Board of Commissioners Meeting
January 28, 2016
Summit Pacific Medical Center, Elma, WA

Grays Harbor County Public Hospital District No.1

Agenda

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
      ii. 2015 Quality Plan Review
      iii. 2016 Quality Improvement Plan
   b. 6:45 – CEO Report, Renée Jensen, CEO
      i. CEO Annual Report
      ii. Care Transformation update – see report in packet
   c. 7:30 – Finance – Will Callicoat, CFO
      i. Financial summary
      ii. Financial dashboards and statements
      iii. Resolution 2016-02 Authorizing Additional Credit Card Debt Capacity
   d. 7:45 – CMO report – Dr. William Hurley, CMO

4. 8:00 – Commissioner Business
   a. Board By-Laws review
   b. CEO and Trustee Patient Safety Summit Tuesday, May 17, 2016
   c. Secretary Appointment to Board
   d. Resolution 2016-01 Compensation Limit
   e. CEO Evaluation Process
   f. Medical staff privileges –
      i. Tammy Moore, DNP (Davis)-Reappointment to Family Medicine
      ii. Blaise Bellows, MD - Initial Appointment to Emergency Medicine
      iii. Valerie McWhorter, MD – Initial Appointment to Pathology
      iv. Kenneth Hyde, PA – Initial Appointment to Urgent Care/Emergency Medicine
   g. Old Business
      i. New Commissioner Orientation update
   h. Wrap up – Drew Hooper

5. Adjournment
EBITDA – Earnings before Interest, Taxes, Depreciation and Amortization
WWRHCC – Western Washington Rural Health Care Collaborative

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

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<td>Minutes – December 29, 2015</td>
<td>Special Meeting Minutes</td>
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<td>A/P Operations Disbursements</td>
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<tr>
<td>A/P Construction Disbursements</td>
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<td>Community Care</td>
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<td>Bad Debt</td>
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<td>Property tax Credit</td>
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**NOTE:** For the Period December 1-31, 2015
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<th>Dates</th>
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Average per month

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<th>Payroll</th>
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<th>Community Care</th>
<th>Bad Debts</th>
<th>Property Tax Credit</th>
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<td>RECOMMENDATIONS/ACIONS/FOLLOW-UP</td>
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| CALL TO ORDER | 6:13pm-CALL TO ORDER  
The special meeting of the Board of Commissioners of the Grays Harbor County Public Hospital District No. 1 was called to order at 6:13 pm by Chair Drew Hooper.  

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

Also Present: Renée Jensen, Will Callicoat, Brenda West, Tim O’Haver, Ron Hulscher, Shannon Brear, Renee Smith, Shauna DePrato, Brent Meldrum, Richard Armstrong, Michelle Marti | | |
| Business from Audience | None | | |
| CONSENT AGENDA | CONSENT AGENDA-SEE SEPARATE CONSENT AGENDA | Gary Thumser made a motion to approve the consent agenda. Louie Figueroa seconded the motion and it was approved by a unanimous vote. | |
| COMMITTEE REPORTS | Quality Committee Report – Brenda West, CCO  
• See Quality Report for details  
• Employee flu vaccines are at 99%  
• Environment of Care Committee is constructing an after hours manual for charge nurse to use for emergencies that lists who to contact for alarms, maintenance issues, etc.  
• Currently looking at improving lighting in the parking lots  
• Clinic immunization process improvement project is complete  
• The Board viewed a YouTube video featuring Brenda West, CCO, about a sepsis process improvement project that SPMC was involved in. The link is: https://www.youtube.com/watch?v=cF8g5Sz3L0Q  
• Urgent Care to Emergency Department Transfer process improvement | |
To improve communication with Emergency Department patients, Brenda recommends the physicians do the same hand-off with patients that the nurses do.

Suggest put on dashboard percentage of patients from ED who transferred to our medical unit – would like to put transfers on dashboard – Brenda to discuss at upcoming Quality meeting for 2016 where dashboard measures are set.

QHI Indicators – Brenda West shared Quality Health Indicator information and will share these quarterly.

CEO Report, Renee Jensen, CEO

- Jensen met with the Healthcare Authority – looking at grant monies to help get specific payors to the table to have discussions on Value Based Purchasing contracts.
- Grays Harbor Community Hospital is looking to perhaps join the WRHC Collaborative. They will attend meetings for the next few months to determine whether this would be of value to their facility. If they decide to join they would pay dues from the start of their attendance at meetings.
- Peak Wellness 2.0 – Our new wellness program will kick off on January 5, 2016.
- Human Resources Director search is progressing well. We are finishing up in person interviews this week.
- The McCleary replacement clinic needs to gather bids for installing the information technology wiring needed and may delay the project.
- Jody Carona at Health Facilities Planning and Development is working on a market analysis to give us better data on our primary care expansion needs and feasibility. This will help determine what the scope we should target over the next few years.
- A Care Transformation Summary Report by Tammy Moore (previously Tammy Davis) will be included monthly with board packets.

Strategic Plan 2016
## BOARD OF COMMISSIONER’S MEETING
**December 29, 2015**

- See Strategic Plan report for details
- Renee Jensen presented the 2016 Strategic Plan to the board.

### Finance Report – Will Callicoat
- See Finance Summary for details
- Shauna DePrato recently served on a WSHA committee to look at charity/community care practices across the state
- Days in AR are at 70
- We renegotiation our contract with CBO, our Central Billing Office
- The Collaborative is requesting an RFP for billing office services
- Emergency Department visits are down since August where Urgent Care visits have increased
- Our door to doc time measuring process is not reliable. Brenda West, Michelle Marti and Dr. William Hurley will travel to Jefferson Hospital on 1/5/2016 to look at their process
- In 2016 the emphasis will be to increase the skill set of nurses on the medical unit so we can take higher acuity patients
- Will presented a draft Finance Committee charter and clarified that the Finance Committee is a hospital committee and not a subcommittee of the board
- Will shared a story of a community member we put in touch with the CBO to consolidate bills who was very appreciative

Amy Thomason made a motion to approve the 2016 Strategic Plan. Louie Figueroa seconded the motion and it passed unanimously.

Chad Searls made a motion to approve the Finance Committee Charter. Amy Thomason seconded the motion and it passed unanimously.

### Commissioner Training
- The Commissioner Training Manual was updated for 2015. A hardcopy is found in Administration. Shannon Brear will email a pdf copy to commissioners.
- Renee Jensen has a commissioner training scheduled with oncoming commissioner Brent Meldrum on January 25th at 1pm. If another
<table>
<thead>
<tr>
<th>Adjournment</th>
<th>Commissioner is interested in attending, contact Shannon Brear.</th>
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</thead>
</table>
| **Individual Secured Executive Reward Program (iSerp)** | - Drew Hooper excused himself from the discussion.  
- Commissioners reviewed recommended changes to the policy  
- Louie Figueroa signed the policy in place of Drew Hooper who abstained from the discussion and the vote. |
| **Oaths of Office**   | - Commissioners Louie Figueroa and Brent Meldrum took their oaths of office for their new terms starting in January 1, 2016. |
| The Board of Commissioner's meeting was adjourned at 8:12pm |

Louie Figueroa made a motion to approve the updated iSerp policy. Gary Thumser seconded the motion and it passed unanimously. Drew abstained from the discussion and the vote.

Amy Thomason made a motion to adjourn the meeting. Chad Searls seconded the motion and it passed unanimously.
On the Trail to Realizing Summit Care

Vision: To be THE National Model for Patient Centered Care
A message from Renée Jensen, Chief Executive Officer

Vision:

To be THE national model for patient centered care.

Mission Statement

In partnership with our community, we passionately advance the health of all individuals with an emphasis on quality, access and compassion.

Core Values

Passion
Respect
Integrity
Compassion
Excellence

Each year when I prepare this report for the Board, I am always humbled by the tremendous amount and quality of work our staff accomplish every year; it is truly amazing. The theme of the report this year, “On the trail to realizing Summit Care” is very significant. This has been a year of preparation for the long journey ahead. Much like you would prepare to Summit a grand mountain, we have been preparing and beginning the journey of value based care delivery. 2015 has been a year of laying the groundwork and conditioning our organization for the difficult transformation and journey ahead. Our journey, to what we are branding as “Summit Care”, will be one of unchartered territory. We know where we are going but we are still not exactly sure how we will get there or when exactly we will arrive. One thing that we do know for sure is that we are on a mission to transform how we care for our community, a future state that will reward us for partnering with those around us to ensure we are providing care for the whole person and not just providing sick care. I am truly excited about this path that we are on and honored to be at a point in my career that I can actually make a difference in the long term delivery system. As you read this report and reflect on all of the preparation that has occurred in 2015, just remember this is merely the preparation; we have a long journey ahead. One thing I know for sure is that a well prepared team will thrive on their path to the summit. Knowing that this team is not new to difficult challenges and this is not their first Summit gives me confidence that they will once again set the pace and excel at the challenges that face them ahead.

-Renée K. Jensen, CEO
The strategic work for stewardship focused on operating expenses as a percent of gross revenue to be targeted at 38% or less. We closed December at 36.4% achieving our single objective for this bucket of work. Due to the good stewardship of the management team and staff we were able to maintain a low cost to care ratio. Highlights of the strategies supporting this achievement were ICD-10 readiness, new service lines, and an expanded marketing plan to include additional social media and radio coverage.

Alternative funding sources was also a key strategy that will continue to be a theme in the 2016 plan. For this year we were successful in creating a value based purchasing roadmap that will allow us to transition from a fee for service environment, to a performance based system. This roadmap is guiding our conversations with payors and developing partnerships that are revolutionary. The fruit of this work will not be fully evident until 2016 and 2017. Other alternate funding came in the form of a significant grant to help pay for suicide prevention work in collaboration with the county. We were granted a contract through the 1/10th of 1% sales tax initiative which will support integration of mental health services into our primary care offices. Federal AIM funding was awarded through our 2016 Accountable Care Organization that will offset some of the cost of care coordination for our Medicare patients. Significant work and time has been devoted to the Accountable Community of Health, which will lay the ground work for SPMC to access future funds available for innovative, transformative care delivery redesign via the potential Washington State Waiver program.

It is always exciting when we can offer a new service line that serves an unmet need of our community. This year we launched Urgent Care seven days a week! This has been a tremendous asset to the community providing over 4,600 visits over a partial year, with 70% of those patients being new to SPMC. Outpatient therapy services were also launched this year with great success. The service is open to established patients only and is already at maximum capacity.

