LAKE CHELAN HEALTH

BOARD PACKET

Chelan County Public Hospital District No. 2

12/19/2023

LAKE CHELAN HEALTH

Chelan County Public Hospital District No. 2
Regular Meeting of the Board of Commissioners
December 19, 2023, at 2:45 pm via TEAMS
Meeting ID: 263 126 243 784 Passcode: dkJHdr

Agenda

Mission- "To provide the highest quality healthcare with compassion and respect to the community we serve."

FI – For Information; FD – For Discussion; FM – For Motion; FA – For Acceptance; FR-For Resolution

Time	*Agenda Item*	*Facilitator*	*Topic/Action*
2:45	• Call to Order	J. LaPorte	
2:47	• Public Comment		
2:50	• Chair Report • Oath	J. LaPorte J. LaPorte	• Len England – New Commissioner
2:55	• Consent Agenda	Commission	A. Regular Board Meeting Minutes 11/28/2023 (FA) B. Warrants & Vouchers (October& November) (FM) C. Bad Debt & Charity Care (FM) D. Finance Committee Minutes 12/14/2023 (FA)
3:00	• Executive Session		A. To consider information regarding staff privileges or quality improvement committees under RCW 70.41.205 and RCW 42.30.110(1)(o)
3:45	• Reports	L. Sahlinger B. Truman R. Montgomery A. Edwards B. Truman A. Edwards S. Ottley S. Ottley Commission	A. Med Staff Report & Credentialing (FM) B. Financial Committee Report (FA) i. OB Service Line/OB Staffing i. OB RN Contract (FM) ii. Auditors iii. Charity Care Policy Changes C. CEO Report (FI) i. Capital Projects D. Strat Plan KPI Report (FI) E. Board Advocacy (FI)
4:45	• New Business	Commission S. Ottley S. Ottley S. Ottley S. Ottley Commission L. Sahlinger S. Ottley J. LaPorte	A. Resolutions *a.* 2023-7 *2024 Board of Commissioners Meeting Dates* (FR) b. 2023-8 2024 *Legal Holidays* (FR) B. Policies: a. Cardiac, Stroke & Trauma Quality Improvement Plan (FI) b. End of Life Care (FI) c. 2024 Nurse Staffing Plan (FM) d. Board of Commissioners Continuing Education (CAH) (FI) e. Credentialing Policy (FI) f. Conflict of Interest Policy (FI) C. Year End Board Community Message (FI)
5:30	• Roundtable /Action Items	Commission	
5:35	• Public Comment		
5:45	• Executive Session		A. Evaluate the performance of a public employee. RCW 42.30.110(1)(g)

			B. To discuss with legal counsel representing the agency matters relating to agency enforcement actions. RCW 42.30.110(1)(I)
6:15	• Adjournment		

Board Calendar Reminders:

12/6/2023	Compliance, Privacy, & Risk Committee	1212 Conference Room	10 am – 11 am
12/14/2023	Med Staff	Bragg Room/ TEAMS	7:15 am – 9 am
12/14/2023	Quality Committee	Bragg Room/ TEAMS	1 pm – 3 pm
12/14/2023	Finance Committee	Bragg Room/ TEAMS	11 am
12/19/2023	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

1/3/2024	Compliance, Privacy, & Risk Committee	1212 Conference Room	10 am – 11 am
1/8/2024	TBA (Special Meeting of the Board)	Bragg Room/ TEAMS	9 am
TBA	Med /OB Staff	TBA	TBA
TBA	Quality Committee	TBA	TBA
1/18/2024	Finance Committee	TBA	TBA
TBA	Regular Board Meeting	TBA	TBA

Chelan County Public Hospital District No. 2
Regular Meeting of the Board of Commissioners
Meeting Minutes 11/28/2023 1:30 pm in person and via Microsoft TEAMS

Commission Attendance:

(☐ not present ☒ present)

☒Mary Murphy, Secretary via TEAMS ☒Jordana LaPorte, Chair	☒Doug Gibson ☒Barbara Jensen arrived at 4pm	☒Lori Withrow, Vice Chair

Staff Participants: A. Edwards, B. Truman, S. Ottley, A. Benegas, R. Montgomery, M. Hillman, L. Sahlinger, B. McCracken, L. Simons,
Community Members: L. England

Recorder: Wendy Kenck

Agenda Item	Topic/Action
1. Call to Order	• J. LaPorte called the meeting to order at 1:32 pm and recited the mission statement.
2. Public Comment	• No public comment
3. Chair's Report	• J. LaPorte extended congratulations on the first anniversary of the building and expressed gratitude for the efforts in resolving the issues.
4. Consent Agenda	• Edits to the Consent Agenda: o Correction of spelling for J. LaPorte's name on the 10/24/23 Minutes o Clarification that the Governance Committee meeting was held in person o Removal of the Warrants & Vouchers (FM) item. o M. Murphy motioned to accept the Consent Agenda with suggested edits, seconded, motion approved
5. Reports	• M. Murphy verified all credential files are complete for the proposed list of providers and motioned to approve the appointments and removals as presented by B. McCracken, seconded, motion passed. • B. Truman presented October's Unaudited Finance Report o M. Murphy motioned to accept October's unaudited Finance Report, seconded, motion approved. • Surgical large power is budgeted in the approved 2024 budget, however the current one is out of service and the need is urgent. o L. Withrow motion to approve the 3 Stryker quotes, with a total cost not to exceed $260K, seconded, motion approved. • M. Murphy showcased the update of the Board and CEO Decision Matrix. o Changes: Item 30 first column change to (I), Item 38 first column change to (I) and last column to (D) o D. Gibson motion to adopt the Board and CEO Matrix Policy as presented and amended, seconded, approved. • A. Edwards presented a CEO update (included in packet) and an update from Forte Architecture document. o Discussion regarding the TIF and issues/solutions moving forward.

	• M. Hillman discussed his process for integration into the Chief Medical Officer (CMO) role. The primary focus of the plans moving forward is to deliver excellent care to the community while emphasizing competency maintenance, broadening skills, and ensuring efficiency of the providers. • S. Ottley presented the Board KPI Matrix, explaining the adjustments to the Aggregate Quality measurement with changes to the weight and tracking measures being implemented.
6. Old Business	• Completion and photography of the Inventory of Artifacts were reported. • Highland Campus zone change - Attendance at the City Planning Committee for the text amendment was noted, and the process is set to move to the city council for approval. • Changes to the LCH Board Orientation Policy were discussed, specifically the addition of certification training to be reported and tracked by the Executive Assistance o M. Murphy motioned to accept the policy as revised, seconded, and approved. • D. Gibson motioned to adopt the Complaint and Grievance Resolution Policy and Procedure, seconded, motion passed
7. New Business	• L. Sahlinger presented an updated version of the Tort Claims Policy. o M. Murphy motioned to approve the Tort Claims Policy, seconded, motion approved • D. Gibson motioned to approve the Equipment Disposal list as presented, seconded, motion approved.
8. Roundtable/Action Items	• B. Truman to reach out to Joe regarding representative at the Health and Wellness Foundation Meeting on Dec. 7th. • D. Gibson to attend the Foundation Meeting on Dec. 7th as a Board representative. • W. Kenck to upload the edited CEO Policy and Matrix into Policy Stat to review annually in October. • A. Edwards to attend the Dec 7th meeting with the city and Forte Architecture • Gift Policy to be added to the Board agenda in January (FM) • Edwards to contact the Museum regarding the three paintings located at the Highland Campus for display on loan • W. Kenck to draft Resolution for 2024 Holidays and update the task calendar
9. Public Comment	• No public comment
10. Executive Session	• J. LaPorte announced executive session at 4:00 pm for 60 minutes to evaluate the performance of a public employee. RCW 42.30.110(1)(g) and to consider the minimum price at which real estate will be offered for sale or lease. RCW 42.30.110(c) • L. Withrow extended the Executive Session 30 minutes. • Executive Session ended at 5:30 pm
11. Adjournment	• No action was taken as a result of the Executive Session • J. LaPorte adjourned the meeting at 5:31 pm

Attest:

_____ _____

M. Murphy, Secretary Aaron Edwards, CEO

_____

W. Kenck, Executive Assistant

WARRANT #'S A/P		AMOUNT		CAPITAL	BOARD MTG -2023	*NEW HOSPT AMNT FROM CKRN*	WARRANT#'S PAYROLL		AMOUNT	
233429-233571	$	159,842.57			10/13/2023		77510	$	1,020.78	10/16/2023
233572-233654	$	294,545.13	$	566,334.12	10/20/2023		DIRECT DEPOSIT	$	492,187.36	10/21/2023
233655-233717	$	453,857.35			10/26/2023		DIRECT DEPOSIT	$	498,586.06	11/4/2023
	$	*908,245.05*	*$*	*566,334.12*				*$*	*991,794.20*	

