Original Proposal

LAI Proposal to provide Financial and Operational CAH Assessment Services

Submitted by:

Luke and Associates, Inc.

Bill Luke, President

11 Camelot Way, Kearney, Nebraska 68845

September 2019

SOLICITATION NUMBER	RELEASE DATE
RFP 6134 Z1	August 20, 2019
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
September 17, 2019 2:00 p.m. Central Time	Dianna Gilliland/Connie Heinrichs

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Original Request for Proposal for Contractual Services Form-Signed

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

By signing this Request for Proposal for Contractual Services form, the contractor

CONTRACTOR MUST COMPLETE THE FOLLOWING

guarantees compliance with the procedures stated in this Solicitation, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that contractor maintains a drug free work place.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

XX NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	**Luke and Associates, Inc.**
COMPLETE ADDRESS:	**11 Camelot Way** **Kearney, NE 68845**
TELEPHONE NUMBER:	**308.627.4900**
FAX NUMBER:	**N/A**
DATE:	**September 13, 2019**
SIGNATURE:	William C. Luke
TYPED NAME & TITLE OF SIGNER:	**William C. Luke** **President**

This proposal on the next four pages (pages numbered 3 – 6) is presented to match the sequence prescribed in Section VI. A. 1. & 2 of the Request for Proposal.

Corporate Overview

a. CONTRACTOR IDENTIFICATION AND INFORMATION

Luke and Associates, Inc.
11 Camelot Way
Kearney, NE 68845

Incorporated in 2005 in Nebraska, with no changes in name or form or organization since first organized.

b. FINANCIAL STATEMENTS

See Exhibit 2A and 2B for financial statements of Luke and Associates, Inc., a non-publicly held firm. LAI has been profitable every year since it was founded in 2005.

Description of the organization:
Luke and Associates, Inc. (LAI) is wholly owned by its founder and president, Bill Luke, who is its only employee. It has been successfully serving health systems and hospitals since 2005 by providing Bill to fill interim executive (CEO, COO, CFO) and other leadership and consulting roles.

Client base:
Clients have included (see Bill's resume, Exhibit 3, for more details):
- National health systems (e.g. Catholic Health Initiatives, Denver, which is now CommonSpirit after merging with Dignity Health)
- Regional divisions of large health systems (e.g. CHI Health, Omaha, and Mercy Health - Toledo Region, Toledo, Ohio)
- Regional health systems (e.g. Bryan Health, Lincoln, NE)
- *Larger local health systems and hospitals (e.g. Saint Elizabeth Health System, Lincoln, NE;* Columbus Community Hospital, Columbus, NE; Faith Regional Health Services, Norfolk, NE)
- Critical access hospitals (e.g. Saunders Medical Center, Wahoo, NE; Valley County Health System, Ord, NE; NorthStar Health System, Iron River, Michigan)
- Regional preferred provider organization (e.g. Midlands Choice)

Prior to forming LAI, Bill served at Good Samaritan, Kearney, NE for over 26 years, and was VP, Finance and CFO during the last 19+ of those years.

Areas of specialization and expertise:
This depth and breadth of experience that Bill has gained personally has been a great asset to the CAH assessment project from 2011 through 2019. Being personally involved in many levels of responsibility for hospital finances, operations, leadership, planning, implementation and management has prepared Bill to make a broad range of assessments and recommendations for the CAHs that have volunteered to participate in the project. After completing his most recent interim role in November 2018, Bill is now focusing more on serving in consulting roles such as the CAH assessments (if this LAI proposal is chosen), facilitation of strategic planning sessions, and the like.

Banking:
LAI uses the checking account services of First National Bank, Kearney branch (formerly Platte Valley State Bank and Trust Company in Kearney). LAI has never borrowed from a bank.

Judgments, pending or expected litigation, or other real or potential financial reversals:
None

c. CHANGE OF OWNERSHIP

None anticipated during the next 12 months.

d. OFFICE LOCATION

The LAI office location in Kearney, Nebraska, is well situated to perform on-site services throughout the state, and has done so for the 9 years of this project.

e. RELATIONSHIPS WITH THE STATE

Nebraska DHHS, Office of Rural Health, has contracted either directly or indirectly with LAI for Bill Luke to perform the 28 CAH assessments that have been done from 2011 through 2019.
Document #: 84157 O4
Envelope Id: 94316330FA5B40BABF8F714A4D6AC38F

f. CONTRACTOR'S EMPLOYEE RELATIONS TO STATE

No such relationships exist or have existed.

g. CONTRACT PERFORMANCE

N/A - No contract terminations in the past five years.

h. SUMMARY OF CONTRACTOR'S CORPORATE EXPERIENCE

As stated in Section e. immediately above, Nebraska DHHS, Office of Rural Health, has contracted either directly or indirectly with LAI for Bill Luke to perform the 28 CAH assessments that have been done from 2011 through 2019.
Accordingly, LAI has been doing this project for 9 years, demonstrating its ability to successfully complete a project of this size, scope and complexity. See Exhibit 1 for the listing of the 28 CAHs who have participated.

All 28 assessments were completed as scheduled with the CAHs, and were done within the budget. LAI has not used a subcontractor in connection with this project.

i. SUMMARY OF CONTRACTOR'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

LAI will assign its founder and president, Bill Luke, to the State's project, just as has been done for every CAH assessment performed from 2011 through 2019, with no use of subcontractors. Bill is the author of all 28 project reports that have been completed to date, and is the author of this proposal. Bill is also the only employee of LAI.
See Exhibit 3 for Bill's resume.
See Exhibit 4 for Bill's references.

j. SUBCONTRACTORS

LAI does not intend to subcontract any part of its performance of the CAH assessments.

Technical Approach - RFP Section V - Project Description and Scope of Work

A. PROJECT OVERVIEW

Accepted by LAI.

B. PROJECT ENVIRONMENT

Accepted by LAI.

C. SCOPE OF WORK

Accepted by LAI.
In addition, LAI has typically reviewed additional areas such as:

- Governing Board
- Ownership
- Leadership team
- Culture
- Marketing and business development plans
- Competitive position
- IT plans
- Community relations
- Master facility plan
- Strategic plan
- Quality indicators
- Volunteer programs
- Fund raising and Foundation
- Community health needs assessments
- Change management
- And more

D. PROJECT REQUIREMENTS

Accepted by LAI.

E. DHHS REQUIREMENTS

Accepted by LAI.

F. BIDDER REQUIREMENTS – TECHNICAL APPROACH

1	**The bidder should describe its approach to and knowledge of assessing an organization's financial and operational health; please address knowledge of hospitals in rural areas.**
	Bidder Response: LAI uses a comprehensive approach which includes: - A review of key documents in advance of the on-site work - Typically one week on-site (Monday – Friday) – o Getting a tour of the facility o Observing the community o Conducting standardized interviews of 25-35 people (as many as possible in each of these groups – governing Board members, medical staff/providers, community leaders, leadership and management - Developing detailed recommendations (categorized as major, minor and incidental) The depth and breadth of experience that LAI can supply by assigning Bill Luke to personally do the assessments has been a great asset to the CAH assessment project from 2011 through 2019. Being personally involved in many levels of responsibility for hospital finances, operations, leadership, planning, implementation and management, along with having done 28 CAH assessments, has prepared Bill to make

<table>
<tr><td></td><td>a broad range of assessments and recommendations for the CAHs that have volunteered to participate in the project. Most of Bill's career has been spent serving in rural hospitals.</td></tr>
<tr><td rowspan="2">2</td><td>The bidder should provide one (1) example of previous assessment completed that demonstrates their expertise and ability to conduct required assessments.</td></tr>
<tr><td>Bidder Response:

In 2011 the staff of the Nebraska DHHS Office of Rural Health arranged the Flex financing to assess the operational and financial performance of a few volunteer CAHs with the objective of making recommendations that would help them implement improvements. With the financing in place, the next step was to retain a consultant to do the assessments and develop the recommendations so Bill Luke was approached because of his background and experience in the operations and finances of hospitals and health systems, including CAHs. (See his resume, attached as Exhibit 3.)

The details were worked out and a pilot group of four volunteer CAHs were assessed in 2011. Upon completion of the four reports, DHHS staff convened a meeting of the CAH leaders to get feedback regarding the assessments and recommendations. The CAH leaders were in unanimous agreement that the project was indeed worthwhile, and recommended that Flex funding be continued to allow other volunteer CAHs to benefit from participation. Subsequent input from participating CAHs has periodically confirmed the value of the project.

The project has continued annually for nine years, resulting in 28 assessments, all performed by Bill Luke, founder and president of Luke and Associates, Inc. See the list of assessments attached as Exhibit 1.

Over the past nine years Luke and Associates, Inc. has demonstrated that Bill Luke has the expertise, ability, capacity and skill to accomplish the objectives of this solicitation.

The Nebraska DHHS, Office of Rural Health, has all 28 assessment reports prepared by LAI over the last nine years. To be responsive to the request, see Attachment 1 for the report issued to Harlan County Health Services dated September 24, 2018.</td></tr>
<tr><td rowspan="2">3</td><td>The bidder should describe its company's proposed approach to completing the work detailed in Section V.C Scope of Work. Provide an in-depth description of the proposed services to provide, the methods to be used, and the proposed outcomes to be achieved.</td></tr>
<tr><td>Bidder Response:

LAI works with staff in the DHHS, Office of Rural Health, to identify CAHs who could benefit from participating in the project, and then inviting them to do so. LAI confirms participation and performs the administrative functions of the project for each CAH.
See section F.1. above for LAIs approach to completing the work
See section V.C. above for some of the aspects of LAIs assessment that makes it comprehensive, and thus more valuable to the CAH
The proposed outcome is always to give the CAH valuable and actionable recommendations that will help it succeed in its mission – stated in numerous ways, but universally summed up as providing a high quality of needed healthcare services to the people it serves in a way that is economically sustainable.</td></tr>
</table>

G. DELIVERABLES

Accepted by LAI.

RFP Section II - Terms and Conditions

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

C. GOVERNING LAW (Statutory)

D. BEGINNING OF WORK

E. AMENDMENT

F. CHANGE ORDERS OR SUBSTITUTIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

G. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

H. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

I. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

J. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

K. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

L. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

M. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

N. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS OF THE STATE OR ANOTHER STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

O. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

P. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

Q. OFFICE OF PUBLIC COUNSEL (Statutory)

R. LONG-TERM CARE OMBUDSMAN (Statutory)

S. SUSPENSION OF SERVICE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

T. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

U. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

RFP Section III - Contractor Duties

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

E. DISCOUNTS

F. PRICES

G. COST CLARIFICATION

H. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

I. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

J. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
		LAI	The Nebraska DHHS Office of Rural Health already had a series of contracts with Luke and Associates, Inc. to do the work specified in this request for proposal in prior years. The insurance requirements section of those contracts was variously removed and/or modified to be acceptable to both parties. The alternative solution requested by Luke and Associates is to either (a) remove the requirements totally, since they do not apply to the nature of the services being performed and LAI is exempt from Workers' Compensation requirements, or (b) use the insurance requirements language in the previous contract to replace the language in this request for proposal - see Exhibit 5 for the wording included in a prior contract.

K. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

L. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

M. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

N. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

O. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

P. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

Q. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

R. WARRANTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

RFP Section IV - Payment

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory

B. TAXES (Statutory)

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

E. PAYMENT (Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

F. LATE PAYMENT (Statutory)

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Statutory)

H. RIGHT TO AUDIT (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
LAI			

RFP Section VI - Form A - Contractor Proposal Point of Contact

Form A
Contractor Proposal Point of Contact
Request for Proposal Number 6134 Z1

Form A should be completed and submitted with each response to this solicitation. This is intended to provide the State with information on the contractor's name and address, and the specific person(s) who are responsible for preparation of the contractor's response.

Preparation of Response Contact Information	
Contractor Name:	Luke and Associates, Inc.
Contractor Address:	11 Camelot Way Kearney, Nebraska 68845
Contact Person & Title:	Bill Luke, President
E-mail Address:	Bluke444@gmail.com
Telephone Number (Office):	308.627.4900
Telephone Number (Cellular):	308.627.4900
Fax Number:	N/A

Each contractor should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the contractor's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Contractor Name:	Luke and Associates, Inc.
Contractor Address:	11 Camelot Way Kearney, Nebraska 68845
Contact Person & Title:	Bill Luke, President
E-mail Address:	bluke444@gmail.com
Telephone Number (Office):	308.627.4900
Telephone Number (Cellular):	308.627.4900
Fax Number:	N/A

Exhibits And Attachment

Exhibit 1 - CAH Project Participation Summary for 2011-2019

CAH *(name as of site visit date)*	***Town***	***CEO/Administrator*** *(as of site visit date)*
Group 1 (Pilot) - 2011		
Franklin County Memorial Hospital	Franklin	*Linda Bush,* CEO
Litzenberg Memorial County Hospital	Central City	*Tad Hunt,* CEO
Niobrara Valley Hospital	Lynch	*Kelly Kalkowski,* CEO
Garden County Health Services	Oshkosh	*Jim Hansel,* CEO
Group 2 - 2012		
Dundy County Hospital	Benkelman	*Rita Jones,* CEO
Rock County Hospital	Bassett	*Stacey Knox,* CEO
Gordon Memorial Hospital	Gordon	*Jim LeBrun,* CEO
Group 3 - 2013		
Morrill County Community Hospital	Bridgeport	*Robin Stuart*, (Interim) Administrator
Genoa Medical Facilities (#1)	Genoa	*Larry Schrage*, Admin
Brown County Hospital	Ainsworth	*Shannon Sorensen*, CEO
Saunders Medical Center	Wahoo	*Ken Archer,* CEO
Lexington Regional Health Center	Lexington	*Leslie Marsh*, CEO
Group 4 - 2014		
Pawnee County Memorial Hospital	Pawnee City	*Jim Kubik,* CEO
Warren Memorial Hospital	Friend	*Chris Bjornberg,* CEO
Fillmore County Hospital	Geneva	*Paul Utemark,* CEO
Thayer County Health Services	Hebron	*Mike Burcham,* CEO
Group 5 - 2015		
Chase County Hospital	Imperial	*Steve Lewis,* CEO
CHI Health - Plainview	Plainview	*Rick Gamel,* CEO
Kimball Health Services	Kimball	*Ken Hunter,* CEO
Group 6 - 2016		
Osmond General Hospital	Osmond	*Lon Knievel,* CEO
Tri-Valley Health System	Cambridge	*Deb Herzberg,* CEO
Genoa Medical Facilities (#2)	Genoa	*Cory Nelson*, CEO
Group 7 - 2017		
Oakland Mercy Hospital	Oakland	*John Werner,* CEO
Group 8 - 2018		
Chadron Community Hospital	Chadron	*Anna Turman,* CEO
Harlan County Health System	Alma	*Mark Miller,* CEO
Group 9 – 2019 *(Grant year ending 8.31.2019)*		
Cozad Community Health System	Cozad	*Lyle Davis,* CEO
Pender Community Hospital	Pender	*Melissa Kelly,* CEO
Henderson Health Care Services, Inc.	Henderson	*Cheryl Brown*, CEO
(28 total)		

Luke and Associates, Inc.
Balance Sheet
As of December 31, 2018

Exhibit 2A - LAI Balance Sheet

Unaudited	Dec 31, 2018
ASSETS	
Current Assets	
Total Checking/Savings	116,251
Total Current Assets	116,251
Fixed Assets	
Equipment	
Accum Depr-Sec 179 Deduct	-8,045
Equipment - Other	8,045
Total Equipment	0
Total Fixed Assets	0
TOTAL ASSETS	**116,251**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Total Accounts Payable	29,063
Total Current Liabilities	29,063
Total Liabilities	29,063
Equity	
Capital Stock	500
Opening Bal Equity	60,856
Shareholder Drawing	-59,000
Net Income	84,832
Total Equity	87,187
TOTAL LIABILITIES & EQUITY	**116,251**

Luke and Associates, Inc.
Income Statement
January through December 2018

Exhibit 2B - LAI Income Statement

Unaudited	Jan - Dec 18
Income	
Consulting and Interim	235,288
Reimbursed Expenses	22,315
Other	200
Total Income	257,803
Cost of Goods Sold	
Total Billable Expenses	22,179
Total COGS	22,179
Gross Profit	235,623
Expense	
Depreciation Expense	2,940
Dues and Subscriptions	1,813
Total Insurance	9,090
Total Payroll Expenses	107,650
Retirement Expense-SEP	26,000
Other	3,299
Total Expense	150,792
Net Income	**84,832**

Exhibit 3 – Resume of Bill Luke

William C. Luke

OBJECTIVE

Seasoned healthcare executive (CEO, CFO, COO) with deep and broad executive leadership experience is available for consulting roles where my skills can be used to help an organization be successful and achieve its goals.

AREAS OF EXPERTISE

Overall Leadership and Culture Improvement	Financial Leadership
Strategy Development and Implementation	Corporate Compliance
Change Management and Team Development	CAH Assessments

EXPERIENCE

2005 – Present – Luke and Associates, Inc., Kearney, NE (LAI) – LAI provides consulting services to the healthcare industry.

