Jefferson Healthcare

Jefferson County Public Hospital District No.2
Board of Commissioners Meeting
Jefferson Healthcare Conference Room
2500 W. Sims Way, Suite 302 3rd Floor

# Regular Session Agenda
## Wednesday, July 6, 2016

**Call to Order**: 3:30

**Patient Story**: Jackie Mossakowski 3:31

**Minutes:** Action Requested 3:35
- June 15 Regular Session (pages 2-3)

**Required Approvals**: Action Requested 3:40
- Medical Staff Credentials/Appointments/Reappointments (page 4)
- Medical Staff Policies (pages 5-21)
- Resolution 2016-15 Surplus Equipment (page 22)

**Public Comment:** 3:45
*(Alternative methods of providing public comment on any item on the agenda or any other hospital issue is through a letter addressed to Commissioners at 834 Sheridan Street, Port Townsend, WA 98368 or email to Commissioners at commissioners@jgh.org)*

**Patient Advocate Report:** Jackie Levin 3:50
- First & Second Quarter Data

**CAH Annual Report:** Brandie Manuel 4:05
- Presentation

**Administrator's Update:** 4:25

**Board Reports:** 4:30
- Approve The Board Book

**Conclude:** 5:00

This Regular Session will be officially audio recorded.

# Jefferson County Public Hospital District No.2
# Board of Commissioners
# Regular Session Minutes
# Wednesday, June 15, 2016
# Jefferson Healthcare Conf Room
# 2500 W. Sims Way suite 302

**Call to Order:**
The meeting was called to order at 3:30 pm by Commissioner Buhler. Present were Commissioners Buhler, De Leo, Dressler, Kolff and Ready. Also present were Mike Glenn, CEO, Jackie Mossakowski, CNO, Lisa Holt, CAO, Brandie Manuel, Executive Director Quality, Steve Feland, CHRO, Kate Burke, Marketing Director, Joe Mattern, CMO, Molly Hong, Chief of Medical Staff, and Suzy White, Administrative Assistant. This meeting is being officially audio recorded by Jefferson Healthcare.

**Employee Recognition:**
Mike Glenn was pleased to announce the first quarter 2016 winners in our Employee and Team Recognition Program. These individuals consistently demonstrate our service standards and are an inspiration to others. Hilary Whittington announced Elaina Harland as employee of the quarter and Mike Glenn announced the Administrative Assistants as team of the quarter: Amber Rukkila, Mallory Long, Brittany Huntingford, Suzy White, Penny Westerfield, Elaina Harland, Gin Rourke, Tina Herschelman, and not present Lyn Moan, Virginia Moon, and Terrie Comstock.

**Patient Story**:
Jackie Mossakowski shared a story about a sleep lab patient that gained significant improvements to their daily life.

**Public Comment:**
A citizen distributed an invitation to the commissioners to attend the NAMI (National Alliance of Mental Illness) Board meeting on August 9.

**2015 Financial Audit Report**:
Mike Glenn introduced Tom Dingus of Dingus, Zarecor & Associates PLLC. Mr. Dingus distributed financial statements and independent Auditor's report, financial indicators and gave a presentation on the 2015 financial audit. Mr. Dingus reported there are no material weaknesses or significant deficiencies reported.

**Financial Report:**
Hilary Whittington gave a presentation on the financial performance for the months of April and May.

**Minutes:**
- May 3 Special Session Minutes

Commissioner Ready made a motion to approve May 3 special session minutes as presented. Commissioner Kolff seconded the motion.
**Action:** Motion passed unanimously.

- May 4 Regular Session Minutes

Commissioner Kolff made a motion to approve May 4 regular session minutes as presented. Commissioner Dressler seconded the motion.
**Action:** Motion passed unanimously.

**Required Approvals**:

- Medical Staff Credentials/Appointments/Reappointments
- Medical Staff Policies
- April & May Warrants and Adjustments
- Resolution 2016-14 cancel April & May warrants
- Emergency Chief Executive Officer Succession Policy

Commissioner De Leo made a motion to approve Medical Staff Credentials/ Appointments/Reappointments as presented, medical staff policies as presented, April and May warrants and adjustments as presented, Resolution 2016-14 to cancel warrants as presented, and Emergency CEO Succession policy as presented. Commissioner Dressler seconded the motion.
**Action:** Motion passed unanimously.

**Chief Medical Officer Report:**
Dr. Mattern reviewed medical staff activities including: ACO update, rural health leadership conference, palliative care program, advance directives initiative, honoring choices campaign, Medical Director positions, strategic planning for medical groups, provider engagement events, patient advocate reports, and a physician recruitment update.

