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

October 26, 2017

In Attendance: Commissioners: Thomas Garrett; Lois Robertson, Terry Zakar, Lynnette Elswick, and Raymond King; Clayton Kersting, MD, Chief of Medical Staff; Curtis Gill, DO; Tom Wilbur, CEO; Directors: Kim Manus, CFO; Walter "Buzz" Price, Pete Peterson; Chris Wagar; Others: Trina Gleese, Diane Waldrup, Casi Densley, Jen Allbee, Jenny Smith, and Nancy Shaw.

Excused: Clayton Kersting, MD and Joseph Clouse, HR Director.

CALL TO ORDER:

Chairperson Tom Garrett called the meeting to order at 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: September 2017: Warrants #203560-#203929 and wire transfers #1555-#1570 in the amounts of $1,078,751.56 and $1,520,564.06, respectively, plus an automatic loan payment deduction of $40,000 for a grand total of $2,639,315.62.

Bad Debt/Charity Care: all-inclusive September 2017 District Write-off's for $127,781.20.

APPROVAL OF PREVIOUS MEETING MINUTES

The regular meeting minutes of September 28, 2017 were approved by motion, seconded and passed.

BUSINESS FROM THE AUDIENCE:

Trina Gleese, Compliance Officer welcomed and introduced Dr. Curtis Gill, who will be providing physician coverage in the Emergency Dept.

Commissioner Thomas Garrett complimented Jenny Smith for her efforts in making "Doctoberfest" a success. The event was sponsored by the District as a means to introduce our new providers to the community via a meet and greet opportunity.

2017 Compliance Report – Trina Gleese, Compliance Officer presented a review of the District's Corporate Compliance Program. Members of the Compliance Committee include: Julie Lohman, Privacy Officer, Walter "Buzz" Price, Security Officer, Kim Manus, Leif Furman, Sue Schwartz, Pete Peterson, Lynnette Elswick, Chris Wagar, Lisa Morse, Michael Zeimantz, Tina Batsch, Jennifer Johnston and Brian Burkhead.

The Committee implements and oversees policies, procedures and standards of conduct, and ensures that standards are enforced through well-publicized disciplinary guidelines. In addition, the Committee provides internal education, conducts monitoring and auditing work, and responds promptly to detected offenses by developing corrective action plans. Means used by the Committee to develop effective communication include: participating in employee orientation, providing computer based MyNet Learning tools, publishing a quarterly health information newsletter, and ensuring that forms and a compliance hotline are available for reporting potential issues.

The OIG, WRHC, CMS sets forth the standards for conducting internal monitoring and auditing. For example, IV therapy, wound care, osteopathic manipulation, transitional care, EKG documentation and E&M code compliance were/are audited by the Committee.

The Board members thanked Trina and the Committee for the informational report.

COMMITTEE REPORTS:

Joint Conference/Planning – Dr. Kersting, Chief of Medical Staff was unavailable for the meeting; Tom noted that, by and large, the providers were doing pretty well with no significant issues.

Finance – Casi Densley, Controller noted that budget season is well underway. The team is also focusing on revenue cycle issues and the current billing dept. staffing challenges. The latter has caused a coding backlog and has enlisted the services of HRG, an outsourced coding service, to come in and assist for the next several months. Casi noted clinic coding is current through the end of September. In addition, claims on hold and denials have improved significantly. They are working one-on-one with managers to identify reasons for denials, ensure proper authorizations, and implement improvement processes.

Cost Report – Kim noted that she is reviewing clinic rates in an effort to increase the estimated mid-2017 calculated amount; she noted the estimate is not reflected in our current financial reports.

Commissioner Elswick asked about the $300,000 operating loss. Along with the potential Medicare cost settlements, Kim noted that she is re-evaluating contractual adjustments and balance sheet reserves as Medicaid rates increased this year.

Tom W. offered a financial trend report incorporating 2011-2017. He noted that we have incurred one-time costs associated with recruiting all new providers, in addition to adding MD expenses in the ED. He pointed out historic trends vs. the 2017 budget, which he noted projected an increase of approx. 6,000 clinic visits – which Kim enhanced (rightfully so) with corresponding increases in ancillary revenue (lab, x-ray), which would have resulted two things: 1) an increase in revenue deductions and 2) a decrease in our ratio of costs to charges. But our changes have fallen short pf budget.

Tom noted our Finance team's historic budgeting accuracy has been second to none; they rarely miss budgeted expenses by more than 1%. . He noted last year's budget was a difficult challenge; trying to project the impacts of recruiting, on-boarding, and determining the productivity of new providers. Compounding that was the changes in the Emergency Department costs which were still evolving – though reflected in our 2016 financial data.

