1. **6:00 - CALL TO ORDER**
   a. Introductions as needed
   b. Business from audience

2. **6:05 - CONSENT AGENDA** – See separate Consent Agenda

3. **6:10 - Executive Reports**
   a. 6:10 – Quality Committee report – Brenda West, CCO
      i. QHI Quality Health Indicators
   b. 6:30 – CEO Report, Renée Jensen, CEO
      i. CEO Report
      ii. Nursing Association Negotiations
      iii. Accountable Communities of Health Presentation
   c. 7:30 – Finance – Shauna DePrato, Finance Director
      i. Financial summary
      ii. Financial dashboards and statements
      iii. WRHC QHI Report
      iv. Washington State Audit Report
   d. 8:00 – CMO report – Dr. William Hurley

4. **8:10 – Commissioner Business**
   a. Value Based Payment Model – Brianna Bobiak
   b. Agreed Upon Board Purpose, Role and Norms
   c. Medical staff privileges –
      i. Karen McGrane, MD- Initial appointment to Emergency Medicine
      ii. Mary Schroeder, ARNP- Initial appointment to Behavioral Health
   d. Phone system update – Tim O'Haver
   e. Wrap up – Drew Hooper

5. **Adjournment**
Consent Agenda

A very useful technique involves the use of a consent agenda. The board agenda planners (usually the executive or governance committee, but occasionally the board chair with the CEO) divide agenda issues into two groups of items. The first are those items that must be acted on because of legal, regulatory, or other requirements, but are not significant enough to warrant discussion by the full board. Such issues are combined into a single section of the board agenda book; members review these materials prior to the meeting, and if no one has any questions or concerns, the entire block of issues is approved with one board vote and no discussion. This frees up a tremendous amount of time that would otherwise be squandered on minor issues. Any member can request that an item be removed from the consent agenda and discussed by the full board. The success of the consent agenda is predicated upon all board members reading the material in the consent agenda section of the board agenda book. If they do not, then the board becomes a veritable rubber stamp. The second group of agenda items are those important issues that require discussion, deliberation, and action by the board. These are addressed one by one.

Executive Session Justification

Executive Session is convened to discuss the following topics, as permitted by the cited sections of the Revised Code of Washington (RCW):

- Executive session (RCW 42.30.110)
  - (a) national security
  - (b) (c) real estate
  - (d) negotiations of publicly bid contracts
  - (e) export trading
  - (f) complaints against public officers/employees
  - (g) qualifications of applicant or review performance of public employee/elective office
  - (h) evaluate qualifications of candidate for appointment to elective office
  - (i) discuss claims with legal counsel
    - existing or reasonably expected litigation
    - litigation or legal risks expected to result in adverse legal or financial consequences
    - presence of legal counsel alone does not justify executive session
  - QI/peer review committee documents and discussions
- Final action must be in open meeting
### Consent Agenda Items

<table>
<thead>
<tr>
<th>Dates</th>
<th>Payroll</th>
<th>Operational A/P Disbursements</th>
<th>Construction A/P Disbursements</th>
<th>Community Care</th>
<th>Bad Debts</th>
<th>Property Tax Credit</th>
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<tr>
<td>Jul-14</td>
<td>$1,030,938</td>
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**Average per month**

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<th>Payroll</th>
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<th>Construction A/P Disbursements</th>
<th>Community Care</th>
<th>Bad Debts</th>
<th>Property Tax Credit</th>
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7/31/2015
## Consent Agenda

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<tr>
<td>Payroll Warrants</td>
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<tr>
<td>A/P Operations Disbursements</td>
<td>$864,974.00</td>
</tr>
<tr>
<td>A/P Construction Disbursements</td>
<td>$171,950.00</td>
</tr>
<tr>
<td>Community Care</td>
<td>$16,494.00</td>
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<tr>
<td>Bad Debt</td>
<td>$207,421.00</td>
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<tr>
<td>Property tax Credit</td>
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</tr>
<tr>
<td><strong>TOTAL</strong></td>
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NOTE: For the Period July 1-31, 2015
**BOARD OF COMMISSIONER’S MEETING**  
*July 23, 2015*

<table>
<thead>
<tr>
<th>AGENDA</th>
<th>DISCUSSION/CONCLUSIONS</th>
<th>RECOMMENDATIONS/ACCTIONS/FOLLOW-UP</th>
</tr>
</thead>
</table>
| CALL TO ORDER           | The meeting of the Board of Commissioners of the Grays Harbor County Public Hospital District No. 1 was called to order at 6:01pm by Chair Drew Hooper.  

**Present:** Commissioners present: Amy Thomason, Chad Searls, Louie Figueroa, Gary Thumser, Drew Hooper.  

Also Present: Will Callicoat, Tim O’Haver, Ron Hulscher, Dr. William Hurley, Brenda West, Shauna DePrato, Brianna Bobiak, Shannon Brear, Joy Iversen, Kathy Sakas, Sherrie Willan, John Delia  

**Business from Audience**  
None  

**CONSENT AGENDA**  
CONSENT AGENDA—SEE SEPARATE CONSENT AGENDA  

**COMMITTEE REPORTS**  
Quality Committee Report  
- See Quality Report for details.  
- Brenda West reviewed the dashboard.  
- We moved from a Trauma Level V to a Trauma Level IV. Thank you to all of the staff in the ED, Lab, DI, our partners EMS, St. Peters. Level IV requires all ED physicians to be board certified. We also need to be able to transfer the patient quickly and have 24/7 lab and radiology. The community education we do also helped us achieve this goal.  
- Our left without being seen (LWBS) numbers are inching up. This may be due to increased volumes in the ED. We’ll watch this closely and see if this will be affected by 7 day a week Urgent Care.  
- Joy Iversen facilitated a Root Cause Analysis meeting today on patient identifiers. There will be two more meetings as the investigation continues.  

