Jefferson Healthcare

Jefferson County Public Hospital District No.2
Board of Commissioners Meeting

Due to the presence of multiple respiratory illness, Jefferson Healthcare is still highly encouraging practice of infection protocols. You may choose to attend this meeting virtually by accessing the below information or can attend in person in the Sheridan Conference Room at 915 Sheridan Street. Limited seating available.

Audio Only: Dial Phone Conference Line: **(509) 598-2842**
When prompted, enter Conference ID number: **572 938 342#**

Microsoft Teams Meeting: Join on your computer or mobile app.
This option will allow you to attend the meeting live.
Click here to join the meeting

Special Session Agenda

Monday, March 25, 2024

- **Call to Order:** 2:00pm
- **Via Retreat Summary** (pages 2-12) 2:20pm
- **New Board Member Manual** (pages 13-51) 2:40pm
- **Board Book: New Agenda Setting Language** (pages 52-80) 3:00pm
- **Committees** (pages 81-82) 3:20pm
- **Board Calendar** (pages 83-86) 3:40pm
- **Conclude** 4:00pm

Jefferson County Public Hospital District No. 2 Board of Commissioners acknowledge that Jefferson Healthcare is on the ancestral and contemporary homelands of the S'Klallam, Chemakum, Twana and other indigenous nations and we recognize these tribal governments' sovereignty across the region.

Jefferson Healthcare

Board of Commissioners' Special Work Session Summary Report from February 7, 2024

Background and Overview

The Jefferson Healthcare Board of Commissioners met for a one-day work session on February 7, 2024. The session objectives that had been identified in advance were:

- Identify the scope of the board's role and process for agenda items
- Gain a greater understanding of the community and patient advocate function and the board's role in issue management
- Enhance knowledge and understanding to improve governance effectiveness

The following individuals attended:

Commissioners:	**Executives, Staff, and Consultants:**
Jill Buhler	Mike Glenn, President & CEO
Marie Dressler, RN	Christina Avila, Administrative Assistant
Kees Kolff, MD	Karma Bass, Via Healthcare Consulting
Bruce McComas	Linda Summers, Via Healthcare Consulting
Matt Ready	

Overview

The agenda for the meeting was reviewed and approved by the commissioners. Karma Bass began the meeting with a review of the objectives for the board retreat. The commissioners shared the following as additional goals and objectives for this retreat:

- Review of and adherence to the board book to ensure consensus
- Review of and adherence to the board calendar
- Advocacy, agenda, and committees
- Agreement on what generative governance really means

Karma reviewed the meeting guidelines.

Board Self-Assessment Results

Linda Summers led the commissioners through a review of the 2023 board self-assessment. The highest scoring and lowest scoring statements were reviewed and discussed. The high scoring areas were reviewed. The areas of identified greatest strength include: the board being well informed regarding matters of the hospital's performance as well as remediation plans when performance is not being met, and strength of the board chair's leadership. Members commented that the strength in these areas is credited to the CEO and the SLG team and their effectiveness in managing the operations and performance of the organization.

The areas of assessed lower performance were presented and discussed. These areas include adherence to the board book, commissioner involvement in advocacy, and development of a board orientation manual. A discussion followed regarding member perceptions in each of these areas. It was agreed that these items are on the agenda at this work session and will be further discussed at that time.

The content of the interviews was discussed. Members identified the improved trust, strong adherence to fiduciary duties, strong CEO and SLG leadership, and alignment and skills of the current commissioners as strengths. Opportunities were identified as needing to "let go of the past," improving the way members interact with one another at times, sticking to the commitments made, and engaging in dialogue regarding the future of Jefferson Healthcare District.

Using Generative Governance to Define Scope and Agenda

Karma introduced this session with a description of the modes of governance and suggested that the commissioners may benefit from defining what generative governance is and how they will use it in service of the organization. An overview of the aspects of health and well-being were reviewed: patient care, community health, population health, and public health and policy. A discussion ensued regarding generative governance. Members shared their perspectives and opinions regarding the board's current use of generative discussions. A member reminded the commissioners regarding the need to stay closely aligned with the organization's mission in all of their work. The commissioners discussed the percentage of time they are spending across fiduciary, strategic, and generative modes of governance. There were varying perspectives on whether time is being spent "in the right spaces." One member shared that, "At times generative governance evolves to become strategic and that we don't always recognize that is what is happening." This was seen as an appropriate and good evolution. Several members discussed they would like to spend time thinking about the longer term of "what could be." It was agreed that the commissioners would like to have guidelines, similar to brainstorming guidelines, for how they engage in generative governance, and Linda and Karma agreed to provide guidelines in follow-up.

One member defined generative governance as "allowing us to think out of the box, at a high level, to improve health for our community, down the road." Several members validated that this was a good description of what generative governance really is. One member expressed reconsidering a previously held definition and thinking of generative governance more as "top down" than starting with the details. The CEO shared that it is difficult to determine where generative stops and strategic begins. He also shared that following the last generative session, he developed a list of "cool ideas," many of which have been achieved. The team agreed there is a need for awareness of not creating a volume of work for the leadership team that is not realistic or focused on the current operational needs of the organization.

Karma asked the commissioners, "What are the agreed upon 'rules' of generative governance?" One member shared disappointment that at times the board has not taken enough opportunity to talk about the future of Jefferson Hospital. The member requested more conversations among board members, rather than only hearing staff reports, asking a few questions, and then moving on to the next report. Concern was shared that the meetings are already long, and it was asked if there is another way to hold these conversations. It was suggested that perhaps quarterly sessions to hold generative discussions may meet the need. It was also suggested that members could submit suggestions, if desired, to inform the conversation.

Karma led the group in a discussion regarding agenda setting. She discussed a recent issue with a request to place a resolution on the board's agenda. Upon receiving the request, the chair had made the decision that the topic was not a good fit for the board's agenda and had declined to include it in the draft agenda that was presented at the beginning of the meeting. A robust conversation ensued as to the outcome of that request and how the item then was placed on the agenda. The resolution itself was also discussed. One member shared the belief that if the board is going to adopt a resolution, it should ideally be something that is supported by the entire board. Another member shared that the board's focus should be on local issues that occur in the community, referencing a recent local case.

It was generally agreed that in this instance, the board used Robert's Rule of Order appropriately, and it resulted in the appropriate outcome. The commissioners agreed to continue following this process and to add some language to the Board Policy Book to clarify how agenda setting works. It was agreed that Karma and Linda will develop language to support this agreement and bring it to the board for future consideration.

Community and Patient Advocate Role and Services Overview

The CEO shared that the community and patient advocacy work began 12 years ago at which time the patient advocacy role reported to the board. Over time, it was determined that perhaps a different structure would work better with that role reporting to the CEO. Additionally, it was determined that there was not a clear administrative path for those "non-patient care issues." Approximately one year ago, a decision was made to try to address both of those challenges by redesigning the role. Brandie Manuel, chief patient safety and quality officer, then shared a presentation that highlighted what the patient experience performance has been, team

updates, and goals and strategies for 2024. Brandie shared information regarding both Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) and Inpatient Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) performance. Brandie also highlighted the patient experience, community advocacy highlights, and team updates for 2023. Mike Glenn shared the development of TEAM STEPPS across the organization and the correlation with increased safety. This supported the investment of Jefferson Healthcare in the broad and wide training of the staff. Brandie then discussed the 2024 goals for the Patient Experience & Community Advocacy team. The following goals were shared:

- Be the point of contact for concerns.
- Connect the community's voice with our care teams.
- Promote person-centered respectful care and best practices in service excellence.
- Care for caregivers and support employee well-being.
- To be the one stop resource for commissioners for complaints, inquiries, and requests for information.

Brandie has committed to providing the commissioners with cards to carry that will provide the patient and community advocate contact information so they can share the cards with people in the community, when needed. Brandie also agreed to share the date, time, and location of an upcoming session being offered by hospital IT support to assist community members with participation in MyChart and the use of the hospital's electronic bill pay, access to providers, etc. It was requested that the board would like to see trending over time of patient experience scores. Brandie agreed to share those.

Leadership Development and Transition Planning

There was a discussion of commissioner succession. If members decide not to run for reelection in November of 2025, there could potentially be new members on the board. It was suggested that the board should begin to discuss succession planning, perhaps through a generative discussion of what is needed in seeking additional skills and abilities to support the healthcare district. Karma shared that AWPHD (Association of Washington Public Hospital Districts) provides training and education regarding what is involved in being a commissioner. This may be useful to those considering running for a commissioner role. A discussion ensued regarding CEO succession planning. It was clearly stated that the commissioners are seeking to begin the development of a process as a responsibility of the board, not due to any impending or anticipated vacancy in that role. Commissioners requested Karma provide information on how Via Healthcare Consulting might be able to support helping the board to determine what the process should be in terms of CEO succession planning for Jefferson Healthcare. The board has agreed that they would like to receive a proposal for that support. Again, it was clarified that the board is undergoing developing a structure for succession planning for the future, not planning for near-term succession.

Governance Effectiveness

Advocacy

Members entered into a robust discussion of advocacy and the commissioners' roles. One member shared thoughts that the commissioners should seek other advocacy concerns that may not be on WSHA's (Washington State Hospital Association) list. Karma reflected that the board seems to be open to creating space for this work. It was discussed that spring into early summer could be a good timeframe for the commissioners to dedicate a generative session on advocacy. Karma suggested that the commissioners use the next generative discussion session to discuss advocacy and how this board might better address advocacy efforts. It was proposed that at the time of the election of officers, the commissioners would select two individuals to represent the district for legislative activities. Following the upcoming board discussion on committees and appointments, language will be added to the board book regarding advocacy member selection. Via will assist in drafting language to address advocacy members following that discussion. That language will be provided to the board for approval.

The board of commissioners went into executive session for approximately 45 minutes. Action was taken when the commissioners came out of executive session.

Committees

The next agenda item was the issue of committees and committee assignments. There was some concern raised that committees are not meeting or, if they are, at times the commissioners are not notified. Other members shared that their participation in other committees has been quite favorable. The members discussed both internal and external committees. The following were identified as committees:

Board Committees
Finance
Patient Experience and Community Advisory
Agenda Setting
Legislative Advocacy

Administrative Committees
Jefferson Hospital OAC Meeting
Equity
Green (has been on hold for 18 months)
Executive Quality

Medical Staff Committee
Credentialing

External Committees
Behavioral Health
CHIP-BHC
Climate Action (designated BOD representative)
Foundation (designated BOD representative?)
Board of Health*****

*******This is no longer a Jefferson-designated seat in association with changes in Board of Health bylaws.*

Board Roles

The subject of committees and board roles will be revisited at a future meeting when selection or appointment will be completed.

Conclusion

The special work session adjourned at 5:10 p.m. PST.

Respectfully submitted,

Linda Summers
Via Healthcare Consulting

Board Retreat Evaluations

Number of Surveys Received: 5

Rating Scale:	Excellent 5	Good 4	Fair 3	OK 2	Poor 1	*Average Response*
Quality of the Presentations and Facilitation	**4**	**1**				**4.8**
Relevance and Quality of Content/Topics Covered	**4**	**1**				**4.8**
Quality of Discussion	**4**	**1**				**4.8**
Quality of Facilities/Setting	**2**	**2**	**1**			**4.2**
Please Complete the Following: "This workshop was a/an _____, **excellent, excellent, good, good** use of my time."						
How well did we accomplish the following objectives of this meeting?						
Identify the scope of the board's role and process for agenda items	**4**	**1**				**4.8**
Gain a greater understanding of the community and patient advocate function and the board's role in issue management	**5**					**5**
Enhance knowledge and understanding to improve governance effectiveness	**4**	**1**				**4.8**

What was the most important or useful aspect of this retreat for you?

- Well facilitated conversation. Great committee discussion.
- Insight from differing perspectives.
- Great discussion regarding agenda setting, resolution.
- Time and space for open and honest dialogue.

What would you change? How could we have made this retreat better?

- Less advocacy for more CEO money.
- Nothing. Impossible – it was great.
- Hard to imagine.
- Works better at an off-site facility.

What topics would you like to see covered at future retreats?

- New trends in governing and/or fine-tuning board documents.
- Steps – preliminary ones, looking towards filling the CEO position in the future.

Any other comments or feedback?

- Great job pushing for clarity on roles and committees.
- Always an excellent use of time and resources! You have made a huge difference to our board – very positive.
- Thank you both – excellent day.
- Another great retreat.
- Always things to learn about operating better as a board.

APPENDIX

Board Agenda Creation

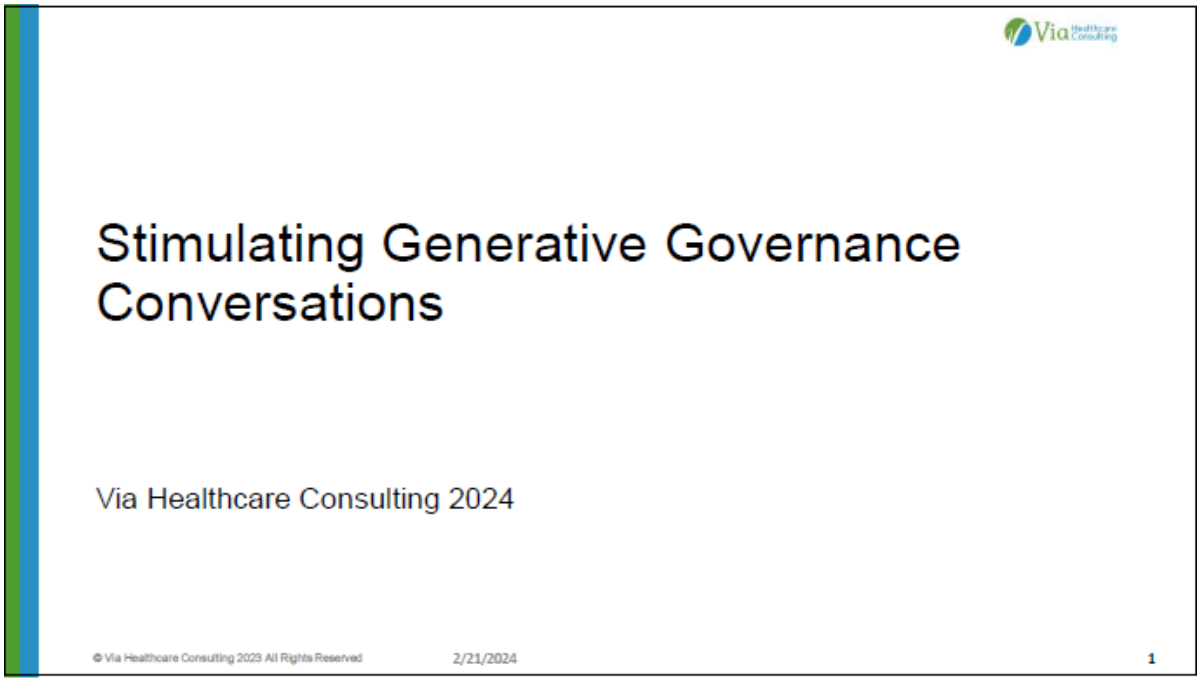
The following is the current Jefferson Healthcare District board book language regarding "Board Agenda Creation."

