BOARD OF COMMISSIONERS
PUBLIC HOSPITAL DISTRICT NO. 1 OF PEND OREILLE COUNTY
JOINT SESSION – 11:00 AM
December 17, 2015

In Attendance: Commissioners: Lois Robertson, Terry Zakar, Thomas Garrett, Ray King, and Lynnette Elswick; Thomas Wilbur, CEO; Directors: Kim Manus, Michele Page; Chris Wagar; Shelley Froehlich; Buzz Price; Jeremy Lewis, DO; Clayton Kersting, MD; Angelika Kraus, MD; Shannon Radke, MD; Geoff Jones, MD; Other: Jenny Cooper, Bob Eugene, Jenny Smith, and Nancy Shaw.

Excused: Joseph Clouse.

CALL TO ORDER:

President, Lois Robertson called the meeting to order at 11:15 am.

READING OF LEGAL NOTICE:

The legal notice was distributed as required.

APPROVAL OF AGENDA:

The agenda was reviewed and approved as presented. The objective of the meeting was to discuss strategic and business planning for Public Hospital District #1 and obtain input from providers, staff and community members.

BUSINESS FROM THE AUDIENCE

There was no business from the audience.

BUSINESS AND STRATEGIC PLANNING

Tom Wilbur opened the session with an overview of the agenda, packet materials, and the primary goals of the planning session: 1) recap and takeaways from the November 19th meeting; 2) review the District's capital planning history, status, and 2016 targets; and 3) provide the basic outline/targets for our tactical business plans for 2016.

Tom recapped the November meeting takeaways:

- The District's 2015-16 Strategic Guides [Mission/Vision/Values and Clarity Targets], Core Goals [Autonomy and Local/Regional Affiliations] had few changes.
- Recruitment and onboarding of FP's with OB will continue to be a focus; as will
- Continuing to build on our local/regional affiliations to ensure we can provide full spectrum medical/health/wellness services for the community and those we serve.

District Key Affiliations: include the WA Rural Health Collaborative (WRHC) and Rocky Mountain ACO (RMACO), the Eastern WA CAHN, and our local POHC.

Medical Home initiatives: care coordination/care teams established to address population health and to stratify at-risk vs. chronic vs. healthy patients. For NHHS, filling the gap in home care remains a challenge and how to best transition from the first to second curve

(delivery and reimbursement). We will continue to seek grant funds and shared savings to offset potential revenue losses as we improve care coordination.

Tom noted our development of comprehensive systems of care delivery will depend upon seeking the best methods to coordinate and integrate care and will require use of informatics, system adaption, and building and/or purchasing sub-specialty services.

2016 Business Planning

For NHHS, reform is now: the ACO (Medicare) model (via RMACO is effective January 2016) and both the ACH/CCO (Medicaid) and Medicare models will require affiliation and development investment – some costs of which have been factored in our 2016 budget.

Tom expects our economics will continue to change during the transition to second curve care delivery model and that "shift to value" will occur at a quicker pace.

Director/manager plans/tactical elements include:

- Develop/ empower staff to build better, patient centered systems of care;
- Recognize and quickly adapt to change to meet operational and cash flow targets;
- Enhance/develop IT systems and platforms to support coordinated system of care;
- Maintain financial viability: right size operations, develop new ACO/ACH payment system models, and explore self-insured medical/professional liability plans;
- Affiliate: to enhance/develop our ACO/ACH systems;
- Use capital efficiently and effectively (right size); and,
- Market/brand of our medical home using proven customer service, quality, and convenience measures.

Tom outlined his strategic "big bullet" goals:

1) Recruit and retain providers: FP w/OB, ED physicians and sub-specialty providers;
2) Develop our human resource: leadership/staff development, PI/LEAN Team engineering, and Success Factors/goal setting/compensation alignment;
3) Continue to build upon our quality/service measurement systems (w/transparency);
4) Retain 1st curve market share during transition: primary, ancillary and core specialty services; and continue to pursue expanded residential and sub-specialty services; and
5) Fully develop our PCMH/ACH, care coordinated system models: the success of which will depend partly upon affiliating providers and insurance carriers under contract design.