**Administrator's Report:**
Mr. Glenn distributed a written report and gave a brief presentation with updates on the expansion of reproductive services, 20 by 18 Initiative, Medical Staff leadership structure, community health services discussion, CT accreditation, and introduced Steve Feland new Chief Human Resource Officer.

**Board Reports:**
Commissioner Ready announced he and Commissioner Kolff have arranged a meeting to discuss single payer healthcare at the annual rural WSHA conference in Chelan on Tuesday, June 28 4-5:30 in the Edmonds room.

**Conclude:**
Commissioner Dressler made a motion to conclude the meeting. Commissioner De Leo seconded the motion.
**Action:** Motion passed unanimously.

Meeting concluded at 5:22pm.

Approved by the Commission:

President of Commission: Jill Buhler _____

Secretary of Commission: Marie Dressler _____

FROM: Barbara York – Medical Staff Services
RE: 6/28/2016 Medical Executive Committee appointments/reappointments and annual policy review recommendations for Board approval 7/6/2016

C-0241
§485.627(a) Standard: Governing Body or Responsible Individual
The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

Interpretive Guidelines §485.627(a)
*It is the responsibility of the governing body (or responsible individual) to appoint, with the advice of the medical staff, the individual practitioners to the medical staff. After considering medical staff recommendations, and in accordance with established CAH medical staff criteria and State and Federal laws and regulations, the governing body (or responsible individual) decides whether or not to appoint new medical staff members or to continue current members of the medical staff.*

Recommended appointment to the provisional active/courtesy/allied health staff:

1. Arslan, Melike, MD – Tele-Cardiology (Echo and Nuclear Imaging interpretations)
2. Osland, Jacqueline, MD – General Surgery
3. Puerner, Debra, ARNP – Sleep Clinic (temporary privileges in effect since 6/13/2016)
4. Patel, Jigish, MD – Tele-Radiology
5. Hoang, Priscilla, MD – Tele-Cardiology (Echo and Nuclear Imaging interpretations)

Reappointments:

Recommended reappointments to active staff with privileges as requested:
1. Rosenbloom, Frank, MD – IM/Hospitalist

Recommended Reappointments to allied health staff with privileges as requested:
1. Pieratt, Angela, ARNP – Family Medicine

Recommended Reappointments to courtesy staff with privileges as requested:

1. Bell, James, MD – Diag. Radiology
2. Chan, Alan, MD - Diag. Radiology
3. Hallam-Shah, Paula, MD – Tele-Radiology
4. Irick, Chance, DO – Emergency Medicine
5. Liou, Lee, MD – Tele-Neurology (Swedish)
6. Marks, William, MD – Diag. Radiology
7. McWhorter, Valerie, MD – Clinical/Anatomical Pathology
8. Menon, Ravi, MD – Tele-Neurology (Swedish)
9. Millan, Juan, MD – Tele-Radiology
10. Pfleger, Mark, MD – Tele-Radiology
11. Schroetlin, Renee, MD – Emergency Medicine
12. Shaw, Hillary, MD – Tele-Radiology
13. VanHise, Milton, MD – Diagnostic Radiology

Annual policy review – no changes:

# Access and Confidentiality Agreement

## PURPOSE:

To adhere to applicable confidentiality laws, HIPPA policies and Jefferson Healthcare policies governing confidential information.

SCOPE:

Hospital Staff, Volunteers, Students, Medical Staff, Commissioners.

## DEFINITION:

You may have access to confidential information while performing your duties at Jefferson Healthcare. You are required to conduct yourself in strict conformance to applicable laws (including HIPAA policies) and Jefferson Healthcare policies governing confidential information. Your principal obligations in this area are explained below. The violation of any of these duties will subject you to discipline, which might include but is not limited to termination of employment/medical staff status and privileges and to legal liability.

Confidential information includes patient records, employee personnel/ payroll/ employment medical records, medical staff credentialing records, financial and operating data, records pertaining to the quality improvement process and any other information of a private or sensitive nature. Employees may not look up another employee's information in the electronic record even at the employee's request. Employees may not access the record of their spouse, their partner, their adult children, their friends or relatives unless the information is required to allow them to perform assigned duties of their employment (see Policy "Employees Accessing Their Own or Family Members Medical Record"). These matters should only be discussed in the appropriate business or clinical setting on a need to know basis.