Chad Searls made a motion to approve the consent agenda. Amy Thomason seconded the motion and it was approved by a unanimous vote.
COO- Tim O'Haver

- See COO Report for details
- Saturday, August 8th is the company picnic and awards banquet.
- October 17th is the Health Fair. We are working with the county to get an interlocal agreement in place to support the use of the fairgrounds for this event.
- Dr. Wooden should be joining us in September. Orientation is September 8th, 2015.
- Molly Mellon, ARNP will join our team the first week in October.
- Interviewing another MD tomorrow.
- Volumes in Urgent Care of patients new to the district should help fill these new provider panels.
- Outpatient Therapy services started July 8, 2015.
- Parking lot expansion and walking path were completed July 21, 2015.
- A WSHA video “The new meaning of the big blue H” was played.
- Successful Groundbreaking attended by over 70 people was held on July 13th at 5pm at the new McCleary Clinic site.

Finance-Wil Calliccoat

- See Finance Summary for details
- Dashboards were reviewed.
- State auditors have been onsite. They will come back for an exit conference in August. If three or more commissioners attend, we will need to publish a special meeting notice.
- We have leased our printers. We evaluated the cost of leasing vs. purchasing. We have terminated our lease and are purchasing printers.
- Kayla Godfrey does a great job in her role as our In-Person Assister.

CMO Report – Dr. William Hurley

- See CMO report for details
- Primary Care Committee redesigned the schedule. They are doing great
## Medical Staff Privileges

1. None for July

## Conference Room Reservations Updated Policy

Changes to the policy were discussed.

## Phone System

Discussion on continuing issues with the phone system. Tim O'Haver is looking at the routing of the phones.

The meeting was adjourned at 7:09pm

---

**COMMISSIONER BUSINESS**

**ADJOURNMENT**

**Recording Secretary**

**Board Secretary**
August 20, 2015
The following is a summary of the major work efforts across the strategic areas of work since the last board meeting in June/July 2015.

“Failure is a part of innovation – Perhaps the most important part”. – Curt Richardson

Stewardship
Cultivate responsible growth, development and management of resources to achieve our mission and vision.

- **Nursing Association** – We were unable to reach agreement on four key issues. Summary letter will be included in the board packets. Due to this it was agreed that we were at impasse so SPMC implemented the Last Best and Final Offer, effective on August 10th. This was necessary so we could pay our nurses fair wages and not continue to delay implementation of the significant wage increases.

- **Value Based Purchasing** – We are in the process of educating our staff, providers, management, and community about this project. Our summer MHA intern has been doing many presentations over the past several weeks. Next steps will be letters sent to our target payors, meetings established to begin negotiations on experimental contract terms, and establishing a value based purchasing committee.

- **State Audit** – We completed our state audit and had the exit interview this month. The audit was clean with no findings and no management letters. Great job finance team!

- **See finance summary for more details on this bucket.**

Collaboration
Build collaborative relationships and partnerships to improve the well-being of our community.

- **SPMC Foundation** – The wellness trail is complete for phase one! There has been much excitement and planning for the future vision of the trail. The foundation is now busy working on the final details of the Sip and Sail which is the fall fundraising event for the foundation which will be held on September 19th.

- **Mitch Cohen Scholarship fund** – Dr. Andrews and many volunteers completed sport physicals at the school to raise funds for the Mitch Cohen scholarship fund. The event was very successful and scholarships will be given to graduating seniors next spring in honor of Dr. Cohen.

- **WSHA Board Meeting** – CEO Jensen presented on behalf of the Cascade Pacific Action Alliance at the annual WSHA board retreat. The short presentation gave the background of the ACH, governance structure, and a brief description of the work being done in the region.

- **Congressional visit** – We hosted two representatives from Patty Murry’s office for a tour, lunch and discussion about current challenges and hot topics in rural health care.
Organizational Development
Foster a culture of passion, performance and innovation that attracts, develops and retains the highest caliber talent.

- **Physician Recruitment** – The primary care director position has been offered to a candidate. We are waiting to hear if he accepts the position. A reminder that Dr. Wooden joins our team in mid-September.

- **Strategic Planning** – The board and Executive team completed their strategic planning sessions. The work has been synthesized and is currently with the Management Team. They are reviewing and discussing with their staff to gather staff input for their upcoming planning session at the end of August. We will have a difficult time right sizing the plan given the large amount of suggested work ahead combined with the required work. We anticipate a draft coming back to the board as early as October.

- **Annual Picnic and Awards** – The picnic was held on campus this year, highlighting the versatility of our property. The picnic had to compete with the fair and some rain showers which impacted attendance. For those that attended, it was a great event which staff genuinely appreciated. We may consider looking at alternative ideas for next year to change things up a little.

Physical Environment
Develop and maintain a physical environment that inspires our team to achieve the highest possible results.

- **McCleary replacement clinic** – The zoning hearing was conducted on 6/25/15 to allow public comment to amend the zoning to allow medical buildings and pharmacies. The hearing examiner’s recommendation was to support the proposed changes. The groundbreaking ceremony was held July 13th and demolition is underway. Final construction permits from the city are taking longer than expected and slowing the process.

- **Parking** – Completed! The additional parking area has had a significant impact on accessibility and improved patient access. There is ample open parking near the building each day even during peak times.

- **EMR** – Planning is underway and the implementation plan is being built. Currently assessing work flows, staffing and FTE impact for the upcoming implementing phase.

Effective & Efficient Operations
Continuously develop effective, efficient and well-coordinated processes to ensure patient centered care.

