Washington Township Health Care District
2000 Mowry Avenue, Fremont, California 94538-1716 | 510.797.1111
Kimberly Hartz, Chief Executive Officer

BOARD OF DIRECTORS MEETING

Wednesday, December 9, 2020 – 6:00 P.M.
Meeting Conducted by Zoom
Join from PC, Mac, Linux, iOS or Android:
https://us02web.zoom.us/j/81901915891?pwd=S2JpTUxGWFpQdDdKSng2Umpvek9mQT09
Password: 705631

AGENDA

		PRESENTED BY:
I.	**CALL TO ORDER & PLEDGE OF ALLEGIANCE**	Michael J. Wallace Board President
II.	**ROLL CALL**	Dee Antonio District Clerk
III.	**CONSIDERATION OF RESOLUTION NO. 1219, CERTIFICATE OF NOVEMBER 3, 2020 GENERAL ELECTION, BOARD OF DIRECTORS**	*Motion Required*
IV.	**OATH OF OFFICE** A. William Nicholson B. Jeannie Yee	The Honorable Thomas Nixon
V.	**CONSIDERATION OF RESOLUTION NO. 1220 CONFIRMING CANVASS OF VOTES CAST IN WASHINGTON TOWNSHIP HEALTH CARE DISTRICT GENERAL ELECTION AND DECLARATION OF ELECTION RETURNS BOND MEASURE XX**	*Motion Required*
VI.	**ELECTION OF OFFICERS**	*Motion Required*
VII.	**CONSENT CALENDAR** *Items listed under the Consent Calendar include reviewed reports and recommendations and are acted upon by one motion of the Board. Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Michael J. Wallace Board President

Motion Required

A. Consideration of Minutes of the Regular Meetings of the District Board: November 11, November 16, and November 23, 2020

B. Consideration of Medical Staff Credentialing Action Items (November 16, 2020)

C. Consideration of Medical Staff: UCSF Pediatric Hospital Medicine Fellows Proposal

D. Consideration of Medical Staff: Amendments to Standardized Procedure for Rapid Response Team Care Initiated by the Certified Registered Nurse

E. Consideration of Medical Staff New Standardized Procedure: RSTU COVID-19 Nurse Initiated Protocol

F. Consideration of Budgeted Capital Request: Two Cardiac Monitors ($131,945.00)

VIII. COMMUNICATIONS

A. Oral

This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not on the agenda and within the subject matter of jurisdiction of the Board.. "Request to Speak" cards should be filled out in advance and presented to the District Clerk. For the record, please state your name.

B. Written

IX. PRESENTATION

A. Ethics Training	Kristin Ferguson Chief of Compliance

X. REPORTS

	PRESENTED BY:
A. Medical Staff Report	Prasad Kilaru, M.D. Chief of Medical Staff
B. Lean Report: Improving Patient Experience	Galen Hamilton Chief Operating Officer Washington Township Medical Foundation

	C. Quality Report: 2020 Critical Care Program Update	Carmen Agcaoili, M.D. Medical Director, Critical Care
	D. Finance Report	Chris Henry Vice President & Chief Financial Officer
	E. Hospital Operations Report	Kimberly Hartz Chief Executive Officer
XI.	**ACTION ITEMS**	*Motions Required*
	A. Consideration of Non-Budgeted Capital Request: Design Fees for the Infill Projects for the Morris Hyman Critical Care Pavilion ($6,000,000.00)	
	B. Consideration of Non-Budgeted Capital Request: Respiratory Waiting Tent ($71,000.00 plus tax)	
XII.	**ANNOUNCEMENTS**	Kimberly Hartz Chief Executive Officer
XIII.	**ADJOURN TO CLOSED SESSION** *In accordance with Section 32106 and 32155 of the California Health & Safety Code, portions of this meeting may be held in closed session.*	
	A. Report of Medical Staff and Quality Assurance Committee, Health & Safety Code section 32155	
XIV.	**RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION**	Michael J. Wallace Board President
XV.	**ADJOURNMENT**	Michael J. Wallace Board President

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact the District Clerk at (510) 818-6500. Notification two working days prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to this meeting.

CALL TO ORDER

PLEDGE OF ALLEGIANCE

A meeting of the Board of Directors of the Washington Township Health Care District was held on Wednesday, November 11, 2020 via Zoom in order to comply with California Governor Gavin Newsom's and Alameda County's mandatory orders to slow the spread of COVID-19 and to maintain restrictions on movement and public gathering. Director Wallace called the meeting to order at 6:00 pm, recognized Veterans Day, and led those in attendance of the meeting in the Pledge of Allegiance.

ROLL CALL

Roll call was taken: Directors present: Michael Wallace; William Nicholson, MD; Jeannie Yee; Jacob Eapen, MD; Bernard Stewart, DDS
Absent:

Also present: Kimberly Hartz, Chief Executive Officer; Dee Antonio, District Clerk

Guests: Ed Fayen, Chris Henry, Tina Nunez, Stephanie Williams, Paul Kozachenko, Prasad Kilaru MD, Mary Bowron, John Lee, Angus Cochran, Dr. Jeff Stuart, Dr. David Lee, Erica Luna, Kel Kanady, Sri Boddu, Larry Tramutola, Gordon Howie, Lisalee Wells, Graham Beck, and Scott Haggerty

OPENING REMARKS

Director Wallace welcomed any members of the general public to the meeting. He stated that Governor's Newsom's Executive Order N-29-20 explicitly waives The Brown Act provision that requires physical presence of members, the clerk or other personnel of the body, or of the public as a condition of participation in, or quorum for, a public meeting. He noted that Washington Township Health Care District continues to comply with the Brown Act in providing appropriate connection information in order to provide the public the opportunity to participate in the meeting and that Public Notice for this meeting, including connection information, was posted appropriately on our website.

Mr. Wallace announced that this meeting, conducted via Zoom, will be recorded for broadcast at a later date.

When asked if any members of the general public were in attendance and/or interested in speaking, there was no response.

CONSENT CALENDAR

Director Wallace presented the Consent Calendar for consideration:

A. Minutes of the Regular Meetings of the District Board: October 14, 19, 26, and 28, 2020
B. Medical Staff Credentialing Action Items
C. Non-Budgeted Capital Request: Pneumatic Tube System Upgrade ($201,294.00)
D. Budgeted Capital Request: FY21 PACS Upgrade Project ($237,220.00)
E. Budgeted Capital Request: Epic Infrastructure Upgrade Project ($261,477.00)
F. Unbudgeted Capital Request: Paving of the Old Emergency Room Parking Lot ($62,288.00)

In accordance with District law, policies, and procedures, Director Eapen moved that the Board of Directors approve the Consent Calendar, items A through F.

Director Yee seconded the motion.

Roll call was taken:

Michael Wallace – aye
William Nicholson, MD – aye
Jeannie Yee - aye
Jacob Eapen, MD - aye
Bernard Stewart, DDS – aye

The motion unanimously carried.

There were no Oral communications.

COMMUNICATIONS: ORAL

There were no Written communications.

COMMUNICATIONS: WRITTEN

On behalf of the Board of Directors, Director Wallace virtually presented Scott Haggerty with a Commendation for representing Alameda County's District 1 for twenty-four years. The Commendation was read in its entirety. The Commendation Plaque will be given to Mr. Haggerty in person at a future date.

COMMENDATION: SCOTT HAGGERTY

Kimberly Hartz, Chief Executive Officer, introduced Consultant Larry Tramutola who talked about the pending results of the Measure XX Initiative on the November 3rd election ballot.

ANNOUNCEMENT: MEASURE XX ELECTION RESULTS

Kimberly Hartz introduced Dr. David Lee, Medical Director for the UCSF-WHHS Oncology Program. He presented information on the immune system and the ways that cancer evades the immune system. He talked about the development of immunotherapy in treating cancer by stimulating one's own body's immune system to fight off various forms of cancer cells. He discussed modern immunotherapy and described a successful treatment for one of his patients with a diagnosis of metastatic lung cancer. Dr. Lee talked about the UCSF-Washington partnership in providing immunotherapy treatments as a routine part of day-t0-day cancer care as well as the two newly opened clinical trials.

PRESENTATION: CANCER IMMUNOTHERAPY

Kimberly Hartz introduced Dr. Ramin Beygui, Medical Director for the UCSF-WHHS Cardiothoracic Surgery Program, and Dr. Jeff Stuart, WHHS Chief Medical Officer. Dr. Stuart introduced the Program noting that Dr. Beygui will be the site director for the program. The anticipated start date will be in December. This program was originally approved by UCSF in 1968, expanded in 2006, and is being extended to Washington Hospital in 2020. We are expected to do as many as 125 cases per year, including pre-operative care, evaluation, post-operative care, and follow up. This will be an Action Item for Board Approval at the November 16th meeting.

PRESENTATION: UCSF CARDIOTHORACIC SURGERY RESIDENCY PROGRAM/CT FELLOWSHIP PROGRAM

Kimberly Hartz spoke on the celebration of Veterans Day and the commemorative Veterans Recognition Wall located at Washington West. The following names were added to the Veterans Recognition Wall this year: Jamie Conley, Troy Evans, Javier

PRESENTATION: VETERANS DAY RECOGNITION

Flores, Michael Meade, and Marc O'Campo. Ms. Hartz spoke on Washington Hospital's leave policy that allows members of the Armed Forces or National Guard to be granted military leave from work for the period required when called to active duty for training, inactive duty training, or active duty.

MEDICAL STAFF REPORT

Dr. Prasad Kilaru reported there are 586 Medical Staff members including 348 active members.

QUALITY REPORT: QUALITY DASHBOARD QUARTER ENDING SEPTEMBER 30, 2020

Mary Bowron, Chief of Quality and Resource Management presented the Quality Dashboard for the quarter ending September 30, 2020 comparing WHHS statistics to State and National benchmarks. We had Zero MRSA Bloodstream Infections this past quarter and one VRE Infection this past quarter. Central Line Associated Bloodstream Infections: Our infection rate was higher than predicted. Catheter Associated Urinary Tract Infection: Our infection rate was higher than predicted at 4.350. C-Difficile: We were lower than predicted this past quarter. We had no infections following colon surgery which was below the predicted number of infections. We had no infections following abdominal hysterectomy which was below the predicted number of infections. Hand Hygiene was at 86.1%.

Our moderate fall with injury rate was higher than the national rate for the quarter at 13.64. Hospital Acquired Pressure Ulcer rate was below the national rate this past quarter.

We had a higher percent of 30-day medicare pneumonia readmissions compared to the CMS national benchmark (28.5% versus 16.6%). Our 30-day readmission rate for AMI discharges was above the CMS benchmark (24.0% versus 16.1%). 30-day Medicare Heart Failure readmissions were higher (25.4% versus 21.9%) than the CMS benchmark. Our 30-day Medicare CABG readmission rate was lower (0.0% versus 12.7%) than the CMS benchmark. Our 30-day Medicare Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) was lower than the CMS benchmark (2.1% versus 4.0%). Our 30-day Medicare Chronic Obstructive Pulmonary Disease (COPD) readmission rate was lower than the CMS benchmark (12.5% versus 19.6%).

