Call to Order:
The meeting was called to order at 2:29pm by Board Chair Buhler Rienstra. Present were Commissioners Kolff, McComas and Ready. Also, in attendance were Mike Glenn, CEO, Hilary Whittington, Chief Administrative Officer/Chief Financial Officer, Jon French, Chief Legal Officer, Tina Toner, Chief Nursing Officer, Brandie Manuel, Chief Patient Safety and Quality Officer, Jenn Wharton, Chief Ambulatory and Medical Group Officer, Dr. Joe Mattern, Chief Medical Officer, Caitlin Harrison, Chief Human Resources Officer, and Alyssa Rodrigues, Administrative Assistant were also in attendance. This meeting was officially audio recorded by Jefferson Healthcare. Commissioner Dressler was excused.

Education:
Dr. Steve Butterfield, Chief Medical Officer, Medical Group and Jenn Wharton, Chief Ambulatory and Medical Group Officer presented the Jefferson Healthcare Medical Group update.

Discussion ensued.

Break:
Commissioners recessed for break at 3:18pm.

Commissioners reconvened from break at 3:30pm.

Approve Agenda:
Commissioner McComas made a motion to approve the agenda with the removal of Medical Staff Policy in the Required Approvals. Commissioner Ready seconded.

Action: Motion passed unanimously.

Patient Story:
Tina Toner, CNO, provided the patient story regarding a patient who had chronic respiratory problems and obstructive sleep apnea. The patient reported to the hospital with influenza resulting in acute and chronic respiratory failure. Providers, RNs, and Respiratory Therapists tried to convince the patient to wear a device called a biPAP machine to avoid having to be intubated and put on a breathing machine, the patient refused. The next morning an RT was able to convince the patient to wear the machine by promising the patient she wouldn’t leave the room; she would hold it up to her face and not put the straps around her head. The RT held the mask for up to 60 minutes. The patient grew comfortable with the machine and the therapist and eventually agreed to wear it independently. The patient wore the mask independently the whole next day and did not have to be intubated. Tina Toner, CNO, described the teamwork between all parties and continued to explain the importance of the Respiratory Therapy department.
Minutes:
• March 19 Special Session
• March 27 Regular Session
Commissioner Kolff made a motion to approve the March 19 Special Session Minutes and March 27 Regular Session Minutes. Commissioner McComas seconded.
Action: Motion passed unanimously.

Required Approvals: Action Requested
• March Warrants and Adjustments
• Resolution 2019-06 Cancelled Warrants
• Medical Staff Credentials/Appointments/Reappointments
Commissioner Kolff made a motion to approve March Warrants and Adjustments, Resolution 2019-06 Cancelled Warrants, Medical Staff Credentials/ Appointments/ Reappointments. Commissioner Ready seconded.
Action: Motion passed unanimously.

Report on Exercise for Health:
Mitzi Hazard, Director of Wellness and Rehab, provided a report on Exercise for Health.
Discussion ensued.

Report on Washington State Collection Practices:
Discussion ensued around Washington State and Jefferson Healthcare Collections Practices.

Public Comment:
Public comment was made.

Patient Advocate Report: Jackie Levin, Patient Advocate
Jackie Levin, Patient Advocate, presented the 1st quarter Patient Advocate Report.
Discussion ensued.

Financial Report:
Discussion ensued.

Quality Report:
Brandie Manuel, Chief Patient Safety and Quality Officer, presented the Critical Access Hospital Report.
Discussion ensued.
Commissioner Kolff made a motion to approve the 2018 Critical Access Hospital Report. Commissioner McComas seconded. 
**Action:** Motion passed unanimously.

**Administrative Report**
Mike Glenn, CEO, presented the Administrative report.

Discussion ensued.

Commissioner Ready made a motion to approve the new Mission Statement. Commissioner McComas seconded.

**Action:** Motion passed unanimously.

**Chief Medical Officer Report:**
Dr. Joseph Mattern, CMO, reported on the Chief Medical Report which included potentially presenting more topics to the board, epic upgrade, and Exercise for Health.

**Board Business:**
Commissioner Kolff acknowledged a letter that was written to the board and requested an update from Dr. Mattern to report on the MAT program.

Commissioner Kolff asked if it was possible to set up a transition from Exercise for Health.

Discussion ensued.

**Meeting Evaluation:**
Commissioners evaluated the meeting.

**Conclude:**
Commissioner McComas made a motion to conclude the meeting. Commissioner Kolff seconded.

**Action:** Motion passed unanimously.

Meeting concluded at 5:40pm.

Approved by the Commission:

Chair of Commission: Jill Rienstra_______________________________________

Secretary of Commission: Marie Dressler _______________________________
Jefferson Healthcare
Medical Group

Dr. Steve Butterfield, Chief Medical Officer, Medical Group
Jenn Wharton, Chief Ambulatory and Medical Group Officer

April 24, 2019
Agenda

- What is a Medical Group
- Medical Group Purpose and Evolution
- Jefferson Healthcare’s Medical Group Evolution and Purpose
- Jefferson Healthcare’s Medical Group Version 1.0 and 2.0
What is a Medical Group?

1. A department made up by Jenn Wharton so she could work at a 5-Star CMS hospital.

2. A collection of multi-specialty providers employed or contracted by a health system.
Purpose of Medical Groups?

1. **Hospital**: Management of physician practices. Create an integrated provider network and enhance the coordination and delivery of care.