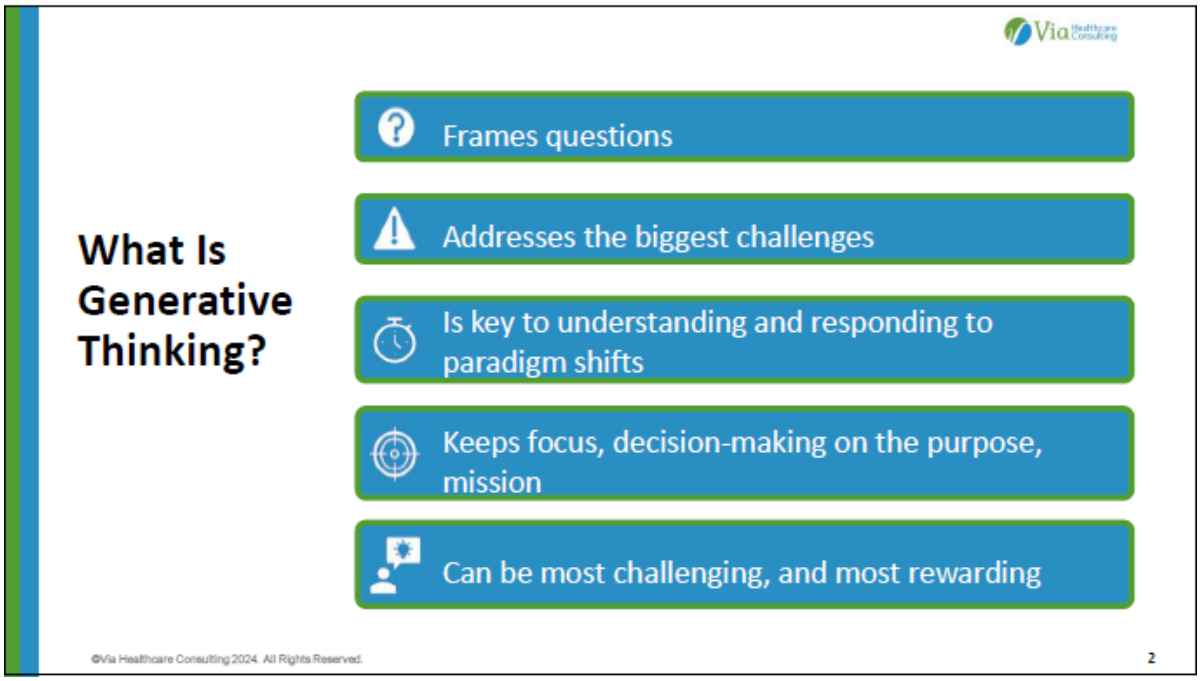
Board Agenda Creation
The Chair and/or Secretary will meet with the CEO to jointly set a draft agenda for the upcoming meeting no less than five business days prior to the meeting. To be in compliance with the intent of RCW 42.30.077 [2014 c 61] of the Open Public Meetings Act, Commissioners are encouraged to submit agenda items to the Chair no less than seven business days before the Board meeting so they may be added to the agenda prior to publication. However, to accommodate emergent items, at the beginning of each meeting, the Chair will call for addition or modifications to the agenda before accepting a motion to adopt the agenda.

The following is **proposed** board book language regarding agenda setting and the process for commissioners to add items to the agenda.

Board Agenda Creation
The Chair and/or Secretary will meet with the CEO to jointly set a draft agenda for the upcoming meeting no less than five business days prior to the meeting. To be in compliance with the intent of RCW 42.30.077 [2014 c 61] of the Open Public Meetings Act, Commissioners are encouraged to submit agenda items to the Chair no less than seven business days before the Board meeting. The Chair will determine if the proposed agenda item will be placed on the agenda, and prior to the publication of the agenda will notify the submitting Commissioner if his/her item has or has not been added to the agenda. If the item has not been added, a brief description of that decision will be provided to the submitting Commissioner. At the beginning of each meeting, the Chair will call for additions or modifications to the agenda before accepting a motion to adopt the agenda. Commissioners may amend the agenda before or after someone makes a motion to adopt the agenda. Once a motion is made to amend the agenda, the board votes, and majority rules.

Generative Governance Questions and Brainstorming Techniques





Questions to Stimulate Generative Thinking

COMMUNITY NEEDS	CHALLENGING OUR CURRENT STATE	FORWARD THINKING
What do our patients need?	What are our BHAGs? (big hairy audacious goals)	If we could "become" tomorrow something we are not today, what would that be?
What are the drivers of good health and poor health in our community?	What are the greatest threats to meeting our mission and vision?	How can we anticipate changes in the environment that may affect our strategic plan?
What needs are being overlooked?	What are we good at?	How might we adapt to be prepared for possible changes?
How does our community encourage residents' health and well-being....poor health behaviors?	How do we leverage what we are good at?	What are we overlooking at the organization's potential peril?
What other organizations or agencies in our community are doing this or similar work?	What was the most important problem we tackled in the last year?	What are the JHC strengths that we are not leveraging as well as we should for our community?
How can we partner with other organizations for maximum impact to our community?	What was the most important lesson we learned in the last year?	What did we learn from the pandemic that we should be considering for future unforeseen events?

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Brainstorming is a group discussion designed to produce ideas and solve problems.

Free flow of information

Uncensored

Encourages all to participate

Ideally in an informal and relaxed environment

Builds on ideas of others

Spontaneous

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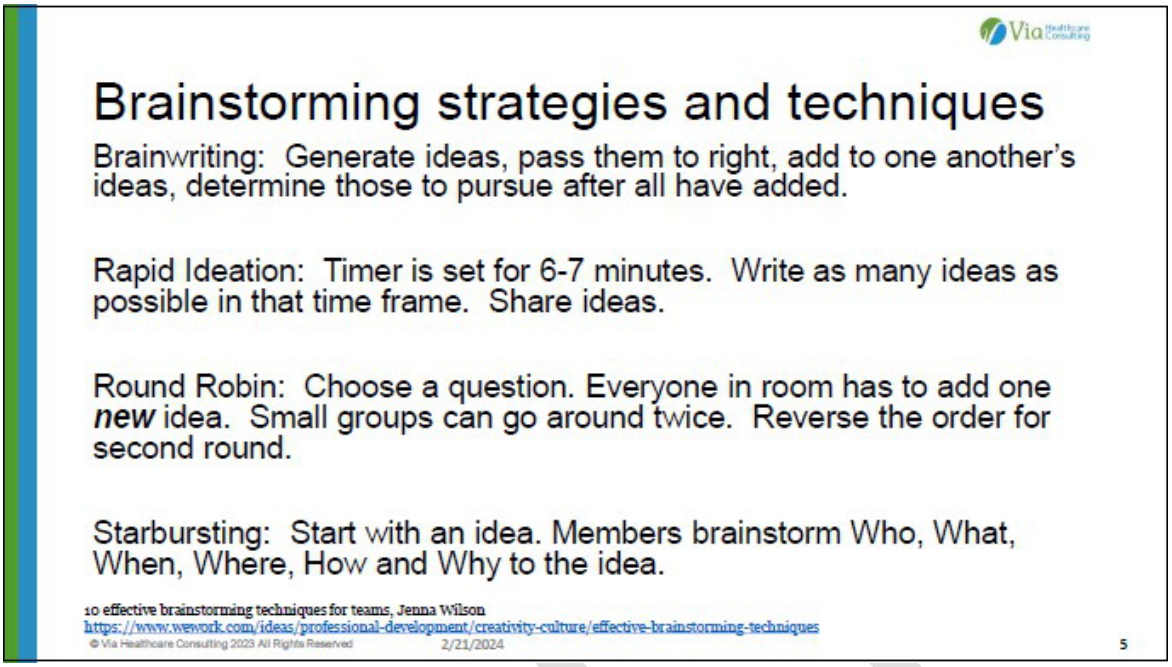
Via Healthcare Consulting
Brainstorming strategies and techniques
Brainwriting: Generate ideas, pass them to right, add to one another's ideas, determine those to pursue after all have added.
Rapid Ideation: Timer is set for 6-7 minutes. Write as many ideas as possible in that time frame. Share ideas.
Round Robin: Choose a question. Everyone in room has to add one new idea. Small groups can go around twice. Reverse the order for second round.
Starbursting: Start with an idea. Members brainstorm Who, What, When, Where, How and Why to the idea.
10 effective brainstorming techniques for teams, Jenna Wilson
https://www.wework.com/ideas/professional-development/creativity-culture/effective-brainstorming-techniques
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2/21/2024
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List for commissioners for 3/25/24 special meeting:

- **New Board Member Orientation Manual** (some portions to be added later)
- **The Board Book** latest draft is included within the *New Board Orientation Manual* on pages 41-54.
    - The Board Book has not been adopted, and changes suggested by VIA are included in this packet in a separate document titled "Agenda Via Update 8.23.2023, Review of Changes and Revisions to Board Book".
    - New content for the Board Agenda Creation is on the Appendix (Page 5) of the Special Work Session Summary Report from February 7 and on a separate page.
- **Summary Report from Via for Special Work Session February 7, 2024**
    - A compendium of action items indicated in the summary is included for discussion.
    - Board Agenda Creation language suggestions are on the Appendix (Page 5), and on a separate page to be considered for the Board Book discussion.
- **Committee Assignments**
    - Suggestions from the Special Work Session are on page 4 of the Summary Report and on a separate page.
    - A draft of 2024 committee assignments is included for discussion at this meeting.
- **Board Calendar**
    - An updated Board Calendar will be sent later, along with a list of legal and Board Book requirements for placement in the Board Calendar.

Please note that THESE ARE ALL DRAFT DOCUMENTS. Nothing in concrete yet (except our new building, I hope).

Thanks,

Jill and Marie

JHC February 7, 2024 Retreat Summary of Action Items:

To Do:

Generative governance guidelines: *Provided by Karma and Linda to be used in Governance Sessions)*

Quarterly generative discussions: *Add to Board Calendar in January, April, July, November*

(to avoid Budget Hearing and Deep Dive in October).)

How to set agendas: *Provided by Karma and Linda to be adopted for Board Book in March*

Patient Experience and Community Advocacy: Brandie to provide commissioners with cards; provide the board with trending patient experience scores: *Add to Board Calendar after discussion with Brandie*

Transition Planning: Begin discussion of board succession planning at upcoming generative discussion. *Add to Board Calendar in November*

CEO Succession planning: *Proposal provided for services from Karma.*

Governance advocacy: Commissioners use generative session to discuss advocacy efforts. *Add to Board Calendar in January or November*

Commissioners will select 2 individuals to represent the district for legislative activities and Karma to assist in drafting language to address advocacy members following that discussion: *Add to Board Calendar when selecting committee members.*

Committee Assignments: Revisited at future meeting when selection or appointment will be completed; *Add to Board Calendar in January?*

Jefferson Healthcare District Governing Board New Board Member Orientation Manual

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Mission, Vision, Goals, and Values

Mission, Vision and Values

MISSION

To hold the trust and improve the health of the communities we serve.

VISION

Jefferson Healthcare will be the community's first choice for quality health care by providing exceptional patient care to every person we serve

GOALS

- Deliver the highest quality care
- Provide a patient experience that we are proud of
- Be a great place to work
- Provide needed services in the most accessible way
- Remain independent, operationally and financially

VALUES

- Compassion
- Stewardship
- Integrity
- Respect
- Excellence
- Teamwork

WE ACKNOWLEDGE

Jefferson Healthcare is on the ancestral and contemporary homelands of the S'Klallam, Chemakum, T'wana and other indigenous nations, and we recognize the tribal sovereignty across the region.

History and Heritage

History and Heritage of Jefferson County Public Hospital District No. 2

The District is a 25-bed critical access hospital (CAH) in Port Townsend, Washington. It is a municipal corporation organized and operated consistent with RCW 70.44, the Washington Public Hospital District statute.

The Sisters of Providence founded the hospital in 1890. They owned and operated it as St. John Hospital until 1975, when ownership transferred to Jefferson County Public Hospital District No. 2, which had been formed following a special election in 1961. In 1985, the facility was renamed Jefferson General Hospital, and in 2004, the name was updated to Jefferson Healthcare to better reflect its status as the nucleus of an integrated healthcare system that had grown to include a number of hospital-based primary care and specialty services.

The hospital is located in the city of Port Townsend, Washington, the only incorporated city in the County and serves as the County seat. Port Townsend is located on Washington State Highway 20 at the northeast corner of the Olympic Peninsula, and approximately a 75-minute drive and ferry ride northwest of Seattle. The District is the only hospital and clinic provider serving the entirety of Jefferson County, and it is also the county's largest employer. The district also operates six rural health clinics, one of which offers dental services. Four of these clinics are in Port Townsend, and the remaining two are located in Quilcene, Washington and Port Ludlow, Washington. The district also operates a retail pharmacy in Port Ludlow, Washington.

The district is the principal provider of health care services for the population living in Port Townsend and the surrounding area, including the unincorporated towns of Port Ludlow, Quilcene and Chimacum, and draws patients from the eastern half of the county.

The county encompasses 2,183 square miles and the district serves an area of approximately 1,152 square miles in the eastern portion of the county.

The district operates six clinics, four of which are located directly across the Hospital in Port Townsend, Washington, a wellness center, and pharmacy. Included below is a description of the district's clinics:

7th Street Clinic. The 7th Street Clinic is located across the street from the Hospital and home to the district's urology clinic.

Sheridan Building. The Sheridan Building is across the street from the Hospital and home to internal medicine, pediatrics, family medicine and dental services.

Townsend Building. The Townsend Building is across the street from the Hospital and home to family medicine providers. The district's primary care providers offer care to patients at all stages of life and provide obstetrical services.

Watership Building. The Watership Building is across the street from the Hospital and home to surgical services, internal medicine, and family medicine.

Wellness Center. The Wellness Center is a renovated space dedicated to illness prevention through education, empowerment, and movement. It is staffed by physical therapists from the district's rehabilitation department and allows instructors to show patients how to harness their healing power to improve quality of life.

Port Ludlow Clinic. The Port Ludlow Clinic is located in Port Ludlow and home to primary care doctors and nurses, diabetes care, cardiology, orthopedics, dermatology and radiology. The Port Ludlow Clinic offers care to patients at all stages of life.

Port Ludlow Pharmacy. Pharmacy services are provided at the Port Ludlow Pharmacy.

South County Clinic. The South County Clinic is the primary care home for the district's community in Quilcene. It offers care to patients at all stages of life, including routine checkups, medication refills and immunizations for children and adults.

The district offers a range of other health services at the Hospital and district facilities. The Hospital provides inpatient pharmacy services, full-time, 24-hours per day hospitalist program. The following summarizes all the Hospital's Services:

Primary Care:

- Family Medicine
- Dental Care
- Diabetes Care
- Internal Medicine
- Pediatrics

Emergency and Express Care:

- Emergency Services
- Sexual Assault Services
- Express Clinic

Specialty Services:

- Anesthesiology
- Behavioral Health
- Cardiology
- Cardiac Rehabilitation
- Hospitalist Care
- Imaging and Radiology
- Infusion Services
- Laboratory Services
- Obstetrics and Gynecology
- Occupational Therapy
- Oncology
- Orthopedics
- Dermatology
- Family Birth Center
- Hospice Care
- Home Health
- Palliative Care
- Pharmacy
- Physical Therapy
- Plastic and Reconstructive Surgery
- Pulmonary Rehabilitation
- Respiratory Care
- Rehabilitation Services
- Sleep Medicine

Speech Therapy	Urology
Surgery	Wellness Center for Excellence
Surgical Services	Women’s Health
Telemedicine	Wound Care

The district is governed by a five-member Board of Commissioners (the "Commission"). The Commissioners are elected by the residents of the district and serve six-year terms. The current Commissioners are:

- Chair and Commissioner Jill Buhler Rienstra
- Secretary and Commissioner Marie Dressler, RN
- Commissioner Kees Kolff, MD
- Commissioner Bruce McComas
- Commissioner Matt Ready

The day-to-day management of the district is delegated by the Commission to the district's Chief Executive Officer, and to its administrative staff.

Community Health Needs Assessment Summary

JEFFERSON COUNTY COMMUNITY HEALTH ASSESSMENT REPORT: QUALITATIVE FINDINGS FROM COMMUNITY INPUT, MAY 2019

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Introduction

In 2019 Jefferson Healthcare and Jefferson County Public Health conducted a Community Health Assessment (CHA) to inform the development of the next Jefferson County Community Health Improvement Plan (CHIP). In addition to the primary CHA activities involving quantitative data collection on indicators of health status, behaviors and outcomes, we solicited qualitative input from the community to gain a richer understanding. This report summarizes findings from the community input activities, involving two community forums and twelve key informant interviews. We describe overall key findings as well as indicator-specific insights that supplement the quantitative CHA indicators.