FINANCE REPORT

Chris Henry, Vice President & Chief Financial Officer, presented the Finance Report for September 2020. The average daily census was 142.6 with admissions of 797 resulting in 4,279 patient days. Outpatient observation equivalent days were 214. The average length of stay was 5.90 days. The case mix index was 1.679. Deliveries were 113. Surgical cases were 367. Joint Replacement cases were 158. Neurosurgical cases were 27. Cardiac Surgical cases were 12. The Outpatient visits were 7,092; Emergency visits were 3,482; RSTU visits were 1,260. Total productive FTEs were 1,366.5. FTEs per adjusted occupied bed were 6.94.

HOSPITAL OPERATIONS REPORT

Kimberly Hartz, Chief Executive Officer, presented the Hospital Operations Report for October 2020. Preliminary information for the month indicated gross revenue at approximately $173,663,000. The Average Length of Stay was 5.16, which was due in part to the shift in joint surgeries from inpatient to outpatient. Approximately 77% of all joint replacements were performed as outpatient cases in October. The Average Daily Census was 133.4. There were 4,135 patient days. There were 381 Surgical Cases and 330 Cath Lab procedures at the Hospital. Deliveries were 115. Non-Emergency Outpatient visits were 7,912. RSTU visits were 1,894. Total Government Sponsored Preliminary Payor Mix was 73.1%, against the budget of 71.1%. Total FTEs per Adjusted Occupied Bed were 6.82. The Washington Outpatient Surgery Center had 482 cases and the clinics saw approximately 3,173 patients. Homeless Patient Total Encounters were 179 with an estimated unreimbursed cost of homeless care of $59,000 for the month of October. The estimated total unreimbursed cost of homeless care for FY21 Year-to-Date was $1.7M.

ANNOUNCEMENTS

- Thursday, October 15th: Annual Think Pink Breast Health Awareness event on Facebook Live and YouTube.
- Saturday, October 24th: WTMF hosted a flu vaccination drive-through event at the Nakamura Clinic in Union City. 171 community members received flu vaccination.
- Wednesday, November 4th: "Emotional Wellness During the Holidays" on Facebook Live and YouTube
- The Macquerade Jewelry Sale will be hosted online this year through December 31st.
- Joyce Calixto, RN MSN, Staff Nurse II, 4-West, is the November Employee of the Month.

ACTION: RESOLUTION 1218

In accordance with District Policies and Procedures, Director Eapen moved that the Board adopt Resolution No. 1218 which is the Resolution of the Board of Directors of Washington Township Health Care District approving the issuance and sale of and determining to proceed with the negotiated sale of certain refunding bonds of the District in an aggregate principal amount not to exceed $51,000,000, approving the execution and delivery of a supplemental indenture, a bond purchase contract, an escrow agreement, a continuing disclosure agreement, a preliminary official statement and certain other actions related thereto.

Director Yee seconded the motion.

Roll call was taken:

Michael Wallace – aye
William Nicholson, MD – aye
Jeannie Yee - aye
Jacob Eapen, MD - aye
Bernard Stewart, DDS – aye

The motion unanimously carried.

ADJOURN TO CLOSED SESSION

In accordance with Health & Safety Code Sections 32106 and 32155 and California Government Code 54956.9(d)(2), Director Wallace adjourned the meeting to closed session at 8:07 p.m., as the discussion pertained to a Report of Medical Staff and Quality Assurance pursuant to Health & Safety Code Section 32155. Mr. Wallace stated that the public has a right to know what, if any, reportable action takes place during closed session. Since this is a Teleconference call and we have no way of knowing when the closed session will end, the public was informed they could contact the District Clerk for the Board's report beginning November 12, 2020. He indicated that the minutes of this meeting will reflect any reportable actions.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Wallace reconvened the meeting to open session at 8:15 p.m. and reported that no reportable action occurred in closed session.

ADJOURNMENT

There being no further business, Director Wallace adjourned the meeting at 8:15 pm.

_____ _____

Michael J. Wallace
President

Bernard Stewart, DDS
Secretary

CALL TO ORDER

A regular meeting of the Board of Directors of the Washington Township Health Care District was held on Monday, November 16, 2020 via Teleconference in order to comply with Alameda County's orders as revised on October 23, 2020 to slow the spread of COVID-19 and to maintain restrictions on movement and public gathering. Director Wallace called the meeting to order at 6:00 p.m. and led those present in the Pledge of Allegiance.

ROLL CALL

Roll call was taken. Directors present: Michael Wallace; William Nicholson, MD; Jeannie Yee; Jacob Eapen, MD; Bernard Stewart, DDS

Absent:

Also present: Kimberly Hartz, Chief Executive Officer; Ed Fayen, Executive Vice President; Tina Nunez, Vice President; Stephanie Williams, Vice President; Paul Kozachenko, Legal Counsel; Dee Antonio, District Clerk

COMMUNICATIONS

There were no oral communications.

There were no written communications.

CONSENT CALENDAR

Director Wallace presented the Consent Calendar for consideration:

A. Proposed Amendments to the Medical Staff Bylaws
B. Thoracic Surgery Resident Guidelines

In accordance with District law, policies, and procedures, Director Eapen moved that the Board of Directors approve the Consent Calendar, items A and B.

Director Yee seconded the motion.

Roll call was taken:

Michael Wallace – aye
William Nicholson, MD – aye
Jeannie Yee - aye
Jacob Eapen, MD - aye
Bernard Stewart, DDS – aye

The motion unanimously carried.

ADJOURN TO CLOSED SESSION

In accordance with Health & Safety Code Sections 32106 and 32155 and California Government Code 54956.9(d)(2), Director Wallace adjourned the meeting to closed session at 6:05 p.m., as the discussion pertained to a trade secret pursuant to Health & Safety Code section 32106, a Report of Medical Staff and Quality Assurance pursuant to Health & Safety Code Section 32155, and a Conference Involving Personnel Matters: Chief Executive Officer. Mr. Wallace stated that the public has a right to know what, if any, reportable action takes place during closed session. Since this is a Teleconference call and we have no way of knowing when the closed session will end, the public was informed they could contact the District Clerk for the Board's report beginning November 17, 2020. He indicated that the minutes of this meeting will reflect any reportable actions.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Wallace reconvened the meeting to open session at 8:05 p.m. and reported that during the closed session, the Board denied the claim of Ji Young Park and the claim of Brigitte Gullatt. The following board members voted to deny the Ji Young Park claim: Michael Wallace, William Nicholson MD, Jeannie Yee, Jacob Eapen MD, and Bernard Stewart DDS. The following board members voted to deny the Brigitte Gullatt claim: Michael Wallace, Jeannie Yee, Jacob Eapen MD, and Bernard Stewart DDS; the following board member abstained: William Nicholson MD.

ADJOURNMENT

There being no further business, Director Wallace adjourned the meeting at 8:08 pm.

_____ _____

Michael J. Wallace
President

Bernard Stewart, DDS
Secretary

CALL TO ORDER

A meeting of the Board of Directors of the Washington Township Health Care District was held on Monday, November 23, 2020 via Zoom in order to comply with Alameda County's orders as revised on October 23, 2020 to slow the spread of COVID-19 and reduce the rate of transmission by sheltering at home and continued social distancing. Director Nicholson called the meeting to order at 7:30 a.m.

ROLL CALL

Roll call was taken. Directors present: William Nicholson, MD; Bernard Stewart DDS; Jacob Eapen; Jeannie Yee
Excused: Michael Wallace

Also present: Prasad Kilaru, MD; Kranthi Achanta, MD; Shakir Hyder, MD; Tim Tsoi, MD; Jan Henstorf, MD; Jeff Stuart, MD; Kimberly Hartz, Chief Executive Officer; Stephanie Williams, Vice President & Chief Nursing Officer

COMMUNICATIONS

There were no oral or written communications.

ADJOURN TO CLOSED SESSION

Director Nicholson adjourned the meeting to closed session at 7:30 a.m. as the discussion pertained to Medical Audit and Quality Assurance Matters pursuant to Health & Safety Code Sections 1461 and 32155.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Nicholson reconvened the meeting to open session at 8:30 a.m. and reported no reportable action taken in closed session.

ADJOURNMENT

There being no further business, the meeting adjourned at 8:30 a.m.

_____ _____

Michael Wallace
President

Bernard Stewart
Secretary

RESOLUTION NO. 1219

RESOLUTION AND ORDER OF THE BOARD OF DIRECTORS OF WASHINGTON TOWNSHIP HEALTH CARE DISTRICT ACKNOWLEDGING THE ELECTION OF WILLIAM NICHOLSON AND JEANNIE YEE AS DIRECTORS OF THE BOARD OF DIRECTORS OF WASHINGTON TOWNSHIP HEALTH CARE DISTRICT

WHEREAS, members of the Board of Directors of the Washington Township Health Care District ("District") are elected by eligible voters residing within the geographic boundary of the District for terms of four years, with elections to fill seats for two or three members every two years; and

WHEREAS, at the last General Election held on November 3, 2020, the number of candidates for the office of Director of Washington Township Health Care District did exceed the minimum number required to be elected director and a petition was filed requesting an election; and

WHEREAS, the District is in receipt of a separate "Certificate of Appointment and Oath of Office" from the Registrar of Voters dated December 1, 2020 for each of the following persons: William Nicholson and Jeannie Yee (attached to this Resolution as Exhibit 1) certifying that at the General Election held in and for the County of Alameda on November 3, 2020, each of the aforementioned persons "was elected to the office of Washington Township Healthcare District Director as appears by the official returns of said election, and the statement of votes cast now on file."

NOW THEREFORE, THE BOARD OF DIRECTORS OF WASHINGTON TOWNSHIP HEALTH CARE DISTRICT DOES HEREBY RESOLVE, DETERMINE AND ORDER, AS FOLLOWS:

1. The Board of Directors hereby acknowledges receipt of a "Certificate of Appointment and Oath of Office" from the Registrar of Voters for each of the following persons: William Nicholson and Jeannie Yee.

2. The Secretary of the Board of Directors of the District be and is hereby instructed to enter this Resolution into the District record acknowledging that William Nicholson and Jeannie Yee have been elected to the office of Director of the Board of Directors of the District.

Passed and adopted by the Board of Directors of the Washington Township Health Care District this 9th day of December, 2020 by the following vote:

AYES:

NOES:

ABSENT:

_____	_____
Michael Wallace	Bernard Stewart.
President, Board of Directors	Secretary, Board of Directors
Washington Township	Washington Township
Health Care District	Health Care District

RESOLUTION NO. 1220

RESOLUTION CONFIRMING CANVASS OF VOTES CAST IN WASHINGTON TOWNSHIP HEALTH CARE DISTRICT GENERAL ELECTION AND DECLARATION OF ELECTION RETURNS BOND MEASURE XX

WHEREAS, the Board of Directors of the WASHINGTON TOWNSHIP HEALTH CARE DISTRICT has duly passed and adopted resolution # 1213 calling a health care district general election on November 3, 2020, which election was ordered consolidated with the State of California General Election, to vote for the following measure:

> Measure XX: To complete the construction necessary to make Washington Hospital earthquake safe and ensure the hospital remains open and accessible to provide life-saving care during a major disaster to provide modern operating rooms, intensive care for infants and modern patient facilities, shall community-owned Washington Township Health Care District authorize $425,000,000 in bonds at legal rates, generating approximately $21,000,000 annually at an average rate of 1 cent per $100 of assessed valuation while bonds are outstanding, with all money staying local?