Having only a 3,000 visit increase in clinic visits (2017 YTD, annualized) we are off budget but very much back in line with historic trends – which is very important. Tom pointed to a key income statement line item: revenue deduction (contractual adjustment) percentages and noted that he felt the current YTD number (38%) was probably 2% points higher than it should be (or would be by year end when the cost report is finalized). He felt the mid-year numbers might be low, noting Kim was still reviewing calculations with our auditors and had yet to finalize or make any adjustments to date.

Tom noted the miss in clinic volumes is reflected in actual revenues and our cost-to-charge ratio, which includes the one-time recruitment and on-boarding costs, should actually run higher in 2017 – and potentially reduce revenue deductions even more. Tom noted a 2% adjustment in revenue deductions (cost settlements) would equate to a $700K bump in our bottom line – again, placing us right back on our seven year trend line; which he noted has been extremely consistent due to our service lines and operating/budgeting policies and charge adjustments.

Tom also reviewed historical balance sheet data; highlights included cash position, property, plant and equipment purchases, and third party settlements – which are cost settlements (payable or receivable) due within a year. He noted as of 12/31/2011, cash and investments were $3.3M; by 2013 =$6.6M; and at the end of 2016 =$10M. As of 9/30/2017 =$10.5M, though most of the current year increases were UTGO taxes to pay future bond principal and interest.

Gross property, plant, and equipment (PP&E) investment totaled $23M at year end 2011, which has increased an additional $3.0M by the end of 2014; $9.0M by the end of 2016, and $10M by the Sept. 2017. During that period we have constructed or redesigned/remodeled 8,500 sf. of hospital space, built a new clinic, and invested significant funds to keep up with technology and equipment upgrades. To recap, we are up $7.2 in cash (+55 days operating expenses in cash on hand), have invested over $10M (net) in property/plant/equipment, and since 2011 to present have only added $2M (net) in additional long term debt.

Tom noted that the last few years have felt "uncertain" due to the transitions to value based care and the future remains unpredictable, but he remains confident that our current financial position is stable and in good standing – probably better than any time in our NHHS history, even with all of the changes.

Quality Assurance – Jennifer Allbee explained that a POLST form is a Physician Order for Life Sustaining Treatment. The form indicates a patient's Code status when admitted to the hospital. A recent issue identified the need to ensure all POLST forms are on file, accurate, and updated. Since that time, POLST forms generated at the clinic are scanned to the Centricity system and copied to the hospital/ Paperwise system (vice-versa for forms that are generated at ACU). The forms are not valid until signed by both physician and patient.

MIPS – the Merit Based Incentive Program's purpose is to move Medicare Part B providers (hospital based services) to a performance-based measurement system (again, the shift to value). The program is intended to streamline three previous programs: PQRS, VBP Modifier and the EHR Incentive Program (Meaningful Use) into one program. Providers not participating in 2017 would be subject to a negative 4% payment adjustment for Medicare Part B reimbursement in 2019.

Jenn noted quality is the bulk of the scoring system at 60% of the grade. Of 300 quality measures to choose from, we were required to select 15. There are no scores or points associated with costs for 2017. Due to our participation in the RMACO, the District received full credit for improvement activities. Advancing care scored 25%, comprised of five items – 1) security risk analysis; 2) E-Prescribing; 3) access via a patient portal (available, but not yet operational); 4) sending a summary of care following a clinic visit; and 5) requesting, accepting and receiving a summary of care from other providers.

In order to participate and receive credit towards the MIPS score quality measures, Meditech assistance was required to download the reports; our 2017 costs were budgeted at $50K; plus an additional $10K in provider licenses. However, since we are members of the Rocky Mountain ACO the reports were submitted on our behalf; saving us that $60K. There have been several discrepancies identified in the data reports and Jenn continues to troubleshoot the causes.

Walter "Buzz" Price explained outlined specifications for extracting data was required for e-Clinical Works (e-CW) on our ACO aggregation. The files are separate demographic files in raw data form. In reviewing the dashboard for the ACO, Buzz discovered discrepancies in the reports. Two simple measures were audited: A1c and BMI, which were compared against our raw data. The calculations were inaccurate (worse) than what we calculated using the same data files. For example, their data on BMI evidenced that we were 35% non-compliant, as compared to our result of 9%.

Buzz noted that this is a real concern, as the data can impact future reimbursement. When Buzz brought this to the attention of their IT specialist, she indicated that no other facility had validated the accuracy of the data. He will continue to pursue solutions – the Board members thanked Buzz and the IT crew for their efforts and diligence.

The Medicare Critical Access Hospital Value Based Purchasing (VBP) Impact Analysis was included. The data included VBP score estimates, contribution amounts, program impact and total performance scores. Our aim remains to score high for quality outcomes. Patient satisfaction scores were also included. We scored positively, at 61% in the patient experience of care domain, ranking #5 of 34 Washington VBP hospitals, which equates to $7000.

