STOUGHTON HEALTH

MEETING AGENDA

Stoughton Hospital Association Governing Board

Thursday, March 24, 2022 | 7:15 a.m. – 9:00 a.m.

Zoom Link: https://us06web.zoom.us/j/83516380816?pwd=NjRwOUd3UE8wYVVFMU9aWTRVQ1BFdz09

Phone: 312.626.6799 | Meeting ID: 835 1638 0816| Password: 777513 ***(use phone if no Zoom capability)***

Governing Board Members

Tom Fendrick | Donna Olson | Steve Staton | Dr. Ashish Rawal | Dr. Aaron Schwaab | Margo Francisco | Matt Kinsella | David Locke | Glenn Kruser | Kris Krentz | Nick Probst | Tim Rusch

	Item #	Agenda	Time
	I.	Call to Order (Tom Fendrick)	7:15 a.m.
A	II.	Review Minutes of January 26, 2022 Governing Board Meeting – ***(See Attached)*** (Tom Fendrick)	
	III.	Old Business A) COVID Updates (Amy Hermes)	
	IV.	New Business ***(See Attached)***	
A		A) Shoulder Specialty Business Plan (Dr. Ashish Rawal)	
A		B) Community Health Needs Implementation Plan (Laura Mays)	
	V.	SSM Updates (Margo Francisco/Matt Kinsella)	
	VI.	Committee Updates A) Executive Committee (Tom Fendrick)	
A		• Review Minutes of February 28, 2022 Executive Committee Meeting • Next meeting: April 25, 2022 B) Finance Committee (Steve Staton) • Next meeting: April 22, 2022	
	VII.	Administration Team Updates (Dan DeGroot, Michelle Abey, Teresa Lindfors, Amy Hermes, Chris Schmitz, and Laura Mays)	
		A) CEO Summary Report (Dan DeGroot) 1. 2026 Key Assumptions ***(See Attached)***	

Item #	Agenda	Time

2. Master Facility Plan Updates
3. Organizational Structure/Review – Org Chart ***(See Attached)***
4. Operations Update
5. Governing Board Retreat Deadlines/Agenda ***(See Attached)***

A B) CFO Summary Report (Michelle Abey)
1. February 2022 Financials ***(See Attached)***

C) Chief Strategy and Business Development Officer Summary Report (Teresa Lindfors)
1. Growth Updates

A D) CNO Summary Report (Amy Hermes) – ***(See Attached)***
1. MCE Meeting Minutes – January and February 2022 (Dr. Aaron Schwaab)

2. MEC Meeting Minutes – March 2022 (Dr. Aaron Schwaab)

3. Quality/Safety ***(See Attached)***:
   - Report Cards
     - Quality Safety Report Card – Q2 FY2022
     - Quality Safety Report Card – P4P – Q2 FY2022
     - Balanced Score Card – Q4 FY2021
     - 2022 BSC Planning – Determination of Fiscal Year Measures and Goals

   - Patient Satisfaction Rankings
     - Providers – Q1 CY2022
     - Departments – Q1 CY2022

4. CI Council Updates:
   - CI Council – On Hold

5. Patient Safety ***(See Attached)***:
   - 2021 SH Annual Performance Evaluation for Emergency Management
   - Patient Safety Minutes – January 2022

6. Infection Prevention ***(See Attached)***:
   - Infection Prevention Minutes – February 2022

7. Medical Staff Policies ***(See Attached)***
   - Admission of Discharge of Patients Policy
   - Confidentiality Retention of Credentialing Files Policy

- Direct Admissions Policy
- Disaster Credentialing Policy
- Emergency Services Policy
- Expedited Privileges Policy
- FPPE Policy
- General Conduct of Patient Care Policy
- General Rules Regarding Surgical Care Policy
- Medical Staff Health Screen Immunization Requirements Policy
- OPPE Policy
- Stoughton Health CI Policy
- Temporary Privileges Policy

E) VP, HR, Campus Planning, Operational Support Services Summary Report (Chris Schmitz)
1. HR / Campus Projects
2. Staffing Updates

F) Foundation/Marketing/PR/Business Development Director Summary Report (Laura Mays) – ***(See Attached)***
1. Foundation Dashboard
2. Fundraising/Events
3. PR Report

A VIII. Chief of Staff Report
(Dr. Aaron Schwaab)

A) One Year Appointments:

1) Steven Falconer, MD, Radiology, Madison Radiology, Courtesy
2) Mary Hickner, DPM, Podiatry, Independent, Active
3) Maria Fassari, MD, Hospital Medicine, Beam Healthcare, Active
4) Dana Ley, MD, Hospital Medicine, Beam Healthcare, Active
5) Mary Embrescia, MD, Psychiatry, ITP, Courtesy
6) Maria Askew, APNP, ITP, Allied Health Professional
7) Atul Sheth, MD, Psychiatry, ITP, Courtesy
8) Neza Bharucha, MD, Psychiatry, ITP, Courtesy
9) Naga Dharmavaram, MD, Hospital Medicine, Beam Healthcare, Active

Flagged Files: None at this time

B) Two Year Re-Appointments:

1) Rebecca Hamman, NP, SSM, Allied Health Professional
2) Derek Hubbard, MD, Family Medicine, SSM, Courtesy

Item #	Agenda	Time

3) Clifford King, MD, Plastic Surgery, SSM, Active
4) Peter Lee, MD, Cardiology, SSM, Courtesy
5) Alisha Maly, PA, Emergency Med, SWEA, Allied Health Professional
6) Mark McDade, MD, General Surgery, SSM, Active
7) Robert Nerad, PA, Emergency Med, SWEA, Allied Health Professional
8) Paula Riebe, PA, Emergency Medicine, SWEA, Allied Health Professional
9) Cecelia Thompson, DDS, Dental,Children's Dental Center, Dental
10) David Worth, DPM, Podiatry, SSM, Courtesy
11) Thor Anderson, DDS, Dental, Independent, Dental
12) Drew Dean, MD, Emergency Medicine, SWEA , Active
13) Jennifer Hamilton, PA, Orthopedic Surgery, Sto Health, Allied Health Professional
14) Daniel Holt MD, Radiology, Madison Radiology, Courtesy
15) Richard Huntsman, MD, General Surg, SSM, Active
16) Andrew Laczniak, MD, Radiology, Madison Radiology, Courtesy
17) Krista Mosley PA, Emergency Med, SWEA, Allied Health Professional
18) Anne O'Connor, MD, Cardiology, UW, Courtesy
19) Andrew Schemmel, MD, Radiology, Madison Radiology, Courtesy
20) Sean Shannahan, MD, Radiology, Madison Radiology, Courtesy
21) Matthew Shore, MD, Radiology, Madison Radiology, Courtesy
22) Hugh Sugar, PA, Emergency Medicine, SWEA, Allied Health Professional
23) Robert Wells, MD, Radiology, Madison Radiology, Courtesy

Flagged Files: None at this time

IX.	Adjourn	9:00 a.m.

Upcoming Meetings:

- Finance Committee Meeting: Friday, April 22, 2022 at 7:30 a.m.
- Executive Committee Meeting: Monday, April 25, 2022 at 7:30 a.m.
- Governing Board Meeting: Friday, May 20, 2022 at 9:00 a.m. (during Board Retreat)

Note:

- A = Item requiring a Board/Committee Action, Approval, Recommendation or Acceptance
- R = Item requiring a formal Board Resolution

MISSION

The mission of Stoughton Hospital is to provide safe, quality health care with exceptional personalized service.

VISION

We grow to meet the changing needs of the communities we serve and become their health partner of choice.

VALUES

Our patients and community are our number one priority.

STOUGHTON HEALTH

MEETING MINUTES

Stoughton Hospital Association Governing Board

Wednesday, January 26, 2022 | 7:15 a.m. – 9:00 a.m.

Zoom Link: https://us06web.zoom.us/j/84882591294?pwd=N2x0OC84SDQvOVl6KzlUOXA0VEdoZz09

Phone: 312.626.6799 | Meeting ID: 848 8256 8259 1294 | Password: 425523 ***(use phone if no Zoom capability)***

Board Members Present: Tom Fendrick, Donna Olson, Steve Staton, Dr. Ashish Rawal, Dr. Aaron Schwaab, Margo Francisco, David Locke, Kris Krentz, Nick Probst, Tim Rusch

Hospital Staff Present: Michelle Abey, Dan DeGroot, Amy Hermes, Teresa Lindfors, Laura Mays, Chris Schmitz, Angie Polster

Excused: Matt Kinsella

Item #	Agenda	Time
I.	Call to Order (Tom Fendrick)	7:15 a.m.

Mr. Fendrick called the January 26, 2022 Governing Board meeting to order at 7:15 a.m. and introduced new Board members Dr. Ashish Rawal and Mr. David Locke.

II. Old Business

A) None

III. New Business

A) Regional Shoulder Center of Excellence Overview (Dr. Ashish Rawal)

Dr. Rawal shared an overview of plans to develop a Regional Shoulder Center of Excellence. The final business plan will be presented to the Board for approval at the Governing Board meeting on Thursday, March 24, 2022. Dr. Rawal noted he has identified surgical needs of several thousand patients per year (within two hours of campus). Mr. Fendrick added this would be a great addition to an underserved market.

Dr. Schwaab asked if there was a national certification for these procedures. Dr. Rawal stated there are general qualifications and added he has reviewed/modeled other facilities nationwide who have successfully implemented this specialty. Finally, he stated he would further research whether the program is certified.

B) Conflict of Interest Statement Completion (Michelle Abey)

Ms. Abey reminded all Board members to complete and return their 2022 Conflict of Interest forms as soon as possible to Angie Polster via the HelloSign platform.

IV. SSM Updates
(Margo Francisco/Matt Kinsella)

Ms. Francisco shared SSM Health will be opening a new south Madison clinic by the end of February to replace the Fish Hatchery Road clinic. Mr. Fendrick asked Ms. Francisco whether their recent partnership with Optum has helped with inpatient care management. Ms. Francisco stated SSM now has access to specific tools and pathways designed to reduce patient length of stays. She added there are approximately 2,000 employees across SSM Health who became Optum employees in this partnership. Those employees were able to retain their benefits and pay ranges, and were able to keep same or similar titles. She also added those employees can return to SSM Health at any time should they decide to end their relationship with Optum.

Finally, Ms. Francisco shared an update on the recruitment of SSM Health's new Wisconsin CEO and noted there are four candidates who are working through the interview process, and should have a status update by end of next week.

A V. Committee Updates

A) Appoint Members of 2022 Board Committees (Tom Fendrick)

Mr. Fendrick stated all Governing Board members are welcome to attend Committee meetings and asked for a motion to appoint members of 2022 Governing Board Committees.

Action: Ms. Olson made a motion to appoint members as listed for 2022 Board Committees. Ms. Francisco seconded the motion. Motion carried.

B) Executive Committee/Finance Committee Updates (Tom Fendrick)
- Executive Committee Meeting: February 28, 2022
- Finance Committee Meeting: April 22, 2022

Mr. Fendrick provided a brief update on Executive and Finance Committees and noted our Investment Advisor will provide an investment portfolio update at the April 22, 2022 Finance Committee meeting.

C) Nominating Committee (Donna Olson)
- Recommendation for Vacant Class III Director: Mr. Glenn Kruser (Retired Physician Assistant from SSM Health - Evansville Clinic)

Ms. Olson recommended Mr. Glenn Kruser for a Class III Director to serve Ms. Julie Johnson's remaining term on the Stoughton Health Governing Board.

Action: Mr. Krentz made a motion to appoint Mr. Glenn Kruser as a Class III Director to serve the remainder of Ms. Julie Johnson's term. Mr. Staton seconded the motion. Motion carried.

VI. COVID-19: Year Three Status Update u
(Dan DeGroot, Michelle Abey, Teresa Lindfors, Amy Hermes, Chris Schmitz, and Laura Mays)

A) Pandemic Status (Amy Hermes)
1. Current Variant
2. Infection Rate
3. Hospitalization Rate
4. Staff Vaccination Status
   - Vaccinated %
   - Boosted %
5. Number of COVID(+) Staff

Ms. Hermes provided a pandemic status update and noted even with the far more infectious Omicron variant, we have seen a reduction in hospital stays (mainly in the vaccinated population). Hospitalized patients average length of stays have been 5.5 days, with some outliers being admitted for two to three weeks. Ms. Hermes added we are working towards obtaining oral COVID treatment medication.

B) Workforce (Chris Schmitz)
1. Total Number of Open Positions
2. Percentage of Workforce
3. Recruitment Successes/Challenges
4. Staff Morale
5. Partners Impact

Mr. Schmitz shared a brief workforce update and noted we filled 28 positions in the last year, with approximately 50% of the new hires referred by current Stoughton Health staff.

C) Finance (Michelle Abey)
1. Three Year Financials
   - 2020 – Fiscal Year End
   - 2021 – Fiscal Year End
   - 2022 – 1st Quarter Fiscal Year
2. SBA, PRF, Other Funds

- Realized
- Pending/Possible

3. Cash/Investments Position

Ms. Abey shared an overview of Stoughton Health finances and trends over the last few years. She stated patients per day in Q1 2022 are comparable to pre-COVID years (averaging 86.4 patients per day). She also shared details on various forms of COVID funding received by Stoughton Health:

- SBA Paycheck Protection Act Loan: Received in April 2020 in amount of $4,064,937 (forgiven July 2021).

- Provider Relief Funds:
  - Phase 1 Funding: $5,023,434 (Reporting completed November 2021, single audit pending). Eide Bailly will begin the single audit in next couple months and will report findings to Governing Board in spring. This will be filed with the Department of Health and Human Services by June 30, 2022..
  - Phase 4 Funding: $407,331 (Received in November/December 2021 and can use until 12/31/2022. Required to report by February 2023).

- Medicare Accelerated Payments: Recorded as liability and due back to CMS by 9/30/2022. Balance is $3,914,436 as of 12/31/2021.

- Various other grants: SHIP COVID Testing & Mitigation Grant (Pending) ($258,199), SHIP Grant - CARES Act ($84,317), and WHA Sub recipient Grant ($15,026).

Ms. Olson thanked Ms. Abey for her efforts on securing and tracking these funds.

D) Growth (Teresa Lindfors)

1. Impact of Current Service Line Volumes
2. Impact on New Service Development

Ms. Lindfors shared a growth update and noted we have slowly resumed elective services after being required to shut down due to the pandemic, as well as opened a new McFarland Urgent Care facility in June of 2021. Ms. Lindfors stated that although McFarland Urgent Care has not reached their goal of greater than 15 patients per day, the trend line continues to track in a positive direction. She added that 44% of December patients were new to Stoughton Health.

Ms. Lindfors shared over the past year we have brought on new providers, as well as secured 24/7 orthopedic on call coverage. She added we have also

secured a relationship with Integrated Telehealth Partners and they are slated to start in February 2022.

E) Marketing/Communications (Laura Mays)
1. Community Education Efforts
2. Prior Messaging
3. Current Messaging
4. Foundation Impact

Ms. Mays shared we have seen an increase in virtual class attendance and noted Dr. Schwaab recently hosted a talk on GERD where 31 out of 35 registrants attended the class. She also noted approximately 20% of class participants become Stoughton Health patients.

Ms. Mays stated the Foundation has been busy fundraising and shared they acquired nine new donors during their recent "Kwik Trip Giving Tuesday" fundraiser. She added the Foundation's Annual Appeal letter was mailed in early December to 900+ community members and raised over $24,000. Finally, Ms. Mays shared information on a recently received donation of nearly $10,000 to support women who are healing emotionally after breast cancer diagnosis.

F) Next Steps (Dan DeGroot)
1. Retention Focus
   - 2022 Pay Increases
2. Day-to-Day Priorities
3. Recovery Plan as Abatement Occurs
   - Staff
     - Wellbeing Focus
     - Director, Engagement and Experience
   - Re-engage Dormant Processes in Sequence (i.e. Continuous Improvement, Tri-Annual Manager Meetings, Leadership Development Days, etc.)
4. Re-implement Meeting Cadences
5. Strategy Validation
6. Increase Master Facility Plan (MFP) Pace

Mr. DeGroot stated Stoughton Health's main focus has been on the current workforce and retaining staff by recognizing them via various means. He added the staff have been notified they will receive a 5% pay increase in late February 2022.

Finally, Mr. DeGroot shared a brief overview of the status of Stoughton Health's Master Facility Planning and stated he plans to provide additional in-depth information at a future meeting.

Item #		Agenda	Time
A	VII.	CNO Summary (Amy Hermes)	

1. MCE Meeting Minutes – November 2021
(Dr. Aaron Schwaab)

Dr. Schwaab shared a brief summary of the November 2021 MCE Meeting and stated they approved a new code blue protocol which was passed on to Medical Executive Committee (MEC). Dr. Schwaab also acknowledged the Lab received an excellent survey and stated Dr. Mark Menet will head the MCE committee as Chairman. Dr. Schwaab will continue providing MCE reports to the Governing Board.

Action: Dr. Rawal made a motion to approve the November 2021 MCE Meeting Minutes. Ms. Olson seconded the motion. Motion carried.

2. MEC Meeting Minutes – January 2022
(Dr. Aaron Schwaab)

Dr. Schwaab shared a brief summary of the January 2022 MEC Meeting and stated the committee approved a code blue form and also endorsed an Infection Prevention nurse.

Action: Ms. Francisco made a motion to approve the January 2022 MEC Meeting Minutes. Mr. Rusch seconded the motion. Motion carried.

A VIII. December 2021 Financials (Michelle Abey)

1. December 2021 Financials

Ms. Abey shared December 2021 financials noting operating income was $1,078,132 which was more than the budget of $76,490 by $1,001,642. She stated the month was good primarily due to higher ER volumes and rural care supplement funds which were received earlier than expected. Ms. Abey shared year-to-date operating income is $2,352,923, exceeding the budget by $1,801,839, with year-to-date excess of revenues over expenses of $2,874,319.

Ms. Abey shared a Kronos update and added the payroll portion of the system is back online. The Accounting department is finalizing employee W2s and expect them to be released soon. Ms. Abey shared plans to release final reports on the security breach within the next couple weeks. Mr. Fendrick asked if Kronos would reimburse companies due to the security breech. Ms. Abey plans to meet with a Kronos Account Representative and should receive additional information at that time.

Action: Mr. Locke made a motion to approve December 2021 Financials. Ms. Francisco seconded the motion. Motion carried.

A IX. Consent Agenda:

1. Minutes of November 22, 2021 Governing Board Meeting
2. Minutes of November 29, 2021 Annual Meeting
3. Final Evaluation of Clinical Contract Services List
4. November 2021 Financials
5. Quarterly Corporate Compliance Committee Report
6. Infection Prevention Meeting Minutes – December 2021
7. Patient Safety Minutes – November 2021
8. Policy 4.06: Sentinel and Serious Events
9. CI Council: November Meeting Minutes / Cohort B Dashboard

Action: Ms. Francisco made a motion to approve all items listed on the consent agenda. Mr. Staton seconded the motion. Motion carried.

A X. Chief of Staff Report
(Dr. Aaron Schwaab)

A) One Year Appointments:
1. Puneet Dhillon, MD, Hospital Medicine, Beam Healthcare
2. Clark Collins, PA-C, Orthopedic PA, Stoughton Health
3. Amr Youssef, MD, Cardiology, UW Health
4. Jason Sansone, MD, Orthopedic Surgeon, SSM Health
5. Sarah Endicott, NP, Independent

Flagged Files: None at this time

Action: Ms. Francisco made a motion to approve the One Year Appointments. Mr. Rusch seconded the motion. Motion carried.

B) Two Year Re-Appointments:
1. Sarjoo Patel, MD, Hospital Medicine, Beam Healthcare
2. Parag Tipnis, MD, Cardiology, UW
3. Harold Bennett, MD, Radiology, Madison Radiology
4. Cenon Buencamino, MD, Radiology, Madison Radiology
5. Douglas Davis, MD, Radiology, Madison Radiology
6. Gretchen Foltz, MD, Radiology, Madison Radiology
7. Daniel Hoefer, MD, Radiology, Madison Radiology

Flagged Files: None at this time

Item #	Agenda	Time
	Action: Mr. Staton made a motion to approve the Two Year Re-Appointments. Ms. Francisco seconded the motion. Motion carried.	
	C) Request for Additional Privileges 1. Harry Scholtz, DO, Infectious Disease, Beam Healthcare	
	Action: Mr. Rusch made a motion to approve the Request for Additional Privileges for Harry Scholtz, DO. Ms. Francisco seconded the motion. Motion carried.	
XI.	Adjourn	9:00 a.m.
	Mr. Fendrick requested a motion to adjourn the January 26, 2022 Governing Board meeting.	
	Action: Ms. Olson made a motion to adjourn the Stoughton Health Governing Board Meeting at 9:12 a.m. Mr. Staton seconded the motion. Motion carried.	

Respectfully submitted,

Steve Staton
Secretary/Treasurer

Stoughton Health Shoulder Surgery Service Business Plan

March, 2022

Link with Mission and Strategic Plan

Stoughton Health's mission is to provide safe, quality health care with exceptional personalized service. Our vision is to grow to meet the changing needs of the communities we serve and become their health partner of choice. We value our patients and community as our number one priority. Stoughton Health delivers comprehensive health care to the people of Stoughton, Evansville, Oregon, McFarland, Brooklyn, Cambridge, Deerfield, Cottage Grove, and surrounding areas.
Stoughton Health is committed to continue to achieve market share growth through reducing outmigration, broadening service portfolios, enhancing access and exploring new opportunities. Our goal is to provide service line growth for efficient and convenient access to care paired with Stoughton Health's excellent culture, quality and safety scores, providers and employee engagement levels.

The Opportunity of Project

In our local service area and beyond (3 hours driving radius), there is a paucity of comprehensive quality shoulder care, with no dedicated shoulder surgery service lines. Only 2 shoulder surgeons in the region (UW Madison and Mercy Janesville) provide comprehensive shoulder care of both simple and comprehensive shoulder problems. Query of the Kaavio healthcare database, the local and extended area (3 hour drive from Stoughton Hospital) shows over 5,000 visits per quarter for the most common CPT codes for shoulder pathology/ symptoms (see Table 3). This data was retrieved from the Kaavio Database created and maintained by the Wisconsin Hospital Association Information Center. Based on this data, there is a robust need in the area for shoulder care. Many patients are left to find specific "shoulder surgeons" within an entire group or be confronted with a surgeon that may not perform comprehensive shoulder care.

Our project would create a destination center for comprehensive shoulder care within the region. Through a robust marketing program, we would be able to highlight the extensive capabilities and quality of care through a destination center. The website would highlight the dedicated program, highlighting the services offered, and illustrate patient testimonials. Paired with this website would be a phone line to allow patients to obtain expedited appointments through dedicated appointment slots for shoulder patients. Additionally, we would have specific appointment slots for imaging and physical therapy to allow for expedient care for patients traveling from a distance. Our team would help arrange all aspects of their care, including appointments, imaging, insurance authorization, and lodging accommodations. We plan to partner with a local hotel to provide discounted accommodations for patients before

and after surgery. Stoughton and the local area is rich in activities, restaurants, and entertainment. Convenient therapy services will be offered before and after surgery for patients traveling from a distance.

From a surgical standpoint, we would be offering the latest in shoulder innovations with full access to the latest proven technologies. Our plan includes adding additional surgical equipment to enhance the efficiency and care within our surgical suites.

Our current patient reported outcomes research platform (Arthrex SOS) would be expanded to our shoulder line in order to collect robust data. This data can be used to highlight our outcomes, to patients, providers, insurance companies, as well as individual companies seeking direct care models. Patient reported outcomes would be compared to aggregate data from the entire US and internationally to highlight the program. Additionally, the outcomes data provides feedback that would allow us to improve our care and track at-risk patients.

Finally, we would like to also create a direct payment model for surgical services in which insurance would not be used. This would include a bundled package including imaging, surgical care, therapy, and associated 90 day aftercare (provided by Stoughton Health in person or virtually). This direct payment model would be an attractive alternative for patients who are out of network and have high deductible plans.

Context

Dr. Rawal is the sole employed orthopaedic surgeon working at a full time status, with the support of 2 experienced physician assistants. The current practice is a mix of shoulder, knee, and hip surgeries. The current volume has been between 250-300 surgeries per year, with capacity to grow up and beyond 400 surgeries per year. The current practice has created a service line for custom knee replacements which has seen tremendous growth over the past 7 years. Currently, approximately 60-80 shoulder surgeries are being performed per year. There is significant untapped capacity to allow for growth of the shoulder service line.

Risk Analysis

The main risk involved is the cost and effort involved with creating this service line. Currently, there is capacity within the current marketing budget to allow for marketing of the new service line without any direct cost, however an incremental amount of $55,000 in Year 1 and then $100,000 for Years 2 & 3 has been allocated for the launch of a new service line. Additionally, an analyst will be required to collect and analyze the appropriate research data (recruiting for data analyst position) as well as manage the concierge services. An educational assistant for patients will also be part of the team's success.

In the surgical suite, additional surgical equipment will need to be purchased to allow for increased volume efficiency. These items include a shoulder surgical positioner, electric arm holder, arthroscopy tower, etc. at approximately $96,000 (see Chart 1).

Additionally, dedicated times slots for physical therapy with dedicated therapists, and also dedicated imaging appointment slots for patients traveling from a distance.

Marketing Plan

The shoulder destination program will be marketed to the public using a variety of marketing channels including: TV, radio, print, billboards, social, website and digital media. In addition, targeted outreach would be completed by purchasing lists from the state of professions which have higher incidence of shoulder injuries and a list of physical therapists which we can directly market this program to. The program marketing would be enhanced incrementally over the first three years to reach our target audience of a 3 hour drive radius.

Direct outreach will be extended to a variety of sports venues including baseball, basketball and hockey. This will include high school, collegiate and traveling youth teams. Outreach and talks with community groups such as Senior Centers, Rotary, Lions, Optimist, Kiwanis, Veterans Organizations, Assisted Livings and more to help increase awareness of the program.

Benefits

By creating a dedicated patient volume from shoulder surgery, we mitigate the potential risk of decreased volume if there was a decrease in custom knee replacement volume for unforeseen reasons. By diversifying our surgical service lines in orthopedics, we prevent risk of decreased volume if another surgical service line were to fail.

Financially, there is increased financial gain noted from increased surgical volume. This increase in financial benefits is outlined in Chart 2. These financial benefits would be seen not only in surgical services, but also in associated ancillary services including imaging and therapy. Based on modest projections, we are anticipating increasing shoulder surgical volume by 20-25% per year, which would mean an additional 15-20 surgeries in the first year. Our current operating room has significant room for expansion of surgical volume, without compromise of other service lines.

Conclusion & Recommendations

Recommend capital investment of $96,000 (not to exceed $100,000) to begin implementation of this shoulder specialty program to enhance our orthopedic service line.

Figures

Estimated Cost for Shoulder Service Line			
Table 1 - Incremental Expense Schedule			
	1st year	2nd year	3rd year
Website	0	11,000	11,000
Marketing	55,000	100,000	100,000
Data Analyst	5,000	5,000	5,000
Capital investment in OR	96,000	$ -	$ -
Dedicated Imaging and therapy	5,000	10,000	15,000
Totals	**161,000**	**126,000**	**131,000**
Table 2 - Net Incremental Revenue Schedule			
	1st year	2nd year	3rd year
Surgical Net Revenues	$270,000	$540,000	$810,000
Imaging Net Revenue	$30,000	$60,000	$90,000
Therapy Net Revenue	$10,000	$20,000	$30,000
Professional Fees	$30,000	$60,000	$90,000
Totals	**$340,000**	**$680,000**	**$1,020,000**
Revenues over Expenses	**$179,000**	**$554,000**	**$889,000**
Note: Cost of implant included in calculations			

Table 3- CPT

Code	Procedure
23472	Total Shoulder Arthroplasty
23472	Reverse Shoulder Arthroplasty
23472	Revision Total Shoulder Arthroplasty
23470	Hemiarthroplasty Shoulder (w/wo Reaming)
23470	Revision Shoulder Hemiarthroplasty
23455	Open Bankart Repair
23460	Anterior bone block
23465	Posterior bone block
23662	Coracoid process transfer
23466	Capsular shift/capsulorrhaphy for multidirectional instability
23412	Open RCR - Chronic
23410	Open RCR - Acute
23420	Reconstruction of complete shoulder [rotator] cuff avulsion, chronic [includes acromioplasty]
23130	Smooth and Move (Acromioplasty)
23020	Capsular Release
23430	Biceps Tenodesis (long head)
24342	Reinsertion distal biceps tendon
24341	Pectoralis Repair
23700	MUA of Shoulder
23515	Clavicle ORIF
23552	CCL reconstruction c graft
23550	Open CCL repair s graft (Weaver-Dunn)
23120	Clavicle Resection (Mumford)
29805	diagnostic / biopsy
29827	Rotator Cuff Repair
29826	Acromioplasty
29806	Bankart or RIP only
29807	with SLAP repair
29825	with lysis of adhesion/MUA
29822	SLAP debridement (limited debridement)
29823	with extensive debridement
29824	with distal clavicle resection
29819	with loose body removal
29820	with partial synovectomy
29826	with subacromial decompression

29821 with complete synovectomy

References:

1. Harvard Medical School, Surgical Leadership Program, **Capstone Example Business Plan**, SLP, 2021.
2. **Kaavio Database,** Wisconsin Hospital Association Information Center, Fitchburg, WI, 2021.
3. **AMA CPT Professional 2021**, American Medical Association, Chicago, IL, 2021.

2022-2024

Community Health Needs Implementation Plan

STOUGHTON HEALTH

Creating Excellence Together

900 Ridge St., Stoughton, WI 53589

stoughtonhealth.com

Table of Contents

STOUGHTON HEALTH
Creating Excellence Together

Assessment

Implementation

Message to Our Community

STOUGHTON HEALTH
Creating Excellence Together

Stoughton Hospital is a 35-bed critical access hospital serving the counties of Dane, Rock, Green, and Jefferson along with many other communities. We are an independent community hospital owned and operated by the Stoughton Hospital Association while also being an affiliate of SSM Health of Wisconsin. Due to continued growth and an increased focus on wellness and keeping people healthy, the Stoughton Hospital Governing Board approved a brand refresh to do business as Stoughton Health. While Stoughton Health values and recognizes all the communities it serves, for purposes of the Community Health Needs Assessment (CHNA), Stoughton Health defines its community as the service area of Dane County, more specifically Stoughton, Oregon, McFarland and Cottage Grove. The residents of Dane County account for approximately 75% of inpatient cases, 78% of Emergency Department patients, and over 73% of ambulatory patients at Stoughton Health.

Beginning in 2013, Stoughton Hospital combined forces and joined three Dane County area hospitals (Meriter Hospital, St. Mary's Hospital, and UW Hospital and Clinics) along with Public Health Madison and Dane County to form the Healthy Dane Collaborative (HDC). The HDC completed the most recent community health needs assessment (CHNA) in late 2021, which is located at stoughtonhealth.com. As part of the assessment, data was reviewed, one-on-one interviews conducted, focus groups held and concerns of organizations and partners in the community were listened to. While Stoughton Health remains committed to addressing all identified health issues, we recognize we have limited resources. The health issues we have chosen to focus on are:

- Behavioral Health
  - Mental Health
  - Substance Misuse
- Chronic Disease
- Injuries

We have chosen these health issues based on community partnerships, internal resources, severity of need in our communities, and the Stoughton Health's ability to make a difference. We welcome you to join us in responding to these needs and look forward to *creating excellence together* as we improve the health and well-being of our community.

Sincerely,

Daniel D. Groot

Dan DeGroot
President & CEO
Stoughton Health

Dan DeGroot, President & CEO

The Health Needs of Our Community

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Community health needs were identified from existing sources of secondary data (regarding demographics, health status indicators, and measures of health care access), and by gathering community perspectives from individuals with expertise in public health, as well as from individuals who live, work, learn, play, and/or grow in Dane County.

key priorities

Behavioral Health

In Dane County, a majority of people said they take four mental health days a month.

Dane County residents identify “Substance Abuse” as the second most critical health need.

Behavioral health encompasses people’s psychological well-being and ability to function in everyday life.

Chronic Disease

4+ out of every 5 dollars spent on healthcare in the U.S. are spent on people with 1+ chronic conditions.

For many individuals suffering from chronic conditions, associated risk factors can be addressed and treated. By focusing on risk factors, complications and comorbidities can be prevented.

Injuries

Dane County is higher than State (20.6) and National (9.3) at 31.2 deaths per 100,000 population.

Falls are the leading cause of unintentional injury and injury deaths in older adults ages 65+ in Dane County.

Strategic Implementation Plan

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Priority #1 Behavioral Health
- -Mental Health
- -Substance Misuse

Priority #2 Chronic Disease

Priority #3 Injuries

Behavioral Health

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Priority #1

Behavioral health conditions include mental health disorders and substance use disorders. There is a growing body of evidence that links behavioral health to physical health.

Mental Health includes our emotional, psychological, and social well-being. It helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Without treatment, the consequences of mental illness to the individual and society are staggering. Poor outcomes include disability, unemployment, substance abuse, homelessness, incarceration, and suicide. The economic cost of untreated mental illness is more than 193 billion dollars each year in the US.

11.2% of Dane County residents stated that their mental health, which includes stress, depression, and problems with emotions, was not good for 14 or more of the past 30 days.[1]

The age group with the highest suicide rate in Dane County was ages 65+ at 18.9 deaths per 100,000.[4]

The overall age-adjusted death rate due to Alzheimer's disease in Dane County is higher than state and national rates at 34.3 deaths per 100,000. [2]

Substance Misuse is one of the most serious public health problems in the United States. Alcohol is the most frequently used and misused substance in the United States, and it can have devastating consequences. People who drink to excess, including binge and heavy drinkers, are at great risk for health and economic problems.

