TAHOE FOREST HOSPITAL DISTRICT

2020-02-27 Regular Meeting of the Board of Directors

Thursday, February 27, 2020 at 4:00 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2020-02-27 Regular Meeting of the Board of Directors

02/27/2020 Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, February 27, 2020 at 4:00 p.m.

Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **DELETIONS/CORRECTIONS TO THE POSTED AGENDA**

4. **INPUT AUDIENCE**
   This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Clerk of the Board 24 hours prior to the meeting to allow for distribution.

5. **BOARD MEMBER OATH OF OFFICE**
   If the Board of Directors appoints a director to the vacant seat, the Clerk will swear in the appointed director.

6. **CLOSED SESSION**
   - **6.1. Conference with Labor Negotiator (Government Code § 54957.6**)
     Name of District Negotiator(s) to Attend Closed Session: Alyce Wong
     Unrepresented Employee(s): President & Chief Executive Officer
   - **6.2. Conference with Labor Negotiator (Government Code § 54957.6**)
     Name of District Negotiator(s) to Attend Closed Session: Alex MacLennan
     Employee Organization(s): Employees Association and Employees Association of Professionals
   - **6.3. Hearing (Health & Safety Code § 32155**)◈
     Subject Matter: 2016-2019 Peer Review Summary
     Number of items: One (1)
   - **6.4. Hearing (Health & Safety Code § 32155**)◈
     Subject Matter: 2016-2019 Complaints, Grievances & Compliments Report
     Number of items: One (1)
   - **6.5. Hearing (Health & Safety Code § 32155**)◈
     Subject Matter: July-December 2019 Service Excellence Report
     Number of items: One (1)
   - **6.6. Report Involving Trade Secrets (Health & Safety Code § 32106**)
     Discussion will concern: Proposed new programs and facilities
     Estimated date of disclosure: September 2020
   - **6.7. Report Involving Trade Secrets (Health & Safety Code § 32106**)
     Discussion will concern: Proposed new programs and facilities
     Estimated date of disclosure: June 2021
   - **6.8. Approval of Closed Session Minutes**◈
     01/23/2020

◈ Denotes Action Item

6.9. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)◈
Subject Matter: Medical Staff Credentials

6.10. Hearing (Health & Safety Code § 32155)
Subject Matter: Annual Exclusive Contracting Quality Review FY2019

APPROXIMATELY 6:00 P.M.

7. DINNER BREAK

8. OPEN SESSION – CALL TO ORDER

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

10. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

11. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board President may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

12. INPUT FROM EMPLOYEE ASSOCIATIONS
This is an opportunity for members of the Employee Associations to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes.

13. SAFETY FIRST
13.1. February Safety First Topic

14. ACKNOWLEDGMENTS
14.1. February 2020 Employee of the Month..... ATTACHMENT
14.2. TFHS CIIO named to Becker's Hospital Review 100 CIOs to Know List..... ATTACHMENT

15. MEDICAL STAFF EXECUTIVE COMMITTEE◈
15.1. Medical Executive Committee (MEC) Meeting Consent Agenda ..... ATTACHMENT
MEC recommends the following for approval by the Board of Directors:
Annual Policy Review (no content changes)

- *Computerized Physician Order Entry – CPOE, MSGEN-1701*
- *ANS Policies and Procedures*
- *Respiratory Therapy Policies*
- *Coagulation Guidelines for Invasive Procedures, DINT-1802*
- *Acute Abdominal Pain, DTMSC-2003*
- *Chest Pain Protocol, DTMSC-2001*
- *Suspected Acute Urinary Tract Infection, DTMSC-2004*

- *Suspected Extremity Fracture or Dislocation, DTMSC-2002*
- *Suspected influenza, DTMSC-2006*
- *Suspected Streptococcal Pharyngitis – Strep Throat, DTMSC-2005*
- *Dietary Policies and Procedures*
- *Med/Surg Policies*
- *ICU Policies*

Annual Policy Review (with content changes)

- *Dues and Fees MSCP-6*
- *Fellows Residents Students Policy*
- *Medical Staff Professionalism Complaint Process, MSGEN1*
- *Enteral Feeding and Gastrointestinal Tubes, ANS-1503*
- *AHP Guidelines*

Order Sets

- *TFH Neutropenic Order Set*

Annual Plans & Reports

- *Peer Review/ Professional Practice Evaluation, MSGEN-1401*
- *Quality Assessment/ Performance Improvement (QA/PI) Plan*
- *Utilization Review Plan*
- *Risk Management Plan*
- *Patient Safety Plan*
- *Discharge Plan*
- *Infection Control Plan*
- *Infection Control Plan Goals 2020*
- *Emergency Operations Plan*
- *Environment of Care Management Program*
- *Trauma Performance Improvement Plan*
- *Home Health & Hospice Quality Plan*

Medical Staff Privileges (with content changes)

- *Family Medicine Privileges*
- *Internal Medicine Privileges*
- *Orthopedic Surgery Privileges*

16. CONSENT CALENDAR◈

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

16.1. Approval of Minutes of Meetings

16.1.1. 01/23/2020 ..... ATTACHMENT

16.2. Financial Reports

16.2.1. Financial Report – January 2020 ..... ATTACHMENT

16.3. Staff Reports

16.3.1. CEO Board Report ..... ATTACHMENT
16.3.2. COO Board Report ..... ATTACHMENT
16.3.3. CNO Board Report ..... ATTACHMENT
16.3.4. CIIO Board Report ..... ATTACHMENT

◈ Denotes Action Item

16.3.5. CMO Board Report ..... ATTACHMENT

16.4. Policy Review

16.4.1. Credit and Collection Policy, ABD-08 ..... ATTACHMENT

16.4.2. Financial Assistance Program Full Charity Care and Discount Partial Charity Care, ABD-09 ..... ATTACHMENT

16.4.3. Debt Management Policy, ABD-25 ..... ATTACHMENT

16.5. Approve Revised TFHD Fiduciary Responsibility Delegation Charter

16.5.1. Fiduciary Responsibility Delegation Charter ..... ATTACHMENT

16.6. Approve Quality Assessment/Performance Improvement Plan

16.6.1. Quality Assessment/Performance Improvement (QA/PI) Plan, AQPI-05 ..... ATTACHMENT

17. ITEMS FOR BOARD DISCUSSION

17.1. Press Ganey Physician Engagement Survey Results ..... ATTACHMENT*

The Board of Directors will review the results of a recent physician engagement survey.

17.2. AHA Rural Health Care Leadership Conference Takeaways

The Board of Directors will discuss their takeaways from attendance at a recent AHA conference.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

19. BOARD COMMITTEE REPORTS

20. BOARD MEMBERS REPORTS/CLOSING REMARKS

21. CLOSED SESSION CONTINUED, IF NECESSARY

22. OPEN SESSION

23. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY

24. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 26, 2020 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

Employee of the Month

Bailey Honea, Unit Clerk – Women & Family

We are honored to announce Bailey Honea as our February 2020 Employee of the Month!

Here is what Bailey's coworkers have to say about her:

"Bailey always goes above and beyond the expectation of her job duties. She demonstrates extreme flexibility in scheduling to meet the needs not only of Women & Family, but MedSurg as well. Bailey is always two steps ahead in anticipating both the needs of our staff and our customers. She exceeds our expectations regularly.

Thank you and congratulations, Bailey!

Please join us in congratulating all of our Terrific Nominees!

Blanca Lopez

Erika Rojas

Michele Thomas

Svetlana Schopp

Stephen Hicks

Karen Hollister

Jillian Blide

FOR IMMEDIATE RELEASE
February 20, 2020

Contact: Paige Thomason
Director of Marketing and Communications, TFHS
(530) 582-6290
pthomason@tfhd.com

Tahoe Forest Health System's Chief Information and Innovation Officer, Jake Dorst, Recognized by Becker's Hospital Review

100 Hospital and Health System CIOs to Know 2020

www.tfhd.com

(Tahoe/Truckee. Calif.) – Tahoe Forest Health System is pleased to announce that Jake Dorst, Chief Information and Innovation Officer, was recently named to the 100 Hospital and Health System CIOs to Know 2020 list by *Becker's Hospital Review*. The list features some of the most impressive health IT leaders who lead technology and health IT initiatives for hospitals and health systems across the country.

Mr. Dorst has led the IT department at Tahoe Forest Health System since September 2014. Under his leadership, Tahoe Forest Health System successfully transitioned to a single electronic health record platform and most recently modernized its patient care infrastructure, improving the network performance across the health system's two hospitals and six specialty clinics.

Mr. Dorst's dedication to advancements and innovation in the industry is marked by other recognitions received in the past year. Dorst received this designation previously in 2019. Additionally, he was among 71 CIOs who were named in *Becker's Hospital Review's* Community Hospital CIOs to Know list. He was also recognized by Constellation Research on its 2020 Business Transformation 150, an elite list of executives leading business transformation efforts around the globe.

The CIOs featured on the Becker's list oversee electronic health records installations, cybersecurity, data management and telemedicine services- many who have built robust IT departments and teams. These leaders have received recognition by organizations such as the Healthcare Information and Management Systems Society and the College of Healthcare Information Management Executives (CHIME). In many cases, their organizations have earned CHIME's HealthCare's Most Wired designation.

For the complete list of recognized hospital and health system CIOs, go to Becker's Hospital Review.

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About Tahoe Forest Health System

Tahoe Forest Health System, which includes Tahoe Forest Hospital in Truckee, CA, and Incline Village Community Hospital in Incline Village, NV, offers 24-hour emergency care, primary and specialty health care clinics including Tahoe Forest Orthopedics and Sports Medicine, CoC-accredited cancer center, the Gene Upshaw Memorial Tahoe Forest Cancer Center, the Joseph Family Center for Women and Newborn Care and the Tahoe Forest Primary Care Clinic with same-day appointments. With a strong focus on high quality patient care, community collaboration, clinical excellence and innovation, Tahoe Forest Health System is a UC Davis Rural Center of Excellence. For a complete list of physician specialties and services, visit www.tfhd.com.

About *Becker's Hospital Review*

Becker's Hospital Review is a monthly publication offering up-to-date business and legal news and analysis relating to hospitals and health systems. Content is geared toward high-level hospital leaders, and valuable content is provided, including hospital and health system news, best practices and legal guidance specifically for these decision-makers. Each issue of Becker's Hospital Review reaches more than 18,000 people, primarily acute-care hospital CEOs, CFOs and CIOs.

High-resolution photo attached. Jake Dorst.jpg. Caption - Jake Dorst, Chief Information and Innovation Officer, Tahoe Forest Health System.

AGENDA ITEM COVER SHEET

ITEM	Medical Executive Committee (MEC) Consent Agenda
RESPONSIBLE PARTY	Greg Tirdel, MD Chief of Staff
ACTION REQUESTED?	For Board Action
BACKGROUND: During the February 20, 2020 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the February 27, 2020 meeting.	
SUMMARY/OBJECTIVES: Approval of the following consent agenda items:	

AGENDA ITEM COVER SHEET

Annual Policy Review (no content changes)

1. Computerized Physician Order Entry – CPOE, MSGEN-1701
2. ANS Policies and Procedures
3. Respiratory Therapy Policies
4. Coagulation Guidelines for Invasive procedures, DINT-1802
5. Acute Abdominal Pain, DTMSC-2003
6. Chest Pain Protocol, DTMSC-2001
7. Suspected Acute Urinary Tract Infection, DTMSC-2004
8. Suspected Extremity Fracture or Dislocation, DTMSC-2002
9. Suspected influenza, DTMSC-2006
10. Suspected Streptococcal Pharyngitis – Strep Throat, DTMSC-2005
11. Dietary Policies and Procedures
12. Med/Surg Policies
13. ICU Policies

Annual Policy Review (with content changes)

14. Dues and Fees MSCP-6
15. Fellows Residents Students Policy
16. Medical Staff Professionalism Complaint Process, MSGEN1
17. Enteral Feeding and Gastrointestinal Tubes, ANS-1503
18. AHP Guidelines

Order Sets

19. TFH Neutropenic Order Set

Annual Plans & Reports

20. Peer Review/ Professional Practice Evaluation, MSGEN-1401
21. Quality Assessment/ Performance Improvement (QA/PI) Plan
22. Utilization Review Plan
23. Risk Management Plan
24. Patient Safety Plan
25. Discharge Plan
26. Infection Control Plan
27. Infection Control Plan Goals 2020
28. Emergency Operations Plan
29. Environment of Care Management Program
30. Trauma Performance Improvement Plan
31. Home Health & Hospice Quality Plan

Medical Staff Privileges (with content changes)

32. Family Medicine Privileges
33. Internal Medicine Privileges
34. Orthopedic Surgery Privileges

**All are attached.

SUGGESTED DISCUSSION POINTS:

- None

SUGGESTED MOTION/ALTERNATIVES:

Move to approve the Medical Executive Committee consent agenda as presented.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*12/2017*
Last Approved:	*11/2018*
Last Revised:	*01/2018*
Next Review:	*11/2019*
Department:	*Medical Staff - MSGEN*
Applicabilities:	*System*

Computerized Physician Order Entry (CPOE), MSGEN-1701

PURPOSE:

To define the official method for order entry at Tahoe Forest Healthcare System (TFHS). Computerized physician order entry (CPOE) in the Electronic Health Record (EHR) is to enhance patient safety and to decrease medical errors. In addition, analysis of the data captured by the system will facilitate improvements in evidenced based patient care and improve adherence to standards by regulatory agencies.

POLICY:

It is the expectation that all caregivers will enter orders electronically into the EHR. Physicians will enter orders as they round on patients, or remotely by logging on to the EHR in a secure manner. Physicians who use Physician Assistants or Nurse Practitioners (PA/NP) to write/enter orders on their behalf are responsible for ensuring that their PA/NP adhere to this policy.

EXCEPTIONS:

A. The use of verbal, telephone or hand written orders is to be minimized to the fullest extent possible. All orders will be entered in the TFHS EHR by the physician or their PA/NP, unless electronic communication is not feasible or the order type is restricted/ limited. Verbal, telephone, and hand-written orders are not to be used for provider convenience. Texting of patient orders and patient information is prohibited.

   1. Orders are needed and the physician/PA/NP does not have access to a device to communicate such orders electronically. This includes but is not limited to routine, STAT, and admission orders.
   2. Pre-approved typed orders for preoperative surgical/ procedure patients.
   3. Verbal orders during a bona fide emergency/situation that prevents the physician/PA/NP from entering orders immediately.
   4. Verbal orders during a procedure/surgery.
   5. Computer system down time (Refer to policy: Downtime Procedures for HIS, AIT-128).
   6. Care provider called away for an emergency.

PROCEDURE:

A. All physicians and PA/NP will electronically enter their patient care orders into the EHR with exceptions

listed above.

B. Verbal, telephone or hand written orders that are accepted by TFHS employees will be promptly entered into the EHR by the authorized person who received the order (Refer to policy: Telephone/Verbal Orders - Receiving and Documenting, ANS-1702).

C. Physicians and PA/NP who are unable or unwilling to do electronic order entry and do not fall into the exception guidelines listed above will be reported to the Chief Medical Officer (CMO) and/or chief of their department and managed in accordance with the Medical Staff policy *Medical Staff Professionalism Complaint Process*, MSGEN1. The CMO and/or chief of the department, or designee will address the specific circumstances of each event according to the TFHD Medical Staff Bylaws, Rules and Regulations.

D. Supervising physicians are responsible for the conduct of their PAs/NPs. Non-compliance to CPOE by a PA/NP will be reported to the appropriate supervising physician, the CMO, the chair of the Interdisciplinary Planning Committee, and/or chief of their department.

Related Policies/Forms:

Downtime Procedures for HIS, AIT-128

Telephone/Verbal Orders - Receiving and Documenting, ANS-1702

Medical Staff Professionalism Complaint Process, MSGEN1

Medical Staff Bylaws, Rules and Regulations - MREG-2

Special Instructions / Definitions:

EHR - Electronic Health Record

CPOE - Computerized Physician Order Entry

CMO - Chief Medical Officer

All revision dates: 01/2018, 12/2017

Attachments:

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	11/2018
	Jean Steinberg: Director, Medical Staff Svs.	11/2018

ANS Policy and Procedure Title	Next approval Date	Final Approver	Owner	Policy #	Policy Applies to: TFH, IVCH, System?	Review or Revision in Past year
Accessing Venouse Access Devices in Outpatient Depts.	7/2020	K. Baffone	NLC	ANS - 157	System	7/2019
Admission to ECC from Acute	4/2020	K. Baffone	NEC	ANS - 139	TFH	4/2019
Admissions	1/2020	K. Baffone	NEC	ANS - 2	TFH	1/2019
AMA Leaving Against Medical Advice	6/2020	K. Baffone	NEC	ANS - 211	TFH/IVCH	6/2019
Ambulance Transfers	11/2020	K. Baffone	NEC	ANS - 212	System	11/2019
Assessment / Reassessment	7/2020	K. Baffone	NEC	ANS - 214	System	7/2019
Assigning of Patient Care - RN's Responsibility	4/2020	K. Baffone	NEC	ANS - 215	TFH/IVCH	4/2019
Audibility of Clinical Monitoring	7/2020	K. Baffone	NLC	ANS - 7	TFH/IVCH	7/2019
Average Length of Stay	1/2020	K. Baffone	NEC	ANS - 218	TFH/IVCH	1/2019
Blood - Refusal of Blood Products	7/2020	K. Baffone	NLC	ANS - 220	TFH/IVCH	7/2019
Blood Transfusion	7/2020	K. Baffone	NLC	ANS - 10	System	7/2019
Bonus Pay for Critical Staffing Shortages	6/2020	K. Baffone	NEC	ANS - 1806	TFH/IVCH	6/2019
Brain Death Care of Patient Family	5/2020	K. Baffone	NLC	ANS - 115	TFH/IVCH	5/2019
Breast Milk Storage	5/2020	K. Baffone	NLC	ANS - 121	TFH	5/2019
Catheter Management - Urinary	7/2020	K. Baffone	NLC	ANS - 13	System	7/2019
Census Management Policy	6/2020	K. Baffone	NEC	ANS - 14	TFH	6/2019
Chain of Command for Medical Plan of Care	12/2020	K. Baffone	NEC	ANS-1404	TFH/IVCH	12/2019
Chart Check	12/2020	K. Baffone	NLC	ANS - 224	TFH/IVCH	12/2019
Chemotherapy - Care of Patients Receiving	5/2020	K. Baffone	NLC	ANS - 1302	System	5/2019
Chest Tube Drainage	7/2020	K. Baffone	NLC	ANS - 19	TFH/IVCH	7/2019
Child Safety Seat Policy	3/2020	K. Baffone	NLC	ANS - 20	TFH/IVCH	3/2019
Code Blue Code White	1/2020	K. Baffone	NLC	ANS - 21	TFH	1/2019
Computer Downtime Inpatient Units	10/2020	K. Baffone	NEC	ANS-1602	TFH/IVCH	10/2019
Continuous Peripheral Nerve Block	7/2020	K. Baffone	NLC	ANS - 229	TFH/IVCH	7/2019
Controlled Substance Inventory Counts	7/2020	K. Baffone	NLC	ANS-1805	TFH/IVCH	7/2019
Core Education Requirements for Nursing	4/2020	K. Baffone	NEC	ANS - 144	System	4/2019
Crash Cart Checks	1/2020	K. Baffone	NEC	ANS - 25	TFH/IVCH	1/2019
Crash Carts Standardization	1/2020	K. Baffone	NEC	ANS - 234	TFH/IVCH	1/2019

Death Care Release of Body	7/2020	K. Baffone	NEC	ANS - 28	TFH/IVCH	7/2019
Death Determination	5/2020	K. Baffone	NLC	ANS - 29	TFH	5/2019
Death Pronouncement by an RN	5/2020	K. Baffone	NLC	ANS - 30	TFH	5/2019
Discharge Planning	7/2020	K. Baffone	NEC	ANS - 238	TFH/IVCH	7/2019
Discharging a Patient without Transportation	12/2020	K. Baffone	NLC	ANS - 33	System	12/2019
Discharging Inpatient	11/2020	K. Baffone	NEC	ANS - 239	TFH/IVCH	11/2019
Distribution and Reconciliation of Prescription Paper	1/2020	K. Baffone	NEC	ANS-1801	TFH/IVCH	1/2019
DME- Durable Medical Equipment	12/2020	K. Baffone	NLC	ANS - 400	TFH/IVCH	12/2019
DNAR - Withholding or Withdrawing Life Sustaining Proc.	12/2020	K. Baffone	NLC	ANS - 35	TFH/IVCH	12/2019
Dress Code	4/2020	K. Baffone	NEC	ANS-1701	TFH/IVCH	4/2019
Education - Patient and Family	9/2020	K. Baffone	NLC	ANS - 243	TFH/IVCH	9/2019
Enteral Feeding Clogged Tube	10/2020	K. Baffone	NLC	ANS - 37	TFH	10/2019
Enteral Feeding and Gastrointestinal Tubes	10/2020	K. Baffone	NLC	ANS - 1503	TFH/IVCH	10/2019
Epidural Analgesia Continuous Infusion	7/2020	K. Baffone	NLC	ANS - 39	TFH	7/2019
Extended Recovery of Surgical Procedural Outpatients outside PACU/ASU	1/2020	K. Baffone	NLC	ANS - 100	TFH/IVCH	10/2019
Fall Program	12/2020	K. Baffone	NLC	ANS - 246	TFH/IVCH	12/2019
Float Policy	12/2020	K. Baffone	NLC	ANS - 158	System	12/2019
Floor Collected Specimen	7/2020	K. Baffone	NLC	ANS - 43	TFH	7/2019
Heating - Cooling Measures	7/2020	K. Baffone	NLC	ANS - 45	TFH/IVCH	7/2019
Helicopter Transport of Patients	7/2020	K. Baffone	NEC	ANS - 46	TFH/IVCH	7/2019
Hospice Inpatients	12/2020	K. Baffone	NLC	ANS - 47	TFH/IVCH	12/2019
Hourly Rounding	12/2020	K. Baffone	NLC	ANS - 130	TFH/IVCH	12/2019
House Supervisior Structure Standards	6/2020	K. Baffone	NEC	ANS - 48	System	6/2019
Initial Data Collection	9/2020	K. Baffone	NLC	ANS - 123	TFH/IVCH	9/2019
Instrument Management	9/2020	K. Baffone	NLC	ANS - 252	TFH/IVCH	9/2019
Interventional Radiology Nursing Coverage	11/2020	K. Baffone	NEC	ANS - 51	TFH	11/2019
Intraosseous Device (IO)	10/2020	K. Baffone	NLC	ANS - 1401	TFH/IVCH	10/2019
IV Documentation Guidelines	10/2020	K. Baffone	NLC	ANS - 52	System	10/2019
IV Medication Administration	9/2020	K. Baffone	NLC	ANS - 54	System	9/2019
IV Therapy - Central (PICC, Port, CVAD)	10/2020	K. Baffone	NLC	ANS - 1303	System	10/2019
IV Therapy - Peripheral	10/2020	K. Baffone	NLC	ANS - 1305	TFH/IVCH	10/2019

IV Therapy - Tubing Change and Device Flush Grid	10/202	K. Baffone	NLC	ANS - 1304	System	10/2019
IV Therapy Competency Verification	10/2020	K. Baffone	NLC	ANS - 58	TFH/IVCH	10/2019
Laboratory and Nursing Ancillary Testing	7/2020	K. Baffone	NLC	ANS - 263	TFH/IVCH	7/2019
Latex Sensitivities and Allergies	3/2020	K. Baffone	NLC	ANS - 264	System	3/2019
Low-Dose Ketamine Administration for the Treatment of Pain	5/2020	K. Baffone	NLC	ANS-1802	TFH	5/2019
Master Staffing Plan	10/2020	K. Baffone	NEC	ANS - 145	TFH/IVCH	10/2019
Medical Records - Release of Copy	12/2020	K. Baffone	NLC	ANS - 265	System	12/2019
Mental / Behavioral Health Patient Management	12/2020	K. Baffone	NEC	ANS - 96	TFH/IVCH	12/2019
Moderate and Deep Sedation	10/2020	K. Baffone	NEC	ANS - 1301	System	10/2019
MRI - Moderate Anesthesia Care	11/2020	K. Baffone	NEC	ANS - 1407	TFH	11/2019
Newborn Safe Surrender (Abandonment)	3/2020	K. Baffone	NLC	ANS - 279	System	3/2019
Nurse Compounding of Medications	2/2020	K. Baffone	NEC	ANS-1901	System	2/2019
Nurses of Excellence	1/2020	K. Baffone	NEC	ANS - 69	TFH/IVCH	1/2019
Nursing Documentation - Inpatient	11/2020	K. Baffone	NEC	ANS-1507	TFH/IVCH	11/2019
Nursing Management	5/2020	K. Baffone	NEC	ANS - 70	TFH/IVCH	5/2019
Nursing Management of Pediatric Patient	1/2020	K. Baffone	NEC	ANS - 298	TFH/IVCH	1/2019
Nursing Procedures, Text Reference Guide	12/2020	K. Baffone	NLC	ANS - 71	System	12/2019
Nursing Structure Standards	6/2020	K. Baffone	NEC	ANS - 72	TFH/IVCH	6/2019
ON-Q Catheter and Pump	12/2020	K. Baffone	NLC	ANS - 160	TFH	12/2019
Organ Tissue Body Donation	10/202	K. Baffone	NEC	ANS - 283	System	10/2019
Ostomy Care Standards of Care	5/2020	K. Baffone	NLC	ANS - 76	System	5/2019
Pain Management	9/2020	K. Baffone	NLC	ANS - 284	TFH/IVCH	9/2019
Patient Capacity Competency	12/2020	K. Baffone	NEC	ANS - 287	System	12/2019
Patient Controlled Analgesia	9/2020	K. Baffone	NLC	ANS - 81	TFH/IVCH	9/2019
Patient with Dependent Child	6/2020	K. Baffone	NEC	ANS - 125	TFH/IVCH	6/2019
Pediatric Early Warning Score (PEWS) and Algorithm	3/2020	K. Baffone	NLC	ANS-1804	TFH	3/2019
Pediatric Immunizations	3/2020	K. Baffone	NLC	ANS - 296	TFH/IVCH	3/2019
Pediatric Preparation for Inpatient Emergency Care	3/2020	K. Baffone	NLC	ANS - 1501	TFH/IVCH	3/2019
Pediatric Safety	3/2020	K. Baffone	NLC	ANS - 306	TFH/IVCH	3/2019
Pediatric Vital Signs, Weights	3/2020	K. Baffone	NPC	ANS - 304	TFH/IVCH	3/2019
Pediatrics Structure Standards	6/2020	K. Baffone	NLC	ANS - 85	TFH	6/2019

Plan of Care Inpatients	12/2020	K. Baffone	NLC	ANS - 124	TFH/IVCH	12/2019
PleurX Catheter	5/2020	K. Baffone	NLC	ANS - 1504	TFH	5/2019
Pre-Op and Post-Op Inpatient Preparation	3/2020	K. Baffone	NLC	ANS - 309	TFH/IVCH	3/2019
Pre-Operative Antibiotic Administration	12/2020	K. Baffone	NLC	ANS - 92	TFH/IVCH	12/2019
PureWick FemaleExternal Catheter,	5/2020	K. Baffone	NLC	ANS-1803	System	5/2019
Quality Assurance Improvement Plan	6/2020	K. Baffone	NEC	ANS - 312	TFH/IVCH	6/2019
Rapid Response Team	1/2020	K. Baffone	NLC	ANS - 99	TFH	1/2019
Respiratory Therapy Scope of Services	9/2020	K. Baffone	NEC	ANS - 204	IVCH	9/2019
Safe Patient Handling	5/2020	K. Baffone	NLC	ANS - 140	TFH	5/2019
Series Interim Patients	6/2020	K. Baffone	NEC	ANS - 1405	TFH/IVCH	6/2019
Skin Assessment Wound Care and Photo Documentation	5/2020	K. Baffone	NLC	ANS - 1502	TFH/IVCH	5/2019
Social Services Referrals	12/2020	K. Baffone	NLC	ANS - 103	System	12/2019
SocioCultural Services	12/2020	K. Baffone	NLC	ANS - 315	TFH/IVCH	12/2019
Standards of Care and Practice	12/2020	K. Baffone	NEC	ANS - 319	System	12/2019
Standards of Professional Perfomance	12/2020	K. Baffone	NEC	ANS - 109	System	12/2019
Suicide Attempt - Self Harm Precautions	1/2020	K. Baffone	NEC	ANS - 1402	TFH/IVCH	1/2019
Surgery Calling in the Team	6/2020	K. Baffone	NEC	ANS - 112	TFH	6/2019
Telephone/Verbal Orders - Receiving and Documenting	6/2020	K. Baffone	NEC	ANS - 1702	System	6/2019
Therapy Services Referrals	12/2020	K. Baffone	NLC	ANS - 113	TFH/IVCH	12/2019
Time out for Procedures Done Outside the OR	1/2020	K. Baffone	NLC	ANS - 114	TFH/IVCH	10/2019
TPA for Central Venous Catheter Occlusion	10/2020	K. Baffone	NLC	ANS - 324	TFH/IVCH	10/2019
Use of Restraints	6/2020	K. Baffone	NLC	ANS - 04	TFH/IVCH	6/2019
Vaccine Screening, Administration and Documentation	10/2020	K. Baffone	NLC	ANS - 1601	System	10/2019
Validating Accuracy of Verbal Order	11/2020	K. Baffone	NEC	ANS - 116	System	11/2019
Venous Thromboembolism VTE Risk	3/2020	K. Baffone	NLC	ANS - 117	TFH/IVCH	3/2019
Visitors for Patient Care Units	10/2020	K. Baffone	NEC	ANS - 118	TFH/IVCH	10/2019
Wound Vac Procedure	3/2020	K. Baffone	NLC	ANS - 1211	TFH/IVCH	3/2019
Wound Vac System Ordering	3/2020	K. Baffone	NLC	ANS - 120	TFH	3/2019

