

COVID-19 Notice

No in-person attendance will be allowed, pursuant to Governor Inslee's Proclamation 20-28.

All meeting attendees, including Board of Commissioners, staff and members of the public shall 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: 383682973#

Regular Session Agenda
Wednesday, September 22, 2021

<u>Call to Order:</u>	2:00
<u>Approve Agenda:</u>	2:00
<u>Board Governance Education:</u>	2:01
• Karma Bass, MPH, FACHE, President, Via Healthcare Consulting Discussion	
<u>Education Topic:</u>	2:15
o Sexual Assault Nurse Examiner Update- Dr. Molly Parker, SANE Medical Director and Katie Rose Fischer-Price, SANE Program Coordinator	
<u>Break:</u>	3:15
<u>Patient Story:</u> Tina Toner, CNO	3:30
<u>Minutes:</u>	3:40
• August 25, 2021 Regular Session Minutes (pg. 2-4)	
<u>Required Approvals:</u> Action Requested	3:50
• August Warrants and Adjustments (pg. 5-10)	
• Resolution 2021-03 Canceled Warrants (pg. 11)	
• Medical Staff Credentials/ Appointments/ Reappointments (pg. 12-13)	
• Medical Staff Policies (pg. 14-38)	
<u>Patient Advocate Report:</u> Jackie Levin, RN, Patient Advocate	4:00
<u>Quality Report:</u> Brandie Manuel, CPSO	4:15
• Emergency Preparedness	
<u>Financial Report:</u> Tyler Freeman, CFO	4:30
<u>Administrative Report:</u> Mike Glenn, CEO	5:00
• Strategic Plan Update	
<u>CMO Report:</u> Dr. Joe Mattern, CMO	5:15
<u>Board Business:</u>	5:30
• Resolution 2021-04 Honoring Jefferson Healthcare Team Members During the COVID-19 Pandemic 2020-2021(pg. 39-40)	
• Resolution 2021-05 Jefferson County Board of Health Resolution 56-21 of the Jefferson County Board of Health in the Matter of the Spread of Health Misinformation and Support for Public Health and Healthcare Workers. (pg. 41-43)	
• Board of Health Report	
• Agenda Evaluation	
<u>Meeting Evaluation:</u>	5:50
<u>Conclude:</u>	6:00

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
Owned and Operated by Jefferson County Public Hospital District No. 2
834 Sheridan Street, Port Townsend, WA 98368
We are an equal opportunity provider and employer.

Jefferson County Public Hospital District No. 2 Board of Commissioners acknowledge that Jefferson Healthcare is on the ancestral and contemporary homelands of the S'Klallam, Chemakum, Twana and other indigenous nations and we recognize the tribal governments sovereignty across the region.

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Jefferson County Public Hospital District No.2
Board of Commissioners, Regular Session Minutes
Wednesday, August 25, 2021

Call to Order:

The meeting was called to order at 2:00pm by Board Chair Buhler Rienstra. Present by phone and video were Commissioners Dressler, McComas and Ready. Also, in attendance by phone were Mike Glenn, CEO, Tyler Freeman, Chief Financial Officer, Jon French, Chief Legal Officer, Jake Davidson, Chief Ancillary & Specialty Services Officer, Caitlin Harrison, Chief Human Resources Officer, Jenn Wharton, Chief Ambulatory and Medical Group Officer, Dr. Joseph Mattern, Chief Medical Officer, and Alyssa Rodrigues, Administrative Assistant. This meeting was officially audio recorded by Jefferson Healthcare. Commissioner Kolff was excused.

Approve Agenda:

Commissioner Dressler made a motion to approve the agenda. Commissioner McComas seconded.

Action: Motion passed unanimously

Board Governance Education

- Review Community Health Improvement Plan Update
- Commissioners reviewed the Community Health Improvement Plan Update.

Discussion ensued.

Education Topic:

- Pharmaceutical Update- Nell Allen, Pharmacy Technician Specialist

Nell Allen, Pharmacy Technician Specialist provided the Pharmaceutical Update.

Discussion ensued.

- Home Health and Hospice Update- Tammy Tarsa, Executive Director, HHH

Tammy Tarsa, Executive Director, HHH provided the Quarterly Home Health and Hospice Update.

Discussion ensued.

Break:

Commissioners recessed for break at 3:18pm.

Commissioner reconvened from break at 3:30pm.

Patient Story:

Tina Toner, CNO, provided the Patient Story and detailed the difficult past 18 months with COVID and staffing crisis. She explained how proud she is of her team and how much they are giving our patients. She acknowledged how they continue to be there for their patients even though they are experiencing the toughest days they have been experiencing in healthcare and how proud she is to work with them. She thanked her team.

Minutes:

- June 28, 2021 Regular Session Minutes
- August 9, 2021 Special Session Minutes

Commissioner Dressler made a motion to approve the June 28, 2021 Regular Session Minutes and August 9, 2021 Special Session Minutes. Commissioner McComas seconded.

Action: Motion passed unanimously.

Required Approvals: Action Requested

- July Warrants and Adjustments
- Medical Staff Credentials/Appointments/Reappointments
- Medical Staff Policies

Commissioner Dressler made a motion to approve the July Warrants and Adjustments, Medical Staff Credentials/ Appointments/ Reappointments, Medical Staff Policies. Commissioner McComas seconded.

Action: Motion passed unanimously.

Quality Report:

Brandie Manuel, CPSO, presented the July Quality Report

Discussion ensued.

Financial Report:

Tyler Freeman, CFO, presented the July Financial Report.

Discussion ensued.

Administrative Report

Mike Glenn, CEO, presented the August Administrative report.

Discussion ensued.

CMO Report

Dr. Joe Mattern, CMO, provided the CMO report which included COVID Update, Vaccine Mandate, Bed Capacity, COVID testing, Immunocompromised, and Masking.

Discussion ensued.

Board Business:

- Board of Health Report

Commissioner Buhler Rienstra read aloud the Board of Health Report which included updates on leadership changes at Jefferson County Public Health, New Legislation with Public Health Officers and addition of new elective member, COVID-19 pandemic, Opioid Epidemic Deaths, and Community Health Improvement Plan.

- Amendment to Superintendent Employment Agreement- Carryover of Paid Time Off.

Commissioner Dressler made a motion to modify certain provisions of the Agreement to allow Mr. Glenn to use, carry over and dispose of Paid Time Off on substantially the same terms as other District senior management. Commissioner McComas seconded.

Action: Motion passed unanimously.

Meeting Evaluation:

Commissioners evaluated the meeting.

Conclude:

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

Action: Motion passed unanimously.

Meeting concluded at 5:27pm.

Approved by the Commission:

Chair of Commission: Jill Buhler Rienstra _____

Secretary of Commission: Marie Dressler _____

Jefferson County Public Hospital District No. 2 Board of Commissioners acknowledge that Jefferson Healthcare is on the ancestral and contemporary homelands of the S'Klallam, Chemakum, Twana and other indigenous nations and we recognize the tribal governments sovereignty across the region.

Gross Revenue
Inpatient Revenue
Outpatient Revenue

Total Gross Revenue

Revenue Adjustments

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

Total Revenue Adjustments

Net Patient Service Revenue

Other Revenue

340B Revenue
Other Operating Revenue

Total Operating Revenues

Operating Expenses

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

Total Operating Expenses

Operating Income (Loss)

Non Operating Revenues (Expenses)

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

Total Non Operating Revenues (Ex

Change in Net Position (Loss)

	August 2021 Actual	August 2021 Budget	Variance Favorable/ (Unfavorable)	%	August 2021 YTD	August 2021 Budget YTD	Variance Favorable/ (Unfavorable)	%	August 2020 YTD
Inpatient Revenue	3,323,835	4,255,558	(931,723)	-22%	24,950,958	33,358,083	(8,407,125)	-25%	24,838,469
Outpatient Revenue	22,149,396	20,250,194	1,899,203	9%	173,875,132	158,735,389	15,139,743	10%	137,956,415
Total Gross Revenue	25,473,232	24,505,752	967,480	4%	198,826,090	192,093,472	6,732,618	4%	162,794,884
Revenue Adjustments									
Cost Adjustment Medicaid	1,975,009	2,644,398	669,390	25%	15,970,834	20,728,671	4,757,837	23%	13,637,336
Cost Adjustment Medicare	7,839,706	7,947,468	107,762	1%	69,537,993	62,297,895	(7,240,098)	-12%	59,725,827
Charity Care	553,668	233,043	(320,625)	-138%	2,797,389	1,826,757	(970,632)	-53%	1,836,018
Contractual Allowances Other	1,764,909	1,872,869	107,960	6%	17,290,658	14,680,880	(2,609,778)	-18%	15,353,689
Administrative Adjustments	31,390	110,023	78,633	71%	311,307	862,438	551,131	64%	285,745
Allowance for Uncollectible Accounts	1,886,748	461,901	(1,424,847)	-308%	5,092,366	3,620,711	(1,471,655)	-41%	1,652,859
Total Revenue Adjustments	14,051,431	13,269,703	(781,728)	-6%	111,000,547	104,017,352	(6,983,195)	-7%	92,491,475
Net Patient Service Revenue	11,421,800	11,236,048	185,752	2%	87,825,543	88,076,120	(250,577)	0%	70,303,410
Other Revenue									
340B Revenue	379,626	314,247	65,380	21%	2,627,845	2,463,288	164,557	7%	1,972,374
Other Operating Revenue	221,695	235,586	(13,891)	-6%	2,757,978	1,846,691	911,287	49%	9,429,196
Total Operating Revenues	12,023,122	11,785,881	237,241	2%	93,211,366	92,386,099	825,267	1%	81,704,980
Operating Expenses									
Salaries And Wages	5,897,201	5,796,936	(100,265)	-2%	46,091,075	45,440,501	(650,574)	-1%	42,546,191
Employee Benefits	1,250,259	1,487,709	237,450	16%	10,614,280	11,661,721	1,047,441	9%	9,779,721
Professional Fees	172,341	133,343	(38,997)	-29%	1,310,242	1,045,241	(265,001)	-25%	1,783,852
Purchased Services	698,935	701,077	2,142	0%	5,928,672	5,495,541	(433,131)	-8%	5,348,607
Supplies	2,499,996	2,188,327	(311,669)	-14%	18,611,841	17,153,663	(1,458,178)	-9%	15,807,890
Insurance	100,623	85,425	(15,198)	-18%	709,636	669,623	(40,013)	-6%	519,502
Leases And Rentals	(9,894)	35,778	45,672	128%	177,274	280,450	103,176	37%	149,038
Depreciation And Amortization	489,701	537,192	47,491	9%	3,958,799	4,210,892	252,093	6%	4,070,306
Repairs And Maintenance	52,205	103,261	51,056	49%	432,931	809,434	376,503	47%	631,252
Utilities	86,246	98,536	12,290	12%	817,783	772,393	(45,390)	-6%	789,911
Licenses And Taxes	46,718	64,054	17,336	27%	512,922	502,104	(10,818)	-2%	467,730
Other	126,887	199,859	72,972	37%	1,237,103	1,566,637	329,534	21%	1,230,414
Total Operating Expenses	11,411,219	11,431,499	20,280	0%	90,402,558	89,608,200	(794,358)	-1%	83,124,414
Operating Income (Loss)	611,903	354,382	257,520	73%	2,808,808	2,777,899	30,909	1%	(1,419,434)
Non Operating Revenues (Expenses)									
Taxation For Maint Operations	23,101	23,798	(697)	-3%	184,807	186,544	(1,737)	-1%	172,768
Taxation For Debt Service	21,029	18,668	2,361	13%	281,069	146,333	134,736	92%	148,474
Investment Income	10,201	28,197	(17,996)	-64%	39,017	221,030	(182,013)	-82%	154,193
Interest Expense	(77,286)	(89,636)	12,350	14%	(696,782)	(702,629)	5,847	1%	(696,452)
Bond Issuance Costs	-	-	-	0%	-	-	-	0%	0
Gain or (Loss) on Disposed Asset	-	-	-	0%	-	-	-	0%	-
Contributions	2,366	18,473	(16,107)	-87%	32,387	144,801	(112,414)	-78%	245,920
Total Non Operating Revenues (Ex	(20,590)	(500)	(20,090)	-4017%	(159,502)	(3,921)	(155,581)	-3968%	24,903
Change in Net Position (Loss)	591,313	353,882	237,431	67%	2,649,306	2,773,978	(124,672)	-4%	(1,394,531)