23.5% of adults in Dane County reported that they binge drink [3]

63.0% of high school youth in Dane County using marijuana used it in a vaping device[5]

Data Source:

1.County Health Rankings. (2018). Retrieved from: http://healthydane.org

2.Wisconsin Department of Health Services. (2016-2018) Retrieved from: http://healthydane.org

3.Wisconsin Department of Health Services. (2017-2019) Retrieved from: http://healthydane.org

4.Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, https://www.dhs.wisconsin.gov/wish/index.htm Injury Mortality, hospitalization and emergency department Module

5.2021 Dane County Youth Assessment, Dane County Youth Commission

Behavioral Health

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Mental Health Goals 2022-2024

- Decrease the number of 14+ poor mental health days in a month in Dane County to less than 11.9% and decrease Stoughton zip code- specific rates to less than 12.3%.
- Decrease the percentage of Medicare beneficiaries (65+) who are treated for depression to less than 18.1/100,000 population.

Action Plan

- Implement virtual health visits at Stoughton Health ER with Integrated Telehealth Partners (ITP)
- Expand and support programs for older adults that offer educational, social or physical group activities
- Treat acute mental health disorders in adults 55 years and over through the Stoughton Hospital Geriatric Psychiatry Inpatient Program
- Educate and train community on becoming dementia friendly
- Host memory café for individuals with Alzheimer's and their families
- Screen middle school students for mental health and substance abuse risk factors through cognitive behavioral intervention for trauma in schools (CBITS)
- Offer numerous free classes to manage improved well-being; three ways to relieve stress now, freedom through forgiveness, meditation, mindfulness, yoga, and more
- Train police officers with CIT (Crisis Intervention Team) training designed to de-escalate situations
- Continue work with LGBTQ+ committee with the focus of providing safe inclusive and welcoming healthcare for all
- Support local police departments with fidgets and other de-escalation items
- Provide training to staff on the Zero Suicide Initiative

Partners in the Community

- Alzheimer's Association Wisconsin Chapter
- Dane County Behavioral Health Services
- Journey Mental Health
- Libraries
- LGBTQ+ Community
- Local Churches
- Local Police Departments
- Local EMS
- National Alliance of Mental Health Dane
- Neighborhood Free Health Clinic
- Ocean Hawk Counseling
- Oregon Area Wellness Coalition
- Oregon Mental Health Services, L.L.C.
- Safe Communities
- START
- Stoughton Wellness Coalition
- Tellurian

Behavioral Health

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Substance Misuse Goals 2022-2024

- Decrease in hospitalization rate for alcohol abuse in Dane County to less than 21.1/10,000 population over age 18 due to alcohol abuse and decrease Stoughton zip code- specific rates to less than 26.2/10,000 population.
- Decrease in ER rate due to adolescent (10-17 yrs.) alcohol use in Dane County to less than 8.3/10,000 population and decrease Stoughton zip code- specific rates to less than 18.9/10,000 population.

Action Plan

- Maintain certification by the state of WI for Behavioral Health and Medication Management of Detoxification
- Provide AODA/Detox to increasing number of patients through Stoughton Health's AODA Program
- Promote and support alcohol free community and family events such as proms, movie nights and more
- Support advocacy work of coalitions for policy, systems and environmental changes
- Screen middle school aged students for mental health and substance use risk factors through cognitive behavioral intervention for trauma in schools (CBITS)
- Conduct multi-media campaign with billboards, radio, digital, advertising and print for med drop box
- Continue use of case managers/patient navigators with patients as they are discharged from the hospital
- Maintain pain management resource tools and follow up protocols
- Continue to work with SAFE Communities on the Recovery Coach Program
- Continue work and support with Stoughton Wellness Coalition and Oregon Area Wellness Coalition
- Establish protocol with providers to increase alternatives to opioid medication prescriptions
- Offer Overdose education, free Narcan distribution and participate with the medication disposal 2 times a year

Partners in the Community

- Catholic Charities
- Local Schools
- Local Churches
- Local EMS
- Local Businesses
- Local Police
- Neighborhood Free Health Clinic
- Ocean Hawk Counseling
- Oregon Area Wellness Coalition
- Oregon Mental Health
- START
- Stoughton Wellness Coalition
- SAFE communities
- Tellurian

Chronic Disease

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Chronic conditions account for the greatest number of poor health outcomes and increasing healthcare costs in Wisconsin. Currently, the state annually spends an estimated $3.9 billion and $4.1 billion in healthcare and lost productivity costs on diabetes and heart disease alone. For many individuals suffering from chronic conditions, associated risk factors can be addressed and treated. By focusing on risk factors for chronic conditions, complications and comorbidities can be prevented.

26.5% of adults in Dane county are limited in any activities because of physical, mental, or emotional problems.[1]

The age-adjusted hospitalization rate due to hypertension in Dane is 10.1 hospitalizations per 10,000 population ages 18 or older.[2]

Hospitalization rates due to asthma are highest among young children and adults over age 65.[2]

The age-adjusted hospitalization rate due to pediatric asthma in Dane County is higher than state rate at 11.0 hospitalizations per 100,000.[2]

23.1% of Medicare beneficiaries were treated for rheumatoid arthritis or osteoarthritis.[3]

The age adjusted hospitalization rate due to diabetes in Dane County is 36.0 hospitalizations per 100,000 population ages 18 or older.[4]

Priority #2

Data Source:
1.American Community Survey. (2015-2019) Retrieved from: http://healthydane.org
2.WHA Information Center. (2017-2019) Retrieved from: http://healthydane.org
3.Centers for Medicare & Medicaid Services. (2018) Retrieved from: http://healthydane.org
4.WHA Information Center. (2020) Retrieved from: http://healthydane.org

Chronic Disease

Chronic Disease Goals 2022-2024

- Decrease in hospitalization rate for diabetes (type 1&2) in Dane County to less than 11.8/10,000 population and decrease Stoughton zip code- specific rates to less than 17.7/10,000 population.
- Decrease in hospitalization rate for heart failure in Dane County to less than 26.0/10,000 and decrease Stoughton zip code- specific rates to less than 30.4/10,000 population.

Action Plan

- Continue to expand and support offerings of exercise programs for older adults.
- Continue to offer multiple free educational trainings with staff on healthy eating, Five Ways to Improve your Heart Health, Healthy Summer Cooking, Top Ways to Protect your Heart Health, Understanding Heart Disease, Understanding Cholesterol, Understanding Risk Factors for Heart Disease
- Continue to offer Healthy Living with Diabetes six-week workshop
- Continue promoting 5210 Program on our website, social media, and with banners
- Offer Powerful Tools for Caregivers training
- Continue to offer services through diabetic foot clinics
- Continue Diabetic and Crohns support groups in Stoughton
- Continue offering free nutrition and exercise presentations with physicians, dietitians and rehab dept.
- Build educational library with Health Talk –podcasts added to website from interviews with physicians and hospital experts to address healthy behaviors
- Provide screenings at the Community Health and Wellness Center to staff, businesses, and community members
- Continue to offer Cardiac Rehab for heart disease patients
- Continue use of case managers/patient navigators with patients as they are discharged from the hospital
- Offer yoga for individuals with breast cancer
- Offer financial assistance for the Infinite Boundaries Retreat for breast cancer

Partners in the Community

- Civic Organizations
- Local Businesses
- Local EMS
- Local Senior Centers
- Local Schools
- Local Youth Centers
- Neighborhood Free Health Clinic
- Oregon Area Wellness Coalition
- Parish Nurses
- Skaalen Retirement Services
- Stoughton Hospital Foundation
- Stoughton Wellness Coalition

Injuries

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Injuries can be caused by many different factors such as: self-harm, pediatric injuries, violence, motor vehicle crashes, and falls. Falls are a leading cause of unintentional injury and injury death. Falls commonly produce bruises, hip fractures, and head trauma. These injuries can increase the risk of early death and can make it difficult for older adults to live independently. Most falls are preventable. Effective prevention strategies create safer environments and reduce risk factors, from installing handrails and improving lighting and visibility, to reducing tripping hazards and exercising regularly to enhance balance.

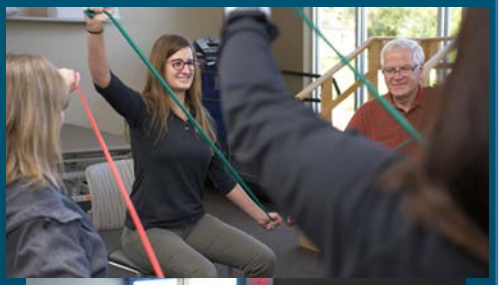
Injuries, such as motor vehicle crashes, falls, suicides and violence are leading causes of death and disability for both Dane County adults and children. [1]

Age-adjusted death rate due to falls in Dane County is at 30.3 deaths per 100,000 population. [1,2]

The age group with the highest suicide rate in Dane County was ages 65+ at 18.9 deaths per 100,000.[1]

17.2% of 9th-12th and 17.7% of 7th-8th grade youth report they had intentionally harmed themselves in the past 12 months.[3]

Priority #3



Data Source:
1.Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, https://www.dhs.wisconsin.gov/wish/index.htm Injury Mortality, hospitalization and emergency department Module
2.Wisconsin Department of Health Services. (2016-2018) Retrieved from: http://healthydane.org
3.2021 Dane County Youth Assessment, Dane County Youth Commission

Injuries

Injuries Goals 2022-2024

- Decrease the age-adjusted death rate due to falls in Dane County to less than 31.2/100,000 population.
- Reduce the age-adjusted death rate due to unintentional injuries in Dane County to less than 66.1/100,000 population.

Action Plan

- Continue to offer community classes focused on improving balance such as Tai Chi, Parkinson's, and Balance Class
- Continue to offer Safe Sitter and Safe@Home kids classes to help decrease pediatric injuries
- Explore offering car seat safety training and installation in partnership with EMS
- Offer social media safety and a variety of other injury prevention classes and education
- Partner with local senior centers on Stepping On Fall Prevention Workshop
- Explore the implementation of the Safe at Home program for aging population
- Continue to promote Wisconsin Elder Abuse Hotline in our clinics and hospital
- Explore the Community Para medicine: Partnering to Empower Patients Program
- Provide training opportunities for staff on Mental Health First Aid Training

Partners in the Community

- Area Senior Centers
- Greater Wisconsin Agency on Aging Resources, Inc.
- Local EMS
- Local Fire Departments
- Local Nursing Homes and Assisted Livings
- Local Police
- Local Youth Centers
- Neighborhood Free Health Clinic
- Oregon Area Wellness Coalition
- SAFE Communities
- Stoughton Wellness Coalition
- Wisconsin Institute of Healthy Aging

Thank You to our Many Partners Working to Improve Community Health

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- Alzheimer's Association Wisconsin Chapter
- American Cancer Society
- American Heart Association
- Dane County Behavioral Health Services
- Catholic Charities
- Civic Organizations
- Greater Wisconsin Agency on Aging
- Resources, Inc.
- Journey Mental Health
- LGBTQ+ Community
- Local Area Businesses
- Local Area Churches
- Local Area EMS
- Local Area Fire Department
- Local Area Libraries
- Local Area Nursing Homes & Assisted Living
- Local Area Police Department
- Local Area Senior Centers
- Local Area School District
- Local Area Youth Center
- National Alliance of Mental Health of
- Dane County
- Neighborhood Free Health Clinic
- Ocean Hawk Counseling
- Oregon Area Wellness Coalition
- Oregon Mental Health
- Oregon School District
- Parish Nurses
- SAFE Communities
- Skaalen Retirement Services
- START
- Stoughton Hospital Foundation
- Stoughton Wellness Coalition
- Tellurian
- The Partners of Stoughton Hospital
- Wisconsin Institute on Healthy Aging

Approved By
Stoughton Hospital Governing Board _____

Affiliated with
SSMHealth

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STOUGHTON HEALTH

MEETING MINUTES

Stoughton Hospital Association Executive Committee

Monday February 28, 2022 | 7:30 a.m. – 8:30 a.m.

Phone: 312.626.6799 | Meeting ID: 856 6127 2843 | Passcode: 752094

Zoom info: https://us06web.zoom.us/j/85661272843?pwd=aFBSQk52dHRiQ3gyZGxMQmRqQzNFQT09

Board Members Present: Tom Fendrick, Donna Olson, Steve Staton, Dr. Aaron Schwaab, Margo Francisco, Kris Krentz, Tim Rusch

Hospital Staff Present: Michelle Abey, Dan DeGroot, Amy Hermes, Teresa Lindfors, Laura Mays, Chris Schmitz, Angie Polster

Item	Discussion	Presenter
1.	Call to Order	Tom Fendrick
	Mr. Fendrick called the Executive Committee meeting to order at 7:30 a.m.	
2.	2026 Key Assumptions	Dan DeGroot
	Mr. DeGroot shared various critical assumptions developed by hospital leadership. These assumptions focused on Strategic, Workforce, Demographics, Services, Finance, and Operations. Mr. DeGroot stated we are expecting steady growth moving forward and will likely see continued progression towards outpatient services. Ms. Francisco stated SSM Health performed the same exercise and noted Stoughton Health's workforce assumptions are similar to their own.	
3.	Master Facility Plan Review	Dan DeGroot
	Mr. DeGroot shared a detailed summary of Stoughton Health's Master Facility Plan which included two potential options for future campus expansion. He noted Stoughton Health prefers Option 2 which would expand the hospital footprint into the parking lot area near Dean Clinic. Mr. Schmitz added we would need to add approximately 170 additional parking stalls to accommodate the expansion.	
4.	Organizational Structure Update/Review	Dan DeGroot
	Mr. DeGroot reviewed Stoughton Health's current organizational structure and reminded Governing Board members of plans to recruit for the newly developed Director of Engagement and Experience position.	

Item		Discussion	Presenter
	5.	Operations Update • COVID • Robotic Exploration (Orthopedics) • Workforce Management • DNV vs. The Joint Commission Discussion • Pharmacy Renovation Update Mr. DeGroot shared our Incident Command Center (ICC) group plans to meet today to discuss reimplementation plans for items that were stopped or started during the COVID-19 pandemic. He also shared various other operational updates to include recent robotics exploration, the potential for a relationship with DNV (for hospital accreditation), and status of the Pharmacy renovation.	Dan DeGroot/ Michelle Abey
A	6.	January 2022 Financials Ms. Abey shared January 2022 financials and stated operating income was $947,093 which was above budget by $663,410. She noted we continue to see strong volumes specifically on the outpatient side where gross revenues were ahead of budget by approximately $1.4 million. The gross revenue variances are mainly attributed to Medical Imaging and Emergency Room which includes Urgent Care in Stoughton and McFarland. Ms. Abey added Surgical Services also contributed to the positive budget variance. Ms. Abey shared Stoughton Health invoiced approximately $125,000 of the $258,000 SHIP COVID Testing & Mitigation grant which the hospital obtained through the American Rescue Plan (ARP). This attributed to a positive budget variance of contribution revenue. Finally, Ms. Abey shared one of the biggest challenges Stoughton Health is facing is recruiting and retaining staff to handle increased patient volumes being seen in several areas of the organization. ***Action: Mr. Staton made a motion to approve January 2022 Financials. Ms. Francisco seconded the motion. Motion carried.***	Michelle Abey
	7.	February Gross Revenue Month-to-Date Ms. Abey shared February 2022 gross revenues to date and noted gross charges are above budget by 7.7%. She added that given anticipated gross revenues are above budget we do expect a positive month.	Michelle Abey

Item	Discussion	Presenter
8.	Conflict of Interest Statement Update Ms. Abey briefly summarized Stoughton Health's assessment of Conflict of Interest questionnaires completed by Governing Board members. She stated Board members who were found to have potential conflicts of interest should abstain from any voting or decisions related to those conflicts.	Michelle Abey
9.	Final Audit Report – FY2021 Ms. Abey stated the FY2021 audit report was approved by the Governing Board at the November 22, 2021 Governing Board meeting and noted the final audit report was included for informational purposes.	Michelle Abey
10.	Adjournment – Motion from Margo, seconded Steve. Mr. Fendrick requested a motion to adjourn the February 28, 2022 Executive Committee meeting. ***Action: Ms. Francisco made a motion to adjourn the Stoughton Health Executive Committee meeting. Mr. Staton seconded the motion. Motion carried.***	Tom Fendrick

Respectfully submitted,

Steve Staton
Secretary/Treasurer

Stoughton Health - 2026 Key Assumptions

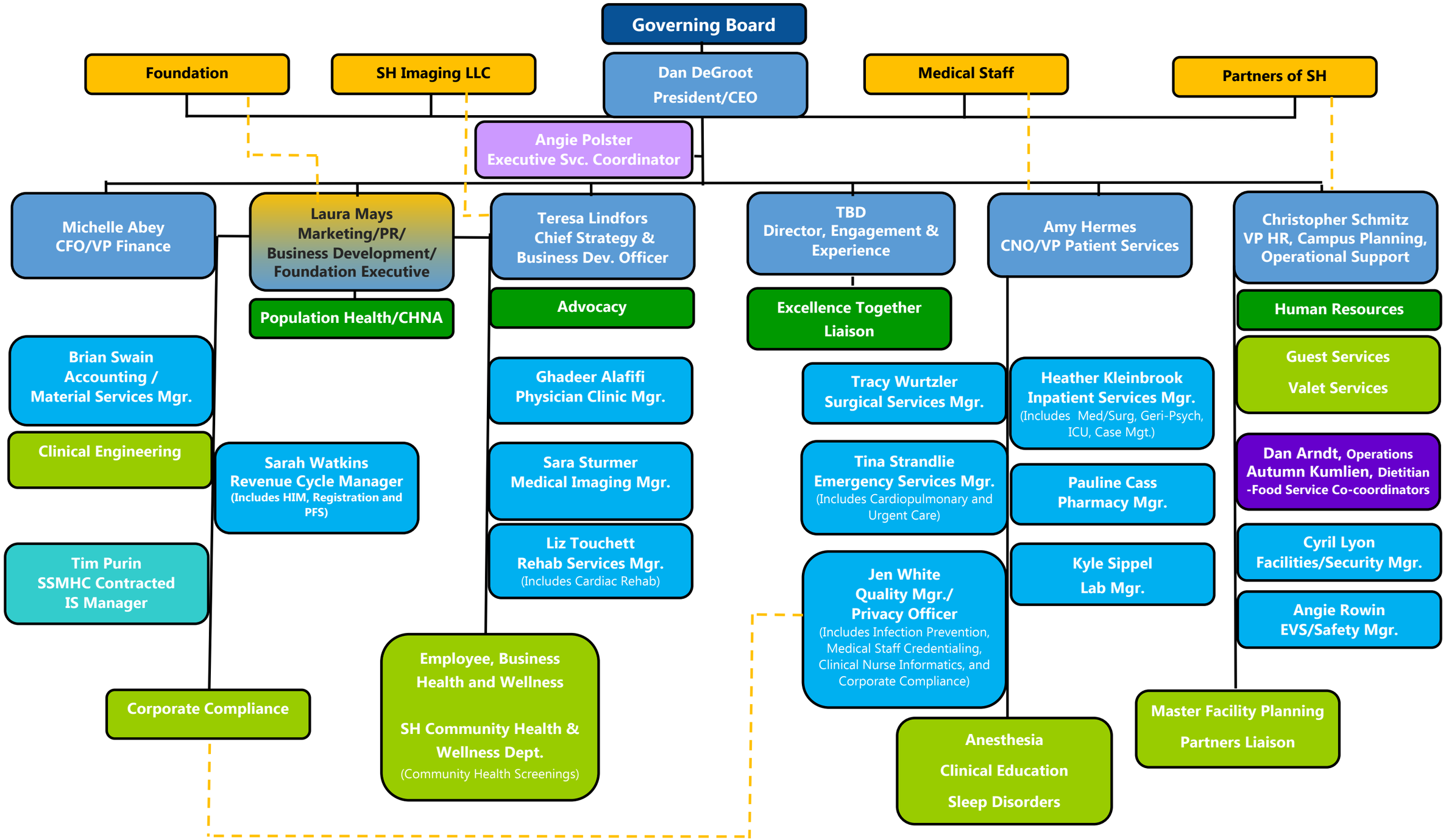
2026 KEY ASSUMPTIONS AS OF 2/20/22					
STRATEGIC	**WORKFORCE**	**DEMOGRAPHICS**	**SERVICES**	**FINANCE**	**OPERATIONS**
SH will continue to be Affiliate of SSM (who will continue with 40% ownership status).	Workforce issues (wage inflation, labor shortages) will persist into foreseeable future.	SH's primary service area will continue to see steady population growth both organic and due to immigration as housing development continues (esp. Oregon, Stoughton, McFarland).	Where care delivery occurs will continue to change, being driven by payers to lower cost and consumers to increasingly convenient settings.	There will be an intense downward pressure on health care costs and reimbursement at all levels (Federal, State, and Commercial).	Combination of employed specialists, independent specialists and outreaching SSM/UW specialists will dictate need for 3 vs 2 ORs.
Creation of an ASC IV between SH and SSM would serve both organizations well, mitigating historical outmigration challenges for SH while creating additional revenue stream and thus ROI for SSM Specialty outreach services.	Future facilities will need to reflect optimally efficient environments maximizing workflows and leveraging technology to reduce reliance on workforce.	Demand for healthcare services associated with the aging of general population (Boomers) will increase over next decade: • Cardiology Services • Pulmonary Services • Orthopedics • Urology • Cardiac Rehab • Physical Therapy • Medical admissions • GI • Breast Health • Chemotherapy • Long term infusion therapy	95% of SH surgical and procedural volumes will be provided as outpatient services.	Given aging Boomer population, payor mix will reflect increasing % Medicare, Medicaid vs other payers with subsequent downward pressure on margins.	SH will need to preserve IP OR, pre - post surgery space for remaining IP cases and/or emergent IP cases.

Stoughton Health - 2026 Key Assumptions

STRATEGIC	WORKFORCE	DEMOGRAPHICS	SERVICES	FINANCE	OPERATIONS
SH will continue to operate as a Critical Access Hospital paneled by both Quartz and DHP for their full portfolio of products.	Due to workforce challenges (supply : demand inequity) employee engagement, wellbeing and retention will be critical to sustain services and programs.	Services driven by population growth (vs aging population) will grow more slowly • General Surgery • ENT	Creation of micro-niche services within broader service portfolios will be critical to sustain volume growth and brand strength. • General Surgery o EVLT o LYNX • Orthopedics o Shoulder o Conformis o Therapy	The shift from Fee for Service (FFS) to Value Based Alternative Payment Models will accelerate as 2026 approaches.	
		Behavioral Health availability will continue to fall far short of demand. Dementia related I.P. care (Geri Psych) will continue to grow as a result of Boomer aging.	UC sites will increase volumes as PCP shortage grows. SWAC services return to SH campus.	SH will need to partner with other systems in order to add value within an ACO structure.	
				Disruptive technologies will impact historical procedural volumes (i.e., Cologuard testing vs screening colonoscopies)	

Stoughton Health Organizational Chart

(Updated 3/14/22)



Stoughton Health
2022 Governing Board Retreat – Agenda

Grand Geneva Resort & Spa
7036 Grand Geneva Way, Lake Geneva, WI 53147
Phone: 262-248-8811

Wednesday May 18, 2022

4:00 p.m. or later	Board member arrivals for those choosing to come in Wednesday evening
5:30 p.m.	Dinner at Grand Café (Main Level)

Thursday May 19, 2022

7:45 a.m. to 8:00 a.m.	Arrivals for those coming in Thursday morning
8:30 a.m. to 9:15 a.m.	Breakfast Buffet at Geneva Chophouse (Main Level)
9:15 a.m. to 10:15 a.m.	***Session 1:*** WHA Updates | Federal/State Advocacy Updates, Eric Borgerding (Linwood Ballroom, Main Level)
10:15 a.m. to 10:30 a.m.	Break
10:30 a.m. to 11:30 a.m.	***Session 1 (cont.):*** WHA Updates | Federal/State Advocacy Updates, Eric Borgerding (Linwood Ballroom, Main Level)
11:30 a.m. to 12:30 p.m.	Lunch at The Landing (Main Level)
12:30 p.m. to 1:50 p.m.	***Session 2:*** Excellence in Governance, Pam Knecht (Linwood Ballroom, Main Level)
1:50 p.m. to 2:00 p.m.	Break
2:00 p.m. to 3:00 p.m.	***Session 3:*** SSM Health Overview, Margo Francisco (Linwood Ballroom, Main Level)
3:00 p.m. to 3:15 p.m.	Break
3:15 p.m. to 4:15 p.m.	***Session 4:*** SSM Health Accountable Care Organization (ACO) Model, Dr. Mark Thompson (Linwood Ballroom, Main Level)
4:15 p.m. to 4:30 p.m.	Day One Wrap-up, Dan DeGroot
4:30 p.m. to 5:00 p.m.	Open
5:00 p.m. to 6:00 p.m.	Social Hour at The Landing (Main Level)
6:00 p.m. to 7:30 p.m.	Dinner at Geneva Chop House in Private Dining Room (Main Level)
7:30 p.m.	Bonfire at Embers Terrace (Main Level)

Friday May 20, 2022

8:00 a.m. to 8:45 a.m.	Breakfast Buffet at Geneva Chophouse (Main Level)
8:45 a.m. to 9:00 a.m.	Day Two Wrap-up/Next Steps/Updates, Dan DeGroot (Linwood Ballroom, Main Level)
9:00 a.m. to 11:00 a.m.	Stoughton Health Governing Board Meeting (Linwood Ballroom, Main Level)
11:00 a.m. to 11:30 a.m.	Annual Board of Directors Compliance Review, Sarah Coyne, Quarles & Brady (Linwood Ballroom, Main Level)
11:30 a.m. to 12:30 p.m.	Lunch at The Landing (Main Level)
12:30 p.m.	Departure

STOUGHTON HEALTH

SERVICES AND FINANCIAL REPORTS

February 28, 2022

STOUGHTON HEALTH
FINANCIAL AND SERVICES REPORTS
February 28, 2022

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Stoughton Health
February 2022 Operational Executive Summary

Situation: February operating income was $498,730 which was more than the budget of $392,884 by $105,846. February excess of revenues over expenses is $368,372, which is ($76,612) under the budget of $444,984. Year-to-date operating income is $3,797,929 which is better than budget by $2,570,282 and year-to-date excess of revenues over expenses is $3,841,361 which is $2,336,048 better than budget.

Background:

Balance Sheet

- Days cash on hand was 415 days at the end of February (line 33 on pg 7) is over the budgeted days cash on hand of 376 and lower than days cash on hand at the end of January which was 421. The days cash on hand continued to decline as predicted in February due to ~$659,000 which was paid out to tentatively settle the FY2021 cost report when it was filed in late February and $197,660 of Medicare Advanced payments which were repaid. To date, ~$2.3M of the $5.8M of CMS Medicare Advanced Payments have been repaid.
- The estimated third party payer settlements liability has increased by $483,000 in the first five months of fiscal year 2022. This liability represents the estimated amount which Stoughton Health anticipates it's being overpaid on Medicare claims and potential amounts due upon cost report audit settlement. This liability fluctuates with changes in the payer mix and distribution of expenses.

Income Statement

- Outpatient gross revenues were significantly ahead of budget for the month of February by approximately $817,000. The areas seeing the most significant gross revenue variances over budget were Medical imaging– specifically CT and MRI (~$407,000), and Emergency Room including urgent care in Stoughton & McFarland (~$376,000). Surgical services did (12) less procedures than budgeted which was approximately ($125,000) lower than budget as a result. Despite February 2022 being below budget for surgical procedures, the 128 cases done is 32% higher than February of last year.

Specialty	Feb 21	Feb 22	% Change from LY	Budget Feb	% Change from Budget
Orthopedics	8	13	63%	27	-52%
Gynecology	0	0	0%	0	0%
Urology	2	0	0%	1	-100%
General	18	20	11%	23	-13%
Ophthalmology (Phaco)	12	13	8%	24	-46%
Podiatry	8	6	-25%	8	-25%
Dental	18	13	-28%	19	-32%
Ear, Nose,Throat (ENT)	4	4	0%	5	-20%
GI Endoscopy	27	59	119%	33	79%
Total OR Procedures	97	128	32%	140	-9%

- Contribution revenue (pg 8, line 9) is lower than budget for the month of February as Stoughton Health received the Rural Critical Care Supplement earlier than anticipated in the budget so the contribution was recognized in a previous month this year. Year-to-date contribution revenue is

$129,932 ahead of budget as Stoughton Health obtained a grant for COVID testing and mitigation of which ~$125,000 has been recognized in this fiscal year.

- Purchased services (pg 8 line 15) was higher than budget by approximately ($99,000) as a result of increased volumes in the medical imaging areas, thus increased purchased services expense of (~$38,000). In addition, we are using more agency staff (medical/surgical, intensive care and emergency room) than was budgeted resulting in an additional ($39,000) in expense than what was anticipated in the budget.
- Supplies expense (pg 8 line 16) was higher than budget by approximately ($58,000) which is the result of increased volumes in the infusion and emergency room areas creating additional pharmaceutical drug (~$32,000) costs than budgeted.
- This month's mix resulted in a contractual discount percentage of 57.4% for the month vs a budgeted contractual discount of 60.5%, resulting in a net revenue increase from budget of approximately $324,000.
- Unrealized gains (losses) on investments (pg 8 line 24) were $224,076 below budget for the month as a result of significant market fluctuations.

Assessment:

Volumes in most areas continued to be strong for February resulting in gross patient revenues being approximately $828,000 ahead of budget for the month.

The biggest challenge facing the organization continues to be how to recruit and retain staff in order to be able to handle the patient volumes we are presented with in many areas of the organization.

Recommendation:

1. Recruit and retain staff in order to serve the patients of our communities.
2. Continue to follow CDC recommendations for caring for COVID and Non-COVID patients in the safest possible manner. Promote vaccinations including booster shots whenever and wherever possible.
3. Remain nimble to changing circumstances and recalibrate operations, including the evaluation of new and old programs, as needed to adjust course.
4. Resume master facility planning so that the organization is ready to move forward when it is prudent to do so.