- *President, founder, and lead consultant.*
  Have contracted to serve as interim CEO, CFO, COO and other executive and consultant roles. Clients to date are: Nebraska Department of Health and Human Services, Bryan Health, Mercy Health – Toledo Region, CHI Health, Bryan Health for Bryan Medical Center, NORTH*STAR* Health System, Saunders Medical Center, Saint Elizabeth Regional Medical Center, Faith Regional Health Services, Bryan Health for Valley County Health System and Saunders Medical Center, Columbus Community Hospital, Saint Elizabeth Health System, Catholic Health Initiatives, Jewish Hospital and St. Mary's HealthCare, Midlands Choice, and CARITAS Health Services, as detailed below.

2011-Ongoing – Nebraska Department of Health and Human Services, Lincoln, NE (DHHS) – Contracted with DHHS to be the consultant in a voluntary (by invitation) project to improve the operational and financial performance of Nebraska critical access hospitals (CAHs). Project deliverables are recommendations that will demonstrably improve the operational and financial performance for each participating CAH. To date 28 CAHs have participated over 9 years.

2018 – Bryan Health, Lincoln, NE (BH)* – Bryan Health operates Bryan Medical Center East and West and various outpatient locations in Lincoln, NE, and CAHs in Crete and Central City, NE. Served as ***interim Consulting Controller*** during recruiting.

2018 – Mercy Health-Toledo Region, Toledo, OH (Mercy-Toledo)* – Served as ***interim CFO – Toledo Region*** during the recruiting process. Mercy-Toledo operates physician networks and hospitals across northwest Ohio with approximately 5,500 FTEs.

2016-2017 – CHI Health, Omaha, NE (CHI-H)* – Served as ***interim VP, Divisional Finance*** during the recruiting process. CHI-H operates physician networks and hospitals across Nebraska and southwest Iowa with approximately 11,000 FTEs.

2015 – CHI Health, Omaha, NE (CHI-H)* – Served as ***interim VP, Divisional Finance*** while the incumbent was out on medical leave. CHI-H operates physician networks and hospitals across Nebraska and southwest Iowa with approximately 11,000 FTEs.

2015 – Bryan Health for Bryan Medical Center, Lincoln, NE (BMC)* – Bryan Health operates Bryan Medical Center East and West and various outpatient locations in Lincoln, NE, and Crete Medical Center in Crete, NE. Served as ***interim Consulting Director of Revenue Cycle.***

2013-2014 – Saunders Medical Center, Wahoo, NE (SMC) – See Saunders Medical Center, below. Contracted with SMC as an ***independent consultant*** to assess the operational and financial position of SMC, and to help the Board examine options and make decisions regarding affiliation alternatives. This work was successfully completed with a unanimous Board decision.

2013-2014 – NORTH*STAR* Health System, Iron River, MI (NHS)* – NHS is a not-for-profit corporation that operates a CAH, multiple primary and specialty physician clinics, home health and hospice, and county-wide EMS, totaling approximately 300 employees. Was ***interim COO*** until NHS merged with Aspirus Health.

2013 – Saint Elizabeth Regional Medical Center, Lincoln, NE (SERMC)* – Served as ***interim VP, Finance*** for SERMC, which was part of CHI Nebraska. See SEHS below.

2012 – Faith Regional Health Services, Norfolk, NE (FRHS)* – Served as ***interim CFO*** for this full service health system with tertiary level services such as open heart surgery, 20+ employed physician network and 1,100+ employees.

2011 – Valley County Health System, Ord, NE (VCHS)* through **Bryan Health,** Lincoln, NE (Bryan)* - ***Led the CEO search*** for VCHS, and VCHS asked that I serve as ***interim CEO***. VCHS has a critical access hospital, multiple rural health clinics and a long-term care center totaling 200+ employees and is operated by Valley County.

2010-2011 – Saunders Medical Center, Wahoo, NE (SMC)* through **Bryan Health,** Lincoln, NE (Bryan) - SMC contracted with Bryan for my services as the ***interim CEO*** for SMC. SMC has a critical access hospital, rural health clinic and long-term care center with 200+ employees.

2008-2009 – Columbus Community Hospital, Columbus, NE (CCH)* – Served as ***interim CEO*** for this community hospital with 47 licensed beds, 500+ employees, level II trauma designation, regional occupational health services, home health and hospice, physician hospital organization, and Foundation.

2007-2008 – Saint Elizabeth Health System, Lincoln, NE (SEHS)* – Served as ***interim CFO*** for this full service health system with tertiary burn center, Neonatal ICU and open heart surgery, 90+ employed physician network, Foundation, and 2,000+ employees.

2006-2007 – Catholic Health Initiatives, Denver, CO (CHI)* – Served as ***interim Vice President, Financial Management*** in the national office for CHI, the second largest Catholic healthcare system in the United States, consisting of over 60 hospitals in 18 states and approximately 65,000 employees. Consolidated assets exceed $11 billion.

2006 – Jewish Hospital and St Mary's HealthCare, Louisville, KY (JHSMH)* – Served as ***Integration Team Leader (financial services) and special projects consultant*** for this academic and research healthcare delivery system created by the merger of JHHS and CHS (see CHS below) with revenues exceeding $800 million and 7,000+ employees. Provides tertiary and quaternary services recognized nationally and internationally.

2006 – Midlands Choice, Inc., Omaha, NE (MC)* – Served as ***Consultant – strategic and financial issues.*** MC is a health system owned preferred-provider organization with a network of more than 18,000 physicians and other licensed healthcare professionals, 290 hospitals, and nearly 900 ancillary healthcare providers.

2005 – CARITAS Health Services, Inc., Louisville, KY (CHS)* – Served as ***interim Vice President, Finance and CFO*** for this suburban medical center and major regional mental health provider with employed physicians and large home health agency, all totaling 2,000+ employees.

1985 - 2005 -- Good Samaritan Health Systems, Inc. Kearney, NE (GSHS)* – Tertiary rural integrated delivery system with 200+ beds, over 1,500 employees, and 100+ local physicians.

- ***Vice President, Finance and CFO,*** Actively participated in executive leadership and strategic planning, including major decisions regarding operations, mergers and acquisitions, formation of joint ventures and subsidiaries, starting new lines of business, and divestitures. Responsible for typical CFO duties such and supervised various other operating departments.
- ***Governance and Leadership,*** Various Board roles for subsidiaries and joint ventures including Board Chair, Vice Chair, Secretary, Treasurer, President, and VP.
- ***Interim President and CEO,*** November 1987 - May 1988 (Richard Young Hospital)
- ***Interim President and CEO,*** April - September 2000 (GSHS)
- ***Acting President and CEO,*** December 2001 - January 2002 (GSHS)

1978 - 1985 -- Good Samaritan Hospital, Kearney, NE
As ***Director of Accounting and Data Processing,*** directed staff for budgeting, financial and variance reporting, general and cost accounting, governmental reporting, etc.

1974 - 1978 -- Arthur Andersen & Co. Omaha, NE

- As ***Senior Accountant (1974-1976 Staff Accountant), audit division*** led independent audits that were conducted in accordance with generally accepted auditing standards, for industries such as insurance, health care, mutual funds, manufacturing, etc.

1973 - 1974 – Abilene Christian University, Abilene, TX
Computer Programmer – employed part time while a full time student.

EDUCATION

1970 - 1974 -- Abilene Christian University, Abilene, TX
Bachelor of Science degree in Accounting, Summa Cum Laude
1974 - 2019 – Many educational conferences, seminars, books, and training courses in strategic planning, healthcare topics, governance, leadership, administration, management and finance.

PROFESSIONAL AND COMMUNITY (Partial List)

Healthcare Financial Management Association, advanced member
American Institute of Certified Public Accountants, member
Nebraska Society of Certified Public Accountants, member
Certified Public Accountant, Nebraska certificate #1662 (Inactive registration)
Rotary Club, member, and active in local church
Past member, Finance Committee of the Board of Trustees, Centura Health, Denver CO
Past member (treasurer) of American Red Cross, Ft. Kearney Chapter, Board of Directors
American College of Healthcare Executives, past member
As of July 22, 2019 *** Entity information was current as of the dates of service.**

Exhibit 4 – References for Bill Luke

Lyle Davis, CEO
Cozad Community Hospital
P. O. Box 108
Cozad, NE 69130
308.784.2261

Russ Gronewold, CFO
Bryan Health
1600 South 48th Street
Lincoln, NE 68506
402.481.3190

Robin Stuart, CEO
Morrill County Community Hospital
1313 S Street
Bridgeport, NE 69336
308.262.1616

Exhibit 5 – Proposed Revised Wording for Insurance Requirements

V. INSURANCE.

1. *General Requirement.* The Contractor shall not commence work under this contract until all the insurance required herein has been obtained. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that DHHS has the most current certificate of insurance throughout the life of this contract.

a. If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

b. Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this paragraph.

2. *Workers' Compensation Required.* The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of DHHS. The amounts of such insurance shall not be less than the following limits:

WORKERS' COMPENSATION

Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory

SUBROGATION WAIVER

"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."

Note: LAI is exempt from Workers' Compensation coverage requirements under Nebraska laws and regulations.

Attachment 1 – Recommendations Report for Harlan County Health Services

Attachment 1

Recommendations for Harlan County Health System (HCHS):

From the Critical Access Hospital Evaluation and Performance Improvement Project

Project Sponsor:

State of Nebraska, Department of Health and Human Services, Office of Rural Health (DHHS)

Margaret Brockman, Director, Office of Rural Health

Nancy Jo Hansen, FLEX Grant Project Coordinator

Funding: State Rural Hospital Flexibility Grant Program

Federal Budget Period: September 1, 2017 – August 31, 2018

Federal Agency: Health Resources & Services Administration (HRSA)

Project Leader/Consultant:

Luke and Associates, Inc.

Bill Luke, President

Harlan County Health System Project Timeline:

August, 2018 – Develop performance improvement recommendations

Through Dec 31, 2020 – Reporting to DHHS on progress and impact

Document date: Sep 24, 2018

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2. Develop and use plans to return to profitability and identify, communicate and implement key strategies.... 9
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Introduction and Project Definition:

The Nebraska Department of Health and Human Services, Office of Rural Health (DHHS) obtained grant funding for a pilot project to assess and recommend improvements in the operational and financial performance of CAHs that have a demonstrated history of negative or low margins (the Project). In September of 2011 the following four pilot CAHs were recruited, whose participation was voluntary:

- ➢ Franklin County Memorial Hospital, Franklin, Nebraska, *Linda Bush,* CEO
- ➢ Litzenberg Memorial County Hospital, Central City, Nebraska, *Tad Hunt,* CEO
- ➢ Niobrara Valley Hospital, Lynch, Nebraska, *Kelly Kalkowski,* CEO
- ➢ Garden County Health Services, Oshkosh, Nebraska, *Jim Hansel,* CEO

The recommendations were issued by mid-December of 2011, with periodic progress reports to DHHS over the following two years.

The project was met with enough enthusiasm that DHHS chose to allocate funds from the subsequent annual grant cycles to extend the Project to several other CAHs each year. In January of 2012 the following CAHs accepted the invitation to participate:

- ❖ Dundy County Hospital, Benkelman, Nebraska, *Rita Jones,* CEO
- ❖ Rock County Hospital, Bassett, Nebraska, *Stacey Knox,* CEO
- ❖ Gordon Memorial Hospital, Gordon, Nebraska, *Jim LeBrun,* CEO

These recommendations were done by September of 2012, with each CAH submitting progress reports to DHHS over the next two years.

The following CAHs accepted the invitation to participate in the 2012-2013 Project year:

- ✓ Morrill County Community Hospital, Bridgeport, Nebraska, *Robin Stuart*, Interim Administrator
- ✓ Genoa Medical Facilities, Genoa, Nebraska, *Larry Schrage*, Administrator
- ✓ Brown County Hospital, Ainsworth, Nebraska, *Shannon Sorensen*, CEO
- ✓ Lexington Regional Health Center, Lexington, Nebraska, *Leslie Marsh*, CEO
- ✓ Saunders County Medical Center, Wahoo, Nebraska, *Ken Archer*, CEO

These recommendations were done by late 2013, and each CAH was to submit progress reports to DHHS on a set schedule over two years.

The following CAHs accepted the invitation to participate in the 2013-2014 grant cycle:

- ▪ Pawnee County Memorial Hospital, Pawnee City, Nebraska, *Jim Kubik*, CEO
- ▪ Warren Memorial Hospital, Friend, Nebraska, *Chris Bjornberg*, CEO
- ▪ Fillmore County Hospital, Geneva, Nebraska, *Paul Utemark*, CEO
- ▪ Thayer County Health Services, Hebron, Nebraska, *Mike Burcham*, CEO

These recommendations were completed by December 31, 2014. Progress reports are submitted to DHHS over the trailing two years.

The following CAHs accepted the invitation to participate in the 2014-2015 Project year:

- Chase County Community Hospital, Imperial, Nebraska, *Steve Lewis*, CEO
- CHI Health Plainview, Plainview, Nebraska, *Rick Gamel*, President
- Kimball Health Services, Kimball, Nebraska, *Ken Hunter*, CEO

These recommendations were done by November 2015. Progress reports will be submitted to DHHS over the trailing two years.

The following CAHs accepted the invitation to participate in the 2015-2016 Project year:

- Osmond General Hospital, Osmond, Nebraska, *Lon Knievel*, CEO
- Tri-Valley Health System, Cambridge, Nebraska, *Deborah Herzberg*, CEO
- Genoa Medical Facilities, Genoa, Nebraska *Cory Nelson*, CEO

These recommendations were done by July 2016. Progress reports will be submitted to DHHS over the following two years.

The following CAH accepted the invitation to participate in the 2016-2017 Project year:

- Oakland Mercy Hospital, Oakland, Nebraska, *John Werner*, CEO

The recommendations were done by August 2017. Progress reports will be submitted to DHHS over the trailing two years.

The following CAHs accepted the invitation to participate in the 2017-2018 Project year:

- Chadron Community Hospital and Health Services, Chadron, Nebraska, *Anna Turman*, CEO
- Harlan County Health System, Alma, Nebraska, *Mark Miller*, CEO

The recommendations for Chadron Community Hospital were done by May 2018 and for Harlan County Health System were done in August 2018. Progress reports will be submitted to DHHS over the following two years.

Participating CAHs made in-kind investments in the Project (e.g. time, preparing information and analyses, planning, reporting, etc.) but were not charged for fees or expenses directly related to the assessment and developing the recommendations; rather, the grant funds provided the technical assistance resources for the evaluation and to formulate the performance improvement plan.

The CAHs make reports to DHHS for approximately two years to allow an ongoing assessment of the impact and value of the Project.

In 2015 DHHS entered into an agreement with Luke and Associates, Inc., to continue leading the Project and to expand involvement to include the phase 4 follow-up along with being available for limited ongoing consultation with the CEO as needed.

Project Timeline and Phases:

Phase 1: Develop the work plan to accomplish the Project objectives (essentially the same for each year).

Phase 2: Recruit the qualifying CAHs to participate.

Phase 3: Perform the evaluations and develop performance improvement plans (addressing both operations and finances) for each participating CAH.

Phase 4: Work to implement the recommendations and do the agreed upon periodic reporting to DHHS regarding actual activity, and an assessment of the value of the Project for each CAH. The CEO at each CAH is responsible for implementation and reporting.

Phase 5: Report Project findings and impacts that could be helpful to other CAHs, agencies of other states, or federal officials. In mid-2013 a document was prepared to describe the Project and to report on its early impact; it is available from Margaret Brockman at DHHS.

Project Methodology and Findings:

The Project consultant reviewed numerous documents that were provided by each of the participants. The consultant also spent several days on-site at each CAH, getting a tour of the facilities and conducting a confidential standardized interview (typically lasting about an hour) with all or most of the members in each of the following groups:

- *Board of Directors/Trustees*
- *Providers* (physicians and mid-levels, excluding visiting specialists)
- *Management* (including the Administrator/CEO, senior and middle managers and, if applicable, Foundation leaders)
- *Elected members* of the County Board or City Council owning the CAH, if applicable (typically 2 or 3 people)
- *Key community leaders* (usually 4 to 6 people)

The standardized interviews yielded both quantifiable responses (e.g. ratings on a scale from 1 to 10) and narrative responses. The quantified responses were summarized and are presented in Appendix A.

The narrative responses were combined with information from the document reviews, the quantified responses, and the consultant's experience and professional judgment, to develop the recommendations.

The consultant saw the need to separate the recommendations into the following categories: major, minor, and incidental. The major recommendations are presented in the body of this report. The minor recommendations are presented in a separate letter to the CEO, which is attached as Appendix B. The incidental recommendations are simply discussed with the CEO. This approach was selected to save the minor and incidental recommendations from being lost and to keep them from diverting attention from the importance of effectively addressing the major recommendations.

