

Medical Staff

Education Packet



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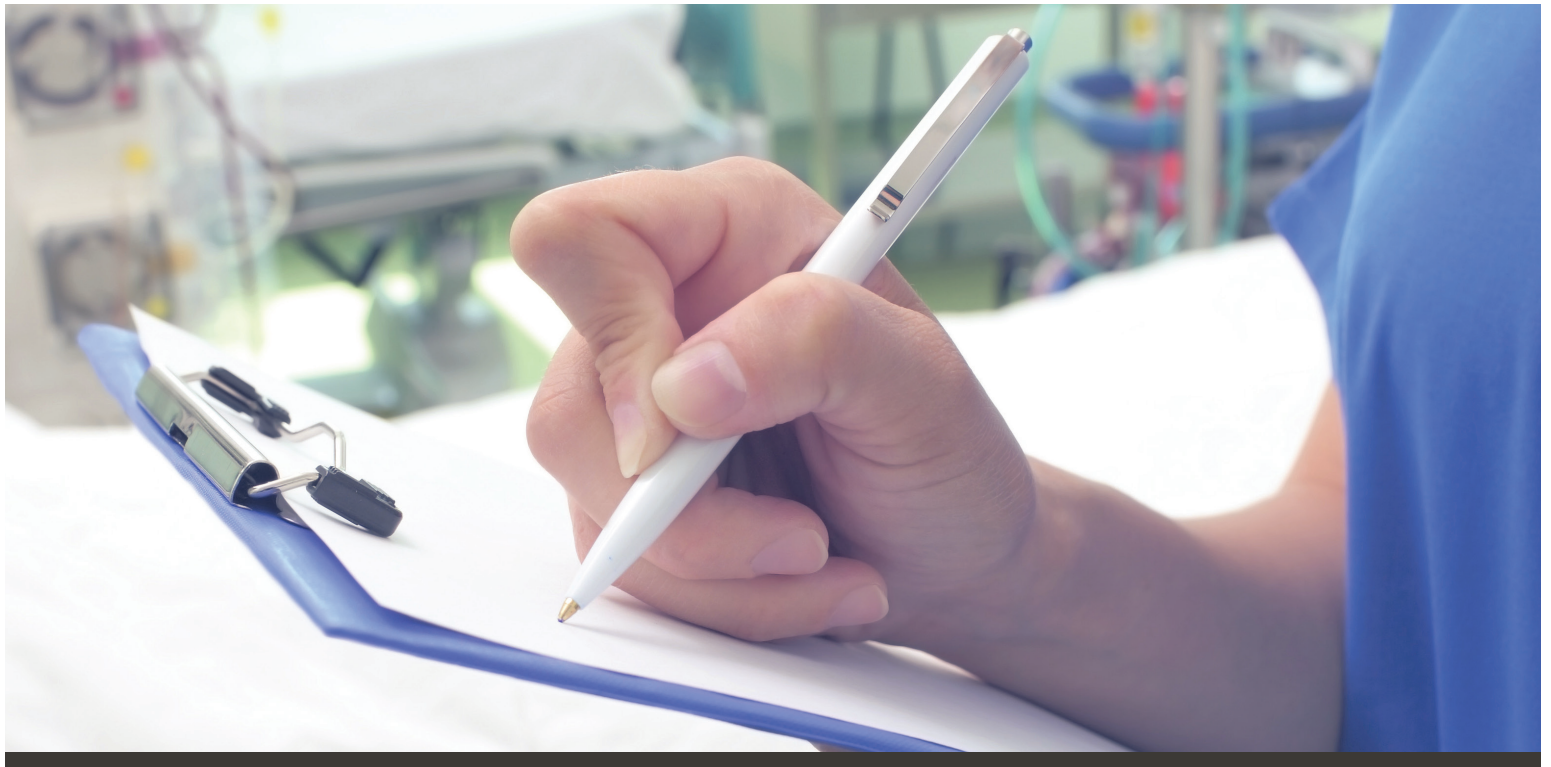
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Medical Staff Orientation & Education Acknowledgement

Initial and ongoing education are required by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) and Department of Health (DOH) for our practitioners, thus the following topics reviewed in the packet will ensure that the Hospital is in compliance with the standard requirements for the following:

- Accreditation Participation Requirements
- Environment of Care
 - Fire Safety
 - Emergency Codes
 - MSDS/Hazardous Materials
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- Safety Imperative
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 - Preventing and Detecting Fraud, Waste, and Abuse
 - Anti-Kickback Statutes
 - Stark Laws
 - Conflicts of Interest
 - Drug Free Workplace
- Reporting Concerns- HIPAA & Privacy
- Providing Information to Patients
- Medical Staff Office Directory



Accreditation Participation Requirements:

Federal deemed status

In order for a health care organization to participate in and receive federal payment from Medicare or Medicaid programs, one of the requirements is that a health care organization meet the government requirements for program participation, including a certification of compliance with the health and safety requirements called Conditions of Participation (CoPs) or Conditions for Coverage (CfCs), which are set forth in federal regulations. The certification is achieved based on either a survey conducted by a state agency on behalf of the federal government, such as the Centers for Medicare & Medicaid Services (CMS), or by a national accrediting organization, such as The Joint Commission, that has been approved by CMS as having standards and a survey process that meets or exceeds Medicare's requirements. Health care organizations that achieve accreditation through a Joint Commission "deemed status" survey are determined to meet or exceed Medicare and Medicaid requirements.

WA Department of Health (DOH) is required to inspect acute care hospitals every 36 months (if accredited by another approved organization such as the Joint Commission).

Any individual who provides care, treatment, and services can report concerns about safety or the quality of care to The Joint Commission or the Washington State Department of Health without retaliatory action from the hospital.

- The Joint Commission, Division of Accreditation Operations at complaint@jointcommission.org
- Washington State Department of Health, Office of Customer Service HSQA Complaint Intake, 360-236-4700, or hsqacomplaintintake@doh.wa.gov

The Joint Commission/WA DOH encourages anyone who has concerns or complaints about the safety and quality of care to bring those concerns or complaints first to the attention of the health care organization's leaders, which will often lead to more immediate resolution of the matter.



Environment of Care

Fire Safety: Code Red Fire Response

In the event of a fire, follow the acronym RACE/E:

Remove anyone in immediate danger.

Alert others by sounding the alarm

- Pull alarm pull-station
- Notify the switchboard- x8123

Confine the fire by closing all doors; close other doors/ windows in the immediate area.

Extinguish the fire:

- Retrieve a fire extinguisher and extinguish, if possible.
- Refer to Fire Extinguishers- Ratings & Use Policy

Evacuate all patients from the affected smoke compartment of the fire into the nearest unaffected smoke compartment, exit enclosure, or exterior exit.

- Do not take patients past the room of origin when relocating when possible.
- Take an outside route if necessary.
- Refer to YVM Fire Safety Plan
- **Important:** Close door behind you as room is evacuated and place a pillow or up-side-down waste basket in front of the door or mark an "X" on front of door with tape or non-permanent marker.

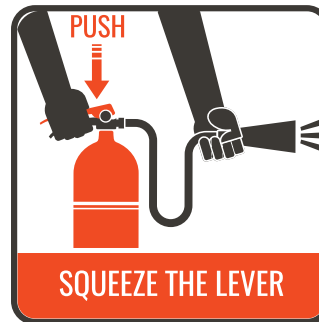
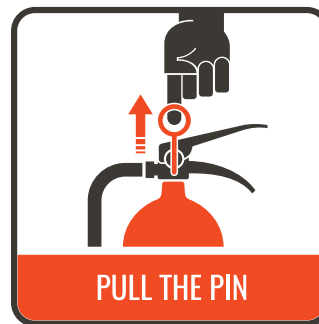
To use a fire extinguisher, follow the acronym PASS:

Pull the pin.

Aim at the base of the fire.

Squeeze the handles together.

Sweep from side to side.



