
Regular Session Agenda
Wednesday, February 27, 2019

<u>Call to Order:</u>	2:30
<u>Education Topic:</u>	2:31
<ul style="list-style-type: none"> • Patient Advocate Report • Jefferson Healthcare Foundation Update • AHA Rural Health Care Leadership Conference Debrief 	
<u>Break:</u>	3:15
<u>Approve Agenda:</u>	3:30
<u>Team/ Employee/ Provider of the Quarter</u>	3:31
<u>Patient Story:</u> Tina Toner CNO	3:45
<u>Minutes:</u> Action Requested	3:55
<ul style="list-style-type: none"> • January 9 Special Session (pg. 2-4) • January 23 Regular Session (pg. 5-8) 	
<u>Required Approvals:</u> Action Requested	4:00
<ul style="list-style-type: none"> • January Warrants and Adjustment (pg. 9-14) • Resolution 2019-03 Cancel Warrants (pg. 15) • Medical Staff Credentials/ Appointments/ Reappointments (pg. 16) • Medical Staff Policy (pg. 17-37) 	
<u>Public Comment:</u>	4:10
<i>(In lieu of in-person comment, members of the public may provide comment on any agenda item or any other matter related to the District via a letter addressed to the Commissioners at 834 Sheridan Street, Port Townsend, Washington 98368, or via email to commissioners@jeffersonhealthcare.org.)</i>	
<u>Chief Human Resources Officer Presentation:</u> Caitlin Harrison, CHRO	4:20
<ul style="list-style-type: none"> • Resolution 2019-04 Union Contracts Ratification 	
<u>Financial Report:</u> Hilary Whittington, CAO/CFO	4:30
<u>Quality Report:</u> Brandie Manuel, Chief Pt Safety and Quality Officer	4:40
<u>Administrative Report</u> Mike Glenn, CEO	
<u>Chief Medical Officer Report:</u> Joe Mattern, MD, CMO	4:50
<u>Board Business:</u>	5:10
<u>Meeting Evaluation:</u>	5:15
<u>Executive Session:</u>	5:20
<ul style="list-style-type: none"> • To Review the Performance of a Public Employee 	
<u>Conclude:</u>	5:35
This Regular Session will be officially audio recorded. Times shown in agenda are estimates only.	

Jefferson County Public Hospital District No.2
Board of Commissioners, Special Session Minutes
Wednesday, January 9, 2019
Victor J. Dirksen Conference Room

Call to Order:

The meeting was called to order at 2:30pm by Board Chair Rienstra. Also, present were Commissioners Dressler, Kolff, McComas, and Ready, Mike Glenn, CEO, and Alyssa Rodrigues, Administrative Assistant. This meeting was officially audio recorded by Jefferson Healthcare.

Work Session:

The purpose of this special session is to elect board officers, introduce administrative committee assignments, review and discuss the Board Book, review and discuss 2019 board calendar, finalize advocacy agenda, and discuss other board business. Action may be taken.

Election of Officers

Commissioner Kolff made a motion to elect Jill Rienstra as Board Chair. Commissioner Dressler seconded.

Action: Motion passed unanimously.

Commissioner Dressler made a motion to nominate Commissioner McComas as Secretary. Ready seconded.

Discussion ensued.

Action: Motion failed 3 to 1. Commissioner Dressler in favor. Commissioners Ready, Kolff, and Rienstra abstained.

Commissioner Kolff made a motion to nominate Commissioner Dressler as Secretary. McComas seconded.

Discussion ensued.

Action: Motion passed 2 to 2. Commissioner Kolff and McComas in favor. Commissioner Ready and Rienstra abstained.

Discussion ensued.

Advocacy Agenda

Commissioners and Mike Glenn, CEO, discussed the topics to put on advocacy agenda.

Mike Glenn, CEO will work on drafting an advocacy letter for approval by the board at the January 23, 2019 meeting.

Introducing the Administrative Committee Assignments

Commissioners discussed their current administrative committee assignments.

Commissioners will review their administrative committee assignments and vote on January 23, 2019.

Discussion ensued.

Review and Discuss the Board Book

Commissioner Dressler made a motion to remove “unless excused by the Board” from 2nd paragraph page 3 of board book and to add sentence following that says, “If unable to attend please notify board chair in a timely manner”. Commissioner Kolff seconded.

Action: Motion passed unanimously.

Commissioner Kolff made a motion to add “is to foster a healthier community by 1) working to assure all residents have access to high quality healthcare services they need, 2) partnering with the community to implement the Community Health Improvement Plans, while maintaining a healthy locally controlled financially sustainable organization” to the preamble. Commissioner Ready seconded.

Discussion ensued.

Action: Motion failed 1 to 3. Commissioner Kolff in favor, Commissioners Ready, Dressler, and McComas opposed.

Discussion ensued.

Commissioner Dressler made a motion to change it to “, is to foster a healthier community, work to assure all residents have access to high quality health care services and maintain a healthy, locally controlled, financially sustainable organization.” Commissioner Ready seconded.

Commissioner Ready made an amendment to Commissioners Dressler’s motion adding in “they need”. Commissioner McComas seconded.

Discussion ensued.

Action: Motion passed 3 to 1. Commissioner Kolff, McComas, Ready in favor. Commissioner Dressler abstained.

Commissioner Dressler made a motion to change it to “, is to foster a healthier community, work to assure all residents have access to high quality health care services they need and maintain a healthy, locally controlled, financially sustainable organization.”

Commissioner Kolff made an amendment to Commissioners Dressler’s motion adding “Jefferson Healthcare, is to partner with others to foster a healthier community...”

Commissioner Kolff withdrew his motion.

Commission Dressler made an amendment to her motion rewording pre-amble to state "...work, and partner with others, to assure all residents have access to high quality health care services they need and maintain a healthy, locally controlled, financially sustainable organization"

Commissioner Kolff seconded.

Action: Motion passed unanimously.

Commissioner Rienstra called for the original motion made by Commissioner Dressler stating the preamble as, "The purpose of Jefferson County Public Hospital District no.2, dba: Jefferson Healthcare, is to foster a healthier community, work and partner with others to ensure all residents have access to high quality healthcare services they need and maintain a healthy, locally controlled, financially sustainable organization."

Action: Motion passed unanimously.

Commissioner Ready made a motion to change working "...board meetings may be recorded by the secretary or his or her designee...". Commissioner Kolff seconded.

Action: Motion passed unanimously

Commissioner recessed for break at 3:55pm

Commissioners reconvened from break at 3:59pm.

Board Calendar:

Commissioners discussed the 2019 Board Calendar.

Conclude:

Commissioner Dressler made a motion to conclude. Commission McComas seconded.

Action: Motion passed unanimously.

Meeting concluded at 4:12pm.

Approved by the Commission:

Chair of Commission: Jill Rienstra_____

Secretary of Commission: Marie Dressler_____

Jefferson County Public Hospital District No.2
Board of Commissioners, Regular Session Minutes
Wednesday, January 23, 2019
Victor J. Dirksen Conference Room

Call to Order:

The meeting was called to order at 2:30pm by Board Chair Rienstra. Present were Commissioners Dressler, Kolff, McComas, and Ready, Mike Glenn, CEO, Hilary Whittington, Chief Administrative Officer/ Chief Financial Officer, Jon French, Chief Legal Officer, Tina Toner, Chief Nursing Officer, Brandie Manuel, Chief Quality Officer, and Alyssa Rodrigues, Administrative Assistant. This meeting was officially audio recorded by Jefferson Healthcare.

