LAKE CHELAN HEALTH

BOARD PACKET

Chelan County Public Hospital District No. 2

Special Meeting of the Board of Commissioners

Strategic Planning with The Infinity Consulting Group

02/07/2023

LAKE CHELAN HEALTH

Lake Chelan Health
Strategic Planning Session
February 6-7, 2023
Location Lake Chelan Hospital, Bragg Conference Room

Vision: As our community grows, hospital leadership recognizes the need for high quality medical services will increase as well. We are committed to continue planning for the future of healthcare in the Lake Chelan Valley, ensuring the availability of those services close to home. It is our priority to work with our Lake Chelan neighbors and partners to build a healthier community.
Mission: To provide patient-centered, quality healthcare with compassion and respect.
Values: Relationships, Integrity, Compassion, Respect

Strategic Planning Goals:

- Review and discuss contemporary dynamics related to rural health care.
- Review current issues and trends related to Lake Chelan Health.
- Review the recent survey results and recommend strategic focus.
- Update/clarify vision for Lake Chelan Health.
- Identify the four most important strategic initiatives for the next 2-3 years.

February 6 - Monday Evening Dinner

	6:00pm	**Social Dinner:** Stormy Mountain Brewery		

Tuesday, February 7
Location: Lake Chelan Hospital; Bragg Conference Room
Facilitator: Alan Yordy

	8:00am	***Breakfast (60")***		
	8:30am	Introduction-Opening Presentation • Issues and Trends in Rural Healthcare	**Brock Slabach**	Presentation/ Discussion
	9:00am	Opening Comments-Introductions	**Aaron Edwards & Jordana LaPorte, Chair**	
	9:15am	Facilitator/Presentation • Expectations/Goals for the Day • Healthcare Trends and Impact on Strategy	**Alan Yordy**	Presentation/ Discussion
	10:15am	Overview of LCH Mission/Vision/Values • Identification of potential updates	**Aaron**	Presentation/ Discussion

	10:30am	**BREAK**		
	10:45am	Survey Results • Overview • Discussion of key issues	**Alan/Aaron**	Presentation/ Discussion
	12:00pm	***LUNCH (30')***		
	12:30pm	Introduction to Table Exercise Exercise • Mission/Vison, Values Updates • Identify top four strategic initiatives • Rationale for each • Table reports • Confirm top four initiatives (group)	**All Participants**	Discussion
	2:15pm	**BREAK**		
	2:30pm	Suggested Updates to Mission/Vision/Values	**Aaron/Alan**	Discussion
	3:30 pm	Next Steps • Summary of the Day • Finalize strategies • Build KPIs for each strategy • Develop an Operating Plan for time horizon • Accountability and feedback	**Alan**	
	4:00 pm	Closing Comments	**Aaron Edwards & Jordana LaPorte, Chair**	
	4:15 pm	**Adjourn**		

Participants

Commissioners: Jordana LaPorte (Chair), Jeremy Jaech, Mary Murphy, Mary Signorelli, Lori Withrow

Leadership: Aaron Edwards (CEO), Shawn Ottley(CNO/COO), Brant Truman (CFO), Tara Lautiki (HR Manager), Tabetha Bradley (CMO), Louise Sahlinger (CQO)

Support: Wendy Kenck, Executive Assistant

LAKE CHELAN HEALTH

Values Statement

April 2012

As caregivers of Lake Chelan Community Hospital, we support our mission and vision by basing our decisions and actions on the following core values:

Relationships

Relationships form the foundation for our care and service.
We strive to develop, nurture, and enhance relationships with:

- Our patients and their families
- Our community
- Physicians and other healthcare providers
- Each other

Integrity

Our actions tell our community what Lake Chelan Community Hospital stands for and who we are.
We strive to:

- Do the right things for our patients, their families, and for each other.
- Work to earn the trust of those we serve.
- Communicate openly, honestly, and with the highest ethical standards.

Compassion

Every Lake Chelan Community Hospital caregiver touches the lives of the patients and families we serve.
We strive to:

- Treat each patient, family member, and other caregivers with kindness and caring.
- Improve our understanding of, and respond to the needs of, our diverse community
- Respect and meet the physical, emotional, and spiritual needs of our patients and their families, and recognize that compassion is essential to healing
- Give each other grace by recognizing that we are human, and therefore not perfect, as we strive for excellence

Respect

We honor the dignity and worth of each individual.
We strive to:

- Treat everyone we serve and those with whom we work with the highest levels of professionalism, acceptance, and dignity.
- Be open to everyone who needs our care and time, recognizing they have the right to our services.
- Be open-minded and appreciate the perspectives and life experiences that others bring to the table.
- Acknowledge and celebrate diversity in our community and our organization.

Caregiver Behavioral Expectations

All caregivers at LCCH are expected to support the Mission and Vision of the organization by demonstrating our core values in our everyday care and service. Following are examples of the minimum behavioral expectations in relation to our values and provide guidance for how we perform our jobs. This is not intended to be a complete list.

RELATIONSHIPS (Use AIDET)

- **Acknowledge-Acknowledge** the patient by name. Smile, make eye contact. Ask: "Is there anything I can do for you?"
- **Introduce-Introduce** yourself, your skill set, your professional certification, and if appropriate, your experience.
- **Duration-Give** an accurate time expectation for tests, physician arrival, and tray delivery.
- **Explanation-Explain** step by step what will happen, answer questions, and leave a phone number where you can be reached.
- **Thank-Thank** the patient for choosing our hospital, and for their communication and cooperation. Thank the family for assistance and being there to support the patient. Thank physicians and other providers for collaborating with us to improve care and service.

- "Manage up" other caregivers in your own and in other departments; for example, "Mary will be your nurse tonight after I go home. She is a great nurse, and I know she will take excellent care of you," or "Dr. Smith is working in the Emergency Department this evening, and he will take excellent care or you, or "Mary has worked in Registration for many years, and she will complete your admission quickly and efficiently."
- Attempt to resolve interpersonal differences with other caregivers directly and respectfully, and if support is needed, ask a supervisor. Don't gossip or "badmouth" other caregivers or providers to each other.
- Offer help to other caregivers, providers, family members.
- Help new caregivers feel welcome to the organization and the team - introduce yourself, offer your support in helping them become part of the team.
- Value the relationships with those you work with. Strive to make as big a difference in the lives of your co-workers as you do in the lives of our patients and their families.
- Anticipate patient and family needs - ask what else we can do for them, without making them feel rushed.
- Acknowledge patients, visitors, or others who appear to be lost. If at all possible, take them to their destination rather than simply telling them how to get there.
- Be empathetic to your co-workers. Frequently check in with others to see how they are doing and how they are feeling. Offer help to those you work with and be understanding when others are having a bad day.
- Know being right is sometimes not as important as being a part of something larger than yourself.

RESPECT

- Ask patient (and peers) how they prefer to be called and do so consistently, make eye contact with others when in conversation, listen without interrupting, and smile!

- If having a difference in opinion or conflict with another caregiver, speak with them directly and privately. Do not gossip or complain about other caregivers, and if you hear another caregiver do so, ask them to stop.

- Maintain patient confidentiality - only access patient information as essential to provide care or service. Do not discuss patient information in a public location or in front of other caregivers who do not have a need for that information. Do not leave computer screens up with patient information or leave hard copies of patient information, where others may see it.
- Practice good personal hygiene and grooming, assuring you and your clothing are clean and neat in appearance, including hair and oral hygiene.
- Be mindful of body odors. Avoid wearing strong fragrances or entering the building with the smell of cigarette smoke on your clothing or on your breath.
- Read e-mail, department postings, and other communication sources regularly for important notices. Respond to e-mails and voice mails promptly.
- When providing care or service, do so consistently and with excellence, without judgment about patient's ethnic background, religion or financial status. Thank others for their assistance and acknowledge their demonstration of meeting expectations and our organizational values.
- Don't bring organizational issues into conversations with patients, visitors, vendors, etc., e.g., "We're so short-staffed," "I'm working an extra shift," or "That process/department/individual is horrible." Manage yourself and others "up" to earn the trust and confidence of patients and their families.
- Keep voice low and other noise to a minimum, respecting not only patients' need for quiet and rest, but also other caregivers' need to focus on their work, e.g., don't yell or talk loudly down the hall, in the stairwell, or across the dining room.

Three tips for cultivating humility

BY VICKI ZAKRZEWSKI | JANUARY 12, 2016

Given what scientists have discovered about humility, it's evident that cultivating this quality is not for the faint-hearted, nor does it appear overnight. Yet it would seem that one of the great rewards of humility is an inner freedom from having to protect those parts that we try to hide from ourselves and others. In other words, we develop a quiet, understanding, and compassionate heart.

Here are some scientifically-based ways to start.

1. Embrace your humanness

For many, when we fail at something that is important to us—a job or a relationship, for example—our self-esteem plummets because we tied our self-worth to those things. All of a sudden, we become bad or unworthy people, and it can be a long road to recovery.

Not so for people with humility. As stated earlier, their ability to withstand failure or criticism comes from their sense of intrinsic value of being human rather than outer means. So when they fail at a task or don't live up to expectations, it doesn't mean that there is something wrong with them. It just means that they are human like the rest of us.

Scientists suggest that this intrinsic value stems from secure attachment, or the healthy emotional bond formed with close others, usually our childhood caregivers. Having the experience of unconditional acceptance and love, particularly when we're young, can serve as a buffer against the effects of criticism or failure. Unfortunately, many of us did not experience secure attachment when we were children. One study found that a whopping 40 percent of adults are not securely attached, but thankfully this does not mean we are doomed. We can heal through healthy adult relationships, such as

friends, romantic partners, or even with a higher power. This recent GGSC article suggests some ways.

2. Practice mindfulness and self-compassion
In recent years, mindfulness and self-compassion have been linked to greater psychological resilience and emotional well-being. And I can't imagine developing humility without them.
According to scientists, humble people have an accurate picture of themselves—both their faults and their gifts—which helps them to see what might need changing within.

Mindfulness grows our self-awareness by giving us permission to stop and notice our thoughts and emotions without judgment (if we judge what's going on inside us, we paint a distorted view of ourselves).

The more we become aware of our inner lives, the easier it is to see where unhealthy beliefs and actions might be limiting us. Noticing and then accepting those parts of ourselves that are wreaking havoc and that require us to change calls for self-compassion, or treating oneself with kindness and understanding.

Once we accept what needs changing, then we can start the process of transformation. I love the saying by a wise sage, "If you are in a dark room, don't beat the darkness with a stick. Rather, turn on the light." In other words, just gently and patiently replace a negative thought or action with a positive one and over time, we may not even recognize the person we once were.

3. Express gratitude
Saying "thank you" means that we recognize the gifts that come into our lives and, as a result, acknowledge the value of other people. Very simply, gratitude can make us less self-focused and more focused on those around us—a hallmark of humble people.

Indeed, a recent study found that gratitude and humility are mutually reinforcing. Expressing gratitude can induce humility in us, and humble people have a greater capacity for conveying gratitude.

Both gratitude letters and gratitude diaries were used in this study—easy to perform practices that are described in greater detail on the GGSC's Greater Good in Action website.
Perhaps the key to humility is seeing life as a journey towards cultivating those qualities that bring out the best in ourselves and others and make this world a better place.

And this journey is not just for the average person, but one that many of our greatest leaders have embarked upon. To close with the words of one who knew humility, Nelson Mandela:

> As I have said, the first thing is to be honest with yourself. You can never have an impact on society if you have not changed yourself…Great peacemakers are all people of integrity, of honesty, and humility.

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The Two Different Types of Hospitals in the U.S.

Hospitals are an essential part of the healthcare system. Although far more care is being delivered in patients' homes, physicians' offices, and ambulatory surgery centers today than in the past, there are many types of services that cannot be safely delivered in any setting other than a hospital.

Moreover, it is important for every community to have adequate hospital capacity available when it is needed. During the coronavirus pandemic, hospitals unexpectedly needed to provide care for tens of thousands of patients with COVID-19. Some communities were forced to erect temporary hospitals or inpatient units in order to ensure there would be adequate capacity to treat all patients who needed care.

However, hospitals are also very expensive. The United States spends more than $1.2 trillion each year on hospital services. More than one-third (38%) of total healthcare spending goes to hospitals, a far larger share than any other healthcare sector. Over the past two decades, national spending on hospital services tripled, more than the increase in total healthcare spending and far more than the growth in personal income. Hospital spending is expected to increase even faster now due to inflation, supply chain problems, and staff shortages.

