Three Rivers Hospital
Board of Commissioners Special Meeting
Strategic Planning Retreat
April 5, 2018 Minutes

The Three Rivers Hospital Board of Commissioners called a special meeting to order at 9:02 a.m. Thursday, April 5, 2018 in the McKinley Building Conference Room at 507 Hospital Way, Brewster WA 98812. The presiding officer was Vicki Orford, Chair. She turned over control of the meeting to Chief Executive Officer J. Scott Graham, who served as facilitator for the retreat.

A quorum was present, including:

Vicki Orford, Chair
Mike Pruett, Vice Chair
Cherri Thomas, Member
Leslie McNamara, Member

Others present:

J. Scott Graham, Chief Executive Officer
Melanie Neddo, Chief Operating Officer
Jennifer Munson, Chief Financial Officer
Gretchen Aguilar, Chief Nursing Officer
Anita Fisk, Director of Human Resources
Jennifer Best, Administrative Assistant
Christopher Majors, Business Development Coordinator
Dr. Gordon Tagge, General Surgery, Medical Director
Dr. Ty Witt, Gynecology
Dr. James Wallace, Family Health Centers
Tonya Vallance, Director of EMS, Okanogan-Douglas County Fire District 15
Cindy Button, Executive Director, Aero Methow Rescue Service

Vision, Mission & Values
All took turns reading the hospital's vision, mission, and values statements.

Welcome
S. Graham thanked everyone for taking the time to attend this strategic retreat. He estimated two or three more meetings may be needed to complete this strategic planning process.
C. Thomas asked S. Graham to provide a summary of the things the hospital is facing and working on, for the benefit of the guests. Part of the purpose of these retreats is to help steer everyone in the same direction, so everyone in the organization and who has an interest in helping it succeed are pulling in the same direction at the same time. The other purpose is to provide education. C. Button asked if there will be time to talk about the HRSA grant; yes.
S. Graham reviewed some ground rules for the day regarding respectful discussion and showed a short video to help inspire and motivate the group. He hopes to get a clearer focus on why we're here today, and asked everyone to introduce themselves and explain why they're here today. Everyone agreed that they do the work they do because they care about the communities we serve and want to make a difference.

Playing to Our Strengths
Watched a video from motivational speaker Marcus Buckingham about channeling personality traits and strengths into success later in life, into jobs wherein you feel that you are playing to your strengths a majority of the time. You grow the most in areas where you already have natural strength, whereas you can improve in your areas of weakness but those weaknesses will never be as good as your strengths. Instead, manage around your weaknesses. To be part of a winning team, use your strengths a majority of the time.

L. McNamara likes the concept of focusing on our strengths and building on that moving forward. S. Graham asked if everyone thinks this is possible to do organizationally as well as individually; yes.
C. Thomas said we may have potential strengths we could use to strategize. What are the things we could do well that we aren't currently acting on? Or can we take our inherent strengths and apply them in a different manner?
Does the organization have a personality? M. Pruett would like to reflect on what the hospital's driving forces were when it was founded compared to what they are now, and what their strengths were then that help guide us today. C. Button compared teamwork to an ensemble, wherein everybody brings in different notes and strengths to create harmony. G. Aguilar thinks our personality is optimistic, but we haven't quite figured out what our niche is. We may have operational struggles in terms of less patients and resources, but we have a stronger team than other organizations.
M. Neddo stated that one of the longstanding myths at Three Rivers is we can't succeed financially, and many of our own employees believe that myth. But it is possible to be financially viable, and getting everyone to believe that will be hard work. We spend a lot more time talking about our weaknesses than our strengths, and less time focusing on the things we do well. C. Thomas would like to list our strengths. S. Graham asked what if our strengths don't match up to what the community wants?

Break
S. Graham announced a 10-minute break at 10:11 a.m. The meeting reconvened at 10:22 a.m.

Identifying Our Strengths
Watched another Marcus Buckingham video as follow-up to the previous discussion, about focusing on activities that make you feel strong. Strengths aren't necessarily things you're good at doing; they invigorate and interest you. You can always improve on strengths through practice.
What are the things we do that strengthen us? What do we do that weakens us?
L. McNamara thinks that by excelling at our strengths, that elation will carry through to bolster the activities we aren't as good at.

