LAKE CHELAN HEALTH

BOARD PACKET

Chelan County Public Hospital District No. 2

4/23/2024

LAKE CHELAN HEALTH

Chelan County Public Hospital District No. 2
Regular Meeting of the Board of Commissioners
April 23, 2024, at 1:30 am via TEAMS

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*
1:30	• Call to Order	L. Withrow	
1:32	• Chair Report	L. Withrow	
1:35	• Consent Agenda	Commission	A. Regular Board Meeting Minutes 3/26/2024 (FM) B. Special Board Meeting Minutes 4/8/2024 (FM) C. Warrants & Vouchers (FM) D. Bad Debt & Charity Care (FM) E. Finance Committee Minutes 4/17/2024 (FA)
1:45	• Executive Session		A. RCW 42.30.110(1)(o) To consider information regarding staff privileges or quality improvement committees under RCW 70.41.205
2:00	• Public Comment		
2:05	• Reports	L. Sahlinger/M. Hillman B. Truman A. Edwards S. Ottley L. England	A. Credentialing (FM)/Med Staff Report (FI) B. Financial Committee Report (FA) C. CEO Report (FI) D. Strat Plan KPI Report (FI) E. Board Advocacy/Community Connections (FD)
2:45	• Old Business		A. Strat Plan/Retreat (FD) B. Community Meeting (FD) C. Community Center- Weagant Paintings (FD)
3:15	• New Business	Commission S. Ottley	A. Resolution 2024-2 Amendment to CEO Contract (FR) B. Policies a. Complaint & Grievance Resolution Policy and Procedure (FM) b. Peer Review (FM) c. Outpatient Service Orders by Non-Privileged Providers (FM)
4:00	• Roundtable /Action Items	Commissioners	
4:10	• Public Comment		
4:15	• Executive Session		A. RCW 42.30.110(1)(g) Evaluate the performance of a public employee.
5:00	• Adjournment		

Board Calendar Reminders:

5/1/2024	Compliance, Privacy, & Risk Committee	1212 Conference Room	10 am – 11 am
5/9/2024	Med Staff/Peer Review	Bragg Room/ TEAMS	7:15 am – 9 am
5/9/2024	Quality Committee	Bragg Room/ TEAMS	1 pm – 3 pm
5/13/2024	TBA	Bragg Room/ TEAMS	9 am
5/16/2024	DEI Committee	1212 Conference/ TEAMS	1 pm
5/22/24	Strategic Planning	TBD	TBD
5/23/24	Finance Committee	Bragg Room/ TEAMS	11 am
5/28/24	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

6/5/2024	Compliance, Privacy, & Risk Committee	1212 Conference Room	10 am – 11 am
6/10/2024	TBA	Bragg Room/ TEAMS	9 am
6/13/2024	Med /OB Staff/ED Clinical Line Services	Bragg Room/TEAMS	7am-9am
6/13/2024	Quality Committee	Bragg Room/ TEAMS	1 pm – 3 pm
6/17/2024	Finance Committee	Bragg Room/ TEAMS	9 am
6/18/2024	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm
6/20/2024	DEI Committee	1212 Conference/ TEAMS	1 pm

7/3/2024	Compliance, Privacy, & Risk Committee	1212 Conference Room	10 am – 11 am
7/8/2024	TBA	Bragg Room/ TEAMS	9 am
7/11/2024	Med /OB Staff/ED Clinical Line Services	Bragg Room/TEAMS	7am-9am
7/11/2024	Quality Committee	Bragg Room/ TEAMS	1 pm – 3 pm
7/18/2024	DEI Committee	1212 Conference/ TEAMS	1 pm
7/17/2024	Finance Committee	Bragg Room/ TEAMS	10 am – 12 pm
7/23/2024	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

Chelan County Public Hospital District No. 2
Regular Meeting of the Board of Commissioners
Meeting Minutes March 26, 2024 1:30 pm
in person and via Microsoft TEAMS

Commission Attendance:

(☐ not present ☒ present)

☒Mary Murphy, Secretary via TEAMS ☒Jordana LaPorte, Chair	☒Doug Gibson ☒Len England	☒Lori Withrow, Vice Chair

Staff Participants: A. Edwards, B. Truman, S. Ottley, V. Monteleone, M. Hillman, M. Miller, B. McCracken, M. McCormick, L. Stone, R. Montgomery, A. Thomas, Brenda B., C. Henning
Guests:
Community Members: P. Gleasman, D. Griggs, Dr. Hippe, M. Griggs, Guest x2

Recorder: Wendy Kenck

Agenda Item	Topic/Action
1. Call to Order	• J. LaPorte called the meeting to order at 1:30 pm and recited the mission statement.
2. Public Comment	• No Public Comment
3. Chair's Report	
4. Consent Agenda	• *M. Murphy motioned to approve Consent Agenda with the below edits, seconded, motion passed* o Edits: Remove 'December' and replace with 'January' on KPI Report
5. Executive Session	
6. Reports	• *M. Murphy verified all credential files are complete for the proposed list of providers & CRNA's and motioned to approve the appointments as presented, seconded, motion passed.* • Finance: o J. LaPorte presented the unaudited February 2024 Finance ▪ Notable increase in Charity Care ▪ HFMA efforts focused on cash collections, team has done an excellent job in completing task and Net Days in AR at 42. ▪ J. LaPorte offered insight on the discussion with the USDA. ▪ USDA representative Rick Rose sent a message he will be on vacation in April. Currently working with USDA to facilitate a representative to help complete the loan agreement. ▪ Decrease in Inpatient days (research the reasoning) ▪ Income increased due to Surgeries and Specialty Clinic o *D .Gibson motioned to accept the February unaudited Finance Report, seconded, motion approved.* • A. Edwards provided an overview of the CEO report o It was discussed that a representative from the Community Center is interested

	in the Weagant art paintings for display at the Community Center. These paintings will be accompanied by a plaque indicating that they are on loan from LCH, allowing the public to appreciate the artwork. • S. Ottley presented an overview of February's Key Performance Indicator (KPI) dashboard. o There was a decline in the aggregate quality score, primarily attributed to the addition of clinic quality measures. o February witnessed the lowest net promoter score. • Board Advocacy: o M. Murphy attended the Diabetes Community Meeting and provided an update on their ongoing progress. o There is an upcoming city meeting scheduled to vote on the Conditional Use Permit (CUP) concerning the Highland Campus. o Discussion on the importance of establishing a Leadership-to-Leadership dialogue between Lake Chelan Health and Columbia Valley Community Health to foster a collaborative partnership for the communities' interests. ▪ Highlighting the importance of identifying both overlapping and non-overlapping strategic goals and devising strategies for collaboration to address areas of divergence for the betterment of the community.
7. Old Business	• Discussion regarding the scheduling of the Strategic Planning retreat. • The Community Forum is scheduled for April 30th at the Senior Center for
8. New Business	• Policies: o Cardiac, Stroke & Trauma Quality Improvement Plan policy edits: Addition of Pharmacy as a member. o *D Gibson motion to approve the Cardiac, Stroke & Trauma Quality Improvement Plan with edits, seconded, motion approved.* o Discussion and edits regarding the current Grievance Resolution Policy ▪ A. Edwards introduced The Grievance Resolution Workflow from Ferry County, highlighting its clear guidelines for addressing grievances and proposed modeling a similar process at LCH. • *D Gibson motioned to approve Resolution 2024-1 Cancelling Warrants, seconded, motion approved* • S. Ottley presented a floor plan from Forte Architects o In process of completing the Geotech for the EMS building o Displayed various areas including EMS facilities, sleeping quarters, Training Center/Conference Room, Admin, Business Office, and HR. o Proposal to re-locate current Admin offices to better accommodate patient care needs. • *M. Murphy motioned to approve the surplus of the Capital Disposal Treadmill, seconded, motion approved.*
9. Roundtable/Action Items	• Board: o L. England will attend the Foundation Meetings as a Board representative (1st Thursday of the month at 4pm) o Email items of interest to add to the community forum agenda to M. Murphy or L. Withrow. • Admin: o The Administration will work with the Foundation to enhance support for each organization. o Coordinate a group to draft a Grievance Resolution Process and send it for legal review.

