Prosser Memorial Health

Board of Commissioners

Board Packet

October 29, 2020

Whitehead Conference Room

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser
Memorial Health

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

Mission: To improve the health of our community.

BOARD OF COMMISSIONERS – WORK SESSION
TUESDAY, OCTOBER 27, 2020
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
Kevin Hardiek, CIO
Kristi Mellema, CQO
Dr. Brian Sollers, CMO

GUESTS:
Kurt Broeckelmann, Architect, bcDG
Hillary Beashore, Associate/Architect
Paul Kramer, Project Director, NV5
Meg Hohnholt, Project Manager, NV5

I. CALL TO ORDER
  A. Pledge of Allegiance

II. SERVICES
  A. Replacement Facility Update **(Attachment E,F,G,H)**
    1. New Hospital Visioning **(Attachment D)**   **Paul/Meg**
    2. Construction Method **(Attachments I, I-1, I-2)**   **Paul/Meg**
    3. Design Update   **Kurt**
  B. 2021 Strategic Planning **(Attachment A,B,C,D)**   **Craig**

III. EMPLOYEE DEVELOPMENT
  A. PMH Retirement Plan **(Attachment V)**   **Craig/David**
  B. LEM Scorecard **(Attachment Y)**   **Craig**

IV. ADJOURN

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BOARD OF COMMISSIONERS
THURSDAY, October 29, 2020 REVISED*
6:00 PM, WHITEHEAD CONFERENCE ROOM
AGENDA

COMMISSIONERS:	**STAFF**:
Stephen Kenny, Ph.D.	Craig Marks, CEO
Sharon Dietrich, M.D.	Merry Fuller, CNO/COO
Glenn Bestebreur	David Rollins, CFO
Susan Reams	Kevin Hardiek, CIO
Keith Sattler	Shannon Hitchcock, CCO
Brandon Bowden	Kristi Mellema, CQO
Neilan McPartland	Dr. Brian Sollers, CMO

I. CALL TO ORDER
   A. Pledge of Allegiance
   B. Certificate of Appointment/Oath of Office – Neilan McPartland

II. PUBLIC COMMENT

III. APPROVE AGENDA
   Action Requested – Agenda

IV. CONSENT AGENDA
   Action Requested – Consent Agenda
   A. Board of Commissioners Meeting Minutes for September 24, 2020 and Special Board Meeting September 29, 2020.
   B. **Payroll and AP Vouchers** #153785 through #154514, dated 09-17-20 through 10-22-20, in the amount of $7,060,590.30. **Surplus Items Property Description**: 4 Mattress Overlays; #001038 OR Table.

V. MEDICAL STAFF DEVELOPMENT
   A. Medical Staff Report and Credentialing   **Dr. Sollers**
      1. Advancement from Provisional
         Bailey Padilla, CNM – Allied Health Professional privileges in Midwifery effective October 29, 2020 through April 29, 2022.

         Tyler M. Neitlich, MD – Telemedicine privileges in Diagnostic Radiology effective October 29, 2020 through April 29, 2022.

         Veronica Ruvo, DO – Telemedicine privileges in Diagnostic Radiology effective October 29, 2020 through April 29, 2022.

Jenny Siv, MD – Telemedicine privileges in Neurology effective October 29, 2020 through April 29, 2022.

Jennifer Plymale, MD – Courtesy privileges in Pediatric Cardiology effective October 29, 2020 through April 29, 2022.

Jeremy Nicolarsen, MD – Courtesy privileges in Pediatric Cardiology effective October 29, 2020 through April 29, 2022.

2. **New Appointment**
   <mark>**Action Requested** – **New Appointment and Requested Clinical Privileges**</mark>

   Stephen Burton, MD – Provisional/Telemedicine staff with requested privileges in Neurology effective October 29, 2020 through April 29, 2021.

   Aixa Espinosa Morales, MD – Provisional/Telemedicine staff with requested privileges in Neurology effective October 29, 2020 through April 29, 2021.

   Rizwan Kalani, MD – Provisional/Telemedicine staff with requested privileges in Neurology effective October 29, 2020 through April 29, 2021.

   George A. Lopez, MD – Provisional/Telemedicine staff with requested privileges in Neurology effective October 29, 2020 through April 29, 2021.

3. **Reappointment**
   <mark>**Action Requested** – **Reappointment and Requested Clinical Privileges**</mark>

   Fadi Akoum, MD – Reappointment to Consulting staff with requested clinical privileges in Nephrology from October 29, 2020 through October 28, 2022.

VI. **FINANCIAL STEWARDSHIP**
   A. Review Financial Reports for September 2020 **(Attachment CC)**   **David**
      <mark>**Action Requested – Financial Reports**</mark>

   B. PMH Clinic Financial Performance (**Attachment DD**)   **David**

   C. COVID-19 Financial Plan **(Attachments KK & LL)**   **David/Craig**

   D. Cleverly Dashboard **(Attachment FF)**   **David**

   E. Capital Requests
      <mark>**Action Requested – Capital Request**</mark>s   **David**
      1. Elevator Railings Upgrade
      2. Water Cooled Ice Machine/Water Dispenser   (cont'd)

*3. Express Chemistry Analyzer
*4. Smith Medical Epidural and Patient-Controlled Analgesia Pumps (PCA)

VII.   EMPLOYEE DEVELOPMENT
    A. PMH Retirement Plan **(Attachment V)**   **Craig/David**
    <mark>**Action Requested** – PMH Retirement Plan Change</mark>

VIII. SERVICES
    A. PMH EPIC Annual Report (**Attachment O**)   **Kevin**

 IV. QUALITY
     A. COVID-19 Update   **Dr. Sollers**

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

    C. CEO/Operations Report   **Craig**

 V. **ADJOURN**

PMH
Board of Commissioners
Work Plan – FY2020

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Month	Goals & Objectives	Education
January	**QUALITY:** • Review/Approve 2020 Strategic Plan and 2020 Patient Care Scorecards • Sign Financial Disclosure and Conflict of Interest Statements • Approve 2020 Risk Management and Quality Assurance Plans • Select and Approve Board Officers	**EMPLOYEE DEVELOPMENT:** • Review 2019 Employee Engagement Survey Results • Review 2019 Medical Staff Engagement Survey Results **QUALITY:** • Review Board Self-Evaluation **FINANCIAL STEWARDSHIP:** • Review semi-annual financial performance report for PMH Clinics **SERVICES:** • Wellness Center • Sunnyside • Astria Health • Update Architectural Services

Month	Goals & Objectives	Education
February	**PATIENT LOYALTY:** • Approve Studer Contract **QUALITY:** • Approve 2020 Corporate Compliance Plan • Approve 2020 Infection Prevention Control Plan • Approve 2020 Board Action Plan **EMPLOYEE DEVELOPMENT:** • Approve Hospital-wide Patient Monitoring System • Review and Approve 2020 Leadership Incentive Compensation Program	**PATIENT LOYALTY:** • Review Customer Service Program **EMPLOYEE DEVELOPMENT:** • Attend AHA Governance Conference **QUALITY:** • Review 2019 Corporate Compliance Report • Review 2019 Infection Prevention Summary
March	**QUALITY:** • Review/Approve Board Polices **MEDICAL STAFF DEVELOPMENT:** • Support Providers' Day Celebration **EMPLOYEE DEVELOPMENT:** • Approve IAFF Contract (EMS) **FINANCIAL STEWARDSHIP:** • Accept 2019 Audit Report	**PATIENT LOYALITY:** • Review Patient Engagement Plan • Review 2019 Utilization Review Performance • Approve 2020 Utilization Review Plan **EMPLOYEE DEVELOPMENT:** • Review Employee Performance Report • Regulatory Compliance **FINANCIAL STEWARDSHIP:** • Presentation of the 2018 Audit Report by Auditors
April	**QUALITY:** • Approve 2020 Community Benefits Report	**QUALITY:** • Strategic & Patient Care Score Cards • Review 2019 Community Benefits Report

Month	Goals & Objectives	Education
	EMPLOYEE DEVELOPMENT • Conduct CEO Evaluation	EMPLOYEE DEVELOPMENT: • Review Employee Engagement Plan • Review 2019 Leadership Performance (LEM) MEDICAL STAFF DEVELOPMENT: • Review 2019 FPPE/OPPE Summary
May	EMPLOYEE DEVELOPMENT: • Support Hospital Week	EMPLOYEE DEVELOPMENT: • Review PMH Uniform Program FINANCIAL STEWARDSHP: • PMH Foundation Update SERVICES: • Review Replacement Facility Feasibility Study MEDICAL STAFF • Medical Staff Engagement Plan
June	QUALITY: • Review/Approve Board Polices • Approve 2019 CAH Annual Review	QUALITY: • Report 2020 Q1 Utilization Review • Contract Review Process EMPLOYEE DEVELOPMENT: • Review New Employee Orientation Process SERVICES: • Marketing Update • Review PMH IT Security Plan

Month	Goals & Objectives	Education
July	**SERVICES:** • Approve Nuclear Medicine Renovation • Acquisition of ENT and Urology Equipment • Replacement Facility Update	**SERVICES:** • EMS Review • Review Nuclear Medicine Services **QUALITY:** • Quality Committee Report • Strategic & Patient Care Score Cards **EMPLOYEE DEVELOPMENT:** • Employee Health Update **FINANCIAL STEWARDSHIP:** • Review Semi-Annual Financial Performance Report for PMH Clinics • Review HR/Payroll Software (IT)
August	**EMPLOYEE DEVELOPMENT:** • Attend end of summer Engagement Activity for BOC, Medical Staff, and all staff	No Board Work Session **QUALITY:** • iVantage Update **FINANCIAL STEWARDSHIP:** • Centralized Scheduling/POS Collections Update
September	**EMPLOYEE DEVELOPMENT:** • Attend midsummer BOC, Medical Staff, and Leadership Engagement Activity **QUALITY:** • Review/Approve Board Polices	**FINANCIAL STEWARDSHIP:** • Auditor Selection Review **EMPLOYEE DEVELOPMENT:** • Review Employee Benefit Changes

Month	Goals & Objectives	Education
	FINANCIAL STEWARDSHIP: • Approve Audit Firm	
October		QUALITY: • Conduct 2021 Strategic Planning Retreat • Strategic & Patient Care Score Cards FINANCIAL STEWARDSHIP • Compare PMH Financial Metrics to National Standards (Cleverly)
November	EMPLOYEE DEVELOPMENT: • Approve AFSCME Contract FINANCIAL STEWARDSHIP: • Approve Budget and Property Tax Request for County Commissioners	QUALITY: • iVantage Update EMPLOYEE DEVELOPMENT: • Review LDIs and status update on key Studer initiatives SERVICES: • Review draft 2021 Strategic Plan; 2021 Marketing and IT Plans; and Medical Staff Model/2021 Provider Recruitment Plan FINANCIAL STEWARDSHIP: • Review draft 2020 Budget
December	QUALITY: • Complete Board Self-Evaluations	QUALITY:

Month	Goals & Objectives	Education
	• Review/Approve Board Polices • Approve the 2021 Environment of Care Plan SERVICES: • Approve 2021 Strategic Plan; 2021 Marketing and IT Plans; and Medical Staff Model/2021 Provider Recruitment Plan FINANCIAL STEWARDSHIP: • Approve 2021 Operating and Capital Budgets • Select PMH Banking Institution EMPLOYEE DEVELOPMENT: • Attend holiday celebration	• Review the 2020 Environment of Care Plan FINANCIAL STEWARDSHIP: • Review Banking Services

Prosser Memorial Health

2020 - Patient Care Scorecard

Major Goal Areas & Indicators	2019 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 YTD	2019	2018
Quality																
Left Without Being Seen (ED & iVantage)	<1.0%	1.24%	0.90%	1.03%	0.13%	0.86%	0.41%	0.61%	0.17%	0.78				0.74%	1.11%	1.00%
All-Cause Unplanned 30 Day Inpatient Readmissions (AC & iVantage)	<2.7%	2.33%	6.67%	9.30%	7.89%	2.94%	0.00%	4.76%	1.92%	0.00%				3.93%	5.4%	2.7%
Sepsis - Early Management Bundle (AC)	>84.6%	33.33%	50.00%	N/A	66.67%	100.00%	100.00%	66.67%	100.00%	N/A				70.59%	80.0%	84.6%
Head CT Interpretation within 45 minutes - Stroke (DI)	>90%	100.00%	100.00%	66.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				94.44%	62.16%	N/A
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.29%	0.0%				0.10%	0.07%	0.10%
Diabetes Management - Outpatient A1C>9 or missing result (PT)	<30.25%	37.43%	30.27%	32.62%	28.30%	32.09%	33.33%	28.43%	25.00%	24.56%				30.00%	30.25%	34.50%
Medication Reconciliation Completed	>90%	89.26%	90.32%	44.72%	89.90%	55.76%	42.31%	43.64%	34.84%	36.83%				49.70%	90.00%	2019 value is 65.16%
Turnaround time of 30 minutes or less for STAT testing (LAB)	<30 Minutes	34	31	34	38	39	37	36	36	38				35.88889	30	30
Median Time to ECG (CP & iVantage)	< 7 Minutes	6	4	6	3.5	7	7	6	11	12				6	7	NA
Surgical Site Infection (OR)	<2.0%	0.00%	0.00%	0.00%	0.00%	2.27%	1.39%	0.00%	0.00%	0.00%				0.36%	0.3%	0.3%
Colonoscopy Follow-up (OR/Clinic & iVantage)	>90%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	83.33%	87.50%	100.00%				94.59%	90.0%	NA
Safe Medication Scanning	>90%	88.80%	91.10%	93.82%	90.55%	93.48%	93.70%	92.89%	93.56%	92.15%				92.37%	90.0%	NA
*Overall Quality Performance Benchmark (iVantage)	>48	48	48	48	52	53	58	49	49	49				48	48	0
*Inductions <39 Weeks without Clinical Indications (OB & iVantage)	<1	0	0	0	0	0	0	0	0	0				0	1	3
*Falls with Injury	<3	0	1	0	0	0	0	1	0	0				2	3	3

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

Prosser Memorial Health

2020 - Strategic Plan Scorecard

Major Goal Areas & Indicators	2020 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 YTD	2019 Avg	2018 Avg
Patient Loyalty																
IP - "Would Recommend"	> 85.1%	84.4%	85.7%	97.2%	95.7%	84.4%	88.9%	90.7%	95.5%	88.9%				89.3%	85.1%	83.8%
ED - "Would Recommend"	> 80.7%	73.8%	80.0%	85.0%	77.4%	83.3%	91.3%	72.7%	80.0%	22.0%				89.9%	80.3%	80.7%
Acute Care - "Would Recommend"	> 79.7%	80.3%	80.0%	94.4%	90.0%	82.6%	81.8%	86.2%	92.3%	75.0%				85.4%	78.6%	79.7%
OB - "Would Recommend"	> 92.2%	93.3%	92.3%	100.0%	100.0%	86.4%	92.9%	90.7%	100.0%	100.0%				93.3%	92.2%	88.6%
Outpatient Surgery - "Would Recommend"	> 91%	86.4%	83.3%	94.3%	85.0%	96.3%	95.2%	95.2%	87.5%	100.0%				90.3%	91.0%	84.9%
Swing Bed - "Would Recommend"	> 94.1%	100.0%	50.0%	100.0%	0.0%	100.0%	100.0%	100.0%	50.0%	100.0%				78.9%	85.3%	94.1%
Clinic - "Would Recommend"	> 87.1%	92.9%	91.1%	27.9%	85.2%	87.0%	83.3%	86.0%	83.1%	92.3%				87.5%	87.1%	85.2%
Outpatient - "Would Recommend"	> 88.4%	88.5%	82.5%	85.0%	85.0%	97.3%	91.7%	94.0%	88.6%	88.0%				89.0%	88.4%	84.7%
Medical Staff Development																
Medical Staff Turnover	< 0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				0.0%	0.2%	0.6%
Specialty Clinic Visits	> 1068	1,197	1,101	1,021	588	685	807	931	939	1,027				922	950	872
Benton City Clinic Visits	> 1005	1,118	950	984	643	723	856	930	740	897				871	958	857
Prosser RHC Clinic Visits	> 1052	1,030	1,011	988	842	903	1,152	1,158	1,308	1,552				1,114	960	821
Grandview Clinic Visits	> 618	702	724	650	474	570	564	643	585	578				610	568	N/A
Women's Health Center	> 709	673	605	633	455	442	583	646	603	629				585	469	N/A
Comprehensive Pain Clinic	> 91	86	83	81	28	58	68	35	42	60				60	80	55
*# of Active Medical Staff	> 51	43	43	43	43	43	43	44	47	48				44	41	40
Employee Development																
Average Recruitment Time (days)	< 28	19	28	50	41	23	37	39	31	39				34	28	N/A
# of Open Positions (Vacancies)	< 29	35.0	27.0	27.0	24.0	22.0	21.0	28.0	43.0	39.0				28.7	29	8.8
Hours of Overtime - Overtime/Total Hours Worked	< 4.5%	7.9%	5.4%	6.0%	4.0%	4.2%	5.5%	6.1%	6.1%	6.2%				5.7%	5.7%	4.5%
Agency - Cost/Total Labor	< 8.7%	7.7%	9.0%	10.3%	8.1%	4.5%	5.6%	5.3%	6.0%	7.3%				7.6%	14.5%	10.5%
Turnover Rate	< 0.7%	0.3%	0.4%	0.7%	1.1%	2.4%	0.0%	0.0%	1.0%	0.7%				0.5%	0.7%	0.7%
Timely Evaluations	> 79.6%	89.0%	54.0%	91.0%	31.0%	54.0%	78.0%	85.7%	74.2%	69.6%				75.2%	79.6%	60.5%
Education Hours/FTE	> 2.15	1.57	0.01	1.93	0.98	0.55	0.86	0.83	1.71	1.49				1.10	1.55	2.15
New Hire (Tenure) < 1 year	< 10%	3%	0%	0%	0%	0%	0%	0%	0%	0%				0%	0%	N/A
* Lost Workdays due to On-the-Job Injuries	< 167	3.00	8.00	8.00	16.00	8.00	15.00	1.00	0	2.00				7.35	167	163
Quality																
ED Encounters - Left Without Being Seen	< 1.0%	1.2%	0.9%	1.03%	0.2%	0.9%	0.4%	0.6%	0.1%	0.8%				0.7%	1%	1.0%
*Falls with Injury	< 3	0	1	0	0	0	0	1	0	0					3	3
Healthcare Associated Infection Rate per 100 Inpatient Days	< 0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%				0.0%	0.1%	0.1%
All-Cause Unplanned Readmissions within 30 Days	< 2.7%	2.3%	6.7%	9.3%	7.9%	2.9%	0.0%	4.8%	1.8%	0.0%				4.0%	5.4%	2.7%
Diabetes Management - Outpatient A1C>9 or missing result	< 30.3%	37%	30%	33%	28%	32%	33%	22%	25%	25%				29%	30.3%	34.50%
Services																
ED Visits	> 1,023	1,131	1,000	874	526	700	723	819	799	767				815	1,016	930
Inpatient Admissions	> 86	83	77	72	70	79	91	79	93	87				81	83	75
OB Deliveries	> 38	38	26	38	36	39	35	52	48	41				41	37	31
Surgeries and Endoscopies	> 126	109	100	90	32	44	110	128	132	101				94	118	117
Diagnostic Imaging Procedures	> 2,116	2,466	2,308	2,078	1,358	1,784	2,159	2,229	2,334	2,348				2,118	1,957	1,649
Lab Procedures	> 12,262	13,098	11,587	9,776	7,900	10,591	12,119	13,249	13,603	12,306				11,403	11,051	9,671
Adjusted Patient Days	>1,769	1,603	1,490	1,355	871	1,250	1,376	1,364	1,568	1,337				1,357	1,624	1,373
Therapy Visits	> 1,706	1,692	1,792	1,374	324	959	1,131	1,247	1,399	1,454				1,264	1,145	1,084
Outpatient Special Procedures Visits	> 225	268	228	319	222	211	189	198	235	265				237	224	225
Financial Performance																
Net Days in Accounts Receivable	< 48.62	59.97	64.28	61.84	48.35	48.00	52.15	54.46	56.64	57.18				57.18	63.79	50.96
*Total Margin	> 7.06%	4.50%	1.20%	-0.20%	16.40%	18.90%	32.60%	31.40%	-33.40%	19.00%				9.20%	5.30%	1.8%
Net Operating Revenue/FTE	> $16,753	$ 16,075	$ 14,867	$ 15,320	$ 19,523	$ 19,245	$ 22,112	$ 16,939	$ 15,719	$ 22,234				$ 18,010	$15,794	$16,094
Labor as % of net Revenue	< 60.2%	60.3%	65.0%	63.8%	53.5%	53.5%	43.2%	60.6%	80.8%	52.1%				59.7%	59.6%	62.6%
Operating Expense/FTE	< $15,760	$ 15,534	$ 15,443	$ 15,969	$ 16,562	$ 15,823	$ 14,866	$ 16,479	$ 11,690	$ 18,165				$ 15,616	$15,190	$16,190
*Days Cash on Hand	> 120.39	96.39	93.02	97.86	152.37	121.00	228.60	229.59	221.33	222.59				222.59	120.39	108.23
Commercial %	> 28.7%	27.1%	27.4%	28.8%	28.9%	28.8%	30.0%	29.4%	29.1%	28.9%				29.1%	28.7%	28.2%
Total Labor Expense/Total Expense	< 62%	62.4%	62.6%	61.2%	63.7%	65.1%	64.3%	62.3%	63.2%	63.8%				62.9%	62%	63%

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

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BOARD WORK SESSION	September 22, 2020		WHITEHEAD CONFERENCE ROOM
COMMISSIONERS PRESENT	**STAFF PRESENT**	**GUESTS**	**COMMUNITY MEMBERS**
• Dr. Steve Kenny • Keith Sattler • Glenn Bestebreur • Susan Reams • Brandon Bowden • Sharon Dietrich, M.D.	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO • Shannon Hitchcock, CCO • Kevin Hardiek, CIO • Kristi Mellema, CCO • Dr. Brian Sollers		

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
I. CALL TO ORDER	Meeting was called to order by Commissioner Kenny at 6:02 p.m.		
II. EMPLOYEE DEVELOPMENT			
A. PMH Retirement Plan (Attachments M, N, O, P)	Craig and David gave an overview of the current PMH Retirement Plan and proposed options for increased employee participation.	None	This will be discussed again at the September Board Meeting.
B. Employee Compensation Award (Attachment Q)	Craig shared the proposed Employee Compensation Award Plan with the Board.	None	None
III. SERVICES			
A. Replacement Facility Update **1. Tour Mock Rooms**	Kurt Broeckelmann and Paul Kramer gave an update on the Mock Rooms and provided a tour for the Board.	None	None
IV. ADJOURN			
There being no further regular business to attend to, Commissioner Kenny adjourned the meeting at 6:55 p.m.			

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BOARD MEETING	September 24, 2020		WHITEHEAD CONFERENCE ROOM
COMMISSIONERS PRESENT	**STAFF PRESENT**	**MEDICAL STAFF**	**GUESTS**
• Dr. Steve Kenny • Glenn Bestebreur • Susan Reams • Keith Sattler • Sharon Dietrich, M.D. • Brandon Bowden	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO • Kevin Hardiek, CIO • Shannon Hitchcock, CCO • Dr. Brian Sollers • Kristi Mellema		

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
I. Call to Order	Meeting was called to order by Commissioner Kenny at 6:00 p.m.	None	None
II. Public Comment	None	None	None
III. APPROVE AGENDA	None	Commissioner Dietrich made a motion to approve the Agenda. The Motion was seconded by Commissioner Reams and passed with 6 in favor, 0 opposed, and 0 abstained.	None
AGENDA	**DISCUSSION**	**ACTION**	**FOLLOW-UP**
IV. APPROVE CONSENT AGENDA	None	Commissioner Sattler made a motion to approve the Consent Agenda. The Motion was seconded by Commissioner Bowden and passed with 6 in favor, 0 opposed, and 0 abstained.	None

V. MEDICAL STAFF DEVELOPMENT		ACTION	
A. Medical Staff Report and Credentialing	Dr. Sollers presented the following **New Appointments:** **Joseph Freeburg, MD** – Provisional/Telemedicine staff with requested privileges in Neurology effective September 24, 2020 through March 24, 2021. **Kyle Ogami, MD** – Provisional/Telemedicine staff with requested privileges in Neurology effective September 24, 2020 through March 24, 2021. **Kishan Patel, MD** - Provisional/Telemedicine staff with requested privileges in Neurology effective September 24, 2020 through March 24, 2021.	A motion to approve the New Appointments and requested Clinical Privileges that have been reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the following providers was made by Commissioner Reams and seconded by Commissioner Dietrich. The Motion passed with 6 in favor, 0 opposed, and 0 abstained. • Joseph Freeburg, MD • Kyle Ogami, MD • Kishan Patel, MD	None
	Dr. Sollers presented the following **Reappointments:** **Yung Huang, MD** – Reappointment to Active staff with requested clinical privileges in General Surgery from September 24, 2020 through September 23, 2022. **Toni Diane Microulis, MHNP** – Reappointment to Allied Health Professional staff with requested clinical privileges in Mental Health from September 24, 2020 through September 23, 2022. **Richard Unger, DO** – Reappointment to Locum Tenens staff with requested clinical privileges in General Surgery from September 24, 2020 through September 23, 2022. **Katheryn Norris, DO** – Reappointment to Courtesy staff with requested clinical privileges in Family Medicine from September 24, 2020 through September 23, 2022.	A motion to approve the Reappointments and requested Clinical Privileges that have been reviewed and recommended by the Department Chair, the Credentialing Committee and the Medical Executive Committee for the following providers was made by Commissioner Reams and seconded Commissioner Sattler. The Motion passed with 6 in favor, 0 opposed and 0 abstained. • Yung Huang, MD • Toni Diane Microulis, MHNP • Richard Unger, DO • Katheryn Norris, DO • Flint Orr, MD • Jeffrey Lehr, MD • Praveen Korimerla, MD • Dane Sandquist, MD • Yi Mao, MD	

	Flint Orr, MD – Reappointment to Courtesy staff with requested clinical privileges in Internal Medicine from September 24, 2020 through September 23, 2022. Jeffrey Lehr, MD – Reappointment to Consulting staff with requested clinical privileges in Cardiology from September 24, 2020 through September 23, 2022. Praveen Korimerla, MD – Reappointment to Consulting staff with requested clinical privileges in Cardiology from September 24, 2020 through September 23, 2022. Dane Sandquist, MD – Reappointment to Consulting staff with requested clinical privileges in Pathology from September 24, 2020 through September 23, 2022. Yi Mao, MD – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from September 24, 2020 through September 23, 2022.		
VI. FINANCIAL STEWARDSHIP	**DISCUSSION**	**ACTION**	
A. Review Financial Reports for August 2020 (Attachment V)	David Rollins presented the August 2020 Financial Reports.	Commissioner Sattler made a motion to accept the Financial Report for August 2020 which was seconded by Commissioner Bestebruer. The Motion passed with 6 in favor, 0 opposed and 0 abstained.	None
B. COVID-19 Financial Plan (Attachment W,X)	David Rollins presented the COVID-19 Financial Operations Forecast through December 2020. We will be applying for the SBA loan forgiveness when it opens up.	None	None
C. Audit Firm Selection (Attachment V1)	The Finance Committee recommended to the Board that we stay with our current audit firm, DZA, for the next three years.	Following a recommendation by the Finance Committee , Commissioner Sattler made a motion to accept DZA as the PMH Auditor for	None

		the next 3 years which was seconded by Commissioner Reams. The Motion passed with 6 in favor, 0 opposed and 0 abstained.	
VII. EMPLOYEE DEVELOPMENT		**ACTION**	
A. PMH Retirement Plan (Attachment M,N,O,P)	David Rollins gave an overview of the current PMH Retirement Plan and shared the recommendation made by the Leadership Team that PMH modify its current retirement plan contributions from an automatic 3% to all employees, to a matching system of up to a 4% contribution and auto-enroll employees in the new retirement plan, with an opt-out option.	None.	The Plan will be re-worked and be brought back to the Board in October.
B. PMH Employee Compensation Award (Attachment Q)	Craig gave an overview of the proposed PMH Employee Compensation Award, which included all employees and providers (excluding leadership) who worked from March 22, 2020 – August 23, 2020 to receive an additional compensation award related to the number of paid hours during this period. The hours include Regular, Overtime, Holiday, Vacation, Sick, CME, and callback excluding On-Call hours. The awards would range from $250 to $1,000 per employee depending on how many hours our staff were paid for and be distributed next week to staff.	Commissioner Bestebruer made a Motion to approve the payment of a one-time compensation award as outlined on Attachment Q, to the PMH Staff, not to exceed $245,000, which was seconded by Commissioner Reams. The Motion passed with 6 in favor, 0 opposed and 0 abstained.	None
VIII. SERVICES		**ACTION**	
A. Replacement Facility Update – Board Resolution – USDA Application (Attachment B)	Our Financial Advisor for USDA funding, Gary Hicks, is preparing documents to submit to the USDA for their review prior to submission of the full application. The Board will once again need to approve a Resolution allowing David Rollins and Craig Marks to submit a formal/final application to the USDA to provide funding for the replacement facility for PMH.	Commissioner Dietrich made a Motion to approve the Board Resolution as outlined in Attachment B, allowing David and Craig to submit a final application to the USDA to provide funding for the replacement Facility for PMH, which was seconded by Commissioner Reams. The Motion passed with 6 in favor, 0 opposed and 0 abstained.	None
IV. QUALITY			
A. Special Board Meeting – Board Candidate Interviews (Attachment EE)	Commissioner Kenny shared the urgency to reschedule interviews of the Board Candidates, when the previous date had to be cancelled due to COVID.	Commissioner Reams made a Motion to approve two options for the interviews, September 29, 2020 or October 12, 2020, depending upon the candidates' availability, which was seconded by Commissioner	Dr. Kenny will contact the candidates and notify Carol to make arrangements.

		Dietrich. The Motion passed with 6 in favor, 0 opposed and 0 abstained.	
B. COVID-19 Update	Merry Fuller gave a brief update on COVID-19. Kristi Mellema reported that she has scheduled dates for employee flu shots. Kristi will be available at October's Work Session (10/27) to give flu shots to the Board.	None	None
C. Legislative and Political Updates	Commissioner Bestebreur gave a brief overview of the current hot topics on the political front both Federally and State-wide.	None	None
D. CEO Report	Craig reminded and encouraged the Board to take the MBS test. Shannon will email the MBS link to the Board. The employee feedback was very positive following Kurt Broeckelmann's site visit (Sept. 21-23) and the opportunity given to employees to visit the mock-up rooms for the replacement hospital was greatly appreciated. Kurt and the Design Team will be back on site on October 12-14.		None

X. ADJOURN

There being no further business to attend to, Commissioner Kenny adjourned the meeting at 7:24 p.m.

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SPECIAL BOARD MEETING	September 29, 2020		WHITEHEAD CONFERENCE ROOM
COMMISSIONERS PRESENT	**STAFF PRESENT**	**MEDICAL STAFF**	**GUESTS**
• Dr. Steve Kenny • Glenn Bestebreur • Susan Reams • Keith Sattler • Sharon Dietrich, M.D. • Brandon Bowden	• Craig Marks, CEO		

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
I. **Call to Order**	The Special Meeting of the Board of Commissioners was called to order by Commissioner Kenny at 5:25p.m. followed by the Pledge of Allegiance.	None	None
II. **Board Candidate Interviews/Selection:** A. **Neilan McPartland** 5:30 p.m. B. **Samantha Markus** 6:00 p.m. C. **Petra Atilano** 6:30 p.m. D. **Evan Tidball** 7:00 p.m.	Each candidate was interviewed as scheduled for the vacant board position following the resignation of Kit Watson, July 17, 2020.	Following discussion of each of the candidates, Commissioner Bowden made a motion to appoint Neilan McPartland to the vacant position. The motion was seconded by Commissioner Reams. And passed with 5 in favor and 1 opposed.	Dr. Kenny will call each candidate with the results tonight and email Craig's assistant to contact the Benton County Auditor's office to notify them about the appointment.

X. ADJOURN
There being no further business to attend to, Commissioner Kenny adjourned the meeting at 8:33 p.m.

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JOINT CONFERENCE COMMITTEE	October 21, 2020	VINEYARD CONFERENCE ROOM	
COMMITTEE MEMBERS PRESENT		**NON-MEMBERS PRESENT**	
• Commissioner S. Reams • Commissioner S. Kenny • Commissioner S. Dietrich • C. Marks, CEO • Dr. B. Sollers • Dr. T. Murphy • Dr. D. Weaver		• Kristi Mellema, CQO, CCO • Merry Fuller, CNO, COO • Dr. S. Hashmi	

AGENDA ITEM	DISCUSSION	RECOMMENDATION	FOLLOW-UP
CALL TO ORDER	Meeting was called to order by Commissioner S. Reams at 0704.		
APPROVAL OF MINUTES	Minutes for September were reviewed and approved.	C. Marks made a motion to approve the minutes as presented. The motion was seconded by Dr. Dietrich and passed with 7 in favor, 0 opposed.	Standing agenda item.
QUALITY			
COVID-19 Update	Dr. Murphy reported that Washington State now has 99,000 positive COVID cases. Benton Franklin Health Department reports the number of patients hospitalized at 21 today. There has been a lot of discussion in a variety of healthcare forums of a second wave of flu plus COVID.	For informational purposes only.	No follow up necessary.
Strategic & Patient Care Scorecards	K. Mellema reported that for the month of September there were 6 patient's who left the ED without being seen out of 767 ED visits. No 30-day readmissions or sepsis cases that were within criteria. 100% for head CT interpretation. No HAIs. Diabetes 24.56%. Medication	For informational purposes only.	No follow up necessary.

	reconciliation continues to be a struggle at 36.83%. STAT labs went up to 38 minutes due to the analyzer machine being down for over a week. Median time to ECG increased to 12 minutes. No SSIs. 100% on Colonoscopy follow-up. Safe medication scanning at 92.15%. iVantage quality number of 49. This is done quarterly and should have an updated number for October. No inductions <39 weeks and no falls with injury. Highlights from the Strategic Plan Scorecard for September: • 3 departments got 100% on "Would Recommend" • Prosser Clinic had a total of 1552 visits • Agency-Cost/Total labor was 7.5% • Lab procedures were 12,306		
PATIENT LOYALTY			
Patient Experience Results	M. Fuller reported that the mid-year "Would Recommend" was at 86.7%. YTD is 88.6%. ED "Would Recommend" was at 22% for September. The lowest it has ever been. However, there were only 9 surveys that went out. Of the 9 patients, two were extremely upset, five said we were fine and two said phenomenal. Patients are asked open ended questions. The two most common complaints were wait time and people not being treated with respect. There were three departments with 100% "Would Recommend". We are planning to move to Press Ganey from PRC in January. We will be transitioning from phone surveys to mailed surveys. Unlimited email surveys and text invitations. Email surveys are for our information. Mailed surveys are for publicly reported data.	For informational purposes only.	No follow up necessary.
MEDICAL STAFF DEVELOPMENT			
Medical Staff Recruitment	Dr. Sollers reported that Dr. Unger officially signed his contract and should be starting mid-January. We continue to look for a GI physician. C. Marks reported that we continue to look for a dermatology provider. We have plans to speak with one today and another will be visiting Monday from Seattle. Primary Care remains an area of focus for Benton City and Grandview. We would like to get an IM for Benton City since they see an older population. Dr. smiley will be coming back for another visit.	For informational purposes only.	Standing agenda item.

MBS (Management by Strengths)	C. Marks reported on MBS. Studer program has an expert that will explain the MBS profiles at the November Medical Staff meeting. We have been doing this survey throughout the hospital with all employees. Each department will sit down and look at this as a team to recognize the different personalities to help with communication.	For informational purposes only.	No follow up necessary.
EMPLOYEE DEVELOPMENT			
Employee Engagement	C. Marks reported that Halloween activities are planned with pumpkin decorating contest between departments. Engagement surveys went out to Medical Staff and employees on Monday. We are giving staff a $5 gift card when they complete the survey.	For informational purposes only.	Standing agenda item.
HR Director Update	C. Marks stated that we have hired a new HR director, Bryon Dirkes. Engagement and development of leadership is what stood out the most. Bryon has a track record with an emphasis on leader development, negotiations and commitment of law. Bryon will start the beginning of December.	For informational purposes only.	No follow up necessary.
Employee Flu Vaccine	K. Mellema reported that employee flu vaccine clinics started last week on Monday morning and Tuesday afternoon. Last flu clinic will be this Friday morning. Employee flu vaccines were taken to all the clinics for self-administration. Current, compliance rate is 34%.	For informational purposes only.	No follow up necessary.
SERVICES			
2021 Strategic Planning Update	C. Marks reported that we are actively engaged in the process with a focus on the new facility. We will be doing a Visioning process with the Board. This was also done with the employees and Medical Staff. We are still doing the regular Strategic Plan and asking for input from staff as to what they want to do while we are still here in this location. Department directors have been asked to complete the Fiscal Year 2021-2024 form with their staff and return to Administration. Our future goal would be to get the Strategic Plan on one page.	For informational purposes only.	No follow up necessary.
Replacement Hospital Update	C. Marks reported that there is a lot of activity going on. Our challenge is we want to involve everyone which includes 7am meetings for physicians and having multiple sessions for staff to attend when they can. Next week we will be reviewing the floor plans with leaders and staff. We had created mock rooms where staff toured and gave feedback. Based on that feedback, the mock rooms were torn them down and rebuilt again.	For informational purposes only.	No follow up necessary.

FINANCIAL STEWARDSHIP			
Financial Performance – September 2020	C. Marks shared the Income Statement/Statement of Operations. For September, we had a $1.3 million profit which was driven by $1.3 million of HHS funds. Year to date we are at a $4.5 million profit.	For informational purposes only.	Standing agenda item.
COVID-19 Financial Plan	C. Marks reported that we have a $12.2 million profit. The reason is from the Payroll Protection Program (PPP) has not been forgiven yet. However, we can start submitting data to have that forgiven by the end of the year.	For informational purposes only.	Standing agenda item.
ADJOURNMENT & NEXT SCHEDULED MEETING			
Meeting adjourned at 0843			
Next scheduled meeting is November 18, 2020			

Km 10/21/2020

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FINANCE COMMITTEE MEETING
WEDNESDAY – OCTOBER 28, 2020
12:00 p.m. - ORCHARD CONFERENCE ROOM
AGENDA

MEMBERS:
Keith Sattler
Glenn Bestebreur
Brandon Bowden

STAFF:
Craig Marks
David Rollins
Stephanie Titus

CALL TO ORDER

I. APPROVE MINUTES
Action Requested – September 23, 2020 Minutes

II. FINANCIAL STEWARDSHIP

   A. Review Financials – September 2020 **(Attachment CC)**   **David**
   Action Requested – September 2020 Financial Statements

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

   C. COVID-19 Financial Projection Plan **(Attachments KK,LL)**   **David**

   D. Voucher Lists
   Action Requested - Voucher List Payroll and AP Vouchers #153785 through #154514,   **David**
   dated 09-17-20 through 10-22-20, in the amount of $7,060,590.30.

   E. Surplus Items Resolution
   Action Requested - Surplus Items Property Description: 4 Mattress Overlays (FBC)   **David**
   #001038 OR Table.

   F. Capital Requests   David
   Action Requested – Capital Requests
   1. Elevator Railings Upgrade
   2. Water Cooled Ice Machine/Water Dispenser

III. ADJOURN

October 28, 2020 Finance Committee

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FINANCE COMMITTEE MEETING MINUTES
WEDNESDAY – SEPTEMBER 23, 2020
NOON - ORCHARD CONFERENCE ROOM

MEMBERS:
Keith Sattler
Brandon Bowden

STAFF:
Craig Marks
David Rollins
Stephanie Titus

CALL TO ORDER
Keith Sattler called the meeting to order at 12:24 p.m.

I. **APPROVE MINUTES**
    ACTION ITEM
    A motion to approve the Finance Committee Meeting minutes for August, 2020 as
    presented was made by Brandon Bowden. The Motion was seconded by Keith Sattler and
    approved.

II. **FINANCIAL STEWARDSHIP**
     A. David Rollins reviewed the Financial Statements for August 2020 showing Net Income as negative
         ($1,219,339) due to reversal of recognizing SBA Paycheck Protection Program (PPP) Funds as
         government entities have to receive written forgiveness before recognition of income. Net
         Income would have been $187,749 without any adjustments or COVID Funds.
         ACTION ITEM
         A motion to recommend acceptance of the August Financial Statements as presented to the PMH
         Board of Commissioners was made by Brandon Bowden. The Motion was seconded by Keith
         Sattler and approved.

     B. Review Accounts Receivable and Cash Goal
         Stephanie reviewed accounts receivable and cash receipts of $5.3 million and updated progress
         on Revenue Cycle initiatives.

     C. COVID-19 Financial Projection Plan (Attachment W,X)
         Current projection is 2020 Net Income of $12,649,643 with $12,973,265 of COVID Funds, SBA, PPP
         Funds for $6,350,000 will be recognized in December 2020 or final audit calculations.

D. Voucher List #153360 through #15378 In the amount of $5,336,372.75.)
ACTION ITEM
A motion to recommend approval of the Voucher List #153360 through # 153784 in the amount of $5,336,372.75) as presented to the PMH Board of Commissioners was made by Brandon Bowden and seconded Keith Sattler and approved.

E. Surplus Items Resolution: Everest Side by Side Refrigerator-Freezer; Office Chair; Bookshelf/Cabinet; Bookshelf; Desk.
ACTION ITEM

A motion to recommend approval of the Surplus Item Resolutions Everest Side by Side Refrigerator-Freezer; Office Chair; Bookshelf/Cabinet; Bookshelf; Desk as presented to the PMH Board of Commissioners was made by Brandon Bowden and seconded by Keith Sattler and approved

F. Audit Firms Responses – Recommendation
ACTION ITEM
The submissions by DZA, Eide Bailly and WipFli were discussed. DZA was low bidder and since there were no performance issues, a motion to recommend approval of DZA as the Audit Firm was made by Brandon Bowden and seconded by Keith Sattler and approved.

III.   ADJOURN
Having declared no further business, the meeting was adjourned at 1:17 p.m.

MEMORANDUM

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

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

DATE: **OCTOBER 2020**

RE: **CEO REPORT**

SERVICES

1. 2020 Strategic Planning

We are off and running on our 2021 Strategic Planning Process with the distribution of our 2021 Strategic Planning Packet (**Attachment A**) to all members of the PMH Team. In addition, printed versions of the packet will be distributed throughout PMH. As in past years, the planning packet and process take an external look at the healthcare industry and an internal look at Prosser Memorial Health, and how we are performing and positioned for the future. There is a tremendous amount of information in the packet that will help us plan for the future but unfortunately there is no information about the impact the COVID-19 pandemic will have on the industry. While there is some speculation (e.g. increase in telehealth) it is still too early to know what permanent changes the pandemic will bring.

While there is much to look forward to in the coming year, our largest project focuses on the replacement of our current hospital. To that end, a significant portion of our planning process is dedicated to meeting with all PMH Team members to discuss their vision for our new facility. In other words, using our six Pillars of Excellence as a guide to understanding what is important for them to see included in the new hospital (**Attachment B**). We began meeting with our team and asking this question last week (**Attachment C**) and will ask the Board to respond to this question at the October Board Work Session. We will use this information to create a Project Vision By Pillar with measurable goals, which will be approved by the Board and used to hold us accountable on this significant project.

We are also asking for input from our team on what they would like to see us accomplish by Pillar in 2021 (**Attachment D**). We are asking each department to meet with their staff and complete this worksheet. We will also ask the Board for their suggestions on this worksheet at the October Board Work Session. We will use this input to create our 2021 Strategic Plan which will be reviewed with the Board in November and the Board will be asked to approve it in December. One of our goals with the 2021 Strategic Plan is to make it shorter and less complex. Our ultimate goal will be to eventually have a strategic plan that fits on one page. While a worthy goal, that may take several years to accomplish.

2. Replacement Facility Update

While our replacement facility is the primary focus of our 2021 Strategic Planning Process, we also continue to work on many other fronts of the replacement facility project. This past week we spent several days **(Attachment E)** refining our plans for our acute care, LDRP and ED patient rooms **(Attachment F)**. These drawings represent the feedback from the first mock rooms, and were once again built as mock rooms for our staff to tour and try out. Based on the feedback received last week, additional adjustments will be made to each room and these rooms will be what we plan to build. In addition to viewing the rooms again, we also asked our staff where to put light switches, electrical outlets, gasses, etc. While no one was able to get everything they want, we did reach a consensus that will address the needs of our patients, staff, and providers. I would like to thank everyone that has participated in the process, we could not do this without your input!

The team has also been focused on MEP (Mechanical, Electrical, Plumbing) plans, initial floor plans and site layouts. Since there is no natural gas service on the north side of the Yakima River in Prosser, we have been planning for an all-electric facility. However, with the assistance of the Prosser Economic Development Association and the City of Prosser, we have been able to discuss the possibility of a new gas line that would run to our property by Cascade Natural Gas. While we are still early in this discussion, Cascade Natural Gas has informed us they will know the feasibility and cost of such a line by November 1, 2020. We need an answer by then to continue our MEP planning for the new building. We also met with our civil engineer to begin looking at possible site layouts for the hospital, roads, parking lots, medical office buildings, a heliport, the irrigation canal, etc. We are early in the process, but they hope to have some ideas to share with the Board next week.

Our design team has been busy working on possible floor plans for the first and second floors of the facility. We plan to spend a lot of time next week reviewing the floor plans with department leaders **(Attachment G)** and continuing to work on site, MEP and building exterior (massing) plans. Our Owner's Representatives (NV5) are assisting us with a review of these areas. They are also helping us with conversations with the Department of Health regarding our need for a Certificate of Need (CON) for our replacement facility **(Attachment H)**. Our interpretations of the State statutes indicate that we do not need a CON, but we are required to pay $1,965 to the DOH to have them officially tell us whether or not we need a CON. We sent the letter and are now waiting for their response. Last month we planned to discuss the construction contracting methods used by public entities in the State of Washington with the Board, however, we forgot. Therefore, our Owner's Representatives plan to discuss our options (Design, Bid, Build/ General Contractor/Construction Manager **(Attachment I-1)** with the Board during the October Board Work Session. I have also included our application to the Capital Project, , Advisory Review Board (CPARB), which will allow us to utilize the GC/CM method if we so choose **(Attachment I-2)**. Finally, we have begun to collect Letters of Support for our replacement facility to share with the USDA when we submit our final/formal application **(Attachments J & K)**.

3. Nuclear Medicine Update

Work continues at a very rapid pace on our nuclear medicine renovation project. This project is another reminder of when it is better to build new as opposed to renovate. At times the noise levels are very disruptive and if this was a larger project, it would cause problems. Fortunately, the area is temporarily walled off and the primary area impacted is Administration (the CEO's Office), so it is not a problem. We continue to work with the Department of Health and recently received letters sent by the City of Prosser announcing our intent to have radioactive material on our campus for the provision of nuclear medicine services (**Attachment L**). At this point, everything appears to be progressing as expected regarding our license. Aurora Weddle, Director of Diagnostic Imaging, is beginning to conduct interviews for our nuclear medicine technician. She has several candidates and plans to make a decision in the near future so that the technician can be here as the new equipment is being installed (first week of November) and become oriented to the renovated space and new technology. Our plan remains to be operations before the end of 2020, which will enable us to say that something good happened in this crazy year!

4. da Vinci Robot

We have begun to explore the feasibility of acquiring a da Vinci Robot to perform urology, gynecological, colorectal and general surgery cases. Our new general surgeon, Dr. Unger and Urologist, Dr. Tieu are interested in robotic surgery and our two OB/GYN's are already trained in robotic surgery. This technology can enhance patient outcomes (e.g. less invasive, faster recovery times) and most surgeons are now trained with this technology. Originally, we were planning to add this service in our new hospital, but with the current level of interest by our surgeons we are exploring the option now. As you recall, we are currently performing robot assisted joint (knees and hips) replacement surgeries with a Stryker Mako Robot. Because we are a critical access hospital (CAH) we have a distinct advantage in paying for this technology (cost reimbursement) compared to fee for service hospitals. To begin the process, we recently met with representatives from Intuitive, the owners of the da Vinci Robot. Intuitive and their DaVinci platform have pioneered new capabilities in the OR, transforming the field of minimally invasive surgery over the last 20 years (**Attachment M**).

Intuitive is working with us to identify the type of robot we would need, the space requirements, number of cases we need to perform to pay for the technology, etc. We are also reviewing additional sources of information (**Attachment N**) and discussing this with our providers. One of our big questions is whether or not a da Vinci Robot will fit in our largest operating room without disrupting our other surgeries. Because this is a large investment ($1-2 million) we will do our homework to ensure we are ready for this technology. If we determine we are prepared, we will budget to acquire the technology in 2021. We may also determine that it is best to wait until we have a new hospital in 2024, but we will be more prepared when that day arrives. In the meantime, if we delay acquisition of this technology until 2024, our providers can be privileged at Kadlec and/or Trios and use their da Vince Robots. We will keep you informed as we study this exciting technology and remember, even if this technology appears in the 2021 Capital Budget, the Board will have an opportunity to review the proposal and approve or reject it before acquisition of the technology.

5. EPIC Annual Report

I recently wrote about Providence Health taking their Community Connect product (the ability for independent, smaller hospitals to share EPIC with the other Providence-owned hospital) and creating a new organization centered around it called Community Technologies The Community Technologies organization is now off and running and conducted a day-long virtual seminar to discuss their new organization, global IT challenges (e.g. cybersecurity) and new offerings for Community Technologies customers. One of these new products is an EPIC executive packet that contains our EPIC performance compared to other EPIC users **(Attachment 0)**. We are just beginning to sort through all the data contained in the report, but believe it will help us identify opportunities for improvement and celebrate areas where our performance is strong. Kevin Hardiek, Chief Information Officer, will briefly review this report at the October Board meeting.

6. Lab Equipment

A capital request for an Abbott Abaxis Piccolo Xpress Chemistry Analyzer is being submitted for approval this month ($14,298). The chemistry analyzer utilized in the central lab is both expensive and requires a large amount of space. When the chemistry analyzer goes down, patient care delivery, especially in the Emergency Department, is significantly impacted. Failure of the chemistry analyzer occurred earlier this month for several days, required multiple courier trips to Tri-city laboratory around the clock to have critical tests run. A cost-effective and space-sparing way to prevent delayed results of critical tests is the Piccolo Xpress. This analyzer will provide another alternative for multi-chemistry and electrolyte test results. All departments are considering innovations of this kind as we are planning the new hospital. The goal is to ensure the reliability of providing critical diagnostics through redundancy without duplicating more expensive equipment.

PATIENT LOYALTY

1. Patient Thank Yous

We continue to receive a steady stream of thank yous **(Attachment P)** from patients as our team provides outstanding care to our patients. It is wonderful to read how our staff have positively impacted our patients and their families in many different ways. It also says a lot about the communities we serve, when our local citizens take the time to say, "thank you!" This doesn't happen everywhere and demonstrates that we live in a very special place. I also want to let the Board know that our staff is very appreciative of everything they have done for them during these challenging times, ranging from the Pool Party gift cards **(Attachment Q)** to the COVID-19 thank you gift **(Attachment R)**. I cannot objectively tell you how many staff have asked me to thank the Board, but it has been a lot. It would not be possible for us to be where we are today without the strong support of our Board. Thank you!!

EMPLOYEE DEVELOPMENT

1. HR Director Update

After several months searching for the best candidate to become the next Director of Human Resources at PMH, I am pleased to announce that I have selected Bryon Dirkes (**Attachment S**). Bryon is currently the Director of Human Resources at Forks Community Hospital in Forks, Washington, and has over twenty-five years of healthcare human resources experience. Included in his experience is seventeen years within Providence Health and three years at Trios. Bryon's strengths include employee engagement and leadership development, and he is very excited to join PMH and assist us in our pursuit of excellence. Bryon currently lives in Walla Walla and plans to join us in early December. Please join me in welcoming Bryon to our team and thanking Rocky, Nora and Crystal for the outstanding job they are doing every day in Human Resources!

2. Engagement Surveys

The Annual PMH Employee and Medical Staff Engagement Surveys were sent out October 19 and will close on November 13 (**Attachment T**). We are using the same basic survey instrument we have used in past years, but have included the opportunity to provide specifics if staff believe communication is less than expected (**Attachment U**). We have worked hard to improve communication and need more actionable ideas so that we can continue to improve. The survey is 100% confidential and will identify areas where we are performing well and also opportunities for improvement. I encourage everyone to participate in the survey and give us your honest feedback. Everyone that participates in the survey will receive a $5 gift card for the Busy Bean or Hole in the Wall, for taking the time to engage with us. Regardless of the results of the survey, we will never stop trying to improve engagement with our team!

3. PMH Retirement Plan

For the past several months we have been discussing with the Board, ways to enhance employee participating in the PMH Retirement Plan. Currently, PMH contributes 3% of each employees' gross pay toward their retirement and only 38% of our staff contribute any additional funds. Across the country, 73% of employees participate in contributing to their retirement plans. In addition, 3% is not nearly enough for anyone to retire comfortably. After looking at many different options, we have developed a plan which is a combination of our current plan along with the addition of a matching component that would be rolled out over the next four years (**Attachment V**). We are proposing that full and part-time employees will continue to receive the automatic 3% contribution from PMH. Per diem staff will no longer receive it because they already receive a 10% hourly increase for not receiving benefits. PMH will then contributed $1.00 for every $10 employees contributed up to a total of 1%. Each year we would increase the match and decrease the automatic hospital contribution until 2024 when the program would be 100% match up to 4%. Depending upon the participating levels, the match could also be increased in future years. We are also proposing an opt-out approach, meaning that 4% will automatically be set aside for retirement, unless the employee choose not to participate or opts out. The current annual cost of the PMH Retirement Plan is $658,823 per

year and the cost of the new plan will range over the years from $818,313 to $796,547, depending upon the participation level. We will discuss this plan at the October Board Work Session and the Board will be asked to vote on it at the October Board Meeting, with a proposed implementation date of January 1, 2021.

4. Employee Engagement

Now that we are officially into fall, we are looking forward to our Annual Halloween Extravaganza. The Employee Engagement Team is once again hosting the fun which will include a departmental and individual costume contest, pumpkin decorating contest and lunch served by the Administrative Team (**Attachment W**). Unfortunately, because of the pandemic, we are not able to have our Annual Chili Cook-off, but it will return next year. We will have our departments decorated, so we are encouraging our staff to trick-or-treat to each department utilizing appropriate COVID-19 precautions. It is also time to start thinking about the upcoming holidays. At this time, we are still planning to host our Annual Holiday Party on December 12, however, with the resurgence of the COVID-19 virus in the area, and across the country, it is getting less and less likely that we will be able to have our party. We will notify everyone as soon as a final decision is made. I have also included the October newsletter which highlights some of the activities at PMH in September/October (**Attachment X**).

5. 2020 Leadership Evaluation Management (LEM)

For the past three years we have been using the Studer Leadership Evaluation Management system to evaluate the performance of our Leadership Team. Our current LEM (2020) indicates that we are performing well with the exception of the Services Pillar (**Attachment Y**). The reason for this is that the Services Pillar is measured based on adjusted patient days and they are down at PMH and all hospitals across the country because of the pandemic. Because we lost several months of patient volumes due to the pandemic, it is virtually impossible for us to achieve our budgeted goal. This decline in volumes was unexpected and outside of our control. For this reason, I would like to purpose to the Board that for this year, and this year only, the Service Pillar be excluded from the LEM and the weights redistributed to the Quality and Financial Stewardship Pillars. This change would make the Quality and Finance Pillars worth 15% rather than 10%. We can discuss this idea at the October Board Meeting.

MEDICAL STAFF DEVELOPMENT

1. Medical Staff Recruitment

I am pleased to announce that after several months of discussion Dr. Richard Unger, general surgeon, has decided to join the PMH Team (**Attachment Z**). Dr. Unger provided locum tenens services at PMH after Dr. Chaugle left and was well liked by our patients, staff and providers. Dr. Unger has a long history of practicing in smaller rural communities and is looking forward to expanding the scope of general surgery services we provide at PMH. Dr. Unger plans to join us full-time in January. Please join me in welcoming Dr. Unger back to PMH. With our general surgery needs addressed, we are now actively recruiting for a gastroenterologist, dermatologist

and primary care providers (IM, Family Practice, Pediatrics) for Benton City and Grandview. We currently have two dermatologists interested in our opportunity and one of them currently resides in the Seattle area, but would like to relocate. We plan to have at least one of these candidates visit in the next couple of weeks. One of the keys to our current success has been our ability for everyone to review our draft 2021 Medical Staff Model and Provider Recruitment Plan. The proposed Plan continues to build our primary care base, while adding two specialists (GI, dermatology). We welcome your feedback as it relates to this Plan, which will go to the Board for approval in December.

FINANCIAL STEWARDSHIP

1. Financial Performance - September

We continue to work our way back to normal, but continue to be 5-10% behind our expectations (budget) while exceeding our last year's performance (**Attachment CC**). For the second month in a row, we were profitable without the benefit of COVID-19 Relief Funds. While our profits without the Relief Funds were small (Operating Income - $,075, Net Income - $53,443) they were positive and begin to position us for a strong 2021. In September, our gross revenue was 7% below budget as a result of hospital and clinic volumes continuing to be slightly below expectations. Our deductions from revenue were better than expected and with the addition of $1.3 million of COVID-19 Relief Funds, our net revenue was $1.675 million (31%) better than budget. Our expenses in September were higher than expected because of our COVID-19 incentive payments to our staff and the purchase of supplies and minor equipment for our new surgeons (urology, ENT). The net result was an operating income of $1.3 million and a net income of $1.353 million, both significantly over budget and last year.

As a result of our slowly recovering volumes and COVID-19 Relief Funds, our year-to-date financial performance is excellent. Our gross revenue is trending at 13% below budget, but only 1% last year at this time. Our deductions from revenue are in line with our decreased gross revenue and budget expectations and we have recognized $5.1 million of Relief Funds. As a result, our net revenue is 3% ($1.6 million) better than budget and 13% ($5.6 million) better than last year. Our expenses, in total, are trending right at budget despite the recently unbudgeted incentive compensation payments. The result is a year-to-date operating income of $4.1 million (8.3%) and a net income of $4.568 million (10.2%). Both margins far exceed our Pillar Goal (6.0%) and position us well for the future. As good as our income statement looks, our balance sheet looks even better. We currently have 222.58 days of cash on hand and our payor mix continues to be strong. While we have not yet recognized the $6.35 million of Payroll Protection Program funds on our income statement yet, we are beginning to submit the required forgiveness data and expect to show the $6.35 million of our income statement before the end of the year. Our primary financial opportunity for improvement is to enhance our billing and collection process. We currently have 57.18 days in net accounts receivable, while our long-term goal is 45 days. Our team is aggressively attacking this opportunity and plan to improve in the coming months.

2. PMH Clinic Quarterly Financial Performance

The past several months has been a struggle for our clinics and clinics all across the country. Volumes are down, but slowly recovering. However, the lack of volume has created financial deficits that cannot be made up in a few months. Our clinics in total are $1.4 million below their budget and $1.5 million behind last year (**Attachment DD**). However, if we allocate their share of the COVID-19 Relief Funds to the clinics (approximately $1.2 million), they are much closer to budget and last year. In addition, our clinics contribute significantly to overall hospital volumes and revenue.

3. 2021 Budget Process

As we begin to collect information as part of our Strategic Planning process, we have also begun to develop our Operating and Capital Budgets for FY 2021. Our department leaders are currently projecting their revenue and expenses for next year. Because this was such an unusual year, we are advising our leaders to start with their 2020 Budget and make adjustments as necessary for 2021. If we use 2020 actual data and annualize it, we believe our numbers will be artificially low. To say the lease, 2021 will be a challenging year to budget. By the end of October/early November, we will total all department input and see how close we are to our total margin goal of 6.0%. We will then meet with department leaders to identify additional opportunities for improvement (revenue growth and expense reduction), if need to meet our total margin goal. In addition to working on our Operating Budget, we are also collecting capital acquisition requests from our Medical Staff and all PMH departments, including our clinics. A preliminary budget will be presented to the Finance Committee and Board, for review and setting tax rates, in November and the final 2021 Operating and Capital Budges will be presented to the Board for approval in December.

4. Malpractice Costs

While we are all speculating what the future holds as it relates to the COVID-19 pandemic and its aftermath, we were recently notified by our malpractice insurance broker, that malpractice costs are going up across the country. At PMH we have been very fortunate and have not had any significant malpractice claims or payouts for well over 5 years,. Despite our positive track record, Physicians Insurance is telling us to expect premium increases going forward (**Attachment EE**). While this is only one expense area at PMH, we are concerned that the cost of the pandemic may be passed on to us in other areas. This is another reason why 2021 will be very challenging to budget.

5. Cleverly Hospital Dashboard Report

Cleverly and Associates is a top hospital financial consulting company in the country. For the past several years we have used them to assist us in setting our charges which has been very successful. Cleverly helps us keep our charges below our competition, yet maximize our revenue potential based upon our payor mix. Cleverly is also known for their Dashboard Report which compares hospitals' financial performance against other U.S. hospitals. (**Attachment FF**) We just received our report and are beginning to examine it to identify opportunities for improvement. Our report compares us to hospitals with similar net revenue and all U.S. hospitals. It should be noted that Cleverly obtains this information from Medicare Cost Reports

filed by every hospital in the country. Unfortunately, however, our data is from our 2018 Medicare Cost Report, while most hospitals are using their 2019 Cost Report. Our 2019 Cost Report should be available to Cleverly in a couple month and we will have them run the report again. Regardless, the information is very valuable and David Rollins, CFO, will briefly review the Dashboard with the Board at the October Board Meeting.

6. PMH Foundation Update

The Foundation began phase 1 of the capital campaign feasibility study this week, including the development of a PMH New Hospital Prospectus (**Attachment GG**). For the next three weeks we will have Andy Coe and Jay Werth from Convergent Non-Profit Solutions, in town conducting one-on-one, confidential interviews with people on the donor prospect list we created. The goal is to have a minimum of 50 interviews done in that three-week span.

When the interviews are completed, Convergent will supply the Foundation with a report based on feedback from the interviews with a recommendation on what a realistic capital campaign goal should be set at. They will also provide qualitative information in an aggregate form on what the overall community support is for building a new hospital. Both the financial target and the aggregate will be included in our USDA loan to demonstrate community support for the project.

QUALITY

1. New PMH Board Commissioner

On September 29th, the PMH Board of Commissioners interviewed four individuals interested in the position vacated by Kit Watson when he moved out of the Hospital District. All four candidates interviewed were well qualified and in the end, the Board selected Neilan McPartland to fill the vacant position (**Attachment HH**). Neilan will begin his duties in October and will fill the remainder of Kit's term, which was through December 2021. Please join me in welcoming Neilan to the PMH Board of Commissioners! We plan to schedule orientation for Neilan to PMH at his convenience and before the end of the year if possible.

2. COVID-19 Update

The PMH COVID-19 Task Force continues to meet on a weekly basis and the good news is that the number of positive cases has been declining at PMH and Benton -Franklin Counties (**Attachment II**). Nationally the number of cases is increasing again, but the average age of those infected is younger and the deaths from COVID-19 have significantly decreased. We are doing a much better job protecting the vulnerable and the treatment regimens (e.g. Remdesivir, zinc, vitamin D, Dexamethasone, etc.) are more effective. PMH has done a good job of maintaining adequate supplies of PPE, medications, COVID-19 lab reagents, etc. and we do not anticipate any challenges in the near future, but we are closely monitoring COVID-19 activity throughout the area. With the onset of fall and colder temperatures, we are also opening up all of our clinics to care for patients with respiratory issues, rather than sending them exclusively to the Prosser COVID-19 Clinic. Each clinic is establishing a well and sick

section in their waiting rooms, and the sick patients are being cared for in designated treatment rooms. It is also important to remember that all patients are masked when they enter a clinic. The Prosser COVID-19 Clinic will also remain open seven days a week for the foreseeable future.

Now that fall has arrived, that is also a sign that it is flu season. We are now offering flu shots to our staff and encouraging everyone to get one (**Attachment JJ**). The last thing we need is for hospital beds to be filled with both COVID-19 and flu patients, which would put our capacity to care for everyone at risk. Hospitals have reinvented themselves in many ways to respond to COVID-19. Since March, decades of standard operating procedures have been reexamined, redesigned and refined, with the goal of saving lives while protecting our caregivers and patient's' families during the pandemic. For example, we have increased COVID-19 testing capabilities; implemented social distancing and mask use through our facilities; limited visitors, etc. The precautions have made PMH and other hospitals among the safest environments found anywhere today. Despite this, we continue to see evidence that people are putting off necessary care due to unfounded fears of contractingCOVID-19 from a hospital visit. A CDC study found that during the first five moths of 2020 the number of visits to emergency departments for life-threatening illnesses declined by 42%. In addition, it was found that there was a dramatic drop in Medicaid pediatric visits for primary and preventive care services. These delays can have an adverse effect on a person's health and have caused us and the AHA to promote the safety and availability of our services. Hopefully, with the support of organizations like the AHA, and the ads we are running, local citizens will pursue the healthcare services they need and deserve, without the fear of contracting COVID-19.

3. COVID-19 Financial Plan

PMH continues to perform well financially because of our ability to access COVID-19 Relief Funds and our patient volumes consistently being over 90% of our 2020 budget. Year-to-date (through September) we have received $19,971,754 of COVID-19 Relief Funds (**Attachment KK**). Of those funds, $5,196,271 have been recognized on our income statements, leaving $8,183,503 to be used or recognized in the future. We have already determined that we will not need the $6,35 million of Medicare Advanced Payments and will pay this back over the next year. We also have not recognized the SBA Payroll Protection Loan of $6,35 million because it has not yet been forgiven. We anticipate that is will be forgiven before the end of the year which will add $6,35 million to our net income (**Attachment LL**). As a result, we are projecting that our net income for 2020 will be $12,299,041. This would be an incredible financial year for PMH and is based on the guidelines we were given by HHS several months ago. However, they recently changed the guidelines which would have a negative impact on PMH.

In June, HHS stated that hospitals could "use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if hospitals had prepared a budget without taking into account the impact of COVID-19 (such as PMH), the estimated lost revenue could be the difference between budgeted revenue and actual revenue. It was also considered reasonable to compare the revenues to the same period last year. However, on September 19th, HHS issued a new

definition of lost revenue, stating that is was "represented as a negative change in year-over-year net patient care operating income." This definition change has serious financial implications for the hospital industry and is being fought by the AHA and several members of Congress (**Attachment MM**). This change could cost PMH up to approximately $5 million. While that would be a significant loss, we would still end 1010 with a net income of approximately $7.3 million. This would far exceed our budget expectations and our Financial Stewardship Pillar goal.

4. October Board Meetings

We have a busy October Board Work Session planned as we continue to work on our Replacement Facility Project by discussing the Board's Vision for the new facility, learning about the construction methods we are allowed to use in Washington and receive an update the work the Design Team is doing. We would also like to spend a brief time discussing items the Board would like to see in the 2021 Strategic Plan. Finally, we have two Employee Development topics we would like to discuss which include another revised PMH Retirement Plan and the 2020 PMH LEM Scorecard. The October Board Meeting will be very straight forward with a possible action item related to the PMH Retirement Plan and informational reports regarding the Cleverly Dashboard Report and the PMH EPIC Annual Report. Also, a reminder that the November Board Meetings will be held on November 17 and 19th and the December Board Meetings will be held on December 15th and 17th. These changes were all made to avoid conflicts with the upcoming holiday season.

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

Fiscal Year 2021

Strategic Planning Document

Pillars of Excellence

- Patient Loyalty
- Employee Engagement
- Medical Staff Development
- Quality
- Services
- Financial Stewardship

Prosser
Memorial Health

723 Memorial Street
Prosser, WA 99350
ProsserHealth.org

Contains Confidential Information

Table of Contents

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Prosser
Memorial Health

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

Mission: To improve the health of our community.

October 9, 2020

Dear Team,

"Success is what happens when opportunity meets planning." - Thomas Edison

It's once again time to roll up our collective sleeves, put pencil to paper, and chart our course for 2021, during the Strategic Planning process we have established at Prosser Memorial Health. While the process can be a little daunting, and the information provided to you more than a little overwhelming, I would like each of you to reflect on the last four years that we have engaged in strategic planning and think of Thomas Edison's quote.

In 2017, we put a plan together, establishing our Six Pillars of Excellence, created a Mission, Vision and Values that we hold each other to, and identified specific goals and objectives to achieve excellence in each of our pillars. The growth and success we have experienced since that time is not by accident. It is a true reflection of what we can do as an organization when we have a clear road map that defines where we want to be and the commitment of every team member to do their part to help us get there.

Yes, 2020 has brought incredible disruption to our organization and the goals and objectives we had in our Strategic Plan this year. However, our continued success is our resilience and trust in one another. We are committed to our Mission: *To Improve the Health of Those We Serve.* We believe in our Vision: *To Become a Top 100 Critical Access Hospital in the Country,* and we are committed to our ASPIRE values. We've had to be flexible and pivot to meet the needs a pandemic has brought to PMH, but we have not lost sight of what is important.

In our planning process this year, we will focus on recommitting to each of our Six Pillars of Success that will take us into 2024, and how these Six Pillars will make building a new hospital an attainable goal for our organization in 2024. It won't always be easy, but I commit to you that it will be worth it.

Part of the 2021 strategic planning process, is to seek out your ideas. I encourage you to read through the 2021 Strategic Planning document and share your ideas and feedback on how we can make Prosser Memorial Health stronger in each of our six pillars for 2021 and beyond. There are two worksheets in this packet; one is called **New Hospital Visioning Worksheet**, please provide feedback about what you would like to see for the new hospital as it relates to our Six Pillars of Excellence, and the other is our standard **Strategic Planning Session Worksheet** for general ideas and feedback.

Thank you for everything you do for our patients, their families, our community and each other.
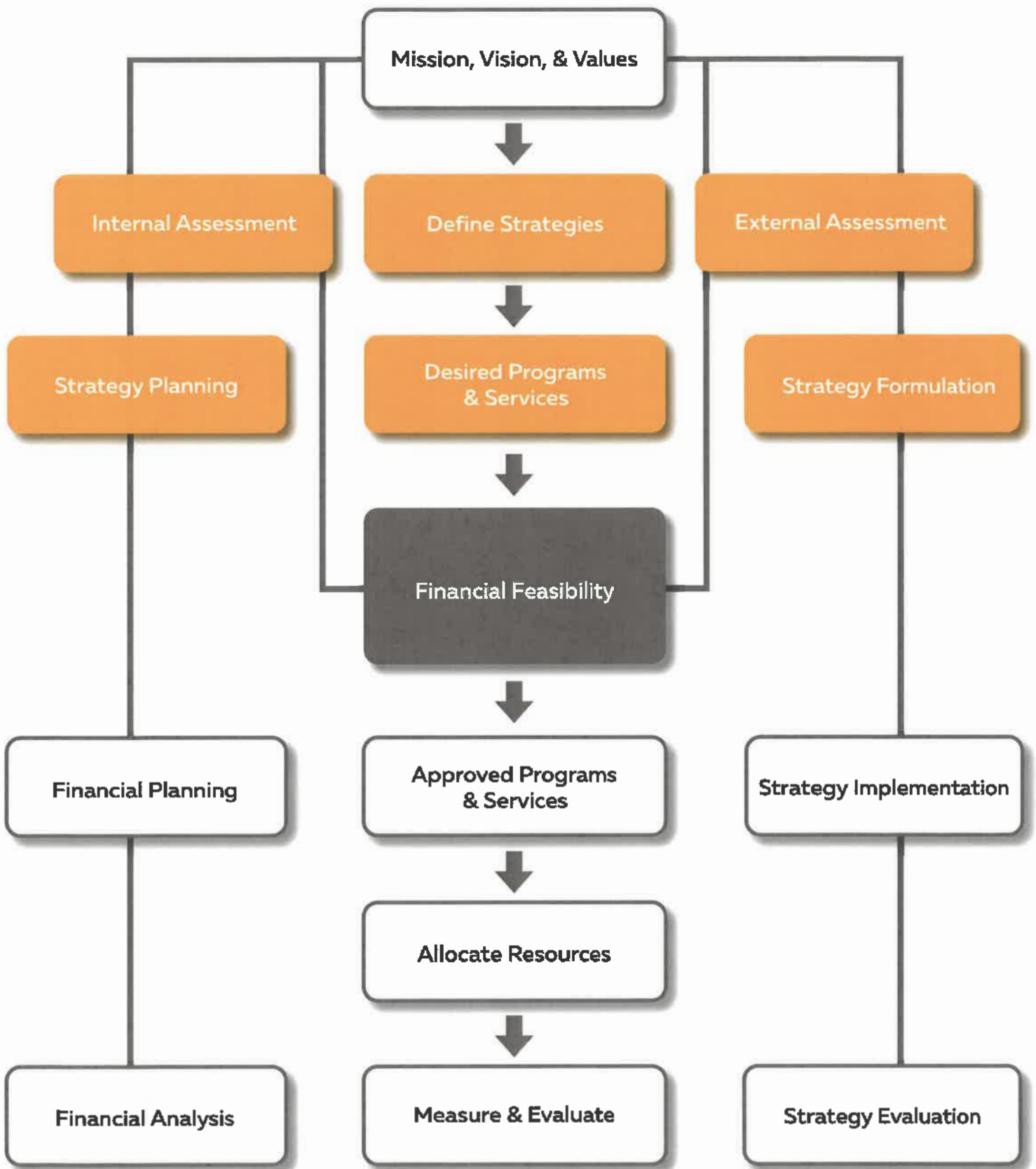#ThisISHowWeCare #ThisISWhereHereosWork!

Sincerely,

Craig

Craig J. Marks, FACHE
Chief Executive Officer
Prosser Memorial Health
(Find the hidden syringe and email the page number to Carol Allen to win a gift certificate.)

I. Strategic Planning Model

FY 2021 Prosser Memorial Health Strategic Planning Model

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                    ┌─────────────────────────┐
                    │ Mission, Vision, & Values │
                    └─────────────────────────┘

Internal Assessment      Define Strategies       External Assessment

Strategy Planning        Desired Programs         Strategy Formulation
                         & Services

                         Financial Feasibility

Financial Planning       Approved Programs        Strategy Implementation
                         & Services