You may not release any official information concerning any aspect of the hospital, patients or operations. Only the administrator or designee can authorize the release.

In your duties at Jefferson Healthcare, you understand that you may have access to confidential information. This confidential information may include but is not limited to information relating to medical records, credentialing records, conversations, financial information, salaries, employment records, disciplinary actions, etc. Human Resources and Medical Staff Services Departments are responsible for obtaining and maintaining signed agreements. The signed copy of the agreement shown below will be kept in the appropriate Human Resources or Medical Staff file.

## ACCESS AND CONFIDENTIALITY AGREEMENT:

Accordingly, as a condition of and in consideration of your access to confidential information, you agree to use confidential information only as needed to perform the legitimate duties associated with your affiliation with Jefferson Healthcare. This means, among other things, that you will only access confidential information on a need-to-know basis; you will not in any way divulge, copy, release, alter or

destroy any confidential information except as properly authorized within the scope of your professional activities, you will safeguard your access code or any other authorization that allows you to access confidential information including your computer log on and payroll codes, and you will report activities by any individual or entity that you suspect may compromise the confidentiality of information. You understand that your failure to comply with this Agreement may result in disciplinary action up to and including termination of employment/affiliation at Jefferson Healthcare.

Annual review – no changes

# Access to Provider Credentialing and Quality Files

## POLICY/PURPOSE:

It is the policy of the Medical Staff of Jefferson Healthcare to maintain the confidentiality of all records, discussions and deliberations relating to credentialing, medical staff quality assessment and peer review committees. All practitioners have the right to access their credentialing quality data files upon request. Disclosure and/or access are as follows.

## PROCEDURE:

**Location and Security:** All records shall be maintained under the care and custody of Jefferson Healthcare's Medical Staff Services Coordinator. Credentialing and peer review records must remain stored and locked in office and file cabinets except when in use for official business. Records stored electronically must have passwords and possess read/write control protections.

## ACCESS TO RECORDS:

The following individuals may access credentialing and peer review records to the extent necessary to conduct official business and as described:

1. An individual practitioner may review his or her credentials and quality assessment file providing:
    - The practitioner will contact the Medical Staff Coordinator to make an appointment.
    - The Medical Staff Services Coordinator or officer of the medical staff is present during the file review.
    - The practitioner understands that he/she may not remove any items from the credentials file.
    - The practitioner understands that he/she may add an explanatory note or other document to the file and correct erroneous information.
    - The practitioner understands that he/she may not review confidential letters of reference received during the initial appointment or any subsequent reappointment.
    - Photocopying: The practitioner may photocopy items that he/she submitted as part of the application or reappointment process (i.e., application, diplomas, licenses, clinical performance reviews, etc.). The practitioner may not photocopy any other items unless express written permission is received from the Chief Executive Officer.
    - For initial and reappointment application processes, the practitioner may receive status on his application upon request.
2. Medical Executive Committee member
3. Medical Staff Committee member conducting credentialing or peer review
4. A representative of the Governing Board
5. The Chief Executive Officer or designated Assistant Administrator
6. Medical Staff Services personnel for purposes of official medical staff committee

business and routine filing of information
7. Consultants or attorneys engaged by Jefferson Healthcare
8. Representatives of regulatory or accreditation agencies

## SUBPOENAS:

The hospital will refer all subpoenas pertaining to medical staff records to the Risk Manager and Medical Staff Services Coordinator, who shall consult with legal counsel regarding appropriate response and shall notify the involved practitioner and the Chief of Staff.

## VERIFICATION OF INFORMATION:

Routine requests for verifications of affiliation and appointment, reappointment and privileges recommendations shall be released with an appropriate release of information form signed by the practitioner. Routine releases shall not be kept on file. Legal counsel will be obtained by Medical Staff Services Coordinator for release of adverse information and such release shall be documented.

## DOCUMENTATION OF ACCESS:

Any person accessing credentialing or quality assessment files (other than Medical Staff Services Director/personnel conducting routine medical staff file upkeep) shall sign and document the purpose and date of the access on the *Access and Released Information* form to be kept in each file.

## REFERENCED DOCUMENTS:

NCQA, CR.1, Element B

Annual review with change - Quality of Service Expectations (item 2)

# Expectations of Providers

## POLICY:

This policy sets forth expectations for all medical staff and allied health professional staff with regard to quality of care and service, resource utilization, professional behavior and contributions to hospital and community.