WHEREAS, notice of said election was thereafter duly given as required by law and by said resolution; that said election was duly held in accordance with law and with said resolution; that the polls for said election were kept open during the time required by law and results thereof ascertained, determined and declared, all as provided by the laws of the State of California and by said Resolution; and,

WHEREAS, Tim Dupuis, Registrar of Voters of Alameda County has canvassed the votes cast at said election, and the returns of said election have been reported to this Board of Directors; and,

WHEREAS, on this date, this Board of Directors met at its meeting place and has reviewed the canvass and certification of the returns of said election as required by law and the result of said canvass is found to be as hereinafter stated and set forth;

NOW, THEREFORE, THE BOARD OF DIRECTORS OF WASHINGTON TOWNSHIP HEALTH CARE DISTRICT DOES HEREBY RESOLVE, DETERMINE AND ORDER, AS FOLLOWS:

1. The foregoing recitals are, and each of them is true and correct and this Board of Directors so finds and determines.

2. At said election held on Tuesday, November 3, 2020, foregoing Measure XX appeared on the ballot thereof and the total number of votes cast for the Measure XX were as follows:

Yes 93,852 (67.22%)	No 45,763 (32.78%)

3. The Secretary of the Board of Directors of the District be and is hereby instructed to enter this Resolution confirming the canvass of returns upon the minutes of this Board of Directors as a statement of the results of said WASHINGTON TOWNSHIP HEALTH CARE DISTRICT General Election, Measure XX, held on November 3, 2020.

Passed and adopted by the Board of Directors of the Washington Township Health Care District this 9th day of December, 2020, by the following votes:

AYES:

NOES:

ABSENT:

_____	_____
Michael J. Wallace President, Board of Directors Washington Township Health Care District	Bernard Stewart Secretary, Board of Directors Washington Township Health Care District

Washington Hospital Healthcare System
SINCE 1948

Memorandum

DATE: December 1, 2020

TO: Kimberly Hartz, Chief Executive Officer

FROM: Prasad Kilaru, MD
Chief of Staff

SUBJECT: Final Credentials Actions

The Medical Executive Committee approved the Credential Action Items on November 16, 2020. Please accept this memorandum as a formal request for consideration of approval by the Board of Directors of the Credential Action Items as attached.

WASHINGTON HOSPITAL MEDICAL STAFF
FINAL CREDENTIALS ACTION ITEMS November 23, 2020

The following written communication received from Prasad Kilaru, MD, Chief of Staff, dated November 10, 2020 requesting approval of Medical Staff Credentialing Action Items as follows:

Initial Appointments – Two Year
Folse, Michael MD; Green, David MD; Hoang, Brittany NP; Hsia, Henry MD; Moraveji, Sharareh MD; Moss, Joshua MD

Initial Appointments – One Year
None

Temporary Privileges
Franco, Kelly NP; Moraveji, Sharareh MD

Disaster Privileges – approved while application is waiting for Board approval
None

LocumTenens
None

30 Days Extension Request – Application Not Complete
None

Waiver Request
None

Reappointments – Two Year
Adie, Elizabeth MD; Angroola, Amardeep MD; Chan, Jennifer MD; Chari, Sumitra MD; Chickaballapur Narayanaswamy, Ajith MD; Kamboj, Vineet DPM; Kang, Young MD; Karamloo, Sara DPM; Khoury, Basel MD; Lin, Roy MD; Lyell, Dierdre MD; Maung, Linn DDS MD; Maxwell, Andrew MD; Peela, Bhaskari MD; Kumar, Latha MD; Swan, Megan MD; Taylor, Daniel MD; Veerappan, Annamalai MD; Vo, Phuong MD

Reappointments – One Year
Davila, Edmundo MD; Dearborn,John MD; Mahal, Surjit MD; Mehigan, John MD; Sharma, Ranjana MD

Addition of Physician Supervisor
None

Conditional Reappointments
None

Non-Reappointments – Deemed to Have Resigned
None

Transfer in Staff Category
Costouros, John MD; Irani, Adil MD; Kamboj, Vineet MD; Maung, Linn DDS MD; Shamin, Sadiya MD; Singh, Sarabjot MD; Trevathan, Elizabeth MD

Completion of Proctoring Prior to Eligibility for Advancement in Staff Category
Grewal, Harkiran MD; Grewal, Navjot MD; Perez, Carlos MD; Rajan, Jay MD; Ribeiro, Monica MD; Singh, Manu MD; Vo, Christopher DO

Completion of Proctoring and Advancement in Staff Category
Karamloo, Sara DPM; Nunes, Maria NP; Parmar, Kalgi DPM; Schechter, Sarah MD

Extension of Proctorship and Provisional Category 1-year
Nguyen, Kieu MD

New Privilege Requests
Borses, Mary MD; Franco, Kelly NP; Goldin, Michael MD; Kang, Young MD; Kilaru, Prasad MD; Sehgal, Rohit MD; Wartman, Sarah MD

Delete Privilege Requests
Chan, Jennifer MD; Karamloo, Sara DPM; Parmar, Kalgi DPM; Rajan, Jay MD; Sharma, Ranjana MD

Conflict of Interest Statement Updated
Kang, Young MD

Leave of Absence
None

Reinstatement of Leave of Absence
Wilkins, Christopher PA-C

Withdrawal of Application
None

Suspensions / Relinquishment
None

Resignations
Lam, Manuel MD; Wat, Norman DDS

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: November 16, 2020

TO: Kimberly Hartz, Chief Executive Officer

FROM: Prasad Kilaru, MD, Chief of Staff

SUBJECT: MEC for Board Approval:

The Medical Executive Committee, at its meeting of November 16, 2020, approved the UCSF Pediatric Hospital Medicine Fellows Proposal.

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval of the attached UCSF Pediatric Hospital Medicine Fellows Proposal. .

University of California
San Francisco

School of Medicine

Department of Pediatrics

550 16th Street, 4th Floor, Box 0110
San Francisco, CA 94143
Tel: (415) 476-9181

www.pediatrics.ucsf.edu

Raphael Hirsch, MD
WH & Marie Wattis Distinguished Professor
Chair, Department of Pediatrics
Physician-in-Chief,
UCSF Benioff Children's Hospitals

VICE CHAIRS

Michael Anderson, MD, MBA
Benioff Children's Hospitals

Lee Atkinson-McEvoy, MD
Primary Care & Population Health

Jeffrey Fineman, MD
Inpatient Services

Elena Fuentes-Afflick, MD, MPH
Zuckerberg S. F. General Hospital

James Huang, MD
Ambulatory Services

Roberta Keller, MD
Clinical & Translational Research

Phillip Moore, MD, MBA
Finance

Philip O'Brien, MA
Finance & Administration

Kevin Shannon, MD
Faculty Affairs & Basic Research

Scott Soifer, MD
Hospital Planning

Sandrijn van Schaik, MD, PhD
Medical Education

DIVISIONS

Adolescent Medicine
Allergy/Immunology/BMT
Cardiology
Critical Care
Developmental Medicine
Endocrinology
Gastroenterology
General Pediatrics
Genetics
Hematology/Oncology
Hospital Medicine
Infectious Diseases
Medical Education
Neonatology
Nephrology
Pulmonology

October 27, 2020

Dear Dr. Stuart,

Thank you for considering our request to have UCSF Pediatric Hospital Medicine Fellows continue rotating at Washington Hospital. Attached you will find a proposal describing the context and background, the details of the clinical rotation, and fellow supervision guidelines. Please do not hesitate to contact us with any clarifying questions or to discuss further.

Sincerely,

Darren Fiore, MD
Clinical Professor of Pediatrics
Associate Division Chief and Fellowship Program Director
UCSF Division of Pediatric Hospital Medicine

Sohil Sud, MD, MA
Associate Professor of Pediatrics
WHHS Site Director, UCSF Pediatric Hospital Medicine Fellowship
UCSF Division of Pediatric Hospital Medicine

Proposal: To allow UCSF Pediatric Hospital Medicine (PHM) Fellows to continue having a community hospital medicine rotation at WHHS, but to change their onboarding *from* members of the medical staff with attending privileges, *to* fellowship trainees practicing under attending supervision.

Background: UCSF Pediatric Hospital Medicine has provided pediatric inpatient and newborn nursery services at WHHS since 2014. UCSF PHM fellows have been rotating at WHHS since 2015, for experience in community hospital medicine.

The reason for the change in the fellow's rotation at WHHS is as follows: Previously, fellows were appointed to the Medical Staff (both at UCSF and WHHS), as attending physicians. This is because the fellowship program was a non-ACGME accredited program, which allows fellows to essentially practice as faculty, while in an academic training program. PHM was recently recognized by the American Board of Pediatrics as a new subspecialty, apart from General Pediatrics. This means that nationally, all of the fellowship training programs in PHM need to become accredited by the ACGME. UCSF's program achieved accreditation effective July 1, 2020. Fellows in an ACGME-accredited program *cannot* be appointed as both attendings *and* fellows at the same time (just as a cardiology fellow cannot simultaneously practice as a cardiology attending while in fellowship). Rather, fellows (like all ACGME trainees), practice under attending supervision.

In sum, PHM fellows can no longer be onboarded at WHHS with attending privileges through the Medical Staff Office. However, the educational and clinical experience the fellows get at WHHS is a critically important part of their fellowship, and we want that experience to continue. We therefore propose that PHM Fellows continue to rotate at WHHS, no longer as attending physicians, but as fellowship trainees, under the supervision of PHM attendings.

All fellows have completed Pediatric residency training and are board certified (or board eligible) in General Pediatrics. They are now in a PHM subspecialty fellowship training program.

Of note, this change was discussed on June 3, 2020 during an annual leadership meeting between the UCSF PHM Division Chief (Karen Sun, MD) and WHHS senior leadership (Stephanie Williams and Donald Pipkin).

UCSF PHM Fellow Community Hospital Medicine Rotation at WHHS

Leadership / Supervision:

- Darren Fiore, MD (Fellowship Program Director)
- Sohil Sud, MD (WHHS Fellowship Site Director)
- Simon Lee, MD (WHHS PHM Program Medical Director)
- While on clinical service at WHHS, fellows will be supervised by attending pediatricians on faculty in the Division of Pediatric Hospital Medicine at UCSF who are also licensed, credentialed, and members of the medical staff at Washington Hospital.

Goals and Objectives

The UCSF Benioff Children's Hospital fellowship in pediatric hospital medicine embodies the rich tradition of academic fellowship training at UCSF. The program's mission is to train leaders in academic PHM, who are expert clinicians in the family-centered care of sick, hospitalized children in the Northern California community, and who approach this work in a scholarly way. Our vision is that graduates become experts in the care of complex, highly specialized, hospitalized children, leaders in hospital safety and quality, excellent educators, and researchers in academic hospital medicine.

This is a two-year ACGME-accredited training program, and we recruit two fellows/year.