	• S. Ottley o Present current building plans to the City of Chelan and discuss water needs with the EMS build. • A. Edwards o Initiate a high-level meeting with CVCH, including Admin, Board Chair, and Vice Chair. o Reach out to facilitator Alan to schedule a timeframe for Strategic Planning. o Inform Board members about the city's voting on the Conditional Use Permit (CU-P). • W. Kenck o Send dates to Governance Committee to draft an Agenda for the Community Forum.
10. Public Comment	• No Public Comment
11. Executive Session	• J. LaPorte announced Executive Session at 4:15 pm for 45 minutes RCW 42.30.110(1)(g) to Evaluate the performance of a public employee and RCW 42.30.110(1)(o) To consider information regarding quality improvement committees under RCW 70.41.205 o L. Withrow extended the Executive Session 30 minutes o L. Withrow extended the Executive Session 30 minutes o L. Withrow extended the Executive Session 15 minutes o L. Withrow extended the Executive Session 15 minutes o L. Withrow extended the Executive Session 15 minutes o L. Withrow extended the Executive Session 15 minutes
12. Adjournment	• No action was taken as a result of the Executive Session • J. LaPorte adjourned the meeting at 7:05 pm

Attest:

_____ _____

M. Murphy, Secretary Aaron Edwards, CEO

_____

W. Kenck, Executive Assistant

Chelan County Public Hospital District No. 2
Special Meeting of the Board of Commissioners
Meeting Minutes April 8, 2024 9:00 am
in person and via Microsoft TEAMS

Commission Attendance:

(☐ not present ☒ present)

☒ Jordana LaPorte, Chair	☒ Mary Murphy, Secretary	☒Len England
☒ Lori Withrow, Vice Chair	☒Doug Gibson	

Staff Participants: A. Edwards, S. Ottley,
Guests:
Community Members: D. Griggs
Recorder: Wendy Kenck

Agenda Item	Topic/Action
1. Call to Order	• J. LaPorte called the meeting to order at 9:06 am and recited the mission statement.
2. Public Comment	• No Public Comment
3. Executive Session	• J. LaPorte announced Executive Session at 9:10 am for 1 hour RCW 42.30.110(1)(g) to Evaluate the performance of a public employee o L. Withrow extended the Executive Session 20 minutes o L. Withrow extended the Executive Session 15 minutes o L. Withrow extended the Executive Session 10 minutes o L. Withrow extended the Executive Session 20 minutes, A. Edwards joined the session o L. Withrow extended the Executive Session 15 minutes o L. Withrow extended the Executive Session 15 minutes o L. Withrow extended the Executive Session 10 minutes
4. Adjournment	• No action was taken as a result of the Executive Session • J. LaPorte adjourned the meeting at 11:55 am

Attest:

_____ _____

M. Murphy, Secretary Aaron Edwards, CEO

_____

W. Kenck, Executive Assistant

WARRANT #'S A/P	AMOUNT	CAPITAL	BOARD MTG - april 2024	*NEW HOSPT AMNT FROM CKRN*	WARRANT#'S PAYROLL	AMOUNT	pay period
235124-235255	$ 197,325.22				Direct Deposit	$ 511,099.82	3/9/2024
DOR ACH AMOUNT	$ 13,935.42				PAYROLL TAXES	$ 205,948.53	3/9/2024
235256-235261	$ 9,899.10				CHILD SUPPORT	$ 430.68	3/9/2024
235262-235331	$ 285,016.19				Payroll warrant	$ 13,121.83	3/9/2024
RETIREMENT	$ 48,381.03				Direct Deposit	$ 506,878.95	3/23/2024
235332-235402	$ 253,620.52				PAYROLL TAXES	$ 197,388.99	3/23/2024
235403-235448	$ 387,552.54				CHILD SUPPORT	$ 430.68	3/23/2024
235449-235518	$ 327,015.86						
RETIREMENT	$ 45,998.36						
	$ 1,568,744.24					*$ 1,435,299.48*	

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*	

WARRANT #'S A/P	AMOUNT	CAPITAL	BOARD MTG - Jan 2024	*NEW HOSPT AMNT FROM CKRN*	WARRANT#'S PAYROLL	AMOUNT	pay period
234172-234277	$ 234,487.12	$ 38,152.19	12/14/2023		Direct Deposit	$ 496,118.44	12/16/2023
234278			12/15/2023	$ 26,316.15			
234279-234352	$ 298,824.30		12/21/2023				
234353-234387	$ 314,405.51		12/27/2023				
234388-234389	$ 160.00		12/28/2023				
	$ 847,876.93	*$ 38,152.19*		*$ 26,316.15*		*$ 496,118.44*	

WARRANT #'S A/P	AMOUNT	CAPITAL	BOARD MTG - FEB 2024	*NEW HOSPT AMNT FROM CKRN*	WARRANT#'S PAYROLL	AMOUNT	pay period
234390-234391	$ 8,010.05		1/4/2024		Direct Deposit	$ 489,629.05	12/30/2023
234392-234450	$ 181,661.51	$ 131,008.12	1/5/2024		Direct Deposit	$ 499,173.71	1/13/2024
234451	$ 3,855.24		1/10/2024		Direct Deposit	$ 494,102.81	1/27/2024
234452-234548	$ 305,417.66		1/11/2024				
234549-234628	$ 347,635.52		1/18/2024				
234629-234771	$ 428,718.71		1/25/2024				
234772-234837	$ 271,150.46		2/1/2024				
	$ 1,546,449.15	*$ 131,008.12*				*$ 1,482,905.57*	

WARRANT #'S A/P	AMOUNT	CAPITAL	BOARD MTG - MARCH 2024	*NEW HOSPT AMNT FROM CKRN*	WARRANT#'S PAYROLL	AMOUNT	pay period
Retirement	$ 40,650.33		1/10/2024		PAYROLL TAXES	$ 184,817.98	12/30/2023
DOR	$ 16,573.51		1/16/2024		CHILD SUPPORT	$ 430.68	12/30/2023
Unclaimed Property	$ 214.07		1/23/2024		PAYROLL TAXES	$ 193,091.60	1/13/2024
Retirement	$ 44,485.01		1/24/2024		CHILD SUPPORT	$ 430.68	1/13/2024
Family Paid Leave	$ 28,415.27		1/29/2024		PAYROLL TAXES	$ 187,737.79	1/27/2024
Long term care	$ 21,964.41		1/29/2024		CHILD SUPPORT	$ 430.68	1/27/2024
Retirement	$ 48,957.40		2/6/2024		Direct Deposit	$ 473,376.24	2/10/2024
JANUARY DEPT OF REV	$ 12,992.21		2/13/2024		PAYROLL TAXES	$ 179,018.98	2/10/2024
Retirement	$ 40,399.23		2/16/2024		CHILD SUPPORT	$ 430.68	2/10/2024
234838-234840	$ 24,163.00		2/5/2024		Direct Deposit	$ 498,886.85	2/24/2024
234841-234916	$ 240,362.45		2/8/2024		PAYROLL TAXES	$ 189,990.15	2/24/2024
234917-234984	$ 280,520.66	$ 44,007.22	2/15/2024		CHILD SUPPORT	$ 430.68	2/24/2024
234985-235065	$ 398,902.29		2/22/2024		Payroll Warrant	$ 80.68	2/10/2024
235066-235122	$ 430,341.02		2/29/2024				
235123	$ 2,800.00		3/1/2024				
Retirement	$ 49,201.17						
	$ 1,680,942.03	*$ 44,007.22*				*$ 1,909,153.67*	