Title	Approval Flow	Department	Owner	Last Approved	Next Review
ABG: Sampling, DRT - 21	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Absence of Specific Orders, DRT - 1	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Aerosol Administration - Bland, DRT- 2	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Aerosol Delivery Devices, DRT-3	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Aerosols & Humidity, DRT-4	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Air Flow Meters and Regulators, DRT-5	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Airway Emergencies Management - RCP, DRT-6	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Allen's Test, DRT-16	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
ARDS Net Protocol, DRT-31	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Assessment and Reassessment: Education & Plan of Care Documentation, DRT-24	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Cardiopulmonary Resuscitation, DRT-38	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
CPAP BiPAP, DRT-13	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
EEG Electroencephalogram, DRT-30	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Equipment Replacement/Augmentation of Life Support Systems, DRT-25	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Hand-Held Nebulizer - Continuous Nebulizer Administration, DRT-26	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Humidified High Flow Nasal Cannula, DRT-1611	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Incentive Spirometry, DRT-10	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Infant Mechanical Ventilation, DRT-1601	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Intermittent Positive Pressure Breathing (IPPB) Therapy, DRT-19	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Intrapulmonary Percussive Ventilation - IPV, DRT-27	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Mechanical Ventilation - Inline Medication Delivery, DRT-20	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Mechanical Ventilation, DRT-22	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Medical Director Backup, DRT-8	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Medical Director for Respiratory Care Services, DRT-7	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Methacholine Challenge Test, DRT-1901	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	12/2/2019	12/1/2020
Oxygen Administration, DRT-29	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
PEFR Measurement, DRT-27	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
PFT Testing and Scheduling, DRT-9	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	11/20/2019	11/19/2020
Portable Oxygen Supply, DRT-17	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Positive Airway Pressure Therapy, DRT-1602	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Postural Drainage and Percussion, DRT-28	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Pulse Oximetry, DRT-14	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
Respiratory Medication, DRT-39	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	11/20/2019	11/19/2020
Respiratory Therapy Charting Documentation, DRT-33	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Respiratory Therapy Orders, DRT-34	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Respiratory Therapy Staffing, DRT-32	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
RT Charge Entry, DRT-1603	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	1/3/2020	1/2/2021
RT Equipment and Supply Levels, DRT-37	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
RT Equipment Breakdown, DRT-36	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
RT Equipment Operation, DRT-35	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
RT O.B. Standby, DRT-15	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Scope of Service, DRT-18	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020
Sputum Induction, DRT-29	Respiratory Therapy - DRT	Respiratory Therapy - DRT	Becker, Jason: Respiratory Care Supervisor	7/18/2019	7/17/2020

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*02/2018*
Last Approved:	*02/2018*
Last Revised:	*02/2018*
Next Review:	*02/2019*
Department:	*Interventional Radiology - DINT*
Applicabilities:	*Tahoe Forest Hospital*

Coagulation Guidelines for Invasive Procedures, DINT-1802

PURPOSE:

Recommendations for patients undergoing Interventional radiology procedures regarding anticoagulant medications and pre procedure lab testing requirements

POLICY:

Coagulation Guidelines for Invasive Procedures

Category 1: Procedures with Low Risk of Bleeding, Easily Detected and Controllable		
Procedures	**Preprocedure Laboratory Testing**	**Management**
Vascular-PICC line placement Nonvascular Drainage catheter exchange (biliary,nephrostomy, abscess catheter) Thoracentesis Paracentesis Superficial aspiration and biopsy(excludes intrathoracic or intraabdominal sites):thyroid, superficial lymph node Superficial abscess drainage	**INR:** Routinely recommended for patients receiving warfarin anticoagulation or with known or suspected liver disease **Activated PTT:** Routinely recommended for patients receiving intravenous unfractionated heparin. **Platelet count:** Not routinely recommended **Hematocrit:** Not routinely recommended	INR >2.0: Threshold for treatment (ie, FFP, vitamin K) PTT: No consensus Hematocrit: No recommended threshold for transfusion Platelets: Transfusion recommended for counts <50,000/UL Plavix: Do not withhold Aspirin: Do not withhold Low-molecular-weight heparin (therapeutic dose): Withhold one dose before procedure DDAVP: Not indicated

Category 2: Procedures with Moderate Risk of Bleeding		
Procedures	**Preprocedure Laboratory Testing**	**Management**
Nonvascular Intraabdominal, chest wall, or retroperitoneal abscess drainage or biopsy Lung biopsy Transabdominal liver biopsy (core needle) Percutaneous cholecystectomy Spine procedures Lumbar puncture, myelogram	**INR:** Required **Activated PTT:** Required in patients receiving intravenous unfractionated heparin **Platelet count:** Required **Hematocrit:** Required	INR: Correct above 1.5 Activated PTT: No consensus (trend toward correcting for values >1.5 times control, 73%) Platelets: Transfusion recommended for counts <50,000/UL Hematocrit: No recommended threshold for transfusion Plavix: Withhold for 5 d before procedure Aspirin: Do not withhold Low-molecular-weight heparin (therapeutic dose): Withhold one dose before procedure DDAVP: not indicated

Category 3: Procedures with Significant Bleeding Risk, Difficult to Detect or Control		
Procedures	**Preprocedure Laboratory Testing**	**Management**
Nonvascular Renal biopsy Biliary interventions (new tract)	**INR:** Required **Activated PTT:** Required in patients receiving intravenous	INR: Correct above 1.5 Activated PTT: Stop or reverse heparin for values >1.5 times control)

Nephrostomy tube placement	unfractionated heparin **Platelet count:** Required **Hematocrit:** Required	Platelets <50,000: Transfuse Hematocrit: No recommended threshold for transfusion Plavix: Withhold for 5 d before procedure Aspirin: Withhold for 5 d Fractionated heparin: withhold for 24 h or up to two doses DDAVP: Not indicated

A. **Fistulogram, Shuntogram:**

1. Do NOT need to discontinue anticoagulants. If patient is on Coumadin®, the patient will need to have PT/INR the day prior and abnormal results should be sent to I.R. **Acceptable INR is less than or equal to 2.0**

PROCEDURE:

A. **Inpatients:** INR and Platelet count within 24 hours of procedure

B. **Inpatient:** on Warfarin. INR day of procedure

C. **Outpatients:** INR and Platelets within 1 week of procedure if previously normal. Repeat INR and platelet count if previously abnormal within 24 hours prior to procedure. INR the day of procedure if history of Warfarin

D. **In-Patients whose INR is greater 1.5 will be referred back to the referring physician immediately.**

1. **The referring Physician is then responsible for re-referring the patient when the INR is within range.**
2. **All necessary labs need to be ordered by the referring physician**

E. Note that these time limits are somewhat arbitrary and can be changed at the discretion of the attending radiologist.

Medication	Discontinue Prior to Procedure
Argatroban	2 hours prior
Aspirin	5 days prior -Only for Significant Bleeding Risk (Category 3)
Clopidogrel (Plavix®), prasugrel (Effient®), ticagrelor (Brilinta®)	5 days prior
Dabigatran (Pradaxa®)	3 days prior
Enoxaparin (Lovenox®), Dalteparin (Fragmin ®)	12 hours prior
Heparin	Check with Radiologist
Rivaroxaban (Xarelto®), apixaban (Eliquis®)	3 days prior
Avastain	Discontinue for 28 days prior to major procedure. Requires discussion with patient's physician, usually an oncologist.
Warfarin (Coumadin®)	5 days prior
Cilostazol (Pletal®)	*Do NOT discontinue*

References:

SIR Guidelines Supplement (JVIR, Volume 20 Number 7S July, 2009) Consensus Guidelines for Periprocedural Management of Coagulation Studies and Hemostasis Risk in Percutaneous Image-Guided Interventions

All revision dates: 02/2018

Attachments:

Approval Signatures

Step Description	Approver	Date
	Peter Stokich: Director, Diagnostic Imaging	02/2018
	Peter Stokich: Director, Diagnostic Imaging	02/2018

TAHOE FOREST HEALTH SYSTEM

Origination Date: *N/A*
Last Approved: *N/A*
Last Revised: *N/A*
Next Review: *N/A*
Department: *Tahoe Multi-Specialty Clinics - DTMSC*
Applicabilities:

Standardized Procedure - Ambulatory Clinic: Acute Abdominal Pain, DTMSC-2003

PURPOSE:

To provide expedited care of the patient presenting to Tahoe Forest Multispeciallty Clinics (MSC) with acute abdominal pain.

SPECIFIC REQUIREMENTS:

The evaluation of patient and the implementation of the standardized procedure for the patient presenting with acute abdominal pain will only be performed by a qualified MSC evaluator. A qualified evaluator is the attending MSC provider or a registered nurse (RN) employed in the Tahoe Forest MSC with at least one year ambulatory clinic experience (or equivallent) and the competencies defined in this standardized procedure.

EXPERIENCE, TRAINING, AND CONTINUED EDUCATIONAL REQUIREMENTS:

To implement this standardized procedure, the qualified evaluator must be a licensed RN with at least one year ambulatory clinic experience (or equivalent) and successful completion of the following required competencies:

A. Tahoe Forest MSC orientation including submission of completed skills checklist.
B. Tahoe Forest POC urinalysis and urine human chorionic gonadotropin (hCG) initial, six month, and annual competencies.
C. The MSC RN will complete annual competency requirements and maintain all required licensing as directed by Department Manager and hospital policy.

SETTING:

This standardized procedure applies to any patient presenting to a Tahoe Forest MSC for evaluation.

STANDARDIZED PROCEDURE REQUIREMENTS:

A. The RN may initiate the standardized procedure for Acute Abdominal Pain for any patient presenting with the complaints of acute abdominal pain and based on clinical judgment of the RN.

NURSING INTERVENTION AND PROCEDURE:

A. If the RN initiates this standardized procedure:
    1. RN will evaluate the patient's subjective concerns and clinical presentation to determine if they meet criteria for a urinalysis and an hCG test.
    2. The RN will alert provider immediately of any patient presenting with emergent or critical symptoms.
    3. RN will order a urinalysis and hCG test and follow Tahoe Forest Hospital Lab protocol for obtaining clean catch urine sample from patient and perform test.
    4. Test results will be reviewed by provider and provider will discuss with the patient.

SUPERVISION AND SPECIAL INSTRUCTIONS/ DEFINITIONS:

A. The MSC provider on duty will assume all responsibility for this standardized procedure.
B. Prior to initiating any orders, the RN will immediately inform the provider of any patient presenting with emergent or critical symptoms requiring prompt medical intervention.
C. If at any time, the RN needs clarification of this standardized procedure or orders not covered in this standardized procedure, they will confer with the provider on duty for guidance.

DOCUMENTATION OF RN QUALIFICATIONS:

A. A list of all MSC RNs who may initiate Standardized Procedures will be kept in the Tahoe Forest MSC administration office.
B. The list will be updated annually and as changes occur.

RECORD KEEPING:

A. The RN caring for the patient will complete all documentation in the EMR.

DEVELOPMENT AND APPROVAL:

A. This standardized procedure was developed through collaboration between Nursing, Nursing Leadership, Laboratory Leadership, Education, and Medical Staff.
B. This standardized procedure will be reviewed annually by MSC Leadership.

All revision dates:

Attachments

No Attachments

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Tahoe Multi-Specialty Clinics - DTMSC*
Applicabilities:	

Standardized Procedure - Ambulatory Clinic: Chest Pain Protocol, DTMSC-2001

PURPOSE:

This protocol covers the assessment and treatment of patients presenting to the Tahoe Forest Multi Specialty Clinics (MSC) and/or Urgent Care with chest pain.

POLICY:

To facilitate and guide the Registered Nurse (RN) with documented competency in the assessment and treatment of patients with chest pain in the outpatient setting.

SUPERVISION:

Treatment of chest pain is furnished under the physician's overall direction and control, but the physician's presence is not required at the time of treatment.

EXPERIENCE, TRAINING, AND EDUCATIONAL REQUIREMENTS:

A. Documented competency via the following:
   1. Current BLS certification
   2. MSC department-specific orientation and annual Acute Coronary Syndrome online learning module.

B. Competency will be reviewed within 30 days of hire and annually at staff evaluation.

C. A list of competent RNs will be kept by MSC administration and updated annually and as changes occur.

PERSONNEL:

Assessment and treatment of chest pain must be performed by an RN or provider of higher licensure.

SETTING:

This Standardized Procedure applies to any patient presenting to the Tahoe Forest MSC for evaluation.

PROCEDURE:

A. Data Collection - Subjective:
   1. Chief complaint (document in the patient's own words).
   2. Date and time of onset.
   3. Activity at onset (rest, exertion, sleep, other).
   4. Location of the pain (e.g., left chest, right chest, substernal).
   5. Severity of the pain (rate on a scale of 0-10, with 0=no pain and 10= the worst pain).
   6. Allergies.
   7. Current medications.

B. Data Collection - Objective:
   1. Vital signs and weight if patient is stable.
   2. Observe and document the following:
      a. Appearance of anxiety or fright.
      b. Pallor.
      c. Diaphoresis.
      d. Cyanosis.
      e. Pulse oximeter reading.

C. **Notify physician STAT and call 911 if patient is unstable or provider directed.**

D. Place patient in position of comfort.

E. If patient's oxygen saturation is <90% or there is evidence of respiratory distress, administer O2 at 4 L/ minute via nasal cannula or 4-10L/minute via mask to maintain oxygen saturation ≥ 94%.

F. Monitor cardiac rate and rhythm via cardiac monitor or EKG if available.
   1. In the Urgent Care clinics, RN will order EKG and Chest Xray.

G. Monitor level of consciousness, vital signs, cardiac rate and rhythm, and oxygen saturation every 5 minutes until paramedics arrive.

H. Prepare to transfer patient to outside facility or admit to a facility capable of providing a higher level of care if indicated. **Do not delay patient to higher level of care.**

Special Instructions / Definitions:

Acute Coronary Syndrome (ACS) frequently presents as: Chest pain accompanied by lightheadedness, nausea, sweating, or shortness of breath; pain spreading to shoulders, neck, arms, jaw; pain in back between shoulder blades; uncomfortable pressure, or pain in the center of the chest lasting more than 15 minutes. Chest pain, associated with palpitations or arrhythmias, tachycardia or bradycardia, hypotension. However, an ACS may be present in the absence of many of these signs and symptoms.

DOCUMENTATION:

The RN will complete all documentation in the Electronic Medical Record (EMR).

DEVELOPMENT AND APPROVAL:

A. This Standardized Procedure was developed through collaboration between Nursing, Nursing Leadership, and Medical Staff.

B. This Standardized Procedure is reviewed and approved by:

   1. Pharmacy and Therapeutics (P&T) Committee
   2. Medical Executive Committee

PERIODIC REVIEW:

A. A review of the patient record by the responsible physician will be completed in a timely manner and the reviewing physician will co-sign any necessary orders or progress notes entered by the RN.

B. This Standardized Procedure will be reviewed annually and updated as necessary.

References:

American Heart Association (AHA) Acute Coronary Syndromes Algorithm (2015).

All revision dates:

Attachments

No Attachments

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Tahoe Multi-Specialty Clinics - DTMSC*
Applicabilities:	

Standardized Procedure - Ambulatory Clinic: Suspected Acute Urinary Tract Infection, DTMSC-2004

PURPOSE:

To provide expedited care of the patient presenting to Tahoe Forest Multispecialty Clinics (MSC) with suspected urinary tract infection (UTI).

SPECIFIC REQUIREMENTS:

The evaluation of patient and the implementation of the standardized procedure for the patient presenting with suspected UTI will only be performed by a qualified MSC evaluator. A qualified evaluator is the attending MSC provider or a registered nurse (RN) employed in the Tahoe Forest MSC with at least one year ambulatory clinic experience (or equivalent) and the competencies defined in this standardized procedure.

EXPERIENCE, TRAINING, AND CONTINUED EDUCATIONAL REQUIREMENTS:

To implement this standardized procedure, the qualified evaluator must be a licensed RN with at least one year ambulatory clinic experience (or equivalent) and successful completion of the following required competencies:

A. Tahoe Forest MSC orientation including submission of completed skills checklist.

B. Tahoe Forest POC urinalysis initial, six month, and annual competencies.

C. The MSC RN will complete annual competency requirements and maintain all required licensing as directed by Department Manager and hospital policy.

SETTING:

This standardized procedure applies to any patient presenting to a Tahoe Forest MSC for evaluation.

STANDARDIZED PROCEDURE REQUIREMENTS:

A. The RN may initiate the standardized procedure for Suspected Acute Urinary Tract Infection for any patient presenting with the following complaints and based on clinical judgment of the RN.

B. Any patient presenting to the MSC with complaint of one or more of the following:
    1. Dysuria
    2. Urinary frequency
    3. Urinary urgency
    4. Flank pain
    5. Hematuria

NURSING INTERVENTION AND PROCEDURE:

A. If the RN initiates this standardized procedure:
    1. RN will evaluate the patient's subjective concerns and clinical presentation to determine if they meet criteria for a urinalysis.
    2. The RN will alert provider immediately of any patient presenting with emergent or critical symptoms.
    3. RN will order a urinalysis and follow Tahoe Forest Hospital Lab protocol for obtaining clean catch urine sample from patient and perform test.
    4. Test results will be reviewed by provider and provider will discuss with the patient.

SUPERVISION AND SPECIAL INSTRUCTIONS/ DEFINITIONS:

A. The Urgent Care provider on duty will assume all responsibility for this standardized procedure.
B. Prior to initiating any orders, the RN will immediately inform the provider of any patient presenting with emergent or critical symptoms requiring prompt medical intervention.
C. If at any time, the RN needs clarification of this standardized procedure or orders not covered in this standardized procedure, they will confer with the provider on duty for guidance.

DOCUMENTATION OF RN QUALIFICATIONS:

A. A list of all MSC RNs who may initiate Standardized Procedures will be kept in the Tahoe Forest MSC administration office.
B. The list will be updated annually and as changes occur.

RECORD KEEPING:

A. The RN caring for the patient will complete all documentation in the EMR.

DEVELOPMENT AND APPROVAL:

A. This standardized procedure was developed through collaboration between Nursing, Nursing Leadership, Laboratory Leadership, Education, and Medical Staff.
B. This standardized procedure will be reviewed annually by Multispecialty Clinic Leadership.

All revision dates:

Attachments

No Attachments

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Tahoe Multi-Specialty Clinics - DTMSC*
Applicabilities:	

Standardized Procedure - Ambulatory Clinic: Suspected Extremity Fracture or Dislocation, DTMSC-2002

PURPOSE:

To provide expedited care of the patient presenting to Tahoe Forest Multispecialty Clinic (MSC) with suspected extremity fracture or dislocation.

SPECIFIC REQUIREMENTS:

The evaluation of patient and the implementation of the standardized procedure for the patient presenting with suspected extremity fracture or dislocation will only be performed by a qualified MSC evaluator. A qualified evaluator is the attending MSC provider or a registered nurse (RN) employed in the Tahoe Forest Urgent Care with at least one year ambulatory clinic experience (or equivalent) and the competencies defined in this standardized procedure.

EXPERIENCE, TRAINING, AND CONTINUED EDUCATIONAL REQUIREMENTS:

A. To implement this standardized procedure, the qualified evaluator must be a licensed RN with at least one year ambulatory clinic experience (or equivalent) and successful completion of the following required competencies:
    1. Tahoe Forest MSC orientation including submission of completed skills checklist.
    2. Annual review of MSC diagnostic imaging protocol book and any associated competencies.
    3. The MSC RN will complete annual competency requirements and maintain all required licensing as directed by Department Manager and hospital policy.

SETTING:

A. This standardized procedure applies to any patient presenting to a Tahoe Forest MSC for evaluation.

STANDARDIZED PROCEDURE REQUIREMENTS:

A. The RN may initiate the standardized procedure for Suspected Extremity Fracture or Dislocation for any

patient presenting with the following complaints and based on clinical judgment of the RN.

1. Any patient presenting to the MSC with complaint of:
    a. Extremity injury
    b. Extremity pain
    c. Extremity deformity

NURSING INTERVENTION AND PROCEDURE:

Based on this standardized procedure and the the nurses' clinical judgment, the MSC RN may place the order for the following in the electronic medical record (EMR).

A. RN may place order for extremity xray to include laterality and number of views per diagnostic imaging protocol.

B. The RN will alert provider immediately of any patient presenting with suspected long bone fracture.

C. The RN will alert provider immediately of any patient presenting with emergent or critical symptoms.

SUPERVISION AND SPECIAL INSTRUCTIONS/ DEFINITIONS:

A. The MSC provider on duty will assume all responsibility for this standardized procedure.

B. Prior to initiating any orders, the RN will immediately inform the provider of any patient presenting with emergent or critical symptoms requiring prompt medical intervention.

C. If at any time, the RN needs clarification of this standardized procedure or orders not covered in this standardized procedure, they will confer with the provider on duty for guidance.

PERIODIC REVIEW:

A. A review of the patient EMR will be performed by the responsible MSC provider in a timely manner and the reviewing provider will co-sign orders entered by the RN.

B. Annual chart reviews will be completed by MSC Leadership.

DOCUMENTATION OF RN QUALIFICATIONS:

A. A list of all MSC RNs who may initiate Standardized Procedures will be kept in the Tahoe Forest MSC administration office.

B. The list will be updated annually and as changes occur.

RECORD KEEPING:

A. The RN caring for the patient will complete all documentation in the EMR.

DEVELOPMENT AND APPROVAL:

A. This standardized procedure was developed through collaboration between Nursing, Nursing Leadership, Education, Diagnostic Imaging Leadership, and Medical Staff.

B. This standardized procedure will be reviewed annually by MSC Leadership.

All revision dates:

Attachments

No Attachments

TAHOE FOREST HEALTH SYSTEM

Origination Date: *N/A*
Last Approved: *N/A*
Last Revised: *N/A*
Next Review: *N/A*
Department: *Tahoe Multi-Specialty Clinics - DTMSC*
Applicabilities:

Standardized Procedure - Ambulatory Clinic: Suspected Influenza, DTMSC-2006

PURPOSE:

To provide expedited care of the patient presenting to Tahoe Forest Multispecialty Clinics (MSC) with suspected influenza.

SPECIFIC REQUIREMENTS:

The evaluation of patient and the implementation of the standardized procedure for the patient presenting with suspected influenza will only be performed by a qualified MSC evaluator. A qualified evaluator is the attending MSC provider or a registered nurse (RN) employed in the Tahoe Forest MSC with at least one year ambulatory clinic experience (or equivalent) and the competencies defined in this standardized procedure.

EXPERIENCE, TRAINING, AND CONTINUED EDUCATIONAL REQUIREMENTS:

To implement this standardized procedure, the qualified evaluator must be a licensed RN with at least one year ambulatory clinic experience (or equivalent) and successful completion of the following required competencies:

A. Tahoe Forest MSC orientation including submission of completed skills checklist.
B. Tahoe Forest POC lab rapid flu test initial, six month, and annual competencies.
C. The MSC RN will complete annual competency requirements and maintain all required licensing as directed by Department Manager and hospital policy.

SETTING:

This standardized procedure applies to any patient presenting to a Tahoe Forest MSC for evaluation.

STANDARDIZED PROCEDURE REQUIREMENTS:

A. The RN may initiate the standardized procedure for Suspected Influenza, for any patient presenting with the following complaints and based on clinical judgment of the RN.
B. Any patient presenting to the MSC with complaint of the following symptoms ≤ 48 hours:

1. Fever
2. Cough
3. Myalgias

NURSING INTERVENTION AND PROCEDURE:

A. If the RN initiates this standardized procedure:
   1. RN will evaluate the patient's subjective concerns and clinical presentation to determine if they meet criteria for a rapid flu test.
   2. The RN will alert provider immediately of any patient presenting with emergent or critical symptoms.
   3. RN will order a rapid flu test and follow Tahoe Forest Hospital Lab protocol for performing test.
   4. Test results will be reviewed by provider and provider will discuss with the patient.

SUPERVISION AND SPECIAL INSTRUCTIONS/ DEFINITIONS:

A. The MSC provider on duty will assume all responsibility for this standardized procedure.
B. Prior to initiating any orders, the RN will immediately inform the provider of any patient presenting with emergent or critical symptoms requiring prompt medical intervention.
C. If at any time, the RN needs clarification of this standardized procedure or orders not covered in this standardized procedure, they will confer with the provider on duty for guidance.

DOCUMENTATION OF RN QUALIFICATIONS:

A. A list of all MSC RNs who may initiate Standardized Procedures will be kept in the Tahoe Forest MSC administration office.
B. The list will be updated annually and as changes occur.

RECORD KEEPING:

A. The RN caring for the patient will complete all documentation in the EMR.

DEVELOPMENT AND APPROVAL:

A. This standardized procedure was developed through collaboration between Nursing, Nursing Leadership, Laboratory Leadership, Education, and Medical Staff.
B. This standardized procedure will be reviewed annually by MSC Leadership.

All revision dates:

Attachments

No Attachments

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Tahoe Multi-Specialty Clinics - DTMSC*
Applicabilities:	

Standardized Procedure - Ambulatory Clinic: Suspected Streptococcal Pharyngitis (Strep Throat), DTMSC-2005

PURPOSE:

To provide expedited care of the patient presenting to Tahoe Forest Multispecialty Clinic (MSC) with suspected streptococcal pharyngitis (strep throat).

SPECIFIC REQUIREMENTS:

The evaluation of patient and the implementation of the standardized procedure for the patient presenting with suspected strep throat will only be performed by a qualified MSC evaluator. A qualified evaluator is the attending MSC provider or a registered nurse (RN) employed in the Tahoe Forest MSC with at least one year ambulatory clinic experience (or equivalent) and the competencies defined in this standardized procedure.

EXPERIENCE, TRAINING, AND CONTINUED EDUCATIONAL REQUIREMENTS:

To implement this standardized procedure, the qualified evaluator must be a licensed RN with at least one year ambulatory clinc experience (or equivalent) and successful completion of the following required competencies:

A. Tahoe Forest MSC orientation including submission of completed skills checklist.

B. Tahoe Forest POC rapid strep test initial, six month, and annual competency.

C. The MSC RN will complete annual competency requirements and maintain all required licensing as directed by Department Manager and hospital policy.

SETTING:

This standardized procedure applies to any patient presenting to a Tahoe Forest MSC for evaluation.

STANDARDIZED PROCEDURE REQUIREMENTS:

A. The RN may initiate the standardized procedure for Suspected Streptococcal Pharyngitis (Strep Throat), for any patient presenting with the following complaints and based on clinical judgment of the RN.

B. Any patient presenting to the MSC with complaint of:

1. Sore throat
2. Fever
3. No cough
4. Or patient request for a rapid strep test

NURSING INTERVENTION AND PROCEDURE:

A. If the RN initiates this standardized procedure:

1. RN will evaluate the patient's subjective concerns and clinical presentation to determine if they meet criteria for a rapid strep A test.
2. The RN will alert provider immediately of any patient presenting with emergent or critical symptoms including, but not limited to, signs of upper airway obstruction.
3. RN will order a rapid strep A test and follow Tahoe Forest Hospital Lab protocol for performing test.
4. Test results will be reviewed by provider and provider will discuss with the patient.

SUPERVISION AND SPECIAL INSTRUCTIONS/ DEFINITIONS:

A. The MSC provider on duty will assume all responsibility for this standardized procedure.

B. Prior to initiating any orders, the RN will immediately inform the provider of any patient presenting with emergent or critical symptoms requiring prompt medical intervention.

C. If at any time, the RN needs clarification of this standardized procedure or orders not covered in this standardized procedure, they will confer with the provider on duty for guidance.

DOCUMENTATION OF RN QUALIFICATIONS:

A. A list of all MSC RNs who may initiate Standardized Procedures will be kept in the Tahoe Forest MSC administration office.

B. The list will be updated annually and as changes occur.

RECORD KEEPING:

A. The RN caring for the patient will complete all documentation in the EMR.

DEVELOPMENT AND APPROVAL:

A. This standardized procedure was developed through collaboration between Nursing, Nursing Leadership, Laboratory Leadership, Education, and Medical Staff.