231608-231659	$	376,886.55	ck 231629 voided			DIRECT DEPOSIT	$	443,777.28	
231660-231727	$	189,869.53							
231728-231773	$	371,193.54							
231774-231851	$	225,571.07							
231852-231877	$	5,890.62							
231878-231953	$	235,252.88							
	$	1,543,037.50		$	23,094.11		$	874,691.14	

WARRANT #'S A/P		AMOUNT	BOARD MTG -JUNE 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL		AMOUNT	
231954-232029	$	328,567.74			DIRECT DEPOSIT	$	434,900.90	5/6/2023
232030-232107	$	419,419.71	wasted cks 232062,232085&232106		DIRECT DEPOSIT	$	456,697.46	5/20/2023
232108-232155	$	187,332.83			CK# 77497	$	6,359.90	5/6/2023
					DIRECT DEPOSIT	$	467,589.05	6/3/2023
	$	*935,320.28*				$	*1,365,547.31*	

WARRANT #'S A/P		AMOUNT	BOARD MTG -JULY 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL		AMOUNT	
232156-232228	$	152,577.70	6/8/2023		DIRECT DEPOSIT	$	434,216.82	6/17/2023
232229-232240	$	4,130.34	6/9/2023		DIRECT DEPOSIT	$	444,917.43	7/1/2023
232241-232311	$	195,280.23	6/15/2023		77498	$	305.84	7/10/2023
232312-232408	$	268,413.06	6/22/2023					
232409-232453	$	433,573.78	6/29/2023					
232454-232528	$	185,488.77	7/7/2023					
232529	$	1,178.55	7/12/2023					
232530-232600	$	195,894.10	7/13/2023					
	$	*1,436,536.53*				$	*879,440.09*	

WARRANT #'S A/P		AMOUNT	BOARD MTG - AUGUST 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL		AMOUNT	
232601-232661	$	257,729.27	7/21/2023		DIRECT DEPOSIT	$	456,606.12	7/15/2023
232662-232704	$	375,670.14	7/27/2023		DIRECT DEPOSIT	$	467,927.79	7/29/2023
232705-232776	$	222,950.65	8/4/2023					
	$	*856,350.06*				$	*924,533.91*	

WARRANT #'S A/P		AMOUNT	BOARD MTG - SEPTEMBER 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL		AMOUNT	
232777-232902	$	190,644.71	8/11/2023		DIRECT DEPOSIT	$	464,478.03	8/12/2023
232903	$	51.06	8/14/2023		77499	$	1,481.98	8/18/2023
232904-232975	$	242,049.16	8/18/2023	$ 470,362.77	DIRECT DEPOSIT	$	522,975.44	9/1/2023
232976-233029	$	371,672.85	8/24/2023					
233030-233035	voided/miss fed checks							
233036-233043	$	197,480.50	8/31/2023					
233044-233083	$	121,494.90	9/5/2023					
233084-233146	$	291,815.36	9/8/2023					
233147-233151	voided checks for CPSI to test new signatures							
	$	*1,415,408.54*		$ *470,362.77*		$	*988,935.45*	

WARRANT #'S A/P		AMOUNT	BOARD MTG -OCTOBER 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL		AMOUNT	
233152-23322	$	284,368.92	9/15/2023		77500-77502	$	7,049.03	9/5/2023
233223-223224			voided cks/miss fed		77503-77507	voided checks for CPSI to test new signatures		
233225-233299	$	308,699.31			DIRECT DEPOSIT	$	489,562.53	9/15/2023
233300-233359	$	357,477.75	9/29/2023		77508	$	439.51	9/15/2023
233360-233362	$	28,303.00	10/5/2023		DIRECT DEPOSIT	$	511,470.19	9/23/2023
233363-233428	$	214,145.35	10/9/2023		77509	$	250.27	10/2/2023
					DIRECT DEPOSIT	$	492,159.68	10/7/2023
	$	*1,193,014.33*				$	*1,500,931.21*	

WARRANT #'S A/P		AMOUNT	BOARD MTG - Dec 2022	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL	AMOUNT
229665-229693				$ 444,168.97	Direct Deposit	$ 441,022.70
229694-229766	$	185,380.45			Direct Deposit	$ 435,739.06
229767-229781	$	6,000.00		$ 441,268.80	77494	$ 345.91
229782-229836	$	220,410.54				
229837	$	3,120.00				
229838-229840	$	188,361.88				
229841-229931	$	261,021.87				
229932-230006	$	202,550.75		$ 6,045.38		
	$	*1,066,845.49*		$ *891,483.15*		$ *877,107.67*

WARRANT #'S A/P		AMOUNT	BOARD MTG - JAN 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL	AMOUNT	
230007-230008				$ 1,280,194.19	Direct Deposit	$ 457,338.94	
230009-230028				$ 186,125.43	Direct Deposit	$ 429,594.68	
230029-230099	$	206,773.64					
230100-230164	$	228,748.04		$ 12,936.07			
230165-230262	$	266,670.18					
230263-230264	$	50,044.35					
230265	$	22,681.98					
	$	*774,918.19*		$ *1,479,255.69*		$ *886,933.62*	

WARRANT #'S A/P		AMOUNT	BOARD MTG - FEB 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL	AMOUNT	
230266-230283	$	39,586.84		$ 309,869.12	DIRECT DEPOSIT	$ 437,765.28	
230284-230377	$	255,994.20			DIRECT DEPOSIT	$ 425,799.49	
230378-230379	$	1,285.03					
230380-230459	$	169,801.83					
230460-230464				$ 77,152.44			
230545-230553	$	4,617.42		$ 221,986.92			
230554-230632	$	266,504.64					
230633-230634	$	185,650.64					
230635-230637	$	-		$ 31,166.06			
230638-230713	$	219,549.97					
230714-230818	$	195,854.97		$ 61,165.00			
	$	*1,338,845.54*		$ *701,339.54*		$ *863,564.77*	

WARRANT #'S A/P		AMOUNT	BOARD MTG - MARCH 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL	AMOUNT	
230819-230882	$	217,873.74			DIRECT DEPOSIT	$ 441,319.63	
230883-230952	$	250,722.50			DIRECT DEPOSIT	$ 409,661.70	
230953-230955	$	248,439.43			DIRECT DEPOSIT	$ 431,514.04	
230956-230961				$ 483,341.34	77495	$ 809.72	
230962-231043	$	24,696.06					
231044-231124	$	189,074.90					
231125-231216	$	26,944.04					
231217-231277	$	655,017.93					
231278-231354	$	174,812.85					
231355-231357	$	16,304.16					
	$	*1,803,885.61*		$ *483,341.34*		$ *1,283,305.09*	

WARRANT #'S A/P		AMOUNT	BOARD MTG - APRIL 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL	AMOUNT	
231358-231435	$	269,944.06	ck 231401 voided	$ 3,000.00	77496	$ 1,379.84	
231436-231534	$	405,383.34		$ 187,083.81	DIRECT DEPOSIT	$ 465,483.63	
231535-231538	$	20,550.95					
	$	*695,878.35*		$ *190,083.81*		$ *466,863.47*	

WARRANT #'S A/P		AMOUNT	BOARD MTG -MAY 2023	NEW HOSPT AMNT FROM CKRN	WARRANT#'S PAYROLL	AMOUNT	
231539-231607	$	138,373.31		$ 23,094.11	DIRECT DEPOSIT	$ 430,913.86	

WARRANT #'S A/P		AMOUNT		CAPITAL	BOARD MTG - Dec 2023	*NEW HOSPT AMNT FROM CKRN*	WARRANT#'S PAYROLL		AMOUNT	
233718-233795	$	340,793.59	$	16,803.88	11/2/2023					
233796-233890	$	212,808.29	$	13,618.05		$ 220,374.46	DIRECT DEPOSIT	$	498,907.23	11/18/2023
233891-233997	$	432,587.89			11/16/2023		DIRECT DEPOSIT	$	492,077.01	12/2/2023
233998-233999	$	73,883.22			11/21/2023					
234000-234003	$	1,733.88			11/22/2023					
234004-234092	$	479,872.93			11/30/2023					
234093	$	12,950.00			12/1/2023					
234094-234096	$	25,803.00			12/4/2023					
234097-234171	$	125,590.87			12/8/2023					
	$	*1,706,023.67*	*$*	*30,421.93*		*$ 220,374.46*		*$*	*990,984.24*	

DATE November 2023

TOTAL BAD DEBTS - HOSPITAL $96,508.33
TOTAL MEDICARE BAD DEBTS $5,339.10
TOTAL BANKRUPTCY $0.00
TOTAL CHARITY CARE – HOSPITAL $22,254.61
TOTAL MEDICARE CHARITY CARE - $5,984.08

TOTAL ATTESTATION $130,086.12

I, The undersigned, do hereby certify that the accounts, as described on the attached "bad debt list", have been duly examined and have been duly processed in accordance with the hospital credit/collection policies. It is hereby submitted and recommended to the Governing Board that the said accounts be turned over to outside professional collector (s) as indicated on the attached list.

