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

Wednesday, April 13, 2022 – 6:00 P.M.
Meeting Conducted by Zoom
https://us06web.zoom.us/j/84943001989?pwd=SnB3SjlyOGMvUiswZ0FMNHU4a3R1UT09
Password: 205492

AGENDA

		PRESENTED BY:
I.	**CALL TO ORDER & PLEDGE OF ALLEGIANCE**	Jeannie Yee Board President
II.	**ROLL CALL**	Dee Antonio District Clerk
III.	**BROWN ACT FINDING** GOVERNMENT Code § 54953(e)(3)(B)(ii)	*Motion Required*
IV.	**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	
V.	**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.*	Jeannie Yee Board President
	A. Consideration of Minutes of the Regular Meetings of the District Board: March 9, 21, 23 and 28, 2022	*Motion Required*
	B. Consideration of Medical Staff: Emergency Medicine Section Manual – Department of Medicine	

C. Consideration of Medical Staff: Rules and Regulations

D. Consideration of CredentialStream Implementation

E. Consideration of Copier Replacement

F. Consideration of Patient Financial Assistance and Charity Care Policy

VI.	**PRESENTATION**	**PRESENTED BY:**
	A. Low Back Pain: When Is It Surgical and When Is It Not?	Rajiv Saigal, M.D., PhD, FAANS, OCN Associate Professor, Department of Neurosurgery, U.C.S.F.
VII.	**REPORTS**	**PRESENTED BY:**
	A. Medical Staff Report	Shakir Hyder, M.D. Chief of Medical Staff
	B. Service League Report	Debbie Feary Service League President
	C. Lean Report Diabetes Program	Prasad Katta, M.D. Medical Co-Director, Diabetes Program
	D. Quality Report: Antimicrobial Stewardship / C. difficile	Dianne Martin, M.D. Anti-Microbial Stewardship Leader
	E. Finance Report	Chris Henry Vice President & Chief Financial Officer
	F. Hospital Operations Report	Kimberly Hartz Chief Executive Officer
VIII.	**ACTION**	
	A. Consideration of Six Merge Radiologist Workstations and Software	*Motion Required*
IX.	**ANNOUNCEMENTS**	

X. ADJOURN TO CLOSED SESSION

A. Conference involving Trade Secrets pursuant to Health & Safety Code section 32106

XI. RECONVENE TO OPEN SESSION & REPORT ON PERMISSIBLE ACTIONS TAKEN DURING CLOSED SESSION — Jeannie Yee, Board President

XII. ADJOURNMENT — Jeannie Yee, 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

A meeting of the Board of Directors of the Washington Township Health Care District was held on Wednesday, March 9, 2022 via Zoom. Director Yee called the meeting to order at 6:00 pm and led those in attendance of the meeting in the Pledge of Allegiance.

PLEDGE OF ALLEGIANCE

ROLL CALL

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

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

Guests: Chris Henry, Tina Nunez, Larry LaBossiere, Paul Kozachenko, Graham Beck, Mary Bowron, Walter Choto, Dr. Jacquelyn Chyu, Angus Cochran, Debbie Feary, Kristin Ferguson, Benjamin Gevercer, Gisela Hernandez, Gordon Howie, Dr. Shakir Hyder, Kel Kanady, John Lee, Nick Legge, Donald Pipkin, Marcus Watkins, Lisel Wells, Ed Wohlleb, and Sri Boddu.

OPENING REMARKS

Director Yee welcomed any members of the general public to the meeting. She noted that in order to continue to protect the health and safety of the members of the Board, District staff, and members of the public from the dangers posed by the SARS-CoV-2 virus, the Brown Act allows a local agency to continue to hold its meetings remotely as opposed to being required to meet in-person. Section 54953(e)(3) of the Government Code requires that the Board make certain findings every 30 days to continue meeting remotely. One such finding is that "state or local officials continue to impose or recommend measures to promote social distancing." The Alameda County Health Officer continues to recommend social distancing and the wearing of masks indoors, as referenced by the Alameda County Health Care Services Public Health Department COVID-19 website at www.covid-19.acgov.org.

In accordance with District law, policies, and procedures, Director Eapen moved that the Board of Directors make the finding required by Section 54953(e)(3)(B)(ii) of the Government Code that "state or local officials continue to impose or recommend measures to promote social distancing." Director Nicholson seconded the motion.

Roll call was taken:

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

The motion carried and the finding is affirmed.

Director Yee noted that Public Notice for this meeting, including connection information, was posted appropriately on our website. This meeting, conducted via Zoom, will be recorded for broadcast at a later date.

COMMUNICATIONS: ORAL

There were no Oral communications.

COMMUNICATIONS: WRITTEN

There were no Written communications.

CONSENT CALENDAR

Director Yee presented the Consent Calendar for consideration:

A. Minutes of the Regular Meetings of the District Board: February 9, February 23, and February 28, 2022

In accordance with District law, policies, and procedures, Director Eapen moved that the Board of Directors approve the Consent Calendar, item A. Director Nicholson seconded the motion.

Roll call was taken:

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

The motion carried.

PRESENTATION: THE WASHINGTON PRENATAL DIAGNOSTIC CENTER: A MODEL FOR THE SUCCESSFUL COLLABORATION OF ACADEMIA AND COMMUNITY

Kimberly Hartz, CEO, introduced Dr. Jacquelyn Chyu, Medical Director of the Washington Prenatal Diagnostic Center, who presented The Washington Prenatal Diagnostic Center: A model for the successful collaboration of academia and community. She began a description of the strategic vision, established in 2017, to provide state-of-the-art medical services in our local community. The Mission is to bring the most advanced prenatal diagnostic care to the community while supporting the WHHS obstetric community by providing high-risk pregnancy care. Services provided include: advanced 2D and 3D fetal ultrasound, Doppler flow studies, fetal echocardiography, comprehensive genetic counseling and genetic carrier screening, invasive fetal testing, and high-risk pregnancy care. Dr. Chyu reviewed the total PDC activity since its inception, noting the slight drop in 2020 due to the pandemic with patients returning in 2021 with safety measures in place.

Dr. Chyu noted that Academic Medical Centers tend to be "medical product leaders" while Community Hospitals tend to be "patient experience leaders." In discussing the challenge of collaboration between the two, Dr. Chyu presented three patient cases that demonstrated the establishment of seamless communication between the systems so that optimal benefit for our patients was obtained from both academic center and community hospital. Both institutions collaborated to provide advanced resources when needed plus the continuity of care and personalized approach of care within the patient's own community (close to home). Both institutions provided "whatever is best for the patient."

This collaborative model is based on the premise of UCSF faculty joining the continuum of inpatient and outpatient services within the local community as opposed to "referral to higher level of care" with easy access to academic center resources when needed with an easy return to the community hospital as soon as feasible.

PRESENTATION: 2022 GENERAL OBLIGATION BONDS PLAN OF FINANCE

Chris Henry, CFO, introduced Gordon Howie, Ed Wohlleb, and Lisalee Wells, Financial Consultants who presented information on the issuance of Series 2022 General Obligation Bonds which would total approximately $20M. Mr. Henry explained that the District residents generously approved Measure XX in November 2020 which provided authority for Washington Hospital to issue up to $425M in General Obligation Bonds. The bonds will finance new construction needed to fulfill state-mandated seismic requirements for earthquake safety.

The proposed financing would use approximately 5.0% of Measure XX approved par amount. Series 2022 would fund pre-construction costs for the build-out of undeveloped space in the Morris Hyman Critical Care Pavilion which includes the construction of eight operating rooms, Sterile Processing Department, Pharmacy, and Imaging Department. Series 2022 would also fund construction costs of the bridge connecting the hospital tower to the Pavilion and the cost of issuance.

Financing at this time would preserve $20M in unrestricted funds that otherwise would be expended, but could be reimbursed when future bonds are issued. Historically attractive interest rates (slightly above estimates in Measure XX ballot materials) facilitate an efficient use of voter-approved funds. Straightforward issuance process can be accomplished by mid-April 2022.

While the Plan of Finance was presented to the Board at tonight's meeting, the final resolution and preliminary official statement will be presented for consideration of approval at the March 21, 2022 Board of Directors meeting.

MEDICAL STAFF REPORT

Dr. Shakir Hyder, Chief of Staff, reported there are 573 Medical Staff members including 349 active members and 90 ambulatory members. The General Medical Staff meeting was held on March 8, 2022. Dr. Hyder talked about a new Medical Staff initiative on Utilization and Quality. He expressed appreciation for the strong collaborative relationship of the Medical Staff with the Board of Directors.

SERVICE LEAGUE REPORT

Debbie Feary, Service League President, reported that the Service League contributed 1,234 hours over the past month. The annual meeting for the Service League was held February 18, 2022 and the board members were voted into office at that time. There was a huge decrease in the number of COVID-19 test kits requested by the Lab (3.075 in January versus 1,600 in February) which coincided with the end of the Omicron surge. The labeling of vaccination syringes dropped from 1,451 in January to 34 in February.

QUALITY REPORT: QUALITY DASHBOARD QUARTER ENDING DECEMBER 2021

Mary Bowron, Chief of Quality and Resource Management presented the Quality Dashboard for the quarter ending December 31, 2021 comparing WHHS statistics to State and National benchmarks. We had one MRSA Bloodstream Infections this past quarter. We had zero Central Line Associated Bloodstream Infections (CLABSI), which was lower than predicted. We had one Catheter Associated Urinary Tract Infection, which was below the predicted number of infections (1.224). We had zero infections following colon surgery and zero infections

following abdominal hysterectomy. C-Difficile: We had one hospital-wide C. diff infection. Hand Hygiene was at 83%.

Our moderate fall with injury rate was lower than the national rate for the quarter at 0.36. Hospital Acquired Pressure Ulcer rate of 0% was lower than the national rate this past quarter.

Our 30-day readmission rate for AMI discharges was above the CMS benchmark (17.2% versus 15.8%). We had a higher percent of 30-day Medicare pneumonia readmissions compared to the CMS national benchmark (29% versus 16.7%). 30-day Medicare Heart Failure readmissions were lower (20% versus 21.9%) than the CMS benchmark. Our 30-day Medicare Chronic Obstructive Pulmonary Disease (COPD) readmission rate was higher than the CMS benchmark (20% versus 19.7%). Our 30-day Medicare CABG readmission rate was lower (4.5% versus 12.6%) than the CMS benchmark. Our 30-day Medicare Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) was higher than the CMS benchmark (6.7% versus 4.0%).

FINANCE REPORT

Chris Henry, Vice President & Chief Financial Officer, presented the Finance Report for January 2022. The average daily inpatient census was 178.7 with admissions of 894 resulting in 5,539 patient days. Outpatient observation equivalent days were 271. The average length of stay was 5.51 days. The case mix index was 1.680. Deliveries were 114. Surgical cases were 406. The Outpatient visits were 6,944. Emergency visits were 5,154. Cath Lab cases were 171. Joint Replacement cases were 406. Neurosurgical cases were 30. Cardiac Surgical cases were 10. Total FTEs were 1,598.7. FTEs per adjusted occupied bed were 5.55.

HOSPITAL OPERATIONS REPORT

Kimberly Hartz, Chief Executive Officer, presented the Hospital Operations Report for February 2022. Preliminary information for the month indicated total gross revenue at approximately $194,541,000 against a budget of $169,722,000. We had 130 COVID-19 discharges which represented 16% of total discharges.

The Average Length of Stay was 6.38. The Average Daily Inpatient Census was 178.0. There were 11 discharges with lengths of stay greater than 30 days, ranging from 31 to 117. Still in house at the end of February were fifteen patients with length of stays of over 30 days and counting (highest at 280).

There were 4,985 patient days. There were 392 Surgical Cases and 216 Cath Lab cases at the Hospital. Outpatient joint cases were budgeted to begin migrating to Peninsula Surgery Center in October 2021; pending accreditation, these are now expected to begin during the first half of CY2022.

Deliveries were 88 (the lowest this fiscal year). Non-Emergency Outpatient visits were 7,047. Emergency Room visits were 3,855. Total Government Sponsored Preliminary Payor Mix was 74.6%, against the budget of 73.1%. Total FTEs per

Adjusted Occupied Bed were 5.85. The Washington Outpatient Surgery Center had 471 cases and the clinics had approximately 16,021 visits.

There were $145,640 in charity care applications pending or approved in February. It was noted that we went a $1.4M matching contribution to the State for the District Municipal Public Hospital Quality Incentive Pool (DMPH-QIP). We expect to get back $5.4M in April after Federal Matching funds are applied. We also funded $2.8M into the Warm Springs Health Center Partnership LLC as the District's 51% share of initial working capital contribution.

CONSIDERATION OF POTENTIAL PARCEL TAX

Kimberly Hartz, Chief Executive Officer, introduced Benjamin Gevercer, associate attorney at Olson Remcho, LLP. Following the February 23, 2022 board meeting, staff was directed to research and prepare a parcel tax measure. The law firm of Olson Remcho was approached to advise the District regarding the preparation of the parcel tax measure. The requirements and available procedures for placing a District Parcel Tax on the Ballot were outlined in a memo to board and reviewed by Mr. Gevercer at this meeting.

As drafted the measure, if passed, would establish a parcel tax at $98 on each parcel located within the District to be used for funding the continued operations of the District, including operation of the emergency department, the purchase and maintenance of trauma and other lifesaving medical equipment, disaster preparedness, public health emergency preparation, operating room technology, and diagnostic imaging technology. With a filing deadline of August 12, 2022, there is still time to place the measure for the upcoming November election. It is Ms. Hartz' recommendation that the Board table the parcel tax measure to allow for further study.

Director Eapen moved that the Board hold off placing the tax measure on the November ballot and further direct staff to continue to explore and study the matter as circumstances evolve and report back to the Board by the end of July. Director Nicholson seconded the motion.

Roll call was taken:

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

The motion carried.

CONSIDERATION OF RESOLUTION No.1238: AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO ENTER

Consideration of Resolution No. 1238 regarding the Joint Venture with UCSF was postponed to a future meeting.

INTO AN OPERATING AGREEMENT RELATED TO A PROPOSED JOINT VENTURE WITH UCSF FOR A JOINT CANCER CENTER

CONSIDERATION OF RESOLUTION No. 1237: APPROVAL OF REVISIONS TO ASSET ALLOCATION IN THE DISTRICT'S RETIREMENT PLAN AND OTHER POST-EMPLOYMENT BENEFITS AND APPROVAL OF SUBSCRIPTION AGREEMENTS

In accordance with District Law, Policies, and Procedures, Director Eapen moved that the board approve the revisions to Asset Allocation in the District's Retirement Plan and other post-employment benefits and approval of subscription agreements. Director Nicholson seconded the motion.

Roll call was taken:

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

The motion carried.

ANNOUNCEMENTS

- The Community vaccination clinic has moved outside Washington West to the COVID Testing Tent and is scheduling people 5 years of age and older. As of Friday, March 4th, a total of 86,069 COVID vaccine doses have been administered to community members at our vaccination clinic, including 3,331 vaccinations of children ages 5-11 years old.
- Thursday, February 17th: Advances in Joint Replacement Surgery
- Wednesday, February 23rd: COVID-19: What Families Need to Know
- Wednesday, March 2nd: Improve Your Balance with Yoga
- Scheduled for Tuesday, March 22nd: Overactive Bladder: Causes, Symptoms, and Treatment
- Scheduled for Thursday, May 5, 2022: 35th Annual Golf Tournament on the Hill Course at Castlewood Country Club in support of Surgical Services at WHHS.
- March Employee of the Month: Emebet Mussa, Certified Nurse Assistant, 6 West

ADJOURNMENT

There being no further business, Director Yee adjourned the meeting at 8:10 pm.

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Jeannie Yee, President

William Nicholson, M.D., Secretary

CALL TO ORDER

A regular meeting of the Board of Directors of the Washington Township Health Care District was held on Monday, March 21, 2022 via Teleconference. Director Yee called the meeting to order at 6:01 p.m. and led those present in the Pledge of Allegiance.

