Jefferson County Public Hospital District No.2
Board of Commissioners, Regular Session Minutes
Wednesday, August 28, 2019
Victor J. Dirksen Conference Room

Call to Order:
The meeting was called to order at 2:30pm by Board Chair Buhler Rienstra. present were Commissioners Dressler, Kolff, McComas, Ready. Also in attendance were Mike Glenn, CEO, Hilary Whittington, Chief Administrative Officer/ Chief Financial Officer, Jon French, Chief Legal Officer, Brandie Manuel, Chief Patient Safety and Quality Officer, Jenn Wharton, Chief Ambulatory and Medical Group Officer, Caitlin Harrison, Chief Human Resources Officer, Dr. Joseph Mattern, Chief Medical officer. Alyssa Rodrigues, Administrative Assistant was also in attendance. This meeting was officially audio recorded by Jefferson Healthcare.

Approve Agenda:
Commissioner McComas made a motion to approve the agenda with the addition of Cardiology Privileges in Required Approvals. Commissioner Dressler seconded.
Action: Motion passed unanimously.

Education:
Jon French, Chief Legal Officer presented the Compliance Report.

Discussion ensued.

Jackie Levin, Patient Advocate presented the Patient Advocate Report.

Discussion ensued.

Break:
Commissioners recessed for break at 3:16pm.

Commissioners reconvened from break at 3:30pm.

Team/Employee/Provider of the Quarter:
Mike Glenn, CEO, announced the Employee of the Quarter, Corinna Clemens, Team of the Quarter, Emergency Department, and Provider of the Quarter, Dr. Matthew Crowell.

Minutes:
- July 24 Regular Session

Commissioner Dressler made a motion to approve the July 24 Regular Session minutes. Commissioner McComas seconded.
Action: Motion passed unanimously.

Required Approvals: Action Requested
- July Warrants and Adjustments

- Resolution 2019-16 Surplus Equipment
- Medical Staff Credentials/Appointments/Reappointments
- Medical Staff Policy

Commissioner Dressler made a motion to approve the July Warrants and Adjustments, Resolution 2019-16 Surplus Equipment, Medical Staff Credentials/ Appointments/ Reappointment, and Medical Staff Policy with the inclusion of Cardiology Privileges. Commissioner Kolff seconded.
Action: Motion passed unanimously.

Public Comment:
Public comment was made.

Financial Report:
Hilary Whittington, CFO/CAO presented the July Financial Report.

Discussion ensued.

Quality Report:
Brandie Manuel, Chief Patient Safety and Quality Officer, presented the Quality report.

Discussion ensued.

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

Discussion ensued.

Chief Medical Officer Report;
Dr. Joseph Mattern, CMO, provided the CMO report which included ED transition update, staffing, and Greely update.

Board Business:
Commissioner Buhler Rienstra sadly announced the passing of Renate Wheeler. She explained how wonderful of a person she was and how instrumental she was to the success of Jefferson Healthcare Foundation. She will be greatly missed.

Commissioner Dressler reported the Jefferson Healthcare Foundation event “Sip of Summer” was a success at the Port Townsend Vineyards.

Meeting Evaluation:
Commissioners evaluated the meeting.

Commissioner recessed for break at 5:20pm.
Commissioners returned from break at 5:30pm.

Executive Session:
Commissioners went into Executive Session at 5:30pm to Consider the Purchase and Sale of certain Real Estate. Action may be taken.

Commissioner came out of Executive Session at 5:45pm. No public was present.

Commissioners went into Executive Session at 5:45pm.

Commissioner came out of Executive Session at 5:50pm.

Commissioner Ready made a motion to authorize administration to sell the mineral rights to the property holding in North Dakota for the recommended price.
Commissioner McComas seconded.
Action: Motion passed unanimously.

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

Meeting concluded at 5:50pm.

Approved by the Commission:

Chair of Commission: Jill Buhler Rienstra _____

Secretary of Commission: Marie Dressler _____

Compliance and Integrity Program Report

Jon French
CHIEF LEGAL OFFICER
& COMPLIANCE OFFICER

8.28.2019

Jefferson Healthcare

Agenda

- Compliance and Integrity Program Structure
- Enforcement Trends
- Roles and Rules to Know
- 2019 Program Updates
  - Focus Area: Conflicts of Interest and Disclosure
- Reporting Non-Compliance
- Questions

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Compliance Program Structure

THE SEVEN ELEMENTS*

1. Standards, policies and procedures
2. Compliance leaders and resources
3. Screening and evaluation of personnel
4. Communication, education and training
5. Monitoring, auditing, reporting systems
6. Investigation and remediation processes
7. Discipline and enforcement processes

PLUS

Periodic review and reporting to Executive Quality Council (EQC) and Board of Commissioners

**Source: Office of Inspector General (OIG), U.S. Department of Health and Human Services*

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Why Do We Need a Compliance and Integrity Program (CIP)?

1. DEFINES OUR GOALS, ROLES AND RULES

GOALS

Prevent, **detect** and **correct** improper conduct; enhance organizational excellence; protect patient safety and rights

ROLES

Board of Commissioners: provides oversight to CIP; sets tone; receives periodic reports

JH Leadership: implements/drives CIP; monitors effectiveness

All JH Personnel: know standards; report instances of non-compliance; hold each other accountable to our ethical values

RULES

Laws and regulations that affect our ability to participate in government reimbursement programs (e.g. Medicare) **PLUS** JH internal policies and procedures; focus is on **patient protection,** preventing **fraud, waste and abuse** in healthcare payments

2. IMPLEMENTS AND UPHOLDS OUR ETHICAL VALUES

WE VALUE

- **Ethical culture**, not simply compliance
- **Being proactive**, not only reactive
- **Our JH Mission Statement**: "To hold the trust…"
- **Doing the right thing** simply because it's right

3. ENCOURAGES US ALL TO REPORT CONCERNS

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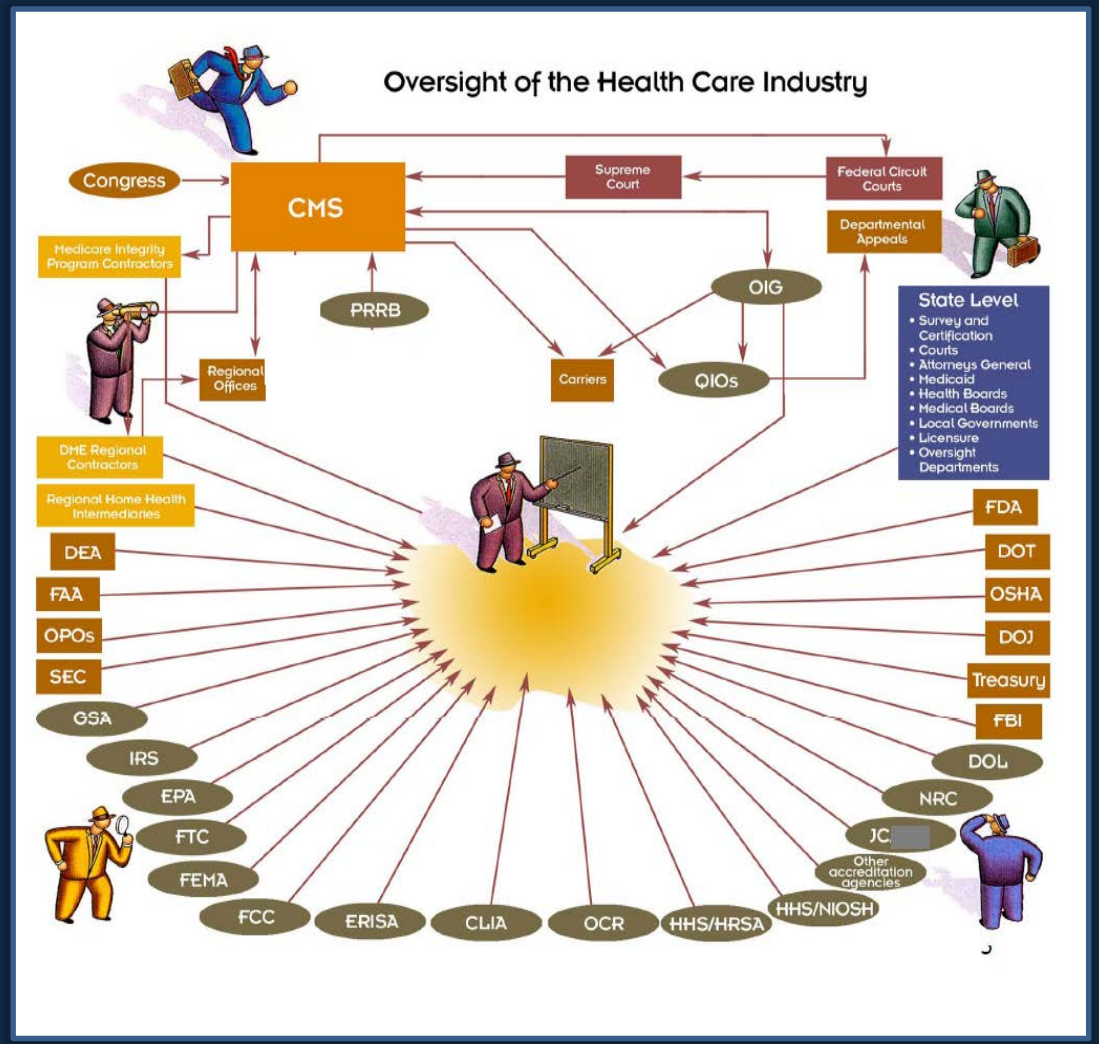
Who's Watching How We Behave?

WE ARE ACCOUNTABLE TO:

- Patients
- Taxpayers (including us)
- Payors (Medicare, Medicaid, Private)
- Licensing Agencies (e.g. Dept. of Health)
- Accrediting Bodies (DNV)
- Lawmakers & Regulators (State & Federal)
- Enforcement Agencies (DHHS OIG, OCR)
- **OURSELVES** and **EACH OTHER**



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Enforcement Trends

2018 TAKEDOWN BY THE NUMBERS

601	Defendants Charged, Including:
165	Medical Professionals
$2	Billion in Losses
587	Exclusions Issued
58	Federal Districts
30	Medicaid Fraud Control Units
350	OIG Agents

U.S. Department of Health and Human Services Office of Inspector General

KEY FOCUS AREAS IN 2019*

- **Referral relationships (Stark Law & Antikickback Statute)**
- **Billing and coding for medical services**
- **Privacy and security of patient healthcare information**
- **Opioid prescribing and kickbacks**
- **Home Health & Hospice**

**Based on recent enforcement actions and OIG Workplan*

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Role of the Board

- Federal Sentencing Guidelines:

  "The organization's governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program."

