

Southern Coos Health District
Board of Directors Meeting
April 21, 2011 – 7:30 p.m.

Minutes

- I. **Call to Order** - The regular monthly meeting of the Board of Directors for the Southern Coos Health District was called to order at 7:35 p.m. by Chairman, Bob Hundhausen

Members present: Bob Hundhausen, Chair; David Allen; Brian Vick; and Marilyn Noorda.

Others present: Jim Wathen, Alan Dow; Dennis Jurgenson, Lonnie Scarborough, Donna Reilly; Megan Holland, M.D.; Patty Clark; Carol Acklin; Esther Williams; and Linda Olsen.

- II. **Public Input** – There was no input.

- III. **Approval of Consent Agenda** – Mr. Allen **Moved** to accept the Consent Agenda. Mr. Vick **Seconded** and the motion passed unanimously.

IV. Staff Reports

CEO Report – Mr. Wathen introduced Patty Clark, project coordinator for the South Coast Health Alliance (SCHA). She also serves as Continuing Medical Education coordinator for Bay Area Hospital and does a very good job in both roles. He thanked Ms. Clark for joining our Board meeting and said that she would be attending a meeting once a quarter and giving an update of the activities of the SCHA. He reminded everyone that the SCHA included Bay Area Hospital, Coquille Valley Hospital, Curry General Hospital, and Southern Coos Hospital.

He then expressed his appreciation to the Board for their participation in the all day educational workshop with Mr. Bill Charney. It was a very good educational session and very enlightening, exposing the Board to a lot of good ideas that will be of use in the future. The more you know about health care and expectations of being a Board member the better you are able to carry through with your responsibilities as a Board member.

Mr. Wathen then updated members on a very important part of our Paragon installation that sets us up to make sure that everything we have been doing has been done correctly and is going to work for the hospital. It is called the integrated testing session where our billing items and clinical billing for patients were entered and tested to see what the outcome was and it went very well. We found some things that needed to be corrected. There were people here from Paragon who sat

down with staff and worked through the system and helped identify where things were not working as well as expected and were able to correct these problems. The representatives told us that this was one of the best integration testings they have seen and that says a lot for our staff who have been involved in the system build. We are on our projected schedule and are now in the process of training our end users and this will continue through the month of May, June and into July. Go-live is at the end of July. Question was asked regarding meetings with representatives of the BCHC. Mr. Wathen said we still meet with their staff physician, a director of their Board and discuss issues and make sure we each know what the other is intending to do, that people are supportive of the directions that are being taken. Mr. Hundhausen said BCHC had received a donation from a group in Bandon. Mr. Wathen confirmed BCHC had received an \$800 donation from the Episcopal Church that was meant for their patients that require mammograms. A part of that was a request that Southern Coos give discounts for some of their patients. We already have an agreement established that patients in financial need get the same amount of discount as done by BCHC. Mr. Hundhausen asked if we need to do anything further. Mr. Wathen said we have the policies in place to be able to accommodate those who cannot afford a mammogram. Mr. Allen said the hospital has adopted a schedule similar to that of the Clinic that says that people they consider needy we will consider needy, but if we are talking about a discount over and above the standard that has been accepted and agreed upon, then that is something that needs to come to the Board for discussion. Mr. Wathen said that would apply to those who did not have the means for payment. Mr. Allen said we already have a policy in place for that.

CFO Report – Mr. Dow highlighted a few items in his report starting with our operations results and said he was pleased to report that we had a month that was very close to budget in patient volumes and bottom line, considering the below budget volumes the last several months and it was good to see the volumes up. Contractuals were up this month. Charity Care was higher this month, so we ended with a bottom line of just a little over \$6,500. Our operating loss was about \$32,000 compared to a budget of \$43,000, so that was above budget as well. We have a YTD net operating loss of \$700,000; after you account for non-operating revenue we have a loss of about \$60,000. He then told the Board that because of low volumes we have been using our unrestricted reserves. Our A/R days improved in the months that we used our reserves because our A/R days are based on our average revenue for the past three months.