2. **Provider**: Seek shelter from the volatility of running their own practice. Income security, predictable work hours, and less exposure to government regulations.
Evolution of Medical Groups

- 1800s: Mayo Clinic
- 1980: Specialization of Medicine
- 2009: HITECH ACT
- 1970: Managed Care & DRGs
- 2005: Decrease CMS Reimbursement & Deficit Reduction Act
Evolution of Medical Groups

- **1800s**: Mayo Clinic
- **1980**: Specialization of Medicine
- **2009**: HITECH Act
- **2010**: Affordable Care Act
- **2005**: Decrease CMS Reimbursement & Deficit Reduction Act
- **2011**: Competition Market Share
- **2011**: Bargaining Power
- **2017**: Merit-Based Incentive Payment System (MIPS)
Evolution of the JH’s Medical Group

- **1800s**: Mayo Clinic
- **1970**: Managed Care & DRGs
- **1980**: Specialization of Medicine
- **2005**: Decrease CMS Reimbursement & Deficit Reduction Act
- **2009**: HITECH ACT
- **2010**: Affordable Care Act
- **2011**: Community Need
- **2011**: Rural Medicine Gap
- **2011**: Provider Network
- **2017**: Merit-Based Incentive Payment System (MIPS)
Evolution of the JH’s Medical Group
2018 Medical Group Stats

Physicians 32
Advanced Practice Providers 23
Support Team 123
Clinic Visits 83,600
Behavioral Health/MAT Visits 2,077
MOHS 214
Surgeries 362
Orthopedic Surgeries 414
Gross Operating Income $36.9 M
Jefferson Healthcare’s Medical Group Purpose

Your life is here, your care should be too.
Medical Group Purpose
Collaboration.
Medical Group Purpose

Collaboration.

Providers working together systematically to improve their collective ability to deliver high quality, safe, and value care to their patients and the community*.

Medical Group Purpose

Care.

- Population Health
- Enhanced Provider Experience
- Experience of Care
- Lower Cost of Care
Medical Group Purpose

Care. Quadruple Aim

1. **Population Health:**
   - Manage Chronic disease
   - Prevent disease
   - Promote health

2. **Patient Care Experience:**
   - Access to care
   - Reliability of care

3. **Provider Experience:**
   - Integrate support systems
   - Decrease administrative burdens
   - Design care team support
   - Develop physician leaders and governance

4. **Per Capita Cost of Care:**
   - Avoid cost
   - Reduce cost
What is Value Based Care?
Aims to advance the Quadruple Aim by Improving clinical quality and health outcomes for patients and bending the healthcare cost curve.

What is Value Based Purchasing?
A Form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. This form of reimbursement has emerged as an alternative and potential replacement for fee-for-service reimbursement which pays providers retrospectively for services delivered based on bill charges or annual fee schedules.
Medical Group Purpose

Care. Quadruple Aim
Medical Group 1.0
Primary Care Specialties
Primary Care
Medical Group 1.0

- Physician Led Quality Committee
- Quality Metrics and Dashboards
- Integrated Behavioral Health
- Addiction Services (MAT)/Hub and Spoke
- RN Care Coordinator
- Transitions of Care
- Diabetic Care
- Responsible Opioid Prescribing
- Chronic Pain Management
- Dental Care
- Care Gap Closure
- Reproductive Health/SANE
- Housing
- Food Insecurity
Primary Care
Medical Group 1.0

2018 Quality Goals

<table>
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<tr>
<th>Metrics</th>
<th>US Average</th>
<th>2020 Goal</th>
<th>2018 Primary Care</th>
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<tr>
<td>Pneumonia vaccine</td>
<td>60%</td>
<td>90%</td>
<td>79%</td>
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<tr>
<td>Colon cancer screening</td>
<td>52.1%</td>
<td>70.5%</td>
<td>69%</td>
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<tr>
<td>A1c greater than 9</td>
<td>18%</td>
<td>16%</td>
<td>15%</td>
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<tr>
<td>Tobacco counseling</td>
<td>62.4%</td>
<td>68.6%</td>
<td>99%</td>
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</table>
Primary Care
Medical Group 1.0

2019 Quality Goals

- Depression screening and follow up
- Controlled medication agreement
- Naloxone prescription when appropriate
- Opiate risk tool utilization
Primary Care

Medical Group 1.0

- Access Breakthrough Objective
- Physician Led Access Committee
- Panel Size Review
- Schedule Standardization
- Scheduling Team
- Phone Process
Primary Care
Medical Group 1.0

Experience of Care
Population Health
Enhanced Provider Experience
Lower Cost of Care

Third Next Available

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<tr>
<td>2018</td>
<td>13</td>
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<tr>
<td>Jan-19</td>
<td>11</td>
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<tr>
<td>Feb-19</td>
<td>12</td>
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<tr>
<td>Mar-19</td>
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</table>
Primary Care
Medical Group 1.0

2018 Next Available New Patient within 30 days

- February: 43%
- March: 39%
- April: 53%
- May: 89%
- June: 88%
- July: 95%
- August: 89%
- September: 91%
- October: 90%
- November: 95%
- December: 90%
Primary Care
Medical Group 1.0

Population Health

Experience of Care

Enhanced Provider Experience

Lower Cost of Care

- Shared Vision and Strategy
- Provider Leadership & Dyads
- Governance Structure
- Care Teams
- Quarterly Fellowship and Meetings
- Provider Recruiter
Primary Care
Medical Group 1.0

- Prevention and Screening
- Express Clinic
- Data Analytics
- Utilization of Services
## Primary Care

### Medical Group 1.0

<table>
<thead>
<tr>
<th>ACO Participant</th>
<th>Patients</th>
<th>Avg. Total Expenses</th>
<th>Avg. ER Admits</th>
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<td>2004</td>
<td>$11,103.51</td>
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<td>Mason General Hospital</td>
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<td>Memorial Regional Health</td>
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<td>Rangely District Hospital</td>
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<td>Summit Pacific</td>
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**Note: These data were collected and reported by our ACO. Representing July 1, 2017 through June 30, 2018**
Medical Group 2.0
Multi-Specialty Team
### GETTING OUT OF THE BLOCKS

**Shared Vision**

- Physicians view themselves as part of a single organization with a common purpose.
- Administrators and physicians agree on a vision of shared values and goals.
- Clinicians more easily accept new processes and standards.
- Group able to achieve economies of scale through shared resources.
- Open information exchange facilitates administrative and clinical coordination.

### GAINING YOUR STRIDE

**Coordination & Integration**

- Culture-Base candidate and screening minimizes later physician turnover.
- New hires more rapidly internalize group processes, cultural norms.
- Administrators able to easily spot best improvement opportunities.
- Enhanced in-network referral capture boosts revenue performance.
- Group begins to move dial on quality, efficiency, patient satisfaction.

### FINISHING STRONG

**Care Design**

- Improved access, convenience, and service attract patients.
- Unnecessary-and-expensive-variation in clinical care reduced.
- Care management efforts improve outcomes for complex patients.
- Clinicians streamline patient handoffs, eliminate care redundancies.
- Health system prepared to meet emerging value-based imperatives.