Fellows complete their community hospital medicine rotation at WHHS in two 1-month blocks; one during each year of fellowship. During this block, fellows work a mix of 24 and 8 hour shifts. The goals and objectives of these two rotations (listed below) should be seen as a continuum with progressive acquisition of knowledge, skills and attitudes. To accomplish the objectives during their rotations, fellows:

- Participate in all aspects of the direct patient care of hospitalized children on a small community hospital ward
- Provide well newborn care
- Attend deliveries
- Cross-cover a level II intensive care nursery with neonatology back-up
- Consult in the Emergency Room
- Assist with stabilization and transfer of critical patients to a higher level of care
- Supervise, teach, and give feedback medical students
- Interface with community PCPs around patient care
- Document in the EMR
- Handoff the service at change of shift

Objectives: At the end of the Community Hospital Medicine **rotation** fellows should be able to...	**Mapping to ACGME Competencies**
Carry out PHM consults and advice calls: ● Obtain the essential information from the primary provider, patient and family. ● Create a diagnostic impression and plan. ● Communicate the consultation impression and plan to referring provider, other	PC MK ICS PPD

consulting physicians and to the patient/family using bidirectional communication. Recognize the indications for consultation ● Focus and clarify the clinical question to be addressed as well as the role of the consultant in the care of the patient. ● Acknowledge the uncertainty in the diagnosis and/or prognosis that requires the engagement of a second consultant.	
Recognize, evaluate and manage common conditions presenting in the neonatal setting: jaundice, hypoglycemia, neonatal sepsis, neonatal fever, respiratory distress, poor feeding and weight loss, prematurity, minor birth trauma (brachial plexus injury, clavicle fracture, cephalohematoma), common rashes. Recognize, evaluate and manage common pediatric conditions: acute abdominal pain, BRUE, asthma, bone and joint infections, bronchiolitis, CNS infection, diabetes mellitus, FTT, FUO, gastroenteritis, KD, pneumonia, respiratory failure, seizures, shock, sickle cell disease, skin and soft tissue infection, toxic ingestion, upper airway infections, urinary tract infections, AKI/ARF, AMS, fluid and electrolyte disturbances.	PC MK ICS SBP
Determine level of acuity, stabilize, and triage to the appropriate care setting. ● Initiate necessary stabilizing work-up and management ● Monitor for and recognize changes in physical and mental status ● Identify criteria for transfer to another level or site of care ● Execute complete and safe handoffs and transfers of care	
Perform procedures common to the care of hospitalized children, which at Washington Hospital include: ● Airway management and respiratory support ● Oxygen delivery devices ● Bag-mask ventilation ● Suctioning ● Neonatal resuscitation (NRP) ● Pediatric resuscitation and stabilization (PALS) ● Lumbar puncture ● Bladder catheterization ● Access (intravenous, intraosseous)	PC PBLI ICS SBP PPD
Recognize the inherent risks involved in patient transport and other transitions of care and use a systems-approach to mitigate them	PC PBLI SBP PPD
Advocate for subspecialty-related health issues, recognizing vulnerabilities unique to these subspecialty populations	PC ICS SBP PPD

Fellow Supervision and EMR (EPIC) Guidelines

- All WHHS patients will have an attending of record.
- Fellows will be clinically supervised by attending pediatricians on faculty in the Division of Pediatric Hospital Medicine at UCSF, per ACGME oversight and supervision requirements.
- Fellows hold a valid CA Medical License and DEA certificate, and as such are authorized to enter orders in the EMR and prescribe medications.
- EPIC access/security should be equivalent to all PHM attendings
- Fellows can document in EPIC, including:
    - H&P's
    - Discharge Summaries
    - Progress Notes
    - Consult Notes
    - Procedure Notes
    - Event Notes
- Fellow notes will be cosigned in EPIC by an attending, in accordance with WHHS Medical Staff Rules & Regulations guiding patient visits by an attending, within 24 hours.

Addendum #1: Competencies for PHM fellows on file with UCSF Medical Staff Office

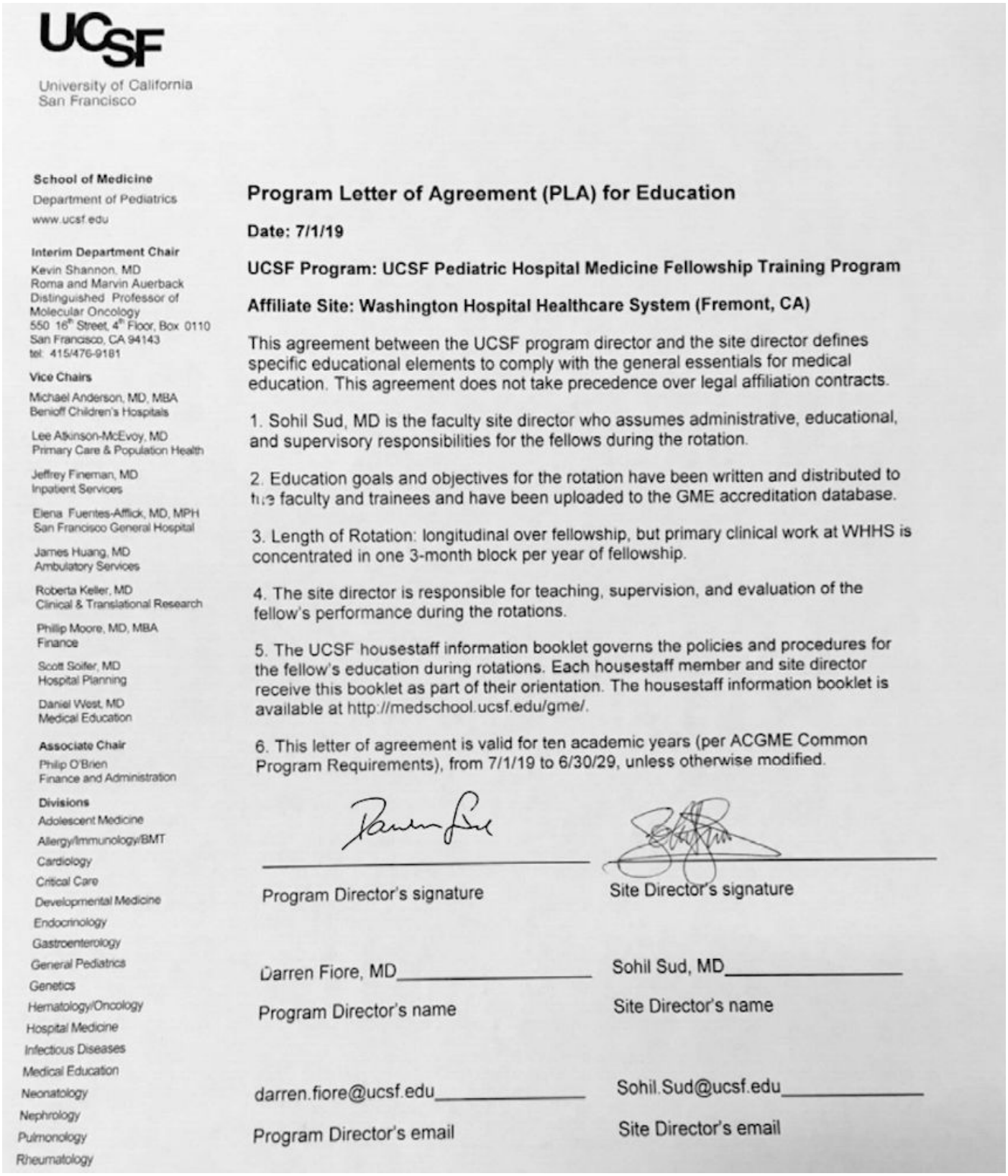
Pediatric Hospital Medicine Fellowship Competencies, Darren Fiore, MD, Program Director

Competencies define procedures or activities that the resident/clinical fellow can usually perform without on site supervision: Patient management, including H&Ps and diagnostic and therapeutic treatments, procedures and interventions encompassing the areas described below and similar activities. The underlying patient condition and complexity of the procedure might dictate the need for direct supervision and physical presence of the attending physician. Whenever a question arises about resident/clinical fellow competency to perform a procedure independently, the attending physician should be consulted.

Inpatient management, including H&Ps, rounding, discharge care.
Well newborn care and neonatal resuscitation
Preventive medical services and medical care of children from birth through adolescence.
Diagnostic and therapeutic treatments, procedures and interventions including the areas described below and similar activities:

Airway management, stable/unstable, trauma: Pediatrics
Anesthesia - local: Pediatrics
Arterial line -insert and remove: Pediatrics
Blood gases - arterial: Pediatrics
Cardiopulmonary resuscitation - closed: Pediatrics
Cultures - urine/sputum/wound: Pediatrics
Defibrillation: Pediatrics
Drug administration - intravenous: Pediatrics
Drug administration - intra-arterial: Pediatrics
Endotracheal suctioning: Pediatrics
Endotracheal/nasotracheal intubation: Pediatrics
Foley catheter - insert and remove: Pediatrics
Gastric lavage: Pediatrics
Incision and drainage, abscess/fluid collection/cyst: Pediatrics
Laceration repair: Pediatrics
Laryngoscopy: Pediatrics
Lumbar puncture: Pediatrics
NG tube - insert and remove: Pediatrics
Other wound care - not debridement (change/replace dressing; clean): Pediatrics
Perform/interpret lab tests (spin Hct/do, UA/EKG/gram stain/peripheral smear/etc): Pediatrics
Phlebotomy - including blood cultures: Pediatrics
Cardioversion: Pediatrics
Remove foreign body: Pediatrics
Sutures/staples - insert and remove: Pediatrics
Umbilical artery catheter - insert and remove: Pediatrics
Intraosseus line placement and infusion: Pediatrics

Addendum #2: Signed Program Letter of Agreement between UCSF PHM Fellowship and WHHS Site Director



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Hematology/Oncology
Hospital Medicine
Infectious Diseases
Medical Education
Neonatology
Nephrology
Pulmonology
Rheumatology

Program Letter of Agreement (PLA) for Education

Date: 7/1/19

UCSF Program: UCSF Pediatric Hospital Medicine Fellowship Training Program

Affiliate Site: Washington Hospital Healthcare System (Fremont, CA)

This agreement between the UCSF program director and the site director defines specific educational elements to comply with the general essentials for medical education. This agreement does not take precedence over legal affiliation contracts.

1. Sohil Sud, MD is the faculty site director who assumes administrative, educational, and supervisory responsibilities for the fellows during the rotation.

2. Education goals and objectives for the rotation have been written and distributed to the faculty and trainees and have been uploaded to the GME accreditation database.

3. Length of Rotation: longitudinal over fellowship, but primary clinical work at WHHS is concentrated in one 3-month block per year of fellowship.

4. The site director is responsible for teaching, supervision, and evaluation of the fellow's performance during the rotations.

5. The UCSF housestaff information booklet governs the policies and procedures for the fellow's education during rotations. Each housestaff member and site director receive this booklet as part of their orientation. The housestaff information booklet is available at http://medschool.ucsf.edu/gme/.

6. This letter of agreement is valid for ten academic years (per ACGME Common Program Requirements), from 7/1/19 to 6/30/29, unless otherwise modified.

