

Jefferson County Public Hospital District No.2
Board of Commissioners, Regular Session Minutes
Wednesday, April 24, 2019
Victor J. Dirksen Conference Room

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:

Hilary Whittington, CFO/CAO presented the March 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?

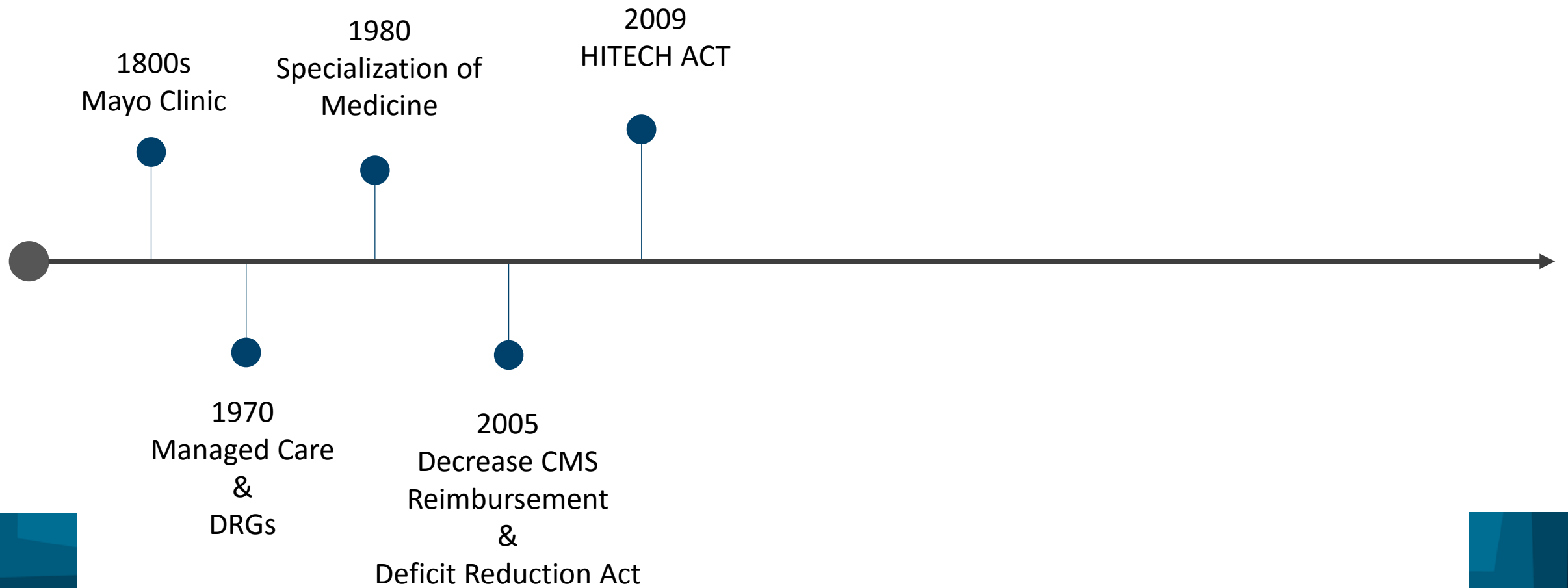
1. A department made up by Jenn Wharton so she could work at a 5-Star CMS hospital.
2. A collection of multi-specialty providers employed or contracted by a health system.

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.