                         Allocate Resources

Financial Analysis       Measure & Evaluate       Strategy Evaluation
```

II. Mission, Vision, Values, and Standards of Behavior

Mission, Vision, Values
&
Standards of Behavior

Accountability　　Service　　Promote Teamwork　　Integrity　　Respect　　Excellence

Our Mission

Prosser Memorial Health will improve the health of our community.

Our Vision

FY 2021-2024

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

Pillars of Excellence

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

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

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

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

3. **Employee Development Pillar:** PMH will encourage and provide for the ongoing development of our employees. We will provide an atmosphere that values our employees and promotes:
   - Open communication.
   - Competitive wages and benefits.
   - Selection and retention of effective, caring personnel.
   - Utilization and development of talent throughout the organization.
   - On-going education.
   - Employee recognition.

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

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

   GOAL: Achieve an iVantage Quality score of 49 or higher.

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

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

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

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

Administrative Team

Pillar Champions

Patient Loyalty
Chief Nursing Officer Chief Operations Officer

Medical Staff Development	Employee Engagement
Chief Medical Officer	Chief Human Resources Officer

Quality	Services	Financial Stewardship
Chief Quality / Compliance Risk Officer	Chief Communications Officer Chief Information Officer	Chief Financial Officer

Our Values

Accountability   Service   Promote Teamwork   Integrity   Respect   Excellence

Our Values

ASPIRE to soar to a great height

A   **Accountability:** Take responsibility for our own behavior

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

P   **Promote Teamwork:** Work together to achieve common goals

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

R   **Respect:** Respect the inherent value and worth of each person

E   **Excellence:** Exceed the expectations of those we serve

Our Shared Values
&
Standards of Behavior

Staff and Auxiliary

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

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

Craig J. Marks, FACHE
CEO
Prosser Memorial Health

Introduction

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

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

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

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

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

A   **Accountability:** Take responsibility for our own behavior

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

P   **Promote Teamwork:** Work together to achieve common goals

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

R   **Respect:** Respect the inherent value and worth of each person

E   **Excellence:** Exceed the expectations of those we serve

Vision of Success FY2021 to 2025

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

Patient Loyalty

Goal: 95% Exceed Patient Expectations

Medical Staff Development

Goal: 90% Medical Staff Satisfaction

Employee Engagement

Goal: 90% Employee Satisfaction

Quality

Goal: 10% Selected Quality Attributes

Services

Goal: 50% Market Share

Financial Stewardship

Goal: Total Margin > 6%

Our Values

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

ASPIRE Values & Standards of Behavior

Our Values

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

We Value ACCOUNTABILITY:

Take responsibility for our own behavior.

I WILL:

- Set a good example, project self-confidence, and not allow personal issues to interfere with the quality of my work.

- Anticipate and correct problems before they become complaints.

- Apologize to those we serve for problems or delays, do my best to make it right, initiate service recovery as warranted, and thank them for their understanding and patience.

- Seek out available education opportunities to improve my personal and professional skills so I can participate, learn, and grow.

- Avoid blaming others when problems occur by becoming part of the solution, and take responsibility for my own behavior.

- Take initiative to hold myself and others accountable for creating a positive environment.

- Take pride in what I do and my professional appearance, language and behavior.

- Own and resolve guest problems.

We Value SERVICE:

Care enough to exceed the expectations of those we serve.

I WILL:

- Immediately acknowledge everyone I meet, smile and, if possible, address them by name.

- Assist and/or escort those we serve to their destination or introduce them to someone who can help them.

- Contribute to the creation of a clean, safe environment for those we serve.

- Answer the phone with a smile in my voice and identify myself by name and department.

- Be professional, providing help in a friendly and compassionate manner.

- Seek out opportunities to promote a positive experience for our customers.

- Thank customers for choosing PMH.

We Promote TEAMWORK

Work together to accomplish great things

I WILL:

- Focus more on "we" and less on "me".

- Be open to new ideas and embrace change.

- Speak favorably about PMH, all departments, and coworkers, and go out of my way to make my team-members look good.

- Welcome new employees.

- Recognize and praise achievement.

- Communicate effectively.

- Have a positive, encouraging attitude when encountering co-workers.

- Seek partners in the community with common values and goals.

We Value INTEGRITY:

Do the right thing even when no one is watching.

I WILL:

- Do the right thing even when no one is watching.

- Be honest, trustworthy, responsible, and dependable.

- Be considerate of how I am perceived in my body language, eye contact, verbal tone, and writing style, realizing that this perception affects others and the outcome I am trying to achieve.

- Take ownership in positively representing PMH in and out of the workplace.

- Follow through with what I say.

- Take pride in what I do.

- Promote mutual respect and build community within PMH.

- Seek input from those impacted by decisions.

- Always wear my name badge.

We Value RESPECT:

Treat others with Dignity.

I WILL:

- Protect everyone's privacy and confidentiality.

- Be aware and considerate of generational, physical, religious, financial and cultural diversity.

- Praise in public, coach in private.

- Recognize each person, situation and idea as significant.

- Not engage in gossip, inappropriate behavior or language.

- Treat others as they want to be treated.

- Provide services to the underserved and encourage others to do the same.

- Anticipate and provide for the needs of those we serve.

- Provide fairness and justice in internal policies and practices and external relationships.

We Value EXCELLENCE:

Exceed the expectations of those we serve.

I WILL:

- Participate in continuous improvement, recognizing that everything I do is a process that can be improved.

- Contribute to the creation of a just culture and not accept excuses, mediocrity, and carelessness.

- Do my best and remain positive.

- Use my time effectively.

- Anticipate and provide for the needs of those we serve.

- Provide compassionate and personalized service in a timely manner, and build strong relationships that create PMH guests for life.

- Strive to "raise the bar" in exceeding expectations.

- Promote effective use of resources.

- Ensure accountability for the development and use of resources in the present and their availability for the future.

- Always begin each day and each activity with quality in mind.

- Begin each customer interaction by considering their expectations and going beyond their expectations by providing care with compassion, integrity, respect and stewardship.

Commitment to ASPIRE

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

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

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

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

_____   _____

Signature   **Date**

_____   _____

Print Name   **Department**

III. External Assessment

A. Hospital & Health Network Environmental Scan 2020
B. J.P. Morgan's Top 10 Questions Every CEO Must Answer
C. Top 10 Trends to Watch (and Act Upon) in 2020
D. ASHE 2020 Hospital Construction Survey

III. External Assessment
A. Hospital & Health Network Environmental Scan 2020

Welcome to the 2020 Environmental Scan

They say that change is the only constant in life. That certainly holds true today. Fresh technologies, new players in the market, increased emphasis on population health and social determinants of health, the advance of consumer-friendly care delivery models ... all of these factors and more promise a significant and lasting transformation of health care.

For those in health care, we *welcome* this change. Because as we have always done, hospitals and health systems are leading this transformation, helping to shape and direct the future.

As a field, we have a remarkable track record for adaptability, seamlessly integrating decades of major breakthroughs in technology, biology and science — evolving treatments for cancer come to mind — into improved patient care.

In health care, change brings with it the opportunity to continue improving. It means better care for our patients. Change is what hospitals have been doing for far longer than any of us have been around. We know that there will always be changes we need to make to prepare for the future. That's what we're doing today.

To help you, each year, we publish the AHA Environmental Scan. This year's scan offers an overview of the trends, statistics and economic forecasts likely to affect patients and providers at every level of care.

We track, interpret and share developments to make your job easier. With that in mind, we have identified several key topic areas that will likely impact health care in 2020 and beyond.

• **Access.** The cornerstone of healthy communities is having access to the right care at the right time in the right setting. Many factors affect this: availability of government programs such as Medicare, Medicaid and the Children's Health Insurance Program, private insurance coverage and a strong and resilient workforce.

RICK POLLACK

President and CEO American Hospital Association

• **Health.** The health care system continues to evolve beyond the walls of the hospital as hospitals and health systems seek to manage and prevent chronic disease and improve the well-being of patients. This includes addressing the social determinants of health such as housing, food insecurity and violence in partnership with community organizations, providing access to behavioral health resources and working to stem the tide of tragic drug overdose.

• **Innovation.** Innovative strategies are becoming the norm. Eighty-six percent of health systems have at least one executive dedicated to exploring partnerships, investments and other tactics to position for the future. Top priorities for innovation initiatives and investments will include IT/data analytics, patient/consumer engagement and use of artificial intelligence to improve care delivery.

• **Affordability and value.** Affordable health care is one of the biggest concerns facing families, employers and government. Hospitals and health systems are doing their part to make care more affordable. They are leading the charge toward value-based care with new models that provide better coordinated care at a lower cost. They are using the best technology and data to improve patient outcomes.

• **Individual as partner.** Today's consumers want health care when and where they want it. The availability of virtual care, patient-friendly online portals and alternative places of care such as retail clinics will be more important than ever.

This scan offers facts, predictions and statistics to think about and plan for, but nothing to fear. We've embraced change in the past and grown from it, and we will again.
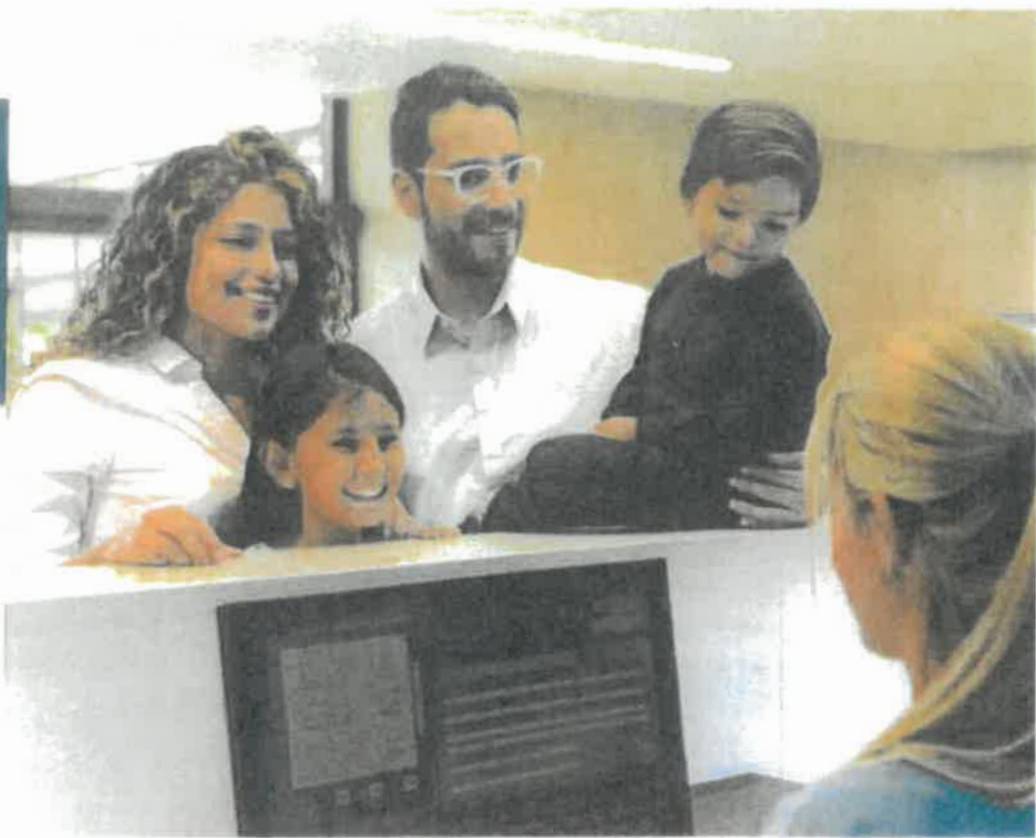
As always, the AHA will stay on top of it as part of our commitment to helping America's hospitals and health systems as they care for their communities ... saving lives, performing miracles and keeping people healthy.
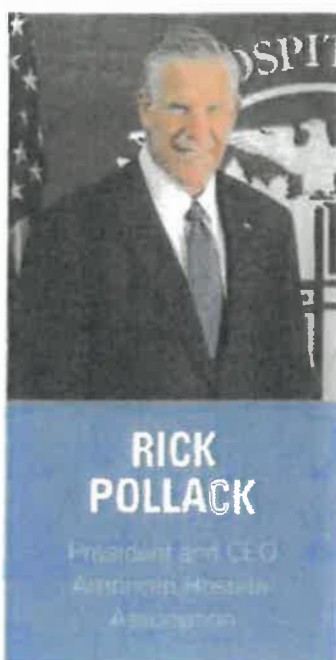
ACCESS

Access to affordable, equitable health, behavioral and social services
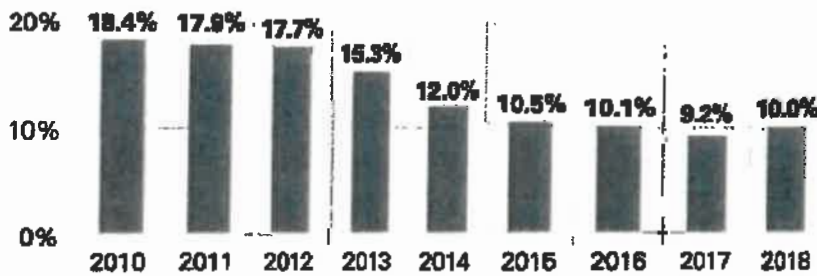
Hospitals, health systems and health care organizations recognize that access to care for individuals is the cornerstone for developing healthy communities across the nation. Insurance coverage and a strong workforce are key elements that influence access to health care.
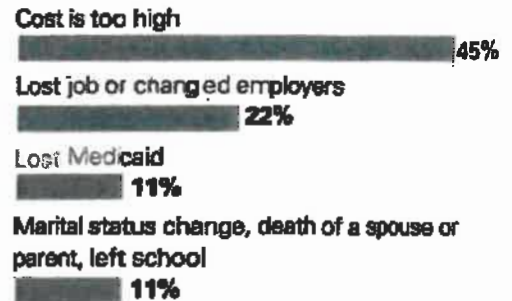
COVERAGE

The Uninsured

UNINSURED RATE: YOUNGER THAN 65

Bar chart values by year:
- 2010: 18.4%
- 2011: 17.9%
- 2012: 17.7%
- 2013: 15.3%
- 2014: 12.0%
- 2015: 10.5%
- 2016: 10.1%
- 2017: 9.2%
- 2018: 10.0%

"Health Insurance Coverage in the United States, 2013-2018" and "Income, Poverty, and Health Insurance Coverage in the United States: 2010-2012," www.census.gov/topics/health/health-insurance/library.html, U.S Census Bureau.

TOP REASONS FOR BEING UNINSURED AMONG NONELDERLY ADULTS

Cost is too high
45%

Lost job or changed employers
22%

Lost Medicaid
11%

Marital status change, death of a spouse or parent, left school
11%

Source: "Key Facts about the Uninsured Population," Kaiser Family Foundation, kkf.org, Dec. 7, 2018.

The Underinsured

UNDERINSURED RATE: ADULTS AGES 19-64
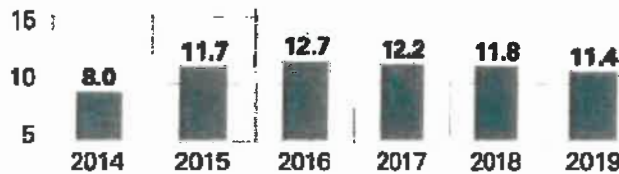

Bar chart values:
- 2010: 22%
- 2018: 29%
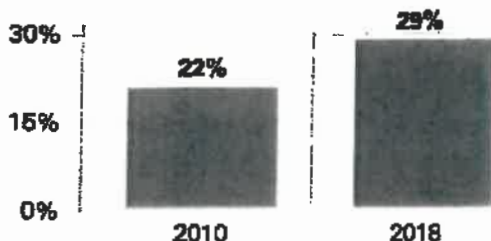
- In 2018, high out-of-pocket costs and deductibles contributed to underinsurance.
- The greatest growth in the number of underinsured adults occurred among those with employer plans.
- Continuously insured adults, including the underinsured, are more likely to get preventive care and cancer screenings.

Collins, Sara R. et al. "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured," The Commonwealth Fund, Feb. 7, 2019.
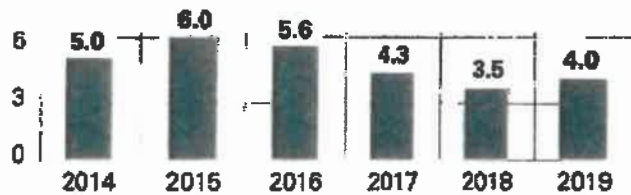
27

The Affordable Care Act (ACA)
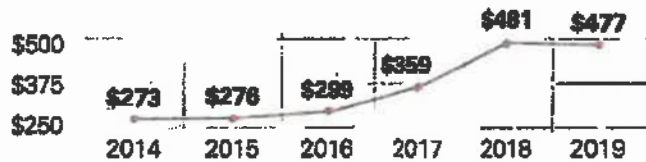
The ACA individual marketplace

MARKETPLACE ENROLLMENT (in millions)

Year	Value
2014	8.0
2015	11.7
2016	12.7
2017	12.2
2018	11.8
2019	11.4

AVERAGE NUMBER OF PARTICIPATING INSURERS PER STATE

Year	Value
2014	5.0
2015	6.0
2016	5.6
2017	4.3
2018	3.5
2019	4.0

MARKETPLACE AVERAGE BENCHMARK PREMIUM

Year	Value
2014	$273
2015	$276
2016	$299
2017	$359
2018	$481
2019	$477

Note: Average calculated using second-lowest cost silver plans per market.
"Marketplace Enrollment, 2014-2019, Marketplace Average benchmark premiums, Number of Issuers Participating in the Individual Health Insurance Marketplaces" Kaiser Family Foundation. kkf.org. Accessed July 29, 2019.

Medicare

As measured by expenditures, Medicare is the largest health care insurance program in the U.S.

2017 ENROLLMENT

	No. of people	% of U.S. population
Medicare Part A	58 million	18.0%
Medicare Part B	53 million	16.0%
Medicare Part D	44 million	13.5%

Klees, Barbara S. and Wolfe, Christian J. "Brief Summaries of Medicare & Medicaid," Office of the Actuary, CMS, Department of Health & Human Services, Oct. 15, 2018.

IMPACT OF SUBSIDIES ON ENROLLMENT (between 2017 and 2018)

-24% Unsubsidized enrollment

Subsidized enrollment +4%

"Trends in Subsidized and Unsubsidized Enrollment," Centers for Medicare & Medicaid Services, Aug. 12, 2019.

The ACA linked to reduced disparities

- Gaps in insurance coverage among racial and ethnic groups decreased after implementation of the ACA coverage expansions. These effects were greatest in states that expanded Medicaid.[*]

- Under the ACA, women with ovarian cancer were more likely to be diagnosed at an early stage and receive treatment within 30 days of diagnosis.[†]

[*] Chaudry, Alay et al. "Issue Brief: Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?" The Commonwealth Fund, August 2019.
[†] Smith, Anna Jo and Nickels, Amanda. "Impact of the Affordable Care Act on early-stage diagnosis and treatment for women with ovarian cancer," Journal of Clinical Oncology, vol. 37, no. 18, June 5, 2019. Reprinted with permission. © 2019 American Society of Clinical Oncology. All rights reserved.

AFRICAN AMERICAN CANCER PATIENTS

+6% Increase in African American patients beginning treatment within a month of receiving diagnoses of advanced cancers in Medicaid expansion states post-expansion.

Doerr, Anne. "Yale study finds link between Medicaid expansion and equity in cancer care," YaleNews, June 2, 2019.

Impact of a potential Medicare public option

- By 2025, 6.3 million people would gain coverage, as opposed to 9.1 million people gaining coverage through additional support of the ACA.
- A reduction of $836 billion to hospitals over a 10-year period.
- A significant disruption to the employer-sponsored insurance market, which provides coverage to more than 150 million Americans.

Koenig, Lane et al. "The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals," KNG Health Consulting, LLC, March 12, 2019, and supplemental report August 6, 2019.

Medicaid and the Children's Health Insurance Program (CHIP)

ENROLLMENT

- More than 72 million people, or 22% of the U.S. population.
- Medicaid expansion adult enrollment nearly 17 million people.
- 47% of Medicaid and CHIP recipients are younger than 21.
- 11% of Medicaid recipients are 65 years or older.

"Who enrolls in Medicaid and CHIP," Medicaid.gov, July 29, 2019.

MEDICAID PAYS:

- $1 in $6 in the health care system.
- $1 in $3 to safety net hospitals and health centers.
- $1 in $2 for long-term care.
- For nearly half of all births in a typical state.

"Medicaid in the United States," fact sheet, Kaiser Family Foundation, November 2018.
Rudowitz, Robin, et al. "10 things to Know about Medicaid: Setting the Facts Straight," Kaiser Family Foundation, March 6, 2019.

WORKFORCE

Workforce shortages

PHYSICIAN SHORTAGE PROJECTIONS BY 2032

Primary care physicians	21,100-55,200
Non-primary care specialties	24,800-65,800
Surgical specialties	14,300-23,400

"2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032," prepared for the Association of American Medical Colleges; submitted by IHS Markit Ltd., April 2019.

HEALTH CARE WORKFORCE SHORTAGE PROJECTIONS BY 2025

Home health aides	446,300
Nursing assistants	95,000
Medical and lab technologists/technicians	98,700
Nurse practitioners	29,400

Stevenson, Matthew. "Demand for Healthcare Workers Will Outpace Supply by 2025: An Analysis of the US Healthcare Labor Market," Mercer HPA, May 2018.

PSYCHIATRIST SHORTAGES BY 2030

Psychiatrist supply

-27%

Psychiatrist demand

+6%

Behavioral Health Workforce Projections, 2016-2030," HRSA National Center for Health Workforce Analysis, 2018.

PERCENTAGE OF COUNTIES WITHOUT A PSYCHIATRIST

Metropolitan   27%

Non-metropolitan   65%

Andrilla, C. Holly A. et al. "Geographic Variation in the Supply of Selected Behavioral Health Providers," American Journal of Preventive Medicine, vol. 54, no. 6, supplement 3 (June 2018): S199-S207.
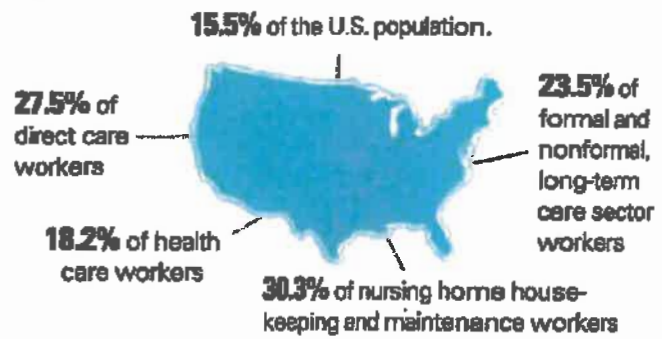
NURSING EDUCATION CAPACITY

75K Number of qualified applicants turned away from baccalaureate and graduate nursing programs by U.S. nursing schools in 2018 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors and budget constraints.

"Fact Sheet: Nursing Faculty Shortage," American Association of Colleges of Nursing, aacnnursing.org, April 2019.

Workforce and immigration

IN 2017, IMMIGRANTS* ACCOUNTED FOR:

15.5% of the U.S. population.

27.5% of direct care workers

23.5% of formal and nonformal, long-term care sector workers

18.2% of health care workers

30.3% of nursing home housekeeping and maintenance workers

*Immigrants are defined as those born outside the U.S. and are naturalized citizens, legal noncitizens and unauthorized immigrants.
Zallman, Leah et al. "Care For America's Elderly And Disabled People Relies On Immigrant Labor," Health Affairs, vol. 38, no. 6 (June 2019).

Drivers of workforce changes

- Generational shifts
- Technology
- Consumerism
- Open talent models (e.g. gig, virtual and contract)
- Diversity*

Redin, Jennifer et al. "The future of work: How can health systems and health plans prepare and transform their workforce?" Deloitte Insights, Deloitte Center for Health Solutions, March 7, 2018. © 2019 Deloitte Development LLC.
* "The Imperative for Strategic Workforce Planning and Development: Challenges and Opportunities," American Hospital Association, 2017.

Artificial intelligence (AI) and the workforce

PERCENTAGE OF TASKS THAT COULD BE AUTOMATED IN HEALTH CARE

Support occupations   40%

Practitioners/technical occupations   33%

Implications:

- Improved efficiency, productivity and performance.
- Expanded job responsibilities.
- Practicing at the top of license.
- "Soft" skills will matter more.
- Workforce will acquire new digital skills to be able to collaborate with AI teams.

"AI and the Health Care Workforce," Market Insights, AHA Center for Health Innovation, Sept. 23, 2019.

Learn More at **AHA.ORG**

Learn more about the AHA's workforce agenda. aha.org/workforce

Distribution of physicians by employment status

- Owner
- Employee
- Independent contractor

5.0% — 6.7%
41.8% — 47.4%
53.2% — 45.9%

2012 2018
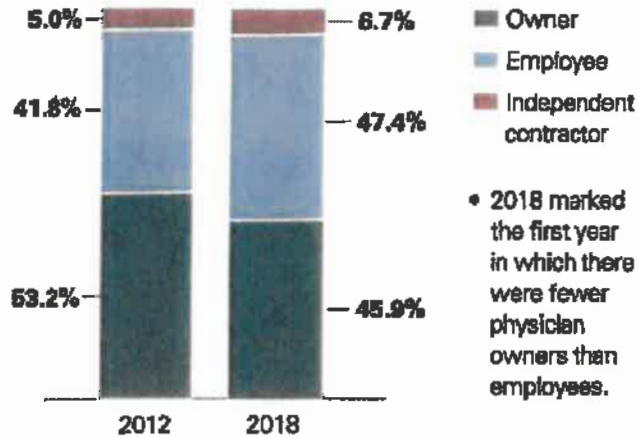
- 2018 marked the first year in which there were fewer physician owners than employees.

Kane, Carol. Policy Research Perspectives — "Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees," AMA Economic and Health Policy Research, American Medical Association, May 2019.

Clinician burnout

PHYSICIAN BURNOUT AND DEPRESSION

Burnout — 44%
Colloquial depression — 11%
Clinical depression — 4%
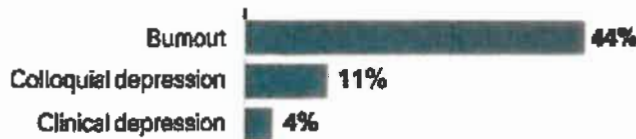
Kane, Leslie. "Medscape National Physician Burnout, Depression & Suicide Report 2019," Medscape, Jan. 16, 2019.

NURSE BURNOUT

Nurses reporting burnout — 63%
Nurses considering changing jobs due to burnout — 41%

"Wake Up to the Facts About Fatigue eBook," Kronos, 2018.

PHYSICIAN BURNOUT COST*

Focusing on physician turnover and reduced clinical hours, the annual cost of burnout on a national scale:

$4.6 billion, or $7,600 per employed physician

NURSE BURNOUT COST†

Annual cost of nurse burnout to the average hospital:

$5.2 – $8.1 million

* Han, Shasha et al. "Estimating the Attributable Cost of Physician Burnout in the United States," Annals of Internal Medicine, vol. 170, no. 11 (2019): 784-790.
† "2016 National Healthcare Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2016.

Nonmedical tasks take time

- Primary care physicians spend more than one-half of their workday, nearly 6 hours, interacting with the EHR during and after clinic hours.*

- During the time spent interacting with the EHR, 44% is focused on administrative tasks like order entry and billing and coding, and 24% is focused on inbox management.*

- An ED physician makes 4,000 mouse clicks over the course of a shift.†

* Arndt, Brian G. et al. "Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations," Annals of Family Medicine, vol. 16 no. 5 (Sept./Oct. 2017): 419-426.
† Fry, Erika and Schulte, Fred. "Death by a Thousand Clicks: Where Electronic Health Records Went Wrong," Fortune, March 18, 2019.

Workplace violence

HOSPITALS THAT HAVE FORMAL WORKPLACE VIOLENCE PREVENTION PROGRAMS

60%
40%
20%
0%

47.1% — 2016
53.0% — 2017
55.5% — 2018*
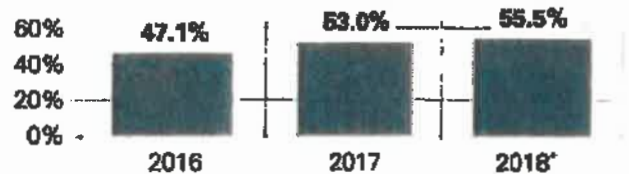
AHA Annual Survey of Hospitals data, American Hospital Association, 2017 - 2019
* 2018 data is preliminary.

RATE OF INTENTIONAL INJURIES BY OTHERS, PER 10,000 WORKERS IN 2017

Health care and social assistance workers — 9.1
All private industry — 1.9

"Injuries, Illnesses, and Fatalities," Department of Labor, Bureau of Labor Statistics, www.bls.gov/web/osh/od_r8.htm. Accessed Aug. 7, 2019.

VIOLENCE IN THE EMERGENCY DEPARTMENT (ED)

- Nearly half of emergency physicians stated they have been physically assaulted at work.

- 71% personally witnessed others being assaulted during their shifts.

- 96% of female emergency physicians and 80% of male emergency physicians reported that a patient or visitor made inappropriate or unwanted advances toward them.

"ACEP Emergency Department Violence Poll Research Results," Marketing General Inc. and the American College of Emergency Physicians, September 2018.

Learn More at AHA.ORG

Learn more about the AHA's Hospitals Against Violence initiative.
aha.org/workplace-violence

HEALTH

Focus on holistic well-being in partnership with community resources

The health care system is evolving outside the walls of the hospital and into the community in an effort to manage and prevent chronic disease and improve the well-being of patients.

Social determinants of health

SOCIETAL ISSUES HAVE A MAJOR IMPACT ON CONSUMER HEALTH

Factors that contribute to health outcomes, %

Social determinants of health	~40
Health behaviors	~20
Clinical care	~15
Nonmodifiable factors (e.g., genetics)	~25

Average amount of data generated over a person's lifetime

1,100 terabytes (volume, variety, velocity, veracity)

0.4 terabytes (clinical data)

6 terabytes

Note: This graphic has been adjusted from the original version.
Singhal, Shubham and Carlton, Stephanie. "The era of exponential improvement in healthcare?" McKinsey & Company, May 2019.

HOUSING*

- 11% of households spend more than half their income on housing costs.

- Severe housing-cost burden is associated with an increase in food insecurity, child poverty and people in fair or poor health.

FOOD INSECURITY†

- 11.8% of households were food insecure in 2017.

- 40 million people lived in food-insecure households.

* Givens, Marjory et al. "2019 County Health Rankings Key Findings Report," Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, March 2019.
† "Food Security Status of U.S. Households in 2017," Department of Agriculture, Economic Research Service, www.ers.usda.gov, Sept. 5, 2018.

SOCIAL DETERMINANTS AND YOUTH VIOLENCE

Many risk factors of youth violence are the result of chronic stress from living in impoverished neighborhoods or poor housing, food insecurity, racism and other instability.

- Each day, 14 young people become victims of homicide and 1,300 are treated in EDs for nonfatal, assault-related injuries.

$21 BILLION Estimated cost of youth violence annually

1 in 5 high school students reported being bullied at school

"Preventing Youth Violence — Fast Facts," Centers for Disease Control and Prevention, cdc.gov, Feb. 28, 2019.

31

Hospitals and social determinants

SCREENING FOR SOCIAL DETERMINANTS
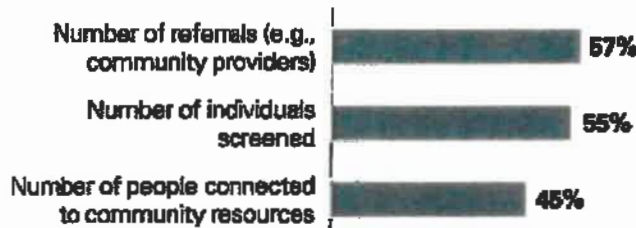
88% of hospitals screen for social needs.

UNMET SOCIAL NEEDS ARE ASSOCIATED WITH:

- Nearly twice the rate of depression.
- 60% higher prevalence of diabetes.
- More than double the rate of ED visits.
- More than double the rate of missed medical appointments.

TOP 3 GOALS UNDERLYING HOSPITALS' STRATEGY ON HEALTH-RELATED SOCIAL NEEDS

Improving health outcomes	70%
Improving patient experience	67%
Building community relations	50%

TOP 3 TYPES OF SOCIAL NEEDS METRICS TRACKED BY HOSPITALS

Number of referrals (e.g., community providers)	57%
Number of individuals screened	55%
Number of people connected to community resources	45%

Lee, Josh and Korba, Casey. "Social determinants of health: How are hospitals and health systems investing in and addressing social needs?" Deloitte Center for Health Solutions, 2017 © 2017 Deloitte Development LLC.

Behavioral health

NATIONAL LANDSCAPE

1 in 5 Americans affected by behavioral health disorders

- 70% of adults with behavioral health disorders also have physical health conditions.
- Costs are 75% higher for people with both behavioral and physical conditions.
- Fewer than half of adults with any mental health disorder receive treatment.

"Behavioral Health Care is High-Value Care," American Hospital Association, May 2019.

HOSPITALS, HEALTH ORGANIZATIONS AND BEHAVIORAL HEALTH

- Nearly 30% of patients who visited a hospital ED had at least one behavioral health diagnosis.

2,538 Number of community mental health centers in operation across the country in 2017

"Behavioral Health Integration: Treating the Whole Person," American Hospital Association Center for Health Innovation, 2019.

PERCENTAGE OF HOSPITALS REPORTING INTEGRATION OF ROUTINE BEHAVIORAL HEALTH SERVICES INTO THE FOLLOWING AREAS:

54.6% Emergency services

49.6% Acute inpatient services

41.2% Primary care services

17.3% Extended care

AHA Annual Survey of Hospitals data, American Hospital Association, 2018. Data is preliminary.

Major depression

DEPRESSION AND TREATMENT IN THE U.S.

People in the U.S. reporting at least one major depressive episode in 2017:

	No. of people	% of the respective population	% not receiving treatment
Adults	17.3 million	7.1%	35.0%
Adolescents (ages 12 to 17)	3.2 million	13.3%	60.1%

- The prevalence of adults with a major depressive episode was highest among individuals ages 18 to 25.
- The prevalence of a major depressive episode was 13.2% higher among adolescent females compared with males.

"Major Depression," National Institute of Mental Health, www.nimh.nih.gov, February 2019.

Suicide

IN 2017:

- More than 47,000 Americans died by suicide.
- The most common method of suicide — firearm (51%).
- Tenth-leading cause of death in the U.S.
- Second-leading cause of death among individuals ages 10-34.
- There were twice as many suicides as there were homicides.
- 4.3% of adults 18 and older had thoughts about suicide.

Suicide Statistics, National Institute of Mental Health, www.nimh.nih.gov, April 2019.

Veterans' behavioral health

- About 20 former and current veterans die by suicide each day.
- The suicide rate is 22% higher than the general population.
- The Department of Veterans Affairs (VA) is using algorithms to identify potential veterans at risk.
- Since the VA adopted this technology in 2017, 250 fewer veterans have died by suicide than would have been expected based on the previous rate.

Ravindranath, Mohana. "How the VA uses algorithms to predict suicide," Politico, June 25, 2019.

Reversing the tide of drug misuse

DRUG OVERDOSES

Preliminary data from the CDC indicates that overdose deaths declined 5.1% in 2018, the first drop in the U.S. since 1990.

- Deaths from heroin and prescription painkillers are decreasing.

Finnegan, Joanne. "Decline in opioid prescriptions translates to drop in drug overdose deaths for the first time in decades," FierceHealthcare.com, July 18, 2019.

Opioids and naloxone

HIGH-DOSE OPIOID PRESCRIPTIONS (in millions)

NALOXONE PRESCRIPTIONS INCREASE (in thousands)

Guy, Gery Jr. et al. "Vital Signs: Pharmacy-Based Naloxone Dispensing—United States, 2012–2018," Morbidity and Mortality Weekly Report, 2019 68:679–686.

MISUSE OF PRESCRIPTION PAIN RELIEVERS BY U.S. RESIDENTS 12 OR OLDER (in millions)


"Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health," Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, HHS Publication No. PEP19-5068, 2019.

Aging population

AMERICANS 65 AND OLDER

	No. of people	% of population
2018	52 million	16%
2060	95 million	23%

AMERICANS 65 AND OLDER REQUIRING NURSING HOME CARE (in millions)
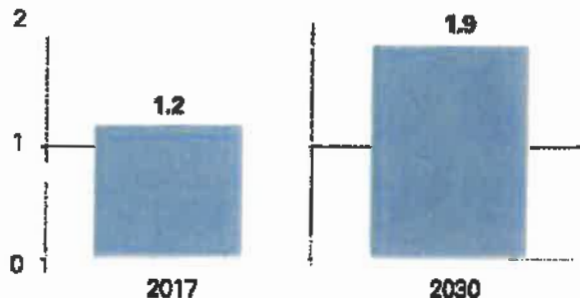
Mather, Mark. et al. "Fact Sheet: Aging in the United States," Population Reference Bureau, July 15, 2019.

LONELINESS

Older adults ages 50 to 80:

Feel a lack of companionship — 34%
Feel isolated from others — 27%

- Chronic loneliness can impact memory, physical well-being, mental health and life expectancy.

Solway, Erica et al. "Loneliness and health," University of Michigan Institute for Healthcare Policy and Innovation's National Poll on Healthy Aging, March 2019.

ALZHEIMER'S DISEASE

- The sixth-leading cause of death in the U.S.
- 5.8 million Americans are living with the disease.
- By 2050, it is projected that 14 million Americans will have the disease.
- Every 65 seconds someone in the U.S. develops the disease.

$290 BILLION In 2019, Alzheimer's and other dementia will cost the nation $290 billion. By 2050, these costs could rise to $1.1 trillion.

"2019 Alzheimer's Disease Facts and Figures Infographic" Alzheimer's Association, alz.org, 2019.

Learn More at **AHA.ORG**

Learn more about the AHA's efforts to create age-friendly health systems aha.org/agefriendly
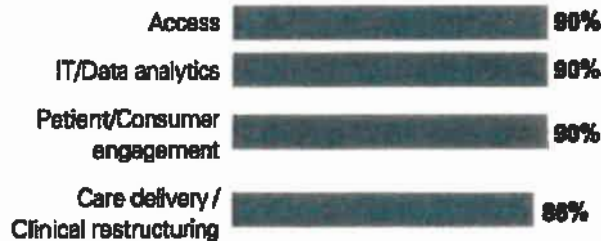
INNOVATION

Seamless care propelled by teams, technology, innovation and data

The health care field is transforming. The digital health evolution, consumerism, clinical advancements, new entrants and unique partnerships are accelerating this transformation. Hospitals and health systems are taking a leadership role in preparing for the future by investing in innovative technologies, practices and cultures with the goals of improving outcomes, addressing affordability and reducing friction for individuals.

Health system innovation

TOP PRIORITIES FOR INNOVATION INITIATIVES AND INVESTMENTS

Priority	
Access	90%
IT/Data analytics	90%
Patient/Consumer engagement	90%
Care delivery / Clinical restructuring	88%

Innovation infrastructure

86% of health systems have one or more executives responsible for innovation strategy and oversight.

HEALTH SYSTEMS THAT HAVE A DEFINED DEPARTMENT DEDICATED TO INNOVATION
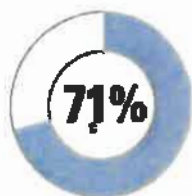
**71%**
Large health systems
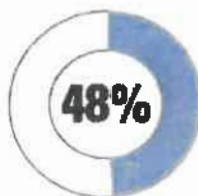
48%
All health systems

Forces driving health system innovation

- Prioritizing consumerism.
- Disruption from new entrants.
- Improving quality of care.
- Increasing value-based contracting.
- Decreasing operating margins.

INNOVATION INVESTMENT

14% of health systems have a formal investment or ventures arm.

MOST COMMON HEALTH SYSTEM INNOVATION PARTNERSHIPS

Partner	
Technology companies	67%
Academic institutions	52%
Pharmaceutical companies	48%
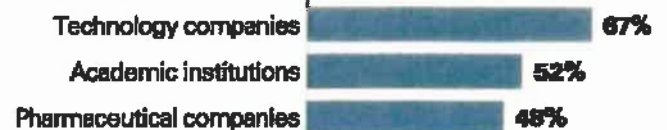
### SPEED OF IMPLEMENTING AND SCALING INNOVATION

- 38% of health systems report the ability to scale quickly.
- 88% of health systems with a formal process for scaling innovation report the ability to scale quickly.

"Trends for Scaling Innovation in Health Care," Center for Connected Medicine and the Health Management Academy, June 2019.

Health IT

Based on a survey of health care IT leaders

TOP HEALTH CARE IT SECTORS TO EXPERIENCE GROWTH IN THE NEXT YEAR

Analytics and big data	94%
Telemedicine	83%
Wearables/Consumer sensors	88%
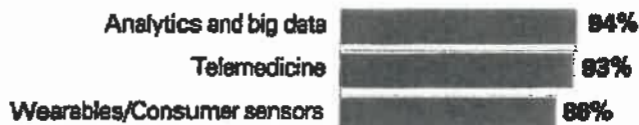
TOP CHALLENGES TO HEALTH CARE IT INNOVATION IN THE NEXT YEAR

Talent/Hiring	72%
Economic uncertainty	64%
Competition	54%

Roberts, Bryan. "2019 Healthcare Prognosis." Venrock. April 12, 2019.

Digital Health Forecast

Health care IT leaders predict that digital health innovators will work to demonstrate real-world applications.

Examples:

- Broader adoption of AI and machine learning in population health to improve identification of those at risk and delivery of personalized services.
- Virtual reality/augmented reality as a routine treatment for pain control.
- Wearables and implantable health devices to enable detection of chronic conditions and monitor treatments.
- Broader use of voice recognition and intelligent assistants to reduce clinician burden.
- Increased use and impact of digital therapeutics.

"2019 Healthcare Trends Forecast: The Beginning of a Consumer-Driven Reformation." Healthcare Information and Management Systems Society (HIMSS), 2019.
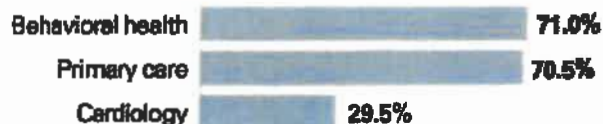
HEALTH TECH AND DIGITAL HEALTH INVESTMENTS (In billions)

	2010	2018	
	$10.8	$30.8	+186%

Singhal, Shubham and Carlton, Stephanie. "The era of exponential improvement in healthcare?" McKinsey & Company, May 2019.

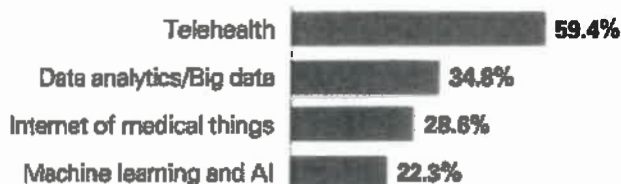*Based on a survey of health care leaders*

SERVICE LINES MOST RIPE FOR DISRUPTION FROM TECHNOLOGY

Behavioral health	71.0%
Primary care	70.5%
Cardiology	29.5%

TECHNOLOGY THAT WILL HAVE THE BIGGEST IMPACT ON HEALTH CARE IN 2020

Telehealth	59.4%
Data analytics/Big data	34.8%
Internet of medical things	28.6%
Machine learning and AI	22.3%

Survey to Health Care Leaders and Strategists, AHA Society for Health Care Strategy & Market Development, June 2019.

ORGANIZATIONS POSING STRONG COMPETITION TO HOSPITALS AND HEALTH SYSTEMS
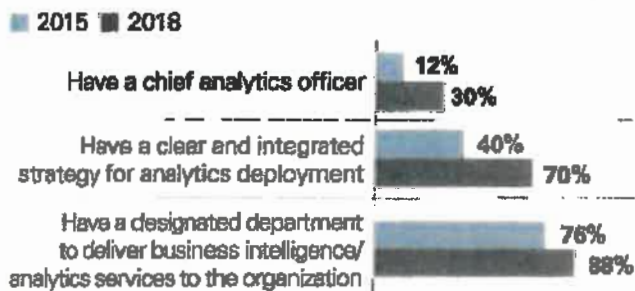
UNITEDHEALTH GROUP
OPTUM — 67%

CVS Health.
aetna — 66%

amazon — 56%

39%

Google — 38%

Apple
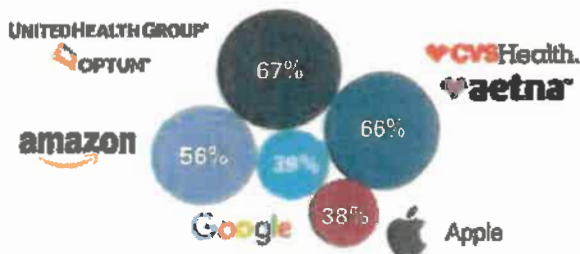
Crnkovich, Paul et al. "2019 State of Consumerism in Healthcare: The Bar is Rising." Kaufman Hall, 2019.

Health analytics

- Health systems with a higher number of value-based care arrangements are more likely to have a mature approach to analytics.

HEALTH SYSTEMS' INVESTMENT IN ANALYTICS

■ 2015 ■ 2018

	2015	2018
Have a chief analytics officer	12%	30%
Have a clear and integrated strategy for analytics deployment	40%	70%
Have a designated department to deliver business intelligence/analytics services to the organization	76%	88%

Hagen, Allison et al. "Shifting into high gear: Health systems have a growing strategic focus on analytics today for the future." Deloitte Insights, Deloitte Center for Health Solutions, 2018. © 2018 Deloitte Development LLC.

Artificial Intelligence (AI)

HEALTH AI MARKET SIZE
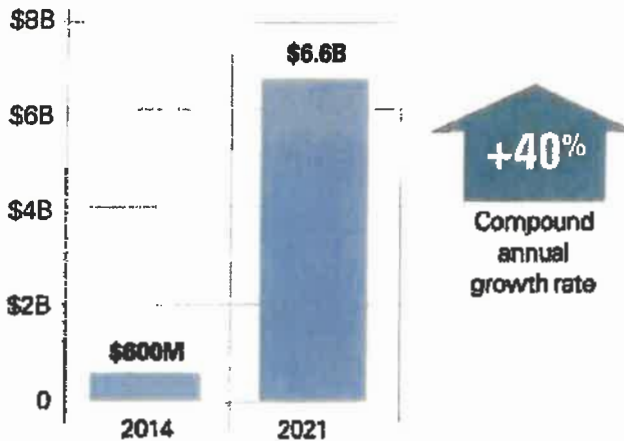
+40%
Compound annual growth rate

Collier, Matt, Fu, Richard and Yin, Lucy. "Artificial Intelligence: Healthcare's New Nervous System," Accenture, June 2017.

10 AI applications with the greatest near-term impact in health care

- Robot-assisted surgery
- Virtual nursing assistants
- Administrative workflow assistance
- Fraud detection
- Dosage error reduction
- Connected machines
- Clinical trial participant identifier
- Preliminary diagnosis
- Automated image diagnosis
- Cybersecurity

$150 BILLION
possible resulting savings by 2026

Collier, Matt, Fu, Richard and Yin, Lucy. "Artificial Intelligence: Healthcare's New Nervous System," Accenture, June 2017

Personal genetic data

- By the start of 2019, more than 26 million consumers added their DNA to four leading commercial ancestry and health databases.
- As many people purchased consumer DNA tests in 2018 as in all previous years combined.
- If the pace continues, these companies could have the genetic makeup of more than 100 million people by the start of 2021.

Regalado, Antonio. "More than 26 million people have taken an at-home ancestry test," MIT Technology Review, Feb. 11, 2019.

Internet of Things (IoT)

AVERAGE NUMBER OF INTERNET-CONNECTED DEVICES PER PERSON IN THE U.S.

Cisco "Complete Visual Networking Index (VNI) Forecast, 2017-2022."

Opportunities and challenges of IoT

Opportunities:

Telehealth and remote monitoring, smart sensors, medical device integration, health care building facilities that optimize clinical processes and operational systems, voice assistants, robotics, smart pills and treatments of diseases.[t]
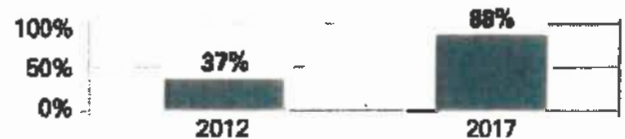
Challenges:

Data storage capability, cyberrisk, the need to update hospital infrastructure and human error.[t]

[t] "IoT in Healthcare: Are We Witnessing a New Revolution?" Scifocca, Medium.com, Mar. 7, 2018.
[t] Matthews, Kayla "5 Challenges Facing Health Care IoT in 2019," iotforall.com, Dec. 27, 2018.

Interoperability

PERCENTAGE OF HOSPITALS THAT SEND RECORDS TO AMBULATORY CARE PROVIDERS OUTSIDE THEIR SYSTEMS

BARRIERS TO INTEROPERABILITY

Other providers do not have an EHR or lack capability to receive information	63%
Experience challenges sending/receiving data across different vendor platforms	67%
Difficult to match or identify the correct patient between systems	37%
Additional costs to send/receive data with organizations outside system	35%
Had to develop customized interfaces to exchange information electronically	28%

"Sharing Data, Saving Lives: The Hospital Agenda for Interoperability," American Hospital Association, January 2019.

Learn More at AHA.ORG

Learn more about the AHA Center for Health Innovation aha.org/center

AFFORDABILITY AND VALUE

The best care that adds value to lives

Affordable health care is one of the biggest concerns facing families, employers and government. Health care transformation and value-based care models focusing on populations can improve the quality of care at a lower cost.

COST TO STAKEHOLDERS

U.S. national health expenditures

Year	% growth	Amount	% of GDP
2017	3.9%	$3.5 trillion	17.9%
2018*	4.4%	$3.6 trillion	17.8%
2019*	4.8%	$3.8 trillion	17.8%
2020-2027*	5.7% average	$6.0 trillion by 2027	19.4% by 2027

*Projection

National Health Expenditures Projections 2018-2027 — Tables, Office of the Actuaries Actuary, CMS, cms.gov, Feb. 20, 2019.

Financial impact for hospitals

HOSPITALS' COST TO PROVIDE UNCOMPENSATED CARE (in billions)

$50B
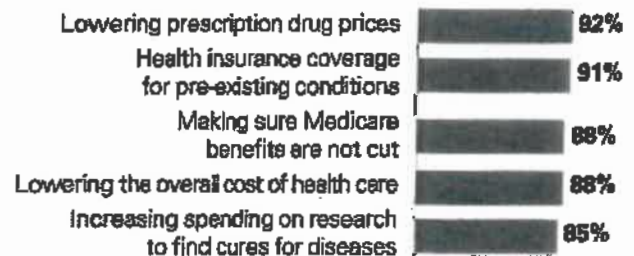$38.4 ——— $41.3
$25B
0
2017   2018*

AHA Annual Survey of Hospitals data, American Hospital Association, 2018 and 2019.
* 2018 data is preliminary.

$76.6
BILLION
Combined Medicare and Medicaid underpayments to hospitals in 2018*

Patient perspective

69%
Reducing health care costs should be a top national priority.

TOP HEALTH CARE PRIORITIES

Lowering prescription drug prices	92%
Health insurance coverage for pre-existing conditions	91%
Making sure Medicare benefits are not cut	88%
Lowering the overall cost of health care	88%
Increasing spending on research to find cures for diseases	85%

Blendon, Robert J. et al. "The Upcoming U.S. Health Care Cost Debate — The Public's Views," *New England Journal of Medicine*, vol. 380 no. 26 (2019): 2487-2492.

OUT-OF-POCKET COSTS

- Out-of-pocket costs increased by 12% for inpatient, outpatient and ED care from 2017 to 2018*

- Medical fundraisers account for 1 in 3 campaigns for the crowdsourcing website GoFundMe.†

* "Out-of-Pocket Costs Rising Even as Patients Transition to Lower Cost Settings of Care," TransUnion Healthcare, June 25, 2018.
† Zdechlik, Mark. "Patients Are Turning To GoFundMe To Fill Health Insurance Gaps," National Public Radio, npr.org, Dec. 27, 2018.

Employer-sponsored plans

INDIVIDUALS ENROLLED IN EMPLOYER-SPONSORED PLANS

- Half of Americans say they or an immediate family member have put off going to the doctor, not filled a prescription or delayed other medical care because of cost.*
- Four in 10 had difficulty paying a medical bill or insurance premium within the past year.†
- Four in 10 enrolled in a high-deductible plan do not have enough savings to cover the deductible.†
- One in 5 say health care costs have used up all or most of their savings.†

* Martin, Rachel. "Employees Start To Feel The Squeeze Of High-Deductible Health Plans," National Public Radio, npr.org, May 3, 2019.
† Levey, Noam N. "Health insurance deductibles soar, leaving Americans with unaffordable bills," Los Angeles Times, May 2, 2019.

TRENDS AMONG CONSUMERS WITH EMPLOYER-SPONSORED INSURANCE FROM 2012 TO 2016

Visits to primary care physicians -18%

Visits to nurse practitioners and physician assistants 129%

Frost, Amanda and Hargraves, John. "HCCI Brief: Trends in Primary Care Visits," Health Care Cost Institute, October 2018.

Medical cost trend

THE MEDICAL COSTS IN THE EMPLOYER INSURANCE MARKET PROJECTED TO INCREASE

	2018	2019	2020
6%	5.7%	5.7%	6.0%
5%			

Drivers of medical cost trend

Retail drugs

Between 2020 and 2027, retail drug spending under private health insurance is projected to increase 3-6% a year.

Chronic disease

Adults with one chronic disease 60%

Adults with two or more 40%

- For employers, per capita spending on an individual with a complex chronic disease is 8 times that of a healthy individual.

"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Mental health services

PERCENTAGE OF EMPLOYERS OFFERING MENTAL HEALTH DISEASE-MANAGEMENT PROGRAMS

	2016	2017	2018
80% / 40% / 0%	44%	66%	75%
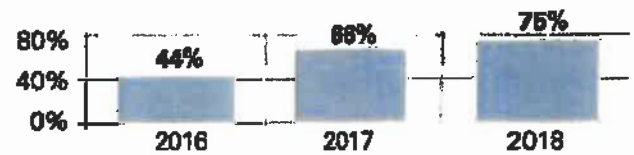
- Costs will go up in the short term. In the long term, addressing mental health is a significant deflator of medical cost trend.

"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Employees bear the cost

- Average deductibles for employer-sponsored plans tripled between 2008 and 2018.*
- Average annual rate of cost sharing outpaced growth in wages from 2006 to 2016.*

Cost-sharing 4.5%
Annual median wages 1.8%

- 84% of employers offered a High-Deductible Health Plan (HDHP) in 2019.*
- Enrollment in HDHPs reached 47% of the commercially insured, pre-Medicare population in 2018, representing a 3.3% increase from 2017.†

* "Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.
† Daly, Rich. "High-Deductible Plans Surge: CDC," Healthcare Financial Management Association, Aug. 28, 2018.

Prescription drugs

PRICES FOR MORE THAN 3,400 DRUGS INCREASED IN THE FIRST SIX MONTHS OF 2019

- An increase of 17% in the number of drug price increases.
- Average increase is 10.5% — five times the rate of inflation.

Picchi, Aimee. "Drug prices in 2019 are surging, with hikes at 5 times inflation," CBS News, cbsnews.com, July 1, 2019.

HOSPITAL PRESCRIPTION DRUG SPENDING

- Average total drug spending per hospital admission increased by 18.5% from 2015 to 2017.

"Recent Trends in Hospital Drug Spending and Manufacturer Shortages," NORC at the University of Chicago, Jan. 15, 2019.

MEDICARE AND MEDICAID DRUG SPENDING

From 2013 to 2017, prescription drug spending grew at an annual rate of 10.6% in Medicare Part D, 10.0% in Part B and 14.8% in Medicaid.

"CMS Updates Drug Dashboards with Prescription Drug Pricing and Spending Data," cms.gov, March 14, 2019.

PRESCRIPTION SPECIALTY DRUG COSTS IN 2017

$78,781
The average annual cost of prescription specialty drugs

vs.

$60,336
The median U.S. household income

7.0%
Increase in cost vs. 2016

vs.

2.1%
General rate of inflation

Schondelmeyer, Stephen W. and Purvis, Leigh. "Trends in Retail Prices of Specialty Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update," AARP Public Policy Institute, June 2018.

Drug shortages

- Cost hospitals $359 million a year in additional labor costs.
- More than half of hospitals reported they had managed at least 20 shortages during a six-month period.

Vizient, Inc. Survey, "Drug shortages and labor costs, Measuring the hidden costs of drug shortages on U.S. hospitals," Vizient, Inc., June 2019.

Learn More at **AHA.ORG**

Learn more about AHA's The Value Initiative at aha.org/value-initiative

Advanced illness and palliative care

- Advanced illness accounts for 4% of the Medicare population and 25% of its costs.[*]
- 12 million U.S. adults and 400,000 children are living with serious illness.[†]
- 72% of hospitals with 50+ beds have a palliative care program.[†]

PALLIATIVE CARE IMPACT

$3.5 BILLION
per year savings if hospitals nationwide implement high-quality palliative programs

66%
reduction in symptom distress reported by palliative care patients

[*] Stuart, Brad et al. "A Large-Scale Advanced Illness Intervention Informs Medicare's New Serious Illness Payment Model," Health Affairs, vol. 38, no. 6 (2019): 950-956.
[†] "Changing how we think about palliative care," American Hospital Association, aha.org/palcare. Accessed Aug. 9, 2019.
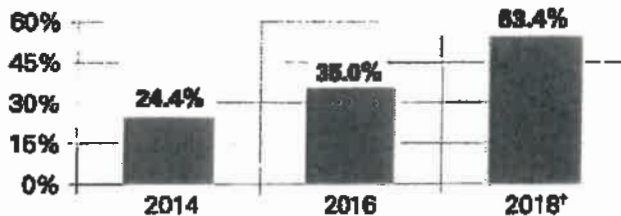

Learn More at **AHA.ORG**

Learn more about the AHA partnership with the Center to Advance Palliative Care aha.org/palcare

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CARE MODELS

Trends in delivery models

HOSPITALS PARTICIPATING IN AN ACCOUNTABLE CARE ORGANIZATION (ACO)[*]

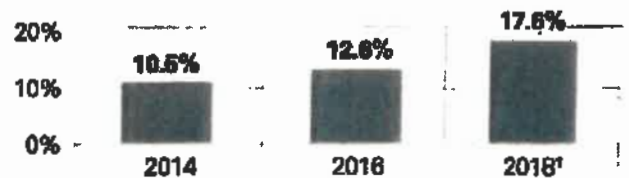|	2014	2016	2018[†]
	24.4%	35.0%	53.4%

NOTE: 2018 survey question is not directly comparable to prior years.

HOSPITALS WITH CONTRACTS WITH COMMERCIAL PAYERS TIED TO QUALITY/SAFETY PERFORMANCE[*]

	2014	2016	2018[†]
	40.7%	48.7%	56.0%
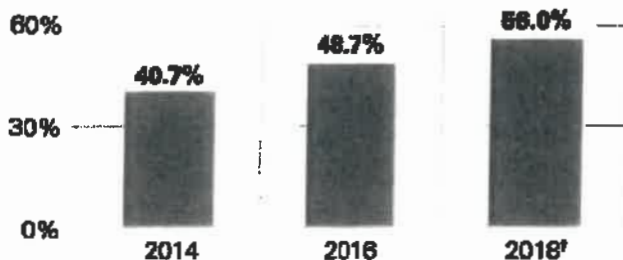
HOSPITALS WITH SOME PERCENTAGE OF NET PATIENT REVENUE PAID ON A SHARED RISK BASIS[*]

	2014	2016	2018[†]
	10.5%	12.6%	17.6%

HEALTH CARE LEADERS THINK VALUE-BASED RELATIONSHIPS THAT CONTAIN BOTH UPSIDE AND DOWNSIDE RISK WILL OCCUR[‡]

	Less than 1 year	9.7%
	1-2 years	26.7%
	3-5 years	39.8%
	5 or more years	17.5%
	Never	6.3%

- Obstacles to shared-risk, value-based contracts: limitations in data sharing, no agreement on outcomes measures and a lack of incentives for payers and providers to work together

[*] AHA Annual Survey of Hospitals data, American Hospital Association 2015-2018.
[†] 2018 data is preliminary.
[‡] "White Paper: The 9th Annual Industry Pulse Survey," Change Healthcare and the HealthCare Executive Group, March 18, 2019.

ACOs

ACOs BY THE NUMBERS

- The number of ACOs has multiplied 5 times since 2012.
- At the end of the first quarter of 2018, there were more than 1,000 ACOs across the U.S., covering 33 million lives and representing almost 1,500 commercial and public payment arrangements.
- 33% of ACOs had at least one contract with downside risk.

IN 2018, ACOs CONTRACTED WITH:

Medicare	84%
Commercial payers	72%
Medicaid	23%
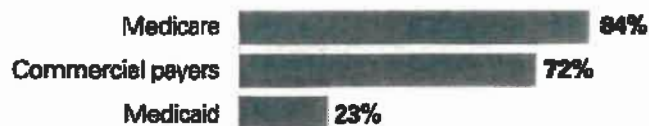
Pifer, Rebecca. "ACOs may need stronger financial incentives, like downside risk, to succeed." *Healthcare Dive*, July 3, 2019.

$740 MILLION

Net savings generated by Medicare ACOs in 2018.

Verma, Seema. "Interest in 'Pathways To Success Grows: 2018 ACO Results Show Trends Supporting Program Redesign Continue," *HealthAffairs* blog, Sept. 30, 2019.

Top ACO priorities

TOP 5 PRIORITIES OF INTEGRATED SYSTEM/ HOSPITAL-LED ACOs

Reduce avoidable emergency department visits and inpatient admissions	57%
Manage post-acute care spending and quality	50%
Prevent readmissions through better care transitions	42%
Actively manage high-need, high-cost patients	37%
Reduce avoidable/unnecessary care	29%

TOP 5 CHALLENGES OF INTEGRATED SYSTEM/ HOSPITAL-LED ACOs

Difficulty aligning physician compensation with value-based contracts	63%
Ability to design and implement care delivery changes	57%
Quality of data provided by payers	36%
Lack of data analytic capability and tools	33%
Prospect of/participation in mandatory downside risk	22%

Edwards, Keratin, et al. "The 2018 ACO Survey: Unique Paths to Success," Leavitt Partners, March 2019.

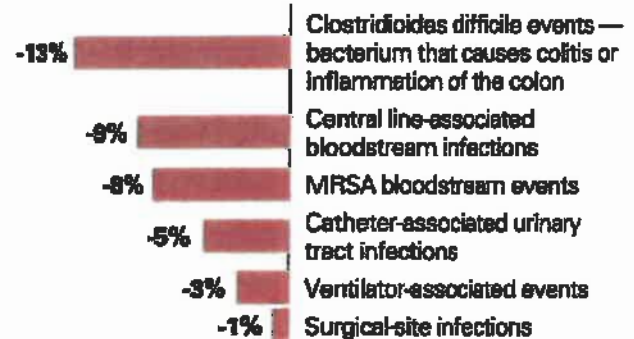# VALUE AND PERFORMANCE IMPROVEMENT

Performance improvement practices yield positive outcomes

HOSPITAL-ACQUIRED CONDITIONS: PROGRESS BETWEEN 2014 AND 2017

- 13% decrease in conditions
- 20,500 lives saved
- $7.7 billion saved in health care costs

"AHRQ National Scorecard on Hospital-Acquired Conditions," Agency for Healthcare Research and Quality, Rockville, Md. https://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html, January 2019.

PERCENTAGE DECREASE IN HOSPITAL-ACQUIRED INFECTIONS BETWEEN 2016 AND 2017 IN ACUTE CARE HOSPITALS

-13%	Clostridioides difficile events — bacterium that causes colitis or inflammation of the colon
-9%	Central line-associated bloodstream infections
-8%	MRSA bloodstream events
-5%	Catheter-associated urinary tract infections
-3%	Ventilator-associated events
-1%	Surgical-site infections

"2017 National and State Healthcare-Associated Infections Progress Report," Centers for Disease Control and Prevention, cdc.gov. Accessed July 29, 2019.

Top 5 patient safety concerns

- Diagnostic stewardship and test result management using EHRs
- Antimicrobial stewardship in physician practices and aging services
- Burnout and its impact on patient safety
- Patient safety concerns involving mobile health
- Reducing discomfort with behavioral health

"2019 Top 10 Patient Safety Concerns — Executive Brief," ECRI Institute, https://www.ecri.org/landing-top-10-patient-safety-concerns-2019. Accessed March 12, 2019.

Learn More at AHA.ORG

Learn more about how the AHA accelerates performance improvement and advances patient safety aha.org/center/performance-improvement
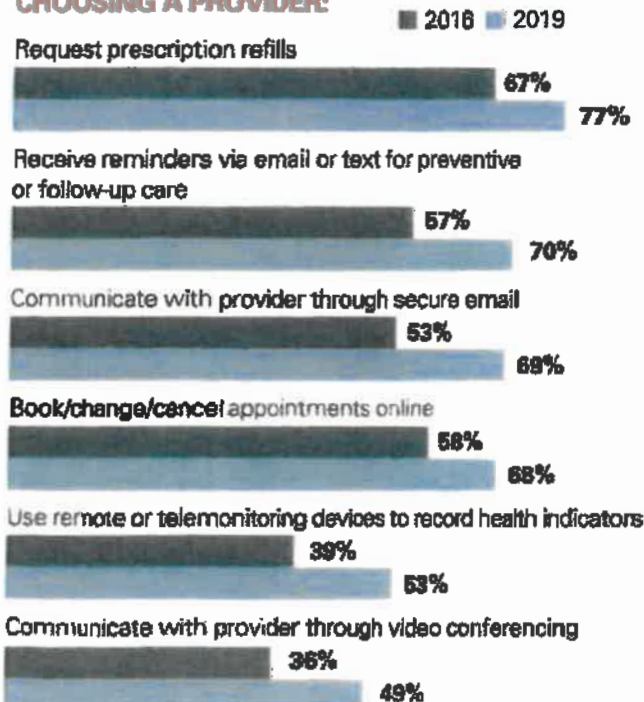
INDIVIDUAL AS PARTNER

Recognize the diversity of individuals and serve as partners in their health

Health care providers are fostering true patient engagement, recognizing that individuals are increasingly viewing health care through a consumer lens and connecting in ways that make sense in today's digital world.
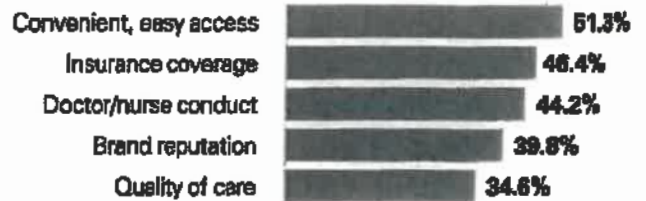
The consumer perspective

THE FOLLOWING ELECTRONIC CAPABILITIES INCREASE THE LIKELIHOOD OF AN INDIVIDUAL CHOOSING A PROVIDER:

■ 2016 ■ 2019

Request prescription refills
67%
77%

Receive reminders via email or text for preventive or follow-up care
57%
70%

Communicate with provider through secure email
53%
69%

Book/change/cancel appointments online
58%
68%

Use remote or telemonitoring devices to record health indicators
39%
53%

Communicate with provider through video conferencing
36%
49%

Safavi, Kaveh and Kalis, Brian. "Today's Consumers Reveal the Future of Healthcare: The Accenture 2019 Digital Health Consumer Survey." Accenture, Feb. 12, 2019.

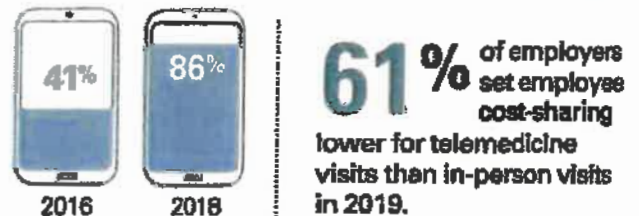## MOST IMPORTANT HEALTH CARE FACTORS INFLUENCING CONSUMERS' DECISION-MAKING

Convenient, easy access — 51.3%
Insurance coverage — 46.4%
Doctor/nurse conduct — 44.2%
Brand reputation — 39.8%
Quality of care — 34.6%

"2019 Healthcare Consumer Trends Report." NRC Health, Jan. 6, 2019.

Virtual care

Interest in virtual care is higher among consumers with more complex needs.*

EMPLOYERS OFFERING TELEHEALTH SERVICES[†]

41% — 2016
86% — 2018

61% of employers set employee cost-sharing lower for telemedicine visits than in-person visits in 2019.

### CONSUMERS WITH EMPLOYER COVERAGE ARE WILLING TO USE TELEHEALTH FOR:[†]

Ongoing assessment of a physical condition or ailment	62%
Initial assessment of a physical condition or ailment	43%
Mental/behavioral health services	27%
Emergency situations, such as urgent care	25%

* Safavi, Kaveh and Kalis, Brian. "Today's Consumers Reveal the Future of Healthcare: The Accenture 2019 Digital Health Consumer Survey." Accenture, Feb. 12, 2019.
† "Medical cost trend: Behind the numbers 2020." PWC Health Research Institute, June 2019.
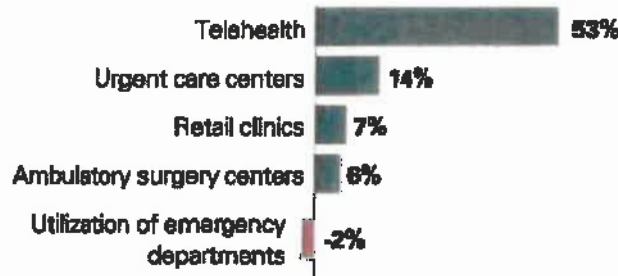
Online Access

PERCENTAGE OF HOSPITALS THAT PROVIDE PATIENTS WITH THE ABILITY TO VIEW HEALTH INFORMATION ONLINE

27% — 2012
92% — 2018
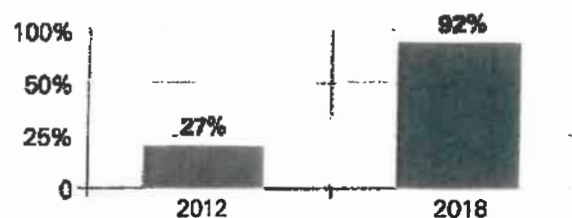
AHA Annual Survey Information Technology Supplement, American Hospital Association, 2018.

Alternative places of health care services: Consumer trends

UTILIZATION GROWTH RATES FROM 2016 TO 2017 ACCORDING TO PRIVATELY INSURED HEALTH CARE CLAIMS DATA

Telehealth	53%
Urgent care centers	14%
Retail clinics	7%
Ambulatory surgery centers	6%
Utilization of emergency departments	-2%

"FH Healthcare Indicators® and FH Medical Price Index® 2018: An Annual View of Place of Service Trends and Medical Pricing." White Paper, FAIR Health®, Inc., April 2018.

Who has a primary care physician?

92%	82%	73%	57%
Silent generation	Baby boomers	Gen Xers	Millennials
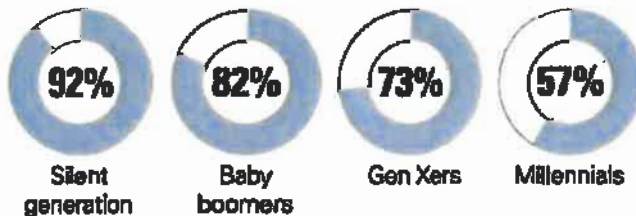
MacCracken, Linda and Meklaus, Gerry. "Digital Health: When Primary Care is not Always Primary," Accenture, Sept. 19, 2018.

LGBTQ disparities

- 16% of people who identify as lesbian, gay, bisexual, trans, queer/questioning (LGBTQ) report being personally discriminated against when going to a doctor or health clinic because they are part of the LGBTQ community.*

- 18% of people who identify as LGBTQ say they have avoided medical care, even when in need, citing fear of discrimination.*

- High school students who identify as LGB are almost 5 times as likely to attempt suicide compared with their heterosexual peers.†

- Adults ages 50 to 95 who identify as LGBT reported greater rates of disability, depression and loneliness and increased likeliness to smoke and binge-drink compared with heterosexuals of similar ages.‡

* "Discrimination in America: Experiences and View of LGBTQ Americans," National Public Radio, Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health, November 2017.
† LGBTQ, National Alliance on Mental Health, www.nami.org/find-support/lgbtq, Accessed Sept. 12, 2018.
‡ Seegert, Liz. "National study finds LGBT seniors face tougher old age," Association of Health Care Journalists, July 18, 2018.

Learn More at **AHA.ORG**

Learn more is on the AHA's Institute for Diversity and Health Equity diversityconnection.org

IMPACT AND LANDSCAPE OF HOSPITALS AND HEALTH SYSTEMS

Hospitals and health systems serve patients and communities as critical access points of health care services across the country.

Health care and the economy

11% of all jobs in the overall U.S. economy at the end of 2018 were in the health care sector.*

1 in 7 new jobs in the overall U.S. economy at the end of 2018 were in the health care sector.*

2.8 MILLION Number of jobs added to the health care sector between 2006 and 2016, a rate of growth almost 7 times faster than the rest of the economy†

Projections

- Employment of health care occupations is projected to grow 18% from 2016 to 2026, much faster than the average for all occupations, adding about 2.4 million new jobs.†

- Job growth in the home health field is projected to grow 54% from 2016 to 2026.‡

* Commins, John. "Healthcare Job Growth Outpaced Nearly Every Other Sector in 2018," HealthLeaders, Jan. 4, 2019.
† Salsberg, Edward and Martiniano, Robert. "Health Care Jobs Projected To Continue To Grow Far Faster Than Jobs In The General Economy," Health Affairs, May 9, 2018.
‡ "Occupational Outlook Handbook," Department of Labor, Bureau of Labor Statistics. Accessed Aug. 13, 2018.

Hospital prices

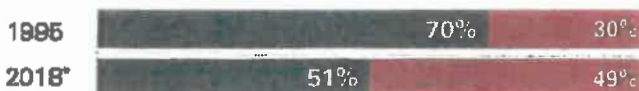## HOSPITAL PRICE GROWTH REMAINS LOW

In August 2019, annual health insurance inflation hit a five-year peak of 18.6%, while hospital prices increased just 2.1%.

Bureau of Labor Statistics Consumer Price Index data, 2019.

Community hospitals

INPATIENT/OUTPATIENT REVENUES FOR COMMUNITY HOSPITALS

■ Inpatient ■ Outpatient

1995	70%	30%
2018*	51%	49%

AHA Annual Survey of Hospitals data, American Hospital Association, 1995–2019.
*2018 data is preliminary.

Cybersecurity

Health care cyber incidents

NUMBER OF U.S. HEALTH CARE DATA BREACHES

	600	503		
300			285	
0		2018	Jan.-June 2019	

NUMBER OF PATIENT RECORDS AFFECTED (in millions)

40M			31.6
20M	14.2		
0	2018		Jan.-June 2019

FROM JANUARY THROUGH JUNE 2019:

- External hacking was responsible for 88% of breached records.
- 72% of incidents occurred in the provider setting.
- Incidents involving business associates/third parties affected 74% of total patient records.

"Protenus 2019 Mid-Year Breach Barometer, Breached Patient Records in First Half of 2019 Double the Total for All of 2018." Protenus, Inc. in collaboration with DataBreaches.net, July 2019.

Learn More at
AHA.ORG
Learn more about AHA cybersecurity and more resources and services. aha.org/cybersecurity

The rural landscape

Rural hospitals at risk

- According to a study of hospital closure impacts, rural closures were associated with a 5.9% increase in inpatient mortality.*

AS OF SEPTEMBER 2019[†]

- 118 rural hospitals have closed since January 2010.
- 17 hospitals closed in 2019 alone, outpacing previous years.

* Gujral, Kritee, et al. "Impact of Rural and Urban Hospital Closures on Inpatient Mortality," Working Paper Series, National Bureau of Economic Research, July 22, 2019.
† The Cecil G. Sheps Center for Health Services Research, University of North Carolina, shepscenter.unc.edu. Accessed Oct. 10, 2019.

Rural health care workforce shortages

- While almost 20% of the U.S. population lives in rural areas, less than 10% of physicians practice in these communities.*

66% of primary care physician shortages in the U.S. in 2018 were located in rural or partially rural areas.[†]

62% of mental health professional shortages in the U.S. in 2018 were located in rural or partially rural areas.[†]

-23% Decrease in the supply of physicians in rural areas by 2030 while remaining steady in urban areas[†]

- In 2017, more than 50% of rural physicians were at least 50 years old and more than 25% were at least 60 years old.[†]
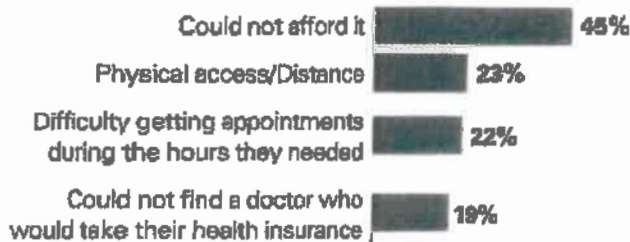
* Joynt E. Karen, et al. "Rural Hospital Participation and Performance in Value-Based Purchasing and Other Delivery System Reform Initiatives," ASPE Office of Health Policy, October 19, 2016.
† Skinner, Lucy, et al., "Implications of an Aging Rural Physician Workforce," New England Journal of Medicine, 2019; 381:299-301.

Health care access in rural America

- 42% of rural adults without health insurance reported they did not get care when they needed it, while 24% of those with health insurance did not get care when they needed it.

REASONS FOR NOT GETTING CARE

Could not afford it	45%
Physical access/Distance	23%
Difficulty getting appointments during the hours they needed	22%
Could not find a doctor who would take their health insurance	19%

"Life in Rural America, Part II," National Public Radio, Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health, May 1, 2019.

Learn More at
AHA.ORG
Learn more about AHA rural health resources aha.org/rural

AHA Agenda for Innovation and Transformation

The AHA continually examines the environment to develop strategies that both address the issues of today and proactively prepare our field for the future. The AHA's Agenda for Innovation and Transformation advances the areas of public policy, field engagement and innovation to enhance our support, value and leadership for members. Maryjane Wurth is responsible for AHA's overall strategic direction and is the lead executive for the AHA Center for Health Innovation.

Q&A

QUESTION: Hospitals and health systems are investing in innovation to address access, affordability and outcomes. What role does the AHA play in assisting and encouraging innovative culture, processes and solutions throughout the hospital field?

WURTH: Over a year ago, we launched the AHA Center for Health Innovation to help members drive high-impact innovation and transformation within their organizations and communities. The Center provides market intelligence, key insights, targeted education and actionable data and tools that support the unique situations of our members. One goal is to help hospitals and health systems build innovation capacity within their institutions.

Additionally, the AHA is uniquely positioned to provide a national perspective on forward-looking ideas and solutions, helping members learn from each other as well as traditional and nontraditional stakeholders. Examples include the AHA's work with more than 1,600 hospitals in the Hospital Improvement Innovation Network, efforts to address affordability through The Value Initiative, creation of a data collaborative with state hospital associations, exploration of new delivery models and development of resources to support population health management.

We're taking the work of spreading ideas and best practices to the next level. We are developing a process to scale transformation throughout the field through the Center's new virtual entity called the Design Studio, created in partnership with members, that focuses on advancing the next-generation health care system.

MARYJANE WURTH

Executive Vice President and Chief Operating Officer of the American Hospital Association

QUESTION: Can you tell us more about the AHA Design Studio? How is it different from hospital and health system innovation centers?

WURTH: The purpose of the Design Studio is to accelerate and lead transformation, addressing complex challenges in the field with unique member collaborations. The Design Studio will not duplicate what hospitals and systems are doing in their labs. The goal is to harness hospitals' and health systems' collaborative energy to discover novel solutions that would be much more challenging, or perhaps impossible, to develop alone.

The work in the Design Studio is based on a human-centered design approach. As the virtual studio 'rooms' progress, the design teams may take different paths and employ unique approaches. The Design Studio will emphasize issues that matter to our members and will rely on their input, engagement and enthusiasm. Our initial areas of focus, supported by the AHA's Board of Trustees, are behavioral health, EHR data usability and risk approaches.

A key outcome of the Design Studio will be the spread of curated learnings to all members throughout the design process. Other outcomes could include transformational partnerships, products, resources or tools or other outcomes we have yet to imagine. Our journey may take surprising turns. All together, the Design Studio ideas, solutions and results will drive value to address affordability and better health for patients, families and communities.

III. External Assessment
B. J.P. Morgan's Top 10 Questions Every CEO Must Answer

The top 10 questions from the 2020 J.P. Morgan Healthcare Conference that every CEO must answer

Dan Michelson, CEO, Strata Decision Technology - Thursday, January 16th,

As we enter a new decade, everyone is searching for something to truly change the game in healthcare over the next 10 years. To find that answer, an estimated 50,000 people headed to San Francisco this week for the prestigious J.P. Morgan Healthcare Conference. Every one of them is placing big bets on who will win and lose in the future of healthcare. The shortcut to figuring this out is actually a question — or 10 questions to be more precise. And what matters most is whether or not the right people are asking and answering those questions.

While the prophets are ever present and ever ready to pitch their promises in every corner of the city, the pragmatists head up to the 32nd floor of the Westin St. Francis Hotel to hear from the CEOs and CFOs of close to 30 of the largest and most prestigious providers of care in the country. Why? Remember, this is an investor conference and if you want to understand any market, the first rule is to follow the money. And if you want to understand the future business model of healthcare, you better listen closely to the health providers in that room and take notes.

What providers are saying matters to everyone in healthcare

Healthcare is the largest industry in our economy with over $4 trillion spent per year. Healthcare delivery systems and healthcare providers account for over $2 trillion of that spend, so that feels like a pretty good place to start, right? For that reason alone, it's critical to listen closely to the executives in those organizations, as their decisions will affect the quality, access and cost of care more than any other stakeholder in healthcare.

Some will say that what they saw this year from healthcare providers was more of the same, but I encourage you to ignore that cynicism and look more closely. As the futurist William Gibson once said, "The future is already here — it's just not evenly distributed." The potential for any health system to drive major change is certainly there and the examples are everywhere. The biggest blocker is whether they are asking the right questions. One question can change everything. Here's proof.

The stunning power of and need for good questions

Last year I titled my summary *"The #1 Takeaway from the 2019 JP Morgan Conference - It's the Platform, Stupid."* The overwhelming response to the article was pretty surprising to me — it really resonated with leaders. One example was Jeff Bolton, the chief administrative officer of Mayo Clinic, who told me that the article had inspired their team to ask a single question, "Does

Mayo need to be a platform?" They answered the question "yes" and then took aggressive action to activate a strategy around it. Keep reading to learn about what they set in motion.

Soon after, I had a discussion with John Starcher, CEO of Cincinnati-based Bon Secours Mercy Health, one of the largest health systems in the country, who shared with me that he is taking his team off site for a few days to think about their future. It occurred to me that the most helpful thing for his team wouldn't be a laundry list of ideas from the other 30 healthcare delivery systems that presented, but rather the questions that they asked at the board and executive level that drove their strategy. Any of those questions would have the potential to change the game for John's team or any executive team. After all, if you're going to change anything, the first thing you need to do is change is your mind.

The wisdom of the crowd

So, I set out to figure this out: If you were having a leadership or board retreat, what are the 10 questions you should be asking and answering that may change the future of your organization over the next 10 years? I didn't have the answers, so I decided to tap into the wisdom of the crowd, listening to all 30 of the nonprofit provider presentations, spending additional time with a number of the presenters and reaching out to dozens of experts in the market to help define and refine a set of 10 questions that could spark the conversation that fires up an executive team to develop to the right strategy for their organization.

A special thank you to a number of the most respected leaders in healthcare who took their time to contribute to and help think through these questions:

- Mike Allen, CFO of OSF Healthcare (Peoria, Ill.)
- Jeff Bolton, CAO of Mayo Clinic (Rochester, Minn.)
- Robin Damschroder, CFO of Henry Ford Health System (Detroit)
- JP Gallagher, CEO of NorthShore University HealthSystem (Evanston, Ill.)
- Kris Zimmer, CFO of SSM Health (St. Louis)
- Wright Lassiter, CEO of Henry Ford Health System (Detroit)
- Mary Lou Mastro, CEO of Edwards-Elmhurst Health (Warrenville, Ill.)

Here are the top 10 questions from the 2020 J.P. Morgan Healthcare Conference

Based on the wisdom of the crowd including the 30 nonprofit provider presentations at the 2020 JP Morgan Healthcare Conference, here are the Top 10 Questions that every CEO needs to answer that may make or break their next 10 years.

1. Business model: Will we think differently and truly leverage our "platform?" As referenced earlier in this article, this was the major theme from last year — health systems leveraging their current assets to build high-value offerings and new revenue streams on top of the infrastructure they have in place. Providers are pivoting from the traditional strategy of buying and building hospitals and simply providing care toward a new and more dynamic strategy that focuses on leveraging the platform they have in place to create more value and growth. **Mayo Clinic** is an organization that all health systems follow closely. Mayo adopted the platform model around their 'digital assets' into what they refer to as Mayo Clinic Platform, which initially targets three game-changing initiatives: a Home Hospital to deliver more health in

the home even for high acuity patients, a Clinical Data Analytics Platform for research and development and an Advanced Diagnostics Platform focused on predictive analytics, using algorithms to capture subtle signals before a disease even develops. **Children's Hospital of Philadelphia**, one of the top pediatric hospitals in the world, is leveraging their platform to drive international volume, where revenue is 3.5x more per patient. They are also making investments in cell and gene therapy, where their spinoff of Spark Therapeutics returned hundreds of millions of dollars back to their organization. Both organizations were clear that any returns that they generate will be re-invested back into raising the bar on both access to care and quality of care.

2. Market share: Are we leveraging a "share of cup" strategy? Starbucks had dominant share in the market against Caribou Coffee, Peet's Coffee and Dunkin' Donuts. Instead of solely focusing on how to grab a little more market share, they reframed the definition of their market. They called it "share of cup" meaning that anywhere and any time a cup of coffee was consumed, they wanted it to be Starbucks. In that definition of the market, they had very little share, but enormous growth potential. **Hospital for Special Surgery** in New York is the largest and highest volume orthopedic shop in the world. Their belief is that wherever and whenever a musculoskeletal issue occurs, they should be part of that conversation. This thinking has led them to build a robust referral network, which 33 percent of the time leads to no surgical treatment. So instead of fighting for share of market in New York, they have a very small share and a very big opportunity in a "share of cup" approach. **NorthShore University Health System** in Illinois has taken a similar approach on a regional level, converting one of their full-service hospitals into the first orthopedic and spine institute in the state. The results have exceeded expectations on every measure and they already have to increase their capacity due to even higher demand than they originally modeled.

3. Structure: Are we a holding company or an operating company? There has been a tremendous amount of consolidation over the last few years, but questions remain over the merits of those moves. The reality is that many of these organizations haven't made the tough decisions and are essentially operating as a holding company. They are not getting any strategic or operational leverage. You can place all health systems on a continuum along these two endpoints — being a holding vs. an operating company — but the most critical step is to have an open conversation about where you're at today, where you intend to be in the future, when you're going to get there and how you're going to make it happen. **Bon Secours Mercy Health's** CEO John Starcher shared, "It makes sense to merge, but only if you're willing to make the tough decisions." His team hit the mark on every measure of their integration following their merger. They then leveraged that same competency to acquire the largest private provider of care in Ireland, as well as seven hospitals in South Carolina and Virginia. **Northwestern Medicine** has leveraged a similar approach to transform from a $1 billion hospital into a $5 billion health system in a handful of years. Both of these organizations prioritized and made tough decisions quickly and each has created an organizational competency in executing efficiently and effectively on mergers and acquisitions.

4. Culture: Do we have employees or a team? Every organization states that their employees are their most important asset, but few have truly engaged them as a team. Hospitals and healthcare delivery systems can become extraordinarily political, and it's easy to see why. These are incredibly complex businesses with tens of thousands of employees in hundreds of locations and thousands of departments. Getting that type of organization to move in the same direction is

incredibly challenging in any industry. At the same time, the upside of breaking through is perhaps the most important test of any leadership team. JP Gallagher, CEO of **NorthShore University HealthSystem**, shared his perspective that, "Healthcare is a team sport." The tough question is whether or not your employees are truly working as a team. **Christiana Care** provides care in four states — Delaware, Maryland, Pennsylvania and New Jersey. They have taken a unique approach that they frame as "for the love of health," incorporating the essence of what they do in every communication both internally and externally, in their values and in their marketing. In a multi-state system, it is tricky to create a caring and collaborative culture, but it's critical and they've nailed it. Their CEO shared that, "If you lead with love, excellence will follow." That's not only well said but spot-on. Creating a world-class team requires not only loving what you do, but the team you're part of.

5. Physicians: Are our physicians optimistic or pessimistic? There's a lot of concern about "physician burnout" with a reflex to blame it on EHRs, cutting off the needed conversation to dive deeper into where it really comes from and how best to address it. The challenge over the next decade is to create an optimistic, engaged and collaborative culture with physicians. In reading this, some will react with skepticism, which is exactly why leadership here is so important. One suggestion I was given was to make this question edgier and ask, "Are our physicians with us or not?" However the question is asked, the bottom line is that leadership needs to find a way to turn this into a dynamic, hyper-engaged model. A little while back I spent the day with the leadership team at **Cleveland Clinic**. At the end of the day, their CEO Dr. Tom Mihaljevic was asked what he would tell someone who was thinking of going to medical school. He said he would tell them that, "This is absolutely the best time to be a doctor." His answer was based on the fact that there has never been a time when you could do more to help people. He wasn't ignoring the challenges, he was simply reframing those issues as important problems that smart people need to help solve in the future. Those who adopt that type of optimism and truly engage and partner with their physicians will create a major competitive advantage over the next decade.

6. Customer: Do we treat sick patients or care for consumers? Words matter here - patients vs. consumers. Most hospitals are in a B2B, not B2C, mindset. Patients get sick, they try to access care, they check into an ER, they get admitted, they are treated, they get discharged. People get confused, anxious and concerned, then they seek not only care, but simplicity, compassion and comfort. With half of America coming through their stores every week, **Walmart** is already the largest provider organization that no one thinks of as they provide 'consumer' care, not 'patient' care. But they are starting to broaden their lens, and health systems will need to make moves as well. Competing with Walmart, CVS and other consumer-centric models will require a different mindset. I think Dr. Janice Nevin, the CEO **ChristianaCare**, captured this really well when she said, "Our mindset is that our role is to ensure everything that can be digital will be digital. Everything than can be done in the home will be done in the home." Henry Ford Health System CEO Wright Lassiter commented, "Trust is the fundamental currency in healthcare." Building that trust will require a digital experience in the future that is just as compassionate and caring as what health systems strive to deliver in person in the past.

7. Data: Will we make data liquid? The most undervalued and misunderstood asset of health systems may be their data. While some at the conference refer to this as having the economic

equivalent of being the "oil of healthcare," the real and more practical question is whether or not your organization will make data liquid, available and accessible to the right players on your team at the right time. Jeff Bolton from **Mayo** commented that, "The current model is broken. Data and tech can eliminate fragmentation." In a recent Strata survey, we asked leaders in health systems whether they had access to the information they needed to do their job, and 90 percent said no. For many health systems, data is a science project, hidden behind the scenes primarily used for research and impossible to access for most stakeholders. The call to action is activating that data to improve clinical outcomes, operations and/or financial performance.

8. Cost: Are we serious about reducing the cost of care and delivering value? Affordability is a hot topic, and for good reason, as high deductible plans, price transparency and other factors have accelerated its urgency. As Intermountain Healthcare CEO Dr. Marc Harrison shared, "We have an absolute responsibility to make healthcare affordable." While the consumer side will be a moving target for some time, the No. 1 challenge for hospitals right now is to lower their cost structure so they can compete more effectively in the future. **Advocate Aurora Health, Baylor Scott & White Health, CommonSpirit Health** and many others are targeting cost reductions of over $1 billion over the next few years. As most hospitals are now in a continuous process to reduce cost in order to compete more effectively in the future, organizations like **Yale New Haven Health** in Connecticut have implemented advanced cost accounting solutions to better understand both cost and margins. Yale is using this data to understand variation, supporting an initiative that drove over $150 million in savings. Additionally, they have combined cost data with clinical feeds from their EHR to understand the cost of harm events, which turn out to be 5x more expensive. As more providers take on risk, having a "source of truth" on the cost of care will be essential. **Advocate Aurora Health** CFO Dominic Nakis shared that, "We believe the market will continue to move to taking on risk." Many of the presenting organizations shared that same perspective, but they won't be able to manage that risk unless they understand the cost of care for every patient at every point of care across the continuum every day.

9. Capital: Do we have an "asset-light" strategy? Traditional strategy for health systems was defined primarily by what they built or bought. Many hospitals still maintain an "if you build it, they will come" strategy at the board level. Yet, Uber has become the biggest transportation company in the world without owning a single car and Airbnb has become the biggest hospitality company in the world without owning a single room. These models are important to reflect upon as healthcare delivery systems assess their capital investment strategy. **Intermountain Healthcare CFO** Bert Zimmerli refers to their overall thought process as an "asset-light expansion strategy." In 2019, they opened a virtual hospital and they have now delivered over 700,000 virtual interactions. The number of virtual visits at **Kaiser Permanente** now exceeds the number of in-person visits at their facilities. With that said, there will be a balance. I really like how Robin Damschroder the CFO of **Henry Ford Health** System framed it: "We believe healthcare will be more like the airline and banking industry, both of which are fully digitally enabled but have a balance of 'bricks and clicks' with defined roles where you can seamlessly move between the two. Clearly, we have a lot of 'bricks' so building out the platform that integrates 'clicks' is essential."

10. Performance: Do we want our team to build a budget or improve performance? The most significant barrier to driving change that many organizations have baked into their operating model is their budget process. The typical hospital spends close to five months creating

a budget that is typically more than $100 million off the mark. After it's presented to the board, it is typically thrown out within 90 days. It creates a culture of politics, entitlement and inertia. According to a Strata survey of 200 organizations, close to 40 percent are now ditching the traditional budget process in favor of a more dynamic approach, often referred to as Advanced Planning. **OSF HealthCare** leverages a rolling approach, radically simplifying and streamlining the planning process while holding their team accountable for driving improvement vs. hitting a budget. When it comes to driving performance, **SSM Health** CEO Laura Kaiser captured the underlying mindset that's needed: "We have a strong bias toward purposeful action." Well said, and it certainly applies to all of the questions here among the top 10.

5 additional questions to consider

As you would imagine or might suggest, the questions above can and in some cases should be replaced with others. Additional critical questions to answer that came from the group included the following:

1. **Competition:** Who else will we compete with in the future and are we positioned to win?
2. **Digital health:** Are we going to be a "digital health" company, providing tech-enabled services?
3. **Affordability:** How are we making care more affordable and easier to understand and access?
4. **Social determinants:** Is this a mission, marketing or operations strategy?
5. **Leadership:** Have we made the tough decisions we need to make, and will we in the future?

Start asking questions

The point here isn't to get locked into a single list of questions, but rather to force your team to ask and answer the most important and challenging ones that will take you from where you are today to where you want to be in the future. After reviewing these questions with your team, the one additional question you need to consider is one of competency: Do you have the ability and bandwidth to execute on what you've targeted? In the end, that's what matters most. While there are many interesting opportunities, too many teams end up chasing too much and delivering too little.

The next 10 years can and should be the best 10 years for every health system and every healthcare provider, but making it happen will require some really tough questions. "The current path we're on will leave us with a healthcare delivery model that is completely unsustainable," stated Randy Osstra, CEO of **ProMedica Health System.** "We need to take meaningful action toward creating a new model of health and well-being — one that supports healthy aging, addresses social determinants of health, encourages appropriate care in the lowest cost setting, and creates funding and incentives to force a truly integrated approach."

Strong leaders are needed now more than ever. The rest of healthcare is watching, not just professionally but personally. We are all grateful to you for the extraordinary and often heroic care that you deliver without hesitation to our family and friends every day both in our communities and across our country. But now we all need you to not only deliver care, but a new

and better version of healthcare. So, ask and answer these and other tough questions. We know you will do everything that you can to help make healthcare healthier for all of us over the next 10 years.

Dan Michelson is the CEO of Chicago-based Strata Decision Technology. Mr. Michelson has authored recaps of JP Morgan Healthcare conferences for the past several years for Becker's. *Read his account of the 2019 event* here, *2018 event here and the 2017 event here.*

III. External Assessment
C. Top 10 Trends to Watch (and Act Upon) in 2020

Trustee Insights

TOP 10 TRENDS
to Watch (and Act Upon) in
2020

BY LAURA P. JACOBS

Beyond election-year dialogue, which will continue to place health care front and center, what should health care system trustees be watching in 2020? In some cases, what may seem routine trends will require more innovative and bold solutions, and some ground-breaking trends may indicate "watchful waiting."

The Fundamentals

Don't be fooled if these seem "ordinary." Solving the challenges that some of these ongoing trends present may require bold thinking and creative solutions to achieve the kind of impactful and sustainable results that this environment requires.

① Economic Pressures

For many, the continual financial pressures created by expenses rising faster than revenues will be all-consuming. A slowing economy, or worse, a recession, could pose new challenges, including shifting payer mix to increased Medicaid or uninsured patients as well as deferred elective care. The continued growth of high-deductible health plans will require an attentive point-of-service collections process and a thoughtful pricing strategy. With relentless capital needs for IT infrastructure and replacing/expanding facilities, a focus on margin improvement will be critical. Pharmacy cost management will

💬 TRUSTEE TALKING POINTS

- Routine trends present challenges that may require more creative solutions to effect sustainable change.

- Fundamental trends include ongoing economic pressures, rising consumer expectations, an evolving workforce and continued movement toward value-based payment.

- Acceleration of telemedicine, virtual care and advances in biotechnology, diagnostic equipment and analytic and digital tools have the potential for dramatic impact.

be top of nmind, as the volatility of drug costs can create surprises in managing expenses. Taking a new look at ways to optimize human and capital resources through re-engineering care delivery and leveraging technology effectively will be necessary, as "the low-hanging fruit" of prior cost-reduction efforts has likely been plucked. A renewed focus on ways to reduce waste and unwarranted care variation through integrating data and analytics with lean processes and team engagement will require strong leadership. The call to make health care more affordable will be loud and continuous, as will the need to challenge traditional approaches and solutions to yield sustainable cost reduction that maintains or improves patient outcomes.

Trustees Should Discuss: Does current operating performance match the expectations built into your long-term financial plans and target bond ratings? That is, does your current cash flow generate the cash required to fund current and anticipated capital needs? If not, what actions are being taken to address costs and revenue growth? Have previous improvement efforts been sustained? How does the organization foster an environment that encourages new thinking and bold solutions that position it for future success?

② Consumer Expectations

Rising consumer expectations of a multicultural/multigenerational demographic coupled with an aging population will continue to create both opportunities and threats to traditional health systems. Health care consumers seeking accessible, affordable and Amazon-like experiences will be attracted to the many new entrants that seek to fill that void. These will include technology-based companies, new primary care models, national providers of outpatient surgery and imaging, and hospital-at-home providers, all leveraging an ability to test new models of care, unencumbered by the politics and complex decision-making (and fixed costs) of a large hospital or health system.

As the population ages, keeping a watchful eye on Medicare payment policies as well as continuing to improve the coordination of care across the continuum for patients with complex, chronic conditions must be a priority for all health systems. Implementing strategies and working with other community organizations to address mental health and health issues caused by poverty and hunger or malnutrition also must receive attention from health system leaders; the overuse of emergency departments and overlong hospital stays are often due to these issues and can best be addressed through influencing social determinants of health.