## DEFINITIONS:

**Personal Accountability:**

1. Follow Provider Conduct policy
2. Act in a professional manner

- Take steps to deal with personal stress if it is affecting your work
- Commit to finding solutions to problems
- Take appropriate action if you see disruptive behavior in others, including any form of discrimination, abuse or harassment.
- Maintain a warm and welcoming attitude in the workplace
- Work together as an organization; not only as individuals or departments

**Quality of Care:**

1. Practice the standard of care for your specialty.
2. Maintain skills and participate in CME on a regular basis.
3. Participate in peer review/performance improvement and outcomes.
4. Utilize medical staff resources appropriately and seek early consultation willingly.

**Quality of Service Expectations:**

1. Treat all patients with dignity and respect.
2. **Complete all medical records within 30 days and ensure that documentation supports billed level of care.**
3. Assure there is an appropriate progress note for each acute care patient at least once every day.
4. When on call, provider will return phone call from emergency physician within 10 minutes of receiving the call.
5. The on call physician is to present to the Emergency Department within 30 minutes of request **or** at the clinical discretion of the ED provider.
6. Communicate feedback to patients, consultants and fellow staff members in a timely manner.
7. Provide for or arrange continuous care for hospitalized patients.

**Resource Utilization:**

1. Be a responsible steward of available resources by providing care that is cost effective in accordance with current standards in your field.
2. Always consider transfer of patients requiring treatment beyond the practical capability of this institution.
3. Willingly provide Emergency Department coverage as defined by Medical Staff Policy.

**Respectful Communication:**

1. Work to communicate effectively and respectfully with co-workers and patients
2. Whenever possible resolve conflict with one-to one communication
3. Do not triangulate issues that arise; use appropriate chain of command for resolution -do not gossip
4. Give constructive feedback on issues

**Peer and Co-Worker Relationships:**

1. Treat all fellow medical staff, administrative staff and hospital staff with the respect deserved of a fellow member of the healthcare team at all times.
2. Handle disagreements in a civilized and professional manner, in private surrounds, through the proper channels.
3. Avoid acts of sexual harassment or any violation of the civil rights of patients, their families, hospital employees or medical staff members.
4. Maintain strict adherence of patient confidentiality at all times regardless of the source of information or the circumstances of your surroundings.

**Contributions to Hospital and Community:**

1. Actively participate in the medical staff organization by attending meetings, and serving on committees.
2. Be open to participate in hospital functions.
3. Be aware of community needs and the activities the hospital participates in to meet those needs.

**Personal Improvement:**

1. Follow Standard Work including work developed in Lean Events
2. If you do not know where to find Standard Work, seek instruction or training
3. Participate in Lean Events
4. Strive to master the skills needed to do your best work

**Recognition of Excellence:**

1. Expect excellence in yourself and others and take time to recognize it.
2. Bring out the best in each individual and group, acknowledging others' moments of excellence
3. Give praise for a job well done

**What You Can Expect:**

1. We will be respectful and professional
2. We will recognize and acknowledge excellence and exemplary behavior in care and service
3. We will provide clear guidelines for conflict resolution
4. We will support you in problem resolution and performance improvement

## CONDUCT AND EXPECTATIONS:

My signature below indicates that I have received a copy of the Jefferson Healthcare Medical Staff policies, ***Conduct and Expectations*** and I agree to abide by the policies.

_____

Signature Date

Annual Review with no changes:

# Initial Appointment Processing

## POLICY:

The medical staff shall have a uniform process to obtain and verify evidence of a practitioner's education, relevant training, experience and current competency.

## PURPOSE:

Qualifications need to be met to be appointed to the Medical Staff.

## PROCEDURE:

A. Applicants who meet the qualifications described in the Medical Staff Bylaws, Qualifications for Membership, Article 3.2, shall receive the following information and forms:
    1. Medical Staff Application
    2. Forms to request privileges, as appropriate
    3. Letter "Information for Applicants"
    4. Copy of Medical Staff Bylaws and Rules & Regulations and Policies and Procedures
    5. Disclosure statement
    6. Washington State Patrol Form/Justifacts (Employment Background Investigation)
    7. Other forms as deemed appropriate.