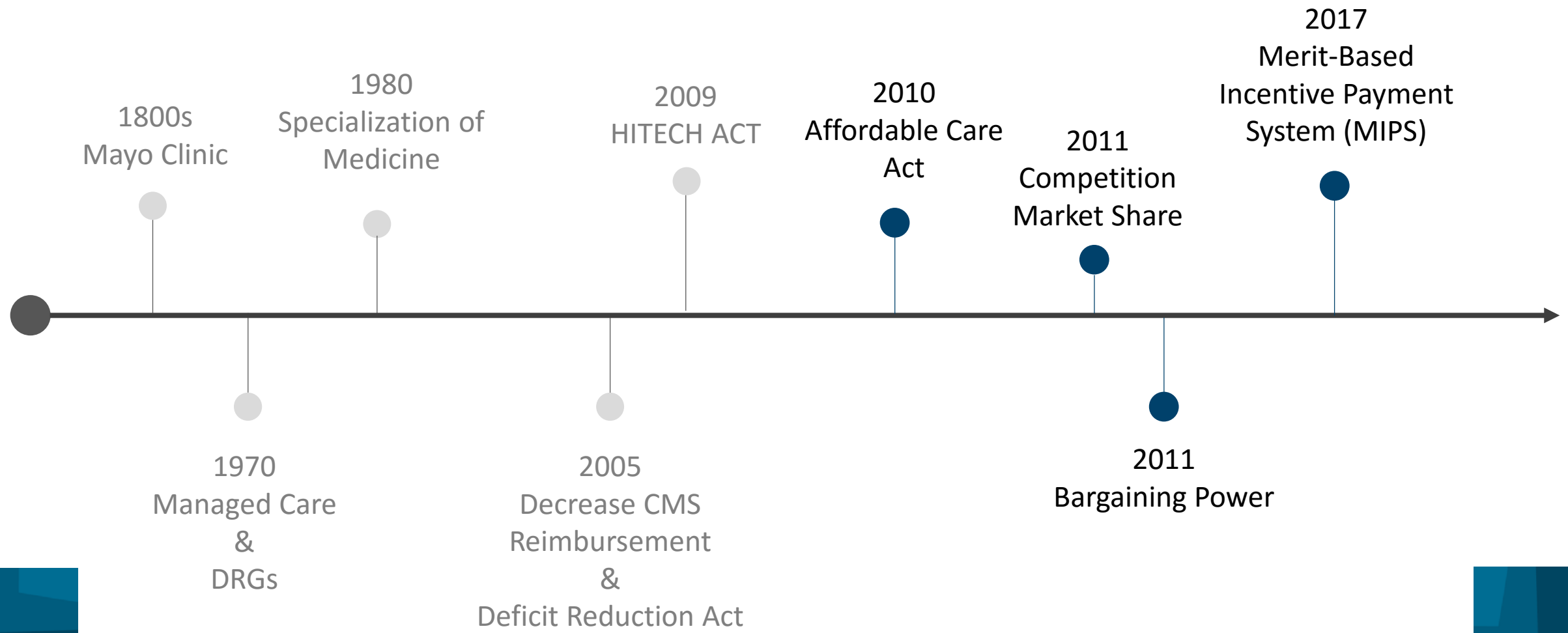


Evolution of Medical Groups

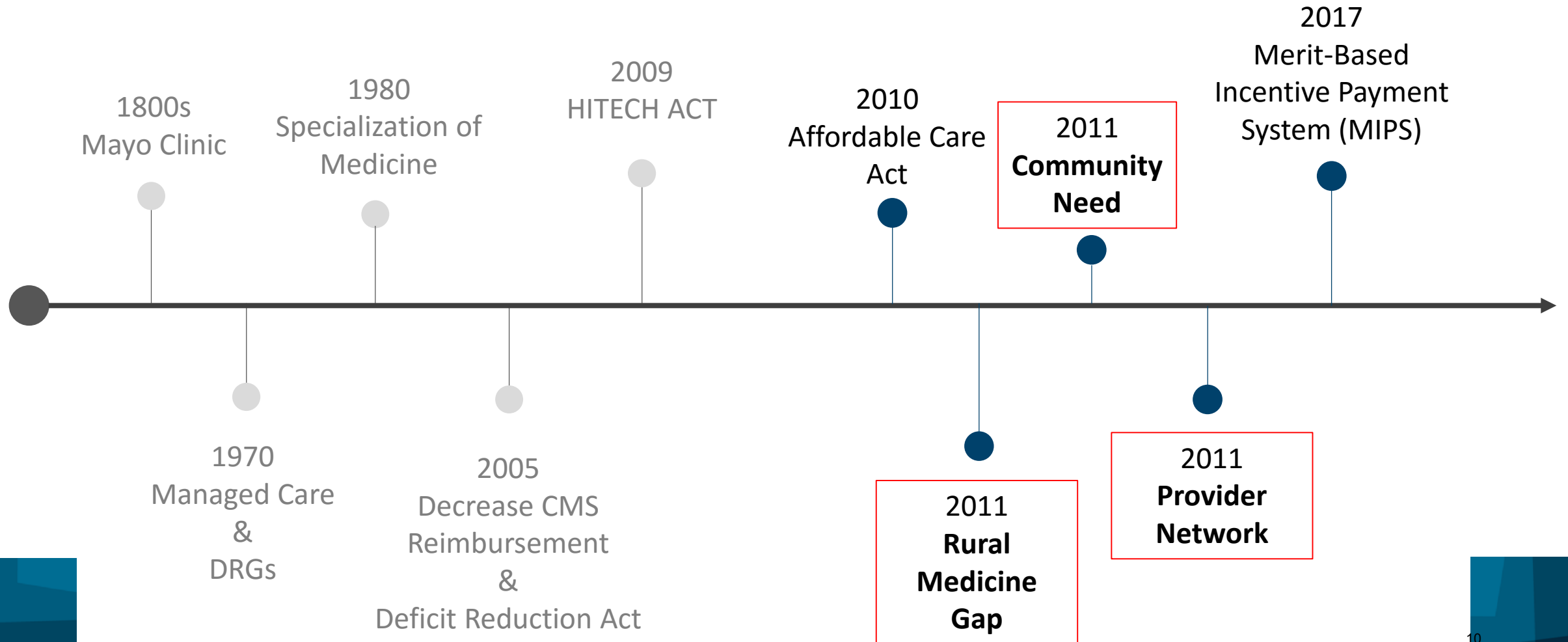




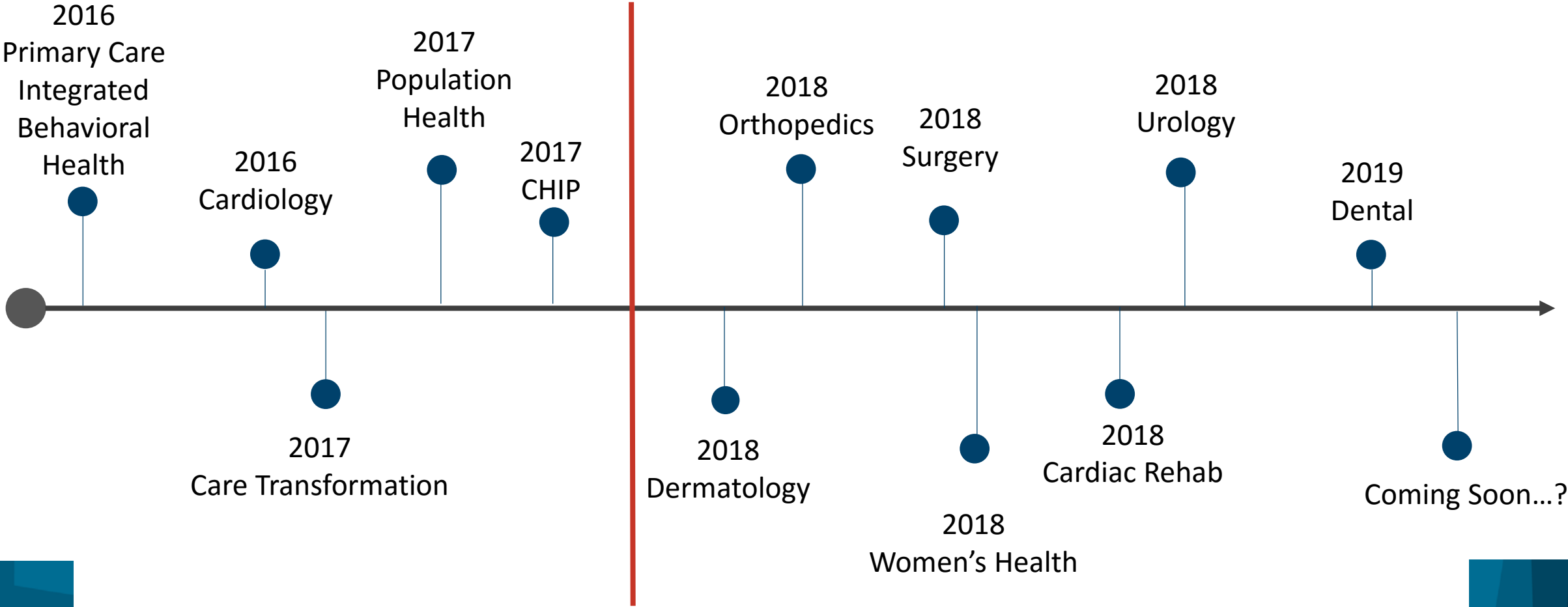
Evolution of Medical Groups

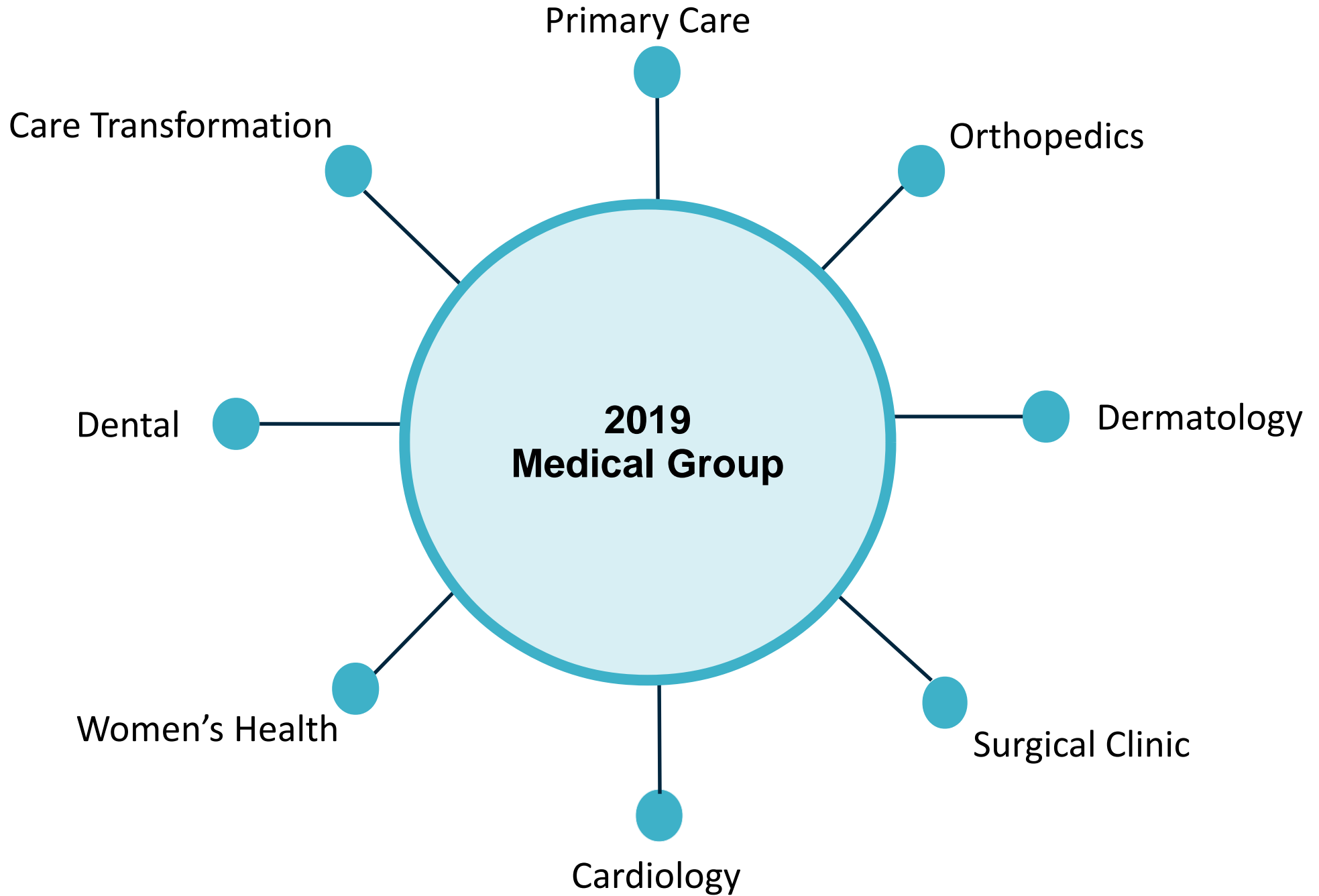


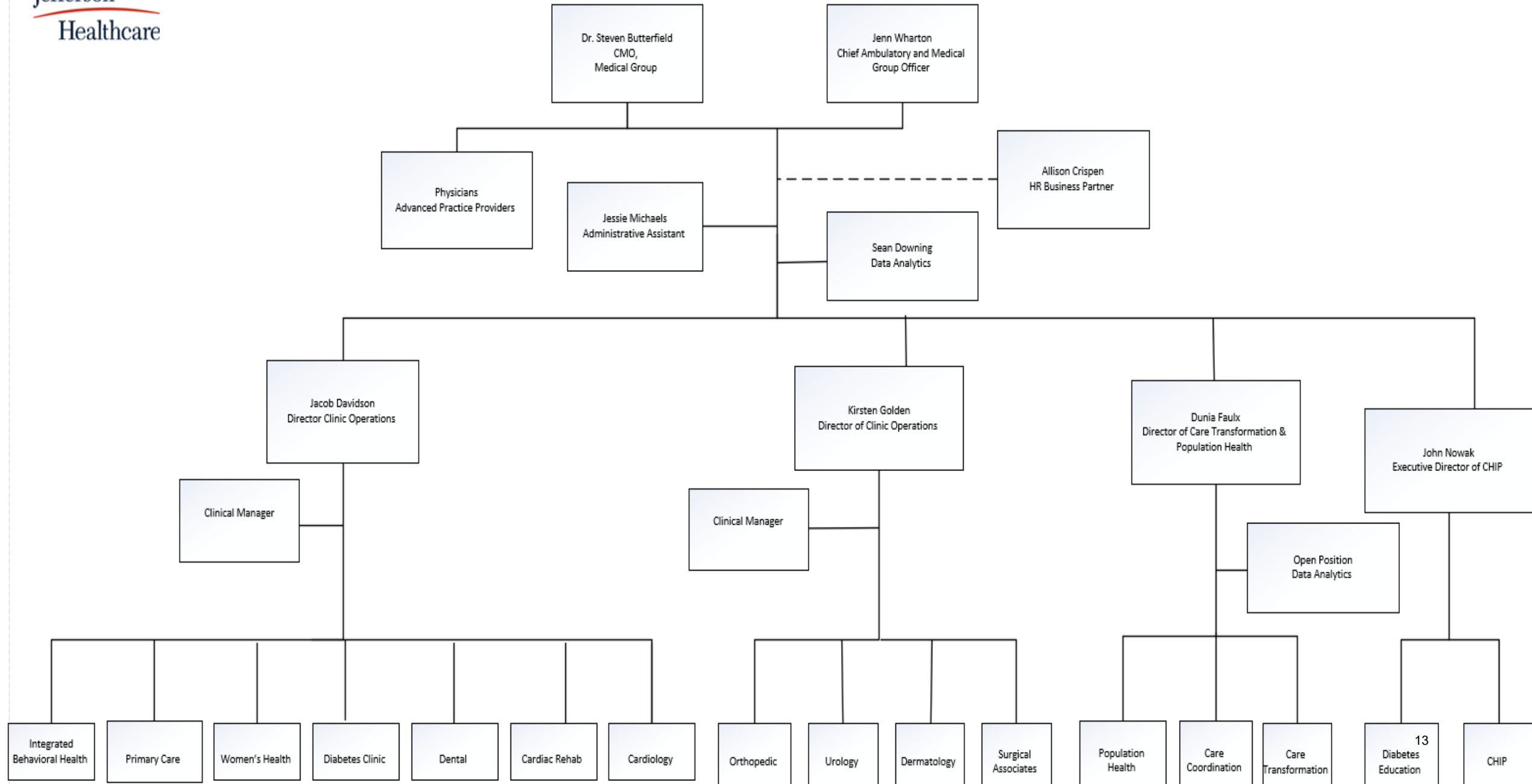
Evolution of the JH's Medical Group

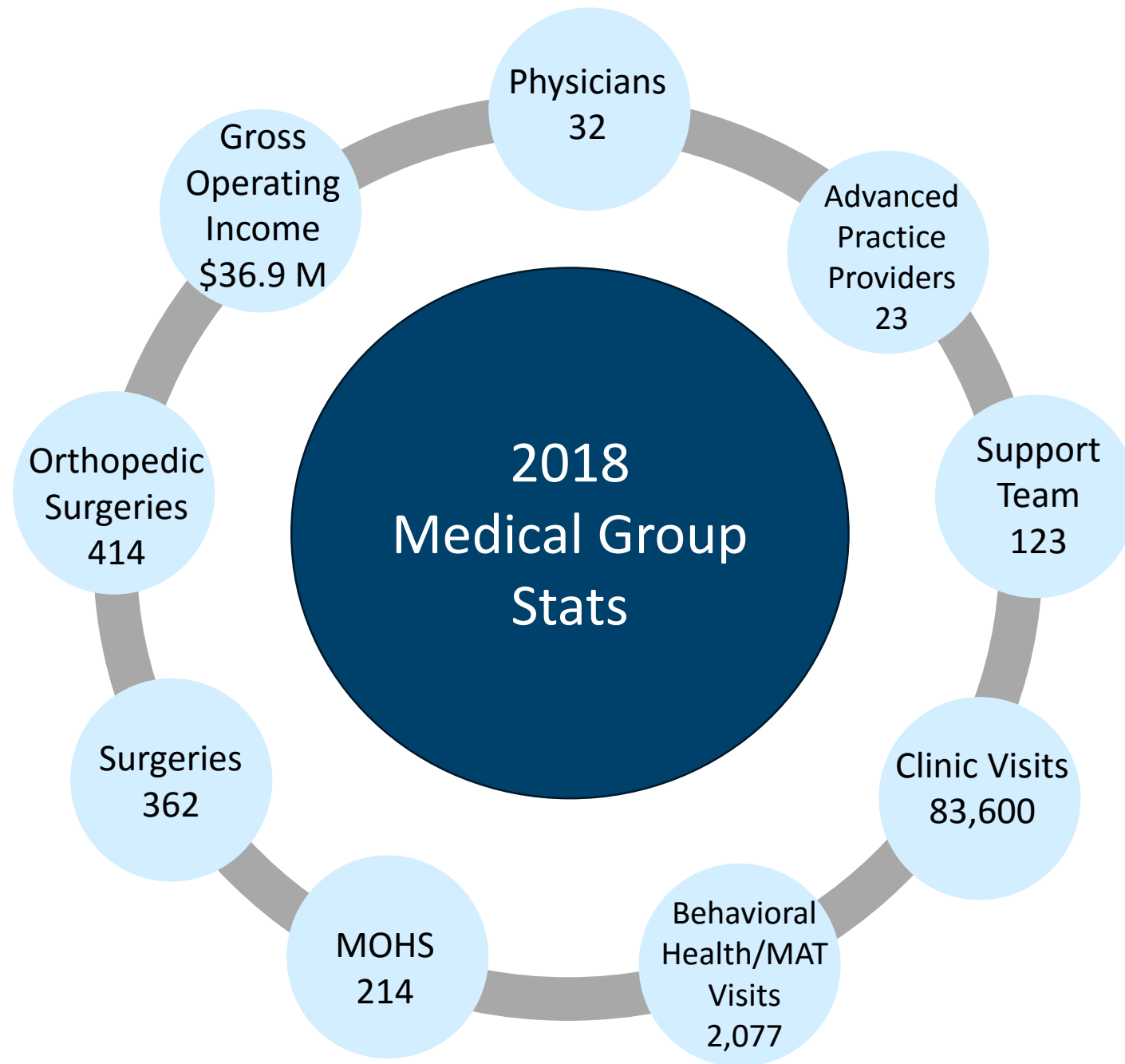


Evolution of the JH's Medical Group











Jefferson Healthcare's Medical Group Purpose

Community. Collaboration. Care.

Medical Group Purpose

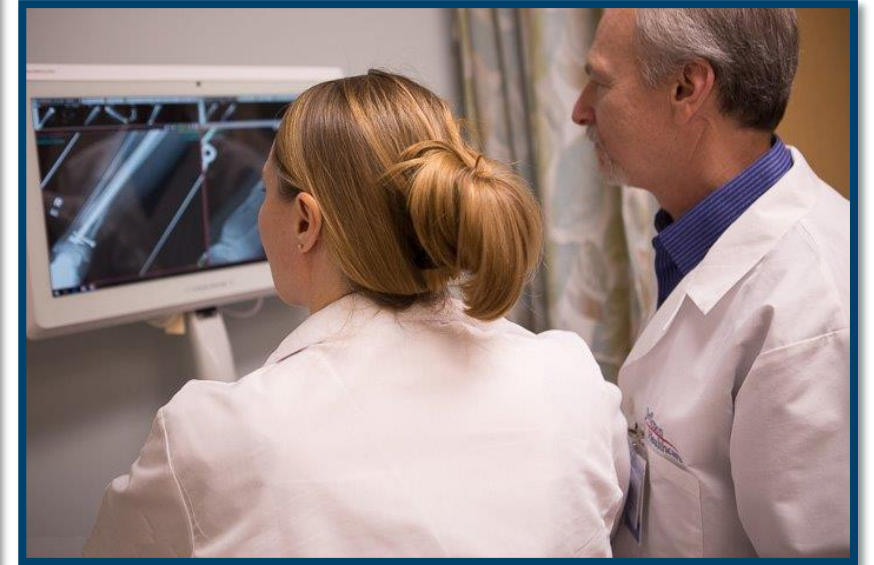
Community.



Your life is here,
your care should be too

Medical Group Purpose

Collaboration.



