# *COVID-19 Notice*
# No in-person attendance allowed, pursuant to Governor Inslee's Proclamation 20-28.

**All meeting attendees, including Board of Commissioners, staff and members of the public must participate virtually. No physical meeting location will be provided.**

To attend the meeting, dial Phone Conference Line: **(509) 598-2842**
When prompted, enter Conference ID number: **946510324**

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Regular Session Agenda
Wednesday, April 22, 2020

| | |
|---|---|
| **Call to Order**: | 2:30 |
| **Approve Agenda**: | 2:30 |
| **Required Approvals**: Action Requested<br>• February and March Warrants and Adjustment (pg. 2-13)<br>• Resolution 2020-03 Surplus Equipment (pg. 14)<br>• Medical Staff Credentials/ Appointments/ Reappointments (pg. 15)<br>• Medical Staff Policies (pg. 16-31) | 2:35 |
| **Financial Report**: Hilary Whittington, CAO/CFO | 2:45 |
| **Administrative Report**: Mike Glenn, CEO | 3:05 |
| **Chief Medical Officer Report**: Dr. Joseph Mattern, MD, CMO | 3:25 |
| **Board Business**: | 3:45 |
| **Meeting Evaluation**: | 3:55 |
| **Conclude**: | 4:00 |

This Regular Session will be officially recorded.
Times shown in agenda are estimates only.

**No Live Public Comment**
In lieu of live comments, members of the public may comment on any agenda item or any other matter related to the District via a letter addressed to the Commissioners at 834 Sheridan Street, Port Townsend, Washington 98368, or via email to commissioners@jeffersonhealthcare.org.

Jefferson Healthcare

| | February 2020 Actual | February 2020 Budget | Variance Favorable/ (Unfavorable) | % | February 2020 YTD | February 2020 Budget YTD | Variance Favorable/ (Unfavorable) | % | February 2019 YTD |
|---|---|---|---|---|---|---|---|---|---|
| **Gross Revenue** | | | | | | | | | |
| Inpatient Revenue | 3,566,467 | 4,053,017 | (486,550) | -12% | 7,298,628 | 8,385,554 | (1,086,926) | -13% | 8,513,852 |
| Outpatient Revenue | 17,750,445 | 18,534,061 | (783,616) | -4% | 37,397,278 | 38,346,339 | (949,061) | -2% | 32,108,377 |
| **Total Gross Revenue** | 21,316,912 | 22,587,078 | (1,270,166) | -6% | 44,695,906 | 46,731,892 | (2,035,986) | -4% | 40,622,229 |
| **Revenue Adjustments** | | | | | | | | | |
| Cost Adjustment Medicaid | 1,763,027 | 2,078,310 | 315,283 | 15% | 3,517,637 | 4,299,952 | 782,315 | 18% | 3,813,926 |
| Cost Adjustment Medicare | 7,594,706 | 7,720,024 | 125,318 | 2% | 16,017,445 | 15,972,466 | (44,979) | 0% | 14,025,052 |
| Charity Care | 256,196 | 218,450 | (37,746) | -17% | 433,672 | 451,966 | 18,294 | 4% | 297,106 |
| Contractual Allowances Other | 1,848,539 | 1,761,996 | (86,543) | -5% | 3,681,566 | 3,645,510 | (36,057) | -1% | 2,847,727 |
| Administrative Adjustments | 15,478 | 103,133 | 87,655 | 85% | 250,722 | 213,379 | (37,344) | -18% | 176,188 |
| Allowance for Uncollectible Accounts | 725,390 | 412,662 | (312,728) | -76% | 750,518 | 853,783 | 103,265 | 12% | 977,019 |
| **Total Revenue Adjustments** | 12,203,336 | 12,294,575 | 91,239 | 1% | 24,651,561 | 25,437,056 | 785,495 | 3% | 22,137,019 |
| **Net Patient Service Revenue** | 9,113,577 | 10,292,503 | (1,178,926) | -11% | 20,044,344 | 21,294,836 | (1,250,492) | -6% | 18,485,210 |
| **Other Revenue** | | | | | | | | | |
| 340B Revenue | 340,960 | 259,463 | 81,498 | 31% | 603,637 | 536,819 | 66,817 | 12% | 598,750 |
| Other Operating Revenue | 356,502 | 285,117 | 71,384 | 25% | 558,210 | 589,898 | (31,688) | -5% | 172,097 |
| **Total Operating Revenues** | 9,811,039 | 10,837,083 | (1,026,044) | -9% | 21,206,191 | 22,421,554 | (1,215,363) | -5% | 19,256,057 |
| **Operating Expenses** | | | | | | | | | |
| Salaries And Wages | 4,997,518 | 5,197,009 | 199,492 | 4% | 10,628,277 | 10,752,435 | 124,158 | 1% | 9,203,391 |
| Employee Benefits | 1,269,032 | 1,338,877 | 69,845 | 5% | 2,712,533 | 2,770,090 | 57,557 | 2% | 2,298,086 |
| Professional Fees | 157,874 | 181,714 | 23,840 | 13% | 369,980 | 375,960 | 5,980 | 2% | 873,714 |
| Purchased Services | 769,882 | 669,468 | (100,414) | -15% | 1,334,197 | 1,385,106 | 50,910 | 4% | 908,409 |
| Supplies | 1,883,773 | 1,974,722 | 90,949 | 5% | 3,707,950 | 4,085,631 | 377,681 | 9% | 3,240,016 |
| Insurance | 64,935 | 54,787 | (10,148) | -19% | 128,041 | 113,352 | (14,688) | -13% | 116,138 |
| Leases And Rentals | (103,754) | 14,463 | 118,217 | 817% | 30,939 | 29,924 | (1,015) | -3% | 296,948 |
| Depreciation And Amortization | 639,258 | 514,064 | (125,194) | -24% | 1,040,958 | 1,063,580 | 22,622 | 2% | 773,147 |
| Repairs And Maintenance | 135,686 | 100,732 | (34,955) | -35% | 204,988 | 208,410 | 3,422 | 2% | 95,556 |
| Utilities | 98,620 | 98,987 | 367 | 0% | 210,483 | 204,801 | (5,683) | -3% | 178,769 |
| Licenses And Taxes | 50,832 | 52,903 | 2,071 | 4% | 124,784 | 109,455 | (15,329) | -14% | 112,958 |
| Other | 206,506 | 212,746 | 6,240 | 3% | 407,939 | 440,164 | 32,225 | 7% | 308,001 |
| **Total Operating Expenses** | 10,170,161 | 10,410,471 | 240,310 | 2% | 20,901,068 | 21,538,908 | 637,841 | 3% | 18,405,134 |
| **Operating Income (Loss)** | (359,123) | 426,612 | (785,734) | -184% | 305,123 | 882,645 | (577,522) | -65% | 850,923 |
| **Non Operating Revenues (Expenses)** | | | | | | | | | |
| Taxation For Maint Operations | 22,098 | 21,282 | 815 | 4% | 44,196 | 44,033 | 163 | 0% | 22,844 |
| Taxation For Debt Service | 18,975 | 17,622 | 1,353 | 8% | 37,951 | 36,459 | 1,492 | 4% | 21,710 |
| Investment Income | 34,124 | 26,290 | 7,834 | 30% | 65,977 | 54,393 | 11,584 | 21% | 101,088 |
| Interest Expense | (98,098) | (88,031) | (10,068) | -11% | (178,340) | (182,132) | 3,792 | 2% | (166,977) |
| Bond Issuance Costs | - | - | - | 0% | - | 0 | - | 0% | 0 |
| Gain or (Loss) on Disposed Asset | - | - | - | 0% | - | 0 | - | 0% | 0 |
| Contributions | 12,249 | 15,847 | (3,598) | -23% | 12,749 | 32,787 | (20,038) | -61% | 13,836 |
| **Total Non Operating Revenues (Expenses)** | (10,652) | (6,989) | (3,663) | 52% | (17,468) | (14,460) | (3,008) | 21% | (7,499) |
| **Change in Net Position (Loss)** | (369,774) | 419,622 | (789,397) | -188% | 287,655 | 868,185 | (580,530) | -67% | 843,424 |