Program Director's signature	Site Director's signature
Darren Fiore, MD	Sohil Sud, MD
Program Director's name	Site Director's name
darren.fiore@ucsf.edu	Sohil.Sud@ucsf.edu
Program Director's email	Site Director's email

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: November 16, 2020

TO: Kimberly Hartz, Chief Executive Officer

FROM: Prasad Kilaru, MD, Chief of Staff

SUBJECT: MEC for Board Approval:

The Medical Executive Committee, at its meeting of November 16, 2020, approved the Standardized Procedure: Rapid Response Team Care Initiated by the Certified Registered Nurse.

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval of the attached Standardized Procedure: Rapid Response Team Care Initiated by the Certified Registered Nurse.

WASHINGTON HOSPTIAL
PATIENT CARE SERVICES DIVISION

STANDARDIZED PROCEDURE FOR
RAPID RESPONSE TEAM CARE INITIATED BY THE CERTIFIED REGISTERED NURSE

I. POLICY

A. Procedure To Be Performed:

1. Standardized procedure for ordering diagnostic tests, medication administration, and initiating care to med/surg patients with Rapid Response Team (RRT) calls. This is urgent care provided while waiting for a call back form the attending physician.
2. Ordering diagnostic tests, medication administration limited to oxygen, hypoglycemia treatment medications~~50% dextrose~~, Albuterol, Naloxone, 0.9% Sodium Chloride (NS), and initiating urgent care to patients seen by the RRT (i.e. sitting the patient up, suctioning the patient, administering pain medication, etc.).

B. Responsible Party:

The Rapid Response RN and Critical Care Charge RN must complete all competencies related to these procedures.

In the event when the Rapid Response Nurse is unable to respond to the call, the Critical Care Charge RN will help respond to the call.

C. Supervision:

1. The Rapid Response Team Committee will review RRT interventions.
2. The attending physician will supervise all care after notified..

D. Conditions for Physician Consultation:

The attending physician will be notified on all RRT calls where procedures outlined in this protocol are employed. Interventions by the RRT are only made when urgent response is needed per RRT assessment based on this standardized procedure (see Addendum D).

E. Review Process:

1. QI monitoring is ongoing ~~in the monthly~~ with six charts per quarter. ~~RRT Committee Meetings~~.
2. Review will be conducted annually involving the Department of Nursing, Administration, and Interdisciplinary Practice Committee.

II. PROTOCOL

A. Purpose/Definition:

To allow designated Rapid Response Team RNs to order diagnostic tests, medication, and initiate care.

B. Patient Selection Criteria: For Protocol use

Chest Pain presumed cardiac in nature (RRT)
Altered Level of Consciousness (ALOC) presumed secondary to hypoglycemia or narcotics
Hypotension
Respiratory Distress / Failure
~~Deterioration of patient's condition~~
Signs/Symptoms of Acute Stroke
Signs /Symptoms of Sepsis

C. Documentation:

Nurse initiated diagnostic ordering, medications, and/or initial care will be documented in the Rapid Response Team Record.

III. QUALIFICATIONS AND EVALUATION

A. Requirements:

1. RN with active State of California License.
2. Washington Hospital Healthcare System employee.
3. RN is BLS and ACLS certified.
4. Stroke nurse or experienced critical care nurse.

B. Initial Evaluation:

Selected RNs will be precepted on two (2) Rapid Response Team calls by an RRT nurse.

C. Ongoing Evaluation:

RRT cases will be reviewed by the RRT Committee during monthly meetings. Activity and outcomes will be recorded in committee minutes.

APPROVAL/REVIEW/REVISION: 4/08; Reviewed 5/09; 5/10; 3/11; 2/12; Revised 8/12; 03/13; Reviewed 01/14; Reviewed 09/16; Approved by Interdisciplinary 04/11/17, Critical Care Committee 04/18/17, and PNT 04/20/17

REFERENCES:

1. Antonelli, M., D'Arrigo, S., & Sandroni, C. (2015). Rapid response systems: are they really effective?. *Critical Care*, March 2015, Vol. 19 no. 104, Retrieved from https://ccforum.biomedcentral.com/articles/10.1186/s13054-015-0807-y
2. Shimemeri, A. (2014). Implementation of critical care response team. *International Journal of Critical Illness and Injury Science*, April-June, 2014, Vol. 4 no. 2, Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4093966/
3. Francis, H., Mitchell, A., & Schantz, M. (2014). Designing a Critical Care Nurse-Led Rapid Response Team Using Only Available Resources: 6 Years Later. *Critical Care Nurse*, June 2014, Vol. 34 no. 3, Retrieved from http://ccn.aacnjournals.org/content/34/3/41.full
4. Burg, M., & Sebat, F. (2010). Taking Your Rapid Response Team to the Next Level. *Society of Critical Care Medicine*, December 2010, Retrieved from http://www.sccm.org/Communications/Critical-Connections/Archives/Pages/Taking-Your-Rapid-Response-Team-to-the-Next-Level.aspx
5. Institute for Clinical System Improvement, (2011). Health Care Protocol: Rapid Response Team. Fourth Edition, Retrieved from https://www.icsi.org/_asset/8snj28/RRT.pdf

ADDENDUM A

RAPID RESPONSE TEAM INITIATED CARE BY THE AUTHORIZED RN EDUCATIONAL COMPONENT

Objectives

Upon completion of this class/module the RN will be able to:

1. Describe the policy detailing patient selection criteria for ordering diagnostic tests, medication administration, and initiating care on the Med/Surg units during RRT calls.

2. List patient selection criteria, contraindications, and appropriate diagnostic test/intervention per identified patient complaint/symptom:

    - Chest Pain presumed cardiac in nature (RRT)
    - Altered Level of Consciousness (ALOC) presumed secondary to hypoglycemia or narcotics
    - Hypotension
    - Respiratory Distress/Failure
    - Deteriorating of patient's condition
    - Signs/Symptoms of Acute Stroke
    - Signs/Symptoms of Sepsis

Outline

1. Policy/Patient Selection

2. Procedure

3. Documentation

4. Skill validation

5. Quality Improvement

ADDENDUM B

STANDARDIZED PROCEDURE SKILL VALIDATION

NAME/TITLE:_____ **DATE:**_____ **UNIT:**_____

TITLE: Ordering Diagnostic Tests, Medication Administration, & Initiating Care in Rapid Response Calls.

SKILL VALIDATION: Demonstrates ability to initiate care for identified patients according to the standardized procedure and protocol.

CRITERIA	***COMMENTS (only if participant needs additional assistance)**
1. Reviews standardized procedure for ordering diagnostic tests, medication administration, and initiating care in Rapid Response Team calls.	
2. Utilizes patient history and physical findings to initiate appropriate care according to chief complaint and specific protocol. • Chest Pain presumed cardiac in nature (RRT) • ALOC presumed secondary to hypoglycemia • Hypotension • Respiratory Distress / Failure • Signs/Symptoms Acute Stroke • Signs/ Symptoms of Sepsis	
3. Notifies attending physician on all RRT calls where standardized procedures are employed.	
4. Documents interventions in the Rapid Response Team Record.	

Evaluation Method Codes: ☐ Observation ☐ Module ☐ Test ☐ Return Demonstration ☐ Computer

Standard Met: ☐ **Yes** ☐ **No, needs additional assistance – see comments above***

Instructor Signature: _____ **Date:** _____

Employee Signature: _____ **Date:** _____

ADDENDUM C

QUALITY IMPROVEMENT DATA COLLECTION

Protocol implemented:

- ☐ Chest Pain Presumed Cardiac in Nature (RRT)
- ☐ ALOC Presumed Secondary to Hypoglycemia/Adverse Reaction to Narcotics
- ☐ Hypotension
- ☐ Respiratory Distress/Failure
- ☐ Signs/Symptoms of Acute Stroke
- ☐ Signs/ Symptoms of Sepsis

Rapid Response Committee's evaluation of the interventions:

1. Patient selection by RRT meets established hospital criteria?
   ☐ yes ☐ no Comments: _____
   _____

2. Appropriate care initiated per protocol?
   ☐ yes ☐ no Comments: _____
   _____

~~3. Complications / difficulties encountered?~~
~~☐ yes ☐ no Comments: _____~~
_____

4.3 Required documentation entered on RRT Record?
☐ yes ☐ no Comments: _____
_____

RRT Committee member signature: _____

~~**The RRT nurse will attach this sheet to a legible copy of the Rapid Response Record and return it to the Stroke Coordinator mailbox when any of the above measures are initiated.**~~

Patient ID Sticker

ADDENDUM D

PATIENT CARE PROTOCOLS FOR THE RAPID RESPONSE RN

PROTOCOL: Chest Pain Presumed Cardiac in Nature (RRT)

A. Purpose/Definition

To allow designated RNs to initiate diagnostic studies and or initiate care prior to physician contact.

B. Supportive Data

This protocol pertains to those nurses that have completed the competency for this standardized procedure.

C. Data Base

1. Patients with chest pain or discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back; with or without radiation to the left arm, neck, or jaw; described as an uncomfortable pressure, squeezing, fullness, heaviness, crushing, tightness, burning, or pain and may occur at rest or with activity. Patients may have associated symptoms of shortness of breath, diaphoresis, nausea, pallor, syncope, and/or palpitations.
2. Males > 40 with epigastric discomfort.
3. Females > 50 with epigastric discomfort.
4. Patients with a cardiac history & chest discomfort.
5. Other signs may include breaking out in a cold sweat, syncope, pallor, nausea or lightheadedness.
6. Women, diabetics, and the elderly are more likely to have atypical symptoms with vague complaints, such as weakness, shortness of breath lightheadedness, nausea/vomiting, and back or jaw pain.

D. Patient Management

1. Obtain STAT EKG and be ready to fax to the attending MD or show to the MD on arrival to the bedside.
2. Assist patient's nurse with the administration of medications for chest pain that have been ordered.
3. Oxygen by cannula or mask to keep O_2 Saturation > 92%.

E. Documentation

1. Patient symptoms justifying protocol implementation.
2. Diagnostic tests ordered.
3. Treatment administered.

ADDENDUM D (Cont.)

PATIENT CARE PROTOCOLS FOR THE RAPID RESPONSE RN

PROTOCOL: ALOC Presumed Secondary to Hypoglycemia or Narcotics

A. Purpose/Definition

1. To allow designated RNs to perform Finger Stick Blood Sugar (FSBS) and administer hypoglycemia treatment medications ~~50ml 50% Dextrose (D50W)~~ per H~~h~~ypoglycemia protocol/algorithm.
2. To reverse narcotics with Naloxone Hydrochloride.

B. Supportive Data

This protocol refers to nurses who have completed the skills validation for these procedures and the skills validation for Sure Step Glucometer Bedside Testing.

C. Patient Selection

1. History of diabetes mellitus or hypoglycemia.
2. History of taking any form of serum glucose lowering medications.
3. Recent history of acute liver dysfunction.
4. History of having received narcotics.

D. Patient Management

1. In symptomatic patients (confused, somnolent, extreme weakness, diaphoresis, unresponsive) ~~and~~ after proper assessment, perform FSBS bedside testing.
2. If patient is symptomatic (confused, somnolent, extreme weakness, diaphoresis, unresponsive) ~~administer D50W 50 ml IV~~ follow the intervention per Hypoglycemia protocol/ algorithm attached below .

