SUPPLEMENTAL

BOARD OF COMMISSIONERS' REGULAR MEETING
March 31, 2016 – 5:00 p.m.
KVH Conference Rooms A/B
AGENDA

1. **Call Regular Meeting to Order**

2. ****Approval of Agenda:** **(1-2)**
   - (Items to be pulled from the Consent Agenda)

3. ****Consent Agenda:**
   a. Minutes of Board Meetings: Feb. 25, 2016 Special Meeting; Feb. 25, 2016 Regular Meeting; March 7, 2016 Special Meeting **(3-10)**
   b. Approval of Checks **(11)**
   c. Report: Foundation **(12)**
   d. Report: Clinic Operations
   e. Minutes: Finance Committee **(13)**

4. **Quality:**
   a. Rhonda Holden, Chief Nursing Officer, Cathy Bambrick, Chief Operating Officer, Dr. Don Solberg, Chief Medical Officer, Mandee Olsen, Director of Quality Assurance:
      - Mandee Olsen: Patient Story
      - QI Council Committee **(14)**
      - QI Council Dashboard **(15-16)**

5. **Public Comment/Announcements**

6. **Monique Ziebro, Ph.D., Organizational Psychologist: NBRI Employee Survey** **(17)**

7. **Chief Executive Officer's Report:**
   a. Paul Nurick, CEO: CEO Report **(18)**
      - Cathy Bambrick, COO: HR Dashboard **(19-20)**

8. **Chief of Staff Report:**
   a. Dr. Timothy O'Brien, Chief of Staff
      - **Medical Staff Exec. Committee Report-**Updated Memo-Replace pg. 21** **(21)**

9. **Financials:**
   a. Libby Allgood, CFO: Treasurer's Report **(22)**
   b. Finance Committee
      - **Approval of Capital Expenditure Requests-**Updated-Replace pg. 23** **(23)**
      - **Approval of Retirement Pension Plan Resolutions **(24)**

10. **Education:**
   - Erica Libenow and Liahna Armstrong: Report on attendance at Washington Rural Hospital Association Conference in Spokane, Wash.
   - **WSHA CEO and Trustee Patient Safety Summit, Seattle Airport Marriott, May 16 or May 17, 2016 **(25)**

11. **Public Policy:**

12. **Old Business:**
   a. Board Meeting Evaluation Summary **(26-39)**

13. **New Business:**
   a. Conduct of Meetings: Open Public Meetings Act

14. **Articles and Communications: - Additional Items** **(40-72)**

15. **Completion of Board Meeting Evaluation Summary**

16. **Recess to Executive Session:** Personnel; Quality Improvement; **Real Estate**
   RCW 42.30.110(g)(b); RCW 70.44.062(2)

17. **Convene to Open Session**

18. **Adjournment**

EMERGING HEALTHCARE ISSUES – POTENTIAL TOPICS

Population Health
Patient Centered Med. Home/Behavioral Health
Information Technology
ED Patient Issues/Protocol
Development of a Continuing Care Network

Kittitas Valley Healthcare
Board of Commissioners
Special Board Meeting
February 25, 2016
Mezzanine

BOARD MEMBERS PRESENT: Matt Altman, Liahna Armstrong, Erica Libenow, Pam Wilson

At 3:30 p.m., the special Board meeting was called to order. The purpose of the meeting was for a meet and greet for the new Board members to meet hospital employees and the public.

With no further business and no action being taken, the meeting was adjourned at 4:28 p.m.

Respectfully submitted,

Bob Davis/Franki Storlie
Secretary, Board of Commissioners

Kittitas Valley Healthcare
Board of Commissioners
February 25, 2016
KVH Conference Rooms A/B

BOARD MEMBERS PRESENT: Matt Altman, Liahna Armstrong, Erica Libenow, Pam Wilson

KVH STAFF PRESENT: Paul Nurick, Libby Allgood, Cathy Bambrick, Randi Christensen, Rhonda Holden

MEDICAL STAFF PRESENT: Dr. Timothy O'Brien

1. At 4:30 p.m., President Liahna Armstrong called the regular Board meeting to order. President Armstrong announced that Bob Davis was excused from attendance at the meeting.

2. **Approval of Agenda:**

   ACTION: On motion of Pam Wilson and second of Erica Libenow, the Board members unanimously approved the agenda as revised removing the Foundation Report from the Consent Agenda.

3. **Public Comment/Announcements**:

   Bob Ota requested that the Board members and other meeting participants use the microphones. Tom Stoffle asked about the possible closure of Spokane Street due to future facility construction. Cathy Bambrick asked for Mr. Stoffle's contact information so that a meeting could be scheduled with him to explain the process.

4. **Consent Agenda**:

   ACTION: On motion of Pam Wilson and second of Erica Libenow, the Board members unanimously approved the Consent Agenda as revised.

5. **Quality:**

   Mandee Olsen presented the Safety Catch Awards to the following staff: Stacey Botten, Director of Family Birthing; Susan Barton, Family Medicine-Cle Elum; Nicole Hinkle, RN, Surgical OutPatient; and Cassy Sterkel, Environmental Services.

   The Board members reviewed the QI Council summary and dashboards. They also reviewed the 2015 Quality Improvement Summary, the 2016 Quality Improvement Plan and indicators, and the Home Health and Hospice Improvement Plan.

6. **Chief Executive Officer's Report**:

   Paul Nurick reported that Libby will be presenting the topic Value Based Pricing at the March Board meeting. He reported about the competitive market between hospitals in the Yakima area with Virginia Mason acquiring Yakima Valley Memorial Hospital. He stated that the Hospitalists met with the senior leadership team about changes to the program. Matt Altman asked about the process regarding a final decision on the direction of the program. Paul responded that he may have this information available at the March Board meeting.

Libby Allgood reported that an RFI is going out to select an IT company to perform an IT assessment on KVH's medical record systems. She said that the physicians, including non-KVH physicians, will be included on a committee regarding selection and implementation of a future system.

The Board members reviewed the Human Resources Dashboard.

7. **Chief of Staff Report:**

This item was moved to the executive session portion of the meeting.

8. **Financials:**

Libby Allgood presented a short financial summary for the month of January noting that the operations for the month resulted in a $59,037 gain. Liahna Armstrong asked why the clinic revenues were low and the response was that this was due to getting new physicians on board and started during the month.

ACTION: On motion of Pam Wilson and second of Matt Altman, the Board members unanimously approved Resolution No. 16-01 regarding surplus property.

ACTION: On motion of Pam Wilson and second of Matt Altman, the Board members unanimously approved the capital expenditure request for the design humidity control/HVAC system for the Family Birthing Center.

9. **Education:**

Liahna Armstrong, Pam Wilson and Cathy Bambrick reported about the sessions they attended at the AHA conference recently held in Phoenix, Arizona. They reported that overall the conference was good with concern being expressed about the possibility of Obama Care going away with upcoming elections. They reported that sessions focused on governance, retail healthcare with the importance of value and transparency to customers, and virtual healthcare.

10. **Public Policy:**

Paul Nurick reviewed the agenda items that were discussed at a recent WSHA Public Policy Committee meeting he recently attended.

11. **Old Business:**

a. Board Meeting Evaluation Summary:

The Board members reviewed the Board meeting evaluation summary. After some discussion regarding the effectiveness of the evaluation format, it was agreed to continue to revisit this at the next Board meeting and offer a tutorial regarding how to complete the evaluation summary for new Board members.

President Armstrong noticed that Joanna Markell of the Daily Record was recording the meeting; Joanna responded that she was peri-operatively recording the meeting. President Armstrong responded that it would be courteous to those attending the meeting to inform them that the meeting was being recorded prior to starting the actual recording. Paul Nurick was directed to get a legal opinion regarding the legality of the Board meetings being recorded. Matt Altman

indicated that it should be legal for the public to record the Board meetings since they are a public and open meeting.

ACTION: Matt Altman made the motion that anyone can record the open/public portion of the Board of Commissioner meetings. Erica Libenow seconded the motion. After some discussion, the motion was amended to add that a sign would be placed at the entrance to the Board meetings announcing that the Board meeting was being recorded as a courtesy to those attending the meeting. The motion passed with two yes votes from Matt Altman and Erica Libenow and two abstentions from Liahna Armstrong and Pam Wilson.

b. Videotaping of Board Meetings:

The Board members reviewed the proposal submitted by Frank Jones regarding the videotaping of Board meetings. It was agreed that the agenda for Board meetings should be posted on the KVH Facebook site and a link to the KVH website and Facebook should be noted on posted agendas and newspaper announcements. Copies of Board agendas and minutes will also be placed at the hospital's front reception counter for the public.

ACTION: On motion of Erica Libenow and second of Matt Altman, the Board unanimously approved the proposal as submitted by Frank Jones for the videotaping of future Board meetings.

12. **New Business:**

a. KVH Annual Compliance Plan:

Debi Barneycastle presented the KVH Compliance Plan for 2016. She also recapped the 2015 program plan. She noted that in 2016 the focus would be on training staff on compliance procedures and issues. President Armstrong will sign the 2016 KVH Compliance Plan.

b. March 7 Board Retreat:

President Armstrong reminded the Board members to attend the March 7th Board Retreat regarding Master Facility Planning.

c. Foundation Board Report:

Erica Libenow reported that the February 23 Foundation Board meeting to review 2015 Foundation goals and refine them for 2016 went very well. She reported that this year's Magical Evening Fund-A-Need item will be a digital mammography project. Paul Nurick reported that two of the Foundation Board members intend to attend future Board meetings to enhance communications and to keep the Foundation Board apprised of the Board of Commissioner activities.

13. **Clippings, Articles, Correspondence and Board Meeting Evaluation Form:**

The Board members reviewed the various clippings and correspondence items. The Board members completed the Board Meeting Evaluation Summary. Liz Whitaker of the Kittitas County Health Department invited anyone interested to attend an Accountable Communities of Health meeting in the Tri-Cities.

President Armstrong recessed the meeting at 7:15 p.m. for ten minutes. She announced that the meeting would be recessed into executive session at 7:25 p.m. for one hour to discuss personnel and quality improvement. RCW 42.30.110(g); RCW 70.44.062(2)

At 8:25 p.m., the executive session was extended for 35 minutes.

At 9:00 p.m., the meeting was reconvened into open session.

ACTION: On motion of Matt Altman and second of Erica Libenow, the Board members unanimously approved the initial appointments for Dr. Paul Miller, Dr. Joshua Cooks, DO, Dr. Lori Starke, and Jose Diaz, PA-C, and the reappointments for Dr. John Anderson, DO, Dr. Lawrence Bub, Dr. C. Sinclair Cottingham, Dr. John Hwang, Dr. Phillip Menashe, Dr. Norman Shively, Dr. David Stepanek, Dr. Juan Tamariz-Loor, and Chelsea Newman, PA-C.

ACTION: On motion of Matt Altman and second of Erica Libenow, the Board members approved the reappointment for Dr. John Arias, with three yes votes and one no vote by Liahna Armstrong.

ACTION: On motion of Matt Altman and second of Pam Wilson, the Board members approved the reappointment for Dr. Nancy Wells with three yes votes and with Erica Libenow recusing.

With no further action and business, the meeting was adjourned at 9:04 p.m.

CONCLUSIONS:

1. Motion passed to approve the Board agenda as revised.

2. Motion passed to approve the Consent Agendas revised.

3. Motion passed to approve Resolution No. 16-01 regarding surplus property.

4. Motion passed to approve the capital expenditure request for the design humidity control/HVAC system for the Family Birthing Center.

5. Motion passed to approve the recording of the open/public portion of the Board of Commissioner meetings. The motion was amended to add that a sign would be placed at the entrance to the Board meetings announcing that the Board meeting was being recorded as a courtesy to those attending the meeting.

6. Motion passed to approve the proposal as submitted by Frank Jones for the videotaping of future Board meetings.

7. Motion passed to approve the initial appointments for Dr. Paul Miller, Dr. Joshua Cooks, DO, Dr. Lori Starke, and Jose Diaz, PA-C, and the reappointments for Dr. John Anderson, DO, Dr. Lawrence Bub, Dr. C. Sinclair Cottingham, Dr. John Hwang, Dr. Phillip Menashe, Dr. Norman Shively, Dr. David Stepanek, Dr. Juan Tamariz-Loor, and Chelsea Newman, PA-C.

8. Motion passed to approve the reappointment for Dr. John Arias, with three yes votes and one no vote by Liahna Armstrong.

9. Motion passed to approve the reappointment for Dr. Nancy Wells with three yes votes and with Erica Libenow recusing.

Respectfully submitted,

Franki Storlie/Bob Davis
Executive Coordinator/Secretary, Board of Commissioners

Kittitas Valley Healthcare
Board of Commissioners
Special Board Meeting
March 7, 2016
Conf. Rooms A/B

BOARD MEMBERS PRESENT: Matt Altman, Liahna Armstrong, Bob Davis, Erica Libenow, Pam Wilson

KVH STAFF PRESENT: Paul Nurick, Cathy Bambrick, Libby Allgood, Rhonda Holden, Randi Christensen, Dr. Don Solberg, Mandee Olsen, Randy Kaiser, Amy Diaz

GUESTS: Joe Kunkel, Bethany Childress, James Harman

At 8:00 a.m., President Liahna Armstrong called the Special Board meeting to order. She announced that the purpose of the meeting was to conduct master facilities planning. On motion of Pam Wilson and second of Bob Davis, the Board members unanimously approved the agenda.

President Armstrong noted that members of the audience are invited to listen but, because this is a Special Board meeting, they do not participate. Bethany Childress and James Harman, ZGF Architects, presented an overview of Phase 1 and 2 of the master site plan. She stated that Phase 1 would provide for the construction of an outpatient clinic building south of the hospital and would provide additional parking spaces. It was noted that the plan would require vacating Spokane Street and demolishing the hospital-owned houses in that area. Matt Altman noted that the hospital administration would need to inform the bordering neighbors regarding the construction plans. An overview of Phase 2 of the master facility plan was presented that would include demolition of the hospital's community library, the internal medicine clinic, and relocating and building new areas in the hospital for Family Birthing, Med/Surg and ICU/CCU. Liahna Armstrong asked that the owners of Family Medicine-Ellensburg be contacted regarding their ownership of the clinic building since the hospital owns the property on which the clinic is located.

Joe Kunkel, The Healthcare Collaborative Group consultant, and Libby Allgood presented options and plans for capital and budget financing strategies for the Phase 1 and 2 plans.

Joe Kunkel reviewed the potential capital investments and community implications for SEPA, zoning, street vacations and other public processes for Phase 1 and 2. Bob Davis stated that it would be important to also contact neighboring residents on Whitman Street.

On motion of Pam Wilson and second of Bob Davis, the Board members unanimously approved the overall concept of the Master Facility Plan.

On motion of Pam Wilson and second of Bob Davis, the Board members unanimously approved to initiate Phase 1 of the Master Facility Plan.

With no further business and no action being taken, the meeting was adjourned at 11:00 a.m.

Respectfully submitted,

Franki Storlie/Bob Davis
Exec. Coordinator/Secretary, Board of Commissioners

DATE OF BOARD MEETING: March 31, 2016

ACCOUNTS PAYABLE CHECKS/EFTS TO BE APPROVED:

#1	CHECK NUMBERS	218154-218939	NET AMOUNT:	$2,881,271.46

PAYROLL CHECKS/EFTS TO BE APPROVED:

#1	CHECK NUMBERS	76015-76047	NET AMOUNT:	$37,493.95
#2	CHECK NUMBERS	76048-76076	NET AMOUNT:	$39,089.16
#3	PAYROLL DIRECT DEPOSIT	EFT	NET AMOUNT:	$876,924.58
#4	PAYROLL DIRECT DEPOSIT	EFT	NET AMOUNT:	$867,087.39
#5	PAYROLL TAXES	EFT	NET AMOUNT:	$373,730.24
#6	PAYROLL TAXES	EFT	NET AMOUNT:	$365,329.42
		SUB-TOTAL:	$2,559,654.74	

TOTAL CHECKS & EFTs: $5,440,926.20

Prepared by

Sharoll Cummins
Sharoll Cummins
Staff Accountant

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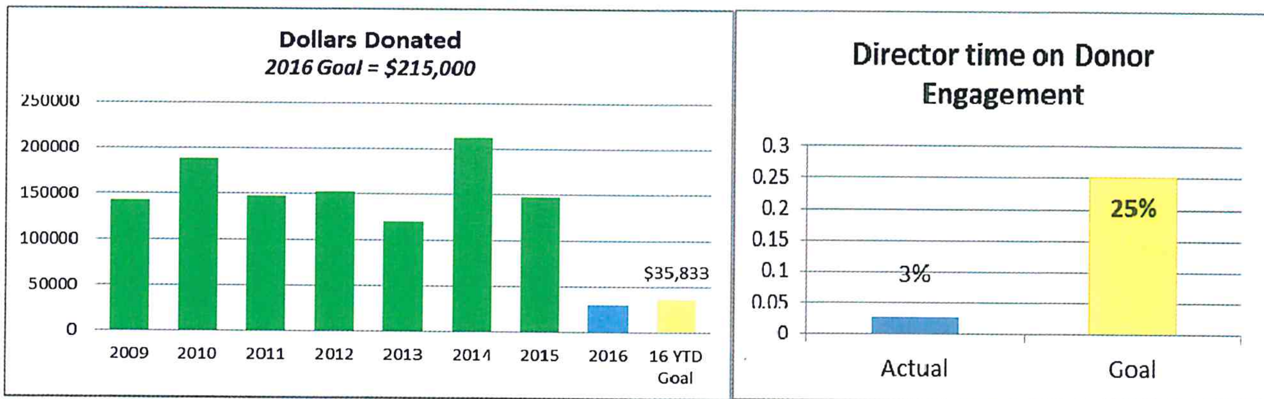
Board of Commissioners Report, March 21, 2016

2016 Goals

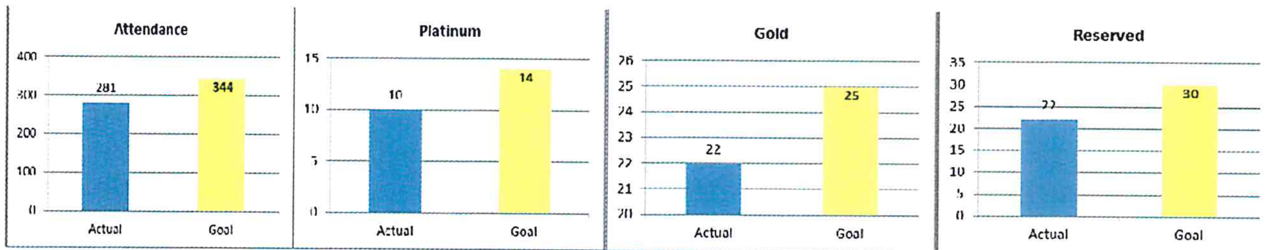
Throughout February and March we have been reviewing the goals set out in 2015 and developing an action plan for 2016. Our two main goals are outlined below. As we move forward, I will report the metrics on our progress.

1. *Develop and implement an effective communication strategy that involves leadership and Board members and incorporates outreach to donors, prospective donors and the community.*
2. *Enhance and sustain relationships with new and existing door by tailoring outreach to meet their individual preferences.*



Magical Evening – April 16, 2015

Get your reservations in now for Magical Evening because tickets are going fast.



Respectfully submitted,

Michele Wurl

Director, The Foundation at KVH

Kittitas Valley Healthcare
Finance Committee Meeting Minutes
February 23, 2016

Present: Pam Wilson, Matt Altman, Bob Crowe, Larry Dunbar, Paul Nurick, Libby Allgood, Randi Christensen, Paul Malinski.

The meeting was called to order by Pam Wilson at 7:30 am.

The agenda was approved as presented.

The minutes of the January 26, 2016 meeting were approved as presented.

January 2016 Financial Summary

Key Metrics:

1. Operating Margin: January 1.1%, YTD 1.1%
2. Days Cash on Hand: 191.8
3. AR Days (Hospital Only): 48.8

Operating Highlights:

1. PHD 1 District January operations resulted in an operating gain of $59,037, a $135,079 negative budget variance.

2. January Admissions were 28.8% below budget resulting in a 31.5% negative variance to inpatient days. Admissions were 23, or 20.5%, below January of last year. Inpatient surgical volumes were below budget in January.

3. Overall operating expenses for January were below budget by $608,907. Employee benefits in January were over budget due to health insurance claims higher than anticipated. Supplies were under budget due to low patient volumes.

4. Total clinic visits in January were 620 below budget and 365 visits below January of the previous year. Clinic operations for the month resulted in an operating loss of $302,244, a negative budget variance of $65,963. January of 2015 had an operating loss of $169,825.

