Harlan County Health System

Hospital | Heartland Family Medicine
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Alma, NE 68920
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Board of Trustees Orientation Manual

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December 2019

COPY

RESTATED BYLAWS

OF THE

BOARD OF TRUSTEES

OF

HARLAN COUNTY HEALTH SYSTEM

ALMA, NEBRASKA

Harlan County Health System

As amended 2014

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ARTICLE I. ORGANIZATION AND PURPOSE

Harlan County Health System ("HCHS") is established under Nebraska Revised Statutes Chapter 23, Article 35 *et seq.*, as amended from time to time. Its purpose is to establish and maintain medical facilities for use in providing care to the sick and injured, principally those who are residents of Harlan County, Nebraska and surrounding communities; and to carry on other health care activities deemed appropriate by the Board of Trustees and as permitted by Nebraska law. For purposes of these Bylaws, all references to HCHS shall be deemed to include all medical facilities owned and operated by HCHS.

ARTICLE II. BOARD OF TRUSTEES

Section 1. Composition. HCHS's governing body is a Board of Trustees (the "Board" or "Board of Trustees") which is appointed by the Harlan County Board of Commissioners (the "County Board"). There shall be seven (7) members of the Board of Trustees unless and until said number is otherwise fixed by the County Board. Trustees satisfying the criteria set forth in Article II, Section 2 shall be appointed by the County Board and shall serve staggered six (6) year terms. Trustees shall hold their respective offices until removal or resignation in accordance with these Bylaws or until their successors are duly appointed and qualified.

Section 2. Qualifications. Each Trustee appointed by the County Board shall have the following qualifications:

a. Be a resident of Harlan County, Nebraska, with reasonable efforts made to ensure representation from residents within and outside the corporate limits of the city where the Health System is located.

b. Not be excluded from participation in any federally funded health care program or listed on any federal exclusionary database. All prospective Trustees shall first be checked among the federal exclusionary databases prior to being appointed by the County Board.

The County Board shall consult with the current Board of Trustees regarding the qualifications and skills of potential appointees prior to appointing new Trustees. The Board of Trustees shall reflect a broad representation of Harlan County, and members of the Board of Trustees shall be appointed for their ability to effectively participate in fulfilling the responsibilities of governing HCHS. Within ten (10) days after appointment, each Trustee shall qualify for office by taking the oath of county officers as set forth in Neb. Rev. Stat. § 11-101. The furnishing of a bond shall not be required unless explicitly required by the County Board upon appointment of a Trustee.

Section 3. Powers. The Board of Trustees shall have all powers provided by Nebraska law to boards of county hospitals. Without limiting the foregoing statement, the Board:

a. May purchase or lease a site for the hospital and other facilities and provide and equip such buildings as necessary to fulfill HCHS's mission.

b. May accept property by gift, devise, bequest, or otherwise, and may execute and carry out such conditions connected to the receipt of any gift, devise, or bequest as deemed appropriate by the Board.

c. May sell, lease, exchange, encumber, or otherwise dispose of the HCHS facilities or any other property under the control of the Board upon a concurring vote of a majority of the Trustees; provided, however, that if such sale, lease, exchange, encumbrance, or disposal is of all or substantially all of the HCHS property, said sale, lease, exchange, encumbrance, or disposal must also be approved by the County Board.

d. May borrow money on an unsecured basis or secured by HCHS's facilities and revenues of those facilities for the purposes of initially financing or refinancing the construction, improvement, maintenance, or replacement of facilities or equipping the facilities and acquiring other property or for any other purpose deemed appropriate by the Board. Any issuance of revenue bonds for which the revenue of the facility or facilities has been pledged shall be subject to the prior approval of the County Board.

e. Shall have the exclusive control of the expenditures of all money collected to the credit of HCHS.

f. Shall have exclusive control over any and all improvements or additions to the HCHS facilities and equipment, including the authority to contract for such improvements, additions, equipment, and other property; provided, however, that if any such improvement or addition to the facility or facilities costs more than fifty percent (50%) of the current replacement cost of such existing facility or facilities, the improvement or addition must first be approved by the County Board. Prior approval of the County Board is not required to purchase or contract for equipment.

g. Shall have exclusive control, supervision, care, and custody of the grounds, rooms, buildings, and other property purchased, constructed, leased, or set apart for the HCHS purposes.

h. Shall have the power to pay all current bills and claims due and owing by HCHS, and shall have the authority to pay the salaries of all employees of HCHS.

i. Shall have the power to expend operating funds for recruitment and the reimbursement of the reasonable expenses of persons interviewed or retained for employment or for medical staff appointment.

j. Upon approval of the County Board, establish and fund a retirement plan for the benefit of its full-time employees; such plan shall be funded by any actuarially recognized method approved by the County Board.

k. May authorize the delivery of any additional health care service, ambulance service, assisted or independent living service, or other ancillary service deemed in the Board of Trustee's opinion to be necessary for the betterment of the health status of the residents of Harlan County.

l. May control, own, and operate clinics and health care facilities both within and outside Harlan County.

m. May enter into contractual joint ventures with other governmental hospitals and health care organizations and nonprofit hospitals and health care organizations when doing so provides a tangible benefit to the residents of Harlan County.

n. May obtain legal and other professional services as necessary.

o. Is granted all other powers and duties necessary for the management, control, and government of the HCHS facilities, including but not limited to, any applicable powers and duties granted boards under other provisions of Nebraska law relating to nonprofit corporations, except as those provisions may otherwise conflict with Neb. Rev. Stat. §§ 23-3501 *et seq.*

Section 4. Duties. The Board of Trustees shall have the following duties:

a. Meet at least once per month and keep a complete record of all of its proceedings in accordance with Nebraska public meeting and open records laws.

b. Adopt bylaws and rules for its own guidance and for the government of the facility and establish and monitor policies deemed necessary and appropriate for the operation, conduct, administration, and management of HCHS.

c. Employ or contract for an administrator as chief executive officer of the facility, fix the administrator's compensation, and review the administrator's job performance on an annual basis.

d. Adopt and approve medical staff bylaws that govern the HCHS medical staff, approve the appointment of a qualified medical staff, and oversee the quality of medical care and services provided at the HCHS facilities.

e. Manage and control HCHS's funds in accordance with guidelines established for political subdivisions by the Nebraska Investment Council under Neb. Rev. Stat. § 72-1259 and invest funds in such investments as are permitted for counties in the State of Nebraska.

f. Fix the price to be charged to patients admitted to HCHS for care and treatment.

g. Establish charity care policies for free treatment or financial assistance for care provided by HCHS.

h. Procure and pay premiums on any and all insurance policies required for the prudent management of HCHS, including, but not limited to, general liability, professional malpractice liability, workers' compensation, vehicle liability, and directors and officers liability.

i. On or before July 15 of each year file with the County Board an annual report of HCHS and a statement of all receipts and expenditures made during the prior fiscal year and certify the amount necessary, if any, to maintain and improve HCHS for the ensuing year.

j. Develop and oversee implementation of annual operating budgets pursuant to the Nebraska County Budget Act, to the extent applicable.

k. Generally oversee the management, direction, and long-range planning of HCHS.

l. Notify the Nebraska Department of Health and Human Services Division of Regulation & Licensure (the "Department") in writing within five (5) business days of the occurrence of a vacancy in the Administrator position, identifying the individual responsible for such duties during the interim, and notify the Department in writing within five (5) business days of filling the position, identifying the new Administrator by name and the effective date of his or her position.

m. Require and approve a quality assurance plan providing for specific review and evaluation activities to assess, preserve, and improve the overall quality and efficiency of patient care at HCHS and in related programs of patient care. The Board shall receive and review a report of quality assurance/performance improvement activities and medical staff and utilization review committee reports on a regular basis.

n. Conduct such other activities and take such other action as the Board of Trustees shall deem necessary and proper to carry out its responsibilities, as permitted by law.

The Administrator and his/her assistants may assist the members of the Board of Trustees in carrying out the foregoing duties.

Section 5. Removal and Vacancy.

a. A Trustee may be removed from office by the County Board at any time with or without cause.

b. When a Trustee is absent from three (3) consecutive Board meetings, either regular or special, without being excused by the remaining Trustees, his or her office shall become vacant.

c. A vacancy shall occur when a Trustee resigns or is removed as set forth above. Resignation shall be effective upon tendering a written resignation to the Board of Trustees with a copy to the County Board. A vacancy shall also occur when a

Trustee is ineligible to continue by virtue of a change in residency or ability to satisfy necessary qualifications or upon a change in laws relating to eligibility to serve as a Trustee.

d. All vacancies on the Board of Trustees shall be filled by the County Board. The person appointed to fill such a vacancy shall hold office for the unexpired term of the Trustee he or she is replacing.

Section 6. Compensation and Mileage. The salaries (if any) of Trustees shall be set by the County Board. If the County Board establishes such a salary, the salary shall be not less than one hundred dollars per year, but not more than one hundred dollars per meeting and shall not exceed one thousand two hundred dollars per year. Trustees shall also be reimbursed for necessary mileage at the statutory rate (Neb. Rev. Stat. § 81-1176) while on business of HCHS. Subject to prior Board approval or established Board policy, necessary expenses of Trustees, while on the business of HCHS, may be paid to the extent permitted by the Local Government Miscellaneous Expenditure Act (Neb. Rev. Stat. §§ 13-2201 *et seq.*) as amended from time to time.

Section 7. Officers. The officers of the Board of Trustees shall be a Chairperson, a Secretary, and a Treasurer, elected from among the Trustees. The Trustees may, if desired, elect one member Vice-Chairperson, to assume the authority and duties of the Chairperson in his or her absence. Officers must be members of the Board of Trustees. The Board shall elect the officers at its regular annual meeting in January. The officers shall take office immediately upon being elected and shall serve until the following annual meeting or until their successors have been duly elected and take office. The Trustees may, at any meeting called for the specific purpose, remove from any office, the person so designated to hold that office. Any vacancy in any office by death, resignation, removal or otherwise, shall be filled for the unexpired portion of the term by the Board at its next regular meeting. The duties and authority of the officers shall be as follows:

a. Chairperson. The Chairperson shall preside at all meetings of the Board, approve the agenda for each meeting, call special meetings as he or she deems necessary, oversee the operations of the Board, execute documents on behalf of HCHS when approved by the Board, and have such other duties and authority as normally pertain to the office or as provided by the Board or these Restated Bylaws.

b. Secretary. The Secretary shall keep a complete record of the proceedings of all meetings and actions of the Board, produce such records when called upon to do so at any meeting of the Board, file with the County Board such reports and statements as are required by law, execute documents and instruments on behalf of HCHS when approved by the Board, assume the duties of the Chairperson in his or her absence in the event there is no Vice Chairperson, and have such duties and authority as normally pertain to the office or as are assigned by the Chairperson, the Board, or these Restated Bylaws.

c. Treasurer. The Treasurer shall receive and pay out all money under the control of the Board as approved by it, report such receipts and expenditures to the Board of Trustees and the County Board as required under these Bylaws, and have such other duties and authority as normally pertain to the office or as are assigned by the Chairperson, the Board, or these Restated Bylaws.

The Administrator shall serve as chief executive officer, and the Administrator and his or her assistants may assist the other officers, identified above, in carrying out the foregoing duties.

Section 8. Regular Meetings/Annual Meeting. The annual meeting of the Board of Trustees shall occur at the beginning of the regular meeting in January of each year. Regular meetings of the Board of Trustees shall be held at a time each month to be determined by the Chairperson, at HCHS. Any business pertaining to HCHS may be placed on the agenda, considered, and acted upon at any regular meeting of the Board of Trustees, subject to the rules set forth below regarding the amendment of agendas under Nebraska open meetings laws.

Section 9. Special Meetings. Special meetings may be called by the Chairperson when he or she deems it necessary, or when no fewer than three (3) Trustees or a majority of the County Board requests such a meeting by delivering such a request to the Chairperson in writing. Special meetings may be of an emergent nature. Special meetings of an emergent nature may be held by electronic or telecommunications equipment or in person.

Section 10. Agenda. The agenda at meetings of the Board of Trustees shall be as follows:

a. Regular Meetings.

(1) Call to order.

(2) Presentation and approval of minutes of last regular meeting.

(3) Presentation of annual or monthly financial reports.

(4) Transaction of other business that may properly be brought before the meeting.

(5) Election of Officers at the annual meeting.

(6) Adjournment.

b. Special Meetings

(1) Call to order.

(2) Reading of official call for meeting.

(3) Transaction of business for which meeting is called.

(4) Adjournment.

Section 11. Meeting Notices.

a. Regular/Special Notice. No notice of regular meetings need be given to the Trustees. Trustees shall receive notice of non-emergent special meetings within the timeline for notice provided to the public as set forth herein. Notice of all regular and special meetings shall be given to the public no less than two (2) days prior to the date of the meeting, except in the case of a special meeting of an emergent nature. Notice shall be deemed given to the Trustee when hand delivered personally to the Trustee, mailed electronically, or when delivered or mailed, postage pre-paid, to the Trustee's designated address. The notice shall specify the time, date, and place of the meeting, and shall contain the agenda or contain a statement that the agenda shall be readily available for public inspection at the Administrator's office during normal business hours.

b. Emergency Meetings. Emergency meetings may be conducted without standard notice when emergent circumstances make standard notice unfeasible. In the case of a special meeting for which reasonable advance public notice is unable to be given due to the exigent nature of the matter, each Trustee shall receive at least twelve (12) hours actual notice of the meeting via electronic mail, in writing, or verbally. When it is necessary to hold a special meeting of an emergent nature without reasonable advance public notice, the nature of the emergency shall be stated in the minutes and any formal action taken in such meeting shall pertain only to the emergency.

c. Media. The Administrator shall maintain a list of the news media requesting notification of meetings, and shall make reasonable efforts to provide advance notification to them of the time and place of each meeting and the subjects to be discussed at the meeting, regardless of whether the meeting is regular, special, or an emergency.

d. Attendance. Trustees may participate in a regular or special meeting of the Board through the use of any means of communication by which all Trustees participating (as well as the public in attendance at the public meeting) may simultaneously hear each other during the meeting. A Trustee participating in a meeting by this means is deemed to be present in person at the meeting. However, telephonic or other attendance pursuant to this subsection shall not be used as a means of avoiding any obligation of the Board pursuant to the Open Meetings Act. Attendance at a meeting by a Trustee, for any purpose other than objecting to lack of proper notice, shall constitute a waiver of notice as to that Trustee.

Section 12. Quorum/Voting. A majority of Trustees shall constitute a quorum for the transacting of business at a meeting of the Board. Unless otherwise stated in these Bylaws or in the law, the affirmative vote of a majority of Trustees in attendance at any meeting at which a quorum is present shall be required for any Board action.

Section 13. Public Meeting Requirements. It is the policy of HCHS that the formation of public policy is public business and may not be conducted in secret. All meetings of the Board of Trustees shall conform to the Open Meetings Act of the state of Nebraska, Neb. Rev. Stat. §84-1408 et seq., as amended from time to time. Subject to such amendments, this shall mean that:

a. All regular, special, and emergency meetings of the Board of Trustees, formal or informal, for the purposes of briefing, discussion of public business, formation of tentative policy, or taking any action of the Board, shall be open to the public, except as provided below in subsections (b) and (c) or as otherwise provided by law.

b. Closed sessions may be called by the affirmative vote of a majority of the Trustees if a closed session is clearly necessary for (i) the protection of the public interest or (ii) the prevention of needless injury to the reputation of an individual, provided such individual has not requested a public meeting.

c. Closed sessions may also be called by the affirmative vote of a majority of the Trustees for strategy sessions with respect to collective bargaining, real estate purchases, pending litigation, or litigation which is imminent as evidenced by communication of a claim or threat of litigation to or by the public body; investigative proceedings regarding allegations of criminal misconduct; evaluation of the job performance of a person; or for peer review activities, professional review activities, review and discussion of medical staff investigations and disciplinary actions, and any strategy session concerning transactional negotiations with any referral source that is required by federal law to be conducted at arms' length.

d. The subject matter of and the reason for the closed session shall be stated in the motion to close. The vote to hold a closed session shall be taken in open session. The vote of each Trustee on the question of holding a closed session, the reason for the closed session, and the time when the closed session commenced and concluded shall be recorded in the minutes. The Administrator shall have authority to attend closed sessions of the Board, unless a conflict of interest is identified, in which case the Administrator shall leave the room. The Board shall restrict its consideration of matters during the closed portions of the meeting to only those purposes set forth in the minutes as the reason for the closed session. The meeting shall be reconvened in open session before any formal action is taken. Formal action does not include negotiating guidance given by the Board to legal counsel or other negotiators in closed sessions authorized by law.

e. Any Trustee may challenge the continuation of the closed session if he or she determines that it has exceeded the reasons stated for the closed session or contends that the closed session is improper. Such challenge may be overruled by a majority vote of the Trustees. The challenge and its disposition shall be recorded in the minutes.

f. Notice of Board meetings shall be given in accordance with Section 10 of this Article and to the general public by posting a copy of the notice in a conspicuous place in the lobby of HCHS and by posting written notice in at least three (3) public

places at least twenty-four (24) hours prior to the meeting; provided, however, if providing such notice is untenable, emergency meetings may take place without such notice so long as the provisions of the law and these Restated Bylaws related to emergency meetings are followed.

g. Agenda items shall be sufficiently detailed in the notice to give the public reasonable advance information about specific proposals, projects, and other issues which are known to be subject to consideration at the meeting. Except for the agenda of an emergency meeting, the meeting agenda shall not be altered later than twenty-four (24) hours before the scheduled commencement of the meeting. The Board shall have the right to modify the agenda at the public meeting to include items of an emergency nature only.

h. The public shall have the right to attend, speak at, record, and/or broadcast meetings of the Board, subject to reasonable rules and regulations established by the Board regarding the conduct of persons attending, speaking at, videotaping, televising, photographing, broadcasting, or recording its meetings. No individual shall be required to identify himself or herself as a condition for admission to the meeting, but the Board may require any member of the public addressing the Board to identify himself or herself.

i. At least one copy of all reproducible written material to be discussed will be available at the meeting for examination and copying by members of the public.

j. At least one current copy of the Open Meetings Act, Neb. Rev. Stat. § 84-1408 through -1414, shall be posted in the meeting room at a location accessible to the members of the public. At the beginning of each meeting, the public shall be informed about the location of the posted information.

k. Any action taken on any question or motion duly moved and seconded shall be by roll call vote of the Board in open session, and the record shall state how each Trustee voted or the Trustee's abstention or absence noted.

l. Minutes of all meetings showing the time, place, members present and absent, and the substance of all matters discussed shall be maintained. The minutes of all meetings and evidence and documentation received or disclosed in open session shall be public records and open to public inspection during normal business hours at the office of the Administrator of HCHS. Minutes of regular and special meetings shall be written and available for inspection within ten (10) working days or prior to the next convened meeting, whichever occurs earlier. Minutes of emergency meetings must specify the nature of the emergency and any formal action taken at the meeting and shall be made available to the public no later than the end of the next regular business day following the emergency meeting.

Section 14. Committees. The Board may establish such committees as the Board shall deem advisable for the study of issues of concern to the Board, and for the recommendation of action to the Board. Committees may be of standing or limited duration, shall include no more than two (2) Board members (or no more than one (1)

Board member if the Board consists of three rather than five members), and may include one or more medical, professional, or administrative staff members as deemed appropriate. Committee actions shall be advisory recommendations only, and shall not be binding or official action of HCHS or the Board.

ARTICLE III. MEDICAL STAFF

Section 1. Appointment and Bylaws. The Board of Trustees shall appoint a Medical Staff comprised of physicians and other practitioners who are authorized by law and by the Board to exercise clinical privileges and render patient care services at the Hospital. The Board shall approve, on the recommendation of the Medical Staff, separate Medical Staff Bylaws which shall outline the nature and purposes of the Medical Staff; the qualifications for membership; the responsibilities of individual Medical Staff members; the procedures and criteria for appointment, reappointment, limitation, and termination of membership or privileges; the organization and operation of the Medical Staff; the qualifications and procedures for approval of other professionals, if any, who may render patient care services in the Hospital other than as Medical Staff members or employees; the procedures for review and amendment of such Bylaws; and such other matters as may be deemed appropriate for such Bylaws. The Board may delegate to the Medical Staff specific responsibilities for quality assurance and peer review within the Hospital, subject always to the ultimate authority of the Board of Trustees.

Section 2. Communications. The Board shall maintain regular and systematic communications with the Medical Staff. The Administrator shall serve as liaison between the Medical Staff and the Board of Trustees, and shall maintain regular contact with both the President of the Medical Staff and the Chairperson of the Board of Trustees. In addition, the Board Chairperson may attend Medical Staff meetings and/or the President of the Medical Staff may attend Board meetings.

ARTICLE IV. ADMINISTRATION

The Board of Trustees shall select and employ a Health System Administrator who shall be its direct executive representative in the management of HCHS. The Administrator shall have authority and responsibility for the administration of HCHS in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued by the Board of Trustees. The Administrator shall act as the duly authorized representative of the Board of Trustees in all matters, except as otherwise directed by the Board. The Administrator shall be the chief executive officer and shall:

a. Maintain a record of, and carry out, all policies established by the Board of Trustees.

b. Oversee the selection, employment, supervision, promotion, demotion, discharge and compensation of employees of HCHS.

c. Develop and maintain personnel policies, and practices for HCHS with the advice and consent of the Board of Trustees.

d. Prepare an annual budget showing the expected receipts and expenditures.

e. See that all physical properties of HCHS are maintained in a good state of repair and operating condition.

f. Supervise all business affairs of HCHS and oversee the collection and expenditure of Health System funds. Funds shall be deposited in financial institution(s) approved by the Board, except that the Administrator may maintain cash on hand in an amount approved by the Board from time to time.

g. Purchase such equipment, supplies and services as may be necessary for the operation of HCHS facilities and programs, provided that Board approval shall be obtained for any purchases which are not within the current budget approved by the Board.

h. Submit to the Board regular reports on all aspects of Health System operations, in such forms as the Board shall require.

i. Serve as liaison between the Board of Trustees and the Medical Staff.

j. Attend meetings of the Board of Trustees and represent the Board of Trustees at meetings of the Medical Staff.

k. Establish schedules of charges for services and supplies provided by HCHS facilities and programs, subject to the approval of the Board.

l. Enroll and reenroll the HCHS's facilities and services in the Medicare and Medicaid programs, to make changes or updates to HCHS's facilities and services status in such programs, to commit HCHS to fully abide by the statutes, regulations, and program instructions applicable to such programs, to communicate with such programs on behalf of HCHS, to execute and deliver cost reports and other required reports related to such programs, and to execute and deliver all documents associated with the foregoing authority.

m. Take such other actions as are assigned by the Board or are otherwise in the best interests of HCHS, and consistent with the laws and Board policies governing operation of HCHS.

n. No assignment, referral, or delegation of authority by the Board of Trustees to the HCHS Administrator, the Medical Staff, or anyone else shall preclude the Board of Trustees from exercising the authority required to meet its responsibility for the conduct of HCHS. The Board of Trustees shall retain the right to rescind any such delegation.

ARTICLE V. CONFLICTS OF INTEREST

Section 1. Policy and Definition. HCHS officials, including members of the Board of Trustees, the Administrator, and employees or Medical Staff members with authority to direct any portion of the business of HCHS, shall strictly refrain from any action which causes, or gives the appearance of causing, a conflict of interest or which may create or give the appearance of creating an improper personal benefit to such individual. All such individuals, as well as the members of their immediate families (parent, spouse, child residing in the same household, or other dependents for federal income tax purposes), and any businesses with which they are associated (as a partner, limited liability company member, director, or officer, or in which the official or a member of the official's immediate family holds more than One Thousand Dollars ($1000) of privately held stock, holds more than a five percent (5%) equity interest in a privately held corporation, or holds more than Ten Thousand Dollars ($10,000) of public traded stock or a ten percent (10%) equity interest in a publicly held corporation), shall be deemed to be "officials" of HCHS for purposes of the rules regarding conflicts of interest.

Section 2. Items of Value. No HCHS official as previously defined, shall accept a gift, loan, contribution, or other item of value from any individual or entity, if offered or accepted in exchange for any actual, implied, or perceived promise that the receipt of such item may influence the official in the performance of his or her duties on behalf of HCHS, or if the circumstances could reasonably create the appearance of such promise or such result. The only exception shall be token items of nominal value which are clearly intended solely as expressions of friendship or appreciation.

Section 3. Use of Position. No HCHS official shall use the official's position or any confidential information received through the holding of that position to obtain financial gain, or use personnel, resources, property, or funds of HCHS for personal financial gain.

Section 4. Contracts. No HCHS official shall have any interest in any contract or business transaction, oral or written, formal or informal, in which HCHS is a party, or receive any fee or commission as the result of any such contract or transaction, unless each of the following steps is followed:

a. The official makes a declaration on the record to the Board of Trustees regarding the nature and extent of his or her interest prior to official consideration of, or execution of, the contract or transaction;

b. The official does not directly influence, approve, or vote on the matter of granting the contract or executing the transaction, except that if the number of Board members declaring an interest in the contract or transaction would prevent the Board from securing a quorum on the issue, then all members may vote on the matter;

c. The official does not act for the Board or HCHS as to inspection of performance under the contract or transaction in which he or she has an interest; and

d. Such contract or transaction is subject to any applicable competitive bidding requirements, and is determined to be fair and reasonable by the Board of Trustees.

Section 5. Records. The Secretary of the Board, with the assistance of the Administrator, shall maintain separately from other HCHS records a ledger regarding each contract or transaction described in Section 4, for five years following the date of the affected official's last day in office, including the names of the contracting parties, the nature of the interest of the official, the date that the contract or transaction was approved, the amount of the contract or transaction, and the basic terms of the contract or transaction. Such information shall be compiled no later than ten (10) days after the contract or transaction has been executed, and such ledger shall be available for public inspection at HCHS during normal working hours. For purposes of this Section and Section 4, the following contracts or transactions shall not be covered:

a. The receiving of deposits, cashing of checks, and buying and selling of warrants and bonds of indebtedness of HCHS by a financial institution.

b. Contracts or transactions involving $100 or less, provided that no contract or transaction shall be divided into multiple contracts or transactions for the purpose of falling below $100.

ARTICLE VI. INDEMNIFICATION AND INSURANCE

Section 1. Covered Individuals. For purposes of this Article, the term "covered individuals" shall include all members of the Board of Trustees, the Administrator, all employees of HCHS, and all HCHS volunteers, when providing services for HCHS; and shall include Medical Staff members and other independent professionals when performing peer review, utilization review, credentialing, quality assurance, and other medical staff organizational functions for HCHS by delegation of authority from the Board of Trustees. The term "covered individuals" expressly excludes, without limitation, Medical Staff members and other health care professionals who are not HCHS employees, when rendering patient care.

Section 2. Defense and Indemnity. HCHS shall defend, hold harmless, and indemnify covered individuals against any and all claims and demands, whether groundless or otherwise, arising out of an alleged act or omission occurring within the scope of their employment or duties, to the fullest extent permitted by Nebraska law. The provisions of this section shall continue to apply to covered individuals and their heirs and representatives after the covered individual ceases to be a covered individual, as to all acts and omissions occurring prior to the date of such cessation.

Section 3. Insurance. The Board of Trustees may authorize the purchase of any and all insurance which the Board deems proper to protect and preserve the assets of HCHS, including without limitation any insurance for HCHS and for covered individuals against any or all expense and liability within HCHS's duty to defend, hold harmless, and indemnify as described above.

ARTICLE VII. AMENDMENTS

These Bylaws may be amended by the affirmative vote of a majority of the members of the Board of Trustees, at any regular or special meeting of the Board, provided each member of the Board shall have received written notice of the proposed amendment no less than ten (10) days prior to the meeting at which the amendment is made. Amendments to the proposed amendments may be offered and adopted at such meeting without additional prior notice, upon the unanimous approval of the Board members present and voting.

ARTICLE VIII. EFFECTIVENESS

If any provision of Nebraska law is amended in such a manner as to render any portion of these Bylaws inconsistent with Nebraska law, then such portion of these Bylaws shall, to the extent necessary, be deemed to be automatically reformed to conform to Nebraska law. In all other respects, these Bylaws shall remain in full force and effect, and unchanged. These Bylaws shall become effective when duly adopted by the Board of Trustees, and shall replace and revoke all prior Bylaws of the Board of Trustees.

Duly adopted on this 16th day of September, 2014.

Bruce Lewis
CHAIRPERSON, BOARD OF TRUSTEES

Susan K. Foster
SECRETARY, BOARD OF TRUSTEES

ADMINISTRATOR/CHIEF EXECUTIVE OFFICER

RESTATED BYLAWS

OF THE

BOARD OF TRUSTEES

OF

HARLAN COUNTY HEALTH SYSTEM

ALMA, NEBRASKA

As amended 2014

Harlan County Health System

717 North Brown
P.O. Box 836
Alma, NE 68920-0836
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Job Description: Individual Hospital Board of Trustees Board Member

General Expectations of a board member:
Prospective and incumbent board members should commit themselves with regard to the following:

- Know the organization's mission, purposes, goals, policies, programs, services, history, strengths, and needs.
- Perform the duties of board membership responsibly and conform to the level of competence expected from board members as outlined in the duties of care, loyalty, and obedience.
- Prepare for the policy discussions and decision making required for governance excellence within the organization.
- Serve in leadership positions and undertake special assignments willingly and enthusiastically.
- Suggest possible nominees to the board who are individuals of achievement and distinction and who can make significant contributions to the work of the board and the organization's progress.
- Avoid prejudiced judgments on the basis of information received from individuals and urge those with grievances to follow established policies and procedures through their supervisors (all matters of potential significance should be called to the attention of the CEO and the board's elected leader as appropriate).
- Avoid asking for special favors of the staff, including special requests for extensive information, without prior consultation with the CEO, board, or appropriate committee chairperson.
- Know the difference between the board's role of governance and the role of the CEO in operations of the health system.
- Counsel the CEO as appropriate and support him or her through difficult relationships with groups or individuals.
- Consider giving an annual gift according to personal means.
- Assist the development committees or affiliated foundation and staff by implementing fundraising strategies through personal influence with others (e.g., corporations, individuals, and foundations).
- Participate annually in educational opportunities to remain current on changing trends and issues affecting governance.

Meetings
Board meetings are the center of governance. The way they are planned and conducted, in addition to the dynamics that emerge in them significantly influence the quality of governance. Therefore, individual board members are expected to:

- Prepare for board and committee meetings, including appropriate organizational activities.
- Participate in board and committee meetings with forethought, courtesy, critical thinking and analysis, and attention to results.
- Ask timely and substantive questions at board and committee meetings consistent with the board member's conscience and convictions, while at the same time supporting the majority decision on issues decided by the board.
- Be aware of the rules and laws that govern the conduction of open meetings in the State of Nebraska.

Duties:

The Fundamental Duty of Oversight

The board is the party responsible for the organization. The board must supervise and direct its own officers and govern the organization's efforts in carrying out its mission. The duties of care, loyalty, and obedience describe the manner in which the directors are required to carry out their fundamental duty of oversight.

Duty of Care

Duty of Care requires board members to have knowledge of all reasonably available and pertinent information before taking action. The board member must act in good faith, with the care of an ordinarily prudent businessperson in similar circumstances, and in a manner he or she reasonably believes to be in the best interest of the organization.

Duty of Loyalty

Duty of Loyalty requires board members to candidly discharge their duties in a manner designed to benefit only the hospital or health system, not the individual interests of the board member. It incorporates the duty to disclose situations that may present a potential for conflict with the organization's mission, as well as a duty to avoid competition with the organization.

Duty of Obedience

Duty of Obedience requires board members to ensure that the organization's decisions and activities adhere to its fundamental corporate purpose and charitable mission, as stated in its bylaws.

Each board member is also entrusted with individual responsibilities as a part of his or her board membership. The obligations of board service are considerable; they extend well beyond the basic expectations of attending meetings or participating in hospital events. Individual board members are expected to meet higher standards of personal conduct on behalf of the organization than what is usually expected of other types of community volunteers.
Yet, despite all of these "special" responsibilities, board members as individuals have no special privileges, prerogatives, or authority to act on behalf of the organization. They must meet in formal sessions to negotiate and make corporate decisions.

Harlan County Health System

717 North Brown
P.O. Box 836
Alma, NE 68920-0836
phone (308) 928-2151
fax (308) 928-2774
www.harlancountyhealth.com

Description of Responsibilities:
Harlan County Health System Board of Trustees

Core Responsibilities
The hospital governing board must fulfill certain fundamental or core responsibilities in overseeing the efforts of the organization. These responsibilities cluster around six major areas:

1. Financial Oversight
2. Quality Oversight
3. Setting Strategic Direction/Mission Oversight
4. Self-Assessment & Development
5. Management Oversight
6. Advocacy

The board fulfills these responsibilities by adopting specific outcome targets against which to measure the organization's performance. To accomplish this, the board must:

- Establish policy guidelines and criteria for implementing the mission statement.
- Evaluate proposals brought to the board to ensure that they are consistent with the mission statement.
- Monitor programs and activities of the hospital and any subsidiary units to ensure mission consistency.
- Periodically review, discuss, and amend the mission statement if necessary to clarify board responsibilities.

Financial Oversight
The board has responsibility for the financial soundness of the organization. To accomplish this, the board must:

- Review and approve overall financial policies and plans for the organization.
- Receive and review financial reports to assess actual performance compared to projections.
- Review and adopt ethical financial policies and guidelines.
- Review major capital plans proposed for the organization and any subsidiaries.
- Ensure that the financial, capital, and strategic plans are aligned.

Quality Oversight
The board has the responsibility to assess the quality of all services provided by individuals who perform their duties in the facilities under the board's sponsorship. To do this, the board should:

- Make quality of care and patient safety top priorities for the organization.
- Review, approve and oversee quality improvement initiatives recommended by senior management and the medical staff

- Review and carefully discuss quality reports that provide comparative statistical data, and set measurable policy targets to ensure continual improvement in quality performance.
- Review recommendations of the medical staff regarding new physicians who wish to practice in the organization and approve these recommendations if appropriate.
- Reappoint individuals to medical staff using comparative outcome data to evaluate how they have performed since their last appointment.
- Appoint physicians to governing body committees and seek physician participation in the governance process to assist the board in its patient quality assessment responsibilities.
- Regularly receive and discuss malpractice data reflecting the organization's experience and the experience of individual physicians who have been appointed to the medical staff.
- Regularly receive and discuss data about medical staff to assure that future staffing will be adequate in terms of ages, numbers, specialties, and other demographic characteristics.
- Monitor programs and services to ensure that they comply with policies and standards relating to quality.
- Take corrective action to improve quality performance when appropriate and/ or necessary.

Setting Strategic Direction/Mission Oversight

The board has the responsibility to recommend the future direction that the organization will take to meet the community's health needs. To fulfill this responsibility, the board must:

- Review and approve a comprehensive strategic plan and supportive policy statements.
- Ensure that the organization's strategic plan is consistent with the mission.
- Regularly review progress toward meeting goals in the strategic plan to assure that the board is fulfilling its mission.
- Periodically review, discuss, and amend the strategic plan to ensure its relevance to the mission.

Self-Assessment & Development

The board must assume responsibility for itself; its own effective and efficient performance. To discharge its stewardship responsibilities to its "owners," the board must:

- Participate annually in a formal board evaluation process.
- Maintain and update policy statements regarding roles, responsibilities, duties, and job descriptions for the board itself and its members, officers, and committees.
- Participate both as a board and as individuals in orientation programs and continuing education programs.

Management Oversight

The board is the final authority regarding oversight of management performance by the CEO and support staff. To exercise this authority, the board must:

- Support and assist the CEO to help achieve the organization's mission.
- Communicate regularly with the CEO regarding goals, expectations, and concerns.

- Evaluate the performance of the CEO annually using goals and objectives agreed upon with him or her at the beginning of the evaluation cycle.
- Periodically survey CEO employment arrangements at comparable organizations to ensure the reasonableness and competitiveness of his or her compensation package.
- Periodically review management succession plans to ensure leadership continuity.
- Establish specific performance policies that provide the CEO with a clear understanding of board expectations, and update these policies based on changing conditions.

Advocacy

The board needs to focus on advocacy and lobbying around public policy issues. In order to take an activist role, the board must:

- Conduct a periodic community health needs assessment to understand the health issues of the communities served.
- Set goals for the organization around the issue of public advocacy.
- Establish a policy regarding the board's role in fund development and philanthropy efforts.

Board Governance

Finally, the board is responsible for managing its own governance affairs in an efficient and effective way. To fulfill this responsibility, the board must:

- Maintain written conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest.
- Periodically review the board's own structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.
- Ensure that each board member understands and agrees to maintain confidentiality with regard to information discussed by the board and its committees.
- Adopt, amend, and, if necessary, repeal the bylaws of the organization.

Harlan

MANAGEMENT AGREEMENT

THIS AGREEMENT, made and entered into this 1st day of January, 2014, by and between the Board of Trustees of the Harlan County Health System, of Alma, Nebraska 68920, hereinafter called "HOSPITAL" and the GREAT PLAINS HEALTH ALLIANCE, INC., a non-profit corporation duly incorporated under the laws of the State of Kansas with Central Office and post office address in the City of Phillipsburg, Kansas 67661 hereinafter called "GREAT PLAINS".

WHEREAS, the Harlan County Health System is a duly organized hospital operating in accordance with the laws of the State of Nebraska, and

WHEREAS, said Board of Trustees is desirous of contracting with Great Plains Health Alliance, Inc., for management of the hospital through its method of shared core services which include Administration, Finance and Reimbursement, Health Information Management, Education, Quality Improvement and Risk Management supervision. The day-by-day supervision of the Hospital will be provided by a qualified person employed by the Hospital who will serve as Hospital Administrator. Great Plains shall be responsible for the oversight of the Hospital Administrator. Routine visits will be made to the Hospital by the administrative staff of Great Plains, and from the other shared services as necessary.

THEREFORE, the undersigned Harlan County Health System Board of Trustees, by the duly constituted officers, does hereby contract with Great Plains Health Alliance, Inc., for the following operating fees:

1. Beginning the effective date hereof, the hospital shall pay to Great Plains as a basic management fee, the annual sum of seventy seven Thousand One Hundred Sixteen Dollars ($77,116.00) payable in twelve (12) monthly installments. This fee covers the services of Administration, Finance and Reimbursement, Health Information Management, Education, Quality Improvement and Risk Management. It also includes all guidance for updating and monitoring the charge master of the hospital, and access to Great Plains purchasing contracts. Beginning January 1, 2015 and each subsequent year thereafter, the management fee will be increased four percent (4%).

2. Great Plains agrees to make available, upon written request to the Secretary of Health and Human Services or upon request to the Comptroller General of the United States or any of their duly authorized representatives, the contract, books, documents and records necessary to certify the nature and extent of management costs. These records will be available up to four years following the termination of said management agreement.

3. Great Plains shall assist the Hospital in all contracts and purchases as may be needed for maintenance and operation of the Hospital, including, but not limited to, the following areas:

- Drugs and Medical Supplies
- Operational Supplies
- Repairs and Maintenance
- Capital Equipment
- Employee Benefits

Bids shall be requested when required by law.

The access to the Great Plains purchasing contracts shall be included in the basic management fee.

4. Notwithstanding any other provision of the Management Agreement, the Hospital and its employees, as a condition precedent to management by Great Plains, shall participate in the Great Plains Health Alliance, Inc. Compliance Program, Code of Conduct and related policies. The Hospital shall have adopted such Compliance Program, Code of Conduct and related policies, including any amendments thereto as may be necessary in the judgment of Great Plains. Notice of any such amendments shall be promptly provided to the Hospital by Great Plains. Upon termination of this Agreement for any reason, the Hospital's participation in the Great Plains Health Alliance, Inc. Compliance Program shall automatically cease as of the date of termination.

5. The Great Plains administrative staff shall operate the hospital under generally accepted administrative standards and in accordance with the polices of Great Plains. The Great Plains administrative staff will meet as requested with the Hospital Board of Trustees, and will operate the hospital under the policies established by this Board with the understanding, however, that the policies cannot alter the operational plan of Great Plains.

6. From time to time, GPHA will develop new services which are not a part of this contract. For those new services for which there will be a charge, the Board of Trustees will be advised and shall determine whether to purchase these services, at a charge in addition to this contract.

7. Nothing in this Agreement shall be deemed to limit the exclusive control of the expenditures of all funds or the supervision, care, and custody of the buildings and other assets of the Hospital by the Harlan County Hospital Board of Trustees. All of the assets of the Hospital, including funds received, are and shall remain the sole and exclusive property of the Hospital, subject to the control of the Harlan County Hospital Board of Trustees. All debts of the Hospital and all accounts payable are and shall remain the sole and exclusive obligations of the Hospital. Great Plains does not undertake to pay any such obligations.

8. Great Plains shall supervise and direct the operation of a suitable hospital accounting system including assistance with the preparation of the annual budget conforming to appropriate governmental regulations which set out major departmental and operating objectives, anticipated revenue, expenses, cash flow and capital expenditures and shall cause the budget to be presented to Hospital prior to the commencement of each fiscal year for its acceptance, rejection or modification. At an appropriate time before the financial budget is presented for adoption, Great Plains shall make recommendations to the Hospital regarding the pay scales of employees and the number of employee positions throughout the Hospital. Upon adoption or any modification of the budget by Hospital, it shall serve as a guide for the operation of the Hospital during the ensuing year.

9. All medical and professional matters shall be the responsibility of Hospital and the Medical Staff of the Hospital. Great Plains shall, however, consult with Hospital and make appropriate recommendations concerning such matters.

10. Great Plains shall use its best efforts to assure that the quality of administrative practices and procedures meet the standards as set by the appropriate licensing agencies, and shall encourage and assist the Medical Staff to ensure that medical practices and procedures meet such standards.

11. This instrument embodies the whole agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein; and this contract shall supersede all previous communications, representations and agreements, either verbal or written, between the parties hereto.

12. Nothing in this Agreement shall create any membership, partnership, or joint venture relationship between the Hospital and Great Plains. It is expressly acknowledged by both parties that Great Plains is an independent contractor and that nothing contained herein is intended nor shall be construed to create an employer-employee relationship between Great Plains and the Hospital, or between the Hospital and any employee of Great Plains.

13. This Management Agreement shall take effect on January 1, 2014, and shall remain in effect for one year, and will automatically renew from year to year unless cancelled by either party. During the terms of this Agreement, either party may terminate and cancel this Agreement by giving the other party ninety (90) days notice in writing of its intention to do so, which notice shall be given by certified mail addressed directly to the other party at its usual address.

14. The above Management Agreement shall be executed in four (4) copies.

IN WITNESS WHEREOF both parties hereto have set their hands and seals of the day and year first above written.

GREAT PLAINS HEALTH ALLIANCE

President & CEO

HARLAN COUNTY HEALTH SYSTEM

Chairman, Board of Trustees

ATTEST:

Asst. Secretary

Secretary, Board of Trustees

ELECTRONIC FILE

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
November 19, 2018

The Harlan County Health System Board of Trustees held their regular meeting **Monday, November 19, 2018** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Mr. Bruce Beins, Chairman, requested a motion to call the meeting to order. Motion was made by **(6)** and seconded by **(5). A Roll Call Vote was held:**

Board Members	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White	X			

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
April Einspahr	Exec Asst
Bill Luke (via phone)	Bill Luke Consulting

CONSENT AGENDA: A motion was entered by **(3)** and seconded by **(2)** to approve the Consent Agenda without financials or utilizations. **A Roll Call Vote was held:**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White	X			

BILL LUKE PRESENTATION: Consultant Bill Luke presented findings from the operational review he completed in September 2018. The project was sponsored by DHHS Office of Rural Health and funded by the FLEX grant. Project timeline is August 2018 through December 2020. Mark will sort and prioritize the recommendations.