Methods

The primary qualitative data collection methods were key informant interviews and community forums. We used the existing quantitative data collection tools (e.g. community survey) to identify a complementary qualitative approach. We adapted materials from neighboring counties to develop discussion questions to achieve the following aims:

1) Describe the main health concerns of Jefferson County residents
2) Understand specific concerns regarding behavioral health outcomes and services
3) Identify significant gaps in resources and coordination related to those concerns
4) Explore key elements that promote the health and safety of Jefferson County residents

KEY INFORMANT INTERVIEWS

The CHIP/CHA leadership identified key informants based on their community involvement, leadership roles, representation of a health service provider, and/or direct involvement with a sub-group or population. Twelve key informants were identified and all participated in the interviews. Key informants represented stakeholder perspectives including emergency services, the justice system, healthcare providers, affordable housing, public health, public schools, local government, social services and others.

For consistency, all interviews were conducted in May 2019 and by the same individual. Each lasted 45-60 minutes. Eleven interviews occurred in person, and one was conducted over the phone. We audio-recorded and transcribed all interviews for accurate collection of responses. Key informants provided written consent prior to participating.

COMMUNITY FORUMS

To gather input from different populations across the county, we identified three areas to host community forums: Port Townsend, Quilcene and Chimacum. The forums were promoted through email, local newspaper, flyers and existing community meetings. One forum attracted only two participants; both were able to provide input in individual conversations. The other two forums each hosted approximately fifteen participants. Participant age, gender, community of residence, and length of residence in Jefferson County varied within each group.

Both forums were held in May 2019 and took place in centrally located community buildings. The same individual facilitated each 60-minute forum. We audio-recorded and transcribed one forum, and a note-

taker documented the other forum due to technical difficulties. All community members provided written consent prior to participating.

We used Otter.ai, a voice recognition and transcription software, to transcribe the audio recordings from the interviews and forums. We used Dedoose software (Version 8.2.14, 2019) to analyze the transcripts and notes. Indicators from the quantitative data informed the analysis framework and coding.

This project was considered a public health surveillance activity for the purpose of directly informing local health improvement efforts and was therefore exempt from review by the Washington State Institutional Review Board.

Key Findings

Key informants and community members broadly identified **access to health care** as the main driver of health concerns in Jefferson County. Health care access concerns were identified across the healthcare system: youth and adult behavioral health services (mental health and substance use), preventive care, geriatric services, crisis stabilization and emergency medical care, dental care, and medical and behavioral specialists. Most respondents considered mental illness and substance use as significant health concerns in the county.

The most commonly cited **barriers to accessing care** included limited county-wide public transportation, hours of clinic operation, care options with Medicaid and Medicare, provider capacity, awareness of available services, as well as having to travel beyond the county for specialty care and feeling stigmatized for seeking behavioral health care. While respondents from Port Townsend and rural communities alike mentioned health care access as a priority concern, it appeared to be a stronger need in rural communities. Key informants also identified significant need for senior care and independent living options to support the large aging population in Jefferson County.

Recent advances towards increasing health care access in the county Mobile youth dental services, school based health clinics and the new dental clinic were noted as. Community members were supportive of telehealth as an opportunity to further increase access to care. Women's health, pregnancy services, and Jefferson Healthcare's responsiveness to community needs were identified as strengths of the healthcare system.

A second major concern among respondents was **affordable housing.** Respondents felt that housing was unaffordable for many populations, including working class county residents, young families, seniors, people seeking mental health treatment and people in the therapeutic court system seeking transitional housing. Growing socioeconomic disparities within the county, cycles of poverty, and adverse childhood experiences were recognized as underlying factors to the issue of affordable housing in addition to unit availability. Other significant concerns related to this were **affordable childcare and support for families with young children.** One key informant shared a common challenge for young families:

"Housing is really difficult. [...] It's that part of getting into that hole, and then trying to dig yourself out. So they might have had a history of poor credit, or some kind of criminal background, which then prevents them from being able to even start at any kind of level of looking [for housing]. So there's that personal piece, as well as just the overall availability of units. So I think that combination is not helpful. Some of us often talk about being able to have

some kind of support network for young families that could help provide some of those things like housing and childcare, and so then the parents are able to actually go out and work, or look for work, without having to worry about who's watching their kid and those kinds of things.
Those support resources are just really minimal."

In addition to affordability, **rural infrastructure challenges** were noted as barriers to housing. Key informants cited limitations in certain rural communities, including no sewer system, internet access, and limited public transportation. **Aging in place** was another significant health-related housing concern. Key informants felt the county is not developed to support an aging population which requires varying levels of assisted living, specialty care, transportation services, and mobility access in the build environment. Affordable, independent and assisted living facilities for the senior population as well as county-wide infrastructure changes were among the priority needs.

A third overarching health concern was the need for better **coordination across behavioral health, medical, justice and emergency response systems**. Attributed partly to underfunded and siloed behavioral health agencies, respondents identified gaps in the behavioral health care system that result in crisis-oriented care and limited capacity to treat moderate, common conditions that help prevent such crises. Key informants felt it is challenging to reach vulnerable populations at risk for health crises (e.g. people experiencing homelessness, mental illness or substance use disorders) until they are admitted to the Emergency Department (ED) or county jail. Key informants expressed need for an alternative to these endpoints. They suggested improving linkages between agencies to help provide care and services efficiently. One key informant reiterated the need to coordinate limited services:

"If we don't consciously collaborate, we'll end up competing and duplicate what we're doing; we'll end up kind of trying to market ourselves to the same populations. And just at this level, at this scale of a rural community, that's a very wasteful thing to do. We just do not have the abundance of resources that allows that kind of competition--you can get away with it in urban areas, where you have excess capacity and have sort of a survival of the fittest kind of thing."

Another respondent expressed the need to integrate behavioral health care with medical care to prevent emergency department (ED) admissions:

"If you want to reduce ED utilization, particularly unnecessary ED utilization, you have to get ahead of mental health issues. Because otherwise, when you don't, the ED is the result. And that's not just directly for the suicide attempts that come in, but the person who doesn't control their diabetes or heart failure because their mental health issues are not controlled. They're going to end up in your hospital--it's going to look like it's a physical health issue, but a lot of times it's driven by mental health, or substance abuse, or things like that. So, some of the work is not necessarily recognized as something a critical access hospital should do, but yet, if you want to improve the health of community, you want to get more upstream."

Furthermore, navigating the behavioral health system appeared to be challenging for residents seeking care. Common concerns included few providers accepting Medicaid, long waits for referrals, transportation to clinics, and lack of inpatient treatment in the county. Key informants felt that system-wide behavioral health integration as well as employing more social workers and navigators would begin to address these concerns. The recently added navigator role with law enforcement, provision of

Medically Assisted Treatment (MAT), and increased number of school counselors were noted as strong points in the behavioral health system.

Community members and key informants felt positively about access to healthy foods and physical activity opportunities in Jefferson County. Proximity to farms and fresh produce, outdoor recreation, and fresh, clean air were considered key elements that promote the health and wellbeing of residents. However, some disparities in healthy food access and indoor recreation opportunities were recognized in rural, remote communities.

Additional health concerns, gaps, strengths and quotes relating to the 2019 Community Health Assessment indicators are provided below in the **Themes** and **Findings** columns. The purpose of presenting these results is to supplement quantitative indicators with community voice.

2019 Jefferson Community Health Assessment – Key Informant Interview and Community Forum Themes and Findings		
THEMES		**FINDINGS**
Part 1. Demographics, Socioeconomics, Community Safety		
Section A: Population		
	Older population	Infrastructure and wellbeing of an aging population As seniors begin losing their functional capacity, key informants suggested improving social infrastructure, or better options for socialization and support, to help prolong their ability to thrive as active community members. "And you're seeing the age-related illness, and they moved here, away from possibly other friends and family, and maybe they established friends, but they don't necessarily have family locally. And what's happening as they age and become more fragile, is **you start to kind of reveal, well, it was good place to retire. But it's not necessarily fully developed to age in place**." "There are some home care options, we've got home health, nursing, private, and through Jefferson [Healthcare]. So these things are good, but they tend be targeted for specific episodes of care: you just came out of the hospital, you just got through kind of a recent illness. **Maintenance care is a different story**." Retired population a significant resource to the community Respondents considered the retiree population in Jefferson County as a valuable resource regarding volunteer capacity and community engagement. Respondents were supportive of additional efforts to engage retired residents in helping to fill community service gaps.
	Growing retiree population	
Section B: Education		
	School districts differ by parental support, involvement	Public schools serve as rural community centers Schools were considered central hubs in rural communities and successful outreach points for increasing access to health services and fostering social support. There were clear disparities in school performance and health outcomes across the county. "Having strong, healthy, viable school districts is hugely important. We have one school district here that is just rocking it and having success with every turn. And you see what impact that has on families. They feel good about where the kids are going and their prospects for the future versus one school district that is like literally hemorrhaging students, hemorrhaging staff, hemorrhaging administrators. Morale is so low--it's going to be a make or break issue for that small community." Providing health care services through the schools was considered a successful model because parents are often outreached directly by the schools, costs are low, and transportation is mitigated. Examples include school based health clinic, Smile-mobile, immunization clinics, vision screenings, and mental health counselors. Community members and key informants expressed **strong need for continued and expanded provision of behavioral health and preventive care in the schools**. Assistance programs for students including the Fresh Fruit and Vegetable Program, summer food assistance, and transportation support were considered successful and well utilized in rural communities.
	limited funding	

Section C: Employment		
	Health of low-wage workers – homeless	<u>High turnover in health services</u> Key informants expressed concern about staff turnover in health care and behavioral health facilities, which were attributed to high volume workload, burnout, and unaffordable housing. One key informant mentioned that many people who work in Jefferson County live in a neighboring county. Recruiting health care professionals to fill positions was a challenge as well. This raised concerns about the health system's ability to provide adequate hours of care and services to meet the needs of residents. <u>Poor working class</u> Respondents shared that many community members may be unaware that working class residents experience homelessness and live out of their cars because of the high housing costs.
	Employees not living in JC – unaffordable	
	HIGH turnover in health services jobs	
Section D: Income and Poverty		
	Poverty	<u>Social determinants of health</u> Key informants and community members felt that poverty and socioeconomic disparities were the main "upstream" factors to many health concerns in Jefferson County. "It's really kind of a **social fabric issue where families are under stress and having to make tough choices** with none of those choices being good choices in terms of health. So, you see a lot of kids who don't have parents around because they have to work three jobs to be able to afford rent here, and don't have time to cook. So, kids aren't eating well. Into to the teenage years, they're home alone a lot, not a lot of activity, and they are very drawn to substance use. **We have a lot of substance use in our adult population, so kids are seeing that. And then, you know, get into addiction. And it's the criminal response to that.** […] And so it again just puts that onus back on at the policy level of [asking], where are the economic and educational opportunities to change this trend of multi-generational poverty here?"
	Social determinants of health	
	Rural poverty vs. Port Townsend	
	Working poor	
	Homelessness	
	Child poverty	
Section E: Household Composition and Marital Status		
	Older adults living alone	<u>Isolation in the aging population (See Part I. A)</u> Many respondents identified **the health and safety of the aging populating as a priority health concern**. Isolation and living alone were considered risk factors for injury, hospital admission, as well as declining mental health, mobility, and social functioning. Key informants expressed need for a wide range of support services, housing, and infrastructure changes that support mobility and socialization.
	Isolation	
Section F: Housing		
	Affordability	<u>Affordable housing (See Part I. C, working poor)</u>
	Homelessness	

		Affordable housing was considered a priority health concern for many populations in Jefferson County: working class residents, seniors, young families, people seeking mental health and substance use treatment, and people seeking transitional housing in the therapeutic court system. Barriers to affordable housing included **socioeconomic disparities in the county, cycles of poverty, limited access behavioral health treatment, and infrastructure challenges** (e.g. sewage). Limited number of available units was also a barrier. "Housing is really difficult. [...] It's that part of getting into that hole, and then trying to dig yourself out. So they might have had a history of poor credit, or some kind of criminal background, which then prevents them from being able to even start at any kind of level of looking [for housing]. So there's that personal piece, as well as just the overall availability of units. So I think that combination is not helpful. Some of us often talk about being able to have some kind of support network for young families that could help provide some of those things like housing and childcare, and so then the parents are able to actually go out and work, or look for work, without having to worry about who's watching their kid and those kinds of things. Those support resources are just really minimal."
Section G: Community Safety		
	Property theft	Key informants were concerned about high instances of child neglect and abuse, particularly in rural communities. Child Protective Services sometimes seemed to be understaffed and unable to respond effectively to each report that was filed. Some community members mentioned property theft as a consequence of substance use and mental health issues observed across the county. In general, community safety and a sense of a "**tight-knit" community were viewed as key elements that promote the health and wellbeing** of Jefferson County residents.
	Domestic violence	
	Child abuse	
Part II. Quality of Life		
Section A:		
	Quality of life	<u>Wellbeing of an aging population (See Part I. A)</u> Community members and key informants identified the aging population as at risk for declining quality of life. There is **need to provide maintenance care and services that bridge the gap between the "thriving" senior population and the in-home, end of life care needs**. Retirees that moved to Jefferson County experience **isolation** and lack of social support in these transition periods, which can lead to mental and physical health declines. Respondents suggested a more **purposeful network of social services to support aging in place efforts**. In particular, collaborations between churches and the healthcare system could be stronger to foster a network of support senior health needs. <u>Limited disability services</u> Respondents commonly cited the lack of care options for children with developmental disabilities or specialized medical care. Schools had limited ability to provide learning disability support.
	Elderly quality of life, Older adults living alone, isolation	
	Rural quality of life	
	Poverty and quality of life	
	ACEs	

		Transportation Transportation was widely considered a **major barrier to health care, financial stability, and overall quality of life**. Many respondents mentioned the infrequent (e.g. twice daily) public transportation available in and out of Port Townsend or to larger cities for care. Residents of rural communities had the most hardship, as a trip to Port Townsend could take a whole day on the bus. Access to personal transportation was financially limiting. Health and social services outreach **Public libraries were regarded as "second responders"** in the community in terms of direct engagement with vulnerable populations, particularly seniors and people experiencing homelessness. Key informants reported success in helping clients learn about available services and providing informational assistance. Key informants felt it is **challenging to communicate and conduct health outreach across the county**. There are pockets of communication networks, but not a central platform. For example respondents mentioned multiple newspapers, inconsistent internet, and multiple radio stations. They saw this as a contributing factor to some residents being unaware of existing services. ACEs (See Part I. D)
	Food Insecurity	
	Healthy food affordability Healthy food access WIC, SNAP	Food insecurity Respondents felt that residents of remote, **rural communities are more likely to experience food insecurity**. Living far away from a grocery store with fresh produce was a main reason, combined with transportation challenges. Existing food banks were considered very successful and substantial resources for food insecure individuals. The ability to use SNAP benefits at farmers markers also was considered helpful to addressing food insecurity. Furthermore, schools have been successful in securing funding to provide healthy food assistance programs. Community members and key informants would like to explore additional **partnering opportunities with local farmers and farmers markets to increase access in remote communities**.
Part III. Health Care		
Section A: Health Care Coverage		
	Health care access Medicaid Insurance coverage-- Medicaid: dental Medicaid dental - youth Insurance coverage-- Medicaid: MH, end of life	Medicaid uncertainties Key informants and community members felt that Medicaid expansion through the Affordable Care Act benefited many residents in Jefferson County, particularly young adults. **Uncertainties about which providers accept Medicaid (e.g. specialty care and behavioral health) was considered a barrier to seeking care**. Prescriptions, referrals, and follow up appointments were also thought to be concerning for Medicaid recipients regarding unexpected costs. Residents who barely do not qualify for Medicaid were noted as high risk for not seeking care or obtaining health insurance due to cost barriers.