Education:

- 2018 Board in Review

Commissioners evaluated the 2018 board year and discussed went well and what had room for improvement.

- Discuss WSHA/AWPHD Governance Webinar

Commissioners discussed the WSHA/AWPHD Governance Webinar and the importance of an orientation process and what they went through when each Commissioner oriented.

Commissioners discussed what a good orientation process would look like.

Commissioner McComas and Dressler were appointed to an ad hoc committee that will be charged with creating a Commissioner Onboarding packet.

Break:

Commissioners recessed for break at 2:57pm.

Commissioners reconvened from break at 3:30pm.

Approve Agenda:

Commissioner Kolff suggested moving public comment after patient story.

Commissioner Rienstra announced the cancellation of Executive Session to collect more information.

Commissioner McComas made a motion to approve the agenda and move public comment after patient story and to cancel Executive Session. Commissioner Dressler seconded.

Action: Motion passed unanimously.

Patient Story:

Tina Toner, CNO, provided the patient story regarding a patient who has Stage 3 Lung Cancer and after being told by other JH oncology patients decided to seek care at JH Oncology center. This patient felt the team was committed to meet their physical, emotional, and financial needs. Patient was soon admitted with small bowel obstruction and there was a concern of possible hidden cancer, surgery was decided and performed, and staff showed upmost care and concern and got them through a difficult time with compassion and humor. The patient felt no other hospital could compete with JH nursing staff. The patient thanked the board and administration for their recruiting efforts for specialties and the providers of direct patient care for their patient centric approach. Tina continued on to explain the oncology department and their Commissioner on Cancer Accreditation.

Public Comment:

Public comment was made.

Minutes:

- December 19 Special Session

Commissioner Dressler made a motion to approve the December 19 Special Session Minutes. Commissioner McComas seconded.

Action: Motion passed unanimously.

Required Approvals: Action Requested

- December Warrants and Adjustments
- Resolution 2019-01 Cancel Warrants
- Medical Staff Credentials/Appointments/Reappointments
- Resolution 2019-02 Washington Rural Health Collaborative Interlocal Agreement

Commissioner Dressler made a motion to approve December Warrants and Adjustments, Resolution 2019-01 Cancelled Warrants, Medical Staff Credentials/ Appointments/ Reappointments, and Resolution 2019-02 Washington Rural Health Collaborative Interlocal Agreement. Commissioner Ready seconded.

Action: Action passed unanimously.

Financial Report:

Hilary Whittington, CFO/CAO presented the December Financial Report.

Discussion ensued.

Quality Report:

Brandie Manuel, Chief Quality Officer presented the December Quality Report.

Discussion ensued.

Administrative Report

Mike Glenn, CEO, presented the December Administrative report.

Discussion ensued.

Commissioner Kolff made a motion to adopt the letter in spirit and allow Mike to make amendments and corrections to it as well as to identify 3-5 key targeted points to speak to. Commissioner Dressler seconded.

Discussion ensued.

Action: Motion passed unanimously.

Chief Medical Officer Report:

Dr. Joe Mattern, CMO, presented the Chief Medical Officer report which included updates on the ACO, MIPS, MAT, Maslach Inventory, and Telemedicine.

Discussion ensued.

Board Business:

- Adopt Board Book

Commissioner Kolff made a motion to add “to maintain” and “to work and partner” to the preamble. Commissioner McComas seconded.

Action: Motion passed unanimously.

Commissioner Ready made a motion to approve the 2019 Board Calendar.

Commissioner Dressler seconded.

Action: Motion passed unanimously.

Commissioner Kolff made a motion to adopt 2019 Committee Assignments.

Commissioner Dressler seconded.

Action: Motion passed unanimously.

Commissioner Rienstra distributed post cards that were sent to her thanking Jefferson Healthcare’s work around SANE.

Commissioner Rienstra read aloud thank you letters that will be sent to the Auxiliary and Foundation for their generous donations from the board.

Commissioner Kolff gave reports from the Board of Health meeting including drug and alcohol facts proclamation, Foundation Public Health Services resolution, Board of Health election of Ariel Speser as chair and Commissioner Kolff as vice chair.

Meeting Evaluation:

Commissioners evaluated the meeting.

Executive Session:

- To review the performance of a public employee.

Executive Session was canceled.

Conclude:

Commissioner Dressler made a motion to conclude the meeting. Commissioner McComas seconded the motion.

Action: Motion passed unanimously.

Meeting concluded at 5:22pm.

Approved by the Commission:

Chair of Commission: Jill Rienstra _____

Secretary of Commission: Marie Dressler _____

DRAFT

Gross Revenue
Inpatient Revenue
Outpatient Revenue

Total Gross Revenue

Revenue Adjustments

Cost Adjustment Medicaid
Cost Adjustment Medicare
Charity Care
Contractual Allowances Other
Administrative Adjustments
Allowance for Uncollectible Accounts

Total Revenue Adjustments

Net Patient Service Revenue

Other Revenue

340B Revenue
Other Operating Revenue

Total Operating Revenues

Operating Expenses

Salaries And Wages
Employee Benefits
Professional Fees
Purchased Services
Supplies
Insurance
Leases And Rentals
Depreciation And Amortization
Repairs And Maintenance
Utilities
Licenses And Taxes
Other

Total Operating Expenses
Operating Income (Loss)

Non Operating Revenues (Expenses)

Taxation For Maint Operations
Taxation For Debt Service
Investment Income
Interest Expense
Bond Issuance Costs
Gain or (Loss) on Disposed Asset
Contributions

Total Non Operating Revenues (Expenses)

Change in Net Position (Loss)

