Kittitas County Public Hospital District No. 2
BOARD OF COMMISSIONERS' REGULAR MEETING

August 15, 2022 at 6:30 p.m.
Upper Kittitas County Medic One Ambulance Station 99
111 Pine Street, Cle Elum

AGENDA

I.	**Introductions**	
II.	**Approval of Agenda***	**(1)**
III.	**Approval of Minutes***	
	a. July 18, 2022	**(2-3)**
IV.	**Public Comments/Announcements/Correspondence**	
V.	**Reports:**	
	a. Operations Report (G. Scherer)	**(4-9)**
	1. Emergency Medical Services Innovative Agreement	**(10-46)**
	b. Superintendent's Report (J. Petersen)	**(47-48)**
	c. Ancillary Report (R. Holden)	**(49-51)**
	1. Community Updates	
	d. Finance Report, Approval of Expenses* (S. Olander)	**(52-61)**
	e. Levy Updates* (F. Rogalski, C. Youngblood & S. Olander)	**(62-63)**
VI.	**Old Business**	
VII.	**New Business**	
	a. New Station 99 Close Out (R. Urlacher)	
	b. Next Meeting Date: September 19, 2022	
VIII.	**Executive Session**	
IX.	**Adjournment**	

Note: Upcoming Agenda Items

Key:
*Action Item

Kittitas County Public Hospital District #2

BOARD MEETING MINUTES

Meeting Date:	Monday: July 18, 2022
Minutes of:	Regular Meeting of the Board of Commissioners
Meeting Place:	Medic One Ambulance Station, 111 Pine Street, Cle Elum, WA
Minutes Submitted By:	Scott Olander, Treasurer

Call to Order:

Meeting: Call to Order – Call to order made by Commissioner Rogalski at 6:30 p.m.

Introductions:

Commissioners: Floyd Rogalski, Ingrid Vimont, Hartwig Vatheuer, Carrie Youngblood and Fred Benjamin. Superintendent: Julie Petersen (excused); Treasurer: Scott Olander; Ancillary Operations: Rhonda Holden and EMS Manager: Cole Gravel via telephone for Geoff Scherer who was excused.

Approval of Agenda:

Action: A motion to approve the agenda was made by Commissioner Vatheuer and seconded by Commissioner Benjamin. Motion carried.

Approval of Minutes:

Action: A motion to approve the minutes of June 20, 2022 as amended was made by Commissioner Benjamin and seconded by Commissioner Vimont. Motion Carried.

Operations Report:

The Commissioners reviewed the written operations report and operating statistics prepared by Geoff for June 2022. June transports exceeded budget by 14. Geoff was out of town so Cole Gravel answered questions from the Commissioners. The new Medic 10 ambulance chassis has been identified but has not been delivered to Braun.

Superintendent's Report:

The commissioners reviewed and discussed the written superintendent's report. Julie's report noted that a joint District 1 and District 2 Board Meeting is scheduled for September 28th from 2:00 to 6:00 pm.

Ancillary Report:

The commissioners reviewed and discussed the written ancillary report.

Finance Report:

The financial statements for June 2022 were reviewed and discussed by the Commissioners. The review included a review of actual versus budgeted revenue and

expense variances. MedicOne did 84 transports in June, 14 transports greater than the June budget. June transport revenue exceeded budget by $43,561. Due to the strong June transport volume and the recent increase in the transport mileage charge. YTD transport revenue exceeds budget by $23,654. June contractual adjustments exceeded budget by $10,772 due to the higher than expected June transport volume. June expenses exceeded budget by $1,775. YTD expenses are $43,866 below budget. Due to the strong June transport volume MedicOne recorded an operating income of $26,563 for the month. YTD the District has a positive net income of $71,693; and a positive budget variance of $80,158.

Action: A motion to approve the warrants for June was made by Commissioner Vatheuer and seconded by Commissioner Youngblood. Motion Carried.

Levy Discussion:

In discussions with the Kittitas County Auditor's office and attorney Brad Berg, Scott learned that to increase the EMS levy to 50 cents per thousand will require a super majority approval from the voters and a voter turnout of at least 40% of the previous general election. The regular levy can be increased to 50 cents per thousand by approval of a simple majority of the voters. Increasing the EMS levy to only 25 cents per thousand would require a simple majority of the voters to approve the levy increase. The Commissioners discussed the needs of the District and the pros and cons of each option. The Commissioners discussed the rapid growth within the district, the levy funds that would be raised by increasing the EMS and regular levies and considered the revenue short fall from MedicOne operations.

Action: A motion to approve Resolution No. 07-18-22-01 to increase the EMS levy to 50 cents per thousand was made by Commissioner Vatheuer and seconded by Commissioner Vimont. Motion carried.

Action: A motion to approve Resolution No. 07-18-22-02 to increase the regular levy to 50 cents per thousand was made by Commissioner Benjamin and seconded by Commissioner Youngblood. Motion carried.

The Commissioners discussed working with Suncadia, Cle Elum Rotary and other community service organizations to raise funds for a levy campaign.

Executive Session:

There was no executive session.

Announcements:

The next regular meeting date: August 15, 2022 at 6:30 pm in the UKC Medic One Ambulance Station located at 111 Pine Street, Cle Elum, WA.

There being no further business the regular meeting was adjourned at 7:30 pm by Commissioner Rogalski.

Operation's Manager Report – July 2022

	July 2022	July 2021
Calls for Service	**147**	**151**
Patient Count	**134**	**118**
Patient Transports	**84**	**86**
Patient Refusals	**27**	**14**
Year to Date Transports	**505**	**478**
Station #73 Transports	**42**	
Station # 99 Transports	**42**	
Passed Calls	**0**	

PERSONNEL

The agency received only 4 applications for part time employment. This is a significant reduction from the last few years when HD2 has put on an assessment center. We will reopen the application deadline and push off the testing until we have more applicants.

APPARATUS

Medic units have been working well. Cross Road Garage in Ellensburg has been working with the agency for ambulance maintenance. Medic 10 chassis has been delivered and is currently in production at Braun.

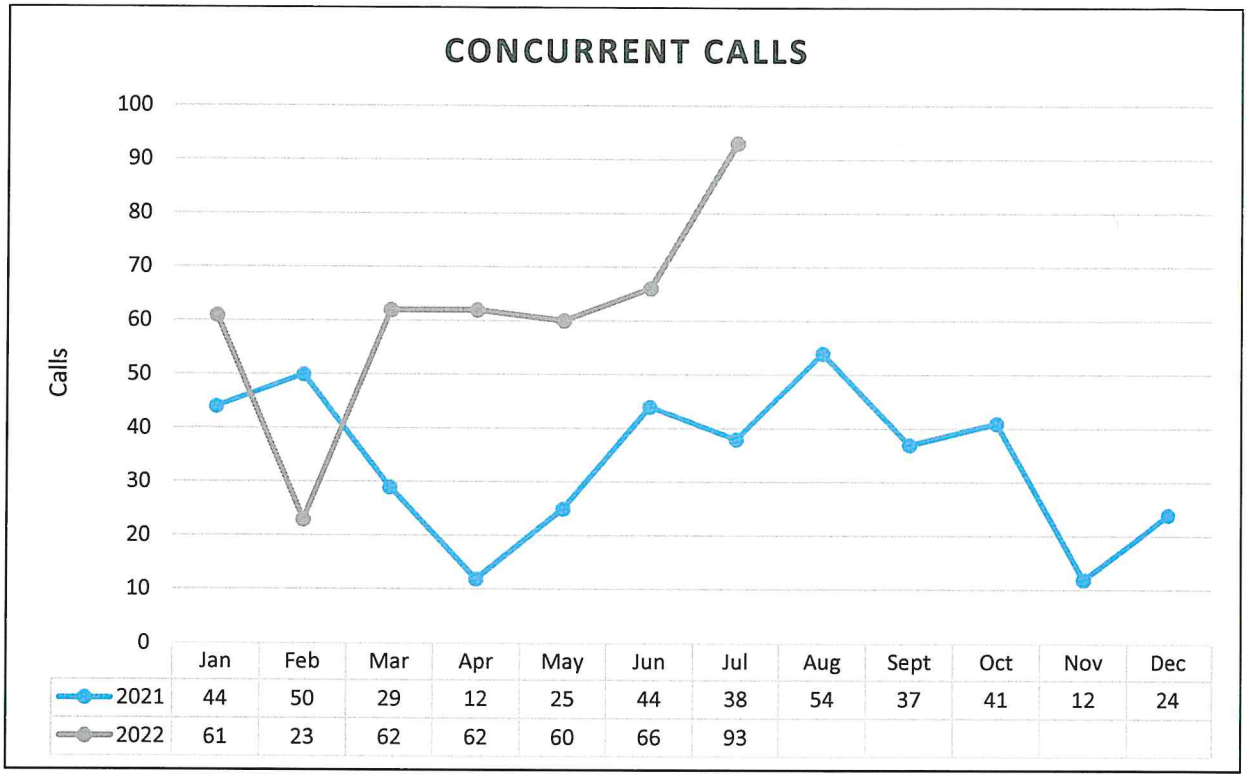
Year	Unit	Beg ODO	End ODO	Miles	Location	Comments
2021	M9	10,850	15,974	5,124	Station 93	1st Our
2019	M8	70,488	72,942	2,454	Station 99	1st Out
2016	M6	140,696	140,696	0	Station 99	Backup
2016	M5	148,314	148,980	666	Station 99	Backup
Total Miles				8,244		

MISCELLANEOUS

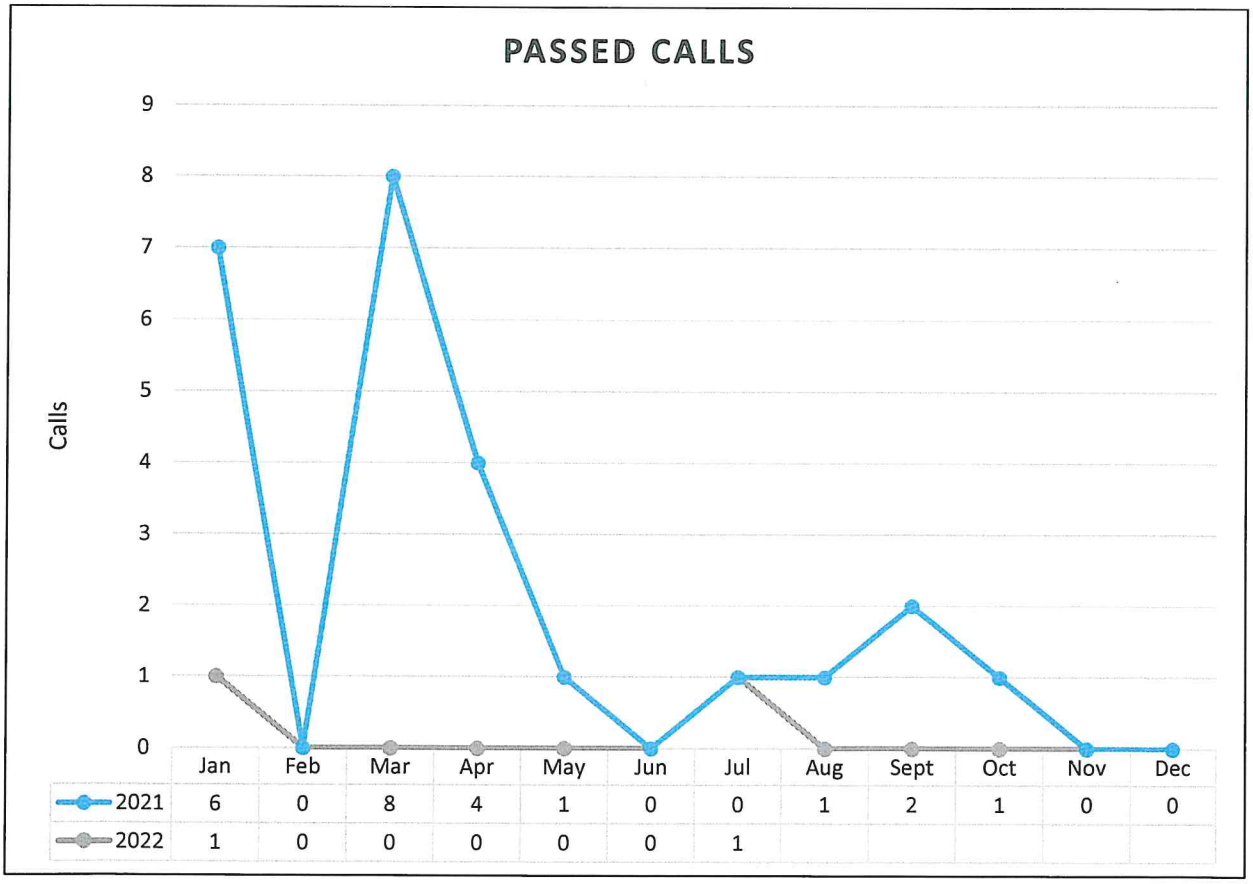
- The agency has received 3 applications for the EMT reserve program
- GCACH has the EMS agreement ready to execute, this is a $150,000 grant for community paramedicine work in the upper county
- The agency needs another Life-Pak-15 for the backup rigs
- Overlapping calls

2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Percent	29.9%	41.7%	24.8%	12.4%	20.5%	30.9%	25.2%	35%	26.8%	33.6%	12.1%	18%
Calls	44	50	29	12	25	44	38	54	37	41	12	24

2022	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Percent	34.86%	38%	47%	44%	51%	54%	37%					
Calls	61	23	54	48	64	78	54					



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2021	44	50	29	12	25	44	38	54	37	41	12	24
2022	61	23	62	62	60	66	93					



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2021	6	0	8	4	1	0	0	1	2	1	0	0
2022	1	0	0	0	0	0	1					

Kittitas County Hospital District #2

Patient Transport Count per Destination - 2022

Hospital	YTD	May	June	July
Centeral Washington Hospital	5	3	1	0
Harborview	23	3	4	2
KVH	308	44	60	68
Snoqualmie Valley Hospital	13	1	3	2
Swedish Issaquah	31	7	6	6
Virginia Mason	4	1	1	0
Yakima Regional	0	0	0	0
Yakima Memorial	11	3	3	2
Childrens	1	0	1	0
University of Washington	0	0	0	0
Other	12	4	4	4
Overlake	11	0	1	0