Capital Expenditure Request: A Capital Expenditure request for Design fees Humidity Control/HVAC System for Family Birthing C- Section Room was presented for review and discussion. The request was approved for recommendation to the Board of Commissioners for approval.

The meeting was adjourned at 8:40 am.

Data Summary – For use in March 2016

Summary of Areas Meeting Goal or Showing Improvement

- Only one failure on influenza immunizations in the patient sample for the month of January. Immunization status was not available during the admission assessment because the patient had dementia. The patient's immunization status was also not rechecked at discharge.
- KVH has met criteria for a Silver Plus award from the American Heart Association/American Stroke Association for Get With the Guidelines compliance during the 2015 calendar year. We have applied for official recognition of this achievement through the AHA/ASA.
- We are above our goal for employee reports for the month of January. Staff reporting of concerns is helpful to identify areas for improvement that might prevent future harm to patients.

Summary of Improvement Opportunities

- Staff override rates for medication barcode scanning vary from 5.7% to 26.6% depending on department. Plan to share with staff during huddles and gembas now and include education about the reason for barcode scanning during employee education fair in May.
- Slight fall in compliance with the new sepsis bundle of recommended care. Most failures are still with compliance of the 6 hour window for a follow-up lactate test. There is also still some confusion with the definitions of diagnosis with sepsis and severe sepsis.
- We are reporting a new measure with clinic data that describes the A1c levels for patients with a diagnosis of diabetes. The goal is that no patients have an A1c level that is higher than 9%. In January 2016, 56% of patients with diabetes who had an A1c test did not meet this goal.

Story:

"In Jan. 2016, I was in your emergency room and then transferred to ICU and was released the next day.

I would like to take this opportunity to acknowledge three nurses that took excellent care of me. Their names were Madeline, Bethany, and Jamie. They are Shining Examples of the Nursing Field in which they work.

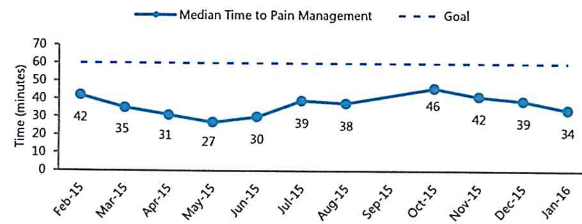
They were professional, courteous, and gave me the feeling that I was being well cared for. They also took a few minutes to be sociable which was comforting.

Going to the emergency room is disconcerting and not knowing what the outcome will be is scary.

I hope you acknowledge them for the wonderful work and attitude they give to their patients."

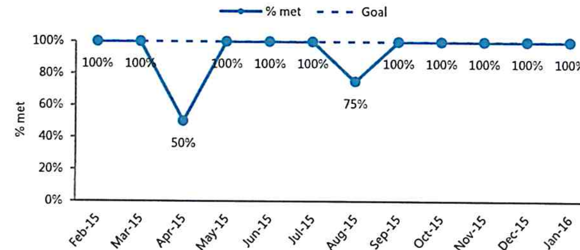
QI Council

Median Time to Pain Management (Long Bone Fracture) ↓



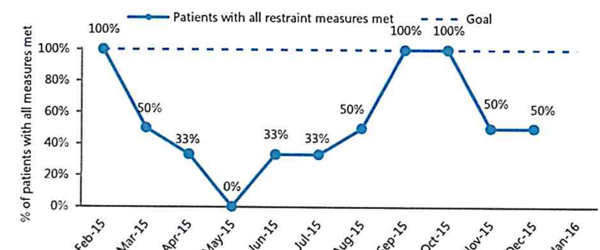
# of pts 6 7 9 9 7 2 10 0 7 6 5 11

Stroke Dysphagia Screening ↑



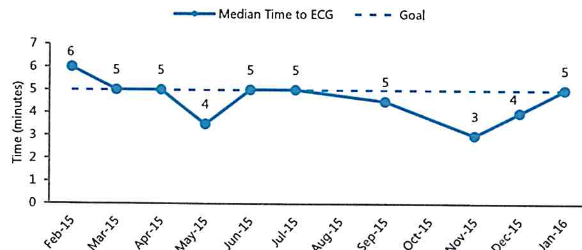
# of pts 2 4 2 2 2 4 4 4 2 3 3 1

Restraints ↑



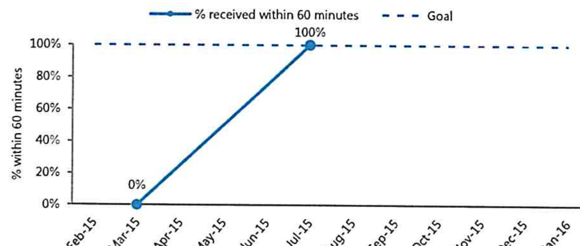
possible 1 2 6 1 3 3 2 3 1 2 2 0

Median Time to ECG (Chest Pain) ↓



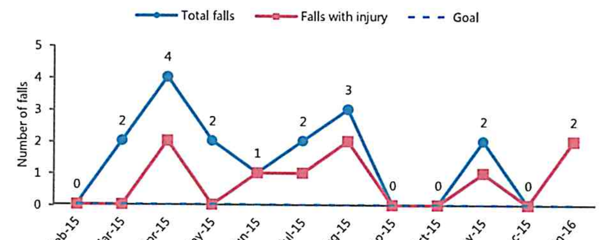
# of pts 1 1 5 4 3 3 0 6 0 2 5 6

Stroke IV Thrombolytics ↑

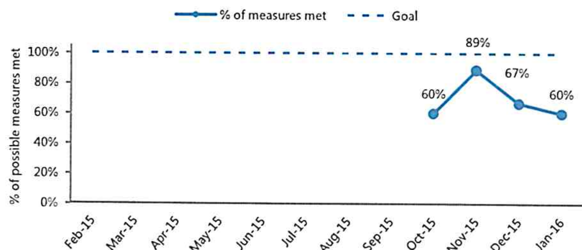


# of pts 0 1 0 0 0 1 0 0 0 0 0 0

Falls ↓



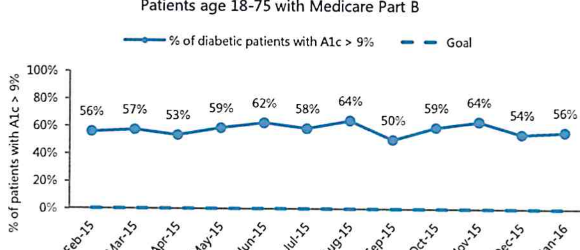
Sepsis Bundle ↑



possible 5 9 3 5

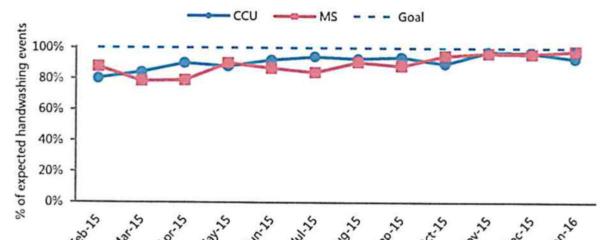
High A1c in Diabetic Patients ↓

Patients age 18-75 with Medicare Part B

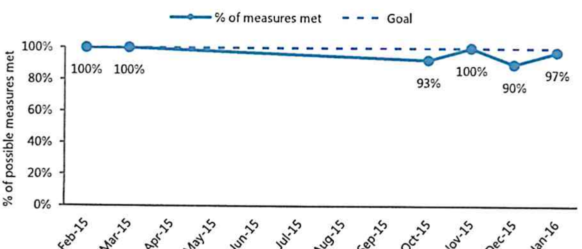


possible 150 131 150 157 130 137 143 140 140 125 114

Hand Hygiene ↑

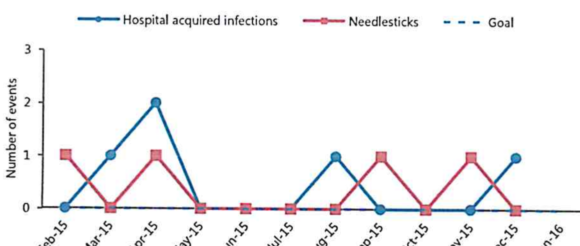


Immunizations Bundle ↑

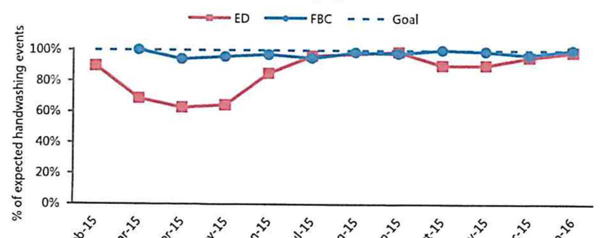


possible 40 42 0 0 0 0 0 0 40 38 39 39

HAIs and Needlesticks ↓

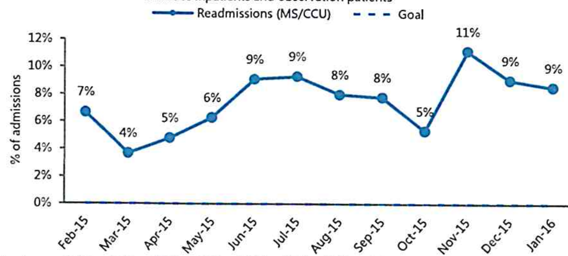


Hand Hygiene ↑



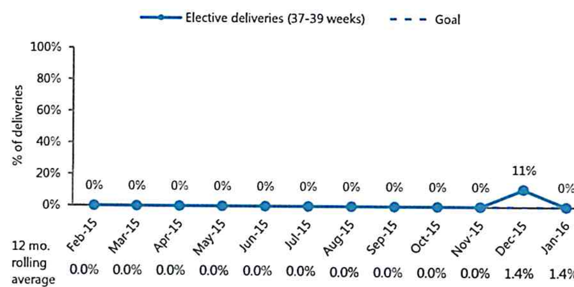
Readmissions Within 30 Days ↓

Includes inpatients and observation patients

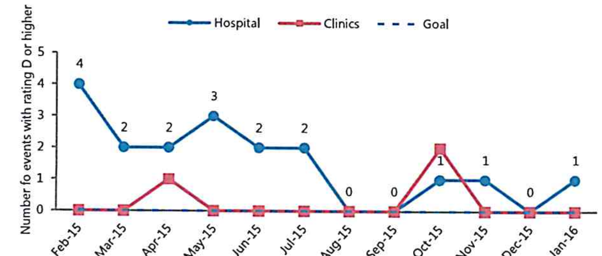


admissions 165 191 188 191 165 172 163 180 169 188 177 164

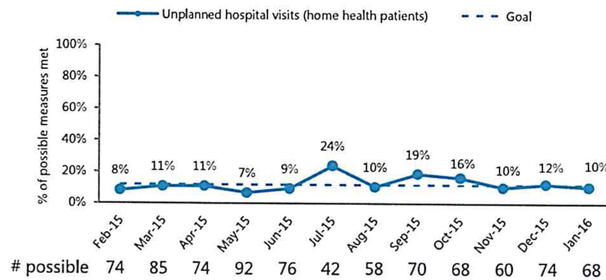
Elective Deliveries ↓



Adverse Medication Events ↓

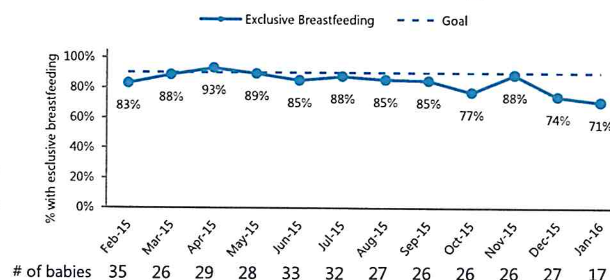


Unplanned Hospital Care Bundle ↓



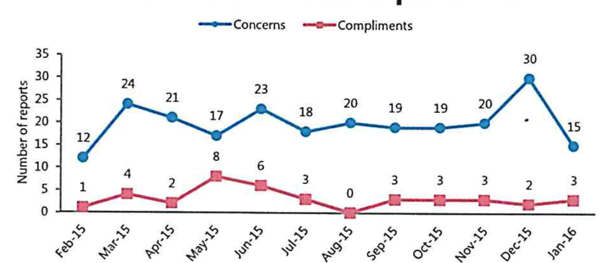
possible 74 85 74 92 76 42 58 70 68 60 74 68

Exclusive Breastfeeding ↑

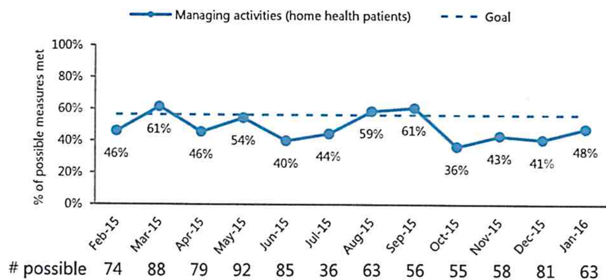


# of babies 35 26 29 28 33 32 27 26 26 26 27 17

Care and Service Reports ↓

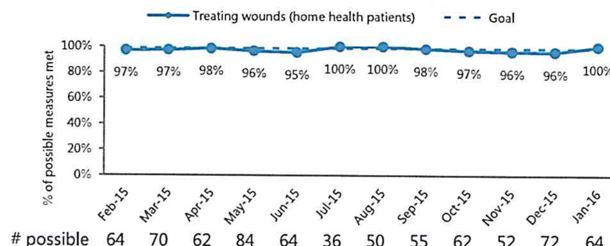


Managing Daily Activities Bundle ↑



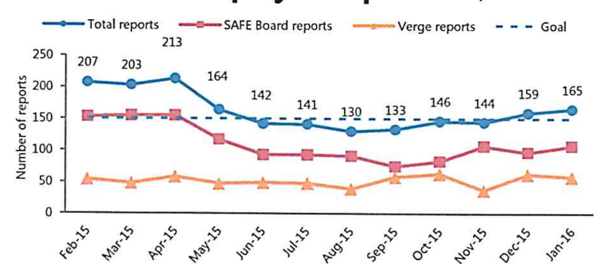
possible 74 88 79 92 85 36 63 56 55 58 81 63

Treating Wounds and Preventing Pressure Bundle ↑

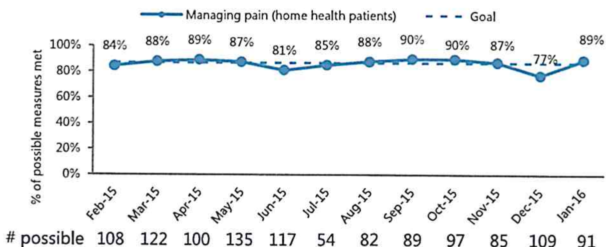


possible 64 70 62 84 64 36 50 55 62 52 72 64

Employee Reports ↑

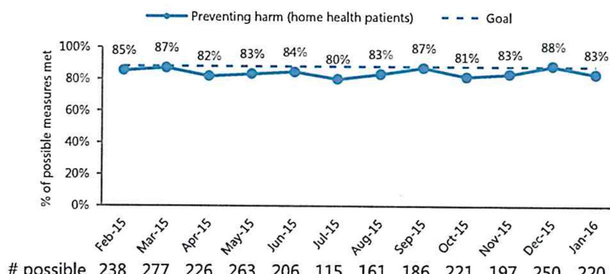


Managing Pain and Treating Symptoms Bundle ↑



possible 108 122 100 135 117 54 82 89 97 85 109 91

Preventing Harm Bundle ↑



possible 238 277 226 263 206 115 161 186 221 197 250 220

Reports of occurences ↓

that require additional monitoring or cause patient harm

Employee Satisfaction Survey Results

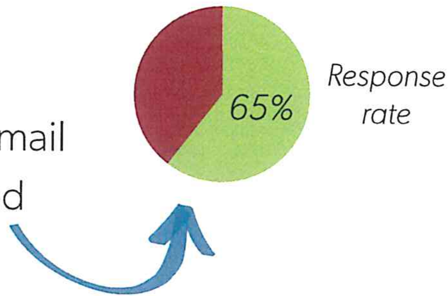
In December, KVH asked for your feedback using a formal survey that allows us to compare ourselves to other healthcare organizations.

Survey dates

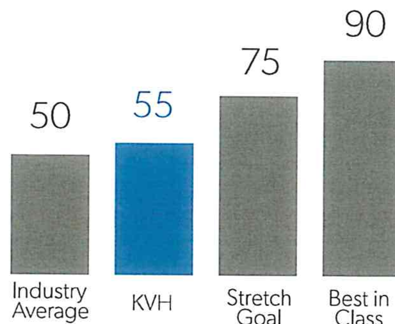
December 9 - 30, 2015

550 surveys sent via email

359 surveys returned



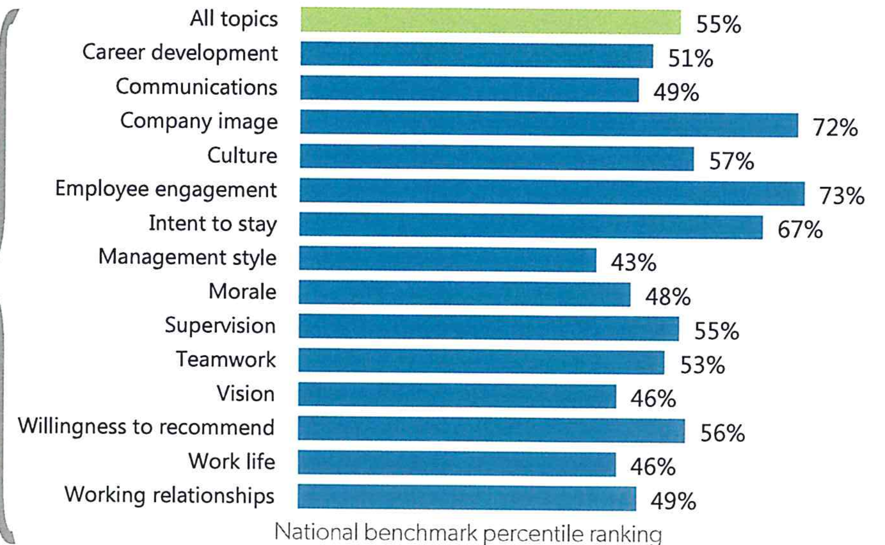
Overall, KVH performed at the 55th percentile when compared to other hospitals and clinics.



KVH responses were compared to more than 25,000 other hospital and clinic employees.

41 questions covered 14 topics

How does KVH compare?



National Research Business Institute identified these specific areas for KVH to focus improvement:

- My supervisor encourages me to make work-related decisions on my own. *Current: 66%*
- Upward communication is encouraged at KVH. *Current: 48%*
- Management decisions are in line with KVH Vision. *Current: 43%*
- Employees are treated with respect. *Current: 48%*
- I am comfortable in my relationships with my peers. *Current: 47%*

CEO REPORT

March 31, 2016

1. **Master Site and Facilities Plan**. We will report on our outreach and communications with stakeholders, both in the community and within the KVH family.

2. **Provider Recruitment**. The status of new and on-going searches for physicians and advanced practice clinicians will be discussed. These include primary care practitioners, specifically family medicine and pediatrics, as well as hospital medicine (hospitalists) and emergency medicine.

3. **Yakima and the Lower Valley**. Significant health service realignment is occurring to the south of Kittitas County. Some disruption for KVH patients is possible. We will update the Board on some of the dynamics as we understand them.

4. **Infrastructure Projects**. The new cooling towers are scheduled to come on line on or around April 15th. At least one additional significant project may be undertaken this year.

5. **Recording System for Board Meetings**. We expect the new system to be in place by the April Board meeting.

6. **Washington State Hospital Association CEO Search**. The KVH CEO is the only rural leader on the six member search committee. The other members are the Providence East CEO, Skagit Health CEO, Evergreen CEO, Children's Hospital President, and Virginia Mason COO.

Human Resources Dashboard Report
February 2015

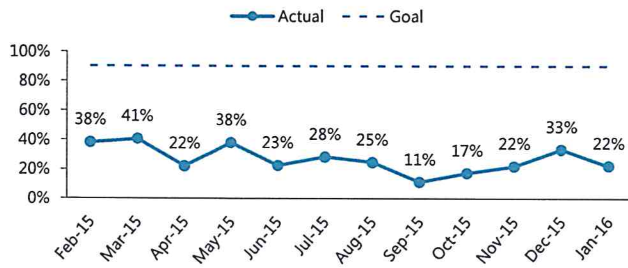
Highlights

- There were positions 25 posted, with 21 being filled or closed during the month. KVH is currently recruiting for 33 positions.
- There was 1 new worker compensation claim with 2 days of time loss.
- Monthly evaluations were at 23% for the month. (10 out of 43)

Prepared by:
Human Resources
3/25/2016

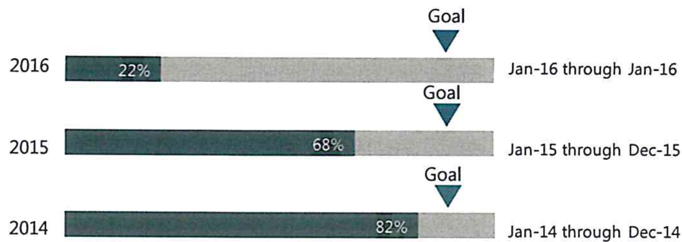
Workforce Development

Timely evaluations ↑



By month of hire, employees receiving an evaluation in or up to three months before their annual anniversary month.