B. Applicant submits the following:
    1. Completed and signed, application and privilege forms.
    2. Current curriculum vitae.
    3. Listing of recent postgraduate medical education activities (past 18 months).
    4. Documentation of special training and experience in the areas where specialized privileges are requested (EKG interpretation, CVP monitoring, etc.).
    5. Copy of current Washington State license.
    6. DEA registration if applicable.
    7. Documentation of CME for prior two years related to privileges requested (excluding graduates of residency or fellowship programs in the past 24 months).
    8. Documentation of liability insurance in the amount required by the Medical Staff and Governing Board.
    9. If applicant has completed a residency program, in the past 24 months, a summary of clinical experience in each of the areas in which privileges are being requested, i.e., types and numbers of cases shall be submitted.
    10. Applicants out of training greater than 24 months shall provide clinical performance data for the last 12 months of practice to include approximate numbers of cases, types of procedures, service areas and types of patients treated. This may come from current hospital affiliations and/or office practice.
    11. Signed Disclosure Statement and Washington State Patrol or Justifacts form.
    12. Documentation of ACLS/BLS/Neonatal Resuscitation certification, as applicable per privilege requirements.

13. Identification: hospital ID badge of a valid picture ID issued by a state or federal agency (driver's license, passport).

C. In the case of delays in responses to verifications or peer recommendations, the applicant will be notified and will be responsible for following up to the degree necessary to obtain adequate response. Failure of the applicant to respond to a request for assistance within 45 days shall result in the application being deemed incomplete with no further processing and considered withdrawn.

D. When collection of documentation and verification is completed, the Medical Staff Services Department submits the application and all supporting information to the Chiefs of Service for evaluation as per *Bylaws 6.1.4.* After the Chiefs of Service reviews are completed, the application is forwarded to the Chief of Staff. The Medical Staff Coordinator shall promptly notify the applicant of any further information required. This must be a special notice and must indicate the nature of the information the applicant is to provide within thirty (30) days. Failure without good cause to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

E. The recommendations of Chiefs of Service and Chief of Staff are forwarded to the Medical Executive Committee and evaluation and actions continue per *Bylaws 6.2.16*

F. Notice of Final Decision:
The Chief Executive Officer provides written notice of the final decision to the applicant. A notice of decision includes:
1. The clinical privileges the applicant may exercise
2. Any special conditions attached to the appointment

G. Documentation:
The recommendations of the Chiefs of Service, Chief of Staff, Executive Committee, and the decision of the Governing Board shall be documented in the individual practitioner's file.

Time Periods for Processing:

Applications shall be processed within the following time periods:

**Medical Staff Services Department/CVO to collect and verify information**: Processing of verification to begin within 7 days of receipt of completed application. Verifications to be completed within 60 working days of receipt of completed application.

**Chief of Service:** 15 days from notification by Medical Staff Services of completed verified application.

**Chief of Staff: After completion of Chief of Service recommendation.**

**Medical Executive Committee:** Next regularly scheduled meeting after receiving recommendation from Chief of Staff.

**Governing Board:** Next regularly scheduled meeting after receiving recommendation from Executive Committee.

These time periods are guidelines and do not create any rights for a practitioner to have an application processed within these precise periods. If the provisions of the Fair Hearing Plan (as defined in the Medical Staff Bylaws) are activated, the time requirements provided therein govern the continued processing of the application. If action does not occur at a particular step in

the process within the time frame specified, and the delay is unwarranted, the next higher authority may immediately proceed to consider the application and all the supporting information, or may be directed by the Chief of Staff on behalf of the Executive Committee or by the Chief Executive Officer on behalf of the Governing Board to so proceed.

The applicant will be notified of the credentialing (and re-credentialing) decision within 60 calendar days of the Board's decision.

RIGHT TO IMPARTIAL, NON-DISCRIMINATORY OF CREDENTIALS:

All Jefferson Healthcare practitioners have the right to an impartial, non-discriminatory, and confidential selection and review process. JHC monitors for and prevents discriminatory credentialing by the following:

JHC does not collect information on an applicant's race, ethnic/national identity and sexual orientation, religion, marital status or other status or characteristics protected under any applicable federal or state law . Medical Executive Committee members are required to sign an annual attestation statement assuring credentialing and re-credentialing decisions are not discriminatory or based on applicant's race, ethnic/national identity, gender, age, sexual orientation, religion, marital status or other status or characteristics protected under any applicable federal or state law.

Current updates of listings in Health Plan practitioner directories and other materials for members are ensured by the payor credentialing team.

## REFERENCES:

DNV MS.6, SR.1; CMS 482.12(A)(5); NCQA CR1, Element A, Factor 7

# Reappointments and Renewal of Clinical Privileges

## POLICY:

All reappointments and the granting of/revision of clinical privileges are for a period not to exceed 2 years.

## DEFINITION:

The renewal/reappraisal of medical staff membership and privileges of a practitioner whose previous service on the medical staff has met the standard of patient care care.