Medical Group Purpose

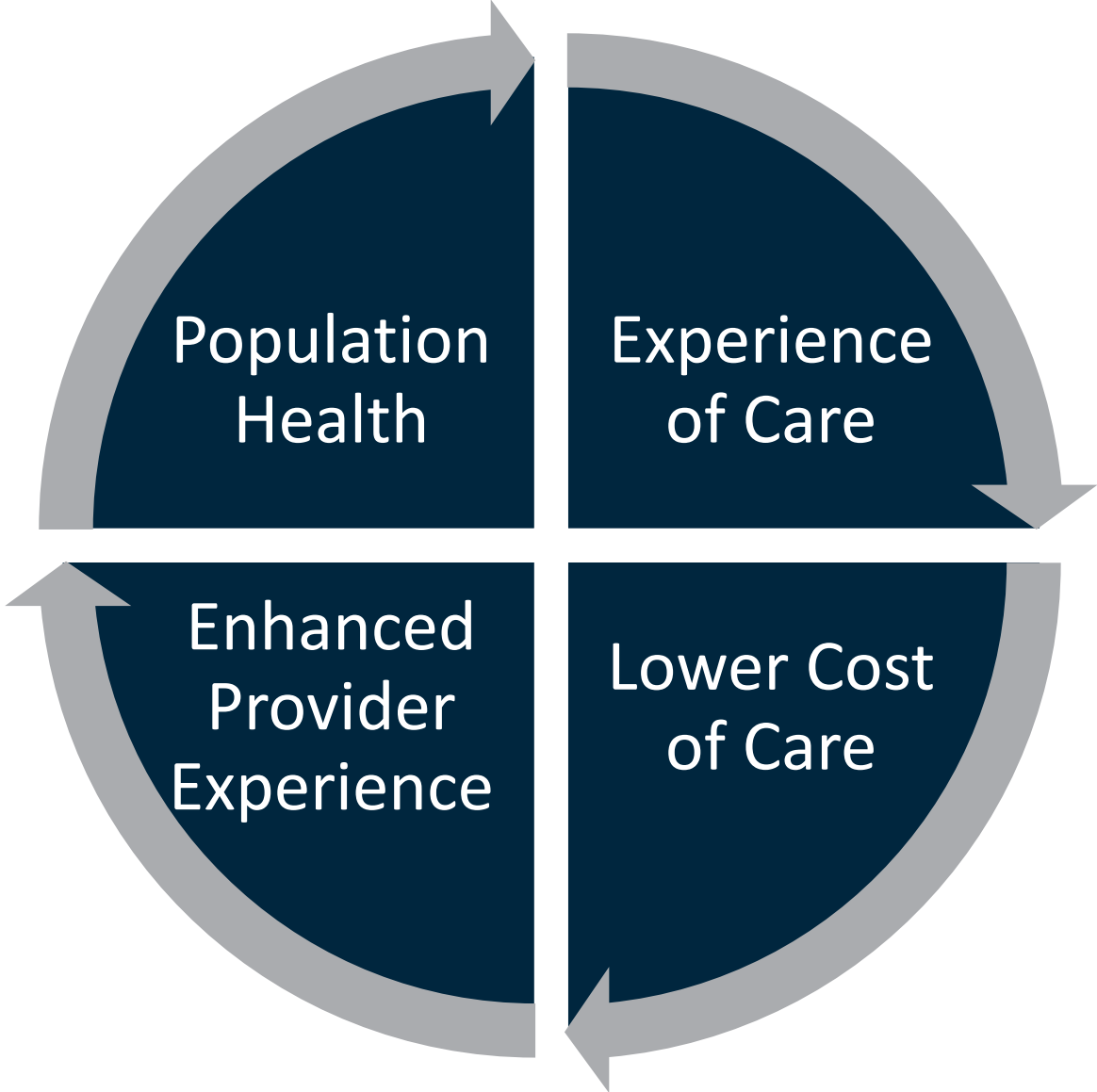
Collaboration.

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.





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



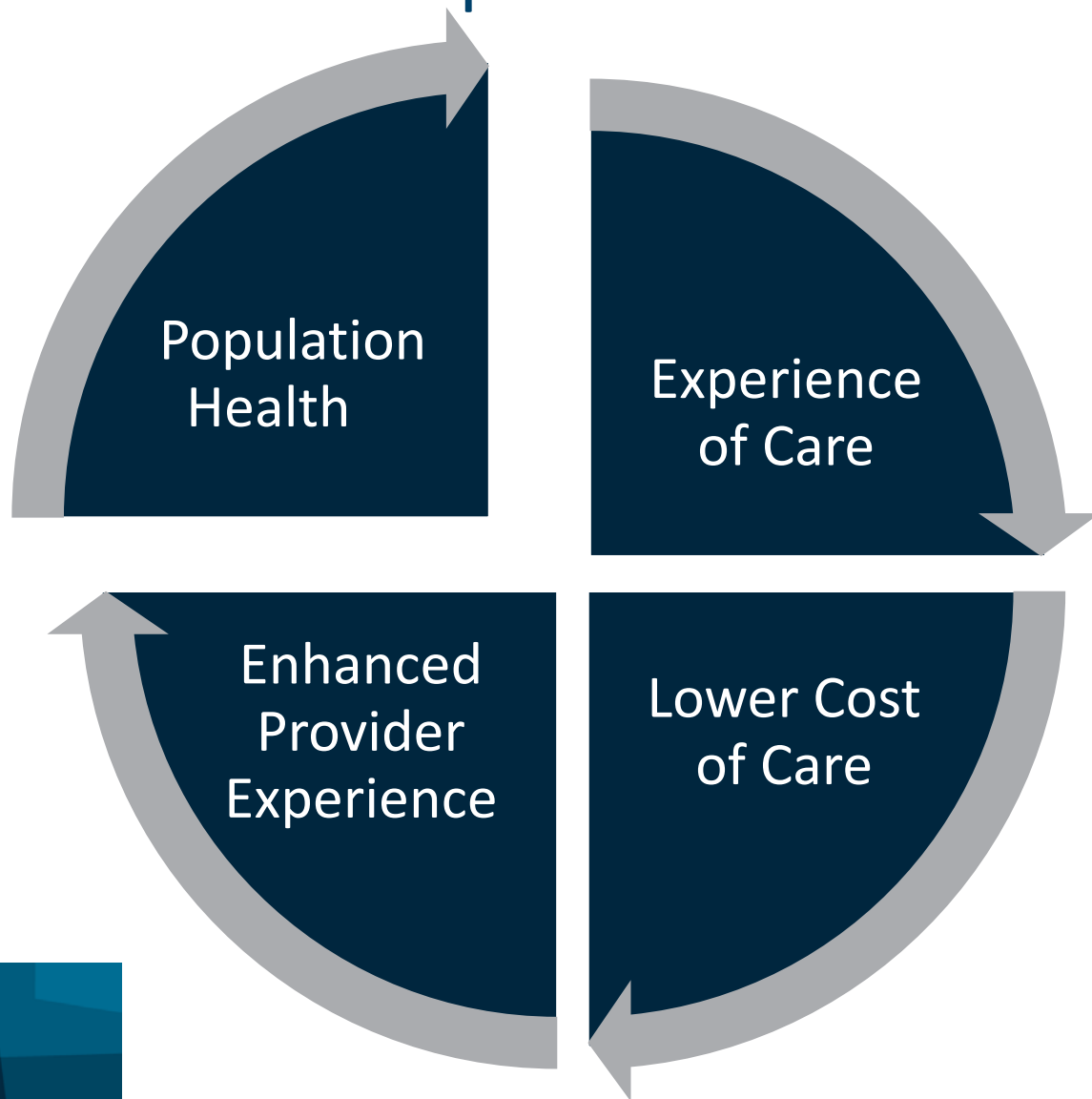
Medical Group 1.0

Primary Care Specialties



Primary Care

Medical Group 1.0

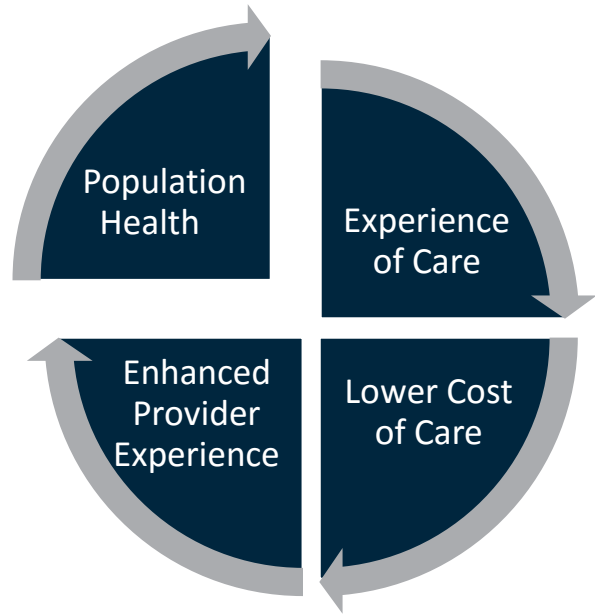


- Physician Led Quality Committee
- Quality Metrics and Dashboards
- Integrated Behavioral Health
- Addiction Services (MAT)/Hub and Spoke
- RN Care Coordinator
- Transitions of Care
- Diabetic Care
- Responsible Opioid Prescribing
- Chronic Pain Management
- Dental Care
- Care Gap Closure
- Reproductive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



Primary Care

Medical Group 1.0



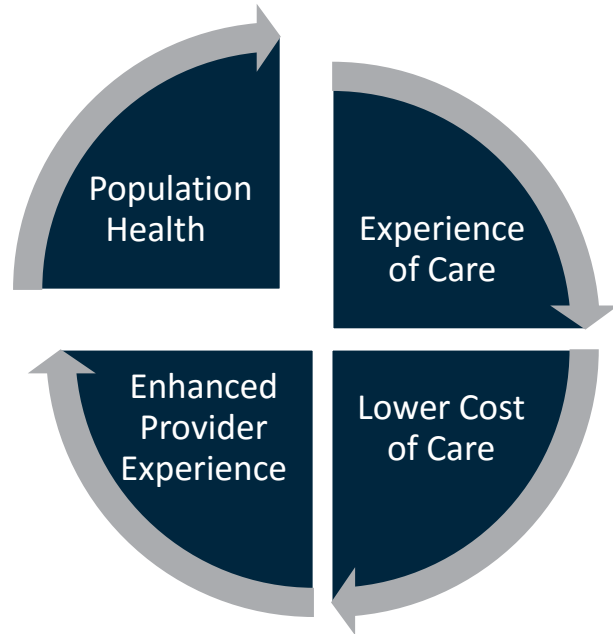
2018 Quality Goals

Metrics	US Average	2020 Goal	2018 Primary Care
Pneumonia vaccine	60%	90%	79%
Colon cancer screening	52.1%	70.5%	69%
A1c greater than 9	18%	16%	15%
Tobacco counseling	62.4%	68.6%	99%



Primary Care

Medical Group 1.0



2019 Quality Goals

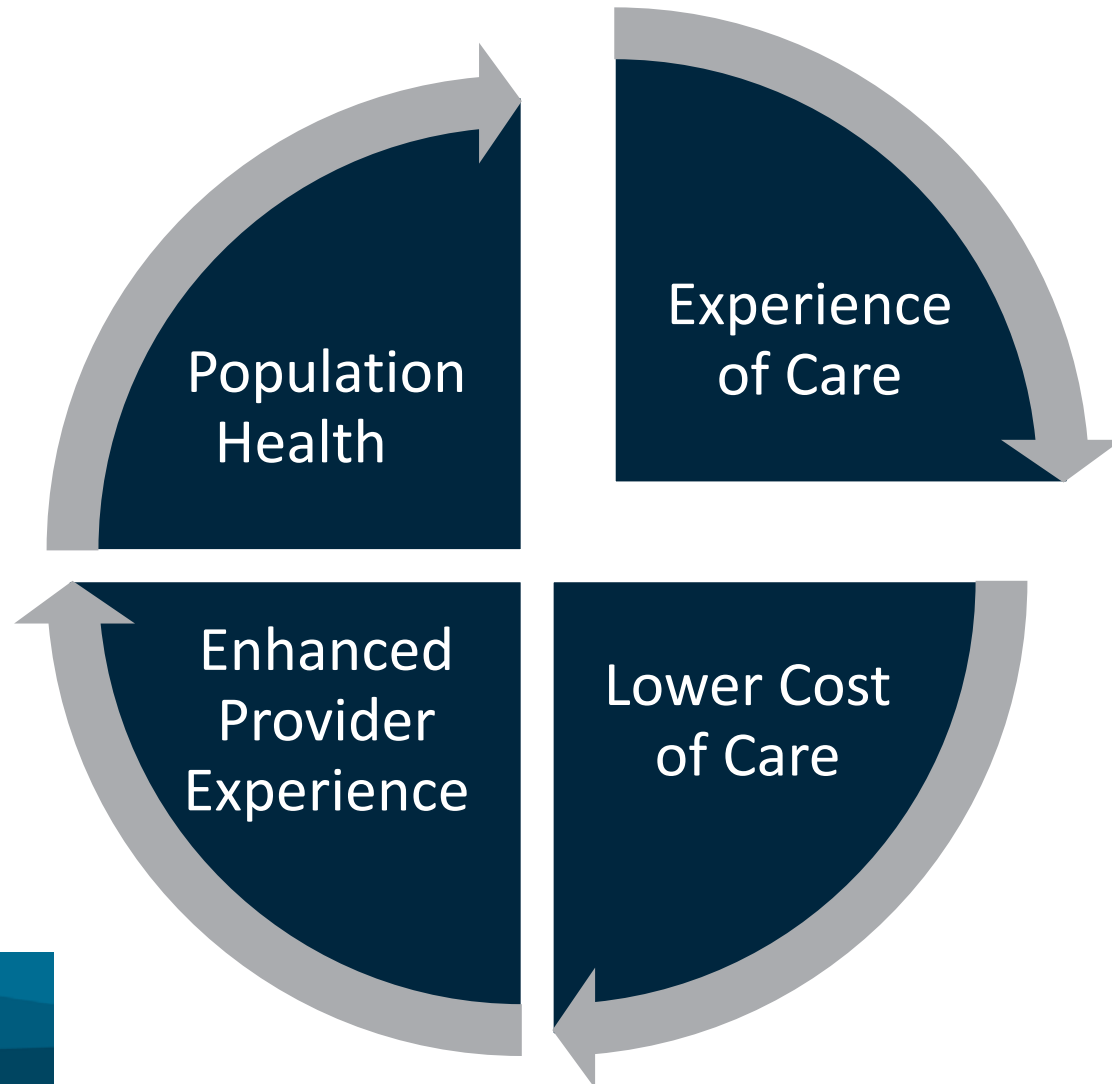
- Depression screening and follow up
- Controlled medication agreement
- Naloxone prescription when appropriate
- Opiate risk tool utilization