Up-to-date evaluations →



Employees receiving an evaluation during the calendar year.

Positions accepted within 49 days →

Positions with an acceptance date within 49 days of posting.

Average days to acceptance **43**

Of **163** *positions that were accepted in the past 12 months.*

Separation rate ↓

Non-standard productive pay

(call back, double time, overtime, overtime meeting)

These 10 departments represent **75.5%** *of the non-standard pay for the payroll period ending on* **01/23/2016**

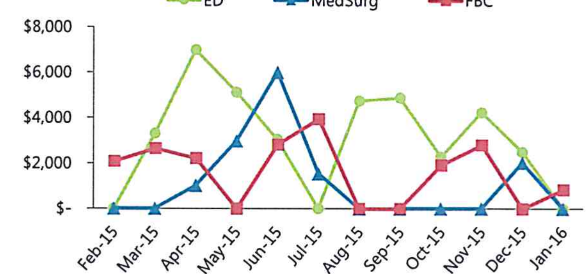
	Department	Amount
1	HOME HEALTH SERVICE*	$ 4,934.90
2	EMERGENCY SERVICE	$ 4,925.29
3	MED SURG	$ 4,737.47
4	PHARMACY	$ 2,989.91
5	ICU CCU	$ 2,463.56
6	SURGICAL SERVICE*	$ 1,499.72
7	FAMILY BIRTHING CENTER	$ 1,202.17
8	KVH FAMILY MEDICINE –ELLENSBUI	$ 1,126.78
9	LABORATORY	$ 943.07
10	ENGINEERING	$ 911.48

These 10 departments represent **76.7%** *of the non-standard pay for the last year of payroll.*

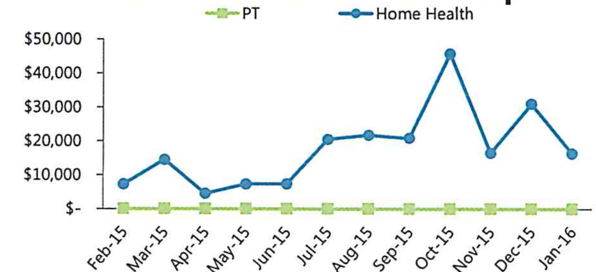
	Department	Amount
1	EMERGENCY SERVICE	$ 113,456.39
2	MED SURG	$ 101,148.47
3	HOME HEALTH SERVICE*	$ 80,058.50
4	FAMILY BIRTHING CENTER	$ 72,286.22
5	ICU CCU	$ 63,551.34
6	LABORATORY	$ 33,255.72
7	PHARMACY	$ 28,175.40
8	SURGICAL SERVICE*	$ 19,911.81
9	SURGICAL OUTPATIENT*	$ 18,384.54
10	KVH URGENT CARE CENTER – CLE E	$ 16,173.75

*Call back pay excluded

Contractual labor - hospital ↓



Contractual labor - non-hospital ↓



Employee satisfaction

Last updated 03/01/2016

NOTIFICATION OF CREDENTIALS FILES FOR REVIEW

Date March 28, 2016

TO: Board of Commissioners

FROM: Shannon Carlson, CPCS
Medical Staff Services

The Medical Executive Committee has reviewed the applications for appointment or reappointment for the practitioners listed below. They recommend to the Board that these practitioners be granted appointment and privileges. Please stop by my office (upstairs in the Administrative area) prior to the next Board meeting if you wish to review these credentials files.

PRACTITIONER	STATUS	APPT/REAPPT
Gabriella Skuta, MD	Provisional/Active Locum	Initial Appointment
Chandra Matadeen-Ali, MD	Provisional/Associate	Initial Appointment
Lauren Musick, PA-C	Provisional/AHP	Initial Appointment
William Waltner, MD	Active	Reappointment
William Feldmann, MD	Associate	Reappointment
Kristen Grubb, MD	Associate	Reappointment
Richard Roux, MD	Associate	Reappointment
Christine Bentley, PA-C	Allied Health Professional	Reappointment
Cassie Gavin, ARNP	Allied Health Professional	Reappointment
Dena Mahre, PA-C	Allied Health Professional	Reappointment

February 2016 Financial Summary

Key Metrics:

1. Operating Margin: February 3.9%, YTD 2.21%
2. Days Cash on Hand: 179.6
3. AR Days (Hospital Only): 49.1

Operating Highlights:

1. PHD 1 District February operations resulted in an operating gain of $224,980, a $83,283 negative budget variance.

2. February Admissions were 25.0% below budget resulting in a 22.6% negative variance in inpatient days. Year to date admissions were 66, or 25% below budget and 27.6% below February of last year. The negative variance in Admissions and Patient Days was the result of lower than budgeted volume for inpatient surgery cases.

3. Overall operating expenses for February were below budget by $9,466. Supplies were under budget due to low patient volumes.

4. Total clinic visits in February were 353 below budget. Year to date the visits are 194 below February year to date of the previous year. Clinic operations for the month resulted in an operating loss of $30,902, a positive budget variance of $97,207.

Kittitas Valley Healthcare
Key Statistics and Indicators
February 2016

		Current Month			Year to Date			Prior YTD		
	Activity Measures	Actual	Budget	Var. %	Actual	Budget	Var. %	Actual	Var. %	
01	Admissions	84	112	-25.0%	173	237	-27.0%	239	-27.6%	01
02	Patient Days - W/O Newborn	233	301	-22.6%	455	625	-27.2%	602	-24.4%	02
03	Avg Daily IP Census	8.0	10.4	-22.6%	7.6	10.4	-27.2%	10.2	-25.7%	03
04	Average Length of Stay	2.8	2.7	3.2%	2.6	2.6	-0.3%	2.5	4.4%	04
05	Deliveries	29	30	-3.3%	46	65	-29.2%	62	-25.8%	05
06	Case Mix	1.01	0.98	3.1%	1.02	0.98	4.1%	0.93	9.7%	06
07	Surgery Minutes - Inpatient	2,523	4,551	-44.6%	5,283	9,416	-43.9%	7,393	-28.5%	07
08	Surgery Minutes - Outpatient	6,325	6,600	-4.2%	13,370	13,653	-2.1%	11,246	18.9%	08
09	Surgery Procedures - Inpatient	19	43	-55.8%	49	88	-44.3%	79	-38.0%	09
10	Surgery Procedures - Outpatient	110	104	5.8%	224	217	3.2%	163	37.4%	10
11	ER Visits	1,158	1,125	2.9%	2,230	2,328	-4.2%	2,195	1.6%	11
12	Laboratory	37,838	37,381	1.2%	74,774	77,339	-3.3%	76,608	-2.4%	12
13	Radiology	24,615	24,153	1.9%	49,875	49,974	-0.2%	48,829	2.1%	13
14	Rehab	3,254	3,279	-0.8%	6,378	6,779	-5.9%	5,916	7.8%	14
15	Outpatient Visits	6,495	6,133	5.9%	12,549	12,688	-1.1%	12,515	0.3%	15
16	Outpatient Percent of Total Revenue	83.1%	78.0%	6.5%	82.9%	77.9%	6.5%	78.3%	6.0%	16
17	Clinic Visits	5,072	5,425	-6.5%	9,616	10,589	-9.2%	9,810	-2.0%	17
18	Adjusted Patient Days	1,376	1,370	0.5%	2,668	2,824	-5.5%	2,772	-3.7%	18
19	Equivalent Observation Days	62	77	-19.3%	122	158	-23.1%	139	-12.8%	19
20	Avg Daily Obs Census	2.1	2.7	-19.3%	2.0	2.6	-23.1%	2.3	-12.8%	20
	Financial Measures									
21	Salaries as % of Net Pt Revenue	49.5%	48.5%	-2.1%	51.2%	48.9%	-4.7%	50.7%	-1.0%	21
22	Salaries/Bene as % of Net Pt Revenue	59.4%	59.3%	0.0%	63.5%	59.9%	-6.1%	60.5%	-4.9%	22
23	Revenue Deduction %	44.0%	44.7%	1.4%	44.5%	44.8%	0.7%	45.7%	2.6%	23
24	Operating Margin	3.9%	5.2%	-25.9%	2.2%	4.2%	-46.9%	3.1%	-28.4%	24
	Operating Measures									
25	Productive FTE's	396.7	409.8	3.2%	389.9	409.8	4.9%	387.0	-0.7%	25
26	Non-Productive FTE's	44.8	48.6	7.7%	48.9	48.6	-0.6%	50.9	4.1%	26
27	Paid FTE's	441.5	458.4	3.7%	438.7	458.4	4.3%	437.9	-0.2%	27
28	Operating Expense per Adj Pat Day	$ 4,051	$ 4,078	0.7%	$ 4,112	$ 4,098	-0.3%	$ 3,725	-10.4%	28
29	Net Revenue per Adj Pat Day	$ 4,215	$ 4,303	-2.1%	$ 4,205	$ 4,276	-1.7%	$ 3,843	9.4%	29
30	A/R Days-Hospital Only	49.1	50.0	1.8%	49.1	50.0	1.8%	50.0	1.8%	30
31	Days Cash on Hand	179.6	170.0	5.6%	179.6	170.0	5.6%	171.5	4.7%	31

Kittitas Valley Healthcare
Income Statement
February 2016

#		Current Month Actual	Current Month Budget	Current Month Variance	Current Month Variance %	Year-to-Date Actual	Year-to-Date Budget	Year-to-Date Variance	Year-to-Date Variance %	Prior Y-T-D Actual	#
	Patient Services Revenue:										
1	Inpatient Revenue	1,708,482	2,293,540	(585,059)	-25.51%	3,387,720	4,745,256	(1,357,536)	-28.61%	4,212,431	1
2	Outpatient Revenue	8,383,320	8,142,312	241,008	2.96%	16,477,446	16,695,626	(218,180)	-1.31%	15,181,458	2
3	Total Patient Services Revenue	$ 10,091,802	$ 10,435,853	$ (344,051)	-3.30%	$ 19,865,165	$ 21,440,882	$ (1,575,716)	-7.35%	$ 19,393,889	3
	Deductions from Revenue:										
4	Contractual Adjustments	4,230,797	4,406,851	176,054	4.00%	8,329,637	9,076,767	747,130	8.23%	8,371,265	4
5	Provision for Bad Debts	165,299	178,279	12,979	7.28%	353,479	368,852	15,373	4.17%	301,654	5
6	Charity and Uncompensated Care	18,328	55,464	37,137	66.96%	89,313	114,754	25,441	22.17%	123,151	6
7	Prior Yr Cost Rep Settle	-	-	-	-	-	-	-	-	-	7
8	Other Allowances	30,631	21,248	(9,383)	-44.16%	63,912	43,962	(19,950)	-45.38%	63,349	8
9	Total Deductions from Revenue	$ 4,445,055	$ 4,661,842	$ 216,787	4.65%	$ 8,836,341	$ 9,604,335	$ 767,994	8.00%	$ 8,859,418	9
10	**Net Patient Services Revenue**	5,646,747	5,774,011	(127,263)	-2.20%	11,028,825	11,836,547	(807,722)	-6.82%	10,534,470	10
11	**Other Operating Revenue**	154,183	119,669	34,514	28.84%	189,418	239,339	(49,920)	-20.86%	116,884	11
12	Total Operating Revenue	$ 5,800,931	$ 5,893,680	$ (92,749)	-1.57%	$ 11,218,243	$ 12,075,885	$ (857,642)	-7.10%	$ 10,651,355	12
	Operating Expenses:										
13	Salaries & Wages	2,794,054	2,798,096	4,042	0.14%	5,649,970	5,789,210	139,240	2.41%	5,344,735	13
14	Employee Benefits	557,820	628,558	70,738	11.25%	1,353,953	1,298,728	(55,225)	-4.25%	1,031,274	14
15	Professional Fees	284,572	274,226	(10,346)	-3.77%	535,299	560,950	25,651	4.57%	427,220	15
16	Supplies	717,253	785,027	67,774	8.63%	1,165,960	1,622,129	456,169	28.12%	1,331,760	16
17	Utilities	88,064	78,681	(9,383)	-11.93%	157,352	160,542	3,190	1.99%	153,255	17
18	Purchased Services	587,399	503,953	(83,445)	-16.56%	1,053,498	1,042,336	(11,162)	-1.07%	1,019,628	18
19	Depreciation	229,513	227,284	(2,229)	-0.98%	452,165	454,567	2,403	0.53%	441,610	19
20	Rent/Lease	89,851	79,795	(10,056)	-12.60%	180,480	155,112	(25,368)	-16.35%	166,130	20
21	Insurance	62,937	53,218	(9,718)	-18.26%	106,772	112,062	5,290	4.72%	98,768	21
22	Travel & Education	49,866	30,946	(18,920)	-61.14%	67,960	72,466	4,506	6.22%	40,061	22
23	Licenses & Taxes	54,022	55,829	1,807	3.24%	125,159	133,902	8,742	6.53%	142,201	23
24	Interest	24,204	24,214	10	0.04%	48,407	48,428	20	0.04%	57,740	24
25	Other Direct Expenses	36,398	45,589	9,191	20.16%	73,667	123,074	49,406	40.14%	68,433	25
26	Total Operating Expenses	$ 5,575,951	$ 5,585,417	$ 9,466	0.17%	$ 10,970,643	$ 11,573,505	$ 602,862	5.21%	$ 10,322,814	26
27	**Operating Income**	$ 224,980	$ 308,263	$ (83,283)	-27.02%	$ 247,601	$ 502,380	$ (254,780)	-50.71%	$ 328,540	27
	Operating Margin %	3.88%	5.23%			2.21%	4.16%			3.1%	
28	**Non-Operating Revenue/Exp**	124,601	130,000	(5,399)	-4.15%	357,600	260,000	97,600	37.54%	266,371	28
29	**Net Income**	$ 349,581	$ 438,263	$ (88,682)	-20.23%	$ 605,200	$ 762,380	$ (157,180)	-20.62%	$ 594,911	29
	Unit Operating Income										
30	Hospital	354,143	496,017	(141,873)	-28.60%	726,439	989,816	(263,377)	-26.61%	695,031	30
31	Clinic Group	(30,902)	(128,109)	97,207	75.88%	(333,146)	(364,389)	31,244	8.57%	(263,860)	31
32	Home Care Grp	(23,743)	8,315	(32,058)	-385.53%	(66,125)	17,601	(83,726)	-475.69%	19,991	32
33	Hospitalist	(39,238)	(70,425)	31,187	44.28%	(49,128)	(145,140)	96,012	66.15%	(129,265)	33
34	Urgent Care	(35,281)	2,465	(37,746)	-1531.28%	(30,439)	4,492	(34,931)	-777.58%	6,642	34
35	Totals	$ 224,980	$ 308,263	$ (83,283)	-27.02%	$ 247,601	$ 502,380	$ (254,780)	-50.71%	$ 328,540	35

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Balance Sheet

February 2016

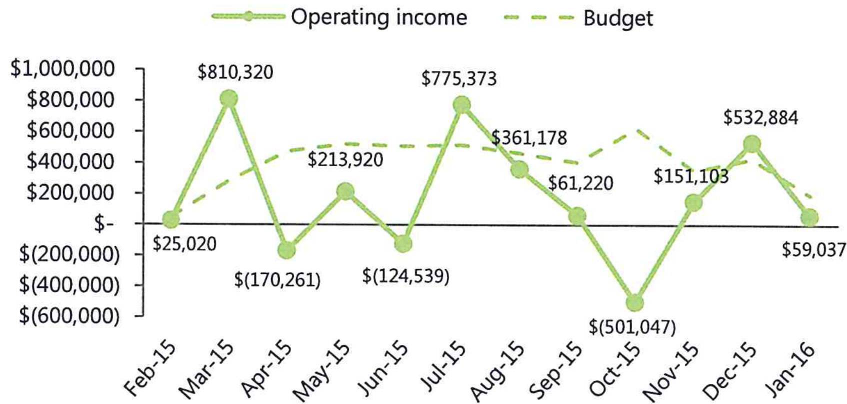
		Current Month	Prior Year End	Change	
	Current Assets:				
1	Cash	6,088,191	7,562,435	(1,474,245)	1
2	Patient Accounts Receivable	8,322,095	7,079,248	1,242,848	2
3	Other Receivable	210,029	106,463	103,566	3
4	Inventories	976,243	910,035	66,208	4
5	Prepaid Expenses and Deposits	628,690	579,944	48,746	5
6	**Total Current Assets**	**16,225,249**	**16,238,125**	**(12,877)**	**6**
	Assets Whose Use is Limited:				
7	Investments	25,395,740	25,253,677	142,063	7
8	**Total Assets Whose Use Is Limited**	**25,395,740**	**25,253,677**	**142,063**	**8**
	Property, Plant & Equipment:				
9	Property, Plant and Equipment	56,934,279	54,926,987	2,007,292	9
10	Less Accumulated Depreciation	33,295,751	32,843,586	452,165	10
11	**Net Property, Plant & Equipment**	**23,638,528**	**22,083,400**	**1,555,128**	**11**
	Other Assets				
12	Bond Issue Costs, Less Amortization	0	0	0	12
13	**Total Other Assets**	**0**	**0**	**0**	**13**
14	**Total Assets**	**65,259,517**	**63,575,203**	**1,684,314**	**14**
	Current Liabilities:				
15	Accounts Payable	2,609,827	1,720,776	889,050	15
16	Cost Reimbursement Payable	51,884	51,884	0	16
17	Accrued Salaries	840,305	603,984	236,320	17
18	Accrued Employee Benefits	425,689	674,274	(248,584)	18
19	Accrued Vacations	1,870,202	1,713,651	156,551	19
20	Current Maturities of Long-Term Debt	1,424,558	1,424,558	0	20
21	Current Maturities of Capital Leases	0	0	0	21
22	**Total Current Liabilities**	**7,222,464**	**6,189,127**	**1,033,337**	**22**
	Other Liabilities:				
23	Accrued Interest 2008 UTGO & 2009 LTGO B	83,123	27,708	55,415	23
24	2008 UTGO Refunding Bonds Premium	89,774	96,782	(7,008)	24
25	Deferred Revenue - Home Health	201	201	0	25
26	**Total Other Liabilities**	**173,099**	**124,692**	**48,407**	**26**
	Long-Term Debt & Capital Leases:				
27	Long-Term Debt - 2008 UTGO Bonds	2,260,442	2,260,442	0	27
28	Long-Term Debt - 2009 LTGO Bonds	3,397,887	3,397,887	0	28
29	Long-Term Debt - Energy Project	(0)	(0)	0	29
30	Long-Term Debt - Dell	(0)	(0)	0	30
31	Long-Term Debt - PACS System	9,213	11,844	(2,631)	31
32	**Total Long-Term Debt & Leases**	**5,667,542**	**5,670,173**	**(2,631)**	**32**
	Fund Balances:				
33	Equity - Hospital Operations	51,591,212	47,859,832	3,731,381	33
34	Income (Loss) Year-to-Date	605,200	3,731,381	(3,126,181)	34
35	**Total Fund Balance**	52,196,412	51,591,212	605,200	35
36	**Total Liabilities & Fund Balance**	65,259,517	63,575,203	1,684,314	36

