, R.N., CPHQ, LSSBB
Vice president of quality, Relias

Organizations are looking to innovative technology solutions to improve access to care, improve care quality and streamline efficiencies in key work processes. As technology expands and grows, we should be prepared to do the same. Technology creates many opportunities for advancing one's career path. For example, technology can expand opportunities in nursing informatics, telehealth/hospital at home models, and even software development. We are also seeing significant advancements in the area of virtual reality which provides a safe space to experience high-risk scenarios that measure competency with protocol-based VR simulation. This adds an additional key element in supporting patient safety and high reliability.

How can organizations help recruit and retain younger staff and keep them committed to the field for the long haul?

Ronald C. Werft
President and CEO, Cottage Health; chair, AHA Board Task Force on Workforce

The good news is that, in spite of the challenges of the pandemic, interest in health professions remains very strong. For the mid- and long-term, we need to engage and partner with regional academic leadership to jointly plan for future workforce needs. For the immediate, we need to better understand what various segments among our employees really want and need. For some younger staff, child care, commuting and rental assistance may be top priorities. For others, flexible work schedules including remote work, housing, pension, and education and advancement opportunities may be more highly valued. With the projected retirements of a high percentage of our experienced workforce, we will need to be much more flexible in providing meaningful support for the diverse members of the team.



By the Numbers

Health Care Job Growth

16% — **Employment in health care occupations is projected to grow 16%**

from 2020 to 2030 — much faster than the average for all occupations — adding 2.6 million jobs.[100]

12% — **The number of licensed nurse practitioners (NPs) increased 12%**

in the last year to a record 325,000-plus after many state executive orders during the pandemic granted them larger roles. Nationwide, more effective use of NPs and physician assistants could have the same impact as adding 44,000 new primary care physicians.[101]

17% — **Jobs in home health care services are expected to grow by 17%**

between 2020 and 2025 compared with 8% for health care overall.[102]

Health-care-related occupations were 18 of the top 30 projected to be the fastest-growing for 2020-2030. Following are the top 5:[103]

- **Nurse practitioners**
- **Physical therapist assistants**
- **Home health and personal care aides**
- **Medical and health services managers**
- **Physician assistants**

Health Care Worker Shortages

» 23% of health care workers say they are likely to leave the field soon.[104]

» Personnel shortages of all types ranked No. 1 on the list of hospital CEOs' top concerns in 2021 — the first time since 2004. [105] 94% of the CEOs ranked RNs as the most pressing deficit, followed by technicians, therapists, primary care physicians, physician specialists and physician extenders.[106]

» Nearly 1,400 hospitals or 31% of hospitals reported a critical staffing shortage to the federal government as of Jan. 19, 2022.[107]

» Of the 6.4 million workers who quit their jobs in November 2021, health care workers had the second highest rate at 6.4%, noted the Bureau of Labor Statistics.[108]

» By 2026, 400,000 skilled and semi-skilled mental health workers are predicted to leave the occupation entirely, leaving a 10% increase in demand.[109]

Ancillary Staff Shortages

Lower-Wage Staff Shortages

» About 9.7 million individuals currently work in lower-wage health care positions (e.g., medical assistants, home health aides, nursing assistants) with the need in the next five years rising to 10.7 million.[110]

» Trends project that 6.5 million employees will permanently leave their positions by 2026 with 1.9 million people replacing them — leaving a deficit of 4.6 million.[111]

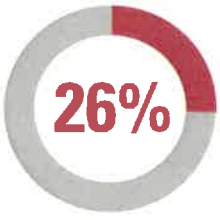
» New York and California will have the largest staff shortages, each projected to fall short by 500,000 by 2026.[112]

» "Ancillary staff such as patient care assistants can take jobs offering the same pay for less strenuous work or more flexible hours, or work from home, or even get better pay … ."[113]

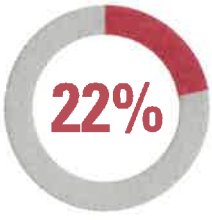
Allied Health Professional Shortages

By 2030, it's projected these will see the most increase for demand:[114]

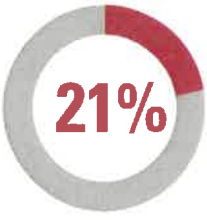
Respiratory Therapists



Physical Therapists



Occupational Therapists



Registered Dietitians

Physician Shortages

- One in five physicians plan on leaving their current practices in the next two years.[115]
- The U.S. will face a physician shortage of as many as 124,000 by 2034.[116]
- Reasons for physician shortage:
  - Restrictions on federally supported postgraduate training.[117]
  - Growth of an aging population, which also means growth in chronic diseases.[118]
  - Number of annual medical care visits is increasing.[119]
  - More than two of five active physicians will be older than 65 in the next 10 years, and may be likely to retire.[120]
- Key retention factors: Increased pay, additional time off, reduced on-call, paid sabbaticals, increased autonomy, more face time with key leaders, more formal recognition for job performance.[121]

Nursing Shortages

The Numbers

- 34% of nurses plan to quit their jobs by end of 2022.[122]
- With more than 500,000 seasoned RNs anticipated to retire by 2022, the Bureau of Labor Statistics projects the need for 1.1 million new RNs for expansion and replacement of retirees, and to avoid a nursing shortage.[123]
- 9.9%: 2020 nurse vacancy rate, a full point higher than in 2019.[124]

Reasons for the Nursing Shortage

- With more than half of the RN workforce older than 50, the rate of nurses retiring is growing rapidly.[125]
- An aging U.S. population continues to drive more demand than ever for nursing services.[126]
- Insufficient staffing — including ancillary support staff like nursing assistants and patient care assistants — is raising the stress level of nurses, negatively impacting job satisfaction and driving many nurses to leave the profession.[127]
- Despite strong interest in baccalaureate and graduate nursing programs, 80,521 qualified applications were not accepted at schools of nursing in 2020 due primarily to a shortage of clinical sites, faculty and resource constraints.[128]

Impact of the Nursing Shortage

» Higher risk of burnout.[129]

» Inadequate nurse staffing levels can affect patient care quality and safety.[130]

» Longer patient wait times and shorter visits.[131]

» Workplace violence: Of the 65% of nurses who say they were verbally or physically assaulted by a patient or a patient's family member within the last year, 47% attribute it to frustration around staffing levels/care.[132]

Nurse Turnover Rates and Costs

» Since 2016, the average hospital turned over about 90% of its workforce and 83% of its RN staff.[133]

» 18.7%: 2020 nurse turnover rate, a 2.8% increase from 2019.[134]

» One contributor to the rapid turnover is the growing percentage of millennials and Gen Zers in the workforce, generations that are more likely to move from job to job than their predecessors.[135]

» Average time for a hospital to hire an experienced RN: 89 days.[136]

» Average cost of turnover for a bedside RN is $40,038.[137]

» Steep increase in travel nurse costs during the height of the pandemic:

  ° As of September 2021, use of agency and temporary full-time labor was up 132% compared with that of November 2020.[138]

  ° From January 2020 to January 2021, advertised pay rates for travel nurses jumped 67%, with staffing firms billing hospitals an additional 28% to 32% over those pay rates.[139]

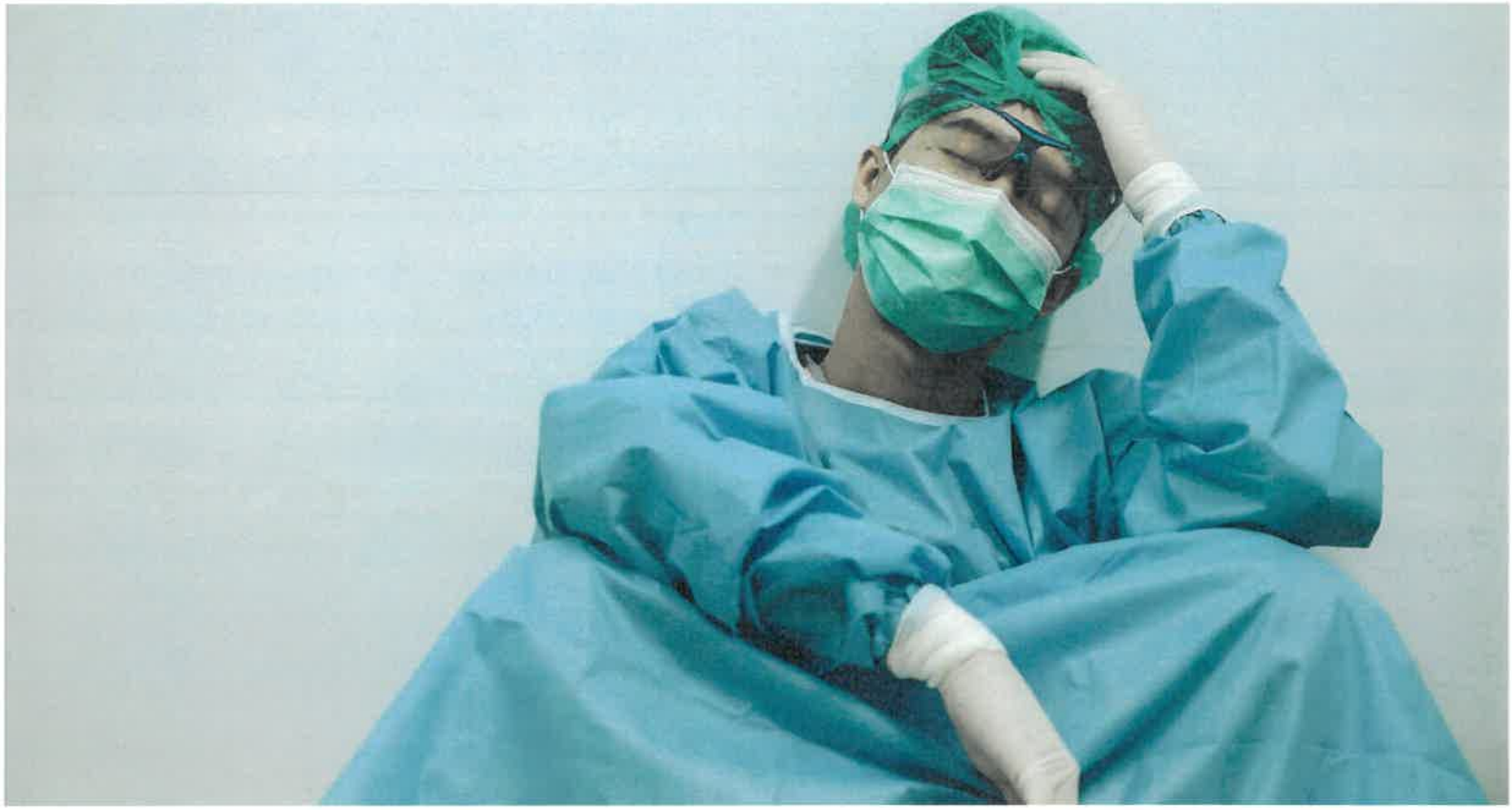
  ° As of October 2021, the average hospital could save $3,083,600 by eliminating 20 travel RNs.[140]

  ° With travel nurse demand dropping 42% from January to July of 2022, travel nurses who once earned $5,000 or more a week now earn less than half of that.[141]

Top 3 Reasons Nurses Consider Leaving Current Position

Different studies lead to varied but similar conclusions:

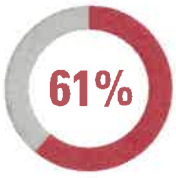
Study 1[142]	Insufficient staffing levels. Demanding nature/intensity of workload. Emotional toll of the job.
Study 2[143]	Relocation and career advancement, tied for first. Retirement.
Study 3[144]	Burnout and high-stress work environments. Pay and benefits. Leaving for jobs with greater flexibility and opportunities for career advancement.



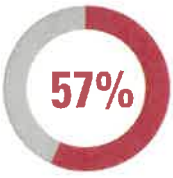
Mental Health Issues & Burnout

Physicians

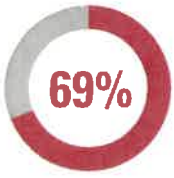
Often Experience Feelings of Burnout:[145]



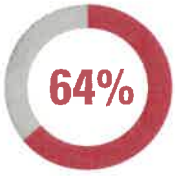
All Physicians



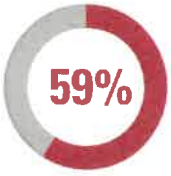
Male Physicians



Female Physicians

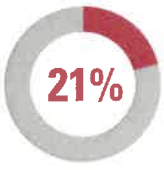


Physicians ≤45 Years Old

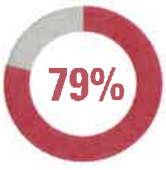


Physicians 46+ Years Old

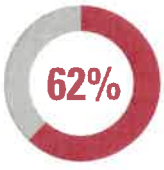
Causes of Burnout:[146]



of physicians say their burnout started with COVID-19.



say burnout's been building for years.



of physicians blame administrators. (Physicians rate their satisfaction with their employer as only 5.5/10.)

of administrators feel it stems from the demands of being a physician.

Nurses

Nurse Burnout

of a 2021 study's participants reported feeling burned out within the last 3 years.[147]

of nurses feel overwhelmed.[148]

report exhaustion and burnout.[149]

3x

Nurse-to-patient workloads have tripled.[150]

Gen Z and Millennial Nurses Hardest Hit by the Pandemic

Reporting not or not at all emotionally healthy:[151]

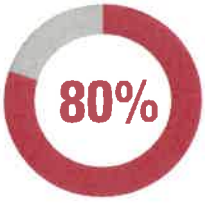
of nurses younger than 35.

of all nurses.

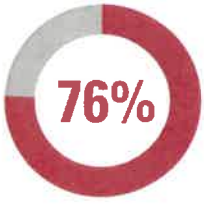
of nurses older than 55.

Causes of Burnout

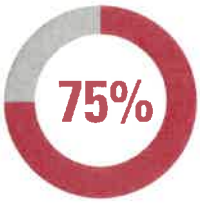
In a national survey, the nurses reporting burnout:[152]



cited low staffing as a factor.



cited emotional exhaustion.



cited high workload demands.

cited COVID-19 direct patient care.

Workforce Education: Challenges and Learnings

- Aspiring nurses face nursing school limitations:
  - More than 80,000 nursing school applicants were turned away in 2020 due to an ongoing decrease in faculty numbers, meaning fewer of those interested in joining the nursing workforce were unable to.[153]
  - Faculty shortages are due to climbing ages and retirements, higher compensation in clinical and private-sector settings, and master's and doctoral programs in nursing not producing a large enough pool of nurse educators to meet demand.[154]

- The pandemic has changed health management education:[155]
  - Resilience in learning modalities:
    - 59% of programs were face-to-face pre-pandemic.
    - 87% were online during the pandemic.
  - While 58% of health care management programs were challenged in placing students in real-world experiences during the pandemic, many were successful with virtual workarounds.

Workforce Resources

www.aha.org/workforce

is the American Hospital Association's hub for workforce-related resources. It includes relevant news, reports and white papers, links to upcoming conferences and webinars and archives of past events, case studies and a variety of resources for workforce development.

The AHA has multiple divisions that address workforce issues:

AHA Physician Alliance

(https://www.aha.org/aha-physician-alliance)

American Organization for Nursing Leadership

(https://www.aonl.org)

American Society for Health Care Risk Management

(https://www.ashrm.org)

AHA Institute for Diversity and Health Equity

(https://ifdhe.aha.org/)

AHA Team Training

(https://www.aha.org/center/performance-improvement/team-training)

Hospitals Against Violence Initiative

(https://www.aha.org/hospitals-against-violence/human-trafficking/workplace-violence)

Society for Health Care Strategy & Market Development

(https://www.shsmd.org/)

COVID-19: Stress and Coping Resources

(https://www.aha.org/behavioralhealth/covid-19-stress-and-coping-resources)

Sources

[1] The Demographic Drought: Bridging the Gap in our Labor Force. Emsi Burning Glass. https://www.economicmodeling.com/wp-content/uploads/2022/04/DD2_Bridging_The_Gap_Final.pdf

[2] The Current State of Hospital Finances: Fall 2022 Update, Kaufman Hall, September 15, 2022. https://www.kaufmanhall.com/insights/research-report/current-state-hospital-finances-fall-2022-update

[3] Ibid.

[4] Ibid.

[5] Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems. American Hospital Association, April 2022. https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf

[6] Pandemic-Driven Deferred Care Has Led to Increased Patient Acuity in America's Hospitals. American Hospital Association, August 15, 2022. https://www.aha.org/guidesreports/2022-08-15-pandemic-driven-deferred-care-has-led-increased-patient-acuity-americas

[7] https://www.ama-assn.org/practice-management/digital/2022-moving-beyond-telehealth-digitally-enabled-care

[8] Environmental Scan. American Hospital Association, 2022. https://www.aha.org/environmentalscan

[9] 2021 Healthcare Trends Survey Report. AMN Healthcare, 2021. https://www.amnhealthcare.com/amn-insights/surveys/2021-healthcare-trends-survey/

[10] Accelerating Nursing, Transforming Healthcare. Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership. https://nursing.jnj.com/anth-organizational-structure

[11] https://www.allinforhealthcare.org/issues/2022-healthcare-workforce-rescue-package

[12] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[13] Environmental Scan. American Hospital Association, 2022. https://www.aha.org/environmentalscan

[14] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[15] Nurse Staffing Think Tank: Priority Topics and Recommendations. Partners for Nurse Staffing Think Tank, 2022. https://www.nursingworld.org/~49940b/globalassets/practiceandpolicy/nurse-staffing/nurse-staffing-think-tank-recommendation.pdf

[16] Pandemic-Driven Deferred Care Has Led to Increased Patient Acuity in America's Hospitals. American Hospital Association, August 2022. https://www.aha.org/system/files/media/file/2022/08/pandemic-driven-deferred-care-has-led-to-increased-patient-acuity-in-americas-hospitals.pdf

[17] Hut, Nick. "More than 2 years into the pandemic, the issue of deferred care continues to affect the healthcare industry," HFMA News, April 13, 2022. https://www.hfma.org/topics/news/2022/04/more-than-2-years-into-the-pandemic--the-issue-of-deferred-care-.html

[18] 2021 NSI National Health Care Retention & RN Staffing Report. NSI Nursing Solutions, Inc. www.nursingsolutions.com

[19] Adams, Katie; Gleeson, Cailey; and Gooch, Kelly. "What will make workers want to stay in healthcare?" Becker's Hospital Review, February 14, 2022. https://www.beckershospitalreview.com/workforce/what-will-make-workers-want-to-stay-in-healthcare-answers-from-22-execs.html

[20] Han, S., Shanafelt, T. D., Sinsky, C. A., Awad, K. M., Dyrbye, L. N., Fiscus, L. C., Trockel, M., & Goh, J. (2019). Estimating the attributable cost of physician burnout in the United States. Annals of Internal Medicine, 170(11), 784–790. https://www.acpjournals.org/doi/abs/10.7326/m18-1422

[21] A New Nursing Crisis: How the Pandemic Has Changed Nurses. Cross Country Healthcare, 2021. https://www.crosscountryhealthcare.com/docs/CCH-20210809-futureofnursing-whitepaper.pdf

[22] Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Workforce. 2022. https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

[23] Plescia, Marissa. "If 1 in 5 healthcare workers have quit, where have they gone?" Becker's Hospital Review, February 11, 2022. https://www.beckershospitalreview.com/workforce/if-1-in-5-healthcare-workers-have-quit-where-have-they-gone.html

[24] Adams, Katie; Gleeson, Cailey; and Gooch, Kelly. "What will make workers want to stay in healthcare?" Becker's Hospital Review, February 14, 2022. https://www.beckershospitalreview.com/workforce/what-will-make-workers-want-to-stay-in-healthcare-answers-from-22-execs.html

[25] Adams, Katie; Gleeson, Cailey; and Gooch, Kelly. "What will make workers want to stay in healthcare?" Becker's Hospital Review, February 14, 2022. https://www.beckershospitalreview.com/workforce/what-will-make-workers-want-to-stay-in-healthcare-answers-from-22-execs.html

[26] Bean, Mackenzie. "What nurses really want during National Nurses Week," Becker's Hospital Review, May 5, 2022. https://www.beckershospitalreview.com/nursing/what-nurse-really-want-during-national-nurses-week.html

[27] Bean, Mackenzie; Gleeson, Cailey; and Gooch, Kelly. "10 things Gen Z, millennial nurses want from their hospitals," Becker's Hospital Review, March 11, 2022. https://www.beckershospitalreview.com/nursing/10-things-gen-z-millennial-nurses-want-from-their-hospitals.html

[28] Hamme, Nate. "Finding Love in Work: The Key to Effective Employee Appreciation in Healthcare," HR Pulse, Spring 2022. www.ashhra.org

[29] Liu, Jennifer. "Why the 'stay interview' is the next big trend of the Great Resignation," CNBC, November 30, 2021. https://www.cnbc.com/2021/11/30/why-stay-interviews-are-the-next-big-trend-of-the-great-resignation.html

[30] Baggot, Deirdre; Hamory, Bruce; and Rudoy, John. "Healthcare Workers Moving to Gig Work in Record Numbers," OliverWyman Health. https://health.oliverwyman.com/2022/03/healthcare-workers-moving-to-gig-work-in-record-numbers.html

[31] Adams, Katie; Gleeson, Cailey; and Gooch, Kelly. "What will make workers want to stay in healthcare?" Becker's Hospital Review, February 14, 2022. https://www.beckershospitalreview.com/workforce/what-will-make-workers-want-to-stay-in-healthcare-answers-from-22-execs.html

[32] A New Nursing Crisis: How the Pandemic Has Changed Nurses. Cross Country Healthcare, 2021. https://www.crosscountryhealthcare.com/docs/CCH-20210809-futureofnursing-whitepaper.pdf

[33] How to Get Ahead of Physician Turnover in Your Medical Practice. Jackson Physician Search, October 2021. https://www.jacksonphysiciansearch.com/white-paper-getting-ahead-of-physician-turnover-in-medical-practices-survey-results/

[34] Bean, Mackenzie. "What nurses really want during National Nurses Week," Becker's Hospital Review, May 5, 2022. https://www.beckershospitalreview.com/nursing/what-nurse-really-want-during-national-nurses-week.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=0917B7585089I7E

[35] Adams, Katie; Gleeson, Cailey; and Gooch, Kelly. "What will make workers want to stay in healthcare?" Becker's Hospital Review, February 14, 2022. https://www.beckershospitalreview.com/workforce/what-will-make-workers-want-to-stay-in-healthcare-answers-from-22-execs.html

[36] Accelerating Nursing, Transforming Healthcare. Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership. https://nursing.jnj.com/anth-care-delivery

[37] Pifer, Rebecca. "How can hospitals improve staff retention?" HealthcareDive, March 17, 2022. https://www.healthcaredive.com/news/hospitals-labor-workforce-nurses-doctors/620534/

[38] AONL COVID-19 Longtidunal Study. August 2021 Report. https://www.aonl.org/system/files/media/file/2021/09/AONL%20COVID-19%20Longitudinal%203%20Written%20Report.pdf

[39] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[40] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[41] Gantayet-Mathur, A., Chan, K. & Kalluri, M. Patient-centered care and interprofessional collaboration in medical resident education: Where we stand and where we need to go. Humanit Soc Sci Commun 9, 206 (2022). https://doi.org/10.1057/s41599-022-01221-5

[42] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[43] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[44] Accelerating Nursing, Transforming Healthcare. Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership. https://nursing.jnj.com/anth-care-delivery

[45] Karri K., Yarra P. Inequities still exist in the use of digital health technology across different sociodemographic subgroups. Evidence-Based Nursing 2022;25:23. https://ebn.bmj.com/content/25/1/23

[46] Colan, Bev; Melton, Brandon; and King, Lori. "Getting Staffing Right: An HR Imperative," HR Pulse, Winter 2021. www.ashhra.org

[47] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[48] Creating Time for Patient Care with Ambient Technology. Webinar, June 21, 2022. https://www.aha.org/education-events/creating-time-care-ambient-intelligence

[49] Pifer, Rebecca. "How can hospitals improve staff retention?" HealthcareDive, March 17, 2022. https://www.healthcaredive.com/news/hospitals-labor-workforce-nurses-doctors/620534/

[50] Nurse Staffing Think Tank: Priority Topics and Recommendations. Partners for Nurse Staffing Think Tank, 2022. https://www.nursingworld.org/~49940b/globalassets/practiceandpolicy/nurse-staffing/nurse-staffing-think-tank-recommendation.pdf

[51] Accelerating Nursing, Transforming Healthcare. Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership. https://nursing.jnj.com/anth-care-delivery

[52] Accelerating Nursing, Transforming Healthcare. Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership. https://nursing.jnj.com/anth-organizational-structure

[53] Clinician of the Future. Elsevier Health, March 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

[54] Accelerating Nursing, Transforming Healthcare. Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership. https://nursing.jnj.com/anth-workforce-of-the-future

[55] The Future of Nursing 2020-2030. Consensus Study Report, The National Academies of Sciences, Engineering, Medicine. https://nap.nationalacademies.org/catalog/25982/the-future-of-nursing-2020-2030-charting-a-path-to

[56] Gantayet-Mathur, A., Chan, K. & Kalluri, M. Patient-centered care and interprofessional collaboration in medical resident education: Where we stand and where we need to go. Humanit Soc Sci Commun 9, 206 (2022). https://doi.org/10.1057/s41599-022-01221-5

[57] 34% of Nurses Plan to Leave their Current Role by the End of 2022. Incredible Health, 2021. https://www.incrediblehealth.com/wp-content/uploads/2022/03/IH-COVID-19-2022-Summary-1.pdf

[58] Sable-Smith, Bram. "Bounties and bonuses leave small hospitals behind in staffing wars," Modern Healthcare, February 7, 2022. https://www.modernhealthcare.com/labor/bounties-and-bonuses-leave-small-hospitals-behind-staffing-wars

[59] Addressing New York's healthcare workforce challenges: HANYS' rapid response survey and recommendations. Healthcare Association of New York State, September 2021.

[60] https://www.nytimes.com/live/2022/07/15/world/covid-19-mandates-vaccine-cases#hospital-nursing-shortage

[61] 34% of Nurses Plan to Leave their Current Role by the End of 2022. Incredible Health, 2021. https://www.incrediblehealth.com/wp-content/uploads/2022/03/IH-COVID-19-2022-Summary-1.pdf

[62] A New Nursing Crisis: How the Pandemic Has Changed Nurses. Cross Country Healthcare, 2021. https://www.crosscountryhealthcare.com/docs/CCH-20210809-futureofnursing-whitepaper.pdf

[63] Auerbach, David; Buerhaus, Peter; Donelan, Karen; and Staiger, Douglas. "A Worrisome Drop In The Number Of Young Nurses," Health Affairs Forefront, April 13, 2022. https://www.healthaffairs.org/do/10.1377/forefront.20220412.311784

[64] How to Get Ahead of Physician Turnover in Your Medical Practice. Jackson Physician Search, October 2021. https://www.jacksonphysiciansearch.com/white-paper-getting-ahead-of-physician-turnover-in-medical-practices-survey-results/

[65] https://www.prnewswire.com/news-releases/medscape-physician-burnout--depression-report-2022-shows-pandemics-continued-impact-301465333.html

[66] AONL COVID-19 Longtidunal Study. August 2021 Report. https://www.aonl.org/system/files/media/file/2021/09/AONL%20COVID-19%20Longitudinal%203%20Written%20Report.pdf

[67] Sable-Smith, Bram. "Bounties and bonuses leave small hospitals behind in staffing wars," Modern Healthcare, February 7, 2022.
https://www.modernhealthcare.com/labor/bounties-and-bonuses-leave-small-hospitals-behind-staffing-wars

[68] Quarterly Market Analysis: Q1 2022. Syntellis, American Hospital Association.
https://www.syntellis.com/sites/default/files/2022-07/Syntellis_AHA_report_2022_FINAL.pdf

[69] Auerbach, David; Buerhaus, Peter; Donelan, Karen; and Staiger, Douglas. "A Worrisome Drop In The Number Of Young Nurses," Health Affairs Forefront, April 13, 2022.
https://www.healthaffairs.org/do/10.1377/forefront.20220412.311784

[70] Data Spotlight: Regional analysis of Qualified Application Denied Admission. American Association of Colleges of Nursing, April 26, 2022.
https://www.aacnnursing.org/News-Information/News/View/ArticleId/25195/Data-Spotlight-Regional-Analysis-of-Qualified-Application-Denied-Admission

[71] 2021 NSI National Health Care Retention & RN Staffing Report. NSI Nursing Solutions, Inc. www.nsinursingsolutions.com

[72] On the Verge of a Physician Turnover Epidemic: Physician Retention Survey Results. Jackson Physician Search, February 25, 2021.
https://www.jacksonphysiciansearch.com/white-paper-on-the-verge-of-a-physician-turnover-epidemic-physician-retention-survey-results/

[73] Earn While You Learn: Innovation During a Pandemic. American Hospital Association.
https://www.aha.org/case-studies/2022-01-18-earn-while-you-learn-innovation-during-pandemic

[74] Plescia, Marissa and Gooch, Kelly. "6 health system execs on how to battle labor shortages beyond pay," Becker's Hospital Review, April 29, 2022.
https://www.beckershospitalreview.com/workforce/6-health-system-execs-on-how-to-battle-labor-shortages-beyond-pay.html

[75] Bean, Mackenzie. "Sanford to hire more than 70 foreign nurses by 2025," Becker's Hospital Review, June 16, 2022.
https://www.beckershospitalreview.com/nursing/sanford-to-hire-more-than-700-foreign-nurses-by-2025.html

[76] https://news.ochsner.org/news-releases/ochsner-health-is-founding-partner-in-pilot-program-to-bring-ukrainian-nurses-to-usa

[77] Gleeson, Cailey. "56 nursing programs launched in 2022," Becker's Hospital Review, June 22, 2022.
https://www.beckershospitalreview.com/nursing/56-nursing-programs-launched-in-2022.htmlE

[78] Walsh, Dustin. "Beaumont-Spectrum gives $20 million to Oakland University to educate more nurses," Modern Healthcare, August 18, 2022.
https://www.modernhealthcare.com/nursing/bhsh-system-will-invest-millions-educate-student-nurses

[79] https://www.aha.org/aha-center-health-innovation-market-scan/2022-05-10-4-health-care-workforce-moves-make-now

[80] Nurse Staffing Think Tank: Priority Topics and Recommendations. Partners for Nurse Staffing Think Tank, 2022.
https://www.nursingworld.org/~49940b/globalassets/practiceandpolicy/nurse-staffing/nurse-staffing-think-tank-recommendation.pdf

[81] Gooch, Kelly. "Allegheny Health System rolls out 'Work Your Way' staffing model," Becker's Hospital Review, August 19, 2022.
https://www.beckershospitalreview.com/workforce/allegheny-health-system-rolls-out-work-your-way-staffing-model.html

[82] https://www.aha.org/system/files/media/file/2022/08/workforce-cs-YNNH-team-based-care-0822.pdf

[83] "UCHealth launches education program to make career advancement in health care more accessible," UCHealth Today, February 3, 2022.
https://www.uchealth.org/today/uchealth-launches-education-program-to-make-career-advancement-more-accessible/

[84] Gooch, Kelly. "Texas hospital will pay employees $10K to get healthcare degree," Becker's Hospital Review, June 1, 2022.
https://www.beckershospitalreview.com/workforce/texas-hospital-will-pay-employees-10k-to-get-a-healthcare-degree.html

[85] Farmer, Blake. "To fill clinical roles, Vanderbilt begins training truck drivers, cleaning workers and other existing staff," WPLN News, May 30, 2022.
https://wpln.org/post/to-fill-clinical-roles-vanderbilt-begins-training-truck-drivers-and-cleaning-staff/

[86] Herath, Ranil. "There is No One-Size-Fits-All Approach to Upskilling in Healthcare," Becker's Hospital Review, May 20, 2022.
https://www.beckershospitalreview.com/there-is-no-one-size-fits-all-approach-to-upskilling-in-healthcare-3-things-leaders-need-to-consider.html?oly_enc_id=0917B7585089I7E

[87] Jobe, Byron. "Three Steps to Navigate the Perfect Storm of Clinical Workforce Shortages," Becker's Hospital Review, May 26, 2022.
https://www.beckershospitalreview.com/three-steps-to-navigate-the-perfect-storm-of-clinical-workforce-shortages.html?oly_enc_id=0917B7585089I7E
https://newsroom.vizientinc.com/ensuring-maximum-well-being-and-engagement-checklist-for-clinician-onboarding.htm?blog/clinical

[88] https://www.aha.org/fact-sheets/2021-05-26-fact-sheet-strengthening-health-care-workforce

[89] Nurse Staffing Think Tank: Priority Topics and Recommendations. Partners for Nurse Staffing Think Tank, 2022.
https://www.nursingworld.org/~49940b/globalassets/practiceandpolicy/nurse-staffing/nurse-staffing-think-tank-recommendation.pdf

[90] MHA Workforce Demand Survey. Spring 2021.

[91] MHA Workforce Demand Survey. Spring 2021.

[92] On the Verge of a Physician Turnover Epidemic: Physician Retention Survey Results. Jackson Physician Search, February 25, 2021.
https://www.jacksonphysiciansearch.com/white-paper-on-the-verge-of-a-physician-turnover-epidemic-physician-retention-survey-results/

[93] MHA Workforce Demand Survey. Spring 2021.

[94] On the Verge of a Physician Turnover Epidemic: Physician Retention Survey Results. Jackson Physician Search, February 25, 2021.
https://www.jacksonphysiciansearch.com/white-paper-on-the-verge-of-a-physician-turnover-epidemic-physician-retention-survey-results/

[95] Plescia, Marissa; Gooch, Kelly; and Gonzalez, Georgina. "5 recent investments in healthcare employee retention, recruitment," Becker's Hospital Review, Feb. 11, 2022.
https://www.beckershospitalreview.com/compensation-issues/5-recent-investments-in-healthcare-employee-retention-recruitment.html

[96] Gooch, Kelly. "With 400 RN vacancies, Broward Health uses pension plan, bonuses as drawing cards," Becker's Hospital Review, July 15, 2022.
https://www.beckershospitalreview.com/workforce/with-400-rn-vacancies-broward-health-uses-pension-plan-bonuses-as-drawing-cards.html

[97] Kacik, Alex. "Recruitment and retention is the top priority, hospital execs say," Modern Healthcare, February 4, 2022.
https://www.modernhealthcare.com/labor/recruitment-and-retention-top-priority-hospital-execs-say

[98] https://www.bronsonhealth.com/news/bronson-travel-staffing-now-hiring-rns/

[99] Bean, Mackenzie. "Jefferson Health boosts staffing flexibility with 'Nursing SEAL Team,'" Becker's Hospital Review, July 6, 2022. https://www.beckershospitalreview.com/nursing/jefferson-health-boosts-staffing-flexibility-with-nursing-seal-team.html

[100] U.S. Bureau of Labor Statistics Occupational Outlook Handbook, Healthcare Occupations. https://www.bls.gov/ooh/healthcare/home.htm

[101] "5 Ways to Ease Staffing Shortages Now and into the Future," AHA Market Scan, February 15, 2022. https://www.aha.org/aha-center-health-innovation-market-scan/2022-02-15-5-ways-ease-staffing-shortages-now-and-future

[102] "Healthcare Sector Update: Crisis to Opportunity," Camoin Associates, January 12, 2022. https://www.camoinassociates.com/resources/healthcare-sector-update-crisis-to-opportunity

[103] U.S. Bureau of Labor Statistics. https://www.bls.gov/emp/tables/fastest-growing-occupations-alt.htm

[104] Gooch, Kelly. "23% of healthcare workers likely to leave healthcare soon, poll finds," Becker's Hospital Review, February 2, 2022. https://www.beckershospitalreview.com/workforce/23-of-healthcare-workers-likely-to-leave-healthcare-soon-poll-finds.html

[105] "Top Issues Confronting Hospitals in 2021," American College of Healthcare Executives, February 2, 2022. https://www.ache.org/learning-center/research/about-the-field/top-issues-confronting-hospitals/top-issues-confronting-hospitals-in-2021

[106] Ibid.

[107] "Data Brief: Workforce Issues Remain at the Forefront of Pandemic-related Challenges for Hospitals," American Hospital Association, January 2022. https://www.aha.org/issue-brief/2022-01-25-data-brief-workforce-issues-remain-forefront-pandemic-related-challenges

[108] "How to address 3 critical health care focus areas for 2022," AHA Market Scan, February 8, 2022. https://sponsors.aha.org/index.php/email/emailWebview?md_id=13042

[109] "Major US healthcare labor shortages projected in every state by 2026, mental health professionals grow in high demand, Mercer report shows," Mercer, September 28, 2021. https://www.mercer.com/newsroom/us-projected-to-have-major-healthcare-labor-shortages-in-every-state-mental-health-professionals-grow-in-high-demand.html#:~:text=There%20will%20be%20a%2010,semi%2Dskilled%20mental%20health%20workers

[110] Gleeson, Cailey. "Healthcare staff shortages projected for every state by 2026: 4 report findings," Becker's Hospital Review, September 29, 2021. https://www.beckershospitalreview.com/workforce/healthcare-staff-shortages-projected-for-every-state-by-2026-4-report-findings.html

[111] Ibid.

[112] Ibid.

[113] Denise Chamberlain, executive vice president and CFO, Edward-Elmhurst Health, quoted in Weldon, David, "THE STAFFING CRISIS WILL DOMINATE 2022 FINANCE TRENDS. HERE'S WHAT TO DO ABOUT IT," HealthLeaders, December 15, 2021. https://www.healthleadersmedia.com/finance/staffing-crisis-will-dominate-2022-finance-trends-heres-what-do-about-it

[114] "Allied Health Workforce Projections," Health Resources & Services Administration, https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/allied-health

[115] Henry, Tanya Albert. "Medicine's Great Resignation: 1 in 5 Doctors Plan Exit in 2 Years," American Medical Association, January 18, 2022. https://www.ama-assn.org/practice-management/physician-health/medicine-s-great-resignation-1-5-doctors-plan-exit-2-years#:~:text=Tanya%20Albert%20Henry&text=One%20in%20five%20physicians%20say,to%20recently%20published%20survey%20research

[116] "The Complexities of Physician Supply and Demand: Projections from 2019 to 2034," Association of American Medical Colleges, June 2021. https://www.aamc.org/media/54681/download

[117] Hooker, Roderick S. et al. "Workforce: Forecasting the physician assistant/associate workforce: 2020–2035," Future Healthcare Journal 2022 Vol. 9, No. 1, p. 57.

[118] Ibid.

[119] Ibid.

[120] Gooch, Kelly. "6 predictions for the future healthcare workforce," Becker's Hospital Review, December 17, 2021. https://www.beckershospitalreview.com/workforce/6-predictions-for-the-future-healthcare-workforce.html

[121] "5 Ways to Ease Staffing Shortages Now and into the Future," AHA Market Scan, February 15, 2022. https://www.aha.org/aha-center-health-innovation-market-scan/2022-02-15-5-ways-ease-staffing-shortages-now-and-future

[122] "Third of nurses plan to quit their jobs by end of 2022, survey shows," Healthcare Dive, March 16, 2022. https://www.healthcaredive.com/news/nurse-burnout-covid-quit-travel-incredible-health/620488

[123] American Nurses Association, https://www.nursingworld.org/practice-policy/workforce

[124] "2021 NSI National Health Care Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2021. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

[125] "The U.S. Nursing Shortage: A State-by-State Breakdown," NurseJournal, March 2, 2022. https://nursejournal.org/articles/the-us-nursing-shortage-state-by-state-breakdown

[126] Ibid.

[127] "Hospitals struggle to fill staffing holes in short, long term amid surge in nurse turnover," Healthcare Dive, March 31, 2022. https://www.healthcaredive.com/news/nursing-schools-covid-shortages-hospitals-partnerships/620662

[128] "Student Enrollment Surged in U.S. Schools of Nursing in 2020 Despite Challenges Presented by the Pandemic," American Association of Colleges of Nursing press release, April 1, 2021. https://www.aacnnursing.org/News-Information/Press-Releases/View/ArticleId/24802/2020-survey-data-student-enrollment

[129] "The 2021 American Nursing Shortage: A Data Study," University of St. Augustine for Health Sciences, May 2021. https://www.usa.edu/blog/nursing-shortage

[130] Ibid.

[131] Ibid.

[132] "STUDY: 34% of Nurses Plan to Leave their Current Role by the End of 2022," Incredible Health, March 16, 2022. https://www.incrediblehealth.com/blog/nursing-report-covid-19-2022

[133] Plescia, Marissa. "The cost of nurse turnover by the numbers," Becker's Hospital Review, October 14, 2021. https://www.beckershospitalreview.com/finance/the-cost-of-nurse-turnover-by-the-numbers.html

[134] "2021 NSI National Health Care Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2021. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

[135] "How can hospitals improve staff retention? Tech and training, experts say," Healthcare Dive, March 17, 2022. https://www.healthcaredive.com/news/hospitals-labor-workforce-nurses-doctors/620534/

[136] "2021 NSI National Health Care Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2021. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

[137] Ibid.

[138] "PINC AI Data Shows Hospitals Paying $24B More for Labor Amid COVID-19 Pandemic," premierinc.com, October 6, 2021. https://www.premierinc.com/newsroom/blog/pinc-ai-data-shows-hospitals-paying-24b-more-for-labor-amid-covid-19-pandemic

[139] Mensic, Hailey. "3 key labor trends for hospitals in 2022," Healthcare Dive, January 27, 2022. https://www.healthcaredive.com/news/key-labor-trends-hospitals-COVID-staffing-2022/617601

[140] Plescia, Marissa. "The cost of nurse turnover by the numbers," Becker's Hospital Review, October 14, 2021. https://www.beckershospitalreview.com/finance/the-cost-of-nurse-turnover-by-the-numbers.html

[141] Carbajal, Erica. "Travel nurses aren't returning to their old jobs," Becker's Hospital Review, September 6, 2022. https://www.beckershospitalreview.com/nursing/travel-nurses-aren-t-returning-to-their-old-jobs.html

[142] Berlin, Gretchen et al. "Nursing in 2021: Retaining the healthcare workforce when we need it most," McKinsey & Company, May 11, 2021. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/nursing-in-2021-retaining-the-healthcare-workforce-when-we-need-it-most

[143] Plescia, Marissa. "The cost of nurse turnover by the numbers," Becker's Hospital Review, October 14, 2021. https://www.beckershospitalreview.com/finance/the-cost-of-nurse-turnover-by-the-numbers.html

[144] "Third of nurses plan to quit their jobs by end of 2022, survey shows," Healthcare Dive, March 16, 2022. https://www.healthcaredive.com/news/nurse-burnout-covid-quit-travel-incredible-health/620488

[145] "The Physicians Foundation 2021 Physician Survey, COVID-19 Impact Edition: A Year Later,"

The Physicians Foundation, 2021. https://physiciansfoundation.org/physician-andpatient-surveys/the-physicians-foundation-2021-physician-survey

[146] Stajduhar, Tony. "The Great Resignation: Why Physicians are Quitting and How Administrators can Mitigate the Impact on Care Delivery," December 12, 2021. https://www.healthcarebusinesstoday.com/why-physicians-are-quitting/

[147] Curry, Morgan, "Nursing CE Central: Nurse Burnout Study 2021," Nursing CE Central, August 6, 2021. https://nursingcecentral.com/nurse-burnout-study-2021

[148] Ciccone, John. "Nurse Burnout Even Bigger Challenge Than Physician Burnout," HIT Consultant, January 26, 2022. https://hitconsultant.net/2022/01/26/nurse-burnout-even-bigger-challenge-than-physician-burnout

[149] Ibid.

[150] Ibid.