Trustees Should Discuss: Who are the nontraditional competitors in your market and how is your organization addressing consumer expectations? How is the organization poised to succeed under Medicare payment models? How are care delivery models adapting to address patients with multiple chronic conditions? What community needs beyond medical care does your community health needs

assessment identify – e.g., housing, poverty, hunger, mental health — which your health system can address either directly or through community partners?

③ An Evolving Workforce

As a field that is primarily dependent on human resources to deliver services, attention must be paid to an evolving workforce. With high demand for physicians of many specialties, especially primary care, to serve in various roles across the health care sector beyond direct patient care, health systems will have to refresh recruitment approaches and evaluate retention strategies. This also holds true for most clinical and technology roles: Health systems must provide a workplace that is appealing to a multigenerational and multicultural workforce seeking flexible work hours, multiple venues for learning, competitive wages and benefits, and opportunities for advancement.

Union activity will continue to put pressure on organizations to engage employees in effective ways. This will put additional economic pressure on hospitals, so going beyond productivity monitoring will be required to assure individuals are working "at the top of their license" in efficient ways. Stress over concern that artificial intelligence (AI) will replace jobs must be replaced with strategies to effectively use AI to reduce the stress of boring, repetitive tasks. Effective change management leadership also will be paramount as "change fatigue" can impact morale, not to mention patient care, across the enterprise.

Trustees Should Discuss: Does your organization have a well-defined human resources strategy that incorporates all elements of the human capital value chain and their interrelationships: recruitment, performance management, compensation and benefits, learning systems, productivity management, leadership development? Does the strategy anticipate more changes in the future to the roles of care team members across the continuum — serving patients in their homes, through virtual technology, as well as in traditional settings? In what areas are vacancies (or overuse of agency or overtime pay) most severe, and what recruitment or retention strategies are being deployed to address the challenge? Has the health system played an active role in working with academic institutions and educational resources to promote the training of individuals at all skill levels in creative ways? What is your organization's leadership development and succession plan?

Shifting Sands

Market movement in the following areas is highly variable, depending on your state, region or town. But they remain highly impactful and require constant observation to avoid missing signs of rapid change.

④ Value-Based Payment

Despite some fits and starts, the ongoing march to value-based payment will continue through 2020 and beyond. While no payment mechanism has yet to become a panacea, most payers continue to move away from "vanilla" fee-for-service to an expectation that value be demonstrated by cost savings and improved quality. Medicare Advantage plans already cover 35 percent of individuals eligible for Medicare across the country, and enrollment continues to grow at a steady pace year over year. Many Medicaid plans are organized around HMO-like structures with defined provider networks and, in some cases, at-risk payment models.

Watch for increasing activity of employers in your market to contract directly with providers for certain specialty services (e.g., Amazon with City of Hope for cancer care) or to take risk for total cost of care. Payers such as UnitedHealth (through Optum) and many Blue Cross Blue Shield plans are developing their own provider networks. Health systems with a blind eye to changes in payer strategies run the risk of being marginalized.

All of these trends require increased collaboration and data sharing between physician organizations (either employed or affiliated groups) and hospitals — and physician leadership to drive the necessary changes in care models to effect value-based care delivery.

Trustees Should Discuss: What is the health system's payer strategy to address commercial, Medicare and Medicaid trends in your region? How is the organization fairing under the current value-based payment structures? How "healthy" are hospital-physician relationships to drive improvements in care across the continuum? What opportunities exist to work directly with employers both within and outside your community?

⑤ Regulatory Changes

Health care is one of the most highly regulated fields in the U.S., so keeping a pulse on federal and state regulatory changes is crucial. Current "hot buttons" revolve around price transparency (beyond just posting your charge master), site-neutral payments and drug costs. Nationwide shifts to single-payer or public options will receive a lot of talk but no action this election year. Site-neutral payments go beyond CMS policies: Many health plans (e.g., Anthem, United) have instituted payment policies requiring pre-authorization and potentially disallowing payment for certain surgical or imaging procedures in hospital-based settings.

Whether mandated or not, being ready for retail medicine by enabling technology and simplified pricing structures to provide consumers accurate information about their potential out-of-pocket costs will be a competitive advantage. Be alert to changes in state-specific Medicaid policies; shifts in coverage, payment models and rates can be severe depending on stresses on state budgets and the political climate.

Trustees Should Discuss: How is your organization prepared for pricing transparency? What is its strategy to respond to site-neutral payments for outpatient care? Does it have a competitive outpatient network — inclusive of outpatient surgery and imaging services? What do you anticipate at the state level in terms of regulatory changes or shifts in Medicaid policies?

6 Growth of Outpatient and Post-Acute Care

The growth of outpatient and post-acute care is not new, but it is receiving greater attention as competition heats up and financial performance is scrutinized. Virtually all health systems continue to grow their physician enterprise, either through acquisition of physician practices or through contracting in clinically integrated networks. But there is also a plethora of primary care and specialty care models that are either privately funded (e.g., Oak Street Health, One Medical) or sponsored by large public companies (CVS, Walmart) that are expanding rapidly across the country. This will put pressure on health systems to assure that their outpatient strategy is competitive in terms of patient service, affordability and care coordination, and provides facilities and other resources attractive to physicians and other clinicians.

Likewise, the high demand for post-acute care, given the aging of the population and push for "right care/right place" has fostered the expansion of a variety of post-acute providers and venues of care, including hospital care at home. Many health systems are finding that partnering with organizations that specialize in rehab, skilled nursing and home care is more feasible than operating their own post-acute services. But setting up service-level agreements and assuring smooth transitions of care still require the constant attention of health system leaders.

Trustees Should Discuss: How is your outpatient network poised to compete with the likes of CVS and Walmart? Is its financial performance sustainable, and how easy is it for prospective patients to access your services? Do you have a post-acute strategy that assures patients can move seamlessly across the continuum of care and receive care consistent with your health system's standards?

7 Health System Complexity

Health system complexity will continue to increase. Whether your organization is a single community hospital or a multihospital, multidimensional system serving multiple states, external trends demand that health systems operate effectively across the care continuum and across multiple functions. Your organization could play a role as a payer, technology/innovation accelerator, clinical research resource, educator and professional training site as well as a care provider in acute, post-acute, outpatient, virtual and retail care.

The sheer complexity of running the information technology or analytics function for many health systems is daunting, let alone the revenue cycle process for so many different care venues and payment models. This level of complexity demands new types of leaders and approaches to leadership. It also requires organizations to determine what they can and should do alone and where partners can bring expertise and focus. Even more importantly, hospitals and health systems must articulate a clear vision of the organization they aspire to be, and what they will (and will not) do to achieve that goal.

Trustees Should Discuss: Do our strategies and actions match our stated vision? What degree of transformation is required to get us there? Do we have the right leaders or leadership approach to get us there? Has organizational structure and function matured consistent with the size and scope of the health system? Is our governance structure and function geared to lead the current and future health care enterprise?

Revolutionary Potential

While not new, many of these trends are gaining traction quickly — how dramatic will the change be in your environment? Close monitoring and, in some cases, advancing the application of these disruptive elements warrant attention for organizations to remain relevant as the future unfolds.

8 Telemedicine and Virtual Care

Telemedicine and virtual care have come of age. They have moved from the pilot stage and use in select areas to being a key consideration for virtually every service — from primary care to intensive care. For many health systems, telemedicine and virtual care are still viewed as a care model in its infancy, but many of the new entrants leverage the convenience of telemedicine and virtual care to attract consumers and create loyalty. They also provide a critical linkage with many specialty services for rural providers.

For example, voice recognition in the hospital and home setting is growing and assisting patients with everything from adjusting the temperature in their hospital room to contacting their care manager from home. Wearables (think Apple watch) that track key health indicators (EKG) as well as using cell phone apps to manage chronic care and leverage behavior modification tools have been and will be widely promoted. The only holdup will be the pace at which payment models keep up with these digital and virtual advances.

Trustees Should Discuss: What is your health system's plan to adopt and scale the use of virtual technology? Has it gone beyond the pilot stage to being a routine way that care is delivered for appropriate services? How are wearable technologies or cell phone apps being incorporated into chronic care pathways — or when is the timing right for that?

⑨ **Biotechnology and Clinical Advances**

Biotechnology and clinical advances continue to incorporate precision health concepts. Many of the most advanced are primarily provided in academic medical centers (e.g., CAR T-cell therapy), but genomics is being applied in many settings to take population health to a new level. Diagnostic equipment is becoming more portable (hand-held devices) and increasingly incorporates AI (imaging equipment), which changes both the venue and role of clinicians in using the equipment.

With organizations like Apple

and Google increasing their role in medical research, leveraging their powerful analytic engines, traditional clinical research organizations may either be challenged or will need to find new partners to accelerate research efforts.

Trustees Should Discuss: How do our medical staff approval processes and care pathways consider new therapies or diagnostic approaches? Do we have a strategy to work with academic medical centers to extend the reach of research and/or new therapies into the commu-

nity setting? How are we considering genomics in our care delivery approaches? Have we set priorities to focus philanthropy on the most critical research efforts?

⑩ **Advanced Analytic and Digital Tools**

Blockchain, AI and other analytic and digital power have the potential to create new levels of efficiency in traditionally cumbersome processes — for example, in revenue cycle. But in many cases, these applications are just

emerging and are still waiting to be unleashed in significant ways. At the same time, organizations that seize the power of some of these advanced digital tools could be the game changers in both reducing administrative costs and driving out waste.

Partnering with technology companies that are working on these applications could be an opportunity or a distraction for hospitals and health systems. Determining the organization's readiness to radically transform key functions will be critical, but in any case, leveraging the potential of advanced analytics in your organization is a first step. Most leaders acknowledge their current dilemma: being data rich and insight poor. Improving basic business intelligence across the organization is fundamental to understanding both

current performance and shedding light on opportunities for redesign.

Trustees Should Discuss: How are we leveraging technology and analytics to (1) make business decisions; (2) drive clinical decisions; and (3) improve efficiencies? What are our plans to embrace AI within the organization? Should we be partnering with others to see how we could transform key functions like revenue cycle or population health management?

Conclusion

Health care remains a tornado of change due to the many demands from all stakeholders: Consumers demand change to make our services more accessible, less fragmented, more

affordable; payers demand more efficiency, less waste, lower cost; our workforce demands greater flexibility, less stress, competitive pay...the list goes on. We can be daunted by the complexity and often conflicting changes expected of health care systems, or we can embrace many of the opportunities that will make health care better for consumers and providers of care. As the saying goes, "running away from the problem only increases the distance to the solution." 2020 will be another year to seize the challenge and embrace change to improve health care.

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III. External Assessment
D. ASHE 2020 Hospital Construction Survey

2020 Hospital Construction Survey

Advanced planning, design and construction technology helps drive building project efficiency
March 19, 2020

Beth Burmahl and Jamie Morgan

Image from Getty Images

Architects who began designing Piedmont Tower in Atlanta in 2016 knew the project would have to move swiftly to meet the target goal of opening by the end of 2020.

The $600 million medical tower is a massive undertaking that will add a cardiovascular care center, more than 400 beds and 13 operating rooms to Piedmont Atlanta Hospital. Designers planned to build the entire structure and up-fit 10 floors of the 16-floor tower, including the cardiovascular center, and then complete one floor per year after that.

ADVANCED CONSTRUCTION TECHNOLOGY

Advanced construction technologies used on health care projects reported by all respondents	
Building information modeling	25%
Prefabrication used for components (e.g., MEP racks, patient room headwalls, etc.)	21%
Drones	15%
360-degree photography	13%
3D projection mapping	12%
Modular construction used for units (e.g., bathrooms, exam rooms, etc.)	11%
Remote monitoring	8%
Radio frequency identification tags used to track equipment	7%
Virtual reality	7%
3D printing	7%
Augmented reality	6%
Radio frequency identification wearables used to track workers	5%
Predictive analytics software	5%
LIDAR (light detection and ranging)	1%
Robot laborers	1%

Top factors for using advanced construction technologies on health care projects by respondents using such technologies	
Control costs	60%
Enhance collaboration and communication	55%
Shorten or maintain schedule	52%
Reduce changes in the field	47%
Improve project safety and quality	44%
Cost estimating	37%
Streamline decision making	35%
Monitor progress	23%
Improve worker safety	18%
Systemwide initiative to adopt new technology	15%
Decision driven by construction management vendor	10%
Mitigate labor shortages	9%

Source: Health Facilities Management/ASHE 2020 Hospital Construction Survey

Click on the image above and click on the arrows to view data from the 2020 Hospital Construction Survey

To accelerate the project, HKS Architects, Chicago, is relying heavily on building information modeling (BIM) and cloud-based collaboration that allows designers, contractors and engineers to coordinate the project in real time and eliminate the need to exchange design models, among other time-savers.

As of early this year, the project is on budget and on schedule to open in late 2020.

"From a design standpoint, BIM is a continually important tool," says Joe Sprague, FAIA, FACHA, FHFI, senior vice president and principal at HKS Architects, Dallas, and a member of the American Society for Health Care Engineering (ASHE) Board. "Along with allowing the team to coordinate throughout the entire project, BIM provides 3D, real-time visualization and allows for input of critical project data. I continue to believe that CAD is also very important in that regard."

Technology like BIM not only helps hospitals save time and money, it offers a cohesiveness that designers even two decades ago could not have imagined.

"BIM is surging in use partly because it's hard not to have BIM in your system," says Brad Pollitt, AIA, vice president of facilities at UF Health, Gainesville, Fla. "BIM is great

for clash detection, enhanced collaboration and easier decision making. It's becoming necessary for most hospital projects."

BIM is just one of the advanced technologies hospitals are relying on to guide the design and construction process from conception to realization, according to the 2020 Hospital Construction Survey conducted by ASHE's *Health Facilities Management* magazine.

The survey, which included responses from more than 400 facilities professionals at hospitals across the country, asked a wide range of questions on everything from design trends and budgets to certification and commissioning.

For the first time, the survey asked respondents which advanced technologies they have used on construction projects in their health care organizations.

Benefits across the board

Along with BIM, prefabrication, 3D projection mapping, modular construction and 360-degree photography are among the most-cited technologies for design and construction projects, according to the survey. Most cited benefits are cost control (80%), enhanced communication (53%) and staying on or ahead of schedule (52%), which is in line with what is happening throughout the field, according to Mark Nichols, AIA, ACHA, LEED AP, principal at Eckenhoff Saunders, Chicago.

RELATED ARTICLE
Technology infrastructure drives renovation projects

"Each of these technologies is different, but they all support one another. And in a sense, they all have a data component," Nichols says. "Hospitals using these technologies are seeing lower costs, faster results and better coordination of documentation, leading to better outcomes all around."

In the survey, respondents were asked open-ended questions about technology-driven projects and offered comments, including:

- "We have used virtual reality, 3D imaging, light detection and ranging (LIDAR), and BIM 360. So far, all have saved time and reduced changes."
- "BIM, prefabrication and 3D projection mapping were used in our construction of a full replacement hospital."

After BIM, prefabrication — building or manufacturing parts of a project at a location other than the job site — was the second most cited advanced technology by survey respondents. While it is not a new construction tool, technology is amplifying the benefits of prefabrication.

Said one respondent: "Using prefab bathrooms has become a standard in our organization. It saves a great deal of time."

RESOURCES

- **"State of U.S. Health Care Facility Infrastructure" monograph**

Modular structures — those constructed in a factory and transported assembled on-site — continue to grow in popularity and are especially beneficial for larger hospitals, says Pollitt. "For something like bathroom design, you can build hundreds of these a year and stockpile them, which saves time and costs. But it wouldn't be as effective for a 200-bed hospital. You would have to get in front of the design team to standardize all the elements from the beginning."

Pollitt says some health care providers in Florida are using modular structures "as big as a semi-truck" to build freestanding emergency rooms.

Said one survey respondent: "Exterior wall panels were constructed at a factory, shipped to the site and assembled in record time with less labor. Cost and time savings benefit."

Though not yet in widespread use, more designers are relying on augmented reality, which layers computer-generated enhancements over an existing reality; and virtual reality, a computer-generated simulation or recreation of a real-life environment.

McCarthy Building Companies Inc., St. Louis, is using 3D technology and augmented reality to create a real-world experience for clients, says Alex Belkofer, director of virtual design and construction at McCarthy.

"We are doing virtual mockups for health care clients and walking them through the project using a 3D model, or doing it live on the job site," Belkofer says. "The feedback we are getting is great. Health care clients say the technology creates an environment that feels real and gives them a feeling of comfort. It gives the health care owner confidence about the project and really helps with buy-in."

Rendered floor plan technology is a great way to provide clients a clear understanding of the project's expectations, says Nichols. "This gives us a 3D approach that leads us to that 'turn on the light' moment, where the stakeholders truly understand the design before construction is underway. Rendered floor plan technology eliminates the possibility of walking into a completed space and saying, 'This is not what I expected.'"

Other technologies gaining in popularity are 360-degree photography, which captures building data for future reference; drones, which can be used to capture construction progress photos and perform 3D scans of existing structures; and radio frequency identification (RFID) to track workers and equipment.

And just as it is disrupting all of health care, Belkofer says artificial intelligence (AI) is among the exciting new technologies that will transform health care design and construction in this decade.

"We are starting to figure out the many ways AI can aid design and construction," Belkofer says. "How do we automate some of these human tasks related to modular and prefab construction? How does the evolution of robotics drive the ability of 3D printing? They are now testing ways to lay brick and concrete blocks with robots. These technologies are the future of design and construction."

Funding construction projects

In terms of funding, hospital construction budgets were in line with the previous year. In 2019, funding for new construction dipped slightly from 25% to 19%, increased from 18% to 20% for infrastructure and stayed level for facility renovation at about 28%.

About this survey

While more than half of the respondents said projects came in under budget and on and/or ahead of schedule, more than 18% said projects were over budget and behind schedule — a number that has increased gradually over the years.

Pollitt says this steady rise may be related to the increasing complexity of hospitals and the need for contractors to get involved earlier. "Hospitals that don't hire the right team early in the process will soon be dealing with schedule overruns and budget overruns. Even 10 years ago, hospital systems were not this complex."

And the vast majority of hospitals are funding renovations and expansions (74%) of acute care hospitals versus new construction (31%), a trend likely to continue in 2020, according to the survey. Forty-eight percent of respondents are planning to increase spending on renovations/expansions this year.

Pollitt says those numbers are consistent with what he is seeing in the field.

"Hospitals are upgrading older facilities to incorporate the latest technologies and services to better please patients, which is cheaper than new construction," he says. "The rise in physical plant infrastructure upgrades is in line with the increase in renovation."

ASHE President Jeffrey Henne, FASHE, CHSP-FSM, CHEP, CHC, safety and emergency manager at the University of Pennsylvania Health System, Philadelphia, says the increase in funding for boilers and chillers is also linked to energy measures and incentives that provide payback to the facility. "I know for our hospital, we received more than $200,000 for chiller optimization," Henne says.

Although the percentage of facilities increasing funding for off-site building dropped from 51% to 41% in the last year, Sprague says the move toward outpatient facilities is still a trend. Health care systems are moving more procedures from inpatient to outpatient settings to diversify revenue and prepare for new payment models. It's also a smart way to move into a new area without building an entirely new facility.

"Consumer willingness to get care in nontraditional environments continues to push health care off-site, which drives workload, staffing and facility operation," Sprague says. "Alternative payment models are also a factor in the shift toward outpatient care."

The survey shows more than 26% of hospitals are building or planning to build medical office buildings over the next three years; and roughly 22% have ambulatory facilities in the pipeline. Freestanding imaging centers and emergency departments are also on the rise.

"There is a continuing effort to take patient care into the communities," Nichols says. "New equipment and communication technology are improving home care support. Through the design and construction of urgent care centers and hospital system-sponsored specialty clinics, the trend continues towards off-site patient access."

The survey also showed an increase in critical access hospital projects, which continue to grow in importance, Sprague says. "Critical access provides emergency treatment to any demographic a health care system plans to serve, including rural areas. Critical access is a key concern when planning a network of facilities," Sprague says.

And although the survey found that construction for acute care hospitals dropped slightly from the previous year, that doesn't signify a major shift in that area. "Hospitals are putting a huge amount into renovation and construction of existing acute care," says Pollitt, citing survey results showing 74% of acute projects will involve expansion and/or renovation.

Investing in the future

Continuing ongoing trends, the survey showed hospitals are investing in behavioral health care and emergency and ambulatory care. While funding for behavioral health

dipped from last year, it is still very much a focus for hospitals and health systems dealing with increasing numbers of behavioral health issues.

"We're doing a lot of behavioral health work, and that will be a trend for the near future," Sprague says. "As a planner, we are working to integrate behavioral health with the rest of the system to make sure it's compatible. Blending these systems together in one design maximizes efficiency and minimizes duplicity."

Major expansion and renovation is often needed in older hospital buildings that aren't equipped to handle the needs of today's behavioral health patients, Pollitt says. "Today, we have drug issues, more violence and lockdown units. The anti-ligature requirement alone often requires major construction," he says.

The survey showed hospitals are also investing in pharmacy, imaging, and emergency and ambulatory care construction projects.

Twenty-six percent of hospitals have pharmacy projects, with roughly 36% planning new or replacement projects in the next three years, and more than 65% planning renovations or expansions. Nichols says the pharmacy construction is likely linked to U.S. Pharmacopeia regulations, which usually require infrastructure and operational changes in the facility.

"Meeting these regulations has generated a big push right now for pharmacy renovation and expansion," says Nichols, whose firm is now handling 18 pharmacy projects in the Chicago and central Illinois area.

Other building projects on the rise include cancer centers and children's, heart and rehabilitation hospitals. In terms of what to watch, Pollitt says orthopedics are quickly shifting to an outpatient model, driven by advancing technology that negates the need for an overnight stay. "A lot of orthopedic work is moving toward an ambulatory environment," Pollitt says. "You can get a new hip at 7 a.m. and be home later that day."

Certification and commissioning

A growing number of facilities are commissioning — conducting an audit to review energy performance, safety and sustainability, among other factors. This year, 74% of respondents reported commissioning, up from 72% last year. ASHE, which offers Health Facility Commissioning Guidelines as part of its Sustainability Roadmap, would like to see these numbers increase, says ASHE Deputy Executive Director, Advocacy, Chad Beebe, AIA, CHFM, FASHE.

New this year, the survey questioned hospitals about qualifications required of general contractors.

The majority (62%) require contractors to complete Infection Control Risk Assessments. In addition, 26% require contractors to have Certified Healthcare Constructor (CHC)

credentials, while 6% require ASHE's newest certification program, Certified Health Care Physical Environment Worker.

"Hospitals are different. We operate around the clock, and we work hard to protect our patients from construction issues that may be common in other types of buildings, such as dust or noise," Beebe says. "By requiring workers to earn this new certification, hospitals can reduce risks by ensuring people working in their facilities understand important patient safety concepts."

Beth Burmahl *is a freelance writer based in Lisle, Ill., and* **Jamie Morgan** *is editor at* Health Facilities Management.

IV. Internal Assessment

A. Demographic Data
B. Community Health Needs Assessment
C. Prosser Community Health Assessment
D. Market Analysis
E. Patient Loyalty
F. Historical Financial Performance
      i.   Hosptial Dashboard Report
      ii. Balance Sheet and Statement of Operations
G. Service Line Analysis
      i.   Organizational Chart
      ii. Statistics
      iii. Trend Line Graphics

IV. Internal Assessment

A. Demographic Data

Prosser, Grandview, Benton City, Sunnyside, Mabton, West Richland

DEMOGRAPHIC PROFILE

Prosser City WA
Geographic Place

EDUCATION

16% No High School Diploma

25% High School Graduate

31% Some College

28% Bachelor's or Grad/Prof Degree

EMPLOYMENT

White Collar — 56%

Blue Collar — 32%

Services — 12%

13.8% Unemployment Rate

KEY FACTS

6,274 Population

34.8 Median Age

2,231 Households
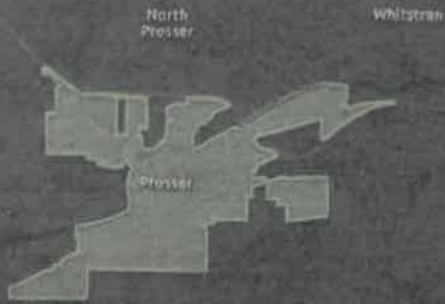
$50,190 Median Disposable Income
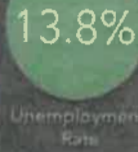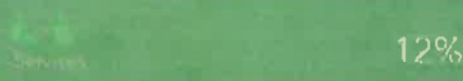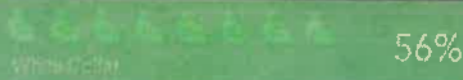
INCOME

$58,610 Median Household Income

$26,965 Per Capita Income

$83,674 Median Net Worth

HOUSEHOLD INCOME ($)

Health Care & Insurance

This infographic provides a set of key demographic and health care indicators. Data sources include: American Community Survey (ACS) 5-year Data, Esri Consumer Spending, and Esri Market Potential data.

Learn more about this data: https://doc.arcgis.com/en/esri-demographics/data/us-intro.htm

Health Care Expenditure

$3,417
Annual Health Insurance Expenditures

$1,907
Medical Care

Health Care (Consumer Spending)	Annual Expenditure
Blue Cross/Blue Shield	$1,058.7
Medicare Payments	$474.5
Physician Services	$230.3
Dental Services	$333.3
Eyecare Services	$86.5
Lab Tests/X-rays	$60.8
Hospital Room & Hospital Service	$189.2
Convalescent/Nursing Home Care	$10.8

Has One Type Of Health Insurance

	19<	19-34	35-64	65+
Has One Type Of Health Insurance	23.6	13.4	30.1	4.9
Population (ACS)	26.0	18.6	38.8	16.6
No Health Insurance	0.0	3.5	3.4	0.0
Population Age	19<	19-34	35-64	65+

%

Medicare: Population 65+

240 Medicare Only

188 Direct-Purch & Medicare

250 Employer & Medicare

147 Medicare & Medicaid

Health Insurance Coverage (ACS)

Pop 19-34   Pop 35-64

VA Health Care
Medicaid Only
Medicare Only
Direct Purchase Ins
Employer Health Ins

0%   10%   20%

Percent

Population

6,076
Civilian Noninstitutionalized Population (ACS)

Exercise (Percent of Adults)

25.7%
Exercise at home 2+ times per week

10.6%
Exercise at club 2+ times per week

DEMOGRAPHIC PROFILE

Grandview City, WA 2

Geographic Place

EDUCATION

39% — No High School Diploma

29% — High School Graduate

24% — Some College

8% — Bachelor's or Grad/Prof Degree

EMPLOYMENT

White Collar — 34%

Blue Collar — 53%

Services — 13%

19.3% Unemployment Rate

KEY FACTS

11,249 Population

26.6 Median Age

3,070 Households

$40,874 Median Disposable Income

INCOME

$49,362 Median Household Income

$15,959 Per Capita Income

$55,603 Median Net Worth

HOUSEHOLD INCOME ($)

73
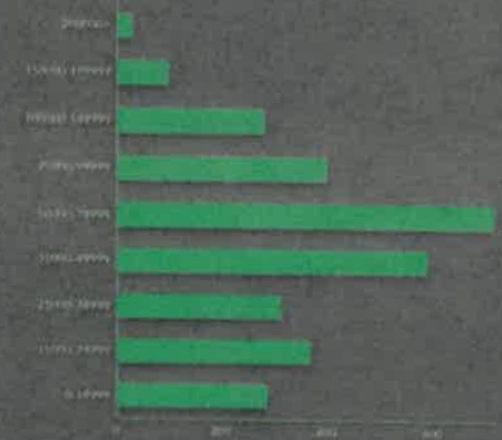
Health Care & Insurance - Grandview, WA

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Learn more about this data: https://doc.arcgis.com/en/esri-demographics/data/us-intro.htm

Has One Type Of Health Insurance

Population (ACS)

No Health Insurance

Population Age	19<	19-34	35-64	65+
Has One Type Of Health Insurance	32.8	14.3	16.9	3.7
Population (ACS)	36.9	22.8	31.5	8.8
No Health Insurance	0.5	7.2	12.5	0.2

%

Population

11,080
Civilian Noninstitutionalized Population (ACS)

Exercise (Percent of Adults)

21.6%
Exercise at home 2+ times per week

14.7%
Exercise at club 2+ times per week

Health Care Expenditure

$2,195
Annual Health Insurance Expenditures

$1,210
Medical Care

Medicare: Population 65+

380
Medicare Only

161
Direct-Purch & Medicare

82
Employer & Medicare

80
Medicare & Medicaid

Health Care (Consumer Spending)	Annual Expenditure
Blue Cross/Blue Shield	$615.7
Medicare Payments	$239.8
Physician Services	$146.6
Dental Services	$260.4
Eyecare Services	$38.6
Lab Tests/X-rays	$39.9
Hospital Room & Hospital Service	$120.5
Convalescent/Nursing Home Care	$9.7
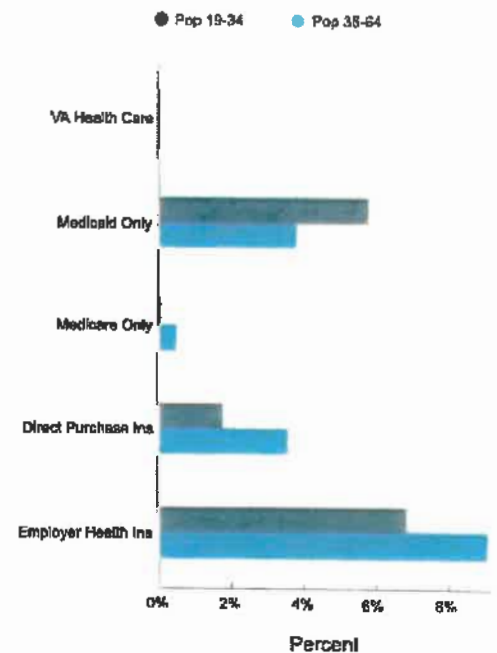
Health Insurance Coverage (ACS)

Pop 19-34   Pop 35-64

VA Health Care
Medicaid Only
Medicare Only
Direct Purchase Ins
Employer Health Ins

0%   2%   4%   6%   8%

Percent

DEMOGRAPHIC PROFILE

Benton City, WA

EDUCATION

15%
No High School Diploma

27%
High School Graduate

40%
Some College

18%
Bachelor's/Grad /Prof Degree

EMPLOYMENT

White Collar — 51%

Blue Collar — 34%

Services — 15%

15.5%
Unemployment Rate

KEY FACTS

3,821
Population

35.5
Median Age

1,372
Households

$47,597
Median Disposable Income

INCOME

$56,399
Median Household Income

$25,660
Per Capita Income

$85,930
Median Net Worth

HOUSEHOLD INCOME ($)

esri
THE SCIENCE OF WHERE

Health Care & Insurance

This infographic provides a set of key demographic and health care indicators. Data sources include: American Community Survey (ACS) 5-year Data, Esri Consumer Spending, and Esri Market Potential data.

Learn more about this data: https://doc.arcgis.com/en/esri-demographics/data/us-intro.htm

Has One Type Of Health Insurance

	19<	19-34	35-64	65+
Population (ACS)	23.2	17.9	28.2	2.4
	26.6	21.8	37.6	14.0
No Health Insurance	0.1	3.3	4.1	0.5

%
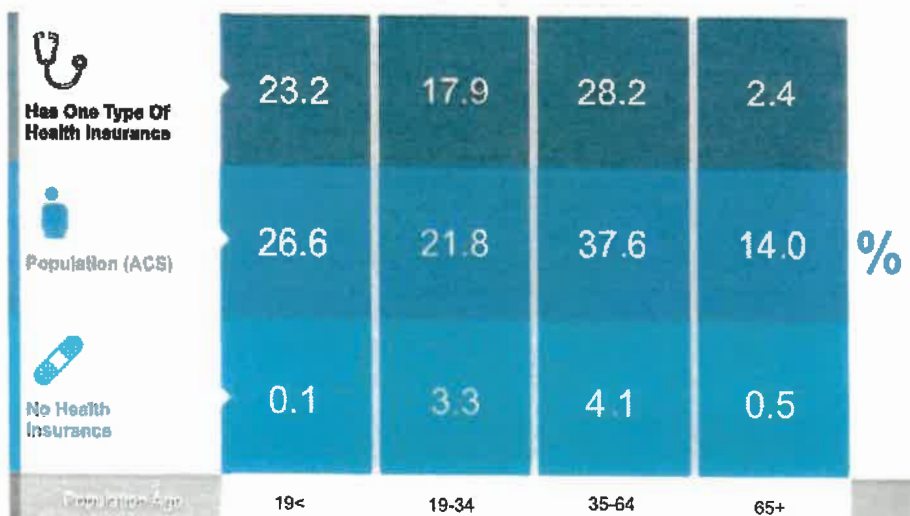
Population Age

Population

3,315
Civilian Noninstitutionalized Population (ACS)

Exercise (Percent of Adults)

22.3%
Exercise at home 2+ times per week

9.3%
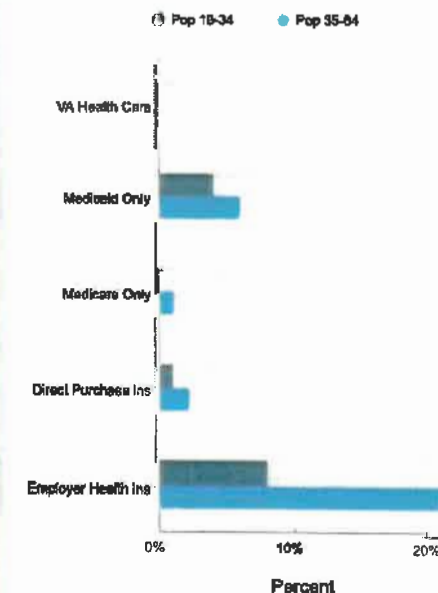Exercise at club 2+ times per week

Health Care Expenditure

$3,170
Annual Health Insurance Expenditures

$1,756
Medical Care

Medicare: Population 65+

78
Medicare Only

101
Direct Purch & Medicare

110
Employer & Medicare

55
Medicare & Medicaid

Health Care (Consumer Spending)	Annual Expenditure
Blue Cross/Blue Shield	$967.2
Medicare Payments	$409.1
Physician Services	$221.6
Dental Services	$315.3
Eyecare Services	$58.5
Lab Tests/X-rays	$57.9
Hospital Room & Hospital Service	$172.2
Convalescent/Nursing Home Care	$11.0

Health Insurance Coverage (ACS)
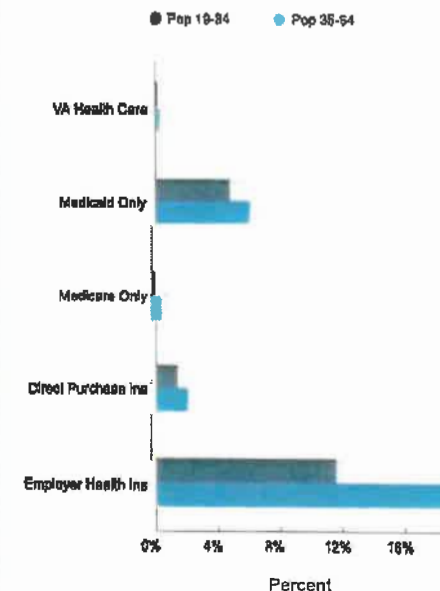
● Pop 19-34   ● Pop 35-64

VA Health Care
Medicaid Only
Medicare Only
Direct Purchase Ins
Employer Health Ins

0%   4%   8%   12%   16%
Percent

DEMOGRAPHIC PROFILE

Sunnyside City, WA

Demographic Place

EDUCATION

47%
No High School Diploma

24%
High School Graduate

21%
Some College

8%
Bachelor's/Grad/Prof Degree

EMPLOYMENT

White Collar — **31%**

Blue Collar — **59%**

Services — **10%**

16.7%
Unemployment Rate

KEY FACTS

17,103
Population

25.6
Median Age

4,644
Households

$36,848
Median Disposable Income
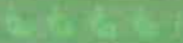
INCOME

$42,373
Median Household Income

$15,772
Per Capita Income

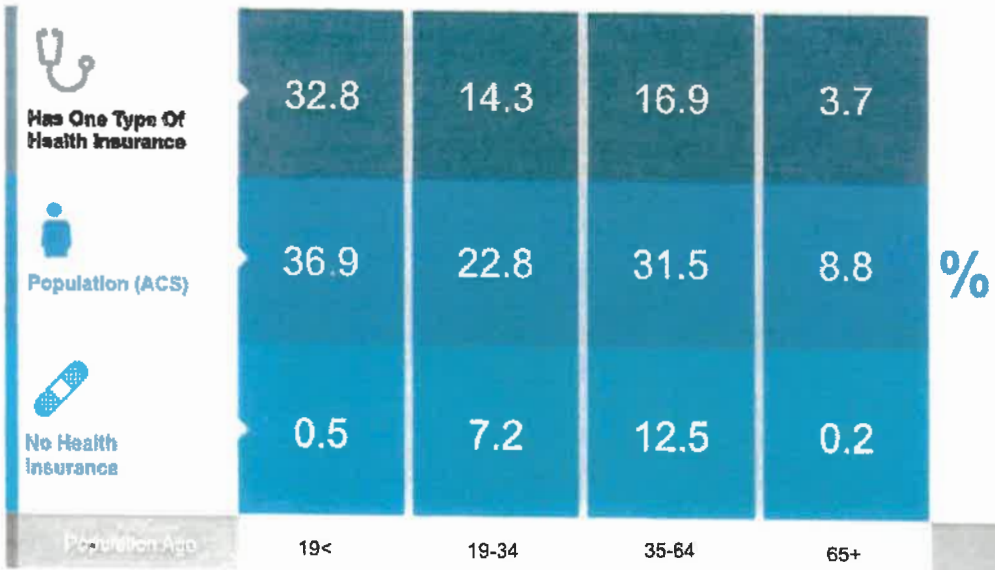**$23,075**
Median Net Worth

HOUSEHOLD INCOME ($)

Outlook

Sunnyside

77

Health Care & Insurance - Sunnyside, WA

This infographic provides a set of key demographic and health care indicators. Data sources include: American Community Survey (ACS) 5-year Data, Esri Consumer Spending, and Esri Market Potential data.
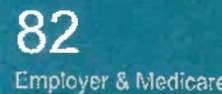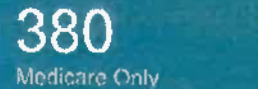
Learn more about this data: https://doc.arcgis.com/en/esri-demographics/data/us-intro.htm

Has One Type Of Health Insurance				
Population (ACS)	36.5	15.0	17.8	2.5
	41.5	23.4	27.5	7.7
No Health Insurance	1.0	7.2	6.8	0.0
Population Age	19<	19-34	35-64	65+

%

Health Care Expenditure

$2,080
Annual Health Insurance Expenditures

$1,137
Medical Care

Medicare: Population 65+

405
Medicare Only

401
Direct-Purch & Medicare

106
Employer & Medicare

217
Medicare & Medicaid

Health Care (Consumer Spending)	Annual Expenditure
Blue Cross/Blue Shield	$572.5
Medicare Payments	$222.1
Physician Services	$139.0
Dental Services	$249.5
Eyecare Services	$35.2
Lab Tests/X-rays	$37.6
Hospital Room & Hospital Service	$108.6
Convalescent/Nursing Home Care	$9.7

Health Insurance Coverage (ACS)

Legend: Pop 19-34   Pop 35-64

VA Health Care
Medicaid Only
Medicare Only
Direct Purchase Ins
Employer Health Ins

0%   2%   4%   6%   8%

Percent

Population

16,296
Civilian Noninstitutionalized Population (ACS)

Exercise (Percent of Adults)

20.3%
Exercise at home 2+ times per week

13.3%
Exercise at club 2+ times per week

esri

This infographic contains data provided by American Community Survey (ACS), Esri and Bureau of Labor Statistics, Esri and GfK MRI. The vintage of the data is 2014-2018, 2020.
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DEMOGRAPHIC PROFILE

Mabton City WA 2

Geography: Place

EDUCATION
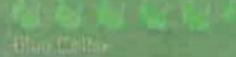
52% No High School Diploma

30% High School Graduate

15% Some College

4% Bachelor's/Grad/Prof Degree

EMPLOYMENT

White Collar — 20%

Blue Collar — 69%

Services — 12%

15.6% Unemployment Rate

KEY FACTS

2,379 Population

25.2 Median Age

547 Households

$37,936 Median Disposable Income
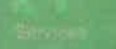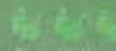
INCOME

$45,401 Median Household Income

$12,688 Per Capita Income

$41,379 Median Net Worth

HOUSEHOLD INCOME ($)

esri
THE SCIENCE OF WHERE

79

Health Care & Insurance - Mabton, WA

This infographic provides a set of key demographic and health care indicators. Data sources include: American Community Survey (ACS) 5-year Data, Esri Consumer Spending, and Esri Market Potential data.

Learn more about this data: https://doc.arcgis.com/en/esri-demographics/data/us-intro.htm

	19<	19-34	35-64	65+
Has One Type Of Health Insurance	36.5	9.1	15.3	7.3
Population (ACS)	39.0	17.0	28.9	15.1
No Health Insurance	2.0	7.1	11.9	0.0

Population Age: 19<, 19-34, 35-64, 65+ %

Population

2,156
Civilian Noninstitutionalized Population (ACS)

Exercise (Percent of Adults)

20.0%
Exercise at home 2+ times per week

15.3%
Exercise at club 2+ times per week

Health Care Expenditure

$1,799
Annual Health Insurance Expenditures

$983
Medical Care

Medicare: Population 65+

149
Medicare Only

78
Direct-Purch & Medicare

17
Employer & Medicare

64
Medicare & Medicaid
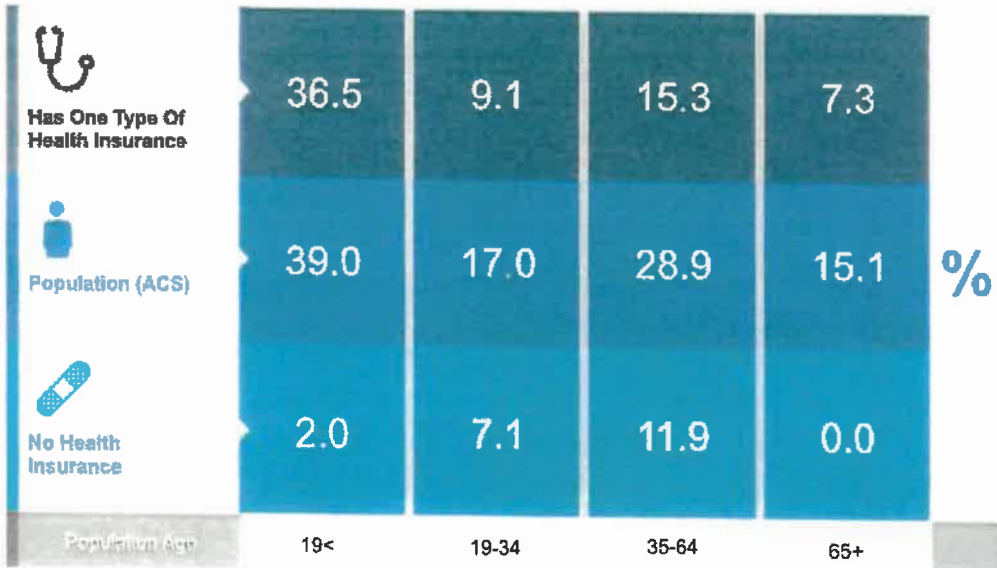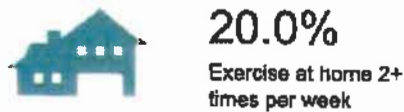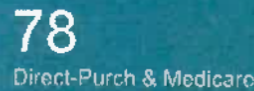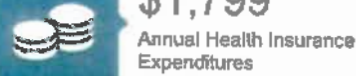
	Annual Expenditure
Blue Cross/Blue Shield	$492.0
Medicare Payments	$194.1
Physician Services	$118.0
Dental Services	$224.1
Eyecare Services	$29.8
Lab Tests/X-rays	$31.5
Hospital Room & Hospital Service	$89.2
Convalescent/Nursing Home Care	$8.6

Health Insurance Coverage (ACS)
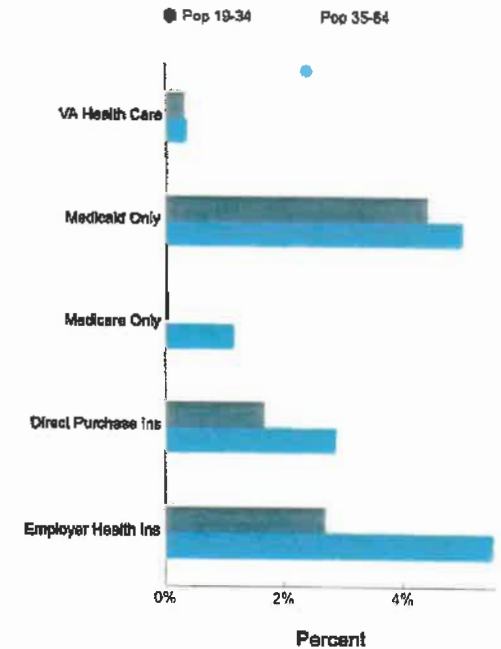
● Pop 19-34   Pop 35-64

VA Health Care
Medicaid Only
Medicare Only
Direct Purchase Ins
Employer Health Ins

0%   2%   4%

Percent

esri

DEMOGRAPHIC PROFILE

West Richland City, WA

Geographic Place

EDUCATION

3% — No High School Diploma

21% — High School Graduate

36% — Some College

40% — Bachelor's/Grad/Prof Degree

EMPLOYMENT

White Collar — 68%

Blue Collar — 20%

Services — 12%

14.5% — Unemployment Rate

KEY FACTS

14,936 — Population

37.6 — Median Age

5,222 — Households

$75,354 — Median Disposable Income

INCOME

$91,074 — Median Household Income

$38,951 — Per Capita Income

$271,773 — Median Net Worth
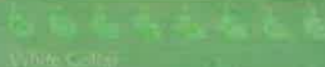
HOUSEHOLD INCOME ($)

esri
THE SCIENCE OF WHERE

Health Care and Insurance Statistics - West Richland
West Richland City, WA
West Richland City, WA (5377685)
Geography: Place

Prepared by Esri

Health Care & Insurance

This infographic provides a set of key demographic and health care indicators. Data sources include: American Community Survey (ACS) 5-year Data, Esri Consumer Spending, and Esri Market Potential data.

Learn more about this data: https://doc.arcgis.com/en/esri-demographics/data/us-intro.htm

Health Care Expenditure

$4,616
Annual Health Insurance Expenditures

$2,547
Medical Care

Medicare:
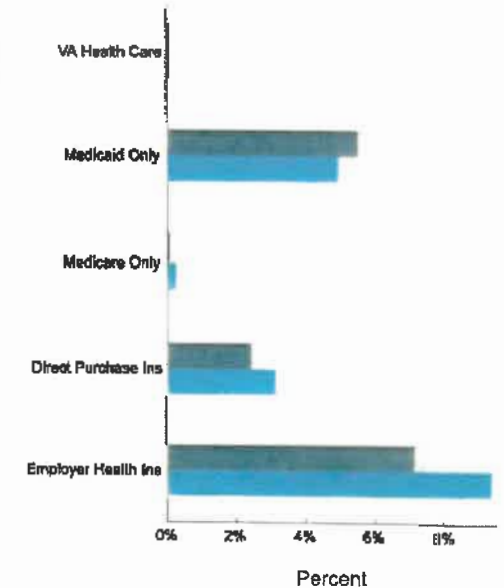Population 65+

200
Medicare Only

265
Direct-Purch & Medicare

411
Employer & Medicare

30
Medicare & Medicaid

Health Care (Consumer Spending)	Annual Expenditure
Blue Cross/Blue Shield	$1,417.6
Medicare Payments	$480.3
Physician Services	$343.9
Dental Services	$480.2
Eyecare Services	$66.0
Lab Tests/X-rays	$90.3
Hospital Room & Hospital Service	$254.1
Convalescent/Nursing Home Care	$16.3
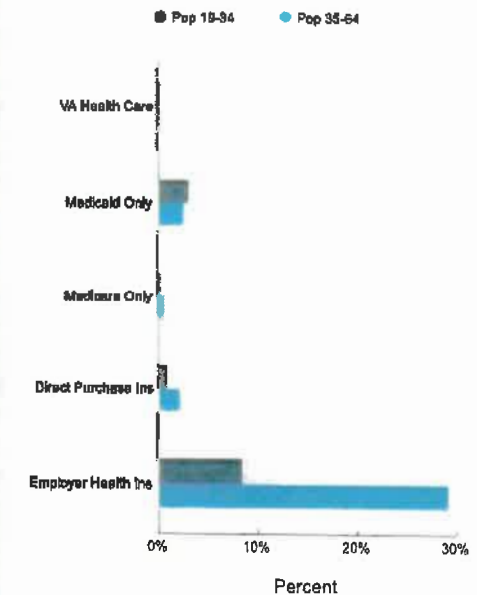
Population

Has One Type Of Health Insurance

Population (ACS)

No Health Insurance

Population Age	19<	19-34	35-64	65+
	30.0	12.3	34.6	1.9
	33.0	14.7	42.6	9.7
	0.3	1.2	2.7	0.0

%

Population

14,171
Civilian Noninstitutionalized Population (ACS)

Exercise (Percent of Adults)

30.1%
Exercise at home 2+ times per week

16.5%
Exercise at club 2+ times per week

Health Insurance Coverage (ACS)

● Pop 19-34 ● Pop 35-64

VA Health Care
Medicaid Only
Medicare Only
Direct Purchase Ins
Employer Health Ins

0% 10% 20% 30%
Percent

esri

This infographic contains data provided by American Community Survey (ACS), Esri and Bureau of Labor Statistics, Esri and GfK MRI. The vintage of the data is 2014-2018, 2020.
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82

IV. Internal Assessment
B. Community Health Needs Assessment

BENTON & FRANKLIN COUNTIES

COMMUNITY HEALTH NEEDS ASSESSMENT

2019

CHNA STEERING COMMITTEE:

Bethany Hickey, MPA
Assessment Coordinator
Benton-Franklin Health District
(BFHD)

Amy Person, MD
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District (BFHD)

Sean Domagalski, RN, BSN, MHA
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Chas Hornbaker
Epidemiologist
Benton-Franklin Health District
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Kirk Williamson
Program Manager
Benton-Franklin Community
Health Alliance (BFCHA)

Karen Hayes, MA
Manager Community Health Investment
Providence St. Joseph Health
(PSJH)

Erin Manukure
Community Benefit & Employee
Events Coordinator
Kadlec Regional Medical Center
(KRMC)

Travis Reed
Growth and Outreach Liaison
Trios Health
Lourdes Health

Kristi Mellema, BSN, RN
Chief Quality and Compliance Officer
Prosser Memorial Health
(PMH)

TABLE OF CONTENTS

EXECUTIVE SUMMARY

PURPOSE:

The Community Health Needs Assessment (CHNA) helps determine which critical health needs the community will focus on addressing over the next 3-5 years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin counties, from Prosser to Connell, from Hover to Hanford. The 2019 CHNA is the result of dozens of stakeholder interviews and focus groups, hours upon hours of research, and multiple community and partner surveys. Not to mention the magic of two large-group exercises to identify and agree on three priority health needs.

Just as our community is more than the sum total of residents and visitors, the health of our community is more than just the health of the individuals who live, work and play in Benton and Franklin Counties. The health status of our residents is important, but equally important is the strength of families and the communities where they live.

Over the past several years, there have been some significant changes in the way our community views itself and its challenges and needs. Those changes are reflected in this document. In 2012, for example, the two strategic priorities were promoting healthy weight/reducing obesity and improving access to health care services. The 2016 CHNA added improving the mental/behavioral health system to the priority needs for our two-county area. The Community Health Improvement Plan (CHIP) was updated in 2017 and highlights on the progress to address these issues are detailed on pages **5-6** of this document.

METHODS:

The framework for the 2019 CHNA is based on a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) reflecting the model used in the prior CHNAs and also provided by Providence St. Joseph Health (PSJH). The CHNA Steering Committee began meeting in March, made up of representatives of the Benton-Franklin Health District (BFHD), Kadlec Regional Medical Center (Kadlec), Trios Health (Trios), Lourdes Health (Lourdes), Prosser Memorial Health (PMH), and the Benton-Franklin Community Health Alliance (BFCHA). PSJH Community Health Investment staff provided invaluable technical assistance including a Spanish-speaking facilitator and qualitative data analysis.

As a result, the 2019 CHNA reflects the health of the community in different ways. The numbers (quantitative data) often tell only part of the story. We were able to flesh out our understanding of the numbers with a formal analysis of the quality of the data by reviewing body language, tone, and frequency of key words/concepts in our interviews and listening sessions. This gives us a much fuller understanding of the needs of our bi-county community.

RESULTS:

Over fifty representatives including public health, hospital and health systems, behavioral health, community service organizations, first responders, business and education gathered for facilitated compression planning session to review and reflect on the data, identify important issues and come to agreement on the critical priorities for change. The three priorities are behavioral health challenges, access and cost of all healthcare and social determinants of health. Social determinants of health are the conditions in the communities where people live, learn work and play. Including them as a priority reflects the growing recognition that factors such as housing, transportation, poverty and even discrimination play an important role in overall health and well-being.

Behavioral Health Challenges

Access and Cost of All Health Care

Social Determinants of Health

HEALTH EQUITY

Health Equity works to optimize conditions so that everyone in the community has the opportunity to attain their highest level of health and achieve positive health outcomes. Health outcomes are influenced by a multitude of factors other than genetics and biology, including behavioral, environmental, and social factors. These external factors, known as **Social Determinants of Health** (SDOH) include housing, education, income, healthcare, public safety, and food access. Race, culture, and gender identity are forces in determining how these social determinants are distributed.

Certain population groups are disproportionately impacted by these factors and are, therefore, at a higher risk of various negative health outcomes and adverse health disparities. **Health Disparities** are differences in health status between groups of people related to factors such as race, gender, income, or geographic region. It is important to recognize that differences in health status related to race, culture, and gender identity may, in fact, reflect systematic inequities in how social determinants like housing, food access, and education are distributed.

The CHNA steering committee made intentional efforts to utilize disparities data during the CHNA process. The steering committee worked to ensure there were a variety of stakeholder interviews and listening sessions for various demographic groups either highlighted in the *2018 Disparities Report* published by BFHD or recognized as historically marginalized groups. Some of these priority populations included the elderly, people of color, people who identify as LGBTQ+, people with low-incomes, people experiencing homelessness, and people living with disabilities. This also led to a greater effort to increase the number of Spanish-speaking sessions offered which resulted in three separate Spanish-speaking listening sessions with a Spanish-speaking facilitator and notetakers present.

EQUALITY
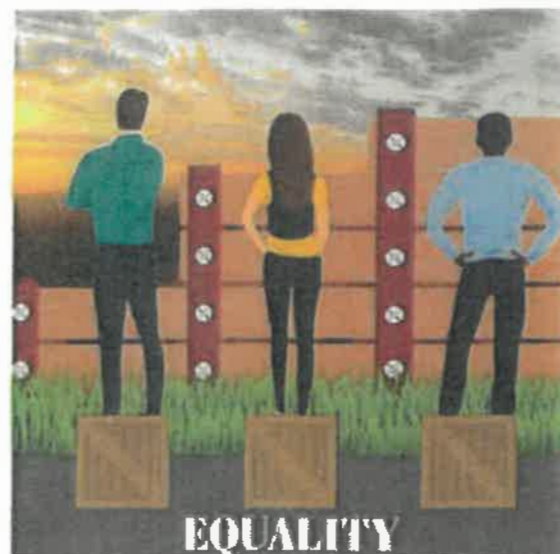
Everyone receives **equal** treatment; assumes everyone benefits from the same supports.
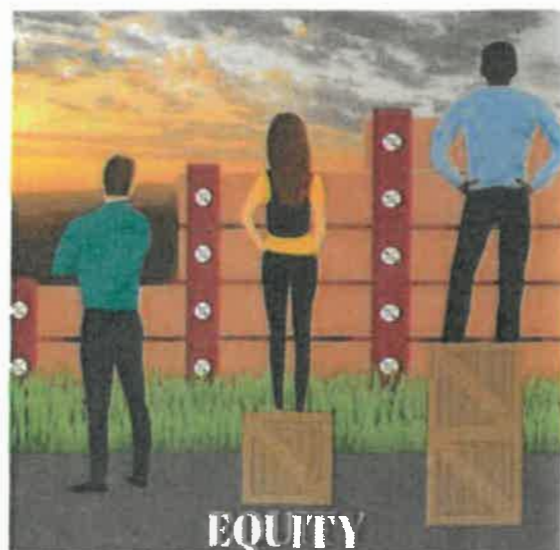
EQUITY

Everyone receives **equitable** treatment is when everyone gets the supports they need.

BARRIER REMOVAL
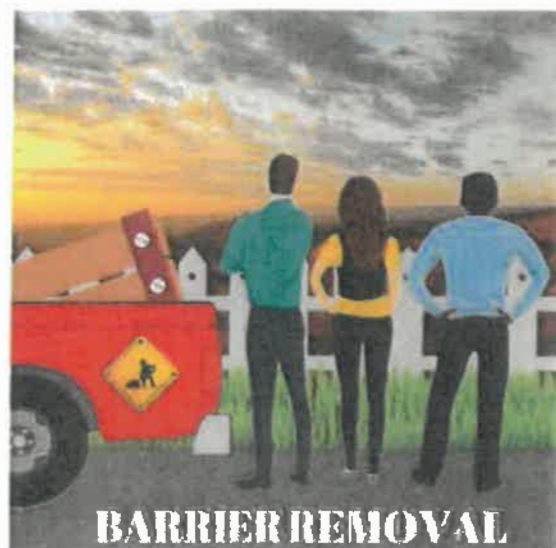
When the systemic **barriers are removed**, everyone can see without supports.

OUR COMMUNITY

Benton and Franklin Counties, located in south-central Washington, have a total population of approximately 290,000 people. Each of the three main municipalities that make up the Tri-Cities are located within one of these two counties; Kennewick and Richland within Benton County and Pasco within Franklin County. There are numerous other smaller cities located within this jurisdiction including Prosser, Connell, Eltopia, Benton City, West Richland, Finley, Mesa, Basin City, and Kahlotus.

The population estimates for the cities and towns within Benton and Franklin Counties in 2019:
- Benton City: 3,520
- Connell: 5,500
- Kahlotus: 165
- Kennewick: 83,670
- Mesa: 495
- Pasco: 75,290
- Prosser: 6,145
- Richland: 56,850
- West Richland: 15,340

Given these numbers, the estimated population of residents living in unincorporated areas in either county (ex: Finley, Eltopia, Basin City) is 43,000 people.

While the population remains predominantly white, there is a substantial Hispanic/Latinx population that has more than doubled over the past two decades.

Race	Benton County	Franklin County
White	70%	39%
Hispanic (as a race)	22.5%	55.5%
Black	1.5%	1.5%
American Indian/Alaskan Native	.5%	.5%
Asian	3%	2%
Multi-race	2.5%	1.5%

Approximately 41,000 people living in the bi-county region are foreign born, regardless of citizenship status, and 30% of households report English is not the primary language spoken in the home.

The age distribution for Benton and Franklin Counties is approximately:
- 0-17 years: 28%
- 18-34 years: 22%
- 35-64 years: 37%
- 65+ years: 13%

Sources:
Washington State Office of Financial Management
Benton-Franklin Trends
Community Health Assessment Tool (CHAT)

Photo Credit: J.D.S/Shutterstock

Counties

Primary service area

Secondary service area

The map below illustrates the approximate hospital service area of the four local healthcare systems in the region: Kadlec Regional Medical Center (Kadlec), Trios Health (Trios), Lourdes Health (Lourdes), and Prosser Memorial Health (PMH).

The bi-county region is also considered to be a health care provider shortage area for primary care providers, mental health providers, and dental providers, meaning there are not enough providers for the population size, geographic location, or facility type. Franklin County is also considered to be a medically underserved area which the federal government classifies as an area that has too few primary care providers, high infant mortality, high poverty, or a high elderly population. These definitions and more information can be found on the website for the Health Resources & Services Administration (HRSA).
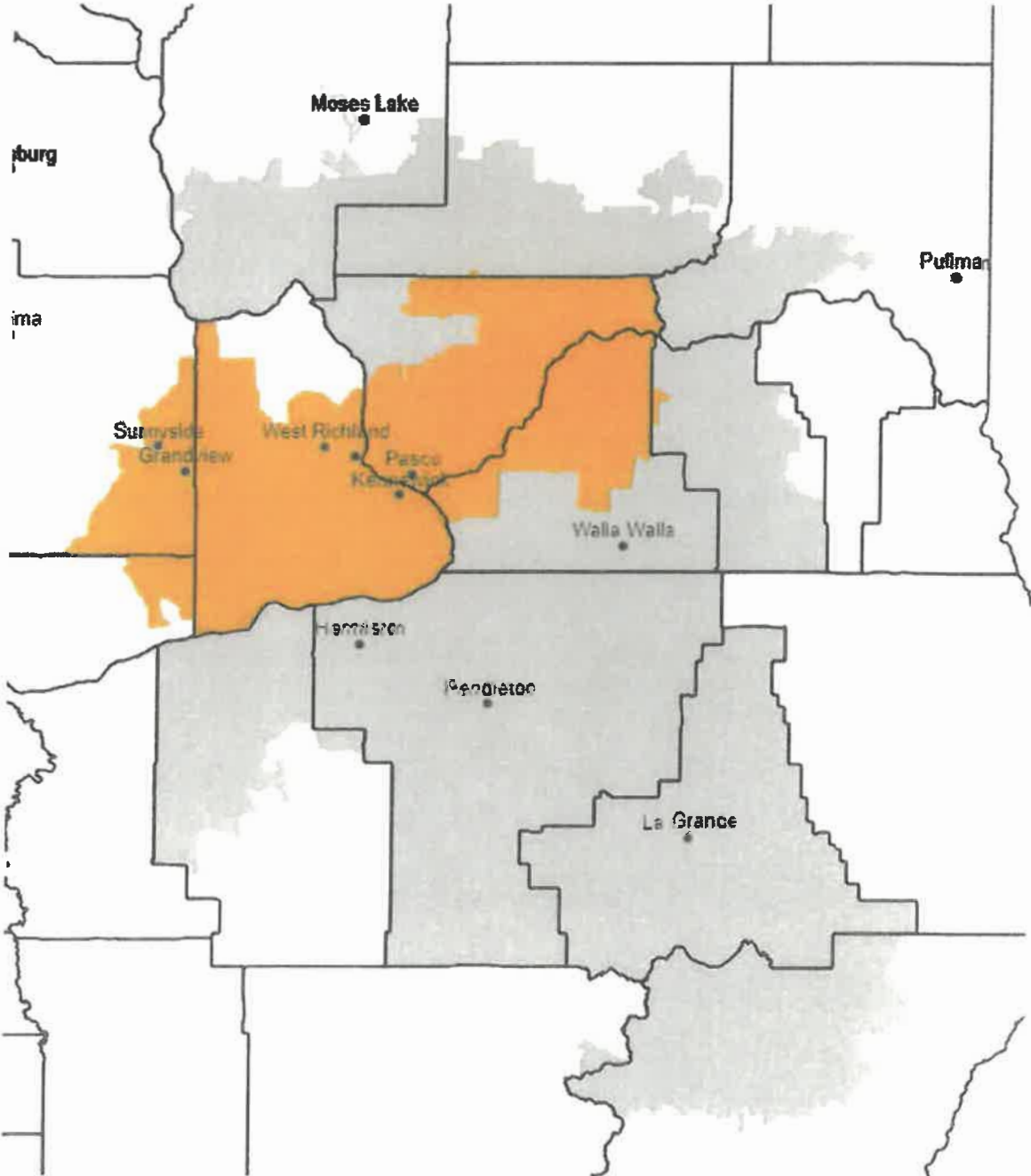
2017 CHIP ACCOMPLISHMENTS

The updated 2016 CHNA resulted in three priority issues to be addressed by the 2017 Community Health Improvement Plan (CHIP). These priorities were:

- Improve access to health care
- Reduce obesity and diabetes rates
- Improve the mental/behavioral health system

Each priority issue was assigned related goals, along with SMART objectives (Specific, Measurable, Achievable, Realistic, and Time-Bound) to support those goals.

Improve Access to Health Care

The priority issue related to access to health care was broken up int three goals:
- Resources will be identified to reduce barriers and costs of health care
- The community will experience coordinated health care
- The health care delivery system will have the capacity to meet the needs of the community.

To achieve these goals, community partners surveyed the populatior over the course of two years to fully understand the local barriers tc health care, increased the number of Community Health Workers (CHW), expanded enrollment of uninsured citizens onto health care coverage through the Washington Health Benefit Exchange, increased the number of partners distributing community education and engagement materials (rack cards, booklets, etc.), and increased dentist interactions with providers and the community through the annual Eastern Washington Medical-Dental Summit.

The goal of improved access also ties heavily into health equity. To address this, Kadlec has expanded its Family Medicine Residency Program that includes rotations with a local clinic that provides primary care for the uninsured. Prosser Memorial Health (PMH) made similar efforts to increase outreach to under-served populations in need of primary health care with their Community Paramedic Program that resulted in over 600 free home visits to community members in 2018 alone.

Reduce Obesity

The priority issue of reducing obesity and diabetes rates was also divided into three goals:
- Community members will be more physically active
- Adults will make more nutritious food choices
- Promote breastfeeding and improve child nutrition

To achieve these goals, the Benton-Franklin Health District (BFHD) has been working in partnership with local schools to implement Safe Routes to Schools programs and support local cities with enacting Complete Streets policies for new commercial and residential development. Both of these programs are nationally recognized ways to improve access and encourage more physical activity. The Health District has also led the community in breastfeeding best practices through partnerships with local hospitals aimed at eventually applying for the Breastfeeding Friendly Washington status and by operating a peer counseling program through WIC that has received state recognition and awards for excellence.

PMH has supported local farmer's market events to promote healthy eating and hosted free events promoting breastfeeding that provided in-person provider support for breastfeeding patients. Kadlec has partnered with more than 30 area schools to offer a free program that teaches health and wellness information to school-age children.

Improve the Mental/Behavioral Health System

The priority issue of improving the mental/behavioral health system was assigned three goals:
- Create more awareness about whole person health, including behavioral/mental health
- Work to eliminate gaps in the system
- Improve integration and coordination of services

BFHD has partnered with Kadlec and other community partners to host community events such as a lockbox giveaway for storage of handguns. BFHD and Kadlec have also been active in offering various community trainings related to behavioral health including Signs of Suicide, Youth Mental Health First Aid, and Adult Mental Health First Aid. Local partners and businesses have worked hard to stand up the first syringe exchange program in the bi-county region and expand treatment services for those with substance use disorders. Lourdes began working with local law enforcement in Richland, Kennewick, and Pasco to establish mobile outreach teams. This program pairs mental health professionals and counselors with local law enforcement officers in order to respond immediately to any calls with a mental health component. This innovative approach is another example of health equity work in action; a program specifically aimed at serving populations who are often outside the traditional health care system, or those who struggle with access to care.

BFHD also hosted a summit in 2018 that brought together community partners to do compression planning around the topic of youth suicide. Priority issues were identified and potential solutions were outlined in the community work plan.
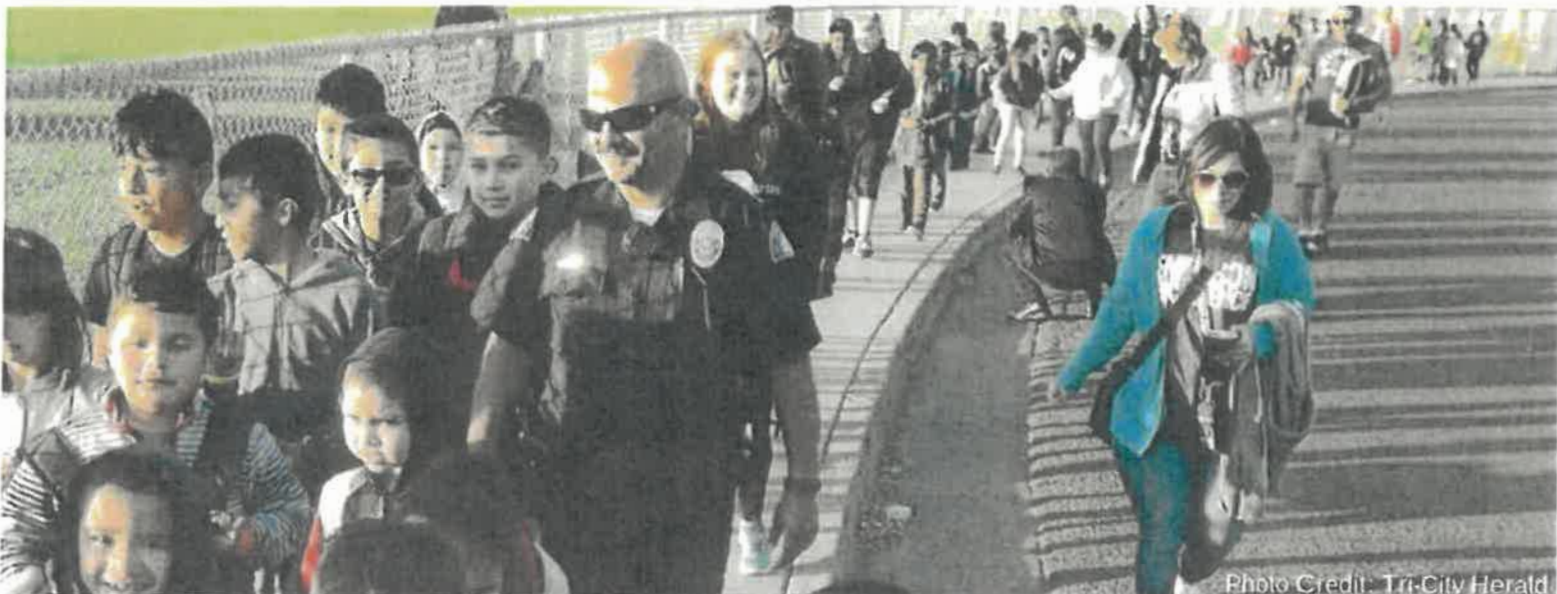
Photo Credit: Tri-City Herald

METHODOLOGY

The steering committee consisted of representatives from all the local health care systems (Kadlec Regional Medical Center, Trios Health, Lourdes Health, and Prosser Memorial Health), the Benton-Franklin Community Health Alliance (BFCHA), and the Benton-Franklin Health District (BFHD). The steering committee was formed in March 2019 and began meeting weekly shortly thereafter. From the members on the steering committee, only one person, the Health Officer from BFHD, had been involved in the previous CHNA process from 2013 and the update in 2016. The group decided to use a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) guidance model promoted by the National Association of County and City Health Officials (NACCHO).

Local Health Status Indicators

Health related data points were identified using the list from the stakeholder survey, the previous 2013 and 2016 CHNA data books, and based on priority issues highlighted by community members and stakeholders. These data points make up the **Local Health Status Indicators**. The Performance Management team from BFHD then compiled the list of desired data points and determined which ones could be supported by a reliable source. Sources used during this process included the Healthy Youth Survey (HYS), Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), Office of the Superintendent of Public Instruction (OSPI), Department of Education, American Community Survey (ACS), and partner-collected data from the local healthcare systems and community organizations. Using all of these sources, the BFHD epidemiologist compiled the most current data on 120 individual data points into a 2019 Data Workbook to bring back to the steering committee for consideration.

Community Input

Qualitative data, or data in the form of words instead of numbers, provides additional context and depth to the CHNA that may not be fully captured by quantitative data. Qualitative data was gathered in an attempt to gain insightful and equitable **Community Input**. This took a significant amount of time and effort in the form of listening sessions with members of priority populations and stakeholder interviews and surveys with those who serve these populations. Based on feedback from the Public Health Officer who participated in the CHNA process in 2016, the steering committee identified community input and involvement as an area of opportunity for improvement. The group wanted to be more intentional about incorporating health equity into this engagement process. One way in which this was accomplished was by utilizing existing tools, like the *2018 Health Disparities Report* published by BFHD. This report helped to inform the ultimate decisions on which priority population groups would be a primary focus for the listening sessions, specifically highlighting the Hispanic/Latinx and the LGBTQ+ communities. Another way the group sought to be more inclusive was to offer multiple listening sessions in Spanish, the other predominant language in Benton and Franklin Counties besides English. A facilitator provided by PSJH was able to conduct three of the 10 listening sessions

completely in Spanish with Spanish-speaking notetakers present at all of them. Finally, the steering committee worked diligently to ensure a wide variety of sectors and populations were represented in the 16 stakeholder interviews including representation from the following population and sector categories: behavioral health, homelessness, healthcare, senior population, Hispanic/Latinx population, domestic and sexual violence, first responders, substance abuse, Pre-K-12th grade education, post-secondary education, LGTBQ+ population, refugee population, and persons living with a disability population. The sessions were typically recorded with participant permission, and one or two notetakers were present to capture response information. Data from all of the stakeholder interviews and listening sessions was sent to a qualitative data analyst provided by PSJH for review and analysis.

In an effort to include input from as many community partners as possible, the steering committee opted to disseminate the stakeholder survey from the stakeholder interview packets. An electronic copy was created to distribute through email distribution lists from BFHD, the hospital partners, and BFCHA. Paper surveys were also distributed to 20 coalitions, boards, or community partner agencies. Over 200 survey responses were received and analyzed as part of the **Community Input** data section.

Photo Credit: Prosser Memorial Health

LOCAL HEALTH STATUS INDICATORS

Since the Steering Committee chose to utilize the survey provided in the stakeholder interview packet, the Performance Management Department at BFHD identified 120 individual indicators that fit within one of the 26 categories outlined in the survey. From there, the Steering Committee compared those 120 indicators with the state numbers and kept only the data points for which the local numbers were performing worse than Washington state as a whole. Members then compared this list of remaining data points to the overarching qualitative data themes from the community input and included a handful of indicators where local performance was better than the state's overall, but still a concern to this community. This resulted in approximately 70 indicators that fit within nine overarching topic areas. The following tables list these indicators, followed by a (B), (F), or (B&F) to indicate if the data point is specific to Benton, Franklin, or both Benton and Franklin Counties.

Obesity

Indicator	Local Rate	WA State Rate
Breastfeeding at birth as noted on birth certificate	89% (B&F)	94%
Exclusive breastfeeding while in hospital	Kadlec: 42-51% Trios: 38-46%	51-53%
Breastfeeding 6 month duration among WIC clients	45% (B&F)	51% (2017)
Children (1-5) in the top 15% BMI enrolled in WIC	27% (B&F)	25%
Teens in the top 15% BMI	16% (B&F)	14%
Adults 18+ who have a BMI of 30 kg/m2	33% (B&F)	28%

Physical Health

Indicator	Local Rate	WA State Rate
Adults reporting excellent or very good health status	49% (B&F)	53%
Adults who have been told they have asthma by a doctor	14% (F)	13%
Adults who have had a stroke	3%	3%
Hospitalization rate due to chronic obstructive pulmonary disease and bronchiectasis	154.16/100,000 (B&F)	87.44/100,000
Adults who have been told by a doctor they have diabetes	10% (B&F)	9%
Rate of unintentional injury hospitalizations	470.71/100,000 (B&F)	435.16/100,000

Suicide and Mental Health

Indicator	Local Rate	WA State Rate
Suicide rate - overall	20.11/100,000 (B&F)	17.1/100,000
Youth suicide rate (10-17)	5.54/100,000 (B)	4.69/100,000
Young adult suicide rate (18-24)	17.7/100,000 (B)	16.43/100,000
Suicide rate (65+)	23.3/100,000 (B&F)	19.58/100,000
Youth suicide ideation	23%* (B)	23%
Youth suicide planning	19% (B)	18%
Hospitalization from self-harm	6.39/100,000 (B&F)	10.09/100,000
Youth depression	40%* (B&F)	40%
Adults reporting 14 poor mental health days a month	15% (B&F)	12%

* indicates that other grade levels had larger differences from the state level data

Sexual and Reproductive Health

Indicator	Local Rate	WA State Rate
Youth who did not use a condom last time they had sex	48% (B&F)	47%
Youth who did not use any form of contraception last time they had sex	26% (B&F)	22%
Teen birth rate	11.6/1,000 (B&F)	7.2/1,000
Rate of reported cases of gonorrhea	142.81/100,000 (F)	137.09/100,000
Rate of reported cases of syphilis	13.02/100,000 (B&F)	16.97/100,000
Rate of reported cases of chlamydia	3,623/100,000 (B&F)	2,950/100,000
Percent of reported chlamydia cases that were treated	91% (B&F)	96%
HIV test done in the past 5 years	18% (B&F)	22%

Violence and Community Safety

Indicator	Local Rate	WA State Rate
Youth who have been bullied	20%* (B&F)	19%
Youth feel safe at school	78%* (B&F)	79%
Domestic violence - overall	761.65/100,000 (F)	742.71/100,000
Domestic violence - youth	10% (B&F)	11%
Physical abuse by an adult - youth	24% (B&F)	25%
Verbal abuse by an adult - youth	15% (B&F)	15%
Child abuse and neglect rate	39/1,000 (B)	37.8/1,000
Reported sexual assaults – overall	125.4/100,000 (B&F)	91.6/100,000
Sexual assault – youth	18%* (B&F)	19%
Youth witnessed sexual assault	32%* (B&F)	31%
Youth gang involvement	6% (B&F)	6%
Youth arrests	42.3/1,000 (B&F)	8.8/1,000
Youth drug related arrests	6.5/1,000 (B&F)	2/1,000

* Indicates that other grade levels had larger differences from the state level data

Substance Abuse

Indicator	Local Rate	WA State Rate
Youth alcohol use	18%* (B&F)	19%
Youth Rx drug abuse	4%* (B&F)	4%
Youth cigarette use	5% (B&F)	2%
Youth E-cigarette use	22% (B)	21%
Youth marijuana use	16%* (B&F)	18%
Opioid overdose hospitalization	19.86/100,000 (B&F)	17.73/100,000
Opioid overdose deaths	8.6/100,000 (B&F)	9.25/100,000
Opioid Prescribing rates	89.9/100 (B)	(57.2/100)

* Indicates that other grade levels had larger differences from the state level data

Homelessness and Poverty

Indicator	Local Rate	WA State Rate
Population experiencing food insecurity	9% (B&F)	12%
Youth living outside parent's home	11%* (B&F)	11%
Elderly living in poverty	9% (F)	8%
People living at or below the federal poverty level	13% (B) & 16% (F)	12%
Families living at or below the federal poverty level	16% (B) & 19% (F)	13%
Population living in a food desert	9% (B&F)	10%

* Indicates that other grade levels had more significant differences from the state level data

Access to Health Care

Indicator	Local Rate	WA State Rate
Adults with health insurance	83% (B&F)	87%
Adults with a personal doctor	72% (B&F)	74%
Adults who have visited a dentist in the past 1-2 years	77% (B&F)	80%
Primary Care Provider (PCP) to population ratio	F: 4100:1 | B: 1470:1	WA: 1220:1
PCP (non-physician) to population ratio	F: 2047:1 | B: 1071:1	WA: 1171:1
Mental Health Provider to population ratio	F: 780:1 | B: 470:1	WA: 310:1
Access to nearby medical facilities	NA	NA

Aging Issues

Indicator	Local Rate	WA State Rate
Hospitalizations for falls – Adults 65+	2,239.35/100,000 (B&F)	1,823.09/100,000
Death rate from Alzheimer's disease	70.72/100,000 (B&F)	45.41/100,000

COMMUNITY INPUT

The CHNA steering committee recognizes the value in having community members and community stakeholders participate in the CHNA process and share their perspectives. As the people who live and work in the counties, they have firsthand knowledge of the needs and strengths of their community. To gather these perspectives, the steering committee conducted listening sessions with community members and surveyed or interviewed community stakeholders.

Listening Sessions

Ten listening sessions were completed with a total of 96 community members. Participants shared their vision for a healthy community, the health-related needs of their community, and the assets that currently help their community be healthy. Following are the dominant themes from the sessions:

- **Community members' vision for a healthy community**
  - People are outside playing, walking, and being active
  - The community is diverse and inclusive, where all people can live well
  - Community members feel safe and kids can play freely
  - People spend time together and take part in social events
  - Local health care services are accessible and affordable
  - People take care of one another, especially those who most need support
- **Health-related needs of the community**
  - Affordable medical care, dental care, and prescriptions, specifically low-cost or free
  - Timely, convenient, and local medical care
  - Resources for people who need help and increase knowledge of local resources
  - Affordable mental health services that are responsive to people's unique needs
  - Shelters and services for individuals experiencing homelessness
  - Safe, affordable, clean housing, especially for individuals with low-incomes
  - Increased community safety
- **Community strengths and assets**
  - Community resource fairs and financial assistance programs
  - Multiple local hospitals and access to free medical services
  - Educational opportunities for adults and children
  - Access to healthy and fresh food
  - Community openness to diversity and people's unique needs
  - Close proximity to natural resources and activities
  - Opportunities for people to exercise outdoors and be physically fit
  - Good transportation services

Community Stakeholder Surveys

The CHNA steering committee wanted to include as many opportunities for input from stakeholders as possible. They surveyed 256 stakeholders to provide additional insight into the prioritization of health-related needs. Stakeholders were asked to identify their top five health-related needs in the community. Stakeholders prioritized one health-related need substantially above the others: behavioral health challenges, including both mental health and substance use disorder. After this need, two more needs were given high priority and tied for importance: access to behavioral health services and homelessness and housing instability. These top three health-related needs mirror those of the stakeholders who completed interviews. The top three health-related needs are summarized as follows:

- Behavioral health challenges
- Access to behavioral health
- Homelessness and housing insecurity

Community Stakeholder Interviews

The steering committee completed 16 community stakeholder interviews, including 40 stakeholders, or people who are invested in the well-being of the community and have firsthand knowledge of community needs and strengths. Stakeholders were asked to rank the unmet health-related needs of their communities. For those identified needs, stakeholders shared which populations are most affected by the needs, gaps in community services to address the need, and barriers to services for community members. The top three unmet health-related needs identified by stakeholders were classified as high priority. The next three unmet-health related needs were classified as medium priority. Stakeholders were also asked to identify community assets that help make the community healthier and opportunities they see for community organizations to better work together

High Priority Unmet Health-Related Needs

- Behavioral health challenges (includes both mental health and substance use disorder): Stakeholders were concerned about the high amount of substance abuse in the community and lack of treatment options. Additionally, they were concerned about youth mental health and rising youth suicide. They identified people experiencing homelessness, young people, older adults, veterans, and individuals who identify as LGBTQ+ as more affected by behavioral health challenges. Stakeholders named stigma and a lack of funding for treatment as barriers to addressing this issue. They saw mental health services in schools and integration of behavioral health screenings in primary care as gaps in services.

- Homelessness/lack of safe, affordable housing: Stakeholders identified housing as foundational to addressing all other health-related needs. They spoke to needing more shelters, affordable housing, transitional housing, and resources to support people experiencing homelessness. They specifically identified young parents, transgender people, women, people with substance abuse disorder, people leaving domestic violence, young people, and families with low-incomes as particularly affected.

- Access to behavioral health care: Stakeholders were particularly concerned about not having a detox center or an inpatient treatment center in Benton and Franklin Counties. Additionally, they shared that a lack of mental health providers and lack of affordable mental health care contributes to the behavioral health challenges.

Medium Priority Unmet Health-Related Needs

- Access to medical care: Stakeholders shared that the complexity of the healthcare system is a barrier to people getting the medical care they need. They stated there are currently not enough providers in the area, particularly specialists, contributing to long wait times for appointment. Specifically, there are gaps in medical care for veterans, people identifying as LGBTQ+, and people who are undocumented.

- Domestic violence, child abuse/neglect: Stakeholders were concerned about the long-term impact child abuse has on children's healthy development, as well as the interaction between domestic violence and other issues such as substance abuse and homelessness. Teen girls, individuals identifying as LGBTQ+ and/or people with disabilities were identified as groups disproportionately affected by violence Stakeholders saw safe places for children currently in dange and community spaces for survivors of domestic violence to support one another as gaps in community services.

- Aging problems (such as memory, hearing, and vision loss): Stakeholders felt their community is aging and the current support services are not sufficient to meet the growing need To better meet this need, stakeholders stated Benton and Franklin Counties need a memory care unit, more geriatric providers, and more caregiver support groups. Additionally, stakeholders shared there needs to be more education around healthy aging, dementia, and Alzheimer's for the general community and providers.

"We got a lot of organizations in town that, while they're doing great things, they think they're the only kids on the block or are the only ones that can do it or they're doing it the most perfect way and it ends up siloing everybody involved, whether it's community members or other organizations."
– Community Stakeholder

Stakeholders were asked, "What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve?" Participants named a variety of organizations, programs, and local services they see as a community strength (See Appendices for a full list). The most shared themes were as follows:

Opportunities for Community Organizations to Work Together

- More collaboration and less competition: Stakeholders shared they need more opportunities to collaborate with one another. They see the current coalitions as a strength and think there need to be more opportunities to learn from one another and collaborate on solutions.

- Communication and relationship building: Stakeholders named numerous community organizations and programs that are currently working to meet health-related needs, but there is little communication between them. They would like to see more relationship building among organizations and sharing of up-to-date information and resources.

Community Strengths and Assets

- Collaboration between organizations and coalitions to address needs: Opportunities for organizations to work together and leverage their unique strengths were highlighted as a community asset.

- Innovative approaches to addressing behavioral health challenges: Programs such as the Trueblood Program and the Mental Health Court are working to provide support to individuals whose mental health impacts their criminal behavior.

- Providing services in schools: 3 Rivers Wraparound with Intensive Services (WISe) and Communities in Schools are providing supports and access to services to students in schools, addressing behavioral health challenges and other needs.

"We also have a couple of really great community organizations that are doing a lot of that coordination and laying over like Communities in Schools. That's been a tremendous boon to all of our school districts that have access there. And every school in the district wants a site coordinator because it allows education folks to do education and then all of those systemic barriers that our families in poverty are often facing, there is somebody that can help coordinate those community services for them. " – Community stakeholder

Photo Credit:

Data Blending

Community members and stakeholders identified many of the same health-related needs as priorities. The specifics of the need may have varied slightly. An overview of the health-related needs of both community members and stakeholders blended together is as follows (in no particular order):

Behavioral Health Care (access to and challenges)

Both groups identified the importance of having affordable mental health services available, particularly for youth and people identifying as LGBTQ+. Both groups identified stigma as a barrier to addressing behavioral health challenges and noted a need for more mental health providers. Stakeholders emphasized a need for substance use disorder treatment and a detox center.

Homelessness/Safe, Affordable Housing

Both groups shared a need for more shelters, more low-income housing for families, more affordable housing for older adults, and more resources (such as showers and laundry facilities) for people experiencing homelessness. Community members emphasized wanting good quality, clean homes. Stakeholders identified a need for more transitional housing and wet shelters.

Access to Medical Care

Both groups identified a need for more specialists and primary care providers to increase access to appointments. Both groups identified a need for more accepting medical services for LGBTQ+ individuals and more affordable services for people who are undocumented. Stakeholders emphasized the need for patient advocates to help navigate the complexity of the health care system, while community members emphasized the need for more affordable care, including dental care.

Community Safety and Child Well-Being

Both groups were concerned with the well-being of children and their safety, as well as the importance of schools in meeting children's social-emotional needs. Community members were most concerned with gang violence in their community, while stakeholders emphasized a concern for domestic violence.

Aging Problems

Both groups acknowledged a need for more specialists and services for older adults, especially those living alone in their homes. Stakeholders were especially concerned about access to services for people with varying forms of dementia, such as Alzheimer's disease, and saw a need to better educate community members on local resources related to aging issues.

PRIORITIZATION PROCESS & CRITERIA

The steering committee chose to evaluate the **Local Health Status Indicators** by comparing them to Washington State rates. Data points that were worse than the state numbers for Benton, Franklin, or Benton and Franklin combined were identified first. The data points were then narrowed down further by the steering committee by considering other factors like change over time, comparison to target numbers outlined by *Healthy People 2020*, and the severity of the difference between the local and state numbers. These data points were then grouped into like categories of overarching topics and the steering committee added additional data points related to each topic and based on the priority issues highlighted through **Community Input**, regardless of local numbers vs state numbers, to present a more complete picture. This resulted in a list of approximately 70 data points categorized into nine topic areas: obesity, physical health, mental health and suicide, substance abuse, homelessness and poverty, aging issues, community violence and safety, access to health care, and sexual and reproductive health.

Community Compression Planning

The steering committee then scheduled a community partner compression planning session to which they invited agencies and partners from their respective distribution lists and specifically invited partners who participated in listening sessions and stakeholder interviews. The compression planning session was held in July 2019 at the location of the normally occurring BFCHA meetings with a professional facilitator. Over 50 representatives from community partners and agencies attended the compression planning session and participated in prioritization activities. Participants included representation from health care networks, local clinics, public health, first responders, behavioral health, long term care facilities, local chambers of commerce, student nursing programs, and other service-oriented community-based organizations. Participants reviewed the 70 data points in a small group discussion format. Participants were also provided visual aids that indicated whether a data point was worse than the state number, identified by community members and partners as an issue, or selected previously as a health priority in the prior CHNAs from 2013 and 2016. Each group shared the data points that were significant to their group and lumped like data points together based on overarching themes, resulting in seven priority health issue topics: obesity, youth sexual and reproductive health, violence and community safety, social determinants of health, behavioral health challenges, access and cost of all health care, and aging and long term care issues. Participants then proceeded to select their top three priorities. This resulted in three issues rising to the top as clear priorities, three falling to the bottom, and one mid-range priority. Participants selected the top three priority issue topics:

- Behavioral Health Challenges
- Access and Cost of All Health Care
- Social Determinants of Health

Photo Credit: Benton-Franklin Health District

Disparities Data

One thing that was clear from the majority of stakeholder interviews, community listening sessions, data review, and compression planning discussions was that not all population groups are affected by these health issues equally. Some population groups, specifically the elderly, youth, and LGBTQ+, experience additional barriers, challenges, or negative health outcomes related to the top three health needs.

Some of these challenges were brought to light in qualitative data from the listening sessions or stakeholder interviews. For example, access to healthcare is an issue for many residents regardless of demographic group, as evident by the provider to population ratios in the area. If someone requires more specialized care, like members of the LGBTQ+ community, living in an area that is already experiencing a healthcare provider shortage makes finding someone who is qualified and able to provide services to them even more difficult.

Other challenges and outcomes were quite apparent in the quantitative data from the local health status indicators. For example, young adults and, even more so, the elderly population, show alarming rates of suicide deaths when compared to other age groups.

These kind of clear disparities in health outcomes and challenges should not be ignored and need to be addressed with targeted interventions. The steering committee, therefore, intends to incorporate these population groups into the upcoming Community Health Improvement Plan, with focused objectives and activities aimed at better addressing the needs of these specific demographic groups.

Public Discussion

The steering committee also wanted to include the general public in the CHNA process and health priorities discussion. They chose to host a Facebook Live event with Dr. Amy Person, a member of the steering committee, to review the three priority health issues and answer questions from community members. Leading up to the event, the steering committee shared advertisements on their social media platforms and sent out invitations to community partners. A summary of the top three health priorities was published on the BFHD website for the community to view before the event and a link was provided for the public to submit questions ahead of time.

The Facebook Live event was held in August 2019 and was viewed and shared from the Benton-Franklin Health District's Facebook page. It also included an incentive for community members to share the video, resulting in 25 shares and over 850 views from just BFHD's Facebook page. Dr. Person answered several submitted questions from the public and walked the audience through the selection process and results with help from visual aids and a Kadlec staff member conducting the interview.

Photo Credit:

> *"I would just be repetitive in saying that addiction is a real disease and yet we don't treat people who are addicted like we treat other sick people. We treat them like outcasts and throwaways and bad people."*
> – Community Stakeholder

FINDINGS: 2019 PRIORITY HEALTH NEEDS

The priority health needs identified through the 2019 CHNA process are as follows:

Behavioral Health Challenges

Access and Cost of all Health Care

Social Determinant of Health

Behavioral Health Challenges

The compression planning group identified this topic as one of the most important unmet health-related needs in the community. Local health status indicators support this as a community issue, as well community input from the Stakeholder Interviews and Listening Sessions. The compression planning participants grouped mental health, suicide, and substance use disorder under this topic.

Stakeholders agreed that mental health needs are so important because they affect almost every population. Groups named as being especially affected by mental health challenges were the following:

- People experiencing homelessness (adults and youth)
- Young people (ranging from elementary school through high school)
- Older adults
- Veterans
- Individuals who identify as LGBTQ+

Participants highlighted the complexity of this issue, stating that these groups often overlap with one another. For example, a person may be experiencing homelessness and also be a veteran or LGBTQ+. Youth were specifically mentioned by multiple stakeholders as a group that has unmet mental health challenges due to exposure to violence and content related to suicide online. Adverse Childhood Experiences (ACEs), such as abuse and neglect, were also cited as strong contributors to mental health issues and substance use disorder later in life. Many stakeholders also mentioned the lack of treatment options and detox facilities, as well as the continuing stigma towards people who use drugs, as a gap in the community that has perpetuated the issue of substance use disorder.

Access and Cost of all Health Care

The compression planning group identified this topic as a priority issue from the previous CHNA that needed to be continued and expanded in this iteration. In the 2013 CHNA, insurance enrollment was a focus under the access priority, but after systematic changes at the federal level that resulted in higher insured rates, the focus for the 2019 CHNA has been shifted. The compression planning participants chose to combine the issues of behavioral health care access and access to medical care, since both components are experiencing similar issues. Another area of focus related to access that was highlighted both through community input and the compression planning session was the cost of health care, even with insurance, and how it can be too much of a financial burden for struggling residents. Finally, another significant area of concern for those at the compression planning meeting was the provider to population ratios for the bi-county region. This concern was echoed in the listening sessions

	Benton County	Franklin County	Washington State
Primary Care Provider to population ratio:	1470:1	4100:0	1220:1
Non-Physician Care Provider to population ratio:	1071:1	2047:1	1171:1
Mental Health Provider to population ratio:	470:1	780:1	310:1

with community members expressing frustration and concern about the wait times to see a provider or access to a provider who also has specialization in the unique needs of specific population groups like LGBTQ+ or adults living with disabilities.

Social Determinants of Health