It should be noted that the drafts prepared by the consultant were reviewed with the CEO and revised as needed so that there was agreement on both the statement of the recommendations and the placement of each recommendation in one of the three categories. This critical step assures that the report will be useful to the CEO in helping their CAH try to improve operational and financial performance.

The CEO is responsible for sharing this report with those who were interviewed by the consultant. Note that almost all those interviewed stated that they wanted to see the final report from the Project; exceptions have been shared with the CEO. If questions arise regarding the recommendations, as part of the Project, the consultant is available to help with clarification, and for some ongoing consultation with the CEO, if desired.

The CEO is also responsible to lead the implementation efforts and to ensure that the periodic reporting to DHHS is done according to the schedule presented towards the end of this report.

Note: References to Harlan County Health System (HCHS) include all services operated by HCHS, such as the Rural Health Clinics (RHCs) in Alma and Oxford and inpatient, swing bed, and outpatient services at the hospital in Alma.

Performance Improvement Recommendation Details:

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

Recommendation 1: Continue to make progress in key areas, with detailed suggestions in the subsequent recommendations

Rationale: Harlan County Health System (HCHS) has experienced significant changes over the last few years in some areas, while in other respects there has been relative stability. Important points include:
- ***Administration and management*** – the Senior Leaders have all changed in the last couple of years, with Mark Miller coming as the interim CEO in early 2018 and then being hired as CEO effective June 1, 2018, after the resignation of the prior CEO Manuela Wolf. The CFO retired in late 2017 and that role has been filled by interim individuals and a person hired into the position who stayed only a couple of months; at the time of this writing Ken Cox is the most recent interim CFO, starting in mid-August 2018. Liz Miller was the Director of Nursing from early 2017 to September 2018, followed by an interim Director of Nursing. There have also been other changes in the director and manager ranks, while the rest of the management team is a good mix of people with longer, mid-range and shorter service. As is typical, the leadership transitions have necessarily resulted in disruption for the organization as everyone, including the providers, adjusts to the style and focus of the new leaders. See recommendation #6 for specific action steps.
- ***Medical staff*** – Heartland Family Medicine Clinic in Alma and the satellite clinic in Oxford are owned by HCHS and are operated as rural health clinics. They are staffed by employed physicians Cameron Knackstedt, DO, (retiring as of Dec. 31, 2018) and John Finkner, MD, who are scheduled as 1.6 FTEs, and Jess Stemper and Jennifer Taylor, employed PA-Cs who are scheduled as 2.0 FTEs. Both physicians have a long history of care in Alma. These four providers also do most of the coverage for the Alma emergency room and call coverage for the hospital, with some ER coverage being done by outside providers. Through the RuralMed cooperative, Jacob Peterson, MD, is signed to start in October 2018 being part-time at Alma and working in Holdrege the remaining time. HCHS is described as always recruiting for providers, and it would be good to have a written provider recruitment and retention policy, formally approved by the Board of Trustees, to guide the provider recruitment process (see recommendation #3).
- ***Specialty clinics*** – have been relatively stable for visiting specialist providers and their specialty clinics, with multiple specialists holding clinics in cardiology and orthopedics. HCHS is trying to recruit additional specialties, and arrange for more procedures to be done at HCHS by the visiting specialists so that local patients will not have to travel as often for procedures. HCHS has various arrangements to bring specialist physician services to the community.
- ***Board of Trustees*** – HCHS is a division of Harlan County, Nebraska, and the Harlan County Board of Supervisors appoints the

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

seven members of the HCHS Board of Trustees to oversee its operations. Trustees are generally appointed from each of the Supervisor districts of the County for six year terms and without any limit on the number of terms. The current Board consists of two Trustees with over 10 years of service and the rest with fewer than four years of service. All current Trustees are certified hospital trustees by a program sponsored by the Nebraska Hospital Association.
- ***Trends in patients served*** – the historical trend line for volume of services is mixed; the overall net patient service revenue in 2017 and 2018 has been trending above the prior year by 3.5% and 8.1%, respectively. Market share information from Nebraska and Kansas can be used to determine if patients have been lost to, or attracted from, competing health systems.
- ***Facilities*** – a hospital renovation and expansion was done about 10 years ago, the Heartland Medical Clinic in Alma is approximately 40 years old and construction of a new clinic has begun (to be financed by a capital campaign), and the Oxford clinic building and equipment is owned by the city of Oxford and is dated.
- ***Information Technology*** – HCHS went live with the Meditech electronic health record system on July 1, 2018, including the RHCs.
- ***Financial performance*** – although revenues have been increasing in recent years, the expenses have been increasing faster, resulting in net losses of $267,000 in 2016, $372,000 in 2017, and on pace for a larger loss in 2018. See recommendation #5.G.
- ***Ongoing changes*** – changes are likely over the next several years, including the following:
  - recruiting new physician and mid-level providers and their transition into HCHS
  - bringing in more visiting specialists for outreach clinics, and perhaps to do some procedures at HCHS
  - hiring a new Director of Nursing and CFO

Some of these changes are being planned and scheduled while others will emerge from within the organization or be imposed from outside. As always, there will be challenges and problems that are impossible to predict, and opportunities that pop up, in addition to what is planned and expected. These unexpected things will have to be addressed, challenging the leadership to decide when to revise their plans and when to push ahead with the existing agenda.

The recommendations in the remainder of this report are intended to add momentum and effectiveness to the plans and direction that leadership has in place, along with being a catalyst for further actions needed to further improve the operational performance and financial stability of HCHS for the benefit of the people that it serves.

Ref. #	Description	Due Date	Leader, Progress and Comments	% Done

Recommendation 2: Develop and use plans to:
~ Return to profitability
~ Identify, communicate and implement key strategies

Rationale: Return to profitability: Looking at recent fiscal years HCHS has had a significant negative total margin which is continuing into 2018. Although it is not the mission of HCHS to make a profit every year, the economic reality is that if losses continue at this magnitude, HCHS will eventually not be able to fulfill its mission. It will take some time for many of the remediating actions to have a positive impact on financial performance, and there could be some additional developments with a further negative impact on financial performance. Therefore, identifying and implementing the needed actions to return to profitability is both urgent and important.

That being the case, major decisions don't have to be made in the next days or weeks. There is time to do the needed communication, assessments, analyses and planning so that HCHS can be repositioned to continue fulfilling its mission of serving the healthcare needs of the people in the service area for many years to come. Making major decisions that are not fully informed could very well make matters worse instead of better.

Identify, communicate and implement key strategies: A process to identify, communicate and implement key strategies is always important, but all the more so when there is turnover in the senior leadership positions of CEO, CNO/Director of Nursing, and CFO. The new leaders will have their own perceptions of the issues, preferences for action, and personal styles, even as they are learning about the organization and its people, and about the community. Going through a solid planning process, clearly articulating the resulting plan, and then keeping it very visible to guide ongoing implementation is one of the most effective ways for the new executives to bring HCHS together and lead it into the future.

A solid planning process will:
- makes a meaningful connection between the daily work of every hospital stakeholder and the defined ***mission*** of the hospital
- helps every stakeholder make a daily contribution towards achieving the adopted ***vision*** of the hospital

Ref. #	Description	Due Date	Leader, Progress and Comments	% Done
- reinforces how the ***core values*** of the hospital are applied in guiding how each stakeholder behaves every day on the job - brings together the functions that drive the hospital (e.g. clinical services, IT, facilities, provider relations, finance/budget, human resources, etc.) in a way that integrates them across the organization, aligns the direction for each function, provides a forum to improve working relationships by identifying and resolving the inevitable conflicts, and uses a creative tension to balance the competing views and needs of each function - gives goals to every stakeholder that guides their daily activities and facilitates holding them accountable to moving HCHS forward - guides resource allocation decisions through the budgeting process (both capital and operating budgets) and at other decision points - use the 2017-2020 strategic plan as one of the inputs. Ideally, these plans will be done in time to guide the goal setting and preparation of the capital and operating budgets for the next fiscal year. A new plan, or an update of the existing plan, should be done annually to inform the organizational, departmental and individual goal setting and budget preparations for each fiscal year thereafter. The following recommendations do not pre-suppose any specific plans, decisions or outcomes; rather, they are intended to provide the outline of a *process* to use in developing and implementing the best possible plan for a return to profitability by identifying, communicating and implementing the selected key strategies.				
2.A.	Administration should lead in developing a *process* to bring in the perspectives and insights of all the major stakeholders, as this will greatly improve the *plan* and the likelihood of its success. The plan could be called "Maintaining our Mission – A Path to Financial Stability" or "Maintaining our Mission – Returning to Profitability" or something along that line. The process should include at least these points: - include all interested stakeholders in the process - educate the stakeholders with relevant information such as the historical and projected trends of: o financial performance	Oct 31 2018	CEO, and possibly some consulting resources. Target to have the plans done and approved ASAP, and no later than the Board meeting in November	

Ref. #	Description	Due Date	Leader, Progress and Comments	% Done
	○ market share* (inpatient and outpatient by service line) ○ patient origin* (inpatient and outpatient by service line) ○ financial contribution and volume of service statistics for all service lines ○ provider and employee productivity ○ general healthcare industry information regarding CAHs and rural settings ○ projected future scenarios (perhaps a range of options showing optimistic, realistically achievable, and pessimistic) ○ other information (such as quality trends, patient satisfaction, etc.) - make the effort and take the time to understand the issues and needs - adopt guiding principles for use throughout the process - consider the advantages and disadvantages of all reasonable alternatives - after choosing each preferred alternative, develop related plans that have the highest potential to succeed - be diligent to implement the plans - adjust the plans as needed when new alternatives emerge or unforeseen obstacles arise - all throughout this process, get the information and resources you need, and - do an excellent job with communications (internal and external) at each step, to multiply the likelihood of returning to profitability. Your attorney, accountants and possibly other consulting resources can give specific guidance and assist in preparing the plans, if needed. The plans should be reviewed and approved by the Board before implementation begins. **Patient origin, and especially market share information, both inpatient and outpatient, may be needed for Nebraska and Kansas since it is reported that a notable number of people cross over the state line for healthcare services. Through your participation in the CAH network with CHI Health Good Samaritan, they may be able to provide the needed information for patient origin and market share by*			

Ref. #	Description	Due Date	Leader, Progress and Comments	% Done
	service line.			
2.B.	The details of the plan should be developed over the next couple of months as you move through the process. The plan should address all major elements of HCHS, such as acute inpatient, swing beds, ER, outpatient, outreach/specialty clinics and related services, rural health clinics, the primary care provider coverage model, etc.	Oct 31 2018	CEO, and possibly some consulting resources. Target to have the Plan done and approved at the Board meeting in November.	
2.C.	Advocacy may be part of the plan since Congress has considered legislation to create another category of licensed provider that would not include inpatient care but would help maintain ER, observation, robust outpatient and clinic services in rural areas. If a federal bill is passed there will likely need to be legislative and regulatory actions at the state level, presenting another opportunity for advocacy. The federal Center for Medicare and Medicaid Services is also considering regulatory changes that can impact HCHS, such as reducing the benefits of the 340B drug program. Being active in both the federal and state processes can help shape the programs to be most beneficial to HCHS and the people that live in rural areas like Alma and the surrounding areas. See recommendation #5.G. for more comments on advocacy.	On-going	CEO, Medical Staff, BOD	
2.D.	After the plan is approved, implementation should begin immediately. The plan should include actions steps with timelines, measurable outcomes and clearly assigned accountability. Best practice includes embedding written communication plans in the overall plan to help ensure that all stakeholders get timely information and participate in a robust feedback loop at key points along the way. It is expected that there will be adjustments to the plan along the way as obstacles arise or new opportunities emerge. The adopted decision making framework should facilitate the consideration of the possible adjustments: - in light of the guiding principles - considering the impact upon the identified issues and needs	On-going	CEO	

Ref. #	Description	Due Date	Leader, Progress and Comments	% Done
	- helping well informed and timely decisions to be made - and facilitate the needed ongoing communications with the various stakeholders in a clear manner that builds trust, minimizes confusion, enhances results, and keeps everyone moving in the same direction.			
2.E.	Annually, amend the plan as needed and perform a formal plan update	On-going	CEO, Board	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

Recommendation 3: Arrange for the needed primary care providers

Rationale: In Alma HCHS has acquired the Heartland Family Medicine Clinic building and in Oxford it rents the building and some related equipment from the Village of Oxford. HCHS operates rural health clinics in both locations with employed providers and clinic staff. Administration has already begun to evaluate the existing clinics, looking at the relevant information such as volume of services, provider productivity, financial performance and sustainability, the model for delivering primary care services, etc.

Using the current model, both clinics are generally open Monday thru Friday, but the Oxford clinic has very low patient volumes and is sometimes without a provider due to a provider illness, vacation, etc. There is the opportunity to consider other schedules to deliver primary care services in Oxford, or evaluate moving to or opening other clinic locations.

The planning effort in recommendation #2 is a good opportunity for an updated provider demand and supply analysis. It can then be refreshed over the years as needed, especially to reflect the then-current supply of providers, and used to maintain an effective provider retention and recruitment plan. It has been stated that HCHS is always recruiting providers, looking for those who will likely serve in the community for an extended period of time.

Some of the key criteria to use in making provider recruitment decisions include:
- the population base in the targeted service area and the number and type of providers it needs and will support
- the operating philosophy that the providers will use as they provide care (e.g. deciding upon the mix and roles of physicians, mid-level providers and support staff; the rural health clinic status and related requirements; the patient centered medical home model)
- how to best fulfill the mission of HCHS in providing the widest range of services to the most people in the service area in a way that delivers excellent quality of service and is economically sustainable over time
- is there an opportunity here to expand the scope of services offered and the size of the primary service area for HCHS?

Regarding the need for provider support for coverage and backup (e.g. in a disaster or during periods of vacation or continuing medical education, illness or provider vacancies), it appears that the RuralMed cooperative might be a regional structure that could

<table>
<tr><th>Ref. #</th><th>Description</th><th>Due Date</th><th>Leader, Progress and Comments</th><th>% Done</th></tr>
<tr><td colspan="5">allow primary care providers in the region to collaborate in forming a mutual support network. Perhaps this could be done throughout southcentral Nebraska for those providers who are willing to participate in a way that alleviates the negative backup and support aspects of being a rural primary care provider, making the practice opportunities more appealing to the practitioners who are considering them and also helping to retain the providers already in place.

Many area residents are interested in efforts to have an adequate supply of good primary care providers in the service area. The recruitment and retention efforts will be most successful if the plan is fully explained to the community and then the provider transitions are intentionally managed to make them as smooth as possible in the short term and help ensure success in the long term.

Transactions between providers and hospitals are subject to significant regulation under various federal and state laws. Thus, the HCHS administration and Board must be aware of relevant compliance issues, and follow competent compliance guidance, whenever such transactions are under consideration. Ideally, HCHS should have a written provider recruitment and retention plan that is formally approved by the Board of Trustees.