- OIG Guidance for Healthcare Governing Boards on Compliance Oversight:

  "Directors have a fiduciary responsibility to exercise a reasonable duty of care in overseeing a company's compliance program."

- Generally Good Practices:

  - Know CIP structure and responsibilities: goals, roles and rules
  - Ask good questions and make sure you're satisfied with the answers
  - Set the tone for a strong culture of compliance and ethical behavior

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Role of the Compliance Function

- Administers the Compliance and Integrity Program (CIP)
- Coordinates/collaborates with partner functions to implement and maintain CIP
  - **Human Resources** (personnel screening, training, disciplinary matters)
  - **Information Technology** (data security, technology solutions)
  - **Privacy** (protection of health information, documentation, notification)
  - **Risk Management** (investigation, incident response, mitigation, reporting)
  - **Internal Audit** (monitoring, evaluation of control systems, corrective actions)
  - **Quality** (Quantros reporting, patient-centered care)
  - **Legal** (advice and counsel on laws and regulations, defense, strategy)
- Develops policies and procedures that provide guidance to JH personnel
- Plans actions to improve and sustain compliance
- Ensures ongoing education and training on compliance topics
- Monitors and measures compliance risks and outcomes
- Reports to management and Board on CIP

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Healthcare Compliance Law + Policy

Code of Conduct (The Cornerstone)	Conflicts of Interest & Disclosure	HIPAA Privacy, Security & Patient Rights
EMTALA	Fraud, Waste & Abuse in Healthcare Payments	Antikickback Statute & Physician Self-Referral (Stark Law)
False Claims Act	How and When to Report Possible Misconduct	Whistleblower Protection

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2019 CIP Updates and Actions

Program and policy development:

- Compliance Support Team (CST) identity and composition
- Contracts Management policy and process improvements
- Compliance and Integrity Program updates:
  - New CIP policy replaced outdated Regulatory Compliance policy
  - Compliance Training and Education policy – **NEW**
  - Conflicts of Interest Policy and Disclosure Process – **NEW**
  - Fraud, Waste and Abuse Policies - before EOY
- Documentation compliance and centralization
  - E-consents task force

Live training:

- NEO – general compliance, how to report, scenarios
- Contracts management
- Conflicts of interest
- EMTALA training with Emergency Department and FBC personnel – PLANNED
- Conflicts of interest training with Home Health and Hospice – PLANNED

Opportunities and planned actions:

- Increase system-wide training, education and visibility for CIP
- Audits in areas of enforcement focus
- Develop reporting dashboard to measure outcomes and effectiveness
- Culture of Compliance Survey to measure engagement, understanding of CIP

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Conflicts of Interest (COI)

A conflict of interest (COI) situation may arise when your personal or professional interests, relationships or affiliations affect (or reasonably call into question) your objectivity or integrity in carrying out your official duties to JH. No actual personal gain is required to allow JH to take preventative, corrective or disciplinary action.

Integrity is part of JH's Ethical Culture. Appearances matter.

- Personal gain (professional, financial or otherwise) related to your position with JH is prohibited if it arises from relationships, interests or affiliations that make others question whether you are placing your own benefit above the best interests of JH.

- All JH personnel, including vendors and contractors, must abide by our JH Conflicts of Interest Policy, which includes the duty to **self-disclose (or report)** all actual or potential COI situations, as soon they become apparent. Failure to disclose or report is itself a violation of the JH Code of Conduct.

- The self-disclosure and reporting requirement helps JH to be aware of and deal with potential COI risks – preferably before they cause harm to you or JH.

- Not every possible COI situation can be spelled out in a policy, and not every COI situation will warrant action by JH. Each situation will be evaluated on its own facts, and JH may elect to waive a COI or require that it be mitigated or eliminated.

Stop and ask yourself: **"What would our patients and the public think if they knew this was going on?"**

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Some COI Examples

Dating someone who reports to you/to whom you report	Working at a second job that interferes with your JH duties	Hiring your uncle, even though he doesn't have the required experience
Campaigning for political office in the workplace	Owning any interest in a business that competes with JH	Using JH resources (including work time, email, computers, etc.) for your side business
Allowing your friend to take days off without submitting PTO hours	Accepting gifts or favors from a vendor seeking to sell items/services to JH	Doing paid consulting work for a JH vendor
Selling your personal services to JH patients on the side	Investigating a complaint against a fellow employee who is a close friend of yours	Negotiating or approving a contract with a company owned by your sister-in-law

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When organizations don’t address conflicts of interest

SECTIONS SEARCH THE BALTIMORE SUN SUBSCRIBE 4 weeks for 99¢ LOG IN

MONDAY MAY 6, 2019 LATEST PUGH RESIGNS ENEWSPAPER PROMS ASK US POPULAR SPORTS OBITS ADVERTISING 68°

University of Maryland Medical System CEO resigns amid controversy over Pugh book deal, no-bid contracts

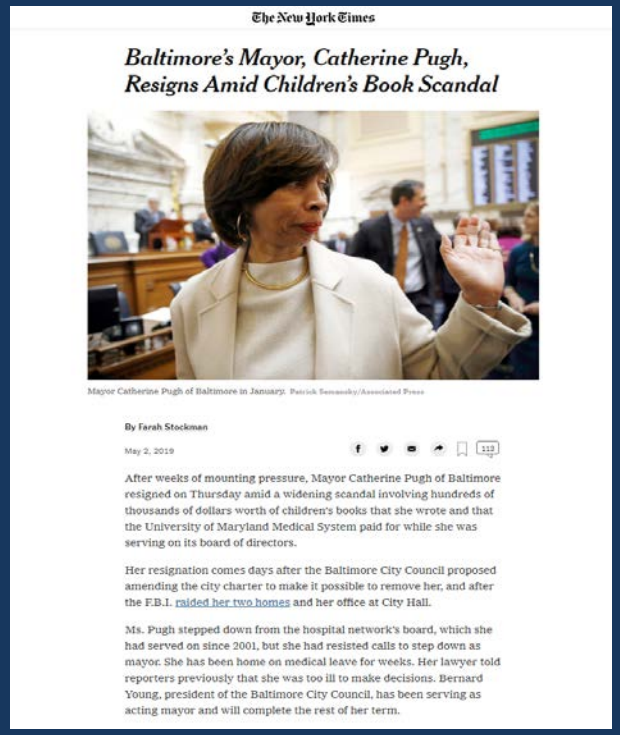
Robert A. Chrencik, president and CEO of the University of Maryland Medical System, listens as Stephen A. Burch, Chairman of the Board of Directors for UMMS, speaks with the media after a meeting with Gov. Hogan and Senate President Mike Miller. (Ulysses Muñoz / Baltimore Sun)

By Luke Broadwater and Meredith Cohn · Contact Reporters
The Baltimore Sun

APRIL 28, 2019, 2:60 PM

Robert A. Chrencik resigned Friday as president and CEO of the University of Maryland Medical System, his long tenure at the hospital network ending amid the controversy surrounding accusations of self-dealing and no-bid contracting.

“Today the Board of Directors and I received and accepted Mr. Chrencik’s resignation from UMMS, effective immediately,” Acting CEO John W. Ashworth said. “This action is an important step in moving the Health System forward during this critical time and we remain focused on delivering exceptional, safe, quality health care across Maryland. We thank Mr. Chrencik for his leadership, service and commitment during his 35 years of executive employment at UMMS.”



The New York Times

Baltimore’s Mayor, Catherine Pugh, Resigns Amid Children’s Book Scandal

Mayor Catherine Pugh of Baltimore in January. Patrick Semansky/Associated Press

By Farah Stockman

May 2, 2019

After weeks of mounting pressure, Mayor Catherine Pugh of Baltimore resigned on Thursday amid a widening scandal involving hundreds of thousands of dollars worth of children’s books that she wrote and that the University of Maryland Medical System paid for while she was serving on its board of directors.

Her resignation comes days after the Baltimore City Council proposed amending the city charter to make it possible to remove her, and after the F.B.I. raided her two homes and her office at City Hall.

Ms. Pugh stepped down from the hospital network’s board, which she had served on since 2001, but she had resisted calls to step down as mayor. She has been home on medical leave for weeks. Her lawyer told reporters previously that she was too ill to make decisions. Bernard Young, president of the Baltimore City Council, has been serving as acting mayor and will complete the rest of her term.

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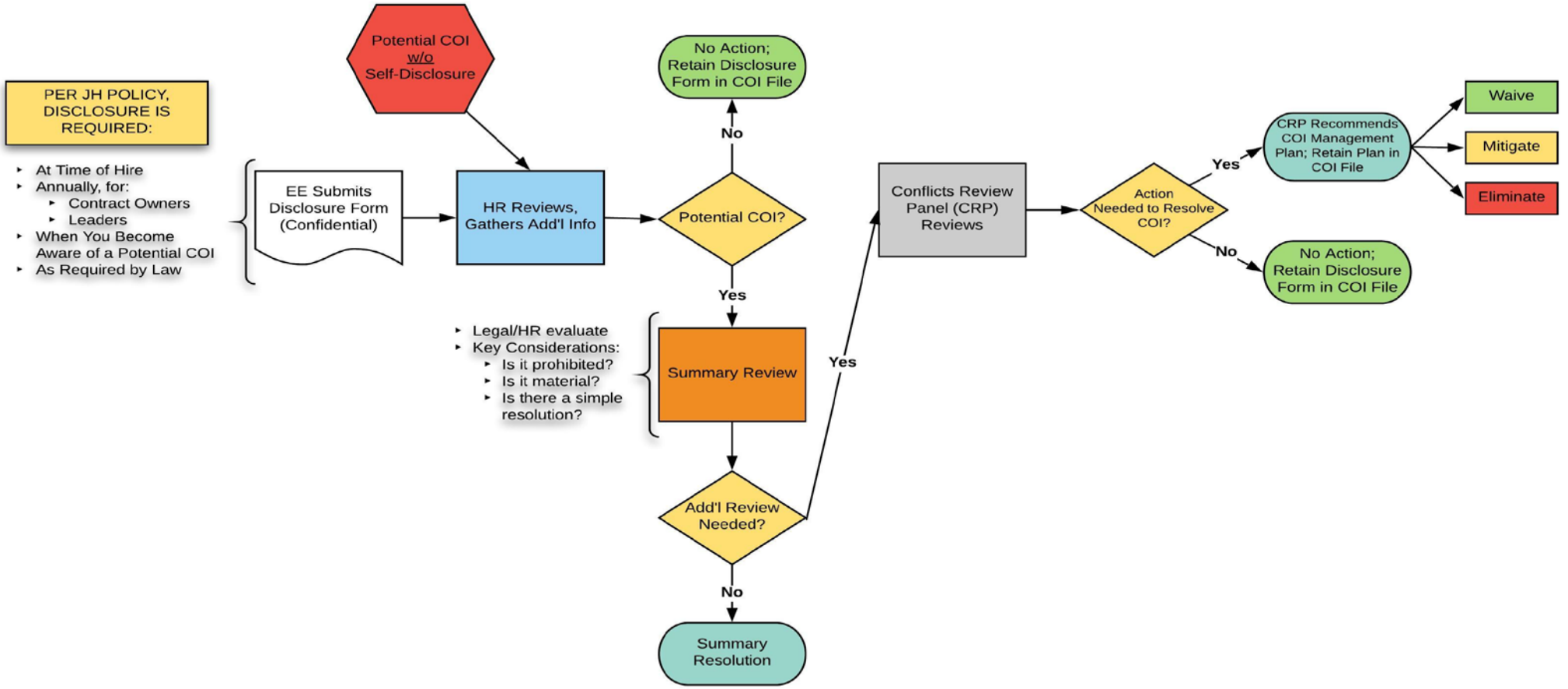
CONFLICTS OF INTEREST: DISCLOSURE, REVIEW and RESOLUTION PROCESS