DATE March 2024

TOTAL BAD DEBTS - HOSPITAL $169,606.24
TOTAL MEDICARE BAD DEBTS $10,314.71
TOTAL BANKRUPTCY $0.00
TOTAL CHARITY CARE – HOSPITAL $67,315.61
TOTAL MEDICARE CHARITY CARE - $2,830.30

TOTAL ATTESTATION $250,066.86

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

MINUTES

Group: Finance Committee 4/17/2024 at 11 am in person and via Teams		
Facilitator: Lori Withrow	**Recorder:** W. Kenck	
Member Attendance:		
☒ Lori Withrow, BOC ☒ Doug Gibson, BOC	☒ Shawn Ottley, COO/CNO ☒ Brant Truman, CFO	☒ Aaron Edwards, CEO
Participants: S. Nau, V. Bodle, M. Miller, M. Hillman, R. Montgomery **Guests:** RPG		

FI – For Information; FD – For Discussion; FR – For Recommendation

Agenda Item	*Topic/Action*
1. Call to Order	• B. Truman called the meeting to order at 11:00am
2. New Business	• RPG presented to the Committee. • Break for lunch 12:15pm for 15 minutes. • B. Truman reviewed LCH's progress to date in purchasing items on the capital budget. • Finance Meeting moved to 5/23 @ 11am 6/17 @ 9am • Audit preparer score report: Eide Bailly received the highest marks; LCH will engage them as auditors.
3. Old Business	• B. Truman provided an update on new hospital budget: $800K retained by USDA; LCH paperwork submitted to L&I, awaiting review. $2.25M portion out for quote from an external organization with USDA experience. • B. Truman presented an MRI overview in anticipation of the Imaging Manger examining a new MRI machine for possible purchase.
4. Reports	• V. Bodle presented March 2024 Financial Statement (unaudited). • S. Nau presented a Revenue Cycle and HFMA update
	Meeting ended @ 1:30pm

LAKE CHELAN
HEALTH

Unaudited Financial Statements

for

For the month ended March 31, 2024

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Balance Sheet

Lake Chelan Health

	Current Month 3/31/2024 unaudited	Prior Year 12/31/2023 Unaudited	Prior Year 3/31/2023 Unaudited
ASSETS:			
CASH	145,113	$ 858,227	$ 131,711
PATIENT RECEIVABLES	11,291,598	9,941,632	$ 7,525,524
LESS: RESERVES FOR ALLOWANCES	(6,014,110)	(5,504,105)	$ (4,006,223)
NET PATIENT ACCOUNTS RECEIVABLES	5,277,489	4,437,527	3,519,301
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	23,012	575,410	(75,181)
OTHER RECEIVABLES	853,767	97,661	970,526
INVENTORIES	328,575	216,700	241,390
PREPAID EXPENSES	300,831	339,306	312,501
TOTAL CURRENT ASSETS	$ 6,928,786	$ 6,524,831	$ 5,100,248
GENERAL RESERVES	$ 1,302,288	1,541,164	$ 373,274
Unrestricted Reserves	$ 3,496,689	3,395,024	$ 3,594,260
Internally Restricted Reserves	$ 4,139,524	4,139,524	$ 4,139,524
2018 BONDS	0	0	$ -
USDA 2023	273,600	273,600	$ 136,800
Bond Payment Transfer	0	0	$ -
TOTAL LIMITED USE ASSETS	$ 9,212,101	$ 9,349,312	$ 8,243,859
LAND	$ 4,787,901	4,787,901	$ 4,787,901
LAND IMPROVEMENTS	5,222,565	5,625,071	$ 5,543,846
BUILDINGS & IMPROVEMENTS	996,641	986,252	$ 986,252
EQUIPMENT	9,731,720	10,523,549	$ 9,684,087
SOFTWARE	2,158,462	2,158,462	$ 2,159,033
NEW HOSPITAL	44,718,237	43,928,486	$ 43,901,486
GASB 87 BUILDINGS AND EQUIPMENT	1,265,419	0	$ -
CONSTRUCTION-IN-PROGRESS - PROJECTS	215,621	674,884	$ 6,806
CONSTRUCTION-IN-PROGRESS - HOSPITAL	12,934	15,378	$ 9,290
GROSS PROPERTY, PLANT, & EQUIPMENT	69,109,501	68,699,983	67,078,702
LESS: ACCUMULATED DEPRECIATION	(18,754,047)	(18,318,226)	$ (15,481,057)
	(489,897)		
NET PROPERTY, PLANT, & EQUIPMENT	**$ 49,865,557**	**$ 50,381,757**	**$ 51,597,645**
DEFERRED ITEMS	2,475,981	2,480,797	$ 2,495,246
TOTAL ASSETS	**$ 68,482,425**	**$ 68,736,697**	**$ 67,436,997**
LIABILITIES:			
ACCOUNTS PAYABLE	$ 679,913	886,533	693,356
ACCRUED PAYROLL	360,007	685,983	230,832
ACCRUED VACATION/HOLIDAY/SICK PAY	907,866	597,882	472,053
PAYROLL TAXES PAYABLE	31,069	55,324	21,290
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	0	0	0
OTHER CURRENT LIABILITIES	1,221,659	906,970	921,657
INTEREST PAYABLE	367,971	93,697	374,859
CURRENT PORTION OF LTD (BONDS/MORTGAGES)	1,046,831	1,046,831	1,001,831
LINE OF CREDIT	0	0	0
TOTAL CURRENT LIABILITIES	$ 4,615,317	$ 4,273,220	$ 3,715,878
CAPITALIZED LEASES	$ -	$ -	$ -
2018 BONDS	$ 18,714,958	18,717,246	19,024,111
2013 BONDS	4,659,568	4,658,279	5,019,412
USDA LOANS	18,029,560	18,136,999	18,445,041
LEASES	1,524,699	1,853,765	1,827,965
PAID LEAVE - LT PORTION	200,959	304,376	304,376
TOTAL LONG TERM LIABILITIES	$ 43,129,744	$ 43,670,665	$ 44,620,904
DEFERRED ITEMS	$ 3,922,975	3,922,975	3,922,975
TOTAL LIABILITIES	$ 51,668,037	$ 51,866,860	$ 52,259,758
FUND BALANCE:			
UNRESTRICTED FUND BALANCE	$ 17,268,072	15,036,657	15,036,657
TEMPORARY RESTRICTED FUND BALANCE	$ -	0	0
YTD Net Revenue/(Expenses)	(453,684)	1,833,180	140,583
TOTAL NET ASSETS	$ 16,814,389	$ 16,869,837	$ 15,177,239
TOTAL LIABILITIES AND NET ASSETS	**$ 68,482,425**	**$ 68,736,697**	**$ 67,436,997**