Jefferson Healthcare

| STATISTIC DESCRIPTION | FEBRUARY 2020 MO ACTUAL | MO BUDGET | % VARIANCE | YTD ACTUAL | YTD BUDGET | % VARIANCE | FEBRUARY 2019 MO ACTUAL | % VARIANCE | YTD ACTUAL | % VARIANCE |
|---|---|---|---|---|---|---|---|---|---|---|
| FTEs - TOTAL (AVG) | 607.32 | 625.21 | 3% | 594.91 | 625.21 | 5% | 565 | -7% | 555 | -7% |
| FTEs - PRODUCTIVE (AVG) | 562.78 | 559.80 | -1% | 530.76 | 559.80 | 5% | 509 | -11% | 478 | -11% |
| ADJUSTED PATIENT DAYS | 1,932 | 2,337 | -17% | 3,872 | 4,836 | -20% | 1,517 | 27% | 4,350 | -11% |
| ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS) | 56 | 79 | -29% | 120 | 163 | -26% | 86 | -35% | 174 | -45% |
| ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS) | 294 | 325 | -10% | 582 | 672 | -13% | 357 | -18% | 649 | -12% |
| SWING IP PATIENT DAYS (MIDNIGHT CENSUS) | 28 | 28 | 0% | 65 | 58 | 12% | 14 | 100% | 41 | 37% |
| PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION | 378 | 432 | -13% | 767 | 893 | -14% | 457 | -17% | 864 | -13% |
| BIRTHS | 12 | 10 | 20% | 18 | 20 | -10% | 6 | 100% | 16 | 11% |
| SURGERY CASES (IN OR) | 116 | 110 | 5% | 245 | 228 | 7% | 97 | 20% | 204 | 17% |
| SURGERY MINUTES (IN OR) | 14,620 | 14,658 | 0% | 32,857 | 30,327 | 8% | 12,336 | 19% | 26,257 | 20% |
| SPECIAL PROCEDURE CASES | 73 | 68 | 7% | 159 | 141 | 13% | 52 | 40% | 110 | 31% |
| LAB BILLABLE TESTS | 17,268 | 18,531 | -7% | 35,934 | 38,340 | -6% | 16,544 | 4% | 36,299 | -1% |
| BLOOD BANK UNITS MATCHED | 51 | 43 | 19% | 121 | 89 | 36% | 44 | 16% | 78 | 36% |
| MRIs COMPLETED | 205 | 184 | 11% | 444 | 380 | 17% | 168 | 22% | 341 | 23% |
| CT SCANS COMPLETED | 459 | 483 | -5% | 915 | 998 | -8% | 423 | 9% | 915 | 0% |
| RADIOLOGY DIAGNOSTIC TESTS | 1,574 | 1,460 | 8% | 3,144 | 3,020 | 4% | 1,358 | 16% | 2,903 | 8% |
| ECHOs COMPLETED | 72 | 130 | -45% | 189 | 269 | -30% | 117 | -38% | 241 | -28% |
| ULTRASOUNDS COMPLETED | 303 | 315 | -4% | 608 | 652 | -7% | 263 | 15% | 609 | 0% |
| MAMMOGRAPHYS COMPLETED | 233 | 293 | -20% | 472 | 607 | -22% | 194 | 20% | 441 | 7% |
| NUCLEAR MEDICINE TESTS | 28 | 39 | -28% | 57 | 81 | -30% | 37 | -24% | 73 | -28% |
| TOTAL DIAGNOSTIC IMAGING TESTS | 2,874 | 2,904 | -1% | 5,829 | 6,007 | -3% | 2,560 | 12% | 5,523 | 5% |
| PHARMACY MEDS DISPENSED | 18,262 | 21,046 | -13% | 39,394 | 43,543 | -10% | 22,076 | -17% | 44,830 | -14% |
| ANTI COAG VISITS | 334 | 365 | -8% | 729 | 755 | -3% | 343 | -3% | 766 | -5% |
| RESPIRATORY THERAPY PROCEDURES | 2,923 | 3,707 | -21% | 6,470 | 7,670 | -16% | 3,762 | -22% | 7,528 | -16% |
| PULMONARY REHAB RVUs | 231 | 205 | 13% | 475 | 425 | 12% | 143 | 62% | 373 | 21% |
| PHYSICAL THERAPY RVUs | 6,032 | 7,159 | -16% | 13,468 | 14,812 | -9% | 6,009 | 0% | 13,676 | -2% |
| OCCUPATIONAL THERAPY RVUs | 1,034 | 1,036 | 0% | 2,098 | 2,143 | -2% | 985 | 5% | 2,143 | -2% |
| SPEECH THERAPY RVUs | 237 | 198 | 20% | 504 | 409 | 23% | 160 | 48% | 383 | 24% |
| REHAB/PT/OT/ST RVUs | 7,534 | 8,598 | -12% | 16,545 | 17,789 | -7% | 7,297 | 3% | 16,575 | 0% |
| ER CENSUS | 1,010 | 1,025 | -1% | 2,056 | 2,122 | -3% | 926 | 9% | 1,942 | 6% |
| EXPRESS CLINIC | 894 | 911 | -2% | 1,843 | 1,885 | -2% | 616 | 45% | 1,363 | 26% |
| SOCO PATIENT VISITS | 189 | 145 | 30% | 349 | 300 | 16% | 92 | 105% | 245 | 30% |
| PORT LUDLOW PATIENT VISITS | 595 | 688 | -14% | 1,183 | 1,424 | -17% | 659 | -10% | 1,478 | -25% |
| SHERIDAN PATIENT VISITS | 2,183 | 2,539 | -14% | 4,534 | 5,253 | -14% | 2,232 | -2% | 5,104 | -13% |
| DENTAL CLINIC | - | 318 | -100% | 339 | 658 | -48% | - | 0% | - | 100% |
| WATERSHIP CLINIC PATIENT VISITS | 886 | 1,028 | -14% | 2,020 | 2,127 | -5% | 998 | -11% | 2,230 | -10% |
| TOWNSEND PATIENT VISITS | 610 | 553 | 10% | 1,145 | 1,143 | 0% | 498 | 22% | 1,053 | 8% |
| TOTAL RURAL HEALTH CLINIC VISITS | 5,357 | 6,182 | -13% | 11,413 | 12,790 | -11% | 5,095 | 5% | 11,473 | -1% |
| CARDIOLOGY CLINIC VISITS | 336 | 342 | -2% | 655 | 707 | -7% | 249 | 35% | 548 | 16% |
| DERMATOLOGY CLINIC VISITS | 531 | 481 | 10% | 1,214 | 995 | 22% | 432 | 23% | 844 | 30% |
| GEN SURG PATIENT VISITS | 265 | 290 | -9% | 559 | 601 | -7% | 265 | 0% | 596 | -7% |
| INFUSION CENTER VISITS | 698 | 800 | -13% | 1,431 | 1,655 | -14% | 558 | 25% | 1,218 | 15% |
| ONCOLOGY VISITS | 440 | 512 | -14% | 936 | 1,059 | -12% | 345 | 28% | 738 | 21% |
| ORTHO PATIENT VISITS | 728 | 691 | 5% | 1,404 | 1,430 | -2% | 561 | 30% | 1,168 | 17% |
| SLEEP CLINIC VISITS | 177 | 228 | -22% | 353 | 472 | -25% | 81 | 119% | 300 | 15% |
| SURGERY CENTER ENDOSCOPIES | 73 | 74 | -1% | 147 | 153 | -4% | 55 | 33% | 130 | 12% |
| WOMENS CLINIC VISITS | 192 | 218 | -12% | 363 | 452 | -20% | 185 | 4% | 407 | -12% |
| WOUND CLINIC VISITS | 230 | 333 | -31% | 461 | 690 | -33% | 244 | -6% | 545 | -18% |
| TOTAL SPECIALTY CLINIC VISITS | 3,670 | 3,969 | -8% | 7,523 | 8,214 | -8% | 2,975 | 23% | 6,494 | 14% |
| SLEEP CENTER SLEEP STUDIES | 56 | 67 | -16% | 114 | 138 | -17% | 46 | 22% | 102 | 11% |
| HOME HEALTH EPISODES | 42 | 79 | -47% | 90 | 164 | -45% | 55 | -24% | 133 | -48% |
| HOSPICE CENSUS/DAYS | 953 | 952 | 0% | 2,026 | 1,969 | 3% | 828 | 15% | 1,661 | 18% |
| CARDIAC REHAB SESSIONS | 146 | 159 | -8% | 329 | 329 | 0% | - | 0% | - | 100% |
| DIETARY TOTAL REVENUE | 79,586 | 90,513 | -12% | 164,090 | 187,267 | -12% | 73,434 | 8% | 147,926 | 10% |
| MAT MGMT TOTAL ORDERS PROCESSED | 1,921 | 2,223 | -14% | 4,212 | 4,599 | -8% | 1,841 | 4% | 4,093 | 3% |
| EXERCISE FOR HEALTH PARTICIPANTS | 494 | 745 | -34% | 1,000 | 1,541 | -35% | 539 | -8% | 1,452 | -45% |