Primary Care

Medical Group 1.0

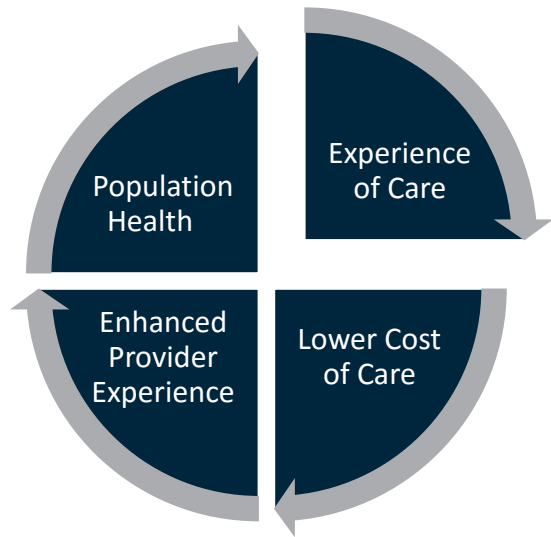


- Access Breakthrough Objective
- Physician Led Access Committee
- Panel Size Review
- Schedule Standardization
- Scheduling Team
- Phone Process

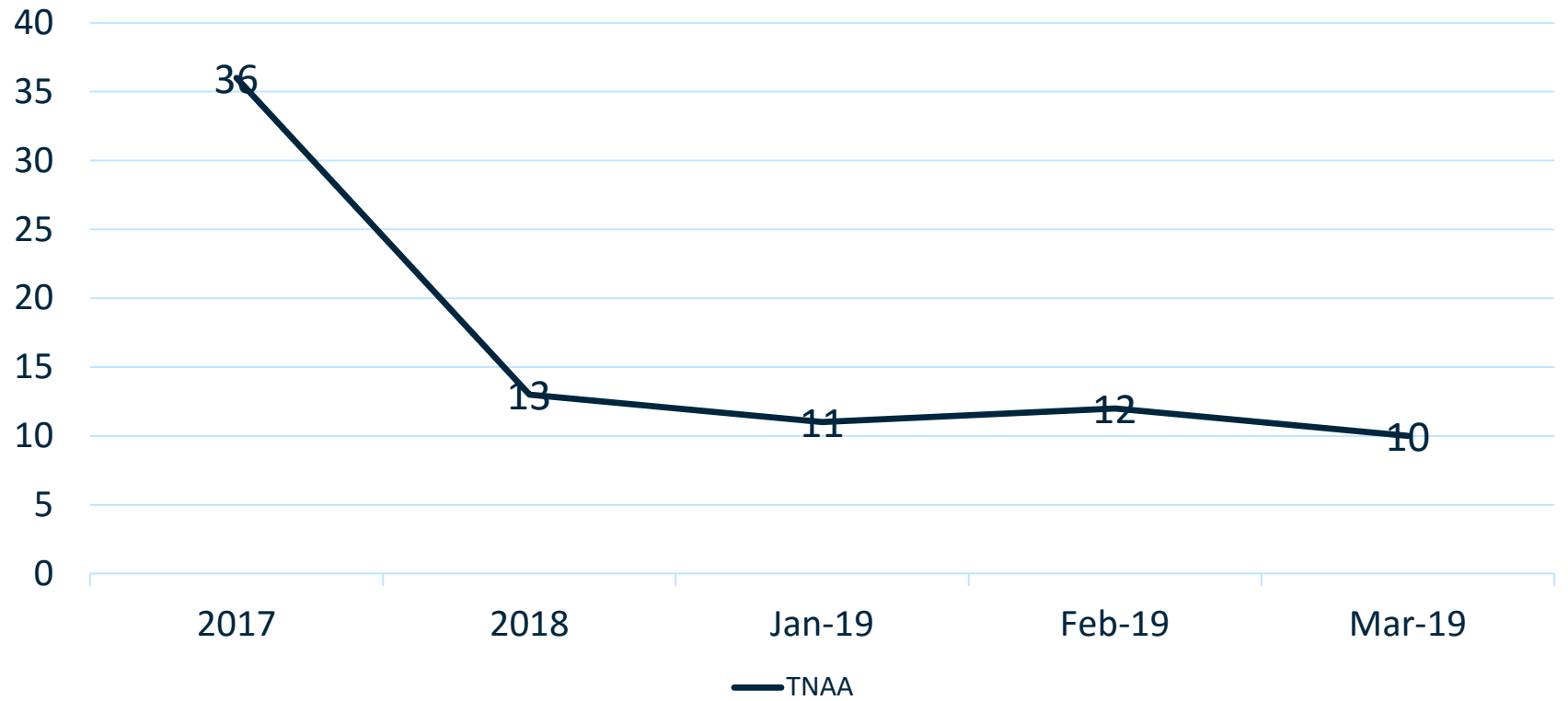




Primary Care Medical Group 1.0

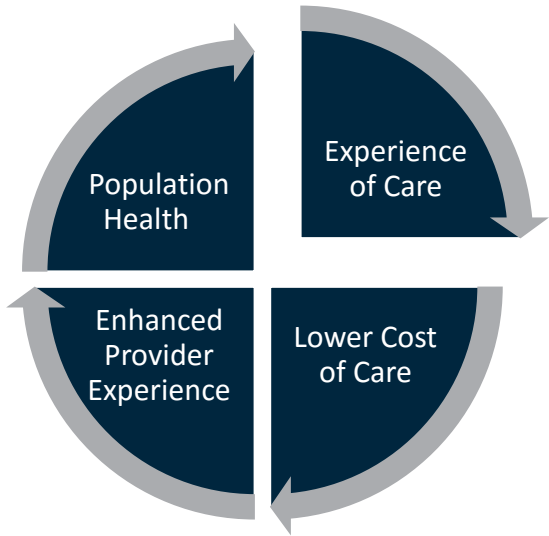


Third Next Available

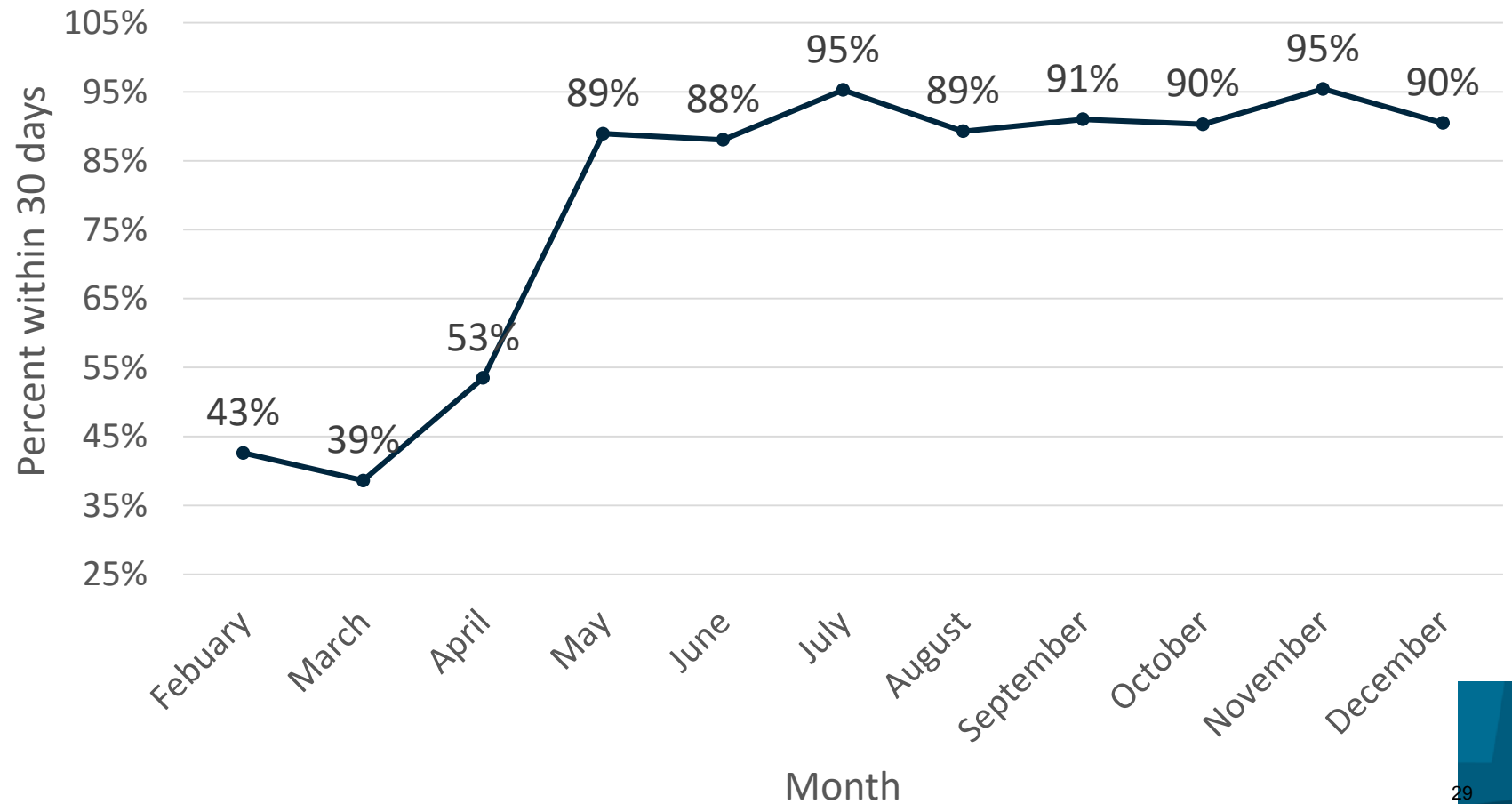


Primary Care

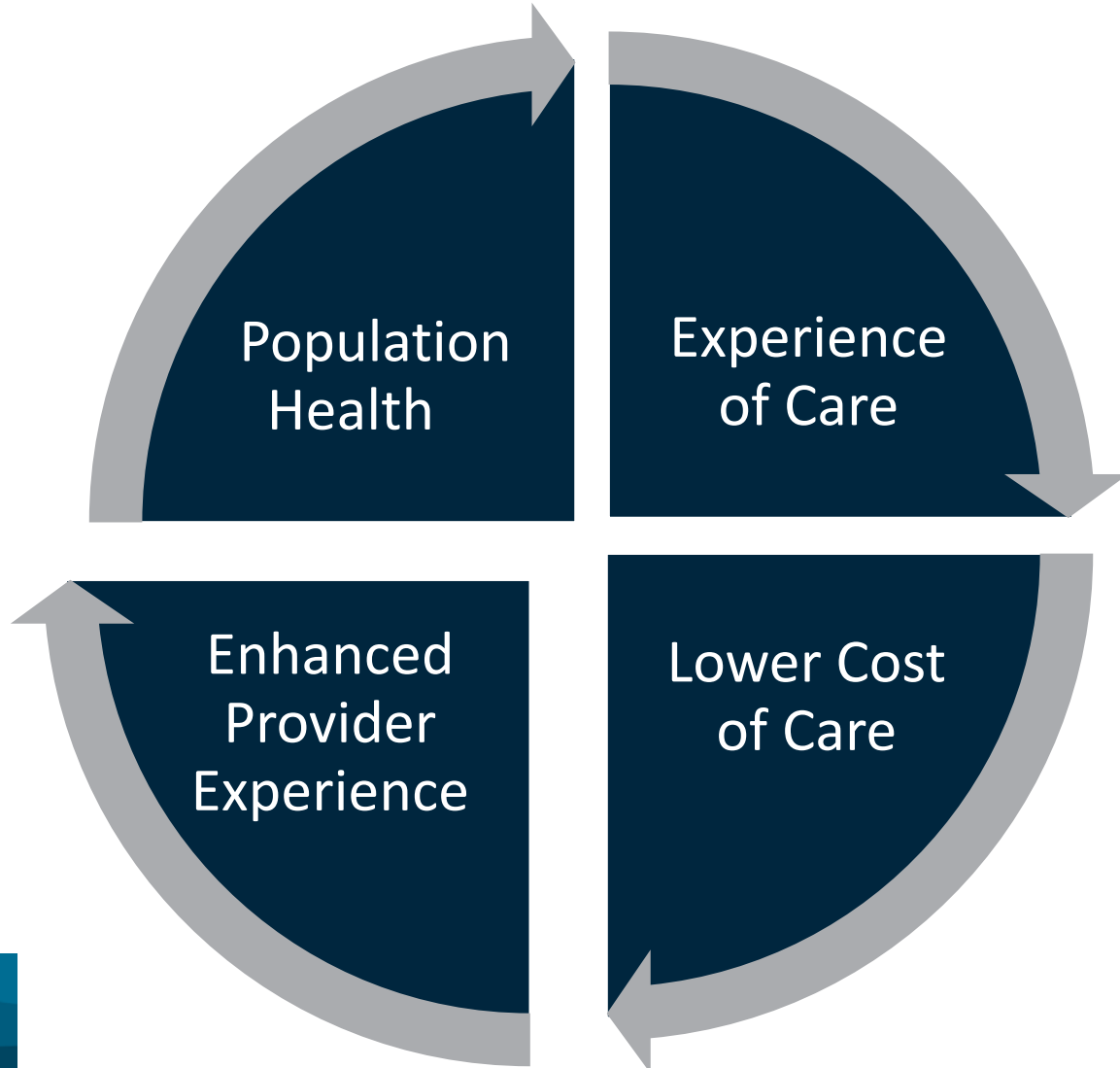
Medical Group 1.0



2018 Next Available New Patient within 30 days



Primary Care Medical Group 1.0



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



Primary Care

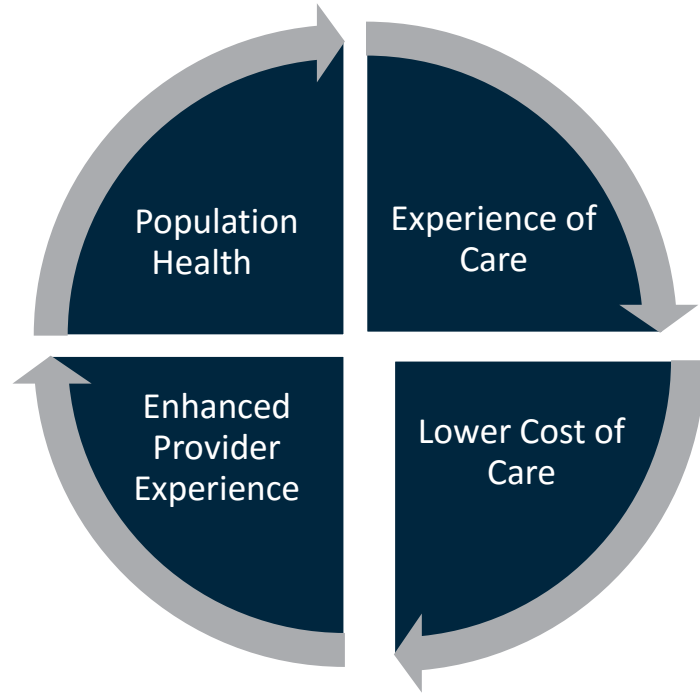
Medical Group 1.0



- Prevention and Screening
- Express Clinic
- Data Analytics
- Utilization of Services



Primary Care Medical Group 1.0

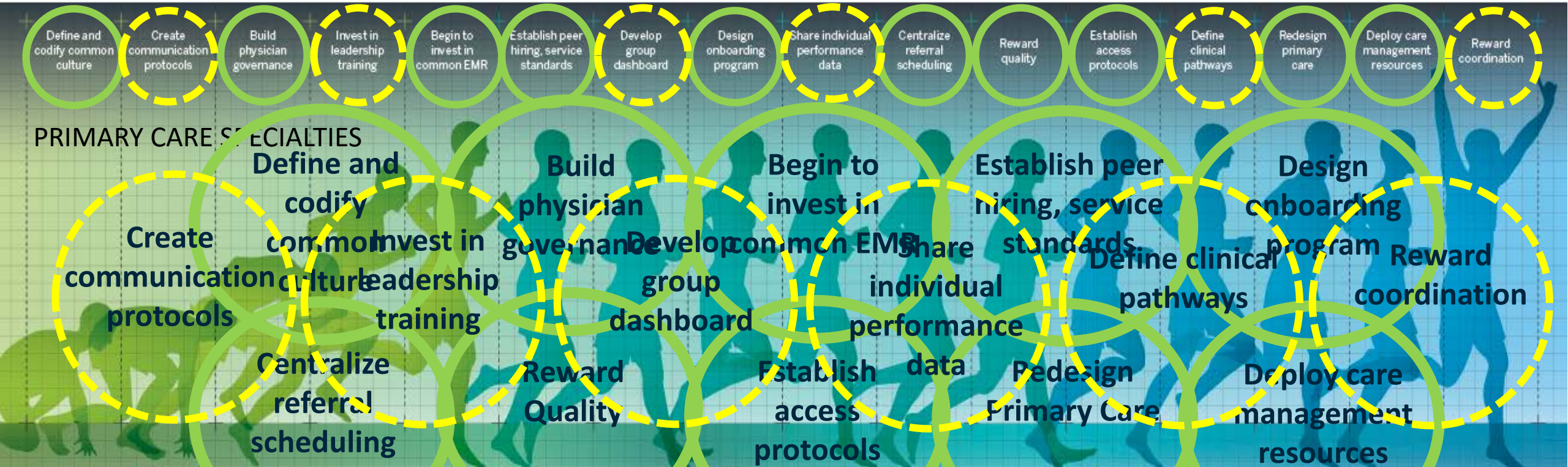


ACO Participant	Patients	Avg. Total Expenses	Avg. ER Admits
Grand River Health	2004	\$11,103.51	0.65
Jefferson Healthcare	6851	\$8,266.70	0.57
Klickitat Valley Health	1634	\$9,753.80	0.90
Mason General Hospital	4422	\$10,014.62	0.76
Memorial Regional Health	896	\$11,166.44	0.86
Mountain Family Health	408	\$8,824.83	0.82
New Castle Family Health	193	\$5,696.48	0.46
Newport Hospital	2245	\$9,251.84	0.66
Pioneers Medical Center	618	\$14,406.30	0.73
Rangely District Hospital	338	\$14,991.20	0.98
Summit Pacific	1434	\$10,367.55	1.00

****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



PRIMARY CARE SPECIALTIES

GETTING OUT OF THE BLOCKS
Shared Vision

- » Physicians view themselves as part of single organization with 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

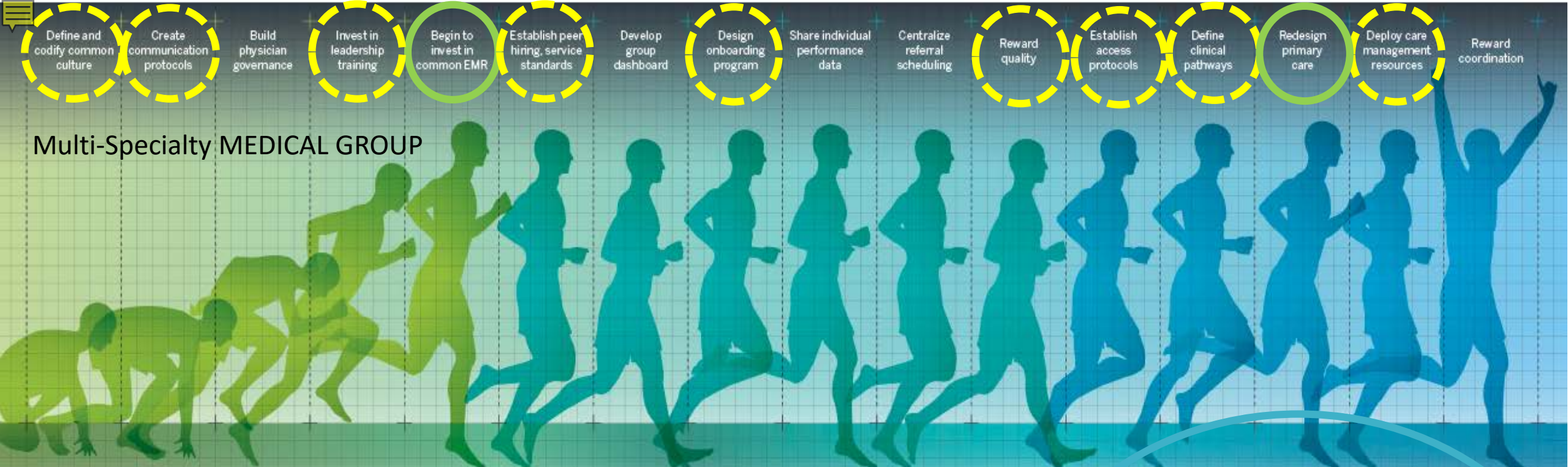
GAINING YOUR STRIDE
Coordination & Integration

- » 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 attracts 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





Multi-Specialty MEDICAL GROUP

GETTING OUT OF THE BLOCKS Shared Vision	GAINING YOUR STRIDE Coordination & Integration	FINISHING STRONG Care Design