Emergency Codes:

Code Name	Emergency Situation
CODE RED	Fire
CODE BLUE	Heart or Respiration Stopping
CODE ORANGE	Hazardous Material Spill
CODE GRAY	Combative Person
CODE SILVER	Person with Weapon/ Hostage Situation
AMBER ALERT	Infant/Child Abduction
EXTERNAL TRIAGE	External Disaster
INTERNAL TRIAGE	Internal Emergency
RAPID RESPONSE TEAM	Rapid Response Team
"CODE NAME" CLEAR	Repeated overhead twice to clear a code.

Material Safety Data Sheets (MSDS):

Are you familiar with the hazards posed by chemicals used in your workplace? Safety Data Sheets are available on the YVM intranet:

msdsmanagement.msdsonline.com/36bbfb14-796e-4328-9c65-aa59b945bb4d/ebinder/?nas=True

Safety and Security:

Safety/Security Dispatch can be reached 24/7 at 509-494-7233 (X8500). For off-site locations please dial 911.

All physicians, staff, volunteers and contractors are required to wear photo identification badges at all times while on duty.

Suspicious Individuals and Theft:

Suspicious individuals are those:

- Without proper identification.
- Without a reason to be on property.
- Who may be resistant to assistance by staff.
- Who may be displaying behavior that makes you feel uncomfortable.

We all have a responsibility to help ensure a safe and secure workplace. Do not be afraid to ask someone if they need assistance. Do not wait to report incidents or suspicious individuals to Safety/Security. It Only Takes Seconds to Become a Victim.

Phone Numbers

Report unauthorized persons to:

Emergency

Main Campus x8123

House Manager:
Vocera or x5660

Emergency

Off Site Locations 9-1-1

Security: Vocera or
731-7339

Facilities Management (**8 a.m. – 4 p.m, M-F**) 575-8052

If no answer: Engineer on duty (**24/7**) Pager 173-443

Violence in the Workplace

YVM Maintains a Zero Tolerance for violence in the workplace and prohibits threatening or actual violence. Some examples of these behaviors include:

- Inflicting or threatening injury or damage to another person's life, health, wellbeing, family, or property.
- Possessing a firearm, explosive, or other dangerous weapon anywhere within YVM.
- Abusing or damaging YVM or employee property.
- Using obscene or abusive language or gestures, or raising your voice in a threatening manner.

All incidents of workplace violence must be reported to Safety/Security immediately.

When confronted with a violent person or situation:

- *Attempt to distance yourself from the situation.*
- *Speak calmly and quietly.*
- *Ensure you have an exit route.*
- *Avoid aggressive body language.*
- *Avoid ultimatums.*
- *Call Code Gray x8123**
- *Alert co-worker(s).*
- *Contact Safety/Security Central Dispatch x8500**
**Outside of main campus, contact 9-1-1.*

Domestic Violence:

- Abusive behavior occurring between two people in an intimate relationship.
- Processes are in place to assist employees.

Parking:

Per YVM policy, all employees, physicians, and volunteers are required to park in their designated areas only.

Campus specific information and maps are located on the YVM [website](#).

Emergency Management:

The Emergency Operation Plan, outlines YVM's response to adverse incidents that impact day-to-day operations. In addition, YVM Medical Staff Bylaws and Policies contain information about expectations of medical staff during emergencies and disasters.

- Internal Triage: In-house disaster
- External Triage: Outside disaster with expected influx of patients

Your role during a disaster:

- **Any LIP desiring to help during a local disaster or emergency should report to the East Physician/Employee Entrance corridor for assignment.**
- Be familiar with the YVM Emergency Operation Plan.
- Keep current contact information on file with the Medical Staff Office.
- **Wear your YVM ID badge at all times** while working and have it with you when arriving to work during a disaster.
- In the event of a natural disaster or other emergency that significantly disrupts YVM's ability to provide care or increases demand for services, the hospital will activate the Emergency Operations Plan.
- Attending physicians are responsible for the care of their hospitalized patients. It is the responsibility of the physician on-call with the ER to maintain his/her on-call obligation.

Infection Control & Prevention

Hand Hygiene

As simple as it seems, hand washing prevents the spread of infection. Hand washing is the vigorous rubbing together of well lathered hands for 10-15 seconds,

followed by rinsing thoroughly under running water. CDC hand hygiene guidelines also encourage the use of waterless alcohol sanitizer. Yakima Valley Memorial has placed this product at the entrance/exit of patients' rooms for use by physicians, employees, volunteers, and visitors. Instant alcohol-based hand sanitizer is very effective.

Hand washing with soap and water is always recommended if the hands are visibly soiled, or if a patient with diarrhea is suspected of having C. difficile.

Be a leader in helping prevent infection by washing your hands.

The World Health Organization has identified the **My 5 Moments for Hand Hygiene** which define the key moments when health-care workers should perform hand hygiene:

1. *Before touching a patient,*
2. *Before clean/aseptic procedures,*
3. *After body fluid exposure/risk,*
4. *After touching a patient, and*
5. *After touching patient surroundings.*

Influenza

Influenza remains one of the top 10 causes of death in the United States despite availability of an effective vaccine to prevent it. Up to 20,000 Americans die from influenza and its complications each year, with an additional 200,000 hospitalized.

People who are pregnant or who have chronic conditions are at much higher risk for complications from influenza, as are the very young or old. Health care workers are at increased risk of exposure to persons with influenza infection, and if infected can spread the virus between patients, to other staff, or bring it home to their families. Approximately 50 percent of influenza infections for healthy people under age 50 are asymptomatic but still infectious, so it can be spread by someone who does not feel ill. For this reason, The Joint Commission includes flu vaccination rates for health care workers as a measure of patient safety.



Annually, prior to November 1st, all providers, employees, and volunteers are mandated to participate in the influenza vaccination program.

A vaccination schedule will be provided. If you have contraindications to the vaccine, (history of Guillain Barre Syndrome or documented religious objection) notify Employee Health at 574-5830 by October 1st. Declination forms are required to be updated each year. Mandatory masking will be required for all non-vaccinated YVM workforce during the entire flu season. The Joint Commission requires YVM to track and report on the aggregated flu vaccination rates for Medical Staff.

Isolation

Ordering isolation is a physician responsibility. Personal protective equipment (PPE) must be worn upon entering any isolation room, and hand hygiene must be performed after removing gloves. PPE includes gowns, gloves, masks and face shields, etc.

Information Management

Downtime Processes for Clinical Systems

Documentation: In the event of planned or unplanned clinical information system downtime, paper forms

are available for substitution in order that care and treatment of the patient may continue. When Downtime System is available, Login to Cerner Downtime System (red login screen) (see instructions in Downtime binder). Obtain printed Downtime packet for your patient(s) from Unit Secretary/Charge Nurse. This packet contains a blank provider order sheet to write Lab, Rad and Med Orders. Limit handwritten orders to ONE TIME only. NOTE: Handwritten orders for any ongoing "Continuous/Active" orders, such as maintenance IVs during downtime, provider will be required to enter the order into CERNER once it is back online.

For Discharging Patients: IF Depart process has not been completed, write DC orders and DC medication list, return to Unit Secretary/RN. **NOTE:** Discharge orders, medication reconciliation and discharge instructions will require entry into **CERNER** once it is back online.

As soon as Downtime Ends announcement is received, Logout of the Cerner Downtime System. Login to normal CERNER system (usual blue login screen) and provide care as usual. Enter any "Continuous/Active" orders into CERNER that were handwritten during downtime. Enter discharge order,

discharge instructions, and medication reconciliation handwritten during the downtime.

Registration

Registration of patients can also be continued in the event of computer system downtime. Procedures are in place in the Emergency Room and Admissions Department to facilitate.

Telecommunication

In the event of telecommunications downtime, there are walkie talkies available throughout the hospital for internal use, as well as a ham radio system in the event of an external disaster.

Laboratory

Laboratory Leadership

Laboratory Medical Director:

Dr. Sheila Lynam, MD | (509)575-8080

Laboratory Administrative Director:

Jessie Fisk, MT | (ASCP) (509)577-5004

Medical Necessity

The federal government will only pay for tests that are covered, reasonable, and medically necessary given the patient's clinical condition. Since labs do not treat patients, or make medical necessity decisions, it is important that the Physician, or other authorized individuals ordering lab tests, make an independent medical necessity decision on each lab test ordered and submit diagnosis information for each test ordered.

