
Educational Session Agenda
Wednesday, August 2, 2017

<u>Call to Order:</u>	3:30
<u>Approve Agenda:</u>	3:35
<u>Patient Story:</u> Brandie Manuel	3:40
<u>Minutes:</u> Action Requested	3:50
• July 19 Regular Session Minutes (pg. 2-3)	
<u>Required Approvals:</u> Action Requested	4:00
• Medical Staff Credentials/Appointments/Reappointments (pg. 4)	
• Medical Staff Policy (pg. 5-10)	
<u>Olympic Community of Health Update:</u>	4:10
• Elya Moore, PhD, Executive Director, Olympic Community of Health	
<u>Board Reports:</u>	4:30
<u>Conclude:</u>	4:40

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

Jefferson County Public Hospital District No.2
Board of Commissioners, Regular Session Minutes
Wednesday, July 19, 2017
Victor J. Dirksen Conference Room

Call to Order:

The meeting was called to order at 3:31 by Commissioner Buhler. Present were Commissioners Buhler, Dressler, De Leo, Kolff, and Ready. Also present were Mike Glenn, Chief Executive Officer, Hilary Whittington, Chief Administrative Officer/Chief Financial Officer, Brandie Manuel, Chief Patient Care Officer, Lisa Holt, Chief Ancillary and Specialty Services Officer, Jenn Wharton, Chief Ambulatory and Medical Group Officer, Caitlin Harrison, Chief Human Resources Officer, Joe Mattern, Chief Medical Officer, and Alyssa Rodrigues, Administrative Assistant. This meeting was officially audio recorded by Jefferson Healthcare.

Approve Agenda:

Commissioner Dressler made a motion to approve the agenda. Commissioner De Leo seconded.

Action: Motion passed unanimously.

Patient Story:

Brandie Manuel, Chief Patient Care Officer, reported on a patient complaint regarding discharge planning that helped Jefferson Healthcare start implementing a new discharge planning tool to help all patients.

Minutes:

- June 28 Special Session minutes

Commissioner De Leo made a motion to approve the June 28 Special Session Minutes. Commissioner Dressler seconded.

Action: Motion passed unanimously.

- July 5 Regular Session minutes

Commissioner De Leo made a motion to approve the July 5 Regular Session minutes. Commissioner Dressler seconded.

Action: Motion passed unanimously.

Required Approvals:

- June Warrants and Adjustments
- Resolution 2017-34 Cancel Warrants

Commissioner Dressler made a motion to approve June Warrants and Adjustment and Resolution 2017-34 Cancel Warrants as presented. Commissioner De Leo seconded the motion.

Action: Motion passed unanimously.

Public Comment:

Public comment was made.

Patient Advocate Report: Jackie Levin, Patient Advocate, gave a presentation on the 2nd quarter patient advocate report.

Discussion ensued.

Primary Care Access: Jenn Wharton, Chief Ambulatory and Medical Group Officer, and Caitlin Harrison, Chief Human Resources Officer, presented on Primary Care Access.

Discussion ensued.

Board Challenge: Stacey Larsen, Director, Port Townsend School District Nutrition Services, gave a presentation on the 5210 board challenge.

Discussion ensued.

Commissioner Kolff made a motion to join the 5210 challenge. Commissioner Ready seconded the motion.

Action: Motion passed unanimously.

Financial Report: Hilary Whittington, Chief Administrative Officer /Chief Financial Officer, presented the June financial report.

Discussion ensued.

Administrator's Report: Mike Glenn, Chief Executive Officer, gave his administrator's report.

Discussion ensued.

Chief Medical Officer Report: Joe Mattern, Chief Medical Officer, was excused. No report given.

Board Reports:

Commissioner Buhler distributed the April 20 and June15 Board of Health meetings.

Conclude:

Commissioner Dressler made a motion to conclude the meeting. Commissioner De Leo seconded the motion.

Action: Motion passed unanimously.

Meeting concluded at 6:18pm.