Harlan County Health System

DISCUSSION ITEMS

FINANCIAL REPORTS: Mark noted a significant learning gap which occurred with the Interim CFO and Meditech. Board members discussed possible solutions. Mark requested the ability to bring financials to the next board meeting or when he is confident the reporting is correct. He will also keep the board up to date via email. Separately, Mark updated the board on possible costs of the new health insurance and noted current cash on hand is positive.

OLD BUSINESS

1. **Clinic Replacement Project**
   Presenter: Mark Miller
   Mark reported the completion date is still mid-March. He attended a construction meeting today that covered multiple topics such as phone lines, furnishings and budget. The hospital is currently within $6,500 of the GMP. The construction loan has been executed and no draws have been made. Once a draw has been made, monthly interest payments will be due on the amount drawn. The foundation has written checks totaling near $300,000.

   Rick noted the landscaping grant was declined due to funding; however, Rotary can reapply in the spring.

2. **Foundation**
   Presenter: Mark Miller
   Mark reported the foundation is still looking for board members. The mass mailing will go out next week. The foundation thermometer sign is being updated with red markers. Mark and Amber recently attended the Oxford Chamber of Commerce meeting and Amber is exploring options for the foundation to be more involved. She has also scheduled a meet and greet for Dr. Peterson.

3. **Board Self-Assessment**
   Presenter: Mark Miller
   Les created a board self-assessment that will be emailed out as a Google document. He will report the results.

NEW BUSINESS

1. **Bond Interest Payment of $21,123.75**
   Presenter: Mark Miller
   Mark noted an interest payment of $21,123.75 is due in December 2018. Motion was entered by (**4**) to make a payment of $21,123.75. Seconded by (**3**). **A Roll Call Vote was held:**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White	X			

2. **Changes to Financial Signature Cards**
Motion was made by (**5**) and seconded b (**2**) to approve Alan Meisinger, CFO, to be added to all financial accounts as of November 19, 2018. Ken Cox shall be removed as of December 1, 2018.
A Roll Call Vote was held:

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White	X			

3. **Administrative Report**
Presenter: Mark Miller
Mark noted several items for discussion including:
- Jason Calhoun was elected by staff to receive the NHA Caring Kind award.
- An employee Christmas catalog has been created and will be delivered to staff in the near future.
- Staff recently researched whether the hospital could provide health insurance to board members. The current plan does not allow for this due to the required 30 hour minimum workweek. Board members showed interested in making insurance available to board members without paying the premiums.
- Flex Med has been contracted to be administered by a third party.
- SunRx will now be the third party administrator for the 340B program. Some local pharmacies have hired a consultant to come to an agreement with the hospital for the program.
- The clinic manager has agreed to open the Alma clinic for more appointments. The new hours are tentatively 7am – 6pm. This would create the need for an additional PA. Mark will pursue this, keep the board informed and involve the current providers.
- Bryan Health will no longer contract with Board Effect. New solutions will be researched. In the interim HCHS will utilize email. April will set up HCHS emails for all board members to be used specifically for sending board packets.
- The auxiliary bazaar was successful and raised around $6,000.
- The Oxford Clinic started half-days today and the day was successful.
- The cleaning services contracted for the Oxford Clinic are currently under review.
- The implementation of the new Kronos timekeeping system is underway.
- Staff is creating an informal marketing plan for Dr. Peterson. Mark noted some discrepancies in scheduling patients between Alma and Holdrege. In addition, his hours are now Wednesdays and Fridays to accommodate med staff meetings.
- Most hospital department heads are attending a free leadership training on Nov. 27.

- Dr. Todorov is now only coming to Alma to perform scopes once a month instead of twice due to reported low referral volume from HCHS providers.
- HR is still entertaining sharing an employee with the Villa. Rick noted the county would entertain the same arrangement.
- The new CFO will have some moving expense that the hospital will be responsible for.
- Trisha Wilhelm has been hired as a part time Lab Director.
- Amber recently requested to work only 20 hours a week.
- The Interim CNO will leave in early to mid-December.
- There are 2-3 vacancies in HR at this time.

Emily White left the meeting at 6:28pm.

EXECUTIVE SESSION: At 6:47pm, Mark Miller requested closed session to discuss a risk management issue. Motion made by (**5**) to enter closed session. Motion seconded by (**6**). **A Roll Call Vote was held:**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

OPEN SESSION: A motion was entered by (**5**) to enter open session. Motion seconded by (**6**) at 6:40pm. **A roll call vote was held.**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

PUBLIC COMMENTS - None

ADJOURN: Being that no further business needs to be discussed, motion made by **(5)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(6).** **A Roll Call Vote was held:**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			

(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

Meeting Adjourned at 6:41pm.

_____

Secretary

Harlan County Health System

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
December 17, 2018

The Harlan County Health System Board of Trustees held their regular meeting **Monday, December 17, 2018** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Mr. Bruce Beins, Chairman, requested a motion to call the meeting to order. Motion was made by **(5)** and seconded by **(2). A Roll Call Vote was held:**

Board Members	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
April Einspahr	Exec Asst
Patrick Calkins	Foundation

TOUR OF NEW CLINIC CONSTRUCTION SITE: Board members toured the new clinic construction site beginning at 4:32pm and reconvened in the conference room at 4:53pm.

CONSENT AGENDA: A motion was entered by **(4)** and seconded by **(3)** to approve the Consent Agenda as presented. **A Roll Call Vote was held:**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

DISCUSSION ITEMS

OLD BUSINESS

1. **Financial Reports, Presenter: Mark Miller and Alan Meisinger**
   Mark introduced Alan and detailed the work Alan has been doing to update the financials. October 2018 financials were presented as part of the board packet. The financials were reviewed by auditors and Alan presented auditor notes line by line. Changes and corrections will be reported via November financials. The board requested November financials to be emailed when they are complete. In addition, unaudited December financials will be presented in January 2019.

   Mark noted administration is now aware of the maximum financial exposure for paying for health insurance deductibles for employees. It is lower than first anticipated. At this time Mark recommends saving money for that possible cost. He also noted the need to rebuild the funded depreciation account. Motion was entered by (**4**) to approve the October 2018 financials as presented. Motion seconded by (**6**). **A Roll Call Vote was held:**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

2. **Clinic Replacement Project, Presenter: Mark Miller**
   Mark reported construction is on schedule. Rick noted Rotary's original landscaping plan is moving forward via donations.

3. **Foundation, Presenter: Mark Miller**
   Patrick reported the foundation mass mailing has generated around $9,000 to date. Pledge letters have also been mailed. There are several open Foundation Board positions. Mark reported the first construction draw has been made, and interest payments will start coming due. *Patrick left the meeting at 5:54pm.*

4. **Board Self-Assessment, Presenter: Les Lacy**
   Les presented results from the Board Self-Assessment for review and discussion. Final reports will be given to Mark and the group will discuss opportunities.

NEW BUSINESS

1. **Budget Discussion, Presenter: Mark Miller**
   No budget was presented; however, the board agreed a January presentation would be most effective.

2. **Administrative Report, Presenter: Mark Miller**

Bruce requested the Board members each review a proposed end of year letter to staff. Board members reviewed and signed the letter for distribution to staff.

Mark noted several items for discussion including:

- The 340b program should bring in extra revenue and 2-3 more pharmacies in the next year. AHA and NHA are strongly encouraging hospitals, including HCHS, to sign a 340b pledge document.
- The Governance Institute has requested a membership renewal. Mark will research benefits.
- Senior Life Solutions made an onsite visit and the project is moving forward.
- Cardiac Rehab conversations are ongoing, and the project is moving forward.
- PT has requested a move to the current clinic, and the board noted a requested budget would be needed to begin discussions.
- Dr. Toderov is no longer visiting to do scopes. Dr. Peterson is able to do scopes but has not received referrals just yet. Mark will develop a plan of action after weighing the need for updating the OR.
- The Board is not able to gain access to the hospital health plan per the plan's trustees.
- Vacancies: A CNO candidate has been interviewed. Interviews with other candidates will be ongoing. Diane Fegter is filling in; however, she is not interested in keeping an Interim position. We have a few clinical vacancies including a PA.
- Mark asked if the board desires to keep the same meeting times. They were affirmative.
- In upcoming months, the hospital will be required to make the charge master available to the public.
- Mark will begin having a regularly scheduled breakfast in the dining room to be available for staff questions.
- Mark presented an opportunity for discussion regarding board email addresses and meeting material delivery. For now, we will email the packet to personal and HCHS email addresses. April will research drop box options.

EXECUTIVE SESSION: At 6:47pm, Mark Miller requested closed session to discuss a risk management issue. Motion made by (**4**) to enter closed session. Motion seconded by (**3**). **A Roll Call Vote was held:**

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

OPEN SESSION: A motion was entered by (**4**) to enter open session. Motion seconded by (**3**) at 7:09pm.
A Roll Call Vote was held:

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

PUBLIC COMMENTS - None

ADJOURN: Being that no further business needs to be discussed, motion made by **(4)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(3).**
A Roll Call Vote was held:

Member	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt	X			
(6) Jill Stoelting	X			
(7) Emily White			X	

Meeting Adjourned at 7:10pm.

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Secretary

Harlan County Health System

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
January 21, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, January 21, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Mr. Bruce Beins, Chairman, requested a motion to call the meeting to order. Motion was made by **(5)** and seconded by **(3). A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting		X
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
April Einspahr	Exec Asst

CONSENT AGENDA
A motion was entered by **(4)** and seconded by **(2)** to approve the Consent Agenda with the exception of the Med Staff Appointment/Reappointment List (none to present). **A Roll Call Vote was held: All Yeas except those absent.**

DISCUSSION ITEMS

FINANCIAL REPORTS

1. **Check Run #6 (71238 through 71263 generated on January 18, 2019)**
   Motion made by **(2)** to approve Check Run #6, motion seconded by **(4). A Roll Call Vote was held: All Yeas except those absent.**

2. **November 2018 Financials**
   Motion made by **(3)** to approve November 2018 Financials as presented, motion seconded by **(5). A Roll Call Vote was held: All Yeas except those absent.**

3. **December 2018 Financials**
   Motion made by **(5)** to approve December 2018 Financials as presented, motion seconded by **(3). A Roll Call Vote was held: All Yeas except those absent.**

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Mark reported he contacted recruiters regarding pursuing a contract with a PA or NP. He will remain open to recruitment for physicians in the future.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported the construction punch list will be created during the beginning of March. He has been working with staff to create a "wish list" for furnishings. The purchases will depend on

adherence to the original budget. Tentative ribbon cutting plans will be presented at the February board meeting. Legal documentation to move the address of the clinic is underway.

3. **Foundation, Mark Miller**
   Mark reported Amber Schultz resigned via email in December. As such, the hospital advertised for and hired an Outreach Coordinator. Duties will be split between marketing and foundation. Potential Foundation Board Members are being recruited. The Foundation direct mail piece was successful and monies will be drawn as possible.

NEW BUSINESS

1. **Possible Change to Credit Card Account, Mark Miller**
   Motion was entered by (**4**) to remove Anamarie Schluntz from the credit card account and add Alan Meisinger. Seconded by (**2**). **A Roll Call Vote was held: All Yeas except those absent.**

2. **Administrative Report, Mark Miller**
   - Mark reported he was unable to attend the county supervisors meeting last week. He would like to extend an invitation to all county supervisors to tour the campus and learn more about the health system. Items of discussion might be financials, CAH reimbursement, board members and terms, bylaws and tours. More details to come.
   - Mark continues to work through Bill Luke's ideas from last year.
   - Board members should contact April if they will attend the March Trustee Symposium.
   - Pay increases were announced to staff last week with positive feedback.
   - Pricing transparency: Charge list has been added to the front page of the hospital website.
   - Renovations of the trailer for Senior Life Solutions will begin soon.
   - Staff was surveyed regarding Meditech training. The nursing staff requested more training and it will be provided.
   - Mark will start meeting weekly with Dr. Finkner.
   - Staff was invited to attend breakfast with the CEO; however, no one attended the most recent event.
   - Lynda Lubeck is spearheading the creation of a cardiac rehab.
   - Mark researched possible annual statements that may be required of board members: HIPAA Confidentiality, Confidentiality, Corporate Compliance and Conflict of Interest.

3. **2019 Budget, Alan Meisinger**
   Alan presented the proposed 2019 budget for review and approval. He noted a different format and offered a budget assumption and explanation and five year capital budget. Motion was entered by (**3**) and seconded by (**5**) to approve the 2019 Budget as presented. **A Roll Call Vote was held: All Yeas except those absent.**

4. **Election of Officers, Mark Miller/Bruce Beins**
   Bruce turned the meeting over to Mark to solicit nominations for Board Chair. For the election of Board Chair, Mark opened the floor for nominations. Board Member (**1**) nominated Board Member (**6**). Board Member (**4**) nominated Board Member (**1**) for Chair. Board Member (**4**) moved nominations cease. Motion seconded by (**2**). Board Member (**1**) Bruce Beins was elected Board Chair by a vote of 5 to 1. **A Roll Call Vote was held: Board Member (1) abstained, all others voted Yea except absent member (6).**

The meeting is returned to Bruce Beins, Board Chair. For the election of Vice-Chair, Bruce opened the floor for nominations. Board Member (**5**) nominated Board Member (**4**) for Vice-Chair. Board Member (**5**) moved nominations cease and Board Member (**4**) is elected by acclimation. Motion seconded by (**3**). Board Member (**4**) was elected Vice-Chair. **A Roll Call Vote was held: Board Member (4) abstained, all others voted Yea except absent member (6).**

For the election of Board Secretary, Bruce opened the floor for nominations. Board Member (**2**) nominated Board Member (**3**) for Board Secretary. Board Member (**4**) moved nominations cease and Board Member (**3**) is elected by acclimation. Motion seconded by (**2**). Board Member (**3**) was elected Secretary. **A Roll Call Vote was held: Board Member (3) abstained, all others voted Yea except absent member (6).**

For the election of Board Treasurer, Bruce opens the floor for nominations. Board Member (**4**) nominates Board Member (**2**) for Treasurer. Board Member (**3**) moves nominations cease and Board Member (**2**) is elected by acclimation. Motion seconded by (**5**). Board Member (**2**) is elected Treasurer. **A Roll Call Vote was held: Board Member (2) abstained, all others voted Yea except absent member (6).**

5. **Annual Board HIPAA Confidentiality Education and Statement, Mark Miller**
   Mark presented an educational video and annual confidentiality statement for signature.

CLOSED SESSION
At 5:55pm Mark requested a closed session to discuss personnel issues. Motion made by (**5**) to enter closed session, motion seconded by (**7**). **A Roll Call Vote was held. All Yeas except those absent.**

A motion was entered by (**5**) to enter open session at 6:30pm. Motion seconded by (**7**). **A roll call vote was held. All Yeas except those absent.**

OPEN SESSION

PUBLIC COMMENTS - None

ADJOURN
Being that no further business needs to be discussed, motion made by **(5)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(7). A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:30pm.

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Secretary

Harlan County Health System

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
January 28, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, January 28, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Mr. Bruce Beins, Chairman, requested a motion to call the meeting to order. Motion was made by **(4)** and seconded by **(2). A Roll Call Vote was held:**

Board Members	Yes	No	Absent	Abstain
(1) Bruce Beins	X			
(2) Deb Neilson	X			
(3) Carol Calkins	X			
(4) Richard Calkins	X			
(5) Rob Schmidt			X	
(6) Jill Stoelting			X	
(7) Emily White	X			

Additional Attendees	Position
Mark Miller	CEO
April Einspahr	Exec Asst

DISCUSSION ITEMS

1. **Foundation/Clinic Business**
   Motion made by **(2)** to name the new clinic building after Dr. James S. Long, provided he agrees, with the actual building name to be negotiated with Dr. Long. Motion seconded by **(4). A Roll Call Vote was held:** All yeas except those absent.

PUBLIC COMMENTS - None

ADJOURN
Being that no further business needs to be discussed, motion made by **(4)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(3). A Roll Call Vote was held:** All yeas except those absent.

Meeting Adjourned at 5:00pm.

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Secretary

Harlan County Health System

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
February 18, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, February 18, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Mr. Rick Calkins, Vice Chair, requested a motion to call the meeting to order. Motion was made by **(6)** and seconded by **(3)**. **A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins		X
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt		X
(6) Jill Stoelting	X	
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
April Einspahr	Exec Asst

CONSENT AGENDA
A motion was entered by **(3)** and seconded by **(2)** to approve the Consent Agenda as presented. **A Roll Call Vote was held: All Yeas except those absent.**

DISCUSSION ITEMS

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Mark reported we are actively recruiting a PA. He sent proposals to seven firms and collected responses; however, no viable solutions were received. He plans to begin the process again.

2. **Clinic Replacement Project, Mark Miller**
   Mark met with the construction group today. He noted a couple of adverse issues that have developed: the size of the clinic entrance, the workstations and printer, and the phone line to the old clinic (previously severed). The clinic will open with the current doors; however, the architect will present costs to enlarge the door. The punch list will be March 4 from 9am – 1pm and board members are invited. We will have access to the building on March 12 and can move in on March 18. Proposed dates for the grand opening are March 23, March 30 or April 13. Dates will be proposed to the Board via email.

   The Long family has agreed to allow the clinic to be named Dr. James S. Long Medical Building. Mark presented options for the lettering.

3. **Foundation, Mark Miller**
   Mark reported the new Foundation Director has been busy and is exceeding expectations. The Foundation is still recruiting board members.

Harlan County Health System

NEW BUSINESS

1. **Appointment of HCHS Compliance Officer, Mark Miller**
   Motion was entered by (**6**) to appoint Mark Miller, CEO, as HCHS Compliance Officer. Seconded by (**2**). **A Roll Call Vote was held: All Yeas except those absent.**

2. **Annual Rural Health Clinic Program Review, Mark Miller**
   Mark presented the Annual RHC Program Review for discussion and approval. Motion made by (**2**) to enter closed session, motion seconded by (**6**). **A Roll Call Vote was held. All Yeas except those absent.**

3. **Administrative Report, Mark Miller**
   - The Interim CNO has expressed a desire to stay at HCHS, and Mark will continue to assess.
   - Mark conducted four phone interviews for HR Directors and narrowed the pool down to two. Two internal candidates applied and one withdrew the application to pursue another opportunity. Two external and one internal candidate were interviewed in person. He plans to offer employment this week.
   - Financial auditors will be in house this week. Much of the work has been completed beforehand.
   - Current vacancies include a Night RN, Coder and Clinic MA. A Night CNA has been hired and the Villa hired a maintenance worker that will start work for us part time this week.
   - The health fair is April 27.
   - Employee appreciation dinner is March 23.
   - The health system is being rebranded as Harlan County Health System with the clinic and hospital both falling underneath that title.
   - CHI Good Sam has presented an opportunity for a wound care clinic and inpatient services.
   - Rotary will be in house Wednesday and our dining room staff will provide lunch. Mark will take them on a tour of the clinic.
   - County Supervisors will be in house Tuesday and our dining room staff will provide lunch. Mark will take them on a tour of the clinic. Mark presented the power point that will be shown during their luncheon.
   - Emily asked if we have pursued nurse training on Meditech. Mark reported the Interim CNO has been aggressively training the nursing staff. In addition, he is waiting on a response from a possible employee who would be able to train.

CLOSED SESSION

At 5:40pm Mark requested a closed session to discuss personnel issues. Motion made by (**6**) to enter closed session, motion seconded by (**3**). **A Roll Call Vote was held. All Yeas except those absent.**

A motion was entered by (**3**) to enter open session at 6:30pm. Motion seconded by (**6**). **A roll call vote was held. All Yeas except those absent.**

OPEN SESSION

PUBLIC COMMENTS - None

ADJOURN

Harlan County Health System

Being that no further business needs to be discussed, motion made by **(6)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(2).** **A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:00pm.

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Secretary

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
March 18, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, March 18, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. Motion was made by **(5)** and seconded by **(4)**. **A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson		X
(3) Carol Calkins		X
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting	X	
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Chris Schluntz	County Supervisor
Jeremy Behrens	Seim Johnson
April Einspahr	Exec Asst

CONSENT AGENDA
A motion was entered by **(6)** and seconded by **(4)** to approve the Consent Agenda, with a change to the first paragraph of the prior meeting minutes. **A Roll Call Vote was held: All Yeas except those absent.**

DISCUSSION ITEMS

FINANCIAL REPORTS

1. **Financial Audit, Jeremy Behrens, Seim Johnson**
   Jeremy presented the draft audited financials for review and discussion.

   Bruce requested information regarding an internal audit for financial policies. **Jeremy** reported that is an option.

   Jeremy left the meeting.

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Mark reported he is conducting initial interviews with APP candidates, and providers will interview them this week. The intent is to bring two candidates for a face to face interview.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported a successful move and opening of the new clinic. The only notable issues are the new TV installation and the fax machine move. The punch list has not been completed as of the board meeting.

3. **Foundation, Mark Miller**
   Mark briefly reviewed the ribbon cutting agenda. The giving thermometer will be updated before the ribbon cutting, and Taylor is creating a slide show with some donators listed.

Harlan County Health System

NEW BUSINESS

1. **Annual CAH Program Evaluation**
   Motion was entered by (**4**) to accept the Annual CAH Program Evaluation as presented. Seconded by (**5**). **A Roll Call Vote was held: All Yeas except those absent.**

2. **Administrative Report, Mark Miller**
   - Mark has scheduled two CNO interviews, and Nicki would like to interview as well. We are interviewing a potential Coder this week, and we have an interview with a potential nurse this week. The new HR Director, Katie Koopman, will be in Alma April 1.
   - SunRx prescription card training will go live in the near future. If a patient without prescription insurance coverage comes into the clinic, they will be charged the 340B pricing, pharmacy billing and processing fee instead of the normal medication cost.
   - Our current infusion hood no longer meets the minimum standards. As such, we will likely stop doing infusions. Board members would like to receive estimated costs and income before we make a final decision.
   - Les noted HCHS is currently in the top quartile in the 2018 Performance Leadership Awards.
   - The cardiac rehab program is still moving forward.

PUBLIC COMMENTS – None

Bruce noted the final audited financials should be presented at the County Supervisor meeting upon the Board's approval.

Mark complimented Alan Meisinger and his staff for the positive audit report.

ADJOURN

Being that no further business needs to be discussed, motion made by **(6)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(5).** **A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:05pm.

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Secretary

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
April 15, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, April 15, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. Motion was made by **(3)** and seconded by **(6)**. **A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting	X	
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
Katie Koopman	HR Director
April Einspahr	Exec Assistant

CONSENT AGENDA
A motion was entered by **(3)** and seconded by **(2)** to approve the Consent Agenda without the financials and 340B report. **A Roll Call Vote was held: All Yeas except those absent.**

A motion was entered by **(3)** and seconded by **(2)** to approve the financials presented via hard copy. **A Roll Call Vote was held: All Yeas except those absent.**

Rob Schmidt joined the meeting at 4:32pm.

A motion was entered by **(2)** and seconded by **(3)** to approve the 340B report as presented. **A Roll Call Vote was held: All Yeas except those absent.**

DISCUSSION ITEMS

FINANCIAL REPORTS

1. **Financial Audit, Alan Meisinger**
   Alan Meisinger presented the audited financials for approval. A motion was entered by **(5)** and seconded by **(2)** to approve the 2018 audited financials as presented. **A Roll Call Vote was held: All Yeas except those absent.**

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Mark reported he continues to search for a PA or APRN. One candidate has been interviewed, and another is scheduled for this week.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported several items still in progress, including warped interior doors, the telephone line, a new office area, bathroom tiles, interior signage and the punch list. The old clinic use is still being discussed. Administration is collecting ideas and will bring to a future meeting.

3. **Foundation, Mark Miller**
   Mark reported we received two $5,000 donations at or closely following the ribbon cutting. The hospital health fair is coming up April 27. Taylor will have a Foundation booth at the fair. Mark and Taylor are working on an electronic donor board. Brian Seylor joined the foundation board. Taylor had a booth at Spring Fling. The Foundation Board is discussing an ongoing BINGO event as a fundraiser. The HCHS Board discussed the merits of obtaining liquor liability insurance.

NEW BUSINESS

1. **Possible Bond Payment, Mark Miller/Alan Meisinger**
   Mark presented policy number ACCT 8003.0008.00 which explains the benchmark and calculations used to determine making the principal and interest bond payment due June 1 of each year. Bruce noted the County Supervisors developed the policy in conjunction with the hospital board. Bruce suggested we make the interest payment. Motion made by **(5)** seconded by **(2)** to make interest only payments for the year. **A Roll Call Vote was held: All Yeas except those absent.**

2. **Administrative Report, Mark Miller**
   - Cardiac Rehab has a planned open date of June 1, 2019.
   - The hospital has property to dispose of, and Mark contacted Brian McQuay to ensure we do not have any obligation to dispose of the property in a unique way. Mark intends to propose a policy to the board in the future.
   - Senior Life Solutions plans to see their first patient May 23. Renovations are going well.
   - The Interim CNO is interested in interviewing for a permanent position. Mark is also interviewing other candidates at this time.
   - Our current bylaws do not specify spending authority limits. Mark would like to present an updated purchasing policy.
   - Employee health insurance renewal information has become available. The health system was originally assessed an extra premium fee and agreed to cover deductibles because of the mid-year change. Both of those costs have gone away. Some changes have been made, such as deleting the pharmacy deductible and offering an HSA again. The insurance agent will be onsite on April 24. Expenditures will be less than budgeted for the health system. In the absence of any increased expense to the health system, no vote is needed.

CLOSED SESSION

At 5:42pm Mark requested a closed session to discuss personnel issues and protect the reputation of those involved. Motion made by (**5**) to enter closed session, motion seconded by (**6**). **A Roll Call Vote was held. All Yeas except those absent.**

A motion was entered by (**5**) to enter open session at **6:02pm**. Motion seconded by (**3**). **A roll call vote was held. All Yeas except those absent.**

OPEN SESSION

PUBLIC COMMENTS - None

ADJOURN

Being that no further business needs to be discussed, motion made by **(5)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(2). A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:02pm.

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Secretary

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
May 20, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, May 20, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. At **4:30 pm** motion was made by **(5)** and seconded by **(2). A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting	X	
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
Katie Koopman	HR Director
April Einspahr	Exec Assistant

CONSENT AGENDA
A motion was entered by **(6)** and seconded by **(4)** to approve the Consent Agenda as presented. **A Roll Call Vote was held: All Yeas except those absent.**

DISCUSSION ITEMS

FINANCIAL REPORTS

1. **Prior Year Comparison of Revenue and Usage, Alan Meisinger**
   Alan presented a report of prior and current year revenue and usage for review and discussion.

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Mark reported he hired an APRN as of May 20. Tentative start date is June 10, 2019 and staff is working on credentialing and privileging. Mark suggested administration should actively search for another physician due to the length of time it takes to secure a contract. He did not recommend using a recruiter at this time.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported there are still ongoing projects. Tiles have been replaced, doors were shipped today and will be hung soon, and a solution for the front door is still in question. Finished grading was not included in the contract. Any further grading should be done separately by the health system. Mark handed out a list of subcontractors and retainage amounts.

Harlan County Health System

NEW BUSINESS

1. **HCHS Health Career Scholarship, Mark Miller**
   Mark reported the process to publicize, gather and select scholarship recipients needs to be reimagined. In prior years, two local high school students were selected to receive $300 each. Mark suggested increasing the amount to $1,500; however, a final plan will be presented at a future board meeting.

2. **Construction Financial Report, Mark Miller/Alan Meisinger**
   Alan provided a summary of monies collected and spent to date.

3. **Administrative Report, Mark Miller**
   - Senior Life Solutions has 3 patients lined up to start the program this Thursday. The clinic provided almost 30 names for referral.
   - Mark recently interviewed 4 CNO candidates.
   - Cardiac Rehab will not be operating June 1, 2019. The equipment will not be in-house and the monitoring system is still under review.
   - Mark does not have a recommendation for using the old clinic space at this time. The executive team will meet in the next few days to discuss ideas.
   - Alan was notified that the health system will undergo a MSP Audit (Medicare Secondary Payor).
   - Vacancies: Night RN, CNO
   - Recent Hires: Outpatient RN, CNA

CLOSED SESSION

At **5:14pm** Mark requested a closed session to discuss personnel issues and protect the reputation of those involved and a risk management issue. Motion made by (**4**) to enter closed session, motion seconded by (**5**). **A Roll Call Vote was held. All Yeas except those absent.**

A motion was entered by (**6**) to enter open session at **6:17pm**. Motion seconded by (**3**). **A roll call vote was held. All Yeas except those absent.**

OPEN SESSION

PUBLIC COMMENTS - None

ADJOURN

Being that no further business needs to be discussed, motion made by **(6)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(3). A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:17pm.

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Secretary

Harlan County Health System

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
June 17, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, June 17, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. At **4:30 pm** motion was made by **(5)** and seconded by **(4). A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting	X	
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
Katie Koopman	HR Director
April Einspahr	Exec Assistant

CONSENT AGENDA
A motion was entered by **(4)** and seconded by **(2)** to approve the Consent Agenda as presented. **A Roll Call Vote was held: All Yeas.**

DISCUSSION ITEMS

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Mark reported we are partnering Dr. Finkner and Keri Foster as a provider team. When we start recruiting another physician, Mark would prefer to seek out an individual who has at least one year of experience at another practice. Bruce noted it would be wise to remain open to other options if doors open.

Emily White joined the meeting at 4:31pm.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported he is working through the final punch list issues. The construction company is ready to close out the list and receive final payment. The irrigation company was onsite today, and Rick arranged for someone to scrape down the ground between the curb and highway.

   The Foundation is about $400,000 shy from meeting the construction goal of $1.3 million. Mark has communicated the need to Taylor Miller.

Jill Stoelting joined the meeting at 4:43pm.

Harlan County Health System

NEW BUSINESS

1. **Administrative Report, Mark Miller**
   - As a reminder, Mark will take a financial report to the County Supervisor's meeting tomorrow.
   - The Executive Team reviewed options for primary use of the old clinic. The first idea being researched is moving the physical therapy department. Marisa has been tasked with bringing back requirements and ROI.
   - Nicki Hunt, former Interim CNO, withdrew her application for a permanent position. As such, another Interim CNO has been secured. She is not likely to stay; however, she brings a lot of experience in a CAH.
   - Dr. Peterson has been interested in performing scopes. As such, Mark lined up scopes to take place on the second Friday of every month.
   - A top performers' raise of 1% was given to five employees. A random team of three department managers discussed the employees who were submitted and chose who would receive the raise.
   - Donna Kindler agreed to take on the role of Activities Director.
   - Senior Life Solutions has six patients and is operating well.
   - Cardiac Rehab is progressing. We are going to use our current cardiac monitoring system rather than procuring a stand-alone system.
   - Sam has been tasked with getting a quote to fix cracked concrete around the hospital.
   - The MSP Audit is complete. We passed and were given a couple of recommendations. Alan is now working on a cost report audit.
   - Mark reviewed the County Purchasing Act and noted the hospital is not subject to the same rules the County must follow.
   - The hospital just completed open enrollment. Katy reported costs from 2017 to now. In 2019 the hospital will realize around $143,000 savings for the hospital and $50,000 cost savings for employees. Employees gave input on supplemental plans and made a few changes.

A board member inquired about assisting patients to set up automatic bill pay for their hospital account.

CLOSED SESSION

At **5:21pm** Mark requested a closed session to discuss personnel issues and protect the reputation of those involved and a risk management issue. Motion made by (**5**) to enter closed session, motion seconded by (**4**). **A Roll Call Vote was held. All Yeas except those absent.**

A motion was entered by (**5**) to enter open session at **6:33pm**. Motion seconded by (**4**). **A roll call vote was held. All Yeas except those absent.**

OPEN SESSION

PUBLIC COMMENTS - None

Harlan County Health System

ADJOURN

Being that no further business needs to be discussed, motion made by **(5)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(4).** **A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:34pm.

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Secretary

Harlan County Health System

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Alma, NE 68920
www.harlancountyhealth.com

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
July 15, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, July 15, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. At **4:30 pm** motion was made by **(4)** and seconded by **(5)**. **A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting		X
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
Katie Koopman	HR Director
April Einspahr	Exec Assistant
Hal Haeker	City Mayor
Patrick Calkins	Foundation Board

CONSENT AGENDA
A motion was entered by **(2)** and seconded by **(4)** to approve the Consent Agenda as presented. **A Roll Call Vote was held: All Yeas.**

Patrick Calkins joined the meeting at 4:36pm.

DISCUSSION ITEMS

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Mark reported no significant news. Keri Foster is settling into her position well.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported no significant news. The landscaping is an ongoing project.

NEW BUSINESS

1. **Administrative Report, Mark Miller**
   - Cardiac Rehab is slated to begin August 5.
   - The hospital procured back up fiber for the internet; however, some specific computer interactions, such as radiology, were not backed up initially. The recent loss of internet due to storms uncovered a few holes that are now being fixed.
   - Three scopes were completed successfully last Friday by Dr. Peterson.

Harlan County Health System

Hospital | Heartland Family Medical
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www.harlancountyhealth.com

- The recent CNO candidate had favorable interviews with the Executive Team, Department Heads, and Nursing. She, her husband, and four children will move to Alma in the August time frame.
- The hospital hired a new LPN. The hospital has had a need for a permanent RN/LPN to replace the agency staff that we have had with us on nights. The executive team recently became aware that we were also short shifts every week on both days and nights. The LPN will help fill those shifts. That leaves one night RN shift to fill and the agency position permanent replacement. We are still recruiting PRNs to cover illnesses and vacations.
- The hospital hired an experienced LPN surgical technologist at PRN status to help us in surgery. Our current method of doing scopes has required us to schedule staff out of their normal duties for scopes. This will become more difficult as we pursue getting back to doing sterile procedures. She will help alleviate this burden as well as provide advice and assistance in acquiring equipment and developing policies and procedures for sterile procedures. She will also be a great asset in establishing relationships for HCHS with surgeons as we look to grow the services we offer.
- Mark met with Marisa regarding PT's request to take over the old clinic. Marisa reported after further investigation, the old clinic space would not offer significantly more room than they currently have. Mark hopes to give another report at the next board meeting.
- Senior Life Solutions is down to 3 patients due to health insurance issues and health issues.
- The Foundation Board will meet tomorrow night. They have encountered a couple of issues with their upcoming BINGO events that may change their plans.
- The Executive Team met with Jayne Jones, an ex-Washington DC staffer. She detailed a plan to acquire legislative funding for hospital initiatives. Mark signed an agreement to work with her for a year after discussing the idea with individual board members.
- According to estimates, we will likely have a Medicare payable of $400,000 due to volumes, and we will plan accordingly.
- Mark requested moving the November board meeting from November 18 to November 25. The board agreed to the request.
- The hospital will likely add Roth IRA to retirement benefit options in the near future.
- We are advertising for a Clinical Informatics position.
- The Executive Team is looking at a pay increase for PRN employees and those qualifying for shift differential; adding an inpatient voluntary extra shift bonus; and adding a part time employee status with partial benefits.

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2. **Special Revenue Fund Request by County Supervisors to City of Alma, Mark Miller**
   Item was moved to the beginning of the meeting to accommodate Mayor Haeker's time. Mark noted the City Resolution passed in 2006. Recently, the County Supervisors passed Resolution #2019-10 requesting monies from the City of Alma. Discussion ensued regarding these resolutions and County financial documents obtained by HCHS. No action was taken.

Mayor Haeker left the meeting at 5:10pm.

CLOSED SESSION

At **6:01pm** Mark requested a closed session to discuss personnel issues to protect the reputation of those involved. Motion made by (**4**) to enter closed session, motion seconded by (**5**). **A Roll Call Vote was held. All Yeas except those absent.**

Patrick Calkins left the meeting at 6:01pm.

A motion was entered by (**5**) to enter open session at **6:16pm**. Motion seconded by (**4**). **A roll call vote was held. All Yeas except those absent.**

OPEN SESSION

PUBLIC COMMENTS - None

ADJOURN

Being that no further business needs to be discussed, motion made by **(5)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(3). A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:16pm.

_____

Secretary

Harlan County Health System

Hospital | Heartland Family Medicine
717 N. Brown | 906 7th Street
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www.harlancountyhealth.com

BOARD OF TRUSTEES
REGULAR MEETING MINUTES
Aug 19, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, August 19, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. At **4:30pm** motion was made by **(5)** and seconded by **(3). A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting	X	
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
Katie Koopman	HR Director
April Einspahr	Exec Assistant
Christian Schluntz	County Supervisor

CONSENT AGENDA
A motion was entered by **(6)** and seconded by **(2)** to approve the Consent Agenda as presented. **A Roll Call Vote was held: All Yeas except those absent.**

DISCUSSION ITEMS

County Supervisors
Bruce welcomed Supervisor Schluntz and turned the meeting over to him for comments and questions. Schluntz referenced a letter of memorandum received by the hospital via USPS Monday, August 19, 2109. The memo was copied to everyone present and Schluntz requested action to be taken on item two in the letter. Bruce requested the item be placed on the September meeting agenda so action may be taken. Schluntz also presented a list of questions gathered from the County Supervisors. The Board of Trustees again offered to pay the hospital auditor to conduct an educational session with the Board of Supervisors.

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Nothing to report.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported the punch list is near completion. Lien releases and final documentations are being gathered to convert the construction project to a loan. Landscaping is underway. The seed is onsite and final grading is being planned.

Emily White joined the meeting at 5:30pm.

NEW BUSINESS

Harlan County Health System

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1. **Administrative Report, Mark Miller**
   - The lab blood refrigerator expired. A spare fridge was put in place temporarily; however, a new fridge and temp recording system must be purchased.
   - Upon the resignation of lab manager Tricia Wilhelm, Christel Wilson was promoted to lab supervisor until an MT is recruited.
   - Positive changes to pay policies, such as PTO practices, have been announced to staff.
   - Administration continues to work with Jayne Jones regarding federal pilot program funding.
   - Our cardiac rehab monitoring system is not up to par; however, no patients have been turned away. The cardiac monitoring system CNS expired 6 months ago. We have been borrowing a system. We ultimately need to purchase a new system and would prefer to purchase something that will work for both cardiac rehab and monitoring.
   - The trailer roof is damaged and needs to be replaced. The campus has a lot of damaged concrete that needs to be replaced.
   - Mark would like to place a large flag and flagpole to place in front of the new clinic. This will only move forward if funds are donated.
   - PolicyTech has been a challenge. We have around 1500 policies that need to be organized, maintained and updated. A few employees from the radiology department may be interested in taking on this project.
   - A Rev Cycle Consultant is coming in next week.
   - An ad-hoc physical security team has been formed and is working on several improvement ideas.
   - Two Kearney oncologists have shown interest in providing a clinic in Alma. They could potentially bring in a lot of new patients. We will research this possibility.
   - Allevant, a subsidiary of The Mayo Clinic, presented program information on transitional care (swing beds) that we will consider utilizing.
   - The second round of BINGO made $700.
   - Louis Hays is now providing home med counseling when patients are discharged.

CLOSED SESSION
At **6:12pm** Mark requested a closed session to discuss personnel issues to protect the reputation of those involved. Motion made by (**5**) to enter closed session, motion seconded by (**3**). **A Roll Call Vote was held. All Yeas except those absent.**

A motion was entered by (**5**) to enter open session at **6:24pm**. Motion seconded by (**2**). **A roll call vote was held. All Yeas except those absent.**

OPEN SESSION

PUBLIC COMMENTS - None

ADJOURN
Being that no further business needs to be discussed, motion made by **(6)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(3). A Roll Call Vote was held: All Yeas except those absent.**

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Meeting Adjourned at 6:25pm.

Secretary

Harlan County Health System

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BOARD OF TRUSTEES
REGULAR MEETING MINUTES
Sept 16, 2019

The Harlan County Health System Board of Trustees held their regular meeting **Monday, September 16, 2019** in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. At **4:30pm** motion was made by **(6)** and seconded by **(3). A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt	X	
(6) Jill Stoelting	X	
(7) Emily White		X

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Alan Meisinger	CFO
Katie Koopman	HR Director
April Einspahr	Exec Assistant
Christian Schluntz	County Supervisor
Mike Clements	County Supervisor

CONSENT AGENDA
A motion was entered by **(4)** and seconded by **(5)** to approve the Consent Agenda with the removal of Board Member (7) vote from the first vote as she was not present. **A Roll Call Vote was held: All Yeas except those absent.**

DISCUSSION ITEMS

OLD BUSINESS

1. **Medical Staff Recruiting, Mark Miller**
   Nothing to report.

2. **Clinic Replacement Project, Mark Miller**
   Mark reported a couple of issues being corrected. Grading and seeding are in progress. The final loan paperwork is in progress as well.

NEW BUSINESS

1. **Administrative Report, Mark Miller**
   - Mark noted our work with a consultant to obtain funding for a private project. He provided a compilation of ideas and themes currently being discussed.
   - The part-time maintenance employee has resigned to move to another community. We will continue the same arrangement with the Villa with the next employee.
   - Christel Wilson was chosen as the NHA Caring Kind recipient and will attend the NHA convention. Mark, Katie and a few board members will be attending.
   - We interviewed two Chief Nursing Officer candidates last week and one will be selected to receive an offer.

- The blood draw room is currently being renovated to include new paint and floors.
- We are in the beginning processes of budgeting for the upcoming year.
- We continue to make progress modernizing the OR and working towards doing sterile procedures again.
- We have one cardiac rehab patient.
- We continue to evaluate moving Senior Life Solutions to the old clinic. The new bathroom estimate is $3,000 and the entire project cost is being analyzed.
- If Senior Life Solutions is moved out of the FEMA trailer, we will contemplate renovating the trailer to become 2 bedrooms with separate entrances.
- Maintenance is interested in renting a skid loader in conjunction with the nursing home. This would allow us to do our own snow removal.
- The air conditioner for the CT malfunctioned, and the repair cost was $4,700.
- A bid to fix concrete came in at $13,000. This will not be pursued this year.
- The trailer roof bid came in at $3,200.
- The cardiac monitoring system is still problematic. We should be able to provide a recommendation at the next board meeting.
- We continue to pursue a possible agreement with Allevant.
- Our current pension program applies to everyone who works with us, including PRN. Moving forward, we will likely recommend a change.

Mike noted he thinks it would be a positive move for the hospital to provide a public presentation by the hospital auditor in upcoming years.

2. **Resolution Regarding County Supervisor Request for Disbursement of Funds by the City of Alma for Bond Payment**
   - Discussion was held regarding the information presented in a recent news article. The comments seemed to infer the bond payments could be applied to the general fund, which is not accurate.
   - Supervisor Schluntz noted the payment could not be applied to anything other than the hospital bond; however, in the future, less could be levied elsewhere.
   - Clements noted to his knowledge, the city's account was set up to only be used for the bond payment.
   - Motion made by (**4**) to pass the resolution as presented. Motion seconded by (**5**). **A Roll Call Vote was held: All Yeas except those absent.**

Rick noted thanks and respect for how the hospital staff members conducted themselves during a traumatic weekend in the community.