Lab Requisition Form

The information that you submit on a lab test requisition form or other approved order form must accurately reflect the medical reasons for requesting the specified tests. In addition, the medical necessity and order for each of the individual tests you order must be appropriately documented in the patient's medical record. If the necessary information is not provided or otherwise not clear, such as a diagnosis, then the hospital staff will contact the physician or other authorized personnel.

1. All orders received in the outpatient area must contain at the very minimum:
 - a. Patient's full name
 - b. Patient's date of birth
 - c. Laboratory tests
 - d. Ordering doctor's signature, if illegible, the doctor's name printed for verification
 - e. Diagnosis Code
2. When applicable requisitions will include:
 - a. Patient sex
 - b. Last menstrual period (for gynecologic specimens)
 - c. Date of specimen collection, and if appropriate, time of collection
 - d. Source of specimen, when appropriate
 - e. Clinical information, when necessary
 - f. Name and address of the physician, legally authorized person ordering the test, or name and address of the laboratory referring the specimen.
3. Outpatient orders can be obtained in ECW and chart connect, by fax or with the patient upon arrival.

Organ and Disease Panels

Medicare has a list of organ and disease related panels that are acceptable and chargeable to Medicare only when all components are medically necessary. Some tests in these panels may be subsets of other panels and may not be ordered together or on the same date of service. In addition, it is not appropriate to order the components of a panel individually.

Our available Chemistry Panels include:

Electrolytes (LYTE)

CL, CO2, K, NA

Basic Metabolic Profile (CX8P)

CL, CO2, K, NA, CA, GLU, BUN, CRE

Lipid Profile (LIPID)

CHOL, HDL, LDL, TG

Hepatic Function Panel (HFP)

TP, ALB, TBIL, ALP, ALT, AST, DBIL

Renal Profile (RENIP)

CL, CO2, K, NA, CA, GLU, BUN, CRE, PHOS, ALB



Comprehensive Metabolic Panel (CMP)

CL, CO2, K, NA, CA, GLU, BUN, CRE, TP, ALB, TBIL, ALP, ALT, AST

General Health Panel (GHP)

CMP, CBC, TSH

General Health Panel w/ Reflex TSH(GHPR)

CMP, CBC, TSHR

National Coverage Determinations ("NCD's") and Local Coverage Determinations ("LCD's")

NCD's and LCD's relate to a Medicare Carrier's (Payor) decision when and under what circumstances a service will be considered covered, reasonable and necessary, and what documentation will support the need for the service. The full text of the NCD's can be found using the CMS searchable Medicare Coverage Database found at cms.gov/mcd/search.asp?from2=search.asp&

Advance Beneficiary Notices ("ABN's")

If a test is determined to not be reasonable and necessary, the patient will be asked to sign an ABN. An ABN is a notice to a patient that the government may not pay for the test(s) and that the patient may be personally responsible for the cost of the test(s).

If you order a test(s) for a patient that is not considered medically necessary by the NCD/LCD guidelines, please present the patient with an ABN form, explain that the ordered test may not be covered, and have the patient fill out the ABN at your office prior to sending the patient and/or a specimen to the hospital. If the patient brings a signed ABN, or a signed ABN is provided with the specimen, this will significantly expedite our process as well as reduce any inconvenience to you or your patients.

Customized Profiles

Each test in a customized profile must be covered, reasonable, and necessary, otherwise Medicare will not pay for the test and an ABN will be necessary.

Standing Orders

The hospital will allow the use of standing orders when executed in connection with an extended course of treatment and written for a fixed period of time, not to exceed one year. These standing orders will require periodic review annually by the ordering physician to verify continued medical necessity.

Transfusion Ordering

Anti-CMV Negative Blood Products: Order indicated for immunocompromised patients- fetuses, low-birthweight premature infants who are born to

CMV-seronegative mothers and CMV-seronegative recipients of solid-organ or allogenic hematopoietic cell transplants from sero-negative donors.

CMV does not appear to survive in frozen/thawed plasma products.

Irradiated Blood Products: Cellular blood components can be irradiated to prevent Graft vs Host Disease. (See

Table below for indications per the AABB)

Reference Lab Resources: If in doubt about reference lab test ordering, please contact the send-out department at 509-576-3889.

If you are unsure of the best testing course, a physician can be consulted at Mayo Medical Laboratories,

Irradiation Indicated	Irradiation usually not indicated
<ul style="list-style-type: none"> • Intrauterine transfusions, low birthweight, prematurity or erythroblastosis fetalis in newborns • Congenital immunodeficiencies • Hematologic malignancies or solid tumors (neuroblastoma, sarcoma, Hodgkin disease) • Peripheral Blood stem cell/ bone marrow transplant • Components that are crossmatched, HLA matched, or directed donations from family members or other related donors • Fludarabine therapy • Granulocyte components 	<ul style="list-style-type: none"> • Patients with HIV • Full-term infants • Non-immunosuppressed patients

Frozen plasma products are generally not irradiated because they are considered noncellular components.

Turnaround Times (Approximate)	
Type and Screen	45 mins
Type and Screen with Cross Match • No antibody present	45 mins <i>*May vary depending on how many Antibodies the patient has. Blood Bank might have to order blood from the American Red Cross</i>
Type and Screen with Cross Match • With antibody present	*2 hrs
Add on Cross Match Without an antibody • Type and Screen already done	20 mins
Add on Cross Match With an antibody • Type and Screen already done	*45 min- 1 hr
*May vary depending on how many Antibodies the patient has. Blood Bank might have to order blood from the American Red Cross	

If you have any questions on ordering please call Blood Bank directly at 509-575-8526

1-800-533-1710 (Account # C7000525), 24/7. They can match you with an expert in the field to help with testing algorithms.

If genetic testing is to be ordered, please contact the Genetics department prior to test ordering. Genetics (routine referrals / questions) 575-8160

Inpatient Consults / Off-hour urgent issues 969-0093

Reflex Testing

Reflex testing occurs when initial test results are positive or outside normal parameters and indicate that a second related test is medically appropriate. It is the policy of this facility to only perform reflex testing when indicated with the physician's original order, in a new physician order, or pursuant to the laboratory policy on reflex testing as approved by the Hospital Medical Staff (see below). Physicians must provide a written order if they want to override reflex testing performed pursuant to the written lab policy.

Current reflex testing by laboratory policy:

1. TSHR: Free T4 will be added if the TSH is abnormal
2. URCIF (UA Culture if Indicated): Culture will be added if:
 - a. Nitrite is positive

Or

- b. Leukocyte esterase is 1+ or greater

Or

- c. WBC >5/HPF

And

- d. Squamous Epithelial cells <3+/HPF
3. URFLX: Urine Chemistries will be performed with a reflex to urine microscopic if required.
4. URFLXI: Urine Chemistries will be performed with a reflex to urine microscopic if required. A culture will be added if required as URCIF above.
5. HIV: Confirmation will be sent to reference lab if HIV reactive.
6. HCV: Confirmation will be sent to reference lab if HCV reactive.

7. PSARF: Free PSA will be added if PSA is abnormal.

Legal

As part of this notice to physicians, the Office of Inspector General (OIG) has requested that we inform all ordering physicians that they take the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or other remedies available under civil, criminal, and administrative law.

We realize that you have choices and appreciate that you have chosen to use Yakima Valley Memorial Laboratory. If you have any questions or comments, please do not hesitate to call.

Sincerely,

Dr. Sheila Lynam, MD

Laboratory Medical Director

Jessie Fisk, MT (ASCP)

Laboratory Administrative Director

Leadership

Mission: Achieving health with you in new ways.

Vision: Creating healthy communities one person at a time.

Values

Respect: Recognizing our differences as strengths, affirming each other, and valuing each other's contributions.

Accountability: Taking responsibility for our actions, being trustworthy and demonstrating integrity.

Teamwork: Healthcare is best delivered by a team working together, sharing unique talents, perspectives, ideas and efforts to achieve our Vision.

Stewardship: Effective & efficient use and preservation of resources (human, environmental, financial, and community).