	January 2019 Actual	January 2019 Budget	Variance Favorable/ (Unfavorable)	%	January 2019 YTD	January 2019 Budget YTD	Variance Favorable/ (Unfavorable)	%	January 2018 YTD
Gross Revenue									
Inpatient Revenue	3,745,972	4,174,885	(428,914)	-10%	3,745,972	4,174,885	(428,914)	-10%	4,197,583
Outpatient Revenue	17,828,346	16,991,840	836,506	5%	17,828,346	16,991,840	836,506	5%	15,772,958
Total Gross Revenue	21,574,318	21,166,726	407,592	2%	21,574,318	21,166,726	407,592	2%	19,970,541
Revenue Adjustments									
Cost Adjustment Medicaid	2,130,283	2,050,705	(79,577)	-4%	2,130,283	2,050,705	(79,577)	-4%	2,446,297
Cost Adjustment Medicare	7,276,468	7,241,073	(35,395)	0%	7,276,468	7,241,073	(35,395)	0%	6,429,052
Charity Care	162,328	242,094	79,766	33%	162,328	242,094	79,766	33%	195,629
Contractual Allowances Other	1,590,518	1,577,989	(12,530)	-1%	1,590,518	1,577,989	(12,530)	-1%	1,484,036
Administrative Adjustments	131,416	94,156	(37,260)	-40%	131,416	94,156	(37,260)	-40%	46,073
Allowance for Uncollectible Accounts	337,298	274,968	(62,329)	-23%	337,298	274,968	(62,329)	-23%	217,634
Total Revenue Adjustments	11,628,310	11,480,985	(147,325)	-1%	11,628,310	11,480,985	(147,325)	-1%	10,818,720
Net Patient Service Revenue	9,946,008	9,685,740	260,268	3%	9,946,008	9,685,740	260,268	3%	9,151,821
Other Revenue									
340B Revenue	300,249	325,967	(25,719)	-8%	300,249	325,967	(25,719)	-8%	260,675
Other Operating Revenue	69,010	449,769	(380,759)	-85%	69,010	449,769	(380,759)	-85%	159,895
Total Operating Revenues	10,315,267	10,461,477	(146,210)	-1%	10,315,267	10,461,477	(146,210)	-1%	9,572,392
Operating Expenses									
Salaries And Wages	4,841,208	5,032,320	191,113	4%	4,841,208	5,032,320	191,113	4%	4,716,382
Employee Benefits	1,216,395	1,258,953	42,557	3%	1,216,395	1,258,953	42,557	3%	1,124,657
Professional Fees	389,613	353,256	(36,357)	-10%	389,613	353,256	(36,357)	-10%	469,822
Purchased Services	490,755	680,889	190,134	28%	490,755	680,889	190,134	28%	505,173
Supplies	1,710,372	1,815,992	105,619	6%	1,710,372	1,815,992	105,619	6%	1,532,293
Insurance	65,055	54,427	(10,628)	-20%	65,055	54,427	(10,628)	-20%	67,065
Leases And Rentals	146,133	159,048	12,915	8%	146,133	159,048	12,915	8%	123,349
Depreciation And Amortization	386,303	417,794	31,491	8%	386,303	417,794	31,491	8%	397,905
Repairs And Maintenance	26,495	97,708	71,213	73%	26,495	97,708	71,213	73%	48,411
Utilities	91,200	107,104	15,903	15%	91,200	107,104	15,903	15%	93,777
Licenses And Taxes	64,464	55,617	(8,847)	-16%	64,464	55,617	(8,847)	-16%	57,305
Other	145,015	206,862	61,847	30%	145,015	206,862	61,847	30%	162,864
Total Operating Expenses	9,573,009	10,239,970	666,961	7%	9,573,009	10,239,970	666,961	7%	9,299,003
Operating Income (Loss)	742,258	221,507	520,751	235%	742,258	221,507	520,751	235%	273,388
Non Operating Revenues (Expenses)									
Taxation For Maint Operations	14,820	21,530	(6,710)	-31%	14,820	21,530	(6,710)	-31%	18,770
Taxation For Debt Service	14,097	19,373	(5,276)	-27%	14,097	19,373	(5,276)	-27%	11,679
Investment Income	53,058	28,180	24,878	88%	53,058	28,180	24,878	88%	22,978
Interest Expense	(83,763)	(84,692)	929	1%	(83,763)	(84,692)	929	1%	(87,963)
Bond Issuance Costs	-	-	-	0%	-	0	-	0%	0
Gain or (Loss) on Disposed Asset	-	-	-	0%	-	0	-	0%	0
Contributions	13,836	21,997	(8,161)	-37%	13,836	21,997	(8,161)	-37%	18,020
Total Non Operating Revenues (Expenses)	12,048	6,388	5,659	-89%	12,048	6,388	5,659	-89%	(16,517)
Change in Net Position (Loss)	754,306	227,896	526,410	231%	754,306	227,896	526,410	231%	256,872

STATISTIC DESCRIPTION	JAN ACTUAL	JAN BUDGET	% VARIANCE	YTD ACTUAL	YTD BUDGET	% VARIANCE
FTEs - TOTAL (AVG)	545.16	615.68	11%	545.16	615.68	11%
FTEs - PRODUCTIVE (AVG)	447.76	553.64	19%	447.76	553.64	19%
ADJUSTED PATIENT DAYS	2,833	2,271	25%	2,833	2,271	25%
ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	88	86	2%	88	86	2%
ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	292	350	-17%	292	350	-17%
SWING IP PATIENT DAYS (MIDNIGHT CENSUS)	27	8	238%	27	8	238%
PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION	407	444	-8%	407	444	-8%
BIRTHS	10	11	-9%	10	11	-9%
SURGERY CASES (IN OR)	107	109	-2%	107	109	-2%
SURGERY MINUTES (IN OR)	20,010	21,787	-8%	20,010	21,787	-8%
SPECIAL PROCEDURE CASES	58	77	-25%	58	77	-25%
LAB BILLABLE TESTS	19,755	18,954	4%	19,755	18,954	4%
BLOOD BANK UNITS MATCHED	34	60	-43%	34	60	-43%
MRIs COMPLETED	173	169	2%	173	169	2%
CT SCANS COMPLETED	492	417	18%	492	417	18%
RADIOLOGY DIAGNOSTIC TESTS	1,545	1,500	3%	1,545	1,500	3%
ECHOs COMPLETED	124	138	-10%	124	138	-10%
ULTRASOUNDS COMPLETED	346	327	6%	346	327	6%
MAMMOGRAPHYS COMPLETED	247	249	-1%	247	249	-1%
NUCLEAR MEDICINE TESTS	36	58	-38%	36	58	-38%
TOTAL DIAGNOSTIC IMAGING TESTS	2,963	2,858	4%	2,963	2,858	4%
MEDS DISPENSED	22,754	24,983	-9%	22,754	24,983	-9%
ANTI COAG VISITS	423	549	-23%	423	549	-23%
RESPIRATORY THERAPY PROCEDURES	3,766	3,467	9%	3,766	3,467	9%
PULMONARY REHAB RVUs	229	272	-16%	229	272	-16%
PHYSICAL THERAPY RVUs	7,530	7,559	0%	7,530	7,559	0%
OCCUPATIONAL THERAPY RVUs	1,151	1,321	-13%	1,151	1,321	-13%
SPEECH THERAPY RVUs	210	220	-5%	210	220	-5%
REHAB/PT/OT/ST RVUs	9,120	9,372	-3%	9,120	9,372	-3%
ER CENSUS	1,016	1,090	-7%	1,016	1,090	-7%
EXPRESS CLINIC	747	671	11%	747	671	11%
SOCO PATIENT VISITS	153	195	-22%	153	195	-22%
PORT LUDLOW PATIENT VISITS	819	722	13%	819	722	13%
JHPC PATIENT VISITS	2,871	2,811	2%	2,871	2,811	2%
WATERSHIP CLINIC PATIENT VISITS	1,232	1,104	12%	1,232	1,104	12%
JHIM PATIENT VISITS	555	630	-12%	555	630	-12%
TOTAL RURAL HEALTH CLINIC VISITS	6,377	6,133	4%	6,377	6,133	4%
CARDIOLOGY CLINIC VISITS	299	285	5%	299	285	5%
DERMATOLOGY CLINIC VISITS	425	560	-24%	425	560	-24%
GEN SURG PATIENT VISITS	331	322	3%	331	322	3%
INFUSION CENTER VISITS	660	654	1%	660	654	1%
ONCOLOGY VISITS	392	510	-23%	392	510	-23%
ORTHO PATIENT VISITS	607	639	-5%	607	639	-5%
SLEEP CLINIC VISITS	219	197	11%	219	197	11%
SURGERY CENTER ENDOSCOPIES	75	70	7%	75	70	7%
WOMENS CLINIC VISITS	222	233	-5%	222	233	-5%
WOUND CLINIC VISITS	301	293	3%	301	293	3%
TOTAL SPECIALTY CLINIC VISITS	3,531	3,763	-6%	3,531	3,763	-6%
SLEEP CENTER SLEEP STUDIES	56	75	-25%	56	75	-25%
HOME HEALTH EPISODES	78	69	13%	78	69	13%
HOSPICE CENSUS/DAYS	833	1,153	-28%	833	1,153	-28%
DIETARY TOTAL REVENUE	74,491	95,823	-22%	74,491	95,823	-22%
MAT MGMT TOTAL ORDERS PROCESSED	2,252	2,081	8%	2,252	2,081	8%
EXERCISE FOR HEALTH PARTICIPANTS	910	866	5%	910	866	5%

**JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368**

**TO: BOARD OF COMMISSIONERS
FROM: HILARY WHITTINGTON, CAO/CFO
RE: JANUARY 2019 WARRANT SUMMARY**

The following items need to be approved at the next commission meeting:

General Fund Warrants & ACH Transfers	\$8,571,560.50	(Provided under separate cover)
Allowance for Uncollectible Accounts / Charity	\$631,041.26	(Attached)
Canceled Warrants	\$7.17	(Attached)

**JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368**

**TO: BOARD OF COMMISSIONERS
FROM: HILARY WHITTINGTON, CAO/CFO
RE: JANUARY 2019 GENERAL FUND WARRANTS & ACH
FUND TRANSFERS**

Submitted for your approval are the following warrants:

GENERAL FUND:

251709 - 252501	\$8,571,560.50
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ACH TRANSFERS

\$8,571,560.50

YEAR-TO-DATE:

\$21,621,234.62

Warrants are available for review if requested.

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: BOARD OF COMMISSIONERS
FROM: HILARY WHITTINGTON, CAO/CFO
RE: JANUARY 2019 ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS, ADMINISTRATIVE, AND CHARITY CARE WRITE OFFS

Submitted for your approval are the following:

	JANUARY	JANUARY YTD	JANUARY YTD BUDGET
Allowance for Uncollectible Accounts:	\$337,297.61	\$337,297.61	\$274,968.36
Charity Care:	\$162,327.56	\$162,327.56	\$242,093.77
Other Administrative Adjustments:	\$131,416.09	\$131,416.09	\$94,156.14
TOTAL FOR MONTH:	\$631,041.26	\$631,041.26	\$611,218.27

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: BOARD OF COMMISSIONERS
FROM: HILARY WHITTINGTON, CAO/CFO
RE: JANUARY 2019 WARRANT CANCELLATIONS

State law requires you to pass a resolution canceling any warrants which are not presented to the Treasurer for payment within one year of issue.

DATE	WARRANT	AMOUNT
1/9/2018	242616	\$ 7.17

TOTAL:	<u>\$ 7.17</u>
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JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

RESOLUTION 2019-03

A RESOLUTION CANCELING CERTAIN WARRANTS IN
THE AMOUNT OF \$7.17

WHEREAS warrants of any municipal corporation not presented within one year of their issue, or, that have been voided or replaced, shall be canceled by the passage of a resolution of the governing body;

NOW, THEREFORE BE IT RESOLVED THAT:

In order to comply with RCW 36.22.100, warrants indicated below in the total amount of \$7.17 be canceled.

Date of Issue	Warrant #	Amount
01/09/2018	242616	7.17
Total		7.17

APPROVED this 27th day of February, 2019.

APPROVED BY THE COMMISSION:

Commission Chair Jill Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Matt Ready: _____

Commissioner Kees Kolff: _____

Commissioner Bruce McComas: _____

FROM: Barbara York – Medical Staff Services
RE: 2/26/2019 Medical Executive Committee appointments/reappointments and annual policy review recommendations for Board approval 02/27/2019

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

1. Jafari, Mitra, MD – General Surgery
Dr. Jafari applied for laparoscopic bowel resection/anastomosis but has had no recent experience. Credentials Committee recommendation with approval by MEC and Board representatives: successful proctoring by qualified proctor of five (5) procedures with Dr. Jafari being the primary surgeon
2. McGlinn, Annaliisa, MD – Rad. Oncology
3. Loch, Ronald, MD – Tele-Radiology

Recommended re-appointment to the active medical staff with privileges as requested:

1. Herzberg, Alex, MD – Orthopedics

Recommended re-appointment to the courtesy medical staff with privileges as requested:

1. Barclay, James, MD – Tele-Psychiatry
2. Gleason, Timothy, MD – Diagnostic Radiology
3. Lee, Lawrence, MD – Tele-Radiology
4. Reichner, Terry, MD – Diagnostic Radiology
5. Fadlon, Iris, MD – Tele-Psychiatry

Recommended re-appointment to the allied health staff with privileges as requested:

1. Keppler, Mary, ARNP – Cardiology
2. Grace, Amy, ARNP – Express Care Clinic
3. Sverchek, Rachel, PA-C – Family Medicine Clinic
4. Speed, J. PA-C – Express Care Clinic

Medical Student Rotation: n/a

90 day provisional performance review completed successfully

1. Pavlov, Sergei, CRNA
2. Botnick, Elisha DO – Emergency Medicine

Annual review – no changes

Practitioner Re-Entry Policy

PURPOSE:

To develop a re-entry plan for such applicant depending on circumstances surrounding the provider's absence which may include among other things, a competency evaluation, a refresher course, and/or retraining in order to ensure that the individual's general and specialty skills are up to date.

SCOPE:

Medical Doctors, Osteopathic Doctors, Advanced Registered Nurse Practitioners, Physician Assistants, Dentists, Doctors of Podiatry out of practice for 24 months or more.

DEFINITION:

Physician reentry is a return to clinical practice in the discipline in which one has been previously trained or certified, following an extended period of clinical inactivity not resulting from discipline or impairment. A practitioner returning to clinical practice in an area or scope of practice in which he or she has not been previously trained or certified or in which he or she has not had an extensive work history is NOT considered a reentry practitioner for the purpose of this policy.

PROCEDURE:

If reentry program calls for a practitioner to use a practice mentor upon return to practice, the mentor will be certified by a member board of the American Board of Medical Specialties or American Osteopathic Association and practice in the same clinical area as the returning practitioner. The mentor shall have the capacity to serve as a practice mentor, have no disciplinary history, an active and unrestricted license.

REFERENCES:

AAFP, RCW Chapter 18.71 and RCW 18.130.050(14), AMA

Jefferson Healthcare
NEW TECHNOLOGY/PROCEDURE BRIEFING

Practitioner Name: _____

Date

NAME OF NEW TECHNOLOGY/PROCEDURE:

**IS THIS A NEW/SERVICE OR AN EXTENSION OF AN EXISTING PRIVILEGE USING A NEW
DEVICE AND/OR TECHNIQUE?**

NAME (3) HOSPITALS WHERE TECHNOLOGY/PROCEDURE IS UTILIZED:

IS THIS PROCEDURE COVERED BY INSURANCE: _____

RISH AND BENEFITS OF THE NEW TECHNOLOGY/PROCEDURE:

FINANCIAL ANALYSIS OF NEW TECHNOLOGY/PROCEDURE

(must include operating revenues, expenses, capital equipment and contribution margin):

ANESTHESIA OR OTHER SPECIALTY CONCERNS:

CLINIAL INDICATORS FOR PEER REVIEW:

Please submit the following materials including this form:

- Copies of research/literature concerning the proposed technology/procedure
- Course materials
- Product literature or educational syllabus addressing the new technology/procedure
- FDA approval letter (if applicable)

Annual review – no changes

Onboarding for clerkship of Medical Students, PA Students and Nurse Practitioner Students

POLICY:

Processing of clerkship of Medical Students, Physician Assistant Students and Nurse Practitioner Students at Jefferson Healthcare

PURPOSE:

Ensure that all required documents are present and employee health requirements have been met before students start clerkship

RESPONSIBILITY:

The administrative assistant or practice manager for the area in which student is training will ensure that all documents are in place (currently ACU/ICU and JHC Primary Care Clinic)

PROCEDURE:

Once administrative assistant/practice manager is notified of the students' schedule, he/she will email student all required documents for signature and return.