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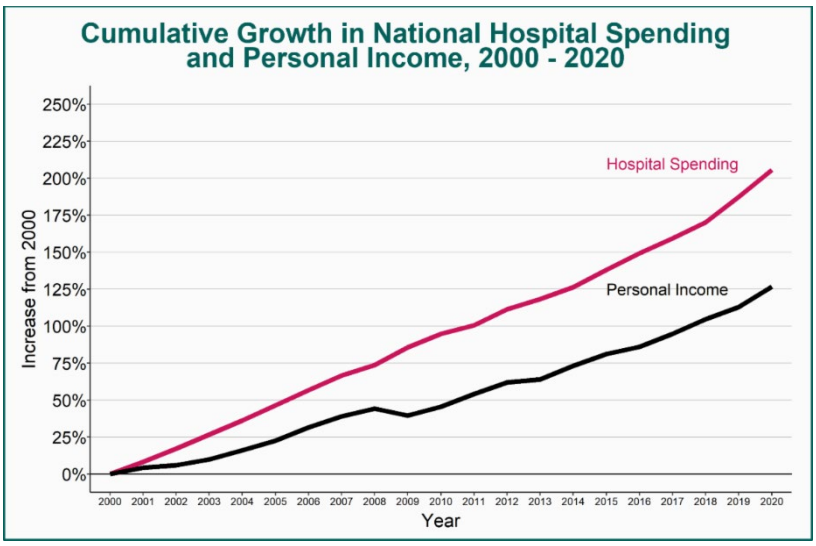


The Need to Control Hospital Spending Without Harming Patients

Because hospitals represent such a large portion of total healthcare spending, it will be almost impossible to make health care or health insurance more affordable unless methods are found to control the growth in spending on hospital care. However, this must also be done in a way that preserves the ability of all citizens to obtain high-quality hospital care in a timely fashion.

As the country searches for policies that will control or reduce hospital spending while maintaining access to quality care, it is essential to recognize that the nation's hospitals fall into two very different categories: (1) small rural hospitals, and (2) urban and larger rural hospitals. These two groups of hospitals differ dramatically in terms of both the amount they contribute to healthcare spending growth and the size of the financial challenges they face in delivering healthcare to the communities they serve.

How Rural Hospitals Differ from Urban Hospitals

Almost one-half of the nation's short-term general hospitals are located in rural areas. Rural hospitals differ from urban hospitals both in terms of their size and their distance from other hospitals:

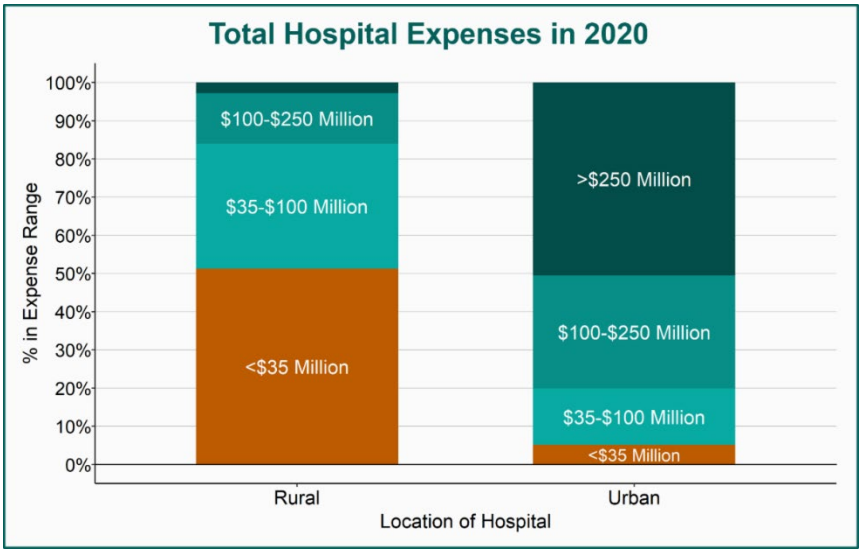
Most rural hospitals are the only source of hospital care in their community. Most cities and urban areas have multiple hospitals that patients can use, but most rural

communities have only one hospital that is easily accessible, if they have a hospital at all.

- Two-thirds of urban hospitals are less than 5 miles away from another hospital, and almost 90% are within a 15 mile drive from another hospital.
- In contrast, almost two-thirds of rural hospitals are more than 20 miles away from the next closest hospital, and one-fourth are 30 miles or more away.

Most rural hospitals are much smaller than urban hospitals. Although there are some large hospitals located in communities that are classified as rural, most rural hospitals are much smaller than most urban hospitals. The size of a hospital has traditionally been defined in terms of the number of inpatient beds it is licensed to operate, but most of the services that hospitals deliver today are ambulatory care services, not inpatient care. Consequently, a hospital's total annual expenses is a better measure of a hospital's relative size than the number of inpatient beds:

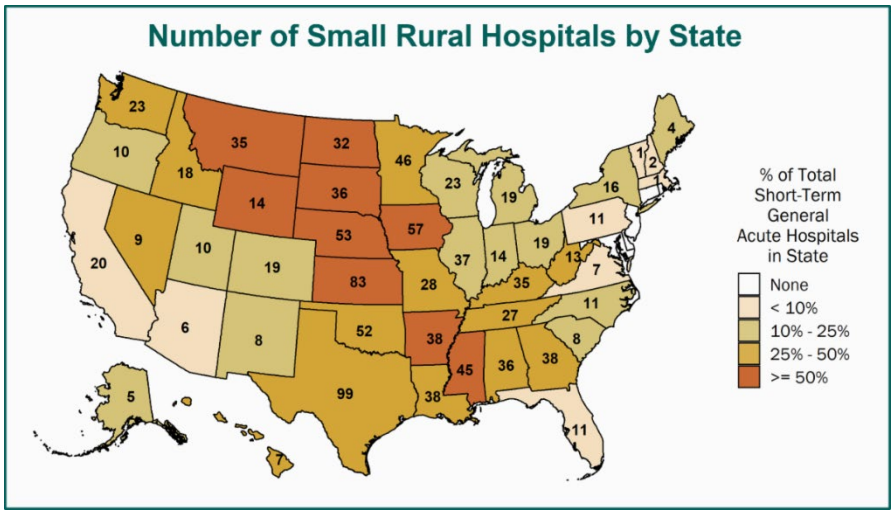
- Most urban hospitals have over 200 inpatient beds, whereas most rural hospitals have 25 or fewer beds.
- One-half of urban hospitals have expenses of $250 million or more, whereas only 2% of rural hospitals are that large.
- One-half of rural hospitals have total expenses of $35 million or less, whereas only 4% of urban hospitals are that small.



Six Differences Between *Small* Rural Hospitals and Other Hospitals

Small rural hospitals – those with annual expenses below the median for rural hospitals ($35 million in 2020) – deliver many of the same kinds of essential services as larger hospitals do – they have emergency services available around the clock, they provide basic laboratory tests and imaging studies, and they provide inpatient care and outpatient care for a wide range of health problems. However, they face far greater financial challenges in delivering essential healthcare services than both urban hospitals and larger rural hospitals.

There are over 1,000 small rural hospitals in the country, representing one-fourth of the nation's total short-term general acute hospitals. Most states (43) have at least one small rural hospital; in 23 states, at least one-fourth of all the hospitals in the state are small rural hospitals, and in 6 of those states, 50% or more of the hospitals are small rural hospitals. Small rural hospitals are the principal source of healthcare for the residents and workers in many of the nation's agricultural areas and ranchlands, which require large amounts of land for crops and animals but have relatively few residents per square mile. In many cases, these hospitals are also the only source of primary care for the communities they serve.

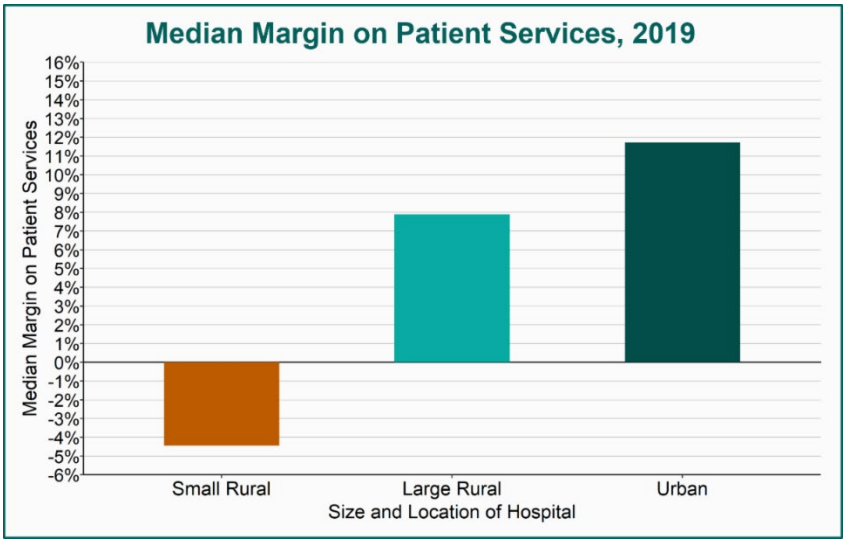


There are six major financial differences between small rural hospitals and other hospitals that must be considered in establishing policies and payments for hospital services:

#1: Most small rural hospitals lose money delivering services to patients, while most urban hospitals and larger rural hospitals make profits on patient services. The primary source of revenues for most hospitals is the payments for services they receive from health insurance plans. Most small rural hospitals are paid less for services by insurance plans than the cost of delivering those services. In

contrast, most larger rural hospitals and urban hospitals have been paid more – often significantly more – than it costs them to deliver services to patients.

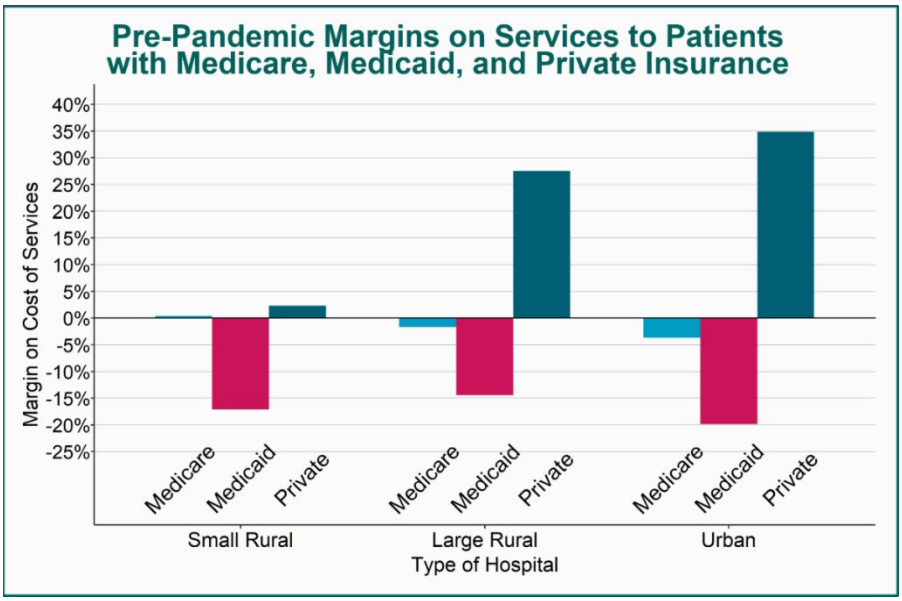
- More than two-thirds of small rural hospitals lose money delivering patient services. Prior to the pandemic, the median margin on patient services for small rural hospitals was -4%, i.e., at the majority of the hospitals, payments were 4% or more below what it cost them to deliver the services. These losses increased during the pandemic.
- Prior to the pandemic, the median margin on patient services for larger rural hospitals was +8% and the median margin on patient services at urban hospitals was +12%, i.e., the larger hospitals were paid significantly more than it cost them to deliver their services. Margins decreased during the pandemic, but most urban and large rural hospitals continued to receive more in payments than it cost to deliver services.



#2: Small rural hospitals lose money on patient services because of inadequate payments from private insurance plans, whereas urban hospitals and larger rural hospitals make large profits on services to patients with private insurance. Most hospitals lose money on Medicaid and uninsured patients. However, while large hospitals can offset these losses with the profits they make on patients who have private insurance, small rural hospitals cannot.

- Prior to the pandemic, the median profit at small rural hospitals on services delivered to patients with private insurance (including Medicare Advantage plans) was only 2.3%. Almost half (46%) of small rural hospitals lost money delivering services to patients with private insurance.

- In contrast, the median profit on services to patients with private insurance was 27% at large rural hospitals and 35% at urban hospitals.
- A common myth about small rural hospitals is that almost all of their patients are on Medicare or Medicaid or are uninsured. In fact, on average, almost half of the services at small rural hospitals are delivered to patients with private insurance, only slightly lower than the percentage in urban hospitals. As a result, low margins or losses on patients with private insurance, combined with losses on Medicaid and uninsured patients, cause small rural hospitals to have large overall losses on patient services.