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

**TO:** **BOARD OF COMMISSIONERS**
**FROM:** **HILARY WHITTINGTON, CAO/CFO**
**RE:** **FEBRUARY 2020 WARRANT SUMMARY**

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

| | | |
|---|---|---|
| General Fund Warrants & ACH Transfers | **$12,014,885.10** | (Provided under separate cover) |
| Allowance for Uncollectible Accounts / Charity | **$997,063.62** | (Attached) |
| Canceled Warrants | **$0.00** | (Attached) |

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

**TO:** **BOARD OF COMMISSIONERS**
**FROM:** **HILARY WHITTINGTON, CAO/CFO**
**RE:** **FEBRUARY 2020 GENERAL FUND WARRANTS & ACH FUND TRANSFERS**

**Submitted for your approval are the following warrants:**

**GENERAL FUND:**

| | |
|---|---|
| **265527 - 263313** | **$3,234,589.65** |
| **ACH TRANSFERS** | **$8,780,295.45** |
| | **$12,014,885.10** |
| **YEAR-TO-DATE:** | **$27,835,280.25** |

Warrants are available for review if requested.

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

**TO:** **BOARD OF COMMISSIONERS**
**FROM:** **HILARY WHITTINGTON, CAO/CFO**
**RE:** **FEBRUARY 2020 ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS, ADMINISTRATIVE, AND CHARITY CARE WRITE OFFS**

**Submitted for your approval are the following:**

| | FEBRUARY | FEBRUARY YTD | FEBRUARY YTD BUDGET |
|---|---|---|---|
| Allowance for Uncollectible Accounts: | 725,389.82 | 750,517.52 | 853,782.90 |
| Charity Care: | 256,195.91 | 433,672.23 | 451,965.81 |
| Other Administrative Adjustments: | 15,477.89 | 250,722.43 | 213,378.89 |
| TOTAL FOR MONTH: | $997,063.62 | $1,434,912.18 | $1,519,127.60 |

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

**TO:** **BOARD OF COMMISSIONERS**
**FROM:** **HILARY WHITTINGTON, CAO/CFO**
**RE:** **FEBRUARY 2020 WARRANT CANCELLATIONS**

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

| DATE | WARRANT | AMOUNT |
|---|---|---|
| **TOTAL:** | | **$ -** |

Jefferson Healthcare

| | March 2020 Actual | March 2020 Budget | Variance Favorable/ (Unfavorable) | % | March 2020 YTD | March 2020 Budget YTD | Variance Favorable/ (Unfavorable) | % | March 2019 YTD |
|---|---|---|---|---|---|---|---|---|---|
| **Gross Revenue** | | | | | | | | | |
| Inpatient Revenue | 2,365,933 | 4,332,537 | (1,966,604) | -45% | 9,664,561 | 12,718,090 | (3,053,530) | -24% | 12,284,510 |
| Outpatient Revenue | 15,628,339 | 19,812,278 | (4,183,938) | -21% | 53,025,617 | 58,158,616 | (5,132,999) | -9% | 49,447,872 |
| **Total Gross Revenue** | 17,994,272 | 24,144,814 | (6,150,542) | -25% | 62,690,178 | 70,876,706 | (8,186,528) | -12% | 61,732,382 |
| **Revenue Adjustments** | | | | | | | | | |
| Cost Adjustment Medicaid | 1,404,738 | 2,221,642 | 816,904 | 37% | 4,922,376 | 6,521,595 | 1,599,219 | 25% | 5,653,411 |
| Cost Adjustment Medicare | 6,183,314 | 8,252,442 | 2,069,128 | 25% | 22,200,760 | 24,224,908 | 2,024,149 | 8% | 21,169,796 |
| Charity Care | 296,287 | 233,516 | (62,771) | -27% | 729,959 | 685,482 | (44,477) | -6% | 507,893 |
| Contractual Allowances Other | 1,713,991 | 1,883,514 | 169,523 | 9% | 5,395,557 | 5,529,023 | 133,466 | 2% | 4,645,842 |
| Administrative Adjustments | 40,445 | 110,246 | 69,801 | 63% | 291,167 | 323,625 | 32,458 | 10% | 269,869 |
| Allowance for Uncollectible Accounts | 333,268 | 441,121 | 107,854 | 24% | 1,083,785 | 1,294,904 | 211,119 | 16% | 1,334,248 |
| **Total Revenue Adjustments** | 9,972,042 | 13,142,481 | 3,170,439 | 24% | 34,623,603 | 38,579,536 | 3,955,933 | 10% | 33,581,060 |
| **Net Patient Service Revenue** | 8,022,230 | 11,002,334 | (2,980,103) | -27% | 28,066,575 | 32,297,170 | (4,230,595) | -13% | 28,151,322 |
| **Other Revenue** | | | | | | | | | |
| 340B Revenue | 247,251 | 277,357 | (30,105) | -11% | 850,888 | 814,176 | 36,712 | 5% | 884,856 |
| Other Operating Revenue | 471,045 | 304,781 | 166,264 | 55% | 1,029,254 | 894,679 | 134,575 | 15% | 525,803 |
| **Total Operating Revenues** | 8,740,526 | 11,584,471 | (2,843,945) | -25% | 29,946,717 | 34,006,025 | (4,059,308) | -12% | 29,561,981 |
| **Operating Expenses** | | | | | | | | | |
| Salaries And Wages | 5,532,434 | 5,555,425 | 22,992 | 0% | 16,160,710 | 16,307,860 | 147,150 | 1% | 14,225,353 |
| Employee Benefits | 1,328,200 | 1,431,213 | 103,013 | 7% | 4,040,733 | 4,201,303 | 160,569 | 4% | 3,616,081 |
| Professional Fees | 252,415 | 194,246 | (58,169) | -30% | 622,395 | 570,207 | (52,189) | -9% | 1,328,272 |
| Purchased Services | 582,177 | 715,638 | 133,461 | 19% | 1,916,374 | 2,100,745 | 184,371 | 9% | 1,438,823 |
| Supplies | 2,088,439 | 2,110,910 | 22,471 | 1% | 5,796,389 | 6,196,541 | 400,152 | 6% | 5,112,136 |
| Insurance | 65,869 | 58,565 | (7,304) | -12% | 193,910 | 171,918 | (21,992) | -13% | 167,333 |
| Leases And Rentals | 12,088 | 15,461 | 3,372 | 22% | 43,027 | 45,384 | 2,357 | 5% | 450,948 |
| Depreciation And Amortization | 489,603 | 549,516 | 59,913 | 11% | 1,530,561 | 1,613,096 | 82,536 | 5% | 1,160,287 |
| Repairs And Maintenance | 85,015 | 107,679 | 22,664 | 21% | 290,003 | 316,089 | 26,086 | 8% | 169,324 |
| Utilities | 97,312 | 105,814 | 8,502 | 8% | 307,795 | 310,615 | 2,819 | 1% | 297,066 |
| Licenses And Taxes | 53,783 | 56,552 | 2,768 | 5% | 178,567 | 166,007 | (12,560) | -8% | 159,018 |
| Other | 176,755 | 227,418 | 50,663 | 22% | 584,694 | 667,582 | 82,889 | 12% | 488,401 |
| **Total Operating Expenses** | 10,764,091 | 11,128,437 | 364,346 | 3% | 31,665,159 | 32,667,346 | 1,002,187 | 3% | 28,613,042 |
| **Operating Income (Loss)** | (2,023,565) | 456,034 | (2,479,598) | -544% | (1,718,442) | 1,338,679 | (3,057,121) | -228% | 948,939 |
| **Non Operating Revenues (Expenses)** | | | | | | | | | |
| Taxation For Maint Operations | 22,098 | 22,750 | (652) | -3% | 66,293 | 66,783 | (490) | -1% | 38,669 |
| Taxation For Debt Service | 18,975 | 18,837 | 138 | 1% | 56,926 | 55,296 | 1,630 | 3% | 36,956 |
| Investment Income | 27,385 | 28,103 | (718) | -3% | 93,362 | 82,497 | 10,865 | 13% | 150,892 |
| Interest Expense | (89,043) | (94,102) | 5,059 | 5% | (267,383) | (276,234) | 8,851 | 3% | (249,918) |
| Bond Issuance Costs | - | - | - | 0% | - | 0 | - | 0% | 0 |
| Gain or (Loss) on Disposed Asset | - | - | - | 0% | - | 0 | - | 0% | 0 |
| Contributions | 7,989 | 16,940 | (8,951) | -53% | 20,738 | 49,727 | (28,988) | -58% | 21,390 |
| **Total Non Operating Revenues (Expenses)** | (12,595) | (7,471) | (5,124) | 69% | (30,063) | (21,931) | (8,132) | 37% | (2,011) |
| **Change in Net Position (Loss)** | (2,036,160) | 448,563 | (2,484,723) | -554% | (1,748,505) | 1,316,748 | (3,065,253) | -233% | 946,927 |