- **ACO** – This has been a very hot topic the past several weeks. As the board is aware we contacted you about an opportunity to join a new ACO based in Colorado. This was necessary because our partner hospital in Oregon chose to withdraw leaving SPMC and MGH without enough lives to sustain the ACO alone. Politics and the relationship with our vendor, the National Renee K. Jensen, Chief Executive Officer
600 East Main Street, Elma, Washington 98541 ∙ Ph. (360) 346-2222
Owned and Operated by Grays Harbor County Public Hospital District No. 1, SPMC is an equal opportunity provider and employer
Rural ACO forced our hand to look for alternate options. In the final days before the application was due we were able to connect and join the Rocky Mountain ACO. This is a very exciting opportunity as this group has a collaborative similar to ours and will be a great learning opportunity. In addition, three collaborative hospitals and one other Washington state based hospital joined our new ACO making for a very strong ACO. We will continue to work on our current ACO through the end of the year. Our new 3 year ACO will officially begin in January. Eric Moll and CEO Jensen have been designated board members to represent WA State.

- **Trauma Status** – Thank you to Brenda West and her team for their efforts in applying and successfully achieving an upgraded trauma status of Level IV trauma center!!! This is an important advancement for SPMC and the community we serve.

- **Virtual Visits** – We are beginning to explore how we can use technology to bring healthcare and wellness to the patient instead of patients coming to us. We are in the exploratory phase of this project and meeting with vendors to see what our options might be.

- **Insurance Renewals** – Both the Medical Malpractice and Healthcare insurance plans had favorable renewal proposals. Both with just slight increases. We will be electing to continue both with our current vendors. More details to come on the healthcare coverage as we roll out the information to staff.

Upcoming events:

- August 31st – September 1st – M-team Strategic planning
- September 9th – HOLD the DATE for a late afternoon Walk to Wellness & BBQ
- September 14-18th – WA DC Rural Advocacy Days
- September 14-15th - Disaster Tent Training
- September 16th - Earthquake Table Top Disaster Drill
- September 19th – Foundation Sip and Sail, Alderbrook Resort, Union
- October 6-8th – WSHA annual meeting, Seattle
- October 17th – Wellness Fair, Elma Fairgrounds

Respectfully,

Renée K. Jensen
A volunteer association of independent stakeholders focused on developing and implementing a shared action agenda established by consensus (collective impact) with the goal of improving our region’s health.

A **Pilot Accountable Community of Health (ACH)**

5/2014 - Present

Designated Fully Functional

**Accountable Community of Health**

July 2015
Participating Local Communities

<table>
<thead>
<tr>
<th>7-County Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cowlitz County</td>
</tr>
<tr>
<td>Grays Harbor County</td>
</tr>
<tr>
<td>Lewis County</td>
</tr>
<tr>
<td>Mason County</td>
</tr>
<tr>
<td>Thurston County</td>
</tr>
<tr>
<td>Pacific County</td>
</tr>
<tr>
<td>Wahkiakum County</td>
</tr>
</tbody>
</table>
Three “Tracks”

Governance

Regional Health Improvement Plan

Pilot Project

Backbone Support
Governance
Operating Principles

- **Inclusiveness:** Keep an open door for new stakeholders.
- **Equality:** All participants have equal voice.
- **Consensus:** Decisions are made by consensus.
- **Shared Learning:** Focus on exploring and sharing opportunities for innovation.
Looking for Regional Alignment

Local Community Forums

State Priorities

Regional Coordinating Council
## Regional Coordinating Council Composition

Regional council with broad representation from multiple sectors

<table>
<thead>
<tr>
<th>Sector</th>
<th>Council Members</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>Each county sends 1 public health representative</td>
<td>7</td>
</tr>
<tr>
<td>Social Services</td>
<td>Each county sends 1 social service representative (e.g., housing, food, transportation, etc.)</td>
<td>7</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>1 mental health provider, 1 chemical dependency provider, &amp; 2 RSN’s</td>
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<tr>
<td>Medical Care</td>
<td>Each county sends 1 health care delivery system representative (e.g., hospital, physician clinics, FQHC, dental, specialists)</td>
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</tr>
<tr>
<td>Health Plans</td>
<td>1 per Medicaid Managed Care Plan</td>
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<tr>
<td>Elected Officials</td>
<td>Each county sends 1 elected official (optional)</td>
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<tr>
<td>Other Key Stakeholders</td>
<td>6 ideally multi-county positions, including criminal justice, education, Economic Development Council, Area Agency on Aging and consumers</td>
<td>6</td>
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<tr>
<td><strong>Total</strong></td>
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<td>44</td>
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Providing **Backbone Support** for the CPAA

CHOICE provides leadership and administrative, financial and other support services for the Cascade Pacific Action Alliance
Regional Membership Collaborative

To improve community health in Central Western Washington through collective planning and action of health care leaders.
Regional Health Improvement Plan

*Shared* Regional Health Priorities

- Improving access to health care focusing on provider capacity
- Enhancing economic and educational opportunities
- Improving care coordination and integration
- Mitigating Adverse Childhood Experiences (ACEs)
- Improving chronic disease prevention and manager
Youth Behavioral Health Coordination Pilot Project
What is This Project About?

GUIDING PRINCIPLE:
TRIPLE AIM: Better health and better quality at less cost.

GOAL:
Identify children with behavioral health challenges as early as possible in both education and health care settings, and connect at risk children with community-based intervention and treatment services.

OUTCOME:
Decreased number of school-aged youth with unmet behavioral and physical health needs. Improved health is expected to lead to better school attendance and academic achievement.
Finance Summary for July 2015
Finance performed a service line assessment of the District’s revenue generating departments. Attached is a graph that shows, by department, the revenue, net revenue (after contractual adjustments), expenses, and net operating income. It shows the degree of significance from the Emergency Department (ED) as well as ancillary departments like diagnostic imaging and lab. The clinics show a negative net operating income, but the orders from the clinic providers drive much of the imaging and lab volumes.

