



# LAKE CHELAN HEALTH

## **BOARD PACKET**

Chelan County Public Hospital District No. 2

4/29/2025



Chelan County Public Hospital District No. 2  
 Regular Meeting of the Board of Commissioners  
 April 29, 2025, at 1:30 am via TEAMS  
 Meeting ID: 298 885 195 850 Passcode:Jm3G8g7G

## Agenda

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

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

Time	Agenda Item	Facilitator	Topic/Action
1:30	A. Call to Order	J. LaPorte	
1:31	B. Public Comment		
1:36	C. Chair Report	J. LaPorte	
1:40	D. Consent Agenda	Commission	<ul style="list-style-type: none"> <li>A. Regular Board Meeting Minutes 3/25/2025(FA)</li> <li>B. Governance Meeting Minutes 4/2/2025 (FA)</li> <li>C. Warrants &amp; Vouchers (FM)</li> <li>D. Bad Debt &amp; Charity Care (FM)</li> <li>E. Finance Committee Minutes 4/23/2025 (FA)</li> </ul>
1:45	E. Executive Session		<ul style="list-style-type: none"> <li>A. RCW 42.30.140(4)(a) Collective bargaining sessions with employee organizations, including contract negotiations and grievance meetings, are exempt from open meeting requirements.</li> <li>B. RCW 42.30.110(1)(o) to consider information regarding staff privileges or quality improvement committees under RCW 70.41.205</li> </ul>
2:45	F. Reports	L. Sahlinger Dr. Gray S. Ottley, Forte & Graham B. Truman  A. Edwards  S. Ottley Commission	<ul style="list-style-type: none"> <li>A. Med Staff Report &amp; Credentialing (FM)</li> <li>B. Quality Improvement Presentation: Residency (FI)</li> <li>C. Capital Project Update (FI)</li> <li>D. Financial Committee Report (FA)               <ul style="list-style-type: none"> <li>i. SAO (FI)</li> <li>ii. Capital Finance Update (FI)</li> </ul> </li> <li>E. CEO Report (FI)               <ul style="list-style-type: none"> <li>i. New Services (Pediatrics, ENT, Cardiology, Derm, Mohs)</li> </ul> </li> <li>F. Strat Plan KPI Report (FI)</li> <li>G. Community Connections               <ul style="list-style-type: none"> <li>i. WSHA Rural Hospital Leadership Conference (FD)</li> <li>ii. District Update Planning (FD)</li> <li>iii. EMS Graduation (FI)</li> </ul> </li> </ul>
3:45	G. Old Business	Commission S. Ottley, A. Benegas	<ul style="list-style-type: none"> <li>A. Strat Planning Retreat – July 14<sup>th</sup> (FD)</li> <li>B. CHNA (FI)</li> </ul>
4:30	H. New Business		<ul style="list-style-type: none"> <li>A. Policies:               <ul style="list-style-type: none"> <li>a. Workflow Diagram (FI)</li> <li>b. 2025 Continuous Quality Improvement &amp; Continuous Process Improvement Plan (FM)</li> <li>c. Reproductive Health Care (FM)</li> <li>d. Governing Board Bylaws (FM)</li> </ul> </li> <li>B. Resolution 2025-4 Disposal of Hospital Surplus Items</li> </ul>
5:00	I. Roundtable /Action Items	Commission	

5:05	J. Public Comment		
5:10	K. Executive Session		A. RCW 42.30.110(1)(g) to evaluate the performance of a public employee.
5:45	L. Adjournment		

## Board Calendar Reminders:

5/7/2025	Compliance, Privacy, & Risk Committee	1212 / TEAMS	10-11am
5/10/2025	TBA	Bragg Room/ TEAMS	9 am
5/13/2025	Med Staff	Bragg Room/ TEAMS	7-8:30
TBA	Quality Committee	TBA	TBA
5/19/2025	Finance Committee	Bragg Room/ TEAMS	10 am
5/27/2025	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

6/9/2025	TBA	Bragg Room/ TEAMS	9 am
6/12/2025	Med Staff	Bragg Room/ TEAMS	7:30-8:30
6/12/2025	Quality Committee	Bragg Room/ TEAMS	1 – 3 pm
6/22-6/25/25	WSHA Rural Hosp Leadership Conf	Campbells	Varies
6/26/2025	Finance Committee	Bragg Room/ TEAMS	10 am
6/30/2025	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

7/10/2025	Med Staff	Bragg Room/ TEAMS	7:30-8:30am
7/10/2025	Quality Committee	Bragg Room/ TEAMS	1 – 3 pm
7/14/2025	Special Board Meeting: Strategic Planning	TBA	TBA
7/23/2025	Finance Committee	Bragg Room/ TEAMS	10 am
7/29/2025	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 March 25, 2025 at 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"/> Lori Withrow, Vice Chair	<input checked="" type="checkbox"/> Mary Murphy, Secretary <input checked="" type="checkbox"/> Doug Gibson	<input checked="" type="checkbox"/> Len England
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**Staff Participants:** A. Edwards, B. Truman, L. Sahlinger, M. Miller, A. Benegas, C. Onda, T. Lautiki, R. Montgomery, Jenel,

**Guests:**  
**Community Members:** Marianne Patton, Manual Navarro, Ana Moroz, Dr. Gray, Dominick Bonny, HW, Lori Trevino, L. Trevino, Nathaniel Mote

**Recorder:** Wendy Kenck

Agenda Item	Topic/Action
1. Call to Order	<ul style="list-style-type: none"> <li>• J. LaPorte called the meeting to order at 1:31 pm and recited the mission statement.</li> </ul>
2. Public Comment	<ul style="list-style-type: none"> <li>• <b>Anna Moroz</b> asked the Board to confirm its commitment to community care, specifically regarding obstetric (OB) services. Expressed concern that if OB services were removed from Lake Chelan Health (LCH), the nearest options for care would be in Wenatchee or Omak. Emphasized the importance of keeping OB services local as long as there are pregnant women in the area. Also voiced concerns about the addition of a hospitalist without public discussion and requested that any decisions regarding OB services include an opportunity for public comment.</li> <li>• <b>Nathaniel Mote</b> urged the board to publish a written proposal regarding OB services and allow public input in a timely manner. Requested that data be provided to the community to clarify the reasoning behind potential changes. Stressed that, as a community hospital, LCH has a duty to meet public healthcare needs, even if it results in a financial deficit.           <ul style="list-style-type: none"> <li>○ <b>L. England</b> thanked attendees for their engagement and assured that OB services are frequently discussed. Clarified that no final decision has been made on the matter.</li> <li>○ <b>J. LaPorte</b> noted that, as a longtime board member, multiple factors—including risk, finances, quality of care, and community needs—must be considered in decision-making. Stated that while the hospital cannot meet every need for every individual, decisions are made based on a balance of these key factors. As a small hospital we cannot be all things to all people, we must focus on what is right for the community and hospital.</li> </ul> </li> </ul>
3. Chair’s Report	<ul style="list-style-type: none"> <li>• <b>J. LaPorte</b> welcomed the visitors and community members joining the meeting and offered a reminder to address each other with professionalism and respect. The Board remains committed to transparency in our efforts to serve both the community and staff. With transparency comes great responsibility—whether it's the media taking statements out of context or staff members sharing incomplete ideas with others that don't align with our facility's goals. In today's age of social media, it seems that anyone feels they can say whatever they want, often without considering the context and factual information. Let’s focus on the facts and have a productive meeting today.</li> </ul>

<p>4. Consent Agenda</p>	<ul style="list-style-type: none"> <li>• Edits to the Regular Board Meeting Minutes: <ul style="list-style-type: none"> <li>○ Remove the word “privileges” from the task: <i>The Credentialing Committee will reach out to the Medical Staff to review privileges and processes.</i></li> </ul> </li> <li>• <i>M Murphy motioned to approve the Consent Agenda with above noted edit, seconded, motion passed</i></li> </ul>
<p>5. Executive Session</p>	<ul style="list-style-type: none"> <li>• <b>J. LaPorte</b> announced Executive Session at 1:45 pm for 15 minutes to consider information regarding staff privileges or quality improvement committees under RCW 70.41.205 and RCW 42.30.110(1)(o) <ul style="list-style-type: none"> <li>○ L. Withrow extended the Executive Session 10 minutes</li> <li>○ L. Withrow extended the Executive Session 10 minutes</li> <li>○ L. Withrow extended the Executive Session 10 minutes</li> <li>○ L. Withrow extended the Executive Session 5 minutes</li> <li>○ Executive session ended at 2:35 pm</li> </ul> </li> </ul>
<p>6. Reports</p>	<ul style="list-style-type: none"> <li>• <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 in Executive Session, seconded, motion passed.</i></li> <li>• <b>Finance:</b> <ul style="list-style-type: none"> <li>○ <b>B. Truman</b> presented the unaudited February 2025 finance report, <ul style="list-style-type: none"> <li>▪ <i>D. Gibson motioned to accept the unaudited February 2025 Finance Report, motion passed.</i></li> </ul> </li> <li>○ An RFP was submitted to banks to explore loan options for the EMS/Admin building.</li> </ul> </li> <li>• <b>A. Edwards</b> shared the CEO Report with additional notes of interest: <ul style="list-style-type: none"> <li>○ The final open OB nurse position, which had been vacant for over three years, has been filled. This will help reduce OB diversion and lessen reliance on traveling nurses.</li> <li>○ Updates from the state legislative session included concerns about: <ul style="list-style-type: none"> <li>▪ Increased B&amp;O taxes</li> <li>▪ A proposed additional 5% payroll tax</li> <li>▪ A 1% decrease in Managed Care reimbursement rates</li> <li>▪ The potential rollback of all 2024 rate increases</li> <li>▪ Discussions on reducing or eliminating SNAP funding</li> <li>▪ A proposed cap lift on property taxes</li> </ul> </li> </ul> </li> <li>• <b>Community Connection Opportunities:</b> <ul style="list-style-type: none"> <li>○ The Governance Committee will start the planning of the next Community Forum, securing venue details and dates for mid-May to mid-June</li> </ul> </li> <li>• <b>M. Murphy</b> presented the "<b>PHD Board Actions- Resolutions Required</b>" from AWPMD as a tool for board members</li> <li>• <b>A. Edwards</b> reviewed the Board KPI dashboard</li> <li>• <b>M. Miller</b> provided a status update to the Clinic and Specialty Care Clinic <ul style="list-style-type: none"> <li>○ Express Clinic: Ongoing patient growth</li> <li>○ Primary Care: Expansion continues. <ul style="list-style-type: none"> <li>▪ Child Vaccine Program: Launched successfully.</li> <li>▪ Medicare Visits: Increasing.</li> <li>▪ Patient Volume: Growth noted compared to 2024.</li> </ul> </li> <li>○ Pediatrics: New pediatrician starting in Fall; recruiting an additional Advance Practice Provider (APP).</li> <li>○ Specialty Care <ul style="list-style-type: none"> <li>▪ Dermatology: Significant program growth; next step is adding MOH's procedures when the Specialty Clinic opens.</li> <li>▪ Orthopedic Sports Medicine: Expansion in progress; recruiting an APP for</li> </ul> </li> </ul> </li> </ul>