Admin assistant/practice manager will create an email via "credentialing" distribution list and cc the Helpdesk with the following information: Name of student, time period she/he will be at Jefferson and Department or Clinic.

Admin assist/practice manager will enter student information into the New User Tracking Tool

Admin assist/practice manager will schedule appointment/communicate with Employee Health nurse and notify applicant

Supporting Documents required:

- A. Immunization Record from educational institution
- B. WA State Patrol Background Check Authorization
- C. Scope of Practice acknowledgement
- D. Disclosure of Conviction
- E. Computer Use Agreement
- F. Code of Conduct Regulatory Compliance acknowledgement
- G. Behavioral Code of Conduct
- H. Access and Confidentiality Agreement
- I. EPIC Access Request Form
- J. Infection Control Policy
- K. Dress Code Policy
- L. Code Silver Policy

Annual review – no changes

Physician Supervision of Physician Assistants

POLICY:

A physician assistant (PA) may practice medicine at Jefferson Healthcare with active medical staff privileges and completion of the delegation agreement by the Washington State Medical Commission (MQAC) to the extent permitted by the Commission.

PURPOSE:

To define the process for supervision of physician assistants.

SCOPE:

The policy applies to all PAs appointed to the active medical staff at Jefferson Healthcare. This includes the inpatient setting, emergency department, specialty clinics, and rural health clinics.

DEFINITIONS:

Physician Assistants means a person who is licensed by the commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services.

Advanced Registered Nurse Practitioners (ARNPs) are independent in their scope of practice including full prescriptive authority. No collaborative agreements are required. Three major subgroups are included in the ARNP title: Nurse Practitioners (NP), Certified Nurse Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA).

Certified Registered Nurse Anesthetists (CRNA) may render care in accordance with federal and state laws within their scope of practice without physician supervision and are deemed exempt from this policy.

Medical Quality Assurance Commission (MQAC) division of the Washington State Department of Health, responsible for the protection of the public by assuring quality health care is provided by physicians and physician assistants.

Remote Site: a setting physically separate from the sponsoring or supervising physician's primary place for meeting patients or a setting where the physician is present less than 25% of the practice time of the licensee.

RESPONSIBILITY:

It is the responsibility of the PA to provide the required information to the Credentials Committee and comply with all medical staff policies and procedures.

The Medical Executive Committee provides oversight of the quality of medical staff services and makes recommendations regarding credentialing and privileging to the Board of Commissioners.

All credentials and privileges of AHPs are reviewed and approved by the Board of Commissioners per the [Medical Staff Reappointments and Renewal of Clinical Privileges Policy](#) and the [Medical Staff Initial Appointment Policy](#).

PROCEDURE:

Application and Approval of PA Privileges

- A. The PA shall apply for appointment and privileges through the Jefferson Healthcare Medical Staff office.
 - 1. The application shall include information regarding education, training, experience, and competency
- B. The appointment, reappointment, delineation of privileges and approval process shall be completed in accordance with Medical Staff Policies as documented above
- C. PAs must be approved by the Governing Board upon recommendation of the Credentials Committee and the Medical Executive Committee

Sponsor and Supervision Requirements

- A. Every PA is required to have an approved delegation agreement with MQAC.
 - 1. The delegation agreement shall delineate the manner and extent to which the PA will practice and be supervised.
 - a. The delegation must specify the detailed description of the scope of practice and the supervision process for the practice
 - b. The sponsoring physician and the PA shall determine which services are provided and the degree of supervision
- B. PAs are required to be sponsored by a physician who is currently appointed to the active medical staff of Jefferson Healthcare.
 - 1. If the sponsoring physician terminates his or her relationship with Jefferson Healthcare, the PA must arrange for a new sponsor prior to the separation of the original sponsor
 - 2. A PA who practices in multiple specialties may need more than one delegation agreement, according to state and federal law and based upon the PAs training and scope of practice
- C. Supervision may consist of concurrent observation; however, it does not *require* the physical presence of the sponsor unless indicated on the privilege list
- D. The sponsoring physician or designee shall review care provided by the PA on a continuous basis and countersign any admission History & Physical (H & P) examinations and Discharge Summary
- E. In accordance with state and federal laws and regulations, for the first year of the PA's practice at Jefferson Healthcare, the sponsoring physician or designee shall review 10 outpatient records per month *for the first year*, then five records per month after.
 - 1. Additional review is not required when the care is provided in collaboration with a physician

Remote Sites

- A. PAs may not be utilized in a remote site without documentation of approval from the MQAC
- B. Exceptions must be approved by the MQAC based upon demonstration of need for such use
 - 1. There must be an adequate provision for the timely communication between the PA and the supervising physician
 - 2. The supervising physician must spend at least 10% of his or her practice time of the PA in the remote site
 - 3. The names of the supervising physician and the PA must be prominently displayed at the entrance to the clinic or in the reception area of the remote site

RECORDS REQUIRED:

Medical records will be reviewed by the sponsoring physician or designee and documentation of their review will be maintained by the office manager.

Reports are provided to the medical staff office at reappointment or as requested by Medical Staff.

REFERENCES:

- CMS Benefit Policy Manual Chapter 13, Rural Health Clinics (RHC)
 - RHC Staffing requirements 30.1.1
- CMS CAH Conditions of Participation: §485.631(b)(1)
- Washington State Legislature RCWs, Chapter 18.71A, Physician's Assistants
- Washington State Legislature WACs; Physician Assistants - Medical Quality Assurance Commission

Autopsy Criteria Policy

I. Purpose/Expected Outcome:

- A. Attempt to identify cause of death in certain circumstances.

II. Definitions:

- A. N/A

III. Policy:

- A. Medical Staff shall attempt to secure autopsies in all deaths meeting criteria.
- B. Jefferson Healthcare does not have the facilities to conduct autopsies on site. Any autopsies will be done at an off-site facility after making arrangements with the attending physician and the Northwest Pathology pathologist on call.

IV. Procedure/Interventions:

A. Financial Responsibility and Consent:

- 1. If the Coroner requests the autopsy, it will be performed by the county agent (Deputy Coroner at Kosec's funeral home), and the county will have financial responsibility.
- 2. If provider requests autopsy arrangements will be made with the NW pathology to conduct the autopsy and consent in accordance with hierarchy of consent shall be obtained by appropriate person. Financial responsibility will be with patient's estate. Reference: Informed Consent policy

B. Criteria:

- 1. All deaths will be evaluated for autopsy by the patient's attending provider including but not limited to the following:
 - i. Death in which an autopsy may explain unknown or unanticipated medical complications.
 - ii. Deaths in which the cause is sufficiently obscure on clinical grounds as to delay completion of the death certificate.
 - iii. Deaths in which an autopsy would allay concerns of the public/family regarding death to provide reassurance to them regarding the same, if not subject to forensic medical jurisdiction.
 - iv. Deaths of patients who participated in clinical trials at Jefferson Healthcare or other institution.
 - v. Intra-operative or intra-procedural death.