Stoughton Health
Executive Financial Summary
February 28, 2022

Variance Key: Better than (worse than) budget

Line	INCOME STATEMENT	Current Mo. February	Current Mo. Budget	Current Mo. Variance	YTD February	YTD Budget	YTD Variance	YTD Prior Year
	REVENUE:							
	Patient service revenues:							
1	Inpatient	$ 1,453,581	$ 1,442,256	$ 11,325	$ 9,613,762	$ 8,566,931	$ 1,046,831	$ 8,014,136
2	Outpatient	9,213,908	8,396,992	816,916	51,876,369	43,955,987	7,920,382	38,878,963
3	Total gross patient service revenues	10,667,489	9,839,248	828,241	61,490,131	52,522,918	8,967,213	46,893,099
4	Deductions from revenue (incl bad debts)	(6,355,547)	(6,081,437)	(274,110)	(38,209,992)	(32,363,339)	(5,846,653)	(28,727,969)
5	Net patient service revenue	4,311,942	3,757,811	554,131	23,280,139	20,159,579	3,120,560	18,165,130
6	Other income	136,142	455,684	(319,542)	1,204,677	991,356	213,321	984,039
7	Total revenues	4,448,084	4,213,495	234,589	24,484,816	21,150,935	3,333,881	19,149,169
	EXPENSES:							
8	Salaries	1,424,173	1,440,600	16,427	7,690,614	7,726,720	36,106	7,239,698
9	Fringe benefits	400,583	440,656	40,073	1,912,711	2,045,206	132,495	1,965,556
10	Supplies and other	1,843,104	1,644,178	(198,926)	9,620,922	8,669,502	(951,420)	7,569,325
11	Interest	32,321	35,329	3,008	179,994	193,268	13,274	232,210
12	Depreciation and amortization	249,173	259,848	10,675	1,282,646	1,288,592	5,946	1,320,296
13	Total expenses	3,949,354	3,820,611	(128,743)	20,686,887	19,923,288	(763,599)	18,327,085
14	**Operating income**	**498,730**	**392,884**	**105,846**	**3,797,929**	**1,227,647**	**2,570,282**	**822,084**
15	Investment income	49,568	11,300	38,268	232,642	79,198	153,444	192,069
16	Unrealized gains (losses) on investments	(199,369)	24,707	(224,076)	(300,219)	123,536	(423,755)	812,360
17	Interest in earnings of MRI Joint Venture	19,443	16,093	3,350	111,009	74,932	36,077	74,932
18	Other non-operating	-	-	-	-	-	-	-
19	**Excess of revenue over expenses**	**$ 368,372**	**$ 444,984**	**$ (76,612)**	**$ 3,841,361**	**$ 1,505,313**	**$ 2,336,048**	**$ 1,901,445**

	BALANCE SHEET	02/28/22	09/30/21
20	Cash & short-term investments	$ 35,955,971	$ 33,873,549
21	A/R (net)	6,868,621	6,759,089
22	Total current assets	44,361,209	41,950,841
23	Certificates of deposit	7,000,000	7,000,000
24	Investments	10,777,365	10,629,724
25	Property & equipment (net)	26,646,342	27,237,551
26	Other assets	9,397,800	9,543,572
27	**Total assets**	**91,182,716**	**89,361,688**
28	Current liabilities	10,445,355	10,858,317
29	Long-term debt	9,320,161	10,923,308
30	Other long-term liabilities	426,882	431,106
31	Total liabilities	20,192,398	22,212,731
32	Net assets	70,990,318	67,148,957
33	**Total liabilities & net assets**	**91,182,716**	**89,361,688**

CASH FLOWS	YTD February	09/30/21
Cash provided by (used in):		
Operating activities	4,855,577	4,628,345
Investing activities:		
Fixed asset purchases & disposals	(701,314)	(1,503,805)
Investments	(351,044)	767,988
Financing activities:		
Issuance of debt	-	-
Payment of debt & related costs	(1,647,594)	(1,298,318)
Forgiveness of long-term debt	-	-
Foundation & other	(73,203)	43,836
Net cash increase (decrease)	2,082,422	2,638,046
Cash, beginning	33,873,549	31,235,503
Cash, ending	**35,955,971**	**33,873,549**

	RATIOS	Desired Direction	FY20	FY21	Dec-21	Jan-22	Feb-22	FY22 Budget	2020 RWHC CAH Avg
34	Current Ratio	↑	3.2	3.9	3.8	3.9	4.2	7.4	3.3
35	Operating Margin-Current Month	↑			20.2%	18.0%	11.2%		
36	Operating Margin YTD	↑	2.3%	5.1%	15.9%	16.5%	15.5%	5.4%	4.7%
37	Total Margin YTD	↑	3.7%	22.7%	19.1%	17.1%	15.5%	6.9%	7.1%
38	Days in Accounts Receivable (net)	↓	40	53	45	47	45	43	48
39	Days in Accounts Receivable (gross)	↓	43	52	42	46	45		
40	Days Cash & Investments on Hand	↑	446	431	425	421	415	376	309
41	Long-term Debt to Equity	↓	0.29	0.16	0.14	0.13	0.13	0.12	0.36
42	Debt Service Coverage (YTD) >1.25	↑	2.6	9.2	8.1	7.5	6.8	4.5	5.3

	STATISTICS	FY20	FY21	Dec-21	Jan-22	Feb-22	YTD February	FY22 Budget
43	Inpatient Days	4,053	3,658	369	266	264	1,654	4,308
44	Adjusted Patient Days (APD)	18,121	24,148	2,242	1,979	1,937	10,579	31,219
45	Net revenue per APD	$2,314	$1,938	$2,160	$2,508	$2,226	$2,201	$1,585
46	FTE's	221.9	227.2	241.7	233.4	234.3	237.6	241.0
47	FTE's per Adjusted Occupied Bed	4.5	3.3	3.3	3.7	3.4	3.4	3.3
48	Avg # of payroll checks per pay period	327	311	326	315	315	316	
49	Salaries per APD	$935	$761	$733	$770	$735	$727	$607
50	Benefits per APD	$269	$179	$96	$248	$207	$181	$158
51	Other Expenses per APD	$1,131	$959	$1,051	$1,141	$1,080	$1,031	$778

STOUGHTON HEALTH
SERVICES SUMMARY
for the five months ended February 28, 2022

INPATIENT SERVICES

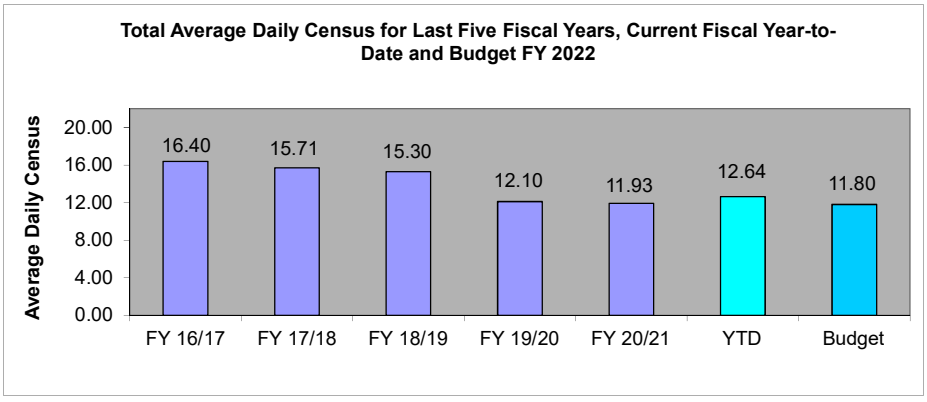
In February, inpatient admissions (including observation patients) averaged 3.05 admissions per day which was below budget by (1.01) admissions per day or (24.9%). Year-to-date inpatient admissions are (0.56) admissions per day or (15.0%) below prior year.

16-17	17-18	18-19	19-20	20-21		THIS MONTH
1.45	1.30	1.12	1.22	1.15	Medical	1.11
0.47	0.54	0.45	0.37	0.29	Surgical	0.25
0.12	0.07	0.18	0.10	0.11	Detoxification	0.04
0.63	0.75	1.67	1.40	1.77	Observation	1.18
0.19	0.13	0.13	0.07	0.06	Swing Bed	0.11
0.16	0.09	0.10	0.08	0.08	Intensive Care	0.04
0.42	0.44	0.36	0.28	0.27	Geriatric Psychiatric	0.32
3.44	3.32	4.01	3.52	3.73	Average Admissions per day	3.05

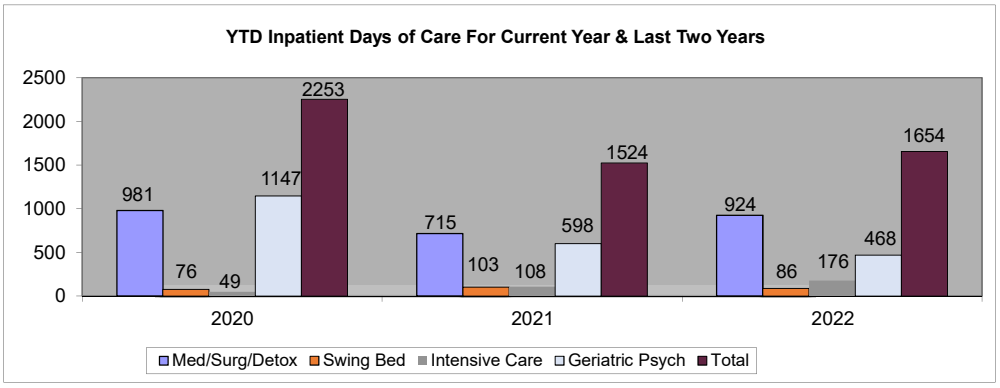
The overall average daily census in February was 10.99 which is below the budgeted average daily census of 11.80 and below the prior year average daily census of 11.93. Inpatient Average Daily Census numbers for the past thirteen months, year-to-date for Fiscal 2022, budget and prior year averages are shown in the following chart:

	FEB 2021	MAR 2021	APR 2021	MAY 2021	JUN 2021	JUL 2021	AUG 2021	SEP 2021	OCT 2021	NOV 2021	DEC 2021	CURRENT FISCAL 2022	BUDGET	PRIOR FISCAL YR
Medical / Surgical Unit	3.21	3.87	5.43	3.45	8.17	3.94	6.61	6.67	6.61	8.27	7.90	6.12	2.95	4.74
Observation	1.87	1.74	2.36	1.55	2.57	2.62	2.71	1.47	2.26	1.78	1.64	1.68	1.90	1.91
Swing Bed	1.11	0.48	0.17	0.00	1.10	0.29	0.48	0.77	0.00	0.00	0.29	0.57	0.55	0.56
Intensive Care Unit	0.21	0.00	0.27	0.06	0.10	0.16	0.16	1.20	1.71	1.47	1.13	1.17	0.27	0.45
Geriatric Psychiatry Unit	3.71	3.74	4.87	3.39	3.97	4.71	5.77	4.97	3.71	3.00	2.58	3.10	6.13	4.27
	10.11	9.83	13.10	8.45	15.91	11.72	15.73	15.08	14.29	14.52	13.54	12.64	11.80	11.93

Inpatient average daily census numbers for the past five fiscal years, year-to-date for Fiscal 2022, and budget are shown in the following graph:



Additional inpatient service volume statistics for the five months ended February 28, 2020, 2021 and 2022 are as follows:



STOUGHTON HEALTH
SERVICES SUMMARY
for the five months ended February 28, 2022

INPATIENT SERVICES - CONTINUED

Discharge Length of Stay

16-17	17-18	18-19	19-20	20-21		THIS MONTH
2.67	3.41	2.77	2.88	2.28	Medical	1.93
2.86	2.68	2.54	1.68	0.29	Surgical	-
5.42	6.47	9.28	9.12	9.59	Swing Bed	8.50
7.00	5.85	2.50	2.73	9.64	Intensive Care	6.50
2.63	3.18	2.48	2.22	2.94	Detoxification	7.00
2.36	2.27	3.47	4.09	3.38	Hospice Acute	-
19.57	16.86	11.46	13.28	12.31	Geriatric Psychiatric	9.50
5.40	5.81	4.35	4.29	3.84		3.91

OUTPATIENT SERVICES

Outpatient/Emergency services averaged 144.37 visits per day in February which was (7.45) visits per day or (4.9%) below budget for the month. Year-to-date Outpatient/Emergency services is 26.03 visits or 19.9% above the prior year average visits per day of 130.69.

16-17	17-18	18-19	19-20	20-21		THIS MONTH
13.73	13.52	13.61	13.36	14.57	Emergency Department	15.86
37.17	35.44	41.67	37.02	34.06	Urgent Care - Stoughton	39.43
9.62	8.67	8.11	6.47	6.30	Urgent Care - Oregon	5.89
-	-	-	-	2.11	Urgent Care - McFarland	6.18
3.92	3.03	2.76	2.95	3.20	Ambulatory Infusion	2.96
3.75	3.87	3.71	3.12	3.72	Surgical	4.86
0.71	0.98	1.02	0.68	1.04	Sleep Lab	0.79
29.01	28.56	29.67	23.79	30.60	PT - SWAC/Hosp Rehab	32.61
20.34	20.49	20.94	15.42	19.82	PT - Oregon	19.54
11.23	12.30	13.25	9.48	15.27	Rehabilitation - Other	16.25
129.48	126.86	134.74	112.29	130.69	Average Visits per day	144.37

DIAGNOSTIC SERVICES

Diagnostic services (laboratory & medical imaging areas) averaged 273.80 service units per day in February which was 26.79 units or 10.8% above budget. Year-to-date diagnostic services are 32.72 service units per day or 13.2% above last year's average.

16-17	17-18	18-19	19-20	20-21		THIS MONTH
181.81	199.67	189.28	176.31	192.08	Lab including reference lab	199.75
23.24	23.17	21.55	20.53	20.57	Medical Imaging	36.11
3.79	4.98	6.12	5.73	8.16	Mammography	7.00
8.48	9.09	10.64	11.01	11.62	CT	14.75
1.17	1.42	1.82	1.42	2.96	Echocardiogram	4.04
5.77	5.76	5.94	4.88	5.92	Ultrasound	5.93
0.81	0.98	0.80	0.61	0.94	Nuclear Medicine	1.36
3.07	3.68	3.76	4.04	4.87	MRI	4.86
228.14	248.75	239.91	224.53	247.12	Average Service Units per Day	273.80

STOUGHTON HEALTH
SERVICES SUMMARY
for the five months ended February 28, 2022

GENERAL SURGERY SERVICES

In February, the General Surgery clinic had a total of 124 visits for the month which was (1.00) visits or (0.8%) below the prior month and below budget by (126.00) visits or (50.4%).

FY 2017	FY 2018	FY 2019	FY 2020	FY 2021		LAST MONTH ACTUAL	YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET
872	926	1,191	1,081	1,001	General Surgery Clinic Visits - Traditional	84	452	856
0	0	0	15	41	General Surgery Clinic Visits - Virtual	2	15	0
255	386	918	879	701	Wound Clinic Visits	39	271	423
1,127	1,312	2,109	1,975	1,743	Total Clinic Visits	125	738	1,279

Dr. Aaron Schwaab, General Surgeon, had 17 surgical cases in February. Inpatient cases were at budget for the month and outpatient cases were below budget by (6) cases or (27.3%).

FY 2017	FY 2018	FY 2019	FY 2020	FY 2021		THIS MONTH ACTUAL	YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET
49	23	30	26	24	Inpatient Surgical Cases	1	14	7
191	234	247	212	218	Outpatient Surgical Cases	16	88	107
240	257	277	238	242	Total Surgical Cases	17	102	114

ORTHOPEDIC SERVICES

During the month of February, the OrthoTeam Clinic (Stoughton and Madison) had 233 visits and averaged 11.7 visits per clinic day. February visits were (58) visits or (19.9%) below budget.

FY 2017	FY 2018	FY 2019	FY 2020	FY 2021		LAST MONTH ACTUAL	YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET
2,122	2,453	2,497	3,002	1,489	OrthoTeam Clinic Visits - Traditional	291	1,149	1,550
0	0	0	261	106	OrthoTeam Clinic Visits - Virtual	30	120	0
2,122	2,453	2,497	3,263	1,595	Total OrthoTeam Visits	321	1,269	1,550

OrthoTeam had 13 surgical cases in February. Inpatient cases were above budget by 1 cases or 50.0% for February. Outpatient cases were below budget by (12) cases or (54.5%) for the month of February.

FY 2017	FY 2018	FY 2019	FY 2020	FY 2021		THIS MONTH ACTUAL	YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET	YEAR-TO-DATE Variance
136	151	151	152	45	Inpatient Surgical Cases	3	17	27	(10)
42	46	116	109	197	Outpatient Surgical Cases	10	98	108	(10)
178	197	267	261	242	Total Surgical Cases	13	115	135	(20)

CARDIOLOGY SERVICES

The Cardiology Clinic opened in July 2021. It had 43 total visits in the month of February.

STOUGHTON HEALTH
BALANCE SHEET
February 28, 2022

Line	ASSETS	2/28/2022	Audited 9/30/2021
	Current Assets		
1	Cash and cash equivalents	$ 35,955,971	$ 33,873,549
2	Patient accounts receivable, net of allowances	6,868,621	6,759,089
3	Supplies	533,361	536,876
4	Other current assets	1,003,256	781,327
5	**Total current assets**	44,361,209	41,950,841
	Assets Limited as to Use		
6	Certificates of deposit	7,000,000	7,000,000
7	Board designated and other	10,777,365	10,629,724
		17,777,365	17,629,724
8	Property and equipment	63,532,709	62,869,570
9	Less accumulated depreciation	(36,886,367)	(35,632,019)
10	Net property and equipment	26,646,342	27,237,551
	Other Assets		
11	Interest in net assets of Stoughton Hospital Foundation Inc.	1,362,830	1,374,175
12	Other non-current assets	4,564	-
13	Investment in Stoughton Hospital Imaging LLC	1,030,406	1,169,397
14	**Total assets**	$ 91,182,716	$ 89,361,688
	LIABILITIES AND NET ASSETS		
	Current Liabilities		
15	Current portion of long-term debt	$ 1,284,472	$ 1,317,080
16	Accounts payable	1,033,454	1,105,863
17	Accrued salaries and related withholdings	830,582	1,061,195
18	Accrued vacation compensation	1,342,846	1,193,641
19	Accrued interest	29,953	37,109
20	Other current liabilities	95,293	102,881
21	Refundable advance - COVID Provider Relief Funds	407,331	-
22	CMS advance payments, current portion	3,488,424	4,590,548
23	Estimated third-party payor settlements	1,933,000	1,450,000
24	**Total current liabilities**	10,445,355	10,858,317
25	Deferred compensation liability	426,882	431,106
26	Long-term debt, net of current portion	9,320,161	10,923,308
27	**Total liabilities**	20,192,398	22,212,731
	Net Assets		
28	Without donor restrictions	69,462,706	65,621,345
29	With donor restrictions	1,527,612	1,527,612
30	**Total net assets**	70,990,318	67,148,957
31	**Total liabilities and net assets**	$ 91,182,716	$ 89,361,688

		Budget		
32	Days revenue in accounts receivable	43	45	53
33	Days cash on hand, all unrestricted sources	376	415	431
34	Current Ratio	7.4	4.2	3.9
35	Age of Plant	13.1	12.0	11.3

STOUGHTON HEALTH
INCOME STATEMENT
For the five month ended February 28, 2022

Variance Key: Better than (worse than) budget

Line		Current Month February	Budget	Variance	Year to Date TOTALS	Budget	Variance	Year to Date LAST YEAR
	REVENUES							
	Patient service revenue:							
1	Inpatient	$ 1,453,581	$ 1,442,256	$ 11,325	$ 9,613,762	$ 8,566,931	$ 1,046,831	$ 8,014,136
2	Outpatient	9,213,908	8,396,992	816,916	51,876,369	43,955,987	7,920,382	38,878,963
3	Gross patient charges	10,667,489	9,839,248	828,241	61,490,131	52,522,918	8,967,213	46,893,099
4	Contractual discounts and allowances	(6,126,103)	(5,949,286)	(176,817)	(37,438,980)	(31,657,901)	(5,781,079)	(28,115,912)
5	Charity care	(20,444)	(26,979)	6,535	(128,012)	(144,018)	16,006	(144,057)
6	Provision for bad debts	(209,000)	(105,172)	(103,828)	(643,000)	(561,420)	(81,580)	(468,000)
7	**Patient service revenue**	4,311,942	3,757,811	554,131	23,280,139	20,159,579	3,120,560	18,165,130
8	Other operating revenue	57,407	63,121	(5,714)	367,950	308,285	59,665	331,348
9	Contributions	5,305	340,003	(334,698)	469,946	340,014	129,932	329,133
10	Rental income	73,430	52,560	20,870	366,781	343,057	23,724	323,558
11	**TOTAL REVENUES**	4,448,084	4,213,495	234,589	24,484,816	21,150,935	3,333,881	19,149,169
12	Salaries	1,424,173	1,440,600	16,427	7,690,614	7,726,720	36,106	7,239,698
13	Employee benefits	400,583	440,656	40,073	1,912,711	2,045,206	132,495	1,965,556
14	Professional fees	505,882	488,485	(17,397)	2,569,814	2,600,924	31,110	2,198,806
15	Purchased services	588,883	489,701	(99,182)	2,997,790	2,454,893	(542,897)	2,275,914
16	Supplies	533,558	475,272	(58,286)	3,070,893	2,662,494	(408,399)	2,246,682
17	Interest	32,321	35,329	3,008	179,994	193,268	13,274	232,210
18	Administrative and general	197,287	171,415	(25,872)	894,238	854,664	(39,574)	772,452
19	Insurance	17,494	19,305	1,811	88,187	96,527	8,340	75,471
20	Depreciation and amortization	249,173	259,848	10,675	1,282,646	1,288,592	5,946	1,320,296
21	**Total expenses**	3,949,354	3,820,611	(128,743)	20,686,887	19,923,288	(763,599)	18,327,085
22	**Operating income (loss)**	498,730	392,884	105,846	3,797,929	1,227,647	2,570,282	822,084
	Other income (loss):							
23	Investment income (loss) - realized	49,568	11,300	38,268	232,642	79,198	153,444	192,069
24	Unrealized gains (losses) on investments	(199,369)	24,707	(224,076)	(300,219)	123,536	(423,755)	812,360
25	Earnings (loss) in Sto Hosp Imaging	19,443	16,093	3,350	111,009	74,932	36,077	74,932
26	Other gains (losses)	-	-	-	-	-	-	-
27	Forgiveness of Refundable Advance - PRF	-	-	-	-	-	-	-
28	Forgiveness of Paycheck Protection Program Loan	-	-	-	-	-	-	-
29	**Excess of revenues over expenses**	**$ 368,372**	**$ 444,984**	**$ (76,612)**	**$ 3,841,361**	**$ 1,505,313**	**$ 2,336,048**	**$ 1,901,445**
30	*Operating Margin*	*11.2%*	*9.3%*		*15.5%*	*5.8%*		*4.3%*
31	*Total Margin*	*8.2%*	*10.5%*		*15.5%*	*7.1%*		*9.8%*
32	*Adjusted Patient Days*	1,937	2,371		10,579	12,655		8,929
33	*Net revenue per APD*	$ 2,226	$ 1,585		$ 2,201	$ 1,593		$ 2,034
34	*Salaries per APD*	$ 735	$ 608		$ 727	$ 611		$ 811
35	*Benefits per APD*	$ 207	$ 186		$ 181	$ 162		$ 220
36	*Supplies per APD*	$ 275	$ 200		$ 290	$ 210		$ 252

STOUGHTON HEALTH
STATEMENT OF CHANGES IN NET ASSETS
For the five month ended February 28, 2022

	2/28/22	Audited 9/30/21
Unrestricted net assets:		
Excess (deficit) of revenues over expenses	3,841,361	13,406,181
Net assets released from restrictions	-	65,901
Contributions and grants for purchases of property and equipment	-	148,521
Increase (decrease) in unrestricted net assets	3,841,361	13,620,603
Temporarily restricted net assets:		
Restricted contributions	-	46,291
Change in interest in net assets of the Foundation	-	90,707
Net assets released from restrictions	-	(65,901)
Increase (decrease) in temporarily restricted net assets	-	71,097
Increase (decrease) in net assets	3,841,361	13,691,700
Net assets, beginning	67,148,957	53,457,257
Net assets, ending	70,990,318	67,148,957

STOUGHTON HEALTH
STATEMENT OF CASH FLOWS
For the five month ended February 28, 2022

	Current Month	YTD February	Audited 9/30/2021
Cash Flows From Operating Activities			
Increase (decrease) in net assets	$ 367,579	$ 3,841,361	$ 13,691,700
Adjustments to reconcile increase (decrease) in net assets			
to net cash provided by operating activities:			
Change in interest in net assets of Stoughton Hospital Foundation Inc.	-	-	(90,707)
Depreciation and amortization	249,173	1,282,646	3,150,926
Amortization of debt issuance costs	2,368	11,839	30,501
Net realized and unrealized gains and losses on investments	170,424	203,403	(1,307,892)
Forgiveness of Paycheck Protection Program Loan	-	-	(4,064,937)
Loss (gain) on disposal of property and equipment	-	9,876	(14,684)
Change in investment in Stoughton Hospital Imaging, LLC	(19,442)	(111,009)	(265,082)
Distribution from Stoughton Hospital Imaging, LLC	-	250,000	200,000
Contributions and grants for property and equipment	-	-	(194,812)
Increase (decrease) from changes in:			
Patient accounts receivable, net	412,152	(109,532)	(2,143,837)
Supplies	(4,877)	3,515	157,584
Estimated third-party payor settlements	(677,000)	483,000	1,575,000
Other current assets	58,340	(226,493)	(107,491)
Refundable advance - provider relief funds (forgiven)	-	407,331	(5,023,434)
CMS advanced payments	(197,660)	(1,102,124)	(1,237,502)
Accounts payable, accrued expenses and other current liabilities	(243,537)	(88,236)	273,012
Net cash provided by (used in) operating activities	117,520	4,855,577	4,628,345
Cash Flows From Investing Activities			
Acquisition of property and equipment	(247,678)	(701,314)	(1,561,623)
Proceeds from disposal of property and equipment	-	-	57,818
Maturities/(Purchases) of certificates of deposit	-	-	-
Purchases of assets limited as to use	(384,160)	(4,418,132)	(11,603,172)
Sales/Proceeds from maturities of assets limited as to use	375,698	4,067,088	12,371,160
Net cash provided by (used in) investing activities	(256,140)	(1,052,358)	(735,817)
Cash Flows From Financing Activities			
Proceeds from issuance of new debt	-	-	-
Payment of debt issuance costs	-	-	-
Payment of accounts payable for equipment and financing costs	-	(84,548)	(150,976)
Repayment of long-term debt	(113,389)	(1,647,594)	(1,298,318)
Restricted contributions and grants	-	11,345	194,812
Net cash provided by (used in) financing activities	(113,389)	(1,720,797)	(1,254,482)
Net increase (decrease) in cash	(252,009)	2,082,422	2,638,046
Cash, beginning	36,207,980	33,873,549	31,235,503
Cash, ending	$ 35,955,971	$ 35,955,971	$ 33,873,549

Stoughton Hospital Medical Care Evaluation Committee Report to Medical Executive Committee and Board of Directors
January 18, 2022

Presiding: Dr. Mark Menet
Members: Amy Hermes, Teresa Lindfors, Rhonda Tesmer, Jennifer White, Dr. Rawal, Erin Meronk, Dan DeGroot, Dr. Liova Rivera, Dr. Aaron Schwaab, Charlie Smith
Absent: Nikki Rowin, Dr. Stolcpart, Dr. McGuire

<table>
<tr><th>Agenda Item (Facilitator)</th><th>Discussion</th><th>Follow Up Action</th></tr>
<tr><td colspan="3">Meeting called to order.</td></tr>
<tr><td>Introductions-New Staff</td><td>The committee welcomed the new Infection Prevention Nurse Bill Wilson who comes with 31 years as an emergency med nurse, and Pharmacy Manager Pauline Cass who has experience in working in several rural hospitals as well as larger facilities.</td><td></td></tr>
<tr><td>Approval of November meeting minutes</td><td>Dr. Schwaab motioned to approve the minutes from November. Dr. Rawal seconded the motion. Motion carried.</td><td></td></tr>
<tr><td>Re-appointments (Dr. Menet)</td><td>
<table>
<tr><th>Name</th><th>Title/Privilege</th><th>Dates of Review</th></tr>
<tr><td>Rebecca Hamman</td><td>APNP/ENT</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Derek Hubbard</td><td>MD/Fam Med/C’scope</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Clifford King</td><td>MD/Plastic Surgery</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Peter Lee</td><td>MD/Cardiology</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Alisha Maly</td><td>PA-C/Emergency Med</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Mark McDade</td><td>MD/General Surgery</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Paula Riebe</td><td>PA-C/Emergency Med</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Robert Nerad</td><td>PA-C/Emergency Med</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>Cecelia Thompson</td><td>DDS/Dentistry</td><td>1/1/2020-12/31/2021</td></tr>
<tr><td>David Worth</td><td>DPM/Podiatry</td><td>1/1/2020-12/31/2021</td></tr>
</table>
</td><td>Letters set to three providers.

Dr. Schwaab moved to approve the reappointments. Dr. Rawal seconded the motion. Will forward to MEC for approval.</td></tr>
<tr><td colspan="3">Consent Agenda Items Action: Dr. Schwaab moved to approve the Consent Agenda Items. Dr. Rivera seconded the motion. Motion carried.</td></tr>
<tr><td>Committee Reports: November CI Council Minutes, CI Program and Plan, November Patient Safety, December Infection Prevention, ER Committee</td><td>The hospital received a grant and plan to put it towards Antibiotic Stewardship and being able to help with some data mining to make sure their goals are where they should be. CI Council is deferred till March due to the surge.

CI Program and Plan was updated. Dr. Schwaab moved to approve the updates to the policy. Dr. Rivera seconded the motion. Motion carried.</td><td>CI Program and Plan to be forwarded to MEC for approval.</td></tr>
<tr><td>Medical Imaging Reports: MRI Utilization</td><td></td><td></td></tr>
</table>

Agenda Item (Facilitator)	Discussion	Follow Up Action
Lab: Anatomic Pathology Quality Management Report—Jan-Jun 2021	Please refer to the PDF attachment.	
Utilization Reports: Surgical Services Procedures & AIC Visits/Treatments; GeriPsych Percent Occupancy; Average Hours per Inpatient Stay	Surgical Services report not available.	
Organ/Tissue Procurement Review-Nov/Dec, Donor Hero, LEBW Dashboard	One tissue donor honored.	
Health Information Management		
Delinquent records/Health Information Management-	No delinquent records as of 01/12/2022	
Old/Recurring Business-		
30 day readmissions reports by month	November 1 readmission (COVID related)/40 eligible discharges, Rate 2.5 readmissions/100 discharges.	
Inpatient Code Reviews	Place holder-process begins this month. Not many IP codes, but nurses have worked on is a code sheet that will contain information that would come to MCE for review. Dr. Dahlberg will review ED Codes for ED Committee.	
OPPE/FPPE (concerns only)	14 providers with no concerns identified. 9 providers who have not completed Annual Education (due 12/31/21)	**Letters to go out to those who don't have education completed.**
New Business/Current Clinical Process Issues		
Wound/Skin Policy for approval	Policy has been reviewed by Dr. Schwaab and the wound team. It provides guidance for standardizing wound care approach on the inpatient units. In the future, the ongoing review can be done by the wound care team and if there are significant changes, it will be referred to MCE. Dr. Schwaab moved to approve the updates to the policy. Dr. Rivera seconded the motion. Motion carried. Teresa is analyzing wound services to see if expanding practice would make sense.	**Policy approved to go to MEC for Approval. The policy will be formatted to match other Stoughton Health policies**

Agenda Item (Facilitator)	Discussion	Follow Up Action
Credentialing form for Pediatric Cardiologist	EHHS and Mile Bluff forms: Looking for recommendation of which to adapt as a Stoughton Health form. See Separate Attachments. Tabled.	**Teresa to look into this further.**
Recent Root Cause Analysis (Jen)	No new RCA's at this time.	
COVID-19 Update (Dan or Amy)	SH switched to the current CDC guidelines for employees who test positive for COVID. 78% of employees have been boosted. SCOTUS upheld mandate for CMS vaccine mandate. Dr. Menet suggested revisiting the visitor restrictions.	
Peer Review Synopsis from last meeting	No cases met criteria for full review.	
Mortality Review- November & December	Two deaths in November (no criteria for review). Six deaths in December, one referred for preliminary review, no concerns identified.	
Surgical Complications/Cancellations for Oct-Dec	Two cases identified for preliminary review of complications. No concerns identified.	
Medical Care Case Review		
ED Case review		
OTHER BUSINESS		
Adjournment:	With no further business to attend to the meeting adjourned.	*Next meeting: February 15, 2022*

OPPE January Review

Highlighted individuals are still in FPPE process as new providers.