Innovation: Creating and implementing original, visionary, inventive, solutions in pursuit of excellence.

Quality & Safety

At Memorial, patients and families come first. We value a safe, reliable, high quality and coordinated experience with a focus on reducing health disparities. By demonstrating cultural sensitivity, we show respect to all individuals.

People

Memorial is a great place to work that values a diverse and inclusive workforce. By focusing on workforce development, communication, and recognition of excellent work, we demonstrate our commitment to employee and provider engagement.

Patients & Families

Sustainability

Memorial will maintain a positive operating margin to fund capital needs and strategic priorities. By implementing best practices that improve our financial health, we can ensure ongoing services to the communities we serve.

Growth

Memorial will continue to grow ambulatory and specialty services and community partnerships. We will increase and simplify access to services across the continuum of care.

Medical Staff

Professionalism

Collegiality, collaboration, and professionalism are essential for the provision of safe and competent patient care. Accordingly, all Practitioners at YVM must treat others with respect, courtesy, and dignity, and must conduct themselves in a professional manner. To that end, all Medical Staff Members shall conduct themselves in a professional and cooperative manner and will refrain from engaging in unprofessional, disruptive conduct. Language, non-verbal behavior and gestures, attitudes, etc. shall reflect this respect and dignity of the individual and affirm his/her value to the process of effective efficient health care. See the Medical Staff Professionalism Policy.

"Unprofessional Conduct" is conduct that is inconsistent with the ethical obligations of health care professionals or that adversely affects the health care team's ability to work effectively. Unprofessional Conduct includes behavior that has a negative effect on morale, concentration, collaboration, and communication. Unprofessional Conduct by Medical Staff Providers is prohibited.

Examples of unprofessional conduct include, but are not limited to the following:

- abusive or threatening language directed at patients, nurses, students, volunteers, visitors, Hospital personnel, or Practitioners (e.g., belittling, berating, or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);
- degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital;
- refusal or failure to answer questions or return phone calls or pages in a timely manner as defined in the MS Bylaws documents or other applicable policies;
- intentional misrepresentation to Hospital administration, Medical Staff Leaders, other Practitioners, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;
- offensive language (which may include profanity or similar language) while in the Hospital or while speaking with patients, nurses, or other Hospital personnel;
- retaliating against any individual who may have reported a quality or behavior concern about a Practitioner, provided information related to such a matter, or otherwise been involved in the professional

practice evaluation/peer review process in any way;

- unprofessional physical contact with another individual or other aggressive behavior that is threatening or intimidating;
- throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;
- repeatedly failing to maintain and renew in a timely manner all credentials required by the MS Bylaws;
- derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate MS or Hospital channels;
- unprofessional medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual, or criticizing the Hospital or the Hospital's policies or processes, or accreditation and regulatory requirements;
- altering or falsifying any medical record entry or hospital document;
- engaging in a pattern of behavior in which medical record entries are based on a template without considering the care actually provided to the patient, or in which the "copy and paste" or "pull forward" functions of the medical record are used to populate fields without verifying that the information is accurate for the patient in question;
- refusal or failure to use or use properly documentation technology;
- unprofessional access, use, disclosure, or release of confidential patient information;
- audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;
- use of social media in a manner that involves Unprofessional Conduct as defined herein;
- disruption of hospital operations, hospital or Medical Staff committees, or departmental affairs;
- refusal to abide by MS requirements as delineated in

the MS Bylaws, Rules and Regulations, or other MS policies.

- sexual harassment and other Identity-Based Harassment, which includes but is not limited to verbal or physical conduct that is unwelcome and offensive to an individual who is subjected to it or who witnessed it; could be considered harassment from the objective standpoint of a "reasonable person"; and is covered by state or federal laws governing discrimination. This includes but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.
- depending on the circumstances, any of the examples of Unprofessional Conduct may also qualify as Sexual Harassment or other Identity-Based Harassment.

Impaired Practitioner:

The term "impaired" is used to describe a practitioner who is prevented by reason of illness or other health problems from performing professional duties at the expected level of skill and competency. Impairment also implies a decreased ability or willingness to acknowledge the problem or to seek help to recover. It places the practitioner at risk and creates a risk to public health and safety.

Some signs of impairment are deterioration of hygiene or appearance, personality or behavior changes, unpredictable behavior, unreliability or neglecting commitments, excessive ordering of drugs, lack of or inappropriate response to pages or calls, and decreasing quality of performance or patient care.

Alertness to signs of impairment in oneself is critical in identifying and preventing professional dysfunction leading to adverse outcomes of care. We believe such alertness may lead to early intervention, which can restore a professional's healthy functioning before more serious problems develop.

If you believe a practitioner is impaired by drug use, including alcohol, contact the appropriate agency:

Washington Physicians Health Program

(MD, DO, DDS, DPM, or PA):

206-583-0127 or 800-552-7236

Washington Health Professional Services

(ARNP, RN, LPN, Psychologists):

360-236-2880

Pain Management

The goal of pain management therapy is not to completely eliminate pain, but to effectively control pain so that the patient can engage in therapeutic activities.

A balanced approach to pain management provides for patient comfort while minimizing the adverse side effects of the medications used to treat pain.

Transfer of Patient to an Outside Facility

The attending physician of record (or his/her same-specialty on-call/covering physician) is responsible for initiating the order for transfer of a patient and for direct communication with an accepting physician at the receiving facility, in the absence of a formal written order by a consultant accepting responsibility for arranging a transfer and communicating with the receiving physician.

In the event that a consulting sub-specialist determines that a patient should be transferred to an outside facility for urgent or emergent care not available at YVM, and the attending physician and/or her/his designee is not immediately available, the consultant should initiate the order for transfer and should communicate with the accepting physician to facilitate timely transfer. In the event that the attending physician is immediately available and initiates the transfer process, the consultant must remain available to communicate with the accepting physician if there are any questions re: patient status/findings.

The Nursing Supervisor will be immediately notified when an order for transfer is initiated and will implement a checklist documenting all necessary steps including physician-to-physician communication.

Medication Management

Antimicrobial Stewardship

Antimicrobial Stewardship (AMS) practices for the Yakima Valley Memorial Family of Services (YVM FOS) include, but are not exclusively limited to:

- Providers are obliged be familiar with the local resistant rates of clinically important pathogens

encountered within their scope of practice. The antibiogram is the YVM document aggregated from local clinical isolates use assist providers in the selection of appropriate antibiotic therapy under the care of YVM FOS. This document is updated annually and accessible through the YVM intranet home page (link address listed at the end of the document).

- Use of locally appropriate antibiotic guidance/ protocols as determined by current standards of care, evidence-based best practices, and the local patient population served by the YVM FOS.
- Restriction of specialized antibiotics limited to specific indications and/or requires authorization/review by the antibiotic stewardship service/Pharmacy & Therapeutics committee approved provider service lines. These agents are categorize (e.g. non-formulary, restricted, monitored, and unrestricted) and detailed within the YVM antibiogram document.
- Ongoing AMS education processes are directed to the needs/interests of both staff and licensed independent practitioners involved in the prescription of antibiotic therapy. Ongoing education will be directed to needs/interests of the YVM FOS stakeholders.
- The AMS service provides prospective review (i.e. real time). The service will contact the responsible provider, when appropriate, to discuss relevant patient specific issues at the initiation and/or after 48 hours of antibiotic therapy. The AMS service functions under the guidance of YVM's Antimicrobial Stewardship Steering Committee (ASSC).
- The Antimicrobial Stewardship Steering Committee (ASSC) will report information, such as antibiotic use and other relevant data, to specific departments/ provider groups to provide feedback and identify potential patient/local public-health centered opportunities.