<p>» Physicians view themselves as part of single organization with common purpose</p>	<p>» Culture-Base candidate and screening minimizes later physician turnover</p>	<p>» Improved access, convenience, and service attracts patients</p>
<p>» Administrators and physicians agree on a vision of shared values and goals</p>	<p>» New hires more rapidly internalize group processes, cultural norms</p>	<p>» Unnecessary-and expensive-variation in clinical care reduced</p>
<p>» Clinicians more easily accept new processes and standards</p>	<p>» Administrators able to easily spot best improvement opportunities</p>	<p>» Care management efforts improve outcomes for complex patients</p>
<p>» Group able to achieve economies of scale through shared resources</p>	<p>» Enhanced in-network referral capture boosts revenue performance</p>	<p>» Clinicians streamline patient handoffs, eliminate care redundancies</p>
<p>» Open information exchange facilitates administrative and clinical coordination</p>	<p>» Group begins to move dial on quality, efficiency, patient satisfaction</p>	<p>» Health system prepared to meet emerging value-based imperatives</p>



Thanks.
Questions?

Jefferson Healthcare

Respiratory Therapy

April 24th, 2019

Respiratory Therapy at Jefferson Healthcare



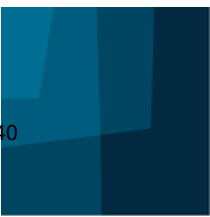


Respiratory Therapy - What's new?

- COPD Education Series
- Methacholine Challenge Testing
- Partnership with EJFR



Questions?



Get well & Stay well

AN UPDATE ON
EXERCISE FOR
HEALTH

History

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.

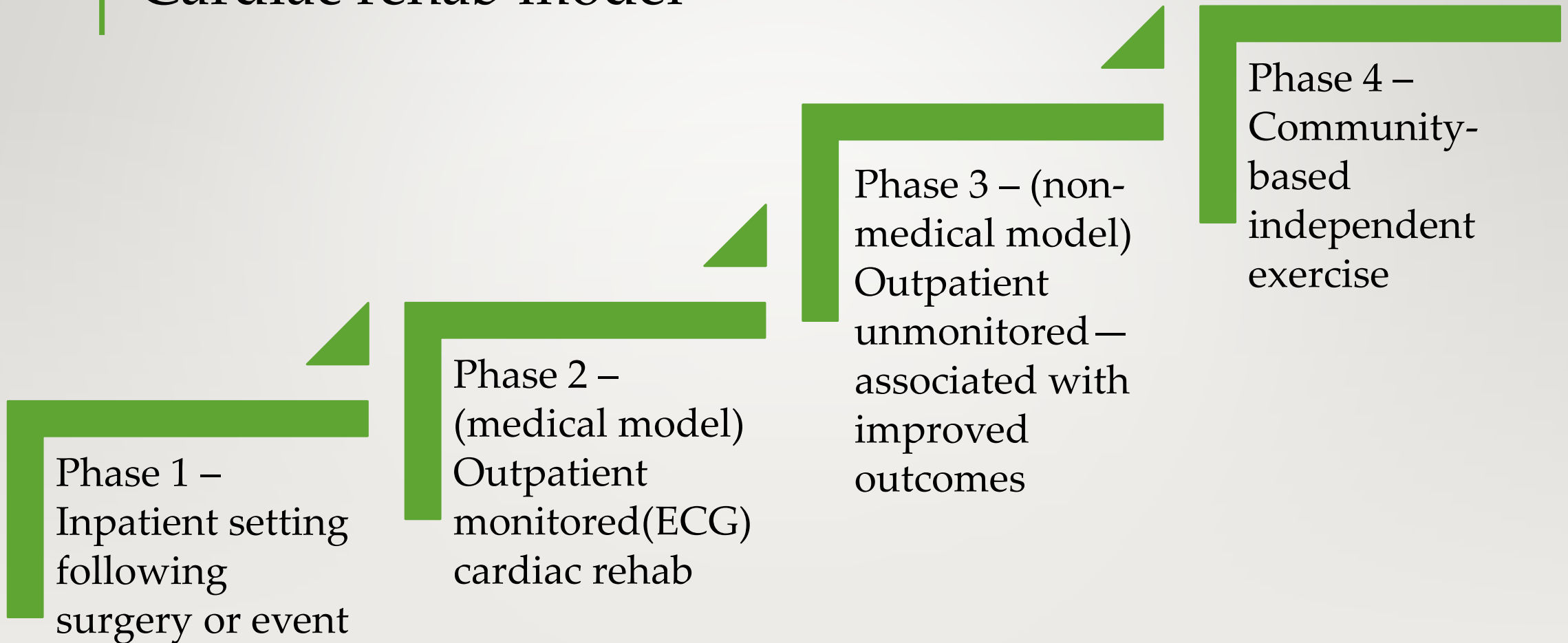
The idea was to educate and train so that participants could then feel comfortable exercising in any setting without monitoring

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



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

- 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 did we
do this now?