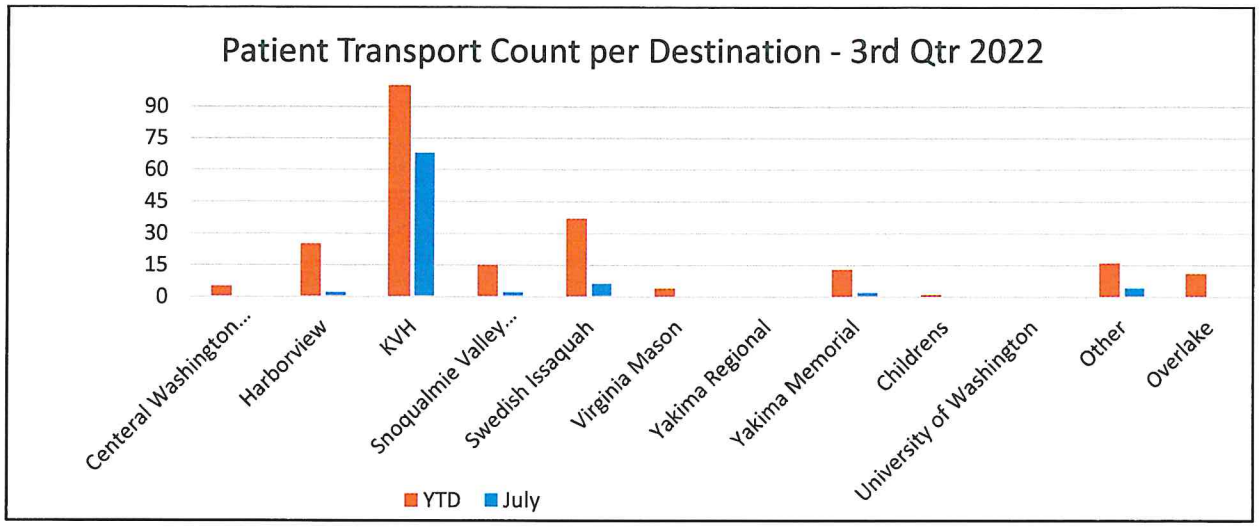
	YTD	May	June	July
Out of County Transports	113	19	21	12

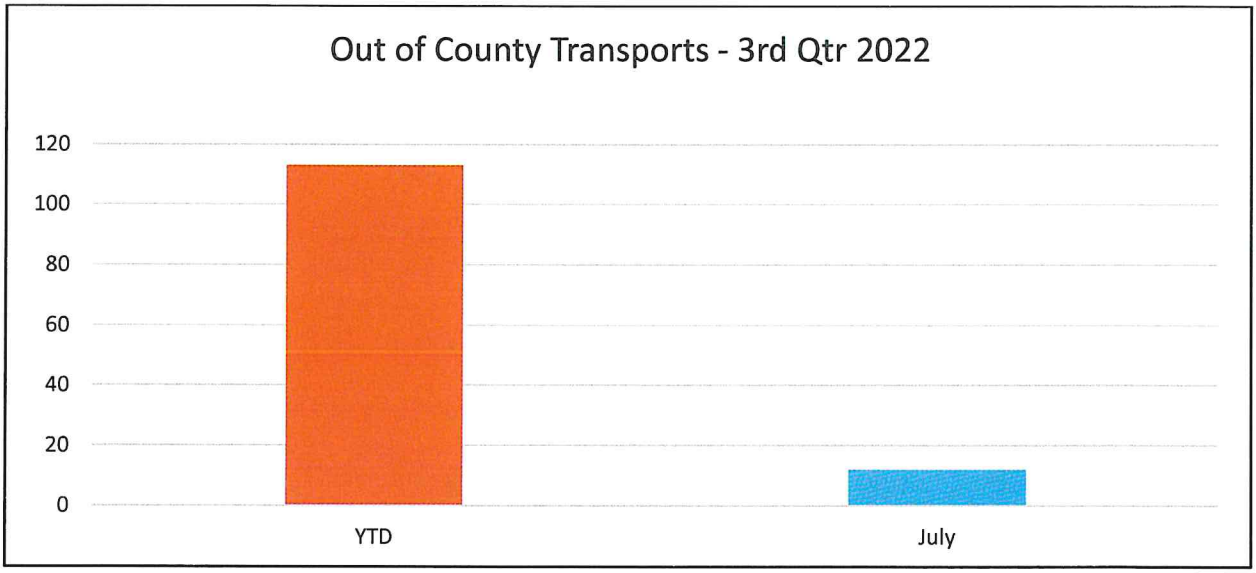
Call For Service Per Zone

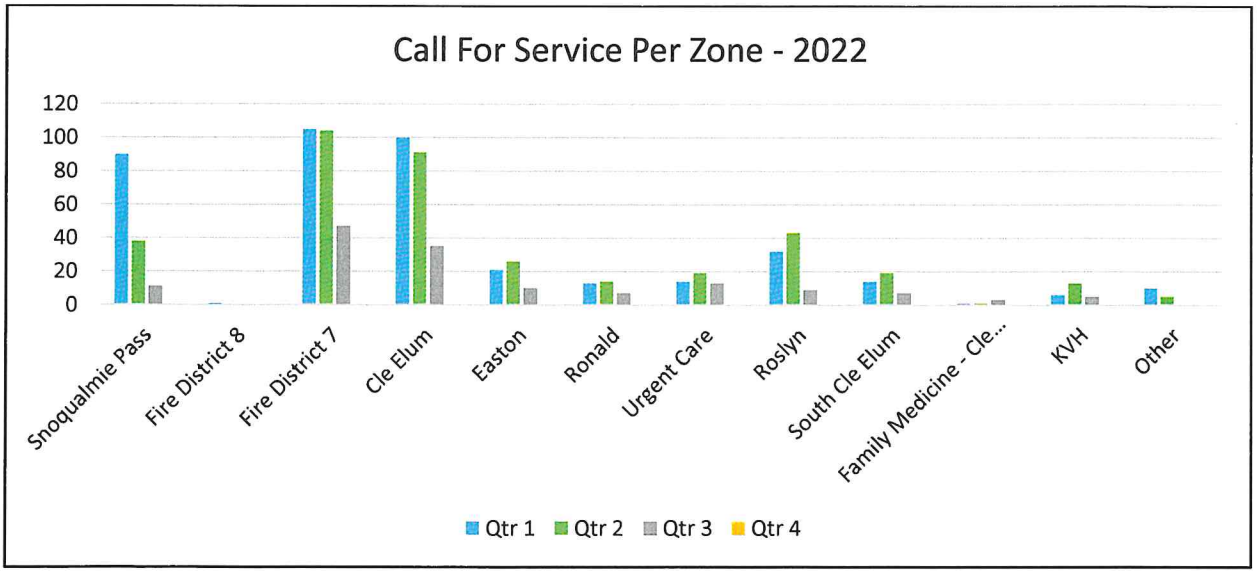
Zone	YTD	May	June	July
Snoqualmie Pass	128	10	13	11
Fire District 8	1	0	0	0
Fire District 7	209	30	30	47
Cle Elum	191	32	27	35
Easton	47	6	7	10
Ronald	27	2	5	7
Urgent Care	33	1	8	13
Roslyn	75	12	19	9
South Cle Elum	33	8	8	7
Family Medicine - Cle Elum	2	1	0	3
KVH	19	3	7	5
Other	15	3	0	0

Zone	YTD	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Snoqualmie Pass	128	90	38	0	0
Fire District 8	1	1	0	0	0
Fire District 7	209	105	104	0	0
Cle Elum	191	100	91	0	0
Easton	47	21	26	0	0
Ronald	27	13	14	0	0
Urgent Care	33	14	19	0	0
Roslyn	75	32	43	0	0
South Cle Elum	33	14	19	0	0
Family Medicine - Cle Elum	2	1	1	0	0
KVH	19	6	13	0	0
Other	15	10	5	0	0

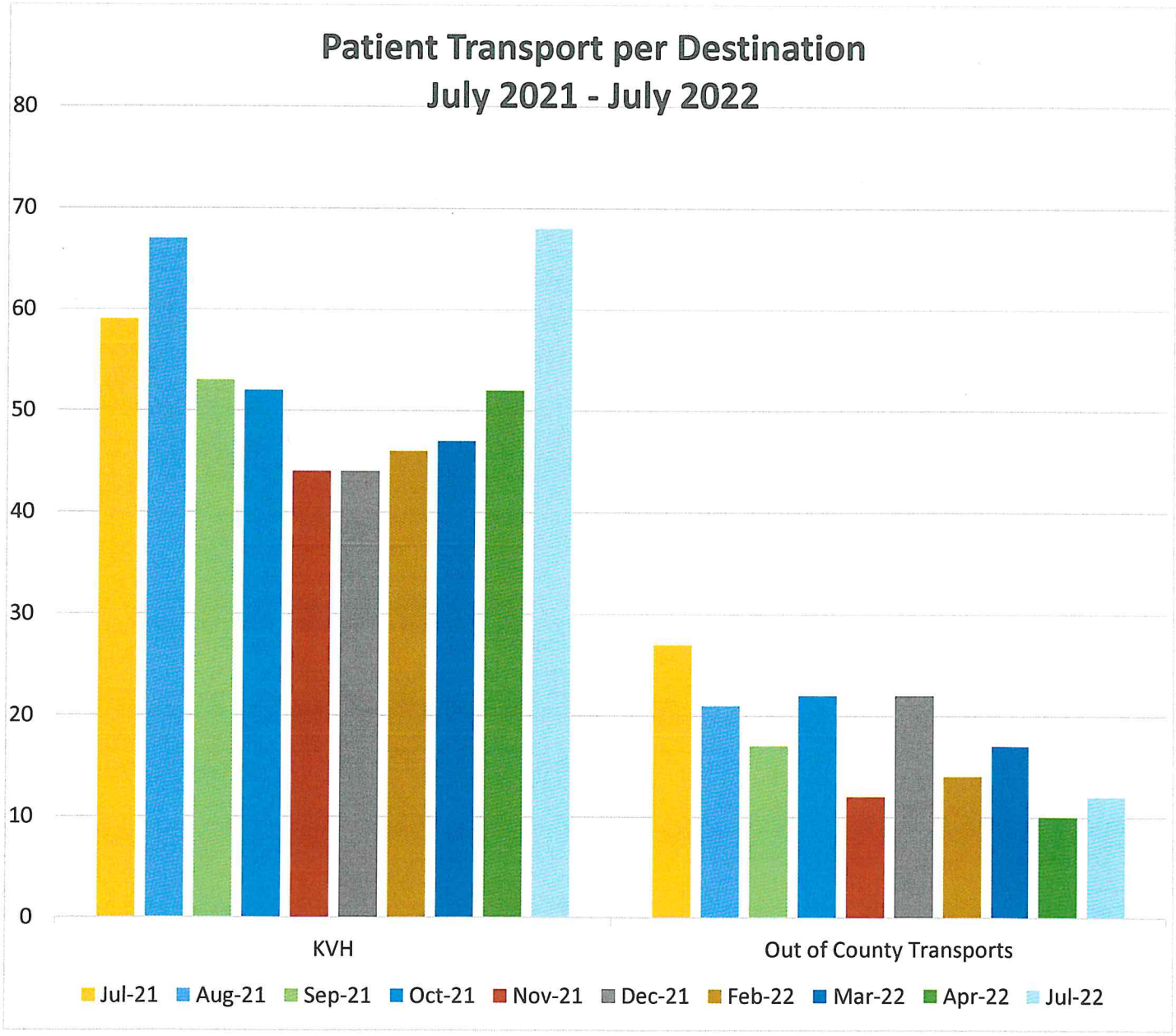
Comments:


Patient Transport Count per Destination - 3rd Qtr 2022
90
75
60
45
30
15
0
Centeral Washington...
Harborview
KVH
Snoqualmie Valley...
Swedish Issaquah
Virginia Mason
Yakima Regional
Yakima Memorial
Childrens
University of Washington
Other
Overlake
YTD
July


Out of County Transports - 3rd Qtr 2022
120
100
80
60
40
20
0
YTD
July


Call For Service Per Zone - 2022
120
100
80
60
40
20
0
Snoqualmie Pass
Fire District 8
Fire District 7
Cle Elum
Easton
Ronald
Urgent Care
Roslyn
South Cle Elum
Family Medicine - Cle...
KVH
Other
Qtr 1
Qtr 2
Qtr 3
Qtr 4

Patient Transport per Destination													
Hospital	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	######	Jun-22	Jul-22
Central Washington Hospital	2	1	0	0	0	3	0	0	1	0	3	1	0
Harborview	5	2	2	6	1	3	5	5	4	2	3	4	2
Snoqualmie Valley Hospital	3	1	0	2	0	1	3	3	3	0	1	3	2
Swedish Issaquah	8	8	2	6	5	7	6	4	4	4	7	6	6
Virginia Mason	1	3	2	2	2	1	1	0	0	1	1	1	0
Yakima Regional	0	0	0	3	0	0	0	0	0	0	0	0	0
Yakima Memorial	3	1	0	3	1	3	1	1	2	1	3	3	2
Children's	0	0	4	1	0	0	0	0	0	0	0	1	0
University of Washington	0	2	1	0	2	0	0	0	0	0	0	0	0
Other	2	2	4	0	1	4	4	0	0	3	4	4	4
Overlake	3	1	2	2	0	0	4	1	3	2	0	1	0
KVH	59	67	53	52	44	44	59	46	47	52	44	60	68
Out of County Transports	27	21	17	22	12	22	24	14	17	10	19	21	12

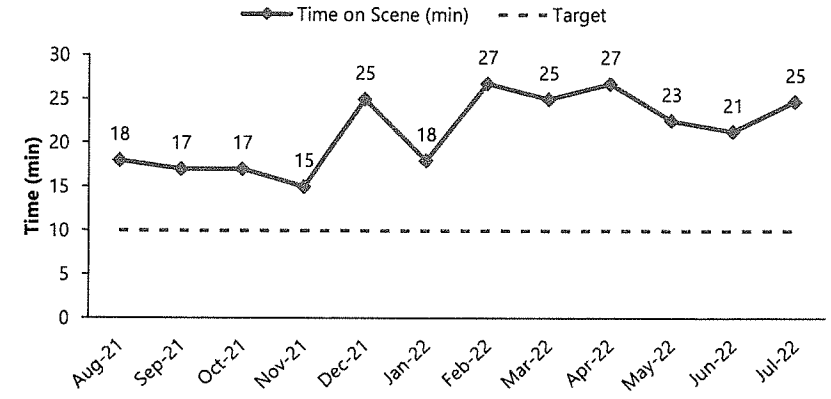


Kittitas County Public Hospital District No. 2

Quality Metrics

Time on Scene ↓

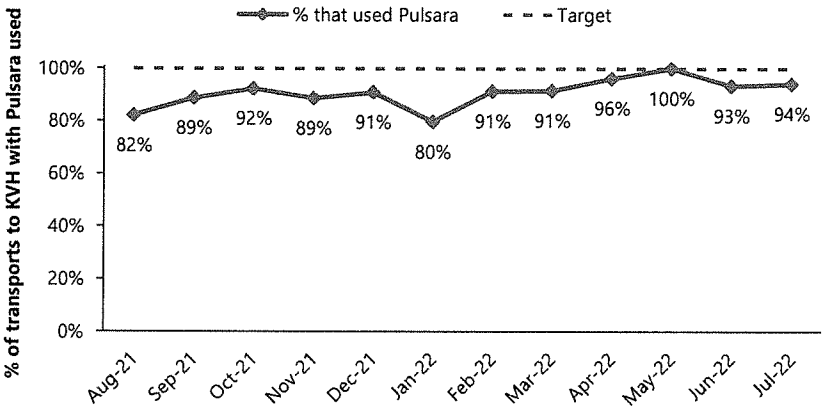
for trauma patients



# of cases	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
	14	10	13	7	12	16	31	14	16	21	17	21

Pulsara Used ↑

for patients transported to KVH



# of transports to KVH	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
	67	53	52	44	44	59	46	47	52	44	60	68

EMERGENCY MEDICAL SERVICES INNOVATIVE AGREEMENT

THIS EMERGENCY MEDICAL SERVICES INNOVATIVE AGREEMENT (EMSI) ("Agreement") is entered into by and between the Greater Columbia Accountable Community of Health, a Washington nonprofit corporation ("GCACH") and Kittitas County Public Hospital #2, a Washington county for the purposes of establishing an EMSI Program which will include the First Responder. The term First Responder shall include Upper Kittitas Medic One ("First Responder").