---

**PRIMARY CARE SPECIALTIES**

- Define and codify common culture
- Create communication protocols
- Invest in leadership training
- Centralize referral scheduling

---

**FINISHING STRONG**

- Design onboarding program
- Reward coordination

---

**Care Design**

- Design clinical pathways
- Redesign primary care
- Deploy care management resources

---

**Coordination & Integration**

- Develop group dashboard
- Begin to invest in common EMR

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**FINISHING STRONG**

**Care Design**
- Define and codify common culture.
- Create communication protocols.
- Build physician governance.
- Invest in leadership training.
- Begin to invest in common EHR.
- Establish physician, service standards.
- Develop group onboarding program.
- Share individual performance data.
- Centralize referral scheduling.
- Reward quality.
- Establish access protocols.
- Define clinical pathways.
- Redesign primary care.
- Deploy care management resources.
- Reward coordination.
Thanks.
Questions?
Respiratory Therapy at Jefferson Healthcare
Respiratory Therapy - What's new?

- COPD Education Series
- Methacholine Challenge Testing
- Partnership with EJFR
Questions?
Get well & Stay well

AN UPDATE ON EXERCISE FOR HEALTH
EFH was originally conceived as a transition program for patients between intensely monitored medical rehab (cardiac/pulmonary) and independent exercise and community function.

Also seen as a program that allowed those with chronic disease an opportunity to learn how to safely exercise with the idea that they would be motivated to continue independent exercise.

The idea was to educate and train so that participants could then feel comfortable exercising in any setting without monitoring.

We haven’t had a seamless transition to other exercise options, so attendees are not cycling through to add physical activity to their lives; this has become their exercise class.
What is changing?

- In order to improve access to our program and to align it with current Wellness concepts, the format has changed
  - Membership limited to 3 months at a time
  - All participants were given 6 months notice of the changes
    - Notified March 25
    - 3 month program begins June 17
    - First rotation mid-September
  - Participants who meet acute criteria can return, though they are subject to the waiting list. Certain patients are given priority on that list
    - Recent Cardiac and Pulmonary Rehab graduates
    - Recent Physical Therapy graduates on recommendation of their therapist or oncologist
    - Those with diagnosed chronic disease (cardiac, pulmonary and diabetes) who have not had the benefit of the program previously
  - Participants who may no longer meet acute criteria will have 3 months of true stage 3 programming to educate and train them to move in to other programs in our Wellness Center or community
  - New referrals are required to assure that participants are medically cleared for exercise
Cardiac rehab model

Phase 1 – Inpatient setting following surgery or event
Phase 2 – (medical model) Outpatient monitored (ECG) cardiac rehab
Phase 3 – (non-medical model) Outpatient unmonitored—associated with improved outcomes
Phase 4 – Community-based independent exercise
Wellness as a Concept—Life as Exercise

- Give a man a fish vs teaching him to fish
- Lifetime activity model
- Transition from patient to participant and a return to normal life depends on education and personal empowerment and is paramount for permanent behavioral change
- Improved fitness is a function of constantly challenging the human body to improve
- EFH will serve as a place that participants learn to self-monitor and learn to assess their body’s response to exercise to allow them to function fully in their lives 24/7
- EFH will truly serve as stage 3 rehab, and pave the path to stage 4
Why did we do this now?

• Current format limits access to the vast majority of Jefferson County residents
  • Potential participants are frustrated
  • Providers are frustrated
  • Limitations in access jeopardize the fitness gains of cardiac and pulmonary rehab graduates who are at a critical point in their process
    • The literature supports the concept of non-medial “third phase rehab” in terms of long term success and cementing permanent behavior changes in these groups
    • Cardiac Rehab is coming back online
  • Most importantly our new Wellness Center allowed us to look at our continuum differently and follow evidence-based guidelines
Why not expand EFH?

We have!

Our new Wellness Center has allowed us to expand Wellness and EFH is a part of a dynamic continuum.

The new Wellness Center provides a natural, convenient and clinically appropriate transition from monitored exercise and rehabilitation to structured exercise and wellness.

We have and are continuing to build a full complement of exercise programs designed to encourage and challenge fitness in a multitude of ways for community members at all levels.
The Wellness Center
More about wellness classes

The supervision and coaching of wellness classes will be similar to current EFH levels; wellness class sizes are limited to ensure adequate supervision.

We will have the tools for wellness participants to monitor themselves
- Pulse Oximeters
- Automatic BP cuffs

New classes taught in Wellness Center are monitored, taught and supervised by licensed and highly trained PT/OT staff and Certified Exercise instructors

Multiple participants in our classes are in their 80’s and 90’s with multiple chronic diseases

Many of these participants have started classes in chairs to progress to standing as they gain fitness.

The classes are open and beneficial to attendees at all stages of function and fitness
What types of wellness classes are/will be available?

Current offerings:
- Tai Chi for better balance
- Ready, Set, Fit
- Exercise for Low Back Pain
- Medical Yoga
- Dance Parkinson’s

Classes added before September:
- Aerobics and Strength Training
- Low-impact Aikido
- Cardio classes
- 3-4 other classes, currently in design
Serving our community

Currently

Exercise for health
• 60 spots per day
• Current attendance is 34-40 participants per day (due to non attendance)

With added Wellness

Exercise for health
• 60 spots per day
• Attendance is more closely monitored, and participants less likely to have scheduled vacations or absences during their 3-month term

Wellness classes
• 40 spots per day currently;
• Growing to 90 spots per day at full program development
Questions?
Patient Advocate Report

1ST QUARTER 2019
REPORT TO BOARD OF COMMISSIONERS
APRIL 24, 2019
JACKIE LEVIN MS, RN
The Highlights

The average time to close cases was 22.6 days, meeting our target of 30 days or less.

Average receiving concern to acknowledgement letter was 2.8 days.

Total number of concerns for this quarter # 63.

Patient Navigation Calls: # 65

**Increase in Express Clinic concerns from last Quarter**

Meet and Greets with new providers – plan to increase this process for new Primary Care Providers

Access to appointments – remains improved.

