SPECIAL BOARD OF HOSPITAL COMMISSIONERS
August 16, 2021

Those in attendance were Hospital Commissioners Darrin Moody (teleconference), Gayle Weston (teleconference), and Don Wilson (teleconference). Also present were Eric Moll, Mason Health CEO (teleconference); Mark Batty, Mason Health COO (teleconference); Rick Smith, CFO (teleconference), Dr. Dean Gushee, Mason Health CMO (teleconference); Melissa Strong, Mason Health CNO (teleconference) Robert Johnson, Legal Counsel (teleconference) and Shelly Dunnington Senior Executive Assistant (teleconference).

Others in attendance for a portion of the Hospital Commissioners meeting: Pam Schlauderaff, Director of Quality, Dr. Schlauderaff, Jen Capps, CDO, Laura Grubb, Compliance Officer, Kevin Keller, Senior Director of Human Resources, Brad Becker, Senior Director of Revenue Cycle and John Van Gorkom, VG Strategies.

Gayle Weston called the special meeting of the Board of Commissioners to order at 1:00 p.m.

Eric Moll introduced John Van Gorkom and reminded everyone he helps facilitates our annual strategic planning.

Eric reviewed the agenda.

Reviewed 2021 Strategy Dashboard Performance to Date: Eric Moll went over the dashboard and areas of the dashboard we have improved in our reporting.

Strategic Initiatives A3 Update & Key Learning/Insights Year to Date:

COVID Safety – Mel Strong shared that COVID Safety was carried over from last year. Mel shared that staff really felt that the leadership was fully transparent with COVID and had communication daily to keep them informed.

- Successes:
    - What went well and why?
        - Covid – guidelines have remained consistent with very few changes (in contrast to 2020). Consistent guidelines, frequent communication, and accountability have been key to minimize exposure risk.
    - What should we be proud of?
        - We continue to have zero facility acquired Covid infections
- Learnings:
    - What did not go well and why?
        - Masking compliance became lax once the masking mandates were relaxed and the CDC changed HC mandates to allow for non-clinical areas some wiggle room.
    - What limits and problems have we uncovered that we were not aware of earlier?
        - Manager accountability was key to staff compliance and we needed to make that clear.
- Current Reality:
    - What has changed in our world in the last 180 days?
    - What major assumptions in our plan may no longer be valid given the last 180 days?
- Adjustments:
    - What do we need to adjust in our approach for the next quarter/?

        - Mandatory Vaccination plan.
    - Other modifications
        - Continue to be flexible and nimble

Laura Grubb shared the huddles are very helpful and it happens 3x a week and it captures the data and all directors, supervisors are invited. Pam Schlauderaff shared that we need to connect the shortage of staff due to this pandemic.

Eric Moll shared that that has pieces unfold building out COVID safety. The mandate will have a larger impact on us.

Closing Care Gaps – Mark Batty shared in the 2nd quarter the target at 10% and improvement 271, actual 604, which is a 122% improvement.

- Successes:
    - What went well and why?
        - The program has been paused within Primary Care due to competing priorities and the number of position vacancies amongst the Medical Assistants. However, progress has been made within a similar program in the Women's Health Clinic.
    - What should we be proud of?
        - The work of the Kaizen personnel, Care Coordination and the Women's Clinic staff in moving a program forward in women's healthcare.
- Learnings:
    - What did not go well and why?
        - The need to pause this program is unfortunate, with an impending re-start date in flux.
    - What limits and problems have we uncovered that we were not aware of earlier?
        - The lack of available Medical Assistant time and resources. Competing priorities for their time.
- Current Reality:
    - What has changed in our world in the last 180 days?
        - Necessary work on the Medical Assistants in the new domain transition.
    - What major assumptions in our plan may no longer be valid given the last 180 days?
        - Our aim to re-start this program in the second quarter needed to be re-visited.
- Adjustments: What do we need to adjust in our approach for the next quarter/six months?
    - Financial and capital plan modifications?
    - Other modifications**?**
        - Engaging the Kaizen Personnel to observe the current state and to put a plan in place on how to approach this project. This should involve KPO, Clinic Leaders, and selected Medical Assistants and Providers.

Good Idea: Gayle Weston asked about some type of notification to patients that hasn't been to the provider in almost three years so they wouldn't be dismissed from their practice.

PC Patients receiving depression screening annually – Mark Batty went over the depression screening initiatives. Primary Care providers are able to refer their patients to the Behavioral Health Services.