Jefferson Healthcare

| STATISTIC DESCRIPTION | MARCH 2020 MO ACTUAL | MO BUDGET | % VARIANCE | YTD ACTUAL | YTD BUDGET | % VARIANCE | MARCH 2019 MO ACTUAL | % VARIANCE | YTD ACTUAL | % VARIANCE |
|---|---|---|---|---|---|---|---|---|---|---|
| FTEs - TOTAL (AVG) | 611.78 | 625.21 | 2% | 599.73 | 625.21 | 4% | 572 | -7% | 562 | -7% |
| FTEs - PRODUCTIVE (AVG) | 551.08 | 559.80 | 2% | 536.57 | 559.80 | 4% | 522 | -6% | 497 | -8% |
| ADJUSTED PATIENT DAYS | 1,793 | 2,498 | -28% | 5,665 | 7,334 | -23% | 2,229 | -20% | 6,579 | -14% |
| ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS) | 49 | 84 | -42% | 169 | 247 | -32% | 81 | -40% | 255 | -51% |
| ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS) | 198 | 347 | -43% | 780 | 1,019 | -23% | 348 | -43% | 997 | -28% |
| SWING IP PATIENT DAYS (MIDNIGHT CENSUS) | 31 | 30 | 3% | 96 | 87 | 10% | 14 | 121% | 55 | 43% |
| PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION | 278 | 461 | -40% | 1,045 | 1,353 | -23% | 443 | -37% | 1,307 | -25% |
| BIRTHS | 6 | 10 | -40% | 24 | 30 | -20% | 10 | -40% | 26 | -8% |
| SURGERY CASES (IN OR) | 70 | 118 | -41% | 315 | 346 | -9% | 102 | -31% | 306 | 3% |
| SURGERY MINUTES (IN OR) | 8,591 | 15,669 | -45% | 41,448 | 45,996 | -10% | 13,995 | -39% | 40,252 | 3% |
| SPECIAL PROCEDURE CASES | 42 | 73 | -42% | 201 | 214 | -6% | 75 | -44% | 185 | 8% |
| LAB BILLABLE TESTS | 14,158 | 19,809 | -29% | 50,092 | 58,148 | -14% | 19,468 | -27% | 55,767 | -11% |
| BLOOD BANK UNITS MATCHED | 35 | 46 | -24% | 156 | 135 | 16% | 65 | -46% | 143 | 8% |
| MRIs COMPLETED | 190 | 196 | -3% | 634 | 577 | 10% | 173 | 10% | 514 | 19% |
| CT SCANS COMPLETED | 328 | 516 | -36% | 1,243 | 1,514 | -18% | 478 | -31% | 1,393 | -12% |
| RADIOLOGY DIAGNOSTIC TESTS | 1,167 | 1,560 | -25% | 4,311 | 4,580 | -6% | 1,512 | -23% | 4,415 | -2% |
| ECHOs COMPLETED | 83 | 139 | -40% | 272 | 408 | -33% | 132 | -37% | 373 | -37% |
| ULTRASOUNDS COMPLETED | 268 | 337 | -20% | 876 | 988 | -11% | 315 | -15% | 924 | -5% |
| MAMMOGRAPHYS COMPLETED | 158 | 313 | -50% | 630 | 920 | -32% | 243 | -35% | 684 | -9% |
| NUCLEAR MEDICINE TESTS | 27 | 42 | -36% | 84 | 123 | -32% | 42 | -36% | 115 | -37% |
| TOTAL DIAGNOSTIC IMAGING TESTS | 2,221 | 3,103 | -28% | 8,050 | 9,110 | -12% | 2,895 | -23% | 8,418 | -5% |
| PHARMACY MEDS DISPENSED | 15,479 | 22,497 | -31% | 56,919 | 66,041 | -14% | 22,207 | -30% | 67,037 | -18% |
| ANTI COAG VISITS | 319 | 390 | -18% | 1,048 | 1,145 | -8% | 368 | -13% | 1,134 | -8% |
| RESPIRATORY THERAPY PROCEDURES | 2,191 | 3,963 | -45% | 8,918 | 11,632 | -23% | 3,849 | -43% | 11,377 | -28% |
| PULMONARY REHAB RVUs | 133 | 220 | -40% | 644 | 644 | 0% | 205 | -35% | 578 | 10% |
| PHYSICAL THERAPY RVUs | 5,275 | 7,653 | -31% | 19,023 | 22,465 | -15% | 7,246 | -27% | 20,922 | -10% |
| OCCUPATIONAL THERAPY RVUs | 847 | 1,107 | -23% | 3,026 | 3,251 | -7% | 971 | -13% | 3,114 | -3% |
| SPEECH THERAPY RVUs | 146 | 212 | -31% | 700 | 621 | 13% | 228 | -36% | 611 | 13% |
| REHAB/PT/OT/ST RVUs | 6,401 | 9,192 | -30% | 23,393 | 26,981 | -13% | 8,650 | -26% | 25,225 | -8% |
| ER CENSUS | 823 | 1,096 | -25% | 2,879 | 3,218 | -11% | 1,086 | -24% | 3,028 | -5% |
| EXPRESS CLINIC | 582 | 974 | -40% | 2,425 | 2,858 | -15% | 869 | -33% | 2,232 | 8% |
| SOCO PATIENT VISITS | 89 | 155 | -43% | 438 | 455 | -4% | 144 | -38% | 389 | 11% |
| PORT LUDLOW PATIENT VISITS | 449 | 736 | -39% | 1,632 | 2,160 | -24% | 693 | -35% | 2,171 | -33% |
| SHERIDAN PATIENT VISITS | 1,761 | 2,714 | -35% | 6,295 | 7,967 | -21% | 2,828 | -38% | 7,932 | -26% |
| DENTAL CLINIC | 197 | 340 | -42% | 872 | 997 | -13% | - | 0% | - | 100% |
| WATERSHIP CLINIC PATIENT VISITS | 765 | 1,099 | -30% | 2,785 | 3,227 | -14% | 1,035 | -26% | 3,265 | -17% |
| TOWNSEND PATIENT VISITS | 472 | 591 | -20% | 1,617 | 1,734 | -7% | 511 | -8% | 1,564 | 3% |
| TOTAL RURAL HEALTH CLINIC VISITS | 4,315 | 6,609 | -35% | 16,064 | 19,398 | -17% | 6,080 | -29% | 17,553 | -9% |
| OFF-SITE LAB | 132 | - | 0% | 132 | - | 0% | - | 0% | - | 100% |
| DISASTER CLINIC | 354 | - | 0% | 354 | - | 0% | - | 0% | - | 100% |
| CARDIOLOGY CLINIC VISITS | 250 | 365 | -32% | 905 | 1,072 | -16% | 280 | -11% | 1,124 | -24% |
| DERMATOLOGY CLINIC VISITS | 508 | 514 | -1% | 1,722 | 1,508 | 14% | 455 | 12% | 1,299 | 25% |
| GEN SURG PATIENT VISITS | 160 | 310 | -48% | 719 | 911 | -21% | 337 | -53% | 933 | -30% |
| INFUSION CENTER VISITS | 674 | 855 | -21% | 2,105 | 2,511 | -16% | 685 | -2% | 1,903 | 10% |
| ONCOLOGY VISITS | 452 | 547 | -17% | 1,388 | 1,606 | -14% | 389 | 16% | 1,127 | 19% |
| ORTHO PATIENT VISITS | 540 | 739 | -27% | 1,944 | 2,169 | -10% | 584 | -8% | 1,752 | 10% |
| SLEEP CLINIC VISITS | 129 | 244 | -47% | 482 | 716 | -33% | 95 | 36% | 395 | 18% |
| SURGERY CENTER ENDOSCOPIES | 52 | 79 | -34% | 199 | 232 | -14% | 71 | -27% | 201 | -1% |
| WOMENS CLINIC VISITS | 105 | 234 | -55% | 468 | 686 | -32% | 218 | -52% | 625 | -34% |
| WOUND CLINIC VISITS | 195 | 356 | -45% | 656 | 1,046 | -37% | 280 | -30% | 825 | -26% |
| TOTAL SPECIALTY CLINIC VISITS | 3,551 | 4,243 | -16% | 11,074 | 12,457 | -11% | 3,394 | 5% | 10,184 | 8% |
| SLEEP CENTER SLEEP STUDIES | 45 | 71 | -37% | 159 | 209 | -24% | 56 | -20% | 158 | 1% |
| HOME HEALTH EPISODES | 42 | 85 | -51% | 133 | 249 | -47% | 77 | -45% | 210 | -58% |
| HOSPICE CENSUS/DAYS | 1,000 | 1,017 | -2% | 3,026 | 2,986 | 1% | 873 | 15% | 2,534 | 16% |
| CARDIAC REHAB SESSIONS | 79 | 170 | -54% | 408 | 499 | -18% | - | 0% | - | 100% |
| DIETARY TOTAL REVENUE | 67,739 | 96,755 | -30% | 231,829 | 284,022 | -18% | 75,713 | -11% | 223,639 | 4% |
| MAT MGMT TOTAL ORDERS PROCESSED | 2,334 | 2,376 | -2% | 6,546 | 6,976 | -6% | 2,041 | 14% | 6,134 | 6% |
| EXERCISE FOR HEALTH PARTICIPANTS | 240 | 796 | -70% | 1,240 | 2,338 | -47% | 869 | -72% | 2,321 | -87% |