STATISTIC DESCRIPTION

	AUGUST 2021						AUGUST 2020			
	MO ACTUAL	MO BUDGET	% VARIANCE	YTD ACTUAL	YTD BUDGET	% VARIANCE	MO ACTUAL	% VARIANCE	YTD ACTUAL	% VARIANCE
FTEs - TOTAL (AVG)	581.63	625.21	7%	601.84	625.21	4%	591.99	2%	598.39	-1%
FTEs - PRODUCTIVE (AVG)	500.80	559.80	11%	531.74	559.80	5%	591.99	15%	536.90	1%
ADJUSTED PATIENT DAYS	2,744	2,233	23%	22,043	17,507	26%	1,655	66%	14,416	53%
ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	93	76	22%	611	593	3%	54	72%	463	24%
ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	267	331	-19%	2,138	2,591	-17%	252	6%	1,963	8%
SWING IP PATIENT DAYS (MIDNIGHT CENSUS)	10	23	-57%	105	180	-42%	-	0%	119	-13%
PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION	370	430	-14%	2,854	3,364	-15%	306	21%	2,545	11%
BIRTHS	5	10	-50%	61	77	-21%	8	-38%	60	2%
SURGERY CASES (IN OR)	103	127	-19%	1,014	999	2%	98	5%	808	20%
SURGERY MINUTES (IN OR)	15,142	14,861	2%	133,575	116,488	15%	13,670	11%	104,161	22%
SPECIAL PROCEDURE CASES	81	77	5%	596	606	-2%	69	17%	428	28%
LAB BILLABLE TESTS	21,887	21,570	1%	174,948	169,078	3%	20,761	5%	140,208	20%
BLOOD BANK UNITS MATCHED	-	48	-100%	-	375	-100%	17	-100%	309	0%
MRIs COMPLETED	216	238	-9%	1,664	1,864	-11%	167	29%	1,397	16%
CT SCANS COMPLETED	620	544	14%	4,433	4,261	4%	551	13%	3,562	20%
RADIOLOGY DIAGNOSTIC TESTS	1,630	1,583	3%	12,444	12,410	0%	1,477	10%	10,766	13%
ECHOs COMPLETED	190	138	38%	1,304	1,082	21%	173	10%	969	26%
ULTRASOUNDS COMPLETED	364	346	5%	2,736	2,711	1%	302	21%	2,261	17%
MAMMOGRAPHYS COMPLETED	257	260	-1%	2,113	2,039	4%	227	13%	1,560	26%
NUCLEAR MEDICINE TESTS	54	38	42%	398	299	33%	35	54%	255	36%
TOTAL DIAGNOSTIC IMAGING TESTS	3,331	3,147	6%	25,092	24,666	2%	2,932	14%	20,770	17%
PHARMACY MEDS DISPENSED	19,934	24,451	-18%	156,868	191,667	-18%	18,939	5%	145,291	7%
ANTI COAG VISITS	406	409	-1%	3,213	3,203	0%	375	8%	2,937	9%
RESPIRATORY THERAPY PROCEDURES	3,083	3,727	-17%	21,706	29,214	-26%	2,154	43%	19,532	10%
PULMONARY REHAB RVUs	93	237	-61%	908	1,857	-51%	137	-32%	986	-9%
PHYSICAL THERAPY RVUs	6,831	7,650	-11%	59,185	59,963	-1%	6,491	5%	47,855	19%
OCCUPATIONAL THERAPY RVUs	943	1,111	-15%	8,463	8,709	-3%	1,181	-20%	8,340	1%
SPEECH THERAPY RVUs	265	220	20%	2,306	1,728	33%	264	0%	1,701	26%
REHAB/PT/OT/ST RVUs	8,132	9,218	-12%	70,862	72,257	-2%	8,073	1%	58,882	17%
ER CENSUS	1,142	1,110	3%	7,818	8,698	-10%	974	17%	7,170	8%
EXPRESS CLINIC	941	830	13%	5,549	6,503	-15%	619	52%	4,770	14%
SOCO PATIENT VISITS	123	165	-25%	985	1,292	-24%	154	-20%	1,141	-16%
PORT LUDLOW PATIENT VISITS	547	662	-17%	4,982	5,193	-4%	611	-10%	4,290	14%
SHERIDAN PATIENT VISITS	2,533	2,667	-5%	21,068	20,906	1%	2,112	20%	16,677	21%
DENTAL CLINIC	437	398	10%	3,162	3,122	1%	311	41%	1,931	39%
WATERSHIP CLINIC PATIENT VISITS	948	1,194	-21%	8,313	9,360	-11%	1,040	-9%	7,154	14%
TOWNSEND PATIENT VISITS	519	554	-6%	4,439	4,340	2%	575	-10%	4,257	4%
TOTAL RURAL HEALTH CLINIC VISITS	6,048	6,470	-7%	48,498	50,716	-4%	5,422	12%	40,220	17%
OFF-SITE LAB	594	-	0%	7,437	-	0%	1,317	-55%	4,069	45%
DISASTER CLINIC	-	-	0%	127	-	0%	94	-100%	1,180	-829%
TOTAL COVID RESPONSE	594	-	0%	7,564	-	0%	1,411	-58%	5,249	31%
CARDIOLOGY CLINIC VISITS	470	340	38%	3,792	2,663	42%	330	42%	2,501	34%
DERMATOLOGY CLINIC VISITS	579	561	3%	4,376	4,394	0%	651	-11%	4,618	-6%
GEN SURG PATIENT VISITS	284	312	-9%	2,500	2,447	2%	234	21%	1,814	27%
ONCOLOGY VISITS	468	594	-21%	4,284	4,658	-8%	552	-15%	4,041	6%
ORTHO PATIENT VISITS	612	729	-16%	5,488	5,716	-4%	566	8%	4,952	10%
SLEEP CLINIC VISITS	128	142	-10%	728	1,112	-35%	129	-1%	1,208	-66%
UROLOGY VISITS	138	229	-40%	1,407	1,798	-22%	171	-19%	1,228	13%
WOMENS CLINIC VISITS	255	276	-8%	2,371	2,161	10%	171	49%	1,094	54%
WOUND CLINIC VISITS	290	277	5%	2,078	2,170	-4%	269	8%	1,730	17%
TOTAL SPECIALTY CLINIC VISITS	3,224	3,460	-7%	27,024	27,119	0%	3,073	5%	23,186	14%
SLEEP CENTER SLEEP STUDIES	59	65	-9%	279	511	-45%	59	0%	384	-38%
INFUSION CENTER VISITS	721	851	-15%	6,064	6,668	-9%	705	2%	5,599	8%
SURGERY CENTER ENDOSCOPIES	78	79	-1%	613	619	-1%	81	-4%	478	22%
HOME HEALTH EPISODES	43	60	-28%	399	471	-15%	45	-4%	411	-3%
HOSPICE CENSUS/DAYS	1,096	749	46%	8,467	5,871	44%	1,133	-3%	8,515	-1%
CARDIAC REHAB SESSIONS	22	85	-74%	468	666	-30%	73	-70%	550	-18%
DIETARY TOTAL REVENUE	57,322	60,691	-6%	453,502	475,742	-5%	55,422	3%	504,395	-11%
MAT MGMT TOTAL ORDERS PROCESSED	1,531	2,207	-31%	13,663	17,298	-21%	1,911	-20%	15,458	-13%
EXERCISE FOR HEALTH PARTICIPANTS	-	290	-100%	-	2,270	-100%	-	0%	1,240	0%

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

**TO: BOARD OF COMMISSIONERS
FROM: TYLER FREEMAN, CFO
RE: AUGUST 2021 WARRANT SUMMARY**

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

General Fund Warrants & ACH Transfers	\$13,308,460.23	(Provided under separate cover)
Allowance for Uncollectible Accounts / Charity	\$1,517,807.42	(Attached)
Canceled Warrants	\$15.00	(Attached)

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: BOARD OF COMMISSIONERS
FROM: TYLER FREEMAN, CFO
RE: AUGUST 2021 GENERAL FUND WARRANTS & ACH
FUND TRANSFERS

Submitted for your approval are the following warrants:

GENERAL FUND:

279173	283765	\$3,721,030.82
ACH TRANSFERS		<u>\$9,587,429.41</u>
		<u>\$13,308,460.23</u>
YEAR-TO-DATE:		<u><u>\$128,388,701.49</u></u>

Warrants are available for review if requested.

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: BOARD OF COMMISSIONERS
FROM: TYLER FREEMAN, CFO
RE: AUGUST 2021 ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS, ADMINISTRATIVE, AND CHARITY CARE WRITE OFFS

Submitted for your approval are the following:

	AUGUST	AUGUST YTD	AUGUST YTD BUDGET
Allowance for Uncollectible Accounts:	932,748.47	4,138,366.00	3,620,711.00
Charity Care:	553,668.50	2,797,389.00	1,826,757.00
Other Administrative Adjustments:	31,390.45	311,307.00	862,438.00
TOTAL FOR MONTH:	<u>\$1,517,807.42</u>	<u>\$7,247,062.00</u>	<u>\$6,309,906.00</u>

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: BOARD OF COMMISSIONERS
FROM: TYLER FREEMAN, CFO
RE: AUGUST 2021 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
6/25/2020	266374	\$ 7.50
6/25/2020	266417	\$ 7.50

TOTAL:	<u>\$ 15.00</u>
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JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

RESOLUTION 2021-03

A RESOLUTION CANCELING CERTAIN WARRANTS IN
THE AMOUNT OF \$15.00

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

NOW, THEREFORE BE IT RESOLVED THAT:

In order to comply with RCW 36.22.100, warrants indicated below in the total amount of \$15.00 be canceled.

Date of Issue	Warrant #	Amount
06/25/2020	266374	7.50
06/25/2020	266417	7.50
Total		\$15.00

APPROVED this 22nd day of September 2021.

APPROVED BY THE COMMISSION:

Commission Chair Jill Buhler Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Matt Ready: _____

Commissioner Kees Kolff: _____

Commissioner Bruce McComas: _____

FROM: Medical Staff Services
RE: 09/22/2021 Medical Executive Committee appointments/reappointments for Board approval 09/22/2021

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. Pamela Saha, MD – Telepsych
2. Jamie Chu, MD – Telepsych
3. Steven Reiner, DPM – Refer and Follow Privileges

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

1. Alexander Pratt, MD – Hospitalist
2. Pavel Vasilyuk, DDS – Dentist
3. Shayna Lemke, DO – Hospitalist
4. Asif Luqman, MD – OBGYN
5. Christine Skorberg, MD - OBGYN
6. Kelsea Peterman, DO – Surgery
7. Helene Lhamon, MD – Emergency
8. Jakdej Nikomborirak, MD – Sleep Medicine
9. David Harris, MD- Primary Care
10. Mitra Jafari, MD – Surgery
11. Justin Penn, MD – Cardiology

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

1. Ruben Krishnnanathan - Teleradiology
2. Tadesse Eshetu, MD - Teleradiology
3. David Lee, MD - Teleradiology
4. Germaine Johnson, MD – Teleradiology
5. Kavita Gulati, MD – Teleradiology
6. Ron Loch, MD - Teleradiology

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

N/A

Recommended Temporary Privileges:

N/A

Recommended POCUS Privileges:

N/A

FROM: Medical Staff Services
RE: 09/22/2021 Medical Executive Committee appointments/reappointments for Board approval 09/22/2021

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.

Medical Student Rotation:

1. Eva Davis – Intern from Tacoma Family Medicine

Disaster Privileging

1. Omnicure Providers: Dr. Abdalla, Villaneuva, Bernstein, Verma, Sim, Lisenenkov, Solenkova, Subramanian, Thao, Kabani – Critical Care Teleproviders
2. Kurtis Muller, PA-C – Emergency Medicine

90-day provisional performance review completed successfully:

N/A

Resignations:

1. Rizwan Kalani, MD - Teleneurology
2. Theresa Wittenberg, PA – Oncology
3. Carl Weber, MD – Primary Care
4. Rebecca Kimball, ARNP – Oncology
5. Elizabeth Olinger, ARNP – Primary Care
6. J Charles Speed – Express Clinic

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Summary of Changes for Policy and Privilege Review

Policies

1. Practitioner Proctoring
 - a. No changes
2. Practitioner Re-Entry
 - a. No changes
3. Initial Appointment Processing
 - a. No changes
4. Practitioner Rights in the Credentialing Process
 - a. No changes
5. Reappointments and Renewals of Clinical Privileges
 - a. Minor edits
6. Residents and Medical Student Agreement and Scope of Practice
 - a. Added specific language regarding job shadows
7. New or Additional Privileges
 - a. No Changes

Privileges

1. Temporary Medical Staff Privileges
 - a. Minor edits
2. Inpatient Care Privileges
 - a. Minor edits

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; 4/22/2020

PURPOSE:

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

SCOPE:

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

DEFINITION:

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

PROCEDURE:

An individual re-entry plan will be created in conjunction with the Chief of Service, Department Medical Director and/or representative from Credentials Committee which may include a refresher course and retraining and/or formal Focused Professional Practice Evaluation. The formal Focused Professional Practice Evaluation will be presented to MEC or delegate by Department Chair within 90 days or at next available committee meeting.

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

REFERENCES:

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

MEC approved 12/2017

Board approved 1/2018

POLICY:

The medical staff shall have a uniform process to obtain and verify evidence of a practitioner's education, relevant training, experience and current competency.

PURPOSE:

Qualifications need to be met to be appointed to the Medical Staff.