Statement of Revenue and Expense
Lake Chelan Health

For the month ended March 31, 2024

	CURRENT MONTH				
	Actual 03/31/24	Budget 03/31/24	Positive (Negative) Variance		Prior Year 03/31/23
GROSS PATIENT SERVICE REVENUES					
INPATIENT	$ 631,848	$ 4,814,749	(4,182,901)	-87%	$ 559,871
OUTPATIENT	4,559,497	0	4,559,497	0.00%	3,468,757
TOTAL PATIENT SERVICE REVENUES	5,191,345	4,814,749	376,595	8%	4,028,628
DEDUCTIONS FROM REVENUE					
CONTRACTUAL ALLOWANCES	(2,219,123)	(1,906,695)	(312,428)	16%	(1,171,226)
BAD DEBT	(179,921)	0	(179,921)	0.00%	(80,260)
CHARITY	(70,146)	0	(70,146)	0.00%	(15,462)
TOTAL DEDUCTIONS FROM REVENUES	(2,469,190) 47.6%	(1,906,695) 39.6%	(562,495)	-30%	(1,266,948) 31.4%
NET PATIENT SERVICE REVENUES	2,722,155	2,908,054	(185,900)	-6%	2,761,680
OTHER OPERATING REVENUES	33,331	19,402	13,929	72%	12,185
TOTAL OPERATING REVENUES	**2,755,485**	**2,927,456**	(171,971)		**2,773,865**
OPERATING EXPENSES					
SALARIES/WAGES	1,673,011	1,693,600	20,589	1%	1,413,674
EMPLOYEE BENEFITS	318,260	373,722	55,462	15%	284,294
PROFESSIONAL SERVICES	92,473	91,897	(576)	-1%	75,153
FOOD SUPPLIES	19,865	15,044	(4,821)	-32%	17,922
MINOR EQUIPMENT	54,913	17,388	(37,525)	-216%	10,905
SUPPLIES	247,453	178,414	(69,039)	-39%	186,490
PLANT UTILITIES	30,404	29,741	(663)	-2%	34,965
PURCHASED SERVICES	294,378	298,636	4,258	1%	284,874
REPAIR/MAINTENANCE	106,045	98,597	(7,448)	-8%	80,056
PUBLIC RELATIONS/RECRUITM	3,007	11,024	8,017	73%	5,329
RENT/LEASES	56,952	40,833	(16,119)	-39%	40,665
INSURANCE	40,291	43,700	3,409	8%	29,233
LICENSES/TAXES	15,723	19,888	4,165	21%	13,269
DUES/SUBSCRIPTIONS/OTHER	45,376	62,327	16,951	27%	28,740
TRAVEL/TRAINING	11,102	15,830	4,728	30%	4,467
DEPRECIATION	304,701	383,900	79,199	21%	236,575
AMORTIZATION	15,475				
TOTAL OPERATING EXPENSES	**3,329,429**	**3,374,541**	**60,587**	1.8%	**2,746,610**
NET OPERATING SURPLUS (LOSS)	**(573,944)**	**(447,085)**	**(126,859)**		**27,255**
NON-OPERATING REVENUES	228,325	322,084	(93,759)		550,436
TAXES					
INTEREST					
GIFTS & GRANTS	0		0		
PANDEMIC GRANTS PPP LOAN FORGIVENESS	0	0	0		0
NET INCOME	(345,619)	(125,001)	(220,618)		577,690
margin	-12.5%	-4.3%			20.8%
TOTAL NET INCOME (LOSS)	**$ (345,619)**	**$ (125,001)**	**(220,618)**		**$ 577,690**

unaudited

Statement of Revenue and Expense
Lake Chelan Health

For the month ended March 31, 2024

	YEAR-TO-DATE				
	Actual 03/31/24	Budget 03/31/24	Positive (Negative) Variance		Prior Year 03/31/23
GROSS PATIENT SERVICE REVENUES					
INPATIENT	$ 1,919,644	$ 14,287,925	(12,368,281)	-87%	$ 2,001,323
OUTPATIENT	13,282,536	0	13,282,536	0.00%	9,608,520
TOTAL PATIENT SERVICE REVENUES	15,202,181	14,287,925	914,256	6%	11,609,843
DEDUCTIONS FROM REVENUE					
TOTAL DEDUCTIONS FROM REVENUES	(6,019,079)	(5,658,179)	(360,900)	6%	(4,290,507)
BAD DEBT	(380,730)	0	(380,730)	0.00%	(281,746)
CHARITY	(278,121)	0	(278,121)	0.00%	(100,057)
TOTAL DEDUCTIONS FROM REVENUES	(6,677,929)	(5,658,179)	(1,019,750)	-18%	(4,672,310)
	43.9%	39.6%			40.2%
NET PATIENT SERVICE REVENUES	8,524,251	8,629,746	(105,495)	-1%	6,937,532
OTHER OPERATING REVENUES	94,282	58,206	36,076	62%	44,184
TOTAL OPERATING REVENUES	**8,618,534**	**8,687,952**	(69,418)	-1%	**6,981,717**
OPERATING EXPENSES					
SALARIES/WAGES	4,842,769	4,916,904	74,135	2%	3,928,610
EMPLOYEE BENEFITS	966,864	1,084,999	118,135	11%	850,704
PROFESSIONAL SERVICES	280,684	275,691	(4,993)	-2%	239,603
FOOD SUPPLIES	50,320	45,132	(5,188)	-11%	42,101
MINOR EQUIPMENT	262,815	52,164	(210,651)	-404%	22,100
SUPPLIES	642,289	519,780	(122,509)	-24%	496,239
PLANT UTILITIES	109,616	89,223	(20,393)	-23%	111,139
PURCHASED SERVICES	814,910	895,908	80,998	9%	851,074
REPAIR/MAINTENANCE	288,004	295,791	7,787	3%	212,755
PUBLIC RELATIONS/RECRUITMENT	16,697	33,072	16,375	50%	22,279
RENT/LEASES	145,930	122,499	(23,431)	-19%	124,084
INSURANCE	103,565	131,100	27,535	21%	89,000
LICENSES/TAXES	50,064	59,664	9,600	16%	35,168
DUES/SUBSCRIPTIONS/OTHER	141,278	186,981	45,703	24%	92,111
TRAVEL/TRAINING	29,606	47,490	17,884	38%	13,592
DEPRECIATION	938,771	1,151,700	212,929	18%	688,234
AMORTIZATION	47,050	0	(47,050)		
TOTAL OPERATING EXPENSES	**9,731,234**	**9,908,098**	**176,864**	1.8%	**7,818,813**
NET OPERATING SURPLUS (LOSS)	**(1,112,700)**	**(1,220,146)**	**107,446**		**(837,096)**
NON-OPERATING REVENUES		966,248	(966,248)		
PROPERTY TAXES FOR OPERATIONS	680,004				648,631
GRANTS/CONTRIBUTIONS	7,528				378,690
INVESTMENT EARNINGS	103,088				92,278
OTHER EXPENSE	0	0	0		
TAXES FOR DEBT SVC PMTS	318,872				310,380
INTEREST EXPENSE	(450,978)				(452,301)
GAIN / (LOSS) ON ASSET DISPOSAL	500				
NET INCOME	(453,685)	(253,898)	(199,787)		140,582
margin	-5.3%	-2.9%			2.0%
TOTAL NET INCOME (LOSS)	**$ (453,685)**	**$ (253,898)**	**$ (199,787)**		**$ 140,582**

unaudited

Patient Statistics

Lake Chelan Health

For the month ended March 31, 2024

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

Actual vs Budget	Current Month 03/31/24	BUDGET	STATISTICS	Actual vs Budge	Last Year Month 03/31/23	BUDGET
	97	120	Total Days Cash on Hand		104	120
	56	40	Net AR Days		46	40
	0.21	1.25	Debt Coverage Ratio		4.64	1.25
	198	175	Payroll FTEs		188	175

