BOARD OF COMMISSIONERS
PUBLIC HOSPITAL DISTRICT NO. 1 OF PEND OREILLE COUNTY

June 22, 2017

In Attendance: Commissioners: Thomas Garrett; Lois Robertson, Terry Zakar, Raymond King and Lynnette Elswick; Clayton Kersting, Chief of Medical Staff; Thomas Wilbur, CEO; Directors: Kim Manus, CFO; Walter Price, Pete Peterson; Chris Wagar; Others: Diane Waldrup, Vicki Richter, Jennifer Johnston, Sharon Weber, Chelsea McLaughlin, Jen Allbee, and Nancy Shaw.

Excused: Joseph Clouse, HR Director.

CALL TO ORDER:

Chairperson Garrett called the meeting to order at approximately 12:30 p.m.

READING OF LEGAL NOTICE:

The regular meeting legal notice was distributed as required.

APPROVAL OF AGENDA / CONSENT AGENDA:

The meeting Agenda, Auditors Report and Uncompensated Report were included.

The following consent agenda items were approved as presented by a motion made, seconded and passed.

Auditors Report: May 2017: Warrants #201900-#202348 and wire transfers #1485-#1504 in the amounts of $1,635,514.23 and $1,447,369.55, respectively, plus an automatic loan payment deduction of $40,000 for a grand total of $3,122,883.78.

Bad Debt/Charity Care: all-inclusive May 2017 District Write-off's for $140,496.66.

APPROVAL OF PREVIOUS MEETING MINUTES

The regular meeting minutes of May 25, 2017 were approved by motion, seconded and passed.

BUSINESS FROM THE AUDIENCE:

There was no business from the audience.

COMMITTEE REPORTS:

Joint Conference/Planning – Dr. Kersting reported on a recent update to the new assisted living facility budget status/changes, which reflect moving from single rooms to double occupancy. He commented that this may be a positive option for many residents and overall, the medical staff feels informing the public will be important at this juncture. The proposal presented to voters outlined 54 units which may have been interpreted as single occupancy units. Commissioner Garrett also felt it important to notify citizens that the project has been delayed. Tom W. responded, noting that an article will be published in the newspaper next week.

Dr. Kersting indicated that Dr.'s Aaron and Tessa Reinke made a recent visit and are very excited to start their practices this Fall. They officially passed their board exams and have purchased a home in the area. It was also noted that Clinic Manager, Pam Lee has announced her retirement in August; Dr. Kersting is anticipating a smooth transition; Chris W. stated that the position will be posted tomorrow.

Commissioner Zakar noted that she received a recent complaint related to privacy at the clinic check in counter; Dr. Kersting responded, noting that he is not aware of any recent complaints related to privacy issues. However, patients appear to be frustrated with long wait times on the phone and a lack of return phone calls – also, there has been employee turnover in the reception area. Walter "Buzz" Price offered a detailed statistical report on incoming calls; Chris W. stated that she has been focusing on dropped calls, callbacks and duration of calls.

Finance – Kim M. provided a budget-to-actual recap and comments on the variances. A breakdown of YTD revenues for IP, OP and clinic were included. IP/OB volumes were up 30% (644 vs. 500 days) to budget. Outpatient revenues are off 16%; ED visits, budgeted to increase 5%, are flat; though we are entering the busy summer months. The big issue is clinic volumes, up 14% year-over-year, but still running 20% below budget because we don't have enough providers on board. Lower than budget clinic volumes also impact outpatient service Lab, PT and Radiology services. Kim anticipates these will increase when our two new physicians starting in September; she noted that expenses are flat, as there has been no reduction in staffing.

Provider availability and schedules were discussed. Commissioner Garrett asked whether the providers are experiencing down time due to a lack of scheduled patients. It was noted that it depended upon which provider you asked. Most are as busy as they want to be, others think they have more capacity. However, much of our service volume capacity is dependent on the provider schedules and *when they are here*. Over time, the providers have increased their time and days off. Tom added that three providers were signed on in Sept. 2016; which has only helped to offset the loss of two providers at the beginning of the year; he also does not anticipate seeing a significant impact when the two physicians begin in September – it will take time for the numbers to rise.

Tom stated that he polled our providers as to whether we should hire an additional provider – there are varying opinions. He plans to meet with the providers to discuss the statistical data and their ability to truly manage a population of lives under a value based purchasing model.

