



LAKE CHELAN HEALTH

BOARD PACKET

Chelan County Public Hospital District No. 2

Board Calendar Reminders:

2/13/2025	Quality Committee	Bragg Room/ TEAMS	1 pm – 3 pm
2/10/2025	TBA	Bragg Room/ TEAMS	9 am
2/19/2025	Finance Committee	Bragg Room/ TEAMS	11 am
2/25/2025	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

3/5/2025	Compliance, Privacy, & Risk Committee	1212 Conference Room	10 am – 11 am
3/10/2025	TBA	Bragg Room/ TEAMS	9 am
3/18/2025	Med Staff	Bragg Room/ TEAMS	7:30-8:30
TBA	Quality Committee	TBA	TBA
3/19/2025	Finance Committee	Bragg Room/ TEAMS	11 am
3/25/2025	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

4/14/2025	TBA	Bragg Room/ TEAMS	9 am
4/15/2025	Med Staff	Bragg Room/ TEAMS	7:30-8:30am
TBA	Quality Committee	TBA	TBA
4/23/2025	Finance Committee	Bragg Room/ TEAMS	11 am
4/29/2025	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 December 17, 2024 1:30 pm
in person and via Microsoft TEAMS**

Commission Attendance:

(not present present)

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> Jordana LaPorte, Chair | <input checked="" type="checkbox"/> Mary Murphy, Secretary | <input checked="" type="checkbox"/> Len England |
| <input checked="" type="checkbox"/> Lori Withrow, Vice Chair | <input checked="" type="checkbox"/> Doug Gibson | |

Staff Participants: A. Edwards, B. Truman, S. Ottley, A. Oden, L Sahlinger, R. Montgomery, M. McCormick, A. Benegas, J. Phetteplace,

Guests: Guild B Chair, Vice Chair, and Secretary

Community Members: Ruth (Lake Chelan Mirror), A. Moroz, M. Navarro, Sara

Recorder: Wendy Kenck

Agenda Item	Topic/Action
1. Call to Order	<ul style="list-style-type: none"> • J. LaPorte called the meeting to order at 1:30 pm and recited the mission statement. • Agenda Changes <ul style="list-style-type: none"> ○ <i>M Murphy motioned to approve the Meeting Agenda changes (removal of Med Staff Quarterly update and the Charity Care Policy, add Community Connection to Old Business, change Board Nomination item from FM to FD), seconded, motion approved</i>
2. Public Comment	<ul style="list-style-type: none"> • Guild B members, Mary School (Board Chair), joined by Vice Chair and Treasurer, presented two fundraising events from 2024. They thanked the dedication of volunteers, donors, and the support of the hospital. The events were a great success: Paint the Town Pink raised \$20K for standardizing BP machines, and Karen Collins' estate sale raised \$6200 for an EKG machine at the clinic. They expressed excitement for the positive changes these contributions will bring to the hospital and community and thanked everyone for their continued support. • Adrienne Oden introduced herself as the Interim Surgical Director. She works with Whitman Partners and specializes in perioperative leadership. She expressed her excitement to learn and build the department for LCH and the community.
3. Chair's Report	<ul style="list-style-type: none"> • J. LaPorte expressed appreciation for all the effort the Employee Activities Committee (EAC) organized for the employee holiday party, which was a success. Thanks to the staff who were not in attendance but were keeping the hospital up and running.
4. Consent Agenda	<ul style="list-style-type: none"> • <i>Edits to the Consent Agenda: Governance meeting minutes dated 11/20/24, item 2 should read 'Recommend Bylaws updates at December 17 Board meeting.'</i> <ul style="list-style-type: none"> ○ <i>D. Gibson motioned to approve Consent Agenda with edits, seconded, motion passed</i>
5. Executive Session	<ul style="list-style-type: none"> • J. LaPorte announced Executive Session at 1:46 pm for 10 minutes to consider information regarding staff privileges or quality improvement committees under RCW 70.41.205 and RCW 42.30.110(1)(o) • Extended 15 minutes • Executive session ended at 2:10 pm
6. Reports	<ul style="list-style-type: none"> • <i>L. Withrow verified all credential files are complete for the proposed list of providers and motioned to approve the appointments and removals as presented, seconded, motion passed.</i> • Med Staff Report: M. Hillman noted that institutional policies need constant review and

	<p>update. The current focus is on improving and streamlining operating procedures in the OR and Anesthesia and adding policies and procedures for institutional care.</p> <ul style="list-style-type: none"> ● Finance: <ul style="list-style-type: none"> ○ B. Truman presented the unaudited November 2024 Finance Report. <ul style="list-style-type: none"> ▪ <i>D. Gibson motioned to accept the unaudited November 2024 Finance Report</i> ○ Additional Financial items of discussion: <ul style="list-style-type: none"> ▪ \$560K paid out to staff for Board-approved 2024 bonuses. ▪ \$21K paid out to staff for years of service recognition covering 2022, 2023, and 2024. ▪ \$800K in outstanding funding for the new hospital is being finalized with Bouten for release by the USDA. ▪ \$175K soil mitigation. ▪ \$270K currently has been spent on the EMS building to date; reimbursement request will be submitted to the Department of Commerce. ▪ Pre-application to the USDA will be submitted for additional funding related to the EMS and MRI machine. ▪ Revenue Cycle Goal: Reduce AR days from 73 to 53 days. ● CEO Report: A. Edwards shared additional notes of interest, including discussion regarding an increase in B&O taxes and Employee Recognition for years of service for 2022, 2023, and 2024. ● Strat Plan KPI Report: S. Ottley presented the Board KPI Dashboard for 2025 based on feedback received from the Board and proposed its use in 2025
7. Old Business	<ul style="list-style-type: none"> ● EMS/Admin Building Project Update: S. Ottley presented the EMS/Admin Building Project Scope and Total Budget, noting the contingency for water and the goal to reduce overall construction costs by analyzing materials for a hybrid of steel and wood. Approval was sought for Admin to move forward with the scope and total budget. <ul style="list-style-type: none"> ○ <i>D. Gibson motioned to approve the scope of the EMS Building including the budget estimate of \$15.6M, seconded, motion approved.</i> ● Specialty Clinic Update: S. Ottley presented an update on the Specialty Clinic and will provide a biweekly progress report with build updates and pictures to be included in the CEO report. ● Two new ambulances have arrived. ● Board discussion regarding the Board Letter, which will be added to the Lake Chelan Mirror. ● CHNA Update: Five proposals were received. It was proposed that Aaron select one of the companies and proceed to initiate the project. ● Community Connections: <ul style="list-style-type: none"> ○ An Apple Blossom Association meeting to be held in January. L. Withrow to attend. ○ L. England connected with the Manson School District regarding signage and potential partnerships for advertising.
8. New Business	<ul style="list-style-type: none"> ● Discussion among the Board members regarding the 'Governing Bylaws' policy that is in review process. ● Policies: <ul style="list-style-type: none"> ○ <i>L. England motioned to approve the 'CEO and Board Decision Matrix' policy with edits as discussed, seconded, motion approved</i> ○ <i>M. Murphy motioned to accept the 'End of Life' Care policy, seconded, motion approved</i> ○ <i>L. Withrow motioned to accept the 'Hospital Staffing Plan', seconded, motion approved.</i> ● Resolutions: <ul style="list-style-type: none"> ○ <i>D. Gibson motioned to approve Resolution 2024-12 '2025 Legal Holidays', seconded, motion approved.</i>

	<ul style="list-style-type: none"> ○ <i>L. England motioned to approve Resolution 2024-13 '2025 BOC Meeting Dates', seconded, approved</i> ● <i>D. Gibson motioned to approve the surplus of the 2012 Dodge, seconded, motion approved.</i> ● Discussion on Board nominations, and vote scheduled for January.
9. Roundtable/Action Items	<ul style="list-style-type: none"> ● W. Kenck to send WORD version of the letter to J. LaPorte for edits, final review by Aaron. ● Board to review the Board Duties and Responsibilities Governance information provided by J. LaPorte for feedback by mid-January ● Aaron and Agustin to decide on one of the CHNA proposals and get started to meet the requirements. ● L. Withrow to attend the January Apple Blossom Association meeting regarding the HOA dues. ● Wendy to reach out to the Business Office manager regarding updates to the Charity Care policy. ● W. Kenck to email the current Board Bylaws to Dr. Hillman. ● Len mentioned that the holiday party was great, and he enjoyed meeting the staff he hadn't met before.
10. Public Comment	No public comment
11. Executive Session	<ul style="list-style-type: none"> ● L. Withrow announced Executive Session at 4:40 pm for 20 minutes for <ul style="list-style-type: none"> ○ RCW 42.30.110(1)(g) Evaluate the performance of a public employee. ○ RCW 42.30110(1)(d) to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs <ul style="list-style-type: none"> ▪ L. Withrow extended the Executive Session 20 minutes ▪ L. Withrow extended the Executive Session 20 minutes ▪ Executive Session ended at 5:40 pm
12. Adjournment	<ul style="list-style-type: none"> ● No action was taken as a result of the Executive Session ● J. LaPorte adjourned the meeting at 5:41 pm

Attest:

M. Murphy, Secretary

Aaron Edwards, CEO

W. Kenck, Executive Assistant

WARRANT #'S A/P	AMOUNT	CAPITAL	BOARD MTG - JAN 2025	WARRANT#'S PAYROLL	AMOUNT	pay period
238244-238289	\$ 429,013.37			Direct Deposit	\$ 554,431.43	11/30/2024
AP DIRECT DEPOSIT	\$ 50,958.53			PAYROLL TAXES	\$ 199,954.17	11/30/2024
238290-238359	\$ 308,617.08			CHILD SUPPORT	\$ 320.37	11/30/2024
238360-238365	\$ 10,056.20			Direct Deposit	\$ 413,213.82	bonus
Retirement	\$ 50,564.08			PAYROLL TAXES	\$ 206,943.27	bonus
Retirement	\$ 1,729.00			Direct Deposit	\$ 537,544.33	12/14/2024
AP DIRECT DEPOSIT	\$ 1,583.21			PAYROLL TAXES	\$ 191,189.70	12/14/2024
238366-238443	\$ 329,285.32			CHILD SUPPORT	\$ 320.37	12/14/2024
DOR	\$ 21,739.10			77526-77528	\$ 2,847.44	12/14/2024 runs 3&4
IDAHO STATE TAXES	\$ 765.00			PAYROLL TAXES	\$ 44.80	12/14/2024 runs 3&5
238444-238535	\$ 342,882.23			Direct Deposit	\$ 517,169.97	
238536-238544	\$ 9,756.46			PAYROLL TAXES	\$ 199,137.17	
Retirement	\$ 48,286.80			CHILD SUPPORT	\$ 320.37	
238545-238580	\$ 367,104.30					
AP DIRECT DEPOSIT	\$ 88,064.22					
238581-238657	\$ 313,705.89					
IDAHO STATE TAXES	\$ 1,799.00					
Retirement	\$ 59,760.23					
	\$ 2,435,670.02				\$ 2,823,437.21	

DATE December 2024

TOTAL BAD DEBTS - HOSPITAL \$128,933.72
TOTAL MEDICARE BAD DEBTS \$11,138.30
TOTAL BANKRUPTCY \$0
TOTAL CHARITY CARE – HOSPITAL \$77,218.38
TOTAL MEDICARE CHARITY CARE - \$0

TOTAL ATTESTATION \$217,290.40

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 _____



January 2025

Meeting Minutes

Name of Group: DEI Committee	Date of Meeting: 01/16/2025	Meeting Start: 1300 Meeting End: 1343
Title of Meeting: DEI Committee		
Facilitator/ Chairperson: Ray Eickmeyer		Location: TEAMS only
Recorder: Ray Eickmeyer		
Participants:		
<input checked="" type="checkbox"/> Commissioner #1 – (Mary Murphy) <input checked="" type="checkbox"/> Commissioner #2 (Doug Gibson) <input checked="" type="checkbox"/> CEO or designee (Aaron Edwards) <input type="checkbox"/> Nurse manager or designee (Rhianna Montgomery) <input type="checkbox"/> ER representative () <input type="checkbox"/> Clinic manager or designee (Giovanne) <input checked="" type="checkbox"/> CHW representative (George Rohrich) <input checked="" type="checkbox"/> EMS-Community Paramedicine (Ray Eickmeyer) <input checked="" type="checkbox"/> Social worker (Codi Onda) <input checked="" type="checkbox"/> Education worker or designee (Dave Dawson)		<input type="checkbox"/> HR or designee () <input type="checkbox"/> Quality (Louise Sahlinger) <input checked="" type="checkbox"/> XCommunications or designee (Agustin Benegas) <input type="checkbox"/> Adhoc- physician () <input type="checkbox"/> Adhoc- community public member ()
Meeting Objectives(s)/Purpose:		
<ol style="list-style-type: none"> 1. Meet LCH equity policy 2. Create an environment that is inclusive, equitable, and diverse. 		