These recommendations are intended to help with the ongoing provider recruitment and retention efforts.</td></tr>
<tr><td>3.A.</td><td>Best practice is for a written physician/mid-level provider recruitment plan to be prepared by administration and approved by the Board. <u>Among other elements</u>, it should:
- document the need for the providers being recruited
- outline the types and parameters of recruiting activities at HCHS
- identify the practice models that HCHS will support
- support that all amounts paid to providers are fair market value transactions;
Your attorney can give specific guidance and assist in preparing the provider recruitment plan, as needed.
All contracts with physicians and mid-level providers should be reviewed and approved by the Board before they are entered into.</td><td>Jan 31 2019</td><td>CEO, and possibly some consulting resources.
Target to have the Plan done and approved at the Board meeting in February.</td><td></td></tr>
<tr><td>3.B.</td><td>Open communication between administration, all of the providers, and the Board will help everyone navigate these situations in the best possible manner. These</td><td>On-going</td><td>CEO, Board, Providers</td><td></td></tr>
</table>

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	communications should be ongoing throughout the recruiting process and the subsequent period of transition to a stable practice in the community.			
3.C.	Recruiting medical students and providers who have connections to the targeted rural area has proven to be worthwhile for other CAHs. As you identify those you want to recruit, keeping current providers and administration in close contact with them improves the likelihood that they will come to serve here.	On-going	CEO, Medical Staff	
3.D.	It has been proven that recruiting is most effective when it is done by someone who is local and who takes a very personal and passionate approach. Further, involve supporters from the community at key points in the recruiting cycle, not the least of which is raising some funds for such things as help with transitional housing needs, helping with student loan forgiveness plans, etc. The HCHS Foundation could step forward with some resources and volunteers to support provider recruitment and transition. Continue with these efforts and tailor them to fit the unique needs of each provider being recruited.	On-going	CEO, Foundation leader	
3.E.	Develop an adequately detailed plan to help arriving practitioners in their transition to establish a stable practice, including the EHR. The plan should also support them and their family with a successful assimilation into the community.	On-going	CEO, Providers, Board	
3.G.	Consider having regular informal time for CMC providers and HCHS leaders to visit. For example, one medical community has an informal lunch every Friday for the hospital senior leaders and all providers who care to attend; it has been going on for years and has been very valuable in getting to know one another, building trust, keeping communication channels open, and dealing with issues quickly. Would some variation of this be beneficial for the Alma medical community?	On-going	CEO, Providers	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
Recommendation 4: Continue to grow, expand, and better meet the needs of the people in the service area **Rationale:** HCHS has done a good job of attracting visiting specialists, especially cardiologists and orthopedists. There are still some additional or replacement service offerings that probably make sense. Study comprehensive and detailed inpatient and outpatient market share information, including both Nebraska and Kansas data, to look for opportunities to better fill service needs, attract additional patients who are currently leaving the area, and identify potential niche services. For example, work with larger hospitals in the region to find a role in the Medicare bundled payment arrangements, perhaps for primary care follow-up and physical therapy for patients from the HCHS service area, by becoming a part of the formal care plans for such patients and forming a truly integrated care network. Administration is already aware that before any service is added or expanded, these two questions should be addressed: 1. Can a high quality of service be provided? 2. Will it be economically sustainable over time? Of course, only proceed if both are answered "yes". The specific recommendations below add some details that should be helpful in developing and implementing a growth plan.				
4. A.	Use Nebraska and Kansas market share data to evaluate the potential for these new or expanded services *Services mentioned by one or more people in the interviews:* - add more surgical services with Dr. Todorov - build the patient visits to the primary care clinics, especially in Oxford; the new clinic building in Alma could bring more patients - attract more inpatient and swing bed patients - Add specialty outreach clinics for:	Initial by Feb 2019 and then On-going	CEO, Providers, Dept Heads & Board	

	- urology - ophthalmology - dermatology - oncology - neurology - obstetrician who will do prenatal and postnatal checks at HCHS (need might be partially filled by Dr. Peterson beginning in Oct 2018) - pediatrician - pulmonology - endocrinology - rheumatology - mental health evaluations and counseling - wound care (an APRN can bill for wound care services in nursing homes, too) - respiratory therapy - do more healthcare, wellness and prevention education in the community, including diabetes education - additional prevention and immunization services for adults - enhanced population health and case management services for patients with chronic conditions (patient centered medical home in clinics may help with this) - telehealth could be used more for specialists to do virtual clinics - consider other services, such as oncology, dermatology, speech pathology, mental health - urgent care services (maybe only during times of high activity at the lake) - fitness and wellness (maybe partner with others in the community) - cardiac and pulmonary rehab (could be possible with new clinic building) - expanded hours at Heartland Family Medicine Clinic (e.g. already open one night per week until 8p; consider starting at 7a one day per week; get retail pharmacy to coordinate with evening clinic hours) - partnering with other entities to serve the community (e.g. EMS, assisted living villa) *Other services that some CAHs are able to provide or are considering:* - insourcing PT/OT since the therapist shortage has apparently eased - geriatric specialty clinic - nephrology specialty clinic			

	- support groups (e.g. cancer, addictions to drugs, alcohol, pain meds, smoking, obesity) - ENT/allergist - internist/internal medicine A complete *market share analysis* and thorough *patient origin study* (inpatient and especially outpatient – by major service lines, by zip code) is very important information in the assessment of adding services, in the planning process, and for all participants to have so that decisions are not driven by anecdotes and emotional stories. Both Nebraska and Kansas information will be critical to get the true picture on market share and patient outmigration from the HCHS service area. Looking into some of these might lead to discussions on how to cooperate with other providers in the area or other towns to bring services to the area that would not be possible otherwise. There is a mixture of feelings regarding the RuralMed cooperative. Over time, gather information to assess whether the model being used with Dr. Peterson is a success story. HCHS will need to use some innovative ways to effectively attract patients to any new services. Barriers to growth were reported to be limitations on space (especially relating to rehabilitation services), facilities (not being able to meet the regulations to continue providing chemotherapy as of January 1, 2019), equipment (needing a new anesthesia machine if surgical services were to be expanded), (re)training staff to deliver new services, not having the financial resources to overcome these barriers, and the relatively small population base in the service area. Note: Best practice is to use interdisciplinary teams when evaluating and implementing new or expanded services so that all aspects of the organization are fully prepared to support the service right from the beginning. Include all the clinical and non-clinical areas that will be impacted by the new/expanded service and get them around the table so they can contribute. This will minimize start-up glitches, build trust internally and with the community, give high patient and provider satisfaction, and simply put smiles on lots of faces.			

4.B.	Many CAHs are now considering the value of their current affiliation status, and the larger healthcare systems are evaluating their scope and range of services, including their portfolio of owned and managed facilities, to help them fulfill their mission in providing the needed services in their area and from a financial performance perspective. The healthcare landscape is very dynamic now so administration should keep monitoring for developments that could make it desirable to look at some options that might not have been possible before. There could be the opportunity to participate in multiple ACOs. Similarly, watch how the Medicare bundled payment initiatives develop and be ready to respond to changes in the situation. As all of this transpires, opportunities for new care delivery partnerships could emerge. These could be with other CAHs, with larger hospitals or networks especially for bundled payment arrangements, with new ACOs, etc. For example, HCHS might partner with ACOs or larger hospitals in "care continuum" plans where the patients who receive related services at multiple locations have a single defined care plan that is implemented in a coordinated, consistent and continuous flow at each of the service sites. The care delivery partnership allows the single care plan to be developed and implemented, resulting in better care for the patient and lower costs for all of the providers.	On-going	CEO, Board	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

Recommendation 5: Complete the building blocks for a high level of organizational performance:

- ***Continue to strengthen the Quality of care and customer service; adopt a defined CQI process***
- ***Bring the Meditech IT system and related processes to maturity***
- ***Re-establish a standing Revenue Cycle Steering Committee to improve revenue cycle performance***
- ***Build the Directors into a high performing team***
- ***Expand and implement a marketing, community relations and business development plan***
- ***Enhance the financial management functions and financial performance***
- ***Help the Board of Trustees transition to be effective for these times***

Rationale: Quality of care and customer service; CQI process: Although the definition of "quality" in healthcare is still a work in progress, there are now accepted definitions and measurements. Quality measures include specific patient care indicators, and the satisfaction of four key groups: patients, providers, the general public, and employees. Best practice is for the satisfaction levels of each group to be surveyed periodically and reported as historical trends, and in comparison to peer groups when possible, as this is valuable information to help determine what is going well and where some changes are needed. This is often baseline information that is used in planning. While the small number of providers and employees makes that information less valuable than in larger organizations, there is still value in the periodic surveys. However, if the surveys are not conducted, then administration should have some other valid way(s) of getting honest and direct feedback.

It is commendable that information on the typical patient care quality and satisfaction indicators has been routinely collected by HCHS. Some other typical information (such as periodic satisfaction surveys of primary and specialty providers, the consumer or community in general, and employees) has not been collected recently. HCHS should consider conducting provider satisfaction surveys of primary and specialty providers, then sharing the results internally. Continue reporting the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data to the Center for Medicare and Medicaid Services. Communicating the results and trends internally and with the community can help identify specifically where improvements should be made and show the results of the efforts to do better. Over time this should become an important part of how HCHS connects with the community.

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

A good practice is to establish a Patient Satisfaction Committee (with a written charter) to improve on selected measures. Some CAHs set up sub-committees to accomplish targeted improvements. The existing Service Excellence Council is made up of employees from across HCHS and is reported to be active, so it may be addressing patient satisfaction as one of its duties.

Adopting a standard change management process is a best practice to improve the speed at which HCHS can accomplish continuous quality improvement projects. The PDSA and RIPS processes are commonly adopted by CAHs and there is training available to develop skill in using the processes. Whatever process is adopted, it should be used routinely so everyone gets to know the process and develops expertise in using the various tools in connection their clinical and non-clinical quality improvement projects.* This can help greatly with improving customer service to both external parties and internal customers, since improving customer service is only accomplished through intentionally bringing changes to processes, attitudes and behaviors.

Bring the Meditech IT system and related processes to maturity: The Meditech electronic health record and IT system went live for the hospital and rural health clinics in Alma and Oxford on July 1, 2018. As is typical, the system needs to be fine-tuned, some processes need to be revised and documented, and some people need additional training. While some of this has been done, there is reportedly more to do. It is important to keep pushing to optimize the system operations and the related processes to get the most efficient use of the system and to minimize labor costs associated with using the system.

Improve the revenue cycle: Having a standing Revenue Cycle Steering Committee (RCSC) is a best practice that has helped many hospitals clean up bottlenecks throughout their revenue cycles, get resources allocated where needed, properly balance priorities by all involved with the revenue cycle, improve compliance with issues in the CDM, ensure that adequate leadership is in place, help people get whatever additional training might be needed, and generally support higher levels of customer service. It was noted that the CFO who was here for only a couple of months established a RCSC, but that it has gone dormant during the Meditech installation. This should be a high priority now to help the revenue cycle to mature using Meditech.

High performing teams: It is typical for hospitals to have a team approach to leadership, with the CEO being the head of the management team. The Department Directors are an important team within HCHS. It needs to intentionally strive to perform at a high level and set an excellent example for other teams, committees and project-oriented work groups. Continuous quality improvement and various performance improvement activities are almost always carried out by teams and involves changing things, so having a

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

common approach throughout HCHS for change management is an ingredient in having high performing teams. Without a common approach, each new team has to spend time and effort to figure out what process they will use. Additionally, there are many good resources to use in ensuring that all meetings are highly productive and worthwhile. HCHS should adopt some standards regarding how to have highly productive meetings and how to lead high performing teams. Consider requiring that the leader of every meeting use these tools to plan and conduct the meeting, and that the meeting participants would also use the selected tools to do their part in preparation, participation and follow-up. The meeting productivity tools should be used right along with the CQI change management processes as recommended above.

Marketing, community relations and business development: The proper place for marketing in the rural CAH service area is a topic of much discussion and many opinions. On the one hand, there is much market share leakage and it is common to hear potential patients say something like: "I didn't know I could have that done here!" On the other hand, it is difficult to target a relatively small and sparsely populated service area with relatively expensive broadcast media such as TV, radio, and the daily newspapers that are most widely read; even the local weekly newspapers typically miss a significant slice of the population. There is certainly the need for some level of marketing and business development to inform potential patients of what can be done here (especially when there is a new or expanded service) and to routinely get feedback from people in the service area. Community relations activities are vital to keep the CAH in touch with the needs and expectations of the people it serves. Events such as an annual open house and other special events that effectively mix HCHS with the community are good things, too. Perhaps taking a business development approach is more appropriate and value-added than a traditional marketing approach. See #5.E. below for some specific recommendations regarding marketing, community relations and business development.

Enhance the financial management functions and financial performance: As noted in #1 above, revenues have been increasing in recent years but the expenses have been increasing faster, resulting in net losses of $267,000 in 2016, $372,000 in 2017, and on pace for a larger loss in 2018. The cash flow from operations has been positive despite the losses, but continuing losses mean the organization is being consumed and there won't be enough cash set aside for equipment and building upgrades when they are needed. The cash on hand has significantly diminished over the last three years as a large investment has been made in the Meditech EHR and accounts payable have been brought very current in connection with the system conversion. Most hospitals experience sizeable increases in accounts receivable related to system conversions, but that hasn't been the case at HCHS which is a big positive.

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

The retirement of the CFO in late 2017 adds concern for the financial functions and the overall financial performance. Solid interim CFOs certainly are a big help in dealing with the process changes from the IT system conversion and the overall financial challenges. Getting a new CFO in place is a high priority for Administration, and rightly so. The healthcare industry is very dynamic and it will be a challenge to build financial strength in this environment, but it can, and must, be done.

Various measures should be monitored periodically to assess the direction HCHS is headed. In addition to tracking the activity levels for each of the services provided, six of the most important financial measures are the operating margin, total margin, days of revenue in patient accounts receivable, days of cash on hand, debt service coverage ratio and long-term debt to capitalization. Taken together, these measures are some of the most all-encompassing measures of the full scope of operational financial performance and financial position. The financial auditing firm should provide a five year history of important measures to the Board of Trustees and management, including these six key measures with comparisons to their CAH peer group and other helpful information.

Board of Trustees performing at a high level: The waves of change that are crashing through the healthcare industry, along with the complete change of senior leadership at HCHS within the last two years, have thrown the Board into a time of significant transition. These times require that the Board perform at a high level to help HCHS fulfill its mission and continue to be a great asset to Alma and the surrounding area. Keeping educated on the changes that continue in healthcare will not only equip the Board to make crucial decisions, but will also position the members to be effective advocates for rural healthcare in general and specifically for the survival of critical access hospitals, on both a state and federal level. To its credit, the Board has been addressing the various challenges and keeping educated on healthcare industry developments. There are specific recommendations to help it continue its journey to become the Board that HCHS needs to meet the challenges is faces at this time (see #5.G. below).

These recommendations can be a significant boost in moving HCHS towards a higher level of performance in fulfilling its mission.

**Luke and Associates, Inc. has developed a proven, effective and flexible decision making framework that can be provided as part of this Project. It works very well when used in conjunction with any of the change management processes; they are complementary, not mutually exclusive.*

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
5.A.	Quality measures; CQI processes - Patient satisfaction surveys should continue to be done. Employee satisfaction surveys (sometimes referred to as employee engagement surveys) are also recommended. The survey results should be widely shared internally, with the Board, and with the providers. Action plans should be developed after each survey with the goal of improving the performance in targeted areas, as measured by better scores on the subsequent survey. The Service Excellence Council could be a key to developing and achieving the action plans. The satisfaction of the providers (primary care and specialists) should be monitored, which can be done with a survey every year to start with. After baselines and historical trends are established, if scores are high and few issues that need attention are identified, the frequency could be dialed back to bi-annual. The results of these surveys should be widely communicated within HCHS to everyone who can help where applicable, action plans for improvement should be implemented, and then successes can be celebrated. If surveys are not done, other methods should be used to monitor provider satisfaction and to initiate changes when needed. A consumer/community survey is often included with the periodic community health needs assessments (CHNA), done at least every three years. Since HCHS is not required to do a CHNA, perhaps HCHS can participate in, or initiate, another community-wide planning or assessment activity to get this valuable information and remain responsive to the community needs. There will likely need to be cooperation and coordination with other organizations and agencies in the area to accomplish the desired goals as defined by the action plans. Adopt a defined change management process such as PDSA/RIP or LEAN for use in continuous quality improvement efforts all across HCHS. As everyone becomes familiar with the process and tools, improvement projects will move more efficiently and reach their objectives more quickly. Of course, there will need to be ongoing training for people coming into HCHS and/or who are new to the process.	On-going	CEO	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
5.B.	Meditech IT system and related processes – In the short term, continue to refine Meditech and the various process changes to best meet the needs of the users and develop the needed documentation in policies and procedures. Longer term, set up training expectations and opportunities for employees and providers who are new or who change job duties.	Begin by Dec 31, 2018 & on-going	CEO, Dept. Heads and IT resources	
5.C.	Revenue cycle steering committee – A standing RCSC is a best practice to deal with the many processes that need to be functioning well to result in a high performing revenue cycle, have top notch results in collecting accounts receivable, all while maintaining a high level of customer satisfaction. A written charter and senior leadership support for the RCSC will help in keeping the RCSC on track as it goes about setting the priorities, developing specific action plans to make the needed changes, and then monitoring that the implemented changes are made and the issues are effectively resolved. The selected change management process should be used consistently in this work.	On-going	CEO, CFO	
5.D	High performing teams - The teams in HCHS need to perform at a high level, including the Department Directors and special project teams. Be aware of the typical team development stages of: - 1. *forming* (adopts its charter/mission, agrees upon ground rules, and decides details regarding how the team will operate; first meeting) - 2. *storming* (everyone figuring out their role on the team and working out the interpersonal dynamics; often takes several meetings) - 3. *norming* (settling into a pattern that all team members can accept; takes several meetings) - 4. *performing* (now it can effectively carry out its charter; ongoing) Generally, these stages are experienced while the team is doing its work, although stage one requires preparation and intentionality by the leader. Stages 2 and 3 are mentioned here so that the team members are not surprised by them and do not	On-going	CEO	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	become discouraged as they work through them. Remember that *whenever a new person joins the team*, and *especially when the team gets a new leader*, the team will cycle through these steps again, at least to some degree. Continue to build on the recent webinar and other training for managers in how to have effective meetings and develop high performing teams. *Note: The book "Death by Meeting" by Patrick Lencione is an excellent resource to use in developing teams.*			
5.E.	Marketing: The key to marketing, community relations and business development is to find ways to connect with potential patients in ways that build relationships, add value through two-way communication, and increase the utilization of needed healthcare services provided by HCHS, all at a cost-benefit ratio that is sustainable. Quite a few people mentioned that they thought more should be done. Here are some ideas to consider for improving marketing and business development (M/BD) efforts: - *Marketing/Community Relations/Business Development committee* – An internal M/CR/BD committee can be established to give input and guidance to those overall efforts. This is a great way to engage the imagination and creative talents of the committee members. Supporting it with a written charter and operating framework, along with a budget, has proven to be very effective. The committee should meet regularly and develop a written M/BD plan and get the needed approvals prior to rolling it out. The committee will be effective if it uses written guiding principles to address stated issues and needs that are updated at least annually and regularly communicated to internal and external interested parties. Getting wide-spread approval and buy-in for these guiding principles and how to address the identified needs will go a long ways towards having an effective M/BD effort that is widely supported. The decision making framework previously mentioned has proven to be an effective tool for M/BD committees in other hospitals.	Start by Mar 31, 2019, On-going	CEO, Marketing Coordinator and Marketing Committee	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	- *Community ambassadors* – Evaluate whether a formal group of ambassadors to the community would be worthwhile. The idea is to extend beyond marketing and involve some community leaders, former patients, volunteers, etc. in providing additional input to HCHS from the people it serves, while also expecting that these people will function as ambassadors in the community. - *Website and social media* – The HCHS website has a lot of information and appears to be interactive in various ways. The challenge is to keep the website information current and relevant, so consider making some content rotate monthly so that there is routinely new and interesting information being presented in addition to the monthly schedule of specialty clinics. Keeping the website information updated as changes occur is also important so that it is a reliable source of information; a good process should be in place for timely updates. There is already some use of social media (Facebook, Twitter, Instagram, Snapchat, blogs, texting, etc.) to establish communication bridges to the people of the area, especially the younger and more tech-savvy population segment. Some hospitals periodically post video or written items to their blogs to help inform employees and the public of important information. This could be a good way to build up the providers by highlighting awards or certifications they have and promoting areas of special interest and expertise. Using the patient portal to engage the providers could also be promoted in this way. - *Screening and prevention services* – Like many hospitals, HCHS has used health fairs, flu shot clinics, and other disease screening and preventative services to provide needed services in the area, and to connect with area citizens in a positive and helpful way. Often these are provided in cooperation with other organizations such as the public health department, senior centers, school districts, etc. HCHS already does some of this type of activity, and the providers and other employees will have specific ideas, as will the other potential partners, if there are some unmet			