Kim pointed out that voted tax revenues on our TBD bond issue were $293,000 and included in revenues; we also have a budget variance of $142,000 in interest expense that is due to not having issued the UTGO bonds. FTE's are over budget; Tom noting that two are medical assistants hired to support the new physicians arriving in September. Kim is confident the Reinke's will be fully credentialed by all insurance plans with the District. She noted that Medicare will not accept applications until 60 days pre-start date. Cash on hand is at 106.9 days with the UTGO funds excluded from the calculation; the UTGO funds are set aside exclusively for debt service. Days in AR are in the 40's range.

Kim explained that she is reviewing ED charge levels and coding for potential opportunities. EmCare contacted us this morning to advise us that our current contract is unsustainable; they have not been able to recruit "NHHS" based providers and are paying excessive hourly premiums to keep the schedule full. They offered three options: 1) a 90 day opt-out notice – not an ideal option for either EmCare or us; 2) increase our rates by 10% to compensate for the losses; Kim noted that our current

"guarantee" rate is $205 per hour ($170/hr provider + $35 admin fee). She noted that we had been under the impression that EmCare was paying ED providers up to $200 per hour; however, some providers are getting paid as much as $325/hour when they hold out on shifts; their average rate is approximately $230 per hour (and EmCare eats the difference between the $230 and $170/hr); 3) The District would employ the physicians and have to recruit, schedule, retain, and take the risk for the entire service line; which is not much of an option at this time.

Commissioner Robertson stated that her understanding is the Emcare contract is binding until it expires – at which time the contract is re-negotiated. She asked when the existing contract expires and clarity on the current terms. Kim explained there is a 90-day notice to terminate without cause under the contract, which is fairly common for provider contracts. She noted EmCare provided a courtesy call to discuss their need to exercise that option if new terms could not be reached. Tom explained that he is notifying our ED providers of our budget constraints and our desire to come to mutual agreement. He noted part of the problem is trying to determine "market" ED provider rates, which vary depending upon location, ED volumes, provider availability, etc.; you can pay less if providers get to sleep. Tom admitted that he hasn't pressed the issue on taking over recruitment and direct ED provider contracting – as we already had enough recruiting on our plates with primary care, general surgery, and VBP contracting to deal with; however, he plans to explore options and will be proactively trying to find additional solutions.

ALF Facility – Kim explained we have a three year window from the time we *issue UTGO bonds* to the time we *spend down the bond proceeds* on any project; therefore, there is no pressing time constraint on the ALF project even with a slight delay. The general contractors we spoke to feel this is a 12-15 mos. start-to-finish project. However, interest rates remain very low so there is some advantage to issuing bonds sooner rather than later and our bond rating may expire after 90-120 days. She will be exploring options with legal counsel over the next few weeks.

Kim reported that our project team had a very positive meeting with DSHS (Home and Community Services and Residential Care Services groups) to discuss new ALF licensure options. Both HCS (residential care contracting and placement) and RCS (facilities licensing and survey) indicated Newport could be a rural model for the State. Kim noted that the delay may have been a blessing as ALF studio units do not allow for two occupants; which would rule out husband/wife occupancy. The design team also noted that many memory care residents thrive in double occupancy settings. Tom W. stated that we will be researching new layout and design options to manage available staffing resources and build a project within budget.

Kim reported that effective August 1st the WRHC group malpractice insurance will go into effect; our facility will realize approximately $45,000 in annual premium savings. There is no additional risk and we will benefit from the group purchasing arrangement. Kim shared a recap of the WRHC member report statistics.

Quality Assurance –Jennifer Allbee reported that as a result of a Patient Safety Grant award, a project was undertaken to swab (for MRSA) all patients scheduled for general surgery – excluding OB or orthopedic surgical cases. This determines which patients are MRSA positive prior to surgery in an effort to reduce surgical site infections. To date, out of 62 surgeries, 31 have not been swabbed; 4 had a MRSA positive indication and received nasal treatment prior to surgery; two were missed. As a result, MRSA positive rates in general elective surgery cases was 13.8%; this is rather high; in comparison it was 7.4% during 2016.

Jennifer reported the District will receive an award, "Excellence in Rural Quality Improvement" at the WSHA Annual Conference in Chelan next week. The award will also be presented at the July meeting of the Commission by WSHA. WSHA will also be here in late July to discuss progress with our reduction in readmissions. Jenn was thanked for the informational report.