CLOSED SESSION
At **5:37pm** Mark requested a closed session to discuss non-elected personnel issues to protect the reputation of those involved. Motion made by (**5**) to enter closed session, motion seconded by (**6**). **A Roll Call Vote was held. All Yeas except those absent.**

A motion was entered by (**5**) to enter open session at **6:32pm**. Motion seconded by (**3**). **A roll call vote was held. All Yeas except those absent.**

Harlan County Health System

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OPEN SESSION

PUBLIC COMMENTS - None

ADJOURN

Being that no further business needs to be discussed, motion made by **(3)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(2). A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 6:33pm.

_____

Secretary

Harlan County Health System

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BOARD OF TRUSTEES
EMERGENCY MEETING MINUTES
Oct 23, 2019

I. **CALL TO ORDER:** The Harlan County Health System Board of Trustees held an emergency meeting Wednesday, October 23, 2019 in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. **At 6:32pm motion was made by (5) and seconded by (3).**

II. **A Roll Call Vote was held: All Yeas.**

Board Members	Present	Absent	Abstain
(1) Bruce Beins	X		
(2) Deb Neilson	X		
(3) Carol Calkins	X		
(4) Richard Calkins	X		
(5) Rob Schmidt	X		
(6) Jill Stoelting	X		
(7) Emily White	X		

Additional Attendees	Position
Mark Miller	CEO
Katie Koopman	CHRO
April Einspahr	Exec Assistant
Angela Bellware	Harlan County Journal
	Community Members

III. **CLOSED SESSION**

A motion was entered by **(5)** and seconded by **(3)** to move that the Board of Trustees go into closed session for the protection of the public interest and for the prevention of needless injury to the reputation of an individual to discuss personnel and the evaluation of the job performance of an employee since such employee has not requested a public meeting. **A Roll Call Vote was held: All Yeas.** Board went into closed session at 6:33pm.

a. Personnel

Board came out of closed session at **7:15pm.** A motion was entered by **(5)** and seconded by **(6)** to move that the Board of Trustees come out of closed session. **A Roll Call Vote was held: All Yeas.**

IV. **POSSIBLE ACTION ITEMS**

a. Investigation into allegations made against the CEO at the October 21, 2019 meeting of the Board of Trustees: A motion was entered by **(2)** and seconded by **(5)** that the Board of Trustees hereby authorizes the Chairman and Vice-Chairman to oversee, through legal counsel, an investigation into the allegations made against the CEO at the October 21, 2019 meeting of the Board of Trustees. **A Roll Call Vote was held: All Yeas.**

b. Status of CEO during investigation: A motion was entered by **(5)** and seconded by **(3)** that the CEO be placed on paid administrative leave pending completion of the investigation into the allegations made against him at the October 21, 2019 meeting of the Board of Trustees. **A Roll Call Vote was held: All Yeas.**

V. **ADJOURN**

Harlan County Health System

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Being that no further business needs to be discussed, motion made by **(5)** to adjourn the emergency meeting of the board of trustees of Harlan County Health System, motion seconded by **(6)**. **A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 7:17pm.

Secretary

Harlan County Health System

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BOARD OF TRUSTEES
REGULAR MEETING MINUTES
Oct 21, 2019

I. **The Harlan County Health System Board of Trustees held their regular meeting Monday, October 21, 2019 in the HCHS Administrative Board Room. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Bruce Beins requested a motion to call the meeting to order. At 4:37pm motion was made by (3) and seconded by (4). A Roll Call Vote was held:**

Board Members	Present	Absent
(1) Bruce Beins	X	
(2) Deb Neilson	X	
(3) Carol Calkins	X	
(4) Richard Calkins	X	
(5) Rob Schmidt		X
(6) Jill Stoelting	X	
(7) Emily White	X	

Additional Attendees	Position
Mark Miller	CEO
Les Lacy	VP – GPHA
Katie Koopman	CHRO
April Einspahr	Exec Assistant
Angela Bellware	Harlan County Journal
Cindy Boehler	Harlan County Supervisor
Jaclyn Daake	Harlan County Citizen
Mike Clements	Harlan County Supervisor
Tonda Ross	HCHS Employee

II. **CONSENT AGENDA**
A motion was entered by **(6)** and seconded by **(2)** to approve the Consent Agenda as presented. **A Roll Call Vote was held: All Yeas except those absent.**

III. **PRESENTATION BY ALLEVANT (TRANSITIONAL CARE): Jordan Tenanbaum, Mike Lindsay**

Mike Clements joined the meeting at 5:00pm.
Jordan Tenanbaum and Mike Lindsay left the meeting at 5:30pm.
Tonda Ross joined the meeting at 5:30pm.

IV. **DISCUSSION ITEMS**

A. **OLD BUSINESS**

1. **Medical Staff Recruiting, Mark Miller**
   a. No update
2. **Clinic Replacement Project, Mark Miller**
   a. Mark reported he needs partial lien releases to complete the next phase of the loan. Bruce noted the grass seed has been planted.

B. **NEW BUSINESS**

1. **Administrative Report, Mark Miller:**
   - Chronic Care Management has not moved forward due to the expenses that would likely be involved.

- Cardiac Rehab is going well.
- We had an initial meeting with an oncologist from Kearney.
- Mark discussed the idea of forming a budget committee in the future.
- Mark noted the hospital stopped providing flu shots out in the community for various reasons such as payments. This year, we are providing flu shots to local schools, daycare, EMS groups, pharmacy, senior center and assisted living home.

2. **Discussion of County Board of Supervisors Concerns**
   - Bruce noted he directed board members to bring a list of County concerns to this meeting.
   - Cindy reported a recording of the County Supervisors meeting dated October 18, 2019 would likely be available for use if needed. She explained the County would still like to meet with the Auditor when possible. She and Mike agreed the second meeting of the month would be most appropriate; however, she would prefer Bruce touch base with Tracy.
   - Mike reported he would like to see the exact financials at future Supervisors meetings instead of a summary that was previously presented. He stated he was opposed to the special meeting held Friday, October 18.
   - Bruce intends to ask Tracy if she would like the entire Board present at the Supervisors meeting with the auditor.
   - Cindy noted all of the Supervisors were opposed to the wording of item two at the Special meeting held Friday, October 18.
   - Tonda Ross expressed her discontentment with the course of events over the past week. She noted a positive working environment at the hospital.
   - Jaclyn Daake addressed the group and handed each Trustee a document summarizing her clients' allegations against HCHS CEO.
3. **Atrix Server Capital Request**
   - Expenditure was less than $5,000.
4. **Cardiac Monitor Capital Request**
   - Item tabled until the newly hired CNO arrives.
5. **Evaluation of Board of Trustee Bylaws**
   - Mark requests input and recommendations from the Board at the next meeting. Ideas will be reviewed by an attorney and brought back to the board.
6. **Evaluation of Financials Presented to County Supervisors**
   - Mark would like to take the exact financials to the County Supervisors instead of taking an excerpt.
7. **Community Activities and Donations**
   - Item tabled until a future meeting. Board requests a proposed policy.
8. **Board Self-Evaluation**
   - The board would like to utilize this tool this year.
9. **CEO Evaluation**
   - Les has a draft CEO evaluation; however, it is not ready for use at this time.

V. EXECUTIVE SESSION

At **6:47pm** Mark requested a closed session to discuss non-elected personnel issues to protect the reputation of those involved. Motion made by (**4**) to enter closed session, motion seconded by (**7**). Mark, Les and Katie were asked to stay. **A Roll Call Vote was held. All Yeas except those absent.**

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A motion was entered by (**4**) to enter open session at **8:36pm**. Motion seconded by (**2**). **A roll call vote was held. All Yeas except those absent.**

VI. **PUBLIC COMMENTS -** None

VII. **ADJOURN**

Being that no further business needs to be discussed, motion made by **(4)** to adjourn the regular meeting of the board of trustees of the Harlan County Health System, motion seconded by **(2). A Roll Call Vote was held: All Yeas except those absent.**

Meeting Adjourned at 8:36pm.

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Secretary

Harlan County Health System

A Component Unit of Harlan County, Nebraska
Alma, Nebraska

Financial Statements and
Supplementary Information
December 31, 2018 and 2017

Together with Independent Auditor's Report

Harlan County Health System
A Component Unit of Harlan County, Nebraska

Table of Contents

SEIM JOHNSON

Independent Auditor's Report

To the Board of Trustees of
Harlan County Health System
Alma, Nebraska:

Report on the Financial Statements

We have audited the accompanying financial statements of Harlan County Health System (Heath System), a component unit of Harlan County, Nebraska, as of and for the years ended December 31, 2018 and 2017, and the related notes to financial statements, which collectively comprise the Health System's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Harlan County Health System, a component unit of Harlan County, Nebraska, as of December 31, 2018 and 2017, and the changes in its financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Seim Johnson, LLP • 18081 Burt Street, Suite 200 • Omaha, NE 68022-4722 • Tel: 402.330.2660 • Fax: 402.330.5108 • SeimJohnson.com

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 3 through 6 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of the financial reporting for placing the basic financial statement in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 29, 2019 on our consideration of the Health System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Health System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health System's internal control over financial reporting and compliance.

Seim Johnson, LLP

Omaha, Nebraska,
March 29, 2019.

This section of Harlan County Health System (Health System) annual financial report presents background information and management's analysis of Health System financial performance during the fiscal years that ended on December 31, 2018 and 2017. Please read it in conjunction with the financial statements in this report, which follow.

2018 Highlights

- The Health System's 2018 total assets increased by $519,603 or 6%, primarily due to increases in patient accounts receivable and capitalized construction costs related to its replacement rural health clinic building. The Health System's 2018 total liabilities increased by $384,437 or 15%, primarily due to additional debt to fund the construction project and an increase in accounts payable for construction costs.
- During the year ended December 31, 2018, the Health System's total operating revenue increased $600,769 or 7%, from the prior year while operating expenses increased $382,013 or 4%. The increase in operating revenue was due to increases in commercial payor volume as well as an increase in 340B drug pricing program revenue.
- During 2018 the Health System received $408,136 in capital grants and contributions to fund a portion of the construction project.
- The Health System has reported a loss from operations in each of the past five fiscal years.
- The Health System had turnover in its CEO and CFO position in 2018.

Required Financial Statements

- The basic financial statements of Health System report information about Health System using Governmental Accounting Standards Board (GASB) accounting principles. These statements offer short-term and long-term financial information about its activities.
- The statement of net position includes all of Health System's assets and liabilities and provides information about the nature and amounts of investments in resources and the obligations to Health System creditors (liabilities). It also provides the basis for computing rate of return, evaluating the capital structure of Health System, and assessing the liquidity and financial flexibility of Health System.
- All of the current year's revenue and expenses are accounted for in the statements of revenue, expenses, and changes in net position. This statement measures the Health System's operations and can be used to determine whether Health System has been able to recover all of its costs through its patient service revenue and other revenue sources.
- The final required financial statement is the statement of cash flows. The primary purpose of this statement is to provide information about Health System's cash from operations, investing, and financing activities, and to provide answers to such questions as where did cash come from, what was cash used for, and what was the change in cash balance during the reporting period.

Financial Analysis of Health System

The statements of net position and the statements of revenue, expenses, and changes in net position report information about Health System's activities. These two statements report the net position of Health System and its changes. Increases or decreases in Health System's net position are one indicator of whether its financial health is improving or deteriorating. However, other non-financial factors such as changes in the healthcare industry, changes in Medicare and Medicaid regulations, and changes in commercial insurance contracting should also be considered.

Summary Statements of Net Position

	2018	2017	2016	Dollar Change
Total current assets	$ 3,184,107	2,270,595	2,602,393	913,512
Net capital assets	6,095,486	5,848,847	6,390,157	246,639
Other assets	278,315	918,863	816,926	(640,548)
Total assets	$ 9,557,908	9,038,305	9,809,476	519,603
Current liabilities	$ 1,592,449	943,257	1,092,122	649,192
Long-term debt	1,294,264	1,559,019	1,844,264	(264,755)
Total liabilities	2,886,713	2,502,276	2,936,386	384,437
Net position	6,671,195	6,536,029	6,873,090	135,166
Total liabilities and net position	$ 9,557,908	9,038,305	9,809,476	519,603

The Health System's 2018 total assets increased by $519,603 or 6%, primarily due to increases in patient accounts receivable and capitalized construction costs related to its replacement rural health clinic building. The Health System's 2018 total liabilities increased by $384,437 or 15%, primarily due to additional debt to fund the construction project and an increase in accounts payable for construction costs.

The Health System's 2017 total assets decrease by $771,171 or 8%, primarily due to depreciation of capital assets and cash used to pay down debt during the year. The Health System's 2017 total liabilities decreased by $434,110 or 15%, primarily due to payments on capital leases.

Summary Statements of Revenue, Expenses, and Changes in Net Position

	2018	2017	2016	Dollar Change
Operating revenue:				
Net patient service revenue	$ 8,791,360	8,314,657	8,037,321	476,703
Other	781,779	657,713	544,214	124,066
Net operating revenue	9,573,139	8,972,370	8,581,535	600,769
Operating expenses:				
Salaries, wages, and employee benefits	5,083,941	4,906,974	4,647,964	176,967
Professional fees and purchased services	1,966,100	1,795,619	1,568,314	170,481
Supplies and other expenses	2,031,732	1,969,340	1,952,802	62,392
Depreciation and amortization	690,991	718,818	679,147	(27,827)
Total operating expenses	9,772,764	9,390,751	8,848,227	382,013
Operating loss	(199,625)	(418,381)	(266,692)	218,756
Nonoperating revenue (loss), net	(29,336)	46,405	(634)	(75,741)
Deficits of revenue over expenses	(228,961)	(371,976)	(267,326)	143,015
Capital grants and contributions	408,136	81,583	12,002	326,553
Transfers to Harlan County	(44,009)	(46,668)	(215,276)	2,659
Increase (decrease) in net position	135,166	(337,061)	(470,600)	472,227
Net position, beginning of year	6,536,029	6,873,090	7,343,690	(337,061)
Net position, end of year	$ 6,671,195	6,536,029	6,873,090	135,166

Operational and Financial Performance

Operating Revenue and Expense

In fiscal year 2018, gross patient service revenue increased $694,302 due to outpatient volume increases. The Health System saw an increase in commercial payor volume which resulted in net patient service revenue increasing $476,703. In fiscal year 2017, gross patient service revenue increased $36,628 due to outpatient volume increases offsetting inpatient volume decreases while net patient service revenue increased $277,336 due to changes in third-party reimbursement.

Other operating revenue includes $627,039 and $534,649 in 340B drug pricing program revenue for the fiscal years ending December 31, 2018 and 2017, respectively. The Health System began participating in the program in 2015.

In fiscal year 2018, operating expenses increased $382,013 due to increases in salary, wages, and employee benefits as well as contracted labor from increased patient volume. In fiscal year 2017, operating expenses increased $542,524 due to increases in salary, wages, and employee benefits and professional services as the Health System increased overtime of full-time employee as well as increased usage of contracted labor.

Payer Mix

The Health System derives the majority of its total operating revenue from patient service revenue. Patient service revenue includes revenue from the Medicare and Medicaid programs, commercial insurance, and patients, who receive care in Health System's facilities. Reimbursement for the Medicare and Medicaid programs and commercial insurance is based upon established contracts. The difference between the covered charges and the established contract is recognized as a contractual allowance. Other revenue includes 340B drug discount program revenue, rental income, cafeteria sales, and other miscellaneous services.

The following presents the relative percentages of gross charges billed for patient services, by payer, for the fiscal years ended December 31, 2018, 2017, and 2016:

	2018	2017	2016
Medicare	64	67	69
Medicaid	4	4	3
Blue Cross	13	15	15
Other commercial	17	12	11
Self-pay and other	2	2	2
	100	100	100

Capital Assets

The following is a summary of capital assets by fiscal year:

	2018	2017	2016	Dollar Change
Land and land improvements	$ 702,456	702,456	702,456	--
Buildings and building improvements	6,021,101	6,021,101	6,021,101	--
Equipment	5,767,171	4,230,083	4,113,768	1,537,088
Subtotal	12,490,728	10,953,640	10,837,325	1,537,088
Less: accumulated depreciation	7,294,238	6,603,247	5,906,237	690,991
Capital assets, net	5,196,490	4,350,393	4,931,088	846,097
Construction in progress	898,996	1,498,454	1,459,069	(599,458)
Total capital assets, net	$ 6,095,486	5,848,847	6,390,157	246,639

The Health System's 2018 capital assets increased as a result of construction in progress costs related to its replacement rural health clinic building. During 2018 the Health System capitalized the costs associated with its medical record software which were previously in construction in progress. See Note 5 for additional information related to the construction project.

During 2017 the Health System had limited purchases of capital assets. The construction in progress costs were related the medical record software costs incurred during 2016, but not yet placed into service. 2017 capital assets decreased as a result of depreciation expenses exceeding the cost of new acquisitions.

The Health System's 2016 capital assets increased by $1,390,143 as a result of entering into $1,698,043 worth of capital leases during the year. The majority of the costs were in construction in progress at year end. In addition to the capital leases for medical record software and a radiology system, the Health System purchased $367,433 of capital assets.

Long-Term Debt (including Capital Leases)

At December 31, 2018 and 2017, Health System had $1,796,132 and $1,844,125, respectively, in capital leases and notes payable. The Health System entered into a $1,000,000 multiple advance construction loan at the end of 2018 to fund costs incurred related to the replacement rural health clinic building. More detailed information about Health System's long-term debt is presented in the notes to the basic financial statements Note 6.

Contacting Health System's Chief Financial Officer

This financial report is designed to provide our citizens, customers, and creditors with a general overview of Health System's finances and to demonstrate Health System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact:

Alan Meisinger
Chief Financial Officer
Harlan County Health System
717 N Brown Street
Alma, NE 68920
(308) 928-2151

Harlan County Health System
A Component Unit of Harlan County, Nebraska

Statements of Net Position
December 31, 2018 and 2017

	2018	2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 567,985	188,562
Short-term investments	165,077	163,396
Assets limited as to use, current portion	429,223	--
Receivables -		
Patients, net of allowance for doubtful accounts of $379,523 in 2018 and $281,419 in 2017, respectively	1,423,764	1,037,500
Other	64,356	85,608
Inventories	137,800	142,083
Prepaid expenses	49,208	66,102
Estimated third-party payer settlements - Medicare and Medicaid	346,694	587,344
Total current assets	3,184,107	2,270,595
Noncurrent assets:		
Assets limited as to use, net of current portion	278,315	918,863
Capital assets, net	6,095,486	5,848,847
Total noncurrent assets	6,373,801	6,767,710
Total assets	$ 9,557,908	9,038,305
LIABILITIES		
Current liabilities:		
Current portion of capital lease obligations	$ 189,509	212,454
Current portion of notes payable	312,359	72,652
Accounts payable -		
Trade	220,173	239,180
Capital assets	429,223	--
Accrued salaries, vacation, benefits and payroll taxes	390,771	379,541
Other accrued liabilities	50,414	39,430
Total current liabilities	1,592,449	943,257
Noncurrent liabilities:		
Capital lease obligations, net of current portion	1,109,102	1,298,859
Notes payable, net of current portion	185,162	260,160
Total noncurrent liabilities	1,294,264	1,559,019
Total liabilities	2,886,713	2,502,276
NET POSITION		
Net investment in capital assets	3,870,131	4,004,722
Restricted for capital acquisitions or operations	23,138	49,506
Unrestricted	2,777,926	2,481,801
Total net position	6,671,195	6,536,029
Total liabilities and net position	$ 9,557,908	9,038,305

See notes to financial statements

Harlan County Health System
A Component Unit of Harlan County, Nebraska

Statements of Revenue, Expenses, and Changes in Net Position
For the Years Ended December 31, 2018 and 2017

	2018	2017
OPERATING REVENUE:		
Net patient service revenue before provision for bad debts	$ 9,020,693	8,439,031
Provision for bad debts	(229,333)	(124,374)
Net patient service revenue	8,791,360	8,314,657
Other operating revenue	781,779	657,713
Total operating revenue	9,573,139	8,972,370
OPERATING EXPENSES:		
Salaries and wages	3,991,202	3,877,871
Employee benefits	1,092,739	1,029,103
Supplies and other expenses	2,031,732	1,969,340
Professional fees and purchased services	1,966,100	1,795,619
Depreciation and amortization	690,991	718,818
Total operating expenses	9,772,764	9,390,751
OPERATING LOSS	(199,625)	(418,381)
NONOPERATING REVENUE (EXPENSE):		
Property taxes	192	151
Noncapital grants and contributions	1,300	62,273
Investment income	8,428	6,691
Interest expense	(39,256)	(22,710)
Total nonoperating revenue (expense), net	(29,336)	46,405
DEFICITS OF REVENUE OVER EXPENSES BEFORE CAPITAL GRANTS AND CONTRIBUTIONS AND TRANSFERS	(228,961)	(371,976)
CAPITAL GRANTS AND CONTRIBUTIONS	408,136	81,583
TRANSFERS TO HARLAN COUNTY	(44,009)	(46,668)
INCREASE (DECREASE) IN NET POSITION	135,166	(337,061)
NET POSITION, BEGINNING OF YEAR	6,536,029	6,873,090
NET POSITION, END OF YEAR	$ 6,671,195	6,536,029

See notes to financial statements

Harlan County Health System
A Component Unit of Harlan County, Nebraska

Statements of Cash Flows
For the Years Ended December 31, 2018 and 2017

	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash received from patients and third-party payors	$ 8,645,746	7,346,234
Cash paid to suppliers and contractors	(3,963,426)	(3,730,935)
Cash paid for employee salaries and benefits	(5,072,711)	(4,900,625)
Other receipts and payments, net	781,779	656,613
Net cash provided by (used in) operating activities	391,388	(628,713)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:		
Property taxes	192	151
Noncapital grants and contributions	1,300	62,273
Net cash provided by noncapital financing activities	1,492	62,424
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Purchase of capital assets	(492,497)	(162,358)
Capital grants and contributions	408,136	81,583
Proceeds from notes payable	237,063	--
Principal paid on notes payable	(72,354)	(70,514)
Principal paid on capital lease obligations	(212,702)	(263,260)
Interest paid	(55,166)	(55,732)
Transfers to Harlan County	(44,009)	(46,668)
Net cash used in capital and related financing activities	(231,529)	(516,949)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of short-term investments	(1,681)	(979)
Withdrawals from (deposits to) assets limited as to use, net	211,325	(82,965)
Investment income	8,428	6,691
Net cash provided by (used in) investing activities	218,072	(77,253)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	379,423	(1,160,491)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	188,562	1,349,053
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 567,985	188,562
SUPPLEMENTAL CASH FLOW INFORMATION,		
Interest payments capitalized	$ 15,910	33,022

See notes to financial statements

Harlan County Health System
A Component Unit of Harlan County, Nebraska

Statements of Cash Flows (Continued)
For the Years Ended December 31, 2018 and 2017

	2018	2017
RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES:		
Operating loss	$ (199,625)	(418,381)
Adjustments to reconcile operating loss to net cash provided by (used in) operating activities:		
Depreciation and amortization	690,991	718,818
Gain on disposal of capital assets	--	(1,100)
(Increase) decrease in current assets -		
Receivables -		
Patients	(386,264)	(276,847)
Other	21,252	(11,533)
Inventories	4,283	8,306
Prepaid expenses	16,894	20,732
Estimated third-party payor settlements - Medicare and Medicaid	240,650	(587,344)
Increase (decrease) in current liabilities -		
Accounts payable - trade	(19,007)	21,592
Accrued salaries, vacation, benefits and payroll taxes	11,230	6,349
Other accrued liabilities	10,984	(5,073)
Estimated third-party payor settlements - Medicare and Medicaid	--	(104,232)
Net cash provided by (used in) operating activities	$ 391,388	(628,713)

See notes to financial statements

(1) Description of Reporting Entity and Summary of Significant Accounting Policies

The following is a description of the reporting entity and provides a summary of significant accounting policies of Harlan County Health System (Health System). These policies are in accordance with accounting principles generally accepted in the United States of America. The Health System is a component unit of Harlan County, Nebraska, and is exempt from federal and state income taxes.

A. Reporting Entity

The financial statements of Harlan County Health System are used to account for the provisions of acute hospital and rural health clinic services to the residents of Harlan County and the surrounding area.

The Health System's financial statements are an integral part of Harlan County, Nebraska. The accompanying financial statements are not intended to present fairly the financial position, changes in financial position, and cash flows of Harlan County, Nebraska, in conformity with accounting principles generally accepted in the United States of America.

The Budget Reconciliation Act of 1997 (Act) contained many provisions impacting Medicare reimbursement for the Health System. The Act established the Medicare Rural Hospital Flexibility Program to assist states and rural communities to improve access to essential healthcare services through limited service hospitals and rural health networks. The Health System has obtained Critical Access Hospital (CAH) designation. CAH's are acute care facilities that provide emergency, outpatient and short-term inpatient services. Medicare reimburses CAH's on a reasonable cost basis.

B. Industry Environment

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursements for patient services, and Medicare and Medicaid fraud and abuse. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Health System is in compliance with government laws and regulations as they apply to the areas of fraud and abuse. While no regulatory inquiries have been made, compliance with laws and regulations is subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

C. Measurement Focus and Basis of Accounting

Measurement focus refers to when revenue and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The Health System's financial statements are presented on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenue is recognized when earned, expenses are recognized when incurred.

D. Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

E. Cash and Cash Equivalents

Cash and cash equivalents for the purposes of the statements of cash flows include certain investments in highly liquid debt instruments with original maturities of three months or less, excluding assets limited as to use.

F. Short-Term Investments

Short-term investments are assets available for operations without donor imposed restrictions for capital acquisition or endowment.

G. Assets Limited as to Use

Assets limited as to use include the following:

By Board for Future Capital Improvements - Periodically, the Health System's Board of Trustees has set aside assets for future capital improvements over which the Board retains control and may, at its discretion, subsequently use for other purposes.

By Donor – These funds consist of contributed assets that have been restricted by the donor for specific capital improvements or operating activities.

Investment income on assets limited as to use is reported as nonoperating revenue in the statements of revenue, expenses, and changes in net position. Amounts required to meet current liabilities have been reclassified in the statements of net position and are reported in current assets.

H. Patient Receivables, Net

Net patient receivables consist of uncollateralized patient and third party obligations reduced by a valuation allowance for doubtful accounts and contractual adjustments from third party payers. The allowances reflect management's estimate of amounts that will not be collected in the future and are based on reviews of patient balances by payer classes and aging categories. Percentages are applied to each payer class and aging category based on contractual agreements as well as historical collection and recovery information to determine the net realizable value of patient receivables.

Payment for services is expected within thirty days of receipt of the billing statement. Accounts can work out their balance on a payment plan by contacting the Health System. Accounts considered past due are sent to collection agencies when internal collection efforts have been unsuccessful. Any amounts deemed uncollectible are written off on a monthly basis.

I. Inventories

Inventories are stated at the lower of cost or market. Cost is determined principally using the first-in, first-out method.

J. Capital Assets

Capital asset acquisitions are recorded at historical cost. All acquisitions of capital assets over $5,000 are capitalized. Depreciation is provided on the straight-line method based upon useful lives using general guidelines set forth by the American Hospital Association Guide for Estimated Useful Lives of Depreciable Hospital Assets. Contributed capital assets are reported at their estimated fair value at the time of their donation. Equipment under capital lease is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements.

Estimated useful lives of capital assets are as follows:

Land improvements	3 to 25 years
Buildings and building improvements	5 to 35 years
Equipment	3 to 25 years

Gifts of capital assets are reported as unrestricted support and are excluded from the deficit of revenue over expenses unless explicit donor stipulations specify how the donated assets must be used. Gifts of capital assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire capital assets are reported as capital grants and contributions. Absent explicit donor stipulations about how long those capital assets must be maintained, expirations of donor restrictions are reported when the donated or acquired capital assets are placed in service.

K. Net Position

Net position is reported in three categories defined as follows:

Net investment in capital assets – This component of net position consists of capital assets, including any restricted capital assets, net of accumulated depreciation and depreciation and reduced by the outstanding balances of outstanding liabilities that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of constraints placed on net position through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws and regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation.

Unrestricted – This component of net position consists of net position items not meeting the definitions of the two preceding categories. Unrestricted net positions often have constraints on resources imposed by management which can be removed or modified.

When both restricted and unrestricted net positions are available for use, generally it is the Health System's policy to use restricted reserves first.

L. Compensated Absences

Paid time off, which includes vacation, vests at 100% of accrued hours and may be accumulated by an employee at a maximum amount of 240 hours. Paid time off expense is accrued as an expense and a liability as it is earned. Vacation leave expenditures are recognized to the extent they are earned during the year and the vested amount is recorded as a current liability.

M. Grants and Contributions

From time to time, the Health System receives contributions and grants from various individuals and private organizations. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue and expenses.

N. Net Patient Service Revenue

The Health System has agreements with third-party payers that provide for payments to the Health System at amounts different from its established rates. Payment arrangements include reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

O. Charity Care

The Health System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Health System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue in the statements of revenue, expenses, and changes in net position.

P. Risk Management

The Health System is exposed to various risks of loss from torts: theft of, damage to, and destruction of assets; business interruption; errors and emissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Q. Operating Loss

Operating loss includes transactions deemed by management to be ongoing, major or central to the provision of medical services provided by the Health System. Revenue and expenses to provide these services are reported as operating loss for the reporting period.

Operating revenue results from exchange transactions associated with the provision of healthcare services – the Health System's principal activity. Nonexchange revenue, including taxes, grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenue. Operating expenses are all expenses incurred to provide healthcare services.

R. Recent Accounting Pronouncements

In June 2017, the Governmental Accounting Standards Board (GASB) issued Statement No. 87, *Leases*. The standard implements a single approach to accounting for leases. Lessees will be required to recognize a lease liability, measured at the present value of expected payments net of incentives, and an intangible right-to-use asset for all leases with terms of greater than 12 months. As payments are made, lessees will reduce the liability and recognize interest expense. Lease terms will include options to extend or terminate leases if it is reasonably certain that those options will be exercised. The standard will be effective for reporting periods beginning after December 15, 2019. The Health System is currently evaluating the effect the new standard will have on the financial statements.

S. Subsequent Events

The Health System considered events occurring through March 29, 2019 for recognition or disclosure in the financial statements as subsequent events. That date is the date the financial statements were available to be issued.

(2) Bank Deposits and Investments

The statutes of the State of Nebraska authorize the Health System to invest in certificates of deposit and time deposits of banks or capital stock financial institutions, obligations of the United States government and agencies thereof, and securities as provided in the authorized investment guidelines of the Nebraska Investment Council.

Government regulations require that all bank balances be insured or collateralized by U.S. government securities held by the Health System's third-party agent or the pledging financial institution's trust department in the name of the Health System.

The Health System had no investments meeting the disclosure requirements of GASB Statement No. 72.

Short-term investments are recorded at cost, which approximates fair value. These investments as of December 31, 2018 and 2017 are summarized below:

		2018	2017
Certificate of deposit	$	165,077	163,396

Assets limited as to use as of December 31, 2018 and 2017 consist of the following:

		2018	2017
By board for future capital improvements -			
Certificates of deposit	$	632,449	625,984
Cash and cash equivalents		51,951	243,373
By donor -			
Cash and cash equivalents -		23,138	49,506
Assets limited as to use	$	707,538	918,863

Custodial Credit Risk: Custodial credit risk is the risk that in the event of a bank failure, the Health System's deposits may not be returned. At December 31, 2018 and 2017, $954,327 and $546,467 of the Health System's bank balance of $1,592,032 and $1,407,932, respectively, were exposed to custodial credit risk as follows:

		2018	2017
Insured (FDIC) or collateralized with securities held by the Agency	$	637,705	861,465
Collateralized with securities held by the pledging financial institution's trust department or agent in other than the Agency's name		954,327	546,467
Total deposits	$	1,592,032	1,407,932

Interest Rate Risk: The Health System staggers the maturity dates of certificate of deposits as a means of meeting short and long-term cash obligations and managing its exposure to fair value losses arising from changes in interest rates. All certificates of deposits have original maturities of fifteen months or less.

(3) Net Patient Service Revenue

The Health System has agreements with third-party payers that provide for payments to the Health System at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

Medicare - Inpatient acute care services rendered to Medicare program beneficiaries in a Critical Access Hospital are paid based on Medicare defined costs of providing the services. Inpatient nonacute services, certain outpatient services, and rural health clinic services related to Medicare beneficiaries are paid based on a cost reimbursement methodology. The Health System is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual cost reports by the Health System and audits thereof by the Medicare Administrative Contractor. The Health System's Medicare cost reports have been audited by the Medicare Administrative Contractor through December 31, 2016.

The "Budget Control Act of 2011" requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. In general, Medicare claims with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment.

Medicaid - Inpatient acute services and outpatient services rendered to Medicaid program beneficiaries in a Critical Access Hospital are paid based on Medicaid defined costs of providing the services. The Health System is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual cost reports by the Health System.

The Health System has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to the Health System under these agreements primarily includes discounts from established charges.

Net patient service revenue as reflected in the accompanying statements of revenue, expenses and changes in net position consists of the following:

	2018	2017
Gross patient service revenue:		
Inpatient services	$ 1,111,410	1,201,393
Outpatient services	6,100,995	5,339,630
Clinics	1,229,128	1,206,208
Total gross patient service revenue	8,441,533	7,747,231
Deductions from (additions to) gross patient service revenue:		
Medicare	(1,196,015)	(1,222,649)
Medicaid	53,584	67,818
Other payers	562,526	461,729
Charity care	745	1,302
Total additions to gross patient service revenue, net	(579,160)	(691,800)
Net patient service revenue before provision for bad debts	$ 9,020,693	8,439,031

The Health System reports net patient service revenue at estimated net realizable amounts from patients, third-party payers, and others for services rendered and includes estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations.

Revenue from the Medicare and Medicaid programs accounted for approximately 70% of the Health System's net patient revenue for the years ended December 31, 2018 and 2017. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. In 2018 and 2017 net patient service revenue increased approximately $35,000 and $34,000, respectively, due to removal of allowances previously estimated that are no longer necessary as a result of final settlements for years no longer subject to audits, reviews and investigations.

(4) Composition of Patient Receivables

Patient receivables as of December 31, 2018 and 2017 consist of the following:

	2018	2017
Patient accounts	$ 1,657,807	1,390,998
Less estimated third-party contractual adjustments	145,480	(72,079)
Less allowance for doubtful accounts	(379,523)	(281,419)
	$ 1,423,764	1,037,500

The Health System grants credits without collateral to its patients, most of who are local residents and are insured under third-party payer agreements. The mix of receivables from patients and third-party payers was as follows:

	2018	2017
Medicare	38%	44%
Medicaid	2	4
Blue Cross	10	10
Other third-party payers	23	15
Private pay	27	27
	100%	100%

(5) Capital Assets

Capital assets and related accumulated depreciation are summarized as follows:

	December 31, 2017	Additions	Transfers or Disposals	December 31, 2018
Capital assets, not being depreciated/amortized:				
Land	$ 65,040	--	--	65,040
Construction in progress	1,498,454	896,334	(1,495,792)	898,996
	1,563,494	896,334	(1,495,792)	964,036
Capital assets, being depreciated/amortized:				
Land improvements	637,416	--	--	637,416
Buildings	6,021,101	--	--	6,021,101
Fixed equipment	1,488,530	--	--	1,488,530
Major moveable equipment	2,741,553	41,296	1,495,792	4,278,641
Total capital assets, being depreciated/amortized	10,888,600	41,296	1,495,792	12,425,688
Less accumulated depreciation/amortization:				
Land improvements	(385,895)	(40,623)	--	(426,518)
Buildings	(3,323,566)	(264,450)	--	(3,588,016)
Fixed equipment	(803,234)	(84,489)	--	(887,723)
Major moveable equipment	(2,090,552)	(301,429)	--	(2,391,981)
Total accumulated depreciation/amortization	(6,603,247)	(690,991)	--	(7,294,238)
Total capital assets, being depreciated/amortized, net	4,285,353	(649,695)	1,495,792	5,131,450
Total capital assets, net	$ 5,848,847	246,639	--	6,095,486

	December 31, 2016	Additions	Transfers or Disposals	December 31, 2017
Capital assets, not being depreciated/amortized:				
Land	$ 65,040	--	--	65,040
Construction in progress	1,459,069	39,385	--	1,498,454
	1,524,109	39,385	--	1,563,494
Capital assets, being depreciated/amortized:				
Land improvements	637,416	--	--	637,416
Buildings	6,021,101	--	--	6,021,101
Fixed equipment	1,488,530	--	--	1,488,530
Major moveable equipment	2,625,238	138,123	(21,808)	2,741,553
Total capital assets, being depreciated/amortized	10,772,285	138,123	(21,808)	10,888,600
Less accumulated depreciation/amortization:				
Land improvements	(345,272)	(40,623)	--	(385,895)
Buildings	(3,028,525)	(295,041)	--	(3,323,566)
Fixed equipment	(709,002)	(94,232)	--	(803,234)
Major moveable equipment	(1,823,438)	(288,922)	21,808	(2,090,552)
Total accumulated depreciation/amortization	(5,906,237)	(718,818)	21,808	(6,603,247)
Total capital assets, being depreciated/amortized, net	4,866,048	(580,695)	--	4,285,353
Total capital assets, net	$ 6,390,157	(541,310)	--	5,848,847

Depreciation and amortization expense of $690,991 and $718,818 in 2018 and 2017, respectively, is included in depreciation and amortization on the statements of revenue, expenses, and changes in net position.

During 2016, the Health System entered into a ten year capital lease agreement for medical records software. As of December 31, 2017 the software was being built and is included within construction in progress at a cost of $1,498,454. The software was placed into service during 2018. See Note 6 for the related capital lease information.

Construction in progress as of December 31, 2018 consists of costs incurred for the construction of a replacement rural health clinic building. The building is projected to cost approximately $1,600,000 and is expected to be completed in spring 2019. Construction costs are being financed with a construction loan (Note 6), contributions (Note 15), and Health System funds.

(6) Long-Term Debt

A summary of the notes payable and capital lease obligations at December 31, 2018 and 2017 are as follows:

	December 31, 2017	Borrowings	Payments	December 31, 2018	Due Within One Year
Capital lease obligations (a)	$ 1,511,313	–	(212,702)	1,298,611	189,509
Note payable (b)	332,812	–	(72,354)	260,458	75,296
Note payable (c)	--	237,063	--	237,063	237,063
Total long-term debt	$ 1,844,125	237,063	(285,056)	1,796,132	501,868

	December 31, 2016	Borrowings	Payments	December 31, 2017	Due Within One Year
Capital lease obligations (a)	$ 1,774,573	–	(263,260)	1,511,313	212,454
Notes payable (b)	403,326	–	(70,514)	332,812	72,652
Total long-term debt	$ 2,177,899	–	(333,774)	1,844,125	285,106

(a) Capital lease obligations through December 2026 with monthly payments, including interest, ranging from $242 to $13,530 and interest rates ranging from 2.45% to 8.00%.

(b) Note payable collateralized by equipment, due in monthly installments of $6,849, including interest, through May 2022 at 3.08% interest.

(c) Maximum $1,000,000 multiple advance construction note, variable interest at prime less .25% (5.50% as of December 31, 2018), due November 13, 2019. At the conclusion of the construction period management intends to refinance the construction note with long-term debt. Subsequent to December 31, 2018, the Health System withdrew approximately $595,000 in additional funds on the note.

Scheduled payments for the next five years and thereafter are as follows:

Year Ending December 31,	Principal	Interest
2019	$ 501,868	38,927
2020	272,472	30,962
2021	266,652	22,786
2022	174,236	16,376
2023	149,796	12,564
2024 – 2026	431,108	15,134
	$ 1,796,132	136,749

The following is a summary of interest costs incurred during the years ended December 31, 2018 and 2017:

	2018	2017
Expensed	$ 39,256	22,710
Capitalized	15,910	33,022
	$ 55,166	55,732

The following is summary of capital leased assets as of December 31, 2018 and 2017:

	2018	2017
Equipment	$ 1,773,335	2,187,626
Less: Accumulated depreciation	(209,937)	(465,369)
	$ 1,563,398	1,722,257

(7) Designated and Restricted Net Position

Of the $2,777,926 and $2,481,801 of unrestricted net position in 2018 and 2017, respectively, $684,400 and $869,357 has been designated by the Health System's Board of Trustees for capital improvement. Designated funds remain under the control of the Board of Trustees, which may at its discretion later use the funds for other purposes.

Restricted net positions are available for the following purposes at December 31, 2018 and 2017:

	2018	2017
Restricted by grant for capital assets or operating expense	$ 15,675	39,074
Restricted by auxiliary for capital assets or operating expense	7,463	10,432
	$ 23,138	49,506

(8) Professional Liability Insurance

The Health System carries a professional liability insurance policy (including malpractice) which provides $1,000,000 of coverage for injuries per occurrence and $3,000,000 aggregate coverage. The Health System also qualifies under the Nebraska Hospital Medical Liability Act (the Act). The Excess Liability Fund under the Act, on a claims-made basis, pays claims in excess of $500,000 for losses up to $2,250,000 per occurrence. The statutes limit covered claims above $2,250,000 and, in connection therewith, the Health System carries an umbrella policy which also provides $1,000,000 per occurrence and aggregate coverage. The professional liability policy provides coverage on a claims-made basis covering only those claims which have occurred and are reported to the insurance company while the coverage is in force. The general and umbrella policies provide coverage on a claims-incurred basis covering those claims which occurred while the Health System had coverage with the insurance company.

The Health System could have exposure on possible incidents that have occurred for which claims will be made in the future should professional liability insurance not be obtained or should coverage be limited and/or not available.

Accounting principles generally accepted in the United States of America require a healthcare provider to recognize the ultimate costs of malpractice claims or similar contingent liabilities, which include costs associated with litigating or settling claims, when the incidents that give rise to the claims occur. The Health System does evaluate all incidents and claims along with prior claim experienced to determine if a liability is to be recognized. For the years ending December 31, 2018 and 2017, management determined no liability should be recognized for asserted or unasserted claims. Management is not aware of any such claim that would have a material adverse impact on the accompanying financial statements.

(9) Pension Plan

The Health System maintains a 401(a) mandatory contributory pension plan for all eligible employees. Beginning January 1, 2005, eligibility is established for all employees 21 years of age. Once an employee completes one year of service, the employer will make contributions. Employee contributions are computed at 2% of annual compensation up to 19 1/2% of the Social Security Wage Tax Base (SSWTB) and 4% over that amount. Employer contributions are computed at 5% of annual compensation up to 19 1/2% of SSWTB and 10% of compensation greater than that amount.

Benefits are funded by a money purchase annuity with an insurance company. The plan is funded for past service on an installment basis over the estimated remaining duration of employment from the effective date of the plan (January 1, 1975) to the employee's normal retirement date. Benefits vest at 20% per year after two years of service with 100% vesting after six years of service. All funds contributed by the Health System which are not vested will be returned to the Health System. Contributions made by the Health System were $236,776 and $217,597 for 2018 and 2017, respectively.

(10) Management Agreement

The Board of Trustees has a management agreement with Great Plains Health Alliance, Inc. (GPHA), whereby GPHA agrees to administer operations of the Health System. Fees incurred under the management agreement were $90,215 and $86,745 for 2018 and 2017, respectively. Additional fees paid to GPHA for related management services provided outside of the agreement were $17,292 and $18,659 for 2018 and 2017, respectively.