- Successes:
  - What went well and why?
    - The leadership in implementing a pilot program for depression screening amongst several Primary Care Providers. The pilot program has resulted in the completion of the depression screening on all referrals into this program.
  - What should we be proud of?
    - The progress this group is making in integrating behavioral health in primary care. Mason Health continues to be the provider of choice, as most patients wish to stay within their primary care setting for their mental health care.
- Learnings:
  - What did not go well and why?
    - Some providers have been hesitant to complete screenings with concern there is not a timely option for care due to the higher utilization of behavioral health therapy services. Currently the pilot program is limited to 9 PCPs.
  - What limits and problems have we uncovered that we were not aware of earlier?
    - Our capacity to meet the demand has been stretched, although we have taken the necessary steps in increasing our mental health provider pool.
- Current Reality:
  - What has changed in our world in the last 180 days?
    - The need for behavioral health services continues to grow at a rapid pace. Our ability to keep up with this demand has been a challenge. The latest WA state BH report stated there were 1.1 million adult Washington residents with anxiety, 740,000 with depression
  - What major assumptions in our plan may no longer be valid given the last 180 days?
- Adjustments: What do we need to adjust in our approach for the next quarter/six months?
  - Financial and capital plan modifications?
    - Identify locations for the new counselors when they are hired.
  - Other modifications?
    - Getting two new mental health counselors hired and onboarded. These positions have been posted and interviews are ongoing.

Emergency Patient (Overall) - Mel Strong shared that the plan started with post discharge

- Successes:
  - What went well and why?
    - ED patient experience- Switched focus in April from a new service implementation (Nexus) to focus on ED patient flow. We hypothesized that by creating a smoother transfer process it would decrease wait times in the ED and increase patient satisfaction. Inpatient leaders and ED leaders completed workflow mapping and measuring metrics. A questionnaire was used for every patient admitted that was filled out by

the ED and receiving department staff. It asked 'barrier' questions related to delays in transferring the patients between units. The answers revealed a wealth of information on inconsistency of speed of admission, bed placement, occupancy rates, hospitalist working, and other common barriers we were not aware of. We are able to implement Nexus post discharge services beginning in September. We have a report that will be transmitted to Nexus health every 24hours which eliminates the need for Cerner integration.

- What should we be proud of?
  - ED: Despite the reported industry 'burn out', and turnover, we still have engaged staff who care about the patients and the patient experience overall.

- Learnings:
  - What did not go well and why?
    - ED- We collected data during abnormally high census times. Submission of the forms by staff was inconsistent. We stopped collection of the forms after 2 weeks because staff were overwhelmed with Cerner implementation and the high census. Situational awareness is key to walking the fine line between engaged staff and contributing to burn out.
  - What limits and problems have we uncovered that we were not aware of earlier?
    - ED-The length of time the patients spend in the ED waiting for an inpatient bed is extremely complex. Examples of barriers: hospitalist order input, room availability (includes capacity and cleaning), nurse availability to give and/or receive report, capacity of ED and inpatient units.
- Current Reality:
  - What has changed in our world in the last 180 days?
    - ED- overall nursing shortage combined with higher than normal census throughout the region. The nursing staff shortage is predicted to continue, although not at a crisis level as we're experiencing now. Staffing shortages combined with capacity constraints has nurses taking care of higher acuity and higher volumes.
  - What major assumptions in our plan may no longer be valid given the last 180 days?
    - ED- We believed creating smoother and more timely transfer process would improve the patient experience. Quicker admissions would mean open ED rooms and patients waiting could be seen more quickly. The nursing shortage and capacity constraints made it difficult to even get the data we needed to analyze where the gaps and OFI's are.

- Adjustments: What do we need to adjust in our approach for the next quarter/six months?
  - Financial and capital plan modifications?
    - ED- Staff recruitment and retention funding. Recruitment requires sign on bonuses and recruiter feels along with relocation and tuition assistance.
    - Covid- mandatory vaccination plan
  - Other modifications?

- ED -Focus on nurse staffing is/should be, a priority. The patient experience and quality will suffer as a result of higher nurse: patient ratios due to lack of staffing.

Clinic Patient Satisfaction - Mark Batty went over the clinic patient satisfaction. The setting for the patient visit is already in the setting by the time they get to the provider as they have three touches prior to seeing the patient.