An Executive Session will be required following the meeting for approximately 15 minutes to discuss personnel matters.

SUPERINTENDENT REPORT

Tom asked if anyone had read the article in their packets titled, "Rural Health Care Challenges" – from 1989! Lynnette indicated she had and was smiling as she read it, noting that some challenges remain the same, 30 years later.

Quality Measures: Tom W. announced that with Heidi Hedlund departing for Skyline Hospital, (a WRHC partner located in White Salmon), Jennifer Allbee will be assuming the role as Quality Manager. He noted he has the utmost confidence that Jenn will continue the great work we have going and we will continue to provide comparative quality and statistical data with our CAHN, WRHC, rural hospital, and ACO partner groups. There is much more available data and we are trying to respond to all pertinent comparative measures, particularly as it pertains to new VBP measures.

Tom included the ACO quality metrics, noting e-Clinical Works (eCW) is the database tool we are using to compare Medicare quality, patient acuity, and spend data associated with ACO assigned lives for our clinic providers. He noted there are 9 hospitals in the ACO [5 in WA, 4 in CO] with a total of 18,500 Medicare lives – 14,700 based in WA [85% of the ACO]. Details reviewed on the report were: total spend/per-capita, client average risk (clinical acuity); average length of stay, ED utilization/ spend, skilled nursing utilization/spend, annual wellness visit %-tage, etc. Tom noted that NHHS numbers are very good in most every category. One of the cost-saving targets of the ACO is skilled nursing; Tom is pleased with our position as compared to our peers and noted that Dr. Kersting is leading the charge to keep us at the top of the class. We are in good hands.

Commissioner Zakar questioned the co-morbidity (avg. risk) data, asking whether we are properly coding all concurrent conditions. Tom W. noted that was an excellent question and it was probably likely that we were not, noting that we began to better monitor coding data in 2016, but there remains questions as to how the data is entered, captured, measured, and reset every year. We are diving into the data, but we haven't had the opportunity research it thoroughly. However, based upon the fact that our average risk was one of the lowest in the group was probably an indicator we were not capturing all pertinent codes.

Finance: Tom noted he was not satisfied with our financial results, but will wait until the first half of the year is in the books and an interim cost report is complete before passing final judgement.

ALF Project: Doug Hammond met with our A&E team and a general contractor and provided Tom with a project update. It appears we were largely a victim of bad timing in the construction market for key sub-contracts (electrical, plumbing, mechanical). We didn't receive many bids – for instance, only two electrical subcontractors (out of 10 to 12 in the area capable of doing our job) even submitted a bid and those came in at 20% over what our A&E and the general contractor thought would be

competitive in a soft market. There is just too much in the construction pipeline right now. And, based upon what Doug could see in the A&E pipeline, things weren't going to change for at least a few more months. So, Tom noted, we are back to the drawing board with A&E and the design team to bring options back to the Board for further review.

Following the meeting with HCS/RCS representatives, the State is very supportive of our effort especially since they have seen many rural facilities close over the past several years. Tom explained and discussed several scenarios that might conform to our budget and staffing ratios; he noted that he would continue to pursue all options. The Commission and staff general goal remained to build a minimum of 54 beds of single (ALF) and double (EARC) finished occupancy, with an option to expand at a later date. None could foresee demand decreasing over the next twenty years.

OLD/NEW BUSINESS:

Provider Recruitment: Drs.' Aaron and Tessa Reinke will relocate to the area early in September. We continue to search for ED providers and also have an orthopedic surgeon beginning practice (once a week – Weds.). Drs. Kanning and Williams will provide interim general surgical coverage twice a week to bridge the gap when Dr. Stacy Zabriskie departs. Commissioner Elswick asked whether we will continue to provide emergency surgical services. Tom noted that true emergent services are rare and it would depend upon Kanning/Williams regular schedule – they would be available for phone consults regardless, as they are already on-call in Sandpoint. Tom added that our new contract model is intended to be beneficial to both parties. He will keep the board posted.

EMS District: There were no updates – the County will be holding public hearings next month.

Care Coordination: The focus has been on the ACO (Medicare lives) and Dr. Kersting has been very engaged; we remain ahead of the curve. Tom stressed the importance of also managing Medicaid lives with the ability to participate in a shared savings contract with Molina and Amerigroup. We are working on covering the gaps and fine tuning the management of the health population in our region.