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

Agenda

- Commissioner Feedback
- Trends and Highlights
- Responsiveness to Patient Feedback
- New Areas of Concerns
- Breakdown of Care Provider Concerns
- Trends by Service Area
- Patient Advocate Additional Projects

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

1st Quarter 2019

	Acknowledge	Closure
Average	2.8	22.6
Hi	7	45
Lo	0	1
Total		

2nd Quarter 2018

	Acknowledge	Closure
Average	3.55	14.75
Hi	7	47
Lo	0	0

3rd Quarter 2018

	Acknowledge	Closure
Average	1.99	16.94
Hi	7	55
Lo	0	0

4th Quarter 2018

	Acknowledge	Closure
Average	2.59	14.74
Hi	7	59
Lo	0	0

Rolling Year by Quarter

Clinic, ED, EC Concerns/1000 Visits

1st Quarter 2019

	ED	EC	Clinics
1 st Q 2018	4.25/1000 visits	3.5/1000 visits	1.7/1000 visits
Total	13	8	26

2nd Quarter 2018

	ED + EC	Clinics
2nd Q 2018	1.6/1000 visits	.50/1000 visits
Total	5	14

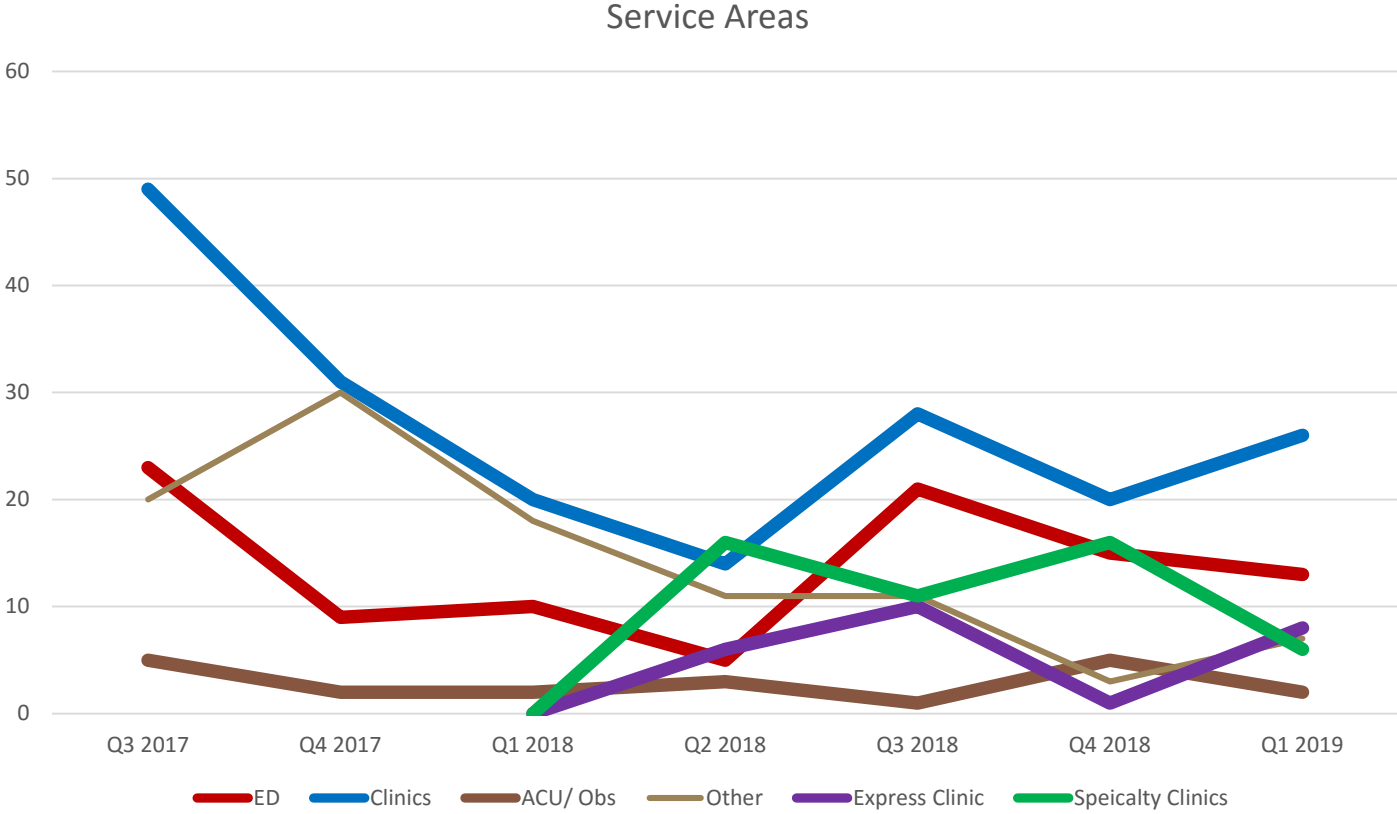
3rd Quarter 2018

	ED + Ex Clinic	Primary Care Clinics
3 rd Q 2018	10/1000	2/1000 visits
Total	32 21 ED; 11 EC	28

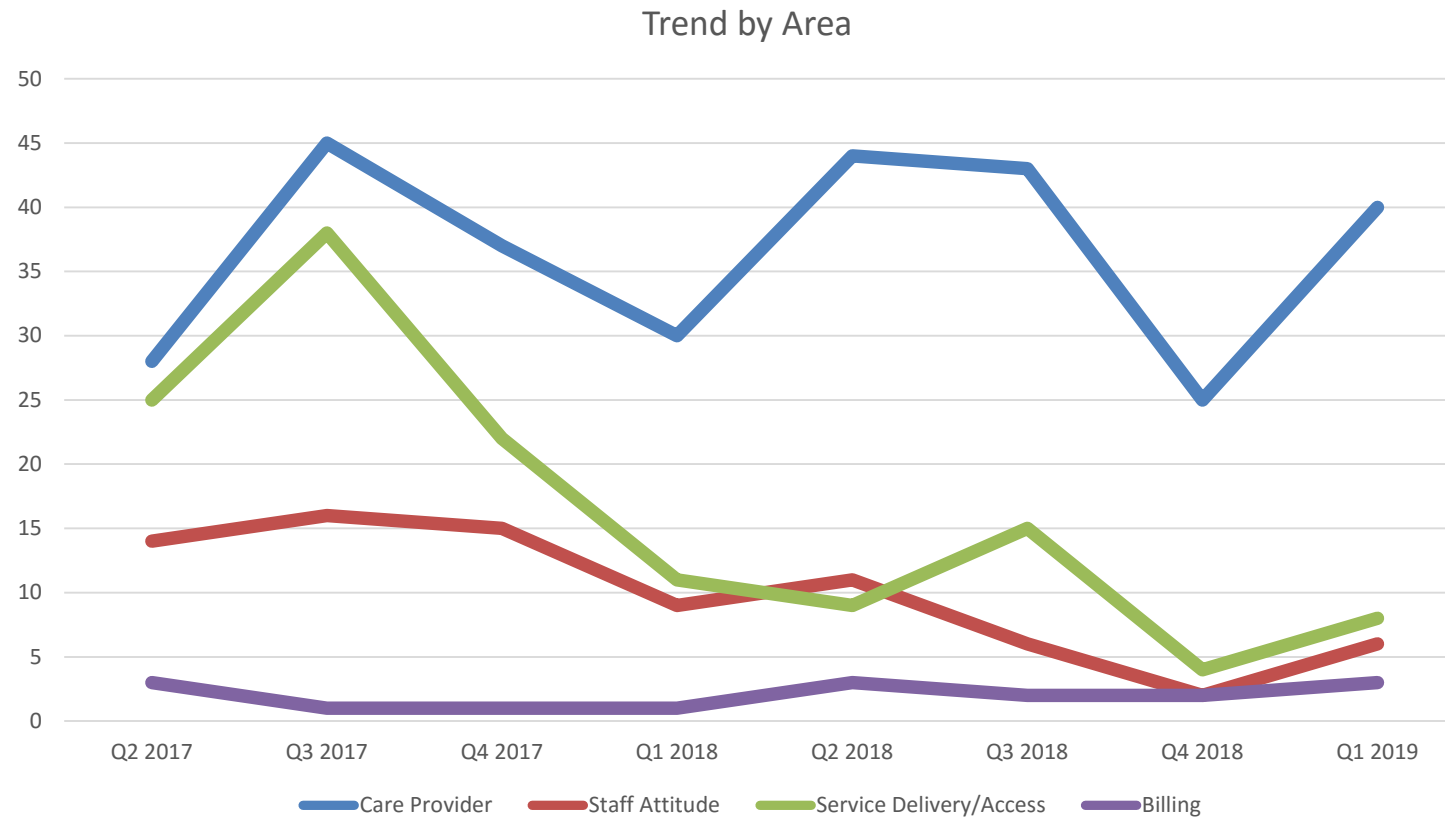
4th Quarter 2018

	ED	EC	Clinics
4 th Q 2018	3.4/1000	1.3/1000	1.32/1000
Total	10	1	15

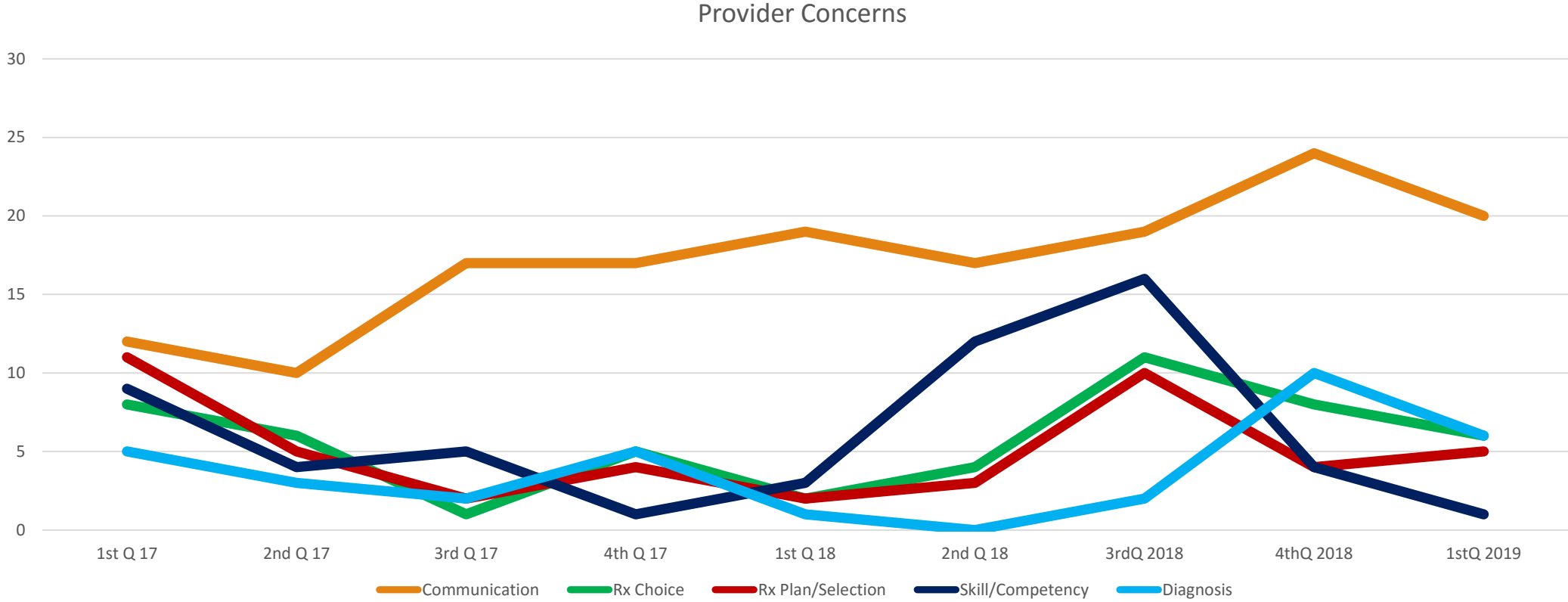
Trends by Area of Concern



Trends by Type of Concerns



Provider Issues



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?

Jefferson Healthcare

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

Service Line Highlight

RESPIRATORY THERAPY – How are we doing on our 2019 objectives?