	<p>support.</p> <ul style="list-style-type: none"> <li>▪ Cardiology &amp; ENT: Significant progress in establishing new practices.</li> <li>▪ Cataract Specialty: Development underway.</li> </ul>
7. Old Business	<ul style="list-style-type: none"> <li>• <b>Strategic Planning:</b> Reserving July 14th.</li> </ul>
• New Business	<ul style="list-style-type: none"> <li>• <b>Dr. Harberd</b> presented the UW Family Medicine Rural Residency Program update to the Board of Commissioners.</li> <li>• <i>M. Murphy motioned to approve Resolution 2025-2, Disposal of Hospital Surplus Items; seconded, motion approved.</i></li> <li>• <b>B. Truman</b> reviewed the verbiage change to the Charity Care Policy as required by the DOH. <ul style="list-style-type: none"> <li>○ <i>D. Gibson motioned to accept the Charity Care Policy; seconded, motion approved.</i></li> </ul> </li> <li>• <i>M. Murphy motioned to approve the Notice of Privacy Practices, seconded, motion approved.</i></li> </ul>
8. Roundtable/Action Items	<ul style="list-style-type: none"> <li>• <b>The Governance Committee</b> will draft the Community Forum agenda and coordinate a meeting space.</li> <li>• <b>M. Murphy</b> will work with L Withrow to update the Board Bylaws to include approval via vote.</li> <li>• <b>EA</b> will send out calendar invites for the July 14<sup>th</sup> Strategic Plan .</li> </ul>
9. Public Comment	<ul style="list-style-type: none"> <li>• No Public Comment</li> </ul>
10. Executive Session	<ul style="list-style-type: none"> <li>• <b>J. LaPorte</b> announced Executive Session at 5:00 pm for 20 minutes for <ul style="list-style-type: none"> <li>○ RCW 42.30.110(1)(o) to consider information regarding staff privileges or quality improvement committees under RCW 70.41.205</li> <li>○ RCW 42.30.110(1)(g) Evaluate the performance of a public employee. <ul style="list-style-type: none"> <li>▪ L. Withrow extended the Executive Session 10 minutes</li> <li>▪ L. Withrow extended the Executive Session 15 minutes</li> <li>▪ L. Withrow extended the Executive Session 15 minutes</li> <li>▪ L. Withrow extended the Executive Session 15 minutes</li> <li>▪ L. Withrow extended the Executive Session 10 minutes</li> <li>▪ Executive Session ended at 6:25 pm</li> </ul> </li> </ul> </li> </ul>
11. Adjournment	<ul style="list-style-type: none"> <li>• No action was taken as a result of the Executive Session</li> <li>• <b>J. LaPorte</b> adjourned the meeting at 6:26 pm</li> </ul>

Attest:

\_\_\_\_\_  
M. Murphy, Secretary

\_\_\_\_\_  
Aaron Edwards, CEO

\_\_\_\_\_  
W. Kenck, Executive Assistant



# LAKE CHELAN HEALTH

## MEETING AGENDA

<b>Name of Group:</b> Governance Committee	<b>Date of Meeting:</b> 4/2/25	<b>Time of Meeting:</b> 8:30 am
<b>Facilitator:</b> Mary Murphy		<b>Location:</b> Zoom
<b>Recorder:</b> Mary Murphy		
<b>Members present:</b>		
X BOC Representative (Mary Murphy)		X BOC Representative (Lori Withrow)
<b>Other: {other attendees or guests}</b>		
<b>Meeting Objectives(s)/Purpose:</b> Develop Community Forum plan, Policy Review Flowchart, and review Board job description and orientation		

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

<b>Time</b>	<b>Agenda Item</b>	<b>Topic/Action</b>
8:30 am	1. Call to Order	
8:30 am	2. Community Forum agenda, logistics  3. Policy Review Flowchart  4. Board Orientation Process and Materials	2. Recommend Board forum approach, topics and location options.  3. Recommend Policy Review Flowchart for Board members to more easily coordinate Board Governance committee work on policies with LCH policy review guidelines.  4. Begin in future meetings to update Board orientation process and materials prior to Board Orientation Policy review/update by December 2025.
9:40 am	5. Adjournment	
<b>Next meeting: TBD</b>		

WARRANT #'S A/P	AMOUNT	CAPITAL	BOARD MTG - APRIL 2025	WARRANT#'S PAYROLL	AMOUNT	pay period
239289-239324	\$ 14,289.92			Direct Deposit	\$ 592,602.12	3/8/2025
239325	\$ 26,364.57			PAYROLL TAXES	\$ 233,285.63	3/8/2025
retirement	\$ 56,727.81			Child Support	\$ 320.37	3/8/2025
239326-239385	\$ 303,168.64			Direct Deposit	\$ 576,254.59	3/22/2025
AP DIRECT DEPOSIT	\$ 93,016.64			PAYROLL TAXES	\$ 222,052.03	3/22/2025
239386-239460	\$ 356,046.09			Child Support	\$ 320.37	3/22/2025
AP DIRECT DEPOSIT	\$ 38,568.44			Direct Deposit	\$ 574,963.28	4/5/2025
IDAHO ST TAXES	\$ 772.00			PAYROLL TAXES	\$ 212,638.29	4/5/2025
RETIREMENT	\$ 60,226.73			Child Support	\$ 320.37	4/5/2025
DOR	\$ 12,945.31					
239461-239483	\$ 235,721.07				<b>\$ 2,412,757.05</b>	
AP DIRECT DEPOSIT	\$ 11,668.70					
239484-239538	\$ 139,766.99					
AP DIRECT DEPOSIT	\$ 21,419.27					
239539-239562	\$ 515,779.13					
AP DIRECT DEPOSIT	\$ 77,230.38					
239563-239664	\$ 89,763.75					
RETIREMENT	\$ 58,697.70					
239665-239753	\$ 402,667.77					
AP DIRECT DEPOSIT	\$ 39,286.14					
IDAHO ST TAXES	\$ 799.00					
239754-239839	\$ 727,064.00					
AP DIRECT DEPOSIT	\$ 99,289.55					
239840-239931	\$ 754,532.29					
AP DIRECT DEPOSIT	\$ 41,369.57					
retirement	\$ 54,259.47					
	<b>\$ 4,231,440.93</b>					

DATE March 2025

**TOTAL BAD DEBTS - HOSPITAL \$162,010.04**  
**TOTAL MEDICARE BAD DEBTS \$15,869.66**  
**TOTAL BANKRUPTCY \$0**  
**TOTAL CHARITY CARE – HOSPITAL \$186,923.27**  
**TOTAL MEDICARE CHARITY CARE - \$8,040.94**

**TOTAL ATTESTATION \$372,843.91**

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 \_\_\_\_\_



**MINUTES**

<b>Group:</b> Finance Committee 4/23/25, 10AM in person and via Teams		
<b>Facilitator:</b> Jordana Laporte		<b>Recorder:</b> W. Kenck
<b>Member Attendance:</b>		
<input checked="" type="checkbox"/> Doug Gibson, BOC	<input checked="" type="checkbox"/> Shawn Ottley, COO	<input checked="" type="checkbox"/> Aaron Edwards, CEO
<input checked="" type="checkbox"/> Lori Withrow, BOC	<input checked="" type="checkbox"/> Brant Truman, CFO	
<b>Participants:</b> V. Bodle, M. Miller, S. Nau, T. Lautiki, L. Sahlinger Guests: Chris Colley – Graham Construction		

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

<i>Agenda Item</i>	<i>Topic/Action</i>
<ul style="list-style-type: none"> <li>• Call to Order</li> </ul>	<ul style="list-style-type: none"> <li>• L. Withrow called meeting to order at 10:04 am</li> </ul>
<ul style="list-style-type: none"> <li>• Goals</li> </ul>	<ul style="list-style-type: none"> <li>• The Committee has set an ambitious target of achieving a net income of \$2M.</li> <li>• Develop a 5-year Capital Budget.</li> </ul>
<ul style="list-style-type: none"> <li>• New Business</li> </ul>	<ul style="list-style-type: none"> <li>• EMS Construction update               <ul style="list-style-type: none"> <li>a. Graham: Reviewed the current Design Development Estimate – Cost Detail Report, which indicates an approximate construction cost of \$10.9M (about \$11M). ETA bid approval July 7 via Board special meeting. A special meeting to be scheduled for July to approve the bid.</li> <li>b. B. Truman: Provided an update on the full EMS building project, including sales tax, soft costs, owner contingency, and water contingency. The total projected cost is \$15.2M.</li> </ul> </li> <li>• B. Truman: Presented a comparison between private placement and a public bond for the construction loan. The preliminary offer sheet has been signed and will be presented to the Board in May for approval to finalize.</li> <li>• B. Truman: Presented a year-over-year comparison of the Retirement Plan.</li> </ul>
<ul style="list-style-type: none"> <li>• <i>Old Business</i></li> </ul>	<ul style="list-style-type: none"> <li>• SAO audit completed</li> </ul>
<ul style="list-style-type: none"> <li>• Reports</li> </ul>	<ul style="list-style-type: none"> <li>• S. Nau reported on the OB and Surgery data from 2023 to date</li> </ul>