BOARD DESIGNATED AUDITOR_____DATE:_____

BOARD APPROVAL

DATE:_____

CHAIR_____

VICE CHAIR_____

SECRETARY_____

MEMBER_____

MEMBER_____

ATTEST. ADMINISTRATOR_____

Form 02-a Revised 4-26-95

LAKE CHELAN HEALTH

Unaudited Financial Statements

for

For the month ended November 30, 2023

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Balance Sheet

Lake Chelan Health

	Current Month 11/30/2023 unaudited	Prior Year 12/31/2022 Audited	Prior Year 11/30/2022 Unaudited
ASSETS:			
CASH	218,988	$ 444,782	$ 2,079,739
PATIENT RECEIVABLES	9,945,935	7,739,790	$ 7,494,785
LESS: RESERVES FOR ALLOWANCES	(5,439,662)	(4,019,725)	$ (3,825,391)
NET PATIENT ACCOUNTS RECEIVABLES	4,506,273	3,720,065	3,669,394
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	(400,790)	30,129	(947,080)
OTHER RECEIVABLES	(201,842)	331,898	681,125
INVENTORIES	221,673	230,102	223,399
PREPAID EXPENSES	292,446	231,742	213,314
TOTAL CURRENT ASSETS	$ 4,636,748	$ 4,988,718	$ 5,919,892
GENERAL RESERVES	$ 1,636,767	1,157,151	$ 2,268,913
Unrestricted Reserves	$ 3,360,592	4,007,377	$ 3,979,166
Internally Restricted Reserves	$ 4,139,524	4,139,524	$ 4,139,524
2018 BONDS	0	30	$ 30
USDA 2023	136,800	0	$ -
Bond Payment Transfer	465,978	0	$ -
TOTAL LIMITED USE ASSETS	$ 9,739,662	$ 9,304,083	$ 10,387,633
LAND	$ 4,787,901	4,787,901	$ 4,787,901
LAND IMPROVEMENTS	5,543,846	5,543,846	$ 5,141,340
BUILDINGS & IMPROVEMENTS	986,252	986,252	$ 986,252
EQUIPMENT	10,648,303	9,707,341	$ 7,310,328
SOFTWARE	2,185,697	2,159,033	$ 2,159,033
NEW HOSPITAL	43,928,486	43,901,486	$ -
CONSTRUCTION-IN-PROGRESS - NEW HOSPITAL	671,774	375	$ 42,730,331
CONSTRUCTION-IN-PROGRESS - HOSPITAL	15,378	18,290	$ 444,081
GROSS PROPERTY, PLANT, & EQUIPMENT	68,767,637	67,104,525	63,559,266
LESS: ACCUMULATED DEPRECIATION	(18,203,321)	(15,132,160)	$ (14,334,905)
NET PROPERTY, PLANT, & EQUIPMENT	$ 50,564,316	$ 51,972,365	$ 49,224,361
DEFERRED ITEMS	2,482,403	2,500,062	$ 2,942,423
TOTAL ASSETS	**$ 67,423,128**	**$ 68,765,227**	**$ 68,474,309**
LIABILITIES:			
ACCOUNTS PAYABLE	$ 501,574	2,045,407	2,111,379
ACCRUED PAYROLL	540,515	750,276	391,594
ACCRUED VACATION/HOLIDAY/SICK PAY	515,057	506,864	484,629
PAYROLL TAXES PAYABLE	39,919	44,673	30,481
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	-	30,129	0
OTHER CURRENT LIABILITIES	1,039,752	605,242	379,237
INTEREST PAYABLE	560,321	95,395	536,500
CURRENT PORTION OF LTD (BONDS/MORTGAGES)	1,001,831	1,001,831	570,000
LINE OF CREDIT	0	0	0
SBA Payroll Protection	0	0	0
CMS Advanced Payments	0	0	0
CMS Stimulus	0	0	1,514,370
TOTAL CURRENT LIABILITIES	$ 4,198,969	$ 5,079,817	$ 6,018,190
CAPITALIZED LEASES	$ -	$ -	$ -
2018 BONDS	$ 19,018,009	19,026,399	19,292,077
2013 BONDS	5,022,850	5,018,123	5,372,693
USDA LOANS	18,172,616	18,548,916	19,776,000
LEASES	1,827,965	1,827,965	396,193
PAID LEAVE - LT PORTION	330,176	304,376	299,828
TOTAL LONG TERM LIABILITIES	$ 44,371,615	$ 44,725,778	$ 45,136,791
DEFERRED ITEMS	$ 3,922,975	3,922,975	3,914,454
TOTAL LIABILITIES	$ 52,493,558	$ 53,728,570	$ 55,069,435
FUND BALANCE:			
UNRESTRICTED FUND BALANCE	$ 15,036,657	10,904,602	10,915,592
TEMPORARY RESTRICTED FUND BALANCE	$ -	0	0
YTD Net Revenue/(Expenses)	(107,087)	4,132,056	2,489,282
TOTAL NET ASSETS	$ 14,929,570	$ 15,036,658	$ 13,404,874
TOTAL LIABILITIES AND NET ASSETS	**$ 67,423,128**	**$ 68,765,227**	**$ 68,474,309**

Statement of Revenue and Expense
Lake Chelan Health

For the month ended November 30, 2023

	CURRENT MONTH					
	Actual 11/30/23	Budget 11/30/23	Positive (Negative) Variance		Prior Year 11/30/22	Incr/(Decr) from 2022 to 2023
GROSS PATIENT SERVICE REVENUES						
INPATIENT	$ 582,740	$ 672,051	(89,311)	-13%	$ 673,062	-13.4%
OUTPATIENT	4,769,455	3,267,924	1,501,531	46%	2,673,597	78.4%
TOTAL PATIENT SERVICE REVENUES	5,352,196	3,939,975	1,412,221	36%	3,346,660	59.9%
DEDUCTIONS FROM REVENUE						
CONTRACTUAL ALLOWANCES	(2,313,450)	(1,570,031)	(743,419)	47%	(1,296,931)	
BAD DEBT	(101,847)	0	(101,847)	0.00%	0	
CHARITY	(28,239)	0	(28,239)	0.00%	0	
TOTAL DEDUCTIONS FROM REVENUES	(2,443,536)	(1,570,031)	(873,505)	-56%	(1,296,931)	88.4%
	45.7%	39.8%			38.8%	
NET PATIENT SERVICE REVENUES	2,908,660	2,369,944	538,716	23%	2,049,729	41.9%
OTHER OPERATING REVENUES	19,766	19,402	364	2%	168,718	-88.3%
TOTAL OPERATING REVENUES	**2,928,426**	**2,389,346**	539,080		**2,218,446**	32.0%
OPERATING EXPENSES						
SALARIES/WAGES	1,519,386	1,311,023	(208,363)	-16%	1,246,953	21.8%
EMPLOYEE BENEFITS	276,965	290,241	13,276	5%	252,861	9.5%
PROFESSIONAL SERVICES	110,485	77,758	(32,727)	-42%	80,889	36.6%
FOOD SUPPLIES	15,304	14,349	(955)	-7%	18,895	-19.0%
MINOR EQUIPMENT	10,858	11,760	902	8%	21,061	-48.4%
SUPPLIES	200,236	151,008	(49,228)	-33%	154,093	29.9%
PLANT UTILITIES	32,424	43,253	10,829	25%	33,704	-3.8%
PURCHASED SERVICES	263,872	253,707	(10,165)	-4%	269,968	-2.3%
REPAIR/MAINTENANCE	91,261	76,892	(14,369)	-19%	72,947	25.1%
PUBLIC RELATIONS/RECRUITM	8,235	7,770	(465)	-6%	32,063	-74.3%
RENT/LEASES	61,869	28,616	(33,253)	-116%	38,038	62.6%
INSURANCE	71,715	34,003	(37,712)	-111%	36,652	95.7%
LICENSES/TAXES	24,585	14,684	(9,901)	-67%	22,677	8.4%
DUES/SUBSCRIPTIONS/OTHER	36,654	38,350	1,696	4%	45,101	-18.7%
TRAVEL/TRAINING	7,689	15,567	7,878	51%	9,361	-17.9%
DEPRECIATION	321,390	240,569	(80,821)	-34%	42,605	654.4%
TOTAL OPERATING EXPENSES	**3,052,926**	**2,609,550**	**(443,376)**	-17.0%	**2,377,867**	28.4%
NET OPERATING SURPLUS (LOSS)	**(124,501)**	**(220,204)**	**95,703**		**(159,420)**	-21.9%
NON-OPERATING REVENUES	207,299	169,292	38,007		258,798	-19.9%
GIFTS & GRANTS	0		0		11,072	-100.0%
PANDEMIC GRANTS PPP LOAN FORGIVENESS	0	0	0		800,000	
NET INCOME	82,798	(50,912)	133,710		910,450	-90.9%
margin	2.8%	-2.1%			41.0%	
TOTAL NET INCOME (LOSS)	**$ 82,798**	**$ (50,912)**	**133,710**		**$ 910,450**	-90.9%