Social Determinants of Health (SDOH) was identified as the third priority issue by the compression planning group. SDOH are external factors that affect one's health besides biology and genetics. Examples of SDOH include housing, education, income, healthcare, public safety, and food access. The compression planning group referenced Maslow's Hierarchy of human needs which asserts that physiological and safety need like a home, food, water, and employment are the most basic, fundamental needs a person requires to survive. Similarly, as the group discussed, these needs are necessary to ensure a person can achieve their greatest level of health and a lack of resources related to these needs affects a person's ability to meet the other health needs addressed in the CHNA. Stakeholders held these same sentiments, arguing that a person who has no home or no food is not going to be able to effectively focus on addressing their mental health challenges or treating their chronic disease. Understanding how these factors are so interconnected to all other health priorities and how broad of a scope SDOH truly is, the compression planning group chose to focus on poverty, housing and homelessness, and food insecurity.

Self-actualization

Esteem

Love and belonging

Safety needs

Physiological needs

"The key to getting people healthy, is keeping them stable and in one location so that they're not, you know, if I have to worry about where I'm going to sleep tonight, probably going to be less concerned about taking that medication or having the ability to go to that doctor to get that medication that I need."
    - Community Stakeholder

COMMUNITY ASSETS & RESOURCES

The listening sessions and stakeholder interviews also gave the steering committee the chance to identify community assets and resources that currently help address these health priorities.

Participants in the listening sessions identified the following aspects of their community as a strength or asset:

- Community resource fairs and financial assistance programs
- Multiple local hospitals and access to free medical services
- Educational opportunities for adults and children
- Access to healthy and fresh food
- Community openness to diversity and people's unique needs
- Close proximity to natural resources and activities
- Opportunities for people to exercise outdoors and be physically fit
- Good transportation services

Participants in the stakeholder interviews identified the following aspects of their community as a strength or asset:

- Collaboration between organizations and coalitions to address needs: Opportunities for organizations to work together and leverage their unique strengths were highlighted as a community asset.
- Innovative approaches to addressing behavioral health challenges: Programs such as the Trueblood Program and the Mental Health Court are working to provide support to individuals whose mental health impacts their criminal behavior.
- Providing services in schools: 3 Rivers Wraparound with Intensive Services (WISe) and Communities in Schools are providing supports and access to services to students in schools, addressing behavioral health challenges and other needs.

Community partnerships are essential in implementing a collective action approach for any community wide level efforts. This CHNA was only possible thanks to the dedication from numerous sectors, agencies, and partners spanning both counties. This list identifies the partner organizations who assisted in the CHNA process through stakeholder interviews, listening sessions, data sharing, compression planning, or completion of the stakeholder survey:

- Adverse Childhood Experiences (ACEs) Collaborative
- Aging and Long Term Care
- Alzheimer's Association
- Amistad Elementary
- A New Start in Life (ANSIL)
- Behavioral Health Committee
- Ben Franklin Transit
- Benton Franklin Community Health Alliance
- Benton Franklin Early Learning Alliance (BFELA)
- Benton-Franklin Health District
- Benton Franklin Recovery Coalition
- Benton Franklin Youth Suicide Prevention Coalition
- Boys and Girls Club of Benton and Franklin Counties
- Chaplaincy Healthcare
- Columbia Basin College (CBC)
- Columbia Basin Veteran's Center
- Community in Schools Benton-Franklin
- Domestic Violence Services of Benton and Franklin Counties (DVS)
- Educational Service District 123 (ESD123)
- Emergency Medical Services (EMS)
- Grace Clinic
- Human Services Coalition

- Kadlec Regional Medical Center
- Law Enforcement/Police Chiefs
- Lourdes Health
- Lower Valley Kiwanis
- My Friend's Place; Safe Harbor
- Parents and Families of Lesbians and Gays (PFLAG)
- People for People; 2-1-1
- Planned Parenthood of Greater Washington and North Idaho (PPGWNI)
- Prosser Memorial Health
- Prosser School District
- Prosser Thrive Coalition
- Senior Life Resources; Meals on Wheels
- Support, Resource, and Advocacy Center (SARC)
- Tierra Vida
- Tri-Cities Cancer Center
- Tri-Cities Community Health (TCCH)
- Tri-Cities Food Bank
- Tri-Cities Residential Services (TCRS)
- Tri-City Regional Chamber of Commerce
- Trios Health
- Lourdes Mobile Outreach Team
- Tri-City Union Gospel Mission
- United Way of Benton and Franklin Counties
- Vintage at Richland
- Washington State University Tri-Cities (WSUTC)
- World Relief
- You Medical

Thank you to all the dedicated members of these agencies and coalitions for their assistance on this project.

GOVERNING APPROVAL

Kadlec Regional Medical Center
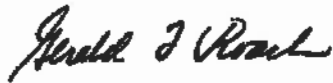
Reza Kaleel

Reza Kaleel, Chief Executive

Jerald J Roach

Jerry Roach, Community Board Chair
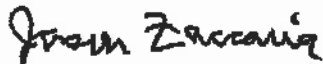
Joel Gilberston

Joel Gilberston, Senior Vice President
Community Partnerships, Providence St. Joseph Health

Benton-Franklin Health District

Jason Zaccaria

Jason Zaccaria, District Administrator

Amy Person

Dr. Amy Person, Health Officer

Trios Health

John Solheim

John Solheim, Chief Executive Officer

Lourdes Health

Rob Monical

Rob Monical, Chief Executive Officer

Prosser Memorial Health

Craig J Marks

Craig J. Marks, Chief Executive Officer

Benton Franklin Community Health Alliance

Kirk Williamson

Kirk Williamson, Program Manager

IV. Internal Assessment

C. Prosser Community Health Needs Assessment

Prosser
Memorial Health

COMMUNITY BENEFIT 2019 REPORT AND 2020 PLAN

At Prosser Memorial Health (PMH), we believe that a healthy and safe community is a strong community. Our commitment to healthier families comes to life in the programs and activities featured in our 2019 Community Benefit Report which meets requirements in Washington State law that not-for-profit hospitals produce an annual community benefit report and plan.

In 2019, PMH provided the following patient financial assistance:

Charity Care Program	$1,671,832
Bad Debt	$4,031,596
Medicaid/Medicare Shortfall	$8,799,638
Total 2019 Uncompensated Care	$14,503,066

2019 Uncompensated Care

■ Charity Care   ■ Bad Debt   ▪ Medicaid/Medicare Shortfall

Prosser
Memorial Health
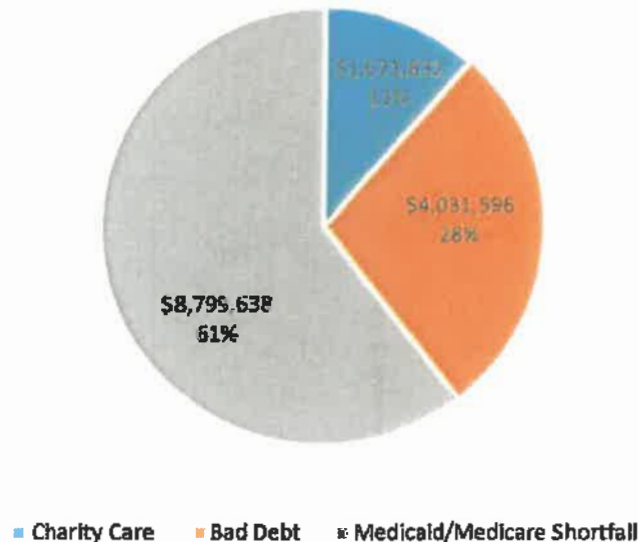
Community Health Needs Assessment

Prosser Memorial Health has a tradition of addressing health service needs and providing benefits to the populations we serve. We continue to prioritize the health and well-being of our communities through our triennial Community Health Needs Assessment (CHNA).

In 2019, PMH participated in the development of the 2019 Benton & Franklin Counties Community Health Needs Assessment in collaboration with the Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Kadlec, Trios Health and Lourdes Health. The CHNA helps determine which critical health needs the community will focus on addressing over the next 3-5 years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin counties, from Prosser to Connell, from Hover to Hanford.

Over fifty representatives including public health, hospital and health systems, behavioral health, community service organizations, first responders, business and education gathered for facilitated compression planning sessions to review and reflect on the data, identify important issues and come to an agreement on the critical priorities for change. The three priorities identified are:

Behavioral Health Challenges

Access and Cost of All Health Care

Social Determinants of Health

Behavioral Health Challenges include mental health, suicide, and substance use disorders. Groups identified as being especially affected are people experiencing homelessness, youth, older adults, veterans and those who identify as LGBTQ.

Access and Cost of All Health Care includes access to behavioral health care and medical health care as well as the ability to pay for care. While insurance enrollment rates have increased due to systemic changes at the federal level, the cost of health care remains a financial burden for many in our community.

Social Determinants of Health are conditions in the places where people, live, work and play that affect a wide range of health risks and outcomes. Significant health-related areas identified include poverty, housing and homelessness and food insecurity.

It is not enough to research ways in which our community's health could be better. As we continue to grow and expand the medical services we offer, we are taking the important data uncovered by the CHNA into account. That way, when we bring in new providers or building new facilities, it is in direct response to a community need.
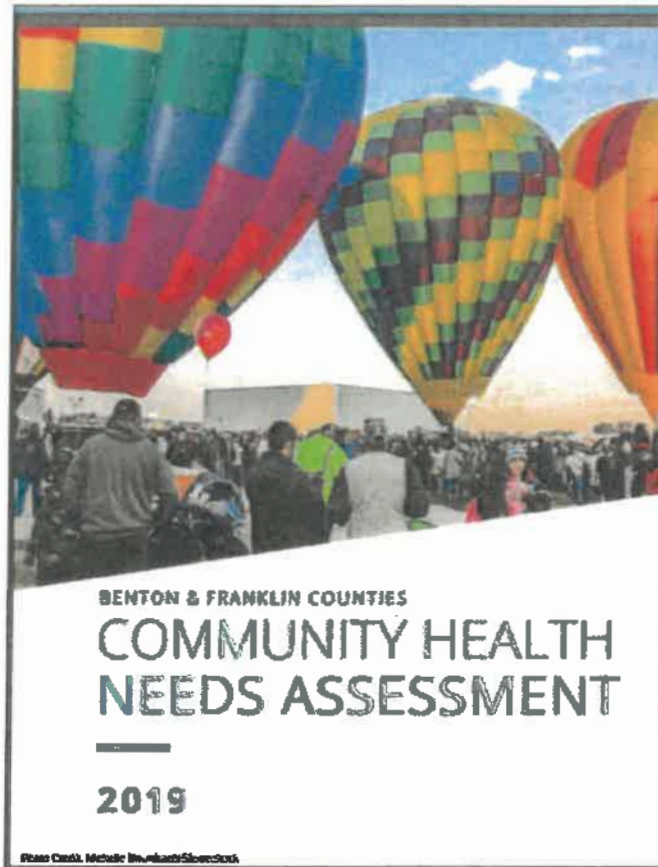
The Community Benefit provided by PMH is far-reaching from making healthcare available for all community residents, educating the next generation of healthcare professionals and supporting community health initiatives through activities and programs that improve access to health services, enhance public health, and advance the community's knowledge.

In addition to the $14,503,066 in Uncompensated Care in 2019, this Community Benefit Report is an important opportunity to highlight the substantial community contributions that PMH made in 2019 to support Behavioral Health Challenges, Access and Cost of all Health Care and Social Determinants of Health.

As a result of the findings of the 2019 CHNA and through a prioritization process aligned with our Mission, resources and hospital strategic plan, PMH has placed focus on the following areas with specific activities targeting the three community health priorities for 2019 and 2020.

2019 Community Benefit Activities

- **Behavioral Health Challenges**
    - Recruitment of Diane Hanks, ARNP (Mental Health)
    - Providers obtained Medical Assisted Treatment (MAT) training to prescribe Suboxone for opioid addiction (Dr. Staudinger and Diane Microulis)
    - Mental health services are provided in all PMH Rural Health Clinics
    - Stop the Stigma (Suicide) Presentation
- **Access and Cost of all Health Care**
    - Schedulers are pre-registering patients as they schedule appointments
    - Opened the Grandview Clinic
    - Expanded Wound Therapy Program
    - Recruitment of the following providers:
        - Dr. Karan Bhatti (Cardiology)
        - Rebecca Warnick, ARNP (Primary Care)
        - Dr. Shem Rode (EM)
        - Dr. Samuel Strebel (Orthopedics)
        - Dr. Heidi Weaver (OB/GYN)
        - Dr. Lindsey Smith (EM)
- **Social Determinants of Health**
    - Diabetes education was provided at the Senior Center
    - Providing care to veterans when they have greater than a two week wait to receive primary care
    - Veterans Day Breakfast
    - Ongoing Community Paramedic visits
    - Annual Health Fair
    - Go Red Health Fair
    - Valley Vista Health Fair
    - Big Latch Event
    - Whitstran Resource Center Literacy Night with Dr. Min
    - Red Cross Blood Drive

2020 Community Benefit Activities Plan

- **Behavioral Health Challenges**
    - Provide psychiatric services including tele-psychiatric services
    - Recruit a Mental Health Counselor (Prosser Clinic)
    - Partner with Prosser Thrive to focus on mental health for local youth
    - Facebook Live Mental and Physical Health
    - Stop the Stigma (Suicide) Presentation
    - Facebook Live on Chronic Pain & Suicide Correlation

- **Access and Cost of all Health Care**
    - Increase current utilization of self-check in
    - Implement at least two additional self-check in options
    - Implement the Provider Recruitment Plan (APCs, MDs and Mid-Wives)
    - Explore e-consult and telehealth options
    - Enhance and expand cardiopulmonary services
    - Enhance the orthopedic surgery program
    - Joint Replacement Lunch & Learn

- **Social Determinants of Health**
    - Create a calendar and promote educational seminars for the community
    - Conduct lunch/breakfast and learns for residents in the community
    - Study the feasibility of providing home health services and implement if appropriate
    - Develop a comprehensive diabetic education program and implement
    - Offer annual Medicare Wellness Exams for Seniors
    - Go Red Women's Luncheon
    - Red Cross Blood Drive
    - Annual Health Fair
    - Veteran's Day Breakfast
    - Diabetes Education Panel
    - Facebook Live Events:
        - Sudden Cardiac Death
        - Concussions
        - Heat Stroke vs. Heat Exhaustion
        - Healthy Aging
        - Women's Health Cancer Screenings
        - Breast Cancer and Mammograms
        - Influenza

Prosser
Memorial Health

2020 Uncompensated Care Budget/Plan

Charity Care Program	$2,001,181
Bad Debt	$4,220,415
Medicaid/Medicare Shortfall	$16,089,283
Total 2020 Uncompensated Care	**$22,310,879**

2020 Uncompensated Care Budget/Plan

$2,001,181
5%

$4,220,415
19%

$16,089,283
72%
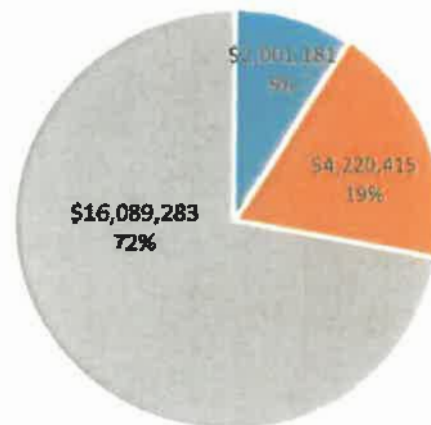
■ Charity Care   ■ Bad Debt   ■ Medicaid/Medicare Shortfall

IV. Internal Assessment

D. Market Analysis

Prosser
Memorial Health

Overview of Service Area and Demographics

October 2020

Prepared by:

HEALTH FACILITIES PLANNING & DEVELOPMENT

RESEARCH · DATA · ANALYTICS · STRATEGY · IMPLEMENTATION

Section 1: Overview of Prosser Memorial Health and the Primary Service Area

A. Brief History

The Prosser Hospital Association was established in 1943 to raise funds for a community hospital. In 1945, after intense community-led fundraising, construction crews broke ground on a new 19-bed hospital. Two years later, on December 26, 1947, Prosser Memorial Hospital (Prosser) opened, dedicated to the memory and service of veterans of World War II. The Prosser Public Hospital District was formed in 1948, and the Prosser Hospital Association was disbanded.

Over the years, there have been numerous additions and expansions to the hospital and its services. and in the recent past, there has been significant clinic development. Today, Prosser is a robust rural health system providing family medicine, specialty care, advanced surgical care, inpatient care, obstetrics, and emergency care. PMH's mission is "to improve the health of our community", and its vision is to become one of the top 100 Critical Access Hospitals in the country.

B. Prosser Today

Prosser is a 25 bed Critical Access Hospital (CAH), meaning that it is rural, operates 25 or fewer beds, meets other applicable requirements and is paid allowable costs from Medicare and Medicaid. The intent of the CAH program is to mitigate financial vulnerability of rural hospitals, thereby assuring that essential services exist in rural communities.

Prosser is located in western Benton County. Its services include a broad array of primary care, specialty care, acute care, outpatient, and post-acute care, including:

- Level 4 Trauma Center
- Emergency Cardiac Level II
- Emergency Stroke Level III
- Inpatient & Outpatient Surgery
- Obstetrics
- Swing Beds
- Behavioral Health
- Teleradiology

Primary Service Area

Patient Origin data for Prosser's inpatients for the period of 2016-2019 is depicted in **Table 1.** As depicted in the Table, the primary service area includes all three of the communities within the legal boundaries of the District, as well as several adjacent communities. The three communities within the legal boundaries of the District: Prosser, Benton City and Paterson, are all located in Western Benton County, and the rest of the primary service area is in adjacent Yakima County.

As seen in Table, in 2019, approximately 44% of Prosser's patients came from the District in 2016, but by 2019, only 34% resided in the District. The adjacent Yakima County cities of Grandview and Mabton consistently account for another 31-34% of discharges. Collectively, these communities account for about 70% of all Prosser inpatient discharges. Hospital primary service areas are typically defined as the geography from which 70-80% of a hospital's patients reside.

Table 1
Prosser Health Patient Origin, by Zip Code and City-2016-2019

Zip Code	City	2016	2017	2018	2019
99350	Prosser	39.2%	41.7%	39.4%	34.2%
99320	Benton City	4.8%	3.8%	3.1%	3.9%
99345	Paterson			0.1%	0.3%
	Subtotal - District	44.0%	45.4%	42.7%	38.4%
98930	Grandview	29.8%	23.2%	25.3%	26.3%
98935	Mabton	4.2%	5.5%	5.9%	5.1%
	PSA Subtotal	78.0%	74.1%	73.8%	69.7%
	PSA Emerging Market -Sunnyside				
98944	Sunnyside	14.6%	15.3%	14.8%	18.2%
	Subtotal PSA + PSA Emerging Market	92.6%	89.4%	88.6%	87.9%
	Other	7.4%	10.6%	11.4%	12.1%
	Total	100.0%	100.0%	100.0%	100.0%

Source: 2016-2019 Inpatient CHARS Data, excludes newborns and swing bed patients

Per Table 1, almost 20% of Prosser's inpatients come from Sunnyside. For the purposes of this report, HFPD has elected to identify Sunnyside as an 'emerging' part of the primary service area. Inclusion as part of the PSA is reasonable for a number of reasons, including 1) Prosser's commitment to expand services to Sunnyside following the bankruptcy of Astria Health and closure of one of its hospitals in Yakima County and 2) available patient origin clearly depicts that, as a percentage of Prosser's total inpatients, the Sunnyside zip code (98944) has increased by nearly 25% between 2016 and 2020[1]. Outpatient data provided directly by Prosser, identifies the same patient origin pattern.

As defined by the Federal Health Resources & Services Administration (HRSA), the entirety of Benton and Yakima Counties are Health Professional Shortage Areas, (HSPA) with designations for primary care, mental health, and dental care. **Table 2** reflects the service area HPSA designations and scoring. The highest score (greatest shortage) for a HPSA is 25.

Table 2
HPSA Designation by Select County

Geography	HPSA	Designation Type	Designation Date	Score
Benton County	Primary Care	Low Income Population HPSA	10/02/2017	16
	Dental Care	Low Income Population HPSA	8/31/2017	18
	Mental Health	Geographic: Entire County	8/27/2017	17
Yakima County	Primary Care	Low Income Population HPSA	09/24/2017	17
	Dental Care	Low Income Population HPSA	07/26/2017	19
	Mental Health	Geographic: Entire County	08/23/2017	18

Source: HPSA Find (https://datawarehouse.hrs.gov/tools/analyzers/hspafind.aspx).

C. Demographics – Primary Service Area

Throughout the report, the PSA is the five communities of Prosser, Benton City, Patterson, Mabton and Grandview. When Sunnyside is added, we refer to the area as the PSA+ Emerging Community.

As depicted in **Table 3**, in 2020, the PSA had a population of nearly 46,000 and nearly 57% of the population is Hispanic. Since the 2010 census, the PSA's total population has grown by 9.3%, while the Hispanic population grew by nearly 20% and the population age 65+ grew by 40.3%. The District is slightly "younger" than the rest of the State, with 12.7% aged 65+ in the District vs 15.9% statewide.

In comparison to the PSA's 9.3% growth, the State grew by nearly 13%; however, the growth in the PSA far surpasses the average growth rate in communities served by the

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[1] HFPD would also typically look at market share in defining the service area. However, Astria Health underreported in 2018 and CHARS, the state data base from which inpatient market share is calculated recently notified all hospitals that 2019 data was not uploaded correctly and understates discharges. They are attempting to correct this data, but there is no ETA.

State's other CAHs (4.9%). The PSA is expected to continue to grow (5.5%) through 2025, with the fastest growth occurring in the 65+ and Hispanic populations. Again, and for comparison, the State is expected to grow by 6.3% between 2020-2025.

The population of females of childbearing age (15-44) grew by nearly 9% between 2010 and 2020 and is expected to another 7% by 2025.

Table 3
Primary Service Area Population

	2010	Pct of Tot Pop	2020 Est	Pct of Tot Pop	Pct Chg. 2010-2020	2025 Proj	Pct of Tot Pop	Pct Chg. 2020-2025
Tot. Pop.	41,910	100.0%	45,811	100.0%	9.3%	48,340	100.0%	5.5%
Pop. By Age								
0-17	13,552	32.3%	14,071	30.7%	3.8%	14,561	30.1%	3.5%
18-44	14,497	34.6%	16,153	35.3%	11.4%	17,264	35.7%	6.9%
45-64	9,708	23.2%	9,762	21.3%	0.6%	9,787	20.2%	0.3%
65-74	2,457	5.9%	3,654	8.0%	48.7%	4,125	8.5%	12.9%
75-84	1,224	2.9%	1,636	3.6%	33.7%	2,048	4.2%	25.2%
85+	472	1.1%	536	1.2%	13.5%	555	1.1%	3.6%
Tot. 0-64	37,757	90.1%	39,986	87.3%	5.9%	41,613	86.1%	4.1%
Tot. 65 +	4,153	9.9%	5,825	12.7%	40.3%	6,728	13.9%	15.5%
Hispanic	21,674	51.7%	25,988	56.7%	19.9%	28,668	59.3%	10.3%
Fem. 15-44	8,236	19.7%	8,962	19.6%	8.8%	9,590	19.8%	7.0%

Source: Nielsen Claritas 2019 and includes: Prosser, Benton City, Paterson, Grandview and Mabton

As seen in **Table 4**, within the PSA, Prosser and Grandview have a higher percentage of Hispanic residents that the PSA as a whole. The District is proper is also growing faster than the communities of Grandview and Mabton. whole. It is also projected to growing more slowly than Benton County, and the State, but faster than Yakima County between 2020 and 2025.

Table 4
Primary Service Area Population Comparisons

	2020 Total Population	2025 Total Population	% Change 20-25	2020 Hispanic Population	% of Total	2025 Hispanic Population	% Change 20-25
99350 – Prosser	14,889	15,892	6.7%	7,019	47.1%	7,949	13.2%
99320 – Benton City	10,334	11,028	6.7%	2,545	24.6%	3,004	18.0%
99345 – Paterson *	POBox						
Subtotal District	25,223	26,920	6.7%	9,564	35.5%	10,953	14.5%
98930 – Grandview	16,225	16,944	4.4%	12,808	78.9%	13,913	8.6%
98935 – Mabton	4,360	4,482	2.8%	3,613	82.9%	3,805	5.3%
Subtotal PSA[2]	45,808	48,346	5.5%	25,985	56.7%	28,671	10.3%
Benton County	207,508	219,250	5.7%	48,369	23.3%	55,089	13.9%
Yakima County	259,116	267,132	3.1%	133,651	21.8%	144,375	8.0%
Washington	7,661,468	8,143,617	6%	1,012,383	13%	1,159,778	15%

Source: Nielsen Claritas 2019. *Patterson is a POBox and is reported with Prosser (99350).

D. Demographics-Emerging Primary Service Area, Sunnyside

As depicted in **Table 5**, in 2020, Sunnyside had a population of nearly 23,000 and more than 80% is Hispanic. The community is exceptionally young with only 9.6% over the age of 65. Since the 2010 census, Sunnyside's total population grew by just over 4%, while the Hispanic population grew by almost 11% and the population age 65+ grew by nearly 12%. The growth in Sunnyside is less than the growth rate of the PSA. Sunnyside is expected to continue to grow (3.6%) through 2025, with the fastest growth continuing to be in the 65+ cohort and Hispanic populations. Again, and as with the PSA, women of childbearing age are expected to continue to grow as well.

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[2] *numbers may not match Table 3 exactly due to rounding.

Table 5
Emerging PSA -Sunnyside

	2010	Pct of Tot Pop	2020 Est	Pct of Tot Pop	Pct Chg. 2010-2020	2025 Proj	Pct of Tot Pop	Pct Chg. 2020-2025
Tot. Pop.	21,879	100.0%	22,809	100.0%	4.2%	23,634	100.0%	3.6%
Pop. By Age								
0-17	8,077	36.9%	8,115	35.6%	0.5%	8,234	34.8%	1.5%
18-44	8,034	36.7%	8,447	37.0%	5.1%	8,777	37.1%	3.9%
45-64	3,805	17.4%	4,054	17.8%	6.5%	4,265	18.0%	5.2%
65-74	999	4.6%	1,228	5.4%	22.9%	1,322	5.6%	7.7%
75-84	634	2.9%	642	2.8%	1.2%	731	3.1%	13.9%
85+	330	1.5%	323	1.4%	-2.1%	304	1.3%	-5.8%
Tot. 0-64	19,916	91.0%	20,616	90.4%	3.5%	21,276	90.0%	3.2%
Tot. 65 +	1,963	9.0%	2,193	9.6%	11.7%	2,358	10.0%	7.5%
Hispanic	16,939	77.4%	18,715	82.1%	10.5%	19,987	84.6%	6.8%
Fem. 15-44	4,505	20.6%	4,711	20.7%	4.6%	4,903	20.7%	4.1%

Source: Nielsen Claritas 2019

E. Demographics PSA+ Emerging

Combined, the PSA and the emerging (Sunnyside) communities have a combined population of almost 70,000. Since 2010, the PSA + Emerging area has grown by nearly 9%. The PSA + Emerging is younger than the State (12% age 65+) and is nearly 66% Hispanic. Growth will by 2025 is estimated to be about 4% with the 65+ age cohort growing more than twice as fast. The females 15-44 are expected to continue to grow.

Table 6
PSA + Sunnyside

	2010	Pct of Tot Pop	2020 Est	Pct of Tot Pop	Pct Chg. 2010-2020	2025 Proj	Pct of Tot Pop	Pct Chg. 2020-2025
Tot. Pop.	63,789	100.0%	69,270	100.0%	8.6%	71,971	100.0%	3.9%
Pop. By Age								
0-17	21,629	33.9%	22,306	32.2%	3.1%	22,795	31.7%	2.2%
18-44	22,531	35.3%	24,882	35.9%	10.4%	26,041	36.2%	4.7%
45-64	13,513	21.2%	13,863	20.0%	2.6%	14,051	19.5%	1.4%
65-74	3,456	5.4%	4,990	7.2%	44.4%	5,447	7.6%	9.2%
75-84	1,858	2.9%	2,370	3.4%	27.6%	2,778	3.9%	17.2%
85+	802	1.3%	859	1.2%	7.1%	859	1.2%	0.0%
Tot. 0-64	57,673	90.4%	61,051	88.1%	5.9%	62,887	87.4%	3.0%
Tot. 65 +	6,116	9.6%	8,219	11.9%	34.4%	9,084	12.6%	10.5%
Hispanic	38,613	60.5%	45,468	65.6%	17.8%	48,654	67.6%	7.0%
Fem. 15-44	12,741	20.0%	13,833	20.0%	8.6%	14,493	20.1%	4.8%

Source: Nielsen Claritas 2019

F. Socioeconomic Characteristics

Unemployment data is available only at the County level. While unemployment rates had generally improved between 2016-2019, rates in Benton and Yakima Counties are still higher than that of Washington State. Benton County's unemployment had decreased by 22% between 6.0% in ⁻2016 (6.0%) to 2019 (4/7%). Comparatively, Washington State's unemployment rate decreased from 5.0% in 2016 to 4.1% in 2019 (a decrease of 18%). Yakima County's unemployment rate has also decreased since 2016, going from 6.4% to 6.1% (a decrease of 4%). However, as a result of COVID-19, unemployment rates have increased to unprecedented levels throughout the State. The data is summarized in **Figure 2.**

Figure 2
Unemployment Rates 2016- August 2020
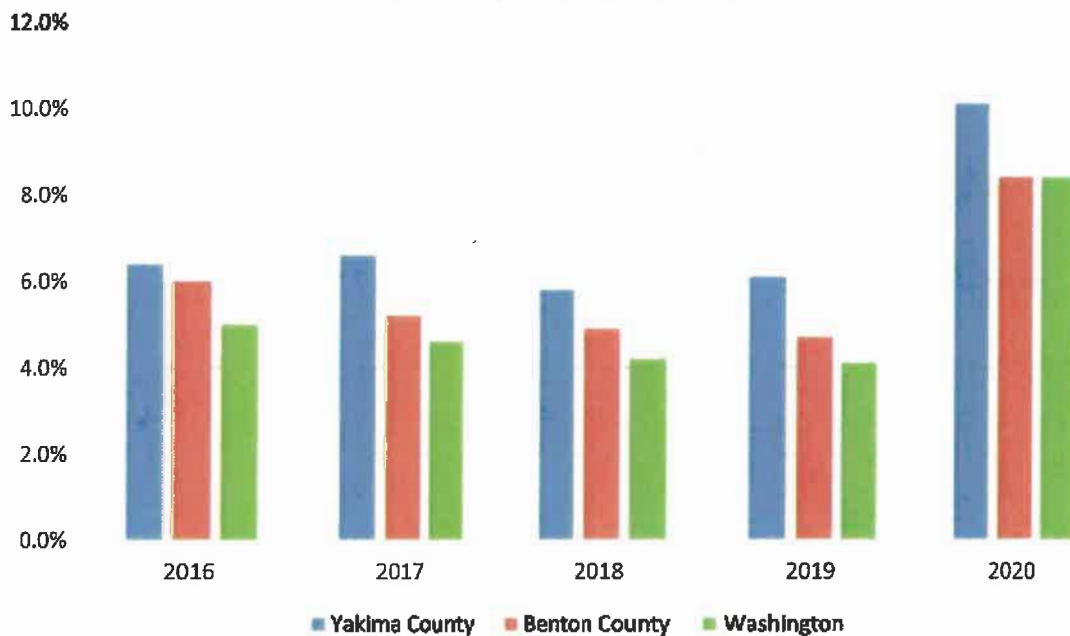
Source: U.S. Bureau of Labor Statistics, Not Seasonally Adjusted, (June)

Table 7 shows the PSA's major employers, which is generally agricultural or public in nature.

Table 7
Employers, by Number of Employees within the PSA

Employer	Employees
Ste. Michelle Wine Estates	1,100
Walmart Grocery Distribution Center	719
Grandview School PSA	562
FruitSmart	368 (218 in Prosser)
Prosser School PSA	316
Prosser Memorial Hospital	300
WSU/IAREC	207
Benton County Government	144
Tree Top, Inc.	125
Milne Fruit	120
Yakima Valley Farm Worker's Clinic	116
Conrad Adams Fruit	100 + 316 seasonal
Chukar Cherries	100
Bleyhel Farm Services	89
J M Smucker Company	75
Yakima Valley College	70
Welch Grape	60
Zirkle Fruit	60 (in Prosser)
City of Grandview	58
Benton Rural Electric	54
City of Prosser	50
Shonan (USA)	50

Source: www.trytricitiessites.org; www.portofgrandview.org; www.prosser.org

The average household income for the entirety of Benton County, Yakima County, and the PSA is lower than the State **(Table 8)**. Within the PSA, the communities of Prosser and Grandview are lower than Benton County and the State.

Table 8
Average Household Income by Area, 2019

	Average HH Income
99350 – Prosser	$79,626
99320 – Benton City	$83,538
99345 – Paterson *	
District	
98930 – Grandview	$62,868
98935 – Mabton	$62,457
PSA	
Benton County	$90,475
Yakima County	$71,263
Washington	$101,633

Source: Nielsen Claritas 2019. *Reported with Prosser (99350).

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*Source: Nielsen Claritas 2019. *Reported with Prosser (99350).*

IV. Internal Assessment
E. Patient Loyalty

Prosser Memorial Health
Patient Satisfaction

Strategic Planning 2021

Prosser Memorial Health
Patient Loyalty Summary Report-August 2020

Survey Group	2020 Goal	Current 2020	# of Surveys	YTD 2020	# of Surveys		Notes						
Emergency Depart.	>80.7%	80%	10	81.3%	299		174	+	69	÷	299	=	81.3
							5	+	3	+	10	=	80
HCAHPS-Inpatient	>85.1%	95.5%	22	89.2%	297		265	+		÷	297	=	89.2
							21	+		÷	22	=	95.5
Acute Care	>79.7%	92.3%	13	86.3%	169		146	+		÷	169	=	86.3
							12	+		÷	13	=	92.3
Family Birthplace	>92.2%	100%	9	93%	128		119	+		÷	128	=	93
							9	+		÷	9	=	100
Out-Patient Surgery	>88.4%	87.5%	16	89.7%	292		262	+		÷	292	=	89.7
							14	+		÷	16	=	87.5
Swing Bed	>94.1%	50%	2	75%	16		9	+	3	+	16	=	75
							1	+	0	÷	2	=	50
Clinic Network	>87.1%	83.1%	59	87.3%	864		566	+	188	÷	864	=	87.3
							34	+	15	÷	59	=	83.1
Out-Patient Services	>88.4%	88.6%	35	89.9%	298		149	+	74	÷	248	=	89.9
							20	+	11	÷	35	=	88.6

	2020 Goal	YTD Score	Equation				*Composite score based on 2019 departmental revenue contributions						
Composite Score	86.61%		ED	.15x	81.3		ED: 15%						
			IP	.209x	89.2		IP: 20.9%						
			OP	.157x	89.7		OP Surgery: 15.7%						
			SW	.064x	75		Swing: 6.4%						
			OP	.336x	87.3		Outpatient: 33.6%						
			Clinic	.084x	89.9		Clinic: 8.4%						
			TOTAL		86.61%								

Prosser Memorial Health

Inpatient Combined Goal: 85.1%

June 2020-86.7%

YTD 2020- 88.6%

Would Recommend

Would Recommend

Prosser
Memorial Health
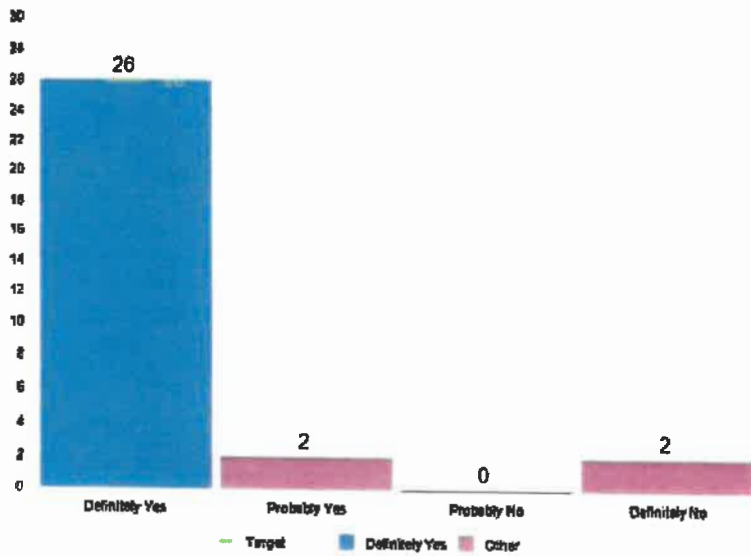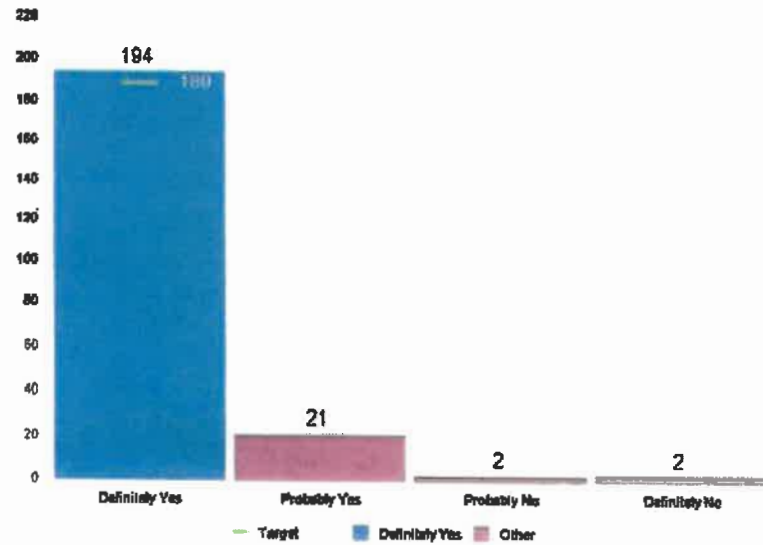
PMH MEDICAL CENTER

2020
Overall Quality of Care
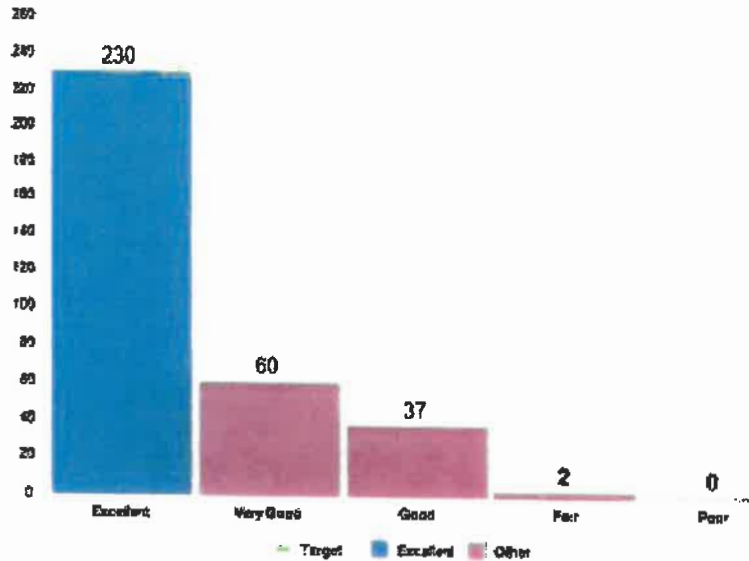
Target: 90th Percentile = 69.8% of patients saying "Excellent"
Your current Percent "Excellent" = 69.9% of patients
Your current Percentile "Excellent" Ranking is 90.7
Norm Group: Inpatient
Your Target = 230 of 329 patients rating you "Excellent"
Your Actual = 230 of 329 patients rating you "Excellent"
Your Target: Met

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For Prosser, WA - HCAHPS+ iphonProfil 10/5/2020 4:03:23 PM

Overall Safety
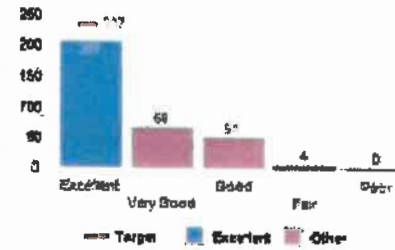
Staff Courtesy/Friendliness

Overall Teamwork

Prosser
Memorial Health
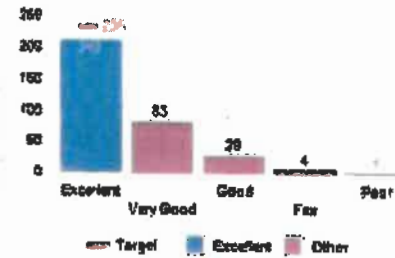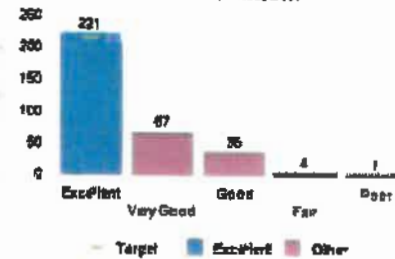
Care Transitions Team Goal: Improve the "Care Transition" score on HCHAPS

- Recognizing Patient Preferences for Care Continuum (Improving continuum of care improves clinical outcomes, reduces preventable readmissions and maximizes reimbursement)
- Helping Patients Understand Post-Discharge Responsibility
- Purpose of Medications

Measures being used to improve Care Transitions

- 1. Interdisciplinary Rounds

- 2. Bedside shift report

- 3. Post visit patient calls on Inpatients, Observation, & Swing bed:
    - ➤ Confirm patient is continuing to improve;
    - ➤ Answer Questions;
    - ➤ Verify access to clinic follow-up;
    - ➤ Verify access to medications.

Acute Care **Goal: >79.7%**

June 2020- 81.3%

YTD 2020-85.2%
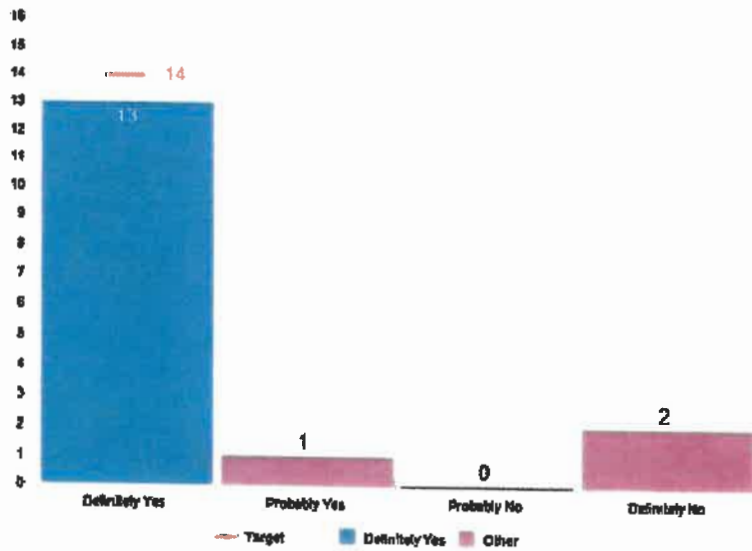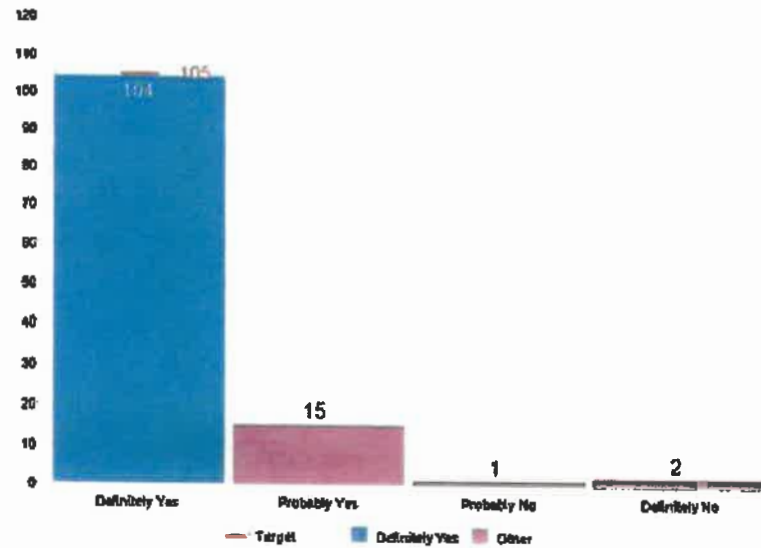
Med/Surg

2020
Overall Quality of Care
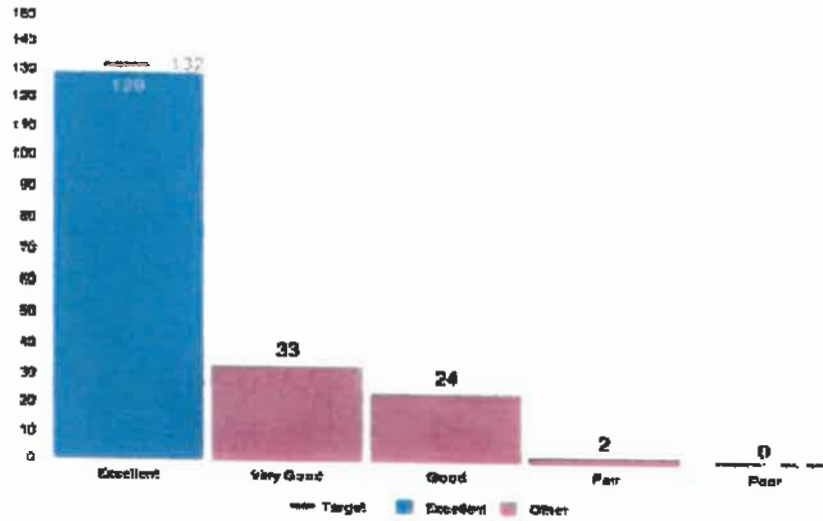
Target: 50th Percentile = 70.1% of patients saying "Excellent"
Your current Percent "Excellent" = 68.6% of patients
Your current Percentile "Excellent" Ranking is 67.7
Norm Group: Inpt Med/Surg
Your Target = 132 of 188 patients rating you "Excellent"
Your Actual = 129 of 188 patients rating you "Excellent"
Your Target: Missed By 3 patients

For Prosser, WA - HCAHPS+ (phone-rat) 10/7/2020 4:07:01 PM

Overall Safety

Overall Teamwork
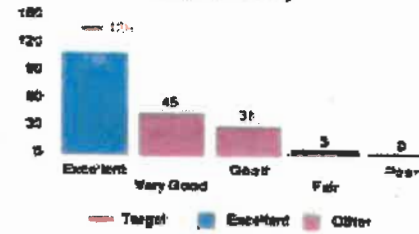
Prosser Memorial Health
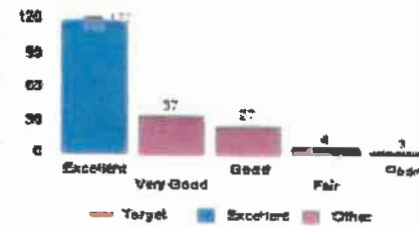
SWING Bed Program Goal: >94.1%

June 2020-100%

Likelihood of Recommending
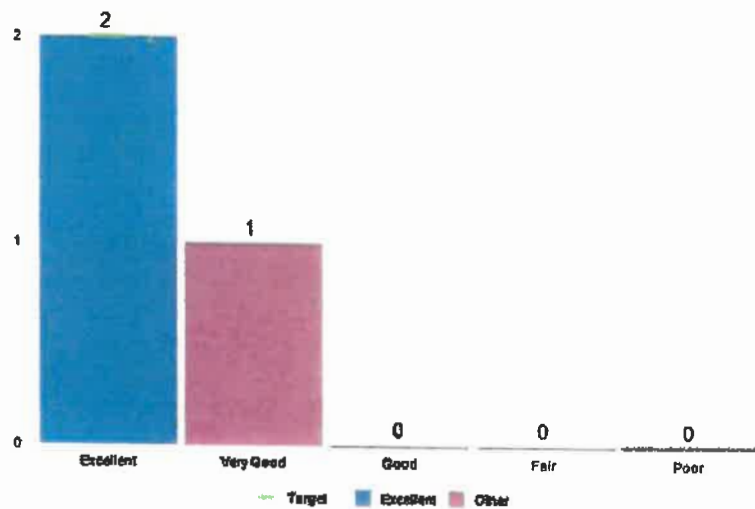
YTD 2020-75%

Likelihood of Recommending
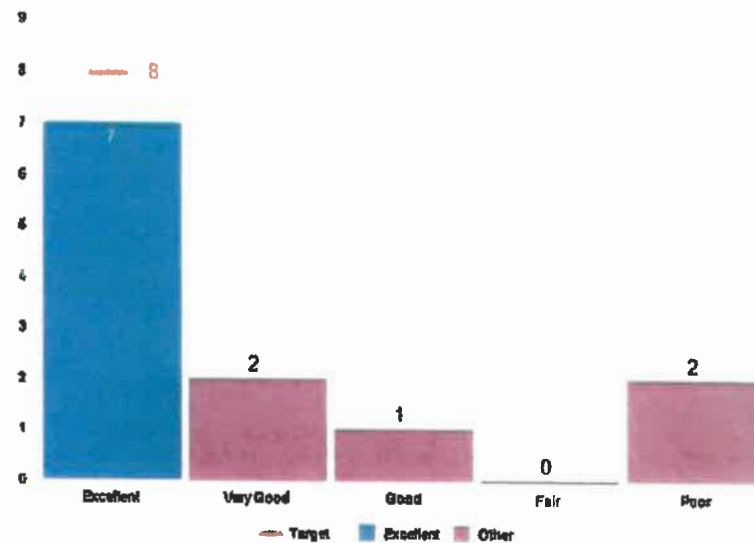
Prosser
Memorial Health

PROSSER MEMORIAL HOSPITAL

2020
Overall Quality of Care

Doctor Understanding/Caring
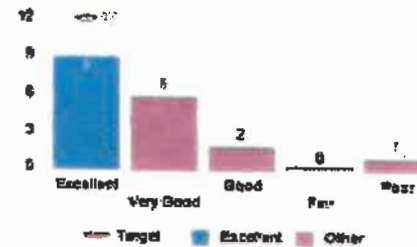
Nurse Instructions/Explanations
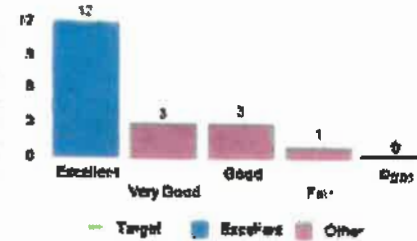
Doctor Communication/Patient Informed

Target: 50th Percentile = 60.7% of patients saying "Excellent"
Your current Percent "Excellent" = 55.6% of patients
Your current Percentile "Excellent" Ranking is 24.7
Norm Group: Inpatient
Your Target = 11 of 18 patients rating you "Excellent"
Your Actual = 10 of 18 patients rating you "Excellent"
Your Target: Missed By 1 patient

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For Prosser, WA - Inpatient Rehab 10/7/2020 4:34:39 PM

Prosser
Memorial Health

Acute Care/Swing

- Patient Education on new medications and side effects.

- Risk Stratified Post-Discharge follow-up phone calls.

- Revised staffing for COVID-19 Isolation patients.

- New Beds being purchased.

Patients are reporting improved medication education!

2018-85.0%; 2019-89.8%
2020 YTD-90.82%

2018- 68.7%; 2019-67.2%
2020 YTD-75.26%

Family Birthplace Goal: >92.2%

Special Delivery!

June 2020- 92.9%

YTD 2020-92.8%%

Would Recommend

Would Recommend

Prosser
Memorial Health

142
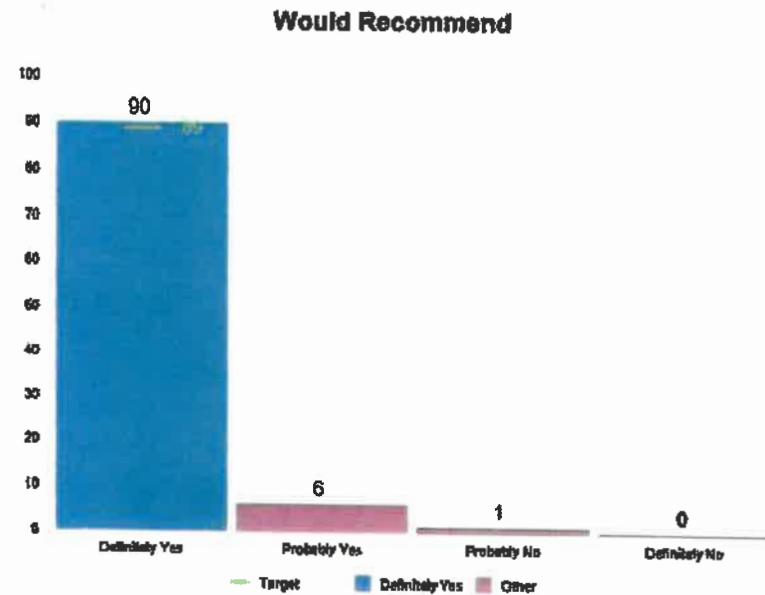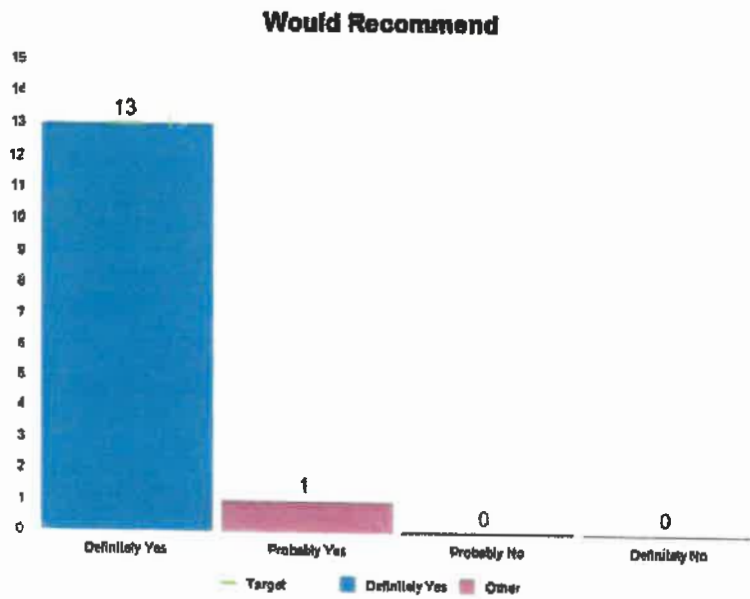
OB

2020
Overall Quality of Care
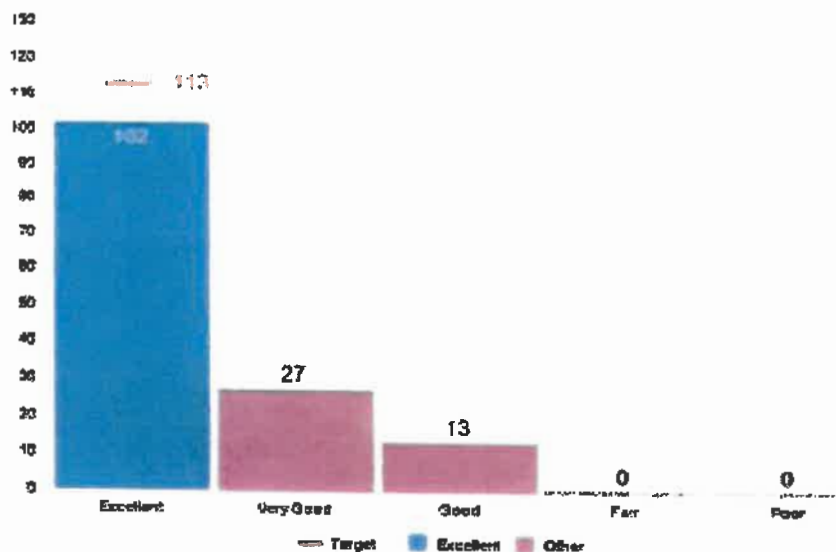
Target: 90th Percentile = 79.5% of patients saying "Excellent"
Your current Percent "Excellent" = 71.8% of patients
Your current Percentile "Excellent" Ranking is 55.6
Norm Group: Inpt OB/GYN
Your Target = 113 of 142 patients rating you "Excellent"
Your Actual = 102 of 142 patients rating you "Excellent"
Your Target: Missed By 11 patients

For Prosser, WA - HCAHPS+ (phone/web) 10/7/2020 4:00:51 PM

Staff Courtesy/Friendliness
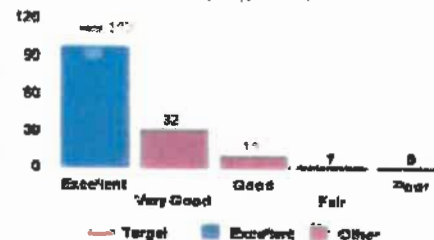
Nurse Respect for Patient Privacy

Doctor Easing Worries/Fears

Prosser
Memorial Health
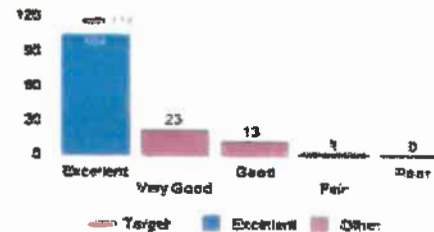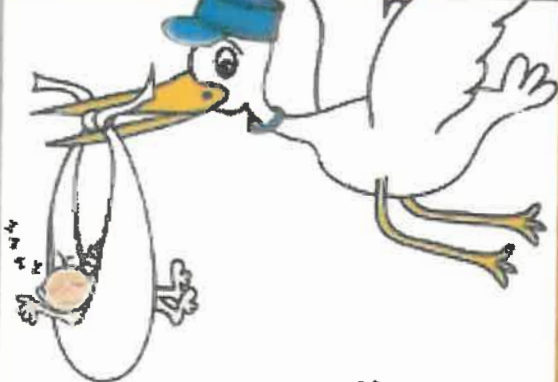
Family Birthplace

- COVID-19 accommodations for positive moms.

- Rapid cross training of Resource and Acute Care Staff for care of the post-partum patients.

- Our first midwife has been onboarded and doing proctored deliveries and the second starts in August.

- Focus on post-partum depression screening.

- Childbirth Education has been offered on-line with a good reception.
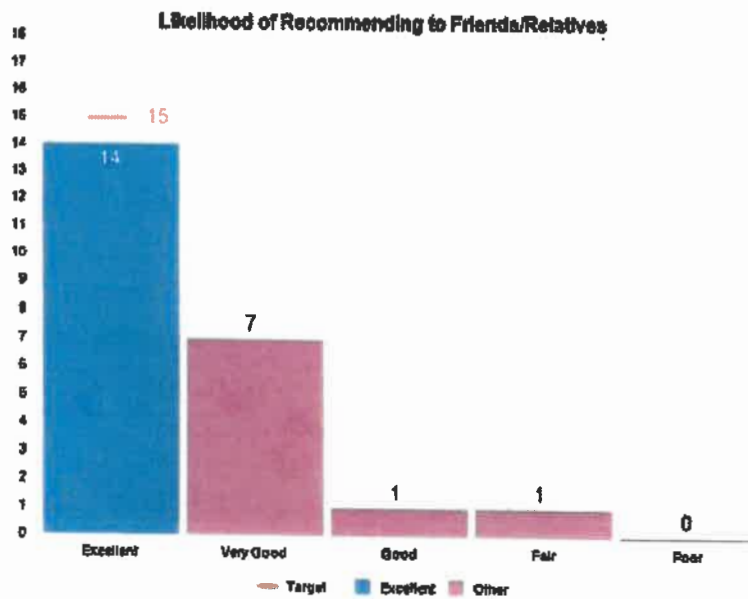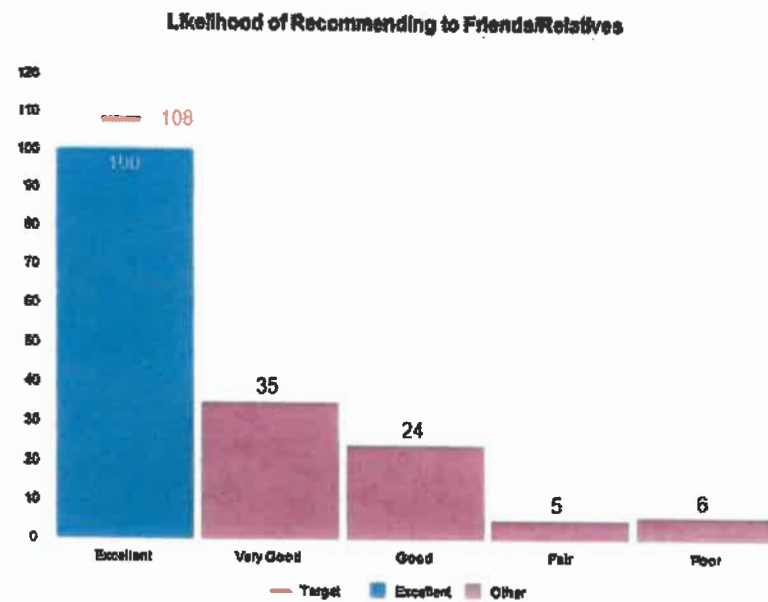
Prosser Memorial Hospital

2020
Overall Quality of Care
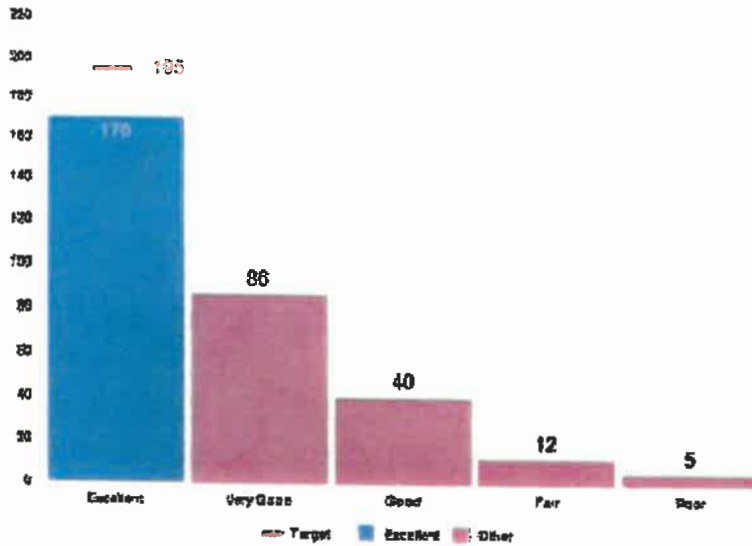
Target: 90th Percentile = 62.2% of patients saying "Excellent"
Your current Percent "Excellent" = 54.3% of patients
Your current Percentile "Excellent" Ranking is 59.8
Norm Group: ED
Your Target = 195 of 313 patients rating you "Excellent"
Your Actual = 170 of 313 patients rating you "Excellent"
Your Target: Missed By 25 patients

Professional Research Consultants, Inc.

For Prosser, WA - Emergency Department (phone/web) 10/7/2020 4:11:01 PM

Overall Teamwork Between Doctors, Nurses, and Staff
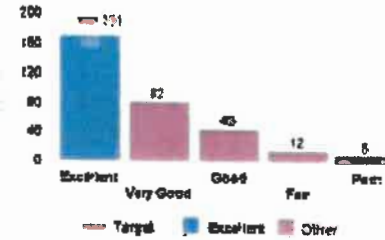
Pain Management by Staff
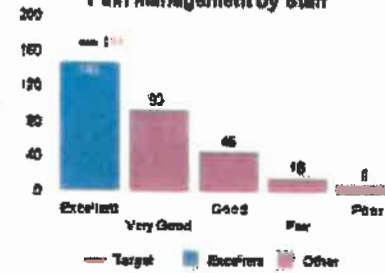
Cleanliness of the Hospital

Prosser
Memorial Health

146
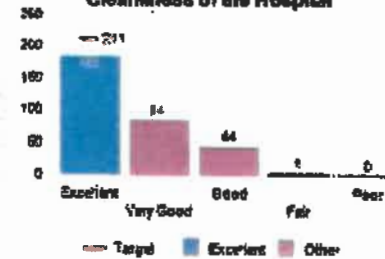
Emergency Department

May: National Stroke Awareness Month

FAST

FACE DROOPING   ARM WEAKNESS   SPEECH DIFFICULTY   TIME TO CALL 9-1-1

Act **FAST** for Stroke
Stroke is an emergency and a "brain attack."
Learn how to act **FAST** and call 9-1-1
at first sign of stroke.

NATIONAL STROKE ASSOCIATION®

Prosser Memorial Health

- Studer will be completing a two day Patient Flow evaluation in August.

- Dr. Wenger has assumed the ED Medical Director role.

- Providers and Staff done an extremely effective job adjusting to the challenges and acuity of COVID-19.

- Stroke Education in May.

Prosser Memorial Health

Surgical Services Goal: >88.4%

June 2020-95.2%

**YTD 2020-91.3%**

Would Recommend
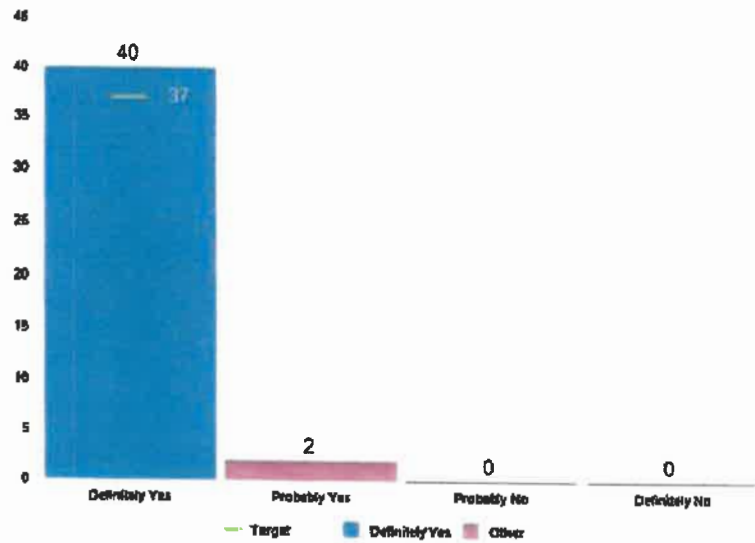
Would Recommend
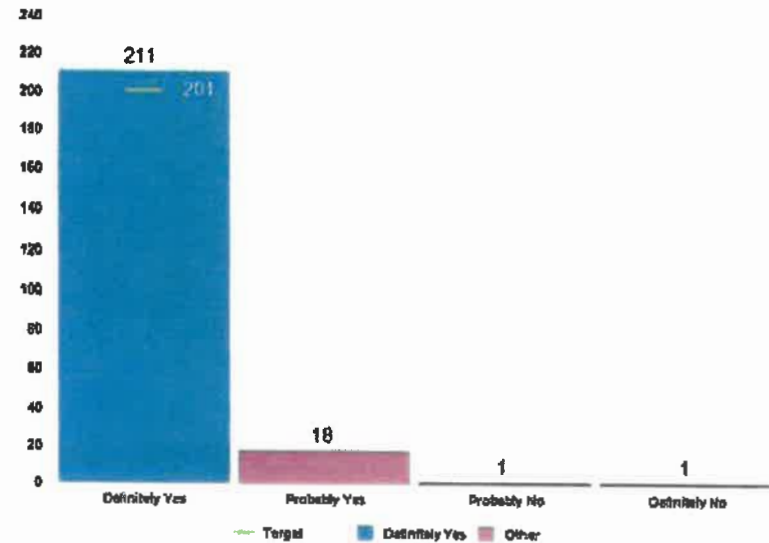
Prosser Memorial Hospital


2020
Overall Quality of Care
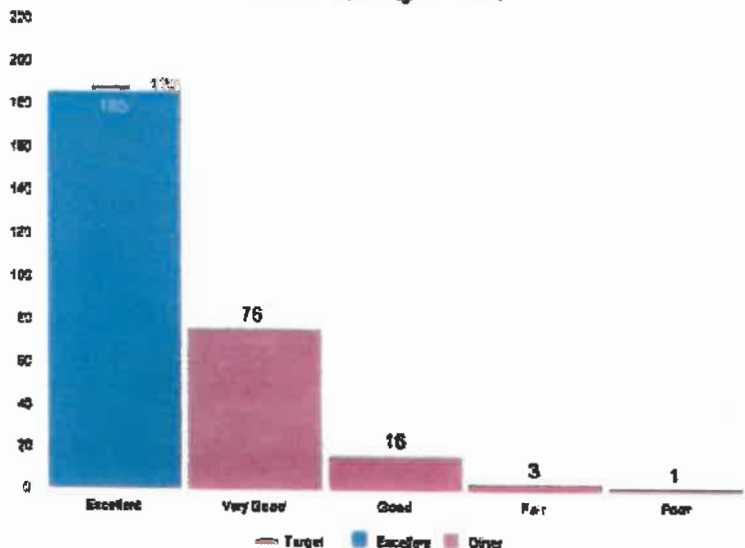
Target: 50th Percentile = 66.8% of patients saying "Excellent"
Your current Percent "Excellent" = 65.8% of patients
Your current Percentile "Excellent" Ranking is 41.8
Norm Group: Outpatient
Your Target = 188 of 281 patients rating you "Excellent"
Your Actual = 185 of 281 patients rating you "Excellent"
Your Target: Missed by 3 patients

For Prosser, WA - Outpatient (phone/web) 10/7/2020 4:24:16 PM

Prosser Memorial Health

Out Patient services Goal: >88.4%

June 2020-91.7 %

YTD 2020-89.5 %
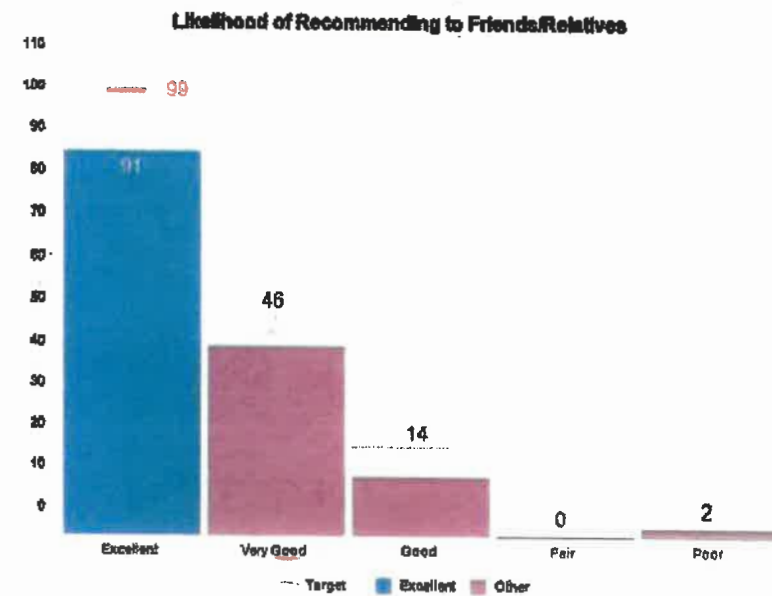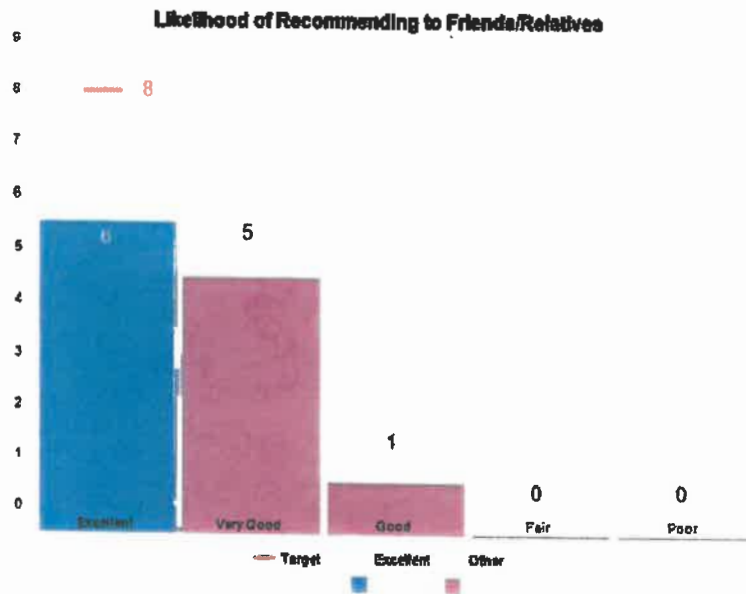
PMH OAS Out Surg

2020
Overall Quality of Care
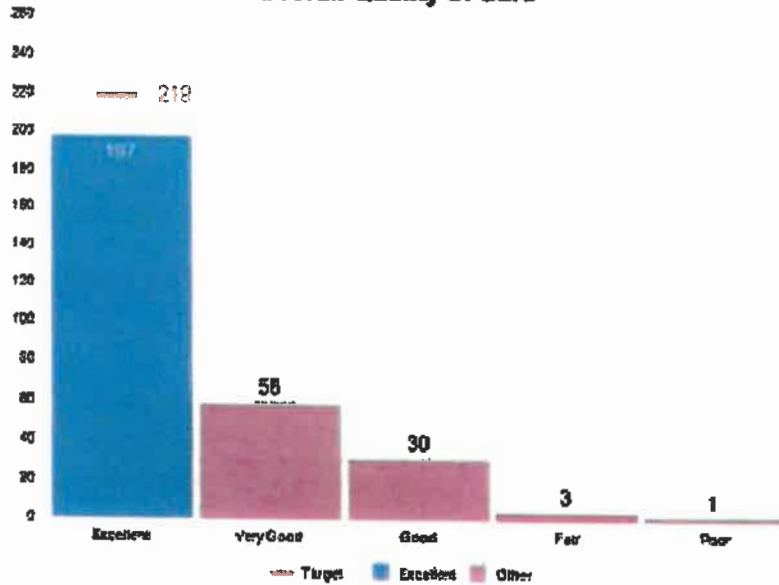
Target: 50th Percentile = 75.5% of patients saying "Excellent"
Your current Percent "Excellent" = 68.2% of patients
Your current Percentile "Excellent" Ranking is 16.3
Norm Group: Out Surg
Your Target = 219 of 289 patients rating you "Excellent"
Your Actual = 197 of 289 patients rating you "Excellent"
Your Target: Missed By 22 patients

Professional Research Consultants, Inc.

Overall Safety
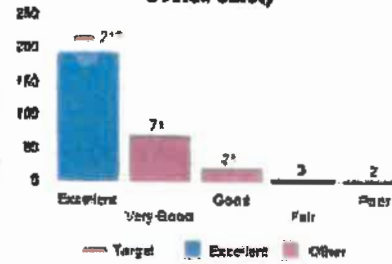
Overall Teamwork

Surgery Center/Receptionists Helpful

Prosser
Memorial Health
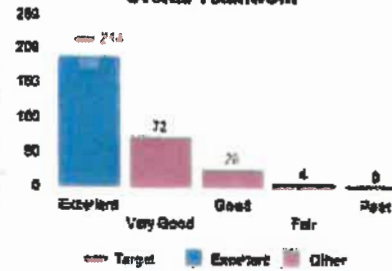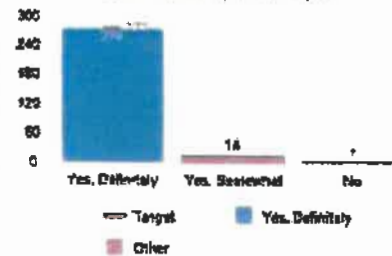
Measures taken in Outpatient Services Department (OSP)

- Updated the design and layout of the department to create better work flow and comfort for the patient

- Sent an internal nurse for training to become Wound Care Certified

- Brought in E.P.I.C. services for PICC line placement (1-2 hr turn around time)

- Cross trained several nurses from OB and Acute Care to care for OSP patients after hours and as needed

- Working to extend hours of coverage for patients treatment

- Met with PMH Medical Providers and visited our clinics to assure the process of getting patients seen in the OSP department.

Areas of expanded services
being reviewed :
1. Hyperbaric Wound Care
2. Home Health Services
3. Oncology Services
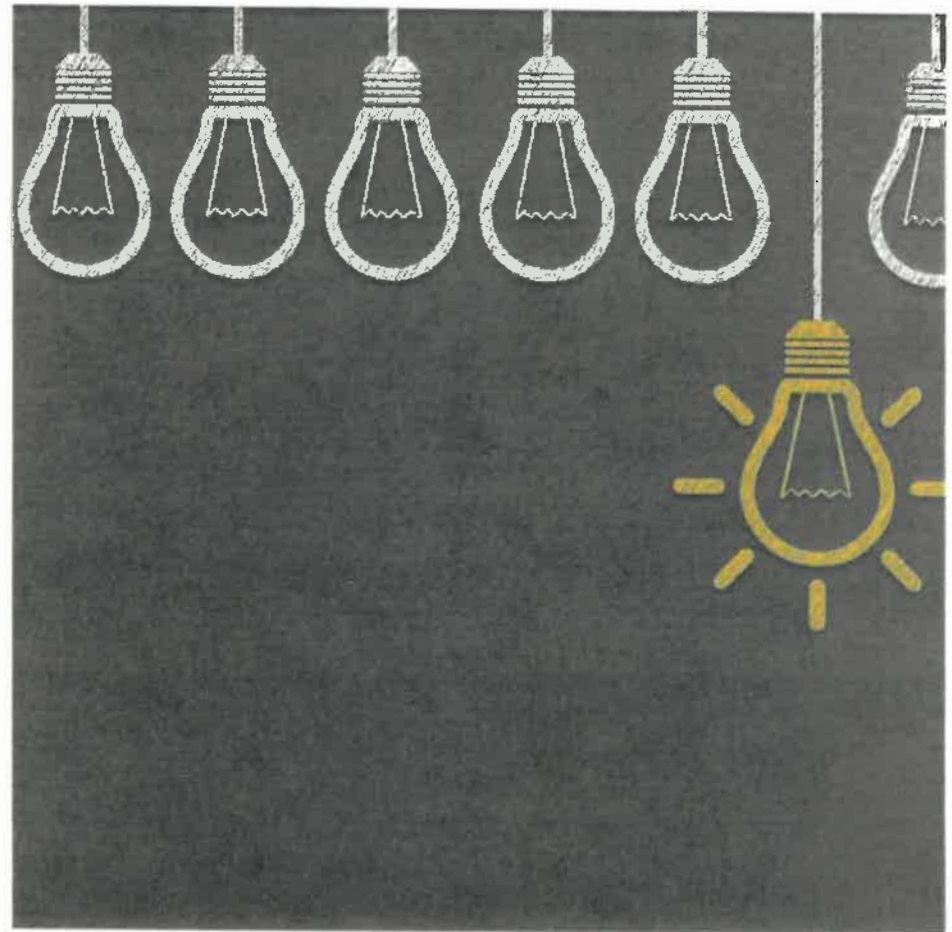
CLINIC ROLL-UP Goal: >87.1%

June 2020-83.3%

Likelihood of Recommending
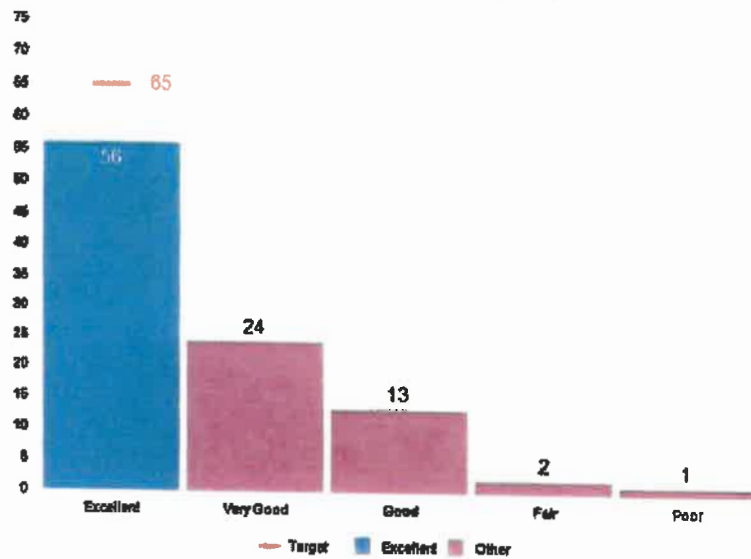
YTD 2020-87.9%

Likelihood of Recommending

Prosser
Memorial Health
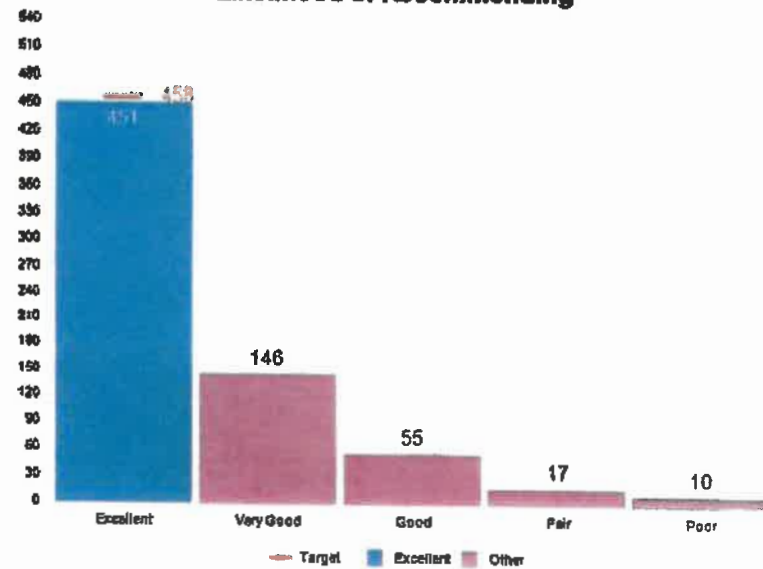
2020
Overall Doctor Rating
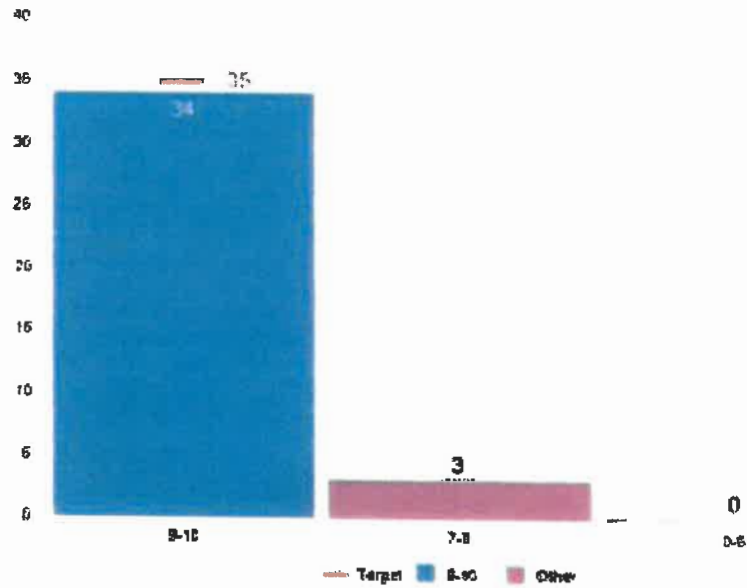
Target: 90th Percentile = 92.5% of patients saying "9-10"
Your current Percent "9-10" = 91.9% of patients
Your current Percentile "9-10" Ranking is 96.7
Norm Group: Prov-FP/GP
Your Target = 35 of 37 patients rating you "9-10"
Your Actual = 34 of 37 patients rating you "9-10"
Your Target: Missed By 1 patient

Professional Research Consultants, Inc.

For Prosser, WA - CGCAHPS- (phone/web) 10/7/2020 4:09:13 PM

Doctor Courtesy/Friendliness
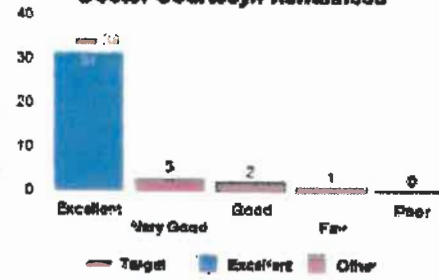
Doctor Listen Carefully
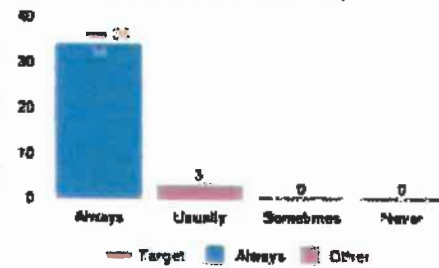
Doctor Knew Medical History

Prosser
Memorial Health
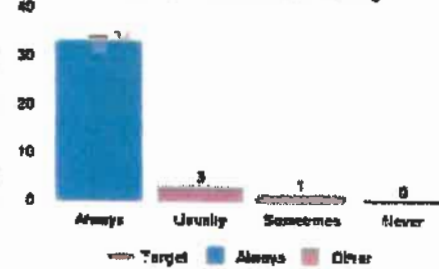
CLINIC ROLL-UP

- COVID-19 Clinic has been well received and utilized.
- Prosser extended hours will begin again in August.
- Benton City extend hours will begin again in September.
- Customer service training for all clinic staff will occur in Q3-4.
- A clinic manager is being hired for Benton City to assist with standardizing the quality of service across the clinic network.

IV. Internal Assessment

F. Historical Financial Performance
  i.   Hospital Dashboard Report
  ii. Balance Sheet & Statement of Operations

IV. Internal Assessment

F. Historical Financial Performance

    i.   Hospital Dashboard Report

Hospital Dashboard Report

Prosser Memorial Hospital [501312]

	Score	Rating
Overall Financial Position	★★	Fair
Performance Drivers		
Market Factors	★★	Fair
Coding & Billing	★★	Fair
Pricing	★★★	Average
Cost Position	★★	Fair
Labor Costs	★★★★	Good
Supply Costs	★★	Fair
Service Intensity	★★★	Average
Non Operating Income	★★	Fair
Investment Efficiency	★★★★	Good
Plant Obsolescence	★★★	Average
Capital Position	★★★	Average

Hospital Dashboard Report

Prosser Memorial Hospital

	Prosser Memorial Hospital [501312]	Revenues: $25 - 75 Million [REV1002]	All U.S. [STA0000]
Balance Sheet			
Cash & Cash Equivalents	1,221,656	4,138,853	41,464,550
Accounts Receivable	8,768,411	8,349,140	54,928,583
Total Current Assets	10,845,529	15,168,371	120,767,151
Net Fixed Assets	12,224,144	25,468,376	144,191,228
Investments	0	3,433,203	62,014,666
Total Assets	39,261,063	49,188,710	378,842,729
Current Liabilities	6,098,331	9,329,174	60,330,039
Long Term Debt	6,648,741	13,155,379	88,939,713
Equity	26,513,991	26,445,035	226,306,226
Income Statement			
Gross Patient Revenue	118,391,490	214,915,014	1,212,652,520
- Deductions	66,792,440	164,423,331	912,243,379
Net Patient Revenue	51,599,050	50,491,684	300,409,142
Other Operating Revenue	1,711,721	2,639,269	22,876,701
Total Operating Revenue	53,310,771	53,130,953	323,285,843
Total Expenses	52,969,155	51,882,512	306,171,928
Operating Income	341,616	1,248,441	17,113,915
Other Income	124,109	377,450	3,152,831
Net Income	465,725	1,625,891	20,266,747

Hospital Dashboard Report

Prosser Memorial Hospital

	Score	Rating	Prosser Memorial Hospital [S01313]	Revenues $25 - 75 Million [REV1002]	All U.S. [STA0000]
Reference					
Source of Financial Data			Medicare Cost Report	Medicare Cost Report	Medicare Cost Report
Source of Inpatient Data			Medicare Provider Analysis & Review (Medpar)	Medicare Provider Analysis & Review (Medpar)	Medicare Provider Analysis & Review (Medpar)
Source of Outpatient Data			Outpatient Analytical File	Outpatient Analytical File	Outpatient Analytical File
Year of Financial Data			2018	2019	2019
Year of Inpatient Data			2019	2019	2019
Year of Outpatient Data			2018	2019	2019
Financial Wage Index			1.0255	0.8411	0.9198
Inpatient Wage Index			1.0427		
Outpatient Wage Index			1.0255		
Financial Overview					
Return on Equity	★★	Fair	1.80	6.50	8
Economic Value Added (000's)	★★	Fair	-1,163	-456	1,183
Financial Strength Index®	★★	Fair	-2.30	-1.40	-0.40
Total Margin	★★	Fair	0.90	1.70	4.50
Operating Margin	★★	Fair	0.60	1.30	3.60
Market Factors					
Inpatient Revenue %	★★★★★	Excellent	25.10	30.50	41.30
Surgical Cases %	★	Poor	8.70	16.50	25
Expected Profit on DRGs %	★★★	Average	2	3	-0.40
Expected Profit on APCs %	★★★	Average	-17.10	-11.60	-15.60
Market Share %	★	Poor	6	100	51.40
Medicaid Days %**	★★★★	Good	16.80	18.10	19.90
Medicare Days %**	★	Poor	68.10	56.70	54.50
Inpatient Disproportionate Share %			N/A	3	3
Medicaid Charges %	★	Poor	32.70	14.50	14.20
Charity Care %	★★★	Average	1.80	1.50	1.60
Uncompensated Care %	★★	Fair	10.90	7.80	6.60
Admissions From SNF %	★	Poor	0	0.20	1.20
Revenue Growth(last year) %	★★★★	Good	7.60	3.30	4
Equivalent Discharges™	★	Poor	6,459	6,084	19,377
Inpatient Equivalent Discharges™	★	Poor	1,633	2,479	9,196
Outpatient Equivalent Discharges™	★★	Fair	4,826	3,399	9,372
2-yr Change in Equivalent Discharges™	★★★★★	Excellent	16.70	1.70	5.30
Coding & Billing					
Change in Medicare CMI %	★	Poor	-7.20	2	2.60
Medicare CMI	★	Poor	1.2044	1.3859	1.6193
CC/ MCC Capture Rate	★★★	Average	60.65	58.01	62.01
MSDRG Family Reporting Rates - Pneumonia	★★★	Average	0.92	0.89	0.91
MSDRG Family Reporting Rates - Heart Failure	★★★★	Good	0.95	0.92	0.95
MSDRG Family Reporting Rates - Sepsis	★	Poor	0.58	0.74	0.78
MSDRG Family Reporting Rates - Major Joint Hip/Knee	★★★★★	Excellent	0.14	0.05	0.06
Short Stay - Chest Pain			N/A	66.70	60
Short Stay - Congestive Heart Failure	★★★	Average	11.80	13.30	13
Short Stay - Back Pain	★	Poor	50	0	30.80
Short Stay - Gastroenteritis	★	Poor	50	20	22.20
Overall Short Stay (LOS = 1)	★★★★	Good	15.20	20	20.80
Overall Short Stay (LOS <=2)	★★	Fair	53.10	49.60	47.20
Inpatient Outlier Payment %	★★★★★	Excellent	0	0.40	1.10
Change in Relative Wt (SMI) %	★★★★	Good	11	4.30	7.30
Avg Relative Wt per Outpatient Visit (SMI)	★★★★★	Excellent	13.2071	7.4227	9.0131
NCCI Error Rate %	★	Poor	2.4044	0.1287	0.1168
Injectable Drug without Administration %			N/A	7.10	9.80
Add-on Code without Parent %			N/A	2.90	36.30
Potential Excessive Payments %	★★★★★	Excellent	0	0.3842	0.3541
Average ED Level	★★★	Average	3.851	3.807	3.904
Average ED Payment	★★★	Average	362†	345†	359†
Pricing					
Hospital Charge Index®			N/A	101.70	105.40
Average Charge per Medicare Discharge (CMI = 1.0)*	★★★★★	Excellent	17,899	25,249	28,769
Average Charge per Visit (RW = 1.0)*	★★★★★	Excellent	239	506	494
Routine Room Rate*	★★	Fair	2,332	1,664	2,003
Chest X - Ray(71020) *	★★★★	Good	305	393	399
Non - Govt.Payers %	★	Poor	15.10	21.70	23.40
Markup(Charges / Cost)	★★★★★	Excellent	2.27	3.55	3.68
Deduction %	★★★★★	Excellent	56.40	71.50	73
Net Patient Revenue per Equivalent Discharge™*	★★	Fair	7,999	9,467	9,034

Hospital Dashboard Report

Prosser Memorial Hospital

	Score	Rating	Prosser Memorial Hospital [501317]	Revenues: $25 - 75 Million [KEY1002]	All U.S. [STA0000]
Cost Position					
Hospital Cost Index®			N/A	104.90	100
Average Cost per Medicare Discharge (CMI = 1.0)*	★★	Fair	9,222	8,162	7,856
Average Cost per Visit (RW = 1.0)*	★★★★	Good	86	96	93
Direct Cost per Routine Day*	★★	Fair	759	612	593
Direct Cost per ICU/CCU Day*			N/A	1,085	1,111
Overhead Cost %	★★★	Average	33	36	34
Capital Costs per Equivalent Discharge™*	★★★★★	Excellent	254	669	607
Average Cost per Equivalent Discharge™*	★★★★	Good	8,178	9,667	9,055
Average Cost per Equivalent Discharge (Excl Subproviders & non-reimbursables)™*	★★★★	Good	6,471	7,932	7,352
Labor Costs					
Net Patient Revenue per FTE*	★★	Fair	191,391	185,578	207,936
Man-hours per Equivalent Discharge™	★★★★★	Excellent	0.0†	98.70	88.50
Physician Cost per Equivalent Discharge™*	★	Poor	1,091†	452	392
Salary per FTE*	★★★★★	Excellent	0†	74,430	74,951
Fringe Benefit %	★★★★★	Excellent	0.0†	23.40	24.50
Supply Costs					
Avg Pharmacy Cost per Medicare Discharge (CMI = 1.0)	★★★	Average	591	547	623
Avg Medical Supply Cost per Medicare Discharge (CMI = 1.0)	★★★★	Good	419	577	738
MSDRG 247 Supply Cost			N/A	2,951	3,216
MSDRG 470 Supply Cost	★	Poor	8,531	5,570	5,385
MSDRG 244 Supply Cost			N/A	4,942	5,156
MSDRG 330 Supply Cost	★★★★★	Excellent	1,038	1,860	2,069
MSDRG 194 Pharmacy Cost	★★	Fair	794	644	668
MSDRG 603 Pharmacy Cost	★★	Fair	984	741	766
MSDRG 392 Pharmacy Cost	★★	Fair	840	591	614
MSDRG 690 Pharmacy Cost	★★★	Average	548	515	542
Service Intensity					
Avg Lab Cost per Medicare Discharge (CMI = 1.0)*	★	Poor	728	438	427
Avg Radiology Cost per Medicare Discharge (CMI = 1.0)*	★★★★★	Excellent	147	240	238
Medicare LOS(CMI = 1.0)	★★★	Average	2.60	2.60	2.70
Ancillary Cost per Medicare Discharge (CMI = 1.0)*	★★★	Average	4,028	4,030	4,111
Non Operating Income					
Days Cash on Hand	★★★	Average	9	10	22
Investment Income / Investment %			N/A	2.20	2.20
Portfolio in Equities %			N/A	N/A	N/A
Investment Efficiency					
Days in A/R	★★	Fair	62	52	52
Inventory/ Net Patient Revenue %	★★★★★	Excellent	0.70	2.10	2
Revenue/ Net Fixed Assets	★★★★★	Excellent	4.37	2.51	2.55
Plant Obsolescence					
Average Age of Plant	★★	Fair	17.30	11.10	11.50
2-yr Change in Net Fixed Assets	★★★★	Good	6.50	-4.60	-1.20
Capital Position					
Long Term Debt/Equity %	★★★	Average	25.10	3.70	13.20
Average Cost of Equity %	★★	Fair	6.30	5.04	5.20
Times Interest Earned	★★★	Average	3.80	2.80	5
Debt Financing %	★★★	Average	32.50	42.60	38.80

IV. Internal Assessment
F. Historical Financial Performance
    ii. Balance Sheet & Statement of Operations

Prosser
Memorial Health

Balance Sheet

Assets	2011	2012	2013	2014	2015	2016	2017	2018	2019	Projected 2020
Current Assets										
Cash and Cash Equivalents	2,211,030	4,788,246	3,262,699	5,065,944	12,118,492	15,356,869	2,282,799	1,279,823	817,760	10,939,566
Short term investments								885,780	437,638	49,228
Receivables	8,046,803	5,600,249	8,203,154	7,347,821	8,238,098	8,395,331	10,004,908	17,006,553	26,427,775	26,187,665
Allowances for uncollectible accounts	2,048,635	872,416	1,752,000	574,991	1,542,678	1,516,520	1,883,000	8,840,000	15,682,980	16,300,000
Net Patient Accounts Receivables	5,998,168	4,727,833	6,451,154	6,772,830	6,695,420	8,878,811	8,121,908	8,166,553	10,744,795	9,887,665
Disproportionate Share and Proshare Receivables	184,338									
Estimated third-party payor settlements			791,820	73,386	378,254	72,844		622,040		1,355,482
Electronic health records incentive payment				200,000	1,651,000		305,494			
Taxes	22,039	21,514	18,968	18,646	14,531	26,065	23,124	24,789	26,908	37,191
Grants		111,342	79,529	65,365	52,456					
Other	457,604	361,716	239,955	134,161	12,531	75,438	171,564	30,756	195,041	183,083
Inventories	124,923	126,045	171,788	199,336	197,654	201,216	291,763	357,940	413,831	464,263
Physician Advances								192,798	220,234	266,619
Prepaid Expenses	274,745	197,720	96,431	165,659	143,768	375,390	304,717	304,724	1,226,953	1,165,505
Patient Trust Fund Assets										
Current portion of assets limited as to use										
Total Current Assets	9,272,847	10,334,416	11,112,344	12,695,327	21,264,106	22,988,633	11,501,369	11,815,203	14,083,160	24,348,602
Assets limited as to use										
Assets Limited as to use, less current portion	1,392,313									-
Cash and cash equivalents limited as to use for capital acquisitions		1,099,974	1,101,672	1,102,077	1,103,934	1,108,279	11,999,425	1,376,480	1,250,261	
Cash and cash equivalents restricted by bond agreement for capital acquisitions				6,928,911	1,799,262	973,969	976,204		346,920	1,212,866
Investments limited as to use for capital acquisitions								12,534,987	13,880,674	17,995,502
Physician Advances								190,267	156,015	
Net assets limited as to use	1,392,313	1,099,974	1,101,672	8,028,988	2,903,196	2,082,248	12,975,629	14,101,734	15,633,870	19,208,368
Capital assets, net	10,257,155	9,930,604	9,504,554	10,453,809	13,198,571	12,087,487	13,367,798	14,313,800	18,314,760	17,898,123
Deferred Financing Costs	8,025	6,242								
Total noncurrent assets	11,649,468	11,030,578	10,606,226	18,482,797	16,101,767	14,169,735	26,343,427	28,415,534	33,948,630	36,906,491
Total assets	20,930,340	21,371,236	21,718,570	31,178,124	37,365,873	37,158,368	37,844,796	39,730,737	48,031,790	61,255,093

Prosser Memorial Health

Balance Sheet

	2011	2012	2013	2014	2015	2016	2017	2018	2019	Projected 2020
Liabilites										
Current liabilities										
Accounts payable	949,543	645,022	715,103	921,137	1,431,512	1,539,941	1,160,673	915,866	1,192,142	1,211,895
Construction Payables	11,060									
Accrued payroll and related liabilities	281,131	375,951	408,645	524,643	795,675	751,863	1,105,709	1,586,757	2,282,536	1,265,684
Accrued paid time off	532,305	618,291	642,229	798,919	861,642	811,520	845,705	953,506	1,233,493	1,278,736
Estimated third-party payor settlements	560,000	696,160	300,270	408,118	582,075	1,214,797	856,120	1,148,700	472,704	1,401,127
Deferred Revenue	92,169									-
Accrued interest payable	1,747	1,184	389	21,099	21,099	21,099	21,099	20,307	19,670	59,009
Current portion of long-term debt	198,672	201,000	215,000	228,000	242,000	230,000	245,000	255,000	806,614	652,808
Current maturities of capital lease obligations								673,075	418,578	478,193
Total Current Liabilities	2,626,627	2,537,608	2,281,636	2,901,916	3,934,003	4,569,220	4,234,306	5,553,211	6,425,737	6,347,452
Other Liabilities										
Long-term debt, net of current portion	886,648	685,000	470,000	7,301,844	7,055,440	6,821,028	6,571,624	6,312,292	11,152,228	10,967,008
Capital Lease Obligations, less current portion								336,449		1,096,379
Total Liabilities	3,513,275	3,222,608	2,751,636	10,203,760	10,989,443	11,390,248	10,805,930	12,201,952	17,577,965	18,410,839
Deferred electronic health records incentive revenue					1,651,000	1,320,800	990,600	660,400	330,200	
Net Assets										
Net investment in capital assets	9,178,113	9,049,662	8,819,165	9,829,777	7,679,294	5,989,329	7,506,279	6,716,677	6,264,590	4,564,796
Restricted, expendable	2,181									
Unrestricted	8,236,771	9,098,966	10,147,769	11,144,587	17,046,136	18,457,991	18,541,987	20,151,708	23,859,035	38,279,458
Total Net Position	17,417,065	18,148,628	18,966,934	20,974,364	24,725,430	24,447,320	26,048,266	26,868,385	30,123,625	42,844,254
Total liabilities, deferred inflow of resources, and net position	20,930,340	21,371,236	21,718,570	31,178,124	37,365,873	37,158,368	37,844,796	39,730,737	48,031,790	61,255,093

Prosser Memorial Health

Statement of Operations

	2011	2012	2013	2014	2015	2016	2017	2018	2019	Projected 2020
Operating Revenues										
Net Patient Revenue, net of provision for bad debts	28,980,690	28,635,796	31,366,573	37,055,710	42,993,763	42,766,039	47,220,568	51,512,050	59,133,934	58,575,383
Electronic health records incentive payment		1,108,842	669,495	710,230	60,813	322,747	991,835	330,200	330,200	330,200
Disproportionate Share and Proshare Programs	317,692									-
Grants	23,662	89,895	623,468	564,277	326,227	57,334	15,480	19,341	1,040,213	13,723,124
Other	118,259	139,789	424,371	597,661	476,004	445,487	595,059	451,283	343,701	260,412
Total operating revenues	29,440,303	29,974,122	33,083,907	38,927,878	43,856,807	43,591,607	48,822,942	52,312,874	60,848,048	72,889,119
Operating Expenses										
Salaries and Wages	15,581,851	14,946,295	15,757,400	17,501,007	19,573,766	19,573,401	20,444,314	23,287,263	27,475,681	28,511,644
Employee Benefits	3,349,605	3,282,164	3,205,632	3,347,049	3,202,052	3,716,382	4,714,799	6,118,772	6,260,013	6,173,102
Professional fees	3,729,999	3,294,158	4,419,441	5,314,238	6,403,831	7,905,694	7,530,166	7,565,035	7,399,636	6,768,480
Purchased Services	2,418,129	2,517,650	2,838,094	3,252,361	3,671,812	3,597,372	4,050,206	4,093,715	4,568,821	2,959,723
Supplies	2,621,505	2,276,892	2,565,911	3,263,492	3,904,007	3,911,537	4,750,644	4,980,870	5,566,480	7,456,132
Insurance	550,767	509,955	542,592	560,892	482,824	362,087	255,248	241,381	312,599	823,287
Utilities	396,374	421,430	460,810	474,444	472,512	476,345	465,846	520,065	535,779	573,047
Depreciation	1,188,333	1,155,509	1,184,500	1,215,387	1,220,902	1,897,848	2,063,342	1,988,410	2,443,594	2,755,866
Repairs and maintenance	177,289	56,279	246,494	220,419	267,896	318,028	489,253	309,142	279,995	460,175
License and taxes	190,701	210,802	194,922	259,297	293,818	344,137	284,240	343,191	425,776	433,926
Leases and rentals	908,586	1,035,366	1,186,234	1,476,517	1,725,839	1,878,800	1,859,223	1,998,258	2,157,531	2,066,676
Other	374,709	369,780	389,755	478,039	485,078	425,139	967,318	1,176,470	1,161,324	571,047
Total Operating Expenses	31,487,848	30,070,280	32,991,785	37,363,142	41,704,337	44,406,870	47,874,599	52,602,572	58,587,229	59,553,105
Operating Income	(2,047,545)	(96,158)	92,122	1,564,736	2,152,470	(815,263)	948,343	(289,698)	2,260,819	13,336,014
Taxation for maintenance and operations	662,404	704,603	714,568	734,247	762,583	781,210	784,095	821,455	846,680	922,372
Investment Income	4,139	2,833	1,873	4,876	8,787	15,002	17,530	192,001	423,827	137,261
Interest Expense	(26,601)	(22,030)	(22,065)	(12,152)	(92,290)	(253,318)	(178,423)	(167,241)	(351,114)	(425,602)
Gain (loss) on disposal of assets		(5,159)	(44,820)	(19,870)	5,027	(5,741)	1,000	(150,726)	61,850	(59,297)
Gift shop revenue								63,687	81,282	40,458
Gift shop expenses								(62,863)	(83,634)	(31,978)
Contributions made to Others								(15,327)	(19,263)	
Fundraising and other Foundation expenses								(12,910)	(4,613)	(8,631)
Contributions								441,741	39,406	64,286
Bond issuance costs				(164,407)						
Total nonoperating revenue (expenses), net	639,942	680,247	649,556	542,694	684,107	537,153	624,202	1,109,817	994,421	638,869
Excess of revenues over expenses before capital contributions and loss on contributions receivable	(1,407,603)	584,089	741,678	2,107,430	2,836,577	(278,110)	1,572,545	820,119	3,255,240	13,974,884
Capital contributions	428,864	147,474	76,628		914,489	-	28,401	-	-	-
Loss on contributions receivable				(100,000)						
Net Income	(978,739)	731,563	818,306	2,007,430	3,751,066	(278,110)	1,600,946	820,119	3,255,240	13,974,884

Prosser
Memorial Health
Financial Analysis Graphs

Net Patient Revenue

Operating Income
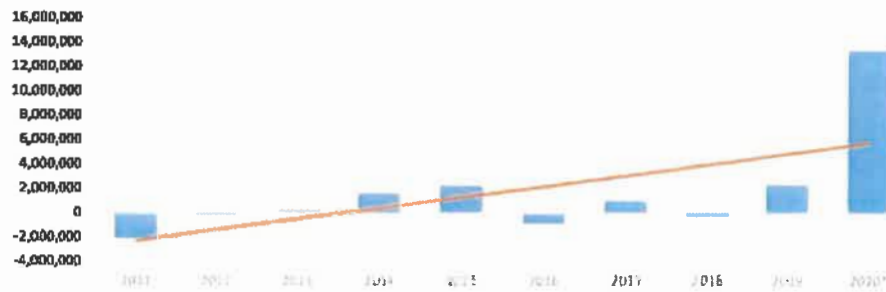
Operating Margin
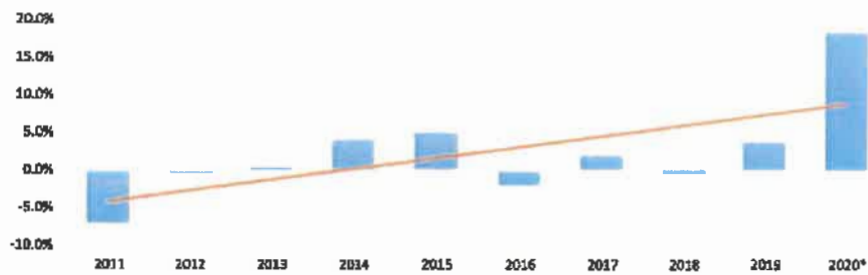
2020 is projected based on August Year To Date Performance.

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Memorial Health
Financial Analysis Graphs

Labor + Benefits % of Net Revenue
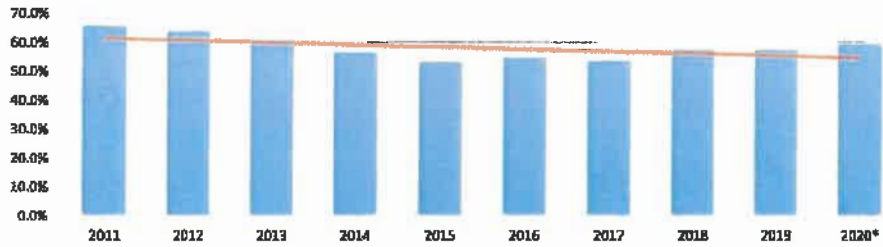
Benefits as a % of Labor
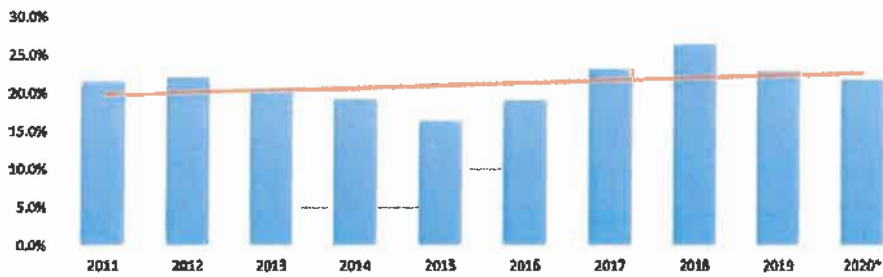
FTE's
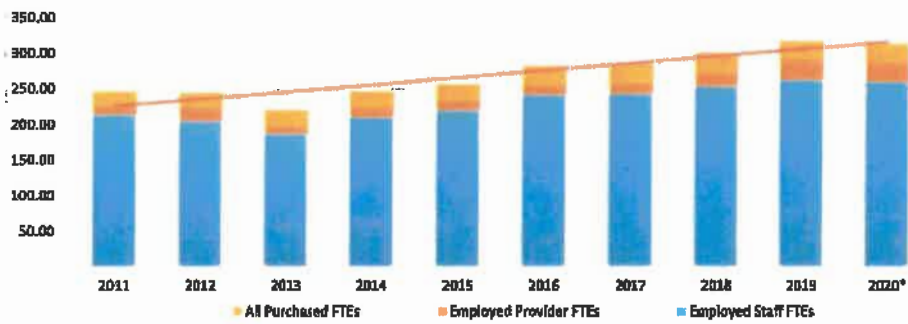
2020 is projected based on August Year To Date Performance.

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Net Operating Revenue per FTE
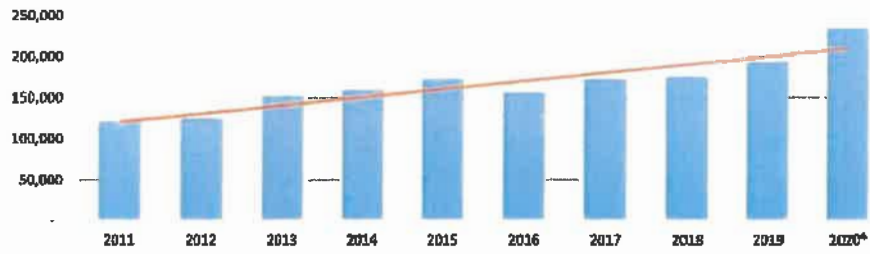
Labor Cost per FTE
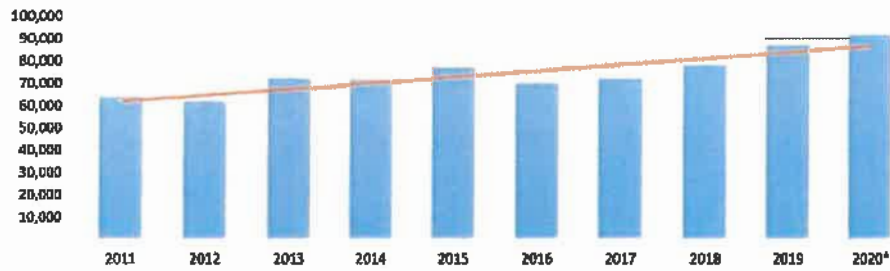
Long-term Debt to Total Assets
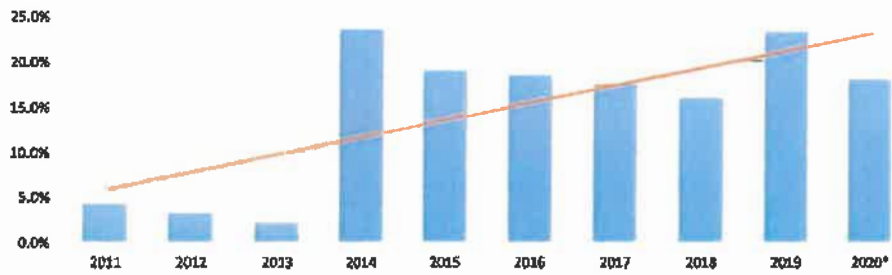
2020 is projected based on August Year To Date Performance.

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Total Debt to Total Assets
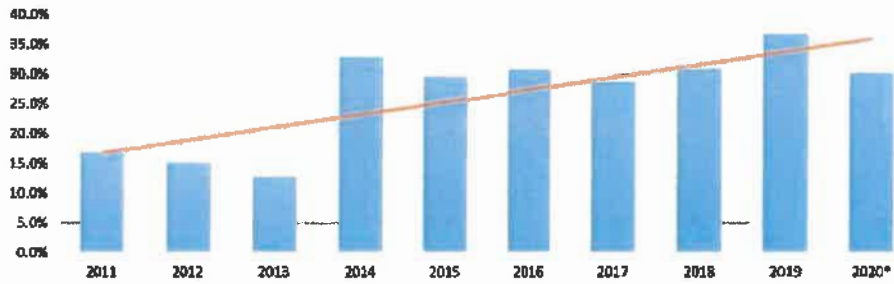
Total Debt to Total Equity
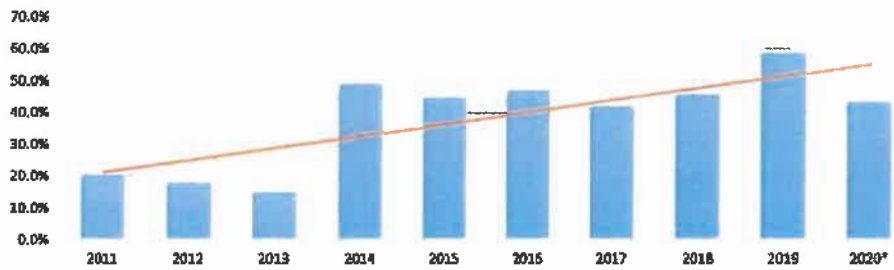
Long-term Debt to Total Equity
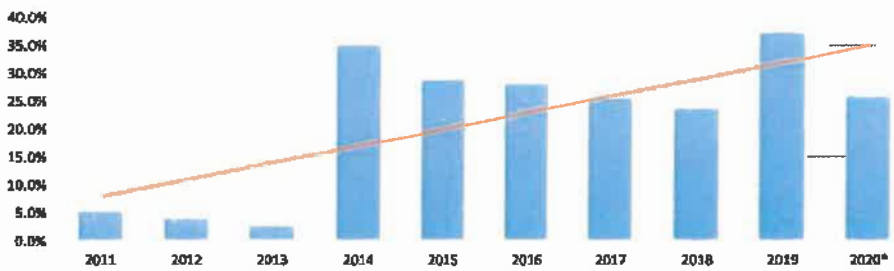
2020 is projected based on August Year To Date Performance.

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Financial Analysis Graphs

Days Cash on Hand
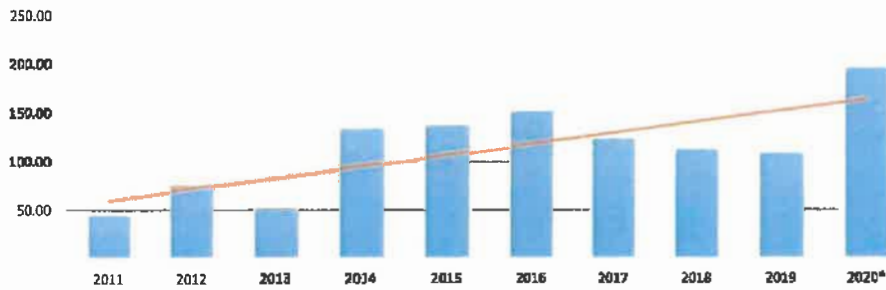
Cash Flow to Total Assets
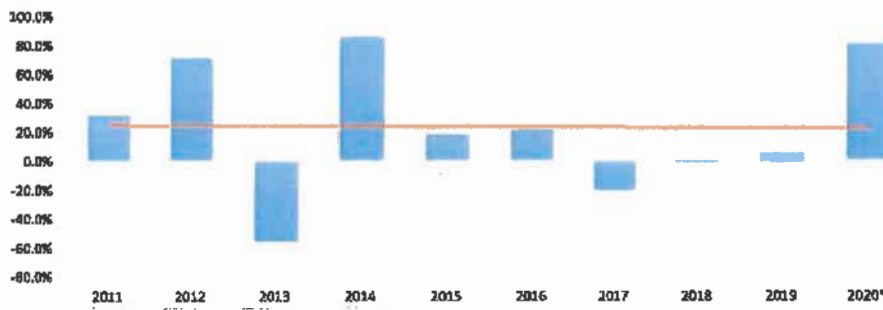
Net Days in A/R
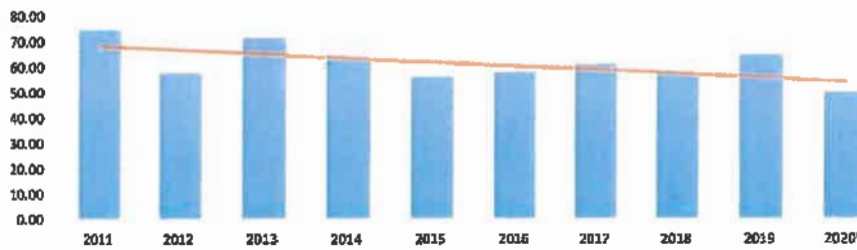
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Return on Assets

Current Ratio
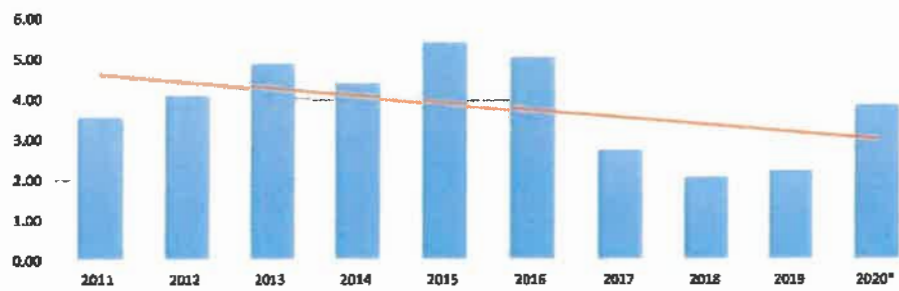
Return on Equity
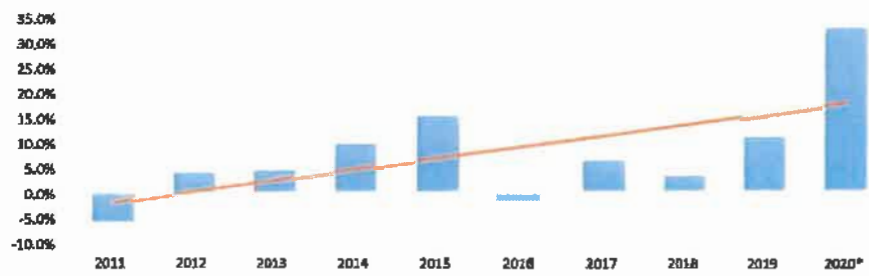
2020 is projected based on August Year To Date Performance.

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Net Income
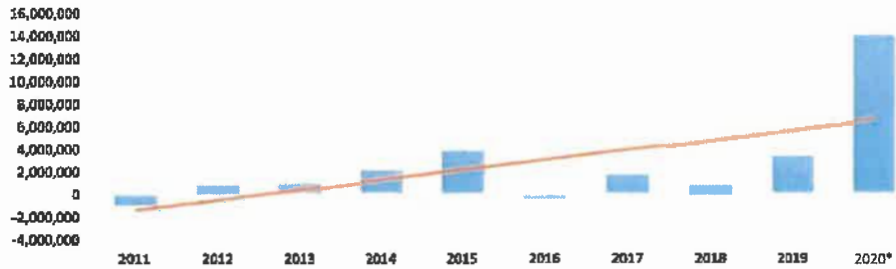
Total Margin

Capital Spend

2020 is projected based on August Year To Date Performance.

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Depreciation
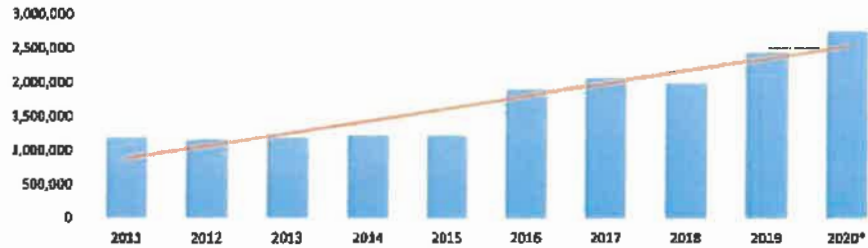
Average Age of Plant
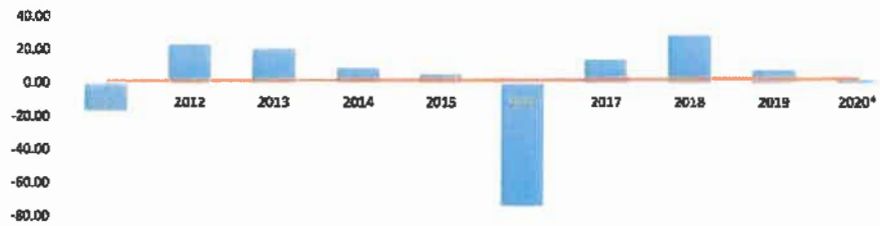
Net Worth
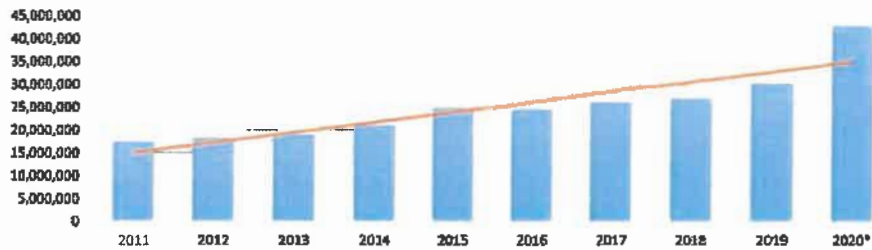
2020 is projected based on August Year To Date Performance.

Prosser
Memorial Health
Financial Analysis Graphs

Excess of Revenues over Expenses
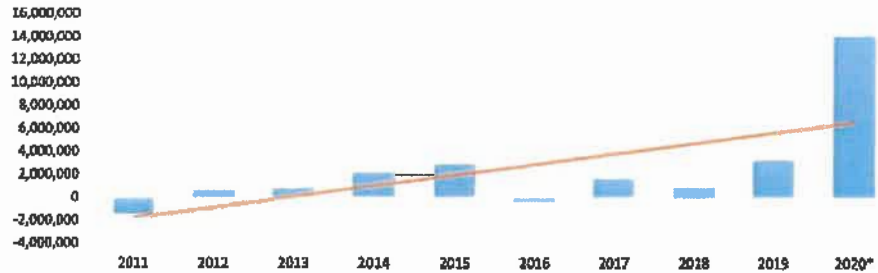
Total Operating Expenses
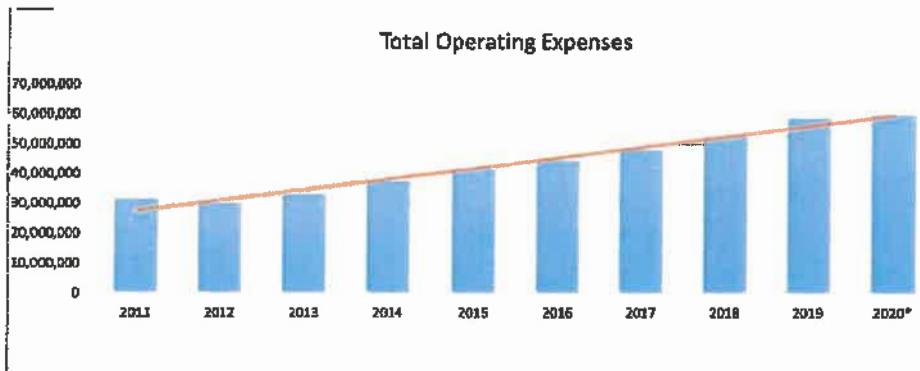
Net Patient / Operating Expense Growth Percentage

■ NET PATIENT REVENUE % GROWTH   ■ TOTAL OPERATING EXPENSE % GROWTH

Medicare Case Mix Index

2020 is projected based on August Year To Date Performance.

176
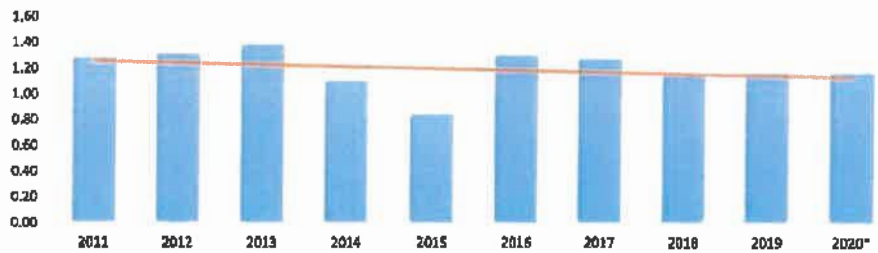
IV. Internal Assessment

G. Service Line Analysis

     i.   Organizational Chart

     ii. Statistics

     iii. Trend Line Graphics

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

Those We Serve

Rehabilitation Services
Joe Ashton

Laboratory
Susan Miklas
Infection Control

Diagnostic Imaging
Aurora Weddle

Cardiopulmonary
Rusti Wilson

Pharmacy
Lindsey McKie

EMS/CPP
Bryon Scheer/Jeff Fitzgerald
Interim

Surgical Services
Sara Dawson

Family Birthplace
Cindy Raymond

Acute Care
Maria Davis
Swing Bed
Case Management/
Social Work

Emergency Services
Christi Doornink-Osborn

PMH Clinics
Alana Pumphrey
- Benton City Clinic
- Pain Management

Primary Care
Molly Schutt
- Prosser
- Women's Health
- Grandview

Prosser Specialty Clinics
Tricia Hawley

Chief Medical Officers
Dr. Brian Sollers
Dr. Terry Murphy
Dr. Syed Hashmi
Dr. Jacobo Rivero

Medical Staff Services
Credentialing

Medical Staff Recruitment

Quality Assurance/Risk
Management
Kristi Mohema (CQO/CCO)

Marketing/Community
Relations/Foundation
Shannon Hitchcock (CCO)

Human Resources

Information Systems
Kevin Hardiek (CIO)

Maintenance/Support Services
Steve Broussard

Environmental Services
Geary Judkins

Nutrition Services
Victor Huyke

Director of Finance
Stephanie Titus
- Payroll/AP
- Accounting

Revenue Cycle Services

Patient Registration
Deann Williams

Health Information
Management
Andrea Vad (CPO)

Material Management

Chief Nursing Officer
Merry Fuller (CNO/COO)

Chief Executive Officer
Craig Marks (CEO)

Chief Financial Officer
David Rollins – (CFO)

Board of Commissioners

Statistics

Description	2011	2012	2013	2014	2015	2016	2017	2018	2019	Projected 2020
Admissions										
Hospital	673	656	678	627	838	887	982	894	992	966
Swing Bed	89	84	76	127	169	142	145	132	141	123
Nursery	343	299	275	174	325	379	389	388	439	480
Patient Days										
Hospital	616	746	935	1,089	1,108	1,195	1,533	1,334	1,595	1,544
Swing Bed	1,168	1,183	849	1,669	2,427	2,170	2,069	2,049	2,160	1,632
Nursery	581	496	465	300	523	552	631	601	684	669
Average Daily Census										
Hospital	2	2	3	3	3	3	4	4	4	4
Swing Bed	3	3	2	5	7	6	6	6	6	4
Nursery	2	1	1	1	1	2	2	2	2	2
Case Mix Index										
Hospital	0.80	0.83	0.83	0.95	0.63	0.94	0.99	0.88	0.89	0.89
Medicare	1.28	1.31	1.38	1.10	0.84	1.30	1.27	1.14	1.16	1.16
Length of Stay										
Hospital	1	1	1	2	1	1	2	1	2	2
Swing Bed	13	14	11	13	14	15	14	16	15	13
OB	2	2	2	2	2	1	2	2	2	1
Adjusted Patient Days	9,642	10,042	8,742	12,419	15,479	14,410	14,564	16,480	19,494	16,311
Surgeries - Inpatient	236	228	240	186	238	158	261	228	226	249
Surgeries - Outpatient	709	640	673	901	1,025	1,094	1,160	1,176	1,192	869
Total Surgeries	945	868	913	1,887	1,263	1,252	1,421	1,404		1,118
Births	343	299	275	174	325	379	389	388	439	480
Laboratory Tests	123,226	114,348	89,184	97,529	96,612	104,523	105,247	116,050	132,610	135,485
EKG Tests	1,603	1,686	2,600	4,227	4,647	3,396	3,046	3,202	3,767	4,196
Cardiopulmonary Tests	23,300	18,316	7,717	6,210	6,880	8,442	9,886	7,866	7,618	6,428
Diagnostic Imaging Exams	14,923	14,013	14,341	17,798	18,756	19,734	17,632	19,786	23,484	25,068
Pharmacy Items	102,581	108,966	101,479	138,024	217,192	706,926	713,914	664,546	884,229	878,451
Nutritional Services Meals	16,533	14,444	13,756	19,070	24,140	37,383	45,395	62,602	32,783	40,913
Laundry Pounds	144,026	145,028	143,494	164,286	196,779	192,177	204,741	213,144	217,818	207,098
Outpatient Special Procedures	1,051	1,250	1,523	2,431	2,047	1,721	1,920	2,705	2,688	2,802
Therapy Clinic Visits	9,692	10,128	11,619	13,900	15,924	16,148	16,894	18,589	19,289	14,877
Emergency Department Visits	8,293	8,242	8,004	9,237	9,558	9,877	10,165	11,162	12,190	9,858
Hospitalists Visits	0	0	0	0	2,956	2,915	3,587	3,551	3,410	2,742
EMS Trips (w. CPP)	2,000	2,001	1,832	2,612	2,825	3,030	2,849	2,842	2,791	2,307
Benton City Clinic Visits	8,165	6,620	8,478	10,797	11,913	11,906	8,734	10,287	11,493	10,466
Prosser Specialty Clinic Visits	7,198	8,317	6,900	8,605	9,315	8,870	9,709	10,459	11,404	11,136
Prosser Clinic (w. Occ Health) Visits	0	0	0	2,038	2,764	2,984	4,808	9,854	11,522	12,876
Comprehensive Pain Mgmt Clinic Visits	0	0	0	0	0	0	0	441	955	722
Grandview Clinic Visits	0	0	0	0	0	0	0	0	6,812	7,395
Prosser Women's Health	0	0	0	0	0	0	0	0	5,627	6,892
Outpatient Hospital Visits	40,485	40,154	42,739	49,652	51,561	52,561	52,532	91,064	109,275	109,839
Labor Full-Time Equivalent										
Employed Staff FTE's	214.34	204.73	186.45	209.65	219.65	241.57	243.20	253.32	262.90	260.09
Employed Provider FTE's	9.94	17.96	9.59	11.72	12.70	11.30	12.21	17.69	27.01	26.10
ALL EMPLOYEE FTE'S	224.28	222.69	196.04	221.37	232.35	252.87	255.41	271.01	289.91	286.19
Outsourced Therapy FTE's	10.96	10.96	10.86	12.96	13.90	15.31	15.11	16.15	16.87	16.35
Contracted Staff FTE's	7.00	7.00	7.00	7.39	4.60	8.03	9.72	3.68	4.11	4.13
Contracted Provider FTE's	3.85	2.99	5.64	4.54	4.61	5.64	5.64	9.18	5.91	5.71
ALL PURCHASED FTE'S	21.81	20.95	23.60	24.89	23.11	28.98	30.47	29.01	26.89	26.19

Prosser
Memorial Health

Service Line Analysis Graphs

Total Admissions
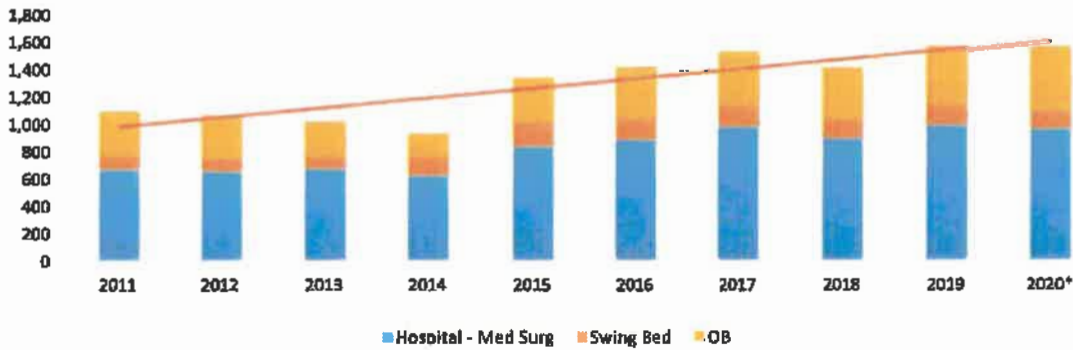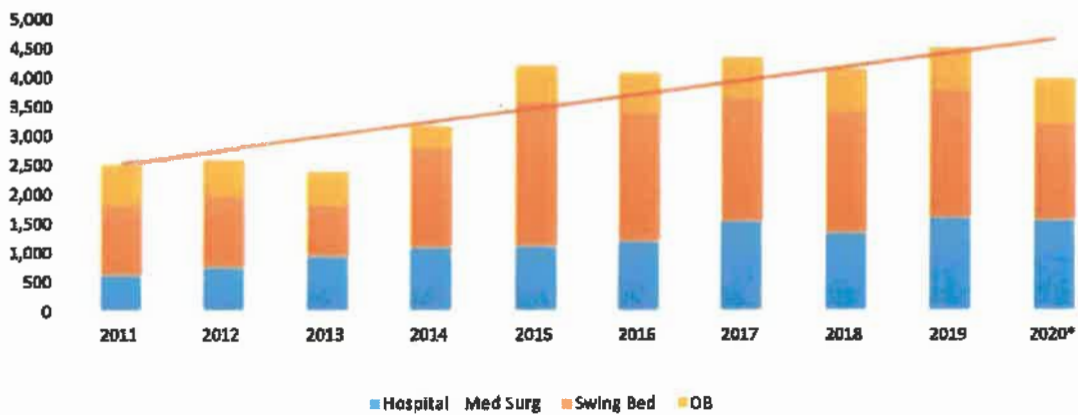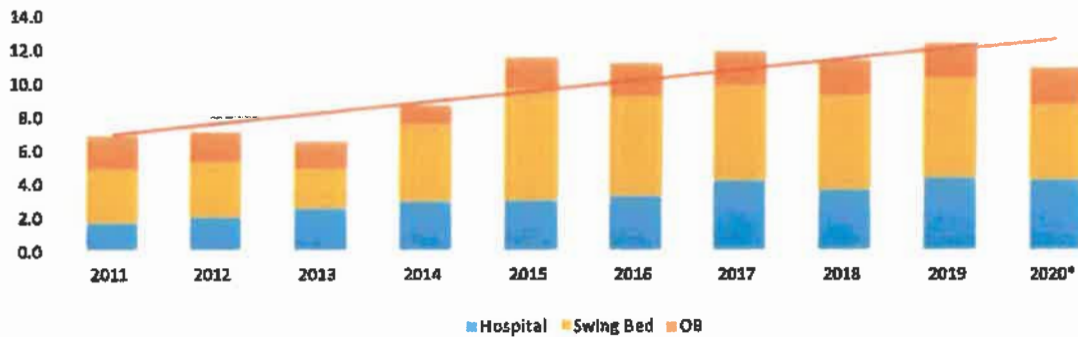
Legend: Hospital - Med Surg | Swing Bed | OB

Total Patient Days

Legend: Hospital Med Surg | Swing Bed | OB

Average Daily Census

Legend: Hospital | Swing Bed | OB

2020 is projected based on August Year To Date Performance.

Prosser
Memorial Health

Service Line Analysis Graphs

Case Mix Index

Hospital

Length of Stay

Hospital   Swing Bed   OB
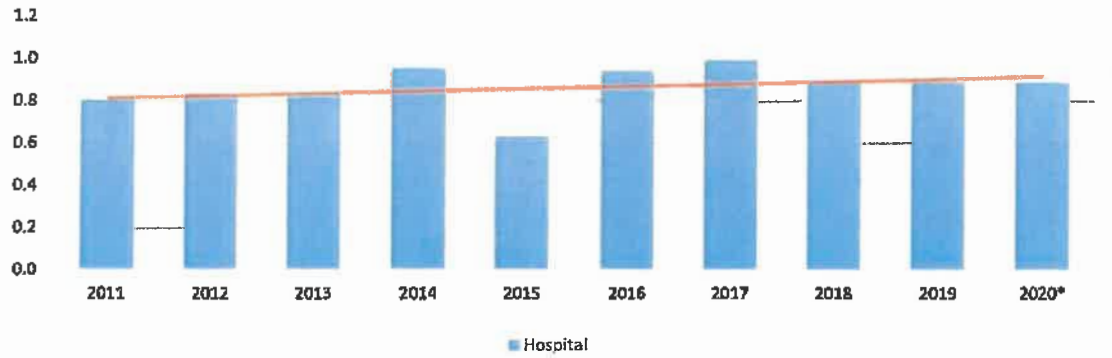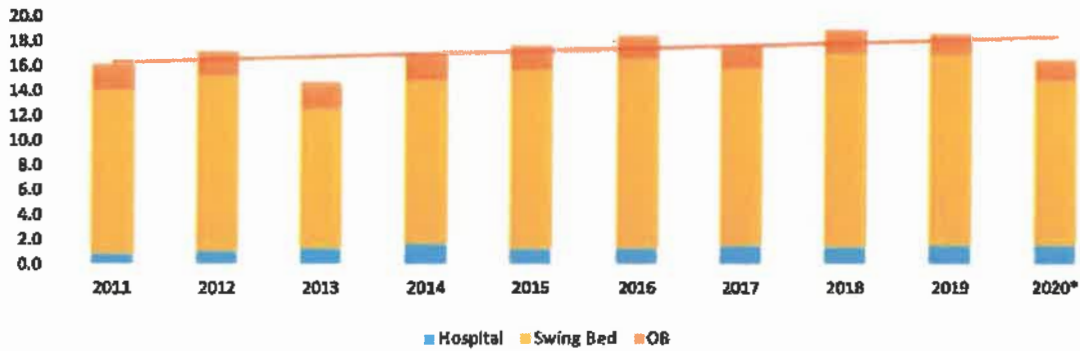
Adjusted Patient Days

2020 is projected based on August Year To Date Performance.

![Prosser Memorial Health logo]

Service Line Analysis Graphs

Surgical Services - Procedures

Surgeries - Inpatient   Surgeries - Outpatient

Surgical Room Minutes

Surgeries - Inpatient   Surgeries - Outpatient
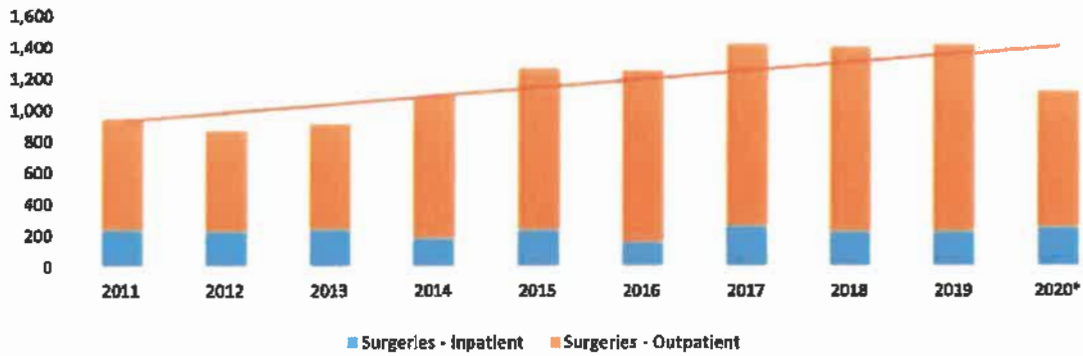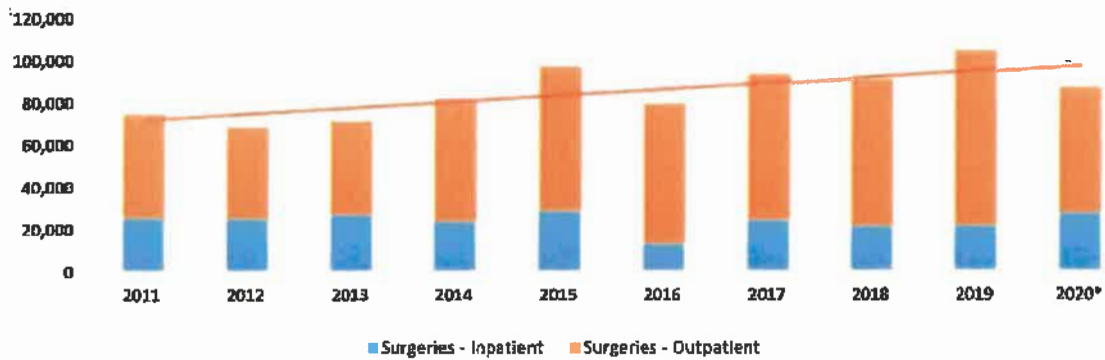
Births

2020 is projected based on August Year To Date Performance.

Prosser
Memorial Health

Service Line Analysis Graphs

Laboratory Tests

Legend: Inpatient, Outpatient

EKG Tests

Note: No data prior to 2013

Legend: Inpatient, Outpatient
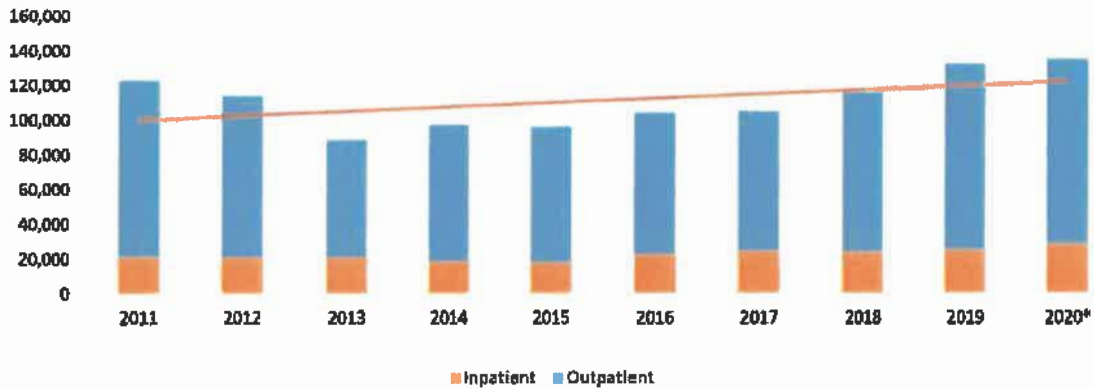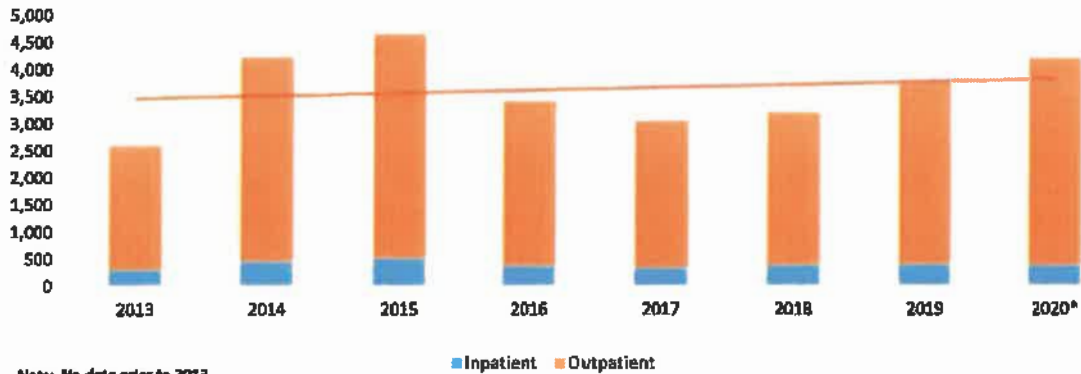
Cardiopulmonary Tests

Note: No data prior to 2013

Legend: Inpatient, Outpatient

*2020 Is projected based on August Year To Date Performance.

Prosser
Memorial Health

Service Line Analysis Graphs

Diagnostic Imaging Exams
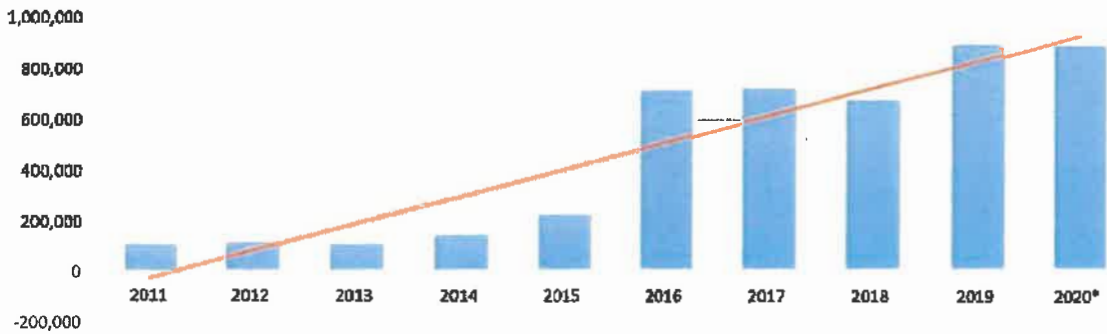
Inpatient ■ Outpatient

Pharmacy Items

2020 is projected based on August Year To Date Performance.

Prosser
Memorial Health

Nutritional Services Meals
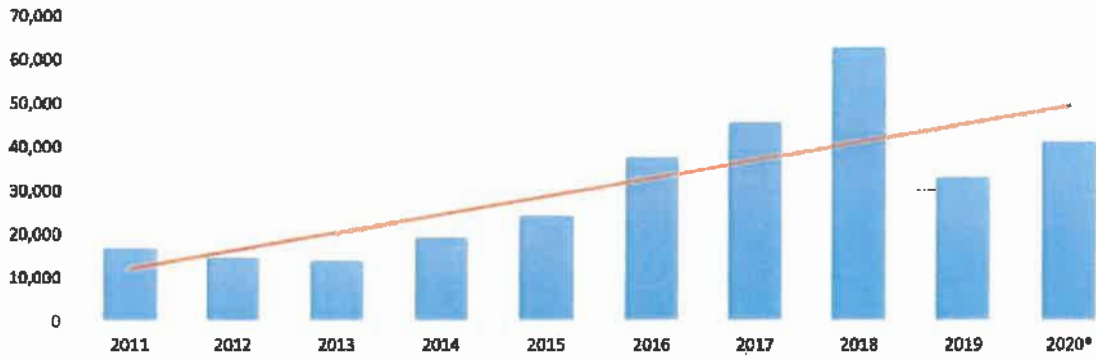
Laundry Pounds
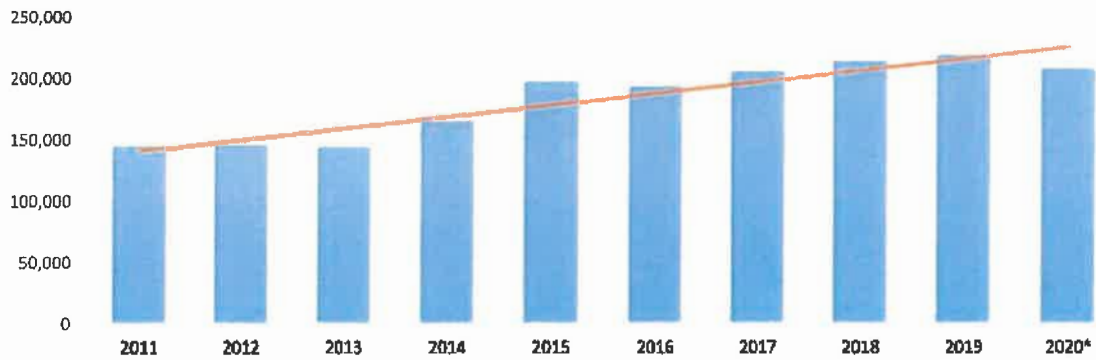
2020 is projected based on August Year To Date Performance.

Prosser
Memorial Health

Service Line Analysis Graphs

Outpatient Special Procedures
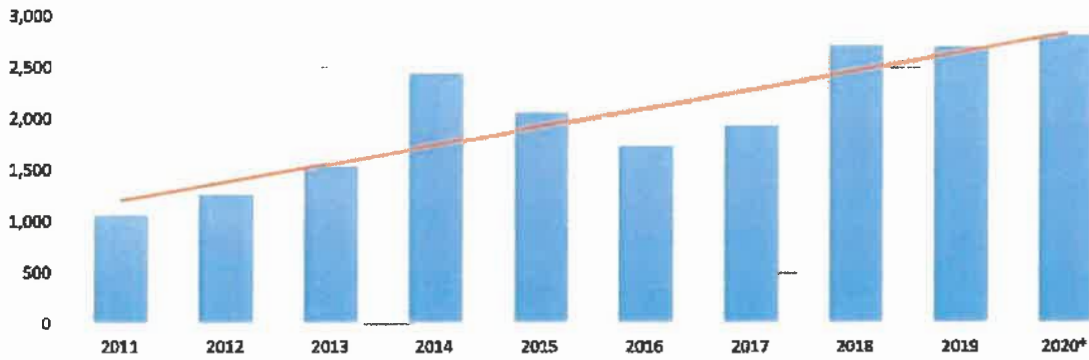
Total Therapy Clinic Visits
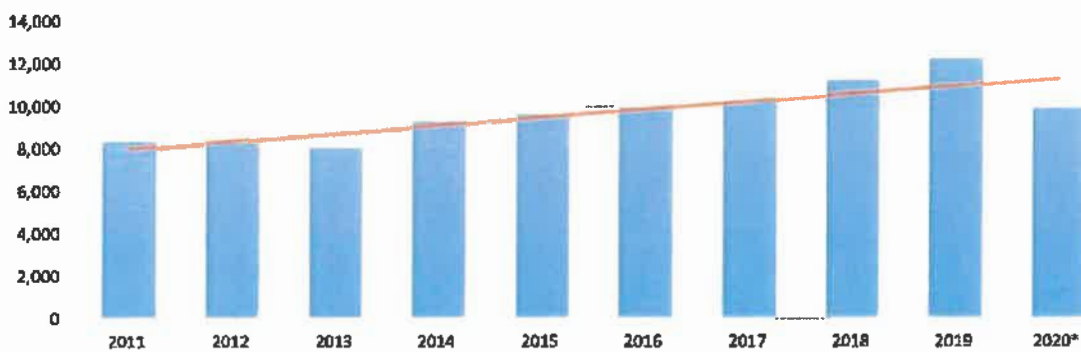
■ Physical Therapy ■ Speech Therapy ■ Occupational Therapy

Emergency Department Visits

2020 is projected based on August Year To Date Performance.

186

Prosser
Memorial Health

Service Line Analysis Graphs

Hospitalists Visits

Emergency Medical Services

■ AMBULANCE ■ :CPP
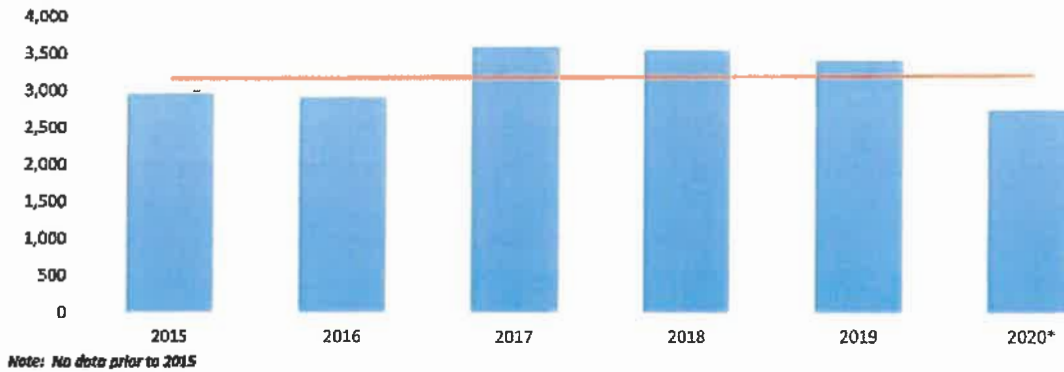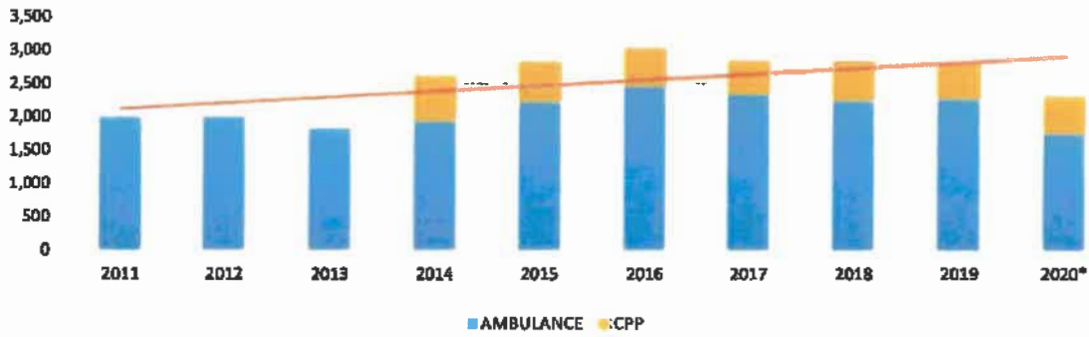
Total Benton City Clinic Visits
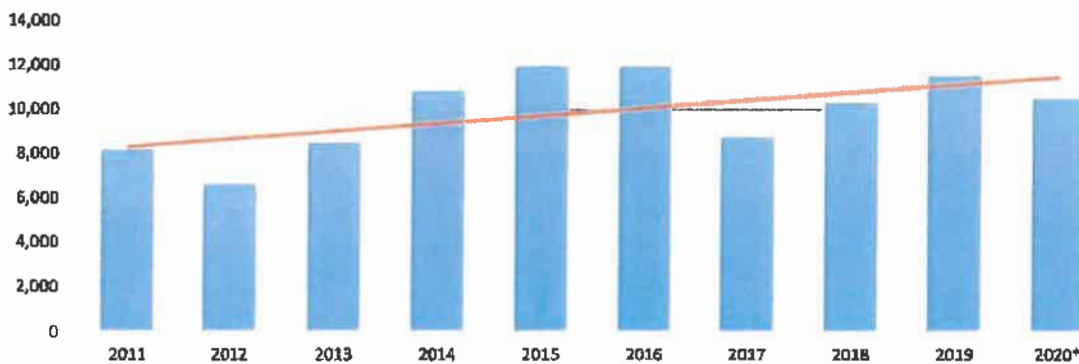
*2020 is projected based on August Year To Date Performance.

187

Prosser
Memorial Health

Total Prosser Specialty Clinic Visits

Total Prosser Clinic Visits
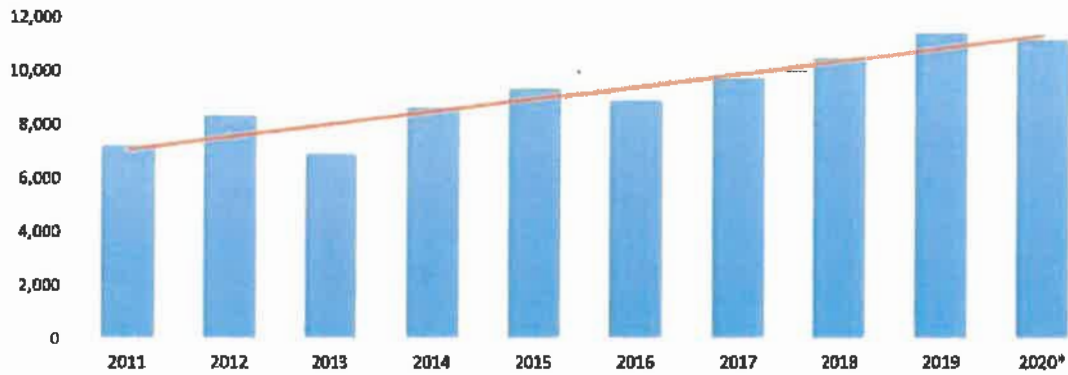
Legend: ■ Prosser Clinic Visits ■ Occupational Health Visits
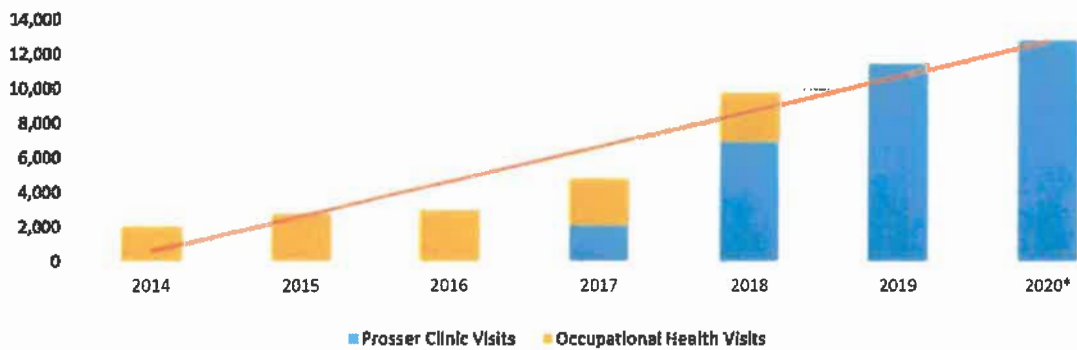
Total Grandview Clinic Visits

Note: Grandview Clinic opened January 2019

*2020 is projected based on August Year To Date Performance.

![Prosser Memorial Health logo]

Service Line Analysis Graphs

Total Women's Health Clinic Visits

Note: Women's Health Clinic opened April 2019

Total Outpatient Visits
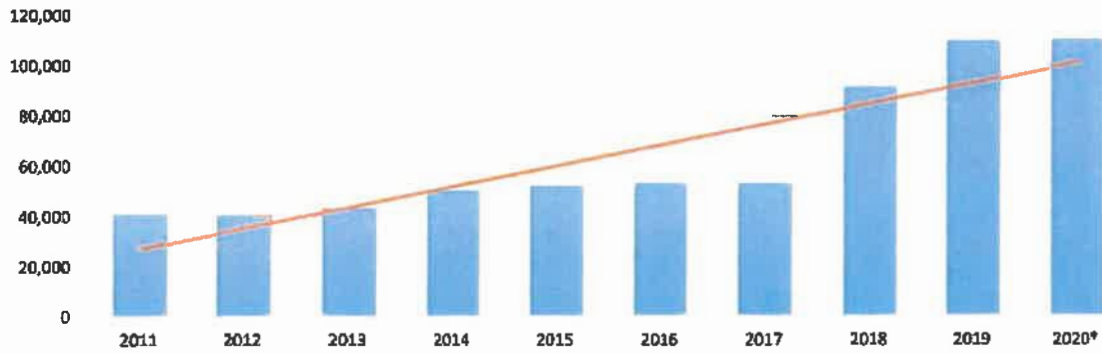
2020 is projected based on August Year To Date Performance.

V. Replacement Facility Update
A. Draft Prospectus Report

Prosser

Memorial Health **Foundation**

Prosser Memorial Health

New Hospital Prospectus

prosserhealth.foundation

Introduction

For more than 70 years, Prosser Memorial Health (PMH), a rural, 25-bed critical access hospital, has served Prosser and its surrounding communities. After years of enthused community-led fundraising, PMH's rich history began in 1945 when construction crews broke ground on the 19-bed facility. Two years later, on December 26, 1947, Prosser Memorial Hospital opened, dedicated to the memory and service of World War II veterans.

This modest, small-town hospital blossomed into a community-focused center for exceptional medical care serving thousands of patients every year. Our care and provider base scope includes family medicine, advanced surgical care, laboratory, state-of-the-art diagnostic imaging, obstetrics, and emergency care.

Today, the hospital's facilities are dated and not fully compliant with the Americans with Disabilities Act. Building a new facility is a more cost-effective approach than renovating the hospital. We have land for a new hospital. We plan to sell the existing grounds and facility.

Our Mission

Prosser Memorial Health will improve the health of our community.

Our Vision

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

Our Six Pillars of Excellence

#1 Patient Loyalty: PMH will provide outstanding customer service, aspiring to treat those we serve the way they want to be treated.
GOAL: PMH will achieve a patient satisfaction rate of 95% or higher.

#2 Medical Staff Development: PMH will respond to the Medical Staff concerns and needs in a timely manner, pursue initiatives in collaboration with our Medical staff and ensure the availability of the appropriate providers for those we serve.
GOAL: PMH will achieve and maintain an annual Medical Staff satisfaction rate of 90% or higher.

#3 Employee Development: PMH will encourage and provide for the ongoing development of our employees. We will provide an atmosphere that values our employees and promotes:
- Open Communication.
- Competitive wages and benefits.
- Selection and retention of effective, caring personnel.
- Utilization and development of talent throughout the organization.
- On-going education.
- Employee recognition.

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

#4 Quality: PMH will develop and maintain a system of continuous improvement which is incorporated into the daily work of every employee and Medical Staff member.
GOAL: PMH will achieve an iVantage score of 49 or higher.

#5 Services: PMH will develop and maintain appropriate facilities, technology and services to meet the needs of those we serve that includes building a replacement facility.
GOAL: PMH will achieve a 50% market share of our great community for those services we provide.

#6 Financial Stewardship: PMH will continue to strengthen its financial stewardship position to enhance the ability to develop new services, obtain needed technology, modernize facilities, recruit physicians and ultimately ensure long-term viability.
GOAL: PMH will achieve an annual total margin of 6% or more.

PMH Stats & Impacts

Major Employer
400+ Full Time Employees

$35,300,000 Salaries & Wages
Compensation multiplies throughout the area spent on groceries, dining, retail goods, services, vehicles, and more!

Hospital Admissions
Category Growth

Hospital Admissions and outpatient services have consistently increased since 2015. Infant births have increased by nearly 24%. Adjusted patient days that include inpatient and outpatient services combined have more than doubled since 2013. We have grown our active medical staff 66% since 2017.

All statistics are 2020 budget or annualized.

About the Foundation

The Prosser Memorial Health Foundation pursues, receives, and administers donations and gifts for PMH. The Foundation supports and enhances healthcare for the Lower Yakima Valley and the surrounding region. The Foundation assists with new equipment purchases, funding for scholarships, building projects, and other organizational advancements.

The Foundation has several designated funds. The Wayne Hogue Capital Fund will "host" gifts for the new hospital.

The Wayne Hogue Capital Fund: *Financial support for staff training, hospital equipment, and facility improvements, including building the new hospital.*

Wayne, a generous philanthropist and businessman, leads by example. As a past Chairman of our Board of Commissioners, he used his many resources and talents to improve the high-quality healthcare we enjoy today.

Wayne believed for fundraising, "You just have to ask." The Hospital and Wayne's objectives are well-aligned for the best options and treatment with advanced technology and resources delivered in an inviting environment.

Community support from businesses, individuals, and foundations for the new hospital will be administered through this fund.

Our Community Need

Before the COVID-19 pandemic, PMH grew at a rate of 10% each year for the last four years. We have expanded service lines, purchased new equipment, and added clinics and providers to our team in response to community needs. Today it is clear we must continue to grow and respond to the increased demand for high-quality, low-cost healthcare in the communities we serve.

Our patient count from both east and west of Prosser continues to grow. Patients have changed their healthcare provider because they trust PMH, and they know they will receive excellent care with dignity, respect, and optimism.

Our current facility is from a post-World War II era with many renovation and expansion rounds to stay current. Unfortunately, we have run out of room to expand the hospital at its current location. The facility is not ADA compliant and struggles to meet state and federal regulations for hospitals.

The hallways are narrow, operating rooms are too small to contain all the new equipment needed, with no private rooms for inpatient care. There is a lack of parking and treacherous winter conditions make navigating the hill upon which the hospital sits challenging.

The Way Forward

This is How We Care is not merely a PMH slogan; it is our way of life. We are committed to delivering high-quality healthcare. To serve our community now and well into the future, we plan to build a new hospital off I-82 and Gap Road. PMH purchased 33 acres there in 2017.

Since 2017, we have worked closely with the United States Department of Agriculture (USDA) on the extensive application process to secure a loan. The USDA approved our pre-application in 2019, which included a site visit to our current hospital. They agreed, PMH requires a new facility to care for patients.

With the USDA loan PMH will not bring a levy or bond to voters to fund this project. The architect and construction consultants project we would open the doors to the new hospital in early 2024, following the hospital's 75th anniversary in 2023.

The USDA loan requires community support as a component of the loan. To demonstrate substantial community support. We anticipate needing to raise $5 million dollars from the community.

Preliminary Cost and Revenue Projections

Estimated USDA loan proceeds	$47,300,000
Estimated PMH contribution	$12,700,000
Community fundraising goal	$5,000,000
Funding Total	**$65,000,000**

With the support and generosity of our community we will be able to build a state-of-the-art facility that will serve our needs for the next 100 years.

Preliminary Layout for a New Hospital

(This is a first phase draft. As the project progresses, we will share the most current renderings with our donors.)

NOTES:

1. +/-84,800 SF
2. Great I2/B separation
3. Good future expansion paths for ED/Imaging/Surgery
4. Admin (soft space) for internal department growth.
5. Good future connection point for future MOB
6. HUB IP unit allows for skeletal staffing.
7. Pharmacy is located upstairs, adjacent to IP and LDRP.
8. Short walks to all departments from main entrance.
9. Best option for future patient room growth.

Outcomes

Prosser Memorial Health will be a **Center of Excellence**, providing high-quality, low-cost healthcare services to the communities we serve. This includes:

- State-of-the-art surgical suites and technology to respond to the needs in our community.

- New Birthing suites will allow for water-birth opportunities, enabling more flexibility to accommodate mothers' preferences in delivery.

- All inpatient rooms will be a private room with amenities to accommodate family and support people for our patients comfortably.

- 16% of rooms will be equipped for ICU, providing a higher level of care for our patients and keeping them close to home.

- Expand the Cardiology Clinic to include cardiac rehab and pulmonology, allowing patients recovering from a heart attack or pulmonary issues to stay in Prosser for their rehabilitation.

- A savings of 10 to 15 percent annually in utility costs with a new facility.

- Expanded Emergency Department.

- Medical Office Building for Specialists.

Why a Capital Campaign?

With most of the new hospital funding proposed to come from a USDA loan, some have questioned the necessity of a community capital campaign. A critical component of the USDA loan process is to demonstrate community support for this project. The capital campaign is the most effective means to illustrate the engagement by our region's stakeholders.

Campaign Oversight and Accountability

The Foundation Board of Directors and Hospital Board of Commissioners will oversee the capital campaign initiative. The Foundation Executive Director Shannon Hitchcock and Foundation CFO Stephanie Titus will manage administrative support and financial reporting.

Thank You!

We appreciate you reviewing this summary of our plan. Your thoughts and counsel about this exciting endeavor are essential.

Prosser Memorial Health Foundation Board of Directors

Officers
President – Julie Sollers
Vice President – Rich Legerski
Secretary – Lois Chilton
Treasurer – Evan Tidball

PMH Staff
Craig Marks – Chief Executive Officer
Shannon Hitchcock – Foundation Executive Director
Stephanie Titus – Foundation Chief Financial Officer

Board Members
Elisa Riley
Emily Carl
Frank Schroeder
Glenn Bestebreur
Keith Sattler
Lisa Veloz
Neal Ripplinger
Stephen Kenny
Susan Reams

VI. Medical Staff Analysis
A. Medical Staff Recruitment Model

MEDICAL STAFF MODEL

&

PROVIDER RECRUITMENT/SUCCESSION PLAN

FY 2017-2024

October 1, 2020

This Medical Staff Model and Provider Recruitment Plan provides us with a roadmap for provider recruitment, retention and succession planning for the next few years. A roadmap alone does not guarantee a successful journey, however, the data presented strongly suggests provider recruitment must remain a top priority for the coming years. The Model will be used as a tool to not only better understand current and future healthcare needs of our Service Area, but also to guide our critical evidence based decisions to address those needs and improve the lives of the residents in the PMH Primary and Secondary Service Areas.

Methodology/Overview

The Model is based upon many different data sources including the Merritt Hawkins Cooper Physician Requirements Model, US Census Bureau, and secondary data from local sources. The most recent data available was collected for this report and five year trends are presented:

1. Population data was divided among five logical geographic communities: Prosser, Grandview, Sunnyside, Benton City, and Mabton. The purpose of the division was to align with the current primary and secondary PMH service areas. Population growth was also factored into the model to give an overall picture of each community;

2. All physicians and advanced practice clinicians in each community service area were identified, regardless of affiliations or specialty;

3. The Cooper Model (which indicates the number of providers by specialty that a community can financially support) was used to identify the physician needs for the communities based on a 100% market share goal; and

4. For each community, the provider shortfall is noted. From this evidence based data, the recruitment plan can begin which will drive our strategic planning and budgeting.

As you review this Medical Staff Model and Provider Recruitment Plan, you will note the obvious: we have plenty of work to continue. If you have any questions, comments or suggestions for improvement, please contact us. We welcome your input in the process as we work together to design the future Prosser Memorial Health.

![Prosser Memorial Health logo]

Prosser
Memorial Health

Comprehensive Pain Management Clinic
701 Dale Ave, Suite B, Benton City

Benton City Clinic
701 Dale Ave, Benton City

Weaver Family Medicine**
2935 Allen Rd, Sunnyside

Prosser Memorial Hospital
723 Memorial St, Prosser

Prosser Clinic
Prosser Women's Health Center
336 Chardonnay Ave, Suite A, Prosser

Sunnyside
(98944)

Benton City
(99320)

Grandview Clinic
1003 Wallace Way,
Grandview

Prosser General Surgery Center
Prosser Heart Center
Prosser Orthopedic Center
Prosser Urology Center
820 Memorial St, Suite 3, Prosser

Grandview
(98930)

Prosser
(99350)

Prosser Allergy Center
Prosser Ear, Nose, & Throat Center
713 Memorial St, Prosser

Mabton
(98935)

Prosser Therapy & Rehab Center
326 Chardonnay Ave, Prosser

Mabton Clinic*

2022

■ = Primary Service Area
■ = Secondary Service Area
★ = Under Consideration
★★ = Affiliated Clinic

This is how we care.
ProsserHealth.org

PROSSER MEMORIAL HEALTH
Medical Staff Recruitment/Succession Model
2017-2023

DRAFT

Primary Service Area

Secondary Service Area

PMH Hospital Based

Primary Care

Secondary/Tertiary Care

Primary Care

Secondary/Tertiary Care

Prosser

Grandview

Benton City

Prosser

Sunnyside

Sunnyside

Medical Hospitalist
3.0 Physicians

ER
5.0 Physicians
2.0 ER Physicians

Pathology
.25 Physicians

Radiology
1.5 Physicians

Anesthesia
4.0 CRNAs

Prosser Clinic
1.0 Pediatrician
1.0 Family Practice
1.0 Internal Medicine
1.0 Mental Health
1.0 Occupational Health
1.0 Mental Health
1.0 Family Practice

Prosser Clinic - Obstetrics & Gynecology
2.0 OB/GYN
1.0 PA/NP

Prosser Clinic - After Hours
2.0 PA/NP

Prosser FW - Valley Vista Medical Group
1.0 Family Practice
2.0 PA-C
2.0 Internal Medicine

Astria Health Center - Prosser
2.0 ARNP – Family Practice

Grandview Clinic
1.0 Family Practice
2.0 PA/NP
1.0 Mental Health
1.0 Women's Health CNM
.2 Internal Medicine
1.0 Pediatrician
1.0 Women's Health/CNM
1.0 Internal Medicine
1.0 Sleep Medicine

Grandview Clinic – After Hours
1.0 PA/NP

Grandview FW Medical Clinic
1.25 Family Practice
.5 PA-C
2.0 Pediatrics

Grandview FW Mountainview Women's HC
.25 Family Practice
1.0 OB/GYN

Astria Health Center - Grandview
1.0 Family Practice
1.0 Internal Medicine
1.0 Psychiatry
1.0 Sleep Medicine

Benton City Clinic
2.0 Family Practice
1.0 PA
1.0 NP
1.0 Mental Health
1.0 Pediatrician
.2 CNM
1.0 Women's Health/CNM
1.0 Family Practice

Astria - Birch Street Clinic
2.0 PA/NP
1.0 Family Practice

Prosser General Surgery Center
2.0 General Surgery

Prosser Orthopedic Center:
2.0 Orthopedic Surgery
1.0 Podiatry

*Prosser Clinic
1.0 Pulmonology
0.5 Rheumatology
0.5 Neurology
1.0 Endocrinology
1.0 Dermatology

Prosser ENT & Allergy Center
1.0 ENT

*Prosser Specialty Center
1.0 Urology
1.0 Gastroenterology
1.0 Ophthalmology
1.0 Nephrology

*Prosser Cancer Center
1.0 Hematology/Oncology

*Prosser Heart Center:
1.0 Cardiology
.5 Cardiology

Astria Health Center
.1 Plastic Surgery
.1 Cardiology

Grandview

Grandview Clinic
0.5 Orthopedic Surgery
0.5 General Surgery
0.5 Cardiology

Benton City

Benton City Pain Clinic
1.0 Physiatry

Weaver Family Medicine
1.0 Family Practice
2.0 PA/FP

Swofford/Halma Clinic
1.5 Family Practice
4.0 PA

Mid Valley Community Clinic
2.0 FP
3.0 NP/PA

Yakima - Neighborhood Health @ Sunnyside
2.0 ARNP
1.0 CNM
1.0 Pediatrician

Astria Health Center Primary Care
2.0 PA

Astria Health OB/GYN
2.0 OB/GYN

Astria Family Medicine/Endocrinology
2.0 Family Medicine
2.0 PA/NP

Astria Health Center
2.0 Internal Medicine
1.0 NP

YVFW - Immediate Care
1.0 NP

Sunnyside Pediatrics
1.0 Ped
1.0 PA/C (Pediatrics)

Astria Occupational Health

Astria John Hughes Student Health Center

Comprehensive Healthcare
12.0 Mental Health

Astria Specialty Center Surgical Group
4.0 General Surgery
3.0 Neurosurgery
2.0 Urology
1.0 Interventional Radiology

Astria Cardiology
2.0 Cardiology

Astria Cancer Center
1.0 Hem/Oncology
1.0 NP

Astria Orthopedics
1.0 Orthopedic Surgery

Astria Health Center
1.0 Nephrology
1.0 Neurology

Astria Health Multi-Specialty Clinic
1.0 ENT
.2 Podiatry

Astria Family Medicine/Endocrinology
1.0 Endocrinology

Legend (Owner)

Prosser Memorial Health (PMH)
Astria
Yakima Valley Farm Workers
Independent

* *denotes potential facility pending feasibility analysis*
BOLD Text identifies new providers/services

203

PMH MEDICAL STAFF RECRUITMENT & SUCCESSION PLAN BY LOCATION AND FISCAL YEAR 2017-2024

	FY 2017	
Family Practice- O'CONNOR	1.0	Prosser Clinic
Mental Health- MORSE	1.0	Prosser Clinic
Family Practice- JOHANSING	1.0	Benton City Clinic
Orthopedic Surgery- HALVORSON	1.0	PMH Specialty Clinic
Family Practice- SANTA-CRUZ	1.0	Grandview Clinic
Pediatrician- CARL	1.0	Benton City Clinic
PA/NP- LUTHER	1.0	Benton City Clinic
Subtotal	7.0	
	FY 2018	
Internal Medicine/Family Practice - ZHMUROUSKI	1.0	Prosser Clinic
Family Practice - STAUDINGER	1.0	Benton City Clinic
Pediatrician – MIN	1.0	Prosser Clinic
Emergency Medicine – WENGER	1.0	Prosser Memorial Hospital
General Surgery – CHEW	1.0	PMH Specialty Clinic
General Surgery – HUANG	1.0	PMH Specialty Clinic
Radiology - ZUCKERMAN	1.0	Prosser Memorial Hospital
Mental Health - MICROULIS	1.0	Benton City Clinic
Physiatry – GRONER	1.0	Comprehensive Pain Management Clinic
PA/NP - GARZA	1.0	Grandview Clinic
Subtotal	10.0	
	FY 2019	
Cardiology - BHATTI	1.0	Prosser Heart Center
Mental Health - HANKS	1.0	Grandview Clinic
OB/GYN – H.WEAVER	1.0	Prosser Women's Health Clinic
PA/NP – WARNICK	1.0	Grandview Clinic – Urgent/After Hours Clinic
Orthopedic Surgery – STREBEL	1.0	PMH Specialty Clinic
Emergency Medicine - SMITH	1.0	Prosser Memorial Hospital
Subtotal	6.0	
	FY 2020	
Emergency Medicine - RODE	1.0	Prosser Memorial Health
ENT- TIEU	1.0	PMH Specialty Clinic
Urology- TIEU	1.0	PMH Specialty Clinic
Certified Nurse Midwife- B.PADILLA	1.0	Benton City
Certified Nurse Midwife- R.MORRIS	1.0	Grandview Clinic
PA/NP- DUNHAM	1.0	Prosser Clinic – Urgent/After Hours Clinic
Subtotal	6.0	
	FY 2021	
Internal Medicine/Family Practice	1.0	Benton City Clinic
Dermatology	1.0	Prosser Specialty Clinic (ENT)
Gastroenterology	1.0	Prosser Specialty Clinic
FP/Peds	1.0	Grandview Clinic
Mental Health Counselor	1.0	Grandview Clinic
PA/NP	1.0	Grandview Clinic – Urgent/After Hours Clinic
Subtotal	6.0	
	FY 2022	
Internal Medicine	1.0	Grandview Clinic
Pulmonology/Sleep Medicine	1.0	Prosser Clinic
Endocrinology	0.5	Prosser Clinic - Telehealth
Neurology	0.5	Prosser Clinic - Telehealth
Subtotal	3.0	
	FY 2023	
Family Practice	1.0	Benton City Clinic
Family Practice	1.0	Prosser Clinic
Endocrinology	1.0	Prosser Clinic
Rheumatology	0.5	Prosser Clinic - Telehealth
Subtotal	3.5	
	FY 2024	
Nephrology	1.0	PMH Specialty Clinic
Ophthalmology	1.0	PMH Specialty Clinic
Neurosurgery	1.0	PMH Specialty Clinic
Hematology/Oncology	1.0	Prosser Cancer Center
Subtotal	4.0	
TOTAL	**45.5**	

	SPECIALTY	2023 QUANTITY	2020 CURRENT
PRIMARY CARE	Family Practice	7.0	3.0
	Internal Medicine	2.0	1.0
	PA/NP – Family Practice	9.0	5.0
	Pediatrics	3.0	2.0
	Women's Health	5.0	4.0
SECONDARY CARE	Cardiology	2.0	1.0
	Hematology/Oncology	1.0	0
	Mental Health	4.0	3.0
	Urology	1.0	1
	Pulmonology	1.0	0
	Orthopedic Surgery	3.0	3.0
	Otorhinolaryngology (ENT)	1.0	1.0
	Ophthalmology	1.0	0
	Dermatology	1.0	0
	General Surgery	2.0	2.0
	Neurology	0.5	0
	Nephrology	1.0	0
	Gastroenterology	1.0	0
	Rheumatology	0.5	0
	Endocrinology	1.0	0
	Physiatry/Physical Medicine	1.0	1.0
	Emergency Medicine	6.0	5.0
TOTAL		**54.0**	**32.0**

PMH Service Area: Total Primary/Secondary Service Area Physician Need 2023	Population Needed/Provider	Needed (FTEs)	Current Supply (FTEs)	Supply Needed (FTEs)
2018 Population: 67,344 2023 Population: 70,395				
Primary Care				
General/Family Practice	3,226	21.8	49.5	27.7
General Internal Medicine	3,247	21.7	7.0	14.7
Pediatrics	5,682	12.4	7.0	5.4
OB/GYN	7,143	9.9	7.0	2.9
Primary Care Subtotal		65.7	70.5	4.8
Secondary Care				
Allergy & Immunology	71,429	1.0	0.2	0.8
Cardiology	12,821	5.5	3.1	2.4
Dermatology	25,000	2.8	0.0	2.8
Gastroenterology	22,727	3.1	0.0	3.1
Hematology/Oncology	23,810	3.0	1.5	1.5
Nephrology	40,000	1.8	1.0	0.8
Neurology	19,608	3.6	1.5	2.1
Mental Health Provider	6,250	11.3	16.0	4.7
Pulmonology	25,000	2.8	0.0	2.8
General Surgery	8,772	8.0	3.0	5.0
Ophthalmology	18,182	3.9	0.0	3.9
Orthopedic Surgery	11,905	5.9	3.2	2.7
Otorhinolaryngology	31,250	2.3	1.3	1.0
Plastic Surgery	41,667	1.7	0.6	1.1
Urology	27,778	2.5	0.5	2.0
Secondary Care Subtotal		59.2	31.9	27.3
Tertiary Care				
Cardio Thoracic Surgery	66,667	1.1	0.0	1.1
Endocrinology	50,000	1.4	0.2	1.2
Infectious Diseases	58,824	1.2	0.0	1.2
Neurosurgery	62,500	1.1	2.0	0.9
Physical Med/Rehab	37,037	1.9	1.0	0.9
Rheumatology	66,667	1.1	0.0	1.1
Vascular Surgery	66,667	1.1	0.0	1.1
Tertiary Subtotal		8.9	3.2	5.7
Total		133.8	105.6	28.2

Revenue by Specialty

UNITES STATES NET REVENUE BY PHYSICIAN SPECIALTY

Specialty *With the use of Hospitalist.	In Patient Discharges	Net In Patient Revenue ($ in thousands)	Net Out Patient Revenue ($ in thousands)	Total Net Revenue ($ in thousands)
Family Practice*	156	$92	$213	$305
Internal Medicine*	11	$103	$172	$285
Pediatrics*	n/a	n/a	n/a	$856
OB/GYN*	144	$759	$481	$1,240
Hospitalist	486	$3,936	$190	$4,127
Cardiology	104	$1,359	$1,010	$2,368
General Surgery	112	$1,522	$852	$2,374
Gastroenterology	15	$103	$728	$831
Neurology	11	$160	$387	$574
Oncology	57	$751	$2,629	$3,380
Otolaryngology	16	$163	$608	$771
Orthopedic Surgery	95	$1,526	$638	$2,164
Podiatry	5	$64	$260	$324
Mental Health Provider	344	$1,458	$173	$1,642
Pulmonology	65	$981	$233	$1,214
Urology	39	$368	$755	$1,123

Source: James Lifton, "Gauging the financial impact of physicians on hospitals." Healthcare Financial Management Association; April 2012.

AVERAGE ANNUAL REVENUE BY SPECIALTY

Cardiovascular Surgery	$3,697,916
Cardiology (Invasive)	$3,484,375
Neurosurgery	$3,437,500
Orthopedic Surgery	$3,286,764
Gastroenterology	$2,965,277
Hematology/Oncology	$2,855,000
General Surgery	$2,707,317
Internal Medicine	$2,673,387
Pulmonology	$2,361,111
Cardiology (Non-Invasive)	$2,310,000
Urology	$2,161,458
Family Medicine	$2,111,931
Neurology	$2,052,884
OB/GYN	$2,024,193
Otolaryngology	$1,937,500
Psychiatry	$1,820,512
Nephrology	$1,789,062
Pediatrics	$1,612,500
U.S. Average Net Revenue per Provider (2018) $2.4 million	
PMH Average Net Revenue per Provider (2018) $1.5 million	

Source: Merritt Hawkins. *2019 Physician Inpatient/Outpatient Revenue Survey.*

Primary & Secondary Service Area Provider List	
Benton City	
Benton City Clinic 701 Dale Avenue Benton City, WA 99320 509.588.4075	Dr. Patrick Johansing (Family Practice) Dr. Suzanne Staudinger (Family Practice) Dr. David Carl (Peds) Dr. John Groner (Physiatry) Jessica Luther, ARNP Diane Microulis, ARNP (Mental Health)
Prosser	
Prosser Clinic 336 Chardonnay Ave. Suite A Prosser, Wa.99350 509.786.1576	Dr. Carolyn O'Connor (Family Practice) Pam Morris, ARNP (Occupational Health) Dr. Sarah Min (Pediatrician) Heather Morse, ARNP (Mental Health) Dr. Dzmitry, Zhmurouski (Internal Medicine)
Prosser Women's Health Center 336 Chardonnay Ave B Prosser,Wa.99350 509.786.0031	Dr. Brian Sollers (OB/GYN) Dr. Heidi Weaver (OB/GYN) Teresa Charvet, PA-C
Prosser General Surgery Center 820 Memorial St #3 Prosser,Wa.99350 509.786.5599	Dr. Weslee Chew (Gen Surgery) Dr. Yung Huang (Gen Surgery)
Prosser Orthopedic Center 820 Memorial St #3 Prosser,Wa.99350 509.786.5599	Dr. Jared Clifford (Podiatrist) Dr. Thomas Halvorson (Orthopedic Surgery) Dr. Samuel Strebel (Orthopedic Surgery)
Prosser Heart Center 820 Memorial St #3 Prosser,Wa.99350 509.786.5599	Dr. Karan Bhatti (Cardiology)
Prosser ENT& Allergy Center 723 Memorial St. Prosser,Wa.99350 509.786.5579	Dr. Combs (ENT)

Valley Vista Medical Center 820 Memorial St Suite 1 Prosser, WA. 99350 509.786.2010	Dr. Gloria Abacan (Internal Medicine) Dr. Flint Orr (Internal Medicine) Dr. Gelar Paul N. Biscaro (Family Practice) Dr. Edward Lane (Family Practice) Dennen Frazier PA-C Rebecca Wray PA-C
Astria Health Center Prosser-Plastic Surgery, **Cardiology, Family Medicine** 355 Chardonnay Ave Prosser, WA. 99350 509.781.6366	Dr. Davis Bronson (Plastic Surgeon) (0.1) Dr. James Kneller (Cardiologist) (0.1) Johnson Otong, ARNP (FP) Selina Diaz, ARNP (FP)