Community 6 week Mindfulness Class with 20 participants held in Wellness Center.
Days to: Acknowledgment & Closure

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<tr>
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<th>Acknowledge</th>
<th>Closure</th>
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## Rolling Year by Quarter Clinic, ED, EC Concerns/1000 Visits

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<th>ED</th>
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<th>Clinics</th>
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<td>3.5/1000 visits</td>
<td>1.7/1000 visits</td>
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<td><strong>3rd Quarter 2018</strong></td>
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Trends by **Area** of Concern
Trends by **Type** of Concerns

![Trend by Area](image_url)
Provider Issues

Provider Concerns

- Communication
- Rx Choice
- Rx Plan/Selection
- Skill/Competency
- Diagnosis

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<tr>
<td>Rx Choice</td>
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<tr>
<td>Rx Plan/Selection</td>
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<td>Skill/Competency</td>
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<tr>
<td>Diagnosis</td>
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</tr>
</tbody>
</table>
Additional Patient Advocate Activities

ONGOING

Patient Family Advisory Council (PFAC)
New Employee Orientation
Health Equity Committee
Quality of Care Projects
  ◦ Readmissions
  ◦ Service Excellence Committees
  ◦ TeamSTEPPS
Mindfulness Programs
Ethics Committee

NEW IDEAS

Patient Family Advisors
  ◦ Rounding on the ACU--general
  ◦ “Quiet at Night” rounds—asking specifically about if the quality of quiet at night.
  ◦ Making sure that ACU providers know that Patient Advocates are available to meet with the “unhappy about the care” patients.
Questions and Thoughts?
March 2019 Finance Report
April 24, 2019
Hilary Whittington, CAO/CFO
Education

Accounting for grants

Arcora

$ 250,000
$ 88,000 recorded in 2018 as CIP at year end
$162,000 recorded in March 2019 as grant revenue, construction well under way.
Will reconcile specific grant eligible expenses as construction is complete.

HRSA

$ 248,700
No money was received in 2018. Funds will be received as expenses are incurred in 2019.
April 2019 will show a lot of grant revenue for eligible expenses, balances will be brought up to entire CIP balance

WA Dept of Commerce

$ 970,000
No money was received in 2018. Funds will be received as expenses are incurred in 2019.
April 2019 will show a lot of grant revenue, balances will be brought up to entire CIP balance.
The remainder for the final construction costs will be recorded in May and June

Total Dental Clinic Grants

$1,468,700
Our primary objectives related to Respiratory Therapy are:

- Continue to work to keep our COPD (Chronic obstructive pulmonary disease) patients healthy by:
  - Outreach educational opportunities for the local long term care facilities
  - Start inpatient teaching curriculum for our readmitted COPD patients
- Create pathways for both pulmonology and tele-pulmonology services to keep our patients local
- Add a new testing procedure in our pulmonary function lab to rule out asthma

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>2019 Objectives</th>
<th>March 2019 Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volumes (procedures)</td>
<td>4% growth</td>
<td>11% over budget for Mar/13% over budget YTD</td>
</tr>
<tr>
<td>Pricing change</td>
<td>12% decrease</td>
<td>Appear in line with volumes both Mar &amp; YTD</td>
</tr>
<tr>
<td>Expenses</td>
<td>8% decrease</td>
<td>Staffing expenses a little over budget, but keeping expenses down elsewhere to stay in line with budget.</td>
</tr>
<tr>
<td>FTE change</td>
<td>+1.5 FTE</td>
<td>Under budget YTD by 0.08 FTE. Ramping up quickly, however.</td>
</tr>
</tbody>
</table>
# March 2019 Operating Statistics

<table>
<thead>
<tr>
<th>STATISTIC DESCRIPTION</th>
<th>MO ACTUAL</th>
<th>MO BUDGET</th>
<th>% VARIANCE</th>
<th>YTD ACTUAL</th>
<th>YTD BUDGET</th>
<th>% VARIANCE</th>
<th>MARCH 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTEs - TOTAL (AVG)</td>
<td>574</td>
<td>616</td>
<td>7%</td>
<td>562</td>
<td>616</td>
<td>9%</td>
<td>553</td>
</tr>
<tr>
<td>ADJUSTED PATIENT DAYS</td>
<td>2,229</td>
<td>2,271</td>
<td>-2%</td>
<td>6,579</td>
<td>6,594</td>
<td>0%</td>
<td>2,174</td>
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<tr>
<td>ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)</td>
<td>81</td>
<td>86</td>
<td>-6%</td>
<td>255</td>
<td>250</td>
<td>2%</td>
<td>89</td>
</tr>
<tr>
<td>ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)</td>
<td>348</td>
<td>350</td>
<td>-1%</td>
<td>997</td>
<td>1,015</td>
<td>-2%</td>
<td>345</td>
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<tr>
<td>PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION</td>
<td>443</td>
<td>444</td>
<td>0%</td>
<td>1,307</td>
<td>1,289</td>
<td>1%</td>
<td>444</td>
</tr>
<tr>
<td>SURGERY CASES (IN OR)</td>
<td>102</td>
<td>109</td>
<td>-6%</td>
<td>306</td>
<td>316</td>
<td>-3%</td>
<td>106</td>
</tr>
<tr>
<td>SPECIAL PROCEDURE CASES</td>
<td>75</td>
<td>77</td>
<td>-3%</td>
<td>185</td>
<td>225</td>
<td>-18%</td>
<td>70</td>
</tr>
<tr>
<td>LAB BILLABLE TESTS</td>
<td>19,468</td>
<td>18,954</td>
<td>3%</td>
<td>55,767</td>
<td>55,028</td>
<td>1%</td>
<td>19,448</td>
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<tr>
<td>TOTAL DIAGNOSTIC IMAGING TESTS</td>
<td>2,895</td>
<td>2,858</td>
<td>1%</td>
<td>8,418</td>
<td>8,298</td>
<td>1%</td>
<td>2,714</td>
</tr>
<tr>
<td>PHARMACY MEDS DISPENSED</td>
<td>22,507</td>
<td>24,983</td>
<td>-10%</td>
<td>67,337</td>
<td>72,530</td>
<td>-7%</td>
<td>24,311</td>
</tr>
<tr>
<td>RESPIRATORY THERAPY PROCEDURES</td>
<td>3,849</td>
<td>3,467</td>
<td>11%</td>
<td>10,656</td>
<td>10,065</td>
<td>13%</td>
<td>3,530</td>
</tr>
<tr>
<td>REHAB/PT/OT/ST RVUs</td>
<td>8,538</td>
<td>9,372</td>
<td>-9%</td>
<td>25,004</td>
<td>27,209</td>
<td>-8%</td>
<td>8,607</td>
</tr>
<tr>
<td>ER CENSUS</td>
<td>1,086</td>
<td>1,090</td>
<td>0%</td>
<td>3,163</td>
<td>3,136</td>
<td>-4%</td>
<td>1,103</td>
</tr>
<tr>
<td>TOTAL RURAL HEALTH CLINIC VISITS</td>
<td>6,080</td>
<td>6,133</td>
<td>-1%</td>
<td>17,808</td>
<td>17,553</td>
<td>-1%</td>
<td>5,260</td>
</tr>
<tr>
<td>TOTAL SPECIALTY CLINIC VISITS</td>
<td>3,405</td>
<td>3,763</td>
<td>-10%</td>
<td>9,143</td>
<td>10,923</td>
<td>-9%</td>
<td>3,172</td>
</tr>
<tr>
<td>HOME HEALTH EPISODES</td>
<td>77</td>
<td>69</td>
<td>12%</td>
<td>210</td>
<td>202</td>
<td>4%</td>
<td>65</td>
</tr>
<tr>
<td>HOSPICE CENSUS/DAYS</td>
<td>873</td>
<td>1,153</td>
<td>-24%</td>
<td>2,534</td>
<td>3,348</td>
<td>-24%</td>
<td>1,010</td>
</tr>
</tbody>
</table>
# March 2019