Status	SpecialtyDescription	Degree	LastName	FirstName
Active	Pulmonary Med	MD	Chapla	Kevin
Active	Hospital Medicine	MD	Davidson-Fiedler	Marlise
Active	Hospital Medicine	MD	Dhillon	Puneet
Active	Hospital Medicine	MD	Ductan	Kerline
Active	Hospital Medicine	MD	Hoversten	Patrick
Active	Hospital Medicine	MD	Lee	Alexander
Active	Hospital Medicine	MD	Menet	Mark
Active	Hospital Medicine	MD	Patel	Sarjoo
Active	Hospital Medicine	MD	Quinn	Roswell
Active	Hospital Medicine	MD	Rai	Nisheeth
Active	Hospital Medicine	MD	Reisman	Jonathan
Active	Hospital Medicine	MD	Saleem	Muhammad
Active	Hospital Medicine	DO	Scholtz	Harry
Active	Hospital Medicine	DO	Shreevatsa	Ajai
Active	Hospital Medicine	DO	Stanfield	Dylan
Allied Health Professional	ENT	apnp	Hamman	Rebecca
Active	ENT	MD	Coughlin	Adam
Active	ENT	MD	Lyon	Steven
Active	Gastroenterology	MD	Whang	Naree
Active	Gastroenterology	MD	Ehrhardt	William
Active	General Surgery	MD	Erickson	Marc
Active	General Surgery	MD	Huntsman	Richard
Active	General Surgery	MD	Kontny	Billie
Active	General Surgery	MD	Modade	Mark
Active	General Surgeon	MD	Mclaughlin	Jonathan
Active	General Surgeon	MD	Rainiero	David
Active	General Surgery	MD	Schwaab	Aaron
Active	Plastic Surgery	MD	King	Clifford
Allied Health Professional	Plastic Surgery	PA-C	Block	Kierstyn
Courtesy	Podiatry	DPM	Worth	David
Active	Podiatry	DPM	Graney	Colin
Active	Podiatry	DPM	Bogue	Stephen
Still in FPPE so no OPPE needed yet				

Stoughton Hospital Medical Care Evaluation Committee Report to MEC/Board of Directors
February 15, 2022

Presiding: Dr. Mark Menet
Members: Amy Hermes, Teresa Lindfors, Rhonda Tesmer, Jennifer White, Dr. Rawal, Erin Meronk, Dan DeGroot, Dr. Liova Rivera, Dr. Aaron Schwaab, Charlie Smith, Dr. McGuire
Not Present: Nikki Rowin, Dr. Stolcpart, Dr. Rawal

<table>
<tr><th>Agenda Item (Facilitator)</th><th>Discussion</th><th>Follow Up Action</th></tr>
<tr><td colspan="3">Meeting called to order.</td></tr>
<tr><td>Approval of January meeting minutes</td><td colspan="2">Dr. Schwaab motioned to approve the minutes from January. Dr. McGuire seconded the motion. Motion carried.</td></tr>
<tr><td>Re-appointments (Dr. Menet)</td><td colspan="2">
<table>
<tr><th>Name</th><th>Title/Privilege</th><th>Dates of Review</th></tr>
<tr><td>Anderson, Thor</td><td>DDS/Dentistry</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Dean, Andrew</td><td>MD/Emergency Med</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Hamilton, Jennifer</td><td>PA-C/Orthopedic Surg</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Holt, Daniel</td><td>MD/Radiology</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Huntsman, Richard</td><td>MD/Gen Surg</td><td>4/1/2021-1/31/2022</td></tr>
<tr><td>Laczniak, Andrew</td><td>MD/Radiology</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Mosley, Krista (Crawford)</td><td>MD/Emergency Med</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>O’Connor, Anne</td><td>MD/Cardiology</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Schemmel, Andrew</td><td>MD/Radiology</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Shannahan, Sean</td><td>MD/Radiology</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Shore, Matthew</td><td>MD/Radiology</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Sugar, Hugh</td><td>PA-C/Emergency Med</td><td>2/1/2020-1/31/2022</td></tr>
<tr><td>Wells, Robert</td><td>MD/Radiology</td><td>2/1/2020-1/31/2022</td></tr>
</table>
</td><td>Dr. Schwaab moved to approve the reappointments. Dr. McGuire seconded the motion. Will forward to MEC for approval.</td></tr>
<tr><td colspan="3">Consent Agenda Items Action: Dr. Schwaab moved to approve the Consent Agenda Items. Dr. McGuire seconded the motion. Motion carried.</td></tr>
<tr><td>Committee Reports: January IP Leadership, January Patient Safety, QSRC</td><td colspan="2">Dan stated that the hospital is planning to encourage COVID boosters for employees. Currently, around 98% of our workforce is vaccinated and around 80% are boosted. If it is approved outside of the EUA, it would become required.
Dan also wanted to highlight that there will be a CI project related to Isolation Signage and making sure staff have the alerts they need to feel safe entering rooms in the correct PPE.</td></tr>
</table>

Agenda Item (Facilitator)	Discussion	Follow Up Action
	There was clarification about the Columbia Suicide Data on the Quality and Safety Report Card, which is specific to the ER. The inpatient units met the goal and moved this into monitoring.	
Medical Imaging Reports: MRI Utilization		
Lab: Transfusion Summary Quarter 4 CY 2021		
Utilization Reports: Surgical Services Procedures & AIC Visits/Treatments; GeriPsych Percent Occupancy; Average Hours per Inpatient Stay	Surgical Services report not available.	
Organ/Tissue Procurement Review-Jan		
Health Information Management		
Delinquent records/Health Information Management-	No delinquent records as of 2.8.2022	
Old/Recurring Business-		
30 day readmissions reports by month	No readmissions.	
Inpatient Code Reviews	One code blue reviewed using the new form with no negative outcome. Everything handled very well.	**No actions required.**
OPPE/FPPE (concerns only)	Last month 9 providers from the January schedule had not completed Annual Education (due 12/31/21) and letters were sent to those provider, as well as 23 other providers who had not completed this requirement. UPDATE: 4 providers remaining	**Amy will contact the 4 providers.**
New Business/Current Clinical Process Issues		
Formulary trial request for Zynrelef	Dr. Schwaab made the motion to recommend trialing Zynrelef. Dr. McGuire seconded the motion. Motion carried.	**Will forward to MEC for approval**
Credentialing form for Pediatric Cardiologist	Tabled from last month. New form available.	**Forward to MEC for approval.**

Agenda Item (Facilitator)	Discussion	Follow Up Action
	There is a new tech in radiology that can do pediatric tests and the providers from UW want to be able to read the tests. Dr. Kaji does not read these tests so there is no competition from a provider standpoint. Remove special privilege section Dr. Schwaab made the motion to approve the Pediatric Cardiology form with the stipulation of removing the special privilege request section on the form. Dr. McGuire seconded the motion. Motion carried.	
Recent Root Cause Analysis (Jen)	No new root cause analyses in process.	
COVID-19 Update (Dan or Amy)	The Dane County mask mandate is ending March 1st. Dane County vaccinator call-SH will be listening to try and make decisions about screeners, visitors etc. MS is seeing a more normal patient flow so there will be discussion taking place about taking on more detox, swing bed, etc.	
Peer Review Synopsis from last meeting	No cases met criteria for full review.	
Mortality Review- January	One death, no criteria for review.	
Surgical Complications/Cancellations for Dec-Jan	One surgical case for review.	
Medical Care Case Review		
ED Case review		
OTHER BUSINESS	Dan expressed his disappointment with the amount of temporary privileges that have been granted over the course of the last year. He wants it made clear that this is not the route that will be normalized. Applicants will be told meeting dates and when to expect to have approval by. Dr. Jacalyn Nelson is retiring in March and there are a few new providers coming on which is causing delay in reads and causing delays billing. If it's a CI project, the CI minutes will come through MCE to be reviewed so the committee can pull it off the consent agenda to discuss further.	
Adjournment:	With no further business to attend to the meeting adjourned.	*Next meeting: March 15, 2022*

OPPE February Review (Highlighted individuals are still in FPPE process as new providers.)

Status	SpecialtyDescription	Degree	LastName	FirstName
Courtesy	Radiology	MD	Andersen	James
Courtesy	Radiology	MD	Baker	Richard
Courtesy	Radiology	MD	Bennett	Harold
Courtesy	Radiology	MD	Bogost	Gregg
Courtesy	Radiology	MD	Budhardjo	Philip
Courtesy	Radiology	MD	Buencamino	Cenon
Courtesy	Radiology	MD	Cassie	Conrad
Courtesy	Radiology	MD	Clifton	David
Courtesy	Radiology	MD	Crummy	Timothy
Courtesy	Radiology	MD	Davis	Douglas
Courtesy	Radiology	MD	Dolin	Ronald
Courtesy	Radiology	MD	Figi	Adam
Courtesy	Radiology	MD	Foltz	Gretchen
Courtesy	Radiology	MD	Gibson	Samuel
Courtesy	Radiology	MD	Goth	Eric
Courtesy	Radiology	MD	Hartmann	Bradley
Courtesy	Radiology	MD	Hoefer	Daniel
Courtesy	Radiology	MD	Holt	Daniel
Courtesy	Radiology	MD	Kennedy	Neil
Courtesy	Radiology	MD	Kitchin	Douglas
Courtesy	Radiology	MD	Klein	Jeffrey
Courtesy	Radiology	MD	Laczniak	Andrew
Courtesy	Radiology	MD	Lisk	Thomas
Courtesy	Radiology	MD	Mcguire	Shawn
Courtesy	Radiology	MD	Mckinnon	Sally
Courtesy	Radiology	MD	Monat	Eric
Courtesy	Radiology	MD	Mossa basha	Feras
Active	Radiology	MD	Norman	Emily
Courtesy	Radiology	MD	Pooler	Bryan
Courtesy	Radiology	MD	Rich	Mark
Courtesy	Radiology	MD	Rossi	Alessandro
Courtesy	Radiology	MD	Schemmel	Andrew
Courtesy	Radiology	MD	Shadman	Shawyon
Courtesy	Radiology	MD	Shannahan	Sean
Courtesy	Radiology	MD	Shlimovitz	Cary
Courtesy	Radiology	MD	Shore	Matthew
Courtesy	Radiology	MD	Wedding	Christopher
Courtesy	Radiology	MD	Wells	Robert

Stoughton Hospital Medical Executive Committee Agenda/Minutes
March 7, 2022 (0730-0830) Board Room/Zoom

Presiding: Dr. Aaron Schwaab
Members: Dr. Guirish Agni, Dr. Abigail Dahlberg, Dr. Mark Menet, Dan DeGroot, Amy Hermes, Teresa Lindfors, Erin Meronk
Absent: Dr. Christina Quale, Dr. Deanne Eccles, Dr. Shawn McGuire, Dr. Ashish Rawal

<table>
<tr><th>Agenda Item (Facilitator)</th><th>Discussion</th><th>Follow Up Action</th></tr>
<tr><td colspan="3">Meeting called to order.</td></tr>
<tr><td>Approval of January Medical Executive Meeting minutes—See attached</td><td colspan="2">Action: Dr. Menet made the motion to accept the minutes as written. Dr. Agni seconded the motion. Motion carried.</td></tr>
<tr><td>New Appointments-One year term</td><td colspan="2">
<table>
<tr><th>Last Name</th><th>First Name</th><th>Title</th><th>Privileges</th><th>Affiliation</th><th>Staff Category</th></tr>
<tr><td>Falconer</td><td>Steven</td><td>MD</td><td>Radiology</td><td>Madison Radiology</td><td>Courtesy</td></tr>
<tr><td>Hickner</td><td>Mary</td><td>DPM</td><td>Podiatry</td><td>Independent</td><td>Active</td></tr>
<tr><td>Fassari</td><td>Maria</td><td>MD</td><td>Hospital Medicine</td><td>Beam Healthcare</td><td>Active</td></tr>
<tr><td>Ley</td><td>Dana</td><td>MD</td><td>Hospital Medicine</td><td>Beam Healthcare</td><td>Active</td></tr>
<tr><td>Embrescia</td><td>Mary</td><td>MD</td><td>Psychiatry</td><td>ITP</td><td>Courtesy</td></tr>
<tr><td>Askew</td><td>Maria</td><td>APNP</td><td>Psych APNP</td><td>ITP</td><td>Courtesy</td></tr>
<tr><td>Sheth</td><td>Atul</td><td>MD</td><td>Psychiatry</td><td>ITP</td><td>Courtesy</td></tr>
<tr><td>Bharucha</td><td>Neza</td><td>MD</td><td>Psychiatry</td><td>ITP</td><td>Courtesy</td></tr>
<tr><td>Dharmavaram</td><td>Naga</td><td>MD</td><td>Hospital Medicine</td><td>Beam Healthcare</td><td>Active</td></tr>
</table>
Action: Dr. Agni recommended the acceptance of the above listed practitioners for a one-year term. Dr. Menet seconded the motion carried.
</td><td></td></tr>
<tr><td>Re-appointments-Two year term</td><td colspan="2">
<table>
<tr><th>Last Name</th><th>First Name</th><th>Title</th><th>Privileges</th><th>Affiliation</th><th>Staff Category</th></tr>
<tr><td>Hamman</td><td>Rebecca</td><td>NP</td><td>NP</td><td>SSM</td><td>Courtesy</td></tr>
<tr><td>Hubbard</td><td>Derek</td><td>MD</td><td>Fam Med</td><td>SSM</td><td>Courtesy</td></tr>
<tr><td>King</td><td>Clifford</td><td>MD</td><td>Plastic Surgery</td><td>SSM</td><td>Active</td></tr>
<tr><td>Lee</td><td>Peter</td><td>MD</td><td>Cardiology</td><td>SSM</td><td>Courtesy</td></tr>
<tr><td>Maly</td><td>Alisha</td><td>PA</td><td>Emergency Med</td><td>SWEA</td><td>AHP</td></tr>
<tr><td>McDade</td><td>Mark</td><td>MD</td><td>General Surgery</td><td>SSM</td><td>Active</td></tr>
<tr><td>Nerad</td><td>Robert</td><td>PA</td><td>Emergency Med</td><td>SWEA</td><td>AHP</td></tr>
<tr><td>Riebe</td><td>Paula</td><td>PA</td><td>Emergency Med</td><td>SWEA</td><td>AHP</td></tr>
</table>
</td><td></td></tr>
</table>

Agenda Item (Facilitator)	Discussion	Follow Up Action

Thompson	Cecelia	DDS	Dental	Children's Dental Center	Dental
Worth	David	DPM	Podiatry	SSM	Courtesy
Anderson	Thor	DDS	Dental	Independent	Dental
Dean	Drew	MD	Emergency Med	SWEA	Active
Hamilton	Jennifer	PA	Orthopedic Surg	Sto Health	AHP
Holt	Daniel	MD	Radiology	Madison Radiology	Courtesy
Huntsman	Richard	MD	General Surg	SSM	Active
Laczniak	Andrew	MD	Radiology	Madison Radiology	Courtesy
Mosley	Krista	PA	Emergency Med	SWEA	AHP
O'Connor	Anne	MD	Cardiology	UW	Courtesy
Schemmel	Andrew	MD	Radiology	Madison Radiology	Courtesy
Shannahan	Sean	MD	Radiology	Madison Radiology	Courtesy
Shore	Matthew	MD	Radiology	Madison Radiology	Courtesy
Sugar	Hugh	PA	Emergency Med	SWEA	AHP
Wells	Robert	MD	Radiology	Madison Radiology	Courtesy

Action: Dr. Agni recommended the acceptance of the above listed practitioners for a two-year term. Dr. Menet seconded the motion. Motion carried.

Medical Staff Resignation/Retirement (FYI)

Dr. Bradley Hartmann, Madison Radiology, Courtesy
Dr. Philip Budiharadjo, Madison Radiology, Courtesy
Dr. George Cherian, Madison Radiology, Courtesy
Dr. Eric Goth, Madison Radiology, Courtesy
Dr. Thomas Lisk, Madison Radiology, Courtesy
Dr. Marc Erickson, General Surgery, Fort Healthcare, Active
Dr. Jonathan McLaughlin, General Surgery, Fort Healthcare, Active
Paul Sabel, PA-C, Emergency Medicine, SWEA, Allied Health Professional

Consent Agenda Items

Reviewed with no concerns.
Action: Dr. Menet moved to approve the Consent Agenda Items. Dr. Agni seconded the motion. Motion carried.

Committee Reports:
January/February MCE Minutes, Patient Safety, CI Council, CI Dashboard ***—See attached***

Agenda Item (Facilitator)	Discussion	Follow Up Action
Quality and Safety Report Card & Stoughton Hospital Balanced Scorecard—*See attached*		
Old/Recurring Business-		
FPPE (concerns only) (Erin Meronk/Amy Hermes) —*See attached*	Reviewed with no concerns.	
Correspondence-		
Treasurer's Report—*See attached* (Dr. Dahlberg)	Dr. Schwaab spoke to Danny and Autumn about the fridge and possibly getting nonperishable snacks to be available. The fridge is going to be relocated to a location where it would be more available to all medical staff, possibly the OR lounge.	
COVID-19 Update (Dan or Amy)	Hospital campuses continue to wear masks. Over the next couple of months, ICC will be looking at what to continue and what not to continue.	
New Business		
Temporary Privileges discussion	After reviewing the last year and the amount of temporary privileges approved, it was determined that this will be closely monitored, and only allowed on very rare occasions. Applicants can expect to use the normal review process.	
1.15 Continuous Improvement Program and Plan Policy update—*See attached*	*Action: Dr. Agni recommended the acceptance of the changes made to the 1.15 Continuous Improvement Program and Plan Policy. Dr. Menet seconded the motion. Motion carried.*	
Stoughton Health Inpatient Skin and Wound Care Policy—*See attached*	*Action: Dr. Agni recommended the acceptance of the Stoughton Health Inpatient Skin and Wound Care Policy. Dr. Menet seconded the motion. Motion carried.*	
Pediatric Cardiologist Privilege form—*See attached*	*Action: Dr. Agni recommended the acceptance of the Pediatric Cardiologist Privilege form. Dr. Menet seconded the motion. Motion carried.*	
Formulary trial request for Zynrelef—*See attached*	*Action: Dr. Agni recommended the acceptance of the formulary trial request for Zynrelef. Dr. Menet seconded the motion. Motion carried.*	
Review edits of Medical Staff Policies and Procedures	Admission Discharge of Patients Policy (see highlight on page 1-no clinical advisor to medicine) Confidentiality Retention of Credentialing Files Policy Direct Admissions Policy Emergency Services Policy General Conduct of Patient Care Policy	**To be forwarded to BOD for approval.**

Agenda Item (Facilitator)	Discussion	Follow Up Action
	General Rules Regarding Surgical Care Policy Stoughton Health CI Policy Temporary Privileges Policy OPPE Policy Expedited Privileges Policy FPPE Policy Disaster Credentialing Policy Medical Staff Health Screen Immunization Requirements Policy ***Action: Dr. Menet recommended the acceptance of the updates to all the Medical Staff Policies and Procedures with exception to those being reviewed by the legal team (marked with an asterisk). Dr. Agni seconded the motion. Motion carried.*** *Impaired Practitioner Policy (tabled while Legal reviews) *EMTALA Compliance Policy (tabled while Legal reviews) *Allied Health Professional Orders Policy (tabled while Legal reviews) *Consent for Treatment or Procedures Policy (tabled for internal review) *Documentation Requirements for the Medical Records Policy (tabled for internal review)	
Administrative Report		
Physician Development/Recruitment Updates (Dan)	Dr. Hickner has obtained temporary privileges to begin helping Dr. Graney.	
Strategic Plan/Master Facility Updates (Dan)	The Master Plan for 2026 will be taken to the March BOD meeting for review/approval. The hospital has purchased an entire block over the last several years and will be looking at adding a 56,000 sf medical staff office building and relocation of some offices. Additional meetings with architects and engineers coming up.	
Patient Satisfaction—***See attached*** (Amy)	Reviewed.	
Patient Services (Amy)	Biggest issue right now is staffing and recruitment. Looking at all ways that we can make sure we are on peoples radars. Some travelers are still in house but will be done at the end of March.	
Business Developments (Teresa)	Teresa to talk with Dr. Graney and Dr. Hickner about a possible Podiatry Clinic to be open this summer or fall. Dr. Schwaab inquired about insured vs. uninsured patient referrals and who other providers choose to accept or not accept.	

Agenda Item (Facilitator)	Discussion	Follow Up Action
Public Relations Board Report- December 2021 & January 2022 — *See attached*	Reviewed.	
Provider Education-	Dr. Zasadil & Dr. Kenny-UW Remote cardiologists Dr. Tom Murwin-SSM Pediatrician Dr. William Ehrhardt-letting privileges lapse	**Erin to draft letter and have to Dr. Schwaab review and sign.**
Opportunities for Improvement		
Adjournment:		**Next meeting: May 2, 2022**

Quality and Safety Report Card – Q2FY2022

Quality Measures	Desired Direction	RWHC	National	GOAL	22-Jan	Oct-Dec 2021	Dec-21	Nov-21	Oct-21	Jul-Sep 2021	Sep-21	Aug-21	Jul-21	Apr-Jun 2021	Jun-21	May-21	Apr-21	Jan-Mar 2021	Mar-21	Feb-21	Jan-21	Oct-Dec 2020	Dec-20
Global Immunization-Core Measure																							
Inpatient Influenza Vaccination Rate (Effective October-March only)	⇧	84% Q1 2021	94% Q4 2019 Median	100%	96%	98%	100%	98%	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%
Pain Management																							
Pain Assessment and Reassessment (Inpatient Only)	⇧	n/a	n/a	> 90%		81%	92%	72%	94%	81%	77%	81%	87%	88%	95%	88%	89%	94%	93%	93%	95%	92%	86%
Patient Flow Measures	Desired Direction	RWHC Jul-Sep 2021	National Oct- Dec 2019	GOAL																			
Emergency Room to Admission (minutes) Core Measures																							
Decision to admit to transport to inpatient unit (median) - previous project, continue to monitor	⇩	68	129	<RWHC	125	86	99	84	106	84	95	81	85	62	60	59	63	73	57	61	91	73	74
Emergency Room to Discharge (minutes) Core Measures		RWHC Jul-Sep 2021	National Oct- Dec 2019	GOAL																			
Length of stay in ER for patients discharged (median)-excl MH and TX	⇩	126	150	<National	171	152	161	138	140	162	160	179	155	145	140	148	159	159	146	156	192	137	137
Median Time to EKG for Chest Pain and Acute MI (minutes) No longer publically reported - continue to monitor to ensure process is hardwired	⇩	n/a	n/a	<10	10.5	3	7.5 min	1 min	4 min	8	6	25	7.5	12	7.5	23.5	18	9	ND	7.5	9	12	ND
		WI	National	GOAL																			
Key Patient Information Communicated with ED Transfer (All EDTC) - public reporting	⇧	74%	75%	>53%	87%	87%	93%	76%	93%	82%	80%	87%	80%	96%	87%	100%	100%	100%	100%	100%	100%	98%	100%
Columbia Suicide Screening completed in ED	⇧	n/a	n/a	100%		97%	97%	97%	97%	98%	98%	97%	98%	97%									

Pay for Performance Measures	Desired Direction	GOAL	Oct-Dec 2021	Jul-Sep 2021	Apr-Jun 2021	Jan-Mar 2021	Oct-Dec 2020	Jul-Sep 2020	Apr-Jun 2020	Jan-Mar 2020	Oct-Dec 2020	Jul-Sep 2019	Apr-Jun 2019
Quality (Dean Insurance and/or Medicaid) DHP *Reporting Period 10/01/2018 - 09/30/2019*													
Healthcare Personnel (HCP) Influenza Vaccination Rate	↑	98%	99%	NA	NA	99%	99%	NA	99%	99%	99%	NA	NA
Colon Surgical Site Infections (COLO)	↓	SIR ≤ .750	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
7 Total Abdominal Hysterectomy Surgical Site Infections (HYST)	↓	SIR ≤ .930	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
Central Line-associated bloodstream infections (CLABSI)	↓	SIR ≤ .570	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Catheter-associated Urinary Tract Infections (CAUTI)	↓	SIR ≤ .910	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Efficiency Measures (Dean Ins.) *DHP Reporting Period 01/01/2019 - 12/31/2019*		**GOAL**											
30 Day Readmissions - Dean Primary Ins (1 year rolling calendar)	↓	≤ 6.1%	8.3%	4.0%	7.4%	6.7%	8.6%	10.8%	7.0%	8.3%	6.3%	14.0%	14%
1-day in-patient Medical Stays (1 year rolling calendar)	↓	≤ 15.4%	11.1%	6.7%	6.3%	5.3%	5.9%	25.0%	34.8%	33.3%	29.0%	26.0%	17.4%
Patient Satisfaction Measures (Dean Ins.) *DHP Reporting Period 07/01/2018 - 06/30/2019*		**GOAL**											
Overall Rank Hospital High (9-10 on a scale of 0-10)	↑	≥ 86%	88%	88%	Pass	Pass	Pass	85%	86%	87%	83%	85%	85%
Doctor's Communicated Well	↑	≥90%	90%	89%	Pass	Pass	Pass	87%	88%	89%	91%	92%	92%
Nurse's Communicated Well	↑	≥89%	90%	92%	Pass	Pass	Pass	88%	88%	88%	88%	88%	91%
Staff Provided Discharge Instructions		≥94%	94%	93%	Pass	Pass	Pass	93%	95%	95%	94%		
Inpatient Psychiatric Services (Medicare) Core Measure		**GOAL**											
Hours of Physical Restraint Use per 1000 patient care hours **	↓	0	0	0.5	0	0	0	3.03	0	0	0	0	0
Hours of Seclusion Use per 1000 patient care hours	↓	0.05	0	0	0	0	0	0	0	0	0	1.27	1.63
2 or more Antipsychotic Meds with Justification - Overall Rate	↑	100%	100%	100%	ND	ND	100%	100%	ND	33%	0%	100%	ND
Transition Record complete with 11 required elements (Started 01/2017)	↑	100%	100%	97%	88%	92%	100%	100%	100%	92%	95%	95%	91%
Timely Transmission of Continuing Care Plan (Started 01/2017)	↑	100%	100%	97%	88%	92%	94%	100%	100%	89%	92%	95%	91%
Alcohol Use Screening Completed (No longer reported but collected internally)	↑	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Alcohol Use Brief Intervention Received or Refused (Effective January 2016)	↑	100%	100%	100%	ND	ND	100%	ND	ND	ND	ND	100%	ND
Alcohol Use received or refused a RX for tx of alcohol or drug use disorder or a referral for addictions treatment.		100%	ND	ND	ND	ND	ND	ND	ND	ND	ND	0%	ND
Tobacco Use Screening Completed (No longer reported but collected internally)	↑	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Tobacco Use Counseling and Treatment Received or Refused (TOB 2)	↑	100%	100%	100%	100%	100%	ND	100%	ND	100%	ND	ND	100%
Geriatric Psych Patient Influenza Immunization (Effective October-March only)	↑	100%	100%	ND	ND	100%	100%	ND	ND	97%	84%	N/A	N/A
Screening for Metabolic Disorders (Effective January 1, 2017)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

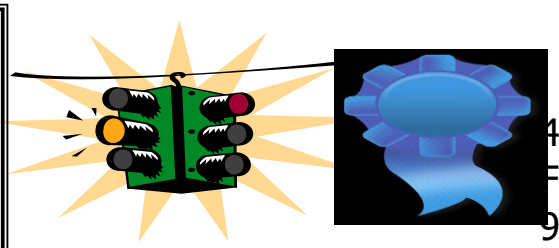
STOUGHTON HOSPITAL BALANCED SCORECARD

Current Indicator Status

Compared to Goals, Best In Class Benchmarks or Other Standards

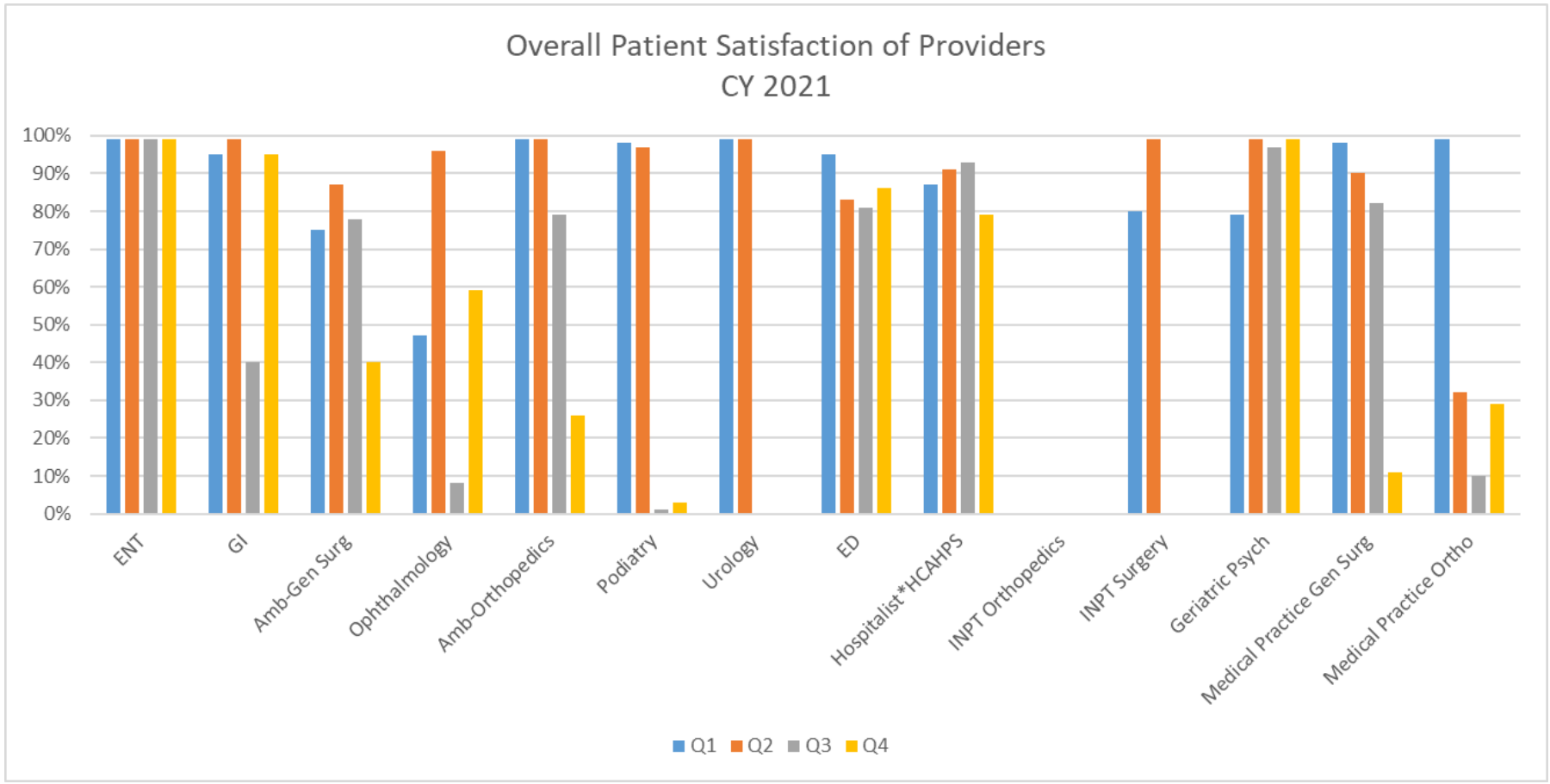
Surpassed Stretch Goal	At or Above Goal	Caution < 5% Below Goal	Action Needed

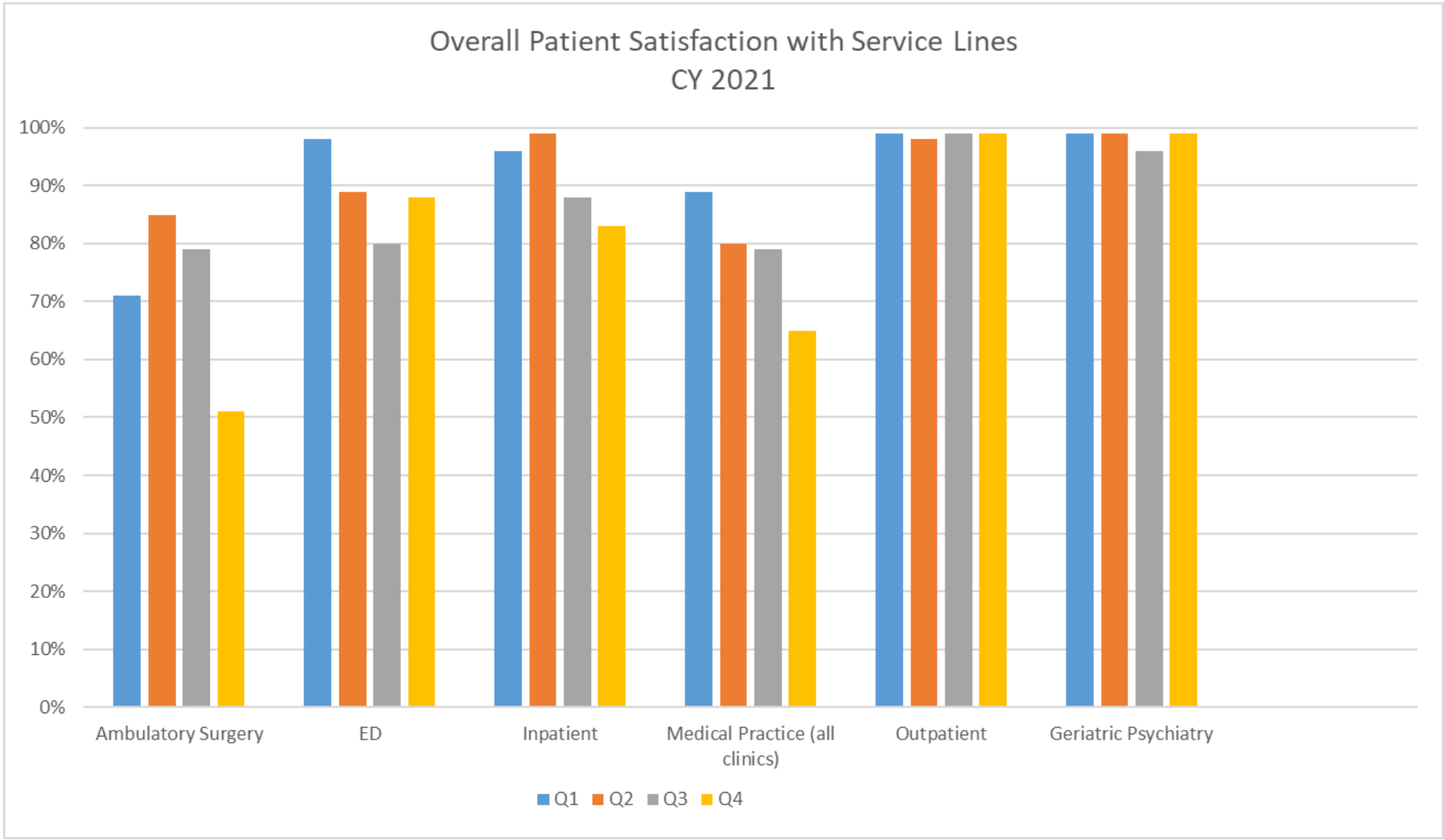
* Corrective Action Plan required for scores in Red Zone. Score is greater than 5% from Goal.