Grandview	
Grandview Clinic 1003 Wallace Way Grandview, WA 98930 509.203.1080	Dr. Santa-Cruz (Family Medicine) Erica Garza, ARNP (FP) Diane Hanks, ARNP (Mental Health) Steve Zirker, PA-C
Astria Health Center – Family Medicine, Psychiatry **and Sleep Medicine** 208 N. Euclid Rd Grandview, WA. 98930 509.882.1855	Dr. Luis Vincenty (Internal Medicine) Dr. Muhammad Riaz (Sleep Medicine) Dr. Pedro Fernandez (Psychiatry) Jody Gray ARNP (Family Medicine)
Grandview Farmworkers Clinic 1000 Wallace Way Grandview, WA 98930 509. 882.3444	Dr. Katheryn Norris (Family Medicine) (0.25) Dr. Tad White (Family Medicine) Dr. Tamera Schille (Peds) Dr. Thatcher Felt (Peds) Brianne Johnson, PA-C Caleb Knight, PA-C Katrina Aguilar, PA-C Jeffrey Johnson, PA-C (0.5) Thomas Jenkins, PA-C (0.5) Mathew Schneider, PA-C (0.5)
Mountain View Women's Health Center Yakima Valley Farmworkers Grandview, WA 98930 509.882.4700	Dr. Ridhima Gupta (OB/GYN) Dr. Benno Marx (Family Medicine) (0.25)
Astria Health Center 222 E. 2nd St Grandview, WA 98930 509.203.6501	Dr. April Biggs (Family Medicine) Deborah Titus, FNP-C Manuel A. Jimenez, PA-C (Internal Medicine)

Weaver Family Medicine 2935 Allen Rd. Sunnyside,Wa.98944 509.837.0070	Dr. Derek Weaver (Family Medicine) Jason Redd, PA-C Ty Nielson, PA-C
Sunnyside Pediatrics 812 Miller Ave Suite C Sunnyside, Wa.98944 509.837.7551	Dr. Ana Garcia (Pediatrician) Mark Gardner PA-C
Astria Health **Multi-Specialty Clinic- ENT, Podiatry** 2705 E Lincoln Ave Suite B Sunnydside,Wa 98944 509.837.1524	Dr. Suzanne Cleland Zamudio (ENT)(0.5) Dr. Jeff Lecherminant (Podiatry) (0.2)
Sunnyside Immediate Care Yakima Valley Farmworkers 2680 Yakima Valley Highway Suite B Sunnyside Wa 98944 509.839.3000	Sarah Dawson, ARNP Danny Thibault, ARNP Maria Elena Thibault, ARNP
Astria Health Center –Primary Care 2705 E Lincoln Ave Suite C Sunnyside Wa. 98944 509.836.4848	Paul Furan, PA-C Johnathan Alvord, PA-C
Swofford & Halma Clinic 2303 Reith Way Sunnyside,Wa. 98944 509.837.3933	Dr. Harlan Halma (Family Medicine) (0.5) Dr. Blake Bond (Family Medicine) Marivel E. Sandoval, PA-C Susan Bussert, PA-C Maricela Ramirez, PA-C Rebecca Souza, PA-C
Mid Valley Community Clinic 700 S 11th St. Sunnyside,Wa. 98944 509.839.6822	Dr. Harlan Halma (Family Medicine) (0.5) Dr. Douglas Wrung (Family Medicine) (0.5) Irma Z. Mejia, ARNP Elba Fernandez, ARNP Ovidio Demiar, PA-C Dr. Kristin Bond (Family Medicine)
Astria Health Center-Family Medicine, **Endocronology** 803 E. Lincoln Ave Sunnyside,Wa. 98944 509.837.6911	Dr. Tatiana Antoci (Family Medicine) Dr. Lincoln Westfall (Family Medicine) Dr. GaryTreece (Endocronologist) (0.2) Benjamin Rodriguez, PA-C Sherry Johnson, ARNP

Astria Health Center 2925 Allen Road Sunnyside, WA 98944 509.836.4830	Dr. Tim Caylon (Internal Medicine) Dr. Andrew Gustavson (Neurology) (0.5) Dr. Vansi Kanneganti (Nephrology) (1.0) Dr. Anna Madej (Internal Medicine) Christina Zoric, ARNP
Astria Health Center- Cardiology 812 Miller Ave, Suite F Sunnyside, WA 98944 509.836.4825	Dr. John Adan (Cardiology) Dr. Michael Becker (Cardiology)
Astria Health- OB 803 E. Lincoln Way Sunnyside, WA 98944 509.837.1550	Dr. Miguel Brizuela (OB/GYN) (1.0) Dr. Robert Wells (OB/GYN) (1.0)
Astria Heallth- Occupational Health 802 Miller Ave Sunnyside, WA 98944 509.837.1564	None Listed
Astria Health Orthopedics 2705 E. Lincoln Ave, Suite A Sunnyside, WA 98944 509.837.1570	Dr. Valentin Antoci (Orthopedic Surgery) (1.0)
Astria Health Cancer Center 1013 E. Edison Ave Sunnyside, WA 98944 509.837.1587	Dr. Danko Martincic (Hematology/Oncology) (0.5) Lee Jackson, NP-C (1.0)
Astria Health Specialty Center **Surgical Group** 500 S. 11th St. Sunnyside, WA 98944 509.837.7722	Dr. Lori Alvord (General Surgery) Dr. Tracy Berg (General Surgery) Dr. Whitney Parnell (General Surgery) Dr. Manuel Ybanez (General Surgery) (1.0) Dr. David Shoemaker (Interventional Radiology) Dr. Natalie Mosley (Urology) (0.25) Dr. Richard Mynatt (Urology) (0.25) Dr. Bard Ward (Neurosurgery) Dr. Donial Drazin (Neurosurgery) Dr. Dave Attebarry (Neruosurgery) (Plastic Surgery) (0.5)
Astria Health John Hughes **Student Health Center** 1801 E. Edison Ave Sunnyside, WA 98944 509.836.4840	None Listed
Virginia Mason Lower Valley Specialty Center 1812 E. Edison Ave. Sunnyside, WA 98944 509.837.0653	No specific providers listed. Cardiology, Urology, ENT, Podiatry, Pulmonology, GI, Hematolgoy/Oncology, Orthopedics, Pain Management

Yakima Neighborhood Health 617 Scoon Road Sunnyside, WA 98944 509.837.8200	Dr. Nana (Pediatrician) Sue Dennis, ARNP, CNM (Women's Health) Brady Moss, ARNP Cynthia Hurtado, ARNP
Comprehensive Healthcare 1319 Saul Rd Sunnyside, WA 98944 509.837.2089	Heidi Graf-LMHC Mary Lamarche Maria Montelongo Melissa Morin Paul O'Neal Susana Martinez Cory Kingsbury Dawn Maxwell Demetrius Straws Miguel Diego Mendoza Jose Sabalsa Crystal C. Liebert Alfanzo Meza Rachel Ramos Debra Dale Jaime Ortiz Christopher C. Devilleneuve

VII. PMH Medical Strategic Plan Performance Update 2017-2020

A. FY 2020 Strategic Plan Update

Prosser
Memorial Health

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

Our Values

Accountability

Service

Promote Teamwork

Integrity

Respect

Excellence

Patient Loyalty
Goal: 95% Exceed Patient Expectations

2019 – 86.6%
2018 – 84.6%
2017 – 84.8%
2016 – 82.3%

Medical Staff Development
% Medical Staff Satisfaction

2019 – 89.0%
2018 – 90.6%
2017 – 80.0%
2016 – 82.6%

Employee Engagement
Goal: 90% Employee Satisfaction

2019 – 85.6%
2018 – 85.0%
2017 – 83.2%
2016 – 83.0%

Quality
Goal: 10% Selected Quality Attributes

2019 – 57.7%
2018 – 63.6%
2017 – 65.95%
2016 – NA

Services
Goal: 50% Market Share
(Proxy = Patient Days)

2019 – 21,106 days
2018 – 16,480 days
2017 – 14,564 days
2016 – 14,487 days

Financial Stewardship
Goal: Total Margin > 6%

2019 – 5.4%
2018 – 0.6%
2017 – 3.9%
2016 – (0.6%)

Vision of Success FY2017 to 2020

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

2020 - Strategic Plan Scorecard

Prosser Memorial Health

Major Goal Areas & Indicators	2020 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2020YTD	2019 Avg	2018 Avg
Patient Loyalty																
IP - "Would Recommend"	> 85.1%	84.4%				84.4%		90.7%							85.1%	83.8%
ED - "Would Recommend"	> 80.7%	73.8%	89.0%		77.4%			72.7%	80.0%						80.3%	80.7%
Acute Care - "Would Recommend"	> 79.7%		80.1%												78.6%	79.7%
OB - "Would Recommend"	> 92.2%		92.3%	100.0%	100.0%	86.4%		90.7%	100.0%						92.2%	88.6%
Outpatient Surgery - "Would Recommend"	> 91%	86.4%	83.3%		85.0%				87.5%						91.0%	84.9%
Swing Bed - "Would Recommend"	> 94.1%	100.0%	50.0%	100.0%		100.0%	100.0%	100.0%							85.3%	94.1%
Clinic - "Would Recommend"	> 87.1%	92.9%	91.1%	87.9%	85.2%	87.0%	83.3%	86.0%	83.1%						87.1%	85.2%
Outpatient - "Would Recommend"	> 88.4%	88.5%	88.5%	85.0%	85.0%		91.7%	94.0%							88.4%	84.7%
Medical Staff Development																
Medical Staff Turnover	< 0.2%	0.0%	1.0%	1.0%	3.0%	0.0%	0.0%	0.0%	0.0%	0.0%					0.2%	0.6%
Specialty Clinic Visits	> 1083		1,101	1,021			807	931	939					909	950	872
Benton City Clinic Visits	> 1006	1,118	950	984	643	723	856	950	740					868	958	857
Prosser RHC Clinic Visits	> 1052	1,030	1,011	988	842		2,152		1,788						960	821
Grandview Clinic Visits	> 618	702	724	650	474	570	564	643	585					614	566	N/A
Women's Health Center	> 709	673	605	633	455	642	583	646	603					580	469	N/A
Comprehensive Pain Clinic	> 91	86	83	81	28	58	64	35	42					60	80	55
*# of Active Medical Staff	> 51	43	43	43	43	43	43	44	47	48				44	41	40
Employee Development																
Average Recruitment Time (days)	< 28	19	28	50	61	23	37	39	31					34	28	N/A
# of Open Positions (Vacancies)	< 23	35.0	27.0	27.0	24.0	22.0	21.0	20.0	41.0					27.4	23	8.8
Hours of Overtime - Overtime/Total Hours Worked	< 4.5%	7.9%	5.4%	6.0%	4.0%	4.2%	5.5%	6.1%	6.1%					5.7%	5.7%	4.5%
Agency - Cost/Total Labor	< 8.7%	7.2%	9.0%	10.9%	8.2%	4.5%	5.4%	5.3%	6.5%						14.5%	10.5%
Turnover Rate	< 0.7%	0.4%	0.4%	0.7%	1.1%	0.4%	0.0%	0.0%	1.0%					0.5%	0.7%	0.7%
Timely Evaluations	> 79.6%	89.0%	54.0%	91.0%	91.0%	54.0%	78.0%	85.3%	54.2%					75.3%	79.6%	60.5%
Education Hours/FTE	> 2.15	1.57	0.01	1.98	0.98	0.55	0.86	0.83	1.74					1.05	1.55	2.15
New Hire (Tenure) < 1 year	< 10%	0%	0%	0%	0%	0%	0%	0%	0%					0%	0%	N/A
* Lost Workdays due to On-the-Job Injuries	< 167	8.00	8.00	8.00	16.00	8.00	15.00	1.00	0					0	167	163
Quality																
ED Encounters - Left Without Being Seen	< 1.0%	1.2%	0.9%	1.03%	0.2%	0.7%	0.8%	0.8%	0.1%					0.7%	1%	1.0%
*Falls with Injury	< 3	0			0	0								0.7	3	3
Healthcare Associated Infection Rate per 100 Inpatient Days	< 0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%					0.0%	0.1%	0.1%
All-Cause Unplanned Readmissions within 30 Days	< 2.7%	2.2%	6.9%	10.5%	8.3%	2.9%	0.0%	4.9%	2.4%					4.9%	5.4%	2.7%
Diabetes Management - Outpatient A1C>9 or missing result	< 30.8%	37%	30%	33%	28%	32%	33%	22%	25%					30%	30.3%	34.50%
Services																
ED Visits	> 1,023	1,131	1,000	874	526	700	723	819	789					822	1,015	980
Inpatient Admissions	> 86	89	77	72	70	79	91	79	91					81	83	75
OB Deliveries	> 98	16	26	16	16	19	18	5	18					40	87	31
Surgeries and Endoscopies	> 125	109	100	90	32	44	110	129	112					94	118	117
Diagnostic Imaging Procedures	> 2,116	2,466	2,308	2,078	1,358	1,784	2,159	2,225	2,338					2,089	1,957	1,649
Lab Procedures	> 12,262	12,608	11,587	9,776	7,900	10,591	12,119	13,289	13,069					11,290	11,051	9,671
Adjusted Patient Days	> 1,789	1,608	1,490	1,355	871	1,250	1,376	1,364	1,568					1,360	1,524	1,373
Therapy Visits	> 1,706	1,692	1,752	1,374	824	959	1,131	1,247	1,399					1,240	1,345	1,084
Outpatient Special Procedures Visits	> 235	268	226	219	222	211	190	198	235					254	224	225
Financial Performance																
Net Days in Accounts Receivable	< 48.62	59.97	68.28	61.84	48.35	48.00	52.15	54.44	56.64					56.64	63.79	50.96
*Total Margin	> 7.06%	4.5%	1.2%	-0.2%	16.40%	18.90%	17.67%	11.40%	11.40%					7.5%	5.30%	1.8%
Net Operating Revenue/FTE	> $16,753	$16,075	$14,867	$15,320	$19,554	$19,345	$22,112	$16,570	$15,719					$17,481	$15,794	$16,094
Labor as % of net Revenue	< 60.2%	60.3%	65.0%	68.8%	47.8%	33.5%	43.2%	60.6%	80.8%					58.7%	59.6%	62.6%
Operating Expense/FTE	< $15,780	$15,554	$15,443	$15,969	$16,562	$15,823	$14,849	$16,479	$13,694					$15,529	$15,190	$16,190
*Days Cash on Hand	> 120.39	96.39	93.02	97.96	155.13	121.00	228.14	225.29	231.33					231.33	120.39	108.23
Commercial %	> 28.7%	27.1%	27.4%	28.8%	28.9%	28.8%	30.0%	29.4%	29.1%					29.1%	28.7%	28.2%
Total Labor Expense/Total Expense	< 62%	62.4%	62.6%	61.2%	63.7%	65.1%	64.3%	62.3%	40.2%					62.9%	62%	63%

215

Prosser
Memorial Health

2020 - Patient Care Scorecard

Major Goal Areas & Indicators	2019 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 YTD	2019	2018
Quality																
Left Without Being Seen (ED & IVantage)	<1.0%	1.24%	0.90%	1.09%	0.19%	0.86%	0.41%	0.61%	0.13%					0.73%	1.11%	1.00%
All-Cause Unplanned 30 Day Inpatient Readmissions (AC & IVantage)	<2.7%	7.33%	8.67%	9.30%	7.89%	2.96%	0.00%	4.76%	2.44%					4.60%	5.4%	2.7%
Sepsis - Early Management Bundle (AC)	>84.6%	33.33%	50.00%	N/A	66.67%	100.00%	100.00%	66.67%	100.00%					70.59%	80.0%	84.6%
Head CT Interpretation within 45 minutes - Stroke (DI)	>90%	100.00%	100.00%	66.67%	100.00%	100.00%	100.00%	100.00%	100.00%					93.75%	80.0%	84.6%
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.29%					0.12%	62.16%	N/A
Diabetes Management - Outpatient A1C>9 or missing result (PT)	<30.25%	37.43%	30.27%	32.67%	28.30%	32.09%	37.33%	21.71%	25.00%					30.43%	0.07%	0.10%
Medication Reconciliation Completed	>80%	89.26%	90.39%	44.72%	89.90%	50.76%	42.31%	48.64%	34.94%					52.01%	30.25%	34.50%
Turnaround time of 30 minutes or less for STAT testing (LAB)	<30 Minutes	34	31	34	36	39	37	36	36					35.625	90.00%	2019 value is 85.16%
Median Time to ECG (CP & IVantage)	<7 Minutes	6		6	3.5	8	9	8	11					7.5	30	30
Surgical Site Infection (OR)	<2.0%	0.00%	0.00%	0.00%	0.00%	2.27%	1.92%	0.00%	0.00%					7	7	NA
Colonoscopy Follow-up (OR/Clinic & IVantage)	>90%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	83.33%	87.50%					94.44%	0.3%	0.3%
Safe Medication Scanning	>90%	88.60%	91.30%	95.82%	95.50%	96.48%	93.70%	92.80%	93.66%					94.77%	90.0%	NA
*Overall Quality Performance Benchmark (IVantage)	>48	45	48	48	55	55	48	49	50					52.36%	90.0%	NA
*Inductions <39 Weeks without Clinical Indications (OB & IVantage)	<1	0	0	0	0	0	0	0	0					48	48	0
*Falls with Injury	<3	0	1	0	0	0	0	0	1					0	1	3
															9	3

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

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
Patient Loyalty - Merry Fuller, Champion				2nd QTR	4th QTR	
Provide outstanding customer service, aspiring to treat those we serve the way they want to be treated. Achieve an overall organizational patient satisfaction rate ("would recommend") of 95% or higher.	19. 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.	• Leverage the Nurse Staffing Committee and Professional Nurse Practice Council to provide oversight and momentum for this NSC/PNPC goal (1/20). • Identify obstacles and problems currently encountered in each patient care area and prioritize based on a failure mode Assessment Evaluation (3/20). • Research and present evidence based practice ideas to the NSC/PNPC. The committee with nurse leadership to prioritize and plan implementation of greater than or equal to 1 innovative practice in each department by the beginning of Q2, 2020 (4/20). • Each innovative idea implemented will be evaluated using a Plan-DO Study Act methodology and reported to the NSC/PNPC and each participating department. Whenever possible, evaluation will include patient perception of care, impact on productivity, employee perception of satisfaction, and any relevant quality/risk outcome data (6/20).	Staffing analysis diverted to COVID-19 response. Staff education provided for PPE and care of the COVID-19 patient. Spotter were initially assigned to areas with COVID-19 positive patients to assist with donning and doffing of PPE and running for supplies to minimize entries in and out of isolation rooms. Staffing assignments modified when needed to 3 COVID-19 positive patients to 1 nurse. Mandatory masking at all times in public and clinical areas implemented and remains in place.	Differed to COVID-19 response.		CNO/COO: Merry Fuller

217

Strategic areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Champion
				2nd QTR	4th QTR	
Medical Staff Development - Dr. Brian Sollers, Champion						
Respond to Medical Staff concerns and needs in a timely manner, pursue initiatives in collaboration with our Medical Staff and ensure the availability of the appropriate providers for those we serve. Achieve an annual Medical Staff satisfaction rate of 90% or higher.	1. Initiate recruitment efforts based on the PMH Medical Staff Model: • Implement FY 2020 Provider Recruitment Plan and support infrastructure for ongoing recruitment.	• Implement the Provider Recruitment Plan as identified in the Medical Staff Model for FY 2020, with goals including: • PA/NP (Prosser Clinic - Urgent/After Hours Clinic) • Family Practice/Pediatrician/OB (Grandview Clinic) • PA/NP (Mabton Clinic) • ENT (PMH Specialty Clinic) • Emergency Medicine (PMH) • Women's Health (Grandview Clinic) • Women's Health (Benton City Clinic) • Mental Health Counselor (Prosser Clinic)	Through the first six months of 2020, we have successfully recruited the following providers: • Emergency Medicine - Dr. Steve Rode • ENT - Dr. Coral Tieu • Urology - Dr. Thomas Tieu • CNM - Bailey Padilla • CNM - Becky Morris •PN/NP - Afton Dunham	67%		ACMO: Dr. Hashmi ACMO: Dr. Sollers Director of Emergency Services/Provider Recruitment & Retention: Christi Doornink
	2. Conduct an annual Medical Staff engagement survey.	• Create a 2020 Satisfaction Survey for the Medical Staff. • Achieve a > 80% participation rate. • Obtain a 90% or better satisfaction rating on the Medical Staff Engagement Survey.	The Medical Staff Engagement Survey will be conducted in October/November.	0%		CMO: Dr. Sollers
	3. Maintain a physician retention plan. Include the following: • On-boarding process; • Include providers in new employee orientation/and/or develop a provider specific orientation; • Epic Optimized Training Plan; • Mentoring; and • Rounding	• Maintain a Medical Staff retention rate of 90% or better (annual).	We have retained 100% of our Medical Staff in the first half of 2020. We anticipate losing three providers in the second half of 2020, however, we have plans to replace each provider that is leaving/retiring.	50%		ACMO: Dr. Rivero ACMO: Dr. Sollers Director of Emergency Services/Provider Recruitment & Retention: Christi Doornink Chief Human Resource Officer: Ro Kmetz
	4. Develop an effective performance evaluation and feedback tool for PMH-employed providers, which supports the Mission, Vision, and Values of PMH.	• Develop an annual physician performance and feedback model for Prosser Memorial Health employed Providers (6/20).	The Provider Annual Performance Review Form has been developed. The form will be reviewed with HR in July, and we plan on testing the new process in August.	75%		ACMO: Dr. Rivero Director of PMH Clinics: Alana Pumphrey
	5. Promote the PMH Medical Staff through a variety of marketing methods, as outlined in the 2020 Marketing Plan.	• Develop and implement a Medical Staff Marketing Plan in support of the overall 2020 Prosser Memorial Health Strategic Plan (5/20). • Feature new and current Medical Staff members in the PMH Employee Newsletter, The Pulse (1/20).	In the first quarter of 2020, our marketing efforts focused on Cardiology - Dr. Bhatti, our Joint Replacement Program - Dr. Strabel and COVID-19. The second quarter focused on dermatology - Dr. Santa Cruz, Pediatrics - Drs. Cari and Min and our COVID Clinic. Our entire Medical Staff was also highlighted in our Annual Providers' Day thank you advertisement in various publications.	50%		COO: Shannon Hitchcock Director of PMH Clinics: Alana Pumphrey
	6. Continue to optimize recognition and appreciation of the Medical Staff: • Include Medical Staff in PMH Activities (e.g. Hospital Holiday Party, Hospital Week, etc.); • Special recognition on Doctor's Day; • Highlight Achievements; • Actively engage physicians on key issues & organizational items; • Develop and implement a formal recognition program; • Conduct Medical Staff socials; and • Continue proactive communications between the Leadership Team and Medical Staff.	• Create and implement a line item in the FY 2020 Budget to fund Medical Staff recognition and appreciation activities (1/20). • Develop a schedule (calendar) of Medical Staff events and coordinate activities with Administration for FY2020 (2/20).	The PMH 2020 Budget fully funded several planned Medical Staff recognition activities, however, the COVID-19 pandemic has negatively impacted our plans. Events that can be postponed (e.g. Annual Dinner Cruise), have been postponed, but they may not be able to be held this year. We continue to focus on communication and have added several new communication tools in 2020 (e.g. COVID-19, Provider Update, MRS). We once again recognized our providers during Hospital Week and National Providers' Day with gifts of appreciation and various advertisement.	50%		ACMO: Dr. Rivero ACMO: Dr. Sollers Director of Emergency Services/Provider Recruitment & Retention: Christi Doornink

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Champion
				2nd QTR	4th QTR	
Medical Staff Development - Dr. Brian Sollers, Champion						
	7. Continue to generate and maintain Epic specific training tailored for Medical Staff.	• Maintain one Super User / Credentialed Trainer in each hospital department in 2019 which will allow for better Epic support and training (6/20). • Develop and implement a mechanism to get regular feedback from the Medical Staff regarding Epic (6/20).	IT began rounding on Medical Staff in June, 2020 during the Epic Upgrade. IT will continue to round on two (2) Providers Monthly and log each meeting going forward to increase Epic Communication and awareness along with receiving continual Epic feedback. Additionally, Providers will be communicated to on a regular basis going forward that scheduled Epic Support is always available to them. The Super User program (or something similar) will be redesigned in the second half of 2020 to help Providers and staff going forward. We are also considering adding a Credentialed Trainer (CT) in Admitting in Q4 of this year.	20%		Chief Information Officer: Kevin Hardiek
Respond to Medical Staff concerns and needs in a timely manner, pursue initiatives in collaboration with our Medical Staff and ensure the availability of the appropriate providers for those we serve. **Achieve an annual Medical Staff satisfaction rate of 90% or higher.**	8. Enhance and expand the Tele-Health Program within Prosser Memorial Health facilities.	• Develop and implement a strategy for expanding the Tele-Health program at Prosser Memorial Health owned/leased facilities (9/20). • Explore the various e-consult and telehealth options to expedite the patient experience for minor illness. (9/20).	Crisis Virtual visits for specialty and primary care clinics were implemented in April (Due to COVID). In Q3 we will begin to look at our options for specialty coverage via telehealth.	23%		Director of PMH Clinics: Alana Pumphrey Clinic Information Officer: Kevin Hardiek
	9. Enhance & grow Medical Staff-led educational seminars/lunch-and-learns for PMH staff and the community.	• Research topics of interest for educational seminars (4/20). • Create a calendar and promote educational seminars for staff and the community (4/20).	2020 started off with a Lunch & Learn Go Red For Women Luncheon with Dr. Bhatti focused on women's cardiac health. We followed that up with a Facebook Live event with Dr. Bhatti for viewers to ask questions of Dr. Bhatti live. Dr. Strebel hosted a Lunch & Learn in Yakima on our Joint Replacement Program. It was sold out and resulted in 2 confirmed surgeries and 5 new patients (pre-COVID). In April, Heather Morse and Pam Morris hosted a Facebook Live event on staying mentally and physically health during the pandemic and lock down. As healthcare "hot topics" continue to evolve and change rapidly so does our response with virtual lunch and learns, social media programing and having our provider record education videos that can be referenced by the public at their leisure.	75%		COO: Shannon Hitchcock
	10. Continue to grow and expand the Comprehensive Pain Management Program.	• Actively recruit additional staff (as needed) and resources to make the pain management clinic a comprehensive pain management program (12/20). • Increase pain management visits by 75% in FY2020.	No additional staff has been recruited. We have seen a very large drop in referrals since COVID hit. This is due to decreased primary care volumes. January-March volumes were at a 30% increase. We will be launching a marketing campaign for Dr. Groner beginning in August.	25%		Director of PMH Clinics: Alana Pumphrey
	11. Implement secure texting policy and program for Prosser Memorial Health Medical Staff.	• Implement a secure texting policy and program for Medical Staff (4/20).	Microsoft Teams will be used as the Secure Texting Platform and will begin implementation in the 3rd Quarter of 2020. Microsoft Teams is HIPAA compliant and fully functional with Apple iOS and Android mobile devices.	5%		Chief Information Officer: Kevin Hardiek
	12. Enhance and expand cardiopulmonary services at PMH.	• Sleep Lab (3/20). • Cardiac Services (9/20). • Pulmonology Services (4/20). • Implement Nuclear Medicine Services (7/20).	We are currently working with a sleep lab specialists interested in opening a comprehensive sleep lab service at PMH in early 2021. We plan to complete a business plan in the third quarter of 2020 and implement the plan if appropriate. Nuclear Medicine services are currently scheduled to be fully operational by the end of 2020, which will significantly enhance our cardiology services. We are also exploring the addition of trans esophageal echos and cardiac pacemaker insertions in early 2021. No expansion of pulmonology services has been pursued to date.	50%		Director of Cardiopulmonary: Rusti Wilson Director of Diagnostic Imaging: Aurora Weddle

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Champion
				2nd QTR	4th QTR	
Medical Staff Development - Dr. Brian Sollers, Champion						
	13. Maintain and enhance the orthopedic surgery program at PMH.	• Develop a Joint Program of comprehensive orthopedics (5/20) including the use of the MAKO Joint Replacement System. • Increase orthopedic visits by 50% and surgeries by 25% (12/20). • Expand and provide orthopedic services to local high schools. • Perform > 90 Mako Procedures (12/20).	The Joint Program workflow, education model, and education material have all been completed. Due to COVID we have not begun our planned formal joint replacement education classes; however, the RN currently schedules a phone visit to review all pre and post op education material. The program content was completed in March at the onset of COVID. We have not yet seen an increase in volumes due to cancellation of elective surgeries.	25%		Clinic Director: Tricia Hawley
	14. Continue the PMH CMO Model which encourages Medical Staff participation in PMH Administrative functions.	• Educate staff about the current CMO Model in 2020. • Focus on attendance at the Administrative Team meetings, attending at least 80% of all meetings in 2020, and 50% of all Leadership Team meetings.	The PMH CMO model (composed of four PMH, Medical Staff members) continues to be utilized and meets quarterly with the CEO. The CMO - Dr. Sollers attends and participates on the Administrative Team and plans to attend Leadership Team Meetings (including LDIs) when available in 2020. It should also be noted that Dr. Derek Weaver was added to the Joint Conference Committee, expanding representation to more PMH employed providers on Administrative/Board Committees.	50%		CMO: Dr. Sollers CMO: Dr. Hashmi CMO: Dr. Murphy CMO: Dr. Rivero
	15. Explore expanding mental health services at PMH to better meet the growing needs of our greater community.	• Provide mental health counselor services in the Prosser clinic (6/20). • Explore the feasibility of providing psychiatric services at PMH and implement as appropriate (6/20).	Due to COVID we have not introduced mental health counseling in our clinics. We are working with Comprehensive Mental Health on a potential partnership for providing counseling services in our primary care clinics.	0%		Prosser Clinic Manager: Molly Schutt
	16. Continue to collaborate with the Yakima Valley Farm Workers Clinic (YVFWC) and other community providers to improve the health of our community.	• Include YVFWC and community providers in PMH Medical Staff activities. • Invite YVFWC and community providers to participate on the PMH Community Clinic Committee (1/20).	In June 2020, PMH entered into a Memorandum of Understanding for YVFWC to once again have their providers participate on our Medical Staff and refer their patients to PMH. We are working on plans to fully re-introduce YVFWC providers to PMH and the services we provide. YVFWC providers will participate on several PMH Medical Staff Committees and participate in our provider call rosters.	75%		Dr. Santa Cruz Medical Staff Coordinator: Lynn Smith
	17. Implement a coding education program for providers.	• Hold a twice yearly coding class for providers (3/20).	Brown Consulting has been sought out as the consulting firm to perform the coding audit and coding education. The roll out of the coding education program has been pushed back to September due to discrepancies in patient reports and COVID-19. Currently, patient reports have been abstracted from EPIC and sent to Brown's Consulting to begin audit. A virtual meeting with the providers is scheduled to begin September 29 - October 1, 2020. A provider group training will be conducted to present audit and coding results. Then individual clinician training sessions will be conducted to provide coding education. Post training on coding education will be conducted in December.			CMO: Dr. Sollers Director HIM: Andrea Valle
	18. Develop a Medical Staff Mentorship Program.	• Develop and implement a Medical Staff Mentorship Program (3/20). • Assign all new Medical Staff members to a mentor in 2020.	This plan is currently still being developed in conjunction with Dr. Rivero and Christi Doornink, who are leading the Medical Staff Engagement Committee efforts.	25%		ACMO: Dr. Sollers Director of PMH Clinics: Alana Pumphrey
	19. Enhance the PMH Provider Rounding Program.	• Develop and implement a plan for Department Directors, Administration and CMOs to round on our providers on a regular basis (3/20).	The Director of Clinics has been rounding on 2 providers monthly in 2020. Our next step will be to develop a tracking system for Physician and Director to appropriately round on all providers annually in a structured and scheduled manner.	25%		ACMO: Dr. Rivero Director of PMH Clinics: Alana Pumphrey CEO: Craig Marks
Respond to Medical Staff concerns and needs in a timely manner, pursue initiatives in collaboration with our Medical Staff and ensure the availability of	20. Enhance the visibility of the PMH Specialty Providers.	• Develop and implement a program for PMH Specialists to visit primary care providers (clinics) in the area (2/20). • Conduct lunch/breakfast and learns for residents in the communities we serve (1/20).	We reached out to Primary Care Clinics in our service area in February to schedule lunches and meet and greets with our specialty providers. All meetings were postponed due to COVID. We will be reaching out in July to discuss any options we may have with low number gatherings or virtual educational opportunities.	50%		Director of Prosser Specialty Clinics: Tricia Hawley CCO: Shannon Hitchcock

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Champion
				2nd QTR	4th QTR	
Medical Staff Development – Dr. Brian Sollers, Champion						
the appropriate providers for those we serve. **Achieve an annual Medical Staff satisfaction rate of 98% or higher.**	21. Explore the provision of holistic/aesthetic services in the PMH Clinics.	• Enhance existing (e.g. Botox) and develop new (e.g. laser hair removal, acupuncture, massage) aesthetic/holistic health services (9/20).	Postponed due to COVID and cancelling of elective procedures and treatment.	50%		Director of PMH Clinics: Alena Pumphrey
	22. Develop a PMH Medical Staff clinic space expansion plan.	• Develop a clinic space expansion plan to accommodate recruitment targets over the next three years, including the possibility of securing additional buildings (9/20).	We have been working with the recently updated medical staff model to develop a plan for space over the next three years. The business plans and proposals for space will be completed by end of September.	25%		Direction of PMH Clinics: Alana Pumphrey Director of Maintenance and Support Services: Steve Broussard CEO: Craig Marks
	23. Explore ways that PMH can become more familiar with area tertiary hospitals and providers.	• Invite area providers (Kadlec, Trios, Astria) to PMH Medical Staff Socials (1/20).	Due to the COVID-19 pandemic, no formal action has been taken to date.	0%		ACMO: Dr. Rivero Director of Emergency Services/Provider Recruitment & Retention: Christi Doornink

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2nd QTR	4th QTR	
Employee Development - Ro Kmetz, Champion						
Encourage and provide for the ongoing development of our employees. Provide an atmosphere that values our employees and promotes: -Open Communications; -Competitive wages and benefits; -Selection and retention of effective, caring personnel; -Utilization and development of talent throughout the organization; -On-going education; -Employee recognition. Achieve and maintain an annual employee satisfaction rate of 90% or higher.	1. Obtain input from all employees utilizing an Employee and Medical Staff Satisfaction Survey designed for Prosser Memorial Health.	• Annual Employee Engagement Survey launch in November, 2020. • 75% Survey Participation Goal for 2020. • Improve Employee Satisfaction as compared to previous year (11/20).	No scheduled action to date. No scheduled action to date. No scheduled action to date.	0% 0% 0%		Chief Human Resources Officer: Ro Kmetz
	2. Achieve an annual employee turnover rate of 10% or less by the end of FY 2020.	• Turnover report to be distributed to Leaders on a quarterly basis (4/20). • Develop and implement strategies to keep turnover at 10% or less in 2020 (2/20).	Turnover percentage provided on the Strategic Plan Scorecard on a monthly basis. Turnover through June, 2020 in 0.6%.	100% 50%		HR Generalist Recruitment: Rocky Snider
	3. Assess wage and benefit structure to ensure Prosser Memorial Health remains competitive.	• Participate in a State of Washington wage survey (4/20). • Receive results and review with the Administrative Team. Adjust wages as needed (7/20). • Participate in a State of Washington benefits survey (8/20). Receive results and share with the Administrative Team. • Recommend benefit adjustments as needed for Open Enrollment (10/20).	Washington State Healthcare Milliman Wage Survey data received in June, 2020. Data will be reviewed by the Administrative Team. No scheduled action to date. No scheduled action to date.	100% 0% 0% 0%		Chief Human Resources Officer: Ro Kmetz
	4. Continue to enhance communication during 2020 with all Prosser Memorial Health staff.	• Publish a calendar/schedule of employee engagement events (1/20). • Conduct Rounding on staff. • Provide open forums for staff to provide input on key initiatives at least three (3) times in 2020. • Increase the use of electronic media, (i.e. SharePoint, Prosser Memorial Health Web Homepage and Facebook, and Twitter) (1/20). • Continue to distribute monthly CEO Report to all staff and Provider Update to Medical Staff (1/20). • Continue to publish an Employee Newsletter on a monthly basis (1/20). • Leadership Team will support and maintain an Open Door Policy (1/20). • Continue to promote utilization of the tuition reimbursement policy for staff seeking to move forward in their educational goals.	Calendar of Employee Engagement Events published in January, 2020; updated as needed. Leaders are expected to conduct rounding on staff. Staff Forums paused in 2020 due to COVID 19. Sharepoint updated with current information. PMH main website updated along with othyer social media outlets such as Facebook, Instagram, Twitter and You-Tube. Monthly CEO Report published. Weekly COVID 19 CEO Report for all staff added along with Dr. Sollar's Weekly COVID 19 Update for Providers. Employee Newsletter, The Pulse, published monthly. Leadership maintains an open door policy. Educational Assistance Policy promoted in the Employee Newsletter.	90% 50% 0% 90% 90% 90% 90%		CCO: Shannon Hitchcock

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2nd QTR	4th QTR	
Employee Development - Ro Kmetz, Champion						
	5. Provide for in-house Education opportunities for staff during 2020. Develop and implement a comprehensive Education Plan for 2020.	• Increase staff education to 18 or more hours per FTE per year (12/20). • Work with managers to develop an in-house education plan including Kronos training and creating job shadowing opportunities. (6/20)	Education opportunities made available to staff during COVID 19 to enhance their professional certification status. Reported Education Hours tracked on the Strategic Plan Scorecard. Virtual and on-line learning opportunities offered for the 2020 EPIC Upgrade. Kronos training paused due to researching new HRIS/Payroll vendor for 2021. Individualized training on Kronos is offered throughout the year by the Payroll Technician. Periodic Kronos instructional emails are sent to leaders by the Director of Finance Operations to assist with FAQs (Frequently Asked Questions) about Kronos. PMH Educational Assistance Policy promoted through the monthly Employee Newsletter.	30% 50% 50%		HR Assistant: Crystal Blanco Chief Quality Officer: Kristi Mellema
	6. Refresh all Job Descriptions and Annual Performance Evaluation Tools to align with the Pillars of Excellence and ASPIRE values. Add incentive program for Exempt (non-leadership) staff.	• Update existing job description template and performance evaluation template for staff covered by collective bargaining agreements to reflect ASPIRE values (7/20). • Incentive program to continue in 2020 for exempt staff (4/20).	Job descriptions are updated as approved personnel requisitions are posted. All updated job descriptions include the ASPIRE Values. Incentive bonuses distributed in April, 2020 to Leadership and Exempt staff based on LEM scores.	40% 100%		Chief Human Resources Officer: Ro Kmetz
Encourage and provide for the ongoing development of our employees. Provide an atmosphere that values our employees and promotes: -Open Communications; -Competitive wages and benefits; -Selection and retention of effective, caring personnel; -Utilization and development of talent throughout the organization; -On-going education; -Employee recognition. Achieve and maintain an annual employee satisfaction rate of 90% or higher.	7. Involve staff and their ideas in the development of the FY2020 Strategic Plan via strategic planning sessions with the CEO and Administration Team members.	• Based on input received from FY2020 planning sessions with staff, Medical Staff, and Board, create a draft Strategic Plan for FY2021 for the Board to review in November, 2020 (10/20).	No scheduled action to date.	0%		CCO: Shannon Hitchcock Chief Executive Officer: Craig Marks
	8. Enhance relationships, trust, and teamwork among the Leadership Team in FY 2019.	• Conduct three (3) Leadership Development Institutes (LDI) in 2020. • Continue Administrative Rounding (2/20). • CEO will round twice annually with all Leadership Team members. (12/20).	1st LDI held on March 11, 2020. 2nd LDI will be held virtually on August 11th & 12th (2 half days) Administrative Rounding paused due to COVID 19. CEO rounds with Leadership Team members on a monthly basis.	67% 0% 50%		LDI Committee CEO: Craig Marks Administrative Team
	9. Enhance the onboarding/orientation of new employees and Medical Staff to Prosser Memorial Health.	• Continue to enhance the PMH New Employee Orientation (NEO) for all levels of staff (1/20). • Reintroduce and implement a coaching/mentoring program in 2020 that identifies leaders of the future and supports their continued development (4/20). • Create and implement a Medical Staff and Leadership Orientation Program (6/20).	27 New Hires have participated in New Employee Orientation through June, 2020. Clinical Administration has floated/reassigned indentified staff to other clinical areas for enhanced training and development. Staff meet with CHRO for one-on-one training in Fierce Conversations - a relationship building program. The Medical Staff Engagement Committee has drafted a Provider Orientation Model.	50% 25% 50%		Chief Human Resources Officer: Ro Kmetz HR Generalist Recruitment: Rocky Snider
	10. Involve staff in the hiring process for new employees.	• Utilizing best practices, create a peer interview template that can be shared and implemented by department leaders (3/20).	No action to date.	0%		HR Generalist Recruitment: Rocky Snider

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
Employee Development - Ro Kmetz, Champion				2nd QTR	4th QTR	
	11. Embrace the ASPIRE Values and Standards of Behavior as identified in the Strategic Plan.	• Continue to educate and enhance the ASPIRE program, recognizing employees, providers, and volunteers who practice and live our Values and Standards of Behavior (2/20).	Employee Rewards and Recognition Team members review ASPIRE Program nominees on a monthly basis.	100%		Rewards & Recognition Committee Aurora Weddle
		• Continue to embrace ASPIRE Program with monthly and year-end awards (12/20).	CEO and committee members recognize Gold, Silver and Bronze awardees monthly. A new Platium category added for 2020 spurred by efforts to combat COVID 19.	50%		
	12. Enhance the exit interview process to identify opportunities for improvement.	• Compile and share exit interview data in real time with the affected department leaders and on a quarterly basis with the Administrative Team (4/20).	Due to very low staff turnover, report still being developed.	25%		HR Generalist Recruitment: Rocky Snider
	13. Work with Hiring Managers to create job position models for pre-employment assessments using PDP Works to help determine their organizational fit with PMH's Mission, Vision and ASPIRE values.	• Work with PDP Works to create employment models to use for pre-employment assessments including specific tie-ins to our ASPIRE Values (2/20).	PDP Training completed.	100%		Chief Human Resources Officer: Ro Kmetz
		• Launch PDP Works (3/20).	Paused due to 2020 hiring trends for affected positions.	0%		
	14. Review and revise existing Health Insurance Plan on an annual basis to ensure competitiveness with the current market.	• Continue to enhance the Health Insurance Plan which adds value-based benefits, reduces employee costs and increases utilization of PMH facilities and providers (9/20).	No scheduled action to date.	0%		HR Generalist Benefits: Nora Newhouse Chief Human Resources Officer: Ro Kmetz Chief Financial Officer: David Rollins
		• Develop direct contracts with area primary and specialty care providers (7/20).	No scheduled action to date.	0%		
		• Audit self-insured health plan (6/20).	Finalizing paperwork for a July/August audit.	50%		
		• Continue to promote healthy lifestyles and a positive work-life balance for 2020.	Employee Engagement Activites scheduled through December, 2020. Activities modified for compliance with Governor's orders as related to COVID 19.	50%		
Encourage and provide for the ongoing development of our employees. Provide an atmosphere that values our employees and promotes: -Open Communications; -Competitive wages and benefits; -Selection and retention of effective, caring personnel; -Utilization and development of talent throughout the organization; -On-going education; -Employee recognition.	15. Review and propose revisions to benefit plans offered at Prosser Memorial Health to be competitive with the current market.	• Using the PTO Committee, assess consolidating benefit buckets and transition to a PTO platform for exempt staff in 2020 (3/20).	PTO Committee work paused due to competing priorities related to COVID 19 and the integration of the new Washington State Sick Leave Law.	60%		Chief Human Resources Officer: Ro Kmetz HR Generalist Benefits: Nora Newhouse
		• Assess health wellness program in support of healthy lifestyles for 2020 (7/20).	No scheduled action to date.	0%		
		• Reduce employee lost work days by 25%.	New metric for 2020. Through June, 63 lost work days reported. Annual goal is less than 167 days.	40%		
	16. Review and redefine the Employee Health Program to improve efficiency and employee satisfaction.	• Establish a comprehensive Employee Health Tracking process for 2020 (6/20).	Comprehensive tracking dcoument created and used for employees for COVID 19.	100%		RN: Karla Greene HR Generalist Benefits: Nora Newhouse
		• Review MRO contract and seek better accountability for drug screens (3/20).	MRO contract enhanced for an additonal $200 for each expanded drug screen required.	100%		
		• Achieve 90% compliance of annual employee health requirements by year end (12/20).	No scheduled action to date.	0%		
		• Reduce employee lost workdays by 25% from previous year (12/20).	Final numbers not available until December, 2020.	0%		

224

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2nd QTR	4th QTR	
Employee Development - Ro Kmetz, Champion						
Achieve and maintain an annual employee satisfaction rate of 90% or higher.	17. Continue to use the employee engagement team for oversight over Prosser Memorial Health employee social events to help transition the culture to align with ASPIRE values, make the workplace a more enjoyable experience and promote employee involvement in our communities.	• Continue to generate and implement ideas that support a variety of employee engagement activities and events including a "Spirit Day" for 2020 (3/20).	Employee Engagement Team meets monthly. The Leadership Car Wash in July offered staff the opportunity to show their PMH Spirit!	100%		Chief Human Resources Officer: Ro Kmetz Employee Engagement Team
		• Create and distribute a calendar of planned employee events for 2020 (1/20). • Involve Leadership to promote and host activities and events (1/20).	Calendar of Events published in January, 2020; monthly reminders of events published in advance of event through email, sharepoint and ASPIRE Boards.	100%		
		• Develop and use a tool whereby employees can provide real-time feedback on activities and events to assist with the planning process (4/20).	Tool being developed.	0%		
		• Continue to include all Prosser Memorial Employees and staff working at partner clinics in activities and events where possible (1/20).	Staff at partner clinics included in all major employee activities events such as Valentine's Day, St. Patrick's Day celebration, Easter Basket distribution, National Hospital Week and Leadership Car Wash Picnic lunch.	100%		
	18. Continue to study the feasibility of transitioning rehabilitation services staff (i.e. PT, OT, Speech Therapy) and Pharmacy Director to employment status with Prosser Memorial Health.	• Analyze current compensation and benefit structures of both organizations (4/20). • Review current service contract agreement and develop a cost analysis of the transition (5/20). • Establish a communication timeline and meet with stakeholders (6/20). • Create a transition plan and prepare for Day 1 requirements (7/20).	Feasibility work suspended due to rehabilitation staff workforce reductions in response to COVID 19. Current staffing as of June, 2020 remains at diminished levels. Analysis will restart when staffing returns to normal levels.	0%		Chief Human Resources Officer: Ro Kmetz CNO/COO: Merry Fuller
	19. Implement a consistent Uniform Policy for PMH to enhance professional appearance and increase customer satisfaction.	• Finalize research healthcare facilities best practices and make recommendations (1/20).	Complete.	100%		Chief Human Resources Officer: Ro Kmetz Uniform Committee
		• Meet with Leadership and obtain feedback on best practice research (2/20).	Complete.	100%		
		• Determine the timeline for implementation and development of policies and procedures (6/20). • Implement the policy as appropriate (8/20).	Administration Team and the Board of Commissioners were presented with a draft Uniform Policy, potential budget and implementation timeline in May, 2020.	100%		
	20. Maintain an environment of positive employee relations with AFSCME, IAFF and SEIU and all exempt staff which supports the Mission, Vision and Values of Prosser Memorial Health.	• Successfully negotiate new AFSCME Collective Bargaining Agreement in 2020 (7/20).	Basic prep work for negotiations will begin in July, 2020. Current CBA expires 12/31/20.	10%		Chief Human Resources Officer: Ro Kmetz
		• Hold IAC (Insurance Advisory Committee) meetings per contracts (10/20).	No scheduled action to date.	0%		

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2nd QTR	4th QTR	
Employee Development – Ro Kmetz, Champion						
	21. Create accessible computer kiosk areas for staff so that those without direct computer access have a centralize access point.	• Create a work team to study need and make recommendations to Administrative Team and implement as appropriate (4/20).	No action to date.	0%		Chief Human Resources Officer: Ro Kmetz Chief Information Officer: Kevin Hardiek
	22. Offer Leader training opportunities for non-leadership staff to promote personal and professional growth.	• Solicit employees for input and develop continuous learning agendas and source trainers (3/30).	CHRO meets with identified staff one-on-one for mentoring on relationship building through the conversational model, Fierce Conversations. MBS (Management by Strengths) leadership tool offered to all staff in June, 2020. CCO and CCQO will coordinate a virtual MBS training with the Studer Group's certified trainer in August, 2020.	75% 25%		Leadership Team
	23. Assess the organizational structure utilized in the PMH Clinics.	• Evaluate the current organizational structure in the PMH Clinics and implement changes as appropriate (3/20).	The Director of Physician Practices is developing a Dyad Leadership Model for the clinics creating a partnership between a physician leader and administrative leader for each clinic. Work initially paused between March and June due to COVID 19.	75%		Director of PMH Clinics - Alana Pumphrey

226

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2nd QTR	4th QTR	
Quality - Kristi Mellema, Champion						
Continue to support the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance. Objectives are designed to: • Attain optimal patient outcomes and patient and family experience • Support an engaged and safe workforce • Enhance appropriate utilization • Minimize risks and hazards of care • Develop and share best practices	1. Maintain an organization-wide Strategic Plan Scorecard of key performance indicators for FY 2020.	• Track and trend FY2020 Strategic Plan Scorecard monthly based on the Pillars of Excellence (12/20) • Assist departments in achieving 2020 quality goals. (12/20) • All indicators will meet goal by end of 2020 (12/20).	* The Strategic Plan Scorecard is tracked and trended on a monthly basis. * Departments are assisted in reviewing and moving towards meeting the 2020 quality goals. * As of June 2020, 20 out of 47 of the metrics were meeting goal (42.6%), eight were within 10% of goal and 19 were 10% below goal.	50%		Chief Quality Officer: Kristi Mellema
	2. Maintain Patient Care Scorecard to measure and trend selected Quality Measures.	• Achieve an overall Patient Care Scorecard improvement 5% above FY2020 across the selected Quality measures (12/20).	* As of June 2020, nine out of 15 metrics were meeting goal (60%), one was within 10% of goal and five were 10% below goal.	50%		Chief Quality Officer: Kristi Mellema
	3. Implement a Clinic Patient Care Scorecard to measure and trend selected Quality Measures.	• Choose clinic specific quality measures to include on the Clinic Patient Care Scorecard (2/20). • FY2020 to establish a baseline across the selected Quality measures (12/20). • Break out metrics by individual Clinic and present at each Clinic Medical Staff meetings. (5/20)	* Clinic specific quality metrics have been established and a Clinic Patient Care Scorecard has been created. * Baselines have been selected for each clinic specific quality metric. * Metrics have been separated by individual clinic, however, this information has yet to be presented to the Medical Staff. Originally, there were issues with pulling the data. Target for presentation is at the July Quality Committee Meeting.	75%		Director of PMH Clinics: Alana Pumphrey
	4. Be in compliance with regulatory standards of applicable agencies (State of Washington, CMS, etc.)	• Create department specific quality reporting calendar including items to go to Joint Conference Committee (1/20). • Submit 2020 Quality Improvement Plan to the Board for Approval (3/20). • Identify and implement survey readiness activities in preparation for the spring 2020 DOH unannounced survey (1/20).	* A calendar of department specific quality presentations has been developed and distributed to all Leaders. * The 2020 Quality Assurance Plan was reviewed and presented to the Board in January 2020. Board approved. *Departmental Tracers were sent and reviewed to all department directors/managers. The tracers are based on the same documents that the DOH uses during their survey. Areas of opportunity were identified and plans of correction	100%		Chief Quality Officer: Kristi Mellema
	5. Revise standardized processes across all Clinics. To include but not limited to the following: MA rooming process, front desk, results reporting, recall letters, late to follow-up, MA documentation.	• Identify education opportunities (3/20). • Create education offerings (3/20). • Develop training for the education opportunities that were identified (6/20). • Provide education and competency assessments to 100% of appropriate staff (12/20).	* Training calendar has been created. * All educators have agreed to teach/majority will be Pam Morris, NP. * Schedule was completed and sent to staff, cancelled due to group number restrictions. We are hopeful this will begin in September 2020. * Competency checklist created. All staff will be checked off by 12/2020.	50%		Director of PMH Clinics: Alana Pumphrey
	6. Bar code scanning for medication	• Achieve an overall medication bar code scanning compliance rate of 95% for the hospital (12/20). • Report medication bar code scanning compliance at each monthly Quality meeting (1/20-12/20).	* As of June 2020, overall Medication Scanning was at 94.48%. This metric has improved month over month. We are not quite to goal but will continue monitoring this metric. * This metric is a standing agenda item and it reported at each monthly Quality Committee meeting.	75%		Director of Pharmacy: Lindsay McKie
	7. Enhance Infection Prevention Program compliance with standards of applicable agencies, as well as, adherence to the PMH Infection Control Plan.	• Implement, educate & communicate an enhanced PMH Infection Control Program Plan which meets all regulatory agency requirements (3/20). • Implement programs to promote compliance. Quarterly communications and/or education (3/20). • Complete Risk Assessment and Infection Control plan for 2020 (3/20).	* The Infection Control Program Plan was reviewed and approved by the Board in February 2020. The plan meets regulatory requirements and has been implemented with education to staff. * Since February, communication and education to all staff has been focused on infection control to prevent COVID-19. This is an ongoing project. * Risk Assessment and Infection Control plan for 2020 were reviewed and approved by the Board in February 2020.	100%		Laboratory Director/Infection Preventionist: Susan Miklas

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
Quality - Kristi Mellema, Champion				2nd QTR	4th QTR	
	8. Enhance Prosser Memorial Health's Environment of Care plans, policies and procedures with current standards of all applicable agencies.	• Perform annual review of all EOC plans, policies and procedures. Update documents as necessary to reflect new or changes to regulations, codes and standards. Distribute all EOC plans to all departments (8/20).	*Revised EOC plans and policies were distributed to all departments on June 10, 2020.	100%		Director of Support Services: Steve Broussard
Continue to support the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance. Objectives are designed to: • Attain optimal patient outcomes and patient and family experience • Support an engaged and safe workforce • Enhance appropriate utilization • Minimize risks and hazards of care • Develop and share best practices	9. Implement a Contract Review Process.	• Update contract review policy (2/20). • Complete annual contract evaluation of all contracts (3/20). • Make a final determination on which software to use (3/20). • Input all contracts to the software (5/20).	* Contract review policy is still under revision. * Annual contract evaluation is still in progress. * Determination was made to use PolicyTech for electronic storage of vendor contracts. * As of June 2020, only 50% of the contracts have been inputted into PolicyTech.	50%		CNO/COO: Merry Fuller Chief Quality Officer: Kristi Mellema
	10. Maintain an effective Corporate Compliance Program.	• Establish areas of focus for 2020, including specific metrics impacting the iVantage quality score (4/20). • Develop an audit schedule for areas of focus (4/20). • Assist areas needing help with meeting corporate compliance standards (1/20 - 12/20). • Submit 2020 Corporate Compliance Plan to the Board for approval (7/20).	* Compliance areas of focus has been established with the committee members. Also the metrics on the Patient Care Scorecard have been tied to some of the metrics in the iVantage report. * An audit schedule for areas of focus has been established with committee members. * There is ongoing assistance to all departments to ensure that corporate compliance standards are maintained. * The 2020 Corporate Compliance Plan was presented and approved by the Board in February 2020.	100%		Chief Compliance Officer: Kristi Mellema
	11. Focused Quality goals based on iVantage.	• Report OP22 - Left without being seen - for 2019 (3/20). • Start reporting OP29 - Colonoscopy follow up (4/20). • Achieve 95% compliance rate on IMM2 Flu Vaccine (inpatient) for 2020. (12/20)	* OP22 was reported in May 2020 to NHSN. * OP29 was reported in May 2020 to NHSN. * Flu Vaccine compliance for 2019/2020 is 96.7%.	100%		Chief Quality Officer: Kristi Mellema
	12. ED scheduling Clinic follow up appointments.	• ED will direct schedule follow up appointments for 25% of ED discharges needing a follow up with a PMH care provider (9/20).	* This project has been put on hold due to COVID-19. Need to consult with IT to find out whether or not the ED can access the Clinic schedule.	0%		ED Director: Christi Doornink-Osborn Director of PMH Clinics: Alana Pumphrey
	13. Enhance hand hygiene at PMH.	• Report hand hygiene compliance to Leaders at the monthly Quality Committee meeting (1/20 - 12/20). • Educate all employees about the importance of hand hygiene (10/20). • Achieve hand hygiene goals by the end of 2020 (12/20). • Standardize hand gel product across PMH organization (6/20).	* Hand hygiene compliance is a standing agenda item at each monthly Quality Committee meeting. * Hand hygiene education has been distributed and redistributed this year due to COVID-19. * Working on achieving hand hygiene goals is an ongoing task and addressed at each Quality Committee meeting. * Hand gel product has been paused due to shortages and nationwide allocations related to COVID-19.	75%		Laboratory Director/Infection Preventionist: Susan Miklas

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2nd QTR	4th QTR	
Quality – Kristi Mellema, Champion						
Continue to support the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance. Objectives are designed to: • Attain optimal patient outcomes and patient and family experience • Support an engaged and safe workforce • Enhance appropriate utilization • Minimize risks and hazards of care • Develop and share best practices	1. Maintain an organization-wide Strategic Plan Scorecard of key performance indicators for FY 2020.	• Track and trend FY2020 Strategic Plan Scorecard monthly based on the Pillars of Excellence (12/20) • Assist departments in achieving 2020 quality goals. (12/20) • All indicators will meet goal by end of 2020 (12/20).	* The Strategic Plan Scorecard is tracked and trended on a monthly basis. * Departments are assisted in reviewing and moving towards meeting the 2020 quality goals. * As of June 2020, 20 out of 47 of the metrics were meeting goal (42.6%), eight were within 10% of goal and 19 were 10% below goal.	50%		Chief Quality Officer: Kristi Mellema
	2. Maintain Patient Care Scorecard to measure and trend selected Quality Measures.	• Achieve an overall Patient Care Scorecard improvement 5% above FY2020 across the selected Quality measures (12/20).	* As of June 2020, nine out of 15 metrics were meeting goal (60%), one was within 10% of goal and five were 10% below goal.	50%		Chief Quality Officer: Kristi Mellema
	3. Implement a Clinic Patient Care Scorecard to measure and trend selected Quality Measures.	• Choose clinic specific quality measures to include on the Clinic Patient Care Scorecard (2/20). • FY2020 to establish a baseline across the selected Quality measures (12/20). • Break out metrics by Individual Clinic and present at each Clinic Medical Staff meetings. (5/20)	* Clinic specific quality metrics have been established and a Clinic Patient Care Scorecard has been created. * Baselines have been selected for each clinic specific quality metric. * Metrics have been separated by individual clinic, however, this information has yet to be presented to the Medical Staff. Originally, there were issues with pulling the data. Target for presentation is at the July Quality Committee Meeting.	75%		Director of PMH Clinics: Alana Pumphrey
	4. Be in compliance with regulatory standards of applicable agencies (State of Washington, CMS, etc.)	• Create department specific quality reporting calendar including items to go to Joint Conference Committee (1/20). • Submit 2020 Quality Improvement Plan to the Board for Approval (3/20). • Identify and implement survey readiness activities in preparation for the spring 2020 DOH unannounced survey (1/20).	* A calendar of department specific quality presentations has been developed and distributed to all Leaders. * The 2020 Quality Assurance Plan was reviewed and presented to the Board in January 2020. Board approved. *Departmental Tracers were sent and reviewed to all department directors/managers. The tracers are based on the same documents that the DOH uses during their survey. Areas of opportunity were identified and plans of correction	100%		Chief Quality Officer: Kristi Mellema
	5. Revise standardized processes across all Clinics. To include but not limited to the following: MA rooming process, front desk, results reporting, recall letters, late to follow-up, MA documentation.	• Identify education opportunities (5/20). • Create education offerings (8/20). • Develop training for the education opportunities that were identified (6/20). • Provide education and competency assessments to 100% of appropriate staff (12/20).	* Training calendar has been created. * All educators have agreed to teach/majority will be Pam Morris, NP. * Schedule was completed and sent to staff, cancelled due to group number restrictions. We are hopeful this will begin in September 2020. * Competency checklist created. All staff will be checked off by 12/2020.	50%		Director of PMH Clinics: Alana Pumphrey
	6. Bar code scanning for medication	• Achieve an overall medication bar code scanning compliance rate of 95% for the hospital (12/20). • Report medication bar code scanning compliance at each monthly Quality meeting (1/20-12/20).	* As of June 2020, overall Medication Scanning was at 94.48%. This metric has improved month over month. We are not quite to goal but will continue monitoring this metric. * This metric is a standing agenda item and it reported at each monthly Quality Committee meeting.	75%		Director of Pharmacy: Lindsay McKie
	7. Enhance Infection Prevention Program compliance with standards of applicable agencies, as well as, adherence to the PMH Infection Control Plan.	• Implement, educate & communicate an enhanced PMH Infection Control Program Plan which meets all regulatory agency requirements (3/20). • Implement programs to promote compliance. Quarterly communications and/or education (3/20). • Complete Risk Assessment and Infection Control plan for 2020 (5/20).	* The Infection Control Program Plan was reviewed and approved by the Board in February 2020. The plan meets regulatory requirements and has been implemented with education to staff. * Since February, communication and education to all staff has been focused on infection control to prevent COVID-19. This is an ongoing project. * Risk Assessment and Infection Control plan for 2020 were reviewed and approved by the Board in February 2020.	100%		Laboratory Director/Infection Preventionist: Susan Miklas

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
Quality - Kristi Mellema, Champion				2nd QTR	4th QTR	
	8. Enhance Prosser Memorial Health's Environment of Care plans, policies and procedures with current standards of all applicable agencies.	• Perform annual review of all EOC plans, policies and procedures. Update documents as necessary to reflect new or changes to regulations, codes and standards. Distribute all EOC plans to all departments (8/20).	*Revised EOC plans and policies were distributed to all departments on June 10, 2020.	100%		Director of Support Services: Steve Broussard
Continue to support the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance. Objectives are designed to:

• Attain optimal patient outcomes and patient and family experience
• Support an engaged and safe workforce
• Enhance appropriate utilization
• Minimize risks and hazards of care
• Develop and share best practices | 9. Implement a Contract Review Process. | • Update contract review policy (2/20).
• Complete annual contract evaluation of all contracts (3/20).
• Make a final determination on which software to use (3/20).
• Input all contracts to the software (5/20). | * Contract review policy is still under revision.
* Annual contract evaluation is still in progress.

* Determination was made to use PolicyTech for electronic storage of vendor contracts.
* As of June 2020, only 50% of the contracts have been inputted into PolicyTech. | 50% | | CNO/COO: Merry Fuller
Chief Quality Officer: Kristi Mellema |
| | 10. Maintain an effective Corporate Compliance Program. | • Establish areas of focus for 2020, including specific metrics impacting the iVantage quality score (4/20).
• Develop an audit schedule for areas of focus (4/20).
• Assist areas needing help with meeting corporate compliance standards (1/20 - 12/20).
• Submit 2020 Corporate Compliance Plan to the Board for approval (7/20). | * Compliance areas of focus has been established with the committee members. Also the metrics on the Patient Care Scorecard have been tied to some of the metrics in the iVantage report.
* An audit schedule for areas of focus has been established with committee members.
* There is ongoing assistance to all departments to ensure that corporate compliance standards are maintained.
* The 2020 Corporate Compliance Plan was presented and approved by the Board in February 2020. | 100% | | Chief Compliance Officer: Kristi Mellema |
| | 11. Focused Quality goals based on iVantage. | • Report OP22 - Left without being seen - for 2019 (3/20).
• Start reporting OP29 - Colonoscopy follow up (4/20).
• Achieve 95% compliance rate on IMM2 Flu Vaccine (inpatient) for 2020. (12/20) | * OP22 was reported in May 2020 to NHSN.
* OP29 was reported in May 2020 to NHSN.
* Flu Vaccine compliance for 2019/2020 is 96.7%. | 100% | | Chief Quality Officer: Kristi Mellema |
| | 12. ED scheduling Clinic follow up appointments. | • ED will direct schedule follow up appointments for 25% of ED discharges needing a follow up with a PMH care provider (9/20). | * This project has been put on hold due to COVID-19. Need to consult with IT to find out whether or not the ED can access the Clinic schedule. | 0% | | ED Director: Christi Doornink-Osborn
Director of PMH Clinics: Alana Pumphrey |
| | 13. Enhance hand hygiene at PMH. | • Report hand hygiene compliance to Leaders at the monthly Quality Committee meeting (1/20 - 12/20).
• Educate all employees about the importance of hand hygiene (10/20).
• Achieve hand hygiene goals by the end of 2020 (12/20).
• Standardize hand gel product across PMH organization (6/20). | * Hand hygiene compliance is a standing agenda item at each monthly Quality Committee meeting.
* Hand hygiene education has been distributed and redistributed this year due to COVID-19.
* Working on achieving hand hygiene goals is an ongoing task and addressed at each Quality Committee meeting.
* Hand gel product has been paused due to shortages and nationwide allocations related to COVID-19. | 75% | | Laboratory Director/Infection Preventionist: Susan Mildas |

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2th QTR	4th QTR	
Financial Stewardship - David Rollins, Champion						
Continue to strengthen its financial stewardship position to enhance the ability to develop new services, obtain needed technology, modernize facilities, recruit physicians and ultimately ensure long term viability.	1. Meet and/or exceed budget expectations for FY2019.	• Earn an operating margin of at least 4.5% and a total margin of 6.0% for FY2020. Publish financial reports every month and • distribute to Management Team, all employees, Medical Staff and Board.	Thanks to federal funding for COVID, PMH has an operating margin of 12.5% and total margin of 12.6%.	50%		CFO: David Rollins
	2. Reduce all costs.	• Reduce total expense per adjusted patient day by 3% versus 2019. Reduce OT utilization by reducing unscheduled sick pay utilization and staffing optimization. • Reduce Contract Labor in Nursing by 25% by staffing optimization and retention. • Reduce product waste by 25% by tracking and reporting out-dates and improving inventory controls. • Review service contracts for opportunities to reduce costs.	Due to COVID Adjusted Patient Days are down 25% and Average Expense per Patient Day is up 28% and most staffing matrix targets have been negatively impacted by mgmt decision to not furlough employees, reduce hours or benefits due to federal funding. Purchasing has begun tracking out-dates and overall inventory is stable despite increasing PPE stock.	50%		CFO: David Rollins
	3. Meet and/or exceed budgeted operating revenue per FTE and share monthly reports in the PMH Report Card.	• Develop and implement a biweekly department productivity report using the resources provided by Brady Company, Inc. (2/20).	Brady & Associates has received all the requested data from PMH and a report is pending.	50%		CFO: David Rollins
	4. Obtain an unqualified audit opinion for FY2018 with no audit adjustments.	• Obtain an unqualified audit opinion for FY2019 and share with the Board (3/20).	PMH received an unqualified audit opinion from its auditors (DZA) at the May board meeting.	100%		Director of Finance: Stephanie Titus
	5. Maintain Net Days in Accounts Receivable below industry standards.	• Create and publish a "net" unbilled days metric (3/20). • Maintain days in Net Accounts Receivable below 47 days and unbilled days under 5 days.	Net AR Days are at 52 overall driven by staffing challenges as several new staff including leadership have been added in the first half of the year. Results are better than budget and prior year at this time but still trailing targeted benchmark of 47 days.	75%		Revenue Cycle Director: TBD
	6. Provide a semi-annual report to the Board of Commissioners regarding the financial performance of PMH owned physician practices.	• Present a semi-annual financial performance report for PMH owned physician practices to the Board (1/20 & 7/20).	Semi-Annual Financial Performance Report is included in the July Board of Directors package.	100%		Director of Finance: Stephanie Titus
	7. Participate on the HCA Rural Payment Model committee.	• Ensure that PMH receives all practice transformation funds possible in 2020 (12/20).	PMH has received 100% of eligible funds to date for the Practice Transformation Project ($XXX,XXX).	50%		CFO: David Rollins CNO: Merry Fuller Director of Clinics: Alana Pumphrey

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2th QTR	4th QTR	
Financial Stewardship - David Rollins, Champion						
	8. Improve Point-of-Service collections.	• Increase Point-of-Service collections by 50% in FY2020 compared to 2019 (12/20). • Implement POS Estimates (6/20). • Implement Insurance Verifications (6/20). • Restructure Self-Pay policies for discounts and financial assistance (6/20).	New Manager of Patient Access has dramatically improved Point-of-Service Collections since her arrival in March 2020. Cash collections has increased from less than $1,000 in March 2020 to over $10,000 in June 2020. PMH is working with Providence to implement the Passport Patient Eligibility software already in use by Providence with the goal of being live by the end of the 3rd quarter. PMH has revised its Self-Pay policies to offer all Self-Pay accounts a 25% discount on gross charges. All Self-Pay payments are eligible for a 5% prompt pay discount if paid within 30 days of initial billing. The patient financial assistance program has been modified from a 3 tier patient discount of 100%, 50% or 35% discount to a true sliding scale of 100% to 0% dependent upon the applicants financial income as compared to the federal poverty level.	50%		Revenue Cycle Director: TBD
	9. Enhance the Anesthesia billing process/structure.	• Develop and implement an enhanced Anesthesia billing "road-map" (8/20). • Increase anesthesia revenue by 10% (12/20).	Currently in discussions with our Anesthesia providers about their contract. Soliciting bids for anesthesia audit and revenue cycle analysis with completion by 09/30.	25%		CFO: David Rollins
Continue to strengthen its financial stewardship position to enhance the ability to develop new services, obtain needed technology, modernize facilities, recruit physicians and ultimately ensure long term viability.	10. Create a culture of Budget accountability down to the department level.	• Create and implement an education module that focuses on budget creation, analysis, and accountability (4/20). • Educate Directors in accordance with the education module and hold them accountable for their financial performance during evaluations (4/20). • Educate Directors on Revenue Cycle and further streamline the process and provide advanced education on EPIC (3/20).	Hosting quarterly meetings for Directors to discuss performance and budget question. Created Revenue Cycle Team that meets weekly is beginning to invite leaders to discuss process improvement issues (example: Surgery Flow and Authorizations).	35%		CFO: David Rollins
	11. Develop plan to solicit capital donations for new hospital.	• Conduct a feasibility study for a potential capital drive beginning in 2020 (9/20). • Raise $100,000 in 2020 (12/20).	Bids for a feasibility study for a capital drive have been received by the Foundation and are being evaluated at this time.	50%		CCO: Shannon Hitchcock
	12. Improve patient value and market competitiveness.	• Conduct a study of competitor and market pricing to ensure PMH is competitive (02/20). • Utilize Cleverly or like service for state and national data comparisons and implement changes as appropriated.	Engaged Cleverly to conduct a pricing and benchmarking study utilizing our current chargemaster and claims data. Expect final report by 09/30.	25%		CFO: David Rollins
	13. Optimize auditing and cost-reporting capabilities.	• Competitively bid out the PMH audit and cost report services (5/20). • Allow the PMH Board to select the auditors for 2019 (7/20).	RFP to regional and national audit firms specializing in critical access hospitals due to sent out by 07/31.	25%		CFO: David Rollins

Strategic Areas of Focus & Goals	FY2020 Objectives	Measures/Metrics	Semi-Annual Progress	% Complete		Objective Lead
				2th QTR	4th QTR	
Financial Stewardship – David Rollins, Champion						
	14. Improve charge accuracy compliance.	• Conduct annual audits of our billing practices to ensure accurate charge capture (5/20). Work to correct all deficiencies and enhance • our current billing practices in 2020 (12/20).	Engaged Brown Consulting to conduct a coding and charge capture audit with results due by 08/31. Engaged Providence to conduct an analysis of our billing processes and are currently working with them on a weekly basis to improve the areas identified.	50%		Director of Patient Financial Services: Linda Bouchard
	15. Enhance the financial performance of the PMH Emergency Medicine Services.	• Explore ways to enhance revenue and reduce costs (4/20). • Create plan to potentially transition service to a non-PMH entity if appropriate (6/20).	Staffing costs reduced by CNO/COO acting as Interim Director while transition planning is ongoing. Engaged in conversations with West Benton Fire District on assuming services.	25%		CNO/COO: Merry Fuller
	16. Improve efficiencies in Accounting and Human Resources through more effective software.	• Explore options to better meet our software needs for Accounting (GL/AP/MM/Payroll) and HR. • Identify options, migration plans and implement as appropriate (12/20).	Negotiating with Kronos to transition all HR/Payroll/Timekeeping to their platform by 1st quarter of 2021.	25%		CFO: David Rollins CIO: Kevin Hardiek CHRO: Ro Kmetz
	17. Improve Inventory controls and cost/charge capture in departments.	• Identify new software options for Materials Management that will improve labor efficiencies, inventory controls and more effective purchasing tools (12/20).	Pending transition to new GL/AP/MM software in 2021.	0%		Director of Materials Management: Wendy Clapp
	18. Optimize banking partnerships for greatest value overall.	• Distribute RFP for banking services that will reduce costs and improve efficiencies and make recommendations to the Board. (9/20)	Put on hold due to COVID crisis. Expect to complete this selection by 12/31.	0%		Director of Finance: Stephanie Titus

VIII. PMH Team Worksheets

Prosser
Memorial Health

Project Visioning –
Based on our Six Pillars of Excellence, what is important for you to see included in the new hospital?

Patient Loyalty
1. Private Patient Rooms
2.
3.

Quality
1.
2.
3.

Services
1.
2.
3.

Financial Stewardship
1.
2.
3.

Medical Staff Development
1.
2.
3.

Employee Engagement
1.
2.
3.

OUR VISION
FISCAL YEAR 2021-2024

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

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

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

1._____

_____

2._____

_____

3._____

_____

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

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

1._____

_____

2._____

_____

3._____

_____

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

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

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

1._____

_____

2._____

_____

3._____

_____

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

GOAL: Achieve an iVantage score of 49 or higher

1._____

_____

2._____

_____

3._____

_____

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

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

1._____

_____

2._____

_____

3._____

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

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

1._____

_____

2._____

_____

3._____

_____

Prosser
Memorial Health

Project Visioning –

Based on our Six Pillars of Excellence, what is important for you to see included in the new hospital?

Patient Loyalty
1. Private Patient Rooms
2.
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Quality
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Medical Staff Development
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Employee Engagement
1.
2.
3.
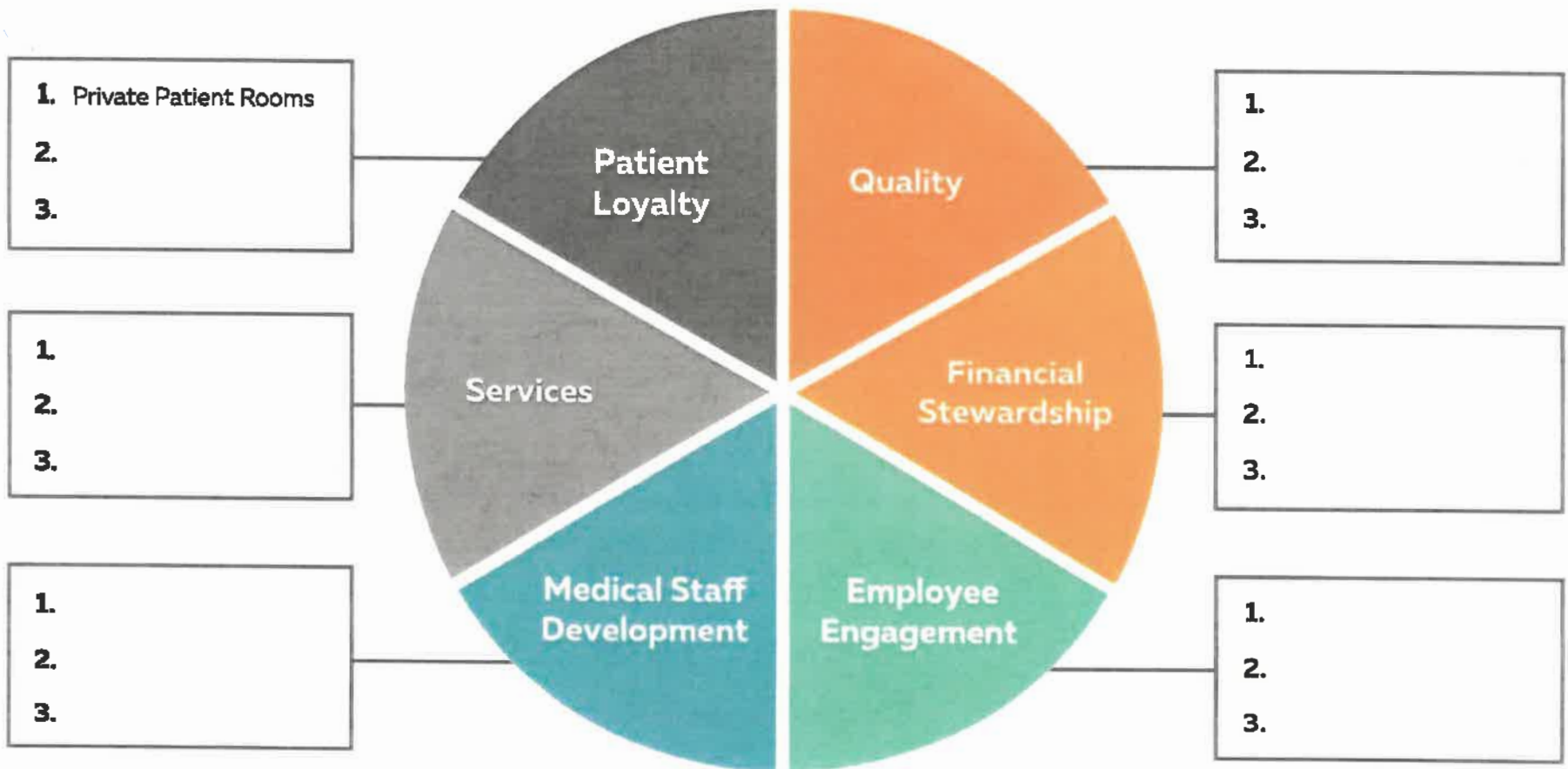
EMPLOYEE FORUM

2021 Strategic Planning

This is your opportunity to provide input! What would you be disappointed about if it wasn't included or addressed for our new hospital? We also want your ideas and feedback for the 2021 Strategic Plan and visioning for the new facility. Employees who participate in person or remotely will be entered in a drawing to win gift certificates.

TUESDAY, OCTOBER 13

3 PM – 4:30 PM · All Staff (Whitehead Conference Room)

WEDNESDAY, OCTOBER 14

7 AM – 8:30 AM · Medical Staff (Whitehead Conference Room)

9 AM – 10:30 AM · All Staff (Whitehead Conference Room)

11:30 AM – 1 PM · All Staff (Whitehead Conference Room)
Pizza will be served for lunch.

All forums will have refreshments. All forums will be accessible on Microsoft Teams.

Prosser
Memorial Health

509.786.2222 | ProsserHealth.org

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

2

OUR VISION
FISCAL YEAR 2021-2024

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

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

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

1._____

2._____

3._____

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

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

1._____

2._____

3._____

MEETING AGENDAS

Project: PMH Replacement Hospital

Dates: October 12 - 14, 2020

Meetings: Various – See Below

Location: Whitehead Conference Room
Mock-Up Room Building
Prosser Memorial Health

Day 1
Monday, 10/12

30 Minutes Kick Off Meeting (at Mock- Up room):   6610 S 1396 PR SW, Prosser, WA

7:00 – 7:30 a.m.   Goal: Review Mock Rooms Agenda and plan for meetings
                    Attendees: Admin. Team, A/E Team, NV5

2.5 Hours   LDRP Mock-Up Review:

7:30 – 10:00   Goal: Review LDRP Room size, clearances, furniture, etc.
                    Attendees: Merry, A/E Team, NV5, LDRP Leaders & Staff

2.0 Hours   ED Treatment Mock-Up Review:

10:00 – 12:00   Goal: Review ED Treatment Room size, clearances, furniture, etc.
                    Attendees: Merry, A/E Team, NV5, ED Leaders, Staff

12:00 – 12:30   **Lunch**

2.5 Hours   Patient Room Mock-Up Review:

12:30 – 3:00   Goal: Review Patient Room size, clearances, furniture, etc.
                    Attendees: Merry, A/E Team, NV5, Med/Surg Leaders & Staff

2.0 Hours   Leadership – Strategic Planning & Visioning Session: Whitehead Conference Room

3:00 – 5:00   Attendees: Leadership Team, NV5, A/E Team

bcDESIGNGROUP
12101 W 110th Street, Suite 100
Overland Park, Kansas 66210
913.232.2123

Day 2

Tuesday, 10/13
Whitehead Conference Room

3 hours	**Review 1st and 2nd Floor Plans:**	
7:00 – 10:00	Goal:	Review first-generation first floor plan.
	Attendees:	Admin Team, NV5, A/E Team
90 Minutes	**MEP Systems Discussions:** (Conference call with City of Prosser)	
10:00-11:30	Goal:	Initial conversations about MEP Systems and Goals.
	Attendees:	Admin. Team, Steve B., A/E Team, NV5
11:30 – 12:30	**Lunch**	
1 Hour	**Site Design:**	**Vineyard Conference Room**
12:30 – 1:30	Goal:	Review site layout options.
	Attendees:	Admin. Team, A/E Team, NV5
1 Hour	**Building Massing Design:**	**Vineyard Conference Room**
1:30 – 2:30	Goal:	Review building massing studies.
	Attendees:	Admin. Team, A/E Team, NV5
1.5 Hours	**Employee Forum** - **Whitehead Conference Room**	
3:00 – 4:30	All Staff	

Day 3

Wednesday, 10/14
Whitehead Conference Room

Medical Staff Forum
7:00 – 8:30   Medical Staff

Employee Forum
9:00 – 10:30   All Staff

30 Minutes	**Wrap-Up Session**	
10:30 – 11:00	Goal:	Talk Next Steps
	Attendees:	Admin. Team, NV5, A/E Team

Employee Forum
11:30 – 1:00   All Staff (Pizza for everyone who shows up)

12'-7"

5'-9"   6'-10"

1/MS2

1'-0"

3'-0"

7'-9"

1'-7 1/2"

2'-9 1/2"

145.00°

145.00°

23'-9"

2/MS3   MED/SURG
ROOM   2/MS2

1/MS3

15'-0"

1'-0"

1'-10"

1 MED/SURG ROOM
1/4" = 1'-0"

2 MED/SURG - E
1/4" = 1'-0"

Dimensions: 4'-6", 3'-8", 4", 2'-10", 2'-1", 2'-0", 1'-10", 25" DP

SIGNAGE
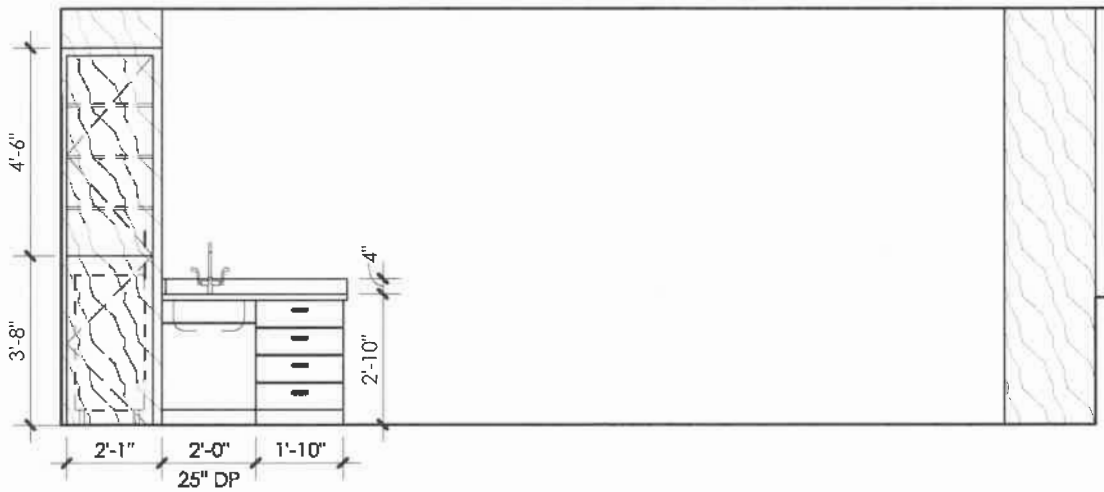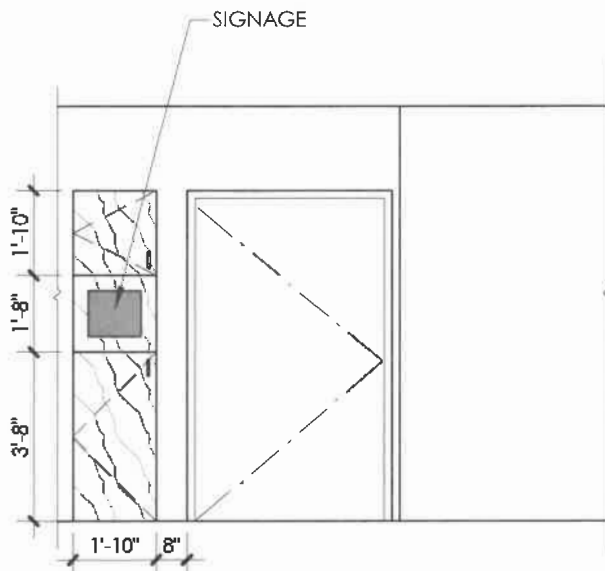
1 MED/SURG CORRIDOR - S
1/4" = 1'-0"

Dimensions: 1'-10", 1'-8", 3'-8", 1'-10", 8"

HEADWALL

8'-0"

2"

3'-6"

2'-2" 1'-4"
18" DP 16" DP

2 MED/SURG - HEADWALL
1/4" = 1'-0"

8'-7"

WINDOW

3'-4"

4'-6"

5'-1"

2'-9"

1'-2"
25" DP

1 MED/SURG - S
1/4" = 1'-0"

ROCKING CHAIR
83" SLEEPER SOFA
19'-8"

11" 3'-1" 2'-5" 5'-0" 6'-1" 2" 2'-0"

1/ LD2

1'-9"

3'-6" 2'-0"

4/LD2 4'-0"

BENCH/PATIENT STORAGE
36" TABLE
CUBICLE CURTAIN
GUEST CHAIRS
BUFFET
TV

BASSINET

8'-9"

HEADWALL

OVERBED TABLE

3/LD2

INFANT ZONE

3'-3"

NURSE WORKSTATION

1'-5"

25'-4"

135.00°

2'-2"

BIRTHING TUB

2'-0" DOOR

2/LD2

NURSE PREP

4'-2"

48" x 36" SHOWER
WITH PORTABLE SEAT

4'-0" DOOR

NURSE SERVER

3'-0"

0"

30" COUNTERTOP WITH SINK

1'-6" LEAF

1 LDRP - PLAN
1/4" = 1'-0"

4 **BENCH - ELEVATION**
1/4" = 1'-0"

BENCH W/
WATERFALL EDGE

OPEN
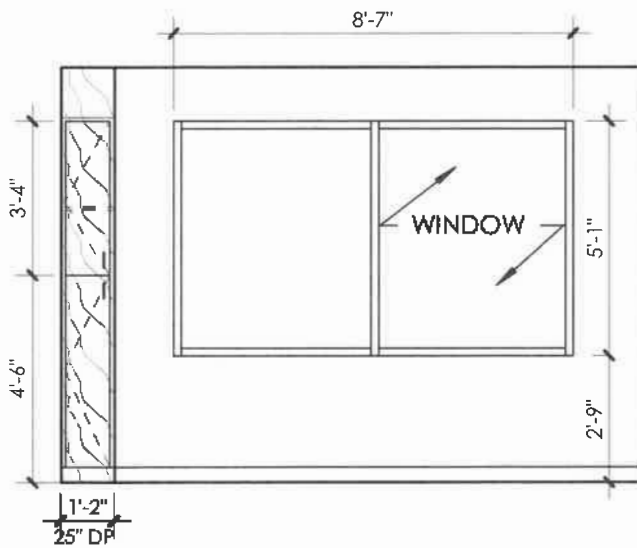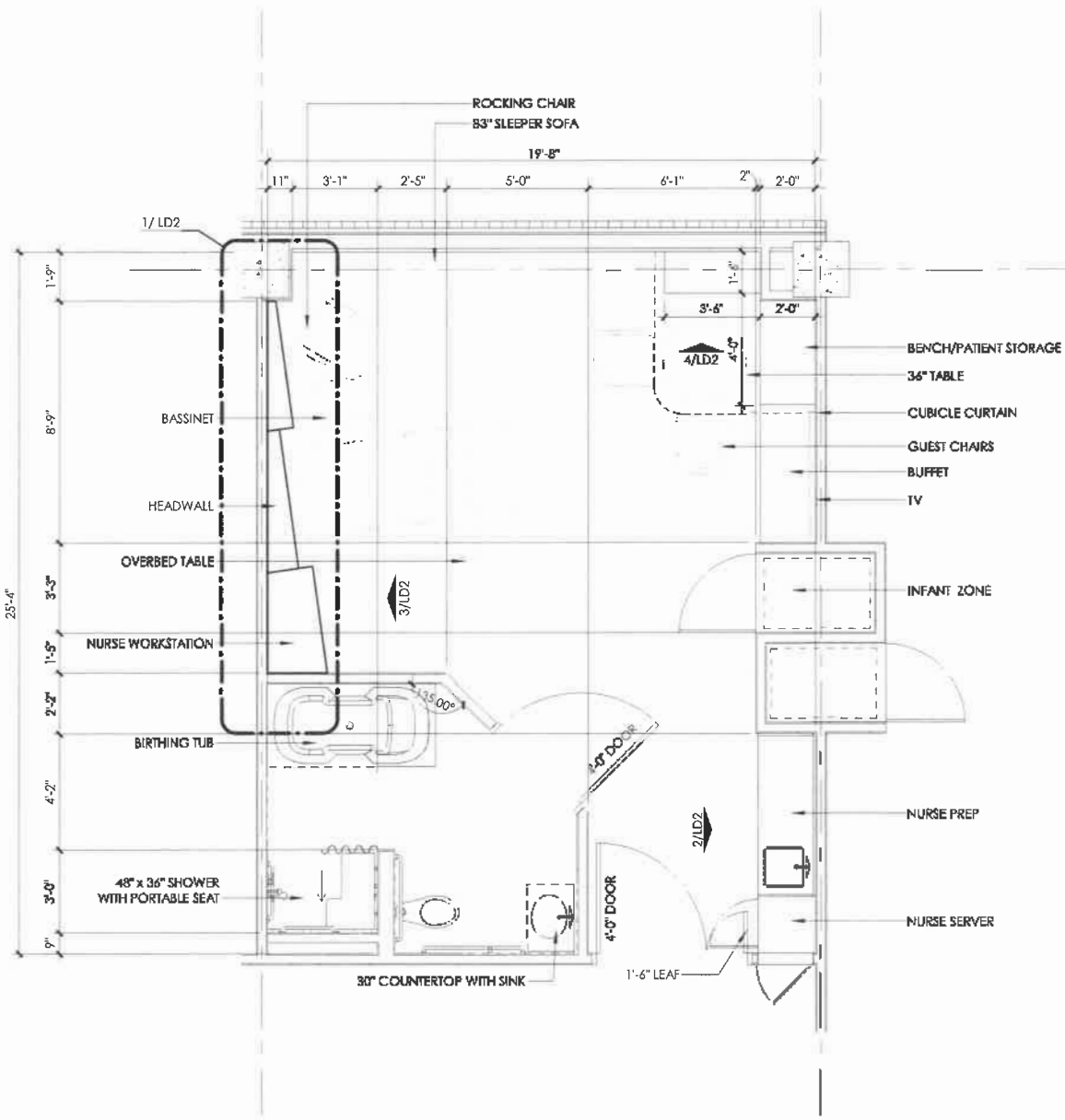
1 **HEADWALL - PLAN**
1/2" = 1'-0"

3 **HEADWALL - ELEVATION**
1/4" = 1'-0"

COUNTER W/
CASEWORK
BELOW,
CASEWORK
CONFIG TBD

3'-10"
DEPTH VARIES, RE: PLAN

FULL HEIGHT CABINET WITH DOOR

T.V.

OPEN

PLAM
NURSE
SERVER
WITH ADJ
UPPER
SHELVES

2'-7" 1'-3" 2'-1" 1'-9"
7'-8"
25" DP
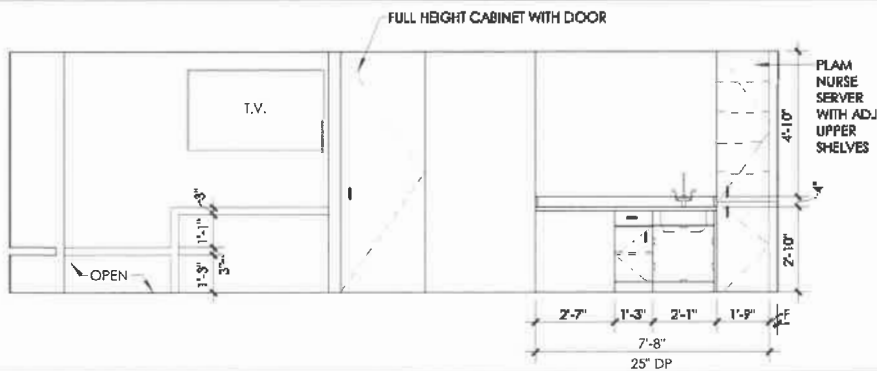
2 **NURSE WORK - ELEVATION**
1/4" = 1'-0"

10'-8"

4" · **8'-0"** · **2'-4"**

NURSE
SERVER

TREATMENT
ROOM

32" T.V.

14'-6"

Cl BED

6'-0"

COMMUNICATION
BOARD

2/TR2

1/TR2

3'-3" · **4'-11"** · **2'-6"**

1 ED TREATMENT ROOM
1/2" = 1'-0"

2 TREATMENT ROOM - E
1/4" = 1'-0"
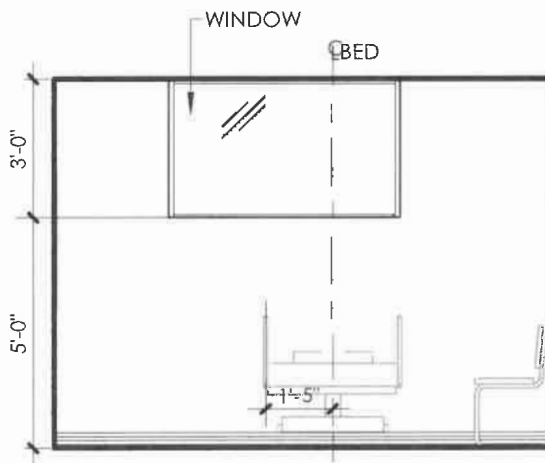
Dimensions: 4'-6", 4'-4", 2'-10", F, 1'-4", 2'-1", 1", 3'-7", 25" DP

TV AND MOUNTING BRACKET

1 TREATMENT ROOM - S
1/4" = 1'-0"

WINDOW
BED
Dimensions: 3'-0", 5'-0", 1'-5"

MEETING AGENDAS

Project:	**PMH Replacement Hospital**
Dates:	**October 26-27, 2020**
Meetings:	**Various – See Below**
Location:	**Whitehead Conference Room** **Prosser Memorial Health**

Day 1
Monday, 10/26

9-Hours	**Departmental Floor Plan Reviews:**	
	Goal:	Review departmental floor plans with departmental leaders
	Attendees:	A/E Team, NV5, departmental leaders

7:00 – 8:00	Surgeons (Merry, Sara, Surgeons)
8:00 – 9:00	Emergency Department (Merry, Christi, Dr. Wenger, Key ED Staff)
9:00 – 11:00	Admin/HR/Registration/Clinic/2nd Floor (Admin. Team)
11:00 – 12:00	Diagnostic Imaging (Merry, Aurora, Key DI Staff)
12:00 – 1:00	Lunch
1:00 – 2:00	Surgery Staff (Merry, Sara, OR/PACU Leads))
2:00 – 3:00	Central Sterile (Merry, Sara, Melissa Garcia))
3:00 – 3:30	Lab (Merry, Susan, Key Lab Staff)
3:30 – 4:00	Materials Management (Merry, David, Steve)
4:00 – 4:30	EVS (Merry, David, Steve, Genny)

Day 2
Tuesday, 10/27

1-hour	**Building Massing Design:**	
7:00 – 8:00	Goal:	Review building massing studies.
	Attendees:	Entire Admin Team, A/E Team, NV5

1-hour	**Site Design:**	
8:00 – 9:00	Goal:	Review site layout options.
	Attendees:	Entire Admin Team, A/E Team, NV5

1-hour	**MEP Systems Discussions:**	
9:00 – 10:00	Goal:	Continued conversations about MEP Systems and Goals.
	Attendees:	Craig, David, Merry, Steve B, A/E Team, NV5

2-hours	**Operational Focus Meetings:**	
10:00 – 12:00	Goal:	Review strategic planning summary and determine focused question to talk about operational flow with departments at the next round of meetings.
	Attendees:	Entire Admin Team, A/E Team, NV5
	Lunch	

1-hour	**Board Work Session:**	
6:00 – 7:00	Goal:	Visioning, Construction Management Options, Design Update
	Attendees:	Entire Admin Team, A/E Team, NV5

Prosser
Memorial Health

October 20, 2020

Karen Nidermayer, Management Analyst
Washington State Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, WA 98501

Subject: Prosser Memorial Health Hospital Replacement
            Revised Certificate of Need Inquiry

Dear Karen,

In follow-up to your conversation with our Owner's Representative, Paul Kramer, the Prosser Memorial Health team is pleased to share with you notification of the proposed relocation of our existing services to a new facility within the city of Prosser, Washington. We are providing this information to assist the Department of Health to determine if a Certificate of Need will be required.

Our current facility, Prosser Memorial Hospital, which is 73 years old and at the end of its useful life, is located at 723 Memorial Street, Prosser, Washington, 99350. As a designated 'Critical Access Hospital', the facility has 25 licensed acute care beds, and currently provides the following services:

- Emergency Medical Treatment
- Inpatient Acute Care
- Family Maternity Labor and Delivery
- In and Outpatient Surgery
- Diagnostic Imaging
- Laboratory
- Pharmacy to Support Hospital Services
- Rehabilitation Services
- Cardiopulmonary Services
- Specialty Services (OB/GYN, Orthopedics, Urology, ENT, Cardiology, General Surgery)
- Administration and Support Services

Our proposed new facility will retain the name Prosser Memorial Hospital, and will be located at the northeast corner of the intersection of Interstate 82, and North Gap Road, in Prosser, Washington, approximately three miles from the current site. It is anticipated that a property address will be
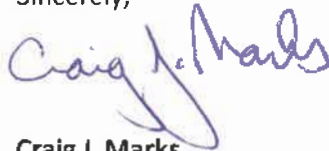
identified once the site has been formally annexed by the City, which is scheduled to occur within the next six-months.

The new facility will remain a Critical Access Hospital, and as such, will have 25 licensed acute care beds, and will provide the same services as our current facility as listed above. It is the Hospital's intent to transition all services from our current facility to the new facility by January 2024, and the existing facility will be decommissioned.

Enclosed, please find payment for the requested fee of $1,965.00 for the Department of Health's assessment. We request that the State confirm receipt of this request to the Hospital and identify next steps if required. If there are any questions regarding this correspondence, please do not hesitate to contact either myself at 509-786-6695 / cmarks@prosserhealth.org, or Paul Kramer at (216) 225-4273 / Paul.Kramer@NV5.com.

We appreciate the State's assistance in this matter and look forward to working with your team.

Sincerely,

Craig J. Marks
Chief Executive Officer

cc: David Rollins   PMH
        Merry Fuller   PMH
        Paul Kramer   NV5
        Kurt Broeckelmann   BCDG

The Advantages of the GC/CM Project Delivery Method

• **Small Business** | • **Managing Employees** | • **Team Building**

By Pat O'Connor

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Push the boundaries of what's possible to create   Learn more

The general contractor/construction manager delivery method is one of the project management options available to companies and organizations about to start a complicated construction project. The point in the project at which the hiring agency consults a general contractor is one of the main differences among the options.

Project Development

A construction project involves different types of team members. Architects, general contractors, construction laborers and the agency overseeing the project all have distinct roles to play. Complicated construction projects take a great deal of coordination among the participating members, and some types of project delivery methods are more effective at facilitating communication. In addition, budget and time-frame constraints play a role in choosing the appropriate method.

Design-Bid-Build Method