		"I think a lot of our kids are on Medicaid. And so that takes away some of the financial fear. But there are still some mysteries, you know, and they're still, you know, once you go to the doctor, then you got to get your prescription filled, and then, you know, getting just regular maintenance care is tough." The new dental clinic is considered a significant success regarding increasing Medicaid coverage for dental care.
Section B: Health Care Access		
	Health Professionals	<u>Health care access</u> Access to health care was broadly considered a main health concern in the county. Access issues included: – Traveling beyond the county for care – Limited specialty care (especially youth) – Limited community clinics – Limited provider capacity, long wait times – Financial barriers, transportation – Stigma (behavioral health treatment) – Lack of crisis stabilization center or inpatient treatment facilities – Vision services for youth (beyond screening) Mobile clinics, school based health clinics, dental care, and integrated behavioral health services in law enforcement were noted as recent advances towards increasing health care access in the county. Women's health and pregnancy services were also identified as strong points in the healthcare system. Key informants reported success in leveraging resources from well-funded health care services to support dental, palliative care, other pilot programs and needs voiced by the community. <u>Geriatric Services</u> Respondents felt that senior care was particularly difficult to access. Many seniors do not drive, especially at night. Public transit is very limited and does not run at night. Furthermore, respondents felt that **geriatric specialty services** were not available in the county to address the needs of an aging population.
	Mental health professional shortage	
	Mental health professional burnout	
	Geriatric care	
	Cost barriers	
	School Based Health Clinic	
Part IV. Pregnancy and Births		
Section A		
	Access to contraception	<u>Minimal services and support for young families</u> Community members and key informants alike felt that there is minimal support for families with young children. "I feel sometimes that the **population [is] almost invisible to the community, that families with young children, and especially the families who are lower income, and struggling with, you know, many things often do not rise to the top of community concern**. It's really been kind of a shift, I think, in the just the general demographics of the population with so many, people moving into the town that are more of retired age. And so I think that families with children just don't see as many of the schools sizes have decreased."
	Education about services	
	WIC well used	
	Services for families with young children	
	Child care	
	Social support	

	Childcare Childcare was a major need. There were thought to be only three licensed childcare providers in the county. Additional programs and social support activities would benefit this population as well. "Childcare providers, that's a huge gap in our early childhood wellness and family wellness, and fitness. **It is often easier for parents to stay home than it is to find affordable childcare that will enable them to move into meaningful long-term work**. That actually is a huge gap right now."
Part V. Behaviors, Illness, Injury, Hospitalizations, Deaths	
Section A. Communicable Diseases	
	N/A
Section B. Immunizations	
Anti-vaccine Traveling vaccine clinic	Community members and key informants expressed some concerns about anti-vaccine views in the county. However, their outlook was relatively optimistic and they mentioned the recent statewide legislation that they think may increase immunization rates. Key informants believed that mistrust of government institutions, education, and misinformation were possible drivers of anti-vaccine views in Jefferson County. **The traveling immunization clinics that visit schools were considered a strength in promoting health and safety among residents.**
Section C. Chronic Disease	
physical activity outside--recreation activities for kids Farm to table Access to fresh foods (good and bad in diff areas)	Physical Activity Community members and key informants felt that having access to outdoor recreation, including hiking trails, hunting and fishing are key elements to promoting physical activity in the community. However, respondents reported challenges in the winter when indoor facilities are unavailable. **"It's hard to get adequate exercise when lots of days in the winter, when I get home, it's already dark, and I think our students are like that, too. By the time we get them dropped off in the buses or when they get home, it's already dark.** We don't live in proximity to any facilities that have health clubs or any other facilities within an hour drive. […] There are months where it's kind of hard, it's wet, it's cold, it's dark. So those are challenges, I think for me and also for the community." In rural communities, residents would like to use community centers, school gyms, and/or leverage healthcare system resources to rent existing spaces for exercise classes to address physical activity challenges in the winter. Building a pool, a basketball court, renovating the community center were also mentioned as strategies for improving physical activity.

		Healthy Food Access Proximity to farms and an active farmers market network were considered key elements that provide access to healthy food in Jefferson County. Some disparities in healthy food access were recognized in rural, remote communities. **Schools help bridge the gap in low-income communities**: "Access to fresh foods is also a challenge. We're lucky to have a really great food bank for our families. They do a good job of trying to bring in produce and things like that. But we just got the local store. And that's chips, a loose apple or loose orange, or your big trips to Poulsbo or Sequim to shop. […] And I think that puts pressure on us at school to try to do a good job with foods, make sure we've got salads and fruits and veggies and things like that."
Section D. Tobacco & Vaping		
	Substance use	Youth One key informant felt that rural communities lack activities for kids and there is a need for more focus on prevention of substance use (including tobacco and vaping). "We see a lot of vaping. We know that's a problem in the schools. We know that there's just not a lot for our kids to do. So, I would have to come back to that preventative piece. Education, prevention, other alternatives, really being able to dive in […], seeing it as a need that's pressing now, rather than waiting for things to happen."
	Alcohol	
	teen tobacco	
	teen vaping	
Section E. Alcohol Use		
		Adult alcohol use Community members felt that alcoholism is a big problem in the community. They are concerned about a lack of support services, especially in the rural communities. Youth alcohol use One key informant felt that among youth, it seems that marijuana use is going up, and alcohol use is going down**.**
Section F. Drug Use		
	Harm reduction	Overall, community members and key informants believed substance use and mental health were significant health concerns in the county. A **major treatment concern was the lack of inpatient substance use and mental health treatment facilities.** Respondents felt it is a barrier to treatment to have to travel outside of the county, as well endure long wait times for treatment referrals or beds to become available. Opioid use and treatment Respondents were supportive about recent additions of medically assisted treatment (MAT) services available in Jefferson County. Respondents were also supportive of existing harm reduction efforts in the community, including needle exchanges and sharps containers installed in public restrooms.
	Opioid treatment	
	Therapeutic Court is a success	
	Drug-related hospitalizations	
	ER admissions for drug or alcohol/ EMS transports	
	Coordination of services	

	One key informant shared that healthcare providers were slow to uptake MAT and support its provision in clinics and hospitals: "It's been very **difficult getting the primary care providers to embrace medication assisted treatment**. I mean, it's happening. But there's just a lot of, you know, kicking and screaming […]I think part of it is, they're very busy. So it's seen as taking on another really challenging, complicated problem--which really is much easier to do than a lot of the stuff you're doing. This is heroin addiction, much easier to treat than diabetes, or congestive heart failure or a lot of other things. And I think they lack experience in that realm. So, the key is to get them to dive in. And once they do, and I know this from working on some projects, **once you can get them actually seeing patients and seeing results, then it becomes one of their favorite things to do. Because it's really gratifying**. And it's not complicated. It's all been worked out. The science is all there. But we've been slow to embrace it." <u>Drug-related hospitalizations/EMS transports</u> Hospitalizations and arrests due to behavioral health crises were common concerns regarding access to health care and behavioral health treatment. Key informants explained in crisis situations, there is no 24/7 accessible alternative to stabilize patients than at the Emergency Department or county jail. Key informants expressed a **strong need for crisis stabilization, as well and behavioral health integration in the health care system** to reduce crisis incidents in the first place. Trained mental health and social worker professionals are needed at all steps in the behavioral health, crisis prevention system. "We just started with a navigator program, which is a social worker, mental health worker embedded with police department. […] You know, we're asked to respond to people in crisis for these things and try and work with it. So, we have training, triage-type training, just like we have first aid training for medical things. […] **But we're still not mental health workers or social workers. And that's what these people need to have. Someone with the police that can do that is immensely beneficial**, because a lot of these contacts don't end up going to the ER or jail, or they may get released.[…] I think coordination is there--**what we lack is the resources from beginning to end."** <u>Agency coordination, behavioral health integration</u> Respondents experienced gaps as well and redundancies in the services offered by behavioral health agencies and non-profits. They felt that some agencies seem to be seeking the same clients, while also not having enough capacity to meet all clients' needs. Key informants suggested **additional efforts to coordinate funds, services, linkages to address gaps and sustain existing programs**.
Section G. Mental Health and Suicide	
Youth mental health services Adult mental health services Suicide Mental illness hospitalizations Medicaid coverage Repeat clients Justice system, recidivism	Community leaders and members considered mental illness and substance use as significant health concerns in the county. Barriers and challenges to getting treatment included: – Limited outpatient options with Medicaid/Medicare coverage – Long referral periods; limited walk-in opportunities – Minimal treatment options for youth – Stigma associated with needing/seeking mental health care – High staff turnover, inconsistent case management and care – Adverse childhood experiences, inter-generational trauma

Youth and adolescent mental health

Respondents expressed specific concerns about mental health care for adolescents, which they felt is lacking in the county. Respondents were supportive of existing efforts to provide services in schools and they requested additional efforts in this area. Existing mental health programs such as Jumping Mouse were considered successful and effective in the community.

"In poverty, sometimes there's a sense of hopelessness, and sometimes there's depression, with the parents and the kids, and accessing care for that is a challenge […] The problem with that care is, if you have strep throat and you go to the doctor, you can just go once and that it's fixed, […] but [with mental health care] you have to have a commitment to keep getting there. So **it's super important to bring those services to the school, core to the community. Because it's not going to be it's not a quick fix.** […] And if you want to get out of the poverty loop, you need to make sure that you're doing a great job educating the kids to give them opportunities and open some doors for them. But you can see how it's kind of a circle, you know, the behavioral health issues, the mental health issues, holds you back. And you're unable to maximize the education that's being offered, and then you're not able to get yourself out of this loop."

Other respondents felt that community programs and activities play a key role in preventing mental illness and substance among youth, especially in transition periods after high school graduation. Respondents encouraged additional efforts to create community support and activities for active engagement.

Behavioral health integration

Many respondents spoke favorably about integrating behavioral health care in the health system to meet access needs. Key informants mentioned clear links between mental health and emergency department utilization, and suggested that continued efforts to provide services, prevent debilitating mental illness, and save costs. It was felt the behavioral health system needs to move away from crisis-oriented care and increase capacity to address the life disrupting, but not disabling, issues that affect more people.

"The big problem is that the regional and the state system just are not to the point that they offer the kind of support, and another big problem is because of their history, the sort of endless crisis and lack of resources. The community behavioral health systems really tend to focus on the most severe problems. **[…] They have to put all their resources into that highest need population, they really don't have resources for much more common problems, you know, anxiety disorders, and bipolar disorder and things that are not disabling but are very life disrupting. And a high functioning system does both.** Because there's a lot of treatment opportunities there. There's a lot of opportunities for community health improvement, and treating conditions before they get disabling. And, in turning around that, that impact on a person's life and their productivity. So that [is] what a behavioral health system should do. Financial integration is the least important thing. It's this sort of functional integration as the goal."

Mental health and justice system

Mental health was a significant concern for populations in the justice system and therapeutic courts. Key informants believed strongly that behavioral health services integrated in the jails, and in the re-entry transition period, would reduce recidivism and help this population successfully rejoin the community. One key informant felt that the services offered currently in the jails are minimal and inconsistent; a greater focus on accountability and sustainability was a common concern regarding effectiveness of mental health care.

"Our county jail is by far the largest mental health facility that we have. We are treating chronically, mentally ill and substance abuse populations there with little training resources as the people in crisis and that's a huge challenge for us. **We see repeat offenders over and over, because we have very few support services to ensure that they have housing and jobs and, some of the factors of stability that would allow them to stay out of the justice system**."

		The case for providing MH services in the jails: "So, you would prefer to avoid the jail. But once they're there, once you've identified the--and it's sort of like once someone's had a heart attack, they're more likely have another heart attack--and when we treat that population the same way, you know, we're not going to let you have another hard time, we're going to do everything we can to try and avoid you failing and so you don't end up back here. And those folks need unity, obviously, need social services, they often need medical care, they often need mental health care, a lot of substance use disorder treatment. **The problem, they lose their insurance when they go into jail, which means that there's not much incentive for healthcare systems or providers to work with them because the reimbursement has to come through the county budgets, and county budgets don't have the money to spend on health care for their inmates. But then you release them and you don't have a plan, and you've missed your opportunity."**
Section H. Injuries		
		N/A
Section I. Hospitalizations		
		Respondents reported common hospitalizations due to mental illness and substance use crises, as well as senior populations living in unsafe, isolated conditions. "Where we get stuck, and what we see in the hospital a lot is that we get people who come in […] with moderate dementia, not safe at home, can't discharge them back, and they end up stuck at the hospital […] because we can't quite find--they don't have the financial resources for one type of facility. […] So we have these tricky dispositions, and we try to send them back into the community trying to kind of do wraparound services, with intermittent success."
Section J. Deaths		
		N/A

New Board Member Orientation Manual
Serving on Jefferson Healthcare District Governing Board

Strategic Plan

2023 – 2025

JEFFERSON HEALTHCARE
STRATEGIC PLAN 2023-2025

Jefferson Healthcare

SHAPING THE HEALTH OF OUR REGION

WHO WE ARE

JEFFERSON HEALTHCARE is a fully accredited, award-winning healthcare organization meeting the care needs of East Jefferson County.

We are a clinically integrated, full-service healthcare delivery system offering inpatient and comprehensive outpatient services and primary and specialty physician care.

We are the largest employer in Jefferson County, employing over 850 employees, including 100 doctors and advanced practice clinicians and generating over $70 million in annual payroll.

We are the healthcare delivery system of the communities we serve.

WHAT WE BELIEVE

1. **We believe local healthcare is better healthcare.**
2. **We believe healthcare should be governed by community representatives, informed by community needs and shaped by community voices and the values they represent.**
3. **We believe healthcare should be easy to navigate, accessible and equitable to all and delivered with the highest level of compassion and quality.**
4. **We believe in the dignity and self-worth of everyone we serve and serve with.**

MISSION

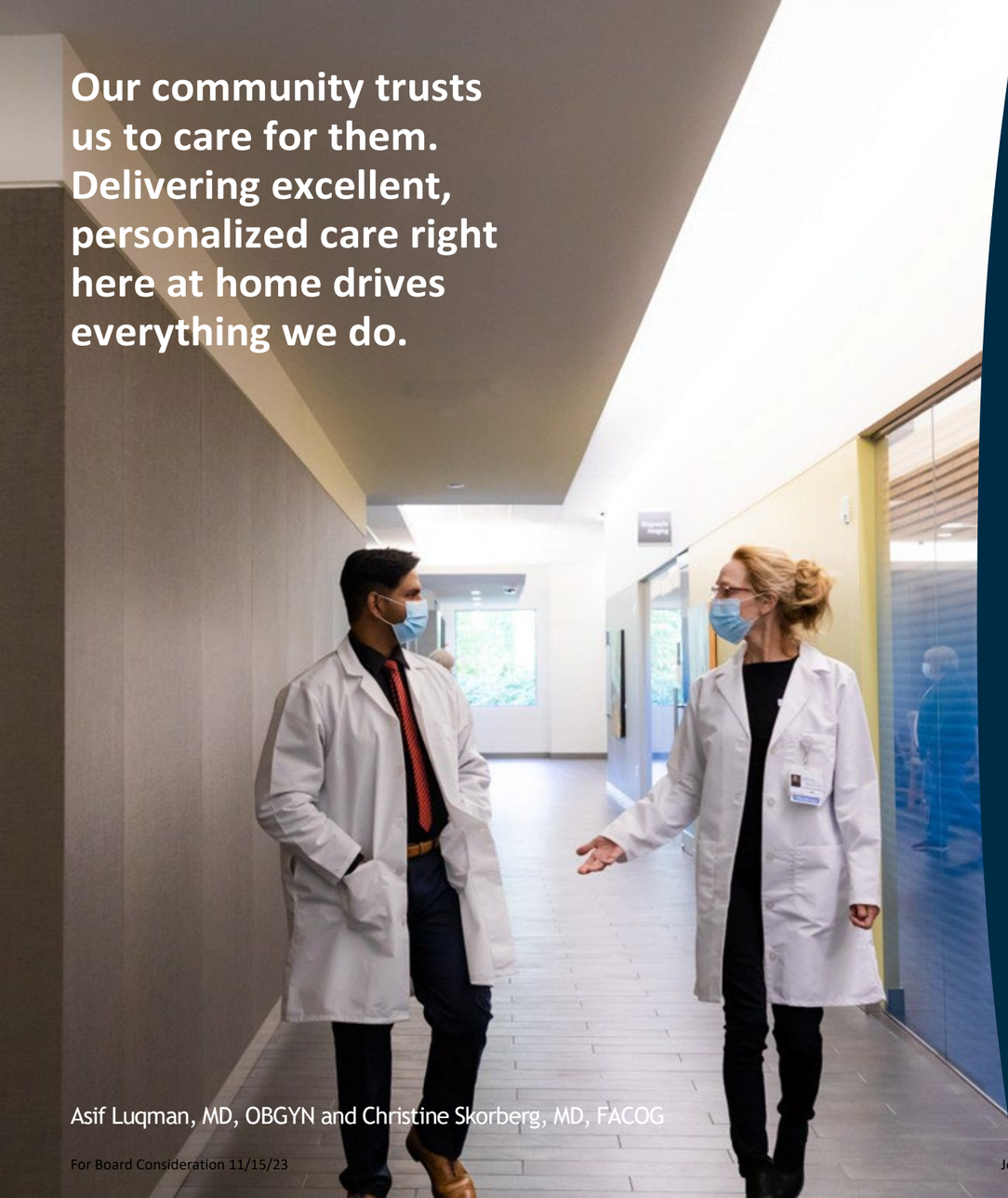
To hold the trust and improve the health of the communities we serve.