Reporting Possible Misconduct

- All JH personnel have a DUTY to report suspected misconduct or non-compliance as soon as you become aware of it. Failure to report is itself a violation of the JH Code of Conduct.
- YOU DON'T HAVE TO "PROVE" YOUR REPORT. You don't even have to be certain, so long as you report in "good faith."
  - A good faith report is made with a sincere belief (even if you're not sure) that improper conduct is occurring or is likely to occur. There is no malice or intent to get someone into trouble.
- WHEN IN DOUBT, DISCLOSE OR REPORT!

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Ways to Report Possible Misconduct

IN PERSON

- Your supervisor
- Manager/Director/SLG
- Compliance/Privacy/Info Security Officer

ANONYMOUS

JH ComplianceLine
(866) 487-0007

Quantros Event Report
https://qxpert.quantros.com/landing/JHC

Compliance Officer	Privacy Officer	Information Security Officer
Jon French	Melody Draper	Roger Harrison
ext. 2027	ext. 2292	ext. 2292
jfrench@jeffersonhealthcare.org	mdraper@jeffersonhealthcare.org	rharrison@jeffersonhealthcare.org

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Questions

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Patient Advocate Report

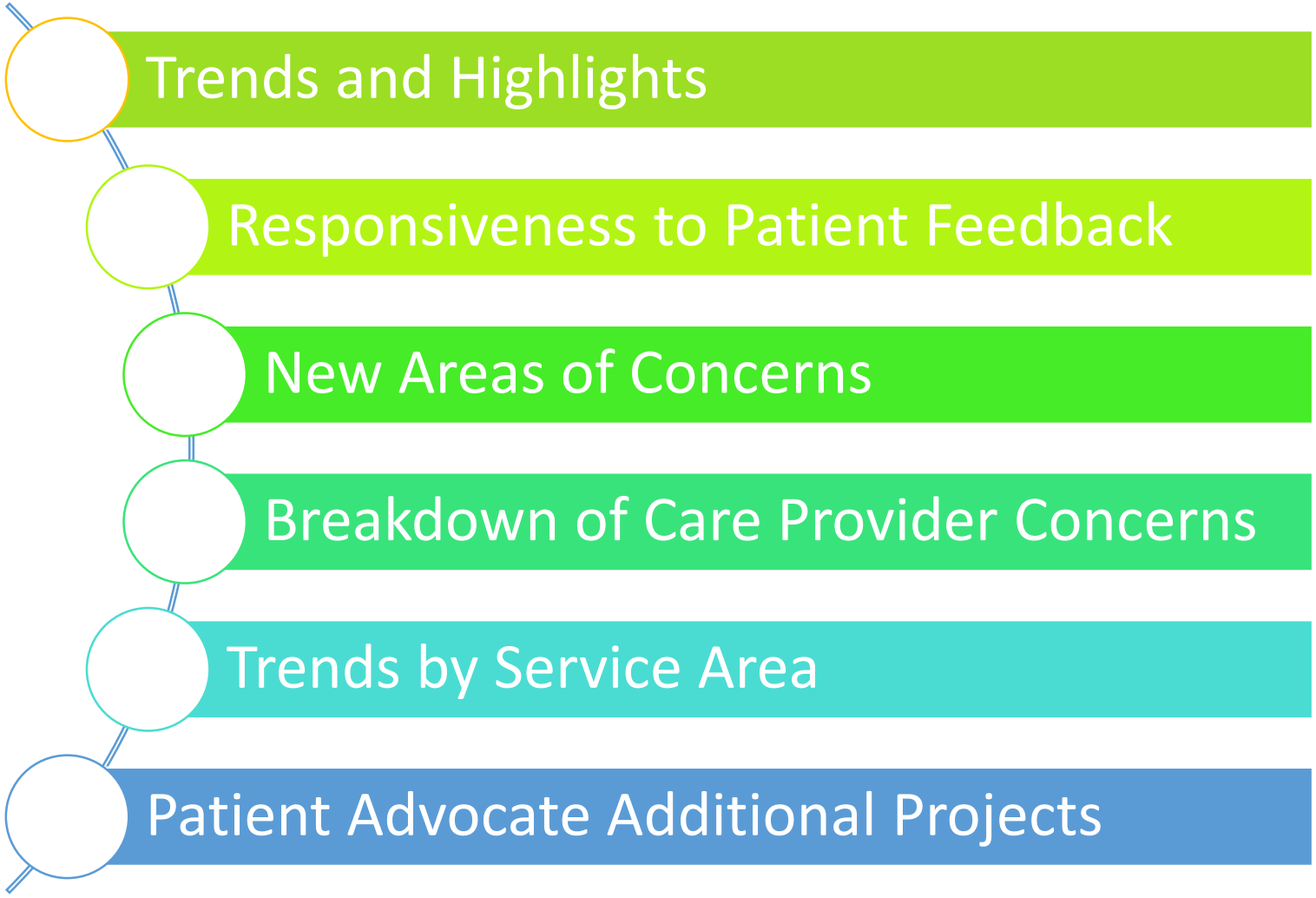
2nd Quarter 2019

Patient Advocate Report

August 28, 2019

Jackie Levin MS, RN, Patient Advocate

Agenda

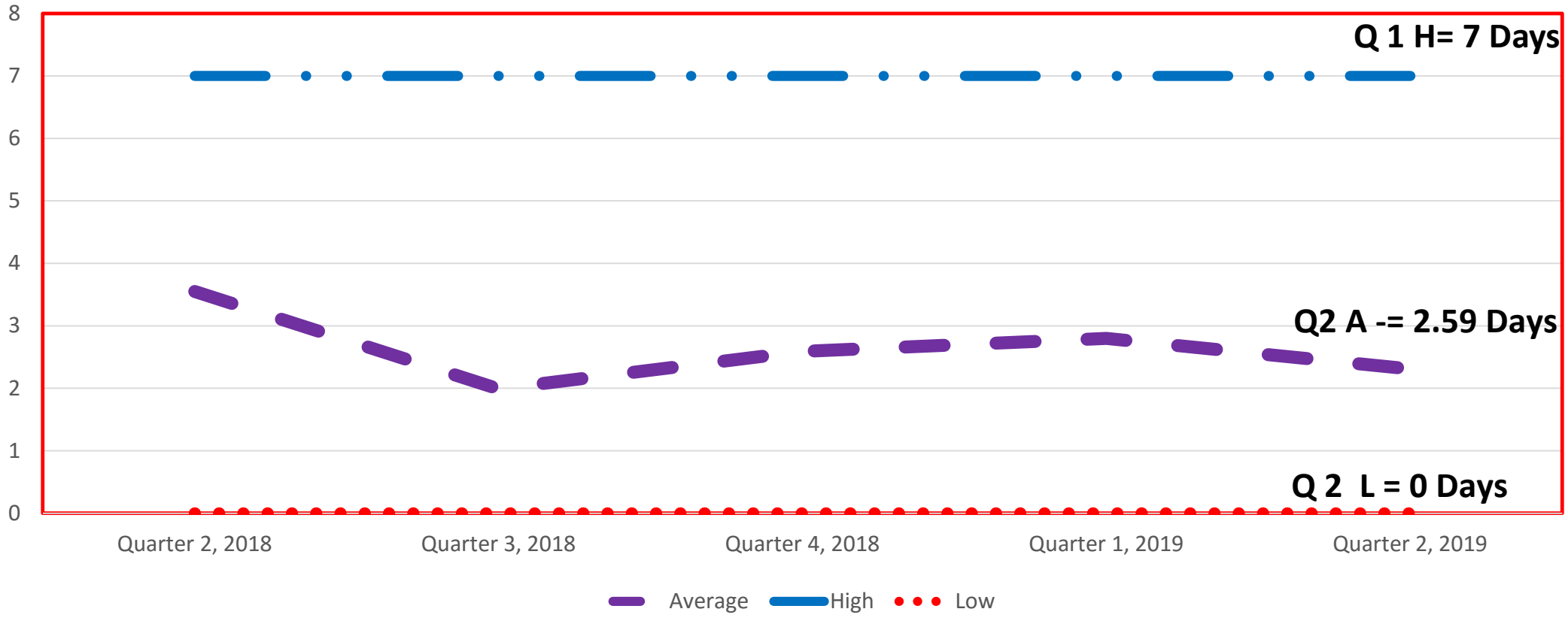

Trends and Highlights
Responsiveness to Patient Feedback
New Areas of Concerns
Breakdown of Care Provider Concerns
Trends by Service Area
Patient Advocate Additional Projects