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**

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

March 2019

Operating Statistics



STATISTIC DESCRIPTION	MARCH 2019						MARCH 2018			
	MO ACTUAL	MO BUDGET	% VARIANCE	YTD ACTUAL	YTD BUDGET	% VARIANCE	MO ACTUAL	YTD ACTUAL		
FTEs - TOTAL (AVG)	574	616	7%	562	616	9%	553	-4%	545	-3%
ADJUSTED PATIENT DAYS	2,229	2,271	-2%	6,579	6,594	0%	2,174	3%	6,283	5%
ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	81	86	-6%	255	250	2%	89	-9%	279	-9%
ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	348	350	-1%	997	1,015	-2%	345	1%	1,117	-12%
PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION	443	444	0%	1,307	1,289	1%	444	0%	1,428	-9%
SURGERY CASES (IN OR)	102	109	-6%	306	316	-3%	106	-4%	296	3%
SPECIAL PROCEDURE CASES	75	77	-3%	185	225	-18%	70	7%	200	-8%
LAB BILLABLE TESTS	19,468	18,954	3%	55,767	55,028	1%	19,448	0%	55,633	0%
TOTAL DIAGNOSTIC IMAGING TESTS	2,895	2,858	1%	8,418	8,298	1%	2,714	7%	7,767	8%
PHARMACY MEDS DISPENSED	22,507	24,983	-10%	67,337	72,530	-7%	24,311	-7%	73,114	-9%
RESPIRATORY THERAPY PROCEDURES	3,849	3,467	11%	11,377	10,065	13%	3,530	9%	10,903	4%
REHAB/PT/OT/ST RVUs	8,538	9,372	-9%	25,004	27,209	-8%	8,607	-1%	27,308	-9%
ER CENSUS	1,086	1,090	0%	3,028	3,163	-4%	1,103	-2%	3,144	-4%
TOTAL RURAL HEALTH CLINIC VISITS	6,080	6,133	-1%	17,553	17,808	-1%	5,260	16%	15,626	11%
TOTAL SPECIALTY CLINIC VISITS	3,405	3,763	-10%	9,930	10,923	-9%	3,172	7%	9,143	8%
HOME HEALTH EPISODES	77	69	12%	210	202	4%	65	18%	199	5%
HOSPICE CENSUS/DAYS	873	1,153	-24%	2,534	3,348	-24%	1,010	-14%	66 3,172	-25%

March 2019

Income Statement Summary

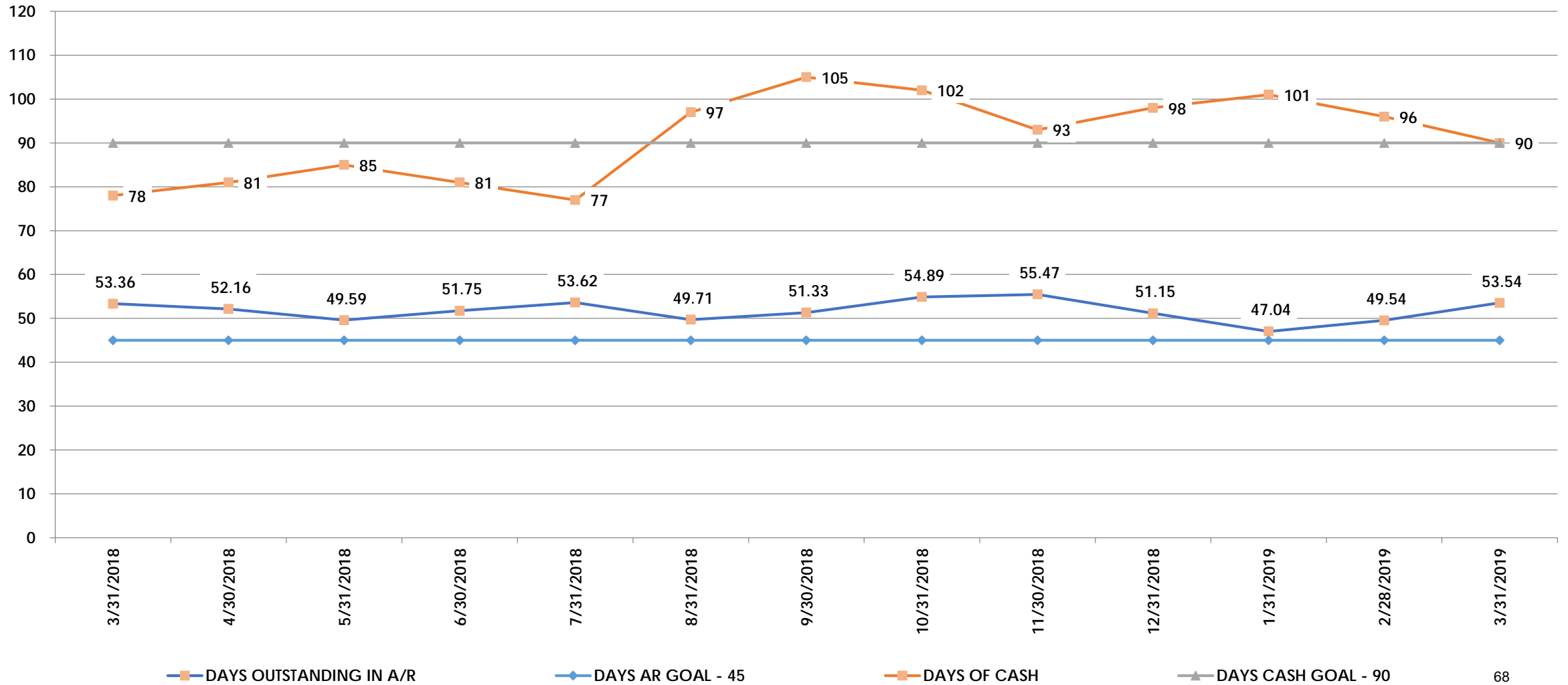


	March 2019 Actual	March 2019 Budget	Variance Favorable/ (Unfavorable)	%	March 2019 YTD	March 2019 Budget YTD	Variance Favorable/ (Unfavorable)	%	March 2018 YTD
Operating Revenue									
Gross Patient Service Revenue	21,110,153	21,166,726	(56,573)	0%	61,732,382	61,451,779	280,603	0%	57,642,271
Revenue Adjustments	11,233,254	11,238,892	5,637	0%	33,073,167	32,629,037	(444,129)	-1%	31,346,703
Charity Care Adjustments	210,786	242,094	31,307	13%	507,893	702,853	194,960	28%	672,566
Net Patient Service Revenue	9,666,112	9,685,740	(19,628)	0%	28,151,322	28,119,889	31,434	0%	25,623,002
Other Revenue	639,812	779,134	(139,322)	-18%	1,410,659	2,262,001	(851,342)	-38%	1,170,901
Total Operating Revenue	10,305,924	10,464,874	(158,950)	-2%	29,561,981	30,381,889	(819,909)	-3%	26,793,903
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



March 2019

Board Financial Report

Dept#	Department	Rev/Exp	Account	Account Description	March Actual	March Budget	March Variance	2019 to Date Actual	2019 to Date Budget	2019 to Date Variance
8612	BOARD	Exp	600010	MANAGEMENT & SUPERVISION WAGES	4,645.00	5,218.00	573.00	14,281.00	15,150.00	869.00
			602300	CONSULT MNGMT FEE	-	2,123.00	2,123.00	-	6,164.00	6,164.00
			602500	AUDIT FEES	-	3,397.00	3,397.00	-	9,863.00	9,863.00
			604200	CATERING	53.00	127.00	74.00	158.00	370.00	212.00
			604500	OFFICE SUPPLIES	-	25.00	25.00	-	72.00	72.00
			604850	COMPUTER EQUIPMENT	-	85.00	85.00	-	247.00	247.00
			606500	OTHER PURCHASED SERVICES	-	849.00	849.00	-	2,466.00	2,466.00
			609400	TRAVEL/MEETINGS/TRAINING	2,658.00	1,699.00	(959.00)	4,106.00	4,932.00	826.00
			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**

Jefferson Healthcare

2018 Critical Access Hospital Report

Presented April 24, 2019

CMS Condition of Participation	Standard	Survey Procedures (Questions that CMS asks to support compliance)	Periodic Review evidence of compliance:	Additional Comments:
C-0331				
§485.641(a)	The CAH Carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year	How is the information obtained and how does the CAH conduct the evaluation? Who is responsible for the periodic evaluation	Periodic Review presented to the Board of Commissioners on April 24, 2019 for the period of January 1, 2018 to December 31, 2018	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
C-0332				
§485.641(a)(1)(i)	The utilization of CAH services, including at least the number of patients served and the volume of services;	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?	The utilization statistics are provided on slides 3-8 of the periodic evaluation report.	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.
C-0333				
§485.641(a)(1)(ii)	A representative sample of both active and closed clinical records; and	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?	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	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.
	“A representative sample of both active and closed clinical records” means not less than 10 percent of both active and closed patient records.			
C-0334				
§485.641(a)(1)(iii)	The CAH'S health care policies	What evidence demonstrates that the health care policies of the CAH are evaluated, reviewed and/or revised as part of the annual program evaluation?	Slides 11 - and a list is provided for review of the new polices in 2018.	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.
C-0335				
§485.641(a)(2)	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	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?	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.	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.
The state operations manual, containing the CMS Critical Access Periodic Review (annual report) can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf				