ROLL CALL

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

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

Guests: Graham Beck, Erica Luna, Donald Pipkin, Ed Wohlleb, Lisel Wells

OPENING REMARKS

Director Yee welcomed any members of the general public to the meeting. She noted that in order to continue to protect the health and safety of the members of the Board, District staff, and members of the public from the dangers posed by the SARS-CoV-2 virus, the Brown Act allows a local agency to continue to hold its meetings remotely as opposed to being required to meet in-person. Section 54953(e)(3) of the Government Code requires that the Board make certain findings every 30 days to continue meeting remotely. One such finding is that "state or local officials continue to impose or recommend measures to promote social distancing." The Alameda County Health Officer continues to recommend social distancing and the wearing of masks indoors, as referenced by the Alameda County Health Care Services Public Health Department COVID-19 website at www.covid-19.acgov.org. The Board made such a finding at its meeting earlier in the month.

COMMUNICATIONS

There were no oral or written communications.

CONSIDERATION OF RESOLUTION NO. 1238: AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO ENTER INTO AN OPERATING AGREEMENT RELATED TO A PROPOSED JOINT VENTURE WITH UCSF FOR A JOINT CANCER CENTER

Director Yee presented the following Resolution No. 1238 for consideration:

Director Eapen moved that the Board of Directors approve Resolution No. 1238 which authorizes the Chief Executive Officer to enter into an Operating Agreement related to a proposed Joint Venture with UCSF for a Joint Cancer Center. Director Stewart seconded the motion.

Roll call was taken:

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

The motion unanimously carried.

CONSIDERATION OF RESOLUTION NO.1239: AUTHORIZE THE ISSUANCE AND SALE, DETERMINING TO PROCEED WITH

Director Yee presented the following Resolution No. 1239 for consideration:

Director Eapen moved that the Board of Directors approve Resolution No. 1238 which authorizes the issuance and sale, determining to proceed with negotiated sale

NEGOTIATED SALE OF CERTAIN GENERAL OBLIGATION BONDS OF THE DISTRICT IN AN AGGREGATE PRINCIPAL AMOUNT NOT TO EXCEED $20,000,000, AND APPROVING CERTAIN OTHER MATTERS RELATING TO THE BONDS

of certain General Obligation Bonds of the District in an aggregate principal amount not to exceed $20,000,000 and approving certain other matters relating to the Bonds. Director Stewart seconded the motion.

Roll call was taken:

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

The motion unanimously carried.

CONSIDERATION FOR RESOLUTION No. 1236 TO AUTHORIZE CHIEF EXECUTIVE OFFICER TO ENTER INTO CERTAIN AGREEMENTS RELATED TO A PROPOSED JOINT VENTURE WITH UCSF FOR A JOINT CANCER CENTER

Donald Pipkin presented a history of cancer care at Washington Hospital which included the broad affiliation with UCSF which began in 2013, providing services in Maternal Child Health (pediatrics and neonatal intensive care), Cardiac Surgery, Genetic Counseling, Prenatal Diagnostic Clinic, and other specialties. He noted that the UCSF-WHHS Cancer Center opened in January 2017 and presented the strategic vision and benefits of the proposed oncology Joint Venture collaboration.

In accordance with District law, policies, and procedures, Director Wallace moved that the Board of Directors approve Resolution No. 1236 to authorize the Chief Executive Officer to enter into certain agreements related to a proposed Joint Venture with UCSF for a Joint Cancer Center.

Roll call was taken:

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

The motion carried.

ADJOURN TO CLOSED SESSION

In accordance with Health & Safety Code Sections 32106, 32155 and California Government Code 54956.9(d)(2), Director Yee adjourned the meeting to closed session at 6:11 p.m., as the discussion pertained to a Report of Medical Staff and Quality Assurance Committee, Health & Safety Code section 32155, Conference involving Trade Secrets pursuant to Health & Safety Code 32106, Conference involving Public Security, Facilities pursuant to California Government Code section 54957, and consideration of closed session Minutes: February 9, and 23, 2022. Director Yee stated that the public has a right to know what, if any, reportable action takes place during closed session. Since this meeting is being conducted via Zoom 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 March 22, 2022. She indicated that the minutes of this meeting will reflect any reportable actions.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Yee reconvened the meeting to open session at 9:30 pm. The District Clerk reported that the Board approved the Closed Session Minutes of February 9, and 23, 2022 and the Medical Staff Credentials Report in closed session by unanimous vote of all Directors present:

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

ADJOURNMENT

There being no further business, Director Yee adjourned the meeting at 9:30 pm.

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Jeannie Yee, President

William Nicholson, M.D., Secretary

CALL TO ORDER

A regular meeting of the Board of Directors of the Washington Township Health Care District was held on Wednesday, March 23, 2022 via Teleconference. Director Yee 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: Jeannie Yee; Bernard Stewart, DDS; Jacob Eapen, MD; William Nicholson, MD

Absent: Michael Wallace

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

Guests: Marta Fernandez, Attorney

OPENING REMARKS

Director Yee welcomed any members of the general public to the meeting. She noted that in order to continue to protect the health and safety of the members of the Board, District staff, and members of the public from the dangers posed by the SARS-CoV-2 virus, the Brown Act allows a local agency to continue to hold its meetings remotely as opposed to being required to meet in-person. Section 54953(e)(3) of the Government Code requires that the Board make certain findings every 30 days to continue meeting remotely. One such finding is that "state or local officials continue to impose or recommend measures to promote social distancing." The Alameda County Health Officer continues to recommend social distancing and the wearing of masks indoors, as referenced by the Alameda County Health Care Services Public Health Department COVID-19 website at www.covid-19.acgov.org. The Board made such a finding at its meeting earlier in the month.

COMMUNICATIONS

There were no oral or written communications.

CONSENT CALENDAR

Director Yee presented the Consent Calendar for consideration:

A. Philips Monitoring Project – Phase III

Director Eapen moved that the Board of Directors approve the Consent Calendar, item A. Director Stewart seconded the motion.

Roll call was taken:

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

The motion carried.

CONSIDERATION OF RESOLUTION NO. 1240: SUPPORT OF LOCATING A TRAUMA

Director Yee presented the following Resolution No. 1240 for consideration.

Kimberly Hartz talked about Alameda County's trauma system and the fact that the two existing trauma centers are distant from South County resulting in travel times

CENTER IN SOUTHERN ALAMEDA COUNTY

anywhere from 45 to 75 minutes, an unacceptable delay in accessing trauma care. She noted that the recent polling of District residents showed that 90% of the residents surveyed want access to life-saving care that is located close to home.

Three Bond Measures have been approved by the voters resulting in almost $1B in bond financing for emergency and critical care infrastructure. Washington Hospital already demonstrates a readiness to meet the strict criteria of a Level II trauma center. The physical plant is able to support trauma operations and the Morris Hyman Critical Care Pavilion trauma-ready Emergency Department already has two trauma bays. Our Life-saving infrastructure is already operational. Our UCSF affiliation provides access to advanced medical specialists. We have a nationally recognized neurosurgical program as well as Advances Primary Stroke Program certification. Our Chief Nursing Officer has extensive trauma experience.

Ms. Hartz stated that two hospitals in Alameda County were interested in applying for a Trauma Center designation: Washington Hospital and Stanford-ValleyCare. Resolution No. 1240 asks for support of the Board of Directors to move forward with this application.

Directors Nicholson, Stewart, Eapen, and Yee all expressed strong support for moving forward with this application process citing the lengthy travel time to transport a critically injured patient to an existing trauma center in North county, especially during heavy commuter traffic hours. Director Nicholson spoke about the golden hour as the hour immediately following a traumatic injury in which medical treatment to prevent irreversible internal damage and optimize the chance of survival is most effective. Director Eapen noted that we are located between Routes 580 and 680 where many traffic accidents occur; those same freeways are the transport routes to the trauma centers. Director Stewart commented that the voters in this District have been requesting trauma services at this end of the county for several years.

Director Eapen moved that the Board of Directors approve Resolution No. 1240 in support of locating a Trauma Center in Southern Alameda County. Director Stewart seconded the motion.

Roll call was taken:

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

The motion carried.

ANNOUNCEMENTS

Ms. Hartz stated that Miroslav Garcia has resigned his position on the DEVCO Board of Directors.

ADJOURN TO CLOSED SESSION

In accordance with Health & Safety Code Sections 32106, 32155 and California Government Code 54956.9(d)(2), Director Yee adjourned the meeting to closed session at 6:18 p.m., as the discussion pertained to a Report of Medical Staff and Quality Assurance Committee, Health & Safety Code section 32155. Director Yee stated that the public has a right to know what, if any, reportable action takes place during closed session. Since this meeting is being conducted via Zoom 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 March 24, 2022. She indicated that the minutes of this meeting will reflect any reportable actions.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Yee reconvened the meeting to open session at 7:02 pm and stated there was no reportable action taken in closed session.

EDUCATION: HARASSMENT TRAINING FOR ELECTED OFFICIALS

Marta Fernandez, Attorney, conducted the mandatory training on Preventing Sexual Harassment to the Board Members. The session was recorded and given to Director Wallace for completion.

ADJOURNMENT

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

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Jeannie Yee
President

William Nicholson, M.D.
Secretary

CALL TO ORDER

A meeting of the Board of Directors of the Washington Township Health Care District was held on Monday, March 28, 2022 via Zoom. Director Yee called the meeting to order at 7:30 a.m.

ROLL CALL

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

Excused: Michael Wallace

Also present: Shakir Hyder, MD; Prasad Kilaru, MD; Tim Tsoi, MD; Jan Henstorf, MD; Kimberly Hartz, CEO; Larry LaBossiere, CNO; Dee Antonio, District Clerk

COMMUNICATIONS

There were no oral or written communications.

ADJOURN TO CLOSED SESSION

Director Yee 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 Yee reconvened the meeting to open session at 8:03 a.m. and reported no reportable action taken in closed session.

ADJOURNMENT

There being no further business, the meeting adjourned at 8:03 a.m.

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Jeannie Yee
President

William Nicholson, M.D.
Secretary

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: March 21, 2022

TO: Kimberly Hartz, Chief Executive Officer

FROM: Shakir Hyder, MD, Chief of Staff

SUBJECT: MEC for Board Approval:

The Medical Executive Committee, at its meeting of March 21, 2022, approved the Department & Service Manual Department of Medicine – Update Emergency Medicine Section.

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval of the attached the Department & Service Manual Department of Medicine – Update Emergency Medicine Section.

DEPARTMENT & SERVICES MANUAL
DEPARTMENT OF MEDICINE
(Changes approved by MEC 5/21/07 and Board 6/13/07 MEC 05/21/2018 and JCC 05/29/18)

EMERGENCY MEDICINE SECTION

Function

The Emergency Medicine Section is a division of the Department of Medicine. It has a Medical Director who is a member of a contract groupphysician. There is also a Chairperson of the Emergency Medicine Section. The Medical Director may serve as the Chairperson.

The Emergency Department is a 23 Bed Level II Facility. The Emergency Department's goal is to provide timely, courteous, appropriate, compassionate, convenient, cost effective emergency medical interventions. that meets or exceeds expectations of patients' private physicians, hospital unit/services and other customers.

The Emergency Medicine Section shall be organized to provide 24-hour professional coverage of medical and surgical emergencies. This coverage shall be the joint responsibility of the Medical Staff, in coordination with the Hospital Administration.

Subject to approval of the MEC, the Section shall perform the functions assigned to it by the Department Chairperson. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privilege delineation and continuing education programs. The Section shall transmit regular reports to the Department Chairperson on its assigned functions. Any recommendation by the Section involving peer review and quality assurance activities is subject to Medical Department Committee approval. Members of the Emergency Medicine Section shall comply with the Bylaws, Policies and Procedures, and Rules and Regulations of the Washington Hospital Medical Staff and the Department of Medicine Manual.

For the purpose of this manual, the definition of the Emergency Department is the physical space in which care is provided. Emergency Services means the place, the care provided and those providing the care.

The Emergency Medicine Section shall assure the following:

1. A Board eligible/certified licensed physician in having knowledge of emergency medicine and and at least one registered nurse are is assigned to the Emergency Department and on the premises 24 hours a day. Specialized laboratory and x-ray personnel will be on the premises or on call.

2. A roster of physicians on call for referral is available maintained in the Emergency Department.

Emergency Department facilities include: separate patient waiting and treatment rooms, a triage area, holding beds, and readily accessible x-ray and laboratory facilities and a fast track service.

Equipment for the appropriate diagnosis, treatment and monitoring of emergency cases will be readily accessible in the Emergency Department.

Supplies such as drugs, blood, plasma, plasma expanders, parenteral solutions, oxygen, splinting and suturing materials will be immediately available in the Emergency Department.

3. Electronic Mmedical records are maintained on all patients who present for treatment. Records of the Emergency Department are regularly reviewed by the existing Medical Staff review committees.

4. No patient can be denied treatment or have treatment delayed for reason of race, creed, color, religion, sex or financial status.

5. Patients presenting to the Emergency Department for care will receive a medical screening examination (MSE) regardless of their ability to pay or insurance coverage in accordance with State/Federal Regulations.

THE OBJECTIVES OF THE EMERGENCY SERVICE

1. To provide evaluation and initial treatment in an organized and directed manner consistent with the defined capability of the hospital.

2. To integrate fully with other departments of the hospital and with the surrounding community, including disaster planning.

3. To ensure that medical care meets general standards of other departments in the Hospital and surrounding hospitals in the community 24 hours a day.

4. To ensure adequate staffing 24 hours a day to meet the needs of emergency patients.

5. To ensure that patients are seen within a reasonable length of time relative to their illness or injuries.

6. To provide, with the Hospital Medical Staff, a means of auditing the quality of emergency care provided.

7. To ensure that all staff members, physicians and hospital staff, working within the Department receive adequate special training and possess the necessary skills for adequate performance of their duties.

8. To ensure that the facilities for emergency service are such as to provide effective care to the patient.

9. To guide emergency patient care with written policies that are supported by appropriate procedure manuals and reference materials.

10. To ensure that adequate medical records are maintained for every patient receiving emergency service.

11. The direction of the Emergency Department is carried out by a member of the Medical Staff who acts as full time Director.

12. Supervision of quality is carried out jointly by the Medical Director of the Emergency Department and by the Medical Staff of the Hospital.

13. The immediate medical care delivered within the Emergency Department is the responsibility of the emergency physicians on duty.

14. If a patient has been admitted to the hospital but is kept in the Emergency Department because a bed is not available on the inpatient units or in ICU-CCU, the admitting physician is responsible for the complete care of that patient, unless emergent intervention is required.

Composition

The Emergency Medicine Section shall consist of all members of the Medical Staff who have limited their practice to the specialty of Emergency Medicine and who have met the requirements of staff membership. They shall provide 24-hour professional coverage in accordance with the Policies of this Section under the supervision of its Director.

The Emergency physician roster shall be prepared by the Emergency Medical Director in coordination with the Administrator responsible for the oversight of the Emergency Department.

Officers

A Chairperson shall be selected from the Active Medical Staff members of the Section for a two-year term. The Chairperson shall be qualified by training and experience and demonstrate current ability in emergency medicine.

Elections shall be held in May of odd years. Chairpersons shall be eligible to succeed themselves.

Vacancies of the Section Chairperson, due to any reason, shall be appointed for the unexpired term by the Department Chairperson and/or the Chief of Staff.

Section Chairperson Responsibilities

1. Assist the Department Chairperson in the development and implementation of programs to carry out the quality review, and monitoring and evaluation functions assigned to the Emergency Medicine Section.

2. Assist in the evaluation of the clinical work performed in the Section.

3. Review credentials and submit reports and recommendations to the Department Chairperson regarding clinical privileges.

4. Perform other appropriate duties as requested by the Department Chairperson, Chief of Staff or the Medical Executive Committee.