4th Quarter
Fiscal Year 2021 Results for
9/30/2021

QUALITY AND SAFETY		SERVICE		SERVICE (Cont)		PEOPLE		GROWTH		FINANCES	
30 - Day Inpatient Readmission Rate Goal: ≤ 4%	Current Qtr 8.2% Recent Qtr 3.7% Prior Qtr 1.9%	Inpatient HCAPHS Rank Your Hospital High (Overall 9/10) Goal: ≥ 95%	Current Qtr 75.0% Recent Qtr 99.0% Prior Qtr 97.0%	Emergency Department HCAPHS Definitely Would Recommend (Loyalty) Goal: ≥ 90%	Current Qtr 91.0% Recent Qtr 84.0% Prior Qtr 96.0%	Turnover (excluding Per Diems) *measuring rolling 12 mo results each Qtr Goal: ≤ 18%	Current Qtr 15.5% Recent Qtr 13.2% Prior Qtr 12.6%	New Patient Records Goal: 370 or more (per Qtr)	Current Qtr 522 Recent Qtr 342 Prior Qtr 241	Operating Margin Year-to-Date Goal: ≥ 3.1 %	Current Qtr 5.1% Recent Qtr 6.5% Prior Qtr 5.8%
Completion of Columbia Suicide Severity Rating Scale Goal: = 100%	Current Qtr 98.0% Recent Qtr 97.0% Prior Qtr 100.0%	Outpatient Rehab & Medical Imaging HCAPHS Definitely Would Recommend (Loyalty) Goal: ≥ 95%	Current Qtr 99.0% Recent Qtr 97.0% Prior Qtr 99.0%	Geriatric Psych HCAPHS Definitely Would Recommend (Loyalty) Goal: ≥ 95%	Current Qtr 99.0% Recent Qtr 99.0% Prior Qtr 99.0%	New Hire Turnover as % of Total YTD turnover Goal: ≤ 31%	Current Qtr 11.0% Recent Qtr 7.0% Prior Qtr 8.0%	Ancillary Hospital Outpatient Visits Goal: 8360 or more (per Qtr)	Current Qtr 10052 Recent Qtr 9134 Prior Qtr 8606	Percentage of Departments Meeting or Progressing Toward Top Quartile Productivity Ranking Goal: ≥ 80%	Current Qtr 88.0% Recent Qtr Prior Qtr
Quarterly Inpatient Fall Free Days/Injury Free Days Goal: ≥ 90 days	Current Qtr 91 Recent Qtr 88 Prior Qtr 90	Ortho Clinic HCAPHS Definitely Would Recommend (Loyalty) Goal: ≥ 95%	Current Qtr 59.0% Recent Qtr 89.0% Prior Qtr 91.0%	Ambulatory Surgery HCAPHS Definitely Would Recommend (Loyalty) Goal: ≥ 95%	Current Qtr 81.0% Recent Qtr 90.0% Prior Qtr 74.0%	Applicant Pool Days to Fill Goal: ≤ 49 days	Current Qtr 51 Recent Qtr 35 Prior Qtr 41	OR Procedures Goal: 350 or more (per Qtr)	Current Qtr 363 Recent Qtr 350 Prior Qtr 327	Total Compensation As % of Net Patient Total Revenues Goal: ≤ 51%	Current Qtr 46.4% Recent Qtr 46.2% Prior Qtr 47.2%
Appropriate Identification and Treatment of Symptomatic Urinary Tract Infections (UTI) Goal: ≥ 60%	Current Qtr Recent Qtr 71% Prior Qtr 58%			General Surgery Clinic HCAPHS Definitely Would Recommend (Loyalty) Goal: ≥ 95%	Current Qtr 99.0% Recent Qtr 97.0% Prior Qtr 81.0%	Worker's Compensation Loss Ratio Goal: ≤ 10%	Current Qtr 87.0% Recent Qtr 74.0% Prior Qtr 23.0%	ER/UC Admissions Goal: 5000 or more (per Qtr)	Current Qtr 7783 Recent Qtr 5314 Prior Qtr 3742	Non Clinical Fixed Cost Goal: ≤ 38%	Current Qtr 38.3% Recent Qtr 36.8% Prior Qtr 39.6%


Overall Patient Satisfaction of Providers
CY 2021
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ENT
GI
Amb-Gen Surg
Ophthalmology
Amb-Orthopedics
Podiatry
Urology
ED
Hospitalist*HCAHPS
INPT Orthopedics
INPT Surgery
Geriatric Psych
Medical Practice Gen Surg
Medical Practice Ortho
Q1
Q2
Q3
Q4


Overall Patient Satisfaction with Service Lines
CY 2021
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Ambulatory Surgery
ED
Inpatient
Medical Practice (all clinics)
Outpatient
Geriatric Psychiatry
Q1
Q2
Q3
Q4

2021 Annual Performance Evaluation
Emergency Management (EM)

Reviewer: **Tracy Buchman, DHA & Tina Strandlie, RN**
Review Date: **February 8, 2022**
Safety Committee Review and Approval Date: February 8, 2022

Risks and hazards facing the organization may change over time. The scope of the Stoughton Health's planning activities may evolve in response to changes in the organization, its structure, patient population, community planning partners, or a few other factors. Such changes can have an impact on the organization's response capabilities, including decisions about its inventory of resources and assets needed during an emergency. The hospital conducts an annual review of its planning activities to identify such changes and support decision making regarding how the hospital responds to emergencies.

SCOPE
The Emergency Management Program/Emergency Operations Plan (EOP) is designed to assure appropriate, effective response to a variety of emergency situations that could affect the safety of patients, staff, and visitors, or the environment of Stoughton Health inclusive of the offsite locations Community Health & Wellness Center, SWAC, Oregon Urgent Care, and McFarland Urgent Care, or adversely impact upon the organization's ability to provide healthcare services to the community. The program is also designed to assure compliance with applicable codes and regulations. The EOP is developed to assure availability of resources for the continuation of patient care during an emergency. The Plan also addresses the medical needs of victims of a hospital or community-based incident.

Review of Program SCOPE
The hospital conducted an annual review of its risks, hazards, and potential emergency as defined in the hazard vulnerability analysis (HVA). An annual review of the EOPs objectives and scope along with a review of its inventory is also conducted. The review of the scope is based on a comparison of actual operating experience to expected results. The review is designed to determine if the current program does not address specific risks or if staff is not using program-related training effectively.

This evaluation applies to all locations for Stoughton Health inclusive of the offsite locations Community Health & Wellness Center, SWAC, Oregon Urgent Care and McFarland Urgent Care where patients are cared for and treated inclusive of both on-site and off-site locations. Data evaluated includes incident reports, reports of outside agencies, independent review by consultants, after action reviews, exercise evaluation improvement plans, and findings from safety rounds. The data is evaluated to determine if trends or patterns can be identified. Any identified deficiencies are addressed in planning objectives for the next calendar year.

Evaluation of SCOPE:

A. Incident Report Review
Total program related incident reports:
An evaluation of all emergency response exercises and all responses to actual emergencies inclusive of identification of deficiencies and opportunities for improvement are assessed as part of this annual review.

Eight reports were evaluated from drills or actual activations.

1. 3/9/21 IT Event
2. 3/9/21 Base Hospital Activation for I39/90/94 rollover crash
3. 3/18/21 Utility Failure Exercise and evaluation of 96-hour plan
4. 4/15/21 Statewide Severe Weather – Tornado Exercise
5. 5/20/21 Dane Co. Regional Airport FAA Exercise
6. 7/28/21 Tornado warning response
7. 10/19/21 Patient decontamination training and skills evaluation
8. 12/18/21 IT Event – Kronos Cyber Security Event

Several of the events/exercises were reviewed and an after-action review/improvement plan (AAR/IP) was completed. No trends were identified after further review of these incidents.

B. HVA and Inventory Review Findings

During 2021, Dane Co. Interhospital Committee along with State and Regional Coalition HVA results were evaluated against the Stoughton Health HVA and determined that the results were in alignment. During the pandemic response, not much variation was seen in terms of increased risk in other areas of the assessment. Results were accepted by the EM committee and adopted at the 2021 HVA. The top three regional prioritized hazards were incorporated into planning and response documents, plans, trainings, and exercises.

In March, inventories printed as part of an email disaster exercise and were evaluated based on par levels and sustainability for 96 hours without community support. The sustainability was evaluated and determined to be adequate at the time. Additionally, inventories were evaluated on an ongoing basis during the response to the pandemic. We will continue to improve inventory data collection and evaluate multiple layers of redundancy where possible along with completing the loss of community support annex of the EOP.

Review of Program OBJECTIVES

The Emergency Management program objectives for the calendar year 2021 were to focus planning and exercises in the target areas of

- Redundant Communications with community partners (county and regional level)
- Business Continuity Planning/Continuity of Operations (COOP)
- Expanded partnership with County Department of Health Services for COVID testing and vaccination distribution

Review of PERFORMANCE

Calendar year 2021 performance for the above listed objectives was:

*** Summary of performance reports for the last 12 months.**

Performance reports indicate:

1. Performance is stable, sustainable, and acceptable: √
2. Performance is stable, sustainable, and unacceptable: ____
3. Performance is unstable: ____

* Performance Improvement Projects (list)

None at this time

Review of Program EFFECTIVENESS

Program effectiveness is evaluated by comparing the review of the program scope to current needs and stated objectives of the program with measurements made related to stated performance measures. Effectiveness is determined based on how well the scope fits current organizational needs and the degree to which current performance met those stated objectives.

This program was found to be stable, sustainable, and acceptable at the time of this review.

Planning objectives for <u>2022</u>

- Finalize the Business Continuity Planning/Continuity of Operations (COOP)
- Continue to work with vendors and community partners to address supply shortages
- Work collaboratively with healthcare coalition partners in the planning and execution of an exercise focused upon responding to a Workplace Violence Event
- Evaluation of hospital evacuation plan, refresher training in Q4 2022; Hospital evacuation exercise with community partners in Q1 2023

Scheduled exercises for 2022 include:
Statewide Tornado Exercise – 4/7/22 at 1:45p and 6:45p

In conformance with the 2022 EM.03.01.01 EP4 standard, this annual emergency management plan review was forwarded to senior hospital leader, Amy Hermes, CNO/Vice President of Patient Services, for review.

Stoughton Hospital Patient Safety Committee Meeting Agenda
January 26, 2022 at 9:00 am 10:00 am Lobby Conference Room

See Meeting Invite for ZOOM information

Members In Attendance: Rhonda Tesmer, Jen White, Heather Kleinbrook, Amy Hermes, Gahdeer Alafifi, Teresa Lindfors, Tina Strandlie, Sara Sturmer, Nikki Rowin, Kyle Sippel, Bill Wilson
Absent: Pauline Cass, Lynn Gifford, Lily Gertsch, Tracy Wurtzler, Angie Rowin

Agenda Item (Facilitator)	Discussion	Follow Up Action
Approval of Previous Minutes	Review and approve November meeting minutes.	Approved
Welcome New Members	Welcome Pauline Cass and Bill Wilson (Pauline was not able to make it today.)	Will welcome Pauline next meeting.
Standing Business		
Medication Management Data Review - Pauline	5 events shared.	
Review of Safety Zone Event Data	Summary report shared. Falls Med/Surg ICU 1 fall, Current Rate 1.19, Q4 1.87 Staying with goal G/P 1 fall, current rate 3.51, Q4 3.85 Other falls: 2 last quarter. Hospital fall goal: Current Quarter 92 days, Q4 =91 days Other: 55 non-fall incidents, 11 near misses (37, 11 respectively last quarter) reviewed 31 Clinical/Test/Procedural 2 Medical Record/Documentation 6 Disruptive patient/visitors 3 facility/security events 1 theft 11 near misses, reviewed	All of these events had appropriate follow-up. Gahdeer asked for clarification about the timeline for follow-up on events and loop closure. Amy stated that it is difficult to assign a specific timeline because of the variability of the severity. Amy suggested closing the loop at safety huddle within the week. Teresa will assist in locating the policy for reference. Sara asked about the staff form in use on nursing units. It can be useful for helping staff look at ways of preventing new occurrence.
Patient Safety and/or Construction	Pharmacy construction has been slated to complete in February. No noise or IP issues ongoing. Heather stated that it has been very quiet. No major construction planned within the next six months.	
Security Concerns – All	Angie identified that staff are not being very careful with securing their personal possessions. Staff should be locking things in lockers or in desk drawers that lock.	Angie will re-implement "Gotcha" cards as a gentle reminder. They have been located and Angie will print them out and begin. Jen to check with Angie.
Product Recalls	Meeting with subcommittee occurred on 01/25/2022 to discuss process for NS and Stock Material Services tracking as part of the product recall process. Determined that the process in place currently is working to disseminate information about recalls, but finding out if we have these items in house is challenging which is an area of risk. Tina used an	Amy will speak with Michelle Abey in her touch base.

Agenda Item (Facilitator)	Discussion	Follow Up Action
	example of a piece of equipment that Dr. Patel had offered to reimburse the hospital for if ordered. Angie Adler ordered it and it came through Material Services and was delivered to Angie. There is no record that this device is in house. There is no bill available to send this to Dr. Patel. There are other types of products: Owen/Minor etc. The committee recognizes this a patient safety concern and recommends this as a potential project.	
Engagement and Patient Safety Survey	Three over-arching concerns identified: Connection to Mission, Vision and Values; patient safety/staffing, and confidence in leadership. Press Ganey will work with the leadership team to action plan. Ghadeer wondered if the survey question too vague and if reviewing the questions with teams could have some value. Amy stated that is could be valuable since prior patient safety surveys were with a different vendor. The following stand out as potential areas to focus on for 2022. • Communication between work units was at 3.8 • My unit is adequately staffed 3.17 • Different units work well together in this organization 3.95 Discussion about the PG reports being delayed lately due to the Kronos issue taking so much time. Amy discussed the Director of Experience position to be hired. A mini survey may be helpful once that position is filled. Amy also asked if any correlations were seen between the AHRQ and PC survey. Jen pulled up the results and shared them with the team. Staffing issues are being worked on but are challenging everywhere within the industry. A brief re-survey is recommend and tying this to the April in-services and having it through Relias seems the best suggestion. Discussion about the difference between happy, satisfied employees and engaged employees and the need to explain that before surveying.	Jen will work on survey questions and send to group for review.
2022 Patient Safety Goals	**2022 Goals**: **Falls (Sentinel Alert and reporting requirement of our SZP grant)** **Hospital Fall Goals: Keep this!** **Suicide Assessment and Safety Plans: Keep! Anything new?** Tina stated with the new group we will be working with, it would be beneficial to see how this goes. **Immunizations: Keep** **Just Culture and encouraging reporting of near misses/close calls. Keep** Goals were reviewed and determined to keep current goals. Amy recommended adding Product Recall process as a new goal for 2022.	
Restraints and Seclusion Review - Rhonda	One behavioral health use and two medical necessity with vented patients. No concerns.	

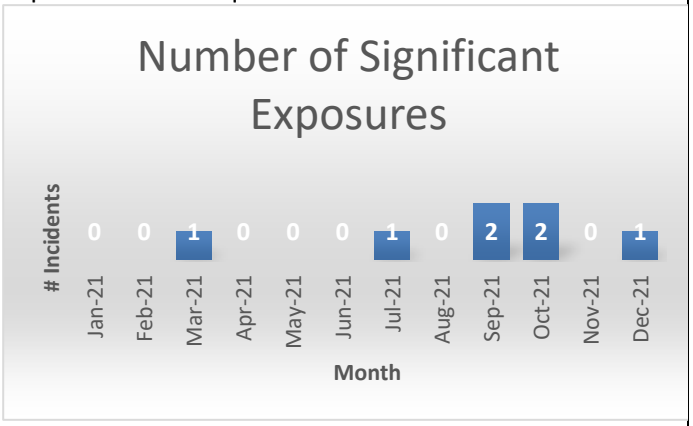
Agenda Item (Facilitator)	Discussion	Follow Up Action
Root Cause Analysis and/or CI Project Updates	No current RCA's	
Antibiotic Usage – Pauline/Bill	Apiari is in process of reviewing fluroquinolone data and will be contacting us to set up a meeting to determine the next steps. We have new staff that will be involved in the project therefore Apiari will provide another overview of the project during that call.	
USP 800 – Kathy/Pauline	Kathy was in house recently and a patient on a high-risk medication was in house. Kathy checked and the signage was up as appropriate. The system worked.	
Trauma Review – Tina	No updates at this time	
Regulatory/Joint Commission Readiness – All	We just completed chapter review. JC is due in November/December. Review of chapters will be done again with the July updates.	
Joint Commission – Sentinel Event Alert	Sentinel Event Alert 64: Addressing HC Disparities by Improving Quality and Safety	Teresa is actively working on the best way to extract this data.
Joint Commission – Quick Safety Monthly Articles	Quick Safety Issue 63: Addressing intimate partner violence and helping to protect patients. Tina discussed options such as providing two different markers for urine specimens, black for initialing but they can use red if they feel that they are in an unsafe situation and only the nurse will see and can then take action.	Amy to discuss adding the topic of approaching a potential victim of trafficking or violence as an April in-service topic.
Other Discussions:		Angie to provide update with reusable gowns. Tabled.
	Next meeting: Wednesday March 30, 2022 9:00 – 10:00 am Lobby Conference Room and/or ZOOM.	
Submitted by: Jen White		

Infection Prevention Committee Meeting Agenda
February 9, 2022 9:30 – 11:00
Lobby Conference Room or ZOOM

Members:
Dr. Raymond Podzorski, Bill Wilson, Heather Kleinbrook, Tina Strandlie, Teresa Lindfors, Rhonda Tesmer, Amy Hermes, Ghadeer Alafifi, Kyle Sippel, Sara Sturmer, Tracy Wurtzler, Jennifer White, Jen Mora, Pauline Cass, Dr. Joel Mendelin, Nikki Rowin
Absent:

Topic	Presenter	Background	Discussion	Follow-up
Approval of November 2021 Meeting Minutes	Committee	Review and approve.		Approved
Standing Agenda Items				
Policy Review	Committee	13.00 IP Prevention Program Plan: minor changes made, HH removed, no term limit for Medical Director, added McFUC as off-site clinic. 13.03 Health Care Associated Infection Surveillance: minor changes and reference updates. 13.07 Infectious Disease Notification: no changes. 13.09 Handlin of infectious Waste, Needles, Sharps: no changes 13.10 Isolation Setup: no changes 12.15 Patient TB skin testing: updated references only 13.20 TB exposure plan: minor updates 13.22 Environmental Sampling: no changes		
Significant Exposure Policy Update		Subcommittee met in January to review process. A group of us met Wednesday January 5, 2022 and we are working on a new process flow. Jen Mora met with Dr. Menet and he is willing to have the Hospitalists provide Physician Oversight for the Significant Exposure for Hospital Employees during daytime hours. We are currently working with Dr. Menet to develop the process.	The ER would be used in the off shift hours when a hospitalist is not in house.	

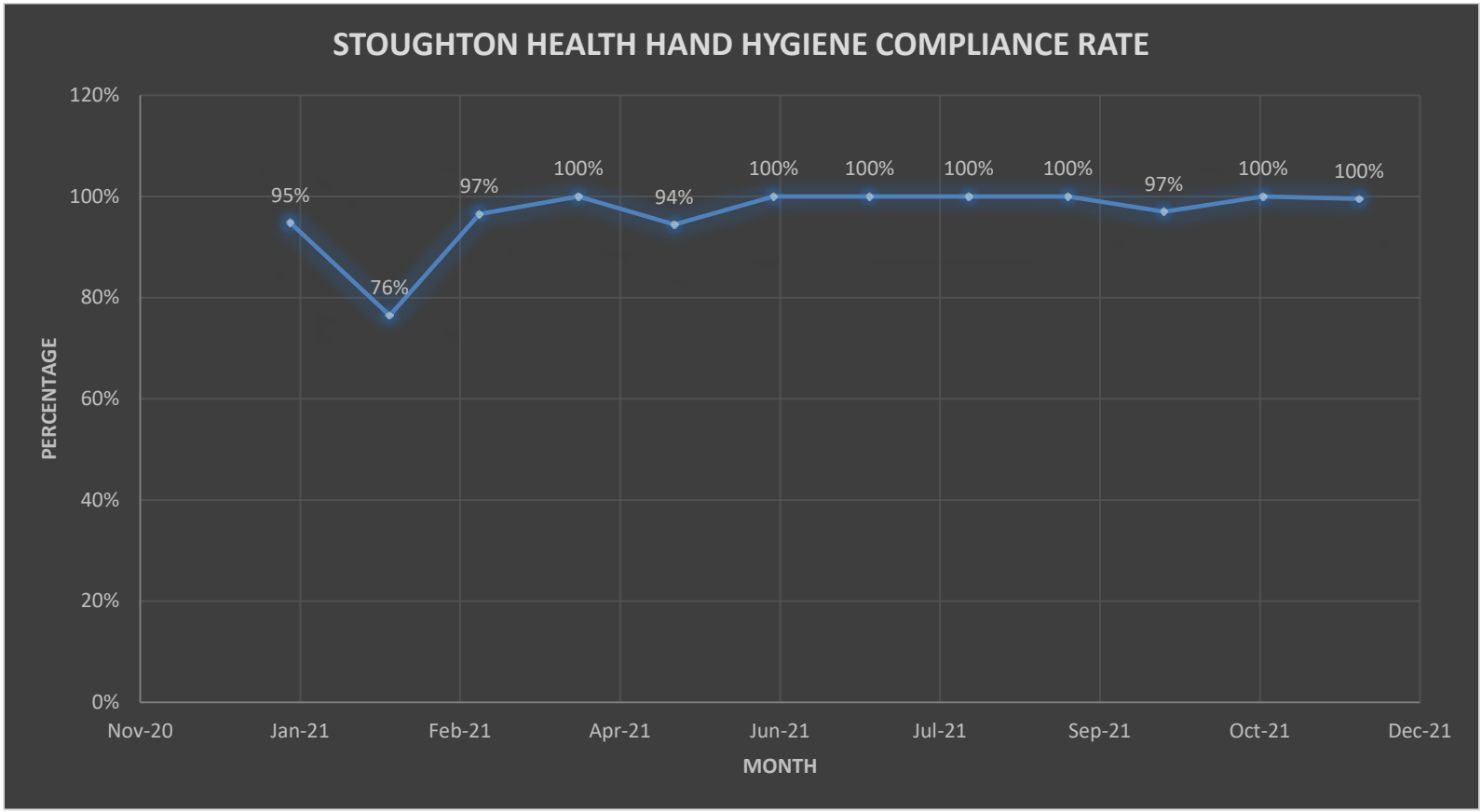
Risk Assessment/ Program Goals/ Infection Prevention Dashboard		Review and approve risk assessment/HVA and 2022 goals. IP Program and Plan was updated based on HVA findings. ..\..\..\Risk Analysis and Program Goals\2022-2023\IC Risk Assessment HVA 2022-2023.xls Infection Prevention Dashboard ..\..\..\Reports\IP Dashboard.xlsx	HVA reviewed and discussed with committee. Goals were also presented and discussed.	Updates due in May-but wondering if we should move the meeting to every other month. Jen will schedule a meeting before May (M.
Hand Hygiene		Hand Hygiene Hospital Observations: ***See graph below*** • No trending identified in individual or departments identified. Observations some departments did not meet goals due to challenging staffing and increased volumes in 2021 Press Ganey Hand Hygiene October – December 2021 Quarterly Scores – ***See graph below*** • Ambulatory Surg -Extent staff washed their hands Rank: 97 (N = 88) • Emergency Dept -Extend staff washed their hands Rank: 94 (N = 224) • Inpatient -Staff cleaned hands Rank: 94 (N = 40) • Outpatient Services -Staff washed hands before exam Rank: 97 (N=527)	Graph shared and there is recognition that this represents in and out observation. We need to have increased peer review inside the room. Bill has been going to the floor daily and there are plans to increase observations and to explain to patients so that they are paying attention.	
Construction Risks- Infection Control Risk Assessments (ICRA)	Jen White Rhonda Tesmer	Pharmacy Renovation in progress. Any concerns during rounding and/or by staff have been reported and resolved immediately. No infection control issues at this time.	New hood will not arrive until April. Current hood will be used on the interim. Flooring is on back-order. They are	

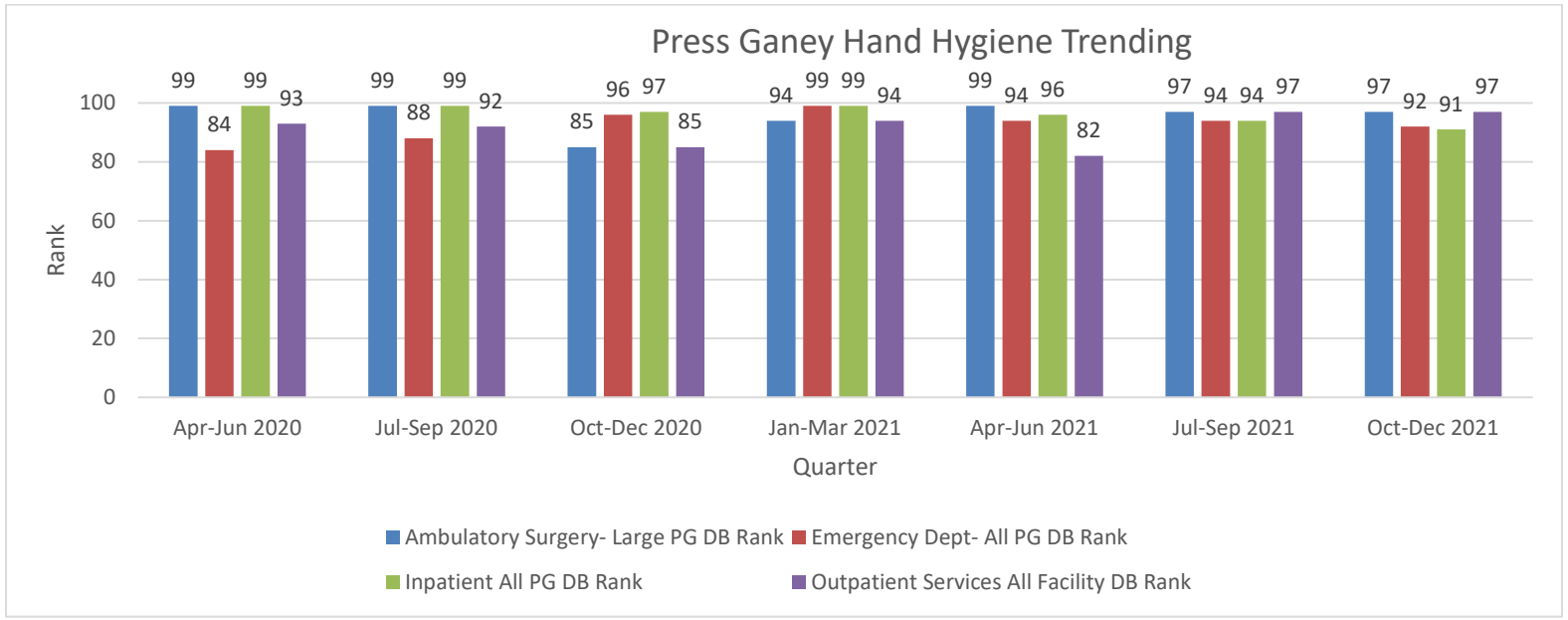
			exploring options for that. Completion is pushed back by around 10 days. There were a few issues but they were addressed right away. A few negative pressure readings were missed but RT has that on their radar (Particle counts were done.)	
Antibiotic Stewardship	Jen White/Bill Wilson/Pauline Cass	New project with Apiari. Apiari has all of our data and they will schedule a meeting with us after their review.	Kick off meeting was held; however, since Bill and Pauline are new to the project, Apiari will review the project details during the data sharing call. We are keeping the UTI project until we Apiari has reviewed our data to determine what direction we go with a new project.	
Employee Health/Sharps Injuries	Jen Mora	• for 2021Q4 (Oct-Dec 2021) There were 3 Significant Exposures for this quarter. 	Monthly data will be shared going forward. Bill will be taking this topic once the new process is in place. Tracy asked if we could use a national benchmark to see how our numbers compare.	Will look to the CDC website for data on significant exposures. Jen Mora and Bill will work on the new process implementation.

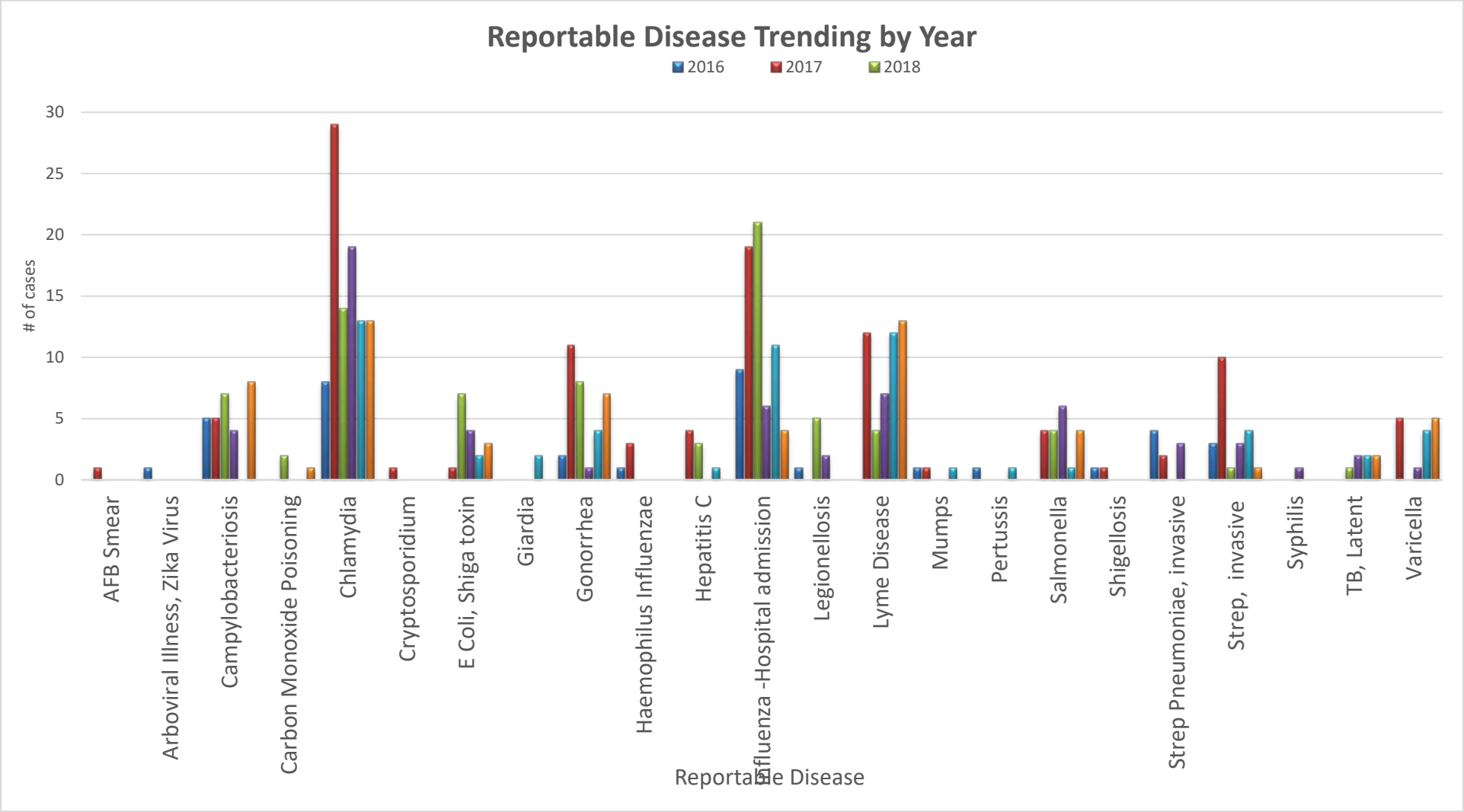
JC Preparedness/ Follow Up	Jen White/Amy Hermes	• 2021 Goal: Reduce risk of infection related to medical supplies
		  • Goal: Determine departments and areas where multi patient use solutions and other liquids are used by March 2022.
		  • Goal: Review and update policies related to use of solutions and other liquids hospital wide by **September 2021**.
		The above was reviewed and determined that we should recommend having patient care areas look at what solutions/liquids they might have in their areas and determine if there is a risk such as multi-use or storage concerns.		

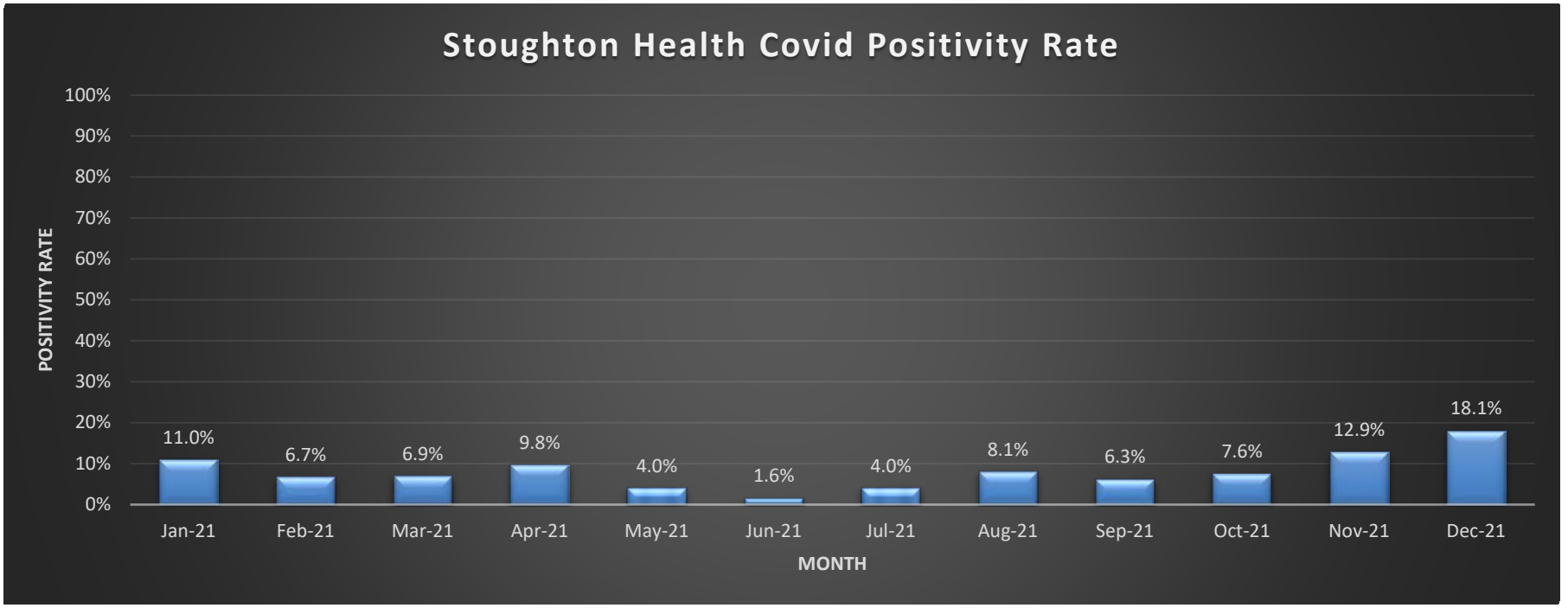
Surveillance Reports				
NHSN Reporting: CAUTI CLABSI Lab ID C Diff or MRSA Bacteremia	Bill Wilson	2021 Quarter 3 (July – September 30) due Feb 15th. One SSI (Colon procedure) Will have the last quarter of CY 2021 available at next meeting.		
NHSN Reporting: SSI	Bill Wilson	2021 Quarter 3 (July 1 – September 30) due Feb 15th.		
Employee Influenza Vaccination Rates	Jen Mora	• 98% of staff are vaccinated for influenza • 5 religious waiver • 1 medical waiver		
Employee COVID-19 Vaccination Rates	Jen Mora	• 98% vaccination rate with primary series • 81% have received a booster • 7 religious waiver for regular hospital staff		
2021 State Reportable Data	Bill Wilson	See Graph Below	2019-2021 Dates missing from legend	Jen will sent out a corrected version
Old Business				
COVID-19	Bill Wilson/Jen Mora/Jen White/Amy Hermes	Covid positivity rates – see data below Kyle provided an update on current rates. Kyle shared that we are seeing a trending down of both the total number of Covid tests performed as well as the positivity Rate. Last Week – 1/30 – 2/5	Significant decrease noted. Discussed the LOS for the COVID patients in Nov and Dec and how the admission rate is a little deceiving.	