FI – For Information; FD – For Discussion; FA – For Action

Agenda Item	Facilitator/Time	Topic/Action
<ol style="list-style-type: none"> 1. Call to Order <ol style="list-style-type: none"> a. Introductions FI b. Approval of last meeting minutes 	R. Eickmeyer / 2	<p>Motion to approve meeting minutes as corrected; Dave 1st, Aaron 2nd , all present approved.</p> <p>Ray will follow up with Tyler for menu in Spanish options.</p>

2. Wins/Manage-Ups FI	N/A	
<p>3. People</p> <p>A. Language services Survey</p> <p>B. Meeting dates and times / Chairperson</p> <p>C. Agenda items for 2025</p> <p>D. 2024 Annual Report</p> <p>E. Charter Review</p> <p>F. Updated CLAS Implementation plan- review only Governance, leadership and workforce</p> <p>G. Reports:</p> <ul style="list-style-type: none"> a. Patient survey report b. Language services report c. Pt outcomes report d. Staff feedback report 		<ul style="list-style-type: none"> a. A language services survey was sent out and we have 65 responses so far. Committee reviewed some results. b. The committee approved leaving the dates and times the same for 2025- 3rd Thursday each month at 1pm. c. Discussion occurred as agenda items for FY 2025 meetings- one agenda item was the review of the DEI policy at the next meeting. Another item was department language services orientation process for staff (how to access language services while at work). d. Ray shared the Annual report for 2024, after discussion it was recommended to add the annual language services report to the annual report. Ray will then send the final report to Wendy to give to the Board for approval. e. The DEI Committee Charter was reviewed and updated with removal of “distributive leadership” to “Chairperson and vice chairperson” for committee facilitation. Aaron made a motion to approve the changes as discussed, Doug 2nd the motion, all present approved. f. Chairperson and Vice Chairperson was then discussed and nominated; George Rohrich as Chairperson for FY 2025 and Ray Eickmeyer as Vice-Chair for FY 2025. Codi made a motion to approve, Dave 2nd motion, all present approved, Ray obtained. g. Agustin shared 2024 totals for Language services and shared that the questions from December meeting re: numbers not adding up,



LAKE CHELAN HEALTH

MEETING AGENDA

Name of Group: Governance Committee	Date of Meeting: 1/9/25	Time of Meeting: 10:00 am
Facilitator: Mary Murphy		Location: Zoom
Recorder: Mary Murphy		
Members present:		
X BOC Representative (Mary Murphy)		X BOC Representative (Lori Withrow)
Other: {other attendees or guests}		
Meeting Objectives(s)/Purpose: Review policies for updates		

FI – For Information; FD – For Discussion; FM – For Motion

Time	Agenda Item	Topic/Action
10:00 am	1. Call to Order	
10:00 am	2. Revise BOC Policy Review Guidelines	2. Revised and recommend revised guidelines to Board for review/approval Include Attachment of list of policies.
	3. Revise BOC Policy and Procedure for Ethical and Legal Matters	3. Revised and recommend revised BOC Policy to Board for review/approval.
	4. Revise Conflict of Interest Policy and ensure match with COI form.	4. Revised and recommend revised Conflict of Interest Policy to Board for review/approval. Send Conflict of Interest Disclosure Form.
	5. Discussed need for flow chart/checklist to track policy update processes	5. Committee to review flow chart /checklist and CCPHD2 Board Health Equity Policy at next meeting Jan 29 at 9 am.
10:40 am	5. Adjournment	

Next meeting: TBD



MINUTES

Group: Finance Committee 1/22/25, 10AM in person and via Teams		
Facilitator: Jordana Laporte		Recorder: W. Kenck
Member Attendance:		
<input checked="" type="checkbox"/> Jordana Laporte, BOC	<input checked="" type="checkbox"/> Shawn Ottley, COO (TEAMS)	<input checked="" type="checkbox"/> Aaron Edwards, CEO
<input checked="" type="checkbox"/> Doug Gibson, BOC	<input checked="" type="checkbox"/> Brant Truman, CFO	
Participants: V. Bodle, M. Miller, L. Sahlinger, R. Montgomery,		

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

<i>Agenda Item</i>	<i>Topic/Action</i>
<ul style="list-style-type: none"> • Call to Order 	<ul style="list-style-type: none"> • J. Laporte called meeting to order at 10:05am
<ul style="list-style-type: none"> • New Business 	<ul style="list-style-type: none"> • GOALS: <ul style="list-style-type: none"> a. Beat 2024 Net Income of \$2M b. 5 year Capital Budget • Dr. Kalliath provided an update on the Hospitalist program, highlighting the goal to create in-house protocols, review chest pain and stroke patient transfers, and build rapport with nursing and provider staff to ensure they feel comfortable calling the Hospitalist for in-person care assistance. He also announced the Compass Program at LCH, offering subspecialist support in Cardiology, Infectious Disease, and Pulmonary Critical Care. Subspecialists will manage orders and patient care throughout their stay. • B. Truman reviewed different underwriters: Piper Sandler, Cain Brothers, and DA Davidson, presenting a side-by-side comparison of their metrics. Based on fee structure and track record, DA Davidson was identified as the best option to move forward with. • The Finance department reviewed social media posts and comments and is currently auditing those accounts. The audit aims to identify issues related to processes, types of pay, etc., and to streamline and clean up internal processes. • Retirement discussion including total amount adjustments and vesting options. • The SAO report was received in December, showing no issues and a clean audit.

<ul style="list-style-type: none"> • <i>Old Business</i> 	<ul style="list-style-type: none"> • B. Truman provided a USDA financing update, noting a request for projected financials. Timing related to funding may not be feasible for current projects as originally discussed. • There is \$800K outstanding, with Bouten finalizing paperwork. • The \$170K Ecology funding should be finalized by the end of the week.
<ul style="list-style-type: none"> • Reports 	<ul style="list-style-type: none"> • V. Bodle presented the unaudited December 2024 Financial Statement
<ul style="list-style-type: none"> • Adjournment 	<ul style="list-style-type: none"> • J. LaPorte adjourned the meeting at 12:00 pm



LAKE CHELAN HEALTH

Unaudited Financial Statements

for

For the month ended December 31, 2024

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Balance Sheet
Lake Chelan Health

	Current Month 12/31/2024 <u>unaudited</u>	Prior Year 12/31/2023 <u>AUDITED</u>	Prior Year 12/31/2023 <u>Unaudited</u>	
ASSETS:				
CASH	658,937	\$ 858,781	\$ 218,988	
PATIENT RECEIVABLES	12,753,621	9,941,632	\$ 9,945,935	November was 12.9m
LESS: RESERVES FOR ALLOWANCES	<u>(6,866,738)</u>	<u>(5,504,105)</u>	<u>\$ (5,439,662)</u>	
NET PATIENT ACCOUNTS RECEIVABLES	5,886,883	4,437,527	4,506,273	
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	(100,278)	961,911	(400,790)	
OTHER RECEIVABLES	390,232	157,502	(201,842)	property taxes are accrued over 12 months
INVENTORIES	335,411	336,059	221,673	
PREPAID EXPENSES	321,417	353,146	292,446	
TOTAL CURRENT ASSETS	<u>\$ 7,492,603</u>	<u>\$ 7,104,927</u>	<u>\$ 4,636,748</u>	
GENERAL RESERVES	\$ 1,341,519	1,541,164	\$ 1,636,767	
Unrestricted Reserves	\$ 6,405,615	3,395,024	\$ 3,360,592	
Internally Restricted Reserves	\$ 4,139,524	4,139,524	\$ 4,139,524	
2018 BONDS	0	0	\$ -	
USDA 2023	410,400	273,600	\$ 136,800	
Coastal Bank	50,000	0	\$ 465,978	
TOTAL LIMITED USE ASSETS	<u>\$ 12,347,058</u>	<u>\$ 9,349,312</u>	<u>\$ 9,739,662</u>	
LAND	\$ 4,133,845	4,620,195	\$ 4,787,901	
LAND IMPROVEMENTS	0	5,222,565	\$ 5,543,846	
BUILDINGS & IMPROVEMENTS	10,390	986,252	\$ 986,252	
EQUIPMENT	10,471,292	9,589,003	\$ 10,648,303	
SOFTWARE	2,166,371	2,146,019	\$ 2,185,697	
NEW HOSPITAL	44,763,709	44,718,237	\$ 43,928,486	
LOCUM HOUSING	635,484	0	\$ -	
GASB 87 BUILDINGS AND EQUIPMENT	1,742,567	1,642,567	\$ -	
CONSTRUCTION-IN-PROGRESS - PROJECTS	928,355	67,113	\$ 671,774	
CONSTRUCTION-IN-PROGRESS - HOSPITAL	9,290	11,490	\$ 15,378	
GROSS PROPERTY, PLANT, & EQUIPMENT	64,859,304	69,003,440	68,767,637	
LESS: ACCUMULATED DEPRECIATION	<u>(14,753,073)</u>	<u>(17,553,759)</u>	<u>\$ (18,203,321)</u>	
GASB 87 AMORTIZATION	<u>(543,279)</u>	<u>(522,446)</u>	<u>\$ -</u>	
NET PROPERTY, PLANT, & EQUIPMENT	<u>\$ 49,562,952</u>	<u>\$ 50,927,235</u>	<u>\$ 50,564,316</u>	
DEFERRED ITEMS	\$ 1,535,731	1,554,995	\$ 2,482,403	
TOTAL ASSETS	<u>\$ 70,938,345</u>	<u>\$ 68,936,469</u>	<u>\$ 67,423,128</u>	
LIABILITIES:				
ACCOUNTS PAYABLE	\$ 1,201,176	979,973	501,574	
ACCRUED PAYROLL	861,750	685,983	540,515	
ACCRUED VACATION/HOLIDAY/SICK PAY	1,005,811	701,299	515,057	
PAYROLL TAXES PAYABLE	(44,816)	55,324	39,919	
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	0	0	0	
OTHER CURRENT LIABILITIES	734,009	1,077,236	1,039,752	Jan 2024 867,440
INTEREST PAYABLE	91,605	93,697	560,321	aper vac/sick
CURRENT PORTION OF LTD (BONDS/MORTGAGES)	1,046,831	1,046,831	1,001,831	as of 1/31 793,882
LINE OF CREDIT	0	0	0	as of 12/31 1,005,811
TOTAL CURRENT LIABILITIES	<u>\$ 4,896,368</u>	<u>\$ 4,640,343</u>	<u>\$ 4,198,969</u>	int on 2018 bonds
CAPITALIZED LEASES	\$ -	\$ -	\$ -	as of 1/31 147,917
2018 BONDS	\$ 18,368,093	18,717,246	19,018,009	as of 12/31 73,088
2013 BONDS	4,283,436	4,658,279	5,022,850	int LTGO bonds
USDA LOANS	17,710,433	18,136,999	18,172,616	as of 1/31 37,205
LEASES	2,114,879	2,091,679	1,853,765	as of 12/31 18,518
PAID LEAVE - LT PORTION	200,959	200,959	304,376	
TOTAL LONG TERM LIABILITIES	<u>\$ 42,677,800</u>	<u>\$ 43,805,163</u>	<u>\$ 44,371,615</u>	
DEFERRED ITEMS	\$ 4,212,308	3,364,205	3,922,975	
TOTAL LIABILITIES	<u>\$ 51,786,475</u>	<u>\$ 51,809,711</u>	<u>\$ 52,493,558</u>	
FUND BALANCE:				
UNRESTRICTED FUND BALANCE	\$ 17,126,756	15,036,656	15,036,657	
TEMPORARY RESTRICTED FUND BALANCE	\$ -	0	0	
YTD Net Revenue/(Expenses)	<u>2,025,114</u>	<u>2,090,102</u>	<u>(107,087)</u>	
TOTAL NET ASSETS	<u>\$ 19,151,870</u>	<u>\$ 17,126,758</u>	<u>\$ 14,929,570</u>	
TOTAL LIABILITIES AND NET ASSETS	<u>\$ 70,938,345</u>	<u>\$ 68,936,469</u>	<u>\$ 67,423,128</u>	

Statement of Revenue and Expense
Lake Chelan Health

For the month ended December 31, 2024

	CURRENT MONTH				Prior Year 12/31/23
	Actual 12/31/24	Budget 12/31/24	Positive (Negative) Variance		
GROSS PATIENT SERVICE REVENUES					
INPATIENT	\$ 617,176	\$ 5,127,395	(4,510,220)	-88%	\$ 505,792
OUTPATIENT	4,458,108	0	4,458,108	0.00%	4,238,299
TOTAL PATIENT SERVICE REVENUES	5,075,284	5,127,395	(52,111)	-1%	4,744,091
DEDUCTIONS FROM REVENUE					
CONTRACTUAL ALLOWANCES	(1,558,364)	(2,018,123)	459,759	-23%	342,018
BAD DEBT	(140,072)	0	(140,072)	0.00%	(81,656)
CHARITY	(77,218)	0	(77,218)	0.00%	(28,484)
TOTAL DEDUCTIONS FROM REVENUES	(1,775,654) 35.0%	(2,018,123) 39.4%	242,469	12%	251,878 -5.3%
NET PATIENT SERVICE REVENUES	3,299,630	3,109,272	190,358	6%	4,995,969
OTHER OPERATING REVENUES	88,148	19,404	68,744	354%	237,018
TOTAL OPERATING REVENUES	3,387,778	3,128,676	259,102		5,232,987
OPERATING EXPENSES					
SALARIES/WAGES	1,666,479	1,693,599	27,120	2%	1,591,981
EMPLOYEE BENEFITS	329,059	373,719	44,660	12%	687,581
PROFESSIONAL SERVICES	146,228	91,902	(54,326)	-59%	98,970
FOOD SUPPLIES	22,531	15,049	(7,482)	-50%	16,245
MINOR EQUIPMENT	24,355	17,392	(6,963)	-40%	16,583
SUPPLIES	335,756	244,900	(90,856)	-37%	120,309
PLANT UTILITIES	29,171	29,741	570	2%	45,703
PURCHASED SERVICES	526,022	298,634	(227,388)	-76%	337,158
REPAIR/MAINTENANCE	151,302	98,596	(52,706)	-53%	104,975
PUBLIC RELATIONS/RECRUITM	3,159	11,021	7,862	71%	7,967
RENT/LEASES	82,657	40,837	(41,820)	-102%	(287,707)
INSURANCE	44,894	43,694	(1,200)	-3%	16,056
LICENSES/TAXES	32,758	19,887	(12,871)	-65%	18,764
DUES/SUBSCRIPTIONS/OTHER	50,949	62,332	11,383	18%	74,147
TRAVEL/TRAINING	10,864	15,831	4,967	31%	11,937
DEPRECIATION	303,088	383,896	80,808	21%	630,581
AMORTIZATION	15,475				
TOTAL OPERATING EXPENSES	3,774,746	3,441,030	(318,241)	-9.2%	3,491,249
NET OPERATING SURPLUS (LOSS)	(386,968)	(312,354)	(74,614)		1,741,738
NON-OPERATING REVENUES					
TAXES	287,179	322,084	(34,905)		455,451
INTEREST					
GIFTS & GRANTS	25,956		25,956		
OTHER	0	0	0		0
NET INCOME margin	(73,832) -2.2%	9,730 0.3%	(83,563)		2,197,189 42.0%
TOTAL NET INCOME (LOSS)	\$ (73,832)	\$ 9,730	(83,563)		\$ 2,197,189