unaudited

Statement of Revenue and Expense
Lake Chelan Health

For the month ended November 30, 2023

	YEAR-TO-DATE					
	Actual 11/30/23	Budget 11/30/23	Positive (Negative) Variance		Prior Year 11/30/22	Incr/(Decr) from 2022 to 2023
GROSS PATIENT SERVICE REVENUES						
INPATIENT	$ 6,564,678	$ 7,458,420	(893,742)	-12%	$ 7,018,789	-6.5%
OUTPATIENT	43,203,834	36,267,439	6,936,395	19%	30,122,445	43.4%
TOTAL PATIENT SERVICE REVENUES	49,768,512	43,725,859	6,042,653	14%	37,141,234	
DEDUCTIONS FROM REVENUE						
TOTAL DEDUCTIONS FROM REVENUES	(18,578,534)	(17,424,209)	(1,154,325)	7%	(14,335,944)	
BAD DEBT	(941,224)	0	(941,224)	0.00%	0	
CHARITY	(395,241)	0	(395,241)	0.00%	0	
TOTAL DEDUCTIONS FROM REVENUES	(20,776,561)	(17,424,209)	(3,352,352)	-19%	(15,197,507)	36.7%
	41.7%	39.8%			40.9%	
NET PATIENT SERVICE REVENUES	28,991,951	26,301,650	2,690,301	10%	21,943,727	32.1%
OTHER OPERATING REVENUES	252,702	213,422	39,280	18%	569,480	-55.6%
TOTAL OPERATING REVENUES	**29,244,653**	**26,515,072**	2,729,581	10%	**22,513,207**	
OPERATING EXPENSES						
SALARIES/WAGES	15,515,135	14,596,058	(919,077)	-6%	13,666,972	13.5%
EMPLOYEE BENEFITS	3,196,261	3,231,352	35,091	1%	2,818,787	13.4%
PROFESSIONAL SERVICES	1,037,736	855,338	(182,398)	-21%	1,195,102	-13.2%
FOOD SUPPLIES	164,094	157,839	(6,255)	-4%	161,622	1.5%
MINOR EQUIPMENT	139,860	129,360	(10,500)	-8%	83,180	68.1%
SUPPLIES	2,052,101	1,675,890	(376,211)	-22%	1,483,300	38.3%
PLANT UTILITIES	358,018	475,783	117,765	25%	234,064	53.0%
PURCHASED SERVICES	3,333,635	2,790,777	(542,858)	-19%	2,829,256	17.8%
REPAIR/MAINTENANCE	869,543	845,812	(23,731)	-3%	765,020	13.7%
PUBLIC RELATIONS/RECRUITMENT	95,607	85,470	(10,137)	-12%	314,126	-69.6%
RENT/LEASES	618,320	314,776	(303,544)	-96%	448,602	37.8%
INSURANCE	355,449	374,033	18,584	5%	295,886	20.1%
LICENSES/TAXES	185,570	161,524	(24,046)	-15%	129,051	43.8%
DUES/SUBSCRIPTIONS/OTHER	412,616	421,850	9,234	2%	407,108	1.4%
TRAVEL/TRAINING	79,856	171,237	91,381	53%	92,489	-13.7%
DEPRECIATION	3,443,080	2,646,259	(796,821)	-30%	619,424	455.9%
TOTAL OPERATING EXPENSES	**31,856,881**	**28,933,358**	**(2,923,523)**	-10.1%	**25,543,987**	24.7%
NET OPERATING SURPLUS (LOSS)	**(2,612,228)**	**(2,418,286)**	**(193,942)**		**(3,030,780)**	-13.8%
NON-OPERATING REVENUES	2,246,515	1,862,212	384,303		2,377,546	-5.5%
GIFTS & GRANTS	258,625		258,625		342,515	-24.5%
PANDEMIC GRANTS PPP LOAN FORGIVENESS	0	0	0		2,800,000	-100.0%
NET INCOME	(107,088)	(556,074)	448,986		2,489,281	-104.3%
margin	-0.4%	-2.1%			11.1%	
TOTAL NET INCOME (LOSS)	**$ (107,088)**	**$ (556,074)**	**$ 448,986**		**$ 2,489,281**	-104.3%

unaudited

Patient Statistics

Lake Chelan Health

For the month ended November 30, 2023

= or > 90% of budget
= or > 70% of budget
< 70% of budget

Actual vs Budget	Current Month 11/30/23	BUDGET	STATISTICS	Actual vs Budget	Last Year Month 11/30/22	BUDGET
	117	120	Total Days Cash on Hand		168	120
	49	40	Net AR Days		48	40
	2.58	1.25	Debt Coverage Ratio		7.96	1.25
	188	175	Payroll FTEs		178	175

Actual vs Budget	Current Month Actual 11/30/23	Prior Year 11/30/22	BUDGET	STATISTICS	Actual vs Budget	Year-To-Date Actual 11/30/23	Prior Year 11/30/22	BUDGET
				Admissions				
NA	19	24	NA	medical	NA	191	207	NA
NA	0	0	NA	surgical	NA	0	0	NA
NA	6	10	NA	OB	NA	90	85	NA
NA	25	34	NA	Acute	NA	281	292	NA
NA	9	11	NA	Swing Bed	NA	74	82	NA
NA	6	8	NA	Total Deliveries	NA	90	86	NA
				Patient Days				
	42	59	60	medical		515	639	662
NA	0	0	NA	surgical	NA	0	0	NA
	16	17	14	OB		177	152	151
	58	76	73	Acute		692	791	813
	71	103	82	Swing Bed		691	901	914
	9	11	11	Total Newborn Days		127	126	127
	138	190	167	TOTAL PATIENT DAYS		1510	1818	1854
				Average Length of Stay				
	2.3	2.2		Total Inpatient		2.5	2.7	
	7.9	9.4		Swing Bed		9.3	11.0	
				Avg Daily Census - Hospital				
	1.9	2.5		Total Inpatient		2.1	2.4	
	2.4	3.4		Swing Bed		2.1	2.7	
	4.3	6.0		Total		4.1	5.1	
	546	451	530	ED Visits		6305	5331	5881
	66	35	58	Surgeries		542	457	649
	1303	644	1001	Imaging Procedures		12349	9144	11110
	3047	2670	3064	Lab Tests		33537	32809	34002
	631	514	445	Rehab Visits		6506	5472	4934
	128	123	132	EMS Runs		1413	1433	1462
	784	817		Clinic Visits		8834	6223	
	155	27		Specialty		1058	863	
	139			Primary care		1471	0	
	490	676		Express clinic		6305	5360	
	22	21		working days		238	235	

Note #1 Contractuals

Contractuals do not include reimbursement that will happen when cost report is filed. AR
increased by $437k from October to November
$79k of the increase is in the Private Pay AR which also is allowed for at a signicantly higher contractual percentage of 75%
Revenues are 14% higher than budgeted

Note #2 SALARIES AND WAGES

ED physician hourly rate was increased for FT only- also affects pto accrual
Nursing wage increases happened in April, others happened after
Dietary - two positions that were not in the budget
Community Health Workers and Support Services have grant related positions that were not budgeted - we received reimbursement through a grant (will show other non-operating)
There were a few new positions, along with wage increases that happened in 2023. These have been added to the 2024 budget.

Note #3 PROFESSIONAL SERVICES

UW Residency Jan - Oct $172k not budgeted
Radiology Pro Fees $484,993 budget $343,750
Other departments are under budget

Note #4 MINOR EQUIPMENT AND SUPPLIES

EMS - defibrillator and pads - new ambulances Dietary - refrigerator
Dietary $50,933 budget $24,671 Food $6k over budget
PT $34,794 budget $13,704
Materials Tagged Supplies $566,857 budget $254,784 (volumes up)
ED $91,638 budget $50,251 (volumes up)
Purchasing $49,588 budget $18,273

Note #5 PURCHASED SERVICES

Lab - $625,800 expense, budget $320,833 traveler's expense
IT $564,174 budget $137,500 Scaled Data Contract
Anesthesia and Opthamology are a total of $285k below budget, other areas are also under budget
Accounting $148k budget $124k. New Hosp Project $38k and Cost Based Amb Reporting and Feasibility Study etc.