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	needs. - *Community health forums* – Conducting periodic town hall health forums in the various communities located in the service area can be an important way to connect with your existing and potential patients and find out how HCHS can stay responsive to their healthcare needs. Some CAHs have found that this Project report is an excellent catalyst to begin an ongoing series of successful community forums. - *Special events that engage the community* – Build on existing annual traditions of special events where there is a high degree of interaction between HCHS and the community in general. Continue the Auxiliary annual meal and folks with good imaginations can come up with other ideas that will be a good fit for this area, whether it be to start a new event or partner to expand existing events. - *Participation in community organizations* – Because the local CAH is one of the major employers and economic engines in the area, the CEO and other hospital managers are often Board members and are otherwise active in the economic development and civic organizations, and in some communities the hospital CEO or some other representative is an ex-officio member of these Boards. The HCHS CEO and other staff have been active in the community Chambers of Commerce, Economic Development Board, and other civic organizations, which is good. Other ideas include: -Have a responsive and prepared speaker's bureau available for community organizations that are looking for a program or for information about a health-related topic. -Efforts to be closely engaged with the schools are good, and partnerships on injury prevention for athletes, health education and vocational career programs have been successful; can more activities be developed? -Some CAHs have developed a mascot that attracts children and can be used in teaching about health topics, as well as appearing in local parades, the County fair, at health fairs, in school health classes, etc.			

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
5.F.	Finance – Continue with efforts to improve the financial management and performance across the organization: - periodically monitor key financial performance metrics and develop related plans and recommendations to improve the financial strength of HCHS - timely responsibility reports to department directors and managers - monitoring new government regulations and payer policy changes for compliance and obtaining full and proper payments - improve budgets – operating, capital and cash flow - consult with independent auditors and other finance experts, as needed - continue to look for ways to lower expenses	On-going	CFO	
5.G.	Board of Trustees – The Board is a team and needs to perform at a high level, and work to assimilate new members as they are appointed by the County Supervisors. The Board might be able to perform at a higher level by consistently using the tools and techniques to have excellent meetings. Specific recommendations for the Board of Trustees are: - consider organizing committees of the Board with written charters regarding responsibilities, authority, membership, and expectations; typical Board committees are: Executive, Quality/Credentialing, Physician Transaction Review, Finance, Nominating, Compensation, and other standing or special purpose committees as needed (Note: all Board committees should be chaired by a Board member, but some committee members may not be Board members); some of these functions could be combined so perhaps only three or four committees would be formed - all Board members should read the monthly *Trustee* magazine (print or electronic) and other periodic updates from the AHA - rotate the Board officer positions periodically among those members who are skilled and willing to serve - Administration should keep the Board orientation manuals up to date so they will be a current source book for foundational documents and information on how to be	Oct 31 2018 and On-going	Board, CEO	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	excellent members of a strong and effective Board - regarding efforts to cooperate with other CAHs and providers in the region, the Board members might need to be personally involved to help engage others in their community and/or to make the needed connections to leaders in other communities - the Board should continuously strive to apply best practices in Boardsmanship (see suggestion below); this is especially important in small communities where there are often overlapping business, family and personal relationships that complicate matters for the Board; ensure there is a solid written Board policy regarding potential conflicts of interest and that it is followed when appropriate - education and advocacy are likely to be great opportunities for Board members as hospital Trustees are in a unique and powerful position to make a difference when they participate in the legislative and regulatory processes, especially when well coordinated with providers and administration. They can plug into education and advocacy opportunities provided through many organizations such as the Nebraska Rural Health Association or the Nebraska and American Hospital Associations. *Suggestion:* *- There are many free Boardsmanship resources available on the internet for not-for-profit boards (e.g. go to BoardSource.org or search for "Boardsmanship"), and membership resources are available from the Nebraska Hospital Association (NHA), The Governance Institute, etc. Note that the NHA has a Board certification program and HCHS has all of their Board members certified.*			

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*

Recommendation 6: Continue to cultivate a healthy culture, specifically:
~ Use the core values as standards of behavior to actively shape the culture
~ Unleash the best employees; deal directly with poor performing employees (attitude or skills)
~ Build the skills for positive and effective confrontation
~ Focus on communication channels and effectiveness

Rationale: Having a healthy culture is important to the leadership of HCHS. Clearly and consistently using the adopted behavior standards to guide behaviors is probably the most impactful next step that leadership can take to cultivate a more healthy culture. The change in senior leadership gives an excellent opportunity to reinforce them throughout HCHS.

A good working definition of "culture" is: *"How we do things around here."* It includes how we treat each other, our patients and visitors, and the general public, but is also much larger than that. Culture isn't defined by what we wanted to do or said we did. No, culture is defined by what we actually do. Culture is shaped by the behavior standards that are actually practiced, even if they are different from the behavior standards that have been officially adopted.

Every organization has a culture, just as every person has a personality; the key questions are: (1) does leadership have an adequate and accurate awareness of the culture it is creating, and (2) is leadership being intentional in fostering a very healthy culture?

There are two general rules regarding culture development:
1. Culture is being shaped and exhibited all day, every day, by everyone, and
2. Leadership can only shape the culture when something else is going on.

In other words, leadership must always have its "cultural IQ" up and running because everything that is done shapes the culture. Also, leadership can't work on culture for an hour and then move on to other tasks; the outcome of this approach is that the leaders first damage the potential health of the culture and then they abdicate their responsibility for the culture as they allow the culture to be shaped by others. Rather, leadership must be constantly aware that everything they do has an impact on the culture.

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<tr><th>Ref. #</th><th>Description</th><th>Due Date</th><th>Leader, Progress and Comments</th><th>% Done</th></tr>
<tr><td colspan="5">From the on-site interviews note that, on average, all four groups were in agreement in rating “the health of the culture now” better than compared to the culture a year ago, although not all individuals rated it that way. (See Appendix A for the tables and charts that show the average ratings by topic and by group). Having made the CEO transition was the most common reason mentioned for the higher ratings now, and the culture ratings now still have plenty of room for improvement. Many people stated that the employees were one of the best things about HCHS, or one of its most important strengths. Generally, it was noted that most employees get along well, help each other, are focused on taking care of their patients, work as a team, do their jobs, are committed to the patients, and are caring. There seems to be general agreement that the management group is a good mix of age and experience on one hand and youth and energy on the other hand, and that they are mostly accessible, responsive, and looking to the future. Comments also indicate that there are still a few people where more progress is needed to root out some persistent negative attitudes or poor performance.

One of the most effective methods to deal with some persistent negative attitudes and areas where customer service needs to be improved is to actively use the formally adopted behavior standards to identifying acceptable and unacceptable behaviors. Applying the core values as behavioral standards daily in a clear and consistent manner is a powerful way to hold all HCHS management and staff to the same high standards, and empowering all staff to call out those who are falling short, but doing so in a respectful way. The behavior standards have been hardwired into annual performance appraisals, which is a best practice. However, take corrective action whenever behaviors violate the standards; don’t wait for the annual performance review.

The following recommendations are intended to help bring the culture up to the next level and help HCHS become even more attractive to patients, employees, providers and the community in general.</td></tr>
<tr><td>6.A.</td><td>HCHS has adopted Behavior Standards based on the core values, which should now be re-affirmed with appropriate communications and an adequate phase-in period for holding employees accountable.

Requiring personal accountability across the organization will go a long ways towards having a healthy culture. The management team seems to do well in holding themselves and employees accountable for technical skills, while some people noted that there are still some negative attitudes that have not been addressed. This requires making sure the expectation of adhering to the behavior</td><td>On-going</td><td>CEO, Department Heads & Managers</td><td></td></tr>
</table>

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	standards are clearly understood, and that there will be consequences for failure to perform up to those standards. It will also require consistency in applying the consequences for underperformance. Of course, a just process will take into consideration the infrequent extenuating circumstances. Accountability, or the lack of it, is the single biggest signal as to who is really in charge; a high level of fair and consistent accountability signals that the leaders and high performers are in charge, while a low level of accountability (or inconsistent accountability) signals that the low performers are really running the place. Setting annual performance goals for every employee as part of the performance review process is a best practice. It is essential in establishing accountability and hardwires the organization's planned goals into the daily activities of each employee. Some hospitals use a tool known as a "behavior contract" in a proactive approach to minimize performance problems, and it is very effective in dealing with the more difficult accountability situations. The behavior contract will document the agreement on the expectations for both parties and can set out the range of consequences for noncompliance. It can also underscore that each person must perform acceptably in attitudes and behaviors to continue in their employment, not just perform well in the area of technical skills. This consultant has observed that the labor pool is both wider and deeper for CAHs that have healthy cultures which root out those who have either unacceptable attitudes/behaviors or skills. Those CAHs who have a reputation of tolerating bad behaviors and attitudes tend to be avoided by the best performers in the labor pool, making the overall pool smaller, shallower and lower quality to those CAHs.			
6.B.	To some extent, the high performing employees are already unleashed. As a higher level of accountability improves the health of the culture, the high performers will	On-going	CEO	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	fly even higher. This is because they will no longer have to cover for the underperformers, who are a huge drain on their motivation, performance and job satisfaction. Perhaps most importantly, as the *low* performers are either moved up to adequate performance levels, are moved into a suitable position where they can meet expectations, or moved out of the organization, the *average* performers will almost universally raise their performance levels.			
6. C.	Accountability requires confrontations. There might be a need for skill building so that the confrontations are positive, to the greatest extent possible. Dealing directly with those individuals who exhibit unacceptable behaviors is the most effective way to help them improve, and is much preferred over using a group approach when most of the group members do not need to make a course correction. There are numerous resources to draw upon to help leaders in holding crucial conversations* and having successful outcomes to critical confrontations*. Avoiding these confrontations should not be an acceptable option, especially after the expectation is established that there will be consequences for underperformance and inappropriate behavior. **Books by these titles (written by Joseph Grenny et. al.) are excellent resources.*	Jan 31 2019 and On-going	CEO	
6.D.	Comments made to the consultant give insight in where leadership can focus to continue improving, and where there are some strong points to build upon: - the Service Excellence Council can be helpful in taking the culture to a higher level (e.g. by leading meetings where the behavior standards are re-presented for understanding and use by all HCHS leaders and employees, with ongoing sessions periodically for new employees) - most employees work hard while a few are not busy - change - required so we can grow; people will either embrace it or run from it	Begin by Nov 2018 / progress by Jan 31, 2019 / On-	CEO	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	- communicate – people make up things to fill in the blanks - staff treats patients well, but we don't always treat each other well - employees generally work together as a team for the benefit of the patient - deal with the grumpy nurses; too much negativity; they run off new nurses - negative attitudes – they know it, talk about it, so why doesn't it change - they do want accountability and need it to be consistent - educate employees on what they need to do, and why - HCHS supports employees in moving to the next level in their career or even in making career changes Leadership can use these comments as beginning points and move on as needed	going		
6.E.	Communication patterns and channels are already being improved, although the comments indicate that communications still need to be improved even more. The burden of timely communication rests with both the information sender and the information receiver; management has started to establish official channels that are as effective as reasonably possible, and the receivers have no basis to complain if they don't tune in to get the latest. Administratively, develop ways to use and reinforce the official communication channels while making the unofficial "grape vine" largely old news and irrelevant. To the greatest extent possible, employees should always have the news through official channels before it gets into the community or into the internal grape vine. Give frequent progress reports, even if there are no final decisions yet. A master calendar can be another way to help with communications. It gives a central place to post upcoming activities that will involve all or most of the organization, allows staff to check there when scheduling things to avoid frustrating "calendar collisions" and becomes an important place where everyone can find out what events are coming up.	On-going	CEO and Dept Managers	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
Recommendation 7: Planning and financing major capital needs: ***~ Prepare a master plan for facility and equipment*** ***~ Generally avoid equipment leases*** **Rationale:** The hospital was renovated and expanded in 2007-2009, so there are some things that are reaching the end of their expected useful life. In regard to the other facilities, construction has just begun on a new clinic building in Alma and the building and equipment in Oxford is older but owned by the Village of Oxford. Efforts have been made to keep up with equipment needs, but there will always be items to replace and update along with keeping up with the need for new technologies, procedures and services. Equipment to support more surgeries and procedures was mentioned. All the identified capital items in the master facility plan should also be in the multi-year year capital budget, including major facility infrastructure needs. On average, the facility and equipment received relatively high ratings by the community and relatively low ratings by the providers (see Appendix A). This indicates that significant needs are not anticipated by people in the community. One benefit of a comprehensive master facility plan is that it will allow management to educate the Board and the community regarding the facility and equipment needs in a way that will be understood in the context of community need and comparability with surrounding hospitals. It also avoids the problem of coming back to the community every year or so with the surprise of yet another major need. Some items of equipment have been leased. While there are certain situations where a lease is appropriate, leasing is usually more expensive than using internally generated funds, targeted fund raising and grants, or borrowing in the form of tax-exempt (County) debt.				
7.A.	Complete a comprehensive master facility planning effort to cover all aspects of the facilities and equipment. Ideally an updated master facility plan is an input to the annual planning process, has goals and activities from the plans, and links directly to the capital and operating budgets. It can also support efforts to raise funds to be	Dec 31 2018 & On-going	CEO, Board	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	available when needed for selected capital budget items, as is being done for the new clinic building in Alma.			
7. B.	A combination of funds generated by the hospital from operations, fund raising and grants should be the first sources for needed plant and equipment. Periodic bundling of projects for tax-exempt (County) borrowing is also appropriate and can be very cost effective compared to leases. Leases should typically be the last resort (although there are some situations where leasing does make good sense).	On-going	CEO, CFO & Board	

<table>
<tr><th>Ref. #</th><th>Description</th><th>Due Date</th><th>Leader, Progress and Comments</th><th>% Done</th></tr>
<tr><td colspan="5">Recommendation 8: Consider developing an active volunteer program
Develop additional fundraising and continue to build the HCHS Foundation

<u>Rationale:</u> <u>Volunteer program:</u> Many CAHs have volunteer programs that provide great benefits to the patients, the employees, the volunteers and the community in general. The hospital has an established volunteer group through the Auxiliary and several individuals so there is a base to build upon. There are many more ways that volunteers can contribute to your efforts, and such programs can strengthen the bond between HCHS and the people it serves. Many people indicated that there are folks who will volunteer if given the chance to plug into a well-organized program that offers meaningful work and makes them feel valuable and appreciated.

<u>HCHS Foundation and additional fundraising:</u> The Foundation is in the process of being rebuilt. A strong and active core of Board members for the Foundation can be another excellent link between HCHS and the communities it serves, and efforts are underway to fill the open Board seats. There have been significant donations to get the new clinic started and now the remaining funds will need to be raised to complete the new building. It appears that more funds can be raised for the hospital over time, especially working off of the new master plan for facilities and equipment and the annual capital budget.