[151] Gonzalez, Georgia. "Gen Z, millennial nurses hit hardest by pandemic," Becker's Hospital Review, March 3, 2022. https://www.beckershospitalreview.com/workforce/gen-z-millennial-nurses-hit-hardest-by-pandemic.html

[152] Curry, Morgan. "Nursing CE Central: Nurse Burnout Study 2021," Nursing CE Central, August 6, 2021. https://nursingcecentral.com/nurse-burnout-study-2021

[153] "The 2021 American Nursing Shortage: A Data Study," University of St. Augustine for Health Sciences, May 2021. https://www.usa.edu/blog/nursing-shortage

[154] "Nursing Faculty Shortage Fact Sheet," American Association of Colleges of Nursing. https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Faculty-Shortage

[155] "CHARTING A NEW COURSE: impact of covid-19 on healthcare management education," Commission on Accreditation of Healthcare Management Education, March 2022. https://drive.google.com/file/d/1i2E3bZGg5EHB--hX6ZV5GV_LwQ7lj0HK/view

Attachment BB

Prosser Memorial Hospital

Prosser Memorial Health
2023 Patient Engagement Plan

PURPOSE:
Patient Loyalty is an organizational priority and foundational to achieving our Mission, Vision, and Values. Patient Loyalty goes beyond the delivery of safe, quality health care. It speaks to the patient's experience and confidence in the care we provide. We must not only deliver appropriate and timely care but must do so in a manner that draws the patient and family into partnership with meeting their healthcare needs. The Prosser Memorial Health Patient Engagement Plan ensures a comprehensive and systematic approach to this end.

A. GUIDING PRINCIPLES: The core concepts of Patient-and-Family-Centered Care (IPFCC) as defined by the Institute for Patient-and-Family-Centered Care, provide the guiding principles behind our efforts:

1. **Dignity and Respect:** "Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care." (IPFCC, 2018).
2. **Information Sharing:** "Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information to participate in care and decision-making effectively." (IPFCC, 2018).
3. **Participation:** "Patients and families are encouraged and supported in participating in care and decision-making at the level they chose." (IPFCC, 2018).
4. **Collaboration:** "Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluation; in facility design; and in professional education, as well as in the delivery of care." (IPFCC, 2018).

B. 2023 INITIATIVES: Initiatives in 2022 will be focused reconnecting with our patients and community in the pandemic recovery period. We will continue to ensure timely information informs our patient care practice and we are providing education to our community.

1. Reestablish the Patient Engagement Committee (PEC):
    a. Committee composition: at least one representative from each department across organization and no less than two community member/patient representatives.
    b. Communication:
        1). Quarterly summary report to the Joint Conference Committee
        2). Quarterly summary report to the Quality Committee
    c. Department level initiatives and progress report as standing PEC agenda item.

2. A review and revision were indicated of the Service Recovery Program and education across the organization.
3. Continue to expand the call center to provide timely patient scheduling.
4. Implementation of the "Super Track" in the Emergency Department to streamline patient flow, facilitate patient care, and reduce long ED stays.
5. Improve the efficacy of post-encounter follow-up across the organization, with a special focus on post-discharge phone calls and scheduling follow-up care appointments.
6. Establish Nurse Triage Protocols and training for hospital and clinic nurses.

7. Promote patient/family access and utilization of MyChart (online patient medical record access portal). across all patient care areas.
8. Continue the establishment and expansion of the Call Center to ensure prompt patient communication and ease of access for patient care services.
9. Complete Huron Customer Service Education across the PMH clinics.
10. Complete Huron Customer Service needs assessment and education in the ED (Quarter 3 & 4).
11. Support ongoing improvement of "must have" customer service behaviors in the inpatient units including, but not limited to: bedside shift report, white board utilization, and patient rounding.
12. Asses, plan, and provide education related to the organizations practices around diversity, equity, inclusion, and respect
13. Implement patient self-management tools across the organization. (i.e., smoking cessation self-management tools, weight reduction self-management tools, &/or Congestive Heart Failure self-management tools).
14. Assess the availability of existing patient transportation options and the feasibility of implementing additional options.
15. Continue to expand access to nurse educators (existing and potential) across the organization including but not limited to: Diabetes, Joint Program, Childbirth Education, Lactation.
16. Continue to improve patient satisfaction with dietary services in the hospital. (Improvement strategies implemented in 2022).
17. Assess and improve patient communication related to clinic messaging, text appointment reminders, and utilization of MyChart for patient-provider communication.
18. Leverage the Press Ganey Survey data to exceed patient satisfaction survey results on all domains and in each area of service.
19. Develop a "patient-friendly" billing system.
20. Develop and implement innovative nurse/support staff processes that will increase the reliability and timely delivery of patient care, reduce unnecessary time expenditure, allow patients/families to participate as members of their care team, and increase employee job satisfaction.

ACCOUNTABILITY:

Progress towards these initiatives requires the participation and intention of employees and leaders across the organization. Coordination of effort and accountability will be achieved in the following ways:

A. Patient Engagement Committee (PEC): The PEC is composed of representatives from across the organization, including volunteers and patients/family members. This quarterly meeting reviews and provides recommendations regarding patient engagement initiatives.
B. Service Recovery Program: The Service Recovery program empowers front line staff to identify and resolve any situation that embarrasses, inconveniences, angers, or disappoints a customer. Service Recovery activity is tracked by the department and triggering concern. Activity is reviewed for trends and recommendations no less than quarterly.
C. Patient Complaints and Grievances: A Patient Complaint and Grievance log are maintained, including corrective action and patient follow up. A summary report including trends and recommendation for improvement is presented to hospital leadership, the Medical Staff, and the Board of Commissioner via the Joint Conference Committee no less than quarterly for compliance with CMS Conditions of Participation. Complaints and Grievances are also logged in the organizations event reporting system for review and by Risk Management and/or the Medical Staff Quality Improvement Committee if indicated.
D. Patient Satisfaction Surveys: Patient Satisfaction Surveys are conducted by a third-party vendor Press Ganey. Survey results are reviewed for trends and recommendations monthly and reported by patient

type on the Strategic Plan Score Card. Each department leader establishes a 90-day plan for improving patient satisfaction within their service area, each quarter, utilizing the Leadership Evaluation Manager (LEM). Survey results are reported monthly on the Strategic Plan Scorecard and reviewed with the Board of Commissioners at Joint Conference Committee no less than quarterly.

E. 2023 Strategic Plan: The Patient Loyalty pillar of the 2023 Strategic Plan outlines the goals and metrics identified through feedback from patients, Medical Staff, employees, administration, and the Board of Commissioners. These initiatives are included in this plan.

REFERENCES:

Institute for Patient-And-Family-Centered Care (IPFCC). (2018). *Advancing the Practice of Patient-And-Family-Centered Care in Hospitals: How to Get Started.* Retrieved May 22, 2018, from: http://www.ipfcc.org/resources/downloads.html

Studer Group. (2018). *AIDET Patient Communication.* Retrieved May 24, 2018, from: https://www.studergroup.com/aidet

Studer Group. (2018). *Leader Rounding on Patients-Guidelines and Key Words.* Retrieved May 24, 2018 from: *https://www.studergroup.com/resources/healthcare-tools/rounding-for-outcomes*

Greater Columbia Accountable Community of Health (GCACH). (2018). *Practice Transformation.* Retrieved March 23, 2020, from: https://gcach.org/news/Past-News/Selected-Organizations-for-Practice-Transformation

Prosser Memorial Health

Balance Sheet
January 31, 2023

Assets

	1/31/2023	12/31/2022	*12/31/2022*	*12/31/2022*
Cash & Temporary Investments	6,969,609	6,167,334	*6,167,334*	*6,167,334*
COVID Cash Holding	-	-	-	-
Gross Patient Accounts Receivable	45,276,668	40,530,516	*40,530,516*	*40,530,516*
Less Allowances for Uncollectible	(28,652,000)	(25,024,000)	*(25,024,000)*	*(25,024,000)*
Net Patient Receivables	16,624,668	15,506,516	*15,506,516*	*15,506,516*
Taxes Receivable	989,456	39,636	*39,636*	*39,636*
Receivable from 3rd Party Payor	56,017	-	-	-
Inventory	639,141	652,122	*652,122*	*652,122*
Prepaid Expenses	1,510,003	1,265,798	*1,265,798*	*1,265,798*
Other Current Assets	8,050	15,331	*15,331*	*15,331*
Total Current Assets	26,796,944	23,646,737	*23,646,737*	*23,646,737*
LEOFF Net Pension Asset	1,106,851	1,106,851	*1,106,851*	*1,106,851*
Whitehead Fund - LGIP	1,239,850	1,235,239	*1,235,239*	*1,235,239*
Funded Depreciation - Cash	1,177,630	960,471	*960,471*	*960,471*
Funded Depreciation - TVI	9,291,641	9,291,641	*9,291,641*	*9,291,641*
Bond Obligation Cash Reserve	767,686	767,621	*767,621*	*767,621*
USDA Debt Reserve Fund	237	-	-	-
Construction Fund - Western Alliance	11,814,576	12,286,283	*12,286,283*	*12,286,283*
Construction Interest Reserve	5,176,126	5,176,278	*5,176,278*	*5,176,278*
Tax Exempt Lease Funds	-	-	-	-
Board Designated Assets	30,574,597	30,824,384	*30,824,384*	*30,824,384*
Land	478,396	478,396	*478,396*	*478,396*
Property Plant & Equipment	48,084,452	48,041,022	*48,041,022*	*48,041,022*
Construction In Progress	7,102,297	6,675,991	*6,675,991*	*6,675,991*
Accumulated Depreciation	(33,423,999)	(33,208,424)	*(33,208,424)*	*(33,208,424)*
Net Property Plant & Equipment	22,241,146	21,986,985	*21,986,985*	*21,986,985*
Investment & Other Non Current Assets	993,012	994,545	*994,545*	*994,545*
Land - Gap Road	1,745,440	1,745,440	*1,745,440*	*1,745,440*
Net Investments & Other Non Current Assets	2,738,452	2,739,985	*2,739,985*	*2,739,985*
Total Assets	**$ 82,351,139**	**$ 79,198,091**	***$ 79,198,091***	***$ 79,198,091***

Liabilities & Fund Balance

	1/31/2023	12/31/2022	*12/31/2022*	*12/31/2021*
Current Portion of Bonds Payable	909,105	907,731	*907,731*	*907,731*
Current Portion of USDA	-	-	-	-
Current Portion Capital Leases	255,662	255,104	*255,104*	*255,104*
Accounts Payable	2,830,592	2,303,842	*2,303,842*	*2,303,842*
Payroll & Related Liabilities	3,848,345	3,379,302	*3,379,302*	*3,379,302*
Cost Report Payable	517,549	508,713	*508,713*	*508,713*
Other Payables to 3rd Parties	1,346,364	1,346,364	*1,346,364*	*1,346,364*
Deferred LEOFF Pension	483,233	483,233	*483,233*	*483,233*
Deferred Tax Revenue	878,996	-	-	-
Deferred EHR Medicare Revenue	-	-	-	-
Deferred COVID Revenue	-	-	-	-
Accrued Interest Payable	36,936	19,670	*19,670*	*19,670*
Other Current Liabilities	-	-	-	-
Total Current Liabilities	11,106,782	9,203,959	*9,203,959*	*9,203,959*
Non Current Liabilities				
Bonds Payable net of CP	8,520,883	8,570,493	*8,570,493*	*8,570,493*
USDA Financing Payable net of CP	-	-	-	-
Western Alliance Construction net of CP	50,001	50,001	*50,001*	*50,001*
Capital Leases net of CP	329,161	350,723	*350,723*	*350,723*
Total Non Current Liabilities	8,900,045	8,971,217	*8,971,217*	*8,971,217*
Total Liabilities	20,006,827	18,175,176	*18,175,176*	*18,175,176*
Fund Balance				
Current YR Unrestricted Fund Balance	1,280,326	11,957,820	*11,957,820*	*11,957,820*
Prior YR Unrestricted Fund Balance	61,063,986	49,065,095	*49,065,095*	*49,065,095*
Restricted Fund Balance	-	-	-	-
Total Fund Balance	62,344,312	61,022,915	*61,022,915*	*61,022,915*
Total Liabilities & Fund Balance	**$ 82,351,139**	**$ 79,198,091**	***$ 79,198,091***	***$ 79,198,091***

Prosser Memorial Health

Statement of Operations
January 31, 2023

Month Ending Actual	Budget	Variance	%	Prior Year	%		Year to Date Actual	Budget	Variance	%	Prior Year	%
						Gross Patient Services Revenue						
$ 4,356,132	$ 3,874,594	$ 481,538	12%	$ *3,605,247*	21%	Inpatient	$ 4,356,132	$ 3,874,594	$ 481,538	12%	$ *3,605,247*	21%
21,165,078	18,660,093	2,504,985	13%	*13,346,293*	59%	Outpatient	21,165,078	18,660,093	2,504,985	13%	*13,346,293*	59%
25,521,210	22,534,687	2,986,523	13%	*16,951,540*	51%	**Total Gross Patient Services Revenue**	25,521,210	22,534,687	2,986,523	13%	*16,951,540*	51%
						Deductions from Revenue						
						Contractual Allowances						
6,258,021	4,769,406	(1,488,615)	-31%	*3,393,158*	84%	Medicare	6,258,021	4,769,406	(1,488,615)	-31%	*3,393,158*	84%
5,380,697	4,774,315	(606,382)	-13%	*4,012,377*	34%	Medicaid	5,380,697	4,774,315	(606,382)	-13%	*4,012,377*	34%
3,535,391	3,667,173	131,782	4%	*2,379,307*	49%	Negotiated Rates	3,535,391	3,667,173	131,782	4%	*2,379,307*	49%
546,536	776,137	229,601	30%	*199,926*	173%	Other Adjustments	546,536	776,137	229,601	30%	*199,926*	173%
15,720,645	13,987,031	(1,733,614)	-12%	*9,984,768*	57%	**Gross Contractual Allowances**	15,720,645	13,987,031	(1,733,614)	-12%	*9,984,768*	57%
290,052	405,715	115,663	29%	*341,961*	-15%	Charity Care	290,052	405,715	115,663	29%	*341,961*	-15%
79,605	153,240	73,635	48%	*214,560*	-63%	Bad Debt	79,605	153,240	73,635	48%	*214,560*	-63%
16,090,302	14,545,986	(1,544,316)	-11%	*10,541,289*	53%	**Total Deductions From Revenue**	16,090,302	14,545,986	(1,544,316)	-11%	*10,541,289*	53%
9,430,908	7,988,701	1,442,207	18%	*6,410,251*	47%	**Net Patient Services Revenue**	9,430,908	7,988,701	1,442,207	18%	*6,410,251*	47%
-	-	-	0%	*455,985*	-100%	COVID Net Revenue	-	-	-	0%	*455,985*	-100%
27,559	22,869	4,690	21%	*118,972*	-77%	Other Operating Revenue	27,559	22,869	4,690	21%	*118,972*	-77%
9,458,467	**8,011,570**	**1,446,897**	**18%**	***6,985,208***	**35%**	**Net Revenue**	**9,458,467**	**8,011,570**	**1,446,897**	**18%**	***6,985,208***	**35%**
						Operating Expenses						
3,435,337	3,328,611	(106,726)	-3%	*2,972,517*	16%	Salaries	3,435,337	3,328,611	(106,726)	-3%	*2,972,517*	16%
1,036,526	812,516	(224,010)	-28%	*827,743*	25%	Benefits	1,036,526	812,516	(224,010)	50800%	*827,743*	25%
398,630	367,527	(31,103)	-8%	*250,000*	59%	Purchased Labor	398,630	367,527	(31,103)	-8%	*250,000*	59%
4,870,493	4,508,654	(361,839)	-8%	*4,050,260*	20%	Sub-Total Labor Costs	4,870,493	4,508,654	(361,839)	-8%	*4,050,260*	20%
506,621	408,621	(98,000)	-24%	*407,364*	24%	Professional Fees - Physicians	506,621	408,621	(98,000)	-24%	*407,364*	24%
69,935	99,749	29,814	30%	*41,222*	70%	Professional Fees - Other	69,935	99,749	29,814	30%	*41,222*	70%
1,399,453	1,453,869	54,416	4%	*1,134,236*	23%	Supplies	1,399,453	1,453,869	54,416	4%	*1,134,236*	23%
63,244	52,364	(10,880)	-21%	*49,802*	27%	Purchased Services - Utilities	63,244	52,364	(10,880)	-21%	*49,802*	27%
655,297	458,916	(196,381)	-43%	*335,478*	95%	Purchased Services - Other	655,297	458,916	(196,381)	-43%	*335,478*	95%
166,274	194,430	28,156	14%	*181,248*	-8%	Rentals & Leases	166,274	194,430	28,156	14%	*181,248*	-8%
156,314	145,242	(11,072)	-8%	*99,053*	58%	Insurance License & Taxes	156,314	145,242	(11,072)	-8%	*99,053*	58%
217,109	253,231	36,122	14%	*212,599*	2%	Depreciation & Amortization	217,109	253,231	36,122	14%	*212,599*	2%
120,464	170,257	49,793	29%	*158,066*	-24%	Other Operating Expenses	120,464	170,257	49,793	29%	*158,066*	-24%
3,354,711	3,236,679	(118,032)	-4%	*2,619,068*	28%	Sub-Total Non-Labor Expenses	3,354,711	3,236,679	(118,032)	-4%	*2,619,068*	28%
8,225,204	**7,745,333**	**(479,871)**	**-6%**	***6,669,328***	**23%**	**Total Operating Expenses**	**8,225,204**	**7,745,333**	**(479,871)**	**-6%**	***6,669,328***	**23%**
1,233,263	**266,237**	**967,026**	**363%**	***315,880***	**290%**	**Operating Income (Loss)**	**1,233,263**	**266,237**	**967,026**	**363%**	***315,880***	**290%**
						Non Operating Income						
79,909	82,859	(2,950)	-4%	*74,817*	7%	Tax Revenue	79,909	82,859	(2,950)	-4%	*74,817*	7%
7,502	4,538	2,964	65%	*476*	1476%	Investment Income	7,502	4,538	2,964	65%	*476*	1476%
(40,348)	(132,477)	92,129	-70%	*(31,143)*	30%	Interest Expense	(40,348)	(132,477)	92,129	-70%	*(31,143)*	30%
-	1,552	(1,552)	-100%	-		Other Non Operating Income (Expense)	-	1,552	(1,552)	-100%	-	0%
47,063	**(43,528)**	**90,591**	**-208%**	***44,150***	**7%**	**Total Non Operating Income**	**47,063**	**(43,528)**	**90,591**	**-208%**	***44,150***	**7%**
$ 1,280,326	**$ 222,709**	**$ 1,057,617**	**475%**	$ ***360,030***	**256%**	**Net Income (Loss)**	**$ 1,280,326**	**$ 222,709**	**$ 1,057,617**	**475%**	$ ***360,030***	**256%**

Prosser
Memorial Health

Statement of Operations 13-month Trend

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Gross Patient Services Revenue													
Inpatient	$ 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	$ 4,071,955	$ 3,394,828	$ 4,640,973	$ 4,356,132
Outpatient	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	18,571,964	20,068,843	19,884,201	21,165,078
Total Gross Patient Services Revenue	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	22,643,919	23,463,671	24,525,174	25,521,210
Deductions from Revenue	*38%*	*40%*	*38%*	*33%*	*38%*	*36%*	*35%*	*39%*	*40%*	*36%*	*35%*	*36%*	*37%*
Contractual Allowances													
Medicare	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	5,059,783	5,374,568	5,363,484	6,258,021
Medicaid	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	4,468,840	4,859,892	5,481,000	5,380,697
Negotiated Rates	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	3,863,693	3,998,907	4,119,440	3,535,391
Other Adjustments	199,926	624,993	626,880	1,328,948	654,495	818,520	652,908	598,097	1,110,368	877,059	563,124	421,974	546,536
Gross Contractual Allowances	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	14,269,375	14,796,491	15,385,898	15,720,645
Charity Care	341,961	354,814	452,226	343,536	438,650	521,022	351,581	287,801	358,727	281,005	278,784	337,833	290,052
Bad Debt	214,560	(24,155)	243,688	(92,400)	221,628	(133,838)	297,843	204,558	339,947	20,517	144,130	22,795	79,605
Total Deductions From Revenue	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	14,570,897	15,219,405	15,746,526	16,090,302
Net Patient Services Revenue	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	8,073,022	8,244,266	8,778,648	9,430,908
COVID Grant Revenue	455,985	107,900	50,843	712,772	52,506	249,375	107,208	38,580	-	-	-	-	-
Other Operating Revenue	118,972	(76,453)	23,220	50,187	23,821	15,152	27,206	15,458	9,756	19,941	14,803	18,123	27,559
Net Revenue	**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**	**8,092,963**	**8,259,069**	**8,796,771**	**9,458,467**
Operating Expenses	*63%*	*52%*	*48%*	*63%*	*60%*	*51%*	*59%*	*45%*	*56%*	*55%*	*51%*	*50%*	*52%*
Salaries	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	3,188,743	3,128,147	3,336,443	3,435,337
Benefits	827,743	492,813	753,577	929,136	864,394	805,166	737,393	614,207	877,804	762,928	662,682	560,598	1,036,526
Purchased Labor	250,000	386,545	269,484	288,146	267,672	328,737	321,151	429,131	438,176	452,568	377,596	500,886	398,630
Sub-Total Labor Costs	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	4,404,239	4,168,425	4,397,927	4,870,493
Professional Fees - Physicians	407,364	333,806	386,705	382,778	391,045	482,125	424,354	533,096	496,634	492,531	405,214	484,073	506,621
Professional Fees - Other	41,222	61,379	103,229	64,244	(26,169)	54,282	41,765	58,784	63,768	75,491	50,368	17,626	69,935
Supplies	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	1,301,845	1,448,039	1,331,388	1,399,453
Purchased Services - Utilities	49,802	23,513	49,904	37,431	33,429	46,709	53,512	58,004	41,073	46,418	32,910	42,832	63,244
Purchased Services - Other	335,478	381,919	365,468	382,103	477,295	319,531	330,670	459,142	441,901	331,699	509,088	581,400	655,297
Rentals & Leases	181,248	191,423	236,771	216,425	119,924	159,032	149,762	210,436	171,163	177,974	179,309	143,787	166,274
Insurance License & Taxes	99,053	87,858	87,811	101,813	94,344	112,234	87,476	83,089	144,742	105,846	127,693	124,185	156,314
Depreciation & Amortization	212,599	211,565	215,248	220,087	207,039	222,140	223,071	223,551	223,632	223,677	217,873	217,875	217,109
Other Operating Expenses	158,066	105,914	110,506	100,267	78,539	133,508	79,775	120,741	78,687	98,663	116,184	124,370	120,464
Sub-Total Non-Labor Expenses	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	2,854,144	3,086,678	3,067,536	3,354,711
Total Operating Expenses	**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**	**7,258,383**	**7,255,103**	**7,465,463**	**8,225,204**
Operating Income (Loss)	**315,880**	**951,701**	**1,565,739**	**777,627**	**384,683**	**1,536,626**	**482,787**	**2,085,738**	**962,242**	**834,580**	**1,003,966**	**1,331,308**	**1,233,263**
Non Operating Income													
Tax Revenue	74,817	80,262	88,426	77,100	74,594	80,517	78,534	76,197	77,946	69,295	83,182	80,307	79,909
Investment Income	476	476	(571,938)	11,722	8,769	(186,482)	2,158	10,012	(268,189)	24,040	1,174	89,105	7,502
Interest Expense	(31,143)	(60,844)	(21,572)	(30,723)	(39,532)	(21,447)	(30,255)	(30,052)	(29,986)	(18,630)	(28,094)	(20,021)	(40,348)
Other Non Operating Income (Expense)	-	81,261	14,920	(2,497)	(20,347)	-	-	4,200	-	(4,625)	-	14,420	-
Total Non Operating Income	**44,150**	**101,155**	**(490,164)**	**55,602**	**23,484**	**(127,412)**	**50,437**	**60,357**	**(220,229)**	**70,080**	**56,262**	**163,811**	**47,063**
Net Income (Loss)	**$ 360,030**	**$ 1,052,856**	**$ 1,075,575**	**$ 833,229**	**$ 408,167**	**$ 1,409,214**	**$ 533,224**	**$ 2,146,095**	**$ 742,013**	**$ 904,660**	**$ 1,060,228**	**$ 1,495,119**	**$ 1,280,326**
Total Margin	5.1%	14.8%	14.1%	11.1%	5.1%	17.1%	7.4%	23.4%	8.7%	11.1%	12.8%	16.7%	13.5%
Margin (Non Operating Income)	4.5%	13.6%	19.3%	10.4%	4.9%	18.3%	6.7%	22.9%	10.9%	10.3%	12.2%	15.1%	13.0%
Salaries as a % of Net Revenue	42.6%	39.6%	35.3%	40.0%	45.5%	35.8%	43.6%	33.3%	41.0%	39.4%	37.9%	37.9%	36.3%
Labor as a % of Net Revenue	58.0%	52.1%	47.9%	56.4%	59.8%	49.4%	58.3%	44.7%	56.0%	54.4%	50.5%	50.0%	51.5%
Operating Expense change from prior month	3%	-7%	1%	3%	16%	6%	10%	8%	21%	12%	12%	15%	27%
Gross Revenue change from prior month	-10%	-8%	11%	7%	10%	19%	21%	24%	18%	20%	24%	30%	35%
Net Revenue change from prior month	-50%	-50%	-42%	-47%	-44%	-40%	9%	-35%	-37%	-42%	-41%	-37%	-32%

Prosser
Memorial Health

Statement of Cash Flows
January 31, 2023

CURRENT MONTH Actual	NET INCOME TO NET CASH BY OPERATIONS	YEAR TO DATE Actual
1,280,326	**NET INCOME (LOSS)**	**1,280,326**
217,109	Depreciation Expense	217,109
-	Amortization	-
-	Loss (Gain) on Sale of Assets	-
1,497,435	**TOTAL**	**1,497,435**
	WORKING CAPITAL	
(2,347,932)	Decrease (Increase) in Assets	(2,347,932)
1,902,823	Increase (Decrease) in Liabilities	1,902,823
1,052,326	**NET CASH PROVIDED BY OPERATIONS**	**1,052,326**
	CASH FLOWS FROM INVESTING ACTIVITIES	
(469,736)	Capital Purchasing	(469,736)
-	Proceeds on Capital Assets Sold	-
(30,102)	Investment Activity	(30,102)
(499,838)	**NET CASH USED BY INVESTING ACTIVITIES**	**(499,838)**
552,488	**NET CHANGE IN CASH**	**552,488**
	CASH BALANCE	
36,991,718	**BEGINNING**	**36,991,718**
37,544,206	**ENDING**	**37,544,206**
552,488	**NET CASH FLOW**	**552,488**

Prosser
Memorial Health

Direct Cash Flow Statement
January 31, 2023

	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	Year to Date 2023
CASH FLOWS FROM OPERATING														
PAYMENTS RECEIVED														
Commercial	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	3,388,970	2,926,872	4,636,521	3,800,465	3,800,465
Medicaid	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	2,184,114	2,095,733	2,788,519	2,084,466	2,084,466
Medicare	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	1,890,580	2,193,475	2,262,862	1,904,078	1,904,078
VA	83,053	37,616	94,447	100,585	74,713	18,848	46,441	74,217	46,243	56,914	(1,510)	110,018	77,242	77,242
Worker's Comp	154,456	80,761	125,210	100,871	123,467	196,392	274,009	213,343	196,405	226,594	155,224	203,986	204,217	204,217
Self Pay	65,480	93,400	120,387	66,663	98,505	69,161	123,196	84,611	65,184	63,010	54,578	58,358	60,191	60,191
Other Non Patient Payments	266,052	212,934	467,464	425,160	996,244	538,087	218,554	253,270	55,276	297,476	353,683	108,764	63,724	63,724
Cash Received (Patients, Insurance, Other)	**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**	**8,107,658**	**7,778,055**	**10,169,028**	**8,194,383**	**8,194,383**
Patient Refunds	(37,922)	(9,381)	(52,430)	(26,079)	(30,262)	(15,402)	(15,948)	(12,661)	(52,077)	(15,728)	(67,027)	(85,933)	(102,208)	(102,208)
AP Expenses	(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)	(4,408,292)	(3,239,466)	(4,150,499)	(3,530,474)	(3,530,474)
Settlement LumpSum Payments	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Payroll Expenses	(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)	(3,605,304)	(3,063,019)	(4,751,166)	(3,424,543)	(3,424,543)
Loan/Interest Expense	(57,467)	(57,467)	(57,467)	(57,467)	(57,467)	(224,627)	(54,467)	(54,467)	(54,467)	(54,467)	(54,467)	(469,161)	(114,934)	(114,934)
NET CASH PROVIDED BY OPERATING	**249,175**	**503,071**	**694,475**	**(855,671)**	**581,723**	**1,483,554**	**311,339**	**1,927,167**	**1,197,523**	**23,867**	**1,354,076**	**712,269**	**1,022,224**	**1,022,224**
CASH FLOWS FROM INVESTING ACTIVITIES														
Capital Purchasing	(641,743)	(216,418)	(134,128)	(249,106)	(371,445)	(658,291)	-	(390,385)	(75,524)	(80,562)	(150,863)	(716,307)	(469,736)	(469,736)
NET CASH USED BY INVESTING ACTIVITIES	**(641,743)**	**(216,418)**	**(134,128)**	**(249,106)**	**(371,445)**	**(658,291)**	-	**(390,385)**	**(75,524)**	**(80,562)**	**(150,863)**	**(716,307)**	**(469,736)**	**(469,736)**
NET CHANGE IN CASH	**(392,568)**	**286,653**	**560,347**	**(1,104,777)**	**210,278**	**825,263**	**311,339**	**1,536,782**	**1,121,999**	**(56,695)**	**1,203,213**	**(4,038)**	**552,488**	**552,488**
CASH BALANCE														
BEGINNING	**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**	**35,792,543**	**36,995,756**	**36,991,718**	**36,991,718**
ENDING	**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**	**35,792,543**	**36,995,756**	**36,991,718**	**37,544,206**	**37,544,206**
NET CASH FLOW	**(392,568)**	**286,653**	**560,347**	**(1,104,777)**	**210,278**	**825,263**	**311,339**	**1,536,782**	**1,121,999**	**(56,695)**	**1,203,213**	**(4,038)**	**552,488**	**552,488**

Prosser
Memorial Health

Key Operating Statistics
January 31, 2023

Month Ending Actual	Budget	Variance	%		Year to Date Actual	Budget	Variance	%	Prior Year	Change
				Key Volumes						
274	314	(40)	-13%	Inpatient Acute Days	274	314	(40)	-13%	318	-14%
43	129	(86)	-67%	Inpatient Swing Days	43	129	(86)	-67%	28	54%
317	443	(126)	-28%	**Total Inpatient Days**	317	443	(126)	-28%	346	-8%
119	176	(57)	-33%	Inpatient Admissions	119	176	(57)	-33%	123	-3%
123	176	(53)	-30%	Inpatient Discharges	123	176	(53)	-30%	118	4%
7	10	(3)	-32%	Swing Bed Discharges	7	10	(3)	-32%	-	#DIV/0!
1,857	2,578	(721)	-28%	Adjusted Patient Days	1,857	2,578	(721)	-28%	1,627	14%
10.23	14.30	(4.08)	-28%	Average Daily Census	10.23	14.30	(4.08)	-28%	11.16	-8%
721	1,026	(306)	-30%	Adjusted Discharges	721	1,026	(306)	-30%	555	30%
2.23	1.78	0.45	25%	Average Length of Stay - Hospital	2.23	1.78	0.45	25%	2.69	-17%
6.14	12.49	(6.35)	-51%	Average Length of Stay - Swing Bed	6.14	12.49	(6.35)	-51%	14.00	-56%
41%	57%	-16%	-28%	Acute Care Occupancy (25)	41%	57%	-16%	-28%	45%	-8%
44	51	(7)	-14%	Deliveries	44	51	(7)	-14%	47	-6%
213	207	6	3%	OR Surgical Procedures	213	207	6	3%	162	31%
137	112	25	*23%*	GI Procedures	137	112	*25*	*23%*	*30*	357%
1,376	1,401	(25)	-2%	Emergency Dept Visits	1,376	1,401	(25)	-2%	1,287	7%
17,652	16,707	945	6%	Laboratory Tests	17,652	16,707	945	6%	14,139	25%
2,967	3,072	(105)	-3%	Radiology Exams	2,967	3,072	(105)	-3%	2,462	21%
1,573	1,575	(2)	0%	PMH Specialty Clinic	1,573	1,575	(2)	0%	1,364	15%
959	842	117	14%	PMH - Benton City Clinic Visits	959	842	117	14%	775	24%
1,039	790	249	32%	PMH - Prosser Clinic Visits	1,039	790	249	32%	1,063	-2%
1,083	937	146	16%	PMH - Grandview Clinic Visits	1,083	937	146	16%	1,055	3%
683	621	62	10%	PMH - Women's Health Clinic Visits	683	621	62	10%	508	34%
				LABOR FULL-TIME EQUIVALENT						
349.27	373.86	24.59	7%	Employed Staff FTE's	349.27	373.86	24.59	7%	314.70	11%
35.78	34.75	(1.03)	-3%	Employed Provider FTE	35.78	34.75	(1.03)	-3%	31.74	13%
385.05	408.61	23.56	6%	All Employee FTE's	385.05	408.61	23.56	6%	346.44	11%
311.58	347.32	35.74	10%	Productive FTE's	311.58	347.32	35.74	10%	288.73	8%
15.93	11.40	(4.53)	-40%	Outsourced Therapy FTE's	15.93	11.40	(4.53)	-40%	11.82	35%
11.59	15.55	3.96	25%	Contracted Staff FTE's	11.59	15.55	3.96	25%	5.22	122%
27.52	26.95	(0.57)		All Purchased Staff FTE's	27.52	26.95	(0.57)	-2%	17.04	62%
8.32	10.00	1.68	17%	Contracted Provider FTE's	8.32	10.00	1.68	17%	7.88	6%
420.89	445.56	24.67	6%	All Labor FTE's	420.89	445.56	24.67	6%	371.36	13%

Prosser
Memorial Health

Financial Operations
January 31, 2023

	YTD 2022	YTD 2023	YTD Budget 2023
Utilization			
Admissions	123	119	176
Adjusted Admissions	578	697	1,026
Average Daily Census	10.3	8.8	10.1
Adjusted Occupied Beds	48.2	51.8	58.9
Average Length of Stay (days)	2.6	2.3	1.8
Outpatient Revenue %	78.7%	82.9%	82.8%
Total Yield (net patient revenue)	-88.8%	-84.8%	-86.9%
Hospital Case Mix Index	1.19	1.41	1.00
Average Charge Per Patient Day	10,420	13,742	8,740
Financial Performance ($000)			
Net Patient Revenue	6,410	9,431	7,989
Total Operating Revenue	6,985	9,458	8,012
Total Operating Expense	6,669	8,225	7,745
Income (Loss) from Operations	316	1,233	266
Excess of Revenue Over Expenses	360	1,280	223
EBIDA (Operating Cash Flow)	528	1,450	519
Additions to Property, Plant, and Equipment	437	470	63
Balance Sheet ($000)			
Unrestricted Cash and Investments	6,167	6,970	10,006
Accounts Receivable (gross)	40,531	45,277	36,027
Net Fixed Assets	6,676	22,241	100,451
Current and Long-Term Liabilities (excluding LT debt)	9,204	11,107	10,199
Long-Term Debt	8,570	8,521	68,727
Total Liabilities	17,774	19,628	78,926
Net Worth	61,023	62,344	67,517

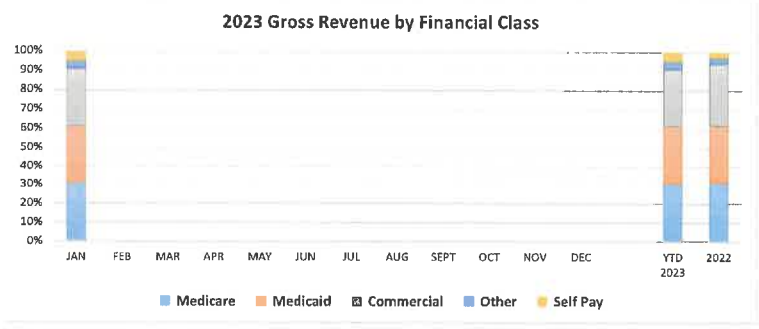
	YTD 2022	YTD 2023	YTD Budget 2023
Key Ratios			
Operating Margin (%)	4.5%	13.0%	3.3%
Total Margin (%)	5.2%	13.5%	2.8%
Operating EBIDA Margin (Operating Cash Flow)	7.6%	15.3%	6.5%
Average Expense per Adjusted Patient Days	4,100	4,429	3,004
Average Net Revenue per Adjusted Patient Days	3,940	5,078	3,098
Net Accounts Receivable (days)	55.49	56.56	60.17
Current Ratio (x)	2.57	2.41	2.52
Cash on Hand (days)	178	145	126
Cushion Ratio (x)	364.24	930.51	20.27
Return on Equity (%)	13.14%	2.05%	4.56%
Capital Spending Ratio	1.31	3.19	0.12
Average Age of Plant (Years)	(18.83)	12.83	11.86
Debt Service	0.58	1.10	5.50
Debt-to-Capitalization (%)	14%	14%	50.85%
Patient Revenue Sources by Gross Revenue (%)			
Medicare	31.2%	30.9%	31.2%
Medicaid	30.6%	30.6%	30.6%
Commercial Insurance	32.0%	29.4%	32.0%
Self-pay and Other	2.8%	4.7%	2.8%
Labor Metrics			
Productive FTE's (incl contract labor)	313.65	347.42	384.27
Total FTE's (incl contract labor)	371.36	420.89	445.56
Labor Cost (incl benefits) per FTE - Annualized	130,879	138,864	121,429
Labor Cost (incl benefits) as a % of Net Operating Revenue	58.0%	51.5%	56.3%
Net Operating Revenue per FTE - Annualized	225,718	269,673	215,771
Operating Expense per FTE - Annualized	215,510	234,511	208,600

Contacts:			
David Rollins	Chief Financial Officer	(509) 786-6605	drollins@prosserhealth.org
Stephanie Titus	Director of Finance	(509) 786-5530	stitus@prosserhealth.org

Prosser
Memorial Health

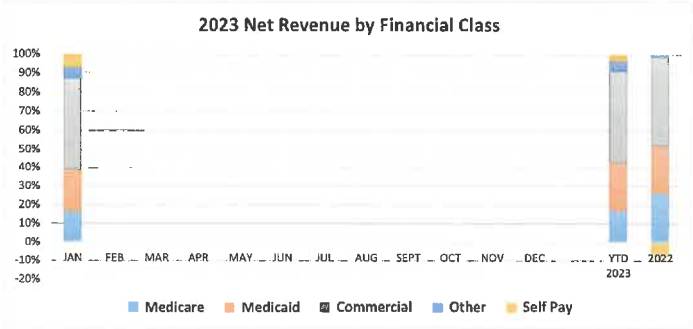
Revenue by Financial Class
January 31, 2023

Month	Medicare	Medicaid	Commercial	Other	Self Pay	Total
JAN	30.9%	30.6%	29.4%	4.3%	4.7%	100.0%
FEB						
MAR						
APR						
MAY						
JUN						
JUL						
AUG						
SEPT						
OCT						
NOV						
DEC						
YTD 2023	30.9%	30.6%	29.4%	4.3%	4.7%	100.0%
2022	31.2%	30.6%	32.0%	3.4%	2.8%	100.0%

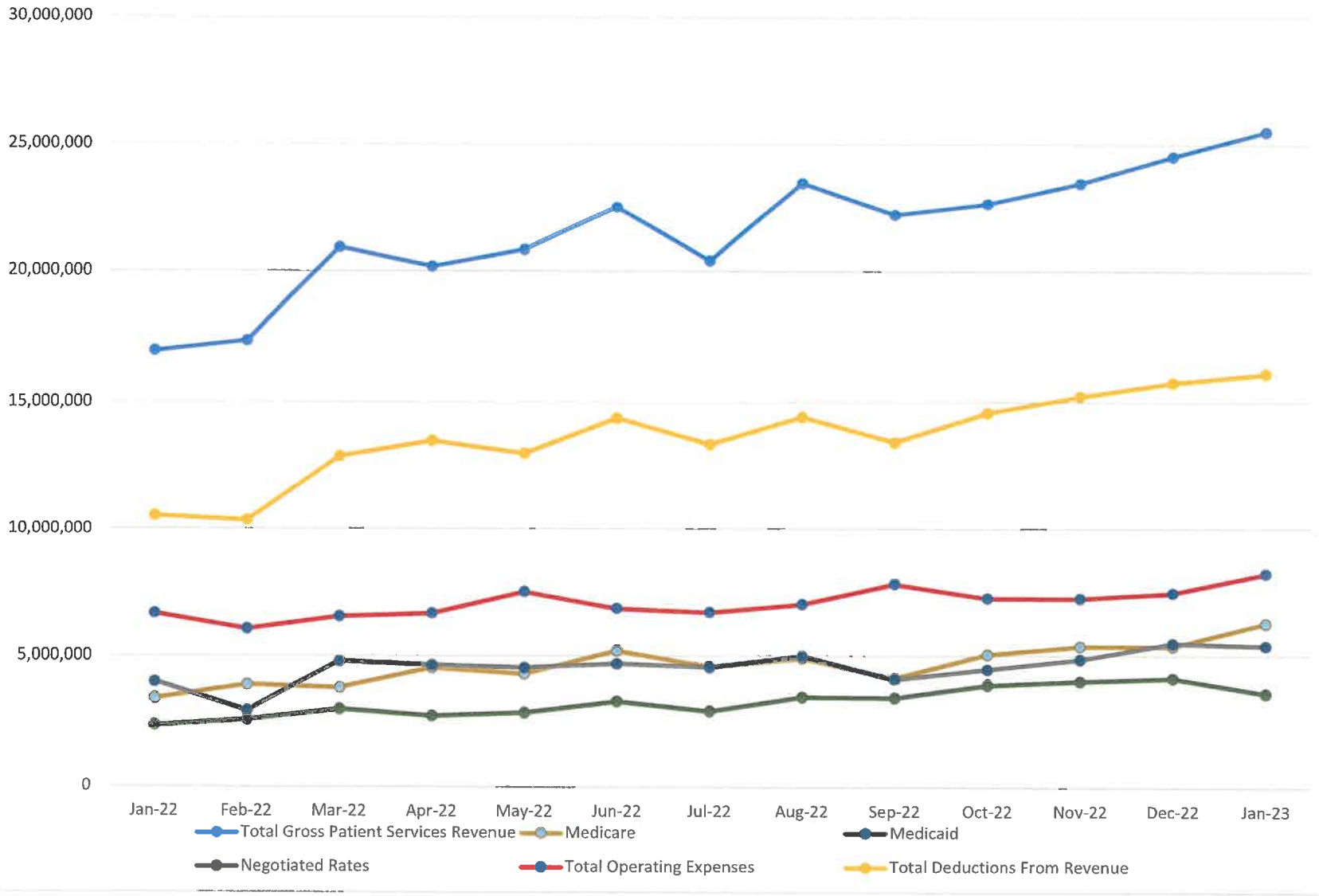


Net Revenue by Financial Class
January 31, 2023

Month	Medicare	Medicaid	Commercial	Other	Self Pay	Total
JAN	16.8%	22.3%	48.4%	6.1%	6.5%	100.0%
FEB						
MAR						
APR						
MAY						
JUN						
JUL						
AUG						
SEPT						
OCT						
NOV						
DEC						
YTD 2023	17.3%	25.8%	48.5%	5.3%	3.1%	100.0%
2022	26.7%	25.7%	46.6%	8.6%	-7.5%	100.0%