Meetings

The Emergency Medicine Section shall meet every other month (except the November meeting will occur the first week in December) and shall generate minutes of the business conducted. The Section shall report in writing, to the Medical Department Committee as requested.

Medical Director Responsibilities

1. Provision shall be made for engaging the services of a full-time physician/director who meets the qualifications for Staff membership, and is primarily trained in emergency medicine and management of acutely ill and traumatized patients.

2. The Medical Director shall be appointed by the group contracted to provide services for the Emergency Department subject to approval by Administration and Board of Directors. ~~from a list of physicians approved by the Medical Executive Committee.~~ The Medical Director shall be administratively responsible to the Board of Directors through the Administrator, and professionally responsible to the Emergency Medicine Section Committee and Department of Medicine ~~Critical Care Committee~~. The Medical Director shall assist the Administration and staff in evaluating applicants for emergency physician positions.

Privileges

A. Evaluation and re-evaluation of applicants:

The Emergency Medicine Section shall evaluate all applicants for Emergency Medicine privileges. The Committee's recommendation will be forwarded to the Department of Medicine and the Medical Executive Committee via the Credentials Committee. Re-evaluation of privileges shall occur every two (2) years.

B. Core Privileges:

The Department of Medicine shall define Core Privileges appropriate to the specialty.

C. Eligibility:

To be eligible for Core Privileges, a practitioner must be Board certified as outlined in the Medical Staff Bylaws. The practitioner must have performed a minimum of 200 cases of a variety of the procedures within the Core in the previous two years.

Responsibilities of Emergency Medicine Physicians

Emergency physicians are provided via contract. Emergency physicians are members of the Medical Staff with privileges granted by the Board of Directors.

1. The Emergency physician's prime responsibility is the prompt evaluation, treatment and disposition of all patients requesting treatment.

2. Emergency physicians shall also respond promptly to "code blue" or other emergency situations arising within the Hospital until the patient's attending physician or another qualified physician is available, providing that such temporary removal from the emergency area does not disrupt an equally life-saving procedure being performed in that area.

3. Updated ACLS certification is recommended but not a requirement for renewal of the privileges of an emergency physician. (Change approved by the MEC 8/17/92)

4. Protection of patient-physician relationships within the community, and cooperative effort of staff and emergency physicians shall be encouraged by clearly defining responsibilities and by mutual understanding of the problems of patient care inherent to each mode of practice.

5. While on duty, emergency physicians shall not accept "sign-out" coverage from members of the Medical Staff outside the Emergency Medicine Section.

6. To assist the staff nurse in deciding the order of urgency of different patients' problems and to treat patients in that order.

7. To interview, examine and establish a tentative diagnosis on all patients he/she attends, to stabilize and initiate appropriate care, to refer for admission or to render outpatient treatment (as appropriate).

8. To treat patients with respect, kindness, compassion, diligence, skill and knowledge compatible with accepted medical standards.

9. To obtain consultations and other assistance whenever necessary.

10. To legibly and accurately record all pertinent details of the evaluation and treatment of patients.

11. To provide the patient with legible and understandable instructions concerning further care and follow-up.

12. To encourage patients to seek on-going care from a primary physician rather than relying on episodic care in the Emergency Department.

13. To determine the time of death in terminal cases and to certify those dead on arrival, to notify the Coroner and the patient's next of kin when necessary.

14. After admission of a patient from the Emergency Department, the emergency physician shall not assume responsibility for future treatment of that patient but may expedite his initial inpatient care by writing orders upon authorization by the patient's physician.

15. Referral and consultation shall be coordinated with members of the Medical Staff as outlined in this manual. Return or follow-up visits to the Emergency Department for the same illness should be discouraged.

16. The Emergency physicians must be capable of evaluating patients involved in alleged rape, sexual assault and child molestation.

17. It shall be the responsibility of the physician to seek assistance from on-call physicians as well as from Emergency Department Nurse Manager when needed so to assure that patients with high priority problems shall be seen immediately, so that those with less severe problems shall not be subjected to unnecessary delays, and so that the patient load in the Emergency Room shall not get so heavy that patients cannot be monitored and otherwise evaluated and treated in an organized manner that will prevent or minimize oversights and errors.

Specialty Coverage for Emergency Department

An on call roster is maintained to ensure the availability of physicians and specialists to provide treatment in accordance with Medical Staff Department and Section Manuals.

PATIENT CARE GUIDELINES

Procedures That May Not Be Performed by the Medical Staff in the Emergency Department

1. No provision of care without proper completion of forms and informed consent.

2. No minor elective surgery other than those specified in this manual.

3. No routine allergy hyposensitization.

4. No procedures or treatment of an experimental nature.

5. No prolonged care of violent or suicidal patients; they will be transferred to an appropriate facility elsewhere as soon as practicable.

6. No holding of patients, in excess of 12 hours, for care of problems without administrative advice.

7. General inhalation anesthesia is not to be administered in the Emergency Department under normal situations.

8. Any delivery that can be done in a delivery room.

9. Any D&C that is greater than 13 weeks size.

10. Laparotomy.

11. Craniotomy, excluding emergency burr holes.

12. Lymph node biopsy/excision.

13. Diagnostic bronchoscopy.

14. Elective cardioversion.

15. Elective placement of pacemaker.

16. Circumcision

17. Removal of cysts, wens, and chalazions

18. Elective D&C

19. Therapeutic abortions

20. Elective therapeutic and diagnostic nerve blocks

21. Plastic revision of scars

22. Scheduled tracheotomy

23. A-V shunts for dialysis patients.

Patient Refusal of Exam or Treatment

In the event that a patient refuses to consent to further examination or treatment, the physician must indicate in writing the risk and benefits of the examination and/or treatment, the reason for the refusal, a description of the examination or treatment that was refused, and steps taken to secure written informed refusal.

Emergency Department Discharge/Admissions/Transfers

Emergency Department transfers are done in accordance with hospital policies and federal and state requirements.

1. Responsibility for Discharge and Disposition

Patient discharge and disposition shall be decided by the physician.

2. Prerequisites for Discharge

Discharged patients shall be instructed regarding:

a) What additional care is recommended.

b) How to obtain and how to use any medicines that may have been prescribed or otherwise recommended. Patients discharged with medications from Washington's Pharmacy will receive a preprinted medication instruction sheet.

c) What follow-up arrangements are recommended and how to make these arrangements.

d) When and how to return or call to the Emergency Department or to otherwise obtain earlier care or advice should they get expectedly worse or should anticipated recovery not take place.

Alcohol Impaired Patients

The Emergency physician must specifically address the patient's improving/sobering/mental status, stable vital signs, ability to safely ambulate and to be prudently discharged to family/friends or where applicable the authorities. Where clinically indicated, the physician should consider a repeat blood alcohol prior to discharge if a baseline blood alcohol was done and was over 0.8%.

Privilege Application Form - Emergency Medicine Section (see attached)

Amendment

Recommended changes to the Emergency Medicine Section Manual shall require an affirmative vote of 51% of the voting members of the Section, followed by approval of the Department of Medicine, the MEC, and the Board of Directors.

APPROVED BY EMERGENCY MEDICINE SECTION
Date: 3/30/07, 4/9/10

APPROVED BY DEPARTMENT OF MEDICINE
Date: 5/2/07

APPROVED BY THE MEC
Date: 5/21/07, 9/27/10, 4/18/11

APPROVED BY THE BOARD OF DIRECTORS
Date: 6/13/07, 10/13/10, 5/11/11

DEPARTMENT OF INTERNAL MEDICINE

CORE - Subspecialty - Emergency Medicine

Cognitive:
Provide treatment or consultative services including examination, admission, work-up diagnosis, initial interpretation of diagnostic procedures, performance of procedures, administration of medication and medical care to correct various conditions, illness or injuries in adults and children.

Description of Procedures:

Anesthesiology procedures including oral and nasal endotracheal intubation with neuromuscular rapid sequence intubation and mechanical ventilation, , local regional and digital block anesthesia. Laryngoscopy and Nasopharyngeal endoscopy.

Medicine procedures including initial evaluation and stabilization of all patients who present to the ER, basic CPR & ACLS including emergency cardioversion, lumbar puncture, gastric lavage, monitoring EKG, arterial puncture and interpretation, intravenous therapy, ~~emergency~~ pericardiocentesis, jugular subclavian, femoral, central line placement with or with ultrasound~~placement~~, intraosseous access, emergency transthoracic pacemaker/paceaid, thoracentesis, anoscopy (diagnostic), child abuse exams for both therapeutic and evidentiary purposes, other life or limb-saving emergency procedures;

Ob/Gyn procedures including: emergency vaginal delivery, removal of IUD, rape exam for both therapeutic and evidentiary purposes, other life and limb-saving emergency procedures;

Surgery procedures including: emergency needle or tube thoracostomy, cutdown venipuncture, emergency diagnostic paracentesis, repair of extensor tendon, emergency reduction of complex fracture with n/v compromise; closed reduction of wrist fractures***;*** reduction of common dislocations (i.e. shoulder, hip, elbow, fingers), reduction of simple fractures (i.e. phalanges), incision and drain or excision of sebaceous cyst, furuncle, subcutaneous abscess, initial ER treatment of 1st, 2nd, or 3rd degree burns including dressing, cautherize turbinates, anterior or posterior pack, emergency tracheostomy, emergency cricothroidostomy, emergency thoracotomy with cardiac massage, finger or toe nail trephination, or removal, repair of lacerations, removal of foreign bodies from ear, eye, nose and soft tissue, joint aspiration, injection of tendon, ligaments and trigger points, slit lamp utilization, other life and limb-saving emergency procedures. Placement of foley catheter and suprapubic catheterization, cervical spine immobilization,

Moderate/Deep Sedation: Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Therefore, the safe administration of moderate/Deep sedation requires not only the knowledge of the relevant pharmacological agents and their antagonists but also the ability to rapidly and competently manage cardiac and respiratory depression as well as the loss of protective reflexes. Refer to the Anesthesiology Dept. for locations where procedure may be performed.

Qualifications:
Licensed M.D. or D.O.

Training:
~~Board certification as outlined in the Medical Staff Bylaws~~ Completion of an ACGME or AOA accredited Residency training program in Emergency medicine.

Certification: Current certification through ABEM or AOA in Emergency Medicine. Exceptions to this requirements can be found in the Bylaws Section 2.2-2.

Experience:
Performance of a minimum of 200 cases of a variety of the procedures within the core in the previous two years.

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Additional Qualifications: Applicant must have a contract with the contracted group to provide services in this specialty.

Proctorship Guidelines: See Department Manual.

Re-credentialing Criteria:
In addition to meeting the qualifications for reappointment stated in the Medical Staff Policies & Procedures, the member must provide documentation of performance of a minimum of 200 of a variety of the procedures within the core in the previous two years.

Special Privileges:

- ~~Moderate Sedation~~
- ~~Deep Sedation~~

~~(see Department Manual for specific criteria)~~

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Criteria for Granting Privileges for Moderate Sedation
(Approved by MEC 3/21/06; by Board 4/12/06, 5/11/11)

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Therefore, the safe administration of moderate sedation requires not only the knowledge of the relevant pharmacological agents and their antagonists but also the ability to rapidly and competently manage cardiac and respiratory depression as well as the loss of protective reflexes. Refer to the Anesthesiology Dept. for locations where procedure may be performed.

Definition
Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Initial Privilege Criteria
Basic Education:
M.D. or D.O.

Minimal Formal Training:
Practitioner must demonstrate via one of the following pathways that they have 1) the requisite knowledge to administer pharmacologic agents to predictably achieve and maintain desired levels of sedation, and 2) have the training and experience to recognize and rescue patients from the cardiovascular and respiratory effects of unavoidably or unintentionally obtaining a deeper than desired level of sedation.

PATHWAY 1: A component of sedation training as well as hemodynamic/respiratory rescue is required:

Current ACLS certification (or similar age-appropriate course such as PALS for pediatricians), plus passage of a written examination on principles of sedation.
-OR-
Pass a course that has been developed or approved by the Department of Anesthesiology. This course will include components on sedation and airway management.

PATHWAY 2: Practitioners who can show that training in the administration of sedation as well as airway management was an integral part of the applicant's training, such as an Anesthesiology or Emergency Medicine Residency or a Pulmonary Medicine Fellowship, or are board certified in such a specialty.

PATHWAY 3: Practitioners with privileges for moderate sedation at another facility may be granted this privilege if the training and testing requirement at that facility is deemed to be essentially comparable by the chair of Anesthesiology.

Required previous experience:
When requested, the applicant must be able to demonstrate that s/he has administered moderate sedation, deep sedation or endotracheal intubation for at least 12 patients in the past 24 months. Practitioners without the requisite prior experience may demonstrate instead successful completion of a CME course on moderate sedation approved in advance by the chair of anesthesiology, and which includes procedural airway skills and/or simulation.

Proctorship:
First three cases to be proctored by a physician with moderate sedation privileges (proctor does not need to be from the same specialty). This proctoring may occur concurrently or separately with proctorship of the procedure requiring the sedation, but clearly documented separately from the primary procedure.

Recredentialing Criteria:
Performance of a combined total of at least 12 moderate sedation cases, deep sedation cases, or endotracheal intubations in the previous two years. Practitioners without adequate case volume must re-qualify for the privilege through Pathway 1 above.

Criteria for Granting Privileges for Deep Sedation
(Approved by Board 5/11/11)

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Therefore, the safe administration of deep sedation requires not only the knowledge of the relevant pharmacological agents and their antagonists but also the ability to rapidly and competently manage cardiac and respiratory depression as well as the loss of protective reflexes. Refer to the Anesthesiology Department Manual for locations where deep sedation may be performed. Appropriate procedures are brief interventions that carry a minimal risk of cardiorespiratory compromise outside of the anesthetic risk; for example, closed reduction of a dislocated joint.

Because deep sedation results in a higher likelihood of respiratory or hemodynamic embarrassment that requires continuous intervention, the physician performing the sedation may not also perform the procedure necessitating the sedation. This requirement does not include sedation for Rapid Sequence Induction/endotracheal intubation, as in that procedure, the airway itself is the purpose of the intervention.

An anesthesiologist must be consulted for patients in ASA category IV or V.

Definition

Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

A. Initial Privilege Criteria

1. Basic Education:

- M.D. or D.O.

2. Minimal Formal Training:

Practitioners must show that training in the administration of deep sedation as well as airway management was an integral part of the applicant's training, such as an Anesthesiology or Emergency Medicine Residency.

3. Required previous experience:
When requested, the applicant must be able to demonstrate that s/he has administered deep sedation or endotracheal intubation for at least 6 patients in the past 24 months,
OR

demonstrate completion of a deep sedation course, approved by the chair of Anesthesiology that includes deep sedation and rescue from General Anesthesia topics.

4. Proctorship:
First three cases to be proctored by a physician with deep sedation privileges or an anesthesiologist.

B. Recredentialing Criteria:

- Performance of a combined total of at least 6 deep sedation cases or endotracheal intubations in the previous two years.
OR

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- ~~demonstrate completion of a deep sedation course, approved by the chair of Anesthesiology that includes deep sedation and rescue from General Anesthesia topics.~~

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Emergency Department Fast Track Guidelines

Goal: To see 20% of shift census in Fast Track and 80%of Fast Track patients in one hour from triage to discharge. To decrease patients who leave without being seen to less than 2%.

Hours

Fast Track will be implemented daily from 1100 to 2300p with final disposition and discharge of patients prior to 2300.

Staffing

The LVN on duty will staff Fast Track. In the absence of an LVN the float RN may staff it. When staffed by a non-licensed person nursing functions will be implemented by the charge or float nurse.

Location

Fast track patients will be seen and treated in the Cast room or clinic. Fast track patients waiting for results of diagnostic studies will wait in the ED cubby area.