PROCEDURE:

- A. Applicants who meet the qualifications described in the [Medical Staff Bylaws](#), Qualifications for Membership, Article 3.2, shall receive the following information and forms:
 1. Medical Staff Application (Washington State Practitioner Application)
 2. Forms to request privileges, as appropriate
 3. Disclosure statement
 4. Criminal Background Check
 5. Other forms as deemed appropriate
- B. Applicant submits the following:
 1. Completed and signed, application and privilege forms.
 2. Current curriculum vitae.
 3. Listing of recent postgraduate medical patient care activities (past 24 months).
 4. Documentation of special training and experience in the areas where specialized privileges are requested
 5. Copy of current Washington State license.
 6. DEA registration if applicable.
 7. Documentation of CME for prior two years (excluding graduates of residency or fellowship programs in the past 24 months) or proof of current MOC (Maintenance-Of-Certification)
 8. Documentation of liability insurance in the amount required by the Medical Staff and Governing Board if not employed by Jefferson Healthcare
 9. If applicant has completed a residency program, in the past 24 months, a summary of clinical experience in each of the areas in which privileges are being requested, i.e., types and numbers of cases shall be submitted.
 10. Applicants out of training greater than 24 months shall provide clinical performance data for the last 12 months of practice to include approximate numbers of cases, types of procedures, service areas and types of patients treated. This may come from current hospital affiliations and/or office practice.
 11. Signed Disclosure Statement and Washington State Patrol or criminal background check form.
 12. Documentation of ACLS/BLS/Neonatal Resuscitation certification, as applicable per privilege requirements.
 13. Identification: Valid picture ID issued by a state or federal agency (driver's license, passport).
- C. In the case of delays in responses to verifications or peer recommendations, the applicant will be notified and will be responsible for following up to the degree necessary to obtain adequate response. Failure of the applicant to respond to a request for assistance within thirty (30) days shall result in the application being deemed incomplete with no further processing and considered withdrawn. This will be communicated with the stakeholders.
- D. When collection of documentation and verification is completed, the Medical Staff Services Department submits the application and all supporting information to the Chiefs of Service for evaluation as per *Bylaws 6.1.4*. After the Chiefs of Service reviews are completed, the application

is forwarded to the Credentials Committee. The Medical Staff Coordinator shall promptly notify the applicant of any further information required. This must be a special notice and must indicate the nature of the information the applicant is to provide within thirty (30) days. Failure without good cause to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

E. The recommendations of Chiefs of Service and Credentials Committee are forwarded to the Medical Executive Committee. Evaluation and actions will continue as outlined in the *Bylaws* 6.2.16

F. Notice of Final Decision:

The Chief Executive Officer provides written notice of the final decision to the applicant.

A notice of decision includes:

1. The clinical privileges the applicant may exercise
2. Any special conditions attached to the appointment

G. Documentation:

The recommendations of the Chiefs of Service, Credentials Committee, Executive Committee, and the decision of the Governing Board shall be documented in the individual practitioner's file.

TELE MEDICINE PROVIDERS: With applicants seeking appointment with clinical privileges to the Medical Staff to perform telemedicine services, Jefferson Healthcare may request information from the telemedicine entity to make a decision to grant the practitioner privileges (shared approach).

Time Periods for Processing:

Applications shall be processed within the following time periods:

Medical Staff Services Department/Credentials Verification Organization to collect and verify information: Processing of verification to begin within 7 days of receipt of completed application. Verifications to be completed within 60 working days of receipt of completed application.

Chief of Service: 15 days from notification by Medical Staff Services of completed verified application.

Credentialing Committee: Refers to Medical Executive Committee

Medical Executive Committee: Next regularly scheduled meeting after receiving recommendation from Credentials Committee

Governing Board: Next regularly scheduled meeting after receiving recommendation from Executive Committee

These time periods are guidelines and do not create any rights for a practitioner to have an application processed within these precise periods. If the provisions of the Fair Hearing Plan (as defined in the Medical Staff Bylaws) are activated, the time requirements provided therein govern the continued processing of the application. If action does not occur at a particular step in the process within the time frame specified, and the delay is unwarranted, the next higher authority may immediately proceed to consider the application and all the supporting information, or may be directed by the Chief of Staff on behalf of the Executive Committee or by the Chief Executive Officer on behalf of the Governing Board to so proceed.

The applicant will be notified of the credentialing (and re-credentialing) decision within 60 calendar days of the Board's decision.

RIGHT TO IMPARTIAL, NON-DISCRIMINATORY OF CREDENTIALS:

All Jefferson Healthcare practitioners have the right to an impartial, non-discriminatory, and confidential selection and review process. JHC monitors for and prevents discriminatory credentialing by the following:

JHC does not collect information on an applicant's race, ethnic/national identity and sexual orientation, religion, marital status or other status or characteristics protected under any applicable federal or state law-. Medical Executive Committee members are required to sign an annual attestation statement assuring credentialing and re-credentialing decisions are not discriminatory or based on applicant's race, ethnic/national identity, gender, age, sexual orientation, religion, marital status or other status or characteristics protected under any applicable federal or state law.

Current updates of listings in Health Plan practitioner directories and other materials for members are ensured by the payor credentialing team.

REFERENCES:

DNV MS.6, SR.1; CMS 482.12(A)(5); NCQA CR1, Element A, Factor 7

Board Approved: 6/7/2017; 6/19/19, 12/2020

POLICY:

Practitioners at Jefferson Healthcare have the right to:

- Review his/her credentialing file
- Correct erroneous information
- Receive status upon request on his application or re-appointment application
- Expect confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.
- Right to an Impartial, non-discriminatory review of credentials and related activities
- Timely notification of Credentialing Committee Decisions

PROCEDURE:

Practitioners will be provided a copy of this policy at initial appointment and upon request thereafter.

All active medical staff members have unrestricted access to Jefferson Healthcare policies and procedures.

SCOPE:

For initial appointments and reappointments to the Jefferson Healthcare Medical Staff.

REFERENCES:

NCQA Standard CR 1, Element B

POLICY:

All reappointments and the granting of/revision of clinical privileges are for a period not to exceed 2 years within the month of last reappointment.

DEFINITION:

The renewal/reappraisal of medical staff membership and privileges of a practitioner whose previous service on the medical staff has met the standard of patient care-~~care~~.

PROCEDURE:

- I. The Medical Staff Coordinator or designee will:
 1. Provide the practitioner at least 90 days prior to expiration of reappointment with the following:
 - a. Cover letter requesting completion of reappointment and/or privileges
 - b. Application for Reappointment
 - c. Copy of currently approved privileges
 - d. New privilege forms
 - e. Other forms as deemed appropriate
 2. If reappointment packet has not been returned within four weeks from issue, a reminder will be sent to the practitioner.
 3. If the reappointment packet has not been returned 6 weeks in advance of expiration of current appointment, a certified letter will be sent informing the practitioner that the appointment will automatically expire at the conclusion of the appointment period. Reinstatement would require a new application for appointment.
 4. The returned application and/or request for privileges shall be reviewed for completion and all necessary documentation. Privilege requests will be reviewed with those currently granted. Any questions, clarifications or additional information required, will be immediately referred to the practitioner.
- II. Complete reappointment and or request for renewal of privileges includes at least the following:
 1. Specific staff category and clinical privileges requested. Any changes shall be noted. Requests for privileges new to practitioner shall follow policy *New or Additional Privileges/ Procedures*.
 2. Evidence of current Washington State license.
 3. Evidence of current DEA registration (if applicable).
 4. Evidence of current professional liability insurance (coverage must meet at least the minimum requirements established by the Governing Board, Executive Committee and Medical Staff).
 5. Attestation of any physical or mental condition that could affect the ability to perform the privileges requested and duties of medical Staff appointment, with or without accommodation. See attached form.
 6. Evidence of continuing medical education obtained during the previous two years which relate in part to privileges granted and requested **is not required** unless requested by Credentials Committee or Medical Executive Committee.
 7. Documentation of any proceedings initiated or pending involving allegation of professional medical misconduct or completed proceedings involving findings of professional medical conduct in this or other states
 8. Documentation of any proceedings initiated, pending or completed involving denial, revocation, suspension, reduction, limitation, probation, or non-renewal of any of the following:
 - a. License or certificate to practice any profession in any state or country

- b. DEA or other controlled substance registration/certification
 - c. Membership or fellowship in local, state or national professional organizations
 - d. Faculty membership at any medical or other professional school
 - e. Appointment or employment status, prerogative or clinical privileges at any other hospital, facility or organizations; or
 - f. Limitation, cancellation, imposition of surcharge on professional liability insurance
9. Documentation of any voluntary relinquishment of medical license or DEA or other controlled substance registration.
 10. Documentation of any voluntary termination of medical staff membership or voluntary limitation, reduction or surrender of clinical privileges.
 11. Documentation of any felony criminal charges pending and/or any charges during the past two (2) years, including their resolutions.
 12. Signed and dated reappointment attestation, confidentiality, consent and release from liability.
 13. Documentation of any malpractice claims or suits initiated, pending, or completed since practitioner's last appointment/reappointment or granting of privileges.
 14. Documentation of any claims or suits for alleged malpractice that resulted in payments by practitioner or on practitioner's behalf by an insurance company (this shall include suits in which a judgment or settlement was made against a professional corporation of which practitioner is/was a member, shareholder, or employee and the practitioner was named in the claim or suit).

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III. Verifications to be completed and information obtained:

1. Verification of current Washington State license and any evidence of disciplinary actions will be completed. Negative responses are referred to the Chief(s) of Service, Vice Chief of Staff and/or Credentials Committee Chair.
 - a. *Washington State license and current licenses held in other states are verified at initial appointment, at reappointment or renewal or revision of clinical privileges, and at the time of expiration of the license.*
2. The National Practitioner Data Bank will be queried. Adverse responses are referred to the Chief(s) of Service, the Chief of Staff and/or Credentials Committee Chair.
3. Federal agency resources (Office of Inspector General, System Awards Management, Noridian) shall be queried for exclusion from participation from government sponsored programs (such as Medicare, Medicaid, Tricare, VA).
4. Patient Activity Information will be requested from other sources, when there is limited patient contact at the hospital (less than 3 patient contacts per year).
 - a. Any practitioner with minimal activity at the hospital must submit evidence of current clinical competency and ability to perform privileges requested such as:
 - i. a copy of his/her confidential quality profile from his/her primary hospital;
 - ii. copy of his/her quality profile from a health care plan/managed care organization; or
 - iii. recommendations from three (3) active members of the Jefferson Healthcare Medical Staff who are knowledgeable about the quality of the practitioner's patient care.
 - iv. Blinded copies of patient records (3) for peer review.
5. *Failure of the practitioner to ensure necessary competency assessment information is provided shall result in the application being deemed incomplete with no further processing and considered a voluntary resignation.*
5. The practitioner is responsible for providing any reasonable evidence of current ability to perform the privileges requested.
6. Information will be requested from any hospital or facility with or at which the physician had or has any association, employment, privilege or practice.
7. Verification of current insurance and claims history will be conducted.
8. Results of peer review, complaints and concerns, quality assessment and improvement activities and practitioner practice information will be considered.
9. Continuing medical education may be considered.
10. The Medical Staff Coordinator or ~~designee~~ designee will ensure that practitioner

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directories and other materials for members are consistent with education, training, certification, specialty, etc.

IV. Review and approval:

After collection of all necessary information the reappointment and/or request for privileges will be referred for evaluation, recommendations and approval as follows:

1. Chief(s) of appropriate service(s) and Credentials Committee Chair shall review the reappointment and or privileges application, credentials file, and quality assessment file and document their evaluation. When the Department Chief is being reappointed, the Chief of Staff or designee (i.e. Chief Medical Officer) and members of the department shall review the reappointment application, credentials file and quality assessment file and document their evaluation. Evaluations will be based on performance, conduct, compliance with Medical Staff Bylaws, Rules and Regulation and Policies and Procedures and includes the **six general competencies** of the ACGME and ABMS:
 - a. **Patient care** as demonstrated in findings of ongoing and/or focused quality assessment/ performance improvement activities
 - b. **Medical/Clinical knowledge**
 - c. **Practice based learning and improvement** (use of scientific evidence and methods to investigate, evaluate and improve patient care – continuing education)
 - d. **Interpersonal and communication skills** (with patients, families, and other members of healthcare teams)
 - e. **Professionalism** reflected by a commitment to continuous professional development, ethical practice and understanding and sensitivity to diversity and a responsible attitude toward patients, profession and society
 - f. **Systems Based Practice** demonstrated by participation and understanding of established systems and the ability to apply this knowledge to improve and optimize health care
2. Evaluations and recommendations of the Chief of Service shall be documented and referred to the Credentials Committee Chair and the Medical Executive Committee.
3. The recommendations from the Medical Executive Committee shall be submitted to the Governing Board for final action.
4. A letter will be sent to the practitioner informing him/her of the Governing Board's decision with a copy of the approved privileges within 60 days of the Board's decision.
5. Approved privileges will be updated (manuals or electronic files) by Medical Staff Services personnel.