National Patient Safety Goals

Anticoagulation Therapy

One of The Joint Commission National Patient Safety Goals (NPSG) for safe use of medications addresses the use of anticoagulants. Anticoagulation medications are more likely than others to cause harm due to complex



dosing, insufficient monitoring, and inconsistent patient compliance. To achieve better patient outcomes, the use of standardized practices for management of anticoagulant therapy and a focus on patient education are vital components of an anticoagulation therapy program. In fact, patient education regarding key aspects of warfarin therapy continues to be a part of the Centers for Medicare and Medicaid Services (CMS) Clinical Quality Measures. In addition, health organizations will be asked to demonstrate improvement in care coordination along with patient and family engagement through Value Based Purchasing and Meaningful Use measures. Effective patient engagement and anticoagulation patient education can be achieved through face-to-face interaction with a trained professional who works closely with patients to ensure that they understand the following: importance of compliance, the possibility of food-drug interactions, the potential for adverse drug reactions and interactions, and where and when to have follow-up monitoring.

YVM's Anticoagulation Management policy delineates how anticoagulants will be ordered, dispensed, and administered to ensure the safe and effective use of these high-risk medications. You can ensure compliance with both the NPSG and CMS standards by

assuring education for patients being discharged on anticoagulants include clear instructions for:

- Dose and importance of follow-up monitoring
- Compliance
- Drug-food interactions
- Potential for adverse drug reactions and interactions

Clinical Alarm Management

The Joint Commission requires education related to the National Patient Safety Goal (NPSG): Improve the safety of clinical alarm systems. Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. Patient care areas have numerous alarm signals, and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. It is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. To improve the safety of clinical alarms, YVM has created an Alarm Management Team whose functions include:

- Development of alarm management policies and procedures.
- Determine the default alarms for equipment being used.
- Continuously review new technologies in the marketplace to assess for additional alarm management safety features.
- Work to change employee culture around alarm management.
- Standardize monitoring practices across clinical environments.

Prevent Spread of Multi-Drug Resistant Organisms (MDRO):

- Place all patients with any history of colonization or infection with MRSA, VRE, gram-negative MDROs (ESBL, CRE), or any organism with a contact isolation flagged on microbiology report in Contact Precautions. This flag indicates the organism has resistance to 2 or more antibiotic drug classes from its baseline. Place patients with *C. difficile*, Rotovirus, or Norovirus in Contact Enteric Precautions.
- Perform hand hygiene, don gown and gloves when entering room, remove all PPE and wash hands after removing PPE and before leaving room. Always wash hands with soap and water when leaving a Contact Enteric Isolation Precaution room.
- Use patient dedicated equipment or always disinfect all equipment between patients, such as your stethoscope. Use Chlorine wipes for equipment that was in a Contact Enteric Isolation room.
- Educate the patient, family, and visitors about the importance of hand hygiene and the purpose and use of contact precautions.

Prevent Central Line Associated Bloodstream Infections (CLABSIs):

1. *Evaluate the clinical need for a central line before insertion and during daily rounds. Remove it as soon as it is no longer indicated.*
 - Follow appropriate indications:
 - Chemotherapy medications
 - Vesicant medications
 - Hypertonic Saline

- Long term antibiotics only when a peripheral IV (PIV) is not appropriate
- Need for Central Venous Pressure (CVP) monitoring
- Potassium in a concentration greater than 20 mEq/50mL
- Total Parenteral Nutrition (TPN)
- Vasoactive medication administration

2. When inserting a central line, follow these best practices:

- Follow the Hand Hygiene policy and remove jewelry before procedure.
- Wear a mask, cap and sterile gown; assistants and the patient (if possible) should also wear a mask
- Use a pre-packaged tray or pre-filled insertion cart, or kit.
- Prepare clean skin at insertion site using CHG and allow to dry COMPLETELY.
- Drape the patient with maximum barrier precautions from head to toe.

Prevent Surgical Site Infections (SSIs):

- Clean and prep the surgical site with Chlorhexidine gluconate and alcohol containing surgical skin prep (if not contraindicated); hair removal should be avoided unless it interferes with surgery and if necessary, clippers will be used instead of razor outside of the surgical suite; routine preoperative bathing with chlorhexidine decreases skin surface pathogen concentrations, include patient in recommendations for bathing the day before and morning of surgery.
- Give first dose of antibiotic prophylaxis within 60 minutes prior to the incision; or within 2 hours for vancomycin or fluoroquinolones, re-dose antibiotics to maintain adequate tissue levels based on agent half-life, discontinue within 24 hours or sooner after pre-op dose, if not contraindicated.
- Perform surgical scrub on hands/forearms prior to gloving; minimize traffic during surgery; and perform hand hygiene before and after examining patient/wound, including when wearing gloves.

- Teach patients how to care for themselves at home after surgery (document the education on discharge instruction sheet). Examples include: use clean (freshly washed) sheets and clothes, care for wound, dressing and drains, do not pick at the surgical wound, do not allow pets near your incision, good hand hygiene particularly before touching dressings or incisions, and healthy eating.

Prevent Catheter Associated Urinary Tract Infections (CAUTIs):

1. *Evaluate the clinical need for an indwelling catheter before insertion and during daily rounds. Remove as soon as it is no longer indicated. Consider alternatives to the urinary catheter such as the condom catheter, diaper, bedpan, or daily weights etc. Communicate the plan for removal during rounds.*
 - Place an order in the electronic chart for an indwelling urinary catheter.
 - Follow appropriate indications:
 - Perioperative use for selected surgical procedures (e.g., surgeries involving the genitourinary tract, anticipated prolonged surgery, operative patients with urinary incontinence, need for intraoperative hemodynamic monitoring, patients anticipated to receive large volume diuretics during surgery).
 - Need for accurate (hourly) urine output in critically ill patients.
 - Management of acute urinary retention and urinary obstruction. A bladder scan should be used as part of the evaluation. When a bladder scan shows 500ml of urine or greater, notify the physician.
 - Assistance in pressure ulcer healing for incontinent patients (stage 3 or 4 sacral decubitus).
 - As an exception, at patient request, to improve comfort and quality of care (i.e., end of life care, hospice/comfort/palliative).
 - For temporary use when the patient has received an epidural during labor and delivery.

2. Follow urine culturing best practices:

- Avoid routine cultures.
- Never pre-inflate the balloon.
- Follow appropriate indications (see above).
- Only trained healthcare professionals should insert urinary retention catheters.

Rapid Response

- The Rapid Response Team brings critical care skills to the bedside. They will respond expeditiously to a decline in a patient's condition.
- If you have concerns about a patient and feel they need immediate and urgent help, please contact the nursing staff and they will call a Rapid Response team.
- Families and patients are instructed to call an SOS in the event of a need for emergency or urgent help.

Provision of Care

Restraint & Seclusion

A collaborative approach is taken in reviewing the need for use of restraint, and efforts are focused upon working toward the least restrictive, effective measures for safety. Non-physical techniques are the preferred intervention in behavior management, and prevention of emergencies that have the potential to lead to restraints or seclusion is the optimal goal. Restraint and seclusion is limited to emergencies in which there is an imminent risk of a patient physically harming himself/herself, staff, or others, and non-physical interventions would not be effective.

Physicians and other licensed practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) are required to have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

Behavioral (Violent/Destructive Behavior) Restraints-

A psychiatrist on the Behavioral Health Unit or a Physician/Advanced Registered Nurse Practitioner order must be obtained as soon as possible. The Physician/Advanced Registered Nurse Practitioner must see the patient within 1 hour of seclusion initiation. (See Behavioral [Violent/Self-Destructive Restraint] Restraint and Seclusion Policy & Behaviorally Disturbed Patient Management Standard Work).



Assessment, Restraint Criteria

When the restraint is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member(s), or others, a physician must see the patient face-to-face within 1 hour after the initiation of the restraint. This physician must evaluate and document:

- The patient's immediate situation;
- The patient's reaction to the intervention;
- The patient's medical and behavioral condition;
- The need to continue or terminate the restraint.

If the face-to-face evaluation is conducted by a physician other than the attending physician, the attending physician who is responsible for the care of the patient must be consulted as soon as possible after completion of the evaluation.

Implementation and Orders:

When restraint or seclusion is initiated for behavioral health purposes, the physician does the following:

- Reviews with staff the patient's physical and psychological status.
- Determines whether restraint or seclusion should be continued.