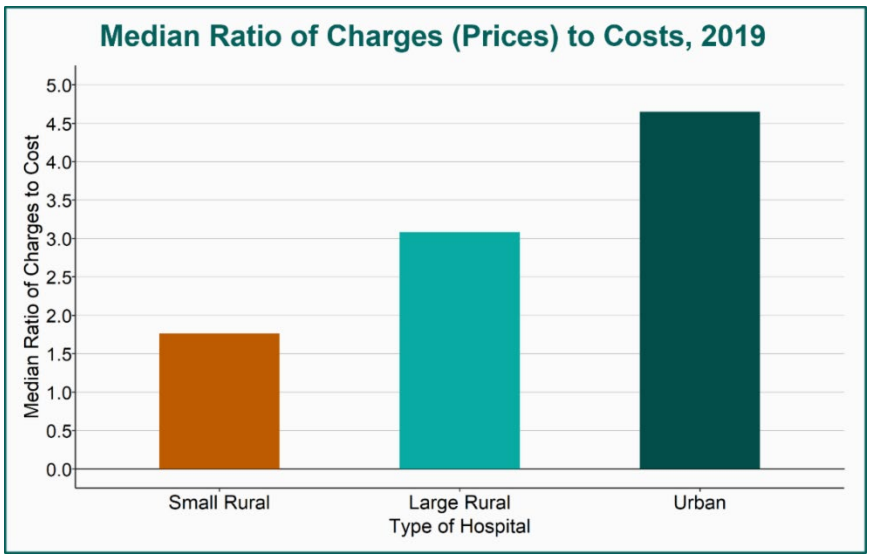
#3: Small rural hospitals need higher payments for essential services than larger hospitals because it costs more to deliver those services in communities with smaller populations. The average cost of an emergency room visit, inpatient day, laboratory test, or imaging study is inherently higher in a small rural hospital than at a larger hospital because there is a minimum level of staffing and equipment required to make sure these "standby" services are available on a 24/7 basis regardless of how many patients actually need to use them on any given day. For example, a hospital Emergency Department (ED) has to have at least one physician available around the clock in order to respond to injuries and medical emergencies quickly and effectively, regardless of how many patients actually have an emergency. The communities served by small rural hospitals have fewer ED visits because they have fewer residents, but the minimum cost of staffing the ED will be the same (or even higher if it costs more to recruit physicians and nurses to the rural community), so the average cost per visit

will be higher. Consequently, payments that are high enough to cover the average cost per service at larger hospitals will fail to cover the costs of the same services at small rural hospitals.

- In 2017, the median small rural hospital had fewer than 4,000 ED visits per year (about 10 visits per day). In contrast, the median was over 16,000 visits per year at larger rural hospitals and over 42,000 visits at urban hospitals (10 times as many as the median small rural hospital).
- Because of the smaller number of visits, the median small rural hospital had an average cost per ED visit of $476 in 2017, 60-70% higher than the $276 cost per ED visit at the median large rural hospital and the $304 cost per ED visit at the median urban hospital.

#4: Small rural hospitals charge less relative to their costs than urban and larger rural hospitals, which contributes to losses from private insurance plans. The prices that any hospital charges for its services have to be high enough to cover the costs of delivering the services and also high enough to offset the losses on services delivered to those patients who do not have insurance, who cannot pay the cost-sharing amounts required by their insurance, or who have an insurance plan that pays less than the cost of services. However, many hospitals charge far more than is necessary to cover their costs.

- Most urban hospitals charge more than four times as much as it costs them to deliver services. As a result, they can provide large discounts to private insurance plans and still make significant profits on their services. In 2019, the median urban hospital charged 4.7 times what it cost to deliver services, more than double the markup at small rural hospitals, and the median large rural hospital charged amounts that were 3.1 times its costs. One-fourth of urban hospitals charged prices more than 6 times what it cost them to deliver services.
- In contrast, at most small rural hospitals, their charges for their services are less than twice what it costs them to deliver those services. In 2019, the median small rural hospital charged only 1.8 times what it cost to deliver services. As a result, small rural hospitals suffer financially when they are forced to provide large discounts to private health insurance plans.

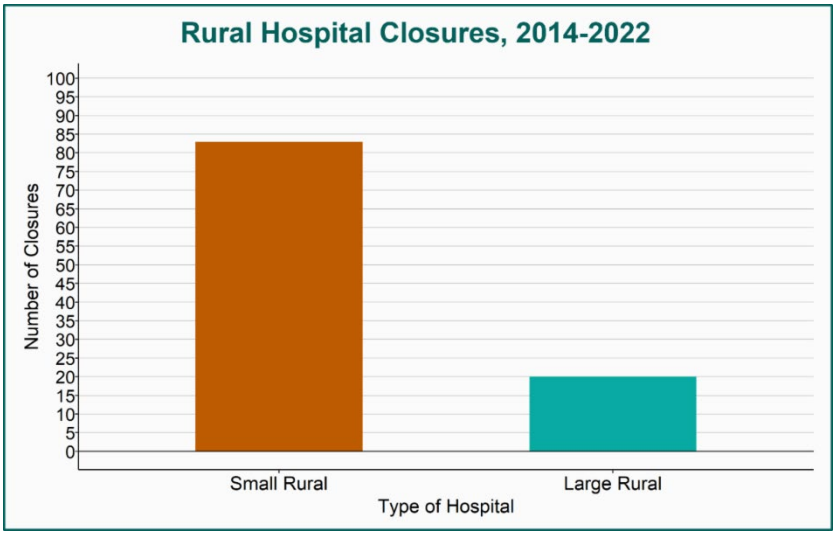


#5: Losses on patient services make small rural hospitals more dependent on local tax levies, government subsidies, and other sources of income than urban hospitals and larger rural hospitals. If a hospital isn't paid enough by health insurance plans to cover the costs of delivering services to patients, the hospital has to find other sources of revenue in order to continue operating. Many small rural hospitals depend on local tax revenues, state grants, or income from other businesses or programs in order to make up the losses on the services they deliver to patients.

- Most small rural hospitals receive more than 8% of their total revenues from sources other than payments for services to patients, and one-fourth receive more than 15% of their revenues that way.
- In contrast, most larger rural hospitals receive less than 5% of their revenues from sources and activities other than patient services, and most urban hospitals receive less than 3% of their revenues that way.
- More than 40% of small rural hospitals are able to receive local and state tax revenues because they are government-owned or are operated by public hospital districts, compared to only 25% of larger rural hospitals and less than 15% of urban hospitals.

#6: Small rural hospitals are more likely to close due to inadequate revenues. If a hospital does not receive sufficient revenues from insurance payments or government funding to cover its costs over multiple years, it will ultimately be forced to close. Over 100 rural hospitals have closed in the past decade, and nearly 80% of these closures have been small rural hospitals. Many more small rural hospitals would likely have been forced to close during the pandemic had it not been for the large federal grants they received. Since these grants were only temporary and small hospitals

experienced significant increases in costs during the pandemic, more small rural hospitals may have to close in the near future unless better ways of paying them are implemented.



Efforts to Control Healthcare Spending Need to Differentiate Small Rural Hospitals and Larger Hospitals

Clearly, there are very significant differences between small rural hospitals and larger hospitals, both urban and rural. These differences have important implications for designing policies that control or reduce spending on hospital services while ensuring access to essential health services for citizens in all parts of the country:

Little in the way of savings can be achieved by reducing payments to small rural hospitals. Although small rural hospitals represent 25% of the short-term general hospitals in the country, they only receive 2% of national spending on hospital services, and they account for less than 2% of the significant increase in national hospital spending that has occurred in recent years. Revenues at small rural hospitals increased by a total of $5 billion nationally from 2013 to 2019, compared to an increase of more than $200 billion at urban hospitals. Even a large reduction in spending on services at small rural hospitals would have only a minuscule impact on total national healthcare spending.

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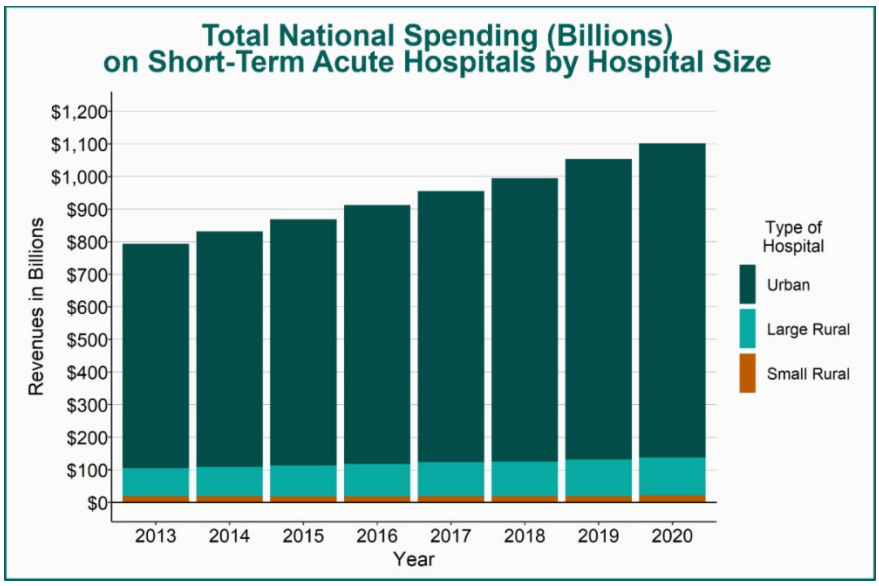

Reducing payments to small rural hospitals will accelerate closures and reduce access to services for rural communities. Policies and programs designed to reduce spending on hospitals by cutting payments for hospital services or reducing utilization of hospital services will have a far more negative impact on small rural hospitals than larger hospitals, because profit margins at most small rural hospitals are already low or negative. Even a small reduction in revenues at small rural hospitals could force more of them to close. Although revenues decreased for most hospitals in 2020 due to the coronavirus pandemic, the majority of urban hospitals and large rural hospitals remained profitable, whereas an even higher proportion of small rural hospitals lost money on patient services. Many small rural hospitals were only able to continue operating because the special federal assistance provided to hospitals during the pandemic enable them to offset these losses.

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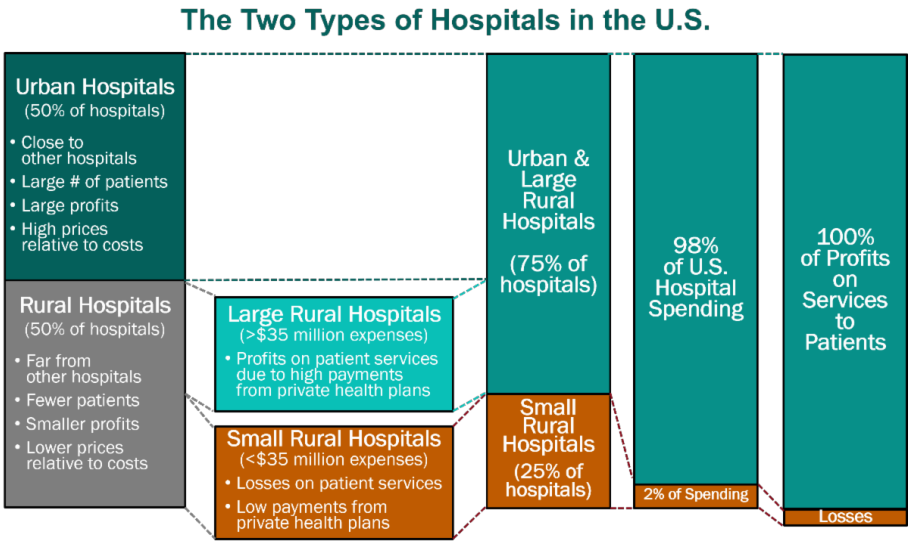


Small Rural Hospitals Need Better Payments from Both Private and Public Payers

The data show that there is little to be gained by reducing spending on small rural hospitals and much to be lost by doing so. Conversely, providing adequate payments to small rural hospitals could preserve access to essential healthcare services for rural communities with minimal impact on overall healthcare spending. The losses on patient services at all of the small rural hospitals in the country could be eliminated for a total of about $2 billion per year – less than two-tenths of one percent of total national spending on hospitals.

Unfortunately, **Medicare payment policies are making things worse for small rural hospitals rather than better**:

- **Cuts in Payments to Critical Access Hospitals.** Although Medicare payments under the Inpatient Prospective Payment System (IPPS) are being increased in 2023 by the highest amount in 25 years, most small rural hospitals will not benefit from this. Over 80% of small rural hospitals are designated as Critical Access Hospitals, which are not paid under IPPS. Medicare payments to Critical Access Hospitals have actually been reduced because of the return of sequestration reductions. Medicare now pays Critical Access Hospitals only 99% of what it costs the hospitals to deliver services, which means that most

small rural hospitals will be guaranteed to lose money on services they deliver to Medicare beneficiaries.