Given the significance of the ED as the economic driver of our cash flow, Finance will work with the hospital CFOs to gather comparative data from the 11 other hospitals in the Collaborative. The Qhi tool has the ability to gather productivity statistics, FTEs, expenses, and revenues from the other hospitals to benchmark our operations against. For now, to show trending data, attached is a graph showing our ED volumes compared to Mason General Hospital.

Volumes
July’s volumes were in-line with that year-to-date statistics. The Medical Unit had a combined average daily census of 4.6 (2.7 acute care and observation and 1.9 swing bed). The Urgent Care began 7-day per week operations on July 8th. There were 28 days that Urgent Care was open (24 between July 8 to the end of the month plus July 3 through 6). During that time, there were 394 visits, creating a daily average of 14 visits per 8-hour day. The ED averaged 34 visits per 24-hour day in July.

Revenue and Expenses
July’s revenue was $4.9 million, which is generally consistent with previous months of 2015. Finance updated the contract adjustment calculation based on recent claims data. This increased both the Medicare and Medicaid contractual adjustment, and decreased the bad debt reserve. The net effect of this was a $275,000 reduction in net operating revenue. This produces a net loss for the month of July, but that number is not reflective of a decrease in revenue or volumes. Rather, it’s a mid-year true-up of the reserves to accounts receivable posted on the balance sheet. The upcoming transition in October to ICD-10 (a major overhaul to the way visits are coded in the United States), may impact the speed at which our claims are adjudicated and paid. Therefore, it is important to ensure appropriate reserves on the balance sheet.

Expenses are within the average monthly ranges, with the exception of benefits and insurance expenses. Benefits are deducted from employees’ paycheck on the first two pay dates of each month. Based on the way the calendar fell, this month, there was only one payroll period that incurred July benefit deductions; yet, there were three pay dates in July. As for the insurance expense, this was due to the annual premiums being expensed over a ten month period. Our
current insurance policy is through August 2015, which means that the District will be completing the annual renewal over the coming days.

**Balance Sheet**

The District’s cash position increased $280,000 in July to nearly $8.3 million. However, accounts payable increased by $250,000, so much of this is timing related to when we paid our invoices. The amount in Construction in Progress is the 10 percent deposit related to the Meditech 6.1 electronic medical records system purchase.

Our days in accounts receivable decreased from 85 in June to 81 in July. Finance performed an analysis for the past 12 months of activity at the external billing office (CBO Solution). During the past 12 months, the billing office processed or cleared $52.7 million in revenue. However, during this time, the District generated $55.0 million in revenue. The accompanying graph illustrates the growth in our revenue during this period (red bars with a red-dotted trend line). The graph also illustrates the amount processed at the billing office (green line with a green-dotted trend line). The activity at the billing office has increased, but not at the pace that the District has grown. This has led to an increase in the District’s days in AR.

Finance also performed a breakdown of the AR aging to determine where the increase has occurred compared to December 2014 (when the District’s days were at 69). That illustration is also included with this report. It shows an increase in the number of Medicare and Medicaid claims over 90 days old. The District has requested a plan of from the billing office on how this will be addressed. In the meantime, on August 14, the Collaborative sent a request for proposal to 10 different billing office companies (including CBO Solution). The request asks the billing office companies to submit a proposal to potentially service 12 hospitals in the Collaborative. This will be a competitive process.

AR Aging Analysis - July 2015

Values
- Sum of 0-90
- Sum of 91-180
- Sum of 180+

Financial Class

- Medicare
- Medicaid
- Commercial
- Self Pay
### Income Statement

**July 31, 2015**

**SUMMIT PACIFIC MEDICAL CENTER**

#### Current Month

<table>
<thead>
<tr>
<th>Current Month</th>
<th>Variance %</th>
<th>Variance</th>
<th>Year-to-Date</th>
<th>Variance %</th>
<th>Variance</th>
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<td>Actual</td>
<td>Budget</td>
<td>Prior Year</td>
<td>VARIANCE</td>
<td>Actual</td>
<td>Budget</td>
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<td>2,324,553</td>
<td>621,626</td>
<td>17,600,515</td>
<td>13,768,067</td>
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4,877,573 4,281,854 4,445,155 561,169 14% 4,085,973 3,876,442 3,968,703 117,746 3% 4,085,973 3,876,442 3,968,703 117,746 3%

#### Gross Operating Revenue

**Revenue Deductions**

- 1,623,276 846,204 820,374 768,043 95% Medicare Contractuals
- 1,623,276 830,358 995,296 466,348 53% Medicaid Contractuals
- 1,623,276 383,391 326,958 (250,308) 69% Other Contractuals
- 1,623,276 340,946 346,914 (276,451) 42% Bad Debt Expense
- 1,623,276 119,156 180,428 (61,272) 76% Community Care
- 1,623,276 55,204 150,657 (95,453) 13% Admin Adjustments

3,202,529 2,385,898 2,063,287 666,631 29% Total Revenue Deductions

7,627,885 6,574,066 5,805,032 762,034 117% Clinic Enhancements

15,120 3,280 9,920 12% Other Operating Income

1,757,649 1,735,238 1,683,899 14,341 1% Net Operating Revenue

#### Operating Expenses

- 903,165 820,387 722,602 46,788 12% Salaries and Wages
- 105,213 176,425 171,342 14,372 34% Employee Benefits
- 196,023 151,073 179,642 37,560 24% Professional Fees
- 100,074 130,427 113,418 (9,012) 42% Supplies
- 20,557 21,713 23,792 (2,079) 15% Utilities
- 251,320 174,911 173,633 107,659 44% Purchased Services
- 100 12,978 1,315 (12,778) 99% Insurance
- 69,623 65,913 45,342 24,281 4% Other Expenses
- 11,187 6,933 12,200 1,063 17% Rentals and Leases

1,642,941 1,626,914 1,389,299 133,625 8% Expenses Subtotal

#### EBITDA

94,708 214,322 187,609 (19,314) 54% 486,377 494,514 444,917 11,513 2%

62,806 63,333 65,379 (477) -1% Interest Expense

142,566 142,070 143,647 692 995,814 14,074 24,000 0.04

1,683,356 1,734,319 1,685,315 154,037 9% Total Expenses

(110,707) (89,117) (119,624) 1,332(2%) Net Income (Loss) from Operations

#### Non-Operating Revenues

- 40,318 45,478 45,402 (5,161) -11% Tax Revenues

45,888 48,068 46,800 (2,240) -5% Total Non-Operating Rev.