B. This standardized procedure will be reviewed annually by MSC Leadership.

All revision dates:

Attachments

No Attachments

DIETARY POLICIES 2020				
Title	**DNS #**	**TFH, IVCH, BOTH, or SYSTEM**	**Updated 2020**	**Comments 1**
IVCH FOOD SERVICE	201	IVCH	No	
IVCH FOOD TRANSPORT DNS 202	202	IVCH	No	
IVCH MICROWAVE USE DNS 203	203	IVCH	No	
IVCH DISASTER PLAN DNS 204	204	IVCH	Yes	Purchased dehydrated disaster food
IVCH NURSING PANTRY DNS 205	205	IVCH	No	
IVCH TFH DIETARY DIFFERENCES DNS 206	206	IVCH	Yes	removed comment on vending
FOOD & NUTRITION SERVICE POLICY INDEX				
Scope of Service DNS 1	1	Both	no	
Disaster Plan for 250 People DNS 3	3	TFH	Yes	Policy overhaul
Quality Assurance and Improvement DNS 4	4	Both	Yes	added detail
Emergency Disaster Plan DNS 5	5	TFH	No	
Kitchen Fire Suppression DNS 6	6	Both	No	
Patient Menus DNS 101	101	TFH	No	
Patient Meal Portion Sizes DNS 103	103	TFH	No	
Patient Tray Delivery Schedule DNS 105	105	TFH	No	
Patient Diet Orders DNS 107	107	Both	Yes	Updating diet details
Patient Profile Cards DNS 108	108	TFH	No	
Patient Nourishments DNS 109	109	Both	No	

DIETARY POLICIES 2020				
Title	**DNS #**	**TFH, IVCH, BOTH, or SYSTEM**	**Updated 2020**	**Comments 1**
Guest Trays DNS 111	111	Both	No	
Patient Food from Home DNS 112	112	Both	No	
Patient Late Trays DNS 1316	1316	Both	Yes	Removed statement about infants and delivery
Dietary Staff Dress Code DNS 301	301	Both	yes	Removed outdated food code ref
Glove Use DNS 302	302	Both	No	
Dietary Staff Safety Measures DNS 303	303	Both	No	
Carts, Safe Use of DNS 304	304	Both	No	
Dietary Staff Meal Benefit DNS 305	305	Both	Yes	clarified details
Employee Meal Availability DNS 306	306	Both	no	
Theft DNS 307	307	Both	Yes	revised A & C
Dishwasher Procedures DNS 401	401	TFH	no	
Equipment & Utensil Sanitation DNS 402	402	Both	no	
Ice Making Machine DNS 403	403	Both	no	
Work Environment Cleanliness DNS 404	404	Both	YES	RETIRE. Redundant
Manual Dishwashing DNS 405	405	Both	no	
Trash Receptacle Cleaning DNS 406	406	Both	Yes	clarified monthly cleaning

DIETARY POLICIES 2020				
Title	**DNS #**	**TFH, IVCH, BOTH, or SYSTEM**	**Updated 2020**	**Comments 1**
Cold Food Sinks DNS 407	407	TFH	no	
Food Preparation DNS 500	500	TFH	Yes	added detail
Recalled Foods DNS 501	501	Both	no	
Food Inventory DNS 502	502	Both	no	
Food Storage DNS 503	503	Both	Yes	clarified procedure
Reheating Food DNS 504	504	Both	Yes	clarify procedure
Safe Use of Leftovers DNS 505	505	Both	no	
Thawing Frozen Food DNS 506	506	TFH	no	
Thermometers DNS 507	507	Both	no	
Food Waste Disposal DNS 508	508	Both	no	
Infection Control and Sanitation DNS 600	600	Both	no	
Infection Control General Standards DNS 601	601	Both	Yes	changed wording to Nutrition
Personal Cleanliness DNS 602	602	Both	yes	added point, no artificial nails
Handwashing DNS 603	603	Both	no	
Open Sores & Wounds DNS 604	604	Both	no	
Personnel Restrictions Due to Illness or Special Conditions DNS 606	606	Both	no	
Food Borne Illness Complaint DNS 607	607	Both	No	

DIETARY POLICIES 2020				
Title	**DNS #**	**TFH, IVCH, BOTH, or SYSTEM**	**Updated 2020**	**Comments 1**
Café Self Serve Food DNS 901	901	TFH	No	
Vending Machines DNS 902	902	Both	No	
MNT POLICY INDEX	**DMNT #**			
Structure & Standards DMNT 1	1	TFH	Yes	Revised for location
Screening & Nutrition Assessments DMNT 2	2	Both	Yes	Extended time from 5 to 7 days.
Priority Identification DMNT 3	3	Both	Yes	updated specific diagnoses
Nutrition Care Manual DMNT 4	4	Both	Yes	Paper backup
Nutrition Support DMNT 5	5	TFH	Yes	Revised for EPIC
Home Health Hospice, Oncology Referrals DMNT 8	8	Both	No	
Nutrition Care in Skilled Nursing DMNT 9	9	TFH	No	
Meal Percentage Intake DMNT 10	10	TFH	No	
Neutropenic Precautions DMNT 12	12	Both	Yes	Food temp detail added 2019
Approved 1/22/2020 Inf Control Comm.				

Med Surg Policies

Title	Department	Last Approved	Origination Date	Last Revised	Next Review
Floating to Med Surg, DMS-32	Medical Surgical - DMS	7/25/2019	3/1/2006	8/24/2018	7/24/2020
Med Surg Staffing, Acuity, and Patient Assignments, DMS-36	Medical Surgical - DMS	8/8/2019	4/1/2000	8/8/2019	8/7/2020
Med Surg Structure Standards, DMS-39	Medical Surgical - DMS	5/7/2019	5/1/2008	5/7/2019	5/6/2020
Nursing Data Collection Form, DMS-31	Medical Surgical - DMS	7/25/2019	5/1/2001	8/24/2018	7/24/2020
Nursing Management of Telemetry Patients, DMS-22	Medical Surgical - DMS	7/25/2019	1/1/2010	8/24/2018	7/24/2020
Observation Status, DMS-216	Medical Surgical - DMS	8/8/2019	3/1/2008	8/8/2019	8/7/2020
Staffing Scheduling, DMS-37	Medical Surgical - DMS	11/5/2019	9/1/1996	1/31/2019	11/4/2020
Team Leader Responsibilities, DMS-1601	Medical Surgical - DMS	7/25/2019	8/18/2016	8/24/2018	7/24/2020

ICU Policies

Title	Department	Changes	Last Approved	Last Revised	Next Review
Acuity Range Guidelines, DICU - 1	Intensive Care Unit - DICU		9/3/2019	8/24/2018	9/2/2020
Admission and Discharge in the ICU, DICU - 2	Intensive Care Unit - DICU		9/11/2019	9/11/2019	9/10/2020
Arterial Blood Draws, DICU - 3	Intensive Care Unit - DICU		10/18/2019	10/18/2019	10/17/2020
Arterial Groin Puncture Management, DICU - 4	Intensive Care Unit - DICU		8/28/2019	8/24/2018	8/27/2020
Arterial Line Set-Up, DICU-5	Intensive Care Unit - DICU		9/3/2019	9/3/2019	9/2/2020
Assessment of ICU Patient, DICU - 6	Intensive Care Unit - DICU		8/8/2019	8/8/2019	8/7/2020
Cardiac Monitoring Standard, DICU - 7	Intensive Care Unit - DICU		9/3/2019	9/3/2019	9/2/2020
Cardioversion, DICU - 10	Intensive Care Unit - DICU		9/11/2019	9/11/2019	9/10/2020
Central Line – Pressure Line Management, DICU - 11	Intensive Care Unit - DICU		9/11/2019	9/11/2019	9/10/2020
Central Venous Pressure: Insertion and Measuring, DICU - 12	Intensive Care Unit - DICU		8/28/2019	8/24/2018	8/27/2020
Closing of Intensive Care Unit, DICU - 13	Intensive Care Unit - DICU		8/28/2019	8/24/2018	8/27/2020
Collaborative Practice Structure Standards, DICU - 14	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020
Competency and Performance Evaluation, DICU - 15	Intensive Care Unit - DICU		9/3/2019	9/3/2019	9/2/2020
Computer System Downtime, DICU - 16	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020
Coverage During Department Manager Absence, DICU - 17	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020
Defibrillation Procedure, DICU - 19	Intensive Care Unit - DICU		9/3/2019	8/24/2018	9/2/2020
Emergency Trays - Location and Restocking, DICU - 21	Intensive Care Unit - DICU		9/11/2019	9/11/2019	9/10/2020
Equipment Breakdown, DICU - 22	Intensive Care Unit - DICU		9/3/2019	9/3/2019	9/2/2020
FlowTrac - Vigileo Set-up, DICU - 24	Intensive Care Unit - DICU	Retired	4/30/2019	1/31/2019	4/29/2020
ICU Medical Director – Role and Function, DICU - 55	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020
Monitor Lead Placement, DICU - 29	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020
Oral Care – Unconscious and Ventilated Patients, DICU - 33	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020
Orientation Plan - ICU, DICU - 34	Intensive Care Unit - DICU		9/11/2019	9/11/2019	9/10/2020
Pacemaker – Transcutaneous (External), DICU - 37	Intensive Care Unit - DICU		8/28/2019	8/24/2018	8/27/2020
Pacemaker – Transvenous Insertion and Standard of Care, DICU - 36	Intensive Care Unit - DICU		9/3/2019	9/3/2019	9/2/2020
Pacemakers, DICU - 35	Intensive Care Unit - DICU		8/28/2019	8/28/2019	8/27/2020
Paralytic Continuous Infusion, DICU - 38	Intensive Care Unit - DICU		8/28/2019	8/24/2018	8/27/2020
Quality Assessment Plan, DICU - 41	Intensive Care Unit - DICU		8/28/2019	8/24/2018	8/27/2020
Staffing Policy - ICU, DICU - 43	Intensive Care Unit - DICU		8/28/2019	8/28/2019	8/27/2020
Structure Standards - ICU, DICU - 54	Intensive Care Unit - DICU		9/11/2019	9/11/2019	9/10/2020
Team Leader Responsibilities, DICU - 26	Intensive Care Unit - DICU		8/28/2019	8/28/2019	8/27/2020
Telemetry in the ICU, DICU - 47	Intensive Care Unit - DICU		10/18/2019	10/18/2019	10/17/2020
Tracheal Suctioning, DICU - 50	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020
Tracheostomy Care, DICU - 49	Intensive Care Unit - DICU		9/3/2019	8/24/2018	9/2/2020
Transfer from ICU to MedSurg, DICU - 51	Intensive Care Unit - DICU		8/28/2019	8/28/2019	8/27/2020
Ventilator – Patient Management, DICU - 53	Intensive Care Unit - DICU		9/11/2019	8/24/2018	9/10/2020

Dues and Fees, MSCP-6

POLICY:

1. All practitioners including Allied Health Professionals submitting an application to the Medical Staff of Tahoe Forest Hospital District must also include a non-refundable processing fee of $300.00, with the exception of the following:
   A. Resident Staff,
   ~~A.~~B. Honorary Staff
   ~~B. TFHD Full-Time Employed Practitioners,~~
   ~~C. Locum Tenens Practitioners contracted by TFHD,~~
   C. Volunteers
   D. Distant-site practitioners holding telemedicine privileges at TFHD are not required to pay medical staff dues.
2. The non-refundable application fee is payable to "TFHD MEDICAL STAFF" and must be submitted to the Medical Staff Services office along with the completed application. The application will not be processed until the fee is received in the Medical Staff Services Office.
3. All members of the Medical Staff and Allied Health Professional Staff (AHP) are required to pay annual dues. The request for payment of the annual Staff Membership Dues is distributed by the Medical Staff Services Office on April 1st of each year and is due and payable by June 1st. The non-refundable dues ~~is~~ is payable to "TFHD MEDICAL STAFF". All dues received after June 10th will be charged a late fee of $10.00 per month until the dues are received. Medical Staff and AHP Staff members who are on Provisional status are not required to pay dues until their second year as a provisional member.
4. Dues shall be charged as described below:

PROVISIONAL:	(not for 1 year)
ACTIVE STAFF:	$300.00
COURTESY:	$300.00
ALLIED HEALTH PROFESSIONAL:	$100.00
DENTAL:	$50.00
PODIATRY:	$300.00

5. Failure to pay Dues/Assessments, per the medical staff bylaws:
   A. Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments shall be grounds for automatic suspension of a Member's Clinical Privileges. Such suspension shall take effect automatically if the dues and assessments remain unpaid thirty (30) calendar days after the Member is given notice of delinquency and warned of the automatic suspension. If the Member still has not paid the required dues or assessments within six (6) months after such notice of delinquency, the Member's membership shall be automatically terminated.

~~4.~~

~~PROVISIONAL:~~ ~~(not for 1 year)~~

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~~ACTIVE STAFF:~~	~~$300.00~~
~~COURTESY:~~	~~$300.00~~
~~ALLIED HEALTH PROFESSIONAL:~~	~~$100.00~~
~~DENTAL:~~	~~$50.00~~
~~PODIATRY:~~	~~$300.00~~

Approved by:

Chief of Staff: 1/10; 1/11; 1/12; 1/13; 1/14; 3/16

Fellows Residents Students Policy

PURPOSE:

To ensure that only qualified individuals provide patient care services and to assure an appropriate review and approval process for fellows, residents, medical and advance practice student clinical rotations.

POLICY:

A. Fellows and Residents shall complete the ~~postgraduate resident rotation~~Medical Staff application and be credentialed through the Medical Staff Office. They must work under the supervision of the supervising physician identified in the Rotation Agreement. The Rotation Agreement also delineates the goals and patient care objectives for the rotation.
B. Students providing patient care services under direct supervision are not granted privileges. However, they must be authorized to provide such services through specified verification and approval methods, prior to their scheduled rotations.
C. Fellows, Residents and Students in various disciplines may, through contract, rotate through the Hospital, or district outpatient facilities from time to time. It is the policy of the TF~~HS~~HD to ensure that the fellows, residents and students are appropriately authorized to provide patient care services under direct supervision, and that appropriate areas within the hospital or district facilities are notified.

PROCEDURE FOR IMPLEMENTATION:

Teaching institutions may utilize Tahoe Forest ~~Health System~~Hospital District Facilities as a clinical rotation site for fellows, residents, medical, physician assistant or nurse practitioner students only after a clinical affiliation agreement using the Tahoe Forest ~~Health System~~Hospital District template and that has been signed. A copy of a current Affiliation Contract must be on file in Medical Staff Services. Other affiliation agreements may be considered.

A. In addition to the Affiliation Agreement, at least 30 days prior to the beginning of a proposed clinical rotation, the student ~~/~~teaching institution must provide the following documentation to Medical Staff Services:
    1. Documentation of enrollment in good standing in an educational program which is consistent with the scheduled rotation;
    2. The name of the preceptor (supervising physician). The preceptor (supervising physician) must be an active member of the medical staff;
    3. Dates of clinical rotation;
    4. Scope of training activities;
    5. Current copy of license if applicable:
    6. Proof of insurance coverage consistent with the coverage requirements established by the Board of Trustees;
    7. Current immunization status (see section D.1.c. related to student health screening); and
    8. Current PPD or Chest X-Ray (see section D.1.c. related to student health screening);
    ~~8.~~

B. 60-90 days prior to the beginning of a proposed clinical rotation, the fellow or resident institution must provide the above documentation to Medical Staff Services in addition to providing a completed ~~Residents must complete the postgraduate rotation~~Medical Staff application.

~~9.~~
C.

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Documentation will be housed in Medical Staff Services and will be available for review upon request.

~~B.~~D. Scheduling

1. Clinical student experiences will be scheduled to ensure appropriate levels of supervision. The student is responsible for coordinating preceptors but may contact Medical Staff Services for assistance with possible preceptors ~~names~~ for the desired specialty.
   ~~1.~~
2. The Department Director/Manager, and if applicable, Medical Director, must be aware and informed of student clinical schedules before students arrive for their rotation in these areas:
   a. Emergency Room
   b. Labor & Delivery
   c. OR and/or PACU
   d. ICU
   e. Medical/Surgical Units
   f. Ancillary Departments
   g. Other departments as approved by Hospital Designee
      ~~g.~~
3. Students will coordinate specific clinical days and shifts with their preceptor (supervising physician).
   ~~3.~~

E. Fellow, Resident and Student Training

~~C.~~

1. The teaching institution will be responsible for fellow, resident and student training and education with respect to infection control, blood-borne pathogens, OSHA illness and injury prevention, basic emergency preparedness, patient rights, confidentiality and HIPAA, harassment and hazardous material safety management.
   a. Student health screening will be supplied by the teaching institution (current PPD or Chest X-Ray (within one year) and immunizations including MMR, Varicella and Hepatitis B.
   b. Student will be given an orientation to the above by Tahoe Forest ~~Health System~~Hospital District.
      ~~b.~~

~~D.~~F. Fellow, Resident and Student Requirements

1. Fellows, Residents and Students will adhere to the Hospital dress code and wear photo ID badges that clearly indicate student status and college or agency affiliation at all times within the hospital, offsite locations and physician offices.
2. Fellows, Residents and Students will comply with all applicable hospital policies, rules and regulations as well as all laws and standards of practice for the student's profession.
3. No patient hands on experience without the specific consent of the preceptor and the patient. Patients or their authorized representative shall be fully informed and concur to the participation of Fellows, Residents and Medical Students in their care. The preceptor (supervising physician) shall communicate consent and/or limitations to the fellow, resident and student. The fellow, resident and student shall also be advised if the patient declines.
4. Fellow, Residents and Students will be under supervision by their preceptor except for purposes of reviewing the medical record prior to patient rounds, interviewing, or examining a patient. The student will notify the charge nurse/lead technician upon arrival to the unit. Preceptor (supervising physician) will be directly responsible for their fellow, resident and student's activities and their appropriate supervision. No independent procedures may be performed.
5. ~~Hospital~~ Tahoe Forest Hospital District shall, on any day when a Fellow, Resident or Student is receiving training at its Facilities, provide to the fellow, resident and Student any necessary emergency health care or first aid for accidents occurring at its Facilities. In no event shall ~~Hospital~~ District be financially or otherwise responsible for said medical care

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and treatment, unless such injury or loss arises solely out of ~~Hospital's~~ District's actions, omissions, gross negligence or willful misconduct.

~~5.~~

~~E.~~G. Educational Training Activities

1. Clinical departments may establish limitations on training activities allowed. These limitations shall be communicated to the fellow, resident, student, and preceptor (supervising physician) during their respective orientations.
2. When requested or required by the preceptor (supervising physician), with the consent of the patient, students are permitted to take a history and physical examination of the patient. Student history and physicals will not be included in the patient chart. The histories and physicals done by the students must be reviewed and countersigned by the (preceptor) supervising physician, and as an educational modality, be reviewed with the student. Preceptors (supervising physicians) must also perform their own history and physicals.
3. All medical student notes must be countersigned by the preceptor (supervising physician).

~~3.~~

H. The student is working under the supervision of the attending physician and can only do a technical procedure with their direct observation. The attending physician may allow the medical student to conduct procedures that the he/she is comfortable with them doing with an understanding that this is under their medical license.

~~F.~~

I. Students shall not order any tests, medications or procedures for any patients. Students shall not write prescriptions for medicine, devices or anything requiring the authority of a licensed physician.

~~G.~~

~~H.~~J. The preceptor physician will be responsible for the evaluation records of any clinical rotations. Copies will not be maintained in Medical Staff Services.

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References:

TUCOM Clinical Rotation Manual for Students and Faculty
"Medicare's Teaching Physician Documentation Instructions," AAMC
"Teaching Students in Compliance with HCFA Guidelines," **Family Practice Management**, May 2000
Buchanan & Associates Consulting, LLC

Approved by:

Medical Executive Committee 9/16/09 and Board of Directors 9/22/09

Medical Staff Professionalism Complaint Process, MSGEN1

PURPOSE:

Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all medical staff members and Allied Health Professionals (herein referred to collectively as "practitioners") practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner. Personal responsibility for individual behaviors is expected.

POLICY:

A. To define principles for enforcement and a streamlined reporting process for anyone to report alleged professionalism complaint for all Practitioners. Please refer to AGOV-1505 Professional Expectations Policy. In addition, this Policy outlines collegial and educational efforts that can be used by medical staff leaders to address behavior that does not meet the Professional Expectations. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised and avoid proceeding through the investigative and disciplinary process in the Medical Staff Bylaws or Allied Health Professional (AHP) Manual. The policy upholds the Professional Expectations Conduct in a manner that is reasonable and fair to all people involved. In dealing with all incidents of alleged inappropriate conduct, the protection of patients, employees, practitioners, any others in the Hospital and the orderly operation of the medical staff and Hospital are paramount concerns.

B. EXAMPLES OF INAPPROPRIATE CONDUCT

1. To aid in both the education of all practitioners and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:
    a. threatening or abusive language directed at patients, nurses, Hospital personnel, or practitioners (e.g., belittling, berating, and/or harsh non-constructive criticism that intimidates, undermines confidence, or implies incompetence);
    b. degrading or demeaning comments regarding patients, families, nurses, practitioners, Hospital personnel, or the Hospital;
    c. profanity or similarly offensive language while in the Hospital and/or directed to hospital and medical staff members;
    d. inappropriate physical contact with another individual that is threatening, intimidating, or abusive;
    e. derogatory comments about the quality of care being provided by the Hospital, another medical staff member, or any other individual outside of appropriate medical staff and/or administrative channels;
    f. inappropriate medical record entries impugning the quality of care being provided by the Hospital, medical staff members or any other individual;
    g. imposing onerous requirements on the nursing staff or other Hospital employees;
    h. refusal to abide by medical staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the medical and hospital staffs);
    i. "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. See VII: Alleged Sexual Harassment Concerns for

specific policies. Examples include, but are not limited to, the following:

i. Verbal: ~~inuendoes~~innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;
ii. Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;
iii. Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and
iv. Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

PROCEDURE:

A. Guiding Principles for Enforcement

1. The person making the complaint shall be referenced in this Policy as the "complainant". All complaints should be submitted to the Medical Staff Leadership through the 530-582-3269 line, select the "professionalism" option, preferable directly by complainant however can be made through the employee's supervisor, or the Event Reporting System located on the TFHD intranet page. The appropriate Chair of the Department will be notified when a complaint is made ~~re: physician~~concerning a practitioner in their department. The Chair of the Department will conduct a review, using Just Culture (JC) principles, and ~~use~~ may consult the JC advocate.
2. JC Advocate: Could be an employee or physician who is well trained in JC, who can act as a mentor/coach to ensure that JC ~~process is followed~~principles are followed. The JC advocate may also~~,~~ act as a ~~along with acting as a~~ mediator when requested.~~, as needed.~~ The JC advocate has developed~~This individual develops~~ experience in dealing with inappropriate behavior and has considerable experience and knowledge of the ~~consistently working with the Professionalism~~Professionalism -Policy. ~~They~~ The JC advocate will emphasize the collegial nature of initial interventions. The Medical Staff Services will have a list of JC Advocates to be available to assist the Chair of the Department.

3. Persons involved in this policy who may have a real or perceived conflict of interest (e.g. partners, associates, relatives, or direct competitors) shall ~~excuse~~ recuse themselves. The Chief of Staff, or their delegate, will appoint a replacement.
4. Satisfactory conclusion or resolution of a professionalism event must be agreed upon by all parties involved, which may include:
    a. Appropriate acknowledgment of misconduct.
    b. Accepting responsibility for changing actions and behaviors in accordance with the Professionalism Policy.
    c. Apology.
    d. Commitment to not repeating the behavior.
    e. Referral to resources to address the system problems or practitioner health.
    f. Written plan or contract or required behavior changes.
5. The Chair of the Department of designee will determine resolution of the event.
6. If resolution of the event is not achievable, the following may occur:
    a. Referral to a higher level of review (e.g., the Medical Executive Committee)
        i. Repetitive incidents that suggest inability to correct actions may also be referred to a higher level of review.
        ii. The seriousness of a particular incident may also be referred to a higher level of review.
        ~~3.~~iii. Incidents that are required by principle, policy or law.

~~4. Understanding that resolution is not always achievable, satisfactory conclusion or resolution of matter addressed through this Policy may be defined, generally, as all of parties involved agreeing that the matter is settled. If disruptive behavior is found, appropriate acknowledgement of misconduct and responsibility for changing actions and behaviors in accordance with the Professionalism Policy is ideal. This may include an~~

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~~apology and commitment to not repeating the behavior, referral to resources to address system problems or practitioner health, or a written plan or contract of required behavior changes. The Chair of the Department will determine resolution. Referral to a higher level of review is required, if resolution is not achieved. Referral to a higher level may also be warranted by repetitive incidents that suggest inability to correct actions and adhere to the Policy, or by the seriousness of a particular incident. Some incidents may require further evaluation based on matter of principle, policy or law. Repetitive at risk behavior or reckless behavior will be dealt with per the Just Culture process.~~

~~5.~~7. Documentation of Professionalism Breeches: Documenting unprofessional behavior allows the Chairs of the Departments to build an "institutional memory" of incidents of inappropriate conduct and the attempts to address them.

~~6.~~8. Neither the involved practitioner's counsel, nor medical staff counsel, shall attend any of the meetings between the practitioner, the Chair of the Department, JC Advocate or other medical staff leaders. This shall not preclude the practitioner from consulting with his or her attorney, or the medical staff leaders from consulting with medical staff counsel, outside of the meeting. There will be no audio or video recording.

~~7.~~9. Any retaliation against the complainant, whether the specific identity is disclosed or not, may be grounds for immediate referral to the Medical Executive Committee pursuant to the Medical Staff Bylaws. Complainants will be instructed to report any actual or perceived retaliation to the Chair of the Department, JC Advocate, Chief of Staff or the Director of Medical Staff Services immediately.

~~8.~~10. Participation by the practitioner is voluntary, but refusal to participate in peer review processes may lead to corrective action.

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B. REPORTING AND ADDRESSING ALLEGED INAPPROPRIATE CONDUCT

1. INITIAL PROCEDURE

a. This Policy encourages direct, timely interventions as the first step when inappropriate conduct is experienced. Therefore, any person who experiences or witnesses inappropriate conduct is encouraged to approach the practitioner promptly in an effort to resolve the matter on a mutually acceptable basis. This might result in the correction of a mistake or misunderstanding about the facts, clarification of the intent or purpose behind a particular statement or act, or agreement on a plan for seeking help from a supervisor, Medical Staff leader, or other third party in resolving the dispute. If resolution is immediate, no documentation is needed. Should such efforts fail, or not be feasible, complaint should be made to the 530-582-3269, select the professionalism option or the Event Reporting System located on the TFHD intranet page.

b. If the complainant is a hospital employee, his or her supervisor should be informed of the matter and participate in attempting to resolve the event ~~it~~ or in reporting it to the Medical Staff leadership through the Chair of the Department, as appropriate to the circumstances and in a manner consistent with the hospital's personnel policies. The employee's supervisor will also advise the employee regarding his or her rights and responsibilities, and will address any improprieties on the part of the employee, pursuant to the applicable hospital policies. The extent to which the employee may be informed of subsequent developments will be based on applicable principles of confidentiality relating to medical staff peer review records and other relevant factors, as determined by the medical staff leadership.

c. ~~The Director of Medical Staff Services or designee will perform an initial review, including obtaining the names of those involved, alleged unprofessional act, preliminary review and initiate the intake form (Addendum B) in order to present to the Department Chair.~~ The Quality Department representative will review the initial report and refer the event to the Director of Medical Staff.

d. The Director of Medical Staff will refer the event to the Risk Management/Privacy Officer to de-identify the complaint and refer the event back to the Director of Medical Staff.

~~c.~~e. The Director of Medical Staff will then refer the case to the Chair of the Department, if conflicts of interest are identified the Medical Staff Director will

refer the case to the Chief of Staff to reassign the event.

f. The Chair of the Department ~~reviews the intake form (Addendum B) and~~ performs a review to determine if the issues are of sufficient concern to warrant further ~~attention~~investigation. If there is not sufficient concern the Chair of the Department or designee may close the case, by notifying the Director of Medical Staff.

g. If the event warrants further investigation, the Chair of the Department or designee will conduct an investigation, which may include:

~~d.~~i. Interviewing ~~T~~the practitioner involved ~~will also be notified, in writing, of the reporting of the alleged event.~~

~~i.~~ii. Interviewing the complainant

~~ii.~~iii. Interviewing any witnesses/supervisor

~~iii.~~iv. Discussing with other colleagues about this type of behavior

~~iv.~~v. Asking open ended questions such as:

a. What happened?
b. What normally happens?
c. Is there a policy and what does it say about this?
d. Why did it happen?
e. Is this a typical behavior for this person reviewing documents?

h. If the investigation concludes that there are no findings, the Chair of the Department or the designee will notify the Medical Staff Director to close the case.

i. If the investigation concludes that there are findings, the Chair of the Department or designee will notify the practitioner involved, by scheduling a conference with the practitioner involved.

~~e.~~j. ~~Interview~~ Conference with the ~~Physician~~Practitioner: A Note to File will be prepared for use by the Department Chair in his/her ~~interview~~ discussion with the ~~Chair~~ practitioner involved outlining the ~~main points to be discussed and the Chair's findings alongside the points~~findings and the Department Chair or designees recommendations for the practitioner involved. The practitioner will be given an opportunity to respond in writing to the recommendations. Any such response shall be attached to the Note to File in the practitioner's confidential Medical Staff peer review file.

~~f.~~k. The Note to File will be maintained in the practitioner's Medical Staff peer review file as a record of the discussion.

C. SUSPECTED IMPAIRMENT:

1. If any person suspects or is concerned about an impaired practitioner due to mental or physical illness or substance abuse, the matter may be reported to the Chair of the Department, Chief of Staff, or Chair of the Well Being Committee, either directly or through the Director of Medical Staff Services. Issues that involve risks to the health or safety of patients or others must be reported to the Medical Staff leadership, as described elsewhere in this policy.

Related Policies/Forms:

Professional Expectations, AGOV-1505, Peer Review, MSGEN-1401, Well Being Policy, MSGEN-9, Harassment in the Workplace, AHR-36

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TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Nursing Services - ANS*
Applicabilities:	*Tahoe Forest Hospital*

Enteral Feeding and Gastrointestinal Tubes, ANS-1503

PURPOSE:

To standardize the process of enteral feeding and gastrointestinal tube care

POLICY:

A. All tube feedings will be ordered using the Electronic Medical Record.

B. All patients receiving tube feedings will be managed according to the following guidelines.

PROCEDURE:

A. Confirmation of tube placement:

1. X ray: Prior to instilling any liquid in oral or nasal feeding tubes, including feeds, medication or flushes, confirm tube placement with abdominal or chest radiograph unless contraindicated.

   a. Auscultation alone should not be relied on to differentiate between gastric and respiratory placement.

   ~~Auscultation: **If x ray is contraindicated**, check for tube placement by auscultating upper left quadrant while instilling 20-30 mL of air.~~

   ~~Auscultate to reconfirm placement prior to each intermittent use.~~

   ~~a. Intermittent auscultation does not apply when patient is receiving continuous feeds.~~

2. Ensure location of tube is documented once placement is confirmed and tube is secured in place.

   a. Assess the length of the tube each shift to check for tube migration.