Cultivate responsible growth, development and management of resources to achieve our mission and vision.
The volume and financial statistics continue to increase by double digit percentages, and have exceeded budget and prior year figures. In 2015, patient days increased by 23% over prior year, emergency department visits increased by 13%, clinic visits increased by 27%, and other outpatient visits (lab, x-ray, therapy, etc.) increased by 25%. We began the year with $6.7 million in cash and ended the year with $10.1 million, which represents 167 days of cash on hand. Standard and Poor’s – a credit rating agency – says a hospital should have 159 days to maintain an A rating. Preliminary figures show the District generated $23.8 million of net operating revenue, $23.5 million in total expenses, and $758,000 in non-operating revenue, which results in a $1 million bottom line.
Build collaborative relationships and partnerships to improve the well-being of our community.

There were three objectives of focus for the collaboration bucket in 2015; leveraging the Washington Rural Health Collaborative (the Collaborative), implementation of the Washington Rural Accountable Care Organization (ACO), and diverse community engagement. We excelled in leveraging the collaborative and community engagement but we missed the mark with our measurement of the ACO success. The implementation, execution and results of the first year of the ACO were absolutely a success however; achieving shared savings was the objective measure. We now know that the success of a rural ACO cannot be measured by shared savings and more importantly, the success of this work is actually the organizational learning that is taking place around delivering value based care. A pre and post ACO, organizational value based readiness assessment was conducted. Scores improved in 2015 over 2014 from minimally prepared to moderately prepared, demonstrating the success and achievement of this objective.

Strategic work relating to the Collaborative focused largely on maximizing the benefits from our Group Purchasing Organization. We had strong engagement from leadership which resulted in utilization of price accuracy audit reports, quote review services to ensure contract compliance and negotiated value for service agreements, warranties and net terms. The GPO is actively engaged in donating and sponsoring organizational events, and offering educational networking and trainings. As a result of this work a Collaborative purchasing group entity was formed necessitating a formally sponsored charter by the Collaborative CEO’s. Additional value from the Collaborative focused work was in the form of shared training opportunities such as ICD-10 readiness and nurse educations.

We have branded the 2015 accountable care work as ACO 1.0. This was a year of creating infrastructure to support value based care delivery in our future. This required a revision of how clinic medical records are handled, improved HIM support services and an overall evaluation of processes related to medical records and coding. Data collection, tracking and analysis are a large portion of the critical work behind the scenes of an ACO. This required the implementation of a database called Light Beam to send and receive patient claims data with Medicare.
Provider support and engagement were critical to the mission of the ACO. Specific attention was given to ensuring their involvement in each step of the process. Their engagement was measured by the increased practice level participation of annual Medicare wellness visits and use of the Care Coordination services for chronic, high risk patients. Additionally several providers have made commitments to champion future care transformation initiatives.

As part of our ACO commitment we created and implemented a registered nurse care coordination program which served over 100 primary care patients. We created the infrastructure to be able to properly bill for these visits and partially compensate for the new service. Another element to the ACO is to monitor patient satisfaction. We deployed a tablet survey tool in the clinics to collect and report patient satisfaction as it pertains to our ACO and clinic experience. The foundation the ACO created has allowed us to develop a strategy to expand the accountable care model to payors beyond Medicare. We have put significant efforts into communicating this strategy to payors and creating what we will be branding as “Summit Care”. This groundwork will result in additional value based contracts in 2016.

The final significant strategic focus of work for the implementation of the ACO was to increase volumes in the primary care clinics to help grow our presence in the community as well as providing financial support for the care transformation work. Clinic volumes grew from 24,916 visits in 2014 to 31,681 visits in 2015 representing a 27% increase.

**ACO Statistics**

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<tr>
<td>Care Coordination Visits</td>
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<td>Care Coordination Revenue</td>
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<td>Medicare Wellness Visits</td>
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<td>Medicare Wellness Revenue</td>
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**Collaboration**

The third major area of focus for collaboration was around diverse opportunities for the community to engage and provide input, increase awareness and improve services. This work took place in many forms including a community wide Wellness Fair and partnering with the local high school to make educational videos, take photographs at the golf tournament and display student art in the building. Leaders engaged in many local civic groups, advisory boards, chambers, city councils, and volunteer organizations. Community education was increased in the forms of evening educational dinners, senior citizen presentations and educations at the high school. We also focused on reinstating community member involvement with our quality committee and implementing In-Demand interpreter services complete with staff education and training to provider language assistance to individuals with communication needs. In addition, there were over 30 community events sponsored or supported by SPMC staff.

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### Sample of the Community Events and Engagement

- Hosted a town hall luncheon for the community to attend to educate about the ACO development
- Hosted food booth at Elma Chamber’s Wine and Seafood Festival
- Attended a community reception to welcome the new Daily World publisher and attended another reception to welcome the Vidette’s new editor
- Hosted a retirement party for Kirsti Brogan, RN in which the community was invited to attend
- Hosted celebration for Dr. Macke on receiving the Provider of the Year award
- An employee driven team supported the East County Relay for Life annual event in May
- Attended KBKW’s Mug Club event at the Satsop Development Park
- Hosted a reception to thank various high school groups like the AV/photography club for the work they have done taking photos, providing art and making videos
- Hosted an open house in McCleary to say goodbye to Larry Conover and welcome Bonnie Anderson to Mark Reed Healthcare Clinic
- Hosted a groundbreaking ceremony at the site of the new McCleary Clinic
- Hosted a booth at the Celebrate McCleary event hosted by the McCleary Chamber of Commerce
- Hosted a Celebrate Wellness event that saw over 100 community members attend and featured booths celebrating various new SPMC service lines and included an inaugural trail walk
- Hosted a booth at the Chehalis Tribe’s Health Fair event in Oakville
- Hosted an insurance enrollment information dinner
- Collected and donated dresses to Montesano High for their prom dress drive
- Passed out candy as part of Elma and McCleary’s Trick or Treat events
- Joe Hopkin’s awarded to Renee Jensen by Board, Scott Bond, community invited
- Staff challenge to collect the most canned goods; split between various east county food banks
- Celebration for Curtis Peek, March of Dimes Nurse of the Year award
- Judged the Veteran’s Day Parade in Elma
- Created community partners collaboration for GH county SNFs, ALFs and group homes to meet for shared education and learning.
- Montesano Festival of Lights parade entry
- December Gingerbread house competition/community invited to view
- Provided support for the following community festivals:
  - Bear Festival, Elma’s Heat on the Street, Montesano’s Historical Car Show, Flower baskets for Main Street, Montesano Chamber Golf Tournament, Grays Harbor Community Hospital Golf Tournament, Mason General Golf Tournament
Objectives in Organizational Development focused on an improved sense of satisfaction for staff and local, state and national recognition to spread the word of the great work and staff at SPMC. Both objectives have been accomplished.

In the past we have measured staff satisfaction by survey of “the best place I have ever worked” however, this year we felt a resurvey at 12 months was too soon so we adjusted the measure to be turnover rate. Making this adjustment also allowed us to benchmark to our peer group in the Collaborative and across the nation. A dramatic achievement was recognized in this area reducing the rate from a high of 32% to ending the year at 29%.

A large scale effort across the organization focused on a critical review of total employee rewards. We are seeking a good balance in this area and trying to target the overall compensation areas that matter most to our employees. One of the most significant changes came in the form of rebasing our salary surveys to be benchmarked to the Puget Sound market. This resulted in a significant increase in wages across the organization and will allow us to be extremely competitive and attract high caliber staff. It has also created a positive culture shift in our hiring processes that empowers hiring managers to ensure they select highly qualified candidates knowing that the pay rates are above the rural market and in line with our large urban facilities. This has helped with the turnover rate of our frontline staff.

In addition to wages, we have increased the tuition reimbursement program to allow more employees to take advantage of continuing their education while employed at SPMC. As part of our effort to focus on employee experience we have improved our onboarding processes, orientations, and department level competencies. To assist with internal education and support we hired a full time RN educator who will focus on ensuring our staff has the educational tools, resources and experiences they need.

Recognition was widespread across the organization this year including, Dr. Macke being awarded the WRHA Dr. John Anderson Memorial Award, receiving the Amerinet Healthcare Achievement Award for Quality, Curtis Peek being named ED Nurse of the year by the March of Dimes, the T-System Client Excellence Award, CEO Jensen was named the WSHA Joe Hopkins Memorial Award winner, and numerous publications, articles and speaking engagements at both the state and national level.
Develop and maintain a physical environment that inspires our team to achieve the highest possible results

Three objectives make up the strategic work in the physical environment. First is the optimization of the indoor and outdoor space. This target was met as evidenced by the completed strategic initiatives. The largest project of the year was the McCleary replacement clinic. This dream became a reality this year as we selected a developer, secured a site and broke ground on a brand new 6 provider clinic in the center of downtown McCleary. The clinic is scheduled to open in April of 2016. Other strategies supporting this objective which were successfully completed were, the beautification of the current campus, improved curb appeal, improving laboratory services, building a maintenance shop, developing a wellness trail and expanding the parking lots on campus at SPMC.

The second objective was to achieve meaningful use stage 1 in the hospital. This is a major, multi-year undertaking which started with the difficult process of selecting a replacement Electronic Medical Record. Months of exploration, investigation and negotiations resulted in the decision to select Meditech with support of a Spokane based company to provide additional support resources during installation and ongoing after the project is complete. Once the vendor was selected the painful process of creating an implementation plan as well as staff planning and budgeting, consumed major time resources in order to prepare the entire organization for the 2016 implementation phase. Significant efforts have also been applied to improve the overall IT infrastructure to gain efficiencies, create stability and prepare for the transition ahead. One notable change was the hiring of a full-time Nurse Informatics expert and an experienced IT/project manager.

The third and final objective focused on meaningful use stage 1 year 2 in our clinics. This work has been successful and the attestation period will begin in 2016.
Two objectives of work make up the focus of operations this year. The first was a focus on improving the delivery of our services to enhance the overall patient experience and organizational patient centeredness. This objective was measured by a decrease in patient complaints as a percentage of volume. In 2015 both the providers and nursing staff participated in patient engagement training to help them understand the view point of the patient. The Acute Care Services worked towards improving the patients experience during discharge planning. The feedback from patients has been very positive and the framework will be integrated into the ACO work and carry over into 2016. The Nurse Manager worked with the Nursing Staff to develop a clinical peer review program that compares current practice against best practice. This has improved the overall care of patients and the patient's experience. The Emergency Department added a new position 4th Quarter, Emergency Department Technician, to assist in keeping patients informed on the next steps in their care. These improvements decreased our patient complaints as percentage of volume to .25% which is a decrease of 50% compared to 2014 (.5%).