- Guides staff in identifying ways to help the patient regain control

There must be a **written, time-limited order**

Four hours for patients ages 18 and older

Two hours for patients ages 9 to 17

One hour for patients under age 9

- When restraint or seclusion is initiated without an order by a physician, within one hour, qualified staff does the following:
 - Notifies the physician as soon as possible
 - Obtains an order (verbal or written) from a physician.
 - Consults with the physician about the patient's physical and psychological condition.
- At the time of the in-person evaluation of the patient who is in restraint or seclusion for behavioral health purposes, the physician does the following:
 - An evaluation of the patient's immediate situation
 - The patient's reaction to the intervention
 - The patient's medical and behavioral condition
 - The need to continue or terminate the restraint or seclusion



Non-Violent Restraints

- The Licensed Practitioner (LP) will complete the order for each episode of restraint.
- LP determines the need for reordering restraints based on the reassessment
- Completion of a written order by the licensed practitioner is required to reinstitute restraints beyond the initial episode.
- LP will participate in the daily review and restraint reduction measures

Assessment, Restraint Criteria

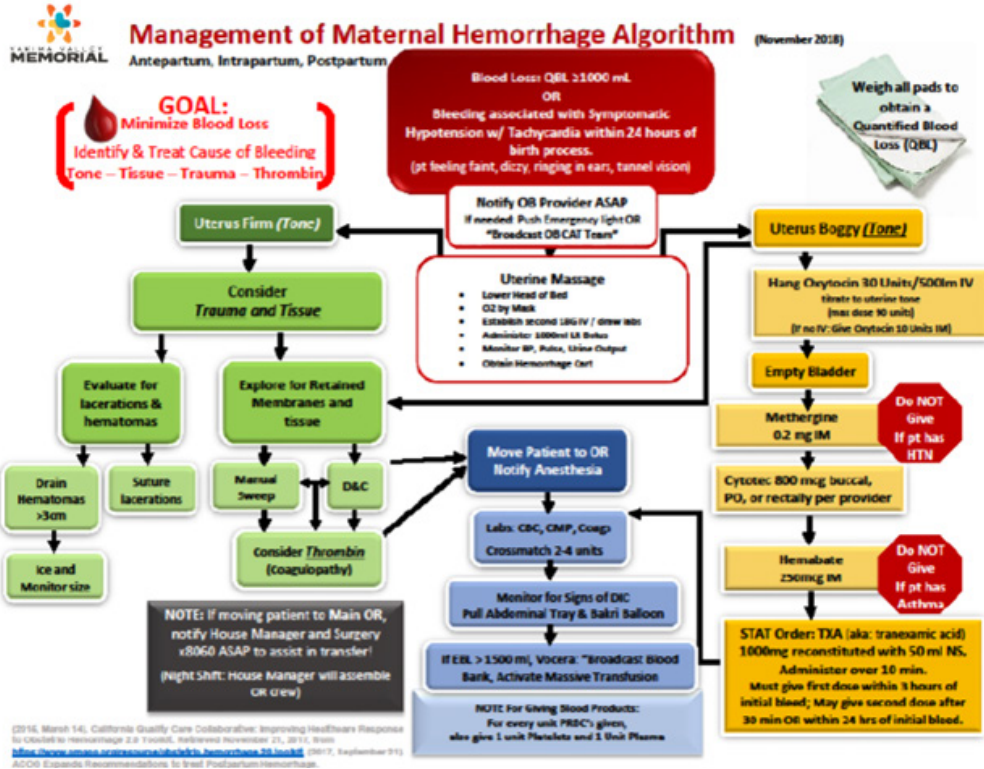
- The patient is assessed by the registered nurse or physician to determine if the patient is at risk for interfering with medical treatment, including:
 - 1.** *Pulling at medical appliances;*
 - 2.** *Attempting independent ambulation but unable to do so/high risk for falls*
 - 3.** *Unable to follow commands/direction with lack of insight or judgment*

Implementation and Orders

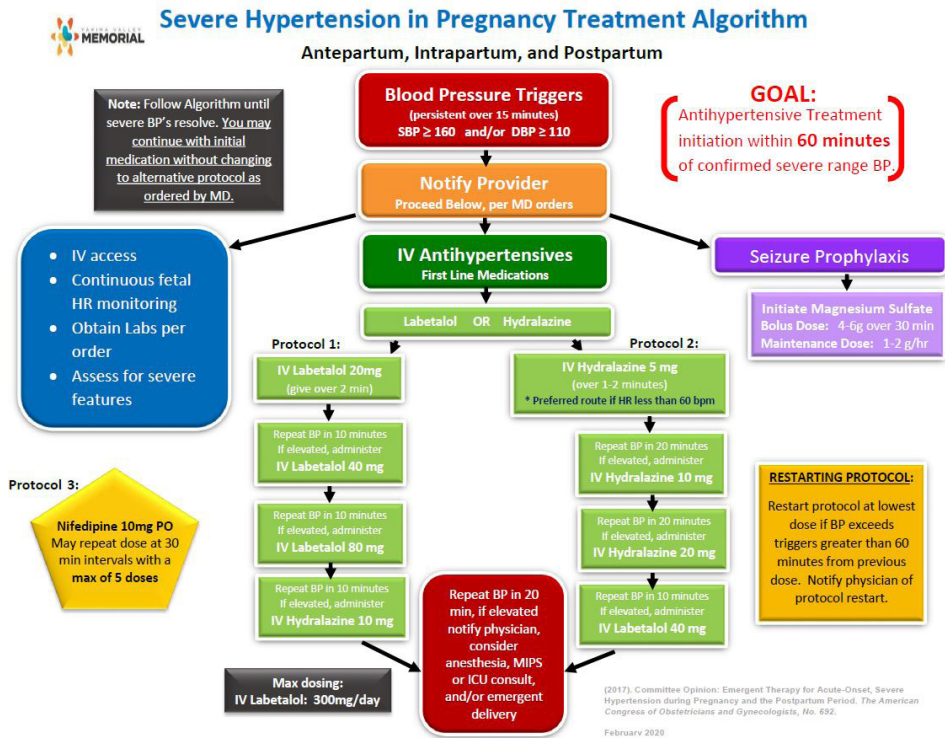
- In a non-emergent situation the registered nurse must obtain an order
- There must be a written order by a physician for restraints.

- The order must include: reason for use, and type of restraint.
- If a physician is not available to issue such an order; restraint use may be initiated by a registered nurse on an emergent basis.
 - In that case, a physician is notified during the emergent application or immediately after the restraint has been applied. A verbal or written order is obtained.
 - The attending physician must be consulted as soon as possible if the attending physician did not order the restraint.
- **Note: PRN orders for restraints are prohibited**
- Death Reporting Requirements: Hospitals must report deaths associated with the use of restraint. The hospital must report to CMS each death that occurs while a patient is in restraint at the hospital.

Maternal Hemorrhage



Maternal Severe Hypertension



Pre-eclampsia- Blue Band Initiative

The Blue Band Initiative has been implemented as a communication tool to Emergency Department staff and other medical providers to more easily identify women who present for care in the post-partum period who are at high risk for pre-eclampsia. Any woman who is monitored or treated for hypertension during pregnancy or in the post-partum period will have a blue neoprene wristband placed on them. The patient is instructed to wear the band through her delivery and until her 6 week follow up exam with OB provider. The patient is instructed to not remove the band until that time.



Fluoroscopy Radiation Protection*

A fluoroscopically guided interventional (FGI) procedure is the practice of medicine while using fluoroscopy systems to conduct diagnostic or therapeutic interventional medical procedures via percutaneous or other access routes in order to localize or characterize a lesion, diagnostic site, or treatment site; to monitor the procedure; or to control and document therapy.

- All Radiation workers must adhere to ALARA principles to keep radiation exposure "As Low As Reasonably Achievable". This also includes knowing your equipment and using the equipment's features appropriately to help reduce exposure to patients and staff.