Cash Flow
Year to Date, February 2016

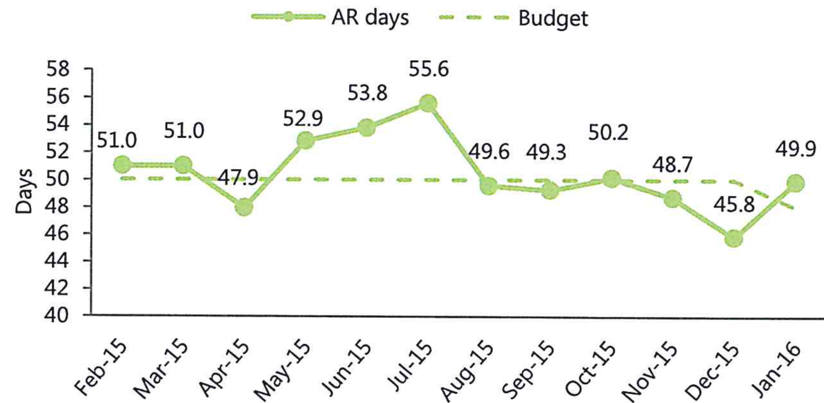
		Cash	Add	Subtract
1	**Net Book Income**	**605,200**	**605,200**	
	Add Back Non Cash Expenses			
2	Depreciation	452,165	452,165	
3	Provision For Bad Debt			
4	Loss on Sale of Assets			
5	**Net Cash From Operations**	**1,057,365**		
	Increase in Current Assets = ( )			
6	Patient Accounts & Other Receivables	(1,242,848)		(1,242,848)
7	Other Receivables	(103,566)		(103,566)
8	Inventories	(66,208)		(66,208)
9	Prepaid Expenses & Deposits	(48,746)		(48,746)
10	**Total Current Assets**	**(1,461,368)**		
11	Investments	**(142,063)**	0	(142,063)
	Purchase of Property, Plant & Equipment:	**(2,007,292)**		(2,007,292)
12	**Net Property, Plant & Equipment**	**(2,007,292)**		
13	Bond Issue Costs, Less Amortization	**0**		
14	**Total Assets**	**(2,553,358)**		
	Decrease in Current Liabilities: = ( )			
15	Accounts Payable	889,050	889,050	
16	Cost Reimbursement Payable	0		
17	Accrued Salaries	236,320	236,320	
18	Accrued Employee Benefits	(248,584)		(248,584)
19	Accrued Vacations	156,551	156,551	
21	Current Maturities of Long-Term Debt	0		
22	Current Maturities of Capital Leases	0		
23	**Total Current Liabilities**	**1,033,337**		
	Decrease in Other Liabilities:= ( )			
24	Accrued Interest on 1998, 1999 UTGO Bonds	55,415	55,415	
25	2008 UTGO Refunding Bonds Premium	(7,008)		(7,008)
26	Deferred Revenue - Home Health	0		
27	**Total Other Liabilities**	**48,407**		
	Decrease in LT Debt & Cap Leases:= ( )			
28	Long-Term Debt - 2008 UTGO Bonds	0		
29	Long-Term Debt - 2009 LTGO Bonds	0		
30	Long-Term Debt - Energy Project	0		
31	Long-Term Debt - Dell	0		
32	Long-Term Debt - PACS System	(2,631)		(2,631)
32	**Total Long-Term Debt & Leases**	**(2,631)**		
33	**Total Liabilities**	**1,079,114**		
34	**Net Change in Cash**	**(1,474,245)**	**2,394,701**	**(3,868,946)**
35	Beginning Cash On Hand	7,562,435		
36	**Ending Cash On Hand**	6,088,191		

Financial Stewardship

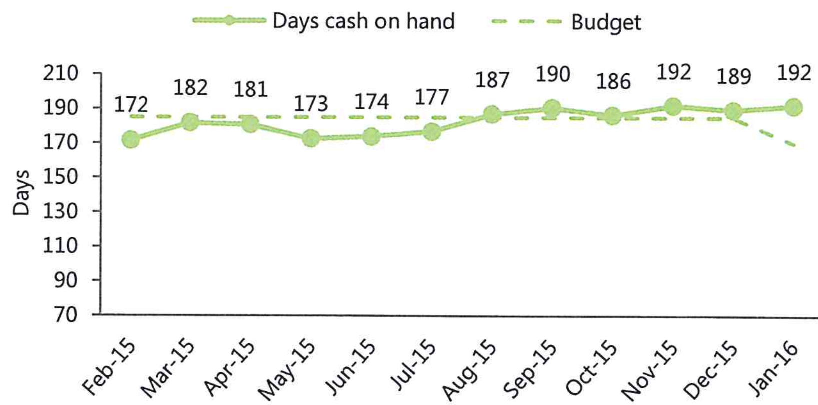
Operating income ↑



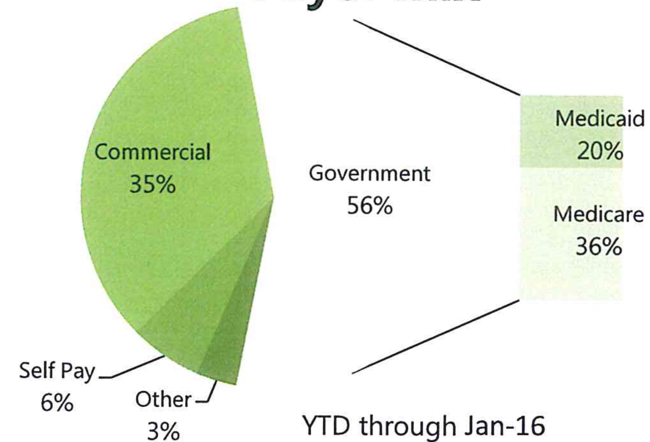
Accounts receivable days ↓



Days cash on hand ↑



Payer mix



Last updated 02/29/2016

KITTITAS VALLEY HEALTHCARE
Capital Expenditure Board Narrative

Requesting Department: Health Information Management (HIM)

Capital Item Requested: OneContent Implementation Services

Function of Equipment: Implementation services to assist in implementation of Clinical data repository electronic system that makes up the largest component of our legal medical records.

Reason Requested: The new repository system was approved by the Board in July 2015. After approval the vendor shared project plan for implementation and KVH does not have the IT resources required to dedicate to this project. We must implement the new repository as the current repository is running on Windows Server 2003 and Microsoft ended support for the system July 14, 2015. We are no longer receiving support and security updates which put us at risk.

Budget: $ none, we were not aware of the need until after the 2016 budget cycle.

Actual Cost:

Item	Cost
Pre-project work	$11,136
Project Management	$34,452
Regression Testing	$15,660
Integrated Testing	$13,920
Go Live Support	$13,920
Est. Tax	$ 7,127
Total	$96,215

To be paid from operations

Submitted By: Patty Kettenton
Director, Health Information Management
and Jim Roberts, Director Information Technology

Date: 03/07/2016

KITTITAS VALLEY HEALTHCARE
Capital Expenditure Board Narrative

Requesting Department: Surgical Outpatient/Engineering

Capital Item Requested: Engineering design fee for converting Endoscopy Room 1 to a dual purpose Endoscopy and Bronchoscopy room.

Function of Equipment: Room designed to accommodate both Endoscopy and Bronchoscopy procedures

Reason Requested: Allow for development of engineering design for a planned space designated to dual services use for bronchoscopy and gastrointestinal endoscopy.

Budget: $ none

Actual Cost: $20,962.80

To be paid from operations

Submitted By: Randy Kaiser
Director, Engineering

Date: 03/01/2016

KITTITAS VALLEY HEALTHCARE
Capital Expenditure Board Narrative

Requesting Department: Cardiopulmonary

Capital Item Requested: Four V-60 BiPAP Non-Invasive Ventilators

Function of Equipment: The ventilators reduce the work of breathing.

Reason Requested: Parts are no longer available to service the current units. SHMC Bio-Med advised that the current unit's blower motors are on their "last leg" and support is no longer available from vendor.

Budget: $ 55,343

Actual Cost: $54,264.16

To be funded from operations

Submitted By: Jim Allen
Director, Cardiopulmonary Services

Date: 03/31/2016

KITTITAS VALLEY HEALTHCARE
Resolution No. 16-02
Resolution Authorizing the following Amendment

WHEREAS, Public Hospital District No. 1, Kittitas County, State of Washington, dba Kittitas Valley Healthcare (formerly known as Kittitas Valley Community Hospital) (hereinafter, the "Employer"), previously established the Kittitas Valley Healthcare Employees' Pension Plan (formerly known as Kittitas Valley Community Hospital Pension Plan) (hereinafter, the "Plan") for the exclusive benefit of its employees and their beneficiaries, which Plan was originally effective as of July 1, 2004; and

WHEREAS, the Employer retained the power to amend and/or terminate the Plan; and

WHEREAS, the Employer now desires to amend and restate the Plan by adopting the VALIC Retirement Services Company Retirement Plan for Governmental Employers document; and

NOW, THEREFORE, BE IT RESOLVED that the Employer hereby amends and restates that Plan, effective January 1, 2016, by adopting the document titled "VALIC Retirement Services Company Retirement Plan for Governmental Employers," in the form and substance as the document heretofore presented to the governing body of the Employee; and

RESOLVED FURTHER that the appropriate representatives of the Employer be, and the same hereby are, authorized and directed to: (i) execute the adoption agreement to the VALIC Retirement Services Company Retirement Plan for Governmental Employers document as approved; (ii) execute all other documents and to do all other things as may be necessary or appropriate to make the VALIC Retirement Services Company Retirement Plan for Governmental Employers document effective January 1, 2016, including the execution of any amendments required by the Internal Revenue Service in order to continue and maintain the qualified and exempt status of the Plan; and (iii) execute any other documents required to obtain reliance on advisory letters issued to the VALIC Retirement Services Company Retirement Plan for Governmental Employers by the Internal Revenue Service.

CERTIFICATION

I, Bob Davis, do hereby certify that the above resolutions were unanimously adopted by the governing body of the Employer at a meeting duly held at Ellensburg Washington, on the 31st day of March 2016.

____
Bob Davis, Secretary
Board of Commissioners
Date:__________________________

KITTITAS VALLEY HEALTHCARE
Resolution No. 16-03
Resolution Authorizing the following Amendment

WHEREAS, Public Hospital District No. 1, Kittitas County, State of Washington, dba Kittitas Valley Healthcare (formerly known as Kittitas Valley Community Hospital) (hereinafter, the "Employer"), previously established the Kittitas Valley Healthcare Physician Pension Plan (formerly known as Kittitas Valley Community Hospital Pension Plan) (hereinafter, the "Plan") for the exclusive benefit of its employees and their beneficiaries, which Plan was originally effective as of July 1, 2002; and

WHEREAS, the Employer retained the power to amend and/or terminate the Plan; and

WHEREAS, the Employer now desires to amend and restate the Plan by adopting the VALIC Retirement Services Company Retirement Plan for Governmental Employers document; and

NOW, THEREFORE, BE IT RESOLVED that the Employer hereby amends and restates that Plan, effective January 1, 2016, by adopting the document titled "VALIC Retirement Services Company Retirement Plan for Governmental Employers," in the form and substance as the document heretofore presented to the governing body of the Employee; and

RESOLVED FURTHER that the appropriate representatives of the Employer be, and the same hereby are, authorized and directed to: (i) execute the adoption agreement to the VALIC Retirement Services Company Retirement Plan for Governmental Employers document as approved; (ii) execute all other documents and to do all other things as may be necessary or appropriate to make the VALIC Retirement Services Company Retirement Plan for Governmental Employers document effective January 1, 2016, including the execution of any amendments required by the Internal Revenue Service in order to continue and maintain the qualified and exempt status of the Plan; and (iii) execute any other documents required to obtain reliance on advisory letters issued to the VALIC Retirement Services Company Retirement Plan for Governmental Employers by the Internal Revenue Service.

CERTIFICATION

I, Bob Davis, do hereby certify that the above resolutions were unanimously adopted by the governing body of the Employer at a meeting duly held at Ellensburg Washington, on the 31st day of March 2016.

____
Bob Davis, Secretary
Board of Commissioners
Date:__________________________

RESOLUTION No. 16-04
RESOLUTION AUTHORIZING INDIVIDUALS
TO ACT ON BEHALF OF PLAN

WHEREAS, Kittitas Valley Healthcare (hereinafter, the "Employer") established Kittitas Valley Healthcare Employees' Pension Plan for the benefit of its employees and their beneficiaries;

WHEREAS, Employer is establishing or has established a Trust account for which AIG Federal Savings Bank serves as Trustee; and

WHEREAS, the Employer desires to authorize individuals holding certain positions with the Employer to act on behalf of the Plan;

NOW, THEREFORE, BE IT RESOLVED that the fullest authority has been invested in any individual (each an "Incumbent") holding a position identified below according to the title of the position (each a "Designated Position") for the duration of the period (the "Incumbency Period") in which such Incumbent holds the Designated Position; that each Incumbent is empowered during his or her Incumbency Period to execute any documents that AIG Federal Savings Bank requires relevant to the opening or maintaining of an account for the Plan; and that each Incumbent is empowered during his or her Incumbency Period to take any and all action deemed by any Incumbent to be proper in connection with said account, including, but not limited to, being empowered to give written or oral instructions to AIG Federal Savings Bank with respect to account transactions.

Chief Executive Officer
Designated Position

Paul Nurick
Current Incumbent Name (Print)

____
Current Incumbent Signature

Chief Operating Officer
Designated Position

Catherine Bambrick
Current Incumbent Name (Print)

____
Current Incumbent Signature

Chief Financial Officer
Designated Position

Elizabeth Allgood
Current Incumbent Name (Print)

____
Current Incumbent Signature

President, Board of Commissioners
Designated Position

Liahna Armstrong
Current Incumbent Name (Print)

____
Current Incumbent Signature

BE IT FURTHER RESOLVED that the responsibility and authority to take whatever actions and to execute whatever instruments that may be necessary or convenient for the day-to-day transactions and plan operations is granted to the person or persons in the positions identified below:

Human Resources Business Partner
Designated Position

Marlo Willis
Current Incumbent Name (Print)

____
Current Incumbent Signature

Director, Human Resources
Designated Position

Carrie Youngblood
Current Incumbent Name (Print)

____
Current Incumbent Signature

HR Benefits & Wellness Coordinator
Designated Position

Brandis Van Iterson
Current Incumbent Name (Print)

____
Current Incumbent Signature

____
Designated Position

____
Current Incumbent Name (Print)

____
Current Incumbent Signature

I, Bob Davis, do hereby certify that the above and foregoing was unanimously adopted by the Board of Directors at their meeting held at Ellensburg, Washington on the 31st day of March in the year 2016.

____
Bob Davis, Secretary, Board of Commissioners

ATTEST:

____
Witness

RESOLUTION No. 16-05
RESOLUTION AUTHORIZING INDIVIDUALS
TO ACT ON BEHALF OF PLAN

WHEREAS, Kittitas Valley Healthcare (hereinafter, the "Employer") established Kittitas Valley Healthcare Physician Pension Plan for the benefit of its employees and their beneficiaries;

WHEREAS, Employer is establishing or has established a Trust account for which AIG Federal Savings Bank serves as Trustee; and

WHEREAS, the Employer desires to authorize individuals holding certain positions with the Employer to act on behalf of the Plan;

NOW, THEREFORE, BE IT RESOLVED that the fullest authority has been invested in any individual (each an "Incumbent") holding a position identified below according to the title of the position (each a "Designated Position") for the duration of the period (the "Incumbency Period") in which such Incumbent holds the Designated Position; that each Incumbent is empowered during his or her Incumbency Period to execute any documents that AIG Federal Savings Bank requires relevant to the opening or maintaining of an account for the Plan; and that each Incumbent is empowered during his or her Incumbency Period to take any and all action deemed by any Incumbent to be proper in connection with said account, including, but not limited to, being empowered to give written or oral instructions to AIG Federal Savings Bank with respect to account transactions.

Chief Executive Officer
Designated Position

Paul Nurick
Current Incumbent Name (Print)

____
Current Incumbent Signature

Chief Operating Officer
Designated Position

Catherine Bambrick
Current Incumbent Name (Print)

____
Current Incumbent Signature

Chief Financial Officer
Designated Position

Elizabeth Allgood
Current Incumbent Name (Print)

____
Current Incumbent Signature

President, Board of Commissioners
Designated Position

Liahna Armstrong
Current Incumbent Name (Print)

____
Current Incumbent Signature

24d

BE IT FURTHER RESOLVED that the responsibility and authority to take whatever actions and to execute whatever instruments that may be necessary or convenient for the day-to-day transactions and plan operations is granted to the person or persons in the positions identified below:

Human Resources Business Partner
Designated Position

Marlo Willis
Current Incumbent Name (Print)

____
Current Incumbent Signature

Director, Human Resources
Designated Position

Carrie Youngblood
Current Incumbent Name (Print)

____
Current Incumbent Signature

HR Benefits & Wellness Coordinator
Designated Position

Brandis Van Iterson
Current Incumbent Name (Print)

____
Current Incumbent Signature

____
Designated Position

____
Current Incumbent Name (Print)

____
Current Incumbent Signature

I, Bob Davis, do hereby certify that the above and foregoing was unanimously adopted by the Board of Directors at their meeting held at Ellensburg, Washington on the 31st day of March in the year 2016.

____
Bob Davis, Secretary, Board of Commissioners

ATTEST:

____
Witness

RESOLUTION NO. 16-06
RESOLUTION AUTHORIZING INDIVIDUALS
TO ACT ON BEHALF OF PLAN

WHEREAS, Kittitas Valley Healthcare (hereinafter, the "Employer") established Kittitas Valley Healthcare Deferred Compensation Savings Plan for the benefit of its employees and their beneficiaries;

WHEREAS, Employer is establishing or has established a Custodial account for which AIG Federal Savings Bank serves as Custodian; and

WHEREAS, the Employer desires to authorize individuals holding certain positions with the Employer to act on behalf of the Plan;

NOW, THEREFORE, BE IT RESOLVED that the fullest authority has been invested in any individual (each an "Incumbent") holding a position identified below according to the title of the position (each a "Designated Position") for the duration of the period (the "Incumbency Period") in which such Incumbent holds the Designated Position; that each Incumbent is empowered during his or her Incumbency Period to execute any documents that AIG Federal Savings Bank requires relevant to the opening or maintaining of an account for the Plan; and that each Incumbent is empowered during his or her Incumbency Period to take any and all action deemed by any Incumbent to be proper in connection with said account, including, but not limited to, being empowered to give written or oral instructions to AIG Federal Savings Bank with respect to account transactions.

Chief Executive Officer
Designated Position

Paul Nurick
Current Incumbent Name (Print)

____
Current Incumbent Signature

Chief Operating Officer
Designated Position

Catherine Bambrick
Current Incumbent Name (Print)

____
Current Incumbent Signature

Chief Financial Officer
Designated Position

Elizabeth Allgood
Current Incumbent Name (Print)

____
Current Incumbent Signature

President, Board of Commissioners
Designated Position

Liahna Armstrong
Current Incumbent Name (Print)

____
Current Incumbent Signature

BE IT FURTHER RESOLVED that the responsibility and authority to take whatever actions and to execute whatever instruments that may be necessary or convenient for the day-to-day transactions and plan operations is granted to the person or persons in the positions identified below:

Human Resources Business Partner
Designated Position

Marlo Willis
Current Incumbent Name (Print)

____
Current Incumbent Signature

Director, Human Resources
Designated Position

Carrie Youngblood
Current Incumbent Name (Print)

____
Current Incumbent Signature

HR Benefits & Wellness Coordinator
Designated Position

Brandis Van Iterson
Current Incumbent Name (Print)

____
Current Incumbent Signature

____
Designated Position

____
Current Incumbent Name (Print)

____
Current Incumbent Signature

I, Bob Davis, do hereby certify that the above and foregoing was unanimously adopted by the Board of Directors at their meeting held at Ellensburg, Washington on the 31st day of March in the year 2016.

____
Bob Davis, Secretary, Board of Commissioners

ATTEST:

____
Witness

Washington State Hospital Association

2016 CEO and Trustee Patient Safety Summit

(With Medical Staff Leadership)

Governance:
Achieving High-Value Health Care

May 16 and 17, 2016 (repeated sessions)
9:00 a.m. – 2:30 p.m. | SeaTac Marriott

AGENDA

9:00 a.m. **Welcome and Patient Story**

Carol Wagner, RN, Senior Vice President Patient Safety at the Washington State Hospital Association will welcome the group. A patient story will set the tone with emphasis on how to utilize patient and family engagement in your health system. Information on advancing quality will be included in the discussion.

10:00 a.m. **Break**

10:15 a.m. **Leading for the Future: Quality and Safety for Boards** — **James Reinertsen**

James Reinertsen, MD, national expert on boards and physician leadership, will discuss how to take your quality agenda to the next level. He will share best practices for boards, providing case studies on working with physicians and illustrating concepts associated with reliability. He will lead your board and physicians through a hot-off-the-press discussion to help you advance your work in quality, safety and delivery of care for the future.

12:30 p.m. **Lunch**

1:15 p.m. **Messages from Healthcare Leadership** — **Scott Bond**

1:30 p.m. **High Performing Boards: Best Practices**

This session will provide specific examples of how boards are helping to lead their organizations. Tangible strategies will be outlined along with discussion on how this aligns with business and community needs, positioning for the future. Discussion will include:

- Board's role
- Improving quality and safety in times of challenge
- How to enhance performance
- Understanding goal-setting, improvement, sustainability
- Examples from hospitals and health systems on how they have used these concepts

2:25 p.m. **Summary and Next Steps**

2:30 p.m. **Adjourn**

3:00 – 4:00 **Optional Board Planning Time**

Boards are welcome to stay and discuss how they can use the tools and concepts presented today.