The second critical objective to measure our success in operations was to have our days in Accounts Receivable be less than 65 prior to go live. With the EMR selection process exceeding the original ambitious goal, the new go live date will be in 2017. This objective has now become a multi-year goal which will be able to be measured in 2016. It is on track and considered successful for 2015. Days in AR closed the year at 69 remaining the same as 2014; however, over the year's period there was a high of 85 and the days were reduced back to finish the year at 69. Major strategies supporting this work focused on reduction of errors in the revenue cycle, supply charge capture, increased co-pay collection, reduction of denied payments, and optimization of prior authorizations and the charge master. Considerable work was also accomplished in increasing patient access in our clinics including the addition of two nurse practitioners and one physician.
Summit Pacific’s goal to have days in accounts receivable (AR) at 65 by the time we go-live with the new electronic medical records system (EMR) is important because changing over to a new system has the potential to disrupt billing and delay the stream of payments coming into the organization. Therefore, it will be extremely important to have the days in AR at a low level. Summit Pacific ended 2015 with 69 days AR. These 69 days can be dissected into billed and unbilled days. Billed days constitute the claims that have been successfully transferred to the Centralized Billing Office (CBO) to bill. Unbilled days are claims that have not been sent yet to CBO and are still at Summit Pacific. As we assessed how to achieve the goal of 65 days we realized some significant barriers to achieving this goal. Most notably, the current EMR is extremely limited in function and does not have the capability to consolidate charges at the patient account level. When Summit sends a claim too quickly to CBO it ends up missing charges. This is grossly inefficient and causes delays in payments from insurance companies. Therefore, Summit Pacific made the conscious decision to increase the number of unbilled days which allowed us to drive down the billed days at CBO. By driving down the billed days of AR we have optimized the portion of the billing cycle that will not be impacted with the EMR conversion. This will set us up nicely to focus on controlling the unbilled days during the conversion period and subsequently achieving the overall objective of driving down total days of AR. At the end of 2014, CBO had 55 days of billed AR. By the end of 2015, CBO had 48 days of billed AR — an improvement of 7 days demonstrating progress in this area toward the 2016 goal.
The foundation had another busy year. Annually they kick off the year with a food booth at Elma’s Wine Festival. They also host a variety of other small fundraisers throughout the year to help promote donations of all levels. For instance, they do “Go Blue” for the Community day where staff can make a small donation and wear jeans to work. The foundation was able to capitalize on the success of the Seahawks this year and raise over $1,100 in 2 days by having staff donate additional money which allowed them to add their favorite Seahawk attire with their jeans. All the money raised from “Go Blue” days benefits the Patient Assistance Fund.

The 2015 Celebrity Golf Tournament was another huge success. This was the 2nd year of having it at Salish Cliff’s Golf Club, and it’s clearly having an impact on attendance as there were a total of 8 new teams that joined the event this year, several of which were community members versus vendors. The event had a net profit of $31,000 which went toward the development of the new health and fitness trail. The foundation was also able to build upon their new event, the Sip and Sail Gala. This was the 2nd year for the event which takes place at Alderbrook Resort and Spa. The event saw massive growth and actually sold out and doubled its income from 2015. The foundation will do the event again in 2016 on Saturday, September 17th. Over $10,000 was able to be donated back to the hospital from this event in which $7,000 was used to fund 2016 mini grant requests submitted by departments and staff. These grants are awarded in November each year to use the following year. Some of the items approved were vaccine storage refrigerators for EFM and MRHC, an additional tracking board for the ED, raised garden beds for nutrition services, a new housekeeping cart, funding for the Spirit Team and more!
In addition to some of the equipment mentioned above, the foundation helped enhance our physical therapy department with close to $10,000 in equipment (a power lift table and a special workout bike). And, thanks in large part to donations by staff, the foundation was able to fund over $1700 in patient assistance items such as medications, transportation help, stuffed animals for kids, etc. The patient assistance fund came in handy this year when one of our providers identified that a patient of hers with frequent recurring visits walked to all of his appointments. When winter weather kicked in she noticed that he had nothing to protect himself from the elements. She contacted the foundation and they worked together to provide this patient with a brand new winter coat and a heavy duty umbrella. Another employee led fund, the Scholarship Fund, was able to provide $4700 in scholarships to local high school students.

“Live life when you have it. Life is a splendid gift—there is nothing small about it.”
— Florence Nightingale
**Top Center** –
Chief Clinical Officer, Brenda West administers Chief Financial Officer, Will Callicoat’s influenza shot during a campaign to encourage all staff members to get immunized.

**Right**–
CEO Renée Jensen presents the new McCleary clinic design during a community meeting outlining how SPMC will support and provide needed services in McCleary.

**Left Center**–
Staff members enjoy lunch catered by Chef Brandon Smith during Hospital Appreciation Week.

**Above** –
Volunteer Bonnie Kennedy greets our patients and assists our staff to create a positive patient experience.

**Left** –
Staff and volunteers participate in the Montesano Parade of Lights during the holiday festival.
Top left – Curtis Peek receives ED Nurse of the year! Andrew Burton, Phar.D., presents a community education seminar.

Top Center – Dr. Macke congratulated by Dr. Shawn Andrews on the Rural Provider of the year award.

Top Right – Chef Brandon Smith plants a fruit tree for each year he works at SPMC creating an edible forest.

Center left – Staff being trained to use virtual interpreter services.

Center Right – Disaster preparedness drill equipment demonstration.

Left – Ashley Smith, new Care Coordinator, launching the accountable care organization.
Finance Summary for 2015 Fiscal Year

Preliminary Report The December 2015 financial statements are not considered final until the Medicare cost report is filed in May 2016. Once filed, the contractual adjustments and due-to-third party liability will be considered final, which will affect net income.

Volumes
Volumes in the Emergency Department started the year strong and tapered slightly during the last six months. However, there was a slight rebound in December to finish the year with 12,064 visits. This represents a 13 percent increase over 2014 volumes. The inpatient unit had 2,073 patient days of acute care, swing bed, and observation stays. This created an average daily census of 5.7 compared to 4.6 during 2014. The three rural health clinics also experienced strong growth with a total 31,681 visits – a 27 percent increase over 2014’s 24,916 visits. This was of course largely aided by the opening of urgent care in February.

Revenue and Expenses
The District generated nearly $58 million in gross revenue, which was $7 million over budget. After contractual adjustments, this results in approximately $23.8 million in net revenue. The District’s expenses were $23.6 million, which results in $255,000 of operating income. After tax revenue and miscellaneous non-operating income of $758,000, the District generated a $1 million margin.

Balance Sheet
The District’s cash position increased by $300,750 to end at just over $10.1 million, which is 167 days of cash on hand. Standard and Poor’s recommends 159 days to maintain a credit rating of A, and 211 days for an AA rating. Attachment 1 shows the change in cash position each month. The District will pay out $3 million in 2016 related to the new electronic medical records system. Of that amount, $220,000 will be an operating expense as maintenance expenses – the rest will be capitalized. The District’s days in accounts receivable decreased from 70 to 69. This was helped by the CBO hiring a Sr. Operations Manager, as well as additional billers.

Year in Review
The District had a busy year focusing to increase business efficiencies and functions. The revenue cycle is an area that experienced change with registration now reporting to Finance. This has helped maintain a low balance on the error log. The District also fielded six different audits from various agencies (2013 Medicare cost report, DSH audit, HCA’s agreed upon procedures audit of three years of rural health clinic claims, a Medicare secondary payer audit, an HCA audit for three years of hospital claims, and our annual audit form the State Auditor’s Office). The District also weathered the ICD-10 conversion, the new national classification and coding system (previously ICD-9).

W. Callicoat 1-21-2016

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1 The final amount will be determined after the 2015 Medicare cost report is filed.
### Variance Table