Note #6 RECRUITMENT

Clinic - Recruitment of Mid Level $15k

Note #7 RENT/LEASES

Building rent costs are evenly spread over 12 months. The plans to move the clinic to the
hospital changed and this expense will be over budget
Clinic $182k budget $90k
Radiology- $211k expense, budget $2k - rent expense for old CT Scan removed in February- expense had to be paid through April, new MRI rent started in May
Plant $58k budget $25k still occupying the modular

Note #8 LICENSES/TAXES

The increase in revenue has resulted in an increase in b&o taxes

Note #9 DEPRECIATION

Accrual was booked using a 25 year life ($148k / month) Cost Segregation Study shortens the overall life to 16.58 years. New monthly accrual is $227k/month.
Change from Jan - July of $552k was booked in August

Statement of Cash Flows

Lake Chelan Health

For the month ended November 30, 2023

10/31/2023	GL ACCOUNT #	ACCT DESCRIPTION	11/30/2023	EXPLANATION	
		General Fund Cash In Bank			
$118,359	10002000	(North Cascades)	$186,280	**$67,920**	
				$2,874,739	deposits
				$0	grant
				$0	gemt cost report
				($5,160)	tsys/payplus fees
				($1,822)	fees mckesson/cardinal
				($33)	fees and interest
					rebates
				$2,196	café sales
				($2,802,000)	transfer to county
		General Fund Cash w/			
$434,850	10004000	Treasurer	$559,240	**$124,390**	
				($1,792,476)	AP
				$0	Voids
				$1,792,476	warrants issued
				($1,532,464)	warrants redeemed
				$2,802,000	Bank Transfers from 10002000
				$320,000	Bank Transfer from 10760000
				($88,992)	Bank Transfer for USDA pmt
				($1,430,246)	Payroll/Benefits
				($12,700)	B&O taxes
				$47,713	Property Taxes
				$19,078	Leasehold Taxes & Misc Taxes
				$0	Bond Fee
					pmts reclassed when supporting documentation was
$25,813	10009000	cash clearing	$27,233	**$1,420**	received
($293,752)	20070000	warrants outstanding	($553,765)	**($260,013)**	
				($997,493)	remits (payroll/benefits/b&0)
				$1,532,464	warrants redeemed
				($1,792,476)	warrants issued ap
				$997,493	remits redeemed
				$0	voids
$1,303,894	10106000	AMB RESERVE	$605,867	**($698,027)**	
				($785,978)	transfer for 12/1 bond pmts
				$87,644	property taxes
				$297	leasehold taxes
				$9	interest
$966,047	10910000	2018 GO BOND	$1,030,869	**$64,822**	
				$64,822	property taxes
$31	10911000	2018 CASH BOND	$31	**$0**	interest
$106,800	10916000		$106,800	**$0**	
$30,000	10917000		$30,000	**$0**	
$136,800			$136,800		
					12/1 bond pmt
$0	10915000	CASH/TREAS LTGO BOND	$465,978	**$465,978**	transfer
$7,466,904	10760000	RESERVES	$7,500,116	**$33,213**	
				$33,213	interest
$10,158,947			$9,958,650	**($200,298)**	

CEO Board Report (as of 12/14/2023)

People:

- Starting in January, we will be able to staff MRI Monday through Friday. Our MRI services are currently as busy as ever.
- The Lab now has no contract workers, which will be a substantial savings for the facility.
- We continue to search for an OB nurse with high-cost contracts, attempting to find travelers without success. The shortage of staffing has frequently led us to OB divert this year and appears to pose a substantial challenge into 2024.
- Last month, we hosted a meeting with all staff to discuss bonuses, changes to PTO, and other matters.

Community:

- The Chelan City Council passed the text amendment to zoning, bringing us a few steps closer to the sale of the Highland campus.
- I attended the WSHA Rural Health Committee meeting in Seattle on 12/13. We are working on a bill that would provide a $350K grant to help offset substantial yearly losses in labor and delivery (-$635,435 loss in 2023). Additionally, there is a bill coming that would allow EMS to provide support services within the hospital to supplement during the summer surge days. I will continue to serve on the committee through 2024. I am also moving to vice chair for the Rural Health Collaborative.
- Anxious to start 2024 with a few new services expected in the later part of the year. Thankful for the return of Orthopedics, a more robust general surgery, add the addition of pain and plastic surgery.

Quality:

- DNV is in the building as I write this report. They are here for recertification, so we expect the inspection will be more in depth than usual.

Financial:

- Gross revenue for November was $5.3M vs $3.3M last year! Overall, the net revenue for November was -$83K. Year to date, we are just shy of $50M gross vs $37M last year. Our loss for the year stands at roughly -$107K. However, we received a 2021 cost report settlement in early December of roughly $600K which will likely push us into the black next month.
- Volumes are significantly up in surgery, imaging, rehab, ED, and lab. Express was down in November, but that could be attributed to primary care picking up express visits.

Building for the Future:

- Had a positive meeting with the city on our TI plan for the specialty clinic across the street. No major surprises or unreasonable expectations from the city.
- HR/Quality/Marketing will be moving to the business center once the workspace is complete (they are close).
- The business office will move to the clinic in February and EMS will move into the BO building for the duration of the EMS/Admin build.

LAKE CHELAN HEALTH	2023 Board of Commissioners KPI DASHBOARD								
	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
**KPI-5. By July 2023 50% of all wages will be within +/- 15% of the standard pay rage defined in the Wage Plan.				100%					
**KPI-8. 100% of all Leader's Meetings and All Staff Meetings will include a Values focus.	100%	100%	100%	100%	100%	100%	100%	100%	
**KPI-9. 100% of all new employee orientation will include a presentation related to LCH values.	100%	100%	100%	100%	100%	100%	100%	100%	
**KPI-10. Employee Satisfaction survey will include a question related to values knowledge (establish baseline).							100%		
** KPI-45. Aggregate Quality Score >90%		86.6%	85.6%	80.0%	86.4%	79.4%	70.0%	65.0%	0.0%
**KPI-47. Service line development / improvement metrics will be executed at => 77%		36%	27%	50%	45%	54%	61%	69%	0%
**KPI-68. Facility Master Plan complete by July 2023. Track to KPI-72 – KPI 76				100%					
**KPI-77. Meet 100% of the 5 key HFMA indicators					20%	40%	40%	20%	0%
**KPI-88. Complete 2 Community Forums 2023.						100%			
**KPI-92. Quarterly rounding / staff meeting attendance, by Administrative Staff.			100%			75%			

CHELAN COUNTY PUBLIC HOSPITAL DISTRICT #2
Lake Chelan Health
Chelan County, WA

RESOLUTION No. 2023-7

2024 Board of Commissioners Meeting Dates

A RESOLUTION of the Commission of Public Hospital District #2, Chelan County, Washington, establishing Board of Commissioners meeting dates and times for 2024, and;

WHERE AS, the District advertises all meeting dates on the website of Lake Chelan Health, and;

WHERE AS, the District normally meets on the fourth Tuesday of each month at 1:30 PM, and;

WHERE AS, the District changes the meeting dates for the months of June, November, and December 2024 from the fourth Tuesday due to holiday conflicts, and;

BE IT RESOLVED, the District shall post the meeting time for the following dates:

January 23	February 27
March 26	April 23
May 28	June 18
July 23	August 27
September 24	October 22
November 19	December 17

ADOPTED AND APPROVED, by the Board of Commissioners, Chelan County Public Hospital District #2, Chelan County, Washington, at an open public meeting thereof this 19th day of December 2023, with the following Commissioners being present and voting in favor of the resolution.

_____	_____
Chairman of the Board	Commissioner
_____	_____
Vice Chairman	Commissioner
_____	_____
Secretary	Chief Executive Officer

CHELAN COUNTY PUBLIC HOSPITAL DISTRICT #2
Lake Chelan Health
Chelan County, WA

RESOLUTION No. 2023-8
2024 Legal Holidays

A RESOLUTION of the Board of Commissioners of Public Hospital District No. 2, Chelan County, Washington (the 'District'), defining certain holidays during the year as recognized; and

WHEREAS RCW 1.16.050 amends the 'Legal Holidays' for calendar year 2024 adopted by the Washington State Legislature; now, therefore,

BE IT RESOLVED that the Board of Commissioners, Chelan County Public Hospital District No. 2 herby adopts and approves the recognition of the following Holidays from the 2024 calendar provided by Washington State Legislature.

New Year's Day

Memorial Day

Independence Day

Labor Day

Thanksgiving Day

Christmas Day

ADOPTED AND APPROVED, by the Board of Commissioners, Chelan County Public Hospital District No. 2, at an open public meeting thereof this 19the day of December 2023, with the following Commissioners being present and voting in favor of the resolution.

_____	_____
CHAIRPERSON OF THE BOARD	SECRETARY
_____	_____
VICE CHAIRPERSON	MEMBER
_____	_____
MEMBER	CEO

Status **Pending** PolicyStat ID **13898058**

Origination	1/1/2012
Last Approved	N/A
Effective	Upon Approval
Last Revised	9/20/2023
Next Review	2 years after approval
Owner	Bryce Kipp: ED Nurse Manager
Area	Emergency Department

Cardiac, Stroke & Trauma Quality Improvement Plan

I. Philosophy of the Cardiac, Stroke, and Trauma Service

The Lake Chelan Health Cardiac, Stroke, and Trauma Service is dedicated to providing cardiac, stroke and trauma care of the highest quality to the community and in alignment with the organization's mission statement and values.

