The Three Rivers Hospital Board of Commissioners called a special meeting to order at 3:04 p.m. Tuesday, December 7, 2021. 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
Leslie McNamara, Secretary
Tracy Shrable, Member
David Garcia, Member

Others present:

J. Scott Graham, Chief Executive Officer
Anita Fisk, Director of Human Resources
Jennifer Munson, Chief Financial Officer
Gretchen Aguilar, Chief Nursing Officer
Christine Smith, Assistant Chief Nursing Officer
Shauna Field, Administrative Assistant
Jennifer Best, Public Relations
Jamie Boyer, Clinic Manager
Grace Gordon, Director of Quality
Rosie Hartmann, Revenue Cycle Director

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

Agenda
G. Gordon requested the agenda be amended as such: Item D regarding the Quality Program and CMS/DOH survey is not required to be an executive session and will be discussed in open session as an action item. The executive session marked as Item C will take 15 minutes, with no action needed, and will be moved to take place after the quality discussion.

Staff Retention
S. Graham presented the Administration Team's proposal and policy for a staff retention incentive. The hospital is having one of its best financial years and Administration would like to utilize that to thank the staff. Other facilities have provided similar incentives. Qualifying employees who worked at the hospital during the past year will receive $1,000, prorated depending on their FTE status and number of hours worked. The total cost to the hospital to provide the incentive will be approximately $100K. The policy will go out to all staff once approved. J. Munson will add verbiage to the policy regarding how hours are calculated. The group discussed developing an incentive program in the new year contingent on the financial status of the hospital and other ways to show appreciation for the staff.

A motion was made by L. McNamara to approve the staff retention incentive proposal; seconded by T. Shrable. Motion carried.

Quality Program and CMS/DOH Survey Results

G. Gordon presented the conditional findings from the recent annual CMS/Department of Health survey and plans of correction. Failure to address the findings could result in a loss of provider status.

There were 6 quality program citations that must be corrected by December 19, 2021 and will be addressed during the special meeting.

	Issue	Plan of Correction
C962	Hospital failed to collect data on its identified quality indicators for up to 22 months.	We have been reviewing quality data but the DOH felt it was not adequately documented in meeting minutes. Going forward any quality improvement data reports will be noted specifically in the meeting minutes.
C1300	Hospital failed to develop, implement, and maintain an annual hospital-wide, data-driven quality assessment and performance improvement program that included systematic data collection, analysis, and implementation of process improvement with oversight of the hospital's BOC	The quality improvement program was approved by the Board on July 28, 2021 and re-approved on November 17, 2021. The plan of correction is to collect quality data from all patient care areas. We are now receiving and analyzing the data which will be presented to the Board in this meeting.
C1306	Hospital failed to develop and implement an ongoing and comprehensive quality program that involved all departments of the hospital and failed to ensure that performance measures for all patient care services including contracted services.	Specific performance improvement measures and collected, analyzed quarterly data will be provided to the Board on a monthly basis. The Board reviewed the Quality Council minutes including a PowerPoint presentation of performance measures for the Emergency Department including Stoke Care and AMI/Chest Pain. In terms of Stroke care it was noted that response times were outside of best practices. Improvement plans will be forthcoming. Also reviewed were Adverse/Safety Events including annual count by location and type; Patient Falls; and Executive Dashboards summarizing Safety Events and patient feedback including complaints and grievances. The Board will monitor the number, types and locations of safety events being reported. The highest number of reports were in the ER and Acute Care which is to be expected. There were only 10 patient falls in 2021, none involved significant patient harm. There were a total of 182 events reported this year. There were 34 complaints and grievances which have all been addressed and resolved. The DOH had no findings for our complaints and grievance process.

C1313	Hospital's leadership and Board of Commissioners failed to provide oversight to ensure full implementation of the quality improvement plan.	There will be a BOC standing agenda item for the Quality Improvement Program Plan reports. Board members who serve on the Quality Council will provide the Board with a summary of the quality information discussed, bringing forward any specific issues or concerns for the full Board to discuss. Monthly, the Quality Director will provide the Board with updated lists of departments submitting Quality Indicators, performance improvement plans and share quarterly performance measures. These quality performance reports will be noted specifically in the Board's meeting minutes.
C1321	Hospital failed to develop a systematic process for creating, implementing, monitoring, and evaluating performance improvement corrective action plans for identified deficiencies as directed by its quality improvement plan.	Surveyors felt the hospital and Board did not give adequate attention to adverse events. It was noted that adverse safety events and patient complaints are reviewed daily by hospital leadership in the Morning Safety Huddle. A reportable adverse event did occur on June 30 when all power was lost to the hospital and resulted in an interruption in patient care. We did not notify the DOH within 48 hours as required under Washington State law. A Root Cause Analysis was performed with a resulting Corrective Action Plan. That Plan was presented to the BOC for its review and approval.
C1325	Hospital failed to ensure that the quality improvement committee received reports and tracked process improvement for quality indicator data as directed by its quality improvement program plan.	The DOH found that the Quality Council did not receive quality indicator measurement reports or plans of correction from hospital departments. The Board members attending the Quality Council will communicate the Board's requirement that all hospital departments, including contracted services, provide the Quality Department with quality indicators, quality measures and quality improvement plans. The Board will expect the Quality Council and Leadership Council to enforce this requirement and report the status of departmental compliance at the January BOC meeting. Progress of indicators will be tracked, and data reports will be analyzed for Board approved quality indicators including but not limited to: Perioperative Chart Reviews, Patient Medication Verifications, Discharge Dispositions, Trauma Chart Reviews, Stroke, Chest Pain, Sepsis, Meaningful Use of the EMR, Monthly Supply Expirations Checks, Patient Falls, and Medication Events. Grace will have a proposed 2022 Quality Improvement Plan prepared for the Board's January 2022 meeting.

A motion was made by L. McNamara to approve the plans of correction for the survey findings and the power outage corrective action plan, as well as accept all the quality items as presented; seconded by D. Garcia. Motion carried.

Executive Session – RCW 42.30.110(1)(i)(ii)
A 15-minute executive session to discuss potentially compensable claims submitted to Physician's Insurance was held between 3:55 p.m. - 4:10 p.m. An extension of 5 minutes was requested. Open session resumed at 4:15 p.m. No action was taken.

Adjournment
A motion was made by T. Shrable to adjourn the meeting at 4:17 p.m.; seconded by D. Garcia. Motion carried.

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Mike Pruett, Board Chair

ABSENT_____
Cherri Thomas, Board Vice Chair

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Tracy Shrable, Board Member

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Leslie McNamara, Board Secretary

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David Garcia, Board Member