B. Gastric feeding via a Nasogastric tube (NG) or gastrointestinal tube (PEG/ G-tube):

1. Feedings may be delivered via an infusion pump, gravity bag or bolus method.
2. Flush tube before and after each intermittent feeding.

C. Small intestine feeding via nasojejunal tube (NJ), jejunostomy tube (J-tube, GJ-tube) or nasoduodenal/ oralduodenal:

1. Only continuous feedings are to be administered.

2. Feedings will be administered through an infusion pump or gravity bag.

D. Flush lines per physician orders.

E. Flush surgically placed PEG/G-tubes used for **gastric** decompression/ drainage every shift with 15-30mL of ~~sterile~~tap water or as directed by physician.

1. Sterile water should be used for immunocompromised patients and for patients with a jejunostomy tube.

~~Gastric Residual Volumes (GRV):~~

~~1. Check for residuals as ordered by the physician.~~

~~2. Re-instill residuals as they contain formula, digestive contents, and electrolytes.~~

~~3. Subtract the flush volume (instilled immediately prior to residual check) from the residual volume in documentation.~~

~~Assess the patient for abdominal distention, discomfort and uncontrolled nausea. If abdominal signs or symptoms are present, hold feeding and notify physician.~~

F. Assessing tolerance:

1. Assess patients daily for tolerance of enteral nutrition.

a. Signs of intolerance include (but are not limited to): Vomiting, persistent nausea, abdominal distention, high NG output, deduced passage of flatus and stool, abnormal abdominal radiograph, diarrhea, high gastric residual volume.

2. Do not use gastric residual volume as part of routine care to monitor patients receiving enteral nutrition. If gastric residual volume is ordered by physician, do not hold enteral feeding for residual volume <500mL in the absence of other signs of intolerance.

3. If signs and symptoms of intolerance are present, hold feeding and notify physician.

G. Administration of Medications Via Feeding Tube

1. Compatible medications may be administered together.
2. Use liquid preparations when available.
3. Use sterile water for mixing and preparing medications regardless of tube placement.
4. Crush pills thoroughly and mix with sterile water

a. Reference the "Do Not Crush" medication list to confirm medications that can be crushed http://www.ismp.org/tools/donotcrush.pdf

b. No particulates should be visible

H. Tubing and Feeding Containers

1. Change entire system every 24 hours.
2. In the event that the feeding tubing becomes clogged, refer to procedure for Declogging Enteral Feeding Tube (ANS-37).

I. Skin Care

1. Cleanse tube and skin at insertion site daily with mild soap and water.
2. Inspect skin for signs of breakdown at time of cleaning. Reposition or resecure tube as needed to maintain skin integrity.

a. Notify physician of mucosal ulcers or skin irritation that does not resolve with standard nursing care.

3. Rotate unsutured tubes 180 degrees at time of cleaning to prevent adherence.
    a. Nasogastric (NG) or nasojejeunal (NJ) tubes are not rotated routinely.

J. Elevate head of bed ~~30~~30-45 degrees while feeding.
    1. When patient is supine, turn off gastric feeds.

K. Documentation
    1. Time, type, and amount of feeding and flushes infused.
    2. Adverse reaction(s) or symptoms of intolerance.
    3. Medication and dosage, if administered.
    4. Weight, Intake and Output, and Residuals (if ordered).

Related Policies/Forms:

Declogging Enteral Feeding Tube, ANS-37; DO NOT CRUSH medication list; ~~Adult~~Nutrition Support: Enteral ~~Nutrition Pre~~and Parenteral, DMNT ~~Printed Physician Orders~~5

References:

ASPEN Safe Practices for Enteral Nutrition Therapy. *Journal of Parenteral and Enteral Nutrition, 41*(1), 15-103. (2017); Guidelines for the Provision and Assessment of Nutrition Support Therapy in the Adult Critically Ill Patient: Society of Critical Care Medicine (SCCM) and American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.), 40(2), 159-211. (2016)

All revision dates:

Attachments:

TAHOE FOREST HOSPITAL DISTRICT

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

2017

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND

STANDARDIZED PROCEDURES

TABLE OF CONTENTS

Page

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

1. PROTOCOL FOR CONSIDERATION OF ALLIED HEALTH PROFESSIONAL CATEGORIES

1.1 Policy

It is the policy of Tahoe Forest Hospital District ("the Hospital") to give appropriate consideration to the question of whether a given category of Allied Health Professionals should be permitted to practice on its premises in Allied Health Professional status. The question will be addressed with respect to a particular category if the Hospital receives a serious expression of interest from the Hospital Administration, a member of the Board of Directors, or a committee or member of the Medical Staff.

The decision whether to accept or reject an Allied Health Professional category will rest with the Board of Directors ("the Board"). To assist the Board in making its decision, the Hospital adopts the procedures in these Guidelines, which are designed to provide the Board with complete information about the relevant issues and to afford all interested persons an opportunity to make their views known. The procedures described herein are intended to serve as guidelines, and may be varied for good cause in a particular case.

1.2 Procedure

A. The Board or the Administration will refer the matter to the appropriate Hospital body for review and recommendation. This may be, for example, the Administration itself, a standing or ad hoc Medical Staff or Department Committee, or a standing or ad hoc Hospital Committee. The Medical Executive Committee, on its own initiative, may also consider whether a particular category should be accepted, and make a recommendation accordingly to the Administration and the Board.

B. The body chosen will investigate the matter, including soliciting the views of those most directly involved and those able to assist it with its inquiry. This may include, for example, members of the Allied Health Professional category under consideration, any Medical Staff members who might provide supervision, practitioners from related areas, other Hospital or Medical Staff personnel, representatives from licensing or certification agencies, representatives from professional associations, insurers, or members of the interested public.

C. On the basis of its review, the body will make a recommendation to the Board or the Administration, as appropriate, to be accompanied by a report describing the underlying reasons for the recommendation. If the Administration initiated the review, it may present the matter to the Board with its own report and recommendations.

D. The Board will review the recommendation(s) and report(s) and will decide whether to hold an open forum before rendering a decision on behalf of the Hospital.

(1) Any open forum shall be designed to permit the Board to receive comments directly from interested persons inside and outside the

Hospital. Comments shall be submitted in writing unless the Board decides to hold an oral proceeding.

(2) If the Board decides to hold an oral proceeding, it will conduct the proceeding as a meeting, at which interested persons are permitted to address comments to the Board according to guidelines established by the Board.

(3) Notice of any open forum, whether or not an oral proceeding is involved, shall be posted in appropriate locations in the Hospital and shall be sent, insofar as is practical, to all persons who have demonstrated an interest in the matter. The notice shall describe the action being considered, the recommendation received by the Board, and the process for participating in the open forum. It shall include a copy of the report(s) received by the Board or shall state where a copy may be obtained.

E. When the Board is satisfied that it has received sufficient information, it shall render its final decision on the matter in the form of a resolution. The Board of Directors shall issue a concise statement of the reasons for its decision, and shall indicate how various comments, arguments, and points of view were considered in arriving at its decision.

2. GENERAL STANDARDS FOR ALLIED HEALTH PROFESSIONALS

2.1 In General

A. Applicability

Generally, these Guidelines apply to non-employee practitioners who are accorded Allied Health Professional status at the Hospital and who are under the jurisdiction of the Medical Staff. These Guidelines do not apply to practitioners who are employed by the Hospital, or who, although in Allied Health Professional status, have been placed by the Hospital and Medical Staff under the jurisdiction of Hospital Administration, with the exception of Section 7, which describes the application of these Guidelines to Hospital-employed Allied Health Professionals. In addition, the Guidelines pertaining to credentialing and review in Sections 2.2and 2.4 apply to all Allied Health Professionals, regardless of their employment status.

B. Terminology

Under these Guidelines, non-employed Allied Health Professionals undergo “credentialing” and “recredentialing” as an Allied Health Professional at the Hospital. .

2.2 Standards

In order to qualify for initial and ongoing Allied Health Professional status at the Hospital, an Allied Health Professional shall:

A. Belong to an Allied Health Professional category that has been admitted to practice at the Hospital by the Board of Directors. The categories which have been so admitted are listed in Exhibit A;

B. Meet one of the following requirements:

(1) Belong to an Allied Health Professional category that is not subject to any exclusive contract or panel arrangement with the Hospital; or

(2) Be accepted by the Hospital as part of any exclusive contract or panel arrangement that applies to the Allied Health Professional's category;

C. Possess any license or certificate required under the laws of California and/or Nevada, as applicable, for his or her category;

D. Possess and document the background, training, experience, judgment, ability, and physical and mental health necessary to demonstrate with sufficient adequacy that he or she is able to provide professional services as requested and authorized in accordance with generally recognized professional standards of quality and efficiency;

E. Provide at least one recent professional reference from a previous hospital, chief, or department chair;

F. Adhere strictly to generally recognized standards of professional ethics;

G. Be capable of working cooperatively with others in furtherance of high quality patient care and efficient hospital operations;

H. Perform services for patients at the Hospital in conjunction with the Medical Staff member responsible for the patient's care;

I. Comply with all Hospital, Medical Staff and department bylaws, rules and regulations, and protocols, to the extent applicable to the Allied Health Professional;

J. Comply with the duties described in Section 11.2 of these Guidelines

K. Be willing to participate in the discharge of administrative responsibilities as reasonably determined by the Medical Staff and the Allied Health Professional's department;

L. Maintain professional liability insurance with a suitable insurer, with the minimum limits as determined by the Medical Executive Committee and the Board;

M. Pay a non-refundable application fee, if required;

N. Pay annual dues and assessments, if required;

O. Meet any specific requirements established by the applicable department, the Medical Executive Committee or the Board for his or her category of Allied Health Professional, including any specific requirements established for his or her category that is set forth in the attached Exhibits hereto;

P. Meet the conditions of any applicable contract with the Hospital; and

Q. Not be excluded from participation in any federally funded health care program, including Medicare or Medi-Cal.

2.3 Exception

From time to time, the Chief of the Medical Staff and the Hospital Administrator may jointly decide to approve clinical privilege(s) for specific individuals who do not meet one or more of the requirements described in Sections 2.2A and 2.2B above.

A. Any such privilege(s) shall be requested in writing by a member of the Medical Staff who will assume supervisory responsibility for the Allied Health Professional.

B. The writing requesting approval shall contain a statement of the facts and circumstances justifying each exception requested.

C. Except as otherwise expressly stated in the approval, all of the standards and requirements set forth in this Section 2 shall apply.

2.4 LEAVE OF ABSENCE

At the discretion of the medical executive committee, an Allied health professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the medical executive Committee. Requests for leaves of absence that are made by allied health professionals shall be processed in the same manner as requests made by Medical Staff members, in accordance with the medical staff bylaws. There shall be no right to a leave of absence; nor shall there be any procedural rights associated with failure to obtain approval for a requested leave.

3. PROTOCOL FOR NON-EMPLOYED ALLIED HEALTH PROFESSIONAL CREDENTIALING AND REVIEW

3.1 Terms of Allied Health Professional Status

A. All non-employed Allied Health Professionals shall receive annual skills/competence assessments and shall be credentialed (pursuant to Section 3.2) and re-credentialed (pursuant to Section 3.3) terms.

3.2 Credentialing Procedures

A. Every Allied Health Professional seeking credentialing as an Allied Health Professional at the Hospital shall make an application on a prescribed form. Failure to complete the application shall preclude consideration of it. An applicant who fails to respond adequately to any request for further information during the review process will be deemed not to have completed the application.

B. The Hospital will request from the Medical Board of California or other appropriate board, if any, verification of current licensure status of the applicant. The National Practitioner Data Bank ("NPDB") shall be queried.

C. The application and all supporting materials shall be forwarded to the responsible department chair or designee. The department chair or designee shall review the application and all supporting material, may arrange for a personal interview of the applicant, and shall make a recommendation concerning Allied Health Professional status, "clinical privileges" (specified services that may be performed),and any special conditions to be attached.

D. The department chair or designee shall forward his or her recommendation to the Medical Executive Committee, along with any supporting documentation. The Medical Executive Committee shall review all pertinent information and shall formulate its recommendation to the Board of Directors.

E. If its recommendation is adverse to the Allied Health Professional, the Medical Executive Committee shall immediately inform the Allied Health Professional and shall hold the decision in abeyance until the Allied Health Professional has exercised or waived his or her right to review set forth in Section 4.2~~4.2~~ below. If the Allied Health Professional exercises his or her right to review, the Hospital and the Allied Health Professional shall follow the prescribed procedure. If the Allied Health Professional waives his or her right to review, the Medical Executive Committee shall forward its recommendation to the Board of Directors for a final decision.

F. If its recommendation is favorable to the Allied Health Professional, the Medical Executive Committee shall forward it, together with any supporting documentation, to the Board for its ultimate decision. Provided, however, if the Board is disposed to deny the Allied Health Professional's application, it shall arrange, prior to rendering its final decision, for a review in which the Allied Health Professional participates, under procedures determined by it.

3.3 Recredentialing Procedures

A. At least one hundred and twenty (120) days prior to the expiration of current Allied Health Professional status, the Allied Health Professional shall receive an application for recredentialing on a prescribed form. The Allied Health Professional shall complete the form, including a request for the renewal or modification of clinical privileges. Failure to complete and return the form in a timely manner may result in termination of Allied Health Professional status, including clinical privileges, as of the date of expiration.

B. The procedures for evaluation of an application for recredentialing shall be identical to those set forth in Section 3.2 above for an application for initial credentialing.

3.4 Procedure for Requesting Additional Clinical Privileges

A. An Allied Health Professional may request additional clinical privilege(s) at any time by filing a written request, together with supporting documentation.

B. The procedures for evaluation of a request for additional clinical privilege(s) shall be identical to those set forth in Section 3.2above for credentialing as an Allied Health Professional at the Hospital.

3.5 Temporary Clinical Privilege(s)

A. A. The Hospital Administrator and the Chief of the Medical Staff, after consultation with the department chair and any supervising physician, may grant an Allied Health Professional temporary clinical privilege(s) if he or she meets the applicable requirements under section 2.2 of these Guidelines. Temporary clinical privilege(s) may be granted in any of the following circumstances following receipt of a complete application for Allied Health Professional status:

(1) During the pendency of review and consideration of a preliminary application for Allied Health Professional status, but only after completion of the processes set forth in Sections 3.2(A)-(D) of these Guidelines, to last for one or more specified periods or for as long as the application is pending, but not to exceed 120 days;

(2) For the care of patients as locum tenens at the Hospital, for a designated period that may not exceed 120 days.

(3) To assist with care of a specific patient for a designated period that may not exceed 120 days.

(4) In times of emergency and/or disaster for a designated period that may not exceed 120 days.

B. An Allied Health Professional who is granted temporary clinical privilege(s) shall be subject to observation under Section 6 of these Guidelines.

C. The Hospital Administrator or the Chief of the Medical Staff may, at any time, suspend or terminate an Allied Health Professional's temporary clinical privilege(s).

D. An Allied Health Professional shall not be entitled to any of the review rights set forth in these Guidelines in the event that a request for temporary clinical privilege(s) is denied or in the event that temporary clinical privilege(s) are suspended or terminated, except as required by law.

4. CORRECTIVE ACTION AND HEARING RIGHTS

4.1 Corrective Action

A. A department chair, the Chair of the Interdisciplinary Practice Committee, the Chief of the Medical Staff, the Hospital Administrator, or the Board may make a request to the Medical Executive Committee for an investigation or corrective action whenever an Allied Health Professional engages in conduct that is perceived to be harmful to patient safety, detrimental to the delivery of quality patient care, in violation of applicable rules, policies, or these Guidelines, or disruptive of Hospital operations. The request shall be in writing and shall be supported by reference to the conduct or activities at issue.

B. The Medical Executive Committee may appoint an ad hoc committee to carry out an investigation. Any such ad hoc committee shall proceed in a prompt manner with the investigation, which may include an informal meeting with the Allied Health Professional. At the conclusion of its investigation, the ad hoc committee shall forward a report, together with any recommendation for corrective action, to the Medical Executive Committee.

C. The Medical Executive Committee shall consider the report and recommendation of any ad hoc committee and shall make its own recommendation concerning any corrective action.

D. In the event that the Medical Executive Committee recommends suspension or termination of Allied Health Professional status or reduction in clinical

privilege(s), the Allied Health Professional shall be entitled to a review under Section 4.2. If the Allied Health Professional waives his or her right to a review, the matter shall be forwarded, together with the supporting materials, to the Board for a final decision.

E. In the event that immediate action is deemed necessary in the interests of patient care or hospital operations, any person or administrative body entitled to request an investigation or corrective action under Section 4.1 above may restrict or suspend an Allied Health Professional's status or clinical privilege(s) immediately. The Allied Health Professional then shall have the right to meet informally as soon as practicable with the Medical Executive Committee, which shall have the authority to continue, modify, or terminate the restriction or suspension. In the event that the restriction or suspension is not lifted the Allied Health Professional shall have the right to obtain review under Section 4.2below. The restriction or suspension shall remain in effect pending any such review.

F. The Allied Health Professional's status and clinical privileges shall be subject to automatic suspension, restriction, revocation, or other action as follows:

(1) If the Allied Health Professional's state license or other legal credential authorizing practice, certificate from the U.S. Drug Enforcement Agency ("DEA"), or provider status in a government-funded program is suspended, restricted, placed on probation, or revoked, his or her status and clinical privileges shall automatically be affected in the same manner.

(2) If an Allied Health Professional fails to comply with the Hospital's requirements for timely and adequate completion of medical records, his or her privileges may be automatically suspended pending resolution of the problem.

(3) If there is a lapse in the Allied Health Professional's maintenance of professional liability insurance as required by the Hospital, his or her privileges shall be automatically suspended until the requisite coverage is reinstated and documented.

(4) For Allied Health Professionals acting under the supervision of another practitioner, any lapse in the supervising practitioner's willingness or ability to provide such supervision shall result automatically in the suspension of the Allied Health Professional's privileges. This includes, without limitation, termination of the supervising practitioner's medical staff membership or suspension of the applicable privileges, whether such termination or suspension is voluntary or involuntary. Where the Allied Health Professional's privileges are automatically suspended for the reasons specified in this Section 4.1.F(4), the Allied Health Professional may apply for reinstatement as soon as approved supervision is reinstated, which might necessitate the Allied Health Professional's procurement of another supervising practitioner in good standing who agrees to supervise the Allied Health Professional and receives the necessary privileges or approval to do so.

4.2 Review

A. An Allied Health Professional shall be given the opportunity to have any of the following actions or recommended actions reviewed, according to the procedures described below, before it becomes final and effective (except for a summary restriction which shall be effective immediately):

(1) Denial of an application for credentialing or recredentialing as an Allied Health Professional for quality of care reasons;

(2) Denial of a request for initial or additional clinical privileges (except temporary clinical privileges) for quality of care reasons;

(3) Reduction or suspension for more than 30 days or termination of existing clinical privileges (except temporary clinical privilege(s) for quality of care reasons; or

(4) Suspension for more than 30 days or termination of Allied Health Professional status for quality of care reasons.

B. Notwithstanding Section 4.2.A above, an Allied Health Professional shall have no right to obtain review in any of the following instances:

(1) When an application is denied or not acted upon because it is incomplete;

(2) When an application is denied or not acted upon because the Allied Health Professional is not from a category that the Hospital has accepted for practice on its premises;

(3) When an application is denied or not acted upon, or Allied Health Professional status or clinical privilege(s) is revoked because of the existence of an employment, contractual, panel, or other relationship between the Hospital and one or more other Allied Health Professionals in the affected category which provides for exclusivity or limits the number of Allied Health Professionals in that category who may practice at the Hospital;

(4) When an application is denied or Allied Health Professional status or clinical privilege(s) is revoked because the physician who has agreed or is required by law or Medical Staff policy to act as the Allied Health Professional's supervising physician has given up or been deprived of that status or no longer holds the requisite Medical Staff membership or clinical privileges;

(5) When temporary clinical privileges are denied, suspended, restricted, or revoked under Section 3.5 above; or

(6) When clinical privileges are suspended, restricted, or revoked because of a lapse in licensure, a lapse in insurance, a lapse in DEA registration, a lapse of provider status in a government-funded health program, a lapse of supervision, medical record delinquencies, or other administrative reasons.

Where there is no right to review under the procedures described herein, the Allied Health Professional may be afforded an opportunity to address the relevant factual issues informally before a final adverse decision is made.

C. The Allied Health Professional shall be notified of his or her right to obtain review as soon as practicable after the Medical Executive Committee has decided to make or recommend an adverse recommendation as described in Section 4.2.A. Notice shall be deemed given when deposited in the United States mail in a properly stamped envelope, certified or registered mail, return receipt requested, or when personally delivered to the Allied Health Professional.

D. To obtain review, the Allied Health Professional shall submit a written request to the Hospital Administrator. Such request must be received within fourteen (14) days of receipt of the notice to the Allied Health Professional. In the event that the Allied Health Professional does not request review in this manner, he or she shall be deemed to have waived any review rights. The matter then shall be forwarded to the Board for a final decision.

E. Review shall be in the form of a meeting with a panel, to be selected in accordance with Section F below. Within a reasonable time in advance of the meeting, the Hospital Administrator shall give the Allied Health Professional written notice of the time and date of the meeting and a written summary of the reasons for the recommendation or action. If appropriate, this summary shall include references to representative patient care situations or to relevant events.

F. The meeting shall be with an ad hoc panel consisting of at least three (3) persons appointed by the Medical Executive Committee. The Medical Executive Committee shall ensure that panel members have not participated earlier in the formal consideration of the case. The Medical Executive Committee shall designate one (1) member of the panel as its chairperson and may include an Allied Health Professional from the appropriate category as a panel member.

G. The panel shall set guidelines to assure that the meeting is held in an orderly manner and that the Allied Health Professional has a reasonable opportunity to challenge the recommendation or action and to respond to the reasons given for it. The guidelines shall allow for the following:

(1) A presentation by a representative of the Medical Executive Committee, in the presence of the Allied Health Professional, of the recommendation or action and the underlying reasons and supporting evidence, together with any additional information that the panel deems necessary.

(2) A presentation by the Allied Health Professional, which may include both an oral and a written statement, together with any other oral or documentary information pertaining to the issues.

(3) The presence of a practitioner who may accompany and represent the Allied Health Professional at the meeting. If possible, this practitioner shall be a member of the Medical Staff or in Allied Health Professional status at the Hospital. The panel in its discretion may permit the Allied Health Professional and the Medical Executive Committee to be accompanied or represented by legal counsel at the meeting. The panel itself may choose to be advised by legal counsel or attorney hearing

officer without regard to whether the parties are represented by counsel. The panel shall arrange for any such counsel through the Hospital Administrator.

(4) A record of the meeting to be maintained by the panel in the form of minutes or a tape recording, or through use of a Certified Shorthand Reporter. If a record is maintained by means of a tape recording or a Certified Shorthand Reporter, any party requesting a transcript or copy thereof will bear the cost of its preparation.

H. The panel shall affirm the recommendation or action of the Medical Executive Committee, unless the Allied Health Professional demonstrates, by a preponderance of the evidence that it is arbitrary or unreasonable in light of the evidence presented at the meeting.

I. Following the meeting, the panel shall deliberate and shall issue a written decision and report. A copy of the decision and report shall be provided to the Allied Health Professional, the Chief of the Medical Staff, and the Board of Directors.

J. The Board of Directors shall consider the decision and report of the panel. In its discretion, the Board of Directors may allow the Medical Executive Committee and the Allied Health Professional to submit written statements to it commenting on the decision and report. The Board of Directors then shall make the final decision on the matter, in accordance with its own procedures.

4.3 Exceptions for Licentiates as Defined by Section 805 of the California Business and Professions Code

If the Allied Health Professional is a "Licentiate" as defined by Section 805 of the California Business and Professions Code (including a clinical psychologist and a physician assistant), and the action or recommendation would be reportable to the state licensing authorities under that statute, the Allied Health Professional shall be afforded the procedural rights described in the Medical Staff Bylaws relating to Medical Staff members.

5. FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments shall be grounds for automatic suspension of an Allied Health Professional's Clinical Privileges. Such suspension shall take effect automatically if the dues and assessments remain unpaid thirty (30) calendar days after the Allied Health Professional is given notice of delinquency and warned of the automatic suspension. If the Allied Health Professional still has not paid the required dues or assessments within six (6) months after such notice of delinquency, the Allied Health Professional's status and clinical privileges shall be automatically terminated.

6. OBSERVATION

6.1 An Allied Health Professional who is initially granted clinical privilege(s) shall automatically be subject to a period of observation, to extend for a minimum of six (6) months or ten (10) cases, whichever is longer. The observation period shall last a maximum of twenty-four (24) months or for such longer time as the department chair may specify, subject to Medical Executive Committee approval. The Allied Health

Professional shall not be entitled to a review under Section 4.2 of the decision to continue or extend observation. In the event that the department chair has not approved the full exercise of a particular clinical privilege within the established observation period, that clinical privilege shall cease, and the Allied Health Professional shall be entitled to review, upon request, pursuant to Section 4.2 above. provided, however, if the department chair has not given his or her approval due to the failure of the Allied Health Professional to perform a sufficient volume of work at the Hospital to facilitate an adequate evaluation within the time allotted, the Allied Health Professional will be deemed to have forfeited the clinical privilege in question, and shall have no right to review.

6.2 The Medical Executive Committee, Chair of the Interdisciplinary Practice Committee, appropriate department chair, Chief of the Medical Staff, or Board of Directors shall have authority at any time to require that an Allied Health Professional be subject to a period of observation to last as long as deemed appropriate, and shall have the authority to adopt any rules or procedures considered necessary to implement this requirement. Such observation requirement does not give rise to the review under Section 4.2, unless the rules or procedures adopted for the observation requirement have the effect of a suspension or reduction of privileges, as specified in Section 4.2A(3).

6.3 Observation may consist of the methods customarily used at hospitals, including concurrent or retrospective chart review, proctoring, or the requirement of consultation. The observation methods shall be consistent with the Hospital's Ongoing Professional Performance Evaluations (OPPE) standards and Focused Professional Practice Evaluation (FPPE) standards, as adapted to the scope of practice and privileges of the Allied Health Professional.

6.4 The observer shall be a practitioner on the Medical Staff or in Allied Health Professional status who exercises clinical privileges relevant to the activity being evaluated and who has previously satisfied their observation requirements. Whenever possible, the observer should not be the sponsoring or supervising practitioner of the Allied Health Professional being observed.

7. ALLIED HEALTH PROFESSIONALS EMPLOYED BY THE HOSPITAL

As noted in Section 2.1A~~2.1A~~, these Guidelines apply to practitioners accorded Allied Health Professional status and who are under the jurisdiction of the Medical Staff. In addition, Hospital-employed Allied Health Professionals must be credentialed pursuant to certain procedures in these Guidelines. This Section **7** describes in full the application of these Guidelines to Hospital-employed Allied Health Professionals. Except as otherwise specified, the rights, responsibilities, and prerogatives of Hospital-employed Allied Health Professionals shall be governed by the policies and procedures of the Hospital's Human Resources Department, and ~~not~~ by these Guidelines.

7.1 General Standards for Employed Allied Health Professionals

In addition to any standards required by the Human Resources Department, an Allied Health Professional applying for employment with the Hospital shall satisfy the standards described in Sections 2.2.

7.2 Terms of Allied Health Professional Credentialing and Recredentialing

All Hospital-employed Allied Health Professionals shall receive annual skills/competence assessments and shall have two-year credentialing and recredentialing terms. This term shall not affect the

evaluation or performance review cycle applicable to the employed Allied Health Professionals under Human Resources Department policies and procedures, which may be more frequent than every two (2) years.

7.3 Credentialing Procedures

For every Allied Health Professional seeking employment with the Hospital, the procedures described in Sections 3.2A through 3.2E shall be followed for credentialing of the applicant.

A. The applicant has no right of review under Sections 3.2F and 4.2. A right of review, if any, would be pursuant to the policies and procedures of the Hospital's Human Resources Department.

7.4 Recredentialing Procedures

For recredentialing of the employed Allied Health Professional upon the expiration of the current credentialing term, the procedures described in Sections 3.3, as modified by Section 7.3, above, shall be followed.

7.5 Procedure for Requesting Additional Clinical Privileges

An Allied Health Professional employed by the Hospital may request additional clinical privileges pursuant to Section 3.4, as modified by Section 7.3 above.

7.6 Temporary Clinical Privilege(s)

Pursuant to Section 3.5, the Hospital Administrator and Chief of the Medical Staff may grant temporary clinical privilege(s) to an Allied Health Professional who has applied for employment at the Hospital and completed the application form and processes set forth in Sections 3.2(A)-(D) of these Guidelines.

7.7 Disciplinary or Corrective Action

Hospital-employed Allied Health Professionals are subject to disciplinary or corrective action pursuant to the policies and procedures of the Hospital's Human Resources Department, and not pursuant to Section **4** of these Guidelines, with the exception of "Licentiates," as defined by Section 805 of the California Business and Professions Code (including a clinical psychologist and a physician assistant), and as set forth in Section 4.3 and 7.7 above.

However, if the Hospital-employed Allied Health Professional's state license or other legal credential authorizing practice, certificate from the U.S. Drug Enforcement Agency ("DEA"), or provider status in a government-funded program is suspended, restricted, placed on probation, or revoked, his or her status and clinical privileges shall automatically be affected in the same manner.

7.8 Duties

In addition to any duties required by the Human Resources Department, Hospital-employed Allied Health Professionals shall be expected upon commencement of employment to satisfy the duties described in Section 11.2.

7.9 Observation

For every Hospital-employed Allied Health Professional who is initially granted clinical privilege(s), the procedures described in Section 6, above, shall be followed for observation of the Allied Health Professional.