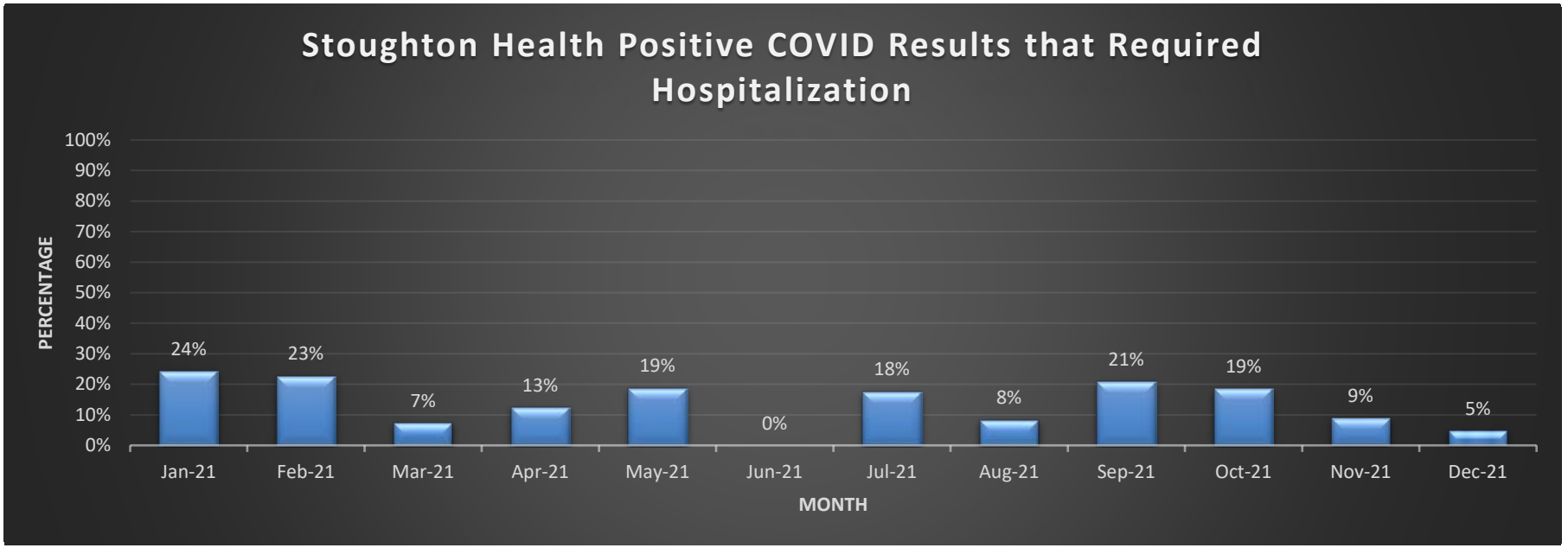
		Stoughton 102 Tests, 17 Pos Rate 16.67% McFarland 7 Tests, 1Pos Rate 14.3% Oregon 5 Tests, 1 Pos Rate 20% Stoughton Health Overall Positivity Rate - 16.3% (119 Total Tests) • (For Comparison the Month of January was >30% positive rate at all 3 locations with an average of 200 Tests per week).	PPE supplies are good. Non-stock N95's have been pulled. Supply chain issues persist for other items. Staff are asking about converting the rooms closest to the nurses' station in the back to regular rooms for patients who are confused. They can be converted back quickly if needed. Tracy reports that they have had many cancelled cases related to positive tests and the patients are asymptomatic and were not tested when they were symptomatic or when the rest of the family was sick.	Committee was supportive of this and discussion will be held with Dwayne. Jen and Bill to look for any changes in recommendations, especially given the havoc it is causing to the OR schedule and with supplies and special equipment.
New Business				
Next Meeting	Wednesday March 30, 2022 10:00 – 12:00 am Lobby Conference Room or Zoom			


STOUGHTON HEALTH HAND HYGIENE COMPLIANCE RATE
120%
100%
80%
60%
40%
20%
0%
PERCENTAGE
95%
76%
97%
100%
94%
100%
100%
100%
100%
97%
100%
100%
Nov-20
Jan-21
Feb-21
Apr-21
Jun-21
Jul-21
Sep-21
Oct-21
Dec-21
MONTH


Press Ganey Hand Hygiene Trending
Rank
100
80
60
40
20
0
99 84 99 93
99 88 99 92
85 96 97 85
94 99 99 94
99 94 96 82
97 94 94 97
97 92 91 97
Apr-Jun 2020
Jul-Sep 2020
Oct-Dec 2020
Jan-Mar 2021
Apr-Jun 2021
Jul-Sep 2021
Oct-Dec 2021
Quarter
Ambulatory Surgery- Large PG DB Rank
Emergency Dept- All PG DB Rank
Inpatient All PG DB Rank
Outpatient Services All Facility DB Rank


Reportable Disease Trending by Year
2016
2017
2018
# of cases
30
25
20
15
10
5
0
AFB Smear
Arboviral Illness, Zika Virus
Campylobacteriosis
Carbon Monoxide Poisoning
Chlamydia
Cryptosporidium
E Coli, Shiga toxin
Giardia
Gonorrhea
Haemophilus Influenzae
Hepatitis C
Influenza -Hospital admission
Legionellosis
Lyme Disease
Mumps
Pertussis
Salmonella
Shigellosis
Strep Pneumoniae, invasive
Strep, invasive
Syphilis
TB, Latent
Varicella
Reportable Disease


Stoughton Health Covid Positivity Rate
POSITIVITY RATE
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
11.0%
6.7%
6.9%
9.8%
4.0%
1.6%
4.0%
8.1%
6.3%
7.6%
12.9%
18.1%
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
MONTH


Stoughton Health Positive COVID Results that Required Hospitalization
PERCENTAGE
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
24%
23%
7%
13%
19%
0%
18%
8%
21%
19%
9%
5%
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
MONTH

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date **January 2019**	**Medical Staff Policy Manual**	
	Original X-Revision- 1/2021	Page 1 of 3	Title: **Admission & Discharge of Patients**

I. GUIDELINES:

A. A patient may be admitted to the Stoughton Health/hospital upon the recommendation of a member of the Medical Staff with admitting privileges, with a physician member of the Medical Staff to be responsible for the medical aspects of care.

B. Each patient admitted to the hospital shall have a provisional diagnosis. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible and within twenty-four (24) hours of admission at the latest.

C. The attending physician is defined as the practitioner who admits, provides a majority of the medical/surgical care, and discharges the patient. The attending physician is responsible for the discharge summary.

Exception: If the patient is turned over to another physician after only a brief period of care or if the patient has undergone a surgical procedure which requires prolonged attendance by the surgeon, then the second or subsequent practitioner becomes the attending physician. Transfer orders should be written in the medical record.

D. All patients admitted or transferred to different levels of care (i.e., ICU, GPU, Transitional Care/ Swing Bed, etc.) the physician must enter new orders into the EHR (Epic orders 'Update Patient Class/Level of Care' or 'Admit To' order). On newly admitted patients, physician must re-write all patient orders (i.e., it is not acceptable for a physician to write "to continue all medications as at home or at the nursing home.").

E. Admission to the Intensive Care Unit (ICU) and Intermediate Care (IMC) shall be under the direction of those practitioners who are privileged to do so. The admitting physician or Hospitalist shall be responsible for physically assessing and documenting in the progress notes all intensive care patients immediately upon admission to the ICU or IMC.

F. If any questions as to the validity of an admission to or the discharge from the Intensive Care Unit should arise, the decision is to be made through consultation with the acting Clinical Advisor to Medicine.

G. Patients shall be discharged from the hospital only on order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner; a notation of the incident should be made in the patient's medical record and the proper release form shall be signed, if possible.

H. In the event of a death, the deceased shall be pronounced dead by the attending practitioner or his or her physician designee. A physician does not have to be physically present to pronounce a patient dead or determine time of death. The RN may call the physician and describe signs of death. The physician may then pronounce death and determine time of death. The time of death documented in the medical record should be the time the physician actually pronounced the patient dead. A Hospice Registered Nurse may pronounce a patient dead if the patient is under Hospice care when death occurs. The Hospice Agency RN must be called into the hospital to pronounce death. A final progress note should indicate the reason for admission, pertinent findings, and the course of hospital events leading to the death.

I. Medical Staff members shall secure meaningful autopsies, if possible, in appropriate clinical situations. Criteria used to identify deaths in which autopsies should be requested are:

1. Cases in which the cause of death is unknown/unexpected;
2. All pediatric cases;

3. Other cases at the discretion of the practitioner.

Copies of all autopsy reports shall be forwarded to the Medical Care Evaluation (MCE) Committee. The MCE Committee will review these reports using clinical classification criteria and will incorporate the results of these reviews into its regular quality assurance activities.

J. History and physical examinations and documentation of history and physical examinations shall be completed in accordance with the requirements outlined in the Medical Staff Bylaws.

K. All inpatient and day-surgery admissions ~~to the~~ hospital shall receive a pre-admission examination, which shall include laboratory tests appropriate to the patient's clinical condition. If the practitioner chooses, admission laboratory studies performed at an outside laboratory may be substituted for admission laboratory studies provided:

1. the laboratory performing the studies is certified under the requirements of Wisconsin Statutes Section 93.12
2. the original reports or facsimile copy is submitted. This report shall include the name of the laboratory performing the studies, the name of the studies, the results, the laboratories reference range for this study, the time the specimen was obtained and the time the report was completed;
3. reports of studies submitted from outside laboratories may be accepted if they were performed within thirty (30) days prior to the date of admission;
4. the laboratory report must be available at the time the patient is admitted to the hospital.

L. Patients presenting for outpatient blood transfusions shall have appropriate laboratory studies and provisional diagnosis as follows:

1. all outpatients receiving blood transfusions shall have a Hgb/Hct drawn no more than five (5) days prior to the transfusion or prior to initiation of the transfusion;
2. prior to transfusions results of the Hgb/Hct shall be documented in the patient record;
3. the patient's practitioner shall be made aware of all pre-transfusion Hgb/Hct results before transfusions are begun unless other specific orders have been given;
4. the provisional diagnosis (reason for transfusion) shall be recorded in the patient's medical record at the time of transfusion;
5. if the provisional diagnosis is not available at the time of registration, the nurse shall contact the patient's practitioner to obtain the diagnosis and record this information in the medical record at the time of the transfusion;
6. all patients receiving blood transfusion should be informed of the risks and benefits of this procedure by the ordering physician and/or the nurse with documentation of the same.

M. All patients placed in outpatient observation status will:

1. be assigned an attending physician
2. have a history and physical completed within twenty-four (24) hours of placement in observation status
3. have orders and progress notes written that show progress of
4. care
5. be discharged, or if appropriate, admitted to inpatient status within forty-eight (48) hours of admission to observation status
6. be provided discharge instructions

N. All patients admitted to swing bed status will:

1. be assigned an attending physician
2. have a history and physical completed or updated within twenty-four (24) hours of admission
3. have a certification for services completed at the time of admission or as soon thereafter as is reasonable and practicable
4. be recertified no later than the 14th day of posthospital skilled nursing facility care, and have subsequent recertifications at least every thirty (30) days after the first recertification
5. be provided discharge instructions

O. All patients utilizing support care services (guest service; not a medical care stay) will:

1. be assigned to a physician provider

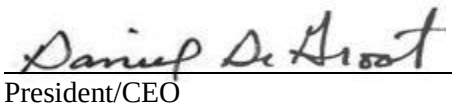
2. have completed physician's plan of care
3. not require daily physician visits

P. All patients placed in hospice status will:
1. be assigned an attending physician
2. have a history and physical completed or updated within 24 hours of admission
3. managed collaboratively with the hospice agency

Q. All patients placed in the Geriatric Psychiatry Unit will:
1. receive medical clearance prior to admitting patient
2. be assigned an attending psychiatrist
3. receive a psychiatric history and physical within 48 hours of admission
4. receive a medical history and physical within 24 hours of admission
5. be recertified for psychiatry admission appropriateness every 12 days
6. be provided discharge instructions

II. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee



President/CEO _____ Date _____

Chief of Staff _____ Date _____

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
	Original X-Revision-1/2021	Page 1 of 3	Title: **Confidentiality/Retention of Credentialing Files**

I. POLICY:

This policy provides guidelines pertaining to Confidentiality, Retention and Release of Information of all Medical Staff records, including Credentialing Files, Medical Staff Meetings and other activities related to professional service at the Stoughton Health.

II. PURPOSE:

A. To provide reassurance to medical staff regarding strict confidentiality and safe custody of all individual staff records, credentialing files and appropriate release of information with permission (per prevailing laws regarding the same).

B. To help enhance quality of patient care within the hospital and to maintain a culture of excellence together by encouraging good faith credentialing, quality assessment, performance improvement, and peer review activities among ~~Medical Staff~~ medical staff appointees.

III. APPLICATION:

A. This policy shall apply to records maintained by or on behalf of the ~~Medical Staff~~ medical staff of ~~the hospital~~ Stoughton Health, including, but not limited to:

1. The credentials and peer review files of individual practitioners
2. Records and minutes of all ~~Medical Staff~~ medical staff committees
3. Records of all ~~Medical Staff~~ medical staff credentialing, quality assessment, performance improvement, and peer review activities conducted under the authority of the hospital.
4. Discussions and/or deliberations regarding credentialing
5. Quality assessment
6. Performance improvement
7. Peer review matters that take place in the course of ~~Medical Staff~~ medical staff committee and ~~Department/Clinical Service~~ department/clinical service meetings are maintained in a separate file and follow peer review guidelines as outlined in the Medical Staff Bylaws.

IV. CONTENTS OF MEDICAL STAFF RECORDS:

A. Files of ~~Individual Practitioners~~ individual practitioners should contain the following:

1. Initial Application Documentation
2. Reappointment Documentation
3. Other documentation pertaining to practitioner performance, accomplishments, other documents related to service in the organization and unique circumstances

V. RECORDS OF MEDICAL STAFF COMMITTEES:

Minutes, reports and related documents of ~~Medical Staff Committees~~ medical staff committees shall be maintained in an orderly and easily accessible fashion by the individuals responsible for recording the meeting minutes. These agenda's and minutes will be kept indefinitely.

VI. ACCESS TO CONFIDENTIAL MEDICAL STAFF RECORDS:

The following individuals shall be permitted access to ~~Medical Staff~~ medical staff records to the extent described:

A. The Chief Executive Officer (CEO) (or designee) shall have access to those ~~Medical Staff~~ medical staff records necessary for the performance of official functions.

B. The Medical Care Evaluation (MCE) Chair, Chief of Staff, Quality Manager or designee and Medical Staff Coordinator shall have access to ~~Medical Staff~~ medical staff records as needed to fulfill their respective responsibilities.

C. Medical Staff Executive Committee (MEC) officers shall have access to Credentialing Files, committee minutes and reports to the extent necessary for the performance of their duties.

D. Department/Clinical Service Chairpersons shall have access to Medical Staff records relating to the activities of individuals seeking or exercising privileges in the respective department/clinical service. Department/Clinical Services chairpersons shall also have access to the credentials, quality assessment, and peer review files of individual practitioners whose qualifications or performance is being reviewed.

VII. RELEASE OF INFORMATION:

Confidential ~~Medical Staff~~ medical staff records may be released only under the following conditions:

A. At the request of a ~~Medical Staff~~ medical staff appointee to review his/her personal file.

B. In the case of an adverse recommendation resulting in a hearing as outlined in the Medical Staff Bylaws.

C. Forwarding of any part of a confidential ~~Medical Staff~~ medical staff record (including letters of reference) to another hospital or healthcare entity will only be done upon receipt of written authorization from the staff member.

D. Subpoenas pertaining to ~~Medical Staff~~ medical staff records shall be referred to the Quality Manager or designee who may first consult with legal counsel regarding the appropriate response.

E. Requests for records covered by this policy from hospital surveyors from the Joint Commission, HCFA, the Wisconsin Department of Health and Family Services or other government agencies shall be immediately referred to the ~~Chief Executive Officer~~ CEO (or designee) for further disposition in accordance with applicable laws, regulations, and/or accreditation standards.

Original or photocopied confidential records cannot be removed from the hospital's premises, unless there is shown to be explicit statutory or regulatory authority to the contrary, which authority has first been reviewed by legal counsel or a photocopy of confidential records can be made following a request with a practitioner's attestation providing his/her permission.

VIII. RETENTION OF MEDICAL STAFF RECORDS:

A. Essential File Documents

Documents necessary to determine the practitioner's competence as outlined per Joint Commission and/or other required regulatory standards and/or documents that contain information not reproducible from the primary source.

Essential Documents Include:

- Initial appointment application and the two most recent reappointments which include privileges
- Medical school/internship/residency verification
- Communicable Disease (TB, Rebella, Hepatitis B)
- Malpractice history, current policy verification & cancellation memos
- Current verification of medical license
- Board Certifications
- Current DEA Certification Verification
- Peer References
- Most recent report from National Practitioner Data Bank
- Correspondence/documents related to special circumstances (i.e., written explanations to disclosure questions and/or malpractice issues)
- Procedure log as appropriate

B. Non Essential File Documents

Materials, which augment the credentialing process, but are not considered core criteria in the decision to appoint or reappoint to the medical staff and/or materials easily reproducible from the primary source.

Non-Essential Documents Include:

- Other state medical license verifications
- Expired license, DEA, malpractice certifications
- Verification of affiliations
- ACLS or other similar certification
- Professional Associations
- Continuing Medical Education Certifications
- Other miscellaneous correspondence

C. Retention Procedure for Active Medical Files

Credential files shall be maintained in hard copy or via electronic storage for a minimum of five (5) years. It is acceptable to destroy the paper copy if electronic storage is utilized.

Active Medical Files with a history of five (5) inclusive years or more can be thinned according to essential and non-essential documents prior to paper or electronic storage as follows:

- Initial appointments can be thinned using the definitions for essential versus non-essential documents
- Reappointments shall be maintained in full for the two most recent reappointment cycles.
- Reappointments from older cycles can be thinned using the definitions of essential versus non-essential documents.

D. Retention of Inactive Files

Files with most recent applications dated within five years of the current date and with no activity for the previous two years can be thinned and all non-essential information can be destroyed. Essential information shall be maintained in hard copy or via electronic storage until they are dated five complete years with no activity for two years.

Retaining credentials files for five (5) inclusive years incorporated two reappointment cycles. Most malpractice claims must be filed within the general three-year statute of limitations (Wisconsin). While some claims have longer filing periods, including pediatrics, most of these are filed within a five (5) year period.

IX. REFERENCE:

Joint Commission

X. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee

Daniel DeHaat — 1/25/21

President/CEO — Date

Chief of Staff — Date

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
	Original – 5/13 Revision– 11/17	Page 1 of 1	Title: **Direct Admissions**

I. POLICY:

All referrals for direct admissions will be channeled through the Hospitalist on duty in accordance with this policy.

II. PURPOSE:

To ensure safe, proper and prompt admission of patients to inpatient, observation or swing bed status from an outside facility or clinic.

III. PROCEDURE:

A. Request for Admission will be received from physicians or allied professionals (NP or PA) for direct admission to the hospital in accordance with this policy. This will bypass Urgent Care or Emergency Room Services.

B. Eligibility for Direct Admission (will be guided by the existing Medicare and other Insurance Plan policies of coverage of care).

1. Direct admission should have a working diagnosis from their primary physician. The diagnosis needs to be supported by an initial lab/imaging/EKG workup.
2. Patients may not be admitted based on symptoms alone. Symptoms such as, but not limited to, shortness of breath, chest pain, GI bleeding, weakness, or failure to thrive need to have basic work up (e.g., chest pain would require EKG, troponin, H&H, D-dimer or chest x-ray; GI bleed: CBC, CMP, INR; Back pain: CT or MRI, failed outpatient narcotics escalation) to aid the Hospitalist in determining appropriateness of admission.
3. A discussion should take place between the referring provider and the Hospitalist before any direct admission.
4. The Hospitalist may consider the clinical work up, information from the referring provider, and utilization review platform guidelines ie: InterQual McKesson etc. ~~guidelines~~ to help determine whether inpatient admission or observation status admission is appropriate.
5. Unstable patients seen by providers may not be considered for direct admissions. Unstable patients may need to be transferred to the Emergency Department to determine further management.

C. The admitting Hospitalist will confer with Case Management or Care Coordinator if there are questions regarding admission status (i.e., Inpatient vs. Observation vs. alternative level of care (swing bed or supportive care).

D. All admissions will be in accordance with the Medical Staff Bylaws, and applicable Hospital and Medical Staff policies.

IV. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee

Daniel De Groot

President/CEO _____ Date _____

Chief of Staff _____ Date _____

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
	Original X-Revision-1/2021	Page 1 of 2	Title: **Disaster Credentialing**

I. PURPOSE:

This policy provides guidelines for immediate provision of staff privileges in the event of a disaster necessitating urgent assistance from volunteer practitioners who are not current members of the medical staff allowing them to practice at Stoughton Health during an officially declared disaster as defined below.

For purposes of this policy, the term "practitioner" includes physicians and allied health professionals seeking Medical Staff membership and privileges in accordance with their respective training.

II. POLICY:

Volunteer practitioners currently not on staff will need to be granted privileges prior to providing patient care, even in a disaster situation. This policy outlines the credentialing and privileging process that will be followed in the event of a disaster.

For purposes of this policy, a “disaster” is an emergency (including a state of emergency related to public health declared by the governor) that, on account of its complexity, scope, or duration, substantially burdens and even threatens the hospital's capabilities, hence creating a requirement for outside assistance to maintain patient care, safety and/or security functions. The disaster privileges outlined in this section may only be granted when the hospital implements its Emergency Operations Plan in response to a disaster and the hospital is unable to meet immediate patient needs.

III. PROCEDURE:

A. Disaster privileges may be granted by the appropriate disaster commander (CEO/designee) handling the disaster, upon recommendation by the Chief of Staff/designee or any officer of the Medical Staff Executive committee if the Chief of Staff is unavailable.

B. Disaster privileges may only be granted to volunteer practitioners (including physicians and allied health professionals) who hold privileges at another health care facility.

C. When the practitioner first reports to the hospital, the disaster commander (CEO or designee) must be presented with the practitioner's valid government-issued photo identification (for example, a driver’s license or passport) and at least one of the following:
   1. Current professional license to practice in the United States
   2. Primary source verification of licensure
   3. Current picture identification from a health care organization that clearly identifies professional designation
   4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
   5. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
   6. Confirmation by a licensed independent practitioner currently privileged by the critical access hospital or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster
   7. Part of our Disaster Plan labor pool.

D. Primary source verification of the practitioner's licensure shall occur as soon as the disaster is under control or within 72 hours from the time the practitioner presents himself or herself to the hospital, whichever comes first, absent extraordinary circumstances. A record of this information should be retained.

E. If primary source verification cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital shall document all of the following:
    1. The reason(s) it could not be performed within 72 hours of the practitioner's arrival;
    2. Evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment, and service; and
    3. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

F. As soon as possible, additional information should be obtained regarding the volunteer practitioner, including but not limited to a list of current hospital affiliation(s) where the practitioner holds active staff privileges; queries of the National Practitioner Data Bank and Office of Inspector General Exclusion Database, the System for Award Management's Excluded Provider System, criminal background checks, and verification of malpractice insurance. Such additional information shall be documented in the practitioner's credentialing file.

G. The hospital will determine within 72 hours of the practitioner's arrival at the hospital if disaster privileges should continue.

H. When possible, any practitioner granted disaster privileges will be identified by an ID badge that identifies the practitioner as a volunteer practitioner.

I. The disaster commander (CEO or designee) will have the overall responsibility for assignment of duties to any practitioner granted disaster privileges. Each volunteer practitioner will be paired with a member of the medical staff and should act only under the supervision of a medical staff member. Such supervision may include, but is not limited to, direct observation, mentoring, and medical records review.

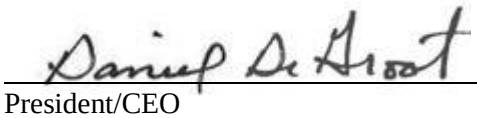
J. The CEO or designee may terminate disaster privileges at any time and for any reason. The disaster privileges shall terminate once the state of emergency ends. A practitioner whose disaster privileges are terminated is not entitled to the hearing and appeal rights set forth in the Fair Hearing Plan. If the practitioner wishes to continue to provide patient care, he or she must apply for Medical Staff membership and/or clinical privileges, as appropriate.

IV. REFERENCES:

1. Joint Commission: EM.02.02.13 – January 2022

V. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee
Legal Counsel



President/CEO _____ Date _____

Chief of Staff _____ Date _____

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
	Original X Revision-1/2021	Page 1 of 2	Title: **Emergency Services**

I. EMERGENCY SERVICES:

A. Emergency/Urgent Care (UC) services will be supervised by the Director of Emergency Services who will be a member of the medical staff.

B. Staffing. Emergency/UC services will be staffed in accordance with the hospital's basic plan for delivery of such services and will be coordinated through the Emergency Medicine Committee. Hospital Administration may contract with an external accredited provider for Emergency Services to staff the Emergency Department.

C. Duties and Responsibilities of Professionals. The duties and responsibilities of physicians, Allied Health Professionals, and other personnel serving patients within the emergency department and UC shall be defined consistent with credentialing, experience and licensure related specifically to this service area. It shall be approved by due process and finally by the CEO and the Governing Board.

D. Medical Records. Electronic or otherwise shall be kept for every patient receiving emergency services. All services provided in the Emergency Department/UC ~~shall~~ should be incorporated into the electronic health record. These would contain appropriate information for prevailing standards of care that would include and not be limited to the following:

1. adequate patient identification;
2. information regarding the time of the patient's arrival, means of arrival, and identification of individual(s) that transported patient to the hospital;
3. pertinent history of the disease or illness, including details relative to any first aid or emergency care given to the patient prior to the patient's arrival at the hospital;
4. description of physical findings, including significant clinical, laboratory, and radiologic findings;
5. laboratory and x-ray reports, if any;
6. diagnosis;
7. record of treatment(s) given;
8. condition of the patient on discharge or at the time of transfer;
9. final disposition, including instructions given to the patient or the patient's family regarding follow-up care;
10. appropriate time notations, including time of physician notification, time of treatments, including administration of medications, and time of patient discharge or transfer from the service.
11. All documentation, electronic or otherwise, shall be completed and signed per prevailing standards of care pertaining to medical care documentation (Ref to Medical Staff policy "Documentation Requirements for the Medical Record").

E. Admission to inpatient department via Emergency Department:

The following guidelines apply to patients being admitted through the Emergency Department:

1. The ED physician must confer with the admitting physician/Hospitalist at the time of admission to inpatient department and document all conversations/communications held regarding that patient in the electronic health record (EHR).
2. All medical orders from the admitting physician must be appropriately documented on the EHR.

F. Emergency Department Disposition of patients following Hospitalist Consultation:

1. ED physician to contact Hospitalist service for possible admission or observation once workup is completed.

2. If Hospitalist should decide that patient does not need to be hospitalized:
    a. ED Provider will be responsible for discharging the patient from the Emergency Department.
    b. ED Provider will document the discussion with the Hospitalist in the progress note with their plan.

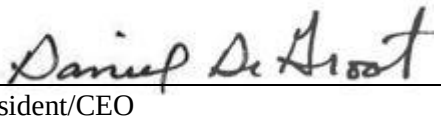
G. Authentication of EHR. Each patient's EHR shall be signed by the Emergency Department practitioner in attendance who is responsible for its clinical accuracy. The chart should be electronically signed and encounter closed in the EHR to assure timely communication with the Primary Care Provider and other collaborating practitioners or healthcare team.

H. Policies. All policies regarding delivery of services must be developed and approved by the Medical Care Evaluation, Medical Executive Committee and Hospital Administration.

I. Disaster Planning. In the event of a disaster, the Stoughton Health ~~Hospital~~ Emergency Management plan will be implemented.

II. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee
Emergency Medicine Committee
Emergency Management Committee
Legal Counsel



President/CEO _____ Date _____

Chief of Staff _____ Date _____

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
	Original x Revision-1/2021	Page 1 of 3	Title: **Expedited Credentialing Policy**

I. PURPOSE:

To expedite the granting of Medical Staff membership and clinical privileges, Stoughton Health may utilize an expedited approval process as outlined in this policy. Pursuant to this process, decisions regarding the appointment, reappointment, and the granting, renewal, or modification of privileges shall be made by a subcommittee of the Board of Directors, which shall be composed of at least three Board members. The delegation of such approval to a subcommittee of the Board of Directors is consistent with the Stoughton Health Corporate Bylaws.

II. POLICY:

It is Stoughton Health's policy to process all applications to the Medical Staff only after the Medical Staff Coordinator receives a completed, verified application from an eligible applicant, as outlined in the Medical Staff bylaws. It is the intent of this policy to expedite applications, when requested, only if the application satisfies predefined, Board approved criteria.

III. PROCEDURE FOR EVALUATION OF APPLICATION:

Once a request for Expedited Credentialing has been received by the Medical Staff Coordinator, the application and all pertinent information will be reviewed by the Chief of Staff. The following criteria will be taken into consideration to determine if the application qualifies for Expedited Credentialing.

The application must meet all Category One criteria.

A. Category One

1. The applicant meets the threshold eligibility criteria outlined in the Medical Staff bylaws.
2. The application is complete, with no discrepancies found between information contained on the application and information received from primary source verification.
3. There are no negative or questionable recommendations, and no references suggesting potential problems.
4. The applicant should have completed all training requirements according to prevailing standards for the respective specialty.
5. There are no current or previous reports of disciplinary actions, legal sanctions or restriction on any active or inactive license.
6. No adverse National Practitioner Data Bank report.
7. There are no reports of malpractice cases within the past five years with negative/punitive outcome.
8. No involuntary termination, suspension, or restriction of medical staff membership at another health care organization.
9. No involuntary limitation, reduction, denial or loss of clinical privileges.
10. The applicant submits a reasonable request for clinical privileges based on experience, training and competence and is in compliance with applicable criteria.
11. The applicant reports an acceptable health status with no ongoing issues that would affect performance of duties i.e. impairment of any kind.
12. The applicant has never had third-party payer (e.g. Medicare, Medicaid, etc.) sanctions and is not and has never been excluded from Medicare, Medicaid or any government payer.

13. The applicant has no felony convictions, or any misdemeanor related to the practice of the individual's profession, other health care-related matters, third-party reimbursement, violence, or controlled substance violations.

14. The applicant's history shows an ability to relate to others in a harmonious, collegial manner.

In addition to meeting the Category One criteria, the application MUST NOT have any Category Two criteria. If the application is found to contain any Category Two criteria, it will not qualify for Expedited Credentialing and will be vetted through the Application Process outlined in the Medical Staff Bylaws.

B. Category Two

1. Peer references and/or prior affiliations indicate potential problems (e.g., difficulty with interpersonal relationships, minor patient care issues, etc).
2. There are discrepancies between information applicant submitted and information received from other sources.
3. The applicant requests privileges that vary from those requested by other practitioners in the same specialty.
4. The application includes unaccounted-for gaps in time.
5. There are unsatisfactory peer references and/or prior affiliation references.
6. A state licensing Board or a state federal regulatory agency took disciplinary action against the applicant, or the applicant has had a criminal conviction.
7. The applicant has experienced voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another healthcare organization.
8. The applicant no longer serves on a provider panel or a managed care entity for reasons of unprofessional conduct or quality-of-care issues.
9. The applicant has been the object of three or more malpractice claims/settlements/judgments in the past five years.
10. The applicant has held a substantial number (more than five) of medical license across the United States.
11. The applicant has had many healthcare organization affiliations in multiple areas during the past five years.