Statement of Revenue and Expense
Lake Chelan Health

For the month ended December 31, 2024

	YEAR-TO-DATE				Prior Year 12/31/23
	Actual 12/31/24	Budget 12/31/24	Positive (Negative) Variance		
GROSS PATIENT SERVICE REVENUES					
INPATIENT	\$ 7,382,997	\$ 31,672,058	(24,289,060)	-77%	\$ 7,070,470
OUTPATIENT	57,917,743	30,857,154	27,060,589	88%	47,442,133
TOTAL PATIENT SERVICE REVENUES	65,300,741	62,529,212	2,771,529	4%	54,512,603
DEDUCTIONS FROM REVENUE					
TOTAL DEDUCTIONS FROM REVENUES	(23,142,420)	(24,762,269)	1,619,849	-7%	(19,098,080)
BAD DEBT	(1,616,424)	0	(1,616,424)	0.00%	(1,002,879)
CHARITY	(973,809)	0	(973,809)	0.00%	(423,724)
TOTAL DEDUCTIONS FROM REVENUES	(25,732,653)	(24,762,269)	(970,384)	-4%	(20,524,683)
	39.4%	39.6%			37.7%
NET PATIENT SERVICE REVENUES	39,568,088	37,766,943	1,801,145	5%	33,987,920
OTHER OPERATING REVENUES	437,652	232,826	204,826	88%	489,720
TOTAL OPERATING REVENUES	40,005,740	37,999,769	2,005,971	5%	34,477,640
OPERATING EXPENSES					
SALARIES/WAGES	20,463,522	19,940,779	(522,743)	-3%	17,107,116
EMPLOYEE BENEFITS	3,936,844	4,400,270	463,426	11%	3,883,841
PROFESSIONAL SERVICES	1,860,280	1,102,769	(757,511)	-69%	1,136,706
FOOD SUPPLIES	231,747	180,533	(51,214)	-26%	180,339
MINOR EQUIPMENT SUPPLIES	532,908	208,660	(324,246)	-155%	156,443
PLANT UTILITIES	2,646,597	2,608,509	(38,088)	-1%	2,172,410
PURCHASED SERVICES	386,300	356,892	(29,408)	-8%	403,721
REPAIR/MAINTENANCE	4,186,376	3,583,630	(582,746)	-16%	3,670,793
PUBLIC RELATIONS/RECRUITMENT	1,154,342	1,183,163	28,821	2%	974,518
RENT/LEASES	87,124	132,285	45,161	34%	103,574
INSURANCE	896,186	490,000	(406,186)	-83%	330,613
LICENSES/TAXES	530,417	524,394	(6,023)	-1%	371,505
DUES/SUBSCRIPTIONS/OTHER	265,186	238,655	(26,531)	-11%	204,334
TRAVEL/TRAINING	595,893	747,929	152,036	20%	486,763
DEPRECIATION	129,807	189,961	60,154	32%	91,793
AMORTIZATION	3,611,990	4,806,796	994,806	22%	4,073,661
TOTAL OPERATING EXPENSES	41,681,215	40,495,225	(1,185,990)	-2.9%	35,348,130
NET OPERATING SURPLUS (LOSS)	(1,675,475)	(2,495,456)	819,981		(870,489)
NON-OPERATING REVENUES		3,865,004			
PROPERTY TAXES FOR OPERATIONS	2,749,980				2,608,151
GRANTS/CONTRIBUTIONS	834,574				678,989
INVESTMENT EARNINGS	419,891				397,534
OTHER EXPENSE		0	0		
TAXES FOR DEBT SVC PMTS	1,275,488				1,233,336
INTEREST EXPENSE	(1,804,746)				(1,908,320)
GAIN / (LOSS) ON ASSET DISPOSAL	225,599				(49,100)
NET INCOME	2,025,112	1,369,548	655,564		2,090,101
margin	5.1%	3.6%			6.1%
TOTAL NET INCOME (LOSS)	\$ 2,025,112	\$ 1,369,548	\$ 655,564		\$ 2,090,101

unaudited

Patient Statistics Lake Chelan Health

For the month ended December 31, 2024



Current Month			Last Year Month			
Actual vs Budget	12/31/24	BUDGET	STATISTICS	Actual vs Budget	12/31/23	BUDGET
■	125	120	Total Days Cash on Hand	■	129	120
■	53	40	Net AR Days	■	51	40
■	0.29	1.25	Debt Coverage Ratio	■	1.40	1.25
■	208	175	Payroll FTEs	■	182	175

Current Month				Year-To-Date				
Actual vs Budget	Actual 12/31/24	Prior Year 12/31/23	BUDGET	STATISTICS	Actual vs Budget	Actual 12/31/24	Prior Year 12/31/23	BUDGET
Admissions								
NA	23	17 NA		medical	NA	224	208 NA	
NA	0	0 NA		surgical	NA	0	0 NA	
NA	7	8 NA		OB	NA	92	98 NA	
NA	30	25 NA		Acute	NA	316	306 NA	
NA	7	3 NA		Swing Bed	NA	69	77 NA	
NA	7	8 NA		Total Deliveries	NA	92	98 NA	

Patient Days								
■	68	53	54	medical	■	673	568	665
NA	0	0 NA		surgical	NA	0	0 NA	
■	14	14	17	OB	■	167	191	210
■	82	67	71	Acute	■	840	759	875
■	39	20	56	Swing Bed	■	670	711	690
■	9	9	13	Total Newborn Days	■	125	136	160
■	130	96	141	TOTAL PATIENT DAYS	■	1635	1606	1725

Average Length of Stay								
■	2.7	2.7		Total Inpatient	■	2.7	2.5	
■	5.6	6.7		Swing Bed	■	9.7	9.2	

Avg Daily Census - Hospital								
	2.6	2.2		Total Inpatient		2.3	2.1	
	1.3	0.6		Swing Bed		1.8	1.9	
	3.9	2.8		Total		4.1	4.0	

■	465	497	608	ED Visits	■	6800	6802	7463
■	62	62	82	Surgeries	■	764	604	1007
■	1125	1123	1073	Imaging Procedures	■	15563	13472	13164
■	3566	2759	3445	Lab Tests	■	39271	36296	42274
■	516	582	719	Rehab Visits	■	8021	7088	8818
■	111	111	130	EMS Runs	■	1600	1515	1598
■	701	774	1009	Total Clinic Visits	■	9846	9524	13099
■	72	112	74	Specialty	■	1030	1172	956
	104	109		Primary care		1829	1622	0
■	525	546	935	Express Care (budget shows primary and express)	■	6987	6730	12143
	22	21		working days		261	269	

Note #1 Contractuals

Contractuals do not include reimbursement that will happen when the cost report is filed.
AR decreased \$144k from November to December
Charity care was \$77,218 for December. Bad Debt was \$140,072.
Charity and Bad Debt are 4.01% of gross charges ytd compared to 2.62% this same time last year and 1.90 in December 2023.

Note #2 SALARIES AND WAGES

The hospital paid a bonus of \$581k in November

Note #3 PROFESSIONAL SERVICES

Radiology Pro Fees budget is \$555k vs expense of \$617k
UW Residency Program budget is \$200k vs expense of \$207k
ED Pro Fees budget \$150k vs expense of \$661k

Note #4 MINOR EQUIPMENT AND SUPPLIES

Surgery - Budget \$28k, Actual \$348k Stryker Orthopaedics \$194k for instruments for total knees and hips (this expense was not known at budget time) \$5k workpointe for desks
Dermatology - Budget \$0, Expense \$10k - started service in November 2024

Note #5 SUPPLIES & FOOD

Revenue is over budget (\$2.8m). Complexity of surgeries = higher supply costs.
Food - Supplies is over \$51k and revenue is over \$37k

Note #6 PURCHASED SERVICES

HR is over budget \$39k, Radiology is over \$64k, Express Clinic is over \$155k
Med Surg \$297k and Surgery \$174k are also over due to the use of travelers. Lab is (\$280k) under budget:
Anesthesia is over budget by \$161k due to the use of contracted employees for anesthesia and pain management.

Note #7 UTILITIES

LCH is still occupying the old hospital building. Winter utility bills were higher. PUD for old hospital was \$26,561 and water/garbage was \$35,528 through November. Roots did help offset some of these costs. The hospital sale is complete and costs have reduced.

Note #8 RENTS/LEASES

Chelan Business Center lease \$4,920 per month (54,120 ytd) not budgeted for Ortho and Gen Surg
Acute Care budget \$28k, expense \$92k (carefusion, pyxis, kelly copier)
The reclass to GASB 87 has not been done in 2024. The budget reflects the reclass.
This is why depreciation and amortization are under budget

Note #9 LICENSES/TAXES

Expense is higher due to increase in revenues and personal property taxes paid for leased assets

Note #10 NON OPERATING REVENUE

The sale of the old hospital resulted in a net gain of \$996,288
There were assets that had not been fully depreciated
Per GASB we are to recognize the gain over 24 months.
Current gain recognized is \$223,185

For the month ended December 31, 2024

11/30/2024	GL ACCOUNT #	ACCT DESCRIPTION	12/31/2024	EXPLANATION	
\$233,957	10002000	General Fund Cash In Bank (Wheatland)	\$126,796	(\$107,161)	
				\$3,425,954 deposits \$48,982 enhancement pmt medicaid cost report (\$14,489) tsys/payplus fees (\$335) fees mckesson/cardinal (320) fees and interest rebates \$2,748 café sales (\$3,570,000) transfer to county	
\$1,002,468	10004000	General Fund Cash w/ Treasurer	\$233,121	(\$769,346)	
				(\$1,355,651) AP (\$14,898) Voids \$1,370,549 warrants issued (\$1,805,249) warrants redeemed \$3,570,000 Bank Transfers from 10002000 \$674,999 Bank Transfer to/from 10105000 (\$88,992) Bank Transfer for USDA pmt \$0 Bank Transfer to USDA reserve (\$3,124,540) Payroll/Benefits (\$23,058) B&O taxes \$6,182 Property Taxes \$21,311 Leasehold Taxes & Misc Taxes Fees	
\$13,278	10009000	cash clearing	\$14,973	\$1,696	pmts posted as remits received
(\$582,720)	20070000	warrants outstanding	\$284,049	\$966,768	
				(\$1,508,037) remits (payroll/benefits/b&O) \$1,805,249 warrants redeemed (\$1,367,702) warrants issued ap \$2,022,360 remits redeemed \$14,898 voids	
\$1,669,190	10105000	AMB RESERVE	\$1,005,591	(\$603,599)	
				transfer to reserves (\$674,999) transfer from reserves (bond pm & ops) \$11,349 property taxes \$44 leasehold taxes \$8 interest	
\$1,071,730	10910000	2018 GO BOND	\$335,928	(\$736,802)	
				\$8,361 property taxes (\$744,163) bond pmt	Days of Cash on Hand Cash: current assets 659,937 unrestricted reserves 1,341,519 unrestricted reserves 6,405,615 8,406,071
\$0	10911000	2018 CASH BOND	\$0	\$0	interest reclassified to general fund
\$320,400	10916000		\$320,400	\$0	funded year 3 per LOC USDA reserve 410,400
\$90,000	10917000		\$90,000	\$0	funded year 3 per LOC restricted reserves - pending covid ca 4,139,524 4,549,924
\$410,400			\$410,400	\$0	
\$0	10915000	CASH/TREAS LTGO BOND	\$0	\$0	paid bond interest Expenses: total YTD 41,681,215 less depreciation -3,797,690 37,883,525
\$10,508,116	10760000	RESERVES	\$10,545,139	\$37,024	\$1,000,000 from general interest 37,023 37,883,525
\$50,000	10764000	COASTAL BANK	\$50,000	\$0	number of days YTD 366
\$14,276,416			\$13,005,997	(\$1,270,420)	6 Days of Cash on Hand 81.2
					Restricted Days Cash on Hand 44.0
					Total Days Cash on Hand 125.2



LAKE CHELAN HEALTH

DEI -ANNUAL
REPORT 2024

The Lake Chelan Health DEI-(Diversity, Equity, and Inclusion) committee was formed and implemented in FY 2024.

The summary timeline included the following:



DEI COMMITTEE ACCOMPLISHMENTS:

- Development of regular meeting committee
- Development of charter
- Development of regular reporting tools
- Development of monitoring reports
- Tracking of CLAS standards
- Development of LCH's first employee language survey

What are the National CLAS Standards?

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care ([the National CLAS Standards](#)) gives health organizations 15 action steps for providing CLAS. The National CLAS Standards and information to help you put them into practice may be found at www.ThinkCulturalHealth.hhs.gov.

The Principal Standard (No. 1) calls on organizations to “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”

The remaining standards are divided into three themes:

1. Governance, Leadership, and Workforce (Standards 2-4);
2. Communication and Language Assistance (Standards 5-8); and
3. Engagement, Continuous Improvement, and Accountability (Standards 9-15).

The National CLAS Standards can be applied to a wide array of professions and sectors, including medical care, behavioral health, public health, social work, community health, emergency health, and more.

The HHS [Office of Minority Health](#) developed the Standards to advance health equity, improve quality of services, and help eliminate disparities. The Standards were first published in 2000 and updated in 2013.

CLAS STANDARDS PROGRESS

DEI

The fair treatment and full participation of all people

Goals:

1. To establish, develop and sustain relationships with members of diverse populations.
2. Fostering diversity throughout the entire organization, ensuring equity in opportunity, contribution, and advancement, and promoting inclusive teams and leadership.
3. To establish an accepting workplace, commitment to change and positive action by being curious, courageous, and committed individuals. This inspires our teams to become more welcoming and inclusive.