Fast Track Patient Criteria

General Criteria:

- patients that can be seen and treated within one hour (i.e. simple rechecks, suture removal, simple lacerations, back pain without fever or neuro symptoms, sore throat, URI, blood and body fluid exposure, conjunctivitis, dysuria without abdominal pain, etc) Generally all Triage level 4 and 5's.
- no blood work
- lab limited to U/A or strep screen
- x-rays limited to chest or single extremity
- no IVs or IV meds
- consults limited to ortho only

Exclusion Criteria:

- Psychiatric complaints
- Patients with potential for admission
- Abdominal pain
- Nausea/vomiting
- Children under 4 months old

Procedure

Triage:	The triage nurse will determine which patients meet Fast Track criteria; will enter FT in the upper right hand corner of the ED clinical record at time of registration; and place a green Fast Track dot on the top of the clinical record.
Patient prep:	Patient is roomed by assigned staff and the patient is prepared for anticipated treatment. Chart racked with green sticker to alert ED physician to waiting fast track patient.
ED MD:	ED Physician evaluates patient and orders any necessary diagnostic studies.
Patient care:	Patient can be placed in ED cubby to wait for results if other fast track patients waiting. Patients are brought back to treatment area for definitive care and patient teaching.
Discharge	Patients are discharged by MD or assigned staff. (remember ED techs may not discharge patients but LVN's may)

Documentation:

ED clinical record:

- Check the box in the secondary survey that refers to the ED Physician notes for assessment.
- The LVN or tech may document focused musculoskeletal findings, pain scale, and screening questions.
- Continue to document all care, teaching, and discharge areas.
- Follow policy for revitals and completion of chart.

Shift report:

- Indicate number of fast track patients treated during the shift.

Fast Track Log

- A Fast Track Log will be kept to facilitate data collection
- Place a patient sticker on the page for all patients seen. Note time roomed on sticker.

Fall Outs

If the patient requires more than Fast Track care, line out the name on the log and note briefly why.

❑ **Chest Pain-Presumed cardiac in nature**	❑ **Dyspnea / CHF / Pneumonia**	❑ **Extremity Injury**
• STAT EKG and show to ED MD • IV saline lock • Draw blood • O2 @ 2L via N/C, Cardiac monitor, pulse oximeter • ASA 324 mg PO chewed (if no allergy to ASA and not taken prior to arrival) • NTG 0.4mg sublingual every 5 min x 3 for chest pain if SBP>90mm Hg • Notify physician of persistent pain.	• Draw blood including Blood cultures x 2 if pneumonia suspected • O2 as appropriate o 2L via N/C for COPD pts o Maintain pulse ox >92% for non-COPD pts • IV saline lock • Chest x-ray • Anticipate administration of antibiotics for pneumonia patients within 6 hours of arrival to ED.	• Determine mechanism of injury and exact location of pain. Evaluate joint above and joint below the injury for tenderness. Order appropriate x-ray ❑ Right / Left (circle) _____ ❑ Right /Left (circle)_____ • Immobilize / Elevate injured extremity • Apply cold compress if injury is less than 48 hours old • Saline lock for obviously displaced fractures / severe pain • Treat pain as indicated below.
❑ ***Asthma***	❑ ***Pain***	❑ **Lacerations/Wounds**
• O2 as appropriate: Maintain pulse ox >92% for non-COPD pts • IV saline lock • Continuous pulse oximetry • Stat Albuterol 2.5mg neb with peak flow before and after • Anticipate administration of IV steroids • Notify ED MD of patient's presence and presentation	Mild to moderate soft tissue and/or musculoskeletal pain; no allergy; no history of GI bleed or asthma: **Adults** • Ibuprofen 400 mg PO **Pediatrics** • Ibuprofen 10mg/kg PO Severe pain, other cause, or need to be NPO consult EDMD	• Cleanse wound with normal saline • Document tetanus immunization status o If longer than 10 years administer 0.5ml Tdap IM • Suture set-up at bedside • Anticipate post-suture clean up and dressing administration
❑ Pediatric Fever	**Protocol related to eye emergencies has been deleted**	**Signatures**
• Determine last dose of antipyretics • Acetaminophen 15 mg/kg PO or fever > 100.4 rectal and if > 4hours from last dose . May give rectally if vomiting. • Ibuprofen 10mg/kg PO if continued fever >1hour post administration of acetaminophen and more than 6 hours since last does of ibuprofen.		_____ ARN Signature _____ Print name and title Date:_____ Time:_____

***Check the appropriate box to activate the order set within the chosen box. May check pain box in addition to laceration/wound or extremity injury

Emergency Department
Nurse Initiated Protocols
Order Sheet

Patient Identification

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: March 21, 2022

TO: Kimberly Hartz, Chief Executive Officer

FROM: Shakir Hyder, MD, Chief of Staff

SUBJECT: MEC for Board Approval:

The Medical Executive Committee, at its meeting of March 21, 2022, approved the Updated Rules & Regulations.

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval of the attached Rules & Regulations.

WASHINGTON HOSPITAL MEDICAL STAFF
RULES AND REGULATIONS MANUAL

ADOPTED BY THE MEDICAL STAFF: March 21, 2022

Last Revision Date: February 11, 2015
October 17, 2011 (MEC); November 9, 2011
September 13, 2010 (MEC); October 13, 2010 (BOD)
May 19, 2009 (MEC); June 10, 2009 (BOD)
March 17, 2014 (MEC); March 19, 2014 (BOD)
September 21, 2015 (MEC); October 14, 2015 (BOD)
April 14, 2017 (MEC), April 24, 2017 (BOD)
September 16, 2019 (MEC), November 1, 2019 (BOD)
November 16, 2020 (MEC), December 9, 2020 (BOD)
March 21, 2022 (MEC) April 13, 2022 (BOD)

WASHINGTON HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

I. Definition

Rules and Regulations apply to all Medical Staff members (and Allied Health Professionals) regardless of staff category or department or section assignment. In addition to these Rules and Regulations, Medical Staff members shall comply with applicable federal and state regulations in effect now and in the future. Rules and Regulations are divided into those concerning patient care responsibilities and those concerning Medical Staff membership.

II. Patient Care Responsibilities

A. Admission

1. Patients may be admitted who require acute care consistent with the license of the Hospital. Admitting criteria shall be equivalent to the scope of service of each department. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated to the Admitting Department. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever.

3. The patient's care shall be managed by their attending physician. In the case of a patient applying for admission and having no physician, he/she shall be referred to the Emergency Department for disposition.

4. In case of acute shortage of available beds, patients shall be admitted in according to the following priorities:

    a) critically ill patients whose condition may be life threatening;
    b) non-critically ill patients who are residents of the Washington Township Hospital District;
    c) non-critically ill patients who are not residents of the Washington Township Hospital District.

    If necessary, arbitration of priority of admission shall be made by the Chief of Staff or designee.

5. Patients admitted to Inpatient Status by an Emergency Department physician between 8 AM and 9 PM must be seen by the attending/covering physician, within 6 hours. Patients admitted to Inpatient Status after 9 PM must be seen by the attending/covering physician by 9 AM the next morning on weekdays and 10 AM the next morning on weekends. An Admission Medication Reconciliation should be completed within 24-hours of admission by the attending/covering physician. If an emergency medical condition arises during this time frame, the attending/covering physician is available and capable to see the patient, as per

the Rules and Regulations.

6. Observation Unit Patient Care
    a) All physicians with current admitting privileges may serve as an attending in the WHHS hospital observation unit.

    b) All ED physicians and attending/covering physicians shall have direct telephone/text or face to face contact agreeing to place the patient in the observation unit under the care of the attending/covering physician. All admit orders for observation care must be entered at the time of admission to the unit. Observation unit contracted physicians will be the attending for all unassigned patients placed in the observation unit as well as any patient upon the request of their attending/covering physician.

    c) Patients placed in the observation unit between 8 AM and 9 PM must be seen by the attending/covering physician, within 4 hours. Patients placed in the observation unit after 9 PM must be seen by the attending/covering physician by 8 AM the next morning. If an emergency medical condition arises during this time frame, the attending/covering physician is required to see the patient within 30 minutes, as per the Rules and Regulations.

    d) Observation unit contracted physicians will be assigned by unit policy to provide care for all patients who cannot be seen in the above time frames and will become the attending while the patient is in the observation unit. Once such patients are discharged from the observation unit, they will be discharged/transferred back to their original attending physician for further care.

    e) All observation unit patients shall be cared for in accordance with the observation unit criteria and guidelines as developed by the Hospital administration.

B. Physician Backup

Each member of the Medical Staff shall name another member of the Medical Staff within the same clinical department who may be called to attend his patients in his/her absence.

When a physician signs out to another physician, that physician is responsible for providing appropriate medical care and/or consultation as required by the patient's needs. In case of failure to name such associate, the Chief of Staff of the Hospital shall have the authority to call any member of the staff to assume that patient's care.

C. Emergency Availability

All practitioners assuming 'on-call' responsibility for in-patient care and/or for Emergency Department coverage must be available at all times and be capable of being on site at the Hospital within an appropriate time (thirty (30) minutes maximum).

D. Consultations

1. Staff members are expected to make use of the consultative services available from members of the Medical Staff when indicated. Request for consultation shall be made by a physician.

2. Consultation is required in the following situations:

   - Patient's clinical course and/or care required are beyond the scope of the individual practitioner;
   - Diagnosis is obscure to the attending physician after routine diagnostic procedures and therapeutic measures have been completed;
   - In the Critical Care Units as outlined in the Critical Care privileging criteria.
   - When the assessment of the patient's needs or condition require specialized assessments to provide optimal care. This may include dental assessments. (Change approved by Board 5/8/02.)

3. A non-Medical Staff member with temporary privileges to consult on a specific patient cannot write orders, or be the attending physician, if not trained and competent in WeCare. (per U.1.d). Management and documentation will be performed by the Medical Staff member who obtained the consultant.

E. Patient Visits by Physician

A. Daily rounds should be initiated by 10 AM and completed, whenever possible, by 12 PM. Discharges should be complete by 12 PM.

B. All patients must be seen by a physician on each day and within twenty-fours (24) hours prior to discharge. If a patient's planned release from the Hospital is to occur beyond 8 hours but within 24 hours of the most recent physician evaluation, the following requirements must be met. The progress notes must be dated and timed and include clear documentation demonstrating the necessity for the patient's final day of hospitalization. The discharge order must include the medical conditions that should be met prior to discharge. There must be telephone communication between the physician and the nurse prior to the patient leaving the hospital.

F. Attending Physician

At the time of admission of a patient, the attending physician must be designated on the doctors order sheet. If no attending physician is so indicated, the admitting physician will automatically be designated as the "attending M.D." Prior consent must be obtained from the new designated attending physician by the physician writing the order of transfer. When there are two or more physicians involved in patient care management, one physician must be designated as primarily responsible to the involved nursing unit. The designated responsible physician should be recorded on the order sheet.

G. Medical Decision Making for the Incapacitated, Unrepresented Patient

In the event that a patient lacks capacity to make decisions and has no one to make decisions for them, assistance will be provided to the patient's physician(s) in making timely, thoughtful decisions regarding medical treatment according to Washington Hospital Numbered Memorandum 3-251 and in compliance with State and Federal regulations.

H. Patient Transfers

Shall be considered when a patient's condition is no longer appropriate to the current care setting. Additional transfer criteria may be developed by specific Departments/Services. In making transfer decisions physicians should refer to Washington Hospital Numbered Memorandum 3-188 as a guide.

I. Pre-operative Verification Process

Prior to starting any invasive procedure, including those at bedside, all members of the team conduct a final verification, or "time out", of the correct patient, procedure, site and, as applicable, implants.

J. Discharge

When a patient no longer requires acute care, and when satisfactory arrangements have been made to assure the continuity of care, discharge shall be considered. Patients shall be discharged only on order of a physician, surgeon, dentist or podiatrist.

K. Informed Consent

The duty to describe invasive procedures to the patient and respond to the patient's questions concerning the nature of the procedure and obtain informed consent is exclusively the duty of the treating physician. Verification that informed consent has been obtained must be documented in the medical record. Refer to Washington Hospital Numbered Memorandum 3-177 as a guide.

L. Blood Transfusion Consent

The duty to describe the risks, benefits and alternatives of blood transfusion is exclusively the responsibility of the physician ordering the transfusion. Verification that informed consent has been obtained must be documented in the medical record.

M. Pathology Examination

All anatomical parts, tissues and foreign objects removed at operation with the exception of those surgical specimens specified by the Department of Health Services to be exempt, shall be sent to the Hospital pathologist who shall make such examinations as he/she may consider necessary to arrive at a pathological diagnosis. The findings shall be part of the patient's medical record.

A list of surgical specimens deemed exempt from pathology examination by the California Department of Public Health is available in the Operating Room. (Change approved by

MEC 5/22, Board 6/12/03)

N. Patient Rights

The Medical Staff shall comply with State regulation and the Hospital policy regarding Patients Rights*.* Refer to Washington Hospital Numbered Memorandum 1-104 as a guide*.*

O. Laboratory Work

1. Pre-surgical lab work is as outlined in the Department of Anesthesiology Manual.

2. Lab work for uncomplicated obstetrical cases is as outlined in the Department of Ob/Gyn Manual, General Guidelines A. (Change approved by Board 5/8/02)

P. Repeated Orders

Repeated Laboratory, EKG, x-ray and respiratory therapy orders should be renewed seventy-two (72) hours after admission and every seventy-two (72) hours thereafter.

Q. Do Not Resuscitate (DNR)

DNR orders shall be documented according to Hospital policy. Refer to Washington Hospital Numbered Memorandum 3-149 as a guide.

R. Restraints and Seclusion

Patients will be assessed for restraint and seclusion. Orders will be documented according to Washington Hospital Numbered Memorandum 3-303, and in compliance with State and Federal regulations. (Change approved by Board 1/9/02)

S. Medical Screening Exam

All patients presenting to the Emergency Department for treatment and evaluation must be given a Medical Screening Exam (MSE) in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. Telephone orders for treatment will not be accepted.

T. Autopsy (approved Board 06/10/09)

Deaths must be reported to the Alameda County Coroner according to Washington Hospital Numbered Memorandum 3-141.

Hospital Autopsy - Deaths that do not require being reported to the Alameda County Coroner or that the Coroner has released or declined to accept must be considered for Hospital autopsy.

All autopsies of deceased Washington Hospital inpatients performed at Washington Hospital are a free service provided by the Hospital and Pathologists. The attending physician must document an attempt to secure a consent for an autopsy for deaths that meet any of the following criteria:

Autopsy Criteria for Non Coroner's Deaths

1. Unknown cause of death
2. Unanticipated death
3. Death contributing complications which are unexplained
4. Pediatric, including neonatal, and obstetric patient deaths
5. Deaths from infectious diseases, which may have epidemiologic information
6. Deaths of patients in clinical trials
7. Deaths due to transplant rejection or complication
8. Family concerned about the patient's death. The family may independently request an autopsy.

Prior to the consented autopsy, the attending and pathologist should discuss the patient and the clinical findings. They may decide to limit to examination to relevant organ systems. The clinical staff is encouraged to attend the autopsy. The autopsy pathologist will chart the preliminary findings within 48 hours. The autopsy will be finalized within ninety days. The autopsy report will be forwarded to the appropriate Medical Staff Department(s) for further review and/or education.