Strategy vs. Tactics
S. Graham reviewed our top strategic pillars: Quality and Safety, Financial Viability, Culture, and Communication. The cumulative goal of all four is to help us be a community asset. Are these strategic objectives making us strong?
Reviewed the path to financial viability. Operational Excellence, Investing in Infrastructure, and Growing Services leads to sufficient cash flow to help us pay off warrants and build cash reserves. Last year we had achieved paying off and staying out of warrants for about six months. It will take quite a while to build 90 days' cash on hand. Operational break-even requires a balance of the cost of providing care with the revenue from providing care. Warrants are no longer an option for us, so we have to be really excellent at operational break-even. We have improved, but we don't have any flexibility for failure or lack of growth.

S. Graham reviewed the hospital's payer mix: about 39% is Medicare, 30% is Medicaid, 18% is commercial insurance, 11% is Blue Cross, and 2% is private pay. This is fairly close to the demographics of our hospital district, in terms of having more low-income and elderly residents. T. Vallance thinks the payer mix isn't necessarily reflective of the community, as residents with commercial insurance sometimes choose to go elsewhere. C. Button noted that doctors in rural areas send patients to other hospitals for tests and procedures, even if Three Rivers is closer and offers the same services. Those with Medicaid and Medicare choose to come here partly due to proximity, possible transportation issues, loyalty, and preference for the care they get here.

C. Button asked which services make more money than others, so the hospital could promote the ones that generate higher revenues. S. Graham and J. Munson agreed that what would make the most difference for the hospital financially is to increase revenues from commercial insurance.
Reviewed revenue sources and expenses. About 45% of revenue comes from outpatient, 24% from inpatient, 12% from operating professional fees, and 3% from the clinic. Essentially, only 6% of our revenue comes from non-operating revenues such as property taxes, while 94% comes from providing patient care.
Regarding expenses, salaries and wages consume 56%, benefits take 11%, 17% are professional fees (contracted providers), and supplies use 5%. Eighty percent of what it costs to do business is tied up in labor. C. Thomas stated that labor is the cost that's easiest to control, but reducing it too much would affect patient care.

When volumes are low, we control our labor by right-sizing staff to anticipated volumes. Forty percent of each dollar we earn is taken out via deductions, because of contracts we have with Medicare. They reimburse at about 60% of cost. C. Button noted that the government is moving toward switching to value-based reimbursement, which hospitals will also need to adapt to.
C. Button asked how the Three Rivers Hospital Foundation fits into this effort. It has been revived and hearts are in the right place, but process is slow-going. There's a lot of room to grow.
What does the data tell us? M. Pruett thinks it's a challenging job, being in the rural and political environment we're in, to turn to the community for input. Patients mainly come here out of necessity.
C. Thomas explained that our strengths may not necessarily make us money. C. Button asked if the North Central Accountable Community of Health projects will benefit this hospital; not as much as the larger ones. The main focus is on integrating primary care with behavioral health. Dr. Wallace said Family Health Centers feels like a small player in the ACH project because their presence is focused in Okanogan County, but the true benefit is in how much they can collaborate with other partners.
The Health Care Authority, Medicare, Medicaid and commercial insurance companies are trying to figure out ways to provide affordable patient care without involving hospitals, which is short-sighted because it removes consideration of the vital role hospitals play in their communities. The tide is against hospitals.
L. McNamara said it may not be feasible for Three Rivers to cut labor costs further, but through collaborative partnerships with other organizations the costs could be shared.
M. Neddo said one of our strengths is that our staff is good at managing through crises. She used the clinic as an example of a potential weakness, and whether we should let others like Family Health Centers handle that work and figure out how to support them and work with them.
S. Graham showed a video called “Green and Clean.” Excellent work is determined objectively so, when there isn’t excellence, we need to own the problems that hinder excellence and the effort it takes to get there.

Lunch
S. Graham announced a break for lunch at 12:04 p.m. The meeting reconvened at 12:35 p.m.

How to Use Our Strengths
Watched another Marcus Buckingham series video that explained how to find people for your team who love to do what you don't, whose strengths are different and enhance the team. If you can't find that person, figure out how to adjust your role so that you can use your strengths most of the time. The third option would be to change your perspective on the activity that makes you weak, looking at it from a position of strength.
In translation to organizations, C. Thomas said if we have services that aren't making us any money, stop doing them. V. Orford said conversely, we could identify those weak services and learn how to make them a strength.