## PROCEDURE:

I. The Medical Staff Coordinator or designee will:
   1. Provide the practitioner at least 90 days prior to expiration of reappointment with the following:
      a. Cover letter requesting completion of reappointment and/or privileges
      b. Application for Reappointment
      c. Copy of currently approved privileges
      d. New privilege forms
      e. Other forms as deemed appropriate
   2. If reappointment packet has not been returned within two weeks from issue, a reminder will be sent to the practitioner.
   3. If the reappointment packet has not been returned 6 weeks in advance of expiration of current appointment, a certified letter will be sent informing the practitioner that the appointment will automatically expire at the conclusion of the appointment period. Reinstatement would require a new application for appointment.
   4. The returned application and/or request for privileges shall be reviewed for completion and all necessary documentation. Privilege requests will be reviewed with those currently granted. Any questions, clarifications or additional information required, will be immediately referred to the practitioner.

II. Complete reappointment and or request for renewal of privileges includes at least the following:
   1. Specific staff category and clinical privileges requested. Any changes shall be noted.
      Requests for privileges new to practitioner shall follow policy *New or Additional Privileges/ Procedures.*
   2. Evidence of current Washington State license.
   3. Evidence of current DEA registration (if applicable).
   4. Evidence of current professional liability insurance (coverage must meet at least the minimum requirements established by the Governing Board, Executive Committee and Medical Staff).
   5. Any physical or mental condition that could affect the ability to perform the privileges requested and duties of medical Staff appointment, with or without accommodation.
   6. **Evidence** of continuing medical education obtained during the previous two years which relate in part to privileges granted and requested is not required unless

requested by Credentials Committee or Medical Executive Committee.

7. Documentation of any proceedings initiated, pending, or completed involving allegations or findings of professional medical misconduct in this state or any other state.
8. Documentation of any proceedings initiated, pending or completed involving denial, revocation, suspension, reduction, limitation, probation, or non-renewal of any of the following:
    a. License or certificate to practice any profession in any state or country
    b. DEA or other controlled substance registration/certification
    c. Membership or fellowship in local, state or national professional organizations
    d. Faculty membership at any medical or other professional school
    e. Appointment or employment status, prerogative or clinical privileges at any other hospital, facility or organizations; or
    f. Limitation, cancellation, imposition of surcharge on professional liability insurance
9. Documentation of any voluntary relinquishment of medical license or DEA or other controlled substance registration.
10. Documentation of any voluntary termination of medical staff membership or voluntary limitation, reduction or surrender of clinical privileges.
11. Documentation of any felony criminal charges pending and/or any charges during the past two (2) years, including their resolutions.
12. Signed and dated reappointment attestation, confidentiality, consent and release from liability.
13. Documentation of any malpractice claims or suits initiated, pending, or completed since practitioner's last appointment/reappointment or granting of privileges.
14. Documentation of any claims or suits for alleged malpractice that resulted in payments by practitioner or on practitioner's behalf by an insurance company (this shall include suits in which a judgment or settlement was made against a professional corporation of which practitioner is/was a member, shareholder, or employee and the practitioner was named in the claim or suit).

III. Verifications to be completed and information obtained:

1. Verification of current Washington State license and any evidence of disciplinary actions will be completed. Negative responses are referred to the Chief(s) of Service and Vice Chief of Staff.
    a. *Washington State license and current licenses held in other states are verified at initial appointment, at reappointment or renewal or revision of clinical privileges, and at the time of expiration of the license.*
2. The National Practitioner Data Bank will be queried. Adverse responses are referred to the Chief(s) of Service and the Vice Chief of Staff.
3. Federal agency resources (Office of Inspector General, System Awards Management, Noridian) shall be queried for exclusion from participation from government sponsored programs (such as Medicare, Medicaid, Tricare, VA).
4. Patient Activity Information will be requested from other sources, when there is limited patient contact at the hospital (less than 3 patient contacts per year).
    a. Any practitioner with minimal activity at the hospital must submit evidence of current clinical competency and ability to perform privileges requested such as:
        i. a copy of his/her confidential quality profile from his/her primary hospital;
        ii. copy of his/her quality profile from a health care plan/managed care organization; or
        iii. recommendations from three (3) active members of the Jefferson

Healthcare Medical Staff who are knowledgeable about the quality of the practitioner's patient care.

iv. Blinded copies of patient records (3) for peer review.