(11) Related Party Transactions

In March 2006, the voters of Harlan County approved the issuance of $6,000,000 of general obligation bonds to be used to expand and renovate the Health System. During 2016, these bonds were refinanced with general obligation refunding bonds. The bonds are a liability of Harlan County and are not reflected on the Health System books, as the Health System has no responsibility for debt service; however, the Health System did transfer funds to Harlan County in 2018 and 2017 in the amount of $44,009 and $46,668, respectively, for interest payments on the bonds. These amounts are included as transfers to Harlan County on the statements of revenue, expenses, and changes in net position.

(12) Functional Expenses

The Health System provides general healthcare services to residents within its geographic location. Expenses included in the statements of revenue, expenses and changes in net position relate to the provision of these services.

(13) Other Operating Revenue

Other operating revenue for the years ended December 31, 2018 and 2017, consisted of the following:

		2018	2017
340B drug pricing program revenue	$	627,039	534,649
Telemedicine		36,144	16,922
Cafeteria sales		22,258	27,965
Gain on disposal of capital assets		--	1,100
Miscellaneous		96,338	77,077
	$	781,779	657,713

340B Drug Pricing Program

The Health System participates in the 340B Drug Pricing Program (340B Program) enabling the Health System to receive discounted prices from drug manufacturers on outpatient pharmaceutical purchases and enter into certain contracts with unrelated pharmacies who provide certain prescriptive drugs to Health System patients who receive rural health clinic and outpatient services. This program is overseen by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). HRSA is currently conducting routine audits of these programs at health care organizations and increasing its compliance monitoring processes. Laws and regulations governing the 340B Program are complex and subject to interpretation and change. As a result, it is reasonably possible that material changes to financial statement amounts related to the 340B Program could occur in the near future. During 2018 and 2017 the Health System recognized $627,039 and $534,649, respectively, of other operating revenue related to the 340B Program contracts with unrelated contract pharmacies.

(14) Budget and Budgetary Accounting

The Board of Trustees annually adopts a budget for operations on the accrual basis of accounting following required public notice and hearings for all funds. The following is a comparison between reported amounts and budget:

Unrestricted Fund		Actual	Budget
Total revenue	$	9,573,139	8,594,042
Total expenses		9,772,764	8,922,333
Operating loss		(199,625)	(328,291)
Nonoperating revenue (expense)		(29,336)	13,657
Deficit of revenue over expenses before capital grants and contributions and transfers	$	(228,961)	(314,634)

(15) Foundation

Harlan County Health System Foundation (Foundation) was established to raise funds to support the Health System. The Foundation is governed by a Board of Trustees independent of the Health System. All funds raised, except funds required for the operations of the Foundation, will be distributed to or be held for the benefit of the Health System as required to comply with the purposes specified by donors. Management has determined that the economic resources received from or held by the Foundation are not significant to the Health System. Therefore, the Foundation is not reported with the Health System pursuant to Section 2600 of the Governmental Accounting Standards Board Codification of Governmental Accounting and Financial Reporting Standards.

The Foundation's unaudited net assets were approximately $266,000 and $669,000 at December 31, 2018 and 2017, respectively. The Foundation donated $408,136 in 2018 to the Health System for construction of the replacement rural health clinic building (Note 5).The Foundation did not donate any funds to the Health System in 2017.

SEIM JOHNSON

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Trustees of
Harlan County Health System
Alma, Nebraska:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the financial statements of Harlan County Health System (Health System), a component unit of Harlan County, Nebraska, as of and for the year ended December 31, 2018, and the related notes to the financial statements, which collectively comprise the Health System's basic financial statements, and have issued our report thereon, dated March 29, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Health System's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify certain deficiencies in internal control, described in the schedule of findings and responses as items 2018-001 and 2018-002 that we consider to be significant deficiencies in internal control over financial reporting.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health System's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Seim Johnson, LLP • 18081 Burt Street, Suite 200 • Omaha, NE 68022-4722 • Tel: 402.330.2660 • Fax: 402.330.5108 • SeimJohnson.com

Health System's Response to Findings

The Health System's response to the findings identified in our audit is described in the accompanying schedule of findings and responses. The Health System's responses were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Seim Johnson, LLP

Omaha, Nebraska,
March 29, 2019.

Schedule of Findings and Responses
For the Year Ended December 31, 2018

FINANCIAL STATEMENT FINDINGS -

Significant Deficiencies:

Item 2018-001

Criteria:	Proper segregation of duties ensures an adequate internal control structure.
Condition:	We identified instances where a lack of segregation of duties exists.
Cause:	Due to a limited number of administrative personnel, a lack of segregation of duties exists.
Effect:	Without proper segregation of duties, a greater risk of fraud and defalcation may exist.
Recommendation:	We recommend Health Services continue to monitor and improve its segregation of duties.
Views of Responsible Officials and Planned Corrective Actions:	Management is aware of this control deficiency and believes it is economically not feasible for Health System to employ additional personnel for the purpose of greater segregation of duties. The Board of Trustees provides oversight over the internal control structure of Health System. The Health System will continue to monitor and improve segregation of duties.
Conclusion:	Response accepted.

Item 2018-002

Criteria:	The design or operation of the Health System's internal controls should allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements in the financial statements on a timely basis.
Condition:	We identified misstatements in the financial statements during the audit that were not detected and corrected by the Health Center's internal controls.
Cause:	The Health System experienced significant turnover in its accounting department.
Effect:	Audit journal entries were required to adjust the financial statements to year end estimates.
Recommendation:	We recommend the Health System continue to monitor and improve its policies and procedures over year end reconciliations.
Views of Responsible Officials and Planned Corrective Actions:	Management agrees with the recommendation and will review its policies and procedures over year end reconciliations.
Conclusion:	Response accepted.

Harlan County Health System
A Component Unit of Harlan County, Nebraska

Schedule of Prior Year Audit Findings
For the Year Ended December 31, 2018

Item 2017-001

Condition:	We identified instances where a lack of segregation of duties exists.
Previous response for finding:	Management is aware of this control deficiency and believes it is economically not feasible for Health System to employ additional personnel for the purpose of greater segregation of duties. The Board of Trustees provides oversight over the internal control structure of Health System. The Health System will continue to monitor and improve segregation of duties.
Status:	Finding not cleared. See item 2018-001.

November 15, 2019

Harlan County Health System
717 N. Brown
P.O. Box 836
Alma, NE 68920

The following report contains supplementary information for the purpose of supporting the Financial Statements of Harlan County Health System for the Period ending October 31, 2019.

Monthly Highlights:

Balance Sheet:

Cash, Accounts Receivable, Est. Third-party payer settlements –

Patient Volumes were much higher in October than in previous months. This was driven in large part by the increase in swing bed days. We had more swing bed days in October than the previous 3 months combined. Several of those patients were still in the hospital at month's end which led to a substantial increase in Net Accounts Receivable. The increase in volumes and revenue also pushed our expected payable to Medicare after filing this year's cost report back up to near $400,000.

Major Moveable Equipment –

We had to replace a server in the radiology department.

Accounts Payable –

The decrease in accounts payable reflects the payment of our final invoice from Hampton Construction.

Income Statement:

Patient Service Revenue –

Total Patient Service Revenue increased in October due to significant increases swing bed days. We also realized a significant increase in clinic visits as well as outpatient services.

Salaries –

When volumes were down in previous months, employees used a lot of their PTO. As employees use PTO it actually reduces salary expense when the balances are recalculated and adjusted at months' end. In October when volumes increased, little PTO was used which creates an increase in the balances and an adjusted increase in salaries expense.

Benefits –

As you may recall, in September we paid off the deductible credits for the employees who had used part or all of their health insurance deductible prior to the switch in insurance carriers. This is reflected in the higher benefits expense realized in September versus October.

Purchased Services –

With increases in swing bed patients and swing bed days comes increases in physical and occupational therapy services. These services are provided through a contracted service. The contracted payment is

based off of WRVU's (Work Relevant Units) provided by the company. As those services increase the cost of those services increase directly as WRVU's increase.

Supplies –

Increases in patient days also drives increases in supplies used. Increases in supplies usage was realized in the pharmacy, medical supply, and dietary departments.

Maintenance –

If you recall, in September we had to replace an air conditioner in the CT department. This is reflected in the higher maintenance costs in September versus October.

Interest –

A review of payments made to Phelps Memorial for the Meditech system uncovered a missed payment back in January 2019. Although the payment was missed, the balance was adjusted at the time based on the amortization schedule of payments. When we caught up on the payments this month, the additional payment was recorded directly to interest expense since the lease balance had already been reduced in a previous month. We will also have a substantial increase in interest expense in November as we record the interest payable to the County for the interest due on the Hospital Bonds.

Cost Report Estimate:

With lower volumes and revenue in July, August, and especially in September, our estimated payable to Medicare had decreased by over $175,000 in the last two months. When are swing bed volumes in October increased by over 3 times what we realized in those previous months, the payable to Medicare increased by $200,000.

Financial Performance Measures:

Working Capital -

	October 31, 2019	September 30, 2019
Current Assets:	$2,619,919	$2,644,702
Current Liabilities:	897,289	1,052,380
Working Capital	$1,722,630	$1,592,322
Working Capital Ratio:	2.92	2.51

Days Cash On Hand -

	October 31, 2019	September 30, 2019
Cash and Investments	$1,087,137	$1,297,705
Annual Expenses (- Depr.)	8,603,557	8,603,557
Days in Year	365	365
Daily Expenses	23,571	23,571
# of Days Expenses Covered by Cash on Hand	46.12	55.06

AR Days -

	October 31, 2019	September 30, 2019
Net AR	$1,614,952	$1,232,520
2018 Annual Net Revenue	8,296,874	8,296,874
Days in Year	365	365
Daily Revenue	22,731	22,731
# Days Revenue in AR	71.05	55.17

HARLAN COUNTY HEALTH SYSTEM
ALMA, NE

FINANCIAL REPORT

FOR THE MONTH ENDING

October 31, 2019

I. Statistical Summary

II. Balance Sheet

III. Income Statement

IV. Payer Mix Analysis

HARLAN COUNTY HEALTH SYSTEM

STATISTICS		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	TOTAL	AVERAGE
INPATIENT															
ADMITS															
	ACUTE	6	4	4	7	6	7	6	7	3	5	1	2	58	5
	SKILLED	4	3	6	6	8	7	4	8	6	4	4	6	66	6
	INTERMEDIATE	0	1	1	0	0	3	0	1	1	1	0	0	8	1
	TOTAL	10	8	11	13	14	17	10	16	10	10	5	8	132	11
DISCHARGES															
	ACUTE	6	2	6	6	7	6	7	8	3	5	1	2	59	5
	SKILLED	4	5	3	7	9	7	4	8	6	3	4	5	65	5
	INTERMEDIATE	0	1	1	0	0	1	0	1	1	2	0	0	7	1
	TOTAL	10	8	10	13	16	14	11	17	10	10	5	7	131	11
PATIENT DAYS															
	ACUTE	14	9	13	16	16	16	21	12	12	15	4	6	154	13
	SKILLED	82	36	36	70	53	57	42	61	34	17	26	108	622	52
	INTERMEDIATE	0	6	2	0	0	28	31	41	37	8	0	0	153	13
	TOTAL	96	51	51	86	69	101	94	114	83	40	30	114	929	77
LENGTH OF STAY															
	ACUTE	2.3	2.3	3.3	2.3	2.7	2.3	3.5	1.7	4.0	3.0	4.0	3.0		3
	SKILLED	20.5	12.0	6.0	11.7	6.6	8.1	10.5	7.6	5.7	4.3	6.5	18.0		10
	INTERMEDIATE	0.0	6.0	2.0	0.0	0.0	28.0	0.0	41.0	37.0	4.0	0.0	0.0		10
OUTPATIENT VISITS															
Visits	EMERGENCY ROOM	59	65	52	58	67	56	78	91	81	78	58	59	802	67
Visits	TREATMENT ROOM	15	27	39	12	16	27	19	26	13	22	13	13	242	20
Visits	SURGERY	3	0	0	0	0	0	0	0	3	2	0	1	9	1
Visits	SPECIALTY CLINIC	70	84	62	95	103	87	85	89	89	93	80	80	1,017	85
DEPARTMENT REVENUE USAGE															
Charges	OBSERVATION	17	46	31	29	101	148	107	156	89	83	70	174	1,051	88
Charges	ER	138	151	94	115	125	111	167	217	156	192	125	159	1,750	146
Charges	LAB	1156	1161	1226	1153	1176	1295	1273	1331	1351	1198	1125	1523	14,968	1247
Charges	RADIOLOGY	247	224	179	205	223	247	240	272	245	245	241	273	2,841	237
Charges	THERAPY	1140	983	1608	1438	1260	1427	1461	1290	1235	1320	1141	1697	16,000	1333
	TOTALS	**2698**	**2565**	**3138**	**2940**	**2885**	**3228**	**3248**	**3266**	**3076**	**3038**	**2702**	**3826**	**36,610**	**3,051**
CLINIC VISITS															
	NON-RHC PHYSICIAN CLINIC	85	98	59	59	59	50	80	98	81	105	58	71	903	75
	RHC - ALMA	633	429	531	401	403	442	439	482	395	438	343	480	5,416	451
	RHC - OXFORD	158	60	69	57	59	53	52	62	37	55	37	65	764	64
	CLINICS TOTAL	**876**	**587**	**659**	**517**	**521**	**545**	**571**	**642**	**513**	**598**	**438**	**616**	**7,083**	**590**

HARLAN COUNTY HEALTH SYSTEM
BALANCE SHEET
October 31, 2019

	DESCRIPTION	10/31/19	9/30/19	+/(-)	10/31/18
	ASSETS				
	CURRENT ASSETS				
0.08	Cash and Investments	$ 1,087,137	$ 1,297,705	$ (210,568)	$ 1,209,516
	Accounts Receivable				
0.10	- Hospital & Clinic	1,742,336	1,656,567	85,769	1,850,772
	Allowances:				
0.12	Allowance for Doubtful Accts.	(215,442)	(282,952)	67,510	(256,495)
0.13	Allowance 3rd Party Contractuals	88,057	(141,096)	229,153	(65,208)
	Net A/R	1,614,952	1,232,520	382,432	1,529,070
0.17	Inventories	152,126	149,585	2,541	136,503
0.18	Other	84,276	83,262	1,014	27,604
0.19	Other Prepaid Expenses	74,841	75,042	(201)	66,173
0.20	Est. Third-party payor settlements receivable	(393,413)	(193,413)	(200,000)	(144,421)
	Other Current Assets	(82,169)	114,476	(196,646)	85,859
	TOTAL CURRENT ASSETS	**2,619,919**	**2,644,702**	**(24,783)**	**2,824,445**
	ASSETS WHOSE USE IS LIMITED				
0.24	Designated Assets	1,060,191	1,058,979	1,212	50,194
	TOTAL DESIGNATED ASSETS	1,060,191	1,058,979	1,212	50,194
	PROPERTY AND EQUIPMENT AT COST				
0.33	Land	65,040	65,040	-	65,040
0.34	Land Improvements	775,341	775,341	-	637,415
0.35	Building	7,355,638	7,355,638	-	6,021,103
0.36	Fixed Equipment	1,517,445	1,517,445	-	1,488,533
0.37	Major Moveable Equipment	4,296,822	4,290,697	6,125	4,308,418
0.38	Construction in Process	-	-	-	70,798
	TOTAL PROPERTY & EQUIPMENT	14,010,286	14,004,161	6,125	12,591,306
0.40	Total Accumulated Depreciation Hospital	(7,937,143)	(7,870,970)	(66,172)	(7,163,109)
	NET PROPERTY AND EQUIPMENT	**6,073,143**	**6,133,191**	**(60,047)**	**5,428,198**
	TOTAL ASSETS	**$ 9,753,254**	**9,836,872**	**$ (83,618)**	**$ 8,302,836**
	LIABILITIES AND FUND BALANCE				
	CURRENT LIABILITIES				
0.49	Accounts Payable	$ 197,099	$ 357,426	$ (160,327)	$ 202,101
0.50	Accrued Expenses	(7,177)	(7,483)	306	(1,897)
0.51	Accrued Payroll	118,025	110,767	7,258	240,949
0.52	Benefits Payable	324,836	327,164	(2,328)	481,376
0.56	Current Portion Capital Leases	264,507	264,507	-	192,059
	TOTAL CURRENT LIABILITIES	**897,289**	**1,052,380**	(155,090)	**1,114,588**
	LONG TERM LIABILITIES				
0.62	Long Term Portion Notes Payable	899,362	$ 899,362	-	-
0.63	Long Term Portion Capital Leases	1,074,237	1,096,489	(22,252)	1,389,136
	TOTAL LONG TERM LIABILITIES	**1,973,599**	**1,995,851**	(22,252)	**1,389,136**
	FUND BALANCE				
0.68	Operating Fund	6,655,862	6,655,862	-	6,486,527
0.69	Invested in capital assets, net of related debt	15,923	15,923	-	49,506
	TOTAL FUND BALANCE	**6,671,785**	**6,671,785**	**-**	**6,536,033**
	NET PROFIT (LOSS)	210,581	116,856	93,724	(736,920)
	TOTAL LIABILITIES AND FUND BALANCE	**$ 9,753,254**	**9,836,872**	**$ (83,618)**	**$ 8,302,836**

HARLAN COUNTY HEALTH SYSTEM
STATEMENT OF REVENUES & EXPENSES
October 31, 2019

DESCRIPTION	MONTHLY STATS	MONTHLY 10/31/19	MONTHLY STATS	MONTHLY 09/30/19	YEAR TO DATE STATS	YEAR TO DATE 10/31/19	YEAR TO DATE STATS	YEAR TO DATE 10/31/18	Variance Between Yrs.	BUDGET STATS	BUDGET	Budget Variance Over/(Under)
PATIENT SERVICE REVENUE												
10 Inpatient (Routine and Ancillary)	6	$ 13,739	4	10,545	131	$ 347,630	117	$ 238,502	45.8%		$ 256,893	35.3%
11 Inpatient (Swing Bed, Int Care and Ancillary)	108	203,777	26	55,557	651	933,819	501	753,297	24.0%		823,456	13.4%
12 Outpatient	3,826	675,788	2,702	594,822	31,347	5,728,825	32,383	5,677,180	0.9%		6,208,855	-7.7%
13 Rural Health Clinic	545	121,626	380	61,680	4,900	874,866	5,650	311,833	180.6%		877,740	-0.3%
Total Patient Service Revenue		1,014,930		722,603		7,885,139		6,980,812	**13.0%**		8,166,944	-3.5%
17 Contractual Adjustments												
18 Medicare		5,611		(64,134)		(536,586)		(491,899)	9.1%		(1,011,278)	-46.9%
19 Medicaid		10,779		8,804		100,811		93,146	8.2%		86,970	15.9%
20 Blue Cross		18,673		11,343		147,129		180,631	-18.5%		320,970	-54.2%
21 Commercial		11,946		2,385		100,407		49,910	101.2%		443,153	-77.3%
22 Discounts		2,255		55		5,199		-	#DIV/0!		(761)	-783.3%
23 Charity Care		-		-		5,499		632	770.6%		574	857.7%
24 Provision for Bad Debts		(24,009)		(27,201)		36,508		75,673	-51.8%		212,297	-82.8%
25 Not Timely Filed		735		-		3,912		9,073	-56.9%		8,370	-53.3%
26 Other (Includes Patient Bankruptcy filings)		31,247		20,010		213,315		94,143	126.6%		118,206	80.5%
Total Deductions		57,236		(48,737)		76,194		11,310	**573.7%**		178,503	-57.3%
NET PATIENT SERVICE REVENUE		957,694		771,340		7,808,946		6,969,503	12.0%		7,988,441	-2.2%
32 Interest Income		1,431		1,528		10,616		5,233	102.9%		6,971	52.3%
33 Tax Appropriations		-		-		-		192	-100.0%		175	-100.0%
34 340b Pharmacy Gross Revenue		40,611		38,426		300,012		195,753	53.3%		661,867	-54.7%
35 Other Operating Revenue		2,641		5,720		54,077		213,212	-74.6%		92,476	-41.5%
TOTAL OPERATING REVENUE		1,002,378		817,015		8,173,652		7,383,892	**10.7%**		8,749,930	-6.6%
OPERATING EXPENSES												
41 Salaries		358,886		327,617		3,305,157		3,533,032	-6.4%		3,664,204	-9.8%
42 Benefits		79,086		104,238		820,742		1,016,911	-19.3%		932,542	-12.0%
43 Professional Fees		750		2,250		66,242		95,978	-31.0%		136,257	-51.4%
44 Purchased Services		235,740		192,386		1,744,749		1,471,368	18.6%		1,513,095	15.3%
45 Supplies		52,503		41,499		478,707		539,335	-11.2%		570,643	-16.1%
46 340b Pharmacy Expenses		26,029		23,462		156,159		162,030	-3.6%		493,299	-68.3%
48 Legal & Auditing		3,710		567		80,797		67,981	18.9%		43,250	86.8%
49 Insurance		6,457		5,337		60,912		55,891	9.0%		83,927	-27.4%
50 Depreciation		66,172		66,377		642,903		534,526	20.3%		636,810	1.0%
51 Telephone & Utilities		15,395		18,099		157,198		158,302	-0.7%		160,417	-2.0%
52 Maintenance		17,331		26,037		202,159		225,124	-10.2%		230,961	-12.5%
53 Minor Equipment		3,906		5,153		49,018		26,100	87.8%		44,229	10.8%
54 Dues & Subscriptions		8,866		7,368		83,050		78,638	5.6%		83,986	-1.1%
55 Licenses/Taxes		-		-		-		(39)	-100.0%		-	#DIV/0!
56 Travel Expense		7,273		8,564		55,376		46,604	18.8%		51,448	7.6%
57 Interest Expense		20,138		7,134		93,870		39,074	140.2%		74,001	26.8%
58 Rent Expense		5,547		6,382		57,701		22,089	161.2%		20,900	176.1%
59 Other Operating Expense		1,185		1,304		45,772		53,942	-15.1%		37,880	20.8%
TOTAL OPERATING EXPENSES		908,975		843,772		8,100,513		8,126,886	**-0.3%**		8,777,848	**-7.7%**
INCOME (LOSS) FROM OPERATIONS		93,403		(26,758)		73,139		(742,994)	-109.8%		(27,918)	-362.0%
NONOPERATING REVENUE												
67 General Contributions - Unrestricted		322		14,366		137,026		6,074			-	
68 Gain (Loss) on Sale of scrap		-		416		416		-			-	
69 Insurance Proceeds		-		-		-		-			-	
70 Other Grants		-		-		-		-			-	
71 Foundation Donations for Capital Equip.		-		-		-		-			-	
TOTAL NONOPERATING REVENUE		322		14,782		137,442		6,074			-	
NET GAIN / (LOSS) ALL SOURCES		**$ 93,724**		**$ (11,975)**		**$ 210,581**		**$ (736,920)**			**$ (27,918)**	-854.3%

Harlan County Health System
Payer Mix by Patient Type
For the Fiscal Year Ended December 31, 2019

		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD
	Inpatient - Acute Care	%	%	%	%	%	%	%	%	%	%	%
IP	Medicare	86%	100%	92%	61%	67%	71%	100%	99%	100%	78%	86%
	MA	0%	0%	0%	0%	20%	0%	0%	0%	0%	0%	3%
	Medicaid	0%	0%	0%	25%	0%	18%	0%	0%	0%	0%	4%
	Commercial	1%	0%	0%	0%	0%	11%	0%	0%	0%	0%	1%
	BCBS	0%	0%	8%	15%	14%	0%	0%	1%	0%	0%	4%
	Other	13%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%
	Self Pay	0%	0%	0%	0%	0%	0%	0%	0%	0%	22%	1%
	Swing Bed Skilled											
SBS	Medicare	88%	77%	64%	85%	89%	100%	100%	100%	100%	100%	89%
	MA	6%	0%	0%	4%	5%	0%	0%	0%	0%	0%	2%
	Medicaid	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Commercial	5%	23%	36%	0%	6%	0%	0%	0%	0%	0%	8%
	BCBS	0%	0%	0%	9%	1%	0%	0%	0%	0%	0%	1%
	Other	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%
	Self Pay	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Swing Bed Intermediate											
SBI	Medicare	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	MA	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Medicaid	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Commercial	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	BCBS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Self Pay	100%	0%	0%	100%	100%	100%	100%	100%	0%	0%	100%
	Outpatient Services											
OP	Medicare	49%	53%	53%	56%	49%	49%	55%	60%	61%	55%	54%
	MA	1%	0%	1%	1%	3%	3%	2%	2%	1%	2%	2%
	Medicaid	6%	4%	5%	4%	7%	2%	5%	1%	3%	3%	4%
	Commercial	15%	16%	15%	16%	17%	18%	11%	12%	10%	16%	15%
	BCBS	19%	14%	18%	13%	13%	16%	20%	16%	13%	13%	15%
	Other	8%	10%	7%	8%	8%	6%	4%	6%	5%	8%	7%
	Self Pay	3%	4%	3%	2%	4%	4%	3%	3%	7%	3%	3%
	Ambulatory Clinic											
AMB	Medicare	39%	35%	38%	47%	41%	47%	44%	45%	52%	43%	43%
	MA	1%	1%	0%	2%	2%	2%	2%	3%	3%	1%	2%
	Medicaid	14%	13%	13%	11%	8%	6%	8%	8%	6%	10%	10%
	Commercial	17%	22%	16%	14%	20%	17%	15%	19%	15%	14%	17%
	BCBS	20%	23%	25%	19%	21%	20%	24%	19%	17%	24%	21%
	Other	2%	2%	1%	2%	2%	1%	1%	2%	1%	1%	2%
	Self Pay	7%	5%	6%	6%	6%	7%	7%	5%	5%	6%	6%

HARLAN COUNTY HEALTH SYSTEM	Quality Assurance
	Subject: **Quality Improvement / Risk Management Plan 2020**
Policy and Procedure Manual	**Policy Number**: QA 8170. 0001.06
	Effective Date: 11/15/2019
Replaces policy:	Next Review Date: 11/15/2020
	Date of Origin: 11/15/2019
Approval Date: 11/15/2019	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE

The purpose of this plan is to provide a mechanism for assessing, quantifying, and improving the quality of services provided by Harlan County Health System and Heartland Family Medicine.

1. To serve as a systematic and ongoing method of identifying opportunities for improvement in the performance of the Health System, both in terms of quality of care provided, and in fiscal performance.

2. To identify, investigate and evaluate opportunities for improvement in service provided.

3. To assure that professional services are regularly, effectively, and validly evaluated.

4. To assure and improve communication across departments to facilitate the efficient operation of the Health System and the maintenance of high quality patient care.

5. To institute a plan of implementation for any opportunities for improvement in service identified and to evaluate the effectiveness of the changes.

6. To provide a mechanism for comparison of performance of the Health System against external standards and against similar hospitals' performance.

7. To assure compliance with Medicare Conditions of Participation (COPs) for Critical Access Hospitals (CAHs) regarding Quality Assurance.

8. To assure accuracy in the completion of documentation in the patient medical record.

AUTHORITY

The Harlan County Health System Board of Trustees, having the ultimate responsibility for the quality of patient care and efficient operation of the Health System, authorizes the Administrator of Harlan County Health System to institute a Quality Improvement program involving the Medical Staff as well as the Health System's clinical, administrative, and support departments. The Administrator directs all departments of the Health System and all contracted service providers to participate in the Quality Improvement program.

ORGANIZATION

A chart is attached which delineates lines of responsibility under the Quality Improvement program HCHS Organizational Chart. As indicated on the organizational chart, the Quality Improvement program encompasses all departments of the Health System; all contracted service providers, and includes participation by Good Samaritan Hospital, Kearney, Nebraska d/b/a CHI Health Good Samaritan (Consulting Hospital). Central Nebraska Critical Access Network is the Critical Access Hospital (CAH) network in which Harlan County Health System is a member. Activities of the Quality Improvement program are coordinated through the Quality Improvement Committee, and organized by the Quality Improvement Coordinator. Much of the quality improvement activity of the Health System will involve cross - departmental work groups, most often organized to work on specific issues or projects. These work groups may be appointed on an ad - hoc basis by the QI Committee, the QI Coordinator, the Administrator, or the Board of Trustees when needed.

The Quality Improvement Committee is comprised of a member of the Medical Staff, the CEO, Director of Nursing, Director of Radiology and the Laboratory Director, the CFO, the Manager of Health Information Management, and the QI Coordinator (if separate from one of the above positions). Other members may be added as deemed appropriate by the QI Committee.

SCOPE

Quality Improvement activities will be integrated and coordinated to evaluate services using an outcomes based approach whenever possible. A cross-departmental approach will most often be appropriate to accomplish this. Contracted services, especially clinical services will be integrated into the program wherever appropriate. The Medical Staff will participate in the plan as described below.

PROCEDURE

ASSIGNMENT OF RESPONSIBILITY

The Board of Trustees recognizes that the preservation of assets and delivery of quality patient care are their major responsibility. Final authority to establish, maintain, alter, and support an ongoing Quality Improvement Program rests with this body. In addition to the fiduciary responsibility inherent upon the Board of Trustees, there is also a regulatory responsibility to

adhere to requirements set forth under the CAH Conditions of Participation. It is intended that this plan fulfill all such regulatory requirements.

The Board of Trustees delegates operational responsibility for the Quality Improvement program to the Health System CEO. In turn, the CEO delegates operational aspects of the program to the Quality Improvement Committee, which acts as the coordinating body for all QI activities in the Health System. The individual designated as the Quality Improvement Coordinator will have organizational and administrative responsibility for the activities of the Quality Improvement Committee. The Quality Committee meets monthly to discuss critical measures that are significantly above or below benchmarks, every department of the hospital reports on their measures quarterly in January, April, July and October.

The Medical Staff will function as a peer review committee, having final authority for evaluation of quality and appropriateness of diagnosis and treatment of patients. As a peer review committee, all records of any review or investigation, including work papers and reports, are protected from discovery under Nebraska law.

DELINEATION OF SCOPE OF ASSESSMENT

All of the following will be considered appropriate subjects for evaluation under the facility wide Quality Improvement program. All subjects will be evaluated against the generally accepted standards of care for a Critical Access Hospital in rural Nebraska. In order to help accomplish this, a benchmarking process described below will be utilized.

1. All inpatient and outpatient medical care provided by personnel employed by or under contract to Harlan County Health System, regardless of where care is provided.

2. Any unusual or undesirable events involving patients, visitors, and / or staff of Harlan County Health System.

3. Any unusual or undesirable events or situations regarding facilities or equipment of the Health System.

4. Routine operations of all departments of Harlan County Health System.

5. Any admission denial notification or notice of quality concern received from the Medicare Quality Improvement Organization (QIO) or Medicare Administrative Contractor (MAC).

6. The overall quality of diagnosis and management reflected by the orders for medical care by the Medical Staff.

7. Issues related to referral or transportation of patients from the hospital under the terms of the Network Participation Agreement in place with Good Samaritan Hospital.

PEER REVIEW

The Medical Staff will implement routine screening criteria to review the quality and appropriateness of diagnosis and management of inpatients and outpatients at Harlan County Health System. Harlan County Health System will work with the Critical Access Hospital Network in conjunction with Good Samaritan Hospital to complete the Peer Review Process. Copies of the current screening criteria utilized by the Medical Staff are appended to this document Internal Peer Review Form External Peer Review Form Central Nebraska Critical Access Hospital Network Peer Review Process Guidelines . Medical Staff will conduct reviews of an episodic nature, generic quality screen failures, adverse findings of the QIO, requests from other committees, review of benchmarked data from outside sources, requests from the Board of Trustees, and requests from other departments of the Health System. Peer Review for Medical Staff Policy

IDENTIFICATION OF IMPORTANT ASPECTS OF CARE

MEDICAL STAFF

Issues to be reviewed on an ongoing basis, generally during the monthly Medical Staff Meeting or during the specific committee meetings include, but are not limited to the following:

- Medical Staff Credentialing and Privileging
- Timely and accurate completion of medical records
- Blood product utilization
- Surgical Tissue analysis
- Mortality and Morbidity
- Infection Control
- Pharmacy and Therapeutics
- Admission and Length of Stay Appropriateness (Utilization Review)
- Risk Management
- Adverse decisions or quality concerns issued by the Medicare or Medicaid Quality Improvement Organization (QIO)
- Privacy concerns
- Other topics related to the quality of diagnosis and management of patients

HEALTH SYSTEM DEPARTMENTS

Harlan County Health System hereby states its intent to utilize the methodology known as Continuous Quality Improvement (CQI) in the evaluation of quality of care. Among other things, this methodology relies on quantified data and an emphasis on analysis of processes. Quality monitoring will focus on four factors: Outcomes, Incidents, Satisfaction, and Benchmarks.

OUTCOMES

This measure of quality focuses on clinical care provided as viewed retrospectively against an expected process or result. Because Harlan County Health System does not provide care to sufficient numbers of patients with any specific health problem, and because of lack of resources for clinical research, we rely on practices, protocols, and standards developed by other

organizations. Once a standard of care is selected, the quality monitoring process focuses on measuring adherence to that standard. The clinical processes we examine represent important aspects of the care we provide, either in terms of the number of cases treated, or the significance of each occurrence.

We utilize abstracting tools provided in conjunction with CIMRO of Nebraska, our Medicare QIO, and the Medicare Beneficiary Quality Improvement Project (MBQIP). We participate in a regional level review process for all trauma patients we serve at this facility, our Trauma Nurse Coordinator meets with local EMS units on an as-needed basis to discuss and review the quality of treatment pre-hospital. With all outcomes based quality reviews the intent is to study processes, not people, in order to identify process issues and improve upon them. Finally we will be part of the Hospital Improvement Innovation Network (HIIN), which has replaced the Nebraska Health Research and Educational Trust/Hospital Engagement Network's (HRET/HEN 1.0 and 2.0) work. Harlan County Health System is committed to participate with the Nebraska Hospital Association in the American Hospital Association (AHA) in measuring and reporting the measures that have been identified for monitoring in the Hospital Improvement Innovation Network (HIIN).

INCIDENTS

This aspect of our Quality Improvement process involves examination of known deviations from an approved standard of care. When such an event occurs, it is documented in the electronic Incident Reporting Program or during computer down-time on an Incident Report Form. This serves two purposes. First, it serves as a tool to collect information for reporting adverse or potentially adverse events to our liability insurance carrier. Second, it provides a mechanism for tracking the frequency of events and for reviewing them with the goal of finding changes in processes to minimize their frequency.

SATISFACTION

Part of our quality monitoring process needs to involve asking questions to determine perceptions of the care from the point of view of the patient and family. To accomplish this, the QI Committee will direct a survey process by which feedback from patients will be sought and quantified. Any concerns identified through this process will become topics for investigation by the QI Committee. We are participating in HCAHPS through the survey process provided by the Illinois Critical Access Hospital Network (ICAHN), where Inpatients, Emergency Room Patients, and Clinic Patients are surveyed on the quality of care they receive in our facility. Every patient encounter with staff provides an opportunity to enhance the quality of care and service provided at our organization. ICAHN reports the collected data to CMS and other agencies for further national benchmarking.

BENCHMARKS

Benchmarking is a process of comparing our performance to someone else's. The comparison can be to another organization inside or outside of health care. Generally, however, the standard or practice against which we measure ourselves, in order to be valid, needs to be drawn from similar organizations. Benchmarking data for several organizations (Nebraska Hospital Association, Great Plains Health Alliance, Nebraska Critical Access Hospital Networks) is received and utilized for Benchmarking.

Clinical Benchmarking

In cooperation with CIMRO Nebraska, Harlan County Health System participates in the collection and reporting of both Hospital Inpatient and Outpatient Quality Reporting, utilizing the standards set in the Hospital Outpatient and/or Inpatient Specifications Manual. In the projects available through this process, individual patient records are abstracted to determine the quality or manner in which care was provided or what the results of the care were. When the clinical records are abstracted, the data is then submitted per secure electronic transmission to the Quality Net - Quality Management System. Feedback is then provided to us regarding our performance against previously identified standards, as well as against the performance of other similar facilities in Nebraska. Additionally, public reporting of this data is performed under the auspices of the Hospital Quality Alliance (HQA) on the Hospital Compare website. The Hospital Compare Website does publish our data, although if the numbers are less than 25 a quarter, which is typical for our facility, the website shows a disclaimer that the data is not large enough to provide reliably predictable hospital performance.

A second clinical benchmarking project is accomplished in conjunction with the Nebraska Hospital Association. NHA has for a number of years operated the Nebraska Hospital Information System (NHIS), which acts as a clearinghouse and data repository through which patient bills are submitted to Medicare, Medicaid, and certain other insurance carriers. In addition, the data repository has allowed compilation of statistical data based on information contained in-patient billing documents. For example, the number of cases of a particular diagnosis treated in a particular facility and in the state as a whole can be abstracted from the database. By abstracting data from the billing database, and using vendor-supplied software, NHA has developed the Clinical Outcomes Measurement System (COMS). This system provides institution specific feedback on a semiannual basis, measuring length of stay, mortality, and readmission data by diagnosis, and provides benchmarks against peer groups by size and hospital type (CAHs and County Hospitals).

Financial Benchmarking

Harlan County Health System participates in a statewide project sponsored by the Nebraska Hospital Association (NHA). Under this project, HCHS submits each year a copy of our audited financial statement to NHA. NHA, in turn, contracts with a national consulting firm to perform data analysis on our financial performance, providing comparisons against data from all hospitals in Nebraska, against national data aggregates, and against a peer group of hospitals within Nebraska. In the case of HCHS, the peer group has been other county hospitals in rural Nebraska. With the growth in the number of Critical Access Hospitals in Nebraska, an additional

peer group of CAHs has been added to this program. The data are trended over five years, and are presented graphically.

In addition HCHS participates in DataBank, a financial benchmarking tool sponsored by the Nebraska Hospital Association. Financial data is entered online every month and comparisons among various peer groups in Nebraska are available for multiple financial indicators.

IMPLEMENTATION OF CORRECTIVE ACTION TO RESOLVE PROBLEMS

When a problem or opportunity for improvement is identified through the Quality Improvement process, action must be designed and implemented to assure correction. The action plan needs to be specific to include the following elements:

1. What is the issue involved or the opportunity for improvement?
2. Who or what departments are involved?
3. What is the expected improvement?
4. What is the plan of implementation for the changes?
5. What will our method of evaluating the change be? How often will we follow up?

COMMUNICATION OF RESULTS OF THE QI PLAN

The Quality Improvement Committee will review collected quality monitoring data from studies of outcomes, incidents, patient satisfaction, and benchmarking. The QI Committee will also be available to assist individual departments with evaluation of problems not outlined in this plan. The QI Committee will serve as a coordinating and evaluation committee. The Committee will evaluate the results of the four categories of data, and draw conclusions from the data. These conclusions, along with samples of data, will be reported to the Board of Trustees on a periodic basis.

The Quality Improvement Committee will perform an evaluation of the Quality Improvement program annually to determine its effectiveness. Revisions will be made as necessary to improve the function of the plan. At least annually, the plan, along with any recommendations for revision, will be submitted to the Board of Trustees for approval.

Bruce Bliss 11-18-19

Chairman Board of Trustees Date

HARLAN COUNTY HEALTH SYSTEM	HEALTH INFORMATION MANAGEMENT
	Subject: **Peer Review for Medical Staff Policy**
Policy and Procedure Manual	**Policy Number**: HIM 8250.0025.02
	Effective Date: 11/18/2019
Replaces policy:	Next Review Date: 11/18/2020
	Date of Origin: 06/27/2019
Approval Date: 11/18/2019	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

Peer Review for physicians and mid-level providers will be accomplished in the following ways: by case review at regularly scheduled medical staff meetings, via face to face/telecommunication with physician and mid-level of individual medical records, and by sending at least one medical record per provider per quarter through the external peer review process.

PROCEDURE:

1. Internal Peer Review will be accomplished primarily at the monthly Medical Staff meetings.
    a. Internal review will be done through the following monitoring and evaluation activities:
        i. Tissue review involving the consulting pathologist
        ii. Blood Usage review
        iii. Deaths
        iv. Transfers to another acute care facility
        v. Unplanned return to the ER within 72 hours with the same diagnosis
        vi. Patient not seen within 30 minutes of notification to provider of patient's arrival in the ER
        vii. Unplanned return to surgery
        viii. Intra-operative injury
        ix. Acute MI, CVA, or Cardiac Arrest within 48 hours of admission for reasons other than those listed
        x. Wrong patient, wrong procedure, or wrong extremity operated on
        xi. Re-admission within 24 hours of discharge of an inpatient stay with the same or related diagnosis

xii. Hospital-Acquired Conditions, including infections, falls, and pressure ulcers

xiii. Leaving AMA

xiv. Re-admission within 30 days

xv. Length of Stay over 96 hours Discharge less than 24 hours

xvi. Any challenging or unusual cases, including traumas

xvii. Other (i.e. requests, complaints, occurrence reports)

b. Medical records identified for review will go to the Quality Improvement Peer Review Sub-Committee. The sub-committee will be made up of the Director of Nursing, Risk Manager, HIM Director, Utilization Review Coordinator, Infection Control Coordinator, and physicians of Medical Staff will complete an Internal Peer Review Form, on each medical record undergoing review.

c. The Peer Review Committee will present a summary of medical records identified for review and provide education quarterly at the Medical Staff meeting. A Level will be assigned to each medical record based on the following criteria: *Level 0*-Systems/Management/Equipment problems identified; *Level 1*-Medical management appropriate, most practitioners would handle the case similarly; *Level 2*-Medical management appropriate, documentation substandard; *Level 3*-Minor deviation from practice standards, most practitioners might handle the case differently; *Level 4*-Major deviation from practice standards, most practitioners would handle the case differently.

d. The following Actions will take place based on the above Assessments: *Level 0*-Non-physician concern, issue will be investigated by hospital personnel; *Level 1*-No further action required; *Level 2*-Further action at the discretion of the Medical Staff reviewer and HIM Director for documentation education; *Level 3*-Sent out for external peer review; *Level 4*-Send out for external peer review.

e. Reports will be kept on file in the HIM Department.

2. Physician Assistant and Nurse Practitioner Peer Review will be conducted on five (5) medical records monthly by the active staff physicians.

a. The five (5) monthly medical records are defined as:

i. Five (5) ER medical records

b. Physician Assistant and Nurse Practitioner medical records will be audited for the following indicators: Diagnosis is consistent with physical, lab, and x-ray findings; treatment plan, including drug therapy is appropriate for symptoms and diagnosis; Physician consultation as appropriate, and Entries are signed and dated.

c. Providers will be required to complete the medical record review via face to face/telecommunication with the physician reviewer via Quality and Appropriatenes of Care PA, which they are required to sign and return to the Risk Manager.

d. A quarterly summary of the Physician Assistant and Nurse Practitioner reviews will be taken to the Medical Staff meeting for discussion and education.