The Highlights

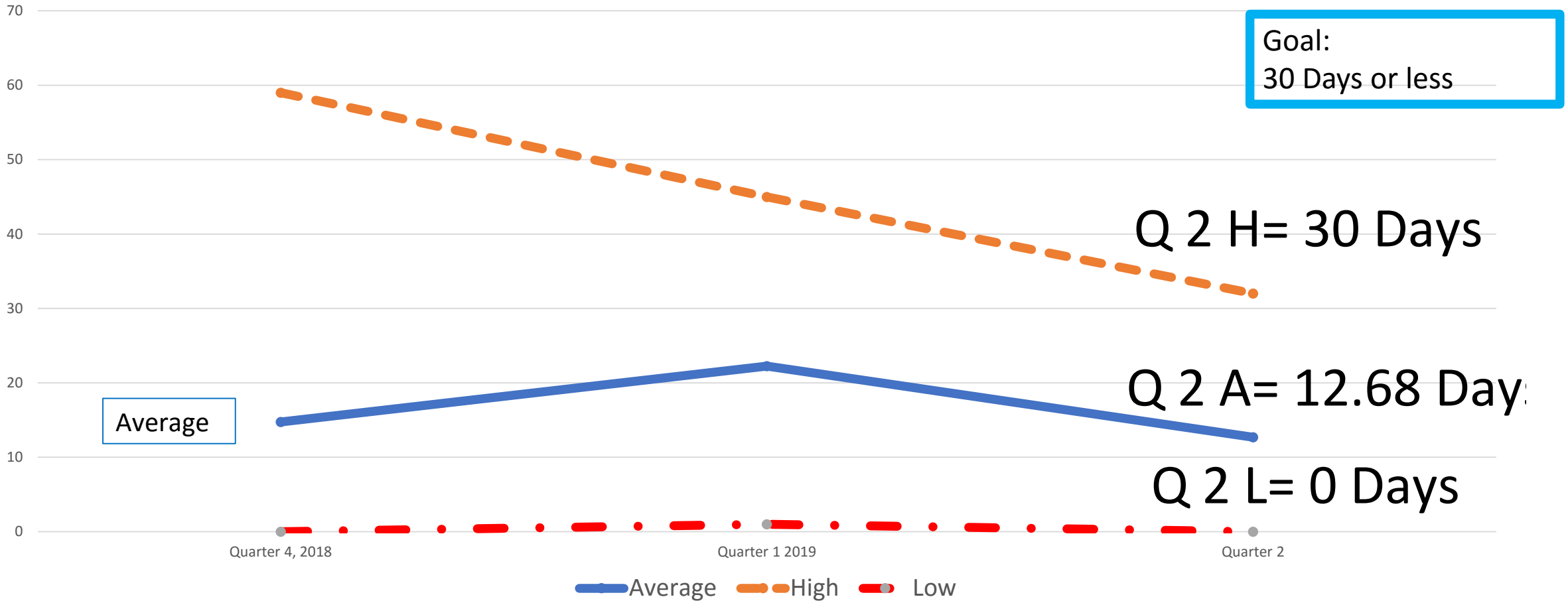
- The average time to close cases was 12.68 days, meeting our target of 30 days or less.
- Average receiving concern to acknowledgement letter was 2.31 days.
- Total number of concerns for this quarter # 49.
- Patient Navigation Calls: # 40