*Failure of the practitioner to ensure necessary competency assessment information is provided shall result in the application being deemed incomplete with no further processing and considered a voluntary resignation.*

5. The practitioner is responsible for providing any reasonable evidence of current ability to perform the privileges requested.
6. Information will be requested from any hospital or facility with or at which the physician had or has any association, employment, privilege or practice.
7. Verification of current insurance and claims history will be conducted.
8. Results of peer review, complaints and concerns, quality assessment and improvement activities and practitioner practice information will be considered.
9. Continuing medical education will be considered.
10. The Medical Staff Coordinator or designess will ensure that practitioner directories and other materials for members are consistent with education, training, certification, specialty, etc.

IV. Review and approval:

After collection of all necessary information the reappointment and/or request for privileges will be referred for evaluation, recommendations and approval as follows:

1. Chief(s) of appropriate service(s) and Vice Chief of Staff shall review the reappointment and or privileges application, credentials file, and quality assessment file and document their evaluation. When the Chief of Medicine or Surgery is being reappointed, the Vice Chief of Staff and members of the department shall review the reappointment application, credentials file and quality assessment file and document their evaluation. Evaluations will be based on performance, conduct, compliance with Medical Staff Bylaws, Rules and Regulation and Policies and Procedures and includes the **six general competencies** of the ACGME and ABMS:
    a. **Patient care** as demonstrated in findings of ongoing and/or focused quality assessment/ performance improvement activities
    b. **Medical/Clinical knowledge**
    c. **Practice based learning and improvement** (use of scientific evidence and methods to investigate, evaluate and improve patient care – continuing education)
    d. **Interpersonal and communication skills** (with patients, families, and other members of healthcare teams)
    e. **Professionalism** reflected by a commitment to continuous professional development, ethical practice and understanding and sensitivity to diversity and a responsible attitude toward patients, profession and society
    f. **Systems Based Practice** demonstrated by participation and understanding of established systems and the ability to apply this knowledge to improve and optimize health care
2. Evaluations and recommendations of the Chief of Service shall be documented and referred to the Medical Executive Committee.
3. The recommendations from the Medical Executive Committee shall be submitted to the Governing Board for final action.
4. A letter will be sent to the practitioner informing him/her of the Governing Board's decision with a copy of the approved privileges within 60 days of the Board's decision.
5. Approved privileges will be updated (manuals or electronic files) by Medical Staff Services personnel.

All Jefferson Healthcare practitioners have the right to an impartial, non-discriminatory, and confidential selection and review process. JHC monitors for and prevents discriminatory credentialing by the following:
JHC does not collect information on an applicant's race, ethnic/national identity and sexual orientation, religion, marital status or other status or characteristics protected under any applicable federal or state law. Medical Executive Committee members are required to sign an annual attestation statement assuring credentialing and re-credentialing decisions are not discriminatory or based on applicant's race, ethnic/national identity, gender, age,sexual orientation, religion, marital status or other status or characteristics protected under any applicable federal or state law.

## REFERENCES

CMS Ref S&C 05-04, Requirements for Hospital Medical Staff Privileging, CoP 482.22
RCW 70.41.230 Duty of hospital to request information on physicians granted privileges
WAC 246-320-182; NCQA CR1, A12; CR1, Element A, Factor 7

Annual review – no changes

# Telemedicine Services

## POLICY:

Jefferson Healthcare (originating site) will grant credentialing and privileging of all telemedicine providers through an agreement with the 'Medicare participating' distant site and will rely upon the credentialing and privileging decisions made by the 'Medicare participating' distant site when making recommendations for appointments/re-appointments.

The written agreement **includes but is not limited to the following conditions**:

- Distant site telemedicine entity medical staff credentialing and privileging process
- The provider is privileged at the distant site
- The provider holds license or is recognized by the state where the originating site (Jefferson Healthcare) is located
- Jefferson Healthcare has evidence of internal review of the distant site practitioner's performance of these privileges and sends the distant site performance information for use in periodic appraisals

Jefferson Healthcare Medical Staff Bylaws and Policies and Procedures for appointment, reappointment and granting of clinical privileges will be followed.

## PURPOSE:

To establish guidelines for credentialing and privileging physicians who provide telemedicine.

## DEFINITION OF TELEMEDICINE:

Licensed, independent practitioners who are responsible for patient care, treatment and services (providing official readings of images, tracings or interpretive studies) via telemedicine link.

Telemedicine sites consist of both an originating site and a distant site. An originating site is the hospital where the patient is receiving care, whereas a distant site is the 'Medicare participating' institution from which the prescribing or treating services are provided.