- vi. Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
- vii. Death incident to pregnancy.
- viii. Death in infants/children with congenital malformations.
- ix. Unexplained, unexpected deaths.

2. Coroner will be notified by Jefferson Healthcare in accordance with RCW 68.50 of the following cases:

- i. All deceased persons who come to their death suddenly when in apparent good health without medical attendance within the 36 hours preceding death.
- ii. Circumstances of death indicate death was caused by unnatural or unlawful means.
- iii. Death occurs under suspicious circumstances.
- iv. Death results from unknown or obscure causes.
- v. Death occurs within one year following an accident.
- vi. Death is caused by any violence whatsoever.
- vii. Death results from a known or suspected abortion, whether self-induced or otherwise.
- viii. Death results from drowning, hanging, burns, electrocution, gunshot wounds, stabs or cuts, lightning, starvation, radiation, exposure, alcoholism, narcotics or other addictions, tetanus, strangulation, suffocation, or smothering.
- ix. Death due to premature birth or still birth.
- x. Death due to a violent contagious disease or suspected contagious disease which may be a public health hazard.
- xi. Death results from alleged rape, carnal knowledge or sodomy.

A preliminary autopsy report will be available to the managing physician within two (2) days of autopsy. The final autopsy report will be completed within thirty (30) days unless special studies are required. A review summary of each autopsy will be presented at appropriate medical staff committee (Acute Care, Surgical, ED, or OB) and forwarded to the Medical Executive Committee.

The managing physician may inform the family of autopsy results.

REFERENCES:

DNV Standards MS19, S.R.1-3
RCW 68.50

Practitioner Proctoring Policy

POLICY:

Proctoring is an objective evaluation of a provider's competence by a proctor who represents and is responsible to the Jefferson Healthcare Medical Staff. Proctoring is a way to assess current competence in performing the clinical privileges granted and provides assessment of the practitioner's clinical judgment, skills and technique. In the absence of a qualified proctor within Jefferson Healthcare, the Medical Executive Committee will modify the proctoring protocol accordingly; examples include but are not limited to hiring an outside proctor or sending a provider to an outside source for proctoring.

PURPOSE:

Proctoring may involve direct observation (or retrospective review) by a practitioners who is experienced in the area of expertise or procedures being performed by another practitioner

SCOPE:

Except as otherwise determined by the Medical Executive Committee, proctoring may apply to the following:

New practitioners appointed to the Medical Staff in the event of specific privileging criteria not being met to the satisfaction of the Department Chair (privileges are considered based on documented education, training and/or experience, specialized training certification, references and other relevant information).

Providers on the Medical Staff who are requesting additional privileges or privileges involving new technology

Providers who are returning from extended leave of absence (as per Medical Staff Bylaws)

Providers requesting renewal of privileges performed so infrequently that assessment of current competence is not feasible

Any practitioner for whom the Medical Executive Committee determines a need a need for specific monitoring or assessment of current competence

RESPONSIBILITY:

The proctor must be a member in good standing (board certified or eligible, no clinical concerns, not under disciplinary action or on initial 90 days standard review) or be an outside delegated provider approved by Medical Executive Committee and must have unrestricted privileges to perform the procedure that is to be proctored.

The proctor's primary responsibility is to evaluate performance, however, if the proctor reasonably believes that intervention is warranted to prevent harm to the patient, he/she has the ability to intervene and take whatever action is reasonably necessary to protect the patient. The intervention shall be reported to the Department Chair.

The proctor will review the results of the proctoring with the physician.

The proctoring report will not be attached to the patient's medical record to assure confidentiality of the proctoring report.

The proctor shall ensure that the evaluation report is completed and sent to the Medical Staff Office within 24 hours of the completion of the proctored procedure(s).

The proctored practitioner must inform the patient that a proctor will be present during the procedure, may examine the patient and may participate in the procedure.

Duties:

The Medical Staff office will notify patient care areas as deemed appropriate (i.e. Surgery Department, ACU/ICU) of the names and privileges of those providers under proctoring requirements and when the requirement has been completed.

Medical Staff Office will notify MEC when the proctoring period has been completed.

Medical Staff Office will secure and confidentially store the evaluations for each case in the practitioners Quality File.

Disclosure of Unanticipated Events and Outcomes

STATEMENT OF PURPOSE:

1. To clarify the role of various disciplines in disclosing information about unanticipated events and outcomes to patients and families in a manner that is supportive, helpful, and informative.
2. To provide a framework for interdisciplinary collaboration and communication for disclosure of unanticipated outcomes or events that cross disciplines to provide optimal care for the patient and family in the aftermath.
3. To comply with Washington State Statutes WAC 246-320-245, Patient Rights and organizational ethics; RCW 70.41.380, Notice of Unanticipated Outcomes; professional associations (American Medical Association's Code of Ethics; the American College of Physicians) and Medical Board Rules & Regulations.

RESPONSIBLE PERSONS:

All Jefferson Healthcare medical staff, employees, and agents who disclose unanticipated outcomes to patients or their surrogate decision makers are responsible and accountable to this policy.

POLICY STATEMENT:

In alignment with Jefferson Healthcare's mission, vision, values and philosophy of patient-centered care patients or their surrogate decision-maker(s) are properly informed about their health care. We believe that open and truthful communication is an integral part of patient centered care delivery. Identified unanticipated outcomes shall be fully disclosed to the patient or surrogate(s) decision makers in accordance with this policy.

This policy addresses the unanticipated outcomes that may have been initiated by the health care process rather than a negative outcome caused by the disease or illness.

SUPPORTIVE DATA:

1. Disclosure of adverse events is associated with decreased patient/family anxiety, ability to provide informed consent for follow up tests or treatments associated with the adverse event, and promotes ongoing cooperation from the patient and family (ASHRM, 2001; Wu, 1997).
2. The risk of litigation doubles, there is a loss of patient/family trust and the statute of limitations could be extended with non-disclosure of adverse incidents that result in patient harm. (ASHRM, 2001)
3. The AMA and the ACP supports physician disclosure to patients about procedural or judgment errors. The ACP further states that errors do not necessarily constitute improper, negligent or unethical behavior, but failure to disclose them may.
4. Washington statute (RCW 70.41.380), "Hospitals shall have in place policies to assure that, when appropriate, information about unanticipated outcomes is provided to patients or their families or any surrogate decision makers identified pursuant to RCW 7.70.065.

Notifications of unanticipated outcomes under this section do not constitute an acknowledgment or admission of liability, nor can the fact of notification, the content disclosed, or any and all statements, affirmations, gestures, or conduct expressing apology be introduced as evidence in a civil action.

5. Healthcare providers involved with non-disclosure of adverse events associated with errors are reported to have anxiety after the event, loss of confidence, depression and unresolved guilt. Those who participate in disclosure of adverse events associated with errors also are reported to make better adjustments after an error, are in an improved position for litigation and are more apt to make constructive changes to practice that will reduce the risk of future errors (Meurier, 1997; Wu, 1991).
6. Patients and families expect healthcare providers to accept responsibility for their errors, provide simple, honest explanations and apologize for the fact that there was an unanticipated outcome.