Days to Acknowledgement

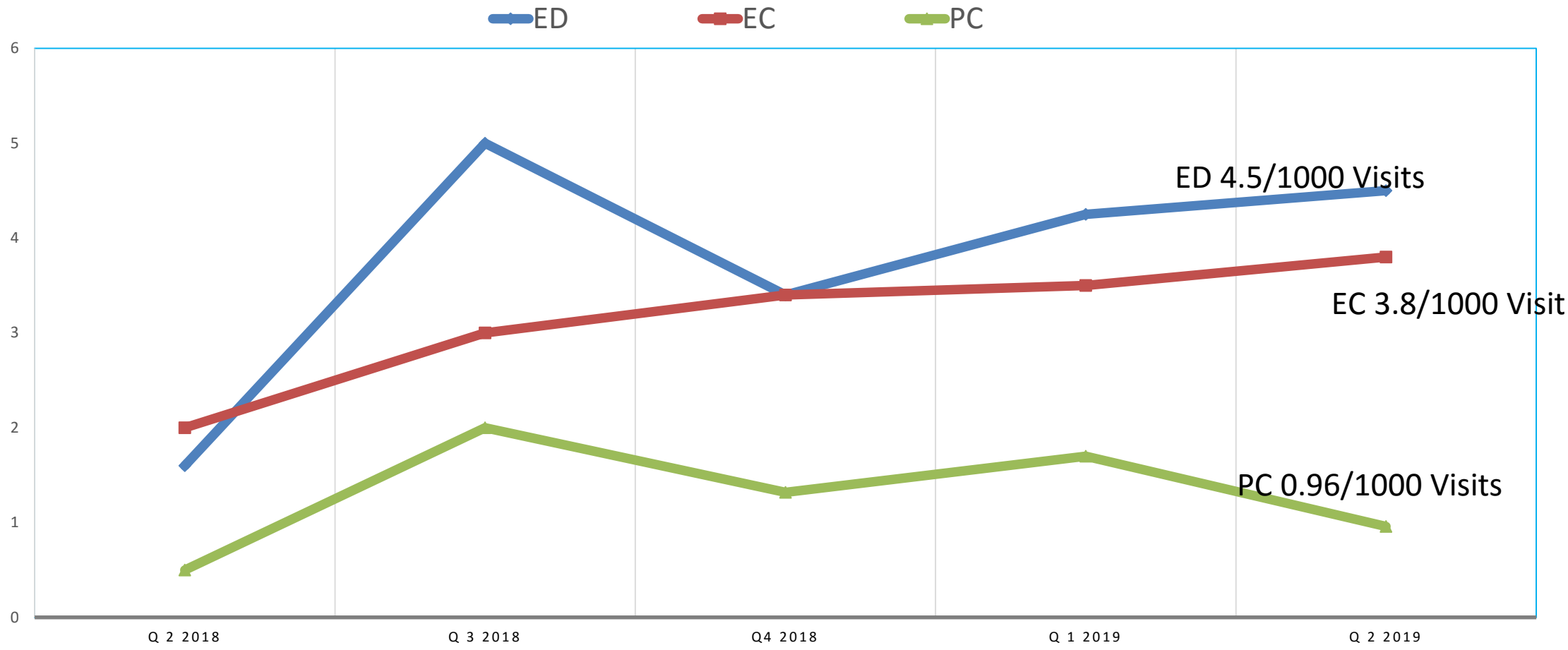
Goal:
7 Business Days



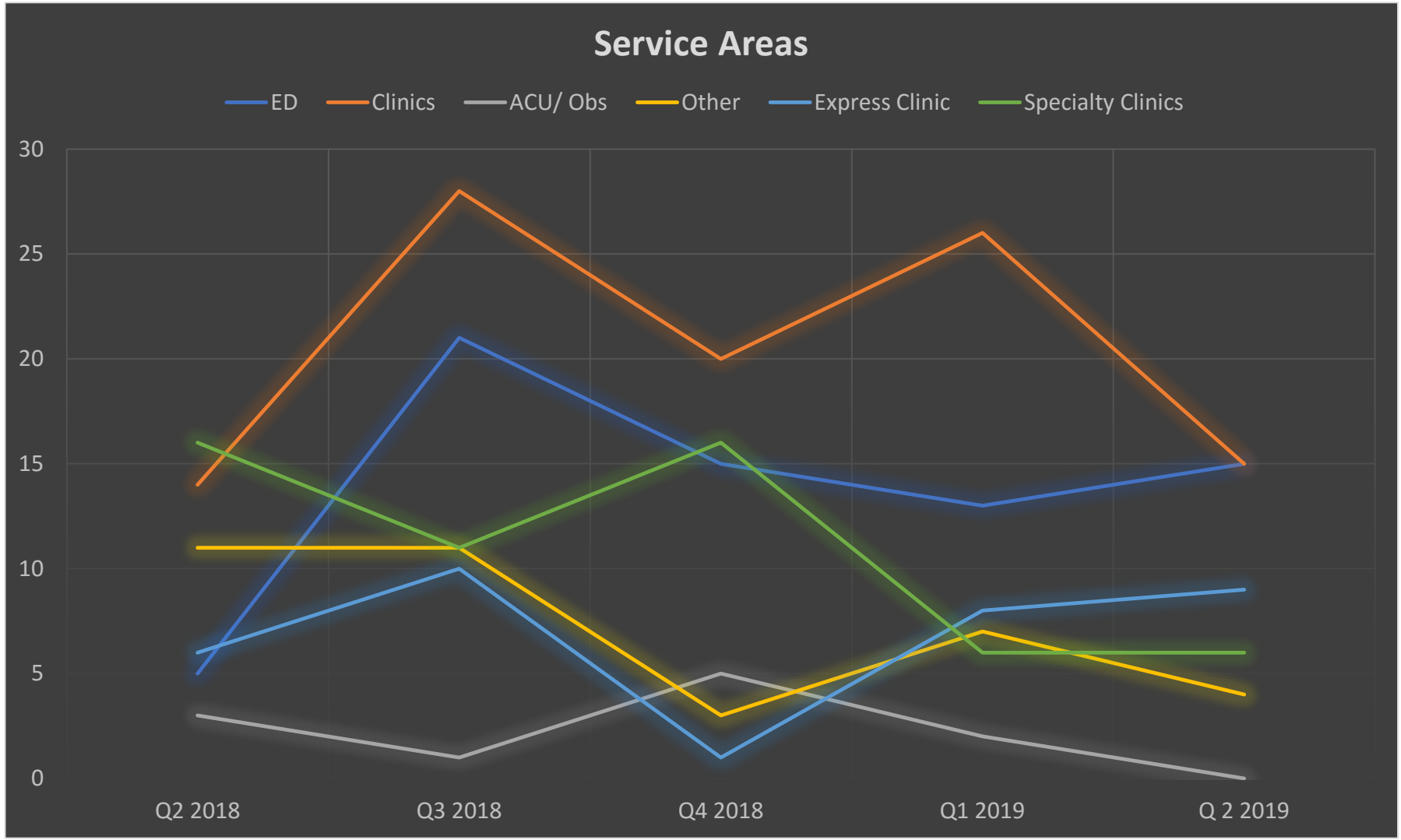
Days to Closure



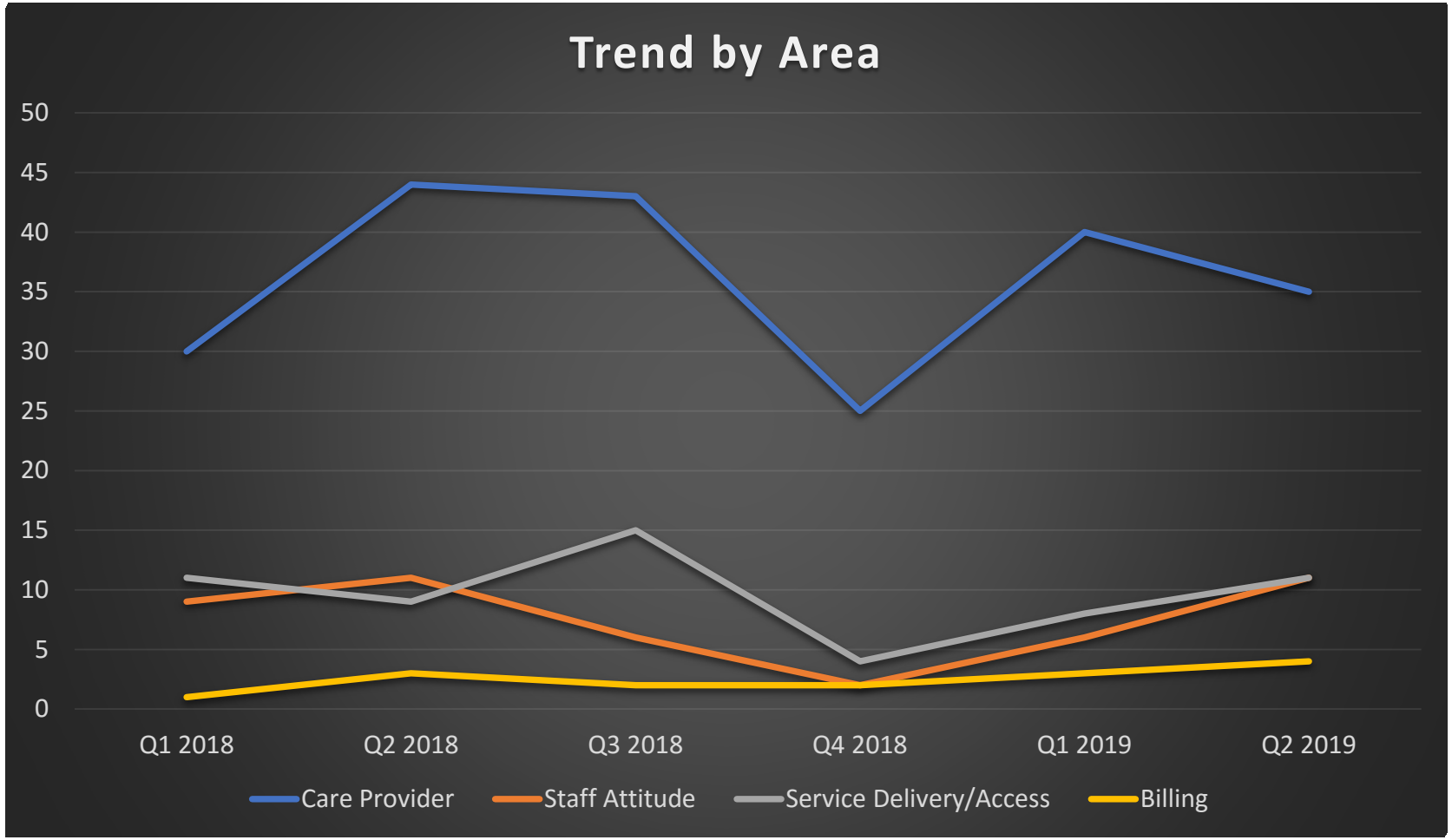
ED, PC and EC Concerns/1000 visits



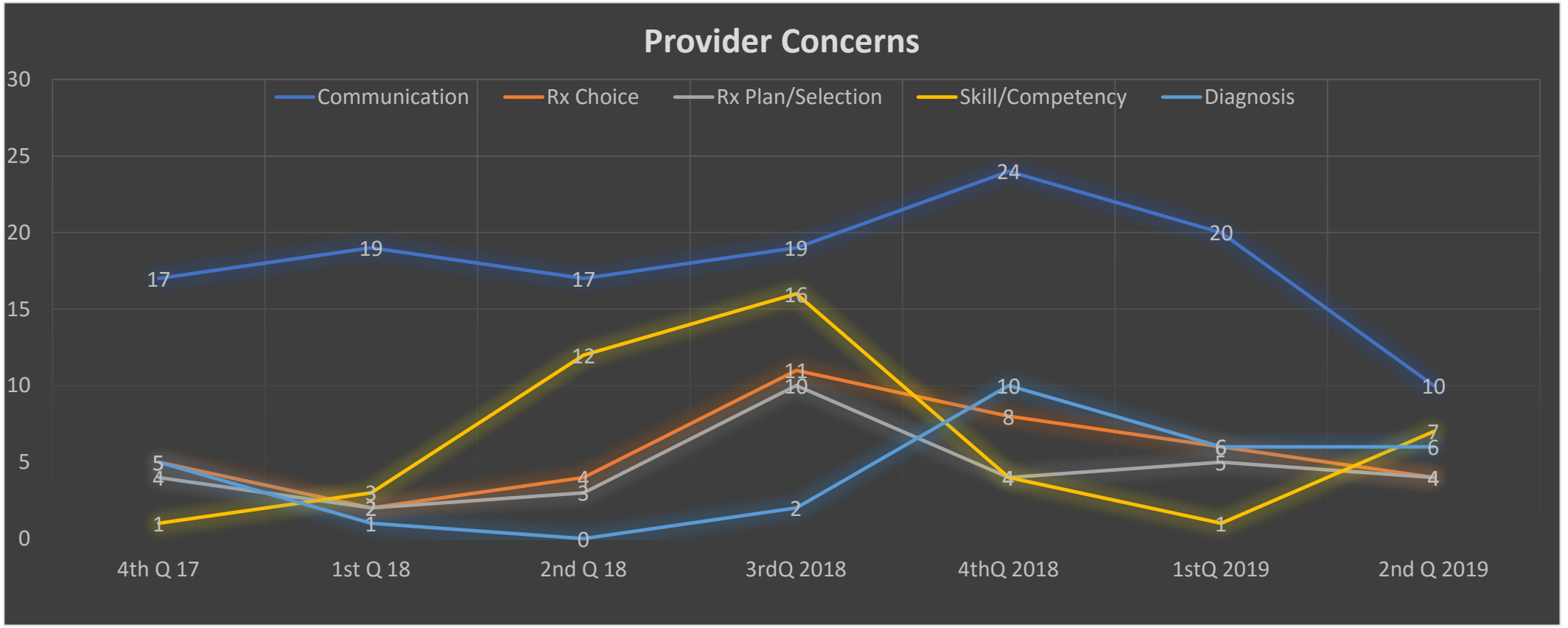
Trends by **Area** of Concern (Raw Data)



Trends by **Type** of Concerns



Provider Issues



Additional Patient Advocate Activities

Ongoing

- Patient Family Advisory Council (PFAC)
- New Employee Orientation—Patient Advocate and Health Equity Committee presentations are now Webinars with videos.
- Health Equity Committee—Jefferson County Pride Event July 13, 2019
- Quality of Care Projects
  - TeamSTEPPS
  - Aqua Pod Primary Care Clinic -7 Week lunch and learn Mindfulness and Wellness Program for teamwork enhancement and staff wellbeing
- Stress Reduction/Mindfulness in Persistent Pain Program

Changes Made because of Resolution Process

Radiology Department has new process for

CD Burner regular checks

- Patient experienced a blank CD when brought to surgeon's appointment

Dr. Wang, PCP from Swedish Medical Center providing training for our providers

- Transgender patients asking for greater medical expertise in gender-affirming care

Changes Made because of Resolution Process

PA Credentialed in Express Clinic

- Patient's insurance didn't cover EC visit, because a specialty provider was not credentialed outside of Orthopedics (but also works in EC—now credentialed in both locations.

New Lab procedure for urine specimens without an order

- Urine spec was dropped off prior to physician order. There was not a clearly defined process for tracking these specimens. New process for transferring, logging and following up on urine samples brought in before orders signed off.

Changes Made because of Resolution Process

New process for positive drug toxicology screens in the ED

- 5-10% toxicology screens have false positive results. This occurs because the drug detection method recognizes some of the molecules, either from food or other prescribed medications, as the drugs being screened for. We did not have a process for reexamining these results.
- New Process: All positive urine drug screens will be frozen for 30 days, so they will be available for confirmation testing if necessary or requested.

Questions and Comments?

Jefferson Healthcare

July 2019 Finance Report

August 28, 2019

Hilary Whittington, CAO/CFO

Education: Collections

- Initial thoughts
- Brief update on the new laws
- High level review of our program
  - Our philosophy on patient payments
  - Overview of the collections process
- Our partnership with Audit and Adjustment

Initial thoughts.

Brief update on the new laws around collections

Overview

The legislature passed two bills in 2019 that impact medical debt.

- SHB 1602 addresses consumer debt generally and changes requirements for post-judgement interest and garnishment.
- SHB 1531 addresses medical debt more specifically and changes requirements for pre-judgement interest, information collection agencies must provide to debtors, and when a medical debt can be assigned or sold to a collection agency.

- https://www.wsha.org/articles/effective-july-28-2019-changes-to-state-law-on-consumer-and-medical-debt-with-charity-care-implications/

Brief update on the new laws around collections

1. **Medical debt cannot be assigned or sold to a collection agency until at least 120 days after the initial bill.**
2. **Interest is capped at 9% per annum**
3. **New exemption for wages (for garnishment)**
   - The greater of 80% disposable earnings or 35 times the state minimum hourly wage
4. **Collections agencies must provide more information:**
   - Include information about the debt in first communication
   - Provide more information about debt upon request (itemized), and cease collection until the itemization is mailed
   - Provide notice of charity care and hospital contact information
   - Cease collections during charity care application or during appeal of final determination
5. **Other provisions**
   - Collections agencies cannot make adverse credit reports until 180 days after debt assigned
   - Bench warrants on medical debt prohibited

High level review of our program

Our philosophy on patient payments

- Those that can pay something, should
- Those that cannot pay something should have options available, and our financial assistance program should be designed to help those that need help
  - Financial assistance of 50% or more is available for those up to 400% of the FPL, scaled by family size
    - *For an individual, this is up to $49,960/year*
    - *For a couple of 2, this is up to $67,640/year*
    - *For a family of 4, this is up to $103,000/year*
- Our approach should be fair
- The hospital should be positioned to be sustainable

High level review of our program (cont'd)

Considerations as a public hospital district

- Gifting of public funds
- Treating all payors the same (PHD and CMS considerations)

A lot is based on “reasonable collection efforts”, as defined by CMS

308. CRITERIA FOR ALLOWABLE BAD DEBT
A debt must meet these criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts. (See §305 for exception.)
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

A lot is based on “reasonable collection efforts”, as defined by CMS (cont’d)

310. REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

A. Collection Agencies.--A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

B. Documentation Required.--The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html – Chapter 3: bad debts, charity and courtesy allowances

High level review of our program: Overview of the collections process

In-House (account at Jefferson Healthcare)

Assuming no engagement with Jefferson Healthcare (or payments)