Under the design-bid-build method, an engineer or architect draws up the plans for the entire facility, and the organization requests build bids from contractors. Everyone knows his role in this method, but the engineer may not have taken the cost of materials into account, and the design for the entire project has to be complete before any construction starts. If the design is faulty, the general contractor isn't accountable and may initiate a lawsuit for payment. In any case, there's apt to be bickering between the designer and the general contractor.

General Contractor/Construction Manager Method

The general contractor/construction manager – gc/cm or cm/gc – method allows the general contractor to participate as an adviser during the design process. This improves communication between the two parties because the general contractor acts as a construction manager and provides input on the availability and cost of suggested materials and perhaps offers cheaper alternatives. This method costs the agency more for the general contractor's time, but his suggestions on the affordability of different designs can save the agency money in materials.

CONSTRUCTION PROJECT DELIVERY METHODS

N|V|5

Method	Design-Bid-Build	General Contractor/Construction Manager (GC/CM)
Description	A traditional project delivery method where the Owner retains an independent Design Team to develop comprehensive documents for a project, then 'bids' the documents competitively to a Contractor who provides a 'lump-sum' cost and schedule to complete the work.	A project delivery method where the Owner retains an independent Design Team and a Construction Manager early in the design process. The Construction Manager participates in the design process by developing cost estimates, schedules, phasing and logistic plans and other pre-construction activities. When the design documents are sufficiently complete, the Construction Manager bids the work, develops a Guaranteed Maximum Price proposal, and transitions to the role of General Contractor.
Pros	• A full set of Design Documents at the time of bidding often results in a high-level of Contractor competition and therefore, the lowest initial construction cost. • The Contractor assumes the risks and penalties related to an extended cost and/or schedule.	• Every dollar that goes into the project can be competitively bid if properly executed. • The Contractor commits to a maximum price early on in the process rather than only providing a price once the documents are complete. This allows for a more collaborative effort in refining the design to ensure the final bid set is in budget. • The Owner can arrange a system to share savings with the Contractor to incentivize additional cost reduction ideas. • Contractor involvement through the design process can reduce change orders. • Preconstruction services in today's market are currently provided at a heavily discounted rate, yielding great Owner value.
Cons	• Unless a preset Pre-Qualified Bidders List is created, Owners of public projects do not always have final say in the successful Construction Team. • Construction is mainly awarded on initial price, which incentivizes Contractors to exclude items not clearly identified in the drawings in order to minimize their initial bid price. This creates the potential risk of cost increases throughout construction. • The final price of construction is not known until the design is complete, so if the project is over budget, major construction delays and additional design fees can result should re-design be necessary. • The Contractor does not provide constructability input or cost-reducing ideas through the design phase, which can result in higher construction costs as well as potential issues for ongoing operations and maintenance. • The Contractor often feels like less a part of the team, but instead may operate as someone the Owner is defending themselves against.	• The Owner is still at risk for change orders from drawing errors and omissions in the documents, as the Contractor is not liable for the final design documents. • Initial cost might not be as low as design-bid-build, however, in a complex project such as a Hospital, this delta is generally mitigated and surpassed through change control afforded by the Contractor's knowledge of the project.

State of Washington
Capital Projects Advisory Review Board (CPARB)
PROJECT REVIEW COMMITTEE (PRC)

APPLICATION FOR PROJECT APPROVAL
To Use the General Contractor/Construction Manager (GC/CM)
Alternative Contracting Procedure

The CPARB PRC will only consider complete applications: Incomplete applications may result in delay of action on your application. Responses to Questions 1-7 and 9 should not exceed 20 pages *(font size 11 or larger)*. Provide no more than six sketches, diagrams or drawings under Question 8.

Identification of Applicant
a) Legal name of Public Body (your organization): **Prosser Public Hospital District**
b) Address: **723 Memorial Street, Prosser, Washington   99354**
c) Contact Person Name: **Craig Marks**   Title: **Chief Executive Officer (CEO)**
d) Phone Number: **(509) 786-6695**   E-mail: **cmarks@prosserhealth.com**

1. Brief Description of Proposed Project
a) Name of Project: **Prosser Memorial Hospital Replacement**
b) County of Project Location: **Benton**
c) Please describe the project in no more than two short paragraphs.

Prosser Public Hospital District, d/b/a Prosser Memorial Health, is a community-based health system, consisting of Prosser Memorial Hospital (PMH) located in Prosser, Washington and several outpatient clinics located throughout the region. Opened in 1947, PMH has served the Prosser community for over 60 years. In 2017, Prosser Memorial Health started their latest expansion effort by purchasing 32 acres of land at the Northeast corner of Gap Road and I-82. This new land will be the future home of Prosser Memorial Health, starting with a replacement hospital and medical office building.

The scope of this project includes the construction of:

- **A new, 2-story critical access hospital, approximately 70,000 SF in size**
- **A new medical office building and clinic space, approximately 10,000 - 15,000 SF in size**
- **A new pre-engineered maintenance building, approximately 1,500 SF in size**
- **Site Improvements, including roads, parking, site lighting and utilities required to support the buildings noted above, and potential future development**

2. Projected Total Cost for the Project:
A. *Project Budget*

Costs for Professional Services (A/E, Legal etc.)	**$3,215,000**
Estimated project construction costs (including construction contingencies):	**$37,500,000**
Equipment and furnishing costs	**$6,500,000**
Off-site costs	**$0**
Contract administration costs (owner, cm etc.) *(included in Values above)*	**$0**
Contingencies (design & owner)	**$3,880,000**
Other related project costs (briefly describe)	**$3,320,000**
Sales Tax	**$3,000,000**
Total	**$57,415,000**

B. Funding Status
Please describe the funding status for the whole project. *Note: If funding is not available, please explain how and when funding is anticipated*

It is anticipated that the majority of the project cost will be funded through USDA Rural Development and Direct Loans. The balance of funding will be provided by the Hospital, including an expected community philanthropic campaign.

3. Anticipated Project Design and Construction Schedule
Please provide:
The anticipated project design and construction schedule, including:
a) Procurement;
b) Hiring consultants if not already hired; and
c) Employing staff or hiring consultants to manage the project if not already employed or hired.

GC/CM Procurement Phase:

08/30/20	Initial GC/CM RFQ Issued
09/20/20	GC/CM RFQ Revision #1 Issued
10/20/20	PRC Application Submitted
10/23/20	GC/CM RFQ Revision #2 Issued
12/2/20	Project Presentation to PRC
12/4/20	GC/CM RFQ Response Due by 1:00 pm PST
12/11/20	GC/CM Short List Announced
12/17-12/18	GC/CM Finalist Interviews
12/21/20	GC/CM Contract Questions Due
1/6/20	GC/CM Sealed Proposals Submitted by 10:00 am PST
1/6/20	GC/CM Selection and Notification
1/13/21	GC/CM Protest Period Closes
1/14 – 1/21	GC/CM Preconstruction Contract Finalized
1/28/21	GC/CM Award & Preconstruction Contract Approval at Board Meeting

Additional Project Team Procurement:

July 2020	Engaged A/E Team Per RCW 39.80
August 2020	Engaged Owner's Representatives
October 2020	Procure Medical Equipment Planner
January 2021	Procure Non-Medical FF&E Consultant and Commissioning Consultant

Design & Construction Phases:

08/14/20	Programming Complete
12/11/20	Schematic Design Complete
02/12/21	Design Development Complete
03/01/21	Estimate Prepared for USDA Grant Application
03/12/21	USDA Application Submitted
08/06/21	Construction Documents 90% Complete
09/24/21	Maximum Allowable Construction Cost (MACC) Established
09/30/21	USDA Funding Approval Received
11/15/21	Funding Finalized
12/01/21	Start of Construction
12/01/23	Substantial Completion of Construction

4. **Why the GC/CM Contracting Procedure is Appropriate for this Project**
   Please provide a detailed explanation of why use of the contracting procedure is appropriate for the proposed project. Please address the following, as appropriate:

   - If implementation of the project involves complex scheduling, phasing, or coordination, what are the complexities?

     As a new hospital facility, the success of the project will rely on the close and thorough coordination of complex building systems and sensitive and technical Owner-provided equipment, all of which will require sophisticated phasing and superior coordination. The project will be highly technical, and involve complex and interrelated systems for Surgery, Diagnostic Imaging, Emergency Medicine, Inpatient, Lab, Central Sterile, Information Technology, Rehabilitation, Dietary Services and other critical programs. On the basis of our teams' past experience, the earlier a construction manager can participate in this coordination to understand the issues involved, and to implement the highly unique and technical requirements that will need to be addressed in the Subcontractor procurement effort, the better the project outcome will be for schedule, cost, and quality.

   - If the project involves construction at an existing facility that must continue to operate during construction, what are the operational impacts on occupants that must be addressed?
     Note: Please identify functions within the existing facility which require relocation during construction and how construction sequencing will affect them. As part of your response you may refer to the drawings or sketches that you provide under Question 8.

     N/A

   - If involvement of the GC/CM is critical during the design phase, why is this involvement critical?

     As noted above, the GC/CM's involvement during the project design will be critical in ensuring the successful phasing and coordination of complex building systems and equipment. Moreover, in order to maximize the funds available for different programs within the facility, the project team believes the input of a construction manager related to Site Issues, Materials Selections, Constructability, and Systems Selections will bring great benefit to the project. As an example, by utilizing Target Value Design and Continuous Estimating principles during the design phase, a GC/CM can assist the Project Team with the selection of specific systems. This in turn should reduce inefficient redesign that would be costly in both time and resources.

   - If the project encompasses a complex or technical work environment, what is this environment?

     As noted previously, almost all elements of the project will be complex and technical. As a new hospital facility, the project will involve the integration of sensitive equipment and systems that must be very closely integrated with construction activities. Additionally, as a partial I2 structure, there will be strict requirements from multiple local, state and federal authorities during Subcontractor procurement. This is particularly important for the Mechanical, Electrical, Plumbing and Low-Voltage trades that will likely account for over 50% of the total contract value. The work scope for these Subcontractors will involve detailed coordination with the GC/CM throughout the pre-construction period.

   - If the project requires specialized work on a building that has historical significance, why is the building of historical significance and what is the specialized work that must be done?

     N/A

   - If the project is declared heavy civil and the public body elects to procure the project as heavy civil, why is the GC/CM heavy civil contracting procedure appropriate for the proposed project?

     N/A

5. **Public Benefit**
   In addition to the above information, please provide information on how use of the GC/CM contracting procedure will serve the public interest. For example, your description must address, but is not limited to:

   - How this contracting method provides a substantial fiscal benefit; or
   - How the use of the traditional method of awarding contracts in a lump sum is not practical for meeting desired quality standards or delivery schedules.
     The project will involve a substantial public benefit, including a significant cost benefit, and the traditional "design-bid-build" process really is not a feasible option given the project complexities. The traditional "design-bid-build" limits transparency in establishing costs and communicating and confirming expected quality standards. Often, issues are not surfaced until the building is well under construction, when a conflict or unforeseen scope gap can lead to both significant cost increases and schedule delays. The GC/CM process allows these risks to be minimized. Additionally, given the size and complexity of the project and the current competitive state of the construction market, there is the possibility that a contractor with limited experience could provide a low-bid without a thorough understanding of challenges the project may present.

   - In the case of heavy civil GC/CM, why the heavy civil contracting procedure serves the public interest.
     N/A

6. **Public Body Qualifications**
   Please provide:

   - A description of your organization's qualifications to use the GC/CM contracting procedure.
     Prosser Memorial Health has formed a comprehensive team with varied experience to help deliver the project successfully. Within the organization, Prosser Memorial Health has significant Washington public works experience, almost all in the medical space, and both the CEO and CFO of Prosser Memorial Health have significant experience in the execution of major hospital projects in previous roles with other institutions, including GC/CM equivalent projects involving $40M+ hospital expansions in both Missouri and Colorado. That said, the Prosser Memorial Health team recognized that this will be their first GC/CM project under RCW 39.10. To supplement their internal team, Prosser Memorial Health retained NV5 as its Owner's Representative. The NV5 Team has decades of experience helping hospitals around the country in the successful execution of over $1B in projects, almost all of which used a GC/CM approach. And to ensure that RCW 39.10 requirements are closely understood and followed, Prosser Memorial Health retained Perkins Coie as its Legal Counsel to advise on the GC/CM process and contracts. The Perkins Coie team has significant experience in helping owners comply with RCW 39.10 requirements.

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- A ***Project*** organizational chart, showing all existing or planned staff and consultant roles.
  Note: *The organizational chart must show the level of involvement and main responsibilities anticipated for each position throughout the project (for example, full-time project manager). If acronyms are used, a key should be provided. (See Example on Project Organizational Chart)*

Prosser Memorial Health
Craig Marks - CEO
David Rollins - CFO
Steve Broussard - Facilities

NV5
Paul Kramer
Project Director
SD - 40%
DD - 40%
CD - 40%
Construction - 10%

Perkins-Coie
Andrew Greene, Esq.
Legal Counsel
Advisor to Project Team on Contracts & RCW 39.10 Requirements

NV5
Meg Hohnholt
Project Manager
SD - 50%
DD - 50%
CD - 50%
Construction - 20%

bcDesignGroup
Kurt Broeckelmann
Project Principal
SD - 30%
DD - 25%
CD - 15%
Construction - 10%

bcDesign Group
Lance White
Project Manager
SD - 30%
DD - 50%
CD - 50%
Construction - 40%

GC/CM
TBD

Subcontractors
TBD

Sub-Consultants
Expediant - Civil Engineer
Bob D. Campbell - Strutural Engineer
Henderson - MEP / LV Engineers
Mills & Assoc. - Food Service Consultant
Cost Estimating

- Staff and consultant short biographies *(not complete résumés)*.

  Prosser Memorial Hospital:

  Craig Marks – CEO: **Craig has over 30 years of experience in leadership roles with acute care facilities. In his 4-Years with PMH, Craig has led the effort to construct a new facility to support the Hospital's continued mission. In a similar role at Western Missouri Medical Center, Craig oversaw the planning, design and successful execution of $42M expansion to the facility.**

  David Rollins – CFO: **With over 15 years of experience leadership roles with acute facilities, David is currently working with Hospital leadership to develop sustainable financial models to support the proposed new Hospital. David acted in the same role supporting a $32M expansion to Mt. San Rafael Hospital in Trinidad, Colorado., a project that utilized both USDA funding and GC/CM-equivalent delivery.**

Steve Broussard – Director of Support Services: Over the past 25 years, Steve has worked for and with PMH on numerous capital improvement projects, including minor and major renovations, and the construction of significant clinic facilities. Steve has strong knowledge of the local construction community and of the regulations that must be met to support healthcare construction and operations.

NV5:

Paul Kramer – Project Director: Over a 30+ year career focused on the design and construction of healthcare facilities and renovations of all types and sizes throughout the country, Paul has worked with Owners to lead teams in the successful execution of several billion dollars of projects. The majority of these projects have been constructed utilizing a form of GC/CM delivery, including most recently, additions to Critical Access Hospitals in Colorado, and a new Family Maternity Center renovation in Ohio.

Meg Hohnholt – Project Manager: With 13 years of experience in the design and construction of public facilities in multiple states, Meg has led project teams in the comprehensive planning, procurement and implementation efforts for numerous Healthcare, K-12 and Civic initiatives. For these projects, Meg has assisted in the coordination of Bond Procurement, Contract Development, Budget and Schedule Development and Compliance, and Project Close-Out, and is well versed in a number of forms of project delivery, including GC/CM.

Perkins Coie:

Andrew Greene – Partner: Over the past 20 years, Andrew has worked from the Seattle office to build Perkins Coie Construction Law practice, of which he is Chair. Supporting over 100 Public Entities throughout the State of Washington, Andrew has assisted Project Teams in compliance with RCW 39.10 requirements supporting their unique construction projects, including the development of multiple GC/CM contracts and procurement support.

bcDesignGroup:

Kurt Broeckelmann – Managing Partner: As a healthcare focused Architect, Kurt has over 20 years' experience working with acute care facilities ranging from Critical Access Hospitals to Academic Medical Centers. Over his career, Kurt has participated in 30+ successful healthcare projects that have been delivered using a GC/CM approach.

Lance White – Project Architect: Lance has 16 years of experience in the development of healthcare projects ranging from interior renovations to complex building additions and new medical office buildings. He has been involved in over 25 GC/CM project, and has worked at a facility with a GC/CM for 12 years as a project manager.

- Provide the *experience <u>and role</u> on previous GC/CM projects delivered* under RCW 39.10 or equivalent experience for each staff member or consultant in key positions on the proposed project. *(See Example Staff\Contractor Project Experience and Role. The applicant shall use the abbreviations as identified in the example in the attachment.)*

Paul Kramer

Project	Value	Involvement	Timeframe
Southwest General Hospital Middleburg Heights, Ohio Family Maternity Renovations GC/CM	$17.6M	Owner's Rep. on GC/CM-equivalent project	2/2020 to 2/2022

Project	Value	Involvement	Timeframe
Pioneers Medical Center **Meeker, Colorado** **Hospital Additions** **GC/CM**	**$14.5M**	**Owner's Rep. on GC/CM- equivalent project**	**9/2019 to 10/2020**
Mt. San Rafael Hospital **Trinidad, Colorado** **Masterplan Additions / Renovations** **GC/CM**	**$32M**	**Owner's Rep. on GC/CM- equivalent project**	**3/2019 to 2/2021**
TUKH Cambridge Tower **Kansas City, Kansas** **New Hospital Project** **GC/CM**	**$340M**	**Owner's Rep. on GC/CM- equivalent project**	**1/2015 to 4/2018**
Southwest General Hospital **Middleburg Heights, Ohio** **Masterplan Expansion / Renovation** **GC/CM**	**$124M**	**Owner's Rep. on GC/CM- equivalent project**	**4/2011 to 4/2016**

Meg Hohnholt

Project	Value	Involvement	Timeframe
Banner Health System **Greeley, Colorado** **Internal Project(s) Support** **GC/CM**	**$12M**	**Owner's Rep. on GC/CM- equivalent project**	**3/2019 to 3/2020**
TUKH MOB **Kansas City, Kansas** **Vertical Expansion** **GC/CM**	**$30M**	**Owner's Rep. on GC/CM- equivalent project**	**9/2018 to 3/2019**
Weld County Schools **Hudson, Colorado** **RE3J District Bond Program** **GC/CM**	**$72M**	**Owner's Rep. on GC/CM- equivalent project**	**10/2016 to 11/2020**
Eben Ezer Lutheran Care Center **Brush, Colorado** **Senior Living** **GC/CM**	**$13.5M**	**Owner's Rep. on GC/CM- equivalent project**	**4/2017 to 1/2018**

Kurt Broeckelmann

Project	Value	Involvement	Timeframe
Fitzgibbon Hospital **Marshall, Missouri** **Expansion & MOB** **GC/CM**	**$16.5M**	**Lead Architect on GC/CM- equivalent project**	**2012 -2014**
Western Missouri Medical Center **Warrensburg, Missouri** **Hospital Expansion**	**$42.6M**	**Lead Architect on GC/CM- equivalent project**	**2009 to 2011**

Project	Value	Involvement	Timeframe
GC/CM			
North Kansas City Hospital **Kansas City, Missouri** **Cardiac Center** **GC/CM**	**$12.5M**	**Lead Architect on GC/CM-equivalent project**	**2009 - 2011**
Heartland Spine & Specialty Hospital **Kansas City, Kansas** **New Hospital** **GC/CM**	**$15.8M**	**Lead Architect on GC/CM-equivalent project**	**2008 to 2010**
North Kansas City Hospital **Kansas City, Missouri** **Maternal Child Renovations** **GC/CM**	**$32M**	**Lead Architect on GC/CM-equivalent project**	**2008 to 2010**

Lance White

Project	Value	Involvement	Timeframe
North Kansas City Hospital **Kansas City, Missouri** **Tiffany Springs MOB** **GC/CM**	**$2.5M**	**A/E Project Manager on GC/CM equivalent project**	**2017 to 2018**
North Kansas City Hospital **Kansas City, Missouri** **Platte City MOB** **GC/CM**	**$3.5M**	**A/E Project Manager on GC/CM equivalent project**	**2016 to 2017**
North Kansas City Hospital **Kansas City, Missouri** **Surgical Department Renovations** **GC/CM**	**$10M**	**A/E Project Manager on GC/CM equivalent project**	**2015 to 2016**
North Kansas City Hospital **Kansas City, Missouri** **Cardiac Center** **GC/CM**	**$12.5M**	**A/E Project Manager on GC/CM equivalent project**	**2009 - 2011**
North Kansas City Hospital **Kansas City, Missouri** **Maternal Child Renovations** **GC/CM**	**$32M**	**A/E Project Manager on GC/CM equivalent project**	**2008 -2010**

- The qualifications of the existing or planned project manager and consultants.

  Prosser Memorial Health recognized that the project will be its first under RCW 39.10 and therefore retained one of the preeminent Owner's Representative nationally for this type of project (NV5). The NV5 team has decades of experience helping hospitals around the country in completing large, complex, and mission-critical projects, almost all using a GC/CM contracting and project-execution approach, and both NV5's Project Director and Project Manager have deep GC/CM-equivalent experience. Because this will be NV5's first project in Washington, Prosser Memorial Health also retained Perkins Coie to ensure that all requirements of RCW 39.10 are addressed.

- If the project manager is interim until your organization has employed staff or hired a consultant as the project manager, indicate whether sufficient funds are available for this purpose and how long it is anticipated the interim project manager will serve.

  As noted previously, NV5 has been retained by Prosser Memorial Health to support the hospital development, and sufficient funds are included in the budget for NV5's fees from Design through the Occupancy / Close-Out Phases.

- A brief summary of the construction experience of your organization's project management team that is relevant to the project.

  See above. Both NV5's Project Director and Project Manager have deep GC/CM-equivalent experience on comparable health care projects, and have helped clients complete over five similar (or more complex) projects over the past five years.

- A description of the controls your organization will have in place to ensure that the project is adequately managed.

  Over the past several months, the Prosser Memorial Health team has established initial comprehensive schedules and budgets for all project activities. These documents are derived from the project's current goals and program and will be subject to continuous refinement through the course of the project. The team uses these tools to establish benchmarks to track the status of associated activities, including financing, site development, consultant procurement, AHJ review, FF&E procurement and contingency status, in order to ensure that each activity supports the project's overall goals. As documentation of this process, sign-offs have been proposed at each critical milestone by the Prosser Memorial Health's administrative team, and this information will then be reviewed and approved by the Prosser Memorial Health's Board. As the project proceeds into construction, clear and concise construction schedule and financial goals will be developed and included in the contract. Any future proposed changes will be thoroughly evaluated against this information, and in conformance with USDA requirements. Concurrently, the project team will continue to coordinate architecturally significant equipment to ensure that it meets the project's budget requirements, and does not affect the progress and cost of construction. All costs will be reconciled, at a minimum, on a monthly basis.

- A brief description of your planned GC/CM procurement process.

  As generally outlined in the anticipated project design and construction schedule included in Section 3 above, the Prosser Memorial Health team has developed an RFQ for interested GC/CM firms, which it will post on its website and advertise through traditional channels. Statements of qualification are scheduled to be submitted following PRC approval of the project (if approved). From these submissions, the team will use the communicated selection criteria to determine the top-scored firms and then schedule interviews with these finalists. Following these interviews, GC/CM finalists will be invited to submit formal cost proposals for the project. Once these proposals are received, the team will analyze the qualifications and cost proposals to determine the highest scored firm. On the basis of this evaluation, a recommendation will be made to the Prosser Memorial Health Board for selection of a GC/CM firm to join the Prosser Memorial Health team for preconstruction services.

- Verification that your organization has already developed (or provide your plan to develop) specific GC/CM or heavy civil GC/CM contract terms.

  The Project team has had recent experience using GC/CM contract forms, including those approved for use by USDA, on comparable projects. For this project, the team will work closely with Perkins Cole to ensure that all requirements of RCW 39.10 are met.

7. **Public Body (your organization) Construction History:**
Provide a matrix summary of your organization's construction activity for the past six years outlining project data in content and format per the attached sample provided: *(See Example Construction History. The applicant shall use the abbreviations as identified in the example in the attachment.)*

- Project Number, Name, and Description
- Contracting method used
- Planned start and finish dates
- Actual start and finish dates
- Planned and actual budget amounts
- Reasons for budget or schedule overruns

Prosser Memorial Health (PMH) - Construction History (10-Years)

#	Project Name	Project Description	Contract Method	Planned Start	Actual Start	Planned Finish	Actual Finish	Planned Budget	Actual Budget	Reason for Budget or Schedule Overrun
1	Chardonnay Clinic TI	Indoor Remodelling to add Exam Rooms	D-B-B	Mar-19	Apr-20	Aug-19	Nov-19	$380K	$409K	Delays in Materials Procurement, Unforeseen Existing Conditions
2	Valley Vista TI	Build-Out of Shell Space to add Exam Rooms	D-B-B	Oct-17	Nov-17	Mar-18	Apr-18	$451K	$474K	Mobilization Delay, Unforeseen Existing Conditions
3	PMH OB Renovations	Interior Renovations to add LDRP's and Dialysis	D-B-B	Mar-14	Aug-14	Aug-14	Sep-14	$1.05M	$1.084M	Mobilization Delay, Unforeseen Existing Conditions
4	Imaging Department Renovations	Interior renovations to accommodate Medical Equipment Up-Grades	D-B-B	Mar-12	Apr-12	Aug-12	Sep-12	$150K	$155K	Mobilization Delay, Unforeseen Existing Conditions
5	PMH OB TI	Interior Renovations	D-B-B	Feb-10	Feb-10	May-10	May-10	$137K	$143K	Unforeseen Existing Conditions

8. **Preliminary Concepts, sketches or plans depicting the project**
To assist the PRC with understanding your proposed project, please provide a combination of up to six concepts, drawings, sketches, diagrams, or plan/section documents which best depict your project. In electronic submissions these documents must be provided in a PDF or JPEG format for easy distribution. *(See Example concepts, sketches or plans depicting the project.)* At a minimum, please try to include the following:

- A overview site plan *(indicating existing structure and new structures)*
  Preliminary Site and Departmental Block Plan(s) for the proposed facility are attached to this Application for reference

- Plan or section views which show existing vs. renovation plans particularly for areas that will remain occupied during construction.
  Note: Applicant may utilize photos to further depict project issues during their presentation to the PRC.
  N/A

9. **Resolution of Audit Findings on Previous Public Works Projects**
If your organization had audit findings on *any* project identified in your response to Question 7, please specify the project, briefly state those findings, and describe how your organization resolved them. **Prosser Memorial Health is not aware of any past audit findings related to previous construction projects at the Hospital.**

10. Subcontractor Outreach

Please describe your subcontractor outreach and how the public body will encourage small, women and minority-owned business participation

The Prosser Memorial Health team has already received over twelve (12) inquiries from interested GC/CM firms, and has been actively speaking with local and national teams that have expressed interest. If approved to utilize a GC/CM approach, Prosser Memorial Health will finalize the diversity promotion qualifications to implement for the project and will request that each of the teams present their own plan for how they will encourage the participation of diverse and underrepresented firms. Once a GC/CM is selected, the project team will then work together to develop a Subcontractor selection process in accordance with RCW 39.10, and cultivate potential MBE / FBE / Small Business participants to the greatest extent possible.

Overall, Prosser Memorial Health is strongly committed to the enforcement of fair contracting and hiring practices that comply with all Local, State and Federal Guidelines.

CAUTION TO APPLICANTS

The definition of the project is at the applicant's discretion. The entire project, including all components, must meet the criteria to be approved.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

In submitting this application, you, as the authorized representative of your organization, understand that: (1) the PRC may request additional information about your organization, its construction history, and the proposed project; and (2) your organization is required to submit the information requested by the PRC. You agree to submit this information in a timely manner and understand that failure to do so may delay action on your application.

If the PRC approves your request to use the GC/CM contracting procedure, you also understand that: (1) your organization is required to participate in brief, state-sponsored surveys at the beginning and the end of your approved project; and (2) the data collected in these surveys will be used in a study by the state to evaluate the effectiveness of the GC/CM process. You also agree that your organization will complete these surveys within the time required by CPARB. Additionally, responding to the 2013 Joint Legislative Audit and Review Committee (JLARC) Recommendations is a priority and focus of CPARB. Data collection shall include GC/CM project information on subcontract awards and payments, and if completed, a final project report. For each GC/CM project, documentation supporting compliance with the limitations on the GC/CM self-performed work will be required. This information may include, but is not limited to: a construction management and contracting plan, final subcontracting plan and/or a final TCC/MACC summary with subcontract awards, or similar.

I have carefully reviewed the information provided and attest that this is a complete, correct and true application.

Signature: _Craig J. Marks_

Name (please print): _Craig Marks_ _(public body personnel)_

Title: _Chief Executive Officer_

Date: _October 20, 2020_

north

100   0   100

SCALE 1" = 100'

LEGEND

PROPERTY LINE	
EXISTING CONTOUR	—727—
EXISTING FENCE	
EXISTING ASPHALT	
EXISTING POWER POLE	
EXISTING OVERHEAD POWER	
EXISTING EASEMENT	
EXISTING CENTERLINE	
PROPOSED 8" SANITARY SEWER	
PROPOSED SEWER MANHOLE	
PROPOSED 6" FIRE LINE	
PROPOSED 8" WATER LINE	
PROPOSED 12" WATERLINE BY CITY	
PROPOSED FIRE HYDRANT BY CITY	
PROPOSED 12" SEWERLINE BY CITY	
PROPOSED UNDERGROUND ELECTRIC	

ENGINEER:

EXPEDIENT CIVIL ENGINEERING, PLLC
BELLA VISTA, AR 72714

DEVELOPER:

PROSSER PUBLIC HOSPITAL DISTRICT
723 MEMORIAL STREET
PROSSER, WA 99300

ZONING:

GS – GENERAL COMMERCIAL

CURRENT COUNTY SETBACKS:

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

PROPOSED GENERAL COMMERCIAL ZONING SETBACKS:

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

PARKING REQUIREMENTS:

1. INPATIENT ADMISSIONS – 1 SPACE PER 5 HOSPITAL BEDS
   VISITORS – 1 SPACE PER BED
   HOSPITAL STAFF – 1 SPACE PER SHIFT PER EMPLOYEE
   OUTPATIENTS – 3 SPACES PER EXAM OR PROCEDURE ROOM
   EMERGENCY PATIENTS – 1 SPACE PER 4 AVERAGE DAILY EMERGENCY VISITS
2. NUMBER OF PARKING SPACES REQUIRED – XX SPACES
3. NUMBER OF STANDARD PARKING SPACES PROVIDED – XX SPACES
4. NUMBER OF HANDICAP SPACES PROVIDED – 9 SPACES
5. TOTAL SPACES PROVIDED – XX SPACES

PROPOSED HOSPITAL

NOT FOR CONSTRUCTION

PRELIMINARY

PROSSER MEMORIAL HOSPITAL
PROSSER, WA
GAP ROAD

bc DESIGN GROUP
100 PARK ST., STE. 202, OLATHE, KS 66061

DRAWN BY: JEI
CHECKED BY: JEI
DATE
JOB NUMBER
19-1459
SHEET NAME
CONCEPTUAL
SITE PLAN
SHEET 1 OF 1
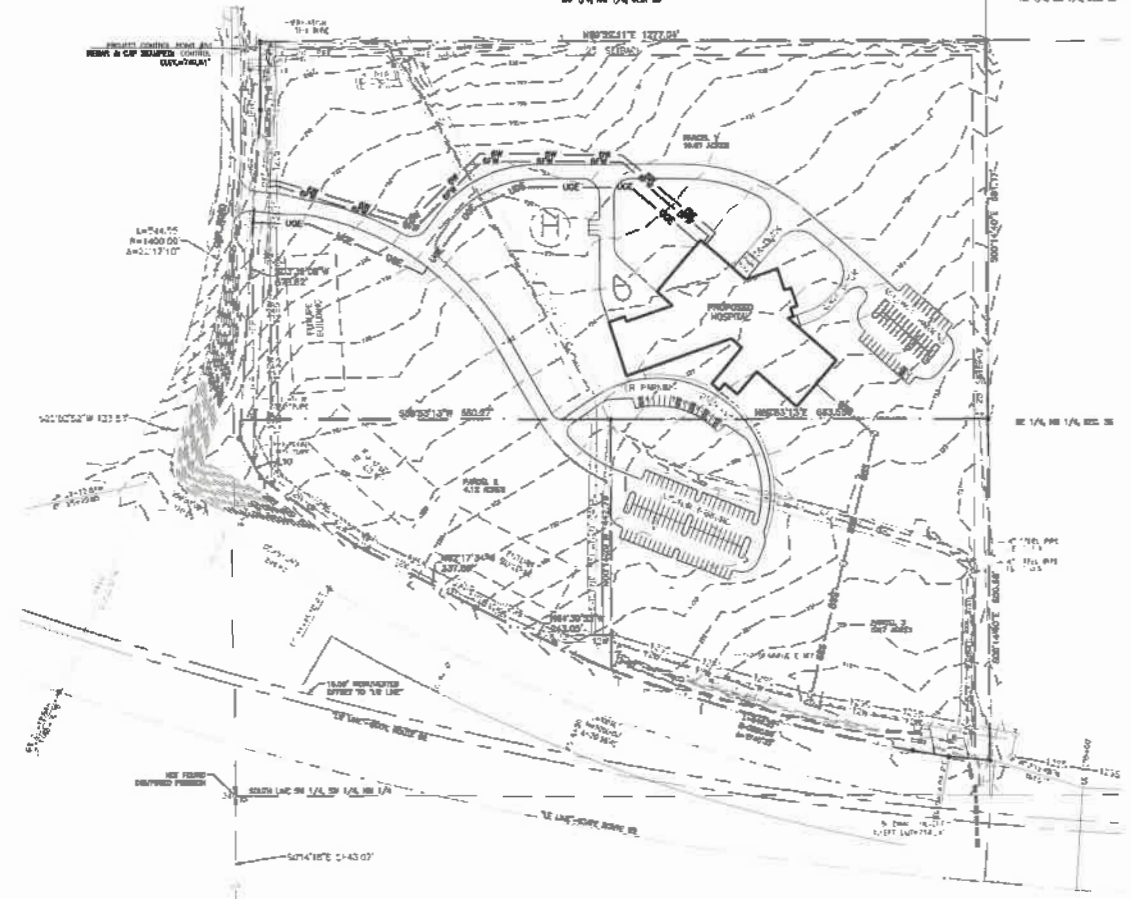
SECOND FLOOR

Second floor labels: Staff Vertical Circulation, Public Vertical Circulation, Pharmacy, ICU (4), Rehab, Med/Surg (15), Hub, LDRP (6)

FIRST FLOOR

First floor labels: Ambulance Entry, Walk-Up ED Entry, Main Entry, Dock, MM, EVS, Lounge, Lab, SPD, Admin, ED, Imaging, Surgery, Staff Vertical Circulation, Public Vertical Circulation, Dietary, Dock, Registration, Lobby, Oncology, Education, Cardio, Future MOB Growth

NOTES:

1. +/-84,800 SF
2. Great I2/B separation
3. Good future expansion paths for ED/Imaging/Surgery
4. Admin (soft space) for internal department growth.
5. Good future connection point for future MOB
6. HUB IP unit allows for skeletal staffing.
7. Pharmacy is located upstairs, adjacent to IP and LDRP.
8. Short walks to all departments from main entrance.
9. Best option for future patient room growth.

Legend:
- Entrances
- Second Floor Outline
- Glass "Spine" element connecting nature to Inside
- Paths of Future Expansion
- Opportunity for Future Addition
- Outdoor Garden + Water Feature
- SUPPORT STAFF
- CIRCULATION HUBS
- IN PATIENT
- HYBRID
- OUTPATIENT

SEPTEMBER 1, 2020

Prosser Memorial Health

bcDESIGNGROUP

Washington State Legislature

October 12, 2020

To whom it may concern:

RE: Letter of Support for USDA funding for Prosser Memorial Health's new hospital facility

We would like to add our full support of the Prosser Memorial Health's application to the U.S. Dept of Agriculture for funding for their new hospital facility.

The current hospital facility is over 70 years old and has been outgrown by the size and needs of the community it serves, so the need for a new hospital is very clear. It brings new patient services and specialties that would have previously required their residents to travel. Having this in one location increases privacy and the quality of patient care.

As a hospital in a rural area, the service area of Prosser Memorial Health is quite large and with this new facility comes the opportunity to add treatment services such as Urology, Oncology, and full-service surgical services on the hospital campus. Currently, many of these treatments are unavailable locally and would require travel of 40 miles or more. This new hospital would alleviate the need for Prosser residents and other local community members to travel for their healthcare needs.

The hospital will be constructed in an area the City of Prosser is planning to further develop, and we believe it will bring additional economic development to the area as well.

Prosser Memorial Health has always been a steadfast partner to the City of Prosser and the outlying areas. This new facility is simply one more way to anticipate the needs of their growing community.

Again, we want to express our full support for this project and acknowledge the tremendous benefit it will have on the citizens of Prosser and the surrounding areas. We are hopeful you will look favorably at their application and thank you for your thoughtful consideration.

Sincerely,

Sen. Maureen Walsh
State Senator
16th Legislative District

Rep. Bill Jenkin
State Representative
16th Legislative District

ECONOMIC DEVELOPMENT ASSOC.
THE DIRECTION YOU'LL WANT TO GROW

To whom it may concern,

This letter is in support of Prosser Memorial Health for their USDA funding for the new hospital facility.

Our current hospital building is over 70 years old and undersized for the growing needs of our community. The new facility would solve many of these needs. It allows for increased patient services and specialties that would usually require travel to different locations. It increases privacy and the quality of the patients care and treatments.

As a hospital in a rural area, the service area of Prosser Memorial Health is quite large and with this new facility comes the opportunity to add treatment services such as Urology, Oncology, and full-service surgical services on the hospital campus. Many of these treatments would have been 40 minutes to an hour away, or more. This is a tremendous opportunity for our city and for our residents to not have to leave the community for their health care needs.

Prosser Economic Development Association believes strongly in Prosser Memorial Health and knows that this new facility will raise the bar for surrounding healthcare organizations as well. We also believe that with this new facility we will see additional benefit to Prosser in future economic growth.

Prosser Memorial Health has always been a wonderful partner in our city and community. This new facility is simply one more way they anticipate the needs we face and strive to meet and exceed them.

We hope you will look at their application favorably. Thank you for your consideration.

Best Regards,

Neal Ripplinger
Executive Director
Prosser Economic Development Association

Attachment L

STATE OF WASHINGTON

DEPARTMENT OF HEALTH
OFFICE OF RADIATION PROTECTION
111 Israel Road SE • PO Box 47827 • Olympia, Washington 98504-7827
TDD Relay Service: 1-800-833-6388

October 2, 2020

Aurora Weddle
Prosser Memorial Health
723 Memorial Street
Prosser, WA 99350
Dear Ms. Weddle:

We received your application on September 4, 2020. Your request for a Radioactive Materials License – Medical, has been logged in and issued Licensing Action Number 20-09-24, and is awaiting complete review by licensing personnel.

The Department of Health has adopted a local Government Notification Policy in response to a code revision enacted by the Washington State Legislature during the 1984 Session, House Bill 1153. The enclosed copy of a letter to your local city or county official explains this process. The original letter has been sent to your local official, along with a copy of the cover page of your license application. Should you desire to speed up the process, you may approach your local official yourself.

If you have any questions regarding your request, please feel free to contact this office at tanner.depert@doh.wa.gov or at 360-236-3209.

Sincerely,

Tanner Depert, Health Services Consultant
Radioactive Materials Section

Enclosure: Letter to Prosser City Hall

STATE OF WASHINGTON

DEPARTMENT OF HEALTH
OFFICE OF RADIATION PROTECTION
243 Israel Road SE • PO Box 47827 • Olympia, Washington 98504-7827
TDD Relay Service: 1-800-833-6384

October 2, 2020

Mayor Randy Taylor
Mayor of City of Prosser
Prosser City Hall
601 7th Street
Prosser, WA 99350

Dear Mayor Taylor:

The Department of Health, Office of Radiation Protection is required by law (RCW 70.98.080 (2)) to notify the appropriate local government officials when a radioactive materials license application is received. The Office must notify either: the Chief Executive Office, if the applicant is located in a city; or the county legislative authority, if located in the county.

This is your official notification of the application for specific use and possession of radioactive material as described in paragraph four below. As a courtesy, we are forwarding a copy to your local jurisdictional health department. We urge that you forward a copy to the appropriate fire department for their review.

The Office of Radiation Protection will delay the issuance of a license at least twenty (20) days from the date of this notice. During this time period, if you deem appropriate, you may file written objections against the applicant or the activity for which the license is sought. The law states that all written objections you may request, and the Office of Radiation Protection may at its discretion hold a formal hearing concerning the applicant or activity.

On September 4, 2020, Prosser Memorial Health, pending license number M0324, submitted an application requesting to be licensed to receive and use radioactive material at 723 Memorial Street, Prosser, WA 99350. The applicant stated that the use for radioactive materials will be for treatment of hyperthyroidism as well as various other medical treatments.

If you have comments, they should be submitted to this office by October 22, 2020. Please submit comments to:

> DOH OFFICE OF RADIATION PROTECTION
> RADIOACTIVE MATERIALS SECTION
> PO BOX 47827
> OLYMPIA WA 98504-7827

If you have any questions, please feel free to contact me at (360) 236-3209, or by email at Tanner.Depert@doh.wa.gov.

Sincerely,

Tanner Depert
Health Services Consultant
Radioactive Materials Section

cc: Benton Franklin Health Department

What is a da Vinci system?

The da Vinci is a surgical system comprised of three components: surgeon console, patient-side cart, and vision cart.

Surgeon console

The surgeon console is where your surgeon sits during the procedure, has a close-up 3D view of your anatomy, and controls the instruments. The instruments are "wristed" and move like a human hand, but with a far greater range of motion.

Patient cart

The patient-side cart is positioned near the patient on the operating table. It is where the instruments used during the operation move in real time in response to your surgeon's hand movements at the surgeon console.

Vision cart

The vision cart makes communication between the components of the system possible and supports the latest 3D high-definition vision system.

SURGEON CONSOLE

Your surgeon sits at the console, controlling the instruments while viewing your anatomy in high-definition 3D.

PATIENT CART

Positioned alongside the bed, the patient cart holds the camera and instruments that the surgeon controls from the console.

VISION CART

The vision cart makes communication between components possible and supports the 3D high-definition vision system.

Your surgeon in control

The da Vinci surgical system gives your surgeon an advanced set of instruments to use in performing robotic-assisted minimally invasive surgery. The term "robotic" often misleads people. Robots don't perform surgery. Your surgeon performs surgery with da Vinci by using instruments that he or she guides via a console.

The da Vinci system translates your surgeon's hand movements at the console in real time, bending and rotating the instruments while performing the procedure. The tiny wristed instruments move like a human hand, but with a greater range of motion. The da Vinci vision system also delivers highly magnified, 3D high-definition views of the surgical area. The instrument size makes it possible for surgeons to operate through one or a few small incisions.

The advantages of robotic assisted surgery:

- **Minimally invasive;** (Complex procedures can be done through on or more small incisions).
- **Shorter patient recovery time;**
- **Reduced complication rate;**
- **Ability to perform more complex surgeries or surgeries were robotic assistance has become the standard of care;**
- **Utilization by multiple specialties:** urology, gynecology, general surgery, and colorectal surgery.

ORIGINAL ARTICLE

WILEY The International Journal of **Medical Robotics** and **Computer Assisted Surgery**

Cost of ownership assessment for a da Vinci robot based on US real-world data

Josh Feldstein[1] 🆔 | Bjoern Schwander[2] | Mark Roberts[3] | Herbert Coussons[1]

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[3]University of Pittsburgh Graduate School of Public Health, Pittsburgh, PA

Correspondence
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Email: jfeldstein@cava-robotics.com

Abstract

Background: Despite growth of robotic surgery, published literature lacks assessment of the cost of ownership (CoO) of a da Vinci robot by surgical service line and the associated benefit such data provides.

Methods: Based on real-world data (RWD) from 14 US hospitals and ≈6000 da Vinci robotic cases, CoO was assessed using all relevant fixed and variable cost components, calculated by surgical service line.

Results: At a representative hospital with an efficient robotic program (n = 424 cases), the weighted average fixed cost per case was $984. Weighted average variable cost per case was $8025 (range: $3325 for Cholecystectomy—multiport, to $16 986 for Rectal Resection). Assessing weighted average by case, main variable cost drivers were non-da Vinci supplies (49.5%), staff costs (28.6%), and da Vinci supplies (21.9%).

Conclusions: Case mix, annual robotic case volumes, and cut-to-close/patient-in-room time by surgical service line represent core variables influencing robotic program CoO, which help drive profitable program management.

KEYWORDS

cost of ownership, da Vinci robot, fixed and variable costs, real-word data

1 | INTRODUCTION

Despite the accelerated growth of robotic surgery in recent years, the published literature offers limited cost of ownership (CoO) assessment of this technology that includes all relevant cost categories. *Cost of ownership* is defined as initial equipment acquisition, variable supply and case costs by service line, and maintenance costs. Gaining insight into these costs can have a direct and positive effect on a robotic program's financial success and overall efficiency. Further, hospitals use a variety of approaches to robotic cost accounting, making it difficult, if not impossible, to determine accurate CoO assessments within a hospital and across hospitals. A recently published systematic review concluded that the methodological quality of studies evaluating costs of robotic surgery was low and insufficient to inform action by hospitals.[1] For example, cost accounting methods vary regarding the inclusion of capital cost of a robot and other indirect cost, such as administrative salaries, housekeeping, and many other nonrelated variables. Even within a given hospital, cost accounting methods may not be standardized for robotic and nonrobotic cases making comparisons difficult. Some look at direct costs only; others spread capital costs across department costs in different ways. These factors motivate the need for a more standardized approach to robotic CoO assessment.

The peer-reviewed literature has traditionally focused on the cost of robotic surgery by case rather than the CoO of the robot itself.[2-7] Additionally, when most US hospitals consider the cost of owning the da Vinci robot, they typically assess robotics differently than capital medical equipment used in laparoscopy, such as towers and generators, etc.[1] Why are there so many different cost accounting methods when it comes to assessing robotic vs laparoscopic costs?

In short, robotics emerged in the 2000s during the era of data capture and value-based medicine—both of which emerged more than a decade after the introduction of laparoscopy. While robotic surgical program performance data are now seen by most hospitals as critical to assessing whether and to what degree a program is "successful," very few such performance data assessments were performed on laparoscopy programs when this technology was introduced. Further complicating cost accounting matters is the fact that, although more data are now being collected than ever before, many hospitals' cost accounting data assessments are flawed due to data collection, auditing, and standardization errors combined with weak analytics.[8]

As of 2017, an estimated 2800 of 5500 US hospitals[9] (51%) have a da Vinci robot, with an estimated 644 000 annual robotic surgeries performed in the USA.[10] When a hospital or Integrated Delivery Network (IDN) is considering the acquisition of robotic technology for a new or existing robotic program, an accurate assessment of the total CoO should be an integral part of the technology acquisition equation. Beyond the fixed capital and service costs of the robot, the significant variable costs include the per procedure cost (supplies and multi-lived, so-called robotic "reposables"), case times, and associated cost of labor. Factors that contribute to these variable costs include case mix by service line and annual robotic case volume. Nevertheless, the published literature has yet to produce a detailed and standardized approach to calculating total CoO for the robot. This paper meets that need by analyzing the CoO of a da Vinci robot using anonymized, aggregated real-world data (RWD) from a range of robotic programs reflecting 14 US hospitals inclusive of an academic medical center (AMC), numerous mid-sized community hospitals, and a small, rural facility. All data were obtained from CAVA Robotics International (www.cava-robotics.com), an independent US-based firm that assists hospitals with optimization of da Vinci robotic program performance. The CAVA database captures and aggregates quality, operational, and financial robotic surgery and program data in connection with hospital engagements.

2 | MATERIAL AND METHODS

The CoO assessment included all relevant fixed and variable cost components: time, OR crew-related labor, capital, supplies, and service. Aggregated, anonymized data were collected from 14 US hospitals sourced from the facility Electronic Medical Records (EMR), supply chain, and cost accounting databases across 20 robotic case types within seven service lines, as summarized in Table 3. The various datasets for each hospital were curated and then synthesized, audited for gaps and errors by surgeons and administrative stakeholders, and then approved by the facility for accuracy. Fixed cost components, including purchasing costs and operational costs, were determined using current list prices for da Vinci robots.[11] Variable costs consisted of supplies for the robot, nonrobotic surgical supplies, case time, and labor.

2.1 | Fixed cost components

Currently, there are five versions of the da Vinci robot available; the most commonly used XI and SI, as well as the X, SiE, and Single Port (SP), with an average sales price of $1.47 M. and a yearly average service contract cost of $154 K.[11,12] To calculate annual CoO, a service life of 5 years was used to estimate annual capital depreciation because in a real-world environment, robotic technology is often obsolete—or perceived as such—within this time frame, leading surgeons and facilities to move to next generation technologies.

To associate these fixed costs to a single robotic case, the yearly capital depreciation and service contract expense was divided by the average yearly number of robotic procedures performed per da Vinci robot at a given facility. This estimate (n = 424 cases annually) was obtained from data from Bellin Health (Green Bay, Wisconsin USA), selected as an example of an efficient robotic program given its excellent data management, analytics, and programmatic best practices. The average case mix by service line and case type is shown in Figure 1

2.2 | Variable cost components

Variable cost was calculated using RWD of ≈ 6000 da Vinci robotic cases from the 14 hospitals. These variable costs included disposable supplies such as drapes, trocars, sutures, and other commonly used surgical supplies. In addition, costs of mesh and single-use disposable laparoscopic instruments were included if surgeons utilized these additional costly supplies. Operating room time was included based on surgical case time, separated into cut-to-close time and patient-in-room time. Although the OR time cost assumptions in this analysis did not include the possible impact of *scheduled vs actual* case times, it should be noted that this differential can impact the cost of robotic ownership due to greater or lesser case efficiency and overall throughput. Associated OR personnel cost calculations were also included, based on aggregated CAVA data. Real-world da Vinci supplies, non-da Vinci supplies, and surgical times (inclusive of cut-to-close time and patient-in-room time) are presented in Table 1 by surgical service line and case type.

Time data were used to estimate operation room (OR) staff costs. Hourly costs were derived based on staffing data and CAVA expert opinion, inclusive of usual and customary OR personnel by surgical case type, and expected pre-, intra-, and post-op times by personnel type, including surgeon, anesthesiologist (ANES), registered nurse circulator (RNC), technical assistant (TA), and mid-level assistant (MLA). The personnel time intervals used in the cost calculation were determined as cut-to-close time for surgeon and TA and as patient-in-room time for ANES, RNC, and MLA. Table 1 illustrates the average time per case, and Table 2 includes OR personnel requirements per case. The related time information (Table 1) was combined with the number of staff required per case type (shown in Table 2) with hourly personnel costs of $418.40 for employed surgeons, $326.66 for ANES, $41.12 for RNC, $26.09 for TA, and $66.11 for MLA.[10]
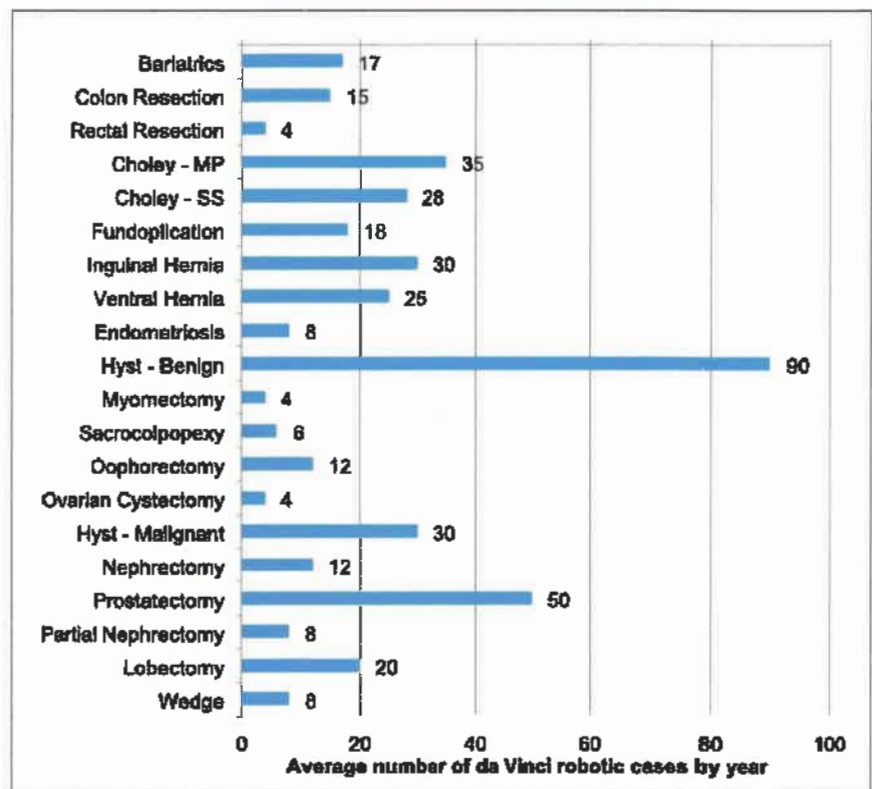
FIGURE 1 Annual real-world robotic cases, by case type, in Bellin Health Green Bay, Wisconsin (total n = 424). Abbreviations: Choley - MP: Cholecystectomy, Multi-Port; Choley - SP: Cholecystectomy, Single-Port; Hyst - Benign: Hysterectomy, Benign; Hyst - Malignant: Hysterectomy, Malignant; Wedge: Wedge Resection

The impact of surgeon learning curves is another cost variable that should be called out, given that learning curves can lead to cost per case being overstated. Average case times always included surgeon learning curves, training surgeons, and poor performing surgeons; these numbers can also be impacted by case complexity. While not included in the current model, such variables may merit subanalysis.

2.2.1 | Real-world cost categories considered

Variable RWD cost categories considered in the CoO assessment include da Vinci supplies (ie, reposable instruments, drapes, seals, and other disposable supplies); non-da Vinci supplies (ports, trocars, gowns, gloves, disposable nonrobotic energy and staple devices as well as other nonrobotic laparoscopic supplies); and personnel costs, based on RWD from the hospitals. For the base-case analysis, the mean values presented in Table 1 were applied, whereas the influence of the upper and lower estimates (informed by the 95% confidence interval limits presented in Table 1) was investigated in sensitivity analyses. For the sensitivity analyses on fixed costs, the case volume was varied between 250 cases (low estimate) and 600 cases (high estimate).

3 | RESULTS

CoO assessment of the da Vinci robotic surgery presents fixed costs, variable costs, and total costs by robotic case as total costs from the hospital perspective, and as weighted average per robotic case, weighted by the number of robotic cases performed by case type (presented in Figure 1). The sensitivity analysis of the CoO results per case

is informed by higher and lower input value estimates (as described above), whereas the base case results reflects the outcomes if the mean values are applied.

3.1 | Base case results

Results of the CoO assessment for the da Vinci robot are presented in Table 3 by robotic case and in Table 4 for the total case mix, respectively. All costs are presented from the hospital perspective.

Assuming no financing costs (due to the extreme variation in payment and finance options available), and adding the yearly service contract costs (including 4 years in a 5-year period in order to reflect the 1-year warranty period), the result is in average yearly fixed cost of $417 200 ($294 000 purchasing costs and $123 200 service contract costs). Applying the efficient *Bellin Health* yearly robotic case number (n = 424 cases) yielded an average fixed cost of $984 per da Vinci robotic case.

Variable costs, however, are highly dependent on case type. The weighted average *variable cost* was $8025, ranging from $3325 (cholecystectomy, multiport) to $16 986 (rectal resection) as presented in Table 3. Looking at weighted average by case, the main variable cost drivers were the non-da Vinci supplies (49.5%), personnel costs (28.6%), followed by da Vinci supplies (21.9%). This cost distribution is case specific and is different for each surgery case type. *Total variable costs for the hospital,* using the efficient number of annual Bellin facility cases as the basis of the calculation (n = 424), were $3 402 560, as illustrated in Table 4.

The total weighted average cost by da Vinci surgical case (Table 3) is $9009, ranging from $4309 (cholecystectomy, multiport) to

TABLE 1 Overview of US hospital, based on CAVA real-world data on da Vinci robotic procedures by case type, used as basis of CoO assessment

Service Line	Case Type	Cut to Close Time				Patient in Room Time				dV Supplies				Non-dV Supplies			
		n	Mean	2.5%CI	97.5%CI	n	Mean	2.5%CI	97.5%CI	n	Mean	2.5%CI	97.5%CI	n	Mean	2.5%CI	97.5%CI
Bariatrics	Bariatrics	35	102.4	53.7	200.2	35	137.1	85.3	249.4	35	$3729	$1708	$8214	35	$7109	$2616	$10 570
Colorectal	Colon resection	452	172.2	65.3	356.0	452	214.4	99.3	408.7	439	$1644	$1060	$2596	452	$5804	$710	$12 752
	Rectal resection	8	357.5	192.7	500.2	8	405.9	229.9	542.5	8	$1601	$1200	$3406	8	$9802	$3369	$15 822
General	Chole—MP	224	83.9	38.6	212.0	224	117.8	67.6	271.8	224	$1153	$1016	$1479	224	$763	$203	$5260
	Chole—SS	90	51.7	34.7	80.6	90	80.4	59.2	119.3	90	$892	$865	$971	90	$2977	$2576	$3739
	Fundoplication	69	146.5	78.5	272.5	69	191.2	102.5	348.1	68	$1710	$1060	$4211	69	$4632	$259	$9607
	Inguinal hernia	482	80.3	24.0	173.0	482	113.1	55.0	220.9	482	$1439	$905	$2504	482	$1352	$420	$5189
	Ventral hernia	478	94.5	35.0	212.3	478	128.1	62.9	260.5	478	$1408	$1076	$2087	478	$1417	$377	$4407
Gyn	Endometriosis	240	101.9	33.0	248.0	248	129.3	57.0	271.8	252	$1300	$1016	$3701	252	$2633	$731	$7232
	Hyst—benign	1944	110.3	47.0	254.0	2246	144.2	78.0	290.0	2379	$1772	$937	$4781	2379	$3548	$593	$9253
	Myomectomy	120	153.7	45.0	320.7	124	183.7	77.2	346.7	128	$1351	$1021	$3497	128	$3274	$739	$8500
	Sacrocolpopexy	86	159.3	81.0	310.8	147	192.6	108.7	337.1	176	$1946	$1044	$3284	175	$6611	$1476	$12 514
	Oophorectomy	43	87.7	31.2	198.8	44	124.2	61.7	233.3	44	$1505	$1016	$2381	44	$4028	$783	$8066
	Ovarian cystectomy	117	138.0	42.5	261.3	124	167.5	71.1	300.6	125	$1242	$1016	$3670	125	$2445	$437	$7064
Gyn oncology	Hyst—malignant	218	194.2	95.4	348.6	443	199.4	114.1	379.0	561	$2274	$1016	$4418	561	$7051	$595	$11 019
Urology	Nephrectomy	22	212.4	105.1	340.0	41	284.6	157.0	429.0	52	$2102	$1016	$3995	51	$6110	$1060	$11 822
	Prostatectomy	218	247.3	144.1	419.9	258	295.6	179.0	484.2	284	$2238	$1016	$4846	284	$4399	$3222	$7386
	Partial nephrectomy	80	203.3	102.6	335.2	94	279.1	172.9	429.7	95	$1664	$1016	$4655	95	$5900	$1074	$11 544
Thoracic	Lobectomy	76	193.5	81.3	360.4	76	265.1	156.8	418.4	76	$1739	$1059	$3463	76	$6365	$800	$18 123
	Wedge	30	154.8	56.9	295.7	30	222.6	125.2	360.8	28	$1407	$993	$2207	30	$4745	$788	$20 620

Abbreviations: Choley - MP, Cholecystectomy, Multi-Port; Choley - SP, Cholecystectomy, Single-Port; Hyst - Benign, Hysterectomy, Benign; Hyst - Malignant, Hysterectomy, Malignant; Wedge, Wedge Resection.

TABLE 2 Overview of required full-time surgery staff by case type[a]

Service Line	Case Type	Required Staff in Full-Time Equivalents				
		Surgeon (n)	ANES (n)	RNC (n)	TA (n)	MLA (n)
Bariatrics	Bariatrics	1.00	1.00	1.00	1.00	1.00
Colorectal	Colon resection	1.00	1.00	1.00	1.00	1.00
	Rectal resection	1.00	1.00	1.00	1.00	1.00
General	Chole—MP	1.00	1.00	1.00	1.00	0.50
	Chole—SS	1.00	1.00	1.00	1.00	1.00
	Fundoplication	1.00	1.00	1.00	1.00	1.00
	Inguinal hernia	1.00	1.00	1.00	1.00	0.50
	Ventral hernia	1.00	1.00	1.00	1.00	1.00
Gyn	Endometriosis	1.00	1.00	1.00	1.00	1.00
	Hyst—benign	1.00	1.00	1.00	1.00	1.00
	Myomectomy	1.00	1.00	1.00	1.00	1.00
	Sacrocolpopexy	1.00	1.00	1.00	1.00	1.00
	Oophorectomy	1.00	1.00	1.00	1.00	0.00
	Ovarian cystectomy	1.00	1.00	1.00	1.00	0.00
Gyn oncology	Hyst—malignant	1.00	1.00	1.00	1.00	1.00
Urology	Nephrectomy	1.00	1.00	2.00	2.00	0.00
	Prostatectomy	1.00	1.00	2.00	2.00	0.00
	Partial nephrectomy	1.00	1.00	2.00	1.00	1.00
Thoracic	Lobectomy	1.00	1.00	1.00	1.00	1.00
	Wedge	1.00	1.00	1.00	1.00	1.00

Abbreviations: ANEAS, Anesthesiologist; Choley - MP, Cholecystectomy, Multi-Port; Choley - SP, Cholecystectomy, Single-Port; Hyst - Benign, Hysterectomy, Benign; Hyst - Malignant, Hysterectomy, Malignant; MLA, Midlevel Assist; RNC, Registered Nurse Circulator; TA, Technical Assistant; Wedge, Wedge Resection.
[a]Based on CAVA Expert Opinion.

$17 970 (rectal resection). Total cost from the hospital perspective (Table 4), using the *efficient number* of annual Bellin Health robotic cases (n = 424) as the basis of the calculation, was estimated at $3 819 760. (See *Discussion* for additional explanation on estimated average annual robotic case volume per robot.)

3.2 | Sensitivity analyses results

Sensitivity analyses for the CoO assessment are presented by robotic case for fixed, variable, and total costs in Table 5. For each category, the base case, low values, and high values are presented in US dollars; the variation from the base case is presented as a percentage change.

In general, the variation of fixed costs (based on between 250 and 600 robotic cases annually) was not as pronounced as the variation of variable costs, while the variation in variable costs was more pronounced for the high estimates, as demonstrated by a higher percentage deviation from the base case compared with the low estimates.

4 | DISCUSSION

Based on the authors' real-world experience providing consulting support at dozens of US hospitals with robotic programs, facilities may begin to experience robot access limitations at 250 to 325 cases annually—due to scheduling challenges, surgeon or crew skill challenges, or all three factors. This annual case volume represents between 30% and 45% of the robot's theoretical capacity (assumed as three cases

per day × 5 days per week × 52 weeks a year = 780 cases, depending on case mix, with a dedicated robotic operating room).

Nevertheless, even a modest annual volume of 300 robotic cases commonly leads to a hospital beginning to experience robot case scheduling and access challenges, which in turn may cause hospital administrators to question the "robot value proposition" (ie, is it possible to get enough profitable robotic cases done annually on a robot, given the cost?). While there are a small number of very efficient robotic programs (doing 600 or more cases per year on a single robot), this is uncommon. The influence of annual case volume—high or low—on the fixed annual cost of robot ownership is highly significant, with more efficient and typically higher volume robotic programs achieving superior fiscal performance to lower efficiency, lower annual case volume programs when assessing reposable use, non-da Vinci supplies, and overall CoO. This component was not assessed in this paper, however, and is thus a limitation of the present analysis.

While case volume and efficiency are indeed related (ie, as a program's case volume increases, average case time typically decreases while per-case supply efficiency improves). However, case volume alone may not *always* be an indicator of a robotic program's efficient use of supplies or reposables (ie, a higher volume program can lose money due to excessive per-case supply consumption, if not well managed). As seen in the sensitivity analysis, variation in variable costs had much greater impact on the robotic program, especially for the high estimates, as demonstrated by a higher percentage deviation from the base case compared with the low estimates. This underscores the importance of programmatic standardization (case times, crew

TABLE 3 CoO results: Fixed and variable costs by Robotic Surgery Case[a]

Service Line Case type	Average Fixed Costs[b]			Average Variable Costs				Total Costs
	Pur-chase	Ser-vice	Total fixed	da Vinci sup.	Non-da Vinci sup.	Staff costs	Total VAR	Fixed and variable
Bariatrics (weighted average)	$693	$291	$984	$3729	$7109	$1750	$12 588	$13 572
Bariatrics	$693	$291	$984	$3729	$7109	$1750	$12 588	$13 572
Colorectal (weighted average)	$693	$291	$984	$1635	$6645	$3406	$11 687	$12 671
Colon resection	$693	$291	$984	$1644	$5804	$2826	$10 274	$11 258
Rectal resection	$693	$291	$984	$1601	$9802	$5583	$16 986	$17 970
Gen Surg (weighted average)	$693	$291	$984	$1283	$1981	$1484	$4748	$5732
Chole—MP	$693	$291	$984	$1153	$763	$1408	$3325	$4309
Chole—SS	$693	$291	$984	$892	$2977	$964	$4833	$5817
Fundoplication	$693	$291	$984	$1710	$4632	$2468	$8810	$9794
Inguinal hernia	$693	$291	$984	$1439	$1352	$1350	$4141	$5125
Ventral hernia	$693	$291	$984	$1408	$1417	$1626	$4451	$5435
Gyn (weighted average)	$693	$291	$984	$1694	$3639	$1866	$7198	$8182
Endometriosis	$693	$291	$984	$1300	$2633	$1690	$5622	$6606
Hyst—benign	$693	$291	$984	$1772	$3548	$1860	$7180	$8164
Myomectomy	$693	$291	$984	$1351	$3274	$2467	$7092	$8076
Sacrocolpopexy	$693	$291	$984	$1946	$6611	$2574	$11 130	$12 114
Oophorectomy	$693	$291	$984	$1505	$4028	$1411	$6943	$7927
Ovarian cystectomy	$693	$291	$984	$1242	$2445	$2049	$5735	$6719
Gyn oncology (weighted average)	$693	$291	$984	$2274	$7051	$2881	$12 206	$13 190
Hyst—malignant	$693	$291	$984	$2274	$7051	$2881	$12 206	$13 190
Urology (weighted average)	$693	$291	$984	$2149	$4864	$3867	$10 880	$11 864
Nephrectomy	$693	$291	$984	$2102	$6110	$3605	$11 818	$12 802
Prostatectomy	$693	$291	$984	$2238	$4399	$3954	$10 591	$11 574
Partial nephrectomy	$693	$291	$984	$1664	$5900	$3716	$11 280	$12 264
Thoracic (weighted average)	$693	$291	$984	$1644	$5902	$3181	$10 727	$11 711
Lobectomy	$693	$291	$984	$1739	$6365	$3351	$11 455	$12 439
Wedge	$693	$291	$984	$1407	$4745	$2756	$8908	$9892
All case types (weighted average)	$693	$291	$984	$1754	$3974	$2297	$8025	$9009

[a]Costs were determined by case using a weighted average on the basis of the average case mix presented in Figure 1 based on an annual case volume of 424 cases related to Bellin Health in Green Bay, Wisconsin.

[b]Based on an annual case volume of 424 cases, Bellin Health, Green Bay, Wisconsin USA.

performance metrics, and da Vinci and non-da Vinci supplies) as a means of reducing robot CoO. Costs may also be artificially constrained due to the arbitrary determination of reposable instrument lives; instrument use and surgeon instrument preferences are another contributor to cost and associated variability.[13,14] When a surgeon demonstrates high instrument variation, this also often leads to increased cost. Thus, robotic case standardization, based on high-utilizing surgeons' consistent use of supplies, can help drive more predictable instrument profiles for each case type. While unique cases may occasionally demand creative approaches to surgery, most cases should be accomplished with standard and predictable instrument profiles. This is also impacted by the overall experience of the surgeon, with surgeons in their learning curve or early in their robotic careers typically far more variable and excessive in instrument use.

4.1 | Misaligned cost accounting

Real-world cost of data obtained from the CAVA Robotics' data base includes capital costs for the robot. It is noted that these data are frequently amortized across all the robotic cases. However, at most hospitals when these same data are pulled for traditional laparoscopy, orthopedics, and other procedure-based service lines, the facility frequently follows different cost accounting methodologies. For example, a hospital may opt to roll up the capital cost of a da Vinci robot into its total robotic cost assessment, but not follow this same treatment of capital costs with other surgical technologies and service lines when attempting cost comparisons. Comparing the actual CoO of a da Vinci robot vs other surgical technologies is therefore challenging. Thus, when assessing robotic costs, a similarly designed

TABLE 4 CoO results: Fixed and variable total costs *For The Hospital*[a]

Service Line Case type	N	Average Fixed Costs			Average Variable Costs				Total Costs
		Purchase	Service	Total fixed	da Vinci sup.	Non-da Vinci sup.	Staff costs	Total VAR	Fixed and variable
Bariatrics (total cases)	17	$11 788	$4940	$16 727	$63 399	$120 854	$29 745	$213 998	$230 725
Bariatrics	17	$11 788	$4940	$16 727	$63 399	$120 854	$29 745	$213 998	$230 725
Colorectal (total cases)	19	$13 175	$5521	$18 695	$31 069	$126 263	$64 723	$222 055	$240 750
Colon resection	15	$10 401	$4358	$14 759	$24 666	$87 054	$42 389	$154 109	$168 869
Rectal resection	4	$2774	$1162	$3936	$6404	$39 208	$22 334	$67 946	$71 882
Gen Surg (total cases)	136	$94 302	$39 517	$133 819	$174 480	$269 438	$201 864	$645 782	$779 600
Chole—MP	35	$24 269	$10 170	$34 439	$40 363	$26 716	$49 284	$116 363	$150 802
Chole—SS	28	$19 415	$8136	$27 551	$24 965	$83 355	$26 997	$135 316	$162 867
Fundoplication	18	$12 481	$5230	$17 711	$30 782	$83 371	$44 422	$158 575	$176 287
Inguinal hernia	30	$20 802	$8717	$29 519	$43 171	$40 566	$40 508	$124 245	$153 764
Ventral hernia	25	$17 335	$7264	$24 599	$35 200	$35 430	$40 652	$111 282	$135 881
Gyn (total cases)	124	$85 981	$36 030	$122 011	$210 018	$451 239	$231 328	$892 585	$1 014 596
Endometriosis	8	$5547	$2325	$7872	$10 399	$21 061	$13 518	$44 979	$52 850
Hyst—benign	90	$62 406	$26 151	$88 557	$159 515	$319 307	$167 374	$646 195	$734 752
Myomectomy	4	$2774	$1162	$3936	$5403	$13 096	$9867	$28 367	$32 302
Sacrocolpopexy	6	$4160	$1743	$5904	$11 676	$39 665	$15 442	$66 782	$72 686
Oophorectomy	12	$8321	$3487	$11 808	$18 057	$48 331	$16 932	$83 321	$95 128
Ovarian cystectomy	4	$2774	$1162	$3936	$4967	$9778	$8196	$22 941	$26 877
Gyn oncology (total cases)	30	$20 802	$8717	$29 519	$68 227	$211 533	$86 432	$366 192	$395 711
Hyst—malignant	30	$20 802	$8717	$29 519	$68 227	$211 533	$86 432	$366 192	$395 711
Urology (total cases)	70	$48 538	$20 340	$68 877	$150 426	$340 476	$270 679	$761 580	$830 458
Nephrectomy	12	$8321	$3487	$11 808	$25 223	$73 325	$43 264	$141 813	$153 620
Prostatectomy	50	$34 670	$14 528	$49 198	$111 893	$219 947	$197 685	$529 526	$578 724
Partial nephrectomy	8	$5547	$2325	$7872	$13 309	$47 203	$29 729	$90 242	$98 114
Thoracic (total cases)	28	$19 415	$8136	$27 551	$46 038	$165 265	$89 066	$300 369	$327 920
Lobectomy	20	$13 868	$5811	$19 679	$34 779	$127 307	$67 016	$229 102	$248 781
Wedge	8	$5547	$2325	$7872	$11 259	$37 958	$22 050	$71 267	$79 139
All case types (total cases)	424	$294 000	$123 200	$417 200	$743 657	$1 685 067	$973 836	$3 402 560	$3 819 760

[a]Costs were determined combined all cases presented in the underlying average case mix presented in Figure 1.

model, as herein described, should be applied to obtain a true comparison with da Vinci robotics.

Why is there a common cost accounting method inequality between robotic and laparoscopic surgery CoO? There are several factors. A decade ago, when robotic surgery experienced significant volume growth and expansion of case mix, supply chain and finance departments of hospitals looked at robotics as *a new service* and wanted to evaluate the profitability of this service through a narrowly defined "cost" lens, but did not take into account an equitable comparison of the robotic costs vis a vis other Minimally Invasive Surgery (MIS) and non-MIS service lines. Amplifying this inconsistency is the fact that 20 years ago, had these same hospitals assessed the cost of laparoscopic surgery in the era of paper cost accounting with its limited ability to assess all the dimensions of surgical costs and provider performance metrics, many institutions may have seen weak or even negative financial performance. Robotics, on the other hand,

emerged in the early big data era, at a time of heightened awareness of cost-effectiveness and value-based medical care—all of which did not exist in US hospital "C-suites" of the late 1980s and 90s.

Further complicating the assessment of robotic CoO is the lack of standardized cost accounting methodologies among US hospitals; attempting to compare the cost of a robotic system between hospitals or IDNs is currently affected by wide variation in cost accounting methodology. One example of this variation is the variety of ways that hospitals treat the cost of da Vinci reposable instruments: some hospitals place robotic surgery in the highest cost tier and add a first minute surcharge to the case to allow for the high instrument cost; some capitalize the cost of the instruments; some meticulously track the use of each instrument and capture the actual cost per use. In the model described herein, however, only hospitals that cost each reposable instrument have been used, an essential component to assure accuracy in the CoO assessment. It is advisable that these elements be

TABLE 5 Sensitivity analysis: Deviation of cost per da Vinci robotic surgery by case, using low and high estimates

Service Line Case type	Fixed Costs					Variable Costs					Total Costs				
	Low	%change	Base case	%change	High	Low	%change	Base case	%change	High	Low	%change	Base case	%change	High
Bariatrics (total cases)	$695	29.3%	$984	69.5%	$1668	$5338	57.6%	$12 588	75.3%	$22 070	$6033	55.5%	$13 572	74.9%	$23 738
Bariatrics	$695	29.3%	$984	69.5%	$1668	$5338	57.6%	$12 588	75.3%	$22 070	$6033	55.5%	$13 572	74.9%	$23 738
Colorectal (total cases)	$695	29.3%	$984	69.5%	$1668	$3958	66.1%	$11 687	89.8%	$22 187	$4653	63.3%	$12 671	88.3%	$23 855
Colon resection	$695	29.3%	$984	69.5%	$1668	$2972	71.1%	$10 274	103.8%	$20 941	$3667	67.4%	$11 258	100.8%	$22 609
Rectal resection	$695	29.3%	$984	69.5%	$1668	$7658	54.9%	$16 986	58.1%	$26 857	$8353	53.5%	$17 970	58.7%	$28 525
Gen Surg (total cases)	$695	29.3%	$984	69.5%	$1668	$2514	47.1%	$4748	119.9%	$10 440	$3209	44.0%	$5732	111.2%	$12 108
Chole—MP	$695	29.3%	$984	69.5%	$1668	$1957	41.1%	$3325	204.5%	$10 126	$2652	38.4%	$4309	173.7%	$11 794
Chole—SS	$695	29.3%	$984	69.5%	$1668	$4126	14.6%	$4833	27.7%	$6170	$4821	17.1%	$5817	34.7%	$7838
Fundoplication	$695	29.3%	$984	69.5%	$1668	$2642	70.0%	$8810	108.3%	$18 354	$3337	65.9%	$9794	104.4%	$20 022
Inguinal hernia	$695	29.3%	$984	69.5%	$1668	$1870	54.8%	$4141	152.4%	$10 451	$2565	49.9%	$5125	136.5%	$12 119
Ventral hernia	$695	29.3%	$984	69.5%	$1668	$2167	51.3%	$4451	123.5%	$9950	$2862	47.3%	$5435	113.8%	$11 618
Gyn (total cases)	$695	29.3%	$984	69.5%	$1668	$2506	65.2%	$7198	140.7%	$17 323	$3201	60.9%	$8182	132.1%	$18 991
Endometriosis	$695	29.3%	$984	69.5%	$1668	$2403	57.3%	$5622	162.1%	$14 737	$3098	53.1%	$6606	148.3%	$16 405
Hyst—benign	$695	29.3%	$984	69.5%	$1668	$2442	66.0%	$7180	150.9%	$18 013	$3137	61.6%	$8164	141.1%	$19 681
Myomectomy	$695	29.3%	$984	69.5%	$1668	$2651	62.6%	$7092	138.0%	$16 880	$3346	58.6%	$8076	129.7%	$18 548
Sacrocolpopexy	$695	29.3%	$984	69.5%	$1668	$3906	64.9%	$11 130	84.5%	$20 538	$4601	62.0%	$12 114	83.3%	$22 206
Oophorectomy	$695	29.3%	$984	69.5%	$1668	$2408	65.3%	$6943	92.3%	$13 349	$3103	60.9%	$7927	89.4%	$15 017
Ovarian cystectomy	$695	29.3%	$984	69.5%	$1668	$2203	61.6%	$5735	153.0%	$14 512	$2898	56.9%	$6719	140.8%	$16 180
Gyn oncology (total cases)	$695	29.3%	$984	69.5%	$1668	$3143	74.3%	$12 206	70.1%	$20 761	$3838	70.9%	$13 190	70.0%	$22 429
Hyst—malignant	$695	29.3%	$984	69.5%	$1668	$3143	74.3%	$12 206	70.1%	$20 761	$3838	70.9%	$13 190	70.0%	$22 429
Urology (total cases)	$695	29.3%	$984	69.5%	$1668	$5816	46.5%	$10 880	80.5%	$19 640	$6 511	45.1%	$11 864	79.6%	$21 308
Nephrectomy	$695	29.3%	$984	69.5%	$1668	$3925	66.8%	$11 818	81.1%	$21 406	$4620	63.9%	$12 802	80.2%	$23 074
Prostatectomy	$695	29.3%	$984	69.5%	$1668	$6526	38.4%	$10 591	77.7%	$18 824	$7221	37.6%	$11 575	77.0%	$20 492
Partial nephrectomy	$695	29.3%	$984	69.5%	$1668	$4219	62.6%	$11 280	95.8%	$22 084	$4914	59.9%	$12 264	93.7%	$23 752
Thoracic (total cases)	$695	29.3%	$984	69.5%	$1668	$3456	67.8%	$10 727	155.2%	$27 380	$4151	64.6%	$11 711	148.0%	$29 048
Lobectomy	$695	29.3%	$984	69.5%	$1668	$3595	68.6%	$11 455	138.2%	$27 282	$4290	65.5%	$12 439	132.7%	$28 950
Wedge	$695	29.3%	$984	69.5%	$1668	$3108	65.1%	$8908	210.1%	$27 627	$3 803	61.6%	$9892	196.1%	$29 295
All case types (total cases)	$695	29.3%	$984	69.5%	$1668	$3341	58.4%	$8025	109.5%	$16 813	$4036	55.2%	$9009	105.1%	$18 481

standardized so that robotic CoO can be universally performed in a reliable manner, and so robotic performance can also be compared correctly to lap and other service lines to achieve an equitable apples-to-apples assessment of CoO.

4.2 | Quality as a cost variable

Moreover, the *quality* of the robotic program itself—ie, the performance characteristics of the robotic surgeons, the efficiency of the crew, the management of supplies, etc.—further impacts the CoO equation. Quality, however, is rarely discussed as a factor in robotic CoO in the peer review literature, with wide variations in time metrics and supply utilization routinely observed in real-world settings. These variations—not strictly accounted for and a limitation of this analysis—are largely influenced by surgeon training and experience, crew training, case selection and case type, program performance policies, and governance.

4.3 | Cost of ownership for future robotic technologies

The current model also provides a base CoO framework which may be useful as a foundation for hospitals to evaluate new robotic systems as future technologies enter the market place. In this context, it is important for hospitals to standardize their cost accounting, as suggested herein, to achieve comparable analyses from the perspective of IDN to IDN/hospital to hospital, as well as from the perspective of assessing the CoO of robotic vs MIS technologies—fully burdened based on identical service line/case mix/case volumes, and all associated fixed and variable costs.

5 | CONCLUSION

Assessing the CoO of a robot using RWD makes it clear that there are many variables that directly and significantly impact CoO. Cost accounting, supply/reposable efficiencies, case mix, case volumes, and case times represent core variables that can drive up or reduce CoO. Robotics is thus often referred to as a "team sport," meaning that highly efficient management and work flow of all robotic stakeholders significantly impacts program quality and robotic CoO. Hospitals/IDNs that understand how robotic CoO is impacted by these variables hold the key to better controlling robotic costs, and thereby achieving improved financial performance of their robotic program. Moving forward, establishing this improved operational and financial approach is critical as new robotic vendors and technologies enter the global market, as administration and clinicians ask, *what does this new robotic technology really cost?*

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Craig Marks

From:	McClain, Kimberlie I <Kimberlie.McClain@providence.org>
Sent:	Friday, October 16, 2020 8:46 AM
To:	Craig Marks; Kevin Hardiek
Cc:	Strawn, Michelle A
Subject:	Epic Executive Packet
Attachments:	Prosser Memorial Health - Oct 2020.pdf

Follow Up Flag:	Follow up
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Dear Craig & Kevin,

We are excited to be sharing Prosser Memorial Health's Epic executive packet with you this year.

It's a comprehensive data-driven report produced by Epic containing key values regarding your organization as well as comparison data with other organizations similar to yours. Additionally, there are opportunities identified to further your organization's usage of the tools available within our current version of Epic.

This is Epic's first time sending these packets to Community Technologies partners and we have an opportunity to provide feedback on Epic's Connect Steering Board. After you have a chance to review and discuss, we welcome any feedback you would like us to pass on, both positive and constructive.

I am happy to schedule a call with your leadership team to go over it if you have any questions.

Thank you.

Kim McClain

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1

EXECUTIVE PACKET

Epic

Prosser Memorial
Health

October 2020

Preface

Rationale

The Executive Packet is a collection of data-driven reports from different areas across your organization. Each page is intended to highlight areas where Epic's technology and automation could better support and advance your organizational goals. We hope you find them useful. Please let us know if any additional data points would be valuable.

Notes on Data

Each page within the packet includes a note describing the date ranges used for the data, the peer group you are being compared against, and the period with which trends are calculated. Trending is calculated as "percent change from prior period" - for example, a change from 40% to 50% would be represented as a 25% increase between periods.

Broadly speaking, most over-time metrics cover the prior 3-month period, while point-in-time metrics represent the most current value we were able to collect.

We use a variety of data sources in the packet: clinical, financial, and feature tracking metrics, feature usage information for your organization from Gold Stars and Nova Release Notes, and a variety of manually gathered data.

Peer Grouping

You are being compared against the peer group **Critical Access**: Resolute Hospital Billing locations. This facility type applies to rural hospitals that are commonly certified as Critical Access Hospitals (CAH) by Medicare and receive cost-based reimbursement.

You can find a list of organizations that are included in benchmarking peer groups by navigating to the most recent Cogito Benchmarking Update post on UserWeb at https://userweb.epic.com/Topic/340 and downloading the "Participation" PDF linked at the bottom of the post.

Contents

Interoperability Exchange Statistics

Standards-based
Exchange of Full
Patient Records

*e*Care
Everywhere

Patient Records Exchanged - Washington Instance

You've exchanged patient records with organizations spanning

50 **STATES**

Darker shading indicates higher exchange volume
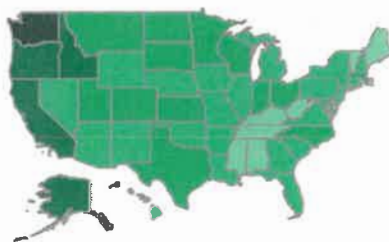
Exchanges in 2020 YTD	**31,656,940**
Exchanges in 2019	**38,200,762**
Since Care Everywhere Go-Live in 2011	**122,379,013**
Hospitals Exchanged with	**1,993**
EDs Exchanged with	**1,634**
Clinics Exchanged with	**41,641**

Implemented Features
Epic Community Adoption

ON **Outside Visits in Chart Review** — 402 / 415

Show internal & external encounters together for a more complete picture.

▶ **283,562** External Encounters Viewed Last Month

ON **Longitudinal Plan of Care** — 17 / 22

Show de-duplicated patient information from external and internal sources.

ON **Happy Together Lab Results** *(Fundamental)* — 254 / 400

Include lab results from Care Everywhere in patient charts (does not include trending local and outside results, which requires complex build).

▶ **1,074,588** Lab Results Auto-Reconciled Last Month

ON **Image Exchange** — 119 / 398

Send and receive reference-quality images via Care Everywhere.

ON **Chart Gateway** — 124 / 391

Efficiently review and process your patients' life insurance release requests.

ON **Government Connections** SSA ✓ DoD & VA ✓ — 124 / 391

OFF **Payer Platform** — 16 / 373

Collaborate with payers to reduce costs, relieve administrative burden, and improve patient outcomes.

Streamlining Exchange
● Sent ● Received

Your Record Exchange Compared to Your Peers *(Percentile)*

90th
●
90th

Features Impacting Your Exchange	You	Your Peers
Effective Authorization Policy	✓	82%
Advanced Record Location	✓	77%
Shared Provider Directory	✓	59%

Top Trading Partners
■ Sent ■ Received

Swedish Medical Center (Historical as of 6-15-19) and Polyclinic (Active)
6,510,610

UW Medicine - Washington
5,163,701

Kaiser Permanente Washington
5,094,994

MultiCare Health System
4,665,023

Clinics using athenahealth
4,022,704

The Everett Clinic
2,923,505

Catholic Health Initiatives Pacific Region
2,198,000

Collective Medical
1,624,640

Overlake Hospital Medical Center
1,466,873

Valley Medical Center
1,360,308

Carequality Exchange by Network
■ Sent ■ Received

Live Since: **05/25/2016**   Sites Exchanged With: **3,710**

athenahealth
4,022,704

Kno2
1,624,641

GE Healthcare (Qvera)
952,272

CommonWell
430,293

NextGen
374,805

eClinicalWorks
172,620

Health Gorilla
23,604

NetSmart
4,956

Patient Records Exchanged

State Map

States are shaded based on the number of records you've exchanged with them, with dark green indicating the most exchanges. The darkest shade indicates an exchange percentage of 10% or greater, and each consecutive lighter shade follows a logarithmic scale (10%, 1%, 0.1%...). The lightest shade indicates that you've exchanged at least one record with an organization in that state. Gray indicates no exchanges with organizations in that state.

Exchanges in <Year>

The sum of incoming and outgoing patient records in a given year, including exchanges with Epic and non-Epic trading partners. A single patient can account for multiple record exchanges if they are linked to multiple organizations and updates are requested for those links.

Hospitals, Emergency Departments, Clinics Exchanged With

The number of Epic hospitals, emergency departments, and clinics you have exchanged with. It does not include any non-Epic hospitals, emergency departments, or clinics because we don't have a way to gather these counts.

Streamlining Exchange

Your Record Exchange Compared to Your Peers

You're compared to your peers based on each organization's exchange counts normalized by the number of unique patients they've seen in the last 2 years. If you're in the 50th percentile, you exchange the same amount of records as peers who see the same number of patients. Features that can improve your exchange compared to your peers' are shown with a blank checkbox.

Effective Authorization Policy

Patients should authorize the exchange of their records when they're seen elsewhere. If this metric appears with a green check mark, at least 90% of your patients seen in the last quarter have authorized Care Everywhere exchange. Restricted or otherwise opted-out patients are excluded from this metric.

Advanced Record Location

Advanced Record Location significantly streamlines record exchange by automating requests for a patient's record, reducing staff time and increasing the likelihood that information is available. If this metric appears with a green check mark, you have Advanced Record Location enabled at patient check-in, ED arrival, and inpatient registration (as applicable).

Shared Provider Directory

Sharing your provider directory improves communication by allowing external providers to send records for patients coming to your organization. If this metric appears with a green check mark, you've shared an updated provider directory in the last quarter.

Top Trading Partners

Top Trading Partners Bar Chart

Your top ten trading partners during the past 12 months, sorted by the total number of patient records exchanged (sent and received) with those partners.

Carequality Exchange by Network

Sites Exchanged With

The number of unique organizations you've exchanged with via Carequality. These organizations do not use Epic, so this count cannot be broken down into hospitals, clinics, and EDs. Each organization you exchange with may represent multiple facilities.

Bar Chart

Your Carequality network trading partners during the past 12 months, sorted by total number of patient records exchanged (sent and received). A network may represent multiple EHR vendors.

Feature Toggle Legend