For the patient:

A Substantial Radiation Dose Level (SRDL) is the quantity of radiation exposure which will require additional dose management actions. The fluoroscopy unit will provide an approximation of patient exposure during the procedure. The SRDL is chosen to be 5000 mGy. This value is chosen because an exposure dose exceeding this level may result in permanent consequences. At 4500 mGy, the physician will be informed that the patient is approaching 5000 mGy of

exposure. When reached, the physician will be informed that 5000 mGy has been reached and asked if he/she intends to proceed. All cases with ≥ 5000 mGy will have a Patient Safety Alert (PSA) entered into the Safety Event Manager (SEM/RLDatix). The expectation is that physicians will ensure their patient receives adequate follow-up post-procedure for those cases ≥ 5000 mGy. There is no implication that a radiation level below an SRDL is absolutely safe or that a radiation level above an SRDL will always cause an injury. (NCRP 168). For the Radiation Worker:

- C-Arm Notice- Surgeons and applicable personnel on the case MUST have their Dosimetry badge on before case can start! The dosimeter badge will be worn on the collar outside of the lead protective apparel. The Radiation Safety Officer may require the radiation worker to wear additional badges depending on the level of exposure.
- Lead protective apparel is required:
 - A skirt type lead apron design is advised to distribute weight. A 0.25mm lead equivalence but with overlap on the front will provide 0.5mm on the front and 0.25mm on the back which provides >90% protection. [Required]
 - Lead glass eyewear with side protection [Optional]
 - Thyroid shield [Required]
 - Leaded gloves are available. [Optional]
- Make good use of time-distance-shielding (TDS) principle
 - Minimize time
 - Maximize distance as much as clinically possible (step away from the table when using cine; use injector whenever possible).
 - Maximize shielding:
 - Use ceiling suspended screens, lateral shields and table curtains. They provide more than 90% protection from scattered radiation in fluoroscopy.
 - Mobile floor shielding is advisable when using cine acquisition.
 - Disposable scatter shielding placed on patient is available and optional.

- Keep hands outside the primary beam unless totally unavoidable. Hands inside the central area of the primary beam will increase exposure factors (kV, mA) and doses to patient and staff.
- Only 1-5% of radiation passing through the patient's body exits to the other side. Stand on the side of the transmitted beam (i.e. by the detector), which contains only 1-5% of the incident radiation and its respective scatter.
- Keep X-ray tube under the patient table and not over it. Undercouch systems provide better protection from scattered dose.
- Use personal dosimetry
 - Your Radiation Safety Officer or Department head may recommend/require additional dosimeters.
 - Wear dosimetry outside the apron at neck or eye level if in the fluoro room.
- Update your knowledge about radiation protection! Radiology staff require annual safety training.
- Radiation workers who are pregnant must immediately inform their manager.
- Address your concerns about radiation protection to your Radiation Safety Officer, Dr. Cheryl Davison.

* iaea.org/sites/default/files/documents/rpop/poster-staff-radiation-protection.pdf

Additional information available:

iaea.org/resources/rpop/resources/training-material#10

Emergency Medical Treatment and Labor Act (EMTALA)

When an individual comes to YVM and a request is made on his/her behalf for an examination or treatment for an emergent medical condition, or a prudent layperson observer would believe that the individual presented with an emergent medical condition, an appropriate medical screening examination, within the capabilities of the hospital's Emergency Department (including ancillary services routinely available and the availability of "on-call" physicians), shall be performed by an individual qualified to perform such examination to determine whether an emergency medical condition (EMC) exists or, with respect to a pregnant woman having contractions, whether the woman is in labor and whether

the treatment requested is explicitly for an EMC.

If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). Such stabilizing treatment shall be applied in a nondiscriminatory manner (e.g., a different level of care because of diagnosis, financial status, race, color, national origin, or handicap).

YVM maintains a list of physicians on its Medical Staff who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual receiving treatment for an EMC. The cooperation of the Medical Staff members with this policy is vital to YVM's success in complying with the on-call provisions of EMTALA.

Physicians may be fined, separate from the hospital, up to \$50,000 per violation and exclusion from Medicare and Medicaid programs.

Interpreter Services & Hearing Impaired

Yakima Valley Memorial is fully committed to provide effective communication methodologies to all those who seek treatment, including persons who are deaf, blind, hard of hearing, or with limited English proficiency (LEP).

Language assistance will be provided through the use of qualified interpreters, qualified bilingual staff members, contracted qualified interpreters (i.e., formal arrangements with local organizations providing interpretation or translation services), or technology services such as Video Remote Interpretation (VRI) or telephonic interpretation services. YVM defines staff qualifications for language interpreters and translators as ALTA qualified and/or Washington State Certified.

The use of family members, minors, and/or friends in providing medical interpreting to LEP, deaf, blind and hard of hearing patients should be avoided except in life threatening situations when a qualified interpreter is not available.



Confidentiality

The rules of privacy and security are closely aligned; they ensure that patient and employee rights are protected. All patient medical records (paper or electronic) are confidential. Access to this information is on a 'need to know' basis. 'Need to know' is defined as a person who is directly involved in the care of the patient. Health Central Hospital has specific administrative and departmental policies and procedures about information protection. Contact Medical Staff Services with questions. Physicians are responsible for ensuring the staff in their respective offices ONLY access information they have a 'need to know' and are authorized to access.

All staff members are encouraged and required by policy to report violations/abuses of protected patient health information to their immediate supervisor(s), Human Resources, or Risk Management.

HIPAA

The use and disclosure of a patient's individually identifiable health information must be in compliance with existing Federal and State regulations. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects an individual's health information and their demographic information. Together these items

are defined as "protected health information" or PHI. Information meets the definition of PHI if, even without the patient's name, you look at certain information and can tell who the person is. Patients have defined rights under HIPAA and may file a complaint with the Facility Privacy Officer or US Department of Health and Human Services if they believe a privacy violation has occurred.

YVM has both a Facility Privacy Officer and Facility Compliance Officer who are tasked with overseeing our HIPAA Compliance program.

In an effort to assist providers with HIPAA compliance, we offer the following recommendations:

- Private consultation rooms are available for use by physicians when discussions with patients and/or family members are necessary.
- When accessing a patient's electronic medical record, please do not leave the computer unattended and remember to log off when you are done.
- Be mindful of discussions held at nursing stations and other public locations. Please keep voices low and minimize the amount of PHI disclosed.
- When reviewing paper charts and documents at nursing stations, please keep records secure and never leave them unattended.



For additional information regarding HIPAA, please visit [hhs.gov/ocr/privacy](https://www.hhs.gov/ocr/privacy)

If you have questions or concerns regarding a privacy matter, please contact the Medical Staff office for assistance.

Patient Safety Events

A Patient Safety Event is an unintentional event of omission or commission causing injury or the risk of injury to a patient. Safety events may be actual (reaching the patient) or near-miss (caught before reaching the patient). Patient Safety Events are to be entered into the RLDatix Safety Event Manager (SEM) within 24 hours

of the event, and shall include the description of the safety event and how it occurred, how the safety event was discovered, how the patient was harmed, and what actions were taken to correct the event or reduce harm.

A [link to RLDatix](#) can be found on the YVM Intranet page. Safety events may be reviewed by nursing Department Managers, Physician Division Chiefs, and other safety/risk staff. Aggregate safety data is presented to the Quality Oversight Committee (QOC) on a quarterly basis. For more information on patient safety or help reporting safety events, please contact safety@yvmh.org.

YVM Safety Imperative

Safety Behaviors - What we believe in...	Safety Tools - What we do...
Peer Coaching	<ul style="list-style-type: none"> • Look out for each other • Encourage (or positively reinforce) safe and productive behaviors • Correct problems in a helpful manner
Speak Up	<ul style="list-style-type: none"> • Ask a question, • Request change, • voice a Concern, • use the Chain of command
Self-Check	<ul style="list-style-type: none"> • Attention on Task <ul style="list-style-type: none"> • Stop- Pause for 1 to 2 seconds • Think- Focus on the act • Act- Perform the act • Review- Check for desired results
Communication	<ul style="list-style-type: none"> • 3-Way Repeat Backs <ul style="list-style-type: none"> • Sender initiates communication • Receiver repeats back • Sender acknowledges accuracy by saying "That's correct" • Ask 1 to 2 Clarifying Questions when in high risk situations or when information is incomplete and/or unclear • Phonetic and Numeric clarifications
Validate & Verify	<ul style="list-style-type: none"> • Validate- consistent with my knowledge? <ol style="list-style-type: none"> 1. What is typical or expected? 2. What is outside of the norm? 3. How do I know this is correct? • Verify- check with a credible source.