3. CRNA Peer Review will be conducted on two (2) medical records monthly by the active staff physicians.
    a. The two (2) monthly medical records are defined as:
        i. Two (2) surgical cases or epidural cases
    b. CRNA medical records will be audited for the following indicators: failed anesthesia, incorrect medication dose given, airway trauma, respiratory distress, and entries that are signed and dated.
    c. Providers will be required to complete the medical record review via face to face/telecommunication with the physician reviewer via Quality and Appropriateness of Care CRNA, which they are required to sign and return to the Risk Manager.
    d. A quarterly summary of the CRNA reviews will be taken to the Medical Staff meeting for discussion and education.
4. External Peer Review will be done through submission of medical records on a quarterly basis to the Central Nebraska Critical Access Hospital Network for review of physician or mid-level provider's practice
    a. Medical records assessed a Level 3 or Level4 by the Quality Improvement Peer Review Sub-Committee will be sent out for External Peer Review.
        i. Attached will be an External Peer Review Form and the medical record will be appropriately de-identified per the De-Identification of PHI and Limited Data Set Information policy.
    b. In addition, any medical record requested by a provider, Risk Management, Quality Improvement, Utilization Review, Director of Nursing, or the CEO will be sent out.
    c. Medical records will be sent to another facility based on the current CAH Network Peer Review Rotation. Any trauma medical records will be sent to a facility that is trauma certified. (Refer to Performance Improvement Network-Critical Access Hospitals Peer Review Rotation Groups and listing of Trauma Certified Hospitals.)
    d. The provider admitting and writing the majority of the orders for the patient will be considered the primary provider for any individual medical record.
    e. If a provider has no medical records identified in a given quarter, one random chart sample will be selected by the HIM Director for external review.
    f. If a provider has no medical records available in a given quarter because of an extended leave of absence or lack of hospital activities, no record will be sent out for that provider.
    g. The HIM Director will determine the number of medical records for submission for review.
    h. Audit forms received back from the professional reviewer will be routed to the Risk Manager for review and closure of the process. Action will be identified at

that time, including: standard met, opportunity for improvement, education letter to the provider, or disciplinary action.

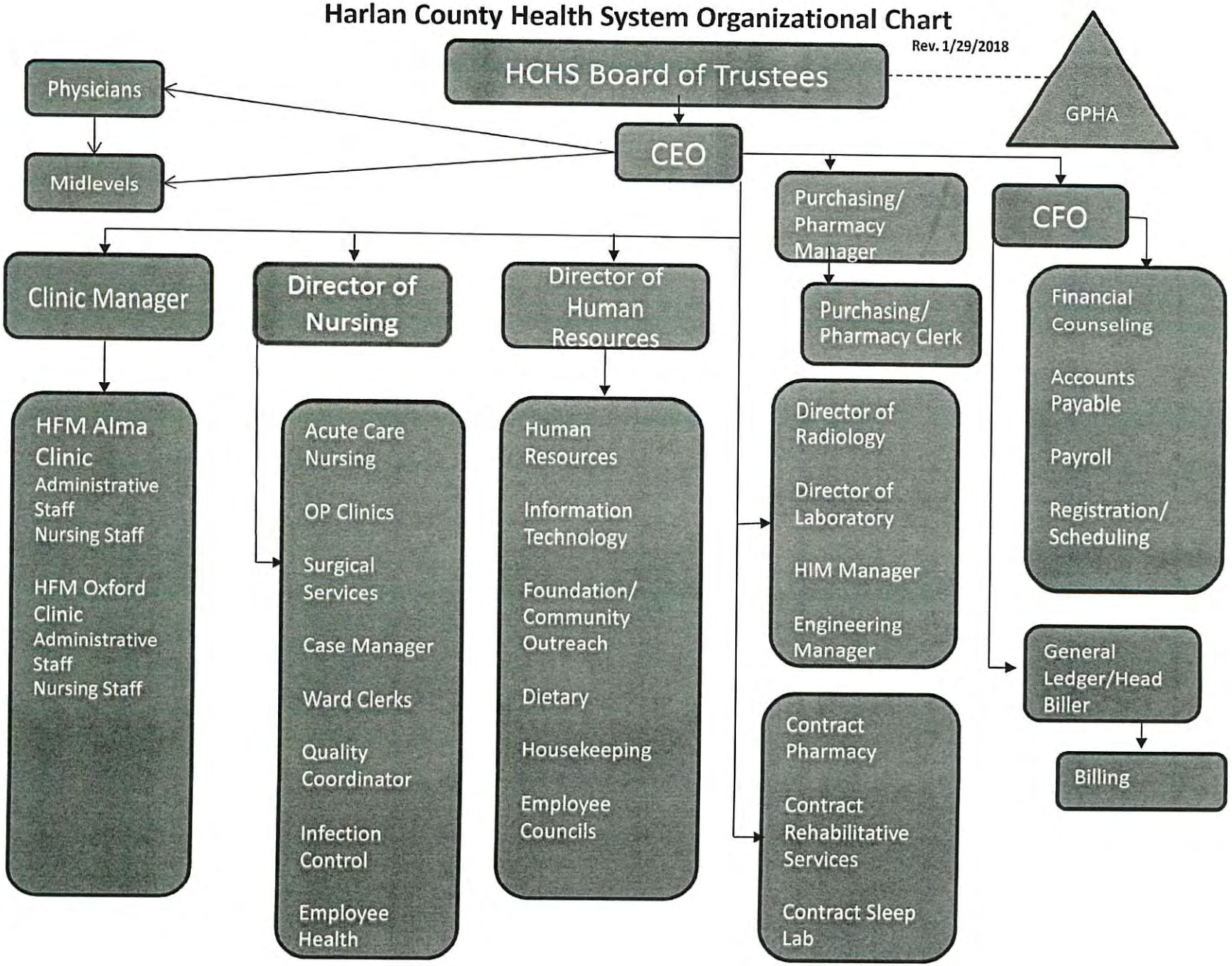
i. A quarterly summary will be taken to the Medical Staff Meeting for discussion and education.

j. Medical records received into our facility for review will be audited by physicians. All physicians will sign the Central Nebraska Critical Access Hospital Network Confidentiality Agreement, which will be kept on file in the HIPAA Privacy Officer's office.

k. See the Central Nebraska Critical Access Hospital Network Peer Review Process Guidelines (v.3) for complete details on the process.

Harlan County Health System Organizational Chart

Rev. 1/29/2018



Harlan County Health System

717 North Brown
P.O. Box 836
Alma, NE 68920-0836
phone (308) 928-2151
fax (308) 928-2774
www.harlancountyhealth.com

Reviewed By: _____

INTERNAL PEER REVIEW

PATIENT NAME: _____ **ACCOUNT #** _____

PROVIDER NAME: _____ **DATE OF SERVICE:** _____

Check all that apply **PART A: INDICATORS/CONCERN** Place notes in the box to the right

☐ Acute MI, CVA, cardiac arrest 48 hours of admit		☐ Unplanned ER return within 72hrs	
☐ Unplanned return to surgery		☐ Patient not seen within 30 min of provider notification	
☐ Wrong patient, Wrong procedure, Wrong extremity		☐ Re-admission 24hrs of discharge same diagnosis	
☐ Transfers		☐ Intraoperative injury	
☐ Unplanned ER		☐ Deaths	
☐ Tissue Review		☐ Tissue Review	
☐ Hospital-Acquired Infection or Conditions		☐ Any Challenging or unusual cases	
☐ Leaving AMA		☐ 30 day Re-admission	
☐ LOS over 96 hrs		☐ Discharge less than 24hrs	
☐ Pediatrics		☐ Trauma	
☐All orders not signed and dated		☐Chart not completed within 30 days	

Check only **one** *level* **PART B: QUALITY REVIEW**

	ASSESSMENT	ACTION
	LEVEL 0-Systems/Management/Equipment problems identified	Non-physician concern; Issue will be investigated by hospital personnel
	LEVEL1-Medical management appropriate; Most practitioners would handle the case similarly.	No further action required.
	LEVEL2-Medical management appropriate; Documentation substandard.	Further action at the discretion of the Medical Staff reviewer and HIM Director for documentation education.
	LEVEL 3-Minor deviation from practice standards; Most practitioners might handle the case differently	Send for external peer review.
	LEVEL 4-Major deviation from practice standards; Most practitioners would handle the case differently.	Send for external peer review.

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PART C: EXTERNAL PEER REVIEW IF INDICATED

☐ Yes Date sent: _____

☐ No

Explanation required

PART D: ACTION

☐ Standard of Care Met _____

☐ Opportunity for Improvement _____

☐ Letter to Provider _____

☐ Education _____

☐ Disciplinary Action _____

Comments:

John Finkner, MD
Jacob Peterson, MD
HIM Manager
Director of Nursing
Infection Control Nurse
Utilization Review/Case Manager

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EXTERNAL PEER REVIEW

Central Nebraska Critical Access Hospital Network

ACCOUNT #: _____ PROVIDER#: _____

DATE OF SERVICE: _____

ADMITTING DIAGNOSIS: _____

FINAL DIAGNOSIS: _____

PROCEDURES and DATES: _____

Nature of Submission

		YES	NO
1.	History adequate	_____	_____
2.	Physical Exam adequate	_____	_____
3.	Entries are legible, signed, and dated	_____	_____
4.	Treatment & medications appropriate	_____	_____
5.	Discharge summary complete & adequate	_____	_____
6.	Treatment is appropriate for symptoms & diagnosis	_____	_____
7.	Diagnosis consistent with history, physical, lab, & x-ray findings	_____	_____

Reviewer's Comments and Recommendations:

Reviewed By: _____ Date: _____

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Heartland Family Medicine
An Affiliate of Harlan County Health System

Quality and Appropriateness of Care

MidLevel

PATIENT NAME _____ **ACCOUNT #** _____

PROVIDER NAME _____ **DATE OF SERVICE:** _____

Based on the review of this medical record, was the appropriateness of the following items met? All "Adverse" must be accompanied by an explanation.

	YES	NO
Appropriateness of diagnosis	_____	_____
Appropriateness of medical management	_____	_____
Appropriateness of drug utilization	_____	_____
Physician consultation as appropriate	_____	_____
Patient stability at discharge	_____	_____
Adequacy of discharge instructions	_____	_____
All orders and notes were signed and dates	_____	_____

Based on the quality indicator screen and review of this medical record, the following classification system for review of this medical record indicated **one** of the following. All marks of 3, 4, or 5 must be accompanied by an explanation.

_____ 1. Criteria met

_____ 2. No affect on patient

_____ 3. Adverse effect on patient with treatment or intervention necessary, no long term effect

_____ 4. Severe adverse effect on patient, problem in patient management directly resulting in an adverse outcome

_____ 5. Death

Physician reviewer comments/suggestions/explanation:

_____

_____

_____

Participation in the review was conducted face to face or via telecommunication between physician reviewer and mid-level.

Physician Reviewer Signature: _____ Date/Time: _____

MidLevel Signature: _____ Date/Time: _____

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Heartland Family Medicine
AN AFFILIATE OF HARLAN COUNTY HEALTH SYSTEM

Quality and Appropriateness of Care

CRNA

PATIENT NAME _____ **ACCOUNT #** _____

PROVIDER NAME _____ **DATE OF SERVICE:** _____

Based on the review of this medical record, was the appropriateness of the following items met? All "Adverse" must be accompanied by an explanation.

	YES	NO
Appropriateness of anesthesia	_____	_____
Appropriateness of medical management	_____	_____
Appropriate medication dose	_____	_____
Induced airway trauma	_____	_____
Induced respiratory distress	_____	_____
Patient stability at discharge	_____	_____
All orders and notes were signed and dates	_____	_____

Based on the quality indicator screen and review of this medical record, the following classification system for review of this medical record indicated **one** of the following. All marks of 3, 4, or 5 must be accompanied by an explanation.

_____ 1. Criteria met

_____ 2. No affect on patient

_____ 3. Adverse effect on patient with treatment or intervention necessary, no long term effect

_____ 4. Severe adverse effect on patient, problem in patient management directly resulting in an adverse outcome

_____ 5. Death

Physician reviewer comments/suggestions/explanation:

_____

_____

_____

Participation in the review was conducted face to face or via telecommunication between physician reviewer and CRNA.

Physician Reviewer Signature: _____ Date/Time: _____

CRNA Signature: _____ Date/Time: _____

Harlan County Health System

IRISk (Incident Report Information System)

Name:
Identifier Number:
Date of Birth:
Male/Female

Demographic:

Check One: ☐ Patient ☐ Visitor ☐ Employee ☐ Other

Date of Incident:	Department:
Time:	Location:
Incident Witnessed? ☐Yes ☐ No	Brief Description of Incident:
Witness Name:	
Address:	
Diagnosis/Treatment:	

Incident:

Severity of Injury	*Injury*	*Mental Status*	*Patient Status*
☐Minor ☐Moderate ☐Serious ☐Death ☐None ☐Not Applicable ☐Unknown	☐Abrasion/Bruise ☐Amputation ☐Anoxia/Resp. Distress ☐Blister ☐Burn ☐Circ. Impairment ☐Contusion ☐Contracture ☐Damaged Teeth ☐Decubitus ☐Death ☐Fracture ☐None	☐Alert ☐Confused ☐Comatose ☐Unconscious ☐Not Applicable	Time of Incident: ☐Inpatient ☐Employee ☐Visitor ☐Home Care ☐Hospice ☐Outpatient ☐Student/Volunteer

Equipment

☐Disconnected/ Dislodged
☐Electrical Issue
☐Implant
☐Improper Use
☐Malfunction/Defect
☐Not Available
☐Tampered With
☐Testing Equipment
☐Wrong Equipment
☐Other

DISPOSITION:
☐Biomed
☐Continued Use
☐Hold for Investigation
☐Hold for Repairs
☐Outside Investigator
☐Sequestered
☐To Manufacturer
☐To Risk Manager
☐Other

EQUIPMENT TYPE:

Serial #:

Model #:

Lot #:

Implanted Date:

Explanted Date:

Operator:

Does this incident need to be reported to the FDA?
☐Yes ☐No

Treatment/ Procedure

☐Adverse Reaction
☐Application or Removal of cast/splint
☐Consent Issue
☐Delay
☐Deviation from P&P
☐Dietary Issue
☐Dressing Change
☐Injection Site
☐Monitoring
☐Not Documented
☐Omitted
☐Patient ID
☐Patient Refused
☐Placement/Invasive Procedure
☐Positioning
☐Prep Issue
☐Procedure Canceled
☐Repeat Procedure
☐Reporting of Test Results
☐Suture Removal
☐Technique
☐Transcription Issue
☐Transfer/Moving Patient
☐Unlabeled/Missing Specimen
☐Wrong Site
☐Other

Occurrence Screens

☐Anesthesia Complication
☐Aspiration
☐Incorrect Sponge/ Needle or Instrument Count
☐Meconium Aspiration Staining
☐Return to Surgery
☐Unattended Delivery
☐Against Medical Advice
☐Ambulating – Other
☐Assault/Violence
☐Change in Dx
☐Combative Behavior
☐Contraband
☐Documentation Issue
☐Left W/O Being Seen by Doctor
☐Elopement
☐Fire
☐In Bed – Other Accident
☐Patient Dx/TX Follow-up
☐Patient Rights Violation
☐Property Missing or Damaged
☐Self-Inflicted Injury
☐Sexual Acting Out
☐Sexual Encounter
☐Struck by Object
☐Other

Falls

☐Ambulating with Assistance
☐Ambulating without Assistance
☐Bedside Commode
☐During Transfer
☐Eased to Floor
☐Faint
☐Found on Floor
☐Scales
☐Other

ACTIVITY
☐Ambulating with Assistance
☐Ambulating with Gait Aid
☐Ambulating without Assistance
☐Bathroom Privileges
☐Bedrest
☐Bedside Commode Only
☐Wheelchair

SIDE RAILS
☐Yes ☐No
☐Two-Up
☐Four-Up
☐Down
☐Non-Applicable
☐Ordered
☐Not Used
☐Unavailable

BED POSITION
☐High
☐Low
☐Non-Applicable

CONDITIONS OF THE FLOOR
☐Dry
☐Icy
☐Snow
☐Wet
☐Other

RESTRAINTS
☐Ankle Restraints
☐Chemical
☐Not Applicable
☐Posey Belt
☐Seat Belt
☐Side Rails
☐Wrist Restraints

Fall Prevention:
☐Yes ☐No

Meds taken in last 4 hours:
☐Yes ☐No

Medication Name:

DO NOT COPY THIS FORM. Send directly to Quality/Risk Manager. **F-QA 8170.0002.00**

Thank you for your efforts to improve quality and patient safety at HCHS!
This form is not part of the Medical Record and is CONFIDENTIAL.

Medication/IV/Blood

MEDICATION NAME

- ☐ Adverse Reaction
- ☐ Allergic Reaction
- ☐ Crossmatch Issue
- ☐ Infiltration
- ☐ Not Available
- ☐ Patient ID
- ☐ Transcription Issue
- ☐ Wrong Additive
- ☐ Wrong Dose
- ☐ Wrong Drug
- ☐ Wrong Route
- ☐ Wrong Solution
- ☐ Wrong Time
- ☐ Other

SIDE EFFECTS:

_____

_____

Communication

- ☐ Confidentiality Issue
- ☐ Consent Issue
- ☐ No Interpreter
- ☐ Patient Education
- ☐ Staff Attitude
- ☐ Systems
- ☐ Other

MISCELLANEOUS

- ☐ Aspiration
- ☐ Assault/Violence
- ☐ Cardiac/Respiratory Arrest
- ☐ Needle/Sharp Stick-Non-Employee
- ☐ Other Accident while Ambulating
- ☐ Procedure Not Followed
- ☐ Other

Follow-Up

Physician Notified?
☐ Yes ☐ No
Physician Name:
Date:
Time:
Treatment:
Action:

_____

_____

_____

_____

_____

_____

Supervisor Notified?
☐ Yes ☐ No
Supervisor Name:
Date:
Time:
Pt./Family Notified?
☐ Yes ☐ No
Name:
Relationship:
Date:
Time:

Please describe what happened.
Facts only:

Completed by:	**Date**

DO NOT COPY THIS FORM. Send directly to Quality/Risk Manager. **F-QA 8170.0002.00**

Thank you for your efforts to improve quality and patient safety at HCHS!
This form is not part of the Medical Record and is CONFIDENTIAL.

CHI Health Good Samaritan Critical Access Hospital Network
External Peer Review Process Guidelines

Purpose: The Good Samaritan Critical Access Hospital Network Peer Review Process is a non-biased confidential activity performed by the physicians within the Network's critical access hospitals. The peer review process will facilitate safe, timely, effective, efficient and equitable patient centered (STEEEP) outcomes through the identification of opportunities for improving processes and delivery of patient care.

Responsibility and Procedure: The Critical Access Hospital (CAH) Condition of Participation Periodic Evaluation and Quality Assurance Review 42 CFR § 485.641 requires that each CAH carries out or arranges for a periodic review of its total program and CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. Interpretive guidelines may be found under Tags C-0330 – C-0343 in the Critical Access Hospital Conditions of Participation Interpretive Guidelines.

Each CAH should have an Internal Peer Review Committee and/or an established internal peer view process. The duties and responsibilities of the hospital's Internal Peer Review Committee and the peer review process must be documented in the Medical Staff Bylaws which have been reviewed and approved by the Medical Staff and Governing Board. The Medical Staff may seek input from all clinical areas of the hospital to establish measures and criterion.

1. Unless the CAH's Medical Staff Bylaws are more prescriptive, the following are recommended to send patients charts for external peer review:
    - At a minimum the CAH should send the type and number of patient charts as required by federal and state regulations, in particular the requirements of the Critical Access Hospital Conditions of Participation Interpretive Guidelines Tag C-0340.
    - Those charts that "fall out" when performing internal physician quality reviews.
    - Quality of care concerns, on a case-by-case basis.
    - When sending a patient chart for external review it is recommended selecting patients with more complex conditions, multiple co-morbidities, etc. as a means of assessing the practitioner's clinical experience. A selected sample of patient records, rather than a random sample, is recommended.

2. Charts that are identified for external peer review will be sent for peer review through the Good Samaritan Critical Access Hospital Network external peer review process and rotation schedule.

3. Peer Review Rotation schedules will be maintained and distributed to the Critical Access Hospitals by the network hub hospital.

4. Best practice to have physicians reviewers within each Critical Access Hospital review the Confidentiality Policy and adopt the Confidentiality agreement as written. These will be kept on file at each hospital.

5. The external peer review contact at the requesting hospital will:
    - Copy the complete acute care and/or swing bed medical record. The record does not have to be blinded, as the chart will be sent via certified mail.
    - Complete the demographic section of the external peer review audit sheet.

- Forward both the medical record and audit sheet via certified mail to the external peer review contact at the reviewing hospital within 14 days of the date on the rotation schedule. If requesting hospital is not able to forward charts within 14 days, it is the responsibility of requesting external peer review contact to make arrangements with reviewing hospital to have charts reviewed.

7. The external peer review contact at the reviewing hospital will:
   - Log in charts received and assign to the reviewing physician.
   - Track charts to ensure the reviewing physicians returns charts within 30 days.
   - Return the review sheets via certified mail to the external peer review contact at the
   - hospital who requested the review. If reviewing hospital is not able to return charts within 14 days of rotation return date, it is the responsibility of reviewing hospital external peer review contact to make arrangements with requesting hospital to have charts returned.
   - Shred all copied medical records.

8. The reviewing physician will:
   - Review the case for quality and appropriateness of diagnosis and treatment furnished by the physician.
   - Complete the Good Samaritan Critical Access Hospital Network CAH External Peer Review Audit Form.
   - Complete the review within 20 days of the receipt of the medical record.
   - Provide rationale for his/her conclusion for every response other than yes.
   - Return all documents to his/her external peer review contact.

It is the responsibility of the CAH, through the Internal Peer Review Committee and/or established internal peer view process, to determine what action, if any, is necessary based on the findings. Provider peer review findings must be made available for review when being considered for reappointment.

Privilege and Confidentiality: All peer review information is privileged and confidential in accordance with Medical Staff and Hospital bylaws, state and federal laws and regulations pertaining to confidentiality and non-discoverability. Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by Hospital staff, preliminary case rating, questions and notes of the physician reviewers and requests for information from the involved physicians as well as any written responses to the committee.

Confirmation and Indemnification: All NPRC physician members/reviewers, CHI Health CAH Network process facilitators and individual medical staff members who act for and on behalf of the individual Hospital and the CHI Health Critical Access Network in discharging their responsibilities and professional review activities pursuant to this policy, the Medical Staff Bylaws the Credentials policy, etc. shall be indemnified when acting in those capacities, to the fullest extent permitted by

law, provided that the individual Hospital Board of Directors and the CHI Health Critical Access Network has confirmed the appointment and/or election of the individual to the position in question.

Regulatory Guidance (Compiled February 6, 2018)

Health Care Quality Improvement Act of 1986: 42 U.S.C. 11101 et seq.: http://www.hcqia.net/

Critical Access Hospital Condition of Participation: Periodic Evaluation and Quality Assurance Review 42 CFR § 485.641: https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol5/pdf/CFR-2017-title42-vol5-sec485-641.pdf

Critical Access Hospital Conditions of Participation Interpretive Guidelines 42 CR § 485.641: Medicare Internet-Only Manual 100.07, Appendix Table of Contents, Appendix W, Tag C-0330 – 343:
https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

Iowa Peer Review Statute: Iowa Code Ann. § 147.1 et seq:
https://www.legis.iowa.gov/docs/code/2017/147.pdf

Iowa Licensure and Regulations of Hospitals, Iowa Code 135B:
https://www.legis.iowa.gov/docs/code/2015/135B.pdf

Kansas Peer Review Statute: Kan. Stat. Ann § 65-442, § 65-4915 et seq.:
http://www.ksrevisor.org/statutes/chapters/ch65/065_004_0042.html;
http://www.ksrevisor.org/statutes/chapters/ch65/065_049_0015.html

Kansas Hospital Licensure Regulations:
http://www.kdheks.gov/bhfr/download/Hospital_Regualtions_Nov_2001.pdf

Nebraska Peer Review Statute: Nebraska Revised Statutes 71-7904 et. seq:
https://nebraskalegislature.gov/laws/statutes.php?statute=71-7904
Nebraska Hospital Licensure Regulations: 175 NAC 9: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-09.pdf

Statutes and Regulations are periodically added, amended and deleted. Please verify with the appropriate governmental source for the most current statutes and regulations.

Harlan County Health System and Heartland Family Medicine

Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
1. Authorized user misusing their access privileges, tampering, or improper use of ePHI and other confidential information including personal financial information	• Users are assigned their own unique User IDs • There are no generic User IDs • A user account is disabled after three unsuccessful login attempts - network • HIPAA reminders are sent to employees awareness reminders regarding their access to patient records and the patient's right to privacy • Users are assigned minimum necessary access • Completion of review process and responsibilities • Audit logs are utilized for random access audits and VIP audits • User access logs are reviewed on a monthly basis • Login audits are performed to discover unusual activity • Audit trails capture sufficient information to determine what events occurred and by whom • Access to VPN is limited to employees that have a need to access the network from outside the organization	• Some employees have access to look at any record in the system, including coworkers or VIPs	Confidentiality Integrity Litigation Financial	M	M	4	• Security Access Control *HIPAA S 8012.0005* • Security Monitoring & Auditing *HIPAA S 8012.0007* • Security Architecture *HIPAA S 8012.0013*		Information Access Management *164.308(a)(4)*	Follow a regular audit schedule, audits are reviewed in the HOC meeting on a monthly basis Responsible: HIPAA Oversight Committee Due Date: monthly ongoing	**Accept Risk** _____ **Accept Plan** _____X_____ **Re-evaluate Plan** _____

Harlan County Health System and Heartland Family Medicine — Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
2. Unauthorized user or inappropriate access, intentional (e.g., network and computer based attacks, malicious software upload, and unauthorized access to EPHI and other confidential information including personal financial information	• Users assigned their own unique User IDs • There are no generic User IDs • Users are assigned minimum necessary access • A user account is disabled after three unsuccessful login attempts • Auto logoff activities after 15 minutes of inactivity • Require users to change their initial password the first time they log into the system with a complex password • Employees have access to the minimum ePHI necessary to perform their job responsibilities • Firewall utilization and monitoring • Completion of review process and responsibilities • User access logs are reviewed on a monthly basis • Login audits are performed to discover unusual activity • Audit trails capture sufficient information to determine what events occurred and by whom	• Employees may share their user IDs and passwords • Employee walks away from a computer prior to its auto logoff time or without locking it	Confidentiality Integrity Availability	[redacted]			• Security Access Control *HIPAA S 8012.0005* • Security Remote Access *HIPAA S 8012.0006* • Security Monitoring & Auditing *HIPAA S 8012.0007* • Security Network *HIPAA S 8012.0012* • Security Architecture *HIPAA S 8012.0013*	• Set up System so it will not allow a user to be logged on to two different computers at the same time • Further discuss how to limit potentially unsafe sites such as private e-mail sites and certain social media sites from being accessed on the secure network. Due Date: 6/1/2017Consider Two factor authentication on email - when using strange computer	Information Access Management *164.308(a)(4)* Access Control *164.312(a)(1)* Integrity *164.312(c)(1)*	Follow a regular audit schedule, audits are reviewed in the HOC meeting on a monthly basis Responsible: HIPAA Oversight Committee Due Date: monthly ongoing Continue education of employees about securing ePHI Responsible: HIPAA Oversight Committee Due Date: ongoing	**Accept Risk** _____ **Accept Plan** __X__ **Re-evaluate Plan** _____
3. Employees with access to ePHI are not supervised	• Background checks are conducted prior to hire • References are contacted prior to hiring. Job descriptions define access to ePHI • Employees are educated about random audit process • Users are assigned minimum necessary access	•	Confidentiality Integrity				• Security Awareness Training Education *HIPAA S 8012.003* • Security Access Control *HIPAA S 8012.0005*		Workforce Security *164.308(a)(3)*	Ensure that job description include defined ePHI access Responsible: HR Due Date: ongoing in new job descriptions and will review current job descriptions annually	**Accept Risk** _____ **Accept Plan** __X__ **Re-evaluate Plan** _____

Harlan County Health System and Heartland Family Medicine — Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
4. User continuing to access ePHI after termination or change	• Termination policy and checklist • Access change policy • Notification email to organization of terminated employee • Monthly review of active user log	• Vendor may not be notified within 24 hours of termination to deactivate users access • Not consistent with checklists and policies	Confidentiality Integrity Reputation	L	H	3	• Security Access Control HIPAA S 8012.0005 • Security Architecture *HIPAA S 8012.0013* • Security Change Control *HIPAA S 8012.0014* • New/Exiting Employee Email *HIPAA 8012.0059*		Workforce Security *164.308(a)(3)*	Consistently enforce checklists and policies with respect to all employees who are terminated or whose duties have changed, whether the termination or change was voluntary or for cause Responsible: IT, HIM Director, HR and HIPAA Officers Due Date: Ongoing	**Accept Risk** _____ **Accept Plan** X **Re-evaluate Plan** _____

5. Accidental disclosure of PHI	• Tablets and Laptops used are encrypted with Sophos
	• Employees review security policies with HR at the time of hire
	• Employees are aware of privacy and security requirements prior to handling PHI
	• Educate employees about the importance of using discretion in all interactions
	• Policies and Procedures related to texting
	• Use of e-mail encryption for PHI sent
	• Additional HIPAA Education modules were added to the mandatory employee education
		• New privacy and security threats in the industry
		• Changes in the software and programming of the EHR
		• Infrastructure allows for oral breach
		• Smart Phone usage
			Confidentiality
			Integrity
			Financial
			Reputation
			Litigation
				M	M	4	• Security Awareness Training Education HIPAA S 8012.003
							• Security Business Continuity and Disaster Recovery Planning *HIPAA S 8012.0009*
							• Mobile Security Policy *HIPAA 8012.0066*
								• Ongoing education for privacy and security officers, so that they can educate the organization
								• Monitor system updates
								• Consider tighter security rules related to internet use and personal e-mail (whitelisting, blacklisting, etc)
								• Plan future construction to address oral breach and visibility of PHI risk
								  • Limit potentially unsafe sites such as private e-mail sites and certain social media sites from being accessed on the secure network.
								  • Responsible:
									Security Awareness and Training *164.308(a)(5)*	Monitor that updates are being satisfied on required devices
										Responsible: IT, HIPAA Officers
										Due Date: Ongoing
										Educate employees on mobile security and danger of verbal breaches
										Responsibility: DON HIM Director, IT, HIPAA Officers, Clinic Manager, HR
										Due Date: Ongoing
											Accept Risk _____
											Accept Plan X
											Re-evaluate Plan _____

6. Lapses in privacy safeguards that indicate a need for training refreshers	• Employees know where to find a copy of security policies and protocols. • Employees are aware of the consequences of noncompliance • Annual review of P&P • Additional HIPAA Education module added to employee orientation process, also new employees required to meet with HIPAA Privacy officer	• Consistently follow security awareness and training program with all new hires • All employees are not aware of mobile device encryption requirements	Confidentiality Integrity Availability	M	M	4	• Security Awareness Training Education *HIPAA S 8012.003*	• Identify security training priorities • Enforce P&P for mobile devices and "bring your own device (BYOD)	Security Awareness and Training *164.308(a)(5)*	Ensure consistency in training of new hires and current employees Responsible: HR, HIM Director Due Date: Ongoing	**Accept Risk** _____ **Accept Plan** X **Re-evaluate Plan** _____

Harlan County Health System and Heartland Family Medicine — Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
7. Server that hosts this application are located at the vendor's data center	• Current contract states security measures • Document all security incidents and their outcomes • An outside vendor (Reach Solutions) has been retained to assist with maintenance and recovery of our current systems • Business Associates Agreement in place with vendors	• Breach at outside vendor's location • HCHS has little control over Business associate's staff	Confidentiality Integrity Availability Financial Reputation Litigation	L	H	3	• Security Incident Reporting and Response *HIPAA S 8012.0008* • Security Business Continuity and Disaster Recovery Planning *HIPAA S 8012.0009*	• Ensure BAA in place with vendors that have access to PHI	Security Incident Procedures *164.308(a)(6)*	Ensure BAA in place with vendors that have access to PHI Responsible: HIPAA Privacy Officer Due Date: Ongoing	**Accept Risk** _____ **Accept Plan** _X_ **Re-evaluate Plan** _____
8. Emergency mode operation plan	• Vendor is responsible for recovery of data • Vendor is able to remotely install and make changes to software (Reach Solutions, GPHA, IT, Phelps) • Backup "snapshot" of patient information is captured on Nurse's station computer every 15 minutes • Backup "snapshot" of medication administration documentation is captured on the print server every 1 hour • Data Replication at GPHA Data Center • Data replication at vendor • Regular backup of systems •	• How would PHI be safeguarded in the event of a disaster	Confidentiality Integrity Availability Financial Reputation Litigation	M	H	6	• Security Incident Reporting and Response *HIPAA S 8012.0008* • Security Business Continuity and Disaster Recovery Planning *HIPAA S 8012.0009*	• Policy and Protocol on how to protect existing PHI • Prioritize what must be restored in the event of system disruption	Contingency Plan *164.308(a)(7)*	Create an emergency operation plan Responsible: HIM Director, IT, HIPAA Officers Due Date: ASAP	**Accept Risk** _____ **Accept Plan** _X_ **Re-evaluate Plan** _____
9. Changes in environment and operation affect the security of ePHI	• Annual Hazard and Vulnerability Assessment • Routine security evaluation • Appropriate personnel and Board of Trustees accept risk or mitigation plan	• Review of HIPAA Policies and Procedures are completed annually	Confidentiality Integrity Availability Financial Reputation Litigation	M	M	4	• Security Risk analysis and management *HIPAA S 8012.0004* • Security Monitoring & Auditing *HIPAA S 8012.0007*	• Any changes in environment and operation affecting the security of ePHI should be reviewed by HOC Committee	Evaluation *164.308(a)(8)*	Mini risk assessment should be completed prior to a major change Responsible: HIM Director Due date: Ongoing Review of new Policies and Procedures within 30-days of go live Responsible: HIPAA Officers, HOC Committee Due Date: Ongoing	**Accept Risk** _____ **Accept Plan** _X_ **Re-evaluate Plan** _____

Harlan County Health System and Heartland Family Medicine

Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
10. ePHI resides or migrates through vendor's systems	• All necessary Business Associate Agreements in place and are compliant with HIPAA and HITECH	• Vendors requiring the covered entity to sign their own BAA	Confidentiality Integrity Availability Financial Reputation Litigation	L	H	3	• Security Responsibilities *HIPAA S 8012.0002*		Business Associate Contracts and Other Arrangements *164.308(b)(1)*	Closely review all BAAs prior to signing Responsible: HIM Director, CEO Due Date: Ongoing While no current Business Associates are off shore vendors, ensure future endeavors also remain in non-high risk area. Responsible: HIM Director, CEO Due Date: Ongoing Ask if vendor has a current and updated Risk Assessment and note. Responsible: CEO, Risk Manager Due Date: Ongoing	**Accept Risk** _____ **Accept Plan** __X__ **Re-evaluate Plan** _____

Harlan County Health System and Heartland Family Medicine — Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
11. Unauthorized physical access, tampering, and theft of facility and equipment	• Key code and proximity badge entry to interior doors securing mobile devices, narcotics, and other equipment • Medical records containing PHI are secured • Maintenance has updated physical controls and keeps track of security updates • The physical therapy department is also a covered entity • Keys and badges are returned to HCHS during employee exit procedures • Key code to simplex door is changed when staff that possesses the code changes • Key code entry to interior doors securing mobile devices, narcotics, and equipment • Medical records containing PHI are secured when the clinic is not open • Master Access List documents who has access to codes to get into the key coded doors • New clinic code entry are the same for all interior doors. • Clinic provider hallway door lock will be changed when staff that possess the code changes.	• Interior door codes are too simple and have not been changed each time there is a change in staff • Share space and some office equipment with the physical therapy department • Mobile devices could easily be stolen • Clinic interior electronic locks are not changed with staff turnover.	Confidentiality Integrity Availability Financial Reputation Litigation	M	H	6	• Security Physical *HIPAA S 8012.010* • Security Device and Media Controls *HIPAA S 8012.0011*	• Change interior door codes	Facility Access Controls *164.310(a)(1)*	Change interior door codes Responsible: Maintenance Due Date: ongoing as staff changes occur Collect keys and key badges from exiting Employees Responsible: HR Due: Ongoing	**Accept Risk** _____ **Accept Plan** __X__ **Re-evaluate Plan** _____

Harlan County Health System and Heartland Family Medicine — Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
12. Unauthorized persons can legibly view content on workstations	• Limited access areas • Devices are to lock after being idle for 15 minutes • Access to ePHI is restricted to authorized users • No ePHI is to be stored on hard drives • Employees are encouraged to lock screens and are continually educated • Monthly security checks • Tablets and Laptops are encrypted with Sophos and are insured • Privacy shield in use where appropriate	• Nurses station is not in a secure location and their screens could be seen • No control of downloading lePHI to storage devices	Confidentiality Integrity Availability Financial Reputation Litigation	[redacted]			• Security Access Control *HIPAA S 8012.0005* • Security Physical *HIPAA S 8012.010* • Security Device and Media Controls *HIPAA S 8012.0011*	• Lock screen, close tablet, or invest in privacy shield • Determine a way to keep ePHI fom being downloaded on internal or external storage devices	Workstation Use *164.310(b)* Workstation Security *164.310(c)*	Plan future construction with privacy and security in mind Responsible: CEO, BOT Due Date: As new construction is planned Continue to educate staff on situational awareness and privacy Due Date: Ongoing Responsible: HIPAA Officers	**Accept Risk** _____ **Accept Plan** X **Re-evaluate Plan** _____
13. Re-using hardware and software that contain ePHI	• Procedure for sanitizing hardware or destroying hardware that contains ePHI prior to re-use • Document the movement of hardware and electronic media and who is responsible for each item • Annual review of P&P • Hard drives are removed from devices that leave the facility and are destroyed per P&P • Inventory • list is up to date	• Periodically check the inventory to ensure computers are where they are supposed to be	Confidentiality Integrity Availability Financial Reputation Litigation	M	M	4	• Security Device and Media Controls *HIPAA S 8012.0011* • Security Configuration MHRgement *HIPAA S 8012.0015* • Security Evaluation *HIPAA S 8012.0016*	• Add inventory list to the disaster recovery file • Take every possible precaution to prevent PHI from leaving the facility when equipment with electronic media decommissioned	Device and Media Controls *164.310(d)(1)*	Negotiate removal or replacement of electronic media from devices prior to being decommissioned Responsible: CEO Due Date: Ongoing Continue updating inventory list Responsible: IT, HIPAA Officers Due Date: Ongoing	**Accept Risk** _____ **Accept Plan** X **Re-evaluate Plan** _____
14. One person being responsible for conducting the audit and reporting results	• All audits are presented to the HOC committee to discuss results • Division of auditing duties whenever possible.	• Due to small staff segregation of duties is not always achievable	Confidentiality Integrity Availability Financial Reputation Litigation	[redacted]			• Security Incident Reporting and Response *HIPAA S 8012.0008* • Security Architecture *HIPAA S 8012.0013*		Audit Controls *164.312(b)* Person or Entity Authentication *164.312(d)*	Divide auditing duties as much as possible. Responsible: IT, HIPAA	**Accept Risk** _____ **Accept Plan** X **Re-evaluate Plan** _____

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
15. ePHI being altered or destroyed in an unauthorized or accidental manner by hackers or employees	• Users are required to authenticate themselves when logging on to the system • The network locks after 15 minutes of being idle • Users must utilize password strength requirements • Security rules are managed according to job duties • Providers are required to re-sign a document after it has been amended • Data is backed up automatically • Audit trail is available to show user and date altered • Employee education regarding cyber security	• Any user with given rights can amend a record even after the provider has signed it • Increasing number of ransomware attacks of healthcare facilities	Confidentiality Integrity Availability Financial Reputation Litigation	M	H	6	• Security Access Control *HIPAA S 8012.0005* • Security Architecture *HIPAA S 8012.0013*	• Limit potentially unsafe sites such as private e-mail sites and certain social media sites from being accessed on the secure network. Due Date: 4/1/2017 • Consider Two factor authentication on email - when using strange computer	Integrity *164.312(c)(1)* Person or Entity Authentication *164.312(d)* Transmission Security *164.312(e)(1)*	Monitor and update user rights as needed Responsible: IT, HIPAA Due Date: Ongoing Limit potentially unsafe sites such as private e-mail sites and certain social media sites from being accessed on the secure network. Due Date: ongoing	Accept Risk _____ Accept Plan __X__ Re-evaluate Plan _____
16. Transmitting ePHI via email or text	• Policies and Procedures are in place addressing the use of texting. • NEHII Direct mail is available as a solution for secure email • HCHS e-mail system allows for sending of encrypted e-malls	• Employees not using the tools that the organization has provided them • Employees not using the tools correctly	Confidentiality Integrity Availability Financial Reputation Litigation	H	M	6	• Security Access Control *HIPAA S 8012.0005* • Security Network *HIPAA S 8012.0012*	• Enforce sanctions on employees that transmit ePHI unsecurely • Update policy to include sanctions statements • Educate Staff on proper use of encryption	Transmission Security *164.312(e)(1)*	Update sanctions statements within policies Responsible: HR Due Date: ongoing Include a section about sanctions at the employee annual HIPAA education Responsible: HIM Director Due Date: Ongoing Educate staff on proper encryption Responsible: HR, IT, HIPAA Officers Due Date: Ongoing	Accept Risk _____ Accept Plan __X__ Re-evaluate Plan _____
17. Mobile devices being removed from the facility by unauthorized individuals on in an unauthorized manner	• Tablets and Laptops are encrypted with Sophos software • Smart phones are to be password protected • Policy states that no ePHI is to be saved on devices • No "paper" medical records are to be removed from the campus • Follow breach notification policy and protocol	• ePHI being saved on a devices rather than on a network drive • Employees breach of oral PHI • Employee not reporting an event immediately	Confidentiality Integrity Availability Financial Reputation Litigation	M	M	4	• Security Access Control *HIPAA S 8012.0005* • Security Incident Reporting and Response *HIPAA S 8012.0008* • Security Business Continuity and Disaster Recovery Planning *HIPAA S 8012.0009* • Security Device and Media Controls *HIPAA S 8012.0011*	• Educate staff on protocol on how to save documents on the server • Educate staff on securing oral PHI • Educating staff that reporting an event is not a bad thing to do • Update policy and protocol for HIM	Breach Notification *45 CFR Part 164 SubpartD*	Update policy and protocol for standard of PHI handling Responsible: HIM Director, Due Date: ongoing Continue updating inventory list Responsible: IT, HIPAA Officers Due Date: ongoing	Accept Risk _____ Accept Plan __X__ Re-evaluate Plan _____

Harlan County Health System and Heartland Family Medicine

Risk Profile

Threats	Current Controls	Vulnerability	Impact or Loss	Like	Impt	Risk	Policy	Suggested Controls	HIPAA Standard	Mitigation Plan	Governing Body
18. Paper Record Security	• Paper records are kept in locked areas • Disposal of records is done using an external shredding service • Paper records are disposed of in a timely manner per retention policy	• Employees not using the tools that the organization has provided them • Employees not using the tools correctly • Inability it audit personnel access to paper records	Confidentiality Integrity Availability Financial Reputation Litigation	M	M	4	• Health System Record Retention *HIM 8250.0059.01* • Shred Bin Usage *HIPAA 8012.0056.01*	• Scan paper records into the electronic file system	Facility Access Controls 164.310(a)(1) Security Awareness and Training 164.308(a)(5) Information Access Management 164.308(a)(4)	Ensure proper handling, storage and disposal of paper records Responsible: HIPAA Privacy Officer, HIM Manager Due Date: ongoing	Accept Risk _____ Accept Plan __X__ Re-evaluate Plan _____

The risk matrix scale, shown below, will determine what is "reasonable and appropriate" for the facility

Impact				
	H	3	6	9
	M	2	4	6
	L	1	2	3
		L	M	H

Probability of Occurrence

Source: The Octave[SM] Approach

In October 2016 HCHS combined the HFM and HCHS Risk assessments. HFM is part of HCHS and utilizes the same IT network and processes. Any risks that are associated with both facilities are noted in black, risks that are specific to the hospital will be highlighted in Blue, risks that are specific to HFM will be highlighted in green, risks specific to HFM Alma will be highlighted in yellow and risks specific to only Oxford will be highlighted in pink

Quarter 3/2019

HR will schedule meetings to review the employee termination checklist. *In process*

In April we will begin bi-weekly security committee meetings to assess current security. When necessary ad-hoc members will be invited to join. *On going*

Confidentiality policy updated to include - I will not access my own, or my family's record in any information system, unless required to perform my job responsibilities.