RECITALS

A. GCACH is a Washington nonprofit corporation operated exclusively for charitable and educational purposes under 501(c)(3) of the Internal Revenue Code. GCACH collaborates with a regional coalition of stakeholders and partners to address health issues through community and healthcare transformation based upon the eight change concepts and evidence-based best practices under the Patient Centered Medical Home (PCMH) model of care.

B. First Responder is a qualified, licensed healthcare business interested in transforming its practice to allow patients/clients to have coordinated access to the full complement of medical and behavioral health services.

C. The purpose of this Agreement is to incentivize First Responder to develop and implement integrated managed care that increases treatment options for the First Responder's patients, and coordinate patients with ancillary services and community – based resources through a holistic integration of primary care, behavioral health, and chemical dependency.

D. Incorporated herein by this reference are the attached "Definitions" marked as Exhibit D that may be used in this Agreement.

FOR VALUABLE CONSIDERATION, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

1. PERIOD OF PERFORMANCE/TERMINATION

This Agreement shall remain in full force and effect from the Effective Date August 1, 2022 until the Completion Date August 31, 2023. Either party may terminate this Agreement within thirty (30) days of written notification to the other party.

First Responder understands that the Funding for this and future related EMERGENCY MEDICAL SERVICES INNOVATIVE (EMSI) Contracts has been and will be based upon the complete performance of this Agreement by First Responder and that there is no guarantee of an extension of this Agreement nor future Agreements. First Responder understands and agrees that the damages suffered by GCACH are difficult if not impossible to estimate on the effective date of this Agreement. In the event of First Responder's breach or abandonment of this Contract, GCACH may thereupon and without further notice, terminate this Agreement. GCACH without waiving any other remedies available to it, may retain any monies otherwise due to First

Responder under this Agreement and may seek compensation from First Responder for breach of this Agreement.

2. PAYMENT DISTRIBUTION AND MILESTONES

Payment for satisfactory completion of any Milestones shall be made to the County for the purpose of the First Responder. Payment shall be made as determined by GCACH and in accordance with the "EMERGENCY MEDICAL SERVICES INNOVATIVE (EMSI) REVENUE SHARING MODEL AND MILESTONE REPORTING SCHEDULE" marked as Exhibit A, incorporated here by this reference.

GCACH shall not be obligated to pay the County for its Milestone achievements or the Milestone achievements of its First Responder until the Director of Practice Transformation is satisfied that the Milestone has been satisfactory completed.

GCACH ensures that all Funding transferred to the County are not federal funds and are otherwise eligible to be used as the non—federal share of Medicaid expenditures consistent with 42 CFR 433.51, by providing funds only from sources that GCACH has approved as allowable sources. County shall maintain records to document the source of transferred Funding and furnish such records to GCACH as requested.

3. ALLOWABLE COSTS

Expenditures used for the purposes of EMSI program shall be reviewed by GCACH through a budget documented "EMSI Budget Template" attached as Exhibit B and incorporated here by this reference. The EMSI Budget Template shall be completed by the First Responder. "Non-allowable Expenditures", attached as Exhibit C and incorporated here by this reference, shall be prohibited if not consistent therewith. GCACH reserves the right to review any and all transaction expenses with regard to Funding. County shall maintain complete financial records relating to this Agreement and services rendered by First Responder. If Non-Allowable Costs are identified during the performance of this Agreement and within ninety (90) days after the Completion Date, such Non-Allowable Costs shall be excluded from any payment to County. GCACH reserves the right to offset Funding that is been used on Non—Allowable Costs and reallocate the same to County upon receiving a revised budget.

4. RESPONSIBILITIES OF COUNTY/FIRST RESPONDER

County shall be responsible for registration in the Washington Financial Executor Portal ("WAFE") and completing the Milestones outlined under the EMERGENCY MEDICAL SERVICES INNOVATIVE (EMSI) REVENUE SHARING MODEL AND MILESTONE REPORTING SCHEDULE.

In the event County has a change in its legal status, organizational structure or fiscal reporting, County shall notify GCACH of such change within thirty (30) days before such change takes effect. Unless otherwise specified in this Agreement, any and all expenses incurred by County/First Responder during the performance of this Agreement are the responsibility of County/First Responder.

County and the First Responder shall be responsible to perform any and all "Milestones" as identified on Exhibit A at the times set forth in accordance with the definitions and expectations in the EMERGENCY MEDICAL SERVICES INNOVATIVE (EMSI) REVENUE SHARING MODEL AND MILESTONE REPORTING SCHEDULE.

First Responder shall report its Milestones by way of the Reporting Platform supplied by GCACH, the software and training for which shall be provided by GCACH.

5. RESPONSIBILITIES OF GCACH

GCACH shall be responsible for distributing payments through the WAFE Portal, providing technical assistance that supports the First Responder in achieving Milestones, working with the First Responder to develop a holistic integration of primary care, behavioral health, and chemical dependency. Unless otherwise specified within this Agreement, any and all expenses incurred by GCACH during the performance of this Agreement are the responsibility of GCACH.

6. REPRESENTATIONS AND WARRANTIES

County represents that First Responder is familiar with, shall be governed by and shall comply with all Federal, State and local statutes, laws, ordinances and regulations including amendments and changes as they occur. County certifies that First Responder and any and all personnel employed or engaged by County: are presently authorized to do business in Washington State and have the authority and possess all licenses to enter into this Agreement; are not presently, and will not be in the future, suspended, ineligible or disbarred wherein they would be unable to assist or perform under this Agreement; are not under investigation, have not been charged or convicted of fraud or a criminal offense in connection with obtaining, and attempting to obtain, or performing a public transaction or contract under a public transaction; have never been accused or convicted of any crime of dishonesty, moral turpitude or violence; are not in violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; are not presently indicted or otherwise criminally or civilly charged by a government entity with the commission of any offenses enumerated above and have not, within a three (3) year period preceding this Agreement, had one or more public transactions terminated for cause or default.

7. INSURANCE

County shall maintain at County's sole expense, general liability insurance from the Effective Date until the Completion Date. The minimum insurance shall be $1,000,000.00 per occurrence, and County's policy shall name GCACH as an "additional insured", further requiring that County's insurer notify GCACH in the event County's insurance will be canceled. County shall provide a Certificate of Insurance to GCACH not later than the Effective Date and shall, upon reasonable notice, provide GCACH adequate assurances of continuing coverage during the performance of the Agreement.

8. INDEMNITY

Each party shall defend, indemnify and hold the other party harmless from and against any and all claims, actions, suits, demands, assessments or judgments asserted and any and all losses, liabilities, damages, costs and expenses (including without limitation attorney's fees, accounting fees, investigation costs, etc.) alleged or incurred arising out of or related to any operations, acts or omissions of the indemnifying party, or any of its employees, agents and invitees in the exercise of the indemnifying party's rights or the performance or observance of the indemnifying parties obligations under this Agreement. The prompt notice must be given of any claim, and the party was providing the indemnification will have control of any defense or settlement.

9. PRIVACY

Any Personal Information collected, used required in connection with this Agreement shall be used solely for the purposes of this Agreement, and shall not be released, divulge, published, transferred, sold or otherwise made known to unauthorized third parties. County agrees to implement physical, electronic and managerial safeguards to prevent unauthorized access to Personal Information. GCACH reserves the right to monitor, review or investigate the use of Personal Information collected, used required by County through this Agreement. The monitoring, auditing or investigating by GCACH may include, without limitation "salting" (the act of placing a record containing unique with false information in a database that can be used later to identify inappropriate disclosure of data contained in the database). County shall certify return or destruction of all Personal Information not later than the Completion Date. A breach of this provision shall constitute a material breach, thereafter resulting in the immediate termination of this Agreement and the right for GCACH to demand the immediate return of any and all personal information. County agrees to defend, indemnify and hold GCACH harmless from any and all damages arising out of or related to County's unauthorized use of Personal Information. For purposes of this provision, "Personal Information" includes, without limitation, information identifiable to an individual that relates to a natural person's health, finances, education, business, use or receipt of government services or other activities, names, addresses, telephone numbers, Social Security numbers, driver's license numbers, financial programs, credit card numbers, and financial identifying numbers.

10. NONDISCRIMINATION

Both parties shall strictly comply with applicable federal, state and local civil rights laws and shall not discriminate on the basis of race, color, national origin, age, disability or sex, or other protected status.

11. FORCE MAJEURE

Any delay or failure of performance by either party shall not constitute a default if such delay or failure was unforeseeable and beyond the control of a party, including Acts of God or the public

enemy, fire or other casualty for which a party is not responsible, quarantine or epidemic, strike or defensive lockout, severe weather conditions, commercial impracticability, and loss of Funding (collectively, "Force Majeure"). Conditioned upon County/First Responder having no contributory fault, County/First Responder shall be entitled to an adjustment in milestone performance date(s), Completion Date directly attributable to any act of Force Majeure upon reasonable request, however shall not be entitled to an adjustment to any payment resulting from an act of Force Majeure.

12. DEBARMENT

By signing this Agreement, County certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded in any Washington State or Federal department or agency from participating in transactions (debarred). County agrees to include the above requirement in any and all subcontracts into which it enters, and also agrees that it will not employ debarred individuals. County must immediately notify GCACH if, during the term of this Contract, County/First Responder becomes debarred. GCACH may immediately terminate this Contract by providing County written notice, if County/First Responder becomes debarred during the term hereof.

13. MISCELLANEOUS

Time is specifically declared to be of the essence. This Agreement was drafted by GCACH. This Agreement shall be interpreted without favor to County as the non-drafting party. The parties agree to cooperate fully in all matters related to or arising out of this Agreement. This Agreement shall be considered at "arms-length" and not be construed as if one of the parties had an advantage. To the extent not expressly prohibited herein, this Agreement shall inure to and be binding upon the heirs, successors and assigns of the respective parties hereto. Waiver by either party of a breach of any covenant, agreement or undertaking contained herein shall be made only by written waiver, and no such waiver shall operate or be construed as a waiver of any prior or subsequent breach of the same covenant, agreement or undertaking. Except as otherwise specifically provided herein, the exercise of any remedy provided by law or otherwise, and the provisions for any remedy in this Agreement, shall not exclude any other remedy. The Parties execute this Agreement solely as parties to a contract. No corporation, partnership, limited partnership, joint venture or joint undertaking shall be construed from these presents, and no third party may rely upon any provision of this Agreement for its direct benefit. This Agreement is deemed entered into in the State of Washington and shall be governed under the laws of the State of Washington. Notwithstanding the stipulation to resolving disputes in accordance with Section 17 below, this transaction shall be deemed to have occurred in Benton County, Washington. If any party is in default, the defaulting party shall reimburse the non-defaulting parties for all notices, demand letters and collection costs, including attorney's fees and costs. The parties agree that this Agreement is the entire agreement between the parties, that each and every section of this Agreement was read, understood and fairly bargained for, and that all preceding and contemporaneous oral and written statements, representations and warranties, whether consistent or inconsistent herewith, are agreed to be of no force and effect unless

expressly stated herein. This Agreement shall only be supplemented or modified in a signed writing by both parties. All exhibits, recitals, references to extrinsic documents, occurrences and situations, attachments and schedules are hereby incorporated herein by this reference as if fully set forth herein. The Parties agree that their signatures and notary acknowledgments that are faxed to each other shall, when accumulated, operate as originals. This Agreement may be executed in counterparts.

14. NOTICES

Any Notices or other communications shall be in writing and shall be considered to have been duly given on the earlier of (1) the date of actual receipt or sent via Electronic Transmission, or, (2) three days after deposit in the first-class certified U.S. mail, postage prepaid, return receipt requested:

If to GCACH, to: Haydee Hill
Director of Finance and Contracts
hhill@gcach.org

If to County, to: Geoff Scherer EMT-IV/RN
Operations Manager
Upper Kittitas Medic One
geoff.scherer@ukcmedicone.org

15. AMENDMENT

This Agreement may be amended at any time prior to the Completion Date by written instrument executed by the parties hereto.

16. PUBLIC STATEMENTS

County/First Responder and GCACH shall not make any public statements, including, without limitation, any press releases, fliers, signage, etc., with respect to this Agreement and the transactions contemplated hereby, without the prior consent of the other party (which consent may not be unreasonably withheld), except as may be required by law.

17. DISPUTE RESOLUTION

All claims and disputes relating to or arising out of this Agreement that are less than the jurisdictional limit shall be filed in the Small Claims Division of the Benton County, Washington, District Court with waiver of the provisions of RCW 12.40.080, meaning that the parties may be represented by legal counsel. The Parties hereby knowingly and voluntarily waive any right to appeal on any Small Claims judgment, including, without limitation, alleged procedural errors. All claims and disputes related to or arising out of this Agreement in excess of the jurisdictional limit or involve equitable remedies, shall be subjected to binding and non-appealable arbitration as the

sole and exclusive remedy. If the parties cannot agree on an arbitrator, the Presiding Judge of the Benton County, Washington Superior Court shall appoint an arbitrator versed in the subject matter of the claim or dispute, which arbitrator need not be a lawyer unless legal interpretation of the Agreement is required. If the arbitrator is a lawyer, the arbitrator may engage the services of any expert to ascertain specialized factual determinations. Substantive discovery shall be allowed in the sole discretion of the arbitrator. The arbitration shall commence not later than ninety (90) days after an arbitration demand. The arbitrator may award damages and injunctive relief and may register a judgment in the court of competent jurisdiction in Benton County, Washington including judgment by default. In any suit, arbitration, proceeding or action to enforce any term, condition or covenant of this Agreement or to procure an adjudication or determination of the rights of the parties hereto, the most prevailing party shall be entitled to recover from the other party reasonable sums as attorney fees and costs.