- First statement is sent after insurance pays (if applicable), and includes a financial assistance policy
- 3 additional statements are sent (every 30 days, for a total of 120 days if no insurance and 150+ days if insurance is processed)
- At least 1 courtesy call is made
- Account is referred to Audit and Adjustment

Assuming patient engages with our Financial Counseling Team

- First statement is sent after insurance pays (if applicable), and includes a financial assistance policy
- Patient engages with Jefferson Healthcare Financial Counseling Team
  - Financial Assistance Form completed and account adjusted
  - Payment plan agreed upon and entered into Epic
- Statements are sent monthly and do not progress to past due status if patient is making regular payments
- If payments cease, the “Assuming no engagement” process above ensues

High level review of our program:
Overview of the collections process (cont'd)

Account referred to Audit and Adjustment

Starting the conversation

- Referring to Audit & Adjustment does not mean they are in legal action – this phase functions as an extension of our business office to determine if the debt is "actually uncollectible"
- Account is received and validated by A&A, ensuring the patient is not bankrupt or deceased
- Address is reviewed in the National Change of Address database
- First notice sent
- A call is made to the patient after a 3-day waiting period; calls made during 8am-5pm on weekdays
- Collectors follow professional collection steps to understand the patient's situation

High level review of our program: Overview of the collections process (cont'd)

Account referred to Audit and Adjustment

Assuming the patient does not engage with Audit and Adjustment

- Assets are verified to determine if the account warrants legal action
- Skip tracing (phone number validation) is used to find better contact information
- A collection manager reviews the accounts, and will ping the account to re-work in 60-90 days
- Legal action is pursued only if collection efforts are exhausted without a response from the patient/guarantor
- Additional calls are made to attempt to contact the patient
- JH does a final review of the account and approves of the legal action; notice is served to the patient
- Accounts referred for credit reporting if >180 days at A&A (>300 days old), and >$100

Assuming patient engages with Audit and Adjustment

- The patient and A&A discuss a payment arrangement
- Financial assistance is discussed; accounts can be referred back to JH if appropriate (pre-legal status)
- There is no further escalation if the payment arrangements are made and satisfied

Our partnership with Audit and Adjustment

Why work with a company?

1. External companies have a larger toolkit to validate addresses and phone numbers
    1. Lexis Nexis products
    2. Credit reports
    3. NCOA – national change of address
    4. DOL – Department of Licensing
2. It is an efficient use of resources as an alternative to hiring staff
3. Most importantly, our staff are also community members

Our partnership with Audit and Adjustment (cont'd)

Collector's Pledge

In every collection situation, it is our commitment to collect the account while preserving the goodwill of both the patient and the client. All Audit & Adjustment Company staff members have signed ACA International's Collector's Pledge which reads:

Collector's Pledge

I believe every person has worth as an individual.

I believe every person should be treated with dignity and respect.

I will make it my responsibility to help consumers find ways to pay their debts.

I will be professional and ethical

I will commit to honoring this pledge.

ACA™ INTERNATIONAL
The Association of Credit and Collection Professionals
Member

- We have selected one company as a partner (some hospitals pick 2+ to encourage competition)
- Our philosophy aligns with that of Audit and Adjustment
- They are flexible in changing their approach based on our needs

Pause for questions.

July 2019

Operating Statistics

STATISTIC DESCRIPTION	JULY 2019 MO ACTUAL	MO BUDGET	% VARIANCE	YTD ACTUAL	YTD BUDGET	% VARIANCE	JULY 2018 MO ACTUAL		YTD ACTUAL	
FTEs - TOTAL (AVG)	572	616	7%	568	616	8%	537	-6%	542	-5%
ADJUSTED PATIENT DAYS	2,160	2,271	-5%	15,627	15,532	1%	1,782	21%	14,010	12%
ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	55	86	-36%	538	589	-9%	74	-26%	566	-5%
ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	312	350	-11%	2,307	2,391	-4%	272	15%	2,270	2%
PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION	387	444	-13%	2,968	3,036	-2%	346	12%	2,883	3%
SURGERY CASES (IN OR)	120	109	10%	752	745	1%	94	28%	688	9%
SPECIAL PROCEDURE CASES	70	77	-9%	487	529	-8%	71	-1%	485	0%
LAB BILLABLE TESTS	18,532	18,954	-2%	130,663	129,621	1%	17,018	9%	125,352	4%
TOTAL DIAGNOSTIC IMAGING TESTS	2,950	2,858	3%	19,949	19,548	2%	2,740	8%	18,532	7%
PHARMACY MEDS DISPENSED	21,409	24,983	-14%	155,146	170,849	-9%	20,301	5%	156,947	-1%
RESPIRATORY THERAPY PROCEDURES	3,003	3,467	-13%	25,652	23,708	8%	2,563	17%	22,187	14%
REHAB/PT/OT/ST RVUs	8,760	9,372	-7%	61,142	64,093	-5%	9,259	-5%	61,246	0%
ER CENSUS	1,133	1,090	4%	7,437	7,451	0%	1,122	1%	7,350	1%
DENTAL CLINIC	208	212	-2%	220	1,452	-85%	-	0%	-	100%
TOTAL RURAL HEALTH CLINIC VISITS	5,854	6,345	-8%	41,269	43,399	-5%	5,156	14%	36,304	12%
TOTAL SPECIALTY CLINIC VISITS	3,582	3,763	-5%	24,345	25,731	-5%	3,279	9%	21,982	10%
HOME HEALTH EPISODES	77	69	12%	530	475	12%	54	43%	451	15%
HOSPICE CENSUS/DAYS	1,235	1,153	7%	6,582	7,888	-17%	1,019	21%	7,365	-12%

July 2019

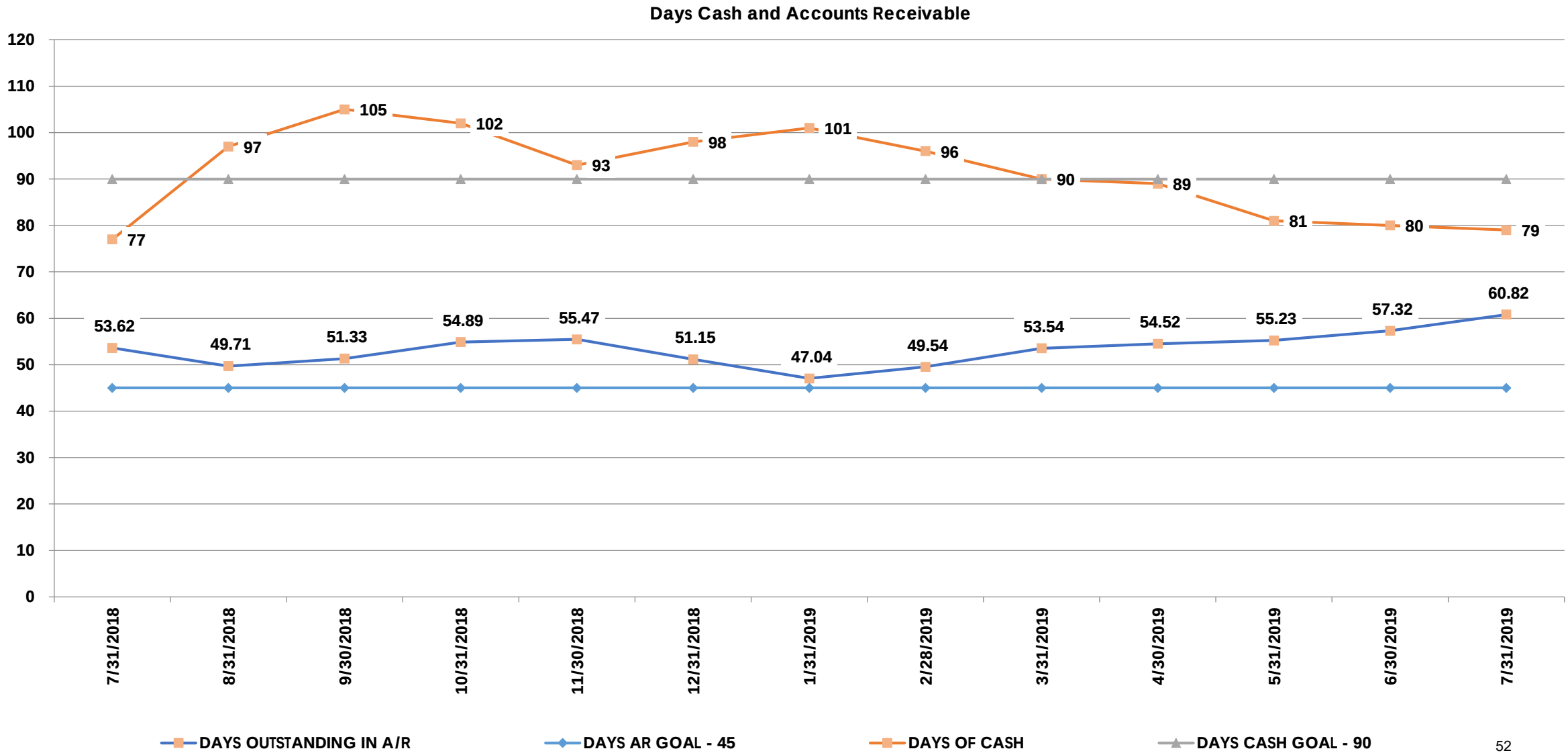
Income Statement Summary

Jefferson Healthcare

	July 2019 Actual	July 2019 Budget	Variance Favorable/ (Unfavorable)	%	July 2019 YTD	July 2019 Budget YTD	Variance Favorable/ (Unfavorable)	%	July 2018 YTD
Operating Revenue									
Gross Patient Service Revenue	22,175,714	21,166,726	1,008,988	5%	149,661,967	144,753,049	4,908,918	3%	132,677,245
Revenue Adjustments	12,017,582	11,238,892	(778,690)	-7%	81,142,657	76,859,494	(4,283,162)	-6%	71,121,965
Charity Care Adjustments	361,746	242,094	(119,652)	-49%	1,594,569	1,655,609	61,039	4%	1,551,273
Net Patient Service Revenue	9,796,386	9,685,740	110,645	1%	66,924,741	66,237,946	686,795	1%	60,004,007
Other Revenue	690,792	779,134	(88,342)	-11%	4,762,453	5,328,267	(565,814)	-11%	3,030,642
Total Operating Revenue	10,487,177	10,464,874	22,303	0%	71,687,194	71,566,214	120,981	0%	63,034,649
Operating Expenses									
Salaries And Wages	4,833,162	5,032,320	199,158	4%	33,373,809	34,414,568	1,040,759	3%	31,099,072
Employee Benefits	1,150,839	1,258,953	108,114	9%	8,479,577	8,609,608	130,031	2%	7,546,581
Other Expenses	4,088,164	3,948,697	(139,467)	-4%	26,490,068	27,003,982	513,914	2%	23,315,045
Total Operating Expenses	10,072,165	10,239,970	167,804	2%	68,343,453	70,028,158	1,684,705	2%	61,960,698
Operating Income (Loss)	415,012	224,904	190,107	85%	3,343,741	1,538,056	1,805,685	117%	1,073,951
Total Non Operating Revenues (Expenses)	(7,131)	6,388	(13,519)	-212%	123,277	43,689	79,588	182%	(61,995)
Change in Net Position (Loss)	407,881	231,293	176,588	76%	3,467,018	1,581,745	1,885,273	119%	1,011,956
Operating Margin	4.0%	2.1%	1.8%	84.1%	4.7%	2.1%	2.52%	117.0%	1.7%
Total margin	3.9%	2.2%	1.7%	76.0%	4.8%	2.2%	2.63%	118.8%	1.6%
Salaries & Benefits as a % of net pt svc rev	-61.1%	-65.0%	3.9%	6.0%	-62.5%	-65.0%	2.42%	3.7%	-64.4%