50,688 57,018 24,671 (121,844) -214% Net Income or (Loss)
<table>
<thead>
<tr>
<th></th>
<th>CURRENT MONTH</th>
<th>LAST MONTH</th>
<th>DECEMBER 31, 2014</th>
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<td><strong>ASSETS</strong></td>
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<td>2,130,858</td>
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<td>(7,238,370)</td>
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<td>RECEIVABLES - OTHER</td>
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<td>INVENTORY</td>
<td>231,838</td>
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<td>DESIGNATED CONSTRUCTION</td>
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<td><strong>TOTAL BOARD DESIGN ASSETS</strong></td>
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<tr>
<td>PROPERTY, PLANT &amp; EQUIP</td>
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<td>LAND</td>
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<td>25,072</td>
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<td>23,580,456</td>
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<td>LESS: ACCUM DEPRECIATION</td>
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<td>(5,310,209)</td>
<td>(4,454,854)</td>
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<td><strong>NET PROP, PLANT &amp; EQUIP</strong></td>
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<td>18,579,828</td>
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<td><strong>LIABILITIES</strong></td>
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<tr>
<td>CURRENT LIABILITIES</td>
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<td>ACCOUNTS PAYABLE</td>
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<td>579,901</td>
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<td><strong>TOTAL CURRENT LIABILITIES</strong></td>
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<td>4,307,101</td>
<td>3,289,918</td>
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<td><strong>GROSS LONG TERM DEBT</strong></td>
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<td>BONDS PAYABLE</td>
<td>20,302,796</td>
<td>20,302,796</td>
<td>20,591,180</td>
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<tr>
<td><strong>TOTAL GROSS LONG TERM DEBT</strong></td>
<td>20,302,796</td>
<td>20,302,796</td>
<td>20,591,180</td>
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<td>LESS CUR. PORTION LTGO/CT</td>
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<td>(590,492)</td>
<td>(579,901)</td>
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<td>19,712,304</td>
<td>20,011,279</td>
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<td>24,019,405</td>
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<td><strong>TOTAL UNRESTRICTED FUND</strong></td>
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<td>6,672,290</td>
<td>6,078,610</td>
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<td><strong>TOTAL LIABILITY &amp; EQUITY</strong></td>
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<td>30,691,695</td>
<td>29,379,807</td>
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<td>MONTH</td>
<td>ACTUAL</td>
<td>BUDGET</td>
<td>PRIOR MONTH</td>
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<td>INPATIENT STATISTICS</td>
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<td>DISCHARGES</td>
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<td>21</td>
<td>12</td>
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<td>PATIENT DAYS</td>
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<td>61</td>
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<td>DISCHARGES</td>
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<td>OUTPATIENT STATISTICS</td>
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<td>605</td>
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<td>SPHC CLINIC VISITS</td>
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<td>OTHER OUTPATIENT VISITS</td>
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<td>1,673</td>
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<td>ANCILLARY STATISTICS</td>
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<td>818</td>
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<td>CT EXAMS</td>
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<td>261</td>
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<td>182</td>
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<td>MRI EXAMS</td>
<td>23</td>
<td>33</td>
<td>23</td>
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<td>OTHER STATISTICS</td>
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<td>Goal</td>
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<td>DAYS IN A/R</td>
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<td>65</td>
<td>69</td>
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<td>15</td>
<td>&lt; 15</td>
<td>9</td>
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<td>149</td>
<td>130</td>
<td>138</td>
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<td>CURRENT RATIO</td>
<td>2.8</td>
<td>2.5</td>
<td>3.2</td>
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</table>

SUMMIT PACIFIC MEDICAL CENTER

July 31, 2015

YEAR TO DATE

ACTUAL  | BUDGET  | PRIOR YEAR |
---------|---------|------------|
98       | 145     | 146        |
273      | 421     | 426        |
41       | 101     | 115        |
2.8      | 2.9     | 2.9        |
43       | 28      | 30         |
590      | 245     | 290        |
8,929    | 4,717   | 4,902      |
7,308    | 5,328   | 5,883      |
4,383    | 5,050   | 4,170      |
4,350    | 4,681   | 2,853      |
6,960    | 6,640   | 7,042      |
1,701    | 2,450   | 0          |
12,303   | 11,600  | 9,998      |
55,806   | 51,276  | 42,799     |
5,713    | 4,634   | 4,497      |
1,861    | 1,362   | 1,397      |
1,411    | 1,214   | 980        |
157      | 210     | 161        |

