



Board Attendance: Jane O’Keeffe, Chair; John Shine, Treasurer; Greg Larson, Secretary; Shannon Theall, Member; Kelsie Bostwick, Member – attended virtually

LHD Managers in Attendance:

Landon Dybdal, CEO; Kyle Byers, COO; Dr. Scott Graham, CMO; TeddiAnne Damuth, Interim CNO; Dala Pardue, Clinics Director; Stacey Van Nes, Clinics Manager; Kim Wright, HR Director; Tyson Lane, EMS Director; Judy Clarke, Public Health Director; Alena Acklin, Process and Quality Improvement Coordinator; Shawn Cosby, Risk, Compliance, Security Manager; Abigail Finneti, CDI Manager

Others in Attendance:

Call to Order:

Jane O’Keeffe, Chairperson, called the meeting to order in open session at 5:47PM.

Consent Agenda Item Approval:

Greg Larson made the motion to approve the consent agenda items, which included:

- December 18, 2025, meeting minutes
- February 2026 check signing calendar

Kelsie Bostwick seconded the motion. The motion was presented, all members voted, and the motion passed unanimously.

Financial Reports: Kelly Johnston, CFO

December 2025 LHD Financial Report

- Cash on Hand: 27
- Contribution Margin: \$(20,085)
- Revenue: \$3,122,940

Kelly provided a financial update for December 2025. The organization recorded a modest loss of approximately \$20,000 for the month, which represents a significant improvement of approximately \$1.4 million compared to December 2024. Year-to-date performance is tracking approximately \$340,000 better than the prior year. Overall, the bottom line is tracking well.

Cash on hand increased to 27 days, up from prior months. Census has been higher, and swing bed days along with acute care admissions have contributed positively to cash position. The goal remains 90 days cash on hand. Days in AR increased due to efforts to clean up old balances and address posting issues; this is a temporary increase related to process improvements rather than collection concerns.

The cost report has been filed. The board will receive the final audited draft by the end of next week. Wipfli is conducting the account audit, and feedback is being provided. Kelly noted that a new requirement to report sick leave on the balance sheet creates an apparent negative impact of



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approximately \$1 million compared to last year; however, this is an accounting presentation change rather than an actual financial decline.

New CDI processes are going well, with training underway for medical staff. These efforts are expected to have a positive impact on net patient revenue. Recruitment efforts for a Revenue Cycle Director are ramping up, as are physician recruitment efforts.

Swing Bed Program Update: The swing bed program continues to expand. Currently there are 10 swing bed patients with a total census of 14. Year-to-date swing bed days are up compared to last year. The January average is slightly above 8 patients, with a goal of 12 patients daily. The board requested that future chart presentations include swing bed goals, cash goals, AR goals, and averages for reference.

Intentional efforts are underway to bring local swing bed patients back to Lake Health District and to recruit patients from neighboring communities. Residents in Klamath Falls have been referring patients to the swing bed program. Klamath Falls hospital is not yet ready for the TEAMS model; Lake Health District is working to support them in swing bed efforts and demonstrate the benefits to both parties.

Marketing efforts include a swing bed advertisement currently running on radio, which is going well. Plans are in place to add a website component to the radio ad and to periodically reword the advertisement to maintain attention. The team is considering surveying swing bed patients from outside the community to determine how they learned about the program (radio ad, family referral, physician referral, etc.).

Transportation remains the biggest barrier to swing bed program growth. Kyle is currently waiting on quotes for transport vans from dealers in Lakeview and Bend, which we would need to outfit. A company in Medford offers vans already outfitted; quote results are pending.

Staffing Update: Staffing in Acute has been challenging. The unit currently has four local RNs, with frequent call-ins creating strain on the team. Swing bed patients require a heavier workload for CNAs, and the department is currently short-handed. One CNA was hired this week, and planning is underway to hold another CNA certification course locally to develop more certified staff from the community.

DME Department: DME year-to-date shows a loss of \$50,337. Kelly will continue to monitor and provide updates.

Receivables on the clinic and outpatient side continue to be a focus area as the organization works toward strategic improvements.

John Shine made a motion to approve the December 2025 financials as presented. Greg Larson seconded the motion. The motion was presented, all members present voted, and the motion was passed unanimously.

Medical Staff Report: *Dr. Scott Graham, CMO*
Privileging Requests: N/A

Grievance Report: *Shawn Cosby, Risk Compliance Manager*



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Shawn reviewed the distinction between a complaint and a grievance. Complaints are typically addressed and resolved at the departmental level, and any hospital staff member may assist in resolving them. If a complaint cannot be resolved, it is elevated to a grievance.

Depending on the nature of grievance, the process may involve department heads, Human Resources, the Risk and Compliance Manager, and a formal investigation. Complaints and grievances may be submitted verbally, by mail, email, or phone.

Shawn noted that most complaints are resolved promptly. All complaints and grievances, along with their resolutions, should be reported and documented in accordance with policy, including detailed communication of the outcome.

Quality Performance Overview: *Alena Acklin, Process & Control Quality Improvement Coordinator*

Alena reported on the 2025 quality performance metrics, noting that 59 metrics were met and 9 were not met, reflecting overall strong performance. Moving forward, reporting will focus on the metrics presented.

One negative complaint was reviewed regarding a patient not receiving a follow-up call. This complaint identified an opportunity for improvement. Investigation revealed that follow-up calls had not been conducted for some time, despite a prior RN assignment for this task. Teddi has since assigned a new RN to resume follow-up calls.