DEFINITIONS:

Severity Categorizations :

- A. An unanticipated event is defined as any event that is intercepted prior to completion or actual harm, which is not part of the plan.
- B. An unanticipated outcome is defined as a result that significantly differs from what was anticipated as a result of treatment or procedures. **Unanticipated outcomes may or may not be associated with errors.**
- C. Unanticipated Events or Outcomes are divided into severity categories and are standardized in context with our occurrence reporting severity scale:

Category A and B are **near miss or close call unanticipated events and do not require disclosure**. Examples include but are not limited to the following events:

1. The wrong medication is found in the patient's medication cassette and is returned to the pharmacy without being administered.
2. A prescriber enters an order on the wrong patient's medical record and this is discovered prior to the order being carried out.

Category C is an **unanticipated outcome that reached the patient, but did not cause patient harm**. Intervention to preclude harm, or, extra monitoring was not required. Examples are as follows:

1. A patient falls and sustains no apparent injury; it is determined that there is no need for x-ray.
2. A patient sustains a small ecchymosis at the neck after an unsuccessful attempt at line insertion.
3. Patient received 25 mg Lisinopril instead of the ordered 15 mg. Patient had no adverse effect from increased medication dosage.

Category D is an **unanticipated outcome that reached the patient but did not cause patient harm. However, intervention to preclude harm or extra monitoring was required, but initial or prolonged hospitalization was not required.** Examples are as follows:

1. A patient who receives an overdose of insulin with decrease in glucose level that requires a bolus of dextrose with continuous IV glucose infusion and frequent glucose monitoring.
2. Patient develops Red man's syndrome after dose of vancomycin.

Category E through F is an **unanticipated outcomes that reached the patient and have resulted in temporary harm and required intervention, treatment or prolonged hospitalization .**

1. Patient develops shortness of breath after IV contrast administered for CT scan.
- a. **Category G through H** is an **unanticipated outcome that may have contributed to or resulted in permanent harm. This outcome may also require intervention necessary to sustain life.** Examples are as follows:
 1. Scheduled colonoscopy results in perforation.
 2. Patient falls on hospital premises and fractures hip.

Category I is an **unanticipated outcome that contributed to or resulted in patient death.**

1. IV bolus given to patient with pulmonary edema and patient expires.
2. Patient falls off scale, hits head on floor and expires.

PROCEDURE:

I. PROVIDER ACCOUNTABILITIES :

The physician, physician's assistant or licensed independent provider is responsible for the following activity:

1. The Primary or Covering Attending is ultimately responsible for disclosing unanticipated outcomes. Consultation with Risk Management is advised prior to meeting with patient and/or family members.
2. Procedural specialists (e.g. Orthopedics, Urology, Obstetrics and Gynecology, General Surgeons, Oncology, Anesthetists and Radiologists, etc.) are responsible for disclosing unanticipated outcomes that may occur during the course of the procedural/interventional phase of care to the patient/surrogate and the primary or covering attending. The Procedural/Consultative Physician is responsible for documenting the disclosure and the name of the attending notified.
3. Discussing the unanticipated outcome inclusive of the follow-up plan and treatment as indicated with the patient taking into consideration the patient's medical status and ability to understand the information.
4. Involving the patient as appropriate about what information is to be given to the family.

5. If it is determined that the family is to be notified the designated professional is responsible for contacting the family via phone in as timely a manner as possible or meeting with the family in person if the family is on the premises.
6. The Primary Attending is responsible for documenting the disclosure of unanticipated outcomes or reviewing notes documenting unanticipated outcomes by other attending and cosigning notes when disclosure of unanticipated outcomes is delegated to nurse practitioners or physician's assistants. Documentation includes the individuals present, the information provided to the patient, family member(s) notified by phone, and response to the disclosure.
7. Covering attending and procedural specialists are responsible for communicating to the primary attending the disclosure of an unanticipated outcome and the interventions or treatment provided.
8. The primary attending or designee is available to the patient and the family for follow up if questions later arise or to reinforce information that may not be understood during the initial disclosure (e.g. for patients post procedure who are still under the influence of sedatives or anesthesia).
9. If the physician is uncertain regarding the event and/or the obligation to disclose or finds it difficult (is unable) to disclose the event to the patient, the physician should discuss the event with the Medical Staff Section Chief of that area in consultation with Risk Management. The Medical Staff Section Chief and the Risk Manager will have responsibility to ensure disclosure of information regarding an unanticipated outcome if the physician cannot or does not inform the patient in a timely manner. If the matter is not resolved at the Medical Staff Section Chief level, Risk Management will consult with the Chief Medical Officer (CMO).

II . NURSING ACCOUNTABILITIES:

The registered nurse is responsible for:

1. Notifying the provider and/or hospitalist of an unanticipated outcome.
2. Documenting unanticipated events and outcomes in the online occurrence reporting tool and/or notifying Risk Management at extension 2010.
3. Collaborating with the medical team to develop a plan for notifying the patient and/or family of an unanticipated outcome and seeking assistance from the hospitalist and/or attending if the family exhibits signs of distress that may require further explanation or support.
4. Providing teaching and explanations about rationales for procedures or diagnostic tests that are being performed as a result of an unanticipated outcome.
5. Contacting the patient advocate and/or the social worker to provide ongoing support as necessary.
6. For those unanticipated outcomes associated with a nursing error, the nurse is responsible for collaborating with the House Supervisor and the provider to be present during disclosure of the incident. If the nurse involved expresses concern or is unable to disclose the event, or investigation determines that the nurse's involvement could exacerbate the problem, the House Supervisor and the medical team determine the appropriate person to handle the

responsibility of disclosure. Risk management and Chief Nurse Officer may be consulted for assistance.

7. Documenting in the medical record the individuals present for the disclosure, the information provided to the patient, the family member(s) notified and response to the disclosure for unanticipated outcomes.

III. COLLABORATIVE ACCOUNTABILITIES:

Both disciplines are responsible for the following activities:

1. Taking prompt action to mitigate the negative effects of the outcome upon discovery.
2. Providing disclosure in a manner that provides support and information to patients, or surrogate(s) to ensure ongoing understanding of care delivery.
3. Apologizing for the outcome without acknowledging fault or criticizing other care providers, expressing compassion, and offering comfort to the patient and/or family with disclosure of the incident.
4. Using non-medical terminology that is easily understood by the patient and/or family.
5. Employing a translator and/or interpreter as necessary to maximize understanding.
Language Line 1-866-874-3972 Client Password 243656
6. Documenting information provided and patient/family response to disclosure of the unanticipated outcome and events in the medical record.
7. Notifying Risk Management of all unanticipated outcomes by using either the online occurrence reporting tool on the Jefferson Healthcare Intranet or contacting Risk Management at extension 2010.
8. Risk Management will notify liability carrier of adverse outcome and initiate adjustment of patient's bill as appropriate.
9. Peer Review and/or Root Cause Analysis will be initiated by Risk Management as appropriate.

IV. DISCLOSURE CONVERSATION PROCESS:

Effective disclosers are sensitive. They consider the readiness and ability of the recipient to learn what happened. Information is provided clearly with non-verbal techniques conveying openness and sincerity. The diversity of the facility's community is acknowledged and accommodated. The special conditions and psychological implications of unanticipated outcomes within specific patient populations and settings are understood.