25

Board Evaluation Results

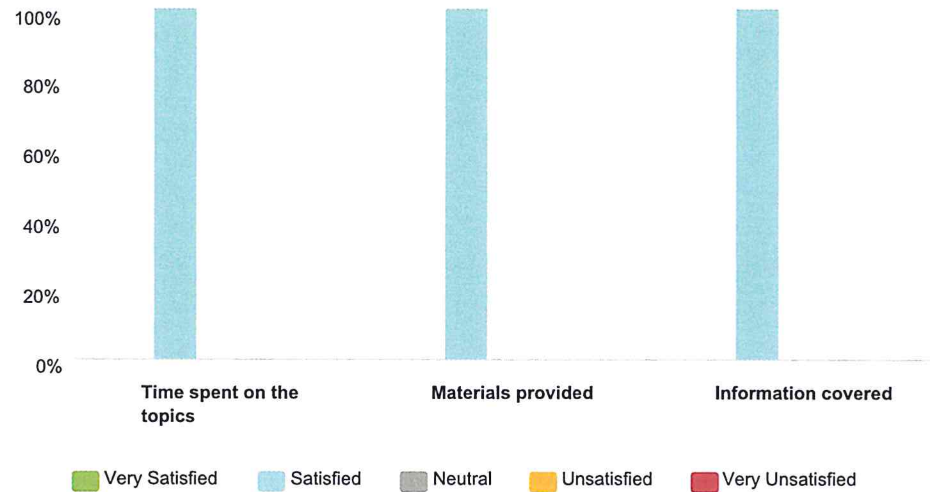
Results from February 2016 meeting

Includes board responses to a survey specific to the last meeting and dashboards displaying data for the past 12 months.

All questions apply to the most recent board meeting.

Q1 How satisfied are you with the QUALITY agenda items covered?

Answered: 1 Skipped: 0



	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1
Materials provided	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1
Information covered	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1

#	Comments (please specify):	Date
	There are no responses.	

All questions apply to the most recent board meeting.

Q2 How satisfied are you with the EMERGING HEALTHCARE ISSUES agenda items covered?

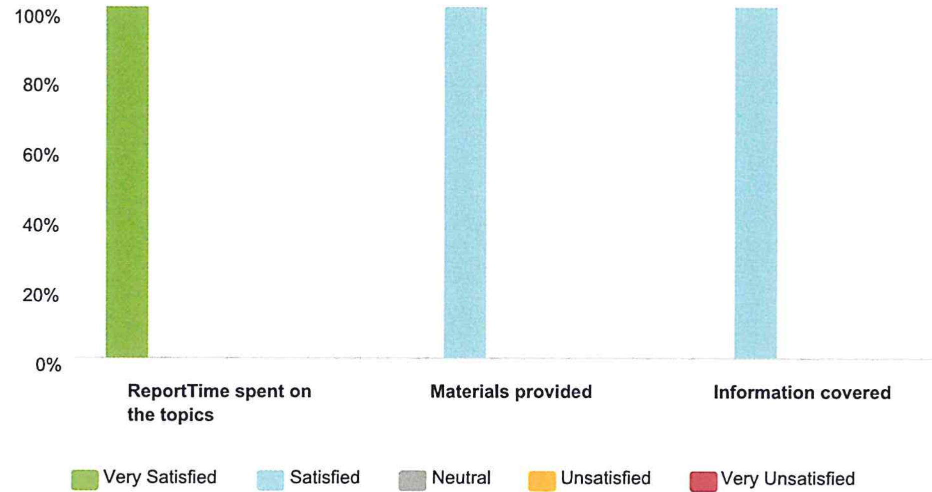
Answered: 0 Skipped: 1

! No matching responses.

	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	0
Materials provided	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	0
Information covered	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	0

#	Comments (please specify):	Date
1	not on the agenda	2/25/2016 7:06 PM

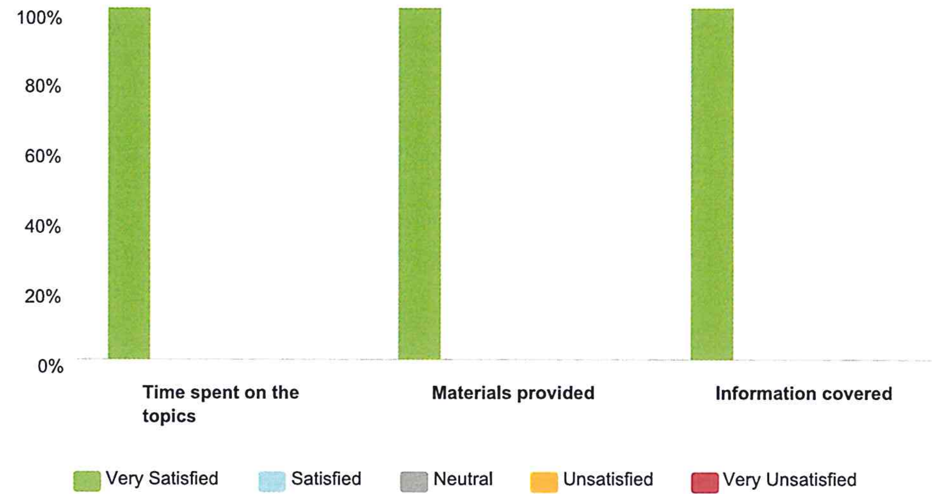
All questions apply to the most recent board meeting.



	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
ReportTime spent on the topics	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	1
Materials provided	**0.00%** 0	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	1
Information covered	**0.00%** 0	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	1

#	Comments (please specify):	Date
	There are no responses.	

All questions apply to the most recent board meeting.



	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	1
Materials provided	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	1
Information covered	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	1

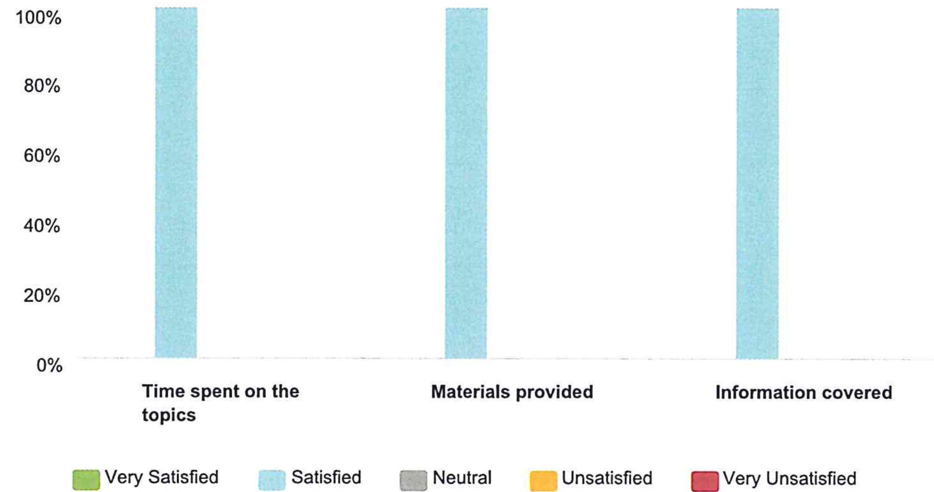
#	Comments (please specify):	Date
	There are no responses.	

30

All questions apply to the most recent board meeting.

Q5 How satisfied are you with the PUBLIC POLICY agenda items covered?

Answered: 1 Skipped: 0



	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	**0.00%** 0	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	1
Materials provided	**0.00%** 0	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	1
Information covered	**0.00%** 0	**100.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	1

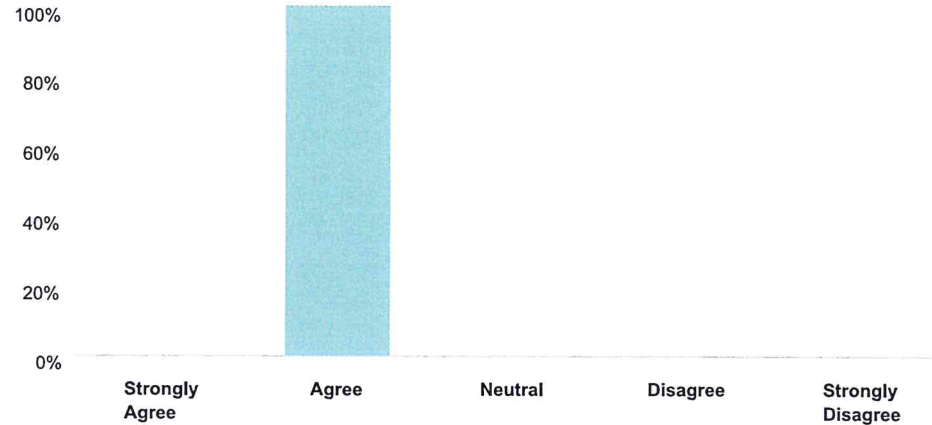
#	Comments (please specify):	Date
	There are no responses.	

31

All questions apply to the most recent board meeting.

Q6 The format and content of the CONSENT AND REPORT agenda packet documents were sufficient enough to support decision making.

Answered: 1 Skipped: 0



Answer Choices	Responses	
Strongly Agree	0.00%	0
Agree	100.00%	1
Neutral	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		**1**

#	Comments (please specify):	Date
	There are no responses.	

32

All questions apply to the most recent board meeting.

Q7 The EMERGING HEALTHCARE ISSUES presentation format supported active board involvement in the discussion.

Answered: 0   Skipped: 1

! No matching responses.

Answer Choices	Responses	
Strongly Agree	0.00%	0
Agree	0.00%	0
Neutral	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		**0**

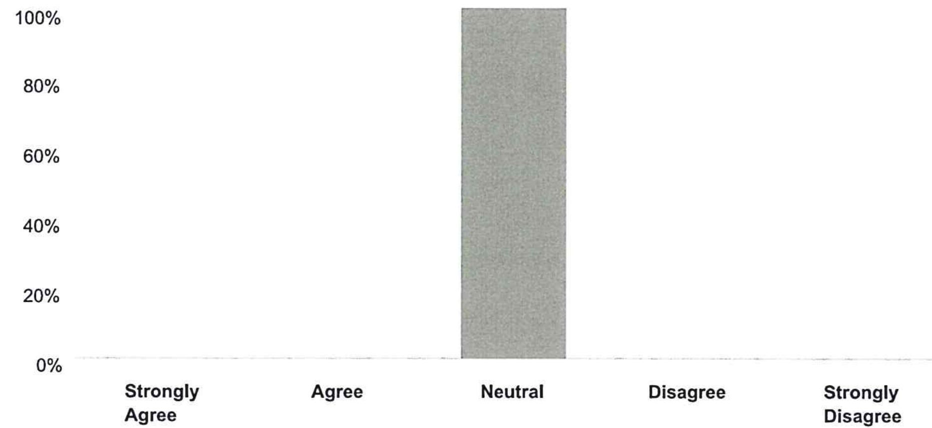
#	Comments (please specify):	Date
	There are no responses.	

33

All questions apply to the most recent board meeting.

Q8 Information presented during the meeting was sufficient to enable decision making.

Answered: 1 Skipped: 0



Answer Choices	Responses	
Strongly Agree	0.00%	0
Agree	0.00%	0
Neutral	100.00%	1
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		**1**

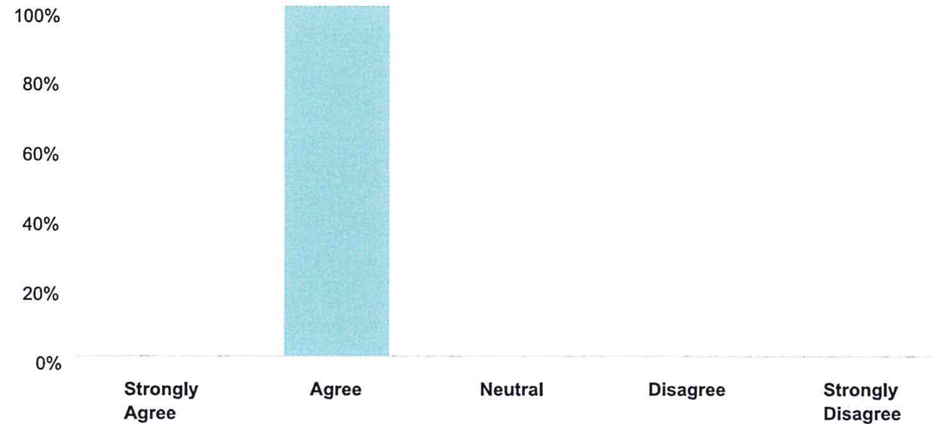
#	Comments (please specify):	Date
	There are no responses.	

34

All questions apply to the most recent board meeting.

Q9 This most recent board meeting met our goal regarding the amount of time spent in discussion vs. reporting: 80% discussion vs 20% reporting.

Answered: 1 Skipped: 0



Answer Choices	Responses	
Strongly Agree	0.00%	0
Agree	100.00%	1
Neutral	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		**1**

#	Comments (please specify):	Date
	There are no responses.	

35

All questions apply to the most recent board meeting.

Q10 Please indicate additional topics for future EMERGING HEALTHCARE ISSUES.

Answered: 0 Skipped: 1

#	Responses	Date
	There are no responses.	

36

All questions apply to the most recent board meeting.

Q11 Additional comments concerning the meeting:

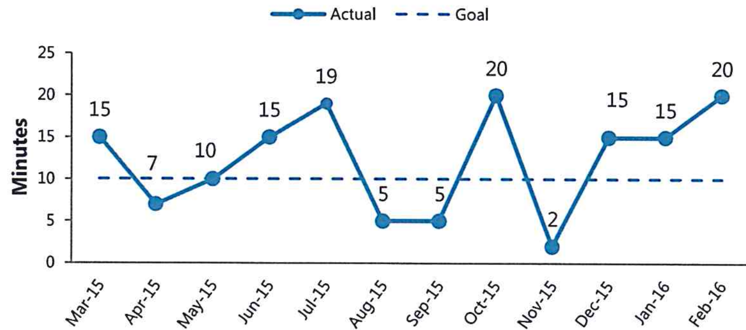
Answered: 0 Skipped: 1

#	Responses	Date
	There are no responses.	

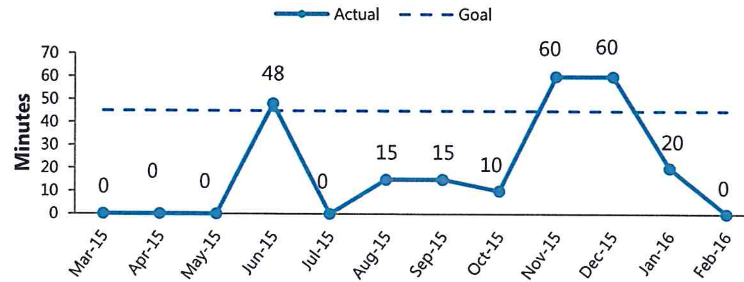
37

Board Meeting Dashboard

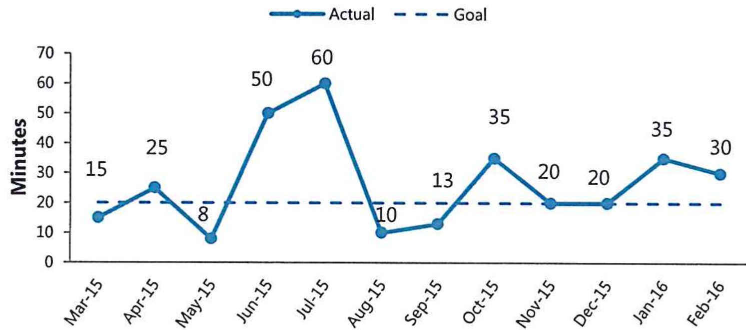
Time spent on financials



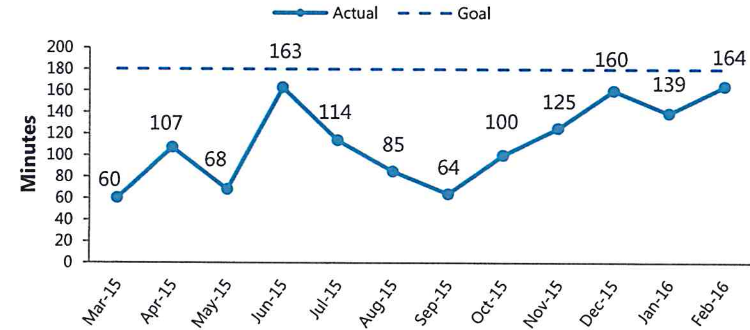
Time spent on emerging health care issues



Time spent on CEO report

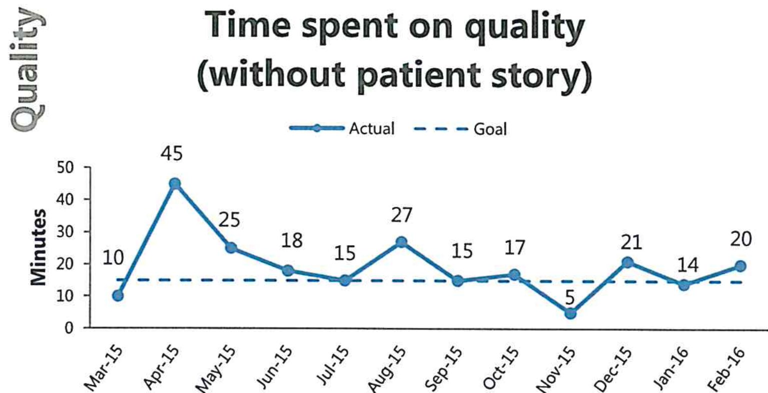


Total meeting time

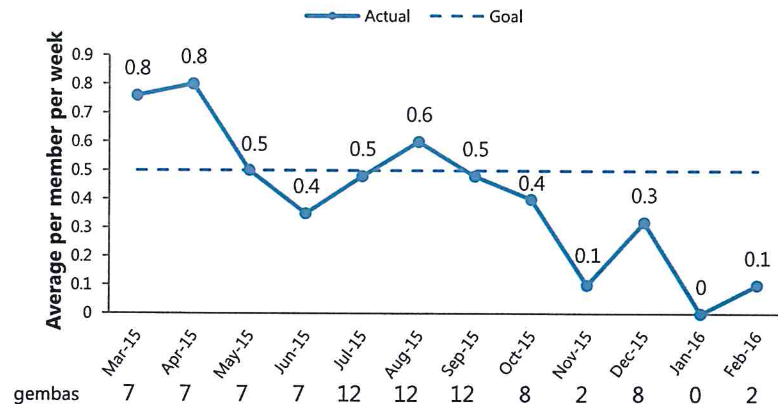


Quality

Time spent on quality (without patient story)



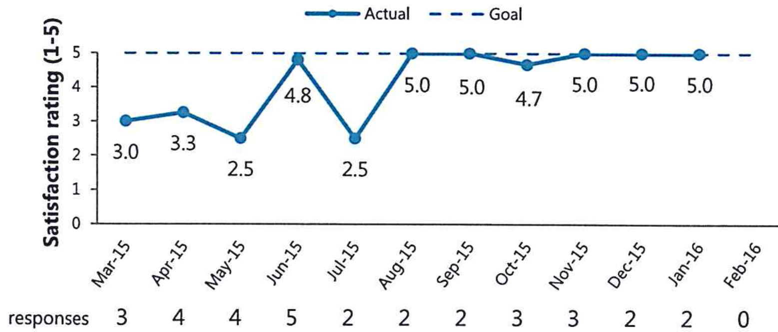
Gemba walks by Board members



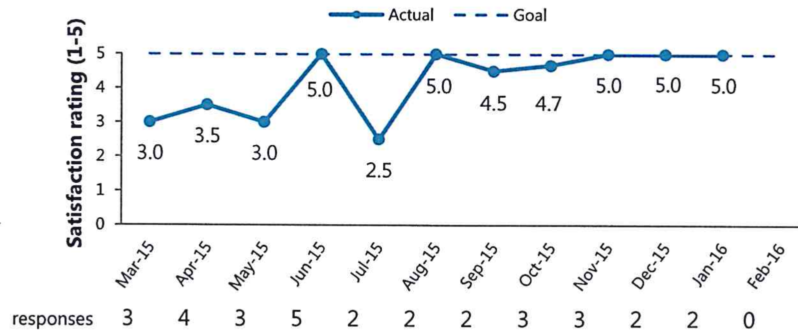
Last updated 03/21/2016

Board Meeting Dashboard

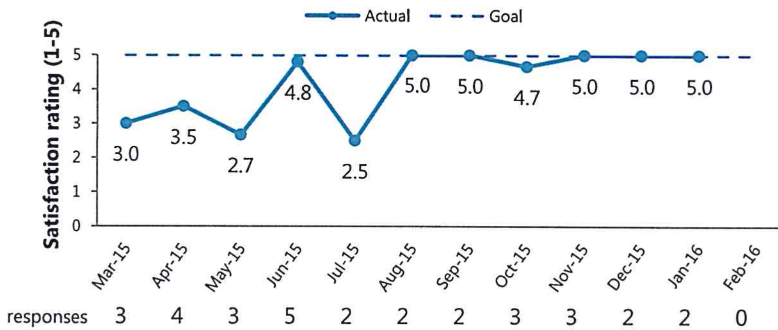
Satisfaction with time spent on emerging health care issues