Standards of Conduct

Our vision is to create healthy communities one person at a time, and is expressed in our values of respect, accountability, teamwork, stewardship and innovation. We are committed to preserve the trust and respect of those we serve. The values in the Standards of Conduct ("Code") extend beyond our obligation to conduct our business in accordance with all applicable standards and laws.

These Standards provide general guidance for our conduct. It does not address every situation where the exercise of integrity, honesty or ethical decision-making may be necessary. In some instances, more explicit guidance can be found in YVM policy, procedure, or process. However, these Standards will be the guide conduct where explicit policy does not exist or an existing policy would appear to conflict with the Standards. Violations of the Standards or any policies or procedures will result in disciplinary action, up to and including termination of employment or privileges when warranted.

These Standards govern the actions of all workforce members, including Board members, corporate officers, staff, medical staff, independent contractors, volunteers, students, and others working on Yakima Valley Memorial property or associated with Yakima Valley Memorial. Each workforce member is expected to read, understand and comply with the Code and request clarification when necessary.

The Standards of Conduct support the workforce to conduct business using sound ethical practices, and the healthcare industry is highly regulated and complex rules and regulations exist at the federal and state level which govern YVM. The following address some complex, integrity-related topics which are important to the healthcare industry:

Preventing and Detecting Fraud, Waste, and Abuse

Yakima Valley Memorial will investigate allegations of fraud, waste or abuse and, where appropriate, take corrective action, including, but not limited to civil or criminal action. A number of federal and state laws

are designed to prevent and detect fraud, waste and abuse in government health care programs and impose liability on any person or entity that submits a claim to the federal government that is known (or should have known) to be false. The federal False Claims Act (FCA) and similar Washington state law prohibit the knowing submission of a false claim to the government for reimbursement, and violations of the FCA can result in significant civil penalties and damages, an obligation to enter into a Corporate Integrity Agreement with the government, exclusion from federal healthcare programs, or even criminal prosecution.

The FCA allows private parties to bring suit on behalf on the government against parties alleged to have committed fraud, protecting these "whistleblowers" from retaliation. Both the federal False Claims Act and state law provide protections against employer retaliation of an employee who reports fraud to the government.

For detailed information on the Federal False Claims Act, please refer to:

Federal False Claims Act (31 U.S.C §§ 3729-3733)

[justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf](https://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf)

For detailed information on the Washington False Claims Act, please refer to:

Washington Medicaid False Claims Act (RCW 74.09)

apps.leg.wa.gov/rcw/default.aspx?cite=74.09

Anti-Kickback Statutes

In general, anti-kickback laws prohibit the offering, payment, solicitation, or acceptance of any form of payment for the referral of a patient. Health care professionals and entities are prohibited from paying directly or indirectly for referrals. Referrals can refer to hospital admissions, durable medical equipment, ordering a particular lab test or drug, or another type of healthcare activity. Payment is defined as any type of cash payment or promise of payment or payment in kind.



Stark Laws

These laws prohibit physicians and their immediate family members from making referrals for certain designated health services payable to Medicare to an entity with which they have a financial relationship (ownership, investment, or compensation), unless a specific exception applies. The Laws also prohibit the entity from presenting claims to Medicare for those referred services. Any questions related to this topic should be directed to Legal Services or the Integrity Officer.

Conflicts of Interest

A conflict of interest may exist if a workforce member's outside activities or personal interests influence or appear to influence the workforce member's ability to make objective decisions in the course of carrying out responsibilities and obligations to YVM. Conflicts must be disclosed and resolved so all parties involved understand the concerns involved, and those not involved in the conflict can make the appropriate business decision.

Safe Environment

We are committed to protecting and enhancing the environment in which we serve our community. A safe

environment supports physical safety and security and mitigates or prevents contact with hazards without appropriate protections. Reducing the impact of a healthcare organization on the environment through sustainability efforts also supports a safe environment by reducing wastes and preserving natural resources.

Drug Free Workplace

We support a drug free environment.

Reporting Concerns

We all are responsible for ensuring compliance with these Standards. This responsibility includes an obligation to seek answers to questions regarding these Standards, policy, or law, and an obligation to report a potential violation of these Standards, policy, or law. In either of these instances, our workforce members should contact their supervisor, another leader, the Integrity Officer, Integrity Program, or the Legal Services Department.

Additionally, Yakima Valley Memorial has a secure and confidential Integrity Help Line at 1-877-684-8658 that may be used for inquiry or for reporting potential Standards violations. Additionally, individuals may report concerns to YVMIntegrityProgram@yvmh.org or

ANONYMOUSLY via the Ethics PointPortal:
[secure.ethicspoint.com/domain/media/en/
gui/76708/index.html](https://secure.ethicspoint.com/domain/media/en/gui/76708/index.html)

All inquiries and reports made to the Integrity Program will be thoroughly investigated and if necessary, appropriate action taken to resolve the issue.

A supervisor or manager to whom a report of a suspected violation is made is obligated to pursue resolution and involve the appropriate administrators and the Integrity Program.

Yakima Valley Memorial is committed to protecting those who, in good faith, report actions that they believe are violations to these Standards, policy, or applicable laws, rules, or regulations. We will not engage in retaliation or reprisal against anyone who properly reports violations of law, regulation, or policy. Anyone who believes that retaliation has occurred subsequent to a report of non-compliance should immediately notify Human Resources, the Integrity Officer, Integrity Program, or Legal Services Department.

HIPAA and other privacy complaints regarding YVM and its affiliates (including but not limited to, Memorial Physicians, PLLC, Central Washington Healthcare Partners d/b/a Signal Health, The Memorial Foundation, and others) can be made privately through the Information Security & Privacy Line at: 509-225-2006 or email PrivacyOffice@yvmh.org. Information Security concerns can be emailed to: ITsecurity@yvmh.org.

Important Links:

[Medical Staff Bylaws](#)

[Medical Staff Rules & Regulations](#)

[Monthly Medical Staff Calendar](#)

[YVM Antibioqram](#) (available on the intranet only)

Providing Information to Patients

House Bill 1608: Health care providers may not be limited in providing medically accurate information to their patients.

This law, chapter 102, Laws of 2020, prohibits health care entities from limiting health care providers' ability to give medically accurate information to their patients if a provider is acting in good faith, within the provider's scope of practice, education, training, and experience, including specialty areas of practice and board certification, and within the accepted standard of care. This includes information related to the Death with Dignity Act (RCW 70.245).

The information that a health care entity may not limit includes information regarding diagnosis, prognosis, recommended treatment, treatment alternatives, and potential risks. The health care entity may not restrict information regarding relevant community resources, and how to access those resources to obtain the care of the patient's choice.

Health care entities may not limit the provision of information regarding the Death with Dignity Act, resources in the community related to Death with Dignity, and access to those resources.

Health care entities may not discharge, demote, suspend, discipline, or otherwise discriminate against health care providers for providing to their patients medically accurate information within scope as described, or information relating to the Death with Dignity Act.

Information regarding this chapter is on the Washington State Department of Health website: [doh.wa.gov/
public-health-healthcare-providers/healthcare-
professions-and-facilities/providing-information-
patients](https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/providing-information-patients)

Medical Staff Office Directory

Phone: 509-575-8247

Fax: 509-575-8775

Maritza Macias

Credentialing Specialist

MarizaMacias@yvmh.org

- Advanced Practice Professional Appointment & Reappointment
- Residents
- Medical Staff Calendar

Josephine Johnston, CPCS-

Credentialing Specialist

JosephineJohnston@yvmh.org

- Physician Appointment
- Non-Reappointment Status Change, Privilege Revision
- Credentials Committee
- Medical Executive Committee

Cathy Howard

Credentialing Specialist

CathrynHoward@yvmh.org

- Physician Reappointment
- Medical Staff Department Meetings

Jason Ackley

Professional Practice Evaluation (PPE) Specialist

JasonAckley@yvmh.org

- Peer Review
- Proctoring
- Committee on Professional Enhancement



YAKIMA VALLEY
MEMORIAL