## Income Statement Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Patient Service Revenue</td>
<td>21,110,153</td>
<td>21,166,726</td>
<td>(56,573)</td>
<td>0%</td>
<td>61,732,382</td>
<td>61,451,779</td>
<td>280,603</td>
<td>0%</td>
<td>57,642,271</td>
</tr>
<tr>
<td>Revenue Adjustments</td>
<td>11,233,254</td>
<td>11,238,892</td>
<td>5,637</td>
<td>0%</td>
<td>33,073,167</td>
<td>32,629,037</td>
<td>(444,129)</td>
<td>-1%</td>
<td>31,346,703</td>
</tr>
<tr>
<td>Charity Care Adjustments</td>
<td>210,786</td>
<td>242,094</td>
<td>31,307</td>
<td>13%</td>
<td>507,893</td>
<td>702,853</td>
<td>194,960</td>
<td>28%</td>
<td>672,566</td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>9,666,112</td>
<td>9,685,740</td>
<td>(19,628)</td>
<td>0%</td>
<td>28,151,322</td>
<td>28,119,889</td>
<td>31,434</td>
<td>0%</td>
<td>25,623,002</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>639,812</td>
<td>779,134</td>
<td>(139,322)</td>
<td>-18%</td>
<td>1,410,659</td>
<td>2,262,001</td>
<td>(851,342)</td>
<td>-38%</td>
<td>1,170,901</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>10,305,924</td>
<td>10,464,874</td>
<td>(158,950)</td>
<td>-2%</td>
<td>29,561,981</td>
<td>30,381,889</td>
<td>(819,909)</td>
<td>-3%</td>
<td>26,793,903</td>
</tr>
</tbody>
</table>

| **Operating Expenses** |                   |                   |                                |        |                     |                       |                                |        |                     |
| Salaries And Wages   | 5,021,961         | 5,032,320         | 10,359                         | 0%     | 14,225,353         | 14,609,961           | 384,608                        | 3%     | 13,530,376          |
| Employee Benefits    | 1,317,994         | 1,258,953         | (59,042)                       | -5%    | 3,616,081          | 3,655,023           | 38,942                         | 1%     | 3,262,834           |
| Other Expenses       | 3,867,953         | 3,948,697         | 80,744                         | 2%     | 10,771,609         | 11,463,957           | 692,348                        | 6%     | 10,245,406          |
| **Total Operating Expenses** | 10,207,908       | 10,239,970        | 32,061                         | 0%     | 28,613,042         | 29,728,941           | 1,115,899                      | 4%     | 27,038,617          |

| **Operating Income (Loss)** | 98,015            | 224,904           | (126,889)                      | -56%   | 948,939            | 652,948              | 295,990                        | 45%    | (244,714)           |
| **Total Non Operating Revenues (Expenses)** | 5,488             | 6,388             | (901)                          | 14%    | (2,011)            | 18,547               | (20,559)                       | 111%   | (51,336)            |
| **Change in Net Position (Loss)** | 103,503           | 231,293           | (127,790)                      | -55%   | 946,927            | 671,496              | 275,432                        | 41%    | (296,050)           |
March 2019
Cash and Accounts Receivable

Days Cash and Accounts Receivable

Days Outstanding in A/R
Days AR Goal - 45
Days of Cash
Days Cash Goal - 90
## March 2019
### Board Financial Report