IV. PROCEDURE FOR PROCESSING AN EXPEDITED APPLICATION:

A. The Medical Staff Coordinator receives and processes the application, and assists in forwarding the file as follows for review and signature:

1. Medical Care Evaluation Committee Chair
2. The Chief of Staff reviews the completed and verified application and all supporting materials.
3. The Chief of Staff forwards a report with findings and a recommendation to the Medical Executive Committee for review and evaluation.
4. If the Medical Executive Committee makes an adverse recommendation regarding the application, or makes a recommendation with limitations, the application shall then be processed in accordance with the standard processing requirements outlined in the Medical Staff bylaws and will no longer be processed through this expedited credentialing process.
5. If the Medical Executive Committee makes a favorable recommendation, it shall forward its report with findings, via the CEO, to a Board of Directors subcommittee, which is composed of at least three Board members (e.g. CEO or Chair of Board), which reviews the recommendation of the Medical Executive Committee and renders a decision regarding the applicants request for appointment or reappointment to the Medical Staff and the requested clinical privileges.

6. If the recommendation of the Board of Directors is adverse to the applicant, the procedures outlined in the Medical Staff bylaws will be followed and the application will no longer be processed through this expedited credentialing process.
7. The credentialing report will be submitted to the Board of Directors for information only at the next regular meeting. The Board does not take action, as the policy allows the Board subcommittee to act on the Board's behalf in granting appointment and clinical privileges to any practitioner who meets the criteria outlined in this policy.

If at any time during the review of the file, a recommendation or decision is adverse to the applicant, the matter will be referred back to the Medical Executive Committee for further evaluation in accordance with the Medical Staff bylaws and the application will no longer be eligible for the expedited credentialing process.

V. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee
Legal Counsel

Daniel DeGroot _____

President/CEO _____ Date _____

Chief of Staff _____ Date _____

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **December 2017**	**Medical Staff Policy Manual**	
	Original X- Revision-1/2021	Page 1 of 5	Title: **Focused Professional Practice Evaluation (FPPE)**

PURPOSE:

A. To establish a systematic process to monitor, evaluate and confirm the current competency of practitioners by examining their performance of privileges at Stoughton Health.

B. To protect the confidentiality of information generated during the evaluation process, and to afford protection to participants in the process, consistent with applicable law, in order to achieve effective participation by the medical staff. The process known as Focused Professional Practice Evaluation ("FPPE" or "focused evaluation") is part of an organized program to improve the quality of health care. As such, those who participate in this process are protected by Wis. Stat. § 146.37. All investigations, inquiries, proceedings, and conclusions associated with FPPE are confidential and protected under Wis. Stat. § 146.38.

C. To promote effective and consistent FPPE processes throughout the hospital by establishing mechanisms that are clearly defined, based on objective and evidence-based criteria, administered fairly, and in furtherance of quality care.

II. GOALS:

A. To promote patient satisfaction and high-quality patient care at Stoughton Health.

B. To ensure appropriate recommendations for delineation of clinical privileges.

C. To provide a process for evaluating professional performance of practitioners when circumstances dictate.

III. POLICY STATEMENT:

A. It is the policy of Stoughton Health to comply with statutory, regulatory, and accreditation requirements regarding ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE). Information resulting from FPPE is used to assess the quality of care of each practitioner during the evaluation period and shall be integrated into the hospital's performance improvement activities. The information is also used to assess the quality of care of each practitioner at the time of reappointment and renewal of privileges and to determine whether to continue, limit or revoke any existing privilege(s). All findings associated with OPPE and FPPE shall be considered confidential and shall be protected to the fullest extent under Wisconsin statutes regarding peer review activities.

B. The procedures set forth in this policy for completion of FPPE shall not operate to prevent the hospital from taking immediate action as necessary to prevent a substantial likelihood of injury to one or more patients or to conduct further investigations or impose corrective action according to the process set forth in the hospital's Medical Staff Bylaws. In the event of any inconsistency between the provisions of the Medical Staff Bylaws and the policy, the relevant provisions of the Medical Staff Bylaws will apply and prevail.

IV. DEFINITIONS

A. "Focused Professional Practice Evaluation" or "FPPE"
FPPE is defined as a time-limited process during which the organization evaluates and assesses how a practitioner is performing the privileges that have been granted to him/her. FPPE will occur for all requests for new privileges and also when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality care.

B. "Practitioner," "New Practitioner," and "Existing Practitioner"
For purposes of this policy, "practitioner" means medical staff members and Allied Health Professionals applying for or who have been granted privileges at Stoughton Health. A reference to a "new practitioner" means a practitioner who is a new applicant for privileges at the hospital. A reference to "existing practitioner" means a practitioner who has existing privileges at the hospital.

C. "Reviewer"
Reviewer, as used in this policy, is a form of "focused evaluation" that refers to the process of obtaining information to confirm a practitioner's competence to perform the privileges subject to review. Reviewing may be prospective, concurrent, or retrospective. Reviewers are not assigned to teach, provide care, or to act as a safety control for a practitioner who is known to have problems. Reviewer is strictly a method of evaluating a practitioner's ability to perform the privileges subject to review. Reviewing is not to be confused with mandatory consultation imposed as a disciplinary measure or other restrictions placed on medical staff members or Allied Health Professionals with privileges as part of the corrective action process. Reviewing is strictly a method of evaluating a practitioner's ability.

V. PROCESS/PROCEDURE:

Overall Responsibilities of Medical Executive Committee and Reviewers:
A period of focused review is required for all new privileges (all privileges for new practitioners and all new privileges granted to practitioners with existing privileges) and when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality care. The FPPE process requires practitioners to be subject to a period of review, regardless of specialty.

The Medical Staff designates the Medical Executive Committee ("MEC") to be responsible for overseeing the evaluation process for all new practitioners and all existing practitioners and for monitoring compliance with this policy.

In each case of FPPE, the MEC, in consultation with the Chief of Staff, will assign an active medical staff member in good standing to serve as the reviewer. Notification of appointed mentorship will be sent to the reviewer along with the practitioner. The reviewer is charged with the responsibility for gathering the information needed for the evaluation. Each reviewer shall provide regular status reports to the MEC regarding the progress of all practitioners whose focused evaluation he or she is responsible for, as well as any issues or problems involving the implementation of this policy. The reviewer may be a specialist in the area of the provider being reviewed or, if not feasible, the reviewer shall be another practitioner whom the MEC and the Chief of Staff deem appropriate. The reviewer must be committed to carrying out the responsibilities of this role. "Monitoring" and "preceptorship" are other terms for this method of assessing current competence to perform the privileges granted.

Responsibilities of Reviewers:
Each reviewer assigned to a practitioner shall:

1. Perform prospective, concurrent, or retrospective review of privileges for the practitioner to whom they are assigned (which may include, but is not limited to, presentation of cases with planned treatment; direct observation of the procedure performed or care provided; concurrent observation of medical management/treatment; and retrospective review of the completed medical record).
2. Complete appropriate forms as requested by the MEC.
3. Submit a summary report at the conclusion of the reviewing period.
4. Ensure confidentiality of reviewer results and forms. Completed forms shall be submitted to the medical staff office.
5. If, at any time during the reviewing period, the reviewer has significant concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient, the reviewer shall promptly notify the MEC.
6. Unless otherwise specified in this policy, reviewers must be members in good standing of the active medical staff of Stoughton Health and must have the same unrestricted privileges as the practitioner's privileges that are the subject of review.

Triggers for FPPE and Mechanisms for Gathering Information:
FPPE will occur for all requests for new privileges and also when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality care.

A focused review may be triggered by a specific or single incident, a sentinel/adverse event, evidence of trends in clinical practice, complaints, infection rates, or other circumstances indicating that patient safety may be compromised. A focused review may also occur as the result of other criteria that may suggest performance problems, including but not limited to:

1. A small number of admissions or procedures over an extended period of time that raise the concern of continued competence;
2. A growing number of longer lengths of stay than other practitioners;
3. Returns to surgery;
4. Frequent or repeat readmission suggesting poor or inadequate initial management/treatment;
5. Patterns of unnecessary diagnostic testing/treatments;
6. Failure to follow approved clinical practice guidelines; and
7. Any other criteria that are identified by the MEC, in consultation with the Services.

Information for FPPE may be derived from, but is not limited to, one or more of the following:

1. Discussion with other individuals involved in the care of each patient (e.g., consulting physician, assistants at surgery, nursing or administrative personnel);
2. Periodic chart review (retrospective or prospective);
3. Monitoring clinical practice patterns;
4. Monitoring diagnostic and treatment techniques;
5. Reviewing;
6. External peer review;
7. Simulation;
8. Comparison of the practitioner's inpatient and/or outpatient complications/outcomes to those of his/her peers; and
9. If the practitioner has significant volume cases related to the privileges in question at another hospital, external peer references specific to the procedures may be obtained.

Scope, Duration and Performance of FPPE:
Following the guidelines outlined below, the appropriate methods for review of each individual practitioner's privileges will be determined by the Chief of Staff and the reviewer, and approved by the MEC. In the event that the Chief of Staff is the subject of review, the MEC, in consultation with the reviewer, shall establish the appropriate method, scope, and duration of the review. The duration and type of monitoring required will depend on the nature/severity of the situation being evaluated, the type of privileges in question and the practitioner's overall activity level. The affected practitioners will be informed of the duration of the review and the mechanism(s) to be used to gather information for the review.

FPPE shall begin with the practitioner's first performance of the privileges subject to review and shall continue throughout the designated period (or designated number of cases, as applicable). The period of focused review may be extended until such time as satisfactory evidence exists to support the practitioner's competence to perform the privilege(s) being reviewed; however, the total period of focused review must not exceed a period of twelve (12) months.

In developing the FPPE for each practitioner, the Chief of Staff and reviewer shall use the following guidelines:

1. New Practitioners. All new practitioners will undergo FPPE for the privileges he/she is granted. The initial FPPE evaluations by the reviewer should be completed within three (3) months but not to exceed (6) months if possible. At a minimum, the focused review should include:
    a. Direct observation.
    b. Chart review.
    c. Monitoring of performance indicators, or aggregate data.
    d. Peer recommendations from previous institutions.
    e. Discussions with other individuals involved in the care of each patient.
    f. Any other type of monitoring activity deemed appropriate to fully evaluate the practitioner's ability to perform the requested privileges.

2. New privileges for existing practitioners.
   All individual practitioners who are granted new privileges will undergo FPPE for the requested privileges and will be assigned a reviewer. The process for the focused review, the duration, and the minimum number of cases required for review shall be determined by the Chief of Staff and the reviewer, and approved by the MEC. The duration and type of monitoring required will be dependent on the type of privileges in question and the practitioner's overall activity level. The practitioners will be informed of the duration of the review and the mechanism(s) to be used to gather information for the review.
3. FPPE required as a result of OPPE, peer review, or other trigger.
   The Chief of Staff and the reviewer will establish an improvement plan on an individual basis to be approved by the MEC when focused evaluation has been recommended as the result of OPPE, peer review, or other trigger. The decision to assign a period of FPPE for a specific privilege(s) should not impact or apply to other existing privileges in good standing.
4. When a privilege is used infrequently.
   The Medical Executive Committee should determine a minimum number of cases to be performed to maintain proficiency. This should be documented in the delineation of privileges. If the minimum amount is not being met, then the Chief of Staff and the reviewer will establish a plan for focused evaluation on an individual basis, which shall be approved by the MEC.

Responsibilities of the Reviewed Practitioner:

1. The practitioner must provide all necessary information in a timely manner to the reviewer for his/her review. If applicable, the practitioner must arrange for the reviewer to attend and observe the procedure and/or the practitioner must provide the reviewer with access to all information regarding the patient's clinical history and care, pertinent physical findings, lab and x-ray results; the course of treatment or management, including a copy of the H&P, operative reports, consultations, and discharge summaries.
2. The practitioner may ask the Chief of Staff for a change of reviewer if disagreements with the current reviewer may adversely affect his/her ability to complete the review timely and satisfactorily.
3. The practitioner shall inform the reviewer of any unusual incidents associated with his/her patients.
4. The practitioner shall work with the reviewer to ensure that there is documentation of the satisfactory completion of his/her review, including the completion and delivery of review forms to the medical staff office.
5. The practitioner shall cooperate with the terms and requirements of his/her focused evaluation.
6. The practitioners shall provide alternative information when the data from Stoughton Health is insufficient.

Circumstances Warranting External Professional Practice Evaluation

Utilization of an external evaluator or consultant (i.e., a practitioner who is not a member of the hospital's medical staff) will take place as necessary:

1. To achieve effective FPPE that would not otherwise be possible by using an internal reviewer.
2. To avoid a conflict of interest. The provisions of the Ongoing Professional Practice Evaluation Policy that address conflicts of interest shall also apply to this policy.
3. When no one on the medical staff has the expertise in the privileges under review or when the only practitioners with expertise are deemed to have a conflict of interest.
4. When a medical staff member requests permission to use a new technology or to perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care provided.
5. When dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and the conclusions would directly affect a practitioner's privileges or medical staff membership.
6. In any other circumstances deemed appropriate by the Chief of Staff, in consultation with the hospital President.

The determination for utilization of an external evaluator or consultant shall be made by the Chief of Staff after consultation with the hospital President. In the event that the Chief of Staff is the subject of review,

the hospital President and the MEC shall make the determination. No practitioner can require the hospital to obtain an external evaluator or consultant if it is not warranted by the circumstances, as determined by the Chief of Staff.

Completion of Reviewing and Focused Evaluation

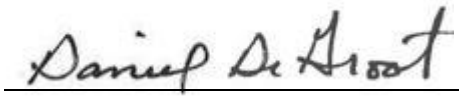
1. Upon completion of the focused evaluation, all forms, reports, and significant findings related to the focused review shall be provided to the MEC. The MEC shall review and evaluate the results of the evaluation and make a recommendation. Recommendations may include, but are not limited to, the following
    a. No further action required.
    b. Extend the period of focused review.
    c. Impose a requirement that the practitioner participate in continuing education or other training to improve performance.
    d. Initiate the corrective action process.
    e. Make a recommendation to suspend, limit, or revoke the practitioner's privileges. Any hearing or other procedural rights will be afforded to the practitioner only in accordance with the medical staff bylaws.
    f. If impairment is suspected, make a recommendation that the issue should be addressed following the hospital's policy on impaired practitioners.
    g. Make a recommendation that the issue(s) be addressed in accordance with another hospital or medical staff policy.
2. The practitioner shall be notified of the outcome of the evaluation, the MEC's recommendation upon the completion of the focused review, the requirements, if any, relative to future exercise of the privilege(s) in question, and if the focused review is complete or will continue (duration will be specified if the focused review will continue).
3. Information resulting from FPPE will be used to assess the quality of care of each practitioner at the time of reappointment and renewal or privileges, and to determine whether to continue, limit or revoke any existing privilege(s).

VI. REFERENCES:

1. Joint Commission: MS.08.01.01-January 2022
2. Wis. Stat. § 482.22(a)(1)

VII. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee
Legal Counsel



President/CEO _____ Date _____

Chief of Staff _____ Date _____

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **November 2019**	**Medical Staff Policy Manual**	
	Original X-Revision-1/2021	Page 1 of 2	Title: **General Conduct of Inpatient ~~Patient~~ Care**

I. GENERAL CONDUCT OF CARE:

A. Each patient at Stoughton Health acute care/in-patient floor shall be seen on a daily basis by the attending, other staff physician, or designated supervised physician assistant or nurse practitioner with similar staff privileges, and a notation will be made in the patient's medical record.

1. For those patients who have been admitted to the psychiatric unit and are being following by the psychiatrist according to pertinent regulations, the primary medical physician shall see these patients according to their level of medical complexity. Daily visits shall be required for those patients whose medical/non-psychiatric condition requires immediate attention and frequent adjustments to medications and treatments. Less than daily visits are allowed when the patient's condition is medically stable and there are no medication or treatment adjustments being made and the focus of medical intervention is psychiatric in nature.
2. Patients admitted to swing bed need to be seen on admission to complete a history and physical and admissions orders. Thereafter, the attending needs to see the patient every thirty (30) days. In addition, swing bed patients are required to have the first recertification no later than the 14th day. Subsequent recertification's are required at least every 30 days after the first recertification
3. Patients admitted between 7p and 7a, will be evaluated by the hospitalist on duty via telemedicine. Admitting orders will be completed and an evaluation note will be entered in the medical record. The oncoming hospitalist will assume care and complete the H&P.

B. Verbal orders are to be used only in emergent situations. Registered nurses, pharmacists and physician assistants are authorized to accept all physician verbal orders. Physical therapists, occupational therapists, speech therapists, respiratory therapists, phlebotomists, medical technologists, medical laboratory technicians, laboratory manager, radiology manager, registered radiology technologist, licensed practical nurses and medical imaging unit clerk are authorized to accept all physician verbal orders pertaining to their area of training. All orders dictated by the physician or through their designated registered nurse or physician assistant shall be signed by the appropriately authorized person to whom it was dictated with the name of the ordering practitioner. The ordering practitioner shall authenticate such orders within guidelines set by the State of Wisconsin and the Joint Commission by signing and dating.

C. Order sets shall be permitted. In conjunction with SSM, Stoughton Health and the Medical Care Evaluation Committee will review and approve order sets every three years. Additionally, new sets need to be reviewed by the Medical Staff Executive Committee for approval.

D. All medications will be reconciled upon admission, when the patient's level of care changes, and at the time of discharge.

E. All medications administered to patients shall be those listed in the latest edition of: United Stated Pharmacopoeia, National Formulary, American Hospital Formulary Service or the A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the State of Principles in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

F. Any practitioner with clinical privileges in this hospital may be called for consultation within their area(s) of expertise.

G. Consultation may be considered in the following situations:

1. when the diagnosis is obscure after initial diagnostic procedures have been completed;
2. when requested by the patient or the patient's family/guardian.

H. The attending practitioner shall be responsible for requesting consultations when indicated. The attending practitioner shall communicate need for consultation with appropriate provider and enter consult order in the electronic health record.

I. If a nurse has any doubt or question about the care provided to any patient or believes that appropriate consultation is needed, the nurse shall discuss his or her concerns with the attending physician.

1. If these efforts fail, the RN will contact the Charge Nurse or Care Coordinator. If the issue is still unresolved, the RN, Charge Nurse, or Care Coordinator will contact the manager or the CNO, or designee, who will recommend further action or resolution.
2. If no agreement can be reached, the CNO or designee will confer with the Chief of Staff. These individuals will meet with the provider and staff involved to discuss concerns and solutions. If this is an ethical concern an ethics consult can be requested.
3. If the provider issue is not resolved, the CNO or Chief of Staff may initiate further investigation as outlined in the Medical Staff Bylaws.

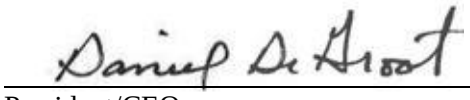
J. A psychiatric consultation is considered for those who are screened to be at high risk and if appropriate, treatment be requested for and offered to all patients who have attempted suicide. A transfer to an in-patient psychiatry unit may be expedited as necessary.

K. Orders ~~written~~ entered in the EHR for the use of restraints and/or seclusion shall be obtained from the practitioner within one (1) hour of restraints applied for behavioral purpose, and twenty-four (24) hours for restraints applied for medical purposes. The order should specify length of time needed. Patients requiring such needs shall be monitored and evaluated by qualified personnel every fifteen (15) minutes. (See General Manual Policy/Patient Care Policy & Procedure - #8.14 – Restraint/Seclusion.) Additionally the latest State rules and regulation governing restraints and seclusion must be followed.

L. Pregnant patients presenting to the Emergency Department, regardless of gestational age, will be transferred if an inpatient admission is needed.

II. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee



President/CEO _____ Date _____

Chief of Staff _____ Date _____

POLICY & PROCEDURE

STOUGHTON HEALTH *Creating Excellence Together*	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
	Original X-Revision-1/2021	Page 1 of 2	Title: **General Conduct of Surgical Care** ~~**Rules Regarding Surgical Care**~~

I. GENERAL RULES REGARDING SURGICAL CARE:

A. A written, signed informed consent form will be obtained from the patient or the patients legally authorized representative following an informed consent discussion prior to all operative procedure(s). The consent discussion along with the completed consent form(s) will be documented in the patient's electronic health record. In an emergency situation involving a minor or unconscious patient where the patient might suffer significant morbidity/mortality and suitable signatures cannot be obtained, a note explaining these circumstances shall be fully documented into the patient's electronic health record.

B. The pre-operative working diagnosis should be established through appropriate physical assessment and required laboratory or imaging studies and should be documented in the patient's electronic health record. Exceptions may occur in the event of an emergency surgery.

C. All surgeries performed shall be fully described in a surgical report by the responsible surgeon. The surgeon shall be responsible for providing or arranging daily post-operative care and the completion of the necessary records. The performing surgeon may delegate another member of the medical staff /e.g. Physician Assistant to provide daily rounding to the patient.

D. A hospital pathologist shall make an examination of all received tissue and foreign bodies that were removed in surgery in order to arrive at a diagnosis. The pathologist's authenticated report shall be made a part of the patient's electronic health record. The surgeon shall determine which removed tissues and foreign bodies shall be sent for pathology.

E. Patients receiving operative procedures in the surgical department shall be classified in one of the following two categories:

1. Inpatient- patient requiring greater than or equal to twenty-four hour stay, overnight stay pre-op and/or post-op;
2. Outpatient – patients requiring less than 24 hour stay.

F. Surgical patients shall receive one of the following categories of anesthesia:

1. General Anesthesia
2. Regional Block
3. Spinal Anesthesia
4. ~~Conscious Sedation~~ Monitored Anesthesia Care (MAC)
5. Local Anesthetic

The requirements for 1-4 shall be:

a. complete a pre-operative history and physical examination in accordance with the requirements. Such history and physical shall be recorded on the patient's electronic health record prior to surgery;
b. pre-operative anesthesia review documented in the electronic health record;
c. results of pre-operative diagnostic studies necessary/relevant to the patient's health status and for the procedure being performed;
d. a completed procedural note, including but not limited to techniques and findings, recorded immediately following surgery and signed by the surgeon;
e. completion of an admission/discharge summary as outlined in Medical Staff Policy Completion of Electronic Health Records.

The requirements for anesthesia type 5 (local anesthesia) shall be:

a. a documented review of systems with an indication for the procedure (copies of the office notes area acceptable) and identification of any pertinent pre-existing physical condition;
b. results of pre-operative studies necessary/relevant to the patient's health status and for the procedure being performed;
c. a completed procedural note, including but not limited to techniques and findings, recorded immediately following surgery and signed by the surgeon;
d. instruction pertinent to the post-procedural recovery shall be given at the time of discharge.

G. In all cases requiring anesthesia, the appropriate anesthesia record will be completed, and shall include evidence of pre-anesthetic evaluation, pre-anesthesia discussion with the patient (or legally authorized representative) regarding anesthesia to be used, the patient's (or legally authorized representative's) consent to proceed with the anesthesia, and post-anesthetic follow-up of the patient's condition. The pre-anesthetic evaluation shall be completed and recorded within forty-eight (48) hours before surgery, except in emergencies. The post-anesthetic examination shall be recorded within forty-eight (48) hours after surgery by the individual who administers the anesthesia.

H. Podiatrists and dentists who are members of the medical staff shall consult with the hospitalist for any medical aspects of care. The primary care provider is responsible for performing and documenting in the electronic health record a history and physical examination and order all necessary pre-operative diagnostic studies. The patient shall be discharged by the attending dentist or podiatrist.

I. Dentists' responsibilities include:

1. a detailed dental history justifying hospital admission;
2. a detailed description of the examination of the oral cavity and a pre-operative diagnosis;
3. a completed operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the name and number of the tooth or teeth removed and/or fragments. All tissue including teeth and fragments shall be sent to the hospital pathologist for examination;
4. a progress note as is pertinent to the dental condition;
5. a discharge summary is completed as outlined in the Electronic Health Record portion of these rules;

II. COORDINATION:

President/CEO
Chief of Staff
Medical Staff Executive Committee
Lead CRNA
Surgical Services Advisor
Legal Counsel

Daniel DeGroot — 1/25/21

President/CEO — Date

Chief of Staff — Date

POLICY & PROCEDURE

	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
STOUGHTON HEALTH Creating Excellence Together	Original - 2016	Page 1 of 4	Title: **Health Screening/Immunization Requirements**

I. POLICY

All members of the Stoughton ~~Hospital~~ Health Medical Staff and Allied Health Professionals (referred to collectively in this Policy as Practitioners) will comply with Stoughton's pre-employment/pre-appointment, including providing documentation of meeting rubella, Hepatitis B, and tuberculosis (TB) monitoring requirements. Telemedicine providers requesting clinical privileges who are located at a distant site are excluded from this requirement.

II. PURPOSE

To protect patients, visitors, employees, and other Practitioners from vaccine preventable diseases in compliance with Wisconsin Administrative Code Section DHS ~~124.07~~ 146, as well as to comply with the recommendations of the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

III. PROCEDURE:

A. Pre-employment Health Assessment.

1. Health Assessment. As part of the credentialing process, all practitioners shall undergo a health assessment. The assessment shall be completed and the results known prior to the assumption of duties. The assessment shall consist of, at minimum:
    a. a health history, including a history of communicable diseases and immunizations;
    b. Mantoux tuberculin skin test consisting of 5 tuberculin units (TU) of purified protein derivative (PPD) (unless able to supply results from a negative TB test dated within the last 12 months) and, if necessary, a chest roentgenogram to determine whether disease is present, unless medically contraindicated. Persons with positive findings shall be referred to a physician for evaluation.
    c. Ability to perform the essential functions (including physical/mental abilities) of privileges requested and/or the position for which applying for.
2. Rubella (German Measles). Wisconsin Administrative Code Section DHS ~~124.07~~ 146 requires that documented vaccination or immunity against rubella must be provided prior to direct contact with rubella patients, pediatric patients, or female patients of childbearing age. Therefore, either or both of the following must be provided before assumption of duties at Stoughton: (a) Serological Laboratory test results of positive immune status; and/or (b) documented administration of one dose of rubella, or measles, mumps, rubella, on or after the Practitioner's first birthday.
3. Hepatitis B Status. The Centers for Disease Control and Prevention (CDC) recommends that health care providers be vaccinated for Hepatitis B. Therefore, all Practitioners must provide one of the following: (a) documentation of completion of primary series of three doses of Hepatitis B vaccine at intervals of zero, one, and six months; (b) documentation of positive serology for Hepatitis B surface antibody; or (c) a copy of signed declination form (attached at the end of this Policy).
4. Evidence of two live measles vaccinations (or MMR), documentation of physician-diagnosed measles disease, or laboratory evidence of measles immunity for all persons born in or after 1957 – CDC recommendation.
5. Tetanus, diphtheria, pertussis – give 1 dose of Tdap as soon as feasible to all healthcare workers who have not previously received Tdap. A Td booster is recommended every 10 years. Advisory Committee on Immunization Practices and CDC recommendation.

6. Varicella (chicken pox) – documentation of 2 doses of varicella vaccine given at least 28 days apart, laboratory evidence of immunity, or diagnosis or verification of history of varicella or herpes zoster (shingles).
7. Influenza Vaccination during Influenza season (see Stoughton Health's Influenza Vaccination Policy)
    a. General Requirements. All practitioners with patient contact must complete the Influenza Vaccination (IV) form by December 1 each calendar year. The Quadrivalent Inactivated Influenza (QIV) will be administered based on vaccine availability and in accordance with the published CDC guidelines. All practitioners who are hired or begin their affiliation with Stoughton Health ~~Hospital~~ during the influenza season must comply with this policy at the time of their pre-placement health assessment or prior to their clinical rotations. The influenza season is generally recognized as September 1st-March 31st, and vaccination will be required (without a medical or religious waiver) for new staff during this time. Influenza vaccine may be given to new employees after March 31st, if it is indicated due to a prolonged flu season.

       Practitioners who decline the vaccination must provide a medical or religious waiver (see below).

    b. **Waivers**
        - Medical Waiver: A medical waiver, indicating that the practitioner has a medical contraindication to the flu vaccine, must be signed by another health care provider/PCP and returned to Medical Staff Office at Stoughton Health ~~Hospital~~ by December 1 **each** calendar year.
        - Religious Waiver: A religious waiver must be signed by the religious/spiritual leader and returned to Medical Staff Office at Stoughton Health ~~Hospital~~ by December 1. This must be renewed annually.
8. New and Emerging Infectious Disease Vaccination
    a. In cases of new disease, or disease that has not typically been seen in our geographic location, staff will follow CDC and/or Public Health guidance for isolation, infection control practices and vaccination recommendations for these types of diseases
9. Ongoing Tuberculosis Screens.
    a. Frequency of Review. Wisconsin Administrative Code Section DHS ~~124.07~~ 146 requires that the "frequency of repeat tuberculin skin test screening for negative reactors shall depend on the risk of an employee becoming infected." The CDC also sets tuberculin skin test (TST) recommendations in 2005, which includes the following:
        - Every health care facility should have a TB Infection Control Program.
        - Every health care facility should conduct an initial TB Risk Assessment and also ongoing TB Risk Assessments.
        - The results of the TB Risk Assessment should be used to determine the need for and frequency of employee TB screening.

    b. Determining Risk Level. Per CDC guidelines, if an inpatient setting with less than 200 beds has less than three (3) TB patients for the preceding year, the setting is classified as low risk. If a setting has three (3) or more patients for the preceding year, the setting is classified as medium risk. The risk analysis is included in the hospital HVA.

    c. Procedure. Per CDC guidelines for low risk inpatient settings, Stoughton Health will comply with the following TB screening procedures:
        - All Practitioners will receive baseline TB screening on hire, using two-step TST or BAMT (blood assay for Mtb) to test for infection with M tuberculosis (unless able to supply results from a negative TB test dated within the last 12)
        - After baseline testing for Mtb infection with negative results, additional TB screening is not necessary unless exposure to Mtb occurs; All Practitioners will complete PPD or BAMT positive questionnaires annually.
        - Practitioners who need to have TB tests completed or who need to complete annual PPD or BAMT Positive questionnaires will be notified 60 days in

advance of the due date and will have until one month after that date to meet the requirements.

- In the event Practitioners come into contact with TB at Stoughton Health, Stoughton Health will make screening for exposure/immunity available in accordance with Section C of this Policy, below.
- Health care workers with baseline or newly positive TST or BAMT or documentation of treatment for LTBI (latent TB infection) or TB disease will receive one chest x-ray to exclude TB disease. Repeat x-rays are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician.

B. Exposure. Practitioners who come into contact with TB or other infectious diseases shall notify the Chief of Staff of such exposure. In the event of such exposure, Stoughton Health will make screening for exposure/immunity, prophylaxis/treatment, and/or counseling available, as appropriate as well as make a referral to Infectious Disease Services.

C. Compliance. Failure to comply with these requirements may result in automatic or corrective action in accordance with the Medical Staff bylaws.

D. Documentation. Stoughton Health will maintain an updated record of each Practitioner's health assessments.

IV. REFERENCES:

1. DHS ~~124.07~~ 146
2. Stoughton Health ~~Hospital~~ Influenza Vaccination Policy 9.88

V. COORDINATION:

President/CEO
Chief of Staff
Medical Executive Committee
Infection Prevention
Employee Health

Daniel De Groot

President/CEO _____ Date _____

Chief of Staff _____ Date _____

STOUGHTON HEALTH

Creating Excellence Together

HEPATITIS B IMMUNIZATION REFUSAL STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____

Practitioner's Name (Print)

_____

Practitioner's Signature Date

POLICY & PROCEDURE

STOUGHTON HEALTH *Creating Excellence Together*	Effective Date: **November 2019**	**Medical Staff Policy Manual**	
	Original x-Revision-1/2021	Page 1 of 3	Title: **Ongoing Professional Practice Evaluation (OPPE)**

I. PURPOSE:

To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff and Allied Health Professionals, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and care. Ongoing professional practice evaluation (OPPE) looks at individuals with clinical privileges on an ongoing basis to allow for timely performance improvement. The Medical Care Evaluation Committee (MCE) will be instrumental in the OPPE monitoring process and will report to Medical Executive any outstanding issues or concerns. The Medical Executive Committee (the MEC) will oversee OPPE as part of an organized program to improve the quality of health care. OPPE is a peer review activity. As such, the MEC and those participating in this process are protected by Wis. Stat. § 146.37. All investigations, inquiries, proceedings and conclusions associated with OPPE are confidential and protected under Wis. Stat. § 146.38.

II. GOALS

A. Identify opportunities for practice and performance improvement of individual practitioners. For purposes of this policy, "practitioners" are Medical Staff members and Allied Health Professionals who hold privileges at the hospital.

B. Monitor for significant trends in performance by analyzing aggregate data and case findings.

C. Assure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful.

D. Monitor clinical performance of practitioners.

E. Improve the quality of care provided by individual practitioners.

F. Ensure appropriate recommendations for delineation of clinical privileges.

III. POLICY STATEMENT:

It is the policy of Stoughton Health to comply with statutory, regulatory and accreditation requirements regarding OPPE and focused professional practice evaluation (FPPE). Ongoing data review and findings about practitioner practice and performance are evaluated by the MEC every six months. The findings of the MEC are used to assess the quality of care of each practitioner at the time of reappointment and renewal of privileges and to determine whether to continue, limit or revoke any existing privilege(s). All findings associated with OPPE and FPPE shall be considered confidential and shall be protected to the fullest extent under Wisconsin statutes regarding peer review activities.

IV. DEFINITIONS:

A. "OPPE" is a program that allows the medical staff to identify professional practice trends that impact on quality of care and patient safety on an ongoing basis. The program:

1. Includes the evaluation of an individual practitioner's professional performance and the offering of opportunities to improve care based on recognized standards of practice. It differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual practitioner's performance and competence related to his/her privileges rather than appraising the quality of care rendered by a group of professionals.
2. Uses multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, compliance with hospital policies, the Rules and Regulations and Bylaws of the medical staff, and clinical standards, and the usage rates compared against established benchmarks or norms when available.