All Jefferson Healthcare practitioners have the right to an impartial, non-discriminatory, and confidential selection and review process. JHC monitors for and prevents discriminatory credentialing by the following:

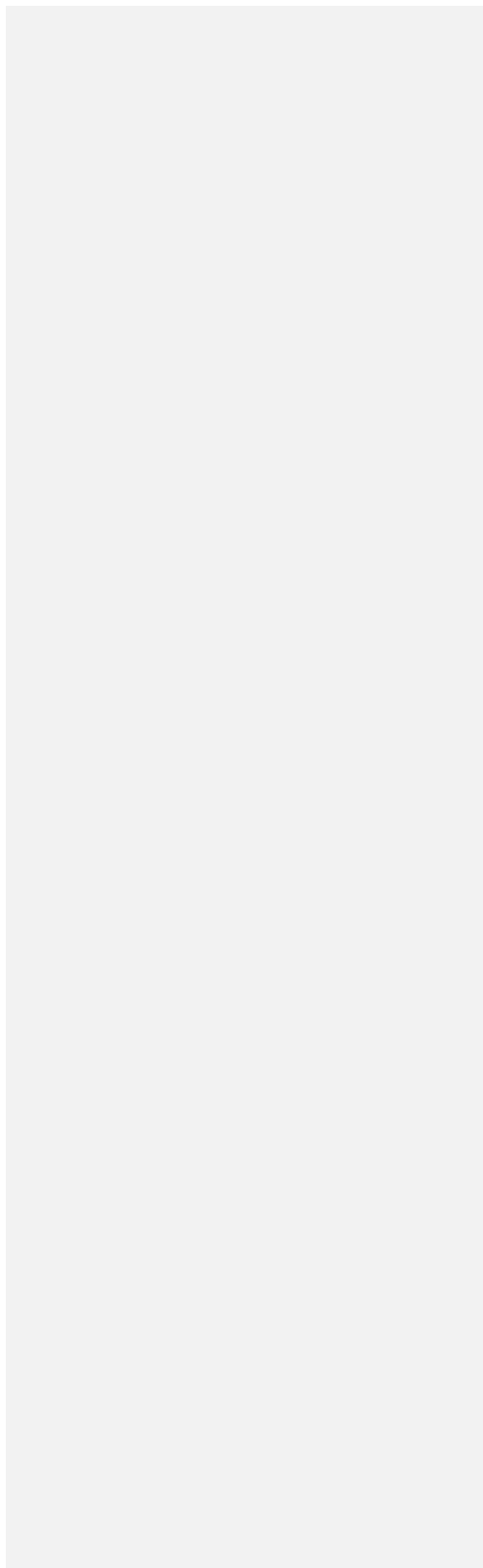
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REFERENCES

CMS Ref S&C 05-04, Requirements for Hospital Medical Staff Privileging, CoP 482.22

RCW 70.41.230 Duty of hospital to request information on physicians granted privileges

WAC 246-320-182; NCQA CR1, A12; CR1, Element A, Factor 7



POLICY:

To manage and delineate the educational experience for residents, medical students, physician assistant students and nurse practitioner students as well as define scope of practice.

PURPOSE:

To provide guidelines and clear understanding for medical staff members who provide an educational learning experience for residents and students within Jefferson Healthcare. To define requirements and process for residents/students to provide patient care activities at Jefferson Healthcare.

SCOPE:

Applies to all members of the medical staff who provide an educational experience and the residents and students who receive the training.

DEFINITION:

Resident: A person who has received a medical degree (usually either a **M.D.** or **D.O.**) who practices medicine usually in a hospital or clinic.

Medical Student: A person accepted into a medical school and undertaking an educational program in medicine towards becoming a medical doctor.

Physician Assistant Student: A person enrolled in a Physician Assistant Program.

Nurse Practitioner Student: A person enrolled in a Nurse Practitioner Program.

Job Shadow: A student who is not enrolled in an affiliated program, has requested and obtained permission to observe a provider at work for a short period of time.

SCOPE OF PATIENT CARE:

- Scope of patient care activities shall be defined upon mutual affiliation agreement with the program and sponsoring physician.
- The scope of patient care activities of the resident/student will not exceed privileges of the physician supervisor(s).

Job Shadow Students:

Job Shadow students, as they are not covered by a letter of affiliation agreement, are allowed to **observe only**. Patient acknowledgement of and consent to the job shadow student's presence is required and must be documented. Job Shadow students are not allowed in the Emergency Department or the Family Birth Center.

Inpatient and Outpatient Students:

Students may participate in patient care activities in accordance with a letter of affiliation agreement as above.

Under the direction of a preceptor, a student may:

1. Perform histories, physicals, order diagnostic and therapeutic modalities, enter progress notes, enter discharge summaries and perform certain procedures. For billing purposes, attendings must verify any student documentation of components of E/M services, rather than re-documenting the work. Attendings must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The attending must personally perform or re-perform the physical exam and medical decision-making activities of the service being billed but may verify any student documentation in the medical record, rather than re-documenting the work. Reports must be countersigned by preceptor within 48 hours before they are accepted as part of the permanent medical record.
2. Scrub-in to surgeries and perform non-critical tasks under the direct supervision of the active medical staff provider.
3. Perform minor diagnostic procedure under the direct supervision of the active medical staff provider.

Restrictions:

Students may document orders in the chart, but the orders must be co-signed with the sponsoring active medical staff provider before the order is taken off.

Outpatient Residents:

Residents shall be precepted and proctored as deemed appropriate by current GME and CMS standards. Reports must be countersigned by preceptor within 24 hours before they are accepted as part of the permanent medical record.

Inpatient Residents:

1. Hospitalized patients will be seen either in the Emergency Department or upon arrival to the medical floor. Admitting orders should be written at that time.
2. After the patient is examined and a plan formulated, the resident will present the case to the attending physician and document a formal History and Physical.
3. IMMEDIATELY refer all the following directly to the attending physician:
 - a. Calls regarding any potential ICU admission
 - b. Calls regarding any patient requiring a transfer (ground or air ambulance)
 - c. Calls regarding patients who are complex with urgent problems, even though ICU admission may not be indicated
4. Residents are to review the chart, examine and evaluate their patients daily and document their findings.
5. On potentially unstable patients, the resident should alert the attending physician of the need for care management changes.
6. Consultation requests are to be made in conjunction with by the attending physician. The attending physician may designate that the resident should make the verbal contact with the consulting physician.
7. ICU admission policy: If an ACU patient is assessed by the resident to need ICU care, the resident should contact the attending physician immediately.

RESPONSIBILITY:

Supervision:

1. The attending physician of record is responsible for the supervision of the resident/student and must be an active member of the medical staff. The attending physician should provide instruction on a case-by-case basis.

2. The attending physician must **countersign resident documentation within 24 hours and student reports within 48 hours.**
3. The attending physician is responsible for mortality summaries.

Roles and Responsibilities in the Clinic/Hospital setting:

1. A name tag must be worn by the resident/student, identifying the program/school and level.
2. Residents/students are required to comply with Jefferson Healthcare's employee health program, Policy and Procedures, and provide to Employee Health Services results to TB skin test within the last twelve months, and documentation of MMR immunity, either through proof of vaccination or titer.
3. Patient acknowledgement of and consent to the resident/student's presence during any appropriate patient care activity is required and must be documented wherever possible (based on condition of patient).
4. The resident/student must inform their supervising provider when they are not proficient in a given procedure so that they may receive the necessary supervision.

PROCEDURE:

Documents and Verifications:

One month prior to student or resident rotation the medical staff services department or designee shall:

- A. Obtain copies of the following documents:
 1. Washington State Medical License (if applicable)
 2. Resident's DEA certificate (or DEA certificate of facility)
 3. Immunization Record
 4. Signed Disclosure, Release of Information and Confidentiality Statements
 5. Approved scope of patient care activities (which shall not exceed sponsor's privileges)
 6. Dates of rotation and name of supervising physician(s)
 7. Copy of the residency program agreement
 8. Scope of Practice for Students
- B. Verifications and Queries will be done in accordance with CMS and GME standards.
- C. Upon receipt and verification of information, forward information to the appropriate chief of service, chief of staff and CEO for review and recommendation to approve the resident's scope of activities.
- D. Notify appropriate departments with resident information to include dates of rotation, approved scope of activities, and supervising physician.

Affiliation Agreement between Jefferson Healthcare and the Residency Program/School: Agreement be signed and completed *at least* two months prior to start date and must contain:

- Written description of the roles, responsibilities, and patient care activities of the participants of the graduate educational program.
- Identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.

The agreement shall outline the responsibility of Jefferson Healthcare Active Staff same specialty physician(s) who will serve as sponsor(s) for the resident/student; assure that the resident/student is in good standing in the residency program or medical program

For residents, the agreement shall also outline that the resident is in compliance with medical licensure requirements of the State of Washington; that the Residency Program will provide salary, benefits and malpractice insurance for the resident during this rotation; outline the sponsor(s) responsibilities.

For both residents and students, the agreement shall state that the residents/students are subject to all Jefferson Healthcare policies, rules and regulations and procedures of the program and those required by Jefferson Healthcare; state that any disciplinary action will be conducted by the Residency Program or school with cooperation from Jefferson Healthcare; state that Jefferson Healthcare shall have the right to discontinue the rotation of any resident or student whose performance, health, general conduct or failure to abide by any policy, directive, rule or regulation is determined to be detrimental to patients or the achievement of the program's objectives.

The agreement will be signed by the Jefferson Healthcare Administration and the administration of the residency program or school. The residency program or school will provide an approved scope of activities which shall be approved by the credentials committee, MEC and Governing Board.

For longstanding interagency relationships, the scope of activities may remain standard without needing approval with each student or resident unless the scope changes.

Medical Staff Oversight and Communication:

The Medical Executive Committee shall oversee resident and student participation in patient care.

Any concerns with quality of care or incidents will be reported immediately to the Chief of Service and the residency program director/school will be notified.

POLICY:

To cover approval process for:

- Privileges/procedures new to the facility
- Requests for additional privilege(s) not previously granted

PURPOSE:

In accordance with CMS, the State of Washington, the Joint Commission and DNV:

1. It must be a privilege/procedure that the hospital can support and offer, evidenced by approval of the Governing Board
2. It includes criteria for determining privileges that will be consistently applied to all practitioners requesting the privilege
3. It includes a process for evaluating the competency of the individual holding the privilege

PROCEDURE:

Requests for privileges/procedures new to the facility:

The interested practitioner shall first meet with their Senior Leadership Group member or designee to determine the scope of request. The practitioner and SLG member or designee will work in collaboration with any needed support to submit the following documentation to the respective Chief(s) of Service and the Credentials Committee:

- New privilege/procedure name
- Names of other hospitals in which it is used;
- Any research demonstrating the risks and benefits of this privilege/procedure;
- Any product literature or educational syllabus addressing the privilege/procedure;
- FDA approval letter if applicable
- Anesthesia or other specialty concerns;
- Recommended minimum education, training, experience necessary to perform the new privilege/procedure
- Extent of proctoring, monitoring and/or supervision, if any, that should occur
- Recommendation for requirements to maintain clinical competency
- Recommendations for clinical indicators for peer review

Review and Approval:

The Chief (s) of Service and Chair of the Credentials Committee shall review the information and make their recommendation to Medical Executive Committee which will then forward their recommendation to the Governing Board. Upon approval of the new privilege/procedure at Jefferson Healthcare, the Medical Staff will be notified. Medical Staff Services personnel will add the new privilege/procedure and the criteria to the appropriate privilege form(s). The interested providers (s) may then apply for the new privilege/procedure, which shall follow the process outlined in *Bylaws, Article 6, Processing the Application*, as applicable.

Requests for privileges new to practitioner's practice:

1. Practitioner shall request the new privilege(s) by completing the attached form with evidence of training, education, or experience that meets established criteria to the Medical Staff Services office. The Chief of Service will review the request and forward recommendation to the Chair of

the Credentials Committee.

- If proctoring is a criteria for obtaining the privilege, that proctoring is to be approved by the Chief of Service prior to the proctoring. It will be the responsibility of the applicant to arrange for proctoring and to ensure that proctors submit any required evaluations.
2. The Chief of Service and Credential Committee Chair's recommendations for privileges will be forwarded to the Medical Executive Committee, which will review and make recommendations to the Governing Board for final action.

Denials of Requests:

Denials of requests for privileges unrelated to quality of care concerns are reviewable by the involved practitioner by requesting a meeting with Medical Executive Committee for reconsideration. Denials based on involved practitioner quality concerns shall be processed in accordance with *Bylaws, Article 12*.

In the event the Chief of Service is the requesting practitioner, the request will be forwarded directly to the Chair of the Credentials Committee for review and recommendation.

REFERENCES:

CMS Memo 11/12/2004 S&C-05-04, Hospital Medical Staff Privileging

CMS Conditions of Participation 482.51 (a) (4)

Joint Commission MS.4.00 , MS .4.15, EP 1 and 2

WAC 246.320.185 Medical Staff, WAC 246.320.145 Leadership

APPROVED:

Approved: MEC 3/24/2015, 3/22/2016; 4/25/2017; 4/24/2018, 12/2020

Approved: Governing Board 4/15/2015, 4/20/2016, 5/17/2017, 4/25/2018, 6/19/2019, 12/2020

Reference Type	Title	Notes
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POLICY:

Temporary privileges may be granted to fulfill an urgent patient care need while awaiting completion of the formal initial appointment process, and are not intended to supplant the [initial appointment process](#).