Mr. Dow then said that with March's recovery and volumes we are not in need of any borrowing from Board restricted funds now, but because we have utilized our unrestricted funds, and with go-live, a possibility that our A/R days will likely rise. Mr. Dow said he felt it would be best, on a contingent basis, to seek authorization for up to \$400,000 for the next several months through our go-live. This is not a permanent request, I believe we will pay it back. Once we start to depreciate the Paragon system, we will start to see about \$150,000 a year in added reimbursement, but that will not happen until after we go-live. He then pointed out that he has proposed we budget a little higher target next year since we have depleted our Unrestricted Cash Reserve. I think it is prudent to ask for up to \$400,000 that can be used on a temporary basis, for operations through our post go-live date (about 60 days). Whatever our A/R days go up to during go-live, he expects that within 60 days we will have them back down. He then told the Board

he was also pleased with the integration testing and more comfortable about going live. We will be working our patient accounts on both systems for a couple of months. Mr. Allen clarified with Mr. Dow that this was a cash flow issue and not an anticipated loss. Mr. Dow confirmed this was the case, assuming our patient volumes stay at a normal level. Mr. Allen **Moved** to authorize administration to expend up to \$400,000 of the Board Restricted Reserve fund, basically our sale on the nursing home, for a period of four (4) months. Mr. Hundhausen asked if there were any questions for Mr. Dow. Mr. Vick **Seconded** the motion. Mr. Wathen clarified the request, and said it is not our intention to use these funds unless absolutely needed for expenditures. We have realized a decent cash flow this month, and if this continues, we will not have to touch those funds. Mr. Hundhausen asked how Mr. Dow had reached the \$400,000 amount. Mr. Dow said he had estimated possibly a \$100,000-\$150,000 between now and go-live, and the balance post go-live due to the A/R days increasing. Mr. Alan said this would be over a four-month period. Mr. Wathen said the Board has been asked many times in the past for use of those funds, and unless we have indicated that it was something that just needed to come out of those funds, we have repaid the fund. The last time we asked for funds was about two years ago. Mr. Hundhausen asked if it time to consider a austerity program. Mr. Wathen said we have already started that with reductions of staff in a number of departments and have deliberately not replaced those who have left. These will remain in place with probably some additional cuts that are being considered as a part of the budget that will be presented next week. Mr. Dow added that with our go-live pending, it is very hard to embark on austerity right now. When we have available staff time in nursing and other areas that could do file building, we have utilized those resources. There was a discussion regarding our Accounts Payable. Discounts are taken and we are better off than we were a year ago. Ms. Noorda commented that it is great that people are well and our hospital is not full or at least where we can meet our expenses. Lonnie has a special event coming up and said this is just the main thing, just letting everybody know how wonderful the hospital is when it comes to meeting their needs. She said she was sure we have cut as much as we can and told Mr. Wathen that she knew he was doing the best he can. Mr. Hundhausen asked for a vote to accept the motion to approve the request, contingent upon need, of the \$400,000 from the Board Designated funds for four months. Motion passed unanimously.

CNO Report – Deferred members to her report in their packet. She thanked the Sprague Foundation and the community for providing funding for the new TVs in the patient rooms. Each bed now has a TV and a pillow speaker. She then told the Board about Hospital Week and the plans for an Open House on May 15. She invited everyone to attend and encourage others to come and see what our hospital has to offer.

Medical Staff – Dr. Holland updated the Board on the last Medical Staff meeting held at Lord Bennett's. She told the Board this was to try and get better participation from the Medical Staff and it went really well, with one physician participating over speaker phone. She was impressed with the amount of passion and dedication that the doctors have. They spent a lot of time talking about the future of the hospital and how we can help. She said there were a couple of concerns she wanted to share. The first one is the loss of a primary care providers' referral base for the hospital and how that is affecting the hospital's bottom line.

There was some extensive brainstorming about different ideas that could be done. Mr. Allen asked Dr. Holland to explain what we had just lost. She said it was the loss of a local providers' referral base; hospitals live and die by the primary care doctors in the community that send them lab and X-ray testing, recommend that patients have surgeries at the hospital, use the hospital's outpatient clinic, and recommend that their patients go to the hospital to be admitted. There has been quite a rapid loss in the last 6-12 months in terms of a doctor actively referring patients to the hospital for surgeries and inpatient admissions. In fact some of the doctors in the community, some of the primary care doctors, are recommending that some of their patients go to Bay Area Hospital. A hospital cannot survive without doctors that trust and have faith in the hospital system because that is how the hospital generates all of their income. There is concern about that for a couple of reasons, the first is just that we all love this hospital and feel like we have provided very good care here and we want to be sure the doctors in the community feel the same way and are sending their patients to the hospital. Without that the hospital cannot survive. And also, as a country, we are facing a growing shortage of primary care providers in general. It is difficult to recruit providers to the area that do not have strong hospitalist systems in place. It is a difficult to recruit providers to hospital who do not have an active, driving hospitalist system. I mentioned some in the past about that. There was a recent study that just came out. She read it to the Board:

'With healthcare reform, 74% of physicians will retire or seek other alternatives as opposed to full-time independent private practice, within the next 10 years because of changes that are being made with healthcare reform. Specifically, that a lot of them will work as employees, work part-time, work as administrators, work with cash only practices, or retire from medicine altogether.'