## REFERENCES:

CMS CoPs: §482.22 (3), § 482.22(4), §482.12(a)(1) through (a)(7) and the Medical Staff standards at § 482.22(a)(1) through (a)(2); DNV MS.17, SR.1

Annual review – minor change to reflect current scope of service:

# Reproductive Services

## POLICY:

It is the policy of Jefferson Healthcare to abide by RCW's 0.02.100 and 9.02.160 within the limitations of the resources and services offered at the organization

## PURPOSE:

To outline the process to meet the reproductive health care requirements of Washington State Department of Health.

## SCOPE:

This policy applies to all areas where reproductive health care is offered and provided at Jefferson Healthcare

## DEFINITIONS:

**RCW 9.02.100, Reproductive privacy—Public Policy:** the sovereign people hereby declare that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions.

Accordingly, it is the public policy of the state of Washington that:

1. Every individual has the fundamental right to choose or refuse birth control;
2. Every woman had the fundamental right to choose or refuse to have an abortion, except as specifically limited by RCW 9.02.100 through 9.02.170 and 9.02.900 through 9.02.902;
3. Except as specifically permitted by RCW 9.02.100 through 9.02.170 and 9.02.900 through 9.02.902, the state shall not deny or interfere with a woman's fundamental right to choose or refuse to have an abortion; and
4. The state shall not discriminate against the exercise of these rights in the regulation or provision of benefits, facilities, services or information.

**RCW 9.02.160, State-provided benefits:**

If the state provides, directly or by contract, maternity care benefits, services, or information to women through any program administered or funded in whole or in part by the state, the state shall also provide women otherwise eligible for any such program with substantially equivalent benefits, services, or information to permit them to voluntarily terminate their pregnancies.

**RCW 9.02.150, Refusing to perform:**

No person or private medical facility may be required by law or contract in any circumstances to participate in the performance of an abortion if such person or private medical facility objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the termination of a pregnancy.

## RESPONSIBILITY:

**Healthcare providers** at Jefferson Healthcare are responsible to be aware of the laws regarding reproductive healthcare.

**Leadership** at Jefferson Healthcare is responsible to be aware of laws regarding reproductive healthcare and to facilitate meeting requirements that are within the scope and resources of the organization.

## PROCEDURE:

Reproductive healthcare services offered at Jefferson Healthcare include women's health exams, low risk prenatal care and childbirth care including childbirth and lactation education, birth control including insertion of IUD's and implants**, low risk abortions and abortion care,** referrals for high risk pregnancies including high risk abortion needs, referrals for fertility management, diagnosis and treatment or referral for reproductive cancer. No person will be discriminated against and no health care within the scope of Jefferson Healthcare services will be refused based upon the choice to terminate a pregnancy.

## RECORDS REQUIRED:

Documentation of all aspects of care will be recorded in the EMR including counseling, procedure notes and any referrals generated regarding reproductive healthcare including voluntary termination of pregnancy.

## REFERENCES:

Washington State Department of Health RCW's 9.02.100 and 9.02.160
Bulletin: WSHA: Submission of Policies to the Washington State Department of Health. Date 1/29/2014

**RESOLUTION 2016-15**

A RESOLUTION TO DECLARE CERTAIN ITEMS SURPLUS TO THE NEEDS OF JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2 AND TO AUTHORIZE THE DISPOSAL OF SAID EQUIPMENT

WHEREAS the item(s) of equipment enumerated below are obsolete and otherwise surplus to the needs of the District, and
WHEREAS said equipment now creates a storage problem and represents an unnecessary cost to the District to retain it,

NOW, THEREFORE BE IT RESOLVED THAT:

1) The following equipment be declared surplus to the immediate needs of Jefferson County Public Hospital District No. 2 and will be disposed of in compliance with appropriate State laws:

| **Description** | **Asset #** | **Serial #** | **Model #** |
|---|---|---|---|
| Hill Rom Stretcher | N/A | C338AN4664 | P8000 |
| Hill Rom Stretcher | N/A | 73D000007Q | 8000 |
| Armstrong XP Warmer | 0011 | F2264 | 22 |

APPROVED THIS 6th day of July, 2016.

JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

APPROVED BY THE COMMISSION:

Commission President – Jill Buhler: _____

Commission Secretary – Marie Dressler: _____

Attest:

Commissioner – Anthony De Leo: _____

Commissioner – Kees Kolff: _____

Commissioner – Matt Ready: _____