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.”*



Acute Care Utilization

- Census
- Length of Stay



Departments and Services

- Departments and Services
- 2018 Annual Volumes

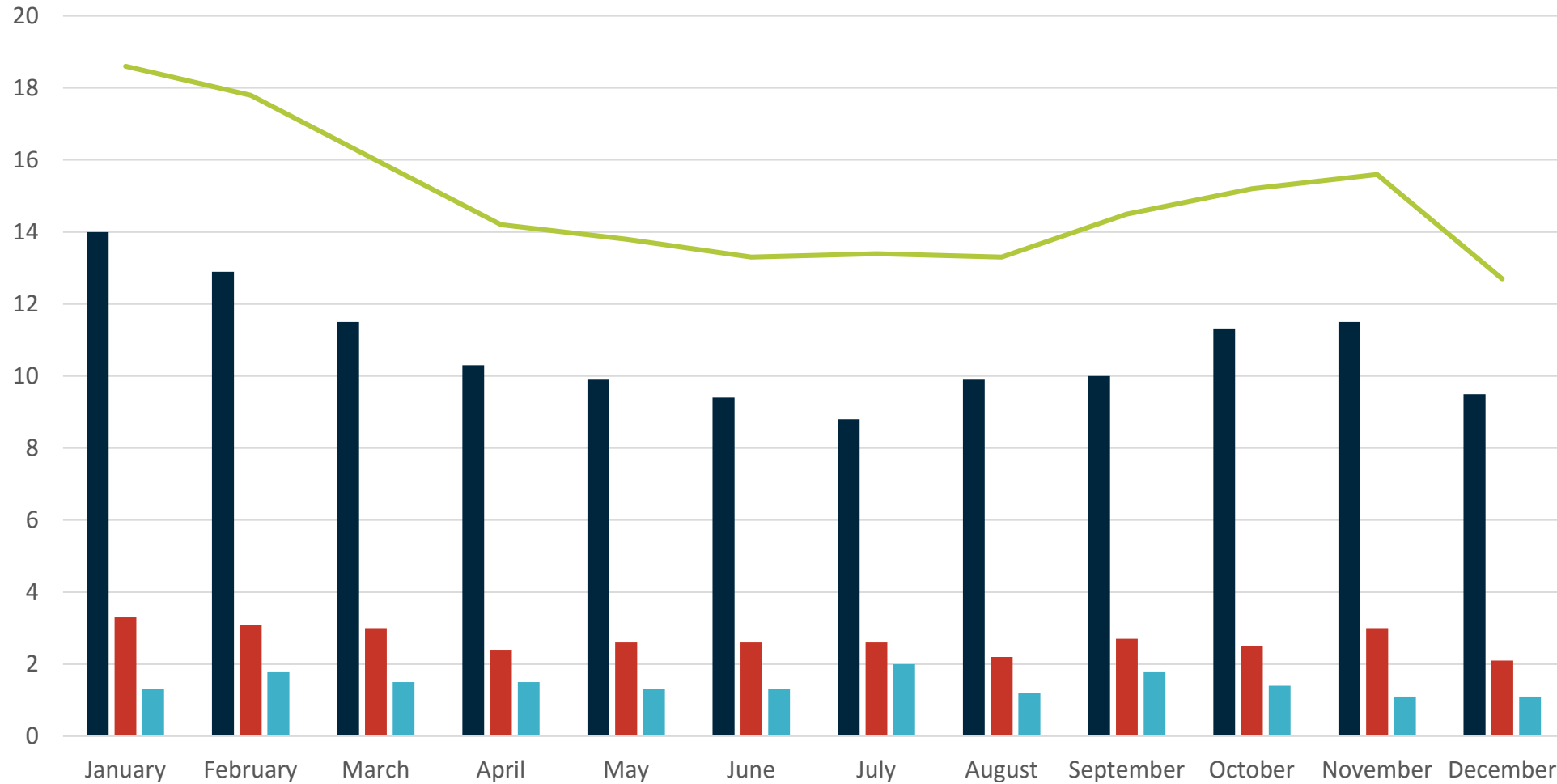


Transfers

- Transfer Statistics
- Top Transfer Diagnoses

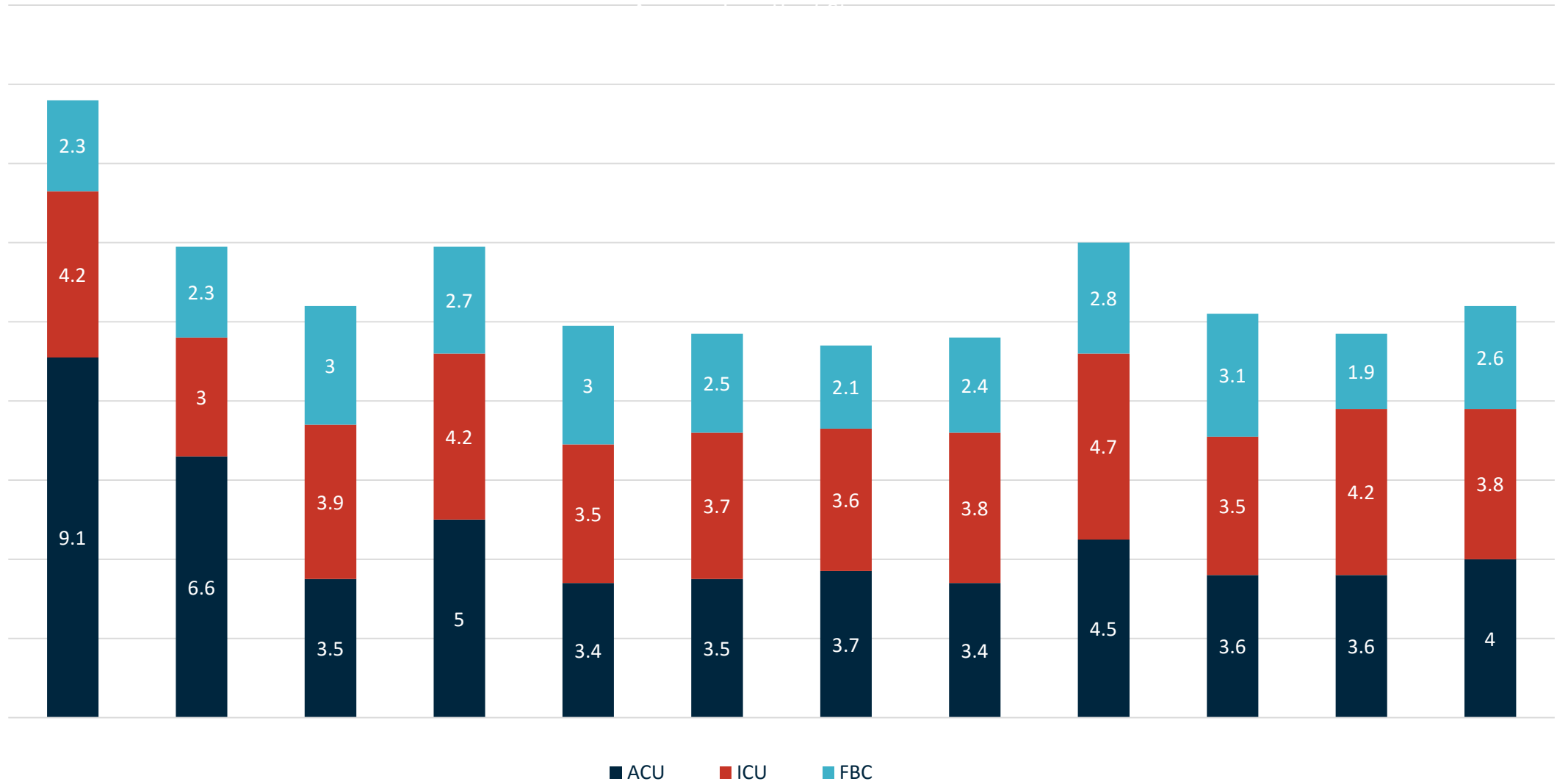
2018 Acute Care Census

Census by Department



■ ACU ■ ICU ■ FBC — Total
2018 Average Daily Census: 14.87
25 beds were not exceeded in 2018

2018 Length of Stay

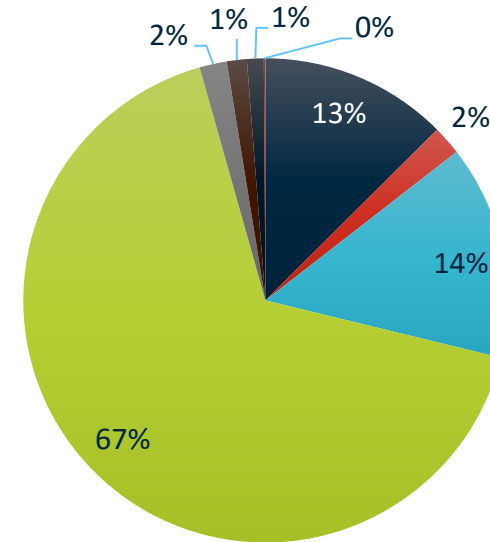


Utilization of Services

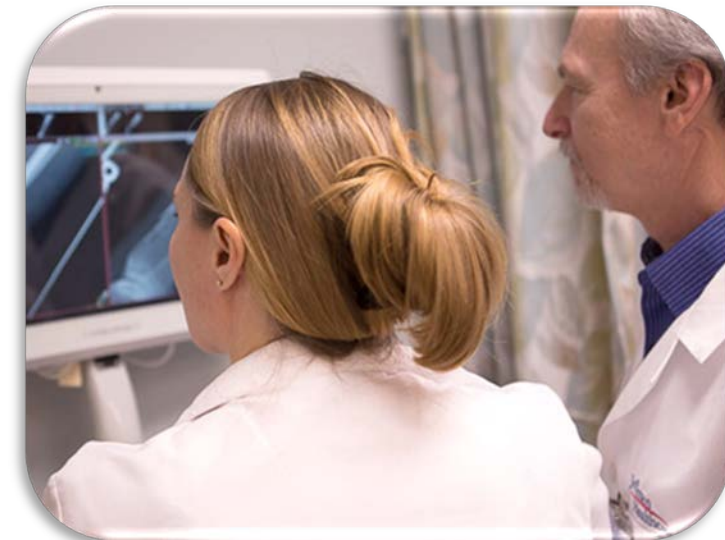
- Outpatient
 - 11,191 Home Health Visits
 - 5,606 Hospice Visits
- Observation
 - 359 Observation Days
- Inpatient Hospice
 - 132 Patient Days
 - Average LOS 6.3 days
- Pharmacy
 - 141,134 Doses Dispensed
- Swing Bed
 - 145 Swing Bed Days

Average IP Length of Stay 89.4 hours

2018 Payor Mix



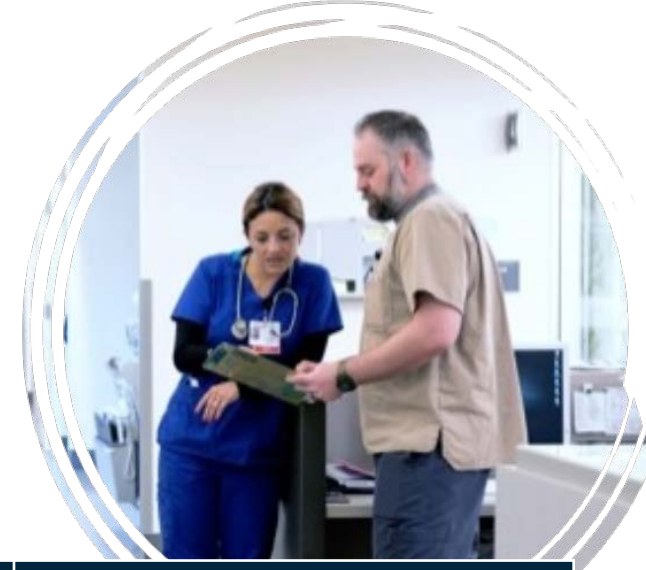
- Private Insurance
- Medicaid
- Medicaid HMO
- Medicare
- Medicare HMO
- Other Gov't
- Self-pay
- Worker's Comp



Departments and Services

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

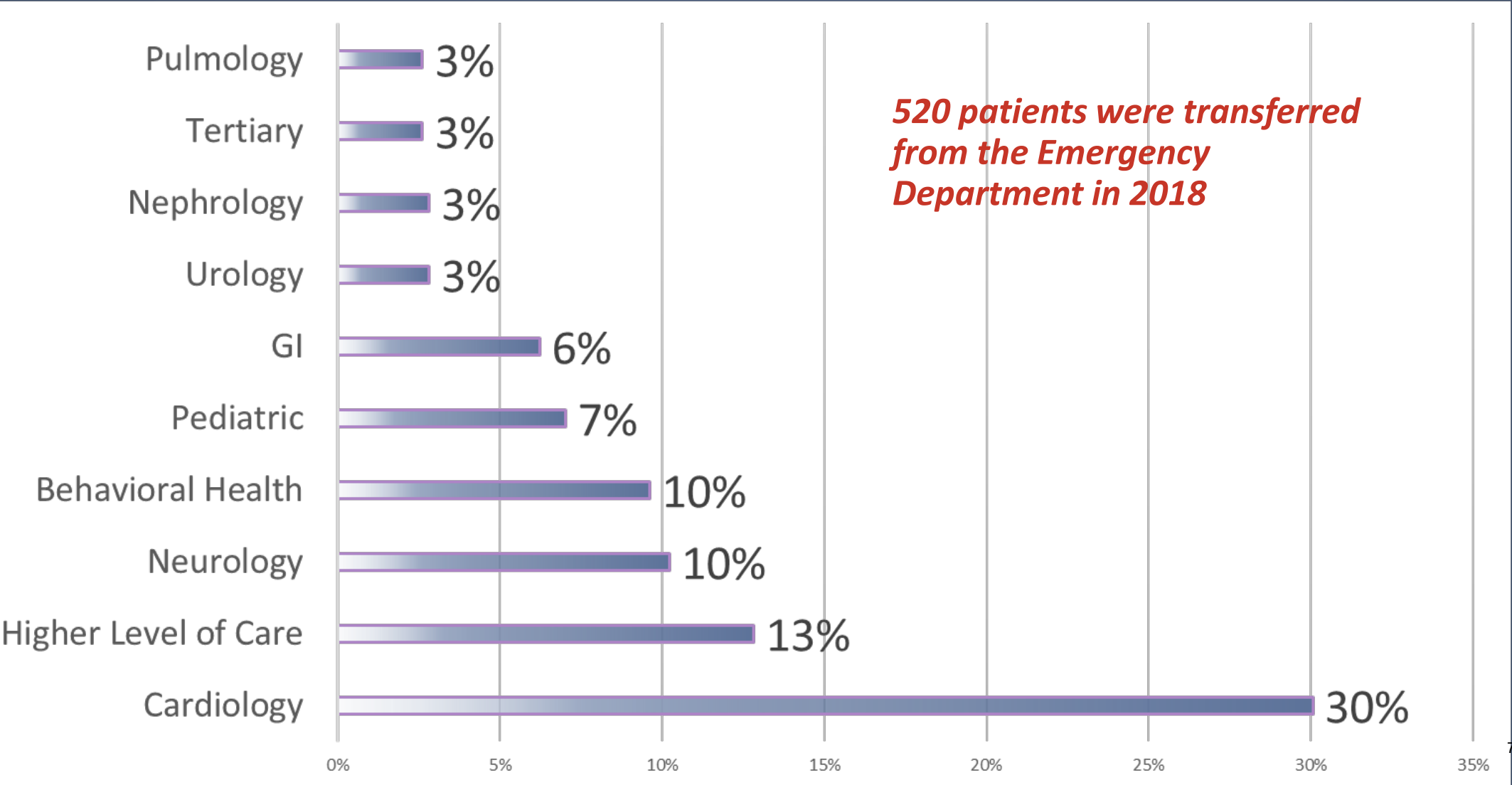
Emergency Department



Disposition	Visits	Percentage of Total Visits
Admitted to JH - Inpatient	1117	8.96%
Transfer – Higher level of care	520	4.17%
Held for Observation	259	2.08%
Left Against Medical Advice	54	0.43%
Left Without Being Seen	243	1.95%

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

Emergency Transfers: Top 10 Reasons for Transfer



Records Reviewed

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

New Policies



- 1838 Total Active Policies and Procedures

Total Policies



- Annual review is required
 - 99.6% compliance

Review



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*

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

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

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

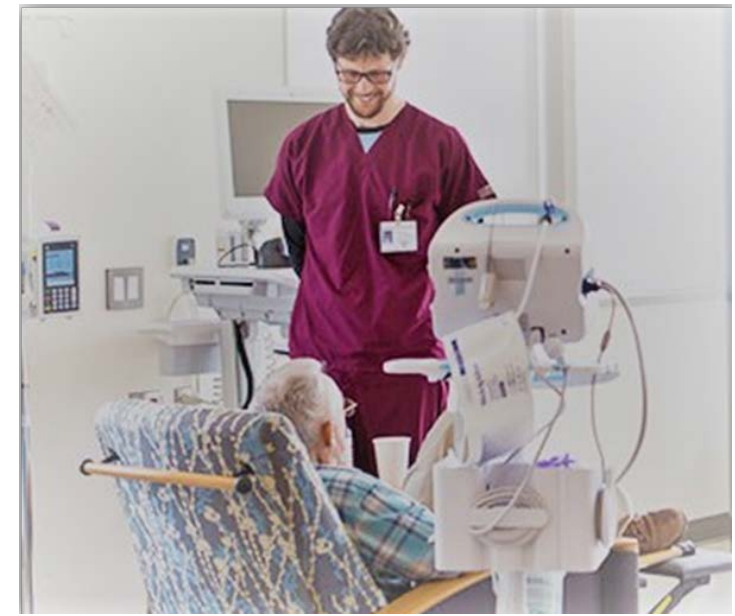
- Jordan Giesler

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?



Jefferson Healthcare

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