	Current Month Actual	Prior Year				Year-To-Date Actual	Prior Year	
Actual vs Budget	03/31/24	03/31/23	BUDGET	STATISTICS	Actual vs Budge	03/31/24	03/31/23	BUDGET
				Admissions				
NA	20	16	NA	medical	NA	57	62	NA
NA	0	0	NA	surgical	NA	0	0	NA
NA	10	8	NA	OB	NA	24	23	NA
NA	30	24	NA	**Acute**	NA	81	85	NA
NA	7	5	NA	**Swing Bed**	NA	19	28	NA
NA	10	8	NA	**Total Deliveries**	NA	23	24	NA
				Patient Days				
	56	47	51	medical		182	185	152
NA	0	0	NA	surgical	NA	0	0	NA
	16	15	16	OB		43	47	48
	72	62	67	**Acute**		225	232	200
	74	39	53	**Swing Bed**		197	239	158
	12	12	12	**Total Newborn Days**		31	35	37
	158	113	133	**TOTAL PATIENT DAYS**		453	506	394
				Average Length of Stay				
	2.4	2.6		Total Inpatient		2.8	2.7	
	10.6	7.8		Swing Bed		10.4	8.5	
				Avg Daily Census - Hospital				
	2.3	2.0		Total Inpatient		2.5	2.6	
	2.4	1.3		Swing Bed		2.2	2.7	
	4.7	3.3		**Total**		4.6	5.2	
	519	518	575	**ED Visits**		1478	1412	1705
	65	48	78	**Surgeries**		212	138	230
	1217	1049	1014	**Imaging Procedures**		3602	2965	3008
	2942	2931	3255	**Lab Tests**		8758	8742	9660
	758	602	679	**Rehab Visits**		2152	1572	2015
	134	102	123	**EMS Runs**		332	299	365
	859	744	1009	**Total Clinic Visits**		2436	1976	2993
	98	27	74	**Specialty**		290	70	218
	139	109		**Primary care**		419	355	0
	622	580	935	**Express Care (budget shows primary and express)**		1727	1551	2775
	21	23		**working days**		64	65	

Note #1 Contractuals

Contractuals do not include reimbursement that will happen when cost report is filed.
AR increased $921k from February to March. This resulted in an increase to contractuals of $444,472
Charity care was $70,146 for March. Bad Debt was $179,921.
Charity and Bad Debt are 4.33% of gross charges ytd compared to 3.32% this same time last year and 2.62% overall.
Revenues are 6% higher than budgeted

Note #2 PROFESSIONAL SERVICES

Radiology budget budget is $139k vs expense of $142k. Stats are over budget by 19% and revenue is also over budget
UW Residency Program budget is $50k vs expense of $52k

Note #3 MINOR EQUIPMENT AND SUPPLIES

Surgery - Budget $7k, Actual $211k Stryker Orthopaedics $190k for instruments for total knees and hips (this expense was not known at budget time) $5k workpointe for desks

Note #4 SUPPLIES

Revenue is over budget. Complexity of surgeries = higher supply costs. Will continue to research.

Note #5 UTILITIES

LCH is still occupying the old hospital building. Winter utilty bills are higher. PUD for old hospital was $13,840 and water/garbage was $13,614. Roots does help offset some of these costs

Note #6 RENTS/LEASES

Chelan Business Center lease $4,920 per month (14,760 ytd) not budgeted for Ortho and Gen Surg
Acute Care budget $7k, expense $13k (carefusion, kelly copier)

Lake Chelan Health
For the month ended March 31, 2024

2/29/2024	GL ACCOUNT #	ACCT DESCRIPTION	3/31/2024	EXPLANATION		
$171,821	10002000	General Fund Cash In Bank (North Cascades)	$125,464	($46,357)		
				$2,276,833	deposits	
					dsh	
					medicaid cost report	
				($7,459)	tsys/payplus fees	
				($425)	fees mckesson/cardinal	
				($31)	fees and interest	
					rebates	
				$3,725	café sales posted in March	
				($2,319,000)	transfer to county	
$687,722	10004000	General Fund Cash w/ Treasurer	$544,307	($143,415)		
				($1,149,335)	AP	
				($5,657)	Voids	
				$1,149,335	warrants issued	
				($1,190,824)	warrants redeemed	
				$2,319,000	Bank Transfers from 10002000	
				$300,000	Bank Transfer to/from 10106000	
				($88,992)	Bank Transfer for USDA pmt	
				$0	Bank Transfer to USDA reserve	
				($1,514,103)	Payroll/Benefits	
				($15,575)	B&O taxes	
				$52,652	Property Taxes	
				$85	Leasehold Taxes & Misc Taxes	
				$0	Bond Fee	
$1,512	10009000	cash clearing	$16,844	$15,332	pmts with missing remits	
($89,762)	20070000	warrants outstanding	($541,503)	($451,741)		
				($1,529,987)	remits (payroll/benefits/b&0)	
				($1,149,335)	warrants redeemed	
				$1,203,946	warrants issued ap	
				$1,017,979	remits redeemed	
				$5,657	voids	
$1,106,533	10106000	AMB RESERVE	$903,361	($203,172)		
				($300,000)	transfer to reserves	
					transfer from reserves	
				$96,662	property taxes	
				$156	leasehold taxes	
				$9	interest	
$329,180	10910000	2018 GO BOND	$398,896	$69,716		
				$69,716	property taxes	
				$0	bond pmt	
$31	10911000	2018 CASH BOND	$31	$0	interest	
$213,600	10916000		$213,600	$0	funded year 2 per LOC	
$60,000	10917000		$60,000	$0	funded year 2 per LOC	
$273,600			$273,600			
$0	10915000	CASH/TREAS LTGO BOND	$0	$0		
$7,601,473	10760000	RESERVES	$7,636,213	$34,740		
				$34,740	interest	
$10,082,110			$9,357,214	($724,896)	6	

Days of Cash on Hand	
Cash:	
current assets	145,113
unrestricted reserves	1,302,288
unrestricted reserves	3,496,689
	4,944,090
USDA reserve	273,600
restricted reserves - pending covid ca	4,139,524
	4,413,124
Expenses:	
total YTD	9,731,234
less depreciation	-985,822
	8,745,412
number of days YTD	31
Days of Cash on Hand	51.45
Restricted Days Cash on Hand	45.92
Total Days Cash on Hand	97.37

CEO Board Report (as of 4/18/2024)

People:

- Working on hard on filling shifts in the ED alongside our CMO and med staff coordinator. Have appreciated the help of our docs and CVCH docs picking up additional shifts. Actively recruiting for new providers.
- Interviewed a promising FP doc candidate. We have some upcoming conversations with additional providers.
- The EMS award banquet is coming up on 4/26.

Community:

- Continue to look for ways to improve our service offerings to the community. Actively working on dermatology, cardiac rehab, and increasing our inpatient capabilities.
- Many of nurses attended a two-day SANE nurse training class which will give us better capability of taking care of very vulnerable patients that have suffered sexual assault. Very proud of our team for stepping up and taking the training. Many facilities, even in large hospitals, don't offer these services.
- 5th graders came and did CPR, ambulance tours and went across the street for some dissection of hearts and lungs.

Quality:

- Working on evaluating an OR consulting team that has come recommended to us to help optimize and set fresh expectations/standards for our growing OR.
- Our ED readmission rate is the lowest it has been in over 2 years.
- Medical staff and nursing staff drilled on our emergency C-section policy.

Financial:

- We will be moving to Edie Bailly for our cost report preparation and auditing. This will give us a fresh set of eyes on our financial practices and operations here. We appreciate all the years of hard work from Wipfli!
- Continue to work with the Collaborative on joint payor contracting.
- Having substantial difficulty with our "Medicare" Advantage Plans and payment. Also have struggled with payors who have contracted with "Change Healthcare" with cash payments.
- Charity care increased 5-fold year over year for March and bad debt two times. We are reviewing account by account to try to understand where the increases are coming from.
- March gross revenue was $5.2M vs $4M last year, however, our net revenue was ($345,619) for the month of March driven by extremely high contractual allowances. Expenses were just below budget.

Building for the Future:

- Preliminary drawings are going to the city (with total water fixtures) on 4/19. Hopeful we can get agreement around the availability of water without substantial costs.
- Marcus Miller (Director of Outpatient Services) submitted for a joint USDA DLT grant to get various telemedicine equipment for future projects (this was through our Accountable Community of Health).