Tom noted that he recently met with the Health Care Authority and CEO's shifting to ACO/ACH models. Discussions centered on the effect of building VBP models – as systems get better an effect can be that payments are taken away from other agencies. For example, if primary care physicians keep populations healthier, hospitals may suffer financially. Conversely, if a local hospital builds a broader scope of service, the need to transfer to tertiary facilities will be reduced. Presently, many change effects are a zero sum game – as somebody wins, somebody else loses and the effect will need to be monitored.

The group reviewed a series of slides identifying VBP Required Functions and the Health Management Continuum and population risk stratification. Tom noted our patient-centered medical home is being developed to encompass all services from birth to end of life, including palliative planning. As part of that process, our goal is to identify all

elements/aspects of care coordination/planning across the continuum including behavioral health, social services and sub-specialty care. Continuity of care/health management becomes important as we will be required to assess community needs to determine key service targets. Our hope is that as we affiliate to become "partners" in health/wellness, we should be afforded an opportunity to provide necessary services using any means possible (i.e.- tele-medicine/remote monitors and building support systems using staff at maximum licensure).

Commissioner Robertson asked whether there was a deadline to become an Accountable Care Organization (as a requirement). Tom indicated that we remain in the zone between the first and second curve systems and nothing is specifically mandated. He noted the State legislature has made some requirements for transition to value based purchasing by 2018; and the State has set a target for full ACH integration by 2020.

Tom noted our cost based reimbursement model allows us more leeway (less risk) to participate vs. those facilities that are paid on a fee-for-service basis. Most hospital systems operate on a 1-2% margin, therefore, there is an inherent risk involved to participate in shared savings models (will you get lost reimbursement back?). In addition, our providers have historically been paid using RVU production (paid to produce a service). Providing care under a managed model will require seeking out new payment methods. This is the dilemma we are faced with as we attempt to navigate from first curve to second curve.

Dr. Jones stressed that transition to the new model of care isn't going away and it would be in our best interest to be as prepared as possible. He noted that health care spending in the US had already become unsustainable and the question remains when it will become effective and how to best implement the new models of care. Commissioner Garrett agreed and stressed our transition should occur as quickly as possible to avoid the greatest risk.

Tom W. noted that a shared savings contract exists under our ACO model but there is no guarantee of success; we are sharing development risk with like facilities. Furthermore, there are no maps for success as this is uncharted territory. Our ACO providers have engaged and agree that the system can work much more efficiently. We do believe that as the provider and carrier are "blended" into a consolidated system, risk can also be mitigated.

Payment systems remain fragmented and it is difficult to coordinate care when agencies are not receiving reimbursement for services. Although future prospects are fraught with uncertainty, Tom stated that he is pleased with our position and is optimistic we can build systems to be successful. He thanked the Board members for their willingness to navigate through the changes ahead. Dr. Jones agreed that the model is based upon "community care," which has always been our focus and mission. Many studies prove that patients do better when they are able to stay in their community.

Capital Planning

10-year Recap: Tom noted we had conducted comprehensive master facility reviews in 2002 and 2006; both were targeted 20-year plans. Both reviews identified key strategic targets: consolidate the clinics, expand/redesign clinical service space: lab, therapies, PACU/ OR and O/P treatment; and expand support services: IT, C/S-Purchasing, Admin/PFS and education. Additional considerations included new ED space and MRI.

The 2006-07 final plan required voter approval to fund the project and when the levy failed we adjusted plans in 2008-09 to redevelop all existing hospital/clinic space available. That

development occurred from 2010-2014 when IT, Purchasing, C/S, Education, and HIM/Housekeeping spaces were all remodeled or developed. In addition, the lab area was re-designed to better fit the service, the OR was remodeled in 2014, and the PACU was relocated to the second floor for patient safety. An essential electrical upgrade to bring the hospital buildings up to code was completed throughout the entire course of the projects. We were able to redevelop/redesign 8,000 sf. of space and do it primarily with operating cash reserves.