U. Medical Record Responsibilities

1. General Rules

   a. Any member of the Medical Staff wishing to exercise admitting or clinical privileges, and any Allied Health Professional wishing to exercise clinical privileges at Washington Hospital must be proficient in the Washington Hospital Healthcare System (WHHS) WeCare system, and must utilize WeCare when providing healthcare within WHHS

   b. Each member of the Medical Staff and each Allied Health Professional as set forth above is required to learn and competently use WeCare to assure that the clinical information in WeCare is complete and accurate, and that other members of the Medical Staff, other Allied Health Professionals, and Hospital personnel may rely upon the clinical information in WeCare. Use of WeCare is essential to the continuous quality improvement program of WHHS.

c. Medical records must be documented electronically into WeCare, electronically signed and updated by all practitioners with privileges providing care to patients. Failure to provide this documentation and signing will be considered a medical records deficiency, and may lead to Medical Staff/MEC disciplinary action as described in the Rules and Regulations.

d. WHHS will grant security access to WeCare only to members of the Medical Staff and Allied Health Professionals who have completed WeCare training and have demonstrated a competency rate of 80 percent or higher on the WeCare examination. For Medical Staff and Allied Health Professionals who do not successfully complete the competency examination, additional training will be available to assure a reasonable opportunity to achieve sufficient competency levels.

e. Any member of the Medical Staff or an Allied Health Professional who is not in compliance with the WeCare training and use provisions of this Rule after a reasonable opportunity to comply will not be eligible for reappointment, and will be subject to automatic suspension of admitting and clinical privileges under Article IV, Section 6.3 of the Medical Staff Bylaws.

f. All medical records are confidential and are the property of the Hospital. They are maintained for the benefit of the patient, the Medical Staff, and the Hospital. Records may be transferred from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In cases of readmission of a patient, all previous records shall be available for the use of the attending physician, whether attended by the same physician or another. Hospital records shall be made available to committees of the Medical Staff, to physicians undertaking statistical and research projects, and in preparation of medical papers.

2. Responsibility for Record Keeping

a. For the purpose of medical record keeping, the Admitting Physician shall be the attending physician unless otherwise indicated in the admitting orders. The attending physician will remain the same for the patient during the hospital stay unless transfer of care to another attending physician is documented in the Physician Orders. In obstetrical cases involving delivery, the physician who delivers the infant shall be the attending physician for the mother and the newborn unless otherwise documented in the Physician Orders. In cases involving a major surgical procedure, the primary surgeon shall become the attending physician **un**less otherwise specified in the orders.

b. For patients admitted to Washington Hospital Healthcare System, the attending physician at the time of discharge (not necessarily the discharging physician), will be responsible for medical record completion, including the discharge summary. The admitting physician, whether or not he/she is the attending physician, is responsible for the admitting history and physical

3. History and Physical Examination

a. A history and physical examination must include the following elements:

- Medical history, including chief complaint, details of present illness, relevant past, social and family histories, and inventory by body system;
- Summary of the patient's psychosocial needs as appropriate to the patient's age;
- Report of relevant physical examinations;
- Statement regarding allergies, immunization status (Pediatrics Only) and current medications;
- Statement on the conclusions or impressions drawn from the admission history and physical examination;
- Statement on the course of action planned for this episode of care and its periodic review, as appropriate;

b. A complete history and physical examination shall in all cases be recorded within twenty-four (24) hours after admission of the patient. History and physical exams for short stay (i.e., same day discharge) must be dictated or documented in the record by 6:00 p.m. on the day prior to surgery. History and physical exams for all other elective surgical and invasive procedures (except PTCA) must be dictated or documented in the record by noon the day prior to that procedure.

c. A completed history and physical within 30 days before the patient is admitted, or if the patient is readmitted, requires an interval note reflecting the patient's current medical condition. If the patient is admitted more than 30 days from the last admission, a new history and physical will be required. (Rev. approved by MEC 6/21/04, Board 7/14/04).

4. Dictation

The following types of documentation must be entered into WeCare and cannot be dictated into the Hospital dictation system:

- Allergies
- Problem lists
- Orders
- Progress notes

5. Orders

All orders shall be entered into WeCare.

a. Orders cannot be dictated via the Hospital dictation system.

b. Preferably, verbal/telephone orders should be given to a registered nurse. For a list of other healthcare professionals who can accept physician orders, refer to Washington Hospital Numbered Memorandum 3-176.

c. Verbal orders are not accepted, except in emergency situations, or in a sterile environment where electronic order entry by the practitioner is not feasible.

d. Telephone orders are accepted only when the physician giving the order is off the

Hospital campus, and cannot easily access a computer. The physician must remain on the phone so the registered nurse (or health care professionals identified in Memorandum #3-176) can enter into WeCare and then read the order back to confirm it.

e. All verbal and telephone orders must be authenticated by the ordering physician within forty-eight (48) hours. The ordering physician must enter all orders in the WeCare system, except for verbal or telephone orders entered by the registered nurse (or health care professionals identified in Memorandum #3-176). In cases where the ordering physician is not available, the attending or covering physician may authenticate verbal orders.

6. Patient Problem List

- During each admission, transfer and discharge the patient problem list must be reviewed and updated for lapsed, duplicate and related problems to maintain a clear, concise and accurate problem list.

7. Progress Notes

a. Daily progress notes are required on all patients and must be dated, timed and authenticated.

8. Post-Operative / Post-Procedure Notes

a. A brief post-operative/post-procedure progress note which includes all pertinent information to anyone required to attend to the patient must be completed immediately after the procedure, and prior to the patient moving to the next level of care. Required elements are:

- name of the primary surgeon, assistants, and anesthesiologist;
- type of anesthesia;
- findings;
- procedures performed;
- descriptions of the procedures;
- estimated blood loss;
- complications;
- specimens removed;
- postoperative diagnosis

9. Operative/procedure report must be entered into WeCare or dictated within 24 hours of the time of the operation/procedure and must record the name of the primary surgeon, assistants, anesthesiologist, type of anesthesia, findings, procedures performed, comprehensive descriptions of the procedures, estimated blood loss, complications, specimens removed, and postoperative diagnosis. The note can be reported if the note includes a comprehensive description of the procedure.

10. Abbreviations

a. Only approved symbols or abbreviations for medical records should be used. Abbreviations listed as never to be used must not appear in any portion of the

medical record. Refer to Washington Hospital Numbered Memorandum 3-198 as a guide. (Rev. approved by MEC 6/21/04, Board 7/14/04)

11. System Features

a. Practitioners are responsible for managing their WeCare In-Basket, which should be reviewed regularly.

b. Copy paste and copy forward should be used sparingly and with extreme caution. The author of the documentation is responsible for the entire content; any information which is copied, pasted, imported, or reused must be reviewed and revised as necessary by the clinician completing the documentation to ensure the patient's record accurately reflects the treatment provided. To avoid plagiarism, the original author of the copied information should be acknowledged.

c. Auto-populated information must be reviewed for timeliness and accuracy prior to electronically signing a note.

12. Discharge Summary and Discharge Diagnosis

a. Discharge summaries are required for all patients with a stay in the hospital, including inpatients, observation patients, and OB patients.

b. The discharge summary must be completed within 72 hours of discharge, and must include:

- the reason for hospitalization;
- significant findings;
- procedures performed;
- care, treatment, and services provided;
- information relative to the condition of the patient at discharge; ,
- instructions to the patient and/or family, particularly in regards to physical activity limitations, medications and diet. (Rev. approved by MEC 6/21/04, Board 6/14/04)

c. A discharge diagnosis is to be made available to the Health Information Management Department within forty-eight (48) hours of the patient's discharge by the patient's attending physician.

13. Medical Record Completion

a. The attending physician, surgeon, dentist or podiatrist shall assure that the record is complete as required by the Bylaws, Policies and Procedures and Rules and Regulations. Incomplete records shall become delinquent fourteen (14) days after discharge from the Hospital.

14. Core Measure Documentation

a. Compliance with core measure documentation requirements shall be mandatory. Failure to complete the discharge checklist shall be deemed an incomplete medical record and subject to the same disciplinary process (Approved by MEC 3/21/05, Board 4/13/05).

b. Core measure order sets, including the admission order set and discharge summary record, are mandatory standing orders. (Approved by MEC 1/11/08, Board 1/23/08)

c. No patient will be discharged unless core measure documentation is complete; failure to comply with core measure documentation requirements prior to discharge will result in a quality report to the Chief of Staff or designee and may result in limited suspension. (Approved by MEC 1/11/08, Board 1/23/08)

15. Coding Queries

a. Coding queries must be answered and returned to the Health Information Management Department within 96 hours once the physician is notified.

V. Request for Radiologic Consultation

Requisitions for outpatient radiological consultation may be submitted electronically or on paper, and must include the clinical findings and/or the working diagnosis, as well as the type of examination desired

W. Use of the Emergency Department

1. No Staff member shall "sign out" to the Emergency Department physician to provide continuous care for his/her patients, and may only sign out to members with like privileges. (change approved by Board 5/8/02)

2. Unnecessary use of the emergency facilities is discouraged.

3. Referral of urgent patients to the Emergency Department shall, when possible, be preceded by notification to the Emergency Department staff and/or physician.

4. Critically ill or injured patients will be stabilized by Emergency Department personnel. If the patient has a private physician on the Medical Staff, that physician will be consulted regarding continuing care and disposition.

X. Infection Control Policies

1. Infection Control Policies are located in the Washington Hospital Numbered Memoranda, Section 6.

2. All practitioners shall comply with the current hospital policy regarding Universal Blood and Body Fluid Precautions. Refer to Washington Hospital Administrative Memo #3-190 as a guide.

3. All practitioners shall comply with the current hospital policy regarding Tuberculosis Screening for Healthcare Workers. Refer to Washington Hospital Administrative Memo #2-186 as a guide.

4. All patients with infectious diseases shall be isolated according to the infection

control policies. If the attending physician wishes to question the isolation precautions instituted, he or she may discuss the matter with the Infection Control Coordinator.

5. Any patient admitted with a draining wound, sinus tract or other purulent draining lesion will be placed on appropriate precautions, according to infection control policies.

6. Certain infectious diseases must, by law, be reported to the Public Health Department. It is the responsibility of the physician in charge to report the diagnosis to the Hospital Infection Control Coordinator. The list of reportable diseases and the procedure for reporting is contained in the Infection Control Policies.

7. Initiation and maintenance of intravenous lines is governed by Infection Control Policies, located in the Infection Control Manual.

8. All practitioners shall comply with current Hospital policy regarding proper hand hygiene. Refer to the Infection Control Policies as a guide (Change approved by MEC 11/15/04, Board 12/8/04).

Y. Patient Smoking Policy

The Medical Staff recognizes that Washington Hospital is a smoke-free environment. Physicians are encouraged to order nicotine replacement procedures for hospitalized patient and promote smoking cessation programs for patients and consider prescription of nicotine replacement products for hospitalized patients. (Rev. approved by MEC 6/21/04, Board 7/14/04)

Z. Standardized Procedures

The Medical Staff has approved the following standardized nursing procedures:

- Standardized Procedure for ED Care Initiated by the Authorized Registered Nurse. (Rev. IDPC 08/05/2020, MEC 08/17/2020, JCC 08/24/2020)
- Standardized Procedure for Peripherally Inserted Central Catheter (PIC Catheters) (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for Pronouncement of Patient Death (Rev. IDPC 08/05/2020, MEC 08/17/2020, JCC 08/24/2020)
- Standardized Procedure for Removal of Jackson-Pratt, Hemovac, & Penrose Surgical Drains (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for Medical Screening Examination for the Obstetrical Patient Performed by Registered Nurse (Rev. IDPC 07/01/2020, MEC 07/20/20, JCC 07/27/2020)
- Standardized Procedure for Sexual Assault Examination (Rev. IDPC 07/01/2020, MEC 07/20/2020, JCC 07/27/2020)
- Standardized Procedure for Evaluation of Patients with Behavioral Emergencies and Involuntary Holds by Authorized Registered Nurses (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for Rapid Response Team (Rev. IDPC 11/04/2020, MEC 11/162020, JCC 11/23/2020)
- Standardized Procedure for Pressure Ulcer Prevention (Rev. IDPC 08/05/2020,

MEC 08/17/2020, JCC 08/24/2020)
- Standard Procedure for Midline Catheter Insertion, Removal, and Management (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for RSTU COVID-19 Nurse Initiated Protocol (IDPC 11/04/2020, MEC 11/16/2020, JCC 11/23/2020)

AA. Form Evaluation Protocol

All requests for new or revised forms and order sets shall be processed through the WECARE Physician Steering Committee in accordance with Hospital policy. All patient instructions, new forms or forms with significant revisions that will become part of the medical record shall be approved by the appropriate departmental committee(s) and the Clinical Evaluation Committee. Following appropriate Medical Staff approval, proposed forms will then be returned the WECARE Physician Steering Committee for processing. (Rev. approved by MEC 6/21/04, Board 7/14/04)

BB. Telemedicine

Telemedicine is the use of electronic communication or other communication technologies to provide or support clinical care at a distance. The following services may be provided via telemedicine: diagnostic medical imaging, EKG interpretation, and communication of laboratory results.

CC. Medical Decision Making for the Incapacitated, Unrepresented Patient

In the event that a patient lacks capacity to make decisions and has no one to make decisions for them, assistance will be provided to the patient's physician(s) in making timely, thoughtful decisions regarding medical treatment according to Washington Hospital Numbered Memorandum 3-251, and in compliance with State and Federal regulations.

III. Staff Membership Responsibilities

A. Department Assignment and Clinical Privileges

Each member shall be assigned to one (1) department and shall request a level of clinical privileges within that department. Except as defined in specific staff categories, each member shall also have delineated privileges. Documentation of appropriate training and experience to support the level and the delineated privileges will be required. Members may request additional privileges in other departments, with evidence of training and experience.

B. Liability Insurance

Minimum professional liability insurance coverage must be maintained by all practitioners in the amounts of $1,000,000/occurrence and $3,000,000/aggregate as designated by the MEC and the Board of Directors.

C. DEA Certificate Schedules

All practitioners are required to maintain schedules 2, 2N, 3, 3N, 4, and 5 on their DEA certificates. (Change approved by MEC 8/19/02, Board 9/11/02).

D. Solicitation and Advertising

All members of the Medical Staff and Allied Health Professionals of Washington Hospital shall govern their professional conduct with regard to solicitation and advertising with concern for the principles of medical ethics. Advertising, whether in professional or non-professional publications, shall not identify Washington Hospital Healthcare System without the permission of the Washington Hospital Administration. Violation of this policy may result in expulsion from the Washington Hospital Medical Staff (Change approved by MEC 10/19/04, Board 12/8/04).

E. Procedure for Initiation of Special Studies

The MEC must approve the initiation of special studies, surveys, or procedural changes.

F. Credential File Access

- Any request by a staff member to view his/her own credentials file must be submitted in writing to the department chairperson and to the Chief of Staff. Access to physicians' personal credentials files is available only upon approval by the Chief of Staff or designee, and must contain the reason for the request. Any review of files will require a specific reason for doing so. Reviews will be individually logged with time, date and stated reason. The log will be kept by the Medical Staff Secretary.

- A Medical Staff member shall be granted access to his/her own credentials file in the Medical Staff Office in the presence of the Chief of Staff or designee. The member may receive a copy of only those documents addressed personally to the member.

- Member's opportunity to request correction/deletion of, and to make addition to information in the file:
  a) when a member has reviewed his/her file as provided above, he/she may address to the Chief of Staff or designee, a written request for correction or deletion from the file. Such request shall include a statement of the basis for the action requested;
  b) the Chief of Staff or designee shall review such a request within a reasonable time and shall recommend to the MEC, after such review, whether or not to make the correction or deletion requested. The MEC, when so informed, shall either ratify or initiate action contrary to this recommendation by a majority vote;
  c) the member shall be notified promptly, in writing, of the decision of the MEC;
  d) in any case, a member shall have the right to add to his/her own credentials file, upon written request to the MEC, a statement responding to any information contained in the file.

G. Operating Room Authority

1. The Director of Perioperative Services is responsible for the scheduling of all operations. The Director shall use, as his/her guideline for scheduling procedures, the best interest of the patient, available staff, and available operating rooms.

2. The Director of Perioperative Services will have the general responsibility for the enforcement and compliance of the Operating Room Rules and Regulations as set forth. In the absence of the Director of Perioperative Services, the Operating Room

Manager or Charge Nurse may call upon the Associate Administrator, Department of Surgery Chair (or designee) Operations & Support.