8. CONTRACT ALLIED HEALTH PROFESSIONALS

8.1 The Board may determine that the interests of patient care or hospital operations are best served by entering into a contract with an entity which provides Allied Health Professionals to work within the Hospital. These Allied Health Professionals are neither employees nor independent contractors of the Hospital, nor are they independent professionals working in their own private practice. Rather, they are employees or independent contractors of an entity that has agreed to provide certain health services to the Hospital's patients. For purposes of these Guidelines, these persons shall be referred to as "Contract AHPs," and the entity employing or contracting with them shall be referred to as the "Contracting Entity."

8.2 Contract AHPs, including Licensed Independent Practitioners (defined as individuals permitted by law and the Hospital to provide care, treatment and services without direction or supervision), must be credentialed individually as described in Section 3 of these Guidelines.

8.3 Unless otherwise provided in the contract, the Administration may suspend or terminate an individual Contract AHP at any time for any lawful reason.

9. FORMAT FOR STANDARDIZED PROCEDURES

9.1 Standardized procedures are appropriate for certain areas of registered nursing that overlap with areas traditionally reserved exclusively to physicians. With the assistance of nurses and physicians, the Interdisciplinary Practice Committee will identify particular medical functions, performed by nurses that are suitable for standardized procedures and will oversee the creation of individual standardized procedures for them.

9.2 In order to be approved by the Interdisciplinary Practice Committee, a standardized procedure must be in writing and must contain the elements set forth below:

A. The standardized procedure must define the medical function, performed by nurses that it covers.

B. The standardized procedure must specify the functions that the registered nurses are authorized to perform and under what circumstances, including the following:

(1) Any specific requirements or steps for performing all or part of the functions covered by the standardized procedure;

(2) The setting or department in which the registered nurse may act;

(3) Any special record keeping requirements; and

(4) The nature and scope of supervision that the registered nurse must receive in performing the standardized procedure, (including any circumstances in which the registered nurse will be expected to communicate immediately with a physician).

C. The standardized procedure must include the following mechanisms for ensuring that only registered nurses with proper qualifications perform the function:

(1) A statement of the education, training, and experience that a registered nurse must have in order to perform the function;

(2) A system for evaluating, both initially and periodically afterwards, the competency of registered nurses to perform the function; and

(3) A mechanism for maintaining a list of the registered nurses at the Hospital who are authorized to perform the function.

D. The standardized procedure must contain the following information concerning its development and review:

(1) A schedule for periodic review and updating; and

(2) The date or dates on which the standardized procedure was approved, including approval by the Interdisciplinary Committee.

10. STANDARDS OF PRACTICE

Standards of practice for categories of Allied Health Professionals admitted by the Hospital to Allied Health Professional status are attached as Exhibits to these Guidelines.

11. MISCELLANEOUS

11.1 Voting Privileges and Committee Meetings

Allied Health Professionals shall not be entitled to vote on Medical Staff matters, except as expressly provided in the Medical Staff Bylaws, Rules and Regulations, and only to the extent consistent with their license and expertise, as determined by the chair of the responsible Medical Staff committee. When authorized by the Medical Staff, they may be invited to attend and participate actively in the clinical meetings of their respective departments or services.

11.2 Duties

All Allied Health Professionals shall satisfy all of the following duties, as applicable.

Upon credentialing, Allied Health Professionals shall be expected to:

A. Comply with these Guidelines, and with all other applicable rules of the Hospital and its Medical Staff, and with all applicable laws and standards.

B. Actively participate in the Hospital's and the Medical Staff's quality assessment program, peer review activities, and other quality evaluation and monitoring activities, as directed by appropriate representatives of the Hospital or the Medical Staff.

C. Promptly notify the Medical Staff Office and, if the Allied Health Professional is a Physician Assistant or Advanced Practice Registered Nurse employed by the Hospital, the Hospital's Human Resources Department, of an action by the Medical Executive Committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct.

D. Exercise independent judgment within their areas of competence, provided that a physician who is a member in good standing of the Medical Staff shall retain the ultimate responsibility for the patient's care.

E. Participate directly in the management of patients to the extent authorized by their license, certificate or other legal credentials.

F. Write and/or record such orders, reports and progress notes on patients' charts as are consistent with the rules and regulations of the Medical Staff.

G. Perform consultation on request as authorized by the Medical Staff.

11.3 Billing

Allied Health Professionals shall bill independently only as permitted by applicable statutes or regulations.

11.4 Confidential

Allied Health Professionals shall at all times respect the confidentiality of any and all information concerning patients treated at the Hospital and the confidentiality of all Medical Staff records and proceedings regarding peer review and credentialing activities.

11.5 Informed Consent

In conjunction with the responsible physician, the Allied Health Professional may obtain the informed consent of the patient or the patient's representative for any care, treatment, or procedure to be performed by the Allied Health Professional. The discussion with the patient shall include explanation of the fact, if applicable, that the Allied Health Professional is not a Hospital employee, but rather practices independently under the supervision of the responsible physician. The responsible physician or Allied Health Professional shall ensure that there is written documentation that informed consent was obtained.

Date of Interdisciplinary Practice Committee Approval: 9/9/2015; 10/12/2016

Date of Medical Executive Committee Approval: 10/21/2015; 02/16/2017

Date of Board of Directors Approval: 10/29/2015; 4/27/2017

EXHIBIT A

ADMITTED CATEGORIES OF ALLIED HEALTH PROFESSIONALS

1. Clinical Psychologists
2. Advanced Nurse Practitioners
3. Physician Assistants
4. Dental Assistants
5. Audiologists
6. Acupuncturists

MED: FEBRILE NEUTROPENIA (TFH) [900505]

Code Status

Code Status (Single Response)

○ Full Code	Details
○ No CPR (in event of cardiopulmonary arrest)	Mechanical Ventilation (for respiratory distress) - Invasive (i.e. intubation):
○ Comfort Measures Only	Details

Patient Disposition

Patient Disposition (Single Response)

OPTIONAL: There is currently an Admit to Inpatient or a Place Patient as Observation/Outpatient order on the Patient's Chart.
If the patient class in the header is incorrect, place appropriate order below.

○ Admit to Inpatient - Patients with documented medical necessity for inpatient services expecting 2 midnights. For CAH's: the patient may be expected to be discharged or transferred within 96 hours after admission. Does not apply to patients under a swing bed.	Certification: Patients with documented medical necessity for inpatient services expecting 2 midnights. For CAH's: the patient may be expected to be discharged or transferred within 96 hours after admission. Does not apply to patients under a swing bed. Patient Class: Inpatient Specialty Bed: ONE TIME, Starting today at 5:00 AM
○ Place Patient as Observation - Do not use prior to procedures. Use for patients that require short term treatment, assessment and reassessment before a decision for IP admission or discharge can be done.	ONE TIME, Starting today at 5:00 AM Patient Class: Observation Specialty Bed: Reason for Observation:
○ Place Patient as Outpatient - Use for routine recovery, NOT for IP ONLY procedures	ONE TIME, Starting today at 5:00 AM Patient Class: Outpatient Reason for Outpatient:
○ Place Patient as Outpatient - Surgical OP/Extended Care (For surgical patients expected to stay overnight , NOT for IP ONLY procedures)	ONE TIME, Starting today at 5:00 AM Patient Class: Surgical OP/Extended Care Reason for Outpatient:

Vital Signs

Vitals

☑ Vital Signs per Facility Department Guidelines	Routine, ONGOING

Patient Activity

Activity

☐ Bedrest	Routine, ONGOING Also:
☐ Bedrest with Bedside Commode	Routine, ONGOING Also: With Bedside Commode
☐ Bedrest with Bathroom Privileges	Routine, ONGOING Also: With Bathroom Privileges
☐ Ambulate with Assist	Routine, THREE TIMES DAILY
☐ Up Ad Lib	Routine, ONGOING

Patient Care

* Consider leaving indwelling central venous catheter in place, despite suspected infection, if appropriate antimicrobial therapy is initiated.

Nursing Assessments

☐ Intake and Output	Routine, EVERY 4 HOURS Notify Physician if urine output less than: 120 milliliter
☐ POC Glucose	Routine, ONE TIME, Starting today at 5:00 AM, Blood, whole, Unit Collect
☐ Pulse Oximetry, Spot	Routine, EVERY 8 HOURS
☐ Pulse Oximetry, Continuous	Routine, CONTINUOUS
☐ Telemetry Monitoring	Routine, ONGOING Can the patient be off telemetry for activities (including therapy, ambulation, off-unit procedures, showers, bathroom)? Yes

Nursing Interventions

☐ Bed Position	Routine, ONGOING Head of Bed: 30°
☐ Insert Foley Catheter	Routine, ONE TIME, Starting today at 5:00 AM When: Reason for Foley:
☐ Insert Peripheral IV	Routine, ONE TIME, Starting today at 5:00 AM Insert with:
☐ Insert PICC Line	Routine, ONE TIME, Starting today at 5:00 AM Criteria:
☐ Airborne Isolation	Details
☐ Contact Isolation	Details
☐ Enhanced Contact Isolation	Details
☐ Droplet Isolation	Details
☐ Neutropenic Precautions	Details

Nursing Communication

☐ Nursing Communication	Routine, ONGOING, ***

Nursing Contigency

☐ Notify Physician	Routine, ONGOING, ***

Education

☑ Education, Smoking Cessation and Second Hand Smoke Avoidance	Routine, ONE TIME, Starting today at 5:00 AM

Respiratory Therapy

☐ Oxygen Via Device to Keep O2 SAT	Routine, CONTINUOUS Above: 92% O2 Device: Per RT/Nursing Humidify Oxygen?
☐ RT Assess and Treat	Routine, ONE TIME, Starting today at 5:00 AM

Nutritional Services

Diet

☐ Diet NPO	DIET EFFECTIVE NOW, Starting today NPO terms: Strict

Diet Clear Liquid

DIET EFFECTIVE NOW, Starting today
Safe Tray:
Fluid/day:
Sodium gm/day:
Schedule:
Additional restrictions:
Fluid consistency:
Clr Liquid:
Tube Feeding Formula:
Calories/day:
Settings:
Neutropenic Diet:
Gluten:
Low Tyramine:
Diabetic:

Diet General

DIET EFFECTIVE NOW, Starting today
Safe Tray:
Fluid consistency:
Fluid/day:
Additional restrictions:
Gluten:
Lactose:
Food Texture:
Portions:
Settings:
Neutropenic Diet:
Low Tyramine:

Diet Diabetic

DIET EFFECTIVE NOW, Starting today
Calories/day:
Fat gm/day:
Protein gm/day:
Sodium gm/day:
Cholesterol:
Schedule:
Daily Carbs:
Renal Type:
Safe Tray:
Fluid consistency:
Lactose:
Food Texture:
Portions:
Additional restrictions:
Settings:
Fluid/day:
Tube Feeding Formula:
Low Tyramine:
Gluten:
Neutropenic Diet:
Diabetic:

☐ Diet Cardiac	DIET EFFECTIVE NOW, Starting today Safe Tray: Fat gm/day: Cholesterol: Low Cholesterol (AHA), Renal Type: Fluid/day: Sodium gm/day: 2GM Sodium (Low), Fluid consistency: Lactose: Food Texture: Portions: Additional restrictions: Settings: Tube Feeding Formula: Low Tyramine: Gluten: Neutropenic Diet: Calories/day: Diabetic:
☐ Diet Neutropenic - Low Bacteria	DIET EFFECTIVE NOW, Starting today Safe Tray: Fluid consistency: Lactose: Food Texture: Portions: Additional restrictions: Settings: Fluid/day: Tube Feeding Formula: Low Tyramine: Gluten: Neutropenic Diet: Calories/day: Diabetic: Sodium gm/day:
☐ Advance Diet as Tolerated	Routine, CONTINUOUS Goal Diet:

IV Fluids

Saline Lock IV

✓ Nursing Communication - IV Flush Panel	Routine, ONE TIME, Starting today at 5:00 AM, Please order the appropriate Standard IV Flush panel for this patient based on IV Line Type
☐ Saline Lock IV	Routine, ONE TIME, Starting today at 5:00 AM When: Now

Maintenance with Additives

☐ sodium chloride 0.9% infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
☐ sodium chloride 0.45% infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
☐ dextrose 5% - sodium chloride 0.9% infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
☐ dextrose 5% - sodium chloride 0.45% infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
☐ lactated ringers infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
☐ potassium Cl 20 mEq in sodium chloride 0.9% 1,000 mL infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
☐ potassium Cl 20 mEq in sodium chloride 0.45% 1,000 mL infusion	IV, at 30 mL/hr, CONTINUOUS, Routine

potassium Cl 20 mEq in dextrose 5% - NaCl 0.9% 1000 mL infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
potassium Cl 20 mEq in dextrose 5% - NaCl 0.45% 1000 mL infusion	IV, at 30 mL/hr, CONTINUOUS, Routine
potassium Cl 20 mEq in lactated ringers 1,000 mL infusion	IV, at 30 mL/hr, CONTINUOUS, Routine

Antiemetics

Make one selection from each section below as indicated for patient condition. Selection is not required.

Antiemetics - First Line Therapy (Single Response)

Please select one of the following medications as first line therapy for nausea with or without vomiting.

ondansetron (ZOFRAN ODT) tablet	4 mg, Oral, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
ondansetron (ZOFRAN) injection	4 mg, IV, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
metoclopramide (REGLAN) injection	10 mg, IV, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
prochlorperazine maleate (COMPAZINE) tablet	10 mg, Oral, EVERY 6 HOURS PRN, Nausea/Emesis, Routine

Antiemetics - Second Line Therapy (Single Response)

Please select one of the following medications as second line therapy for nausea with or without vomiting.

ondansetron (ZOFRAN ODT) tablet	4 mg, Oral, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
ondansetron (ZOFRAN) injection	4 mg, IV, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
metoclopramide (REGLAN) injection	10 mg, IV, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
prochlorperazine maleate (COMPAZINE) tablet	10 mg, Oral, EVERY 6 HOURS PRN, Nausea/Emesis, Routine

Antiemetics - Third Line Therapy (Single Response)

Please select one of the following medications as third line therapy for nausea with or without vomiting.

ondansetron (ZOFRAN ODT) tablet	4 mg, Oral, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
ondansetron (ZOFRAN) injection	4 mg, IV, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
metoclopramide (REGLAN) injection	10 mg, IV, EVERY 6 HOURS PRN, Nausea/Emesis, Routine
prochlorperazine maleate (COMPAZINE) tablet	10 mg, Oral, EVERY 6 HOURS PRN, Nausea/Emesis, Routine

Prophylactic Antibacterial Agents

* Avoid the routine addition of an aminoglycoside to beta-lactam therapy in patients with neutropenic fever.

Beta-Lactam/Beta-Lactamase Inhibitors

piperacillin-tazobactam (ZOSYN) IVPB	3.375 Gram, IV, EVERY 6 HOURS, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient

Cephalosporins, 4th-Generation

cefePIME (MAXIPIME) IVPB	2,000 mg, IV, EVERY 8 HOURS, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient

Carbapenem

imipenem-cilastatin (PRIMAXIN) IVPB - use with caution in patients with penicillin allergy, less than 10% incidence of cross-sensitivity	500 mg, IV, EVERY 6 HOURS, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient

Monobactam

For use in patients with true penicillin allergy, use with Vancomycin

aztreonam (AZACTAM) IVPB	2,000 mg, IV, EVERY 8 HOURS, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient

Glycopeptides

vancomycin (VANCOCIN) IVPB - patient weight less than 45 kg	750 mg, IV, ONE TIME ONLY For 1 Doses, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient
vancomycin (VANCOCIN) IVPB - patient weight 45 - 60 kg	1,000 mg, IV, ONE TIME ONLY For 1 Doses, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient
vancomycin (VANCOCIN) IVPB - patient weight 61 - 80 kg	1,250 mg, IV, ONE TIME ONLY For 1 Doses, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient
vancomycin (VANCOCIN) IVPB - patient weight greater than 80 kg	1,500 mg, IV, ONE TIME ONLY For 1 Doses, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient
Consult to Pharmacy - Vancomycin	Pharmacy to Dose Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient

Quinolones

For use in patients with true penicillin allergy, use with Vancomycin

levoFLOXacin (LEVAQUIN) 750 mg/150 mL in D5W IVPB	750 mg, IV, EVERY 24 HOURS, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient

Nitroimidazoles

metroNIDAZOLE (FLAGYL) IVPB	500 mg, IV, EVERY 6 HOURS, Routine Antibiotic Indication: Neutropenic Fever in immunocompromised patient

Hematopoietic Cell Growth Factors

Granulocyte Colony-Stimulating Factors

filgrastim-sndz (ZARXIO) 300 mcg/0.5 mL injection	300 mcg, subCUT, ONE TIME ONLY For 1 Doses, Routine

Antipyretics

Antipyretics

acetaminophen (TYLENOL) tablet	650 mg, Oral, EVERY 4 HOURS PRN, Temperature, for fever greater than 101 degrees, Routine
acetaminophen (TYLENOL) rectal suppository	650 mg, Rectal, EVERY 4 HOURS PRN, Temperature, for fever greater than 101 degrees, Routine
ibuprofen (MOTRIN) tablet	800 mg, Oral, EVERY 8 HOURS PRN, Temperature, for fever greater than 101 degrees, Routine

Laxatives

Stimulant Laxatives

bisacodyl (DULCOLAX) 10mg rectal suppository	10 mg, Rectal, DAILY PRN, Constipation, Routine

Laxative Stool Softeners

docusate sodium (COLACE) capsule	100 mg, Oral, TWO TIMES DAILY, Routine
magnesium hydroxide (MILK OF MAGNESIA) oral suspension	30 mL, Oral, DAILY PRN, Constipation, Routine

VTE Prophylaxis

Pharmacologic Prophylaxis (Single Response)

enoxaparin (LOVENOX) injection	40 mg, subCUT, EVERY 24 HOURS, Routine Indication: Prophylaxis of VTE Dose to be adjusted per facility protocol? Yes
heparin 5000 unit injection	5,000 Units, subCUT, EVERY 8 HOURS Starting today with First Dose Include Now, Routine
FOR RENAL DYSFUNCTION: CrCl LESS THAN 30 mL/min - enoxaparin (LOVENOX) injection	30 mg, subCUT, EVERY 24 HOURS, Routine Indication: Prophylaxis of VTE Dose to be adjusted per facility protocol? Yes
FOR OBESE DOSING - enoxaparin (LOVENOX) injection	0.5 mg/kg, subCUT, EVERY 24 HOURS, Routine Indication: Prophylaxis of VTE Dose to be adjusted per facility protocol? Yes
REASON FOR NOT ADMINISTERING VTE PHARMACOLOGICAL PROPHYLAXIS	Routine, ONGOING Reason for not administering VTE pharmacological prophylaxis?

Mechanical Prophylaxis (Single Response)

**Mechanical Prophylaxis is recommended for patients ineligible for pharmacologic prophylaxis.

Place Intermittent Pneumatic Compression	Routine, ONGOING Where: BIL LEGS
Reason for Not Initiating Mechanical Prophylaxis	Routine, ONGOING Reason for no VTE mechanical prophylaxis?

Laboratory

Hematology

CBC With Differential	Routine, ONE TIME, Starting today at 5:00 AM, Blood, A manual differential will be performed if appropriate.

Microbiology

* Blood cultures should be obtained before administering antimicrobial therapy.

Blood Culture Panel

Blood Culture - Peripheral - 1st set	Routine, ONE TIME, Starting today at 5:00 AM For 1 Preferred Collection Source: Peripheral
Blood Culture - Line - 1st Set	Routine, ONE TIME, Starting today at 5:00 AM For 1 Preferred Collection Source: Line
Blood Culture - Peripheral - 2nd Set	Routine, ONE TIME, Starting today at 5:00 AM For 1 Preferred Collection Source: Peripheral Wait 5-15 minutes before obtaining the second set of blood cultures.
Blood Culture - Line - 2nd Set	Routine, ONE TIME, Starting today at 5:00 AM For 1 Preferred Collection Source: Line Wait 5-15 minutes before obtaining the second set of blood cultures.

Fungus Blood Culture	Routine, EVERY 15 MINUTES For 2 , Blood, Wait 5 to 15 minutes before obtaining a second set of fungal blood cultures.
Fungus Blood Culture	Routine, EVERY 15 MINUTES For 2 , Blood, Wait 5 to 15 minutes before obtaining a second set of fungal blood cultures.

Panels

Comprehensive Metabolic Panel	Routine, ONE TIME, Starting today at 5:00 AM, Blood

Urine Studies

Urinalysis w/Reflex Microscopic	Routine, ONE TIME, Starting today at 5:00 AM, A microscopy will be reflexively ordered if certain Urinalysis results are significant.
Urinalysis w/Reflex Culture	Routine, ONE TIME, Starting today at 5:00 AM, A microscopy and/or culture will be reflexively ordered if certain Urinalysis results are significant. Specimen Source?

Imaging/Radiology

General Radiology

XR Abdomen Acute Series W CXR	Routine, RAD ONE TIME, Starting today For 1 Reason for Exam: Method of Transportation: Is the Patient Pregnant?
XR Chest PA or AP	Routine, RAD ONE TIME, Starting today For 1 Reason for Exam: Method of Transportation: Portable Is the Patient Pregnant?
XR Chest PA and Lateral	Routine, RAD ONE TIME, Starting today For 1 Reason for Exam: Method of Transportation: Is the Patient Pregnant?
XR Abdomen 1 View	Routine, RAD ONE TIME, Starting today For 1 Reason for Exam: Method of Transportation: Is the Patient Pregnant?

Computed Tomography

CT Abdomen Pelvis W Contrast (IV Contrast)	Routine, RAD ONE TIME, Starting today For 1 Select Oral Contrast: Method of Transportation: Is the Patient Pregnant? Will the exam be performed at St. Anthony's? Intravenously
CT Abdomen Pelvis WO Contrast (Oral Only)	Routine, RAD ONE TIME, Starting today For 1 Select Oral Contrast: Method of Transportation: Is the Patient Pregnant? Will the exam be performed at St. Anthony's? Oral Contrast Only
Ct Abdomen Pelvis WO Contrast (NO Oral NO IV)	Routine, RAD ONE TIME, Starting today For 1 Select Oral Contrast: Method of Transportation: Is the Patient Pregnant? Will the exam be performed at St. Anthony's? (No Oral, No IV)

Procedures/Diagnostic Tests

Cardiology

EKG 12-Lead	Routine, ONE TIME, Starting today at 5:00 AM Reason For Exam: Hospital Performed

Consults

Consults

IP Consult to Case Management	Routine, ONE TIME, Starting today at 5:00 AM Reason for Consult? Assistance with discharge planning
IP Consult to Nutrition Services	Routine, ONE TIME, Starting today at 5:00 AM Reason for consult?
IP Consult to Social Work	Routine, ONE TIME, Starting today at 5:00 AM Reason for Consult? Assistance with discharge planning

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Medical Staff - MSGEN*
Applicabilities:	*System*

Peer Review/Professional Practice Evaluation, MSGEN-1401

PURPOSE:

A. To define the Medical Staff peer review process utilizing High Reliability and Just Culture tenets (AGOV-1; and AGOV-1505) including ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) in order to continuously improve the quality, safety, and effectiveness of care rendered by members of the Medical Staff and Allied Health Professionals as defined in the Allied Health Professional Manual at Tahoe Forest Health System, to whom clinical privileges/scopes of practice are granted.

B. This policy defines procedures for data collection, event review, and clinical case reviews, as well as the mechanisms by which the process will assure that timely, just and fair assessments of practitioner competence are accomplished. When applicable, systems and process issues germane to the quality and safety of patient care will be integrated into the hospital's Quality Assurance Process Improvement Plan (QA PI Plan).

POLICY:

A. All activities and records conducted as part of this policy are confidential and protected from discovery pursuant to the Healthcare Quality Improvement Act and California Evidence Code 1157. As such, all individuals participating in peer review are to abide by the confidentiality provisions of the Medical Staff Bylaws and any other agreements required to participate in the Medical Staff peer review process.

B. The Medical Staff departments are responsible for performance of peer review activities under the leadership of the Department Chairpersons, Medical Director of Quality, Leadership Council (LC), Professional Practice Evaluation Committee (PPEC), with support and direction provided by the Medical Executive Committee. Peer review activities are comprised of individual case review and aggregate rate based review utilizing all available data sources to identify and assess practitioner performance. (*See Addendum A for Data Sources)*

C. The peer review process documentation shall be initiated and maintained by the Medical Staff as outlined in Addendum B algorithm for case identification and peer review process.

CLINICAL COMPETENCIES SUBJECT TO REVIEW

Types of reviews:

A. **Single case or event –** Single case reviews are identified by the screening and case identification elements, using the annually approved peer review indicators (Addendum A), and process defined in Addendum B.

B. **Focused Professional Practice Evaluation (FPPE)** – Described in Medical Staff Bylaws.

C. **Deviation of Care/Practice:** A deviation represents a practitioner who strays from professional standards (clinical and behavioral) and/or patient safety standards. Rules are documented in the Medical Staff Bylaws and Rules and Regulations, and Medical Staff and Hospital Policy and Procedure. A deviation shall be addressed through the High Reliability and Just Culture model with the outcomes including but not limited to consoling, coaching, or punitive action. This may also involve the FPPE and OPPE process, and the Medical Staff bylaws.

DEFINITIONS:

"**Designee**" refers to an appropriate, elected or appointed medical staff leader, who may act on behalf of the individual described in this policy and procedure.

"**Disruptive Behavior**" is defined as conduct that has interfered (or has the potential to interfere) with the delivery of safe, timely, effective, efficient, equitable, patient centered, and quality care. A more detailed definition, with examples, is addressed in the Medical Staff *Medical Staff Professionalism Complaint Policy* (MSGEN-1)

"**General Clinical Competencies**" in this policy are defined by concepts developed by the American Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). These competencies include:

Clinical	Patient Care & Procedural Skills Medical/Clinical Knowledge Practice Based Learning & Improvement
Behavioral	Interpersonal and Communication Skills Professionalism Systems Based Practice

Patient Care = Departmental indicators, procedural complications, infections, appropriate decision making, diagnosis, treatment

Medical / Clinical Knowledge = CME, training/experience, certifications

Practice Based Learning = EXAMPLES:

- *Interpersonal/Communication Skills* = complaints, positive feedback, documentation, patient hand offs, appropriate behavior between colleagues, staff, patients, families
- *Professionalism* = satisfaction survey results, meeting attendance, response time to ED / consults, Code of Conduct (ACMP-01), case presentations, teaching
- *Systems based practice* = medical record delinquencies, suspension, policies and procedures, informed consent, utilization review

"High Reliability" refers to being proactive, not reactive; focus on building a strong system; understanding vulnerabilities; recognize bias; efficient resource management; less rule based and more risk based assessment.

"**Just Culture**" refers to a values-supportive model of shared accountability. It's a culture that holds

organizations accountable for the systems they design and for how they respond to staff behaviors fairly and justly.

"**Medical Staff Quality Committee (MSQC)**" provides oversight of the peer review process, including approving the policy and reviewing the peer review statistics in aggregate, and identifying areas for improvement. Acts as the Professional Practice Evaluation Committee (PPEC).

"**Leadership Council (LC)"** is an ad hoc committee that will meet on an as-needed basis, for the duration necessary, to address a given practitioner's concerns or behavior.

"**Peer Review**" refers to the good faith activities utilized by the organized Medical Staff to conduct patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care provided to patients. The term is used to reflect the activities described in this policy and includes both OPPE and FPPE.

"**Physician Out of Committee Review**" refers to the portion of single case clinical review where the Department Chair or designee peer reviews the case and completes the review worksheet, indicating the review result and final action. Reviewers are encouraged to speak with the provider involved with the case, and cite specific literature or evidence based practice references, which were considered in evaluating the case under review.

"**Peer**" refers to a practitioner who has the clinical experience and training necessary to provide an assessment of the specific issues related to the clinical review of care or the investigation of conduct related to an event.

"**Practitioner**" refers to an individual credentialed by the Medical Staff and includes all Medical Staff Members, including those with temporary privileges, and all Allied Health Practitioners.

"**Preliminary Reviewer**" refers to a staff level individual such as a Registered Nurse, Pharmacist, Infection Preventionist, and so forth, who provide the initial case review and recommendation for peer review.

"**Professional Practice Evaluation Committee**" (PPEC) refers to a multidisciplinary ad hoc committee convened at the request of the Department Chair, Medical Director of Quality, or the Quality & Regulation Director.

"**Peer Review Worksheet**" Each single case review has a peer review worksheet that documents the review content and progress. The physician peer completing out of committee review will complete the review sheet and indicate a review result and final action.

"**Single case Review"** Cases or events requiring review are identified by the screening and case identification elements listed in *Addendum A* and follow the process defined in *Addendum B*. During a specialty specific clinical review, whenever possible, the reviewers are individuals from the same professional discipline, or a related specialty, who possess sufficient training and experience to render a technically sound judgment on the clinical circumstances under review.

"External Peer Review" is a review of individual cases in which concerns have been raised regarding the quality or appropriateness of care. This may occur for any specialty, however, may be necessary for single specialists in order to obtain peer input.

PROCEDURE:

A. **CONCLUSIONS OF REVIEW**

1. **Aggregate Reports**

a. Rate based reviews are used for generating aggregate reports.

b. Trended clinical OPPE Summary Reports will be reviewed by each Department Chair and referred to Medical Staff Quality Committee (MSQC) for review every six (6) months.