Disclosure Skill: Preparation:

Preparation for a disclosure discussion is critical. Circumstances may dictate when and where the communication occurs, so the better prepared the disclosure communicator is, the better chance he/she has of not being caught off guard and making statements that are later found to be erroneous or needlessly inciting. Risk Management consultation during the preparation period of disclosure is recommended.

- Review the facts:

- What do we know as fact (about the event) at this point? D What do we know about any abnormalities following or resulting from treatment? D What do we know about causation factors? D When will we know more? Is there a pending Case Review or Root Cause Analysis?
- Identify and involve the appropriate participants:
- The attending physician. He/she has the relationship with the patient/family and can explain medical outcomes and next steps.
- Never more than two organizational representatives. More than two can be overwhelming to the patient/family. Whoever accompanies the physician should be someone with excellent interpersonal communication skills.
- Almost never the risk manager at the initial meeting. An exception could be made if the risk manager is the most skilled and effective communicator and is very clear about their role with the patient/family during the meeting. This first encounter is a patient/family caregiver conversation about something that has occurred during the process of care, not a discussion about money. At second or subsequent meetings, the presence of the risk manager for the purpose of conflict resolution and possible early intervention would be appropriate and effective.
- Select an appropriate setting -somewhere private and comfortable and free from interruptions.

Disclosure Skill: Verbal initiation of conversation :

- The skill of approaching a sensitive conversation is complex. An effective beginning sets the tone for delivering the difficult information.
- Ensure that participants from the organization are aware of and sensitive to HIP AA Privacy Rule concerns and desires of the patient.
- Discern patient/family readiness and ability to participate. Is the patient conscious or medicated? Is the family tired or so distraught they are unable to process information?
- Assess the patient/family's medical literacy and ability to understand:
 - Confirm the patient/family's understanding of the course of treatment to date and expected outcomes. This will dictate how to introduce the topic.
 - Be sensitive to fact that their beliefs may be contrary to what is considered common medical knowledge.
 - Look for evidence of denial regarding the pre-event condition.
- Determine the patient/family's level of medical understanding in general.
 - Realize that even highly educated people may have medically naive beliefs.
 - Be prepared to gently address questions that appear unrelated to the patient's condition or treatment.
 - Remember that many patients/families can iterate medical terms they have heard on television but do not understand.
 - Use simple, jargon-free language.

Heart of the discussion: Presenting the Facts

If each of these core elements is not covered, it is not possible to say that adequate disclosure has occurred.

- After the patient/family's level of understanding of the medical care and expected outcomes has been established, begin by covering the fact pattern. Simply describe what happened. 33

- Describe what is known about the outcome of the event at this point. Acknowledge that there will be additional conversations when more is known.
- Describe the next steps to be taken.
 - For treatment of the patient.
 - What the organization is doing to find out how the event occurred. Patients do not want their experience to be repeated. Often the question asked is "What is the organization doing to find out how the event occurred and prevent it from happening again?"(4)
- Sincerely acknowledge the patient/family's suffering. A well-crafted expression of empathy can both provide the acknowledgment of suffering and the opportunity for both parties to heal.

Here are some examples of acknowledging the patient's suffering:

- In the event of a known but unusual complication of a procedure: *"As we discussed in the consent, this is a possible complication of the procedure. I feel so badly that you have experienced it."*
- In the case of a medical error ("failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim") (5): *" I am so sad that this has happened. You must be terribly upset, and so am I."*
- After an unanticipated outcome ("any result that differs significantly from what was intended to be the result of a treatment or procedure") (6): *"This is sad and not what any of us expected. I wish it weren't this way and I know you do, too."*

In an effective acknowledgement of suffering, there should be:

- Sincerity and openness.
- Acknowledgement and expression of sadness and pain the patient/ family is having -- not about any caregiver's relationship to the event. If a direct correlation is found between the caregivers' actions and the patient/family's suffering, an investigation could be opened. Then the organization can go back to the patient/family. Assume responsibility and report actions taken to remedy the situation.
- Separation of our human feelings of concern for the human experience from concerns about ourselves. This is a defining moment in the discussion that will determine whether the patient/family believes their caregiver has their best interest at heart.

Disclosure Skill: Concluding the conversation

- Summarize the fact portion of the discussion.
- Repeat key questions raised by the patient/family.
- Establish a follow-up.
- Ensure the patient/family knows from whom they will hear next. Are there unanswered questions about compensation, bills or autopsy results? Is the family services department going to contact the family to set up services in the home? Is a risk management representative going to contact them with the result of investigations? Ensure that the involved parties from the organization know about the promise and live up to it. Patient/family trust in the system is already broken. It could be severed by broken promises at this point.

- Any action the patient/family needs to take should be addressed. *"We need you to call back tomorrow for the results of the test. If I am not available when you call you should..."*
- Offer to be available for future questions. Give them your business card. Disclosers should make themselves available for future questions. If that is not possible, the person who will be available to answer questions should be identified to them with a telephone number.
- Offer the support of other resources: spiritual services, family services, financial services, a place to stay, food to eat, etc.

Disclosure Skill: Documentation

As part of the disclosure process, consideration must be given to what entries, if any, will be made in the medical record. (Any documentation of disclosure should be carefully thought out before its entry, since it will become evidence.) Properly managed, a chart entry will record an objective reflection of what occurred during the disclosure process. Improperly managed, a chart entry could create an impression that the patient and family were not fully informed and that may effect the statute of limitations. Statute of limitations in Washington State is 3 years for an adult from the time that the patient was aware of the event. Statute of limitation for children is when they reach 21 years of age.

- Describe the event. Documentation should be factual -- not an emotional catharsis for the caregiver. Only known facts of the event should be included. Opinions that a particular event caused a specific result do not belong in this record.
- Describe any discussion. If there is a discussion, it should be documented factually, including the list of participants, time and date of the discussion, known facts presented (should be identical and complete as documented in the chart), without opinions and suppositions and by whom, and next steps discussed (e.g. *"Dr. Smith told the family that Mrs. Jones would be in ICU and would be monitored carefully."*)

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Jefferson County Public Hospital District No. 2

RESOLUTION 2019-04

A Resolution of the Jefferson County Public Hospital District No. 2 Board of Commissioners approving two collective bargaining agreements with the United Food & Commercial Workers Local 21 (“UFCW 21”)

WHEREAS, the Public Hospital District has been in negotiations with UFCW 21 in an attempt to arrive at satisfactory contracts for three separate bargaining units of Public Hospital District employees: registered nurses, professional technical/service workers, and certain clinic employees; and

WHEREAS, the Public Hospital District and UFCW 21 have reached tentative agreement on contracts for registered nurses and a combined unit of professional technical/service/clinic employees, and bargaining unit members have ratified their respective contracts.

NOW THEREFORE, BE IT RESOLVED by the Jefferson County Public Hospital District No. 2 Board of Commissioners that it hereby approves the tentative agreements; and

BE IT RESOLVED that the Chief Executive Officer is authorized to take all necessary administrative actions to implement this resolution, and is authorized to execute the final contracts with UFCW 21.

ADOPTED and APPROVED by the Board of Commissioners of Jefferson County Public Hospital District No. 2 at an open public meeting thereof this 27th day of February 2019, the following Commissioners being present and voting in favor of the resolution.

Commission Chair Jill Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Matt Ready: _____

Commissioner Kees Kolff: _____

Commissioner Bruce McComas: _____