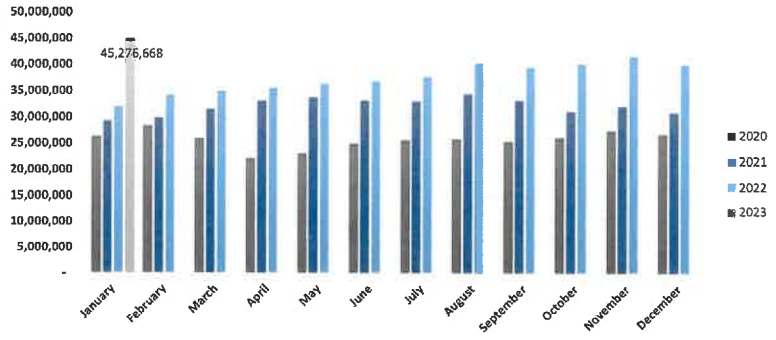


Prosser
Memorial Health



Prosser
Memorial Health

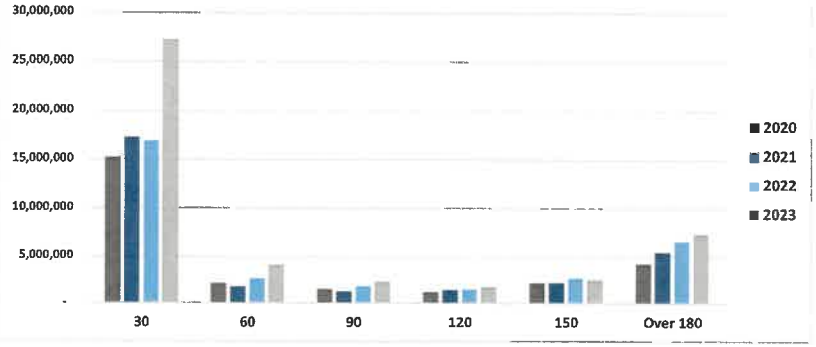
AR Balance Trend - 2020-2023



AR Balance Trend

	2018	2019	2020	2021	2022	2023	% Change
January	16,931,510	19,428,531	26,540,403	29,542,976	32,260,939	45,276,668	9%
February	16,911,324	19,146,130	28,567,785	30,120,411	34,474,143		14%
March	14,989,166	19,513,147	26,130,696	31,816,016	35,287,961		11%
April	15,852,894	19,692,139	22,350,961	33,444,324	35,889,741		7%
May	16,812,980	19,455,887	23,319,876	34,107,637	36,813,211		8%
June	16,291,895	21,223,053	25,197,275	33,577,529	37,192,042		11%
July	15,979,415	20,206,074	25,943,825	33,378,224	38,080,535		14%
August	16,633,907	20,028,246	26,144,421	34,777,364	40,568,933		17%
September	17,129,789	23,681,156	25,640,562	33,643,597	39,883,272		19%
October	16,950,256	25,724,222	26,432,788	31,514,355	40,551,941		29%
November	17,374,013	25,655,024	27,862,474	32,541,479	42,090,356		29%
December	17,137,550	25,486,600	27,102,309	31,324,657	40,530,516		29%

AR Age Comparative 2020-2023



AR Age Balance Comparative

	30	60	90	120	150	Over 180
2016	5,535,693	2,429,170	1,128,025	624,180	871,134	1,774,244
2017	5,470,096	2,167,378	1,054,021	794,004	958,014	3,216,686
2018	8,267,243	2,043,724	1,068,641	1,022,643	972,848	3,556,411
2019	12,682,168	1,621,100	1,112,923	815,430	1,096,709	2,100,200
2020	15,220,328	2,140,220	1,500,137	1,219,231	2,195,338	4,265,150
2021	17,315,900	1,795,815	1,300,624	1,440,357	2,207,682	5,482,599
2022	16,927,609	2,656,237	1,874,281	1,497,770	2,721,629	6,583,413
2023	27,291,629	4,091,645	2,300,084	1,779,041	2,493,982	7,320,287

AR Percentage of Total Balance

2016	45%	20%	9%	5%	7%	14%
2017	40%	16%	8%	6%	7%	24%
2018	49%	12%	6%	6%	6%	21%
2019	65%	8%	6%	4%	6%	11%
2020	57%	8%	6%	5%	8%	16%
2021	50%	6%	4%	5%	7%	19%
2022	52%	8%	6%	5%	8%	20%
2023	60%	9%	5%	4%	6%	16%

Prosser
Memorial Health

Lease Schedule
As of:
January 31, 2023

Building Rentals

Lease	Effective Date	Term Date	Auto Renew	Payment Amount		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Total
Prosser Professional Center	May-17	April-32		20,687.55	RHC	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	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	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	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	19,100							420,200
Yakima Valley Farmworkers	Oct-06	Oct-47		16,539.93	Spec Clinic	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	108,985	49,951						921,824
				Total Building Leases		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		Payment Amount													Total
Stryker - Fee per Case agreeement	Mar-18	Mar-23		7,739.16		23,217											394,697
Biomerieux	Dec-19	Dec-24		798.70		9,584	8,786										47,922
Flex Financial (MAKO)	Oct-19	Oct-24		21,157.04		233,779	175,335										1,168,897
Karl Storz	Mar-21	Aug-23		5,838.37		46,707											175,151
Leaf	Sep-16	Sep-20	Renewed	7,807.00		93,684	93,684										336,000
Baxter - Infusion Pumps	Aug-17	Aug-22		193.80													6,202
Baxter - Spectrum SW	Aug-17	Aug-22		60.00													1,920
Quadient	Apr-20	Jul-25		282.00		3,384	3,384	1,974									17,766
				Total Equipment Leases		410,356	281,188	1,974	-	-	-	-	-				2,701,560
				Total Future Leases		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	Spent To Date	Purchase Date
60700	Med/Surg	**2023**	Umano Acute Beds (x5)	75,000		
70100	Family Birthplace	**2023**	Obstetric Hemorrhage Carts x2	23,500		
		2023	Stryker Labor Bed Mattress x4	15,200		
70200	Surgical Services	**2023**	Patient Communication System	16,500		
		2023	Torniquets for Ortho Surgery	7,805		
		2023	Surgicount - AORN requirement x2	18,635		
		2023	ERCP instrumentation	145,000		
		2023	Stryker Stretchers x2	18,260		
		2023	Scope Cabinet	35,000		
70700	Laboratory	2022	RALS middleware interface	29,363		
		2022	Bugsy - EPIC module IC surveillance	90,000		
71400	Diagnostic Imaging	**2023**	MRI Medrad injector	40,000		
		2023	Stryker Ultrasound Stretcher	7,376		
72300	Emergency Dept	**2023**	Hoyer Lift	12,000		
		2023	ER Computer upgrade	30,000		
		2023	Metro carts	15,000		
72500	OSP	**2023**	EPIC Interface - iHeal	50,000		
72600	Benton City	2022	Repainting of Building	50,000		
72640	Women's Health	2022	Blanket Warmer	5,000		
		2022	Fluid Warmer	5,000		
72700	Specialty Clinic	**2023**	Diabetic Education Build - EPIC	20,556		
84600	Environmental Services	2022	Floor Scrubber	15,000		
85400	Information Technology	**2023**	Radiologist Monitors/Computer Replacemen	94,464		
		2023	Clinic Security - Access Controls	56,400		
		2023	Temperature Alerting - Enterprise-wide	17,892		
85100	Accounting	**2023**	ERP System Implementation	58,000		
		2023	**2023 Capital Items**	**756,587**		
		2022	**2022 Carryover Approved Capital Items**	**308,982**		
			TOTAL	**1,065,569**		
NON BUDGETED CAPITAL - BOARD APPROVED DURING 2023						
71400	Diagnostic Imaging	2023	Volusion Swift Ultrasound System		49,430	1/1/2023

Prosser Memorial Health

As of:

January 31, 2023

Capital Project Expenditures

Project Name	Budget	Nov-22	Dec-22	Jan-23
CIP - New Prosser Hospital		5,953,933	6,482,980	6,954,759
CIP - Gap Rd Land Improvement		118,571	118,571	118,571
	78,400,000	6,072,504	6,601,551	7,073,330
CIP - 1511 Meade Ave		12,378	12,378	12,378
Asset Clearing:				
Zoll Medical - Remote View X-series		5,000	-	-
Telecore Software (50%)		16,589	16,589	16,589
GE Healthcare:				
Voluson Swift USA System			32,046	
C1-5RS Convex Array Probe			7,560	
IC9-RS Probe			5,040	
C1-5-RS Probe Activation			21	
Side Basket			84	
Black & White Printer Set & Paper		-	722	
	81,093,614	6,106,471	6,675,991	7,102,297

SCOPE OF SERVICES AGREEMENT

This Scope of Services Agreement ("Agreement") is made and entered into effective the 1st day of April, 2019 by and between Prosser Public Hospital District No. 1, Benton County, Washington d/b/a Prosser Memorial Health (the "Hospital") and Prosser Memorial Health Foundation, a Washington non-profit support organization (the "Foundation").

WHEREAS, Foundation was formed as a support organization for Hospital under state law and under the Federal Internal Revenue Code; and

WHEREAS, the Foundation is dependent upon the resources of Hospital to conduct its operations and its fundraising activities including, but not limited to, an Executive Director, a Chief Financial Officer, use of office space, recordkeeping capabilities, certain ancillary personnel, marketing services, supplies and equipment and other services; and

WHEREAS, governmental entities like Hospital do not have the authority to perform certain services engaged in by Foundation and cannot donate resources to nonprofit organizations like Foundation without receiving fair market value consideration for those items or services; and

WHEREAS, the Hospital benefits from all the activities of the Foundation and those benefits should increase if the Foundation is able to carry out its purposes without having to develop an administrative infrastructure separate and apart from that of the Hospital.

NOW, THEREFORE, in consideration of the above and for other good and valuable consideration the parties hereby agree as follows:

1. Office Space. Hospital hereby agrees to provide office space to Foundation in consideration for rent paid in cash and/or services provided by Foundation to Hospital as described on Schedule 1 attached hereto, Hospital will provide to Foundation such amount of office space as Hospital deems appropriate to enable Foundation to carry out its services hereunder. The specific location and amount of space is set forth on Schedule 1. In the event the Board of Directors of the Foundation determines that additional space is necessary, the Board of Directors shall contact the Hospital and the Hospital will determine whether additional space is required. Foundation agrees that it will only utilize the space designated by Hospital and no other space unless it receives prior written authority from Hospital.

2. Supplies, Equipment and Insurance. Hospital agrees to provide to Foundation the basic supplies and equipment and insurance coverages necessary for the Foundation to carry out its purposes. The specific supplies, equipment and insurance provided by Hospital to Foundation and the cost of the supplies, equipment and insurance is set forth on Schedule 1.

3. Executive Director. Hospital shall also provide to Foundation an individual to serve as the Executive Director of the Foundation. The cost of the Executive Director shall be set forth on Schedule 1. This individual shall be primarily employed by Hospital and compensated through the Hospital's compensation program. However, the Executive Director shall be responsible to the Board of Directors of Foundation. The Hospital CEO may at any time withdraw the services of the Executive Director and appoint a new Executive Director for the Foundation. The scope of

duties and the time devoted by the Executive Director to Foundation shall be determined by the Hospital after consultation with the Foundation. The specific qualifications and duties of the Executive Director are attached hereto as Exhibit A.

4. Additional Personnel. The Hospital shall provide to the Foundation such additional personnel as the parties deem appropriate including a Chief Financial Officer and a Busy Bean/Gift Shop Coordinator for such amount of time and for such consideration as is described on Schedule 1. The Hospital CEO shall have the authority to remove and replace the Chief Financial Officer at his discretion after discussing the proposed action with the Foundation Board.

5. Fair Market Value. The parties acknowledge that for all purposes hereunder, Foundation will pay fair market value consideration for all items and services it receives from the Hospital. Foundation shall use investment income earned by Foundation and shall not use the corpus of the Foundation to pay for items or services provided by Hospital without the prior written consent of the Hospital. The parties also acknowledge that both parties will be receiving goods and services from the other party and instead of paying cash for each individual item or service, the parties may offset the fair market value of the items or services against what is provided by other party. Any remaining amount owed by one party to the other shall be paid in cash with the reconciliation to occur quarterly.

6. Certain Expenditure of Funds. The Foundation acknowledges that it is a support organization for the Hospital. The Foundation has held itself out to the public that its role is to exclusively support the Hospital and has filed documents with the Internal Revenue Service stating that it will exclusively support the Hospital. Therefore, the Foundation agrees that it will make no expenditures for any purposes that are not directly in furtherance of the purposes and objectives of the Hospital and to the extent there is any question regarding the nature of expenditures made by the Foundation, the Foundation and the Hospital shall meet to determine whether such expenditures or the plan for such expenditures are consistent with the purposes and objectives of Hospital.

7. Items and Services Provided by Foundation. Foundation and Hospital acknowledge that Foundation will provide certain services and items including support volunteers for Hospital which will include staffing the gift shop and other activities on the Hospital premises as described on Schedule 2. Hospital will pay fair market value for the items and services Foundation provides to Hospital as described on Schedule 2. Although all volunteers will report to Foundation, it is acknowledged that all activities of the volunteers and all revenue generated by the volunteers shall belong to and be reported to the Foundation which, in turn, shall report all related revenues and expenses to the Hospital. The Foundation will implement a policy and procedure to assure that no Hospital employees are providing volunteer services during scheduled work time. To the extent there is any dispute between any volunteer and the Foundation or any other issue associated with the activities of a volunteer that cannot be resolved by the Foundation, the Foundation shall immediately contact the Hospital and obtain its assistance in resolving any such issue. The Foundation will appoint a Volunteer Advisory Committee to the Foundation Board that will provide suggestions to the Board relating to expenditures for Hospital purposes from revenues generated by volunteer activities. The Advisory Committee will have no formal voting authority.

8. Intellectual Property. The Foundation may use the name of the Hospital and may develop names for events sponsored by or for the benefit of the Hospital so long as the Foundation receives written approval for such use from Hospital. At all times the names of each activity and the name of the Hospital and any other names associated with events sponsored by Foundation shall belong to and owned by Hospital. Upon the termination of the Foundation for any reason, the Hospital retains the right to use and control all such names. To the extent any intellectual property is developed by the Foundation, the development must be in the best interest of the Hospital and all rights of ownership of the intellectual property shall remain with the Hospital at all times.

9. Meeting of Foundation Board. The Foundation agrees that at any meetings of the Foundation Board the Executive Director may be present at the meeting as well as any authorized officer of the Hospital. The Foundation shall give to the CEO of the Hospital notice of any Foundation meetings and a brief description of the content to be discussed at the meeting. Nothing herein is intended to eliminate or restrict the authority of the Foundation to act as a separate legal entity or restrict its Board making independent decisions regarding the activities of the Foundation to the extent not otherwise inconsistent with this Agreement.

10. Term and Termination. This Agreement shall begin on the effective date first above stated and shall continue for a term of five (5) years and thereafter shall renew for additional five (5) year terms unless terminated as provided herein. Either party shall have the right to terminate this Agreement at any time by providing ninety (90) days prior written notice to the other party. Upon termination of this Agreement for any purpose, all assets of the Foundation and all other legal rights of the Foundation shall immediately revert to Hospital and Foundation shall indemnify Hospital for any liability or expenses incurred by Hospital relating to the termination event.

11. Confidentiality. The Foundation and its Board agree that Foundation and its Board will access confidential information regarding Foundation activities, hospital activities and, potentially, patient information. The Foundation and its Board agree to keep all such information confidential and to comply with The Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Foundation will assure its volunteers also sign agreements requiring they keep information confidential.

12. Accounting. The Hospital shall retain accountants as necessary to account for all activities of the Foundation and to file all appropriate reports and tax returns with appropriate governmental agencies. Foundation shall be given copies of all such documentation and reports.

13. Governing Law. For all purposes, this Agreement shall be governed by the laws of the State of Washington. Jurisdiction for any legal proceedings shall be Prosser, Washington.

IN WITNESS WHEREOF, the undersigned parties hereby execute this Agreement effective the day and year first above written.

Prosser Public Hospital District No. 1,
d/b/a Prosser Memorial Health

By: _____
Authorized Representative

Prosser Memorial Health Foundation

By: _____
Authorized Representative

EXHIBIT A

1. **Qualifications and Duties of Executive Director**. The Executive Director provided by the Hospital to assist the Foundation shall have the following minimum qualifications and duties:

   1.1 To provide clerical support to the Foundation, Board Members, and Sub-Committee Members.

   1.2 To schedule Foundation and Sub-Committee meetings and take notes and draft minutes for each meeting.

   1.3 To complete and distribute agendas for each meeting.

   1.4 Maintain an updated mailing list of Board Members, and keep a detailed and updated database of Donors.

   1.5 Assist the Board in locating Foundation resource, training/educational materials and information.

   1.6 Coordinate training and educational activities.

   1.7 Schedule donor meetings in conjunction with Foundation Board Members and Sub-Committee members.

   1.8 Attend meetings between the Foundation Board Members and potential donors.

   1.9 Keep records of donor paperwork, budgeting and accounting and required filings with state and federal agencies for the Foundation.

   1.10 Create marketing and public relations campaigns for increasing donations to the Foundation.

   1.11 To take such other actions as directed by the Foundation Board.

1.12 Have adequate computer skills and training to accomplish the duties as described above including but not limited to experience with the following Microsoft Office Suite programs: work, excel, access, publisher and accounting.

1.13 Be able to type 50 words per minute.

1.14 Experience with utilization of a multiline telephone system, facsimile machine, and copier.

1.15 Work evenings and weekends when requested.

1.16 Have working knowledge of marketing and promotional concepts and the ability to apply that knowledge to obtain results from the marketing and promotional campaigns.

1.17 Have good interpersonal communication skills.

2. **Supervision of Executive Director**. Hospital shall supervise the Executive Director on a day to day basis and shall be solely responsible for hiring and firing Executive Director in accordance with Hospital policy. Foundation shall have the authority to instruct Executive Director to take or not take certain action on behalf of the Foundation and Hospital shall not interfere with the instructions from the Foundation to the Executive Director so long as the instructions are in furtherance of the purposes of Foundation. Both parties agree that Executive Director during the course of Executive Director's employment may obtain confidences from either party. Neither party shall instruct the Executive Director to disclose a confidence of the other party. Neither party shall discipline the Executive Director for the Executive Director's failure to disclose confidential information regarding the other party.

SCHEDULE 1

Hospital Provided Services

Administrative and Support Staff	$ 104,455
Insurance (Coverage/Board Members)	$ 400
Office Supplies	$ 1,010
Rental Space	$ 8,196
TOTAL	**$ 114,061**

2020

Administrative and Support Staff

Position	Hourly Rate	Weekly Hours	Annualized	Total Expense
Executive Director	$ 64	8	416	$ 26,208
CR Outreach Assistant	$ 17	1	52	$ 884
Chief Financial Officer	$ 64	2	104	$ 6,552
Busy Bean/Gift Shop Coordinator	$ 23	40	2,080	$ 49,920
Benefits				*$ 20,891*
			TOTAL	**$ 104,455**

Insurance

Board Member Quantity	10
Cost Per Member	*$ 40*
Total	**$ 400**

Office Supplies

Printing	$ 350
Telephone	$ 420
Other	$ 240
Total	**$ 1,010**

Rental Space

Area	Square Footage
Gift Shop	206
Busy Bean	306
Storage Room	115
Vineyard Room Closet	56
Total Square Footage	**683**
Rental Cost (FMV Cost $12/per sq. ft)	**$ 8,196**

SCHEDULE 2

Foundation Provided Services

Auxiliary Support	$ 64,025
Therapy Dog Service	$ 1,300
Chaplain	$ 13,000
Advertising	$ 8,000
Capital Expenditures	$ 15,000
TOTAL	**$ 101,325**

2020

Auxiliary Support

Position	Hourly Rate	Weekly Hours	Annualized	Total Expense
Concierge Support	$ 22	40	2,080	$ 45,760
Per Diem Med/Surg Assistant	$ 21	5	260	$ 5,460
Benefits				*$ 12,805*
			TOTAL	**$ 64,025**

Dog Therapy Service

Position	Hourly Rate	Weekly Hours	Annualized	Total Expense
Therapy Dog Service	$ 25	1	52	$ 1,300

Chaplain

Position	Hourly Rate	Weekly Hours	Annualized	Total Expense
Chaplain	$ 50	5	260	$ 13,000

Advertising

Advertisement	$ 8,000
Total	**$ 8,000**

Capital

Capital	15,000
Total	**$ 15,000**

Hospital Provided Services (Schedule 1)	$ 114,061
Foundation Provided Services (Schedule 2)	$ 101,325
Net Expenditures Total (Due to Hospital)	($ 12,736)
FOUNDATION SUPPORT PAYMENT TO HOSPITAL	$ 12,736

2023 Service Agreement/Management Fee

Foundation

Concierge Services	63,206
Per diem Assistant Med/Surg	7,542
Capital Expenditures	15,000
Advertising	8,000
Chaplain	14,365
Therapy Dog Service	1,437
	$ 109,549

Hospital

Insurance (Coverage/Board Members)	600
Administrative and Support Staff	139,936
Office Supplies	1,125
Rental Space	8,196
	$ 149,857

Monthly Service/Management Foundation to Hospital: $ 3,358.98

CHARTIS

CHARTIS RURAL HOSPITAL PERFORMANCE INDEX™ SUMMARY REPORT

PERFORMANCE SUMMARY

Provider Name: PROSSER MEMORIAL HOSPITAL
Medical Provider: 501312
Location: PROSSER, WA 99350
Release Date: Fall 2022

INDEX RANK

13.3

QUARTILE RATING SCALE

1=100-75 2=74.9-50 3=49.9-25 4=24.9-0

MARKET		VALUE					FINANCE
INPATIENT MARKET SHARE	OUTPATIENT MARKET SHARE	QUALITY	OUTCOMES	PATIENT PERSPECTIVE	COST	CHARGE	FINANCE
33	4	38	81	49	50	33	29

METHODOLOGY - The Chartis Rural Hospital Performance INDEX is the industry standard for assessing - and benchmarking - rural and Critical Access Hospital performance. To learn more about the INDEX or request a 2022 methodology, reach out to us at CCRH@chartis.com.

Honoring Outstanding Performance Among Rural Hospitals

February
100
Critical Access
Rural & Community
Top 100 Hospital

May
NRHA
Rural & Community
Top 20 Hospital

September
NRHA
Critical Access
Top 20 Hospital

November
Performance Leadership
Top Quartile Performance

Working with The Chartis Center for Rural Health

How our expertise, analytics and insights can support your strategic goals

INDEX Strategic Advisory Program – *A customized 12-month engagement designed for rural providers seeking to drive improvement utilizing benchmarks from Top 100 hospitals. We work directly with hospital leadership and frontline decision makers to identify areas of opportunity using INDEX, develop action plans, and monitor progress.*

INDEX Comparative Analytics – *Access to the raw INDEX data across 36 metrics for your facility as well as those of your custom 10-hospital peer group. This program can be configured as a single year engagement or a 3-year engagement.*

Strategic & Operational Assessment – *Detailed analysis focusing on specific areas such as patient outmigration, cost and charge, population health, finance, and market share. Presented in a visual and engaging format, this assessment helps to inform and empower the decision-making process. Project time from start to assessment delivery is typically 3 to 4 weeks.*

Leadership and Board Education – *Our leadership team and Board education sessions are designed to help improve understanding of hospital performance and bring greater clarity around the challenges rural hospitals face within the context of vulnerability, health inequity and staffing shortages. This engagement can be done in-person or virtually.*

To learn more about these programs, reach out to us at CCRH@chartis.com.

To learn more about these programs, reach out to us at CCRH@chartis.com.

CHARTIS

Attachment FF

CHARTIS

CHARTIS RURAL HOSPITAL PERFORMANCE INDEX™ SUMMARY REPORT

PERFORMANCE SUMMARY

Provider Name: PROSSER MEMORIAL HOSPITAL
Medical Provider: 501312
Location: PROSSER, WA 99350
Release Date: Winter 2023

INDEX RANK

79.2

QUARTILE RATING SCALE

1=100-75 2=74.9-50 3=49.9-25 4=24.9-0

MARKET		VALUE					FINANCE
INPATIENT MARKET SHARE	OUTPATIENT MARKET SHARE	QUALITY	OUTCOMES	PATIENT PERSPECTIVE	COST	CHARGE	FINANCE
53	4	44	85	66	77	57	81

METHODOLOGY - The Chartis Rural Hospital Performance INDEX is the industry standard for assessing - and benchmarking - rural and Critical Access Hospital performance. To learn more about the INDEX or request a 2023 methodology, reach out to us at CCRH@chartis.com.

Honoring Outstanding Performance Among Rural Hospitals

February
100
Critical Access
Rural & Community
Top 100 Hospital

May
NRHA
Rural & Community
Top 20 Hospital

September
NRHA
Critical Access
Top 20 Hospital

November
Performance Leadership
Top Quartile Performance

Attachment GG

PROSSER MEMORIAL HEALTH
BOARD ACTION PLAN - 2023

Prosser Memorial Health

BOARD INPUT	ACTION PLAN/RECOMMENDATION	RESPONSIBLE COMMITTEE	ACTION TAKEN
The PMH Board would like to consistently review its committee structure, membership, etc.	The PMH Board will review its committees every January with regard to composition, membership, goals, responsibilities and performance.	Full Board	
The PMH Board wants to maintain a high level of communication throughout PMH, including actions they take at their monthly meetings.	An email will be sent by the CEO to all PMH Team members (Employees, Medical Staff) the day after each monthly Board meeting, which will communicate the actions taken by the Board at their monthly meeting.	Full Board	

PROSSER MEMORIAL HEALTH
BOARD ACTION PLAN - 2023

Prosser Memorial Health

BOARD INPUT	ACTION PLAN/RECOMMENDATION	RESPONSIBLE COMMITTEE	ACTION TAKEN
The Board would like to maintain the positive relationship they have with the Medical Staff and Leadership Team.	Conduct a social event for the Board, Medical Staff and Leadership Team to interact and continue to strengthen relationships. Continue to conduct monthly Joint Conference Committee meetings.	Full Board	
The Board has not consistently been receiving the electronic monthly Trustee Insights publication. The Board is also interested in receiving the Becker's Hospital Review publication electronically.	Administration will work with the PMH IT Department to ensure that the Trustee Insights and Becker's Hospital Review publications are sent to all Board members on their hospital and/or personal email accounts.	Full Board	
Continuing education is a high priority for all Board members.	Board Members will be encouraged to attend state and national Board education conferences (e.g. AHA Rural Healthcare Leadership Conference and AWPHD/WSHA Rural Hospital Leadership Conference-Lake Chelan). Management will also present educational materials at Board Work Sessions throughout the year. Consider offering a Board Orientation session for current PMH Board of Commissioners.	Full Board	

PROSSER MEMORIAL HEALTH
BOARD ACTION PLAN - 2023

BOARD INPUT	ACTION PLAN/RECOMMENDATION	RESPONSIBLE COMMITTEE	ACTION TAKEN
Board members have not routinely received relevant PMH announcements, press release, publications, etc.	Board members will be added to appropriate email lists for relevant PMH announcements (e.g. from the CEO), press releases, publications, etc. They will not be included in routine daily emails such as Yammer.	Full Board	
The PMH Board has not heard a legislative update from our local state legislators in several years.	Invite our local State Senator and State Representative to give a legislative update to our Board in 2023.	Full Board	

Attachment HH

American Hospital Association™
Advancing Health in America

Special Bulletin

February 7, 2023

Public Health Emergency to End May 11

AHA outlines implications for hospitals and other providers

The White House announced Jan. 30 it would simultaneously end the COVID-19 national emergency and public health emergency (PHE) declarations on May 11. Hospitals and health systems have approximately 100 days to prepare for the restoration of waived requirements and other changes in policy and practice.

This Special Bulletin highlights the key changes for hospital operations at the end of the COVID-19 PHE. It is not an exhaustive list. Members are encouraged to review the Centers for Medicare & Medicaid Service's (CMS') complete list of waivers that will be ending on May 11.

At the same time, AHA is advocating for the retention of some flexibilities and amendment of others in a letter sent today to Health and Human Services (HHS) Secretary Xavier Becerra. AHA is urging the Administration to retain flexibilities that are necessary for continued recovery from the pandemic and to make permanent those that have been essential for more effective, patient-centered care delivery. We will continue to work closely with the Administration and Congress to further demonstrate the need for and provide analysis supporting continuation of key waivers, such as those outlined in our letter.

During the next few weeks, AHA will distribute additional analyses regarding the ending of the PHE and other tools to assist members in preparing for the end of the PHE.

KEY HIGHLIGHTS

The end of the national emergency declaration and PHE will mean:

- Significant changes in payment for many COVID-19 related services;
- Significant changes in how hospitals and health systems could use expansion sites for the care of COVID-19 patients or to keep non-COVID positive patients isolated;
- The return of regulatory requirements that were waived to ease burdens on the health care system allowing staff to focus on caring for COVID-19 patients, or in the past year, from the tripledemic of COVID-19, influenza and RSV; and
- Varying implementation timelines for reinstating regulatory requirements and other operational changes.

AHA Take

Our nation has been tested by the COVID-19 pandemic more than it has with any other crisis in the past 75 years. Federal agencies put in place numerous flexibilities, provided support for vaccines and therapeutics, and took significant steps to support health care providers who were working to save lives amidst this crisis. After three years of pandemic flexibilities, the return to "normal" will require changes across many parts of hospitals and health systems, and that work should begin now. However, some of the COVID-19 PHE flexibilities led to care that better met the needs of patients and often led to better outcomes. Therefore, federal and state agencies should take this opportunity to reexamine programs and policies and take action to eliminate or amend those necessary to support better, safer and more patient-centered care.

Critical changes in programs and policies that are set in motion by the PHE ending are highlighted below.

KEY CHANGES PROMPTED BY THE ENDING OF THE COVID-19 PHE

The end of the PHE will trigger the wind down of most PHE-specific programs and flexibilities, including those put in place by CMS, the Food and Drug Administration (FDA), the Drug Enforcement Agency (DEA) and other bodies. However, their end dates will vary. While many of these programs and waivers will conclude on May 11 simultaneously with the emergency declarations, others will remain in place through as late as Dec. 31, 2024. As a result, the official end of the COVID-19 PHE will impact hospital and health system operations for an extended period.

Key PHE-related Provisions Ending May 11, 2023

The following policies and programs will end on the last day of the PHE, currently set for May 11, 2023.

1. Use of temporary expansion sites (such as convention centers, vacant stores, tents or others allowed under the Hospital Without Walls program) and spaces within the hospital that do not conform to the conditions of participation requirements for patient rooms, such as conference rooms and surgical suites.
2. Use of provider-based departments that were relocated to settings outside the hospital, including patients' homes, after receipt of an extraordinary circumstances waiver and that provide education and therapy services to hospital outpatients.
3. Skilled nursing facility (SNF) beds available for patients not meeting SNF requirements.
4. EMTALA waiver allowing hospitals to redirect patients from their emergency departments to screening tents for COVID-19 testing.
5. Flexibility on limit of 25 beds for Critical Access Hospitals (CAHs) and the 96-hour rule for average length of stay.

6. Reduced information requirements for post-acute care discharge to a SNF, rehabilitation center, long-term care hospital or home health agency.
7. Flexibility to not have a separate nursing plan of care for each patient.
8. Permission from the Drug Enforcement Agency to prescribe controlled substances without an in-person visit.
9. Medicare's 20% add on payments for patients diagnosed with COVID-19 to offset the cost of complex COVID-19 patient care.
10. Free COVID-19 at-home tests and no cost sharing for testing services and therapeutics for Medicare beneficiaries (including those in Medicare Advantage plans) and those enrolled in private coverage. After the PHE ends, patient cost sharing will be required except for Medicaid beneficiaries who have at least an additional year of tests and therapeutics access at no cost. Additionally, Medicare will continue to pay $40 for COVID-19 vaccines administered in outpatient settings through Dec. 31, 2023.
11. State option to provide Medicaid eligibility for certain uninsured individuals to cover COVID-19 testing, testing-related services, vaccination and treatment coverage at 100% federal match.
12. Health plan requirements to reimburse out-of-network providers for COVID-19 vaccines and testing.

Key PHE-related Provisions Ending Dec. 31, 2023

The following policies and flexibilities end on Dec. 31, 2023, the last day of the year in which the PHE expires.

1. Enhanced federal funding to state Medicaid programs of 6.2% (See note below for additional details on Medicaid coverage).
2. Reimbursement for cardiac, intensive cardiac and pulmonary rehabilitation services provided via telehealth under the physician fee schedule.
3. Reimbursement parity for services performed via telehealth that typically would have been performed in person.
4. Permission for physicians and non-physician practitioners to directly supervise diagnostic services virtually through audio/video real-time communications technology (excluding audio-only).

Key PHE-related Provisions Ending at a Future Date

1. Liability immunity for use of countermeasures for COVID-19 will end Oct. 1, 2024, which is the end of the Public Readiness and Emergency Preparations (PREP) Act declaration.
2. Certain telehealth flexibilities that congress extended through Dec. 31, 2024:
    - Waiver of geographic and location requirements
    - Reimbursement for telehealth services furnished by physical therapists, occupational therapists, speech language pathologists and audiologists

- Reimbursement for audio-only services
- Reimbursement for telehealth services furnished by federally qualified health centers and rural health clinics
- Use of telehealth to recertify eligibility for hospice

Additionally, implementation of the in-person visit requirement for initiation of tele-behavioral health services is delayed until the end of 2024.

3. Acute Care Hospital at Home program, which congress extended through Dec. 31, 2024.
4. Food and Drug Administration (FDA) emergency use authorizations (EUAs) for drugs and devices do not have a specified ending. The FDA has the authority to extend these EUAs at its discretion to ensure continued availability of effective testing, vaccination and therapeutics. Further information has been requested from the agency, but there is no indication it intends to end any of the EUAs soon.
5. Hospital COVID-19 data reporting requirements that were instituted in 2020. The CMS condition of participation (CoP) requiring hospitals and CAHs to submit certain data related to COVID-19 to HHS was originally set to expire at the conclusion of the PHE. However, in the FY 2023 Inpatient Prospective Payment System final rule, CMS revised the CoP to require hospitals to continue reporting COVID-19-related data after the conclusion of the PHE through Apr. 30, 2024, unless the Health and Human Services Secretary establishes an earlier end date.

Note about Medicaid Coverage and Eligibility Redetermination

To assist states in their PHE response and support access to coverage and care, Congress provided enhanced federal funding to state Medicaid programs of 6.2 percentage points. Originally, this funding was linked to the PHE and required that states meet a number of conditions, including providing continuous eligibility. States, therefore, have not conducted eligibility redeterminations for the entirety of the PHE. However, Congress, in the Consolidated Appropriations Act of 2023, decoupled these provisions from the PHE.

Enhanced federal funding is now set to wind down each quarter, beginning on April 1 to 5 percentage points, 2.5 percentage points on July 1, and 1.5 percentage points on October 1, and sunset on Jan. 1, 2024. States also are authorized to resume Medicaid redeterminations as of April 1 and, if necessary, disenrollment. Enrollment in Medicaid and the Children's Health Insurance Program has reached more than 90 million, and some estimates suggest that 15 million could lose coverage during the redetermination process. We encourage members to engage with their state Medicaid agencies, state hospital associations and community-based partners on ways to help facilitate this process and ensure minimal coverage loss. We also encourage you to review a set of AHA resources here.

FURTHER QUESTIONS

If you have further questions, contact Mark Howell, AHA's director of policy, at mhowell@aha.org or Nancy Foster, AHA's vice president for quality and patient safety policy, at nfoster@aha.org.

American Hospital Association™

Advancing Health in America

Attachment II

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

February 7, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Creating a Glide Path from Public Health Emergency to a More Effective, Equitable, Patient-focused and Stable Health Care System

Dear Secretary Becerra:

Our nation has been tested by the COVID-19 pandemic more than it has with any other crisis in the past 75 years. The health care system, with America's approximately 6,000 hospitals and health systems at the center, met the challenges posed by the disease and saved countless lives with skill, compassion, and often great personal sacrifice on the part of the health care workforce. **The recent decision to sunset the COVID-19 public health emergency (PHE) is a testament to the progress we have made; however, as we prepare for that transition, we should not revert to care delivery as it was prior to the pandemic. Instead let us build on the lessons we have learned and the advancements in care delivery and access we have made. Let us use this crisis to create a more effective, equitable, patient-focused and stable health care system.**

Achieving these goals requires immediate action by the Administration as the conclusion of the PHE will end several PHE-specific programs and policies that are critical to the evolution of the health care system. Specifically, we urge you to take actions to help **stabilize the health care delivery system** to ensure care remains available to patients when and where they need it; **support the health care workforce** as they continue to shoulder a disproportionate amount of strain caused by the PHE; and **remove unnecessary administrative and regulatory burdens** that prevent providers from modernizing care delivery while adding cost and friction in the health care system. These actions include:

- Making permanent many of the policies authorized through waiver authority during the PHE that enabled hospitals and health care systems to deliver care more effectively and efficiently. These policies include expanded use of

telehealth, workforce flexibilities, and the reduction of unnecessary regulatory and data reporting requirements;
- Continuing to assist states and other stakeholders in ensuring that the Medicaid redetermination process does not leave individuals, especially children, without access to coverage and care; and
- Seizing on the lessons learned to create new processes for evaluating and revising certain hospital Conditions of Participation, as well as updating the Department's emergency preparedness plan enabling America's hospitals and health systems to innovate in ways that will improve the quality of and access to care while also adequately preparing them for the next national emergency.

We recognize that while the Administration has significant ability to act, there are some reforms that require congressional authorization, such as the ability to make permanent certain telehealth flexibilities and address the challenge of patient boarding in hospitals. We urge the Administration to work with Congress to advance these reforms.

We expand on each of these recommendations in the attached. We thank the Administration for its continued support and look forward to working with you to implement meaningful and necessary change. Please contact me if you have questions, or feel free to have a member of your team contact Mark Howell, AHA's director of policy, at 202-626-2317 or mhowell@aha.org.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

Attachment A: Recommendations for Immediate Administrative Action
Attachment B: Recommendations for Congressional Action
Attachment C: Summary Chart of Recommendations

Attachment A: Recommendations for Immediate Administrative Action

Stabilizing the Health Care Delivery System

Hospitals' and health systems' capacity to care for individuals is strained as they continue to experience an influx of high acuity patients, struggle to discharge existing patients to post-acute sites of care and navigate ongoing labor shortages and supply disruptions. Among other challenges, these factors have led to both rising costs and constricted revenue, which combined have created an unprecedented fiscal crisis. Indeed, approximately half of hospitals and health systems are operating with negative margins. This situation is not sustainable and jeopardizes providers' ability to continue serving their patients. The expiration of a number of waivers that have been critical to enabling hospitals and health systems to provide — and be reimbursed for — care will only further destabilize their operations and finances. **We therefore urge you to take the following steps as the PHE winds down to help ensure that the health care delivery system can be there when patients need it:**

- **Permanently Authorize Expanded Coverage of Telehealth Services.** COVID-19 forced hospitals and health systems to rapidly deploy new and innovative ways of delivering care, like expanded telehealth, to care for patients. This progress was spurred by the immediate need to expand access to services, while simultaneously working to prevent increased transmission of COVID-19 and was supported by a series of waivers approved by the Centers for Medicare & Medicaid Services (CMS). While the impetus for these programs was COVID-19, their value beyond the pandemic could not be more evident. Therefore, we encourage the Administration to permanently extend coverage of certain telehealth services, including:
    - The ability to use telehealth services to meet the face-to-face recertification requirement for hospice care;
    - Telehealth reimbursement parity based on the place of service where the visit would have been performed in person;
    - Incident to billing and direct supervision via telehealth;
    - Removal of the in-person visit requirement for the prescribing of controlled substances through rulemaking by the Drug Enforcement Agency (DEA); and
    - Coverage and payment for audio-only telehealth services.

- **Bolster Rural Capacity.** Rural hospitals play a unique role in preserving patient access to care. Many of the flexibilities provided during the pandemic enabled rural hospitals to keep their doors open and caring for patients — and those flexibilities, if continued, would continue to support these uniquely challenged providers. To support rural capacity, we urge you to adopt a permanent policy of flexibility in bed capacity in rural areas when an emergency requires such action, by proactively holding hospitals harmless for increased bed capacity and

allowing providers to maintain pre-emergency counts for applicable payment programs, designations and other operations.

- **Recognize and Support Distinct Sites of Post-acute Care.** The pandemic has provided valuable insight into the unique role and capabilities of the distinct sites of institutional post-acute care. However, rising costs and workforce shortages, as well as lagging reimbursement has made it difficult for these providers to meet patient care demands. Therefore, HHS should ensure that post-acute care coverage and reimbursement policies, including any effort to reform post-acute care payments, reflect these insights, and preserve robust patient access to long-term care hospitals, rehabilitation hospitals, skilled nursing facilities and home health agencies.

- **Mitigate Coverage Loss.** Comprehensive health care coverage is critical to patient access to care and adequate resourcing of the health care system. Several policies related to the PHE resulted in the lowest rate of uninsured in U.S. history, including expansions of coverage under both Medicaid and the Health Insurance Marketplaces. As we look toward the end of the COVID-19 PHE, certain vulnerable populations are at risk of losing coverage, particularly through the Medicaid redetermination process. While CMS has gone to great lengths to provide resources and assistance to states to ease the process and Congress has provided greater clarity in the timeline and rules, there remain concerns that some individuals could lose coverage during this time. A substantial loss of coverage would both put patient access to care at risk, while also threating the financial viability of the providers who care for them. **We urge the Administration to continue efforts to ensure that the rollback of certain coverage gains made during the PHE do not detrimentally impact those individuals who rely on these programs, including through finalizing policies that ease the transition between Medicaid and the Marketplaces, public messaging campaigns, stakeholder engagement and support to states.**

- **Monitor for Continued Access to Vital COVID-19 Care.** At the expiration of the PHE, coverage of certain COVID-19 care provided at no cost-sharing will expire. In addition, the federal government will no longer procure and provide free of charge vaccines and certain drugs. While we are optimistic that payers will recognize the inherent value of these services and establish appropriate coverage policies, **we urge the Administration to monitor patient access to such services and move swiftly, if necessary, to ensure that payers are adequately covering all medically necessary care.**

- **Extend New COVID-19 Treatments Add-On Payment (NCTAP) and Incorporate the Cost of Care for Treating COVID-19 Patients.** NCTAPs are enhanced payments for eligible inpatient cases that use certain new products to treat COVID-19. Currently, these additional payments will expire in the fiscal

year in which the PHE ends. Hospitals and providers need continued support to help care for patients with COVID-19, and these products remain lifesaving treatments for hospitalized patients. These products include convalescent plasma, remdesivir and PAXLOVID, among others. **We urge the Administration to extend these payments beyond the fiscal year and to carefully evaluate the high cost of care associated with treating COVID-19 patients.**

- **Provide Waiver-related Resource to Assist Providers with Anticipated Audits.** As part of our work preparing for the PHE to sunset, there is some concern that future audits of hospitals and health systems could be mired by confusion or uncertainty around which policies and requirements were waived, when they were waived and for how long. Given this concern, and the potential issues it could raise in the future, we urge the Administration to create and disseminate resources that explain the scope and scale of the waivers and COVID-19-specific policies that were implemented over the course of the pandemic so that hospitals and health systems can use that resource during audits, if necessary.

Supporting the Health Care Workforce

Hospitals and health systems exist and function because of the doctors, nurses, technologists, facilities management specialists and many other professionals who work in them. They cannot take care of patients without these caregivers, and yet, across the country, hospitals continue to report critical shortages of nurses, physicians and other vital health care professionals. Many health care workers are suffering from stress and trauma from the last three years of the pandemic, and we must do more to support the health care workforce. **We urge the Administration to permanently:**

- **Eliminate Specific Nurse Practitioner Practice Limitations that Are More Restrictive under CMS Rules than Under State Licensure**. Nurses play some of the most vital roles in our care delivery system, yet we have failed to fully recognize and implement the skillset and expertise of many nurses. Allowing nurses to practice at the top of their license not only can help to alleviate some current workforce challenges, but it also will serve as a strong tool for recruitment and retention.