HCHS has received some significant grant funds over the years. Additional grant writing can be done either through the Foundation or through HCHS directly, and some sources of funds prefer to work with a Foundation.</td></tr>
<tr><td>8. A.</td><td>Evaluate the potential for having a more active volunteer program. If it is found to be feasible, proceed to plan and implement the program.
Just a few of the many possible areas for volunteers to help could be:
- gardening and outdoor campus work-surely there are master gardeners in the area
- filing or scanning invoices in finance
- scanning documents into the computer systems
- receptionist/greeter on specialty clinic days
- general maintenance work (e.g. painting, carpentry, changing light bulbs)</td><td>May 31 2019</td><td>CEO & Dept Heads</td><td></td></tr>
</table>

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
	- expand the auxiliary to raise more funds and provide supporting resources The key is to find folks with an inclination to do something that you need to have done and then see if a way can be made for their resources to be used to benefit HCHS and the people it serves. Consider including the youth in the area to draw them into community service (the schools may have community service requirements for the students) and to give them some exposure to healthcare as they think about their career choices. All volunteers will need to feel that they are making a positive difference and that their efforts are meaningful and appreciated. Other CAHs have been able to find acceptable ways to manage the risks associated with a robust volunteer program, and have enjoyed considerable benefits from the programs, both financially and in improved community relations.			
8.B.	Re-energize the Foundation and work closely with that group to develop a targeted fundraising plan using the new facility and equipment master plan (see recommendation #7) and capital budget. Set specific goals for each year and publicize the needs, with #1 being the new clinic building. Use grant writing resources as applicable. Publicly and routinely, celebrate fundraising successes and praise the Foundation for their important efforts in support of HCHS. Perhaps a gift-giving legacy in the area could be established by the Foundation initiating a donor estate planning program* that is very supportive of the attorneys, accountants and financial planners in the area. **Thompson & Associates has such a program used by some medical foundations.*	Dec 31 2018 and on-going	CEO and leaders of the Foundation	

Ref. #	Description	Due Date	*Leader, Progress and Comments*	*% Done*
Periodic reporting to DHHS regarding actual activity and impact, and assessing the value of the Project. Periodic progress reports need to be submitted to Nancy Jo Hansen at DHHS on the following schedule. *The reports should be made using the two right-hand columns provided above in this document to identify the person responsible to implement the recommendation, document progress and make relevant comments, along with indicating the estimated percentage of completion for each recommendation as of the reporting date.* As the impact of the recommendations becomes apparent, evidence of the impact should be included in the progress reports, even if the impact is zero or negative. Supplemental materials can also be submitted to help document and measure the impact.				
Progress reporting schedule: Report 1 – 4 months after the recommendations are final Report 2 – 4 months after Report 1 (8 months into the Project) Report 3 – 4 months after Report 2 (12 months into the Project) Report 4 – 6 months after Report 3 (18 months into the Project) Report 5 – 6 months after Report 4 (24 months into the Project)		Dec 31 2018 Apr 30 2019 Aug 31 2019 Feb 29 2020 Aug 31 2020	CEO	
	Final Project assessment	Dec 31 2020	CEO	
	Determination regarding publishing outcomes from the Project.	Jan 31 2021		

Appendix A

Summary of quantifiable responses to the confidential standardized interviews

HCHS Performance Improvement Recommendations

Results of Rating Questions, August 2018

People were asked to rate HCHS on 8 characteristics.
Purpose: Give quantifiable information on key characteristics to help in assessing HCHS and developing recommendations for performance improvement.

The ratings were tabulated and the averages are presented in the table below for each of the eight characteristics. The results are also shown in the charts on the following pages.

The rankings were given during a confidential, 1:1 , face-to-face (in most cases) meeting with Bill Luke done August 13-17, 2018.

Rate how HCHS is doing for each area:

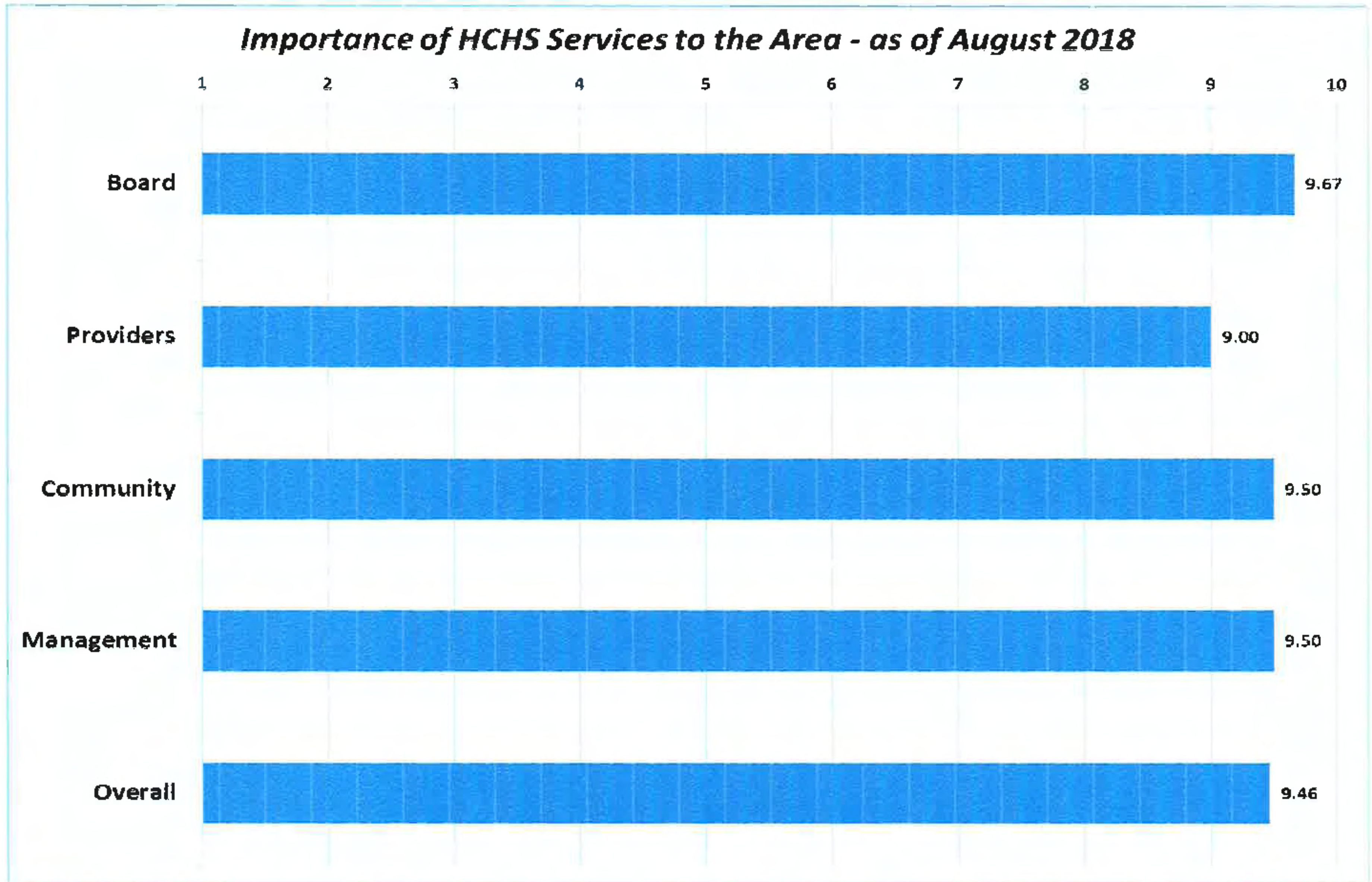
a. Importance of services
b. Quality of services
c. Scope of services
d. Facilities & equipment
e. Confidence in leadership
f. Confidence in providers
g. Confidence in caregivers/employees
h-1. Health of culture-now
h-2. Health of culture-year ago

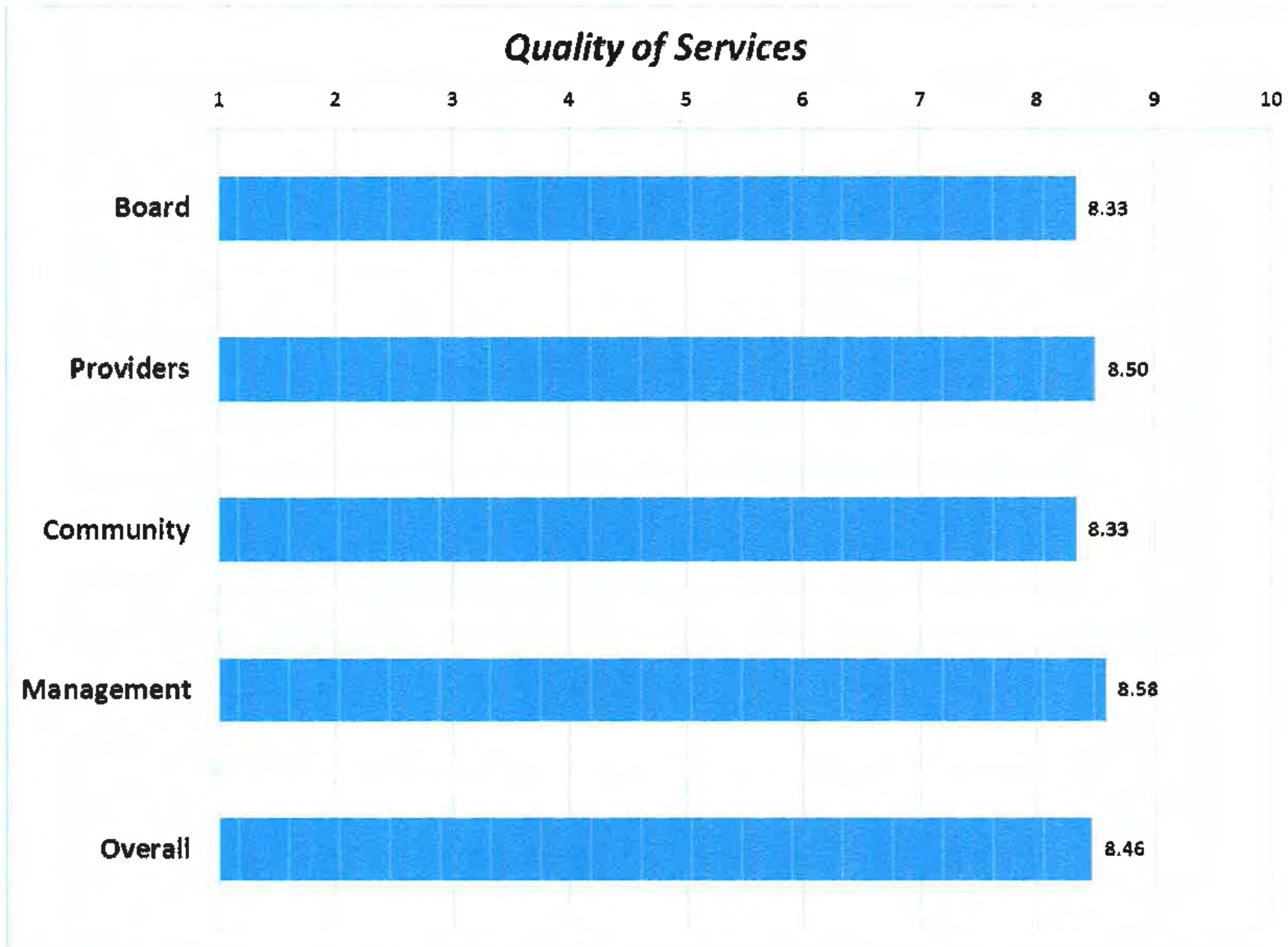
Scale of 1 to 10
1 = low; 10 = high

# of Respondents (n):	
Board	6
Providers	4
Community	6
Management	12
Total	28

Average	*Board*	*Providers*	*Community*	*Management*	Overall
Importance	9.67	9.00	9.50	9.50	9.46
	Board	*Providers*	*Community*	*Management*	Overall
Quality of Services	8.33	8.50	8.33	8.58	8.46
	Board	*Providers*	*Community*	*Management*	Overall
Scope of Services	7.00	7.50	7.17	7.08	7.14
	Board	*Providers*	*Community*	*Management*	Overall
Facilities and Equipment	8.00	7.25	8.83	8.08	8.11
	Board	*Providers*	*Community*	*Management*	Overall
Confidence in Leadership	8.83	7.25	8.50	8.33	8.32
	Board	*Providers*	*Community*	*Management*	Overall
Confidence in Providers	8.17	8.25	8.17	7.91	8.07
	Board	*Providers*	*Community*	*Management*	Overall
Confidence in Employees	8.33	8.00	8.67	8.58	8.46
Health of Culture	*Board*	*Providers*	*Community*	*Management*	Overall
Culture-Now	7.67	7.50	8.33	7.10	7.58
Culture-Year Ago	6.50	5.50	7.17	6.50	6.50

These average ratings are presented in the charts on the following pages.


Importance of HCHS Services to the Area - as of August 2018
1
2
3
4
5
6
7
8
9
10
Board
9.67
Providers
9.00
Community
9.50
Management
9.50
Overall
9.46