#### Preliminary vs. Actual

<table>
<thead>
<tr>
<th>Category</th>
<th>Preliminary</th>
<th>Actual</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross Operating Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>4,196,018</td>
<td>4,375,272</td>
<td>(199,254)</td>
<td>-4%</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>17,309,901</td>
<td>16,985,424</td>
<td>324,477</td>
<td>2%</td>
</tr>
<tr>
<td><strong>SPHC</strong></td>
<td>2,313,566</td>
<td>2,214,324</td>
<td>99,242</td>
<td>4%</td>
</tr>
<tr>
<td><strong>MRHC</strong></td>
<td>1,624,213</td>
<td>1,637,928</td>
<td>(3,715)</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>URGENT CARE</strong></td>
<td>839,082</td>
<td>738,504</td>
<td>100,578</td>
<td>14%</td>
</tr>
<tr>
<td><strong>EMERGENCY</strong></td>
<td>30,100,132</td>
<td>23,598,972</td>
<td>6,501,160</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>57,982,978</td>
<td>51,142,248</td>
<td>6,840,730</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Revenue Deductions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Contractuals</strong></td>
<td>11,426,741</td>
<td>10,178,448</td>
<td>1,248,293</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Medicaid Contractuals</strong></td>
<td>15,930,848</td>
<td>11,583,780</td>
<td>5,855,028</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Other Contractuals</strong></td>
<td>4,816,929</td>
<td>4,602,804</td>
<td>8,11,165</td>
<td>47%</td>
</tr>
<tr>
<td><strong>Bad Debt Expense</strong></td>
<td>2,168,587</td>
<td>2,091,376</td>
<td>77,211</td>
<td>-3%</td>
</tr>
<tr>
<td><strong>Community Care</strong></td>
<td>485,792</td>
<td>418,280</td>
<td>67,512</td>
<td>-15%</td>
</tr>
<tr>
<td><strong>Total Revenue Deductions</strong></td>
<td>35,194,630</td>
<td>30,430,776</td>
<td>4,763,854</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Salaries and Wages</strong></td>
<td>11,033,803</td>
<td>9,700,764</td>
<td>1,333,039</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td>2,029,551</td>
<td>1,912,092</td>
<td>117,459</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Professional Fees</strong></td>
<td>2,234,740</td>
<td>1,932,876</td>
<td>301,864</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Supplies</strong></td>
<td>1,612,764</td>
<td>1,301,112</td>
<td>311,652</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Utilities</strong></td>
<td>365,572</td>
<td>368,508</td>
<td>3,936</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>Purchased Services</strong></td>
<td>2,852,606</td>
<td>2,062,449</td>
<td>790,133</td>
<td>36%</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td>133,687</td>
<td>179,639</td>
<td>(45,952)</td>
<td>-26%</td>
</tr>
<tr>
<td><strong>Other Expenses</strong></td>
<td>699,272</td>
<td>766,380</td>
<td>67,108</td>
<td>-9%</td>
</tr>
<tr>
<td><strong>Rental and Leases</strong></td>
<td>125,403</td>
<td>114,408</td>
<td>10,995</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Expenses Subtotal</strong></td>
<td>21,087,398</td>
<td>18,346,968</td>
<td>2,740,430</td>
<td>15%</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>23,821,610</td>
<td>20,918,832</td>
<td>3,902,778</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Total Income or (Loss)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interest Expense</strong></td>
<td>749,486</td>
<td>759,996</td>
<td>7,509</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>Depreciation &amp; Amortization Expense</strong></td>
<td>1,729,474</td>
<td>1,704,864</td>
<td>19,598</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>23,566,388</td>
<td>20,811,828</td>
<td>2,754,530</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Operating Income</strong></td>
<td>21,087,398</td>
<td>18,346,968</td>
<td>2,740,430</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Total Non-Operating Income</strong></td>
<td>6,089</td>
<td>6,917</td>
<td>828</td>
<td>-32%</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td>212,183</td>
<td>214,322</td>
<td>2,139</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>Interest Expense</strong></td>
<td>61,971</td>
<td>63,333</td>
<td>(3,362)</td>
<td>-5%</td>
</tr>
<tr>
<td><strong>Depreciation &amp; Amortization Expense</strong></td>
<td>144,123</td>
<td>142,072</td>
<td>1,051</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>2,032,194</td>
<td>1,734,319</td>
<td>297,875</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Total Income or (Loss)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Operating Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tax Revenues</strong></td>
<td>549,379</td>
<td>545,748</td>
<td>3,631</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Misc. Non-Operating Revenue</strong></td>
<td>208,556</td>
<td>31,428</td>
<td>177,128</td>
<td>564%</td>
</tr>
<tr>
<td><strong>Total Non-Operating Revenue</strong></td>
<td>757,935</td>
<td>577,176</td>
<td>180,759</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Net Income or (Loss)</strong></td>
<td>1,013,187</td>
<td>684,180</td>
<td>329,007</td>
<td>48%</td>
</tr>
</tbody>
</table>
# Balance Sheet

**Preliminary Balance Sheet**

As of December 31, 2015

## Assets

<table>
<thead>
<tr>
<th>Category</th>
<th>Preliminary Current Month</th>
<th>Preliminary Last Month</th>
<th>December 31, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Cash</td>
<td>8,776,893</td>
<td>8,476,143</td>
<td>4,778,471</td>
</tr>
<tr>
<td>Debt Reserve</td>
<td>1,339,442</td>
<td>1,339,442</td>
<td>1,919,721</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>10,853,693</td>
<td>11,397,158</td>
<td>9,885,996</td>
</tr>
<tr>
<td>Allowance for Bad Debts</td>
<td>(2,457,089)</td>
<td>(2,315,089)</td>
<td>(2,096,352)</td>
</tr>
<tr>
<td>Receivables - Taxes</td>
<td>36,850</td>
<td>(444)</td>
<td>49,227</td>
</tr>
<tr>
<td>Receivables - Other</td>
<td>109,598</td>
<td>211,162</td>
<td>264,157</td>
</tr>
<tr>
<td>Inventory</td>
<td>207,139</td>
<td>244,952</td>
<td>178,392</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>120,025</td>
<td>101,401</td>
<td>98,348</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>13,461,465</td>
<td>13,356,639</td>
<td>10,254,206</td>
</tr>
<tr>
<td><strong>Board Designated Assets</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Funded Depreciation</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Designated Construction</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Board Design Assets</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Property, Plant &amp; Equipment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>1,652,029</td>
<td>1,652,029</td>
<td>1,652,029</td>
</tr>
<tr>
<td>Land Improvements</td>
<td>364,672</td>
<td>364,672</td>
<td>65,147</td>
</tr>
<tr>
<td>Buildings</td>
<td>18,169,644</td>
<td>18,169,644</td>
<td>18,090,231</td>
</tr>
<tr>
<td>Equipment</td>
<td>3,888,032</td>
<td>3,888,032</td>
<td>3,747,977</td>
</tr>
<tr>
<td>Construction in Progress</td>
<td>171,845</td>
<td>171,845</td>
<td>25,072</td>
</tr>
<tr>
<td><strong>Total Prop, Plant, &amp; Equipment</strong></td>
<td>24,246,222</td>
<td>24,246,222</td>
<td>23,580,456</td>
</tr>
<tr>
<td><strong>Less: Accum Depreciation</strong></td>
<td>(6,184,328)</td>
<td>(6,040,205)</td>
<td>(4,454,854)</td>
</tr>
<tr>
<td><strong>Net Prop, Plant &amp; Equipment</strong></td>
<td>18,061,894</td>
<td>18,206,017</td>
<td>19,125,602</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>31,523,359</td>
<td>31,562,656</td>
<td>29,379,808</td>
</tr>
</tbody>
</table>

## Liabilities

<table>
<thead>
<tr>
<th>Category</th>
<th>Preliminary Current Month</th>
<th>Preliminary Last Month</th>
<th>December 31, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>782,537</td>
<td>538,889</td>
<td>447,401</td>
</tr>
<tr>
<td>Payroll &amp; Related Liab</td>
<td>1,224,903</td>
<td>1,572,652</td>
<td>780,210</td>
</tr>
<tr>
<td>Other Payables</td>
<td>129,017</td>
<td>67,045</td>
<td>139,027</td>
</tr>
<tr>
<td>Other Accrued Expenses</td>
<td>2,255,500</td>
<td>2,283,363</td>
<td>1,126,796</td>
</tr>
<tr>
<td>Patient Refund Payable</td>
<td>-</td>
<td>-</td>
<td>1,478</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>5,009,755</td>
<td>5,136,301</td>
<td>3,289,918</td>
</tr>
<tr>
<td><strong>Gross Long Term Debt</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt Payable</td>
<td>20,011,245</td>
<td>20,011,245</td>
<td>20,591,180</td>
</tr>
<tr>
<td><strong>Total Gross Long Term Debt</strong></td>
<td>20,011,245</td>
<td>20,011,245</td>
<td>20,591,180</td>
</tr>
<tr>
<td><strong>Less: Accum Depreciation</strong></td>
<td>(589,439)</td>
<td>(589,439)</td>
<td>(579,901)</td>
</tr>
<tr>
<td><strong>Net Long Term Debt</strong></td>
<td>19,421,806</td>
<td>19,421,806</td>
<td>20,011,279</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>24,431,561</td>
<td>24,558,107</td>
<td>23,301,197</td>
</tr>
<tr>
<td><strong>Unrestricted Fund Balance</strong></td>
<td>6,078,611</td>
<td>6,078,611</td>
<td>4,878,234</td>
</tr>
<tr>
<td><strong>Excess Revenue/(Expense)</strong></td>
<td>1,013,187</td>
<td>925,938</td>
<td>1,200,377</td>
</tr>
<tr>
<td><strong>Total Unrestricted Fund</strong></td>
<td>7,091,798</td>
<td>7,004,549</td>
<td>6,078,611</td>
</tr>
<tr>
<td><strong>Total Liability &amp; Equity</strong></td>
<td>31,523,359</td>
<td>31,562,656</td>
<td>29,379,808</td>
</tr>
</tbody>
</table>
## Statistics

**December 31, 2015**

### Inpatient Statistics

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Budget</th>
<th>Prior Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DISCHARGES</td>
<td>PATIENT DAYS</td>
<td>EMERGENCY ADMITS</td>
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<td>178</td>
<td>250</td>
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<tr>
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<td>471</td>
<td>726</td>
<td>744</td>
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<td>2</td>
<td>76</td>
<td>174</td>
<td>191</td>
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<tr>
<td>2.8</td>
<td>2.6</td>
<td>2.9</td>
<td>2.9</td>
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### Swing Beds

<table>
<thead>
<tr>
<th>Month</th>
<th>DISCHARGES</th>
<th>PATIENT DAYS</th>
</tr>
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<tbody>
<tr>
<td>6</td>
<td>66</td>
<td>49</td>
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<tr>
<td>68</td>
<td>951</td>
<td>429</td>
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### Outpatient Statistics

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<tr>
<th>Month</th>
<th>Observation Hours</th>
<th>Emergency Room Visits</th>
<th>Mrhc Clinic Visits</th>
<th>EfM Clinic Visits</th>
<th>Emergency Care Visits</th>
<th>Other Outpatient Visits</th>
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<tr>
<td>1,826</td>
<td>15,626</td>
<td>12,064</td>
<td>8,099</td>
<td>7,387</td>
<td>4,693</td>
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<tr>
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<td>8,595</td>
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### Ancillary Statistics

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<tr>
<th>Month</th>
<th>Lab Billable Test</th>
<th>Xray Exams</th>
<th>Ct Exams</th>
<th>Ultrasound Exams</th>
<th>Mri Exams</th>
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<td>9,265</td>
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### Other Statistics

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<th>Statistic</th>
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<tr>
<td>Days in A/R</td>
<td>69</td>
<td>69</td>
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<tr>
<td>Days in Payable Excl 3rd/Debt</td>
<td>&lt;15</td>
<td>9</td>
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<tr>
<td>Days in Cash</td>
<td>167</td>
<td>130</td>
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<tr>
<td>Current Ratio</td>
<td>2.7</td>
<td>3.2</td>
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</table>
Attachment 1 - Monthly Change in Cash Balance

Current Month Cash
Prior Month Cash
Resolution 2016-02
Authorizing Additional Credit Card Debt Capacity

A Resolution of the Board of Commissioners of Public Hospital District No. 1 of Grays Harbor County, Washington, authorizing an additional $30,000 credit debt capacity to the District.

