The Three Rivers Hospital Board of Commissioners called a special meeting to order at 10:01 a.m. Wednesday, June 3rd, 2020. In order to comply with State Governor's mandates regarding social distancing, the meeting was held virtually via the Microsoft Teams platform. The presiding officer was Mike Pruett, Chair.

A quorum was present, including:

Mike Pruett, Chair
Cherri Thomas, Vice-Chair
Tracy Shrable, Secretary
Leslie McNamara, Member
David Garcia, Member

Others present:

J. Scott Graham, Chief Executive Officer
Melanie Neddo, Chief Operating Officer
Anita Fisk, Director of Human Resources
Jennifer Munson, Chief Financial Officer
Gretchen Aguilar, Chief Nursing Officer
Shauna Field, Administrative Assistant
Jennifer Best, Public Relations
Dr. Ty Witt, Chief Medical Officer

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

Agenda

Purpose and Overview
S. Graham opened the meeting by discussing the purpose of the meeting, which is to provide support and information to the Board members regarding the hospital's current situation and discuss strategy for recovery going forward.

The COVID-19 pandemic has devastated our already fragile financial position. We have received federal financial aid, but we are uncertain when the pandemic will end or if patient volumes will improve, so we will need to develop a response and plan for the future. Do we continue to focus on growth, or reconfigure, or close?

Reality
Our current gross revenue per month is 1 million dollars. In order to stay viable and cover our operating costs, we need to double our gross revenue by the end of the year or we will not be able to sustain our current operation after 2020. To reach this goal, we will need to perform 20 surgeries per month and maintain an average daily census of 2 swing beds and 1.4 acute patients per day.

Our short-term recovery goals are to increase our swing bed and surgery volumes, continue to support and build the clinic, and look at ways to right-size in terms of the staff, buildings, and services.

Our long-term goals are to continue integrating with partner facilities like North Valley Hospital and Mid-Valley Hospital, develop additional services like outpatient therapy, behavioral health, and explore adding specialties like dermatology, eye care, cardiology as well as non-traditional services like plastic surgery, massage, spa therapies, and acupuncture.

Review of Data

Community Needs Assessment – The group discussed the Community Needs Assessment provided at the April regular board meeting. We have a stable and predictable demographic for a rural hospital of older and low-income patients with chronic health conditions and a diverse range of wealth. L. McNamara noted our lack of cardiology services compared to the number of patients with heart issues. She suggested bringing in a visiting specialist.

Financial Data – The group reviewed our current financial data and patient volumes compared to previous years. Our summer tourism and harvest driven revenues have been lower than expected for the past two years. Medicare, Medicaid, and L&I make up the majority of our revenue while private pay accounts make up the majority of our bad debt and charity care. We receive far less than what we bill out, with the exception of the Medicare swing beds, which reimburses us more than what we bill. C. Thomas asked about any changes we might see with the Rural Health Clinic designation; it will double the reimbursement for our rural health care encounters but this will not happen until after our first cost report for the clinic later this year or next year. M. Pruett asked about the cause of the large discrepancies for inpatient versus outpatient remit amounts; ratio of cost of charges and allowable costs. L. McNamara asked about the pilot program for the global budget; Scott is working with WSHA to re-engage the state about the idea. More hospitals may be open to the idea now than before. A global budget would provide a flat amount annually to cover operating costs and so there would be no traditional billing like we do now. The amount would be based on past revenue, and would increase by a certain amount each year. The financial aid we've received for COVID-19 so far acts as an example of a global budget.

Discussion

C. Thomas, Swing Beds – What is our plan for increasing swing bed volumes? The financial commitment is significant because we need a physical therapist, speech therapist, dietician, and occupational therapist to build the service. Sharing providers is difficult due to scheduling and the assessment and timeline requirements and many providers are already shared between districts and facilities. In order to get referrals, we need to be able to offer the necessary services or else the facilities will contact someone else that does have those services. Recruitment is also an issue. Occupational therapists are difficult to find, but we may be able to share an occupational therapy assistant with North Valley Hospital because the assessment times are not so rigid. M. Pruett asked if there was a reason why we were not getting swing beds from Confluence; a lack of occupational therapy and discharging to a nursing home has a lower cost rate. The more costs we add to the swing bed program, the higher our reimbursement will be.