<table>
<thead>
<tr>
<th>Dept#</th>
<th>Department</th>
<th>Rev/Exp</th>
<th>Account</th>
<th>Account Description</th>
<th>March Actual</th>
<th>March Budget</th>
<th>March Variance</th>
<th>2019 to Date Actual</th>
<th>2019 to Date Budget</th>
<th>2019 to Date Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>8612</td>
<td>BOARD</td>
<td>Exp</td>
<td>60010</td>
<td>MANAGEMENT &amp; SUPERVISION WAGES</td>
<td>4,645.00</td>
<td>5,218.00</td>
<td>573.00</td>
<td>14,281.00</td>
<td>15,150.00</td>
<td>869.00</td>
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<tr>
<td>602300</td>
<td></td>
<td></td>
<td></td>
<td>CONSULT MNGMT FEE</td>
<td>-</td>
<td>2,123.00</td>
<td>2,123.00</td>
<td>-</td>
<td>6,164.00</td>
<td>6,164.00</td>
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<tr>
<td>602500</td>
<td></td>
<td></td>
<td>602500</td>
<td>AUDIT FEES</td>
<td>-</td>
<td>3,397.00</td>
<td>3,397.00</td>
<td>-</td>
<td>9,863.00</td>
<td>9,863.00</td>
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<tr>
<td>604200</td>
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<td>604200</td>
<td>CATERING</td>
<td>53.00</td>
<td>127.00</td>
<td>74.00</td>
<td>158.00</td>
<td>370.00</td>
<td>212.00</td>
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<tr>
<td>604500</td>
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<td>604500</td>
<td>OFFICE SUPPLIES</td>
<td>-</td>
<td>25.00</td>
<td>25.00</td>
<td>-</td>
<td>72.00</td>
<td>72.00</td>
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<tr>
<td>604850</td>
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<td>604850</td>
<td>COMPUTER EQUIPMENT</td>
<td>-</td>
<td>85.00</td>
<td>85.00</td>
<td>-</td>
<td>247.00</td>
<td>247.00</td>
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<tr>
<td>606500</td>
<td></td>
<td></td>
<td>606500</td>
<td>OTHER PURCHASED SERVICES</td>
<td>-</td>
<td>849.00</td>
<td>849.00</td>
<td>-</td>
<td>2,466.00</td>
<td>2,466.00</td>
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<tr>
<td>609400</td>
<td></td>
<td></td>
<td>609400</td>
<td>TRAVEL/MEETINGS/TRAINING</td>
<td>2,658.00</td>
<td>1,699.00</td>
<td>(959.00)</td>
<td>4,106.00</td>
<td>4,932.00</td>
<td>826.00</td>
</tr>
</tbody>
</table>

| Exp Total | 7,356.00 | 13,523.00 | 6,167.00 | 18,545.00 | 39,264.00 | 20,719.00 |
| BOARD Total | 7,356.00 | 13,523.00 | 6,167.00 | 18,545.00 | 39,264.00 | 20,719.00 |
April 2019
Preview – (*as of 0:00 04/24/19)

- $22,242,068 in HB charges
  - Average: $741,402/day (HB only)
  - Budget: $669,505/day
  - 110.7% of Budget

- $8,386,589 in HB cash collections
  - Average: $279,553/day (HB only)
  - Goal: $294,582/day

- 54.0 Days in A/R

- Questions
<table>
<thead>
<tr>
<th>CMS Condition of Participation</th>
<th>Standard</th>
<th>Survey Procedures (Questions that CMS asks to support compliance)</th>
<th>Periodic Review evidence of compliance:</th>
<th>Additional Comments:</th>
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</thead>
<tbody>
<tr>
<td>485.641(a)</td>
<td>The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year.</td>
<td>How is the information obtained and how does the CAH conduct the evaluation? Who is responsible for the periodic evaluation?</td>
<td>Periodic Review presented to the Board of Commissioners on April 24, 2019 for the period of January 1, 2018 to December 31, 2018</td>
<td>Information is obtained via: epic reports, finance reports, quality and medical staff reports, public reporting data, and staff/leader interviews. The Chief Patient Safety and Quality Officer is responsible for the periodic evaluation.</td>
</tr>
<tr>
<td>485.641(a)(1)(i)</td>
<td>The utilization of CAH services, including at least the number of patients served and the volume of services;</td>
<td>How does the CAH ensure that the yearly program evaluation includes a review of all CAH services, the number of patients served and the volume of services provided?</td>
<td>The utilization statistics are provided on slides 3-8 of the periodic evaluation report.</td>
<td>The yearly evaluation also considers quality/PI activity of departments and includes a brief report of their services. For example, PI, revenue cycle, and clinical informatics updates.</td>
</tr>
<tr>
<td>485.641(a)(1)(ii)</td>
<td>A representative sample of both active and closed clinical records; and</td>
<td>Who is responsible for the review of both active and closed clinical records? How are records selected in the periodic evaluation? How does the evaluation process ensure that the sample is representative of the services furnished? What criteria are utilized in the review of both active and closed records?</td>
<td>Slides 12-13 outline the review of both open and closed clinical records. The criteria utilized in the review of the records are listed on slide #12</td>
<td>As discussed in the presentation, records are selected by pre-determined criteria, patient advocate referral, or quality/safety activity from the organization. Indicators are linked with the strategic plan, as well as regulatory requirements.</td>
</tr>
<tr>
<td>485.641(a)(1)(iii)</td>
<td>The CAH'S health care policies</td>
<td>What evidence demonstrates that the health care policies of the CAH are evaluated, reviewed and/or revised as part of the annual program evaluation?</td>
<td>Slides 11 - and a list is provided for review of the new policies in 2018.</td>
<td>The process for policy review, and the considerations for review were discussed during the presentation. These include a review for accuracy, compliance with regulatory requirements, and adherence to best practices.</td>
</tr>
<tr>
<td>485.641(a)(2)</td>
<td>The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.</td>
<td>How does the CAH use the results of the yearly program evaluation? Were policies, procedures and/or facility practices added, deleted or revised as a result of the yearly program evaluation? If needed?</td>
<td>Quality and performance improvement are ongoing at Jefferson Healthcare. As opportunities are identified, plans are developed to improve the process, changes are implemented, the data/process is studied and acted upon. The yearly program evaluation is a summary of this process.</td>
<td>Policies and procedures may be created, revised, or retired based upon the needs of the organization and the opportunities within the quality management system. This work is ongoing.</td>
</tr>
</tbody>
</table>

Utilization of Services

§ 42 CFR 485.641 “The CAH Carries out a periodic evaluation of its total program. This evaluation is done once a year and includes a review of: patients served, volume of services, representative sample of both active and closed clinical records, and the CAH Policies.”
2018 Acute Care Census

Census by Department

2018 Average Daily Census: 14.87

25 beds were not exceeded in 2018
### 2018 Length of Stay

<table>
<thead>
<tr>
<th>Month</th>
<th>ACU</th>
<th>ICU</th>
<th>FBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>2.3</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>February</td>
<td>4.2</td>
<td>3</td>
<td>3.9</td>
</tr>
<tr>
<td>March</td>
<td>2.3</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>April</td>
<td>2.7</td>
<td>3.4</td>
<td>3.5</td>
</tr>
<tr>
<td>May</td>
<td>2.7</td>
<td>3.4</td>
<td>3.5</td>
</tr>
<tr>
<td>June</td>
<td>4.2</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>July</td>
<td>4.2</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>August</td>
<td>3</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td>September</td>
<td>3</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td>October</td>
<td>2.3</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>November</td>
<td>2.3</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>December</td>
<td>2</td>
<td>3</td>
<td>3.5</td>
</tr>
</tbody>
</table>