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

**TO:** **BOARD OF COMMISSIONERS**
**FROM:** **HILARY WHITTINGTON, CAO/CFO**
**RE:** **MARCH 2020 WARRANT SUMMARY**

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

| | | |
|---|---|---|
| General Fund Warrants & ACH Transfers | **$16,290,373.37** | (Provided under separate cover) |
| Allowance for Uncollectible Accounts / Charity | **$669,998.96** | (Attached) |
| Canceled Warrants | **$0.00** | (Attached) |

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

**TO:** **BOARD OF COMMISSIONERS**
**FROM:** **HILARY WHITTINGTON, CAO/CFO**
**RE:** **MARCH 2020 GENERAL FUND WARRANTS & ACH FUND TRANSFERS**

**Submitted for your approval are the following warrants:**

**GENERAL FUND:**

| | | |
|---|---|---|
| **263314** | **264247** | **$3,980,669.02** |
| **ACH TRANSFERS** | | **$12,309,704.35** |
| | | **$16,290,373.37** |
| **YEAR-TO-DATE:** | | **$44,125,653.62** |

Warrants are available for review if requested.

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

**TO:** BOARD OF COMMISSIONERS
**FROM:** HILARY WHITTINGTON, CAO/CFO
**RE:** MARCH 2020 ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS, ADMINISTRATIVE, AND CHARITY CARE WRITE OFFS

**Submitted for your approval are the following:**

| | MARCH | MARCH YTD | MARCH YTD BUDGET |
|---|---|---|---|
| Allowance for Uncollectible Accounts: | 333,267.67 | 1,083,785.19 | 1,294,904.13 |
| Charity Care: | 296,286.64 | 729,958.87 | 685,481.51 |
| Other Administrative Adjustments: | 40,444.65 | 291,167.08 | 323,624.66 |
| TOTAL FOR MONTH: | $669,998.96 | $2,104,911.14 | $2,304,010.30 |

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

**TO:** **BOARD OF COMMISSIONERS**
**FROM:** **HILARY WHITTINGTON, CAO/CFO**
**RE:** **MARCH 2020 WARRANT CANCELLATIONS**

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

| DATE | WARRANT | AMOUNT |
|---|---|---|
| **TOTAL:** | | **$ -** |

JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

RESOLUTION 2020-03

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

WHEREAS the item(s) of equipment enumerated below are obsolete and otherwise surplus to the District, and;

WHEREAS said equipment now represents an unnecessary cost to the District to retain and store it,

NOW, THEREFORE, BE IT RESOLVED THAT:

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

| **Description** | **Asset #** | **Serial #** | **Model #** |
|---|---|---|---|
| FormaScientific C02 microbology incubator | LAB03522 | 26582-2172 | 3110 |

APPROVED this 22nd day of April 2020.

APPROVED BY THE COMMISSION:

Commission Chair Jill Buhler Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Bruce McComas: _____

Commissioner Kees Kolff: _____

Commissioner Matt Ready: _____

**FROM:** **Medical Staff Services**
**RE:** **4/21/2020 Medical Executive Committee appointments/reappointments for Board approval 4/22/2020**

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

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

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

1. Bruce Geryk, MD – Teleneurology
2. Lindsay Frischmann, DO – Teleneurology
3. Jenn Siv, MD – Teleneurology
4. Carol Venable, MD – Internal Medicine
5. Frank Martinez, MD – Emergency Medicine

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

N/A

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

1. David Atkins, MD – Teleradiology
2. Ruth (Treat) Thomson, DO - Telenureology

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

N/A

**Medical Student Rotation:**

N/A

**90-day provisional performance review completed successfully:**

N/A

**Resignations:**

1. Andrew J. Harrison, DO – Teleradiology

# Delineation of Privileges: ARNP General Privileges

To be eligible to request ARNP privileges, the following minimum threshold criteria must be met:

**Basic education:** Advance Registered Nurse Practitioner

**Minimum formal training:**

- Master's degree in nursing from accredited college or university if training was completed after January 1, 1995 or certified by a board approved national certification program prior to December 31, 1994 and recognized by another state board of nursing for advanced practice prior to December 31, 1994.
  **Credentials:**
- Current Washington State advanced registered nurse practitioner license
- Current Washington State registered nurse license
- Certification by American Nurses Credentialing Center (ANCC), AANP or NCC
- Valid DEA registration for ordering medications and prescriptions
- Current BLS certification (ACLS supersedes BLS for care of adult patients)

**Required previous experience:**

- Minimum of one year of experience in a clinic or hospital setting
  **Reappointment Criteria:**
- Documented clinical activity within the scope of privileges without significant variations identified
- Continuing education related to applicant's primary practice area is required.