There is no right to temporary privileges. If available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until they have been satisfactorily resolved.

A determination to grant temporary privileges shall not be binding or ~~conclusive~~inconclusive with respect to applicant's pending request for appointment to the Medical Staff.

Conditions Permitting Grant of Temporary Clinical Privileges and Staff Membership

Temporary privileges are not intended for routine use. An applicant with a current or previous challenge to licensure or registration, who has been subject to involuntary termination of medical staff membership at another organization, or has been subject to involuntary limitation, reduction, denial or loss of clinical privileges is not eligible for temporary staff membership.

Temporary privileges may be granted to an appropriately licensed practitioner only in the following circumstances:

- A. Pending Board Action: After proper processing of an application for Professional Staff appointment and review and approval of application by the Credentials Committee and MEC.
 - 1. Temporary clinical privileges and Staff appointment may be granted by the President/CEO and Chief of Staff, or their designees, for a period not to exceed the time until the next scheduled Board meeting following processing and approval of an applicant
- B. Care Specific Patients: Temporary clinical privileges and Staff appointment may be granted to an individual by the President/CEO and Chief of Staff, or their designees, when the Hospital has identified a patient care, treatment and service need for the admission or care of one or more specified patients. Such privileges shall not exceed 120 days and shall not be granted for treatment of more than three (3) identified patients in any 12-month period, after which the person shall be required to apply for appointment to the Active, Courtesy, or Consulting Professional Staff or for AHP privileges before being allowed to attend additional patients.
- C. Locum Tenens: Temporary privileges and Staff appointment may be granted by the President/CEO and Chief of Staff or their designees, to a Locum Tenens physician when the Hospital has identified a patient care, treatment and service need in his or her specific practice area. Locum Tenens privileges will be granted, not to exceed 120 days.

QUALIFICATIONS:

The Temporary Professional Staff shall consist of those practitioners who:

- A. Meet the basic qualifications of the Initial Appointment Policy
- B. During the time they hold Temporary Staff appointment, when responsible for call coverage, reside within reasonable proximity to Jefferson Healthcare to appropriately meet clinical care obligations to patients they admit or have responsibility for;
- C. Regularly practice at the Jefferson Healthcare during the time they hold Temporary Appointment; and
- D. Have obtained and hold appointment to the Temporary Staff

PREROGATIVES:

- A. Prerogatives: Practitioners holding Temporary Staff appointment shall not be eligible to hold Professional Staff administrative office (Chief of Staff, ~~V~~ice Chief of Staff, Chair of Department

or Chair of a standing Committee) and may not vote in Departmental matters, but may serve as voting members of hearing panels.

RESPONSIBILITY:

The Department Chair and/or Credentials Committee Chair has the discretion to determine if additional information is necessary prior to granting temporary privileges. Such information may include, but not be limited to: -case review, performance data, or references from peers.

All temporary privileges are granted by the CEO, or designee, on the recommendation of the department chair and Chief of Staff and Credentials Committee Chair/designee where the privileges will be exercised.

All appointees to the Temporary Medical Staff shall:

- A. Fulfill the agreements set forth in the Medical Staff bylaws and policies and procedures
- B. Attend their own and assigned patients in the Hospital, regardless of ability to pay. Such assignment shall be based on a fair and equitable rotation system
- C. Contribute to the administrative organization of those who practice at the Hospital, which may include:
 1. Service on Committees as requested;
 2. Participation in quality assurance, utilization review and educational activities as requested;
 3. Provision of specialty coverage and consultation in an emergency as consistent with their delineated privileges;
 4. Participation in Emergency Department and other Departmental call coverage
 5. Discharge of such other functions as reasonably require the expertise or cooperation of Staff appointees and are delegated by the Board or MEC

PROCEDURE:

Application Process:

Once the complete application has been received, the following information will be verified within two weeks:

- National practitioner database report
- Verification of licensure in each state where a license is held
- DEA confirmation
- Board Certification verification
- AMA/AOA (education/training verification)
- Malpractice Claims Report
 - Current insurance carrier only is queried
- Work History without unexplained gaps in practice
- Peer References
- Requested privileges
- Attestation that the applicant has not been subject to involuntary termination of medical staff membership at another organization
- Attestation that the applicant has not been subject to the involuntary limitation, reduction, denial, or loss of clinical privileges at any organization

Upon receipt of the above information, file will be reviewed/approved by department chair and the Chief of Staff/designee and Credentials Committee Chair/designee and recommended to the CEO (or designee) for approval of temporary privileges not to exceed 120 days during which time the credentialing process will be completed.

Conditions:

Special requirements of consultation, co-admission, proctors, surgical assistance or reporting may, but need not, be imposed in the grant of temporary privileges. The Chair of the Department shall take steps to be generally informed about the quality and results of work performed by persons granted temporary privileges, and to be available for administrative conference with respect to such cases when appropriate.

Termination of Temporary Clinical Privileges:

Upon notice of the occurrence of any event indicating a person holding temporary clinical privileges has failed to comply with the conditions of the temporary privileges, or upon receipt of any information which raises a question about such person's professional qualifications or ability to exercise any or all of the temporary privileges granted, any person authorized to impose a Summary Suspension may terminate the temporary privileges and Staff appointment, subject to review and reinstatement as provided in the Fair Hearing Plan as outlined in the [Medical Staff Bylaws](#) for disputed Automatic Suspensions.

Transfer of Patients:

In the event of any termination or suspension of temporary privileges, the person's patients shall be assisted in selecting another professional with relevant privileges by the Chair of Department if the person has not made arrangements to transfer. The wishes of the patient, when determinable, shall be followed in designating a substitute professional if the chosen person has the required clinical privileges.

Review Rights:

No person is entitled to a hearing because of his or her inability to obtain or renew temporary privileges or Staff appointment or because of modification of temporary privileges, but revocation or modification of temporary privileges may be reviewed in the manner provided for Disputed Temporary and Automatic Suspensions.

**Jefferson Healthcare
Inpatient Care (Hospitalist) Core Privileges**

To be eligible to request Hospital Based privileges the following minimum threshold criteria must be met:

Basic education:

Doctor of Medicine or Doctor of Osteopathy Degree (MD/DO) from an accredited program.

Physician Assistant must have graduated from an accredited program.

Formal training and experience at initial appointment:

- Successful completion of an approved residency in Internal Medicine or Family Medicine approved by the Accreditation Council for Graduate Medical Education (ACGME) or AOA.
- Board Certification in Internal Medicine or Family Medicine by an ABMS or AOA approved Board or active participation in the examination process leading to certification. Must have current re-certification, if required by certifying board.
- Evidence of ~~provision of inpatient services to at least 100 patients in the past twenty-four months, or completion of residency program within the past 24 months~~ activity within the scope of privileges requested without significant quality variations identified.
- **Must maintain current ACLS certification.**
 - If applicant does not meet criteria for inpatient services as above, the physician will participate in a preceptor program for a minimum of 50 patients and successfully demonstrate competency as evaluated by the preceptor(s).

Reappointment requirements:

Documentation of clinical activity within the scope of privileges requested without significant quality variations identified.

~~Continuing medical education related to medical specialty is required.~~



Core Privileges:

Privileges include being able to ~~consult~~ **assess and treat in an outpatient clinic** or admit to the Acute Care Unit and Intensive Care Unit, evaluate, diagnose, treat, provide consultation and care, to patients presenting with common and complex illnesses, afflictions, diseases and functional disorders of the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, neurologic, hematopoietic and eliminative systems.

A representative, but not a complete list of Inpatient Care Core Procedures is stated below. It is assumed that other procedures and problems of similar complexity will fall within the identified scope of Inpatient Care Core Privileges.

- Abdominal paracentesis
- Ambulatory arrhythmia monitoring interpretation
- Arterial line placement
- Arthrocentesis
- Arterial puncture for blood gas analysis
- Central line placement
- EKG interpretation
- Emergency airway management
- Lumbar puncture
- Thoracentesis
- Ventilator management

Privileges Delineated Separately:

Applicant **must provide evidence of training and experience** for privileges delineated separately below. This is a representative list of procedures outside of Inpatient Care Core privileges. The applicant may request others not listed, by adding the privilege to the list.

1.

- ___ Cardiac Stress Testing
- ___ Elective Cardioversion
- ___ Chest Tube Placement
- ___ Elective Pericardiocentesis
- ___ Swan-Ganz Catheter Placement
- ___ Temporary Venous Pacemaker Insertion
- ___ Esophagogastroduodenoscopy
- ___ Flexible sigmoidoscopy
- ___ Chemical Pleurodesis
- ___ Endo-tracheal intubation

- Required previous experience: evidence of 20 endotracheal intubations during initial training program
- Renewal of privilege criteria: 5 completed or proctored endotracheal intubations with demonstrated competence during the previous reappointment cycle (either bedside or via CRNA proctoring)

___ Procedural sedation:

Criteria: Evidence of completion of sedation competency module must be evident before privilege will be granted.

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

X:\Departments\Medical Staff Services\Privilege Forms\Inpatient Care Core Privileges.Doc

Approved:
MEC: 7/28/2015; Rev MEC appr 8/23/2016;

APPENDIX A

**Jefferson Healthcare
Internal Medicine and Family Medicine
Cardiac Privileges**

In addition to meeting requirements of Internal Medicine or Family Medicine, the following criteria apply:

Initial Privilege Requirement:

The applicant must meet one of the following criteria:

1. Board certified or eligible in Family Practice or Internal Medicine with confirmation of **treadmill training in residency** for the specific privilege requested, or,
2. Board certified in Family Medicine or Internal Medicine with **proctoring of at least 3 (three) routine treadmills** by a physician on the Active Medical Staff with current treadmill privileges in the specific privilege requested or,
3. Written confirmation from a hospital of **5 treadmill procedures** in the specific privilege request within the past year **and** a letter from the Department/Service Chair indication satisfactory performance.

Reappointment Requirement:

Documentation of clinical activity within the scope of privileges requested without significant quality variations Identified and evidence of at least 25+ tests for the previous year.

Check privileges requested	Cardiac Stress Testing Privileges	Review above criteria and indicate below (1,2,3) which criteria you meet for each privilege requested and attach documentation		
	<input type="checkbox"/> General treadmill interpretation	1	2	3
	<input type="checkbox"/> Supervision of stress ECGs	1	2	3
	<input type="checkbox"/> Interpretation of Stress ECGs	1	2	3
	Post myocardial infarction treadmill (inpatient)	1	2	3

For cardiac procedures performed at Jefferson Healthcare off-site facilities, please check:

_____ I attest to my ability to initiate emergency cardiac care

I request the privileges checked above and attest that I have met the requirements. I understand that by making this Request, I am bound by the applicable laws, policies and procedures of the hospital and the Medical Staff and hereby Stipulate that I met the threshold criteria for each privilege requested.

Provider signature	Date
Proctoring physician signature (for at least 3 procedures) if applicable	Date
Governing Board Approval	Date

Hello,

As part of our ongoing commitment to patient safety and quality and in compliance with DNV Rules and Regulations, Jefferson Healthcare is standardizing its approach to procedural sedation training. Documented completion of procedural sedation training is required every 2 years.

Therefore, following please find instructions for online Procedural Sedation training. Please note that this training document is for the sole use of Jefferson Healthcare Authorized Users. Do not reproduce, retain or redistribute this document without prior authorization.

Please review the instructions below, complete the training, print a copy of the completion certificate and forward it to Barbara York, Medical Staff Services, no later than as soon as possible. Thank you!

PROCEDURAL SEDATION ONLINE

For Physicians, CNRAs, and ARNPs:

An online Procedural Sedation Course is offered to JHC physicians, CRNAs, and ANRPs through Swedish.

To access the course, please copy & paste the following link on the address bar of JHC’s intranet or the internet: <http://www.swedish.org/for-health-professionals/cme/online-cmes/adult-procedural-sedation#axzz1rwF8ljki>

Once the Swedish Procedural Sedation page opens, you are asked to review the information and read all materials listed under “Course Materials & Self Assessment” before completing the online assessment. These materials consist of:

- ~~Procedural Sedation: Adult Clinical procedure~~
- ~~Addendum 1 to Procedural Sedation: Adult Clinical procedure~~
- ~~Addendum 2 to Procedural Sedation: Adult Clinical procedure~~
- ~~Adult Procedural Sedation Self Learning Packet~~
- ~~On the last page of this packet, you will find the “Next Steps” box which will direct you to complete an evaluation, register for CME credit, and print your certificate of completion~~

Participation Overview

- ~~This is a self learning module~~
- ~~CME credit will be granted only if your quiz score is 100%~~
- ~~Estimated time to complete the training module and exam is one hour~~
- ~~The registration fee will be waived if you click on “Swedish Provider” (for Swedish affiliates—Jefferson Healthcare employees only)~~

Online Self Assessment

- ~~If asked, “Would you like to resume the quiz where you left off?” click “No.”~~
- After passing the quiz, you will be directed to:
- ~~Complete the CME Evaluation of this activity~~
 - ~~Register to record participation and claim credit~~
 - ~~Print your CME Certificate~~

Please note that this training is required every two years. Please forward a copy of your completion certificate to Jefferson Healthcare Medical Staff Services. Thank you.