ON On   OFF Off   N/A Not applicable to your organization   MONTH YEAR Available in a future version

Patient Experience

Activation & Logins

Patients with a MyChart Account

▼ You ■ Bottom 25% ■ Middle 50% ■ Median ■ Best 25% ■ Best 10%

Metric	You	
Patients Seen Who Have a MyChart Account (Past 12 months)	21.3% ↑3%	21% 30% 41% 64%
Patients Seen 3+ Times Who Have a MyChart Account (Past 12 months)	28.6% ↑3%	29% 40% 52% 55% 64%
MyChart Users Who Have Logged In (Past 90 days)	40%	39% 48% 52% 57% 65%
Inactive Patients Activated Within 7 Days of Encounter	1% ↓27%	1% 3% 4% 5% 6% 8%
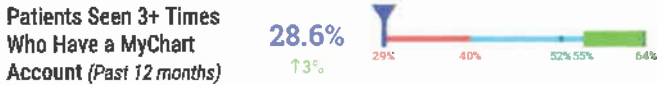
ON	Automatic Activation	Peer Group Adoption	18 / 22
ON	Instant Activation	Peer Group Adoption	22 / 22
ON	Front Desk Signup	Peer Group Adoption	18 / 22

Clinical

▼ You ■ Bottom 25% ■ Middle 50% ■ Median ■ Best 25% ■ Best 10%

Metric	You	
Test Results Released Within 24 Hours	53.4% ↑7%	20% 44% 63% 76% 85%
Test Results Released Within 30 Days	98.5% ↑1%	74% 84% 91% 94% 98%
Turnaround Time for Patient Messages (Avg)	1.8 Days ↑14%	0.6 1.0 3+
Patient Notes Shared in MyChart	40.6% ↑298%	0% 65% 90%
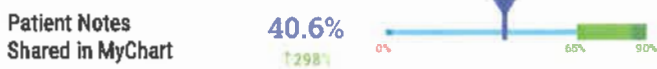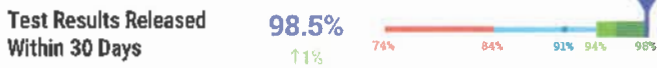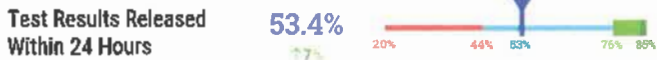
MyChart Bedside Use (% of admissions)
▶ For 7 Live Departments out of 229   1%

ON	Happy Together	Peer Group Adoption	22 / 22

Telemedicine & Virtual Care

Integrated Video Visit Volume	Not Using
E-Visits Received	Not Using
Patients Enrolled in Care Companion	Not Using

Financial

Patient Payments Collected Through MyChart & Welcome (Past 3 months) –

▼ You ■ Bottom 25% ■ Middle 50% ■ Median ■ Best 25% ■ Best 10%

Metric	You	
Patient Payments Collected Through MyChart	–	21% 23% 28% 33% 38% 44%
Paperless Statements (% of total statements)	0.0%	0% 4% 6% 11% 15% 17%

OFF	Patient-Initiated Estimates	Peer Group Adoption	7 / 20
ON	Pay as Guest	Peer Group Adoption	19 / 20
ON	Payment Plans	Peer Group Adoption	17 / 20
ON	Financial Assistance	Peer Group Adoption	7 / 14

Access

▼ You ■ Bottom 25% ■ Middle 50% ■ Median ■ Best 25% ■ Best 10%

Metric	You	
Appointments Scheduled Online for MyChart Patients	0.0%	0% 2% 4% 8% 10%
Appointments Checked-In Through MyChart or Welcome	5.5%	1% 4% 7% 11% 17% 19%
Open Slots Filled Through Fast Pass	0.0%	0% 6% 17% 20% 24%
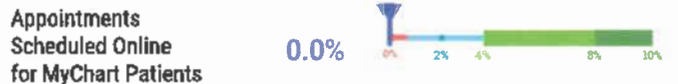
Sooner Appointment Time Offers Sent to Patients Through Fast Pass (Past 3 months)   0

Average Days Improvement from a Fast Pass Offer   –

OFF	Ticket Scheduling	Peer Group Adoption	7 / 22
ON	Open Scheduling	Peer Group Adoption	17 / 22
ON	MyChart eCheck-In	Peer Group Adoption	21 / 22
ON	Hello Patient	Peer Group Adoption	9 / 22
OFF	Welcome Kiosk Check-In	Peer Group Adoption	12 / 21
ON	On My Way	Peer Group Adoption	4 / 22
ON	eSignature	Peer Group Adoption	15 / 21

Activation

Total Patients with a MyChart Account	Count of patients active on MyChart. A patient with two proxies (e.g., a child with two parents) is counted as 1.
Patients Seen Who Have a MyChart Account	Percentage of unique patients seen in the past 12 months who are active on MyChart. Also shown as patients who have been seen 3 or more times in the past 12 months.
MyChart Users Who Have Logged In	Percentage of active MyChart users who have logged into their account in the past 90 days.
Inactive Patients Activated Within 7 Days of Encounter	Clinical encounters for which the patient's MyChart status changed from inactive to active within 7 days of being seen.
Automatic Activation	Use configurable automated triggers to send an email or text message to patients for MyChart signup.
Instant Activation	Staff can quickly send patients an activation URL by email or text message for a streamlined mobile signup workflow.
Front Desk Signup	Prompt front desk staff to sign patients up during check-in/out.

Clinical

Test Results Released	Data on the time it takes to release finalized test results to MyChart.
Turnaround Time for Patient Messages	Average time (in days) it takes for someone at your clinic to respond to a patient message.
Patient Notes Shared in MyChart	The percentage of patient notes available for sharing that have been shared in MyChart.
MyChart Bedside Use	Percentage of admissions using MyChart Bedside on the tablet or MyChart Mobile for live departments.
Happy Together	A design philosophy dedicated to improving patient care and care coordination, Happy Together allows patients to see a combined view of their healthcare record across many organizations in one comprehensive narrative in MyChart.

Telemedicine & Virtual Care

Integrated Video Visit Volume	A count of scheduled video visits where a patient and a staff member were connected simultaneously.
Total E-Visits Submitted	The total number of e-visits submitted from MyChart. E-Visits are an asynchronous form of telehealth that allow providers to respond to patient symptoms on their own schedule.
Patients Enrolled in Care Companion	Number of patients currently enrolled in a MyChart Care Companion Care Plan. MyChart Care Companion is an individualized plan of care delivered to patients through user-friendly technology.

Financial

Patient Payments Collected Through MyChart & Welcome	The sum of electronic payments made over the past 90 days. Patients can pay their outstanding balances by logging into MyChart, logging on as a guest, or using Welcome. Payments from payment plans are also included.
Patient Payments Collected via MyChart	The percentage of payments made over the last 90 days that came from MyChart, Pay as Guest, Welcome, and payment plans rather than manual collection by your staff, calculated as a percent of the count of payments.
Paperless Statements	Percentage of total billing statements made available to the patient in MyChart rather than sent via mail. Patients are counted whether they are active on MyChart or not
Patient-Initiated Estimates	Patients can view and create estimates for common procedures based on information your organization provides.
Pay as Guest	Allows for patients and guarantors to pay bills online without signing up or signing in to their MyChart account.
Payment Plans	Patients and guarantors can set up an auto payment plan in MyChart with the monthly amount, pay date, and details.
Financial Assistance	A patient or guarantor can complete a form to request financial assistance and track its progress and approval online.

Access

Appointments Scheduled Online for MyChart Patients	Percentage of visits for MyChart-active patients that were scheduled through MyChart.
Appointments Checked In via MyChart or Welcome	Percentage of appointments where the patient checked in using MyChart or Welcome before the visit.
Open Slots Filled Through Fast Pass	Percentage of appointments offered through Fast Pass where a patient accepted the offer. Fast Pass helps patients secure an earlier appointment time and improves providers' schedule utilization.
Sooner Appointment Time Offers Sent to Patients and Average Days Improvement from Fast Pass	The count of appointments offered through Fast Pass, and the corresponding average number of days an appointment was moved advanced forward.
Ticket Scheduling	Clinicians create scheduling tickets for visits or procedures, or the system auto-generates tickets when a clinician orders a certain procedure or lab test. Patients can use the ticket to schedule the appointment online through MyChart.
Open Scheduling	Open scheduling allows patients to schedule an appointment online without needing a MyChart account. Patients can schedule appointments through a central scheduling page or from within your organization's provider directory.
MyChart eCheck-In	Allow patients to skip the line for check-in by empowering them to update their insurance, sign documents, and answer clinical questionnaires through MyChart.
Hello Patient	Digitally greet patients as they arrive at the clinic and automatically sign or check them in
Welcome Kiosk Check-in	Offer patients self-service check-in at the start of the care process, via an intuitive touch screen interface.
eSignature	Allow patients to quickly sign documents prior to arrival via MyChart eCheck-in.

Outpatient Physician Well-Being

See Signal (signal.epic.com), Epic's online portal for provider efficiency data trending, insights, and drill-downs.

Minutes Working After Hours *(Unscheduled time on weekdays between 5:30 PM and 7:00 AM and any time on weekends, AKA Pajama Time)*

	Your Average per Physician	Peer Group Best 25%	Peer Group Median	Your Distribution	Your Physicians in Bottom 25% of Specialty	Total Physicians
				☐ 0 Minutes ▨ < 15 Minutes ▨ 15 - 30 Minutes ▨ > 30 Minutes		
Overall	8.2	22.5	26.7		N/A	19
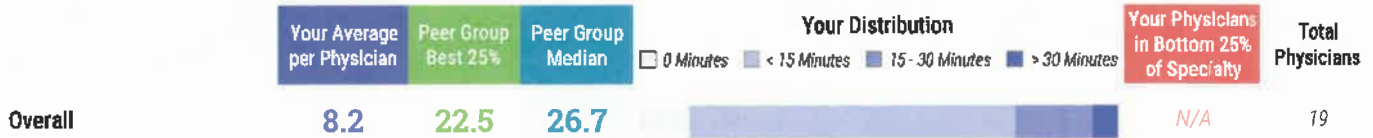
Largest Specialties by Number of Physicians

Bottom Outlier Specialties *(Furthest from the Epic community specialty-specific benchmark)*

Progress Notes *(Time in notes vs progress notes length)*

Inefficient Note Composition — Potential Note Bloat

Short Efficient Notes — Long Efficient Notes

Time in Notes (Minutes) / Note Length (Characters)

1 Family Medicine

Active Signal Users per Week
(Per 500 physicians - Washington Instance)

■ You - - Best 25% ···· Median

Jul 13	Jul 20	Jul 27	Aug 03	Aug 10	Aug 17	Aug 24	Aug 31	Sep 07	Sep 14	Sep 21	Sep 28	Oct 05	Oct 12
1.4	2.4	4.8	3.4	4.1	4.5	6.2	7.9	8.4	5.0	6.0	5.3	6.2	1.0

Clinical Review *(Higher is better)*

● You ▮ Best 25% ▮ Median

Chart Search	29%
Personalized Quick Filters	21%

0% 20% 40% 60% 80% 100%
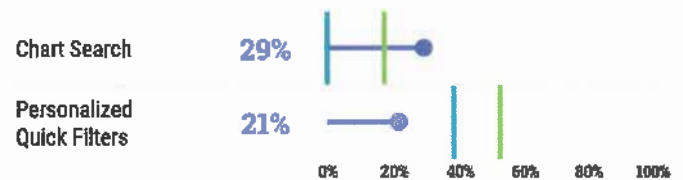
Team-Based Care *(Higher is better)*

● You ▮ Best 25% ▮ Median

Orders Placed with Team Contributions	26%
Note Text Written by Others	32%

0% 20% 40% 60% 80% 100%
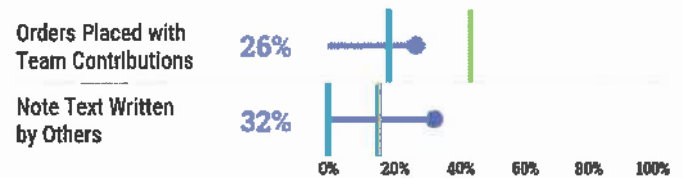
Chart Closure Rate *(Higher is better)*

● You ▮ Best 25% ▮ Median

Same Day Chart Closure Rate	91%

0% 20% 40% 60% 80% 100%

Minutes Working After Hours

Overall	This section shows the percentage of providers across your organization who spend time in the system on weekdays outside the hours of 7:00 AM and 5:30 PM and any time on weekends and non-scheduled holidays. Time is also divided into buckets of minutes per day spent on average. If a provider is scheduled on weekends or off hours, this metric does not include the time during those scheduled hours. It also excludes time spent personalizing tools like SmartPhrases and preference lists, time spent using reporting tools such as SlicerDicer and Reporting Workbench, and time spent in inpatient encounters.
Largest Specialties by Number of Physicians	The average amount of after hours time per provider in the two largest specialties at your organization.
Bottom Outlier Specialties	The average amount of after hours time per provider in the two specialties at your organization that are furthest from their peers at other organizations in the Epic community.

Progress Notes

This sections shows your top specialties by size. Each specialty is graphed in standard deviations away from the community average for that specialty. The size of the circle corresponds to the relative size of that specialty at your organization.

Time in Notes	Average time spent writing a note for each note written per provider.
Note Length	Average length of a provider's notes, in characters.

Manual Note Composition

The percentage of text in notes written manually for the three specialties at your organization that are furthest from their peers at other organizations in the Epic community.

Physician Builders and Training

Self-Reported Physician Builders or Power Users	Count of certified Physician Builders or Power Users at your organization (self-reported). A Physician Builder is a practicing clinician that understands your organization's workflows and contributes to records built in your Epic system. Power Users are Epic-trained providers that have shown an understanding and usage of optimization tools.
Active Thrive Program	Shows whether your organization has an active Physician Thrive program. Thrive After Go-Live is Epic's post-live, efficiency, and advanced personalization program for end users. Research on provider satisfaction shows that ongoing training and system personalization improve overall end user happiness. The Thrive program provides a framework for you to establish an ongoing training program targeting efficiency tips and advanced personalization, starting 2-3 months after go-live.

Active Signal Users per Week

The number of unique staff members from your organization who viewed Signal at least once in the given week, normalized to users per 500 physicians. This metric is calculated by dividing the count of unique users in a given week by the number of physicians at your organization and multiplying that number by 500.

Clinical Review

Chart Search	The percentage of providers who used Chart Search at least once during the reporting period.
Quick Filters	The percentage of providers who have created at least one Quick Filter in Chart Review.

Team-Based Care

Orders Placed with Team Help	The percentage of orders signed by the provider that were pended by another provider.
Note Text Written by Others	The percentage of notes authored by physicians that were added or written by other providers.

Chart Closure Rate

Same Day Chart Closure Rate	The percentage of appointments that were closed the same day as the appointment date.

Outpatient Physician Efficiency - In Basket

Higher than necessary message volume could distract from important messages and take time away from patient care. Improve outpatient physician efficiency in In Basket by rerouting appropriate messages to support staff and by enabling features that help your physicians quickly respond to common messages. For more information on improving physician efficiency, contact your BFF or TC. See Signal (signal.epic.com), Epic's online portal for provider efficiency data trending, insights, and drill-downs.

Messages Received per Provider per Day

Your Overall Average
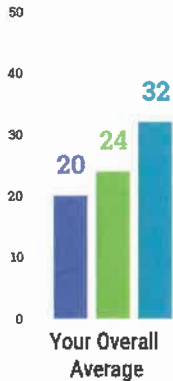
	You	Best 25%	Median

Message Types to Review

Messages per Provider per Week

Type	Recommended Action Item	You	Best 25%	Median
Refills	*Help support staff handle these messages more efficiently through Refill Protocols.*	13	0.79	5.0
Canceled Orders	*These messages are often only informational. Assess the value and suppress or re-route to support staff as appropriate.*	5.1	0.45	2.1
Care Everywhere	*These messages are often only informational. Assess the value and suppress or re-route to support staff as appropriate.*	1.0	0.14	0.83
Chart Completion	*Adjust message generation rules and determine if people other than the provider can assist with certain messages.*	11	2.6	9.2
Clinic Orders Cosign	*Review top message-generating orders and determine which could fall under a written protocol instead.*	9.6	3.0	12
CC Charts	*Reduce clutter by consolidating these messages with other encounter summary messages.*	2.7	1.4	4.0

Impactful Features You Are Not Using

 # / # Peer Group Adoption

OFF **Automatically Remove Completed Messages** 86 / 399
Give providers immediate feedback on progress by automatically removing a message from the In Basket when it is marked Done.

OFF **Email Ticklers** 72 / 399
Help users who only work in Epic a few days a week stay connected to their patients by subscribing to email reminders for new In Basket messages.

Descriptions & Benefits

Messages Received per Provider per Day	The average number of In Basket messages received per provider per day.
Your Specialties with the Highest Message Volume	Compares average message volume in specialties at your organization to the Epic community's top quartile for those specialties. The graph highlights specialties with the largest difference from the Epic community average.
Message Types to Review	Shows In Basket message types whose value and audience should be reviewed, including strategies to decrease the number of messages of that type in your physicians' In Baskets.
Impactful Features You Are Not Using	These features are available on your current Epic release version and are not fully in use in your organization. Implementing these features would help to make In Basket more efficient for your providers. Thresholds for use of these features are available at Signal.epic.com.

Acute Care Nursing

▼ You ■ Bottom 25% ■ Middle 50% ■ Best 25% ■ Median

Track System Time *(90 second inactivity timeout)*

Data from 409 shifts across 105 nurses: Mar 22 - Jul 10

Active Time per 12-Hour Shift
(Hyperspace)

118 Minutes

How You Compare

100   153 57   175   200

130
114
98
82
66
50

109   126

53

Dec 19   Apr 20   Jun 20

Active Time in Hyperspace by Category *(Minutes)*

■ Flowsheets   ■ MAR   ■ Clinical Review   ■ Care Plans
■ Orders   ■ Time Management   ■ Notes   ■ Other

You

| 39 | 14 | 13 | 14 | 12 | 21 |

| 51 | 16 | 17 | 22 | 14 | 26 |
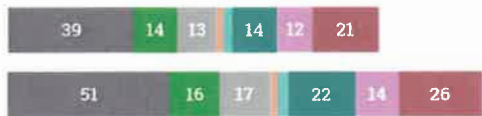
Average of Best 25%

Patient Monitoring

		Peer Group Adoption
OFF	Deterioration Index	8 / 21
OFF	Early Sepsis Detection	17 / 21
OFF	Fall Risk	1 / 21
OFF	ICU Length of Stay	2 / 21
OFF	ICU Mortality Risk	2 / 21
OFF	Risk of Unplanned Readmission	10 / 21

Provide Lean Flowsheets

See reverse for data date ranges

Device-Entered Flowsheet Data in ICUs
(Of data that can be automated)

18%

How You Compare

18%   58%   78% 82% 86%

Most Used Flowsheet Templates	Total Minutes Spent	Initial Rows Displayed
Adult PCS	6,404	103
Labor Record	2,451	122
Vital Signs	1,740	43
Intake/Output	1,432	29
PACU	1,373	100

Flowsheet Features		Peer Group Adoption
ON	Infusion Pump Integration	7 / 20
ON	Rule-Based Flowsheets	18 / 21
ON	Ventilator Device Integration	17 / 21

Precision Staffing

		Peer Group Adoption
OFF	Assignment Wizard	5 / 21
ON	Capacity Management	17 / 21
OFF	Nurse Scorecard	10 / 21
ON	Workload Scoring	16 / 21

Monitor BestPractice Advisories (BPAs)

Pop-Up BPAs Acted On   **9%**

How You Compare

5% 6%   12%   17%   24%

Track System Time

Active Time in Hyperspace

Clinician active time spent in Hyperspace is collected and summarized through our Nursing Efficiency and Assessment Tool (NEAT). This tool breaks down how nurses use the system to help identify actionable feature and configuration options to improve efficiency. Your EpicCare Inpatient Technical Services representative can share this data with you on a quarterly basis. We currently capture user click and keystroke information and apply a 30-section inactivity timeout in calculations. We are transitioning to a newer data model that also captures mouse movements and lowers the timeout threshold to 5 seconds. Peer benchmarks are not mixed across data models in order to preserve fair comparisons.

How You Compare

This graph shows the distribution of the average time nurses spend in Hyperspace across organizations. The measurement is limited to Registered Nurses in similar shift durations (e.g., 8, 10, 12 hours) and the selected packet peer group.

Active Time in Hyperspace by Category

The double bar graph shows where time is being spent in Hyperspace activities as compared to the organizations in the top quartile. The graph shows the top seven areas where nurses spend time, and all remaining time appears in the Other category. You can see a more detailed breakdown of this information in your NEAT workbook mentioned above.

Monitor BestPractice Advisories (BPAs)

Pop-Up BPAs Acted On

Measures the percentage of inpatient interruptive BPAs (such as pop-up BPAs) presented to nurses with at least one non-acknowledgement reason action taken. Refer to the Reducing Medication Timing Errors Using BestPractice Advisories program for ideas on how to use this metric.

Frequently Presented BPAs with Lowest Acted On %

Displays the BPAs that were presented to nurses most frequently in the reporting period and had low action taken. Consider more targeted display of these alerts or adjusting logic accordingly.

Provide Lean Flowsheets

Nurses spend a lot of time in flowsheets. That data entry is vital for patient care and is a core component in the Cognitive Computing Models below. Help your nurses document this data in real time and more efficiently by improving your Flowsheet content. Work with your Inpatient TS to run the Flowsheet utilization tool to help inform you in that work.

Device Entered Flowsheet Data in ICUs

Percentage of flowsheet values entered by an integrated device compared to the number of values that could have been entered by an integrated device. This metric is limited to values entered from ICU departments where device integration is most prevalent. A single day of data was sampled.

Timely Flowsheet Documentation

Percentage of flowsheet values filed by a nurse within 60 minutes of the value being measured.

Most Used Flowsheet Templates

Flowsheet templates where users spend the most time, along with the number of initial rows show by the template. You can use this information to prioritize build improvements by their impact on nursing practice. Usage data from 409 shifts across 105 clinicans: Mar 22, 2020 - Jul 10, 2020

Flowsheet Features

Consider the following top tier Gold Stars features to help bring added integration, safety, and efficiency to nurses' most-used workspace.

Patient Monitoring

Clinical cognitive computing models use historical trends based on data from patients' charts to predict future events, such as a patient's likelihood of developing sepsis or having an unplanned readmission. These models can help your organization do the most good with the resources you have available by focusing the attention of clinicians, care managers, and administrative staff on the patients who are most likely in need of that attention. These inpatient cognitive computing models are intended to directly affect patient care by driving interventions that reduce negative outcomes, improve care, and lower the costs associated with that care.

Precision Staffing

Epic's precision staffing tools can help your organization granularly evaluate, assign, and monitor nursing workloads for improved clinician satisfaction and patient care. Use scoring tools in Epic to distribute patient assignments, reduce staffing shortfalls, and improve continuity of care.

Feature Toggle Legend

ON On

OFF Off

ON ! On, but not operationalized

N/A Not Applicable to your Organization

Available in a future version

Revenue Cycle Performance Index

This page provides a peer-based comparison of some key revenue cycle measures. It highlights areas of strength and opportunities to improve financial performance.

Financial Pulse Trophies

Your gold (best 5%), silver (best 10%), and bronze (best 25%) metrics compared to the peer group.

0

0

1

Metrics Compared to Median

The number of metrics above and below the peer group median.

1   **5**
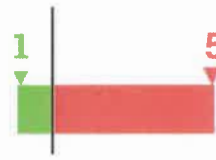
Metric Movement (Since last quarter)

The # of metrics that improved, dropped, or stayed the same compared to last quarter (July 2020).

Improved >5%	**3**
Within 5% of Prior Value	**1**
Declined >5%	**2**

Metrics

*Higher is Better

Hospital Billing		Your Value	Best 25%	▼ You	■ Bottom 25%	■ Middle 50%	■ Best 25%	■ Median
🔴 AR Days	↓16.1%	**55.8**	**32.8**	22.9	32.8	43.1 50.1		66.8
DNFB Days	↓32.0%	**8.7**	**7.5**	5.4	7.5	9.4	11.8	16.4
🔴 Insurance 90+	↑7.3%	**25.0%**	**12.2%**	7.3%	12.2% 16.1%	21.2%		35.0%
Primary Denial Rate	↓29.5%	**12.2%**	**8.9%**	6.2%	8.9% 11.1%	15.0%		24.7%
* Net Collection Ratio	↓7.1%	**90.3%**	**94.2%**	71.5%		85.9%	91.3%	97.2%
🔴 * Clean Paid Claims	→0.0%	**30.0%**	**65.7%**	27.8%		45.9% 56.5%		74.0%

Definitions

Data is collected weekly via Financial Pulse for the service area(s) listed and compared to the peer group as designated below. Financial Pulse trophies are based on this peer group. For more measures and other service areas or comparisons, visit Financial Pulse in Epic or speak with your Financial Performance Analyst.

Service Area	CC WPM PROSSER MEMORIAL HEALTH SA
Peer Group	All Epic
Financial Performance Analyst	Mark Bledsoe - mbledsoe@epic.com

Financial Pulse Trophies

HB Trophies (1 / 18)

🏆 Claim Error Days

Metrics

HB

AR Days	Number of days of outstanding balances in accounts receivable.
DNFB Days	Number of days of balances that have been discharged but have not been final billed.
Insurance 90+	Percentage of insurance balances older than 90 days from discharge.
Primary Denial Rate	Denial rate for payments posted for primary payers.
Net Collection Ratio	Ratio of payments (less refunds) to net charges on fully resolved accounts.
Clean Paid Claims	Percentage of claims resolved that did not require a touch in Epic (no edits or denials).

Revenue Cycle Automation

This page gives a quick glimpse into how often key Revenue Cycle activities take place without anyone at your organization needing to lift a finger. You can learn about opportunities to improve automation within your Revenue Cycle by reviewing the Financial Programs on the UserWeb.

Automation Pulse Trophies

Your gold (best 5%), silver (best 10%), and bronze (best 25%) metrics compared to the peer group.

0 **1** **0**

Metrics Compared to Median

The number of metrics above and below the peer group median.

6
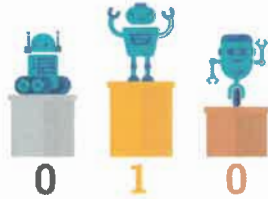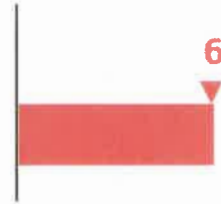
Metric Movement (Since last quarter)

The # of metrics that improved, dropped, or stayed the same compared to last quarter (July 2020).

Improved >5%	**0**
Within 5% of Prior Value	**5**
Declined >5%	**0**

Metrics

		Your Value	Best 25%	▼ You ■ Bottom 25% ■ Middle 50% ■ Best 25% ■ Median
🛑 HB Charges Triggered Clinically	↓0.4%	**97.9%**	**99.7%**	90.8% ... 98.2% 99.1% 99.9%
🛑 HB Outpatient Accounts Coded by SVC	↑N/A	**34.8%**	**85.3%**	8.2% 37.9% 64.9% 96.8%
🛑 HB Consecutive Accounts Auto Combined	→0.0%	**0.0%**	**71.8%**	0.0% 17.6% 42.5% 94.8%
🛑 HB Late Charges Auto Processed	→0.0%	**0.0%**	**71.8%**	0.0% 34.1% 53.7% 92.8%
🛑 HB Payment Plans Using Auto Pay	→0.0%	**0.0%**	**62.0%**	0.0% 34.4% 50.0% 86.1%
🛑 HB Insurance Payments Auto Posted	↑1.1%	**72.6%**	**97.3%**	72.6% 92.0% 95.5% 99.1%

Definitions

Service Area	CC WPM PROSSER MEMORIAL HEALTH SA
Peer Group	All Epic

Automation Pulse Trophies

🏆 HB Estimates Auto Created

Metrics

Metric	Definition	Your Value	Sample Size
HB Charges Triggered Clinically	Percentage of hospital billing charges triggered through clinical workflows instead of back-end revenue cycle workflows, such as Charge Router Charge Entry and Batch Charge Entry.	97.9% *30,515 / 31,167*	416
HB Outpatient Accounts Coded by SVC	Percentage of outpatient non-surgical accounts successfully coded using simple visit coding (SVC).	34.8% *2,202 / 6,321*	385
HB Consecutive Accounts Auto Combined	Percentage of consecutive hospital accounts that were combined automatically using a system action compared to the total number of consecutive accounts that were combined or which had the DNB check overridden. This metric excludes recurring accounts.	0.0% *0 / 80*	268
HB Late Charges Auto Processed	Percentage of late charge processing actions that were automated by a system action.	0.0% *0 / 144*	387
HB Payment Plans Using Auto Pay	Percentage of payments set up to use Auto Pay.	0.0% *0 / 1,161*	282
HB Insurance Payments Auto Posted	Percentage of insurance payments which are posted without user intervention. This includes payments posted via electronic remittance.	72.6% *8,148 / 11,217*	413

Cogito Pulse Benchmarking

Cogito Pulse Benchmarking is Epic's built-in performance benchmarking infrastructure. You can compare your performance on clinical, operational, and financial metrics to peers across the Epic community. A sample of the available metrics are listed below.

Participation Rate & Performance

Published Metrics You Submit

677

0 ————————————————————— 767

How You Compare to Your Peers

Your Metrics in the Best 25%	36%
Your Metrics in the Middle 50%	33%
Your Metrics in the Bottom 25%	31%
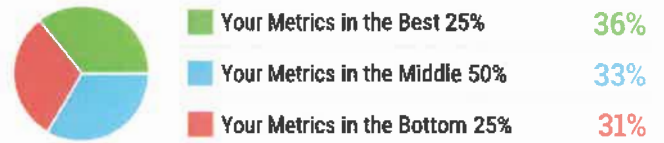
How You Stack Up

Lower is Better

Popular Metrics — Your Value — Your Percentile — You, Bottom 25%, Middle 50%, Best 25%, Median

Metric	Your Value	Your Percentile
* Day of Surgery Cancellations	3.6%	76th
Percent of Inpatient Discharges Before 2 PM	39.9%	45th
Breast Cancer Screening	55.0%	44th
Cervical Cancer Screening	35.5%	38th

Leading the Pack

Metric	Your Value	Your Percentile
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	100%	94th
* Bed Request Turnaround Time - ED Turnaround	73m	90th
* Bed Request Turnaround Time - Bed Ready to Completed	34m	100th

Room for Improvement

Metric	Your Value	Your Percentile
MyChart Enterprise Activation Percentage	21.0%	0th
* Average Wait Time After Check-In	34m	5th
* Diabetes: Hemoglobin A1c Poor Control	47.1%	6th

How You Stack Up

Popular Metrics

Day of Surgery Cancellations

The percentage of day of surgery cancellations. A case is considered canceled if the case is canceled, rescheduled, or marked procedure not performed on the day of surgery. Add-on cases are excluded.

Percent of Inpatient Discharges Before 2 PM

The percent of inpatient discharges completed before 2 PM. A higher value generally indicates a more efficient discharge process.

Breast Cancer Screening

The percentage of women age 50-74 who had a mammogram to screen for breast cancer.

Cervical Cancer Screening

The percentage of women age 21-64 who were screened for cervical cancer using either of the following criteria: age 21-64 and had cervical cytology performed every 3 years, or age 30-64 and had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Leading the Pack

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The percentage of children age 3 months-18 years who were diagnosed with an upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or within three days after the episode.

Bed Request Turnaround Time - ED Turnaround

The average time required to complete a bed request originating in the ED. Incomplete bed requests are excluded. A lower value is better.

Bed Request Turnaround Time - Bed Ready to Completed

The average time elapsed between when a bed request was submitted and when it was completed. Incomplete bed requests are excluded. A lower value is better.

Room for Improvement

MyChart Enterprise Activation Percentage

The percentage of unique patients seen in the previous 12 months who had an active MyChart account.

Average Wait Time After Check-In

The average time a patient waits between check-in and the beginning of rooming. A lower value is better.

Diabetes: Hemoglobin A1c Poor Control

The percentage of patients age 18-75 with diabetes (type 1 or type 2) who had an HbA1c result >9.0% or no HbA1c test result. A lower score is better.

Epic

Epic

To each & everyone of you
who cared for our mom -
                    Ida Van Klinken

Thankyou does not seem
nearly enough for all you have
done for our mom!

Thank you for loving on her
when we could not be there!

Thankyou for your kindness
& patience you showed her!

Thankyou for encouraging
her & helping her regain
some of her strength!

Also for killing the
flies in her room! LOL.

SO THANKFUL FOR YOU.

I thank God for each
of you!

I pray for your protection
& strength to continue
to care for all of those
who need you!

God bless you always
Sincerely,
    Daughter Susan &
all of Ida's family

8-18-20

To

Prosser Memorial Hospital
Staff.
Just want thank you all for caring
for me. While I was in Prosser mem Hosp.

I want to let you know
how much you're appreciated.

You're the best!

Sincerely
Dona Clark

Dr. Sam & Staff,

I want to let you know
how much you're appreciated.

You're the best!

Thank-you for the
bag of goodies, I
loved the blanket.

Maria T. Alvarez

Thank you for my gift.
XOXO
Sofia

Thanks!
Bailey

Tella
S.

Thank-you!
Lisa RNC

Thank you!
Sidney

Thank
you

Thanks
so much!!

Love it!
Thank you!
Mandy

Thank you so much
for the hats and
Gift cards
Cindy

Thank you for
all your LOVE.
♡ mena

Thank you
for everything
you do for
every one of
us ♡ Joanne

Thank you for
everything! Rut.

thank you
for the hats:
gift cards!
— madi

Thank you for
all the gifts you
give us! we really
appreciate it! ☺
Cassi

Thanks! -Jaien

Thanks!

Thank you
for gift cards,♡
Gift cards.
♡ Veronica

Prosser
Memorial Health

September 28, 2020

Dear Prosser Memorial Health Team,

Adversity can make or break a team. People in the military know it. So do coaches and athletes involved in competitive team sports. Ropes challenge courses evolved to create stress and adversity to see how a team would respond. The idea being that when people come together and share a physical or mental stress, they form a close group bond and build trust.

The COVID-19 pandemic has pushed us outside of our comfort zone. We have had to rely on one another as a team as we navigate through the "unknown." As frontline workers, none of us had the luxury of quarantining at home with our family until we knew more about this virus. Instead, we donned our PPE, created a pop-up clinic, and took every safety measure to ensure that our patients and our staff were safe. It has been challenging and stressful and I know there have been times when you have been tired and worried.

Our Prosser Memorial Health family met adversity head on, and we never wavered. Each of you knew what needed to be done and you did it! You shared your opinions and your fears to keep an open dialogue with your fellow team members and we learned from each other as we moved through each day. It hasn't been easy, but no one ever shied away from the challenges we faced. There aren't adequate words to put in a letter to let each of you know how proud I am to work along side of you. Your professionalism, respect for one another, and your dedication and commitment to our patients has been nothing short of awesome to witness.

Enclosed with this letter is a monetary thank you for everything you have done during these challenging times. Our community thanks you, our Board of Commissioners thank you, and I personally thank you. I know it hasn't been easy and I can't promise that there aren't still more challenges ahead, but I know that together we can face whatever comes our way.

You should all be very proud of yourselves and your Prosser Memorial Health family. I am!

With sincere gratitude,

Craig J. Marks
CEO

Bryon Dirkes, MA
695 YELLOWHAWK STREET
WALLA WALLA, WA 99362
MOBILE: 425-359-8635 – WORK: 360-327-8313

https://www.linkedin.com/in/bryon-dirkes-ma-628469a/

Summary of Experience:

Extensive experience in leading large and small Human Resources and Organizational Development teams within highly matrixed, health care continuums with union and non-union employees. Currently hold accountability for leading the delivery of H.R. services for a 24-hour, multi-site, unionized healthcare network in Forks Washington.

Employee Relations	Leadership Development	Employee Engagement	Executive Coaching
Labor Relations / Negotiations	Compensation Administration	Payroll Oversight	Employee Health / Education
Legal Administration	Investigations	Corrective Guidance	Strategic Planning
Process Improvement	Talent Acquisition	Benefits Administration	Policy & Procedure Mgt.

Director, Human Resources: 1/6/2020 – Present
Forks Community Hospital, Forks WA
Lead the Human Resources function in a critical access hospital healthcare continuum, with an acute care hospital, behavioral health program, a network of primary care and specialty clinics, supported by unionized and non-union caregivers, employed and contracted providers. *(My primary home is located in Walla Walla, and I commute to Forks Washington every week.)*

Director, Human Resources: 11/16 – 9/27/2019
Lourdes Health Network /LifePoint, Pasco WA
Lead the Human Resources function supporting Mid-Columbia region's healthcare needs, through an acute care medical center, behavioral health hospital providing both inpatient and outpatient programs, a network of over seventeen primary care and specialty clinics, with numerous other outpatient services, supported by unionized and non-union caregivers, employed and contracted providers.

PROVIDENCE HEALTH & SERVICES - (17 Years)
Kadlec Health System (A Providence Affiliate)
Kadlec Medical Center & Physician Group, Richland, WA
Senior Human Resources Strategic Partner: 5/16 – 11/16
Transferred into a Sr. HR Strategic partner role within the Providence system and held primary responsibility for leading HR services in the Physician network.

Providence Health & Services: 06/1999 – 11/16
Providence Regional Medical Center, Everett, WA
Regional Director (Interim), Human Resources: 04/15 – 11/15
Senior Human Resources Strategic Partner: 1/2013 – 5/16
As a member of the HR Leadership team, provide HR business partner consultation and support in a highly unionized, multi-site, health care organization with more than 3,400 employees and over 78,000 in the Health System. Serve as the representative on system and local efforts for employee engagement and leadership development. Manage day to day leave management, employment efforts, employee/labor relations issues, contract negotiations and grievances management. Coach leaders in performance management and provide individual and team coaching and development.

Director, Organizational Development: 10/2006 – 1/2013
Providence Health & Services, Renton, WA
Set strategy and direction for a team of senior OD consultants in delivering consultation and coaching services impacting over 63,000 employees in four west-coast states. Lead a regional matrixed team of 25+ HR/OD in preparing, deploying and providing diagnostic & coaching services for annual employee engagement survey. Oversee OD efforts for corporate integration, merger & standardization during "One Transformations". Hold accountability for development of annual OD budget and related analysis.

Bryon Dirkes, MA

DIRECTOR, OD / LEADERSHIP DEVELOPMENT: 5/2005 – 10/2006
Providence Regional Medical Center, Everett, WA
As part of the Sr. HR Leadership team, assessed organizational and functional unit needs to develop and deliver leadership development and OD services within the Northwest Region, comprised 3,200 employees working in hospitals, physician clinics, business offices, and supply chain locations. Served as chief representative on councils and task forces governing regional and system-level OD, employee engagement and leadership development efforts. Chaired the *Leadership Development* team comprised of operations directors and managers and responsible for setting learning strategies to address business needs, identifying course content and then building a development team of operational leaders to deliver curriculum. Oversee the deployment of annual employee engagement surveys, diagnostics, leadership coaching, education and action planning efforts. Provide counsel to executive leadership regarding engagement performance and leader accountabilities.

SENIOR MANAGER, HUMAN RESOURCES: 4/2003 – 5/2005
Providence Regional Medical Center, Everett, WA
As a member of the Sr. HR Leadership team, provided strategic direction, leadership, and operational oversight for team of eight professional and administrative HR staff in a multi-site, health care organization with more than 3,200 employees and over 35,000 in the system. Served as the chief representative on system, regional and local-level task forces and councils governing benefits, compensation, HRIS, policy, employee engagement, leadership development and provider privileging and credentialing. Directed the compensation strategies and plans for both union and non-union employees, ensuring market competitiveness. Accountable for benefits administration and compensation administration under three union contracts, including per-pay period adjustment coordination with payroll services.

SENIOR MANAGER, HUMAN RESOURCES: 6/1999 – 4/2003
PROVIDENCE MEDICAL GROUP / PROVIDENCE REGIONAL MEDICAL CENTER, EVERETT, WA
As a member of the executive leadership team, Provided hands-on leadership for the HR operations of a multi-site primary & specialty care physician practice. Partnered with service area human resources staff in brokering benefits, compensation, employee relations, and recruiting services.

DIRECTOR, HUMAN RESOURCES: 1997 - 1999
VALLEY CITIES COUNSELING AND CONSULTATION, AUBURN, WA
As part of the leadership team of a multi-site behavioral health & day treatment health system, was responsible for all aspects of human resources including talent acquisition, performance management, compensation, employee relations, benefits design and administration, employee & leadership development, regulatory and Joint Commission compliance, and physician / credentialing.

DIRECTOR, HUMAN RESOURCES: 1994 - 1996
PROVIDENCE - ST. BRENDAN CARE CENTER, SPOKANE, WA
Led human resources team of eight in providing strategic planning, talent acquisition, employee relations, performance management, benefits design and administration, compensation administration, leadership development employee health and education, infection control compliance, risk management, safety, workers compensation, and payroll administration. Oversight of a State-certified nursing assistant education program providing a pipeline of healthcare talent. Provided 18-month project management input into facility building expansion project, resulting in additional space for increased patient occupancy and higher revenues.

MANAGER, HUMAN RESOURCES: 1992 - 1994
CAROLINE KLINE GALLAND HOME, SEATTLE, WA
Hired to develop a human resources function in a privately held, 24-healthcare center. Accountable for staff general orientation, applicant sourcing, interviewing and selection, workers compensation administration, unemployment management, community calendar preparation and events tracking, personnel file maintenance, federal, state and local compliance documentation and employee relations.

Bryon Dirkes, MA

Professional Qualifications

Master of Arts, Organizational Management, University of Phoenix, Phoenix, AZ

BA Communication Studies, E.W.U., Cheney, WA

<u>Certifications / Specialized Education</u>
- Leading Organizational Design Facilitator / Coach, KatesKessler, Organization Consulting
- Targeted Selection Facilitator / Coach, Development Dimensions International, (DDI)
- Certified Program Management - Targeted Selection, DDI
- Success Profile Analyst, DDI
- Master Trainer / Coach -- Select Interviewing, Select International
- Personalysis Facilitator / Coach, Personalysis Corporation
- Development Dimensions International, Certified Master Trainer /Coach
- Transitions & Change Management Facilitator / Coach, Linkage International
- Lominger Leadership Architects Products Coach, Korn/Ferry Leadership and Talent Consulting
- Q-12 Impact Planning Coach, Gallup Corporation
- Six Sigma CAP & Workout Facilitator / Coach, General Electric
- Five Dysfunctions of a Team Facilitator: Lencioni, The Table Group
- Select Interviewing Facilitator, Select International

Bryon Dirkes, MA

Craig Marks

From:	Shannon Hitchcock
Sent:	Tuesday, October 13, 2020 1:24 PM
To:	!All Staff
Subject:	Employee Engagement Survey Starts October 19

Prosser Memorial Health

Your Feedback Makes a Difference

We care about your work experience with us and want to make Prosser Memorial Health an even better place to work. We are happy to partner with People Element to give you a chance to provide confidential feedback. Your feedback gives us the opportunity to hear the collective voice of our workforce and the ability to take targeted action. Your 2020 Employee Survey will be available to take on October 19. If you complete the survey by October 25, tell your manager and receive a $5 gift card to the Busy Bean! The survey will close on November 13.

YOUR RESPONSES ARE CONFIDENTIAL
We partner with People Element to ensure all individual responses are kept confidential. Only aggregated results will be reported back to Prosser Memorial Health. Your name will not be reported with your responses, so please provide your honest feedback.

YOUR FEEDBACK CAN ASSIST US IN:
- Making this an even better place to work
- Identifying what drives people to be engaged
- Identifying what we do well and what can be improved
- Developing our organization

If you have any questions or concerns about this process, please contact:

Rocky Snider
(509) 788-6027
rsnider@prosserhealth.org

People element

This is how we care.

Prosser Memorial Health Engagement Survey People Element					

No Answer/ Does not Apply	Strongly Disagree	Disagree	Somewhat Agree/Somewhat Disagree	Agree	Strongly Agree
N	1	2	3	4	5

Culture & Climate

Employees	1.	I feel proud to work for Prosser Memorial Health EI*
Employees	2.	I would recommend Prosser Memorial Health as a good place to work EI*
Employees	3.	I plan to be with Prosser Memorial Health at least 1 year from now EI*
Employees	4.	I don't consider looking for a new job elsewhere EI*
Employees	5.	Overall, I am satisfied working at Prosser Memorial Health EI*
Both	6.	I would recommend Prosser Memorial Health to my friends and family for care
Both	7.	There is a high level of respect between medical staff and employees
Both	8.	I agree with the Mission, Vision, and Values of Prosser Memorial Health
Both	9.	Prosser Memorial Health shows recognition for meeting goals
Med Staff	10.	Other physicians treat me as an important element of the health team
Med Staff	11.	I tell others that Prosser Memorial Health is a good place to practice
Med Staff	12.	I am satisfied with my current relationship with Prosser Memorial Health
Med Staff	13.	The hospital sees physicians as important resources

Job Satisfaction

Employees	14.	I am motivated to go beyond what is normally expected of me to help Prosser Memorial Health be successful EI*
Employees	15.	My work gives me a sense of personal accomplishment EI*
Both	16.	My workload allows me to maintain a good work/life balance
Med Staff	17.	I am confident in the medical expertise of the specialists
Med Staff	18.	Prosser Memorial Health is effective in resolving staff concerns
Med Staff	19.	Prosser Memorial Health is effective in resolving patient concerns

Immediate Supervisor (Refers to the person who manages your day-to-day activities)

Employees	20.	My supervisor clearly communicates expectations for my performance
Employees	21.	My supervisor gives me useful feedback on my performance
Employees	22.	My supervisor provides recognition for good work
Employees	23.	My supervisor supports my professional development
Employees	24.	My supervisor is effective in resolving issues
Employees	25.	My supervisor treats employees respectfully

Administration (Refers to the CCO, CEO, CFO, CHRO, CIO, CNO, CMO and CQO)

Both	26.	There is sufficient communication from Administration
Both	27.	Administration communicates a clear vision and plan for Prosser Memorial Health's future
Both	28.	Administration actions show they care about employees and medical staff
Med Staff	29.	Administration effectively balances quality care and fiscal policy
Med Staff	30.	Prosser Memorial Health Administration and physicians are in agreement on organizational goals
Med Staff	31.	The decision-making process at Prosser Memorial Health is fair

Communication

Both	32. Prosser Memorial Health's communication tools (i.e. newsletters, bulletin boards, emails, company website) are useful
Both	33. I trust the information I receive from Prosser Memorial Health
Both	34. I receive important company information in a timely manner
Both	35. I feel comfortable voicing my opinion and offering suggestions
Both	36. My ideas and suggestions are given consideration
Both	37. Communication between departments is effective
Both	38. If you answered 3 or below to the previous item, please explain how communication between departments could be improved
Med Staff	39. Prosser Memorial Health information systems allow for timely and accurate reporting of information
Med Staff	40. Communication between medical staff and nurses is effective

Service & Quality

Employees	41. My coworkers are committed to delivering high quality work
Both	42. Patient satisfaction is a top priority at Prosser Memorial Health
Both	43. I am encouraged to share ideas for improving service and quality
Both	44. Prosser Memorial Health emphasizes the importance of safety
Both	45. Safety standards are consistently enforced
Med Staff	46. I know the plans for improvement and my role

Staffing & Resource Management

Employees	47. I am given flexibility in my schedule when I need it
Employees	48. The amount of work I am expected to do is realistic
Employees	49. I have the resources and equipment I need to be successful at my job
Employees	50. Prosser Memorial Health does a good job of recruiting quality people
Employees	51. There is sufficient staff in my department to maintain quality work

Training & Career Development

Employees	52. Prosser Memorial Health provides me with opportunities to grow professionally
Both	53. I receive adequate training to be successful at my job
Both	54. The EPIC EMR/EHR training helps me better understand the Epic software and my department's Epic workflow
Both	55. I am satisfied with the EPIC EMR/EHR
Med Staff	56. Employees are adequately trained to help me be successful

Compensation & Benefits

Employees	57. I am paid fairly for the work I do
Employees	58. My compensation is competitive with other healthcare organizations in the area
Employees	59. Overall, the benefit package meets my needs
Employees	60. My benefits are competitive with other healthcare organizations in the area
Employees	61. My benefits are clearly communicated so that I understand them

Department Satisfaction: Please indicate your level of overall satisfaction in working with the following departments

No Answer Does Not Apply	Very Dissatisfied	Dissatisfied	Somewhat Agree/Somewhat Disagree	Satisfied	Very Satisfied

N	1	2	3	4	5
62. Cardiopulmonary/Respiratory					
63. Pharmacy					
64. Ambulance					
65. Surgical Services					
66. Family Birthplace					
67. Acute Care Services					
68. Emergency Department					
69. Benton City Clinic					
70. Specialty Clinic					
71. Diagnostic Imaging					
72. Quality Assurance					
73. Laboratory					
74. Marketing/Community Relations					
75. Human Resources					
76. Rehabilitation/Therapy Services					
77. Maintenance					
78. Dietary					
79. Environmental Services					
80. Information Technology (IT)					
81. Payroll/Accounting					
82. Materials Management					
83. Admitting					
84. Patient Financial Services (PFS)/Billing					
85. Health Information Management (HIM)/Medical Records					
86. Administration					
87. Outpatient Special Procedures					
88. Community Paramedic Program					
89. Laundry Services					
90. Prosser Clinic					
91. Social Services					
92. Comprehensive Pain Management Clinic					
93. Grandview Clinic					
94. Prosser Women's Health Clinic					

Comments (Your responses in the following open-ended comment section will remain confidential, meaning that your name will not be associated with each comment; however, any identifiable information included in your comments will be reported as entered.)

95. What do you enjoy most about working at Prosser Memorial Health?

96. What 1 or 2 things would most improve Prosser Memorial Health as a place to work?

Prosser Memorial Health
403B Contribution Matrix

Total Earnings		Average Earnings		Participation Level	45%	55%	65%	73%	80%
$	12,103,330	$	106,170	Contributing	114	139	164	184	201
$	9,857,420	$	71,431	Not Contributing	138	113	88	68	51
$	21,960,750	$	87,146						

	2020	2021	2022	2023	2024
Automatic Contributions	3%	3%	2%	1%	0%
Hospital Contributions	0%	1%	2%	3%	4%
Employee Contributions	0%	1%	2%	3%	4%
Employee Savings Target	3%	5%	6%	7%	8%

	2020	2021	2022	2023	2024
Automatic Contributions	$ 658,823	$ 681,882	$ 470,498	$ 243,483	$ -
Match Contributions	$ -	$ 111,893	$ 222,487	$ 337,780	$ 451,773
Increase in Match Participation	$ -	$ 24,538	$ 97,582	$ 207,409	$ 344,774
	$ 658,823	$ 818,313	$ 790,567	$ 788,672	$ 796,547
Annual Change		$ 159,490	$ (27,745)	$ (1,896)	$ 7,875
Cumulative Change			$ 131,744	$ 129,849	$ 137,724

Prosser
Memorial Health

ANNUAL HALLOWEEN
FESTIVITIES

Pumpkin Decorating and Costume Contest, Ghoulish Grub and more!

Save the Date: Friday, October 30th

Lunch
Lunch will be served in the Vineyard. If you have dietary restrictions let Nora Newhouse know by October 23.

Costume Contest
Take a picture of your department and individual costumes, send them to Shannon Hitchcock and then vote on Sharepoint for the best! All entries will be posted on Sharepoint for voting through November 5. Prizes will be awarded for Best Department Theme (1st and 2nd place AND Best Individual Costume (1st and 2nd place).

Pumpkin Decorating Contest
Employees and Departments will show off their skills decorating or carving a pumpkin. Pick up your pumpkins outside between the hospital and the maintenance building Monday, October 26. Return your pumpkin to the Whitehead Conference room Friday, October 30 by noon. All entries will be posted on Sharepoint for voting through November 5. Prizes will be awarded for Best Department Pumpkin (1st and 2nd place AND Best Individual Pumpkin (1st and 2nd place).

Evening Staff
Stop by the Vineyard between 8-9pm to pick up dinner and your Halloween treat. Take pictures of your pumpkins and costumes and send them to Shannon Hitchcock for entry in the contests.

This is how we$are.

THE PULSE

PROSSER MEMORIAL HEALTH EMPLOYEE NEWSLETTER

OCTOBER 2020

News & Events

Blood Drive

On September 11, PMH hosted a blood drive in partnership with the Red Cross. We had 24 donors including Sara Dawson, pictured here. Some of our Health Occupational Students assisted Red Cross Volunteer Dave throughout the day.

Extended Hours

Beginning September 21, Benton City Clinic will be open Monday–Thursday from 8am-7pm.

Fridays 8am-5pm.

Dr. Carl will see pediatric patients Mondays and Thursdays until 7pm.

This is how we care.

Benton City Clinic
Prosser Memorial Health

509.588.4075
ProsserHealth.org

Benton City Clinic Extended Hours

Beginning September 21, Benton City Clinic will be open Monday-Thursday from 8am-7pm. Fridays 8am-5pm.

October is Physical Therapy Month

Physical Therapists

are movement experts.

Talk to a Physical Therapist today.

Prosser Therapy & Rehab Center
Prosser Memorial Health

509.786.6626 | ProsserHealth.org

STAY TUNED!

More info coming soon on this year's Halloween Costume Contest!

October is Breast Cancer Awareness Month

Mandy Hibbs
Mammographer

Judy McCormick
Mammographer

Heightened Detail 3D Mammography

Call 509.786.5596 to schedule your mammogram.

- High Quality Detailed Images
- Faster Exam Times
- Increased Accuracy
- Patient Friendly Design
- Se Habla Español

Welcome Becky Morris
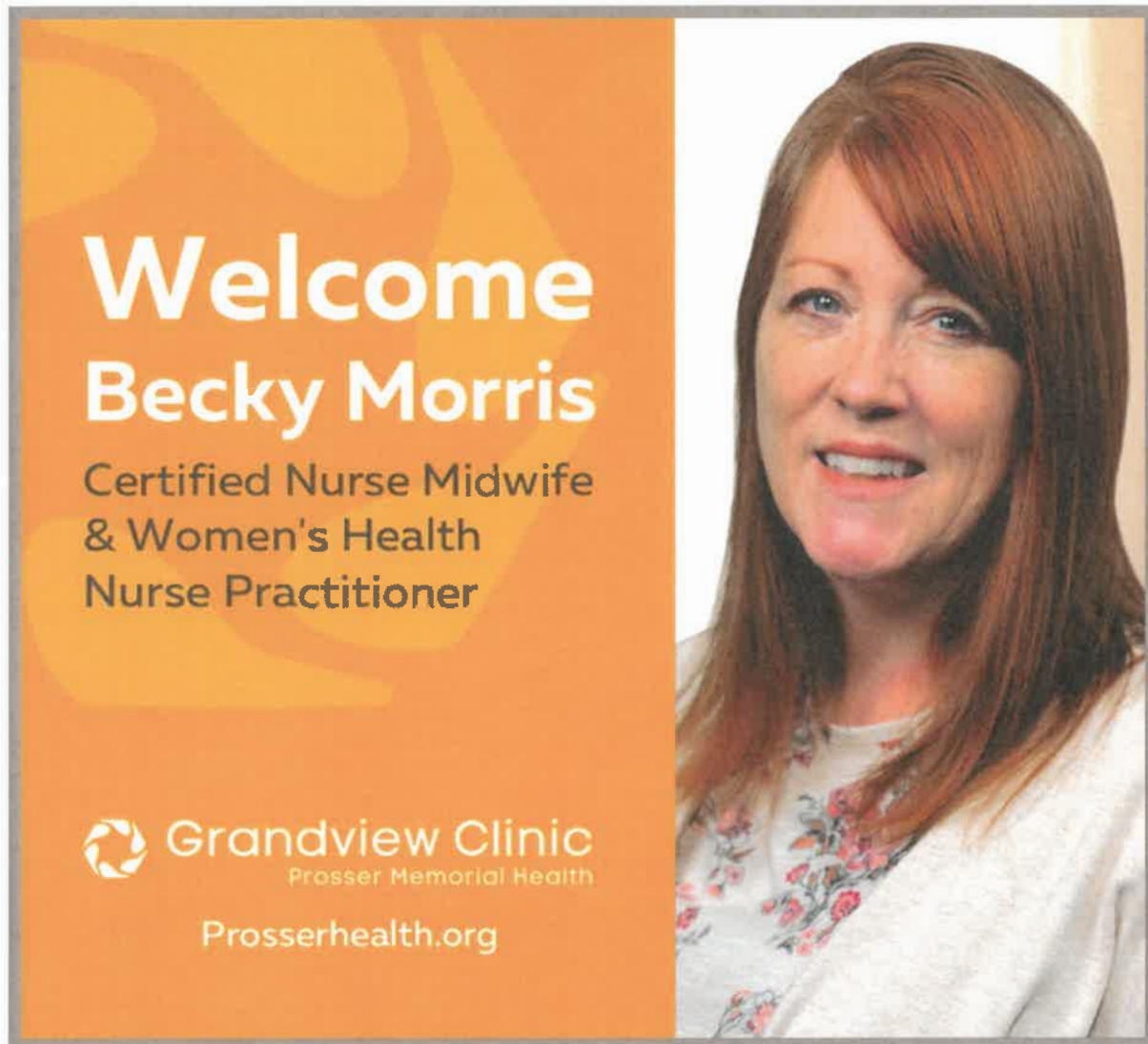
Help us welcome Certified Nurse Midwife & Women's Health Nurse Practitioner Becky Morris, CNM-WHNP, to the team at our Grandview Clinic! Becky's services include women's health, routine exams, pap smear screening, prenatal care, and more. Call the Grandview Clinic at 509.203.1080 to schedule an appointment. Welcome to the PMH Family, Becky!

"I came to Prosser Memorial Health because I believe they are committed to providing women with access to the latest medical technology and care. I look forward to partnering with the Prosser Memorial Health team in supporting and caring for the women of Prosser, Grandview and surrounding areas." - Becky Morris, CNM-WHNP

Welcome to the Team!

Hollie Wood, Wyatt Johnson, Victoria Torrico, Leticia Navarro, Tabitha Troutman, Magdalena Fernandez.

How do you spend your time outside of work?

Hollie Wood, EMT-B: "I love spending time with my fiancé and our 11 animals. I also enjoy stand up paddle boarding and horseback riding."

Wyatt Johnson, EMT-B: "Hunting, fishing, playing games, spending time with the wife/family and hanging out with friends, shooting, golfing."

Victoria Torrico, Nurse Extern: "Playing with kids and spending time with family."

Leticia Navarro, ER Tech: "Spending time with family and crafting."

Tabitha Troutman, Med/Surg Tech: "Camping, playing with my kids, campfires, cooking/baking, raising chickens, dogs, cats, and bearded dragons."

Magdalena Fernandez, Housekeeper/EVS: "I like making candy, watching movies with my kids, coloring with my kids, and hiking."

What have your enjoyed so far working at PMH?

Hollie Wood, EMT-B: "I've enjoyed being a part of a great group of people doing a job that I love."

Wyatt Johnson, EMT-B: "The people. Everyone I've met so far have been so welcoming and kind. I love that kind of environment."

Victoria Torrico, Nurse Extern: "The environment is a wonderful one and makes it nice to come to work."

Leticia Navarro, ER Tech: "Friendly environment and benefits."

Tabitha Troutman, Med/Surg Tech: "My boss, patients and coworkers."

Magdalena Fernandez, Housekeeper/EVS: "Everyone has welcomed me in and have greeted me every time."

Employee
Flu Shots

October 12

7:30 AM – 10:00 AM

October 13

3:30 PM – 5:30 PM

October 23

7:30 AM – 9:30 AM

Location

Vineyard Conference Room

Get Your Flu Shot

Prosser
Memorial Health

509.786.2222
ProsserHealth.org

Anniversaries

Happy 1 Year

Lindsay Mckie
Pharmacist

Alex Carballo-Martinez
MRI Tech

Michelle Smith
Prosser Specialty Clinic RN

Lucia Magana
Prosser Specialty Clinic CMA

Heidi Weaver
Prosser Women's Health Clinic

Maria Padilla
Pharmacy Technician II

Connor Speights
Dietary Cook

Happy 2 Years

Yung Huang
Prosser Specialty Clinic

Lindsay Oswalt
Benton City Clinic CMA

Grady Winn
Paramedic

Happy 3 Years

Victor Silvia-Frayle
Medical Technologist

Jessenia Garcia
Prosser Clinic Patient
Services Rep

Kaylee Swan
Patient Billing Services Collector

Diana Johnson
OP Special Procedure RN

Happy 4 Years

Veronica Flores
Patient Billing Services Collector

Karolynn Thompson
Patient Billing Services Collector

Happy 5 Years

Amanda Schilperoort
Medical/Surgical Acute Care Tech

Andres Vanguardia
Groundskeeper

Tonya Carreon
RN Resources Nurse

Happy 6 Years

Michelle Morgan
Medical/Surgical RN

Happy 8 Years

Cynthia Alaniz
Lab Assistant II

Happy 9 Years

Sunshine Zavala
Housekeeper

Happy 10 Years

Sarah Moritzky
Emergency Department RN

Happy 12 Years

Nancy Sanchez
Patient Registrar

Happy 13 Years

Amanda Hibbs
CT Technologist

Happy 14 Years

Nora Newhouse
HR Generalist

Happy 16 Years

Jessica Gonzalez
Patient Billing Services Collector

Happy 17 Years

Janie Gonzalez
CNA/Unit Secretary

Birthdays

Cynthia Alaniz
Laboratory

Carolyn O'Connor
Prosser Clinic

Andrea Moreno
Medical/Surgical

Rebecca Pettis
Ambulance

Donna Tuning
MIS

Cindi Pineda
Prosser Clinic

Brian Sollers
Prosser Women's Health Center

Sara Benitz
Emergency Department

Diana Ramirez
Patient Billing Services

Kimberly Winters
Medical Records

Teresa Charvet
Prosser Women's Health Center

Jennifer Kernan
Prosser Specialty Clinic

Sergio Merino
Surgical Services

Jonathan Friend
Ambulance

Anna Kellog
Surgical Services

Danielle St. Amant
Radiology

Rosemary Mendoza
Grandview Clinic

Maria Flores
Surgical Services

Maria Rivera
Medical/Surgical

Phillip Braem
MIS

Ernestina Salguero
Housekeeping

Francie Poole
Administration

Sara Dawson
Surgical Services

Erika Raver
Medical/Surgical

Steven Rode
Emergency Department

Diana Wilson
Prosser Specialty Clinic

Hollis Ferritto
Prosser Specialty Clinic

Maria Cardenas
Medical Records

Rodelito Mallari
Laboratory

Maria Rubalcaba
Patient Billing Services

Elizabeth Gonzalez
Labor & Delivery

Samantha Santos
Radiology

Anna Atilano
Medical/Surgical

Mary Dawsey
Accounting

Veronica Huerta Monjes
Labor & Delivery

Thomas Halvorson
Prosser Specialty Clinic

Stephanie Titus
Accounting

Susie Cervantes
Emergency Department

Katy Davis
Nursing Administration

Free 20oz Busy Bean Coffee on your birthday!

ASPIRE Awards

This is how we care.

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

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

Janie Gonzales

Janie was recognized for the excellent patient care she delivers from the moment a surgical patient walks through our front door. Janie greets them in the main lobby and walks them down to the surgical center, talking to them, and answering any questions they might have. She takes extra time and care with our pediatric patients, assuring both patient and parent, that they are in great hands and we will take excellent care of them. Thank you Janie! You truly live our ASPIRE values every day, every shift, and with every patient!

The following PMH team members were nominated for ASPIRE Awards in September. Thank you to all of you!

Ana Martin
ED Tech

Katy Davis
House Supervisor

Ivan Castellanos

Carina Montelongo
CNA, ACU

Meaghan Luther
EVS

Eileen Sheppard
RN, Surgical Services

Jaron Raymond
RN, ED

Rosa Rivera
CNA, Specialty Clinic

Carling Vaux
RN, Surgical Services

Lisa Lewis
RN, Family Birthplace

Gloria Zuniga
MA, Prosser Clinic

Lynn Smith
Medical Staff Coordinator

Low-Carb Autumn Tin Foil Dinners
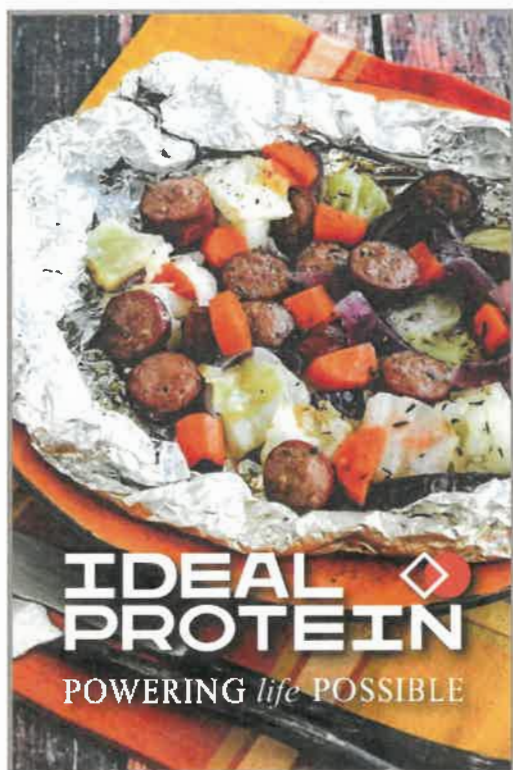
Servings: 4
Prep Time: 15 Min
Cook Time: 35 Min

Ingredients

12 oz. polish sausage

1 small head of cabbage

2 medium carrots

1/2 large red onion

4 tbsp butter

1/2 - 1 tsp. dried thyme

Salt and fresh-ground black pepper to taste

Instructions:

Preheat grill to medium-high or preheat oven to 450F.

Cut up a small or medium-sized head of cabbage into bite-sized chunks.

Slice four sausage links into slices about 3/4 inch thick, cut red onion into thick slivers, and cut carrots into slices or half-moon slices just slightly thinner than the sausage.

Lay out four double sheets of foil big enough to hold all the ingredients when it's wrapped into a packet, and spray foil with non-stick spray.

Divide the cabbage, carrots, and onions so one-fourth is on each set of foil sheets, season the vegetables with salt and fresh-ground black pepper to taste and some dried thyme and add about 1 tablespoon of butter. You can add mushrooms or peppers if you'd like.

Then add the slices of sausage on top of the vegetables.

Wrap the inner packet first, then fold over the outer sheet of foil and tightly roll up the ends.

Cook Autumn Tin Foil Dinners about 20-25 minutes on a grill that's pre-heated to medium high, or cook about 30-35 minutes if you're using the oven. Turn once about half-way through. Serve hot.

Annual Evaluation - 2020

Attachment Y

Date: 09/30/2020

Name	Leader	Department	Division	Job Title	Year Ending
Marks, Craig		Administration		CEO	2020

Total Weight: 100 / 100

Overall Performance Score: 3.10

Overall Performance Score

Pillar	Goal	Rating Description	Result	Total Weight	Score	Weighted Score	Status
Patient Loyalty	Achieve a patient satisfaction score of 86.61% or higher (2019 – 86.6%) (Would Recommend – Weighted): Department Weights below: ED: 15% IP: 20.9% OP Surgery: 15.7% Swing: 6.4% OP: 33.6% Clinic: 8.4%	Units : HCAHPS Percentage Higher is better 5 is 90.61 and above 4 is 88.61 to 90.6 3 is 86.61 to 88.6 2 is 84.61 to 86.6 1 is 84.6 and below	86.61 for Jan thru Aug	30%	3	0.9	(green)
Medical Staff Engagement	Achieve a Medical Staff satisfaction rate of 89.01% or higher (2019 – 89%). Strategic Programs Medical Staff survey – Question #12: I am satisfied with my current relationship with PMH.	Units : Percentage Higher is better 5 is 93.01 and above 4 is 91.01 to 93 3 is 89.01 to 91 2 is 87.01 to 89 1 is 87 and below	89 for Jan thru Jan	20%	2.99	0.6	(yellow)
Employee Engagement	Achieve an annual employee satisfaction rate of 85.61% or higher (2019 – 85.6%). Strategic Program Employee Survey – Question #5: Overall, I am satisfied working at PMH.	Units : Percentage Higher is better 5 is 89.61 and above 4 is 87.61 to 89.6 3 is 85.61 to 87.6 2 is 83.61 to 85.6 1 is 83.6 and below	85.60 for Jan thru Jan	15%	2.99	0.45	(yellow)
Employee Engagement	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 95 to 99.99 3 is 90 to 94.99 2 is 85 to 89.99 1 is 84.99 and below	100 for Apr thru Dec	5%	5	0.25	(green)
Service	Achieve an Adjusted Patient Days Per Day calculation of 56.0 (2019 Budgeted – 20,511/366 = 56.0) or above.	Units : Days Higher is better 5 is 60 and above 4 is 58 to 59.9 3 is 56 to 57.9 2 is 54 to 55.9 1 is 53.9 and below	45.3 for Jan thru Aug	10%	1	0.1	(red)
Quality	Achieve an iVantage Score of 49 or higher	Units : Percentage Higher is better 5 is 55 and above 4 is 52 to 54.9 3 is 49 to 51.9 2 is 46 to 48.9 1 is 45.9 and below	49 for Jan thru Aug	10%	3	0.3	(green)
Finance	Prosser Memorial Health will achieve a percentage variance of budgeted total margin for FY 2019 of 0% or greater. (annual total margin is 7% for 2020). Note: 5% increments	Units : Percentage Higher is better 5 is 6 and above 4 is 3 to 5.9 3 is 0 to 2.9 2 is -3 to -0.1 1 is -3.1 and below	17 for Jan thru Jul	10%	5	0.5	(green)

Curriculum Vitae
Richard Unger, DO

(515) 851-2223

rjungerdo@gmail.com

PROFESSIONAL SUMMARY

General surgeon providing surgical and cesarean section coverage in community hospitals. Also supervision of the wound clinic.

EDUCATION AND TRAINING

1995 Deaconness Hospital, St. Louis, Missouri Surgical Residency

1990 Metropolitan Medical Center, St. Louis, Missouri Rotating Internship

1989 Kirksville College of Osteopathic Medicine, St. Louis, Missouri Doctor of Osteopathy

1985 Olivet Nazarene University, Bourbonnais, Illinois Bachelor of Arts: Chemistry

CERTIFICATIONS AND LICENSURE

ATLS

ACLS

BLS

Wound and Hyperbaric Oxygen

Robotics (Da Vinci)

Licensed in the state of Iowa

Licensed in the state of Missouri (Inactive)

Board Certified, 1998

EMPLOYMENT HISTORY

04/2016-04/2018

Regional Medical Center, Manchester, IA

General Surgeon - Providing surgical and cesarean section coverage - This included robotics

05/2006-04/2016

Boone County Hospital, Boone, IA General Surgeon - Providing surgical and cesarean section coverage for Boone County Hospital - Traveling to Hancock County Hospital in Britt, Iowa for elective procedures once a week - Providing supervision of wound clinic - Starting and supervising a wound center at BCH - This included supervising Hyperbaric oxygen chambers

07/1995-05/2006

Mid Iowa Surgery, Boone, Iowa General Surgeon - Private practice providing surgical coverage to several community hospitals - This included cesarean sections and general surgery - This also included bariatric surgery at Boone

AFFILIATIONS

American Osteopathic Association

American Board of Osteopathic Surgery

MBS for
Prosser Memorial Health

Karan
Bhatti

David
Carl

Teresa
Charvet

Jared
Clifford

Afton
Dunham

Todd
Garrett

Erica
Garza

Thomas
Halvorson

Diane
Hanks

Syed
Hashmi

Yung
Huang

Jessica
Luther

Wali
Martin

Ryan
McDonald

Sarah
Min

Pam
Morris

Rebecca
Morris
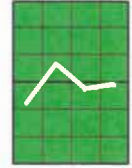
Heather
Morse

Terry
Murphy

Carolyn
O Connor

Bailey
Padilla

Jacobo
Rivero

Steven
Rode

Jose
Santa-Cruz

Lindsey
Smith

Brian
Sollers

Suzanne
Staudinger

Samuel
Strebel

Coral
Tieu
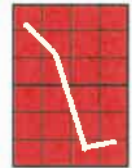
Thomas
Tieu

Derek
Weaver
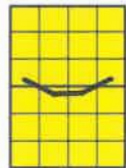
Heidi
Weaver

Rob
Wenger

Susan
Whitaker

Dzmitry
Zhmurouski
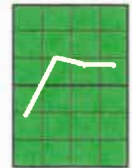
Steven
Zirker

MBS for
Prosser Memorial Health
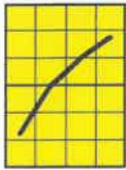
Carol
Allen

Joseph
Ashton

Steve
Broussard

Marla
Davis

Sara
Dawson

Christi
Doornink-Osborn
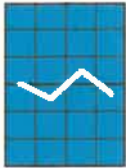
Merry
Fuller

Kevin
Hardiek

Tricia
Hawley

Shannon
Hitchcock

Victor
Huyke

Genny
Judkins

Craig
Marks

Lindsay
McKie
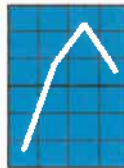
Kristi
Mellema

Susan
Miklas

Alana
Pumphrey

Cinthia
Raymond

Jacobo
Rivero

David
Rollins
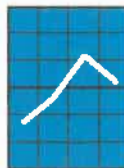
Molly
Schutt

Lynn
Smith

Rocky
Snider

Brian
Sollers

Stephanie
Titus

Andrea
Valle

Aurora
Weddle

Donna
Williams

Rusti
Wilson

Prosser
Memorial Health

Balance Sheet
September 30, 2020

Assets	9/30/2020	8/31/2020	9/30/2019	Liabilities & Fund Balance	9/30/2020	8/31/2020	9/30/2019
Cash & Temporary Investments	16,694,731	17,535,055	1,105,684	Current Portion of Bonds Payable	692,623	652,808	563,989
				Current Portion Capital Leases	-	478,193	342,633
Gross Patient Accounts Receivable	26,457,922	26,185,115	23,681,156	Accounts Payable	1,733,802	1,206,173	1,597,568
Less Allowances for Uncollectible	(16,083,000)	(16,300,000)	(14,188,552)	Payroll & Related Liabilities	2,774,898	2,544,420	2,282,525
Net Patient Receivables	10,374,922	9,885,115	9,492,604	Cost Report Payable	7,344,253	7,527,398	1,882,424
				Other Payables to 3rd Parties	465,709	465,709	830,700
Taxes Receivable	356,917	387,191	359,683	Deferred Tax Revenue	208,397	277,863	208,287
Receivable from 3rd Party Payor	1,712,341	1,355,482	722,000	Deferred EHR Medicare Revenue	82,550	110,067	412,750
Inventory	458,840	452,056	348,717	Deferred COVID Revenue	8,183,503	9,483,503	-
Prepaid Expenses	1,279,402	1,432,124	1,398,715	Accrued Interest Payable	78,679	59,009	81,229
Other Current Assets	156,230	173,038	148,986	Other Current Liabilities	-	-	-
Total Current Assets	31,033,383	31,220,061	13,576,389	Total Current Liabilities	21,564,414	22,805,143	8,202,105
Whitehead Fund - LGIP	1,213,071	1,212,866	1,200,173				
Funded Depreciation - Cash	1,302,545	1,069,591	800,976	Non Current Liabilities			
Funded Depreciation - TVI	14,362,714	14,362,714	13,162,885	Bonds Payable net of CP	10,966,665	10,967,008	11,782,509
Bond Obligation Cash Reserve	767,459	767,446	-	Capital Leases net of CP	1,096,379	1,096,379	169,056
Tax Exempt Lease Funds	1,002,109	1,002,105	1,636,631	Total Non Current Liabilities	12,063,044	12,063,387	11,951,565
Board Designated Assets	18,647,898	18,414,722	16,800,665				
Land	478,396	478,396	478,396	Total Liabilities	33,627,458	34,868,530	20,153,670
Property Plant & Equipment	42,671,241	42,514,694	40,693,367				
Accumulated Depreciation	(27,805,019)	(27,712,257)	(25,387,055)				
Net Property Plant & Equipment	15,344,618	15,280,833	15,784,708	Fund Balance			
				Unrestricted Fund Balance	34,191,546	32,841,782	28,820,285
Investment & Other Non Current Assets	1,047,665	1,049,256	1,066,753	Restricted Fund Balance	-	-	-
Land - Gap Road	1,745,440	1,745,440	1,745,440	Total Fund Balance	34,191,546	32,841,782	28,820,285
Net Investments & Other Non Current Assets	2,793,105	2,794,696	2,812,193				
Total Assets	$ 67,819,004	$ 67,710,312	$ 48,973,955	Total Liabilities & Fund Balance	$ 67,819,004	$ 67,710,312	$ 48,973,955

Prosser Memorial Health

Balance Sheet
September 30, 2020

Assets

	9/30/2020	8/31/2020	12/31/2019
Cash & Temporary Investments	16,694,731	17,535,055	790,127
	-	-	
Gross Patient Accounts Receivable	26,457,922	26,185,115	26,420,075
Less Allowances for Uncollectible	(16,083,000)	(16,300,000)	(15,682,980)
Net Patient Receivables	10,374,922	9,885,115	10,737,095
	-	-	
Taxes Receivable	356,917	387,191	26,908
Receivable from 3rd Party Payor	1,712,341	1,355,482	832,383
Inventory	458,840	452,056	401,623
Prepaid Expenses	1,279,402	1,432,124	1,608,293
Other Current Assets	156,230	173,038	204,486
Total Current Assets	31,033,383	31,220,061	14,600,915
	-	-	
Whitehead Fund - LGIP	1,213,071	1,212,866	1,205,889
Funded Depreciation - Cash	1,302,545	1,069,591	44,372
Funded Depreciation - TVI	14,362,714	14,362,714	13,880,674
Bond Obligation Cash Reserve	767,459	767,446	-
Tax Exempt Lease Funds	1,002,109	1,002,105	346,920
Board Designated Assets	18,647,898	18,414,722	15,477,855
	-	-	
Land	478,396	478,396	478,396
Property Plant & Equipment	42,671,241	42,514,694	41,059,108
Accumulated Depreciation	(27,805,019)	(27,712,257)	(26,030,986)
Net Property Plant & Equipment	15,344,618	15,280,833	15,506,518
	-	-	
Investment & Other Non Current Assets	1,047,665	1,049,256	1,061,981
Land - Gap Road	1,745,440	1,745,440	1,745,440
Net Investments & Other Non Current Assets	2,793,105	2,794,696	2,807,421
Total Assets	**$ 67,819,004**	**$ 67,710,312**	**$ 48,392,709**

Liabilities & Fund Balance

	9/30/2020	8/31/2020	12/31/2019
Current Portion of Bonds Payable	692,623	652,808	447,395
Current Portion Capital Leases	-	478,193	418,578
Accounts Payable	1,733,802	1,206,173	1,217,346
Payroll & Related Liabilities	2,774,898	2,544,420	3,516,028
Cost Report Payable	7,344,253	7,527,398	839,378
Other Payables to 3rd Parties	465,709	465,709	465,709
Deferred Tax Revenue	208,397	277,863	-
Deferred EHR Medicare Revenue	82,550	110,067	330,200
Deferred COVID Revenue	8,183,503	9,483,503	-
Accrued Interest Payable	78,679	59,009	19,670
Other Current Liabilities	-	-	-
Total Current Liabilities	21,564,414	22,805,143	7,254,304
	-	-	
Non Current Liabilities	-	-	
Bonds Payable net of CP	10,966,665	10,967,008	11,511,447
Capital Leases net of CP	1,096,379	1,096,379	-
Total Non Current Liabilities	12,063,044	12,063,387	11,511,447
	0	0	
	-	-	
Total Liabilities	33,627,458	34,868,530	18,765,751
	-	-	
	-	-	
Fund Balance	-	-	
Unrestricted Fund Balance	34,191,546	32,841,782	29,626,958
Restricted Fund Balance	-	-	-
Total Fund Balance	34,191,546	32,841,782	29,626,958
Total Liabilities & Fund Balance	**$ 67,819,004**	**$ 67,710,312**	**$ 48,392,709**

Prosser Memorial Health

Statement of Operations
September 30, 2020

	Month Ending			Prior			Year to Date			Prior	
Actual	Budget	Variance	%	Year	%		Actual	Budget	Variance	%	Year	%
						Gross Patient Services Revenue						
$ 2,669,699	$ 2,875,793	$ (206,094)	-7%	$ 2,501,168	7%	Inpatient	$ 24,887,405	$ 25,730,050	$ (842,645)	-3%	$ 23,804,958	5%
9,721,811	10,469,387	(747,576)	-7%	8,313,652	17%	Outpatient	78,916,507	93,670,815	(14,754,308)	-16%	81,099,501	-3%
12,391,510	13,345,180	(953,670)	-7%	10,814,820	15%	**Total Gross Patient Services Revenue**	103,803,912	119,400,865	(15,596,953)	-13%	104,904,459	-1%
						Deductions from Revenue						
						Contractual Allowances						
1,817,288	2,682,040	864,752	32%	2,181,816	-17%	Medicare	18,456,558	23,996,518	5,539,960	23%	19,935,624	-7%
2,528,387	2,965,665	437,278	15%	1,633,944	55%	Medicaid	22,650,267	26,534,143	3,883,876	15%	22,981,914	-1%
1,799,267	1,713,236	(86,031)	-5%	1,882,777	-4%	Negotiated Rates	13,212,212	15,328,520	2,116,308	14%	13,574,991	-3%
(362,398)	187,341	549,739	293%	96,291	-476%	Other Adjustments	1,472,632	1,676,162	203,530	12%	1,276,046	15%
5,782,544	7,548,282	1,765,738	23%	5,794,828	0%	**Gross Contractual Allowances**	55,791,669	67,535,343	11,743,674	17%	57,768,575	-3%
5,782,544	7,548,282	1,765,738	23%	5,794,828	0%	**Net Contractual Allowances**	55,791,669	67,535,343	11,743,674	17%	57,768,575	-3%
79,533	166,498	86,965	52%	112,577	-29%	Charity Care	1,159,828	1,489,679	329,851	22%	1,365,695	-15%
836,019	351,138	(484,881)	-138%	89,162	838%	Bad Debt	2,928,194	3,141,677	213,483	7%	2,920,547	0%
6,698,096	8,065,918	1,367,822	17%	5,996,567	12%	**Total Deductions From Revenue**	59,879,691	72,166,699	12,287,008	17%	62,054,817	-4%
5,693,414	5,279,262	414,152	8%	4,818,253	18%	**Net Patient Services Revenue**	43,924,221	47,234,166	(3,309,945)	-7%	42,849,642	3%
1,300,000	-	1,300,000	0%	-	0%	COVID Net Revenue	5,115,455	-	5,115,455	0%	-	0%
132,732	171,395	(38,663)	-23%	321,886	-59%	Other Operating Revenue	672,776	870,010	(197,234)	-23%	1,250,611	-46%
7,126,146	5,450,657	1,675,489	31%	5,140,139	39%	**Net Revenue**	49,712,452	48,104,176	1,608,276	3%	44,100,253	13%
						Operating Expenses						
2,802,563	2,385,460	(417,103)	-17%	2,272,947	23%	Salaries	21,724,758	21,348,311	(376,447)	-2%	19,973,337	9%
632,020	551,645	(80,375)	-15%	450,455	40%	Benefits	4,917,754	4,955,404	37,650	1%	4,306,557	14%
277,138	196,270	(80,868)	-41%	264,793	5%	Purchased Labor	2,048,974	1,756,046	(292,928)	-17%	2,109,125	-3%
3,711,721	3,133,375	(578,346)	-18%	2,988,195	24%	**Sub-Total Labor Costs**	28,691,486	28,059,761	(631,725)	-2%	26,389,019	9%
356,882	316,609	(40,273)	-13%	332,200	7%	Professional Fees - Physicians	3,042,293	2,849,483	(192,810)	-7%	2,990,116	2%
17,314	45,205	27,891	62%	5,802	198%	Professional Fees - Other	272,114	406,843	134,729	33%	377,222	-28%
901,242	639,864	(261,378)	-41%	700,353	29%	Supplies	5,789,147	5,797,634	8,487	0%	4,879,231	19%
57,118	44,683	(12,435)	-28%	39,600	44%	Purchased Services - Utilities	420,210	402,148	(18,062)	-4%	362,330	16%
166,143	280,078	113,935	41%	299,771	-45%	Purchased Services - Other	2,337,072	2,524,288	187,216	7%	2,517,503	-7%
172,722	188,579	15,857	8%	166,916	3%	Rentals & Leases	1,538,221	1,697,208	158,987	9%	1,608,505	-4%
77,705	61,442	(16,263)	-26%	69,509	12%	Insurance License & Taxes	626,563	549,412	(77,151)	-14%	552,999	13%
232,977	226,667	(6,310)	-3%	214,609	9%	Depreciation & Amortization	2,060,828	2,040,000	(20,828)	-1%	1,774,886	16%
128,247	122,505	(5,742)	-5%	144,048	-11%	Other Operating Expenses	790,459	1,102,545	312,086	28%	926,545	-15%
2,110,350	1,925,632	(184,718)	-10%	1,972,808	7%	**Sub-Total Non-Labor Expenses**	16,876,907	17,369,561	492,654	3%	15,989,337	6%
5,822,071	5,059,007	(763,064)	-15%	4,961,003	17%	**Total Operating Expenses**	45,568,393	45,429,322	(139,071)	0%	42,378,356	8%
1,304,075	391,650	912,425	233%	179,136	628%	**Operating Income (Loss)**	4,144,059	2,674,854	1,469,205	55%	1,721,897	141%
						Non Operating Income						
69,246	69,466	(220)	0%	69,701	-1%	Tax Revenue	641,618	625,192	16,426	3%	635,745	1%
2,542	22,706	(20,164)	-89%	31,189	-92%	Investment Income	115,500	204,357	(88,857)	-43%	235,705	-51%
(22,420)	(33,632)	11,212	-33%	(76,310)	-71%	Interest Expense	(293,377)	(302,690)	9,313	-3%	(253,604)	16%
-	537	(537)	-100%	-	0%	Other Non Operating Income (Expense)	(39,531)	4,830	(44,361)	-918%	4,937	-901%
49,368	59,077	(9,709)	-16%	24,580	101%	**Total Non Operating Income**	424,210	531,689	(107,479)	-20%	622,783	-32%
$ 1,353,443	$ 450,727	$ 902,716	200%	$ 203,716	564%	**Net Income (Loss)**	$ 4,568,269	$ 3,206,543	$ 1,361,726	42%	$ 2,344,680	95%

Prosser
Memorial Health
Statement of Cash Flows
September 30, 2020

CURRENT MONTH Actual		YEAR TO DATE Actual
	NET INCOME TO NET CASH BY OPERATIONS	
1,353,443	**NET INCOME (LOSS)**	4,568,269
232,977	Depreciation Expense	2,060,828
-	Amortization	-
-	Loss (Gain) on Sale of Assets	43,731
1,586,420	**TOTAL**	6,672,828
	WORKING CAPITAL	
(653,646)	Decrease (Increase) In Assets	527,864
(1,240,729)	Increase (Decrease) in Liabilities	14,310,110
(307,955)	**NET CASH PROVIDED BY OPERATIONS**	21,510,802
	CASH FLOWS FROM INVESTING ACTIVITIES	
(170,231)	Capital Purchasing	(2,659,868)
13,684	Proceeds on Capital Assets Sold	14,184
(142,646)	Investment Activity	209,529
(299,193)	**NET CASH USED BY INVESTING ACTIVITIES**	(2,436,155)
(607,148)	**NET CHANGE IN CASH**	19,074,647
	CASH BALANCE	
35,949,777	**BEGINNING**	16,267,982
35,342,629	**ENDING**	35,342,629
(607,148)	**NET CASH FLOW**	19,074,647

Prosser
Memorial Health
Statement of Cash Flows - 12 Month Trend
September 30, 2020

	Sep-19 Actual	Oct-19 Actual	Nov-19 Actual	Dec-19 Actual	Jan-20 Actual	Feb-20 Actual	Mar-20 Actual	Apr-20 Actual	May-20 Actual	Jun-20 Actual	Jul-20 Actual
NET INCOME TO NET CASH BY OPERATIONS											
NET INCOME (LOSS)	203,716	281,784	(360,709)	369,020	240,864	(120,425)	(149,776)	986,436	1,070,603	2,224,029	182,430
Depreciation Expense	214,609	222,284	222,109	224,314	222,577	227,538	224,010	228,367	229,348	231,347	232,391
Amortization	-	-	-	-	-	-	-	-	-	-	-
Loss (Gain) on Sale of Assets	-	-	-	-	-	-	-	(500)	(13,684)	57,915	57,915
TOTAL	418,325	504,068	(138,600)	593,334	463,441	107,113	74,234	1,214,303	1,286,267	2,513,291	472,736
WORKING CAPITAL											
Decrease (Increase) in Assets	(1,351,916)	(492,108)	14,884	(645,214)	(518,949)	(469,109)	555,768	(2,528,363)	3,723,881	(486,472)	(318,018)
Increase (Decrease) in Liabilities	666,840	109,671	83,018	(772,023)	(648,957)	83,249	262,126	9,360,425	6,000,562	(1,245,038)	150,847
NET CASH PROVIDED BY OPERATIONS	(266,751)	121,631	(40,698)	(823,903)	(704,465)	(278,747)	892,128	8,046,365	11,010,710	781,781	305,565
CASH FLOWS FROM INVESTING ACTIVITIES											
Capital Purchasing	(842,075)	(193,078)	(380,203)	207,539	(292,919)	(35,283)	(124,590)	(350,621)	(231,586)	(44,273)	(95,029)
Proceeds on Capital Assets Sold	-	-	-	-	-	-	-	500	13,684	13,684	13,684
Investment Activity	(354)	(20,139)	248,949	(758,465)	69,190	95,603	(343)	993,481	(542,037)	(15,858)	(346)
NET CASH USED BY INVESTING ACTIVITIES	(842,429)	(213,217)	(131,254)	(550,926)	(223,729)	60,320	(124,933)	643,360	(759,939)	(46,447)	(81,691)
NET CHANGE IN CASH	(1,109,180)	(91,586)	(171,952)	(1,374,829)	(928,194)	(218,427)	767,195	8,689,725	10,250,771	735,334	223,874
CASH BALANCE											
BEGINNING	19,015,529	17,906,349	17,814,763	17,642,811	16,267,982	15,339,788	15,121,361	15,888,556	24,578,281	34,829,052	35,564,386
ENDING	17,906,349	17,814,763	17,642,811	16,267,982	15,339,788	15,121,361	15,888,556	24,578,281	34,829,052	35,564,386	35,788,260
NET CASH FLOW	(1,109,180)	(91,586)	(171,952)	(1,374,829)	(928,194)	(218,427)	767,195	8,689,725	10,250,771	735,334	223,874

Prosser
Memorial Health
Direct Cash Flow Statement
September 30, 2020

	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020
CASH FLOWS FROM OPERATING												
PAYMENTS RECEIVED												
Commercial		1,425,376	1,658,587	1,712,336	2,110,960	2,164,596	1,790,819	2,042,936	2,163,134	1,479,262	1,568,932	1,966,089
Medicaid		974,783	1,332,291	1,150,609	1,223,633	1,287,731	1,116,011	1,207,273	1,200,088	1,130,387	1,262,461	1,296,508
Medicare		501,296	1,299,895	1,316,188	1,730,631	1,555,473	597,037	1,403,309	1,326,305	808,729	1,045,301	949,542
VA		41,311	10,616	28,210	26,049	24,261	82,909	34,277	86,268	45,965	70,641	70,064
Worker's Comp		74,716	98,824	126,432	66,062	396,141	180,120	165,706	151,215	95,669	83,546	248,425
Self Pay		263,000	265,218	680,997	265,490	37,674	182,202	162,759	149,324	131,139	128,649	132,739
Other Non Patient Payments		497,206	364,841	287,781	660,275	212,931	210,958	475,782	8,941,682	10,681,077	971,815	1,655,778
Cash Received (Patients, Insurance, Other)	5,118,733	3,777,628	5,030,272	5,252,553	6,083,101	5,678,807	4,160,056	5,492,042	14,018,016	14,372,228	5,131,345	6,319,145
Patient Refunds	(14,770)	(5,755)	(106,029)	(7,988)	(6,268)	(4,845)	(4,203)	(4,127)	(1,869)	(4,541)	(27,317)	(5,139)
AP Expenses	(2,054,652)	(1,764,710)	(2,578,749)	(2,649,740)	(3,762,411)	(2,627,585)	(2,059,339)	(2,101,189)	(2,556,196)	(1,622,076)	(1,936,338)	(2,292,598)
Settlement LumpSum Payments					(1,187,000)	-	-		-			
Payroll Expenses	(3,418,696)	(2,216,802)	(2,186,535)	(2,329,107)	(2,652,323)	(3,566,717)	(2,279,658)	(2,437,474)	(2,362,138)	(2,148,321)	(2,270,065)	(3,645,038)
Loan/Interest Expense	(57,467)	(57,467)	(57,467)	(57,467)	(57,467)	(114,934)	-	(57,467)	(57,467)	(114,934)	(118,019)	(57,467)
NET CASH PROVIDED BY OPERATING	(426,852)	(267,105)	101,492	208,251	(1,582,368)	(635,275)	(183,144)	891,785	9,040,346	10,482,357	779,607	318,903
CASH FLOWS FROM INVESTING ACTIVITIES												
Capital Purchasing	(151,396)	(842,075)	(193,078)	(380,203)	207,539	(292,919)	(35,283)	(124,590)	(350,621)	(231,586)	(44,273)	(95,029)
NET CASH USED BY INVESTING ACTIVITIES	(151,396)	(842,075)	(193,078)	(380,203)	207,539	(292,919)	(35,283)	(124,590)	(350,621)	(231,586)	(44,273)	(95,029)
NET CHANGE IN CASH	(578,248)	(1,109,180)	(91,586)	(171,952)	(1,374,829)	(928,194)	(218,427)	767,195	8,689,725	10,250,771	735,334	223,874
CASH BALANCE												
BEGINNING	19,593,777	19,015,529	17,906,349	17,814,763	17,642,811	16,267,982	15,339,788	15,121,361	15,888,556	24,578,281	34,829,052	35,564,386
ENDING	19,015,529	17,906,349	17,814,763	17,642,811	16,267,982	15,339,788	15,121,361	15,888,556	24,578,281	34,829,052	35,564,386	35,788,260
NET CASH FLOW	(578,248)	(1,109,180)	(91,586)	(171,952)	(1,374,829)	(928,194)	(218,427)	767,195	8,689,725	10,250,771	735,334	223,874

Prosser
Memorial Health

Key Operating Statistics
September 30, 2020

Month Ending					Year to Date				Prior	Change
Actual	Budget	Variance	%		Actual	Budget	Variance	%	Year	
				Key Volumes						
191	204	(13)	-6%	Inpatient Acute Days	1,768	1,862	(94)	-5%	1,794	-1%
97	172	(75)	-44%	Inpatient Swing Days	1,148	1,571	(423)	-27%	1,506	-24%
288	376	(88)	-23%	**Total Inpatient Days**	2,916	3,434	(518)	-15%	3,300	-12%
87	82	5	6%	Inpatient Admissions	761	748	13	2%	748	2%
85	82	3	4%	Inpatient Discharges	760	748	12	2%	755	1%
9	12	(3)	-28%	Swing Bed Discharges	83	114	(31)	-27%	100	-17%
1,337	1,745	(408)	-23%	Adjusted Patient Days	12,162	15,934	(3,771)	-24%	14,543	-16%
9.60	12.53	(2.93)	-23%	Average Daily Census	10.64	12.53	(1.89)	-15%	12.09	-12%
395	380	15	4%	Adjusted Discharges	3,170	3,470	(300)	-9%	3,327	-5%
2.25	2.49	(0.24)	-10%	Average Length of Stay - Hospital	2.33	2.49	(0.16)	-7%	2.38	-2%
10.78	13.77	(2.99)	-22%	Average Length of Stay - Swing Bed	13.83	13.77	0.06	0%	15.06	-8%
38%	50%	-12%	-23%	Acute Care Occupancy (25)	43%	50%	-8%	-15%	48%	-12%
45	37	8	22%	Deliveries	365	338	27	8%	328	11%
101	124	(23)	-19%	Surgical Procedures	834	1,134	(300)	-26%	1,083	-23%
767	1,008	(241)	-24%	Emergency Dept Visits	7,339	9,211	(1,872)	-20%	8,935	-18%
12,306	12,094	212	2%	Laboratory Tests	102,629	110,456	(7,827)	-7%	101,026	2%
2,348	2,087	261	13%	Radiology Exams	19,060	19,060	0	0%	16,819	13%
1,027	1,048	(21)	-2%	PMH Specialty Clinic	8,451	9,575	(1,124)	-12%	8,586	-2%
897	991	(94)	-10%	PMH - Benton City Clinic Visits	7,874	9,055	(1,181)	-13%	8,493	-7%
1,552	1,038	514	50%	PMH - Prosser Clinic Visits	10,136	9,478	658	7%	8,609	18%
578	610	(32)	-5%	PMH - Grandview Clinic Visits	5,508	5,568	(60)	-1%	4,807	15%
629	699	(70)	-10%	PMH - Women's Health Clinic Visits	5,290	6,383	(1,093)	-17%	3,813	39%
				LABOR FULL-TIME EQUIVALENT						
265.59	290.82	25.23	9%	Employed Staff FTE's	262.45	290.82	28.37	10%	260.49	1%
28.99	30.48	1.49	5%	Employed Provider FTE	29.26	30.48	1.22	4%	26.36	11%
294.58	321.30	26.72	8%	All Employee FTE's	291.71	321.30	29.59	9%	286.85	2%
257.26	273.11	15.85	6%	Productive FTE's	256.34	273.11	16.77	6%	252.10	2%
14.83	20.86	6.03	29%	Outsourced Therapy FTE's	13.86	20.86	7.00	34%	16.44	-16%
3.85	1.56	(2.29)	-147%	Contracted Staff FTE's	4.19	4.07	(0.12)	-3%	4.15	1%
18.68	22.42	3.74		All Purchased Staff FTE's	18.05	22.42	6.88	31%	20.59	-12%
7.25	4.58	(2.67)	-58%	Contracted Provider FTE's	6.92	4.58	(2.34)	-51%	5.73	21%
320.51	348.30	27.79	8%	All Labor FTE's	316.68	348.30	34.13	10%	313.17	1%

Prosser
Memorial Health
Financial Operations
September 30, 2020

	YTD 2019	YTD 2020	YTD Budget 2020
Utilization			
Admissions	748	761	748
Adjusted Admissions	3,296	3,174	3,470
Average Daily Census	6.5	6.5	6.8
Adjusted Occupied Beds	28.9	26.9	31.5
Average Length of Stay (days)	2.4	2.3	2.5
Outpatient Revenue %	77.3%	76.0%	78.5%
Total Yield (net patient revenue)	53.0%	45.4%	66.9%
Hospital Case Mix Index	TBD	0.99	1.00
Financial Performance ($000)			
Net Patient Revenue	42,850	43,924	47,234
Total Operating Revenue	44,100	49,712	48,104
Total Operating Expense	42,378	45,568	45,429
Income (Loss) from Operations	1,722	4,144	2,675
Excess of Revenue Over Expenses	2,345	4,568	3,207
EBIDA (Operating Cash Flow)	3,497	6,205	4,715
Additions to Property, Plant, and Equipment	4,967	2,660	559
Balance Sheet ($000)			
Unrestricted Cash and Investments	1,106	16,695	3,915
Accounts Receivable (gross)	23,681	26,458	17,104
Net Fixed Assets	15,785	15,345	12,758
Current and Long-Term Liabilities (excluding LT debt)	8,202	21,564	5,413
Long-Term Debt	11,783	10,967	6,441
Total Liabilities	19,985	32,531	11,854
Net Worth	28,820	34,192	29,769
Key Ratios			
Operating Margin (%)	3.9%	8.3%	5.6%
Excess Margin (%)	5.3%	10.2%	6.7%
Operating EBIDA Margin (Operating Cash Flow)	7.9%	12.5%	9.8%
Average Expense per Adjusted Patient Days	3,747	2,851	2,914
Net Accounts Receivable (days)	58.98	57.18	54.07
Current Ratio (x)	1.66	1.44	1.55
Cash on Hand (days)	120.84	222.58	120.39
Cushion Ratio (x)	70.61	120.47	53.80
Return on Equity (%)	8.14%	13.36%	13.33%
Capital Spending Ratio	1.64	2.49	5.13
Average Age of Plant (Years)	10.73	10.12	10.84
Debt Service	2.59	6.60	4.58
Debt-to-Capitalization (%)	31%	27%	27.07%
Patient Revenue Sources by Gross Revenue (%)			
Medicare	31.5%	29.7%	31.5%
Medicaid	31.8%	32.1%	31.7%
Commercial Insurance	28.6%	28.9%	28.7%
Self-pay and Other	8.1%	9.3%	8.1%
Labor Metrics			
Productive FTE's (incl contract labor)	278.42	281.31	300.11
Total FTE's (incl contract labor)	313.17	316.68	348.30
Labor Cost (incl benefits) per FTE - Annualized	84,264.20	90,600.88	80,562.05
Labor Cost (incl benefits) as a % of Net Operating Revenue	59.8%	57.7%	58.3%
Net Operating Revenue per FTE	140,818.89	156,980.08	138,111.33
Operating Expense per FTE	135,320.61	143,894.13	130,431.59

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Prosser
Memorial Health

Revenue by Financial Class
September 30, 2020

Month	Medicare	Medicaid	Commercial Insurance	Self Pay and Other	Total
JAN	33.3%	32.3%	27.1%	7.4%	100.0%
FEB	33.6%	30.5%	27.7%	8.1%	100.0%
MAR	27.9%	32.0%	31.7%	8.4%	100.0%
APR	28.1%	31.3%	29.7%	10.8%	100.0%
MAY	31.9%	29.3%	28.1%	10.6%	100.0%
JUN	26.0%	32.3%	30.0%	11.7%	100.0%
JUL	25.8%	35.2%	31.3%	7.6%	100.0%
AUG	31.4%	31.8%	27.4%	9.4%	100.0%
SEPT	28.5%	32.9%	27.8%	10.8%	100.0%
OCT					
NOV					
DEC					
YTD 2020	29.7%	32.1%	28.9%	9.3%	100.0%
2019	31.5%	31.8%	28.6%	8.1%	100.0%

2020 Gross Revenue by Financial Class
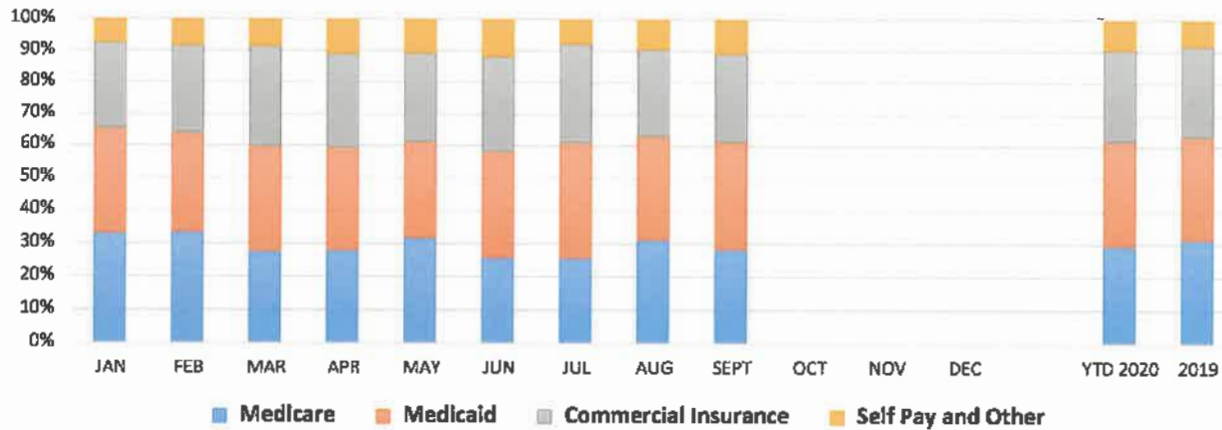
Legend: Medicare, Medicaid, Commercial Insurance, Self Pay and Other

Prosser
Memorial Health
Net Revenue by Financial Class
September 30, 2020

Month	Medicare	Medicaid	Commercial Insurance	Self Pay and Other	Total
JAN	28.2%	23.9%	44.7%	3.2%	100.0%
FEB	25.2%	20.8%	44.1%	9.8%	100.0%
MAR	24.4%	24.3%	44.6%	6.8%	100.0%
APR	29.2%	24.9%	41.2%	4.7%	100.0%
MAY	34.2%	15.3%	36.9%	13.5%	100.0%
JUN	18.4%	25.8%	40.0%	15.8%	100.0%
JUL	20.6%	31.0%	45.8%	2.6%	100.0%
AUG	33.8%	18.4%	34.0%	13.7%	100.0%
SEPT	15.9%	26.6%	37.3%	20.2%	100.0%
OCT					
NOV					
DEC					
YTD 2020	23.4%	24.1%	41.2%	11.3%	100.0%
2019	29.4%	21.7%	38.8%	10.2%	100.0%

2020 Net Revenue by Financial Class
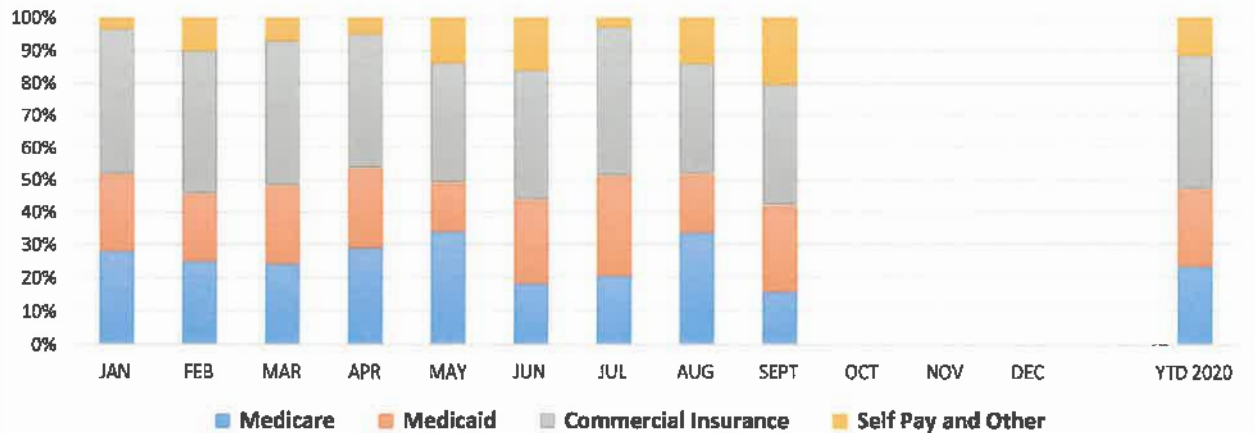
Prosser
Memorial Health
Statement of Operations 13-month Trend

	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Gross Patient Services Revenue														
Inpatient	$ 2,526,300	$ 2,501,168	$ 3,012,630	$ 2,617,549	$ 2,864,852	$ 2,864,636	$ 3,010,011	$ 2,635,344	$ 2,206,745	$ 2,520,235	$ 3,042,365	$ 3,178,603	$ 2,759,767	$ 2,669,699
Outpatient	8,421,340	8,313,652	9,717,569	8,716,943	10,233,791	10,071,001	9,445,153	8,882,599	5,357,211	6,692,398	9,162,181	9,501,319	10,082,833	9,721,811
Total Gross Patient Services Revenue	10,947,640	10,814,820	12,730,199	11,334,492	13,098,643	12,935,637	12,455,164	11,517,943	7,563,956	9,212,633	12,204,546	12,679,922	12,842,600	12,391,510
Deductions from Revenue	59%	55%	59%	59%	52%	59%	61%	57%	50%	54%	37%	60%	62%	54%
Contractual Allowances														
Medicare	2,000,591	2,181,816	2,860,807	2,234,020	2,611,913	2,632,393	2,720,808	1,772,267	995,183	1,611,449	2,019,352	2,123,486	2,764,934	1,817,288
Medicaid	2,250,702	1,633,944	2,626,636	3,351,182	2,593,535	2,462,158	2,881,363	2,364,561	2,088,300	1,938,730	2,427,413	3,115,446	2,843,908	2,528,387
Negotiated Rates	1,484,291	1,882,777	1,698,297	490,384	1,053,995	1,970,832	1,535,802	1,559,890	363,732	1,146,693	1,738,176	1,625,968	1,471,853	1,799,267
Other Adjustments	236,997	96,291	117,115	12,337	(62,054)	152,100	143,288	395,710	40,602	(68,462)	265,524	291,657	496,025	(362,398)