**Average Length of Stay by Department**

- **ACU**
- **ICU**
- **FBC**
Utilization of Services

• Outpatient
  • 11,191 Home Health Visits
  • 5,606 Hospice Visits

• Observation
  • 359 Observation Days

• Inpatient Hospice
  • 132 Patient Days
  • Average LOS 6.3 days

• Pharmacy
  • 141,134 Doses Dispensed

• Swing Bed
  • 145 Swing Bed Days

Average IP Length of Stay 89.4 hours
## Departments and Services

<table>
<thead>
<tr>
<th>Department</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visits</td>
<td>9,256</td>
<td>10,481</td>
<td>11,641</td>
<td>12,908</td>
<td>12,464</td>
</tr>
<tr>
<td>Express Clinic Visits</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>7,201</td>
</tr>
<tr>
<td>Family Birthing Center Births</td>
<td>107</td>
<td>125</td>
<td>99</td>
<td>115</td>
<td>115</td>
</tr>
<tr>
<td>Acute Care Unit Patient Days (includes SB)</td>
<td>3,580</td>
<td>3,857</td>
<td>3,622</td>
<td>4,415</td>
<td>3,937</td>
</tr>
<tr>
<td>Intensive Care Unit Patient Days</td>
<td>515</td>
<td>541</td>
<td>611</td>
<td>838</td>
<td>761</td>
</tr>
<tr>
<td>Operating Room Cases</td>
<td>1,865</td>
<td>927</td>
<td>834</td>
<td>1,162</td>
<td>1,217</td>
</tr>
<tr>
<td>Outpatient Testing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>19,150</td>
<td>23,702</td>
<td>23,586</td>
<td>29,587</td>
<td>33,791</td>
</tr>
<tr>
<td>Imaging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>185,784</td>
<td>175,333</td>
<td>186,584</td>
<td>204,659</td>
<td>211,095</td>
</tr>
<tr>
<td>OP Rehab Visits (OT, ST, PT)</td>
<td>6,985</td>
<td>12,256</td>
<td>12,262</td>
<td>21,002</td>
<td>24,430</td>
</tr>
<tr>
<td>Rural Health Clinic Visits</td>
<td>45,818</td>
<td>64,867</td>
<td>62,170</td>
<td>61,825</td>
<td>64,428</td>
</tr>
<tr>
<td>Specialty Clinic Visits</td>
<td>14,636</td>
<td>24,164</td>
<td>22,754</td>
<td>34,564</td>
<td>39,509</td>
</tr>
</tbody>
</table>
### Emergency Department

12,464 Patients were seen in the Emergency Department in 2018
15.21% were kept for observation, admitted, or transferred

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Visits</th>
<th>Percentage of Total Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to JH - Inpatient</td>
<td>1117</td>
<td>8.96%</td>
</tr>
<tr>
<td>Transfer – Higher level of care</td>
<td>520</td>
<td>4.17%</td>
</tr>
<tr>
<td>Held for Observation</td>
<td>259</td>
<td>2.08%</td>
</tr>
<tr>
<td>Left Against Medical Advice</td>
<td>54</td>
<td>0.43%</td>
</tr>
<tr>
<td>Left Without Being Seen</td>
<td>243</td>
<td>1.95%</td>
</tr>
</tbody>
</table>
Emergency Transfers: Top 10 Reasons for Transfer

520 patients were transferred from the Emergency Department in 2018.
Medical Records, Policies, and Procedures

§ 485.641(a)(1)(ii) A representative sample of both active and closed clinical records
2018 Policies and Procedures

- 127 New Policies Created and Approved
- 1838 Total Active Policies and Procedures
- Annual review is required
  - 99.6% compliance
Medical Record Review

Record Review:

• Does the patient meet criteria for the services being provided?
• Is the written communication clear between team members?
• Are we meeting Regulatory Requirements?
• Is the record complete?
• Does the documentation support the coding and billing?
• Did we provide evidence based medicine to the best of our ability?
• Was the standard of care met?
• Were there opportunities for improvement?

Record Review Completed:

Critical Access Hospitals are required to review 10% of their records for quality, appropriateness of services, and compliance

• Jefferson Healthcare exceeded this goal in 2018
  ✓ Quality Review
  ✓ Risk Management Review
  ✓ Utilization Review
  ✓ Infection Control
  ✓ Medical Staff Review
  ✓ Compliance Review
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Quantity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
<td>338</td>
<td>Appropriateness of patient status; review of non-billable services; identify delays in patient flow; compliance with Observation notice</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>1133</td>
<td>Appropriateness of level of care, discharge planning, readmission risk</td>
</tr>
<tr>
<td>Readmissions</td>
<td>47</td>
<td>Each potential readmission is screened x 2 (original admission and subsequent readmission)</td>
</tr>
<tr>
<td>Infection Control</td>
<td>1100</td>
<td>Open and closed record review active surveillance</td>
</tr>
<tr>
<td>Restraints</td>
<td>533</td>
<td>100% of restraint episodes are audited</td>
</tr>
<tr>
<td>EDTC</td>
<td>180</td>
<td>Sample size: 15 records per month</td>
</tr>
<tr>
<td>GPRO</td>
<td>1061</td>
<td>ACO Quality reporting</td>
</tr>
<tr>
<td>Stroke</td>
<td>44</td>
<td>GWTG Stroke Reporting</td>
</tr>
<tr>
<td>Compliance (DNV)</td>
<td>110</td>
<td>Chart audits to follow up on DNV Non-Conformities (77 pain management, 33 epidurals in OB)</td>
</tr>
<tr>
<td>Sepsis</td>
<td>111</td>
<td>Core Measure Reporting - primary dx severe sepsis and septic shock</td>
</tr>
<tr>
<td>Chest pain/STEMI</td>
<td>43</td>
<td>Public reporting/collaborative quality - Harrison</td>
</tr>
<tr>
<td>Mortality</td>
<td>78</td>
<td>100% review of inpatient deaths</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>73</td>
<td>Medical Staff Case Review</td>
</tr>
<tr>
<td>Patient Falls</td>
<td>35</td>
<td>100% of patient fall reviews (includes all clinical areas (IP and OP)</td>
</tr>
<tr>
<td>OB Roadmap</td>
<td>115</td>
<td>Multiple quality indicators - 100% of deliveries reported.</td>
</tr>
<tr>
<td><strong>Subtotal</strong>*</td>
<td>5001</td>
<td>*Does not include additional audits for patient complaints and billing compliance</td>
</tr>
</tbody>
</table>
Serving our Community

