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

September 28, 2017

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

Excused: 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: August 2017: Warrants #203114-#203559 and wire transfers #1541-#1554 in the amounts of $1,008,997.93 and $1,458,150.22, respectively, plus an automatic loan payment deduction of $40,000 for a grand total of $2,507,148.15.

Bad Debt/Charity Care: all-inclusive August 2017 District Write-off's for $117,555.79.

APPROVAL OF PREVIOUS MEETING MINUTES

The regular meeting minutes of August 24, 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, Chief of Medical Staff reported that Drs. Aaron and Tessa Reinke are transitioning nicely into the medical practice. Drs. Kanning and Williams are covering general surgeries and have started doing cases here and Dr. Mike Schicker has established a weekly orthopedic surgical clinic which should continue to expand. He indicated Dr. Schicker would eventually like to build up to perform total joint replacement procedures here.

Dr. Kersting has been fine-tuning discharge forms for our Medicare annual wellness visits; he noted that everyone has missed Pam Lee since her retirement; however, she has returned and is helping part-time until a manager is hired.

Dr. Kersting introduced Katie Ralston, a recent graduate of the Running Start program attending the University of Washington. Katie is from the area with a desire to return to the community to practice medicine.

Finance – Casi Densley, Controller reviewed the August financial report. Notes: a 2017 interim cost settlement is nearly complete by our auditing firm, DZA, who has estimated a $340,000 receivable for the first six months of the year. In addition, $548,000 was received on our 2016 hospital cost settlement (w/bump in cash). As reported last month, AR increased approx. $920K since May, but $550K was received to add to our increase in cash for the month. The Financial Services team is working with staff members to interpret new billing guidelines and a weekly denial and claims on hold report is being generated in an effort to keep current and decrease our AR balance.

A Billing/Coder recently resigned and we are looking to outsource some coding to stay current. Commissioner Elswick provided the name of a former employee who may be able to assist. Kim noted that the firm we are considering was originally based out of Spokane and now does business nationally. A meeting is scheduled on Monday; Kim noted that the company provided references to three WHRC rural health clinics that she will contact.

Emcare – Casey Densley, Controller explained a new contract change that went into effect September 1st. Under the new contract guidelines, physician hourly rates above $176 (our prior cap) will now be passed thru to us. Kim noted the contract was re-negotiated in Sept. 2016, when the District took over ED provider billing, and the hourly rate was fixed at $176. Any costs in excess of $176/hour were paid by EmCare. Under our renewal this year, Emcare provided an ultimatum to terminate our contract or pass the excess costs on to us (presently, the pass-thru option was our best choice).

Tom explained that this has more to do with the rural ED provider market (supply/demand); our initial provider contract rate was set at $140/hour (again, regardless of EmCare's cost) and was set by EmCare using data from seven other hospitals they contract with in WA. However, by Sept. 2016, it was determined the rate wasn't reflective of market, hence out rate change to $176/hour. Emcare had absorbed all additional costs since the inception of the contract (now 21 months). Tom noted that some providers will wait until the schedule is published before committing to provide coverage; the closer it gets to an open date, the higher the incentivized shift cost. He noted that we have recruited two providers (Dr. Curtis Gill will be coming in October), but progress has been slow.

Going back even further, the shift in physician culture, gravitating towards lifestyle and family, was the reason why our ED mid-level model was no longer sustainable; there simply were no providers willing to commit to the rigorous schedule required for the ED backup coverage. Even after the switch, it took us over a year to recruit two family practice providers. He anticipates that will become even worse over the course of the next 5-10 years, as many physicians begin to retire.

Kim noted that with the assistance of Buzz Price and the ability to use the ED logs, we have improved monitoring for provider "availability time" - which shifts provider expenses to an allowable technical cost for Medicaid/Medicare reimbursement. Also, we are processing EMR patient tracking reports to stream data and provide a clearer picture of true availability time. Kim explained that, at ($200/hr) every minute considered to be "technical" time helps. Kim will provide a better picture of our "true" professional component costs at the next meeting. Bringing availability up to the 45% range will make a considerable difference in the amount of claimed costs.