2. **Single Case Review** (*Addenda A & B*)

a. Review includes:

i. Preliminary Quality staff screening with Physician and Department Chair notification of the peer review

ii. Physician Department Chair, Vice Chair, or designee - Physician reviewer provides an out of committee review and completes the peer review worksheet

iii. Case can be referred to the PPEC,to provide conclusions and recommendations - Committee discusses the case with the physician involved and determines any additional follow up needed.

iv. All clinical case review, aggregate results and final action, are reported to the MSQC and the Medical Staff Departments biannually, and to the Board of Directors annually.

B. **PRACTITIONER PARTICIPATION**

1. All members of the organized Medical Staff are expected to participate in the peer review process in good faith.

2. All peer review activities are confidential with discussion to occur in Medical Staff Department and Committees, except as reasonably necessary to perform an official peer review function confidentially outside of a committee meeting.

3. **Clinical Case Review/Event Review**

a. The Department Chair or MSQC (PPEC) may question all parties involved, including the physician, to understand all aspects of care (including but not limited to equipment, staffing, and supplies concerns, competing values, call burden, human factors, patient interaction, communication, etc.). Department Chairs, MSQC (PPEC), or designee, may request written response from a practitioner to clarify questions or concerns identified during the review process, or they may require a practitioner to attend a meeting in person.

b. When either request is made, the practitioner's participation is mandatory as described in Article 6.8-6 of the Medical Staff Bylaws.

c. When a clinical case results in "educate provider," the Department Chair or designee will contact the involved practitioner to share the review findings. The practitioner may provide a written response to the clinical review or attend the Department, or MSQC (PPEC) meeting, to discuss the case.

4. **Behavioral Event Review** – Full details of behavioral event review are described in the Medical Staff Policy titled MSGEN-1 Medical Staff Professionalism Complaint Process, and AGOV-1505 Professional Expectations policy.

5. Physicians may review their OPPE information file at any time for review of completed single case review and/or to review OPPE reports. Physicians will receive a copy of their personal OPPE report on a rolling six month basis, after the report has been reviewed by the Department Chair. File access is coordinated through the Medical Staff Office.

C. **CLINICAL REVIEW EFFICIENCY (TIMELINESS)**

1. Routine review is for those clinical situations where the immediate action of the Medical Staff leadership is not required. Single case review shall be conducted in a timely manner. Single cases requiring practitioner review will be assigned for review as near the time of identification as possible. Whenever reasonably possible, a review will be completed by the Department Chair, or the MSQC (PPEC), within three months of initiation.
2. Significant adverse events identified through the Medical Staff peer review process may be subject to accelerated review, when immediate review is required in light of the level of risk involved.
    a. Upon determination by the Director Medical Staff Services, Director of Quality and Regulations, Department Chair, Chief of Staff, CEO, COO, and/or Medical Director of Quality, that a significant adverse event has occurred involving a practitioner(s), an assessment of the situation shall be undertaken. The Chief of Staff and/or Medical Director of Quality with an Administrative representative shall conduct an assessment of the event.
    b. Findings from the accelerated review will be summarized and reported to the Department Chair, Medical Director of Quality, and other Medical Staff leadership as appropriate.

D. **External Peer Review**: Circumstances that may warrant external peer review and the procedures for obtaining it are described in the Medical Staff Bylaws.

E. **ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

1. OPPE is a review of an individual's performance compared to peers' performances and national benchmarks, as available and appropriate, over time using six-month intervals, with trends evaluated for adequacy of clinical competence and professional conduct (s*ee Addendum A Data Sources).*
2. OPPE data is evaluated every six (6) months to identify trends or patterns of professional practice or conduct that may have an adverse impact on the quality of care and patient safety.
3. When an OPPE threshold or trigger is exceeded, or significant deviations from expected performance have been identified, these findings and/or results will be communicated to the appropriate Department Chair. As appropriate, the Medical Director of Quality and MSQC (PPEC) will be notified. Using High Reliability and Just Culture tenets, should the Department Chair, Medical Director of Quality, or MSQC (PPEC) conclude that a FPPE is warranted, a FPPE will be initiated.
4. A summary aggregate report of OPPE trend reports shall be submitted to the MSQC, every six (6) months.
5. Semi-annually, an individual physician's OPPE Report will be sent to each practitioner after review by the Department Chair.

F. **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)**
This process is described in the Medical Staff Bylaws.

G. **INTENT**
This policy is intended to assist the Medical Staff in establishing and enforcing appropriate standards of professional competence and conduct, and is to be construed in a manner consistent with High Reliability and Just Culture tenets. It is not intended to constrain or conflict with the good faith efforts by the Medical Staff to perform the functions described in its Bylaws, or to create procedural rights or remedies beyond those existing under applicable law. Documentary or testimonial evidence, that is otherwise reasonable to consider in the conduct or Medical Staff affairs, shall not be deemed inappropriate for such use solely because of a technical deviation from the procedures described in this policy.

Related Policies/Forms:

Clinical Privileges for New Procedures or Treatment at Tahoe Forest Hospital District MSCP-5;
Professionalism Complaint Policy MSGEN-1;
Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906;
Professional Expectations, AGOV-1505
Medical Staff Bylaws

Reviewed by:

Medical Staff Quality Committee
Medical Executive Committee
Board of Directors
Approved by: CEO

ADDENDUM A: Data Sources FPPE (Focused Professional Practice Evaluation)

The data sources/methods for focused review are described in the Medical Staff Bylaws and one form of FPPE is sometimes called proctoring, which is required at the beginning of a practitioner's practice at the Hospital. This is to document clinical competency to perform the privileges granted. Completion of proctoring is during the initial provisional period, and will be completed as soon as possible after privileges are approved by the Board of Directors (BOD).

The second form of FPPE is activated as individual case review may be prompted by any of the following identified data elements:

1. Assessment of operative and other clinical procedures
2. The use of medications, blood, and blood products
3. Documentation review for accuracy, completeness, timeliness and/or legibility. Compliance with the Medical Staff Bylaws, Rules and Regulations, and relevant hospital and/or medical staff policy and procedure
4. Morbidity and mortality review/Evidence-based process review/periodic case review
5. Unexpected occurrences, unusual event reports, sentinel events, adverse events and "near misses," including those identified by Discussions with individuals involved in the care of a patient(s) including physicians, assistants at surgery, nursing staff administrative staff, patients, and others involved in patient care processes (Event Reporting, RCA)
6. Core Measures compliance, nosocomial infections, and hospital acquired conditions
7. Length of stay, utilization review identification of avoidable days, insurance denial for lack of documented medical necessity
8. Autopsy information (Coroner Reports)
9. Patient and family complaints (Patient satisfaction responses, grievances, complaints)
10. Coding data including complication, present on admission, procedural sequence codes,
11. Case screening by Coding Staff utilizing pre-established "**Generic Screens**"
    a. Generic Screens are reviewed and approved annually by the medical staff.

b. See Addendum B for complete list of Generic Screens

12. Physician referrals to Medical Staff leadership or hospital administrative or management staff
13. Cases referred from PI activities.
14. Third party payer, regulatory or accreditation agency notices specific to an individual case

A third type of FPPE is when a significant trend is noted and a focused review of the range of a practitioner's practice or practice of a specific specialty is requested.

OPPE (Ongoing Professional Practice Evaluation)

The methods for ongoing review may include, but are not limited to, assessment(s) of the following:

1. Types and volume of clinical activity
2. Conclusions of individual case review including: morbidity and morality review
3. Conclusions of case reviews for medications, blood/blood products utilization
4. Conclusions of reviews for accuracy, completeness, timeliness and legibility of medical records
5. Summary data related to compliance with the Medical Staff Bylaws, Rules and Regulations, and relevant hospital and/or medical staff policy and procedure
6. Summary data for evidence-based process review Summary data for unexpected occurrences, sentinel events, adverse events and "near misses"
7. Summary data for Core Measures compliance, and hospital acquired conditions (Clinical databases, Patient Safety Indicator Reports – AHRQ Patient Safety Indicators and inpatient Quality Indicators)
8. Length of stay/UR patterns
9. Proctoring, including direct observation and retrospective evaluation reports
10. Summary data for patient and family complaints
11. Conclusions from analysis of coding data including complication, present on admission, and procedural sequence codes

INDICATORS FOR TFHD FY 2020

DEPARTMENTAL INDICATORS

An indicator is a mechanism to assess the state or condition of another object. It is impossible to list all possible mechanisms to assess the care we provide our patients in the general context of healthcare, but there are certain commonalities among care experiences that should routinely be assessed. With that understanding, this list of indicators is considered non-exhaustive for the purposes of defining what and why something may be peer reviewed. Additionally, as indicators pertain to healthcare, it is important to understand that an indicator can be met but that the standard of care was ultimately followed, meaning the physician will not be found at fault.

The above naturally implies that some leeway and discretion is involved in determining what can and should be peer reviewed. As such, the Department Chair, Quality Medical Director, or the Director of Quality and Regulations reserve the ultimate non-punitive right to put a case through the Peer Review process even if an indicator is not listed below.

EVERY DEPARTMENT

A. Death or worsening condition as a direct result of care provided

B. Unplanned patient readmission within 30 days

C. Code Blue/White

D. Complaints regarding medical care and treatment

E. Unexpected transfer to a higher level of care

F. Use of any rescue or reversal drug

G. Track and trend Surgical Site Infection (SSI)

ANESTHESIA

1. **Multimodal Pain Management** (AQI59)

a. Definition: use of two or more classes of medications and/or interventions NOT including systemic opioids including NSAIDs, ketamine, acetaminophen, gabapentinoids, regional blocks, and local anesthetics

b. Exception(s): documented allergy to class(es) of medications, urgent/emergent procedures

2.**Post-Operative Pain** (MIPS 131)

a. Definition: adequate post-operative pain control, including an initial PACU pain score < 7/10

b. Exception(s): patients < 18 years old, patients unable to report pain score

3. **Post-Operative Nausea & Vomiting** (MIPS 430)

a. Definition: use of two or more classes of medications and/or interventions including serotonin receptor antagonists, dopamine-2 receptor antagonists, corticosteroids, anticholinergics, and TIVA in patients with 3 risk factors for PONV (history of PONV/motion sickness, female, non-smoker, use of post-operative opioids)

b. Exception(s): patients < 3 years old, documented allergy to class(es) of medications

4. **Re-intubation in PACU** (AQI31)

a. Definition: intubation in PACU after general anesthesia or monitored anesthesia care

b. Exception(s): n/a

5. **Unintended Dural Puncture**

a. Definition: unintentional puncture of the dural sac during an anesthetic procedure

b. Exception (s): n/a

6. **Unplanned Admissions**

a. Definition:

i. Unplanned overnight admission of outpatient surgery patient related to anesthesia

ii. Unplanned admission to ICU related to anesthesia up through end of PACU care (MD51)

b. Exception(s): n/a

7. **Adverse Outcomes Related to Anesthesia**

a. Definition: critical events occurring within 48 hours of induction of anesthesia deemed related to anesthetic

i. Death

ii. Acute Myocardial Infarction

iii. Cardiac Arrest

iv. Renal Failure

v. Cerebrovascular Accident

vi. Non-cardiogenic Pulmonary Edema

8. **Patient-Reported Experience with Anesthesia** (AQI48)

a. Definition: percentage of patients > 18 years old surveyed who reported a positive experience

i. Requires a minimum of 20 surveys

ii. Must be sent within 30 days of discharge from hospital

iii. Recommended question: On a scale of 1 to 5 (where 1 indicates a very negative experience and 5 indicates an excellent experience), how would you rate your anesthesia experience? ***I attached a ASA white paper with additional question suggestions if anyone wants to look through those and change the question.

b. Exception(s): patients who died within 30 days of procedure

DIAGNOSTIC IMAGING

A. Discrepancies > level 3 or 4

B. Any unusual or unexpected patient injury/complication during/following invasive procedure

EMERGENCY MEDICINE

A. Unexpected patient readmission within 72 hours to emergency department

B. Final radiology report differs from ED diagnosis, and/or X-ray interpretation by ED Physician

MEDICINE

A. Unexpected inpatient-to-inpatient transfer to another facility

B. Unexpected transfer to a higher level of care (e.g., Med Surg to ICU) within 12 hours

OBSTETRICS

A. Postpartum hemorrhage > 1000 cc EBL

B. Maternal complication

C. Live born infant with gestational age of < 35 weeks

D. Live born infant with an Apgar score of < 7at 5 minutes or cord pH < 7.0

E. Newborn with discharge diagnosis of clinically significant birth trauma, excluding clavicle fractures and

cephalohematomas

F. Hemocrit < 25 after birth

PEDIATRICS

A. Newborn on Oxygen for > 24-hours

B. Newborn in the nursery > 24 hours

C. Unexpected readmission of infant for hyperbilirubinemia

SURGERY

A. Transfer to another facility due to at least one perioperative complication

B. Unplanned return to the operating room during an admission

C. Unusual or unexpected patient injury/complication during/following surgery or invasive procedure

D. Embolus causing change of treatment

E. Wrong-site surgery

F. Unplanned readmission related to prior surgery

CANCER CENTER

A. Unusual or unexpected patient injury or complication during or following cancer or radiation treatment

B. Unexpected change in treatment plan

PATHOLOGY

A. Report the # of cases and break that down to include both the % that did not survive processing and the % where no tissue at all was received

B. Cases in which there are marked disparity between the preoperative and postoperative diagnoses

RELATIVE INDICATORS FOR AUTOPSY

Member of the Medical Staff are encouraged to request authorization for autopsy from

Family members under the following circumstances (Excluding request from Coroner):

A. In the event of an enigmatic presentation or difficult case perplexing from the standpoint of clinical management and diagnosis.

B. In the event of case felt to be of extraordinary educational value.

C. In the event that the physician is made aware the patient has been included in an experimental protocol from another facility that has an expressed interest in the outcome.

D. Unexpected death

E. Intra or post-operative death

F. At the request of a family member

BLOOD USAGE

A. 100% review of all blood products transfusion and wastage to include:

1. Appropriateness of Transfusions
2. Reactions
3. Adequacy of Service
4. Ordering Practices

OUTPATIENT CLINIC:

A. Documented complication during clinic procedure

B. Cardiac or Respiratory arrest in clinic

C. Delay in diagnosis (to be determined by providers or staff)

D. Unexpected return to clinic (timeframe will be determined by provider)

E. Post-procedure infection

F. Request or concern from Medical Staff or clinical staff

G. Request from antimicrobial stewardship team

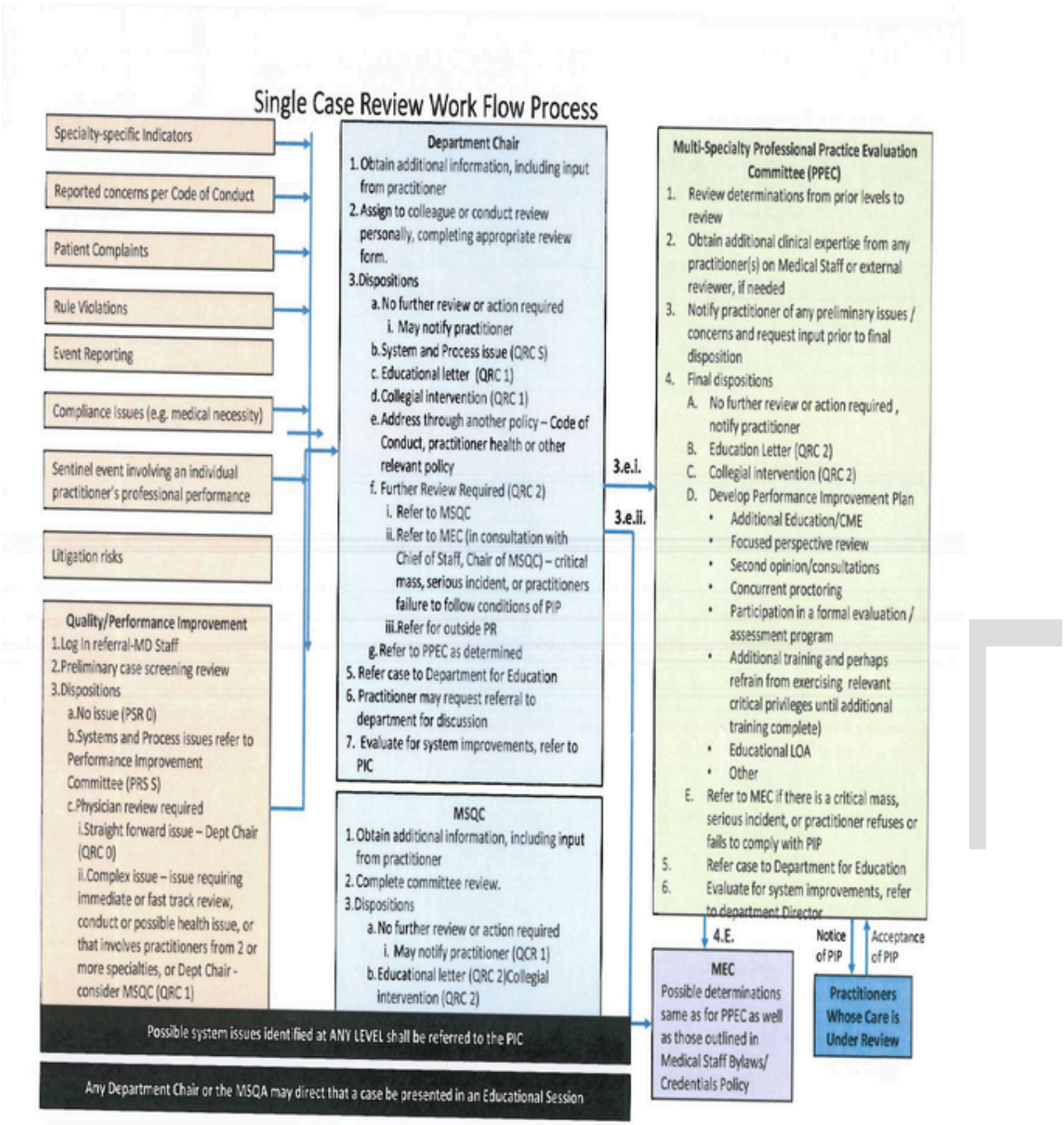
H. Referral from another medical staff committee

I. Referred from random clinical review of medical records (chart review)

J. Unexpected death of clinic patient within 30 days (from last clinic visit)

ADDENDUM B

SINGLE CASE REVIEW WORKFLOW PROCESS



All revision dates:

Attachments

2020 Peer Review Indicators
ADDENDUM B Single Case Review Workflow
Peer Review Worksheet

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System, Truckee Surgery Center*

Quality Assessment/ Performance Improvement (QA/PI) Plan, AQPI-05

PURPOSE:

The purpose of the Quality Assessment/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and High Reliability tenets to promote and improve awareness of patient safety. Tahoe Forest Health System has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

POLICY:

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"We exist to make a difference in the health of our communities through excellence and compassion in all we do."*

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To serve our region by striving to be the best mountain health system in the nation."*

VALUES STATEMENT

Our vision and mission is supported by our values. These include:

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.

B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.

D. Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality health care.

E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.

1. Quality – provide excellence in clinical outcomes
2. Service – best place to be cared for
3. People – best place to work, practice, and volunteer
4. Finance – provide superior financial performance
5. Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2020 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations;
3. Reducing the per capita cost of health care;
4. Staff engagement and joy in work.

B. Priorities identified include:

1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    a. Striving for the Perfect Care Experience
    b. Identify and promote best practice and evidence-based medicine
2. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial Healthcare Facilities Accreditation Program (HFAP) survey
3. Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    a. Continued participatioin in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting
4. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system

c. Understand vulnerabilities
d. Recognize bias
e. Efficient resource management
f. Evaluate system based on risk, not rules

5. Support Patient and Family Centered Care and the Patient and Family Advisory Council
   a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
   b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
   c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
   d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
6. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
7. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
8. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

C. Tahoe Forest Health System's vision will be achieved through these strategic priorities and performance improvement initiatives. Each strategic priority is driven by leadership oversight and teams developed to ensure improvement and implementation (Attachment A -- Quality Initiatives).

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all departments, services, and external partners, including third-party payors and other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement and positive outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Governing Board

A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for the quality of care and services provided throughout the system Attachment B – CAH Services). The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.

B. The Board:
   1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
   2. Responsible for determining, implementing, and monitoring policies governing the Critical Access

Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))

3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities.

B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

The Board Quality Committee is to provide oversight for the Health System QA/PI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.

B. The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

A. The Department Chairs:

1. Provide a communications channel to the Medical Executive Committee;
2. Monitor Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE) and make recommendations regarding reappointment based on data regarding quality of care;
3. Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:

1. Foster an environment of collaboration and open communication with both internal and external customers;
2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
3. Advance the philosophy of High Reliability within their departments;
4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/

Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

C. Employees are expected to do the following:

1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

With designated authority from the Medical Executive Committee, the Medical Staff Quality Assessment Committee (MS QAC) is responsible for prioritizing the performance improvement activities in the organization, chartering cross-functional teams, improving processes within the Health System, and supporting the efforts of all performance improvement activities. The MS QAC is an interdisciplinary committee led by the Medical Director of Quality. The committee has representatives from each Medical Staff department, Health System leadership, nursing, ancillary and support services ad hoc. Meetings are held at least quarterly each year. The Medical Director of Quality, Chief Medical Officer, and the Vice Chief of Staff are members of the Board of Director's Quality Committee.

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Emergency Operations Plan, Utilization Review Plan, Risk Management Plan, Trauma Performance Improvement Plan, and the Patient Safety Plan.

B. Regularly reviews progress to the aforementioned plans.

C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;

D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;

E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety

standards that may require further investigation;

F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;

G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;

H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.

J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.

K. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.

B. The Performance Improvement Committee will:

1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
2. Set performance improvement priorities and provide the resources to achieve improvement
3. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

Tahoe Forest Health System utilizes DMAIC Rapid Cycle Teams (Define, Measure, Analyze, Improve, Control). The Administrative Council, Director of Quality & Regulations, or the Medical Staff Quality Committee charter formal cross-functional teams to improve current processes and design new services, while each department utilizes tools and techniques to address opportunities for improvement within their individual areas.

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

B. Performance Improvement Teams will:

1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
2. Establish specific, measurable goals and monitoring for identified initiatives
3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.

C. Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.

D. Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

B. Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
5. Processes related to patient flow
6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:

1. Identified needs from data collection and analysis
2. Unanticipated adverse occurrences affecting patients
3. Processes identified as error prone or high risk regarding patient safety
4. Processes identified by proactive risk assessment
5. Changing regulatory requirements
6. Significant needs of patients and/or staff
7. Changes in the environment of care
8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:
        a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
        b. It is clinically sound and current
        c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
        d. It is consistent with sound business practices
        e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
        f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
        g. It incorporates the results of performance improvement activities
        h. It incorporates consideration of staffing effectiveness
        i. It incorporates consideration of patient safety issues
        j. It incorporates consideration of patient flow issues
    4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
        a. They can identify the events it is intended to identify
        b. They have a documented numerator and denominator or description of the population to which

it is applicable

c. They have defined data elements and allowable values

d. They can detect changes in performance over time

e. They allow for comparison over time within the organization and between other entities

f. The data to be collected is available

g. Results can be reported in a way that is useful to the organization and other interested stakeholders

B. An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:

1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
    a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
    b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
    c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.
    d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
    e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
    f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
    g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written

infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:

1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
19. Summaries of performance improvement actions and actions to reduce risks to patients

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:

1. Quality measures delineated in clinical contracts will be reviewed annually

2. Pharmacy transactions as required by law and to control and account for all drugs
3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
4. Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
5. Reports of required reporting to federal, state, authorities
6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

C. These data are reviewed regularly by the PIC, MSQAC, and the BOD with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

B. The data is used to monitor the effectiveness and safety of services and quality of care. The data analysis identifies opportunities for process improvement and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.

C. Data is analyzed in many ways including:
1. Using appropriate performance improvement problem solving tools
2. Making internal comparisons of the performance of processes and outcomes over time
3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

D. Intensive analysis is completed for:
1. Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
2. Significant and undesirable performance variations from the performance of other operations
3. Significant and undesirable performance variations from recognized standards
4. A sentinel event which has occurred (see Sentinel Event Policy)
5. Variations which have occurred in the performance of processes that affect patient safety
6. Hazardous conditions which would place patients at risk
7. The occurrence of an undesirable variation which changes priorities

E. The following events will automatically result in intense analysis:

1. Significant confirmed transfusion reactions
2. Significant adverse drug reactions
3. Significant medication errors
4. All major discrepancies between preoperative and postoperative diagnosis
5. Adverse events or patterns related to the use of sedation or anesthesia
6. Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
7. Staffing effectiveness issues
8. Deaths associated with a hospital acquired infection
9. Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC annually.

C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

E. Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in quality reporting initiatives (See Attachment E for External Reporting listing).

CONFIDENTIALITY AND CONFLICT OF INTEREST

A. All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any Medical Staff Department or Committee, the Administrative Council, or Health System department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure.

B. Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to participate in the review. All information related to performance improvement activities performed by the Medical Staff or Health System staff in accordance with this plan is confidential and are protected by disclosure and discoverability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

Quality Assessment Performance Improvement Plan will be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Trauma Performance Improvement Plan, ??

Discharge Planning, ANS-238

References:

HFAP and CMS

All revision dates:

Attachments

A. Quality Initiatives 2020.docx
B. CAH Services by Agreement 2020
C. QA PI Reporting Measures 2020
D. QI Indicator Definitions 2020
E. External Reporting 2020

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*03/2013*
Last Approved:	*12/2019*
Last Revised:	*12/2019*
Next Review:	*12/2020*
Department:	*Case Management - DCM*
Applicabilities:	*System*

Utilization Review Plan(UR), DCM-1701

PURPOSE:

As medical necessity and cost effectiveness are considered to be essential components of the definition of quality in health care delivery, and as the Board of Directors (Board) of this facility is responsible for establishing policy and maintaining quality patient care, The Board, through the Administration and Medical Staff has established a comprehensive Utilization process. The goal of the process is appropriate allocation of resources through identification and elimination of over-utilization, under-utilization, and the inefficient delivery of health care services.

POLICY:

A. Under this Plan, Tahoe Forest Hospital District
   1. Facilitates the delivery of health care services in the most appropriate setting for the patient's needs.
   2. Establishes the protocols for review for medical necessity of admissions, extended stays and professional services.
   3. Requires the review of outlier cases based on extended length of stay.
   4. Specifies the procedures for denials, appeals and referrals for secondary review.
   5. Facilitates timely discharge and use of community resources through early identification and referral of patients with complicated post-hospital needs.
   6. Establishes the reporting, corrective action and requirements for the utilization review process.
   7. Minimize patient, physician, and facility financial liability through consistent screening for required authorizations by insurance companies for admissions and/or procedures
   8. Requires the review of over-utilization, under-utilization and inefficient utilization of resources

B. Process Integration for facilities
   1. The following components will be integrated into the facilitates quality management program
      a. Admission planning
      b. Continuing care planning
      c. Admission/Continued Stay review
      d. Level of Care appropriateness and necessity
      e. Monitoring of denial of payments and implementation of Appeals procedure

f. Analysis and interpretation of Utilization Data
Ongoing process effectiveness assessment

g. Standardized extended review of outlier cases (those admitted for 7 or more midnights)

C. Program Scope

1. Extends to all inpatient and outpatients regardless of payment source

D. Authority and Responsibility

1. Board of Directors

a. Delegates to the Medical Staff and Hospital Administration the authority and responsibility to carry out the UR function.

b. The board monitors reports from the Medical Executive Committee and the Medical Quality Board Committee

2. Administration

a. Delegates oversight of the utilization process to the Medical Quality Board Committee

3. Medical Quality Board Committee

a. Assess utilization of resources as they relate to aspects of patient care within the hospital provided services as outlined in the UR plan.

b. Annual review of plan prior to approval by the Medical Executive Committee

4. Utilization Review Committee

a. Maintaining an ongoing Utilization process in compliance with all applicable regulations and special agreements.

b. At least two physicians must serve on this committee

c. This committee acts to facilitate, monitor, and promote the effectiveness of the Utilization Process.

i. Optimal quality of care of patients

ii. Medical necessity of resource utilization

iii. Cost effectiveness

iv. Compliance with State and Federal requirements for participation in Medicare and Medical programs

v. Fulfills hospital and medical staff Utilization Review obligations

5. Utilization Review/Case Management Staff

a. Delegation for utilization process related duties as defined in this plan, in departmental policies and procedures and in respective position descriptions.

E. Utilization Review Committee(UR) functions

1. The Utilization Management components of the Committee include the following duties and functions:

a. To maintain an ongoing Utilization Management Program in compliance with applicable regulations and special UR or contract care arrangements.

b. To establish and maintain a criterion-based system for the concurrent monitoring of

appropriateness of level of care and the use of hospital resources and services.

c. Oversight of UM Physician Advisor (PA) services

d. To evaluate information generated through the Utilization Management Program and, where appropriate, to recommend action to correct patterns of over-, under- or otherwise inappropriate resource utilization.

e. To monitor the effectiveness of actions taken to improve efficiency or resolve problems.

f. To review cases of payment denials and determine whether reconsideration through appeal process should be undertaken or supported by the hospital.

g. To make recommendations as determined appropriate for focused review activity in admission planning, concurrent review and ancillary service utilization monitoring.

h. To coordinate the Utilization Management Program with other Medical and Hospital committees

i. To develop program goals and objectives defining program accountability for impacting the Hospital's delivery of quality, cost effective health care.

j. To provide input into administration on resource utilization and UR aspects of proposals and plans for contracting delivery of care on preferred provider or other special contact basis

k. To perform an annual review of the effectiveness and functioning of the UM program, and to make recommendations as indicated on program scope, organization, procedures, criteria and screening tools.

2. Meetings and Committee Records

   a. Meet biannually and as needed.