- **Expand Role of Pathologists and Other Laboratory Personnel.** Allow pathologists and other laboratory personnel to perform certain diagnostic tests and review the results remotely through a secure network to ensure continued patient access to the best possible care. By allowing these individuals to perform their job remotely, CMS will create the opportunity for a more efficient process that provides the same, high-level quality care.

- **Maintain Flexibility in Supervision Requirements of Diagnostic Services by Allowing the Virtual Presence of a Physician through Audio or Video Real-time Communications Technology.** As hospitals and health systems continue to manage challenging bandwidth issues among their workforce, allowing for the increased utilization of technology affords providers the ability to serve more patients while providing the same high-quality care.

- **Allow Extensions to Residency Cap-building Periods.** America's hospitals and health systems have not only had to go to extraordinary lengths to retain current staff, but they also have had to navigate difficulty in recruitment of new staff. The health care workforce pipeline has been a concern for some time, but the COVID-19 pandemic accelerated the scope and scale of those concerns, leaving many providers in a dire situation when it comes to securing staff for the future. To help alleviate some of the immediate pipeline issues, the Administration should continue to allow extensions to residency cap-building periods for new graduate medical education programs. These extensions will not only account for the many COVID-19-related challenges, but will provide longer-term recruitment opportunities, increase resource availability and support program operations.

Removing Unnecessary Administrative and Regulatory Burden

Every day, hospitals and health systems confront the daunting task of complying with a complex set of federal regulatory requirements, many of which have outlasted their relevance. The associated burden contributes to clinician burnout and drives up the cost of delivering care. At the outset of the COVID-19 pandemic, HHS waived many regulatory requirements for hospitals and health systems to ease burdens on the health care system allowing doctors, nurses and other care givers to focus their time and energy on patient needs. In many cases, those waivers demonstrated changes to the Conditions of Participation (CoP), that should be made permanent. To advance efforts towards appropriate burden reduction and regulatory relief, we encourage the Administration to take the following steps.

- **Revise and Simplify Discharge Planning Requirements.** The pandemic required significant action to simplify regulatory requirements to ensure providers could focus as much time as possible on patient care. The scaling back of discharge planning requirements was one of the most critical reductions in regulatory burden during our response to COVID-19. However, the benefits associated with these scaled back requirements also have demonstrated their need for revision. The current requirements overwhelm both patients and providers by requiring the providers to share information that is overly complicated and often not germane to a patient's specific situation. Rather than reinstitute this practice, we should take advantage of the opportunity to rethink what information is necessary and more useful for patients as part of the discharge planning process. We urge the Administration to continue with the

scaled back version of discharge planning while focusing on releasing updated requirements in the near future. Those revisions should place an emphasis on patients, the information that is most meaningful for them, and providing that information in an easy-to-understand, clear and concise manner as they leave the hospital.

- **Permanently Permit Verbal Orders.** Verbal orders provide a level of timeliness and efficiency not afforded by written orders, while also demonstrating the ability to reduce errors that may not be as easily corrected when using written orders. While preference around the type of order employed and when should remain the decision of the organization and its health care workers, the option to choose one should be available to providers.

- **Continue Flexibility in Patient Assessment Timelines.** Continue to provide flexibility on timeframes related to pre- and post-admission patient assessment and evaluation criteria to ensure patients are treated in a timely manner and allow hospitals to better manage an influx of non-COVID-19 patients returning for care. While this current waiver does not need to be made permanent, it provides necessary flexibility for clinicians so that they can focus their time more efficiently and effectively on the current influx of increased patient care needs.

- **Streamline Public Health Data Reporting.** Hospitals and health systems support the collection and reporting of data that meaningfully informs decisions related to the nation's health and well-being. However, the approach to collecting COVID-19 data exposed myriad challenges, including unrealistically burdensome requests during a time when all available personnel were responding to an emerging situation on the ground, as well as excessively punitive consequences for failure to report. Some of these data reporting requirements persist and the end of the PHE marks an appropriate time to rethink our PHE data collection strategy. **To that end, we recommend the following actions to improve the current data collection and reporting requirements to focus on value and quality of the data over quantity:**
    - Let the COVID-19 data reporting CoP expire at the end of the PHE and re-establish HHS' voluntary mechanism to collect COVID-19-related data;
    - Partner with hospitals and health systems to focus and streamline the number of requested data elements and take steps to reduce the frequency of the reporting;
    - Provide a rationale that justifies the value of and projected use for the collection of specific data and seek input from hospitals and health systems on the meaningfulness of that perceived value; and
    - Act, in collaboration with necessary stakeholders, to build out a national data infrastructure capable of sharing important public health information between providers and federal and state agencies.

Ensuring Proper Regulatory Requirements and Emergency Preparedness

There is a clear and necessary opportunity for HHS to place a renewed focus on establishing a regulatory framework that ensures patient safety, while taking steps to reduce unnecessary burden and refocus on the future of health care delivery. The issues we suggest are meant to build on that which we have learned from the COVID-19 pandemic to ensure America's hospitals and health systems can dedicate more time to patient care, while also preparing providers for the challenges that lay ahead.

- **Establish Routine Review and Updating of Regulatory Requirements.** While the pandemic accelerated certain changes within the health care system, the reality is that care delivery is evolving at a rapid pace. One key learning from the pandemic is the need to routinely and systematically review the regulatory framework and eliminate outdated, unnecessary or duplicative requirements. For example, as hospitals and health systems make decisions about the future of their facilities, they often find that local or state code regulations conflict with outdated CMS life safety codes. These conflicts stifle innovation and prevent hospitals from making investments in the most up-to-date construction and building advancements by forcing compliance with federal LSC requirements that have failed to adapt to the changes around them. Further, the Inflation Reduction Act (IRA) presents a great deal of opportunity for hospitals and health systems seeking to invest in cleaner, newer energy technologies, like microgrids; however, outdated LSCs are putting providers in a difficult position where opportunity to invest in cleaner, more reliable energy exists, but it is outweighed by the potential for regulatory noncompliance. **To alleviate these constraints and ensure a coordinated approach moving forward, the Administration should establish a routine rulemaking process to be undertaken every three years with the goal of determining which LSCs should be updated or eliminated to mirror code updates across the country.**

- **Update HHS' Emergency Preparedness Playbook.** COVID-19 demonstrated the need for significant changes to emergency preparedness processes and procedures across the health care sector. Currently, emergency preparedness CoPs exist for hospitals and health systems, but COVID-19 demonstrated that the current emergency preparedness framework for our national health care delivery infrastructure is insufficient for effectively responding to a national public emergency of this scale.

  In general, the national emergency preparedness plan anticipates emergencies of limited size and duration, such as a hurricane, earthquake or mass casualty event in a community. Similarly, many hospital plans and drills were built around responding to such scenarios. While such emergencies are far more common than nationwide emergencies, the challenges of a broader, longer-lasting emergency such as the pandemic necessitate planning for and practicing responses to such events. Most importantly, broad-scale emergencies and long duration emergencies require connections and collaborations that far exceed those used in a more localized, time-limited emergency. That collaboration

creates and fosters the opportunity to use the strengths of health care systems and the experiences of practitioners on the front line of the emergency to inform other clinicians across the country in ways that would not be needed in a more localized emergency. Further, national emergencies have unique challenges, such as discordant decisions about the right approaches to safeguarding citizens, uneven distribution of life-saving resources and expertise, lack of clarity around who oversees what aspect of care and a more significant drain on available resources. CMS' requirements for hospitals and other sites of care need to be rethought and modernized to emphasize the need for better planning, better coordination and better collaboration among care delivery sites.

It also is likely that HHS' own plans for responding to a national emergency need to be rethought and better coordinated with partners not only at the state-level, but also with the organizations that will be key to an effective national response, including hospitals. For example, the Administration for Strategic Preparedness and Response's Strategic National Stockpile was not designed to provide sufficient backup during an event like the COVID-19 PHE; the Center for Disease Control and Prevention's plans for managing the distribution of information and critical supplies, like vaccines and therapeutics, only extended to the point of distributing the vital resources to the state but failed to follow-through to the point of ensuring safe administration to intended recipients; and opportunities for clinicians to get their critical questions answered in the first year of the pandemic were quite limited until CMS stepped up to provide frequent mass calls. **These issues and others require serious thought and attention, and we encourage the Administration to consider and address them in HHS' updated emergency preparedness playbook.**

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Attachment B: Recommendations for Congressional Action

While the Administration has tremendous ability to make advancements in federal policy and programs to effectively transition the health care system out of the PHE, we recognize that there are some areas where Congress must provide new authority. We encourage the Administration to work with Congress in the following ways in pursuit of our vision for a more effective, equitable, patient-centered and stable health care system.

- **Expand Access to Care via Telehealth.** As previously noted, the expanded use of telehealth has been a fundamental catalyst of positive health care system transformation during the PHE, enabling providers to safely expand access to care and provide high-quality care more conveniently for patients. In addition to the recommendations for changes under the Administration's purview, we encourage you to work with Congress on changes in law that would further support hospitals' and health systems' ability to improve access using these technologies.
    - **Enable Coverage of Telehealth Services No Matter the Patient's Location.** Under current Medicare law, under most circumstances, patients cannot receive services via telehealth unless they are physically located in a specific location, e.g., a physician's office and in a rural area. These provisions have always been significant limiting factors for providers' ability to use telehealth to expand access to care. The waiver of geographic and patient site restrictions during the pandemic enabled the health care system to demonstrate the utility, safety and convenience for patients of receiving telehealth services in other sites, including their home, and in both urban and rural locations. We urge Congress to enable the originating site to be any site at which the patient is located, including the patient's home.

    - **Continue the Ability for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to Furnish Telehealth Services.** Historically, restrictions have been made on allowed distant sites (the locations where providers administering telehealth could be located). Since part of the benefit of telehealth is the ability to connect patient demand with provider capacity, restricting the sites for providers to administer services can negatively impact access and, in some cases, reduce patients' abilities to connect with their own providers. We support

allowing RHCs and FQHCs to serve as distant sites, so that these facilities may use the providers at their own sites to offer care to patients, ensuring patients remain connected to their primary providers.

- **Repeal the Six-month In-person Requirement for Mental Health Services Furnished through Telehealth, including the In-person Requirements for FQHCs and RHCs.** The Consolidated Appropriations Act of 2021 requires that a patient must receive an in-person evaluation six months before they can initiate behavioral telehealth treatment and must have an in-person visit annually thereafter. However, this requirement may, in fact, adversely impact access, quality and cost for behavioral health services. While some patients may benefit from a periodic in-person evaluation, it should be left to clinical judgment rather than an arbitrary general requirement. We recommend repealing the in-person visit requirements for behavioral telehealth services.

- **Expand Practitioners Eligible to Furnish Telehealth Services to include Occupational Therapist, Physical Therapist, Speech-language Pathologist and Audiologist.** Historically, Section 1834 of the Social Security Act limited the types of providers who were able to administer telehealth services; during the pandemic, the list was expanded to include additional provider types like rehabilitation therapists which improved access to services. Given the improved access and high levels of satisfaction we encourage permanent expansion of eligible provider types able to perform telehealth services.

- **Bolster Rural Capacity.** In addition to our previous recommendations, we encourage the Administration to work with Congress to:
  - Permanently remove the 96-hour physician certification requirement for Critical Access Hospitals (CAHs), which would allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours. Enforcement of this requirement has resulted in CAHs either refusing care, forgoing payment or being forced into an unnecessary and expensive transfer of a patient to a larger facility; and
  - Eliminate the 96-hour annual average length of stay (LOS) given ongoing capacity issues at CAHs and the critical role they play in providing care in rural communities. Patients who can be safely and effectively treated and require more than a 96-hour stay in their local hospital should be afforded the option of receiving care closer to their homes, families and usual doctors.

- **Establish a Permanent Hospital-at-Home Program.** Like the expansion of telehealth services, hospital-at-home programs across the country served as a critical mechanism in expanding hospital capacity while limiting risk of exposure to COVID-19. These programs have demonstrated high-levels of patient

satisfaction, strong health care workforce buy-in and engagement and opportunities to provide care that is better informed by the patient's home environment. In addition, hospital-at-home patients frequently experienced decreased recovery times and fewer adverse events related to the care they received. The CoP waivers allowing for hospital-at-home programs to operate was extended for two years in the Consolidated Appropriations Act of 2023, but additional action will be necessary to secure the program's long-term permanency and demonstrate investment and confidence in new care delivery models for the future. **We urge the Administration to work with Congress to develop and establish a permanent hospital-at-home program.**

- **Support Hospitals' Ability to Discharge Patients.** One of the most significant challenges facing hospitals is the inability to move patients ready for discharge to the next appropriate site of care. The average length-of-stay for patients being discharged to post-acute care providers has increased nearly 24% from 2019 to 2022. This remains true even after accounting for patients being sicker and requiring more complex and intensive care now as compared to pre-pandemic levels. Delays in discharge can negatively impact patients' health outcomes or slow their recovery by forcing them to stay in the hospital longer than medically necessary. They also put additional pressure on an already overwhelmed workforce and strain hospital resources as hospitals are not reimbursed for the costs of caring for patients being boarded in hospitals. **As such, we urge the Administration to work with Congress on the following two policies.**

    - **Give CMS Authority to Waive Prior Authorization Requirements during PHEs.** During the PHE, providers' ability to access timely care for their patients was often severely curtailed by health plan utilization management rules, especially prior authorization. This not only delayed critical patient care, but it also hampered hospitals' ability to free up inpatient capacity for the influx of patients who desperately needed care. While the Administration encouraged Medicare Advantage (MA) plans to ease their use of these rules to facilitate access, they lacked the authority to require it. As we look toward the future, we encourage Congress to give CMS the tools it needs to respond effectively and comprehensively. **We therefore urge Congress to provide CMS with the authority to suspend MA plan prior authorization processes during times of declared emergency.**

    - **Ensure Medicare Coverage for Excess Patient Days and Support for Post-acute Care Providers.** Medicare generally pays for an inpatient's hospital stay by one fixed amount based on their diagnosis and severity, regardless of how long they are in the hospital. As a result, hospitals are incurring more costs to care for sicker patients for longer periods of time, while facing reimbursement levels that fall short of these higher costs. **We urge Congress to establish a temporary per diem Medicare payment**

targeted to hospitals to ease capacity issues. Per diem payments should be made for inpatient cases identified and assigned with a specific discharge code that fall under such type of long stays where the patient is documented to be ready for discharge but is unable to be discharged appropriately. **Similarly, we urge Congress and the Administration to ensure they provide additional resources to post-acute care providers to allow them to continue to ensure patient access to high-quality care.**

Attachment C: Summary Chart of Recommendations

Recommendations for Administrative Action		
Goal	**Recommendation**	**Status**
Stabilize the Health Care System	1. Permanently authorize expanded coverage of telehealth services, including:	
	• The ability to use telehealth services to meet the face-to-face recertification requirement for hospice care	Authorized by Congress through 2024. HHS has authority to make permanent.
	• Telehealth reimbursement parity based on the place of service where the visit would have been performed in person	Authorized via rulemaking through 2023. HHS has authority to make permanent.
	• Incident to billing and direct supervision via telehealth	Authorized via rulemaking through 2023. HHS has authority to make permanent.
	• Waiver of the in-person visit requirement for the prescribing of controlled substances in certain instances through rulemaking by the DEA	Authorized via waiver that will expire at end of the PHE. DEA has authority to permanently establish via rulemaking circumstances that would result in waiver.
	• Coverage and payment for audio-only telehealth services	HHS has authority to make permanent.
	2. Bolster rural capacity by allowing increased bed capacity in rural areas when an emergency requires such action.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	3. Recognize and support distinct sites of post-acute care.	New action. HHS has authority to act.
	4. Extend New COVID-19 Treatments Add-On Payment (NCTAP) and incorporate the cost of care for treating COVID-19 patients.	Set to expire in the fiscal year in which the PHE ends. HHS has authority to extend.
	5. Mitigate coverage losses by adopting policies to streamline the transition from Medicaid to the Marketplaces, undertaking consumer education and public messaging, and supporting states.	Administration can act through existing authority.
	6. Monitor for continued access to vital COVID-19 care.	HHS oversight authority generally exists but may

		require Congress to authorize new coverage.
	7. Provide waiver-related resources to assist providers with anticipated audits.	New action. HHS has authority to act.
Support the Health Care Workforce	8. Eliminate nurse practitioner practice limitations that are more restrictive under CMS rules than under state licensure.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	9. Permanently allow pathologists and other laboratory personnel to virtually perform certain diagnostic tests and related services.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	10. Permanently allow provider flexibility in supervision requirements of diagnostic services by allowing the virtual presence of a physician through audio or video real-time communications technology.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	11. Permanently allow extensions to residency cap-building periods.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
Remove Unnecessary Administrative and Regulatory Burden	12. Scale back overly burdensome requirements associated with discharge planning.	Authorized via waiver that will expire at the end of the PHE. HHS has authority to act.
	13. Permanently allow for the use of verbal orders under the CoPs.	Authorized via waiver that will expire at end of the PHE. HHS has authority to act.
	14. Permanently provide flexibility on timeframes related to pre- and post-admission patient assessment and evaluation criteria.	Authorized via waiver that will expire at end of the PHE. HHS has authority to act.
	15. Streamline public health data reporting.	New action. HHS has authority to act.
Ensure Proper Regulatory Requirements and Emergency Preparedness	16. Establish routine review and updating of regulatory requirements.	New action. HHS has authority to act.
	17. Update HHS' emergency playbook.	New action. HHS has authority to act.

Recommendations for Congressional Action	
Recommendation	**Status**
18. Allow the originating site to be any site at which the patient is located, including the patient's home.	Authorized by Congress through 2024. Congress must act to make permanent.
19. Allow FQHCs and RHCs to furnish telehealth services.	Authorized by Congress through 2024. Congress must act to make permanent.
20. Repeal the six-month in-person requirement for mental health services furnished through telehealth, including the in-person requirements for FQHCs and RHCs.	Authorized by Congress through 2024. Congress must act to make permanent.
21. Expand practitioners eligible to furnish telehealth services to include occupational therapist, physical therapist, speech-language pathologist and audiologist.	Authorized via waiver that will expire at the end of PHE. Congress must act to make permanent.
22. Establish a permanent hospital-at-home program.	Authorized by Congress through 2024. Congress must act to make permanent.
23. Expedite the safe discharge of patients to appropriate post-acute sites of care by giving CMS authority to waive MA prior authorization and other utilization management rules during PHEs.	New action. Congress must act to make permanent.
24. Compensate hospitals for days spent boarding Medicare patients who are ready for discharge and provide additional support for post-acute care providers.	New action. Congress must act to make permanent.
25. Permanently remove the 96-hour physician certification requirement for CAHs.	Enforcement deprioritized during PHE. Congress must act to make permanent.
26. Eliminate the 96-hour annual average LOS requirement at CAHs.	Authorized via waiver that will expire at the end of the PHE. Congress must act to make permanent.

Attachment JJ

American Hospital Association™

(https://www.aha.org)

(/)

2023 ANNUAL MEMBERSHIP MEETING

Search

Search this site Search all of AHA

Registration Now Open! (/registration)

Register Now! (https://web.cvent.com/event/84acd480-4e0d-48a2-96b5-73d8c68138dd/summary)

TUESDAY, JUNE 27 & WEDNESDAY, JUNE 28, 2023

Rural Hospital Leadership Conference

Please note Registration will open on the evening of 6/26.

Audience: Rural C-Suite Leaders, Trustees & Commissioners
Location: Campbell's Resort – Chelan, WA
Hotel Block Available Nights: 6/26, 6/27

Please only reserve lodging for the duration of the event you plan to attend. Capacity at Campbell's Resort is very limited. WSHA will be monitoring the reservations to ensure accuracy.

To make hotel reservations: please call 800-553-8225 and reference the group details below. Online reservations are not available for the room block rate.

- Group Block Name – WA St Hospital Association
- Group Block Number – 578020

Please contact Valerie Aussem (ValerieA@wsha.org) with any questions.

Attachment LL

American Hospital Association®

Advancing Health in America

2022 National Health Care Governance Survey Report

AHA Trustee Services

TABLE OF CONTENTS

Contact: trustees@aha.org

EXECUTIVE SUMMARY

Periodically since 2005, the American Hospital Association (AHA) has surveyed the nation's hospitals and health systems to develop a comprehensive picture of the state of health care governance structures and practices in the United States. Consistent with trends in a health care field that continues to undergo substantial transformation, the AHA's 2022 National Health Care Governance Survey report describes board structures, practices and focus areas that are continuing to evolve in the changing environment.

AHA collected survey data from 933 hospital and health system CEOs between November 2021 and March 2022. To provide a deeper longitudinal view, the survey gathered data on a variety of questions about board membership, structure and practices. Similar to the AHA's 2018 and 2014 surveys, the 2022 survey also examined findings across all respondents and by system, system subsidiary hospital and freestanding hospital boards.

New questions in the 2022 report delved into aspects of diversity, equity and inclusion as well as board practices during the COVID-19 pandemic.

To help boards and executives put the results into perspective, the 2022 report provides commentary on survey findings from an array of governance experts as well as sets of discussion questions to help boards reflect on survey findings in the context of their own structure and practices.

To help readers better understand the survey results and their implications for board work, this report is divided into nine sections:

- **Survey Methodology**, which describes survey design and process.
- **Board Composition**, which addresses board size, member voting status, emeritus board members and outside board members.
- **Board Diversity**, which describes the make-up of boards across the dimensions of diversity including race/ethnicity, gender, age, among others.
- **Board Structure**, including term limits and term length, board compensation, board committees, and board restructuring and support.
- **Board Selection**, which describes board member competencies, board member replacement and effort required to recruit board members.
- **Board Orientation and Education**, which addresses position descriptions, orientation and education practices.
- **Board Evaluation**, including assessment types and focus, use of assessment results and board member evaluation criteria.
- **Performance Oversight**, which focuses on executive oversight, accountability and organizational performance.
- **Board Culture**, which addresses board meetings, executive sessions and time commitment for board work.

Positive trends indicated by report findings include:

- Some progress in racial/ethnic diversity and gender diversity on boards.
- 91% of respondents said they are interested in identifying and engaging board candidates who represent diverse characteristics.
- Nearly 70% of all responding boards have engaged in restructuring efforts to improve their governance.
- The use of knowledge, skills and behavioral competencies to select board members has steadily increased in the past decade. This is considered a governance best practice.
- The use of a board portal, considered a governance best practice, has become more prevalent.

However, there are opportunities for improvement:

- A third of respondents did not use term limits.
- Survey results indicated a growing number of older board members and a declining number of younger members.
- More than 75% either did not replace board members during their terms or continued to reappoint them when eligible during the past three years, resulting in low levels of board turnover.
- 61% said they do not have a board member continuing education requirement.
- More than a quarter of boards did not do any type of assessment in the past three years.
- About half of all boards do not hold the CEO accountable for diversity, equity and inclusion goals as part of their performance review.

Boards and executives reflecting on the results of the 2022 survey can gain useful insights by comparing their own structures and practices with survey report findings and evaluating where they are rising to meeting the modern challenges of governing and what opportunities exist to improve their own performance and practices.

AHA extends its appreciation to the governance consultants who provided commentary to this report.

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

SECTION 1

Survey Methodology

The American Hospital Association (AHA) developed the 2022 national health care governance survey. It builds on the results of previous national governance surveys conducted by the AHA in 2005, 2011, 2014 and 2018.

The current survey instrument, designed for completion by hospital and health system chief executive officers (CEOs), was sent via electronic mail to the CEOs of 5,232 nonfederal community hospitals and health systems in the U.S. Specialty hospitals, such as eye-and-ear and psychiatric hospitals, were not included.

Survey responses were collected between November 2021 and March 2022. A total of 933 CEOs responded to the survey (a 17.8% response rate). Overall, the respondents were generally representative of hospital bed size and geographic distribution in the U.S. (Figure 1.1). Not-for-profit organizations were somewhat overrepresented and investor-owned organizations were underrepresented in the survey results.

Figure 1.1 Survey Respondents Compared to All Hospitals

	Responders	Universe
Ownership		
Public	26%	20%
Not for profit	67%	56%
Investor owned	10%	24%
Total	100%	100%

	Responders	Universe
System		
System	61%	67%
Non-System	39%	33%
Total	100%	100%

Location		
Urban	60%	66%
Rural	40%	34%
Total	100%	100%

Region		
Territories	1%	1%
Midwest	31%	28%
Northeast	16%	12%
South	28%	40%
West	24%	19%
Total	100%	100%

Bed size		
< 100	54%	57%
100 - 299	35%	34%
> 299	11%	9%
Total	100%	100%

SECTION 2

Board Composition

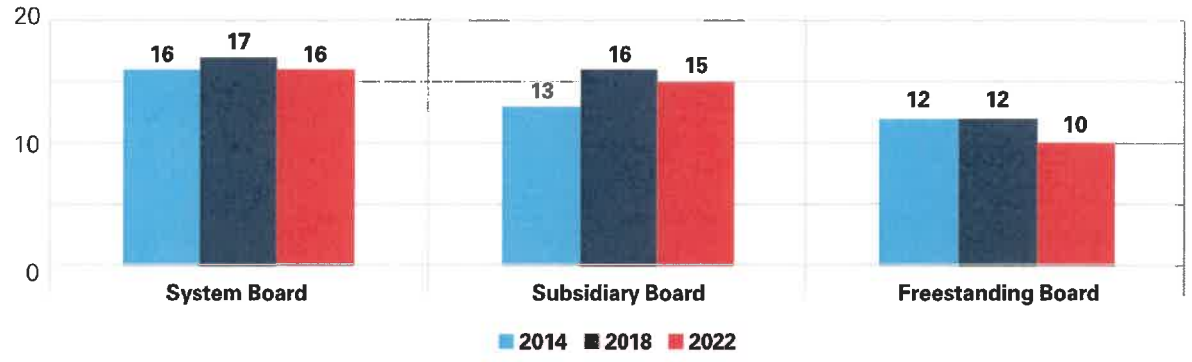
Data Points

Data from the AHA 2022 national health care governance survey indicate a decrease in board size. Boards report that more non-employed physicians have voting privileges than employed physicians. The percentage of system boards that include the CEO as a voting member has significantly increased. Inclusion of board members from outside the organization's service area has also increased.

Board Size

- In 2022, the average board size overall was 13 members, compared to 14 in 2018 and 13 in 2014 (Figure 2.1).
- The average size of all boards was smaller in 2022 than in 2018 (Figure 2.1) with freestanding hospital boards reporting the greatest change in size, averaging 10 members in 2022 and 12 members in 2018 (Figure 2.1).
- A subsidiary board is a hospital board within a health system that may or may not have fiduciary responsibilities..

Figure 2.1 Board Size

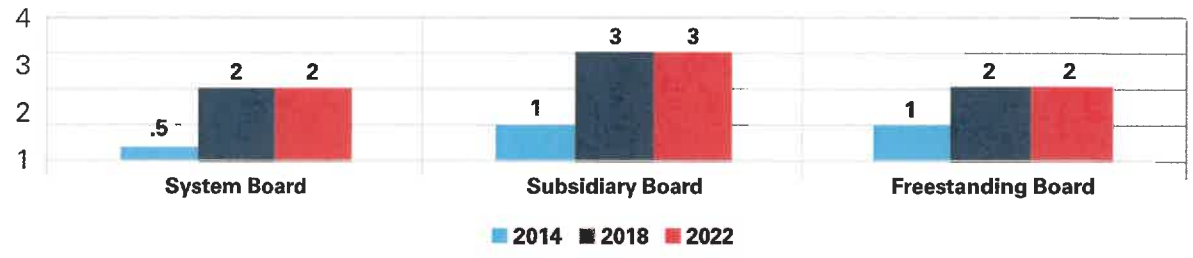


2022 Average all respondents = 13
2018 Average all respondents = 14
2014 Average all respondents = 13

Member Voting Status

- The average number of nonvoting members across all boards remained the same in 2022 as compared to 2018 with two nonvoting members for system boards, three nonvoting members of system subsidiary hospital boards, and two nonvoting members for freestanding hospital boards (Figure 2.2).

Figure 2.2 Average Numbers of Nonvoting Board Members



2022 Average all respondents = 2
2018 Average all respondents = 2
2014 Average all respondents = 1

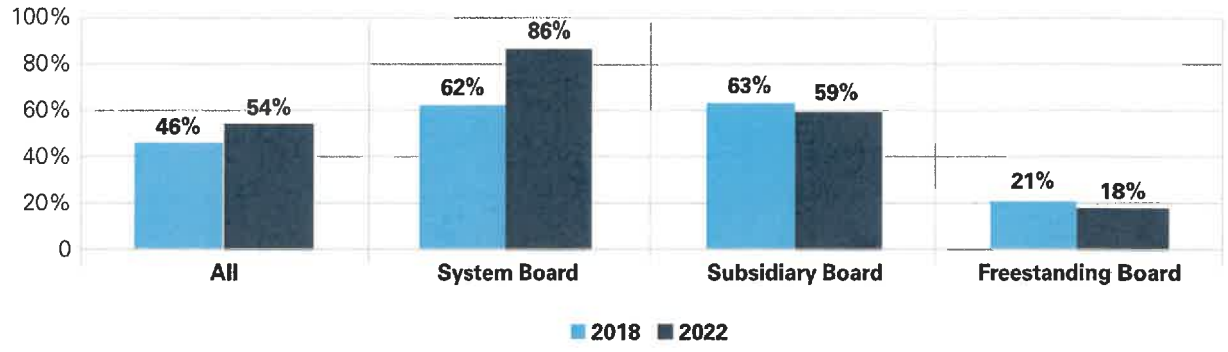
- On boards with physician members, respondents reported that on average, a higher number of physician board members *not* employed by the hospital or system had voting privileges than those who were employed. On average, system subsidiary hospital boards reported that more employed physician board members had voting privileges than those that did not (Figure 2.3).

Figure 2.3 Employment and Voting Status of Physician Board Members

Average number of physician board members ...	All	System Board	Subsidiary Board	Freestanding Board
Employed by your hospital/system a. Voting	1	1	2	1
Employed by your hospital/system b. Non - Voting	1	2	1	0
Not employed by your hospital/system a. Voting	3	2	2	3
Not employed by your hospital/system b. Non - Voting	0	0	1	0

- In 2022, 86% of system boards reported that their CEO was a voting member of the board compared to 2018 (62%), a significant increase. By contrast, system subsidiary boards and freestanding hospital boards reported a decline in the percentage of CEOs having voting status at 59% and 18%, respectively (Figure 2.4).

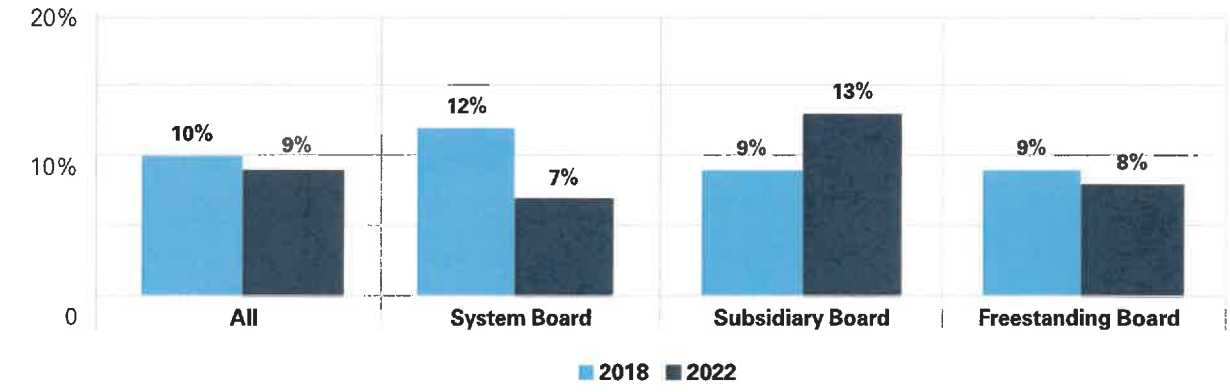
Figure 2.4 CEO as a Voting Board Member



Emeritus Board Members

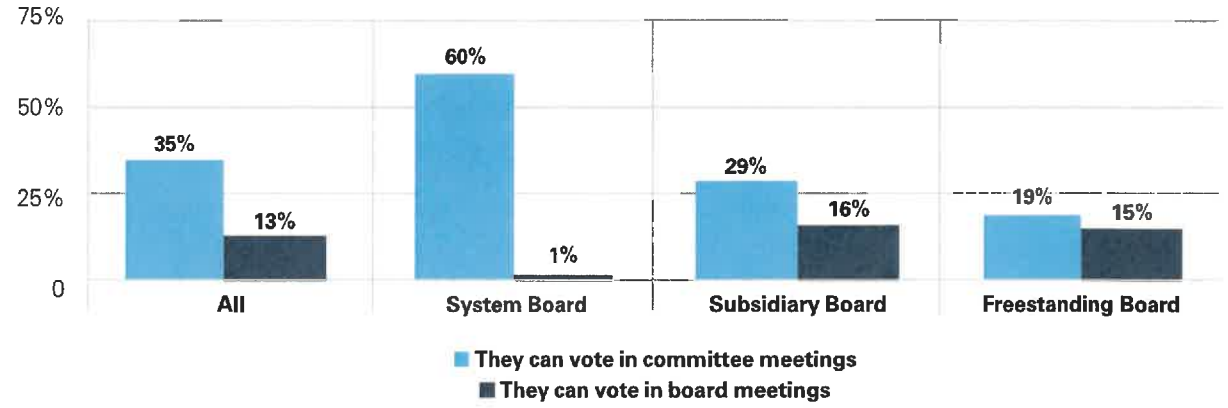
- As shown in Figure 2.5, system boards reported having fewer emeritus members in 2022 (7%) as compared to 2018 (12%). By contrast, system subsidiary hospital boards reported having more emeritus members in 2022 (13%) as compared to 2018 (9%).

Figure 2.5 Emeritus Member Voting Status



- Of those overall respondents who included emeritus members, 48% said they are able to vote in board and/or committee meetings (Figure 2.6).

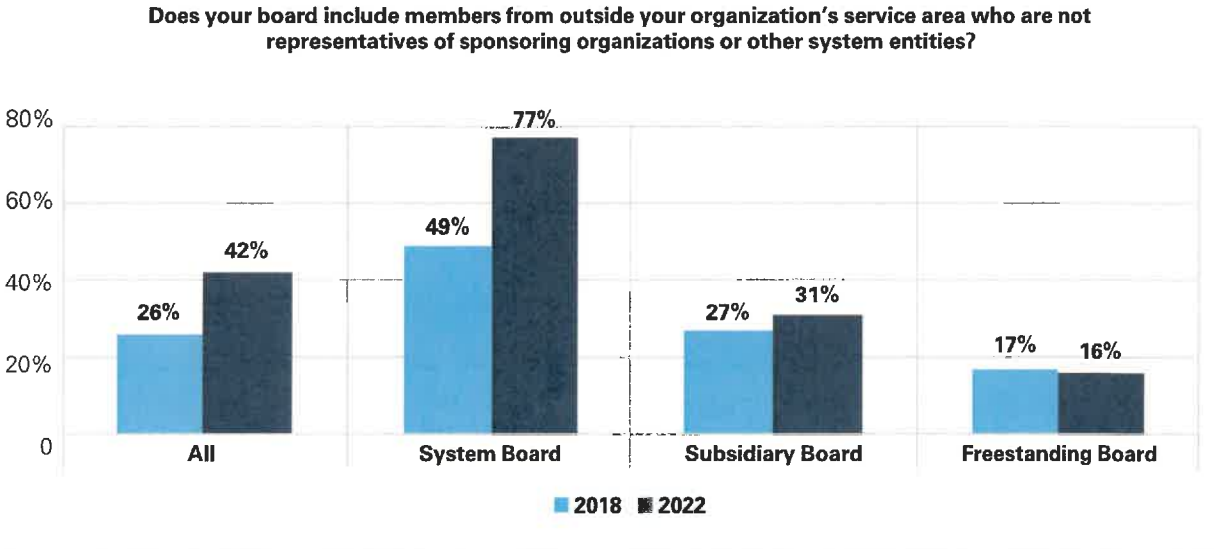
Figure 2.6 Emeritus Member Voting Status



Outside Board Members

- Overall, the percentage of respondents reporting having outside board members (those from outside the service area who are not from sponsoring organizations or other system entities) increased from 26% in 2018 to 42% in 2022 (Figure 2.7).
- More than three-fourths of system boards (77%) reporting having outside board members. Only 16% of freestanding hospital boards reported having outside board members (Figure 2.7).

Figure 2.7 Outside Board Members



Commentary on Board Composition

By Pamela R. Knecht, (pknecht@accordlimited.com), president & CEO, ACCORD LIMITED

Introduction

The size and composition of the board are critical success factors for effective and efficient governance. Boards must be small enough to encourage robust, candid discussions that engage all members. And smaller boards can often make more timely decisions in these complex times.

With fewer available seats, every board seat counts, so advanced boards are revisiting their approach to board composition. They are evolving from using a representational approach to utilizing a competency-based approach to board composition. This practice decreases conflicts of interest and increases the expertise and objectivity of the board.

In addition, the best boards ensure all members are on equal footing. To do that, they eliminate nonvoting members, change the voting status of emeritus members, and add their CEO as a voting member.

As a result, everyone in the boardroom can function as equally important partners in decision-making about how best to serve their communities.

Fortunately, the survey data show positive movement in all these key areas of board effectiveness.

Observations about Survey Findings

Too often, boards are too large and as a result, it is difficult for all members to contribute to important deliberations. Therefore, the survey findings about board size are encouraging. All types of boards have decreased in size and the average board size is now 13 (down from 14 in 2018). Freestanding hospital boards report even smaller boards; the average is 10 members. Ten members is a little smaller than most governance consultants recommend for freestanding boards. Perhaps there were more survey respondents from public/governmental hospitals, which typically have smaller boards (e.g., 7-9 members). In general, 11-13 members creates the right balance between being small enough for good engagement yet big enough to include needed competencies and diversity to perform their roles. (Note: There are separate sections in this report with the survey findings on board competencies and diversity.)

Another positive finding is that now 86% of system boards report that their CEO is a voting member of the board (versus 62% in 2018). In today's complex health care environment, CEOs and boards need to partner in understanding the critical issues facing the organization and in making decisions that are in the best interest of all those served. This partnering is easier when the CEO also is a voting board member. Unfortunately, this trend has not continued with subsidiary or freestanding hospital boards. They each reported a decline in the percentage of CEOs with voting status. CEOs are often barred from serving as voting board members in public/governmental hospitals/systems, so perhaps these results reflect a higher percentage of respondents from that type of organization.

A more neutral finding is that the average number of nonvoting board members stayed the same from 2018 to 2022 across all types of boards *(see table 1.3 for the details)*. This could be interpreted as good news — at least boards are not increasing the number of nonvoting members. Since boards often become confused about the role of their nonvoting members, it is not a commonly recommended practice today. It is better to have all board members be voting members who have equal voice in discussions and decisions. If the board would like to hear from certain types of people on (e.g., the Chief of the Medical Staff), they could be invited as guests. This practice helps to differentiate and clarify the role and authority of each person in the boardroom.

On a related note, system and freestanding boards reported they did not have any nonvoting, nonemployed physicians serving on their boards. Subsidiary boards replied that only one of their members was in this category. Perhaps in the future, subsidiary boards will follow the other boards in decreasing or retiring this older model of nonvoting board members.

It is important to mention that physicians should be involved in the governance of hospitals and health

systems. The key question is how to do that in appropriate ways, given that most physicians are now employed by those same organizations. Some of the governance-related concerns with physicians on boards and committees are that they are considered 'insiders' by the Internal Revenue Service (therefore not objective) and that they are simultaneously reporting to the CEO (as employees) and overseeing the CEO's performance (in their board capacity).

Another complicating factor is that in the traditional model of governance, physicians served on the board to be representatives of the whole medical staff, their own specialty, or their private practice. All voting board members (including physicians) have a legal, fiduciary duty to the mission, not to any constituency.

The survey results provide additional information on how hospital and system boards are balancing the need for the physician/clinician perspective with the above-mentioned concerns about physicians serving on boards. Across the three types of boards, the preferred approach seems to be having 2-3 *nonemployed, voting* physician board members. It is not clear from the data whether these physicians are on the active medical staff or from outside the service area altogether. Perhaps the next survey can shed light on that key question.

There may be a relationship between the finding about physician board members and another topic addressed by the survey — outside board members. Now, 42% of *all* boards have members from outside their organization's service area (versus only 26% in 2018). And 77% of system boards include outside board members (up from only 49% in 2018).

For instance, boards can 'kill two birds with one stone' if they look outside their service area for physicians or clinicians who have expertise in population health management or clinical integration. These individuals would not have the built-in conflict of interest / lack of independence issues of those on the active medical staff; they may bring ideas about best practices from elsewhere, and they could provide an objective perspective to board discussions.

The last topic in this section focuses on emeritus board members. There was a slight decrease in the percentage of all boards that have emeritus members (now 9%) and a significant decrease in the percentage of system boards with emeritus members (7% down from 12%). Again, the system boards are leading the way for other types of boards. As mentioned earlier, it is better if all board members have the same status — current, voting members. Exceptions for emeritus status adds to the number of people in the room and has the potential to confuse roles. System boards appear to have learned that allowing emeritus members to vote in board meetings is very confusing — only 1% allow that practice.

Other approaches to keeping valued individuals engaged are better. For instance, having a previous board member serve as a voting member of a committee, on the foundation board, or on an advisory council keeps them involved and contributing. It also clarifies roles for all those involved in governance.

In conclusion, the survey results indicate that health care governance is moving in the right direction, often led by system boards. Paying close attention to the board's size and composition results in boards that have the correct number and type of people who are appropriately objective and engaged as partners with the CEO in ensuring achievement of the mission.

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

Discussion Questions on Board Composition

- Does your board's size facilitate engaged participation by all board members?
- In order to ensure equal participation by all, has your board eliminated nonvoting members and emeritus members, and made the CEO a voting member of the board?
- How might your board benefit from the inclusion of outside board members (those from outside the service area who are not from sponsoring organizations or other system entities)?
- What opportunities exist to strengthen your board's composition to better serve your patients and communities?

SECTION 3

Board Diversity

Data Points

Boards report they are becoming more ethnically/racially diverse, a higher percentage of female members and a growing percentage of older members. More boards reported having at least one clinician on their board. Less than half of respondents are undertaking efforts to recruit millennials. Nearly all reported they are interested in recruiting diverse board members, and most indicated that the effort to do so is not difficult.

Board Race/Ethnicity

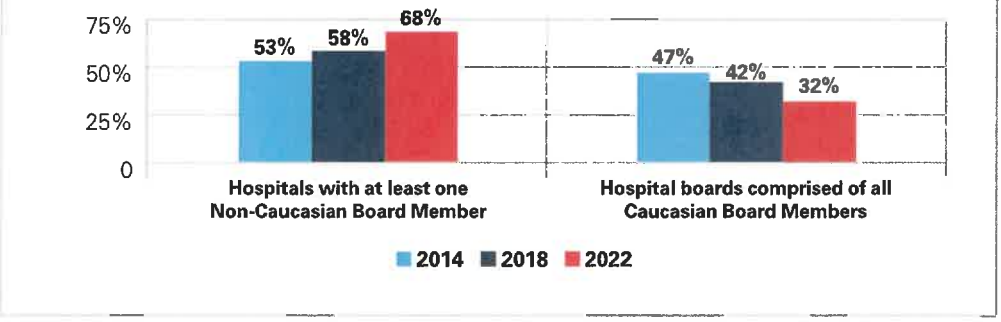
- System boards report the highest level of racial/ethnic diversity, with 26% of their members representing historically underrepresented groups in 2022, compared with 18% of system subsidiary hospital boards and 9% of freestanding hospital boards (Figure 3.1).