II. Mission and Vision of the Cardiac, Stroke, and Trauma Quality Improvement Program

The Cardiac, Stroke, and Trauma Services will have a formal validated internal quality improvement program, which allows for a multidisciplinary approach to rapid problem identification, data-driven analysis, and resolution of issues within the quality framework of this institution.

III. Cardiac, Stroke, and Trauma Quality Improvement Program Leadership

The Cardiac, Stroke, and Trauma Quality Improvement Program is coordinated by the ED Nurse Manager and the Cardiac, Stroke, and Trauma Coordinator. Peer review is performed quarterly by Washington Hospital Services Healthcare Quality Services (WHS HQS), and Medical Staff QI occurs quarterly. The Clinical Quality Committee reviews cardiac, stroke, and trauma cases which are deemed a level three review by either the ED Medical Director, ED Nurse Manager, or program coordinator.

The Clinical Quality Committee has the authority to:

1. Evaluate and discuss cardiac, stroke, and trauma cases or other concerns brought forth by the ED Medical Director, ED Nurse Manager or program coordinator that occur during the continuum of care from pre-hospital to discharge.
2. Develop standards of quality for cardiac, stroke, and trauma care.
3. Monitor and review standards.
4. Implement and change care policies, procedures, and guidelines.
5. Take corrective measures for problems or deficiencies identified.
6. Analyze and evaluate the corrective measures taken.

The Cardiac, Stroke, Trauma Program Coordinator and ED Nurse Manager are responsible for:

1. Coordinating and facilitating the Cardiac, Stroke, and Trauma QI program.
2. Participating in the Clinical Quality Committee meetings.
3. Identifying and validating all potential cardiac, trauma, or stroke care issues.
4. Data analysis and identification of trends.
5. Ensuring documentation and tracking of QI discussions, decisions, actions, and evaluation with follow-up.
6. Coordinating surveillance of protocols, guidelines, and clinical pathways.
7. Participating in the Regional Trauma, Cardiac and Stroke QI.
8. Referring cases for peer review at Medical Staff QA Committee as indicated.
9. Maintaining the cardiac, trauma and stroke QI database/files with confidentiality.

IV. The Role of the Clinical Quality Committee

The Clinical Quality Committee is responsible for ensuring all standards of patient care are met. This committee has the authority to evaluate system issues in relation to patient care, quality issues, patient flow. CQC's authority and scope of responsibility is to:

1. Review, develop, and approve policy and procedure for trauma, cardiac, stroke and subsequent medical care.
2. Assure standards of care that are consistent throughout the hospital related to trauma, cardiac and stroke care.
3. Ensure regulatory standards are met.
4. Direct case review of cardiac, stroke and trauma cases, ensuring that the physician reviews his/her own case for evaluation of care and provides recommendations related to care.
5. Monitor, analyze, and use patient data to improve patient outcomes.

6. Plan and provide continuing cardiac, stroke and trauma education programs.

V. Reporting Structure

The ED Medical Director reports the action items to the medical staff QI committee and LCH Board of Commissioners. The ED Medical Director, ED Nurse Manager, and the program coordinator implement change and/or process improvements as indicated.

VI. Credentialing/Competency

Physicians who practice in the ED will be credentialed and proctored per Medical Staff policy and bylaws.

The RNs and ED Techs will maintain educational standards per hospital policy and yearly competencies.

VII. Clinical Quality Committee Team Members

Membership and Ad Hoc staff include representation from departments and services that provide cardiac, trauma, and stroke patient care. The following list includes all current members. If a member is unable to attend the CQC meeting, then an alternate may attend.

Member Status	Role
Chair	Director of Quality
Member	Emergency Department Medical Director
Member	Trauma, Cardiac, and Stroke Coordinator
Member	Emergency Department Nurse Manager
Member	CNO
Member	Director of Nursing Services
Member	Radiology Manager
Member	Nurse Educator
Member	Infection Prevention
Member	Lab Manager
Member	Surgical Services Manger
Member	EMS
Member	HIMS Manager

VIII. Cardiac, Stroke, and Trauma Patient Population Criteria

Cardiac is defined by the Washington State RCW 70.168.010 as acute coronary syndrome, and is used to cover any group of clinical symptoms compatible with acute myocardial ischemia, including chest

discomfort or other symptoms related to insufficient blood supply to the heart muscle that results from coronary artery disease. It also includes out of hospital cardiac arrest, (cessation of mechanical heart activity), or other acute heart conditions. Patients with any of the following discharge diagnoses will be a first level review:

1. STEMI (ST elevation myocardial infarction).
2. NSTEMI (Non-ST elevation myocardial infarction).
3. Chest Pain, A-fib (atrial fibrillation), or Shortness of Breath who transfer out of LCH.

Stroke is defined as an acute neurologic injury occurring as a result of one of the following pathologic processes: brain ischemia due to thrombosis, embolism, systemic hypoperfusion, or brain hemorrhage due to intracerebral hemorrhage or subarachnoid hemorrhage. Patients with any of the following discharge diagnoses will be reviewed:

1. Ischemic Stroke.
2. Transient Ischemic Attack (TIA).
3. Subarachnoid Hemorrhage.
4. Intracerebral Hemorrhage.
5. Stroke not otherwise specified.

The trauma patient is defined by the Washington State trauma plan as a victim of external cause of injury that results in major or minor tissue damage or destruction. More specifically, the trauma patient population criteria include all patients with a discharge ICD10-CM diagnosis code of S02.0XXA-S95.109A, S07.0XXA-T07.XXXA, T75.1XXA, T71.111-T71.123, T75.4XXA AND any one of these Washington State Trauma Registry Inclusion Criteria:

1. All patients (any diagnosis) for whom the trauma team was activated.
2. All trauma patients who were dead on arrival.
3. All trauma patients who died.
4. All trauma patients transferred out to another facility by EMS/ambulance.
5. All trauma patients transferred in from another facility by EMS/ambulance.
6. All pediatric patients (age 0-14) trauma patients admitted.
7. All adult (age 15+) trauma patients admitted with a length of stay > 48 hours.

IX. Data Collection

All data collection on trauma patients is achieved through the Washington State Trauma Registry, using Collector software that has been provided by the Washington State Department of Health. Data collection for Stroke and Cardiac patients will be achieved through abstracting information from patient records and tracked on an excel spreadsheet. Information for the cardiac, stroke, and trauma quality improvement program may be acquired from the following sources:

1. T-system history log and patient record.

2. Health Information Management Services.
3. Trauma registry.
4. Emergency Department Medical Director, ED Nurse Manager, and Cardiac, Stroke, and Trauma Program Manager.
5. Referrals from staff and departments involved in care of the cardiac, stroke or trauma patient.
6. CQC and Regional QI committee meetings.
7. EMS records.

X. Quality Improvement Review Process

All patient care is monitored continuously to ensure compliance with current standards and evidence-based practices. (Quality indicators are determined by the Clinical Quality Committee.) Policies, procedures, guidelines, and protocol changes will reflect evidence-based practice to meet quality indicators. CQC reviews system issue and identifies and implements opportunities for improvement. Cases reviewed at CQC may be referred to WHS HQS for peer review quarterly.

First Level Review: The Trauma, Stroke, and Cardiac Program Coordinator and/or the ED Nurse Manager reviews all qualifying cases presenting to the facility. If the review affirms clinical care followed protocol and no provider or system issues are identified, then no further review is needed.

Second Level Review (Further Investigation and Validate Issues; Refers): The Emergency Department Medical Director performs the second level of review when protocol is not followed and/or the standard of care is not met. The ED Medical Director may implement action without formal referral to committee, and/or refer to an outside physician peer review by WHS HQS.

Third Level Review (Formal Committee Review): Cases referred from the Trauma, Cardiac, and Stroke Program Coordinator, ED Nurse Manager, or ED Medical Director for a third level review, are reviewed at CQC. Additionally all Full Trauma Team Activations (FTTA), Modified Trauma Team Activations (MTTA), Stroke Alerts, and Cardiac Medical Alerts that require a Third Level Review, will be reviewed at CQC. The Cardiac, Stroke, and Trauma Coordinator or ED Nurse Manager may request a physician peer review from WHS HQS at any time. CQC recommends process improvements, including policy and protocol changes, and ensures outcomes as well as loop closure.

XI. Determination of Judgments

CQC and/or WHS HQS peer review physician will render a judgment regarding the appropriateness of the care related to the issues being reviewed. Each issue will be placed into one of the following categories:

Rating 0:	No quality concerns.
Rating 1:	Minor questions without compromise to patient outcome.
Rating 2:	Quality concerns without adverse clinical outcome.
Rating 3:	Quality concerns with adverse clinical judgment.
Rating 4:	Concerns with unacceptable quality, with significant adverse impact.

XII. Documentation of Analysis and Monitoring

Cardiac, Stroke, and Trauma QI issues are documented in the CQC meeting minutes. Documentation includes a summary of clinical care, identified issues, judgement, actions, evaluation, and loop closure.