- **Reducing Access to Inpatient Care.** A new federal Rural Emergency Hospital program has been promoted as a way of preventing rural hospital closures. However, it would require a small rural hospital to close its inpatient unit, thereby eliminating a service that proved to be essential in most communities during the pandemic. In addition, the payments for the hospital's outpatient services would no longer be based on the cost of delivering hospital services in rural areas.
- **Creating Budgets That Are Smaller Than What It Costs to Deliver Care.** The Center for Medicare and Medicaid Innovation (CMMI) has proposed creating "global budgets" as a way of helping small rural hospitals. However, CMMI's demonstration program to test this concept (called the CHART Model) would cut the amount of Medicare revenue the hospitals have received in the past, and their payments in the future would no longer be based on the actual increases in the costs of delivering services in rural areas.

Moreover, while most proposals for helping small rural hospitals have focused on changing payments under Traditional Medicare, the primary cause of financial losses at small rural hospitals has been inadequate payments from private health insurance plans (including both employer-sponsored insurance and Medicare Advantage plans). As a result, **even if Medicare payments for small rural hospitals were increased, it would not be enough to prevent rural hospital closures unless there are also significant increases in payments from private health insurance plans and state Medicaid programs.**

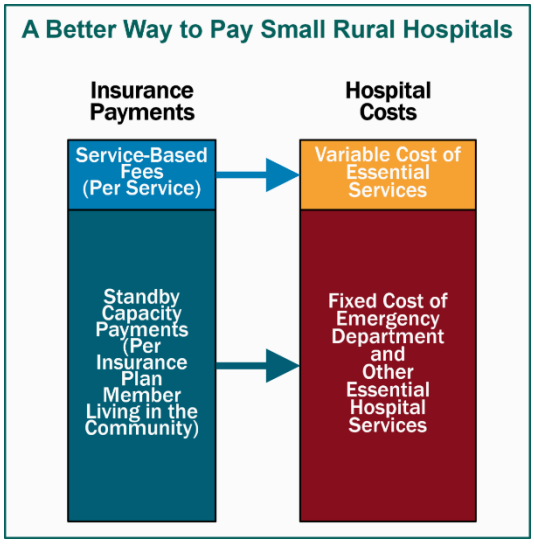
Creating a Better Way of Paying Small Rural Hospitals

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers use to pay for services. Small rural hospitals are paid for delivering individual services to patients, but there is no fee or other payment at all for what residents of a rural community would likely view as one of the most important services of all – the *availability* of physicians, nurses, and other staff to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

A hospital's ability to deliver a service on short notice is often referred to as "standby capacity," because a minimum level of personnel and equipment must be standing by in case a patient needs the service, even if it turns out that no patient actually does need it. The coronavirus pandemic made many people aware for the first time that current payment systems do not ensure that hospitals have enough standby capacity to handle unexpectedly large increases in the number of patients who need hospital care. While large hospitals can pay for the costs of standby capacity using the profits they make on delivering services, small rural hospitals do not have that ability.

Community fire departments aren't supported by fees charged for fighting fires, and small rural hospitals can't be supported solely through fees paid when people are sick. In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive **Standby Capacity Payments** from both private and public payers in addition to being paid Service-Based Fees when individual services are delivered. The Standby Capacity Payment would support the fixed costs of essential services at the hospital, and Service-Based Fees would only need to cover the variable costs of those services.



The details on how to design and implement this approach are described in the Center for Healthcare Quality and Payment Reform's report ***Saving Rural Hospitals and Strengthening Rural Healthcare***. Citizens, businesses, local governments, state government, and the federal government must all take action to ensure that every payer provides adequate and appropriate payments for small rural hospitals before more rural communities lose access to essential healthcare services.

A PDF version of this article can be downloaded here:
https://chqpr.org/downloads/Two_Types_of_Hospitals_in_US.pdf

NAVIGANT

HEALTHCARE

RURAL HOSPITAL SUSTAINABILITY:

New Data Show Worsening Situation for Rural Hospitals, Residents

David Mosley and Daniel DeBehnke, MD, Navigant — February 2019

BACKGROUND

Rural hospitals are essential to the health of the 60 million Americans who live in rural communities.[1] Beyond providing care, they're also economic engines, often the largest employers and drivers of additional businesses and jobs to communities.

But for close to three decades, rural population growth has been significantly lower than urban areas,[2] a factor contributing to the closing of 95 rural hospitals across 26 states since 2010.[3] And the economic effects are immediate — a study found[4] that when a community loses its hospital, per capita income falls 4% and the unemployment rate rises 1.6%.

ANALYSIS OF RURAL HOSPITAL FINANCIAL VIABILITY, COMMUNITY ESSENTIALITY

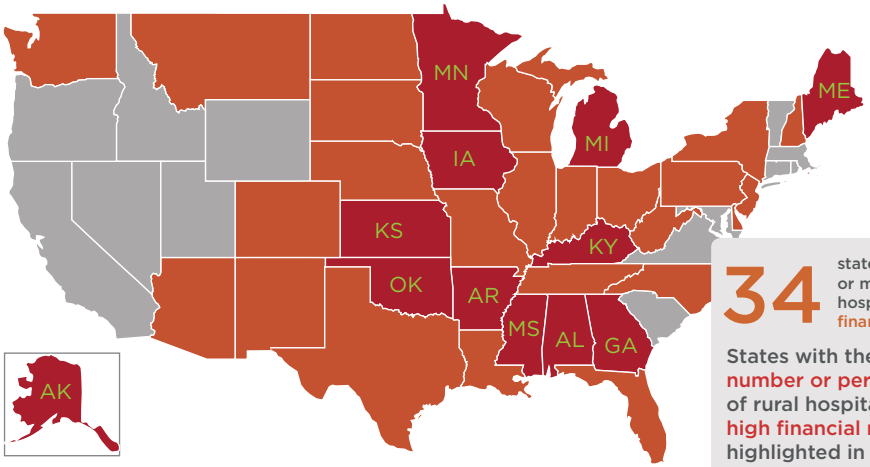
Rural Hospital Financial Risk

A Navigant analysis* of the financial viability (total operating margin, days cash on hand, and debt-to-capitalization ratio) of rural hospitals nationwide shows 21% or 430 hospitals across 43 states are at high risk of closing unless their financial situations improve. These hospitals represent 21,547 staffed beds, 707,000 annual discharges, 150,000 employees, and $21.2 billion total patient revenue. State-by-state data can be found in Figure 1 and Exhibit A.

Figure 1: Rural Hospital Financial Risk

THE NUMBER AND PERCENTAGE OF RURAL HOSPITALS AT HIGH RISK OF CLOSING*

21% OF U.S. RURAL HOSPITALS are at a HIGH RISK OF CLOSING unless their financial situations improve



34 states have 5 or more rural hospitals at high financial risk

States with the highest number or percentage of rural hospitals at high financial risk are highlighted in red

*(DE, NJ, and RI have no qualifying rural hospitals)

STATE	HOSPITALS AT HIGH FINANCIAL RISK	PERCENT AT HIGH FINANCIAL RISK
AL	21	50.0%
MS	31	48.4%
GA	26	41.3%
ME	8	40.0%
AK	6	40.0%
AR	18	36.7%
OK	17	29.3%
KS	29	28.7%
MI	18	25.4%
KY	16	24.6%
MN	19	21.3%
IA	17	17.9%

1. "One in Five Americans Live in Rural Areas," United States Census Bureau, August 9, 2017, https://www.census.gov/library/stories/2017/08/rural-america.html.
2. Brian D. Feinstein, JD, PhD, "RURAL AMERICA IS LOSING YOUNG PEOPLE," Penn Wharton Public Policy Initiative, March 23, 2018, https://publicpolicy.wharton.upenn.edu/live/news/2393-rural-america-is-losing-young-people-.
3. University of North Carolina Cecil G. Sheps Center for Health Services Research, "95 Rural Hospital Closures: January 2010 – Present," https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
4. George M. Holmes et al., "The Effect of Rural Hospital Closures on Community Economic Health," Health Services Research, April 2006, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/.

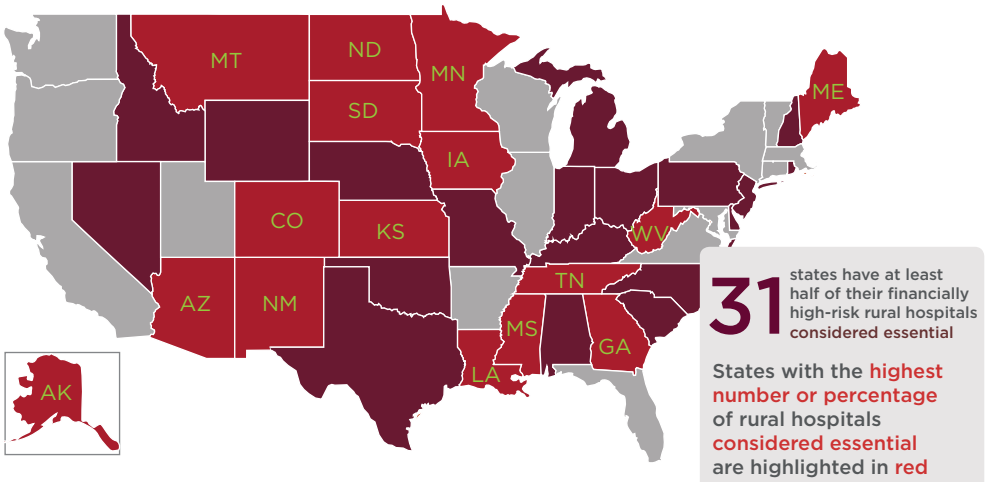
Rural Hospital Community Essentiality

Further analysis of the community essentiality (trauma status, service to vulnerable populations, geographic isolation, economic impact) of rural hospitals at high financial risk shows 64% or 277 of these hospitals are considered essential to their communities. See Figure 2 and Exhibit B for individual state results.

Figure 2: Rural Hospital Community Essentiality

THE NUMBER AND PERCENTAGE OF HIGH FINANCIAL-RISK RURAL HOSPITALS CONSIDERED ESSENTIAL TO THEIR COMMUNITIES*

Of high financial-risk rural hospitals, 64% ARE CONSIDERED ESSENTIAL to their communities



31 states have at least half of their financially high-risk rural hospitals considered essential

States with the highest number or percentage of rural hospitals considered essential are highlighted in red

*(based on an analysis of trauma status, service to vulnerable populations, geographic isolation, economic impact)

STATE	ESSENTIAL AT-RISK RURAL HOSPITALS	PERCENT ESSENTIAL AT-RISK RURAL HOSPITALS
MT	12	100%
AK	6	100%
CO	5	100%
ND	5	100%
AZ	8	89%
IA	15	88%
ME	7	88%
KS	25	86%
TN	6	86%
NM	6	86%
WV	8	80%
LA	8	80%
SD	4	80%
GA	20	77%
MN	12	63%
MS	19	61%

FACTORS DRIVING RURAL HOSPITAL CRISIS

The factors that have led to this rural hospital crisis are as complex as the ones that helped hollow out the communities they're meant to serve. In some ways, they're interconnected.

Payer mix degradation. A loss of agricultural and manufacturing jobs has led to a corresponding degradation of the payer mix. Residents who remain in rural communities tend to be either very old or very young, and these communities often have higher rates of uninsured, Medicaid, and Medicare patients, leading to more uncompensated and under-compensated care. Medicare payment reductions are also a major factor, with the average rural hospital counting on Medicare for 46% of gross patient revenue.[5]

Declining inpatient care driving excess capacity. Many rural hospitals were originally built in the post-World War II era to provide a level and volume of care that is no longer needed. This factor, combined with the ascendance of managed care and an increased focus on outpatient services, has left many rural hospitals overstaffed and underused. According to research,[6] the average rural hospital has 50 beds and 321 employees, but a daily census of just seven patients.

Inability to leverage innovation. Many already budget-strapped rural hospitals have been unable to keep up with technological trends as they lack the capital to invest in updated, innovative technology, such as electronic health records (EHRs) and advanced imaging platforms.

5. United States Government Accountability Office, "Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors," August 2018, https://www.gao.gov/assets/700/694125.pdf.
6. Jane Wishner et al., "A Look at Rural Hospital Closures and Implications for Access to Care," Kaiser Family Foundation, July 7, 2016, https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/.

LEGISLATIVE ACTION, HEALTH SYSTEM PARTNERSHIPS NEEDED

While rural hospital struggles have been documented for years, our analysis shines a new light on a crisis that must be addressed. The fact that all of this is happening during the longest uninterrupted period of economic growth in American history[7] should be added cause for concern. Local, state, and federal politicians, as well as health system administrators, need to act.

Advance legislation — In 2017, Senators Chuck Grassley, R-Iowa, Amy Klobuchar, D-Minn., and Cory Gardner, R-Colo., reintroduced the Rural Emergency Acute Care Hospital Act, or REACH Act.[8] The bipartisan legislation was meant to help rural hospitals by allowing them to sidestep a regulatory hurdle that had become an added burden.