**Orders:**

Diagnostic tests, medications (including Schedule II-V controlled substance with appropriate DEA registration), and other patient treatments may be ordered by the ARNP and treated as a physician's orders.

May initiate referrals to other disciplines or specialist as necessary.

**Medical Records:**

The ARNP will document all care provided **in accordance with standard work/policies and procedures**.

A representative but not inclusive list of ARNP scope of services and specific procedures is stated below.

Other procedures and problems of similar complexity will fall within the identified core privileges.

The ARNP must obtain consultation for all clinical situations that lie outside his/her training or experience.

Please check privilege requests:

**Core Privileges for outpatient/clinic:**

Evaluate, assess (including history and physical) and treat adults and children with routine and urgent conditions within scope of licensure

- Perform and document complete, system-focused, or symptom-specific physical examination
- Assess the need for and perform additional screening and diagnostic testing, based on initial assessment findings
- Prioritize data collection
- Manage diagnostic tests through ordering and interpretation
- Formulate differential diagnoses by priority
- Prescribe appropriate pharmacologic and non-pharmacologic treatment modalities
- Utilize evidence-based, approved practice protocols in planning and implementing care
- Initiate appropriate referrals and consultations
- Provide specialty specific consultation services upon request and within specialty scope of practice
- Facilitate the patient's transition between and within health care settings, such as admitting, transferring, and discharging
- patients
- Identify patient and family needs regarding preventative care, disease entity, medications, dietary restrictions and other therapeutic forms

**Outpatient/Clinic Privileges**

- Biopsy/removal of skin lesions

- Endometrial and vulvar

- Laceration repair
- I & D of abscess
- Nail removal
- Trigger point/soft tissue injections
- Insulin pump
- Continuous glucose monitoring

**Special Requests:**

Sub-specialty areas: In the event that certification exists and has not yet been obtained, or the provider has not had recent experience (within two years), the provider requires physician supervision and/or a formal training plan, approved by the Medical Staff prior to full independent practice.

**Initial Appointment:**

A. For Initial Application the ARNP must indicate for each procedure if they have been:
    1. Trained in initial program to do the procedure;
    2. Received post-graduate training in the procedure (attach copy of certificate)
    3. Will be supervised by a staff member with privileges in the procedure until demonstrated to be competent.

**Reappointment requirement**: Continued competence in performing these procedures is demonstrated by ongoing quality review.

ARNPs practicing in the hospital are required to have a physician sponsor that is a member of the Active Medical Staff. Privileges in the Hospital shall be exercised only under the supervision of the physician sponsor. Supervision shall not require the actual physical presence of the sponsor unless so indicated on the privilege list. The sponsoring physician or designee shall review care provided by the ARNP on a continuous basis and for admitted patients, shall countersign the admitting history and physical and the discharge summary.

_____ _____

**Physician Sponsor** signature (if applicable) Date

*I request the privileges checked above and attest that I have met the requirements for these privileges. I have crossed out any procedures that I do not currently perform or request. I understand that by making this request I am bound by the applicable bylaws, policies and procedures of the hospital and the Medical Staff and hereby stipulate that I meet the threshold criteria for each privilege requested.*

Provider Signature Date

Governing Board Approval Date _____

Privileges form approved by MEC: 07/15/2011

Governing Board: 8/3/2011

reviewed by CC 7/9/2018

# Autopsy Criteria policy

# Statement of Purpose:

Attempt to identify cause in certain patient death outcomes that meets RCW 68.50 or request for autopsy from patient's attending provider or family.

# Statement of Policy:

Patient's attending provider shall attempt to secure autopsies in all deaths meeting the autopsy criteria in this policy.

Jefferson Healthcare does not have the facilities to conduct autopsies on site. Any autopsies will be done at an off-site facility after making arrangements with the attending physician and the pathologist on call.

# Procedure/Interventions:

**Financial Responsibility and Consent:**

1. If the death meets the coroner's criteria in accordance with RCW 68.50, it will be performed by the county agent (Deputy Coroner at Kosec's funeral home), and the county will have financial responsibility.

2. If a provider requests autopsy arrangements that does not meet the coroner's criteria arrangements can be made with Kosec's or NW pathology to conduct the autopsy. Obtain consent in accordance with Informed Consent policy. Financial responsibility may be with patient's estate.

**Criteria:**

1. All deaths will be evaluated for autopsy by the patient's attending provider including but not limited to the following:

i. Death in which an autopsy may explain unknown or unanticipated medical complications.

ii. Deaths in which the cause is sufficiently obscure on clinical grounds as to delay completion of the death certificate.

iii. Deaths in which an autopsy would allay concerns of the public/family regarding death to provide reassurance to them regarding the same, if not subject to forensic medical jurisdiction.

iv. Deaths of patients who participated in clinical trials at Jefferson Healthcare or other institution.

v. Intra-operative or intra-procedural death.

vi. Death occurring within 48 hours after surgery or an invasive diagnostic procedure.

vii. Death incident to pregnancy.

viii. Death in infants/children with congenital malformations.

ix. Unexplained, unexpected deaths.

x. Death of a woman while pregnant or within one year of the end of a pregnancy, from any cause.

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

i. All deceased persons who come to their death suddenly when in apparent good health without medical attendance within the 36 hours preceding death.

ii. Circumstances of death indicate death was caused by unnatural or unlawful means.

iii. Death occurs under suspicious circumstances.

iv. Death results from unknown or obscure causes.

v. Death occurs within one year following an accident.

vi. Death is caused by any violence whatsoever.

vii. Death results from a known or suspected abortion, whether self-induced or otherwise.

viii. Death results from drowning, hanging, burns, electrocution, gunshot wounds, stabs or cuts, lightning, starvation, radiation, exposure, alcoholism, narcotics or other addictions, tetanus, strangulation, suffocation, or smothering.

ix. Death due to premature birth or still birth.

x. Death due to a violent contagious disease or suspected contagious disease which may be a public health hazard.

xi. Death results from alleged rape, carnal knowledge or sodomy.

xii. Deaths that occur during pregnancy or within forty-two days of the end of pregnancy.

A preliminary autopsy report will be available to the managing physician within two (2) days of autopsy. The final autopsy report will be completed within thirty (30) days unless special studies are required.

The managing physician may inform the family of autopsy results.

**REFERENCES:**

DNV Standards MS19, S.R.1-3

Coroner's jurisdiction over remains, RCW 68.50.010

Maternal Mortality Review Panel (MMRP), RCW 70.54.450

# Disaster Credentialing – Medical Staff and Allied Health Professionals policy

# PURPOSE:

When the Emergency Management Plan of Jefferson Healthcare has been activated, the organization may not be able to care for the emergent needs of mass casualties or increased surge capacity of victims. During a disaster, it may be necessary to grant temporary privileges to volunteer physicians, physician assistants or nurse practitioners who are eligible as Licensed Independent Practitioners.

# POLICY:

To obtain privileges in the event of a disaster for which the Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs. During a disaster, primary source verification will occur according the Medical Staff Bylaws. Upon activation of Incident Command, this Disaster Credentialing Policy will go into effect.

# PROCEDURE:

The practitioner must be identified at a minimum by a valid government issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

1. Current hospital photo ID card that clearly identifies professional designation
2. Current license to practice in the State of Washington
3. Primary source verification of license.
4. ID as a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP or other state/federal organizations or groups.
5. ID indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity).
6. ID by current hospital or medical staff member(s) who possess personal knowledge regarding volunteer's ability to act as a LIP during a disaster.