3. Conflict of interest

   a. Any person holding substantial financial interest in the hospital will not be eligible for appointment to the Committee. No person shall participate in the review of any case in which that person has been professionally involved.

4. Committee Reporting

   a. Reports to Medical Staff Quality committee

5. Medical Direction for the Utilization Review Committee

   a. Medical Direction come from Medical Director of Medical Staff Quality Committee and physician advisor.

6. Utilization Review Physician Advisors

   a. Provides clinical consultation to utilization/case management staff

   b. Provides education to medical staff regarding utilization management

   c. Reviews cases initially denied by a non-physician utilization reviewer or case manager

   d. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays

   e. Assists UM / Case Management staff in writing letters of appeal for denials of payment

7. Physician Advisor Role

   a. Provides clinical consultation to utilization/case management staff

b. Is an active member of the UR Committee

c. Provides oversight and support to UR staff as needed

d. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays

F. Utilization Management/Case Management Staff

1. Coordination

a. Delegates UM responsibilities as needed to appropriate designee(s) as required to ensure weekend and night coverage

b. Provides guidance to the medical and hospital staff, regarding medical necessity criteria

2. Utilization Review / Case Management Process

a. Reviews medical record documentation thoroughly to obtain information necessary to make UM determinations

b. Participates in daily inter-disciplinary rounds on Med-Surg and ICU floors.

c. Uses only documentation provided in the medical record to make determinations

d. Applies utilization review criteria objectively for admissions, continued stay, level of care and discharge readiness, using InterQual guidelines.

e. Screens and coordinates admissions and transfers, including emergency and elective admissions, 23-hour observation, conversions from outpatient to inpatient care, and out of area transfers

f. Provides utilization review to all admissions and continued stays, regardless of payer, including private and no-pay categories and cases that have been pre-authorized or certified by third-party payers

g. Reviews all admissions to the facility within 24 hours of admission or next working day after weekend/holiday

h. Reviews all continued stays at a scheduled frequency, but not less than every 3 days

i. Reviews all patients with extended stays at 5 days. CM to complete Extended Stay Review with attending practitioner within 7 days of extended day notice. Reviewed information includes UR criteria/status for IP continued stay, discharge or transfer plans, and any changes to original plan of care. Review will documented in Epic under "Utilization Review Note".

j. Reviews for timeliness, safety and appropriateness of hospital services and resources, including drugs and biological.

k. Meets for complex case review as needed. Implements Retrospective or Focused Review as directed by the UM Committee

l. Utilizes Physician Advisor consulting firm on cases that are difficult to determine with Interqual, require physician review (such as Condition Code 44 cases), certain denial appeals and/or reviews that require a peer to peer consult when the attending practitioner is unable to provide the service.

3. Denials / Appeals

a. Appeals denials by external review organizations, using only information documented in the medical record

b. Identifies patients who do not meet admission or continued stay criteria
c. Notifies the attending physician that a patient is not meeting criteria
d. Refers patients who do not meet criteria for acute care admission, continued stay or inappropriate treatment to the consulting Physician Advisor firm for secondary review when unable to reach consensus with the attending physician
e. Expedites and facilitates attending physician-to-physician advisor reviews
f. Refers cases of physician non-responsiveness or dispute between the attending physician and the Case Manager to the consulting Physician Advisor for secondary review.
g. If an adverse determination occurs regarding the insureds current hospitalization, the attending physician will be notified. If the physician concurs, the patient will be discharged. If the physician disagrees with the adverse determination and believes continued inpatient hospitalization is justified, care will continue and the appeal process initiated.
h. Livanta LLC is the Quality Improvement Organization (QIO) or peer review organization (PRO) authorized by the Center for Medicare and Medicaid Services (CMS) to review inpatient services provided to Medicare patients in the State of California. Tahoe Forest Hospital has a current Memorandum of Agreement (MOA) with Livanta LLC and will cooperate in the peer review process to facilitate review requirements relating to hospital Notice of Non-Coverage

4. External Review
   a. Provides clinical information as required by and to third party payer sources
   b. Facilitates medical record access and supervision for external insurance reviewers coming to the hospital for utilization review, adhering to the protocols established by the Utilization Management Committee
   c. Communicates UM denial determinations to patient and/or family when the patient remains in the hospital
5. Discharge Planning by either RN NCM or Social Service
   a. Maintains current, accurate information regarding community resources to facilitate discharge planning
   b. Provides focused discharge assessment and planning, initiated as early as possible after admission to facilitate time and appropriate discharges per CMS CoP 482.43.
   c. Identifies patients with complex discharge planning needs arising from diagnoses, therapies, socioeconomic, psychosocial or other relevant circumstances.
   d. Follows California State law in the discharge planning of the homeless patient
   e. Coordinates referrals and resources for patients requiring or requesting discharge planning services.
   f. Documents discharge planning activities in the medical record
   g. Facilitates transfers to appropriate higher level of care facilities when services not available
   h. Facilitates placement in alternative care facilities and coordinating any post acute needs identified for a successful transition of care
6. Information Management
   a. Maintains utilization management files and results

b. If available, uses automated information management systems to optimize efficiency

c. Collects and aggregates utilization data for tracking and trending reports

d. Coordinates and maintains data to address issues of over-utilization, under-utilization and admission necessity.

All revision dates: 12/2019, 10/2019, 03/2019, 02/2019, 04/2018, 03/2017, 01/2016, 03/2015, 02/2014, 03/2013, 12/2008

Attachments

Extended Stay Review Form.docx

Approval Signatures

Step Description	Approver	Date
	Karyn Grow: Director	12/2019
	Karyn Grow: Director	12/2019

Risk Management Plan 2020

POLICY:

A. The Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of a Risk Management Program that will identify, evaluate, and take appropriate action to prevent incident recurrences, as well as protect the District's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.
B. This policy is integrated with the Patient Safety Plan AQPI-02
C. The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the Collaborative Culture of Safety in the investigation of adverse events and unexpected occurrences.

PROCEDURE:

A. **RISK MANAGEMENT PROGRAM FUNCTIONS**
    1. Risk Detection
        a. Systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm across the entire environment of care.
        b. Monitor and evaluate potential risk related to patient care and patient safety and actively participate in identifying cases with potential risk.
    2. Risk Assessment
        a. The Director of Quality and Regulations will establish a proactive, systematic, organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.
        b. Coordinate with the support of the Risk Manager, all Risk Management activities and will provide for the flow of information among Quality Improvement, Medical Staff Services and Peer Review, Medical Staff Quality Committee and Board of Directors. The ongoing Risk Management monitoring and evaluation activities will include, but will not be limited to, the following:
            i. Safety Risk Management reporting refer to policy Event Reporting, AQPI-06
            ii. Customer Satisfaction
            iii. Claims Litigation Data
            iv. Patient Rights
                a. Access to care
                b. Patient complaints
                c. Informed consent
                d. Advance directives
            v. Staff Performance
                a. Medical staff
                b. Non-medical staff
            vi. Process of Care
            vii. Outcome of Care
            viii. Organizational Data

a. Utilization management
b. Management process

c. The Director of Quality and Regulations, Risk Manager, or designees shall carefully evaluate all concerns and further investigate specific complaints when deemed appropriate. Complaints may be generated by patients, relatives, visitors, the general public, physicians, employees, and other health care organization representatives. Once a concern has been generated, it is logged into the Risk Management Department's Event Reporting ~~System review system and~~System and is scheduled for further investigation as appropriate.

d. Identification of variations representing quality of care and potential liability issues shall be referred to the appropriate department/committee, Chair/Director for action when necessary using the tenets and practices of Collaborative Culture of Safety and Just Culture.

3. Risk Prevention – Findings reported through Administration, Medical Staff Committees, Patient Safety, etc., are utilized to enhance the quality of patient care, improve patient, employee, visitor, and health care practitioners' safety and to minimize risk and losses. Findings will be documented through the appropriate department/committee minutes.

4. Risk Appraisal – To determine the overall Risk Management program's effectiveness and efficiency, the program shall be internally evaluated on an annual basis with revisions made as indicated. The risk appraisal process will include an external risk assessment at least every two (2) years. Typically, the external appraisal will be conducted by the District's professional liability insurance carrier or their designee.

~~4.~~

B. **RISK MANAGEMENT PROGRAM COMPONENTS**

~~1.~~ The objectives of the Risk Management Program include, but are not limited to:~~Program Goals and Objectives~~

~~2.~~1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur

~~3.~~2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses

~~4.~~3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified

~~5.~~4. Contribute to PI activities and plans to resolve patient safety issues

~~6.~~5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes

~~7.~~6. Manage losses, claims or litigation when adverse events occur.

~~8.~~7. Incident/occurrence Reporting – The process of reporting and review and evaluation of incidents/occurrences shall be organization-wide and performed in accordance with the established organizational policy for reporting incidents.

a. Occurrence Screening Criteria – A clinical screening system used as a continuous monitoring tool that address quality of care, utilization, and risk issues:

i. Identifies patient outcome/events that could potentially result in liability; immediately reviews any notice of claim, filed or threatened litigation.

ii. Enables the identification of information, retrieval and early action as close to the time of the event as possible to assist the hospital and its professionals in minimizing the likelihood of a claim and financial loss, including following the District policy on disclosure of unintended outcomes or known errors; and, assisting the Medical staff with same. Refer to policy Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909.

iii. Supplements ~~incident~~ event reporting.

iv. Assists the hospital in determining how liability exposure can be minimized.

v. Increases Medial Staff involvement in Risk Management activities.

vi. Provides a course of information for the hospital's quality review effort.

b. Medical Staff credentialing and supervised review shall be in accordance with the hospital's written credentialing procedure.

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c. Patient Safety and Risk Management Programs shall encompass ~~encompasses~~ the entire environment of care and shall include, but will not be limited to:
    i. Preventive maintenance program
    ii. External and internal disaster program
    iii. Liaison with Infection Control, Quality Improvement, and Employee Health
    iv. Review of policies and procedures
    v. Interaction with legal counsel, insurance carriers and other regulatory agencies, as appropriate.
    vi. In-service education programs
~~vii.~~ vii. Comments from Environment of Care program

C. ~~C.~~ **RISK MANAGEMENT PROGRAM REPORTING AND ACCOUNTABILITY (See Attachment A)**

1. Board of Directors – The Board of Directors shall provide for resources and support for Risk Management functions related to patient care and patient safety, as well as the safety of employees, visitors and health care practitioners. The Board of Directors shall receive and evaluate, at least quarterly and as requested, the Risk Management activities.
2. Medical Staff – The Medical staff actively participates, as appropriate, in the following Risk Management activities related to patient care and patient safety:
    a. Identification of areas of potential risk.
    b. Development of criteria for identifying cases.
    c. Correction of problems identified by Risk Management and/or Performance Improvement activities.
    d. Design of programs to reduce risk.
3. Administration
    a. Establish and maintain operational linkages between Risk and Quality Improvement functions related to patient care and patient safety.
    b. Existing information relative to the quality of patient care is readily accessible for support of the Quality and Risk Management functions.
4. Other Department/Committee Roles
    a. Departments systematically monitor and evaluate patient care as it relates to quality, risk, and utilization; pursue opportunities to improve patient care and resolve unidentified problems.
    b. Other review functions are performed, such as review of accidents, injuries, and patient safety and safety hazards.
5. Risk Manager (The Risk Manager's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment A)
    a. Coordinate the functions of Risk Management (risk detection, assessment, prevention, appraisal and mitigation of actual harm) with appropriate individuals.
    b. Monitor Risk Management indicators to assess program effectiveness and provides reports at least quarterly to the Board of Directors.
    c. Maintain all records in a secure and confidential manner.
    d. Integrate Risk Management activities with Patient Safety and Quality Improvement.
    e. Coordinate educational programs to minimize the risk of harm to patients, staff and visitors. These education programs address, but are not limited to:
        i. General orientation for all new employees.
        ii. Ongoing education to the staff as indicated by risk appraisal and event reporting.
        iii. Specific programs tailored to the individual departments to address high-risk clinical areas, such as: the operating suite, labor and delivery, emergency department and anesthesia.
    f. Trend incidents and report findings to the appropriate individuals.
    g. Conduct internal investigations under applicable policies and processes for the review and investigation of all serious unanticipated or unexpected outcomes where an actual injury has occurred, a significant near-miss event or when organizational safety has been impaired.

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~~g.~~

D. **CONFIDENTIALITY**

1. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any committee shall be confidential..
2. To protect the confidentiality of each report and subsequent reporting, the following must be adhered to:
    a. ~~Safety Risk Management Reports shall not be printed.~~ Event Reports shall be maintained as confidential and should not be printed and distributed.
    b. All occurrences, when possible, should be reported to the Risk Manager within 24 hours of the incident, or discovery of the incident.
    c. All pre-electronic Quality Review Reports must be kept in accordance with the TFHD refer to policy Record Retention & Destruction ALG-1917.
    d. Access to ~~Safety Risk Management~~Event Reports ~~reports~~ shall be limited to approved users with assigned privileges.
    e. To maintain protective status, there~~There~~ must not be documentation in the medical record that an Event Report ~~Safety/Risk Management report~~ has been submitted.

~~e.~~

E. **LINK WITH QUALITY ASSESSMENT/IMPROVEMENT**

Tahoe Forest Hospital District Quality Assurance/Performance Improvement activities, Patient Safety Plan and Risk Management Plan are integrated through communication and the cooperation of everyone within the Hospital environment. Each program has mechanisms or activities designed to identify problems or risk exposures, both analyze these problems or risks to determine how to reduce/prevent them, and then monitor the effectiveness of the chosen risk reduction/prevention strategy. An exposure may be identified, evaluated and analyzed through either risk management or quality assessment activities, and once identified, the information communicated to the appropriate person/committee.

Related Policies/Forms:

Event Reporting AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909**;** Record Retention & Destruction ALG-1917; Patient Safety Plan AQPI-02; The National Quality Forum: "Safe Practices for Better Healthcare-2/2013 Update"

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TAHOE FOREST HEALTH SYSTEM

Origination Date:	*12/2005*
Last Approved:	*02/2020*
Last Revised:	*02/2020*
Next Review:	*02/2021*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System*

Patient Safety Plan, AQPI-02

PURPOSE:

To develop, implement, and evaluate a patient safety program for the Tahoe Forest Health System which includes Tahoe Forest Hospital (TFH) and Incline Village Community Hospital (IVCH), (hereinafter referred to as the "organization").

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the High Reliability Organizations and the Just Culture program in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results. Patients

and patient representatives are informed of unexpected/unintended outcomes as described in 4.8.1 below.

C. AUTHORITY & RESPONSIBILITY

1. **Governing Body**
    a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.
2. **Senior Leader**
    a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.
3. **Medical Staff**
    a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
    b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.
4. **Management Team**
    a. The Management Team, through the Director of Quality and Regulations and Patient Safety Officer, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.
5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**
    a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.
6. **Patient Safety/Medical Staff Quality Committee**
    1. The Patient Safety Committee shall:
        1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety

Officer

2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
5. Report quarterly, and as requested, to the executive committee and governing body
6. The Patient Safety Committee members shall include, at least, the following individuals:
    1. Director of Quality and Regulations or the Patient Safety Officer
    2. Members of the Medical Staff
    3. One member of the nursing staff (CNO or designee)
    4. Director of Pharmacy
    5. Medical Director of Quality
    6. Risk Manager
    7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
6. Manage losses, claims or litigation when adverse events occur.
7. Designing or Re-designing Processes
    a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
8. Identification of Potential Patient Safety Issues
    a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
        i. Processes identified through a review of the literature

ii. Issues identified during daily safety huddles.

iii. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).

iv. Processes identified through the organization's performance improvement program

v. Processes identified through Safety Risk Management Reports (Event Reporting, AQPI-06) and sentinel events (Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906)

vi. Processes identified as the result of findings by regulatory and/or accrediting agencies

vii. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

viii. Adverse events or potential adverse advents as described in HSC 1279.1 (Attachment A)

ix. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)

x. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

9. Performance Related to Patient Safety

   a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:

   b. The perceptions of risk to patients and suggestions for improving care.

      i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.

   c. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

   d. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of the Just Culture.

10. Proactive Risk Assessments

   a. Through implementation of this Patient Safety Plan, and integrated with the Risk Management Plan and other performance improvement processes, the Department of Quality and Regulations will systemically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm. Identified opportunities for improvement will then undergo redesign (as necessary) to mitigate any risks identified. Additionally, the Reliability Management Team (RMT), meets and discusses risks to the the organization on a weekly and monthly basis, analyzing and making recommendations for improvement as described herein under "reporting structure." Lastly, a patient safety risk assessment by an external resource will be performed at least every 24-36 months and reported to the organization as described herein under "reporting structure."

11. Responding to Errors

   a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of

the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).

b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations and Just Culture. Management of these types of errors is described in Sentinel/ Adverse Event/Error or Unanticipated Outcome, AQPI-1906.

12. Supporting Staff Involved in Errors

    a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602)

13. Educating the Patient on Error Prevention

    a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. Informing the Patient of Errors in Care

    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/ families is described in the policy, Disclosure of Error or Unanticipated Outcome to Patients/ Families, AQPI-1909.

15. Reporting of Medical Errors

    a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.

    b. Errors will be reported internally to the appropriate administrative or medical staff entity.

    c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906.

16. Evaluating the Effectiveness of the Program

    1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

E. Priorities for the 2020 Calendar Year

    1. Complete the SCOR Culture of Safety Survey and department specific SCOR survey action plans

2. Complete Care for the Caregiver and Response domains for Beta HEART by implementing Peer Support team at TFHD and by completing investigation training and sending additional staff to BETA HEART workshops
3. Utilize implemented surveillance module for case finding for additional safety and quality opportunities
4. Submit patient safety data to CHPSO quarterly for inclusion in reporting and benchmarking
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools
6. Complete a successful hospital accreditation survey (Healthcare Facilities Accreditation Program - HFAP)

Related Policies/Forms:

Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906; Event Reporting, AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909; Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602; Risk Management Plan AQPI-04; The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All revision dates: 02/2020, 03/2019, 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/2009

Attachments

image1.jpeg
Process Flow for Risk Manager-Patient Safety.pdf

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	02/2020
	Dawn Colvin: Patient Safety Officer	02/2020

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*12/1982*
Last Approved:	*12/2019*
Last Revised:	*12/2019*
Next Review:	*12/2020*
Department:	*Nursing Services - ANS*
Applies Towards:	*Incline Village Community Hospital, Tahoe Forest Hospital*

Discharge Planning, ANS-238

PURPOSE:

A. To assist all patients and families requiring assistance in a successful transition from the acute care setting to the next appropriate level of care including, but not limited to, care at home, skilled nursing or sub acute care, acute rehabilitation, or to other Post Acute Service, or to facilitate the provision and delivery of necessary Durable Medical Equipment (DME).

B. To provide for continuing care or an alternative plan of care based upon the patient's individual needs that have been assessed, beginning at the time of admission through discharge to an alternate level of care.

C. To give an opportunity for the patient to name a designated caregiver.

POLICY:

Discharge planning begins on admission to the hospital. The planning activities are based on the changing needs of the patient, but will in all cases be coordinated prior to discharge. These services are directed to those patients who are likely to suffer adverse health consequences upon discharge without adequate discharge planning. A discharge planning referral will be initiated when a member of the health-care team, staff nurse, ancillary staff, or physician, identifies the need for discharge planning or when a patient and/or significant other, or family member requests assistance.

Definitions:

A. IM: Important Message for Medicare Beneficiaries

B. Financial Disclosure of Tahoe Forest Hospital District (TFHD) owned entities: Patient Choice in providers of all services

PROCEDURE:

A. Screening and referrals of patients to determine those in need of discharge planning services for successful transition to next level of care post-discharge.

   a. The admitting staff nurse or Pre-Op Screening RN will conduct an initial discharge planning screen of all admitted patients to evaluate limitations due to:

      a. Risk of adverse health consequences

      b. Medical issues

c. The patient's capacity for self-care
d. Family/support structure in the community
e. Psycho social issues
f. Social Determinants of Health

b. A discharge planning referral can be generated by the following
    a. Nursing, staff or physician/practitioner request for Case Management consult
    b. Monday-Friday interdisciplinary rounds
    c. Patient, significant other, or family request for assistance with the discharge planning process
c. Referrals can be made by
    a. Telephone request on the Case Management line
    b. Electronic Medical Record (EMR) referral or messaging in Epic system.
d. The Case Manager will conduct a discharge plan assessment same day as referral or within one business day for after-hour or holiday referrals. Assessment will include an interview of the patient/ family/caregivers, review of the medical record and collaboration with the health-care team. During the interview, the parties are to be made aware of care giving options orally or in writing. This would include, as appropriate, the Social Services Referral Contact Packet which includes contact information on long term care considerations and home care giving opportunities. Counseling in preparation for post hospital care will be provided by the appropriate discipline when needed and documented in the medical record.
e. For patients needing discharge planning services in an outpatient setting (pre-operative or in the Emergency Department), referrals will occur within 2 hours of notification; referrals will be made to the Case Management line or to the ED Case Manager directly. For patients identified days before an outpatient scheduled surgical procedure, Case Management will conduct a discharge plan within one business day.

B. Development of a discharge plan as indicated:
    1. Interview of the patient, decision-maker, and/or family shall assess:
        a. Patient’s functional status and cognitive ability
        b. Patient’s capacity for self-care
        c. Type of post-hospital care the patient may require
        d. Patient's concerns or goals.
        e. Prior level of functioning;
        f. Residence prior to hospitalization and any potential barriers for returning to the same setting.
        g. Support structure, including a designated caregiver, and/or community resources accessed prior to hospitalization
        h. Current and anticipated functional deficits and self-care capacity at discharge
        i. Support options and resources required for discharge to the appropriate level of care, including caregiver and DME needs.
    2. From these identified patient needs, a discharge plan is developed that is discussed with the patient and/or family and health-care team. A registered nurse or social worker will develop or supervise the

development of the discharge plan.

3. The discharge plan will be developed in a timely manner to allow arrangements for hospital post-care and to prevent a delay in discharge. All patients requiring a discharge plan and intervention shall be seen within one business day of admission or referral.
4. Discharge plans will be discussed with the patient or individual acting on his/her behalf and provided to patient/caregiver as requested.
5. Case Management shall re-evaluate the needs of the patient on an ongoing basis primarily through huddles and interdisciplinary care rounds and seek involvement and agreement from the patient/ family/healthcare team.

C. Implementation of the Discharge plan

1. Patients or individual acting on his behalf, will be counseled to prepare them for post-hospital care.
2. All discharge planning activities and discussions are documented in the patients' permanent medical record.
3. Transfers and referrals to other facilities/organizations for alternative services, follow up or ancillary care will be facilitated. Appropriate sharing of medical records as indicated.
    a. Discharge from TFHD and transition to next level of care to be coordinated between patient's clinical needs, MD orders and acceptance of receiving facility.
    b. Transportation to alternative level of care will be arranged by case management staff.
4. Prior to the patient's discharge, as appropriate, referrals and/or recommendations to health-care service agencies shall be made (i.e. DME, Home Health care, and/or placement to another level of care provider).
    a. A list of providers of Post Acute Services including but not limited to Home Health, DME, Skilled Care, Outpatient Therapy Service, Long Term Acute Care Hospitalization, Inpatient Rehabilitation, or Hospice services will be provided to all patients needing these services. Patients are advised that they have the right to choose the post-acute care provider. Provision of the list will be documented in the EMR.
    b. Financial disclosure letter for any TFHD owned entities will be given to patient or representative.
    c. Initial IM to be distributed to patient on admission
    d. Second IM Medicare Notice to be given at least 2 days and no less than 4 hrs prior to discharge.

D. Reassessment

1. The hospital will reassess the effectiveness of the discharge planning process on an ongoing basis and report findings to the Quality Assessment Performance Improvement (QAPI) Committee.
    a. All readmissions reviewed in the Electronic Reporting System for appropriate discharge planning intervention.
    b. All Transitional Care Management (TCM) patients that are readmitted will receive a readmission RCA.

E. Discharge Planning for the Homeless Patient. **This does not apply to Incline Village Community Hospital (IVCH).** Please refer to the Toolkits located in Emergency Department (ED), Case Management and the Nursing Supervisor office.

1. Homeless patients are defined in the law as an individual who:
    a. Lacks a fixed and regular nighttime residence.
    b. Has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary accommodation or
    c. Is residing in a private or public place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.
2. Particular attention will be given to the homeless patient that is at high-risk post discharge. Homeless patients are identified at the registration and/or nursing admission process in the ED, hospital units, pre-admission screening and other routes. The following steps and services will be provided to this at-risk group:
    a. The discharging physician must determine that the homeless patient is stable and communicated post discharge medical needs.
    b. Refer to Case Management or Social Services for assessment and coordination of resources. If after-hours, please refer patient to the Nursing Supervisor.
    c. If patient is uninsured, refer to Patient Financial Services or Eligibility Advocate for health coverage screening. After hours, refer to patient registration for Medi-Cal application. Refer to policy Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901.
    d. Offering of a meal prior to discharge unless medically contra-indicated; this can be provided immediately or on a "to-go" or bagged lunch basis.
    e. Offering of seasonal-specific clothing prior to discharge. Refer to Toolkit for resources. Clothing is available in ED Ortho room. For children, please call Thrift Store with size and gender information and a packet will be delivered prior to discharge.
    f. TFHD lacks an outpatient license to dispense medications. There will be an attempt to provide patient with an "appropriate" (as determined by the physician and CM/Social Services) supply of medication at discharge.
        i. If the patient has insurance and the TF Retail Pharmacy is open, fill Rxs through the Retail Pharmacy or other pharmacy of patient choice.
        ii. If the patient has insurance and TF Retail Pharmacy is closed, fill Rx at open pharmacy of patient choice.
        iii. If the patient does not have insurance and Retail Pharmacy is open, fill Rx through the Retail Pharmacy.
        iv. If the patient does not have insurance and the TF Retail Pharmacy is closed, provide patient with Rx for medications and instructions to come back during open hours for CM assistance for filling of meds.
        v. If the patient does not have insurance and the TF Retail Pharmacy is open, provide with "appropriate" (as determined by physician) medications through the TF Retail Pharmacy.
        vi. If patient is uninsured or unable to pay for medications, refer to policy Financial Assistance, Authority to Offer, DCM-6.
        vii. *Note: If patient is an ED patient, there is some access to a short supply of limited medications through the pyxis system.*
    g. Patient will also receive medication education/counseling by pharmacist, physician/practitioner

or nursing prior to discharge.

h. Vaccinations as indicated by medical symptom/diagnostic presentation and per patient consent. Please check the appropriate immunization registry (for California CAIR2) for vaccination history prior to delivery of vaccine.

i. Homeless patient was alert and oriented to person, place, and time; or, if the treating physician determined the homeless patient needed follow-up mental health care, that the hospital contacted the homeless patient's health plan, primary care provider, or another appropriate provider such as the coordinated entry system, as applicable

j. Infectious disease health screening per Nevada County Public Health Department. Screening must include HIV, Hepatitis C and Syphilis. Screening for Tb and Hepatitis B as indicated. Patient will be provided an order set and encourage to go directly to the TFHD Outpatient Lab for screening. Provide patient with "Homeless ID Screening Requisition Form" (attached) after completed and signed by physician/practitioner. Results will be forwarded to TF Primary Care physican that is providing follow-up to patient or will be forwarded to the patient's PCP.

k. Offer of transportation up to 30 minutes or 30 miles. See Toolkit for bus vouchers and resources.

l. Provide list of housing, health and food resources in community. List attached to policy and in Toolkit.

m. Referral for follow-up care and contact/arrangements prior to discharge.

n. Written discharge plan of services. If patient is referred to a social-services agency or governmental provider, provide information on healthcare/behavioral health needs to accepting provider. **Release of information consent is not required.**

3. A log of patients and referral specifics will be kept on the G drive under Public>Homeless DCP Log. All homeless patients will be tracked on this log.
4. A Toolkit for Discharge Planning for the Homeless Patient will be kept in Case Management/Social Services office, the Nursing Supervisor office and the ED.

Related Policies/Forms:

Homeless DCP Log, Social Service Reference Packet, Discharge Summary, Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901; Housing, Health and Food Resources, Financial Assistance, Authority to Offer, DCM-6,

References:

CMS SOM- Hospital Appendix A 482.43 May 2013; CDPH AFL SB1152 - Homeless Patient Discharge Planning Policy and Process HSC section 1262.5, California CAIR2

All revision dates:	12/2019, 09/2019, 07/2019, 01/2019, 06/2018, 11/2017, 06/2016, 05/2015, 05/2014, 07/2013, 07/2012, 04/2012

Attachments:

Homeless ID Screening Requisition.doc
Housing, Health and Food Resources

Approval Signatures

Step Description	Approver	Date
	Karen Baffone: CNO	12/2019
	Barbara Widder: Administrative Assistant, Nursing Administration	11/2019

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*08/2012*
Last Approved:	*03/2019*
Last Revised:	*03/2019*
Next Review:	*03/2020*
Department:	*Infection Prevention and Control - AIPC*
Applicabilities:	*System*

Infection Control Plan, AIPC-64

PURPOSE:

Clearly define the Tahoe Forest Hospital System's (TFHS) Infection Control Plan (ICP).

POLICY:

System-wide infection prevention and control processes to avoid sources and transmission of infections and disease reduce the likelihood of preventable healthcare acquired infections (HAIs).