18. ELECTRONIC TRANSMISSION CONSENT

By their signatures below, the parties hereby agree and consent to receive Notices by way of Electronic Transmission to the email addresses set forth therein. Any party can reject such consent upon 30-day's Notice as set forth therein. Upon change of email address, it shall be the obligation of the changing party to notify the other party of an email address change.

APPROVAL

This Contract is executed by the persons signing below, who warrant that they have the authority to execute it.

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH	KITTITAS COUNTY PUBLIC HOSPITAL #2
By: Sharon R. Brown	By: Floyd Rogalski
Its: Executive Director	Its: Board Chair

EXHIBIT "A"
EMERGENCY MEDICAL SERVICES INNOVATIVE (EMSI) REVENUE SHARING MODEL AND MILESTONE REPORTING SCHEDULE

The document shall be attached as a separate file in PDF format.

EXHIBIT "B"
EMSI BUDGET TEMPLATE

The document shall be attached as a separate file in PDF format.

Incentive Funding	
Planned Use of Funding	**Planned Budget**
New billing or electronic health record system	
Technical assistance	
Operating expenses for Quarter	
Recruitment and retention of staff	
Improvements to provider network	
Staffing	
Quality improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other (specify)	
TOTAL:	**$**

Incentive Funding	
Actual Use of Funding	**Actual Cost**
New billing or electronic health record system	
Technical assistance	
Operating expenses for Quarter	
Recruitment and retention of staff	
Improvements to provider network	
Staffing	
Quality improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other (specify)	
TOTAL:	**$**

EXHIBIT "C"
NON-ALLOWABLE EXPENDITURES

The document shall be attached as a separate file in PDF format.

The following list of non-allowable expenditures is subject to change. County/First Responder is not permitted to duplicate or supplant other federal or state funds from this Agreement. Several sources were reviewed to develop this list of non-allowable expenditures, including current state and federal funding guidance and other program guidance.

- Alcoholic Beverages
- Debt restructuring and bad debt
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations and contributions
- Entertainment
- Capital expenditures for general purpose equipment, building and land, except for:
    - Costs for ordinary and normal rearrangement or alteration of facilities
- Fines and penalties
- Fund raising and investment management costs
- Foods or services for personal use
- Idle facilities and idle capacity
- Interest expense
- Lobbying
- Memberships and subscription costs
- Patent costs

All costs must be considered reasonable. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. In determining reasonableness of a given cost, consideration must be given to:

a. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the entity or the proper and efficient performance of the award.

b. The restrains or requirements imposed by such factors as: sound business practices; arm's-length bargaining; Federal, state and other laws and regulations; and terms and conditions of the award.

EXHIBIT "D"
NATIONAL METRICS FOR CP INTERVENTIONS

The document shall be attached as a separate file in PDF format.

EXHIBIT "E"
DEFINITIONS

The document shall be attached as a separate file in PDF format.

Health Information Technology (HIT)
Information technology that is applied to the management of health information across computerized systems and the secure exchange of health information between consumers, providers, payers and quality monitors.

Integration
Integration could include these models:
Bree Collaborative - Integrating behavioral health services into primary care.
Collaborative Care Model (AIMS) - Team-based model that adds a behavioral health care manager and a psychiatric consultant to support the primary care provider's management of individual patients' behavioral health needs. Can be practice-based or telehealth-based. Used to treat a wide range of behavioral health conditions, including depression, substance use disorders, bipolar disorder, PTSD, and other conditions.
For any approach, apply core principles of the Collaborative Care Model into the Behavioral Health Setting
Other Integration Models could include: Mental Health with Substance Use Disorder (SUD), SUD with Mental Health, Mental Health with Pharmacy, SUD with Primary Care, Mental Health in outpatient settings like Skilled Nursing Facilities, Schools, Adult Family Homes, telehealth, or behavioral health

Patient Centered Medical Home (PCMH)
The patient-centered medical home (PCMH) is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents, and adults.

Population Health Management (PHM)
The collection and analysis of patient data across multiple health information technology recourses into a single actionable patient record.

Practice Transformation Implementation Workplan (PTIW)
Actions needed to make change systems, processes, technology, equipment, timing, budget and training that addresses new knowledge, skills, behavior and capabilities needed for change.

Web Reporting Portal
A web-based reporting and content management tool to assist First Responders in the monitoring of Participating First Responders performance and in the management of Practice Transformation and Project Areas. The First Responders Reporting Portal would also support First Responders engagement and facilitate learning by acting as a repository of information.

EMERGENCY MEDICAL SERVICES INNOVATIVE (EMSI) REVENUE SHARING MODEL AND MILESTONE REPORTING SCHEDULE

Milestones	Description	2022-2023 Quarterly Maximum Revenue Sharing potential based on Milestones				
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
		8/1/22 - 10/31/22	11/1/22 - 1/3/23	2/01/23- 4/30/23	5/1/23 - 7/31/23	
Budget						
1A.1 Budget Development	Using the GCACH Budget Template, provide an estimated budget during the fist quarter and a final funding and costs at the end of the program year.	625	0	0	625	1,250
1A.2 Budget Reconciled						
Care Management						
2A.1 Empanelment	Creating client panels, assigning them to a care team, assigning them to a care manager, identifying a specific subset of clients that will be a part of the program i.e., high volume ER visits, non-emergent ER visits, MAT treatment, etc.					
2A.2.A Risk Stratification/2A.2.B Risk Stratification Statistics	Identify the data types that your practice uses to risk stratify your client population (e.g. SDoH, ethnicity, sex). The risk stratification methodology your EMS develops can use multiple types and sources of data (e.g., clinical, claims, utilization, etc.).					
2A.3 Opportunities for those at Highest Risk	Targeting initially those at highest risk for poor outcomes and preventable harm.					
2B.2 Self-Management Support	All members of the care team have basic communication skills to support client self-management. The practice routinely uses tools and techniques that reinforce client self-management skills. For client management: Conduct routine interval follow-up with clients about their goals and plans.	5,188	5,188	5,188	5,188	20,750
2B.3.A Medication Management	Medication inventory, help clients manage medications i.e., help set up reminders, explain dosing instructions, identify medication management issues like improper storage, uncover errors in their medication list and Medication reconciliation					
3A.1 Access and Continuity	Provide 24 hour access to services and access to clinical notes if case management is provided					
4A.1 Patient Centered Interactions	Developing genuine partnerships that require collaborating with clients and family members, those same key elements can apply: - Customized care/service according to needs and values, shared knowledge, freely flowing information - Evidence-based decision making, safety is a system property, transparency is necessary, anticipated needs, decreased waste; improved efficiency, cooperation among providers is priority					
4A.2 Shared Decision Making	Use of decision aids to support shared decision making between providers and clients in preference-sensitive care i.e., establishing a primary care, medication reminders, etc.					
2B.1 Bi-Directional Integration	Use of evidence based tools i.e., PHQ 2 and PHQ9 to identify clients that need crisis or BH referral, crisis interventions, integrated BH etc. Formation of collaborative agreements to share information between agencies.	2,000	2,000	2,000	2,000	8,000
5A.1 QI Team		1,875	1,875	1,875	1,875	7,500
Reporting						
5A.2 Clinical Quality Metrics	National Metrics for CP Interventions and other state, MCO, government aligned metrics that are specific to the program areas i.e., transitional care, chronic disease management, opioid crisis, bi-directional (See Attachment D)	10,000	10,000	10,000	10,000	40,000
5A.3 Practice Transformation Implementation Workplan (PTIW)	Actively engage with your Practice Transformation Navigator to implement and update the PTIW document throughout the demonstration. At a minimum, met with your Practice Transformation Navigator monthly	625	625	625	625	2,500
Care Coordination						
6A.1 Selection: Identify patients without PCP and make referral	Transitional Care: Coordination and transitions of care for your client population	2,250	2,250	2,250	2,250	9,000
6A.1 Selection: Care Compact/Agreements	Identify the Community Partners and/or Natural Community Partnerships; other EMS agencies, fire services, county officials, hospitals, community members, etc.					
6A.1 HIT Attestations (Collective Medical, DSM)	Collective Medical Platform, which includes Emergency Department Information Exchange (EDIE), PreManage and Direct Secure Messaging (DSM). This follow-up contact is likely to require new workflow processes	1,000	1,000	1,000	1,000	4,000
6A:1 HIT- one time payment for Collective Medical Implementation	https://www.healthcareitnews.com/news/health-data-aggregation-platform-helps-northwest-physician-network-drastically-reduce-er-care	5,000				5,000
Training & Learning Collaboratives						
7A.1 Training/Mentoring 7A1. Practice Transformation Learning Collaboratives	Participation in both your region's state and national learning collaboratives; each EMS has a responsibility to actively engage and share in the learning with other EMS , regionally and nationally					
Assessments (must be completed quarter 1 or 2)						
8A.1 Patient Centered Medical Home-Assessment (PCMH-A)	The PCMH-A is an excellent tool to establish a baseline and then track progress towards practice transformation	2,000				2,000
8A:1 ONC certified EMR (Infrastructure)	Optimal use of the electronic health record in the care of clients i.e. Image Trend	50,000				50,000
Total 2022-2023 Maximum Available Revenue		**80,563**	**22,938**	**22,938**	**23,563**	**150,000**

Mobile Integrated Healthcare Program

Measurement Strategy Overview

Aim

A clearly articulated goal statement that describes how much improvement by when and links all the specific outcome measures; what are we trying to accomplish?

Develop a uniform set of measures which leads to the optimum sustainability and utilization of patient centered, mobile resources in the out-of hospital environment and achieves the Triple Aim® — improve the quality and experience of care; improve the health of populations; and reduce per capita cost.

Measures Definition:

1. **18 Core Measures {"CORE MEASURE" in the description}**
   a. Measures that are considered by the measures development team through experience as ***essential for program integrity, patient safety and outcome demonstration***.

2. **CMMI Big Four Measures (RED)**
   a. Measures that have been identified by the CMS Center for Medicare and Medicaid Improvement (CMMI) as the four primary outcome measures for healthcare utilization.

3. **MIH Big Four Measures (ORANGE)**
   a. Measures that are considered *mandatory* to be reported in order to classify the program as a bona-fide MIH or Community Paramedic program.

4. **Top 18 Measures (Highlighted)**
   a. The 18 measures identified by the numerous operating MIH/CP programs as ***essential, collectable and highest priority to their healthcare partners***.

Notes:

1. All financial calculations are based on the ***national average Medicare payment*** for the intervention described. Providers are encouraged to also determine the ***regional average Medicare payment*** for the interventions described.
2. Value may also be determined by local stakeholders in different ways such as reduced opportunity cost, enhanced availability of resources. Program sponsors should develop local measures to demonstrate this value as well.

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Measure Categories

Structure: Describes the acquisition of physical materials and development of system infrastructures needed to execute the service (Rand). For example:

- Community Health Needs Assessment
- Community Resource Capacity Assessment
- Executive Sponsorship, Strategic Plan & Program Launch Milestones
- Organizational Readiness Assessment – Health Information Technology Systems
- Organizational Readiness Assessment – Medical Oversight
- Plan for Integration with Healthcare, Social Services and Public Safety Systems

Outcomes: Describes how the system impacts the values of patients, their health and wellbeing (IHI). For example:

Quality of Care Metrics

- Patient Safety
- Care Plan Acceptance and Adherence
- Medical Home
- Medication Inventories

Utilization Metrics

- All-cause Hospital Admissions
- Emergency Department Visits
- Unplanned 30-day Hospital Readmissions

Cost of Care Metrics

- Expenditure Savings by Intervention

Experience of Care Metrics

- Patient Quality of Life
- Patient Satisfaction

Balancing: Describes how changes designed to improve one part of the system are impacting other parts of the system, such as, impacts on other stakeholders such as payers, employees, or community partners (IHI). For example:

- Partner (healthcare, behavior health, public safety, community) satisfaction
- Practitioner (EMS/MIH) satisfaction
- Public and stakeholder engagement
- PCP and other healthcare utilization

Process: Describes the status of fundamental activities associated with the service; describes how the components in the system are performing; describes progress towards improvement goals (Rand/IHI). For example:

- Clinical & Operational Metrics
- Referral & Enrollment Metrics
- Volume of Contacts, Visits, Transports, Readmissions

Definitions: Throughout the document, hyperlinks for certain defined terms are included.

Structure/Program Design Measures

Describes the development of system infrastructures and the acquisition of physical materials necessary to successfully execute the program

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Executive Sponsorship	**S1:** Program has Executive Level commitment and the program manager reports directly to the Executive leadership of the organization. ***{CORE MEASURE}***	The community paramedicine program plan clearly identifies organizational executive level commitment for the human, financial, capital and equipment necessary to develop, implement, and manage the community paramedicine program both clinically and administratively.	0. There is no evidence of organizational executive level commitment 1. There is some evidence of limited commitment for the program. 2. There is evidence of full commitment for the program.	Documents submitted by agency demonstrating this commitment such as approved budgets, organizational chart and job descriptions
Strategic Plan	**S2:** The program has an Executive Level approved strategic plan. ***{CORE MEASURE}***	The strategic plan should be based on the knowledge of improvement science and rapid cycle testing, and include the key components of a Driver Diagram, specific measurement strategies, implementation milestones, a communication plan that includes engagement with local and regional stakeholders and a Financial Sustainability Plan.	0. No evidence of a strategic plan. 1. A written strategic plan, but it lacks key components. 2. A written strategic plan that includes all key components.	Institute for Healthcare Improvement

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Healthcare Delivery System Gap Analysis	**S3:** Program is designed to serve unmet needs in the local community. ***{CORE MEASURE}***	There is a description of illnesses and/or injuries within the community paramedicine service area including the distribution by geographic area, high-risk populations (i.e.: high utilizer populations, populations with high prevalence of chronic diseases, etc.), using payer, provider, public health, public safety and other data sources. There is a description of the process and methods used to conduct the HDSGA; describe community input received.	0. There is no written description of illness and/or injuries within the community paramedicine service area. 1. One or more target population-based data sources to describe illness and injury within the target population, but healthcare system utilization data sources are not used. 2. One or more target population-based data sources and one or more healthcare system utilization data sources are used to describe illness and injury prevalence and healthcare system utilization within the service area.	Adapted from HRSA Community Paramedic Evaluation Tool