Jennifer noted that Heidi Hedlund is the Chairperson of the Washington Rural Health Collaborative. During a recent meeting, members of WSHA were provided an explanation of the reporting. It was noted at that time that data discrepancies were discovered.

QRUR – The purpose of the Quality Resource and Use Report is to evidence payment receivables under Medicare Part B fee for service adjustments based upon quality and costs. The reports are produced by CMS; they include information regarding performance on quality, cost of care measures delivered to patients, utilizing Medicare claims to calculate outcomes and cost measures.

Performance is compared to benchmarks of similar peer groups. The data in the QRUR reports is used to calculate payment adjustments, which could be interpreted as positive, negative, or neutral. The 2016 QRUR reports for our ACO group is identified by Medicare tax ID number. Performance during the calendar year quality and cost measures is used to calculate the value-based payment modifier. Jenn noted as members of a Shared Savings ACO, the 2018 value modifier is based on our ACO's

quality performance, as one overall score for our group of 10 ACO hospital participants. Tom W. added that our ultimate goal is to be within the high-quality, low-cost quadrant.

Flu Vaccination Rate – Jenn explained that last year we strived to improve the employee flu vaccination rate; it was 74% overall. Our goal this year is to achieve 90% (currently 68%); the campaign kicked off on October 2 with 208 vaccines administered and 41 declinations. Jenn encouraged the Board members to have their flu vaccinations.

Walter "Buzz" Price, IT Director announced a substantial Centricity upgrade is scheduled next month. The enhancement will improve ICD-10 coding, forms, etc. Another strategic objective will be accomplished in making our wireless network capable of supporting reliable, real-time medical applications without interruption. To date, we are seeing approximately 40% increase in power, especially in the patient care areas.

Buzz wished to acknowledge an IT employee, Derek Thomas, for going above and beyond the normal scope of duties. He explained that Derek worked diligently to troubleshoot problems with fax line degradation due to external net neutrality routing. Some of our faxes were above 50% failure on the receiving end. Repairing the problem became critical to patient safety and required extensive coordination with off-site vendors. The Commissioners agreed and approved the recommendation to recognize Derek Thomas' efforts.

An Executive Session will be not be required for the meeting.

SUPERINTENDENT REPORT

Strategic Planning: Tom W. announced that in preparation for the upcoming planning retreat he will be reviewing baselines (FTE's, financial recap, etc.) for moving forward. Last month, a question was raised regarding the 3-year recap provided on our financial/FTE information. Tom referred to a statistical FTE period trend report from 2004-2017. It was broken into four basic periods: 2004-2006, our first three years with all existing operations (two clinics, RMV, and CAH hospital status); 2007-2009, when volumes and FTE's increased, culminating in a high of 279 FTE's in 2008, and adjusting back in 2009 after the economic meltdown; 2010-2014, when FTE's hovered around 250 for a five year period; and finally 2015-17, when we started transitioning to value based care. Tom noted that at that time we recognized there would be a need to make significant system (e.g.- ACO/ VBP models, network system upgrades, provider access and support, etc.

Tom reviewed the report with the Board and reviewed the significant changes between the four periods, using 2004-06 as the baseline. He noted between 2010-14 we added approx. 8 FTE's (net), but that included (+17 FTE) in hospital patient care areas, which aligned with increased census and service volumes; (-5 FTE) in clinic (2006 EMR implementation created back-end efficiencies, but subsequently added back with VBP based support positions by 2017), and (-3) in residential care services due to census. He noted work/care hour standards were established and changed (patient volume/FTE) in 2006-07 that have been used for budgeting purposes since.

In 2014, when we decided (realized) that survival was not a strategy, was when we started adding support services staff. From 2004-14, the only (net) support service staff added to our rolls was the Foundation Director. In 2014, we started adding staff including Buzz Price (IT/Materials Director) and IT staff; Director of Primary/Ancillary Care (Chris W.) to lead the clinic/VBP shifts, HR resources to support staff education, training, and leadership, and billing and social services support.

Tom noted that in going through the exercise and reflecting on the changes, he is hard pressed to identify anything he would have done differently. Buzz and his crew have played an invaluable role to keep us current with the challenges and pace of change for technology, IT system and informatics demands. They have really set a high bar for system up-time, response to provider demands, and now quality reporting and informatics requests.

Chris W. has been invaluable in role with the clinic (VBP transformation, oversee the building project, provider communication) and ancillary service support. The Foundation Department has provided critical outreach services (POHC development); HR/Staff Educ. has supported our Seven Habits/Five Choices programs, leadership development, and quality reporting. In addition, care coordination positions are focusing on managing chronic disease and wellness outreach programs. We will continue to make investments and work towards solving the challenges ahead.