LAKE CHELAN HEALTH	2023 Board of Commissioners KPI DASHBOARD									2024 Board of Commissioners KPI DASHBOARD				
	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY
**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%	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%	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%	57.0%	72.0%	49.0%	48.0%		
**KPI-47. Service line development / improvement metrics will be executed at => 77%		36%	27%	50%	45%	54%	61%	69%	50%					
**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%	20%	40%	40%	40%		
**KPI-88. Complete 2 Community Forums 2023.						100%								
**KPI-92. Quarterly rounding / staff meeting attendance, by Administrative Staff.			100%			75%			75%			75%		
Governance Committee KPI-1: Complete 3 Board Community Forums 2024														
Governance Committee KPI-2: Representation of hospital at Community meetings.										100%	100%	100%		

Status **Pending** PolicyStat ID **15329257**

Origination	10/10/2003
Last Approved	N/A
Effective	Upon Approval
Last Revised	4/9/2024
Next Review	2 years after approval
Owner	Louise Sahlinger: Director Of Quality
Area	Quality

Complaint & Grievance Resolution Policy and Procedure

Purpose

~~To assure all patient complaints and grievances are addressed and appropriately resolved in a timely, reasonable, and consistent manner.~~

To assure consistent and effective communication and resolution of patient complaints and grievances, all Lake Chelan Health employees should be aware of the processes in place to immediately resolve issues or how to escalate them in order to provide an acceptable resolution to the patient and also take advantage of the opportunity to learn and support our commitment to continuous improvement.

Policy

- The Board of Commissioners delegates authority for managing grievances to the Grievance Committee.
    - The Grievance Committee is an ad hoc committee comprised of the Executive Director of Quality, Safety & ~~Patient Safety~~Risk, or designee, the Department Manager or Director where the grievance originated, and other staff as appropriate including the Risk Manager, medical providers, and executive leadership team.
- Patients are informed of their rights upon seeking care or admission, including the right to voice complaints or grievances.
- Signs are to be posted in patient care areas detailing the options for filing a grievance via phone to the Executive Director of Quality, Safety & Risk and the Department of Health.
- Complaints or grievances may be filed by a patient or patient representative, or any person who witnesses a potential patient rights or patient safety violation.

- A patient or patient representative may bypass the complaint or grievance process and contact the Washington State Department of Health directly to file a complaint or grievance.
    - Washington State Department of Health
      1-800-633-6828 or hsqa.csc@doh.wa.gov
- Legal claims are managed by Risk Management and/or Legal Services and not considered grievances for resolution according to this policy.
- Complaints or grievances made through online platform reviews (i.e., Google, Yelp, etc.) and social media will not be processed according to this policy.
- Billing complaints will be reviewed by the Business Office Manager or other designee in collaboration with other leaders, as appropriate, and ultimately resolved by the Executive Director of Quality, Safety & ~~Patient Safety~~Risk. If the billing complaint involves a clinical care concern, it will be reviewed by the Executive Director of Quality, Safety & ~~Patient Safety~~Risk separately from the billing complaint (to include medical director chart review) and the findings and recommended resolution will be communicated to the Business Office Manager or designee.

Definitions

Complaint: Verbal ~~complaint~~expression of dissatisfaction by a patient or patient representative that is made to staff regarding patient care, patient experience or patient satisfaction and can be resolved promptly prior to the patient's discharge from LCH. Complaints may include but are not limited to:

1. Standard of care or quality of care issues;
2. Reports of inadequate pain management;
3. Miscommunication between patients/families and healthcare providers;
4. Housekeeping, diet/food, or facility issues.

Grievance: Either an informal or formal written or verbal complaint that is made to ~~the Critical Access Hospital~~Lake Chelan Health by a patient, or the patient's representative, when a patient issue cannot be resolved promptly by staff present. If a complaint cannot be resolved promptly by staff present or is referred to the Quality department, patient advocate, or ~~Critical Access Hospital~~Lake Chelan Health management, it is to be considered a grievance. To include high medical/legal/reputation risk or identified care concerns. A complaint becomes a grievance when:

1. It is received in writing;
2. A patient or their representative requests that their complaint be handled as a formal complaint or grievance;
3. A patient or their representative requests a written response;
4. A patient care complaint requires another team member's review or investigation to occur, including a formal clinical chart review.

Patient Representative: The patient's representative is someone who, in accordance with state law, may speak for the patient. This would include but is not limited to: Legal Guardian, Medical Durable Power of Attorney for Healthcare, family members (spouse, adult child, parent, adult sibling, and grandparent). The

representative may also be someone whom the patient has indicated may speak for them. If the patient is unable to communicate this information, it will be assumed that anyone coming forward with a complaint is acting on behalf of the patient and will be considered a patient representative.

Grievances can be received through the following venues:

- Phone call/voicemail
- Email
- USPS letter or certified mail
- ~~Patient Satisfaction Survey~~ Response to patient satisfaction survey detractor letter, or patient satisfaction comments that cause the Quality department to investigate further
- Face to Face

Billing complaints: A written or verbal complaint regarding a bill that is not related to quality of care and does not include any patient safety or quality care ~~or services and does not include any patient safety or quality care~~ concerns in the clinical setting.

Procedure

Complaints

1. Patients or patient representative may contact any staff member to file a complaint.
2. Staff members aim to resolve concerns or complaints at the time they are received.
3. Complaints are escalated based on the chain of command if appropriate.
4. At any time during the complaint resolution process, the Quality Department may be contacted for assistance, advice, or support.
5. At any time during the complaint process, the patient's physician may be notified if appropriate under the circumstances and should be given the opportunity to assist in resolving any complaints related to clinical care.
6. If staff are unable to resolve the complaint, they are to complete a Quality Management Memo (QMM) including the person's contact information making the complaint, and a description of the complaint, for resolution through the grievance procedure.
7. The QMM submitter shall immediately notify the Compliance Officer of any complaint concerning privacy/patient confidentiality in addition to entering the QMM.

Grievances

1. Patients or patient representatives may contact the Executive Director of Quality, Safety & ~~Patient Safety~~Risk at 509-682-3300 ext. 7814, or designee, to file a grievance; they can also call the designated LCH ~~helpline at 1-844-729-4088 to file their grievance~~Compliance Hotline at 1-888-866-6321.
2. The Grievance Committee reviews and~~/or~~ investigates all grievances.
    1. The Grievance Committee membership (stated above) is an ad hoc committee.

3. The Executive Director of Quality, Safety & Risk will contact the patient or patient representative to gather all pertinent information if they did not originally speak with the patient.
4. A letter notifying the patient of receipt of the complaint/grievance will be drafted and mailed to the patient or patient's representative. The letter will explain that an investigation will be conducted and that it is expected to close within 30 days.
    1. If the patient or authorized representative of the patient is not the person making the grievance, Protected Health Information of a patient that may be included in the investigation summary can only be released as allowed by law.
5. Every effort is made to resolve grievances within 30 days.
    a. If the review and/or investigation is likely to take more than ~~10~~30 days, or ~~10~~30 days has elapsed since the grievance has been filed, the patient or patient representative is notified in writing.
6. All grievances that have a completed investigation will be responded to in writing. Responses include:
    a. the contact person for the grievance
    b. steps taken to investigate the grievance
    c. results of the grievance process
    d. the date of completion
7. A grievance is considered resolved when the patient or patient representative is satisfied with the actions taken on their behalf.
    a. The grievance resolution will include:
        a. Identification of ~~the Critical Access Hospital~~Lake Chelan Health's contact person;
        b. Steps taken to investigate;
        c. Results of the grievance process; and,
        d. Date of completion.
    b. There may be situations where the organization has taken appropriate and reasonable action to resolve the grievance and the patient or patient representative remains unsatisfied. The organization may consider these closed if regulatory requirements have been met and are documented and no further clinical or operational concerns are identified. Alternatively, the grievances can be forwarded to the Chief Executive Officer for final disposition.
    c. If any grievance remains open after 30 days since the filing and without any further communication from the patient, a letter will be sent to the patient notifying them that their grievance case will be closed; should they wish to keep the grievance open (as appropriate) they are to contact the Executive Director of Quality, Safety & ~~Patient Safety~~Risk.
    d. If the grievance remains open after 60 days since the original filing of the grievance (and communication attempts are also documented), and after 30-60 days without

any further communication from the patient, the grievance case will be closed.