Governance, Leadership, Workforce		Notes
Completed	Identify DEI champions (DEI committee for responsible to learn, promote, and share DEI resources)	<p>Completed members of a committee and formed a formal committee with a charter for a formal plan.</p> <p>Target recruitment is in progress. Mentorship program: some ideas are 1. mentor new hires, 2. Succession mentor, 3. Job shadow -cross dept/role learning DEI training- required to all staff with Relias. DEI communication platforms: looking for ideas, i.e. CVCH webpage for employees. DEI competency- is four things: patient survey, language services, patient outcomes, staff feedback</p>
Completed	Create a formal plan	
In progress	Target recruitment efforts to the populations served to increase the recruitment of culturally and linguistically diverse individuals , through actions such as: posting job descriptions in multiple languages in local community media, holding job fairs in the community(ies) served, and/or working with leaders of local community institutions to create mentorship and training programs targeting populations served.	
In progress	Create internal organizational mentorship programs	
Completed	Provide access to DEI training to all staff	
In progress	Create and disseminate new resources about DEI within the organization using widely accessible platforms (e.g., employee-dedicated webpages, employee Intranet, employee break room).	
Completed	Incorporate assessment of DEI competencies (e.g., bilingual communication, cross-cultural communication, cultural and linguistic knowledge) on an ongoing basis into staff performance ratings.	
Communication and Language Assistance		Notes
In progress	Complete an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient.	<p>1. is language services survey being done via normal survey? Add to CHW/EMS follow-up question to language services. 2. competency check list for all staff who can use interpretation 3. Is signage for patients, there is language in patient rights, sharing it is FREE. There is language information on the website. Ask patient access for signage. 5. Rhianna will look at what other hospitals are doing for incentive for interpretation education we get \$1 more an hour. 6. Have policy in place for translation of materials into other languages.</p>
completed	Standardize procedures for staff members and train staff in those procedures . It may be appropriate to provide staff with a script to ensure that they inform individuals of the availability of language assistance and to inquire whether they will need to utilize any of the available services.	
In progress	Provide individuals with notification that describes what communication and language assistance is available, in what languages the assistance is available, and to whom they are available . Notification should clearly state that communication and language assistance is provided by the organization free of charge to individuals.	
Completed	Require that all individuals serving as interpreters complete certification or other formal assessments of linguistic and health care terminology skills to demonstrate competency.	
completed	Provide financial and/or human resource incentives to staff who complete interpreter training and meet assessment criteria , to build organizational capacity to provide competent language assistance.	
Completed	Formalize processes for translating materials into languages other than English and for evaluating the quality of these translations . This may include testing materials with target audiences.	
Engagement, Improvement, Accountability		Notes
Completed	Incorporate CLAS into mission, vision, and/or strategic plans by determining how organization acknowledges and addresses concepts such as diversity, equity, inclusion, and practices such as asking individuals about preferences for care/services.	<p>1. Board has incorporating CLAS in mission, vision, and plans. 2. in progress of creating measure for DEI .. how can we know we have effective DEI? 3. We are re-assising at each DEI committee meeting with reporting of DEI culture and logistics. 4. Reviewing how to collect this data. 5. Reviewing the data we have, but will review when we have a written informatics plan. 6. Collaboration with stakeholders- currently doing with other projects, looking at what to add the DEI measures. 7. not started 8. not started 9. Board does this on a regular basis and provides the opportunity with the community, but not a formal process.</p>
In progress	Tailor existing evaluation efforts to include measures of CLAS implementation (e.g., patient/client satisfaction measures can include questions about CLAS; outcome data can be stratified by REAL data to determine demographic differences).	
Completed	Complete a CLAS-related organizational assessment of the cultural and linguistic needs of populations served and of organizational resources to address these needs.	
Completed	Collect race, ethnicity, and language (REAL) data (at a minimum) from all individuals receiving services , either by tailoring existing data collection approaches or creating a new data collection process.	
in-progress	Use REAL data to identify needs, describe current care and service provision trends, and improve care and service provision.	
in-progress	Collaborate with stakeholders and community members in community health needs assessment data collection, analysis, and reporting efforts to increase data reliability and validity.	
not started	Include community members in the process of planning programs and developing policies to ensure cultural and linguistic appropriateness by convening town hall meetings, conducting focus groups, and/or creating community advisory groups.	
not started	Consider using staff as cultural brokers to help improve feedback mechanisms, conflict resolution process, and communication with culturally and linguistically diverse individuals.	
in-progress	Partner with community organizations to lead discussions about the services provided and progress made and to create advisory boards on issues affecting diverse populations and how best to serve and reach them.	

Language Service Reports for 2024



OPI Dashboard Over Phone Interpreting (OPI)

Parent Account Name: Lake Chelan Health

Account Name: All

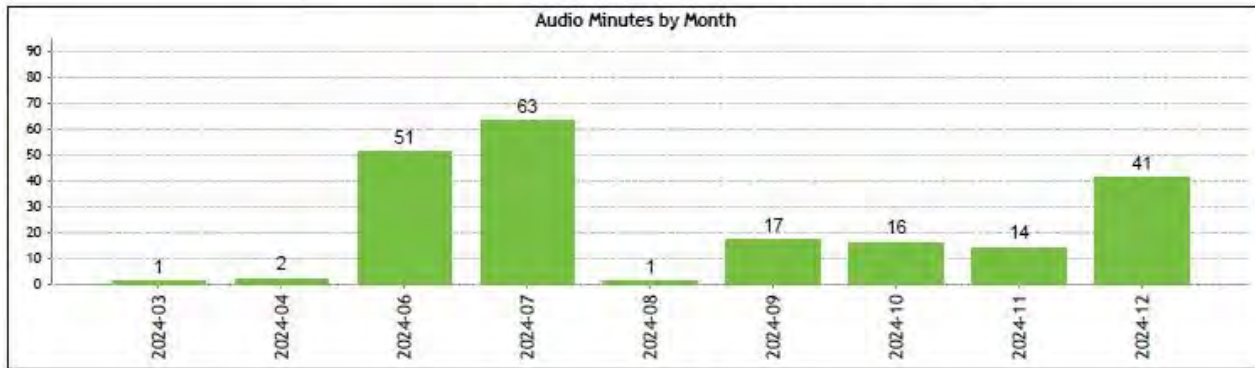
Start Date: January 01, 2024

End Date: January 15, 2025

Created on: January 16, 2025 @ 02:06

Created by: abenegas@lcch.net

Top 5 Languages	Minutes	Calls	Avg. Duration	Avg. Speed of Answer*
Spanish	195	24	8.13	8
Vietnamese	4	1	4.00	7
Bosnian	2	1	2.00	285
Croatian	2	1	2.00	2
Dari	1	1	1.00	7
All Other Languages	2	2	1.00	5
Total	206	30	6.87	17





VRIDashboard Video Remote Interpreting (VRI)

Parent Account Name: Lake Chelan Health

Account Name: Lake Chelan Health

Start Date: January 01, 2024

End Date: January 15, 2025

Created on: January 16, 2025 @ 02:00

Created by: abenegas@lcch.net

Top 5 Languages	Minutes	Calls	Avg. Duration	Avg. Speed of Answer	Rollover Calls
Spanish	48,285	4,280	11.28	11	0
ASL	142	10	14.20	8	0
Russian	53	6	8.83	16	0
CDI	38	2	19.00	5	0
Vietnamese	17	2	8.50	3	0
All Other Languages	21	14	1.50	6	0
Total	48,556	4,314	11.26	11	0



Continuing Progress

Continue to implement CLAS standards and improve areas of weakness within our organization

-2024 DEI Committee

- Aaron Edwards
- Mary Murphy
- Doug Gibson
- Rhianna Montgomery
- Giovanne Valleloza
- George Rohrich
- Codi Onda
- Dave Dawson
- Louise Sahlinger
- Tara Lautiki
- Agustin Benegas
- Ray Eickmeyer



LAKE CHELAN HEALTH

2025

Lake Chelan Health

Continuous Quality Improvement

&

Continuous Process Improvement Plan

Scope

The Continuous Quality Improvement, Continuous Process Improvement Plan (CQI/CPI plan), outlines the goals, strategies, and processes that promote safe, optimal patient care, and a high performing culture of safety. This will be achieved through interdisciplinary collaboration for identification, assessment, and continued improvement of process/performance indicators and care outcomes, collectively referred to as the organization's Quality Assurance Process Improvement Plan (QAPI). The scope of this plan will include all patient care and support services organization- wide. The Lake Chelan Health Board of Commissioners approves this plan which supports the Mission of Lake Chelan Health. The Lake Chelan Health Board of Commissioners delegates the oversight of the CQI/CPI Plan to the Lake Chelan Health Chief Executive Officer (CEO). The Lake Chelan Health CEO delegates operational oversight to the Director of Quality, to the committee reporting hierarchy represented in *Appendix 1*, and to the Lake Chelan Health Executive Leadership Team. The Lake Chelan Health Medical Staff is charged with actively participating in the CQI/CPI Plan to achieve quality patient care and compliance with regulatory/accreditation organizations. Medical Staff members will contribute to all CQI/CPI activities through Medical Staff Service committees, project team activities and by assuming leadership roles, as necessary in CQI/CPI processes and activities.

Organizational Context

The Vision of Lake Chelan Health is a healthy community. We will accomplish this as our superb medical staff and caregivers partner with others to provide patient- centered care in a respectful, healing environment, while ensuring fiscal responsibility.

The Mission of Lake Chelan Health to provide quality healthcare with compassion and respect to the community we serve.

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

Core Values:

- ***Relationships***
- ***Integrity***
- ***Compassion***
- ***Respect***
- ***Excellence***

Purpose and Objectives

To uphold the Mission, Vision, and Values of Lake Chelan Health, all members of the organization will be committed to Continuous Quality and Continuous Process Improvement activities using an interdisciplinary approach as laid out in this Enterprise CQI/CPI Plan. This includes but is not limited to:

- Assure safe and effective patient care is provided at a level consistent with professional standards and evidence-based practice.
- Mitigate potential or actual liability exposure through proactive evaluation of systems, processes and patient care delivery.
- Provide a framework for continuous, interdisciplinary process and outcome assessment, monitoring, and improvement across the organization's scope of services (QAPI).
- Prioritize opportunities for improvement based on, but not limited to, identified trends, level of risk, and/or benchmarking data.
- Comply with the requirements of all State, Federal and accrediting agencies in accordance with performance improvement activities.

Quality and Performance Improvement Principles

Quality and Performance Improvement is a systematic approach to assessing services and improving them on a priority basis. The Lake Chelan Health approach to quality is based on the following principles:

- **Patient Focus.** High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations and achieving equitable results.
- **Employee Empowerment.** Effective programs involve people at all levels of the organization in improving quality.
- **Leadership Involvement.** Strong leadership, direction, and support of quality improvement activities by the governing body and CEO are key to improvement.
- **Data Driven & Informed Practice.** Successful improvement processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.
- **Statistical Tools.** For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. Continuous Quality Improvement (CQI) organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms and control charts to turn data into information.
- **Prevention Over Correction.** Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- **Continuous Improvement.** Processes must be continually reviewed, improved and evaluated for effectiveness and sustainability. Small incremental changes do make an impact and staff can always find an opportunity to make things better.

Confidentiality

All matters and activities relating to the performance improvement process will be held in confidence to the extent permitted by law. Performance improvement activities are conducted pursuant to Sections 4.24.250, 43.70.510, 70.41.200 & 74.42.640 of the Revised Code of Washington (RCW) regarding peer review of health care providers. Confidential information may include, but is not limited to, the Medical Staff Quality Committee minutes, Quality Committee minutes, Board of Commissioner Reports, chart abstraction data and reporting, unexpected event reporting, clinical and peer reviews. All employees receive the Lake Chelan Health confidentiality policy and are required to sign a confidentiality agreement upon hire.

The Quality Committee Responsibilities

- Develop, revise, approve and oversee the implementation of the Continuous Quality Improvement, Continuous Process Improvement Plan, Work Plan and ongoing action plans to improve the quality of care, services and processes.
- Evaluate and make recommendations for improvement to the CQI/CPI plan and send to Board of Commissioners for final approval.
- Review the Hospital-Wide Continuous Quality Improvement, Continuous Process Improvement Plan and supporting documents annually.
- Establish measurable objectives based upon priorities identified through use of established criteria for improving quality and safety, regulatory requirements, etc.
- Periodically assess information based on the indicators, taking action via performance improvement initiatives to solve problems and pursue opportunities to improve performance.
- Establish and support specific quality improvement initiatives.
- Report to the Board of Commissioners on performance improvement activities of Lake Chelan Health on a regular basis.
- Utilization of formal, best practice, improvement methodologies.
- Determination of annual QAPI projects to be overseen by the CQI/CPI Committee.
- Evaluation of effectiveness of improvement actions and any recommendations to ensure continued effectiveness.

Medical Staff Responsibilities: The Lake Chelan Health Medical staff participate in all phases of CQI CPI activities including representative leadership in the CQI/CPI Committee, and quality subcommittees – refer to *appendix 1*. Medical Staff participate in peer review, credentialing/privileging.

Physicians will also serve as members of Quality Improvement Teams and subcommittees as they are created. The goal of physician involvement is to provide an avenue for physician engagement in organization- wide improvement work.

Board of Commissioners Responsibilities:

- Support and guide implementation of CQI/CPI activities at Lake Chelan Health
- Review, evaluate, and approve the CQI/CPI Plan annually.

Leader Responsibilities: Support CQI/CPI activities through planned coordination and communication of the results of measurement activities and overall efforts to continually improve the quality of care provided. Leaders, through a planned and shared communication approach, ensure the Board of Commissioners, staff, patients, and family members have knowledge of and input into ongoing CQI/CPI initiatives. Annual review of the Quality Management System (QMS) through the Procedure for Management Review.

Leadership roles required to participate includes the CEO, COO, CNO, and CFO.

Quality Sub-Committees

- Refer to Appendix 1.
- Each quality sub-committee will have a formal Committee Charter that specifies:
 - Committee Purpose
 - Scope of Responsibility

- Committee Membership
- Reporting Relationship
- Meeting Structure
- Will have an annual work plan that lays out the scope of the work for that committee for the coming year.
- Will maintain an agenda and take meeting minutes in an action item focused format.
- Will track data that is specific to the area of focus to aid in identifying areas of improvement and conduct formal improvement work to achieve desired goals.
- Will report out quarterly to the CQI/CPI Committee, and representative Medical Staff meeting on current committee progress.