Figure 3.1 Voting Board Member Demographics

	All	System Board	Subsidiary Board	Freestanding Board
Race/Ethnicity				
White	80%	74%	82%	87%
Black or African American	10%	15%	7%	5%
Hispanic/Latino	5%	6%	4%	3%
Asian	3%	4%	3%	2%
American Indian or Alaska Native	1%	0%	1%	1%
Native Hawaiian or Pacific Islander	0%	0%	0%	0%
Other	2%	1%	2%	2%
Total	100%	100%	100%	100%
Gender				
Male	64%	63%	65%	65%
Female	36%	37%	35%	35%
Other	0%	0%	0%	0%
Total	100%	100%	100%	100%
Age				
35 or younger	2%	2%	2%	2%
36-50	17%	10%	23%	23%
51-70	63%	66%	62%	60%
71 or older	18%	22%	12%	15%
Total	100%	100%	100%	100%
Clinical Background				
Nurse	19%	16%	20%	21%
Physician	70%	80%	66%	59%
Other Clinician	11%	4%	13%	20%
Total	100%	100%	100%	100%

- Survey data indicate that today's system and hospital boards are becoming more ethnically/racially diverse, with 68% reporting at least one non-Caucasian member in 2022, compared with 58% in 2018 and 53% in 2014 (Figure 3.2).

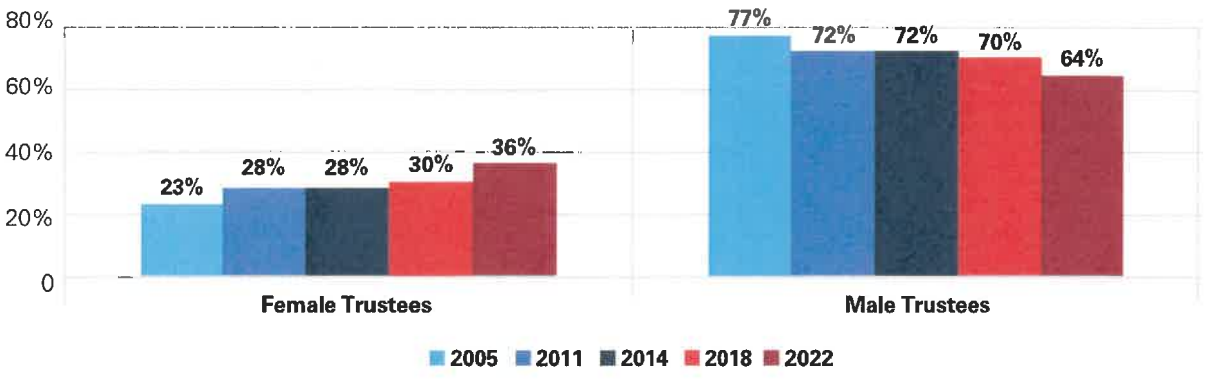
Figure 3.2 Systems and Hospitals with at Least One Non-Caucasian Board Member



Board Gender

- Gender diversity on boards has gradually increased over the past 17 years. In 2022, survey respondents reported 36% of their members were female, compared with 30% in 2018, 28% in 2014 and 2011, and 23% in 2005 (Figure 3.3).

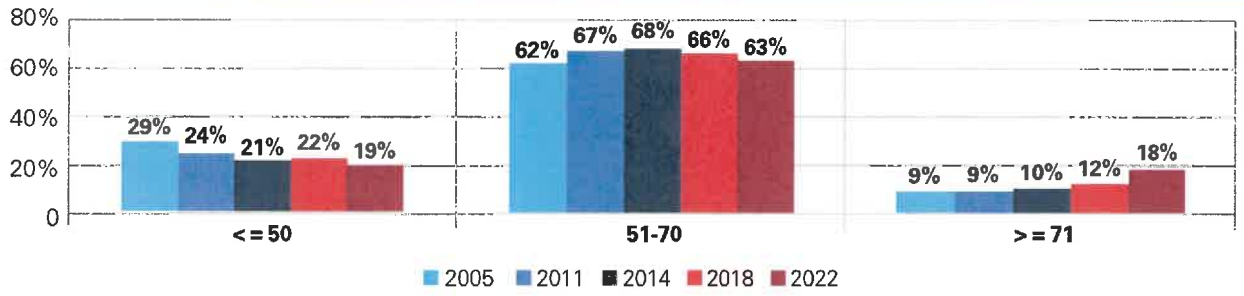
Figure 3.3 Board Gender



Board Age

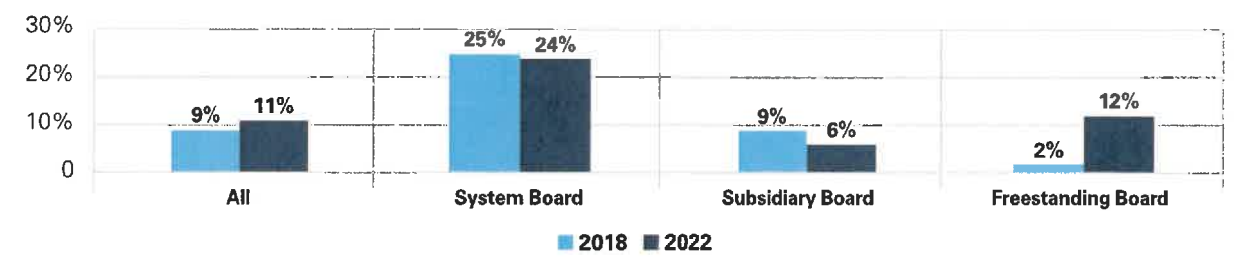
- As shown in Figure 3.4, survey data indicate that the percentage of boards with members age 50 or younger (19%) continued to decline compared to 2018 (22%), 2014 (21%), 2011 (24%) and 2005 (29%).
- In 2022, boards overall had a higher percentage of members age 71 or older (18%) than did boards in 2018 (12%), 2014 (10%), 2011 and 2005 at 9% each (Figure 3.4).

Figure 3.4 Board Age



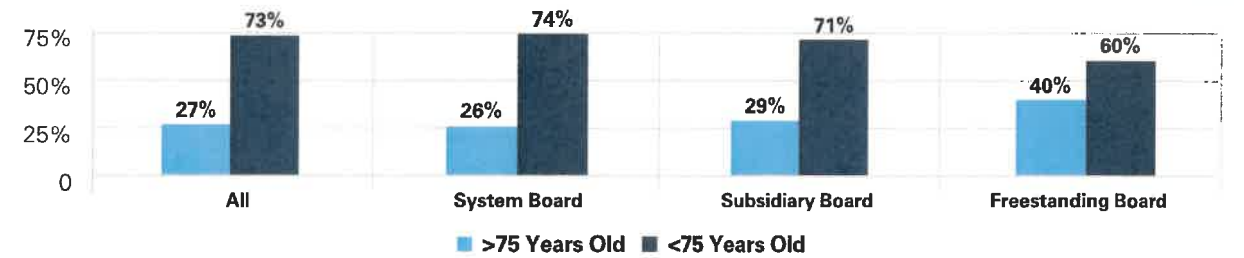
- In 2022, 12% of freestanding hospital boards reported having a board member age limit compared with only 2% in 2018 (Figure 3.5).

Figure 3.5 Board Member Age Limit



- Of those 2022 respondents overall that reported having an age limit, the majority (73%) indicated a maximum age of less than 75 years for board members (Figure 3.6).

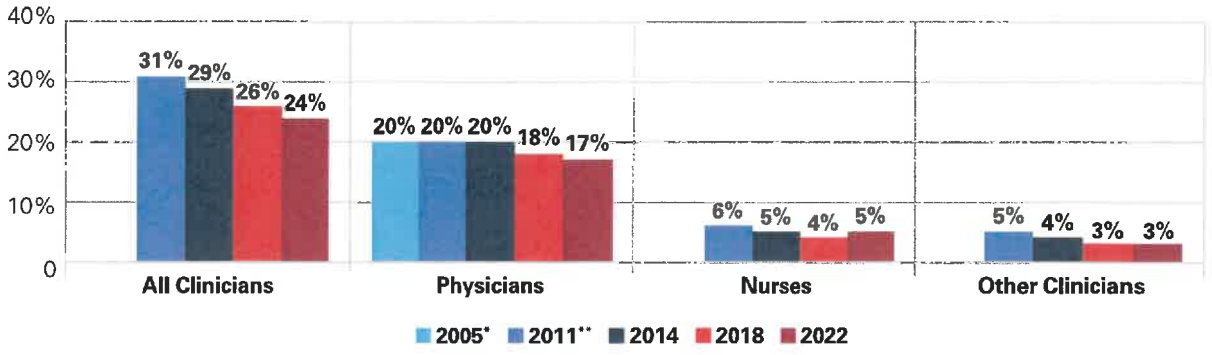
Figure 3.6 Maximum Age for Board Members



Clinician Board Members

- 2022 survey data show the percentage of board members who are clinicians continues to decline overall across most categories (physicians and other clinicians). There was a slight increase in the percentage of nurses on boards, up to 5% in 2022 as compared to 4% in 2018 (Figure 3.7).

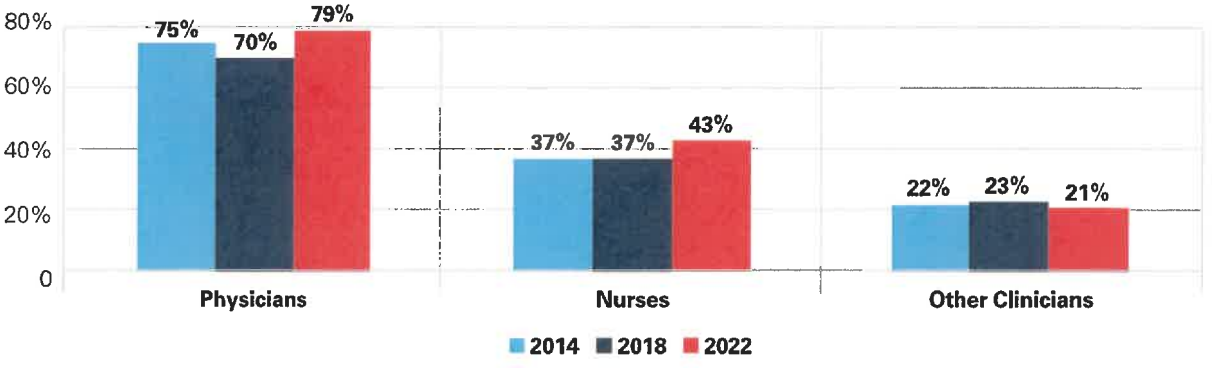
Figure 3.7 Clinician Board Membership



* The only data available in 2005 was for physicians
** 2011 was the first survey to ask about clinicians other than physicians

- A higher percentage of hospitals and systems (79%) reported having at least one physician board member in 2022, compared with 70% in 2018. Similarly, more respondents had at least one nurse on their board (43%), compared to 37% in 2018 (Figure 3.8).

Figure 3.8 Percentage of Hospitals with Clinician Board Members



- Overall in 2022, all board types increased the percentage of nurses on their boards. System subsidiary hospital boards and freestanding hospital boards reported fewer percentages of physician members in 2022 than in 2018 (Figure 3.9).

Figure 3.9 Board Composition by Board Type by Year

	System Board			Subsidiary Board			Freestanding Board		
	2014	2018	2022	2014	2018	2022	2014	2018	2022
Race/Ethnicity									
White	86%	83%	74%	86%	85%	82%	90%	91%	87%
Black or African American	7%	9%	15%	6%	6%	7%	4%	4%	5%
Hispanic/Latino	3%	4%	6%	3%	4%	4%	3%	2%	3%
Asian	2%	2%	4%	2%	2%	3%	1%	1%	2%
American Indian or Alaska Native	1%	0%	0%	0%	1%	1%	1%	1%	1%
Native Hawaiian or Pacific Islander	N/A	N/A	0%	N/A	N/A	0%	N/A	N/A	0%
Other	1%	2%	1%	4%	2%	2%	1%	1%	2%
Gender									
Male	76%	72%	63%	69%	70%	65%	72%	70%	65%
Female	24%	28%	37%	31%	30%	35%	28%	30%	35%
Other	N/A	0%	0%	N/A	0%	0%	N/A	0%	0%
Age									
35 or younger	N/A	2%	2%	N/A	2%	2%	N/A	3%	2%
36-50	12%	14%	10%	19%	22%	23%	17%	22%	23%
51-70	81%	73%	66%	70%	64%	62%	63%	62%	60%
71 or older	7%	11%	22%	11%	12%	12%	20%	13%	15%
Clinical Background									
Nurse	4%	13%	16%	6%	18%	20%	4%	17%	21%
Physician	26%	78%	80%	22%	73%	66%	17%	65%	59%
Other Clinician	2%	10%	4%	3%	9%	13%	5%	18%	20%

Diversity Recruitment

- As shown in Figure 3.10, more than half of all respondents (58%) reported that they had not undertaken efforts to engage millennials (individuals born between 1981 and 1996) in governance. System boards reported the greatest efforts to engage millennials (54%) as compared to system subsidiary hospital boards (39%) and freestanding hospital boards (31%).

Figure 3.10 Efforts to Engage Millennials in Governance

What efforts, if any, has your board/organizations undertaken to engage Millennials (individuals between the ages of 21-35) in governance?

	All	System Board	Subsidiary Board	Freestanding Board
Established a Millennial Council that can help identify potential board candidates	1%	1%	3%	1%
Specifically targeted Millennials when seeking new board members	26%	31%	22%	22%
Included Millennials as outside (non-board) members on board committees	10%	31%	13%	7%
Other	10%	10%	7%	5%
None of the above	58%	46%	61%	69%

- Overall, 88% of 2022 survey respondents reported that recruiting diverse members (age, race, gender, ethnicity, skill set on the board) required little to moderate effort (Figure 3.11).

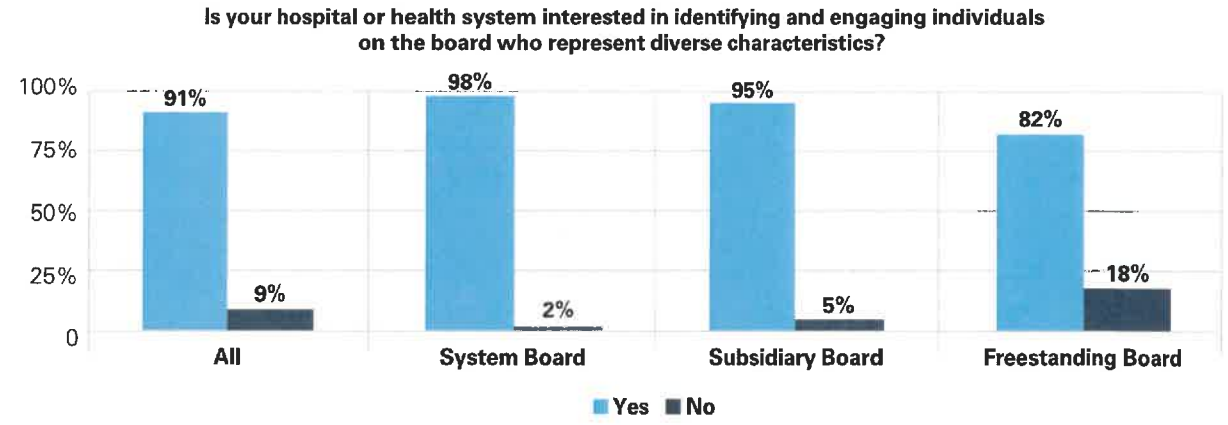
Figure 3.11 Effort Required to Recruit Diverse Board Members

On a scale of 1 - 5, how much effort is required to recruit diverse members (age, race, gender, ethnicity, skill set) on your board?

	All	System Board	Subsidiary Board	Freestanding Board
5 - extreme effort	6%	1%	8%	11%
4	6%	2%	5%	9%
3	31%	36%	28%	27%
2	31%	31%	34%	28%
1 - little effort	26%	30%	24%	25%

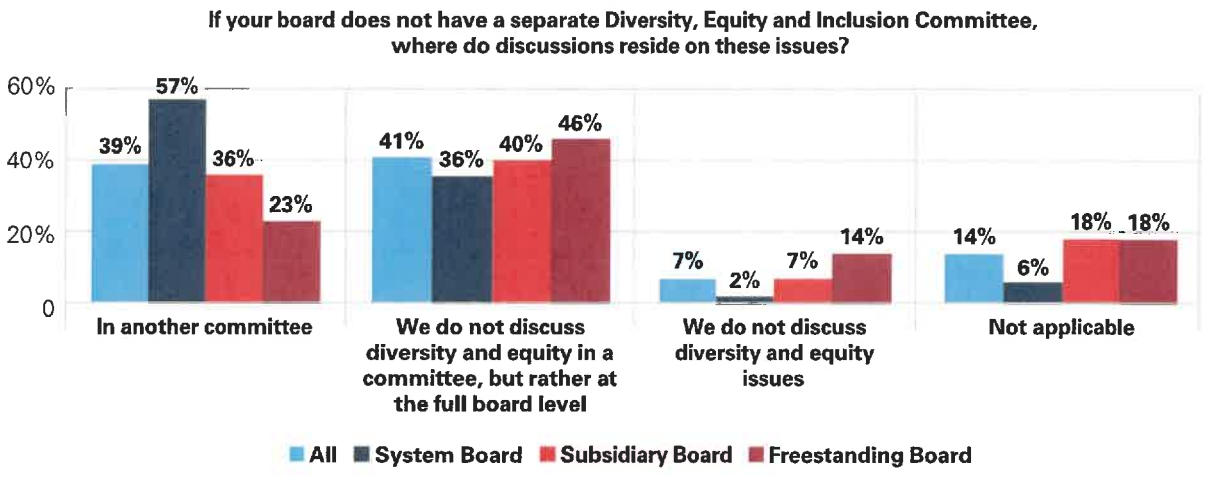
- Nearly all (91%) of 2022 survey respondents reported that they were interested in identifying and engaging individuals on the board who represent diverse characteristics (Figure 3.12).

Figure 3.12 Interest in Identifying and Engaging Diverse Board Members



More system subsidiary hospital boards (40%) and freestanding hospital boards (46%) reported that they discuss diversity, equity and inclusion (DEI) at the full board level, while system boards reported that these discussions occur in a committee (57%) (Figure 3.13).

Figure 3.13 Governance Discussion of Diversity, Equity and Inclusion



Commentary on Board Diversity

By Karma H. Bass, (kbass@viahcc.com), managing principal, Via Healthcare Consulting

Introduction

Health care organizations are in the midst of a painful and previously unimaginable transformation that necessitates its leadership take new and different approaches to its challenges.

One of these challenges is the lack of diversity among board members. Based on the results of the 2022 AHA Governance Survey, the governing boards of today's hospitals and health systems remain insufficiently diverse to adequately represent the patients and overall communities that our not-for-profit health care organizations serve.

Observations about Survey Findings

No Substantive Progress

A board's good intentions to diversify its membership don't absolve it from the need to achieve greater diversity. While this year's survey results show some changes, they are not enough. At the rate we're going, it will take approximately 20 years before hospital and health system boards accomplish the basic step of equal male/female representation. The racial and ethnic diversity of our boards is even more dismal. Our nation is now 40% comprised of Blacks, Latinos and other people of color. But our freestanding hospital boards are, on average, 9% nonwhite, our subsidiary boards are 18% nonwhite and our system boards are 2% nonwhite.

The important work being done by many health care organizations around diversity, equity and inclusion (DEI) will ring hollow unless an organization's leadership reflects its commitment. A board's diversity (or lack thereof) is a highly visible signal of the organization's true intentions around DEI.

Governance is about leadership, and leadership should be focused on doing the right thing. Making room at the table for people of color, women, millennials, the LGBTQ+ community, people with disabilities and others who have been historically marginalized is where today's boards should be focused. A lack of board diversity is not a minor concern, nor one that should be delegated solely to a committee. Addressing the need for greater diversity should be a focus for the entire board.

What's at stake is considerable. Not taking the time and doing the work to diversify the board could have harmful, long-term ramifications for the entire organization.

What's Not Working and What Is?

How do we make space at the table for other voices and new leaders? If boards are serious about increasing their gender, racial and ethnic diversity, they need to take proactive steps to increase the proportion of board members who represent their communities more closely.

The approaches we've been using to identify, recruit and retain nonwhite and female board members have not been working. The lack of results speaks for itself. I, for one, am not interested in waiting another 20 years to see if continuing to do what we've done will bring different results. If your board is serious about this work, I suggest consulting the many resources gathered by AHA on its Trustee Services page (trustees.aha.org). It is hard work, true, but not an impossible task.

The boards that have made significant strides in achieving diversity were dogged in their pursuit of it. They spent many hours in governance and nominating committee meetings designing transparent and thorough processes for identification and recruitment of qualified candidates from underrepresented groups. They had full-board conversations about work being done on DEI, as well. They made a clear statement of their intent in the form of policies, goals and communications to the organization's leadership. They had frank discussions about the board's current composition and areas of need. They were willing to change their approach or leave a board seat open if they had not found the best candidate.

New Approaches Are Required

Greater diversity will change the way the board does its work, and it should. In fact, boards should

reconsider how they structure their meetings, service requirements, and other ways of doing business to make board service more feasible and inclusive for the historically underrepresented groups of board members. Attracting and retaining the next generation of board members will require such sustained effort and a willingness to try new approaches.

It stands to reason that the current structure favors those who currently tend to serve. There are unintentionally exclusionary practices in the way we do governance now. These include overly frequent, overly lengthy board and committee meetings held during working hours. There is nothing sacred about having monthly board meetings that last an entire weekday afternoon.

In my 25 years of studying boards, I've never seen a correlation between board effectiveness and the number or duration of meetings. Other practices, like the requirement that board members serve on at least two committees, should be reconsidered as well since they may impose an unacceptable time burden to mid-career women, younger board members, or those with greater family, financial, or personal demands on their free time.

Boards need to retool themselves to attract the female and more diverse candidates they seek. The need to attract and retain more diverse and younger board members also should be viewed as an opportunity to reexamine what issues the board focuses on.

Talking about the business of the hospital or health system should no longer be the primary focus of board and committee meetings. The highly qualified professionals running our nation's hospitals do not need volunteer board members checking the math on their operating and financial calculations. They need thought-partners in reimagining the way their community receives its health care and envisioning what a healthy community looks like for them. If discussion at board meetings focus on what really matters for a community's health, it should not be difficult to capture the interest of the next generation of board leaders.

Don't Wait to Be Imposed Upon

Stakeholders of not-for-profit health care include the community, patients, employees, providers, unions, state attorneys general, as well as the local, state and federal government. These stakeholder groups are increasingly expecting accountability from health care organizations. We should expect this will include an evaluation of the board.

The racial, ethnic and gender composition of a board will be a factor these stakeholders consider when making assessments regarding the strength and fitness of the organization's leadership. If we cannot find a path to building more diverse boards — and soon — we should expect that it will be imposed on our hospitals and health systems by external stakeholder groups; with this will come much public castigation of the organizations that have failed to address such a glaringly discordant feature. Having a board of directors that is not representative of the community will be an institutional failing.

More importantly, the longer we wait to build the boards our organizations need and our communities deserve, the longer we will go without the broad range and depth of leadership that our important organizations need during these difficult times.

Bringing more people from marginalized and underrepresented groups to sit on our hospital and health system boards is only the first step. Boards must recognize that the purpose of diversity is transformation that leads to a more equitable, just, and healthy society. Tapping into the newest board members' experience, expertise and wisdom, we must be willing to retool how we practice governance. This may seem like a lot — and it is. But our communities and our patients deserve nothing less.

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

Discussion Questions on Board Diversity

- How does your board's diversity compare with the findings of the AHA's 2022 governance survey? How might similarities and differences between your board and others around the country influence the effectiveness of your organization's governance?
- Has your board had frank conversations about its current composition and areas of need?
- What are your board's quantifiable goals to diversify its membership?
- Does your board chair have access to a targeted orientation manual and/or coaching?
- Has your full board had at least one conversation about your organization's work on DEI? Has the board communicated its intent about DEI in policies, goals and communications to the organization's leadership?
- How could your board restructure current meeting practices and service requirements to make serving on your board more attractive to diverse candidates?

SECTION 4

Board Structure

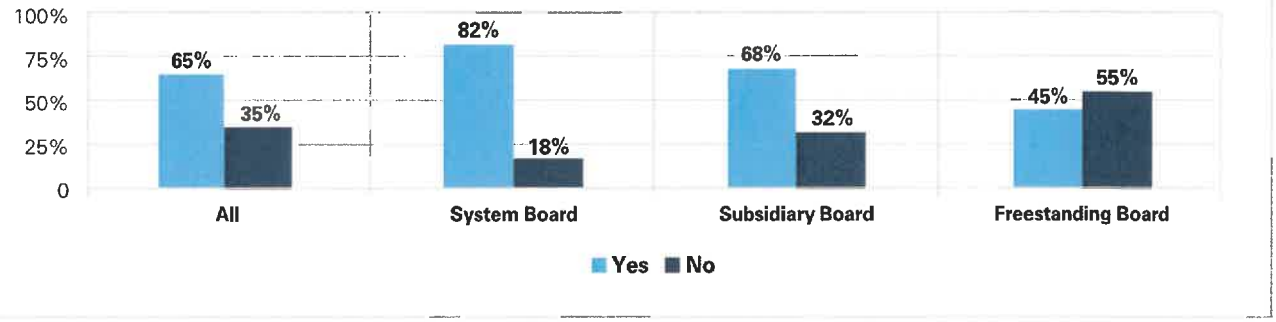
Data Points

One-third of all respondents reported they do not use term limits. The practice of compensating board members has doubled since 2022, particularly among system boards. The most common standing board committees are finance, quality and executive. Over two-thirds of all respondents indicated participating in specific board restructuring activities during the past three years.

Term Limits and Term Length

- Two-thirds (65%) of all respondents reported having term limits for their board members. Term limits were most prevalent among system boards (82%) and least prevalent among freestanding hospital boards at 52% (Figure 4.1).

Figure 4.1 Term Limits



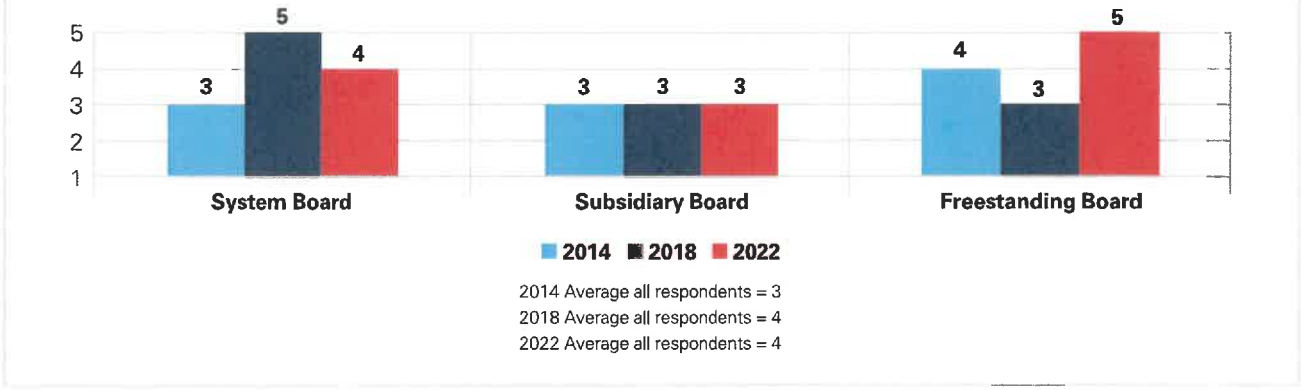
- Across all respondents, the average board member term length was reported to be four years. System hospital subsidiary boards reported an average board member term length of three years (Figure 4.2).

Figure 4.2 Average Board Member Term Length in Years

2014 Average all respondents = 4
2018 Average all respondents = 4
2022 Average all respondents = 4

- In 2022, freestanding hospital boards allowed their members to serve more consecutive terms (five) compared to four for system boards and three for system subsidiary hospital boards (Figure 4.3).

Figure 4.3 Maximum Number of Consecutive Terms on Average



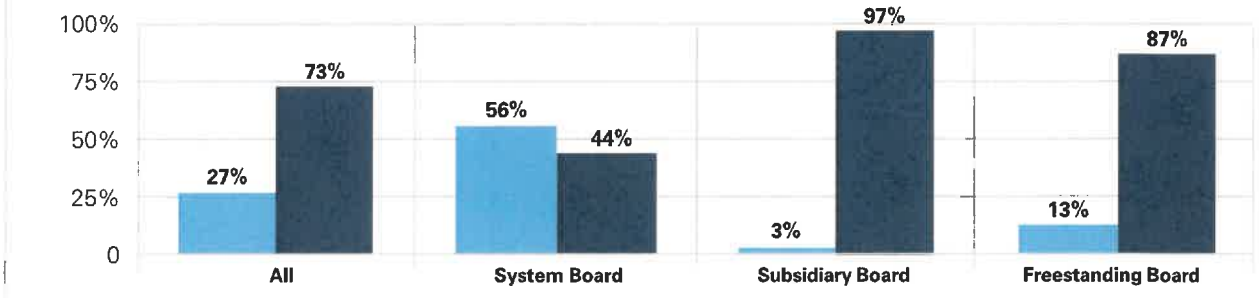
2014 Average all respondents = 3
2018 Average all respondents = 4
2022 Average all respondents = 4

Board Compensation

- The overall percentage of boards that compensate their members more than doubled in 2022 (27%), compared to 13% in 2018 and 10% in 2014 (Figure 4.4).
- Of those boards that reported compensating their members, system boards were most likely to do so at 56%, compared with 3% of system subsidiary boards and 13% of freestanding boards (Figure 4.4).

Figure 4.4 Board Member Compensation

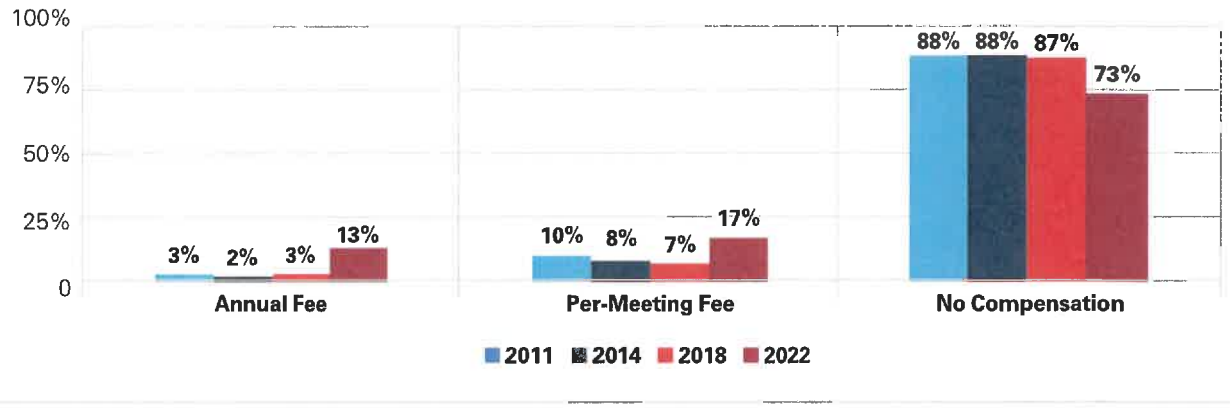
Do you compensate board members excluding reimbursement for out-of-pocket expenses?



2014 Average all respondents = 10%
2018 Average all respondents = 13%
2022 Average all respondents = 27%

- Of those boards who provide compensation, 13% reported they provide an annual fee while 17% said they offer per-meeting fees (Figure 4.5).

Figure 4.5 Type of Board Member Compensation by Year



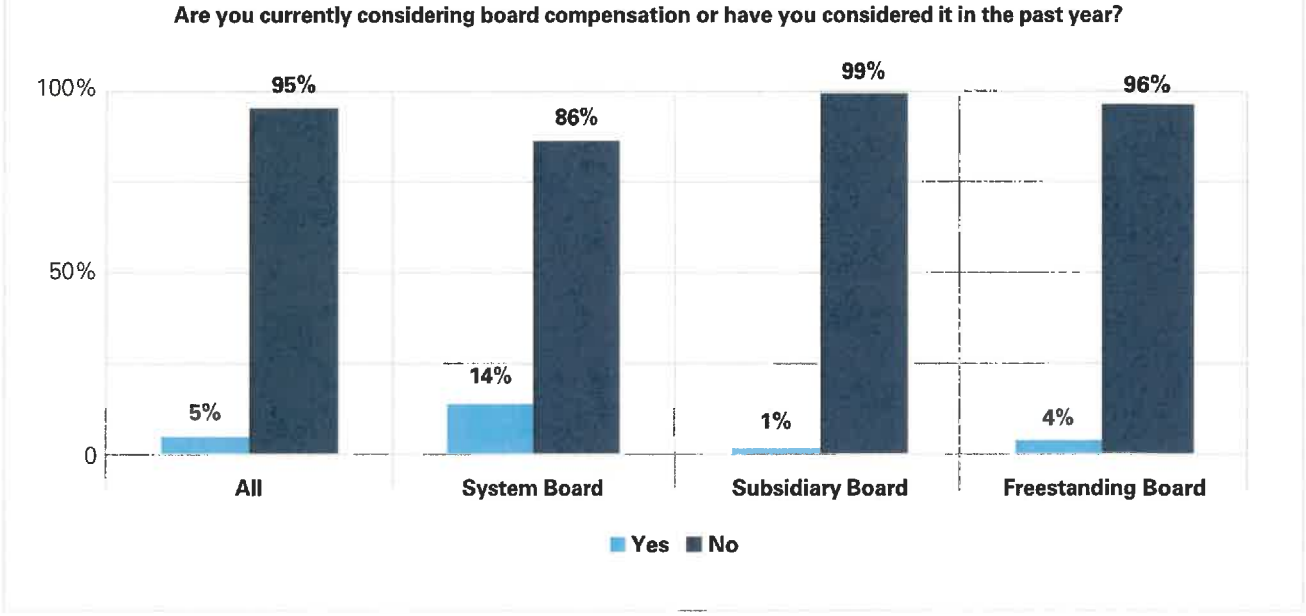
- In 2022, 44% of system boards reported they did not compensate their members, compared to 75% in 2018 and 92% in 2014 (Figure 4.6).

Figure 4.6 Forms of Board Member Compensation by Board Type by Year

	2014	2018	2022
Annual Fee			
System Board	4%	3%	34%
Subsidiary Board	3%	2%	0%
Freestanding Board	3%	2%	1%
Per-Meeting Fee			
System Board	4%	6%	43%
Subsidiary Board	6%	4%	0%
Freestanding Board	12%	12%	1%
No Compensation			
System Board	92%	75%	44%
Subsidiary Board	91%	94%	97%
Freestanding Board	85%	84%	87%

- System boards who have not provided compensation were more likely to consider doing so (14%) as compared to either system hospital subsidiary boards or freestanding boards at 1% and 4%, respectively (Figure 4.7).

Figure 4.7 Boards Considering Compensation



Board Committees

- The most common standing committees across all boards responding to the 2022 survey were finance (83%), quality (80%) and executive (74%). System boards reporting having the highest percentage of quality committees, 91%, compared to 78% of system subsidiary hospital boards and 70% of freestanding hospital boards (Figure 4.8).
- Audit/compliance, governance/nominating and executive compensation committees were far more common among system boards than hospital boards. Fundraising/development, strategic planning and workforce were more common among freestanding boards than boards in systems (Figure 4.8).

Figure 4.8 Standing Committees by Board Type

	All	System Board	Subsidiary Board	Freestanding Board
Finance	83%	99%	54%	86%
Quality	80%	91%	78%	70%
Executive	74%	88%	60%	70%
Audit/Compliance	60%	96%	32%	41%
Governance/Nominating	60%	90%	57%	48%
Executive Compensation	45%	79%	13%	29%
Strategic Planning	30%	25%	21%	41%
Community Benefit/Mission	18%	27%	18%	10%
Fundraising/Development	11%	7%	13%	67%
Workforce	7%	3%	5%	12%
Advocacy/Government Relations	6%	8%	4%	4%
Diversity, Equity & Inclusion	5%	6%	7%	4%
Enterprise Risk Management	4%	2%	5%	6%
Innovation	2%	1%	2%	2%
Cybersecurity	2%	1%	1%	3%
Other	31%	46%	18%	24%

- Overall, a higher percentage of boards reported having finance, quality, executive, audit/compliance and advocacy/government relations committees in 2022 than in 2018 (Figure 4.9).

Figure 4.9 Standing Committees by Year				
	2011	**2014**	**2018**	**2022**
Finance	83%	80%	76%	83%
Quality	75%	82%	77%	80%
Executive	68%	66%	66%	74%
Governance/Nominating	60%	60%	60%	60%
Audit/Compliance	51%	52%	47%	60%
Executive Compensation	36%	37%	31%	45%
Strategic Planning	44%	42%	35%	30%
Community Benefit/ Mission	14%	17%	21%	11%
Fundraising/ Development	18%	19%	12%	11%
Advocacy/Government Relations	4%	6%	4%	6%

- The percentage of system boards that reported having audit compliance committees increased to 96% in 2022 from 81% in 2018. The percentage of system boards that reported having a governance/nominating committee also increased to 90% in 2022 from 78% in 2018 (Figure 4.10).

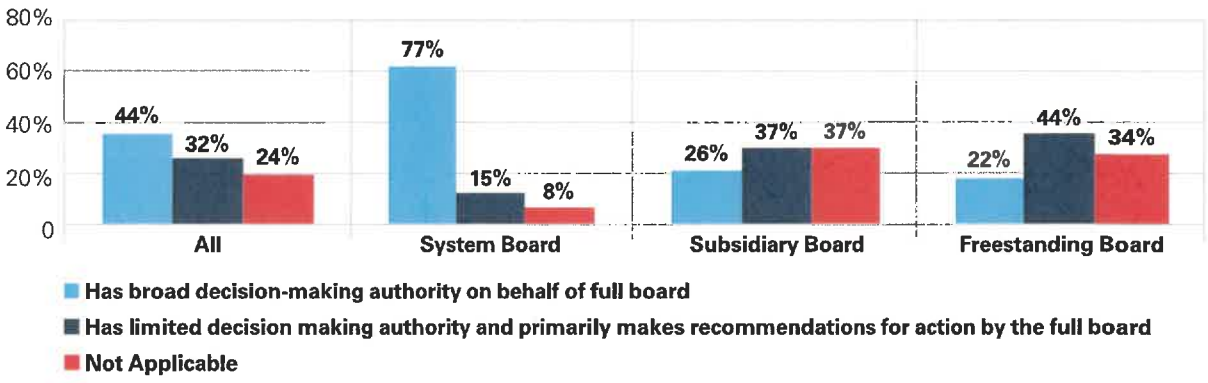
Figure 4.10 Standing Committees by Board Type by Year

	System Board			Subsidiary Board			Freestanding Board		
	2014	2018	2022	2014	2018	2022	2014	2018	2022
Quality	94%	91%	92%	87%	78%	78%	76%	70%	70%
Finance	98%	90%	99%	60%	56%	54%	85%	90%	86%
Audit/Compliance	21%	81%	96%	20%	30%	32%	13%	47%	41%
Governance/ Nominating	88%	78%	90%	56%	58%	57%	54%	54%	48%
Community Benefit/ Mission	20%	43%	27%	21%	22%	18%	18%	11%	10%
Diversity, Equity and Inclusion**	N/A	N/A	6%	N/A	N/A	7%	N/A	N/A	4%
Executive	86%	78%	88%	34%	59%	60%	51%	66%	70%
Strategic Planning	80%	35%	25%	58%	28%	21%	66%	42%	41%
Executive Compensation	52%	71%	79%	33%	12%	13%	44%	31%	29%
Fundraising/ Development	62%	14%	7%	20%	12%	13%	39%	12%	13%
Advocacy/ Government Relations	14%	6%	8%	7%	3%	4%	4%	4%	4%
Workforce*	N/A	6%	3%	N/A	5%	5%	N/A	10%	12%
Innovation*	N/A	1%	2%	N/A	0%	2%	N/A	1%	2%
Enterprise Risk Management*	N/A	5%	2%	N/A	5%	5%	N/A	5%	6%
Cybersecurity**	N/A	N/A	1%	N/A	N/A	1%	N/A	N/A	3%
Other**	N/A	N/A	46%	N/A	N/A	18%	N/A	N/A	24%
Other Clinician	2%	10%	4%	3%	9%	13%	5%	18%	20%

* Not asked in 2014 **Added in 2022

- Of the 2022 respondents that said their boards had executive committees, the percentage of system boards that allowed these committees to have broad decision-making authority on behalf of the full board (77%) was significantly higher than the percentages for hospital boards (Figure 4.11).

Figure 4.11 Executive Committee Authority



- A higher percentage of system boards (70%) reported having outsiders (nonboard members and nonstaff) as members of some board committees than did hospital boards (Figure 4.12). The percentage of all boards who have outsiders serve on some board committees increased to 47% in 2022 compared to 42% in 2018 (Figure 4.13).

Figure 4.12 Outsiders on Board Committees

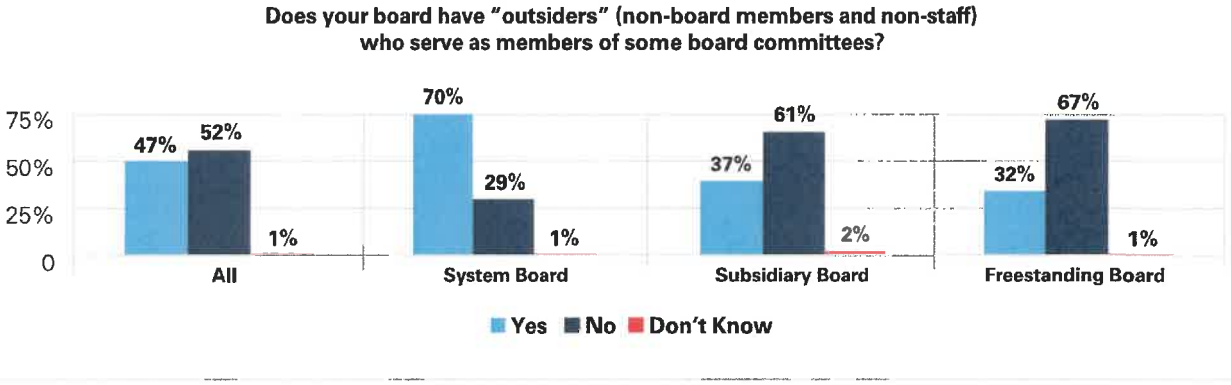
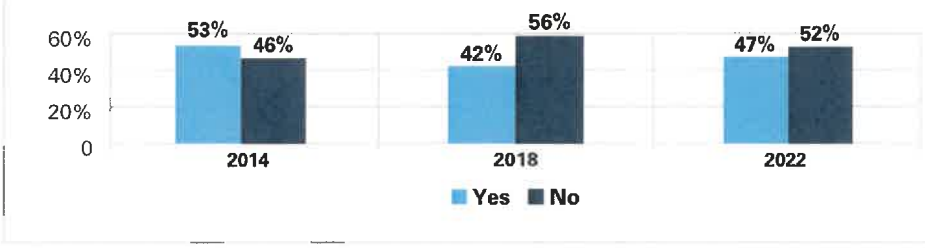


Figure 4.13 - Outsiders on Board Committees by Year



Board Restructuring and Support

- 2022 survey data indicate that 69% of all boards have engaged in specific board restructuring activities in the past three years. A higher percentage of freestanding hospitals (49%) reported not engaging in any board restructuring activities than did systems at 14% (Figure 4.14).