July 2019

Cash and Accounts Receivable



July 2019

Board Financial Report

Dept#	Department	Rev/Exp	Account	Account Description	Jul Actual	Jul Budget	Jul Variance	2019 to Date Actual	2019 to Date Budget	2019 to Date Variance
8612	BOARD	Exp	600010	MANAGEMENT & SUPERVISION WAGES	4,142.00	5,218.00	1,076.00	33,015.00	35,686.00	2,671.00
			601400	BENEFITS MEDICAL INS-UNION	-	4,404.00	4,404.00	29,942.00	30,116.00	174.00
			601900	BENEFITS EMPLOYEE ASSISTANCE	-	-	-	56.00	-	(56.00)
			602300	CONSULT MNGMT FEE	-	2,123.00	2,123.00	4,250.00	14,521.00	10,271.00
			602500	AUDIT FEES	-	3,397.00	3,397.00	31,428.00	23,233.00	(8,195.00)
			604200	CATERING	53.00	127.00	74.00	420.00	871.00	451.00
			604500	OFFICE SUPPLIES	-	25.00	25.00	-	171.00	171.00
			604850	COMPUTER EQUIPMENT	-	85.00	85.00	-	581.00	581.00
			606500	OTHER PURCHASED SERVICES	-	849.00	849.00	-	5,808.00	5,808.00
			609400	TRAVEL/MEETINGS/TRAINING	2,168.00	1,699.00	(469.00)	10,076.00	11,616.00	1,540.00
		Exp Total			6,363.00	17,927.00	11,564.00	109,187.00	122,603.00	13,416.00
	BOARD Total				**6,363.00**	**17,927.00**	**11,564.00**	**109,187.00**	**122,603.00**	**13,416.00**

August 2019

Preview – (*as of 0:00 08/28/19)

- **$20,814,374 in HB charges**
  - Average: $671,431/day (HB only)
  - Budget: $669,505/day
  - 100.3% of Budget
- **$7,372,853 in HB cash collections**
  - Average: $237,834/day (HB only)
  - Goal: $294,582/day
- **64.0 Days in A/R**
- **Questions**

Jefferson Healthcare

Patient Safety and Quality Report

Wednesday, August 28, 2019

Topics


Accreditation Update
Patient Safety & Quality
Patient Experience
Current Projects and Focus Areas

Accreditation Update

August: Submitted evidence of compliance with corrective action plan

DNV accepted our report without further clarification or reporting elements

2019 Internal Audits:

- Patient Status (Acute Care)
- Urine Culture Contamination (Lab)
- ADA Compliance (Registration)
- Care of Suicidal Patients (ED/ICU/ACU)
- Completion of Medical Records (HIM)
- Communication of lab results to patients (Medical Group/Lab)
- Administration of Blood Products (Infusion Center/Lab/Acute Care)

Next Steps:

- Continuous monitoring of Quality Management System and Audits
- Close Corrective Action Plans

Jefferson Healthcare	Goals	Strategy	Initiatives	Targets
Quality and Safety	***Provide the Highest Quality, Safest Care***	*Drive Best Practice Clinical Care*	Achieve zero harm events	Target: Zero avoidable healthcare acquired harm events
		Achieve Excellent Quality Outcomes	Antimicrobial Stewardship	80% reduction in reportable cases of c.Difficile (Target); Zero reported cases in May
				10% decrease in DOT (IP); Avoidance of antibiotics for URI (clinics); 80% reduction in reportable cases of c.Difficile
			Implement and adhere to evidence based practices.	90% or greater compliance with core measures
		Enhance Culture of Safety	Hardwire team training	Team Training Attendance 48.4%
			Leader Rounding	Weekly Rounding Compliance
		Align care with patient goals	Implement a palliative care program	Readmission rate < 12%

Highlights:

- *Prevention of Healthcare-Acquired Infections*
- *Provider management of stroke*
- *Decreased contamination rates (Lab)*
- *Patient Flow in the ER*

Opportunities:

- *Swallow Screen (Stroke)*
- *Time to CT (Stroke)*
- *Urine contamination rates*
- *Fall Prevention*

Provide the Highest Quality, Safest Care of any Hospital in the Region

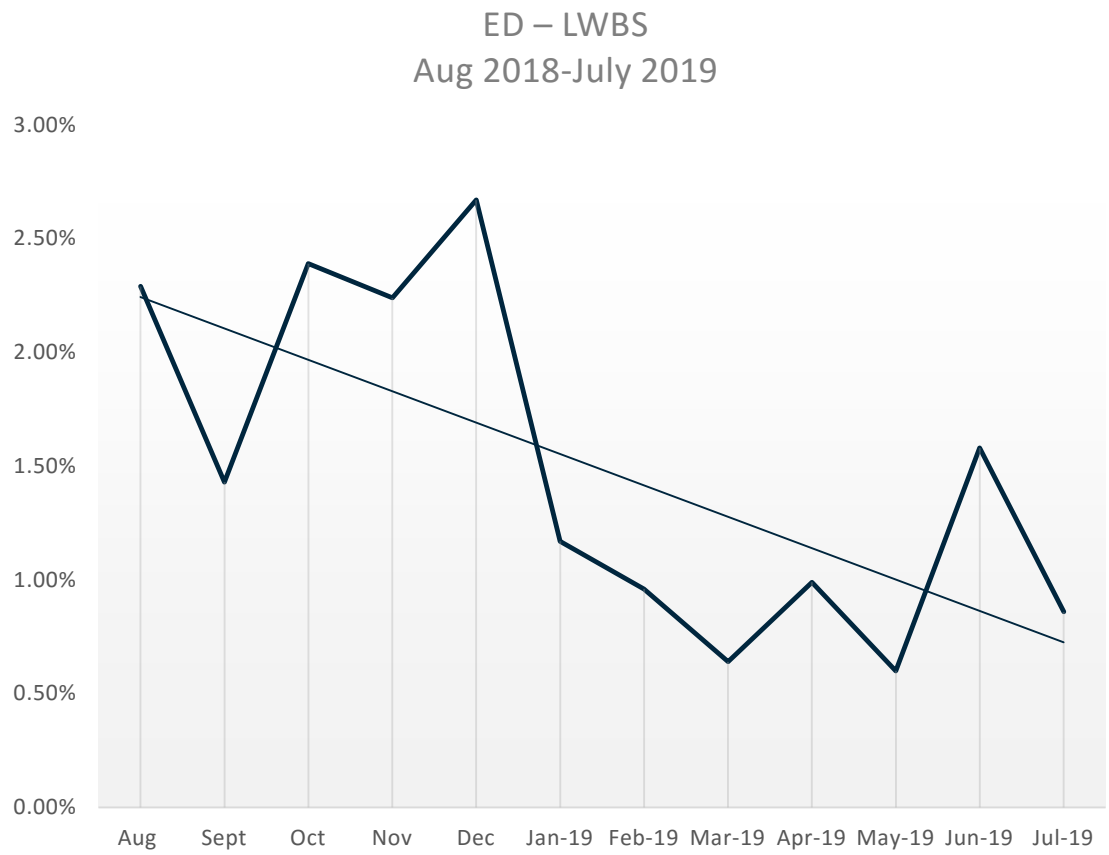
Patient Safety Outcomes														
Metric	August	Sept	Oct	Nov	Dec	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	YTD	Goal
Pressure Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0.000	0
Patient Falls with Injury (IP)	0	0	0	0	0	0	0	0	2.3	2.5	0	2.6	0.62	0.66
Bar Code Compliance (Patient Scanning)										96.5%	97.6%	96.0%	96.7%	>95%
Bar Code Compliance (Medication Scanning)										95.0%	95.1%	93.4%	94.5%	>95%
Adverse Drug Events	0.0%	0.01%	0.9%	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	0.0%	1.0%	0.0%	0.23%	< 1%
Specimen Mislabeling	0	0	0	1	0	3	7	9	7	2	3	ND	2.91	0

Patient Engagement														
	August	September	October	November	December	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	YTD	Goal
Advance Care Planning	In Progress	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	One event Bi-
Patient Initiated RRT	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PFE 1: Planning Checklists	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PFE 2: Bedside Reporting	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PFE 4: Quality Teams with PFAC Involvement	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Leverage Technology Connect Staff to Patient Safety Advance Care Planning TeamSTEPPS

Just Culture Engage Patients in Care (Patient Centered)

Highlight: Emergency Department Quality



- Quality Improvement initiated in February 2019
- Process Measures:
  - Door to provider decreased by 42%
  - Length of stay decreased by 9.2%
  - Length of stay for Level 4 & 5 visits decreased by 28.2%
- Outcome Measure (the big dot):
  - Patients who leave without being seen decreased by 64.5%

Emergency

Metric	Q3 2018	Oct	Nov	Dec	Q4 2018	Jan-19	Feb-19	Mar-19	Q1 2019	Apr-19	May-19	Jun-19	Q2 2019	Jul-19	NRC Average	Top Quartile
Median Length of Stay (discharged)	123	136	142	131	136	136	134	124	131	132	119	123	125	122	< 104 min	
Median Length of Stay (admitted)	226	237	267	240	248	234	251	248	244	234	234	227	232	247	< 199 min	
Overall	70.4%	73.1%	72.0%	78.1%	74.7%	60.6%	69.0%	80.0%	69.6%	70.6%	75.0%	85.7%	75.0%	100.0%	66.3%	80.1%
Confidence in Provider	76.8%	69.6%	64.0%	80.6%	71.3%	63.6%	70.4%	68.4%	67.1%	69.7%	88.9%	78.6%	76.9%	100.0%	70.4%	81.1%
Likely to Recommend	75.5%	76.9%	84.0%	78.1%	79.5%	64.7%	78.6%	76.9%	72.7%	70.6%	100.0%	80.0%	81.2%	100.0%	68.9%	82.4%
Communication (MD/RN)	75.3%	76.0%	56.0%	74.2%	69.1%	66.7%	55.6%	80.0%	67.1%	64.7%	60.0%	83.3%	66.7%	100.0%	66.5%	79.2%