~~2. .~~

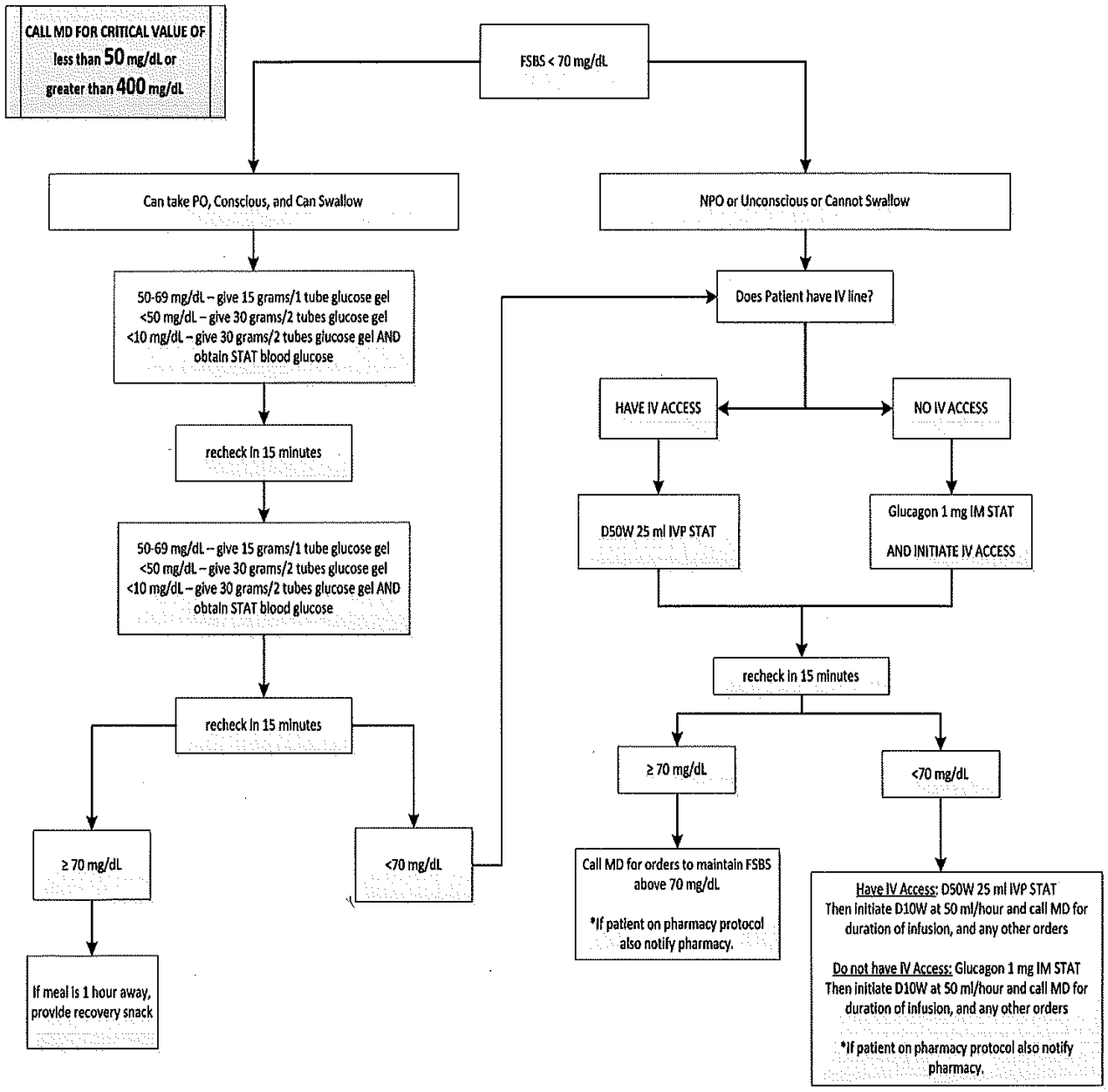
3. In cases where there is an adverse ~~a~~effect from narcotics, administer ~~0.4~~ 0.2 ~~mg~~ Naloxone Hydrochloride 0.2 mg IV once.

E. Documentation

1. Document FSBS pre and post administration of hypoglycemia treatment medications. ~~D50W.~~
2. Document patient response to treatment on the Rapid Response Team Record.

ADDENDUM A

HYPOGLYCEMIA ALGORITHM



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ADDENDUM D (Cont.)

PATIENT CARE PROTOCOLS FOR THE RAPID RESPONSE RN

PROTOCOL: Hypotension

A. Purpose/Definition

1. To allow designated RNs to administer an IV fluid bolus to urgently treat symptomatic hypotension until the attending MD can be contacted for further orders.

B. Supportive Data

1. This protocol pertains to those nurses who have completed the skills validation for this standardized procedure.

C. Data Base (Patient Selection)

For adult patients with symptomatic hypotension.

Symptoms:

- Lightheadedness
- Chest pain
- Anxiety
- Pallor
- Diaphoresis
- Tachycardia

D. Management of Hypotension

After proper patient assessment, and in absence of congestive heart failure (distended neck veins, crackles in the lungs, shortness of breath, etc.), a 250 ml IV bolus of 0.9% Sodium Chloride (NS) ~~Normal Saline of~~ is administered over 15 minutes. May repeat once in 15 minutes ~~times one (1)~~, if needed.

E. Documentation

The RRT shall document:

1. Indications for fluid bolus.
2. Amount of fluid administered.
3. E~~A~~ffect of treatment.

ADDENDUM D (Cont.)

PATIENT CARE PROTOCOLS FOR THE RAPID RESPONSE RN

PROTOCOL: Respiratory Distress/Failure

A. Purpose/Definition

To allow designated RNs and Respiratory Therapists (RTs) to draw a radial or brachial arterial blood gas (ABG); administer oxygen by cannula or mask; and to administer a breathing treatment to reduce wheezing.

B. Supportive Data

This protocol pertains to those RNs and RTs who have completed the skills validation for this standardized procedure.

C. Data Base (Patient Selection)

For adult patients with rapid respiratory rate > 24/min.; oxygen saturation < 92%; cyanosis, feeling of anxiety, shortness of breath, wheezing, etc., or for signs of inadequate ventilation.

Review patient history for possible diagnosis of Congestive Heart Ff~~,~~ailure or Pneumonia.

D. Patient Management

1. Provide oxygen by cannula or mask to improve the oxygenation of patients exhibiting shortness of breath or appearing cyanotic.
2. Respiratory Therapist will draw ABG in patients where ventilatory status is in question.
3. Administer Albuterol 2.5 mg via nebulizer once for wheezing that leads to respiratory distress.

E. Documentation

Documentation of oxygen saturation, respiratory rate, level of oxygen support, ABG results, effect of nebulizer treatment, and signs of patient improvement with treatment are entered into the Rapid Response Team Record.

ADDENDUM D (Cont.)

PATIENT CARE PROTOCOLS FOR THE RAPID RESPONSE RN

PROTOCOL: Signs/Symptoms of Acute Stroke

A. Purpose/Definition

To allow designated RNs trained to recognize acute stroke to order and facilitate a STAT non-contrast CT of the Brain for Stroke. This quick response will help assure optimal timing vital for the best acute stroke outcomes.

B. Supportive Data

This protocol pertains to those RNs who have completed the skills validation for this standardized procedure.

C. Data Base (Patient Selection)

For adult patients demonstrating acute symptom onset as determined from an NIH Stroke Scale evaluation. Time "last seen normal" should be within the previous 24 hours.

D. Patient Management

1. Assure the order for "STAT non-contrast CT of ~~of~~ the Brain for Stroke" is entered into the computerized order-entry system.
2. Notify CT scan tech and quickly assist with patient transport to CT scan.
3. Follow-up with official radiologist/Nighthawk reading of the scan. Provide the result to the attending physician and obtain appropriate orders based on findings.

E. Documentation

Documentation of NIHSS exam results, narrative evaluation, and attending physician's orders for stroke treatment going forward are entered electronically into the Rapid Response Team Record.

ADDENDUM D (Cont.)

PATIENT CARE PROTOCOLS FOR THE RAPID RESPONSE RN

PROTOCOL: Signs/Symptoms of Sepsis

A. Purpose/Definition

To allow designated RN's to recognize the early signs and symptoms of sepsis and facilitate early-goal directed therapy and management of patients by ordering STAT-blood tests, imaging, and medications. Patients will be closely monitored, and the attending physician will be contacted expeditiously for further orders.

B. Supportive Data

This protocol pertains to those RNs who have completed the skills validation for this standardized procedure.

C. Data Base (Patient Selection)

For adult patients, early signs/symptoms of sepsis may be characterized by hemodynamic changes and a profound inflammatory response to an infection or injury. Systemic inflammatory response syndrome (SIRS) is a widespread inflammatory response to a variety of infectious and non-infectious bodily insults. SIRS is clinically defined by the presence of 2 or more of the following signs:

- Body temperature >38.3° C or < 36.0° C (>100.9F or 96.8F)
- Heart rate >90 beats per minute
- Respiratory rate >20 breaths per minute
- White blood cell count > 12,000/mm^3 or < 4,000/mm^3 or bands > 10%

In Sepsis, the clinical signs of SIRS are present together with definitive or highly suspected evidence of infection. Sepsis is considered severe when it is associated with any one or more of the following signs of organ dysfunction:

- Systolic blood pressure (SBP) <90 mmHg or mean arterial pressure<65 mmHg
- Acute respiratory failure as evidenced by a new need for invasive or non-invasive mechanical ventilation
- Creatinine >2 mg/dL (exclude ESRD)
- Urine output <0.5 mL/kg/hour for two (2) consecutive hours
- Total Bilirubin >2 mg/dL
- Platelet count <100,000
- Lactate > 2 mmol/L
- INR > 1.5 or aPTT > 60 sec (exclude if on anticoagulants)

D. Patient Management

After comprehensive assessment and identification of patients with sepsis

- Initiate monitoring for: assess airway, breathing and circulation.
- Obtain laboratory tests and imaging to aid in determining severity of illness and to potentially identify a source of infection. These may include but are not limited to:
  - CBC with Auto differential
  - Lactic acid with auto reflex (if initial value >2 mmol/L)
  - Comprehensive Metabolic Panel
  - Urinalysis with Microscopic, Culture if indicated
  - Blood Cultures x2 prior to antibiotic therapy
  - Coagulation studies/panel
  - Chest X-ray, ABG if indicated by the attending physician

- Initiate goal-directed therapy:
  - Ensure patients has large bore IV placement.
  - Initiate fluid resuscitation with 0.9 % Sodium Chloride (NS) bolus of 500 mL administered over 15 minutes if SBP is less than 90 mmHg or Lactic acid is > 4 mmol/L. Administer one bolus of 500 mL then contact the attending physician for further recommended fluid bolus order (to infuse the remaining 30 mL/kg of crystalloid fluid.
  - The attending physician will be updated regarding patient status and for further orders.
  - Initiate broad spectrum antibiotic therapy as directed by the attending physician, after blood cultures are obtained.

E. Documentation

Documentation of patient assessment and interventions including vital signs, oxygen requirements, ABG results (if indicated), notation of abnormal blood test results, amount of fluid bolus if administered and signs of patient stabilization or deterioration.