	<ul style="list-style-type: none"><li>• V. Bodle presented the unaudited March 2025 Financial Statement</li></ul>
<ul style="list-style-type: none"><li>• Adjournment</li></ul>	<ul style="list-style-type: none"><li>• L. Withrow adjourned the meeting at 12:19 pm</li></ul>



# LAKE CHELAN HEALTH

**Unaudited Financial Statements**

**for**

**For the month ended March 31, 2025**

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**Balance Sheet**  
**Lake Chelan Health**

	<b>Current Month</b> <b>3/31/2025</b> <b>unaudited</b>	<b>Prior Year</b> <b>12/31/2024</b> <b>AUDITED</b>	<b>Prior Year</b> <b>3/31/2024</b> <b>Unaudited</b>
<b>ASSETS:</b>			
CASH	325,195	\$ 658,937	\$ 145,113
PATIENT RECEIVABLES	13,842,400	12,753,621	\$ 11,291,598
LESS: RESERVES FOR ALLOWANCES	<u>(6,658,631)</u>	<u>(6,866,738)</u>	<u>\$ (6,014,110)</u>
NET PATIENT ACCOUNTS RECEIVABLES	7,183,769	5,886,883	5,277,489
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	170,097	(100,276)	23,012
OTHER RECEIVABLES	1,085,769	390,232	853,767
INVENTORIES	335,975	335,411	328,575
PREPAID EXPENSES	552,010	321,417	300,831
TOTAL CURRENT ASSETS	<u>\$ 9,652,814</u>	<u>\$ 7,492,603</u>	<u>\$ 6,928,786</u>
GENERAL RESERVES	\$ 446,811	1,341,519	\$ 1,302,288
Unrestricted Reserves	\$ 6,238,093	6,405,615	\$ 3,496,689
Internally Restricted Reserves	\$ 4,139,524	4,139,524	\$ 4,139,524
2018 BONDS	0	0	\$ -
USDA 2023	410,400	410,400	\$ 273,600
Coastal Bank	50,004	50,000	\$ -
TOTAL LIMITED USE ASSETS	<u>\$ 11,284,832</u>	<u>\$ 12,347,058</u>	<u>\$ 9,212,101</u>
LAND	\$ 4,133,845	4,133,845	\$ 4,787,901
LAND IMPROVEMENTS	0	0	\$ 5,222,565
BUILDINGS & IMPROVEMENTS	10,390	10,390	\$ 996,641
EQUIPMENT	10,277,581	10,471,292	\$ 9,731,720
SOFTWARE	2,342,827	2,166,371	\$ 2,158,462
NEW HOSPITAL	44,757,019	44,763,709	\$ 44,718,237
LOCUM HOUSING	635,382	635,484	\$ -
GASB 87 BUILDINGS AND EQUIPMENT	1,742,567	1,742,567	1,265,419
CONSTRUCTION-IN-PROGRESS - PROJECTS	1,947,402	926,355	\$ 215,621
CONSTRUCTION-IN-PROGRESS - HOSPITAL	114,045	9,290	\$ 12,934
GROSS PROPERTY, PLANT, & EQUIPMENT	65,961,059	64,859,304	69,109,501
LESS: ACCUMULATED DEPRECIATION	<u>(15,264,258)</u>	<u>(14,753,073)</u>	<u>\$ (18,754,047)</u>
GASB 87 AMORTIZATION	<u>(555,779)</u>	<u>(543,279)</u>	<u>(489,897)</u>
NET PROPERTY, PLANT, & EQUIPMENT	<u>\$ 50,141,022</u>	<u>\$ 49,562,952</u>	<u>\$ 49,865,557</u>
DEFERRED ITEMS	\$ 1,530,915	1,535,731	\$ 2,475,981
TOTAL ASSETS	<u>\$ 72,609,583</u>	<u>\$ 70,938,345</u>	<u>\$ 68,482,425</u>
<b>LIABILITIES:</b>			
ACCOUNTS PAYABLE	\$ 1,802,990	1,201,176	679,913
ACCRUED PAYROLL	475,047	861,750	360,007
ACCRUED VACATION/HOLIDAY/SICK PAY	1,280,641	1,005,811	907,866
PAYROLL TAXES PAYABLE	39,791	(44,816)	31,069
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	0	0	0
OTHER CURRENT LIABILITIES	1,205,896	734,009	1,221,659
INTEREST PAYABLE	359,563	91,605	367,971
CURRENT PORTION OF LTD (BONDS/MORTGAGES)	1,129,475	1,046,831	1,046,831
LINE OF CREDIT	0	0	0
TOTAL CURRENT LIABILITIES	<u>\$ 6,293,402</u>	<u>\$ 4,896,368</u>	<u>\$ 4,615,317</u>
CAPITALIZED LEASES	\$ -	\$ -	\$ -
2018 BONDS	\$ 18,354,690	18,368,093	18,714,958
2013 BONDS	4,284,725	4,283,436	4,659,568
USDA LOANS	18,421,537	17,710,433	18,029,560
LEASES	1,680,054	2,114,879	1,524,699
PAID LEAVE - LT PORTION	82,334	200,959	200,959
TOTAL LONG TERM LIABILITIES	<u>\$ 42,823,341</u>	<u>\$ 42,677,800</u>	<u>\$ 43,129,744</u>
DEFERRED ITEMS	\$ 4,101,555	4,212,308	3,922,975
TOTAL LIABILITIES	<u>\$ 53,218,298</u>	<u>\$ 51,786,475</u>	<u>\$ 51,668,037</u>
<b>FUND BALANCE:</b>			
UNRESTRICTED FUND BALANCE	\$ 19,490,670	17,126,756	17,268,072
TEMPORARY RESTRICTED FUND BALANCE	\$ -	0	0
YTD Net Revenue/(Expenses)	<u>(99,386)</u>	<u>2,025,114</u>	<u>(453,684)</u>
TOTAL NET ASSETS	<u>\$ 19,391,284</u>	<u>\$ 19,151,870</u>	<u>\$ 16,814,389</u>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<u><b>\$ 72,609,583</b></u>	<u><b>\$ 70,938,345</b></u>	<u><b>\$ 68,482,425</b></u>

property taxes are accrued over 12 months

**Statement of Revenue and Expense**  
**Lake Chelan Health**

For the month ended March 31, 2025

	CURRENT MONTH				Prior Year 03/31/24
	Actual 03/31/25	Budget 03/31/25	Positive (Negative) Variance		
GROSS PATIENT SERVICE REVENUES					
INPATIENT	\$ 596,978	\$ 678,844	(81,866)	-12%	\$ 631,848
OUTPATIENT	4,804,072	5,319,921	(515,849)	-10%	4,559,497
TOTAL PATIENT SERVICE REVENUES	5,401,049	5,998,765	(597,715)	-10%	5,191,345
DEDUCTIONS FROM REVENUE					
CONTRACTUAL ALLOWANCES	(1,865,646)	(2,481,256)	615,610	-25%	(2,219,123)
BAD DEBT	(177,880)	0	(177,880)	0.00%	(179,921)
CHARITY	(194,964)	0	(194,964)	0.00%	(70,146)
TOTAL DEDUCTIONS FROM REVENUES	(2,238,490) 41.4%	(2,481,256) 41.4%	242,766	10%	(2,469,190) 47.6%
NET PATIENT SERVICE REVENUES	3,162,559	3,517,509	(354,949)	-10%	2,722,155
OTHER OPERATING REVENUES	30,794	22,417	8,378	37%	33,331
<b>TOTAL OPERATING REVENUES</b>	<b>3,193,354</b>	<b>3,539,926</b>	<b>(346,572)</b>		<b>2,755,485</b>
OPERATING EXPENSES					
SALARIES/WAGES	1,838,213	1,922,215	84,002	4%	1,673,011
EMPLOYEE BENEFITS	336,810	416,463	79,654	19%	318,260
PROFESSIONAL SERVICES	270,370	261,209	(9,161)	-4%	92,473
FOOD SUPPLIES	22,281	19,329	(2,952)	-15%	19,865
MINOR EQUIPMENT	19,798	31,093	11,295	36%	54,913
SUPPLIES	219,729	225,968	6,239	3%	247,453
PLANT UTILITIES	28,309	30,254	1,945	6%	30,404
PURCHASED SERVICES	469,465	327,951	(141,515)	-43%	294,378
REPAIR/MAINTENANCE	117,695	100,412	(17,283)	-17%	106,045
PUBLIC RELATIONS/RECRUITM	4,500	13,009	8,509	65%	3,007
RENT/LEASES	99,895	61,633	(38,261)	-62%	56,952
INSURANCE	39,611	45,774	6,163	13%	40,291
LICENSES/TAXES	11,379	31,325	19,946	64%	15,723
DUES/SUBSCRIPTIONS/OTHER	61,725	67,200	5,474	8%	45,376
TRAVEL/TRAINING	9,836	14,736	4,900	33%	11,102
DEPRECIATION	307,932	362,973	55,041	15%	320,176
AMORTIZATION	15,475				
TOTAL OPERATING EXPENSES	3,873,023	3,931,545	73,997	1.9%	3,329,429
<b>NET OPERATING SURPLUS (LOSS)</b>	<b>(679,669)</b>	<b>(391,619)</b>	<b>(288,050)</b>		<b>(573,944)</b>
NON-OPERATING REVENUES	276,655	256,233	20,422		228,325
TAXES					
INTEREST					
GIFTS & GRANTS	231,865		231,865		
OTHER	0	0	0		0
NET INCOME margin	(171,150) -5.4%	(135,386) -3.8%	(35,763)		(345,619) -12.5%
<b>TOTAL NET INCOME (LOSS)</b>	<b>\$ (171,150)</b>	<b>\$ (135,386)</b>	<b>(35,763)</b>		<b>\$ (345,619)</b>