8. Documents pertaining to the review and/or investigation will be maintained by Executive Director of Quality, Safety & ~~Patient Safety~~Risk or designee.

Billing Complaints

1. Patients or patient representatives may contact any staff member to file a complaint.
2. Staff members aim to resolve concerns or complaints at the time they are received.
3. Complaints are escalated based on the chain of command if appropriate.
4. Staff should complete a Quality Management Memo including the patient or patient representative contact information, and a description of the complaint, or grievance.
5. Should the complaint include quality of care or clinical care concerns, the Executive Director of Quality, Safety & ~~Patient Safety~~Risk will follow up with the patient and follow the formal Grievance procedure described above for clinical care concerns.
6. The Business Office Manager, or designee, will work to resolve any billing complaints they receive according to their own complaint procedure(s).
7. Documents pertaining to the review and/or investigation will be maintained by the Revenue Cycle Director, Business Office Manager or designee.

Reporting

1. Grievances and complaints are reported internally via the QMM report which is published for review every quarter.
2. All QMMs, including grievances and complaints are tracked and trended to identify opportunities for improvement. Results are shared with the appropriate leaders and/or committees.
3. Data is shared with the Quality Committee no less than once per quarter.

Confidentiality

All records, reports, database information, investigations, and other related documents are prepared for quality improvement processes under Lake Chelan Health Executive Leadership, quality related committees, other medical staff committees and medical staff peer review. As such, this information is confidential, privileged, and protected from discovery and inappropriate disclosure. Employees should not openly discuss grievances that they receive outside of the established grievance process set forth by this policy.

Retaliation

No person may retaliate against any patient or person acting on behalf of a patient for filing a complaint or grievance with the organization.

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Executive Approval	Shawn Ottley: Chief Operating Officer	4/9/2024
Quality Director	Louise Sahlinger: Executive Director of Quality, Safety and Risk	4/9/2024

Status **Pending** PolicyStat ID **9116981**

Origination	3/14/2014
Last Approved	N/A
Effective	Upon Approval
Last Revised	11/22/2023
Next Review	2 years after approval
Owner	Louise Sahlinger: Executive Director of Quality, Safety and Risk
Area	Quality

Peer Review

PURPOSE

To ensure that ~~the hospital~~Lake Chelan Health, through the activities of its medical staff, evaluates the ~~ongoing professional practice~~Ongoing Professional Practice (OPPE) of all individuals granted clinical privileges and performs a Focused Professional Practice Evaluation (FPPE) when indicated. The purpose of Peer Review will be to:

- Improve the quality of care provided by individual practitioners;
- Monitor the ongoing performance of practitioners who have been granted privileges;
- Acknowledge practitioners for exemplary performance in the hospital/clinic environment, whether related to patient care, service to the medical staff, or service to ~~the hospital~~Lake Chelan Health;
- Identify individual and collective opportunities for performance improvement;
- Analyze aggregate data to identify significant trends, and; ~~and 22.1.6. Assure that the process for peer review is clearly defined, fair, defensible, timely, and useful across the entire multidisciplinary medical staff.~~
- Assure that the process for peer review is clearly defined, fair, defensible, timely, and useful across the entire multidisciplinary medical staff.

DEFINITIONS

Peer Review. "Peer review" is the evaluation of the professional performance of the entire Medical Staff collectively and individually and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of

an individual practitioner's performance as well as appraising the quality of care rendered by a group of professionals or a system.

Peer review is conducted using multiple sources of information including:

- the review of individual cases;
- the review of aggregate data for compliance with general rules of the medical staff and;
- clinical standards and use of rates in comparison with established benchmarks or norms.

Evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for improvement or confirmation of achievement related to the effectiveness of professional practice as defined by the Accredited Council for Graduate Medical Education (ACGME) general competencies described below:

- **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.
- **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences; as well as the application of their knowledge to patient care and to the education of others.
- **Practice Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
- **Systems Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize ~~healthcare~~health care.

Peer. A "peer" is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis.

Peer Review Body. The peer review body designated to perform the initial review by the Medical Executive Committee or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital.

Ongoing Monitoring or Ongoing Professional Practice Evaluation (OPPE): The routine monitoring and evaluation of current competency for Medical Staff members. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment.

Proctoring or Focused Professional Practice Evaluation (FPPE): The establishment of current

competency for new medical staff members, new privileges and or concerns identified from OPPE. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances. Lake Chelan Health primarily engages in retrospective review.

Conflict of Interest: A member of the medical staff requested to perform peer review may have a conflict of interest if they are potentially unable to render an unbiased opinion. An automatic conflict of interest would result if the practitioner is the provider under review. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner or key referral source. It is the obligation of the individual reviewer to disclose to the peer review body any potential conflict. It is the responsibility of the peer review body to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participation in peer review. When a potential relative conflict is identified, the MEC chair will be informed and make a final determination if a substantial conflict exists. When either an automatic or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions. Relevant specific information may still be requested of an individual with a conflict of interest if required for the Peer Review Process.

POLICY.

Peer review is part of the coordinated quality improvement program of the Hospital and its Medical Staff. All documents and discussions related to Peer Review activities are privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability subject to the Federal Health Care Quality Improvement Act, RCW 4.24.250, and RCW 70.41.200, and will not be subject to subpoena or discovery proceedings in any civil action, except as provided in RCW 4.24.250 and RCW 70.41.200.

- ~~Each member of the Medical Staff will receive provider-specific peer review information on a routine basis. This may consist of information related to:~~
- ~~performance data for all dimensions of clinical activity for which an individual practitioner has been granted privileges;~~
- ~~The individual practitioner's role in sentinel events, significant incidents or near misses,~~
- ~~Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action.~~
- ~~Practitioner~~ Each member of the Medical Staff will receive provider-specific ~~data will be available to the Professional Practice Committee for~~peer review ~~during the credentialing and privileging process and, as appropriate, for use in ongoing performance improvement activities~~information on a routine basis. This may consist of information related to:
    - Performance data for all dimensions of clinical activity for which an individual practitioner has been granted privileges;
    - The individual practitioner's role in sentinel events, significant incidents or near misses,
    - Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action.

    - Practitioner specific data will be available to the Medical Executive Committee for review during the credentialing and privileging process and, as appropriate, for use in ongoing performance improvement activities.

- Peer review information in the individual provider quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee. Access to protected information shall only be to the extent necessary to carry out assigned responsibilities. The Director of Quality and/or Medical Staff Coordinator will assure that only authorized individuals have access to individual provider quality files and that the files are reviewed under the supervision of the Medical Staff Coordinator ~~of~~or Medical ~~Staff Services~~Executive Committee, or designee. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement.
    - The specific practitioner will have an opportunity to review his/her own file with his/her department chair and Chief Medical Officer;
    - The Chief of Staff for purposes of considering corrective action;
    - Members of the Medical Executive Committee, for purposes of considering corrective action;
    - Director of Quality/Risk Director and Staff supporting the peer review process;
    - Medical staff services professionals to the extent that access to this information is necessary for the re-credentialing process or formal corrective action;
    - Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. CMS, DOH, DNV, or state/federal regulatory bodies; Individuals with a legitimate purpose for access as determined by the hospital Board; and
    - The hospital CEO when information is needed to take immediate formal corrective action for purposes of summary suspension by the CEO.