H. Emergency Department Call Roster Responsibilities (Changes approved by MEC 12/20/04, Board 1/12/05)

1. The Hospital shall be responsible for developing an on-call rotation of medical specialists, which consists of members with appropriate privilege level designation. Individual physicians shall participate on the roster pursuant to a contract with the Hospital. On-call rotation schedules shall be maintained in the ED.

2. When a Staff member is on call for the Emergency Department call roster, that physician is responsible for and cannot refuse to evaluate a patient in an emergency situation anywhere in the Hospital, provided that the emergency falls within the member's area of clinical privileges.

3. On-call rotation schedules shall be maintained in a manner that best meets the needs of the residents of the District, considering the services offered by the Hospital and the availability of physician specialists.

4. Accurate rosters of on-call specialists and sub-specialists shall be retained for a period of five years.

5. Transfer arrangements with other hospitals that can provide the specialty service shall be made to cover the service when an on-call physician is not available. If a patient presents needing care when a specialty is not covered, the patient shall be transferred in accordance with Hospital policy.

6. When an on-call physician is contacted by the ED and requested to respond, the physician must do so within thirty (30) minutes, as required by these Rules & Regulations. The ED physician, in consultation with the on-call physician, shall determine whether the patient's condition requires the on-call physician to see the patient immediately. The determination of the ED physician shall be controlling in this regard.

7. An on-call physician is responsible for the care of a patient until the emergency medical condition is stable. An on-call physician shall not require insurance information or a co-payment before assuming responsibility for care of the patient.

8. A refusal or failure to timely respond shall be reported immediately to the appropriate Department Chairperson who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate disciplinary action. In this situation, the Department Chairperson shall notify the Chief of Staff and the Chief Executive Officer of the event.

9. In the case of subsequent referral to an on-call physician, a copy of the Emergency Department record, including diagnosis and initial treatment may be placed in the on-call physician's mailbox. The Emergency Department shall inform the patient of his/her responsibility to make an appointment with the referral physician.

I. Medical Record Completion

Failure to meet the medical record requirements of the Medical Staff described in this document will result in the following corrective action. After the third suspension or when the cumulative number of suspension days reaches 20 within any Medical Staff year for failure to complete medical records, the member will be referred to the MEC for review of their Medical Staff status.

The month after a physician meets the threshold, a letter will be sent to the physician from the Clinical Evaluation Committee notifying him/her of the referral to MEC. If sanctions are deemed by the MEC to be necessary, they will follow the procedure defined below. (approved by MEC 2/29/02, Board 3/13/02)

1. Warning letter from the MEC for first referral to the Medical Executive Committee;
2. 30-day limited suspension for a second referral within a Medical Staff year to the MEC;
3. 60-day limited suspension for a third referral within a Medical Staff year to the MEC;
4. Termination of Medical Staff appointment to include submission of an 805 report to the Medical Board of California for a fourth referral within a Medical Staff year to the MEC

In addition, corrective action will apply to members failing to adhere to meeting attendance requirements. Meeting attendance will be reviewed at the completion of each Medical Staff year.

Each year, in December, members will receive notification of their meeting attendance status for the current Medical Staff year. In June, at the end of the Medical Staff year, those members who do not meet the 50% meeting attendance requirement will be referred to the MEC for review of their medical staff status. If sanctions are deemed by the MEC to be necessary, the MEC will follow the procedure defined below.

1. Warning letter from the MEC for first referral to the Medical Executive Committee;
2. 30-day limited suspension for a second referral to the MEC;
3. 60-day limited suspension for a third referral to the MEC;
4. Termination of Medical Staff appointment to include submission of an 805 report to the Medical Board of California for a fourth referral to the MEC.

J. Physician Availability

To assure the availability of the physicians and continuity of patient care, all members must:

1. provide the Medical Staff Office, at the time of appointment and reappointment and as may be necessary, with the name of a physician with like privileges who may be called in the member's absence;

2. maintain a reliable system by which to be reached during non-business hours. An answering service is recommended; however, if a pager system or cell phone is used, it must be easy and effective for patients and Hospital Staff to use;

3. be available at all times while on-call. It is not appropriate to ask an answering service to "hold" calls.

K. Physician Hand-Off and Covering Physician Guidelines

The following are guidelines for the Medical Staff regarding "hand-off" situations, particularly, those situations that involve the transferring of on-call patient care responsibilities:

1. At the time of transfer of patient care responsibility to an on-call physician ("sign-off"), there must be clear 2-way communication with an opportunity for feedback of up-to-date information regarding:

    a) The patients who are covered and their locations;
    b) Current condition/status of patient(s) and relevant ongoing interventions;
    c) Any anticipated changes or likely problems to occur during the coverage period;
    d) any pending diagnostic studies that should be checked or followed up during the coverage period;
    e) Consultants involved and the scope of their activity and involvement in the case;
    f) Discharge planning considerations, especially if the patient is to be discharged during the period of coverage.

2. There must be clear communication to answering services and, when appropriate, nursing units, as to which physician in on-call and any permanent or temporary changes in the on-call schedule.

3. The physician is responsible for insuring that the answering service should, at all times, know who is covering a physician's patients and the answering service should be easily reached by calling the physician's office number when the office is closed.

4. Covering physicians should always be available through a phone call to the attending physician's office, which is then picked up by the answering service. Additional methods to contact the on-call physician are permissible (e.g., direct paging) as long as instructions to each nursing unit involved are clear and concise.

5. The attending physician or the physician covering the attending physician shall have the ultimate responsibility for responding to patient care issues. If there are multiple consultants involved and if the there is any confusion, disagreement, or other lack of clarity regarding which physician should respond to a problem the attending physician, or the attending physician's coverage, is responsible for responding to the problem in a timely manner.

6. If an attending physician is signing off on a case and will be transferring care of the patient to a new physician, the attending MUST:

    a) Confer with the physician who will be assuming the care of the patient.
    b) Place an order in the medical record transferring the patient to the new attending physician's service.

7. Urgent and emergent consultations for acute changes in a patient's condition should, whenever possible, be made through physician-to-physician verbal communication.

L. Photo I.D.

All members of the Medical Staff are required to obtain appropriate photo identification issued by Washington Hospital and to display the identification prominently above the waist while in the Hospital.

M. Medical Staff Meeting

There will be four general staff meetings held on the second Tuesday in September, January, March and June. The Annual Dinner/Dance will be held in May with installation of Medical Staff Officers.

N. MEC/Medical Staff Dispute Resolution Process

Disputes between the Medial Executive Committee (MEC) and voting members of the Active Staff shall be resolved as follows. If at least one-third of the members of the Active Staff sign a petition proposing a change to the Bylaws, Rules and Regulations and policies or procedures or objecting to an action of the MEC relating to the Bylaws, Rules and Regulations, policies or other official MEC actions, the petition shall be presented to the full MEC. The MEC shall then arrange to meet with representatives of those who have signed the petition to discuss and attempt to resolve the matter. If the MEC and representatives mutually agree, consultants or a mediator may be engaged to assist. If a matter relating to bylaws, rules and regulations or policies is not resolved within 180 days, both the MEC and the representatives shall prepare written statements of position which shall be considered by the Board of Directors.

O. Requesting and Providing Confidential Peer Review Information

During the processing of an application, reapplication or corrective action investigation, the Medical Staff requests information from another peer review body regarding its peer review of practitioner for medical disciplinary cause or reason, in accordance with California Business and Professions Code § 809.08, practitioner will pay reasonable costs associated with obtaining such information. Failure to pay reasonable costs will result in an automatic withdrawal of the practitioner's application or reapplication or the practitioner will be deemed to have resigned. Such action shall not entitle the practitioner to the procedural rights set forth in Article VII of the Bylaws and will not be reported to the Medical Board of California or the National Practitioner Data Bank

P. Medical Students

Academic Medical Center Affiliated (AMCA) Medical Students may function in patient care roles at the Hospital as follows:

1. Pursuant to the provisions of written affiliation agreements approved by the Hospital and the Medical Staff;

2. In compliance with protocols established by the Medical Staff in conjunction with the (AMCA) Program Director regarding the scope of the Medical Student's authority, direction and supervision, and any other conditions imposed by the

Hospital or Medical Staff; and

3. Subject to the following:

a. Medical Students shall at all times wear a photo identification badge that indicates the student's level of education and role at the Hospital;

b. Medical Students may examine patients, participate in patient care and assist at procedures only with the consent of the attending physician and under the direct supervision of a Supervising Physician, who shall be a qualified Medical Staff member with a (AMCA) Clinical Faculty appointment;

c. Medical Students may record initial histories and progress notes in the medical record provided, however, that all entries in the medical record shall include identification of student status and be countersigned by the Supervising Physician within 24 hours; and

d. Medical Students may write orders provided, however, that each such order must be countersigned by the Supervising Physician prior to being carried out.

IV. Finances

A. Application Fee

1. There shall be an application processing fee payable at the time the application is submitted.

2. Application fees shall be assessed in the following amounts (change approved 11/01/19):

Application for Medical Staff Membership	$600.00
Application for Locum Tenens Temporary Privileges	$600.00
Reapplication for Locum Tenens Temporary Privileges	$450.00
Application for Temporary Privileges (approved by Board 6/12/02)	$250.00

B. 1 Year Reappointment Fee

A reprocessing fee of $500 will be assessed to physicians who have 10 or more delinquent medical records at the time of reappointment and need to be placed on a 1-year re-credentialing cycle. This fee is meant to cover the extra costs incurred by the Medical Staff Office, which will be required to perform the vetting process annually, instead of every 2 years for the physician. It is not a punitive fine. (Change approved by MEC 3/15/2022 and Board 4/13/2022)

C. Annual Dues

1. The MEC with the approval of the Active Staff will establish the amount and manner of disposition of annual dues, if any. Dues are payable at the beginning of each new Medical

Staff year (July 1). Failure, unless excused by the MEC for good cause, to render payment within two months of the start of the new staff year (September 1) shall, after special notice of the delinquency, result in summary suspension of staff membership (including all prerogatives) and clinical privileges until the delinquency is remedied. When a member's suspension has reached a maximum of 14 days, he/she will be deemed to have resigned. (Change approved by Board 11/13/02.)

2. Staff dues are assessed by the Medical Staff in the following amounts per Medical Staff year: (Change approved by Board 7/10/02, 11/01/19)

For Active, Consulting, Ambulatory, Administrative Staff, Allied Health Professionals, and Provisional/Active and Provisional Allied Health Professionals who join the staff July through December of the current year.	$300.00
For Provisional/Active Staff, Ambulatory, and Provisional Allied Health Professionals who join January through June of the current year.	$150.00
For Courtesy and Provisional/Courtesy Staff who join the staff July through December of the current year.	$400.00
For Provisional/Courtesy Staff who join January through June of the current year	$200.00
Dentists (does not include oral surgeons).	$100.00
Honorary and Retired Staff	$0.00
Members on Leave of Absence - the full amount becomes due and payable when privileges are reinstated.	

3. Authority to Disburse Medical Staff Funds - The signature of any two Medical Staff Officers shall be required for disbursal of Medical Staff funds over $500.00. Any one Medical Staff Officer may sign checks in amounts up to $500.00.

4. Medical Staff Budget - The annual Medical Staff budget along with a balance sheet and cash flow statement will be presented to the Medical Executive Committee prior to the start of the Medical Staff year and to the General Staff at the September quarterly staff meeting.

5. Expenditure Limits - Any expenditure over $500.00 shall require the approval of the MEC. Request for Medical Staff funds shall be directed in writing to the MEC who will evaluate the request. It may be brought to the general staff if appropriate. Verbal requests for funds at Staff Meetings without previous consideration of the MEC shall not be allowed.

C. Stipends

The Medical Staff shall pay the stipend of the Chief of Staff and the amount will be reviewed periodically by the MEC. The Medical Staff may provide a stipend to other officers or chairpersons at the discretion of the MEC.

V. Amendment to the Rules and Regulations

Rules and Regulations shall be amended as outlined in the Medical Staff Bylaws, Article IX .

ADOPTED by the Medical Staff on November 16, 2020

APPROVED by the Board of Directors on December 9, 2020

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: **March 30, 2022**

TO: Kimberly Hartz, CEO

FROM: John Lee, CIO

SUBJECT: CredentialStream Implementation

The Medical Staff Office has utilized a system solution called MSOW (Medical Staff Office for the Web) for the past ten years in order to track and process credentialing for providers. This current solution allowed the Medical Staff Office to move from a home grown database to a hosted setup and to build workflow standardization. However, the current system is not being fully supported any more by the company and is in need of an upgrade. Team would like to implement an improved solution that allows providers to share required paperwork electronically and streamlines the credentialing process that still has several manual components.

CredentialStream is a solution from VerityStream that focuses on standard credentialing workflows and enables integration with third-party validation databases to expedite the privileging approval process. Providers would be able to submit paperwork electronically and monitor steps in the credentialing and re-credentialing process online while Medical Staff Office staff would have a clear and concise interface to manage all requests. During this project, standard workflows will be implemented and data will be converted from our existing MSOW system to the new CredentialStream system.

In accordance with District Law, Policies and Procedures, it is requested that the Board of Directors authorize the Chief Executive Officer to enter into the necessary contracts and proceed with the purchase of implementation services and internal labor necessary for a total amount not to exceed **$48,964**. This project was not included in the fiscal year 2022 capital budget but budgeted dollars have been traded out from other approved projects.

Washington Hospital Healthcare System

S I N C E 1 9 4 8

Memorandum

DATE: March 30, 2022

TO: Kimberly Hartz, Chief Executive Officer

FROM: John Lee, Chief Information Officer

SUBJECT: Copier Replacement

Hospital departments utilize multi-function copier equipment throughout the hospital for printing, scanning and copying data on a day to day basis. Each year, the Information Services department reviews service call history, page counts and technology usage for all copiers to identify which equipment needs to be replaced.

This year, we have identified seven copiers that need to be replaced. The copiers marked for replacement service various departments including patient care floors, the medical records department and the nurse staffing office. By replacing older and more problematic copiers we improve the efficiency of operations and allow staff to focus foremost on patient care concerns.

In accordance with District Law, Policies and Procedures, it is requested that the Board of Directors authorize the Chief Executive Officer to enter into the necessary contracts and proceed with the purchase of hardware for a total amount not to exceed **$45,380**. This is an approved equipment line item in the fiscal year 2022 capital budget.

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: April 7, 2022

TO: Board of Directors

FROM: Chris Henry, Vice President and Chief Financial Officer

SUBJECT: Charity Policy Update

Attached for your review is an updated version of Washington Hospital Healthcare System's charity policy.

The policy has been updated to conform to current federal law. While our policy was substantially compliant, we increased the family income threshold used to determine eligibility from 350% of federal poverty level to 400% as required by the new rules.

Not related to the new federal rules, we also added language to allow WHHS some flexibility to provide relief outside of the stated eligibility requirements on a case-by-case basis based on individual circumstances. We also made several clerical corrections to the document.

The revised charity policy will appear for your consideration as part of the consent calendar at the April 13, 2022. Thank you for your consideration.

Washington Hospital Healthcare System
Patient Financial Assistance and Charity Care Policy

I. Purpose

The purpose of this Patient Financial Assistance and Charity Care Policy ("Policy") is to provide guidelines for patient financial assistance and charity care to low income, uninsured or underinsured individuals who receive services at Washington Hospital. This Policy is consistent with Washington Hospital's mission and reflects Washington Hospital's commitment to providing assistance to those in the community who are in need of financial assistance. This Policy is intended to comply with California Health & Safety Code section 127400 *et seq.*, Hospital Fair Pricing Policies, as amended.

II. Limitation

This Policy is not intended to waive or alter any contractual provisions or rates negotiated by and between Washington Hospital and a third-party payer, nor is the policy intended to provide discounts to a non-contracted third-party payer or other entities that are legally responsible to make payment on behalf of a beneficiary covered person or insured.