**Statement of Revenue and Expense**  
**Lake Chelan Health**









For the month ended March 31, 2025

	YEAR-TO-DATE				Prior Year 03/31/24
	Actual 03/31/25	Budget 03/31/25	Positive (Negative) Variance		
GROSS PATIENT SERVICE REVENUES					
INPATIENT	\$ 2,214,373	\$ 1,987,909	226,464	11%	\$ 1,919,644
OUTPATIENT	14,258,711	15,578,696	(1,319,984)	-8%	13,282,536
TOTAL PATIENT SERVICE REVENUES	16,473,085	17,566,605	(1,093,520)	-6%	15,202,181
DEDUCTIONS FROM REVENUE					
TOTAL DEDUCTIONS FROM REVENUES	(6,025,297)	(7,266,036)	1,240,739	-17%	(6,019,079)
BAD DEBT	(475,400)	0	(475,400)	0.00%	(380,730)
CHARITY	(330,779)	0	(330,779)	0.00%	(278,121)
TOTAL DEDUCTIONS FROM REVENUES	(6,831,476)	(7,266,036)	434,560	6%	(6,677,929)
	41.5%	41.4%			43.9%
NET PATIENT SERVICE REVENUES	9,641,609	10,300,569	(658,960)	-6%	8,524,251
OTHER OPERATING REVENUES	93,470	67,250	26,220	39%	94,282
TOTAL OPERATING REVENUES	9,735,079	10,367,819	(632,740)	-6%	8,618,534
OPERATING EXPENSES					
SALARIES/WAGES	5,166,395	5,580,624	414,229	7%	4,842,769
EMPLOYEE BENEFITS	1,066,585	1,209,087	142,502	12%	966,864
PROFESSIONAL SERVICES	818,195	783,628	(34,567)	-4%	280,684
FOOD SUPPLIES	61,276	57,988	(3,289)	-6%	50,320
MINOR EQUIPMENT SUPPLIES	57,483	93,260	35,797	38%	262,815
PLANT UTILITIES	91,927	90,762	(1,165)	-1%	109,616
PURCHASED SERVICES	1,329,686	983,852	(345,834)	-35%	814,910
REPAIR/MAINTENANCE	294,177	301,237	7,059	2%	288,004
PUBLIC RELATIONS/RECRUITMENT	34,283	39,027	4,743	12%	16,697
RENT/LEASES	256,092	184,900	(71,193)	-39%	180,930
INSURANCE	127,856	137,323	9,468	7%	103,565
LICENSES/TAXES	74,309	93,978	19,667	21%	50,064
DUES/SUBSCRIPTIONS/OTHER	174,695	201,599	26,904	13%	141,278
TRAVEL/TRAINING	19,770	44,206	24,438	55%	29,606
DEPRECIATION AMORTIZATION	945,753	1,088,918	143,165	13%	950,822
TOTAL OPERATING EXPENSES	11,069,532	11,552,125	482,593	4.2%	9,731,234
<b>NET OPERATING SURPLUS (LOSS)</b>	<b>(1,334,452)</b>	<b>(1,184,306)</b>	<b>(150,147)</b>		<b>(1,112,700)</b>
NON-OPERATING REVENUES		768,699			
PROPERTY TAXES FOR OPERATIONS	698,203				680,004
GRANTS/CONTRIBUTIONS	417,512				7,528
INVESTMENT EARNINGS	98,650				103,088
OTHER EXPENSE		0	0		
TAXES FOR DEBT SVC PMTS	325,166				318,872
INTEREST EXPENSE	(440,389)				(450,978)
GAIN / (LOSS) ON ASSET DISPOSAL	135,924				500
NET INCOME	(99,387)	(415,607)	316,221		(453,685)
margin	-1.0%	-4.0%			-5.3%
<b>TOTAL NET INCOME (LOSS)</b>	<b>\$ (99,387)</b>	<b>\$ (415,607)</b>	<b>\$ 316,221</b>		<b>\$ (453,685)</b>













## Patient Statistics Lake Chelan Health





For the month ended March 31, 2025

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

Current Month			Last Year Month			
Actual vs Budget	03/31/25	BUDGET	STATISTICS	Actual vs Budget	03/31/24	BUDGET
	103	120	Total Days Cash on Hand		95	120
	67	40	Net AR Days		56	40
	0.79	1.25	Debt Coverage Ratio		0.21	1.25
	214	176	Payroll FTEs		198	175

Current Month			Year-To-Date					
Actual	Prior Year	BUDGET	STATISTICS	Actual	Prior Year	BUDGET		
03/31/25	03/31/24			03/31/25	03/31/24			
<b>Admissions</b>								
NA	19	20	NA	medical	NA	61	57	NA
NA	0	0	NA	surgical	NA	0	0	NA
NA	6	10	NA	OB	NA	20	24	NA
NA	25	30	NA	Acute	NA	81	81	NA
NA	7	7	NA	Swing Bed	NA	18	19	NA
NA	6	10	NA	Total Deliveries	NA	19	23	NA

Current Month			Year-To-Date					
Actual	Prior Year	BUDGET	STATISTICS	Actual	Prior Year	BUDGET		
03/31/25	03/31/24			03/31/25	03/31/24			
<b>Patient Days</b>								
	53	56	69	medical		166	182	202
NA	0	0	NA	surgical	NA	0	0	NA
	11	16	15	OB		44	43	43
	64	72	84	Acute		210	226	245
	56	74	63	Swing Bed		201	197	183
	7	12	10	Total Newborn Days		29	31	31
	127	158	157	TOTAL PATIENT DAYS		440	453	459

Current Month			Year-To-Date				
Actual	Prior Year	BUDGET	STATISTICS	Actual	Prior Year	BUDGET	
03/31/25	03/31/24			03/31/25	03/31/24		
<b>Average Length of Stay</b>							
	2.6	2.4		Total Inpatient		2.6	2.8
	8.0	10.6		Swing Bed		11.0	10.4

Current Month			Year-To-Date			
Actual	Prior Year	BUDGET	STATISTICS	Actual	Prior Year	BUDGET
03/31/25	03/31/24			03/31/25	03/31/24	
<b>Avg Daily Census - Hospital</b>						
	2.1	2.3		Total Inpatient	2.3	2.5
	1.8	2.4		Swing Bed	2.2	2.2
	3.9	4.7		Total	4.6	4.6

Current Month			Year-To-Date					
Actual	Prior Year	BUDGET	STATISTICS	Actual	Prior Year	BUDGET		
03/31/25	03/31/24			03/31/25	03/31/24			
	483	519	564	ED Visits		1416	1478	1652
	47	65	83	Surgeries		161	212	242
	1288	1217	1299	Imaging Procedures		3576	3602	3803
	3833	2942	3148	Lab Tests		11016	8758	9219
	755	758	744	Rehab Visits		2067	2152	2180
	84	134	131	EMS Runs		308	332	383
	833	859	1111	Total Clinic Visits		2609	2436	3254
	141	98	91	Specialty		356	290	265
	126	109		Primary care	439	419	0	
				Express Care (budget shows primary and express)				
	566	622	1021	primary and express)		1814	1727	2988
	21	21		working days		65	64	

**Note #1 Contractuals**

Contractuals do not include reimbursement that will happen when the cost report is filed.  
AR increased \$549k from February to March  
Charity care was \$177,880 for March. Bad Debt was \$194,964.  
Charity and Bad Debt are 4.76% of gross charges ytd compared to 4.39% this same time last year.

**Note #2 PROFESSIONAL SERVICES**

ED Pro Fees over budget \$18,839  
Dermatology is over budget \$29,207

**Note #3 PURCHASED SERVICES**

Med Surg is over budget \$144,572 due to increase use in travelers  
Surgery is over budget by \$75,382. Whitman Partners was not budgeted. Will look at amending.  
Lab is over budget by \$50,449. Budget appears too low based on history. Will look at amending.  
Pharmacy is over budget by \$10,194  
Business Office is over budget by \$17,856.  
Provider Based clinic is over budget by \$142,479 due to traveler agency expenses  
Laundry is over budget by \$13,883 due to Vestis expenses

**Note #4 RENTS/LEASES**

Radiology is over budget by \$41,999 due to MRI lease. All expenses were spread over 12 and this is expected to end in May.  
The reclass to GASB 87 has not been done in 2025. The budget reflects the reclass.  
This is why depreciation and amortization are under budget

**Note #5 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  
Current gain recognized is \$223,185 for 2024 and \$135,874 for 2025

**Grants/Contributions -**

WA ST Ecology 151,277  
Foundation 3,775  
CWH Grant 43,355  
Dept of Commerce EMS 185,270  
Community Choice 22,603  
WA ST Health 778  
WA ST ED Traume 8,454

For the month ended March 31, 2025

2/28/2025	GL ACCOUNT #	ACCT DESCRIPTION	3/31/2025	EXPLANATION	
\$113,454	10002000	General Fund Cash In Bank (Wheatland)	\$302,351	<b>\$188,897</b> \$3,072,790 deposits \$0 enhancement pmt medicaid cost report (\$11,518) tsys/payplus fees (\$1,827) fees mckesson/cardinal (\$25) fees and interest rebates \$4,477 café sales (\$2,875,000) transfer to county	
\$628,301	10004000	General Fund Cash w/ Treasurer	\$923,874	<b>\$295,573</b> (\$1,667,148) AP (\$13,992) Voids \$1,680,900 warrants issued (\$1,371,095) warrants redeemed \$2,875,000 Bank Transfers from 10002000 \$550,000 Bank Transfer to/from 10106000 (\$98,992) Bank Transfer for USDA pmt \$264,969 Bank Transfer to/from 10760000 (\$1,984,465) Payroll/Benefits (\$12,945) B&O taxes \$63,323 Property Taxes \$19 Leasehold Taxes & Misc Taxes USDA final loan close out	
\$21,234	10009000	cash clearing	\$23,084	<b>\$1,849</b> pmts posted as remits received	
(\$528,301)	20070000	warrants outstanding	(\$924,114)	<b>(\$295,813)</b> (\$1,168,857) remits (payroll/benefits/b&O) \$1,371,095 warrants redeemed (\$1,680,900) warrants issued ap \$1,168,857 remits redeemed \$13,992 voids	
\$457,003	10106000	AMB RESERVE	\$23,227	<b>(\$433,775)</b> transfer to reserves (\$550,000) transfer from reserves (bond pmt & ops) \$116,182 property taxes \$34 leasehold taxes \$8 interest	
\$340,150	10910000	2018 GO BOND	\$423,584	<b>\$83,434</b> \$83,434 property taxes \$0 bond pmt	<b>Days of Cash on Hand</b> Cash: current assets 325,195 unrestricted reserves 446,811 unrestricted reserves 6,238,093 7,010,099
\$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 460,404
\$90,000	10917000		\$90,000	\$0 funded year 3 per LOC	restricted reserves - pending covid ca 4,139,524 4,599,928
\$410,400			\$410,400	\$0	
\$0	10915000	CASH/TREAS LTGO BOND	\$0	\$0 paid bond interest	Expenses: total YTD 11,069,532 less depreciation -945,753 10,123,778
\$10,609,092	10760000	RESERVES	\$10,377,617	<b>(\$231,475)</b> \$33,493 interest (\$264,969) (\$0) interest	number of days YTD 90
\$50,004	10764000	COASTAL BANK	\$50,004	<b>(\$0)</b> interest	
\$12,001,337			\$11,610,026	<b>(\$391,310)</b>	<b>6</b> <b>Days of Cash on Hand</b> 62.3
					<b>Restricted Days Cash on Hand</b> 40.9
					<b>Total Days Cash on Hand</b> 103.2