Organizational Departments / Service Lines:

- Each department and/or service line will be actively engaged in CQI/CPI activities.
- These departments will work directly with the Department of Quality to develop their improvement projects and develop tracking systems using accepted improvement methodologies.
- Each department and/or service line will report to the CQI/CPI committee at least once per quarter on their progress.
- Department leaders will actively engage the participation of all team members on improvement work and will formulate strategies to communicate improvement work to staff, patients, and family.
- A list of projects underway will be kept on the Quality SharePoint site in the Quality Committee folder.
 - All projects underway will provide documentation that outlines why the project was chosen and how it intends to use data to inform and drive positive change.
- Records of current and previous QI/PI projects will be retained and maintained on the Quality SharePoint site in the Quality Committee folder.

Attachments

1. Appendix 1. CQI/CPI Committee Reporting Structure
2. Appendix 2. CQI/CPI Committee Charter
4. Appendix 3. CQI/CPI Annual Work Plan

References

1. NIAHO Accreditation for Healthcare Organizations: Accreditation Requirements, Interpretive Guidelines and Surveyor Guidance for Critical Access Hospitals Revision 23-1, October 3, 2023.
2. HQ Solutions: Resource for the Healthcare Quality Professional, Fourth Edition, Pelletier, Luc R., Beaudin, Christy L., National Association for Healthcare Quality, 2018.
3. [Medicare 42 CFR 482.21 Conditions of Participation](#)
4. [WAC 246-320-136, Leadership](#)
5. [WAC 246-320-171, Improving Organizational Performance](#)
6. NIAHO Accreditation for Healthcare Organizations: Accreditation Requirements, Interpretive Guidelines and Surveyor Guidance for Critical Access Hospitals Revision 18, 02-20-18. <https://brandcentral.dnvgl.com/fr/gallery/10651/files/original/96194cdda02d4e0493a2bf25c03574b0.pdf> Accessed 4/21/20.

Continuous Quality Improvement, Continuous Process Improvement Plan Approval

The CQI/CPI Plan has been reviewed, approved, and adopted by Lake Chelan Health Executive Administration, Medical Staff, and the Board of Commissioners – attested by the signatures below:

_____ Director of Quality	_____ Date
_____ Chief Executive Officer	_____ Date
_____ Chief Medical Officer	_____ Date
_____ Chairperson of the Board of Commissioners	_____ Date

2025 LCH QUALITY COMMITTEE OBJECTIVES

The Quality Committee will identify/designate a workgroup by 1/31/2025 to develop a staff satisfaction survey that allows for the utilization of an Employee Promoter Score for the benefit of benchmarking and improving staff satisfaction across the organization.

The Employee Satisfaction Survey workgroup will develop and distribute a staff satisfaction survey by 3/1/2025 to gather data on the level of staff satisfaction at LCH and highlight areas for improvement and develop the Employee Promoter Score.

Policy owners will complete the following percentage of policies according to the new policy writing guidelines by March 31, 2025, based on the overall number of policies they own in order to meet organizational Quality Management System standards.

- 1-10 policies - 100%
- 11-20 policies - 65%
- 21-30 policies - 45%
- 31-40 policies - 30%
- 41-50 policies - 25%
- 51-60 policies - 20%
- 61 + policies - 10%

Lake Chelan Health's aggregate quality score will achieve an average over the performance period of 80% by 10/31/2025 in order to support the organization's commitment to excellence.

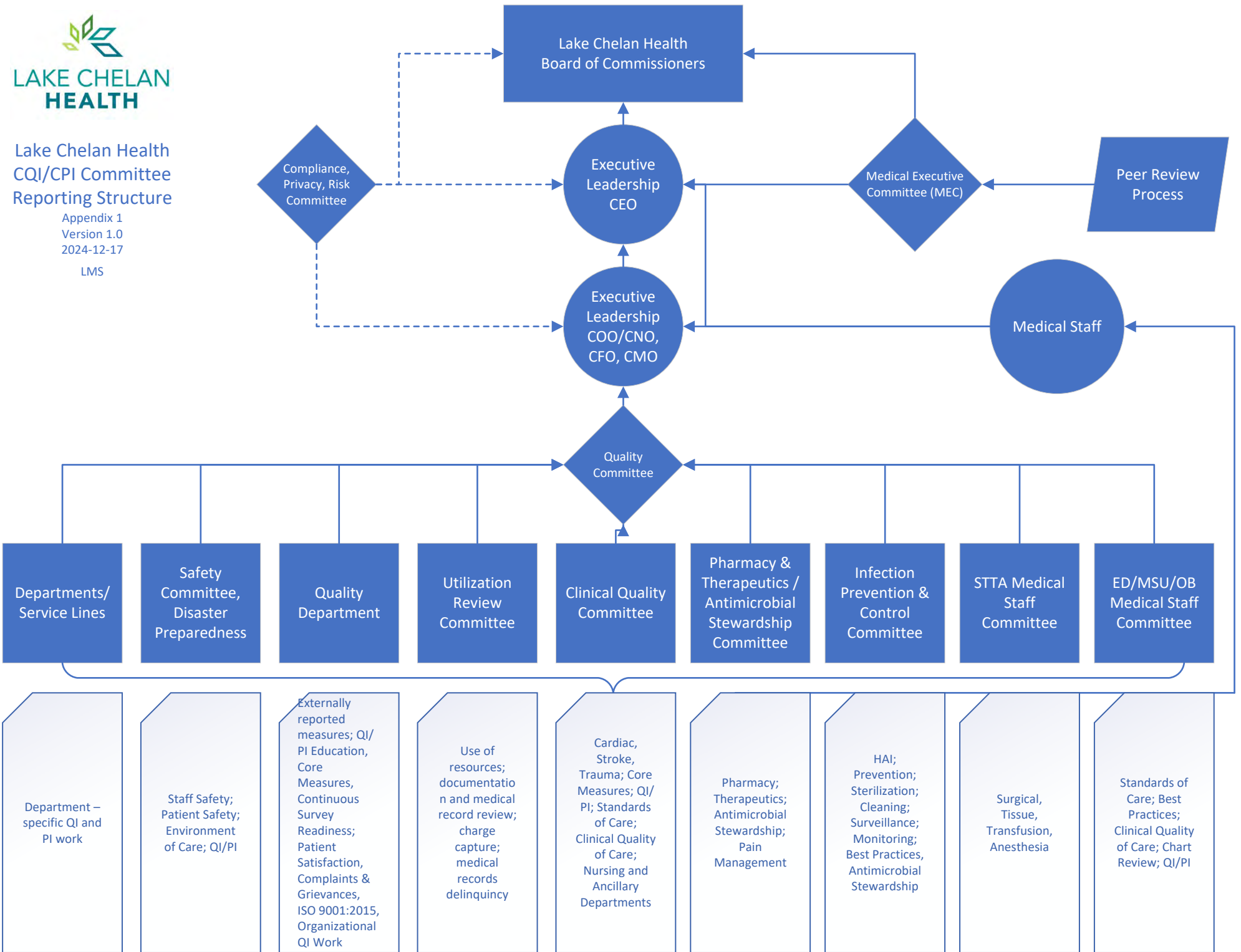
Each department at LCH will be rounded on by one or two board members in 2025, to include department managers, one or two board members and one or two representatives from Quality.



Lake Chelan Health
CQI/CPI Committee
Reporting Structure

Appendix 1
Version 1.0
2024-12-17

LMS



Department – specific QI and PI work

Staff Safety; Patient Safety; Environment of Care; QI/PI

Externally reported measures; QI/PI Education, Core Measures, Continuous Survey Readiness; Patient Satisfaction, Complaints & Grievances, ISO 9001:2015, Organizational QI Work

Use of resources; documentation and medical record review; charge capture; medical records delinquency

Cardiac, Stroke, Trauma; Core Measures; QI/PI; Standards of Care; Clinical Quality of Care; Nursing and Ancillary Departments

Pharmacy; Therapeutics; Antimicrobial Stewardship; Pain Management

HAI; Prevention; Sterilization; Cleaning; Surveillance; Monitoring; Best Practices, Antimicrobial Stewardship

Surgical, Tissue, Transfusion, Anesthesia

Standards of Care; Best Practices; Clinical Quality of Care; Chart Review; QI/PI



Lake Chelan Health – 2025, Continuous Quality Improvement & Continuous Process Improvement Committee

Purpose:

To uphold the Mission, Vision, and Values of Lake Chelan Health, all members of the organization will be committed to Continuous Quality, and Continuous Process Improvement activities using an interdisciplinary approach as laid out in the 2025 Enterprise CQI CPI Plan. This will include:

- Assure patient care is provided at a level consistent with professional standards and evidence-based practice.
- Mitigate potential or actual liability exposure through proactive evaluation of systems and patient care delivery.
- Provide a framework for continuous, interdisciplinary process and outcome assessment, monitoring, and improvement across the organization's scope of services.
- Prioritize opportunities for improvement based on, but not limited to, identified trends, level of risk, and/or benchmarking data.
- Comply with the requirements of all State, Federal and accrediting agencies regarding performance improvement activities.
- Provide administrative oversight and guidance for all matters related to Quality, Improvement, Safety, and Risk. This Oversight will include but is not limited to:
 - Review of performance and improvement data from all quality related sub committees and departments per the CQI CPI 2025 Committee Reporting Structure.
 - Oversight of organizational event reporting data, patient safety data, and staff safety data.
 - Quality, safety, and risk evaluations of any new, or additional services or ventures.
 - Development of organizational quality indicators based on current best practice – and available data, and track to these measures for improvement.
 - Monitor patient, and staff satisfaction – provide guidance for opportunities for improvement.
 - Provide organizational guidance for survey readiness and preparedness activities.
 - Formulate and implement educational opportunities for staff regarding quality, process improvement, value, safety, and risk.

Scope of Responsibility:

The Continuous Quality Improvement, Continuous Process Improvement Committee is responsible for developing, revising, approving and implementation of the Continuous Quality Improvement, Continuous Process Improvement Plan to improve the quality of care and service, which affects patient health, safety.

Committee Membership:

Chair	Executive Director of Quality	Louise Sahlinger
Board Representative	Board Member	Len England
Board Representative	Board Member	Doug Gibson
Record Keeper	Quality Dept. Specialist	Madison McCormick
Executive Sponsor	Chief Executive Officer	Aaron Edwards
Nurse Executive	Chief Operating Officer	Shawn Ottley
Physician Executive	Chief Medical Officer	Matthew Hillman
Physician Representative	ED Medical Director	Matthew Hillman
Nursing Representative	Chief Nursing Officer	Rhianna Montgomery
Nursing Representative	ED Nurse Manager	Bryce Kipp
EMS / Safety Representative	Safety Officer	Ray Eickmeyer
Facilities Representative	Director of Facilities	Kenneth Peters
Infection Prevention Representative	Infection Preventionist	James Phetteplace
Employee Health Representative	Employee Health RN	James Phetteplace
Informatics Representative	Clinical Informaticist	Sheri Krupla
AD-HOC MEMBERSHIP		
Ad-Hoc Member	Chief Financial Officer	Brant Truman
Ad-Hoc Member	Chief Informational Officer	Amy Thomas
Ad-Hoc Member	HR Manager	Tara Lautiki
Ad-Hoc Member	Surgical Services Manager	
Ad-Hoc Member	Lab Manager	Byron Schmidt
Ad-Hoc Member	Radiology Manager	Chris Schmidt
Ad-Hoc Member	HIMS Manager	Samuel Nau
Ad-Hoc Member	Patient Access Manager	Patti Peters
Ad-Hoc Member	Environmental Services Manager	Tyler Ehlert
Ad-Hoc Member	Materials Manager	Joseph Thompson
Ad-Hoc Member	Dietary Manager	Tyler Ehlert
Ad-Hoc Member	Pharmacy Manager	Lindsey Hippe
Ad-Hoc Member	Rehab Manager	Jeffery England
Ad-Hoc Member	OB Coordinator	Juliana England
Ad-Hoc Member	Sterile Processing Coordinator	
Ad-Hoc Member	Communications/Outreach	Agustin Benegas
Ad-Hoc Member	Clinic Manager	Jodi Sweeney
Ad-Hoc Member	Accounting/Finance	Vickie Bodle

Reporting Relationship:

The CQI CPI Committee reports directly to the Lake Chelan Health Board of Commissioners, and provides information updates to Medical Staff, and Executive Leadership.

Meetings:

The CQI CPI Committee will meet no less than monthly on the first Thursday of the month, for two hours. Ad-Hoc meetings may be called for urgent issues needing committee attention. Guests and ad-hoc members will attend at the discretion of the committee chair, based on the needs of the committee and according to the predetermined reporting schedule. Case review will be conducted under closed session with committee members only and operated under RCW 70.41.200. The committee may choose to form 'sub-committees' or 'task forces' to work on specific tactical work, these groups will serve at the direction of, and report directly to, the CQI CPI committee. Meeting minutes will be made available to committee members no later than 10 days after the close of the meeting. Meeting agendas and supporting documentation will be provided to committee members one week prior to meeting start via email. Members are expected to attend 83% of scheduled meetings during the calendar year – ad-hoc members are expected to attend 100% of the meetings they are scheduled to report-out at.