Strategic Planning: Tom noted our two core goals for 2017: 1) review operating efficiencies [services and FTE's/labor costs, including overtime] to ensure efficient process, quality service, and a positive bottom line; and 2) continue to efficiently translate all care services to appropriate billings to collect 100% of what we are due for the services we provide [care-to-revenue cycle]. Those two targets were closely followed by staff development/empowerment to allow the District to quickly adapt to industry changes and keep moving forward.

Tom will continue to work with the Board and physicians to engage them in leadership and "shared" governance as we need to adapt to change in the most efficient way possible, with tremendous uncertainty. New business practices/delivery systems, facility planning/design, care management/ population health, and health plans/payment models are all evolving; but not necessarily in alignment. In fact, some are completely contradictory at the moment.

Tom provided the latest on the Health Care Authority's (HCA) plans to transform healthcare using Accountable Communities of Health (ACH's) between now and 2020. Under the plan, 90% of HCA payments will be value based (VBP) by 2020 – rather than present day fee for service (FFS). The idea is to reduce the use of intensive services, reducing reimbursements and accelerating transition to VBP, by encouraging providers and managed care organizations (MCO's) to share risk/management of

clients; the intent being to improve population health through prevention and management, and ensure that our WA Medicaid cost growth is below our National average. Again, reducing costs translates to reducing provider (NHHS) payments.

Tom noted the HCA update (now for its 2.2M covered lives – up from its 1.4M in 2014) builds upon the original planning framework published in 2014 [SB-6312: to combine medical/behavioral health and HB-2572: to form Accountable Communities of Health] which, three years later, is right on track; lest anyone think they are not moving along a predefined path. In fact, our local POHC formed in 2014 was predicated on the HCA outline.

Tom outlined the 2017-2020 program transition as he understood it and indicated we would be going over these materials at future Board meetings and our Fall strategic planning session because the detail 1115 waiver program applications, rules and program guides/outcomes are being updated. However, the funding plans and general program initiatives are somewhat set. Tom explained the funding pools and project targets and noted NHHS (and our local POHC partners) are working with Better Health Together (Spokane region ACH) to participate in the 1115 waiver programs. Ultimately, our target is to receive the $2.2M earmarked for Pend Oreille County under the program waiver funding.

The HCA will utilize the ACH's and a fiscal intermediary to vet programs and determine funding; however, the funding will be paid directly to providers (via the intermediary). Tom noted that the first two years of the program are pay-for-reporting (quality metrics and outcomes) and years 3 thru 5 payments shift to value based (for achieving outcome targets). Tom will have more information over the next several months as the programs take shape. We will also continue to work with managed care organizations to jointly track and manage lives with the intent to secure shared savings contracts.

Legislative Updates: Tom will learn more information next week related to the State's budget. The Senate is developing a new health care bill – there remain many unknown factors.

ACTION ITEM AGENDA

There were no Action Items to approve or discuss.

OTHER BUSINESS:

The Annual WSHA Rural Summer Workshop is June 26-28 in Chelan, WA.

The Board Retreat scheduled for July 21 has been postponed to occur in September.

Per the recommendation of the Medical Staff Executive Committee, the Commissioners approved:

Appointments from Provision to Full Status

Emergency Medicine:
- Carlos Montiel, MD
- Tyler Pedersen, MD
- Aaron Petersen, MD

Tele-neurology:
- Todd Czartoski, MD
- Sarabjit Atwal, MD

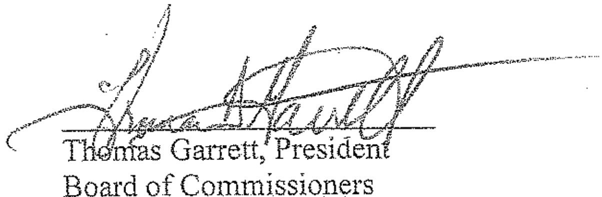
EXECUTIVE SESSION
The meeting moved to Executive session at approximately 2:05 pm. to discuss personnel matters.

RETURN TO OPEN SESSION
The Board returned to open session at 2:20 pm. and there was no action taken.

NEXT MEETING DATE-
The next regular meeting of the Commission will occur on July 27, 2017.

ADJOURNMENT
There being no further business, the meeting adjourned at 2:30 pm.

Minutes recorded by Nancy Shaw, Executive Administrative Assistant and Tom Wilbur, CEO.



Thomas Garrett, President
Board of Commissioners

Terry Zakar, Secretary
Board of Commissioners