Many rural hospitals are designated as Critical Access Hospitals, meaning they are required to provide a certain number of inpatient beds along with an emergency room. Those requirements often force hospitals that could still be turned around to close instead.

The REACH Act offers them another option: to resize and stabilize. Under a new classification known as the Rural Emergency Hospital, these hospitals would be able to rid themselves of the excess inpatient beds. Instead, they would have to maintain enough operational flexibility to move patients to larger hospitals — academic health systems in particular — while focusing on outpatient services.

While the REACH Act has been read in, it has not been voted upon by the appropriate committee.

Tertiary and academic health system collaboration — Partnerships between rural hospitals and regional tertiary and academic health systems need to be advanced in such areas as telehealth, back office functionality (revenue cycle, human capital, finance, EHR use), physician training, and clinical/service line optimization. Through these partnerships, rural hospitals can leverage the resources and capabilities of their better-funded, savvier peers.

For example, EHR provisioning allows hospitals with EHR technical and operational acumen to extend their capabilities to community/rural facilities hard-pressed to afford and operate a top-shelf EHR. In addition, extension of tertiary/academic specialty clinical programs can help develop a hub-and-spoke network of clinical care that augments rural hospital services. This leverages regional/academic specialty expertise while allowing care to remain local at rural partner facilities.

CONCLUSION

While the potential for a rural hospital crisis has been known for years, this predictive data sheds light on just how dire the situation could become. Now, by being able to accurately assess the economic health of all rural hospitals in America, there is no choice but to pay attention. Local, state, and federal political leaders, as well as hospital administrators, must act to protect the well-being of rural hospitals nationwide and the communities they serve.

David Mosley, managing director, has extensive government regulatory healthcare experience, having served two governors, been employed as a city manager, and directed financial operations of a $10 billion state Medicaid program.

Daniel DeBehnke, MD, MBA, managing director, most recently served as CEO of the Nebraska Medicine health system and CEO of Medical College Physicians. He also was senior associate dean for clinical affairs and chief clinical integration officer at the Medical College of Wisconsin and has practiced on the front lines of Level I trauma centers, led a research laboratory, and participated on U.S. National Institutes of Health review panels.

7. Heather Long, "The U.S. is on track for the longest expansion ever, but it's coming at a cost," The Washington Post, April 18, 2018, https://www.washingtonpost.com/news/wonk/wp/2018/04/18/the-u-s-is-on-track-for-the-longest-expansion-ever-but-its-coming-at-a-cost/?noredirect=on&utm_term=.7866192988e8.
8. Sen. Chuck Grassley, "Grassley, Klobuchar, Gardner Introduce Legislation to Help Rural Hospitals Stay Open, Focus on Emergency Room Care, Outpatient Services," May 16, 2017, https://www.grassley.senate.gov/news/news-releases/grassley-klobuchar-gardner-introduce-legislation-help-rural-hospitals-stay-open.

Exhibit A: Rural Hospitals at High Financial Risk

The number and percent of rural hospitals that are at high risk of closing unless their financial situations improve.

STATE	TOTAL RURAL HOSPITALS	HOSPITALS AT HIGH FINANCIAL RISK	PERCENT AT HIGH FINANCIAL RISK
CT	5	3	60.0%
AL	42	21	50.0%
MS	64	31	48.4%
GA	63	26	41.3%
AK	15	6	40.0%
ME	20	8	40.0%
WV	27	10	37.0%
AR	49	18	36.7%
FL	23	8	34.8%
NH	17	5	29.4%
OK	58	17	29.3%
KS	101	29	28.7%
SC	15	4	26.7%
NM	27	7	25.9%
MI	71	18	25.4%
AZ	36	9	25.0%
KY	65	16	24.6%
IN	39	9	23.1%
MO	61	14	23.0%
PA	41	9	22.0%
MN	89	19	21.3%
MT	57	12	21.1%
LA	50	10	20.0%
TN	37	7	18.9%
NY	48	9	18.8%
IA	95	17	17.9%
IL	75	13	17.3%
WA	40	6	15.0%
ND	34	5	14.7%
NC	47	6	12.8%
ID	25	3	12.0%
WI	75	9	12.0%
CO	43	5	11.6%
NE	70	8	11.4%
SD	44	5	11.4%
OH	65	7	10.8%
HI	10	1	10.0%
TX	127	12	9.4%
CA	50	4	8.0%
NV	13	1	7.7%
WY	21	1	4.8%
VA	22	1	4.5%
OR	28	1	3.6%
MA	6	0	0.0%
MD	5	0	0.0%
UT	17	0	0.0%
VT	13	0	0.0%
TOTAL	2045	430	21.0%

(DE, NJ, and RI have no qualifying rural hospitals)

Exhibit B: Essentiality of High Financial-Risk Rural Hospitals

The number and percent of high financial-risk rural hospitals considered essential to their communities.

STATE	TOTAL AT-RISK RURAL HOSPITALS	ESSENTIAL AT-RISK RURAL HOSPITALS	PERCENT ESSENTIAL AT-RISK RURAL HOSPITALS
KS	29	25	86%
GA	26	20	77%
MS	31	19	61%
IA	17	15	88%
MT	12	12	100%
MN	19	12	63%
OK	17	11	65%
KY	16	10	63%
MI	18	10	56%
AL	21	10	48%
AZ	9	8	89%
WV	10	8	80%
LA	10	8	80%
TX	12	8	67%
AR	18	8	44%
ME	8	7	88%
MO	14	7	50%
AK	6	6	100%
NM	7	6	86%
TN	7	6	86%
ND	5	5	100%
CO	5	5	100%
NE	8	5	63%
IN	9	5	56%
PA	9	5	56%
SD	5	4	80%
OH	7	4	57%
IL	13	4	31%
SC	4	3	75%
NH	5	3	60%
NC	6	3	50%
FL	8	3	38%
NY	9	3	33%
ID	3	2	67%
WA	6	2	33%
WI	9	2	22%
NV	1	1	100%
WY	1	1	100%
CA	4	1	25%
CT	3	0	0%
HI	1	0	0%
VA	1	0	0%
OR	1	0	0%
MA	0		
MD	0		
UT	0		
VT	0		
TOTAL	430	277	

(based on an analysis of trauma status, service to vulnerable populations, geographic isolation, economic impact)

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About Navigant

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***Rural Hospital Sustainability Index Data**

All analyses based on most recently available data submitted by hospitals to the Centers for Medicare & Medicaid Services.

Financial risk — Derived from a weighted analysis of the following hospital metrics tied to Moody's bond ratings ratios.

- Total operating margin performance trended over three years: Less than 1.4% (Moody's Baa median/lowest investment grade) each of past three years
- Days cash on hand: Less than 78.5 days (half of Moody's Baa median)
- Debt-to-capitalization ratio: More than 49.8% (Moody's noninvestment grade grouping median)

Hospitals were assigned a score of 1-3 on each metric. Total scores of 3 or 4 are considered high financial risk.

Community essentiality — Hospitals meeting all the following metrics are considered essential.

- Trauma status: Hospitals designated a Level I or II trauma center are automatically designated essential, regardless of scoring on other indicators.
- Service to vulnerable populations: Either Medicaid days as a proportion of or uncompensated care as a percentage of net revenue are above national averages.
- Geographic isolation: Hospital represents at least 25% of beds in 25-mile radius.
- Economic impact on community: Hospital employee-to-county population ratio in the 3rd quartile or above, or at least 4.8 employees per 1,000 residents.

Hospitals were assigned a score of 1-3 on each metric. Total scores of 3 to 6 or hospitals designated Level I or II trauma centers are considered essential to communities.

BECKER'S HOSPITAL REVIEW

Retired baby boomers are flocking to rural areas, boosting hospital demand

Georgina Gonzalez (Twitter) - Monday, May 9th, 2022

Retired people are moving to rural areas in search of natural beauty and a slower pace of life, boosting desperate local economies and bringing demand for services, including healthcare, reported *The Wall Street Journal* May 8.

At 162 rural spots in the U.S., the population increased faster than the national average, bucking the trend that plagues most rural locations of population decline. Drawn in by natural attractions such as mountains and lakes, more retired people are settling down in areas such as Sevier County, Tenn., that saw a 13 percent increase in population over the past decade.

The influx of retirees brings a boost to the local economies of these sleepy towns. More residents means more consumers for local business, increased school services and a boosted workforce. In Sevier County, a new high school recently opened and a 79-bed hospital opened.

LAKE CHELAN HEALTH

LCH Planning Survey

December 2022

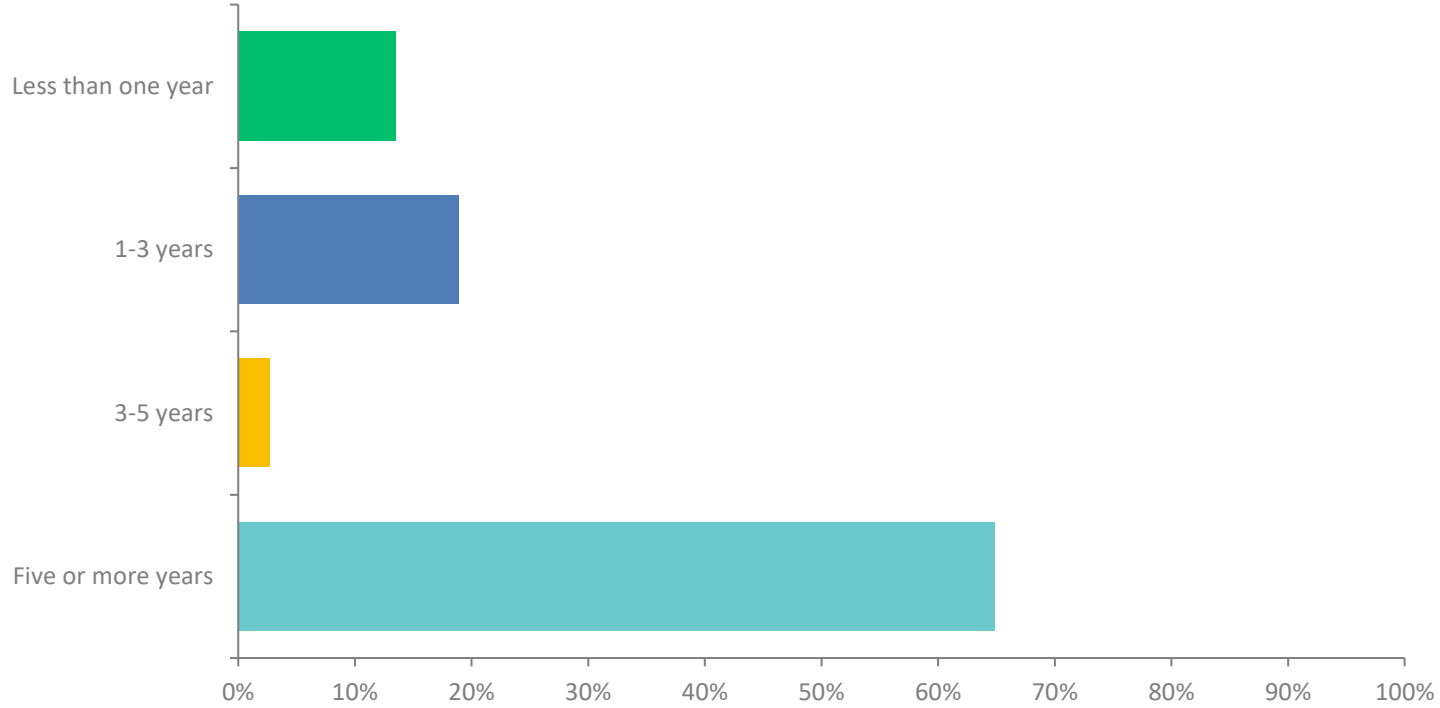
LAKE CHELAN HEALTH

66% Response Rate (37 answers)

ANSWER CHOICES	RESPONSES	
Commissioner	13.51%	5
Member of LCH management	32.43%	12
Medical Staff member	18.92%	7
Community member/volunteer	8.11%	3
LCH staff member	27.03%	10
TOTAL		37