2025 LCH QUALITY COMMITTEE WORK PLAN

MONTH	TOPIC, ACTION ITEM(S), AGENDA ITEM(S)	OWNER
January 2025	<ul style="list-style-type: none"> • Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking • New Business <ul style="list-style-type: none"> ○ Review 2025 Workplan ○ 2025 Committee Education • Education – • Department Report Out <ul style="list-style-type: none"> ○ MSU ○ ED ○ Surgical Services ○ Rehab Services ○ EMS ○ OB ○ Express Care/Primary Care/Specialty Clinic • ISO 9001 Review • Radiology High Radiations Review • Data <ul style="list-style-type: none"> ○ Event Reporting ○ Complaints/Grievances ○ Patient Satisfaction • DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-1 ○ NC-1-2 ○ NC-1-3 ○ NC-1-4 • Sub-Committee Report Out <ul style="list-style-type: none"> ○ Clinical Quality Committee ○ Safety Committee ○ Pharmacy & Therapeutics • Open Discussion 	<ul style="list-style-type: none"> • Lab Manager • CNO • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Committee • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • CNO • ED RN Manager • Surgical Services Manager • Rehab Services Manager • Director of EMS • OB Manager • Clinic Manager • ISO Task Force Team • Radiology Manager • Executive Director of Quality • Quality Dept. Specialist • Executive Director of Quality, ED RN Manager, Surgical Services Manager, Safety Officer • CNO • Safety Officer • Director of Pharmacy
February 2025	<ul style="list-style-type: none"> • Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking • New Business <ul style="list-style-type: none"> ○ LCH CAH Annual Report • Education – Tara, Adrienne • Department Report Out <ul style="list-style-type: none"> ○ Dietary, EVS ○ Pharmacy ○ Patient Access ○ Radiology ○ Lab 	<ul style="list-style-type: none"> • Lab Manager • CNO • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Director of EVS and Dietary Services • Director of Pharmacy • Patient Access/Business Office Manager • Radiology Manager • Lab Manager



2025 LCH QUALITY COMMITTEE WORK PLAN

	<ul style="list-style-type: none"> ○ HIMS ● ISO 9001 Review ● Data <ul style="list-style-type: none"> ○ CMS Measures ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-5 ○ NC-2-1 ○ NC-2-2 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ STTA Committee ○ Compliance Committee ○ IP Committee ● Open Discussion 	<ul style="list-style-type: none"> ● Director of Revenue Cycle ● ISO Task Force Team ● Director of Quality/Quality Dept. Specialist ● Director of Facilities, Director of Pharmacy, Surgical Services Manager ● CMO/Surgical Services Manager ● COO/CNO ● Infection Preventionist & Employee Health RN
<p>March 2025</p>	<ul style="list-style-type: none"> ● Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking ● New Business <ul style="list-style-type: none"> ○ 2024 Annual Safety Committee Report & Review ● Education – ● Department Report Out <ul style="list-style-type: none"> ○ IT ○ Billing ○ Materials Management ○ Facilities ○ Accounting ○ HR ● ISO 9001 Review ● Data <ul style="list-style-type: none"> ○ WSHA – Clinic, OB, Falls ○ HAIs ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-2-3 ○ NC-2-4 ○ NC-2-5 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ Obstetrics ○ UR Committee ● Open Discussion 	<ul style="list-style-type: none"> ● Lab Manager ● CNO ● Executive Director of Quality ● Executive Director of Quality ● Safety Officer ● Director of IT ● Business Office Manager ● Materials Manager ● Director of Facilities ● Controller ● HR Manager ● ISO Task Force Team ● Executive Director of Quality/Quality Dept. Specialist ● Infection Preventionist, CMO, Director of Facilities/Safety Officer ● OB Manager ● Social Worker



2025 LCH QUALITY COMMITTEE WORK PLAN

<p>April 2025</p>	<ul style="list-style-type: none"> • Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking • New Business • Education – • Department Report Out <ul style="list-style-type: none"> ○ MSU ○ ED ○ Surgical Services ○ Rehab Services ○ EMS ○ OB ○ Express Care/Primary Care/Specialty Clinic • ISO 9001 Review • Radiology High Radiations Review • Data <ul style="list-style-type: none"> ○ Event Reporting ○ Complaints/Grievances ○ Patient Satisfaction • DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-1 ○ NC-1-2 ○ NC-1-3 ○ NC-1-4 • Sub-Committee Report Out <ul style="list-style-type: none"> ○ Clinical Quality Committee ○ Safety Committee ○ Pharmacy & Therapeutics • Open Discussion 	<ul style="list-style-type: none"> • Lab Manager • CNO • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality <ul style="list-style-type: none"> • CNO • ED RN Manager • Surgical Services Manager • Director of Rehab Services • Director of EMS • OB Manager • Clinic Manager <ul style="list-style-type: none"> • Radiology Manager • Executive Director of Quality/Quality Data Specialist <ul style="list-style-type: none"> • Executive Director of Quality, ED RN Manager, Surgical Services Manager, Safety Officer <ul style="list-style-type: none"> • CNO • Safety Officer • Director of Pharmacy
<p>May 2025</p>	<ul style="list-style-type: none"> • Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking • New Business • Education – • Department Report Out <ul style="list-style-type: none"> ○ Dietary, EVS ○ Pharmacy ○ Patient Access ○ Radiology ○ Lab ○ HIMS • ISO 9001 Review • Data 	<ul style="list-style-type: none"> • Lab Manager • CNO • Executive Director of Quality • Executive Director of Quality <ul style="list-style-type: none"> • Director of EVS and Dietary Services • Director of Pharmacy • Patient Access Manager • Radiology Manager • Lab Manager • Director of Revenue Cycle • ISO Task Force Team



2025 LCH QUALITY COMMITTEE WORK PLAN

	<ul style="list-style-type: none"> ○ CMS Measures ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-5 ○ NC-2-1 ○ NC-2-2 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ STTA Committee ○ Compliance Committee ○ IP Committee ● Open Discussion 	<ul style="list-style-type: none"> ● Executive Director of Quality ● Quality Dept. Specialist ● Director of Facilities, Director of Pharmacy, Surgical Services Manager ● CMO/Surgical Services Manager ● COO/CNO ● Infection Preventionist/Employee Health RN
<p>June 2025</p>	<ul style="list-style-type: none"> ● Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking ● New Business ● Education – ● Department Report Out <ul style="list-style-type: none"> ○ IT ○ Billing ○ Materials Management ○ Facilities ○ Accounting ○ HR ● ISO 9001 Review ● Data <ul style="list-style-type: none"> ○ WSHA – Clinic, OB, Falls ○ HAIs ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-2-3 ○ NC-2-4 ○ NC-2-5 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ Obstetrics ○ UR Committee ● Open Discussion 	<ul style="list-style-type: none"> ● Lab Manager ● CNO ● Executive Director of Quality ● Executive Director of Quality ● Director of IT ● CNO ● Emergency Dept Manager ● Surgical Services Manager ● Lab Manager ● Radiology Manager ● OB Manager ● Surgical Services Manager ● ISO Task Force Team ● Executive Director of Quality ● Quality Data Specialist ● Infection Preventionist, CMO, Director of Facilities/Safety Officer ● OB Manager ● Social Worker
<p>July 2025</p>	<ul style="list-style-type: none"> ● Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ Quality Committee Objectives Tracking ● New Business ● Education – ● Department Report Out <ul style="list-style-type: none"> ○ MSU 	<ul style="list-style-type: none"> ● Lab Manager ● CNO ● Executive Director of Quality ● Executive Director of Quality ● Executive Director of Quality ● Executive Director of Quality ● CNO ● ED RN Manager



2025 LCH QUALITY COMMITTEE WORK PLAN

	<ul style="list-style-type: none"> ○ ED ○ Surgical Services ○ Rehab Services ○ EMS ○ OB ○ Express Care/Primary Care/Specialty Clinic ● ISO 9001 Review ● Radiology High Radiations Review ● Data <ul style="list-style-type: none"> ○ Event Reporting ○ Complaints/Grievances ○ Patient Satisfaction ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-1 ○ NC-1-2 ○ NC-1-3 ○ NC-1-4 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ Clinical Quality Committee ○ Safety Committee ○ Pharmacy & Therapeutics ● Open Discussion 	<ul style="list-style-type: none"> ● Surgical Services Manager ● Rehab Services Director ● EMS Director ● OB Manager ● Clinic Manager ● ISO Task Force Team ● Radiology Manager ● Executive Director of Quality ● Quality Dept. Specialist ● Executive Director of Quality, ED RN Manager, Surgical Services Manager, Safety Officer ● CNO ● Safety Officer ● Director of Pharmacy
<p>August 2025</p>	<ul style="list-style-type: none"> ● Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ Quality Committee Objectives Tracking ● New Business ● Education – ● Department Report Out <ul style="list-style-type: none"> ○ Dietary, EVS ○ Pharmacy ○ Patient Access ○ Radiology ○ Lab ○ HIMS ● ISO 9001 Review ● Data <ul style="list-style-type: none"> ○ CMS Measures ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-5 ○ NC-2-1 ○ NC-2-2 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ STTA Committee ○ Compliance Committee ○ IP Committee ● Open Discussion 	<ul style="list-style-type: none"> ● Lab Manager ● CNO ● Executive Director of Quality ● Executive Director of Quality ● Director of EVS and Dietary Services ● Director of Pharmacy ● Business Office Manager ● Radiology Manager ● Lab Manager ● Director of Revenue Cycle ● ISO Task Force Team ● Director of Quality/Quality Data Specialist ● Director of Facilities, Director of Pharmacy, Surgical Services Manager ● CMO/Surgical Services Manager ● COO/CNO ● Infection Preventionist/Employee Health RN



2025 LCH QUALITY COMMITTEE WORK PLAN

<p>September 2025</p>	<ul style="list-style-type: none"> • Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking • New Business • Education – • Department Report Out <ul style="list-style-type: none"> ○ IT ○ Billing ○ Materials Management ○ Facilities ○ Accounting ○ HR • ISO 9001 Review • Data <ul style="list-style-type: none"> ○ WSHA – Clinic, OB, Falls ○ HAIs • DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-2-3 ○ NC-2-4 ○ NC-2-5 • Sub-Committee Report Out <ul style="list-style-type: none"> ○ Obstetrics ○ UR Committee • Open Discussion 	<ul style="list-style-type: none"> • Lab Manager • CNO • Executive Director of Quality • Executive Director of Quality • Director of IT • CNO • Emergency Dept Manager • Surgical Services Manager • Lab Manager • Radiology Manager • OB Manager • Surgical Services Manager • ISO Task Force Team • Executive Director of Quality • Quality Dept. Specialist • Infection Preventionist, CMO, Director of Facilities/Safety Officer • OB Manager • Social Worker
<p>October 2025</p>	<ul style="list-style-type: none"> • Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ Quality Committee Objectives Tracking • New Business <ul style="list-style-type: none"> ○ 2025 Quality Committee Planning to include objectives • Education – • Department Report Out <ul style="list-style-type: none"> ○ MSU ○ ED ○ Surgical Services ○ Rehab Services ○ EMS ○ OB ○ Express Care/Primary Care/Specialty Clinic • ISO 9001 Review • Radiology High Radiations Review • Data <ul style="list-style-type: none"> ○ Event Reporting ○ Complaints/Grievances 	<ul style="list-style-type: none"> • Lab Manager • CNO • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • Executive Director of Quality • CNO • ED RN Manager • Surgical Services Manager • Director of Rehab Services • Director of EMS • OB Manager • Clinic Manager • ISO Task Force Team • Radiology Manager • Executive Director of Quality/Quality Dept. Specialist



2025 LCH QUALITY COMMITTEE WORK PLAN

	<ul style="list-style-type: none"> ○ Patient Satisfaction ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-1 ○ NC-1-2 ○ NC-1-3 ○ NC-1-4 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ Clinical Quality Committee ○ Safety Committee ○ Pharmacy & Therapeutics ● Open Discussion 	<ul style="list-style-type: none"> ● Executive Director of Quality, ED RN Manager, Surgical Services Manager, Safety Officer ● CNO ● Safety Officer ● Director of Pharmacy
<p>November 2025</p>	<ul style="list-style-type: none"> ● Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ Quality Committee Objectives Tracking ● New Business ● Education – ● Department Report Out <ul style="list-style-type: none"> ○ Dietary, EVS ○ Pharmacy ○ Patient Access ○ Radiology ○ Lab ○ HIMS ● ISO 9001 Review ● Data <ul style="list-style-type: none"> ○ CMS Measures ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-1-5 ○ NC-2-1 ○ NC-2-2 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ STTA Committee ○ Compliance Committee ○ IP Committee ● Open Discussion 	<ul style="list-style-type: none"> ● Lab Manager ● CNO ● Executive Director of Quality ● Executive Director of Quality ● Dietary & EVS Manager ● Director of Pharmacy ● Patient Access Manager ● Radiology Manager ● Lab Manager ● Director of Revenue Cycle ● ISO Task Force Team ● Executive Director of Quality ● Quality Dept. Specialist ● Director of Facilities, Director of Pharmacy, Surgical Services Manager ● CMO/Surgical Services Manager ● Executive Director of Quality ● Infection Preventionist/Employee Health RN
<p>December 2025</p>	<ul style="list-style-type: none"> ● Old Business <ul style="list-style-type: none"> ○ Blood Transfusion Documentation ○ Restraints Documentation ○ Contracts/Policies Evaluation Review ○ DNV CAP Tracking Review ○ Aggregate Quality Score ○ QM 7 Tracking ○ Quality Committee Objectives Tracking ● New Business ● Education - ● Department Report Out <ul style="list-style-type: none"> ○ IT ○ Billing 	<ul style="list-style-type: none"> ● Lab Manager ● CNO ● Executive Director of Quality ● Executive Director of Quality ● Director of IT ● Business Office Manager ● Materials Manager



2025 LCH QUALITY COMMITTEE WORK PLAN

	<ul style="list-style-type: none"> ○ Materials Management ○ Facilities ○ Accounting ○ HR ● ISO 9001 Review ● Data <ul style="list-style-type: none"> ○ WSHA – Clinic, OB, Falls ○ HAIs ● DNV Quality Committee Oversight of NCs <ul style="list-style-type: none"> ○ NC-2-3 ○ NC-2-4 ○ NC-2-5 ● Sub-Committee Report Out <ul style="list-style-type: none"> ○ Obstetrics ○ UR Committee ● Open Discussion 	<ul style="list-style-type: none"> ● Director of Facilities ● Controller ● HR Director ● ISO Task Force Team ● Executive Director of Quality ● Quality Dept. Specialist ● Infection Preventionist, CMO, Director of Facilities/Safety Officer ● OB Manager ● Social Worker
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CEO Board Report (as of 1/23/25)

People:

- We will give out 4 Daisy Awards to various nursing staff this week. More to come when all have been announce we will get names and pictures out on social media and to various news outlets.
- Thank you to Shawn Ottley (COO) and our ELT for taking care of the hospital while I attended to a family emergency and traveled overseas during the holidays.
- Hospitalists have started and it seems as if they are enjoying the work and staff and patients are doing well with the change.
- Our visiting dermatologist (Dr. Touloe) is seeing a substantial and growing number of patients each visit to our facility.
- Dr. Goeser and PA Guadalupe Martinez-Vera are accepting new patients down at the clinic and often have same day access to appointments!
- Continue to work on filling open positions at MA, CNA, nursing in OB &MSU), PT/OT, Plant engineer, MRI and Lab Tech, patient access, family practice provider, internist (both MD/DO and APP), and our business office. Go to www.lakechelanhealth.org/careers/ to see what is available and apply and see which positions have additional incentives!