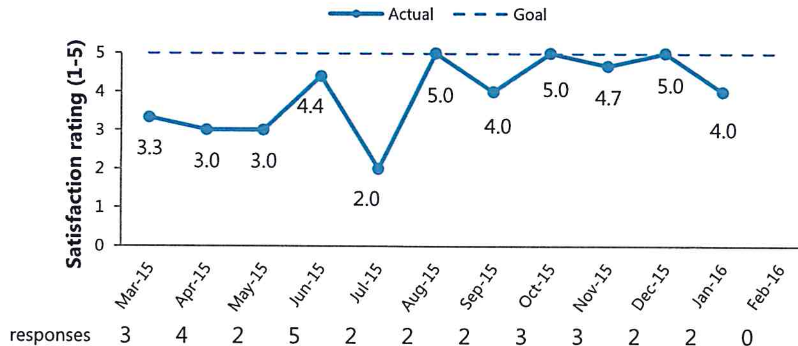
Satisfaction with materials provided for emerging health care issues



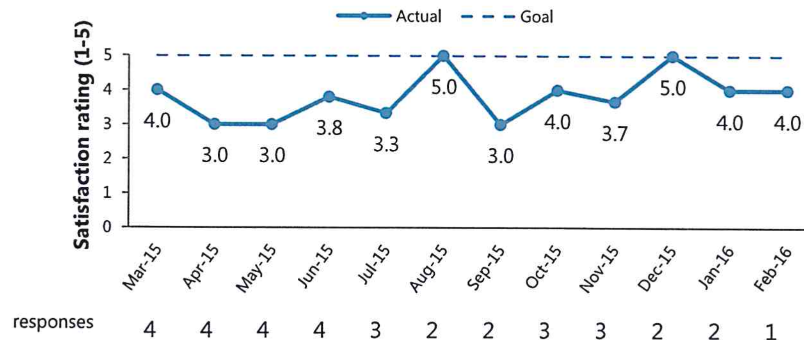
Satisfaction with information covered for emerging health care



Emerging health care issues presentation format promotes board involvement in discussion



Belief that board met goal of 80% discussion, 20% reporting



Last updated 03/21/2016

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Daily Record, page A1, 2/24/16

KVH plans to launch virtual care

Patients with minor illnesses will be able to visit a provider online

By JESSE MAJOR staff writer

Kittitas Valley Healthcare is preparing to launch a new service that would allow patients to visit a doctor from anywhere at anytime.

KVH Virtual Care will allow patients with minor illnesses to receive care via a computer or mobile device.

"This will allow them, if they have a concern late at night or early in the morning, to have a face-to-face with a provider," said Rhonda Holden, administrator of patient care services.

Virtual care could be introduced as early as April. Patients can access it through a web browser or through an app on their phone or tablet.

She said those likely to benefit most are people who live in the Upper County, where there aren't as many medical services.

Once KVH Urgent Care - Cle Elum closes at 11 p.m., residents in the Upper County don't have access to a health care provider until the following morning, she said.

Currently, those who need to see a doctor late at night or early in the morning have to visit the Emergency Department in Ellensburg or call 911. Ellensburg doesn't have a urgent care center.

Holden suspects that some people might use virtual care in lieu of making a trip to see a doctor in person.

Keep patients out of ER

Holden said the new program will help keep people who don't have emergencies out of the Emergency Department. Virtual care isn't intended to replace a patient's relationship with their primary care provider.

It functions similarly to an urgent care facility.

Appointments aren't needed and most patients will be seen within 30 minutes of their request.

Some common conditions that can generally be treated via virtual care include cold or flu symptoms, sore throat, headache, pink eye, cold sores, rashes and urinary tract infections.

The providers can write prescriptions if needed.

The company that provides the services is conservative when it comes to writing prescriptions. The company also monitors prescriptions and is careful about antibiotic prescriptions, which is one reason KVH chose the company, Holden said.

Daily Record, page A1, 2/24/16

Providers contracted

Patients using virtual care will talk to a provider contracted through the company, and can have a summary of the virtual visit sent to their regular KVH providers.

Once virtual care is rolled out, providers at KVH will have the option to see patients through the program, but that's farther down the road, she said.

Providing virtual care has been in the works already for about six months, she said.

KVH heard from focus groups last year they wanted different ways to access care.

Virtual care then became a priority.

Services like virtual care are already common throughout the West Side, she said.

The KVH service will cost $40 per visit. Commercial insurance is not accepted for virtual visits. In Washington, people covered by a government sponsored insurance plan, such as Medicare, Medicare Advantage, Medicare or Tricare, are not eligible to receive virtual care.

Daily Record editorial, 2/25/16

Follow up: Pay attention to KVH board

During the last election cycle the races for the Kittitas County Hospital District 1 (Kittitas Valley Healthcare) board of commissioner races drew the most interest from candidates and the general public.

The election resulted in three new members joining the board — Matthew Altman, Bob Davis and Erica Libenow.

It's tempting to think the public's responsibility ended with the election. The real work actually lies ahead — following and participating in KVH board meetings and activities.

A good first step will be to attend a meet and greet with the new KVH commissioners from 3:30 to 4:30 p.m. today at the KVH Hospital. Light refreshments will be provided. That forum is followed by the KVH board meeting at 4:30 p.m.

The fact is we (including the Daily Record) were all to blame for not following the workings and proceedings of the KVH board closely over the past 10 to 15 years. That's not a knock on the KVH board or an implication that they were doing something wrong. It was just that when an issue surfaced — termination of physician contracts — there was not a base of understanding for how the board functioned.

The campaigns served a purpose of generating a public discussion of the role and purpose of the KVH board. To be blunt, KVH meetings can be difficult to follow. Medical jargon is almost a second language. There is more specialized knowledge on tap at a hospital board meeting than a city council meeting.

That is a challenge, but it is one worth tackling given the importance of medical care to the community.

The hospital has always played a vital role, but in the contemporary model where the hospital also employs most of the physicians in the community that role becomes even more crucial. It dramatically increases our personal involvement with KVH management strategies and philosophy.

One of the first roadblocks to public involvement in KVH board meetings is the time of the meetings — 4:30 p.m. The start time and the location of the meeting is to allow staff to attend and timed around shift changes.

That's an important point, but the first and main group an elected board needs to consider is the public that elects the board. The meetings need to cater to the public and maximize its ability to attend meetings.

Daily Record editorial, 2/25/16

Would there be more public involvement in board meetings if they started at 7 p.m.? The board probably needs to test that out.

People are interested in local health care. KVH is the primary provider of local health care. Find time in your schedule to attend the meet and greet and/or a board meeting and express how you feel the board can best be accessible to the public.

Daily Record, page A3, 2/26/16

Hospital board approves video expense

Commissioners debate whether public can broadcast meetings

By JOANNA MARKELL managing editor

The Kittitas County Hospital Board District 1 voted Thursday to spend $22,000 to install equipment to record its meetings on video, and will experiment with the start time of its meetings to encourage more public participation.

Hospital commissioners said the changes are intended to increase transparency. They also debated whether members of the public can broadcast their discussions.

The board voted 4-0 to move ahead with a plan to install mobile cameras at KVH Hospital to record hospital board meetings. The meetings won't be broadcast live, but would be posted online for viewing later. The cameras also can be used for other hospital needs, staff said.

Board President Liahna Armstrong said the move was a commitment to transparency, and would provide an official record that would be more substantive than written minutes. Anyone who wants more information about a particular topic will be able go back and watch meetings, she said.

Some board members and staff voiced discomfort, however, when the Daily Record broadcast a short segment of the discussion live on Periscope. Periscope is a mobile app that allows anyone to broadcast video on the Internet using a mobile device. It also allows viewers to submit questions and make comments.

KVH is a public hospital, and its board meetings are covered by the Washington Open Public Meetings Act. Anyone can record a public meeting on audio or video provided it does not disrupt the meeting, according to the state Attorney General's office.

Hospital COO Cathy Bambrick said the issue was a matter of respect.

"People need to know it's happening," she said. "If it's streaming live, I'd like to know it's being taped."

Hospital commissioner Erica Libenow said the board should always operate under the assumption it is being recorded.

Armstrong said it did raise the issue of why the board would spend $20,000 on a recording system if anyone could broadcast the meeting from their smartphone.

Hospital commissioner Matthew Altman introduced a motion to give anyone permission to tape board meetings until the new system is installed. The motion passed with him and Libenow voting yes, and Armstrong and Pam Wilson abstaining. Wilson said she needed more information to make an informed decision. Board member Bob Davis was absent.

Hospital CEO Paul Nurick said he could seek a legal opinion on the issue.

Daily Record, page A3, 2/26/16

Meeting times

The board also agreed to experiment with the start time of meetings to encourage more public participation.

Board meetings start at 4:30 p.m. at KVH, a time that was selected so hospital staff can attend. Altman suggested a couple of alternatives, including starting the board's closed-door executive sessions at 4:30 then going into open session at 5:30 p.m.

Wilson said a start time at 7:30 p.m. would be an issue if meetings lasted until 1 a.m. Sometimes executive sessions are 10 minutes and sometimes they last two hours or more, she added.

Armstrong said participation of hospital staff is important. She suggested moving public comment to 6 p.m.

The board agreed to experiment with a 5 p.m. start time with public comment at 6. Executive sessions would remain at the end of the meeting.

The board also discussed ways to make background material given to board members for the meetings available to the public. Board members receive sizable digital packets of information that contain financial reports, metrics on hospital operations, articles about the health care industry and other updates.

Daily Record, page A1, 3/9/16

KVH board gives nod to new building

Plans will come back for more review, public meeting planned

By JESSE MAJOR staff writer

Kittitas Valley Healthcare commissioners gave a thumbs up to begin immediate in-depth planning for a new medical office building on Monday.

If the Hospital District 1 board approves the plans later this year, a fully functioning medical office building could be finished as early as mid-2018.

It is the first of two phases in the master site facility plan for the future of the KVH campus the board also approved Monday.

Hospital CEO Paul Nurick emphasized during the board's special meeting Monday that the two phases are independent from each other and that phase two won't necessarily happen simply because phase one was approved.

The new outpatient building would have 40 exam rooms and comes with a price tag of about $17 million.

The first phase of the plan also includes a new electronic health care records system, which would replace the four that are being used now throughout KVH. The cost of a new building and the electronic health system upgrade would be $25 million.

KVH plans to foot the bill for phase one itself and does not plan to ask taxpayers for help.

A decision on exactly how KVH will finance the project won't come until after a decision to build, though the board discussed four options Monday.

Changing medicine

Designers and hospital administrators said Monday the new building would be a significant improvement to current outpatient services and allows for more flexibility.

The board was told that this design would allow for doctors and staff to be more efficient and would cater to how medicine is changing.

Chief Operating Officer Cathy Bambrick told the board the new building would allow for telemedicine, which would help keep patients at home instead of on campus.

"The brick and mortar model is going away," she said.

The building would be designed in a way that would be familiar to younger doctors recently out of medical school, but might be unfamiliar to those who have been practicing for years.

The design of the building, which is currently planned to be only one story, would allow for a second story to be built if needed. The plan also calls for more parking on the KVH campus.

Daily Record, page A1, 3/9/16

Across Spokane Street

The plan to build across Spokane Street has caught the attention of neighborhood residents.

Hospital staff and board members looked at a variety of options for the KVH campus, and concluded growth to the south — toward Mountain View Avenue — made the most sense.

Tom Stoffle would live directly across the street from the new building and the parking lot that comes with it.

The plan as presented to the board calls for closing a portion of Spokane Street and building on eight properties owned by KVH.

KVH does not own three properties directly east of the planned outpatient building, but there was discussion Monday about moving the outpatient building east if those could be acquired.

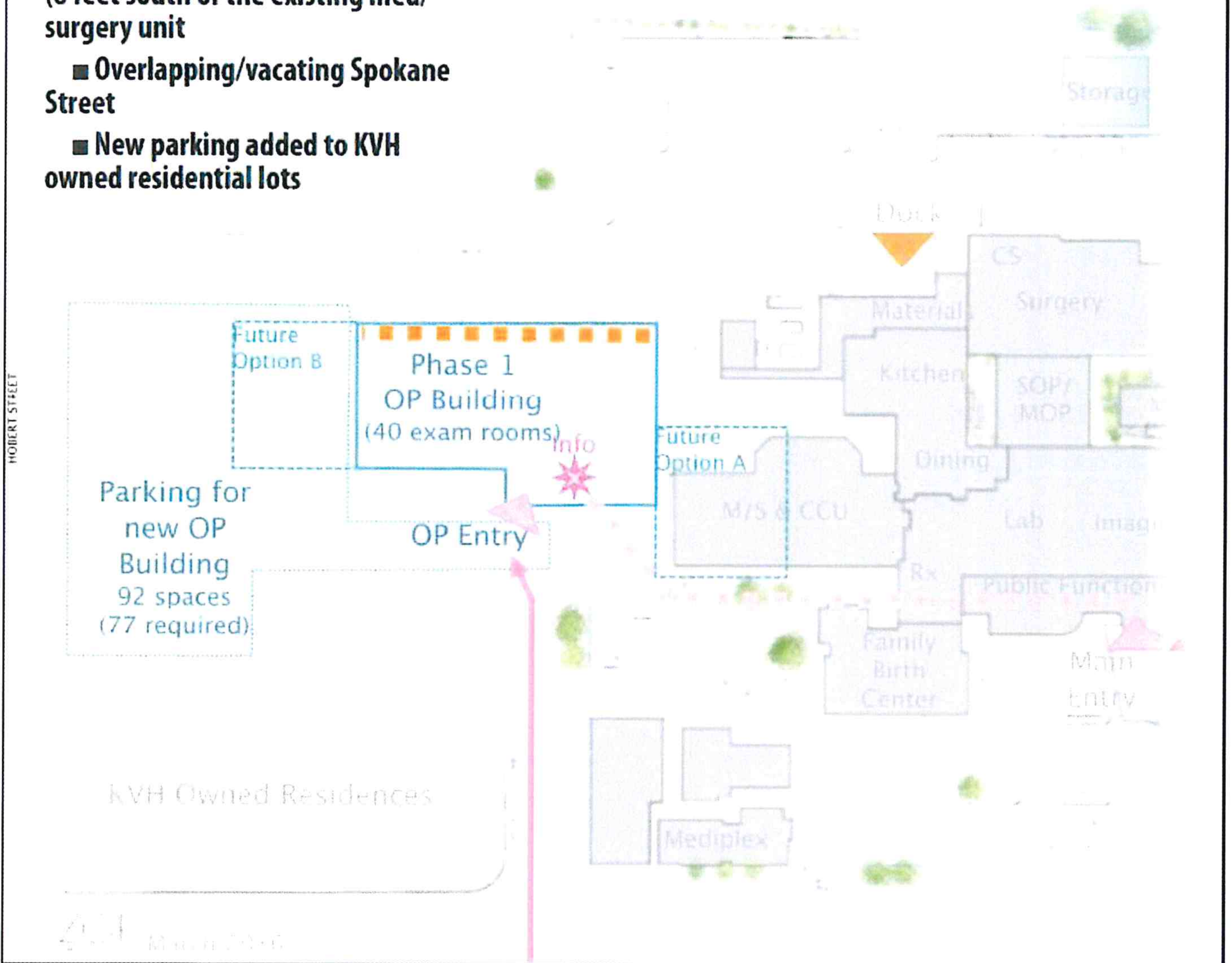
Stoffle said he wants to be sure there is there is a visual barrier between his neighborhood and the new facility. The plan approved Monday calls for landscaping around the parking lot, in an effort to lessen the visual impact on the neighborhood.

Stoffle also wants to be sure residents in his neighborhood don't have to spend any money out of their own pockets for any upgrades that may be required as a result of KVH's expansion.

Though he has concerns about the project, he was supportive in general. He applauded KVH for its transparency in the project and helping him understand its intentions.

"The hospital is showing they want to be a good neighbor," he said. "It makes me feel reassured."

Daily Record, page A1, 3/9/16



ZGF Architects

Plans for Kittitas Valley Healthcare's proposed outpatient building show it would be built across Spokane Street on properties currently owned by KVH.

Daily Record, 3/9/16
IN OUR VIEW

KVH getting used to public spotlight

Before we lose sight of the big picture by delving into some pesky details, we'd like to commend Kittitas County Hospital Board 1 for a major step in transparency last month.

The board agreed to videotape its board meetings and post them online for viewing later. It is a big step. It will make meetings more accessible and will allow people to better follow important decisions involving health care in the community. Kittitas County is lucky to have two public hospital districts which give the public a say in local health care decisions, and having ready access to the information presented at board meetings will improve dialogue in the community.

Board members also discussed making their full meeting packets of information available to the public online, another good step. Health care is a rapidly changing industry, and health care in rural communities presents some particular challenges. All that information is valuable to everyone.

All this positive discussion ran into one hiccup, though, when the Daily Record decided to broadcast part of the discussion live on Periscope. Periscope is a mobile app that allows anyone to broadcast live from a mobile device. It gives viewers the ability to comment and ask questions.

Live broadcasts of public meetings aren't unusual in Kittitas County. The Ellensburg City Council and Ellensburg School Board broadcast their meetings live on cable access television and post them at ECTV2.com.

We commend the board for moving forward with the video plan, but we hope staff and some hospital board members can get past concerns with recording and broadcasting by the public. Some said people should seek permission in advance before recording.

In response, hospital commissioners Matthew Altman put forward a motion stating that the board gives its permission for anyone to record meetings.

Hospital commissioner Erica Libenow said the board should always operate under the assumption it is being recorded.

Permission not required

The law is clear — no one needs to ask permission. Requiring someone to seek permission to take a photograph or record a public meeting is the same thing as requiring the public to seek permission to take notes with pencil and paper. It thwarts the intent of the law, and limits public participation. No one should feel like they need to register with hospital officials to attend a public meeting or record it.

The Open Public Meetings Act doesn't specifically address the issue of recording by video or audio tape, but an opinion issued by the state Attorney General's Office in 1998 found that recording may not be limited at public meetings.

The only condition that can be imposed on a person attending a public meeting is orderly conduct. Members of the public cannot be required as a condition of attendance at a meeting to register their name or other information, complete a questionnaire or otherwise fulfill any condition precedent to attendance, the opinion said.

Daily Record, 3/9/16

Resources are available. The state recently required all elected public officials undergo video training about public records and open meetings. KVH might want to consider putting staff who deal with the county's two public hospital boards through that short training as well. The state's Attorney General's office has an ombudsman who is available to answer questions about open government.

All that aside, the decision to videotape meetings puts the KVH board ahead of other local governments in terms of public access (ahem, Kittitas County commissioners). Kudos to the board for leading the way.

Daily Record, 3/18/16

Charting the future course for KVH

It is a bit frightening to live through a phase of rapid change — particularly when it involves a vital service like health care — but it is also somewhat fascinating.

Even though the hospital was remodeled in the 1990s it is not designed to reflect the current health-care delivery system. The changes may be driven on a national and state level but they are going to be implemented locally.

Where are we going to end up?

Kittitas Valley Healthcare officials are asking themselves and the community this question as they embark on a master site facility plan for the KVH campus.

In the Affordable Care Act era what would a financially feasible community hospital look like? What would be its array of services? What services currently provided would be shifted to a regional facility? What new tasks will fall on the local health care community?

Is there anyone out there who knows the answers to all these questions? That might be the only question that's easy to answer because the answer is no.

Health care is an emotional issue. Depending on who you talk to it's a "right," or a "commodity" to distribute and purchase. It's both.

We experience the dichotomy of health care every time we make use of the service. An emergency or critical health concern arises and the focus is purely on the treatment or the cure. Weeks or months later when the bills arrive the focus shifts to "how are we going to pay for this?"