Community Events, Education, Sponsorships, Population Health, Health Equity
Community

• Girls Night Out
• Rhody Run
• Jefferson County Fair
• Quilcene Fair
• Port Ludlow Drive In Boat In
• Hadlock Days
• All County Picnic
• Mindfulness-Based Stress Reduction Classes for the Community
• Immunization Outreach in Brinnon
• Community Fall Prevention
• Memorial Stadium Lighting
• Childbirth Education Classes
• Advance Care Planning Workshops
• …and more!
Population Health: Housing, Food, and Friends

• Implement programs that address the social and economic factors that determine health outcomes

• Support clinical care gap closure

• Coordinate community wide projects to improve health

• Promote a data-driven culture

• Characterize population health needs

• Received the population health flex grant from the DOH for the third time
  • 2019: Piloting a Participatory Planning and Budgeting (PPB) program at Chimacum
Health Equity

• Health Equity Committee:
  • We are Here: Transgender sensitivity training education/training video for health care staff and providers
  • Training: Trans Health for Providers
    • 2 hour educational training for Primary Care Providers by Dr. Kevin Wang, Swedish Medical Center

• Health Equity Internal Audit: Front-line staff properly addressing, registering patients, updating policies,

• Health Equity Leadership Award 2018

• Presentation:
  • WSHA Conference Safe Table: Health Equity.
  • HEI: More than an Award
New and Enhanced Services

Medical Staff, New Services Lines, Enhanced Services, Quality and Performance Improvement
• Credentialing and Privileging
  • Total New Providers Includes telemedicine): 35
  • Active Medical Staff Resignations: 14
  • Telemedicine Resignations: 12
  • Total AHP on Staff: 42
  • Total Providers on Staff: 263

• Medical Staff Policies
  • Review of 25 Medical Staff Policies
  • Creation of 2 New Policies
  • Revision of 2 Policies

2018 Medical Staff Updates
Welcome to...

CRNA
• Sergei Pavlov
Dermatology
• Katie Ernst
Radiology
• Timothy Gleason
• Terri Reichner
• Felix Nautsch
• Kenneth Hebert
Emergency Medicine
• Kartik Rao
• David Frick
• Evan Kroh
Express Care
• Amy Grace
• Brittany Yahraus
• Charles J Speed
• Stephanie Walker-Leu

General Surgery
• Daniel Nadig
Hospital Medicine
• William Janss
• Martin Ellbogen
• Shayna Lemke
Primary Care
• Laura Wulff
• Rachel Sverchek
• Lisa Galbreath
• Elizabeth Olinger
• Christine Doyle
• Kari Griffin-Harte
• Denise Sample
• Sarah Heiner
Psychiatry
• Kari Heistand

Oncology
• Mary Towns
Teleneurology
• Jed Gorden
Telepsychiatry
• Iris Fadlon
• James Barclay
• Leszek Michalewicz
Teleradiology
• Lawrence Lee
• Michael Peters
Orthopedics
• Alex Herzberg
• Jordan Giesler
New & Expanded Services in 2018

- Express Clinic Grand Opening
- Dental Clinic Kickoff *(opening in 2019)*
- Lab
  - Added FFN (Fetal Fibronectin Test) test to the lab
- Updated Telemetry System
  - New monitors in the Emergency Department and PACU
- ACU/ICU
  - Brain Rest Program
- FBC
  - Smooth Transitions Program
- Respiratory Therapy
  - Laryngeal Mask Airway (LMA) for newborn babies
  - Pulmonary Rehab: Increased access by 28%
- Expanded Specialty Services: Port Ludlow Clinic
  - Cardiology, Orthopedics, Dermatology, LCSW, ACS
- Retail Pharmacy Phase I
  - Specialty Pharmacy
  - 2019 Port Ludlow Retail Pharmacy planned
- Orthopedics
  - Protein Rich Plasma Injections
- Additional Dermatology Provider
Quality and Process Improvements

- Patient Family Advisory Council:
  - Signage for hallways and Emergency Department parking area
  - Participation in new Mission Statement creation process
- C. Diff Taskforce: decrease in over-testing for c.diff
- Antimicrobial Stewardship: decreased IP antibiotic use
- Alarm Safety: 71% decrease in non-critical bedside alarms
- Acute Care: Early Mobility Program for Inpatient Population
- Code Blue Committee
- Workplace Violence Prevention Team
- Nursing Education:
  - Essentials of Critical Care Orientation for RN’s
  - Charge nurse training program
  - Medical Surgical Certification program for RN’s
  - FBC Shoulder dystocia drills/simulation training
- Third Floor ‘Refresh’
- RT and Nursing Care Protocols
- PFT Lab Enhancements: American Thoracic Standards
2018 Accreditation & Awards
Questions?
Administrative Report

April 24, 2019

Mike Glenn, CEO
Jefferson Healthcare Mission Statement

Existing:

Working together to serve our community with personalized care and medical excellence.

Proposed:

To hold the trust and improve the health of our community through compassionate care, innovation and medical excellence.
New Services Update

- Dental Clinic
- Retail Pharmacy
Education/ Activity Opportunities

April 29  
2019 CEO/Trustee Safety and Quality Summit

May 15  
National Hospital Week- Employee Appreciation BBQ

June 24-26  
WSHA 2019 Rural Hospital Leadership Conference

Other/FYI

May 13  
Washington State Supreme Court Justices Lunch
Advocacy Update

• Olympia

• Washington D.C.
Questions