Whereas, Grays Harbor County Public District No. 1 (the District) maintains accounts with Elan Financial services, through Timberland Bank, and

Whereas, the District has three credit cards, each with $15,000 credit limits, and

Whereas, there are occasions when those three credit cards are deployed or otherwise out of service, and

Whereas, there have been instances when a card must be destroyed and replaced from time to time, and

Whereas, the District Treasurer/Chief Financial Officer has identified the need for two additional cards to facilitate business operations, and

Whereas, RCW 70.44.060 (Powers and Duties), Section 5, gives the District the authority to contract indebtedness or borrow money for corporate purposes on the credit of the corporation, and

Now, therefore, be it resolved that the Board of Commissioners of Grays Harbor County Public Hospital District No. 1 approves the addition of two additional credit cards each with $15,000 limits, which will increase the District’s total credit card debt capacity to five cards for a total credit limit of $75,000.
Adopted by Board of Commissioners of Public Hospital District No. 1 of Grays Harbor County, Washington, at an open public meeting of the Board on the 28th day of January, 2016, the following Commissioners being present and voting:

PUBLIC HOSPITAL DISTRICT NO. 1
GRAYS HARBOR COUNTY, WASHINGTON

_________________________________________
Chair and Commissioner

_________________________________________
Vice Chair and Commissioner

_________________________________________
Secretary and Commissioner

_________________________________________
Commissioner

_________________________________________
Commissioner
Resolution 2016-02
Authorizing Additional Credit Card Debt Capacity
Page 3

I, _____________________________, Secretary to the Board of Commissioners of Public Hospital District No. 1, Grays Harbor County, Washington, certify that the attached copy of Resolution No. 2016-02 is a true and correct copy of the original resolution adopted on January 28, 2016 as that resolution appears on the Minute Book of the District.

DATED this 28th day of January, 2016.

________________________________
Secretary to the Board of Commissioners
Chief Medical Officer Report  
Highlights of Medical Staff Activities for the Board of Commissioners January 28, 2016

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

Electronic Medical Record. Successful development and implementation of MediTech 6.1 across our system will require significant attention, dedication, & work by our providers and staff over the next year. **Shawn Andrews, MD** was offered the position of Provider Champion. She and Dr. Hurley have begun training and organization of the providers into the Provider Advisory Committee, Subject Matter Experts, and Provider Trainers.

Rural Healthcare Clinics. Medical Directors have been selected for each of the clinics. Congratulations to **Mary Ellen Biggerstaff, DNP** at Summit Pacific, **Shawn Andrews, MD** at Elma Family Medicine, & **John Rodakowski, MD** at the McCleary Clinic. The Medical Directors will partner with their Nurse Managers (Jacob Eaton, RN at Summit Pacific, Kathy Miller, RN at Elma Family Medicine, & Tawnya Weber, RN at the McCleary Clinic) to develop and standardize policies, procedures, and work processes to provide more streamlined, effective, & vaccine practices across the system. The Clinic Medical Directors will be offered leadership training opportunities and will represent Primary Care on the Medical Executive Committee until a Primary Care Medical Director is in place.

Urgent Care. New providers are coming aboard to facilitate scheduling and provide opportunity for vacations for the full-time providers. Ken Hyde PAC, Jessie Norton PAC, and Paul Taylor PAC are going through credentialing and on-boarding.

Emergency Department. **Kudos** to the Emergency Department for developing a plan and effectively managing a surge of patients during the closure of the Clinics and Urgent Care for the Provider Retreat. An additional RN and Provider (Emergency Medicine Resident) were brought in and a “Fast Track” area activated within the Emergency Department. **Michelle Marti** came in to ensure things went well. Our average ED volume is 33 patients per 24 hours. On 23 January, 44 patients were seen in 12 hours (8:00 am to 8:00 pm) with no increase in waiting times, length of stay, or patients leaving without being seen. This demonstrated ability of the ED to flex & manage a surge of patients with a minimal change in staffing & operations - important information for event & disaster planning.

Acute Care Services. In order to better recognize and optimize the services and opportunities provided through the Summit Pacific **Medical Unit**, their activities have been re-named & re-organized as Acute Care Services. In addition to Observation, In-Patient, and Swing Bed Care - Infusion Services, Rehabilitation, Employee Health, Social Services, Vaccination, and Care Transition are some of the activities currently being provided. A Care Transition project is currently underway in Acute Care Services.

Hospital bed availability is currently near zero in Western Washington. Transfer of patients for admission has become a delayed and resource-intensive endeavor. Several patients have recently required transfer for admission to Vancouver, WA. In order to best serve our patients, a procedure and flow chart to locate the most appropriate and nearby resource has been developed. Included are the expansion of transfers to Grays Harbor Community Hospital (for Orthopedic and General Surgery services) and the potential expansion of capabilities at Summit Pacific.
Organizational Development
Foster a culture of passion, performance and innovation that attracts, develops and retains the highest caliber talent.

Medical Staff.

Medical Staff Retreat was held at Harmony Hills on 22 & 23 January. Provider Wellness & Burnout Prevention was the key topic provided through a series of workshops by Dike Drummond (http://www.TheHappyMD.com). Provider engagement & integration were also topics of focus, discussed through presentations on the Summit Pacific Strategic Plan, Care Transformation, and the Medical Executive Committee. Feedback from the providers was very positive about the topics, venue, & this opportunity provided to them by the Board and Executive Team. The providers expressed gratitude and a big “Thank you!” for the support.

The Medical Executive Committee has formed, met, developed and approved a charter, and selected an initial body of work focused on optimizing Prevention Services. Their plan is to integrate their work with Care Transformation by using measures that are requested & required by our payers (federal & commercial) to measure efficacy and integrate Quality Improvements by leveraging Peer Review into Primary Care, In-Patient Care, and the Emergency Department. They plan to review Appropriate Antibiotic Usage at the next Peer Review in March. I attached the charter.
Medical Executive Committee Charter

Purpose Statement

The purpose of the Summit Pacific Medical Executive Committee (MEC) is to foster Care Transformation through continual evaluation and development of patient centered care in an environment of learning, innovation, and excellence. The MEC will provide the Executive Team with assistance and recommendations to support initiatives from the Board of Commissioners provided in the Strategic Plan. It will foster a two-way conduit for communication and idea transfer between the Medical Staff and Executive Team.

Responsibilities

- Develop medical practice standards, policies and procedures
- Support best practices with an emphasis on the following:
  - Provider engagement, education, and satisfaction
  - Staff engagement, education, and satisfaction
  - Patient safety, engagement, education, and satisfaction
- Advance evidence-based clinical practice
- Develop and mentor future leaders

Meetings:

The Committee will meet monthly in person. Members will be provided the opportunity to attend by teleconference when needed. An agenda will be provided to committee members at least one day prior to meeting dates.

Decision-making process:

- Consensus will be used as the decision-making model
- If a particular issue requires a vote by the committee, the action must be approved by a majority vote of the full committee
- A committee representative will provide recommendations to the Executive Team
- Provider leaders will represent and make decisions for their departments and clinics.

Membership

- The Chief Medical Officer will chair the committee.
- The Director of Care Transformation, Medical Staff President, Primary Care Department Chair, Primary Care Medical Director, Emergency Department Medical Director, and Internal Medicine Medical Director, or their designees, will be voting members of the MEC.
- Other members of the clinics, hospital, administrative, and Medical staff will be sought as ad-hoc members of the committee.

Outcomes – Care Transformation through the following:

- Establishment and development of core best clinical practices.
- Development, coordination, and integration of system-wide peer review.
- Coordination and championing of Summit Care initiatives
PUBLIC HOSPITAL DISTRICT NO. 1
GRAYS HARBOR COUNTY

BYLAWS

AMENDED AND RESTATED
March 2014
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ARTICLE VII. AMENDMENT OF BYLAWS .................................................................... 19
The name of this Municipal Corporation is: Grays Harbor County Public Hospital District No. 1, doing business as (d.b.a.) Summit Pacific Medical Center, hereafter referred to as the “District”.

The Seal of this Municipal Corporation shall be a circular disc so formed as to impress on paper the words: “Grays Harbor County Public Hospital District No. 1, Washington, 1981.”

ARTICLE I. FORMATION AND PURPOSE

The District is a public hospital district and municipal corporation created in 1981 to own and operate hospitals and other health care facilities, and to provide hospital and health care services for the residents of the hospital district and other persons. The activities of the District shall be conducted in the conformity with the constitution and laws of the State of Washington, including Chapter 70.44 of the Revised Code of Washington.

These Bylaws are adopted in furtherance of the lawful purposes of the District, to facilitate governance of the District and operation of its hospital and health care facilities in compliance with standards set by the American Hospital Association and other applicable laws and regulations.

The function of the Board is to represent the people of the District by determining and compelling appropriate organizational performance to accomplish the District’s Mission and Vision.

The Board deliberates as individuals, but a majority vote binds all, and the Board thereafter governs as one voice, supporting the prevailing position. The Board directs, controls and inspires the organization through the careful selection of Executive Leadership and the establishment of polices reflecting the District’s values and perspectives, focusing on long-term impacts rather than the administrative or programmatic details.

The Board governs with an emphasis on: respect, courtesy, and dignity; outward vision; encouragement of diversity in viewpoints; strategic leadership; a clear distinction of governance and managerial roles; promoting a safe environment for patients, visitors, physicians and staff; and, a proactive open style.

The District shall have powers and duties set forth in Chapter 70.44 RCW and other applicable legal provisions.
ARTICLE II. BOARD OF COMMISSIONERS

Section 1. Qualification and Election.

1.1 Qualifications. No person shall be eligible to be elected to the office of Public Hospital District Commissioner unless he or she is a citizen of the United States and the State of Washington, is at least eighteen (18) years of age, the candidate must comply with statutory requirements and be an "elector" (i.e. registered voter) within the district boundaries for at least 30 days in the precinct prior to filing, is a qualified voter of the public hospital district from which he or she is elected, and does not hold any other incompatible office and is not otherwise disqualified pursuant to applicable law. All Hospital District Commissioners shall be elected and serve in the manner and for the term prescribed by law.

1.2 Election Procedures. The election procedures for Commissioners of the Board shall be pursuant to RCW Title 29A and Chapter 70.44 RCW.