Network assessment completed in 3/Q, waiting to assess the results.

BAA spreadsheet will be reviewed and revised in Q/4.

Michael Andrews HIPAA Security Officer — Date: 10/28/19

Heather Behrendt, HIPAA Privacy Officer — Date: 10-28-19

Candy Bell, Clinic Manager — Date: 10/28/2019

Mark Miller, CEO — Date: 12-9-2019

Bruce Beins, Chairman of the Board of Trustees — Date:

Harlan County Health System

Hospital | Heartland Family Medicine
717 N. Brown | 906 7th Street
PO Box 836 | PO Box 665
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www.harlancountyhealth.com

Harlan County Health System Employed Medical Staff:

Dr. Mike Finkner M.D.

Jennifer Taylor, PA-C

Jessica Stemper, PA-C

Keri Foster, APRN

Regularly Contracted Medical Staff:

Dr. Jacob Peterson, M.D. (shared with FMS in Holdrege)

Cameron Ourada, PA-C (PRN)

Kai Englert, PA-C

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NAME	POSITION	PHONE & EMAIL	MAILING ADDRESS	SPOUSE	PLACE OF EMPLOYMENT
Mary Jo Christensen		308-920-1073 christensenmaryjo@frontier.com	70742 Killdeer Alma, NE 68920		HCHS
Lisa Howsden		308-991-7330 howden@atcjet.net	1425 Lock St Rep City, NE 68971		Phelps
Patty Rebman		C: 308-920-1359 H: 308-799-4111 prebman@wilblue.net	11924 712 Rd Rep City, NE 68971		
Christian Schluntz		308-991-6419 ctsfarm@gmail.com	71853 T Road Alma, NE 68920		DM Schluntz Corp
Jeff Bash		308-991-0903 jbash@frontiernet.net	PO Box 408 Orleans, NE		Bash Cattle Co
Vacant					
Vacant					
Les Lacy	VP- GPHA	H: 785-332-3399 C: 785-332-0268 llacy@gpha.com	1510 County Road 5 St. Francis, KS 67756		GPHA

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Schedule of Special Events

March (4th Weekend)	Hospital Employee Appreciation Event	Alma
March (Last Week)	Heartland Health Alliance Spring Governance Retreat	Lincoln
October (3rd week)	Nebraska Hospital Association Convention	Omaha

*Educational opportunities for credit with NHA Trustee Certification are communicated when schedules are released.

Scheduled Board Meetings

Third Monday of the Month @ 4:30pm

January 20, 2020	May 18, 2020	September 21, 2020
February 17, 2020	June 15, 2020	October 19, 2020
March 16, 2020	July 20, 2020	November 16, 2020
April 20, 2020	August 17, 2020	December 21, 2020

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THIS AGENDA IS CONTINUOUSLY UPDATED
24 HOURS BEFORE THE BUSINESS MEETING

BOARD OF TRUSTEES AGENDA

Monday, December 16, 2019, 4:30pm

Note: All Board meetings are conducted within the HCHS Administration conference room unless otherwise indicated.

I. CALL TO ORDER/MOTION FOR APPROVAL OF OPEN SESSION

II. APPROVAL OF CONSENT AGENDA ITEMS AS LISTED:

A. Minutes of Regular Board Meeting: November 18, 2019
B. Minutes of Special Board Meetings: December 1, 2019; December 10, 2019
C. Check Runs
D. Credit Card Usage
E. Financials

III. DISCUSSION ITEMS

A. OLD BUSINESS
1. Medical Staff Recruiting
2. Clinic Replacement Project
3. Amendment of Board of Trustee Bylaws
4. Board Self-Assessment
5. Cardiac Monitor Capital Request
6. Community Donation Policy

B. NEW BUSINESS
1. Administrative Report
2. DPI ProNvest
3. Wound Treatment Associate Program
4. Annual Utilization Program Review (Tabled from Nov. 18, 2019)
5. Budget
6. Discussion of County Board of Supervisors Concerns
7. Grievance Policy
8. CEO Status
9. CEO Search

IV. EXECUTIVE SESSION (Optional)

The Harlan County Health System Trustees are authorized by state statute to hold closed sessions. Closed sessions may be held when clearly necessary for the protection of the public interest or for the prevention of needless injury to the reputation of an individual. Reasons that meet this standard include but are not limited to: (a) strategy sessions with respect to collective bargaining, real estate matters, pending litigation, or litigation which is imminent as evidenced by communication of a claim or threat of litigation to or by the public body; (b) discussion regarding deployment of security personnel or devices; (c) investigative proceedings regarding allegations of criminal misconduct; (d) evaluation of the job performance of a person when necessary to prevent needless injury to the reputation of a person and if such person has not requested a public meeting; and (e) receipt of legal advice.

V. PUBLIC COMMENTS

VI. ADJOURN

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Nebraska Hospital Association
The influential voice of Nebraska's hospitals

https://www.nebraskahospitals.org/education/trustee_education.html

Trustee Education Certification Program

Are you prepared to lead?

In 2007, the Nebraska Hospital Association Research and Educational Foundation (NHAREF) developed a hospital governance education certification process, the "Hospital Trustee Community Accountability Education Certification Program," known simply as Trustee Education Certification Program. Why should you become certified? The NHAREF has developed this special, voluntary trustee education certification to make a good board member great, and a committed board member an exceptional asset. This education certification is a process of verifying an individual trustee's initiative to improve personal health care knowledge, leadership effectiveness and compliance with a variety of governance best practices. Certification is a viable way of assuring various stakeholders such as community members, lawmakers, regulators, physicians, employees and other businesses that Nebraska's hospitals hold themselves to high standards and are accountable for their governing performance. Certification demonstrates that Nebraska hospitals:

- Understand and embrace the need for governance accountability.
- Govern according to a standard of excellence.
- Are willing to formally certify their adherence to governance best practices.
- Are committed to care management and coordination of resources.
- Embrace community accountability and transparency.
- Structure their community benefit and outreach programs to meet identified community needs.
- Utilize data from the NHIS (Nebraska Health Information System) to identify and address areas of need especially for the uninsured and underinsured.
- Utilize performance data to identify opportunities for improvement, and monitor progress to improve quality and safety.
- Integrate local health efforts with state programs This certification process has been designed for hospital trustees as part of a larger effort to hold Nebraska hospitals to a higher standard of accountability. By its use, participating hospitals are demonstrating a commitment to improving performance of their boards, encouraging trustees to pursue ongoing education and educating trustees about their responsibility in serving their community. It also provides trustees with an opportunity to move beyond the basics of governance to a forward-thinking, strategic understanding of the health care environment and how to move their hospital's mission and vision to a new level.

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Job Description: Individual Hospital Board of Trustees Member

General Expectations of a board member:
Prospective and incumbent board members should commit themselves with regards to the following:

- Know the organization's mission, purposes, goals, policies, programs, services, history, strengths, and needs.
- Perform the duties of board membership responsibly and conform to the level of competence expected from board members as outlined in the duties of care, loyalty, and obedience.
- Prepare for the policy discussions and decision making required for governance excellence within the organization.
- Serve in leadership positions and undertake special assignments willingly and enthusiastically.
- Suggest possible nominees to the board who are individuals of achievement and distinction and who can make significant contributions to the work of the board and the organization's progress.
- Avoid prejudiced judgments on the basis of information received from individuals and urge those with grievances to follow established policies and procedures through their supervisors (all matters of potential significance should be called to the attention of the CEO and the board's elected leader as appropriate).
- Avoid asking for special favors of the staff, including special requests for extensive information, without prior consultation with the CEO, board, or appropriate committee chairperson.
- Know the difference between the board's role of governance and the role of the CEO in operations of the health system.
- Counsel the CEO as appropriate and support him or her through difficult relationships with groups or individuals.
- Consider giving an annual gift according to personal means.
- Assist the development committees or affiliated foundation and staff by implementing fundraising strategies through personal influence with others (e.g., corporations, individuals, and foundations).
- Participate annually in educational opportunities to remain current on changing trends and issues affecting governance.

Meetings
The board only exists, in both a legal and functional sense, when it meets. Consequently, board meetings are the center of governance. The way they are planned and conducted, in addition to the dynamics that emerge in them significantly influence the quality of governance. Therefore, individual board members are expected to:

- Prepare for board and committee meetings, including appropriate organizational activities.
- Participate in board and committee meetings with forethought, courtesy, critical thinking and analyses, and attention to results.
- Ask timely and substantive questions at board and committee meetings consistent with the board member's conscience and convictions, while at the same time supporting the majority decision on issues decided by the board.
- Be aware of the rules and laws that govern the conduction of open meetings in the State of Nebraska.

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Duties:

The Fundamental Duty of Oversight

Under state laws, the board of directors of a non-profit organization is the party responsible for the organization. The board must supervise and direct its own officers and govern the organization's efforts in carrying out its mission. The duties of care, loyalty, and obedience describe the manner in which the directors are required to carry out their fundamental duty of oversight.

Duty of Care

Duty of Care requires board members to have knowledge of all reasonably available and pertinent information before taking action. The board member must act in good faith, with the care of an ordinarily prudent businessperson in similar circumstances, and in a manner he or she reasonably believes to be in the best interest of the organization.

Duty of Loyalty

Duty of Loyalty requires board members to candidly discharge their duties in a manner designed to benefit only the hospital or health system, not the individual interests of the board member. It incorporates the duty to disclose situations that may present a potential for conflict with the organization's mission, as well as a duty to avoid competition with the organization.

Duty of Obedience

Duty of Obedience requires board members to ensure that the organization's decisions and activities adhere to its fundamental corporate purpose and charitable mission, as stated in its articles of incorporation and bylaws.

Each board member is also entrusted with individual responsibilities as a part of his or her board membership. The obligations of board service are considerable; they extend well beyond the basic expectations of attending meetings or participating in hospital events. Individual board members are expected to meet higher standards of personal conduct on behalf of the organization than what is usually expected of other types of community volunteers.

Yet, despite all of these "special" responsibilities, board members as individuals have no special privileges, prerogatives, or authority. They must meet in formal sessions to negotiate and make corporate decisions.

Harlan County Health System
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Description of Responsibilities:
Harlan County Health System Board of Trustees

Core Responsibilities

The hospital governing board must fulfill certain fundamental or core responsibilities in overseeing the efforts of the organization. These responsibilities cluster around six major areas:

1. Financial Oversight
2. Quality Oversight
3. Setting Strategic Direction/Mission Oversight
4. Self-Assessment & Development
5. Management Oversight
6. Advocacy

The board fulfills these responsibilities by adopting specific outcome targets against which to measure the organization's performance. To accomplish this, the board must:

- Establish policy guidelines and criteria for implementing the mission statement.
- Evaluate proposals brought to the board to ensure that they are consistent with the mission statement.
- Monitor programs and activities of the hospital and any subsidiary units to ensure mission consistency.
- Periodically review, discuss, and amend the mission statement if necessary to clarify board responsibilities.

Financial Oversight

The board has responsibility for the financial soundness of the organization. To accomplish this, the board must:

- Review and approve overall financial policies and plans for the organization.
- Receive and review financial reports to assess actual performance compared to projections.
- Review and adopt ethical financial policies and guidelines.
- Review major capital plans proposed for the organization and any subsidiaries.
- Ensure that the financial, capital, and strategic plans are aligned.

Quality Oversight

This board has the responsibility to assess the quality of all services provided by all individuals who perform their duties in this facility or under this board's sponsorship. To do this, the board must:

- Make quality of care and patient safety top priorities for the organization.
- Approve and oversee quality improvement initiatives recommended by senior management and the medical staff
- Assume responsibility for the actions of all physicians, nurses, and other individuals who perform their duties in the organization's facilities.
- Review and carefully discuss quality reports that provide comparative statistical data, and set measurable policy targets to ensure continual improvement in quality performance.
- Carefully review recommendations of the medical staff regarding new physicians who wish to practice in the organization and approve these recommendations if appropriate.
- Reappoint individuals to medical staff using comparative outcome data to evaluate how they have performed since their last appointment.

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- Appoint physicians to governing body committees and seek physician participation in the governance process to assist the board in its patient quality assessment responsibilities.
- Regularly receive and discuss malpractice data reflecting the organizations experience and the experience of individual physicians who have been appointed to the medical staff.
- Regularly receive and discuss data about medical staff to assure that future staffing will be adequate in terms of ages, numbers, specialties, and other demographic characteristics.
- Monitor programs and services to ensure that they comply with policies and standards relating to quality.
- Take corrective action to improve quality performance when appropriate and/ or necessary.

Setting Strategic Direction/Mission Oversight
The board has the responsibility to recommend the future direction that the organization will take to meet the community's health needs. To fulfill this responsibility, the board must:

- Review and approve a comprehensive strategic plan and supportive policy statements.
- Ensure that the organization's strategic plan is consistent with the mission.
- Regularly review progress toward meeting goals in the strategic plan to, assure that the board is fulfilling its mission.
- Periodically review, discuss, and amend the strategic plan to ensure its relevance to the mission.

Self-Assessment & Development
A board must assume responsibility for itself-its own effective and efficient performance. To discharge its stewardship responsibilities to its "owners," the board must:

- Participate annually in a formal board evaluation process.
- Evaluate board performance of individual board members to determine the appropriateness of continued service on the board.
- Maintain and update policy statements regarding roles, responsibilities, duties, and job descriptions for the board itself and its members, officers, and committees.
- Participate both as a board and as individuals in orientation programs and continuing education programs.

Management Oversight
The board is the final authority regarding oversight of management performance by the CEO and support staff. To exercise this authority, the board must:

- Support and assist the CEO to help achieve the organization's mission.
- Communicate regularly with the CEO regarding goals, expectations, and concerns.
- Evaluate the performance of the CEO annually using goals and objectives agreed upon with him or her at the beginning of the evaluation cycle.
- Periodically survey CEO employment arrangements at comparable organizations to ensure the reasonableness and competitiveness of his or her compensation package.
- Periodically review management succession plans to ensure leadership continuity.
- Establish specific performance policies that provide the CEO with a clear understanding of board expectations, and update these policies based on changing conditions.

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Advocacy

The board needs to focus on advocacy and lobbying around public policy issues. In order to take an activist role, the board must:

- Direct conduction of a periodic community health needs assessment to understand the health issues of the communities served.
- Set goals for the organization around the issue of public advocacy.
- Establish a policy that spells out the board's role in fund development and philanthropy efforts.

Board Governance

Finally, the board is responsible for managing its own governance affairs in an efficient and effective way. To fulfill this responsibility, the board must:

- Maintain written conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest.
- Periodically review the board's own structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.
- Ensure that each board member understands and agrees to maintain confidentiality with regard to information discussed by the board and its committees.
- Maintain efficient and timely communication with any subsidiary boards.
- Adopt, amend, and, if necessary, repeal the articles and bylaws of the organization.
- Maintain an up-to-date board policy manual, which includes specific policies covering its specific duties of care, loyalty, and obedience, and its oversight responsibilities in the areas of finance, quality, strategic planning, self-assessment and development, management oversight, and advocacy.

Basic Knowledge Standards

Demonstrate basic knowledge of:

- Hospital services
- Board member selection process
- Hospital mission, vision and history
- Hospital bylaws
- Community health status
- Attend board and committee meetings as required by hospital bylaws
- Attend board retreats and participate in strategic planning sessions with stakeholders and medical staff
- Review all board materials distributed prior to and at board meeting
- Assure that there is a standard agenda item to discuss pertinent items such as quality and safety
- Demonstrate knowledge of issues presented before the board
- Participate at board and committee meetings

Commitment to Quality of Patient Care Basic Standards

- Review hospital bylaws periodically
- Demonstrate basic knowledge of licensure, accreditation and Medicare certification standards
- Represent consumers and the community served, including uninsured and underinsured
- Review state and national quality improvement efforts, and be familiar with hospital and community specific results regarding health, quality and safety data
- Act on medical staff credentialing recommendations
- Participate in self-education by regularly reading health care governance periodicals.
- Monitor key indicators and ensure the hospital has proper procedures in place to adequately address the following areas:
    - Quality improvement,
    - Patient safety,
    - Risk Management
- All other committee reports at each board meeting, i.e. standing committees (either regular or ancillary), special committees, task forces or other similar bodies reporting or bringing business before the board

Ethics and Conflicts of Interest Basic Standards

- Sign conflict of interest policy at intervals required by hospital bylaws
- Comply with conflict of interest policy and abstain from voting when appropriate
- Act at all times in the interest of the hospital
- Maintain strict confidentiality in compliance with hospital bylaws/policies

Commitment to the Organization's Financial Health Basic Standards

- Review and analyze annual operating and capital budgets
- Monitor key financial indicators
- Review and analyze financial statement
- Review annual audit report
- Be familiar with Medicare/Medicaid reimbursement practices and procedures

Commitment to governance educational development Basic Standards

- Participate in board education
- Participate in self-education by regularly reading health care governance periodicals
- Report to the board on individual continuing educational activities

Participate in performance evaluation of self, the board and the CEO Basic Standards

- Conduct self-assessment annually
- Participate in assessment of board annually
- Participate in annual CEO evaluation (if applicable)

Participate in advocacy efforts on behalf of your hospital and health care Basic Standards

- Be a personal advocate for your hospital in your community as appropriate
- Introduce yourself to your local elected officials and state senators as a board member of your hospital and contact them as requested by hospital CEO or when appropriate
- Introduce yourself to your U.S. congressperson and Kansas's two U.S. senators and their health aides as a board member of your hospital and contact them as requested by the hospital CEO or when appropriate

ROLES AND RESPONSIBILITIES OF NONPROFIT BOARDS

1. **Determine the organization's mission, vision, values and purpose.** A statement of mission and purposes should articulate the organization's goals, means and primary constituents served. It is the board's responsibility to create the mission statement and review it periodically for accuracy and validity. Each individual board member should fully understand and support it.
2. **Select the chief executive.** Boards must reach consensus on the executive's job description and undertake a careful search to find the most qualified individual for the position.
3. **Support the chief executive and review her performance.** The board should ensure that the executive has the moral and professional support he or she needs to further the goals of the organization. The executive, in partnership with the entire board, should decide upon a periodic evaluation of the executive's performance.
4. **Ensure effective organizational planning.** As stewards of the organization, a board sets the overall direction and establishes general priorities. It must actively participate with the staff in a strategic planning process and assist in implementing the plan's goals.
5. **Ensure adequate resources/raise money.** One of the board's foremost responsibilities is to provide adequate resources for the organization to fulfill its mission. The board should work in partnership with the executive and development staff, if any, to raise funds from the 'community'.
6. **Ensure effective fiduciary oversight.** The board, in order to remain accountable to its donors, the public, and to safeguard its tax-exempt status, must assist in developing the annual budget and ensuring that proper financial controls are in place.
7. **Determine, monitor, and strengthen the organization's programs and services.** The board (in conjunction with the staff) determines which programs are the most consistent with a organization's mission and monitors their effectiveness.
8. **Enhance the organization's public standing.** An organization's primary link to the community, including constituents, the public, and the media, is the board. Clearly articulating the organization's mission, accomplishments, and goals to the public, as well as garnering support from important members of the community, are important elements of a comprehensive public relations strategy.
9. **Ensure legal and ethical integrity and maintain accountability.** The board is ultimately responsible for ensuring adherence to legal standards and ethical norms. Solid personnel policies, grievance procedures, and a clear delegation to the executive of hiring and managing employees will help ensure proper decorum in this area. The board must establish pertinent policies, and adhere to provisions of the organization's articles and bylaws.
10. **Recruit and orient new board members and assess board performance.** All boards have a responsibility to articulate and make known their needs in terms of member experience, skills, and many other considerations that define a "balanced" board composition. The Board must also orient new members to their responsibilities and the organization's history, needs, and challenges. By evaluating its performance in fulfilling its responsibilities, the board can recognize its achievements and reach consensus on which areas need to be improved.

TIPS FOR BECOMING A BETTER BOARD MEMBER

1. **Journals**: subscribe to *Modern Health Care* and *Trustee* magazines. These are great sources for industry news and effective governance. (see resources)

2. **Education**: attend at least one extramural health care and governance educational seminar every other year. (see resources for options).

3. **Financial statements**: if you don't already possess the ability, develop the skill to read and interpret financial statements immediately.

4. **Medical staff and physician groups:** take time to meet with several representatives to better understand these groups aspirations, challenges, and their perspective on health care and of the organization's strengths and weaknesses.

5. **Directors and Officers (D & O) liability insurance coverage and indemnification**: check on the limits and key provisions of your hospital's policy. Request that your hospital's counsel make a presentation on the topic at an upcoming board meeting.

6. **Apprenticeship**: if you are a new board member, expect to serve an apprenticeship with a journeyman board member. It takes the most able and committed person with no health care experience at least a year to get up to speed (that is, understanding the health care industry, your local market, your organization, challenges and opportunities).

7. **Stakeholders**: your overarching and fundamental obligation as a board member is to protect and advance the interest of stakeholders. Issues, policies and decisions should be viewed through their eyes.

8. **Governance responsibilities and roles**: Do everything you can to help your board stay on track, avoiding issues and tasks that are irrelevant, inconsequential, or better handled by others.

9. **Vision**: become fixated on your organization's vision. Everything you do should be directed toward fulfilling it.

10. **Governance not management**: Whenever a board slips into the role of management (meddling) both the quality of governance and management declines.

11. **Information**: the quality of governance can never exceed the quality of information your board receives. Constantly assess it in terms of: timeliness, accuracy, potential bias, what has been left out and unsaid, unstated assumptions, the frame of reference of whoever compiled it.

12. **Preparation**: Prior to board and committee meetings carefully read agenda materials, proposals and recommendations up for discussion and vote.

13. **Participate**: it is impossible to contribute unless you do.

12. **Question and challenge**: One of the most important functions of a board is to serve as a source of checks and balances, particularly when significant issues are being discussed.

13. **Tenacity**: Be tenacious in exploring an issue when your gut tells you that all is not right.

14. **Big issues should have time to match**: It is far easier to deal with simple and inconsequential matters: the routine often drives the non-routine. When a decision has significant consequences and is risky, demand that the board have the patience to deliberate it properly.

15. **Vote your conscience**: be willing to express a dissenting opinion and to vote no. Share your rationale and be sure it is reflected in the notes.

16. **Don't talk too much**: The best boards are characterized by relatively even participation across all members.

17. **Don't show off**: leave your ego at the boardroom door.

18. **Effective and efficient meetings**: the board chair has a particularly important role in facilitating effective and efficient meetings. Learn how to do this well (see resources).

19. **Never take action alone**: your board exists and can only act as a group. When a board meeting is over, your authority evaporates like a referee's at the end of a game. As an individual outside the board room, don't ever make demands of management, make promises to medical staff or employees or meddle in operations.

20. **Do not compromise your ethics and values**: Never do or say anything in the board room that you wouldn't want to read about on the front page of your local newspaper the next morning.

21. **Support your board's decisions and policies** (even if you voted against the decision): To govern well, your board must speak as a single voice. If you are continually unable to join in the chorus after having sung your song, consider resigning.

22. **Express your concerns**: if you have concerns about what your board is doing or how it is going about it, express them. First talk to the board chair, if that doesn't work, request that the matter appear on the agenda.

23. **Never perform nongovernance work for your organization** (even on a nonpaid basis): For example, if you are an information consultant, let someone on staff prepare the RFP for the new computer system. Regardless of the contribution you might make, doing so will jeopardize your objectivity as a board member and blur the line between governance and management.

24. **Keep a professional distance** from second and third-line executives, management staff, and employees. It is essential to scrupulously avoid even the appearance of providing others an opportunity to do an end run around the CEO.

25. **Be aware of conflicts of interest**: As an engaged and successful member of the community you will have conflicts of interest; they're unavoidable. Disclose any personal and professional conflicts on an annual basis, as well as report significant conflicts, as they arise. If others, or you, consider the conflict to be material, extricate yourself from all involvement in the matter-leave the room and do not discuss the issue with management or your board colleagues.

26. **Confidentiality:** keep sensitive information within the board room setting and don't discuss these issues with friends, associates or family members. You will rarely get into trouble (or compromise your board or organization) by saying too little.

27. **If you don't have something good to say, don't say anything at all**. Airing negative opinions outside the boardroom about any aspect of the organization reduces your ability to be effective.

28. **Consider appearances**: be careful about how you interact with the competition, for example, don't be a regular golf partner with a competitive CEO, avoid being a patient at a rival facility, etc.

29. **Get to know your fellow board members**, including the CEO. Good relationships are a powerful elixirs that facilitate how, and how well, a board does its work.

30. **If you are a CEO or board chair**, take each member of the board out to dinner at least once a year.

31. **Do a personal accounting of your board membership**. What are you giving and getting back? Is there rough parity between the two? Relative parity assures continued motivation and energy for your board work.

32. **Self examination**: once a year, engage in a careful, thoughtful, and critical self-examination of your role as a member of the board. Key questions are noted below.

- How am I performing? How can I perform better?
- How much of a contribution have I made over the last year? What specific things could I do to make a greater contribution?
- What are some of the things I do in meetings that impede board performance?
- What are some things that I refrain from doing, but shouldn't?
- Do I have the time and energy to be an engaged and active member of this board?
- Do I still enjoy being a member of this board?

35. **Know your limits**: when you realize that you do not have the time, energy, or commitment to serve on this board, or have had too many instances where you find it difficult (or impossible) to support its policies and decisions-*resign*. Do so gracefully and with style, but do it.

BoardroomBasics

Knowledge Resources for Health Care Governance Effectiveness

Overview of Board Roles and Responsibilities

INSIDE

KNOWLEDGEPOINTS

- Key functions of a highly successful board of trustees
- Practices to improve a board's visionary thinking
- The importance of determining eligibility requirements and developing board member job descriptions

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Overview

The world of health care is a complex and ever-changing environment. To ensure that high quality care is provided to consumers, and to effectively lead organizations to be successful in the coming years, a knowledgeable and loyal governing board is an absolute requirement. This *Boardroom Basics* is designed to educate trustees on the their basic roles and responsibilities as board members of health care organizations.

Major Board Functions

Board members must clearly understand the difference between "governance" and "management." The governing body is responsible for ensuring the mission and vision of the organization, in addition to being legally responsible for the operation of the organization. The governing board must see the "big picture," and work with all of the information available to it in order to lead the organization forward in carrying out its mission and vision.

Management is responsible for the day-to-day tasks of running the hospital. The board delegates the day-to-day management to the chief executive officer (CEO). The CEO and the senior management team is guided, but not directed, by the governing board. They lead the hospital's staff in carrying out the mission and vision that has been developed and approved by the governing board.

The roles and responsibilities of the governing board involves everything from ensuring the cost-effective utilization of resources to determining the organization's mission, and establishing a long-range strategic plan to help attain that mission. Although the responsibilities are many and varied, there are six major areas of responsibility that all governing boards have:

1. Hiring and retaining an effective CEO;
2. Mission development and long-range planning;
3. Ensuring high quality care;
4. Oversight of medical staff credentialing;
5. Financial oversight; and
6. Board education and development, including self-evaluation.

Hiring and retaining an effective CEO — One of the most important jobs of the governing board is selecting and retaining an effective CEO. The CEO is the link between the day-to-day operations of the organization and the board. He/she is responsible for leading the organization to carry out the vision developed with the governing board. Each board is unique, and there is no single right way to identify precisely which responsibilities lie with the board, and which lie with the CEO. Therefore, it is imperative that the CEO and the governing board work cooperatively to identify respective roles and relationships. Continuing review and evaluation of the CEO by the board is then necessary to ensure that the responsibilities are being appropriately carried out.

Several issues and options that boards may wish to consider to help build strong relations between the board and the CEO of the organization are listed below:

- Understand that the selection of the CEO is a major responsibility, in that the CEO will significantly shape the future of the organization;
- Create an employment contract for the CEO which identifies terms of employment, job duties, compensation and benefits, and renewal and termination agreements;
- Use incentive compensation targeted to achievement of strategic objectives as a way to motivate, challenge and reward the CEO;
- Have realistic expectations of the CEO;
- Clarify performance expectations for the CEO in writing, identify measurable goals and evaluation guidelines, and then conduct annual reviews of the CEO's performance;
- If problems are identified, be sure that they are communicated to the CEO in a timely manner, and then allow the CEO sufficient time to correct the problems which are under his/her control;
- Recognize that the board shares ownership and bears overall responsibility for the successful management of the hospital. By approving a plan or recommendation made by the management, the board is approving the work to be done, and bears responsibility for its successful completion and outcomes;
- Support the CEO through the many difficult challenges that he/she will face; and
- Ensure that the CEO is feeling challenged and satisfied with the work.

One of the most important jobs that a governing board has is that of selection and retention of an effective CEO. The CEO is the link between the day-to-day operations of the organization, and the governing board.

Mission development and long-range planning — The responsibility and authority for determining the organization's mission, the statement that defines what the organization is and why it exists, lies with the governing board. The board is also responsible for working with senior management to develop the goals, objectives and policies that grow out of, and are measured against, the mission statement. The long-range strategic plan should be created using the mission statement as its guide, and should identify major goals and strategies to achieve these goals. The plan should be reviewed regularly to assess its ability to meet and further the mission of the organization.

Ensuring high quality care — The board is ultimately responsible for ensuring that high quality care is consistently and effectively delivered to patients. The governing board is responsible for ensuring that the staff has the support and resources necessary to enable them to fulfill their roles. The board is also responsible for reviewing the quality of medical care delivered in the hospital through the quality assurance program.

Oversight of medical staff credentialing — A major function of the hospital governing board is the establishment and use of effective policies and procedures for appointment (and reappointment) of physicians to the medical staff. The board itself is not actually responsible for the collection and validation of information used to evaluate potential medical staff. However, the board must be familiar with the criteria for medical staff appointments and reappointments in order to ensure that the hospital is following the appropriate procedures in evaluation of potential applicants.

Trustees must ensure that the hospital has a credentialing process that considers the following essential pieces of information:

- A valid license in all states that apply;
- Evidence of completed training, including an undergraduate degree, completion of a medical school education, and residency, fellowship, or other training if so claimed;
- No disciplinary actions by previous hospitals, professional societies, or specialty boards that have not been satisfactorily explained;
- Good standing at current hospitals;
- Current and adequate malpractice insurance;

- Valid board certifications, if claimed or required by the organization;
- Satisfactory recommendations regarding professional performance;
- Clinical skills, ethical character, ability to work well with others;
- Statement of health, including any histories of substance abuse or chronic illness;
- Malpractice claims history; and
- Privileges granted at other hospitals and evidence of special training and experience, especially in conducting high-risk or unusual procedures.

Trustees must be comfortable in an environment of ambiguity. They must hold fast to commitment to their community, while recognizing their institutional loyalty.[3]

Financial oversight — A hospital board's responsibilities in financial oversight are critical, as payment sources and systems are constantly changing and becoming more and more complex.

Boards have the broad responsibility of protecting the limited resources of both the organization and the community. In addition, the board must ensure the cost-effective utilization of resources and the establishment of both long-range and short-range financial plans. The board should periodically review financial reports, ensure that adequate capital is available for the organization's investment strategies, and actively participate in and encourage regular philanthropic efforts.

Board education and development, including self-evaluation — Governing boards should continually strive to understand the hospital's programs, services and needs, and the impacts of environmental trends on the hospital's long-term direction. Performance measures should be established, and the board should conduct an annual self-evaluation. Learning boards plan and manage by continuously learning about themselves and their changing environment. Continuing education is a necessity to keep leadership current on key issues, and to perpetuate high quality care. Governing board members must engage in continuous governance improvement, enhance the quality of board thinking, and make a firm commitment to improvement. In addition, board members must develop a high level of understanding, not only of the hospital and the health care field, but of the areas most critical to organizational effectiveness and performance, in order to make fast and informed decisions when the need arises.

A Visionary Board

Today's high-performance board must embrace new ideas, and new ways of thinking, and must be prepared to change with the times. A forward thinking and visionary board must not resist change; they must embrace it.

Identified below are ten key factors that contribute to being a visionary board:[1]

Board Structure

- Utilize highly-focused committees and task forces
- Create streamlined boards capable of making timely, informed decisions
- Provide strategic guidance, and hold management accountable for day-to-day leadership

Communication

- Expect strategy-oriented reports
- Discussion is driven by strategic challenges and opportunities
- Should be brief, clear and concise; written at a high level that facilitates understanding and action
- Use to enhance leadership understanding and decision making
- Use to establish a foundation for dialogue, teamwork and consensus building

CEO Evaluation
- Provide comprehensive, clear criteria
- Create mutual board/CEO agreement on scope and purpose, and tie together with compensation
- Identify specific performance goals related to strategic success

Board Self-Assessment
- Identify continuing quality initiatives by which to measure board performance
- Establish the self-assessment as an annual process
- Use the self-assessment as a means to identify improvement opportunities
- Utilize the assessment to identify education, recruitment and process needs

Membership and Selection

The governing board must see the big picture, and work with all of the information available to lead the organization in a positive direction.

- Utilize a job description and board member "profile"
- Match individual members with organizational strategic needs
- Ensure that the membership is diverse, and has a variety of well-qualified and dedicated individuals
- Key factors in board member selection should be diversity, depth, commitment, involvement and dedication

Leadership and Effectiveness
- Boards should be professional and team-oriented
- Trustees should reinforce each others' competencies and areas of expertise
- Develop a strong understanding of health care issues, challenges, and impacts

Medical Staff Alignment
- Board members must understand medical staff issues and concerns
- Physician and medical staff viewpoints should be communicated to the board through the medical staff executive committee, advisory committees, medical staff surveys and other meaningful ways
- A regular assessment of medical staff attitudes and needs should be conducted

Education and Development
- A thorough and ongoing orientation for new trustees should be established
- Peer-to-peer counseling and assistance should be used for new or "struggling" board members
- A written policy and budget for board education should be established
- Board education should be tied to strategic and organizational challenges
- Board education should be included as a part of every board meeting

Strategic Decision Making
- Agendas should match strategic issues and priorities
- Meetings should be well-organized and tightly structured
- Discussion and planning should be focused on ensuring the future success of the organization

Performance Measurement
- Visual tools should be utilized to compare past, present and future performance (graphs, charts, etc.)
- Performance should be measured against goals, and performance gaps should be identified
- Performance measurements should invite discussion and create educational opportunities

Eligibility Criteria

In order for the board to ensure access to the critical skills and capabilities required to provide effective and informed leadership, trustees must meet specific criteria, and the board as a whole must be a functional and team-oriented unit, with varying strengths and areas of expertise.

The criteria for potential board members should be developed and documented in the form of a trustee job description. Duties and responsibilities should be identified, and qualification requirements and preferred qualities should be included. Trustee job descriptions do not have to be lengthy and detailed, but rather should be an overview of skills and expertise that the nominating committee can use as a guide when recruiting new trustees.

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Effective governance: the roles and responsibilities of board members

DON L. ARNWINE

Don L. Arnwine

Running a health care organization is a team sport. It is very important that all members of the team—whether on the medical staff, in management, or on the board—understand the role of governance and what constitutes effective governance. Many misunderstandings about the roles of boards exist. Many people think that board members are paid, for example, which is not true.

My interest in the subject of governance began when I became chief executive officer (CEO) of an organization that was to establish a major health care and medical educational program in West Virginia. Five organizations merged to create the new organization; 5 boards also merged to create 1 board of 56 members. Two years after the merger, we created a governance committee to study the subject, and that's when my interest in governance began. While CEO of the Voluntary Hospitals of America, which grew from 30 to 850 hospitals during my tenure, I had the opportunity to visit with many boards. More recently, I have given 15 to 20 board retreats annually and have been an advisor to the Governance Institute. If I were allowed to focus on only one subject during the rest of my career, it would be governance.

Governance is fundamental. I have seen good boards become bad boards and bad boards become good boards. I have seen organizations fail because of problems at the governance level. Ineffective governance compromises the ability of the management to succeed. Effective governance, in contrast, greatly assists the organization. Effective governance has the following characteristics: it is efficient, allows a respectful conflict of ideas, is simple, is focused, is integrated and synergistic, has good outcomes, preserves community assets, and leads to enjoyment and personal reward for the individual board members.

In the sections that follow, I review the roles and responsibilities of boards, factors that increase board effectiveness, and the evolution of governance.

ROLES OF BOARDS

Boards have 3 primary roles: to establish policies, to make significant and strategic decisions, and to oversee the organization's activity.

Policy making

Effective execution of policy is necessary to fulfill the other 2 roles. Policies define focus and differentiate responsibilities among the board, the management, and the medical staff. Well-written policies lead to more efficient board functioning. Instead of having the same matter or very similar matters on the agenda repeatedly, the board can develop a policy that covers the issue and leave implementation of the policy to management. Boards have approximately 24 hours together each year, spread over regular meetings. It is essential to use that time wisely.

At the same time, board-level policies should be reviewed regularly. At Baylor Medical Center at Irving, where I chair the board of trustees, we asked a staff member to review past board minutes and extract all policies. We then refined and consolidated them. The board now reviews policies annually to see if they are still needed.

Decision making

Decision making involves making choices about the organization's vision, mission, and strategies. Boards make decisions about issues that are strategic and significant, such as whether to enter an affiliation agreement with another organization. As decision makers, boards can also delegate nongovernance types of decisions to others—and would be wise to do so.

Oversight

Oversight is an important function, but boards must remember that the organization is theirs to oversee, not to manage. Some boards cross the line and try to involve themselves in management. Nevertheless, in the oversight role, the board is legally responsible for everything that happens within the hospital, whether in the emergency department, a clinic, or a nursing unit. In the area of quality, for example, the board's oversight role may include setting the tone by stating that the organization is committed to quality; establishing policies related to quality, such as credentialing; ensuring that mechanisms are in place, such as committees, to establish a plan for quality; and monitoring implementation of the plan.

Board committees play an important role in the governance process. It is useful to periodically review the structure and func-

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tions of the committees and to ensure that everyone knows what to expect from them.

RESPONSIBILITIES OF BOARDS

Boards have numerous responsibilities: they oversee management, finances, and quality; set strategic direction; build community relationships; establish ethical standards, values, and compliance; and select a CEO and monitor his or her progress. I believe that the 2 most important tasks are selecting the CEO and establishing the direction of an organization. Although the management team develops the strategic plan, it is the board's responsibility to accept or modify the strategic plan and to set the direction. The board considers elements in the environment—such as growing competition and changing patterns of care—and develops a vision, a mission, strategic thrusts, goals, and tactics that respond to the environment, all the while showing the organization's values.

Financial oversight is a familiar job that boards usually do well. Boards ensure the use of financial controls; ensure that funds are prudently invested, considering cash management, banking, and contracting parameters; and establish policies related to budgets. Their goal is to protect the community's assets. Oversight of the quality area often involves utilization and risk management in addition to continuous quality improvement.

Attention to community relationships is a responsibility unique to not-for-profit institutions. Inasmuch as board members have contact with the community, they can be sensitive to the expectations and needs of its citizens and bring that knowledge to the board room. The focus is on all those the organization serves: consumers, businesses, elected representatives, payors, and collaborators. Boards are paying more attention to the quality of life in their communities. At Baylor Medical Center at Irving, for example, the board has adopted a community action plan developed by the management team.

The ethical standards of the organization are determined by the behavior of the board. Through its ongoing actions, the board decides what behavior will and will not be tolerated. These actions supersede ethical statements—however important such statements are—in showing an organization's true values. In recent years, compliance issues have risen to board-level responsibility as well, particularly as the media have reported people being sent to jail and organizations and individuals being fined millions of dollars for breaches in government regulations. Compliance is probably the only new issue that has been added to board responsibilities over the past 10 years.

When reviewing these responsibilities, it is important to note that the board as a whole, and not any individual member, has the authority. Further, the board exists only when it is in session. The committee is an appendage of the board, and the board can delegate certain tasks to a committee or an individual, but otherwise an individual board member has no prerogative. Thus, it would be inappropriate for a board member to walk in to a manager's office and ask to review the books or demand certain changes. Such actions, in fact, can cause much disruption. The CEO is the full-time agent of the board and is the only person directly accountable to the board.

THE "WHEEL OF GOVERNANCE": 3 INGREDIENTS FOR AN EFFECTIVE BOARD

The wheel of effective governance has 3 spokes: behavior, structure, and expectations. If one of these spokes breaks down, the board will have a flat tire, and the faulty governance process can compromise the organization's ability to move forward.

Behavior

Appropriate board behavior can be defined as functioning in accord with the board's roles and responsibilities. Thus, board members should know the difference between governance and management, see service as a responsibility of citizenship, and find enjoyment in such service. Appropriate behavior also has key characteristics, the first of which is respect—for the organization, the management, the clinicians, the employees, and other members of the board. Respect is basic, but it doesn't always exist. I've seen many boards whose members were antagonistic towards large segments of the medical staff, for example. Such behavior is distracting and counterproductive.

Respect leads to 2 additional behavioral characteristics that are needed: openness in the board discussions and confidentiality. The two go hand in hand. Last year, when I was asked to consult with a CEO and chairman of the board to improve the climate of the board and eliminate the cliques that seemed to be forming, I discovered that the problems had arisen because of breaches in confidentiality. Some board members were speaking casually about board activities among people at their churches or at parties; others felt they couldn't be open because of this breach. The more sensitive the issue under discussion, the more important confidentiality becomes. As one board chairman used to say, "What you hear here or see here or do here, when you leave here let it stay here."

Conflicts of interest also fall in the category of behavior. Some people believe that a potential conflict of interest precludes service on the board. Based on such a view, some hospital boards do not include physicians, claiming that they could have a conflict. I disagree with this view. An attorney friend of mine told me that there's no evil in conflict of interest; the evil lies in the hiding thereof. All boards need to have a policy about conflict of interest. Usually this policy requires all members to disclose potential conflicts and to abstain from voting on such matters.

Another behavioral element is distinguishing between the important and the unimportant. The board has limited time. If it spends hours and hours on trivial matters, it won't be able to address significant and strategic matters.

Finally, the board needs to work for consensus. In not-for-profit organizations, members don't "vote their shares," with one individual being able to carry the day. Instead, boards work by reaching a common understanding of the issues, dealing with the options, choosing one, and unanimously supporting the decision even if an individual initially voted against it. Unity on the final decision is essential; if it does not exist, some people will take advantage of the discord and create problems. Team players are needed, people who join the board because they support the organization's mission and values. Board members do not participate to implement individual agendas but to help the organization effectively meet its responsibility in the community. The

Table 1. Desired characteristics of board members

I. Knowledge
- Understands and subscribes to the organization's mission and values
- Understands the economics of health care and the plan and budgets required to achieve the organization's mission
- Knows the organization's current financial position
- Understands community demographics and needs
- Knows how to build partnerships with other community groups
- Understands the complexity of the organization's challenges
- Has a grasp of medical information, technology, trends, and consequences
- Knows the difference between governance and management
- Knows how to be a "team player": when to listen and when to speak up
- Sees social/volunteer service as a responsibility of citizenship
- Understands real estate, physical facilities, and land development

II. Skills
- Can work to build consensus
- Can work with and be supportive of administrative and clinical staff
- Is adept at strategic and financial planning
- Has strong communication skills
- Can deal with diverse groups and ideas in a constructive way
- Can interpret financial information
- Has experience in a field or endeavor that contributes to the disciplines that affect the organization, i.e., insurance/managed care, medicine, law, finance/banking, real estate, marketing, information technology, public policy, corporate management, etc.
- Knows how to differentiate the important from the unimportant

III. Attitudes and personal characteristics
- Feels that collaboration is necessary for success
- Possesses openness and honesty
- Subscribes to and practices a high moral standard
- Is optimistic but realistic
- Values personal growth and learning, particularly covering matters confronting the board and the organization
- Sees self as a servant leader
- Accepts that the board has the authority and that individual board members have none (unless delegated by the board)
- Is personally challenged by what is best for the organization and the community
- Can be decisive and comfortable with large-scale decisions
- Accepts that change is our constant companion

"goodwill quotient" is exceedingly important, and these behavioral aspects will contribute significantly to that.