VISION

Jefferson Healthcare will be the community's first choice for quality care by providing exceptional patient care to every person we serve.

VALUES

Compassion
Stewardship
Integrity
Respect
Excellence
Teamwork



Our community trusts us to care for them. Delivering excellent, personalized care right here at home drives everything we do.

Asif Luqman, MD, OBGYN and Christine Skorberg, MD, FACOG

GOAL

Deliver the highest quality care.

STRATEGIES TO ACHIEVE GOAL

One Cultivate a deep-rooted culture of safety.

Two Eliminate health disparities.

Three Deliver care guided by best evidence.

INITIATIVES TO ACHIEVE GOAL

- Ensure every employee is connected to safety and quality.
- Develop a system of shared accountability.
- Identify and mitigate the root causes for safety events and near misses.
- Implement a comprehensive equity program.
- Embed equity into quality reporting.
- Actively work to eliminate health disparities.
- Promote engagement of medical staff in clinical quality monitoring and improvement.
- Ensure the highest standards of practice are met.
- Promote wellness and manage chronic disease.
- Seek and maintain meaningful accreditation.
- Enhance the use of technology, data and analytics to improve quality and safety.

GOAL

Provide a patient experience that we are proud of.

STRATEGIES TO ACHIEVE GOAL

One Make it easier to engage with our healthcare system.

Two Guide patients through every encounter.

Three Prioritize a culture of compassion and kindness.

INITIATIVES TO ACHIEVE GOAL

- Improve ease of access across all service lines.
- Enhance the use of technology to connect patients with health services.
- Ensure equitable access to care.
- Implement best practices for closed-loop referrals.
- Improve care navigation through the system to support transitions of care.
- Provide patient-centered experiences that meet the needs of our community.
- Provide enhanced training for staff working with underserved or unique populations.
- Foster a spirit of service that seeks to understand.

Donica Byers, RN

The health of our region is fueled by our people. We recruit and retain talented people so we can continue to deliver excellent care.

GOAL

Be a great place to work.

STRATEGIES TO ACHIEVE GOAL

One Reconnect to purpose and promote wellness of our teams.

Two Support and invest in our people.

Three Promote thriving and rewarding clinical practices.

Four Recruit, retain and implement innovative solutions to address staffing needs.

INITIATIVES TO ACHIEVE GOAL

- Celebrate our wins and each other.
- Care for our caregivers.
- Assess and address identified systemic healthcare fatigue.
- Advance the work of transforming our culture.
- Develop and support great leaders.
- Promote professional development opportunities and ongoing education.
- Invest in leadership, staff and medical staff leadership resources and development.
- Leverage technology to support staff in operations.
- Reconnect with colleagues.
- Identify and implement practice enhancement tools.
- Reduce barriers to practicing at the top of licensure.
- Identify and reduce barriers to retention and workplace satisfaction.
- Develop a best-in-class talent acquisition program.
- Assess and track diversity in hiring and retention.
- Create pathways to careers at Jefferson Healthcare.

To meet the increasing needs of our community, we must expand our services and continue to invest in advanced technology and facilities.

Campus modernization project begins summer of 2023

GOAL

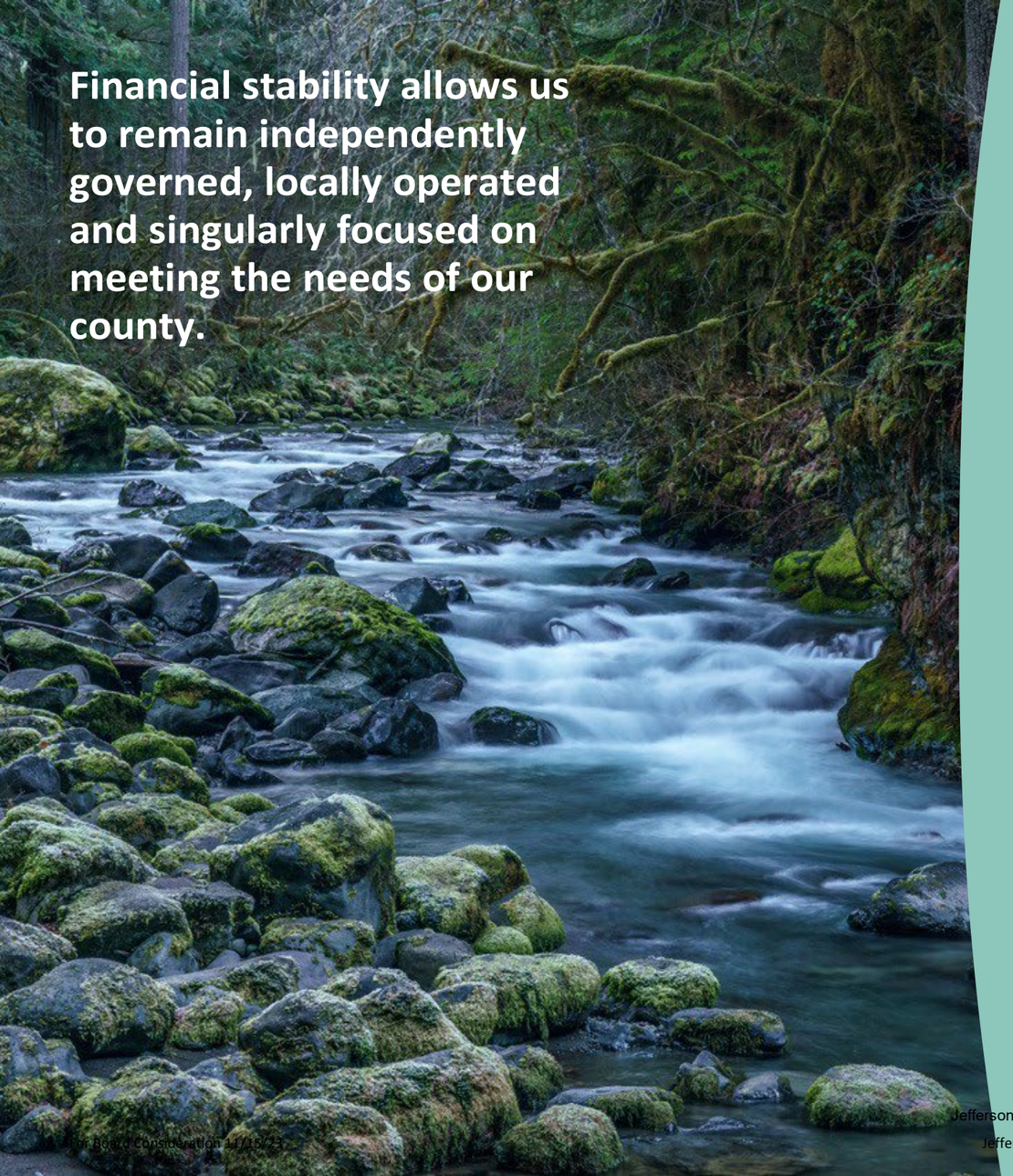
Provide needed services in the most accessible way.

STRATEGIES TO ACHIEVE GOAL

- **One** Identify internal and external areas of growth.
- **Two** Complete hospital replacement and modernization plan.
- **Three** Promote population health to improve community and employee wellness.
- **Four** Use technology and existing resources to elevate patient and clinician experiences.

INITIATIVES TO ACHIEVE GOAL

- **Create** and implement a service expansion roadmap to grow services.
- **Optimize** partnership opportunities to elevate access to care.
- **Minimize** disruption and maintain access to services during construction projects.
- **Ensure** we are the anchor institution we want to be.
- **Understand** and communicate our benefits to the community.
- **Define** and develop an Innovation Team in conjunction with Clinician Technology Team.
- **Implement** technology to ensure the care team has information it needs when they need it.
- **Utilize** technology so our workforce can support clinic growth.



GOAL

Remain independent, operationally and financially.

STRATEGIES TO ACHIEVE GOAL

One Maintain financial sustainability and operational independence.

Two Transition to value-based payment models.

INITIATIVES TO ACHIEVE GOAL

- Actively manage resources to ensure long-term financial health.
- Pursue technology solutions to advance clinical care and business operations.
- Maximize opportunities where financial and clinical alignment exists.
- Develop a road map to excellence in value-based payment models.
- Increase investments in preventative care and chronic disease management.

Our patients are in good hands.

Jefferson Healthcare continually seeks opportunities to become better, improve care and expand services. We are proud to have received these industry accreditations and quality and service awards.

ACCREDITATIONS

Quality Management System
A foundation for quality and patient safety programs

DNV-accredited hospital
Managing risk and improving healthcare delivery

DNV-Infection Prevention
Reducing the risk of healthcare acquired infections

American Academy of Sleep Medicine Accredited
Jefferson Healthcare Sleep Clinic

American College of Pathologists Accredited Facility
Jefferson Healthcare Laboratory

American College of Radiology Accredited Facility
Jefferson Healthcare Diagnostic Imaging

Commission on Cancer Accredited Program
Jefferson Healthcare Oncology Clinic

Accreditation Commission for Health Care
For performance and patient care

American Association of Cardiovascular and Pulmonary Rehabilitation Accredited Facility

AWARDS

Centers for Medicare & Medicaid
Quality ratings in safety of care and patient experience

Performance Leadership Award
Recognizing top performance among rural hospitals

Women's Choice Awards
For minimally invasive surgery, outpatient and patient experience

American Heart Association Awards
Gold Plus for stroke, heart failure and type 2 diabetes

Healthcare Equality Index
LGBTQ+ healthcare equality leader

Coalition on Improving Maternal Services
Providing baby- and mother-friendly care

Peninsula Daily News
Voted best employer in Jefferson County by readers

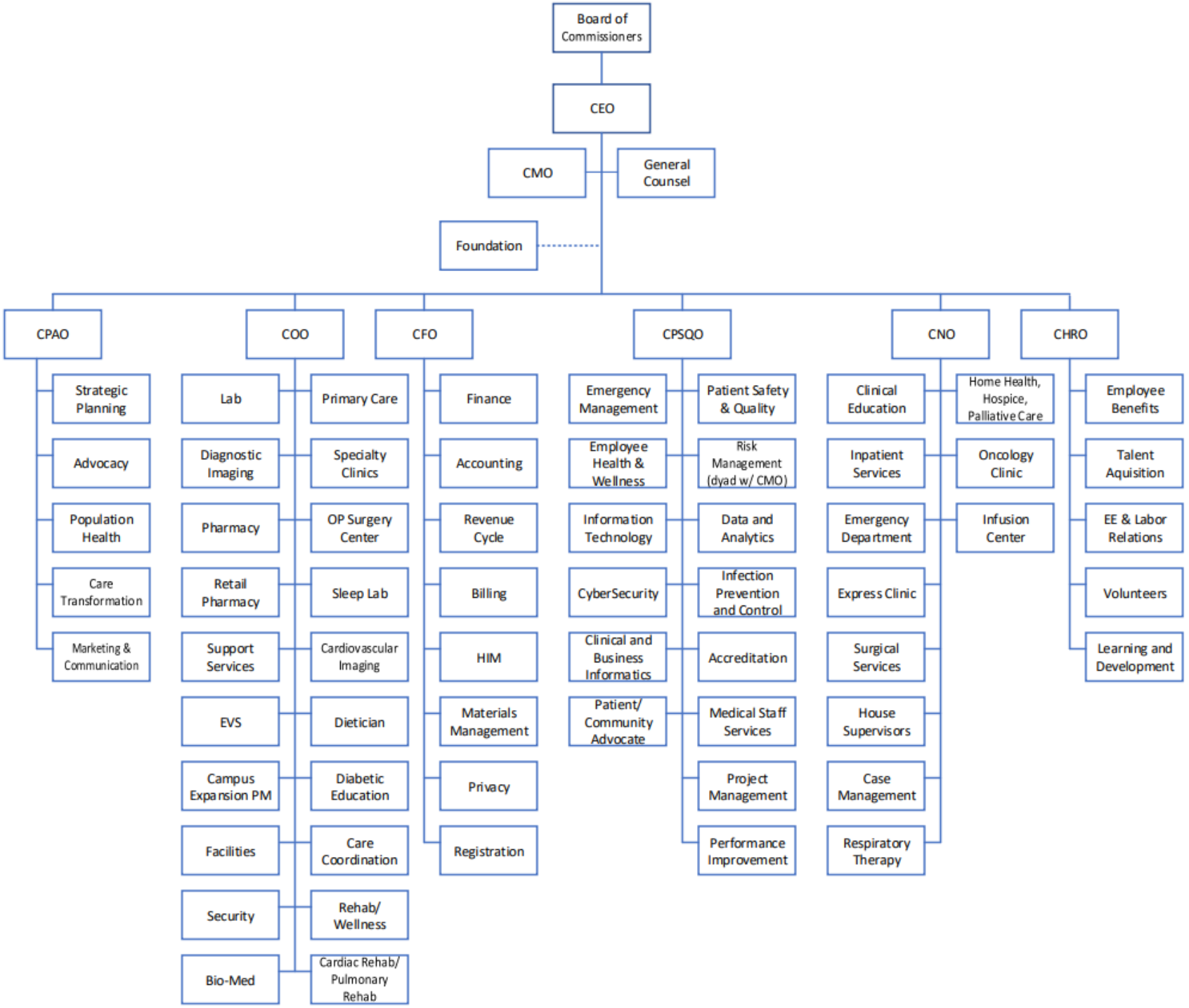
U.S. Environmental Protection Agency
Recognition of superior energy performance

Jefferson Healthcare

Jefferson Healthcare | 834 Sheridan Street | 360.385.2200

jeffersonhealthcare.org

Organizational Structure and Leadership


Board of Commissioners
CEO
CMO
General Counsel
Foundation
CPAO
Strategic Planning
Advocacy
Population Health
Care Transformation
Marketing & Communication
COO
Lab
Diagnostic Imaging
Pharmacy
Retail Pharmacy
Support Services
EVS
Campus Expansion PM
Facilities
Security
Bio-Med
Primary Care
Specialty Clinics
OP Surgery Center
Sleep Lab
Cardiovascular Imaging
Dietician
Diabetic Education
Care Coordination
Rehab/ Wellness
Cardiac Rehab/ Pulmonary Rehab
CFO
Finance
Accounting
Revenue Cycle
Billing
HIM
Materials Management
Privacy
Registration
CPSQO
Emergency Management
Employee Health & Wellness
Information Technology
CyberSecurity
Clinical and Business Informatics
Patient/ Community Advocate
Patient Safety & Quality
Risk Management (dyad w/ CMO)
Data and Analytics
Infection Prevention and Control
Accreditation
Medical Staff Services
Project Management
Performance Improvement
CNO
Clinical Education
Inpatient Services
Emergency Department
Express Clinic
Surgical Services
House Supervisors
Case Management
Respiratory Therapy
Home Health, Hospice, Palliative Care
Oncology Clinic
Infusion Center
CHRO
Employee Benefits
Talent Aquisition
EE & Labor Relations
Volunteers
Learning and Development

Medical Staff

New Board Member Orientation Manual
Serving on Jefferson Healthcare District Governing Board

Foundation Board

Jefferson Healthcare Foundation

The Jefferson Healthcare Foundation (the "Foundation") was founded in 2013 as a 501(c) (3) corporation whose mission is to enhance the excellence of the district's region's medical services through charitable contributions and community involvement so that more patients can find the care they need near their home. The Foundation develops philanthropic funds through donations, grants, special events, capital campaigns and planned giving in support of the projects, programs and people of the Hospital and Clinics. In recent years, among other projects, the Foundation helped to purchase a 3-D mammography machine and nuclear camera, helped the cardiac rehabilitation program, sponsored a new infant warmer for the family birth center, raised funds for echocardiography and charity care for heart patients, raised funds to replace the advanced lifesaving defibrillators throughout the medical campus and provided financial aid for childcare costs for district employees. The Foundation has eight volunteer board members, including a District Board member and the District's Chief Executive Officer. The Foundation supports the Hospital with funds for purchasing capital equipment, capital facility projects, educational scholarships, and community event sponsorships.