Section 2. Compensation and Continuing Education

Each commissioner shall receive compensation/stipend amounts at the rate specified in RCW 70.44.050 for each day or portion thereof spent in actual attendance at official meetings of the District Commission, or in performance of other official services or duties on behalf of the District, to include meetings of the Commission of the District, or meetings attended by one or more commissioners of two or more public hospital districts called to consider business common to them, and as provided for by these bylaws, except the total amount of compensation shall not exceed the maximum amount specified by RCW 70.44.050. Any commissioner may waive all or any portion of his or her compensation payable under RCW 70.44.050 as to any month or months during his or her term of office, by a written waiver filed with the District in compliance with RCW 70.44.050. The waiver, to be effective, must be filed any time after the commissioner’s election and prior to the date on which the compensation would otherwise be paid. The waiver shall specify the month or period of months for which it is made.

As a matter of adopted board policy, commissioners agree to submit stipend/compensation reimbursement using the following guidelines for submittal:

1. One board meeting per month
2. One meeting per month per committee
3. Required work sessions
4. In person educational meetings
5. One stipend per day
6. Documentation of value received or provided should be linked to each stipend
The Board of Commissioners shall also establish an annual budget for commissioner compensation/stipends and be responsible for the management of same. The Executive Committee of the Board shall be responsible for monitoring and overseeing appropriate use and disbursement of the compensation/stipends of commissioners.

Section 3. Commissioner Education

Each Board Commissioner is required to complete a minimum of ten (10) hours of CEU (Continuing Education Unit) per calendar year. The education shall be a formal program and documentation reported to the District's Human Resources Department for tracking purposes.

Section 4. Organization and Office of the Board of Commissioners.

4.1 Number of Commissioners. There shall be five (5) commissioners that serve on the Board of Commissioners.

4.2 Oath of Office. All members of the Board of Commissioners, whether elected or appointed, shall be required to take an oath of office in the form prescribed by the laws of the State of Washington relating to public officials, RCW 29A.04.133; RCW 70.44.040(2). The oath to be administered shall be:

I ______________________ do solemnly swear (or affirm) that I will support the Constitution of the United States and the Constitution of the State of Washington, and that I will faithfully and impartially perform and discharge the duties of the office of Hospital District Commissioner according to law, to the best of my ability.

4.3 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 reelected to the same position for consecutive terms.

4.4 Board Vacancy. A Board vacancy may occur as a result of such occurrences as resignation, death, removal, conviction of a felony, unexcused nonattendance at meetings over a sixty (60) day period, statutory disqualification, recall, or permanent disability preventing proper discharge of the commissioner’s duties. A vacant commissioner position occurring for reasons prescribed in RCW 42.12.010, shall be filled by the Board appointing a new member in the manner prescribed by law, RCW 42.12; RCW 70.44.045. A commissioner shall forfeit his or her office by non-attendance at meetings of the commission for 60 days, unless excused by the commission, RCW 70.44.045.
The remaining commissioners shall name a replacement to fill the vacancy on a temporary basis. This appointment is effective only until the next regular election for public hospital district commissioners, at which time a commissioner must be elected to fill the balance of the vacant term. Where only one or no commissioners remain to make appointments or where the vacancy is not filled within ninety (90) days of the vacancy, applicable statutory provisions apply.

4.5 **The Chairperson.** The President 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 the President’s signature. The President shall be a member of the Executive Committee.

4.6 **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.

4.7 **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 (Chair) and Vice President (Vice Chair), the Secretary shall preside at Board meetings, RCW 42.32.030; RCW 70.44.050.

4.8 **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.

**Section 5. Meetings of the Board of Commissioners**

5.1 **All meetings.** All meetings of the Board shall be open and public in compliance with the Open Meetings Act, RCW 42.30, and all persons shall be permitted to attend any meeting of the Board of Commissioners except as otherwise provided by law and as identified herein for Executive Sessions, RCW 42.30.030.

In the event that meeting is interrupted by a group or groups of persons so as to render the orderly conduct of such meeting unfeasible, and order cannot be restored by the removal of individuals who are interrupting the meeting, the Board may order the meeting room cleared and continue in session or may adjourn the meeting and reconvene at another location selected by majority vote of the Board. In such a session, final disposition may be taken only on matters appearing on the agenda. Representatives of the press or other news media, except those participating in the disturbance, shall be allowed to attend any session held pursuant to this section. Nothing in this section shall prohibit the Board from establishing a procedure for readmitting an individual or individuals
not responsible for disturbing the orderly conduct of the meeting, RCW 42.030.050.

5.2 **Regular Meetings.** The Board shall provide the time for holding regular meetings by resolution. Regular meetings of the Board of Commissioners shall be held on the fourth Thursday of each month at 6:00 p.m. at the hospital or any other place so designated by the Board of Commissioners or as otherwise changed by the Board by resolution. In the event that a regular meeting falls on a holiday, or when other scheduling conflicts arise, the meeting shall be held on a date agreed upon by the Board and appropriate notice shall be published.

Unless otherwise provided for by law, meetings of the Board need not be held within the boundaries of the District.

For the purposes of this section “regular” meetings shall mean recurring meetings held in accordance with a periodic schedule declared by resolution of the Board from time to time.

5.3 **Annual Strategic Planning Session.** It is anticipated that the Board will hold an annual strategic planning session one time per year. This session may or may not be held outside of the District. The regular meeting of Board that month may be conducted in conjunction with the strategic planning session.

5.4 **Special Meetings.** Special meetings may be called at any time by the President of the Board of Commissioners or by a majority of the membership of the Board by delivering notice personally, by mail, or by other notice method authorized by the particular individual, to each member of the Board, and to each local newspaper of general circulation and to each local radio or television station which has on file with the Board of Commissioners of the District a written request to be notified of such special meeting or of all special meetings.

Such notice must be delivered at least twenty-four (24) hours before the time of such meeting as specified in the notice. The call and notice shall specify the time and place of the special meeting and the business to be transacted. Final disposition shall not be taken on any other matter at such special meetings of the Board. Such written notice may also be dispensed with as to any member who is actually present at the time the meeting is called.

Such written notice may be dispensed with as to any member who at or prior to the time the meeting convenes files with the Secretary a written waiver of notice. Such waiver may be given by telegram, fax or electronic mail. Such written notice may also be dispensed with (i) as to any member who is actually present at the meeting at the time it convenes or (ii) as to any member who, prior to the time the meeting convenes, receives notice of the meeting by email and files a written consent to receive meeting notices by email, RCW 42.30.080.
5.5 **Emergency Meetings.** If, by reason of fire, flood, earthquake or other emergency, there is a need for expedited action by the Board to meet the emergency, the Chairperson may provide for a meeting site other than the regular meeting site and the notice requirements of these bylaws shall be suspended during such emergency, RCW 42.30.070. The meeting notices required by these bylaws and RCW 42.30 may be dispensed with in the event a special meeting is called to deal with an emergency involving injury or damage to persons or property or the likelihood of such injury or damage, when time requirements of such notice would make notice impractical and increase the likelihood of such injury or damage, RCW 42.30.080.

5.6 **The Order of Business.** The suggested order of business at the meetings of the Board of Commissioners shall generally be include and be as follows:

A. **Regular Meetings**
   1. Call to Order
   2. Public Comments
   3. Approval of minutes of the last regular meeting and any special meetings
   4. Consent Agenda
   5. Committee Reports
   6. Chief Executive Officer Report
   7. Commissioner Old Business
   8. Commissioner New Business
   9. Consideration of items on the agenda or other matters properly before the Board and action thereon
   10. Executive Session appropriate business
   11. Next meeting dates and times
   12. Adjournment

B. **Special Meetings**
   1. Call to Order
   2. Reading of the Notice of Special Meeting
   3. Consideration of matters stated in the Notice and action thereon
   4. Adjournment

**Section 6. Action by the Board of Commissioners.** As used herein “action” means the transaction of the official business and collective positive or negative decision, or an actual vote by a majority of the members of the Board sitting as a body or entity, upon a motion or resolution, RCW 42.30.020(3). All proceedings of the Board shall be by motion or resolution recorded in a book or books kept for such purposes, RCW 70.44.050. Minutes of all regular and special meetings, except executive sessions thereof, shall be promptly recorded and shall be open to public inspection, RCW 42.32.030. The Board shall not adopt any motion, resolution, rule, regulation, or directive, except in a meeting open to the public and then only at a meeting, the date of which is fixed by law or rule, or at a meeting of which notice has been given.
Any action taken at meetings failing to comply with the provisions of this section shall be null and void, RCW 42.30.030(1). The Board shall not vote by secret ballot. Any vote taken in violation of this section shall be null and void and shall be considered an “action” within the meaning of this section and the Open Public Meetings Act, RCW 42.30, RCW 42.30.060(2).

Section 7. Executive Sessions. Nothing contained in these bylaws may be construed to prevent the Board from holding an executive session during a regular or special meeting. RCW 42.30.110(1).

Before convening in executive session, the Chairperson of the Board shall publicly announce the purpose for excluding the public from the meeting place and the time when the executive session will be concluded. The executive session may be extended to a stated later time by announcement of the Chairperson of the Board, RCW 42.30.110(2).