Figure 4.14 Board Restructuring in the Past Three Years

	All	System Board	Subsidiary Board	Freestanding Board
Sought new board member skills/ competencies	59%	78%	56%	42%
Added board committees	23%	38%	14%	13%
Redefined authority among system & subsidiary boards	21%	41%	18%	4%
Reduced board size	16%	29%	11%	7%
Reduced the number of board committees	12%	17%	11%	6%
Expanded board size	8%	7%	10%	8%
Eliminated all board committees	0%	0%	0%	1%
None of the above	31%	14%	30%	49%

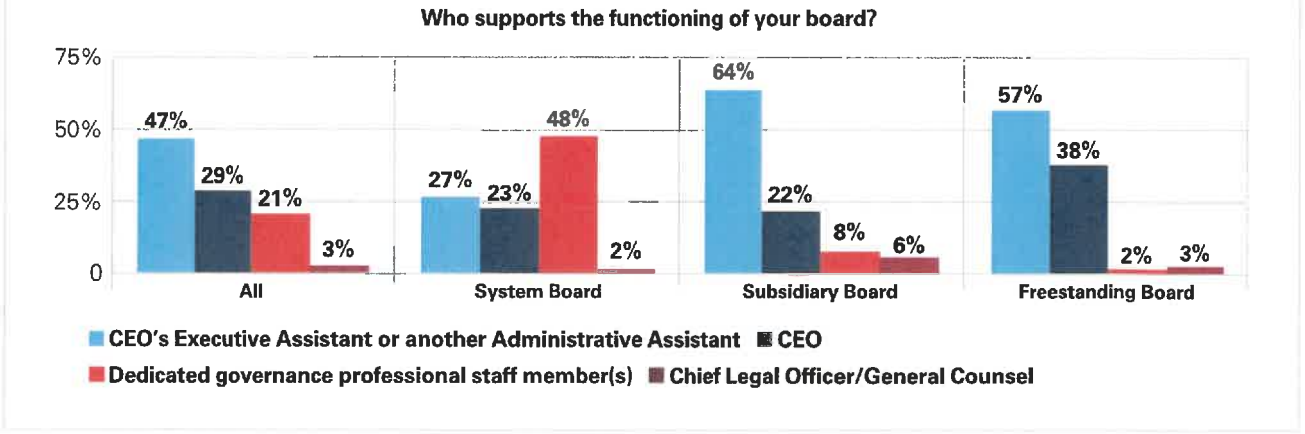
- Among all boards, the most common board restructuring activity in 2022 was to seek new board member skills and competencies at 59%, compared to 2018 when this activity was reported by 48% of respondents (Figure 4.15).

Figure 4.15 Board Restructuring in Past Three Years by Year

	2018	2022
Sought new board member skills/competencies	48%	59%
Added board committees	16%	23%
Redefined authority among system & subsidiary boards	12%	21%
Reduced board size	11%	16%
Reduced the number of board committees	12%	12%
Expanded board size	11%	8%
Eliminated all board committees	1%	0%
None of the above	33%	31%

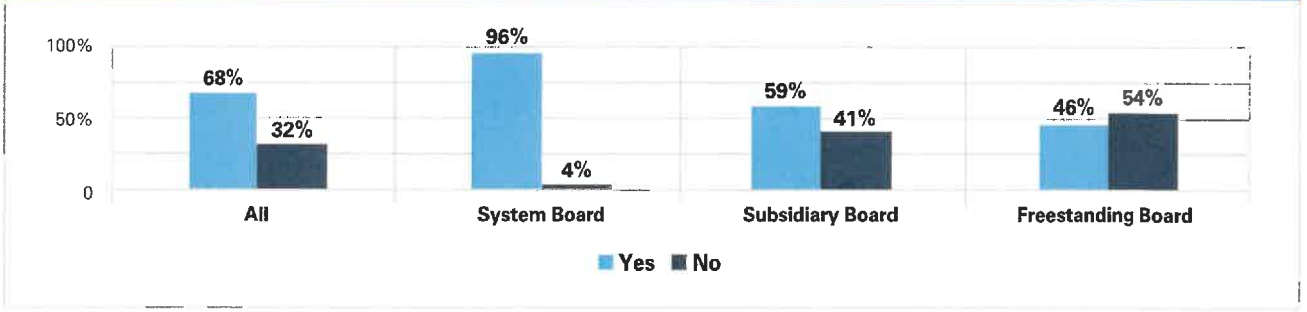
- The highest percentage of respondents overall in 2022 reported that the CEO's executive assistant or another administrative assistant (47%) or the CEO (29%) supported board function. Higher percentages of system boards (48%) reported having a dedicated governance professional staff member(s) provide board support than did hospital boards (Figure 4.16).

Figure 4.16 Board Support Staff



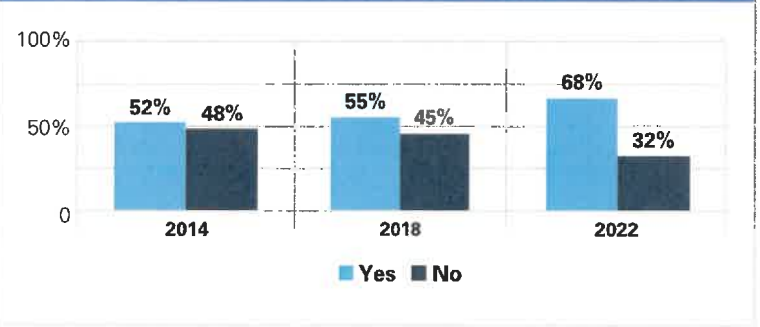
- Over two-thirds of all respondents (68%) reported using an electronic board portal. Nearly all systems (96%) said they use a board portal (Figure 4.17).

Figure 4.17 Use of a Board Portal



- The prevalence of using an electronic board portal has grown steadily, at 68% in 2022, up from 55% in 2018 and 52% in 2014 (Figure 4.18).

Figure 4.18 Use of Board Portal by Year



Commentary on Board Structure

By Jamie Orlikoff, (j.orlikoff@att.net), president of Orlikoff & Associates and the national adviser on governance and leadership to the AHA

Introduction

What a board does is clearly more important than how it does it. The outcomes a board generates matters more than the structures that support the work of the board. Form, after all, should follow function. Yet, it is undeniable that inappropriate, outmoded or limiting governance structure is one of the most common causes of ineffective governance function. Equally true is that thoughtful, well-designed governance structure facilitates effective governance function.

Governance structure is a broad category that arguably involves all aspects of the form of a board or boards and the mechanisms that frame the engagement of the board with its members and leaders. But, as this section clearly demonstrates, the category of board structure is not static as new technologies and new cultural imperatives create new structural forms and norms.

Although there is much debate on what the ideal governance structures are for health care organizations, one thing is clear from this section of the 2022 survey results: board structures are changing to both confront 21st century challenges and keep pace with technological innovations and societal changes.

Observations about Survey Findings

By far the most striking and significant results of this section relate to the exponential growth in the number of boards that provide cash compensation to their members. Figure 4.4 shows that the overall percentage of boards that compensate their members more than doubled in 2022 compared to 2018, from 13% to 27%. By comparison, the growth in compensation from 2014 to 2018 was a much more modest 3 percentage points: from 10% in 2014 to 13% in 2018.

More significantly, the most explosive growth in compensation was found in system boards, with 56% of systems board providing some type of compensation to their members (Figure 4.4). 34% of system boards reported payment of an annual fee to their members in 2022, an order of magnitude increase from the 3% of systems that did so in 2018 (Figure 4.6)! The fact that a clear majority of system boards engage in a practice that is still regarded as controversial and a matter of significant debate is quite noteworthy. What might be driving this trend? What could the functional impact of the structure of board compensation be?

Governing a system of hospitals is much more complex than governing a freestanding hospital. The larger the system the greater the complexity. And, in addition to hospitals most large systems are now comprised of different organizations and businesses, such as insurance companies, physician groups, skilled nursing facilities, ambulatory surgery centers and many others. Governing such an integrated delivery system is much more complex than even a multi-hospital system. This is one likely reason for the growth of compensation of board members of systems: it is an increasingly complex and demanding job that requires board members with specific and uncommon skill sets.

Another reason relates to the fact that large, complex, multi-billion-dollar systems increasingly find themselves competing with publicly traded companies for board member talent. Adding to that challenge is the recent concept of "Director Distraction" which emerged from pension funds, investor groups and regulators. These groups increasingly scrutinize boards of publicly traded companies to assure that their members do not serve on an excessive number of boards, as it is now recognized that they cannot do so and be reasonably expected to do a good job. As recently as 20 years ago, it was common for individuals to serve on eight or more corporate boards simultaneously. With the passage of Sarbanes-Oxley Act in 2002, and the growth of corporate governance best practices and board member accountability, this practice is increasingly monitored and frowned upon. Also, the growing liability and reputational risk for corporate

board members has caused individuals to be more discerning in assessing and accepting invitations to join corporate boards, further constraining the pool of potential board members. Finally, significant compensation of publicly traded company board members is the norm. It is likely that these factors are significant drivers of the growing trend of compensation of not-for-profit health care system board members.

It also is likely the explosive growth in compensation of health system board members heralds the death of the traditional model of hospital governance. This model, going back to the days of Ben Franklin, has several implicit components: voluntary (uncompensated) trustees; community-based governance; minimal-to-manageable time commitments; lack of standardized or mandatory training; diffuse and variable accountability of both boards and their members; long tenure and lack of term limits; and a tolerance for conflicts of interest on the board in service of community relationships. As health care systems evolved directly from hospitals, they naturally adopted this traditional model of governance into the initial models of system governance.

But the fact that most system boards (56%) now compensate their members while most freestanding hospital boards (87%) do not suggests that it is time to explicitly recognize that this old model is not conducive to the effective governance of systems (Figure 4.4). So does the fact that 82% of system boards had term limits for their board members in 2022 compared to only 45% of freestanding hospital boards (Figure 4.1). Further, the traditional model is not relevant to the broad societal, economic and demographic changes and challenges or to those daunting and disruptive pressures unique to the health care environment.

But, if the significant growth in system board member compensation suggests the emergence of a new model of governance, it begs the question: will compensation stimulate better governance? There is no data to suggest that the structure of board member compensation in and of itself will improve the function and outcomes of governance. In fact, some argue that compensation could paradoxically weaken not-for-profit health system and hospital governance by diverting board member loyalty away from the mission and the fulfillment of fiduciary duty, and toward seeking and maintaining financial reward for serving on the board.

However, it is logical to assume that compensation in exchange for accountability can drive more effective system governance. And this may be part of the emerging new model of governance: the routine and robust evaluation of the performance of individual system board members pursuant to the renewal of their terms. In other words, if boards are willing to pay their members, they may also be more willing to "fire" them for substandard performance. This implies the further professionalization of the role of governance of the system, and in time the hospital, via board member and leader job descriptions, performance objectives and evaluation, formal feedback, and, as stated, a willingness to terminate or not re-appoint to additional terms of office for failing to fulfill defined duties.

Strong indications of the emergence of a new model of governance can also be seen throughout this section of the survey results, and again are led by systems. In addition to board member compensation and term limits, 96% of system boards reported having an audit and compliance committee in 2022, up from 81% in 2018 (Figure 4.10). Also noteworthy is that 86% of system boards engaged in board restructuring efforts to adjust their structures for greater efficiency and effectiveness in the three-year period from 2018 — 2022 (Figure 4.14 and 4.15). And, nearly all systems, 96%, used an electronic board portal in 2022 to provide information, facilitate communication, offer real-time governance education and monitor board member preparation and engagement (Figure 4.17).

Effective governance is a delicate latticework of interrelated structural, functional and cultural factors. To change one of the many variables within these categories in the belief that the others will not be affected is naive. To change one of the variables without thinking through the whole process, the whole gestalt, of governance can be deleterious to governance and to the system or hospital being governed. The good news reflected in this section

is that the vast majority of systems and a significant proportion of hospitals are attempting to improve governance through integrated efforts that address many of the variables addressed in this and other sections of the survey results.

Taken in total, these trends support the conclusion that the boards of health systems are leading the way in the structural creation of a new model of more professional governance. Hopefully, this will in turn generate measurable improvements in governance effectiveness that will drive better performance of systems and hospitals and result in better health care for the communities they serve.

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

Discussion Questions on Board Structure

- Are your board members provided compensation for their service? If so, has that compensation improved the quality of governance? How?
- If you are opposed to the concept of compensating members of the board of not-for-profit hospitals and health systems what are the reasons for the opposition, or your concerns regarding compensation?
- If your hospital or health system does not currently provide compensation to its board members, are you considering it? If so, why? If not, why not?
- Has your board created new board committees, merged committees, or eliminated board committees in the recent past? Why? What was the outcome of these structural changes?
- If you had a "magic wand" and could remodel your board, what would you change and why (consider board size, number and type of board committees, compensation, time spent on governance, number of boards)?

SECTION 5

Board Selection

Data Points

Nearly all system boards use competencies in board member selection while nearly two-thirds of freestanding hospital boards do not. More than 75% of all respondents indicated that no board member had been replaced or not been re-appointed when eligible over the past three years. Over half of boards report that it requires the same effort now to recruit new board members compared with three years ago. Over two-thirds of respondents indicated that recruiting millennials requires the same or less effort than recruiting other age cohorts for board service.

Board Member Competencies

- In 2022, 61% of all respondents reported that their selection committee used an approved set of knowledge, skills and behavioral competencies for selecting all board members. Nearly all system boards (91%) reported using competencies for all board members, as compared to system subsidiary hospital boards at 54% and freestanding hospital boards at 35% (Figure 5.1)
- Higher percentages of system boards reporting using competencies for selection of board chairs (18%), committee chairs (16%) and committee members (8%) than did either system subsidiary hospital boards or freestanding hospital boards (Figure 5.1).

Figure 5.1 Use of Competencies

Does your board or board's selection committee use a set of approved knowledge, skills and behavioral competencies for selecting the following?

	All	System Board	Subsidiary Board	Freestanding Board
Yes, for all board members	61%	91%	54%	35%
Yes, for board chairs	18%	35%	12%	6%
Yes, for committee chairs	10%	16%	9%	6%
Yes, for committee members	11%	15%	9%	7%
No	37%	8%	45%	62%

- Overall, the use of competencies by all boards has increased steadily since 2011, with 42% using competencies in 2018 compared to 61% in 2022 (Figure 5.2).

Figure 5.2 Use of Competencies by Year				
	2011	**2014**	**2018**	**2022**
Yes, for all board members	32%	35%	42%	61%
Yes, for board chairs	5%	7%	7%	18%
Yes, for committee chairs*	N/A	N/A	5%	10%
Yes, for committee members*	N/A	N/A	6%	11%
No	40%	42%	57%	37%
Don't know**	28%	21%	N/A	N/A

*Not asked in 2011 or 2014

**Not asked in 2018 or 2022

- As indicated in Figure 5.3, across all 2022 survey respondents, the top five knowledge, skills and behavior competencies used to select board members were: knowledge of business and finance (62%); strategic orientation (59%); community orientation (52%); innovative thinking (41%); and collaboration (34%).
- System boards (35%) included quality and safety expertise among their top five competencies; hospital boards did not (Figure 5.3).

Figure 5.3 Top Five Competencies for Board Member Selection				
Indicate the top 5 essential knowledge, skills and behavior competencies you used most recently when selecting board members.				
	All	**System Board**	**Subsidiary Board**	**Freestanding Board**
Knowledge of business and finance	62%	68%	53%	59%
Strategic orientation	59%	82%	36%	34%
Community Orientation	52%		78%	65%
Innovative Thinking	41%	58%		
Collaboration	34%	37%	32%	30%
Impact and influence			32%	
Professionalism				30%
Quality and safety expertise		35%		

- Of the small percentage of hospitals and systems that use competencies to select board chairs, Figure 5.4 shows that the top five knowledge, skills and behavior competences were: past governance experience (46%); community orientation (41%); collaboration (40%); strategic orientation (34%); and knowledge of business and finance (32%)

Figure 5.4 Top Five Competencies for Board Chair Selection

Indicate below the top 5 essential knowledge, skills and behavior competencies you used most recently when selecting board chairs.

	All	System Board	Subsidiary Board	Freestanding Board
Past governance experience	46%	60%		37%
Community Orientation	41%		52%	43%
Collaboration	40%	42%	36%	34%
Strategic orientation	34%		37%	28%
Knowledge of business and finance	32%		37%	34%
Complexity management		44%		
Systems thinking		39%		
Achievement orientation		36%		
Impact and influence			34%	

Board Member Replacement

- Some 76% of 2022 survey respondents overall reported that no board member had been replaced or not been re-appointed when eligible over the past three years (Figure 5.5). That percentage remains unchanged from 2018 data (Figure 5.6).

Figure 5.5 Board Member Replacement in Past 3 Years

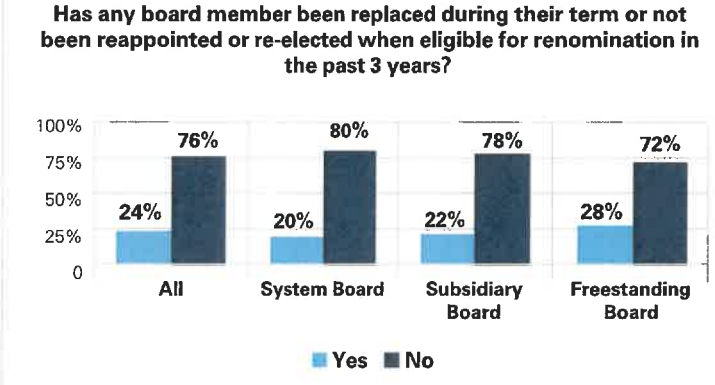
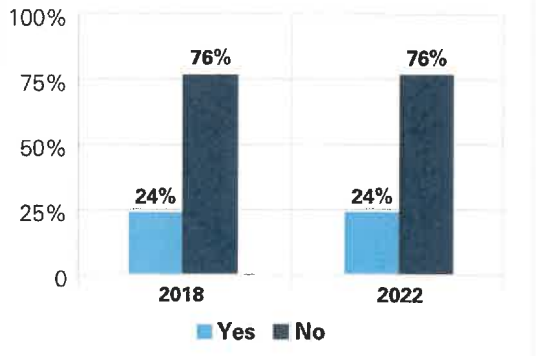
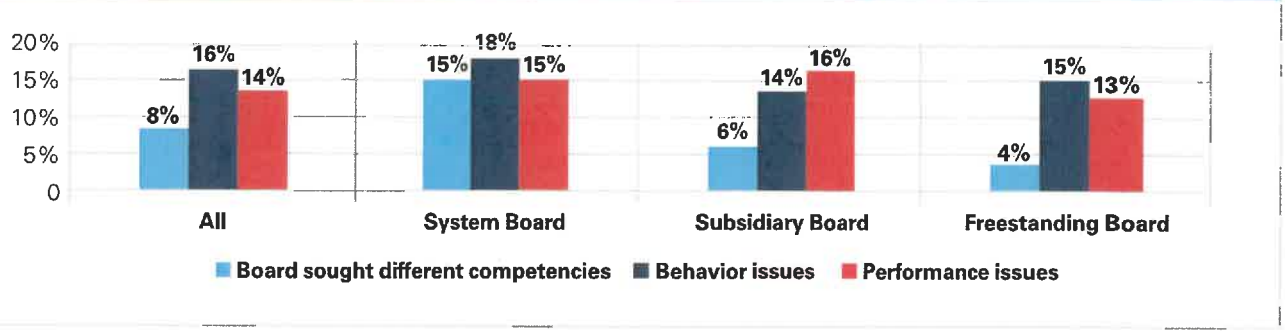


Figure 5.6 Board Member Replacement in Past 3 Years by Year



- Of those who did replace board members in the past three years, higher percentages of system boards did so because of behavioral issues or because they were seeking new competencies than did hospital boards (Figure 5.7).

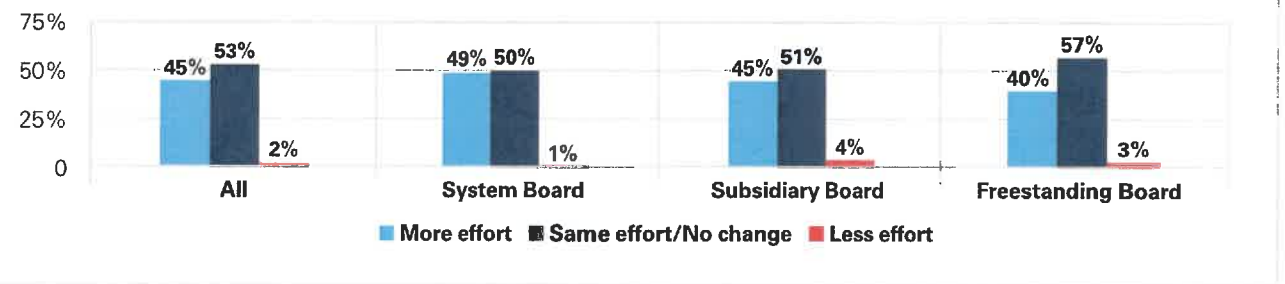
Figure 5.7 Reasons for Board Member Replacement



Effort to Recruit Board Members

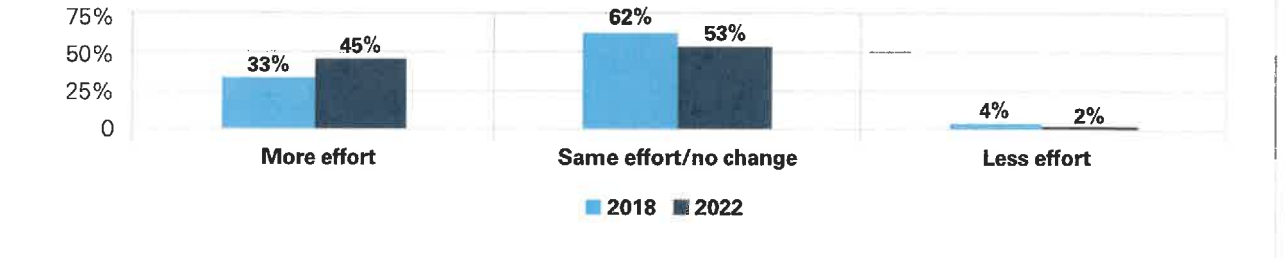
- Nearly half of system boards (49%) indicated that recruiting new board members now requires more effort compared to three years ago (Figure 5.8).

Figure 5.8 Effort Required to Recruit New Board Members Compared to 3 Years Ago



- Of all respondents to the 2022 survey, 45% reported that new board member recruitment required more effort, as compared to 33% of respondents to the 2018 survey (Figure 5.9).

Figure 5.9 Effort Required to Recruit New Board Members Compared to 3 Years Ago by Year



- According to 2022 survey data, system boards (36%) reported that recruiting millennials to the board requires more effort than recruiting other age cohorts as compared to system subsidiary hospital boards at 25% and freestanding boards at 26% (Figure 5.10).

Figure 5.10 Effort to Recruit Millennials Compared to Other Age Cohorts

Compared to other age cohorts, on a scale of 1-5, how much effort is required to recruit Millennials to your board?

	All	System Board	Subsidiary Board	Freestanding Board
Extreme effort - 5	17%	17%	18%	17%
4	12%	19%	7%	9%
Same effort - 3	27%	18%	33%	31%
2	22%	17%	31%	21%
Minimal effort - 1	21%	29%	11%	21%

- Some 70% of 2022 survey respondents overall reported that recruiting millennials for board service requires the same or minimal effort than recruiting other percentage cohorts compared to 2018 data at 65% (Figure 5.11).

Figure 5.11 Effort to Recruit Millennials Compared to Other Age Cohorts by Year

Compared to other age cohorts, on a scale of 1-5, how much effort is required to recruit Millennials to your board?

	2018	2022
Extreme effort - 5	17%	17%
4	19%	12%
Same effort - 3	26%	27%
2	12%	22%
Minimal effort - 1	27%	21%

Commentary on Board Selection

By Todd Linden, (tlinden@lconsult.org), partner of Linden Consulting, adviser for GHI governWell™ and CEO emeritus of Grinnell (Iowa) Regional Medical Center

Introduction

Common sense would suggest that any team, group or board performance would in large part be best based on the abilities, skills, knowledge and motivation of the members of the group. High performing health care executive teams spend significant efforts to recruit, retain and develop their members. Health care governing boards would certainly expect their CEOs to excel in building their teams, yet as the 2022 AHA governance survey results indicate, many boards do not demand the same efforts in building their own teams. Today's health care challenges require high performing boards made up of individuals who collectively bring the talent necessary to govern the highly complex hospitals and health systems for which they are responsible.

Observations about Survey Results

Board Member Competencies

Although the use of board approved competencies has consistently increased since the 2011 survey, their use is barely over half (61%) for all respondents. Health system boards pull that average up significantly with 91% utilizing competencies when selecting board members, just over half (54%) for subsidiary boards and a paltry 35% for freestanding hospital boards. Hospital boards would be outraged if the hospitals they govern failed to use competencies for selecting hospital personnel or medical staff. The low percentages reported by freestanding hospitals for board use of competencies needs board attention going forward.

Arguably, serving as the board chair of a freestanding hospital, health system or subsidiary board is one of the most significant roles for any health care organization. Yet, when it comes to selecting board chairs, use of approved knowledge, skills and behavioral competencies are rare with only 35% of system boards using them and almost nonexistent for subsidiary boards (12%) and for freestanding hospital boards (6%). The survey indicates that use of competencies for committee leadership and membership are even lower. This begs the question, how do most hospital boards choose their leadership, if not competency-based? Although the survey shows improvement from previous years, these numbers are surprisingly low and is clearly another area for improvement going forward.

For the boards that do report using competencies for member selection, the top three essential knowledge and skills areas included: knowledge of business and finance, strategic orientation, and community orientation. While innovative thinking and collaboration barely made the list, only health system boards had quality and safety coming in at 35%. When it comes to board chair competencies, past governance experience topped the list for all respondents, with similar ratings for overall board selection.

Board Member Replacement

Using a typical bell curve on performance by individuals of any group, it would be reasonable to believe that about a quarter of the group are high performers, half are in the middle and a quarter rate as low performers. Yet, when it comes to health care board member replacement, over three-quarters of all survey respondents reported not a single member replacement. That same percentage indicated that if a member was eligible for re-appointment, it was automatic. It is safe to assume many boards have sub-par board members who continue to serve because boards simply tolerate this low performance or lack a mechanism for culling their boards. These statistics have not changed since the 2018 report and are another indicator of the challenges all health care organizations seem to be facing with board member selection issues.

Efforts to Recruit Board Members

Perhaps one of the top reasons health care boards of all sizes do a relatively poor job with use of competencies for selection and rarely replace low performing board members is the difficulty in recruitment in general.

Nearly half of system boards (49%) indicated that recruiting new board members requires more effort than three years ago. Although a bit less for subsidiary boards (45%) and freestanding boards (40%), these are still high numbers and likely to go higher as the time commitment, complexity and significant issues facing America's health care organizations will most certainly increase in the coming years. Although one might imagine it would be more difficult to recruit younger board members, the survey seems to indicate it is not more difficult to find millennials than other age cohorts.

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

Discussion Questions on Board Selection

- Does your board utilize a board approved set of knowledge, skills and behavioral competencies for board member selection? If not, why not?
- If your board does currently use competencies for board member selection, how do your competencies compare to those noted by boards in the AHA governance survey?
- Does your board use competencies for board leadership selection? If not, why not and if so, how do your competencies compare to the AHA survey?
- Does your board have a process for removing or replacing poor performing members? If not, why not?
- Is it automatic for board members to serve additional terms if eligible, regardless of performance? How might you consider ways to make continued board service performance based?
- How difficult is it for your board to recruit the board members? What new ideas do you have to recruit members with the skills, knowledge and behaviors that would improve the overall performance of the board?
- Does your board represent the diversity of the communities you serve? What can be done to make it more representative of your community?

SECTION 6

Board Orientation and Education

Data Points

Nearly a third of all boards do not have position descriptions for any type of board role. Most boards reported having a formal orientation for new board members but not for new board chairs. Systems indicated they were providing formal board education on a quarterly basis to their members while hospitals reported an annual frequency.

Position Descriptions

- Nearly one-third (32%) of 2022 survey respondents overall reported they did not have position descriptions for board members, the board chair or committee chairs (Figure 6.1).

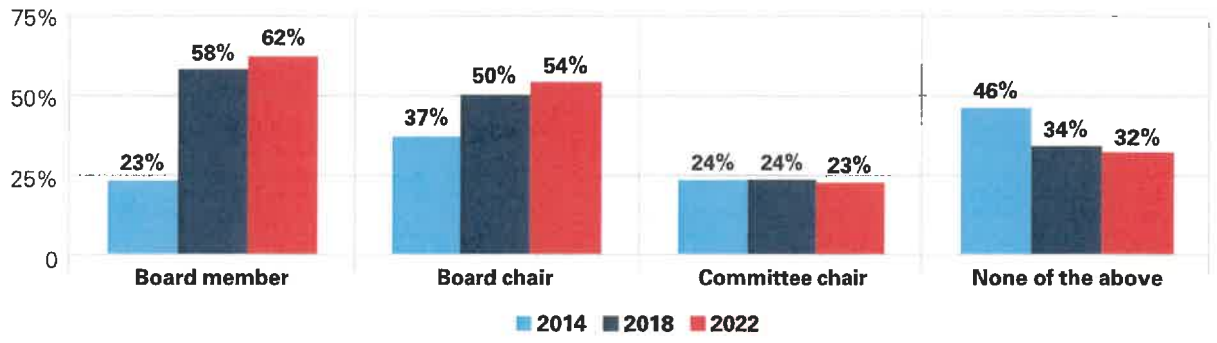
Figure 6.1 Use of Position Descriptions

For which of the following positions does your board have job descriptions?

	All	System Board	Subsidiary Board	Freestanding Board
Board member	62%	76%	56%	53%
Board chair	54%	59%	48%	49%
Committee chair	23%	28%	20%	20%
None of the above	32%	19%	38%	40%

- Higher percentages of overall respondents to the 2022 survey reported having board member (62%) and board chair (54%) position descriptions than did respondents to both the 2018 and 2014 surveys (Figure 6.2).

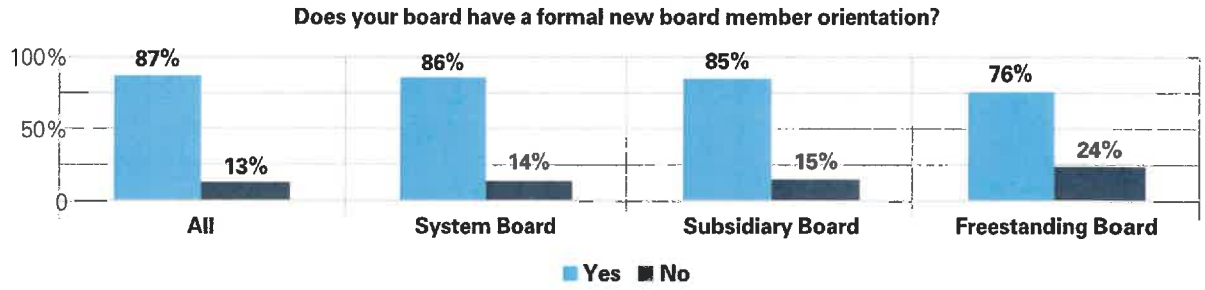
Figure 6.2 Use of Position Descriptions by Year



Orientation

- For the 2022 survey, 87% of all respondents reported having a formal orientation for new board members. This compares with 82% in 2018 and 97% in 2014 (Figure 6.3).

Figure 6.3 New Board Member Orientation



2014 Average all respondents = 97% 2018 Average all respondents = 82% 2022 Average all respondents = 87%

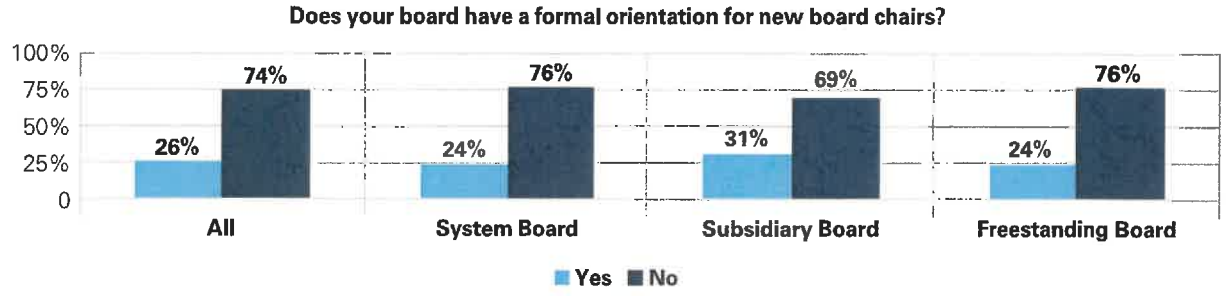
- As Figure 6.4 indicates, the highest percentages of respondents overall reported including the following activities in their new board member orientation: meeting with CEO and/or senior leadership team (96%), health care governance orientation (89%), and health care orientation (78%).
- The least reported orientation activity, across all types of boards, was formal mentoring with a senior board member (Figure 6.4).

Figure 6.4 Elements Included in New Board Member Orientation

	All	System Board	Subsidiary Board	Freestanding Board
Meeting with the CEO and/or senior leadership team	96%	93%	93%	94%
Health care governance orientation	89%	94%	82%	88%
Health care orientation	78%	71%	79%	85%
System/hospital orientation	77%	98%	85%	45%
Facility tour	61%	27%	82%	89%
Meeting with the board chair	57%	50%	71%	56%
Community served	29%	15%	43%	36%
Formal mentoring with a senior board member	24%	26%	23%	22%
Other	6%	2%	7%	11%

- Nearly three-quarters (74%) of respondents to the 2022 survey indicated they did not have a formal orientation for new board chairs (Figure 6.5).

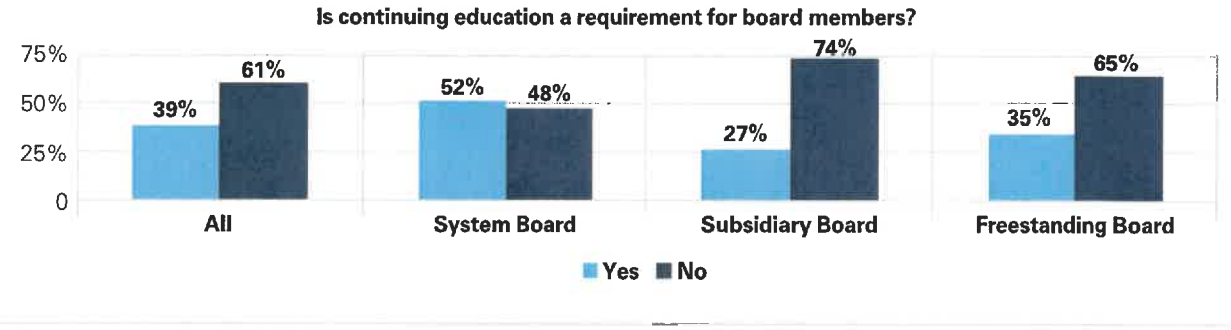
Figure 6.5 New Board Chair Orientation



Board Education

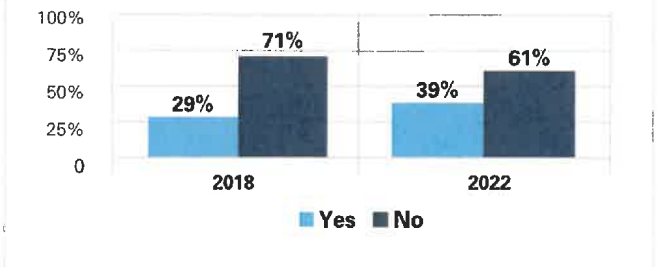
- System boards (52%) were more likely to have a board member continuing education requirement as compared to system subsidiary hospital boards at 27% and freestanding hospital boards at 35% (Figure 6.6).

Figure 6.6 Board Member Continuing Education Requirement



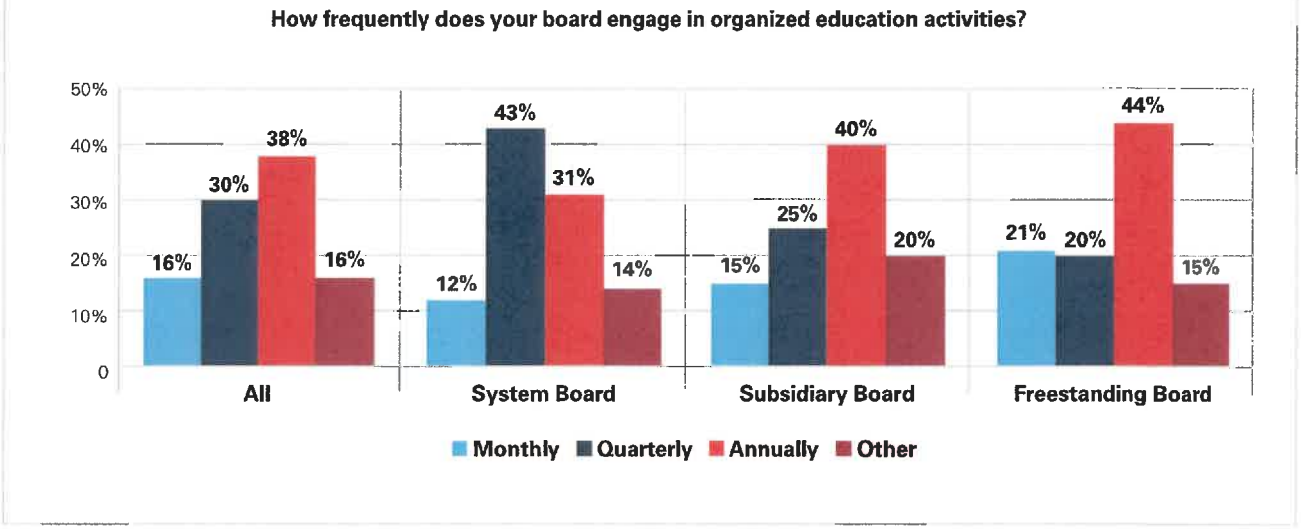
- In 2022, 61% of all survey respondents reported they did not have a board member continuing education requirement, compared to 71% of 2018 survey respondents (Figure 6.7).

Figure 6.7 Board Member Continuing Education Requirement by Year



- When asked about frequency of organized education activities, systems (43%) reported that these activities occurred quarterly. System subsidiary hospitals (40%) and freestanding hospital boards (44%) indicated that their boards most frequently engage in organized education on an annual basis (Figure 6.8).

Figure 6.8 Frequency of Organized Board Education Activities



- The highest percentage of 2022 survey respondents overall (76%) reported that continuing education for their boards is delivered at board/committee meetings (Figure 6.9).
- Nearly all system boards reported that their board members engage in both boardroom/committee meeting education (91%) and self-directed education (91%) on a regular basis (Figure 6.9).

Figure 6.9 Delivery of Board Education

How do board members engage in continuing education?

	All	System Board	Subsidiary Board	Freestanding Board
At board/ committee meetings	76%	91%	68%	67%
Self-directed (articles, online resources, etc)	72%	91%	56%	62%
At board retreats	57%	72%	52%	45%
At outside conferences	56%	64%	34%	62%
None of the above	4%	1%	4%	6%

- The highest percentage of 2022 survey respondents overall (89%) reported receiving an educational briefing on compliance issues from legal counsel, followed by briefings on trustee conflicts of interest/ independence at 75% (Figure 6.10).

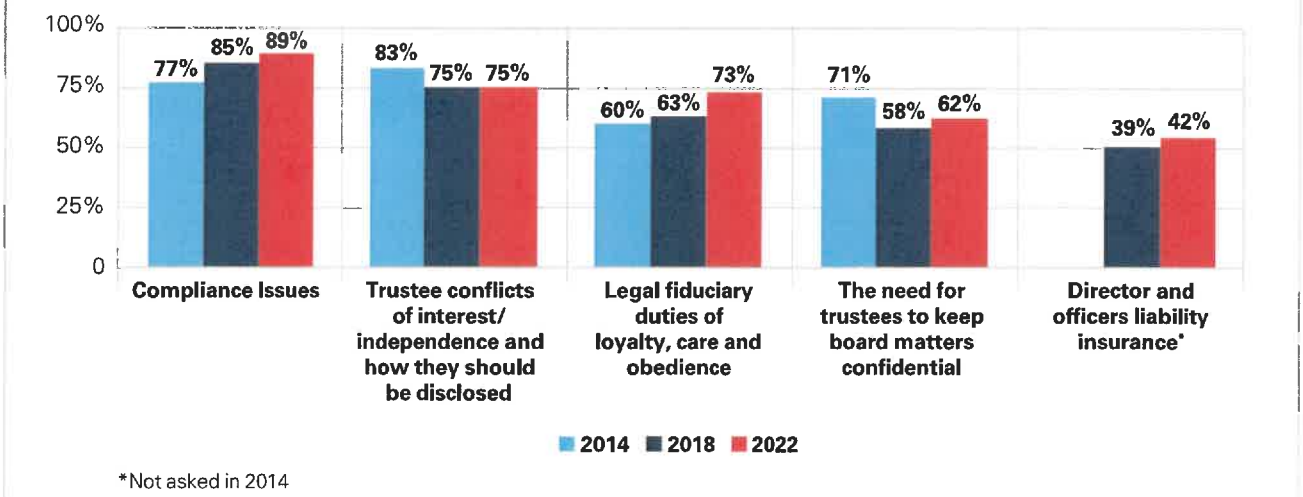
Figure 6.10 Legal Counsel Briefing Topics

On which of the following does your board periodically receive an educational briefing with legal counsel?

	All	System Board	Subsidiary Board	Freestanding Board
Compliance issues	89%	95%	87%	81%
Trustee conflicts of interest/ independence and how they should be disclosed	75%	81%	73%	71%
Legal fiduciary duties of loyalty, care and obedience	73%	83%	66%	66%
The need for trustees to keep board matters confidential	62%	70%	57%	55%
Director and officers liability insurance	42%	46%	33%	42%

- Higher percentages of respondents overall in 2022 reported receiving briefings from legal counsel on compliance issues and fiduciary duties than in 2018 (Figure 6.11).

Figure 6.11 Legal Counsel Briefing Topics by Year



*Not asked in 2014

Commentary on Board Orientation and Education

by Barbara H. Lorsbach, (blorsbach@governwell.net), president, GHI govemWell™

Introduction

Boards do not become excellent by chance. They become outstanding by purposefully practicing key leadership behaviors that work together to ensure effectiveness. Findings from the AHA 2022 governance survey provide a keen glimpse into board leadership behaviors during one of the most compelling circumstances in recent history—the COVID-19 pandemic. Crisis situations and innovation both require motivated, knowledgeable trustees who understand how to think and lead in a rapidly changing and challenging environment. Fundamental to the ability to lead, adapt and innovate is a commitment to learning. Through effective use of board orientations and ongoing education, trustees are better prepared to fulfill their vital leadership roles.

Observations about Survey Findings

The first step in an effective board orientation and education process should happen before an individual is offered an invitation to serve on the board or decides to run for election. Trustee candidates who receive a written description of board roles and responsibilities are better able to assess the level of commitment that will be needed if selected or elected to serve. Frequently when there is role confusion or unfulfilled responsibilities, the lack of a position description is the root cause of the problem.