## CEO Board Report (as of 4/25/25)

### People:

- Had great interviews with surgical director candidates. Hopefully we will have a permanent soon.
- Dr. Goeser and PA Guadalupe Martinez-Vera are accepting new patients down at the clinic and often have same day access to appointments! Our express care team is doing a great job seeing patients, we are about 100 visits higher year to date than last year.
- Continue to work on filling open positions at MA, CNA, OT, MRI and Lab Tech, Orthopedic APP, PT aid, paramedic as well as many other opportunities. Go to [www.lakechelanhealth.org/careers/](http://www.lakechelanhealth.org/careers/) to see what is available and apply and see which positions have additional incentives!

### Community:

- Took a trip to Washington DC and visited with various Senate and House staffers + legislator's staff around some proposed adjustments to the critical access hospital cost report.
- Visited with Sen. Cantwell and Rep. Kim Schrier down in East Wenatchee to discuss the possible impacts of Medicaid cuts.
- Had both AWPHD and Rural Collaborative board meetings this past month.
- The UW is delayed with contracting for the residency. Hopefully a decision point at next board to approve a new contract.

### Quality:

- The recent Net Promotor Score (patient satisfaction) is currently running at 90.1. 50 or higher in the healthcare industry is considered excellent!

### Financial:

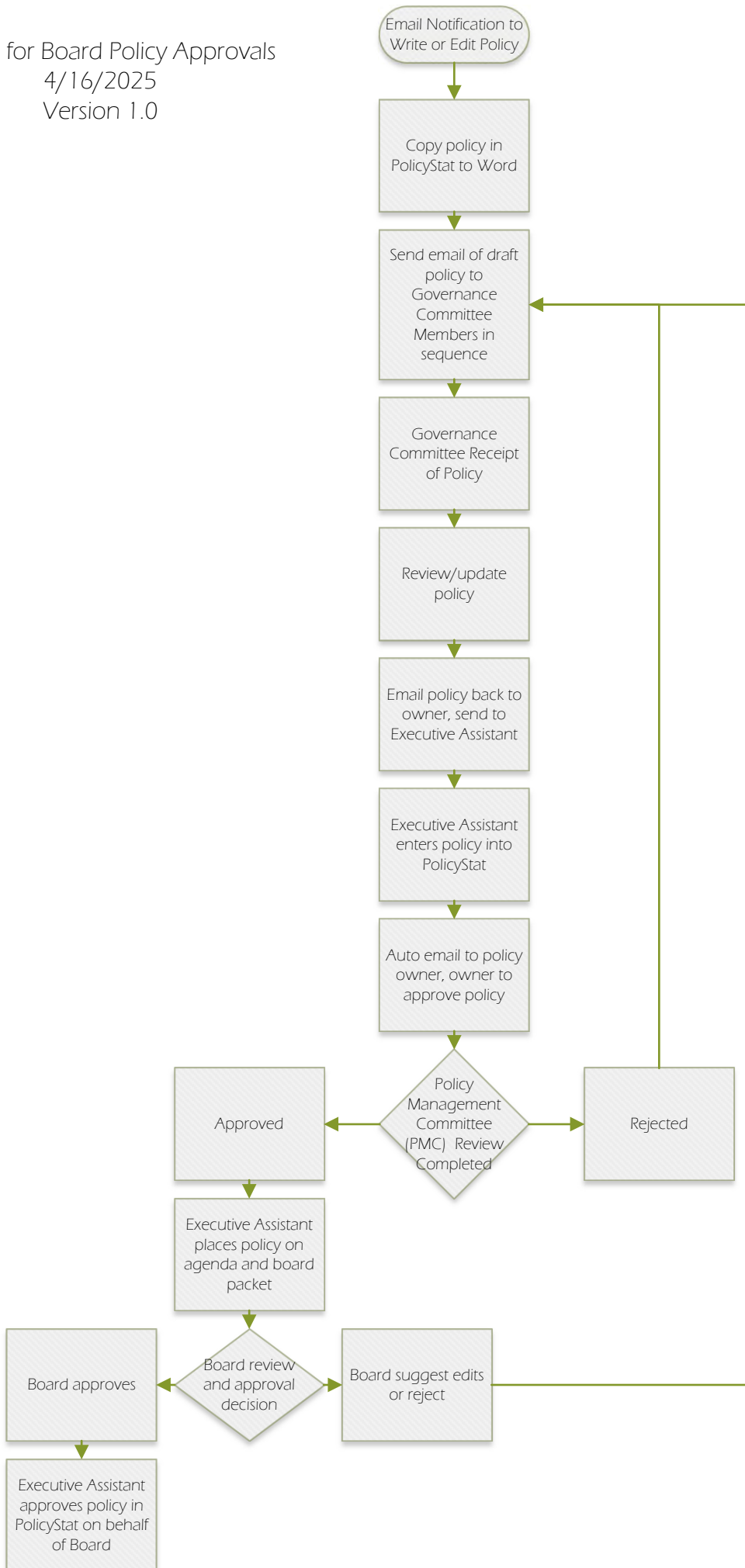
- Overall loss of \$99K this past month with gross revenue for March '24 by roughly \$300K. Year to date we have a small loss of \$171K (last year we were at a loss of \$346K at this same point in the year). We are missing budget by roughly \$600k for gross revenue.
- Hospital inpatient revenue is ahead of last year by +/--\$300K, 11% above our projected budget despite ED visits being down year over year. Lab, Rehab, imaging, and specialty visits are all up. We are down 60+ visits year over year in the ED. Surgeries, and EMS runs are trending behind as well.
- Charity Care and Bad Debt are both seeing alarming increases year over year (a little under \$200K year to date more than the same period last year, which was also way up over the prior year).

### Building for the Future:

- Working on the addition of cardiology, ENT, more derm days, mohs, cataract, and possibly urology (all part time). Will be asking for approvals for a few of these services soon.
- With the help of the hospitalists we had a DKA (Diabetic Ketoacidosis), we are working on stroke protocols as well.
- Rehab has started our cardiac rehab program with several patients already utilizing the service.



Process for Board Policy Approvals  
4/16/2025  
Version 1.0





Origination 2/24/2014  
Last Approved N/A  
Effective Upon Approval  
Last Revised 3/17/2025  
Next Review 2 years after approval

Owner Juliana England:  
RN/OB  
Area Patient Care  
Services

## Reproductive Health Care

### PURPOSE

Define what reproductive health services are provided by Lake Chelan Health.

### POLICY STATEMENT

Lake Chelan Health (LCH) recognizes an individual's fundamental right to make informed decisions regarding their reproductive health. LCH provides a range of outpatient and inpatient reproductive health benefits, services, and information to meet the reproductive needs and choices of individuals in our community.

To ensure the safety of our patients, reproductive health services and/or procedures that are deemed by a provider to be more appropriately and safely performed at another facility by a qualified provider will be promptly referred. Lake Chelan Health does not mandate that its health care professionals perform or participate in procedures that are in violation of their conscience, beliefs, or values.

### SCOPE

Lake Chelan Health

### ROLES AND RESPONSIBILITIES

Patient Care Services where reproductive health is offered.

# DEFINITIONS

WAC- Washington Administrative Code

# PROCEDURE

This policy is in recognition of our obligations under the following rules and regulations regarding reproductive health:

Emergency Care Provided to Victims of Sexual Assault, RCW 70.41.350

Emergency Medical Treatment and Active Labor Act, 42 U.S.C §1395dd

Reproductive Privacy Act, RCW 9.02.100 through 9.02.170 and 9.02.900 though 9.02.802

Patient Rights and Organizational Ethics, WAC 246-320-141

Any changes to this policy must be submitted to the Department of Health within 30 days of a change and an updated policy must be posted on the hospital district website.

# REFERENCES

N/A

# ATTACHMENTS

N/A

COPY

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## Attachments

[📎 Hospital Reproductive Services\\_Lake Chelan Health\\_2025-03-13 - signed.pdf](#)

## Approval Signatures

Step Description	Approver	Date
Medical Staff Review	Louise Sahlinger: Director Of Quality	Pending
Director of Nursing Services	Rhianna Montgomery: ED/Med Surg Nurse Manager	3/27/2025

Policy Management  
Committee

Committee Policy  
Management: Policy  
Management Committee

3/27/2025

Juliana England: RN/OB

3/27/2025

COPY



Origination 11/1/1995  
Last Approved 2/19/2025  
Effective 2/19/2025  
Last Revised 2/19/2025  
Next Review 2/19/2027

Owner **Mary Murphy:**  
Board Governance Committee Member  
Area Hospital Commission

## Governing Board Bylaws

### I. PURPOSE

The primary purpose of the Hospital District is to operate a hospital and other health care facilities and to provide hospital and other health care services appropriate to the needs of the residents of the Hospital District and other persons served.

### II. POLICY STATEMENT

These Bylaws are adopted in furtherance of the lawful purposes of the Hospital District and in conformity with the constitution and laws of the State of Washington, including Chapter 70.44 RCW (the "PHD Statute"). The Hospital District and its hospital and other health care facilities shall be operated in compliance with all applicable laws and regulations.