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RESOLUTION 2021-04
HONORING JEFFERSON HEALTHCARE TEAM MEMBERS DURING THE
COVID-19 PANDEMIC OF 2020-2021

WHEREAS, there has never been a more appropriate time to thank the people who work at Jefferson Healthcare than 2020 and 2021; and

WHEREAS, Jefferson Healthcare employees in every department have, over the years, consistently performed at the highest professional levels, earning for Jefferson Healthcare and their departments the respect and admiration of our community along with numerous accreditations, certifications and accolades on statewide and national levels; and

WHEREAS, in early 2020, the global virus COVID-19 inundated healthcare systems throughout the world, presenting a crushing burden on our health care workers and threatening to overwhelm our critical resources; and

WHEREAS, our team members did not run away in the daunting face of such a challenging situation, but stood strong on the frontlines, becoming the wall between life and death while protecting our community; and

WHEREAS, faced with unprecedented workloads, our staff works around the clock, risking their own health and often sacrificing time with their families to help those suffering from COVID while also maintaining other essential health services and ensuring the safety of non-COVID patients and visitors; and

WHEREAS, our staff continuously and completely demonstrate their professionalism and untiring commitment to care for all members of our community by dealing with the virus face-to face every day at work; and

WHEREAS, extraordinary situations call for extraordinary responses, and the work of our healthcare team exemplifies the deepest values of humanity and inspires everyone else to rise above the situation; and their coordination, skill, expertise and teamwork has resulted in untold lives saved; therefore, be it

RESOLVED, by the Board of Commissioners that a unanimous accolade of praise and tribute be accorded to all who have persevered through the challenges of this unprecedented ordeal; and

RESOLVED, that we celebrate you as true champions, whose day-to-day life-saving efforts and personal sacrifices amid increased risk persevere not *because* of COVID-19, but *in spite* of it. Our community is forever indebted to you for your courage and selflessness.

JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

APPROVED this 22nd day of September 2021.

APPROVED BY THE COMMISSION:

Commission Chair Jill Buhler Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Matt Ready: _____

Commissioner Kees Kolff: _____

Commissioner Bruce McComas: _____

DRAFT

JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

RESOLUTION 2021-05

Jefferson County Public Hospital Districts No. 2 adopts the following resolution from the Jefferson County Board of Health.

JEFFERSON COUNTY BOARD OF HEALTH

A RESOLUTION OF THE JEFFERSON
COUNTY BOARD OF HEALTH IN THE
MATTER OF THE SPREAD OF HEALTH
MISINFORMATION AND SUPPORT FOR
PUBLIC HEALTH AND HEALTHCARE
WORKERS

Resolution No. 56-21

Preamble:

I am urging all Americans to help slow the spread of health misinformation during the COVID-19 pandemic and beyond. Health misinformation is a serious threat to public health. It can cause confusion, sow mistrust, harm people's health, and undermine public health efforts. Limiting the spread of health misinformation is a moral and civic imperative that will require a whole-of-society effort.

Vivek H. Murthy, M.D., M.B.A. Vice Admiral, U.S. Public Health Service
Surgeon General of the United States

<https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf>

We, the members of the Jefferson County Board of Health adopt this resolution in support of all public health and hospital district employees and declaring health misinformation a public health crisis. In so doing, we adopt the following findings, facts, statements and good faith beliefs:

- 1) The coronavirus pandemic is surging in Jefferson County with more disease and more deaths than at any other time in the past twenty months.
- 2) Our healthcare system is at the breaking point, with a shortage of staff and critical care beds as well as overwhelmed emergency facilities.
- 3) Our public health services are stretched to the point where we can barely perform the best-practice COVID-19 case and contact tracing and follow-up.

- 4) Our dedicated healthcare and public health employees are working overtime, are psychologically stressed, and are physically exhausted by meeting the needs of our community.
- 5) Public health measures like masking, physical distancing, vaccinations and specific activity restrictions, many of which should be considered privileges and not personal rights, are proven ways of slowing the spread of this virus, saving lives, and ending the pandemic.
- 6) Allison Berry, M.D., M.P.H., the Public Health Officer for both Jefferson and Clallam Counties, found that unvaccinated patrons in bars and restaurants spread the virus and instead of closing down the industry or limiting occupancy, issued a vaccine mandate for bar and restaurant customers in order to help protect the local economy, the employees of those businesses, our vulnerable children, and our struggling healthcare and public health systems.
- 7) There are some people in our community who disagree with actions taken by Dr. Berry and believe that it is appropriate to use intimidation and threats of violence to get their way in opposing reasonable and proven public health measures.
- 8) There are some people in our community who are discouraging vaccinations, contributing to more cases and more deaths by spreading virus and pandemic misinformation that is not supported by the valid scientific data provided by reliable professional experts.
- 9) There are some people in our community who are vaccine hesitant for a variety of reasons, most of which are fed by misinformation campaigns and most of which can be addressed with appropriate, compassionate advice or overcome with a variety of vaccination incentives and requirements, including employment vaccination requirements and privilege restrictions.
- 10) The health of our community depends not only on the behavior of us as individuals but also on the health of our healthcare and public health services and the essential workers who provide those services.

NOW THEREFORE, BE IT RESOLVED by the Jefferson County Board of Health to:

- A. Urge all residents of our county to get vaccinated with appropriate age-approved vaccines;
- B. Urge all those who are spreading information about the vaccine and the pandemic to use reliable sources of data that follow the preponderance of evidence;
- C. Urge all those who disagree with public health mandates to use civil dialogue and to avoid intimidation and threats of violence;
- D. Urge us all to hold each other accountable for our behavior; and

- E. Urge everyone in our community to appreciate, support and thank our dedicated public health and healthcare employees, since the health of our community depends on them.

APPROVED this 16th day of September 2021.

Kate Dean, Chair

Denis Stearns, Vice Chair

Heidi Eisenhour, Member

Sheila Westerman Member

Greg Brotherton, Member

Kees Kolff, Member

Pamela Adams, Member

APPROVED this 22nd day of September 2021.

APPROVED BY THE COMMISSION:

Commission Chair Jill Buhler Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Matt Ready: _____

Commissioner Kees Kolff: _____

Commissioner Bruce McComas: _____



COUNTY OF SAN DIEGO

2021 AUG 27 AM 8:33

CLERK OF THE BOARD
OF SUPERVISORS

NATHAN FLETCHER

CHAIR

SUPERVISOR, FOURTH DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

AGENDA ITEM

DATE: August 31, 2021

TO: Board of Supervisors

19

SUBJECT

**FRAMEWORK FOR OUR FUTURE: DECLARING HEALTH MISINFORMATION A
PUBLIC HEALTH CRISIS (DISTRICTS: ALL)**

OVERVIEW

The resurging pandemic has led to more infections and hospitalizations than the region has seen since the beginning of the year and ICU capacity is once again being tested. The U.S. Surgeon General has recently warned that health misinformation presents an urgent threat to public health. Therefore, urgent action is needed to curb the spread of the Delta variant by combatting misinformation, thereby supporting our health care system and, in turn, saving lives. There would be a substantial detrimental effect on the County and public if not acted upon immediately. For these reasons, this Board Letter requires immediate action at the next Board meeting.

This Board Letter declares health misinformation to be a public health crisis. At a pivotal time in our history, with an FDA-approved vaccine available to all San Diegans free of charge and booster shots recommended later this year, health misinformation now presents a greater threat to public health than a variant of COVID-19. In response, the Board of Supervisors of the County of San Diego recognizes the vaccine hesitancy, that stands in the way of the County moving beyond the COVID-19 pandemic, is being fueled by the spread of health misinformation, and commits to developing strategies to actively combat health misinformation.

Following the recommendations of the U.S. Surgeon General Vivek H. Murthy in his advisory entitled "Confronting Health Misinformation,"¹ this board letter acknowledges the role misinformation has had in the resurgence of COVID-19 infections, once again filling hospital capacity, and driving the deaths and hospitalizations of thousands, including San Diegans² and committing County resources to work with trusted stakeholders to aggressively counter misinformation in our community and engage in outreach based on best practices.

We strongly urge your support for the recommendations in this letter to recognize health misinformation as the threat to public health that it is, and take the necessary steps towards a stronger, healthier future.

**SUBJECT: FRAMEWORK FOR OUR FUTURE: DECLARING HEALTH
 MISINFORMATION A PUBLIC HEALTH CRISIS (DISTRICTS: ALL)**

**RECOMMENDATION(S)
CHAIR NATHAN FLETCHER**

- 1.) Approve resolution titled “Resolution of the Board of Supervisors of the County of San Diego Declaring Health Misinformation a Public Health Crisis.”
- 2.) Direct the Chief Administrative Officer (CAO) to implement the following strategies cited by the U.S. Surgeon General Vivek H. Murthy in his advisory entitled “Confronting Health Misinformation,” and report back within 90 days on the status of implementation and within 180 days upon completion:
 - a.) Devote resources to identify and label health misinformation and disseminate timely health information to counter misinformation that is impeding our ability to keep our community safe,
 - b.) Modernize public health communications with investments to better understand gaps in health information, and questions and concerns of the community, especially in hard-to-reach communities. Develop targeted community engagement strategies, including partnerships with trusted messengers,
 - c.) Expand our research efforts to better define and understand the sources of health misinformation, document and trace its costs and negative impacts, and develop strategies to address and counter it across mediums and diverse communities,
 - d.) Invest in resilience against health misinformation including digital resources and training for health practitioners and health workers. Explore educational programs to help our communities distinguish evidence-based information from opinion and personal stories.
 - e.) Partner with federal, state, territorial, tribal, private, nonprofit, research, and other local entities to identify best practices to stop the spread of health misinformation and develop and implement coordinated recommendations.
 - f.) Identify resource gaps to combating health misinformation and working with state and federal partners to meet ongoing needs.
 - g.) Work with the medical community and local partners to develop a website that will serve as a central resource for combating health misinformation in our community.

EQUITY IMPACT STATEMENT

The COVID-19 pandemic has had a significant impact on the lives of individuals, businesses, and communities across San Diego County. Recent studies have found that online misinformation campaigns are associated with a decrease in vaccinations over time, which impacts all communities’ ability to reach herd immunity.³ But, the impacts are greater in ethnic minority communities as a majority of non-white adults were found to be hesitant to receive the Covid-19 vaccine.⁴ Studies have found vaccine and healthcare distrust continue to serve as major barriers to addressing racial equity in Covid-19 vaccine efforts.⁵ It is believed that developing sustainable and sound strategies to mitigate and combat misinformation, such through the actions proposed in this Board action, is crucial to closing health outcomes gaps within Black and Hispanic communities and achieving overall public health goals.⁶

**SUBJECT: FRAMEWORK FOR OUR FUTURE: DECLARING HEALTH
 MISINFORMATION A PUBLIC HEALTH CRISIS (DISTRICTS: ALL)**

FISCAL IMPACT

There is no fiscal impact associated with this action. There may be future fiscal impacts associated with final recommendations which would need to be approved by the Board.

BUSINESS IMPACT STATEMENT

N/A

ADVISORY BOARD STATEMENT

N/A

BACKGROUND

This Board Letter declares health misinformation to be a public health crisis. At a pivotal time in our history, with an FDA-approved vaccine available to all San Diegans free of charge, health misinformation now presents a greater threat to public health than a variant of COVID-19. In response, the Board of Supervisors of the County of San Diego recognizes the vaccine hesitancy, that stands in the way of the County moving beyond the COVID-19 pandemic, is being fueled by the spread of health misinformation, and commits to developing strategies to actively combat health misinformation.

Since vaccines became widely available in mid-April, there has been a local and national surge in COVID-19 infections and hospitalizations that has once again threatened to strain hospital resources and put the health and safety of our community at risk. Slowing vaccination rates have made more San Diegans susceptible to contracting the more contagious Delta variant which has led to infection rates not seen since January of 2021.⁷

Research has shown that people are increasingly turning to the internet and social media channels for health information which has enabled public health professionals, including local health departments, to expand their reach but it has also facilitated the rapid spread of misinformation and disinformation.⁸ The prevalence of falsehoods undermining confidence in the vaccine has surged in recent months fueling unfounded notions that vaccines don't work, that they contain microchips, that people should rely on their "natural immunity" instead of getting vaccinated, that the vaccines cause miscarriages, among other erroneous assertions.⁹

While empirical data and the broad scientific consensus point to the fact that COVID-19 vaccines are safe and effective against preventing severe disease, hospitalization, and death from the Delta variant,¹⁰ misinformation and disinformation has played a significant role in undermining vaccine utilization and compliance with public health guidelines, such as those related to masks.¹¹ Misinformed beliefs about vaccines and public health guidelines have turned this into what many have labeled a "pandemic of the unvaccinated."¹²

On August 23rd, the Food and Drug Administration granted full approval to Pfizer-BioNTech's coronavirus vaccine for people 16 and older.¹³ As our community and our country looks to turn the page on the pandemic, and as booster shots become more important to maintaining our recovery, confronting and combating misinformation becomes vital to saving lives and realizing our shared public health goals.