V. Orford asked to talk about the service lines and whether we should get rid of any. C. Button said the Methow

Valley residents feel very strongly about keeping the OB program. L. McNamara noted that without an OB program we'd still have to deliver babies if mothers come here with urgency, and our OB program is highly regarded. The answer may be to put more effort into seeking out more commercially insured patients to deliver here. Is our OB program a strength? The service itself, not its ability to make money. C. Thomas asked if there's any data to find out how the program impacts the community. J. Munson estimated about 90% of OB patients are Medicaid. L. McNamara asked if that could be changed by offering more birthing classes. C. Thomas thinks we need to examine the strength of service lines from a public perspective and from an economic perspective. Dr. Witt thinks the OB program is a strength. We delivered 90 babies in 2017, and the program lost money. J. Munson stated we'd need to double the number of commercially insured patients to make money. S. Graham suggested the possibility of asking the community to help subsidize the cost of having an OB program if they want to keep it. V. Orford asked why the program loses money now, where in the past it was estimated to make a small profit; the volumes have changed and costs have gone up.
G. Aguilar explained that when she first started working at Three Rivers, we were delivering over 200 annually and that has dwindled. M. Pruett asked if the mothers are drawn to newer or bigger hospitals, or if the primary care doctors are referring them elsewhere. Dr. Wallace said some patients are directed elsewhere by their doctors, and some patients do associate nicer buildings with better quality care. Patients that look more at quality and statistics for C-section and infection rates choose to come to Three Rivers, rather than judging based on outer appearance. L. McNamara asked if our advertising could be stepped up. L. McNamara asked what the total number of births in the community are, and stated that might help guide a decision. C. Thomas asked what other services can bring in the revenues to offset any potential losses in OB. J. Munson estimated we lost about $200,000 last year on that program. C. Thomas noted that we should be able to make enough with other services to make up for what is a relatively small loss. J. Munson said we'd need to make it up in surgery, because we are required to have surgical staff in order to maintain the OB program. Dr. Wallace asked which services make us strong through revenues; laboratory and radiology. Acute care is more highly reimbursed.
In S. Graham's opinion, OB is a strength. It's part of our identity and helps us be a good community partner. The ER program is also a strength. V. Orford thinks the swing bed program could be a strength, but we lack an occupational therapist and more patients. Dr. Witt thinks surgery is a strong service line, and generates the revenue to help keep the hospital afloat. We had 23 surgeries in March, and J. Munson noted that reimbursement for the month wasn't good.
C. Thomas asked if there are any outpatient services we could provide that are well-reimbursed. Dr. Witt thinks there's some room to grow in customer service. Dr. Wallace thinks FHC might be able to do more with referring patients, and they welcomed a visit recently from Dr. Miller and Rob Lamberton. Building relationships between providers is important. L. McNamara was pleased to hear that, as the hospital wants to support FHC. S. Graham thinks our desire to collaborate and share is a strength.

External Pressures
Negative cash limits what we can do. Costs for doing business always goes up. Patient volumes declined sharply in November through January. Increased regulations increase costs. Health insurance costs go up and discourage people from seeking care when they get sick. Recruiting and retention is also expensive, and it costs even more to get providers to come work in rural communities. We also see competition from other health care organizations and partners. The cost we have the most control over is labor. Looking toward the idea of sharing labor, Three Rivers and North Valley Hospital are co-recruiting for a general surgeon who would work in both locations. Dr. Wallace said FHC is looking at sharing opportunities for physicians. L. McNamara asked if cross-training could be done; yes.
Other ideas included forming a consortium to negotiate better benefits for staff, sharing administrative staff and functions with other facilities, and/or negotiating better prices for supplies. Discussed contracting out lab

services with other health care facilities.

J. Munson listed same-day services as one of our strengths.

What could we bring in or enhance to improve reimbursements to cover our strengths that may not be money-makers? A Rural Health Clinic would have better reimbursement than the one we have now, but it would be competing with FHC. Our clinic also has orthopedics and general surgery, but it would need to have primary care to be considered an RHC. J. Munson asked why we couldn't merge in a way with FHC; M. Neddo suggested renting out Hillcrest House to FHC for clinic space. Having both entities closer together would offer benefits on both sides and foster a more collaborative partnership.

How do we capture more business from patients, especially those with commercial insurance? V. Orford said a new building would do it, since so many people still have a perception that our equipment is also outdated. M. Neddo thinks it's important to market to providers so they refer more to the hospital. C. Thomas agreed and stated we need to gain the trust of the providers.

Can your greatest strength be your greatest weakness as well? Yes. For example, S. Graham said one of our best strengths is the ability to persevere, but that can sometimes inhibit our ability to adapt to change. Are we up for looking at the hospital being different than it is? L. McNamara thinks we need to have a bigger presence in the Methow Valley, such as an urgent care clinic. C. Button said that would be a great way to partner with FHC or Confluence, to staff after-hours. She thinks telemedicine could play a huge role in that. It would decrease Aero Methow's costs through unnecessary transports and would decrease unnecessary ED visits at the hospital. There are grants to fund telemedicine.