Seventy-four percent of physicians is an awful lot. In rural communities it is already hard to recruit primary care doctors. This is across all specialties, but primary care takes a particularly hit, it always does. So they wanted to express their level of concern they have about the loss of the hospitalist referral base, because that is critical. They also wanted me to let you know they are all very uncomfortable with the amount of instability in the hospitalist schedule since Sandy Wilson has not been replaced yet. It has placed quite a burden on some of the doctors, in particular, we have to thank Dr. Pasternak and Dr. McQueen. Dr. McQueen and Dr. Pasternak have been covering ED and Hospitalist at the same time, but they never intended to be doing that during the week as well. When there are shifts that are not covered, the hospital has to pay quite a bit extra to get locums in and there is always a wide range of quality and what you can expect from a locums doctor. You have to take what you get usually, because there is such a shortage of doctors that provide temporary coverage as well. So they just wanted it expressed to you that they are not happy with the situation and would like some resolution in terms for what the plan is for covering hospital shifts.

Mr. Hundhausen asked if among the physicians, if there were any solutions. Dr. Holland responded that there is continuing support for the idea of hiring one or two additional providers that will be willing to do both ED call and Hospitalist care at the same time. That has some difficulties inherent in it if the hospital was to get busy, or if two people were having a crisis at the same time, the emergency room and one on the floor. There is only one doctor in a setting like that. They also discussed the possibility of having the hospital doctor, if there is a full-time

hospitalist available, doing some primary care coverage in the late afternoon and evenings. Dr. Riddick was more than happy to share his office and that would help provide some financial support for the hospitalist salary because they would be able to bill for outpatient medical care as well. So some kind of combination of hospitalist and outpatient primary care was suggested. The reality is that in a lot of the hospital systems across the country, hospitals are starting to partner up with physician groups, both to improve their referral base and to improve their hospital coverage. And a lot of clinics are doing a combination role where they are doing outpatient medicine part of the day and hospital medicine part of the day. Those were the main ideas they had. They both have problems that you can pick apart. I just thought it was important to you that they are looking and hoping to help the Board to find a solution that will work and be supportive for the long term.

Ms. Noorda commented that long ago the doctor that checked a patient into the hospital, the doctor was the one that checked the patient out. Maybe that just doesn't work these days. Surely Coquille and the smaller hospitals have this same problem. We are not so busy that I cannot imagine this being a problem. She said she was wondering how Dr. Holland fit into this situation. Dr. Holland said she had been covering for shifts for hospitalist when I can. When the hospital has had an emergency need I have stepped in many times already in the last 2 months. Actually it is very difficult. Right now, on average I work 70 hours a week and this is not seeing patients in the hospital. I have teenagers, I have a family, and I am not alone in that. Primary care doctors have long been the workforce of medicine. We have to manage a lot of different things and even our time when not seeing patients is frequently spent doing things like reviewing notes from consultants, reviewing X-ray and lab reports. I don't see patients on Wednesdays but I was in my office yesterday from 6:30 a.m. until 7 p.m. that night and I was working the entire time. That is typical for doctors working with outpatients. If you as a doctor, want to work part-time, do you want to know that they consider part-time? Forty hours a week is considered part-time for a doctor. Most people would never consider working the number of hours a regular doctor actually works and then say, how am I going to fit that into my day. I got to clinic at 6:30 this morning, am I going to get up at 5 in the morning and round all my patients and when I get done at 6:30 in the evening, am I going to go back to the hospital and round my patients again until 8 p.m. and then go home and try and spend a few minutes with my kids before they go to bed. That is the reality that most doctors face that work in primary care or in outpatient medicine. The doctors who are doing it do not want to do it anymore and the doctors that are coming out of medical school and residency are saying absolutely no way are they going to do it. Mr. Vick then showed those present an article he had asked Jim to copy. It is in the Board notes. The title is '*More Physicians Say No To Endless Work Days*'. He explained that it was about a lady whose father and grandfather were physicians and she followed into the business. She says "Quite frankly I cannot imagine raising my children and working as hard as my father did." It almost encapsulates what Dr. Holland just said. It is just a fact of life. Ms. Noorda asked about trading around with other hospitals. Dr. Holland said she could comment one thing about Coquille. I have asked them and what they do is, when they cover, they do not do clinic the next day. Or if they do, they have clinic in the afternoon so they have time to recover from their call and get home to their family. They have a large group that shares it but with small clinics like in Bandon, frequently there is no coverage at all. It does not happen that way. When I was on call for the hospital I spent 10 hours in the hospital on a Saturday and when I was

on call for Monday night I came into the hospital at 1:30 in the morning and did not leave until 4 and had to go to my long day at the clinic that started at 9 a.m. and I saw patients until 7:30 that night. I couldn't afford to cancel those patients after being up all night at the hospital. That was just one patient that got really sick and needed me to be there 4 hours.