Inpatient (ACU/ICU/FBC)

Metric	Q3 2018	Oct	Nov	Dec	Q4 2018	Jan-19	Feb-19	Mar-19	Q1 2019	Apr-19	May-19	Jun-19	Q2 2019	Jul-19	NRC Average	Top Quartile
Overall	78.7%	75.0%	87.5%	81.3%	80.8%	83.3%	92.3%	73.3%	82.7%	84.0%	80.8%	72.7%	79.2%	68.4%	73.5%	84.1%
Likely to Recommend	78.9%	76.2%	80.0%	93.8%	82.7%	91.7%	100.0%	93.3%	94.2%	88.0%	80.8%	87.0%	85.3%	84.2%	75.5%	86.4%
Quiet at Night	44.0%	38.1%	73.3%	40.0%	49.0%	62.5%	76.9%	46.7%	61.5%	52.0%	53.8%	62.5%	56.1%	50.0%	58.7%	76.3%
Confidence in Nurse	80.5%	80.0%	94.1%	81.3%	84.9%	87.5%	78.6%	66.7%	79.2%	91.7%	96.2%	56.5%	81.5%	78.9%	74.6%	84.3%
Confidence in Provider	81.8%	80.0%	76.5%	93.8%	83.0%	87.5%	92.9%	80.0%	86.8%	91.7%	84.6%	73.9%	83.4%	84.2%	78.4%	88.8%
Communication (MD/RN)	66.7%	63.2%	85.7%	86.7%	77.1%	78.3%	78.6%	73.3%	76.9%	87.0%	79.2%	71.4%	79.2%	77.8%	61.4%	74.0%

Clinics (Primary Care and Specialty Clinics)

Metric	Q3 2018	Oct	Nov	Dec	Q4 2018	Jan-19	Feb-19	Mar-19	Q1 2019	Apr-19	May-19	Jun-19	Q2 2019	Jul-19	NRC Average	Top Quartile
Rate Provider	80.6%	78.4%	79.8%	83.6%	80.8%	85.1%	85.2%	76.3%	82.4%	82.5%	81.7%	84.2%	82.8%	79.7%	83.1%	93.8%
Likely to Recommend	88.2%	90.4%	90.7%	87.9%	89.5%	91.4%	91.3%	85.3%	89.5%	89.6%	87.8%	88.5%	88.6%	81.4%	89.3%	97.5%
Confidence in Provider	90.2%	93.2%	92.5%	93.7%	93.1%	93.1%	92.1%	89.4%	91.6%	90.5%	92.3%	91.8%	91.5%	86.7%	90.0%	97.5%
Access to Care Dimension	66.6%	65.5%	64.2%	67.5%	65.9%	62.9%	67.6%	63.0%	64.9%	63.5%	63.4%	64.8%	63.9%	64.8%	64.3%	79.5%
Established Patient Visit	14.3	12.0	14.5	14.3	13.6	10.3	9.9	12.98	11.10	12.26	13.81	20.63	15.57	ND	< 10 days	
New patient visit	53.27	47.5	45.9	62.9	52.1	46.6	46.8	49.2	47.53	56	62.1	60.6	59.57	ND	30	

Rehab Therapy

Metric	Q3 2018	Oct	Nov	Dec	Q4 2018	Jan-19	Feb-19	Mar-19	Q1 2019	Apr-19	May-19	Jun-19	Q2 2019	Jul-19	NRC Average	Top Quartile
Overall	81.6%	100.0%	86.4%	83.3%	90.7%	73.3%	78.6%	81.3%	78.0%	73.3%	76.9%	82.4%	77.5%	ND	86.0%	92.3%
Likely to Recommend	83.3%	95.0%	95.5%	81.8%	92.5%	80.0%	79.3%	87.5%	81.7%	92.9%	76.9%	100.0%	89.9%	ND	88.5%	94.6%
Access to Care Dimension	66.0%	85.0%	80.4%	70.8%	80.0%	73.3%	67.2%	75.0%	69.2%	73.3%	73.4%	58.8%	68.5%	ND	75.0%	85.3%
Confidence in Therapist	77.6%	90.0%	69.6%	91.7%	81.8%	86.7%	86.2%	87.5%	86.7%	80.0%	83.3%	88.2%	83.8%	ND	88.9%	94.3%

Home Health

Metric	Q3 2018	Oct	Nov	Dec	Q4 2018	Jan-19	Feb-19	Mar-19	Q1 2019	Apr-19	May-19	Jun-19	Q2 2019	Jul-19	NRC Average	Top Quartile
Overall	78.6%	75.0%	100.0%	77.8%	84.4%	81.8%	84.6%	88.9%	84.8%	93.8%	78.6%	81.8%	84.7%	100.0%	85.1%	92.8%
Likely to Recommend	85.2%	91.7%	100.0%	90.0%	93.9%	90.9%	76.9%	100.0%	87.9%	87.5%	86.7%	100.0%	91.4%	87.5%	80.3%	89.6%
Confidence in Care Provider	85.7%	91.7%	72.7%	80.0%	81.8%	81.8%	76.9%	100.0%	84.4%	80.0%	69.2%	90.9%	80.0%	87.5%	82.5%	91.0%

Outpatient Testing (Sleep, Lab, DI)

Metric	Q3 2018	Oct	Nov	Dec	Q4 2018	Jan-19	Feb-19	Mar-19	Q1 2019	Apr-19	May-19	Jun-19	Q2 2019	Jul-19	NRC Average	Goal
Overall	78.2%	88.2%	85.7%	83.9%	85.8%	92.5%	79.7%	84.8%	85.8%	85.5%	88.3%	80.0%	84.6%	82.9%	82.5%	90.4%
Likely to Recommend	82.0%	88.3%	90.8%	84.1%	87.6%	90.0%	86.5%	79.4%	85.7%	87.0%	80.3%	84.3%	83.9%	88.6%	83.1%	90.6%
Told when/how to receive results	73.7%	69.2%	71.8%	68.2%	69.7%	76.5%	65.8%	63.1%	68.9%	72.7%	72.4%	68.1%	71.1%	57.1%	71.4%	82.6%
Confidence in Staff	84.9%	87.2%	89.6%	89.9%	88.9%	87.7%	89.2%	75.8%	84.6%	94.0%	86.5%	91.0%	90.5%	85.7%	85.5%	91.1%

Patient Advocate Reports

Metric	Q3 2018	Oct	Nov	Dec	Q4 2018	Jan-19	Feb-19	Mar-19	Q1 2019	Apr-19	May-19	Jun-19	Q2 2019	Jul-19	Goal
Days to Acknowledgement	2.32	3.26	1.74	2.17	2.39	3.04	3.25	1.96	2.75	1.76	3.59	1.3	2.22	2.7	7
Days to Closure	11.97	13.65	12.8	14.14	13.53	18.28	9.66	11.42	13.2	11.16	11.21	6.85	9.74	11.95	≤ 30

PATIENT EXPERIENCE

DELIVER AN EXPERIENCE THAT EXCEEDS EXPECTATIONS FOR PATIENTS AND FAMILY MEMBERS

- Highlights:
  - Improved MD/RN communication (IP)
  - HHCAHPS increased Likelihood of Recommending
  - Confidence in RN and Provider increased in ER
- Opportunities:
  - Access to care dimension in Rehab and clinics
  - Quiet at Night scores (HCAHPS)
  - MD/RN Communication (Emergency)
  - Communication about test results

Current Projects and Focus Areas

- Cancer Quality Committee – evaluating 2019 and planning for 2020
- Culture of Safety Surveys: October, 2019
- Health Equity Committee(Spoiler Alert)
- Care Transformation and Value Based Care
- Strategic Plan Update (New Look – same information)
- Coverdell Stroke Project
- Transitions of care/Referral and Test Tracking
- Upcoming Events:
  - September 11: American Hospital Association Presentation
  - November 6: DNV Symposium Presentation
  - Upcoming: WSHA presentation on c. Diff Reduction Quality Improvement


Questions?

Jefferson Healthcare

Administrative Report

August 28, 2019

Mike Glenn, CEO

Behavioral Health Update

- Jefferson Healthcare
  - Integrated Primary Care/ Behavioral Health Model
  - MAT Program

- Jefferson Behavioral Health Coalition
  - Multi-organization efforts
  - Working to fund local crisis center
  - Under CHIP leadership

- Sequim Behavioral Health Campus
  - Single/Daily Dose Suboxone Clinic
  - 16 bed MAT center

SANE Update

- External Stakeholder Meeting held 08/21
- 2020 Funding Plan proposed

Jefferson Healthcare	$10,000
Jefferson County	$10,000
City of Port Townsend	$10,000
Dove House/ External	$10,000
Others	

Budget 2019

Assumptions	2019	2020
Number of Cases	5	16
Profit and Loss	**Year 1**	**Year 2**
Reimburse from State for SANE Exam	$2,125	$6,800
Net Revenue	2,125	6,800
Staffing Expenses		
Coordinator	18,425	20,586
Nursing (case stipend)	2,000	6,400
Nurse Preceptor (Year 1)	2,000	1,200
Nursing 24/7 (to be evaluated over time)	0	0
General and Administrative		
Office Supplies	619	300
Medical Supplies	274	479
Travel and off-site proctoring	10,820	10,820
Continuing education	8,738	6,720
Start up costs	3,690	0
Net Income	($44,441)	($39,705)

Jefferson Healthcare Employee Recognition Event

Emergency Department Transition Update

- We are in the process of transitioning ED professional services from Team Health to Jefferson Healthcare employed providers.
- The transition is scheduled to occur 01/01/2020.
- We are pleased to announce Drs. Smith, Parker, Irick, and Churchley (the Core Four!) have agreed to join Jefferson Healthcare as employees.

Provider	FTE
Dr. Kent Smith	1.0
Dr. Reina Parker	.75
Dr. Chance Irick	.9
Dr. Stephen Churchley	.9

- We are nearing completion of negotiations with the other members of the team.

Questions