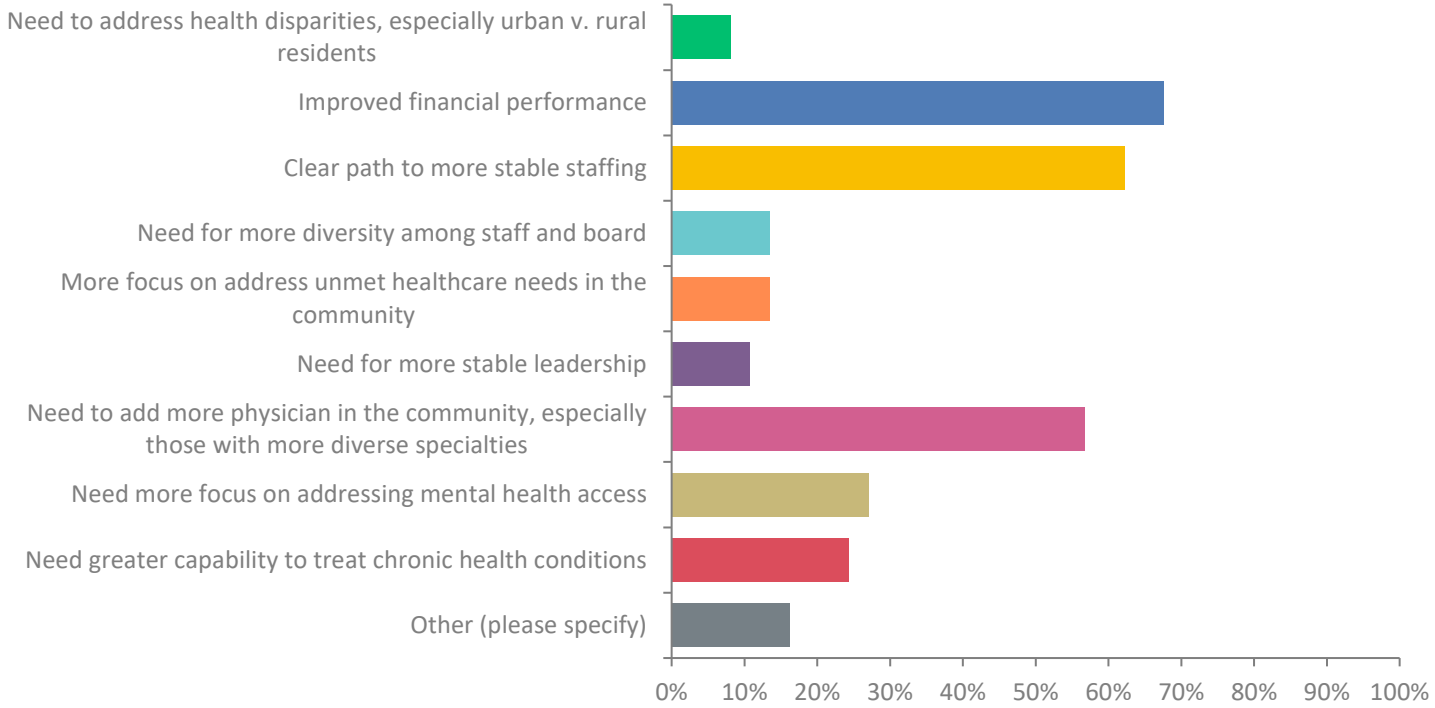
Q1: I have been involved with or employed by Lake Chelan Health for:

Answered: 37 Skipped: 0



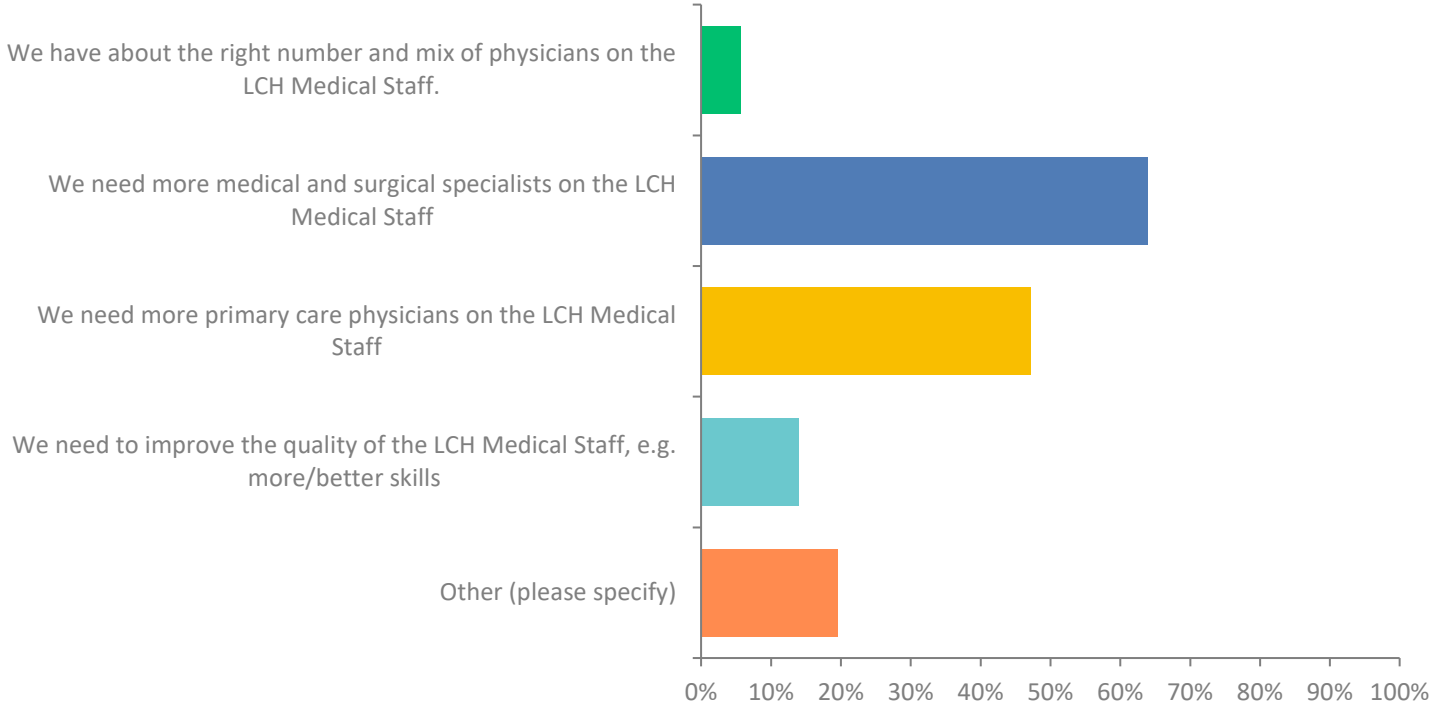
Q2: The most pressing issue(s) facing Lake Chelan Health are (check all that apply):

Answered: 37 Skipped: 0



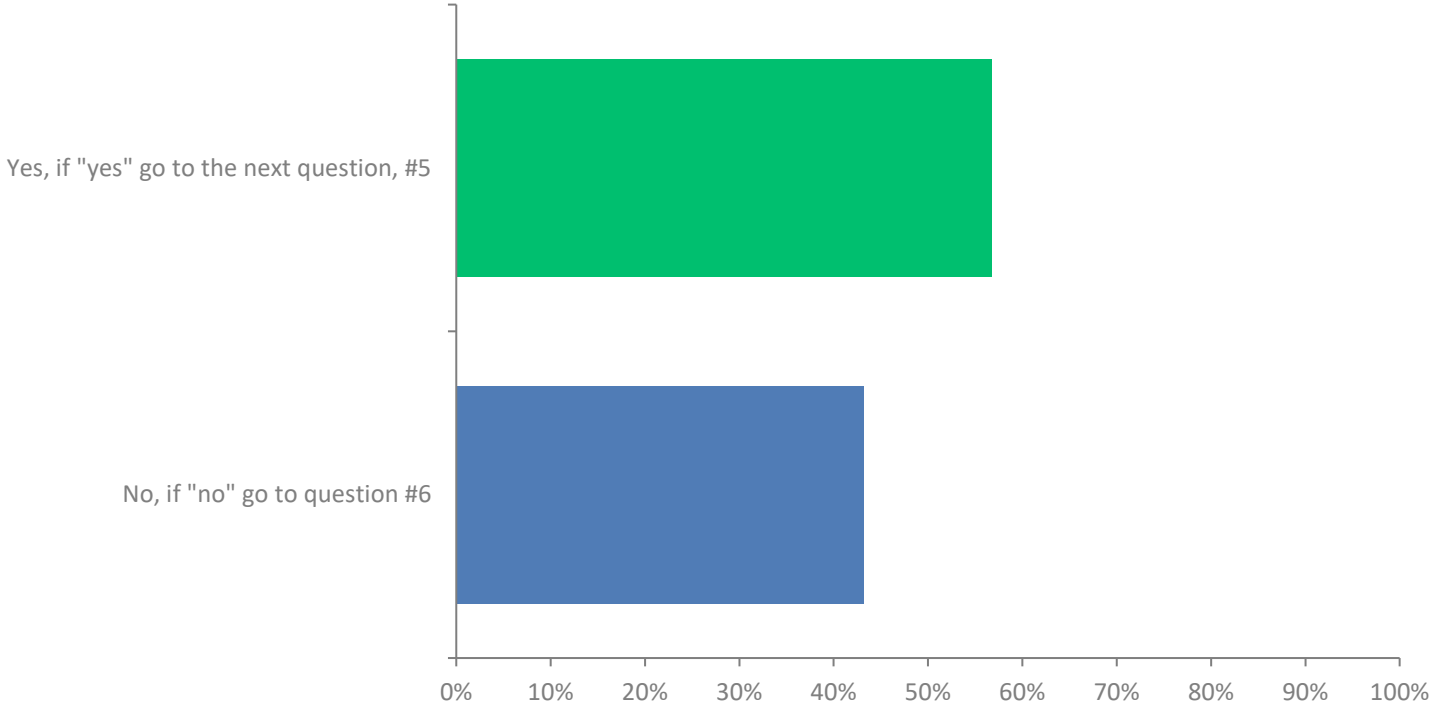
Q3: Regarding the Medical Staff at Lake Chelan Health (check all that apply)

Answered: 36 Skipped: 1



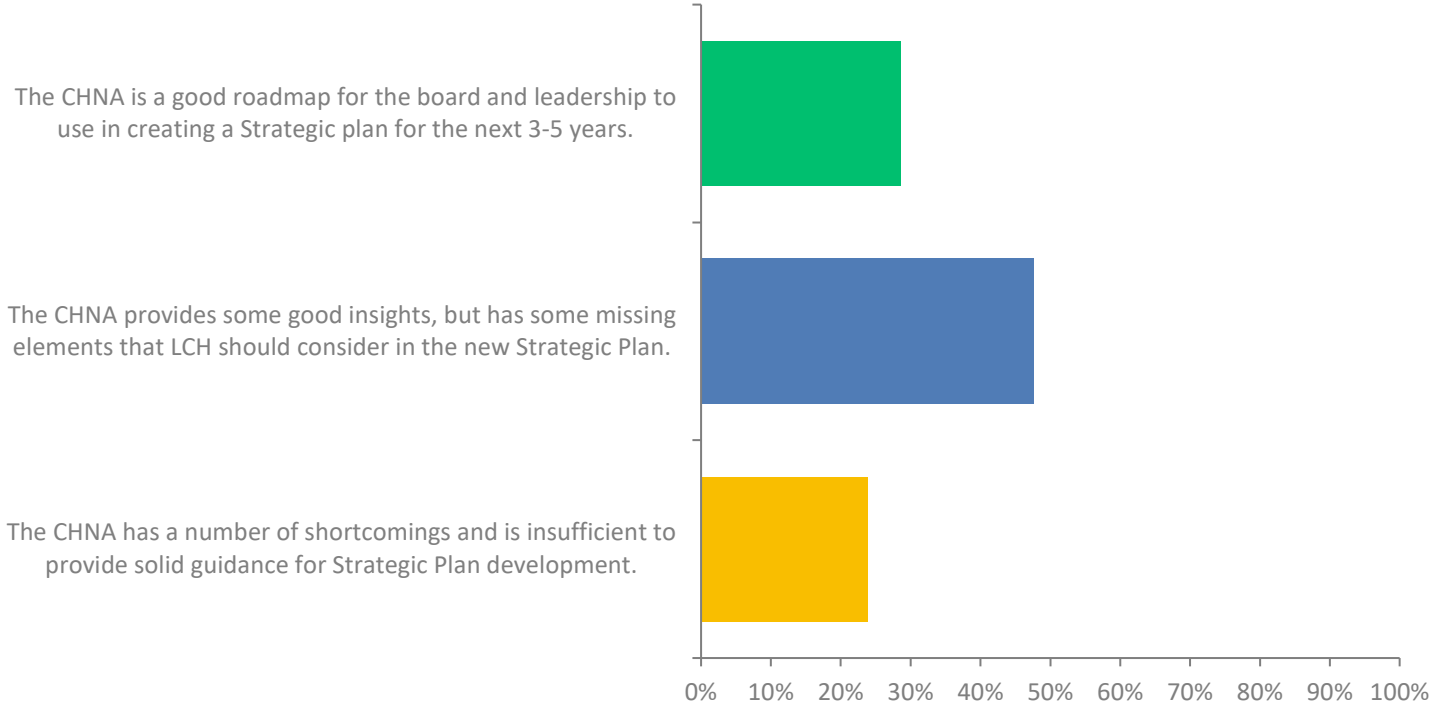
Q4: I have read and understand the Community Health Needs Assessment Survey - Yes/No