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Community Resource Capacity Assessment	**S4:** Program is designed to address gaps in resource capacity.	The community paramedicine program has completed a comprehensive inventory that identifies the availability and distribution of current capabilities and resources from a variety of partners and organizations throughout the community.	0. There is no community-wide resource assessment. 1. A resource assessment has been completed that documents the resources available to help meet the clinical needs of patients that may be enrolled in the community paramedicine program. 2. A community-wide resource assessment has been completed that documents the resources available in the local community to help meet the clinical, behavioral and social needs of patients that may be enrolled in the community paramedicine program.	Adapted from HRSA Community Paramedic Evaluation Tool
Integration/Program Integrity	**S5:** Program integrates with external regional healthcare system stakeholders	There has been an initial assessment (and periodic reassessment) of overall program effectiveness completed by an external agency (i.e.: CMS Quality Improvement Network or external stakeholder group comprised of healthcare, payer, social service and patient representatives).	0. No external examination of the community paramedicine program overall or individual components has occurred. 1. An outside group of stakeholders has conducted a formal assessment and has made specific recommendations to the program. 2. Independent external reassessment occurs regularly, at least every two years.	Adapted from HRSA Community Paramedic Evaluation Tool

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Organizational Readiness Assessment – Medical Oversight	**S6:** Organization is committed to strong medical oversight, effective clinical quality improvement, comprehensive education and continuing education program.	The community paramedicine program medical director has the authority to adopt protocols, implement a performance improvement system, ensure appropriate practice of community paramedicine providers, and generally ensure medical appropriateness of the community paramedicine program based on regulatory agency scope of practice and accepted standards of medical care.	0. There is no community paramedicine program medical director. 1. There is a community paramedicine program medical director with a written job description; however, the individual has no specific authority or time allocated for those tasks. 2. There is a community paramedicine program medical director with a written job description. The community program medical director has adopted protocols, implemented a performance improvement program, and is generally taking steps to improve the medical appropriateness of the community paramedicine program.	Adapted from HRSA Community Paramedic Evaluation Tool NAEMSP Position Paper on MIH/CP program development

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Organizational Readiness Assessment - Health Information Technology (HIT)	**S7:** Organization has advanced health information technology systems and infrastructure.	The community paramedicine program has a unique medical record for each enrolled patient; and collects and uses patient data as well as provider data to assess system performance and to improve quality of care.	0. There is no patient centric medical record of CP interventions. 1. Patient centric medical records are used manually but are not used to assess system performance or quality of care. 2. Patient centric medical records are collected electronically and are used to assess both system performance and to improve quality of care across the program.	Adapted from HRSA Community Paramedic Evaluation Tool
HIT Integration with Local/Regional Healthcare System	**S8:** Organization has advanced health information technology systems and infrastructure.	The community paramedicine HIT system is integrated with the local healthcare providers to facilitate access to patient records by healthcare system participants.	0. There is no exchange of patient data with other healthcare providers. 1. CP medical records and data are pushed to healthcare providers or a health information exchange or its equivalent. 2. There is bi-directional exchange of the electronic medical record and data for each patient/client contact that can be accessed by primary care providers, case managers, social service agencies and/or payers.	Adapted from HRSA Community Paramedic Evaluation Tool

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Public & Stakeholder Engagement	**S9:** Care Coordination Advisory Committee	Community paramedicine program, in concert with relevant stakeholders meets ~~regularly~~ and advises the program on strategies for improving care coordination.	0. There is no care coordination advisory committee. 1. There is evidence of engagement with relevant stakeholders. 2. There is an established care coordination advisory committee and all key stakeholders are represented.	Adapted from HRSA Community Paramedic Evaluation Tool
Specialized Training & Education	**S10:** Specialized original and continuing education for community paramedic practitioners	A specialized educational program has been used to provide foundational knowledge for community paramedic practitioners based on a nationally recognized or state approved curriculum.	0. There is no specialized education offered. 1. There is specialized education offered, but it lacks key elements of instruction. 2. There is specialized education offered meeting or exceeding a nationally recognized or state approved curriculum.	North Central EMS Institute Community Paramedic Curriculum or equivalent.
Compliance with State and Federal Regulations	**S11:** Compliance Plan ***{CORE MEASURE}***	The community paramedicine program has a plan in place which assures compliance with all applicable laws and regulations and which prevents waste, fraud, abuse.	0. No evidence of a compliance plan. 1. A written compliance plan, but it lacks key components. 2. A written compliance plan that includes all key components.	Centers for Medicare and Medicaid Services

Outcome Measures for Community Paramedic Program Component

Describes how the system impacts the values of patients, their health and well-being

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Quality of Care & Patient Safety Metrics	**Q1:** Primary Care Utilization ***{CORE MEASURE}***	Increase the number and percent of patients *utilizing* a Primary Care Provider (if none upon enrollment)	Number of Enrolled Patients with an established PCP relationship upon graduation	Number of enrolled patients without an established PCP relationship upon enrollment	Value 1 Value 1/Value 2	Agency records
	Q2: Medication Inventory	Increase the number and percent of medication inventories conducted with issues identified and communicated to PCP	Number of medication inventories with issues identified and communicated to PCP	Number of medication inventories completed	Value 1 Value 1/Value 2	Agency records
	Q3.1: Care Plan Developed ***{CORE MEASURE}***	Increase the number and percent of patients who have an identified and documented plan of care with outcome goals established by a physician and facilitated by the CP	Number of patients with a plan of care communicated by the patient's PCP	All enrolled patients	Value 1 Value 1/Value 2	Agency records
	Q3.2: Care Plan Developed ***{CORE MEASURE}***	Increase the number and percent of patients who have an identified and documented plan of care with outcome goals established by the patient's PCP and facilitated by the CP	Number of patients with a plan of care communicated by the patient's PCP	All enrolled patients	Value 1 Value 1/Value 2	Agency records

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	Q4: Provider Protocol Compliance ***{CORE MEASURE}***	Eliminate plan of care deviations without specific medical direction supporting the deviation	Number of plan of care deviations without medical direction support	All patient encounters/interventions	Value 1 Value 1/Value 2	Agency records
	Q5: Unplanned Acute Care Utilization (e.g.: emergency ambulance response, urgent ED visit)	Minimize rate of patients who require unplanned acute care related to the CP care plan within 24 hours after a CP intervention	Number of patients who require unplanned acute care related to the CP care plan within 24 hours after a CP intervention	All CP visits in which a referral to Acute Care was NOT REQUIRED	Value 1/Value 2	Agency records
	Q6: Adverse Outcomes ***{CORE MEASURE}***	Minimize adverse effects (harmful or undesired effects) resulting from a medication or other treatment related to CP intervention within 24 hours of the CP intervention	Number of deaths from a cause related to CP intervention	All patient encounters/interventions	Value 1/ Value 2	Agency records
			Number of Critical Care Admissions related to CP intervention	All patient encounters/interventions		
	Q7: Community Resource Referral	Increase portion of patients referred to community resources for reconciliation of immediate social, transportation and environmental hazards and risks	Number of referrals to community resources (3 referrals for 1 patient = 3 referrals)	Number of enrolled patients with an identified need	Value 1/ Value 2	Agency records

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	Q8: Behavioral Health Services Referral	Increase portion of patients referred to a behavioral health professional for behavioral health intervention	Number of patients with an established therapeutic relationship with behavioral health resources	Number of enrolled patients with an identified need	Value 1/ Value 2	Agency records
	Q9: Case Management Referral	Increase portion of patients referred to case management services	Number of patients with an established therapeutic relationship to case management resources	Number of enrolled patients with an identified need	Value 1/ Value 2	Agency records

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Experience of Care Metrics	**E1:** Patient Satisfaction ***{CORE MEASURE}***	Optimize patient satisfaction scores by intervention.	To be determined based on tools developed	To be determined based on tools developed		Recommend an externally administered and nationally adopted tool, such as, HCAPHS; Home Healthcare CAPHS (HHCAPHS)
	E2: Patient Quality of Life	Improve patient self-reported quality of life scores.	To be determined based on tools developed	To be determined based on tools developed		Recommended tools (EuroQol EQ-5D-5L, CDC HRQoL, University of Nevada-Reno)

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Notes
Utilization Metrics	**U1:** Ambulance Transports ***{CORE MEASURE}***	Reduce rate of unplanned ambulance transports to an ED by *enrolled patients*	Number of *unplanned* ambulance transports up to 12 months post-graduation	Number of *unplanned* ambulance transports up to 12 months pre-Enrollment	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U2: Hospital ED Visits ***{CORE MEASURE}***	Reduce rate of ED visits by *enrolled patients* by intervention	ED visits up to 12 months post-graduation ***OR*** Number of ED Visits avoided in CP intervention patient	ED visits up to 12 months pre-enrollment	(Value 1-Value 2)/Value 2 Value 1	Monthly run chart reporting and/or pre-post intervention comparison
	U2.1: Emergency Department Capacity	Increase number of hours of ED bed utilization avoided by CP patients during measurement period	Number of ED visits post enrollment * average Door to Disposition time for all ED patients	Number of ED visits pre enrollment * average Door to Disposition time or all ED patients	Value 1-Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U3: All - cause Hospital Admissions ***{CORE MEASURE}***	Reduce rate of all-cause hospital admissions by *enrolled patients* by intervention	Number of hospital admissions up to 12 months post-graduation	Number of hospital admissions up to 12 months pre-enrollment	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U4: Unplanned 30-day Hospital Readmissions ***{CORE MEASURE}***	Reduce rate of all-cause, unplanned, 30-day hospital readmissions by *enrolled patients* by intervention	Number of actual 30-day readmissions	Number of anticipated 30-day readmissions	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U5: Length of Stay	Reduce Average Length of Stay by enrolled patients by DRG	ALOS by DRG for enrolled patients at end of implementation year X	ALOS by DRG for patients NOT enrolled at the end of implementation year X	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Cost of Care Metrics -- Expenditure Savings	**C1: Ambulance Transport Savings (ATS) {*CORE MEASURE*}**	Reduce Expenditures for unplanned ambulance transports to an ED *pre and post enrollment or per event*	Ambulance transport utilization change in measure period X average payment per transport for enrolled patients MINUS Expenditure per CP Patient Contact	Number of patients enrolled in the CP program	Value 1 / Value 2	Monthly run chart reporting and/or pre-post intervention comparison CMS Public Use Files (PUF) for ambulance supplier expenditures or locally derived number
	C2: Hospital ED Visit Savings (HEDS) {*CORE MEASURE*}	Reduce expenditures for ED visits *pre and post enrollment or per event*	ED utilization change in measure period X average payment per ED visit for enrolled patients MINUS Expenditure per CP patient contact	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data
	C3: All-cause Hospital Admission Savings (ACHAS) {*CORE MEASURE*}	Reduce expenditures for All-Cause Hospital Admissions *pre and post enrollment or per event*	Hospital admission change in measure period X average payment per admission for enrolled patients MINUS Expenditure per CP patient contact	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	C4: Unplanned 30-day Hospital Readmission Savings (UHRS) ***{CORE MEASURE}***	Reduce expenditures for all-cause, unplanned, 30-day hospital readmissions *pre and post enrollment or per event*	Hospital readmission change in measure period X average payment per readmission for enrolled patients	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data
	C5: Unplanned Skilled Nursing (SNF) and Assisted Living Facility (ALF) Savings (USNFS)	Reduce expenditures for all-cause, unplanned, skilled nursing and/or assisted living facility admissions pre and post enrollment or per event	SNF and/or ALF admissions change in measure period X average payment per admission for enrolled patients	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data
	C6: Total Expenditure Savings ***{CORE MEASURE}***	Total expenditure savings for all CP interventions	Calculated savings for each enrollee (ATS+HEDS + (ACHAS or UHRS)+USNFS)) MINUS the Expenditure of the CP interventions for intervention per enrollee, including alternative sources of care Expenditures		Sum of Value 1	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	C7: Total Cost of Care	Reduce total healthcare expenditures for enrolled patients	Total cost of care for enrolled patients for 12 months post enrollment MINUS total cost of care for enrolled patients pre-enrollment			Payer Derived

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Balancing Metrics	**B1:** Practitioner (EMS/MIH) Satisfaction	Optimize practitioner satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B2: Partner Satisfaction	Optimize partner (healthcare, behavior health, public safety, community) satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B3: Primary Care Provider (PCP) Use	Optimize Number of PCP visits resulting from program referrals during enrollment	Number of PCP visits during enrollment		Value 1	Network provider or patient reported
	B4: Specialty Care Provider (SCP) Use	Optimize number of SCP visits resulting from program referrals during enrollment	Number of SCP visits during enrollment		Value 1	Network provider or patient reported
	B5: Behavioral Care Provider (BCP) Use	Optimize number of BCP visits resulting from program referrals during enrollment	Number of BCP visits during enrollment		Value 1	Network provider or patient reported
	B6: Social Service Provider (SSP) Use	Optimize number of SSP visits resulting from program referrals during enrollment	Number of SSP visits during enrollment		Value 1	Network provider or patient reported
	B7: Emergency Department Capacity	Decrease number of hours of ED bed utilization by CP patients during measurement period	Number of ED visits post enrollment * average Door to Disposition time for all ED patients	Number of ED visits pre enrollment * average Door to Disposition time or all ED patients	Value 1-Value 2	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	B8: System Capacity - PCP	Number and percent of patients ***unable*** to receive PCP services that they would otherwise be eligible to receive as a result of lack of PCP system capacity	Number of patients referred to PCP services that were unable to receive PCP services due to lack of PCP capacity	Number of patients referred to PCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B9: System Capacity - SCP	Number and percent of patients ***unable*** to receive SCP services that they would otherwise be eligible to receive as a result of lack of SPC system capacity	Number of patients referred to SCP services that were unable to receive SPC services due to lack of SPC capacity	Number of patients referred to SCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B10: System Capacity - BCP	Number and percent of patients ***unable*** to receive BCP services that they would otherwise be eligible to receive as a result of lack of BCP system capacity	Number of patients referred to BCP services that were unable to receive BCP services due to lack of BCP capacity	Number of patients referred to BCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B11: System Capacity - SSP	Number and percent of patients ***unable*** to receive SSP services that they would otherwise be eligible to receive as a result of lack of SSP system capacity	Number of patients referred to SSP services that were unable to receive SSP services due to lack of SSP capacity	Number of patients referred to SSP services	Value 1 Value 1/Value 2	Network provider or patient reported

Definitions

Specific Metric Definitions:

Expenditure: The amount ***PAID*** for the referenced service. Expenditures should generally be based on the national and regional amounts paid by Medicare for the covered services provided.

Examples:

Service	Cost to Provide the Service by the Provider	Amount Charged (*billed*) by the Provider	Average Amount Paid by Medicare
Ambulance Transport	$350	$1,500	**$420**
ED Visit	$500	$2,000	**$969**
PCP Office Visit	$85	$199	**$218**

National CMS Expenditure by Service Type (note: it is preferable to use local or regional data if available, if not, these sources can be surrogate data if needed):

Service	Average Expenditure	Source
Emergency Ambulance Transport	$419	Medicare Tables from CY 2012 as published
ED Visit	$969	http://www.cdc.gov/nchs/data/hus/hus12.pdf
PCP Office Visit	$218	http://meps.ahrq.gov/data_files/publications/st381/stat381.pdf
Hospital Admission	$10,500	http://www.hcup-us.ahrq.gov/reports/projections/2013-01.pdf

Triple Aim

- Improve the quality and experience of care
- Improve the health of populations
- Reduce per capita cost

Driver Diagram: A Driver Diagram is a strong one-page conceptual model which describes the projects' theory of change and action. It is a central organizing element of the operations/implementation plan and includes the aim of the project and its goals, measures, primary drivers and secondary drivers. The aim statement describes what is to be accomplished, by how much, by when and where?