The Finance Committee met to discuss Milliman wage survey data and the potential effects the WA State minimum wage adjustments would have for 2018 and beyond. Joseph Clouse is researching cost factors relating to current staff as well as planning a joint Personnel/Finance Committee meeting to discuss the options.

Staff medical insurance premiums are proposed to increase to $818/mos., per person; (still considered a relatively low cost compared to our WHRC peers). Casi explained that the budget process is underway and they are meeting with managers to prepare the 2018 budget next month.

The Board Strategic Planning session will occur on November 3 at the Camas Wellness Center.

Quality Assurance – Jennifer Allbee presented a quality indicator report for the Acute Care area. Categories included Admissions, Patient Days, Mortality, Readmissions, Patient falls, Influenza/ Pneumonia Vaccines, Medication Events and Barcode Scanning, the WSHA Partnership for Patients Adverse Drug Events and Press Ganey Scores.

Jennifer explained that Medicare can potentially deny payment on readmissions (mostly for PPS hospitals) and we had 25 inpatient readmissions in 2013; 22 in 2014; 20 in 2015; and 17 in 2016. Year-to-date (YTD) readmissions for 2017 is 21, matching our average annual rate from 2013-16. Readmission causes are discussed monthly by our group and include chronic illness, co-morbidities/ exacerbation/other underlying problems; readmission to other facilities, and patient "went home too soon". At present, we rank 4th in the State (WRHC group) for readmissions using Qualis statistics. It was noted that the national Medicare readmission rate is 18%.

Annual fall rates were reviewed – the average rate from 2009-2016 was 16.4 falls/year; there were 8 falls YTD. The Falls Team meets on a quarterly basis to discuss fall prevention strategies. Our District ranks 10th as compared to the Washington Rural Health Collaborative peer hospitals. In addition, a post-fall huddle team reviews causes and prevention and the nursing assistants make hourly rounds to address, pain, positioning, etc. The program has proven to be beneficial; Jennifer noted that last year at this time there were 14 documented falls; this year there were only 8. It was noted a "fall" is defined as any "sudden change in elevation."

The influenza vaccination rate nearly doubled over last year; all discharges are reviewed to ensure that every patient is offered the vaccinations for influenza and pneumonia at discharge.

The medication error/event rate has declined since bar code scanning was implemented in 2014. There are 4 medication errors to date. Our bar code scanning accuracy goal is 95%, which was met during the first two months in 2017. Jennifer noted that we participate in the Washington State Hospital Association's Partnership for Patients group as a collaborative effort to prevent medication errors.

Infection prevention will be a topic that Jennifer will discuss in the future. Tom W. noted that we participate in the WRHC and RMACO groups and will also become involved in E-clinical Works reporting.

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

SUPERINTENDENT REPORT

ALF Project: Color boards for the building interior were provided for Board review; a recent A&E meeting occurred and determined that we might have another $100K potential re-engineering savings. Tom remains encouraged by the work being done by the design team and the activity in the greater project market. He noted, for the sake of being conservative, the new project budget includes no savings for either re-engineering or bid timing – only reduction in square footage on the redesign.

Budget: Tom provided the latest budget update – the conservative "all-in" cost estimate is $12M, with $675K already spent ($875K if you add bond issue costs), and approx. $10.2 expected bond proceeds (net), District out-of-pocket to complete the project would be approx. $1.0M – to be paid between Q2, 2018 and Q2, 2019. Kim will bring a revised project budget next month to include an estimated return-on-investment analysis for an additional 18 units – an additive change for this bid go around - to be roughed in and finished at a later date (bringing our project total to 72 beds) . Jenny Smith published a media/web information update to keep the community informed of project status.