**SUBJECT: FRAMEWORK FOR OUR FUTURE: DECLARING HEALTH
 MISINFORMATION A PUBLIC HEALTH CRISIS (DISTRICTS: ALL)**

The Surgeon General has said “health misinformation is a serious threat to public health. It can cause confusion, sow mistrust, harm people’s health, and undermine public health efforts. Limiting the spread of health misinformation is a moral and civic imperative.”¹⁴ This board letter signals the Board’s agreement with the Surgeon General and affirms the Board’s commitment to taking action to combat misinformation. We strongly urge your support for the recommendations in this letter to recognize health misinformation as the threat to public health that it is, and take the necessary steps towards a stronger, healthier future.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN

Today’s proposed actions support the Live Well San Diego Initiative in the County’s Strategic Plan, and its vision for San Diego that is Building Better Health, Living Safely, Thriving, by supporting and defending public health efforts.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Nathan Fletcher", with a long horizontal stroke extending to the right.

NATHAN FLETCHER
Supervisor, Fourth District

ATTACHMENT(S)
Resolution

SUBJECT: FRAMEWORK FOR OUR FUTURE: DECLARING HEALTH
MISINFORMATION A PUBLIC HEALTH CRISIS (DISTRICTS: ALL)

AGENDA ITEM INFORMATION SHEET

REQUIRES FOUR VOTES: ☐ Yes ☒ No

WRITTEN DISCLOSURE PER COUNTY CHARTER SECTION 1000.1 REQUIRED

☐ Yes ☒ No

PREVIOUS RELEVANT BOARD ACTIONS:

N/A

BOARD POLICIES APPLICABLE:

N/A

BOARD POLICY STATEMENTS:

N/A

MANDATORY COMPLIANCE:

N/A

**ORACLE AWARD NUMBER(S) AND CONTRACT AND/OR REQUISITION
NUMBER(S):**

N/A

ORIGINATING DEPARTMENT: Fourth Board District

OTHER CONCURRENCE(S): N/A

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**SUBJECT: FRAMEWORK FOR OUR FUTURE: DECLARING HEALTH
 MISINFORMATION A PUBLIC HEALTH CRISIS (DISTRICTS: ALL)**

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- ¹ [“Confronting Health Misinformation, The U.S. Surgeon General’s Advisory on Building a Healthy Information Environment,”](#) Surgeon General Vivek H. Murthy, July 2021
- ² [“Coronavirus Doctors Battle Another Scourge: Misinformation,”](#) August 17, 2020, New York Times
- ³ Wilson S.L., Wiysonge C. Social media and vaccine hesitancy. BMJ Global Health. 2020;5(10)
- ⁴ Reinhart R.J. Gallup; 2020. [More Americans now willing to get COVID-19 vaccine.](#)
- ⁵ Ndugga N., Artiga S., Pham O. Kaiser Family Foundation; 2021. [How are states addressing racial equity in COVID-19 vaccine efforts? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8117478/](#)
- ⁶ Xiang D, Lehmann L., Health Policy Technol. 2021 Sep; 10(3): 100520. Confronting the misinformation pandemic
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- ⁹ [“Virus Misinformation Spikes as Delta Cases Surge,”](#) August 10, 2021, New York Times
- ¹⁰ [Safety and Effectiveness of COVID-19 Vaccines,](#) Johns Hopkins Medicine
- ¹¹ [Health-related misinformation dangerously undermines response to public health crisis,](#) Center for Health Security
- ¹² Dr. Rochelle Walensky, CDC director, on [July 16th at briefing of the White House COVID-19 Response Team](#)
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- ¹⁴ [“Misinformation is ‘serious threat to public health,’ surgeon general warns,”](#) July 15, 2021, NBC News



CONFRONTING HEALTH MISINFORMATION

*The U.S. Surgeon General's Advisory on
Building a Healthy Information Environment*

2021

I am urging all Americans to help slow the spread of health misinformation during the COVID-19 pandemic and beyond. Health misinformation is a serious threat to public health. It can cause confusion, sow mistrust, harm people's health, and undermine public health efforts. Limiting the spread of health misinformation is a moral and civic imperative that will require a whole-of-society effort.



Vivek H. Murthy, M.D., M.B.A.
Vice Admiral, U.S. Public Health Service
Surgeon General of the United States



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ABOUT THE ADVISORY

A Surgeon General's Advisory is a public statement that calls the American people's attention to a public health issue and provides recommendations for how that issue should be addressed. Advisories are reserved for significant public health challenges that need the American people's immediate awareness. For additional background, visit [SurgeonGeneral.gov](https://www.surgeongeneral.gov).

BACKGROUND

During the COVID-19 pandemic, people have been exposed to a great deal of information: news, public health guidance, fact sheets, infographics, research, opinions, rumors, myths, falsehoods, and more. The World Health Organization and the United Nations have characterized this unprecedented spread of information as an “infodemic.”¹

While information has helped people stay safe throughout the pandemic, it has at times led to confusion. For example, scientific knowledge about COVID-19 has evolved rapidly over the past year, sometimes leading to changes in public health recommendations. Updating assessments and recommendations based on new evidence is an essential part of the scientific process, and further changes are to be expected as we continue learning more about COVID-19.² But without sufficient communication that provides clarity and context, many people have had trouble figuring out what to believe, which sources to trust, and how to keep up with changing knowledge and guidance.^{3, 4, 5}

Amid all this information, many people have also been exposed to health misinformation: information that is false, inaccurate, or misleading according to the best available evidence at the time.^{6, 7, 8 *} Misinformation has caused confusion and led people to decline COVID-19 vaccines, reject public health measures such as masking and physical distancing, and use unproven treatments.^{5, 9, 10} For example, a recent study showed that even brief exposure to COVID-19 vaccine misinformation made people less likely to want a COVID-19 vaccine.¹¹ Misinformation has also led to harassment of and violence against public health workers, health professionals, airline staff, and other frontline workers tasked with communicating evolving public health measures.^{12, 13}

Misinformation can sometimes be spread intentionally to serve a malicious purpose, such as to trick people into believing something for financial gain or political advantage. This is usually called “disinformation.”^{14, 15} But many people who share misinformation aren’t trying to misinform. Instead, they may be raising a concern, making sense of conflicting information, or seeking answers to honest questions.¹⁶

Health misinformation is not a recent phenomenon. In the late 1990s, a poorly designed study, later retracted, falsely claimed that the measles, mumps, rubella (MMR) vaccine causes autism.¹⁷ Even after the retraction, the claim gained some traction and contributed to lower immunization rates over the next twenty years.¹⁸ Just since 2017, we have seen measles outbreaks in Washington State, Minnesota, New York City, and other areas.^{19, 20, 21} Health misinformation is also a global problem. In South Africa, for example, “AIDS denialism”—a false belief denying that HIV causes AIDS—was adopted at the highest levels of the national government, reducing access to effective treatment and contributing to more than 330,000 deaths between 2000 and 2005.²² Health misinformation has also reduced the willingness of people to seek effective treatment for cancer, heart disease, and other conditions.^{1, 23, 24, 25}

** This advisory focuses on health information specifically, not other kinds of misinformation. Defining misinformation is a challenging task, and any definition has limitations. See References for further discussion of the definition used in this Advisory, including the benchmark of ‘best available evidence at the time.’*

In recent years, the rapidly changing information environment has made it easier for misinformation to spread at unprecedented speed and scale, especially on social media and online retail sites, as well as via search engines.^{26, 27} Misinformation tends to spread quickly on these platforms for several reasons.

First, misinformation is often framed in a sensational and emotional manner that can connect viscerally, distort memory, align with cognitive biases, and heighten psychological responses such as anxiety.^{28, 29, 30} People can feel a sense of urgency to react to and share emotionally charged misinformation with others, enabling it to spread quickly and go “viral.”^{24, 31}

In recent years, the rapidly changing information environment has made it easier for misinformation to spread at unprecedented speed and scale.

Second, product features built into technology platforms have contributed to the spread of misinformation. For example, social media platforms incentivize people to share content to get likes, comments, and other positive signals of engagement.³² These features help connect and inform people but reward engagement rather than accuracy, allowing emotionally charged misinformation to spread more easily than emotionally neutral content.³³ One study found that false news stories were 70 percent more likely to be shared on social media than true stories.³¹

Third, algorithms that determine what users see online often prioritize content based on its popularity or similarity to previously seen content. As a result, a user exposed to misinformation once could see more and more of it over time, further reinforcing one’s misunderstanding.³⁴ Some websites also combine different kinds of information, such as news, ads, and posts from users, into a single feed, which can leave consumers confused about the underlying source of any given piece of content.³⁵

The growing number of places people go to for information—such as smaller outlets and online forums—has also made misinformation harder to find and correct.³⁶ And, although media outlets can help inform and educate consumers, they can sometimes inadvertently amplify false or misleading narratives.^{37, 38}

Misinformation also thrives in the absence of easily accessible, credible information.^{39, 40} When people look for information online and see limited or contradictory search results, they may be left confused or misinformed.

More broadly, misinformation tends to flourish in environments of significant societal division, animosity, and distrust. For example, distrust of the health care system due to experiences with racism and other inequities may make it easier for misinformation to spread in some communities.⁴¹ Growing polarization, including in the political sphere, may also contribute to the spread of misinformation.^{42, 43}

Additional research is needed to better understand how people are exposed to and affected by misinformation and how this may vary across subpopulations based on factors such as race, ethnicity, socioeconomic status, education, age, sexual orientation, gender identity, cultural and religious practices, hobbies and interests, and personal networks.⁴⁴

WE CAN TAKE ACTION

Because it pollutes our information environment, misinformation is harmful to individual and public health. Together, we have the power to build a healthier information environment. Just as we have all benefited from efforts to improve air and water quality, we can all benefit from taking steps to improve the quality of health information we consume. Limiting the prevalence and impact of misinformation will help all of us make more informed decisions about our health and the health of our loved ones and communities.

Together, we have the power to build a healthier information environment.

During the COVID-19 pandemic, there have been significant efforts to address health misinformation. Here are just a few examples:

- Trusted community members, such as health professionals, faith leaders, and educators, have spoken directly to their communities to address COVID-19-related questions (e.g., in town halls, community meetings, via social and traditional media)
- Researchers have identified leading sources of COVID-19 misinformation, including misinformation “super-spreaders”⁴⁵
- Media organizations have devoted more resources to identify and debunk misinformation about COVID-19^{46, 47}
- Some technology platforms have improved efforts to monitor and address misinformation by reducing the distribution of false or misleading posts and directing users to health information from credible sources^{48, 49, 50}
- Governments have increased their efforts to disseminate clear public health information in partnership with trusted messengers⁵¹

But there is much more to be done, and each of us has a role to play. Before posting or sharing an item on social media, for example, we can take a moment to verify whether the information is accurate and whether the original source is trustworthy. If we're not sure, we can choose not to share. When talking to friends and family who have misperceptions, we can ask questions to understand their concerns, listen with empathy, and offer guidance on finding sources of accurate information.^{52, 53, 54, 55, 56}

It will take more than individual efforts, however, to address health misinformation. The threat of misinformation raises important questions we must answer **together**: How do we curb the spread of

harmful misinformation while safeguarding user privacy and free expression? What kinds of measures should technology platforms, media entities, and other groups adopt to address misinformation? What role is appropriate for the government to play? How can local communities ensure that information being exchanged—online and offline—is reliable and trustworthy? How can we help family and friends who may have been exposed to harmful misinformation?

Addressing health misinformation will require a whole-of-society effort. We can start by focusing on the following areas of action:

- **Equip Americans with the tools to identify misinformation**, make informed choices about what information they share, and address health misinformation in their communities, in partnership with trusted local leaders
- **Expand research that deepens our understanding of health misinformation**, including how it spreads and evolves; how and why it impacts people; who is most susceptible; and which strategies are most effective in addressing it
- **Implement product design and policy changes on technology platforms** to slow the spread of misinformation
- **Invest in longer-term efforts to build resilience against health misinformation**, such as media, science, digital, data, and health literacy programs and training for health practitioners, journalists, librarians, and others
- **Convene federal, state, local, territorial, tribal, private, nonprofit, and research partners** to explore the impact of health misinformation, identify best practices to prevent and address it, issue recommendations, and find common ground on difficult questions, including appropriate legal and regulatory measures that address health misinformation while protecting user privacy and freedom of expression

Addressing health misinformation will require a whole-of-society effort.