Jefferson County Public Hospital District No. 2 Board of Commissioners

The Board Book

THE BOARD BOOK

JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
BOARD OF COMMISSIONERS

Revised August 2023

PREAMBLE

The purpose of Jefferson County Public Hospital District No. 2, dba Jefferson Healthcare, is to foster a healthier community, to work and partner with others, to assure all residents have access to the high quality health care services they need, and to maintain a healthy, locally controlled and financially sustainable organization.

TABLE OF CONTENTS:

THE MISSION

To hold the trust and improve the health of our community through compassionate care, innovation and medical excellence.

THE VISION

Jefferson Healthcare will be the community's first choice for quality healthcare by providing exceptional patient care to every person we serve. We will do this by:

- Delivering the safest, highest quality care of any health care organization in our region.
- Providing leadership to improve the health, wellness and vitality of our community.
- Championing an engaged workforce by inspiring professional excellence and personal commitment to the success of our organization.
- Demonstrating fiscal stewardship and thoughtful decision-making to provide sustainable, high-value care.

THE VALUES

To meet our mission and work towards our vision, we are committed to the following core values.

- Compassion
- Respect
- Excellence
- Integrity
- Teamwork
- Stewardship

The mission and vision statements are to be reviewed every six years; it was last reviewed in 2019.

IT'S THE LAW

RCW: Revised Code of Washington

WAC: Washington Administrative Code

RCW CHAPTER 42.12: Vacancies

RCW CHAPTER 40.14: Preservation and destruction of public records

RCW CHAPTER 42.17: Campaign disclosure and contributions

RCW CHAPTER 42.20: Misconduct of public officers

RCW CHAPTER 42.23: Code of ethics for municipal officers – contract interests

RCW CHAPTER 42.30: Open public meetings act

RCW CHAPTER 42.52: Ethics in public service

RCW CHAPTER 42.56: Public records act

RCW CHAPTER 70.44: Public hospital districts

WAC CHAPTER 44.14: Public records act – model rules

WAC CHAPTER 434-662: Preservation of electronic public record

THE DISTRICT

Jefferson County Public Hospital District No. 2, hereafter referred to as the "District," doing business as Jefferson Healthcare, encompasses Eastern Jefferson County, WA.

The District is governed by the Jefferson County Public Hospital District No. 2 Board of Commissioners, hereafter referred to as the "Board."

"RCW 70.44.003 Purpose: The purpose of chapter 70.44 RCW is to authorize the establishment of public hospital districts to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons."

THE BOARD

Membership and Terms of Service
The Board is comprised of five publicly elected Hospital Commissioners. Each Hospital Commissioner, hereafter referred to as a "Commissioner," is elected to a six-year term per RCW 70.44.40. Since the Board abolished separate Hospital Commissioner districts per RCW 70.44.042, each Commissioner represents all citizens residing within the District.

Vacancies
Should a vacancy occur on the Board as provided in RCW 42.12 or by nonattendance by a Commissioner at meetings for 60 days, unless excused by the Board as provided in RCW 70.44.045, the vacancy shall be filled as provided RCW 42.12.

Board Officers
The Board will, each year, at their first regular meeting in January, elect a Board Chairperson, hereafter referred to as the "Chair," and a Board Secretary, hereafter referred to as the "Secretary," as required by RCW 70.44.050.

The Chair will preside over all Board meetings and ensure that such meetings are conducted in accordance with Board policies and applicable state and federal laws. The Chair will be the official voice of the Board.

The Secretary will prepare or have prepared all minutes and other documents of the Board and will assure that all such documents are retained and made available to the public as prescribed by law. The Secretary will assume the duties and authority of the Chair in his or her absence.

Board Appointed Officers
The Board will appoint, by resolution, the following District officers:

- The District Superintendent, also known as Administrator or Chief Executive Officer (CEO).
- The District Treasurer, currently the Jefferson County Treasurer.
- The District's independent Auditor, who reports directly to the Board.

Board Code of Conduct
Each Commissioner commits to ethical, businesslike, and lawful conduct, including proper use of authority and appropriate decorum and in compliance with RCW 42.20, RCW 42.23 and RCW 42.52 and any other applicable laws, regulations, or requirements for accreditation.

Each Commissioner must commit to and demonstrate loyalty to the residents and constituents of the District and the Board, and not be conflicted by loyalties to staff, other organizations, personal agendas or any personal interests.

Conflict of Interest
Each Commissioner must avoid conflict of interest with respect to his or her fiduciary responsibility:

- There will be no self-dealing or business by a Commissioner with the organization, except when a Commissioner or his or her family are patients.
- The Board should be judicious in taking a position on any issue.
- Each Commissioner will annually disclose, in writing, a report listing his or her involvement with other organizations or with vendors or any associations that might be a potential conflict of interest. This includes the instance where a Commissioner serves on boards in the community, service clubs or community advisory groups. The Washington State Public Disclosure Commission (PDC) report will comply with the requirements of RCW 42.17A and policies of the PDC.
- Any potential conflict(s) of interest, which arise between PDC filings, will be immediately reported, in writing, to the Chair.
- When the Board is to decide on an issue about which a Commissioner has an unavoidable conflict of interest, that Commissioner shall state that there is a conflict and will absent himself or herself, without further comment, not only from the vote but also any deliberation regarding that issue.

Commissioner Compact
Each Commissioner will respect the confidentiality appropriate to issues of a sensitive nature and will comply with the District's Access and Confidentiality Agreement (Attachment B) as well any other applicable laws, regulations or accreditation requirements.

During deliberation on a subject at a meeting, each Commissioner is encouraged to speak, stating his/her position openly, frankly and respectfully. Each Commissioner will support the legitimacy and authority of the final determination or action of the Board on any matter, both publicly and privately, irrespective of the individual Commissioner's personal position on the issue. Any concerns regarding the legitimacy and/or authority of the Board's decision or action will be raised and deliberated prior to Board action.

Any action taken by a Commissioner found in violation of any Board or District policies may subject the offending Commissioner to Board sanctions, including, but not limited to, official censure. Any action or failure to act on the part of a Commissioner, found to be in violation of any state or federal law or regulation, shall be reported to the appropriate authority according to RCW 70.42.30.123.

Board/District Employee & Community Interaction

It is common for staff and community members to approach individual commissioners to discuss concerns, or to seek assistance in resolving issues. While commissioners need to demonstrate concern and interest in appropriate resolution, individual commissioners should adhere to the established administrative channels for issue resolution.

In the event that an employee or community member approaches an individual Commissioner about a health care or service problem he/she or his/her family, friend, or community member experienced in receiving District service, the Commissioner will explain the limited role of the Commissioner and the Board, will listen and acknowledge what was heard, and refer the employee to the Patient Advocate. If the Commissioner deems the concern to be of a serious nature, the Commissioner may choose to also notify the CEO.

In the event that an employee approaches an individual Commissioner with a work problem he/she experienced as an employee, the Commissioner will explain the limited role of an individual Commissioner and of the Board, will listen and acknowledge what was heard, and refer the employee to the Human Resources Department, or if the work problem is about the Human Resources Department, the Commissioner will refer the employee to the CEO.

In the event that an employee approaches an individual Commissioner with a problem related to the CEO, that Commissioner will ask for the problem in writing and review it with the Board Chair. The Board Chair and that Commissioner will assess the level of seriousness of the problem and any possible violation of Federal or State laws and/or District Policy. They will either convene an Executive Session or discuss the problem with the CEO before convening the Executive Session.

A Commissioner may not attempt to exercise individual authority over the District, its staff or operation:

- Commissioner interaction with the CEO or staff must recognize the lack of authority vested in the individual Commissioner except when explicitly authorized by the Board.
- Commissioner interactions with the public, news organizations or other entities must recognize the same limitation and the inability of any individual Commissioner to speak for the Board, or the District, except to repeat explicitly stated Board decisions or positions. Commissioners are encouraged to direct news organizations to the Board Chairperson or the CEO.
- At no time will an individual Commissioner, nor will the Board as a whole, evaluate the performance of any staff member other than the CEO.

COMMISSIONER ROLES AND RESPONSIBILITIES

The role of a commissioner is to serve the interests of the organization and the community. Authority vests in commissioners only when they are gathered in a duly constituted District Board meeting. An individual Commissioner shall have no authority over the operations of the District, its CEO or any other District staff, and shall not make public statements for the District.

The powers and duties of the Board are delineated in RCW 70.44.060. The authority and powers granted under this statute remain with the Board and only official action of the Board will be binding on the District**,** its staff and operations.

The Board retains ultimate responsibility for all actions and operations of the District**,** but grants all operational authority, per RCW 70.44.080, to the Board-appointed Hospital District Superintendent, also known as Administrator or Chief Executive Officer, hereafter referred to as the "CEO."

Commissioner Advocacy

It is the role of commissioners to advocate for public policies and activities designed to enhance the mission of the District. Commissioners can play an important role in political advocacy by utilizing their contacts and influence with legislators and other public officials. Commissioners may be asked by the CEO to engage in activities such as meeting with public officials or writing letters or speaking at public forums. All legislative advocacy will reflect the consensus of the board. At least annually, the board will take a vote on the Washington State Hospital Association advocacy platform. Individual commissioners, acting as a commissioner, will not represent positions that have not been adopted by the district. If individual commissioners choose to represent positions that have not been adopted by the District, they will clearly communicate that their position is personal and not as a commissioner.

A Commissioner is prohibited from receiving compensation or reimbursement for expenses other than those allowed by RCW 70.44.050. A Commissioner will not accept a gift, presented in a way that may infer obligation, from a staff member, vendor, organization or constituent. Any gift received, associated with or resulting from holding the office of Commissioner, will be reported as required by the Washington State Public Disclosure Commission and RCW42.17A.

Each Commissioner will abide by all applicable state and federal laws, District and Board rules and policies, including, but not limited to, the Jefferson Healthcare Code of Conduct (Attachment A) and the Board of Commissioners Member's Code of Conduct.

Each Commissioner is expected to attend all Board meetings, any commissioner unable to attend a meeting must inform the Board Chair of his/her impending absence and be prepared for and will actively participate during each meeting and will participate in all District and other community functions as appropriate.

Board Operating Budget

The Board**,** in conjunction with its designated staff person(s), will develop and submit its annual Board operating budget in concurrence with the District's budget process and timeline. This Board budget will be included in the District annual budget. This budget will include, but not be limited to, Commissioner education and stipends, costs of the Board's independent auditor, travel expenses, staff support and Commission office space and other related expenses.

The Board will be expected to operate within its budgetary limits, as are all departments of the District**.** The status of the Board budget will be included in regular District financial reports.

Medical Staff Appointments
As required by federal and/or state regulations and policies of any accrediting body, the Board will approve or disapprove any application for medical staff privileges to be granted by the District. Prior to the presentation to the Board of such application, a Commissioner, designated by the Board, will, in conjunction with appropriate staff, review the documentation submitted with the application and present a recommendation for Board action on the application.

Community Collaboration
The Board will collaborate wherever possible and appropriate with other community entities promoting the health of Jefferson County residents.

In collaboration with the CEO, no later than December 1st of each year, the Board will evaluate and consider its role in potential Community Assessment activities and in the Community Health Improvement process.

Strategic Plan
The Board and CEO will jointly develop the District's mission, vision and value statements and the highest level of the strategic goals on a schedule approved by the Board.
The CEO will develop the operational strategic plan with goals and objectives, including annual budgets and timelines, based on the Board-approved mission, vision and values statements and Board level strategic goals. These plans, submitted by the CEO**,** will be presented to the Board for final approval.

As part of the strategic planning process, the Board and the CEO will collaborate to identify the three to seven highest priorities for attention during the coming year.

Preferred Board Schedule:

- Values statements will generally be re-evaluated every 12 years;
- Vision and Mission Statements every 6 years;
- Objectives and other metrics may be modified every year or as needed to meet internal and/or external circumstances.

Board/CEO Interaction
The Board fully delegates the operations of the District to the appointed CEO with exceptions noted in this book.

The CEO makes every effort to fully communicate the status of the operations of the District to the Board.

Board/CEO collaborative activities are listed in this book; however, do not intend to exclude opportunities that may arise during the year.

Requests by a Commissioner for significant use of District resources, including employee time, will be directed to the Chair for approval and then the CEO, who retains the right to decline.

CEO Performance Evaluation
The Board will evaluate the performance of the CEO on an annual basis and such evaluation shall be conducted during the month of December. Based on this evaluation, the Board will, by resolution, set the CEO compensation for the coming year in compliance with applicable law and the terms of the CEO'S employment contract.

The performance of the CEO will be considered the same as the performance of the District. The evaluation of the CEO will be based on his or her compliance with the District's purpose, mission, vision and values statements, the Board's high level strategic goals and the operational strategic plan, budgets and timelines presented by the CEO and approved by the Board. The CEO evaluation will be based on the above-mentioned topics applicable during the period of time being evaluated and will place emphasis on the highest priorities of the Strategic Plan as identified by the Board and CEO.

The Board will create, jointly with the CEO**,** during each November, the report calendar delineating any reports required to be given by the CEO or his/her designate during the coming year. Such reports may be used as part of the CEO annual evaluation.

Any such report showing performance not in compliance with any plan, timeline or budget will include a corrective action plan with expected date for compliance. The CEO will continue to report regularly on the progress of any outstanding corrective action plan until compliance and/or a satisfactory resolution is reached.

The Board, in collaboration with the CEO, will also consider using various other evaluation tools regarding the CEO's performance.

CEO Succession Plan
The CEO will annually present a succession plan to the Board and update that plan, as soon as possible, should the status of any designated staff member(s) change. This plan will ideally include at least two staff members sufficiently familiar with the duties and responsibilities of the CEO to be able to direct the operations of the District should the CEO no longer be able or available to perform his or her duties.

BOARD MEETINGS

Procedures used during Board meetings will be based on the most current edition of *Robert's Rules of Order, Newly Revised*. Where specifically stated, sections within these policies shall take precedence over *Robert's Rules*.

Actions of the Board will be by a vote of the Board. The Chair may, at his or her discretion, call for a consensus of the Board**.**

Board meetings will be ended by the Chair following an adopted motion to "conclude" the meeting as recommended by District legal counsel.

Regular Board Meetings
The time and date of regular meetings of the Board shall be set by resolution per RCW 42.30.70. Special Board meetings may be called as allowed by, and in compliance with, RCW 42.30.080.

All meetings of the Board will comply with the letter and spirit of the Washington State Open Public Meetings Act, RCW 42.30, and every effort will be made to assure that meetings of the Board are accessible to the public, with the exception of executive sessions as provided by RCW
42.30 and RCW 70.44.062.

The Board shall follow a general practice of not responding to individual public comments at the time they are made. This will enable the District to properly research issues prior to any response.

Meeting Recordings
Each regular and special Board meeting may be audio recorded by the Secretary or his or her designee and such recordings will be retained as long as possible as per appropriate state laws, including, but not limited to RCW 40.14, and WAC 434-662. All such audio recordings will be made available directly to the public via a link on the District's website.

Any recordings created by a Jefferson Healthcare Commissioner or other district employee must be promptly (i.e. at once or without delay) forwarded to the District. This will assist the District in meeting its obligations under the Public Records Act if a request is made for the recording and helps ensure that the District's public records are treated appropriately under state records retention laws.