Answered: 37 Skipped: 0



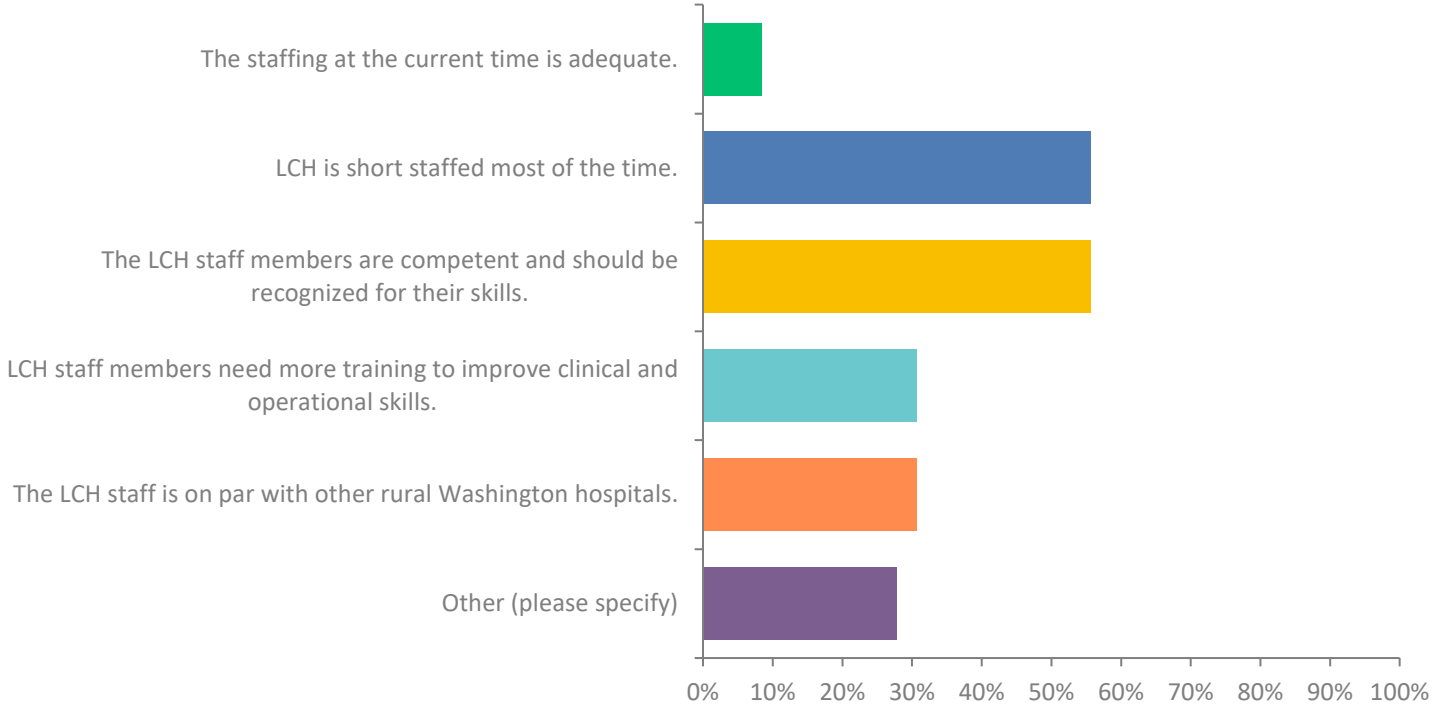
Q5: Describe your perception of the Community Health Needs Assessment (CHNA).

Answered: 21 Skipped: 16



Q6: Describe the staffing at Lake Chelan Health. (check all that apply)

Answered: 36 Skipped: 1



Q7: In general, the community perceives LCH as a major community asset.

Answered: 35 Skipped: 2

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
0% 0	42.86% 15	22.86% 8	34.29% 12	0% 0	35	2.91

Q7 Comments:

- Difficult question, supporting does not necessarily lead to seeking care. (Commission)
- Need to remove the negative history (Commission)
- Our hospital has amazing potential to become a leader in rural health care. But it will require more training. (Medical staff)
- It's all we have locally - but Wenatchee and Confluence is not that far away and given the option most do not feel confident in LCH as a provider of routine medical care - and certainly not medical operations with a staff that does 2 similar procedures a month when Confluence, Spokane or Seattle offers medical teams that do10 a week. (Community)
- We have made great strides in this area. I feel like a quality orthopedic surgeon will put us in a better place. Having physicians in the ER, rather than PAs, has significantly improved the quality/feedback I hear from the community. (Leader)
- We are continually fighting against the one negative that surfaces now and again and causes disruption (Commission)
- Many people support, but could still be better (Leader)
- The community does not support the hospital as it should. Our Board needs to do a better job of promoting us to the public and let us perform the day-to-day functions. (Staff)

Q8: Regarding philanthropy, the community could help raise at least $1 million annually to fund the right discretionary projects and/or programs.

Answered: 35 Skipped: 2

1	2	3	4	TOTAL	WEIGHTED AVERAGE
5.71% 2	45.71% 16	37.14% 13	11.43% 4	35	2.54

Q8 Comments:

- I believe so - but the leadership needs to come clean and admit their errors and lay out a realistic plan that will build trust. Bringing Confluence physicians to Chelan frequently would be a start. Chelan does not need to be a surgery center - it needs to be a highly qualified and efficient ER facility and a place where local patients can return and recover after surgeries and emergencies dealt with initially in the regional facility at Confluence (Community)
- Would be nice to see more philanthropy vs additional tax support (Commission)
- However, there are many competing needs and current projects all looking for funding. (Commission)
- We are a small (in numbers) community with many needs, not just health care. (Commission)
- There is an abundance of money in this area and raising a million would be easy. (Staff)

Q9: Describe the amount of tax support Lake Chelan Health receives from the community.

Answered: 31 Skipped: 6

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
0% 0	0% 0	58.06% 18	32.26% 10	9.68% 3	31	3.52

Q9 Comments:

- Unsure how to answer. How much tax support do we get ? i.e. how dependent are we on it as opposed to financially self-sustaining? (Leader)
- I say limited - because until public trust is accomplished - no amount of tax income will off set the skeptic eye if those who have seen the deception of the past. (Community)
- We could always use more support, we're not particular about where it comes from. (Commission)

Q10: Thinking of patient safety and quality, Lake Chelan Health provides a high level of clinical quality, regularly measuring and monitoring results.

Answered: 35 Skipped: 2

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
11.43% 4	2.86% 1	42.86% 15	37.14% 13	5.71% 2	35	3.23

Q11: Rate the level of engagement by the Medical Staff in the work of Lake Chelan Health, especially regarding improvement of Patient Safety/Quality.

Answered: 32 Skipped: 5

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
3.12% 1	12.50% 4	56.25% 18	21.88% 7	6.25% 2	32	3.16

Q11 Comments:

- CVCH providers don't seem enthused to be on committees, etc. (Leader)
- I’m unfamiliar with current staff engagement. In the past staff engagement was nearly employees running the show with little regard to the financial hole they were digging and it seemed total disregard for the lack of public trust. It used to be that a job at LCCH was a cushy job with few patients and little accountability. Today - that has changed a great deal and I am counting on the future CEO and Commissioners to never let the tail wag the dog again. (Community)
- Difficult to assess when we have had to use locums and travelers so much. (Commission)
- I do not know of the engagement of the Med Staff in this regard. This would be better answered by peers or Admin Staff. (Commission)
- The level of engagement is continuing to improve. (Staff)

Q12: Based on your knowledge of the clinical and operation staff at LCH, how would you rate their level of engagement

Answered: 34 Skipped: 3

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
0% 0	5.88% 2	47.06% 16	41.18% 14	5.88% 2	34	3.47

Q12 Comments:

- Like any organization, there are those who are more engaged than others. Some of the RNs especially don't like their work, but it has been hard to find RNs, so our options are not great. We also don't pay our RNs as much as the Seattle area, so some of the good ones continue working there even though they live here and would rather work for us if we paid better. (Leader)
- Better than in recent past (Community)
- I don’t know my response as a fact, but I sense it is true. After a mostly voluntary house cleaning of 80% of the 209 employees at LCCH (now LCH) I have strong indications that today’s team is working hard and working together. And I’m not familiar with any free loaders or folks who think they have a cushy job. I think most understand they have their work cut out and are trying hard to get there. (Community)
- I feel like there are departmental differences here, however it also seems that more staff understand their interdependence. (Commission)
- There is a level of complacency present based on tenure of staff. (Commission)
- The work ethic needs to improve. There are far too many entitled individuals in the organization who simply show up to collect a check. Current Administration has helped change this but there is still work to do. (Staff)

Q13: Rate the quality of facilities the Lake Chelan Health provides for the community. (Assume the new hospital building is open and operational.)

Answered: 35 Skipped: 2

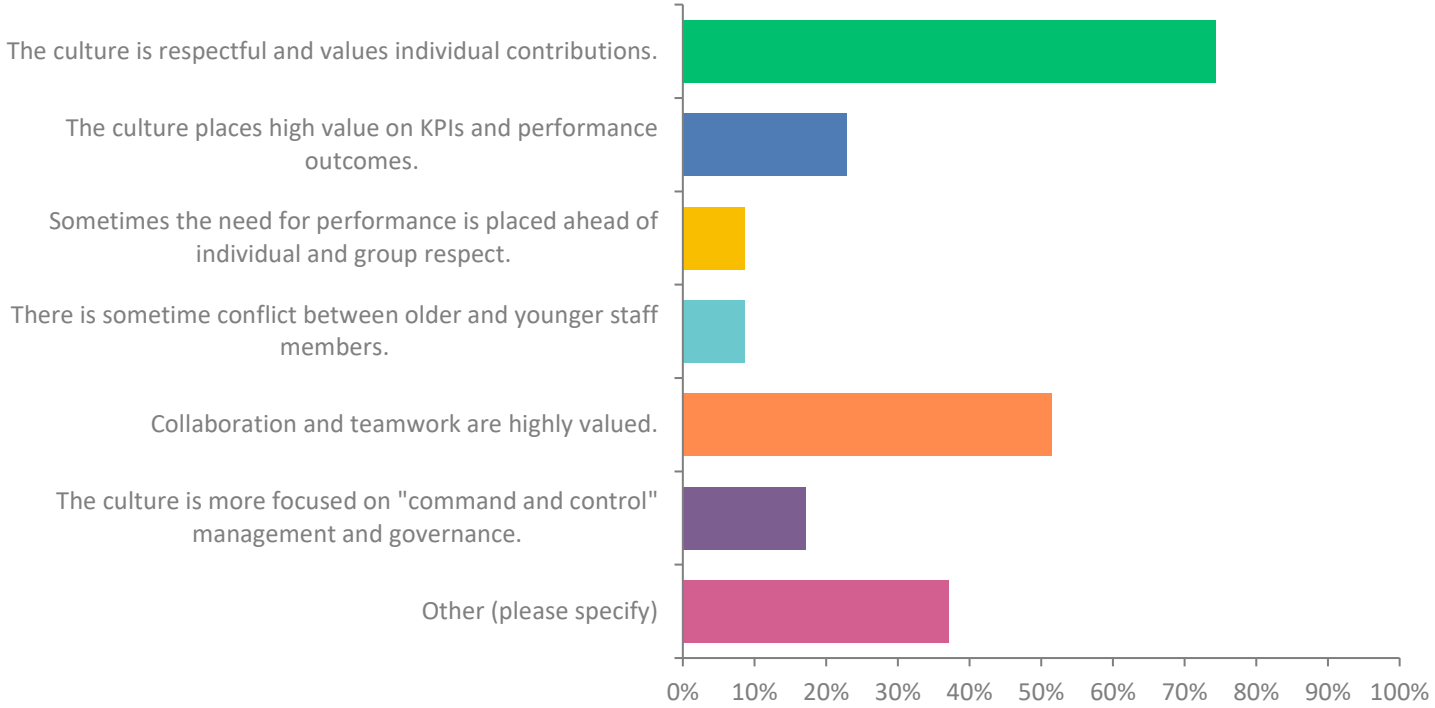
1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
2.86% 1	5.71% 2	17.14% 6	54.29% 19	20.0% 7	35	3.83

Q13 Comments:

- Except for the temperature of the building. (Leader)
- Great for new hospital services; good for clinic space; uninviting for patient billing/financial counseling access. (Leader)
- Need a solid plan for outpatient specialty services. (Community)
- It's new - it's functional - and I see it attracting Confluence specialist to come to Chelan . And I don't hear pressure being out on anyone to have procedures done in Chelan when Wenatchee has a much total better total staff to care for patients in the critical 24-48 hours after surgery. (Community)
- Community would prefer a one-stop shop. While Apple Blossom is new, Clinic and Highland are sub par facilities. (Commission)
- Design did not adjust during initial construction, post Covid. Design team failed to take into account area environmental factors like fire and snow. (Community)
- I believe once we have worked out all of the "kinks" we will provide the community with an exceptional quality experience. (Commission)
- Poor engineering and design has caused some issues. (Staff)
- Too many issues at new hospital. (Staff)

Q14: Describe the culture within Lake Chelan Health (check all that apply).