December 31, 2014
### Consent Agenda Items

**SUMMIT PACIFIC MEDICAL CENTER**

#### 7/31/2015

<table>
<thead>
<tr>
<th>Dates</th>
<th>Payroll</th>
<th>Operational A/P Disbursements</th>
<th>Construction A/P Disbursements</th>
<th>Community Care</th>
<th>Bad Debts</th>
<th>Property Tax Credit</th>
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<tr>
<td>Jul-14</td>
<td>$1,030,938</td>
<td>$733,062</td>
<td>$-</td>
<td>$180,428</td>
<td>$790,704</td>
<td>$337</td>
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<td>Aug-14</td>
<td>$645,036</td>
<td>$571,440</td>
<td>$-</td>
<td>$33,093</td>
<td>$266,201</td>
<td>$681</td>
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<td>Sep-14</td>
<td>$633,815</td>
<td>$663,352</td>
<td>$-</td>
<td>$46,954</td>
<td>$255,227</td>
<td>$764</td>
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<td>$-</td>
<td>$22,718</td>
<td>$140,275</td>
<td>$489</td>
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<td>Dec-14</td>
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<td>$839,618</td>
<td>$-</td>
<td>$51,806</td>
<td>$232,212</td>
<td>$283</td>
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<td>Jan-15</td>
<td>$745,189</td>
<td>$721,486</td>
<td>$-</td>
<td>$8,447</td>
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<td>$514</td>
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<td>Feb-15</td>
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<td>$889,439</td>
<td>$-</td>
<td>$39,447</td>
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<td>Mar-15</td>
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<td>$760,221</td>
<td>$-</td>
<td>$68,574</td>
<td>$271,233</td>
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<td>$12,111</td>
<td>$28,659</td>
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<td>$171,950</td>
<td>$16,494</td>
<td>$207,421</td>
<td>$706</td>
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**Average per month**: $809,679 | $900,236 | $54,291 | $45,403 | $249,399 | $654
Washington Rural Health Collaborative

WRHC Dashboard

Approved 7-24-2015
WRHC Scorecard Source

- QHi Measures – most current 3-month rolling average
- Comparisons:
  - Hospitals
  - WRHC Average (n= Number of Collaborative hospitals reporting each measure)
  - QHi Average (n= Number of hospitals reporting each measure)
- “*” by hospital name indicates incomplete data for the 3-month period.
### Days Cash on Hand
**Date Range 3/2015 - 5/2015**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Forks Community Hospital</th>
<th>Jefferson Healthcare</th>
<th>Klickitat Valley Hospital</th>
<th>Mason General Hospital</th>
<th>Morton General Hospital</th>
<th>PMH</th>
<th>Skyline Hospital</th>
<th>Snoqualmie Valley Hospital</th>
<th>Summit Pacific Medical Center</th>
<th>Whidbey General Hospital</th>
<th>Willapa Harbor Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>0</td>
<td>73</td>
<td>53</td>
<td>168</td>
<td>35</td>
<td>145</td>
<td>138</td>
<td>39</td>
<td>128</td>
<td>27</td>
<td>38</td>
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<tr>
<td><strong>WRHC (n=8)</strong></td>
<td>0</td>
<td>88</td>
<td>88</td>
<td>88</td>
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<td>88</td>
<td>88</td>
<td>88</td>
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<tr>
<td><strong>QHi (n=35)</strong></td>
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<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>90</td>
</tr>
</tbody>
</table>

**Cash on Hand / [(Operating Expense - Depreciation Expense) / 30.4]**
Benefits as % of Salary
Date Range 3/2015 - 5/2015

[Total cost of benefits provided to employees / Total of cost of salary payment to employees (wages only)] x 100
### Gross Days in AR
**Date Range 3/2015 - 5/2015**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Forks Community Hospital</th>
<th>Jefferson Healthcare</th>
<th>Klickitat Valley Hospital</th>
<th>Mason General Hospital</th>
<th>Morton General Hospital</th>
<th>PMH</th>
<th>Skyline Hospital</th>
<th>Snoqualmie Valley Hospital</th>
<th>Summit Pacific Medical Center</th>
<th>Whidbey General Hospital</th>
<th>Willapa Harbor Hospital</th>
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</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
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<td>39.3</td>
<td>49.3</td>
<td>61.8</td>
<td>71.4</td>
<td>50.1</td>
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<td>77.1</td>
<td>80.7</td>
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<td>61.4</td>
<td>61.4</td>
<td>61.4</td>
<td>61.4</td>
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<td>61.4</td>
<td>61.4</td>
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<tr>
<td><strong>QHI (n=34)</strong></td>
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<td>63.6</td>
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<td>63.6</td>
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**Gross Patients Accounts Receivable / 3-month Avg. Daily Charge = AR Days**
Total Margin %
Date Range 3/2015 - 5/2015

\[
\frac{(\text{Net Patient Revenue} + \text{Other Operating Revenue} - \text{Operating Expense} + \text{Non-Operating Revenue})}{(\text{Net Patient Revenue} + \text{Other Operating Revenue} + \text{Non-Operating Revenue})} \times 100
\]
Thank You!!!

Questions or concerns? Please contact Tina Shoemaker at tinas@washingtonruralhealth.org
- Average lab charge per test before the change, $113  (Avg. $239 per clinic visit).
- Average lab charge per test after the change, $76  (Avg. $169 per clinic visit).
- 33% decrease per test.
- Our increased volumes have softened the impact to a 18% decrease in revenue for the District.
- The more patients using our lab will help with our ability to keep prices low.
Chief Medical Officer Report
Highlights of Medical Staff Activities for the Board of Commissioners August 27, 2015

Effective & Efficient Operations
Continuously develop effective, efficient and well-coordinated processes to ensure patient centered care.

Rural Healthcare Clinics. The Urgent Care service is attracting new patients from outside of the district who would like to establish primary care through Summit Pacific. The new volume is stretching the capacity of the existing clinics. New providers will add to capacity in September & October. Development of additional capacity through another clinic site is being explored.

Emergency Department. Our certification as a Level IV Trauma Receiving Facility will require additional training and quality measurement. Michelle Marti will work with our in-coming Educator (Joe Kohn) to ensure we continue to grow our capabilities for Trauma, Cardiac, & Stroke care.

We had a recent save in the Emergency Department. A patient undergoing evaluation for chest pain went into cardiac arrest. She was successfully resuscitated with 3 defibrillations in only 6 minutes and was transferred for definitive heart studies. Kudos to the team for their quick & effective care.