Approved by the Commission:

President of Commission: Jill Buhler _____

Secretary of Commission: Marie Dressler _____

FROM: Barbara York – Medical Staff Services
RE: 7-25-2017 Medical Executive Committee appointments/reappointments and annual policy review recommendations for Board approval 8-2-2017

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 appointment to the active/courtesy/allied health provisional staff with privileges as requested:

- Harn, Beverly, MD – Emergency Medicine
- McQuinn, Garland, MD – Tele-Radiology
- Rago, John, MD – Tele-Radiology
- Thurlow, Peter, MD – Tele-Radiology

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

- Hoyecki, Patti, ARNP – Wound Care Specialist

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

- Bickling, Rachel, MD – FM/OB

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

- Mank, Catherine, DO – Emergency Medicine (Ultrasound privileges **approval is pending** evidence of competency – currently not granted)
- Toofaninejad, Azadeh, DO – Tele-Cardiology
- Cox, Patrick, MD – Tele-Radiology

Satisfactory completion of provisional status

- Peet, Andrew, MD – Emergency Medicine
- Hoffman, Ann, DO – OB/GYN

Annual Review of Medical Staff Policies with minor changes approved:

1. Autopsy Policy (no changes)
2. Orientation Policy (recommend deleting sentence as indicated in document below)
3. Reappointment and renewal of clinical privileges (no changes recommended by July Cred Co)
4. Telemedicine Service (no changes recommended by July Cred Co)

AUTOPSIES

POLICY:

The Medical Staff is encouraged to obtain autopsies in all deaths at Jefferson Healthcare that meet criteria and whenever appropriate. The managing physician will be notified when autopsy criteria are met or when the family requests an autopsy. The physician ordering the autopsy shall be informed of the time and location of the autopsy.

PROCEDURE:

No autopsy shall be performed without written consent of the responsible relative except when ordered by lawful authority, **typically the Coroner**. If the death is not deemed by the coroner to fall under his/her jurisdiction, and if the death occurs at Jefferson Healthcare and an autopsy is ordered by the managing physician, the autopsy will be performed by the on-call pathologist from NWP.

The essential unit in deciding on the performance of an autopsy is the managing physician and family. Direct communication between managing physician and pathologist is expected. The following criteria are a guideline for consideration of an autopsy. These guidelines neither mandate nor limit selection of case

1. *Intra-operative or intra-procedural death.*
2. *Death occurring within 48 hours after surgery or an invasive diagnostic procedure.*
3. *Death incident to pregnancy.*
4. *Death in infants/children with congenital malformations.*
5. *Unexplained, unexpected deaths.*

1. A preliminary autopsy report will be available to the managing physician within two (2) days. The final autopsy report will be completed within thirty (30) days unless special studies are required. A review summary of each autopsy will be presented at appropriate medical staff committee (Acute Care, Surgical, ED, or OB) and forwarded to the Medical Executive Committee.
2. The managing physician will inform the family of autopsy results.

*** In accordance with RCW 68.50.010 the following causes of death are considered Coroners' cases and in each of these circumstances Medical Staff should request the physical presence of the Coroner at Jefferson Healthcare.**

1. Death of a person in apparent good health when that person is unattended by a physician during the 36 hrs prior to death
2. Unknown or obscure cause of death
3. Violent death
4. Known or suspected abortion
5. Addiction
6. Auto accidents
7. Carnal knowledge or sodomy
8. Death in prison
9. Drowning
10. Electrocution
11. Gunshot wounds
12. Hanging
13. Premature birth > 20 weeks gestation
14. Radiation exposure
15. Rape, alleged or actual
16. Stab wounds or cuts
17. Starvation
18. Stillbirth
19. Strangulation
20. Suffocation or smothering
21. Tetanus
22. Virulent contagious disease or suspected contagious disease
23. Lightning
24. One year following accident (if cause of death is unknown)
25. Unclaimed bodies

REFERENCES:

DNV Standards MS19, S.R.1-3
RCW 68.50.010

PROVIDER ORIENTATION

POLICY:

Every newly appointed Medical Staff provider will complete an orientation **before they see their first patient**. This orientation, designed to help promote and build a positive relationship with the provider, will be a personal, interactive orientation overseen by and including Medical Staff leadership, Hospital leadership, Medical Staff Services and other key personnel within the hospital. As a tool to assist in orienting the Medical Staff provider, a resource manual has been developed and will be presented and reviewed at the time of orientation.