Community:

- Will be attending a rural health legislative day in Olympia coming up in early February.
- The Health and Wellness Foundation will be hosting a Heart Health Lunch on Feb 13, at Sigillo Cellars. Tickets are available at the chamber of commerce.
- Have volunteered to be a committee member on the Washington State Hospital Association Rural Workforce Committee and had our first meeting discussing various ways to find and attract staff.

Quality:

- The Net promoter score (patient satisfaction score) remains high and has improved slightly over the past few weeks.
- A yearly quality plan will be presented at our January meeting.
- Will be working hard on updating our delineation of privileges for various departments within the hospital.

Financial:

- Finished the year with a small net gain of \$2M (unaudited) which was very similar to 2023's results (note that 2023 did not include a bonus to staff). December was a slight loss of \$74K missing expectations due to less surgeries than expected. For the year we had a few less deliveries, a slight increase in inpatient visits, a steep decrease in swing beds, ED volume was flat. Imaging, lab, and rehab visits were up quite a bit. Clinic visits were up slightly year-over-year.
- Expecting the remaining new hospital financing soon as Bouten has returned all the necessary documents to the USDA. Also expect to see cash coming in from the department of ecology (for past soil mitigation), and we will begin to see reimbursement from commerce on the EMS project soon.

Building for the Future:

- Specialty clinic is in framing and appears to be on time.
- Preparing for our pre application meeting with the city for the EMS building. Plans are coming together well and hopefully we can share with the public soon.
- Working on additional services such as cardiology, ENT, and other offerings with announcements hopefully coming soon.
- Rural Enterprise is well on their way to building a nurse staffing agency. We are in the cue to be included in their service in the near future.



Origination 3/11/2022
Last Approved N/A
Effective Upon Approval
Last Revised 1/13/2025
Next Review 2 years after approval

Owner Mary Murphy:
Board Governance
Committee Member
Area Hospital
Commission

Board of Commissioners Policy and Procedure regarding Ethical and Legal Matters

I. PURPOSE

N/A

The purpose of the Board of Commissioners Policy and Procedure regarding Ethical and Legal Matters is essential to clarify expectations for the behaviors of board members who represent the community in governing the Public Hospital District and to ensure their compliance with ethical and legal standards to protect the Hospital District from legal and reputational risk.

II. POLICY STATEMENT

The Board of Commissioners shall apply the highest ethical and legal standards in fulfilling in their role. The Board members should hold themselves accountable to each other, to Chelan County Public Hospital District 2, and to the public for their actions and omissions. From time to time governance and /or Board issues might arise that indicate or require the Board to seek legal counsel to identify the best way to address a Board or governance issue.

III. SCOPE

N/A

IV. ROLES AND RESPONSIBILITIES

N/A

The Board of Commissioners roles and responsibilities are to apply and enforce the highest ethical and legal standards for the Board. Failure of any board member to comply with these standards could subject the member to Board censure, sanctions and/or removal from specific Board committees.

V. DEFINITIONS

N/A

An alleged "(improper) governmental action," is defined by RCW 42.41.020(1) to mean:

1. Action by a local government officer or employee;
2. Taken in the performance of the officer's or employee's official duties, whether or not the action is within the scope of the officer's duties or employee's employment.

VI. PROCEDURE

1. When a Board member identifies an improper governmental action that increases a risk of legal or ethical issue, or does not comply with law(s) or Lake Chelan Health's (LCH) Compliance Plan or policies and procedures, the Board member must promptly report this matter to the Compliance Officer according to the Compliance Plan. In the case that the Compliance Officer is the person whose action allegedly places the District at legal risk, the Board member must report this action to the CEO.

2. The Board duty includes an obligation to report suspected violations of laws, regulations, or organizational policies to appropriate officials and to avoid retaliation against others who in good faith report such violations. A Board member may in good faith, report the suspected violation to the Hospital District Board Chair or CEO, (or the Compliance Officer, if the CEO and/or Board Chair made the suspected violation), ~~an alleged "improper governmental action," which is defined by RCW 42.41.020(1) to mean:~~

- ~~1. Action by a local government officer or employee;~~
- ~~2. Taken in the performance of the officer's or employee's official duties, whether or not the action is within the scope of the officer's duties or employee's employment.~~

In these circumstances, the reporting Board member is protected by the Whistle-Blower Protection policy.

3. The Board duty includes an obligation to prohibit retaliation against others who in good faith report such violations. In these circumstances, the reporting Board member and /or employee is protected by the Whistle-Blower Protection policy

4. Board members are encouraged to seek legal advice from the Municipal Research and Services Center (MRSC) as appropriate. MRSC legal advice services are free to individual Board members of the public hospital district through its membership in Association of Washington Public Hospital Districts.

5. Written advice may be requested from MRSC, and may be distributed as appropriate to all or select Board members, to assist them in their specific role. If MRSC attorney advises that a District seek advice from the hospital's contracted legal counsel, the Board member must request action through the Board

Chair and/or CEO, as appropriate.

6. The Hospital District may contract legal counsel services with one or more outside law firms according to their special expertise to provide services regarding Board or governance matters, such as legal advice, investigation and report of findings, representation of the Hospital District in dealings with other entities, preparation of documents such as Board resolutions, and review and/or development of contracts.. Contracted legal counsel works for the Hospital District and not any individual Board member or employee of the District. Therefore, communication with contracted legal counsel regarding Board matters shall be conducted by CEO, Board Chair or authorized representative as indicated. See [LCHLake Chelan Health](#) Compliance Plan.

7. When contracted legal counsel is deemed necessary, the CEO or Board Chair should discuss the need to determine the most effective approach.

8. Confidentiality in all legal matters of the Hospital District is imperative to protect attorney- client privilege. See the policy, Compliance Plan

VII. REFERENCES

[Lake Chelan Health](#) Compliance Plan

[Lake Chelan Health Whistle-Blower Protection policy](#)

[Revised Code of Washington](#)

[Municipal Resource and Services \(MRSC\)](#)

VIII. ATTACHMENTS

N/A

*This policy may be revised at any time without prior notice. All revisions supersede prior policy and are effective immediately upon approval." AND "Any printed policy is not valid past the print date and should not be relied on for official purposes. Current versions of all policies can be found in PolicyStat.

Approval Signatures

Step Description	Approver	Date
Policy Management Committee	Committee Policy Management: Policy Management Committee	Pending
	Mary Murphy: Board Governance Committee Member	1/13/2025



Origination 2/25/2020
Last Approved N/A
Effective Upon Approval
Last Revised 1/14/2025
Next Review 1 year after approval

Owner Mary Murphy:
Board Governance
Committee Member
Area Hospital
Commission

Conflict of Interest Policy

~~Purpose Statement~~

I. PURPOSE

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~~

II. 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, [Board bylaws and Lake Chelan Health policies and procedures](#). 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~~

III. SCOPE

[This policy applies to the Lake Chelan Health Board of Commissioners as a whole, individual Board members, and Board Committee members when exercising duties for Lake Chelan Health.](#)

IV. ROLES & RESPONSIBILITIES

Lake Chelan Health Board of Commissioners as a whole, individual Board members, and Board Committee members are responsible to monitor their behavior to ensure compliance with all laws and organizational policies and procedures regarding conflict of interest.

V. DEFINITIONS

Conflict of Interest is defined by Revised Code of Washington and Lake Chelan Board Bylaws.

VI. PROCEDURE

The Board shall on an annual basis complete and sign a Lake Chelan Health Conflict of Interest form that documents any circumstances or factors that could create actual or potential conflicts of interest.

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~~staff's, 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 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 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 explicitly Board authorized.

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

VII. REFERENCES

[RCW 42.20 AND RCW 42.23](#)

[Lake Chelan Health Board of Commissioner Bylaws](#)

[Open Public Meeting Act](#)

VIII. ATTACHMENT

[Lake Chelan Health Conflict of Interest Disclosure Form](#)

[This policy may be revised at any time without prior notice. All revisions supersede prior policy and are effective immediately upon approval.](#)

[Any printed policy is not valid past the print date and should not be relied on for official purposes. Current versions of all policies can be found in PolicyStat.](#)

Attachments

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Administration	Aaron Edwards: CEO	1/20/2025
Policy Management Committee	Committee Policy Management: Policy Management Committee	1/20/2025
	Mary Murphy: Board Governance Committee Member	1/14/2025

COPY

Status **Pending** PolicyStat ID **16462350**



Origination 4/10/2018
Last Approved N/A
Effective Upon Approval
Last Revised 1/10/2025
Next Review 2 years after approval

Owner Mary Murphy:
Board Governance
Committee Member
Area Hospital
Commission

Board of Commissioners Policy Review Guidelines

~~The Board of Commissioners will review and approve the following policies:~~

- ~~• Any policy requested by the CEO for review and approval by the Board.~~
- ~~• Any policy requested by the Board of Commissioners for review and approval.~~
- ~~• Policies published by the Washington state DOH to be reviewed annually:
 - ~~▫ Admissions~~
 - ~~▫ Charity Care~~
 - ~~▫ End of Life~~
 - ~~▫ Non-discrimination~~
 - ~~▫ Nurse staffing~~
 - ~~▫ Reproductive Health~~
 - ~~▫ Reproductive Health Services Provided~~
 - ~~▫ Conflict of Interest~~~~
- ~~• Board specific policies to be reviewed annually:
 - ~~▫ Governing Board Bylaws~~
 - ~~▫ Governing Board Orientation~~
 - ~~▫ Governing Board Policy~~
 - ~~▫ Board of Commissioners Policy Review Guidelines~~
 - ~~▫ Board of Commissioners Continuing Education~~
 - ~~▫ Continuous Quality Improvement Plan~~
 - ~~▫ Cardiac, Stroke, & Trauma Plan~~~~

- ~~Medical Staff Bylaws~~
- ~~Risk Management and Patient Safety Plan~~
- ~~Infection Prevention Plan~~
- ~~Other policies to be reviewed within every three years:~~
 - ~~Administrative Operating Guidelines~~
 - ~~Credentialing~~
 - ~~Cyber Security Policy~~
 - ~~Financial Management Policies~~
 - ~~Administrative Policies~~
 - ~~Capital Procedures~~
 - ~~Accident Prevention Policy~~
 - ~~Tort Claims~~
 - ~~Accounts Receivable Small Balance Write-off~~

I. PURPOSE

The purpose of the Lake Chelan Health Board of Commissioners Policy and Plan Review Guidelines is to establish a clear and structured process for the review and approval of select policies and plans that relate to Board governance responsibilities. This ensures that the specific policies and plans are thoroughly evaluated, comply with legal requirements, and align with the strategic objectives of the organization. By doing so, the Board of Commissioners can maintain effective governance, uphold accountability, and support the organization's mission and goals.

II. POLICY STATEMENT

Lake Chelan Health Board of Commissioners are expected to adopt new policies from time to time and to review and approve existing policies and plans on a scheduled basis to ensure compliance with laws and organizational policies, and timely implementation.

III. SCOPE

This policy applies to all Board members and covers various organizational policies, and specifically Lake Chelan Health policies that must be posted on the Washington State Department of Health website.

Review and Approval by the Chief Executive Officer (CEO): Any new policy and plan requested by the CEO for review and approval by the Board.

- i. The policy will be reviewed initially by the CEO. Once approved by the Board, the approval will revert to the appropriate approval workflow.

Board-Initiated Review: Any policy and plan requested by the Board of Commissioners for review and approval.

Legal Requirements: Any policy and plan review required by law and or regulatory agencies

This scope ensures that all relevant policies and plans are reviewed and approved by the Board of Commissioners, whether initiated by the CEO, the Board itself, or mandated by legal requirements.

IV. ROLES & RESPONSIBILITIES

The Board's role is to establish, review and approve specific Board policies for implementation by administration and/or Board. The Board is also responsible on a scheduled basis to review and update existing organizational plans, policies and procedures that are within the scope described above.

V. DEFINITIONS

N/A

VI. PROCEDURE

The Board of Commissioners will review and approve plans, policies and procedures as shown in Hospital Commission Policy List. See attached. The Board of Commissioners may initiate Board plans, policies and procedures as necessary and refer to administration to review and to complete the preparation of the document for Board approval and placement in PolicyStat.

VII. REFERENCES

N/A

VIII. ATTACHMENTS

Hospital Commission Policy List

This policy may be revised at any time without prior notice. All revisions supersede prior policy and are effective immediately upon approval.

Any printed policy is not valid past the print date and should not be relied on for official purposes. Current versions of all policies can be found in PolicyStat.

Attachments

 [Hospital Commission Policy List.pdf](#)

Approval Signatures

Step Description

Approver

Date

Board Approval	Wendy Kenck: Executive Assistant	Pending
Administration	Aaron Edwards: CEO	1/20/2025
Policy Management Committee	Committee Policy Management: Policy Management Committee	1/13/2025
	Mary Murphy: Board Governance Committee Member	1/10/2025

COPY



Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	2 years after approval

Owner	Patti Peters: Business Office/ Patient Access/ HIMS Manager
Area	Patient Financial Services

Charity Care Policy

I. PURPOSE

This Financial Assistance Policy is intended to ensure that patients who are at or near the federal poverty level receive Appropriate Hospital-Based Medical Services and Appropriate Non-Hospital-Based Medical Services at a cost that is based on their ability to pay for services up to and including care without charge. Financial Assistance will be granted to all eligible persons regardless of age, race, color, religion, sex, sexual orientation, or national origin in accordance with WAC Chapter 246-453 and RCW 70.170.

The written policy includes:

- (a1) eligibility criteria for Financial Assistance,
- (b2) describes the basis for calculating amounts charged to patients eligible for Financial Assistance,
- (e3) describes the method by which patients may apply for Financial Assistance and
- (d4) describe how the District will publicize the policy with the community services by the District.