In 2022, survey results show that nearly one-third (32%) of the responding organizations did not have position descriptions for board members. System board members were the most likely to have job descriptions (75%). For freestanding hospital and system subsidiary hospital boards, slightly more than half reported using position descriptions. The likelihood that board and committee chairs will have position descriptions to guide and orient them in their responsibilities is lower than for board members. Only 54% of respondents use board chair job descriptions. Even fewer, 23%, had position descriptions for committee chairs.

Trustees are fully accountable for their decisions and fulfillment of their responsibilities beginning with day one of their board term. Many will admit it takes at least one if not more years for most trustees to truly gain the depth of knowledge and understanding needed to be an effective board member. Trustees may be thrust into board service with insufficient orientation and little or no ongoing governance education. Even organizations with sound orientation programs in place may need to reconsider how to best prepare new board members for the work and responsibilities of today's board.

Despite the demands of the pandemic, survey data indicate that 87% of all boards reported providing a formal new board member orientation. This percentage is higher than in 2018 when 82% of respondents reported using board orientations but notably lower than in 2014 when 97% of boards reported providing a formal new member orientation.

An initial orientation session should give new trustees a broad, high-level understanding of the organization, the health care environment and the issues they will be expected to address as board members. Nearly all, 96%, of the organizations that reported providing a new board member orientation also indicated that their orientation included meeting with the CEO and/or the senior leadership team.

An orientation to health care varied among hospitals and health systems. With the pace of change and innovation, it was surprising that not all new board members received this important component of an effective orientation program. Freestanding hospital and system subsidiary hospital boards were more likely than system board members to receive a health care orientation — 85%, 79% and 71% respectively. This may be because experience in health care was a clearly articulated requirement in the board member position description and/or was an attribute that was strongly considered in selecting board members. If not, there could be potential gaps between roles and knowledge regardless of the size of the health care organization and the type of board.

Formal mentoring was the least reported orientation activity across all types of boards. Only approximately 25% of boards reported providing a mentoring program. This percentage has remained unchanged since 2018 and demonstrates a missed opportunity for new board members.

Great boards have great board leadership. The chair is not only a role model for members of the board and executive team but is responsible for ensuring that board members function as a cohesive team capable of acting efficiently and effectively in the best interests of the hospital or health system. The 2022 survey data indicate many health systems and hospitals limit their orientation program to just board members. Overall, only 24% of respondents had a formal board chair orientation even though the role of the board chair is one of the critical governance leadership positions.

Every board member, not just some, must have a common level of understanding of critical issues and developments, and their implications for the organization. Well-planned educational efforts lead to better decisions based on broader knowledge and insights; increased capacity to engage in challenging and productive governance dialogue; and the ability to think beyond conventional wisdom. Although nearly all 2022 survey respondents reported that their board members engaged in continuing educational activities, less than half (39%) reported having a formal continuing education requirement. The percentage has increased somewhat since 2018 when 29% of survey respondents reported that their board members had a continuing education requirement.

Board members usually have varying levels of awareness and knowledge of the issues discussed and the decisions made at board meetings. Survey respondents reported using a combination of educational formats, including board/committee meetings, self-directed learning, and board retreats and outside conferences. Other educational findings that stood out included:

Boards differed in how often they engaged in organized educational activities. Annually organized education was the most common; 16% of boards engaged in monthly educational activities and 30% quarterly.

System boards reported using both educational activities at board meetings and self-directed educational resources (91%). Subsidiary and freestanding boards also reported a mix of formats but less often.

Only 57% of hospitals and health systems overall reported engaging board members in continuing education during board retreats. The pandemic required social distancing and resulted in greater use of virtual meetings, which may explain the relatively low use of retreat formats.

Trustee conflict of interest and independence, disclosure and compliance issues were reported as the most frequent topics during briefings provided by legal counsel to boards.

Legal counsel briefings on the need for trustees to keep board matters confidential were reported by 62% of survey respondents.

Education empowers boards to make decisions that help their organizations expand their ability to save lives, improve patient care, enhance the clinical experience and improve community well-being. Passing on knowledge and general awareness are not enough. While survey data show hospitals and health system boards are moving in the right direction, there are many opportunities for boards to continue to elevate their commitment to learning as an essential leadership responsibility.

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

Discussion Questions on Board Orientation and Education

- How do your board's educational practices compare with the AHA 2022 governance survey results?
- What are the three most critical issues confronting your board in the next year? What educational activities are needed to ensure that all board members are knowledgeable and understand these issues?
- Does your board have an annual governance education plan?
- Does your board chair have access to an orientation and/or coaching?
- How would your board benefit from making participation in education a condition of board appointment and/or reappointment?

SECTION 7

Board Evaluation

Data Points

More than a quarter of all boards reported that they had not used any type of assessment with boards, committees, members or chairs in the past three years. Those boards conducting a full board assessment used results to improve board performance. The most common individual board member performance criterion was "meets the board and committee attendance requirement."

Assessment Types and Focus

- Some 27% of 2022 survey respondents overall reported not using, in the past three years, any of the following types of board assessments: full board, board member, board chair or board/committee meeting (Figure 7.1).

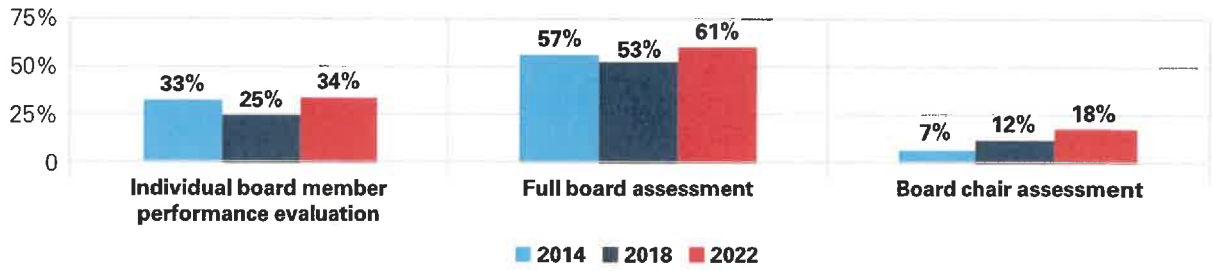
Figure 7.1 Use of Governance Assessments

Which of the following types of assessments has your board used in the past three years?

	All	System Board	Subsidiary Board	Freestanding Board
Full board assessment	61%	83%	50%	46%
Individual board member performance evaluation	34%	62%	14%	18%
Board chair assessment	18%	38%	7%	4%
Board meeting evaluation	44%	81%	22%	21%
Committee meeting evaluation	27%	54%	11%	10%
None	27%	4%	39%	43%

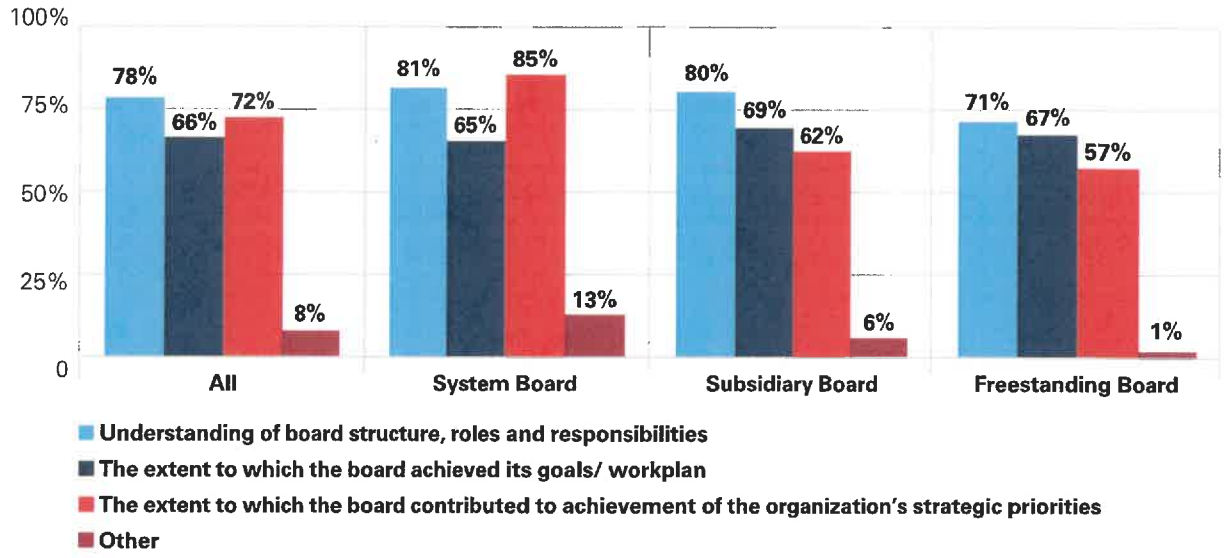
- Greater percentages of respondents to the 2022 survey reported conducting both board member and full board evaluations than did respondents to the 2018 survey (Figure 7.2).

Figure 7.2 Use of Governance Assessments by Year



- As shown in Figure 7.3, of 2022 respondents overall that conducted a full board assessment, the highest percentages said the assessment focused on understanding board structure, roles and responsibilities (78%) and the extent to which the board contributed to achievement of the organization's strategic priorities (72%).

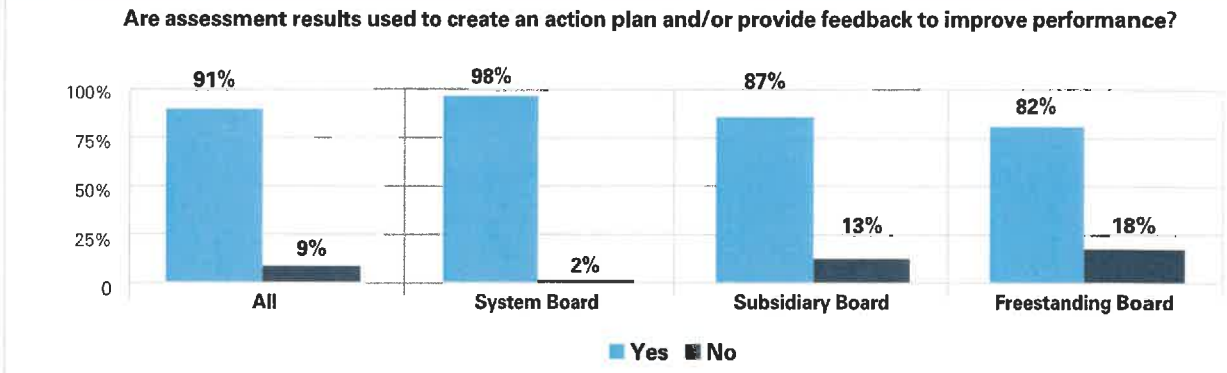
Figure 7.3 Focus of Full Board Assessment



Use of Assessment Results

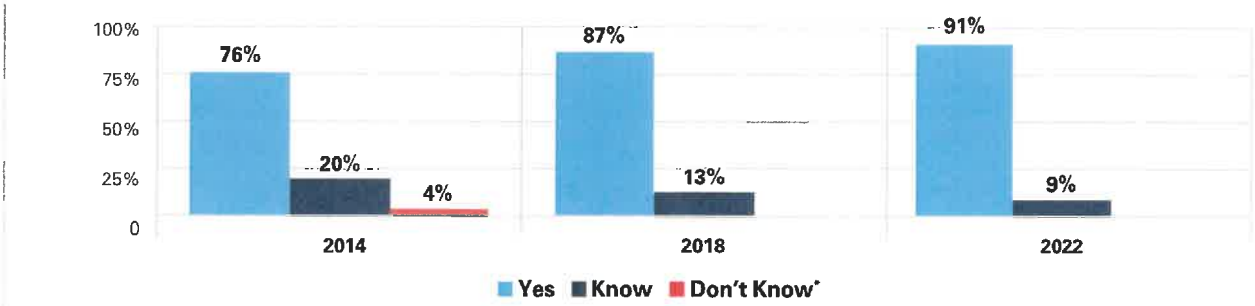
- The vast majority of overall respondents to the 2022 survey (91%) reported they used assessment results to create an action plan and/or provide feedback to improve performance (Figure 7.4).

Figure 7.4 Use of Assessment Results



- A higher percentage of 2022 survey respondents overall (91%) reported using assessment results to improve board performance compared to 2018 survey respondents (Figure 7.5).

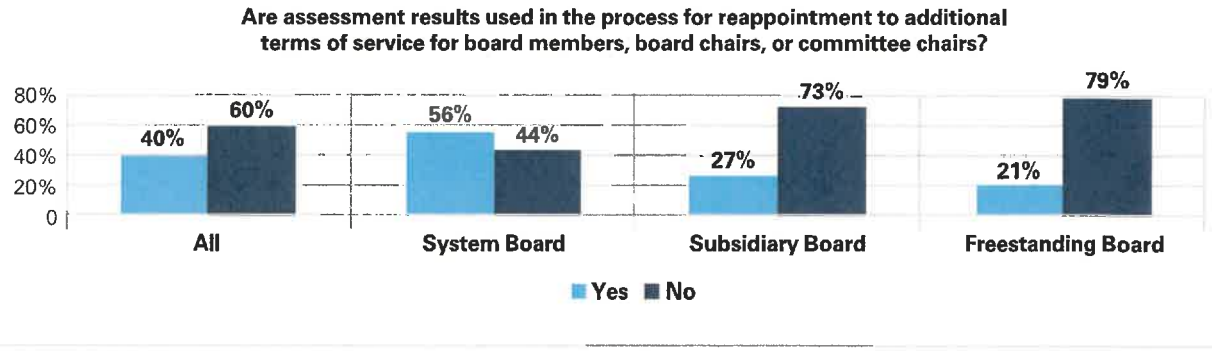
Figure 7.5 Use of Assessment Results by Year



*Not an option in 2018 or 2022

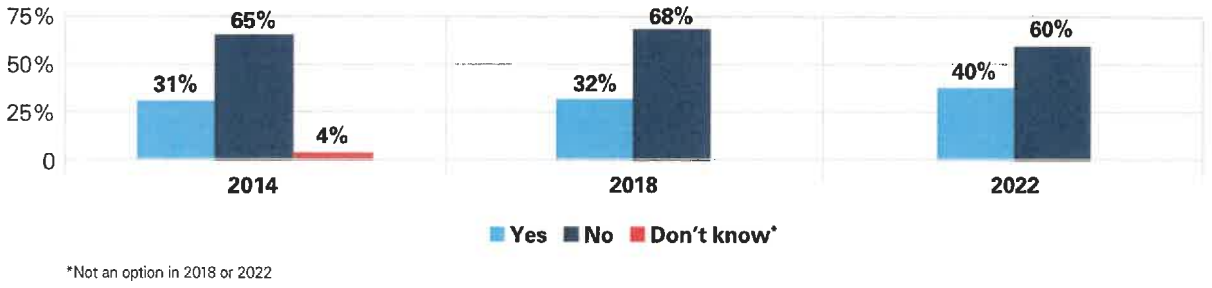
- Some 60% of overall respondents to the 2022 survey did not use assessment results in the process for reappointment of board members, board chairs or committee chairs (Figure 7.6).

Figure 7.6 Use of Assessment Results for Reappointment



- In 2022, more boards overall (40%) included assessment results in board member or board/committee chair reappointment as compared to 2018 (Figure 7.7).

Figure 7.7 Use of Assessment Results for Reappointment by Year



*Not an option in 2018 or 2022

Board Member Evaluation Criteria

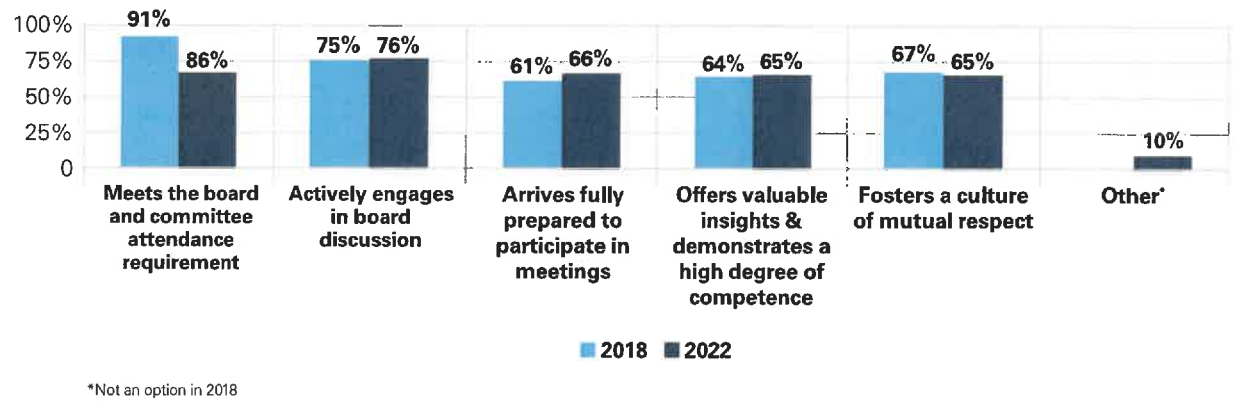
- Some 86% of 2022 respondents overall report "meets the board and committee attendance requirement" as a criterion used to evaluate individual board member performance (Figure 7.8).
- System boards indicated they used "actively engages in board discussion" (90%) and "arrives fully prepared to participate in meetings" (87%) as criteria for individual board member performance evaluation than did hospital boards (Figure 7.8).

Figure 7.8 Criteria for Individual Board Member Performance Evaluation

	All	System Board	Subsidiary Board	Freestanding Board
Meets the board and committee attendance requirement	86%	91%	85%	78%
Actively engages in board discussion	76%	90%	68%	65%
Arrives fully prepared to participate in meetings	66%	87%	54%	50%
Offers valuable insights & demonstrates a high degree of competence	65%	78%	61%	53%
Fosters a culture of mutual respect	65%	78%	64%	51%
Other	10%	8%	9%	13%

- 2022 survey results for criteria for individual board member performance evaluation were similar to 2018 results (Figure 7.9).

Figure 7.9 Criteria for Individual Board Member Performance Evaluation by Year



Commentary on Board Evaluation

By Barbara H. Lorsbach, (blorsbach@governwell.net), president, GHI governWell™

Introduction

Lead by example. It is a principle that is foundational to nearly all leadership models. The AHA's 2022 governance survey results show notable strengths as well as persistent weaknesses in the extent to which health system and hospital boards lead by example when evaluating their own performance. Boards must be agile, astute and highly competent in carrying out their responsibilities and duties. They face significant leadership challenges, including constant vigilance in oversight of quality and service excellence, financial shortfalls, ensuring the recruitment and retention of a strong workforce as well as understanding changing community needs and consumer preferences. Boards will be successful in dealing with these issues if they understand the most critical components of leadership effectiveness and successfully evaluate their own leadership.

Observations about Survey Findings

In the same way that the board is responsible for oversight of continuous quality improvement, it also is responsible for ensuring continuous improvement of its own performance. To accomplish this, the board should regularly self-assess. According to the AHA governance survey, 61% of hospital and health system boards conducted a full board assessment in the past three years. Of boards that assessed themselves, a notable 90% used the results to create an action plan or feedback to improve performance. These boards put their results to work to achieve actionable and measurable governance gains.

While the majority of organizations reported conducting a board assessment, survey data also indicated that more than 25% of all boards reported they had not used any type of assessment in the past three years — not full board assessments, individual board member assessments, board chair or board or committee meeting evaluations. This finding is shocking given the scopes of responsibility and authority of health system and hospital boards. With so many aspects of a board's oversight role relying on evaluating and monitoring performance across the organization, the fact that many boards do not use the same standard of excellence to hold themselves accountable is a persistent weakness highlighted by the survey results.

When boards do conduct assessments, full board assessments were the most frequently reported form of evaluation. 83% of system boards, 50% of system subsidiary hospital boards and 46% of freestanding hospital boards reported conducting board assessments in the past three years. A full governance performance assessment (board self-assessment) uses a combination of quantitative and qualitative measurements of board performance. Effective assessments enable boards to identify leadership roles and responsibilities that the board performs well and areas that have the greatest potential for improvement. The assessment process facilitates the development of initiatives and strategies to improve leadership performance.

Survey data indicated that leadership characteristics evaluated in full board assessments vary across types of boards that conducted them. Key findings included:

- Board members' understanding of board structure, roles and responsibilities were the most frequently assessed governance characteristics. Seventy-eight percent reported assessing their board's governance practices in these areas.
- System and system subsidiary hospital boards more frequently assessed members' understanding of board structure, roles and responsibilities than freestanding hospitals (80% compared to 71%).
- Assessment of the extent to which the board contributed to the achievement of the organization's strategic priorities was the second most frequently evaluated. System boards were more likely to assess their contributions (85%) as compared to system subsidiary hospital boards (62%) and freestanding hospital boards (57%).

- Overall, only 66% of hospitals and health system boards that conducted assessments evaluated the extent to which the board achieved its goals and/or work plan.

The second most frequently conducted assessments were board meeting evaluations. Still, less than half (44%) of hospitals and health systems indicated that their boards used this type of assessment. Whereas 81% of system boards evaluated their board meetings, only approximately 20% of system subsidiary hospital and freestanding hospital boards did so. Committee meetings were even less likely to be evaluated.

Given that meeting evaluations are the easiest form of assessment to conduct, the low level of use of this governance practice raises questions as to why boards do not evaluate their meetings. Is the issue a lack of time, discomfort with providing feedback or a lack of awareness of the importance of doing so? All three can be factors. In failing to evaluate meeting effectiveness boards and committees miss out on the ability to improve outcomes and increase board member engagement.

An individual performance assessment is an important part of the governance assessment process. The ability to reflect on one's own strengths and areas that could benefit from intentional improvement efforts is a hallmark of an outstanding leader. However, this leading governance practice is one that has not been widely embraced by the field. In 2022, only 34% of survey respondents reported conducting individual assessments. In 2018, the percentage declined to only 25% before trending upward again in 2022.

For the hospitals and health systems that did evaluate individual board member performance, the criteria most frequently included were board and committee attendance, whether the trustee actively engaged in board discussion, preparation for meetings, the ability to offer valuable insights and the extent to which the board member fostered a culture of mutual respect.

Regular evaluation of the board's performance is a core part of the accountability process. Boards that pay close attention to their own performance will find that their governance processes will improve, their leadership skills will be enhanced, and the quality of their governance decision-making and strategic focus will be sharpened. Most importantly, boards that conduct a self-assessment set a leadership example that then cascades down through the entire organization as it strives for excellence.

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

Discussion Questions on Board Evaluation

- How does your board hold itself accountable for continuous leadership improvement?
- Does your board conduct a governance assessment annually? Bi-annually? If not, what are the barriers to using this governance best practice?
- If your board conducts a self-assessment, is it anonymous allowing trustees to express their opinions and ideas freely and candidly for governance change?
- Does the full board review the results of the assessment, discuss their interpretation of the findings, and determine potential areas for necessary board improvement?
- Does your board conduct a brief meeting evaluation at the end of each board and committee meeting?
- What are the reasons your board does or does not conduct peer assessments? How might board performance improve if individual members' performances were evaluated?

SECTION 8

Performance Oversight

Data Points

Approximately half of all boards do not hold the CEO accountable for diversity, equity and inclusion goals in their performance review. Most boards reported that they use an authority matrix to define management versus governance oversight and accountability for various types of decisions. Some 90% or more of respondents said they use clinical quality, service/satisfaction, financial and patient safety metrics to evaluate organizational performance.

Executive Oversight

- The highest percentage (41%) of 2022 survey respondents overall reported that the board had updated its CEO succession plan within the last year (Figure 8.1).

Figure 8.1 Timing of CEO Succession Plan Update

When did your board last update its CEO succession plan?

	All	System Board	Subsidiary Board	Freestanding Board
Less than a year ago	41%	74%	13%	28%
At least 1 year ago, but less than 2 years ago	10%	8%	10%	12%
At least 2 years ago	11%	10%	11%	12%
Don't know	10%	2%	18%	12%
N/A - Board does not have a formal CEO succession plan	28%	6%	48%	36%

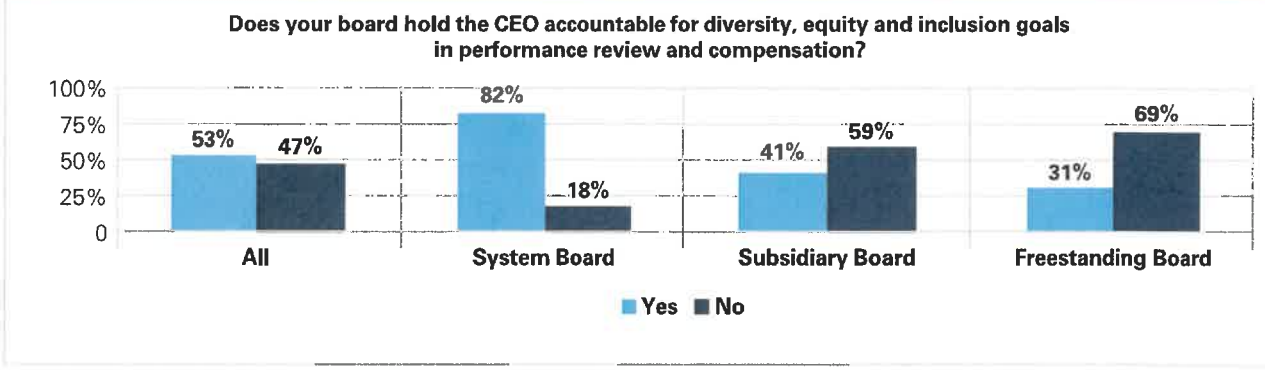
- 2022 survey data indicated that the percentage of respondents reporting their board does not have a formal CEO succession plan has declined steadily since 2018 and 2014 (Figure 8.2).

Figure 8.2 Timing of CEO Succession Plan Update by Year

	2014	2018	2022
Less than a year ago	18%	19%	41%
At least 1 year ago, but less than 2 years ago	7%	12%	10%
At least 2 years ago	6%	9%	11%
Don't know	14%	10%	10%
Board does not have a formal CEO succession plan	55%	49%	28%

- Nearly half (47%) of all 2022 survey respondents reported that their boards do not hold the CEO accountable for diversity, equity and inclusion goals as part of their performance review and compensation (Figure 8.3).

8.3 CEO Accountability for Diversity, Equity and Inclusion Goals



- When asked how their board oversees executive leadership development, 63% of 2022 survey respondents overall reported that the board ensured executive leadership development was a key priority for the CEO (Figure 8.4).

Figure 8.4 Executive Leadership Oversight

How does your board oversee executive leadership development?

	All	System Board	Subsidiary Board	Freestanding Board
Ensures that executive leadership development is a key priority for the CEO	63%	67%	52%	66%
Ensures candidates for executive leadership positions interact with the board at meetings, retreats and other forums	52%	58%	49%	47%
Reviews executive leadership development plans for specific positions at least annually	25%	33%	15%	23%
Other	19%	26%	19%	11%

Accountability

- Nearly all systems (90%) indicated that their boards had an authority matrix or policy delineating management versus governance oversight and accountability for various types of decisions (Figure 8.5).
- The use of an authority matrix has increased overall from 69% in 2018 to 75% in 2022 (Figure 8.6).

Figure 8.5 Use of an Authority Matrix

Does your board have an authority matrix or policy that defines management oversight and accountability versus governance oversight and accountability for spending limits, signature authorities, when certain actions require board approval?

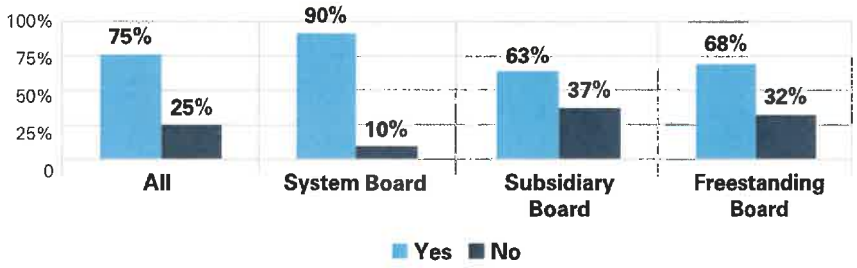
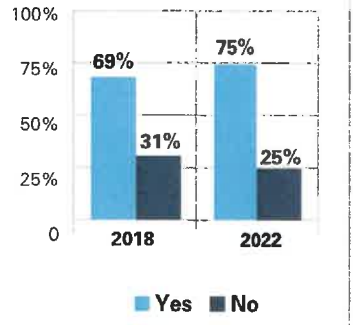


Figure 8.6 Use of an Authority Matrix by Year



Organizational Performance

- When asked which types of metrics and objectives the board uses to evaluate organizational performance (Figure 8.7), the highest percentages of 2022 survey respondents overall cited the following: clinical quality (95%), service quality/patient satisfaction (93%), financial performance (92%) and patient safety (90%).
- As indicated in Figure 8.7, use of diversity and health equity metrics and objectives represented the lowest percentage of responses overall and for hospital boards.

Figure 8.7 Use of Metrics/Objectives to Evaluate Organization Performance

Does your board use precise and quantifiable metrics and objectives to evaluate organizational performance in the following areas?

	All	System Board	Subsidiary Board	Freestanding Board
Clinical quality	95%	99%	97%	89%
Service quality/patient satisfaction	93%	99%	92%	87%
Financial/capital allocation/ investment performance	92%	95%	91%	90%
Patient safety	90%	96%	94%	81%
Employee satisfaction	83%	96%	83%	67%
Achievement of strategic priorities	75%	87%	72%	65%
Physician engagement/satisfaction	60%	72%	62%	46%
Community/population health	54%	75%	51%	32%
Diversity and Health Equity	44%	77%	35%	15%
Other	2%	1%	1%	2%

- The majority of respondents to the 2022 survey overall (86%) indicated they considered the results of the organization's community health needs assessment (CHNA) in developing the strategic plan (Figure 8.8). Some 86% of overall respondents to the 2022 survey reported using CHNA results in strategic plan development, compared with 81% in 2018 (Figure 8.9).

Figure 8.8 Use of Community Health Needs Assessment Results in Strategic Plan Development

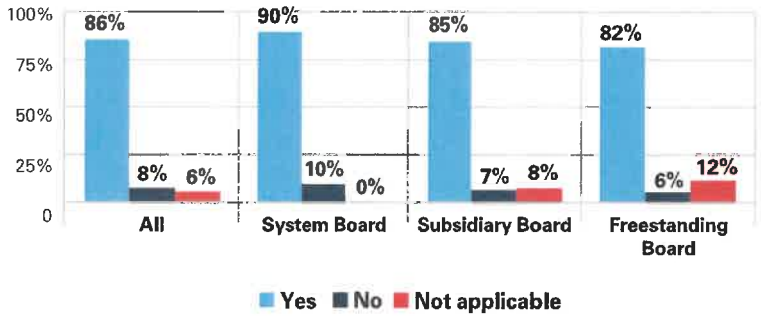
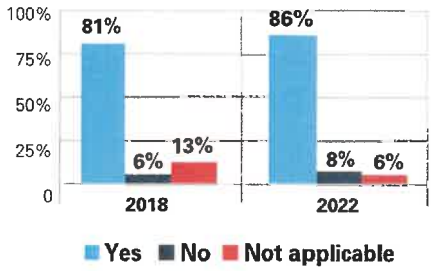


Figure 8.9 Use of Community Health Needs Assessment Results in Strategic Plan Development by Year



Commentary on Performance Oversight

By Kimberly A. Russel, (russelmha@yahoo.com), chief executive officer, Russel Advisors

Introduction

The board's relationship with its CEO directly impacts the health care organization's success in meeting the mission and vision. The details underlying the structure of this crucial relationship are revealed in this section of the survey. The survey data provide insights that will help boards carry out their oversight responsibilities while simultaneously supporting the CEO's effectiveness. This branch of the survey examines how the board carries out its performance oversight role with respect to both the CEO and the organization. The "how" includes CEO succession planning, executive leadership development, the use of a board policy clarifying governance and executive roles and the measurement of overall organizational performance. For the first time, the survey delves into CEO accountability for the organization's diversity, equity and inclusion goals. The survey also probes the linkage between identified community health needs and the strategic plan.

Survey findings for these elements generally show positive governance gains. As this survey covers the pandemic period, the improvement is particularly noteworthy. However, along with the positive progress in several aspects of performance oversight, the survey highlights several key areas in need of further board attention.

Observations about Survey Findings

As the pandemic transitions to the endemic phase, every board should be aware of national and regional CEO retention and turnover trends. Not surprisingly, health care CEO retirement announcements in 2022 are ubiquitous and the executive search industry predicts continuing high levels of CEO turnover. These market realities make it imperative for boards to double down on CEO succession planning and associated internal executive development. The survey demonstrates strong attention to CEO succession planning from health system boards with 74% reporting an update to the CEO succession plan within the past year.

The survey reveals a very concerning governance weakness for freestanding boards, with only 28% reporting an update to its CEO succession plan within the past year (and only an additional 12% reporting an update within the past two years). Boards that are not addressing CEO succession are placing their organizations at undue risk.

Closely related to CEO succession planning is the board's role in executive leadership development oversight. Boards must understand that high-performing health care executives are in high demand. The board will mitigate the impact of executive turnover by establishing a clear expectation that the CEO prioritize internal executive leadership development. The leadership development strategy should include specific action plans, stretch experiences and other professional development opportunities.

The survey reports strong progress (63%) among all boards in ensuring that executive leadership development is a key CEO priority. However, there is room for improvement in crafting more interaction opportunities between key board members and other executive leaders as only 52% report this practice.

Finally, a troubling survey outcome is that only a minority of boards (25%) are reviewing leadership development plans for specific key executive roles. It is appropriate to delegate oversight of executive leadership development to a board committee. Ideally, the designated board committee should receive a high-level overview from the CEO regarding the status of each key executive's leadership development plan. The summation of this work will provide the board with an accurate understanding of the level of ready versus still developing talent within the organization.

A welcome addition to the survey is a glimpse of the movement of boards to hold the CEO accountable for organizational DEI goals. In this instance, accountability is defined as including DEI results in the CEO's annual performance assessment and compensation package. Because this is the first year for this survey question, the 2022 data serves

as a baseline. DEI strategies are in various stages of development across all health care organizations. However, including DEI results in the CEO's compensation design is a further step that most subsidiary and independent hospital boards have yet to implement. In contrast, most system boards (82%) report this accountability practice in place.

The use of an authority matrix or similar policy distinguishing management authority from governance oversight is a vital tool that supports a strong relationship between the board and CEO. The authority matrix provides clarity to all parties and is a proactive step that prevents misunderstanding and miscommunication. The survey reveals strong progress in this area with 75% of all boards having an authority matrix or policy (compared to 69% in 2018).

The consistency of results between the 2018 and 2022 surveys for the use of specific metrics of organizational performance is surprising due to the intervening pandemic years. Anecdotally, many boards and CEOs reported stepping away from these metrics for executive compensation purposes in 2020 and 2021 due to the unanticipated pandemic impact. Perhaps the 2022 survey represents boards returning to pre-pandemic organizational performance metrics. There is also strong consistency between 2018 and 2022 related to the selection of metrics used for evaluation purposes, with clinical quality, service quality, financial performance and patient safety universally adopted by nearly all (at least 90%) survey respondents.

The survey indicates that the majority of boards (86%) incorporate community health needs assessment results into strategic plan development. This is a particularly important finding as the pandemic has highlighted the importance of deep connections between hospitals and their local communities.

Given the challenging external factors that face our nation's hospitals and health systems, the board's approach to its performance oversight responsibilities remains in the spotlight. As health care organizations in 2022 are reporting disappointing financial and quality results due to pandemic-related challenges, will boards have the fortitude to continue to set high standards and to expect strong performance from hospitals and health systems?

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

Discussion Questions on Performance Oversight

- Has your board assigned CEO succession planning and executive leadership development to a designated board committee? Is the board (or its designated committee) up to date on the health care CEO and executive market?
- Has your board established an annual cadence to update the CEO succession plan? If not, why not and what is the plan for the board to tackle CEO succession planning?
- Has your board reinforced to the CEO his or her accountability for internal executive development? How is the board providing oversight?
- Has your board clarified to the CEO its expectations related to DEI strategies?
- Are the organizational performance metrics selected by the board in sync with the board's expectations for high performance?

SECTION 9

Board Culture

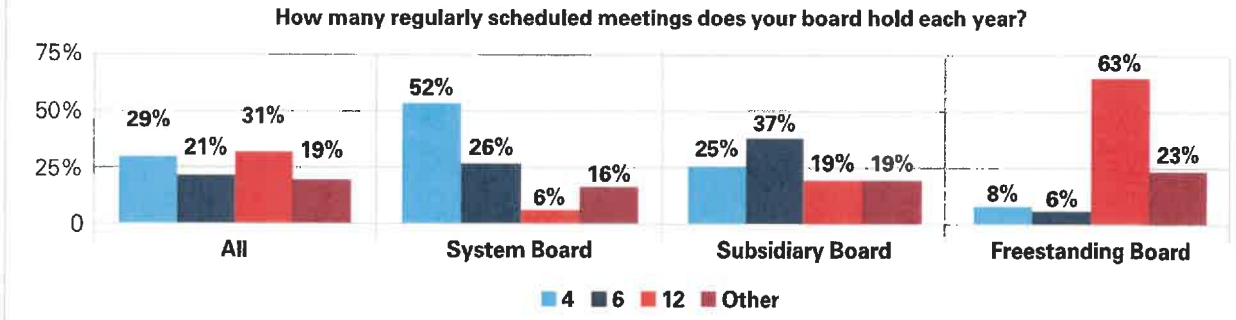
Data Points

A significant majority of respondents to the 2022 survey have not increased the number or length of their board meetings in the past three years. Half of systems reported their meetings now last five hours or more. A majority, some 65%, report spending 50% or less of board meeting time in active discussion, deliberation and debate. More than half of all boards reported no change in the time spent on board activities in the past three years.

Board Meetings

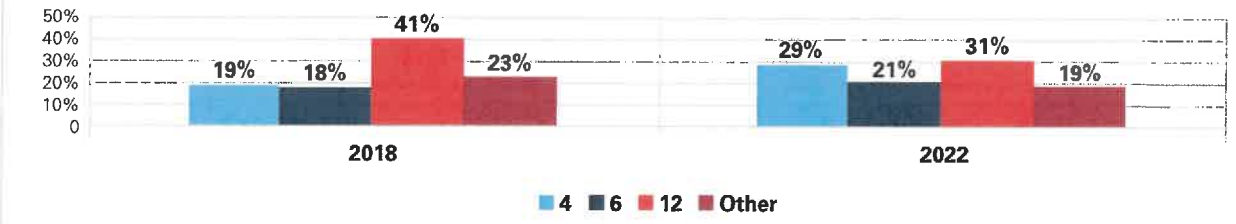
As indicated in Figure 9.1, the highest percentage of system boards (52%) reported holding four regularly scheduled meetings each year. The highest percentage of system subsidiary boards (37%) reported holding six meetings per year. The majority of freestanding hospitals (63%) reported their boards held 12 regularly scheduled meetings each year.

Figure 9.1 Number of Regularly Scheduled Board Meetings Each Year



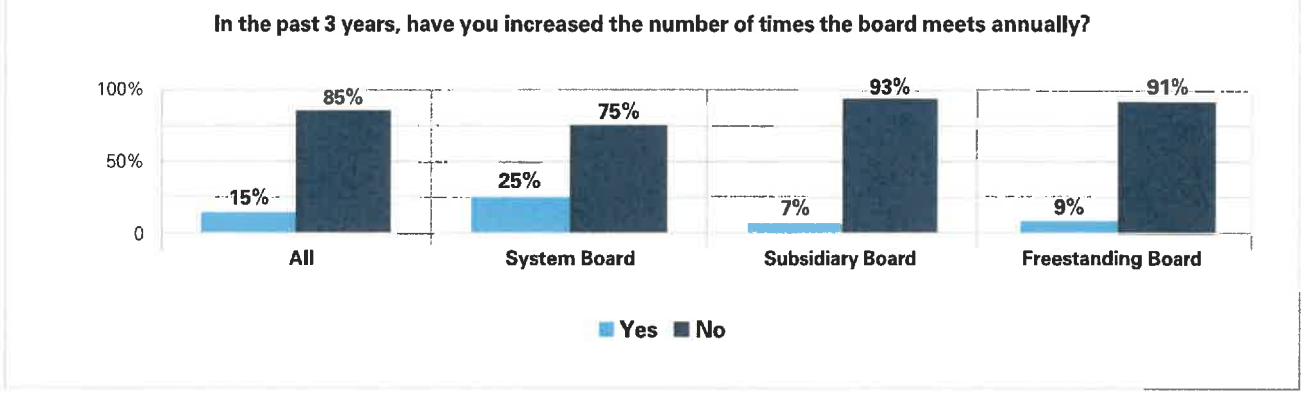
- Of all respondents to the 2022 survey, a greater percentage (29%) reported holding four regularly scheduled board meetings per year, while fewer (31%) reported their boards held 12 regularly scheduled meetings in comparison to 2018 survey results (Figure 9.2).

Figure 9.2 Number of Regularly Scheduled Board Meetings by Year



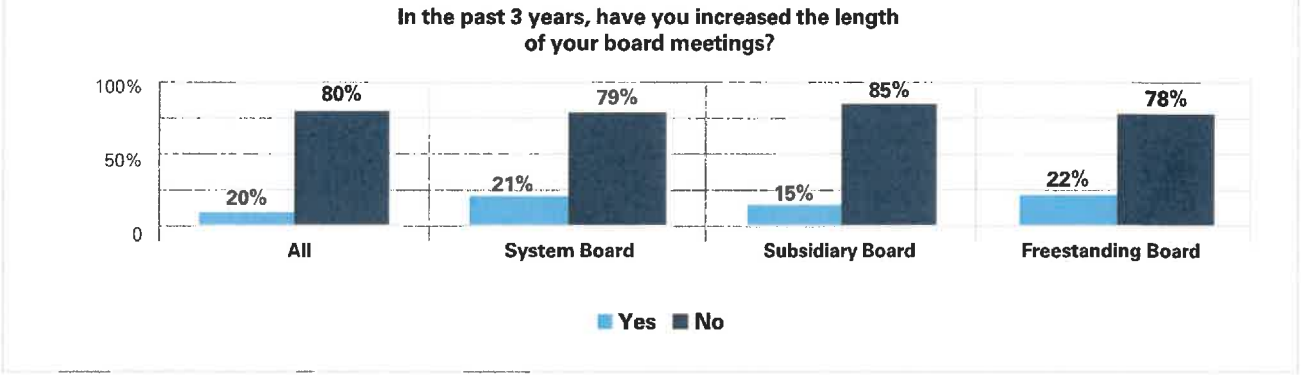
- The majority of overall respondents to the 2022 survey (85%) reported that in the past three years they had not increased the number of times the board met annually (Figure 9.3).

Figure 9.3 Increase in Number of Board MeetingsAnnually in Past 3 Years



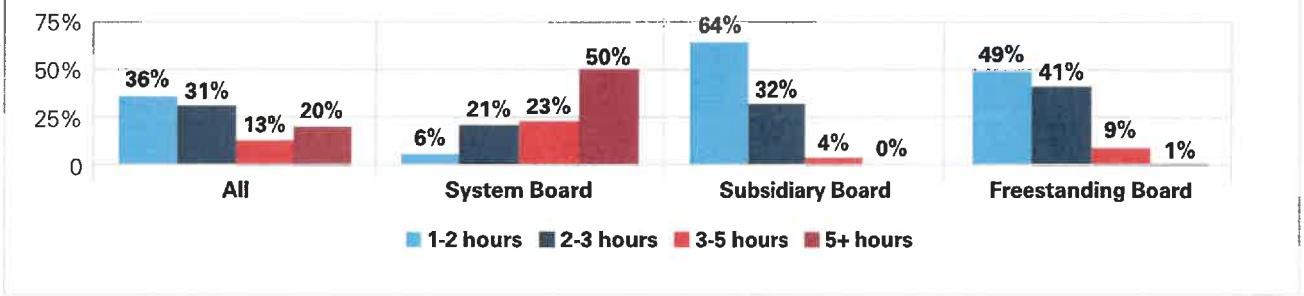
- The majority of overall respondents to the 2022 survey (80%) reported not increasing the length of board meetings in the past three years (Figure 9.4)

Figure 9.4 Increase in Board Meeting Length in Past 3 Years



- The highest percentages of hospital boards (both system subsidiary and freestanding) reported a typical board meeting lasts one to two hours. The highest percentage of system boards (50%) reported that a typical board meeting lasts five hours or more (Figure 9.5).