- Aim – A clearly articulated goal statement that describes how much improvement by when and links all the specific measures. What are we trying to accomplish? CMMI/IHI.
- Primary Drivers – System components that contribute directly to achieving the aim; each primary driver is linked to clearly defined outcome measure(s). CMMI.
- Secondary Drivers – Actions necessary to achieve the primary driver; each secondary driver is linked to clearly defined process measure(s). CMMI.

General Definitions

- *Adverse Outcome*: Death, temporary and/or permanent disability requiring intervention.
- *All Cause Hospital Admission:* Admission to an acute care hospital for any admission DRG.
- *Average Length of Stay:* The average duration, measured in days, of an in-patient admission to an acute care, long term care, or skilled nursing facility
- *Care Plan*: A written plan that addresses the medical and psychosocial needs of an enrolled patient that has been agreed to by the patient and the patient's primary care provider.
- *Case Management Services*: Care coordination activities provided by another social service agency, health insurance payer, or other organization.
- *Compliance Plan*: A Compliance Plan clearly articulates policies, procedures and processes to assure compliance with all applicable laws and regulations associated with the community paramedicine program, including; prevention, detection and correction; conflict of interest policies; and mechanisms for identifying and addressing noncompliance.
- *Core Measure*: Required measurement for reporting on MIH-CP services.
- *Critical Care Unit Admissions or Deaths*: Admission to critical care unit within 48 hours of CP intervention; unexpected (non-hospice) patient death within 48 hours of CP visit.
- *Desirable Metric*: Optional measurement.
- *Door to Disposition Time*: "Door" time is defined according to the EMTALA and the AHA STEMI Guidelines: "The time at which the ambulance arrives at the hospital." Disposition time means the time at which the patient is admitted to the hospital as an inpatient or observation patient; or a patient is designated for observation within a Clinical Decision area of the ED, or is discharged from the ED.
- *Enrolled Patient*: A patient who is enrolled with the EMS/MIH program through either; 1) a 9-1-1 or 10-digit call; 2) a formal referral and enrollment process, or 3) contact by a provider within the EMS system with additional training on handling special patient populations.
- *Evaluation*: determination of merit using standard criteria.
- *Executive Level*: The most senior leadership of the organization. For governmental agencies, this should be the Chief of the Department, City/County Manager, City/County Commission, or other similar leadership. For private agencies, this would be the owner, CEO, President, Executive Director, or other similar leadership.
- *Expenditure per CP Patient Contact*: The average payment received by the agency calculated at a per patient contact rate. For example, if the agency is receiving payments on a per patient contact basis of $75, then the average expenditure per patient contact is $75. If the agency is getting an enrollment fee of $1,200 and the average number of patient contacts per enrollment is 9, then the expenditure per patient contact is $1,200 / 9 = $133.34.
- *Financial Sustainability Plan*: a document that describes the expected revenue and/or the economic model used to sustain the program.
- *Guideline*: a statement, policy or procedure to determine course of action.

- *Hotspotter/ High Utilizer*: Any patient utilizing EMS or ED services 12 times in a 12 month period, or as defined by local program goals.
- *Measure*: dimension, quantity or capacity compared to a standard.
- *Medication Inventory*: The process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
- *Metric*: a standard of measurement.
- *Payer Derived:* Measure that must be generated by a payer from their database of expenditures for a member patient.
- *Pre and Post Enrollment*: The beginning date and ending date of an enrolled patient.
- *Primary Care Provider*: The licensed care provider who is primarily responsible for the medical care of the patient. Generally, this provider develops the patient's care plan, including the assessments and interventions to be completed by a community paramedic. It could be a physician, or an established Patient Centered Medical Home such as a community clinic or Federally Qualified Health Center.
- *Repatriation*: Returning a person to their original intended destination, such as an emergency department, following an intervention
- *Social & Environmental Hazards and Risks*: include trip/fall hazards, transportation, electricity, food, etc.
- *Standard*: criteria as basis for making a judgment.
- *Total Expenditure Savings*: The calculated savings based on the number of avoided events (i.e.: ambulance transports, ED visits, admissions) for all enrolled patients in the CP intervention.
- *Unplanned*: Any service that is not part of a patient's plan of care.

UPPER KITTITAS COUNTY HOSPITAL DISTRICT #2

SUPERINTENDENT'S REPORT – Julie Petersen
July 2022

Prohibition Against Open Carry

Public Hospitals in Washington State, unlike their not or profit and for profit counter parts, do not operate as "weapons free zones". Prior to the passage of HB 1630 during the 2022 legislative session, PHDs were prohibited from adopting any policy that would interfere with the permitted rights of a gun owner. Below is he Association of Washington Public Hospital Districts (AWPHD) and Municipal Research and Service Center (MRSC) interpretation and guidance regarding HB 1630.

AWPHD Members,

This past legislative session HB 1630 was passed that regulates the open carry of firearms in public meeting spaces. After much review with MRSC and AWPHD legal counsel we have come to the conclusion that the legislation applies to PHDs.

A few points that you should be aware;

1. The statutory language is set forth in RCW 9.41.305(1)(b), which prohibits open carry of firearms in: "City, town, county, or other municipality buildings used in connection with meetings of the governing body of the city, town, county, or other municipality, or any location of a public meeting or hearing of the governing body of a city, town, county, or other municipality during the hearing or meeting."

   MRSC interprets that to mean the prohibition on open carry of firearms applies to the *entire building* where a meeting of the governing body is regularly held even when the meeting is not currently in progress. The prohibition also applies to non-municipal buildings where a meeting or hearing of the governing body is held but only when that meeting or hearing is in progress.

   Essentially, the statute creates a 24/7 rule for the building where meetings are regularly held and a "while the meeting is in progress" rule for meetings in other locations.

2. The Hospital District, must also post signs at locations where the open carry is prohibited. We are working with WHSA to add a template to the sign guide.

3. Concealed carry of firearms is still allowed for property licensed individuals.

We received clarification this morning that the prohibition is currently in effect and that it would also apply to hospital districts that do not operate hospitals. The new law prohibits open carry at Station 99 since BOC meetings are regularly held there. The Washington State Hospital Association (WSHA) is working on required signage language.

Joint Hospital Board Meeting

Hospital District #1 has charged the Board Financial Sustainability Committee, Chaired by Commissioner Jon Ward, with preparing a presentation for the joint meeting on planning for future service demand in Upper

UPPER KITTITAS COUNTY
HOSPITAL DISTRICT #2

SUPERINTENDENT'S REPORT – Julie Petersen

July 2022

County. This information, coupled with a review of the 2018 HD#2 Master Site Plan I believe will provide for a great four hour planning session.

Ancillary Services report to Hospital District #2 Board of Commissioners August 2022

Ancillary Service Operation Report:

Labor Day Weekend

Roslyn will again be hosting the High Country Log Show on Saturday September 3rd and Sunday September 4. This will be a busy weekend in Upper County and I'm sure that the Log Show Committee will be asking Medic One to keep an ambulance on site at the event if they are able.

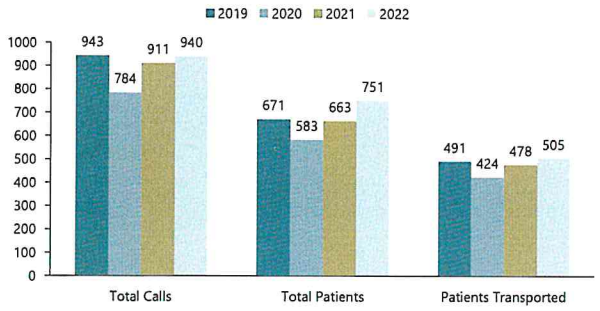
Levies

I am sure you are aware that the levies for KVFR, Fire District 6 and Fire District 7 passed. The City of Roslyn is currently behind by one vote, with a recount vote on August 14.

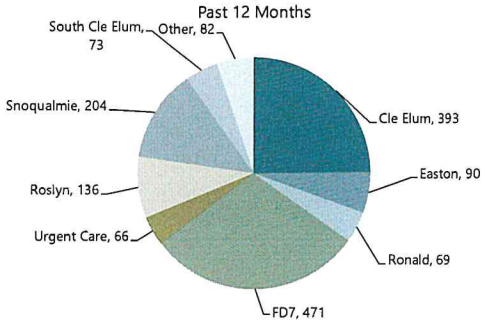
Respectfully submitted by Rhonda Holden, MSN

Kittitas County Public Hospital District No. 2

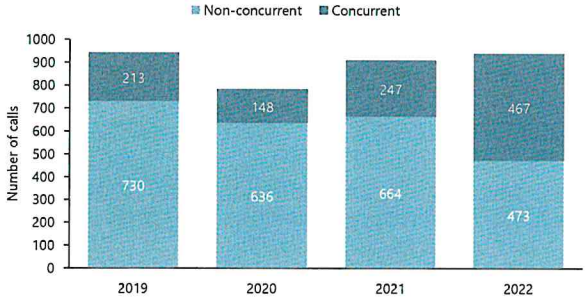
Volumes, YTD



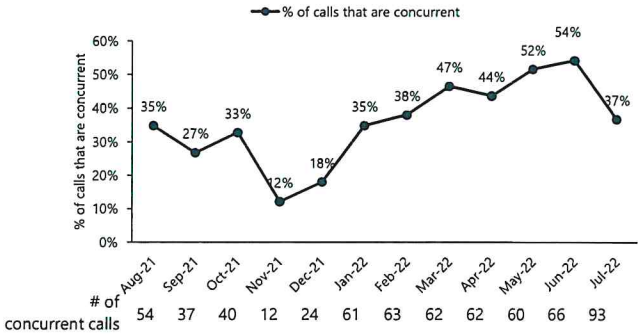
Calls by Zone



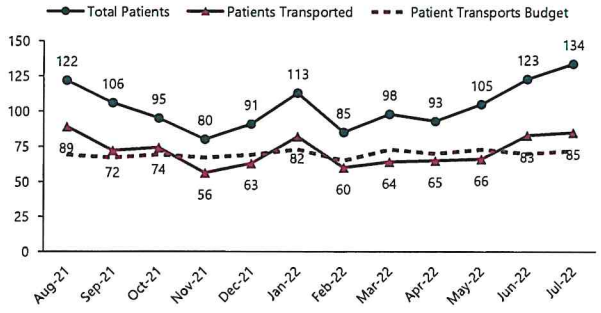
Concurrent Calls, YTD



Concurrent Calls



Patients and Transports



Days Cash on Hand

YTD values through end of previous month

Last updated 8/4/2022

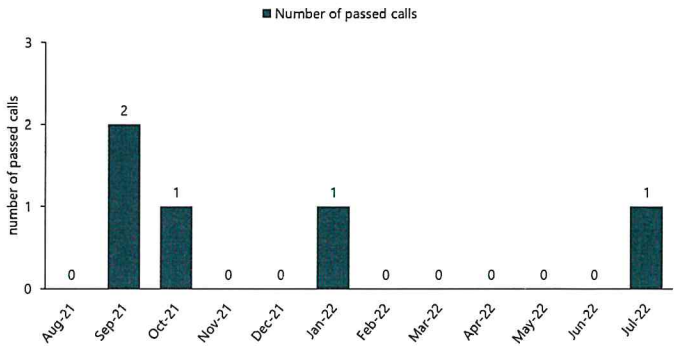
Kittitas County Public Hospital District No. 2

Turnout Time - Dispatch to Enroute

8/1/2021 to 7/31/2022

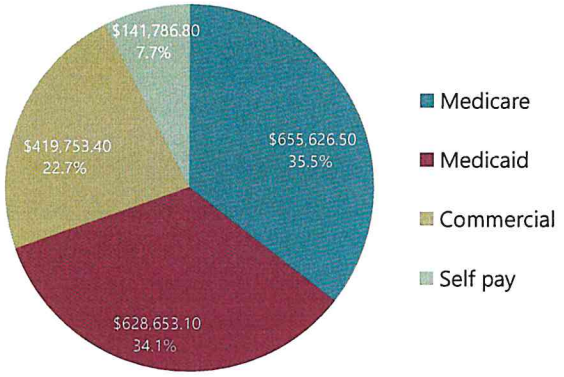
Apparatus	Responses	Turnout Time
A511 (CEFD)	0	
CEFD Overall	*0*	
A731 (FD7)	4	5:34
FD7 Overall	*4*	*5:34*
M931(HD2)	618	3:52
M932 (HD2)	1	2:33
M991 (HD2)	813	4:15
M992 (HD2)	53	3:25
HD2 Overall	*1485*	*4:04*