Structure

Boards may not pay much attention to structure, thinking that it is covered in the bylaws and requires no further comment. Nevertheless, problems often arise from structure rather than behavior. For example, I've encountered several boards in which the chairman had served for ≥30 years, and members were discontented and ready for someone new. Many board bylaws do not address tenure. Whether the term limit is 2 or 3 years or something different, it is helpful if everyone knows what to expect. Dissatisfied members know that they will be able to vote for someone else, and volunteers may be more willing to take on the role of chairman if they know it is for a designated period. Other issues may concern the frequency of meetings or the size of the board.

I believe strongly in agenda creation and management. Since the board's deliberations are determined by the agenda, that one

Table 2. A sample board service commitment letter*

I, _____, recognizing the important responsibility I am undertaking in serving as a member of the board of trustees of this organization, hereby pledge to carry out in a trustworthy and diligent manner the duties and obligations in my role as a board member.

The organization will be governed by individuals selected for their experiences and personal attributes. No individual will be selected because of his or her membership in or representation of any particular constituency. Once selected, each individual shall be required to fulfill his/her fiduciary duty with care and loyalty in the best interest of the system and the people it serves. The following characteristics will be utilized in selecting people to serve.

My role: I acknowledge that my primary roles as a board member are 1) to contribute to defining the organization's mission and governing the fulfillment of that mission, and 2) to carry out the functions of the office of board member as stated in the bylaws.

My role as a board member will focus on the development of policies that govern the implementation of institutional plans and purposes. This role is separate and distinct from the role of the chief executive officer, who determines the means of implementation.

My commitment: I will exercise the duties and responsibilities of this office with integrity, collegiality, and care.

Pledge
- To establish as a high priority my attendance at all meetings of the board and committees on which I serve.
- To be prepared to discuss the issues and business addressed at scheduled meetings, having read the agenda and all background material relevant to the topics at hand.
- To maintain the confidentiality of what is said or seen at board or board committee meetings.
- To work with and respect the opinions of my peers who serve on this board.
- To always act for the good of the community and the organization.
- To represent the organization in a positive and supportive manner at all times and in all places.
- To observe the parliamentary procedures and display courteous conduct in all board and committee meetings.
- To refrain from intruding on administrative issues that are the responsibility of management, except to monitor the results and prohibit methods that conflict with board policy.
- To avoid conflicts of interest between my position as a board member and my personal life. If such a conflict does arise, I will declare that conflict before the board and refrain from voting on matters in which I have conflict.
- To support in a positive manner all actions taken by the board of trustees even when I am in a minority position on such actions.
- To agree to serve on at least one committee or task force and participate in the accomplishment of its objectives.
- To participate in the annual strategic planning retreat, board self-evaluation programs, and board development workshops, seminars, and other educational events that enhance my skills as a board member.

If, for any reason, I find myself unable to carry out the above duties as best I can, I agree to resign my position as a board member.

*Modified from Gillis J. *1995 Board Member Manual.* Gaithersburg, Md: Aspen Publishers, 1994.

document relates closely to the board's effectiveness. The agenda can be organized into 3 categories: items for information, items for action, and items for strategic discussion. This agenda organization helps members know what is expected of them and eliminates worry, for example, about having to vote on an item that is just for information. If executive committees and task forces are appropriately established and charged, the board can trust their efforts and avoid recreating what happened at a committee meeting. Committee suggestions and other smaller, noncontroversial action items can be grouped into a "consent agenda," requiring only one motion and one vote. Background information on items in the consent agenda can be provided in the board book sent out before the meeting. Use of a consent agenda saves time and allows the board to focus on the most significant issues.

Structure also includes the nomination of new members. At Baylor Medical Center at Irving, we keep a matrix that indicates current members' skills in 8 essential areas. If attrition occurs, we look at the matrix and determine which skills are needed most. While the list of desired characteristics of board members developed by the Governance Institute is long *(Table 1)*, it is understood that every board member will not have all the attributes. The average hospital board—now 12 members—is smaller than it used to be and includes physicians (both internal and external to the community).

Expectations

The final spoke consists of expectations or, more specifically, board members' knowledge of what is expected of them and what they can expect from others. One of the best ways to clarify expectations is to have new members sign a letter that outlines those expectations *(Table 2)*. Such a document also makes it easier to remove a board member if, for example, his or her attendance has been poor. It also serves to clarify the requirements of board membership when approaching a potential volunteer.

In return for their service, board members should expect respect, a proper orientation, proper flow of communications, advanced preparation for board discussions, judicious use of their time, educational opportunities, and the opportunity to contribute. In addition, boards should be able to expect "no surprises." Boards will be comfortable with the CEO if they feel that he or she is being open with them. More than anything else, surprises damage the board's comfort level; members worry that other important matters are not being communicated. Finally, the board member can expect to participate in a board that is well led, informed, experienced in proper board function, well sized, properly motivated, consistent, a unit, and respectful of management and professionals.

THE EVOLUTION OF GOVERNANCE

The focus of governance has evolved. When hospitals were being built after World War II, roles focused on stewardship, civic duty, and fundraising. Today, the focus is on management oversight, financial management, and community response. The focus of the future is on strategic performance. The board needs to ensure that it has the right expertise around the table to deal with critical issues of the time. Today, for example, boards may need expertise in information technology, just as in an earlier era they needed expertise in architecture and construction. Other critical issues to be addressed by boards today include declining reimbursements, physician relationships, consumer and community relationships, and philanthropy.

If boards understand their roles and responsibilities, have a proper structure including well-chosen members, exhibit appropriate behaviors, and know what is expected of them, they can live up to the challenges of the future and keep health care organizations on track for the good of the community.

https://www.healthstream.com/resources/blog/blog/2019/02/04/10-healthcare-trends-to-watch-in-2019

10 Healthcare Trends to Watch in 2019

February 04, 2019

This post is taken from an article by Robin L. Rose, MBA VP, Healthcare Resource Group, HealthStream, where she looks ahead at the coming year, with an eye to big picture trends that could have a significant impact on how we provide and experience care.

Nothing in Healthcare Should Be Taken for Granted

The healthcare industry as we have known it is disappearing. A multitude of factors such as ever increasing prices, growing numbers of seniors, serious provider shortages, and a lack of affordability, even for many with good insurance, are driving change. New technologies, such as artificial intelligence, are slowly infiltrating the industry. Disrupters like Amazon are seeing opportunity amidst the turbulence, and usage and practice patterns are changing dramatically as the industry attempts to move from fee-for-service to value-based care. Although change always takes a bit longer than we think or expect, it is inevitable in this case. When we look back in 10 years, healthcare practice and delivery may be unrecognizable from what we experience today. The following are ten of the trends driving this transformation.

1. Amazon is becoming a major disrupter in many areas of healthcare.
2. Healthcare costs are becoming scarier than the illness itself.
3. We need to prepare for new health risks.
4. Artificial Intelligence (AI) is dramatically changing healthcare.
5. We are finally addressing population health.
6. CMS is changing course.

https://www.healthstream.com/resources/blog/blog/2019/02/04/10-healthcare-trends-to-watch-in-2019

7. We need more joy in the work of healthcare.

8. The nursing shortage is getting worse.

9. Physicians are in short supply too.

10. Digital healthcare organizations are emerging.

https://blog.definitivehc.com/top-8-healthcare-trends-2019

TOP 8 HEALTHCARE TRENDS IN 2019

MARCH 19, 2019 BY TORY WALDRON

Recently, our CEO, Jason Krantz, hosted a webinar: 8 Healthcare Trends that Will Impact your Sales in 2019.

We were excited to have over a thousand attendees participate in a live Q&A and survey, which asked "Which trends covered today are the most important to you?" In this survey, consolidation won by a landslide:

1. Consolidation – 288 votes
2. Consumerism – 164 votes
3. Telehealth – 158 votes
4. AI & Machine Learning – 128 votes

https://blog.definitivehc.com/top-8-healthcare-trends-2019

5. Staffing Shortages – 127 votes
6. Cybersecurity – 108 votes
7. Ancillary Technology – 108 votes
8. Wearables – 61 votes

Did you miss the webinar? Here is a recap, in order of our viewers' preferences:

1. Industry consolidation & new entrants

The healthcare industry is consolidating rapidly as it moves toward value-based care. In 2018, Definitive Healthcare tracked an astounding 803 mergers and acquisitions (M&As) and 858 affiliation and partnership announcements, which means that consolidations were taking place almost every single business day of the year.

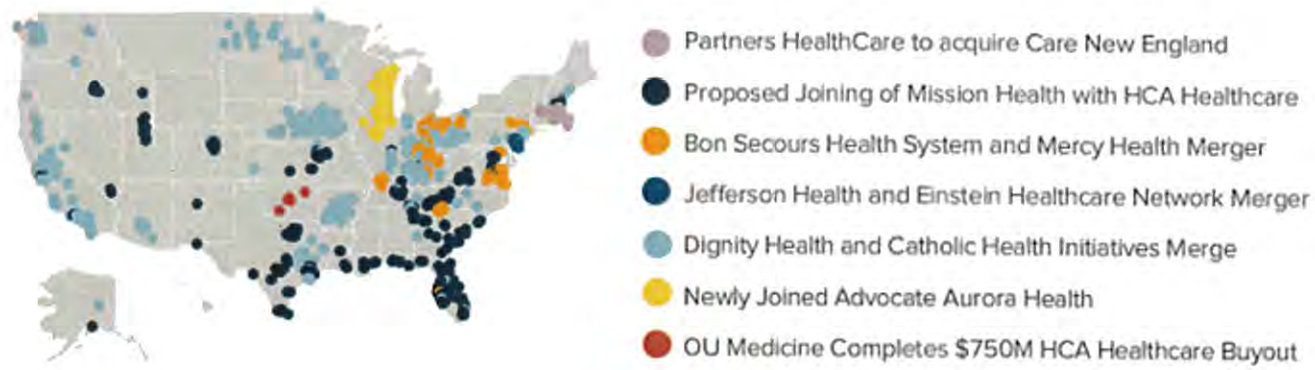

Fig 1: 2018 M&A data from Definitive Healthcare's platform

There are conflicting views on what all of this means. Some see the consolidation trend as a movement toward lower costs and better care, as smaller hospitals become affiliated with bigger healthcare systems and better technologies, but others are concerned about the growing power of healthcare industry giants. Either way, this trend is here to stay – and is even slated to accelerate over the next few years.

2. Consumerism

The healthcare consumer today is frugal, technology savvy, and seeking convenience:

- **Cost**: 65 percent of commercial insurance respondents selected cost as a top factor when choosing where to seek care.
- **Technology-driven**: Patients are increasingly looking at online reviews, transparent pricing, and satisfaction ratings for local providers to determine where they will go to get their treatments.
- **Convenience:** McKinsey's surveys show the growing proliferation of post-acute environments, like retail clinics. In fact, over the past four years, consumers who report using retail clinics has climbed from 9 percent to 24 percent in younger generations.

Personalization is becoming very important – there's no longer a "one-size-fits-all" care model in place, and we see this in the reduction of the number of people that see a primary care provider. Younger generations may be content to simply visit a nearby urgent care clinic to receive treatment.

3. Telehealth

According to Definitive Healthcare's 2017 Inpatient Telemedicine Study, over 70 percent of consumers would rather use video than visit their primary care provider in person. Telehealth is already growing fast, accounting for almost $22B in 2017, and it is expected to reach $93.45B by 2026.

4. AI & machine learning

Artificial Intelligence is the most talked about technology since the cloud, and for a good reason. There is an explosion of data in our society with 2.5 quintillion bytes of data generated each day. Hospitals, in particular, have more data than they know what to do with. The first wave of technology adoption in hospitals has been focused on collecting process, patient, financial, and organizational data, but now there is an increasing need to move toward understanding and utilizing this data to decrease costs and improve care. Many hospitals are starting to turn toward artificial intelligence to solve this problem.

5. Staffing shortages

There are two reasons behind the recent healthcare staffing shortage – a shifting workforce and shifting patient demographics. Approximately 55 percent of all

registered nurses are 50 years old or older, and 52 percent of the active physician workforce is 55 or older.

With an aging population, we need more care than ever, but there are fewer nurses and physicians available. On top of this, regulations are changing. For example, in 2018, Massachusetts had a ballot question that would have required an increase in the nurse-to-patient ratio. Although this particular question did not pass, other states may place similar votes on the ballot to increase the mandated ratio of nurses to patients – making this issue even more prominent.

6. Cybersecurity

An increase in mergers and acquisitions have created new vulnerabilities in information sharing. In 2018 alone, we saw many data breaches that exploited healthcare records; eight of those breaches exposed over 500,000 healthcare records, and three of those breaches revealed over a million. These attacks are high-profile and often highly-targeted, with the majority being financially motivated. Healthcare is already high stakes with personal, sensitive data – and will continue to be a main target for attacks in the coming years.

7. Optimization & Ancillary Technology

Currently, the healthcare technology install base is varied. There are many different vendors targeting different areas of the market, and this creates a lot of barriers to interoperability. If you look at the vendor market share for outpatient EHR systems, you can see that there are over 18 different vendors across the space.

https://blog.definitivehc.com/top-8-healthcare-trends-2019

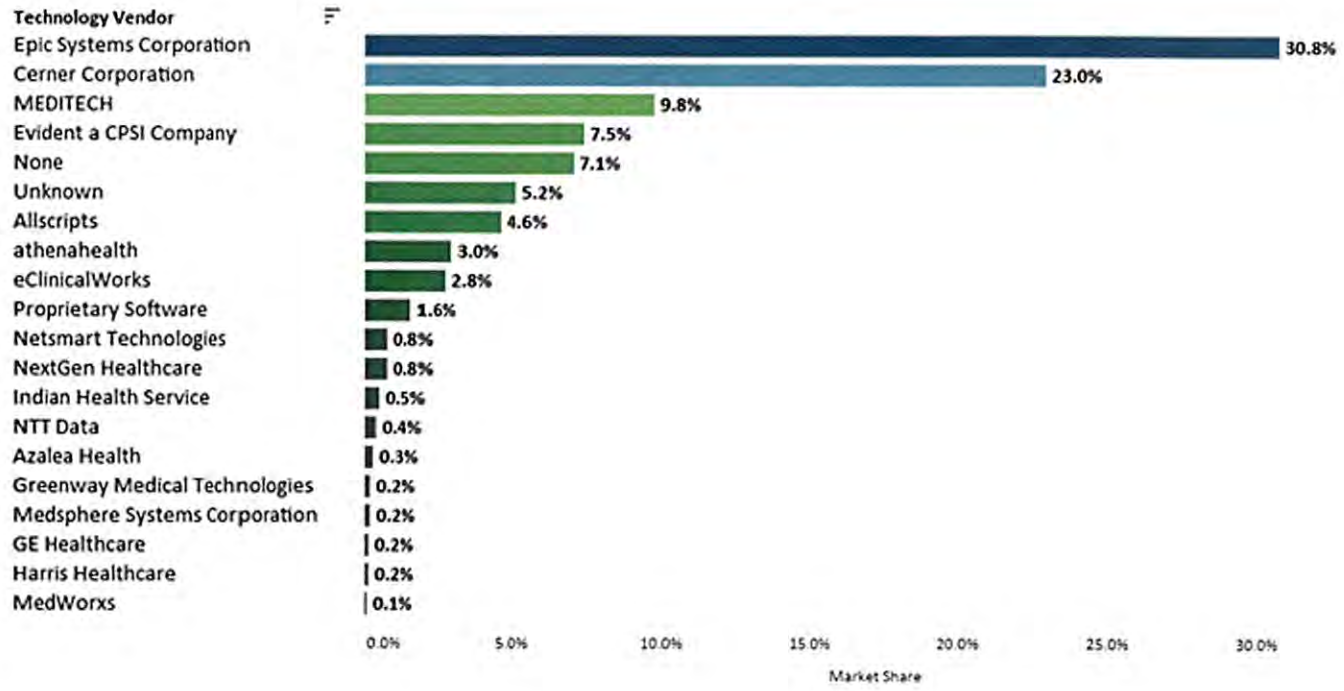

Fig 2: Vendor market share of outpatient EHR technologies from the Definitive Healthcare platform, accessed March 2019

Clearly, the healthcare technology space is crowded and complicated. Information systems need to be able to send a patient's medical information back and forth in a coordinated manner - within and across organizational boundaries - in order to access and exchange data sets. In 2019, there will be a greater shift toward semantic operability, which allows information management systems to interpret and derive insights from the shared data.

8. Wearables

The wearable and remote patient monitoring market has just started to take off; the Apple watch can now detect irregular heart rhythms and diabetics can monitor their blood sugar levels with digital glucose monitors.

This trend is still in its early stages, with only 1,800 hospitals using mobile applications (less than 25 percent of all U.S. hospitals), according to Definitive

https://blog.definitivehc.com/top-8-healthcare-trends-2019

Healthcare's data. But, the wearable market is projected to reach $12.1B by 2021 and the remote monitoring market is projected to grow to $31.3B by 2023 – almost double where it is today.

Small Rural Hospital and Clinic Finance 101

Updated July 2018

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PURPOSE

This manual was developed for use by state Medicare Rural Hospital Flexibility (Flex) Program personnel as well as staff and boards of critical access hospitals (CAHs), small rural prospective payment system (PPS) hospitals and provider based rural health clinics (RHC). The content is designed to be as non-technical as possible and to provide answers to frequently asked questions regarding CAH, PPS and RHC finance and financial performance.

GOVERNMENT INSURANCE PROGRAMS

What is Medicare?

The Medicare program, an amendment to Social Security legislation known as Title XVIII, provides medical coverage to all Americans 65 years of age and older. The bill was signed into law by President Lyndon B. Johnson in 1965 and took effect in 1966. The enactment of the Medicare program was significant because it was the beginning of the federal government's role as a major financer of health care. Medicare is health insurance for people 65 or older, people under 65 with certain disabilities and people of any age with End-Stage Renal Disease. Medicare is funded by both Social Security payroll taxes and insurance premiums, with coverage categories divided into "Parts." Medicare Part A is the hospital insurance portion of the program and includes acute hospital inpatient care and inpatient skilled nursing care. Medicare Part B is the medical insurance component and includes coverage for doctor visits and outpatient care. Medicare Part C, known as Medicare Advantage, covers both Part A and Part B options. And, Medicare Part D is the prescription drug coverage component of the program, which went into effect on January 1, 2006.

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care
- Most people do not have to pay a premium for Medicare Part A because they, or a spouse, paid Medicare taxes while working in the United States. If they do not automatically get premium-free Part A, they may still be able to enroll and pay a premium.

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment and home health care
- Helps cover some preventive services
- Most people pay up to the standard monthly Medicare Part B premium
- Some Medicare recipients buy coverage that fills gaps in Medicare coverage, such as Medicare Supplemental Insurance (Medigap)

Medicare Part C (also known as Medicare Advantage)

- Offers health plan options run by Medicare-approved private insurance companies. Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
- Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
- Some Medicare Advantage Plans may include additional benefits for an additional cost

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs
- Run by Medicare-approved private insurance companies
- Costs and benefits vary by plan

What is Medicaid?

Medicaid is health coverage available to people and families who have limited income and resources. It is funded both by the federal government and state governments but is managed at the state level. The program was enacted in 1965 as Title XIX of the Social Security Act. The funding of Medicaid is a major component of state spending, on average comprising 25 percent of the total state budget. Nationally, 60 percent of Medicaid spending goes toward acute care services and over a third goes toward long-term care services.

Medicaid recipients who are disabled or elderly may also receive coverage for services such as nursing home care or home and community-based services. Depending on the state's rules, individuals may also be asked to pay a small part of the cost (copayment) for some medical services. If an

individual qualifies for both Medicare and Medicaid, most of their health care costs will be covered, including prescription drug coverage.

Frequently, nursing home residents run out of financial resources during their stay, at which point they become eligible for Medicaid coverage. States attempt to control the costs by ensuring that those receiving Medicaid benefits are truly eligible and at times adopt payment methodologies of the Medicare program. Because Medicaid programs are managed at the state level, there is state-to-state variation in eligibility requirements, coverage and reimbursement.

Medicaid reimbursement, in general, is lower than both Medicare and private insurance reimbursement. Thus, the proportion of Medicaid business for any health care organization is particularly relevant to its financial performance. Moreover, because Medicaid programs place stress on state budgets, state regulators often carry out cost containment measures to reduce Medicaid spending. State cost containment activities include the reduction of payments to providers, reduction in covered services and reduced pharmacy benefits. As of April 2014, 13 states receive cost-based reimbursement for inpatient services. In addition, as of July 2016, 16 states receive cost-based reimbursement for outpatient service. For information on state-specific Medicaid reimbursement rates for CAHs, please visit: https://www.ruralhealthinfo.org/topics/critical-access-hospitals#medicaid.

What is Children's Health Insurance Program (CHIP)?

The Children's Health Insurance Program (CHIP) provides access to low cost health insurance coverage for children in families who earn too much to qualify for Medicaid but not enough to be able to buy private health insurance. These families are eligible for free or low-cost health insurance that pays for doctor and dental visits as well as prescription drugs, hospitalizations and more.

GOVERNMENT HEALTH CARE REIMBURSEMENT

What is the prospective payment system?

In 1983, the payment methodology for inpatient acute hospital care (Medicare Part A) changed from cost-based reimbursement to a prospective payment system (PPS). In this new payment system, all the various clinical diagnoses were classified into groups called Diagnosis Related Groups

(DRGs). With the establishment of DRG categories, of which there were more than 500, hospitals were paid a fixed amount to treat each patient based on age, sex, International Classification of Diseases (ICD) diagnoses, procedures, discharge status and the presence of comorbidities or complications. Subsequently in 2007, Medicare updated this methodology to Medicare Severity-Diagnosis Related Groups (MS-DRG) of which there are approximately 1,000 categories. Upon admission, each patient is assigned a MS-DRG based on his or her primary diagnosis, for example, pneumonia. The hospital is then paid a specific dollar amount for that pneumonia patient based on the MS-DRG code assigned. Some patients need more anticipated services to treat their specific ailment(s), while other cases require fewer services. Regardless, the hospital is still paid the same amount for that MS-DRG code. Naturally, some diagnoses, and their corresponding MS-DRGs, have very high levels of complexity and thus are more costly to treat. For example, a heart transplant is vastly more complicated and requires more resources than a normal newborn birth. Consequently, MS-DRG reimbursement for heart transplants is higher than for the normal newborn MS-DRG.

Base MS-DRG rates can be adjusted for several reasons, including a hospital's location. Just as the cost of living in the United States varies by location, the cost of providing health care varies by location as well. A heart transplant performed in San Francisco, California, would likely cost more than one performed in Omaha, Nebraska, due to wage differences, supply costs differences, etc. The MS-DRG system adjusts for this by varying MS-DRG payments according to market forces across the country.

Inherent in the MS-DRG reimbursement system is the incentive for hospitals to treat and discharge patients as quickly as possible. Because this reimbursement program pays hospitals on a per-patient basis, there is a financial incentive for hospitals to treat as many patients as possible, as efficiently as possible. By discharging patients in a timely manner, it frees more bed space which can be used to treat more incoming patients. Additionally, the reduced number of days spent in the hospital for a given patient reduces the required resources and associated costs of caring for that patient. In this way, for any MS-DRG, a shorter length of stay can be more profitable for the hospital than a longer length of stay. However, it is important to note that Medicare has implemented some reductions in payment under the MS-DRG methodology when the Medicare beneficiary is discharged before the Medicare average length of stay with a discharge to a

covered skilled nursing stay in a nursing home or to a home health agency. Because of this direct impact on profitability, the Average Length of Stay metric is used by hospitals to assess the efficiency of their organization.

Outpatient services are reimbursed prospectively under one of three methodologies. The first methodology is the Clinical Lab Fee Schedule. This fee schedule applies to outpatient lab services rendered by prospective payment hospitals. The second methodology is the Medicare Physician Fee Schedule which provides for the payment methodology for outpatient therapies (i.e., Physical Therapy, Occupational Therapy and Speech Therapy). Under these methodologies, the payment is based on a fee schedule that is assigned according to the Current Procedural Terminology (CPT) codes reported for the services. The final methodology is the Ambulatory Payment Classification (APC) methodology. Initially implemented by CMS in 2000, this methodology provides for payments of services by grouping a CPT code or group of CPT codes into an APC classification. Each APC classification then has a payment level assigned. This methodology provides for significant bundling of services.

What is the Medicare Swing Bed program?

As discussed earlier, hospitals are reimbursed on a MS-DRG basis for inpatient acute care. Often, patients who require acute inpatient services require inpatient rehabilitative aftercare or skilled nursing care. MS-DRG acute payment rates are set based upon the resources required to treat the acute condition only and not those expended on the subsequent rehabilitation. Therefore, the Medicare program created a separate reimbursement system to compensate providers for the extended care service they provide. The amount of extended care required by patients for any condition is highly variable because of differences in age, overall health and other factors that determine the speed of recovery. Due to this length of stay variation, hospitals receive reimbursement based on the overall assessed condition of the patient, the amount of which is determined by the assigned Resource Utilization Group (RUG).

The RUG system classifies patients into one of 66 RUG levels, based on the expected amount of provider resources to be expended. RUG payments are larger for most severe conditions that require a great deal of attention and service. In cases in which extended care is required, PPS hospitals receive two payments for a patient: MS-DRG payment for the treatment of the acute

condition and the RUG payment for care offered to patients after the acute treatment.

The Medicare swing bed program allows hospitals with 100 beds or fewer to provide both acute care treatment and skilled nursing treatment to patients without having to physically move the patient to another bed. The hospital receives both forms of reimbursement described above, simply by discharging patients from acute care beds and admitting them to skilled nursing beds when the patient meets the coverage guidelines for skilled care. The skilled nursing bed is sometimes referred to as a swing bed because the hospital swings a bed from an acute care designation to a skilled nursing designation. Patients must be in the medically necessary acute care bed for at least 72 hours before they can be discharged to a swing bed unless a waiver has been granted by CMS to the provider as a participant in special Medicare programs (i.e., Tracks 1+ and 3 accountable care organizations (ACO)).

What is CAH cost-based reimbursement?

During the 1980s and 1990s, almost 400 hospitals closed across the US because of financial losses from the PPS system. In 1997, the Balanced Budget Act created the Medicare Rural Hospital Flexibility (Flex) Program and CAH provider type. Medicare pays for the same services from CAHs as for other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days). However, CAH payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

CAHs receive cost-based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients depending on the policy of the state in which they are located). Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101 percent of costs on all of their hospital Medicare revenue. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports.

What is CAH Medicare ambulance reimbursement?

Under Medicare ambulance reimbursement, if a CAH, or an entity that is owned and operated by the CAH, is the only provider or supplier of ambulance service located within a 35-mile drive of that CAH, the CAH, or

the CAH-owned and operated entity, is paid 101 percent of the reasonable costs of the CAH or entity in furnishing ambulance services. Additionally, if there is no other provider or supplier of ambulance services within a 35-mile drive of the CAH but there is a CAH-owned and operated entity furnishing ambulance services that is more than a 35-mile drive from the CAH, that CAH-owned and operated entity can be paid 101 percent of reasonable costs for its ambulance services as long as it is the closest provider or supplier of ambulance services to the CAH.

What are allowable costs for 101 percent cost-based reimbursement from Medicare?

Medicare pays CAHs for most inpatient, outpatient and swing bed services to Medicare beneficiaries on the basis of reasonable cost. Reasonable cost is the cost that was incurred to provide a medical service, to the extent the cost is necessary to efficiently deliver that service. Expenses must be prudent and reasonable as well as related to patient care. For a condensed list of allowable vs. non-allowable expenses, please refer to Table A below.

Table A. Allowable Costs in CAH

Type of Expense	Allowable or Not Allowable
Public education	Allowable
Employee recruitment	Allowable
Taxes based on income	Not Allowable
Sales tax	Allowable
Property taxes	Allowable
Entertainment	Not Allowable
Civic organizations	Allowable
Legal fees	Depends on activity
Collection agency fees	Allowable
Political/lobbying costs	Not Allowable

What is the difference between PPS and cost-based reimbursement?

PPS is a system where payment levels are set ahead of time or prospectively before health care services are delivered, as opposed to after the diagnosis

and treatment. Because rates are set prior to services, each service has a pre-determined rate associated with it. These rates are based on estimates of the resources that must be expended for any particular service (i.e., physician time and effort, supplies, etc.). In this way, this reimbursement system attempts to appropriately match payments to the acuity of patient illnesses. For example, hospitals are paid a fixed amount for performing a hip replacement and a different fixed amount for treating a patient with heart failure. This type of reimbursement methodology controls for costs because providers are paid a fixed rate per service, regardless of the costs they incur.

What is Optional (Method II) Billing?

A CAH may elect the Optional (Method II) Payment Method under which it bills the fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) for both facility services and professional services to its outpatients on a single claim. Eligible medical professionals affiliated with CAHs can elect the Optional (Method II) Payment Method whereby the CAH bills on behalf of these professionals for their outpatient services. These services include when a CAH physician reassigns outpatient billing services to the CAH, for example, in pathology, radiology, emergency room, outpatient surgery and outpatient clinics. This payment does not include services provided at a rural health clinic and only applies to the CAH outpatient services.

It is important to note that Optional (Method II) Payment Method billing is setting-specific, not provider-specific. If a provider works in an RHC, they cannot use Optional (Method II) Payment Method for those clinic services. However, if that same provider also provides outpatient services in the CAH, that provider could use Optional (Method II) Payment Method for those outpatient CAH services under the Optional (Method II) Payment Method based on the sum of:

- For facility services: 101 percent of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner has reassigned his or her billing rights to the CAH; and
- For physician professional services: 115 percent of the allowable amount, after applicable deductibles and coinsurance, under the Medicare Physician Fee Schedule. Payment for non-physician practitioner services is 115 percent of the amount that otherwise

would be paid for the practitioner's professional services under the Medicare Physician Fee Schedule.

Physicians reassign their billing to the hospital and the hospital must do the billing. All providers of the CAH do not need to use Optional (Method II) Payment Method but can individually elect to do so. Overall, it is beneficial for the CAH to elect the Optional (Method II) Payment Method, as it results in higher reimbursement. However, software and other system limitations can make it difficult to impossible to implement this methodology.

In the past, if a CAH chose to be paid under the Optional (Method II) Payment Method, it was required to make that election on an annual basis. However, in the Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS) Final Rule, CMS changed the regulations for the optional method election. Effective for cost reporting periods beginning on or after October 1, 2010:

- If a CAH elects the optional method in its most recent cost reporting period beginning before October 1, 2010, that election remains in place until the CAH submits a termination request to its FI/MAC. CAHs will no longer be required to make an annual election. However, the CAH must continue to submit 855R forms for any newly hired/contracted practitioners.
- If a CAH chooses to make a change or terminate its optional method election, the CAH will need to notify its FI/MAC in writing at least 30 days prior to the start of the next cost reporting period

What is a Medicare Administrative Contractor (MAC)?

Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established Medicare Contracting Reform (MCR). This statute required the Department of Health and Human Services (HHS) to replace Medicare's 48 carriers and fiscal intermediaries who process Medicare Part A and B Fee-for-Service claims with the new MAC authority. The primary reasons for instituting this change were to increase the contractor's efficiency in the receipt, processing and payment of Fee-For-Service claims. For more information on the MACs, please visit: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html.

If CAHs are reimbursed at 101 percent, why might they not make a profit?

Some CAH expenses, such as recruiting and bad debts, are not included in the cost-based reimbursement formula. In addition, a 2 percent sequestration reduction applies to Medicare's portion of the reimbursement after deductibles and coinsurance has been calculated. Therefore, CAHs earn less than 101 percent of cost for care of their Medicare patients. Consequently, profitability of CAHs is dependent on private insurance business, for both inpatient and, increasingly, outpatient services. Private insurance payors do not reimburse CAHs on a cost basis, but rather follow a PPS system or reimburse on a percent of charges. In fact, the profitability of commercial business is enhanced because of the cost-based reimbursement received for Medicare/Medicaid revenue.

Suppose a CAH administrator decides to purchase and install a CT scanner for $1 million and assume 40 percent of patient care at the CAH in the CT department is Medicare revenue. The CAH will receive $400,000 in cost reimbursement over the useful life of the scanner ($1 million * 40 percent = $400,000) from Medicare for their portion of this scanner used to serve patients. This reduces the hospital's remaining costs for the CT scanner to $600,000. The use of the scanner from other patients would need to be available in order to offset the remaining costs based on overall demand.

It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers. When performing financial assessments of CAHs, it is essential to evaluate both the proportion of private insurance business as well as the rates negotiated with the private payor.

What is a hospital cost report?

The Medicare Cost Report is a financial document filed annually by all Medicare providers participating in the program, including: hospitals, skilled nursing facilities, home health agencies, RHCs, federally qualified health centers (FQHC), hospice, renal dialysis and home office. The Medicare Cost Report is submitted annually to CMS for settlement of costs relating to health care services rendered to Medicare beneficiaries. The Medicare Cost Report records: each institution's total costs and charges associated with providing services to all patients; the portion of those costs and charges allocated to Medicare patients; and the Medicare payments received.

The Medicare Cost Report must be filed with the FI/MAC within five months of fiscal year end of the CAH to achieve settlement of costs for health care services. Final settlement will equal the total reimbursable costs incurred by or on behalf of the CAH for furnishing covered care to the CAH's Medicare enrollees (less applicable deductible and coinsurance). Throughout the course of the year, the hospital receives interim payments from Medicare for its services. These payments are based on historical costs as claims are processed. At the end of the hospital's fiscal year, if the final settlement determination is greater than payments already made to the CAH through interim settlement, an underpayment will be declared, and CMS will make a lump-sum payment to the CAH. Conversely, if the final settlement determination is less than the total payment made, the CAH has been overpaid and CMS must recover the overpayment. This is like the filing of individual taxes each year, where a person will either owe money or be paid a refund from the state or federal government, based on estimated tax payments from the previous year. The above payment methodology illustrates the importance of up-to-date charges, billing and coding methodologies, and cost reporting strategies for the hospital to ensure accuracy and maximize allowable payment.

If a CAH or PPS hospital has an RHC attached, how do they bill for those services and file their expenses?

The primary benefit of RHC status is enhanced reimbursement from Medicare and Medicaid. Medicare reimburses RHCs based on allowable and reasonable costs. There are two types of RHCs: independent RHCs and provider based RHCs. Provider based RHCs work as a department of another provider, such as a CAH, providing health care services to the same population. Independent RHCs, on the other hand, are not affiliated with other providers. There can be significant reimbursement implications associated with each type of designation; for example, independent RHCs are subject to a payment cap, whereas provider based RHCs are not subject to a payment cap if the parent entity is a hospital with fewer than 50 available acute care beds (not licensed beds). Provider based RHCs are reported on the main provider's cost report as a department of that provider. As a result, overhead is allocated to the RHC through the step-down overhead allocation process in the same manner that impacts all of the provider's patient care service departments. Throughout the year, the RHC receives interim per visit payments based on past Medicare cost reports or

other relevant information provided to CMS. At the end of the fiscal year, Medicare calculates the actual payments to be made to the RHC per the Medicare Cost Report. These payments are compared to the actual payments previously made to the RHC to determine if a payable is due to, or a receivable due from, the RHC.

CAH FINANCES

What are the most important CAH financial indicators?

Financial indicators closely aligned with financial strength can be used to determine the financial status of a CAH. Financial indicators, often ratios, combine line items from the balance sheet, statement of operations and/or statement of cash flows in a meaningful way to help interpret strengths or weaknesses in operations or financing activities. Examining these ratios over time can help determine an organization's future trajectory or momentum.

In June 2012, a group of CAH financial experts met in Minneapolis, Minnesota at a CAH Financial Leadership Summit. Of the many identified financial ratios proven useful for assessing organizations financial conditions, the Summit participants identified the 10 most important indicators for evaluating CAH financial performance. Table B displays each of these 10 indicators with the 2016 CAH US medians as listed in the *CAH Financial Indicators Report: Summary of 2016 Medians by State* updated by the Flex Monitoring Team in April 2018. Each indicator also notes if favorable values are trending above or below the median.

Table B. CAH Financial Indicator Medians, 2016

CAH Financial Indicator	2016 US Median	Favorable Trending
Days in Accounts Receivable	51.34	Down
Days Cash on Hand	77.72	Up
Total Margin	2.74%	Up
Operating Margin	0.93%	Up
Debt Service Coverage	3.35	Up
Salaries to Net Patient Revenue	44.90%	Down
Medicare Inpatient Payer Mix*	72.70%	Down
Average Age of Plant (years)	10.48	Down
Long Term Debt to Capitalization	27.20%	Down

*Summit participants agreed Overall Payor Mix was a more comprehensive indicator of financial performance than Medicare Inpatient Payor Mix alone.
Source: Flex Monitoring Team CAH Financial Indicators Reports Primer and Calculator Resources, Template for Presentation of CAHFIR Data, April 2018.

A definition, formula and benchmarks for each of the 10 most important indicators of CAH financial performance is provided below. Each indicator also includes an example data table, which is meant to be used as a reference when calculating these ratios for a specific CAH. Sample data corresponds with the financial statements in the Appendix, including a balance sheet, statement of operations and statement of cash flows. Many of the line items on the financial statements have a letter designation under the column titled "Row". These letters are referenced in the descriptions of the indicator calculations.

Days in Net Accounts Receivable

Days in Net Accounts Receivable measures the number of days it takes an organization to collect its payments.

How values are calculated:

- Net Accounts Receivable: [Row B] – [Row C]
- Net Patient Revenue: [Row Q]
- Days in Net Accounts Receivable: ([Row B] - [Row C]) ÷ ([Row Q] ÷ 365)

Example data:

	2015	2016	2017
Net Accounts Receivable	771,000	802,000	778,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Days in Net Accounts Receivable	**54.17**	**54.92**	**52.70**

High values reflect a long collection period and indicate problems in the organization's business office with regards to billing or collecting payments. The ability to collect payments for services is increasingly difficult, but extremely important. Improvement in days in accounts receivable can mean hundreds of thousands of dollars in improvement in cash on hand. Common problems include out of date chargemasters, poor registration processes and bad communication. Days in Accounts Receivable is a good measure of how the billing process is working and its efficiency, but it does not indicate the overall financial strength of the hospital. Favorable values are **below** the median and the 2016 CAH US Median = **51.34 days**. Reductions to accounts receivable will improve cash on hand.

Days in Gross Accounts Receivable

Days in Gross Accounts Receivable tests the net days in accounts receivable with a goal of being the same amount of time as net days in accounts receivable.

How values are calculated:

- Gross Accounts Receivable: [Row B]
- Gross Revenue: [Row P]
- Days in Gross Accounts Receivable: [Row B] ÷ ([Row P] ÷ 365)

Example data:

	2015	2016	2017
Gross Accounts Receivable	1,001,000	1,012,000	993,000
Gross Revenue	6,395,000	6,460,000	6,503,000
Days in Gross Accounts Receivable	**57.13**	**57.18**	**55.74**

Days in Gross Accounts Receivable is important to track and compare to net accounts receivable to assess the revenue cycle performance. Gross and net days are close in value in highly functioning business offices. Gross accounts receivable does not include any accounting adjustments which makes it a good measure of overall performance when compared to net days in accounts receivable. For example, if gross days are higher than net days,

the organization's allowances (i.e., write offs) may require further analysis. Favorable values are **below** the median and the 2016 CAH US Median = **58.91 days**.

Days Cash on Hand

Days Cash on Hand measures the number of days an organization could operate if no additional cash was collected or received. This reflects the organization's safety net relative to the size of the hospital's expenses.

How values are calculated:

- Cash and Temporary Investments: [Row A]
- Total Expenses: [Row X]
- Depreciation and Amortization: [Row U]
- Provision for Doubtful Accounts/Bad Debt: [Row W]
- Days Cash on Hand: [Row A] ÷ (([Row X] - [Row U] - [Row W]) ÷ 365)

Note: Provision for Doubtful Accounts/Bad Debt is only included in this equation if classified as an operating expense on the Income Statement.

Example data:

	2015	2016	2017
Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
Total Expenses	5,688,000	5,747,000	5,817,000
Depreciation and Amortization	229,000	218,000	211,000
Bad Debt	102,000	107,000	126,000
Days Cash on Hand	**76.31**	**86.17**	**121.96**

Lending organizations view this ratio as critical in the assessment of a project's feasibility, as it represents the amount of dollars readily available to meet short term obligations and make debt payments, should an organization experience short term financial distress. Favorable values are **above** the median and the 2016 CAH US Median = **77.72 days**.

Total Margin

Total Margin measures the control of expenses relative to revenues.

How values are calculated:

- Change in Net Assets: [Row Z]
- Total Revenue: [Row S]
- Total Margin: [Row Z] ÷ [Row S]

Example data:

	2015	2016	2017
Change in Net Assets	64,000	87,000	159,000
Total Revenue	5,752,000	5,834,000	5,976,000
Total Margin	**1.11%**	**1.49%**	**2.66%**

Total Margin indicates the organization's overall profit. It is important to note that organizations need at least a small measure of profit to reinvest in their facilities, staff and infrastructure. Consistently negative total margins may eventually lead to hospital closure. While Total Margin is a good indicator of financial strength, it is important to look at operating margin as well. An organization might have a high Total Margin ratio if, for example, it is the recipient of non-operating sources of revenue, such as a county subsidy to provide quality health care to indigent residents. Margin driven by supplemental funding sources may be at risk with more pressure on local and county governmental budgets, for example. Favorable values are **above** the median and the 2016 CAH US Median = **2.74 percent**.

Operating Margin

Operating Margin measures the control of operating expenses relative to operating revenues related to patient care. Operating expenses are all expenses incurred from the hospital in delivering services. Examples are salaries and benefits, purchased services, depreciation and amortization, supplies, interest expense, professional fees and bad debt expense.

How values are calculated:

- Net Operating Income: [Row R] – [Row X]
- Total Operating Income: [Row R]
- Operating Margin: ([Row R] – [Row X]) ÷ [Row R]

Example data:

	2015	2016	2017
Net Operating Income	-7,000	10,000	63,000
Total Operating Income	5,681,000	5,757,000	5,880,000
Operating Margin	**-0.12%**	**0.17%**	**1.07%**

This measure reflects the overall performance on the CAH's core business: providing patient care. It is important to note that it takes into account the deductions from revenue, such as contractual allowances, bad debt and charity care. Favorable values are **above** the median and the 2016 CAH US Median = **0.93 percent**.

Debt Service Coverage Ratio

Debt Service Coverage Ratio measures the ability to pay obligations related to long-term debt.