Answered: 35 Skipped: 2



Q14 Other:

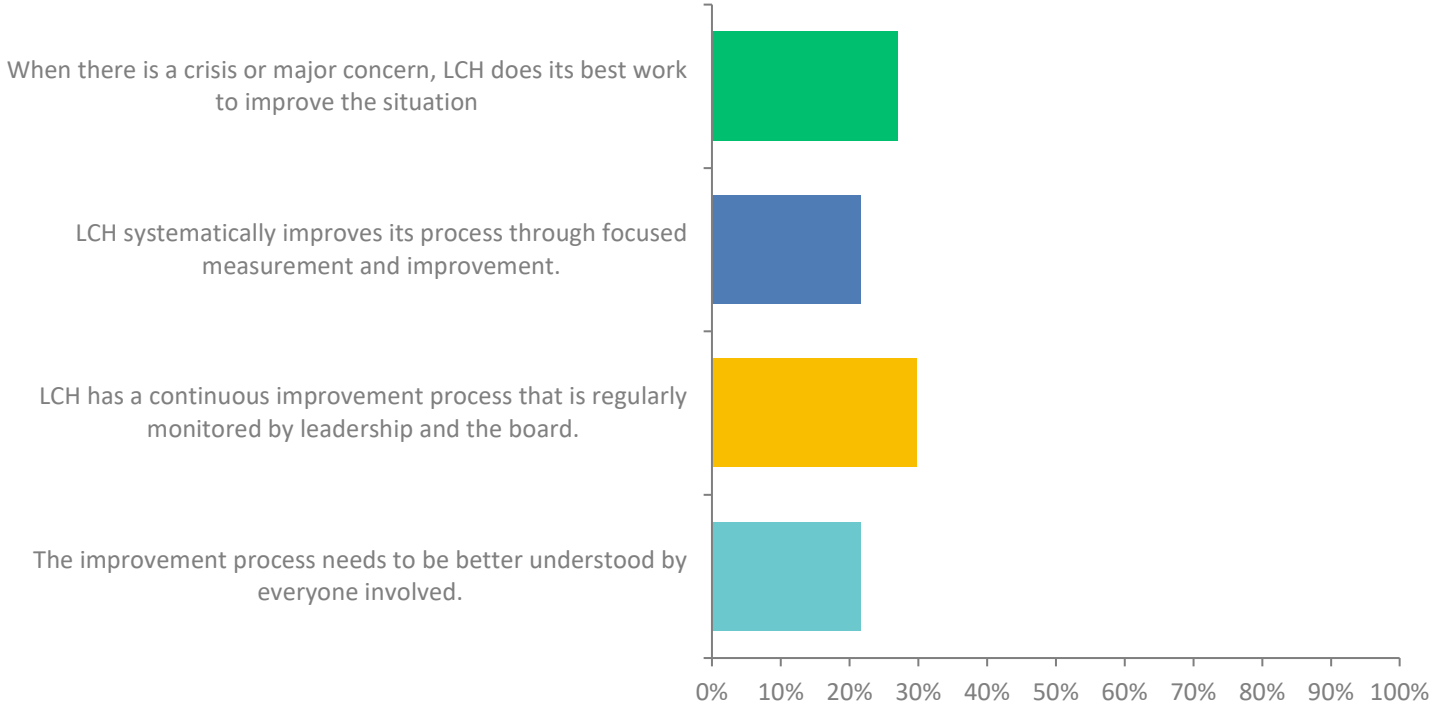
- New administration is VAST improvement over previous two. (Medical staff)
- I do appreciate not having a strict productivity standard. But, I do think we need to hold clinicians a little more accountable on their productivity. I also believe our community is not fully aware of all the services the hospital can offer. I hear on the radio about pain management and general surgery, but no mention of Physical Therapy or wound care services. We are the only clinic in Chelan and Manson that specializes in orthopedics, and we still have athletes going to Wenatchee for Physical therapy. We really need to amp up our advertising and let the community know the great service we offer. (Medical staff)
- Some board members are out of touch with clinical/community needs. (Community)
- The Commissioners are finally doing their job and not micro-managing via committees without accountability. (Community)
- The culture is generally respectful, can be stuck in "we've always done it this way". Many changes lately, and culture is changing, appear to be more team oriented, more accountability, more positive. (Commission)
- All of the above has yet to be seen. (Commission)
- Culture can emanate from several sources. I base my answers on observation of how the Administrative Staff works to cultivate the working relationships among the caregivers (all staff included). (Commission)

Q14 Other, Cont.:

- Current Administration has been a blessing and the culture is vastly improving. (Staff)
- The value of KPIs is growing. Most leaders recognize the value and are learning to incorporate them. (Staff)
- Mostly positive, some department have issues, which are being addressed. (Staff)
- The culture has improved greatly with the new administration we have. (Staff)
- Disconnect between clinical and non-clinical staff. (Staff)

Q15: Which statement best describes the understanding and approach to clinical and operational improvement used by Lake Chelan Health.

Answered: 37 Skipped: 0



Q16: How would you rate the current state of access to health insurance coverage in the region served by Lake Chelan Health.

Answered: 34 Skipped: 3

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
5.88% 2	14.71% 5	44.12% 15	35.29% 12	0% 0	34	3.09

Q16 Comments:

- The biggest problem arises with outpatients who have a high deductible plan. With how we bill, pts need to meet their deductible before their insurance kicks in. They often expect a copay. This is a CAH problem- not specific to us, and admin is supportive of ways to address it as best we can. (Leader)
- Reasonable amount of options, but very spendy (Leader)
- Collaboration with CVCH and CHPW helps (Community)
- I only know my experience and it is good (Community)
- Limited options that provide coverage for local resources (Commission)
- I have no facts to base my answer on specifically. My view that there is limited access comes more so from what I have heard and observed. (Commission)
- I really do not know (Staff)

Q17: The Board of Commissioners clearly understands its role in governing (v. managing) Lake Chelan Health

Answered: 33 Skipped: 4

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
27.27% 9	51.52% 17	15.15% 5	6.06% 2	0% 0	33	2

Q17 Comments:

- Maybe because of poor performance by CEOs in the past, but our board seems overly involved in some ways. At the same time, most board members are unknown by hospital staff who does not attend board meetings. I wish board members would attend hospital gatherings and make it easier for hospital staff to get to know them as people. I would think the board members could lead better by knowing more about us. (Leader)
- In my opinion the past board lost site of the hospital's mission to provide care to the people of the district. (Medical staff)
- I have met maybe one of the board members. I also do not know what the vision is for the hospital. What is the hospitals 5 or 10-year plan? I think the vision and goals for the hospital needs to be better communicated to the employees. (Medical staff)
- I feel the board frequently oversteps and is too involved in day to day management. We have strong leadership team and they need to trust them to make decisions. (Medical staff)
- Personal agendas and sacred cows prevent necessary growth/change. (Community)
- It’s been a tough journey - but a critical one . The score could be exceptional but I have little to compare with. It certainly is exceptional compared to the past. (Community)

Q17 Comments, Cont.:

- More of an issue with governing vs not governing. (Commission)
- Why would a rural health district have different expectations? (Commission)
- We still have a ways to go before we reasonably understand this role. I think in all honesty, the Management team could give you a more accurate answer. (Commission)
- The Board is broken, and we suffer because of it. They are to focused on trying to be involved in operations and provide poor leadership and representation to the public. (Staff)
- The Board's understanding is really not known. (Staff)

Q18: Management of Lake Chelan Health clearly understands its role in managing (v. governing) the organization.

Answered: 35 Skipped: 2

1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
0% 0	8.57% 3	22.86% 8	37.14% 13	31.43% 11	35	3.91

Q18 Comments:

- Management does a great job of not micro-managing and supporting our department. (Mgmt.)
- Present administration understands its role. (Medical staff)
- Only what I observe. But it's much much better than what it has been, thanks to a Commission who has demanded it from the CEO. (Community)
- Management yes, general staff – no (Commission)
- We have a strong CEO, CFO and CNO that understand this role. (Commission)
- Again, if left without unreasonable interference, our organization would flourish. (Commission)

Q19: What are the four issues to be addressed in the LCH 2023-26 Strategic Plan?

Issue	Number of Responses	Comment
Employee/medical staff recognition and retention (pay, benefits, communication, culture)	14	
Facilities management and planning; campus consolidation	13	
Identify specific services to add, enhance or discontinue; service line development	11	
Long term finances; financial stability	10	

Q 19 Response, Cont.

Issue	Number of Responses	Comment
Stabilize/Enhance nursing and physician staffing (primary care, ED and specialty care)	7	
Improve community image of LCH; marketing, communication, advertising	7	
Clinical quality improvement; more focus and process	5	
Executive retention (too much turnover in last 5 years)	4	
Focus on revenue cycle/financial stability	4	

Q 19 Response, Cont.

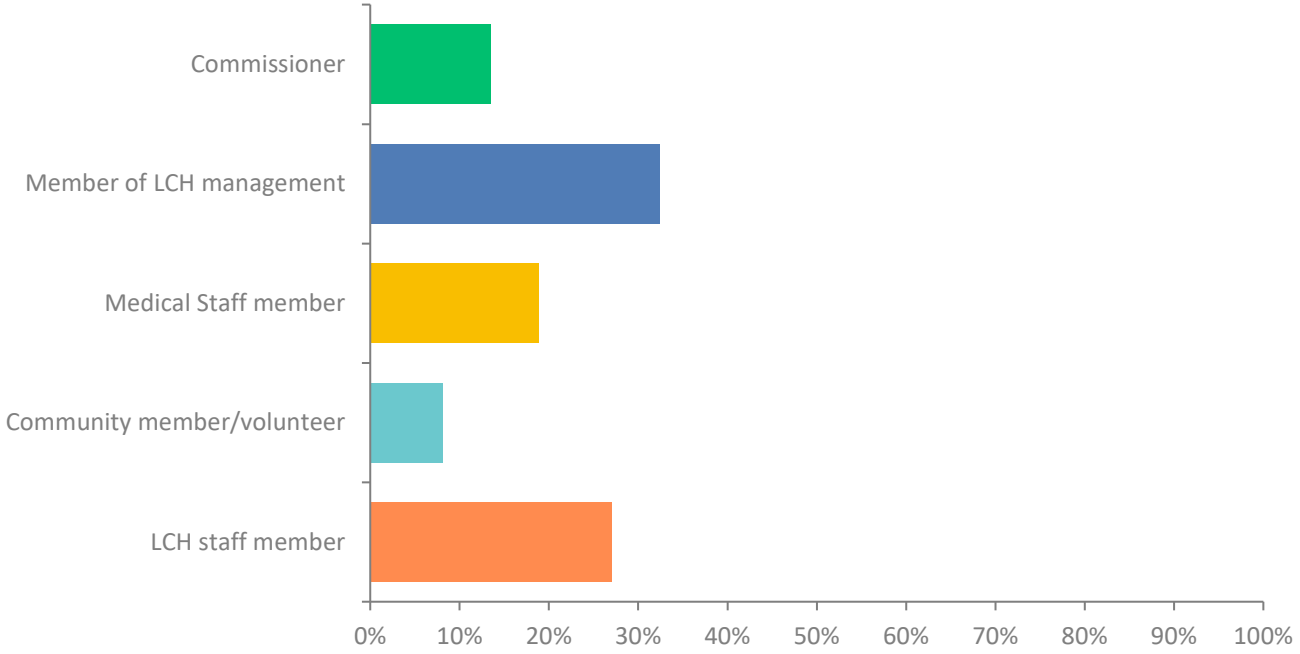
Issue	Number of Responses	Comment
Improve Board/Leadership relations and function	3	
More hiring to minimize staff shortage	3	
Support and grow primary care services	2	
Increase community education services	2	
Improve mental health access for the community	2	
Increase diversity and DEI training; board and staff	2	
Patient/customer service; patient-focused culture	2	

Q 19 Response, Cont.

Issue	Number of Responses	Comment
Patient/customer service; patient-focused culture	2	
Enhance/expand existing services	2	
Implement new EMR	2	

Q20: Which of the following best describes your role with Lake Chelan Health?

Answered: 37 Skipped: 0



Q20: Which of the following best describes your role with Lake Chelan Health?

Answered: 37 Skipped: 0

ANSWER CHOICES	RESPONSES	
Commissioner	13.51%	5
Member of LCH management	32.43%	12
Medical Staff member	18.92%	7
Community member/volunteer	8.11%	3
LCH staff member	27.03%	10
TOTAL		37