An executive session may be held for one or more of the purposes identified below or as otherwise permitted by RCW 42.30.110(1) or other applicable law:

a. To consider matters affecting national security;

b. To consider the selection of a site or the acquisition of real estate by lease or purchase when public knowledge regarding such consideration would cause a likelihood of increased price;

c. To consider the minimum price at which real estate will be offered for sale or lease when public knowledge regarding such consideration would cause a likelihood of decreased price. However, final action selling or leasing public property shall be taken in a meeting open to the public;

d. To review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs;

e. To receive and evaluate complaints or charges brought against a public officer or employee. However, upon the request of such officer or employee, a public hearing or a meeting open to the public shall be conducted upon such complaint or charge;

f. To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee. Strategic union discussions may be held in executive session. However, subject to RCW 42.30.140(4), discussion by a governing body of salaries, wages, and other conditions of employment to be generally applied within the agency shall occur in a meeting open to the public, and when a governing body elects to take final action in hiring, setting the salary of an individual employee or class of employees, or discharging or disciplining an employee, that action shall be taken in a meeting open to the public;
g. To evaluate the qualifications of a candidate for appointment to elective office. However, any interview of such candidate and final action appointing a candidate to elective office shall be in a meeting open to the public;

h. To discuss with legal counsel representing the District litigation or potential litigation to which the District, the Board, or a member acting in an official capacity is, or is likely to become, a party, when public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the District; provided, however, this exception does not permit the Board to hold an executive session solely because an attorney representing the District is present. For purposes of this exception, “potential litigation” means matters protected by RPC 1.6 or RCW 5.60.060(2)(a) concerning: (A) litigation that has been specifically threatened to which the District, the Board, or a member acting in an official capacity is, or is likely to become, a party; (B) litigation that the District reasonably believes may be commenced by or against the District, the Board, or a member acting in an official capacity; or (C) litigation or legal risks of a proposed action or current practice that the District has identified when public discussion of the litigation or legal risks is likely to result in an adverse legal or financial consequence to the District;

i. To conduct meetings, proceedings, and deliberations of the Board, its staff or agents, concerning the granting, denial, revocation, restriction, or other consideration of the status of the clinical or staff privileges of a physician or other health care provider as that term is defined in RCW 7.70.020, if such other providers at the discretion of the Board are considered for such privileges provided that the final action of the Board as to the denial, revocation, or restriction of clinical or staff privileges of a physician or other health care provider as defined in RCW 7.70.020 shall be done in public session, RCW 42.30.110; RCW 70.44.062; and

j. All meetings, proceedings, and deliberations of a quality improvement committee established under RCW 4.24.250, 43.70.510, or 70.41.200 and all meetings, proceedings, and deliberations of the Board of Commissioners, its staff or agents to review the report of the activities of a quality improvement committee established under RCW 4.24.250, 43.70.510, or 70.41.200 may, at the discretion of the quality improvement committee of the Board of Commissioners, be confidential and may be conducted in executive session. Any review conducted by the Board of Commissioners or quality improvement committee, or their staffs or agents, shall be subject to the same protections, limitations, and exemptions that apply to quality improvement committee activities under RCW 4.24.240, 4.24.250, 43.70.510, and 70.41.200. However, any final action of the Board of Commissioners on the report of the quality improvement committee shall be done in public session, RCW 70.44.062(2).
Section 8. Quorum. A majority of the persons holding the office of public hospital district commissioner shall constitute a quorum of the Board for the transaction of business, and the concurrence of a majority of the Board shall be necessary and shall be sufficient for the passage of any motion or resolution, except as required by law, RCW 70.44.050.

Section 9. Committees and Representatives. The Board may from time to time act as a committee of the whole or appoint such other committees as it may deem necessary or advisable in the conduct of its affairs. The Board may from time to time choose to change committee appointments as needed. The activities of any committees so appointed shall be conducted lawfully and be recorded in written minutes. Chairpersons of such committees shall be appointed by the Board to serve for terms not to exceed one year, subject both to removal at the will of the Board and to reappointment in the sole discretion of the Board. Committees of the Board shall meet periodically as provided in these bylaws or as provided by resolution of the Board.

Section 10. Powers and Duties of the Board or Commission. The Board shall be the governing body to which the superintendent (also referred to as the Chief Executive Officer or CEO), other District employees and the medical staff ultimately are responsible to for all facilities, services and activities of the District, including the condition of the physical plant. While the authority of the Board may be delegated to the CEO and the medical staff by resolution, any delegation of authority by the Board may be rescinded in its sole discretion, as provided for by law, WAC 246-320-125.

All of the powers authorized in RCW 70.44 and as amended may be exercised consistent with this enabling authority by the Board in the performance of its duties prescribed therein. Among other things, the Board shall strive to:

1. Determine the policies of the District and the purposes of the hospital and other District health care facilities and services in proper relation to community needs;

2. Establish a program for the ongoing management of a hospital quality improvement program and malpractice prevention program, including medical staff sanction and grievance procedures and information collection and reporting procedures. The quality improvement program will review the services rendered in the hospital and other District health care facilities and services in order to improve the quality of medical care of patients and to prevent medical malpractice;

3. Exercise proper care and judgment in the selection of a qualified CEO who shall be responsible for implementing policies adopted by the Board;

4. Promote planning and coordinate professional interests with administrative, financial, and community needs, the policies of the District, and the purposes of the hospital and other District health care facilities and services;

5. Provide for the periodic evaluation of the Board and its members;
6. Provide facilities, equipment, and personnel to meet the needs of patients within the purposes of the hospital and other District health care facilities and services and consistent with present and future community needs;

7. Assure that an appropriate standard of professional care is maintained, requiring the medical staff of the hospital to be accountable to the Board;

8. Assure that the medical staff possesses appropriate current qualifications and determine in its discretion which kinds of health care providers shall be considered for clinical privileges or medical staff membership;

9. Provide for the sound administration and application of public funds, adopting annual budgets for the District and the hospital at the times and in the manner required by law;

10. Maintain accurate records of District finances and all related activities;

11. Furnish every reasonable protection to the patient, thereby fulfilling the moral and legal responsibilities of the Board.

12. Follow all Employee Health Policies, including receiving an annual flu shot.

The Board is not obligated nor expected to manage the day-to-day affairs of the District. The Board is expected to delegate that function to others but may exercise reasonable and prudent oversight. In the performance of their duties, the Board may rely on information and reports received from the CEO, senior management, professional advisors and/or consultants who are knowledgeable with respect to the subject matter at hand.

However, the Board is charged with the organizational guidance and oversight responsibilities of hospital resources and staff to support safe patient care. The Board must:

1. Establish and review governing authority policies including requirements for:
   a. Reporting practitioners according to RCW 70.41.210;
   b. Informing patients of any unanticipated outcomes according to RCW 70.41.380;
   c. Establishing and approving a performance improvement plan;
   d. Providing organizational management and planning;
   e. Reporting adverse events and conducting root cause analyses according to RCW 70.56.020;
   f. Providing a patient and family grievance process including a time frame for resolving each grievance;
   g. Defining who can give and receive patient care orders that are consistent with professional licensing laws; and
   h. Providing communication and conflict resolution between the medical staff and the governing authority.
2. Establish a process for selecting and periodically evaluating a chief executive officer or administrator;

3. Appoint and approve a medical staff;

4. Require written or electronic orders, authenticated by a legally authorized practitioner, for all drugs, intravenous solutions, blood, medical treatments and nutrition; and

5. Approve and periodically review bylaws, rules and regulations adopted by the medical staff before they become effective, WAC 246-320-131.

Section 11. Avoidance of Conflicts of Interest. District commissioners, being aware of the fiduciary nature of their positions, shall avoid actions and relationships that result in a conflict between their private financial interests and their public responsibilities. Commissioners shall not violate the conflict of interest provisions of these bylaws, RCW 42.20, RCW 42.23.

Recognizing that even the appearance of impropriety should be avoided, no commissioner shall:

1. Be beneficially interested in or otherwise expect to profit from, directly or indirectly, any contract, sale, lease, or purchase made by the District, except as specifically permitted under RCW 42.23.030 or RCW 42.23.040, as now in effect or hereafter amended, or under other applicable law;

2. Accept, directly or indirectly, any compensation, gratuity, favor, or award from any party seeking to do business with the District, or in connection with any contract made by the District, other than (a) compensation and reimbursement for expenses as provided by law, or (b) compensation in connection with contracts permitted under RCW 42.23.030, as now in effect or hereafter amended, or under other applicable law;

3. Employ, use or appropriate any District employee, money, or property for his or her private benefit;

4. Hold any office, engage in any employment, or occupy any position, public or private, which could create conflicts between the duties, interests, and opportunities inherent in such office, employment, or position and the commissioner’s public responsibilities as a member of the Board;

5. Reveal or divulge to any other party unless authorized by the Board, any confidential information received in the performance of his or her duties as a commissioner, nor use such information for personal gain.

Any commissioner, upon discovering or suspecting that he or she has or may have a conflict of interest contrary to the policies and standards set forth in this section, shall promptly report the Public Hospital District No. 1
Grays Harbor County Bylaws
March, 2014
same to the Board. In such cases, a commissioner shall take such action as may be required to comply with the provisions of these bylaws and applicable law, including, if required, abstaining from discussing and voting on the matter.

**Section 12. Code of Conduct and Ethics.** The Board commits itself and its members to ethical, professional, and lawful conduct. This includes proper use of authority and appropriate decorum when acting as Board members and conformance with the provisions of RCW 42.23.

Board members must represent no conflicted loyalty to the interests of the District. This accountability supersedes any conflicting loyalty such as that to advocacy or interest groups, memberships to other boards or staffs, and the personal interests of any Board member acting as a consumer of services provided by the District.

Board members will be judicious in their interfacing with District staff and in communicating with others outside of the District on matters related to District governance. Members are expected to be mindful of the perception by others in the conduct of official and non-official personal communications with individuals in the District and external organizations.

**ARTICLE III. OTHER OFFICERS**

**Section 1. Chief Executive Officer (“CEO” or “Superintendent”).**

1. **Appointment.** The Board shall select and appoint as CEO a competent and experienced hospital administrator who shall be its direct representative in the management of the hospital and the District. The CEO shall be appointed for an indefinite term, removable at the will of the Board, and shall receive such compensation as the Board shall establish by resolution. The appointment or removal of the CEO shall be by resolution of the Board, introduced at a regular meeting and adopted at a subsequent regular meeting by majority vote, RCW 70.44.070.

2. **Powers and Duties.** The CEO shall be the chief executive and administrative officer of the hospital and of the District. In direct charge with full authority to act, as representative of the Board, and subject to its policies, he or she shall be responsible for the efficient administration of all affairs of the hospital and the District, RCW 70.44.080.

   In the performance of his or her duties prescribed by law, all of which shall be faithfully discharged, and not by way of limitation of his or her authority, the CEO shall:

   1. Carry out the orders of the Board;

   2. Ensure that all the laws of the state pertaining to matters within the functions of the District are duly enforced;
3. Ensure that the Board is fully advised regarding the District’s financial matters;

4. Submit to the Board for approval a plan of organization for the personnel concerned with the operation of the hospital, which shall be periodically reviewed;

5. Prepare annually a budget showing anticipated receipts and expenditures for the ensuing fiscal year which shall be submitted to the Board to allow timely filing and hearing thereon before adoption as required by law;

6. Select, employ, control and discharge all employees authorized by the budget;

7. Assure that all buildings, equipment and other facilities are maintained in good repair;

8. Furnish periodic recommendations to the Board with respect to the acquisition, development and extension of desirable health care facilities, equipment and services, and recommend a range of salaries to be paid to District employees;

9. Supervise through the auditor (business manager or controller) all business affairs including the disbursement of funds, recording of financial transactions, collection of accounts and purchase and issue of supplies;

10. Cooperate with the medical staff and secure like cooperation on the part of all those concerned with rendering professional services, to the end that patients may receive the best possible care;

11. Regularly submit and certify to the Board reports regarding professional services, bills, allowances and payrolls, including claims due contractors of public works, and other financial activities of the hospital, along with any special reports that may be requested by the Board;

12. Prepare the agenda for and attend all meetings of the Board at which he or she may participate in the discussion of matters being considered;

13. Execute on behalf of the District all contracts, agreements and other documents and papers that he or she may be authorized by the Board to sign;

14. Undertake on his or her own initiative the performance of such other duties, consistent with the law and policies of the Board, as may be in the interest of the hospital.
15. The CEO shall submit an annual Report of the CEO to the Board of Commissioners.