~~Newly appointed Medical Staff providers will have 4 weeks to complete their orientation. Tracking of completion dates will be managed by Medical Staff Services. Any provider who does not complete their orientation within the four (4) week time frame will be subject to voluntary resignation of privileges and will be required to complete the entire reapplication process, including all applicable fees for membership to the medical staff. This resignation will not be subject to any Medical Staff appeals process.~~

Providers working from a remote site (tele-radiology, tele-stroke) shall have full orientation requirements waived, however, essential elements of JHC and medical staff protocols, and guidelines appropriate to the services shall be communicated to the provider. All providers who require EPIC access will receive training by the Informatics Department before their first shift in the facilities.

PURPOSE:

To ensure that all newly appointed Medical Staff Providers are oriented to Jefferson Healthcare and Medical Staff leadership, contribute to patient safety and to relay pertinent clinical, operational and regulatory information and expectations.

PROCEDURE:

1. Mission, Vision and Values
2. Patient Rights and Responsibilities
3. Patient Safety, Quality, Facility Accreditation, Restraint Use
4. Infection Control
5. Medical Staff Officers and Committees
6. Phone Directory
7. Organizational Chart
8. Bylaws, Rules and Regulations
9. Health Information Management, and HIPAA
10. CME and Tumor Board Information, PolicyStat Instructions
11. Conduct Expectations
12. Provision Evaluation Process
13. Peer Review Process

RECORD REQUIRED:

Jefferson Healthcare Orientation Manual

REAPPOINTMENT AND RENEWAL OF CLINICAL PRIVILEGES

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.

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 two 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 or an email to the responsible office manager will be sent informing the manager/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. 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.
 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, pending, or completed involving allegations or findings of professional medical misconduct in this state or any other state.
 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. ⁷

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).

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 and Vice Chief of Staff.
 - 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, **Credentials Committee, MEC** and the Vice Chief of Staff.
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.

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. The Medical Staff Coordinator or designee will ensure that practitioner 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 shall review the reappointment and or privileges application, credentials file, and quality assessment file and document their evaluation. When the Chief of Medicine or Surgery is being reappointed, the Vice Chief of Staff 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 Medical Executive Committee.
3. The recommendations from the Medical Executive Committee shall be submitted to the Governing Board for final action.
4. Practitioner will be notified 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:

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.

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

TELEMEDICINE SERVICES

POLICY:

Jefferson Healthcare (originating site) will grant credentialing and privileging of all telemedicine providers through an agreement with the 'Medicare participating' distant site or a telemedicine entity and will rely upon the credentialing and privileging decisions made by the 'Medicare participating' distant site or telemedicine entity when making recommendations for appointments/re-appointments.

The written agreement **includes but is not limited to the following conditions:**

- Distant site telemedicine entity medical staff credentialing and privileging process
- The provider is privileged at the distant site
- The provider holds license or is recognized by the state where the originating site (Jefferson Healthcare) is located
- Jefferson Healthcare has evidence of internal review of the distant site practitioner's performance of these privileges and sends the distant site performance information for use in periodic appraisals (at a minimum patient complaints and adverse events).

Jefferson Healthcare Medical Staff Bylaws and Policies and Procedures for appointment, reappointment and granting of clinical privileges will be followed.

PURPOSE:

To establish guidelines for credentialing and privileging physicians who provide telemedicine.

DEFINITION OF TELEMEDICINE:

Remote licensed, independent practitioners who are responsible for patient care, treatment and services (e.g: providing official readings of images, tracings or interpretive studies, consultations) via telemedicine link. Telemedicine sites consist of both an originating site and a distant site. An originating site is the hospital where the patient is receiving care, whereas a distant site is the 'Medicare participating' institution or telemedicine entity from which the prescribing or treating services are provided.

REFERENCES:

CMS CoPs: §482.22 (3), § 482.22(4), §482.12(a)(1) through (a)(7) and the Medical Staff standards at § 482.22(a)(1) through (a)(2); DNV MS.17, SR.1; 42 C.F.R. 485.616(c)