Additionally, it was identified that the follow-up communication had been sent electronically to Athena EHR associated with Dr. Graham's former office, resulting in the message not being received. The complaint prompted review of several processes and highlighted multiple opportunities for system improvement.

Shannon Theall made a motion to approve the Quality Measures as presented. John Shine seconded the motion. The motion was presented, all members present voted, and the motion was passed unanimously.

QAPI 2026 Plan: *Alena Acklin, Process & Control Quality Improvement Coordinator*

Alena Acklin presented the 2026 QAPI Plan to the board.

Greg Larson made a motion to approve the QAPI Plan as presented. Shannon Theall seconded the motion. The motion was presented, all members present voted, and the motion was passed unanimously.

Manager Report: *Kim Wright, HR Director*

Kim Wright presented an overview of the Human Resources department, highlighting the department's alignment with the SHRM Body of Applied Skills & Knowledge (BASK) competency framework. The HR department provides comprehensive services across multiple areas including talent acquisition, employee relations, compensation and benefits administration, compliance, training and development, and organizational culture initiatives.



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HR Staffing: The department currently consists of one full-time Human Resources Generalist, Alicia Yoder, and one part-time Human Resources Generalist, Tina Johnson-Smith. Alicia has been in HR since 2008 and brings healthcare experience specifically from Critical Access Hospitals since 2009. Tina transitioned to HR after over 20 years as a Nuclear Medicine Technologist and joined LHD in March 2022, bringing experience in medical management, billing, and EHR implementation.

Leadership Development Initiative: Kim completed Gallup Global Strengths Coach Certification training in San Diego in Fall 2025. Implementation of the strengths-based approach begins next week with the Management team. This initiative supports the organization's broader culture development efforts.

Recruitment Challenges: Kim identified recruitment as the biggest challenge facing the department. In 2025, the HR team posted 53 positions and received 890 applications, of which 518 were sent to hiring managers. Ultimately, 67 candidates were hired, with an average time for hire of 38 business days.

Employee Retention Success: Kim reported employee longevity as the department's biggest success. Of the organization's 244 total employees, retention metrics demonstrate strong employee satisfaction and organizational stability.

CEO Report:

Landon reported that recruitment for OB services continues to progress slowly, with limited movement toward securing a permanent provider at this time. Recruitment efforts for Family Practice providers demonstrate strong long-term potential, though short-term progress remains gradual. For FPOB, leadership is optimistic that one to two providers may be secured within the next few months, as site visits are currently underway.

Regarding Surgery services, positive progress has been made with a strong surgeon candidate. The candidate is anticipated to provide coverage approximately two weeks per month and is scheduled for an onsite visit next week. With a well-rounded background that includes thyroid procedures as well as endoscopic and laparoscopic training, this candidate offers a promising opportunity for a collaborative and potentially long-term relationship.

Landon provided an update on the state survey process. The survey was conducted in August 2025. On December 10, 2025, the state issued findings citing numerous deficiencies and allowed ten days for a response. A first Plan of Correction (POC) was submitted and subsequently denied with notice provided to us on December 24, 2025, with another ten-day response period. Due to the holidays, an extension was requested and granted for an additional three days; however, the second POC was also denied.

Two of the cited deficiencies relate to training requirements for two staff positions. The certifications requested by the state are not required under CMS guidelines. Leadership believes the state's actions have been targeted in nature. Kyle and Landon submitted a response outlining inconsistencies and discrepancies in the state's findings and included the state legislature, HOA president, and the Office of Rural Health in



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the correspondence to ensure transparency and alignment given the inconsistencies identified. A state revisit is expected within the next couple of weeks.

Landon and Kyle also reported that the supervisor of the state survey department participated in a call with Kyle and Shawn this afternoon. Leadership felt the discussion was productive, particularly regarding conditional-level discrepancies related to specialty clinic licensure. All parties expressed a desire to resolve the issues and move forward.

Although the state technically has the authority to terminate CMS funding following two denied plans of correction, leadership believes such action would be disproportionate, inconsistent with CMS standards, and unlikely given the nature of the cited deficiencies and the ongoing engagement to resolve them.

Leadership expressed concern that the survey actions may be connected to the recent separation of Behavioral Health into an independent 501(c)(3). This decision was made as part of the organization's financial turnaround strategy and was supported by all parties, as it allows Behavioral Health to pursue additional grants and funding opportunities while benefiting both entities. Leadership believes the state may have misunderstood the business rationale and benefits of this decision, contributing to a perception of retaliation.

Once the survey issues are resolved, leadership plans to pursue accreditation through DNV to remove reliance on state surveys. DNV currently accredits 12 Critical Access Hospitals in Oregon, and Landon has spoken with several CEOs regarding their experiences. While DNV accreditation involves additional cost and annual surveys, leadership noted several advantages, including ongoing performance insight, collaborative survey processes, and positive contributions to organizational culture and quality outcomes. If the organization proceeds with DNV accreditation, the anticipated timeline would target April 2027.

Landon reported that Kyle and Shawn have each spent over 100 hours on survey response efforts, with significant support from nursing staff and minimal guidance from state surveyors.

Public Comment: N/A

Adjournment:

At 6:51PM, Chair Jane O'Keeffe adjourned the open session for the 501(c)(3) and convened an executive session pursuant to ORS 192.660(2)(f). The executive session began at 7:01PM and was adjourned at 7:50PM.

Respectfully submitted,



Greg Larson, Secretary



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