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: November 16, 2020

TO: Kimberly Hartz, Chief Executive Officer

FROM: Prasad Kilaru, MD, Chief of Staff

SUBJECT: MEC for Board Approval:

The Medical Executive Committee, at its meeting of November 16, 2020, approved the NEW: Standardized Procedure: RSTU COVID-19 Nurse Initiated Protocol.

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval of the attached NEW: Standardized Procedure: RSTU COVID-19 Nurse Initiated Protocol.

PROTOCOL: RSTU COVID-19 Nurse Initiated Protocol

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1. Purpose/Definition

The purpose of this Nurse Initiated Protocol is to provide nurses with guidelines to allow for ordering a COVID test prior to the provider interaction:

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Guidelines will allow nurses to:

1) Screen and identify patients who meet criteria for specimen collection of COVID-19 swab;

2) Order the corresponding lab; and

3) Facilitate collection of the COVID-19 specimen by established nursing and lab protocols.

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2. Supportive Data

All patients will receive a medical screening exam by the provided whether the RN orders the COVID-19 test or not.

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Provide for safe and consistent identification and care of COVID-19 patients during evaluation and collection of the nasopharyngeal specimens for testing.

Registered Nurses, within their scope of practice, will have the authority to enact the Nurse Initiated protocol for COVID-19 Screening and Specimen Collection for patients who meet the inclusion criteria in RSTU upon completing the educational component of the standardized procedure.

COVID precautions will be implemented on all suspected/ confirmed cases of COVID-19.

For additional information, refer to the Infection Control Numbered Memorandums.

3. Data Base (Patient Selection Criteria)

Initiate screening:

1) All patients who present to the ED will receive screening for COVID-19. Based on the following criteria, the nurse may initiate the corresponding COVID swab orders.

Inclusion Criteria for RSTU COVID-19 NIP:

1. Age >1 year old and
2. Direct exposure with a person with suspected or confirmed positive COVID-19 result within-the previous 14 days or
3. Presence of one or more of the following symptoms:

- Fever or chills

- Cough
- Fatigue
- Muscle or body aches
- Headache
- New loss of smell or taste
- Sore throat
- Congestion or runny nose
- Nausea

Exclusion Criteria for RSTU COVID-19 NIP:

1. Short of breath/difficulty breathing
2. Diarrhea
3. Vomiting
4. Patients displaying disruptive behavior Unstable Vial Signs
5. Immunocompromised patients
6. Unaccompanied minors

Special Considerations requiring provider consultation before ordering:

1. Travel screening
2. Screenings for emergent procedures that are not treatable at WHHS such as dental abscesses and other referrals for treatment.

D. Patient Management

1. Order SARS-COV-2 RNA by PCR lab test corresponding to current lab recommendation
2. Obtain nasopharyngeal swab specimen
3. Label and send specimen to lab

E. Patient Teaching

Reinforce home isolation instructions per Alameda County Public Health Officer.

F. Documentation

1. Patient symptoms
2. Collection of sample
3. Isolation instructions with patient acknowledgement

References:

Centers for Disease Control and Prevention. (2020). Symptoms of Coronavirus Infection. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html on 5/13/2020

Health Officer Order for the Control of COVID-19 No.20-05c. Public Health Emergency Isolation Order, June 8, 2020.

Washington Hospital Healthcare System
SINCE 1948

Memorandum

DATE: **December 7, 2020**

TO: Kimberly Hartz, Chief Executive Officer

FROM: Ed Fayen, Executive Vice President & Chief Operations Officer

SUBJECT: Purchase of Continuous Cardiac Output Monitors

We currently own four 10 year old cardiac output monitors from Edwards Life Sciences. The end of the support of these devices was December 31, 2018. We have been supporting these monitors in-house since then.

When Morris Hyman was opened, one additional Edwards Life Sciences cardiac output monitor was purchased. Due to it being a different model than our current inventory, it has not been utilized. We want to purchase two more of the same, newer model of cardiac output monitors, so that we can replace the four 10 year old monitors that are no longer supported.

Cardiac output monitors measure the volume of blood pumped from the heart and provide vital information about the overall cardiac status and quality of tissue perfusion. It is utilized in the operating room, Cath Lab, and critical care units.

We budgeted $131,945.00 to purchase two additional Edwards Life Sciences Advanced Cardiac Monitoring Systems.

In accordance with District Law, Policies and Procedures, it is requested that the Board of Directors authorize the Chief Executive Officer to proceed with the contracts and purchase orders necessary to purchase two Edwards Life Sciences Hemosphere Continuous Output Cardiac Monitors for an amount not to exceed $131,945.00.

Washington Hospital Healthcare System

WASHINGTON HOSPITAL

MONTHLY OPERATING REPORT

October 2020

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
INDEX TO BOARD FINANCIAL STATEMENTS
October 2020

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: December 3, 2020

TO: Board of Directors

FROM: Kimberly Hartz, Chief Executive Officer

SUBJECT: Washington Hospital – October 2020 Operating & Financial Activity

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SUMMARY OF OPERATIONS – (Blue Schedules)

1. **Utilization – Schedule Board 3**

	October Actual	October Budget	Current 12 Month Avg.
ACUTE INPATIENT:			
Average Daily Census	133.4	131.9	143.5
# of Admissions	732	836	830
Patient Days	4,135	4,089	4,376
Discharge ALOS	5.16	4.89	5.15
OUTPATIENT:			
OP Visits	7,912	7,580	6,579
ER Visits, excluding RSTU	3,530	3,903	3,661
RSTU visits	1,894	2,122	1,015
Observation Equivalent Days – OP	193	173	178

Comparison of October acute inpatient statistics to those of the budget showed a lower level of admissions and a higher level of patient days. The average length of stay (ALOS) based on discharged days was above budget. Outpatient visits were higher than budget. Emergency Room visits and RSTU visits were both below budget for the month.

2. **Staffing – Schedule Board 3**

Total paid FTEs were 89.2 above budget. Total productive FTEs for October were 1,310.8, 99.0 above the budgeted level of 1,211.8. Nonproductive FTEs were 9.8 below budget. Productive FTEs per adjusted occupied bed were 6.14, 0.44 above the budgeted level of 5.70. Total FTEs per adjusted occupied bed were 6.82, 0.39 above the budgeted level of 6.43.

3. **Income - Schedule Board 1**

For the month of October the Hospital realized a loss of $2,889,000 from operations.

Total Gross Patient Service Revenue of $173,664,000 for October was 4.6% above budget.

Deductions from Revenue of $135,268,000 represented 77.89% of Total Gross Patient Service Revenue. This percentage is above the budgeted amount of 77.55% primarily due to payor mix.

Total Operating Revenue of $38,728,000 was $1,116,000 (3.0%) above the budget.

Total Operating Expense of $41,617,000 was $2,696,000 (6.9%) above the budgeted amount.

The Total Non-Operating Loss of $350,000 for the month includes an unrealized loss on investments of $429,000 and property tax revenue of $1,447,000.

The Total Net Loss for October was $3,239,000, which was $2,016,000 more than the budgeted loss of $1,223,000.

The Total Net Loss for October using FASB accounting principles, in which the unrealized loss or income on investments, net interest expense on GO bonds and property tax revenues are removed from the non-operating income and expense, was $3,113,000 compared to a budgeted loss of $1,499,000.

4. **Balance Sheet – Schedule Board 2**

There were no noteworthy changes in assets and liabilities when compared to September 2020.

KIMBERLY HARTZ
Chief Executive Officer

KH/CH

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
October 2020
GASB FORMAT
(In thousands)

October						YEAR TO DATE			
ACTUAL	BUDGET	FAV (UNFAV) VAR	% VAR.			ACTUAL	BUDGET	FAV (UNFAV) VAR	% VAR.
					OPERATING REVENUE				
$ 108,443	$ 102,926	$ 5,517	5.4%	1	INPATIENT REVENUE	$ 454,813	$ 421,597	$ 33,216	7.9%
65,221	63,112	2,109	3.3%	2	OUTPATIENT REVENUE	244,024	244,973	(949)	-0.4%
173,664	**166,038**	**7,626**	4.6%	3	**TOTAL PATIENT REVENUE**	**698,837**	**666,570**	**32,267**	4.8%
(132,607)	(125,361)	(7,246)	-5.8%	4	CONTRACTUAL ALLOWANCES	(530,554)	(502,257)	(28,297)	-5.6%
(2,661)	(3,401)	740	21.8%	5	PROVISION FOR DOUBTFUL ACCOUNTS	(14,230)	(13,654)	(576)	-4.2%
(135,268)	**(128,762)**	**(6,506)**	-5.1%	6	**DEDUCTIONS FROM REVENUE**	**(544,784)**	**(515,911)**	**(28,873)**	-5.6%
77.89%	**77.55%**			7	**DEDUCTIONS AS % OF REVENUE**	**77.96%**	**77.40%**		
38,396	**37,276**	**1,120**	3.0%	8	**NET PATIENT REVENUE**	**154,053**	**150,659**	**3,394**	2.3%
332	336	(4)	-1.2%	9	OTHER OPERATING INCOME	1,194	1,345	(151)	-11.2%
38,728	**37,612**	**1,116**	3.0%	10	**TOTAL OPERATING REVENUE**	**155,247**	**152,004**	**3,243**	2.1%
					OPERATING EXPENSES				
18,231	16,914	(1,317)	-7.8%	11	SALARIES & WAGES	75,967	67,525	(8,442)	-12.5%
7,244	6,336	(908)	-14.3%	12	EMPLOYEE BENEFITS	27,250	25,823	(1,427)	-5.5%
5,554	4,993	(561)	-11.2%	13	SUPPLIES	21,162	20,318	(844)	-4.2%
4,714	4,855	141	2.9%	14	PURCHASED SERVICES & PROF FEES	19,247	19,003	(244)	-1.3%
1,855	1,804	(51)	-2.8%	15	INSURANCE, UTILITIES & OTHER	7,204	6,884	(320)	-4.6%
4,019	4,019	-	0.0%	16	DEPRECIATION	16,025	16,025	-	0.0%
41,617	**38,921**	**(2,696)**	-6.9%	17	**TOTAL OPERATING EXPENSE**	**166,855**	**155,578**	**(11,277)**	-7.2%
(2,889)	**(1,309)**	**(1,580)**	-120.7%	18	**OPERATING INCOME (LOSS)**	**(11,608)**	**(3,574)**	**(8,034)**	-224.8%
-7.46%	**-3.48%**			19	**OPERATING INCOME MARGIN %**	**-7.48%**	**-2.35%**		
					NON-OPERATING INCOME & (EXPENSE)				
290	316	(26)	-8.2%	20	INVESTMENT INCOME	1,232	1,265	(33)	-2.6%
28	-	28	0.0%	21	REALIZED GAIN/(LOSS) ON INVESTMENTS	86	-	86	0.0%
(1,849)	(1,912)	63	3.3%	22	INTEREST EXPENSE	(7,413)	(7,684)	271	3.5%
163	278	(115)	-41.4%	23	RENTAL INCOME, NET	658	1,088	(430)	-39.5%
-	(39)	39	100.0%	24	BOND ISSUANCE COSTS	-	(155)	155	100.0%
-		-	0.0%	25	FEDERAL GRANT REVENUE	1,069	-	1,069	0.0%
1,447	1,443	4	0.3%	26	PROPERTY TAX REVENUE	5,741	5,772	(31)	-0.5%
(429)	-	(429)	0.0%	27	UNREALIZED GAIN/(LOSS) ON INVESTMENTS	(509)	-	(509)	0.0%
(350)	**86**	**(436)**	-507.0%	28	**TOTAL NON-OPERATING INCOME & EXPENSE**	**864**	**286**	**578**	202.1%
$ (3,239)	**$ (1,223)**	**$ (2,016)**	-164.8%	29	**NET INCOME (LOSS)**	**$ (10,744)**	**$ (3,288)**	**$ (7,456)**	-226.8%
-8.36%	**-3.25%**			30	**NET INCOME MARGIN %**	**-6.92%**	**-2.16%**		
$ (3,113)	**$ (1,499)**	**$ (1,614)**	-107.7%	31	**NET INCOME (LOSS) USING FASB PRINCIPLES****	**$ (11,399)**	**$ (4,379)**	**$ (7,020)**	-160.3%
-8.04%	**-3.99%**				**NET INCOME MARGIN %**	**-7.34%**	**-2.88%**		