II. POLICY STATEMENT

Financial Assistance may cover all appropriate hospital-based medical services, received in the **hospital** inpatient or outpatient/clinic setting. Services not qualifying under financial assistance may include elective or experimental procedures or separately billable professional services provided by the hospital's medical staff. Non-residents of Washington State are eligible for Financial Assistance consistent with Washington Administrative Code 246-453, which includes emergent, non-scheduled services only. Financial Assistance will not be denied based on immigration status.

III. SCOPE

Lake Chelan Health is required to provide notice of its Financial Assistance program and will make a good-faith effort to provide every patient with information regarding its availability. Lake Chelan Health (inpatient and hospital-based outpatient clinics/facilities) will post signs in Patient Access, Business Office/Financial Counseling, Emergency Department, and Outpatient Registration that will notify the public of the Financial Assistance Policy. Eligibility for Financial Assistance requires that patients must fulfill all requirements and expectations as outlined in the Financial Assistance Policy. This Financial Assistance Policy and applications for Financial Assistance are available in any language spoken by more than five percent of the population or 1,000 individuals in the applicable hospital's service area. Additionally, interpreter services will be made available for other non-English speaking or limited-English speaking or other patients who cannot read or understand the written application materials

IV. ROLES & RESPONSIBILITIES

All LCH staff can provide a charity care application for LCH patients. The financial counselor will receive the charity care application and supporting documentation to support the determination of a discounted rate based on the FPL LCH accounting department and will review and validate the charity care application. Upon approval, the accounting department will provide the requested adjustment to the business office manager for the appropriate discount

V. DEFINITIONS

Residence and Scope of Services:

~~A person is not a Washington State resident and is not eligible for Financial Assistance when that person enters Washington State solely for the purpose of seeking medical care. Refugees, asylees, and those seeking asylum are exempt from the Washington State residency requirement for Financial Assistance eligibility. Also exempt from the Washington State residency requirement are those patients who have an Emergency Medical Condition. Financial Assistance will not be denied based on immigration status. Exceptions to residence and scope of services requirements outlined in this paragraph may be made only in extraordinary circumstances and with the approval of the Lake Chelan Health Chief Financial Officer or designee. While not required by federal or state law, eligibility for Financial Assistance will be extended to individuals who receive Appropriate Non-Hospital Based Medical Services and meet the above criteria. Financial Assistance: Medically necessary hospital health care rendered to indigent persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. Persons who have exhausted any third-party coverage, including Medicare and Medicaid, and whose income is above 200% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer, may be eligible for Financial Assistance under this policy. Appropriate Hospital-Based Medical Services: Those Lake Chelan Health hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate~~

~~a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment where appropriate, no treatment at all. Appropriate Non-Hospital Based Medical Services: Those services rendered at the clinic offices by LCH Members, which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. A course of treatment may include mere observation or, where appropriate, no treatment at all. For purposes of this Financial Assistance Policy, preventive care services may be considered "Appropriate Non-Hospital-Based Medical Services". LCH Members: For purposes of this policy, a physician or other qualified healthcare professional who has executed a practice agreement with LCH, or has otherwise reassigned their services to LCH under a contractual arrangement, and provides services at approved LCH sites of practice.~~

Financial Assistance will not be denied based on resident or immigration status. Patients seeking Medically necessary health care qualify when Third-Party Coverage, if any, has been exhausted, to the extent that the persons cannot pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. Persons who have exhausted any third-party coverage, including Medicare and Medicaid, and whose income is above 200% of the federal poverty standards, adjusted for family size, or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer, may be eligible for Financial Assistance under this policy.

Appropriate Hospital-Based Medical Services:

Those Lake Chelan Health hospital services that are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment where appropriate, no treatment at all.

Appropriate Non-Hospital Based Medical Services:

Those services are rendered at the clinic offices by LCH Members, which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. A course of treatment may include mere observation or, where appropriate, no treatment at all. For purposes of this Financial Assistance Policy, preventive care services may be considered "Appropriate Non-Hospital-Based Medical Services". LCH Members: For purposes of this policy, a physician or other qualified healthcare professional who has executed a practice agreement with LCH, or has otherwise reassigned their services to LCH under a contractual arrangement, and provides services at approved LCH sites of practice.

APPLICATION

When a patient wishes to apply for Financial Assistance, the patient shall complete a Confidential Financial Information (CFI) Form (Attachment B) and provide necessary and reasonable supplementary financial documentation to support the entries on the CFI. Lake Chelan Health will make an initial determination of a patient's Financial Assistance status at the time of admission or as soon as possible following the initiation of services to the patient. Financial Assistance application procedures shall not place an unreasonable burden upon the patient, taking into account any barriers ~~which~~that may hinder the patient's capability of complying with the application procedures. Screening for eligibility for Medicaid or other relevant public assistance benefits will be coordinated through the Patient Access Department, Discharge Planning/Outcome Management (if not nursing home placement), or through Patient Financial Services. Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of Financial Assistance eligibility:

1. "W-2" withholding statement.
2. Current pay stubs (3 months);
3. Bank statements (3 months);
4. Last year's income tax return, including schedules, if applicable;
5. Written, signed statements from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income;
6. Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance;
7. Forms approving or denying unemployment compensation; or written statements from employers or welfare agencies.

In addition, in the event the patient is not able to provide any of the documents described above, Lake Chelan Health shall rely upon written and signed statements from either the responsible party or another party describing the applicant's income. If none of the above is available, Lake Chelan Health may ~~make a determination~~decide based on knowledge of a prior grant of financial assistance or based on verbal representation.

Income shall be annualized from the date of application based on documentation and verbal information provided ~~and verbal information provided~~ by the patient. ~~This process~~The information will be ~~determined by the District and~~processed by the financial counselor using the Hospital's Charity Care calculator. ~~Seasonal and/or temporary employment, as well as fluctuation in income, will take into consideration seasonal employment and temporary increases and/or decreases in income~~be considered when processing the application.

Lake Chelan Health may waive income requirements, documentation, and verification if Financial Assistance eligibility is obvious. Lake Chelan Health staff discretion will be exercised in situations where factors such as from the responsible party for making a final determination of eligibility.

Lake Chelan Health shall make a final determination within 14 days of receipt of financial assistance applications and supporting documentation. Supporting documentation includes items listed on the Confidential Financial Information Form Instructions.

VI. PROCEDURE

1. Initial Determination

For the purpose of reaching an initial determination of eligibility, the District shall rely upon information provided orally or in written form for Financial Assistance as outlined in the Financial Assistance Application Form Instructions. The district may require the responsible party to sign a statement attesting to the accuracy of the information provided to the District for purposes of the initial determination of eligibility. Patients will be screened for other forms of coverage such as Medicaid and Health Benefits Exchange eligibility. This application, along with full disclosure of their financial status with supporting documentation, will be considered in the final determination of eligibility. who do not have applicable Third-Party Coverage to assess whether such patients/families may be eligible for Medicaid and/or health care coverage through Washington's Health Benefit Exchange (RCW 43.71). Staff will provide assistance with Medicaid and Qualified Health Plan applications and including but not limited to providing the patient/family with information about the application process, assisting patients through the application process, providing necessary forms that must be completed, and/or connecting the patient/family with other agencies or resources who can assist the patient/family in completing such applications. Lake Chelan Health will not initiate collection efforts until an initial determination of Financial Assistance eligibility status is made. Where Lake Chelan Health initially determines that a patient may be eligible for Financial Assistance, any and all extraordinary collection actions (including civil actions, garnishments, and reports to collections or credit agencies) shall cease pending a final determination of Financial Assistance eligibility. However, as set forth in WAC 246-453-020 the failure of a patient or responsible party to reasonably complete Financial Assistance application procedures under this policy shall be sufficient grounds for Lake Chelan Health to initiate collection efforts directed at the patient. Accordingly, for purposes of this policy, a patient or responsible party has failed to reasonably complete financial assistance application procedures when the patient or responsible party does not submit application materials within 15 business days of the patient's or responsible party's receipt of the materials. Any collection efforts will be halted if the patient or responsible party reengages in the application process. Lake Chelan health excludes assets in the calculation of determining eligibility for financial assistance.

2. Third-Party Coverage

Financial Assistance is generally secondary to all other third-party coverage resources available to the patient.

This includes:

1. Group or individual medical plans.
2. Workers' compensation programs.
3. Medicare, Medicaid or other medical assistance programs.
4. Other state, federal or military programs.
5. Third-party liability situations. (e.g.: auto accidents or personal injuries).

6. Tribal health benefits.
7. Health care sharing ministry as defined in 26 U.S.C. Sec. 5000A.
8. Other situations in which another person or entity may have a legal responsibility to pay for the costs of medical services.

The medically indigent patient will be granted Financial Assistance regardless of race, color, sex, religion, age, national origin, or immigration status. In the event that the responsible party's identification as an indigent person is obvious to District personnel, the District is not obligated to establish the exact income level or request the documentation specified in the financial assistance application. Such individuals are determined to have presumptive eligibility (e.g., have qualified under the state Medicaid or Apple Health program).

In those situations where appropriate primary payment sources are not available, patients shall be considered for Financial Assistance under this District policy based on the following criteria consistent with requirements of WAC 246453-040.

3. Income

By policy, persons ~~whose~~ income is equal to or below 300% of the federal poverty standard may be eligible to receive Financial Assistance. Lake Chelan Health will consider all sources of income in establishing income eligibility for Financial Assistance. Income includes total cash receipts before taxes derived from wages and salaries; welfare payments; Social Security payments; strike benefits; unemployment or disability benefits; child support; alimony; and net earnings from business and investment activities paid to the individual patient/guarantor. gross family income is at or below 100% of the current federal poverty guidelines (consistent with WAC code 246453-050. These patients shall receive a 100% adjustment on their patient balance.

A sliding fee scale shall be used to determine the amount that shall be written off for patients with incomes ~~between 101~~ greater than 100% ~~and less than or equal to~~ 300% of the current federal poverty level. All resources of the family as defined by WAC 246453-050 are considered in determining the applicability of the sliding fee scale in Attachment A.

The sliding fee scale shall take into account the potential necessity for allowing the responsible party to satisfy the maximum amount of charges for which the responsible party will be expected to provide payment over a reasonable period ~~of time~~, without interest or late fees. In determining the maximum amount of charges, the District calculates this by using the Amounts Generally Billed (AGB) look-back methodology. For the current year, the District's AGB percentage is listed ~~on~~ in Attachment A (enclosed). No individual qualifying under the Financial Assistance Policy shall be charged more than the AGB for emergency care ~~of~~ or other medically necessary services. See 26 USC §501(r)(5)(A)

4. Catastrophic Financial Assistance

The District may ~~also write off, as offer~~ Financial Assistance, ~~amounts~~ for patients with family income ~~in excess of 400~~ above 300% of the federal poverty level or at a higher percentage for those above 100% of the federal poverty guidelines when circumstances indicate severe financial hardship or personal loss.

This will be done only upon recommendation by the business office manager with adequate justification and only upon approval by the Chief Financial Officer. These adjustments shall be included in the Chief Financial Officer's regular financial assistance report to the Board of Commissioners

5. Notifications

Lake Chelan Health shall notify persons applying for Financial Assistance of its determination of eligibility for Financial Assistance within 14 days of a receiving person's completed application for Financial Assistance and supporting documentation. Approvals, Requests for More Information or Denials for Financial Assistance applications shall be in writing and shall include instructions for appeal or reconsideration. In the event that Lake Chelan Health denies Financial Assistance, Lake Chelan Health shall notify the person applying for Financial Assistance of the basis for the denial. If denied the patient/guarantor may provide additional documentation to Lake Chelan Health or request review by the Chief Financial Officer or their designee within 30 days of receipt of the notification of denial. If this review affirms the previous denial of Financial Assistance, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

6. Documentation of Records

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the financial assistance application form and retained for seven years.

VII. REFERENCES

1. Washington Administrative Code, Chapter 246-453, "Hospital Financial Assistance" with specific reference to the following:
2. WAC 246-453-020 Uniform procedures for the identification of indigent persons
3. WAC 246-453-030 Data requirements for the identification of indigent persons
4. WAC 246-453-040 Uniform criteria for the identification of indigent persons
5. RCW 70.170.060 Financial Assistance – Prohibited and required hospital practices and policies
6. 26 USC §501(r)(5)(A) and (B)
7. Lake Chelan Health Billing & Collection Policy
8. Lake Chelan Health (Policy Stat ID 8989696 – "Duty to Provide Appropriate Medical Screen Examination
9. Policy (CAH) - Emergency Medical Treatment and Active Labor Act (EMTALA)"

VIII. ATTACHMENTS

1. Attachment A: Federal Poverty Guidelines/Sliding Fee Scale
2. Attachment B: Financial Assistance Application / Confidential Financial Information (CFI) Form

**This policy may be revised at any time without prior notice. All revisions supersede prior policy and are*

effective immediately upon approval.

*Any printed policy is not valid past the print date and should not be relied on for official purposes. Current versions of all policies can be found in PolicyStat.

Attachments

 [2025 Sliding Scale - Charity Care Eligibility \(4\).xlsx](#)

 [CHARITY CARE APPLICATION.pdf](#)

Approval Signatures

Step Description	Approver	Date
Policy Management Committee	Committee Policy Management: Policy Management Committee	Pending
	Patti Peters: Business Office/ Patient Access/HIMS Manager	1/7/2025



Board Responsibilities 2025	Jordana LaPorte	Lori Withrow	Mary Murhpy	Doug Gibson	Len England
Governance Committee (2)					
Quality Committee (2)					
Finance Committee (2)					
Credentialing (1)					
Warrants & Vouchers (1)					
DEI Committee (1)					
Retirement Representative (1)					
Education Topic Month (1/mo)	May June	Jan Apr	Feb Mar	Jul Sep	Aug Oct

Board Responsibilities 2024	Jordana LaPorte	Lori Withrow	Mary Murhpy	Doug Gibson	Len England
Governance Committee (2)		X	X		
Quality Committee (2)				X	X
Finance Committee (2)	X	X			
Credentialing (1)			X		
Warrants & Vouchers (1)		X			
DEI Committee (1)			X	X	
Retirement Representative (1)	X				