Quality of Services
1
2
3
4
5
6
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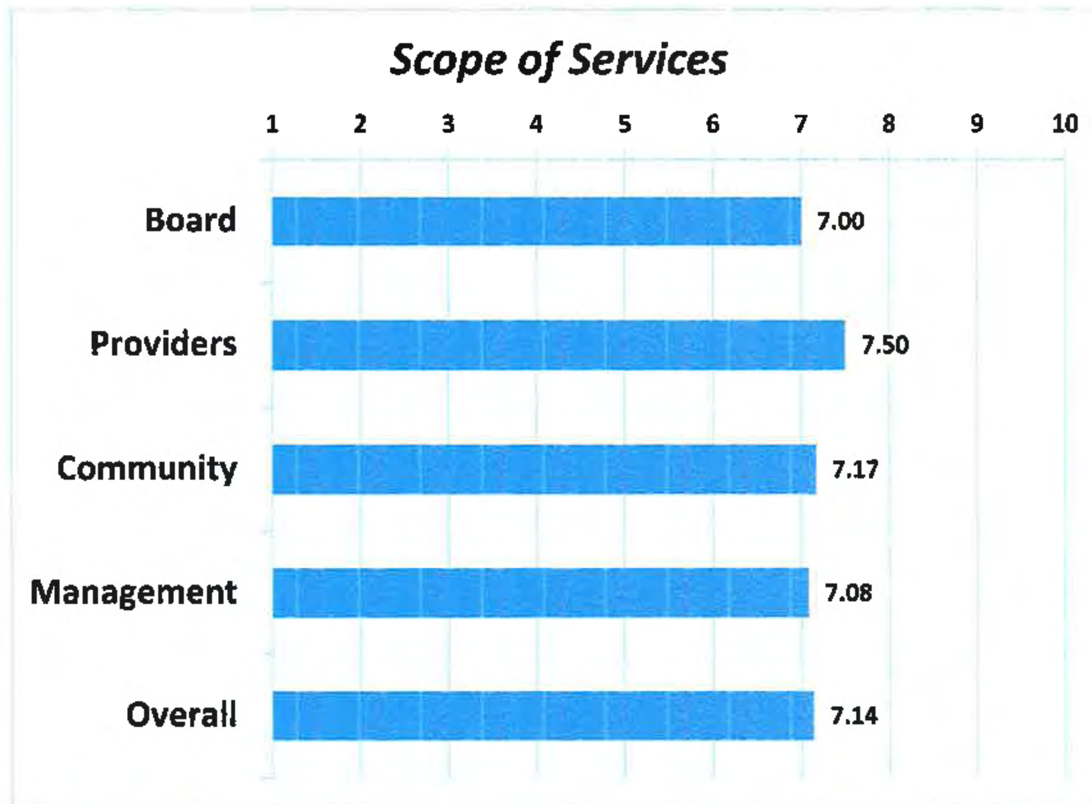
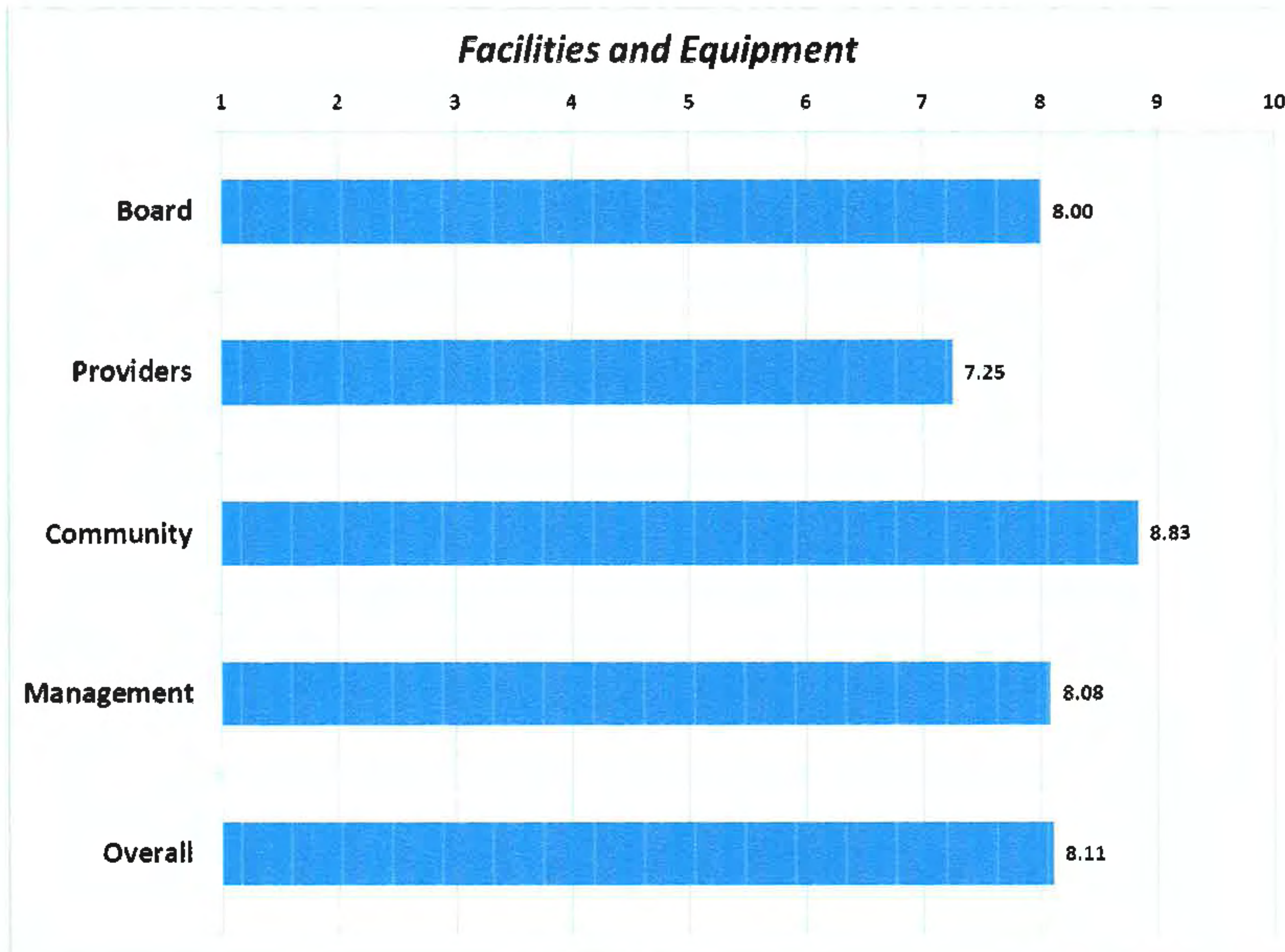
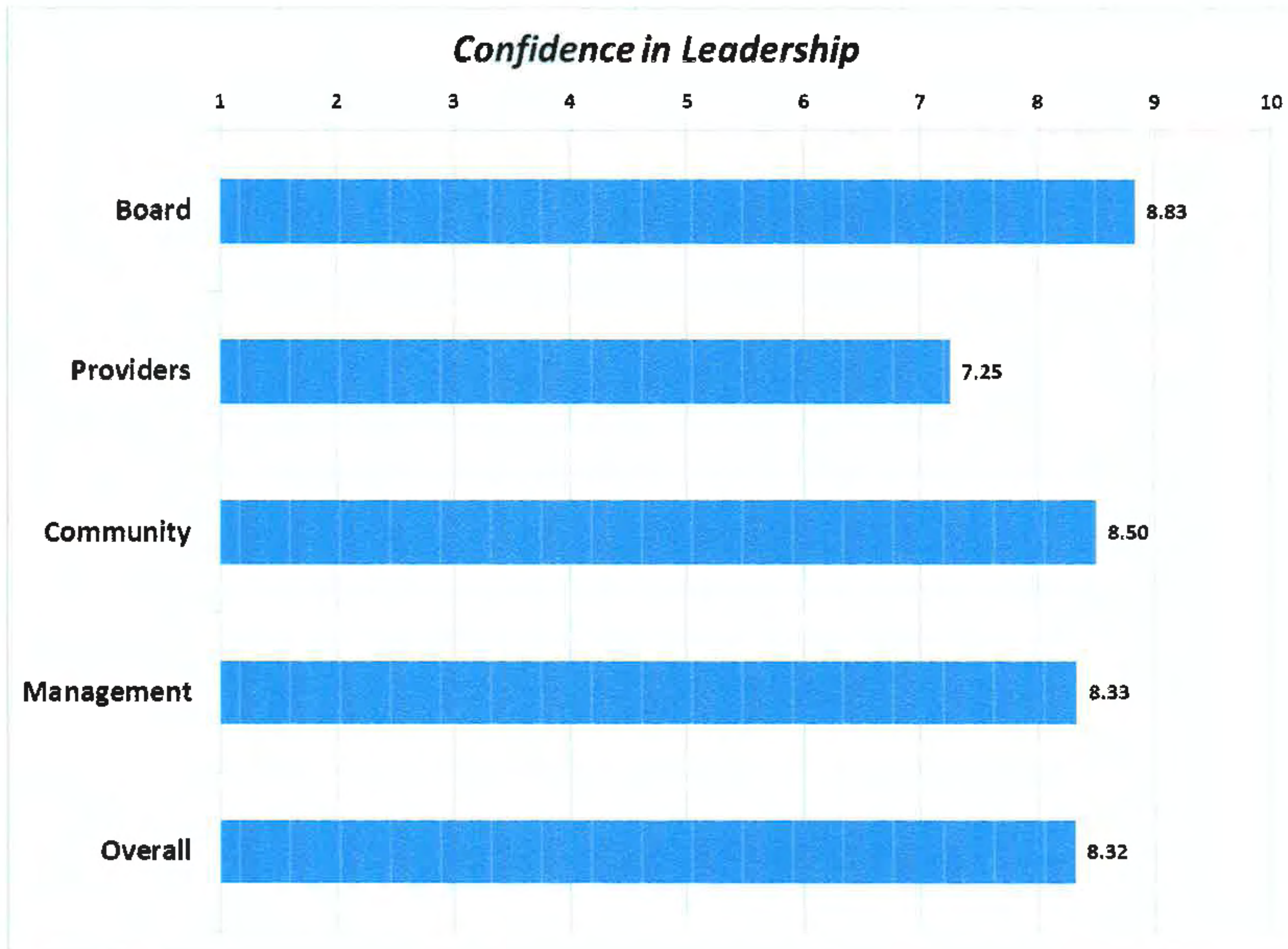
8
9
10
Board
8.33
Providers
8.50
Community
8.33
Management
8.58
Overall
8.46


Scope of Services
1
2
3
4
5
6
7
8
9
10
Board
7.00
Providers
7.50
Community
7.17
Management
7.08
Overall
7.14


Facilities and Equipment
1
2
3
4
5
6
7
8
9
10
Board
8.00
Providers
7.25
Community
8.83
Management
8.08
Overall
8.11


Confidence in Leadership
1
2
3
4
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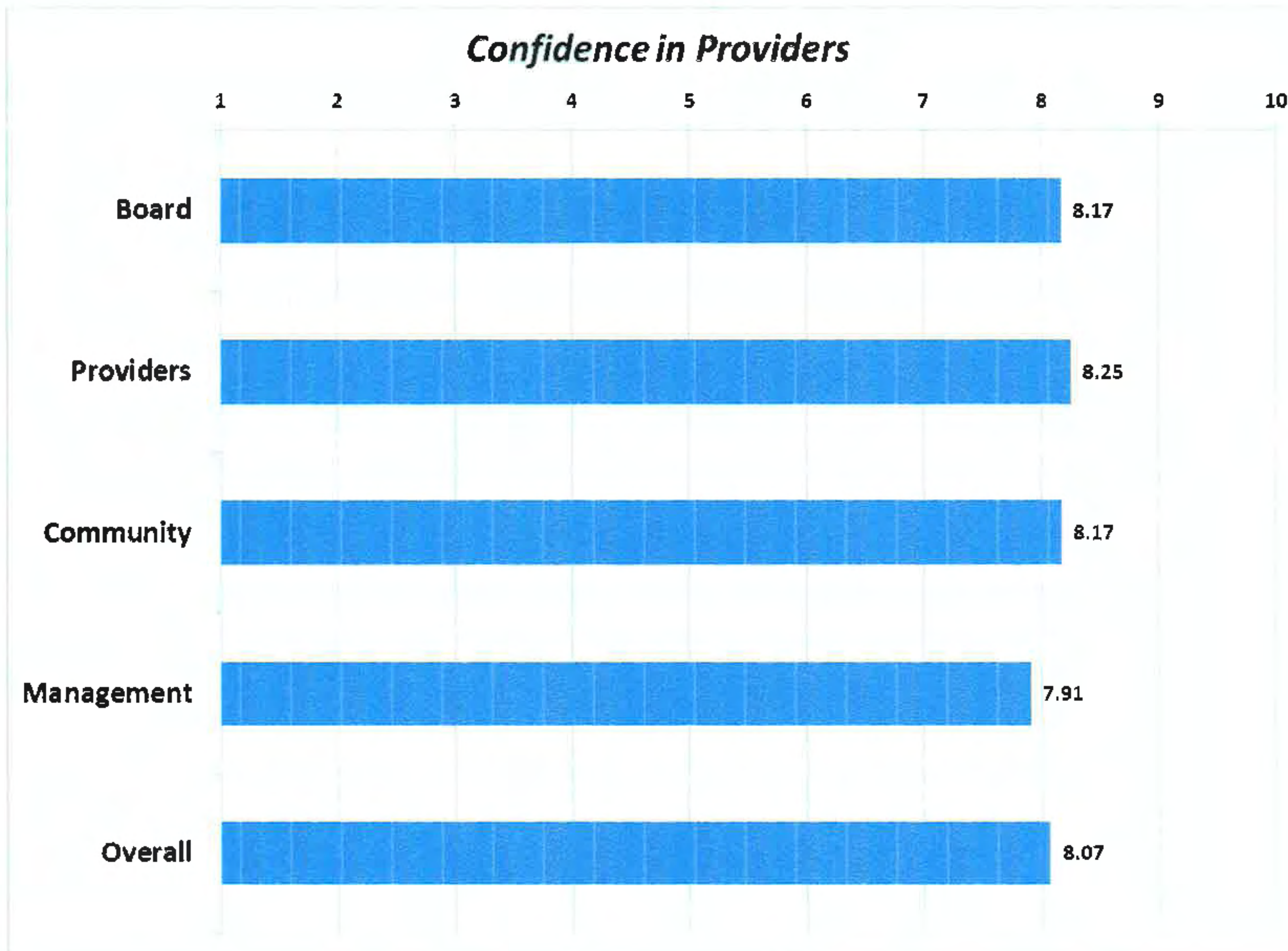
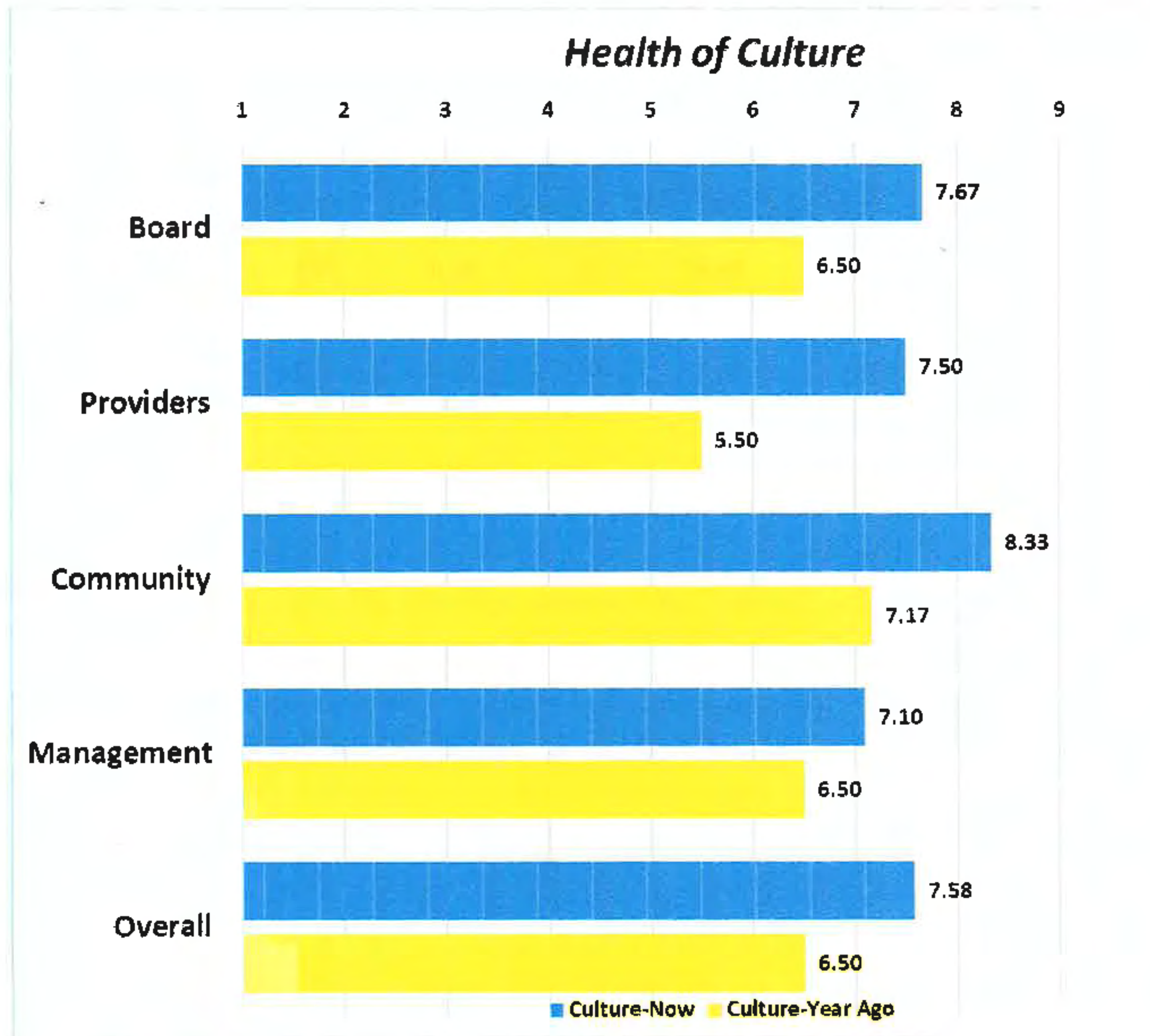
8
9
10
Board
8.83
Providers
7.25
Community
8.50
Management
8.33
Overall
8.32


Confidence in Providers
1
2
3
4
5
6
7
8
9
10
Board
8.17
Providers
8.25
Community
8.17
Management
7.91
Overall
8.07

Confidence in Employees
1
2
3
4
5
6
7
8
9
10
Board
8.33
Providers
8.00
Community
8.67
Management
8.58
Overall
8.46