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- ~~The Chief of Staff for purposes of considering corrective action;~~
- ~~Members of the Medical Executive Committee, for purposes of considering corrective action;~~
- ~~Risk Director and Staff supporting the peer review process;~~
- ~~Medical staff services professionals to the extent that access to this information is necessary for the re-credentialing process or formal corrective action;~~
- ~~Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. CMS, DOH, or state/federal regulatory bodies; Individuals with a legitimate purpose for access as determined by the hospital Board; and~~
- ~~The hospital CEO when information is needed to take immediate formal corrective action for purposes of summary suspension by the CEO.~~
- Only the final determination of the ~~MPRC~~Medical Executive Committee and any subsequent actions are considered part of an individual provider's quality file. Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be maintained by policy after the committee decision has been made. Working notes include potential issues identified by

hospital staff, preliminary case rating, questions and notes and the practitioner reviewers and requests for information from the involved practitioners and any written responses to the committee.

- No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, the Board or by mutual agreement between the Chief of Staff of the Medical Staff for purposes of deliberations regarding corrective action on specific cases.

Circumstances requiring peer review: The procedures for conducting peer review for an individual case and for aggregate performance measures are described in the ~~Med~~Medical Staff Bylaws.

In the event a decision is made by the ~~MEC~~Medical Executive Committee, or the Board of ~~Trustees~~Commissioners to investigate a practitioner's performance or circumstances warrant the evaluation of one or more practitioners with privileges, the Medical Executive Committee or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as described in the Medical Staff Bylaws.

Circumstances requiring external peer review: Either the ~~MEC~~Medical Executive Committee or the Board of ~~Trustees~~Commissioners will make determinations on the need for external peer review. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the ~~MEC~~Medical Executive Committee, or Board of ~~Trustees~~Commissioners. Circumstances requiring external peer review include:

~~**Litigation:** when dealing with the potential for a lawsuit.~~

~~**Ambiguity:** when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.~~

~~Lack of internal expertise: when no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the medical executive committee or governing board.~~

~~**New Technology/Procedure:** when a practitioner requests permission to use new technology or perform a new procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.~~

~~**Miscellaneous Issues:** when the medical staff needs an expert witness for a fair hearing for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or Board of Trustees may require external peer review in any circumstances deemed appropriate by either of these bodies.~~

- **Litigation:** when dealing with the potential for a lawsuit.
- **Ambiguity:** when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.

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- **New Technology/Procedure:** when a practitioner requests permission to use new technology or perform a new procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
- **Miscellaneous Issues:** when the medical staff needs an expert witness for a fair hearing for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or Board of Commissioners may require external peer review in any circumstances deemed appropriate by either of these bodies.

The peer review body will consider the views and input of the person whose care is under review prior to making a final determination regarding the care provided by that individual under review responds in the ~~timeframe~~time frame outlined in Med Staff By-laws.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the ~~MEC~~Medical Executive Committee will replace, appoint or determine who will participate in the process so that bias does not interfere in the decision-making process.

Selection of Practitioner Performance Measures. Measures of practitioner performance will be selected by the ~~MEC~~Medical Executive Committee to reflect the six General Competencies and will utilize multiple sources of data described in the (Medical Staff Indicator List).

Thresholds for Focused Professional Practice Evaluation: If the results of Ongoing Professional Practice Evaluation indicate a potential issue with practitioner performance, the ~~MEC~~Medical Executive Committee may initiate a focused evaluation to determine if there is a problem with current competency of the practitioner for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or rule or rate indicators

Individual Case Review. Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the Quality and Risk Management staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.

Statutory Authority. This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq, and the Revised Code of Washington (RCW) 70.41.200. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled with language consistent with the following:

~~"Statement of confidentiality"~~**"Statement of confidentiality"**

Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential,

not public records, shall be used by the MEC and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena in accordance with RCW 70.41.200 and Washington case law."

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Executive Review	Wendy Kenck: Executive Assistant	4/2/2024
Med Exec Committee	Becky McCracken: Medical Staff Coordinator	1/4/2024
CMO Review	Matthew Hillman	12/21/2023
Owner	Louise Sahlinger: Director Of Quality	11/22/2023

Status **Pending** PolicyStat ID **13660864**

Origination	7/31/2013
Last Approved	N/A
Effective	Upon Approval
Last Revised	11/22/2023
Next Review	2 years after approval
Owner	Patti Peters: Business Office Director
Area	Patient Access Services

Outpatient Service Orders by Non-Privileged Providers

POLICY STATEMENT:

Lake Chelan Health allows licensed non-staff practitioners or advanced practice professionals to order outpatient tests and services in accordance with CMS Guidelines and as permitted by their license, scope of practice and the State of Washington. An appropriate verification process will be followed to ensure any ordering individual has an NPI and current state licensure.

PURPOSE:

To provide a process for licensed practitioners who are not members of the medical staff to order outpatient tests and services in accordance with Washington State law. For the purpose of this policy, licensed practitioners are defined as health care personnel who are qualified and authorized to order outpatient diagnostic tests and services, and refer patients to outpatient and/or specialty services.

PROCEDURE:

1. The requesting practitioner must fax an order on their office/facility letterhead and include their NPI and state license numbers.
    a. For non-privileged providers, the request must also include the address and contact numbers(s) of the patient and the name, address, and contact number of the Practitioner responsible for the results.
2. Upon receipt of the order, the reception staff will verify that the ordering or referring practitioner is a member of the Medical Staff or in the Hospital's database.
3. If the provider is not a member of the Medical Staff, nor in the Hospital's data base, the

reception staff will verify the validity and status of the provider's State License by going to the appropriate State's medical practitioner license website.

4. Patient Access Services staff will then print a copy of the practitioner's license status and scan that, along with the faxed order form into the patient's chart.
5. The reception staff will then notify the appropriate department of the patient and the ordered test or service.
6. It is at the discretion of the Laboratory's Medical Director to review and / or reject the non-privileged Providers orders. If lab staff reject an order, they will notify the ordering clinician.
7. All reports are to be sent directly to the requesting Practitioner. If there is any questions about the requests, the Practitioner should be contacted for verification.

DIAGNOSTIC TESTS AND SERVICES:

1. Non-staff providers, (MD, DO, DPM, DDS, PAC, PA, ARNP, CRNA, DC, & NT) may order the following tests/outpatient services:
    - Diagnostic imaging
    - Laboratory Services
    - Physical Therapy / Occupational Therapy
    - EKG
    - Wound Care Therapy
    - Blood Transfusions
    - Infusion Therapy
    - PICC Insertion
2. It is also permissible to allow physicians with a confirmed, valid license in their state to order services as defined in item #1.

LIMITATIONS:

1. Chiropractors are limited to ordering non-invasive diagnostic radiological tests (x-rays, MRI or CT scans) and physical therapy or rehabilitation services.
2. Naturopaths are authorized to order only outpatient laboratory tests.

EXCEPTIONS:

1. Orders cannot be accepted from a member of Lake Chelan Health's medical staff or allied health professional whose clinical privileges have been suspended for disciplinary reasons.
2. The Administrator On-Call may make exceptions to this policy under unusual circumstances taking into account the best interest of the patient's medical needs.

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Executive Review	Wendy Kenck: Executive Assistant	4/2/2024
Med Exec Committee	Becky McCracken: Medical Staff Coordinator	1/23/2024
CMO Review	Matthew Hillman	12/21/2023
Owner	Patti Peters: Business Office/ Patient Acess/HIMS Manager	10/5/2023