Take that kitchen table experience and project it on a communitywide scale, except that the "how are we going to pay for it" part better come first.

In our jobs many of us have seen the post-Great Recession reshaping of our individual industries with a push toward regionalization and consolidation of services. It may be a mistake to apply the private sector practices to health care given the heavy involvement of government, but some economic realities cannot be ignored. If it is cheaper to do something somewhere else, chances are it's going to get done somewhere else. But what does that mean for KVH and for the particular challenges faced by rural, critical care hospitals?

It is also important to remember that while KVH is our hospital, it is also a neighbor to people who live in that area. The neighbors have a stake in the hospital and the traffic it brings.

As KVH embarks on the planning process for renovating and/or expanding KVH it will need to lean heavily on professionals, people with an understanding of the complexities of the health care system. But it is also going to need to respond and reflect the input of as wide a swath of the community as possible.

Daily Record, 3/18/16

Because at the end of the day, the community owns the community hospital and it either benefits or pays the price for the decisions made.

A community forum on the plan is at 5:30 p.m. March 24 in the upstairs conference room at KVH.

First Providence, Walgreens Express Care clinics open today

Feb 29, 2016, 2:00pm PST

Enlarge

The Sisters of Providence Providence Health & Services headquarters building in Renton.

BUSINESS JOURNAL PHOTO | MARCUS R. DONNER

Providence Health & Services opened its first Walgreens health clinics in the Puget Sound area Monday. In doing so, it's moving forward with plans to open 25 clinics in Washington and Oregon over the next two years.

The move is part of a growing trend among health care providers to open retail clinics in drug stores.

The three Providence Express Care clinic location, called Swedish Express Care in Washington, now open in the Seattle area are:

- 6300 East Lake Sammamish Parkway S.E. in Issaquah
- 12405 Northeast 85th St. in Kirkland

- 4105 Northeast 4th St. in Renton

Three locations in the Portland area also opened Monday.

The original announcement of the partnership came in August, touting convenience and simplicity for patients to be treated quickly for common conditions from head colds, chest colds, minor sprains and strains to burns, skin infections, stomach pain and even children's sport physicals.

But, the announcement also set in motion a firestorm, stemmed by the fear that the clinic will stop offering contraception services and abortion drugs because Renton-based Providence is a Catholic health care system.

The American Civil Liberties Union (ACLU) and 18 other groups, including Planned Parenthood, Legal Voice and NARAL, sent a strongly-worded letter to Walgreens officials in December, noting that other health organizations restricted access to contraception and other services after partnering with Providence.

Monday, a spokeswoman for Providence said the letter was sent to Walgreens, not Providence. But, in the last couple of weeks Providence has been in contact with the ACLU, responding to some of the organization's questions.

Providence spokeswoman Colleen Wadden said in an email to the ACLU she reiterated that the services will be the same regardless of if a patient goes to a Providence Express Care, which has a religious affiliation, or a Swedish Express Care, which is secular.

"The issue of Catholic health care or secular health care won't change what a patient can access," she said in an email.

In a blog post Monday, the ACLU said this news from Providence was welcome, but the organization will be watching to see how these clinics and pharmacies operate in practice.

Seattle-based Group Health Cooperative formed a similar partnership with Bartell Drugs last year.

Providence Health & Services operates more than 35 hospitals and health facilities and employs more than 20,000 across Washington state.

Coral Garnick covers health care and retail for the Puget Sound Business Journal.

http://www.yakimaherald.com/news/yakima-memorial-virginia-mason-hospital-merger-expectations-high/article_97eafeb0-e1d7-11e5-87ed-77095a16a3ef.html

CENTERPIECE

Yakima Memorial-Virginia Mason hospital merger expectations high

By Molly Rosbach
mrosbach@yakimaherald.com Updated 8 hrs ago

An entrance to Yakima Valley Memorial Hospital. (GORDON KING/Yakima Herald-Republic file)

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Virginia Mason CEO Gary Kaplan visited Yakima on Thursday to offer more detail about what the community might expect as the Seattle hospital begins implementing its merger with Yakima Valley Memorial Hospital.

The goal of the affiliation is not to take services away from Yakima, but to improve care and expand opportunities here, Kaplan said.

"Our objective with Virginia Mason is not to create a giant sucking sound to Seattle, but rather to ensure that every patient can get the kind of care that they should be able to get in the Yakima Valley close to home, whenever possible," he said in a meeting with the Yakima Herald-Republic.

Kaplan and Memorial CEO Russ Myers again declined to list any specific services that might be expanded in Yakima in the near future, saying that teams of specialty providers from both hospitals are working to determine where those opportunities might be.

There are some things that make more sense to go to Seattle, Kaplan said, because of the high degree of specialization required and the relatively low patient volumes seen in Yakima. For example, he said for procedures like pancreatic surgery and esophageal surgery, doctors at Virginia Mason have more expertise.

"There will be times when care in a tertiary facility (Virginia Mason) will be necessary and required," Kaplan said. "We want to make those experiences as seamless and coordinated as possible, but also make sure the patients have rapid return to their community, where there's support services, and also rapid return to function in all the things that are important in their lives."

For the past 15 years, Virginia Mason has been working under a tailored health care approach modeled on the world-renowned Toyota production system, using it to eliminate waste within its medical facilities and ensuring a high-quality, efficient patient experience.

Introducing that model to Memorial is something both sides are excited about, Myers said. In fact, he said, when the two hospitals announced the signing of their affiliation agreement at the beginning of January, one of the first questions from Memorial physicians was when they would start to get the benefits of Virginia Mason's process.

While acknowledging it will be a significant learning curve to implement those practices, Myers said, "We're going to take on the journey with energy and intent and the understanding that, (in the health care arena) time is not on our side."

Those same provider teams will help assess which areas of the Memorial system should be first priority for finding more efficient solutions, he said.

Finding efficiencies doesn't mean standing behind someone with a stopwatch and a clipboard, tracking their every move, Kaplan said. But it requires a complete understanding of existing practices before beginning to improve workflow.

"By understanding our current processes, that gives you an opportunity to identify the waste," he said. As a physician himself, "If I'm waiting or the patient's waiting, that's the absence of flow."

Once problem areas are identified, multidisciplinary teams work together to redesign the process.

"So the people closest to the work redesign the work," Kaplan said. "So it's a very powerful way to engage the workforce. Frankly, as a chief executive I don't know the solutions. What I know is, the people who are working in the process — they know the solutions. It's been far too long that we haven't asked them."

Patients and family members have been part of those redesign teams, too, he said.

One area that many physicians would like to see redesigned is the burden of paperwork: Completing charts in the electronic health record to meet "Meaningful Use" and other federal requirements can take hours, often keeping providers in the office long after their last patient appointment has ended.

Part of the solution is deciding whether some tasks could be done by other members of the care team, freeing physicians to care for patients.

"One of our basic tenets is that people operate at the top of their skill set, so that nurses are doing work nurses should be doing; physicians are doing work physicians should be doing; medical assistants are doing work they should be doing," Kaplan said.

In his own practice, he sometimes completes the chart with the patient sitting side-by-side, he said.

The impact of the affiliation on Memorial's workforce — as the largest employer in Yakima County — is still unknown, but Myers and Kaplan again stressed that they don't plan on any staff reductions.

While there's "waste in everything we do," Kaplan said, "we do not envision layoffs at this time."

"We're looking to expand services here in Yakima," he continued. "I think when you expand services and hopefully attract more patients ... that there will be plenty of opportunity, plenty of work. And at the same time, we will continue to make things more efficient."

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673 rural hospitals vulnerable to closure: 5 things to know

Written by Ayla Ellison (Twitter | Google+) | February 03, 2016

305 Share Tweet 98 Share 7 G+1

More than 60 rural hospitals have closed since 2010 and another 673 rural hospitals across the nation are vulnerable to closure, according to a report from iVantage Health Analytics, a firm that compiles a hospital strength index that is based on data about financial stability, patients and quality indicators.

Here are five things to know about the financial struggles many rural hospitals are facing, according to iVantage.

1. The 673 rural hospitals vulnerable to shutting down are located across 42 states.

2. Southern states have especially high rates of vulnerability when compared to their total number of rural facilities. States in this region with high rates of vulnerability include Mississippi (79 percent), Louisiana (58 percent) and Georgia (53 percent).

3. Sixty-three percent of the hospitals vulnerable to closure are located in states that have not expanded Medicaid.

4. Sixty-eight percent of the hospitals vulnerable to closure are critical access hospitals.

5. If the 673 vulnerable hospitals were to shut down, 99,000 healthcare jobs in rural communities would be lost, and it would result in an estimated $277 billion loss to the GDP.

More articles on healthcare finance:

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6. Ohio hospital at risk of losing Medicare funding
7. CMS releases OPPS rule for 2016, finalizes two-midnight changes: 10 things to know
8. 3 costly healthcare megatrends to watch in 2016
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Northwest MedStar to Integrate Into Life Flight Network Creating an Expanded ICU-Level Critical Care Transport Program

www.khq.com/story/31488395/northwest-medstar-to-integrate-into-life-flight-network-creating-an-expanded-icu-level-critical-care-transport-program

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SOURCE Life Flight Network

Life Flight Network to open new bases in Colville and Walla Walla

SPOKANE, Wash., March 16, 2016 /PRNewswire/ -- Northwest MedStar is integrating its critical care transport program into Life Flight Network, an Oregon-based, not-for-profit air medical program serving the Pacific Northwest and Intermountain West. As a result of this expanded program, Life Flight Network will open new helicopter bases in Colville and Walla Walla, Wash. and add a fixed-wing aircraft to an existing base in Moses Lake, Wash. This collaboration is creating an expanded, hospital-owned and community-based company built on a foundation of safety, customer service and clinical excellence.

Logo - http://photos.prnewswire.com/prnh/20160316/345092LOGO
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"Similar to how Northwest MedStar was formed more than two decades ago, this collaboration takes best practices from each program to create broader, more comprehensive air medical services," said Nancy Vorhees, chief administrative officer for Northwest MedStar and Inland Northwest Health Services (INHS). "We have history to guide us as we move into the future to better care for our health care partners, our patients and our members. Life Flight Network is that partner."

As part of the integration, Providence, the sole member of INHS, increases its ownership interest in Life Flight Network. Other members in Life Flight Network are Legacy Emanuel Medical Center, Saint Alphonsus Regional Medical Center and Oregon Health & Science University.

"To further our mission to care for those in need, we must look for opportunities to partner and collaborate with others," said Elaine Couture, Providence Health Care regional chief executive and INHS CEO. "Integrating Northwest MedStar into Life Flight Network expands a hospital-owned and community-based company and ensures critical care transport services are readily available. Together, we are finding an even better way to care for our communities."

ICU-level transport services will continue without interruption. All Northwest MedStar critical care flight team members were offered positions within Life Flight Network and will continue delivering patient care. The highly skilled and experienced teams will be working together, as one organization, to more efficiently respond to people in need of life-saving critical care transport.

"We are proud to welcome Northwest MedStar to the Life Flight Network family and at the same time expand ICU-level transport services in the region," stated Michael Griffiths, Life Flight Network CEO. "We look forward to partnering with all hospitals, EMS, police and fire departments to continue our collective, award-winning critical care transport services built on safety, customer service and clinical excellence."

With expanded critical care ICU teams and resources, Life Flight Network will open two helicopter bases this summer in Walla Walla and Colville, and add a fixed-wing aircraft to an existing base in Moses Lake. "We continually evaluate

critical care transport needs and determined adding bases and positioning an additional airplane in the region further meets the needs of the communities we serve," added Griffiths.

Northwest MedStar and Life Flight Network are operating successful, nationally-recognized critical care transport organizations. Both programs are certified by the Commission on Accreditation of Medical Transport Systems (CAMTS) and have been awarded "Program of the Year" honors by the Association of Air Medical Services, recognizing a focus on safety and quality. By joining the services of Life Flight Network and Northwest MedStar, best practices from both well-established and respected organizations will be used to better serve the public.

Community members with current Northwest MedStar memberships automatically become Life Flight Network members. Members will receive a renewal notice mailed to their mailing address directly from Life Flight Network one month in advance of their expiration date. New members will join through Life Flight Network. In addition to the same reciprocity partnerships that Northwest MedStar offered, Life Flight Network's reciprocal partnership with other air medical programs expands coverage for members throughout the nation.

While the Northwest MedStar name on the aircraft, ground vehicles and flight suits will remain for a period of time, the program becomes fully integrated and operated by Life Flight Network on April 1, 2016.

Life Flight Network is a not-for-profit medical transport service that started in 1978 as Emanuel Life Flight, making it one of the nation's oldest air ambulance services. Headquartered in Aurora, Oregon, Life Flight Network provides critical care transport services in Oregon, Idaho, Washington and Montana.

With the integration of Northwest MedStar and announcement of two additional bases, Life Flight Network has expanded its program to be the largest and industry-leading, nationally-recognized not-for-profit air ambulance program with 27 helicopters, 10 fixed-wing aircraft, 22 air medical bases, extensive ground ambulance transports, more than 600 employees, and a combined membership program that will cover more than 200,000 families and individuals.

Life Flight Network has been able to accomplish this growth while maintaining its core mission – to serve the community by providing critical care transportation to ill or injured patients in a safe, compassionate, efficient and expeditious manner.

"It's an honor for our owners, our organization and team members to be able to expand critical care transport to the communities we serve," said Griffiths. "Each and every time our teams are sent out, the lives of family members and loved ones are in our care. We take that responsibility, along with safety, to be the two most important values of Life Flight Network."

For more information about Life Flight Network, including photos and b-roll, visit www.lifeflight.org.

About Northwest MedStar: Northwest MedStar, a service of Inland Northwest Health Services (INHS), has bases in Spokane, Tri-Cities, Moses Lake, Pullman and Brewster, Wash. and Missoula, Mont. All flights are conducted by and operational control over all aircraft is exercised solely by Metro Aviation, Inc. For more information about Northwest MedStar or INHS, visit nwmedstar.org or inhs.org.

About Life Flight Network:
Life Flight Network, the largest not-for-profit air medical service in the nation, is owned by a consortium of Legacy Emanuel Medical Center, Oregon Health & Science University, Saint Alphonsus Regional Medical Center and Providence Health & Services. Rotor-wing services are provided by Life Flight Network and fixed-wing services are provided by Life Flight Network and Jackson Jet Center. For more information about Life Flight Network, visit www.lifeflight.org. Aviation services provided by Metro Aviation to existing Northwest MedStar bases will continue to be provided by Metro Aviation until further notice.

Media Contacts: INHS/Northwest MedStar: Nicole Stewart, Email or 509-768-6665 Life Flight Network: Justin Dillingham, Email or 503-756-8031

Northwest MedStar Backgrounder

- *Northwest MedStar, the first service operated by Inland Northwest Health Services (INHS), was created in 1994 when Sacred Heart's Heartflight and Deaconess' Lifebird air transport programs came together.*
- *6 bases:*
  - *Spokane, Richland, Moses Lake, Pullman and Brewster, WA*
  - *Missoula, Montana*
- *Modes of transportation:*
  - *Helicopters (rotor wing) – 7*
  - *Airplanes (fixed wing) – 5*
  - *Critical care ground ambulances – 8*

Life Flight Network Backgrounder

- *Emanuel Life Flight started in 1978.*
- *Life Flight Network was created in 1993 when Emanuel Hospital's Life Flight program and St. Vincent's AirCare program came together.*
- *Currently operates 16 bases across Oregon, Washington, Idaho and Montana:*
  - *Aurora, Cottage Grove, Ontario, La Grande, Redmond, Astoria and Pendleton, Oregon*
  - *Longview and Dallesport, Washington*
  - *Boise, Lewiston, Coeur d'Alene, Rexburg, Burley and Sandpoint, Idaho*
  - *Butte, Montana*
- *Modes of transportation:*
  - *Helicopters (rotor wing) –20*
  - *Airplanes (fixed wing) – 5*
  - *Critical care ground ambulances in several locations through partnerships with local EMS agencies.*

To view the original version on PR Newswire, visit:http://www.prnewswire.com/news-releases/northwest-medstar-to-integrate-into-life-flight-network-creating-an-expanded-icu-level-critical-care-transport-program-300237415.html

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U.S. Health System Performance Has Gotten Better, Not Worse

www.hhnmag.com/articles/7018-us-health-system-performance-has-gotten-better-not-worse

The argument that we have not received societal benefits along with the rise in health costs is difficult to defend.

March 14, 2016

Jeff Goldsmith

In late 1979, while working for the University of Chicago Medical Center administration, I witnessed an exciting new surgical technology up close and personal: total hip replacement for severe arthritis. Scrubbed in with an enthusiastic young orthopedic surgeon, I watched over his shoulder as he methodically cut through layers of muscle in the patient's posterior with an electric cautery, laid the joint bare, removed the ball and replaced it with a metal prosthesis and a new plastic socket in a 4½-hour procedure. The 80-something-year-old patient stayed in the hospital for about three weeks and expected a lengthy and arduous six-month-plus course of rehabilitation.

Flash forward 36 years, and on Nov. 19 I went under the knife at Martha Jefferson Hospital (part of Sentara Healthcare in Charlottesville, Va.) to have my own left hip replaced. Same problem: a painful, severely arthritic hip joint. Basically, the same technology: a (much smaller) ceramic ball and a much more durable plastic socket. Access was from the front, facilitated by a special table that held me up on my side. Yet, how times have changed.

For one thing, my surgeon was a young woman, a member of a tiny female vanguard in what remains the most robust fraternity in medicine. For another, not a single muscle was severed; she employed an anterior approach, which simply pushed the muscles aside to lay bare the joint. Cautery was mostly limited to blood vessels in the dermal layer. The procedure took a little over an hour. (Some surgeons today perform total hips in 45 minutes!) I was awake and walking on the joint within 90 minutes post-op; walking stairs, albeit gingerly, the next morning; and discharged to home within roughly 24 hours of waking up.

Physical therapy began at home less than 24 hours after discharge and 48 hours post-op, as did a week of home health visits to make sure pain was being managed effectively, as well as the risk of blood clots, infection and other potential post-operative complications. Thanks to the full court press of scripted visitations, managed by what my surgeon called a "rapid recovery protocol," there weren't any complications. My surgeon was hovering continuously in the background, connected to me by text messaging. The biggest problem I faced: the lack of pain — leading to overexertion, consequent swelling and risk to the incision. I was walking without a limp in two weeks and driving my manual transmission car in a month. "Rapid recovery" was exactly what I got.

Progress Without 'Breakthroughs'

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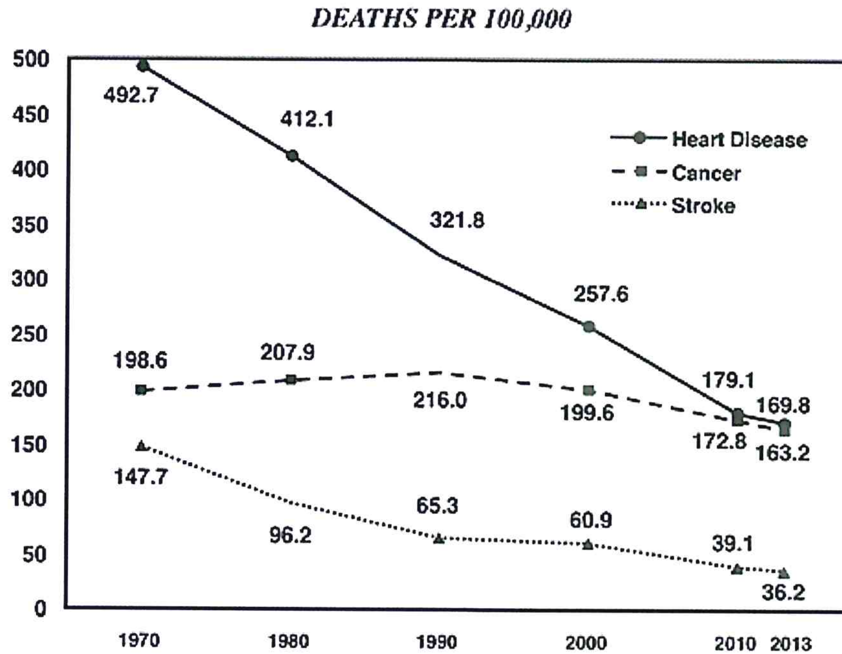
LEADING CAUSES OF DEATH FOR ALL AGES
United States, 1970-2013



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

Much is made in medicine about the need for technological breakthroughs. That wasn't what I experienced when I had my hip replaced. The "breakthrough" took place in the mid-1970's. There has been no cure for arthritis since and, sadly, none appears even remotely likely. Rather, the real progress in total hip replacement came from continual refinement by the orthopedic community not only of hardware but also of clinical processes inside and outside the operating room.