Health of Culture
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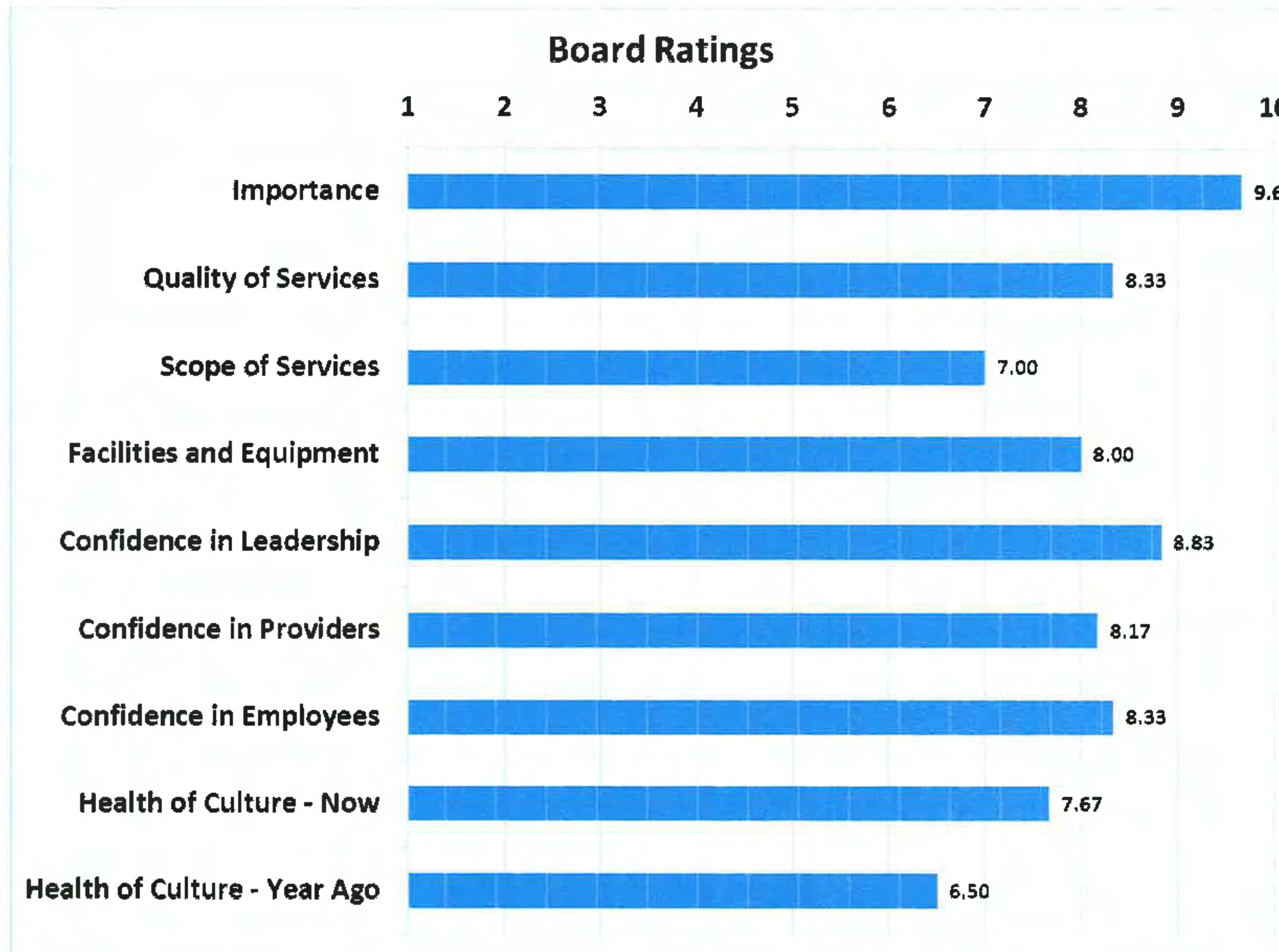
2
3
4
5
6
7
8
9
10
Board
7.67
6.50
Providers
7.50
5.50
Community
8.33
7.17
Management
7.10
6.50
Overall
7.58
6.50
Culture-Now
Culture-Year Ago


Board Ratings
1
2
3
4
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6
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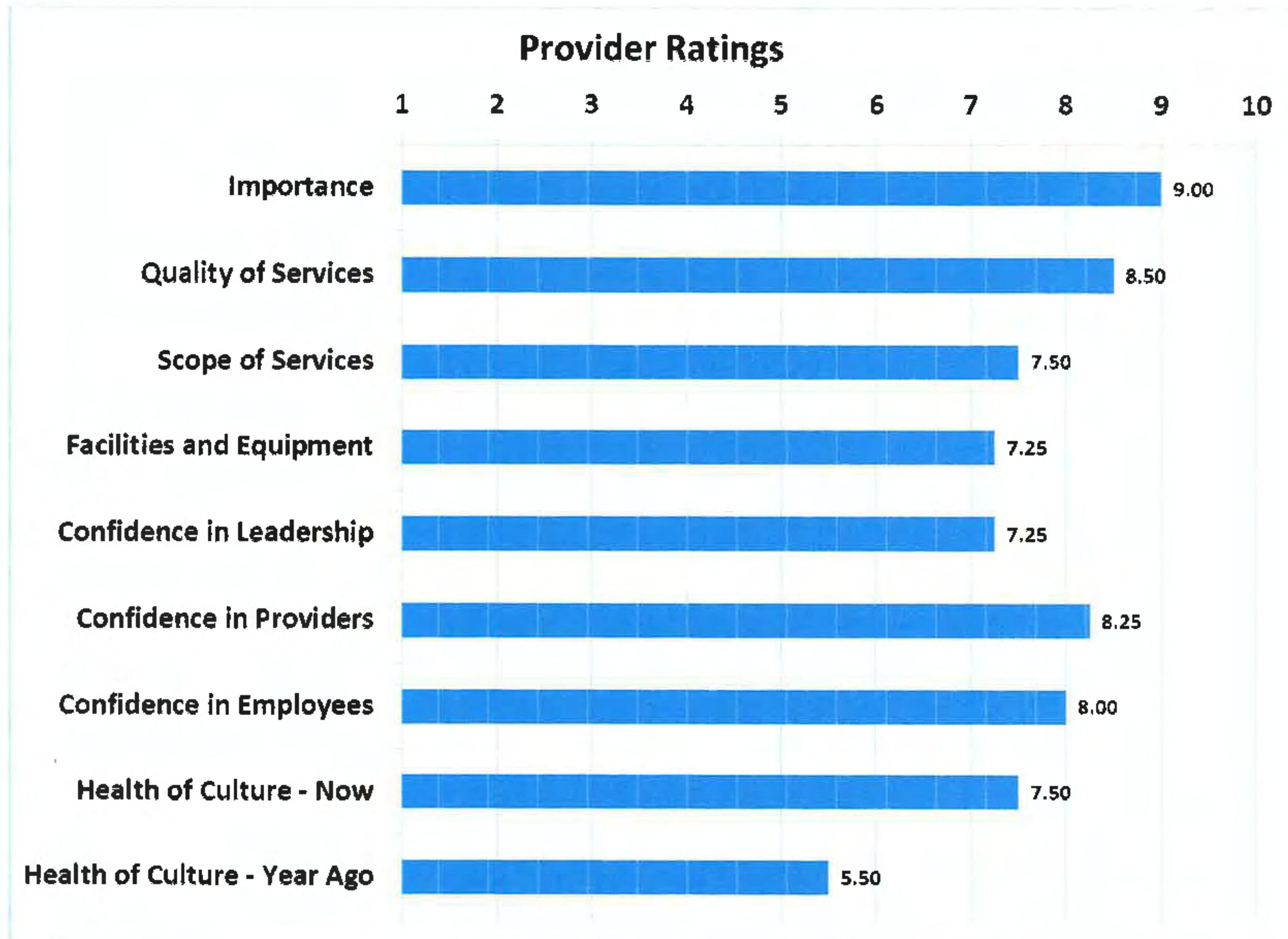
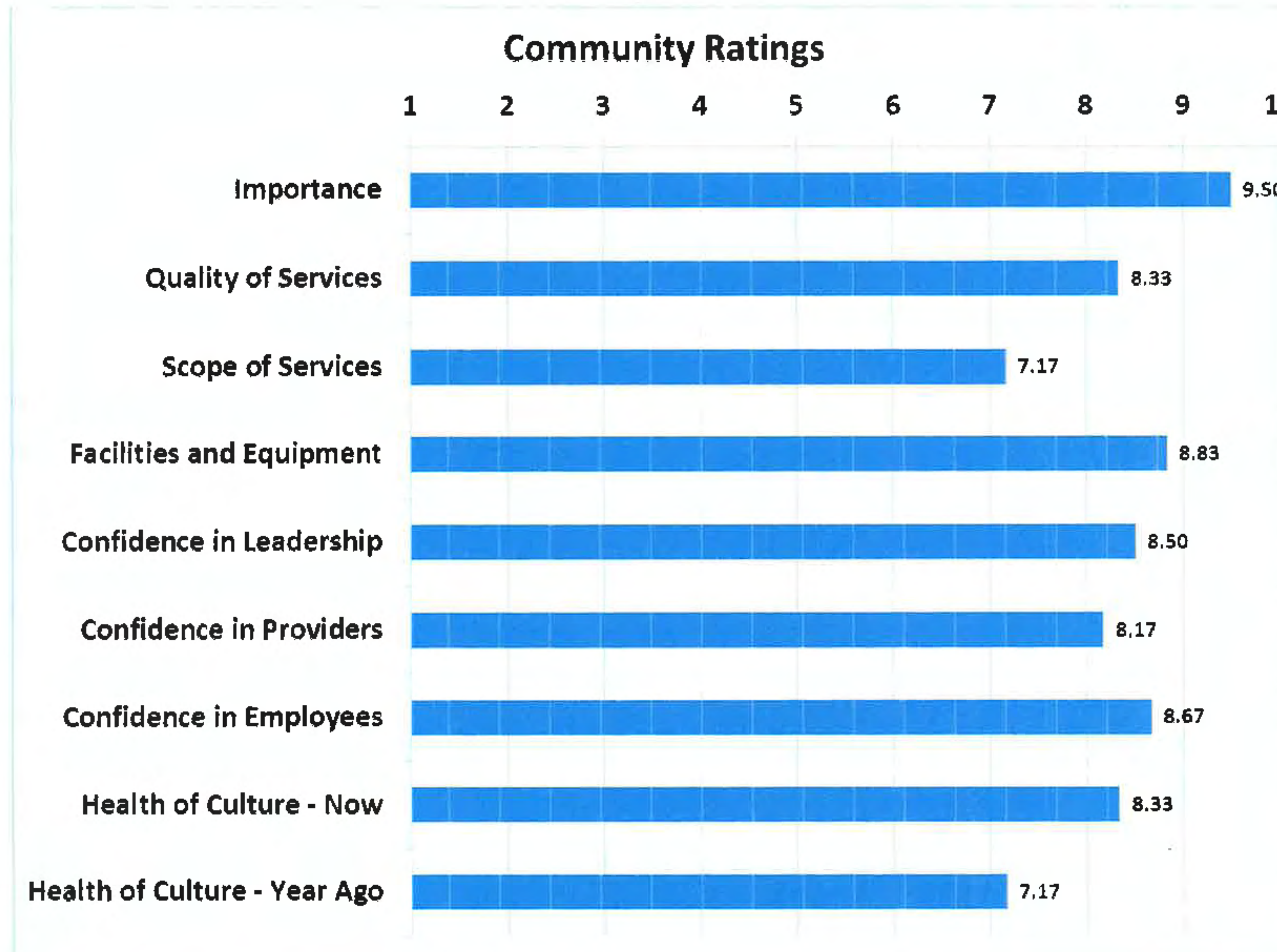
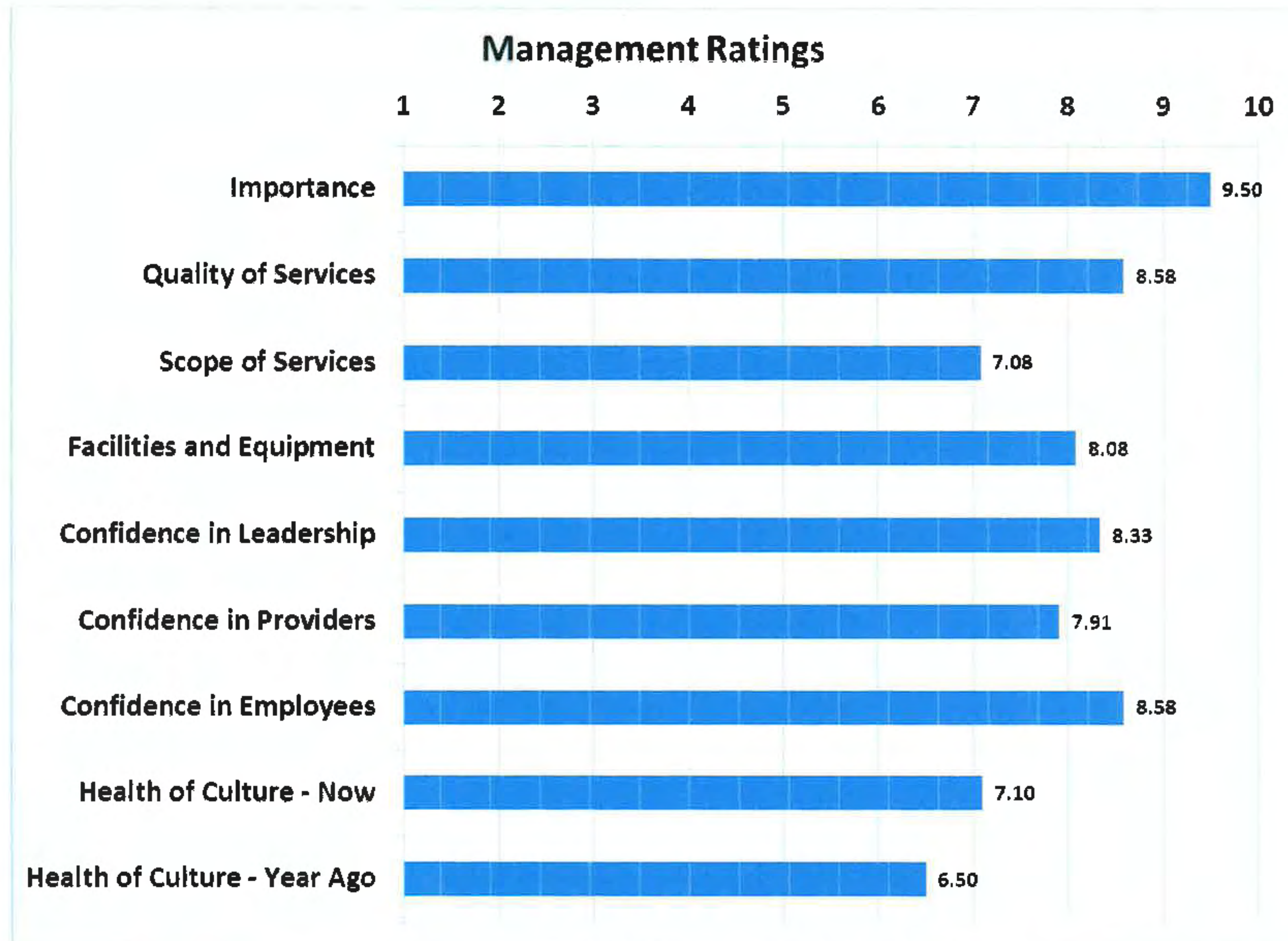
8
9
10
Importance
9.67
Quality of Services
8.33
Scope of Services
7.00
Facilities and Equipment
8.00
Confidence in Leadership
8.83
Confidence in Providers
8.17
Confidence in Employees
8.33
Health of Culture - Now
7.67
Health of Culture - Year Ago
6.50


Provider Ratings
1
2
3
4
5
6
7
8
9
10
Importance
9.00
Quality of Services
8.50
Scope of Services
7.50
Facilities and Equipment
7.25
Confidence in Leadership
7.25
Confidence in Providers
8.25
Confidence in Employees
8.00
Health of Culture - Now
7.50
Health of Culture - Year Ago
5.50


Community Ratings
1
2
3
4
5
6
7
8
9
10
Importance
9.50
Quality of Services
8.33
Scope of Services
7.17
Facilities and Equipment
8.83
Confidence in Leadership
8.50
Confidence in Providers
8.17
Confidence in Employees
8.67
Health of Culture - Now
8.33
Health of Culture - Year Ago
7.17


Management Ratings
1
2
3
4
5
6
7
8
9
10
Importance
9.50
Quality of Services
8.58
Scope of Services
7.08
Facilities and Equipment
8.08
Confidence in Leadership
8.33
Confidence in Providers
7.91
Confidence in Employees
8.58
Health of Culture - Now
7.10
Health of Culture - Year Ago
6.50

Appendix B

Letter to CEO containing the minor recommendations

Sep 24, 2018

Mark Miller
CEO
Harlan County Health System
717 N. Brown Street
Alma, Nebraska 68920

Dear Mark,

This letter presents the minor recommendations from the operational and financial improvement Project. The major recommendations are included in the body of the report from that Project. That report discusses the Project and the methodology that was used to develop the recommendations.

Although these recommendations are considered to be minor compared to those classified as major, they still have value for HCHS and it is important that they are not lost or ignored.

Minor Recommendations:

- Maintain good working relationships with the Board, and specifically help new Trustees in their learning curve related to healthcare in general and HCHS in particular
- Keep HCHS in close touch with the Two Rivers Public Health Department
- Continue good working relationships between HCHS and area EMS squads, law enforcement agencies (City Police, County Sheriff and State Patrol) and the Volunteer Fire Departments around the area
- The annual goals for all members of management could include professional and personal development items which are supported by their supervisor and, if appropriate, funded in the budget
- Be a catalyst to help the community dream for a better future; don't let the "good" be the enemy of the "best"

- Enhance community involvement by HCHS leaders and employees in Oxford, and keep it up in Alma
- Actively participate as a partner in economic development initiatives in each community in the service area
- Pursue grant funds in innovative ways
- Continue to look at ways to reduce cost and improve efficiency

As with the major recommendations, the recommendations above should be verified, prioritized and implemented over time. It will likely be most efficient to work some of these implementation efforts in with related implementation work on the major recommendations.

Please let me know if I can be of any further assistance with these items.

Thank you for your assistance with this Project!

Sincerely,

Bill Luke

Bill Luke
President
Luke and Associates, Inc
11 Camelot Way
Kearney, Nebraska 68845
Cell: 308.627.4900
Email: bluke444@gmail.com