XIII.Confidentiality Protection

All quality improvement activities and related documents are confidential and protected as specified in Washington State law (RCW 70.168.090), hospital policy, and HIPAA.

XIII. Evaluation and Loop Closure

All identified patient care issues (physician, nursing, pre-hospital, departmental, and system) are subject to review, which may result in the formation of an action plan. The Emergency Department Medical Director oversees all corrective action planning and implementation for physicians providing care for the trauma/cardiac/stroke patients. The trauma program coordinator and ED Nurse Manager work with the CNO/Director of Quality to determine all corrective action planning for the nursing staff involved. In order to close the CQI loop, the outcome of the corrective action plan will be monitored via CQI processes for the expected change and outcomes.

XIV. Indicator List

1. **Cardiac**
    a. **Door to EKG time**
    b. **Door to transfer time**
2. **Stroke**
    a. **Door to CT time**
    b. **Door to lytic time**
    c. **Initial NIHSS Documentation**
    d. **NIHSS every 15 minutes after lytic administration**
3. **Trauma**
    a. **Trauma Team Activation**
        i. **Over/Under Triage**
        ii. **General Surgeon arrival time for full trauma team activation**
        iii. **Length of stay ≥180 minutes**
        iv. **GCS documentation: Initial and follow up**
    b. **Screening, Brief Intervention, and Referral to Treatment**

Please see attachments for approval signatures.

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Administration	Aaron Edwards: CEO	12/8/2023
Executive Assistant	Wendy Kenck: Executive Assistant	12/8/2023
	Shawn Ottley: COO, CNO	12/8/2023
	Rhianna Montgomery: ED/Med Surg Nurse Manager	11/2/2023
	Bryce Kipp: ED Nurse Manager	9/20/2023

Status **Pending** PolicyStat ID **14761458**

Origination	3/7/2014
Last Approved	N/A
Effective	Upon Approval
Last Revised	3/30/2021
Next Review	2 years after approval
Owner	Rhianna Montgomery: ED/ Med Surg Nurse Manager
Area	Patient Care Services
References	DOH

End of Life Care

PURPOSE:

Lake Chelan Health values relationships, integrity, compassion and respect. These are integrated into end of life care with provision of optimum patient and family-centered care, and caring to support the patient and family through the life-death transition.

POLICY:

End of life care will focus on symptom management and emotional and spiritual support to provide comfort to the patient and family. Therapeutic presence is an essential intervention to provide appropriate, supportive, end of life care.

PROCEDURE:

Upon admission, or upon identification that a patient is nearing end of life, the patient care staff will discuss with the patient and family any advance directives, as well as additional details related to their desires and priorities for symptom management and comfort care. The interdisciplinary care team will collaborate to assure appropriate orders are provided, end of life care is coordinated, and goals and desired outcomes are documented in the plan of care. End of life care will follow current best practice guidelines.

Symptom management may include the following:

A. Pain management – for patient comfort, opiods and other adjunct medications may be used as indicated.

B. Constipation – can result from opioids and decreased mobility and may require aggressive

management until end of life is imminent.

C. Infections – if causing discomfort, antibiotics may be used to decrease associated symptoms.

D. Anorexia – small amounts of easily digested food and/or liquids frequently may be more palatable to patient; near end of life, a "recreational diet," where patient chooses what and how much to eat or drink, without regard to issues of hydration, aspiration, or disease control may be most appropriate.

E. Oral care – frequent oral care can increase comfort by removing secretions and moistening oral mucosa.

F. Nausea/vomiting – may be related to opioids or constipation; dietary measures include use of ginger, ginger ale, or ginger teas and bland, low-fat foods served cold or at room temperature.

G. Skin care – important to prevent skin breakdown and associated discomfort; care team will consider using pressure relieving mattresses or surfaces, turning patient frequently, massage, especially bony prominences, and applying lotion to dry skin; if incontinence is an issue care team may discuss appropriateness of an indwelling catheter with provider, and obtain order if indicated; if pain is exacerbated by movement, administer appropriate pain medications pro-actively.

H. Adjunctive therapies – care team will consider and implement other adjunctive therapies as appropriate.

I. Family participation – include the family in providing care and comfort measures to the extent they are comfortable; support their presence and comfort as well.

As the patient enters the final stage of life-death transition, consider the following, and consult with provider as necessary:

- Eliminate unnecessary medications
- Consider alternative routes for end-of -life medications, such as sublingual, rectal, or topical; consult with Pharmacist regarding options
- Manage secretions with atropine drops of scopolamine patch
- Continue providing oral and skin care to maximize comfort
- Constipation management is no longer a priority at end-of-life
- Continue complementary/adjunctive therapies as indicated
- Continue to provide support to family/friends

REFERENCES:

WAC 246-320-141

RELATED POLICIES:

Advance Directives

Physician Orders for Life-Sustaining Treatment (POLST) Policy

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Administration	Aaron Edwards: CEO	12/8/2023
Executive Assistant	Wendy Kenck: Executive Assistant	12/8/2023
	Rhianna Montgomery: ED/Med Surg Nurse Manager	11/21/2023

2024 Staffing Plan Overview

Applicable To: Lake Chelan Health (Hospital)

Department: Patient Care Services/Nurse Staffing Committee

Date: 11/21/2023– Annual Review

All information listed and any revisions to this plan will be based on RCW 70.41.410 and RCW 70.41.420

Purpose Statement

The Staffing Plan for Nursing Services reflects the specific needs of Lake Chelan Health to meet patient care and organizational needs. This plan will have an ongoing evaluation by the Nurse Staffing Committee (at least semi-annually) and as a component of the annual budget process. All nursing staff and supervisory staff may provide input to the Nursing Staff Committee relevant to providing patient care.

Nurse Staffing Plan

The Nursing Staffing Plan has been formulated to identify the staffing needs based on the following criteria listed below:

1. Patient population and individual patient needs (acuity)
2. Average Daily census
3. Length of stay
4. Physical environment and available technology
5. Staff skill mix, including level of experience and required competencies
6. Availability of other personnel supporting nursing services on the unit
7. Strategies to enable registered nurses to take meal and rest breaks as required by law.
8. Standards of Nursing Practice as set forth by the State of Washington, national nursing professional associations, specialty nursing organizations and other health professional organizations.

Lake Chelan Health will post, in public areas, on each patient care unit, the core nurse staffing plan and the nurse staffing schedule for that shift for that unit, as well as the relevant clinical staffing for that shift. The staffing plan and current staffing levels will also be made available to patients and visitors upon request.

Core Nursing Staff for Patient Care Units

Med-Surg Unit (Includes Acute Care, Sub-Acute Rehab, Observation, Obstetrics)

Day Shift 0700-1930
RN-2
CNA-1
Unit Coordinator-1 (0600-1630)

Night Shift 1900-0730
RN-2
CNA-1

Emergency Department

Day Shift 0700-1930
RN-1
ED Tech-1

Night Shift 1900-0730
RN-1
ED Tech-1

Surgical Department

0700-0700, 24/7
RN-1
Surgical Tech-1
CRNA-1
PACU RN – 1-3 (Variable staff/hours depending on surgery schedule. Typically, Monday-Friday)

House Supervisor

Day Shift 0630-1900
RN-1

Night Shift 1830-0700
RN-1

Float/Resource Nurse

1000-2230
RN-1

Staffing Plan Variation

Additional staffing may be required for 1:1 patients, including behavioral, high acuity, and obstetric patients or increased patient census/volume at the discretion of the House Supervisor or Nurse Manager. In the event of low census, an RN and/or CNA may be floated if properly trained or placed on-call at discretion of the House Supervisor or Nurse Manager. If census, acuity, or patient mix indicates need, an additional RN may be placed on-call/called in to work at discretion of the House Supervisor or designee. ED Tech hours may shift according to census, acuity, and season. Surgical Department staffing is addressed each weekday to support the volumes of procedures for the next day.

Chain of Command/Staffing Decision Tree

The House Supervisor or Nurse Manager (Monday - Friday) will make shift to shift assignment adjustments based on acuity, intensity, and census/volume. The Nurse Leader on Call or Administrator on Call are available 24/7.

Meals and Rest Breaks

RNs and CNAs are assigned meal breaks at the beginning of each shift by the House Supervisor. The House Supervisor and Float/Resource are available to provide breaks for units unable to break themselves.

National or Professional Guidelines

For Obstetrics staffing Lake Chelan Health follows the Standards for Professional Registered Nurse Staffing for Perinatal Units from the Association of Women's Health, Obstetric and Neonatal Nurses. For the Surgical Department best practice guidelines from the Association of periOperative Registered Nurses are followed, including Conscious Sedation guidelines. For the Emergency Department best practice guidelines from the Emergency Nurses Association are followed.