Board Agenda Creation
The Chair and/or Secretary will meet with the CEO to jointly set a draft agenda for the upcoming meeting no less than five business days prior to the meeting. To be in compliance with the intent
of RCW 42.30.077 [2014 c 61] of the Open Public Meetings Act, Commissioners are encouraged to submit agenda items to the Chair no less than seven business days before the Board meeting so they may be added to the agenda prior to publication. However, to accommodate emergent items, at the beginning of each meeting, the Chair will call for addition or modifications to the agenda before accepting a motion to adopt the agenda.

BOARD EDUCATION AND ORIENTATION

A new Commissioner orientation will be used to prepare new Commissioners with knowledge and understanding of the services provided by the District. The CEO and Board Chair will design the orientation schedule to accomplish the objective.

Keeping the Board informed:

- Each Commissioner will be expected to seek out and participate in continuing education on Hospital District governance and other related topics in order to best serve those he or she represents and to assure the most efficient functioning of the Board.
- The CEO will select Departments for reports or Board rounding based on an annual agenda of reports and/or new developments established by Board and CEO.
- Individual Commissioner observation of committees:
    1. Annually in January, the CEO and the Board will identify committees that would be useful for Commissioners' observation.
    2. One or two Commissioners will be assigned to observe selected committee meetings throughout a calendar year.
    3. Each Commissioner will list his/her choices for committee observation in order of priority interest.
    4. Assignments to committees will be made by the Board Chair and ratified by Board action.

- In the event the Board is invited to have representation on a special committee, defined as any committee, board or group not directly organized by the District, the Board will follow this process:
    1. The purpose of the committee and role of the Board's representation will be discussed and the Board will decide on the appropriateness and feasibility of appointing a Board representative.
    2. Nominations for an approved Board representative will take place and a vote by the Board will determine representation.
    3. Selections for special committee participation will be voted on at least an annual basis every January.
    4. Board representatives to special committees will report on the special committees' activities and bring any items requiring the direction of the whole Board to the Board for discussion and possible action.

- Individual Commissioners shall report/inform the Board as a whole relevant and material (substantial) information/insight gained from individual attendance asa Commissioner at District committees, official community events and outside conferences.

BOARD SELF-EVALUATION

In January of each year the Board will review and modify as deemed necessary the policies and contents of The Board Book. The Board, by official action, will annually adopt these policies as they may or may not have been modified no later than the first meeting in the month of February. Each Commissioner will, at that time, commit to abide by these policies.

The Board, as part of its goal to assure the quality and efficiency of its actions, will, during the month of January of each year, evaluate itself as to its compliance with its own policies and the applicable laws and requirements of regulatory and accreditation bodies.

In April of each year the Board will hold a special session to allow Commissioners to share their views related to their roles, responsibilities and opportunities as Hospital District Commissioners. At this time, Board performance will be determined through rigorous written evaluations by each Commissioner for collective review.

In March and September of each year, the Board will evaluate how well its agendas are working to address the priorities of the District and to fulfill the Boards' need to be informed.

SURVIVABILITY

Should a section or sections of this Board Book be found to be in violation of law, the remainder of this document will remain in force.

Adopted by Resolution #_____this_____day of_____, 2023

Attest:_____
Marie Dressler, Secretary

2023 Board Meeting Calendar and Board Work Plan

2023 Board Calendar

4th Wednesday of the Month
2:00-5:30pm

FYI's

June 27-28-Leadership Summit, Chelan WA
September 18-20- Rural Advocacy Days WA DC
October 22-23- WSHA Annual retreat Renton

Date	Topic/Reports	Lead	Notes
January			
Special Session 01/18/2023 Education 2:00-3:15	Education Topic: Nursing Services Update Replacement and Expansion project update	Tina Toner ZGF	Moved up a week- Mike at a Population Health Conference 4th Wednesday
Special Session 01/18/2023 Business 3:30-5:30	Board Business: Team, Provider, Employee of the Quarter Finance/Quality/Administrative	Caitlin K	Moved up a week- Mike at a Population Health Conference 4th Wednesday
Special Session 1.20.2023 9-4:30pm	Special Session- Board Retreat Election of Officers Review Board book Review Board Calendar Board Self Evaluation (per board book pg. 8) Review Committee Assignments Agenda Evaluation		*With Karma Bass and Megan McAdams of Via Healthcare*
February			
Special Session 02/28/2023 Education 2:00-3:15	Education Topic: OPMA/OPRA education		Moved due to- Mike, Jill, and Marie at AHA 2023 Rural Healthcare Leadership Conference
Special Session 02/28/2023 Business 3:30-5:30	Board Business: Finance/Quality/Administrative Patient Advocate Report Review/Adopt Board Calendar Review/Adopt Committee Assignments Executive Session ** CEO Evaluation	Jackie L Board Board	Moved due to- Mike, Jill and Marie at AHA 2023 Rural Healthcare Leadership Conference
March			
03/22/2023- Education 2:00-3:15	Education Topic: Methodology of Patient and Employee Satisfaction	Brandie/ CHRO	
3/22/2023– 3:30-5:30 Business	Board Business: Finance/Quality/Administrative Adopt Board Book Agenda Evaluation (per board book pg. 8)	Board Board	
April			
04/26/2023 Business 2:00-5:30	Board Business: Team, Provider, Employee of the Quarter Finance/Quality/Administrative	Caitlin K	

	Board Evaluation (per board book page 8)		
May			
5/24/2023 Education 2:00-3:15	Education Topic: Independent Auditors Report	DZA- Tom Dingus	
5/24/2023 Business 3:30-5:30	Board Business: Finance/Quality/Administrative Patient Advocate Report	Jackie L	
June			
6/30/2023 Education 2:00-3:15	Education Topic: Recap Leadership Summit		June 27-28 Leadership Summit
6/30/2023 Business 3:30-4:30	Board Business: Finance/Quality/Administrative Compliance Report CEO Emergency Succession Plan	Judith Mike	
July			
7/26/2023 Education 2:00-3:15	Education Topic: Medical Group Update	Jake	
7/26/2023 Business 3:30-5:30	Board Business: Team, Provider, Employee of the Quarter Finance/Quality/Administrative CAH Annual Review	Caitlin K	
August			
8/23/2023 Education 2:00-3:15	Education Topic: Cassie Sauer and Darcy Jaffe- WSHA Update	Cassie Sauer/Darcy Jaffe	
8/23/2023 Business 3:30-5:30	Board Business: Finance/Quality/Administrative		
September			
9/27/2023 Education 2:00-3:15	Education Topic: Emergency Preparedness	Brandie	WA DC Rural Advocacy Days- 9/18-20
9/27/2023 Business 3:30-5:30	Board Business: Finance/Quality/Administrative Patient Advocate Report Agenda Evaluation (per board book pg. 8)	Jackie L Board	
October			
Special Session 10/11/2023	Special Session Budget Deep Dive	CFO	
10/25/2023 Education 2:00-3:15	Education Topic: Annual Hospice Report (include quarterly update)	HHH ED.	
10/25/2023 Business 3:30-5:30	Board Business: Team, Provider, Employee of the Quarter Finance/Quality/Administrative	Caitlin K	WSHA Annual Meeting October 22-23 Renton, WA

	Appoint Independent Auditor Budget Hearing: Approve • Capital Budget • Operating Budget • Tax or no tax • Levy • Substantial need **Budget must be approved before Nov. 15 **CEO Evaluation forms & self-evaluation to board	Board CFO	
November			
Special Session 11/15/2023 Education 2:00-3:15	Education Topic: Community Health Improvement Plan update Create board calendar (per board book pg.10)	Barb/Apple Board	Moved to 3rd Wednesday
Special Session 11/15/2023- Business 3:30-5:30	Board Business: Finance/Quality/Administrative Executive Session ** CEO Evaluation- Board-only discussion		Moved to 3rd Wednesday
December			
Special Session 12/20/2023- Business 2:00-5:30	Board Business: Finance/Quality/Administrative Executive Session ** CEO Evaluation- Board to CEO	Mike	Moved to 3rd Wednesday

Board Director Roster, Bios, and Terms of Service

Board Members and Bios:

-Jill Buhler Rienstra

jbuhler@jeffersonheatlhcare.org

Jill Buhler Rienstra was appointed to the commission in 1995 and has been reelected three times. She brings to the commission a professional journalism background that enables her to analyze and evaluate complex issues; high standards and strong ethics; and a long-time knowledge of the community.

The daughter of Port Townsend High School graduates who chose a military lifestyle, she has a lifelong affiliation with Jefferson County, spending summers here with family and friends. In 1988, following a successful career as an award-winning magazine editor and writer, Buhler Rienstra returned permanently to Port Townsend, where she married long-time friend and Jefferson County native John Buhler.

Currently Chief Governance Officer, Commissioner Buhler Rienstra has served six terms in that position; was on the Executive Quality Council; liaison to the Jefferson County Board of Health; on the Finance and Health Access committees; and attended surgical section and medical staff meetings. Statewide, she has been a featured speaker at state conferences and was appointed to the Washington State Hospital Association's Governing Bodies and Legislative Reform Committees and the Education Task Force. For the past 12 years, Buhler Rienstra has advocated on behalf of rural hospitals to congressional representatives in Washington, D.C., and to state representatives in Olympia.

Buhler Rienstra has first-hand knowledge of Jefferson Healthcare as patient and caretaker. The oncology and surgical teams guided her successfully through breast cancer, and she was primary caretaker for her late husband John during his 6-year struggle with Parkinson's disease and dementia.

Her community involvement includes Chamber of Commerce president, Kiwanis treasurer, Northwest Maritime Center secretary; committee work for Centrum, the city of Port Townsend and the Elks club; president of the Human Right Coalition; and Guardian ad Litem for Jefferson County.

Buhler Rienstra strongly believes that, "High quality basic health care is the very foundation of a viable, thriving community. We must and we do provide access to excellent care to all of our citizens, regardless of their ability to pay. If those of us who are financially vulnerable are forced to delay care until an emergency exists, it costs much more. It's imperative to get our people into our system early, when they can benefit the most, treatments cost less and they can remain productive. It's simply the right thing to do."

In September 2018, several years following John's passing, she married Douwe Rienstra M.D., a long-time Port Townsend physician who maintains an independent family practice clinic.

Buhler Rienstra invites you to email comments, ideas, concerns or questions to her at jbuhler@jeffersonhealthcare.org.

Commissioner Buhler Rienstra's current term expires December 2025.

-Marie Dressler, RN

mdressler@jeffersonhealthcare.org

Marie Dressler, RN, was elected to the commission in November 2009 and took her seat in January 2010. She was born, raised, and educated in England, where she became a registered nurse and certified nurse midwife. Residing in Jefferson

County since 1981, Dressler was employed for 26 years by the hospital district, working as a registered nurse and primarily providing direct patient care to mothers and babies in the Family Birth Center.

After taking early retirement in 2008, Dressler's strong desire to continue contributing to the health and well-being of Jefferson County residents manifested as a bid for a position on the commission. She brings 40 years of practical health care experience to her board position, along with management skills learned through two decades of involvement in a small family business and insights gained through employment with a leading pharmaceutical company. Dressler has been a dedicated patient advocate throughout her nursing career. She believes that administrative decisions must take into consideration the effect on patient care. Dressler says that one of her major goals is to ensure that all patients have access to health care services in a timely manner. She also would like to see additional medical specialists available to county residents, as patient needs dictate, even if only on a part-time basis. In addition to her commitment to patient care, Dressler is a strong advocate for fiscal responsibility. She believes that the financial status of the hospital district can and must be improved. Commissioner Dressler's current term expires December 2027.

-Bruce McComas

bmccomas@jeffersonhealthcare.org

Bruce McComas was elected to the hospital board in November 2017 and assumed office January 2018. He was born and raised in Anacortes and has lived all but 3 years of his life in Washington State. He earned both a Chemical Engineering degree and an MBA from the University of Washington. Bruce and his wife, Teri, moved to Jefferson County in 1981. He worked in the pulp and paper industry for over 40 years, mostly in supervisory and management roles, including serving as General Manager for Port Townsend Paper Corporation. He took early retirement in 2014 to care for Teri as she battled cancer.

Bruce has been an active volunteer in the community, having served on the school board for 7 years, the hospital financial advisory committee for 9 years, on the founding boards for the Jefferson County Education Foundation, Habitat for Humanity of East Jefferson County, and the Jefferson Community Foundation, where he served as its first president. He also served on other community service organizations; Kiwanis, Chamber of Commerce, and the Law & Justice Council. After his wife passed away in 2016 he has been a volunteer on the hospital's Oncology Support Team, The Patient & Family Advisory Council, and the Patient Financial Experience Task Force.

As a patient advocate for his wife, Bruce learned first-hand what's good and what can be improved in the local healthcare system. He believes that people want access to quality, affordable healthcare close to where they live and that it should be easier to understand and navigate the system. Using his professional business experience, along with this patient advocate experience, Bruce will work to continue improving the quality and scope of services provided by the District while increasing access and affordability for all patients while maintaining financial stability, to the benefit of all Jefferson County citizens. Bruce welcomes your comments and feedback. Commissioner McComas' current term expires 2023.

-Kees Kolff

kkolff@jeffersonhealthcare.org

Dr. Kees Kolff joined the Hospital District Board in 2016. He and his wife moved to Jefferson County in 1997 where he has served as president of Jefferson Land Trust and as founding chair of the Jefferson County/Port Townsend Climate Action Committee. He spent 4 years on City Council, served 2 years as Mayor, and is currently president of the Jefferson County ReCyclery. Kees and Helen founded and live in the Port Townsend EcoVillage. They have a daughter Adri who lives in Seattle with her husband Randy and 2 children, Adam and Cora. Kees (pronounced "Case") is the Dutch nickname for Cornelis. He was born in the Netherlands where universal healthcare has worked well for 100 years. He and his family immigrated when he was 5 and his high school senior speech was on the need for a single-payer healthcare system.

Kees obtained an MD and a Masters in Public Health from Harvard and his Pediatric training at Seattle Children's Hospital and the University of Washington. He served 2 years with the Centers for Disease Control in Puerto Rico and was a Robert Wood Johnson Clinical Scholar at UW. In 1978 he joined the newly forming Sea Mar Community Health Centers in Seattle, where he served as Medical Director until 1995, helping establish clinics for under-served populations in numerous western Washington counties.

"I believe that healthcare is a right – for everyone. I will work to maintain a fiscally strong district where the providers and support staff offer quality, continuity care. I will help develop and implement Community Health Improvement Plans that create partnerships to address the 4 major health priorities in our county: 1. access to medical and dental care, 2. access to mental health and substance abuse care, 3. immunizations and 4. healthy eating, active living and chronic disease prevention. Ultimately, the only way we can provide healthcare for all is if we join the rest of the developed world and establish a universal healthcare system. I will do what I can to help bring about such a system at the state and/or the national level." Commissioner Kolff's current term expires 2027.

-Matt Ready

mready@jeffersonhealthcare.org

Matt Ready was elected to the hospital board in November 2013 and assumed office January 2014. Matt worked at Jefferson Healthcare for 15 years up until the day he was elected to office. His career at Jefferson Healthcare began in the Information Systems department where he worked as a computer technician, application specialist, database administrator, and briefly as the Interim Director. In 2007, Matt joined the Performance Improvement Department where he worked as a workshop facilitator, data analyst, and problem solver. In seven years with the Performance Improvement Department Matt lead over 30 improvement workshops and facilitated 50 focused improvement projects with at least one project in virtually every area of the Jefferson Healthcare system.

Matt brings to the board intimate knowledge of operations as well as a deep understanding of the district's internal strengths and weaknesses. Matt believes the purpose of a hospital district is to foster a healthy community. To do that, our hospital district must work relentlessly to ensure that all residents have access to affordable high-quality healthcare for all their healthcare needs. The job of the commissioners is to continuously and rigorously assess the healthcare needs of the community and help guide the hospital district to ensure those healthcare needs are met. Matt is committed to leveraging his skills and experience to collaborate with the current board of commissioners to achieve that fundamental purpose and help our community be the healthiest it can possibly be. Matt welcomes your comments and feedback. Commissioner Ready's current term expires December 2025.