The bid-ready documents are scheduled to be complete by mid-November. The project has been re-programmed to have a mix of one and two bed studio style apartments that will offer both ALF and EARC services for up to 54 residents. The goal remains to construct a high acuity assisted care facility that can handle a level of care sufficient for our current long term care residents. It has been shown that many memory care (EARC) residents thrive in 2-bed vs. 1-bed units. Tom noted that most ALF facilities include assisted and/or memory care wings, but our population has been co-mingled forever and most residents have some form of cognitive impairment. When our design/finance team met with the State, we learned that a mixed use license was feasible. That change has resulted in what the team feels is a better designed, with more flexible neighborhoods, and more efficient and cost-effective building and lot lay-out.

Patient Financial Services has re-located to the newly remodeled (former) Family Medicine building and our space lease with Dr. Cool will be terminated in Oct. Tom encouraged the members of the Board to tour the newly remodeled facility.

Provider Recruitment – Tom reported that Drs. Aaron and Tessa Reinke (full service Family Practice w/surgical OB) started practice in the clinic this month; Dr. Michael Schicker started up his orthopedic practice last month (Aug.) and Drs. Kanning and Williams started this month.

Tom continues to work with Annabelle Payne and Pend Oreille Counseling Services to coordinate mental and behavioral health care. Staffing has been a recent challenge, as many of the MHP's tend to relocate to Spokane.

Four individuals have interviewed for the Clinic Manager position; two were selected to return for a second interview; however, one of the candidates has since declined. Another position is also open to lead our population health/chronic disease management programs and to support providers and patients.

Dr. Jones has indicated the need to recruit more providers.

Health Coalitions – progress continues in collaborating with the NWRHC and WRHC as the care delivery system changes and evolves. Tom will present in-depth information at the upcoming Strategic Planning session in November.

There were no significant Legislative updates to report.

Tom shared information related to WA State's 1115 Waiver application with CMS for the Medicaid program and how that fits with our Pend Oreille Health Coalition (POHC) work.

State – 1115 Waiver – the State Health Care Authority (HCA) has contracted with CMS to change how it will be paying for care services under its new 1115 Medicaid Waiver. Tom provided a presentation to the Board that recapped the evolution of the State's Innovation Plan, its proposed next steps under the waiver, and our plans (NHHS) to ensure Pend Oreille County receives the full funding it is due (approximately $2.2M) under regional ACH funding. He noted, we will continue to identify the plans of Better Health Together vs. the Health Care Authority and the function of the POHC group under the initiatives as the program moves forward.

The highlights:

- The WA State Innovation Plan started in 2013-14 w/two pieces of legislation. SB-6312 would push mental health and chemical dependency in with medical care under one contract by 2020 and HB-2572 formed 9 regional accountable communities of heath (ACH's).
- The Plan would cover all State funded lives: Medicaid and PEBB (municipal employees). It started with 1.4M lives and now covers 2.2M lives w/Medicaid expansion.
- The WA/HCA goals: drive value-based contracts, improve health through prevention and early mitigation, improve chronic illness as the first mover in quality, price transparency, etc., engage patients and caregivers, provide a patient-centered medical home, participate in regional support networks (create ACH's), and create/bolster health information exchanges.
- WA added two pieces of legislation: HB-1388 more formally pushes BH_CD services from DSHS to the HCA (all RCW/WAC references) and the CMS, 1115 Medicaid demonstration waiver program.

Tom noted the local Pend Oreille Health Coalition (POHC) was formed in 2014 using the State's ACH outline (a fine premise) and we have been moving along the same trajectory. In fact, the State's outline/timeline remains on track – they are doing what they set out to do; and, if they stay on pace, the rate of change is only going to pick up over the next three years (2018-2020). He explained that he was going to share all of this information with the POHC Board next week (as he did with Med. staff the week before) because the District is the local entity at greatest risk with a shift to value based payments (VBP). The timing of any payment/service shift is critical as the efficiencies gained (cuts to providers) needed to be offset with shared savings payments (or grants/1115 waiver funding) in order to minimize the risk of the potential rate cuts.