- Successes:
  - What went well and why?
    - Have narrowed the focus on specific questions to improve patient satisfaction results. The four questions are shown to have the biggest impact on the overall percentile rank. Are also re-focusing on new topics for our customer service huddles.
  - What should we be proud of?
    - Engagement of the majority of the Providers and staff. Good dialogue during survey result discussions**.**
- Learnings:
  - What did not go well and why?
    - The focus during the second quarter has decreased a bit, which was evident in an attendance drop in our customer service huddles.
  - What limits and problems have we uncovered that we were not aware of earlier?
    - The level of competing priorities and the turnover of staff.
- Current Reality:
  - What has changed in our world in the last 180 days?
    - Competing priority of the new domain transition has taken a fair amount of time and energy.
  - What major assumptions in our plan may no longer be valid given the last 180 days?
    - The maintaining of momentum will be a challenge. We need to allow some grace to the Providers and staff for a period of time. However, this will allow us to re-energize and refine our focus and methods to improvement.
- Adjustments: What do we need to adjust in our approach for the next quarter/six months?
  - Financial and capital plan modifications?
  - Other modifications?
    - Refine, refocus and re-energize once it is determined the Providers and staff are ready to place focus back on patient satisfaction.

Gayle Weston asked about our scores. Mark shared we are in the 30th percentile. Employee recognition is still happening, and we have put the recognitions in the waiting room, so patient can read the recognition. Brad and Mark discussed that some of the changes is going from a score 4 to 5 or vice a versa, so they are not bad scores but do have an impact on the overall score. Eric Moll asked where the phone system falls. Mark Batty shared that Colby is working with the vendor Mark feels like they are tasks on phone system that will impact patient satisfaction, but Mark doesn't believe they are measurable.

Referral Management – Nicole Eddins provided a referral update and shared having a referral team has really made a different.

Successes:

- What went well and why?
  - Monthly meetings with the key stakeholders really helped shine light on the potential for district wide improvements. For example, most all departments had the same struggles with Clarity slowness and not being able to view which referrals are marked as “stat”.
- What should we be proud of?
  - The collaborative efforts in improving referrals has been profound. Everyone is owning the problem and producing concerted dialogue to help fix it instead of resorting to blame.

- Learnings:
  - What did not go well and why?
    - We were hoping with ComJ we could make some improvements in the Clarity/Cerner workflow but so far, we are still having problems with the HL-7 interface. I am confident we will continue to work through these and improve the workflow.
  - What limits and problems have we uncovered that we were not aware of earlier?
    - The turn-around times from the moment the order is put in to when the patient gets scheduled an appointment really drives patient satisfaction (this was evident from Press Ganey comments). When we looked at our referral lists, we realized we had a large backlog of unscheduled orders and there was a huge opportunity for improvement. The good news is, “what gets attention, gets fixed”. For example:
      - DI is expanding scheduling staff, physical exam rooms, and getting a Lean overhaul in their scheduling process
      - Behavioral Health is adding staff to their team to open up more appointments
      - PT is expanding their physical footprint
- Current Reality:
  - What has changed in our world in the last 180 days?
    - The influx of patients who have waited to see their provider (due to COVID-19 shutdowns) and now are needing care has caused a major shift in demand/capacity. This has caused a large scale up in orders/referrals.
  - What major assumptions in our plan may no longer be valid given the last 180 days?
    - The capacity to work on referral process improvement has been deeply impacted by the pandemic and major project go-lives. We are able to continue to work on this, just not at the pace we were originally hoping.
- Adjustments: What do we need to adjust in our approach for the next quarter/six months?
    - The major adjustment the referral team is doing is focused mostly on ComJ and staffing needs as mentioned above.
  - Financial and capital plan modifications?
    - We don’t have unexpected financial needs for the next 6 months but might potentially have a need for either a Clarity replacement or supplement system in the next 2-3 years.
  - Other modifications?

- Many of our key stakeholders have changed (Peggy retired, Christine stepped in and Amber took on her new role). This will be a great way to put fresh eyes on the process and revamp things as we need to.

Gayle Weston asked about STAT order. This is one of the 2 or 3 priorities that this team sees in the new rebuild.

Where do you see this initiative rounding in 2022? Nicole sees there a long way to go. There are a lot of overlap. Once we see COMJ then take another look at Clarity. Darrin sees it as long-term change.

Employee Engagement -Improve the Experience of the Onboarding Experience of MH Staff –

Kevin shared the engagement/onboarding.