Hospital Association Websites and Other Recommended Resources

Hospital Associations and Other Resources

1. Alaska State Hospital and Nursing Home Association: https://www.ashnha.com/education-training/
2. American Hospital Association: https://www.aha.org/
3. AHA Trustee Services: https://trustees.aha.org/
4. California Hospital Association: https://www.calhospital.org/
5. Hospital Association of Southern California: https://www.hasc.org/
6. Hospital Council of Northern and Central California: https://www.hospitalcouncil.org/
7. New Mexico Hospital Association: https://www.nmhanet.org/
8. Montana Hospital Association: https://mtha.org/
9. Oregon Association of Hospitals and Health Systems: https://www.oahhs.org/
10. Texas Healthcare Trustees: https://www.tht.org/
11. Texas Hospital Association: https://www.tha.org/
12. Washington State Hospital Association: https://www.wsha.org/events-resources/governance-education/

Frequently Used Healthcare Acronyms

FREQUENTLY USED HEALTHCARE ACRONYMS

HIT = Health Information Technology
HITECH = Health Information Technology for Economic and Clinical Health Act
HIX = Health Insurance Exchange
HPSA = Health Professional Shortage Area
HRA = Health Risk Assessment
HRO = High Reliability Organization
HAS = Health Savings Account
HSMR = Hospital Standardized Mortality Rate
HVI = Heart and Vascular Institute
ICD-11 = International Classification of Diseases, 11th Revision
ICU = Intensive Care Unit
ICVR = Interventional Cardiovascular Radiology (lab)
IDS = Integrated Delivery System
IEC = Independent Ethics Committee
IHS = Integrated Health System
IM = Internal Medicine
IP = Inpatient
IPA = Independent Practice Association
IPPS = Inpatient Prospective Payment System
IQR = Hospital Inpatient Quality Reporting Program
IRB = Institutional Review Board
IRF = Inpatient Rehabilitation Facility
IT = Information Technology
L&D = Labor and Delivery
LOS = Length of Stay
LTC = Long Term Care
LWOBS = Left without being seen
MA = Medicare Advantage
MAC = Medicare Administrative Contractor
MACRA = Medicare Access & CHIP Reauthorization Act
MED = Medical Executive Committee
MOB = medical office building
LTAC = Long-Term Acute Care
LTCF = Long-Term Care Facility
LTD = Long-Term Disability
LVN = Licensed Vocational Nurse
M&M = Mortality and Morbidity
MCC = Major Complications and Co-Morbidities
MCO = Managed Care Organization
MEC = Medical Executive Committee
MedPAC = Medicare Payment Advisory Commission
MER = Medication Errors Reporting Program
MFS = Medicare Fee Schedule
M.H.A. = Master of Health Administration
MI = Myocardial Infarction
MIPS = Merit-Based Incentive Payment System
MIS = Management Information System
MLR = Medical Loss Ratio
MMA = Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MOB = Medical Office Building
M.P.H. = Master of Public Health
MRSA = Methicillin-Resistant Staphylococcus Aureus
MS-DRG = Medicare Severity-Diagnosis Related Group
MSA = Metropolitan Statistical Area
MSG = Multi-Specialty Group
M.S.N. = Master of Science in Nursing
MSO = Management Services Organization
MSP = Medical Secondary Payer
MSSP = Medicare Shared Savings Program
MU = Meaningful Use
MUA = Medically Underserved Area
NQIG = National Quality Improvement Goal
NICU = Neonatal Intensive Care Unit
NP = Nurse Practitioner
NPI = National Provider Identifier
OBS = Observational Status
O/E = Observed over Expected Ratio

- >1 = higher than expected
- 1.0 = as expected
- <1 = less than expected

OIG = Office of Inspector General
OON = Out-of-Network
OOP = Out-of-Pocket
OP = Outpatient
OPC = Outpatient Clinic
OPPE = Ongoing Professional Practice Evaluation
OPPS = Outpatient Prospective Payment System
OR = Operating Room
OSG = Office of the Surgeon General
OTC = Over the Counter
P4P = Pay for Performance
PA = Physician Assistant
PAC = Post-Acute Care
PCMH = Patient-Centered Medical Home
PCN = Primary Care Network
PCP = Primary Care Physician
PFS = Physician Fee Schedule
PHI = Protected Health Information
PHM = Population Health Management
PHO = Physician-Hospital Organization
PHC = Physician Health Committee
PHP = Providence Health Plan
PHR = Personal Health Record
PICU = Pediatric Intensive Care Unit
PMPM = Per Member Per Month
POA = Present on Admission
PIP = Performance Improvement Plan
PMG = Providence Medical Group

FREQUENTLY USED HEALTHCARE ACRONYMS

PPACA = Patient Protection and Affordable Care Act
PPEC = Professional Practice Evaluation Committee
PPO = Preferred Provider Organization
PPR= Potentially Preventable Readmission
PPS = Prospective Payment System
PQR = Prevention Quality Indicator
PQRI = Physician Quality Reporting Initiative
PQRS = Physician Quality Reporting System
PRO = Peer Review Organization
PSJH = Providence St. Joseph Health
PSQRC = Professional Staff Quality Review Committee
PT = Physical Therapy/Therapist
QA = Quality Assurance
QC = Quality Control
QHP = Qualified Health Plan
QI = Quality Improvement
QPP = Quality Payment Program
QR = Quality Review
QSP = Quality Strategic Plan
RAC = Recovery Audit Contractor (Medicare)
RCA = Root Cause Analysis
RN = Registered Nurse
RVU = Relative Value Unit
Rx = Prescription
SARS = Severe Acute Respiratory Syndrome
SCH = Sole Community Hospital
SCHIP = State Children's Health Insurance Program
SCIP = Surgical Care Improvement Project
SE = Sentinel Event
SEIU = Service Employees International Union
SG = Surgeon General
SICU = Surgical Intensive Care Unit
SNF = Skilled Nursing Facilityingo9!
SNFIST = Physician working at a Skilled Nursing Facility
SOA = Sarbanes-Oxley Act of 2002
SSP = Shared Savings Program
SSU = Short Stay Unit (surgery)
STAT = Sooner than already there
STEMI= ST Elevation Myocardial Infarction
TCM = Transitional Care Management
TPA = Third-Party Administrator
TJC = The Joint Commission
UCR = Usual, Customary, and Reasonable (Charges)
UM/UR = Utilization Management/Utilization Review
VBC = Value-Based Care
VBID = Value-Based Insurance Design
VBP= Value-Based Purchasing
VBR = Value-Based Reimbursement
VOC = Voice of the Customer
WNV = West Nile Virus

Misc.: Providence employees are referred to as Caregivers

FREQUENTLY USED FINANCIAL ACRONYMS

AAPCC = Average adjusted per capital cost
AIPBP = All Inclusive Population-Based Payments
ALM = Asset and Liability Management
A/P = Accounts Payable
ALM = Alternative Payment Model
A/R = Accounts Receivable
ASO = Administrative Services Only Contract
AV = Actuarial Value
AWI = Adjusted Wage Index
CCR = Cost coverage ratio or cost to charge ratio
DRG = Diagnosis-related Group
EBIDA = Earnings before interest, depreciation, and amortization
EDITDA = Earnings before interest, taxes, depreciation, and amortization
EFT = Electronic Funds Transfer
FASB = Financial Accounting Standards Board
FY = Fiscal Year
GAAP = Generally Accepted Accounting Principles
GAO = Government Accountability Office
GPO = Group Purchasing Organization
GSA = Group Service Agreement
JOA = Joint Operating Agreement
JOC = Joint Operating Company
JV = Joint Venture
LOI = Letter of Intent
LUPA = Low Utilization Payment Adjustment
M&A = Mergers and Acquisitions
MAGI = Modified Adjusted Gross Income
MAP = Medical Audit Program
MLR = Medical Loss Ratio
MOR = monthly operating review
MOU = memorandum of understanding
NDA = non-disclosure agreement
NOI = net-operating income
NPV = Net Present Value
PBT = Participating Tax-Exempt Bond Transaction
PP&E = Property, Plant and Equipment
PPI = Producer Price Index
REIT = Real Estate Investment Trust
RFP = request for proposal
ROA = Return on Assets
ROE = Return on Equity
ROI = Return on Investment
SGR = Sustainable Growth Rate
UBI = Unrelated Business Income
VBP = value based purchasing
YE = year end
YTD = year to date
ZEBRA = Zero Balanced Reimbursement Account

Committees

The next agenda item was the issue of committees and committee assignments. There was some concern raised that committees are not meeting or, if they are, at times the commissioners are not notified. Other members shared that their participation in other committees has been quite favorable. The members discussed both internal and external committees. The following were identified as committees:

Board Committees

Finance

Patient Experience and Community Advisory

Agenda Setting

Legislative Advocacy

Administrative Committees

Jefferson Hospital OAC Meeting

Equity

Green (has been on hold for 18 months)

Executive Quality

Medical Staff Committee

Credentialing

External Committees

Behavioral Health

CHIP-BHC

Climate Action (designated BOD representative)

Foundation (designated BOD representative?)

Board of Health*

*This is no longer a Jefferson-designated seat in association with changes in Board of Health bylaws. Board Roles

The subject of committees and board roles will be revisited at a future meeting when selection or appointment will be completed. Conclusion

DRAFT: Jefferson Healthcare Committees with 2024 representatives:

(Committees have been restructured to form Board Committees rather than Administrative Committees. The full board receives regular Quality and Patient Experience and Community Advisory reports.

Board Committees:

Executive Committee (board chair and secretary) *(monthly for agenda setting)***:** Marie Dressler, Jill Buhler Rienstra

Finance Committee (*bimonthly*): Matt Ready, Bruce McComas

Advocacy Committee (*on call*): Marie Dressler, Jill Buhler Rienstra (NOTE: Via Consulting will help draft a charter for this committee.)

Medical Staff Committee:

Credentialing oversight *(intermittent)***:** Marie Dressler

External Committees:

CHIP-BHC: Matt Ready, Kees Kolff

JHC Foundation *(Designated BOD representative):* Bruce McComas

Climate Action Committee *Designated BOD representative)***:** Kees Kolff

Mental Health/Substance Use Advisory Committee *(intermittent, appointed by CC)***:** Jill Buhler Rienstra, Bruce McComas (backup)

2024 Commissioner Assignments <u>by Name</u>:

Buhler Rienstra: MH/SA Committee, Executive Committee, Advocacy

Dressler: Credentialling Oversight, Executive Committee, Advocacy

Kolff: CHIP-BHC, Climate Action

McComas: Finance, Foundation, BU MHSAA)

Ready: CHIP-BHC, Finance

2024 Board Calendar

4th Wednesday of the Month
2:00pm-5:30pm

Reminders:

- June 23-26, 2024 - Leadership Summit: Chelan, WA
- September 16-18, 2024: Rural Advocacy Days: Washington, DC

Date	Topic/Reports	Lead	Notes
January			
01/24/2024	**Board Business:** • Election of Officers • Finance/Quality/Project/Administrative • Executive Session ** CEO Evaluation - Board-only discussion	Board	
February			
Special Session 02/07/2024	**Board Business:** • Review Board Self Self-Assessment • Executive Session ** CEO Evaluation/Compensation		Board Retreat
02/28/2024 Focus	**Focus Topic:** • Methodology of Patient and Employee Satisfaction	Brandie	
02/28/2024 Business	**Board Business:** • Finance/Quality/Project/Administrative • Patient Advocate Report	Jackie	
March			
Governance Special Session 03/25/2024	**Board Business:** • Agenda Evaluation (as per board book) • Review/Adopt Board Book • Review/Adopt Board Calendar • Review/Adopt Committee Assignments • Review/Adopt Summary of February Retreat		
03/27/2024 Focus	**Focus Topic:** • Cybersecurity	Brandie	
3/27/2024 Business	**Board Business:** • Finance/Quality/Project/Administrative • Agenda Evaluation (per board book pg. 8)	Board	
April			
Special Session 04/24/2024 Business	**Board Business:** • State Auditor Exit Conference • Review/Approve HHH/PC QAPI Plan • Finance/Quality/Project/Administrative		
May			
5/22/2024 Focus	**Focus Topic:** • Hear, adopt Independent Auditors Report	DZA - Tom Dingus	

5/22/2024 Business	**Board Business:** • Finance/Quality/Project/Administrative • Patient Experience/Community Advocate Report	Jackie	
June			
Special Session 6/19/2024	**Board Business:** • Finance/Quality-Compliance Report/Administrative • CEO Emergency Succession Plan	Mike	Special session due to date change
July			
Generative Special Session 07/17/2024	**Board Business:** • TBD		
7/24/2024 Focus	**Focus Topic:** • Medical Group Update	Jake	
7/24/2024 Business	**Board Business:** • Review/Approve HHH/PC QAPI Plan • Finance/Quality/Project/Administrative • CAH Annual Review		
August			
8/28/2024 Focus	**Focus Topic:** • Cassie Sauer and Darcy Jaffe - WSHA Update	Cassie Sauer/Darcy Jaffe	
8/28/2024 Business	**Board Business:** • Finance/Quality/Project/Administrative		
September			
9/25/2024 Focus	**Focus Topic:** • Emergency Preparedness	Brandie	
9/25/2024 Business	**Board Business:** • Finance/Quality/Project/Administrative • Patient Experience & Community Advocate Report • Agenda Evaluation (per board book)	Jackie Board	
October			
Special Session 10/16/2024	**Special Session** • Budget Deep Dive	Tyler	
10/23/2024 Focus	**Focus Topic:** • Annual Hospice Report (include quarterly update) & QAPI Plan	David	

10/23/2024
Business
	Board Business:
	• Budget Hearing: Approve
	  ○ Capital Budget
	  ○ Operating Budget
	  ○ Tax or no tax
	  ○ Levy
	  ○ Substantial need		

	• Finance/Quality/Administrative • Appoint Independent Auditor **Budget must be approved before Nov. 15 **CEO Evaluation forms & self-evaluation to board		
November			
Governance Special Session 11/06/2024	**Board Business:** • May include Advocacy Agenda if it is available • Community Health Improvement Plan Update • Evaluation of Boards' role in Community Assessment Activities/CHIP • Evaluate performance criteria for CEO Evaluation (could be deleted if contracted with VIA)		
Special Session 11/20/2024 Focus	**Focus Topic:** • Create board calendar (per board book pg.10)	Board	Moved to 3rd Wednesday due to Thanksgiving Holiday.
11/20/2024 Business	**Board Business:** • Finance/Quality/Project/Administrative • Executive Session ** CEO Evaluation		
December			
Special Session 12/18/2023 Business	**Board Business:** • Finance/Quality/Project/Administrative • Executive Session ** CEO Evaluation - Board to CEO	Mike	Moved to 3rd Wednesday

Board Calendar lists of Events:

Title	Frequency	Month	Cal. Date
The following are legal requirements:			
OPMA/OPRA Training	4 years (3/23 last)	March	3/25/***2026***
Independent Auditor Report	Annual	May/June	5/22/24
CAH Annual Report	Annual	July	7/24/24
Budget Deep Dive (special meeting)	Annual	October	10/16/24
Budget Hearing (must be by 11/15)	Annual	October	10/23/24
Hospice Annual Report	Annual	October	10/23/24
The following are in the Board Book:			
Strategic Plan Objectives Modified	Every year as needed	TBD	Find
Strategic Plan Vision/Mission Statements	Every 6 years	TBD	Find
Strategic Plan Re-Evaluation	Every 12 years	TBD	Find
Generative Special Sessions	Quarterly	Jan, April, July, Nov	2/7; 3/25; 7/17; 11/06/2024
Board Book Review and Modification	Annual	January	8/23/23
Board Self Compliance Evaluation	Annual	January	2/25/24
CEO Compensation	Annual	January	2/7/24
Committee Assignments	Annual	January	3/25/24
Election of Officers	Annual	January	1/24/24
Board Book Adoption	Annual	February	3/25/24
Agenda Annual Assessment	Bi-Annual	March/September	3/25/24-9/25/24
Commissioner Evaluation of Roles and Responsibilities (Special Session)	Annual	April	2/7/24
CEO Emergency Succession Plan	Annual	June	6/19/24
CEO Report Calendar	Annual	November	11/20/24
Vote on WSHA Advocacy Platform	Annual	November?	11/06/24
Evaluation of Role in Community Assessment Activities	Annual	Before Dec. 1	11/06/24
CEO Annual Evaluation	Annual	December	12/18/24