******NET INCOME (FASB FORMAT) EXCLUDES PROPERTY TAX INCOME, NET INTEREST EXPENSE ON GO BONDS AND UNREALIZED GAIN(LOSS) ON INVESTMENTS

SCHEDULE BOARD 2

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
BALANCE SHEET
October 2020
(In thousands)

	ASSETS AND DEFERRED OUTFLOWS	October 2020	Audited June 2020
	CURRENT ASSETS		
1	CASH & CASH EQUIVALENTS	$ 44,237	$ 68,355
2	ACCOUNTS REC NET OF ALLOWANCES	70,643	61,017
3	OTHER CURRENT ASSETS	13,462	12,523
4	TOTAL CURRENT ASSETS	128,342	141,895
	ASSETS LIMITED AS TO USE		
6	BOARD DESIGNATED FOR CAPITAL AND OTHER	215,661	214,744
7	REVENUE BOND FUNDS	10,874	10,923
8	BOND DEBT SERVICE FUNDS	10,471	31,387
9	OTHER ASSETS LIMITED AS TO USE	10,132	10,155
10	**TOTAL ASSETS LIMITED AS TO USE**	247,138	267,209
12	**OTHER ASSETS**	235,242	222,268
13	**OTHER INVESTMENTS**	11,748	11,679
14	**NET PROPERTY, PLANT & EQUIPMENT**	667,120	684,274
15	**TOTAL ASSETS**	**$ 1,289,590**	**$ 1,327,325**
16	**DEFERRED OUTFLOWS**	49,075	62,304
17	**TOTAL ASSETS AND DEFERRED OUTFLOWS**	**$ 1,338,665**	**$ 1,389,629**

	LIABILITIES, NET POSITION AND DEFERRED INFLOWS	October 2020	Audited June 2020
	CURRENT LIABILITIES		
1	CURRENT MATURITIES OF L/T OBLIG	$ 9,920	$ 9,500
2	ACCOUNTS PAYABLE	15,863	18,669
3	OTHER ACCRUED LIABILITIES	110,571	116,193
4	INTEREST	6,954	11,247
5	TOTAL CURRENT LIABILITIES	143,308	155,609
	LONG-TERM DEBT OBLIGATIONS		
6	REVENUE BONDS AND OTHER	216,352	223,881
7	GENERAL OBLIGATION BONDS	328,989	331,992
	OTHER LIABILITIES		
10	NET PENSION LIABILITY	22,083	31,798
11	SUPPLEMENTAL MEDICAL RETIREMENT	41,064	42,578
12	WORKERS' COMP AND OTHER	8,594	8,440
14	**NET POSITION**	521,090	531,834
15	**TOTAL LIABILITIES AND NET POSITION**	**$ 1,281,480**	**$ 1,326,132**
16	**DEFERRED INFLOWS**	57,185	63,497
17	**TOTAL LIABILITIES, NET POSITION AND DEFERRED INFLOWS**	**$ 1,338,665**	**$ 1,389,629**

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
OPERATING INDICATORS
October 2020

12 MONTH AVERAGE	October ACTUAL	October BUDGET	October FAV (UNFAV) VAR	October % VAR.			YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE FAV (UNFAV) VAR	YEAR TO DATE % VAR.
						PATIENTS IN HOSPITAL				
143.5	133.4	131.9	1.5	1%	**1**	ADULT & PEDS AVERAGE DAILY CENSUS	149.9	137.8	12.1	9%
5.8	6.2	5.6	0.6	11%	**2**	OUTPT OBSERVATION AVERAGE DAILY CENSUS	6.2	5.4	0.8	15%
7.9	7.1	8.9	(1.8)	-20%	**3**	NURSERY AVERAGE DAILY CENSUS	7.6	9.4	(1.8)	-19%
157.2	146.7	146.4	0.3	0%	**4**	TOTAL	163.7	152.6	11.1	7%
3.5	2.0	3.3	(1.3)	-39%	**5**	SPECIAL CARE NURSERY AVERAGE DAILY CENSUS *	3.0	3.5	(0.5)	-14%
4,376	4,135	4,089	46	1%	**6**	ADULT & PEDS PATIENT DAYS	18,432	16,953	1,479	9%
178	193	173	20	12%	**7**	OBSERVATION EQUIVALENT DAYS - OP	764	667	97	15%
830	732	836	(104)	-12%	**8**	ADMISSIONS-ADULTS & PEDS	3,204	3,440	(236)	-7%
5.15	5.16	4.89	0.27	6%	**9**	AVERAGE LENGTH OF STAY-ADULTS & PEDS	5.63	4.93	0.70	14%
						OTHER KEY UTILIZATION STATISTICS				
1.532	1.578	1.456	0.122	8%	**10**	OVERALL CASE MIX INDEX (CMI)	1.630	1.484	0.146	10%
						SURGICAL CASES				
140	158	159	(1)	-1%	**11**	JOINT REPLACEMENT CASES	592	649	(57)	-9%
22	28	22	6	27%	**12**	NEUROSURGICAL CASES	102	82	20	24%
9	13	10	3	30%	**13**	CARDIAC SURGICAL CASES	36	41	(5)	-12%
172	182	183	(1)	-1%	**14**	ALL OTHERS	723	751	(28)	-4%
343	381	374	7	2%	**15**	TOTAL CASES	1,453	1,523	(70)	-5%
348	330	360	(30)	-8%	**16**	TOTAL CATH LAB PROCEDURES	1,438	1,448	(10)	-1%
123	115	133	(18)	-14%	**17**	DELIVERIES	482	559	(77)	-14%
6,579	7,912	7,580	332	4%	**18**	OUTPATIENT VISITS	29,045	29,058	(13)	0%
3,661	3,530	3,903	(373)	-10%	**19**	EMERGENCY VISITS, EXCLUDING RSTU VISITS	14,009	15,749	(1,740)	-11%
1,015	1,894	2,122	(228)	-11%	**20**	RSTU VISITS	7,867	8,420	(553)	-7%
						LABOR INDICATORS				
1,302.2	1,310.8	1,211.8	(99.0)	-8%	**21**	PRODUCTIVE FTE'S	1,356.0	1,227.6	(128.4)	-10%
177.4	147.0	156.8	9.8	6%	**22**	NON PRODUCTIVE FTE'S	166.0	180.7	14.7	8%
1,479.6	1,457.8	1,368.6	(89.2)	-7%	**23**	TOTAL FTE'S	1,522.0	1,408.3	(113.7)	-8%
6.09	6.14	5.70	(0.44)	-8%	**24**	PRODUCTIVE FTE/ADJ. OCCUPIED BED	5.89	5.63	(0.26)	-5%
6.93	6.82	6.43	(0.39)	-6%	**25**	TOTAL FTE/ADJ. OCCUPIED BED	6.61	6.46	(0.15)	-2%

* included in Adult and Peds Average Daily Census

Washington Hospital Healthcare System
SINCE 1948

Memorandum

DATE: **December 7, 2020**

TO: Kimberly Hartz, Chief Executive Officer

FROM: Ed Fayen, Executive Vice President & Chief Operations Officer

SUBJECT: Approval of Architectural Fees for the Morris Hyman Critical Care Pavilion Infill Project

On February 12, 2020, the Board approved an amendment to the FY2020 Operating Budget to cover $500,000 worth of architectural fees to start the Morris Hyman Critical Care Pavilion Infill Project. It was about that time the Board also approved moving forward with the Measure XX voter initiative.

With the passing of Measure XX, we would like to move forward with the approval of the entire design fee for the infill projects.

The hospital's construction attorney has approved moving forward with the selection of Ratcliff Architects without putting the work out to bid due to their intimate knowledge of all the mechanical, electrical and structural systems of the existing Morris Hyman Critical Care Pavilion.

We received an original bid from Ratcliff Architects of $7,350,000.00 for the work.

As recommended in the construction attorney's opinion, Washington Hospital then engaged in a negotiating session with Ratcliff Architects and was able to negotiate the fee down to $6,826,657.00. We are recommending that the Board approve these total project fees at this time.

In accordance with District Law, Policies and Procedures, it is requested that the Board of Directors authorize the Chief Executive Officer to proceed with the contracts necessary to complete design services for the Morris Hyman Critical Care Pavilion Infill Project for an amount not to exceed $6,826,657.00.

Washington Hospital Healthcare System

S I N C E 1 9 4 8

Memorandum

DATE: December 3, 2020

TO: Kimberly Hartz, Chief Executive Officer

FROM: Edward Fayen, Executive Vice President & Chief Operating Officer

SUBJECT: **Respiratory Waiting Tent Outside the Emergency Department**

With the Lab assuming responsibility for preop COVID-19 testing, the RSTU will be closed with no defined hours and no prescheduled testing. Asymptomatic COVID-19 exposed patients and symptomatic patients, regardless of their history of exposure, will continue to present themselves to the Emergency Department. Patients presenting to the Emergency Department require a designated respiratory waiting area in order to segregate waiting patients when immediate rooming is not feasible.

With the anticipated surge of COVID-19 patients over the next several months, we need to provide a segregated respiratory waiting area in the main Emergency Department and provide an overflow respiratory waiting area external to the Emergency Department. This area will support an external swabbing station which will allow for more rapid room turnover with fewer terminal cleaning requirements.

Tent rental would cost nearly $22,000.00 for a three-month period and would most likely be needed for more than three months which would incur additional rental fees. A rented tent would also need to be augmented with heating and cooling units..

If purchased, the proposed respiratory tent can be used for surge situations and disasters in the future. It is weather resistant with capacity for heating and cooling, therefore eliminating rental fees for generators. It can be secured and has dividers to provide patient privacy and can accommodate up to sixteen socially-distanced patients. The anticipated delivery window for the tent is three weeks.

This item was not budgeted in this fiscal year. The cost for this item will be covered by the designated COVID-19 monies in the Charitable Foundation.

In accordance with District Law, Policies and Procedures, it is requested that the Board of Directors authorize the Chief Executive Officer to immediately proceed with the purchase of Respiratory Waiting Tent for a total amount not to exceed **$ $71,000.00 plus tax.**