Passed Calls



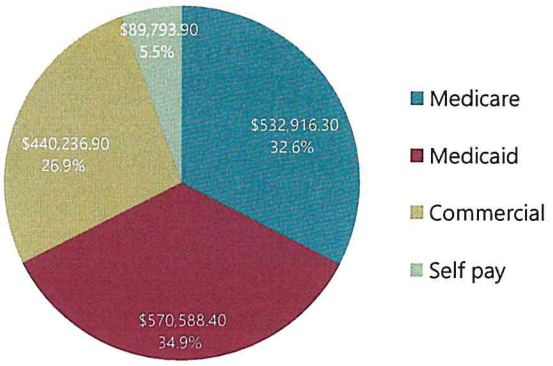
Payor Mix by Charges

4/1/2021 to 3/31/2022



Payor Mix by Charges

4/1/2020 to 3/31/2021



YTD values through end of previous month

Last updated 8/4/2022

Kittitas County Hospital Dist 2
Statement of Revenue and Expense

MEDICAL BILLABLE RUNS	85	72	13	505	496	9	478
AVERAGE CHARGE PER RUN	2,218	2,225	(7)	2,273	2,209	64	2,077
	Current Month			Year to Date			Prior
	Actual	Budget	Variance	Actual	Budget	Variance	YTD
INTEREST INCOME	3,551	15	3,536	(14,764)	100	(14,864)	204
RENTAL INCOME	24,751	25,209	(458)	176,961	176,459	502	166,032
OTHER OPERATING REVENUE	6,124	1,228	4,896	16,429	8,603	7,826	3,557
AMBULANCE REVENUE	188,494	160,222	28,272	1,147,640	1,095,714	51,926	992,797
TOTAL REVENUE	**222,921**	**186,674**	**36,247**	**1,326,265**	**1,280,876**	**45,389**	**1,162,590**
CONTRACTUAL ADJUSTMENTS	66,268	62,417	3,851	389,886	426,848	(36,962)	380,173
BAD DEBT	2,730	7,729	(4,999)	66,592	52,854	13,738	55,565
CHARITY CARE	647	346	301	961	2,420	(1,459)	1,904
DEDUCTIONS FROM REVENUE	**69,645**	**70,492**	**(847)**	**457,439**	**482,122**	**(24,683)**	**437,642**
NET OPERATING REVENUE	**153,276**	**116,182**	**37,094**	**868,826**	**798,754**	**70,072**	**724,948**
SALARIES AND WAGES	104,334	109,152	(4,818)	735,608	746,491	(10,883)	677,498
EMPLOYEE BENEFITS	29,812	36,900	(7,088)	225,572	255,792	(30,220)	224,717
PROFESSIONAL FEES	0	1,833	(1,833)	13,866	12,835	1,031	12,536
SUPPLIES	10,884	8,459	2,425	75,840	58,560	17,280	74,707
UTILITIES	2,863	2,824	39	29,085	19,774	9,311	17,192
PURCHASED SERVICES	23,915	22,870	1,045	159,796	164,217	(4,420)	148,875
CEUCC SUBSIDY EXPENSE	16,253	16,253	0	113,773	113,774	(1)	111,542
DEPRECIATION	38,045	39,443	(1,398)	247,914	276,105	(28,191)	174,086
INSURANCE	3,009	5,016	(2,007)	20,644	35,110	(14,466)	22,650
LICENSES AND TAXES	1,279	1,277	2	8,081	8,936	(855)	8,505
INTEREST EXPENSE	9,982	9,983	(1)	69,877	69,875	2	75,665
TRAVEL AND EDUCATION	0	573	(573)	6,298	4,009	2,288	9,416
OTHER DIRECT EXPENSES	2,238	698	1,540	7,467	4,875	2,592	5,458
EXPENSES	**242,616**	**255,281**	**(12,665)**	**1,713,822**	**1,770,353**	**(56,532)**	**1,562,846**
OPERATING INCOME (LOSS)	**(89,340)**	**(139,099)**	**49,759**	**(844,995)**	**(971,599)**	**126,604**	**(837,898)**
TAX LEVY INCOME	137,115	137,340	(225)	963,604	961,375	2,229	924,847
GAIN LOSS ASSET DISPOSITION	0	0	0	0	0	0	0
NON OPERATING OTHER INCOME OR EXPENS	0	0	0	859	0	859	0
INTERGOVERNMENTAL REV OR EXP	0	0	0	0	0	0	0
NON-OPERATING BOND ISSUE COST	0	0	0	0	0	0	0
NET INCOME (LOSS)	**47,775**	**(1,759)**	**49,534**	**119,467**	**(10,224)**	**129,691**	**86,949**

DAYS CASH ON HAND	365.0
AR DAYS	85.2
CURRENT RATIO	4.99

Kittitas County Hospital Dist 2
Statement of Revenue and Expense

MEDICAL BILLABLE RUNS	85	72	13	505	496	9	478
AVERAGE CHARGE PER RUN	2,218	2,225	(7)	2,273	2,209	64	2,077
	Current Month			Year to Date			Prior
	Actual	Budget	Variance	Actual	Budget	Variance	YTD
INTEREST INCOME	0	0	0	0	0	0	0
RENTAL INCOME	0	0	0	0	0	0	0
OTHER OPERATING REVENUE	6,124	1,228	4,896	16,429	8,603	7,826	3,557
AMBULANCE REVENUE	188,494	160,222	28,272	1,147,640	1,095,714	51,926	992,797
TOTAL REVENUE	**194,618**	**161,450**	**33,168**	**1,164,069**	**1,104,317**	**59,752**	**996,354**
CONTRACTUAL ADJUSTMENTS	66,268	62,417	3,851	389,886	426,848	(36,962)	380,173
BAD DEBT	2,730	7,729	(4,999)	66,592	52,854	13,738	55,565
CHARITY CARE	647	346	301	961	2,420	(1,459)	1,904
DEDUCTIONS FROM REVENUE	**69,645**	**70,492**	**(847)**	**457,439**	**482,122**	**(24,683)**	**437,642**
NET OPERATING REVENUE	**124,973**	**90,958**	**34,015**	**706,630**	**622,195**	**84,435**	**558,712**
SALARIES AND WAGES	103,950	108,946	(4,996)	733,432	745,046	(11,614)	676,510
EMPLOYEE BENEFITS	29,782	36,884	(7,102)	225,102	255,683	(30,581)	224,640
PROFESSIONAL FEES	0	0	0	0	0	0	0
SUPPLIES	10,884	8,456	2,428	61,294	58,537	2,757	74,682
UTILITIES	1,658	2,384	(726)	24,493	16,691	7,802	14,288
PURCHASED SERVICES	9,664	12,771	(3,107)	74,109	89,402	(15,293)	78,630
CEUCC SUBSIDY EXPENSE	0	0	0	0	0	0	0
DEPRECIATION	10,464	14,433	(3,969)	57,103	101,035	(43,932)	78,500
INSURANCE	747	1,516	(769)	6,351	10,610	(4,259)	5,253
LICENSES AND TAXES	1,279	1,277	2	8,056	8,936	(880)	8,505
INTEREST EXPENSE	0	0	0	0	0	0	0
TRAVEL AND EDUCATION	0	573	(573)	6,298	4,009	2,288	9,416
OTHER DIRECT EXPENSES	320	135	185	860	940	(80)	1,130
EXPENSES	**168,748**	**187,375**	**(18,627)**	**1,197,097**	**1,290,891**	**(93,794)**	**1,171,553**
OPERATING INCOME (LOSS)	**(43,775)**	**(96,417)**	**52,642**	**(490,467)**	**(668,696)**	**178,228**	**(612,841)**
TAX LEVY INCOME	66,308	66,357	(49)	464,817	464,495	322	443,908
GAIN LOSS ASSET DISPOSITION	0	0	0	0	0	0	0
NON OPERATING OTHER INCOME OR EXPENS	0	0	0	0	0	0	0
INTERGOVERNMENTAL REV OR EXP	0	0	0	0	0	0	0
NON-OPERATING BOND ISSUE COST	0	0	0	0	0	0	0
NET INCOME (LOSS)	**22,532**	**(30,060)**	**52,592**	**(25,650)**	**(204,201)**	**178,550**	**(168,933)**

Kittitas County Hospital Dist 2
Statement of Revenue and Expense

	Current Month			Year to Date			Prior
	Actual	Budget	Variance	Actual	Budget	Variance	YTD
INTEREST INCOME	3,551	15	3,536	(14,764)	100	(14,864)	204
RENTAL INCOME	24,751	25,209	(458)	176,961	176,459	502	166,032
OTHER OPERATING REVENUE	0	0	0	0	0	0	0
AMBULANCE REVENUE	0	0	0	0	0	0	0
TOTAL REVENUE	**28,303**	**25,224**	**3,079**	**162,196**	**176,559**	**(14,363)**	**166,236**
CONTRACTUAL ADJUSTMENTS	0	0	0	0	0	0	0
BAD DEBT	0	0	0	0	0	0	0
CHARITY CARE	0	0	0	0	0	0	0
DEDUCTIONS FROM REVENUE	**0**	**0**	**0**	**0**	**0**	**0**	**0**
NET OPERATING REVENUE	**28,303**	**25,224**	**3,079**	**162,196**	**176,559**	**(14,363)**	**166,236**
SALARIES AND WAGES	384	206	178	2,176	1,445	731	987
EMPLOYEE BENEFITS	30	16	14	471	109	361	77
PROFESSIONAL FEES	0	1,833	(1,833)	13,866	12,835	1,031	12,536
SUPPLIES	0	3	(3)	14,546	22	14,524	25
UTILITIES	1,206	440	766	4,592	3,083	1,509	2,903
PURCHASED SERVICES	14,252	10,099	4,153	85,687	74,814	10,873	70,245
CEUCC SUBSIDY EXPENSE	16,253	16,253	0	113,773	113,774	(1)	111,542
DEPRECIATION	27,581	25,010	2,571	190,811	175,070	15,741	95,587
INSURANCE	2,262	3,500	(1,238)	14,294	24,500	(10,206)	17,397
LICENSES AND TAXES	0	0	0	25	0	25	0
INTEREST EXPENSE	9,982	9,983	(1)	69,877	69,875	2	75,665
TRAVEL AND EDUCATION	0	0	0	0	0	0	0
OTHER DIRECT EXPENSES	1,918	563	1,355	6,607	3,935	2,672	4,328
EXPENSES	**73,868**	**67,906**	**5,962**	**516,725**	**479,463**	**37,262**	**391,293**
OPERATING INCOME (LOSS)	**(45,565)**	**(42,682)**	**(2,883)**	**(354,528)**	**(302,903)**	**(51,625)**	**(225,057)**
TAX LEVY INCOME	70,807	70,983	(176)	498,787	496,880	1,907	480,939
GAIN LOSS ASSET DISPOSITION	0	0	0	0	0	0	0
NON OPERATING OTHER INCOME OR EXPENS	0	0	0	859	0	859	0
INTERGOVERNMENTAL REV OR EXP	0	0	0	0	0	0	0
NON-OPERATING BOND ISSUE COST	0	0	0	0	0	0	0
NET INCOME (LOSS)	**25,242**	**28,301**	**(3,059)**	**145,118**	**193,977**	**(48,859)**	**255,882**

DAYS CASH ON HAND	365.0
AR DAYS	85.2
CURRENT RATIO	4.99

Kittitas County Hospital Dist 2

Balance Sheet

	Year to Date	Prior Year End	Change
CASH	2,575,857	2,460,034	115,822
ACCOUNTS RECEIVABLE	1,019,676	1,219,832	(200,156)
TAXES RECEIVABLE	676,354	31,012	645,342
PREPAIDS	41,612	9,225	32,387
INVESTMENTS	276,883	292,559	(15,676)
CURRENT ASSETS	**4,590,382**	**4,012,663**	**577,719**
LAND	843,524	843,524	0
PROPERTY, PLANT,& EQUIPMENT	10,512,291	10,157,637	354,654
ACCUMULATED DEPRECIATION	(3,986,592)	(3,738,678)	(247,914)
NON CURRENT ASSETS	**7,369,223**	**7,262,483**	**106,740**
NET PENSION ASSET	1,537,281	1,537,281	0
DEFERRED OUTFLOWS	112,844	112,844	0
ASSETS	**13,609,730**	**12,925,271**	**684,459**
ACCOUNTS PAYABLE	171,790	257,370	(85,581)
INTEREST PAYABLE	18,565	10,263	8,302
ACCRUED PAYROLL	34,503	44,139	(9,636)
ACCRUED BENEFITS	91,076	91,679	(603)
CEUCC SUBSIDY PAYABLE	304,988	191,215	113,773
CURRENT PORTION REVENUE BOND - LTGO	298,445	298,445	0
CURRENT LIABILITIES	**919,366**	**893,111**	**26,255**
LONG TERM REVENUE BOND - LTGO	3,175,663	3,323,628	(147,965)
NET PENSION LIABILITY	5,728	5,728	0
DEFERRED INFLOWS - PENSION	1,207,778	1,207,778	0
DEFERRED INFLOWS - LEVY	686,702	0	686,702
NONCURRENT LIABILITIES	**5,075,871**	**4,537,134**	**538,737**
LIABILITIES	**5,995,237**	**5,430,245**	**564,992**
NET INCOME (LOSS)	119,467	0	119,467
UNRESTRICTED FUND BALANCE	7,495,025	7,495,025	0
FUND BALANCE	**7,614,493**	**7,495,025**	**119,467**
TOTAL LIABILITIES AND NET POSITION	**13,609,730**	**12,925,271**	**684,459**