III. Policy

A. Statement of Policy

1. This Policy is designed to provide assistance to financially qualified patients (as defined below) who require Eligible Hospital Services (as defined below). Patients are granted assistance depending upon their specific circumstances in accordance with this Policy.

2. This Policy permits non-routine waiver of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below.

3. This Policy excludes routine waiver of deductibles, co-payments and/or co-insurance imposed by insurance companies for patients whose family income is greater than 400% of the federal poverty level.

4. This Policy excludes (i) services which are not medically necessary and (ii) separately-billed physician services.

5. This Policy will not apply if the patient/responsible party provides false or misleading information about financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which he or she may be eligible.

6. This Policy and the financial screening criteria will be consistently applied to all cases throughout Washington Hospital. If application of this Policy conflicts with payer contracting or coverage requirements, consult with Washington Hospital legal counsel.

7. This Policy is required to disclose that emergency physicians (as defined in Health and Safety Code section 127450) who provide emergency medical services at Washington Hospital are required by law to provide discounts to Financially Qualified Patients.

B. Definitions

The following definitions apply to this Policy:

1. "Federal Poverty Level" ("FPL") means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

2. "Financially Qualified Patient" means a patient who is **both** of the following:

   (a) A patient who is a "Self-Pay Patient" as defined below or a "Patient with High Medical Costs" as defined below; and

   (b) A patient who has a family income that does not exceed 400 percent of the FPL.

3. "Self-Pay Patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medi-Cal/Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.

4. "A Patient with High Medical Costs" (also referred to in this Policy as "High Medical Cost Patient") means a patient who satisfies any of the following criteria:

   (a) Annual out-of-pocket costs incurred by the individual at Washington Hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months.

   (b) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

5. "Patient's family" means the following:

   (a) For persons 18 years of age and older, the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not.

   (b) For persons under 18 years of age, the patient's parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

6. "Eligible Hospital Services" means the following performed at Washington Hospital:

   (a) Emergency medical services provided in Washington Hospital's emergency department;

(b) Non-elective services provided in response to a life-threatening circumstance in a non-emergency room setting;

(c) Medically necessary services (as defined below) provided to Medi-Cal/Medicaid eligible beneficiaries that are not covered under their respective program;

(d) Services for conditions which if not treated timely would result in an adverse change in the health status of an individual; and

(e) Other medically necessary services not listed above will be evaluated on a case-by-case basis at Washington Hospital's discretion.

C. Notification of Financial Assistance and Charity Care Availability

1. At the time of registration, patients are to be given written notice of this Policy, including eligibility requirements, contact information for our Financial Assistance Coordinator from whom they can obtain further information, a billing overview document, an Application for Financial Assistance, a Medi-Cal application and a Healthy Families application. Notices should be provided in English and in languages as determined by Washington Hospital's geographical area. The notice shall satisfy the requirements of Health and Safety Code section 127410(a).

2. The notice shall be provided to the patient at the time of service if the patient is conscious and able to receive notice at that time. If the patient is not able to receive the notice at the time of service, then the notice shall be provided as part of the discharge process. If the patient is not admitted, the notice shall be provided to when the patient leaves Washington Hospital. If the patient leaves Washington Hospital without receiving the notice, then the notice shall be mailed to the patient within 72 hours of providing services.

3. Notice of the Patient Financial Assistance and Charity Care Policy is to be posted in locations visible to the public, including but not limited to: the Emergency Department, Billing office, Admissions office, Outpatient Registration areas, Cashiers Office (Business Office), and in observation units.

4. In the event Washington Hospital has determined that the patient is a Self-Pay Patient (i.e., lacks third party insurance coverage), Washington Hospital shall provide the patient with an estimate of the cost for the services (including the cost of supplies) received by the patient based on an average length of stay and services provided based on the patient's diagnosis and any past or planned procedures. This estimate may be provided during normal business hours. This estimate may be provided within the notice described in this Section C or after discharge, depending on the timing of the determination that the patient is a Self-Pay Patient.

D. Charity Care Eligibility

1. A patient who satisfies all the following criteria shall receive a 100% charity discount on all Eligible Hospital Services provided by Washington Hospital:

(a) The patient received Eligible Hospital Services, as defined above;

(b) The patient's family income does not exceed 400% of the FPL; and

(c) The patient is a Self-Pay Patient or High Medical Cost Patient.

2. If a patient applies or has a pending application for another health coverage program at the same time that he or she applies for charity care, the patient's application for the other program(s) shall not preclude eligibility for charity care.

E. Application Procedure

1. Patient Financial Services will make every effort to screen all patients who may be eligible for financial assistance at admission or as soon thereafter as possible under the circumstances. Patient Financial Services will assist patients it has identified as candidates for coverage (including private insurance, California Health Benefit Exchange, Medicare, Medi-Cal, the Healthy Families Program, the California Children's Services Program, or any other third-party coverage) apply for coverage.

2. Patients without third-party coverage will be financially screened for potential eligibility for state and federal governmental programs as well as charity care at the time of service or as near to the time of service as possible. If the patient does not indicate coverage by a third-party payer, or requests a discounted price or charity care, Patient Financial Services will provide the patient with an application for the Medi-Cal program, the Healthy Families Program, California Children's Services, or state funded governmental program before the patient leaves Washington Hospital, emergency room, or other outpatient setting.

3. Patient Financial Services will screen low-income patients with third-party coverage for high medical costs. Patient Financial Services will review such patients' prior billings at Washington Hospital to determine eligibility as a High Medical Cost Patient based on past payments to Washington Hospital. Patient Financial Services shall also inform such patients of the criteria of qualification as a High Medical Cost Patient and provide the patient with a charity care application if one has not already been provided. The patient is responsible for applying for charity care if claiming high medical costs based on amounts paid to other providers.

4. All patients whom Patient Financial Services determines may be eligible for health coverage or assistance are expected to apply for and pursue such coverage or assistance. If an application is denied, the patient must provide a copy of the denial to Patient Financial Services as part of the application for charity care. In the event a patient fails to apply for health coverage, fails to pursue an application to completion, or claims that his or her application was denied and fails to provide proof of the denial, then Patient Financial Services may deem the patient to be insured and that the charges issued by Washington Hospital will not be counted by the patient for purposes of determining the patient's out of pocket medical costs in making the determination that the patient is a Self-Pay Patient or a High Medical Cost Patient.

5. Each patient who requests charity care shall complete the Application for Financial Assistance. The form is available in English and in languages as determined by Washington Hospital's geographical area.

F. Review Process

1. The Financial Assistance Coordinator will perform the initial review an applicant's Application for Financial Assistance for completeness and send any needed follow up requests to the application.

2. An application for financial assistance shall provide the following information to Washington Hospital for the purposes of establishing the following: (i) family income is at or below 400% of the FPL; (ii) the patient is a Self-Pay Patient; and/or (iii) the patient is a High Medical Cost Patient.

   (a) To verify income, the patient shall provide Washington Hospital with (i) the patient's most recent tax return(s); and (ii) recent pay stubs. If used to document income, a tax return must be a United States income tax return signed by the taxpayer and filed with the IRS. If used to verify income, pay stubs must be recent and include (i) the name of the patient, (ii) the name of the employer, (iii) the pay period, and (iv) the amount paid, and the patient must provide the name and contact information of a supervisor who can verify the amount paid.

   (b) To verify the absence of medical coverage, the patient shall provide a copy of a denial from Medi-Cal and/or other state and federal programs for which Patient Financial Services determined the patient may be eligible.

   (c) All documents submitted to establish eligibility that are issued by an entity or government outside of the United States must be authenticated or apostilled before they can be considered.

   (d) A patient need not provide all of the above documentation in order to be eligible under this Policy, however, Washington Hospital may consider the failure to provide any of items listed in this Section in making a final determination of eligibility under this Policy.

3. In the event that the necessary documentation is not included with the application, the Financial Assistance Coordinator will notify the patient by mail or phone, if available, requesting additional documentation.

4. The patient's signature on the Application for Financial Assistance will certify that the information contained in the application, which shall be deemed to include any and all documents submitted in connection with the application, is accurate and complete.

5. Patients who have been recognized as homeless and deceased patients with no estate may be deemed eligible without having to meet the documentation requirements. Under these circumstances, the Director of Patient Financial Services will give the approval to waive these requirements.

6. The Financial Assistance Coordinator and Patient Accounting Manager shall be responsible for reviewing the Application and the documentation provided by the patient to determine eligibility for charity care under Section D above. The recommendation shall include the following findings:

(i) the patient's family income does not exceed 400% of the FPL; and (ii) the patient is either a Self-Pay Patient or a High Medical Cost Patient. The recommendation shall also describe any Eligible Hospital Services provided to the patient.

7. The Financial Assistance Coordinator and Patient Accounting Manager shall make a recommendation to approve or deny an Application. The Director of Patient Financial Services and the Chief Financial Officer shall render the final decision to approve or deny an Application.

8. The Director of Patient Financial Services and the Chief Financial Officer shall have the authority to waive the requirements above on a case-by-case basis due to extenuating circumstances.

9. Patient Financial Services shall approve or deny an Application for Financial Assistance within 30 days of receipt of the Application and all necessary documents. Any patient, or patient's legal representative, who requests charity care under this policy shall make every reasonable effort to provide Washington Hospital with documentation of income and all health benefits coverage. For those applications where Washington Hospital has requested further documentation, Washington Hospital allows 60 days for return of additional requested documentation. The failure to provide such documentation within 60 days will result in the denial of charity care and the account shall begin following normal collection practices.

10. The Financial Assistance Coordinator shall notify the applicant patient in writing of approval or denial of the applicant's Application. If the Application has been denied, then the written notice shall include the reason for denial. The notice shall be sent in languages as determined by Washington Hospital's geographical area.

11. A patient must complete a new Application for Financial Assistance each time the patient is admitted, which will be valid for the current admission plus any other outstanding patient liability at Washington Hospital at the time of determination. The Application for Financial Assistance is valid for outpatient services for 6 calendar months starting with the month of eligibility determination and any other patient financial liability at Washington Hospital at the time of determination. High Medical Cost Patients will be evaluated monthly for eligibility, and their status will be valid for the current month or most current service month retroactive to 12 months of service.

12. In the event of a dispute regarding this Policy or a decision resulting in the denial of charity care, a patient may seek review from the Director of Patient Financial Services within 30 days of the date the notice of denial. This shall be the patient's only right to appeal a determination under this Policy.

G. Patient Billing and Collection Process

1. Patients who have not provided proof of coverage by a third-party at or before care is provided will be sent a clear and conspicuous notice that includes the following:

   (a) A statement of charges for services rendered by Washington Hospital;

   (b) A request that the patient inform Washington Hospital if the patient has health insurance coverage, Medicare, Medi-Cal, or other coverage;

(c) A statement that, if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care;

(d) A statement indicating how patients may obtain applications for the Medi-Cal program, coverage offered through the California Health Benefit Exchange, or other state- or county-funded health coverage programs and that the hospital will provide these applications. Washington Hospital shall also provide patients with a referral to a local consumer assistance center housed at legal services offices. If the patient does not indicate coverage by a third-party payer or requests a discounted price or charity care, then the hospital shall provide an application for the Medi-Cal program or other state- or county-funded health coverage programs. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

(e) Information regarding the financially qualified patient and charity care application, including the following:

(1) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care;

(2) The name and telephone number of the Financial Assistance Coordinator from whom or which the patient may obtain information about this Policy; and

(3) If a patient applies, or has a pending application, for another health coverage program at the same time that the patient applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

2. A patient may request an Application for Financial Assistance verbally or in writing, and it is to be given or mailed to the patient or guarantor at the address provided. Written correspondence to the patient shall also be in the languages as determined by Washington Hospital's geographical area.

3. All bills for patients who have submitted an Application for Financial Assistance and necessary documentation will be placed on hold from any collection activity until such time as the final determination, including any appeal, has been made.

4. Patients are required to report to Washington Hospital any change in their financial information promptly.

5. Washington Hospital shall limit expected payment for services it provides to a patient at or below 400 percent of the FPL eligible under this Policy to the amount of payment Washington Hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which Washington Hospital participates, whichever is greater.

6. Prior to commencing collection activities against a patient, Washington Hospital and its agents will provide a notice containing the statements required by subdivision (a) of section 127430 of the Health & Safety Code, which includes a statement that nonprofit credit counseling may be available and containing a summary of the patient's rights. The statements required by subdivision (a) of section 127430 shall also accompany any document indicating that the commencement of collection activities may occur.

7. Patients who have been denied financial assistance will be sent a written notification of denial. Following this notification, normal collection practices will commence. This includes additional letters and statements sent from Washington Hospital in addition to pre-collection letters sent by a non-credit reporting collection agency.

8. If a patient does not respond to the additional collection efforts being made, the account will be referred to an external collection agency. Final approval for accounts to be referred to a collection agency will be made by the Director of Patient Financial Services. For those accounts exceeding $50,000, the Chief Financial Officer will approve.

9. Before assigning a bill to collections or to an external collection agency, Washington Hospital will send a patient a written notice containing the following:

   (a) The date or dates of service of the bill that is being assigned to collections or sold;

   (b) The name of the entity the bill is being assigned or sold to;

   (c) A statement informing the patient how to obtain an itemized hospital bill from Washington Hospital;

   (d) The name and plan type of the health coverage for the patient on record with Washington Hospital at the time of services or a statement that Washington Hospital does not have that information;

   (e) An application for this Policy; and

   (f) The date or dates the patient was originally provided or sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

10. Washington Hospital, or its contracted collection agencies, will undertake reasonable collection efforts to collect amounts due from patients. These efforts will include assistance with application for possible government program coverage, evaluation for charity care, offers of no-interest payment plans, and offers of discounts for prompt payment. Neither Washington Hospital nor its contracted collection agencies will impose wage garnishments or liens on primary residences except as provided below. This requirement does not preclude Washington Hospital from pursuing reimbursement from third-party liability settlements or other legally responsible parties.

11. Agencies that assist Washington Hospital and send a statement to the patient must sign a written agreement that it will adhere to Washington Hospital's standards and scope of practices. The agency must also agree to:

    (a) Not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 180 days after initial billing.

    (b) Not use wage garnishments, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

    (c) Not place liens on primary residences.

    (d) All legal actions such as liens or garnishments taken by a collection agency must be approved in writing by the Director of Patient Financial Services or the Patient Accounting Manager.

    (e) Not use information obtained from a patient pursuant to a request from that patient to determine eligibility for charity care under this policy for collection activities. This shall not prohibit the agency from using information obtained by Washington Hospital, agency, or other third-party independently of the eligibility determination process.

12. Washington Hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this policy, including interest, at the rate set forth in section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by Washington Hospital, to the extent required by section 127440 of the Health and Safety Code.

H. Contact Information

Questions about the implementation of this policy should be directed to the Director of Patient Financial Services at (510) 818-7448. Questions about financial assistance and charity care eligibility should be directed to the Financial Assistance Coordinator at (510) 818-7448.

I. Other Matters

1. The Financial Assistance Coordinator shall work with the Compliance department to submit a copy of this Policy to the Department of Health Care Access and Information as required under section 127435 of the Health and Safety Code.

2. Washington Hospital maintains a separate discount policy entitled *Cash Discount Policy for Uninsured and Underinsured Patients*. Patients may obtain a copy of this policy from Patient Financial Services. This policy provides a discount of hospital-billed charges to uninsured and certain underinsured patients for certain services. Patients under that policy are expected to pay for

emergency services within thirty (30) days of receiving a bill or pre-pay for scheduled elective procedures. The discount is 35% for eligible non-District residents and 45% for eligible District residents. The “District” is the Washington Township Health Care District. Patients claiming District residency must show proof of residency, such as a utility bill in the patient’s name.