In addition to the State program, we are also participating in the Rocky Mountain ACO (RMACO) a Medicare shared savings program that has no downside risk. The RMACO (nine hospitals) is responsible for the care of 18,000 Medicare lives - 80% of which reside in Washington. Tom noted we continue our attempts to manage the health of the population of the two groups using care coordination models. Moving forward, we will continue to attempt to mine care, quality, and cost data that is useful to the providers, patients, and care teams.

Tom then reviewed the limits to our population health management continuum, noting we have focused primarily on the "top 2%" of our patients – those at high risk (due to chronic conditions, co-morbidities, and BH_CD issues that may exacerbate their medical conditions). He noted under the 1115 Waiver (Medicaid) our total population/revenue is 15%/25% of our clinic totals; our Medicare ACO population is 20% of our population/35% of revenue. To keep matters in perspective, our riskiest 2% makes up only 250-350 lives.

1115 Waiver and POHC: our POHC core goal is to eliminate any replication of local services, coordinate care, and ensure we receive our share of the regional funding earmarked for Pend Oreille County. Tom explained the funding amounts and details under the 1115 Waiver, a five-year program.

The highlights: all funding must go to eight designated project categories determined by the regional ACH – Better Health Together. The projects are:

- Bi-Directional care integration (32%) – combine BH_CD services w/medical care
- Community-based care coordination (22%) – using the Pathways HUB model
- Transitions of Care (13%) – help clients move through the health/social care systems
- Diversion interventions (13%) - help clients in crisis with health care/social supports
- Addressing the Opioid Crisis (4%)
- Maternal and Child Health (5%)
- Oral Health (3%)
- Chronic Disease Management/Prevention (8%) for patient and their caregivers

Payments during years 1 & 2 are predicated on setting up defined demonstration projects and developing baseline population data; thereafter, payments shift to performance in year 3 to 5. Tom shared examples of some potential metrics that could be established by the BHT. He noted that our POHC letter of intent included P.O. County projects under each category and noted that by 2021, the State expects to have 90% of its provider contracts in some form of valued-based model. Kim noted we recently signed a VBP contract with Amerigroup and are also working on one with Molina.

Better Health Together will devise a program with up to eight projects and Tom noted that most of the program targets we have something in place here under NHHS or the POHC – population health, care coordination, BH_CD integration, most being done in conjunction with our MCO partners Molina and Amerigroup. Tom noted that Kim and a couple of other rural representative sit on the BHT "Project Steering Committee." He is pleased with our progress and believes that the programs are worthwhile and beneficial to the health of the community.

Commissioner Garrett pointed out it is apparent that this is an entire overhaul of the system as it has existed. He stressed that the community be well-informed that the objective is to better the health of the community in the most cost-effective manner.

OLD/NEW BUSINESS:

Kim Manus proposed November 14 at 12:30 pm as the budget hearing date. There were no objections.

ACTION ITEM AGENDA
Capital Expenditure Cost Increase – Tom W. explained there was a change to the 2017 budgeted amount for the purchase of Laboratory IT equipment – a difference of $1,011.74; a motion made, seconded and unanimously passed the revised capital purchase increase.

OTHER BUSINESS:
Following discussion, it was determined that the next Regular meeting will occur on November 16, 2017 – 1 week earlier due to the Thanksgiving holiday.

The Board Strategic Planning session will occur on November 3, 2017, with the location TBD.

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

Provisional Appointments:

General Surgery
Chase Williams, MD
Nathan Kanning, MD

Emergency:
Mark Mueller, MD

Additional Privilege Request - Colonoscopy and Endoscopy Procedures:
Aaron Reinke, MD

EXECUTIVE SESSION
The meeting moved to Executive session at approximately 2:20 pm. to discuss personnel matters for approx. 15 minutes.

RETURN TO OPEN SESSION
The Board returned to open session at 2:50 pm. and there was no action taken.

NEXT MEETING DATE
The next regular meeting of the Commission will occur on **October 26, 2017**.

ADJOURNMENT

There being no further business, the meeting adjourned at 2:55 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