Gross Contractual Allowances	5,972,581	5,794,828	7,302,855	6,087,923	6,197,389	7,217,483	7,281,261	6,092,428	3,487,817	4,628,410	6,450,465	7,156,557	7,576,120	5,782,544
Charity Care	238,673	112,577	89,746	182,296	34,095	70,465	207,726	147,685	40,927	49,448	149,222	337,712	77,110	79,533
Bad Debt	299,799	89,162	154,222	442,390	514,437	366,493	154,253	325,725	268,555	255,700	326,276	138,652	256,521	836,019
Total Deductions From Revenue	6,511,053	5,996,567	7,546,823	6,712,609	6,745,921	7,654,441	7,643,240	6,565,838	3,797,299	4,933,558	6,925,963	7,632,921	7,909,751	6,698,096
Net Patient Services Revenue	4,436,587	4,818,253	5,183,376	4,621,883	6,352,722	5,281,196	4,811,924	4,952,105	3,766,657	4,279,075	5,278,583	5,047,001	4,932,849	5,693,414
COVID Grant Revenue									2,210,384	1,325,149	1,481,428	205,582	(1,407,088)	1,300,000
Other Operating Revenue	119,837	321,886	44,074	144,372	60,565	54,446	48,156	79,111	49,953	64,385	58,859	61,424	125,401	132,732
Net Revenue	4,556,424	5,140,139	5,227,450	4,766,255	6,413,287	5,335,642	4,860,080	5,031,216	6,026,994	5,668,609	6,818,870	5,314,007	3,651,162	3,651,162
Operating Expenses														
Salaries	2,186,403	2,272,947	2,282,644	2,333,751	2,596,017	2,390,097	2,319,195	2,438,079	2,243,147	2,292,652	2,362,460	2,472,695	2,378,145	2,802,563
Benefits	397,207	450,455	611,076	503,958	765,786	577,012	555,392	440,583	739,833	604,325	419,678	578,549	396,087	632,020
Purchased Labor	236,659	264,793	217,501	246,218	268,266	249,096	283,557	329,407	261,699	135,882	166,436	169,347	176,412	277,138
Sub-Total Labor Costs	2,820,269	2,988,195	3,111,221	3,083,927	3,630,069	3,216,205	3,158,144	3,208,069	3,244,679	3,032,859	2,948,574	3,220,591	2,950,644	3,711,721
Professional Fees - Physicians	355,202	332,200	310,244	352,355	377,019	389,778	279,808	267,635	419,725	288,245	326,140	320,182	393,900	356,882
Professional Fees - Other	40,503	5,802	27,900	57,445	37,967	43,960	58,785	19,051	93,438	49,659	64,682	37,919	(112,693)	17,314
Supplies	493,079	700,353	725,859	764,707	622,645	619,449	675,545	762,215	527,615	481,223	516,166	689,329	720,675	901,242
Purchased Services - Utilities	44,577	39,600	42,598	48,996	37,860	43,249	43,969	40,757	31,315	46,337	46,325	59,031	52,110	57,118
Purchased Services - Other	251,437	299,771	233,945	314,069	269,828	261,428	230,546	359,733	222,165	228,231	255,449	279,915	352,210	166,143
Rentals & Leases	173,040	166,916	168,981	168,019	186,792	194,404	170,987	167,981	152,417	153,829	180,783	176,162	168,937	172,722
Insurance License & Taxes	77,077	69,509	69,709	52,025	63,642	60,430	99,269	87,383	85,150	58,860	36,853	39,883	91,582	77,705
Depreciation & Amortization	207,017	214,609	222,284	222,109	224,314	222,577	227,538	224,010	228,367	229,348	231,347	232,391	232,273	232,977
Other Operating Expenses	101,333	144,048	143,821	135,294	40,759	104,447	103,657	107,679	92,318	92,182	(21,863)	114,301	56,152	128,247
Sub-Total Non-Labor Expenses	1,743,265	1,972,808	1,945,341	2,115,019	1,860,226	1,939,722	1,890,104	2,036,444	1,852,510	1,627,914	1,635,882	1,949,113	1,955,146	2,110,350
Total Operating Expenses	4,563,534	4,961,003	5,056,562	5,198,946	5,490,295	5,155,927	5,048,248	5,244,513	5,097,189	4,660,773	4,584,456	5,169,704	4,905,790	5,822,071
Operating Income (Loss)	(7,110)	179,136	170,888	(432,691)	922,992	179,715	(188,168)	(213,297)	929,805	1,007,836	2,234,414	144,303	(1,254,628)	1,304,075
Non Operating Income														
Tax Revenue	70,601	69,701	71,945	69,785	69,205	71,840	65,599	77,314	73,881	69,589	70,784	72,711	71,007	69,246
Investment Income	31,673	31,189	20,703	21,943	24,574	22,527	22,036	19,425	18,000	12,391	12,242	3,385	2,600	2,542
Interest Expense	(34,475)	(76,310)	(34,270)	(34,166)	(33,322)	(32,996)	(19,892)	(33,218)	(35,750)	(32,897)	(35,496)	(37,969)	(42,518)	(22,420)
Other Non Operating Income (Expense)	9,200	-	52,518	14,420	-	(222)	-	-	500	13,684	(57,915)	-	4,200	-
Total Non Operating Income	76,999	24,580	110,896	71,982	60,457	61,149	67,743	63,521	56,631	62,767	(10,385)	38,127	35,289	49,368
Net Income (Loss)	$ 69,889	$ 203,716	$ 281,784	$ (360,709)	$ 983,449	$ 240,864	$ (120,425)	$ (149,776)	$ 986,436	$ 1,070,603	$ 2,224,029	$ 182,430	$ (1,219,339)	$ 1,353,443
Total Margin	1.5%	3.9%	5.3%	-7.5%	15.2%	4.5%	-2.4%	-2.9%	16.2%	18.7%	32.7%	3.4%	-33.1%	36.6%
Margin (Non Operating Income)	-0.2%	3.5%	3.3%	-9.1%	14.4%	3.4%	-3.9%	-4.2%	15.4%	17.8%	32.8%	2.7%	-34.4%	35.7%
Salaries as a % of Net Revenue	48.0%	44.2%	43.7%	49.0%	40.5%	44.8%	47.7%	48.5%	37.2%	40.4%	34.6%	46.5%	65.1%	76.8%
Labor as a % of Net Revenue	61.9%	58.1%	59.5%	64.7%	56.6%	60.3%	65.0%	63.8%	53.8%	53.5%	43.2%	60.6%	80.8%	101.7%
Operating Expense change from prior month	2%	9%	2%	3%	6%	-6%	-2%	4%	-3%	-9%	-2%	13%	-5%	19%
Gross Revenue change from prior month	-4%	-1%	18%	-11%	16%	-1%	-4%	-8%	-34%	22%	32%	4%	1%	-4%
Net Revenue change from prior month	19%	13%	2%	-9%	35%	-17%	-9%	4%	20%	-6%	20%	-22%	-31%	0%

Prosser Memorial Health

Legend:
- Total Gross Patient Services Revenue
- Gross Contractual Allowances
- Total Deductions From Revenue
- Net Patient Services Revenue
- Sub-Total Labor Costs
- Total Operating Expenses

X-axis: Aug-19, Sep-19, Oct-19, Nov-19, Dec-19, Jan-20, Feb-20, Mar-20, Apr-20, May-20, Jun-20, Jul-20, Aug-20, Sep-20

Y-axis: 2,000,000 to 14,000,000

Prosser
Memorial Health
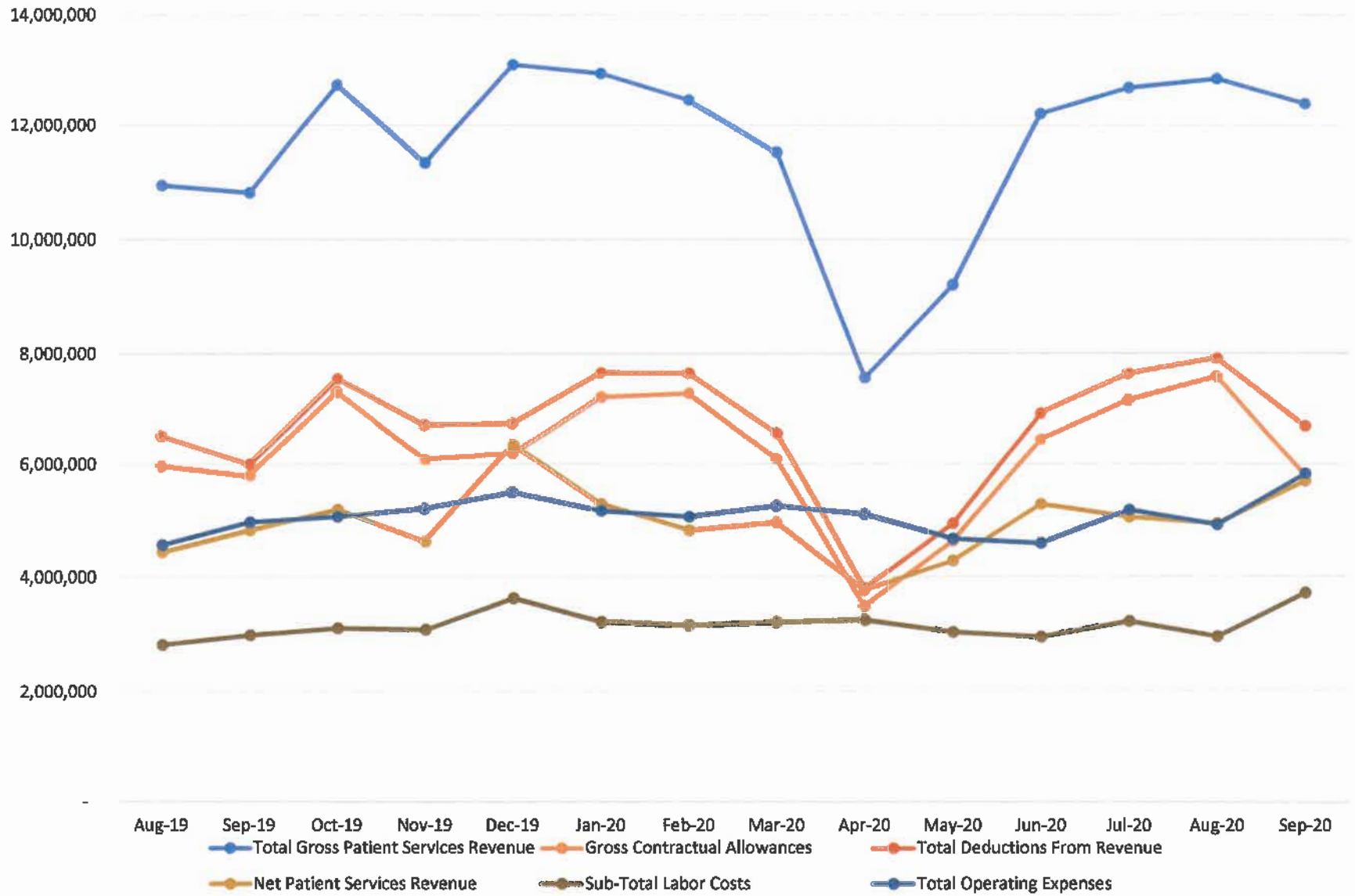
AR Balance Trend - Through July (2018, 2019, 2020)
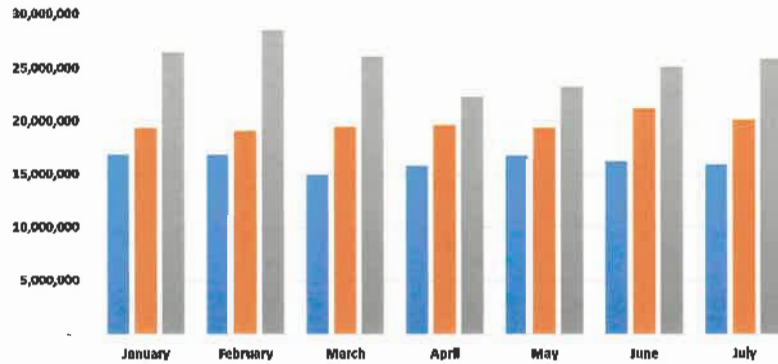
AR Age Comparative (2018, 2019, 2020)
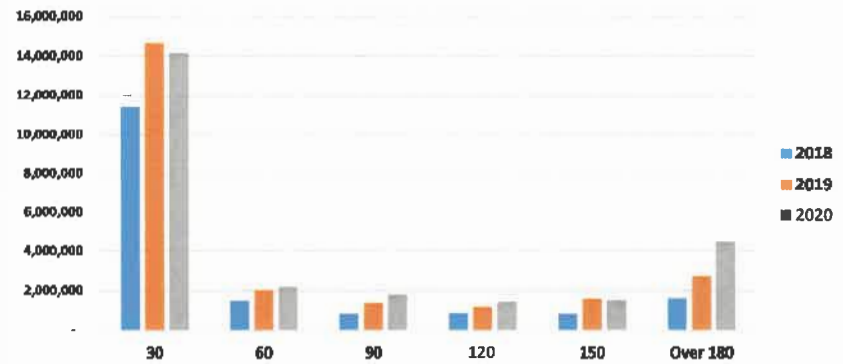
AR Balance Trend

	2016	2017	2018	2019	2020	% Change
January	12,362,446	13,660,199	16,931,510	19,428,531	26,540,403	37%
February	14,494,028	14,529,841	16,911,324	19,146,130	28,567,785	49%
March	20,600,695	15,115,376	14,989,166	19,513,147	26,130,696	34%
April	20,487,742	15,752,955	15,852,894	19,692,139	22,350,961	14%
May	19,464,558	15,131,907	16,812,980	19,455,887	23,319,876	20%
June	17,028,895	15,446,995	16,291,895	21,223,053	25,197,275	19%
July	16,275,033	15,918,959	15,979,415	20,206,074	25,943,825	28%
August	15,812,556	17,412,422	16,633,907	20,028,246	26,144,421	31%
September	14,455,924	17,547,651	17,129,789	23,681,156	25,640,562	8%
October	13,571,867	15,948,473	16,950,256	25,724,222	-	
November	13,789,248	16,292,336	17,374,013	25,655,024	-	
December	13,844,649	16,777,361	17,137,550	25,486,600	-	

AR Age Balance Comparative

	30	60	90	120	150	Over 180	
2016	6,516,378	1,533,379	1,192,796	845,040	1,198,353	3,169,977	14,455,924
2017	8,485,080	2,326,733	1,239,497	1,126,649	1,319,407	3,050,285	17,547,651
2018	11,407,804	1,499,180	856,784	887,912	844,368	1,633,740	17,129,789
2019	14,686,419	2,050,648	1,390,503	1,195,111	1,602,547	2,755,927	23,681,156
2020	14,182,107	2,206,130	1,798,418	1,439,186	1,523,978	4,490,743	25,640,562

AR Percentage of Total Balance

	30	60	90	120	150	Over 180	
2016	45%	11%	8%	6%	8%	22%	100%
2017	48%	13%	7%	6%	8%	17%	100%
2018	67%	9%	5%	5%	5%	10%	100%
2019	62%	9%	6%	5%	7%	12%	100%
2020	55%	9%	7%	6%	6%	18%	100%

Prosser
Memorial Health

Physician Clinics Consolidated
Income Statement As Of: September 30, 2020

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior
Clinical Patient Revenue	10,993,183	12,890,489	(1,897,306)	-15%	10,403,892
Deductions From Revenue	(3,959,363)	(4,637,919)	678,556	-15%	(4,118,152)
Net Patient Revenue	**7,033,821**	**8,252,571**	**(1,218,750)**	**-15%**	**6,285,740**
Other Operating Revenue	**85,851**	**119,250**	**(33,399)**	**-28%**	**99,890**
Salaries	7,679,630	7,384,523	(295,107)	-4%	5,848,005
Benefits	407,415	558,535	151,120	27%	337,965
Purchased Labor	4,438	-	(4,438)	0%	-
Total Salaries and Benefits	8,091,483	7,943,058	(148,424)	-2%	6,185,970
Professional Fees	122,917	175,275	52,358	30%	224,911
Supplies	772,077	627,259	(144,818)	-23%	398,243
Utilities	56,541	53,240	(3,301)	-6%	46,981
Purchased Services	171,432	130,537	(40,895)	-31%	153,572
Rentals & Leases	652,831	664,672	11,841	2%	679,465
Other Direct Expenses	101,791	223,078	121,287	54%	208,970
Total Non Salary Expenses	1,877,588	1,874,060	(3,528)	0%	1,712,142
Total Expenses	**9,969,070**	**9,817,118**	**(151,952)**	**-2%**	**7,898,111**
Contribution Margin	**(2,849,398)**	**(1,445,298)**	**(1,404,100)**	**97%**	**(1,512,482)**
Referred Hospital Revenue	22,450,915				
Net Hospital Contribution Margin	**19,601,517**				
FTE's					
Employed	72.72	83.46	10.74	13%	63.06
Contracted	0.77	4.25	3.48	82%	0.95
Total	73.49	87.71	14.22	16%	64.01
Employed					
Hours Paid	116,350	133,536	17,186	13%	100,902
Hours Worked	100,650	106,829	6,179	6%	89,691
Contracted					
Hours	1,232	6,800	5,568	82%	1,512
Unit of Service (UOS) Total Visits	37,801	40,844	(3,043)	-7%	36,847
Productivity (Worked Hours / UOS)	2.70	2.78	(0)	-3%	2.48

Prosser
Memorial Health

Benton City Clinic
Income Statement As Of: September 30, 2020
RURAL HEALTH CLINIC

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior
Clinical Patient Revenue	1,813,125	2,440,962	(627,837)	-26%	2,201,273
Deductions From Revenue	(453,281)	(610,240)	156,959	-26%	(550,318)
Net Patient Revenue	**1,359,844**	**1,830,721**	**(470,877)**	**-26%**	**1,650,955**
Other Operating Revenue	-	-	-	0%	-
Salaries	1,402,572	1,420,056	17,484	1%	1,533,024
Benefits	92,266	108,416	16,150	15%	93,690
Purchased Labor	-	-	-	0%	-
Total Salaries and Benefits	1,494,837	1,528,471	33,634	2%	1,626,714
Professional Fees	-	-	-	0%	7,094
Supplies	98,378	49,920	(48,459)	-97%	42,296
Utilities	11,801	11,779	(22)	0%	11,651
Purchased Services	23,533	31,017	7,484	24%	37,170
Rentals & Leases	173,551	177,973	4,422	2%	168,975
Other Direct Expenses	7,263	33,300	26,037	78%	11,974
Total Non Salary Expenses	314,526	303,988	(10,539)	-3%	279,160
Total Expenses	**1,809,364**	**1,832,459**	**23,095**	**1%**	**1,905,874**
Contribution Margin	**(449,520)**	**(1,738)**	**(447,782)**	**25771%**	**(254,919)**
FTE's					
Employed	16.41	19.00	2.59	14%	18.23
Contracted	-	-	-	0%	-
Total	16.41	19.00	2.59	14%	18.23
Employed					
Hours Paid	26,264	30,400	4,136	14%	29,175
Hours Worked	22,336	24,320	1,985	8%	26,396
Contracted					
Hours	-	-	-	0%	-
Unit of Service (UOS) Total Visits	8,415	9,868	1,453	15%	9,144
Productivity (Worked Hours / UOS)	2.65	2.46	(0.19)	-8%	2.89

Prosser
Memorial Health
Prosser Clinic
Income Statement As Of: September 30, 2020
RURAL HEALTH CLINIC

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior
Inpatient Revenue	953,645	751,979	201,666	27%	463,391
Outpatient Revenue	3,459,439	4,010,700	(551,261)	-14%	3,141,716
Clinical Patient Revenue	4,413,084	4,762,679	(349,595)	-7%	3,605,107
Deductions From Revenue	(1,103,271)	(1,190,670)	87,399	-7%	(901,277)
Net Patient Revenue	**3,309,813**	**3,572,009**	**(262,196)**	**-7%**	**2,703,830**
Other Operating Revenue	**85,851**	**119,250**	**(33,399)**	**-28%**	**99,890**
Salaries	2,311,266	2,057,166	(254,100)	-12%	1,001,749
Benefits	124,864	157,078	32,214	21%	88,773
Purchased Labor	4,438	-	(4,438)	0%	-
Total Salaries and Benefits	**2,440,568**	**2,214,244**	**(226,324)**	**-10%**	**1,090,522**
Professional Fees	107,705	149,400	41,695	28%	200,516
Supplies	306,059	214,559	(91,501)	-43%	182,871
Utilities	18,220	22,255	4,034	18%	20,008
Purchased Services	60,585	52,942	(7,642)	-14%	66,285
Rentals & Leases	271,919	275,254	3,335	1%	235,258
Other Direct Expenses	62,061	106,350	44,289	42%	108,898
Total Non Salary Expenses	**826,550**	**820,759**	**(5,791)**	**-1%**	**813,835**
Total Expenses	**3,267,118**	**3,035,003**	**(232,115)**	**-8%**	**1,904,356**
Contribution Margin	**128,546**	**656,256**	**(527,709)**	**-80%**	**899,363**

FTE's					
Employed	24.30	26.80	2.50	9%	17.48
Contracted	0.77	2.59	1.82	70%	0.94
Total	25.07	29.39	4.32	15%	18.42

Employed					
Hours Paid	38,886	42,880	3,994	9%	27,970
Hours Worked	34,213	34,304	91	0%	24,816
Contracted					
Hours	1,232	4,144	2,912	70%	1,496

Unit of Service (UOS) Total Visits	15,427	15,847	420	3%	14,310
Productivity (Worked Hours / UOS)	2.30	2.43	0.13	5%	1.84

Prosser
Memorial Health
Specialty Clinic
Income Statement As Of: September 30, 2020
PROVIDER BASED CLINIC

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior
Clinical Patient Revenue	3,561,961	4,288,777	(726,816)	-17%	3,473,711
Deductions From Revenue	(2,101,557)	(2,487,491)	385,934	-16%	(2,014,752)
Net Patient Revenue	1,460,404	1,801,286	(340,882)	-19%	1,458,958
Other Operating Revenue	-	-	-	0%	-
Salaries	3,088,035	2,864,997	(223,038)	-8%	2,521,243
Benefits	131,189	213,440	82,251	39%	109,907
Purchased Labor	-	-	-	0%	-
Total Salaries and Benefits	3,219,225	3,078,437	(140,787)	-5%	2,631,150
Professional Fees	11,400	25,875	14,475	56%	13,901
Supplies	107,691	144,471	36,780	25%	62,226
Utilities	5,883	157	(5,726)	-3655%	3,406
Purchased Services	34,707	4,840	(29,866)	-617%	4,449
Rentals & Leases	124,331	123,331	(999)	-1%	150,233
Other Direct Expenses	22,562	56,728	34,166	60%	25,508
Total Non Salary Expenses	306,573	355,403	48,830	14%	259,723
Total Expenses	3,525,798	3,433,840	(91,958)	-3%	2,890,873
Contribution Margin	(2,065,394)	(1,632,554)	(432,840)	27%	(1,431,914)
FTE's					
Employed	19.67	22.00	2.33	11%	17.93
Contracted	-	-	-	0%	0.01
Total	19.67	22.00	2.33	11%	17.93
Employed					
Hours Paid	31,478	35,200	3,722	11%	28,686
Hours Worked	27,370	28,160	790	3%	25,000
Contracted					
Hours	-	-	-	0%	8
Unit of Service (UOS) Total Visits	8,451	9,566	1,115	12%	8,586
Productivity (Worked Hours / UOS)	3.24	2.94	(0.30)	-10%	2.91

Prosser
Memorial Health

Grandview Clinic
Income Statement As Of: September 30, 2020
RURAL HEALTH CLINIC

	YTD Actual	YTD Budget	Variance	% Var	YTD Prior
Inpatient Revenue	7,666	928	6,738	726%	2,498
Outpatient Revenue	1,197,347	1,397,143	(199,797)	-14%	1,121,305
Clinical Patient Revenue	1,205,013	1,398,072	(193,059)	-14%	1,123,802
Deductions From Revenue	(301,253)	(349,518)			(651,805)
Net Patient Revenue	**903,759**	**1,048,554**	**(144,794)**	**-14%**	**471,997**
Other Operating Revenue	**-**	**-**	**-**	**0%**	**-**
Salaries	877,757	1,042,304	164,548	16%	791,989
Benefits	59,096	79,601	20,505	26%	45,595
Purchased Labor	-	-	-	0%	-
Total Salaries and Benefits	936,853	1,121,906	185,053	16%	837,584
Professional Fees	5,444	-	(5,444)	0%	3,401
Supplies	67,014	55,637	(11,377)	-20%	110,850
Utilities	14,058	13,725	(334)	-2%	11,916
Purchased Services	29,233	21,750	(7,484)	-34%	45,667
Rentals & Leases	-	-	-	0%	125,000
Other Direct Expenses	6,671	15,975	9,304	58%	62,590
Total Non Salary Expenses	122,421	107,087	(15,334)	-14%	359,425
Total Expenses	**1,059,274**	**1,228,992**	**169,718**	**14%**	**1,197,008**
Contribution Margin	**(155,514)**	**(180,438)**	**24,924**	**-14%**	**(725,011)**
FTE's					
Employed	12.33	15.66	3.33	21%	9.42
Contracted	-	1.66	1.66	100%	0.01
Total	12.33	17.32	4.99	29%	9.42
Employed					
Hours Paid	19,722	25,056	5,334	21%	15,070
Hours Worked	16,731	20,045	3,314	17%	13,479
Contracted					
Hours	-	2,656	2,656	100%	8
Unit of Service (UOS) Total Visits	5,508	5,563	55	1%	4,807
Productivity (Worked Hours / UOS)	3.04	4.08	1.04	26%	2.81

![Prosser Memorial Health]

Revenue By Financial Class

Benton City Clinic
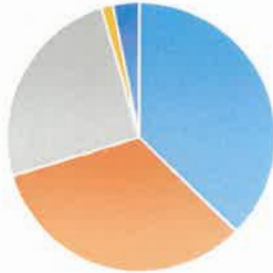
Revenue by Financial Class

Commercial	675,741	37%
Medicaid	600,658	33%
Medicare	452,334	25%
Other	26,236	1%
Self-Pay	58,157	3%
Grand Total	**1,813,126**	

Specialty Clinic
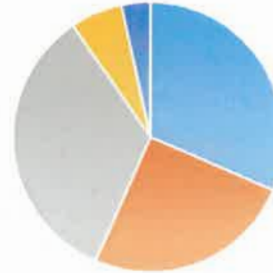
Revenue by Financial Class

Commercial	1,119,332	31%
Medicaid	896,676	25%
Medicare	1,204,164	34%
Other	219,378	6%
Self-Pay	122,412	3%
Grand Total	**3,561,962**	

Prosser Clinic
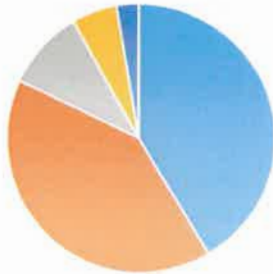
Revenue by Financial Class

Commercial	1,824,272	41%
Medicaid	1,797,013	41%
Medicare	424,351	10%
Other	246,524	6%
Self-Pay	120,924	3%
Grand Total	**4,413,084**	

Grandview Clinic
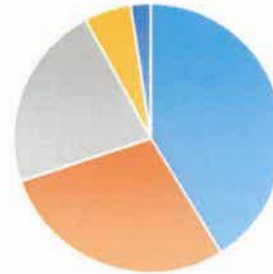
Revenue by Financial Class

Commercial	496,354	41%
Medicaid	344,766	29%
Medicare	267,907	22%
Other	67,242	6%
Self-Pay	28,744	2%
Grand Total	**1,205,013**	

Prosser
Memorial Health
CLINICAL PROVIDER VISITS BY MONTH

Benton City Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
CARL	178	177	135	100	84	107	117	104	160				1,162
JOHANSING	239	238	235	173	172	174	144	-	-				1,375
STUADINGER	201	105	146	116	130	149	200	183	200				1,430
LUTHER	117	154	129	75	119	155	139	123	225				1,236
ZIRKER	214	153	206	61	101	138	185	229	162				1,449
MICROULIS	127	107	107	103	111	133	121	97	129				1,035
GRONER	86	83	81	62	58	68	35	42	60				575
MORSE	7	-	-	-	-	-	-	-	-				7

Prosser Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
OCONNOR	295	243	215	187	228	352	336	322	269				2,447
MIN	188	164	159	106	105	191	156	168	200				1,437
ZHMUROUSKI	209	159	135	109	153	151	157	231	168				1,472
MORRIS	99	173	191	159	300	235	168	136	227				1,688
MORSE	150	99	172	203	98	190	207	184	192				1,495
GARZA		2	-	-	-	-	-	-	-				2
DUNHAM	-	-	-	-	-	-	-	153	225				378
SOLLERS	288	301	321	227	219	262	205	209	219				2,251
WEAVER	215	188	201	168	92	185	173	186	170				1,578
CHARVET	122	125	105	41	62	79	77	147	146				904
GARZA	33	12	4	-	23	-	-	-	-				72
PADILLA	-	-	-	-	46	90	174	193	221				724

Specialty Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
CLIFFORD	245	205	210	162	181	190	205	172	246				1,816
HALVORSON	137	155	162	109	81	145	114	137	117				1,157
STREBEL	138	119	100	69	79	92	89	134	96				916
HUANG	70	72	71	31	37	56	90	104	118				649
CHEW	88	76	71	43	61	57	39	45	21				501
COMBS	196	189	146	7	72	146	106	112	-				974
BHATTI	147	84	101	89	109	121	133	161	159				1,104
C. TIEU	-	-	-	-	-	-	-	-	78				78
T. TIEU	-	-	-	-	-	-	-	-	67				67

Grandview Clinic

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
SANTA-CRUZ	168	179	150	132	135	116	119	132	148				1,279
GARZA	141	143	112	83	88	70	126	104	151				1,018
WARNICK	111	73	51	38	38	67	66	55	92				591
ZIRKER	113	145	125	38	100	67	115	82	-				785
ZHMUROUSKI	22	35	45	15	21	37	40	44	43				302
HANKS	125	134	151	163	173	193	161	165	127				1,392
CHARVET	-	3	-	-	12	14	-	-	-				29
MORRIS	-	-	-	-	-	-	-	-	1				1

Marketplace Update:
Claims Severity and Industry Trends
Impacting Premiums

A Special Report by Physicians Insurance A Mutual Company
September 2020

In 2014, a 16-year-old woman who was 25 weeks pregnant was hospitalized with severe preeclampsia, a serious complication characterized by high blood pressure. Her physicians contend they advised her to undergo an emergency cesarean section, which she refused; the patient claimed that doctors told her that the baby would die or suffer brain damage if she had that procedure. Whatever the case, when the baby was delivered vaginally days later, it suffered severe damage. The mother filed a lawsuit, and in June of 2019 the case went to trial. After the parties rested, the jury came back in just two and half hours with a staggering verdict of over **$229 million** in favor of the plaintiff—the largest medical-malpractice verdict ever recorded.

Since 2013, there have been a total of eight medical-malpractice verdicts exceeding $100 million, including the aforementioned case. Of note, six of those eight cases have come to conclusion in the last two years.

For medical professional liability (MPL) carriers, these increasing claim costs have an enormous impact. For many years, the MPL industry has been experiencing financial pressure in response to the changing healthcare system and social inflation. There has been an extended soft market creating downward, competitive pressure on premiums, while the frequency of severe claims has been steadily rising.

This has prompted the need for economic adjustments in the industry. Most carriers have already responded by filing for rate increases—some multiple times and as early as 2013. However, at Physicians Insurance, we have been trying to keep our rates flat as long as possible by closely managing expenses and trying to offset increases through other means.

Unfortunately, as claim costs continue to rise, investment income is down and our rates are no longer adequate to insure today's exposure. As a mutual company owned by and operated for the benefit of our members, we take changing rates very seriously, and only consider it as a means to continue to serve out our mission to our members.

CONSOLIDATION CHANGES THE RISK LANDSCAPE

Healthcare has changed rapidly in many ways with electronic medical records and changes in technology and reimbursement, but one major change has impacted the MPL marketplace most: the drastic shift towards consolidation and physicians moving to employment at hospitals or large groups. This graph shows the large increase of physicians moving to hospital-owned practices. Note the drastic change between approximately 2014 and 2018, when more than 34,000 independent medical practices were acquired by hospitals.

Physician Practices Owned by Hospitals

Approximately 35,000 independent practices were acquired by hospitals between 2014 and 2018

80,001

45,766
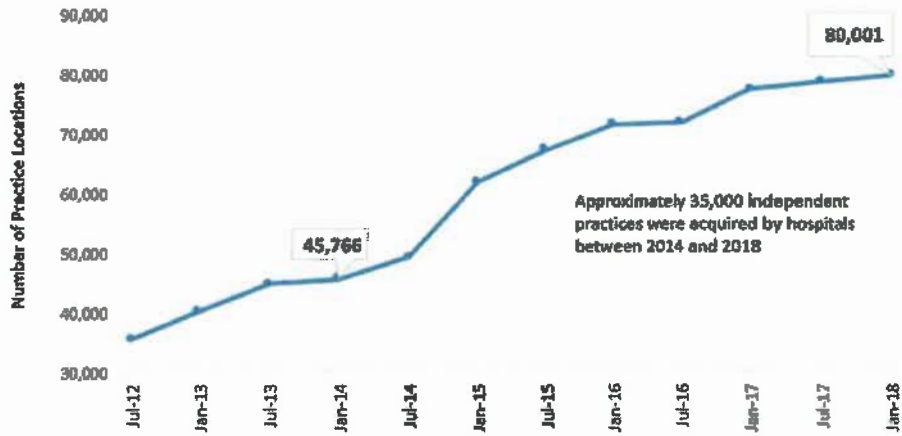
Source: Physician Advocate Institute, 2019

At Physicians Insurance, our book of business mirrored the national trends, with many of our smaller/independent practices moving into hospital employment or joining large multispecialty clinics. For example, in 2015, more than half of our book (57%) consisted of practices with between one and 32 physicians. Just four years later, that dropped to 34%. But during this same time period, our total physician count increased from about 6,500 to more than 8,000 members as the company continued to grow.

That move toward consolidation and employment within the healthcare market reduced the number of independent practices, as smaller practices closed or coverage moved to the larger groups or hospitals. Carriers had to develop new ways to recoup lost revenue, so many responded by moving into new territories to diversify their business. As a result, the Pacific Northwest saw 36 new carrier entrants between 2010 and 2020. This increase in competition put additional downward pressure on pricing and contributed to what is referred to as a *soft market.*

PI Insureds Migrate into Large Practices and Hospitals

Hospital | Practices with 33+ physicians | Practices with 1-32 physicians | Total physician Count
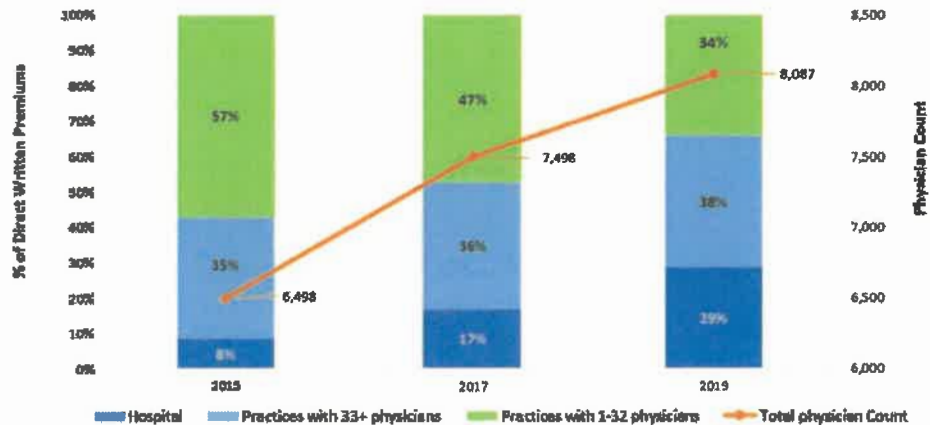
Source: Physicians Insurance, Segmentation Report

INCREASING CLAIMS SEVERITY REVERSES THE SOFT MARKET

Insurance markets have historically gone through somewhat predictable cycles, which influence insurance limits and corresponding premiums. A *soft market* is characterized by abundant capacity, ample competition, and low premiums due to decreases in claims frequency and severity. Soft markets are then followed by *hard markets,* where capacity diminishes, competition lessens, and premiums increase to match changes in claims frequency and severity.

Until recently, the MPL marketplace had been in a prolonged soft market, with ample carriers in the marketplace. During the same time period, there was downward competitive pressure on premiums due to the soft market, and there was an uptick in the frequency of high-severity losses.

Nationally, in just the last three full calendar years, there have been a record number of jury verdicts for greater than $10 million, including two in Washington State in 2019: a $13.9 million verdict in a stroke case and a $23.9 million verdict for a birth-injury case. And in 2018 and 2019

Number of MPL Verdicts in Excess of $10M
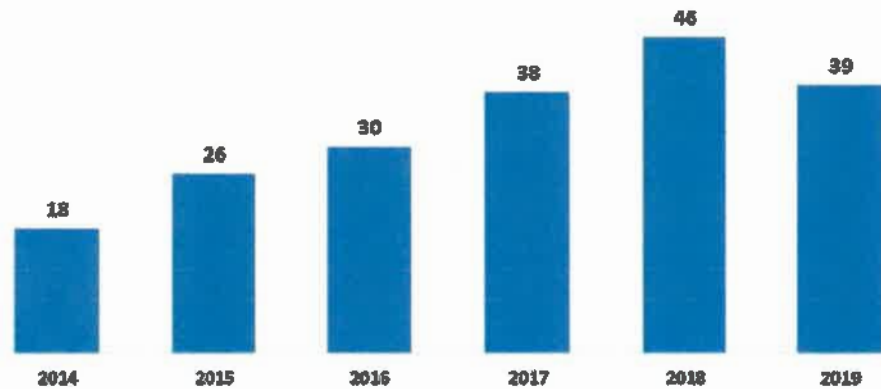
Source: Guy Carpenter, Medical Professional Liability Jury Verdict Trends May 2020

combined, there were three verdicts totaling more than $100 million, including the $229 million case referenced at the beginning of this article.

Another view of the national data shows the average of the largest 50 medical-malpractice verdicts since 2001. The lines in red represent years in which average verdicts exceeded $20 million. The first time this happened during this period was in 2002, and then it took 10 years to hit that mark again in 2012. However, just six years later, the averages well exceeded $20 million in both 2018 and 2019. Physicians

Average of Top 50 Medical Malpractice Verdicts in US
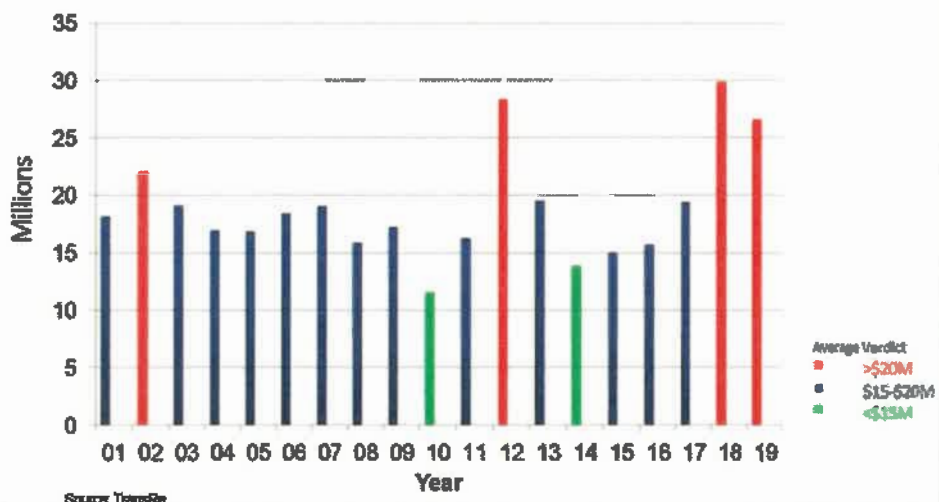
Source: TransRe

Insurance's experience during the same timeframe of 2001 to 2019 shows a large spike in cases settling for

more than $1 million and $2 million, starting after 2016. For example, in 2015, approximately 0.27% of cases resolved for more than $2 million, but in 2019 that figure was over 2%.

Another way of looking at this is that in less than four years, the number of claims settling for more than $1 million and $2 million jumped 100% and 300%, respectively.

Outside of just a pure increase in the frequency and severity of claims, there has been a steady increase in average paid indemnity. National data on NPBD reporting from 1991 to 2019 shows a

Paid Indemnity in Closed Year

Source: Physicians Insurance Company – PI1007 Claims Report

steady increase in average indemnity (excluding shock claims or those with massive payouts), with 2000 averaging approximately $250,000 and 2019 reporting more than $425,000.
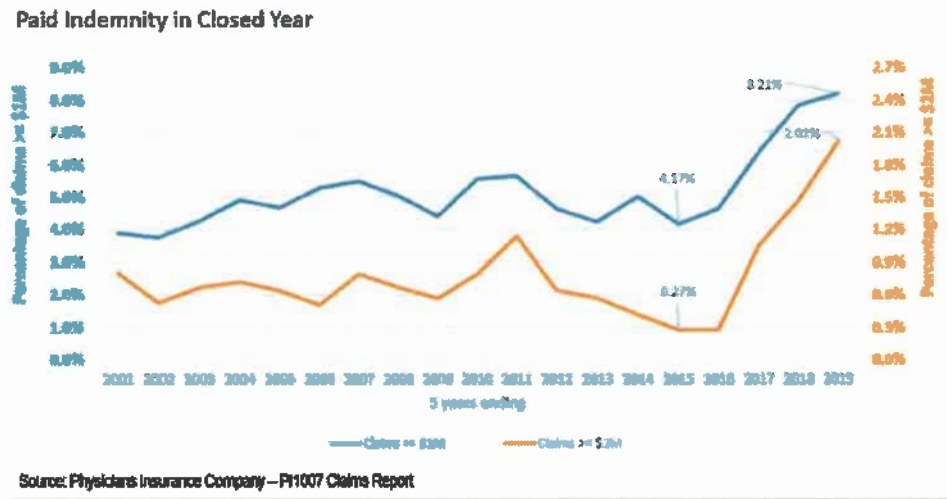
When compared to national statistics, the Pacific Northwest is also seeing this same trend in the frequency of severity. Our data without the largest 10 claims shows a steady increase; however, including the average of the largest 10 claims, particularly in the last four years, there is a marked overall increase.

The surge in indemnity severity can be easily observed when we compare the 2010–2014 indemnity severity level to that of 2015–2019 in Washington and Oregon. The chart shows that paid indemnity severity has almost quadrupled in Oregon, and that of Washington has increased by almost 30%.

Paid Indemnity Severity
2010–2014 Level vs. 2015–2019 Level

Source: Physicians Insurance Company – PI1007 Claims Report
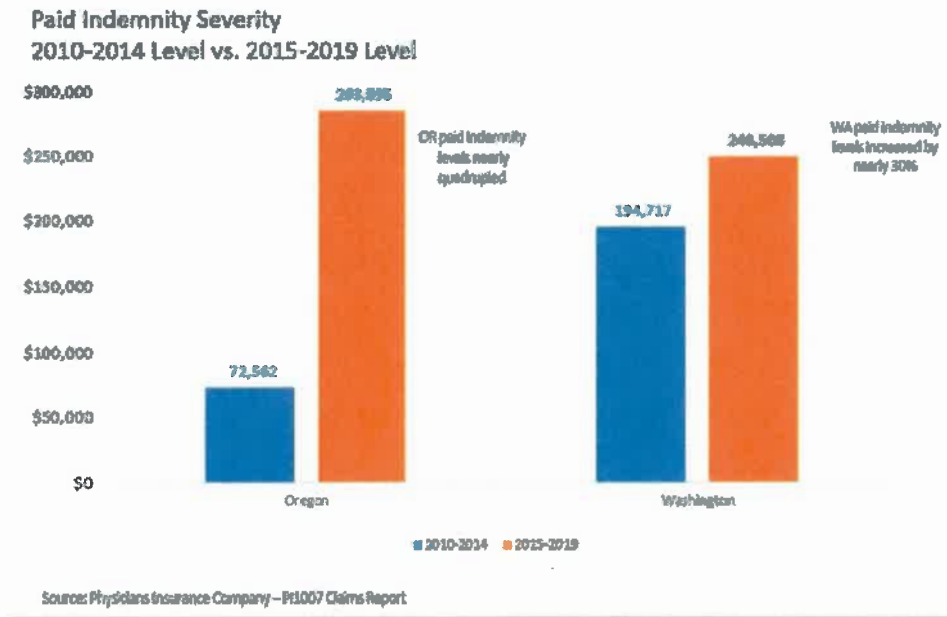
Aside from the increase in the frequency of severity of claims, another factor contributing to overall cost increases is just the costs to defend claims themselves. Using 2007 as a baseline, paid loss adjustment expenses increased 50% between 2007 and 2019—which means that not only are claims resolving for more indemnity, but it's also now costing more to defend them.

LEGISLATIVE CHANGES ARE IMPACTING CLAIMS

What is causing the value of these cases to go up? There are a number of factors, but one thing that certainly has an impact is the legislative and judicial environment in the Pacific Northwest, where meaningful liability reform has been eroded over the years and abuses in the civil justice system—such as venue shopping and junk science—have increasingly been allowed in the courtroom.

In Washington, there was a brief period when a cap on non-economic damages existed—*non-economic damages* referring to more subjective damages, such as pain and suffering and non-monetary losses. Washington also used to require that plaintiffs file a certificate of merit and a 90-day notice of intent before filing suit, both of which laws were later declared unconstitutional by the court.

In 2019, Washington also opened a new class of beneficiaries in wrongful-death cases, enabling parents and siblings of deceased parties to bring suit even if they don't live in the United States and aren't financially dependent on the deceased. Since this measure is new, its effects have not yet been fully realized—but it demonstrates our region's leanings toward ensuring an injured party has rights to unlimited economic recovery.

Additionally, Washington has a joint and several liability rule whereby a defendant who is only minimally liable for a given harm can be required to pay for the *entire* judgement, if a co-defendant is unable to pay their share. The impact of this rule is that parties that otherwise might justifiably contest their minimal liability may look to settle instead, to avoid the risk of paying a large portion of a verdict.

In Oregon, there is no collateral source rule, which means that plaintiffs can show amounts billed for medical expenses (also known as phantom damages) to a jury, rather than the amount actually paid or required to be paid—which is often significantly less, based on the health insurer's contracted amount. This allows plaintiffs to increase their economic damages and thus increase the perceived value of their cases.

In addition, through a recent Supreme Court case, Oregon has enabled a new cause of action in malpractice claims, allowing plaintiffs to claim a "loss of chance of a better outcome." These medical-malpractice claims are unique in that, instead of requiring patients to sue for actual physical harm, they allow them to claim damages on the grounds that they had a chance of a better outcome, and the provider's negligence eliminated that chance. (Notably, while this is new to Oregon, this cause of action already exists in Washington.)

Oregon also has a $500,000 wrongful-death cap, which has been heavily contested over the last few years. The 1987 cap for wrongful death and bodily injury was deemed unconstitutional in 1999 for injuries other than wrongful death. However, in 2016, the Oregon Supreme Court essentially reinstated the 1987 non-economic damage cap in the Horton vs. OHSU decision for all actions. And earlier in 2020, the Oregon Supreme Court reversed course yet again, declaring the bodily-injury cap unconstitutional. The $500,000 cap for wrongful death remains. While this ruling is disappointing, it is not a surprise, as the wrongful-death and bodily-injury cap has been under attack for quite some time. We anticipate more debate in Oregon over the wrongful-death cap in the future.

Idaho has typically been a conservative venue, but there has been recent movement toward it becoming more plaintiff-friendly. The plaintiff trial bar has strategically placed their allies on the courts in states where they do not have successful allies controlling the legislature. Idaho does have a cap on non-economic or subjective damages; however, if a plaintiff can prove that the actions of the parties were "willful and reckless," the cap does not apply. Carriers see cases where plaintiffs successfully get around the cap using this method.

Additionally, at the next legislative session in Idaho, we are expecting the plaintiff bar to push for phantom damages to again allow plaintiffs to increase their perceived damages by being able to show the billed medical expenses, as opposed to what was actually paid. And finally, in other Northwest states, there are movements toward inflating damages and doing away with current liability reforms. Alaska is considering adopting phantom damages, and Montana's Supreme Court is issuing opinions that undermine current liability reforms.

SOCIAL INFLATION CHANGES JURY AWARDS
Another factor that contributes to increasing claim costs is social inflation. The term *social inflation* is a catchall phrase as it is utilized in the insurance industry; but in general, it refers to the increase in loss costs due to shifts in trust of corporations, in juror composition, and in effective plaintiff-attorney strategies.

One significant trend contributing to social inflation is the increase in distrust of corporations that began with the financial collapse of 2008. Since that time, there has been a greater division and separation of wealth, and an increase in feeling that someone needs to pay when something goes wrong. This shift in mentality makes it easier for a jury to believe that a faceless corporation with ample assets (or insurance) should be held responsible. In 2019 in Washington, a jury assigned no fault to providers who provided medical care, and assigned all the fault to a healthcare entity to find a way to compensate the plaintiff.

Plaintiff attorneys have used this distrust of corporations to alter how they file pleadings in malpractice cases. One litigation strategy utilized by plaintiff attorneys is to purposely name only the healthcare entity as the defendant instead of the individual providers who provide the care, in order to take advantage of the public's mistrust of a corporation versus an individual healthcare provider.

Social inflation is also impacted by a new composition of juries. As the millennial generation becomes jurors, their experience and mindset differs from those of prior generations. Most millennials entered the workforce during the economic recession, saddled with student debt. According to some trial consultants, millennials are starting to take leadership roles in juries, drawing upon a social-responsibility mindset while serving. Plaintiff attorneys who want the jury to "send a message" will appeal to this call to action when they believe millennial jurors can impact decisions.

Additionally, younger generations are increasingly less trusting of authority. The Pew Research Center conducted a study in November and December 2018 analyzing the differences in opinion by generation, and found some striking contrasts. For instance, 73% of people under 30 believe that "most of the time, people just look out for themselves," versus the 48% of their baby-boomer counterparts (ages 65+) who believe the opposite. The same study also found that younger Americans are much less likely to have confidence in key institutions such as the military, religious leaders, and police officers (a shift in opinion that we are seeing play out on the national level today).

This affects how a jury might perceive the care being given to patients, and impacts their decisions when they're rendering verdicts. Whereas older generations might assume that hospitals and healthcare workers will do the right thing, younger generations are more skeptical.

Today, jurors of all ages may also be basing larger awards on the skewed value of the dollar and the uncertainly of access to medical insurance. Prior to 2016, the public had some confidence that medical insurance would be available to them through the ACA or private insurers. Today, that assurance is gone, and even those with insurance are increasingly utilizing high-deductible plans. Juries want to make sure that an injured party will have the money available to cover their future cost of care, regardless of insurance status and plan type—and skyrocketing rent, home, food, and healthcare costs, coupled with the widespread knowledge of what professional athletes, celebrities, and influencers make, have impacted juror mindsets on what amount a jury should give a gravely injured patient. If it costs a million dollars or

more for a small house in Seattle or Portland, that will affect how much money a jury in one of those cities is likely to award an injured party.

Lastly, plaintiffs and plaintiff attorneys now have a new tool for bringing claims, in the form of litigation financing. This involves a plaintiff contracting with a third-party funder to obtain financial assistance for their case, in exchange for the funder receiving an interest in the potential recovery. The agreement is usually non-recourse, so if the plaintiff loses the case, the funder receives nothing.

The consequence of these factors is an increase in the number of cases brought, particularly weak ones. It can also prolong litigation, discourage settlement, and direct money away from the injured party, given that a large percentage of each verdict will go to the investor and attorneys. When a plaintiff is considering a settlement offer, they have to think about the cut that is going to their attorney AND the third party, which can again inflate the amount they think they may need to settle their cases. For the most part, this type of activity is completely unregulated, and is projected to grow.

COVID-19 OUTCOMES ARE STILL TO BE DETERMINED
Aside from all these influencing elements, uncertainly surrounding the ongoing nature of the COVID-19 pandemic and its economic impact is significant. In terms of claim trends relative to COVID-19, with any type of new risk, it typically takes several years for claims to materialize, so the full impact of the pandemic is unknown. However, there are some early indicators, based on potential claims and some early pandemic-related lawsuits that we've seen already.

For medical malpractice, claims related to community spread or delay in treatment or deferred non-essential care are already being made. Delay in diagnosis and treatment has historically been a frequent allegation in many claims; the impact that clinical and elective-surgery shutdowns will have on these kinds of claims in the future has yet to be seen. It's also possible that clinics without proper callback systems may not prompt patients to come back soon enough, potentially worsening delays in care.

For employment-related matters, there have been more reports in the industry of whistleblower/retaliation claims—from warnings about inadequate measures to protect personnel and patients from COVID-19, to claims of wrongful termination and violations of FMLA or the Families First Coronavirus Response Act around paid or unpaid leave. For directors' and officers' liability, COVID-19-specific claims have trended toward alleged negligence for wrongful action or specific inactions, such as failures in contingency planning. With all the remote work going on, cyber crime has also been affected, with an uptick in phishing scams and data compromise. We're also likely to see an increase in privacy-related claims to both patients and employees, due to the new risks associated with remote care.

FINANCIAL RATING AGENCIES SHOW A NEGATIVE OUTLOOK
But even before COVID-19, some carriers were experiencing financial struggles. Global credit-rating agency AM Best, in the later part of 2019 and the early part of 2020, downgraded its Financial Security Rating for at least eight MPL carriers—including Norcal and ProAssurance, who have limited market share in the Pacific Northwest—for deteriorating financial performance. This is significant, as these eight companies make up approximately 10% of the total annual MPL premium in the United States.

In fact, AM Best has maintained a negative outlook on the MPL segment for the coming year, citing key factors of "depressed demand, diminishing reserve redundancies, concerns regarding rate adequacy amid rising loss costs trends and social inflation, (and) the impact of the COVID-19 pandemic".

Effective Downgrades by AM Best 2019-2020

Company Name	Effective Date of Downgrade	Prior FSR	Current FSR
Colony Insurance Company	2/26/2020	A u	A-
CMIC Risk Retention Group	10/10/2019	A-u	B++
KAMMCO Casualty Company, Inc.	10/17/2019	A-	B++
PD Insurance Company	2/26/2020	A u	A- u
Medicus Insurance Company	2/26/2020	A u	A- u
NORCAL Mutual Insurance Company	2/26/2020	A u	A- u
Preferred Physicians Med RRG, Mut Ins Co	2/26/2020	A u	A- u
ProAssurance Insurance Co of America	2/26/2020	A+	A

Source: A.M.Best

U; Under Review

While Physicians Insurance has remained financially stable, and even had its A- (Excellent) rating from AM Best confirmed in 2020, the company has operated at an underwriting loss since 2015. Despite rising expenses driven by increases in reinsurance costs, we've remained relatively consistent in our underwriting expense ratio, controlling our expenses in order to spend more of our premium dollars defending our insureds. (In fact, compared to a set of peer companies, Physicians Insurance consistently spends less on running the business and more on defending members and paying claims.)

Additionally, for the last 12 consecutive years the company has returned $5 million in dividends.

This Peer Comparison chart shows a comparison of Physicians Insurance and a composite of 18 of our competitor peer companies. (The composite group is shown in light blue, and Physicians Insurance is shown in dark blue.) The graph is broken out by just the loss-

PEER COMPARISON

LOSS & LAE RATIOS

Source: Prime Advisors, 2020. Composite of 18 MPL insurance carriers with data based on annual statutory financial results, primarily from S&P Global.

■ MPL Composite   ■ Physicians Insurance

adjustment expenses; we have historically had a loss and loss-adjustment ratio of more than 80%, and for 2019, that figure was at 88.5%. Of note is that for 2019, the gap appears to be closing—but really the average is vastly impacted by the adverse loss experience of one competitor, Norcal, which posted a 175.9% combined ratio in 2019. Excluding Norcal, the composite group of our peers is at 79% for 2019.

Overall, what is demonstrated by these numbers is that we are consistently spending a greater percentage of our premium dollars on paying our losses as compared to our peer group. Two of the factors contributing

to this could be that we operate in an environment lacking tort reform, and that we are uniquely willing to spend the money needed to defend cases and take them to trial.

The same comparison study of 18 peer groups also looked at underwriting expenses, the money spent to run each company and cover elements such as reinsurance costs. (Again, the composite group is shown in light blue, and Physicians Insurance in dark blue.) Physicians Insurance consistently spends much less to run its business, operating a leaner operation than its peers. Compared with the prior graph, this chart shows that we are consistently spending a greater percentage of our premium dollars on defending members and covering claims, compared to what we pay ourselves— which is how we believe our members want us to steward their premium dollars.

PEER COMPARISON

UNDERWRITING EXPENSE RATIO
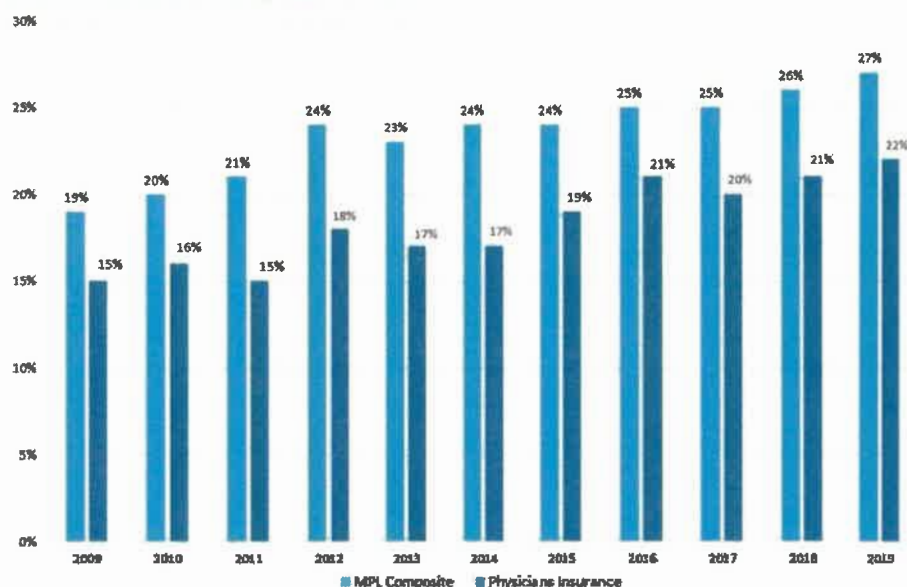
Source: Prime Advisors, 2018. Composite of 18 MPL insurance carriers with data based on annual statutory financial results, primarily from S&P Global.

So what does this mean? Firstly, it means that Physicians Insurance has consistently managed its expense ratio, being effective stewards of members' premium dollars, spending a greater percentage of premium dollars defending members and taking cases to trial compared with its peers. This is part of the benefit of being insured by a mutual company that is owned by and operated for the benefit of our members. However, loss trends within the industry demonstrate the need for premium and rate adjustments. By adjusting rates, the company can ensure that it has adequate premium dollars to pay against future claims to continue to serve its members.

Already across the industry, most carriers have responded to the aforementioned changes by taking rate action. For Physicians Insurance, the last filed rate changes were a 10% rate decrease in Washington in 2009, a 15% decrease in Idaho in 2010 and a 20% rate decrease in Oregon in 2012. Looking at 2019 and beyond, we can see a large uptick in the amount of rate increases that other carriers in the region have taken. MedPro and TDC both increased their rates, sometimes two years in a row for Washington, Oregon, and Idaho. The last rate adjustment by these carriers in these states was a rate reduction in 2012 during the soft market; CNA took early rate action by increasing their overall rates by 12.9% in 2013, and by another 6% in 2015. Physicians Insurance is really the outlier, not having taken any filed rate action since 2012.

MARKET IMPACT FOR THE PACIFIC NORTHWEST

The medical-malpractice industry has undergone significant changes in the past few decades. Changes in the healthcare landscape have eroded solo and smaller practice models in favor of employed and hospital-owned practices. These consolidations have had an indirect impact on MPL insurers as they changed their customer base, necessitating a need for those insurers to find ways to recoup lost revenue. Competition

fueled by increasing loss costs caused combined ratios to rise to unsustainable levels, with MPL carriers like NorCal being forced to sell and other carriers placing a moratorium on writing large groups.

The severity of claims is also rising, and is projected to continue to rise. In our states, just since 2015, we've seen a surge in indemnity, with average paid indemnity almost quadrupling in Oregon and increasing by almost 30% in Washington. We do not anticipate any meaningful tort reform or other legislative changes to combat this uptick in indemnity. Social inflation is expected to continue as well, with a new juror mindset tending to view malpractice claims as a form of hitting the lottery. The trend toward hospitals and groups purchasing higher limits, coupled with plaintiff counsels bringing more claims against multiple defendants, will continue to push average claim settlements and verdicts higher and higher. Early projections of the repercussions of the COVID-19 pandemic indicate that the pandemic will cause further claims increases in years to come.

To address these changes and increases in loss costs, Physicians Insurance took responsible steps in 2019 and early 2020 to improve its financial performance. Our underwriters have taken premium increases on accounts driving losses through debits and reductions in premium credits, have been conservative in writing new business, and have not underbid to win accounts that were priced too low by the competition. The company also grew through new partnerships that brought in business appropriate to our overall risk portfolio.

However, even with these efforts, Physicians Insurance's increasing combined ratio is a warning sign. Although we have sufficient surplus to support combined ratios of more than 100% for several years, that doesn't mean that this is a status quo the company is able maintain in the long term. To maintain its AM Best rating of A-, Physicians Insurance needs to move steadily back to a combined ratio at or below 100%. After careful actuarial review, it has been determined that in addition to the efforts already made, it's time for the company to adjust base rates to reflect the true cost of insuring the delivery of medicine in 2020 and beyond.

The resulting rate increase for Washington is 8.0%. An actuarial study proposed a rate increase of 16.8%, but we felt that a smaller increase would be sufficient, if put in effect along with cost containment and other strategies. For Oregon, the rate increase is 15%. (Again, an actuarial study proposed an indicated mature base rate change of 59.2%, using other carrier rates as a reference.) Interestingly, in Oregon, purchased limits are generally higher than in Washington, and premiums are generally less—and our adjustment to the base rate takes this important factor into account.

Certainly, all the market dynamics described—including social inflation, the legislative environment, a consolidating healthcare industry, and others—will continue to bring changes in the short term. Increased claim severity may be a new constant the MPL industry will have to manage. With so many carriers facing the challenging new financial realities caused by these complex issues, the coming years will continue to see carriers working to adjust their policies and strengthen their financial performance, and Physicians Insurance will respond accordingly—but always with its members in mind. For more information on how these market dynamics and rate changes impact your policy, please contact your Physicians Insurance underwriter by calling (800) 962-1399 or writing to underwriting3@phyins.com.

Hospital Dashboard Report

Prosser Memorial Hospital [501312]

	Score	Rating
Overall Financial Position	★★	**Fair**
Performance Drivers		
Market Factors	★★	Fair
Coding & Billing	★★	Fair
Pricing	★★★	Average
Cost Position	★★	Fair
Labor Costs	★★★★	Good
Supply Costs	★★	Fair
Service Intensity	★★★	Average
Non Operating Income	★★	Fair
Investment Efficiency	★★★★	Good
Plant Obsolescence	★★★	Average
Capital Position	★★★	Average

Hospital Dashboard Report

Prosser Memorial Hospital

	Prosser Memorial Hospital [501312]	Revenues: $25 - 75 Million [REV1002]	All U.S. [STA0000]
Balance Sheet			
Cash & Cash Equivalents	1,221,656	4,138,853	41,464,550
Accounts Receivable	8,768,411	8,349,140	54,928,583
Total Current Assets	10,845,529	15,168,371	120,767,151
Net Fixed Assets	12,224,144	25,468,376	144,191,228
Investments	0	3,433,203	62,014,666
Total Assets	39,261,063	49,188,710	378,842,729
Current Liabilities	6,098,331	9,329,174	60,330,039
Long Term Debt	6,648,741	13,155,379	88,939,713
Equity	26,513,991	26,445,035	226,306,226
Income Statement			
Gross Patient Revenue	118,391,490	214,915,014	1,212,652,520
- Deductions	66,792,440	164,423,331	912,243,379
Net Patient Revenue	51,599,050	50,491,684	300,409,142
Other Operating Revenue	1,711,721	2,639,269	22,876,701
Total Operating Revenue	53,310,771	53,130,953	323,285,843
Total Expenses	52,969,155	51,882,512	306,171,928
Operating Income	341,616	1,248,441	17,113,915
Other Income	124,109	377,450	3,152,831
Net Income	465,725	1,625,891	20,266,747

Hospital Dashboard Report

Prosser Memorial Hospital

	Score	Rating	Prosser Memorial Hospital [501312]	Revenues: $25 - 75 Million [REV1002]	All U.S. [STA0000]
Reference					
Source of Financial Data			Medicare Cost Report	Medicare Cost Report	Medicare Cost Report
Source of Inpatient Data			Medicare Provider Analysis & Review (Medpar)	Medicare Provider Analysis & Review (Medpar)	Medicare Provider Analysis & Review (Medpar)
Source of Outpatient Data			Outpatient Analytical File	Outpatient Analytical File	Outpatient Analytical File
Year of Financial Data			2018	2019	2019
Year of Inpatient Data			2019	2019	2019
Year of Outpatient Data			2018	2019	2019
Financial Wage Index			1.0255	0.8411	0.9198
Inpatient Wage Index			1.0427		
Outpatient Wage Index			1.0255		
Financial Overview					
Return on Equity	★★	Fair	1.80	6.50	8
Economic Value Added (000's)	★★	Fair	-1,163	-456	1,183
Financial Strength Index®	★★	Fair	-2.30	-1.40	-0.40
Total Margin	★★	Fair	0.90	1.70	4.50
Operating Margin	★★	Fair	0.60	1.30	3.60
Market Factors					
Inpatient Revenue %	★★★★★	Excellent	25.10	30.50	41.30
Surgical Cases %	★	Poor	8.70	16.50	25
Expected Profit on DRGs %	★★★	Average	2	3	-0.40
Expected Profit on APCs %	★★★	Average	-17.10	-11.60	-15.60
Market Share %	★	Poor	6	100	51.40
Medicaid Days %**	★★★★	Good	16.80	18.10	19.90
Medicare Days %**	★	Poor	68.10	56.70	54.50
Inpatient Disproportionate Share %			N/A	3	3
Medicaid Charges %	★	Poor	32.70	14.50	14.20
Charity Care %	★★★	Average	1.80	1.50	1.60
Uncompensated Care %	★★	Fair	10.90	7.80	6.60
Admissions From SNF %	★	Poor	0	0.20	1.20
Revenue Growth(last year) %	★★★★	Good	7.60	3.30	4
Equivalent Discharges™	★	Poor	6,459	6,084	19,377
Inpatient Equivalent Discharges™	★	Poor	1,633	2,479	9,196
Outpatient Equivalent Discharges™	★★	Fair	4,826	3,399	9,372
2-yr Change in Equivalent Discharges™	★★★★★	Excellent	16.70	1.70	5.30
Coding & Billing					
Change in Medicare CMI %	★	Poor	-7.20	2	2.60
Medicare CMI	★	Poor	1.2044	1.3859	1.6193
CC/ MCC Capture Rate	★★★	Average	60.65	58.01	62.01
MSDRG Family Reporting Rates - Pneumonia	★★★	Average	0.92	0.89	0.91
MSDRG Family Reporting Rates - Heart Failure	★★★★	Good	0.95	0.92	0.95
MSDRG Family Reporting Rates - Sepsis	★	Poor	0.58	0.74	0.78
MSDRG Family Reporting Rates - Major Joint Hip/Knee	★★★★★	Excellent	0.14	0.05	0.06
Short Stay - Chest Pain			N/A	66.70	60
Short Stay - Congestive Heart Failure	★★★	Average	11.80	13.30	13
Short Stay - Back Pain	★	Poor	50	0	30.80
Short Stay - Gasteroenteritis	★	Poor	50	20	22.20
Overall Short Stay (LOS = 1)	★★★★	Good	15.20	20	20.80
Overall Short Stay (LOS <=2)	★★	Fair	53.10	49.60	47.20
Inpatient Outlier Payment %	★★★★★	Excellent	0	0.40	1.10
Change in Relative Wt (SMI) %	★★★★	Good	11	4.30	7.30
Avg Relative Wt per Outpatient Visit (SMI)	★★★★★	Excellent	13.2071	7.4227	9.0131
NCCI Error Rate %	★	Poor	2.4044	0.1287	0.1168
Injectable Drug without Administration %			N/A	7.10	9.80
Add-on Code without Parent %			N/A	2.90	36.30
Potential Excessive Payments %	★★★★★	Excellent	0	0.3842	0.3541
Average ED Level	★★★	Average	3.851	3.807	3.904
Average ED Payment	★★★	Average	362†	345†	359†
Pricing					
Hospital Charge Index®			N/A	101.70	105.40
Average Charge per Medicare Discharge (CMI = 1.0)*	★★★★★	Excellent	17,899	25,249	28,769
Average Charge per Visit (RW = 1.0)*	★★★★★	Excellent	239	506	494
Routine Room Rate*	★★	Fair	2,332	1,664	2,003
Chest X - Ray(71020) *	★★★★	Good	305	393	399
Non - Govt.Payers %	★	Poor	15.10	21.70	23.40
Markup(Charges / Cost)	★★★★★	Excellent	2.27	3.55	3.68
Deduction %	★★★★★	Excellent	56.40	71.50	73
Net Patient Revenue per Equivalent Discharge™*	★★	Fair	7,989	9,467	9,034

Hospital Dashboard Report

Prosser Memorial Hospital

	Score	Rating	Prosser Memorial Hospital [501312]	Revenues: $25 - 75 Million [REV1002]	All U.S. [STA0000]
Cost Position					
Hospital Cost Index®			N/A	104.90	100
Average Cost per Medicare Discharge (CMI = 1.0)*	★★	Fair	9,222	8,162	7,856
Average Cost per Visit (RW = 1.0)*	★★★★	Good	86	96	93
Direct Cost per Routine Day*	★★	Fair	759	612	593
Direct Cost per ICU/CCU Day*			N/A	1,085	1,111
Overhead Cost %	★★★	Average	33	36	34
Capital Costs per Equivalent Discharge™*	★★★★★	Excellent	254	669	607
Average Cost per Equivalent Discharge™*	★★★★	Good	8,178	9,667	9,055
Average Cost per Equivalent Discharge (Excl Subproviders & non-reimbursables)™*	★★★★	Good	6,471	7,932	7,352
Labor Costs					
Net Patient Revenue per FTE*	★★	Fair	191,391	185,578	207,936
Man-hours per Equivalent Discharge™	★★★★★	Excellent	0.0†	98.70	88.50
Physician Cost per Equivalent Discharge™*	★	Poor	1,091†	452	392
Salary per FTE*	★★★★★	Excellent	0†	74,430	74,951
Fringe Benefit %	★★★★★	Excellent	0.0†	23.40	24.50
Supply Costs					
Avg Pharmacy Cost per Medicare Discharge (CMI = 1.0)	★★★	Average	591	547	623
Avg Medical Supply Cost per Medicare Discharge (CMI = 1.0)	★★★★	Good	419	577	738
MSDRG 247 Supply Cost			N/A	2,951	3,216
MSDRG 470 Supply Cost	★	Poor	8,531	5,570	5,385
MSDRG 244 Supply Cost			N/A	4,942	5,156
MSDRG 330 Supply Cost	★★★★★	Excellent	1,038	1,860	2,069
MSDRG 194 Pharmacy Cost	★★	Fair	794	644	668
MSDRG 603 Pharmacy Cost	★★	Fair	984	741	766
MSDRG 392 Pharmacy Cost	★★	Fair	840	591	614
MSDRG 690 Pharmacy Cost	★★★	Average	548	515	542
Service Intensity					
Avg Lab Cost per Medicare Discharge (CMI = 1.0)*	★	Poor	728	438	427
Avg Radiology Cost per Medicare Discharge (CMI = 1.0)*	★★★★★	Excellent	147	240	238
Medicare LOS(CMI = 1.0)	★★★	Average	2.60	2.60	2.70
Ancillary Cost per Medicare Discharge (CMI = 1.0)*	★★★	Average	4,028	4,030	4,111
Non Operating Income					
Days Cash on Hand	★★★	Average	9	10	22
Investment Income / Investment %			N/A	2.20	2.20
Portfolio in Equities %			N/A	N/A	N/A
Investment Efficiency					
Days in A/R	★★	Fair	62	52	52
Inventory/ Net Patient Revenue %	★★★★★	Excellent	0.70	2.10	2
Revenue/ Net Fixed Assets	★★★★★	Excellent	4.37	2.51	2.55
Plant Obsolescence					
Average Age of Plant	★★	Fair	17.30	11.10	11.50
2-yr Change in Net Fixed Assets	★★★★	Good	6.50	-4.60	-1.20
Capital Position					
Long Term Debt/Equity %	★★★	Average	25.10	3.70	13.20
Average Cost of Equity %	★★	Fair	6.30	5.0†	5.20
Times Interest Earned	★★★	Average	3.80	2.80	5
Debt Financing %	★★★	Average	32.50	42.60	38.80

Prosser
Memorial Health Foundation

Prosser Memorial Health

New Hospital
Prospectus

prosserhealth.foundation

Introduction

For more than 70 years, Prosser Memorial Health (PMH), a rural, 25-bed critical access hospital, has served Prosser and its surrounding communities. After years of enthused community-led fundraising, PMH's rich history began in 1945 when construction crews broke ground on the 19-bed facility. Two years later, on December 26, 1947, Prosser Memorial Hospital opened, dedicated to the memory and service of World War II veterans.

This modest, small-town hospital blossomed into a community-focused center for exceptional medical care serving thousands of patients every year. Our care and provider base scope includes family medicine, advanced surgical care, laboratory, state-of-the-art diagnostic imaging, obstetrics, and emergency care.

Today, the hospital's facilities are dated and not fully compliant with the Americans with Disabilities Act. Building a new facility is a more cost-effective approach than renovating the hospital. We have land for a new hospital. We plan to sell the existing grounds and facility.

Our Mission

Prosser Memorial Health will improve the health of our community.

Our Vision

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

Our Six Pillars of Excellence

#1 Patient Loyalty: PMH will provide outstanding customer service, aspiring to treat those we serve the way they want to be treated.
GOAL: PMH will achieve a patient satisfaction rate of 95% or higher.

#2 Medical Staff Development: PMH will respond to the Medical Staff concerns and needs in a timely manner, pursue initiatives in collaboration with our Medical staff and ensure the availability of the appropriate providers for those we serve.
GOAL: PMH will achieve and maintain an annual Medical Staff satisfaction rate of 90% or higher.

#3 Employee Development: PMH will encourage and provide for the ongoing development of our employees. We will provide an atmosphere that values our employees and promotes:
- Open Communication.
- Competitive wages and benefits.
- Selection and retention of effective, caring personnel.
- Utilization and development of talent throughout the organization.
- On-going education.
- Employee recognition.

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

#4 Quality: PMH will develop and maintain a system of continuous improvement which is incorporated into the daily work of every employee and Medical Staff member.
GOAL: PMH will achieve an iVantage score of 49 or higher.

#5 Service: PMH will develop and maintain appropriate facilities, technology and services to meet the needs of those we serve that includes building a replacement facility.
GOAL: PMH will achieve a 50% market share of our great community for those services we provide.

#6 Financial Stewardship: PMH will continue to strengthen its financial stewardship position to enhance the ability to develop new services, obtain needed technology, modernize facilities, recruit physicians and ultimately ensure long-term viability.
GOAL: PMH will achieve an annual total margin of 6% or more.

PMH Stats & Impacts

Major Employer
400+ Full Time Employees

$35,300,000 Salaries & Wages
Compensation multiplies throughout the area spent on groceries, dining, retail goods, services, vehicles, and more!

Hospital Admissions
Category Growth

Hospital Admissions and outpatient services have consistently increased since 2015. Infant births have increased by nearly 24%. Adjusted patient days that include inpatient and outpatient services combined have more than doubled since 2013. We have grown our active medical staff 66% since 2017.

All statistics are 2020 budget or annualized.

Prosser
Memorial Health Foundation

About the Foundation

The Prosser Memorial Health Foundation pursues, receives, and administers donations and gifts for PMH. The Foundation supports and enhances healthcare for the Lower Yakima Valley and the surrounding region. The Foundation assists with new equipment purchases, funding for scholarships, building projects, and other organizational advancements.

The Foundation has several designated funds. The Wayne Hogue Capital Fund will "host" gifts for the new hospital.

The Wayne Hogue Capital Fund: *Financial support for staff training, hospital equipment, and facility improvements, including building the new hospital.*

Wayne, a generous philanthropist and businessman, leads by example. As a past Chairman of our Board of Commissioners, he used his many resources and talents to improve the high-quality healthcare we enjoy today.

Wayne believed for fundraising, "You just have to ask." The Hospital and Wayne's objectives are well-aligned for the best options and treatment with advanced technology and resources delivered in an inviting environment.

Community support from businesses, individuals, and foundations for the new hospital will be administered through this fund.

Our Community Need

Before the COVID-19 pandemic, PMH grew at a rate of 10% each year for the last four years. We have expanded service lines, purchased new equipment, and added clinics and providers to our team in response to community needs. Today it is clear we must continue to grow and respond to the increased demand for high-quality, low-cost healthcare in the communities we serve.

Our patient count from both east and west of Prosser continues to grow. Patients have changed their healthcare provider because they trust PMH, and they know they will receive excellent care with dignity, respect, and optimism.

Our current facility is from a post-World War II era with many renovation and expansion rounds to stay current. Unfortunately, we have run out of room to expand the hospital at its current location. The facility is not ADA compliant and struggles to meet state and federal regulations for hospitals.

The hallways are narrow, operating rooms are too small to contain all the new equipment needed, with no private rooms for inpatient care. Also, the lack of parking and treacherous winter conditions while navigating the hill upon which the hospital sits add to the inconvenience.

The Way Forward

This is How We Care is not merely a PMH slogan; it is our way of life. We are committed to delivering high-quality healthcare. To serve our community now and well into the future, we plan to build a new hospital off I-82 and Gap Road. PMH purchased 33 acres there in 2017.

Since 2017, we have worked closely with the United States Department of Agriculture (USDA) on the extensive application process to secure a loan. The USDA approved our pre-application in 2019, which included a site visit to our current hospital. They agreed, PMH requires a new facility to care for patients.

With the USDA loan PMH will not bring a levy or bond to voters to fund this project. The architect and construction consultants project we would open the doors to the new hospital in early 2024, following the hospital's 75[th] anniversary in 2023.

The USDA loan requires community support as a component of the loan. To demonstrate substantial community support. We anticipate needing to raise $5 million dollars from the community.

Preliminary Cost and Revenue Projections

Estimated USDA loan proceeds	$47,300,000
Estimated PMH contribution	$12,700,000
Community fundraising goal	$5,000,000
Funding Total	**$65,000,000**

With the support and generosity of our community we will be able to build a state-of-the-art facility that will serve our needs for the next 100 years.

(This is a first phase draft. As the project progresses, we will share the most current renderings with our donors.)

SECOND FLOOR

FIRST FLOOR

NOTES:

1. +/-84,800 SF
2. Great D/B separation
3. Good future expansion paths for ED/Imaging/Surgery
4. Admin (soft space) for internal department growth.
5. Good future connection point for future MOB
6. HUB IP unit allows for skeletal staffing.
7. Pharmacy is located upstairs, adjacent to IP and LDRP.
8. Short walks to all departments from main entrance.
9. Best option for future patient room growth.

Prosser
Memorial Health

Prosser
Memorial Health Foundation

6

Outcomes

Prosser Memorial Health will be a **Center of Excellence**, providing high-quality, low-cost healthcare services to the communities we serve. This includes:

- State-of-the-art surgical suites and technology to respond to the needs in our community.

- New Birthing suites will allow for water-birth opportunities, enabling more flexibility to accommodate mothers' preferences in delivery.

- All inpatient rooms will be a private room with amenities to accommodate family and support people for our patients comfortably.

- 16% of rooms will be equipped for ICU, providing a higher level of care for our patients and keeping them close to home.

- Expand the Cardiology Clinic to include cardiac rehab and pulmonology, allowing patients recovering from a heart attack or pulmonary issues to stay in Prosser for their rehabilitation.

- A savings of 10 to 15 percent annually in utility costs with a new facility.

- Expanded Emergency Department.

- Medical Office Building for Specialists.

Why a Capital Campaign?

With most of the new hospital funding proposed to come from a USDA loan, some have questioned the necessity of a community capital campaign. A critical component of the USDA loan process is to demonstrate community support for this project. The capital campaign is the most effective means to illustrate the engagement by our region's stakeholders.

Campaign Oversight and Accountability

The Foundation Board of Directors and Hospital Board of Commissioners will oversee the capital campaign initiative. The Foundation Executive Director Shannon Hitchcock and Foundation CFO Stephanie Titus will manage administrative support and financial reporting.

Prosser
Memorial Health Foundation

Thank You!

We appreciate you reviewing this summary of our plan. Your thoughts and counsel about this exciting endeavor are essential.

Prosser Memorial Health Foundation Board of Directors

Officers
President – Julie Sollers
Vice President – Rich Legerski
Secretary – Lois Chilton
Treasurer – Evan Tidball

PMH Staff
Craig Marks – Chief Executive Officer
Shannon Hitchcock – Foundation Executive Director
Stephanie Titus – Foundation Chief Financial Officer

Board Members
Elisa Riley
Emily Carl
Frank Schroeder
Glenn Bestebreur
Keith Sattler
Lisa Veloz
Neal Ripplinger
Stephen Kenny
Susan Reams

Prosser
Memorial Health Foundation

Prosser
Memorial Health

Interview Date: August 20, 2020
~~6:45 p.m.~~ 5:30
Teams Meeting

Name: J. Neilan McPartland

Phone Number: 509-339-3141

Email: jmcpartland@numericacu.com

Current Title: Assistant Vice President - Regional Director

Current Employment: Numerica Credit Union

Areas of Expertise: Strategic Planning, Data Analysis

INTRODUCTION: (Please tell us about yourself and why you believe you would be an asset to the Prosser Memorial Health Board of Commissioners. Please describe your current title, company and major responsibilities you are accountable for.)

I believe that I would be an asset to the Board of Commissioners because I am a long term strategic thinker. I understand how to use and take advantage of resources to make quick, sound, and fiscally responsible decisions. In my current role, I am responsible for 60+ staff members and thousands of regional members.

CAREER HISTORY: (Give a brief career history, naming key companies and industries you have worked. If you are responsible for revenue mention that here. Describe the groups you have led, major initiatives you implemented.)

I have been in banking for the last 12 yrs.
I have driven intithatives in the following areas:
- Technology adoption and implementation
- Community out reach
- Hispanic initiative - This was an out reach effort
that has continued within my Company for the
Rst 7 years

BOARD SERVICE, HONORS, SPECIAL SKILLS AND EDUCATION (1 PARAGRAPH)

- Bachelors degree - Washington State University
- Western CUNA Management School - Pomona College
- Leadership Tri Cities Graduate
- Tri-Cities Area Journal of Business Top 10 Young Professionals
- Junior Achievement Volunteer
- School Advisory Committee - Christ the King School
- Board of Directors - Children's Developmental Center

Please complete and return via email to Carol Allen, Executive Assistant, at Prosser Memorial Health, callen@prosserhealth.org by Thursday, August 13. If you have any questions, please contact Carol at 509-786-6651.

Craig Marks

From:	Kristi Mellema
Sent:	Friday, October 02, 2020 11:35 AM
To:	!All Staff
Subject:	COVID Stats

Good morning – I've included some visual graphs regarding positive COVID tests that were done here at PMH. As you can see, there is steady decline which is great news! However, masking and hand hygiene continue to be a necessity. 😊 I've also included the Benton/Franklin graph at the bottom which also shows a decline for both counties. The health department did report this week that they have seen a little "bump" in positive tests the last week and a half which are being attributed to Labor Day weekend.

You can always look at the Benton/Franklin COVID-19 Dashboard at
https://www.bfhd.wa.gov/programs_services/investigations__outbreaks/c_o_v_i_d-19/benton-_franklin_case_count.

Keep up all the great work that you do every day! You are appreciated!!! Thank you!
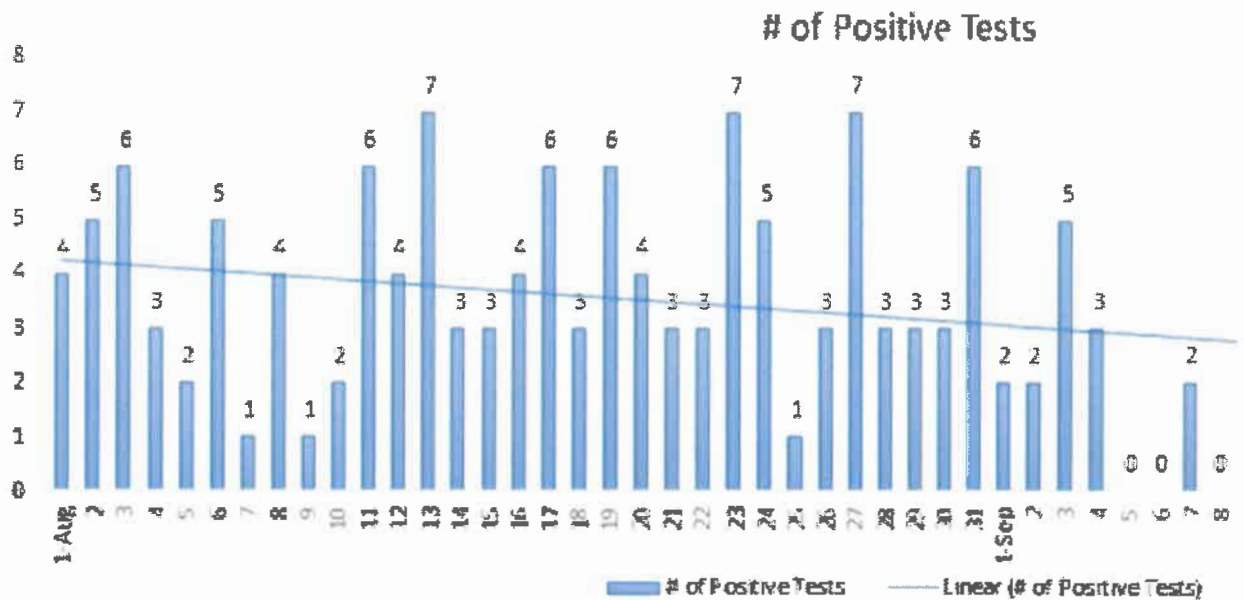
of positive cases
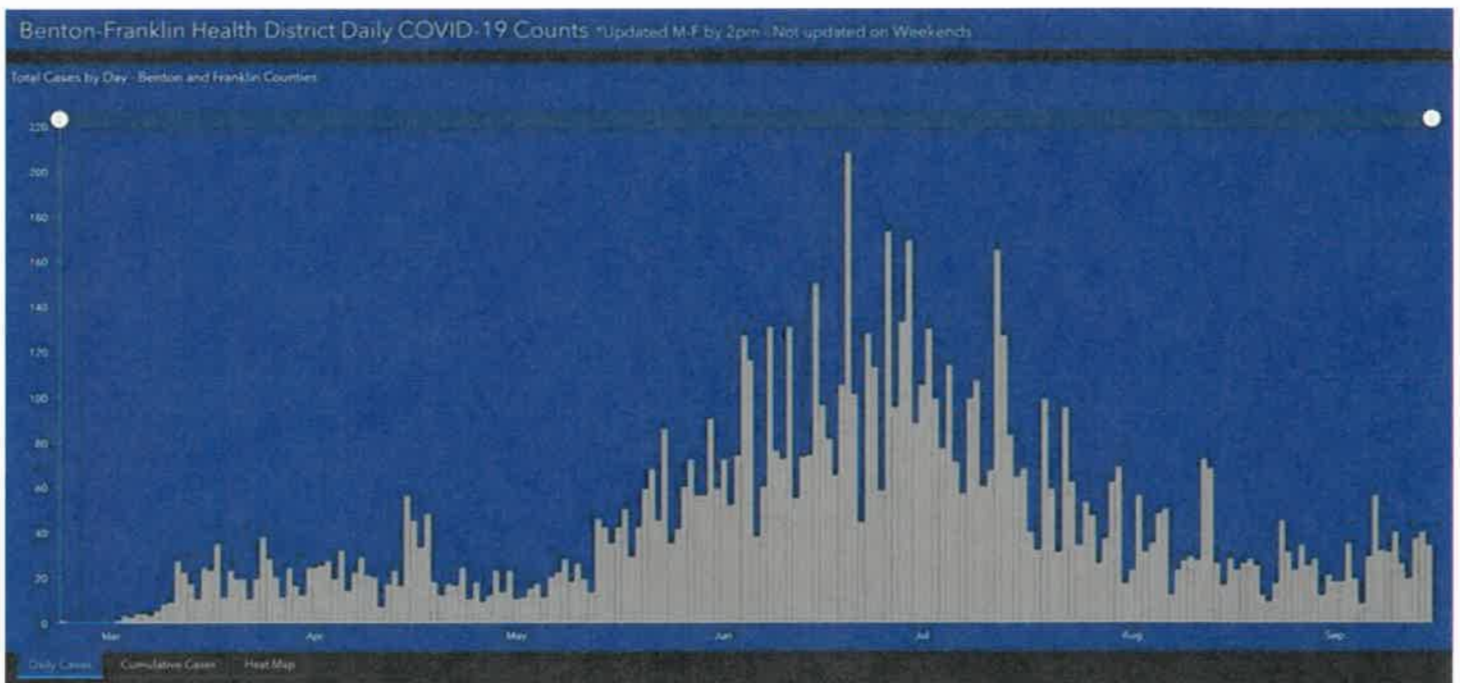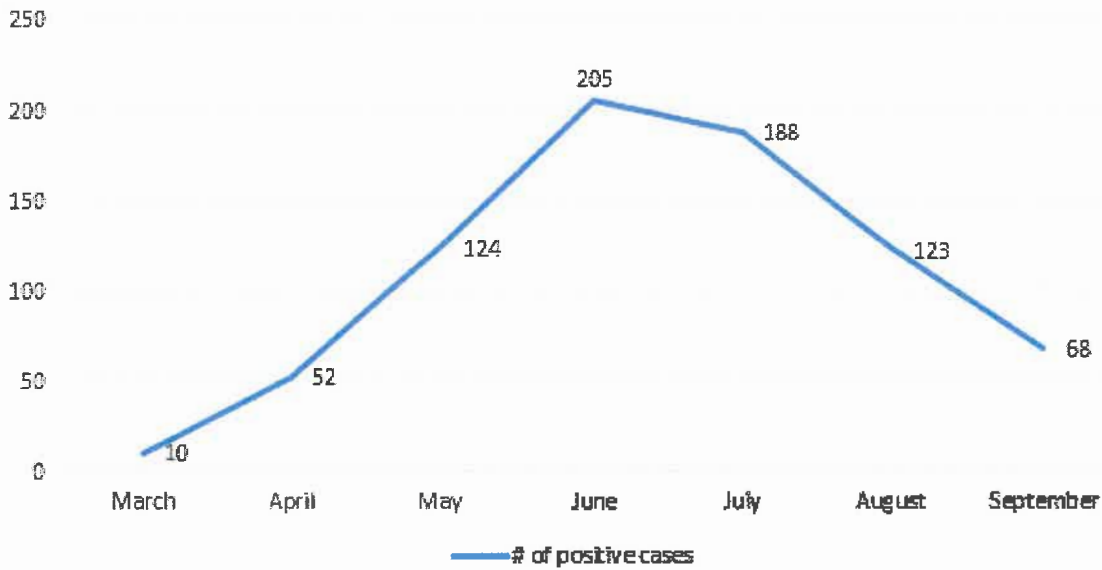
Kristi Mellema, BSN, RN, CPHQ, Chief Compliance & Quality Officer
Chief Compliance & Quality Officer | Administration
PROSSER MEMORIAL HEALTH
723 MEMORIAL ST | PROSSER, WA 99350
o: (509) 786 6646
kmellema@prosserhealth.org | www.prosserhealth.org

Craig Marks

From:	Kristi Mellema
Sent:	Wednesday, October 07, 2020 2:11 PM
To:	!All Staff
Subject:	Employee Flu Shot - REMINDER

Follow Up Flag:	Follow up
Flag Status:	Completed

Employee
Flu Shots

October 12
7:30 AM - 10:00 AM

October 13
3:30 PM - 5:30 PM

Get Your
Flu Shot

October 23
7:30 AM - 9:30 AM

Location
Vineyard Conference Room

***EMPLOYEE FLU SHOTS WILL BE DELIVERED TO THE PRIMARY CARE CLINICS AND WOMEN'S HEALTH CENTER THIS AFTERNOON!

Get a Flu Shot During COVID-19!

Flu vaccine is essential to help prevent illness during the pandemic

Both COVID-19 and the seasonal flu will be spreading simultaneously this fall and winter so everyone should do their part to prevent illness. Make sure you and your family get the flu vaccine and follow basic infection prevention practices to prevent COVID-19. Taking these actions will protect you and your loved ones and also conserve hospital beds and medical supplies for seriously ill patients. Do your part to safeguard your community! Visit vaccinefinder.org to find a flu shot location near you.

Fight Flu with a Flu Shot

Everyone, every year. Each person 6 months of age and older needs a flu vaccine each year. This includes pregnant women and people with chronic health conditions.

Vaccines are updated from one season to the next. Flu viruses are constantly changing so you need to get vaccinated each year.

Protect your herd. Vaccination protects us as a community so that individuals who can not be vaccinated – such as newborns and the immunocompromised – are afforded some protection.

It's not too late to get a flu shot. The flu season usually starts in October and lasts through May. You should get your shot before the end of October but waiting until January or February may still offer protection.

Safe and effective. Flu vaccines have a good safety record. Minor side effects may include soreness or swelling at the injection site and low-grade fever and aches. While some people who get vaccinated still get sick, their illness is usually less severe.

Follow the Basics of COVID-19 Prevention

Wear a facemask outside the home. Masks should completely cover your nose and mouth.

Maintain social distancing. Stay at least 6 feet from others when outside the home.

Keep your hands clean. Wash your hands often with soap and water or use hand sanitizer. Cover your coughs and sneezes with your elbow or a tissue.

Don't touch your face. Keep hands away from your eyes, nose, and mouth.

Stay home if you feel sick. Call your provider immediately if you experience any symptoms of COVID-19 or have had close exposure to someone who has recently tested positive for COVID-19.

Kristi Mellema, BSN, RN, CPHQ, Chief Compliance & Quality Officer
Chief Compliance & Quality Officer | Administration
PROSSER MEMORIAL HEALTH

Prosser Memorial Health

Organization	Purpose	Award	Date Rec'd	Amount Recognized	Balance Remaining	Repayment	Funding Type	Other Notes
Greater Columbia Accountability of Health	Telehealth Application Funding for relief during the COVID19 crisis	$ 6,000	4/3/2020	$ 6,000	$ -	$ -	EFT	Received for initial telehealth expenditures
HHS	Stimulus Payment	$ 760,801	4/10/2020	$ 760,801	$ -	$ -	EFT	Attestation completed within 30 days of funds received (completed 4/13/2020)
CMS Medicare Advanced Benefits	Advance of Medicare Payments	$ 6,591,980	4/21/2020	$ -	$ -	$ 6,591,980	EFT	Three months worth of Medicare payments advanced to PMH. Due to be repaid in November 2020 with zero forgiveness
HHS	Stimulus Payment	$ 271,197	4/24/2020	$ 271,197	$ -	$ -	EFT	Attestation completed within 30 days of funds received (completed 5/27/2020)
US Bank SBA Economic Injury Disaster Loan (EIDL)	Payroll Protection Forgiveness Loan	$ 10,000	4/30/2020	$ 10,000	$ -	$ -	EFT	US Bank SBA grant deposited into our account
US Bank SBA Payroll Protection Program Loan (PPPL)	Payroll Protection Forgiveness Loan	$ 6,350,235	5/4/2020	$ -	$ 6,350,235	$ -	EFT	Equivalent to 2.5 months worth of Payroll expenses and we have been able to maintaine Payroll expenses at historical levels. Due to be forgiven by the end of the year. Have reserved approximately 55% of grant award for Medicare/Medicaid paybacks
HHS	CARES Provider Relief Fund - Rural Allocation	$ 4,170,732	5/6/2020	$ 2,773,457	$ 1,397,275	$ -	EFT	Each CAH will receive at least $1,000,000 with the average CAH/Rural Hospital to receive $4,000,000 and each Rural Health Clinic to receive at least $100,000 with the average to be about $180,000. We recieved $4,170,732. NARHC.ORG (National Association of Rural Health Clinics)
HHS	Stimulus Payment	$ 49,461	5/20/2020	$ -	$ 49,461	$ -	EFT	CARES Act Rural specific relief funds for rural health clinics
WSHA	ASPR PPE purchase from WSHA	$ 20,000	5/21/2020	$ 20,000	$ -	$ -	CHECK	Grant funds processed thru WSHA and spent on PPE for staff
Medicaid SRDSH	SRDSH reallocation of addt'l funds	$ 29,382	5/22/2020	$ 29,382	$ 0		EFT	The SRDSH amount that is funded by the HSHA fund, is set by RCW at $1,009,000, and the federal matching funds has historically been 50%. Due to the current COVID-19 pandemic, congress passed the CARES ACT, which increase the federal matching percentage to 56.2% effective 1/1/2020
HHS	Stimulus Payment	$ 49,461	6/9/2020	$ -	$ 49,461	$ -	EFT	CARES Act Rural specific relief funds for rural health clinics
HHS	Stimulus Payment	$ 150,680	6/16/2020	$ -	$ 150,680	$ -	EFT	CARES Act Rural specific relief funds for rural health clinics
HHS	Stimulus Payment	$ 103,253	6/25/2020	$ -	$ 103,253	$ -	EFT	CARES Act Rural specific relief funds for rural health clinics
HHS	Stimulus Payment	$ 1,300,000	7/20/2020	$ 1,300,000	$ -		EFT	CARES Act Rural specific relief funds for rural health clinics
HRSA (WA DOH)	SHIP	$ 83,136	7/27/2020	$ -	$ 83,136	$ -	EFT	Other HHS conforming your hospital to from the FY 2020 NCC. as HRSA will not need any application information up front. There will be follow up information requested as a condition on your award and quarterly reporting requirements for the hospitals receiving SHIP COVID-19 funds
Molina	PCP Stabilization Payment	$ 25,434	8/4/2020	$ 25,434	$ -	$ -	EFT	Molina Healthcare provided COVID payments to providers
	Totals	$ 19,971,754		$ 5,196,271	$ 8,183,503	$ 6,591,980		

Attachment LL

Prosser
Memorial Health

STATEMENT OF OPERATIONS

	Actual 2018	Actual 2019	Budget 2020			Projected 2020		
Gross Patient Services Revenue								
Inpatient	29,604,722	32,299,988	34,564,819	2,264,831	7.0%	33,280,434	(1,284,385)	-4%
Outpatient	88,786,759	109,767,804	125,833,980	16,066,176	14.6%	109,037,889	(16,796,091)	-13%
Total Gross Patient Services Revenue	**118,391,481**	**142,067,791**	**160,398,799**	**18,331,008**	**12.9%**	**142,318,323**	**(18,080,476)**	**-11%**
								IP
								OP
								Total
Contractual Allowances								
Medicare	20,525,466	27,928,741	32,236,053	4,307,311	15.4%	26,699,663	(5,536,390)	-17%
Medicaid	26,511,175	31,140,282	35,645,007	4,504,715	14.5%	30,346,306	(5,298,702)	-15%
Negotiated Rates	14,177,999	16,817,667	20,591,779	3,774,112	22.4%	17,414,950	(3,176,829)	-15%
Other Adjustments	1,230,238	1,343,734	2,251,696	907,962	67.6%	1,970,277	(281,419)	-12%
Gross Contractual Allowances	**62,444,878**	**77,230,435**	**90,724,536**	**13,494,100**	**17.5%**	**76,431,195**	**(14,293,341)**	**-16%**
Charity Care	2,108,996	1,671,832	2,001,181	329,350	19.7%	2,315,260	314,079	16%
Bad Debt	2,325,567	4,031,596	4,220,415	188,818	4.7%	4,391,742	171,327	4%
Total Deductions From Revenue	**66,879,441**	**82,933,863**	**96,946,132**	**14,012,269**	**16.9%**	**83,138,197**	**(13,807,935)**	**-14%**
Net Patient Services Revenue	**51,512,040**	**59,133,929**	**63,452,668**	**4,318,739**	**7.3%**	**59,180,126**	**(4,272,541)**	**-7%**
HHS Federal Funds						6,378,809	6,378,809	
Other Grants related to COVID19						6,000	6,000	
Paycheck Protection Program (Net of Medicare)						6,360,235	6,360,235	
Other Operating Revenue	704,674	1,680,884	1,140,583	(540,301)	-32.1%	935,793	(204,790)	-18%
Net Revenue	**52,216,714**	**60,814,813**	**64,593,251**	**3,778,438**	**6.2%**	**72,860,963**	**8,267,712**	**13%**
Operating Expenses								
Salaries	23,106,905	27,475,682	28,602,691	1,127,009	4.1%	28,953,408	350,717	1%
Benefits	6,299,128	6,260,014	6,623,166	363,152	5.8%	6,611,241	(11,925)	0%
Purchased Labor	3,345,598	2,843,126	2,359,009	(484,117)	-17.0%	2,629,437	270,428	11%
Sub-Total Labor Costs	**32,751,631**	**36,578,823**	**37,584,866**	**1,006,044**	**2.8%**	**38,194,085**	**609,219**	**2%**
Professional Fees - Physicians	3,477,937	4,047,076	3,799,311	(247,765)	-6.1%	3,992,123	192,812	5%
Professional Fees - Other	741,499	509,434	542,457	33,023	6.5%	407,729	(134,728)	-25%
Supplies	5,194,133	7,040,429	7,749,096	708,667	10.1%	7,873,605	124,509	2%
Purchased Services - Utilities	480,365	491,784	536,197	44,413	9.0%	554,260	18,063	3%
Purchased Services - Other	4,093,714	3,320,394	3,364,521	44,127	1.3%	3,196,054	(168,468)	-5%
Rentals & Leases	1,886,737	2,132,297	2,262,944	130,646	6.1%	2,103,958	(158,986)	-7%
Insurance License & Taxes	584,572	738,376	733,737	(4,639)	-0.6%	892,565	158,828	22%
Depreciation & Amortization	1,988,410	2,443,594	2,720,000	276,406	11.3%	2,748,872	28,872	1%
Other Operating Expenses	1,292,044	1,259,784	1,470,060	210,276	16.7%	1,144,635	(325,425)	-22%
Sub-Total Non-Labor Expenses	**19,741,411**	**21,983,167**	**23,178,324**	**1,195,157**	**5.4%**	**22,913,801**	**(264,522)**	**-1%**
Total Operating Expenses	**52,493,042**	**58,561,990**	**60,763,190**	**2,201,200**	**3.8%**	**61,107,887**	**344,697**	**1%**
Operating Income (Loss)	**(276,328)**	**2,252,823**	**3,830,061**	**1,577,238**	**70.0%**	**11,753,076**	**7,923,015**	**207%**
Non Operating Income								
Tax Revenue	821,458	846,680	833,589	(13,091)	-1.5%	852,155	18,566	2%
Investment Income	215,615	335,335	272,476	(62,859)	-18.7%	121,148	(151,328)	-56%
Interest (Expense)	(171,572)	(355,362)	(403,586)	(48,225)	13.6%	(394,053)	9,534	-2%
Other Non Operating (Expense)	(161,830)	71,875	25,870	(46,005)	-64.0%	(33,285)	(59,155)	-229%
Total Non Operating Income	**703,669**	**898,528**	**728,349**	**(170,179)**	**-18.9%**	**545,965**	**(182,384)**	**-25%**
Net Income (Loss)	**$ 427,341**	**$ 3,151,351**	**$ 4,558,410**	**$ 1,407,059**	**44.6%**	**12,299,041**	**7,740,631**	**170%**
Operating Margin	*-0.54%*	*3.81%*	*6.04%*			*19.86%*		
Total Margin	*0.82%*	*5.18%*	*7.06%*			*16.88%*		

	January	February	March	April	May	June	July	August	September	October	November	December	2020
Gross Patient Services Revenue													
Inpatient	2,864,636	3,010,011	2,635,344	2,206,745	2,520,235	3,042,365	3,178,603	2,759,767	2,669,699	2,922,455	2,712,301	2,758,272	33,280,434
Outpatient	10,071,001	9,445,153	8,882,599	5,357,211	6,692,398	9,162,181	9,501,319	10,082,833	9,721,811	10,415,279	9,770,254	9,935,851	109,037,889
Total Gross Patient Services Revenue	12,935,637	12,455,164	11,517,943	7,563,956	9,212,633	12,204,546	12,679,922	12,842,600	12,391,510	13,337,734	12,482,555	12,694,124	142,318,323
Contractual Allowances													
Medicare	2,632,393	2,720,808	1,872,267	995,183	1,611,449	2,019,352	2,123,486	2,764,334	1,817,288	2,821,330	2,628,148	2,699,625	26,699,683
Medicaid	2,462,158	2,881,363	2,564,561	2,088,300	1,938,730	2,427,413	3,115,446	2,843,908	2,528,387	2,625,849	2,406,365	2,463,825	30,346,306
Negotiated Rates	1,970,832	1,535,802	1,259,890	363,732	1,146,693	1,738,176	1,625,968	1,471,853	1,799,267	1,546,185	1,455,080	1,501,472	17,414,950
Other Adjustments	152,100	143,288	395,710	40,602	(68,462)	265,524	291,657	496,025	(362,398)	213,404	199,721	203,106	1,970,277
Gross Contractual Allowances	7,217,483	7,281,261	6,092,428	3,487,817	4,628,410	6,450,465	7,156,557	7,576,120	5,782,544	7,206,768	6,689,315	6,862,028	76,431,195
Charity Care	70,465	207,726	147,685	40,927	49,448	149,222	337,712	77,110	79,533	400,132	374,477	380,824	2,315,260
Bad Debt	366,493	154,253	325,725	268,555	255,700	326,276	138,652	256,521	836,019	506,834	474,337	482,377	4,391,742
Total Deductions From Revenue	7,654,441	7,643,240	6,565,838	3,797,299	4,933,558	6,925,963	7,632,921	7,909,751	6,698,096	8,113,733	7,538,129	7,725,228	83,138,197
Net Patient Services Revenue	5,281,196	4,811,924	4,952,105	3,766,657	4,279,075	5,278,583	5,047,001	4,932,849	5,693,414	5,224,000	4,944,426	4,968,896	59,180,126
	59%	61%	57%	50%	54%	57%	60%	82%	54%	61%	60%	61%	
HHS Federal Funds			2,200,384				144,553	1,450,518	1,300,000	423,287	395,686	464,381	6,378,809
Other Grants related to COVID19				6,000									6,000
Paycheck Protection Program (Net of Medicare)					1,325,149	1,481,428	61,029	(2,857,606)				6,350,235	6,360,235
Other Operating Revenue	54,446	48,156	79,111	53,953	64,385	58,859	61,424	125,401	132,732	48,412	48,412	160,502	935,793
Net Revenue	5,335,642	4,860,080	5,031,216	6,026,994	5,668,609	6,818,870	5,314,007	3,651,162	7,126,146	5,695,699	5,388,524	11,944,014	72,860,963
	106%	101%	93%	113%	101%	118%	102%	68%	131%	100%	102%	218%	123%
Lost Net Patient Revenue	(270,050)	(1,591,642)	(1,311,105)	(330,633)	(99,010)	(463,520)	414,152	(423,287)	(204,744)	(561,128)			(4,612,986)
Operating Expenses													
Salaries	2,390,097	2,319,195	2,438,079	2,243,147	2,292,652	2,362,460	2,472,695	2,378,145	2,802,563	2,480,189	2,375,660	2,398,526	28,953,408
Benefits	577,012	555,392	440,583	739,833	604,325	419,678	578,549	396,087	632,020	564,043	550,363	553,356	6,611,241
Purchased Labor	249,096	283,557	329,407	261,699	135,882	166,436	169,347	176,412	277,138	202,452	187,354	190,657	2,829,437
Sub-Total Labor Costs	3,216,205	3,158,144	3,208,069	3,244,679	3,032,859	2,948,574	3,220,591	2,950,644	3,711,721	3,246,685	3,113,377	3,142,538	38,194,086
Professional Fees - Physicians	389,778	279,808	257,635	419,725	288,245	326,140	320,182	393,900	356,882	316,609	316,609	316,609	3,992,123
Professional Fees - Other	43,960	58,785	19,051	93,438	49,659	64,682	37,919	(112,693)	17,314	45,205	45,205	45,205	407,729
Supplies	619,449	675,545	762,215	527,615	481,223	516,166	689,329	720,675	901,242	663,338	648,404	668,404	7,873,605
Purchased Services - Utilities	43,249	43,959	40,757	31,315	46,537	46,325	59,031	52,110	57,118	44,683	44,683	44,683	554,280
Purchased Services - Other	261,428	230,546	359,733	222,165	228,231	255,449	279,915	352,210	166,143	280,078	280,078	280,078	3,196,054
Rentals & Leases	194,404	170,987	167,981	152,417	153,829	180,783	176,162	168,937	172,722	188,579	188,579	188,579	2,103,958
Insurance License & Taxes	60,430	99,269	87,383	85,150	58,860	36,853	39,883	91,582	77,705	85,150	85,150	85,150	892,565
Depreciation & Amortization	222,577	227,538	224,010	228,367	229,348	231,347	232,391	232,273	232,977	229,348	229,348	229,348	2,748,872
Other Operating Expenses	104,447	103,657	107,679	92,318	92,182	(21,863)	114,301	56,152	128,247	122,505	122,505	122,505	1,144,635
Sub-Total Non-Labor Expenses	1,939,722	1,890,104	2,036,444	1,852,510	1,627,914	1,635,882	1,949,113	1,955,146	2,110,350	1,975,495	1,960,561	1,980,561	22,913,801
Total Operating Expenses	5,155,927	5,048,248	5,244,513	5,097,189	4,660,773	4,584,456	5,169,704	4,905,790	5,822,071	5,222,179	5,073,938	5,123,099	61,107,887
	104%	105%	103%	101%	90%	88%	103%	97%	115%	100%	101%	101%	
Operating Income (Loss)	179,715	(188,168)	(213,297)	929,805	1,007,836	2,234,414	144,303	(1,254,628)	1,304,075	473,520	314,586	6,820,915	11,753,076
Non Operating Income													
Tax Revenue	71,840	65,599	77,314	73,881	69,589	70,784	72,711	71,007	69,246	70,061	70,061	70,061	852,155
Investment Income	22,527	22,036	19,425	18,000	12,391	12,242	3,385	2,600	2,542	2,000	2,000	2,000	121,148
Interest (Expense)	(32,996)	(19,892)	(33,218)	(35,750)	(32,897)	(35,496)	(37,969)	(42,518)	(22,420)	(33,632)	(33,632)	(33,632)	(394,053)
Other Non Operating (Expense)	(222)	-	-	500	13,684	(57,915)	-	4,200	-	2,156	2,156	2,156	(33,285)
Total Non Operating Income	61,149	67,743	63,521	56,631	62,767	(10,385)	38,127	35,289	49,368	40,585	40,585	40,585	545,965
Net Income (Loss)	240,864	(120,425)	(149,776)	986,436	1,070,603	2,224,029	182,430	(1,219,339)	1,353,443	514,105	355,171	6,861,500	12,299,041
Operating Margin	3.40%	-3.91%	-4.31%	24.69%	23.55%	42.33%	2.85%	-25.43%	22.90%	9.06%	6.36%	137.27%	19.86%
Total Margin	4.51%	-2.48%	-2.98%	16.37%	18.89%	32.62%	3.43%	-33.40%	18.99%	9.03%	6.59%	57.45%	16.88%

Prosser Memorial Health

Organization	Purpose	Award	Date Rec'd	Amount Recognized	Balance Remaining	Repayment	Funding Type	Other Notes
Greater Columbia Accountability of Health	Telehealth Application Funding for relief during the COVID19 crisis	$ 6,000	4/3/2020	$ 6,000	$ -	$ -	EFT	Received for initial telehealth expenditures
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CMS Medicare Advanced Benefits	Advance of Medicare Payments	$ 6,591,980	4/21/2020	$ -	$ -	$ 6,591,980	EFT	Three months worth of Medicare payments advanced to PMH. Due to be repaid in November 2020 with zero forgiveness.
HHS	Stimulus Payment	$ 271,197	4/24/2020	$ 271,197	$ -	$ -	EFT	Attestation completed within 30 days of funds received (completed 4/27/2020)
US Bank SBA Economic Injury Disaster Loan (EIDL)	Payroll Protection Forgiveness Loan	$ 10,000	4/30/2020	$ 10,000	$ -	$ -	EFT	US Bank SBA grant deposited into our account
US Bank SBA Payroll Protection Program Loan (PPPL)	Payroll Protection Forgiveness Loan	$ 6,350,235	5/4/2020	$ -	$ 6,350,235	$ -	EFT	Equivalent to 3.5 months worth of Payroll expenses and forgiveable based upon maintaining Payroll expenses at historical levels. Due to be forgiven by the end of the year. Have recouped approximately 55% of expenses... for Medicare/Medicaid payback.
HHS	CARES Provider Relief Fund - Rural Allocation	$ 4,170,732	5/6/2020	$ 2,773,457	$ 1,397,275	$ -	EFT	...CARES will receive at least $1,000,000 with the average CAH/Rural Hospital to receive $4,000,000 and each Rural Health Clinic to receive at least $100,000 with the average to be about $160,000. We received $4,170,732. NARHC.ORG (National Association of Rural Health Clinics)
HHS	Stimulus Payment	$ 49,461	5/20/2020	$ -	$ 49,461	$ -	EFT	CARES Act. Rural specific relief funds for rural health clinics.
WSHA	ASPR PPE purchase from WSHA	$ 20,000	5/21/2020	$ 20,000	$ -	$ -	CHECK	Grant funds passed through WSHA and spent on PPE for staff.
Medicaid SRDSH	SRDSH reallocation of addt'l funds	$ 29,382	5/22/2020	$ 29,382	$ 0	$ -	EFT	The SRDSH amount that is funded by the PSNA fund, as set by RCW at $1,000,000, and the federal matching funds has historically been 50%. Due to the current COVID-19 pandemic congress passed the CARES ACT, which increases the federal matching percentage to 56.2% effective 1/1/2020
HHS	Stimulus Payment	$ 49,461	6/9/2020	$ -	$ 49,461	$ -	EFT	CARES Act. Rural specific relief funds for rural health clinics
HHS	Stimulus Payment	$ 150,680	6/16/2020	$ -	$ 150,680	$ -	EFT	CARES Act. Rural specific relief funds for rural health clinics
HHS	Stimulus Payment	$ 103,253	6/25/2020	$ -	$ 103,253	$ -	EFT	CARES Act. Rural specific relief funds for rural health clinics
HHS	Stimulus Payment	$ 1,300,000	7/20/2020	$ 1,300,000	$ -		EFT	CARES Act. Rural specific relief funds for rural health clinics
HRSA (WA DOH)	SHIP	$ 83,136	7/27/2020	$ -	$ 83,136	$ -	EFT	Other than confirming your branch office from the FY 2020 RCC, we (HRSA) will not need any application information or grant. There will be follow up information requested as a condition on your award and quarterly reporting requirements for the hospital receiving SHIP COVID-19 funds.
Molina	PCP Stabilization Payment	$ 25,434	8/4/2020	$ 25,434	$ -	$ -	EFT	Molina Healthcare provided COVID payments to providers
	Totals	$ 19,971,754		$ 5,196,271	$ 8,183,503	$ 6,591,980		

October XX, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

The Provider Relief Fund (PRF) authorized under the CARES Act has helped to provide America's health care providers with the resources needed to deliver essential public services during the COVID-19 pandemic. These funds have been deployed to help protect the safety of frontline providers and patients, and in many cases, have helped enable providers to keep their doors open.

On September 19, 2020, the Health and Human Services Department (HHS) announced changes to the PRF reporting requirements that will force many hospitals and other providers to return some of this vital funding and jeopardize patients' access to care while the nation continues to battle the COVID-19 pandemic. This represents an about-face from the stipulations that HHS outlined months ago, which providers based their planning upon during an already tumultuous fiscal environment. HHS should return to PRF reporting requirements established on June 19, 2020.

Congress has acted several times this year to add funding for the Public Health and Social Services Emergency Fund to reimburse health care providers for COVID-19-related health care expenses and lost revenues. Eligible providers are required to submit reports and maintain documentation to ensure compliance with payment rules. On June 19, HHS released a frequently asked question defining lost revenue as any revenue lost due to COVID-19 and said providers should "use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared." Providers applied for and budgeted the use of PRF funds based on this HHS guidance. However, on September 19, HHS changed the definition of lost revenue, placing many struggling providers in an untenable situation. Now, funding is only accessible for COVID-19-related expenses and lost revenue up to the amount of a provider's 2019 net patient operating income. This change will dramatically reduce the amount of lost revenue providers can claim, create a massive administrative burden, and force many struggling providers to return some of their payments.

This sudden and dramatic shift has created numerous problems for the nation's hospitals at the very same time they continue to be our first line of defense against the COVID-19 pandemic. We therefore urge you to reinstate the June 19 requirements so that our frontline providers are able to focus their full resources on protecting the health and safety of the communities they serve.

We thank you for your attention to this matter. Should you have any questions please contact Kirsten Wing of Representative McKinley's office and Kirsten.Wing@mail.house.gov or Faith Williams of Representative Levin's office at Faith.Williams@mail.house.gov.

Sincerely,

David B. McKinley P.E.
Member of Congress

Roger Marshall, M.D.
Member of Congress

Frank D. Lucas
Member of Congress

Mike Thompson
Member of Congress

Mike Levin
Member of Congress

Tom O'Halleran
Member of Congress