Washington Hospital Healthcare System

WASHINGTON HOSPITAL

MONTHLY OPERATING REPORT

February 2022

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
INDEX TO BOARD FINANCIAL STATEMENTS
February 2022

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: March 28, 2022

TO: Board of Directors

FROM: Kimberly Hartz, Chief Executive Officer

SUBJECT: Washington Hospital – February 2022 Operating & Financial Activity

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SUMMARY OF OPERATIONS – (Blue Schedules)

1. **Utilization – Schedule Board 3**

	February Actual	February Budget	Current 12 Month Avg.
ACUTE INPATIENT:			
IP Average Daily Census	178.0	153.5	149.0
Combined Average Daily Census	188.3	159.4	159.2
# of Admissions	764	802	800
Patient Days	4,985	4,299	4,527
Discharge ALOS	6.38	5.36	5.55
OUTPATIENT:			
OP Visits	7,047	6,848	7,616
ER Visits	3,855	3,548	4,212
Observation Equivalent Days – OP	288	166	310

Comparison of February 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 were above budget for the month. Observation equivalent days were higher than budget.

2. **Staffing – Schedule Board 3**

Total paid FTEs were 130.5 above budget. Total productive FTEs for February were 1,497.9, 162.8 above the budgeted level of 1,335.1. Nonproductive FTEs were 32.3 below budget. Productive FTEs per adjusted occupied bed were 5.36, 0.55 below the budgeted level of 5.91. Total FTEs per adjusted occupied bed were 5.85, 0.81 below the budgeted level of 6.66.

3. **Income - Schedule Board 1**

For the month of February the Hospital realized a loss of $833,000 from operations.

Total Gross Patient Service Revenue of $194,541,000 for February was 14.6% above budget.

Deductions from Revenue of $152,308,000 represented 78.29% of Total Gross Patient Service Revenue. This percentage is above the budgeted amount of 77.66%, primarily due to payor mix.

Total Operating Revenue of $42,688,000 was $4,388,000 (11.5%) above the budget.

Total Operating Expense of $43,521,000 was $4,261,000 (10.9%) above the budgeted amount.

The Total Non-Operating Loss of $171,000 for the month includes an unrealized loss on investments of $715,000 and property tax revenue of $1,441,000.

The Total Net Loss/Income for February was $1,004,000, which was $1,075,000 less than the budgeted income of $71,000.

The Total Net Loss for February 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 $573,000 compared to a budgeted loss of $215,000.

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

During February, the Hospital contributed $2.8 million in initial capital to the Warm Springs, LLC joint venture with UCSF, with an associated increase in our investment in the joint venture and made the semi-annual interest payments on the General Obligation bonds. These interest payments are funded by property tax payments from District taxpayers.

There were no other noteworthy changes in assets and liabilities when compared to January 2022.

KIMBERLY HARTZ
Chief Executive Officer

KH/CH

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
February 2022
GASB FORMAT
(In thousands)

February						YEAR TO DATE			
ACTUAL	BUDGET	FAV (UNFAV) VAR	% VAR.			ACTUAL	BUDGET	FAV (UNFAV) VAR	% VAR.
					OPERATING REVENUE				
$ 123,870	$ 115,319	$ 8,551	7.4%	1	INPATIENT REVENUE	$ 930,275	$ 908,997	$ 21,278	2.3%
70,671	54,403	16,268	29.9%	2	OUTPATIENT REVENUE	624,351	475,993	148,358	31.2%
194,541	**169,722**	**24,819**	14.6%	3	**TOTAL PATIENT REVENUE**	**1,554,626**	**1,384,990**	**169,636**	12.2%
(150,568)	(128,606)	(21,962)	-17.1%	4	CONTRACTUAL ALLOWANCES	(1,184,621)	(1,045,536)	(139,085)	-13.3%
(1,740)	(3,194)	1,454	45.5%	5	PROVISION FOR DOUBTFUL ACCOUNTS	(26,275)	(26,064)	(211)	-0.8%
(152,308)	**(131,800)**	**(20,508)**	-15.6%	6	**DEDUCTIONS FROM REVENUE**	**(1,210,896)**	**(1,071,600)**	**(139,296)**	-13.0%
78.29%	**77.66%**			7	**DEDUCTIONS AS % OF REVENUE**	**77.89%**	**77.37%**		
42,233	**37,922**	**4,311**	11.4%	8	**NET PATIENT REVENUE**	**343,730**	**313,390**	**30,340**	9.7%
455	378	77	20.4%	9	OTHER OPERATING INCOME	4,699	3,026	1,673	55.3%
42,688	**38,300**	**4,388**	11.5%	10	**TOTAL OPERATING REVENUE**	**348,429**	**316,416**	**32,013**	10.1%
					OPERATING EXPENSES				
21,650	17,674	(3,976)	-22.5%	11	SALARIES & WAGES	160,226	145,970	(14,256)	-9.8%
5,320	6,158	838	13.6%	12	EMPLOYEE BENEFITS	44,233	46,896	2,663	5.7%
5,822	5,068	(754)	-14.9%	13	SUPPLIES	46,556	40,721	(5,835)	-14.3%
5,046	4,579	(467)	-10.2%	14	PURCHASED SERVICES & PROF FEES	39,973	37,812	(2,161)	-5.7%
1,797	1,821	24	1.3%	15	INSURANCE, UTILITIES & OTHER	14,347	15,194	847	5.6%
3,886	3,960	74	1.9%	16	DEPRECIATION	31,391	31,558	167	0.5%
43,521	**39,260**	**(4,261)**	-10.9%	17	**TOTAL OPERATING EXPENSE**	**336,726**	**318,151**	**(18,575)**	-5.8%
(833)	**(960)**	**127**	13.2%	18	**OPERATING INCOME (LOSS)**	**11,703**	**(1,735)**	**13,438**	774.5%
-1.95%	**-2.51%**			19	**OPERATING INCOME MARGIN %**	**3.36%**	**-0.55%**		
					NON-OPERATING INCOME & (EXPENSE)				
186	262	(76)	-29.0%	20	INVESTMENT INCOME	1,647	2,130	(483)	-22.7%
(102)	-	(102)	0.0%	21	REALIZED GAIN/(LOSS) ON INVESTMENTS	(214)	-	(214)	0.0%
(1,731)	(1,731)	-	0.0%	22	INTEREST EXPENSE	(13,845)	(13,829)	(16)	-0.1%
(3)	114	(117)	-102.6%	23	RENTAL INCOME, NET	141	908	(767)	-84.5%
753	945	(192)	-20.3%	24	FOUNDATION DONATION	753	1,031	(278)	-27.0%
-	-	-	0.0%	25	FEDERAL GRANT REVENUE	153	-	153	0.0%
1,441	1,441	-	0.0%	26	PROPERTY TAX REVENUE	11,534	11,534	-	0.0%
(715)	-	(715)	0.0%	27	UNREALIZED GAIN/(LOSS) ON INVESTMENTS	(4,070)	-	(4,070)	0.0%
(171)	**1,031**	**(1,202)**	-116.6%	28	**TOTAL NON-OPERATING INCOME & EXPENSE**	**(3,901)**	**1,774**	**(5,675)**	-319.9%
$ (1,004)	**$ 71**	**$ (1,075)**	-1514.1%	29	**NET INCOME (LOSS)**	**$ 7,802**	**$ 39**	**$ 7,763**	19905.1%
-2.35%	**0.19%**			30	**NET INCOME MARGIN %**	**2.24%**	**0.01%**		
$ (573)	**$ (215)**	**$ (358)**	-166.5%	31	**NET INCOME (LOSS) USING FASB PRINCIPLES****	**$ 9,595**	**$ (2,245)**	**$ 11,840**	527.4%
-1.34%	**-0.56%**				**NET INCOME MARGIN %**	**2.75%**	**-0.71%**		

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

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
BALANCE SHEET
February 2022
(In thousands)

	ASSETS AND DEFERRED OUTFLOWS	February 2022	Audited June 2021
	CURRENT ASSETS		
1	CASH & CASH EQUIVALENTS	$ 21,060	$ 31,619
2	ACCOUNTS REC NET OF ALLOWANCES	90,545	73,792
3	OTHER CURRENT ASSETS	18,395	12,052
4	TOTAL CURRENT ASSETS	130,000	117,463
	ASSETS LIMITED AS TO USE		
6	BOARD DESIGNATED FOR CAPITAL AND OTHER	203,563	215,928
7	REVENUE BOND FUNDS	6,605	6,643
8	BOND DEBT SERVICE FUNDS	12,233	32,763
9	OTHER ASSETS LIMITED AS TO USE	9,807	10,098
10	**TOTAL ASSETS LIMITED AS TO USE**	232,208	265,432
12	**OTHER ASSETS**	262,456	246,106
13	**PREPAID PENSION**	6,320	5,161
14	**OTHER INVESTMENTS**	15,131	12,163
15	**NET PROPERTY, PLANT & EQUIPMENT**	610,826	640,049
16	**TOTAL ASSETS**	**$ 1,256,941**	**$ 1,286,374**
17	**DEFERRED OUTFLOWS**	26,176	44,063
18	**TOTAL ASSETS AND DEFERRED OUTFLOWS**	**$ 1,283,117**	**$ 1,330,437**

	LIABILITIES, NET POSITION AND DEFERRED INFLOWS	February 2022	Audited June 2021
	CURRENT LIABILITIES		
1	CURRENT MATURITIES OF L/T OBLIG	$ 10,065	$ 10,930
2	ACCOUNTS PAYABLE	20,114	18,246
3	OTHER ACCRUED LIABILITIES	93,629	112,710
4	INTEREST	2,645	10,597
5	TOTAL CURRENT LIABILITIES	126,453	152,483
	LONG-TERM DEBT OBLIGATIONS		
6	REVENUE BONDS AND OTHER	203,112	211,490
7	GENERAL OBLIGATION BONDS	325,332	328,564
	OTHER LIABILITIES		
11	SUPPLEMENTAL MEDICAL RETIREMENT	38,419	40,419
12	WORKERS' COMP AND OTHER	8,593	8,033
15	**NET POSITION**	531,976	524,174
16	**TOTAL LIABILITIES AND NET POSITION**	**$ 1,233,885**	**$ 1,265,163**
17	**DEFERRED INFLOWS**	49,232	65,274
18	**TOTAL LIABILITIES, NET POSITION AND DEFERRED INFLOWS**	**$ 1,283,117**	**$ 1,330,437**

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
OPERATING INDICATORS
February 2022

12 MONTH AVERAGE	February ACTUAL	February BUDGET	February FAV (UNFAV) VAR	February % VAR.			YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE FAV (UNFAV) VAR	YEAR TO DATE % VAR.
						PATIENTS IN HOSPITAL				
149.0	178.0	153.5	24.5	16%	**1**	ADULT & PEDS AVERAGE DAILY CENSUS	154.6	138.7	15.9	11%
10.2	10.3	5.9	4.4	75%	**2**	OUTPT OBSERVATION AVERAGE DAILY CENSUS	10.6	6.4	4.2	66%
159.2	188.3	159.4	28.9	18%	**3**	COMBINED AVERAGE DAILY CENSUS	165.2	145.1	20.1	14%
7.9	5.8	7.3	(1.5)	-21%	**4**	NURSERY AVERAGE DAILY CENSUS	7.9	7.6	0.3	4%
167.1	194.1	166.7	27.4	16%	**5**	TOTAL	173.1	152.7	20.4	13%
2.6	1.1	3.1	(2.0)	-65%	**6**	SPECIAL CARE NURSERY AVERAGE DAILY CENSUS *	2.8	2.6	0.2	8%
4,527	4,985	4,299	686	16%	**7**	ADULT & PEDS PATIENT DAYS	37,578	33,692	3,886	12%
310	288	166	122	73%	**8**	OBSERVATION EQUIVALENT DAYS - OP	2,577	1,561	1,016	65%
800	764	802	(38)	-5%	**9**	ADMISSIONS-ADULTS & PEDS	6,509	6,423	86	1%
5.55	6.38	5.36	1.02	19%	**10**	AVERAGE LENGTH OF STAY-ADULTS & PEDS	5.52	5.25	0.27	5%
						OTHER KEY UTILIZATION STATISTICS				
1.608	1.604	1.547	0.057	4%	**11**	OVERALL CASE MIX INDEX (CMI)	1.586	1.622	(0.036)	-2%
						SURGICAL CASES				
168	159	132	27	20%	**12**	JOINT REPLACEMENT CASES	1,375	1,102	273	25%
23	31	28	3	11%	**13**	NEUROSURGICAL CASES	197	186	11	6%
14	15	5	10	200%	**14**	CARDIAC SURGICAL CASES	105	84	21	25%
184	187	144	43	30%	**15**	OTHER SURGICAL CASES	1,457	1,380	77	6%
389	392	309	83	27%	**16**	TOTAL CASES	3,134	2,752	382	14%
206	216	205	11	5%	**17**	TOTAL CATH LAB CASES	1,610	1,591	19	1%
121	88	108	(20)	-19%	**18**	DELIVERIES	976	959	17	2%
7,616	7,047	6,848	199	3%	**19**	OUTPATIENT VISITS	60,547	59,394	1,153	2%
4,212	3,855	3,548	307	9%	**20**	EMERGENCY VISITS	35,738	30,066	5,672	19%
						LABOR INDICATORS				
1,322.7	1,497.9	1,335.1	(162.8)	-12%	**21**	PRODUCTIVE FTE'S	1,342.2	1,258.6	(83.6)	-7%
185.3	136.6	168.9	32.3	19%	**22**	NON PRODUCTIVE FTE'S	193.7	185.6	(8.1)	-4%
1,508.0	1,634.5	1,504.0	(130.5)	-9%	**23**	TOTAL FTE'S	1,535.9	1,444.2	(91.7)	-6%
5.34	5.36	5.91	0.55	9%	**24**	PRODUCTIVE FTE/ADJ. OCCUPIED BED	5.20	5.96	0.76	13%
6.09	5.85	6.66	0.81	12%	**25**	TOTAL FTE/ADJ. OCCUPIED BED	5.94	6.83	0.89	13%

* included in Adult and Peds Average Daily Census

Washington Hospital Healthcare System

S I N C E 1 9 4 8

Memorandum

DATE: March 30, 2022

TO: Washington Township Health Care District Board of Directors

FROM: Kimberly Hartz, Chief Executive Officer

SUBJECT: Request for Purchase of 6 Merge Workstations and Software in order for the Radiologist to read from home

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The ability to have the Radiologist review cases remotely, via teleradiology, and to dictate final reports from an offsite location, is a capability that is becoming widespread in the industry and is necessary to recruit and retain strong radiologists. This offers multiple advantages to the healthcare system. This capability reduces turnaround time for final reports and increases radiologist efficiency at a time where there is a shortage of radiologists. Currently, when cases are read by our Radiologists from home, they submit reports that are only preliminary. The Radiologists re-read them the next day, in order to provide a final report to the ordering physician. This is inefficient and redundant. Dictating the final reports the next day takes a significant amount of time which would be time better spent on reading and turning around current, new cases.

With this capability, final reports of teleradiology cases can be dictated by our radiologists on call at night and on weekends. In many cases, referring doctors are unwilling to make final decisions on treatment or discharge based on the preliminary reports we are currently able to provide. They wait for the certainty of the final report. Being able to issue final reports at the time of teleradiology review will help reduce patient's length of stay. Another advantage of teleradiology capability is that it contributes to better disaster preparedness. In the event of a disaster, radiologists may not be able to come into the hospital but could read offsite if they have internet access.

We are recommending moving forward with the purchase of the 6 remote reading stations, with the necessary software, for the Radiologists to be able to read remotely. The cost of the reading stations will be $116,549.82, plus tax and shipping. This includes the hardware plus the software necessary to perform the reads. This has been reviewed and approved by our Information Systems Department.

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 purchase of the 6 Merge reading stations, not to exceed $131,000, which includes the tax and shipping. The total amount was not included in the Fiscal Year 2021/22 Fixed Asset Capital Budget.