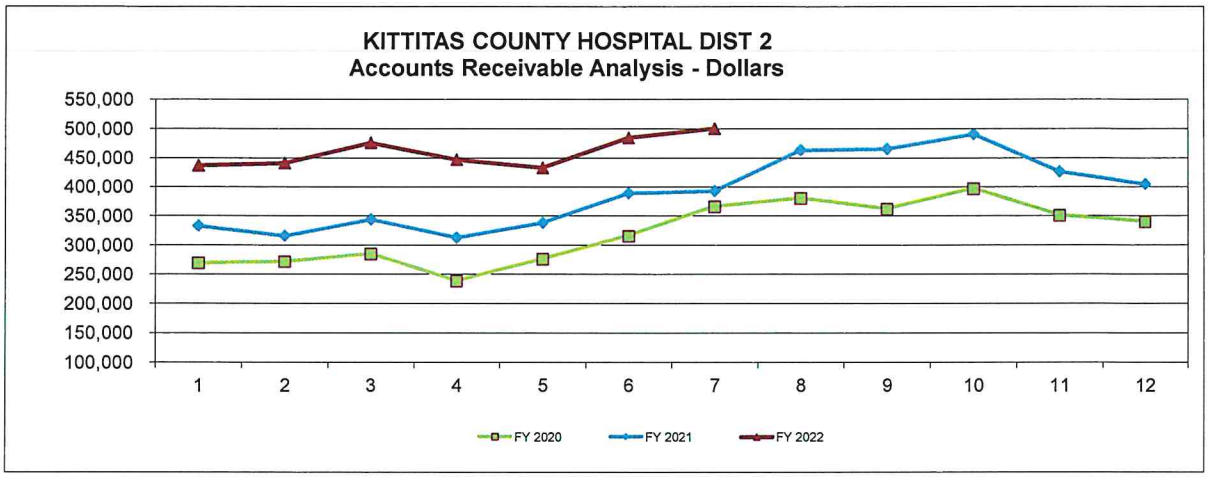
Kittitas County Hospital Dist 2

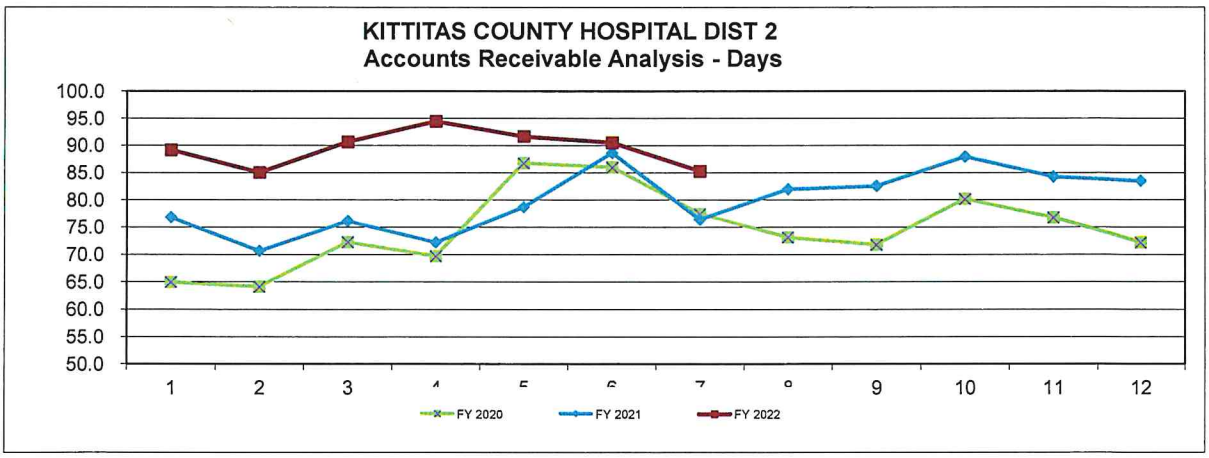
Statement of Cash Flows

	CASH
NET BOOK INCOME	119,467
ADD BACK NON-CASH EXPENSE	
DEPRECIATION	247,914
NET CASH FROM OPERATIONS	**367,381**
CHANGE IN CURRENT ASSETS	
PATIENT ACCOUNTS AND OTHER RECEIVABLES	200,156
PROPERTY TAX RECEIVABLE	(645,342)
PREPAID EXPENSE	(32,387)
TOTAL CHANGE IN CURRENT ASSETS	**(477,573)**
PURCHASE OF PROPERTY, PLANT & EQUIPMENT	(354,654)
NET PENSION ASSET	0
DEFERRED OUTFLOWS	0
INCREASE IN INVESTMENTS	15,676
PROCEEDS FROM SALE/MATURITY OF INVESTMENTS	
TOTAL CHANGE IN ASSETS	**(816,551)**
CHANGES IN CURRENT LIABILITIES	
ACCOUNTS PAYABLE	(85,581)
INTEREST PAYABLE	8,302
ACCRUED PAYROLL	(9,636)
ACCRUED BENEFITS	(603)
CEUCC SUBSIDY PAYABLE	113,773
TOTAL CHANGE CURRENT LIABILITIES	**26,255**
PRINCIPLE PAYMENT ON REVENUE BOND	(147,965)
NET PENSION LIABILITY	0
DEFERRED INFLOWS OF RESOURCES	686,702
NET CHANGE IN CASH	**115,822**
BEGINNING CASH ON HAND	2,460,034
ENDING CASH ON HAND	**2,575,857**

KITTITAS COUNTY HOSPITAL DIST 2
Accounts Receivable Analysis

SYS DESIGN EMS	Jul-22	Jun-22	May-22	Apr-22	Mar-22	Feb-22	Jan-22	Dec-21	Nov-21	Oct-21	Sep-21	Aug-21
A/R Dollars	500,356	484,393	432,815	446,662	$ 475,314	$ 440,429	436,550	404,006	425,335	489,456	464,532	462,266
A/R Days	85.2	90.5	91.6	94.4	90.6	85.0	89.1	83.4	84.1	87.8	82.5	81.9





KITTITAS COUNTY HOSPITAL DIST 2

BOARD MEETING July 2022 ACTIVITY

ACCOUNTS PAYABLE WARRANTS/ EFTS TO BE APPROVED				**CHECK DATE:**
# 1 WARRANT NUMBERS:	13107-13126	NET AMOUNT:	**70,223.24**	11-Jul-22
# 2 WARRANT NUMBERS:	13127-13177	NET AMOUNT:	**73,066.75**	25-Jul-22
# 3 WARRANT NUMBERS: (VOID)	13145	NET AMOUNT:	**(1,384.47)**	25-Jul-22
# 4 WARRANT NUMBERS: (VOID)	13170	NET AMOUNT:	**(61.86)**	25-Jul-22
			141,843.66	

PAYROLL WARRANTS / EFTS TO BE APPROVED			
PPE 07/02/2022	NET AMOUNT:	**39,107.48**	8-Jul-22
PPE 07/16/2022	NET AMOUNT:	**32,756.27**	22-Jul-22
		71,863.75	

TOTAL NET WARRANTS & EFT'S	**213,707.41**

Kittitas County Hospital District #2
Detailed Statement of Accounts Payable Transactions
Month of July 2022

Account Class	Check No	Vendor	Amount
Balance Sheet	13107	AFLAC	740.27
	13110	BROWN & BROWN OF WASHINGTON, INC.	108.36
	13112	DEPARTMENT OF RETIREMENT SYSTEMS	4,472.34
	13113	DEPARTMENT OF RETIREMENT SYSTEMS	305.24
	13115	IAFF 4880	1,346.46
	13124	TW CLARK CONSTRUCTION, LLC	27.81
	13124	TW CLARK CONSTRUCTION, LLC	24,361.41
	13139	DEPARTMENT OF LABOR & INDUSTRIES	4,234.33
	13140	DEPARTMENT OF RETIREMENT SYSTEMS	3,610.61
	13141	DEPARTMENT OF RETIREMENT SYSTEMS	567.89
	13144	EMPLOYMENT SECURITY DEPARTMENT	1,162.45
	13158	KITTCOM	16,352.50
	13168	NW CABLING, LLC	4,284.35
Employee Benefits	13109	BPAS-VEBA	90.00
	13109	BPAS-VEBA	72.00
	13112	DEPARTMENT OF RETIREMENT SYSTEMS	2,859.71
	13116	IAFF HEALTH & WELLNESS TRUST	18,301.97
	13125	WA STATE COUNCIL OF FIREFIGHTERS	900.00
	13127	BETH WILLIAMS	30.00
	13127	BETH WILLIAMS	45.00
	13128	BRITTNEY SILVESTRI	15.00
	13130	CAROL JACQUES	45.00
	13134	COLE GRAVEL	30.00
	13134	COLE GRAVEL	30.00
	13135	CRAIG HALLMARK	30.00
	13135	CRAIG HALLMARK	30.00
	13137	DAKODA FENTER	30.00
	13137	DAKODA FENTER	30.00
	13140	DEPARTMENT OF RETIREMENT SYSTEMS	2,351.00
	13147	HARVEY SMITH	30.00
	13147	HARVEY SMITH	30.00
	13148	IAFF HEALTH & WELLNESS TRUST	18,301.97
	13152	JAMES BRYAN	30.00
	13152	JAMES BRYAN	15.00
	13154	JASON BOITANO	45.00
	13154	JASON BOITANO	30.00
	13155	JEFF BEATY	30.00
	13155	JEFF BEATY	90.00
	13156	JIM SCHOEGGL	15.00
	13156	JIM SCHOEGGL	15.00
	13157	JOHN STORCH	30.00
	13160	KRISTEN KASSOW	15.00
	13162	MATT MCCABE	30.00

	13163	MATT SCHAUER	75.00
	13163	MATT SCHAUER	75.00
	13166	NATE HENDERSON	60.00
	13166	NATE HENDERSON	15.00
	13167	NATHAN HUBBARD	30.00
	13167	NATHAN HUBBARD	30.00
	13171	SONYA VRAVES	75.00
	13171	SONYA VRAVES	105.00
	13173	STEVE CHRISMAN	105.00
	13173	STEVE CHRISMAN	30.00
	13174	TOM WATKINS	30.00
	13174	TOM WATKINS	45.00
Supplies	13108	AMAZON	38.46
	13108	AMAZON	240.23
	13108	AMAZON	61.18
	13108	AMAZON	130.25
	13108	AMAZON	168.32
	13114	GALLS, LLC	56.25
	13114	GALLS, LLC	243.16
	13114	GALLS, LLC	22.46
	13118	KITTITAS VALLEY HEALTHCARE	876.30
	13129	CARDINAL HEALTH 112, LLC	56.13
	13133	CLE ELUM HARDWARE & RENTAL	64.84
	13133	CLE ELUM HARDWARE & RENTAL	30.22
	13133	CLE ELUM HARDWARE & RENTAL	42.12
	13133	CLE ELUM HARDWARE & RENTAL	6.84
	13145	GALLS, LLC	160.11
	13145	GALLS, LLC	162.87
	13145	GALLS, LLC	135.09
	13145	GALLS, LLC	185.92
	13145	GALLS, LLC	29.76
	13145	GALLS, LLC	132.10
	13145	GALLS, LLC	133.26
	13145	GALLS, LLC	110.43
	13145	GALLS, LLC	334.93
	13145	GALLS, LLC	(133.26)
	13145	GALLS, LLC	(135.09)
	13145	GALLS, LLC	(110.43)
	13145	GALLS, LLC	(185.92)
	13145	GALLS, LLC	(160.11)
	13145	GALLS, LLC	(162.87)
	13145	GALLS, LLC	(334.93)
	13145	GALLS, LLC	(132.10)
	13145	GALLS, LLC	(29.76)
	13146	GOOD TO GO	11.70
	13153	JAMES OIL CO., INC.	1,661.34
	13161	LIFE ASSIST, INC.	28.28
	13161	LIFE ASSIST, INC.	37.01
	13161	LIFE ASSIST, INC.	1,768.30
	13165	MOUNTAIN AUTO PARTS	86.25

	13169	OXARC INC	204.62
	13169	OXARC INC	271.11
	13172	STATE DEPARTMENT OF TRANSPORTATION	3,532.28
	13176	WILLETTES SHELL SERVICE	34.59
	13177	GALLS, LLC	132.10
	13177	GALLS, LLC	133.26
	13177	GALLS, LLC	162.87
	13177	GALLS, LLC	29.76
	13177	GALLS, LLC	110.43
	13177	GALLS, LLC	185.92
	13177	GALLS, LLC	160.11
	13177	GALLS, LLC	135.09
Utiltites	13111	CENTURYLINK	140.41
	13119	MCI	36.63
	13120	MCI	35.44
	13122	PUGET SOUND ENERGY	110.66
	13122	PUGET SOUND ENERGY	12.82
	13131	CITY OF CLE ELUM	420.95
	13131	CITY OF CLE ELUM	0.14
	13131	CITY OF CLE ELUM	524.04
	13131	CITY OF CLE ELUM	265.16
	13131	CITY OF CLE ELUM	399.27
	13143	DISH NETWORK	105.64
	13143	DISH NETWORK	177.56
	13150	INLAND NETWORKS	117.91
	13150	INLAND NETWORKS	90.41
	13159	KITTITAS COUNTY FIRE DISTRICT #7	200.00
	13170	PUGET SOUND ENERGY	61.86
	13170	PUGET SOUND ENERGY	(61.86)
	13175	VERIZON	581.07
Purchased Services	13117	JACKSON HORSLEY	400.00
	13118	KITTITAS VALLEY HEALTHCARE	5,459.38
	13118	KITTITAS VALLEY HEALTHCARE	6,167.34
	13123	SYSTEMS DESIGN	2,150.80
	13126	YAKIMA ADJUSTMENT SERVICE INC	237.58
	13132	CITY OF CLE ELUM FIRE DEPARTMENT	200.00
	13132	CITY OF CLE ELUM FIRE DEPARTMENT	200.00
	13138	DALE SCOTT OLANDER	32.76
	13149	IMAGETREND, INC.	5,181.01
	13151	JACKSON HORSLEY	400.00
	13164	MICROSOFT	459.43
	13164	MICROSOFT	15.13
Licenses & Taxes	13142	DEPARTMENT OF REVENUE-EXCISE	1,028.81
Other Direct Expenses	13121	NORTHERN KITTITAS CO TRIBUNE	50.00
	13136	DAILY RECORD	75.86
			141,843.66

Kittitas County Elections
Ballot measure submission cover sheet

This form must accompany each resolution or ordinance and be submitted to:

Kittitas County Elections
205 W. 5th Ave, Suite 105; Ellensburg WA 98926
509.962.7503
elections@co.kittitas.wa.us

district information

Kittitas County Publicv Hospital District No. 2
name of district

Julie Petersen, Superintendent
district contact person and title

509-962-7301 (phone) rholden@kvhealthcare.org (email)

election information

November 8, 2022
election date

Levy
type of measure (levy, bond, advisory vote, etc)

Simple Majority RCW 85.55.010 and RCW 84.55.092
pass / fail requirements (simple majority, super majority, 60%, etc), along with the applicable statutory references

contact information for public

This contact person from the district should be able to respond to questions from voters about the ballot measure. This contact information will be provided upon request.

Rhonda Holden, Chief AncillaryOfficer
district contact person and title

509-962-7320 (phone) rholden@kvhealthcare.org (email)

Voter Pamphlet Contact Info

Pro Committee:	Against Committee
Floyd Rogalski	
Name	name
frog2@q.com	
Contact	Contact

For Office Use Only: Received Date Stamp: Received by:

Kittitas County Elections
Ballot measure submission cover sheet

This form must accompany each resolution or ordinance and be submitted to:

Kittitas County Elections
205 W. 5th Ave, Suite 105; Ellensburg WA 98926
509.962.7503
elections@co.kittitas.wa.us

district information

Kittitas County Public Hospital District No. 2
name of district

Julie Petersen, Superintendent
district contact person and title

509-962-7301 — phone
rholden@kvhealthcare.org — email

election information

November 8, 2022
election date

Levy
type of measure (levy, bond, advisory vote, etc)

Super Majority, 60% RCW 84.52.069
pass / fail requirements (simple majority, super majority, 60%, etc), along with the applicable statutory references

contact information for public

This contact person from the district should be able to respond to questions from voters about the ballot measure. This contact information will be provided upon request.

Rhonda Holden, Chief Ancilllary Officer
district contact person and title

509-962-7320 — phone
rholden@kvhealthcare.org — email

Voter Pamphlet Contact Info

Pro Committee:
Floyd Rogalski
Name
frog2@q.com
Contact

Against Committee
name
Contact

For Office Use Only: Received Date Stamp: Received by:

Why Vaccines are Important for Adults

Every year thousands of adults in the U.S. become seriously ill and are hospitalized because of diseases that vaccines can help prevent. Many adults even die from these diseases. By getting vaccinated, you can help protect yourself from much of this unnecessary suffering. Even if you received the vaccines you needed as a child, the protection from some vaccines can wear off. You may also be at risk for other diseases due to your job, lifestyle, travel, or health conditions.

Vaccines can lower your chance of getting certain diseases. They work with your body's natural defenses to help you safely develop immunity to disease. This lowers your chances of getting certain diseases and suffering from their complications. For instance, Hepatitis B vaccine lowers your risk of liver cancer, HPV vaccine lowers your risk of cervical cancer, flu vaccine lowers your risk of flu-related heart attacks or other flu-related complications from existing health conditions like diabetes and chronic lung disease.

Some people in your family or community may not be able to get certain vaccines due to their age or health condition. They rely on you to help prevent the spread of disease.

You have a busy life and too much responsibility to risk getting sick. Vaccines can help you stay healthy so you don't miss work. If you can avoid getting sick, you will have more time for your family, friends and hobbies. Getting recommended vaccines can give you some peace of mind. You will have the best possible protection available against a number of serious diseases.

Learn more at cdc.gov/vaccines

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