- Successes:
  - What went well and why?
    - Team continues to have enthusiasm targeted toward introducing incremental improvements.
    - Reviewing the new employees' feedback and suggestions to inform potential changes and improvements on a regular basis.
  - What should we be proud of?
    - In the past the Orientation sessions were heavily taken up with presentations and online learning. With that, they were low energy. Over past few months, observations of the classes have revealed much more interaction among the group, laughter, and connectedness.
    - Setting a very positive and lasting first impression with the new hires
- Learnings:
  - What did not go well and why?
    - Not having a back-up presenter for the SME topics.
    - Managing the awkwardness when Manager hasn't submitted system access to program Badge functionality and general system/Department access.
  - What limits and problems have we uncovered that we were not aware of earlier?
    - Mixed understanding of what takes place in Orientation by the department leaders and their role in the orientation process
- Current Reality:
  - What has changed in our world in the last 180 days?
    - Increased presence of Delta Variant; Intensity of War on Talent; Enhanced requirements for vaccination and stronger divisive response resulting in distraction, etc.
  - What assumptions in our plan may no longer be valid given the last 180 days?
    - Classes might reduce in size due to Recruiting volume and retention
- Adjustments: What do we need to adjust in our approach for next quarter/6 months?
    - Enhance Employee Health presence
    - Build in 2 + content items for team building and industry terminology
    - Sketch out New Hire Workbook/Handbook for 2022 introduction

The IT access needs to come from the directors/managers as it makes them accountable and they need to know the access their staff has.

Mel Strong shared a A3 on Nurse Staffing to add as a new initiative in the 3rd quarter. Darrin thinks it is great to do all the avenues of outreach to get staff. Eric "thanked" Mel for putting this together and putting a structure and discipline around it. Shelly Dunnington will add this to our third quarter dashboard and may want to see a sister initiative

Physician Engagement -Domain NW – Colby Snyder shared we have very engagement providers and learn how to keep them engaged in a different way. This is the first of this kind for Cerner and for Mason Health.

What is the timeline to get to that comfort stage? Colby thinks we are getting into that stage now. Darrin shared finding the super users to help others. Gayle Weston. would like those individuals recognized.

- Successes:
  - What went well and why?
    - Domain NW was launched on time.
  - What should we be proud of?
    - In spite of the issues, the staff are resilient and clearly engaged as we work to resolve problems.
- Learnings:
  - What did not go well and why?
    - Major difficulties with the historical upload of data led to significant dissatisfaction among providers. There has been significant cost in terms of trust as a result. The change to ambulatory workflow for the Walk-In clinic was an unexpected change that initially created significant consternation among the providers. The impact of implementation workflows on the MA's (specifically validation of meds/allergies coming from Domain C) have caused loss of morale in that group and in their provider supervisors.
  - What limits and problems have we uncovered that we were not aware of earlier?
    - Strong leadership on the hospital side has led to a more successful go live than on the clinic side where that same level of experience with EMR implementation and leadership is less mature. We also continue to get the question 'Why are we doing this' or 'Why are we doing this now' from staff/providers in spite of months of communication in many different forums.
- Current Reality:
  - What has changed in our world in the last 180 days?
    - Most believed that we would be leaving the pandemic behind. The continuation of the pandemic has continued to erode people's morale and enthusiasm. The EMR implementation on top of this major personal and social stressor amplified the dissatisfaction felt with the implementation on its own.
  - What major assumptions in our plan may no longer be valid given the last 180 days?
    - We can no longer predict an end to the pandemic and therefore must be very cautious about taking on new initiatives that would further strain our rather fragile staff/providers. Even small initiatives have to be considered in the context of a 'just one more thing' background of stress.

- Adjustments: What do we need to adjust in our approach for the next quarter/six months?
    - Financial and capital plan modifications?
        - Additional FTE resources will be necessary to support the EMR going forward both short and long term. The signification issues that occurred in the clinics have demonstrated that the clinics with existing staff and IS with their existing staff are insufficient to support and optimize the EMR in the clinic space.
    - Other modifications?

Operating Margin - Optimizing Supply Chain Processes & Supply Levels (Surgery Dept) - Rick Smith went over the supply chain initiative. Pam Schlauderaff wants to display this in our Baldrige application.