Figure 9.5 Length of Typical Board Meeting



- In 2018, the highest percentage of systems (31%) reported that a typical board meeting lasted two to three hours, while in 2022 the highest percentage of systems (50%) reported their board meetings lasted five hours or more (Figure 9.6).

Figure 9.6 Length of Typical Board Meeting by Year						
	System Board		Subsidiary Board		Freestanding Board	
	2018	2022	2018	2022	2018	2022
1-2 hours	25%	6%	59%	64%	51%	49%
2-3 hours	31%	21%	35%	32%	40%	41%
3-5 hours	22%	23%	7%	4%	9%	9%
5+ hours	21%	50%	0%	0%	1%	1%

- When asked about board meetings during the COVID-19 pandemic (Figure 9.7), the highest percentages of respondents overall to the 2022 survey reported that they met virtually (75%) or met using a hybrid model (54%).

Figure 9.7 Board Meeting Frequency During Covid-19 Pandemic (March 2020-2022)				
During the COVID-19 pandemic (March 2020 to present) has your board:				
	All	System Board	Subsidiary Board	Freestanding Board
Met more frequently	30%	60%	9%	13%
Met less frequently	5%	2%	6%	8%
Met virtually	75%	76%	79%	72%
Met in-person	23%	5%	16%	47%
Met using a hybrid model	54%	43%	51%	67%

- The highest percentages of 2022 survey respondents overall and across all board types reported that they spend greater than 25% but less than 50% of board meeting time in active discussion, deliberation and debate (Figure 9.8). The same was true of respondents to both the 2014 and 2018 surveys (Figure 9.9).

Figure 9.8 Board Meeting Time Spent in Active Discussion, Deliberation and Debate

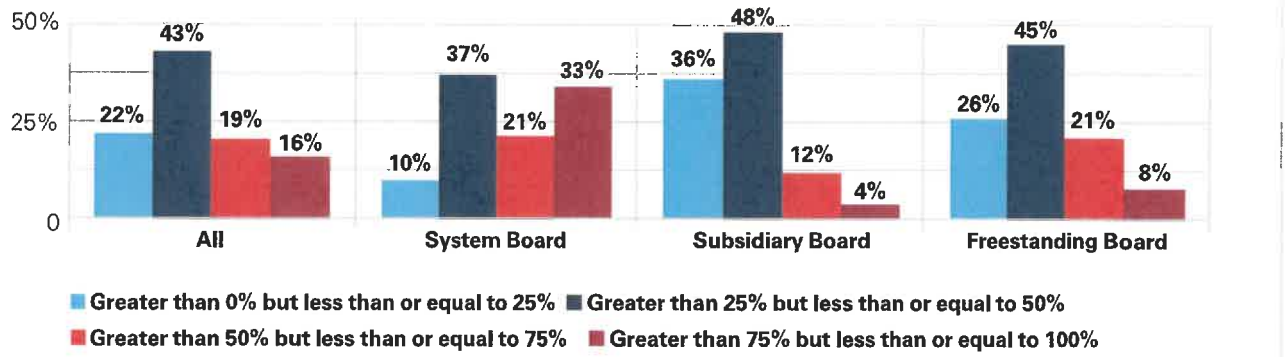
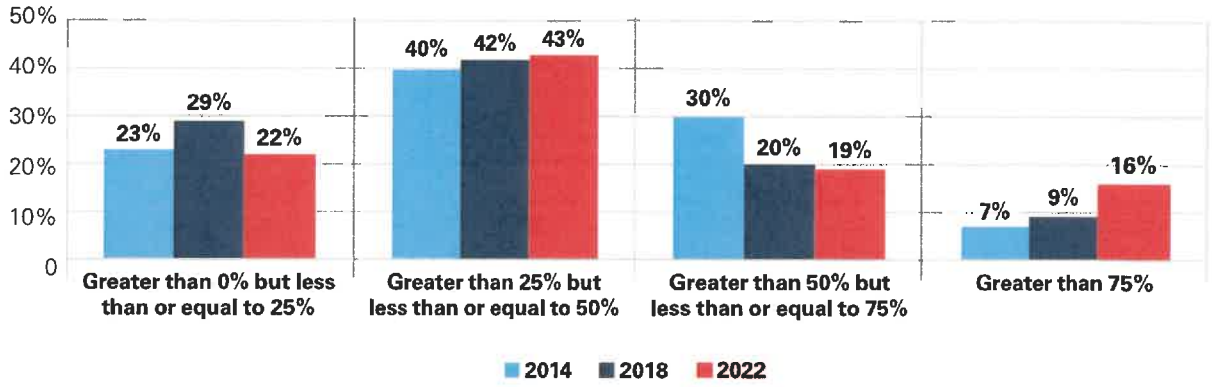


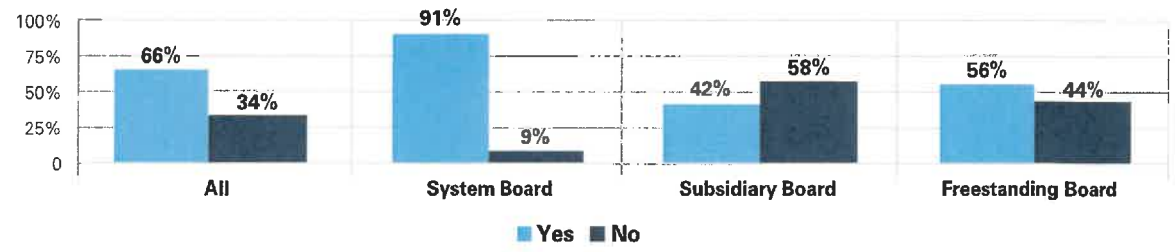
Figure 9.9 Board Meeting Time Spent in Active Discussion, Deliberation and Debate by Year



Executive Sessions

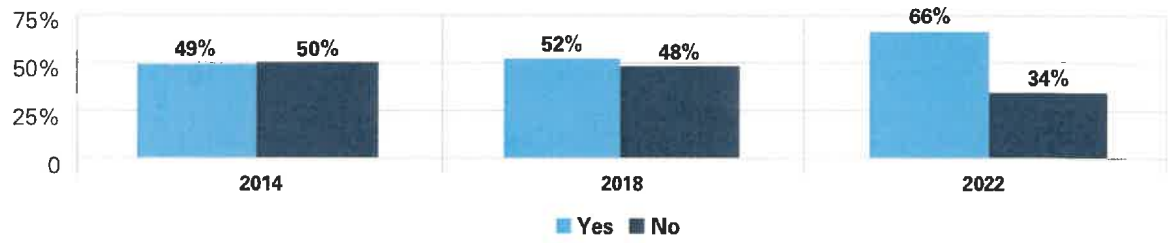
- Some 91% of systems reported they routinely include an executive session in the agenda of every board meeting. In comparison, 56% of freestanding boards and 42% of system subsidiary hospital boards reported this approach to executive sessions (Figure 9.10).

Figure 9.10 Executive Session on Every Board Meeting Agenda



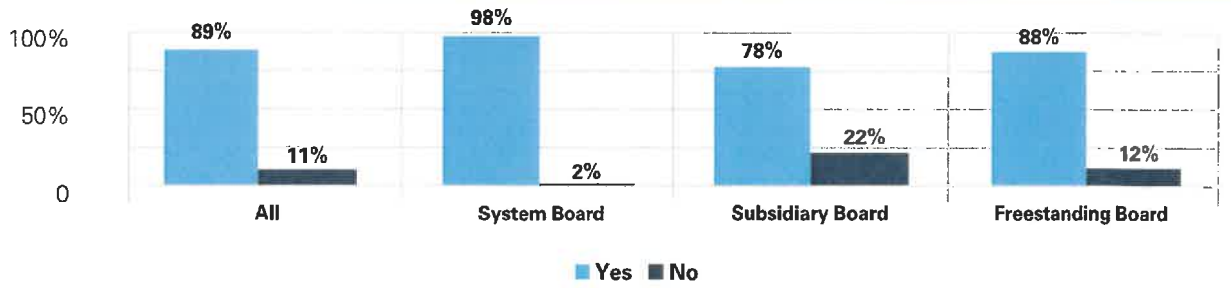
- In 2022, 66% of overall survey respondents reported they routinely include an executive session in the agenda of every board meeting as compared to 52% in 2018 and 49% in 2014 (Figure 9.11).

Figure 9.11 Executive Session on Every Board Meeting Agenda by Year



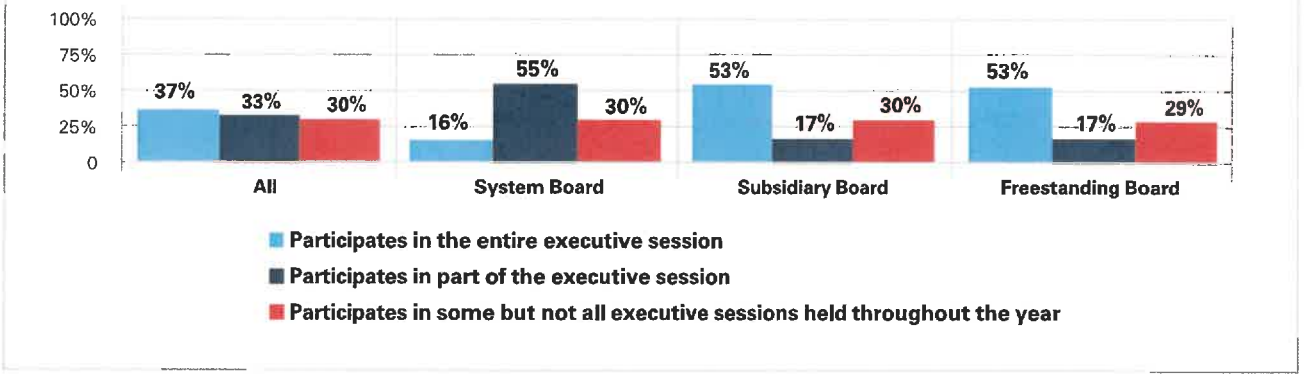
- Of 2022 survey respondents that did have executive sessions, the majority of all respondents and respondents across all board types said the CEO participates in at least a portion of these sessions (Figure 9.12).

Figure 9.12 CEO Participation in Any Portion of Executive Sessions



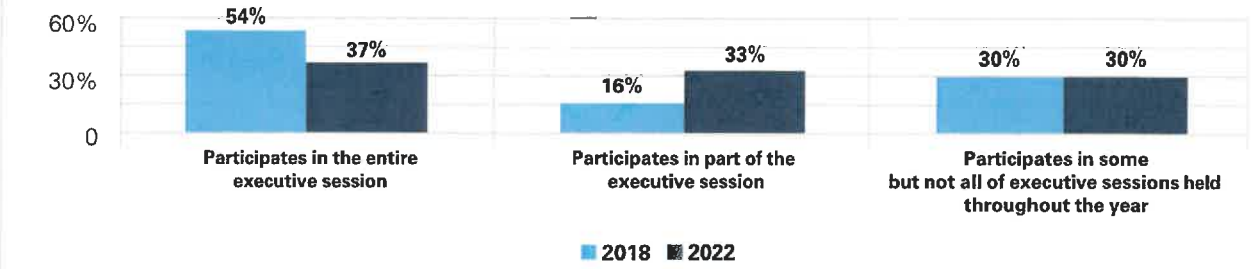
- A majority of hospital boards (53%) indicated that the CEO participates in the entire executive session as compared to 16% of system boards (Figure 9.13).

Figure 9.13 Level of CEO Participation in Executive Sessions



- A higher percentage of respondents to the 2022 survey overall (33%) reported that the CEO participates in part of the executive session than did respondents in 2014 (16%), as shown in Figure 9.14.

Figure 9.14 Level of CEO Participation in Executive Sessions by Year



- Excluding executive performance evaluation and executive compensation, more than 84% of respondents reported that the CEO is present for executive session discussions about all other topics (Figure 9.15).

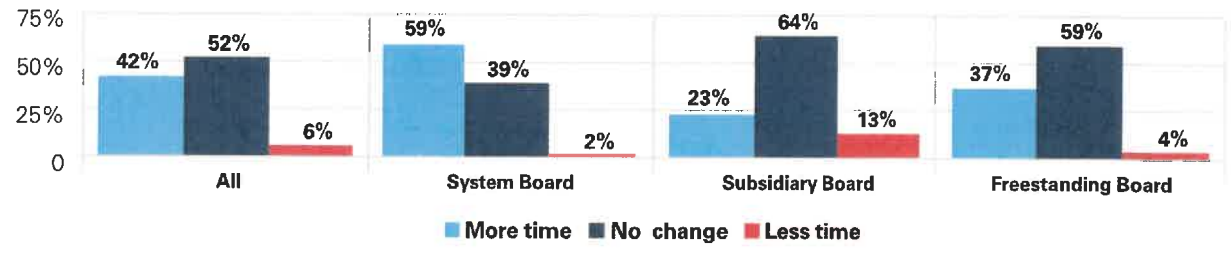
Figure 9.15 CEO Participation in Board Executive Sessions by Topic

		All	All	System Board	Subsidiary Board	Freestanding Board
Financial performance of the health system/ hospital(s)	CEO Present	99%	99%	96%	99%
	CEO Not Present	1%	1%	4%	0%
Clinical or quality performance measures	CEO Present	99%	100%	98%	99%
	CEO Not Present	1%	0%	2%	1%
General strategic issues/ planning	CEO Present	99%	100%	98%	99%
	CEO Not Present	1%	0%	2%	1%
Board development	CEO Present	98%	99%	97%	98%
	CEO Not Present	2%	1%	3%	3%
Board recruitment and selection	CEO Present	95%	99%	95%	92%
	CEO Not Present	5%	1%	5%	9%
Board evaluation	CEO Present	94%	98%	95%	89%
	CEO Not Present	6%	2%	5%	11%
Board member performance evaluation	CEO Present	90%	96%	87%	84%
	CEO Not Present	10%	4%	13%	16%
Executive performance evaluation	CEO Present	26%	16%	29%	37%
	CEO Not Present	74%	84%	71%	63%
Executive compensation	CEO Present	24%	19%	23%	29%
	CEO Not Present	75%	81%	77%	71%

Time Commitment

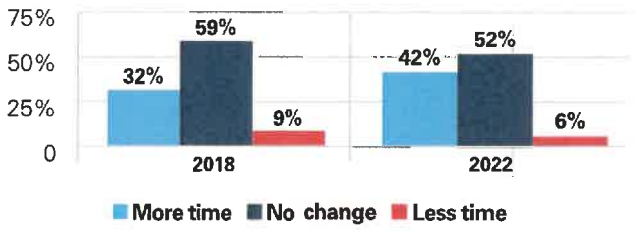
- System boards (59%) reported that they were spending more time on board work and related activities compared to three years ago. Hospital boards reported no change in the amount of time spent on board activities (Figure 9.16).

Figure 9.16 Time Spent on Board Activities Compared to Three Years Ago



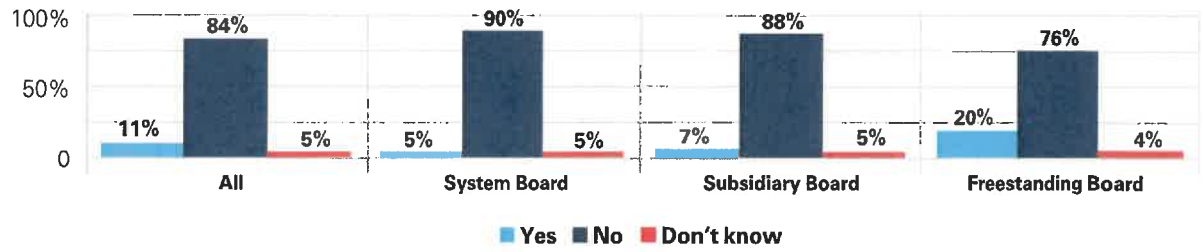
- Some 52% of all 2022 survey respondents reported no change in the past three years in the amount of time spent on board activity, as compared with 59% of all respondents in 2018 (Figure 9.17).

Figure 9.17 Time Spent on Board Activities Compared to 3 Years Ago by Year



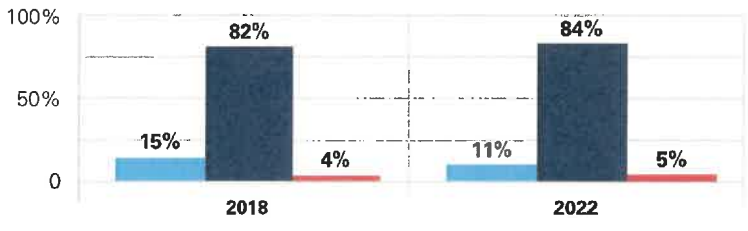
- As Figure 9.18 shows, in 2022 a higher percentage of freestanding hospitals (20%) indicated that board members had voiced concerns about time commitments associated with board service than either system subsidiary hospitals (7%) or systems (5%).

Figure 9.18 Board Member Concern About Board Service Time Commitments



- Fewer respondents overall to the 2022 survey (11%) reported that board members had expressed concerns about time commitments associated with board service as compared to 2018 respondents (11%) overall (Figure 9.19).

Figure 9.19 Board Member Concern About Board Service Time Commitments by Year



Commentary on Board Culture

by Jamie Orlikoff, (j.orlikoff@att.net), president of Orlikoff & Associates and the national adviser on governance and leadership to the AHA

Introduction

The culture of a board can be defined in a variety of ways, from "the way we do things around here" to "shared patterns of meaning" to the "things that shape our thoughts, attitudes and behaviors." Language is often regarded as an expression of the culture of any group, as is the decision-making process and the mechanism of rewarding and excommunicating members of the group. Culture helps a board define itself to its own members, to the other leaders of the organization and to the stakeholders of the organization.

Culture frames the way a board deals with conflict, both internally and between the board and the CEO and clinical leaders. It determines how a board deals with dissent and disagreement within its ranks: does it recognize and encourage respectful disagreement and use it as creative tension to drive better decisions, or does it avoid dissent to maintain the false comfort of unanimity? The culture of a board determines what it focuses on, as well as what it ignores.

Because of its many, varied and amorphous characteristics board culture is one of the most challenging aspects of governance to measure. Hence the focus in this section on one of the most foundational aspects of board culture — how a board spends its time. As a board only exists when it is meeting, the study of board meeting frequency, length and participation (who is in the meeting and when) provides a foundational perspective of governance culture and how it is changing.

One of the most significant aspects of the culture of a board, or any group, relates to how it responds to a crisis. This is when the true character of a board is revealed. This survey was uniquely influenced by the most significant health care crisis in living memory. The COVID-19 pandemic has had seismic impacts on U.S. society, its health care system, and its governance. Hospitals and health systems were needed as never before by America during the pandemic, and for them to function meant that their boards needed to meet to govern them. Governance during the emergency of the pandemic is presumably vastly different than governance during the "normal times" that preceded it. How, or if, hospital and system boards adjusted their meeting practices reflected their cultural approach to the reality of the pandemic, as well as their ability and willingness to adapt to new meeting technologies and the challenges they presented.

Observations about Survey Findings

From March of 2020 to the beginning of 2022, how boards adjusted their approach to meetings was as interesting as it was varied (Figure 9.7). Only 13% of freestanding hospital boards increased the frequency of their meetings during this period, but 60% of systems boards did. Only 5% of system boards met in person during this period, but 47% of freestanding hospital boards continued to do so. Most boards adapted by using technology to facilitate their meetings during periods of pandemic-induced social isolation, with 72% of all boards meeting virtually, using a video conference meeting platform at least once during this period. Seventy-six percent of system boards met virtually, as did 72% of freestanding hospital boards.

Having a board meeting either by virtual or in-person formats was not an exclusive binary choice, as the pandemic introduced and elevated a new cultural term into the governance lexicon: the hybrid meeting. In a hybrid meeting some of the members of a board are together in-person in a meeting room, while other board members participate virtually. Freestanding hospital boards were more likely to use hybrid meeting models (67%) than were system boards (43%).

So, to broadly summarize: most system boards chose to meet more frequently (60%), and to conduct their meetings virtually (76%); only 5% of system boards held in-person meetings during this period. Conversely, most hospital boards kept the same meeting frequency as they had prior to the pandemic (79%), held in-person

meetings (47%); and were more likely to use a hybrid meeting models (67%). What might explain these differences and how might this reflect different cultures of system versus hospital governance?

First, regarding meeting frequency, freestanding hospital boards have historically met more frequently than system boards. This is due to several reasons, but a major one is the fact that hospital boards must perform regular oversight of the medical staff credentialing function, while most system boards do not. These survey results are consistent with the historical trend, with 63% of freestanding hospital boards meeting 12 times per year, compared to 78% of system boards meeting six times a year or less (Figure 9.1). So, the fact that system boards increased meeting frequency during the period of March 2020 through the end of 2021 likely reflected their need to become more engaged during the emergency of the pandemic than their regular meeting schedule allowed. Freestanding hospital boards, on the other hand, were likely able to accommodate the need for increased pandemic-driven board oversight into their regular, more frequent meeting cadence.

The fact that system boards held significantly fewer in-person meetings than freestanding hospital boards may be explained by the fact that systems cover, and system board members tend to come from broader geographic areas than freestanding hospitals and their board members. Freestanding hospital board members tend to live in the more geographically compressed community served by the hospital. Hence, it was likely easier logistically (with no plane travel or long drives, and no overnight hotel stays necessary) to convene in-person meetings for the hospital boards than for the system boards. It is also possible that system boards were more comfortable with and had better access to virtual meeting technology and adopted it earlier than freestanding hospital boards.

More controversially, it is also possible that system boards were composed of members who were more attuned to and accepting of the science of COVID-19 and its transmission and were therefore more unwilling to meet in person - for both personal health and leading by example reasons - than some of the freestanding hospital boards. This could be due to a variety of factors including: different selection criteria and board composition practices for system boards compared to freestanding hospital boards; less community-specific political and social pressure on system board members than on members of freestanding hospital boards; the broader, multi-community perspective required of system boards which may generate a greater tendency to think about population health versus individual rights; and many others.

Whatever the reasons, it is clear from the significant differences in pandemic-related meeting frequencies that the culture of freestanding hospital governance is different from that of system governance. It is left to future surveys to determine if these different cultures will converge over time, or if they will remain distinct, and possibly grow more so.

Other questions also remain that will relate to the culture of governance in the near future. For example: Are hybrid board meetings inherently less effective than either all in-person or all virtual meetings? Some believe that this is true because of variation in participation and engagement between those members who attend in-person and those who attend virtually. The thinking goes that the in-person attendees can chat during breaks and meals and can be more attuned to the "buzz" and meeting energy and "what the real issues are" than can those who attend virtually. Some boards are so convinced of this that they have adopted policies prohibiting hybrid meetings and require all members to participate in meetings the same way if their participation is to be counted toward meeting attendance requirements.

Another question relates to the effectiveness of alternating meeting models. Here, a board might schedule some of its meetings to be held in virtual format, and others using an in-person model. The preliminary thinking here is that the virtual meetings would be held more frequently, but of shorter length, and focus on the more routine and required tasks of governance. Then, the in-person meetings would be interspersed between the virtual meetings, be held less often, but for longer periods of time and focus on more strategic and generative issues and discussions.

Similarly, some boards are already experimenting with other meeting approaches involving board committee meetings. Here, most of the board committee meetings are held virtually, with one or two held in-person at the beginning of the year when there are new members for orientation purposes.

It remains to be seen how board meeting structure, frequency, duration and model (virtual, in-person or hybrid) will evolve over time. But its evolution is clearly underway and will proceed rapidly. Why? The survey shows that 59% of system boards and 37% of freestanding hospital boards reported that their members were spending more time on governance work (Figure 9.16) compared to three years ago. Further, 20% of freestanding hospital board members expressed concerns about growing time commitments associated with board work (Figure 9.18). It is therefore a foregone conclusion that the integration of new technologies like virtual meeting platforms and board portals (Figure 4.17 and 4.18) will both support and change board culture in the future.

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

Discussion Questions on Board Culture

- How would you describe the culture of your board to a board member from another hospital or health care system?
- What are three positive aspects of the culture of your board? What are three negative aspects of the culture of your board? Is there a plan to maintain the positive and minimize the negative aspects of your governance culture?
- How is the culture of your board different because of the pandemic? What differences do you regard as positive and why? What differences do you regard as negative and why?
- How did virtual meetings impact the culture of your board? How will your board incorporate virtual or hybrid meetings into its meeting practices going forward?
- If your board plans to incorporate virtual or hybrid meetings into future practice, what steps will be taken to maintain existing practices that are supportive of your culture?
- If your board or board leaders are spending more time on governance than in the recent past, is this and its impact on the culture of the board being regularly assessed by the board or a board committee?
- Does your board have a statement of the desired culture of the board? If not, what do you think such a statement should include?

Chicago Office:

155 N. Wacker Drive, Suite 400
Chicago, IL 60606
trustees@aha.org

Washington Office:

800 10th Street NW Two City Center, Suite 400
Washington, DC 20001
trustees@aha.org

www.aha.org
trustees.aha.org

HRG
HEALTHCARE RESOURCE GROUP, INC.
Incredible People | Extraordinary Results

Executive Summary
Provision of a Complete Business Office for

Prosser
Memorial Health

Primary Contact:
Kelly Ryan
Sr. Director, Revenue Cycle Solutions
kryan@hrgpros.com
206.295.7101

HRG
HEALTHCARE RESOURCE GROUP, INC
Incredible People | Extraordinary Results

Executive Summary

Healthcare Resource Group (HRG) appreciates the opportunity to become a valued member of the Prosser Memorial Health (PMH) revenue cycle team providing a Complete Business Office (CBO) solution. Coupling the experience and knowledge of our combined staff with tools, technology and a depth of resources will allow us to enhance the current foundation in place, deliver exceptional performance and make an immediate impact by increasing total collections, reducing time to collect, and improving the patient experience.

The Current Challenges:

- Finding, Retaining, and Training staff needed for the scope and volume of work
- Maintaining a bench to cover for holiday, illness, family leave, etc
- Resources and Expertise to clean-up, trend and manage accounts before they exceed timely filing limits
- Technology and Reporting necessary to keep up with payer requirements
- Staff Training, Education & Quality Assurance (QA) to reinforce and ensure employee growth and knowledge retention

The Need:

A solution that includes:

- A high level of Service, Accountability, and Transparency
- A professional and knowledgeable team to represent PMH positively to the community
- Smooth integration of qualified PMH staff as part of the solution team
- State of the Art Technology and Business Intelligence
- High level of value for services delivered

The Solution:

PEOPLE

HRG

- Certified billing director, supervisor & team including current four (4) agency billing staff
- HRG will provide an onsite implementation liaison for at least the first 60 days to assist with the transition, provide a complete end-to-end assessment of the current revenue cycle and develop a go-forward plan to optimize performance
- Bench strength to supplement current staff and bring AR performance to align with industry Best Practices

PMH

- All staff – including those remaining with the hospital, will be quality monitored & scored monthly
  - All staff must maintain a 95% accuracy or higher
  - Ongoing training provided to improve competency and skillsets
- Employees Onboarding with HRG will receive:
  - An equivalent salary plus 5% increase,
  - A $10,000 signing bonus
  - Access to diverse career advancement opportunities

PROCESSES:

- All patient service billing, follow-up, self-pay & cash applications
- Extensive Washington payer experience
- Payer scorecards
- Industry-leading revenue cycle monthly reporting package
- Policy & procedure review and development
- Best potential AR metric goals implemented (based on unique facility metrics)
- Comprehensive weekly and monthly cash projections
- Monthly claim & denial trending reports
- Medicare bad debt tracking (for the cost report) & bad debt reconciliation

HRG
HEALTHCARE RESOURCE GROUP, INC.
Incredible People | Extraordinary Results

TECHNOLOGY:

- Project includes our full Revenue Cycle Management (RCM) billing management suite including:
  - Denial analysis and prioritization
  - Payer contract performance oversite
  - Pricing Transparency
  - Patient Liability Estimator
- Proprietary database (Helix AI™) providing integrated follow-up for optimization
- Patient friendly, full-service, self-pay portal
- High level Charge Description Master (CDM) analytics

Service Level Metrics:

1.	AR days (targeted levels per payer category)	45 days
2.	Cash collection ratio	98%
3.	Insurance Aging days/ percentage over 90	8 days/18%
4.	PMH estimated cash increase	$4-5M

Fee Structure

• Base Fee	1.99% of collections
• Bonus and penalty	.1% over or under goal

Why HRG?

- HRG has delivered revenue cycle services to hospitals and clinics across the U.S. since 1994.
- Our knowledgeable staff consistently provides exceptional performance and accuracy on behalf of our clients.
- Our proven approach makes an immediate impact increasing total collections, reducing time to collect, providing a bench of qualified staff and improving the patient experience.
- Our partnership is based on the capabilities of our people who exemplify the HRG tag line, **"Incredible People, Extraordinary Results"** Our employees are the foundation of our success which is why we promote a positive culture for growth, success and purpose. Our numerous awards for "Best Places to Work" reinforce that philosophy (Includes Best in KLAS® in 2019 and HFMA Peer Review ®).
- HRG employees are driven by a passion for what we do. That passion fuels our client partnerships, and our partnerships lead to success. Our ability to provide immediate and long-term benefits is at the core of those partnerships. HRG recruits, develops, and retains dedicated professionals helping us accomplish these goals and setting us apart from the competition.

Examples of Successful Partnerships:

- Clinch Memorial Hospital - reduced aging and increased overall AR by 50% in 10 months
- Ocean Beach Hospital and Medical Clinics - reduced days by 60% and aging by 47% over a three (3) year period
- Ward Memorial Hospital – 43% increase in cash and reduced AR by 22% over two (2) years

Attachment NN

Healthcare Resource Group
The CBO Partnership

Prosser
Memorial Health

Presented by:

HRG
HEALTHCARE RESOURCE GROUP, INC.

February 16, 2023

 hrgpros.com

Table of Contents

HRG Prosser Memorial Health

 hrgpros.com

- Serving healthcare providers in the U.S. since 1994
- Extensive Washington payer experience
- Experts in revenue cycle – our only focus
- 450+ employee owners (ESOP)
- Served more than 650 hospitals & clinics in 38 states including 31 CBOs
- Sophisticated Helix AI™ proprietary technology to integrate with diverse patient accounting systems
- Became a division of TruBridge in March 2022

HRG HEALTHCARE RESOURCE GROUP, INC. Prosser Memorial Health

About HRG

TruBridge® | HRG HEALTHCARE RESOURCE GROUP, INC.

Combined Companies' Statistics:

- Headquarters (HQ) located in Mobile, AL/ Co-HQ Spokane, WA
- Employees: 1,500+
- Generate $185M annual revenue
- RCM Experience: 20 Years
- Healthcare Clients: 1,400
- 98% client retention rate
- Clients in every state

CBO/EBO

- 114 full outsourced partners
- 45 partial or short-term partners
- Collect $2.4B in cash

Medical Coding

- 180+ certified coders
- 113 outsourced partners
- 3M+ charts coded annually
- Onshore and offshore partners

Early Out Services

- 328 partner facilities
- Manage $700M in patient A/R
- Collect $260M in patient cash

Revenue Cycle Management Technology

- 783 partner facilities
- Process 24M claims for $52B+ in revenue
- Customers average 97% first pass payer acceptance

HRG Prosser Memorial Health

 hrgpros.com

Finding, Retaining & Training the staff needed for the scope and volume of work

Maintaining a bench to cover for illness, holidays, family leave, etc.

Resources & Expertise to clean up, trend & manage aged accounts

Technology & Reporting required to keep up with payer requirements

Staff Training, Education & QA to to reinforce and ensure knowledge retention and growth

HRG HEALTHCARE RESOURCE GROUP, INC. Prosser Memorial Health

Current Challenges For PMH

HB Aging Summary – Active Accounts Receivable (AR)

HB Aging Summary - Active AR

Data collected Tue 2/14 12:00 AM

Financial Class	Open	0 to 30	31 to 60	61 to 90	91 to 120	121 to 180	Over 180	Totals	%
Commercial	421,752	5,439,128	2,369,327	1,037,720	858,836	1,086,713	2,419,490	13,632,967	30 %
Medicaid HMO	323,814	5,081,260	1,389,649	478,968	368,699	460,757	2,719,354	10,822,503	23 %
Medicare	446,857	4,347,523	665,077	322,880	138,306	318,972	783,489	7,023,104	15 %
Medicare HMO	202,172	3,188,344	645,882	322,102	174,428	197,988	577,984	5,308,899	12 %
Outsourced - Self-pay	0	346,980	425,215	376,822	347,864	721,214	1,454,934	3,673,028	8 %
Other	88,392	375,549	484,844	160,220	51,702	917	95	1,161,719	3 %
OTHER GOVERNMENT	32,118	322,809	127,525	200,573	147,313	21,682	188,181	1,040,202	2 %
Worker's Comp	49,727	269,446	210,094	74,379	83,169	90,044	233,482	1,010,341	2 %
Outsourced - Insurance	0	146,336	228,176	178,385	35,581	41,814	243,955	874,247	2 %
Medicaid	17,496	374,682	70,066	19,004	135,124	87,278	73,406	777,056	2 %
Self-Pay	48,140	226,686	56,130	62,045	36,301	110,553	229,329	769,184	2 %
Undistributed	0	-270	-5,012	-1,613	-2,020	-2,610	-219	-11,744	0 %
Active AR Totals	1,630,469	20,118,473	6,666,972	3,231,484	2,375,304	3,135,322	8,923,481	46,081,504	
%	4	44	14	7	5	7	19		

Aging balances after 90 days should continue to fall. Increase due to staff shortages.

HRG HEALTHCARE RESOURCE GROUP, INC. Prosser Memorial Health

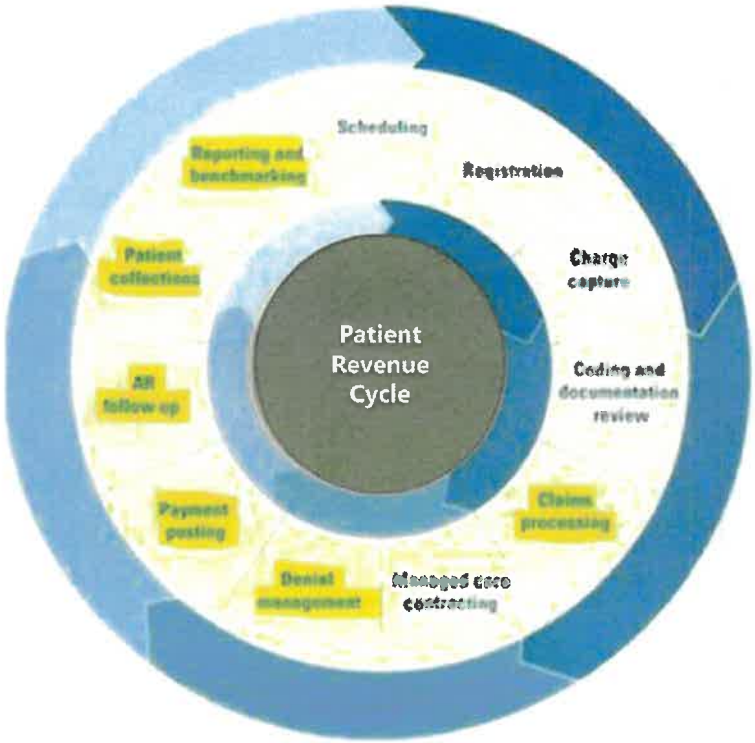
Analytics by Payer

 hrgpros.com

Revenue Cycle

HRG Portions:

- Claims processing
- Denial management
- AR follow up
- Payment posting
- Patient collections
- Reporting and benchmarking



HRG HEALTHCARE RESOURCE GROUP, INC.

Prosser Memorial Health

Business Partnership

 hrgpros.com

People

HRG will provide:

- A certified billing director, supervisor & team plus offering onboarding to current PFS team
- An onsite implementation liaison for at least the first 60 days to assist with transition and complete end-to-end revenue cycle assessment
- Agency support to improve the AR performance before the transfer takes place
- Bench strength to supplement current staff and bring AR performance to Best Practice
- Equivalent salary and benefit package plus incentive opportunities for to PMH staff onboarding
- All staff including those remaining with hospital will be quality monitored & scored monthly
  - All staff must maintain a 95% accuracy or higher
  - Ongoing training

Process

- All patient service billing, follow-up & cash applications
- Extensive Washington payer experience
- Payer scorecards
- Industry-leading revenue cycle monthly reporting package
- Policy & procedure review and development
- Best potential AR metric goals implemented (based on unique facility metrics)
- Comprehensive weekly & monthly cash projections
- Monthly claim & denial trending reports
- Medicare bad debt tracking (for the cost report) & bad debt reconciliation

Technology

- Project incorporates Revenue Cycle Management (RCM) billing tools including:
  - Denial analysis and prioritization
  - Payer contract performance oversite
  - Patient Transparency
  - Patient Liability Estimator
- Proprietary database (Helix AI™) integrated follow-up for optimization
- Patient friendly, full-service self-pay portal
- Charge Description Master (CDM) analytics

HRG HEALTHCARE

Prosser Memorial Health

Business Partnership

Major Tasks	HRG Responsibility	Prosser Responsibility
Patient Access Management		X
Revenue Cycle Management	X	X
Revenue Cycle Reporting	X	
Cash Projections	X	X
Patient Access		X
Charge Entry		X
HIM Management		X
Coding		X
Billing and Follow-up	X	
Cash Applications and Reconciliation	X	
Claim Edit & Denial Management	X	
Charge Master Analytics	X	X
Deposit Preparation – Local and Lock Box	X	X
Self-Pay Management	X	
Early Out Self-Pay	X	

Targeted Service Level Metrics

• Aging days/ percentage over 90	8 days/18%
• AR days (targeted levels per payer category)	45 days
• Cash collection ratio	98%
• PMH estimated cash increase	$4-5M

Fee Structure

• Base fee	1.99% of collections
• Bonus and penalty	.1% over or under goal

Customer Metric Expectations

• Discharged Not Submitted Days:	Less than 4 Days
• Charge Close Lag Days:	3 Days
• Patient Access Denials Percentage:	Less than 5.0%

HRG HEALTHCARE RESOURCE GROUP, INC. Prosser Memorial Health

Service Level Agreement

 hrgpros.com

Onsite consultant for 60-day assessment & transition period

Charge Description Master (CDM) system review

Implement HRG technologies

AR review for recovery potential

Implement a consolidated revenue cycle committee

Payer contract performance
Implement payer scorecards

Opportunity to onboard & train existing staff
Manage all staff
Agency Supplements

HRG HEALTHCARE RESOURCE GROUP, INC.

Prosser Memorial Health

Next Steps

Kick off call to introduce teams and communicate expectations

Start getting access to system and connections

Team travels on-site

- Implementation Director and leadership team from your HRG team
- Review policy and procedures
- Set-up flow
- Set schedule for weekly and monthly meetings
- Kick-off partnership with both teams

30 – 45 days is typical start-up time

At GoLive, we do formal hand-off from implementation to operations

Fast start with clean-up team and long-term team

Weekly revenue cycle status reports start at GoLive

First monthly revenue cycle report comes after first full month of service

HRG HEALTHCARE RESOURCE GROUP, INC. Prosser Memorial Health

How Do We Get Started?

 hrgpros.com

Drew Memorial

Location: AR	Hospital Type: PPS Hospital	Health Info System: CPSI-Thrive	Time as Client: 3 years
Metric	Prior to Project	After Project Start	Notes
Monthly Cash	$2,246,687	$2,532,293	12.7% increase in cash collections
AR Insurance Days	46	30.8	Have been as low as 26.6
Aging - Insurance	22.3%	11.9%	

Notes: Came to us from another vendor. Over the three years we have provided CBO services cash has increased and AR has dropped 25%.

Amberwell

Location: KS	Hospital Type: Critical Access Hospital	Health Info System: Meditech	Time as Client: 5.5 years
Metric	Prior to Project	After Project Start	Notes
Monthly Cash	$2,153,698	$3,300,000	35% increase in cash collections
AR Insurance Days	45	39	
Aging- Insurance	33%	10%	

Notes: We initially provided a CBO for hospital only. Other vendors were providing CBO for Clinics and the pro-fee hospital billing. Facility decided to consolidate under one vendor. We won the bid. Subsequently they partnered with two other facilities and nine clinics to run under a common CBO. We provide all services for the combined CBO. 2022 was a record cash year. Performance is notable enough that they are applying collaboratively with us for the MAP Innovation award for revenue cycle this year.

HRG Prosser Memorial Health

OCEAN BEACH HOSPITAL & MEDICAL CLINICS

Location: WA	**Hospital Type:** Critical Access Hospital	**Health Info System:** Epic	**Time as Client:** 3 years
Metric	Prior to Project	After Project Start	Notes
Monthly Cash	$1,043,700	$1,090,547	4.5% increase in cash collections
AR Insurance Days	67.7	26.8	
Aging- Insurance	37.1%	19.4%	Has been as low as 16.7%

Notes: We replaced another CBO vendor. In the past three years of the engagement, we have been able to clean-up the aged AR reducing days significantly. Having a partner rather than a vendor is important to Ocean Beach making HRG a great match for their needs.

Clinch Memorial HOSPITAL

Location: GA	**Hospital Type:** Critical Access Hospital	**Health Info System:** Med Host	**Time as Client:** 10 months
Metric	Prior to Project	After Project Start	Notes
Monthly Cash	$2,011,678	$2,375,252	18.1% increase in cash collections
AR Insurance Days	94	34.4	
Aging - Insurance	53.0%	27.6%	

Notes: We were hired initially for an aged account clean-up for accounts aged over day 90 – at that time AR was at 140 days. After four months all their billers quit. HRG was asked to pick up the slack and transitioned to full CBO after 4 months. AR was at 94 when we transitioned to CBO. AR is now down to 34 after a year.

Prosser – Insurance Days 41 : Aging 27

HRG HEALTHCARE RESOURCE GROUP, INC. Prosser Memorial Health

Client CBO Successes

LINCOLN HEALTH
Neighbors Caring for Neighbors

Location: CO	Hospital Type: Critical Access Hospital	Health Info System: Centriq	Time as Client: 3 years
Metric	Prior to Project	After Project Start	Notes
Monthly Cash	$1,337,390	$1,591,558	19% increase in cash collections
AR Insurance Days	94.2	45.0	
Aging - Insurance	49%	18%	

Notes: We were hired when Lincolns entire billing team resigned, and they looked for a vendor to fill the void. Within the first year we were able to increase cash and drop the AR. We saw similar trending the second year. Cumulatively over the past three years cash has grown consistently and aged AR has declined by more than 50%.

WARD MEMORIAL HOSPITAL *Neighbors helping Neighbors*

Location: TX	Hospital Type: Critical Access Hospital	Health Info System: CPSI-Thrive	Time as Client: 2 years
Metric	Prior to Project	After Project Start	Notes
Monthly Cash	$969,521	$1,388,478	43% increase in cash collections
AR Insurance Days	42.1	33.0	
Aging - Insurance	17%	13%	

Notes: Came to us from another vendor. Since partnering with Ward we have been able to accelerate cash significantly and drop AR by 22%. Performance is notable enough that we are applying collaboratively this year for the MAP Innovation award for revenue cycle.

HRG Prosser Memorial Health