Nor is this seemingly invisible progress through collective learning an isolated instance confined to orthopedics (see chart). Much has been made of the continued frustration in the search for a "cure" for cancer and of the high cost of new cancer medications. The popular press neglects to mention that while we've been waiting for a "cure" for cancer, there has been a nearly 25 percent decline in the age-adjusted death rate from cancer in the U.S. since 1990. The result is that there were nearly 14.5 million cancer survivors among us in 2014, according to the American Cancer Society.

Though the disease remains scary for patients and their families, cancer treatment today is much less a "one off" search for solutions than it was even a decade ago. Cancer care is increasingly protocol-driven, informed by a comprehensive and growing cancer registry maintained by a network of National Cancer Institute-designated community cancer centers. There has certainly been therapeutic progress for some forms of cancer, including a vaccine for cervical cancer, but the real progress has been an immense and largely invisible collective effort by the cancer community to harness the power of big data and clinical practice experience across millions of cases.

Strokes used to be the third leading cause of death in the U.S. Since 1970, the age-adjusted death rate from strokes/cerebrovascular disease has fallen by 76 percent. Death from strokes is now the fifth leading cause of death in the U.S., eclipsed by both lower-respiratory infections and accidents. Stroke care today begins in the ambulance on the way to the hospital, and hospitals are publicly rated on the number of minutes that elapse between the moment the patient reaches the hospital's front door and the time that catheter-driven therapy (coils or stents) addresses the

cause of the stroke (e.g., bleeding or vascular blockage). Strokes are still a scary health risk, but a massive amount of suffering and brain damage today is avoided by more systematic and focused care.

Though it is still the nation's leading killer, deaths from heart disease have declined by two-thirds since 1970. This is despite the escalation of cardiac risk created by the obesity epidemic and the resulting sharp rise in the prevalence of diabetes. Absent these two linked developments, one suspects the decline in cardiac mortality would have been even more striking than what we have seen. Twin revolutions in invasive cardiac care — bypass graft surgery beginning in the early 1970's and cardiac stenting in the 1990s — helped alleviate symptoms, while marked improvements in cardiac intensive care saved hundreds of thousands of lives after cardiac events.

But the decline in mortality continued during the decade of the 2000s despite a pause in technological progress in heart care. The facts that cardiac bypass volumes fell by more than a third in the decade after 2000 and that catheter-driven interventional cardiology volumes are also declining suggest that something significant has happened to the demand for cardiac care. The wide use of statin drugs as well as drugs to manage hypertension have reduced the prevalence of the underlying disease.

The same pattern of process improvement that we saw in orthopedics, cancer and stroke care appears in cardiac care: incremental but not revolutionary improvements in underlying technology, better education and communication with patients, tighter care management protocols and, most important, an evolving professional conversation leading to consensus on standards for best clinical practice. These are the ingredients of more effective care for complex illnesses.

Are We Getting Value?

This progress never enters into the national "conversation," if you can call it that, about the rise in health costs. There are unquestionably waste and inappropriate care in our health system as well as an inflationary bias in how we pay for care. There also remain troubling disparities in health outcomes and access by race and income. And our care system is by any international comparison the most expensive in the world.

But the argument that we have not received societal benefits that parallel the rise in health cost is difficult to defend. The steady decline in mortality rates for the major killers of Americans suggests we are improving our health system's performance. I do not know many patients who would willingly opt to return to 1970's medical practice standards, were it possible for them to do so, because the care was cheaper. The care our parents and grandparents received was also a good deal riskier and less effective. The real question might be: Is the return on societal investment in basic and applied research in medicine adequate?

While publicly funded research at the National Institutes of Health and private research and development investment in our medical device, pharmaceutical and biotech sectors continue to seek cures for the complex chronic diseases, we should accord more respect to the benefits of professional collaboration that produce better organized care. Hospital management teams can materially assist in this collaboration and use it to improve their results and patient satisfaction.

***Jeff Goldsmith**, Ph.D., is the president of Health Futures Inc. and associate professor of public health sciences at the University of Virginia in Charlottesville.*

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5 Implications for Hospitals Now that Retail is Health Care's New Front Door

www.hhnmag.com/articles/7048-five-implications-for-hospitals-now-that-retail-is-health-cares-new-front-door

The CVS Health associate CMO details the company's growth strategy and the tremendous disruption he expects from telehealth.

March 17, 2016

Marty Stempniak

CHICAGO — There's a new front door to the U.S. health care system, and it's not your hospital's emergency department or doctors' offices.

A new report, released Wednesday by Oliver Wyman, says it's actually retail health clinics, located down the street at places like Walgreens and CVS. While some docs may believe that there's no comparison between the two types of visits, interviews with 2,000 individuals show that consumers feel differently.

Nearly 80 percent of those polled said the experience was the same or better than that of a traditional doctor's office, and about 30 percent of consumers said the experience was "better" or "much better." Consumer interest in retail health clinics is clearly on the upswing, with one-quarter of patients polled saying they've used one, an 11 percent increase from the previous survey in 2013.

"Consumers have spoken; the new front door is here," Graegar Smith, principal in Oliver Wyman's Health & Life Sciences practice, said in a press release. "Now it's up to health care providers, insurers and retailers to build it in a way that has meaning, impact and value."

During a presentation Thursday at the American College of Healthcare Executives 2016 Congress, Andrew Sussman, M.D., executive vice president and associate chief medical officer of CVS Health, told hospital leaders how the company plans to do so. The nation's largest retail clinic chain, with more than 1,135 locations in 33 states, has been in rapid expansion mode in recent years. And they're not providing care in a silo by any means, as they've formed 70 partnerships with health systems across the country and implemented the use of Epic electronic health record systems to coordinate care with those organizations.

Thanks to a cornucopia of different factors — a primary care shortage, aging baby boomers in need of care, a rising epidemic of chronic disease and obesity, and patients spilling into the system because of the Affordable Care Act — the health care system is getting taxed. CVS wants to be there to help with access, with more than 50 percent of the U.S. population living within 10 miles of a MinuteClinic, staffed by nurse practitioners and physician assistants. They offer everything from routine lab tests to minor wound treatment, vaccinations and the ability to diagnose and treat common family illnesses. Sussman said they're not planning on performing open-heart surgery anytime soon, which makes such partnerships with hospitals critical.

"Nobody is going to get an appendectomy in the greeting card section of a CVS. That's not going to happen," he said.

The increasingly consumer-minded patient is also fueling growth for the Woonsocket, R.I., retail chain. With patients being asked to take on a larger share of the health care dollar, they're shopping around more carefully for the most affordable experience. More often than not, they're ending up at CVS's doors. Upward of 50 percent of MinuteClinic patients do not have a primary care physician, and 50 percent of visits come in during evenings and weekends when doc offices are often closed. Sussman pointed to studies showing that patients can save 80 percent on the price of care compared with higher-cost settings.

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Hospital leaders must be vigilant of this shop-for-care trend and find ways to address it. Patients are treating their care similar to a visit to an auto mechanic and just getting the overdue oil change while ignoring the air conditioning filter and wiper blades that also need replacement.

"In a bygone era, most everything was covered," Sussman said. "But now, when it's your money or you feel like it's your money, you're making decisions that might not always be in your best interests, particularly as it relates to preventive services. 'Hey, I feel well. Should I really spend money on this?' "

Telehealth is one growth area that CVS is warming to as a way to provide low-cost services, and consumers are, too. Oliver Wyman's study estimates that 57 percent of consumers are now familiar with the concept of a health and wellness visit conducted remotely via voice or video chat. Some 95 percent of CVS customers said they thought a telehealth visit was "just as good" or "better" than the traditional model, Sussman added.

CVS has partnered with three players in the telehealth space — Doctor on Demand, American Well and Teladoc — aiming to build out its capabilities. Pilots tied to those partnerships include making telehealth services available through the CVS app, having one company beam its doctors into CVS telehealth clinics to look at rashes and other superficial ailments or sending patients from a telehealth provider's app into MinuteClinic if further in-person consultation is required.

Sussman believes telehealth certainly has the potential to turn health care on its head.

"It is absolutely going to be disruptive to the larger health care world, because it creates a link between supply and demand that's very disruptive to bricks and mortar assets," he said. "Let me just say that again: The supply and demand linkage is *very* disruptive to bricks and mortar assets, because now that cardiologist doesn't have to be in the building to see that patient on the other side of the state."

Oliver Wyman certainly agrees with Sussman's statement. Here's that and four more implications for providers taken from the company's report:

1. There are tremendous implications for systems' ambulatory footprints. Some existing assets, such as a market-blanketing primary care footprint, no longer may be needed; and some systems will identify asset gaps. The new front door may provide an efficient vehicle to increase a provider's number of attributable and managed lives, so getting the footprint right will become increasingly important as more providers transition to value.
2. Physicians and care teams must be ready to receive/operate in this environment. Performance metrics, compensation and incentives will need to shift.
3. Coordinating care is easy to say, hard to do. Systems have to get it right — connecting with and transferring information among the various new front-door access points to create a truly integrated experience. Traditional health system thinking will be an encumbrance here; systems must start with consumer needs and hassles in mind.
4. To capitalize on that legacy-brand position, providers must move quickly and determine how they will monetize the brand plus quality plus trust advantage. As they do, they must recognize they are now operating in an arena driven by consumer expectations; what might have passed for customer service in the traditional arena won't fly in the new, consumer-centric front door.
5. Introducing this in a manner that (a) meets with consumer/patient readiness, and (b) that can be effectively resourced (staffed) will be key to creating traction toward a magnetic and impactful experience.

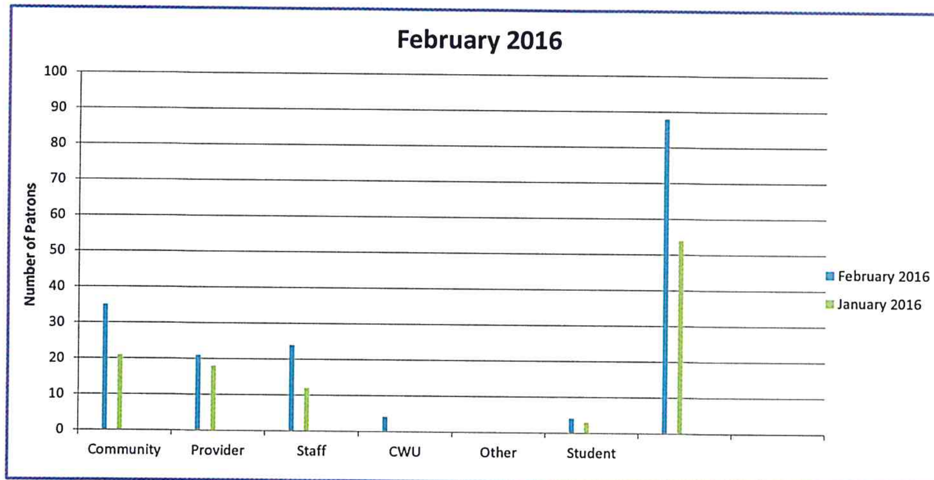
Kittitas Valley Healthcare
Community Health Library
Monthly Patron Statistics

	January			February			March		
		2016	2017		2016	2017		2016	2017
Community		21			35				
Provider		18			21				
Staff		12			24				
CWU		0			4				
Other		0			0				
Student		3			4				
Total		54	0		88	0		0	0

	April			May			June		
		2016	2017		2016	2017	2015	2016	2017
Community							26		
Provider							30		
Staff							16		
CWU							1		
Other							1		
Student							0		
Total		0	0		0	0	74	0	0

	July			August			September		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Community	34			32			32		
Provider	24			22			12		
Staff	19			25			19		
CWU	2			0			1		
Other	0			0			0		
Student	0			0			0		
Total	79	0	0	79	0	0	64	0	0

	October			November			December		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Community	23			16					
Provider	20			21					
Staff	12			26					
CWU	0			3					
Other	0			0					
Student	0			1					
Total	55	0	0	67			0	0	0



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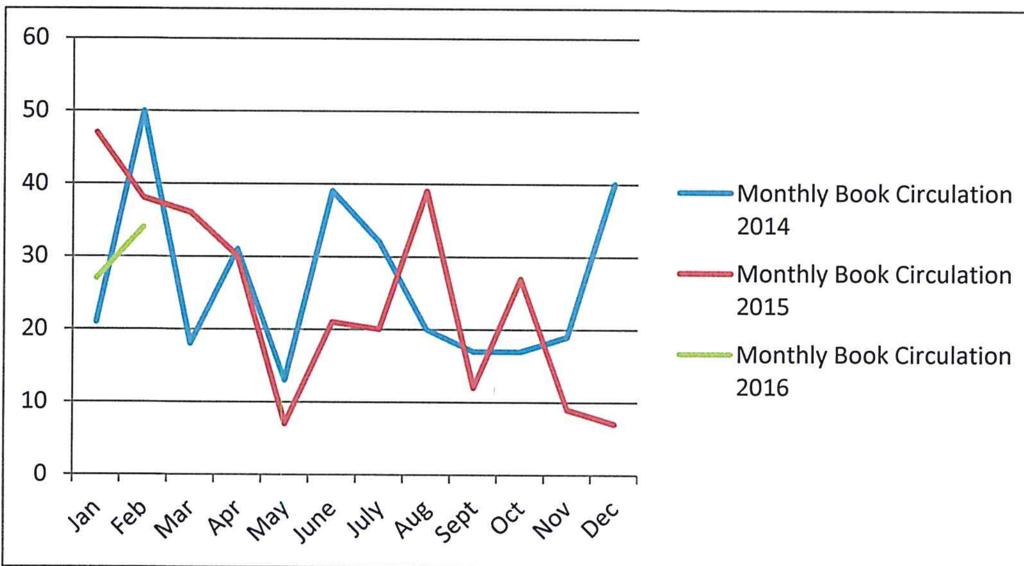
Community Health Library Databases - Number of Searches

Database Name		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL
UpToDate	2015	1063	1165	1407	1112	1154	1742	1288	1655	1814	1654	2025	1772	17851
	2016	1451	1810											3261
ClinicalKey	2015	156	110	163	217	263	99	186	68	79	207	140	132	1820
	2016	442	n/a											442
ClinicalKey for Nurses	2015											48	85	133
	2016	255	n/a											255
EBSCO Consumer Health Complete	2015	18	73	31	38	2	16	27	13	8	3	3	8	240
	2016	1	3											4
ProQuest	2015	14	54	0	0 ?	2	17	12	2	2	2	3	0	105
	2016	13	7											20
Patron Services														
Articles Sent to Patrons & Providers	2015	8	36	10	28	4	15	6	2	64	48	71	43	287
	2016	42	117											159

Monthly Book Circulation

	2014	2015	2016
Jan	21	47	27
Feb	50	38	34
Mar	18	36	
Apr	31	30	
May	13	7	
June	39	21	
July	32	20	
Aug	20	39	
Sept	17	12	
Oct	17	27	
Nov	19	9	
Dec	40	7	
YTD Total	317	293	



Daily Record, page A1, 3/26/16

Neighbors concerned about KVH expansion

New office building planned

By JULIA MARTINEZ staff writer

Jerry Lawler can't eat dinner in his home without the glare of car headlights beaming into his living room.

Lawler lives across from Spokane Street near a Kittitas Valley Healthcare parking lot. Car headlights were just one of many concerns he and about 10 community residents in the area had at a community forum held by KVH on Thursday.

KVH is exploring the possibility of expanding south and building a new medical office building next to the hospital. The first part of a larger facility plan. The medical office building would have 40 exam rooms and replace outdated facilities elsewhere on the KVH campus. The plan would tear down several existing KVH-owned homes across Spokane Street.

A tentative plan has construction slated to begin in December at the earliest, with March 2018 as the earliest date for completion of the first phase. The board would vote on a final construction plan in September or October. At this time, no construction has been approved.

The project would close off a section of Spokane Street. Lawler said the construction would be too close for comfort.

"I know these are little things but they add up," Lawler said during a discussion with KVH Chief Executive Officer Paul Nurick.

Bright headlights were a main issue, and residents wanted to know what dividers would be set up to block out the light from the future neighboring parking lot. Some solutions were trees, dirt berms or hedges.

Traffic and parking

Residents spoke up about how congested the area already is with hospital visitors and staff parking outside of their homes and on Chestnut Street due to the lack of parking spaces at the hospital. KVH's plan would reconfigure and add parking on site. The new office building would involve 92 spaces, more than the 77 required.

Susan Nelson has lived on Chestnut Street for over 30 years, across from a KVH-owned home used to train medical staff, and also owns a rental property next door to her home.

"It's dangerous right now," she said. Nelson noted that drivers couldn't clearly see oncoming traffic on Chestnut because of parked cars.

Nelson proposed the idea of designating a residential parking zone in the area so parking is not an issue, and asked if streets like Spokane or Whitman would be widened during construction to allow for more parking room.

Daily Record, page A1, 3/26/16

"The city will let us know," Nurick said.

Within a month, KVH will submit its proposal to the city for a SEPA review, which includes a traffic study.

"It's difficult to understand as a homeowner what the impact of this project is until the SEPA comes out," said Tom Stoffle, a resident of the area.

"We have to wait for all of this to go through for you to be good neighbors?" Nelson asked.

Rats

Another concern was rats. Many residents have noticed rats have been more common in the area. Although most people agreed the rat issue was citywide, some residents were not happy with how the hospital has addressed the issue. One resident said that they had only seen one rat trap set out, and that walnut trees outside of the hospital were attracting rats.

"It means a lot to us, we're homeowners," Lawler said.

Homeowners also wondered whether their homes would drop in value during construction, or after the first phase was completed. Some asked if the hospital would start buying houses.

Nurick couldn't answer the question of whether home prices would drop, but said KVH will be in the market for more properties.

"We'd certainly be interested in talking to you," he said.

Some residents felt as if they were being forced to sell their homes, and were concerned that houses would be bought at a lower value. Pam Wilson, vice president of the KVH board, said that the hospital buys properties at the appraised value, not assessed value, which is typically lower.

Dr. Byron Haney, a physician who founded Family Health Care of Ellensburg, an independent practice, proposed an idea for building a new hospital across Mountain View, down Chestnut Street.

He cited concerns about space issues that he dealt with when he arrived in Ellensburg 28 years ago and strongly recommended the community look into expanding in the open space at the end of Chestnut Street.

"I have no problem with what you've done here, but in my mind if I think of being good neighbors, I think of efficiency," Haney said. "When I came here, our hospital was already considered old .... We're now dealing with a facility we patched around."

He suggested looking more than 10 years down the road and said he was concerned that the hospital was being shortsighted with its vision for expansion. Haney did not deny the need for space, but added that with the rising aging population there will also be a need to house geriatric patients. Haney said that the current hospital could be used as a training facility for nurses.

The plan

The first phase of the plan would cost $17 million for the office building and $10 million for a new electronic health records system. The hospital does not plan to ask taxpayers for support and will pay for the work itself. The exact financing strategy hasn't been determined, but could involve $25 million to $30 million in revenue-backed financing.

The second phase of KVH's plan calls for remodeling the hospital at its current location. The work would happen three to five years after the medical office building is completed, and require voter support of a bond levy. The possible cost could be $55 million. A proposal wouldn't come to the public until after a 2000 levy for the hospital remodel and addition is paid off at the end of 2018.

Dr. Don Solberg, the chief medical officer at KVH, said the master site plan allows KVH to stop after the first phase and not split services. If the community decided to not continue with the second phase, patients wouldn't have to travel to and from a different site to receive services from KVH.

Throughout the presentation of KVH's plan, administrators stressed that the hospital wants to be a good neighbor.

"Many of the questions you've asked we've asked ourselves," said Solberg as he presented the timeline for the project.

Solberg said the hospital welcomes and will seek community input, assuring community members that there would be plenty of opportunity to voice their concerns.

One community member wished the hospital had notified people sooner about the hospital's expansion plans and that more input from residents had been considered. Nurick said the hospital hasn't had much to show people until now.

"That's where we are today," said Amy Diaz, community relations director for KVH.

Nelson said she had concerns back in 2011 when the idea of expansion came up. She hopes there will be more community input meetings because although she felt like a lot of questions were answered, she didn't feel like residents were being heard.

"I'm not against expansion. I think we live in a town where we will see expansion, and hopefully this town will grow," she said.

Nelson said she will consider selling her home, but only if she can get a decent price for it, and she thinks that won't happen with a hospital and parking lot nearby. She plans on speaking to the city to address the rest of her concerns.

Residents left their phone numbers, addresses, and emails so KVH could update them on upcoming events. The hospital plans to ask for more community input and will host focus groups and administer a community survey.

"We hope we end up with a hospital that people don't mind living next to," Solberg said.