L. McNamara, Behavioral Health, Education, Patient Follow-up, Transportation, Access to Healthcare – There is a lot of need for and a desire to provide ongoing behavioral health treatment. The problem is hospitals need a certain rate of reimbursement to cover the cost of providing the care and the state is reluctant to bring the rates up to what the hospitals need. Private companies often come in on a short-

term basis, but the treatment is basic and brief, which is not effective. We had partnered with OBHC in the past, but they went through some staffing changes and were too short staffed to continue sending someone down to the hospital.

We are open to offering interventional pain management services but have not discussed a full pain rehabilitation program. The service requires highly specialized providers with certifications. We have been exploring this with our new CRNA company, Okanogan Valley Anesthesia.

Before the COVID-19 shutdown, we had met with a mental health provider in Twisp who works with telemedicine who expressed interested in providing onsite mental health services in the clinic.

We do have a care coordination nurse who calls to follow up with patients, but we have not expanded this to the clinic yet.

We've hired a mammography technician and restarted our mammography program after two years without. We have applied for a $100,000 Empire Health grant to upgrade to a 3D mammography machine which costs about $250,000-$300,000.

L. McNamara suggested sending out reminders for preventative health and utilizing telehealth and visiting specialists, as well as encouraging the use of the public transportation system, to increase patient volumes.

We need to continue focusing on growth, but if we do not see the volumes to support that what is our next step? We need to develop a Plan A, B and C.

L. McNamara asked if there were restrictions on admitting swing beds due to COVID-19; no, but in order to re-open our surgical services per the Governor's proclamation, we have to maintain a 20% surge capacity. We have met with the surgical team to discuss pre-op processes and testing and the clinic has been contacting patients to schedule surgeries that had been put on hold.

The group discussed what right-sizing would mean for the hospital; it would involve adjusting staffing depending on growth or a continued lack of volume. The clinic may have room to grow with specialists, family practice, and behavioral health. Under our rural health designation, we can get the same rate for behavioral health as our primary care patients.

M. Pruett discussed hiring an occupational therapist and offering those services to the clinic, adult care homes, or school districts, as well as offering cardiology, as those patients are referred to Wenatchee, and the possibility of a satellite office in the Methow that would complement other services up there. He agreed that the public transportation system would be useful to bring in more patients.

C. Thomas suggested for the clinic, adding a day of hypertension clinic, and using the downstairs area as a coffee shop while people waited.

J. Munson suggested focusing on ways to draw in more commercial insurance patients to increase revenue. We could try to appeal to the school district employees. J. Best suggested including language in our marketing about what insurances we accept.

T. Shrable suggested improving our outreach to different facilities and groups, like the Hispanic community. J. Best has been sending information out on the radio and on Facebook and suggested developing more ads and content in Spanish. D. Garcia suggested partnering with Gebbers and putting up flyers about our clinic and services. S. Graham suggested hiring teens to canvass the local neighborhoods.

Chad has been looking into a low-cost tool that can be used to send out appointment reminders to patients.

Wrap Up and Next Steps

The group agreed to move forward with the short-term goals discussed and will schedule another meeting in July to discuss the alternative plans if revenue does not increase. The Medicare advanced payments we received will need to be paid back starting in July. If volumes do not improve by August, we will need to adjust our plans.

Conclude

Adjournment
The meeting was adjourned at 12:01 p.m.

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Mike Pruett, Board Chair

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Cherri Thomas, Board Vice Chair

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Tracy Shrable, Board Secretary

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Leslie McNamara, Board Member

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David Garcia, Board Member