Break
S. Graham announced a break at 2:34 p.m. The meeting reconvened at 2:41 p.m.

HRSA Grant
C. Button explained the grant Aero Methow is applying for. Three Rivers is one of their partners. The purpose of the grant is to build a network of communication. They're working on a strategic plan now. She'd like to see all entities involved in a patient's care to be on the same page when a patient calls EMS for help, sharing information and being open to welcoming patients. S. Graham asked if TRH and Aero Methow could start a business associate agreement to give Aero Methow access to our patient records. Dr. Witt asked if it would be possible to do post-discharge visits with patients to see how they're doing. C. Button would be open to that, but it would require agreement from the physician and permission from the patient.

Finishing Work
What are our opportunities? C. Thomas would like to explore some of the things discussed today. The number of babies born to hospital district residents should be able to be calculated per zip code. She asked for more data. M. Pruett would also be interested to know if any Chelan residents come to TRH to deliver. S. Graham noted that hospitals across the country are eliminating their OB programs because they lose money. If TRH makes the choice to keep the program, we need to commit to growing it through improving the payer mix, figure out how to subsidize it with other services, get taxpayer support, or do a combination of the three. G. Aguilar asked what would happen with physician and nurse competencies if births keep declining. New providers would struggle to get sufficient training. M. Pruett said another opportunity is proactive collaboration. S. Graham agreed that this would involve doing what we've been doing, and then some. V. Orford

listed proactive Medicare swing bed promotion as an opportunity. M. Neddo said we have pretty consistent physical therapy at this point, but occupational therapy is a bit more of a challenge. We may know of someone who could pick up some shifts here, and we've reached out to another hospital about sharing staff but nothing has come of that yet.
Other opportunities listed include:

- Housing FHC in Hillcrest House.
- Converting our clinic into a Rural Health Clinic.
- Exploring grants for telehealth; C. Thomas said we'll need to be specific about the service(s) we want within the telehealth spectrum. V. Orford asked if our ER could provide telehealth services in the Methow Valley. M. Neddo noted that we have a telehealth agreement already with Providence, and we could potentially approach them about a pilot project.
- Educating district residents that they can request to have procedures and tests done here. Do this through employer insurance outreach. Other information, like not needing a doctor's referral to get a mammogram, could be disseminated.
- Returning to mailing newsletters to district residents, to capture those who don't use computers.
- Text message marketing, with advanced written permission from patients.
- A new building will become a necessity to keep the hospital open, as the existing building continues to age and government regulations become more strident.
- Our capacity to treat patients more quickly is a promotional opportunity.
- IV therapy is another good source of revenue.
- L. McNamara suggested creating a FAQ sheet. We do have service brochures and take them around to local clinics.

S. Graham offered a summary that our strength overall is that we're a community hospital and we care about the people in our district who come here. The opportunities that come to us will need to be enablers of our overall mission. We need to do excellent work. As we explore the possibilities laid out today, our strength needs to be in the mission of being a community hospital and serving these communities, and having the drive, determination and will to do what it takes to make that happen, even if it means making uncomfortable decisions.

C. Thomas asked what the next steps are. The opportunities need to be prioritized. What is the one thing we need to invest in above all else? J. Munson thinks the best investment is in our staff; with high quality employees, we'll have a high quality product. A. Fisk agreed that culture needs to be at the forefront, because we'll have a harder time if employees are resistant to changes.
M. Pruett wants more community input via a needs assessment. S. Graham stated that someone is interested in working with the hospital on a needs assessment. S. Graham asked what would happen if the majority of the community feedback is that they don't want or need a hospital here. Dr. Witt said the hospital may need to look at transforming, but to his mind this team has been extremely successful in getting off warrants. He proposed doing some concussion protection for student athletes, by doing baseline assessments for sports with the greatest risk for head injuries. Then have a provider attend games and assess injured athletes. A similar program is established in Chelan and it's successful. L. McNamara suggested reaching out to companies that provide health insurance to their employees.

C. Thomas asked when the next strategic planning meeting can happen. V. Orford suggested holding it in August, to give administration time to work on the opportunities outlined today. Dr. Witt will talk to Rob Lamberton and Dr. Miller about the idea.

Adjournment
V. Orford adjourned the meeting at 3:55 p.m.

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Vicki Orford, Chair Mike Pruett, Vice Chair

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Tracy Shrable, Secretary Cherri Thomas, Member

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Leslie McNamara, Member