How values are calculated:

- Change in Net Assets: [Row Z]
- Interest: [Row V]
- Depreciation and Amortization: [Row U]
- Repayment of Debt (Principal Payments): [Row AA]
- Interest Paid on Long Term Debt (Interest Payments): [Row BB]
- Debt Service Coverage Ratio: ([Row Z] + [Row V] + [Row U]) ÷ ([Row AA] + [Row BB])

Example data:

	2015	2016	2017
Change in Net Assets	64,000	87,000	159,000
Interest	28,000	17,000	13,000
Depreciation and Amortization	229,000	218,000	211,000
Principal Payments	169,000	145,000	90,000
Interest Payments	28,000	17,000	10,000
Debt Service Coverage Ratio	**1.63**	**1.99**	**3.83**

The measure reflects the availability of capital after debt obligations have been satisfied. The debt service coverage represents a key ratio in determining the ability of an organization to take on additional debt, whether for information technology (IT), equipment or a building project. The higher the value of the debt service coverage ratio, the greater the cushion to repay outstanding debt or take on additional obligations. Favorable values are **above** the median and the 2016 CAH US Median = **3.35**.

Salaries to Net Patient Revenue

Salaries to Net Patient Revenue measures labor costs relative to the generation of operating revenue from patient care.

How values are calculated:

- Salaries: [Row T]
- Net Patient Revenue: [Row Q]
- Salaries to Net Patient Revenue: [Row T] ÷ [Row Q]

Example data:

	2015	2016	2017
Salaries	2,895,000	2,908,000	2,958,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Salaries to Net Patient Revenue	**55.73%**	**54.56%**	**54.90%**

Salaries are a major part of the expense structure and require close management. Reviewing the costs can help a CAH assess its staffing efficiency. Overstaffing can reduce overall hospital profitability. Closely monitoring salaries to net patient revenue and improving efficiencies can improve financial performance. Favorable values are **below** the median and the 2016 CAH US Median = **44.90 percent**.

Payer Mix Percentage

Payer Mix Percentage is the proportion of patients represented by each payer type. As displayed below, inpatient and outpatient payer mix are calculated differently.

Inpatient Payer Mix measures the percentage of total inpatient days that are provided to patients of each payer type. The 2016 CAH US Median for Medicare inpatient payer mix was **72.70 percent**. Favorable values are **below** the median.

$$\frac{\text{Inpatient Days for Payer}}{\text{Total Inpatient Days} - \text{Nursery Bed Days} - \text{Nursing Facility Swing Days}}$$

Outpatient Payer Mix measures the percentage of total outpatient charges that are for patients of each payer type.

$$\frac{\text{Outpatient Charges for Payer}}{\text{Total Outpatient Charges}}$$

Payer mix percentages are particularly important in estimating provider revenue because the final reimbursement amount for any patient ultimately depends on the payment source. For CAHs, reimbursement for Medicare is

101 percent of costs. Real costs for Medicare patients are already below 100 percent since some costs, such as physician recruiting, are not reimbursed by Medicare (see Table A - "Allowable Costs in CAH"). The only alternative source of profits is providing services to privately insured patients. It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers.

Average Age of Plant

Average Age of Plant measures the average age in years of the buildings and equipment of an organization.

How values are calculated:

- Accumulated Depreciation: [Row E]
- Depreciation and Amortization: [Row U]
- Salaries to Net Patient Revenue: [Row E] ÷ [Row U]

Example data:

	2015	2016	2017
Accumulated Depreciation	1,874,000	1,755,000	1,896,000
Depreciation Expense	229,000	218,000	211,000
Average Age of Plant	**8.18**	**8.05**	**8.99**

CAHs often fail to improve or rebuild their facilities. The status of newer facilities has been shown to have a positive effect on financial performance and on the recruitment and retention of physicians and staff. Average age of plant is a good indicator of distress with older hospitals having greater problems. Lower, decreasing values indicate a newer facility or more frequent reinvestments in buildings or equipment over time. Favorable values are **below** the median and the 2016 CAH US Median = **10.48 years**.

Long Term Debt to Capitalization

Long Term Debt to Capitalization measures the percentage of net assets (or equity) that is debt.

How values are calculated:

- Long Term Debt, Net of Current Portion: [Row K]
- Net Assets - Accumulated Earnings (Deficit): [Row M]
- Long Term Debt to Capitalization: [Row K] ÷ ([Row K] + [Row M])

Example data:

	2015	2016	2017
Long Term Debt	186,000	183,000	178,000
Net Assets	1,835,000	2,173,000	2,694,000
Long Term Debt to Capitalization	**9.20%**	**7.77%**	**6.20%**

This ratio measures the amount of capital that is financed with debt, which is important to lenders for long term viability. Higher values signify a riskier situation and indicate that a hospital may have a harder time sustaining debt payments in the future and/or getting financing from lenders. Favorable values are **below** the median and the 2016 CAH US Median = **27.20 percent**.

Is there a model for predicting CAH financial distress?

The Financial Distress Index was developed by researchers from the North Carolina Rural Health Research and Policy Analysis Center at University of North Carolina at Chapel Hill. A well-functioning prediction model, such as this, can be used as an early warning system to identify hospitals at increased risk of facing financial distress. State Flex Programs, CAH CEOs and boards reviewing the model could identify areas of particular distress and develop strategies, or interventions, to improve financial performance. To view more information about the prediction of financial distress among rural hospitals, please visit: https://www.ruralhealthresearch.org/publications/998.

Today's characteristics (recent financial performance and measures of a market in which a hospital operates) are used to assign CAHs to one of four risk levels that predict whether a CAH will be in financial distress two years later. Many financial performance and market characteristics were considered for inclusion. The final model was selected due to its ability to predict performance in a straightforward manner. Variables used in the model are noted below in Tables C, D, E and F.

The model separates hospitals into risk of financial distress categories. Financial distress events include:

- Unprofitability
- Equity decline
- Insolvency
- Closure

Accurate assignment of hospitals to categories that reflect low, mid-low, mid-high and high risk of financial distress can provide an effective early warning system to CAHs, allowing CAH Administrators and state Medicare Flex Program Coordinators to target efforts to those at higher risk.

Table C. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Financial Performance

Variable	Description
Profitability	Total margin; two-year change in total margin
Reinvestment	Retained earnings as a percent of total assets
Benchmark performance	Percent of benchmarks met over two years

Table D. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Government Reimbursement

Variable	Description
Medicare	CAH status
Medicaid	Medicaid to Medicare fee index

Table E. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Hospital Characteristics

Variable	Description
Ownership	Government/not-for-profit, for-profit
Size	Net patient revenue (millions)

Table F. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Market Characteristics

Variable	Description
Competition	Log of miles to nearest hospital more than 100 beds; market share (<25%)
Economic Condition	Log of poverty rate in the market area
Market Size	Log of population in the market area

Where can I find information about the financial performance of CAHs in my state?

The Flex Monitoring Team has created a login protected online tool called the *Critical Access Hospital Measurement and Performance Assessment System* (CAHMPAS). CAHMPAS is available to CAH executives, state Flex Programs

and federal staff to explore the financial, quality and community-benefit performance of CAHs. CAHMPAS provides graphs and data, which allows comparison of CAH performance for various measures across user-defined groups: by location, net patient revenue or other factors. CAHMPAS includes a variety of metrics and allows CAHs to compare their financial performance to peer facilities. For more information visit: http://www.flexmonitoring.org/cahmpas/.

The Flex Monitoring Team has also released primers, a presentation template and a calculator spreadsheet to support communication of the CAH financial data. The primer documents explain the measure calculations and offer insights regarding the roles each measure plays in assessing a hospital's financial health. The presentation temple is an editable PowerPoint file for CAHs to use in presenting their own CAH financial data to others. The calculator spreadsheet is an Excel file that enables CAHs to verify the Flex Monitoring Team's calculations and calculate more recent financial indicators using data on hand. For more information visit: http://www.flexmonitoring.org/publications/cahfir-resources/.

IMPROVING CAH FINANCIAL PERFORMANCE

What interventions can CAHs use to improve their financial performance?

The 2012 CAH Financial Leadership Summit identified several important financial interventions that historically have been associated with improved financial performance. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Financial education for CAH department managers
- Financial education for CAH boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators

A subsequent CAH Financial Leadership Summit was held in 2016 to build upon the knowledge gained from the 2012 Summit. The resulting report, *2016 Financial Leadership Summit Report: Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health,* is designed to help rural hospital leaders meet existing challenges by describing market forces impacting rural hospitals and providing key operational strategies that providers may deploy to overcome these challenges and be successful in alternative payment models. The report highlights success stories and lessons learned that were shared by the panelists during the summit. To view the Summit findings and recommendations, please visit: https://www.ruralcenter.org/resource-library/2016-financial-leadership-summit-report-strategies-for-rural-hospitals.

Why is a review of the cost report important?

A review of the cost report can be completed by an outside party to look for common errors in preparation. Because it drives Medicare payments, errors on the cost report directly affect the bottom line, sometimes as much as hundreds of thousands of dollars. Errors include incorrect allocations of expenses and inaccurate statistics, for example. Most cost reports are outsourced but understanding direct and indirect costs and how cost reports work is a critical input to making sound decisions for chief executive officers (CEOs), chief financial officers (CFOs) and board members.

What is a chargemaster and how often should it be reviewed?

The Charge Description Master (CDM) is primarily a list of services and procedures, room accommodations, supplies, drugs/biologics and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim. It is integral to the CAH's revenue cycle and provides many of the necessary data elements for compliant claims submission for reimbursement. It is recommended to have an outside source perform a comprehensive chargemaster and revenue cycle review annually. Ongoing education is also crucial to having business office staff remain current with information necessary to appropriately bill for services rendered. Code changes and description changes must be communicated to the departments who will be generating the charges and may need to be altered or added to the system. Similarly, charge tickets may need to be updated. Billing and coding workshops are available in many locations throughout the country.

What are strategic, financial and operational assessments?

Strategic, financial and operational assessments provide a broad-based analysis of hospital performance and help identify specific opportunities for CAH improvement. These studies provide an objective review of the areas where many CAHs need help, including:

- Matching services to community needs
- Staffing to benchmarks
- Clinic management
- Medical staff planning
- Organizational culture

Assessments are recommended periodically to determine areas of focus for follow-up improvement work.

What is revenue cycle management?

Revenue cycle management is a means to improve hospital revenue and reimbursement by streamlining workflow, processes and education throughout all financial components of the hospital. A holistic revenue cycle management includes a multi-disciplinary approach focusing on culture change with comprehensive, dramatic and permanent results. Specific areas of focus may include:

- Comprehensive chargemaster and revenue cycle review
- Business office and patient financial services review
- Development of training protocols for revenue capture
- Implementation of an effective revenue control process
- Pricing analysis
- Recovery audit contractor (RAC) preparedness and revenue cycle process improvement
- Revenue process capture audits

These assessments should result in identifying opportunities for improvement and specific, actionable recommendations.

Why are physician practice management assessments useful?

As more and more physicians align and become employees of CAHs, it is critically important to contract with physicians and operate clinics according to best practices. A practice management assessment looks at physician and mid-level provider productivity, scheduling, staffing, billing and collection

practices. These assessments should result in specific recommendations and action plans that have the potential to bring in additional revenue and improve clinic efficiency.

What is Lean and how can it impact CAH finances?

Lean focuses on increasing efficiency and eliminating waste. This creates greater value for customers and uses fewer resources. In the health care setting, Lean processes can result in substantial cost savings, fewer delays and increased patient and staff satisfaction. Lean education, Lean networks and shared Lean expertise have all been successfully used by individual CAHs and networks of rural hospitals.

Why is education on finances important for CAH department managers and board members?

Financial education for CAH department managers can enhance budgeting, planning and financial skills in department heads, whose background may be clinical rather than business or administrative. CAH Board members similarly lack basic CAH financial knowledge. Financial education for CAH Boards provides a fundamental grounding on cost-based reimbursement and CAH financial strategies. Hospital financial management is complex and rural hospital boards need a basic understanding of CAH finances to provide needed oversight. This type of education has been done successfully with rural hospitals using both on-site workshops and web-based presentations, which are often stored and accessible online.

Why is collaboration important for improving finances in CAHs?

Two minds are better than one. Collaboration allows CAH staff to share ideas, lessons learned, best practices and funds with one another. Many state Flex Programs have provided support to develop CFO networks. CFO networks have proven to be a popular method of education, peer learning and peer support. In more than a dozen states, rural hospital CFOs meet periodically, either in person or virtually, to discuss common issues, gain new skills and share experiences and techniques.

Benchmarking financial outcomes among groups of hospitals is a common means of measuring performance and comparing results. By collaboratively comparing results, CAHs identify areas of strength and weakness and measure progress toward strategic goals. This collective benchmarking also

provides an opportunity for the hospitals to share common issues, best practices and lessons learned. The University of North Carolina-Chapel Hill's distribution of annually updated financial indicator data through CAHMPAS is a useful source for benchmarking, but other information sources are also available.

Aside from the value of bringing collective minds together, using various funding sources to achieve an end goal can be strategic. Pooling SHIP dollars among a group of CAHs has provided an effective means of providing financial or Lean education to hospital staff and boards. Economies of scale, shared expertise, access to speakers and resources, peer learning and support have all been reported as benefits of pooling resources.

ADDITIONAL PERFORMANCE INDICATORS AND STRATEGIES

CAH Finance Summit

In May 2018, a group of financial experts met in Minneapolis, Minnesota at a CAH Finance Summit. This summit produced additional indicators to be monitored and strategies to be implemented to assist CAHs in achieving operational and financial success.

Market Indicators

Understanding an organization's market share is vital in developing and updating strategic and marketing plans. Ultimately, a higher market share will be desirable and necessary to allow for operational and financial success. The challenge for providers is obtaining the market share data for their organization as this is based on claims data, typically unavailable publicly and varies by region. Organizations that are looking to obtain market share data will need to explore available sources in their market area. This may include proprietary sources, state hospital associations, state governmental agencies and marketing firms that specialize in the health care industry.

The level of detail available in market share data will drive the amount of analysis to be performed and the nature of the strategies that may be developed. In addition to understanding the overall market share, the ability to understand the nature of services, demographics and unique patients associated with outmigration can assist the organization in developing network, service and/or demographic marketing strategies. Organizations

may find it necessary to employ a skilled health care data analyst or share the employment of a health care data analyst with other CAHs.

Over time, understanding potential patient attribution under a population health reimbursement model is crucial to be the dominate provider of primary health care services. This can be a difficult indicator to obtain for an entity that is not currently in or exploring to be in a population health model. However, for those in a population health model, this information can be a good indicator of the level of primary care being provided as well as brand loyalty for patients in a specific financial class.

Financial Performance and Conditions (liquidity)

The summit identified the Current Ratio as an additional important indicator of liquidity.

Current Ratio measures the number of times short-term obligations can be paid using short-term assets.

How values are calculated:

- Current Assets: [Row D]
- Current Liabilities: [Row J]
- Current Ratio: [Row D] ÷ [Row J]

Example data:

	2015	2016	2017
Current Assets	2,121,000	2,332,000	2,859,000
Current Liabilities	889,000	833,000	803,000
Current Ratio	**2.39**	**2.80**	**3.56**

This ratio measures the amount of current assets that are available to pay off current liabilities. Lower values signify a riskier situation and indicate that a hospital may have a harder time sustaining payment on current liabilities in the future. Favorable values are **above** the median and the 2016 CAH US Median = **2.48**.

CAHs that are looking to maximize their financial performance must ensure they are leveraging the reimbursement and other advantages that are available to rural providers. This includes working with their cost report preparer to ensure the organization has elected the cost reporting strategies that are most beneficial to the organization. They should also work with its licensure and reimbursement specialists to ensure that they are utilizing the most beneficial licensure status for the individual services being offered. This

includes the review of overhead allocation methodologies and the utilization of rural health clinic, provider- based clinic, visit nurse and other reimbursement/licensure opportunities.

High performing providers are also implementing revenue cycle committees to identify and address opportunities to improve the overall reimbursement for services being rendered. This includes the development of standardized processes, charge capture teams and denial management programs as well as assigning and holding individuals accountable for their roles in the revenue cycle process. This includes holding patient care staff accountable in addition to the traditional assignment of business office and health information management accountability.

The ability to obtain timely reports from a management reporting system is crucial in being able to identify potential areas of concern early in the process. The availability of adequate management reporting is a product of system capabilities and the skill set of those responsible for managing the systems.

The provision of education to department heads as it relates to organizational finances and reimbursement is important in all CAHs. Many CAH leaders struggle with organization finances due the lack of education they have been provided in both their formal education as well as education provided in the provider setting. Health care finances are complicated and a failure to understand the financial ramifications of decisions can lead individuals to make decisions without the proper information. Sources for financial education to department heads can be the internal finance department, state hospital associations and trustee seminars.

Operational Efficiency

Improving the efficiency and effectiveness of resource utilization is key in improving the operational and financial performance of the organization. The use of Lean process improvement and other improvement methodologies, as well as benchmarking, can provide for improvement in processes and total resource consumption. The use of Lean concepts is utilized by some CAHs, but many others could benefit from its use.

The use of staffing and other cost benchmarks is a challenge for most CAHs. This is usually due to the lack of access to the desired information for comparison purposes. This is not data that is publicly reported or otherwise available. Therefore, CAHs typically need to look to external proprietary

products and/or utilize internally developed benchmarks based on past performance. However, some states have gathered groups of providers to share their staffing and cost information to develop averages and benchmarks. This can be coordinated through a State Office of Rural Health, State Hospital Association or another similar group.

Once benchmarking data is available, the organization must create a methodology to gather and report this information to organizational leadership on a timely basis. This reporting may be performed utilizing current systems or may require the use of business intelligence software and reporting systems. While once cost prohibitive, the cost of business intelligence software to gather and generate desired reports has become affordable for even the smallest of organizations.

The cost of and scarcity of some professional services and acceptance of remote technologies has led to the increased utilization of telemedicine services. These services can allow a CAH to provide much needed services in the rural setting at a much more affordable cost. In addition, more payors are allowing payment for these services. Currently, one of the biggest hurdles for providing telemedicine services is the low-level reimbursement for the service. In 2018, Medicare provides $25.76 in reimbursement for the originating site. This includes the CAH and rural health clinic. Many organizations are advocating for higher reimbursement for these services at the state and federal level.

Workforce

The adequacy and education of the rural workforce of a CAH has been a challenge for years. It is becoming more difficult due to the continued reported shortages of health care providers and the increased complexity of the health care environment.

While health care workforce adequacy is a national issue and one that will most likely not be solved for some time, CAHs need to develop strategies at the local level to address the challenges today. This includes understanding the local workforce, educating and identifying potential future employees, and understanding staff satisfaction. Organizations may need to work with national, state and local government entities to obtain information regarding the make-up of health care professionals at the national, state and local areas. This may include current data as well projected data to assist in identifying current and future shortage areas. This workforce data can be

used to develop local education programs to educate individuals in middle school and high school on the background and availability of future employment positions in information technology, clinical services, emergency department, emergency medical services, community paramedic, etc. Many schools provide health career courses in high school to introduce opportunities and to provide for job shadowing. The ability to generate interest by local students can help in the recruitment process as the organization provides encouragement and, potentially, financial support during their obtaining of the necessary education and licensure. Workforce analysis may also involve developing strategies to support unpaid family care-givers that are vital to the health care system.

Once staff have been employed, the next challenge is retaining them. Encouraging staff engagement and the provision of staff satisfaction tools can assist organizations to identify the overall health of their workforce pool and also areas of risk that must be addressed to improve overall satisfaction and performance.

Education of the workforce, boards, community members, other stakeholders and legislators on the transition from volume to value is also important. This transition from volume to value is a foreign concept to many as it is no longer business as usual. The transition will require many individuals to rethink past strategies as they work to create new strategies to manage and succeed in this transition. Organizations will struggle if some leaders are developing strategies based on volume while others are pursuing strategies based on value without understanding the process of transition that is occurring.

Care Management

Understanding care management can be key in maintaining and/or increasing market share and part of understanding the transition from volume to value. The first step in implementing successful care management programs is to understand the transition from volume to value. As organizations continue to move forward in the transition, the importance of care management will increase. This is due to the fact that the reimbursement under a value methodology will focus more on earlier interventions and less on the provision of high dollar back end services.

The transition to value-based strategies will result in some providers obtaining Patient Centered Medical Home (PCMH) certification and/or to join

accountable care organizations. Both models will encourage a focus on care management. Medicare and many other payors have developed payment methodologies for these services. This includes annual wellness visits, chronic care management and transitional care management. Annual wellness visits are covered by Medicare and provide for an annual visit to address and plan for a patient's health care for the next year. This includes the provision of other preventive, screening and educational services designed to address, prevent and/or to provide early detection of potential issues that can decrease the quality of life for the patient and drive up the overall cost of health care. Many of these services are provided at little or no cost to the beneficiary.

Chronic Care Management services are covered by Medicare and many other providers. Among the requirements for coverage are the existence of 2 or more chronic conditions. Unaddressed, these chronic conditions can lead to a decrease in the quality of life for the patient and higher long-term costs. Chronic Care Management allows for coverage and payment for monthly follow-up with the patient without a face-to-face visit to discuss adherence to care plans, upcoming appointments, challenges in affording necessary medications, etc. In addition to the potential improvement in health outcomes, these visits are often very popular with the patients as they appreciate the ongoing connection with their care providers.

Transitional Care Management is the management of a patient for the 30 days after discharge from an inpatient stay. Medicare and many other providers provide coverage and payment for this service. The focus of this service it to assist the patient with the transition from the inpatient setting to the home without a readmission to the hospital. This includes making sure all discharge orders are understood and being followed. Some organizations have seen a significant reduction in readmissions once a Transitional Care Management program has been implemented.

The implementation of these programs requires the development of care plans for patients and follow-up by the provider and patient. The ongoing communication between the provider and the patient can often be the encouragement to engage the patient. The success with improved patients' lives can be the encouragement providers need to engage in these programs. Full implementation of care management services can be a differentiator in the market as they have the potential to increase patient and provider engagement and improve overall satisfaction by the patient. In

addition, these services can increase other ancillary services that are often provided by the rural provider while decreasing the higher cost services that may have to be provided in larger organizations and with greater cost. In time, this can help lead to increased market share.

Quality Performance

Monitoring reported quality performance is increasing over time as the information is becoming more readily available to the public. Medicare's Hospital Compare is one example of publicly available data that patients and families are using to make comparisons and choices about health care. Information on individual hospitals can be found at: https://www.medicare.gov/hospitalcompare/search.html. Information on physicians can be found at: https://www.medicare.gov/physiciancompare/. While there are ongoing questions as to the validity of the data and potential challenges of reporting results for providers with smaller volumes, this information is being used by current and potential patients and must be monitored. Over time, it is anticipated that more quality data will be made available to the public. CAHs should develop a process for the long-term monitoring of these programs and strategies for improving any areas of concern that are noted in the reporting.

Increasingly, organizations are transitioning current compensation models with physicians towards a model that provides financial rewards for quality activities and performance with less focus on overall production. The transition is a balancing act as there is still a need for productivity but must include reportable quality results. The transition may take time, but it is expected that the portion of compensation for quality activities and performance will continue to increase. At the same time, organizations will be developing internal strategies to track the activities and performance.

Community Health

The ability to measure the health of a community is crucial in determining the overall success of health care providers efforts. This can be a challenge as much of the information on the factors of success are not being measured. The ability to track social determinants of health and county health rankings are key. Health care providers must strive to identify and measure social determinants of health. This can include:

- Availability of affordable housing and food

- Access to transportation
- Access to health care and community-based resources
- Accessibility and quality of education and job training
- Literacy rates
- Public safety

While facilities may not be able to track data for each determinant, organizations should start with the data that is available and continue to work with external organizations to develop strategies for capturing the necessary data to monitor these statistics. In addition, organizations should be working with their state and county to ensure adequate data and reporting exist on county health. Facilities can monitor trends and their rankings to help determine the level of success for the program as well as areas of opportunity for improvement.

Since the cost of care is an integral part of compensation under the value methodology, providers also need to address Hierarchical Condition Category (HCC) reporting. HCC reporting is based on ICD-10 coding and provides for a methodology to assess the level of medical risk for a patient. The resulting HCC risk score is utilized to determine the expected cost of a patient and to compare the difference in costs between providers for a normalized population. CAHs are at higher risk of under reporting their HCC risk since much of their reimbursement has not been reimbursed based on the completeness of coding since entering the CAH program. Strategies for increasing the accuracy of HCC reporting include initial assessment of coding as well as the development of strategies to improve provider documentation and health information management coding based on the results of the assessment.

For many years, the trend in physician contracts has been to increase the amount of compensation that is based on production. Frequently, these contracts have been successful in increasing the productivity of the physicians. However, under population health concepts there needs to be a balance between production and population health activities that may not be reflective of volumes. This has led to a transition in contracting models to reduce the emphasis on production with an increase in population health and other quality initiatives. While it may be difficult to obtain statistics regarding contract structure for all providers in their community, facilities can gather and track internal information to determine the percentage of contract with

their primary care providers that include incentives for population health activities.

The reported costs of health care typically only include the direct costs associated with the services. This would include insurance premiums, copays, coinsurance, deductibles, medications, etc. However, it rarely tracks the full cost. This would include time, travel, lost wages, etc. Understanding the full cost of care to the patient is critical in managing costs as well as promoting access to care in the long run. Health care providers should be working with local and state resources to develop strategies to capture and monitor these costs over time.

Overarching Strategies

To be successful, providers need to understand their data. For some this will require organizations to develop new strategies to create or obtain the necessary data for analysis. Once the data is obtained, it needs to be converted into quality information that can be used to create actionable strategies. As previously noted, this will require some organizations to add health care data analysts. Once actionable strategies have been identified, responsibility and accountability will need to be assigned in the organization.

Many of the challenges in rural health care are caused by inadequate or inappropriate rural policies established by Congress, CMS and state agencies. There is an ongoing need for advocacy for the establishment of rural health care policies that take into account the unique situations in the rural setting. This advocacy should come from more than just the rural providers, but should include rural patients, business leaders and other stakeholders. Congressional and other state and local leaders need to hear from their constituents regarding the need for workable rural health care policies. Successful discussions will include proposed solutions in addition to the addressing of current problems and challenges with current policies.

HOW ARE SMALL RURAL PPS HOSPITALS REIMBURSED?

Small rural PPS hospitals have many of the same major issues and concerns with a few very specific differences. While they are typically in areas with a larger population base, they are not reimbursed based on cost from Medicare and may be in closer proximity to competitors.

PPS FINANCES

What are the most important financial indicators?

In general, the most important financial indicators for the small rural PPS hospital are the same as those that are important for CAHs. The biggest differences are the strategies employed to impact the indicators and improve performance. While there are CAH US Median's available for these indicators, there is not a central resource for this information for small rural PPS providers. The calculations for these indicators remain the same as previously indicated.

Days in Net Accounts Receivable

The same common issues as found in CAHs will result in poor reported performance in the PPS provider. This includes out of date chargemasters, poor registration processes and bad communication. Lower levels that are stable or declining are favorable.

Days in Gross Accounts Receivable

Low numbers in this category can be an indicator of a highly functioning business office. Again, lower levels that are stable or declining are favorable.

Days Cash on Hand

As a safety net calculation, this indicator is used by lending organizations as a reflection of the amount of dollars that are readily available to meet short term expectations. As such, higher levels or levels that are trending upward are favorable.

Total Margin

The indicator performance in a given year, as well as the trend over time, is important to track as a measure of overall profitability. Ongoing poor performance in this area can have significant impact on other indicators and eventually lead to closure. Higher levels or levels that are trending upward are favorable.

Operating Margin

As a measure of operating expenses in comparison to operating revenues, this indicator of how well an organization is operating in its core business

area. As is the case in Total Margin, higher levels or levels that are increasing over time are favorable.

Debt Service Coverage Ratio

As previously noted, this ratio measures the ability of an organization to pay obligations related to long-term debt. A favorable value is one that is above the median and/or is trending upward.

Salaries to Net Patient Revenue

Just like in a CAH, the major expense in a PPS hospital is related to salaries. Profitability of the organization can often be impacted by overstaffing. A lower value and/or one that is declining is favorable.

Payor Mix Percentage

While Medicare does reimburse PPS hospitals under a different reimbursement methodology, the importance of this indicator remains. This is due to the fact that the profitability of Medicare revenue is still usually the lowest amongst payers in the PPS setting. The ability to generate higher long-term profitability is dependent on a higher percentage of non-Medicare payers. A lower and/or declining value for this indicator is favorable.

Average Age of Plant

As is the case in the CAH, the successful PPS hospital needs to continue its reinvestment in buildings and equipment to attract and retain physicians and staff as well as to keep up with the needs of the patient. Favorable values in this indicator are lower.

Long Term Debt to Capitalization

As a measure that indicates the amount of capital that is financed with debt, higher numbers will be an indication of higher risk for lenders. A lower number is an indication of less risk of sustaining debt payments and may improve the ability for an organization to acquire additional debt.

IMPROVING PPS FINANCIAL PERFORMANCE

What interventions can PPSs use to improve their financial performance?

Many of the same interventions that are effective for the CAH to improve their financial performance can be effective in improving the performance for the PPS hospital. However, the specifics for each intervention may be different. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Financial education for PPS department managers
- Financial education for PPS boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators

Unless otherwise indicated below, the interventions in these areas are essentially similar to those in the PPS.

Why is a review of the cost report important?

While the PPS hospital is not reimbursed based on cost for the majority of its services, there are some areas where Medicare may reimburse for some costs through the cost report. The cost associated with Medicare bad debt can be a major area of opportunity during the review of the Medicare Cost Report. Reportable Medicare bad debt occurs when the Medicare beneficiary fails to pay the hospital for the applicable deductible and coinsurance that is applied on inpatient, swing bed, nursing home, distinct part unit and rural health clinic services. In addition, the bad debt related to outpatient services reimbursed under the outpatient perspective payment system are eligible. To be eligible, the facility must be able to demonstrate the amounts were uncollectible after following the normal collection processes for the organization. Unfortunately, many providers fail to properly capture all of this reimbursement opportunity. Other items related to the wage index, rural

health clinics and disproportionate share may be identified during such a review.

Revenue Cycle Management for the PPS Hospital

The focus of revenue cycle management in the PPS hospital is essentially the same as in a CAH. However, the importance of development of training protocols for revenue capture and revenue process capture audits is usually higher for the PPS hospital. Unlike the CAH, Medicare reimburses the PPS hospital based on revenue capture and coding versus cost, as identified in the Medicare Cost Report. Failure to properly capture and code services in the PPS hospital will impact reimbursement from both non-Medicare payors and Medicare.

Physician Practice Management Assessments

The potential benefits of physician practice management assessments may be greater in a PPS hospital than in the CAH. In a PPS hospital, one would expect to see a lower number of rural health clinics (RHC) in relation to provider based or free-standing clinics. In addition, for those PPS hospitals with more than 50 beds, the provider based RHC would be limited to the cost per visit limit. Due to these differences, a larger portion of any cost savings due to improved efficiencies and/or cost reductions, etc., will have a greater potential of improving the financial performance of the PPS organization.

How can Lean impact PPS finances?

Whereas a portion of any cost savings identified in the CAH are shared with Medicare, cost savings identified in the PPS hospital frequently allow for a 100% impact to the operating and total margin. This is due to the nature of the PPS reimbursement methodology. For this reason, the PPS hospital may be able to use Lean to find smaller cost savings that have a larger net financial impact than would be available under the CAH methodology.

Education on finances for PPS department managers and Board members?

PPS department managers can also enhance their budgeting, planning and financial skills with the proper financial education. PPS Board members will also usually benefit. Unlike the financial education provided to CAH leaders,

the education to PPS leaders should focus on prospective payment methodologies and strategies.

THE PROVIDER BASED RHC IN THE CAH OR PPS HOSPITAL SETTING

The challenges facing provider-based clinics that are part of a CAH or PPS hospital are unique to their licensure status. The nature of the enhanced reimbursement from Medicare and Medicaid, completion of a Medicare Cost Report, potential payment caps and application of productivity standards can provide for opportunities and risks not seen in other provider types.

While the provider based RHC does file a Medicare Cost Report, this information is imbedded into its main provider's cost report and financial statements. Therefore, financial indicators relating to just the RHC are not available for the RHC in the same manner as the CAH. However, that does not preclude the RHC from monitoring specific indicators and initiating interventions to improve financial performance.

The importance and impact of RHCs on hospital finances has continued to grow. Historically, the RHC program has provided for a methodology for RHCs in certain areas with Health Professional Shortage Area (HPSA) designation to receive cost-based reimbursement for professional services. This cost-based reimbursement methodology provides for a significant improvement in reimbursement by Medicare for these professional services. While this has been a popular reimbursement model since its inception in 1977, it has become more popular in recent years due to the growth in the number of rural hospitals employing physicians and the size of the clinics has grown.

Currently, approximately 20% of national health care expenditures occur in the clinic setting. However, this is expected to continue to grow as health care continues its movement from the inpatient hospital setting to the outpatient hospital setting as well as the move from the outpatient hospital to the clinic setting. Advances in technology, introduction of population health reimbursement methodologies and expansion of reimbursement for care coordination services is expected to be a driver in continued growth for clinic-based services. The RHC reimbursement methodology allows the hospital-based clinic to provide these services in a manner that still provides for the enhanced reimbursement levels typically required in the rural setting.

Without this reimbursement methodology, many providers would find it financially impossible to provide clinic-based services.

RHC FINANCES

What are the important RHC financial indicators?

As was previously noted, the Medicare Cost Report and financial statements do not provide for the same type of financial indicators as are available for the CAH. However, some indicators do exist that can be beneficial to RHC leadership.

Days in Accounts Receivable (Gross and Net)

While most of the financial indicators identified for CAHs and PPS cannot be calculated separately for the RHC, the gross and net days in accounts receivable is typically an indicator that can be separately calculated for the RHC. As such, this is a good indicator for monitoring the health of the revenue cycle in the RHC. Higher days in accounts receivable can be an indication of chargemaster, coding, charge capture and communication issues. A lower value is favorable.

Cost per Visit

The Medicare Cost Report calculates an average cost per visit for services in the RHC. In 2014, this average cost was $176. While a higher cost per visit does provide for a higher level of reimbursement from Medicare and potentially Medicaid, it does make services rendered to non-Medicare patients less profitable. A lower cost per visit is favorable over the long run as it allows the facility to improve its financial performance for services rendered to non-Medicare payers.

Medicare Payer Mix

As is the case in the CAH and PPS hospital, a lower Medicare payer mix over time can assist the organization in improving financial performance. However, increasing the non-Medicare payer mix should not come from decreasing Medicare volumes, but rather from increasing the non-Medicare volume. At the same time, the organization needs to be managing its average cost per visit to allow for profitability from the services rendered to the non-Medicare patient.

Visits per Physician/Nurse Practitioner/Physician Assistant

The number of visits by provider is important for two reasons. First, is the application of productivity standard by Medicare on the Medicare Cost Report? If the providers as a whole are producing at a level below this standard, Medicare will calculate the cost per visit with the calculated standard number of visits. This has the effect of reducing the calculated cost per visit and subsequent payment to the RHC. Second, a higher number of visits is an indicator of greater productivity and should reduce the calculated cost per visit over time. A lower cost per visit allows the RHC to improve its profitability with non-Medicare payors. A higher number of visits per provider is a favorable indicator.

Percentage of Nurse Practitioner/Physician Assistant FTEs to Total Provider FTEs

RHCs are required to have a minimum amount of coverage by a nurse practitioner or physician assistant. However, the percentage of the total provider FTEs that are nurse practitioners and/or physician assistants varies significantly. Some RHCs will just staff the minimum requirement of nurse practitioner or physician assistant while others will rely much heavier on these non-physician practitioners. The potential benefits of utilizing a higher percentage of these practitioners is the lower cost associated with these professionals as well as the lower productivity standard that is applied to each non-physician practitioner. A higher percentage of these non-physician practitioners is favorable as it can be an indicator of the ability to control cost and manage the productivity standards that can ultimately impact Medicare reimbursement.

Staffing Cost per Provider FTE

Compensation for practitioners can vary significantly between RHCs. While there may be significant variations by region, large variations can also exist between neighboring RHCs. For this reason, in addition to being able to manage the mix of overall practitioners in the RHC, the RHC needs to be able to manage the cost of each FTE. Facilities can calculate per FTE staffing costs for physicians, nurse practitioners and physician assistants. A lower staffing cost per provider FTE is favorable as it may be an indication of RHCs ability to control the cost per visit and improve the profitability of non-Medicare and non-Medicaid volumes.

Average Charge per Billable Visit

While managing the number of visits is important, the average charge per visit is equally important. While Medicare and Medicaid reimburse based on a cost per visit methodology, 20% of the reimbursement from Medicare is based on the charge submitted. In addition, this indicator may provide insight into the adequacy of pricing for other payers as well as the appropriateness of the coding and documentation processes. A higher average charge per billable visit may indicate that the provider has appropriately priced the services being rendered and/or that the RHC and its staff are appropriately documenting, coding and capturing all reportable services. A lower average charge per billable visit may be an indication that pricing is below average for the services rendered, that there is opportunity to improve documentation, coding and charge capture or that the RHC is seeing less complex patients. A higher average charge per billable visit is typically favorable.

IMPROVING RHC FINANCIAL PERFORMANCE

What interventions can RHCs use to improve their financial performance?

Many of the same interventions that are effective for the CAH and PPS hospital to improve their financial performance can be effective in improving the performance for the RHC. However, the specifics for each intervention may be different. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Developing chief financial officer (CFO) networks
- Benchmarking operational indicators

Unless otherwise indicated below, the interventions in these areas are essentially similar to those in the PPS.

Why is a review of the cost report important?

For the RHC, a cost report review can identify opportunities for the RHC to develop strategies to improve financial performance. Average RHC visits by discipline, limitations of reimbursement due to the application of productivity standards, the impact of lower charges on coinsurance reimbursement, payer mix, cost per visit, etc., are examples of information the RHC may be able to pull from their Medicare Cost Report. The information identified in these areas may lead the provider to consider additional work in the area of operational assessment, revenue cycle management, physician practice management assessment and lean process development.

The Chargemaster in the RHC

The CDM in the RHC is most times less complex than that of the CAH or PPS hospital. However, that does not diminish the importance of ongoing monitoring and maintenance of the chargemaster. The main focus for ongoing monitoring is to ensure annual updates to CPT codes are implemented, new CPT codes related to new physicians in different specialties are added and that pricing is properly established. Any changes that are implemented should include an update to the forms used by the clinic providers to complete the procedures and diagnosis for process payment.

Revenue Cycle Management

In the RHC, the focus of revenue cycle management involves coding assessments, training for revenue capture, revenue process charge capture audits and review of upfront collection efforts. Failure to properly capture and code services in the RHC can significantly impact reimbursement from non-Medicare payors.

Physician Practice Management Assessments

The potential benefits of physician practice management assessments in the RCH cannot be overstated. In the RHC these assessments can include reviews of physician contracts, development of compensation strategies, review of scheduling protocols, process flow assessments and staffing reviews. These assessments can result in increased efficiencies, decreased costs and/or improved patient access.

How can Lean impact RHC finances?

When included as part of the physician practice management assessment, Lean can help improve process flows while also reducing costs. For those RHCs that are subject to the cost per visit limits and are over these limits, any savings in cost over the limits will be reflected in the operating margin and total margin. For those RHCs already below the limits, a large portion of the savings will usually still end up as improvements in the operating margin and total margin.

APPENDIX

Example - Balance Sheet

[Row]		2015	2016	2017
	ASSETS			
	Current Assets:			
A	Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
B	Patient Accounts Receivable, Gross	1,001,000	1,012,000	993,000
C	Less: Provision for Doubtful Accounts	-230,000	-210,000	-215,000
	Other Accounts Receivable	-	24,000	24,000
	Supplies	162,000	169,000	169,000
	Other Current Assets	68,000	57,000	57,000
D	Total Current Assets	2,121,000	2,332,000	2,859,000
	Property, Plant & Equipment:	2,663,000	2,612,000	2,712,000
E	Less: Accumulated Depreciation	-1,874,000	-1,755,000	-1,896,000
	Net Fixed Assets	789,000	857,000	816,000
F	TOTAL ASSETS	2,910,000	3,189,000	3,675,000
	LIABILITIES & NET ASSETS			
	Current Liabilities:			
G	Current Portion of Long Term Debt	144,000	89,000	49,000
H	Accounts Payable & Accrued Liabilities	115,000	148,000	158,000
	Estimated Amounts Due to Third Party	260,000	226,000	226,000
I	Other Current Liabilities	370,000	370,000	370,000
J	Total Current Liabilities	889,000	833,000	803,000
K	Long Term Debt, Net of Current Portion	186,000	183,000	178,000
L	TOTAL LIABILITIES	1,075,000	1,016,000	981,000
	NET ASSETS			
M	Accumulated Earnings (Deficit)	1,835,000	2,173,000	2,694,000
	TOTAL LIABILITIES & NET ASSETS	2,910,000	3,189,000	3,675,000

Example - Statement of Operations

[Row]		2015	2016	2017
	REVENUE			
N	Total Inpatient Revenue	2,402,000	2,445,000	2,471,000
O	Total Outpatient Revenue	3,993,000	4,015,000	4,032,000
P	Total Gross Revenue	6,395,000	6,460,000	6,503,000
	Less: Contractual Allowances	-1,200,000	-1,130,000	-1,115,000
Q	Net Patient Revenue	5,195,000	5,330,000	5,388,000
	Other Operating Revenue	486,000	427,000	492,000
R	Total Operating Revenue	5,681,000	5,757,000	5,880,000
	Gain (Loss) on PP&E Disposal	-2,000	-3,000	-
	Contributions/Grants	65,000	69,000	77,000
	Investment Income	8,000	11,000	19,000
S	Total Revenue	5,752,000	5,834,000	5,976,000
	EXPENSES			
T	Salaries	2,895,000	2,908,000	2,958,000
	Benefits, Supplies & Other	2,434,000	2,497,000	2,509,000
U	Depreciation & Amortization	229,000	218,000	211,000
V	Interest	28,000	17,000	13,000
W	Provision for Doubtful Accounts/Bad Debt	102,000	107,000	126,000
X	Total Expenses	5,688,000	5,747,000	5,817,000
Y	EXCESS OF REVENUES OVER EXPENSES	64,000	87,000	159,000
	Restricted Contributions	-	-	-
Z	CHANGE IN NET ASSETS	64,000	87,000	159,000

Example - Statement of Cash Flows

[Row]		2015	2016	2017
	CASH FLOWS FROM OPERATING ACTIVITIES			
	Change in Net Assets	522,000	547,000	542,000
	Adjustments to reconcile change in net cash provided by operating activities:	246,000	459,000	-210,000
	Purchase of Other Assets	-3,000	-6,000	-
	Other Current Liabilities	34,000	-	-
	Net Cash Provided by Operating Activities	799,000	1,000,000	332,000
	CASH FLOWS FROM FINANCING ACTIVITIES			
AA	Repayment of Debt	-169,000	-145,000	-90,000
	Purchase of PP&E	-63,000	-189,000	-100,000
BB	Interest Paid on Long Term Debt	-28,000	-17,000	-10,000
	Gifts to Purchase Capital Assets	46,000	-	-
	Net Cash Used by Investing Activities	-214,000	-351,000	-200,000
	CASH FLOWS FROM INVESTING ACTIVITIES			
	Interest and Dividends on Investments	8,000	11,000	19,000
	Net Cash Used by Investing Activities	8,000	11,000	19,000
	NET INCREASE (DECREASE) IN CASH	593,000	660,000	151,000
	CASH, BEGINNING OF YEAR	527,000	1,120,000	1,178,000
	CASH, END OF YEAR	1,120,000	1,780,000	1,931,000