Urgent Care. Urgent Care is operating well on a 7-day per week schedule. We are now trying to optimize the interaction between Urgent Care and the Emergency Department (ED), developing teamwork & ensuring a smooth flow of patients transferred to the ED.

Organizational Development
Foster a culture of passion, performance and innovation that attracts, develops and retains the highest caliber talent.

Medical Staff. Dr. Ekaphol (Hank) Wooden will join the Medical Staff as a physician with Summit Pacific and Elma Family Medicine Clinics in September, and Molly Mellon ARNP will join as a Primary Care provider at Summit Pacific in October. We will re-assess the optimal placement of providers as they come aboard.

We have secured a national-level speaker for the Provider Retreat on Friday 22 January. Dr. Dike Drummond - www.theHappyMD.com will provide training workshops on Resilience & Prevention of Provider Burnout. A copy of his book was given to each provider.
Overall Goal

Clinical protocols for preventative care

Care quality and safety

Care coordination

Population Health
Population Health

- Managing overall health of a specific, defined population
  - Demographics, diagnoses, location, etc.
- Addresses social determinants of health
- Accountable for the health of the population as well as the use of healthcare services
- Proactive, communicative, and collaborative
What is Value-Based Payment?

- Organization is accountable for the health of the community
- Providers get paid for quality NOT quantity
- Focus on keeping patients well
- Proactive, not reactive
Why is it Important?

- Healthcare is too expensive
- High costs don’t mean high quality
- Grays Harbor County is sicker than other counties
National Culture Change

50% of Medicare payments based on non-fee-for-service models by 2019

85% of Medicare fee-for-service payments tied to quality or value by end of 2016

Private payors are following
Implementation at SPMC

Medicaid Managed Care

Private Payors

ACO MSSP

Reimbursement for SPMC’s Current Practices

Care Coordination

Investing in Pop. Health Infrastructure
What Does it Look Like at SPMC?

- More innovation
- New payor contracts
- Focus on chronic conditions
- More technology
- Preventative not curative
How Will SPMC Get There?

- Prove to payors we can achieve this
- Integrate psychiatric NP into care continuum
- Expand access to primary and urgent care
- Align provider compensation with value
- Standardize clinical processes
Videos

What is Population Health?

The Future of US Healthcare (start at 4:22)
Board Development Work

Agreed Upon Board Purpose, Role and Norms – Revised 2/2013/2015

Purpose of the Board

A. Revised Code of Washington (RCW) requires
B. Establish and uphold the Set Mission, Vision and Values of the District
C. Address community interests and fiduciary responsibility for health care
D. Monitor and make sure the work of the district is meeting public needs
E. Create policy for the hospital and ensure policies are followed. (examples are tobacco free campus, I-1000 etc)
F. Help drive future sustainability of the hospital District
G. Plan for the future
H. Determine the role and goals of the hospital in the community
I. Oversee the finances
J. Review and support Admin. staff and the decisions they make
K. Understand, stay at a high level, and govern the hospital; board is not involved in day to day operations.
L. Be the public eye- Represent the public
M. We are not the administrator/ management of the hospital- therefore we will not micro manage.
N. Appointment of the CEO
O. Appraisal of the CEO
P. Ears and voice of the community
Q. Champions of the hospital
R. Available to the community
S. Strategic voice of the hospital to the community

Define the Primary Role of the Summit Pacific Board

The Board defined the following responsibilities:

- Read Board materials prior to meetings
- Govern- mission, vision and strategic planning- develop the plan and ensure that its carried out
- Reviewing reports
- Review and approve policies - providing direction to the organization
- Accountability- hold ourselves and administration accountable- follow through with plans, review results and outcomes, provide timely feedback in a proactive manner
- Utilize working committees- focus on particular areas of focus
  - Develop more expertise on certain areas and communicate back to the Board on what’s going on
  - Internal to organization- contributing but not leading
  - Board Committees- Lead and contribute- be accountable to the Board
- Use each other strengths, get feedback and integrate information gained.
- Resource, support and communicate to the CEO
Help staff know who the Board members are by:
  - Attending hospital functions
  - Attending scheduled social meet and greet time with Board
Ask the hard questions to ensure integrity of data and process
Financial and quality oversight
Listen for what’s being said and not being said
Help determine the reality of a situation
Legal public liaison-available for contact and feedback from pubic concerns- represent interests of the public- communicate proactively with the community –involvement with other community organizations
  - Join the CEO with communications to the community with key items
Involved with advocacy and legislative lobbying
Participate on educational activities outside of the hospital in support of role
Address succession planning for Board and Executive replacement

**Election of Officers:**
The Board of Commissioners, herein referred to as the “Board”, shall at its first regular meeting in odd calendar years organize by the election from its own members a President, Vice President, and Secretary, such elections to be by a majority vote of the Commissioners in each case. The terms of the officers shall be for two years. It is acceptable for officers to be re-elected to the same position for consecutive terms.

**The Chair**
The Chair shall act as the presiding officer at meetings of the Board of Commissioners and shall execute on behalf of the District all contracts, agreements, and other documents and papers duly authorized by the Board that may require his signature. The Chair shall be a member of the Executive Committee.