### III. SCOPE

The Bylaws facilitate the governing of the Hospital District and its health care facilities, ensuring compliance with applicable laws and regulations, and outlining the structure and responsibilities of the Governing Board of Commissioners.

### IV. ROLES & RESPONSIBILITIES

The roles and responsibilities outlined in the Governing Board Bylaws include the Board of Commissioners, with the President presiding over meetings, the Vice President acting in the President's absence, and the Secretary managing meeting minutes. Committees are led by a Chair who reports to the Commission, and members actively participate in tasks. The Superintendent (CEO) is appointed by the Commission and oversees the administration of the Hospital District, while the Auditor manages financial transactions and the Treasurer handles fund disbursement. The Chief Financial Officer (CFO),

appointed by the CEO, manages financial practices and reports to the CEO. These roles ensure effective governance and operation of the Hospital District.

## V. DEFINITIONS

N/A

## VI. PROCEDURE

See Attachment

## VII. REFERENCES

RCW 70.44

## VIII. ATTACHMENTS

LCH Board Bylaws Approved 01.28.25

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### Attachments

 [LCH Board Bylaws Approved 01.28.25.pdf](#)

 [LCH Governing Board Bylaws approved 10.25.22 \(002\).pdf](#)

### Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	2/19/2025
Administration	Aaron Edwards: CEO	2/19/2025
Policy Management Committee	Committee Policy Management: Policy Management Committee	2/17/2025
	Mary Murphy: Board Governance Committee Member	2/11/2025

## **ARTICLE I FORMATION AND PURPOSE**

Chelan County Public Hospital District No. 2, Chelan County, Washington (the “Hospital District”), which does business under the name Lake Chelan Health, is organized as a Washington State municipal corporation, and was created in 1968 by the citizens of the Lake Chelan Valley. The primary purpose of the Hospital District is to operate a hospital and other health care facilities and to provide hospital and other health care services appropriate to the needs of the residents of the Hospital District and other persons served.

These Bylaws are adopted in furtherance of the lawful purposes of the Hospital District and in conformity with the constitution and laws of the State of Washington, including Chapter 70.44 RCW (the “PHD Statute”). The Hospital District and its hospital and other health care facilities shall be operated in compliance with all applicable laws and regulations. These Bylaws are hereby adopted to facilitate governing of the Hospital District and its health care facilities.

## **ARTICLE II GOVERNING BOARD OF COMMISSIONERS**

### **2.1 Qualification and Election**

- (i) A board of commissioners (the “Commission”) shall be composed of five (5) members (the “Commissioners”) who shall be elected by the voters of the Hospital District in compliance with the PHD Statute. Commissioners shall serve in the manner and for the term prescribed by law. No person shall be elected or appointed as a Commissioner unless such person is a registered voter within the boundaries of the District.
- (ii) A vacancy shall be filled by the Commission in a manner prescribed by law and Commission policies.
- (iii) All Commissioners, whether elected or appointed, shall be required to take an oath of office in the form prescribed by the laws of the State of Washington relating to public officials.

### **2.2 Organization and Officers**

- (i) The Commission shall at its first regular meeting of each calendar year elect from its own members a president, who shall serve as the Chairperson of the Commission, a vice president, who shall serve as the Vice Chairperson of the Commission, and a Secretary. Such election shall be by a majority vote of the Commission held at the first meeting of the Commission in each calendar year. Each officer shall be elected for a term of one year or until their successor is elected, whichever is later.
- (ii) The Chairperson shall act as the presiding officer at meetings of the Commission.
- (iii) The Vice Chairperson shall act as Chairperson Pro Tem in the absence of the Chairperson.
- (iv) The Secretary or designee shall review minutes of all regular and special meetings of the Commission, present them for approval by the Commission, sign them, and give them to the Executive Assistant to file accordingly. Minutes of all regular and special meetings of the Commission, except executive sessions thereof, shall be promptly recorded and shall be open to public inspection in compliance with applicable law.
- (v) If a vacancy occurs in the office of the Chairperson, the Vice Chairperson, or the Secretary, an election shall be held at the next regular meeting of the Commission to fill the unexpired term created by the vacancy.

### **2.3 Meetings of the Commission**

- (i) Regular meetings of the Commission shall be held at a time, date, and place established by resolution of the Commission, which may be changed from time to time by resolution of the Commission. The Hospital District shall make the agenda for each regular meeting of the Commission available online no later than twenty-four hours in advance of the published start time of the meeting.
- (ii) Special meetings may be called at any time by the Chairperson or by a majority of the members of the Commission in compliance with RCW 42.30.080. Notice of the meeting shall be provided by delivering written notice personally, by mail, by fax, or by electronic mail to each member of the Commission unless written notice is deemed waived in the circumstances specified in RCW 42.30.080. Notice of a special meeting shall also be: (a) delivered to each local newspaper of general circulation and local radio or television station that has on file with the Commission a written request to be notified of such special meeting or of all special meetings; (b) posted on the Hospital District's website; and (c) prominently displayed at the main entrance of the Hospital District's principal location and the meeting site if it is not held at the Hospital District's principal location. Such notice must be delivered or posted, as applicable, at least twenty-four hours before the time of such meeting as specified in the notice. The call and notices required under this section shall specify the time and place of the special meeting and the business to be transacted. Final disposition shall not be taken on any other matter at such meetings by the governing body. The notices provided in this section may be dispensed with in the event a special meeting is called to deal with an emergency involving injury or damage to persons or property or the likelihood of such injury or damage, when time requirements of such notice would make notice impractical and increase the likelihood of such injury or damage.
- (iii) The Order of business at regular or special meetings of the Commission shall be conducted by Roberts' Rules of Order and minutes shall be taken.
- (iv) Meeting attendance is extremely important to the Commission to adequately discharge its fiduciary duties and responsibilities. Members may attend via phone or other method permitted by law, provided they are able to hear and fully participate in discussions and deliberations. If a Commission member is not present in person or attending through some other approved method for three consecutive meetings or any three meetings in one calendar year, the Commission may ask that member to resign from the Commission.
- (v) Regular and special meetings of the Commission shall be open to the public pursuant to Chapter 42.30 RCW.

#### **2.4 Action and Final Action by the Commission**

- (i) As used herein, "action" means the transaction of the official business of the Public Hospital District by the Commission including but not limited to receipt of public testimony, deliberations, discussions, considerations, reviews, evaluations, and final actions. "Final action" means a collective positive or negative decision, or an actual vote by a majority of the members of the Commission when sitting as a body or entity, upon a motion, proposal, or resolution in accordance with applicable law.
- (ii) All final action taken by the Commission shall be by motion or resolution at regular or legally-called special meetings and recorded in minutes of the Commission.
- (iii) All meetings at which action is taken by the Commission shall be open to the public, and all persons shall be permitted to attend any meeting of the Commission except as otherwise provided by law. The Commission shall never adopt any motion or resolution except in a meeting open to the public, and only at a regular meeting duly convened at the prescribed time and place or at a special meeting of which notice has been given in the manner specified above. Any action taken at meetings failing to comply with the provisions of this section shall be null and void.
- (iv) Nothing in this section shall be construed to prevent the Commission from holding executive sessions during a regular or special meeting to consider any matter properly the subject of executive session under RCW 42.30.110 or any other applicable law;

## **2.5 Quorum**

(i) A presence of three (3) Commissioners shall constitute a quorum. Any final action by the Commission, including the adoption of a motion or resolution, shall require a minimum of three (3) affirmative votes to pass.

## **2.6 Committees**

(i) The Commission may from time-to-time act as a committee of the whole or appoint such other committees, as it may deem necessary or advisable in the conduct of its affairs. The activities of any committees so appointed shall be conducted lawfully in accordance with a committee charter adopted by the Commission and shall be recorded in written minutes. Each member of such committees shall be appointed by the Commission during the first regular Commission meeting of each calendar year to serve for a term of not to exceed one year or until the person's successor is appointed, whichever is later. A Commission position vacancy on a committee shall be filled by Commission appointment at the next regular Commission meeting. Members of such committees shall be subject to removal at and re-appointment at the sole discretion of the Commission. Each committee shall include at least one (1) Commissioner, and such other individuals as deemed appropriate by the Commission. A Commissioner or Commission designee shall serve as Chair of each Commission committee and subcommittee.

## **2.7 Powers and Duties of the Commission**

(i) The Commission shall be the governing body to which the Superintendent of the Hospital District (the "Chief Executive Officer" or "CEO") ultimately is responsible for all activities in the Hospital District as well as the condition of the physical plant. While the authority of the Commission may be delegated to the CEO by resolution or motion, any delegation of authority by the Commission may be rescinded at the Commission's sole discretion by a majority vote of a quorum of the Commission at a regular or special meeting.

(ii) All of the powers authorized in Chapter 70.44 RCW and other laws applicable to public hospital districts may be exercised by the Commission in the performance of its duties prescribed therein. Among other things, the Commission shall strive to:

a. Determine the policies of the Hospital District and the purposes of the Hospital District in proper relation to community needs.

b. Provide facilities, equipment, organizational structure and personnel to meet the needs of patients within the purposes of the Hospital District and such other health care facilities as may be provided and consistent with present and future community needs.

c. Assure that the Hospital District has policies and procedures in place to support an appropriate standard of professional care and require the Medical Staff of the Hospital District to be accountable to the Commission in accordance with applicable law. Assure that persons granted credentialing and clinical privileges possess appropriate current qualifications that meet specific criteria approved by the Commission, and the criteria are applied consistently with all applicants. Determine, at its discretion, which kinds of health care providers shall be considered for clinical privileges or Medical Staff membership. A Commissioner shall attend Medical Staff meetings.

d. Annually approve a Hospital District Quality Plan which supports the mission of the hospital and other health care facilities operated by the Hospital District and the quality of the health care services provided by the Hospital District. The Commission delegates the development, implementation, and evaluation of the plan to the CEO.