Section 2. Auditor. The Board shall appoint as auditor of the District a person experienced in account and business practices, who may be referred to as the Chief Financial Officer (CFO) or Controller as auditor. The appointment of the CFO/Controller may be delegated by the Board to the CEO.

The auditor (Chief Financial Officer or Controller) will report on the performance of his or her duties directly to the CEO. The auditor shall direct the drawing and issuance of all warrants or vouchers of the District upon the orders of, or vouchers approved by, the Board of Commissioners and shall perform other such duties relating to business affairs of the District including the recording of financial transactions, collection of accounts, and the routine purchase and issue of supplies, as are assigned by the Board and the CEO, RCW 70.44.171.

The auditor shall draw and issue all warrants for the disbursement of funds of the District upon the orders of, or vouchers approved by the Board, and shall be responsible in the performance of such other duties relating to business affairs of the District including the recording of financial transactions, collection of accounts, and the routine purchase and issue of supplies, RCW 70.44.171.

Section 3. Recording Secretary. The Board shall appoint a recording secretary. The recording secretary shall attend all business meetings of the Board of Commissioners, accurately record and publish the minutes of the Board and maintain the public records of all regular and special meetings of the Board of Commissioners. The Board may also establish a salary for the recording secretary.

ARTICLE IV. MEDICAL STAFF

Section 1. Appointment, Reappointment and Organization. The Board shall appoint the members of the medical staff of the hospital biannually after considering recommendations duly submitted in accordance with the Medical Staff Bylaws provided that all initial appointments shall be to cover the period of time until medical staff reappointments are due.

Such bylaws, rules and regulations governing the appointment, reappointment, organization, liability insurance coverage and activities of the medical staff, including procedures for the assignment, granting, denial, curtailment, reduction or withdrawal and/or termination of staff privileges and the indemnification of the kinds of health care providers eligible to be considered for such privileges or medical staff membership, shall be developed and adopted by the medical staff subject to approval and revision or modification by the Board, which will not be unreasonably withheld. The Board shall assure that the requirements of due process of law are observed, RCW 70.43.010, WAC246-320-185.

Section 2. Powers and Duties. Mindful that the medical management of each person admitted to the hospital shall be under the care of a member of the medical staff possessing clinical
privileges as required by law, such staff also shall have authority and responsibility in the manner prescribed by its bylaws, rules and regulations to:

1. Evaluate the professional competence of medical staff members and applicants for medical staff privileges;

2. Make recommendations to the Board concerning initial medical staff appointments, reappointments and the assignment or curtailment of medical staff privileges;

3. Establish controls designed to ensure the achievement and maintenance of high standards of ethical and professional practice;

4. Participate in the development of hospital policies relative to the effective use of existing facilities, and provision for the improvement or extension thereof where appropriate, to assure adequate patient care now and in the future;

5. Supervise a medical education program in the hospital and render such other services as the Board of Commissioners may consider desirable to enhance the standards of medical practice in the hospital;

6. Be accountable to the Board for the proper discharge of the duties set forth in this section.

Section 3. Professional Liability Insurance Coverage for Medical Staff. The Board of Commissioners require that all practitioners who are granted medical staff privileges to practice within the hospital shall maintain liability insurance with limits of one million ($1,000,000) dollars per occurrence and three million ($3,000,000) dollars aggregate. Proof of coverage shall be the responsibility of the practitioner. The practitioner shall give the hospital thirty (30) days prior written notice of cancellation or termination of any such policy. The practitioner’s insurance company must be acceptable to the District and licensed to write malpractice insurance in the State of Washington. These policy limits will be reviewed by the Board annually and revised as appropriate.

ARTICLE V. INDEMNIFICATION AND INSURANCE

Section 1. Indemnification. The District shall indemnify and hold harmless to the full extent permitted by applicable law each person who was or is made a party to or is threatened to be a party to, or is involved (including, without limitation, as a witness) in an actual or threatened action, suit or other proceeding, whether civil, criminal, administrative or investigative by reason of the fact that he or she is or was a commissioner, officer, employee or agent of the District, or having been such a commissioner, officer, employee or agent, he or she is or was serving at the request of the District as a director, officer, employee, agent, trustee or in any other capacity of another corporation or of a partnership, joint venture, trust or other enterprise, including service with respect to employee benefit plans, whether the basis of such proceeding is alleged action or omission in an official capacity or in any other capacity while serving as a commissioner, officer, employee, agent, trustee or any other capacity, against all expense, liability, and loss (including, without limitation, attorneys’ fees, judgments, fines, ERISA excise taxes or penalties in amounts...
to be paid in settlement) actually or reasonably incurred or suffered by such person in connection therewith. Such indemnification may continue as to a person who has ceased to be a commissioner, officer, employee or agent of the District and shall inure to the benefit of his or her heirs and personal representatives.

Section 2. Insurance. The District may purchase and maintain insurance, at its expense, to protect itself and any commissioner, officer, employee, agent or trustee of the District or another corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss to the full extent permitted by applicable law.

ARTICLE VI. REVIEW AND REVISION OF BYLAWS

The Bylaws of the Hospital District shall be reviewed and revised every two years, and shall be dated, authorized and signed by the commissioners.

ARTICLE VII. AMENDMENT OF BYLAWS

These bylaws may be amended by resolution of the Board of Commissioners introduced at a regular meeting and adopted at a subsequent meeting by majority vote.

REVISED and ADOPTED this ________ day of _________________________, 2014.

____________________________________
Chair and Commissioner

____________________________________
Vice Chair and Commissioner

____________________________________
Secretary and Commissioner

____________________________________
Commissioner

____________________________________
Commissioner
RESOLUTION NO. 2016-01
ADOPTION OF CONTRACTUAL COMPENSATION
LIMITATIONS BY DISTRICT OFFICIALS PURSUANT TO RCW 42.23.030

A Resolution of the Commission of Public Hospital District No. 1, Grays Harbor County, Washington, relating to the adoption of contractual compensation limitations for officials of the District.

WHEREAS, Public Hospital District No. 1, Grays Harbor County, Washington (the “District”) has or may in the future enter into contracts where District officers, to include but not limited to Commission Board members, may have a financial and beneficial interest in a contract with the District; and

WHEREAS, the Board has reviewed and intends to comply with RCW 42.23.030 allowing for exceptions and limitations on a commissioner or officer benefiting from such a contract, to include annual dollar amount limitations; and

WHEREAS, this statute requires full and complete disclosure by commissioners/officers of any interest in a contract with the District and they shall disclose to the governing body and have such disclosure in the official minutes of the Board; and

WHEREAS, the Board further adopts and will require compliance by any commissioner/officer identifying such interest and will ensure that they do not participate in the adoption of any contract; and

WHEREAS, the commissioner or officer is precluded pursuant to statute of participating in the award of the contract or influencing or attempting to influence any other officer; and

WHEREAS, compliance with the statute requires at the beginning of each calendar year, that the legislative authority of the rural public hospital district, shall increase the maximum compensation calendar limitations provided for in statute by an amount equal to the dollar amount for the previous calendar year multiplied by the change in the consumer price index; and

WHEREAS, the statute originally identified this annual amount not to exceed twenty four thousand dollars in any calendar year and whereas the District has calculated subsequent years of the Consumer Price Index to date to determine the annual maximum compensation amount; and
RESOLUTION NO. 2016-01
Page 2 of 3

WHEREAS, the United States Department of Labor Bureau of Labor Statistics for the Seattle, Tacoma, Bremerton CPI-U increase for the twelve months of January through December 2015 was 2.2 percent; and

WHEREAS, this results in the annual maximum compensation amount for officers and commissioners for the District of twenty nine thousand seven hundred twenty three dollars eighty-five cents, ($29,723.85) for the calendar year 2016; and

NOW, THEREFORE, BE IT RESOLVED BY THE COMMISSION OF PUBLIC HOSPITAL DISTRICT NO. 1, GRAYS HARBOR COUNTY, WASHINGTON, adopts these provisions and the annual compensation limitation for those contract amounts of which a commissioner/officer has an interest of up to twenty nine thousand seven hundred twenty three dollars eighty-five cents, ($29,723.85) for the calendar year 2016.
RESOLUTION NO. 2016-01
Page 3 of 3

ADOPTED by Board of Commissioners of Public Hospital District No. 1 of Grays Harbor County, Washington, at an open public meeting of the Board on the 28th day of January, 2016, the following Commissioners being present and voting:

PUBLIC HOSPITAL DISTRICT NO. 1
GRAYS HARBOR COUNTY, WASHINGTON

________________________________________
Chair and Commissioner

________________________________________
Vice Chair and Commissioner

________________________________________
Secretary and Commissioner

________________________________________
Commissioner

________________________________________
Commissioner
January 21, 2016

Will Callicoat, CFO

Dear Will Callicoat:

In 2015 the Board of Commissioners of the Grays Harbor County Public Hospital District No. 1, adopted Resolution 2015-02. This resolution established the limit of compensation that a commissioner or officer of the District may earn related to any contract with the District. The limit in 2015 was $29,084.

For calendar year 2015, did you have any financial or beneficial interest in any contract with the District? If your response is no please so state, sign and return this letter. If your response to the question is yes please identify the contract, state that you do have a financial or beneficial interest and state the amount earned in 2015. Please sign and return this letter with your response.

These responses will be documented in the Board minutes of the next meeting.

For your information this letter is being sent to the five commissioners, the CEO, CFO, CCO, COO and Fiscal Associate.

We will appreciate your prompt response to this letter.

Sincerely,

Renée Jensen
Chief Executive Officer

☐ No

Date ___________________________  Signature

☐ Yes  Please sign and date and add an additional page with details.