In 2014-15, after it was determined we were now "officially" out of space. Our facility plans indicated we still needed a new clinic and also a new residential care facility to replace an aging facility with a service line that was becoming obsolete. We were able to proceed and fund the clinic with existing capital, but we needed a bond levy to fund the new residential care facility.

Our November bond levy failed (but a 55% positive result was respectable) and we have considered putting forth another proposition to the voters in April. Commissioner Garrett raised concerns about spreading the word on the bond proposal, noting some members in the community remain opposed to the levy. Tom W. noted he plans to continue to meet with our community steering group to focus energy and messages on the urgency/need for a new residential care option. Tom and Michele Page are also meeting with representatives from SEIU next Monday to clarify residential care facility needs and past planning efforts – the union opposed the proposition in November.

Tom cautioned staff members that under public disclosure statutes we are limited to providing only factual information on the levy proposal. We cannot promote the threat of closure of LTC, but rather can state a fact (i.e.- 70 nursing homes in the State have closed in the past 12 years). Employees are not able to encourage anyone to vote (while acting as a District employee), and any "promotional materials" must be furnished/ paid for by private citizens. We can also not use District buildings, equipment, or time to "promote" the levy.

Tom is working with community members to order and place signs. He also plans to get in front of the Democratic and Republic parties regarding our facility proposal. All agreed that community education will play an important role in passing the bond. Tom explained that the existing 45 residents in LTC would have first priority to move to the new 54-bed facility; an additional 18 units are slated for future need/expansion in the new building.

Chris Wagar encouraged the Board and providers to become involved in assisting with disseminating information to the community. It was noted that only two members of the Board can serve on the local committee at any given time.

2016 Capital Plans: We will focus on the vacated clinic spaces that become available in August when the new clinic comes on line. Tom furnished space maps to the group for consideration of: need/use, design/remodel cost estimates, priorities, and domino order of spaces. The following items were discussed and considered:

- Ancillary needs – post clinic build: therapy services (growing demand); other O/P services; visiting clinics (buy/host?); vs. sub-specialty care (what/when?)
- When, where, how? In what order?: RFQ – if we utilize A&E services; Building implication – circa 1958; and Financing implications…clinic & other
- Residential care – from levy passing to a new building is (19 – 25 months).
- Existing LTC becomes PCMH continuum support services.
- Funding and financial forecasts.

Tom requested the group consider all available spaces: FMN, Education Center/ Storage building, FHCN, Accounting & Admin buildings, and even Dr. Cool's space (though that will be a last resort). At present, our balance sheet is positive and we are afforded several options for consideration as we are in a good cash position.

Along with the building considerations/service options, Tom presented an updated 9-year income/cash flow forecast (same format as 2014-15 review) and noted his 2015 predications were conservative. 2015 cash flow from operations: 2015 (actual) is $850,000 vs. (projected) of $108,571, not including the increase in capital purchases. Tom noted our operations as a predominantly cost-based, factors an operating margin in the plus or minus 2% range.

Tom reviewed projected capital expenditures for the new clinic (in the queue), remodels (15,000 sq. ft.), and construction of an assisted living facility. Included in the information was a list of assumptions for the projections and calculation of our existing debt limit. Debt balances are very manageable; the non-voted debt capacity is limited to the M&O tax revenue stream.

The group briefly discussed options and Tom indicated we would address capital and facility remodel/expansion plans over the next six months. Our base is expanding and Tom noted he was excited that our two clinics would be located under one roof in Q3, 2016. He noted we will see an increased demand for residential care and we must continue to review services and build relationships with our social, support, sub-specialty and tertiary partners under our PCMH models.

ADJOURNMENT

There being no further business, the meeting adjourned at 11:50 am.

NEXT MEETING DATE

The next regular meeting of the Board of Commissioners will be held on Thursday, January 28, 2015 at 12:30 pm.

Minutes recorded by Nancy J. Shaw, Administrative Assistant and Thomas Wilbur, CEO

Lois Robertson

Lois Robertson, President
Board of Commissioners

Terry Zakar

Terry Zakar, Secretary
Board of Commissioners