1. The primary objectives of the Quality Plan will be to: maintain quality of health care services within the resources available; maintain a safe and secure environment for patients, visitors, employees, health care providers, contractors and vendors; minimize to the extent possible the physical and emotional consequences to any person who has been injured or seriously inconvenienced; and preserve the financial assets of the Hospital District and control/prevent financial losses through risk management, loss control mechanisms and claims handling procedures. At least one Commissioner shall be a member of the Quality Committee.

e. Promote planning accordingly for the Hospital District and coordinate professional interests to address administrative, financial, and community needs, according to the policies and purposes of the Hospital District.

f. Provide for the sound administration and application of public funds, adopting annual budgets at the times and in the manner required by law.

g. Oversee maintenance of accurate records of finances and all related activities.

h. Exercise proper care and judgment in the selection, management and evaluation of a qualified CEO who shall be responsible for implementing policies adopted by the Commission.

i. Approve formation of auxiliary or volunteer groups, whose purpose is the advancement of Hospital District objectives. Auxiliaries or volunteer groups shall operate at the pleasure of the Commission and shall operate according to Hospital District policies approved by the Commission.

j. The members of the Medical Staff of the hospital operated by the Hospital District shall be appointed and credentialed, or reappointed and re-credentialed by the Commission after considering recommendations duly submitted in accordance with the Medical Staff Bylaws and Hospital District policies and procedures.

## **2.8 Avoidance of Conflicts of Interest**

(i) Commission members, being aware of the fiduciary nature of their positions, shall avoid actions and relationships which could result in a conflict between their private financial interests and their public responsibilities. They shall not violate the conflict-of-interest provisions of these Bylaws, Hospital District policies, Chapters 42.20 and 42.23 RCW, or any other applicable law. Recognizing that, even the appearance of impropriety should be avoided, no Commission member shall:

a. Be beneficially interested in or otherwise expect to profit from, directly or indirectly, any contract, sale, lease, or purchase made by the Hospital District except as permitted under RCW 42.23.030 or under other applicable law;

b. Accept, directly or indirectly, any compensation, gratuity, favor, or award from any party seeking to do business with the Hospital District or in connection with any contract made by the Hospital District other than (a) compensation and reimbursement for expenses as provided by law or (b) compensation in connection with contracts permitted under RCW 42.23.030 or under other applicable law;

c. Employ, use, or appropriate any Hospital District employee, money, or property for private benefit;

d. Hold any office, engage in any employment, or occupy any position – public or private – which could create conflicts between the duties, interests, and opportunities inherent in such office, employment, or position and public responsibilities as a Commissioner;

e. Reveal or divulge to any other party, unless authorized by the Commission, any confidential information received in the performance of duties; nor use such information for personal gain;

(ii) Management of Conflict: Any Commissioner, upon discovering or suspecting a conflict of interest contrary to the policies and standards set forth in this section, shall promptly report it to the Commission, and all Commissioners shall comply with Washington State law and the Hospital District's Conflict of Interest Policy regarding any discussion or voting on the matter. None of the funds of the District shall inure to the benefit of any Commission member, but the District may pay compensation for services rendered and expenses incurred in the performance of duties as provided by RCW 70.44.050.

## **ARTICLE III HOSPITAL DISTRICT ADMINISTRATION**

### **3.1 Superintendent ("CEO")**

(i) Appointment: Pursuant to RCW 70.44.070, the Commission shall select and appoint as chief executive officer of the Hospital District a competent and experienced chief executive officer, who shall be its direct representative in the management of the Hospital District. The CEO shall be appointed for an indefinite term, removable at the will of the Commission, and shall receive such compensation as the Commission shall establish by resolution. The appointment or removal of the Administrator shall be by resolution of the Commission introduced at a regular meeting and adopted at the same or a subsequent regular meeting by majority vote.

(ii) Powers and Duties: The CEO shall be the chief executive officer of the Hospital District with full authority to act as representative of the Commission. The CEO shall be responsible for the efficient administration of all affairs of the Hospital District. The CEO duties are identified in RCW 70, 44.060, 70.44.080, and 70.44.090; the CEO job description, and resolutions adopted by the Commission from time to time.

### **3.2 Auditor, Treasurer and Chief Financial Officer**

(i) Auditor: The Commission shall appoint as auditor of the Hospital District a person experienced in accounting and business practices. The auditor shall report in the performance of the duties directly to the CEO. The auditor shall draw, sign and issue all warrants for the disbursement of funds of the Hospital District upon the orders of, or vouchers approved by, the Commission; and shall perform such other duties relating to business affairs of the Hospital District including the recording of financial transactions, collection of accounts, and the routine purchase and issue of supplies, as are assigned by the CEO.

(ii) Treasurer: Pursuant to RCW 70.44.171, the Treasurer of Chelan County, Washington, shall be the ex officio Treasurer of the District, or in the alternative the Commission, by resolution, may designate another person having experience in financial and fiscal matters as Treasurer, subject to the requirement of an adequate bond with an authorized surety company. The Treasurer shall receive and disburse all funds of the District in the manner provided by law, and as directed by resolution of the Commission to the extent of its lawful discretion.

(iii) Chief Financial Officer: The CEO shall appoint as chief financial officer ("CFO") a person experienced in financial and accounting practices applicable to a public hospital district. At least one Commissioner shall participate in CFO candidate interviews. The CFO shall report directly to the CEO.

## **ARTICLE IV INDEMNIFICATION AND INSURANCE**

#### **4.1 Indemnification**

(i) The Hospital District shall indemnify and hold harmless to the full extent permitted by applicable law each person who was or is made a party to or is threatened to be made a party to, or is involved (including, without limitation, as a witness) in an actual or threatened action, suit or other proceeding, whether civil, criminal, administrative or investigative by reason of the fact that the person is or was a Commissioner, officer, employee or agent of the Hospital District, or having been such a Commissioner, officer, employee or agent, the person is or was serving at the request of the Hospital District as a director, officer, employee, agent, trustee or in any other capacity of another corporation or of a partnership, joint venture, trust or other enterprise, including service with respect to employee benefit plans, whether the basis of such proceeding is alleged action or omission in an official capacity or in any other capacity while serving as a commissioner, officer, employee, agent, trustee or any other capacity, against all expenses, liability, and loss (including, without limitation, attorneys' fees, judgments, fines, ERISA excise taxes or penalties in amounts to be paid in settlement) actually or reasonably incurred or suffered by such person in connection therewith, to the extent permitted by law. Such indemnification may continue as to a person who has ceased to be a commissioner, officer, employee or agent of the Hospital District and shall inure to the benefit of the person's heirs, and personal representatives.

#### **4.2 Insurance**

(i) The Hospital District may purchase and maintain insurance, at its expense, to protect itself and any Commissioner, officer, employee, agent or trustee of the District or another corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss to the full extent permitted by applicable law.

## **ARTICLE V CONSTRUCTION AND CONVENTIONS**

#### **5.1 Gender and Number**

(i) As used in these Bylaws, personal pronouns shall be interpreted to refer to persons of any gender identity, and relative words whenever applicable to more than one person shall be read as if written in the plural.

#### **5.2 Titles, Headings, and Captions**

(i) The titles, headings, and captions appearing in these Bylaws are used and intended for convenience of description or reference only and shall not be construed or interpreted to limit, restrict, or define the scope or effect of any provision.

#### **5.3 Severability**

(i) If any provision of these Bylaws or its application to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of these Bylaws or the application of the provision to other persons or circumstances shall not be affected.

#### **5.4 Amendment**

(i) These Bylaws may be amended by the affirmative vote of a majority of the members of the Board at any regular meeting or a special meeting of the Board called for that purpose.

(ii) Upon the approval of these Bylaws, the previously existing Bylaws shall be repealed.

(iii) If deemed appropriate by the Commission, these Bylaws will be reviewed by the Commission every two (2) years.





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

Owner	Louise Sahlinger: Director Of Quality
Area	Quality

## 2025 Continuous Quality Improvement & Continuous Process Improvement Plan

### I. 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 this Enterprise CQI/CPI Plan. This includes but is not limited to:

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

### II. POLICY STATEMENT

It is the policy of Lake Chelan Health to follow and adhere to the 2025 Continuous Quality Improvement and Continuous Process Improvement Plan.

### III. 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:**

1. ***Relationships***
2. ***Integrity***
3. ***Compassion***
4. ***Respect***
5. ***Excellence***

### IV. ROLES & RESPONSIBILITIES

#### **The Quality Committee Responsibilities**

1. 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.

2. Evaluate and make recommendations for improvement to the CQI/CPI plan and send to Board of Commissioners for final approval.
3. Review the Hospital-Wide Continuous Quality Improvement, Continuous Process Improvement Plan and supporting documents annually.
4. Establish measurable objectives based upon priorities identified through use of established criteria for improving quality and safety, regulatory requirements, etc.
5. Periodically assess information based on the indicators, taking action via performance improvement initiatives to solve problems and pursue opportunities to improve performance.
6. Establish and support specific quality improvement initiatives.
7. Report to the Board of Commissioners on performance improvement activities of Lake Chelan Health on a regular basis.
8. Utilization of formal, best practice, improvement methodologies.
9. Determination of annual QAPI projects to be overseen by the CQI/CPI Committee.
10. 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:**

1. Support and guide implementation of CQI/CPI activities at Lake Chelan Health
2. 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.

## V. DEFINITIONS

n/a

# VI. PROCEDURE

## 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:

1. Assure safe and effective patient care is provided at a level consistent with professional standards and evidence-based practice.
2. Mitigate potential or actual liability exposure through proactive evaluation of systems, processes and patient care delivery.
3. Provide a framework for continuous, interdisciplinary process and outcome assessment, monitoring, and improvement across the organization's scope of services (QAPI).
4. Prioritize opportunities for improvement based on, but not limited to, identified trends, level of risk, and/or benchmarking data.
5. 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:

1. **Patient Focus.** High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations and achieving equitable results.
2. **Employee Empowerment.** Effective programs involve people at all levels of the organization in improving quality.
3. **Leadership Involvement.** Strong leadership, direction, and support of quality improvement activities by the governing body and CEO are key to improvement.
4. **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.
5. **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.
6. **Prevention Over Correction.** Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
7. **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.