Primary source verification of licensure will be done as soon as the immediate situation is under control and completed within 72 hours from the time the volunteer practice practitioner presents to the organization. In extraordinary circumstances that primary source verification cannot be completed within 72 hours, it is expected to be completed as soon as possible unless said provider has not rendered patient care during the disaster.

Verification to be performed by the Medical Staff Office, or designee(s), and documented on the Temporary Disaster Privileges Form (see attachment). A record of this information should be retained in the Medical Staff Services Department:

The provider will be assigned to the clinical department of their specialty and supervisory authority shall be under department chairperson of their specialty. When appropriate, the practitioner may be paired with a currently credentialed Hospital Medical Staff or Allied Health Professional Staff member.

These privileges will automatically expire when the disaster situation no longer exists or by action of the CEO, Chief of Staff or designee(s). Termination of these privileges will not give rise to a fair hearing or review.

# REFERENCES:

*National Disaster Medical System under the auspices of the US Public Health Service develops and organizes DMATs which are groups of professional medical personnel designed to provide emergency medical care during a disaster. DMATs deploy to disaster sites with medical supplies and equipment to sustain themselves for a 72-hr period while providing care at a fixed or temporary medical care site.*

# APPROVED:

MEC: 9/22/09, 9/10/2010, 4/2/2013, 4/22/2014, 3/24/2015, 3/22/2016; 9/27/2017; 11/26/2019

Governing Board: 10/7/2009, 10/6/2010, 4/17/2013, 5/7/2014, 4/15/2015, 4/20/2016; 10/18/2017; 11/27/2019

# History and Physical policy

# PURPOSE:

The purpose of a medical history and physical examination (H&P) is to determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's treatment, such as a medication allergy, or a new or existing co-morbid condition that requires additional interventions to reduce risk to the patient.

# PROCEDURE:

A. **Documentation Requirements:**

1. The history and physical must be performed and documented within 30 days prior to a scheduled admission or within twenty-four (24) hours after an unscheduled admission.
2. At the time of admission, or at the time of the physician's first visit, but no longer than 24 hours after admission, all charts must include a documented H&P in EPIC. This note will include the diagnosis, reason for admission, indications for any planned procedure, relevant assessment of the patient's condition and plan for therapeutics and diagnostics.
    - An HP completed within 30 days prior to admission or registration shall include an entry in the medical record documenting an examination for any change in the patient's current medical condition completed by a doctor of medicine or osteopathy.
    - This examination and update of the patient's current medical condition shall be completed and placed in the medical record within twenty four (24) hours after admission or registration, but prior to surgery or other procedure requiring anesthesia services.

B. **History and Physical Requirements by Patient Status:**

1. Inpatient, Same Day Surgery and Observation Charts:
   To include chief complaint, details of the present illness, relevant past medical history, relevant social history, relevant family history, summary of psychosocial needs as appropriate, relevant review of body systems, relevant physical exam, allergies, medications, and impression/plan or conclusion.
    - A preoperative history and physical shall be on chart prior to performance of a non-emergent surgical procedure. If history and physical is not recorded before the time scheduled for procedure, the operation shall be canceled or postponed, unless the attending surgeon documents on the record that such delay would be detrimental to the patient. All cases which are canceled due to absence of history and physical shall be reported to Surgical Services Committee.
2. Recurring Patients, Medical Short Stay Procedures or Treatment (i.e., IV medications, chemo):
    - Initial visit for the recurring, Medical Short Stay patient: The following options are available:
        1. *Complete H&P in EPIC; or*
        2. *Office notes that contain all elements of an H&P, as referenced above in Section B1*
    - Following the initial visit, for recurring medical outpatients: Entries are required at least every four (4) weeks, or prior to the next treatment if the treatment is longer than four (4) weeks apart.
3. Diagnostic Procedures (ie: lab, cath flushes, radiology, physical therapy): No history and physical required.
4. Emergent/Stat Treatment: At the time of admission, the patient's diagnosis must be documented. A progress note, Short Stay Form or office notes that contain all elements of

an H&P, as referenced above in Section B1, need to be entered into EPIC within twenty-four hours.

5. Procedural Sedation (moderate/conscious sedation): Refer to policy for documentation requirements.
6. The obstetrical record shall include a complete prenatal record. The prenatal record may be a copy of the attending practitioner's Office record transmitted to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and subsequent changes in physical findings. Un-established patients will need a full history and physical.

C. **Readmission:** When a patient is readmitted within 30 days for the same problem, an interval history and physical exam may be completed. Reference to the previous history and physical must be inserted in the chart and the interval note must reflect any subsequent changes in the patient.

D. **Who Can Perform the History and Physical:**

A history and physical examination may be performed by physicians and specified allied health professionals.

It is expected that the operating surgeon will be the admitting physician under normal circumstances for scheduled procedures. If the admitting physician is not the operating surgeon, the surgeon must provide a pre-operative consultation which shall be documented in the medical record.

Dentists may perform a history and physical related to dentistry.

Podiatrists may perform a pre-operative history and physical examination independently on their patients of surgical risk ASA Category I or II. The podiatrist is responsible for arranging an additional H&P by a MD, DO, ARNP or PA for podiatric patients with risk greater than ASA category II.

Advanced Registered Nurses Practitioners and Physician Assistants may perform a history and physical; Co-signature by sponsoring physician is required.

Residents and students may perform a history and physical. Co-signature by sponsoring physician who has verified the accuracy via an in depth exam is required.

Admission is defined as patient registration in any inpatient, observation, same day surgery, or short-stay hospital service.

# REFERENCE:

CMS 482.22c5, 485.638 a4ii, 485.639, 482.24 2i, DNV MS.17 H&P

# Practitioner Proctoring policy

# POLICY:

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

# PURPOSE:

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

# SCOPE:

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

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

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

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

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

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

# RESPONSIBILITY:

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

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

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

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

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

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

# Duties:

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

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

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

Board approved 2/27/2018

# Provider Conduct policy

# POLICY:

It is the policy of Jefferson Healthcare that all individuals within the hospital's or clinics' facilities will be treated with courtesy, respect and dignity. To that end, Jefferson Healthcare requires that all individuals working and/or providing patient care within its hospital and clinics, including all members of the medical staff as well as allied health practitioners with granted privileges, conduct themselves in a professional and cooperative manner in the hospital and/or clinic(s). The Governing Board, hospital management, and medical staff will enforce this policy in a firm, fair and equitable manner.

# PURPOSE:

The objective of this policy is to ensure optimal patient care by promoting a safe, cooperative, and professional healthcare environment, and to prevent or eliminate to the extent possible, conduct that disrupts the operation of the hospital/clinics, affects the ability of others to do their jobs, creates a hostile work environment for hospital/clinic employees or other medical staff members, interferes with an individual's ability to practice competently and adversely affects the community's confidence in the hospital's ability to provide quality patient care.

# SCOPE:

All employees of Jefferson Healthcare, as well as individuals providing services through contracts with Jefferson Healthcare, are accountable to the hospital CEO for their conduct within the Jefferson Healthcare premises. The CEO is accountable to the board for effectively addressing unprofessional conduct by these individuals consistent with this policy. All practitioners granted privileges are accountable to the medical staff for their conduct within the hospital and clinics. The medical staff is accountable to the Governing Board for effectively addressing unprofessional conduct by these individuals consistent with this policy. Individual incidents of severe unprofessional conduct or persistent patterns of unprofessional conduct not addressed by the CEO or medical staff in an effective or timely fashion shall be definitely addressed by the Governing Board.

The medical staff will interpret and enforce this policy as its sole process for dealing with egregious incidents and persistent patterns of unprofessional conduct. No other policy or procedure shall be applicable to unprofessional conduct by individuals granted privileges except as designated by the medical staff and governing board.