WHAT INDIVIDUALS, FAMILIES, AND COMMUNITIES CAN DO

Learn how to identify and avoid sharing

health misinformation. When many of us share misinformation, we don't do it intentionally: We are trying to inform others and don't realize the information is false. Social media feeds, blogs, forums, and group chats allow people to follow a range of people, news outlets, and official sources. But not every post on social media can be considered reliable. And misinformation can flourish in group texts or email threads among friends and family. Verify accuracy of information by checking with trustworthy and credible sources. If you're not sure, don't share.

Engage with your friends and family on the problem of health misinformation.

If someone you care about has a misperception, you might be able to make inroads with them by first seeking to understand instead of passing judgment. Try new ways of engaging: Listen with empathy, establish common ground, ask questions, provide alternative explanations and sources of information, stay calm, and don't expect success from one conversation.

Address health misinformation in your

community. Work with schools, community groups such as churches and parent-teacher associations, and trusted leaders such as educators and health care professionals to develop local strategies against misinformation. For example, invite local health professionals to schools or to faith congregations to talk about COVID-19 vaccine facts.

*When many of us share misinformation, we don't do it intentionally: We are trying to inform others and don't realize the information is false...
If you're not sure, don't share.*

WHAT EDUCATORS AND EDUCATIONAL INSTITUTIONS CAN DO

Strengthen and scale the use of evidence-based educational programs that build resilience to misinformation.

Media, science, digital, data, and health literacy programs should be implemented across all educational settings, including elementary, secondary, post-secondary and community settings. In addition to teaching people how to be more discerning about the credibility of news and other content, educators should cover a broader set of topics, such as information overload, internet infrastructure (e.g., IP addresses, metadata), the challenges of content moderation, the impact of algorithms on digital outputs, algorithmic bias, artificial intelligence (AI)-generated misinformation (e.g., deepfakes), visual verification skills, and how to talk to friends and family who are sharing misinformation.

Educate students and the public on common tactics used by those who spread misinformation online.

Recent research suggests that teaching people how to spot these tactics can reduce people's willingness to share misinformation.⁵⁷ Examples of misinformation tactics used by those who deny scientific consensus on health issues include presenting unqualified people as experts; misleading consumers with logical fallacies; setting impossible expectations for scientific research; cherry-picking data or anecdotes; and introducing conspiracy theories.⁵⁸

Establish quality metrics to assess progress in information literacy.

While there is substantial media and information literacy work being carried out across the United States, there is a need for more consistent and empirically evaluated educational materials and practices.

Media, science, digital, data, and health literacy programs should be implemented across all educational settings.

WHAT HEALTH PROFESSIONALS AND HEALTH ORGANIZATIONS CAN DO

Proactively engage with patients and the public on health misinformation. Doctors, nurses, and other clinicians are highly trusted and can be effective in addressing health misinformation.⁵⁹ If you are a clinician, take the time to understand each patient's knowledge, beliefs, and values. Listen with empathy, and when possible, correct misinformation in personalized ways. When addressing health concerns, consider using less technical language that is accessible to all patients. Find opportunities to promote patient health literacy on a regular basis.

Use technology and media platforms to share accurate health information with the public. For example, professional associations can equip their members to serve as subject matter experts for journalists and effectively communicate peer-reviewed research and expert opinions online.

Partner with community groups and other local organizations to prevent and address health misinformation. For example, hospital systems can work with community members to develop localized public health messages. Associations and other health organizations should offer trainings for clinicians on how to address misinformation in ways that account for patients' diverse needs, concerns, backgrounds, and experiences.

Associations and other health organizations should offer trainings for clinicians on how to address misinformation in ways that account for patients' diverse needs, concerns, backgrounds, and experiences.

WHAT JOURNALISTS AND MEDIA ORGANIZATIONS CAN DO

Train journalists, editors, and others to recognize, correct, and avoid amplifying misinformation. Media organizations should develop in-house training programs and partner with journalism schools, nonprofits, technology platforms, and others to democratize access to high-quality training for all media outlets.

Proactively address the public's questions. When something is new—such as a vaccine—people will understandably have questions. By anticipating and proactively answering those questions, media organizations and journalists can help get ahead of misinformation and increase the public's health and information literacy.

Provide the public with context to avoid skewing their perceptions about ongoing debates on health topics. For example, when discussing conflicting views on an issue, give readers a sense of where the scientific community stands and how strong the available evidence is for different views. Consider questions like: How much disagreement is there among experts? Is a given explanation plausible even if it is unlikely? If evidence is not equally strong on all sides of an issue, avoid presenting it as such.

Carefully review information in preprints. Preprints are research papers published online before peer review. They can provide scientists and the public with useful information, especially in rapidly evolving situations such as a pandemic. However, because preprints have not been independently reviewed, reporters should be careful about describing findings from preprints as conclusive. If reporting on such findings,

include strong caveats where appropriate, seek out expert opinions, and provide readers with context.

Use a broader range of credible sources—particularly local sources. Research shows us that people have varying levels of trust in different types of people and institutions.⁴ In addition to relying on federal and state public health authorities as sources, build relationships with local health professionals and local trusted, credible health organizations.

Consider headlines and images that inform rather than shock or provoke. Headlines are often what audiences will see and remember. If a headline is designed to fact-check a rumor, where possible, lead with the truth instead of simply repeating details of the rumor. Images are often shared on social media alongside headlines and can be easily manipulated and used out of context. Picture desk and social media editors should consider how provocative and medically inaccurate imagery can be a vehicle for misinformation.⁶⁰

Give readers a sense of where the scientific community stands and how strong the available evidence is for different views.

WHAT TECHNOLOGY PLATFORMS CAN DO

Assess the benefits and harms of products and platforms and take responsibility for addressing the harms. In particular, make meaningful long-term investments to address misinformation, including product changes. Redesign recommendation algorithms to avoid amplifying misinformation, build in “frictions”—such as suggestions and warnings—to reduce the sharing of misinformation, and make it easier for users to report misinformation.

Give researchers access to useful data to properly analyze the spread and impact of misinformation. Researchers need data on what people see and hear, not just what they engage with, and what content is moderated (e.g., labeled, removed, downranked), including data on automated accounts that spread misinformation. To protect user privacy, data can be anonymized and provided with user consent.

Strengthen the monitoring of misinformation. Platforms should increase staffing of multilingual content moderation teams and improve the effectiveness of machine learning algorithms in languages other than English since non-English-language misinformation continues to proliferate.⁶¹ Platforms should also address misinformation in live streams, which are more difficult to moderate due to their temporary nature and use of audio and video.

Prioritize early detection of misinformation "super-spreaders" and repeat offenders. Impose clear consequences for accounts that repeatedly violate platform policies.

Evaluate the effectiveness of internal policies and practices in addressing misinformation and be transparent with findings. Publish standardized measures of how often users are exposed to misinformation and through what channels, what kinds of misinformation are most prevalent, and what share of misinformation is addressed in a timely manner. Communicate why certain content is flagged, removed, downranked, or left alone. Work to understand potential unintended consequences of content moderation, such as migration of users to less-moderated platforms.

Proactively address information deficits. An information deficit occurs when there is high public interest in a topic but limited quality information available. Provide information from trusted and credible sources to prevent misconceptions from taking hold.⁴⁰

Amplify communications from trusted messengers and subject matter experts. For example, work with health and medical professionals to reach target audiences. Direct users to a broader range of credible sources, including community organizations. It can be particularly helpful to connect people to local trusted leaders who provide accurate information.

Prioritize protecting health professionals, journalists, and others from online harassment, including harassment resulting from people believing in misinformation.

WHAT RESEARCHERS AND RESEARCH INSTITUTIONS CAN DO

Strengthen the monitoring of health questions, concerns, and misinformation. Focus on a broader range of content and platforms, as well as on information flow across platforms. For example, examine image- and video-based content and content in multiple languages. To address existing research limitations, expand data collection methods (e.g., recruit social media users to voluntarily share data).

Assess the impact of health misinformation. There is an urgent need to comprehensively quantify the harms of health misinformation. For example, how and under what conditions does misinformation affect beliefs, behaviors, and health outcomes? What is the role of emotion, cognition, and identity in causing misinformation to “stick”? What is the cost to society if misinformation is left unchecked?

Prioritize understanding how people are exposed to and affected by misinformation, and how this may vary for different subpopulations. Tailor interventions to the needs of specific populations. Invite community members to participate in research design.

Evaluate the effectiveness of strategies and policies to prevent and address health misinformation. For example, can flagging certain content as misinformation have unintended consequences? Is it possible to build resilience to misinformation through inoculation methods such as “prebunking”? (*Debunking* involves correcting misinformation once someone has been exposed to it. *Prebunking*, or preemptively debunking, involves warning people about misinformation they might come across so they will be less likely to believe it when exposed.)⁵⁷

There is an urgent need to comprehensively quantify the harms of health misinformation.

WHAT FUNDERS AND FOUNDATIONS CAN DO

Move with urgency toward coordinated, at-scale investment to tackle misinformation.

Assess funding portfolios to ensure meaningful, multi-year commitments to promising research and programs.

Invest in quantifying the harms of misinformation and identifying evidence-based interventions.

Focus on areas facing private and public funding gaps. Examples could include independent and local journalism, accountability mechanisms for platforms, and community-based health literacy programs.

Provide training and resources for grantees working in communities disproportionately affected by misinformation (e.g., areas with lower vaccine confidence).

Incentivize coordination across grantees to maximize reach, avoid duplication, and bring together a diversity of expertise. For example, encourage coordination around monitoring health misinformation across multiple languages.

Assess funding portfolios to ensure meaningful, multi-year commitments to promising research and programs.

WHAT GOVERNMENTS CAN DO

Convene federal, state, local, territorial, tribal, private, nonprofit, and research partners to explore the impact of health misinformation, identify best practices to prevent and address it, issue recommendations, and find common ground on difficult questions, including appropriate legal and regulatory measures that address health misinformation while protecting user privacy and freedom of expression.

Increase investment in research on misinformation. For example, more research is needed to better define misinformation, document and process its harms, and identify best practices for preventing and addressing misinformation across mediums and diverse communities.

Continue to modernize public health communications. Work to understand Americans' health questions, concerns, and perceptions, especially for hard-to-reach populations. Deploy new messaging and community engagement strategies, including partnerships with trusted messengers. Proactively and rapidly release accurate, easy-to-understand health information in online and in-person settings. Invest in fact-checking and rumor control mechanisms where appropriate.⁶²

Increase resources and technical assistance to state and local public health agencies to help them better address questions, concerns, and misinformation. For example, support the creation of teams within public health agencies that can identify local misinformation patterns and train public health misinformation and infodemic researchers. Work with local and state health leaders and associations to address ongoing needs.

Expand efforts to build long-term resilience to misinformation. For example, promote educational programs that help people distinguish evidence-based information from opinion and personal stories.

Deploy new messaging and community engagement strategies, including partnerships with trusted messengers. Proactively and rapidly release accurate, easy-to-understand health information in online and in-person settings.

WHERE WE GO FROM HERE

We are all still learning how to navigate this new information environment. But we know enough to be sure that misinformation is an urgent threat, and that we can and must confront it together.

During the COVID-19 pandemic, health misinformation has sowed confusion, reduced trust in public health measures, and hindered efforts to get Americans vaccinated. And misinformation hasn't just harmed our physical health—it has also divided our families, friends, and communities.

While health misinformation has always been a problem, today it spreads at unprecedented speed and scale. We are all still learning how to navigate this new information environment. But we know enough to be sure that misinformation is an urgent threat, and that we can and must confront it together.

The only way to address health misinformation is to recognize that all of us, in every sector of society, have a responsibility to act. Every single person can do their part to confront misinformation. But it's not just an individual responsibility. We need institutions to recognize that this issue is their moral and civic responsibility, too, and that they are accountable.

We have the power to shape our information environment, but we must use that power together. Only then can we work toward a healthier information environment—one that empowers us to build a healthier, kinder, and more connected world.

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- * Note: Defining “misinformation” is a challenging task, and any definition has limitations. One key issue is whether there can be an objective benchmark for whether something qualifies as misinformation. Some researchers argue that for something to be considered misinformation, it has to go against “scientific consensus” (e.g., Chou, Gaysynsky, & Cappella (2020)). Others consider misinformation to be information that is contrary to the “best available evidence” (e.g., Johns Hopkins Center for Health Security (2021)). Both approaches recognize that what counts as misinformation can change over time with new evidence and scientific consensus. This Advisory prefers the “best available evidence” benchmark since claims can be highly misleading and harmful even if the science on an issue isn’t yet settled. At the same time, it is important to be careful and avoid conflating controversial or unorthodox claims with misinformation. Transparency, humility, and a commitment to open scientific inquiry are critical. A second key issue is whether misinformation should include not only false information but also misleading information. This Advisory includes misleading claims in the definition. Consider an anecdote about someone experiencing a rare side effect after a routine surgery. The specific anecdote may be true but hide the fact that the side effect is very rare and treatable. By misinforming people about the benefits and risks of the surgery, the anecdote can be highly misleading and harmful to public health. Going forward, there is a need for further alignment on a shared definition of misinformation. However, we can meaningfully improve the health information environment even without a consensus definition of misinformation. For further discussion on definitions, see Vraga & Bode (2020).
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