## **Quality Sub-Committees**

1. Refer to Appendix 1.
2. Each quality sub-committee will have a formal Committee Charter that specifies:
  1. Committee Purpose
  2. Scope of Responsibility
  3. Committee Membership
  4. Reporting Relationship
  5. Meeting Structure
3. Will have an annual work plan that lays out the scope of the work for that committee for the coming year.
4. Will maintain an agenda and take meeting minutes in an action item focused format.
5. 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.
6. Will report out quarterly to the CQI/CPI Committee, and representative Medical Staff meeting on current committee progress.

## **Organizational Departments / Service Lines:**

1. Each department and/or service line will be actively engaged in CQI/CPI activities.
2. These departments will work directly with the Department of Quality to develop their improvement projects and develop tracking systems using accepted improvement methodologies.
3. Each department and/or service line will report to the CQI/CPI committee at least once per quarter on their progress.
4. 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.
5. A list of projects underway will be kept on the Quality SharePoint site in the Quality Committee folder.
  1. 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.

6. Records of current and previous QI/PI projects will be retained and maintained on the Quality SharePoint site in the Quality Committee folder.

## VII. REFERENCES

1. NIAHO Accreditation for Healthcare Organizations: Accreditation Requirements, Interpretive Guidelines and Surveyor Guidance for Critical Access Hospitals Revision 24-0, March 24, 2024.
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](#)

## VIII. ATTACHMENTS

1. Appendix 1. CQI/CPI Committee Reporting Structure
2. Appendix 2. CQI/CPI Committee Charter
3. Appendix 3. CQI/CPI Annual Work Plan
4. 2025 Quality Committee Objectives

*\*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.*

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### Attachments

[📎 2025 Quality Committee Objectives.docx](#)

[📎 Appendix 1. 2025 CQI CPI Committee Reporting Structure - v.1.0\\_2024-12-17.pdf](#)

[📎 Appendix 2. 2025 CQI CPI committee charter.pdf](#)

[📎 Appendix 3. 2025 Quality Committee Workplan.docx](#)

### Approval Signatures

Step Description

Approver

Date

Board Approval	Wendy Kenck: Executive Assistant	Pending
Executive Approval	Shawn Ottley: COO/CNO	4/10/2025
Executive Director of Quality	Louise Sahlinger: Director Of Quality	2/6/2025
Policy Management Committee	Committee Policy Management: Policy Management Committee	2/3/2025
	Louise Sahlinger: Director Of Quality	1/30/2025

COPY

## 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.

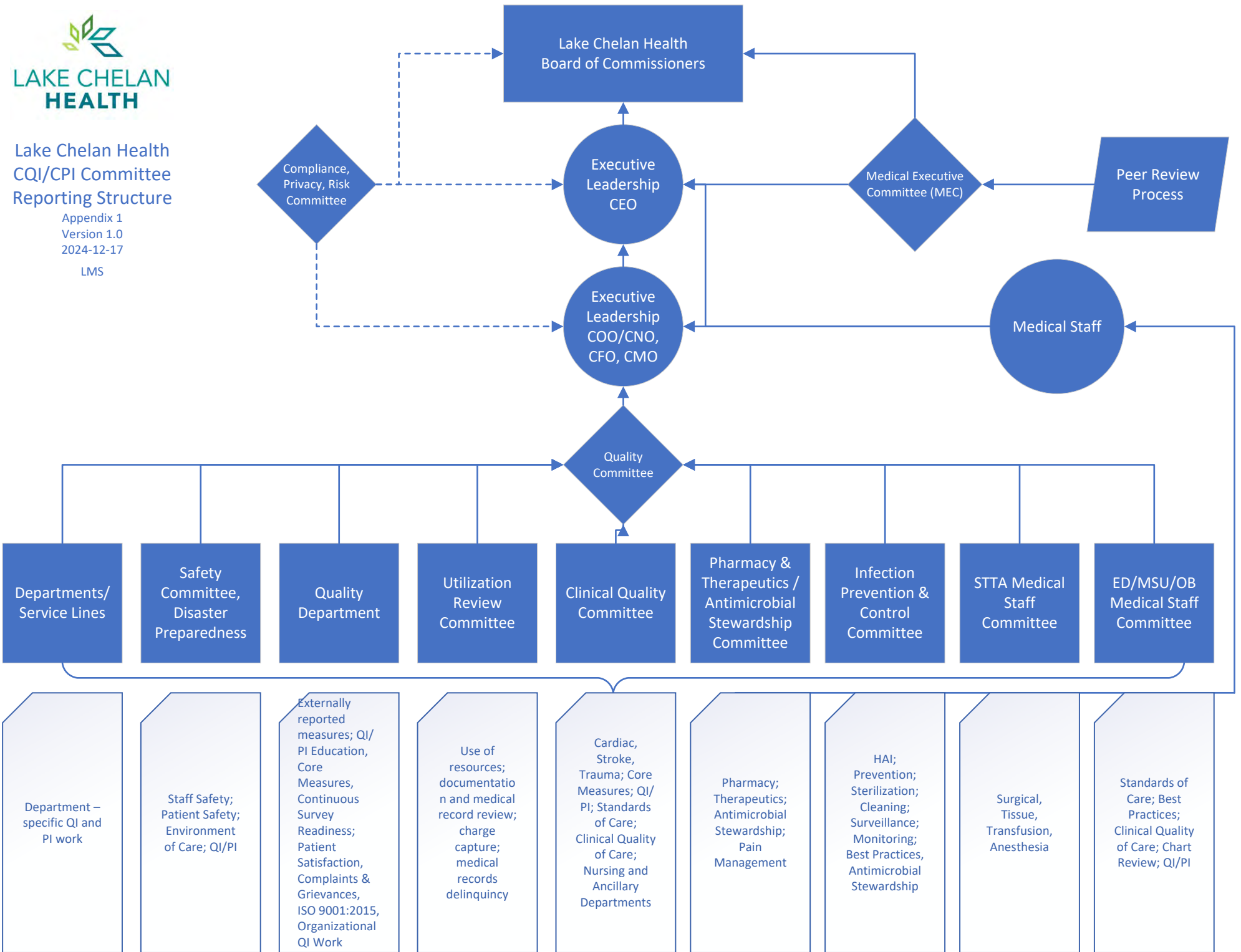
Each department at LCH will be rounded on by one or two board members in 2025, to include department managers, one or two board members and one or two representatives from Quality.



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

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



# 2025 LCH QUALITY COMMITTEE WORK PLAN

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



# 2025 LCH QUALITY COMMITTEE WORK PLAN

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



# 2025 LCH QUALITY COMMITTEE WORK PLAN

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



# 2025 LCH QUALITY COMMITTEE WORK PLAN

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



# 2025 LCH QUALITY COMMITTEE WORK PLAN

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



# 2025 LCH QUALITY COMMITTEE WORK PLAN

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



# 2025 LCH QUALITY COMMITTEE WORK PLAN

	<ul style="list-style-type: none"><li>○ Materials Management</li><li>○ Facilities</li><li>○ Accounting</li><li>○ HR</li><li>● ISO 9001 Review</li><li>● Data<ul style="list-style-type: none"><li>○ WSHA – Clinic, OB, Falls</li><li>○ HAIs</li></ul></li><li>● DNV Quality Committee Oversight of NCs<ul style="list-style-type: none"><li>○ NC-2-3</li><li>○ NC-2-4</li><li>○ NC-2-5</li></ul></li><li>● Sub-Committee Report Out<ul style="list-style-type: none"><li>○ Obstetrics</li><li>○ UR Committee</li></ul></li><li>● Open Discussion</li></ul>	<ul style="list-style-type: none"><li>● Director of Facilities</li><li>● Controller</li><li>● HR Director</li> <li>● ISO Task Force Team</li> <li>● Executive Director of Quality</li><li>● Quality Dept. Specialist</li> <li>● Infection Preventionist, CMO, Director of Facilities/Safety Officer</li> <li>● OB Manager</li><li>● Social Worker</li></ul>
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**CHELAN COUNTY PUBLIC HOSPITAL DISTRICT #2**  
**Lake Chelan Health**  
**Chelan County, WA**

**RESOLUTION No. 2025-4**  
*Disposal of Hospital Surplus Items*

A **RESOLUTION** of the Board of Commissioners of Public Hospital District No. 2, Chelan County, Washington (the ‘District’), to authorize the disposal of hospital surplus items; and

**WHEREAS**, Lake Chelan Health (LCH) a public hospital in the State of Washington, is committed to the responsible management and disposal of assets; and

**WHEREAS**, the Emergency Medical Services (EMS) Department has identified two ventilator systems as surplus, specifically:

Two (2) LTV 1200 Ventilator Systems, Model Number: LTV1200, including spring battery packs, roller stands, and cases; Serial Numbers: E51215 (Asset Tag# 8864) and 21000337 (Asset Tag# 8865)

**WHEREAS**, an assessment has determined that these ventilator systems are no longer needed for patient care and should be disposed of in accordance with applicable laws and hospital policies;

**BE IT RESOLVED** that the Board of Commissioners, Chelan County Public Hospital District No. 2, hereby adopts:

The ventilator systems described above are declared surplus and authorized for disposal.

The disposal shall be conducted through one of the following approved methods:

- **Reuse or Redistribution** – If feasible, the ventilators may be reassigned within the hospital or healthcare system.
- **Donation** – If in usable condition, the ventilators may be donated to an eligible nonprofit organization, community health clinic, or government entity.
- **Sale** – If the ventilators retain residual value, they may be sold through public auction, bid process, or another authorized means, in compliance with Washington state regulations.
- **Recycling or Disposal** – If the ventilators are nonfunctional and cannot be repurposed, they shall be disposed of in accordance with environmental and regulatory guidelines.

The Controller is authorized to oversee and document the disposal process in compliance with all applicable state and local regulations.

A record of the disposal, including method and justification, shall be maintained for auditing purposes.

**ADOPTED AND APPROVED**, by the Board of Commissioners, Chelan County Public Hospital District No. 2, at an open public meeting thereof this 29th day of April 2025, with the following Commissioners being present and voting in favor of the resolution.

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CHAIRPERSON OF THE BOARD

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SECRETARY

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VICE CHAIRPERSON

\_\_\_\_\_  
MEMBER

\_\_\_\_\_  
MEMBER

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CEO