Mr. Allen said he had 3 things for comment. He did not think it behooves us to comment on doctors following their patients in the hospital. It is a reality that we have to accept. Second, I think the administration needs to discuss with us the hospitalist situation. Third, I think the Board needs to address the larger problem about what Dr. Holland started out talking about which is some doctors are not referring patients to us anymore. Part of that, I am sure, is North Bend and that has always been a problem. Perhaps there is more to it and that is something the Board needs to sit down and talk about how we can attract or encourage physicians to refer here. First, we have to get over physicians not following their patients in the hospital. That is just not the reality. Second, we need to solve the hospitalist program. Third, the Board needs to address physician referral to the hospital. Mr. Hundhausen asked if there was a relationship between primary care physician referrals and concern over the Hospitalist/ED schedule. And if solving one problem will help with the other. Dr. Holland stated that unfortunately the decision for not referring to the hospital is largely being made on personal agendas and conflicts and not necessarily what is best for the patient and the quality care and definitely not what is best for the hospital. Mr. Allen commented that Dr. Holland is saying this is a physician problem not a community perception problem. Dr. Holland said unfortunately it is a little bit of both right now. All it takes is one bad outcome for a hospital to get tarred with a bad brush. Unfortunately that outcome sometimes happens in medicine and surgery in spite of best intentions and best physician practice. I think the hospital is experiencing some fallout from a recent bad outcome, but the majority of the problem is not related to that. Mr. Wathen said we have been actively recruiting over the past two months. We have gotten responses from a couple of physicians, but after our initial discussions with them, they did not want to talk much anymore. We have started formal recruiting efforts. Our purpose is to recruit physicians, at least one, possibly two, who will do both ED and Hospitalist coverage. You will see the reason behind this at our Budget meeting next week. Dr. Holland said that a lot of hospitals have actually fixed their primary referral base problem by having their own employed physicians working in an outpatient clinic. That is a 100%, dedicated referral to the hospital when that happens. There still is a primary care referral problem in the community.

V. Old Business – There was none

VI. New Business

- A. Request for Sustainability Fund – Ms. Gillard-Juarez explained that there are two things. One is to establish or help build our Sustainability Fund so the Foundation is here for many years to come to continue to contribute money toward equipment for the facility and technology for the Hospital. The other part is we are trying to raise money to buy the digital technology for the mammography machine which will make the Radiology department completely digital. It needs to be done right away. We would like to use half the money to help in buying the \$80,000 piece of equipment. Also, to make a

memorial to the Boak family. Mr. Allen said as your representative to the Foundation Board I support this wholeheartedly. He also said if the Foundation had been around when the gift was given, there is no question the gift would have gone to the Foundation and not to the hospital. The Foundation works hard for us and they would like to have some seed money in some kind of endowment or sustainability fund. They are only talking about part of it, using some for seed money for a significant gift to the hospital. I appreciate that money we got from the Boaks, but it went into operations. This is something that would be more permanent. Further discussion followed on what should be done with the Boak gift. Mr. Allen **Moved** to commit \$50,000 of the final distribution of the Boak Trust to the Foundation. Mr. Vick **Seconded** the motion. Motion carried 3 Ayes with Mr. Hundhausen voting Nay.

B. Benchmark Reports

- National Core Measures
- Risk Management Report

Mr. Wathen told the Board the reports are there for the Board's information.

Mr. Hundhausen told the Board that Mr. Wathen had requested that his contract be renewed per contract, so the Board is hereby informed that Mr. Wathen wants his contract renewed for another 2-year term and requests that it be placed on the agenda for the June 26 Board meeting. Mr. Allen asked if the Board would have his evaluation done before that time. It was confirmed the evaluation would be completed prior to the June meeting.

VII. Open Discussion

Mr. Vick – No comments except Board training well done and informational

Ms. Noorda – Ditto. It was very, very good. Looking forward to May 15.

Mr. Allen – Appreciated the way distribution discussion was handled.

Mr. Hundhausen – Likewise, he thought it was a very good session and hope to do it on an annual basis. Congratulations to Mr. Wathen and Governor Kitzhaber regarding our participation with OHN. It was outstanding.

VIII. Adjournment - Meeting adjourned at 9 p.m. The next regular meeting of the Southern Coos Health District Board will be Thursday, **May 26, 2011**, at 7:30 p.m. in the Conference Room.

Bob Hundhausen, Chairman

Vicki Gernandt, Secretary