Feedback and Evaluation

The Nurse Staffing Committee will meet quarterly for review and validation of the Staffing Plan, missed meal and lunch breaks, and any submitted Staffing Complaint Forms, ad hoc meetings can be scheduled as needed. Adjustments may be made to the Staffing Plan as needed during the 2023 year due to an anticipated increase in volume related to our new campus.

Approved By:

Aaron Edwards CEO	Date
Shawn Ottley COO/CNO	Date
Rhianna Montgomery DNS (Co-Chair)	Date
ED Staff RN (Co-Chair)	Date
House Supervisor Staff RN	Date
MSU Staff RN	Date

OB Staff RN	Date
OR Staff RN	Date
PACU RN	Date

Status **Active** PolicyStat ID **10889382**

Origination	1/12/2009	Owner	Shawn Ottley: COO, CNO
Last Approved	1/4/2022	Area	Hospital Commission
Effective	1/4/2022		
Last Revised	1/12/2009		
Next Review	1/4/2024		

Board of Commissioners Continuing Education (CAH)

1. Board Continuing Education Policy
    a. Chelan County Public Hospital District No. 2 (CCPHD2) Commissioners must participate in at least forty (40) hours of governance continuing education every two (2) years, relevant to his/her responsibilities as a Commissioner.
    b. Effective July 1, 2014, the Open Government Trainings Act (ESB 5964) requires The Board of Commissioners and all agency records officers to receive training (RCW 42.56.150; RCW 42.56.152; RCW 42.30.205). Open Government Training should be completed within the first 90 days of office and renewed every four years. The public record training and public meeting training is mandatory. http://www.atg.wa.gov/open-government-training%20. Board members will provide evidence of Open Government Training to CCPHD2 Executive Assistant within 30 days of training. Evidence of Board training will be filed in the individual CCPHD2 Board member file.
    c. Board members are strongly encouraged to achieve and maintain Washington State Hospital Association Governance Certification. Conferences, remote learning programs and other programs available through CCPHD2, Association of Washington Public Hospital Districts, Washington State Hospital Association (WSHA) and other recognized health care organizations may be credited toward the 40 required hours and WSHA Governance Certification. Board members must apply for WSHA Governance Certification credit through WSHA.
    d. Commissioners must report all training, educational presentations, or any potentially eligible commissioner education hours and credits earned during the year to the Executive Assistant by December 31.
    e. In addition to continuing education provided in-house, remotely and in-state, Board members may attend one District-financed, out-of-state meeting on hospital governance every other year. The full Board must review and approve funding for individual Board member travel proposals that are exceptions to the out-of-state policy above.

f. CCPHD2 will fund the cost of registration, transportation, food and lodging for Board members within the scope of CCPHD2 Travel and Training policy. Itemized receipts for food must be submitted to the Executive Assistant to receive full reimbursement. No alcohol will be reimbursed. Another person may accompany respective Commissioner; however, travel expenses are not funded by the District.

Approval Signatures

Step Description	Approver	Date
Board Approval	Toni Willis: Executive Assistant	1/4/2022
Administration	Cheryl Cornwell: CEO	12/28/2021
Executive Assistant	Toni Willis: Executive Assistant	12/28/2021
Executive Assistant	Shawn Ottley: Quality Director	12/15/2021

Status **Pending** PolicyStat ID **14398384**

Origination	7/27/2004
Last Approved	N/A
Effective	Upon Approval
Last Revised	11/22/2023
Next Review	2 years after approval

Owner	Becky McCracken: Medical Staff Coordinator
Area	Administration

Credentialing Policy

Purpose

To establish the approval process for practitioners seeking privileges and or Medical Staff membership at Lake Chelan Health.

Policy

A. All provider credentialing is completed by the Medical Staff Coordinator and approved by the Medical Executive Committee. Lake Chelan Health has contracted with Hospital Services Corporation to assist with credentialing on a case by case basis.

B. The Board of Commissioners assumes the ultimate responsibility for practitioners at Lake Chelan Health and shall have final approving authority for all applications.

Procedure

- Applications and processing are handled by the Medical Staff Coordinator.
- The completed application shall be referred to the Medical Executive Committee (MEC) for review of qualifications as established in the Medical Staff Bylaws and supporting documentation.
- The MEC will provide a recommendation to the Board of Commissioners for final approval.

This entire process can take 3-6 months.

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Executive Review	Wendy Kenck: Executive Assistant	12/8/2023
Med Exec Committee	Becky McCracken: Medical Staff Coordinator	11/27/2023
CMO Review	Matthew Hillman	11/24/2023
Owner	Becky McCracken: Medical Staff Coordinator	9/20/2023

Status **Pending** PolicyStat ID **14856660**

Origination	2/25/2020	Owner	Shawn Ottley: COO, CNO
Last Approved	N/A	Area	Hospital Commission
Effective	Upon Approval		
Last Revised	12/8/2023		
Next Review	1 year after approval		

Conflict of Interest Policy

Purpose Statement

So that no conflict of interest concerns arise concerning any particular issue of business transacted by the Board of Commissioners as a whole, or in part.

Policy Statement

Lake Chelan Health Board members, officers of the District and Board committee members shall conform, in the conduct of their office, to the provisions of RCW 42.20 and RCW 42.23. The Board commits itself and its members to ethical, professional, and lawful conduct to include proper use of authority and appropriate decorum when acting as Board members.

Implementation for Procedure

In the event that any Board member or officer has a real or potential conflict of interest on a matter coming before the Board, they shall disclose such real or potential conflict prior to any participation in discussion or voting on the issue. They shall also withdraw from participating and voting on the issue. Should any other Board member disagree, the issue of participation in discussion and/or voting shall be decided by a majority vote of the remaining Board members.

Board members must represent unconflicted loyalty to the interests of the District. This accountability supersedes any conflicting loyalty such as that to advocacy or interest groups, membership to other Boards or staffs, and the personal interests of any Board member acting as a consumer of Lake Chelan Health services. Board members should avoid the following conflicts:

1. Must avoid conflict of interest with respect to their fiduciary responsibility. This means,

specifically, that there must be no self-dealing or any conduct of private business or personal services between any Board member and Lake Chelan Health except as procedurally controlled to assure openness, competitive opportunity, and equal access to “inside” information.

2. Direct or indirect solicitation or acceptance of personal fees or commissions in connection with Hospital business.
3. Use of their position to secure special privileges or exemptions for themselves, spouse, child, parents, or other related persons from vendors, contractors, physicians, patients, the Hospital District, or its staff.
4. Must not use their position to obtain employment at Lake Chelan Health for themselves, family members, or close associates. Should a member desire employment, he or she must first resign from the Board and follow the provisions of the RCW with respect to this subject.
5. Solicitation of gifts or gratuities for personal use for themselves or related parties from our customers,
suppliers, consultants or anyone else doing business with the District. Unsolicited non-cash gifts of nominal value such as flowers, meals, plaques, cups, pens, or calendars may be accepted.
6. Acceptance of a paid trip from a vendor to visit an installation or attend a seminar if the dominant theme is entertainment. Such trips may be acceptable for educational purposes, or an installation visit that is the result of a decision to purchase a specific vendor's product and is directly related to the installation of the product.
7. Placing themselves in a position that may create or lead to a conflict of interest, or the appearance of one, such as engaging in any outside business activity, financial relationship or investment that conflicts with the District, competes with the District, or may interfere with Board members’ responsibilities to the District. Board members are also prohibited from having any personal interest, directly or indirectly, in any transaction with Lake Chelan Health unless disclosed in writing in advance to the Hospital’s CEO. A decision can then be made as to whether a conflict of interest exists.
8. Engage in outside business, other activities, or private employment that would result in the inducement to divulge confidential information about the District, other employees or patients.
9. Disclose confidential information about the District, nor may the Commissioners use such information for their personal gain or benefit. It s a primary responsibility of all Board members to protect the confidentiality of District Information. The breaking of confidentiality is the repeating of any information, written or spoken, when authorized or indiscreet disclosure could be harmful or injurious to the interests of a patient, employee, or the District in general.
10. Board members may not attempt to exercise individual authority over Lake Chelan Health except as explicitly set forth in Board policies. Members' interactions with the CEO or with staff must recognize the lack of authority vested in individuals except when explicityly Board authorized.

Board members may not disclose confidential information about the District, or use such information for their personal gain or benefit. It is a primary responsibility of all Board members to protect the confidentiality of District information. The breaking of confidentiality is the repeating of any information, written or spoken, when unauthorized or indiscrete disclosure could be harmful or injurious to the

interests of a patient, employee, or the District in general.

Board members may not attempt to exercise individual authority over Chelan County Public Hospital District 2 except as explicitly set forth in Board policies. Members' interactions with the CEO or with staff must recognize the lack of authority vested in individuals except when explicitly Board authorized.

Violations of this policy may be reported to the State Auditor and/or Hospital Attorney for investigation.

Approval Signatures

Step Description	Approver	Date
	Shawn Ottley: COO, CNO	Pending