The Board's draft Fiduciary Duties and Committee Responsibilities documents were reviewed. Tom noted document covers the Board's duty of oversight for the business and wanted to ensure the Board had a chance to review the committee structures and routine reporting of financial, quality, safety, retirement plans, compliance, etc. of the District. Tom plans to clarify and review these roles and responsibilities in depth at the strategic planning meeting in November.

In preparation for the Board retreat, Commissioner Garrett requested the other members read the information provided by Tom and highlight any questions. He noted he would be facilitating the session on the Board Fiduciary Responsibilities and Duties. Tom W. requested the Board inform him of any questions or reporting items that they feel are under-reported -especially for collective Director reporting, meeting goals/targets, etc.

Strategic Planning: Tom noted our two primary operational goals for 2017 were: 1) to implement and move towards Value Based Purchasing, with a goal in mind to enroll up to 250 clients in specific chronic care management services; and 2) ensure our revenue cycle was designed and operating to accurately collecting 100% of what we were due for patient services. He noted, by and large we were on track on both fronts. Approximately 25 clients have been enrolled through the Medicaid CCO (secured a shared savings agreement with Amerigroup and Molina) and much work has been accomplished to enhance services to Medicare/ACO clients (annual wellness visits, care planning, and monitoring health information). We have also made improvements with revenue cycle projects (O/P services, patient referrals).

Facilities/Capital Planning – Tom noted that we are in better shape – the RMV project is on track and bids are due in December. Our future cash flow should remain steady; cost-based reimbursement and the 340(b) program will not be going anywhere, anytime soon. We should continue to see annual free cash flow (net earnings + depreciation) remain in the $2.0 to $2.5M range, which should be sufficient to cover our routine capital ($1.0M) and non-UTGO debt service ($600K) need.

OLD/NEW BUSINESS:

The next meeting dates will be:
November 3, 2017 – Strategic Planning Starter
November 14, 2017 – Budget Hearing
November 30, 2017 – Regular Board meeting

Provider Recruitment – Drs. Aaron and Tessa Reinke started practice in the clinic last month; Tom noted that we are pleased with our placements of Drs. Kanning and Williams and Dr. Schicker; however, still seek another one or two core ED provider.

Bethany Osgood (formerly employed by Amerigroup) and Becky Flood were hired to work as Care Coordination Lead and Clinic Manager.

EMS District – the meeting location and time have changed to today at 4:00 pm at the S. Garden Avenue location.

Safety & Security Update - Chris Wagar reported that the service has been very well received by staff and that the Phoenix staff were a tremendous resource is assisting with mandatory fire watches. They have done a great job in canvassing District properties and perimeters and have also assisted in the ED - specifically with psychiatric hold patients while waiting for law enforcement intervention.

Next steps: staff training for those working in "high risk" areas as first priority. Eventually, train all staff for de-escalation and personal safety techniques. Employee parking passes were recently issued to identify which vehicles belong to our employees.

Evacuation Drill – a District and Region 9 evacuation (tabletop) drill occurred yesterday and included members of the County and other facilities in the region. Two members of Panhandle Health Department assisted in the process. Pete announced that we will be considered the receiving facility for the next drill.

ACTION ITEM AGENDA

Property & Auto Insurance renewal - a motion made, seconded and passed unanimously approved the renewal of the District's property and auto insurance premiums.

Employee Retention Benefit – A motion made, seconded and passed unanimously approved the annual retention benefit for staff employed by the District on the date of distribution (November 13th) to issue holiday gift certificates in the amount of $20.00 each.

Set Meeting Date – via a motion made, seconded and unanimously approved, the next regular meeting will occur on November 30, 2017 at 12:30 pm. This is one week later than usual, due to the Thanksgiving holiday. Tom Garrett indicated he could not attend on that date. At that time Tom W. will discuss pertinent compensation changes, incentive compensation, and Milliman adjustments.

OTHER BUSINESS:

The annual Foundation Festival of Trees event will be held on December 2, 2017.

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

Courtesy Appointments:

Radiology
Amy Henkel, MD
Brian Rich, MD

Cardiology
John Peterson, MD

Orthopedic:
Craig Bone, MD
Christopher Lang, MD

Affiliate Appointment:
H. Kent Breckenridge, CRNA

Emergency Provisional Appointments:
Curtis Gill, DO
Mark Mueller, MD

NEXT MEETING DATE

The next **regular** meeting of the Commission will occur on November 30, 2017, one week later than usual due to the Thanksgiving holiday.

A Special strategic planning kick-off meeting of the Commissioner will occur on Friday, November 3, 2017 at the Camas Wellness Center.

A budget hearing will occur on Tuesday, November 14, 2017 at 12:30 pm in the Sandifur meeting room.

ADJOURNMENT

There being no further business, the meeting adjourned at 2:19 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