3. Bases individual evaluation on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

B. "Conflict of Interest"

1. A member of the Medical Staff asked to perform a professional practice evaluation may have a conflict of interest if he or she may not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the practitioner involved as a direct competitor or partner.
2. It is the individual reviewer's obligation to disclose the potential conflict to the MEC.
3. The MEC's responsibility is to determine whether the conflict would prevent the individual from participating and the extent of that participation, if allowed.
4. Individuals determined to have a conflict may be present during the group discussion and professional practice evaluation. They will, however, be required to excuse themselves from voting on the rating of the case.

V. PROCESS/PROCEDURE:

A. Practitioners will have regular ongoing monitoring of their professional practice performance. OPPE will allow practitioners, where appropriate, to take steps to improve performance on a more timely basis. For new practitioners at the hospital, the OPPE process will begin after successful completion of the FPPE.

B. The specific type of data that will be collected shall be determined in consultation with the service with final approval by MCE/MEC. Data shall be collected on all practitioners, and not only those practitioners with performance issues. The Medical Staff in consultation with the Services shall, on a periodic basis, determine whether the type and amount of data collected should be modified. Examples of criteria that may be used in the OPPE may include, without limitation:

- Review of operative and other clinical procedure(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Request for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner's use of consultants
- Other relevant criteria as determined by the Medical Staff

C. The information used in the ongoing professional practice evaluation may be acquired through a variety of sources, including but not limited to:

- Discussions with other individuals involved with the care of the patient (including consulting physicians, assistants at surgery, and nursing and administrative personnel)
- Chart review
- Direct observation
- Monitoring of the practitioner's clinical practice patterns
- Comparisons of the practitioner's inpatient and/or outpatient complications/outcomes to those of his/her peers
- Internal or external peer review
- The practitioner shall provide alternative information if the data from Stoughton Health is insufficient

The data obtained will be retained in a secure and confidential file and placed into the practitioner's credentialing file and incorporated into the process for reappointment, renewal of privileges, and performance improvement activities.

The MEC will assign the Chairman of the MCE to assist the MEC in conducting the ongoing professional practice evaluation.

Ongoing professional practice evaluation will be conducted continuously and the information collected shall be recorded in an OPPE Report. The OPPE Report and any other relevant information shall be provided to the MEC for review and action at least every six (6) months and at the time of reappointment.

The information resulting from the OPPE will be used to determine whether to continue, limit or revoke existing privileges. Information from OPPE may also be used for referral for performance improvement activities or trigger a FPPE. Indicators not meeting the criteria for two or more consecutive 6 month periods or 2 or more indicators not meeting criteria in any given period may trigger a FPPE. Providers will be notified with a letter and contacted by the chair of MCE. Based on the analysis of the data, the MEC may take several possible actions, including but not limited to:

- Determining that the practitioner is performing well or within desired expectations and that no further action is warranted;
- Determining that an issue exists that requires a focused evaluation;
- Determining the significance of zero data. Determining whether zero data is evidence of good performance (e.g., no complaints) or whether zero data is an indication that the practitioner is no longer performing the procedure, and thus, any future and actual performance of the procedure should trigger a focused review;
- Recommending to the Board of Directors that a practitioner's privilege should be revoked because it is no longer required;
- Recommending to the Board of Directors that a practitioner's privilege should be suspended (which suspends the data collection); and
- Recommending the initiation of corrective action.

The determination and evidence to support the determination shall be included in each practitioner's credentials file and shall be incorporated into the process for reappointment, renewal of privileges, and performance improvement activities.

D. After an OPPE Report is generated, a copy shall be provided if requested to the practitioner to whom the report pertains.

VI. REFERENCES:

1. Joint Commission: MS.08.01.03 - January 2022
2. Wis. Stat. § 482.22

VII. COORDINATION:

President/CEO
Chief of Staff
Medical Executive Committee

Daniel De Groot

President/CEO _____ Date _____

Chief of Staff _____ Date _____

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **January 2019**	**Medical Staff Policy Manual**	
	Original X Revision-1/2021	Page 1 of 3	Title: **Stoughton Health Medical Staff Continuous Improvement (CI) Plan**

I. PURPOSE:

The purpose of this policy is to define the process used by Stoughton Health Medical Staff to systematically evaluate the quality and appropriateness of medical care given to our patients. This policy describes our process, which continuously seeks to improve patient care, patient safety and solve identified problems while promoting an integrated approach to patient care.

II. SCOPE OF PRACTICE:

A. The scope of the Medical Staff CI Plan includes inpatient, outpatient, day surgery, geriatric psychiatry, emergency services and clinics. This scope includes surgical case review, anesthesia review, drug usage evaluation, patient safety, medical record review, blood usage review, radiology monitors, pharmacy and therapeutics monitoring; risk management activities as well as infection control, internal and external disaster, utilization review and patient satisfaction. Although it is the intent of the medical staff to monitor and evaluate all aspects of the medical care given at Stoughton Health, priority will be given to:

1. Those aspects of care which occur most frequently or which affect large numbers of patients.
2. Those activities which place patients at risk of serious consequences or are deprived of substantial benefit if the care is not provided correctly
3. Those aspects of care which past experience reveals may result in problems for staff and patients.
4. The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants.
5. New medical services for which new provider privileges have been requested.
6. Sentinel or Serious Events as defined by Stoughton Health Sentinel Event Policy.

III. POLICY:

The objectives of the policy are:

A. To assure medical care and services provided are appropriate to meet or exceed established professional standards.

B. To provide a systematic approach, which objectively monitors and evaluates medical care and services and assures effective and timely communication of performance improvement activities to the Board of Directors, Administration, Medical Staff and Stoughton Health staff as appropriate.

C. To ensure appropriate corrective action is implemented when problems or opportunities for improvement are identified.

D. To integrate information between medical staff committees, which could result in improvement of medical care between physicians or physicians and hospital services.

E. To provide for evaluation of single events, which deviate from expected process or outcome.

F. To provide an avenue of review from outside agencies, such as The Joint Commission, CMS, WI DQA, HMO's, Medicare, Medicaid and private insurers.

G. To adhere to a review process for credentialing individual practitioners as needed.

H. To improve the performance and appropriateness of medical documentation in patient medical records.

I. To increase patient safety and decrease patient risk.

IV. ORGANIZATION & RESPONSIBILITY:

A. The medical staff through its bylaws has delegated CI reviews as previously outlined to the Medical Care Evaluation (MCE) Committee. Physician members of the MCE are appointed by the Chief of Staff. Hospital administration and staff are also represented. MCE meets on a monthly basis and makes recommendations to the Medical Executive Committee in writing after each meeting. The Medical Executive Committee takes action on recommendations and communicates with the general medical staff and others as needed.

B. Continuous Improvement opportunities may be identified during Peer Review process to include follow-up actions in the form of policy or practice changes, providing information on current state of the art care technique, recommendation for continuing medical education, a rule or regulation change, or enforcement of current rules and regulations. In the case of an individual physician, additional continuing education in a specific area of need and/or monitoring of the individual's practice through OPPE process and FPPE for newly credential providers.

C. Monthly MCE minutes are provided to the Board of Directors for their review. All materials from the MCE Committee are considered peer review and kept in a confidential manner according to State of Wisconsin law.

D. Groups with medical staff representation who report to the MCE Committee are: -Pharmacy and Therapeutic Committee, Surgical Services Leadership Council, Emergency Services Committee, Continuous Improvement Council, Patient Safety Committee, Inpatient Leadership Committee, Geriatric Psych Leadership Committee, and Infection Prevention Committee.

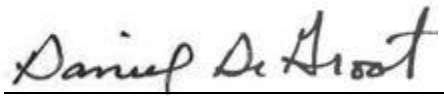
Other groups who report to MCE Committee include, but are not limited to: Utilization Review, Environment of Care Committees, Lab, and Radiology.

V. REFERENCES:

1. Joint Commission: MS.05.01.01 - January 2022

VI. COORDINATION:

President/CEO
Chief of Staff
Medical Executive Committee



President/CEO _____ Date _____

Chief of Staff _____ Date _____

Medical Staff Peer Review Criteria

Complications:

Excessive blood loss leading to transfusion (coded as complication) – source Blood Utilization review

Greater than 1000 ml blood loss without a transfusion (coded as complication)

Return to surgery within same hospital stay (will be captured via EPIC report)

Transfer to outside facility after surgery/procedure (reflected in Discharge Disposition)

Cardiac arrest in OR or PACU (coded as complication)

Injury to surrounding tissues or organs (coded as complication)

Anesthesia complication (captured via Surgical Services Council)

Unscheduled Intra-operative consults (usually linked to complication)

Death within 48 hours after surgery/procedure (captured as complication or mortality)

Trauma Review

Sentinel Events

Surgical site infections using NHSN SSI definitions for the following procedures:

- HPRO (Arthroplasty of hip)
- KPRO (Arthroplasty of knee)
- COLO (Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations)
- HYST (Abdominal hysterectomy; includes that by laparoscope)

CLABSI (Central line-associated bloodstream infections) using NHSN definitions

CAUTI (Catheter-associated urinary tract infections) using NHSN definitions

Acute Care Mortalities

Inpatient mortalities (does not include Hospice or ER deaths)

If patient is DNR and death expected, provide numbers only and no case study.

Any reportable death linked to use of restraints or seclusion, to use of psychotropic medication, or suspected suicide. (See Policy 8.16 Reportable Deaths)

Approved by MCE January 7, 2019

POLICY & PROCEDURE

STOUGHTON HEALTH Creating Excellence Together	Effective Date: **November 2019**	**Medical Staff Policy Manual**	
	☐ Original ☒ Revision-1/2021	Page 1 of 2	Title: **Temporary Privilege Policy**

I. PURPOSE:

The purpose of the temporary privilege policy is to outline circumstances when temporary privileging is acceptable by the Joint Commission Standards, as well as the process for granting such privileges to eligible practitioners.

For purposes of this policy, the term "practitioner" includes individuals seeking Medical Staff membership and privileges, as well as individuals seeking privileges as Allied Health Professionals.

For procedures related to the granting of disaster privileges, see the Disaster Credentialing Policy. For emergency privileges, see the procedures outlined in the Medical Staff bylaws.

II. PROCEDURE:

A. Circumstances.

1. Temporary privileges may only be granted in the following circumstances:
   a. To fulfill an important patient care, treatment, and service need, or
   b. When an applicant for new privileges* with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee (MEC) and the governing body.

   *Note: "Applicant for new privileges" includes an individual applying for clinical privileges at the hospital for the first time; an individual currently holding clinical privileges who is requesting one or more additional privileges; and an individual who is in the reappointment/re-privileging process and is requesting one or more additional privileges.

2. Temporary privileges may be granted by the CEO/Designee, upon recommendation of the Chief of Staff. Temporary privileges shall be granted for a limited period of time, not to exceed 90 days**.**

B. Requirements. Before temporary privileges may be granted to a new applicant or to fulfill an important patient care need, the hospital must query the NPDB database; conduct background checks (including but not limited to, a Caregiver Background Check in accordance with Wisconsin law); query the OIG Exclusion Database and the Systems for Award Management Database, and verify the following:

1. The applicant meets the threshold eligibility criteria outlined in the Medical Staff bylaws;
2. The applicant has submitted a complete application for Medical Staff membership, if applicable, and all other required documentation for temporary privileges, and such documentation raises no concerns;
3. Current licensure;
4. Current DEA registration (if applicable);
5. Education, relevant training and experience;
6. Current competence;
7. Ability to safely and competently perform privileges requested;
8. No current or previously successful challenge to licensure or registration;
9. No current or previous subjection to involuntary termination of medical staff membership at another hospital or health care organization;

10. No current or previous subjection to involuntary limitation, reduction, denial, or loss of clinical privileges at another hospital or health care organization;
11. Current malpractice insurance coverage (in the amount sufficient to satisfy the requirements under Wisconsin law and the Board);
12. No adverse National Practitioner Data Bank Report and no exclusions from Medicare, Medicaid, or any other government payor;
13. The practitioner's identity by viewing a valid picture ID issued by a state or federal agency (e.g., driver's license or passport);
14. The applicant's immunizations/test results for TB and Rubella, and any other health screenings required by the hospital; and
15. Any other criteria required by the Medical Staff or hospital.

C. Special Conditions.
1. All practitioners granted temporary privileges will be subject to a focused professional practice evaluation in accordance with hospital policy**.**
2. Special conditions be imposed by the Chief of Staff or his designee responsible for supervision of a practitioner granted temporary privileges.

D. Termination. A practitioner's temporary privileges may be terminated as follows:
1. On the discovery of any information or the occurrence of any event of a nature which raises question about a practitioner's professional qualification or ability to exercise any or all of the temporary privileges granted, the CEO, upon recommendation of the Chief of Staff, may terminate any or all such practitioner's temporary privileges. The practitioner's patients then in the hospital shall be assigned to another practitioner by the Chief of Staff or his designee. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.
2. If a practitioner who is seeking medical staff membership and privileges withdraws his or her application, or if his/her application is denied, the practitioner's temporary privileges shall be automatically terminated unless the CEO and Chief of Staff approve the continuation of such temporary privileges.

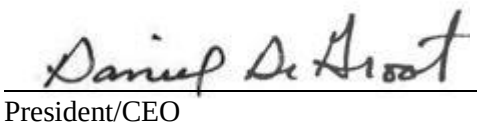
E. Procedural Rights. A practitioner shall not be entitled to the procedural rights afforded by Article 9 of the Medical Staff Bylaws because his request for temporary privileges is refused or because all or any portion of his temporary privileges are terminated or suspended.

III. REFERENCES

Joint Commission MS.06.01.13 - January 2022

IV. COORDINATION

President/CEO
Chief of Staff
Medical Executive Committee



President/CEO _____ Date _____

Chief of Staff _____ Date _____

Stoughton Hospital Foundation Dashboard

	FY 19 Actual	FY 20 Actual	FY 21 Actual	Average FY17-FY21	FY 19 QTR 1	FY 20 QTR 1	FY 21 QTR 1	FY 21 QTR 2	FY 21 QTR 3	FY 21 QTR 4	Total YTD	FY 22 QTR 1	FY 22 QTR 2 3-10-22	FY 22 QTR 3	FY 22 QTR 4	Total YTD	FY 2022 Budget	Strat Goal for FY 2022	Explanation
Donor Count																			
Donor Base	449	374	485	407	166	146	177	87	24	197	485	276	21			297		428	Incr. avg. 5%
Annual Giving Contributions*																			
Restricted Contributions	$140,011	$196,038	$141,787	$139,055	$568	$10,836	$14,678	$3,180	$122,733	$1,196	$141,787	$18,665	$161,224			$179,889	$213,000	$146,008	Incr. avg. 5%
Unrestricted Contributions	$53,940	$54,047	$55,843	$54,047	$30,598	$33,765	$22,445	$22,047	$7,036	$4,315	$55,843	$45,281	$6,006			$51,287	$65,000	$56,749	Incr. avg. 5%
Special Events:																			
Golf Outing Net Returns	$24,329	$34,999	$41,462	$26,944			$0	$0	$0	$41,462	$41,462	$0	$0				$35,000	$28,291	Incr. avg. 5%
Other Fundraising/Walk, Giv Tues	$0	$0	$3,107	$3,107						$3,107	$3,107	*$2,352	$0			*$2,352	$10,000	$3,262	Incr. avg. 5%
Total Contributions	$218,280	$285,084	$242,199	$223,153	$31,166	$44,601	$37,123	$25,227	$129,769	$50,080	$242,199	$63,946	$167,230			$231,176	$323,000	$234,311	Incr. avg. 5%
Capital Campaigns																			
Capital Campaign	$0	$0		N/A															N/A
Wellness Garden Campaign	$195	$500		N/A	$165														N/A
Provisional Commitments																			
Planned Giving Donations	$0	$15,353	$0	$5,477	$0	$0	$0	$0	$0	$0	$0	$6,639				$6,639		$ -	N/A
Planned Giving Commitments	0	1	0	1	0	0	0	0	0	0	0	1						2	Incr. avg. by 1
Special Event Participation																			
Golf/Card Event Participants	130	91	130	110						130	130							116	Incr. avg. 5%,
Circle of Friends Event Attendees	42	0	62	33				62			62							35	Incr. avg. 5%
Community Walk Participants	0	0	99	99						99	99							104	Incr. avg. 5%
Cider in the Garden Participants	0	0										15				15		15	
Giving Tuesday												54				54		54	
Board & Employee Giving																			
Foundation Board-Unrestricted	10	9	10	4	1	1	1	6	0	3	10	4	2			6		11	
Foundation Board - Total	10	10	10	7	1	1	1	8	0	1	10	4	2			6		11	
Foundation Board Total Giving %	100%	100%	100%	60%	10%	10%	10%	80%	0%	10%	100%	36%	18%			55%		100%	Goal 100%
Governing Board-Unrestricted	12	10	12	5	4	5	3	4	1	4	12	5	0			5		12	
Governing Board - Total	12	12	12	7	4	5	3	4	1	4	12	5	0			5		12	
Governing Board Total Giving %	100%	100%	100%	60%	33%	42%	25%	33%	8%	33%	100%	42%	0%			42%		100%	Goal 100%
Adminstration-Unrestricted	6	6	6	2	6	6	6	0	0	0	6	6	0			6		6	
Administration - Total	6	6	6	5	6	6	6	0	0	0	6	6	0			6		6	
Administration Total Giving %	100%	100%	100%	71%	100%	100%	100%	0%	0%	0%	100%	100%	0%			100%		100%	Goal 100%
Management - Unrestricted	22	19	8	10	12	17	2	3	0	3	8	5	0			5		14	
Management - Restricted			6				4	1	1	0	6	4	0			4			
Management - Total	22	22	14	19	16	18	6	4	1	3	14	9	0			9		14	
Management Total Giving %	100%	100%	100%	86%	55%	82%	43%	29%	7%	21%	100%	64%	0%			64%		100%	Goal 100%
	FY 19 Actual	FY 20 Actual	FY 21 Actual	Average FY17-FY21	FY 2019 QTR 1	FY 2020 QTR 1	FY2021 QTR 1	FY 2021 QTR 2	FY 2021 QTR 3	FY 2021 QTR 4	Total YTD	FY 22 QTR 1	FY 22 QTR 2 3-10-22	FY 22 QTR 3	FY 22 QTR 4	Total YTD	Budget	Strat Goal for FY 2022	Explanation
Employee - Unrestricted	87	107	109		33	58	44	33	2	30	109	31	0			31			
Employee - Restricted			16				14	2	0	0	16	37	4			41			
Employee - Total Giving Campaign	113	132	125	99	56	72	58	35	2	30	125	68	4			72		129	Incr. to 30%
Employee Total Giving %	28%	35%	37%	24%	14%	19%	17%	10%	1%	9%	37%	20%	1%			21%		30%	based on 337 em
Cost Per Dollar Raised**																			
Fundraising Cost per $1 Raised	$ 0.64	$ 0.48		$ 0.56	$ 1.01	$ 0.87	$ 0.98	$ 1.31	$ 0.52	$ 0.61	$ 0.61	$ 0.45	$ 0.24					$ 0.50	
5 Year Rolling Average	$ 0.35	$ 0.40			$ 1.01	$ 0.87	$ 0.69	$ 0.71	$ 0.66	$ 0.67	$ 0.67	$ 0.61	$ 0.55						

**Giving Tuesday net returns are included in the Unrestricted Contributions & Totals.*

in the Unrestricted Contributions & Totals.

STOUGHTON HOSPITAL FOUNDATION

2022 MARCH MATCHNESS

Are you a FAN of your local healthcare team?

Dean Health Plan, TRICOR Insurance and Quartz are partnering with Stoughton Hospital Foundation to MATCH DONATIONS up to $3,000 during March Matchness!

Make a donation March 15th - April 4th
Give online at Stoughtonhealth.com

DeanHealthPlan
A member of SSM Health

TRICOR INC. INSURANCE

Quartz

STOUGHTON HOSPITAL FOUNDATION

Pick up your free basketball stress ball compliments of JP Cullen in the lobby of our hospital and clinics!

Community ONE MILE WALK

STOUGHTON HOSPITAL FOUNDATION

SATURDAY, JUNE 25TH

START TIME: 9:00 A.M.

LOCATION: STOUGHTON HOSPITAL
900 RIDGE ST

CHECK-IN: 8:00 TO 9:00 A.M.

WALK REGISTRATION IS $15 PER PERSON

SCAN TO REGISTER →

WWW.STOUGHTONHEALTH.COM/STOUGHTON-HOSPITAL-FOUNDATION/

SPONSORSHIP OPPORTUNITIES: DUE MAY 31

EVENT CO-SPONSOR - $1000.00

T-SHIRT LOGOS - $500.00 LARGE, $250.00 MEDIUM OR $100.00 SMALL

ALL PROCEEDS WILL GO TO THE STOUGHTON HOSPITAL FOUNDATION

QUESTIONS? PLEASE CALL THE STOUGHTON HOSPITAL FOUNDATION AT (608)873-2334

RECOGNITION EVENT AT 8:30 A.M. → LOCATED IN HOSPITAL WELLNESS GARDEN

IN RECOGNITION OF BERT AND MARV KLITZKE FOR THEIR DEDICATION AND SUPPORT OF THE STOUGHTON HOSPITAL FOUNDATION

Stoughton Hospital - Public Relations Board Report
February - March 2022
Prepared by: Laura Mays, Executive Director Foundation/PR Marketing

Highlights: **ADVERTISING/MARKETING**

Television

WKOW-Channel 27 – Fifteen sec. rotating spots on Wake Up WI, 11 am News, WIAA State Basketball, The View, & Rotators on Urgent Care, GERD talk and Ortho shoulder talk, Mid-day WI monthly talk on upcoming blood drive and Power of Attorney/Advanced Directives

WISC-Channel 3 –15 sec. spots on early AM news, 4 & 10 pm news, Price is Right & AM Early Show focused on urgent care locations, GERD Talk, and ortho shoulder.

WMTV-Channel 15 –15 second spots on Today Show, Kelly Clarkson, Rachael Ray, Tonight Show, 10 News, Jeopardy and Wheel of Fortune focused on urgent care, Feb. Blood Drive, GERD Talk, and ortho shoulder talk. Additonal spots on Weather Channel and 55 spots on CW network.

Charter/Spectrum Cable – Stoughton Health high frequency campaigns running with GERD TV, ortho shoulder talk and blood drive spots on BTN, News, HGTV, CNN, Lifetime, Oxygen, Golf Channel & other networks. and sponsor of News on the One Program with general branding, March Match tournament, Olympics with testimonials and general GERD and Ortho spots featured,

Fox 47 – 15 sec spots on 9 pm news, Big Bang Theory, Modern Family, Judge Judy, Sports Channels and Prime focused on urgent care, blood drive, GERD talk and Ortho shoulder talk.

TDS Cable – 30 sec. TV spot during Bucks focused on orthopedics and GERD, Olympics with blood drive, Ortho general, and GERD talk, bonus ads with Cardiology and Urgent Care

Oregon Cable – 15 sec. & 30 sec. updated TV spots and rotates multiple ads: Urgent Care, COVID-19 prevention, medical imaging, various insurances accepted, general surgery and ortho testimonials

Radio

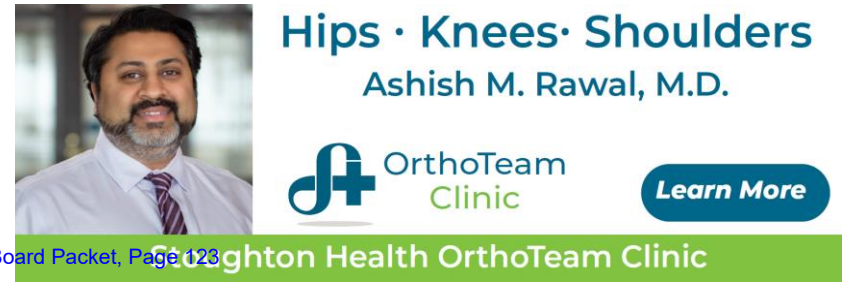
WSJY/107.3 & –30 second spots on air and streaming promoting urgent care locations, SAFE Sitter and blood drive in February at CHWC and GERD talk, Ortho shoulder talk and COVID vaccine confidence campaign

ESPN/100.5 –live mentions about customized knee, shoulder and GERD talks and paid spots running urgent care locations, blood drive spots in February, COVID vaccine campaign and Shoulder Ortho talk in early April

WOLX/94.9 – 15 & 30 sec. spots on air and streaming promoting virtual visits, variety insurance plans accepted, February blood drive, urgent care locations, SAFE Sitter classes, GERD talk, shoulder & COVID confidence campaign.

Print

- Press releases include: Advance Care Planning, Balance Class, Breast Recovery Retreat, Feb. Blood Drive, and other upcoming community education classes including GERD, Shoulder Ortho talk, yoga, and medicare 101
- Urgent Care ad highlighting three locations Stoughton, Cottage Grove and Evansville Community Guides
- OrthoTeam Shoulder Pain Relief class in April in *Madison Westside Neighbors and Lakeside* magazines
- Three Urgent Care locations highlighted in Healthy Living Section distributed to over 100k viewers in February issue
- Business Spotlight article and ad to promote OrthoTeam Clinic and upcoming shoulder class in multiple papers reaching over 100k households
- Article in Journey of Aging, a general overview of when to use UC/ER/Nurse Line



- BRAVA article focused on staying active with OrthoTeam Clinic with PAOrthopedics with Facebook posts and digital ads
- Multiple HR recruitment ads in various papers
- Direct mail pieces highlighting services and insurance of Stoughton Health mailed to over 25k service area households
- COVID Confidence/Get the FACTS print ads in local papers
- Wisconsin State Journal recruitment, COVID confidence, GERD and Shoulder print ads

Other

- Digital ad for OrthoTeam Clinic in BRAVA magazine
- Billboard on Hwy N, 51 near BBG's and Hwy 14 focused on Get the Vaccine and Facts and Hwy 138 Rehab and Sports Medicine Best of Madison
- OTT through TV, tablet, PC and phone focused on Urgent Care in month February
- Continue work with new website to automate event emails for reminders, evaluation and thank you for attending follow-ups
- Best of Madison Rehab and Sports Medicine nomination support
- Digital ad campaign focused on GERD with paid search of 14,389 impressions, 1248 clicks, 8.67% CTR (ave. 5.68% across hospitals and clinics) targeted display with 83,917 impressions, 213 clicks, .25% CTR (natl ave. .05-.09) and 11,918 you tube impressions with over 56% viewed in entirety and social media/facebook 32,668 impressions, 861 clicks, 2.64 CTR with 18 engagements
- Urgent Care and GERD talk digital display ad and geo fencing fitness centers, runs and events for 33,478 impressions, 113 clicks and CTR of .34% in February-March
- Multiple social media posts with focus on virtual classes, blood drive, foundation, community COVID-19 updates & testing and positive staff messages driving likes from 2215 to 2245, .014%
- Update digital screens in hospital, update community benefit form, screen savers, rack cards and elevator flyers promoting education classes, hospital programs, community events & hospital services

COMMUNITY HEALTH NEEDS ASSESSMENT/PLAN

- 2022-2024 CHNA strategic implementation plan preparation
- PR Staff to join Stoughton task force Continue staff and community education and training towards LGBTQ+, inequality, diversity
- Continued collaboration with JangoDX to provide COVID testing at CHWC
- Partner with Stoughton Wellness Coalition (SWC) Candidate Forum March 10th from 6-8 pm at the Council Chambers
- Connected with Stoughton Library to partner on supporting books for medical section where supply is low and demand is high and giveaway books on puberty *to the Girl 2 Girl program in Stoughton*
- Advance Directives talk in partnership with SWC
- Collaboration for Mayoral Candidate Forum with questions regarding social determinants of health
- Helping Brains Thrive Webinar March 14th with Dr. Andrew Louta promoted and shared in community
- Begin work with Reality Maze to be held April 22nd
- Work has began with Mayor Swadley to identify Alcohol Policy Subcommittee members

COMMUNITY EDUCATION CLASSES & EVENTS

- 01/18 – GERD – 35 registered, 31 attended
- 02/02 – StrongBodies – 4 registered, *series class, not completed
- 02/03 – Custom Knee – 78 registered, 56 attended
- 02/07 – Power of Attorney – 8 registered, 9 attended
- 02/18 – Blood Drive – 50 units of blood donated
- 02/26 – SafeSitter – 8 registered, 7 attended
- 02/28 – StrongBodies (2 classes) – 24 registered, *series class, not completed
- 03/08 – GERD – 34 registered, 23 attended
- 03/14 – Balance (Stoughton) – 6 registered,
- 03/14 – Balance (Oregon) – 10 registered,
- 03/17 – Medicare 101 – 3 registered,
- 03/21 – Kula Yoga Gentle Twists to Get Unstuck

BUSINESS DEVELOPMENT, PUBLIC RELATIONS & FOUNDATION

- 2/5/22 - Attended Oregon Chamber Annual Award Night with approx. 120 attendees
- 2/10/22 - Meeting with McFarland Chamber to plan for Family Festival and Couch to 5k run
- 2/17/22 - Meeting with Oregon Chamber Director, Police Chief and Board President for Summerfest involvement
- 2/17/22 – Virtual Meet and Greet for two new Orthoteam PA's Jennifer Hamilton and Clark Collins
- 2/24/22 - Attended Stoughton Chamber Annual Award Night
- 3/3/22 – Meeting with Amy Miller and Cynthia DiCamelli of Oregon CARES
- 3/4/22 – Meeting and tour of Oregon Youth Center
- 3/9/22 – Meeting with Oregon School District re: possible grant collaboration for childcare
- Drop off of rack cards and advertising in Oregon Community to bulletin boards of businesses, clinics, grocery stores
- Continue meetings with school, city, police and Stoughton chamber

FOUNDATION

- Annual foundation mail campaign to over 900 households, raised $25,144
- Meeting with Jerry Gryttenholm from Bryant Foundation to view and understand C-Arm equipment request, received 150k to be used for equipment
- March Match running March 15th – April 4th in partnership with Tricor, Quartz and Dean Health
- Just Desserts April 12th preparation for Foundation and Hospital joint update celebration
- Donation of over 9K for Women's Health initiative focused on Infinite Bundaries Retreat and Yoga for breast cancer patients-1 signed up
- Prepared 10k Main Street Bounceback Grant material for McFarland Urgent Care Clinic
- Prepared grant for Evjue Foundation, the charitable arm of The Capital Times requesting 12k for activity supplies and recliners for the Geri-Psychiatric Dept.
- Update of digital screens in lobby, communication boards and Daily Dose

*Attend Oregon Area Wellness Coalition, Stoughton Wellness Coalition, Joining Forces for Families, Partners, McFarland Library, Oregon Chamber Board, and area Chamber meetings and correspondence with Cottage Grove, Oregon, Stoughton, Evansville, McFarland, and Brooklyn.

A) One Year Appointments:

1) Steven Falconer, MD, Radiology, Madison Radiology, Courtesy
2) Mary Hickner, DPM, Podiatry, Independent, Active
3) Maria Fassari, MD, Hospital Medicine, Beam Healthcare, Active
4) Dana Ley, MD, Hospital Medicine, Beam Healthcare, Active
5) Mary Embrescia, MD, Psychiatry, ITP, Courtesy
6) Maria Askew, APNP, ITP, Allied Health Professional
7) Atul Sheth, MD, Psychiatry, ITP, Courtesy
8) Neza Bharucha, MD, Psychiatry, ITP, Courtesy
9) Naga Dharmavaram, MD, Hospital Medicine, Beam Healthcare, Active

Flagged Files: None at this time

B) Two Year Re-Appointments (Expedited Privileges)

1) Rebecca Hamman, NP, SSM, Allied Health Professional
2) Derek Hubbard, MD, Family Medicine, SSM, Courtesy
3) Clifford King, MD, Plastic Surgery, SSM, Active
4) Peter Lee, MD, Cardiology, SSM, Courtesy
5) Alisha Maly, PA, Emergency Med, SWEA, Allied Health Professional
6) Mark McDade, MD, General Surgery, SSM, Active
7) Robert Nerad, PA, Emergency Med, SWEA, Allied Health Professional
8) Paula Riebe, PA, Emergency Medicine, SWEA, Allied Health Professional
9) Cecelia Thompson, DDS, Dental, Children's Dental Center, Dental
10) David Worth, DPM, Podiatry, SSM, Courtesy
11) Thor Anderson, DDS, Dental, Independent, Dental
12) Drew Dean, MD, Emergency Medicine, SWEA, Active
13) Jennifer Hamilton, PA, Orthopedic Surgery, Sto Health, Allied Health Professional
14) Daniel Holt MD, Radiology, Madison Radiology, Courtesy
15) Richard Huntsman, MD, General Surg, SSM, Active
16) Andrew Laczniak, MD, Radiology, Madison Radiology, Courtesy
17) Krista Mosley PA, Emergency Med, SWEA, Allied Health Professional
18) Anne O'Connor, MD, Cardiology, UW, Courtesy
19) Andrew Schemmel, MD, Radiology, Madison Radiology, Courtesy
20) Sean Shannahan, MD, Radiology, Madison Radiology, Courtesy
21) Matthew Shore, MD, Radiology, Madison Radiology, Courtesy
22) Hugh Sugar, PA, Emergency Medicine, SWEA, Allied Health Professional
23) Robert Wells, MD, Radiology, Madison Radiology, Courtesy

Flagged Files: None at this time