# DEFINITION:

Consistent with the preceding objective, unacceptable, disruptive conduct may include, but is not limited to behavior such as the following:

- **Appropriate behavior** means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice, including practice that may be in competition with the hospital.
- **Inappropriate behavior** means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior."
- **Disruptive behavior** means any abusive conduct, including sexual or other forms of harassment,

or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

- **Sexual Harassment** means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive intimidation or otherwise hostile work environment (please refer to the Non-Discrimination and Anti-Harassment Policy). Incidents involving sexual harassment, discrimination or hostile work environment are reported to Human Resources. Cases involving medical staff members will be handled by MEC in collaboration with HR as subject matter experts. Investigation, documentation, and discipline will be executed through the MEC.

# PROCEDURE:

**This policy will be implemented in a manner that carries out the following activities:**

- Set, communicate and achieve buy-in to clear expectations of behavior through MEC, including wide dissemination of this policy.
- Measure performance compared to these expectations.
- Provide constructive, timely, and periodic feedback of performance to providers as needed.
- Manage poor performance when patterns of inappropriate/disruptive behavior persist.
- Take corrective action as applicable to terminate or limit employment, a contract, or a provider's medical staff membership or privileges following a single egregious incident (intentional harm or neglect of duties to patient or staff) or when the problem cannot otherwise be resolved in a timely manner.

Any provider, employee, patient or visitor may report conduct that he or she deems inappropriate or disruptive. The standard of reporting conduct issues is through the online occurrence reporting tool on the Jefferson Healthcare Intranet. Once it is received, the case will be assigned to the Section Chief or designee and Medical Staff Services to initiate the investigation. The investigating individual (as determined) may dismiss any unfounded report and will notify the individual who initiated the report of his/her decision. A confirmed report will address the following:

It shall be made clear to the offending individual that attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question is a violation of this policy and is grounds for further disciplinary action.

A single, confirmed incident warrants a discussion with the offending individual. This shall be carried out by the Chief of Staff with the support of the CMO/CEO and Medical Staff Services. This initial discussion shall emphasize that such conduct is inappropriate and must cease. The Chief of Staff, CMO and CEO conducting the discussion will provide the offender with a copy of this policy and inform the individual that the governing board requires compliance with this policy. The approach during such an initial intervention should be collegial and helpful to the individual and hospital.

Further incidents that do not cluster into a pattern of persistent disruptive behavior will be handled by providing the individual with notification of each incident and a reminder of the expectation that the individual comply with this policy, that is, as a rule violation.

If it is determined that the individual is demonstrating persistent unprofessional conduct, this will be addressed with the individual as outlined. For a provider granted privileges, these steps will be carried out by the Chief of Staff with the support of the CMO, CEO or their designees.

- As with the single, confirmed incident, the individual(s) conducting the intervention will provide the offending individual with a copy of this policy and inform the individual that the governing board requires compliance with this policy. Failure to agree to abide by the terms of this policy

shall be grounds for loss of employment, contract, or summary suspension of medical staff membership and privileges, as appropriate to the individual's status.

- The individual(s) conducting the intervention will inform the offending individual that if the unprofessional conduct recurs, the management, the Medical Executive Committee, and/or the governing board will take more formal action to stop it. The MEC and CEO will receive notification about the recurrence of this behavior.
- Because documentation of each incident of unprofessional conduct is critical as it is ordinarily not one incident alone that leads to corrective action, but rather a pattern of inappropriate conduct, the individual(s) conducting the intervention shall document all meetings regarding the offending individual. The letter will document the content of the discussion and any specific actions the offending individual has agreed to perform.

The letter shall include the following:

1. The date and time of the questionable behavior
2. A statement of whether the behavior affected or involved a patient in any way, and if so, information identifying the patient
3. The circumstances that precipitated this behavior
4. A factual and objective description of the questionable behavior
5. The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations
6. A record of any action taken to remedy the situation, including the date, time, place, action and name(s) of those intervening and follow-up action steps agreed to by the individual involved and the individual(s) performing the intervention

The hospital will keep a copy of this letter on file in the Medical Staff Office. The involved individual may submit a rebuttal to the charge. This rebuttal will become a permanent part of the record.

If the offending behavior continues, it the responsibility of the CEO to ensure that it stops. To do so, the Chief of Staff will collaborate with the CEO or designee in holding meetings with the offending individual until the behavior stops. To do so, the Chief of Staff or designee will collaborate with the Chief Medical Officer and CEO in holding series of meetings with the offending individual until the behavior stops. Regardless of who is carrying out these meetings, the intervention involved in each meeting will progressively increase in severity until the behavior in question ceases.

If, in spite of these interventions, the behavior continues, the offending individual will receive a final warning. The individuals carrying out this intervention will inform the offending individual that a single recurrence of the offending behavior within a specified time period shall result in separation from the hospital through termination of employment or contract or loss of medical staff membership and privileges, as appropriate. This meeting is not a discussion, but rather constitutes the provider's final warning. The offender will also receive a follow up letter that reiterates the final warning.

If, after this final meeting, the offending behavior recurs within the specified time period, the individual's medical staff membership and privileges shall be summarily suspended consistent with the summary suspension terms of the medical staff bylaws and policies and procedures. The MEC and board then will take action to revoke the individual's membership and privileges.

If a single incident of disruptive behavior or repeated incidents of disruptive behavior are determined to place patient care or the liability and reputation of the hospital at risk, the offending individual may be immediately fired or his or her contract terminated. For providers granted privileges, the individual will be summarily suspended and the medical staff and hospital policies for addressing summary suspension will be followed.

# REFERENCES:

DNV, MS.4; CMS, § 482.22(b); AMA;  RCW 18.130.180; The Greeley Company

Approved: MEC 3/24/2015; 3/22/2016; 9-26-2017

Approved: Board 4/20/2016; 10-18-2017

# Verbal Telephone Computerized Order Entry policy

# POLICY:

Order entry in the EHR (electronic health record) is to be completed by provider and intended to support timely and best care of the patient. Verbal or telephone communication of orders should be limited to urgent situations where immediate electronic communication is not feasible. Verbal and telephone orders will be carried out in accordance with applicable Washington State Laws and CMS Conditions of Participation. Research and Chemotherapy orders must be entered **only** by the provider.

# DEFINITION:

A verbal order is a medical order from a credentialed provider spoken to the registered practitioner. A verbal order may be accepted by a Registered Nurse, Registered Respiratory Therapist, a Registered Pharmacist, a Registered Dietician, a Physical Therapist, an Occupational Therapist, a Speech Therapist or a Medical Technologist, if within their scope of practice. A verbal order may not be accepted by an unlicensed individual such as a Health Unit Coordinator or Certified Nursing Assistant.

# PROCEDURE:

Providers can give verbal/telephone orders to be read back and entered into EPIC by the registered practitioner during the following **two** scenarios:

1. Inability for provider to access EPIC
    - Provider is actively engaged in the care of another patient, performing a procedure or doing a patient examination
    - Provider is on call without computer accessibility
2. Urgent clinical situation

Verbal/telephone orders will be managed the following way:

1. When RN makes the call to the provider with update or to get an order, **the RN will have the patient's EPIC chart OPEN and will enter the order all the way through the signing process before hanging up the phone.** This will prevent having to call the provider back for clarification, etc. due to system alerts. The order will be read back to the provider for verification to ensure accuracy and completeness. Please select order mode of *"verbal with read-back"* **or** *"telephone with read-back"*.
2. Verbal or telephone orders must identify the provider giving the order.
3. The provider may NOT ask a non-licensed employee to enter orders at any time (i.e. HUC or CNA).
4. The ordering provider must sign, date and time a verbal/telephone order as soon as possible, and no later than 48 hours after the verbal/telephone order is received.

# REFERENCES:

CMS CoP 485.635 (d)(3)
WAC 246-873-010; 246-873-090
MEC Approval: 6/4/2013;8/26/2014; 2/24/2015, 11/22/2016, 11/28/2017