Rick Smith provided update on the optimize supply chain.
Successes:

- What went well and why?
    - Collaborative process between multiple key stakeholders including supply chain, business office and surgical services to define the current process and establish the metrics that we wanted to measure
    - The process has been revisited and revised multiple times utilizing the lean process for continuous improvements
- What should we be proud of?
    - Use of DMAIC - Initial documented process was all manual with no use of automation. The process end to end had 16 steps with multiple steps of duplication and was reduced to eight steps.
    - Standard works were documented for each stakeholder area to ensure consistency and accountability.
    - Monitoring and control determined a steady state had been achieved and automation was introduced which led to the removal of four more steps resulting in the current state of four steps with no duplication in work. Final state is (1) step for surgery, (1) step for supply chain and (2) steps for the business office.

Learnings:

- What did not go well and why?
    - Initial observation and understanding of the inputs due to new leadership. Some steps were missed in the define stage, but setting a standing meeting with stakeholders allowed for improved communication and engagement
    - Implementation of Multiview presented initial challenges in the established workflow without connectivity to COMC. Lack of data integrity and disconnection between the two databases resulting in manual work arounds for all teams involved. Cases on hold were increased significantly above target for the 60 days post go live (also due to COMJ implementation at 30 days post go live)
- What limits and problems have we uncovered that we were not aware of earlier?

- Multiview -> Cerner interface still has a few glitches (such as job timing) that we are all still researching when they arise. Multiview -> Cerner interface does not bring over HCPCS or REV. A daily item report was built in COMJ that the business office runs as part of their daily standard work to identify charges that need to be finalized.

Current Reality:

- What has changed in our world in the last 180 days?
  - Staffing – New supply chain director, retirement of two most senior employees in the department, hiring of one replacement staff and one contractor has played a significant role in the growth and dynamic of the supply chain team
  - Acute need for supply agility – an increasing number of supply backorders has increased the workload on the team. The need for someone specialized in inventory control has become undeniable in the current market
  - Charge Capture Review (non-surgical areas) – The migration to COMJ has highlighted that the process for charge capture in the non-surgical areas needs to be more clearly defined, standardized and trained following the similar steps taken in surgery
- What major assumptions in our plan may no longer be valid given the last 180 days
  - That the initial reduction in COVID cases would improve supply reliability. PPE has improved; however many other areas of medical supplies have become at risk categories and are going through cycles of MBO

Adjustments:

- Financial and capital plan modifications?
  - Additional staffing is needed in supply chain to respond to market changes, increase in supply demands, and increased workload as patient care areas have grown busier. Data based decision making for recommended supply levels both in the storeroom and in-patient care areas will result in improved leading indicators for supply risks. Clinic departments moving into the new Mason Clinic has increased the need for supply replenishment at point of use locations in clean supply rooms not serviced before.
  - Increase in minor equipment spend for supply chain as we have started optimizing the supply rooms into the Kanban system for an improved clinical experience and increased agility and supply reliability.
- Other Modifications?

Operating Margin - Implement a Clinically Driven Revenue Cycle

Brad Becker shared the Cerner Domain NW Revenue Cycle Improvements.

- Successes:
  - What went well and why?
    - Implementing single account methodology.
  - What should we be proud of?
    - Ongoing teamwork and various department working together.
- Learnings:
  - What did not go well and why?
    - The need to do last minute pivots and quickly creating new workflows. This occurred as expected new processes were not available to implement.

    - What limits and problems have we uncovered that we were not aware of earlier?
        - Continued complexity of clinically driven revenue cycle and limited training/testing in some departments.
- Current Reality:
    - What has changed in our world in the last 180 days?
        - Increased staffing shortages in some revenue cycle departments is impacting the ability to quickly resolve Domain NW go-live issues and challenges.
    - What major assumptions in our plan may no longer be valid given the last 180 days?
        - Stable and dependable staffing may not occur.
- Adjustments: What do we need to adjust in our approach for the next quarter/six months?
    - Financial and capital plan modifications?
        - Potential impact of Governor's COVID vaccination order is significant wild card.
    - Other modifications?

Gayle Weston asked how many staff we are down. Brad shared we are not down as low as we have been, but we now have to train staff, and then we have staff off for other types of leave.

Strategic Position Assessment – Assess Priorities & Performance Targets:
Start: Emergency Transfer Initiatives, and Nurse Staffing
Stop: Possibly onboarding and move it too operational
Continue: Continuing to move forward with staffing

Performance Targets: No change in outcome targets for 2021.

What action plans to we need to revise for the remainder of this year? Provider engagement resources allocation to support the new domain.

Adjourn: 4:12 p.m.

PUBLIC HOSPITAL DISTRICT NO. 1
OF MASON COUNTY, WASHINGTON

BY:_____

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Attest: _____ _____