**The following are agreed upon attributes of a Board Chair:**
- Very active- participate in meetings- engaged- working with CEO- with communities
- Time flexible and available
- Personable
- Ability to delegate
- Able to speak effectively in public
- Can work effectively with other Board members and CEO
- Passionate about our work
- Visionary- able to focus on big picture, look ahead, identify long term impact and communicate the vision
- Self-starter
- Run an efficient meeting and strong facilitator
- Strong listening skills, even when opinions differ
- Effectively manage information even when disagree
- Follows through with commitments
- Is respected by other Board members
- Strong presence-confident- credible
• Speaks with authority
• Be able to take a stance and support stance
• Think on their feet and willing to make decisions
• Available by phone or email
• Holds others accountable
• Knowledgeable and willing to learn the operations and business
• Willing to go above and beyond on the education side
• Willing to reach out to other Boards to learn and grow
• Understand informational boundaries
• Know what you don’t know and willing to admit limitations
• High integrity
• Driven by organizational values- vs. personal

The Vice Chair
The Vice President shall act as the presiding officer in the absence of the President and is a member of the Executive Committee.

The Secretary
The Secretary shall prepare, or cause to be prepared, minutes of all regular and special meetings of the Board of Commissioners, shall sign the same and shall keep them in a proper book for that purpose. The Secretary shall affix or cause to be affixed such seal to any documents requiring it, attesting the same. In the absence of the President and Vice President, the Secretary shall preside at Board meetings.

Officer Vacancy.
If a vacancy occurs in the President position, the Vice President shall fulfill that position and remaining term. If a vacancy occurs or is created in the Vice President, or Secretary’s office, an election of officers shall take place at the next regular meeting of the Board of Commissioners to fill the unexpired term created by the vacancy.

Current Committees-
✓ Executive (Board)
  o Purpose- Building agenda for Board meetings, make time sensitive decisions to be later reviewed by the entire Board, delineate decision making roles. Supports succession planning and training. Address policy and bylaw review.

✓ Finance (Hospital)
  o Purpose- Review monthly financial statements and summaries prepared by the CFO. Deepen member understanding of financial data. Commissioner feedback to admin. to fine turn financial. Have 2 board members having a strong understanding of financial data. Review and recommend budget proposal to the Board. Board members to report back to full Board on progress.

✓ Quality (Hospital)
**Legislative (Informal Board)**

- **Purpose**: Creating a forum to educate and encourage participation of Commissioners on state and local legislation. Focus on healthcare reform and legislation- talking with sub-committees and dealing with legislators. Board members to report back to full Board on progress. Asked to be available for lobbying and testifying opportunities.

**Medical Staff (Independent Medical Staff – Not Hospital)**

- **Purpose**: Provide access and visibility to Commissioner for local medical providers and vice versa. Learn to about issues and strengthen relationships. Board members to report back to full Board. What did Board members report to MD staff, what feedback has been given by MD’s to Board, general status. Participation is by invitation from the medical staff only.

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### Stipend Policy Defined for Board Members

**Purpose of stipend?**

- To financially compensate Commissioners for loss of revenue and time spent performing hospital business.
- For use when attending a meeting or hospital business that is an hour or more

**Commissioner Stipend**

Commissioners shall receive stipends as defined and regulated by law. As a matter of board policy, commissioners agree to submit stipend reimbursement using the following guidelines:

- One Board meeting per month
- One meeting per month per committee
- Required work sessions
- One stipend per day
- Documentation of value received or report to the board should be linked to each stipend request
- Board to create a budget and manage it through the year.

**The executive committee of the board will be responsible for monitoring and overseeing appropriate use and disbursement of the stipends.**

**Stipends request forms should be filled out and returned to the CEO monthly. You have the option of waiving your stipend but this must be done in writing for each meeting or for a designated period of time. Stipends may also be donated to the SPMC MRHD Foundation, just make this selection on your request form. You may also choose to donate to the WSHA PAC; if you choose to do this, you must write a personal check to the PAC, we cannot pass the funds directly to the PAC on your behalf.**
Agreed Upon Operating Norms for the Board
The Board agreed to the following team norms to support productive and strong relationships:

✓ Asking the hard questions to improve performance
✓ Speak up if you disagree or don’t understand
✓ Understand where the hospital is, its development relative to where we want to be
✓ Kindness and thoughtfulness to others
✓ Spirit of cooperation
✓ Seek common goals
✓ Show up on time
✓ Read literature and data prior to meetings
✓ Give input or consent to agenda before deadline
✓ Honesty with other members
✓ Willing to have open discussion
✓ Courteous in discussions
✓ Don’t interrupt each other when talking
✓ No side conversations
✓ Maintain rapport with team members
✓ Active listening
✓ Seek to create win/ win
✓ Understand the appropriate role of a board member and operate within the scope of those duties.

Expectations of Board Members
✓ Evaluate and educate self- learn what’s needed
✓ Read all literature provided
✓ Come with questions developed
✓ Commit the time required- more than just board meeting attendance
✓ Willing and able to speak up on matters that pertain to issues at hand.
✓ Bring up items in a timely manner
✓ Gain a feeling of serving the community- represent the community
✓ Set aside your opinions / feelings, at times, for the good of all
✓ No pre agenda of one’s own
✓ Seek education when needed
✓ Express ideas freely- don’t look for a fight
✓ Get involved- go extra mile
✓ Get to know key people involved
✓ Be prepared for meetings
✓ Understand the obligation to the district

✓ Regular attendance at meetings
✓ Seek knowledge on public hospital district and apply to job
✓ Meetings
o Mandatory attendance at strategic planning session
o Mandatory attendance at the monthly board meeting unless excused by Board chair for reasonable cause
o Actively participate in at least 1 Board Sub-committee
o Attend 1 annual major training conference a year (WSHA Annual; Rural Hospital Con Chelan; Patient Safety Summit)
o Mandatory attendance at agreed upon special work sessions

✓ Conduct yourself as a positive representative of the hospital and community at all times, not just during official business
✓ Supportive and actively involved in hospital activities
✓ Be a role model of the District’s Core Values

______________________________
Chief Executive Officer

______________________________
Chair and Commissioner

______________________________
Vice Chair and Commissioner

______________________________
Secretary and Commissioner

______________________________
Comissioner

______________________________
Comissioner