PROCEDURE:

A. **INTRODUCTION**

1. In compliance with the Healthcare Facilities Accreditation Program (HFAP), and following public health recommendations and nationally recognized guidance including but not limited to the Association for Professionals in Infection Control (APIC) recommendations for essential components for an infection control program, Tahoe Forest Health System's (TFHS) Infection Control Committee (ICC) shall develop and implement an infection control plan. The overall environment of all facilities in the system shall be sanitary to avoid sources and transmission of infections and disease. The plan:
2. Provides guidelines to prevent, control and investigate the spread of infection and communicable disease to employees, patients, visitors, and others within the healthcare system.
3. Encompasses all departments and patient services.
4. Includes specifications for infection control measures in all clinical and ancillary departments and/or services within the hospital, including:
5. Orients and instructs all personnel of infection control policies;
6. Guides development of policies and procedures in each department/service relative to infection prevention and control with assistance and approval of the Infection Control Committee.
7. Insures provision for cleaning and care of all equipment including a formula for every mixture prepared in the department/service for use in the cleaning procedures. Each solution shall have a proven effective spectrum of germicidal action.
8. This Infection Control and Prevention Plan, developed for TFHS, applies organization-wide to patients, employees and other healthcare workers, and visitors, and includes all patient care services detailed in AGOV-26: Plan for the Provision of Care to Patients.

B. **PURPOSE**

1. The purpose of the Infection Control (IC) and Prevention Plan is to identify infections and reduce the risk of disease transmission through the introduction of preventive measures. The aim of the program is to deliver safe, cost-effective care to patients, staff, visitors, and others in the healthcare environment. There is an emphasis on populations at high risk for infection. The program is designed to prevent and reduce healthcare associated infections (HAIs) and provide information and support to all staff regarding the principles and practices of Infection Control (IC) in order to support the development of a safe environment for all who enter the facilities of TFHS.
2. The goals of the program include recommendation and implementation of risk reduction practices by integrating principles of infection prevention and control into all direct and indirect standards of practice. TFHS's mission: We exist to make a difference in the health of our communities through excellence and compassion; vision: To serve our region by striving to be the best mountain health system in the nation; and values: Quality, Understanding, Excellence, Stewardship, and Teamwork, provide the framework for the IC program.
3. The program for Tahoe Forest Hospital System is designed to provide processes for the infection prevention and control program among all departments and individuals within the organization. It supports the mission to be devoted to excellence in serving all customers and demonstrates commitment to quality and an understanding of the economic environment.

C. **SCOPE OF SERVICE**

1. The scope of service is to minimize the morbidity, mortality, and economic burdens related to hospital-associated infections.
2. Epidemiologic data will be used to plan, implement, evaluate and improve infection control strategies. Surveillance is a critical component of the program. Prevention and control efforts will include activities such as:
   a. Identifying, managing, reporting, and following-up on persons with reportable and/or transmissible diseases.
   b. Measuring, monitoring, evaluating and reporting program effectiveness.
   c. Expanding activities as needed in response to unusual events or to control outbreaks of disease.
   d. Addressing outbreaks and epidemics and unusual activities in a timely manner.
   e. Ensuring that all clinical and paramedical departments alert the Infection Control practitioner (ICP) when an unusual pathogen is isolated or suspected.
   f. Focusing on medical and surgical services that have a high volume of procedures and/or have a population that may be at high risk for infection.
   g. Complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies.

D. **ASSIGNMENT OF RESPONSIBILITY / PROGRAM MANAGEMENT**

1. Members of the Infection Control Committee, a multidisciplinary hospital service committee, reflect the scope of services provided by TFHS.
   a. The risk of healthcare-associated infections (HAIs) exists throughout the hospital. This effective Infection Control program systematically identifies risks, responds appropriately and involves all relevant programs and settings within the hospital system.

i. The annual Hazard Vulnerability Analysis for Disaster Preparedness helps to rate and correlate the risk of infection from biological agents.

b. The chairperson of the medical staff Infection Control Committee (ICC) is a physician appointed by the Chief of Staff; the chair completes a mandatory specialized Centers for Disease Control and Prevention (CDC) training.

c. Consultation with an Infectious Disease physician is available. Members represent: Administration, Surgical Services/Sterile Processing, Inpatient Acute Care (ICU, Med-Surg), Incline Village Community Hospital (IVCH), Women & Family Center, Employee Health, Extended Care Center (ECC), Quality, Laboratory, Pharmacy, Environmental Services, and Multi-specialty clinics. Consultation with Engineering/Safety Officer, Medical Records, Physical Therapy, Dietary, Diagnostic Services, Home Health, Hospice is sought as needed.

2. Duties and Responsibilities of the Infection Control Committee

a. The successful creation of an organization-wide IC program requires collaboration with all relevant components/functions. This collaboration is vital to the successful gathering and interpretation of data, design of interventions, and effective implementation of interventions. Infection Control Committee members approve plans and insure their implementation, make decisions about interventions related to infection prevention and control, and provide feedback and follow-up through their participation in the IC program.

b. The ICC meets quarterly with additional meetings called if necessary to:

i. Review and approve the Infection Control Plan as well as all other IC and IC pertinent polices and procedures at least annually, making revisions as needed.

ii. Provide ongoing consultation regarding all aspects of the Infection Control Program, including Employee Health.

iii. Define the epidemiologically important issues, set specific annual objectives, and modify the Infection Prevention and Control Plan to meet those objectives.

iv. Review surveillance data monitoring for trends in infections, clusters, infections due to unusual pathogens, or any occurrence of healthcare associated (nosocomial) infections

v. Review infection prevention and control issues regarding employee health.

vi. Review antibiotic susceptibility/resistance trends as part of an antibiotic stewardship program in collaboration with Pharmacy and Lab

vii. Review reports on infection control risk assessment as required for construction/renovation projects.

viii. Report proceedings to Medical Quality, Medical Executive and Safety Committees and the Board of Directors

ix. Through the Chairperson or chairperson's designee i.e. Infection Preventionist or nursing staff, is authorized to institute appropriate control measures or studies when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, and/or the community.

x. Communicate policy and procedure updates to appropriate stakeholders.

xi. Maintain and communicate knowledge of regulatory guidelines/standards related to infection control.

xii. Ensure findings and recommendations are submitted to the Medical Staff Quality Committee, the Medical Executive Committee, the Governing Board, and facility-specific committees.

xiii. Respond to questions regarding techniques or policies of infection control.

xiv. Develop or approve protocols, and recommend corrective actions for special infection control studies when indicated.

xv. Maintain current hard copies of IC policies & procedures (P&P) in Nursing Administration and Infection Control (Employee Health clinic) and workable online search function to locate P&P on intranet PolicyStat.

3. Supervision of the Infection Control (IC) Program

   a. The IC program requires management by an individual (or individuals) with knowledge that is appropriate to the risks identified by the hospital, as well as knowledge of the analysis of infection risks, principles of infection prevention and control, and data analysis. This individual may be employed by the hospital or the hospital may contract with this individual. The number of individuals and their qualifications are based on the hospital's size, complexity, and needs. In addition, adequate resources are needed to effectively plan and successfully implement a program of this scope.

   b. Tahoe Forest Hospital System assigns responsibility for directing IC program activities to one or more individuals whose number, competency, and skill mix are determined by the goals and objectives of the IC activities.

   c. Qualifications of the individual(s) responsible for directing the IC program are determined by the risks entailed in the services provided, the hospital's patient population(s), and the complexity of the activities that will be carried out.

   d. The Infection Preventionist (IP) has been given the authority to implement and enforce the Infection Control and Prevention Program policies, coordinate all infection prevention and control within the hospital and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.

   e. The IP or his/her designee (e.g. nursing supervisor) will ensure continuous services (24 hours a day / 7 days a week / 365 days a year) for infection control and prevention program.

   f. The Employee Health Practitioner will assist with infection prevention and control issues pertinent to Employee Health.

   g. The IP will report to the Director of Quality and Regulations.

4. Maintenance of Qualifications for Infection Control Program Leadership

   a. The IP's duties are listed in the Job Description available from Human Resources, and include the following major elements:

      i. Stays abreast of new developments in infection control and maintains qualification status

      ii. Maintains competency in all essential elements of the job through professional licensure and offerings.

      iii. Maintains membership in infection control associations; e.g. APIC

      iv. Attends at least one (1) educational seminar related to infection prevention and control each year

5. Maintains current professional licensure and proof of competency.
6. Allocation of Resources for the Infection Control Program and determination of effectiveness include but are not limited to:
    a. Resources for systems to support infection prevention and control activities including those that allow access to data and necessary information .
    b. Hospital leaders will review on an ongoing basis (but no less frequently than annually) the effectiveness of the hospital's infection prevention and control activities and report their findings to the integrated quality and safety programs.
    c. Systems to access information will be provided to support infection prevention and control activities.
    d. When applicable, laboratory support will be provided to support infection prevention and control activities.
    e. Equipment and supplies will be provided to support infection prevention and control activities.
    f. Infection control personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards and guidelines.
7. Shared Responsibilities for the Infection Control Program
    a. The prevention and control of infections is a shared responsibility among all clinical and non-clinical personnel within the health system.
    b. Medical Staff Responsibilities: The Medical Staff provides expertise from their individual respective areas and disciplines through or in conjunction with the members of the Infection Control Committee to help manage the hospital infection surveillance, prevention, and control program.
    c. Department-Specific Responsibilities: The Department Directors and/or their designees are responsible for monitoring employees and assuring compliance with infection control policies and procedures. Responsibilities include, but are not limited to:
        i. Ensuring current infection control policies and procedures are available in all patient care areas/departments.
        ii. Revising and updating departmental policies and procedures relating to Infection Control in collaboration with the IP; ICC approval is obtained.
        iii. Ensuring proper patient care practices and product safety are maintained within the department.
        iv. Department Directors will ensure that IP receives support for data collection (e.g. line day collection for invasive devices: urinary catheters, central lines, and ventilators) for purposes of process improvement and to comply with state-mandated public reporting of quality measures.
        v. Coordinating with the IP to present educational programs on prevention and control of infections.
    d. Healthcare Worker Responsibilities:
        i. All healthcare workers of the organization will:

i. Adhere to hand hygiene guidelines.

ii. Adhere to the IC program for the prevention and control of infections.

iii. Participate in the annual review of infection control activities within their departments.

iv. Complete the Annual Mandatory Review (AMR) of required infection control modules e.g. Healthstream.

v. Participate fully in the Employee Health/Occupational Health program.

vi. Notify the IP of infection related issues or concerns.

E. **RISK ASSESSMENT AND PERIODIC REASSESSMENT**

1. A hospital's risks of infection will vary based on the hospital's geographic location, the community environment, services provided, and the characteristics and behaviors of the population served. As risks change over time — sometimes rapidly — risk assessment must be an ongoing process.
2. The comprehensive risk analysis for TFHS will include an assessment of the geography, environment, services provided and population served; the available infection prevention and control data; and the care, treatment and services provided by this facility. The Infection Control Program is ongoing and is reviewed and revised at least annually. Surveillance activities will be used to identify risks pertaining to patients, staff, volunteers, and student/trainees and, as warranted, visitors.
3. Risk assessment:
   a. An assessment of the risk for infections is conducted annually based on evaluation of services offered and available infection prevention and control data.
      i. An annual Hazard Vulnerability Analysis performed by the Emergency Preparedness Committee of which an ICP is a member rates the risk of infection from biological weapons of mass destruction and/or epidemic.
   b. Risk factors are identified and interventions are implemented to decrease the incidence of infections. The following outcome and process measures are monitored and reported to public health to comply with current mandates; other measures may be added when deemed to be of value:
      i. Surgical Site infections (SSI)
      ii. Device-related infections e.g. Central line-related bloodstream (CLABSI) infections, Ventilator-associated events/pneumonia (VAE/VAP), cath-associated UTI (CAUTI)
      iii. Multi-drug resistant organisms e.g. MRSA, VRE, ESBL, CRE and c. diff lab ID events
      iv. New and emerging infectious diseases
      v. Compliance with infection control policies and procedures
   c. Additional risk assessments are conducted whenever risks are significantly changed; examples of this include but are not limited to changes in:
      i. scope of the program
      ii. results of the risk analysis
      iii. emerging and re-emerging problems in the health care community that potentially affect the hospital e.g. a highly infectious agent.
      iv. success or failure of interventions for preventing and controlling infection.

v. concerns raised by leadership and others within the health system.

d. evidence or consensus-based infection prevention and control guidelines

4. Licensed Beds, Setting, Employees:

a. TFHS has 2 acute care critical access hospitals, with a total of approximately 850 healthcare workers. Tahoe Forest Hospital (TFH) consists of 25 licensed beds, and Incline Village Hospital (IVCH) has 4 beds. Both hospitals are located in a mountain community setting. TFH is located in Truckee, California a town near a major interstate (Interstate 80), on a corridor between the 2 larger cities of Sacramento, California and Reno, Nevada. IVCH is located in Incline Village, Nevada. Both towns attract many tourists and second homeowners through the year. Snowfall can become a factor when travelers may be stranded when mountain passes are closed. The health system also includes a 37 bed skilled nursing facility.

5. The available infection prevention and control data includes:

Data	**Source Systems / Databases**
device-related infections metrics	G drive/public/dept PI; medical staff quality
surgical–site infections metrics	G drive/public/dept PI; medical staff quality
Antibiograms	Lab/pharmacy/IC
Mandated Public Health Reporting	Lab/IC: CMR; CDPH; NHSN; conferred rights to CalHIN
Occupational BBP exposures Healthcare Worker Flu Vaccine Status	OSHA log G/D&M/flu log
Hand hygiene compliance	CLIP form report; overall & unit-specific rates on G/public/ dept PI

F. **PRIORITIES AND GOALS**

1. The risks of healthcare-associated infections are many, while resources are limited. An effective IC program requires a thoughtful prioritization of the most important risks to be addressed. Priorities and goals related to the identified risks guide the choice and design of strategies for infection prevention and control in the hospital system. These priorities and goals provide a framework for evaluating the strategies.

2. The Infection Control Structure Standards include the following:

a. Description of Program

b. Purpose

c. Goals

d. Administration/Organization of Unit

e. Hours of Operation

f. Utilization or Precautions or Restrictions

g. Operational Policies

h. Staffing

3. Based on the risks identified through the comprehensive risk analysis efforts, the IC Program will set

priorities and goals for preventing the development of HAIs. The priorities and goals may change to comply with state and national mandates and/or as new information becomes available from risk analysis.

4. Priorities and goals are based on risks and include, but are not limited to :
    a. Limiting unprotected exposures to bloodborne and other pathogens;
        i. Reinforcing the use of hand hygiene and other standard precautions;
        ii. Minimizing the risks associated with surgical and other procedures:
        iii. Minimize device-related infections e.g. central line-related bloodstream, ventilator-associated pneumonia; catheter-associated UTIs.
5. Tahoe Forest Hospital Systems' (TFHS) Infection Control Program has identified the following priority areas for which exposure to infections will be limited by implementing specific prevention measures as defined in related policies and procedures:
    a. Prevent and/or Reduce the Risk of Health-care associated HAI:
        i. The first goal is to provide an effective, ongoing program that prevents or reduces the risk of patients, all healthcare workers: staff, contract workers, physicians, volunteers, and visitors from acquiring and/or transmitting an infection while in the TFHS.
        ii. Prevention and/or risk reduction is accomplished through continuous improvement of the functions and processes involved in the prevention of infection that includes:
            a. Identifying and preventing the occurrences of HAI by pursuing sound infection control practices such as pre-employment health assessment, immunization services, aseptic technique, environmental cleaning and disinfection, standard & transmission-based precautions, and monitoring the appropriate use of antibiotics & other antimicrobials as part of a comprehensive antimicrobial stewardship program.
            b. Providing education on infection prevention & control principles to patients, staff and visitors.
            c. Maintaining a systematic program of surveillance and reporting infections internally and to public health agencies according to state and national mandates.
            d. Assisting in the evaluation of infection-related products and equipment.
            e. Complying with current standards, guidelines, and applicable local, state and federal regulations, and accrediting agency standards.
            f. Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments.
6. Minimize the Morbidity, Mortality and Economic Burdens Associated with HAI:
    a. The second goal is to minimize the morbidity, mortality, and economic burdens associated with preventable health-care associated infection through prevention and control efforts in the well and ill populations. Achieving this goal involves:
        i. Recommending and implementing corrective actions based on records, data, and reports of infection or infection potential among patients, staff and visitors.
        ii. Maintaining an effective Employee Health program to prevent exposure to pathogens and to identify communicable disease.

iii. Considering epidemiologically significant issues endemic to the populations served by TFHS and implementation of risk reduction strategies to high-risk patients.

iv. Performing Infection Control Risk Assessments with all renovation/construction performed in or at the facility.

7. Focused surveillance to include but not limited to:
   a. hand hygiene compliance: goal = at least 80% compliance based on direct observations
   b. surgical site infections: goal =<1% SSI rate for class I (clean) surgeries or SIR of = or <1 where applicable
   c. central-line related bloodstream infections: goal = zero CLABSI
   d. ventilator-associated events including pneumonia using CDC guidelines and other nationally recognized prevention standards e.g. Institute for Healthcare Improvement to guide the development of processes and procedures for purposes of quality improvement.
   e. catheter-associated UTI: goal = zero CAUTI
   f. Monitoring of high-touch objects (HTO) cleaning: goal = >80% HTO identified
   g. Healthcare worker annual influenza vaccination rate: goal = 90% vaccination rate and 100% compliance of status documentation e.g. either consent or declination on file in OccHealth
8. Maintain Open-line Communications between Infection Control, Risk Management, Performance Improvement and all stakeholders:
   a. See Figure 1 attached: Communication Plan and Accountability Loop
   b. Communicate identified problems and recommendations to the appropriate individuals, committees and/or departments.
9. The Infection Preventionist maintains active hospital committee participation, such as the Infection Control Committee, Quality Assurance Committee, Safety Committee (another member of Employee Health may attend for IP e.g. Employee Health Practitioner), Products Committee, Emergency Management Committee and any other ad hoc committees as designated by standards or direction from Administration.

G. **STRATEGIES TO MEET GOALS**

1. The hospital plans and implements interventions to address the IC issues that it finds important based on prioritized risks and associated surveillance data.
2. Performance improvement guidelines (policies and procedures) are established to address all aspects of infection prevention, control and investigation of communicable disease or infection using sound, scientifically valid, epidemiologic principles. These guidelines apply to employees, patients, visitors and others within the organization.
3. The specific program activities may vary from year to year based on at least annual review of: patient demographics, services offered, number and type of procedures stratified for high/low volume, high/low risk, and problem prone areas, type of contract services utilized, practicality and cost.
4. The policies and procedures should be scientifically-based toward infection prevention and improved outcomes.
5. Infection prevention and control principles are incorporated into organization-wide and department-

specific infection control policies to encompass all departments and patient services.

6. Department-specific policies are evaluated and used by the infection prevention and control function on a regular basis to evaluate adherence/compliance.
7. The facility-specific Infection Control Program Plan will be evaluated and adjusted, as appropriate, every year.
8. The effectiveness of the infection control program is evaluated annually by the Infection Control Committee. The report will be forwarded to the Medical Executive Committee and to the Governing Board.
9. Specific strategies and resources to meet the goals of TFHS's Infection Control and Prevention Program include the following:
    a. Hand-hygiene program. See Hospital Policy for Hand Hygiene. The CDC Guidelines for Hand Hygiene in Healthcare Settings (2002) were used to guide the development of procedures for the Hand Hygiene program.
    b. Storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment
    c. Sterile Processing Department (SPD) structure standards and policies for the following functions: decontamination & sterilization; decontamination of reusable items; preparing, assembling, wrapping, storage of, & distribution of sterile equipment/supplies; monitoring devices; sterilization data requirements; shelf life; cold sterilization; load control numbers; recall process; and environmental requirements in decontamination rooms.
    d. Provision for department-specific cleaning and care of equipment When solutions are used, auto-dilute methods are employed when possible; formulas are included if mixtures are prepared, with each solution having a proven effective spectrum of germicidal activity provided on MSDS sheet.
    e. Environmental cleaning:
        i. Provisions for maintaining a clean, hygienic patient care environment include schedules for daily, terminal, and deep cleaning and disinfection. Cleaning and disinfecting high-touch surfaces in the patient high germ zone defined by the World Health Organization is a focus; participation in a CDPH sponsored small rural hospital collaborative in Fall 2011 invigorated this effort in the inpatient and outpatient setting.
        ii. Patient rooms are not to be used for purposes other than direct patient care or educational/ training activities. Terminal cleaning of patient rooms follow each patient discharge. Cleaning occurs following use of patient room for any education/training and level of cleaning needed is determined on a case by case basis.
    f. Personal protective equipment:
        i. See Policy for Body Substance Standard Precautions, AIPC-6
        ii. See Policy for Personal Protective Equipment, AIPC-94
        iii. See Policy for Transmission Based (Isolation) Precautions, AIPC-1501
        iv. The CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007, and Management of Multidrug Resistant Organisms in Healthcare Settings, 2006
    g. Programs to reduce the incidence of antimicrobial resistant infections:

i. See Policy Transmission Based (Isolation) Precautions, AIPC-1501 for contact precautions and CDC's Type and Duration Precautions Recommended for Selected Infections and Conditions

h. Programs to prevent HAI: central line-associated blood stream infections (CLABSI), urinary foley catheter-associated infections (CAUTI) and ventilator-associated events (VAE), including pneumonia.

i. CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009

ii. CDC Guidelines for Prevention of Intravascular Catheter-Related Infecitons, 2011

iii. Current National Health Safety Network (NHSN) efinitions and protocols

i. A program to prevent surgical site infections

i. See Policy for Surgical Site Infection Prevention Guidelines, AIPC-119, and Structure Standards for the Operating Rooms at Tahoe Forest Hospital, DOR32

ii. Current NHSN Surgical Site Infection (SSI) Event and the CDC Guideline for the Prevention of Surgical Site Infection, 2017 the development of procedures for preventing Surgical Site Infections.

j. Employee Health/Occupational Health Program (EH/OH): involves interventions for reducing the risk of infection transmission, including recommendations for immunizations and testing for immunity. The IP will collaborate with EH/OH to promote systemwide employee and patient safety.

i. See the Hospital Policies for: Employee Health Program, Employee Health Vaccine Administration, Immunization of Employees, Respiratory Protection, Personnel Restriction due to Illness

ii. Included is screening for health issues, childhood illness/immunization; tuberculosis screening; immunization for hepatitis B and influenza; Tdap status, evaluation of post-exposure assessment to blood/body fluid exposures and/or other communicable diseases; see Exposure Control Plan, AIPC-43

k. When indicated, the program will also include monitoring of employee illnesses in order to identify potential relationships among employee illness, patient infectious processes and/or environmental health factors.

l. The infection control program will review and approve all policies and procedures developed in the employee health program that relate to the transmission of infections in the hospital. Together, the IP and EH/OH staff will develop, implement, and annually review and update the Exposure Control Plan, AIPC-43 (includes plan for OSHA Bloodborne Pathogens & Tuberculosis). Occupational Exposures (sharps, splash, near misses) will be tracked and trended for process improvement opportunities; a process that ensures timely response will be in place to address all employee sharps, splash and near miss events. Reports are also collected and submitted for quarterly review by Safety Committee, the Medical Staff and Infection Control Committee related to work days lost, immunizations and employee screenings and annually to the Board of Directors.

m. The infection control personnel will be available to the employee health program for consultation regarding infectious disease concerns.

n. At the time of employment, all facility personnel will be evaluated by the employee health

program for conditions relating to communicable diseases. The evaluation includes the following:

i. Medical history, including immunization status and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases;

ii. Tuberculosis skin testing;

iii. Serologic screening for vaccine preventable diseases, if indicated;

iv. Need for respiratory protection; fit-testing if needed;

v. Such medical examinations as are indicated by the above.

o. Appropriate employees or other healthcare workers will have periodic medical evaluations to assess for new conditions related to infectious diseases that may have an impact on patient care, the employee, or other healthcare workers, which should include review of immunization and tuberculosis skin-test status, if appropriate.

i. Annual tuberculosis skin-testing is required for all healthcare workers.

ii. Annual influenza vaccination is promoted to all healthcare workers, and offered free of charge.

iii. Immunization for vaccine-preventable illnesses is promoted & offered free of charge.

iv. TFHS will maintain confidential medical records on all healthcare workers.

v. The employee health program will have the capability to track employee immunization and tuberculosis skin-test status.

p. Employees will be offered appropriate immunizations for communicable diseases. Immunizations will be based on regulatory requirements and Advisory Committee on Immunization Practices recommendations for healthcare workers.

q. The employee health program will develop policies and procedures for the evaluation of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees who have been exposed to infectious diseases, including post-exposure prophylaxis and work restrictions.

r. Current CDC Guidelines are used for development and, revision/update of Employee Health policies and procedures. Examples include but are not limited to to those pertaining to Management of Occupational Exposures to Hep B, Hep C, and HIV and Recommendations for Postexposure Prophylaxis, Guidelines for Infection Control in Healthcare Personnel, and; Influenza Vaccination of Healthcare Personnel.

s. The IP participates on the Products Committee to ensure infection prevention and control products and equipment support safe and sound practices and principles. The IP responds to notification of a recalled item (s) specific to infection-related issues.

H. **Program Compliance**

1. To verify compliance with the program, TFHS's IP shall conduct and/or participate in periodic system wide rounds that address infection control elements with verification of follow-up as needed with pertinent Department Director.

2. The Department Director, IC committee member/departmental liaison, or other designee will report direct observations of noncompliance to infection prevention and control practices in their specific clinical areas to the IP and/or infection control committee.

I. **MANAGING CRITICAL DATA AND INFORMATION**

1. There will be an active program for the prevention, control and investigation of infections and communicable diseases that includes a hospital-wide program. Surveillance data will be analyzed appropriately and used to monitor and improve infection control and healthcare outcomes. The collection and management of IC pertinent data will strive to be as automated as resources allow. Data validation opportunities are sought and used to identify potential data mining gaps. An example of this participation voluntary California Department of Public Health (CDPH) data validation offerings; results of data validation are available upon request.
2. Surveillance and Monitoring:
    a. Surveillance is performed as an enhancement and/or component of the facility's quality assessment and performance improvement program," which includes but is not limited to:
    b. Monitoring implemented process measures and submitting data to the National Health Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) according to current state and federal mandates.
    c. Evaluating new programs as well as renovation or construction in conjunction with the hospital's Facilities Management Department (Engineering), and Safety Committee.
    d. Compiling and analyzing surveillance data, presenting findings and making recommendations to the Infection Control Committee and other departments and medical service chiefs as appropriate.
    e. Using baseline surveillance data to determine if an outbreak is occurring.
    f. Investigating trends of infections, clusters, and unusual infections.
    g. Conducting, facilitating, or participating in focus reviews for purposes of infection prevention & control education.
3. Surveillance Methodology
    a. Sources for case findings/infection identification include, but are not limited to review of:
        i. Microbiology lab data/records
        ii. Information Systems reports including patient census/diagnosis, readmission reports
        iii. Chart reviews
        iv. Post-discharge surveillance and tracking following surgical procedures
        v. Staff reports of suspect/known infections or infection control issues
        vi. Device-associated infections (i.e., line day usage for urinary catheters, central line catheters and ventilator days).
        vii. Employee Health reports reflecting epidemiological significant employee infections
        viii. Public Health alerts
4. **Infection Definitions**:
5. TFHS will use current CDC definitions according to defined Patient Safety Component protocols. Reporting through CDC's electronic data base (NHSN) enables monitoring of healthcare-associated events and processes, integrating CDC and healthcare personnel safety surveillance onto a single internet platform.

6. **Data Collection Personnel**
    a. Personnel involved in the collection of infection prevention and control data include: IP, Employee Health case manager, employee health support staff, clinical coordinators, nurse clinician, ICC members, quality/risk; Information Technology (IT)
7. **Data Collection Methods**
    a. Collection methods will utilize standardized NHSN data collection methodology and forms, plus other TFHS surveillance/tracking data collection tools as needed (e.g. post-discharge surveillance for SSI)
8. **Calculation of Infection Rates and use of other metrics e.g. Standardized Infection Ratio (SIR):** ***See Table 1 for examples***
    a. Infection rates are calculated using standardized CDC formulas, per NHSN protocols and replaced or supplemented with other appropriate metrics; e.g. SIR: standardized infection ratio.
    b. Infection rates and ratios will be compared to internal and external benchmarks for improvement opportunity identification.
9. The occurrence and follow-up of infections/communicable diseases among patients, staff and visitors will be documented in the appropriate record, e.g. employee health record, OSHA log, medical record, and reported to the Infection Control Practitioner for subsequent reporting to the Infection Control Committee, Quality, and Safety committees. ***See Figure 1 for Communication Plan and Accountability Loop.***
10. **Environmental Assessment/Surveillance:** Environmental Assessment /Surveillance is performed in conjunction with the Safety Committee. The surveillance tool is attached. ***See Table 2***. Routine sampling of the environment, air, surfaces, water, food, etc is discouraged unless a related infection control issue is identified as a potential epidemiologic link.
11. Additional assessment includes:
    a. Evaluating the surgical services department's flash sterilization report by instrument type to determine if adequate supplies are being maintained. (SPD report)
    b. Assisting in the implementation of the hospital's internal product recall program
    c. Assisting in the evaluation of sterilization failures, reporting findings to the Infection Control Committee, Medical Staff, Risk Management, Patient Safety Director, attending physician, and patient care manager of area involved.
    d. Items inteded for single use are not re-processed or re-sterilized for re-use at TFH SPD.
    e. Evaluating cooling tower reports from Engineering
    f. Reviewing PT pool records
    g. Evaluating Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment; ICRAs are to be approved by the appropriate committees, which may include, but are not limited to: Safety, ICC
    h. Inspecting construction/renovation site to evaluate compliance with ICRA requirements. The IP will have the authority to stop any project that is in substantial non-compliance with the requirements. Any time there is construction or renovation, the IP will be consulted prior to final design.
    i. Evaluating the use of negative pressure environments in the care of patients with airborne

diseases.

j. Evaluating the use of positive pressure environments in surgical suites.

k. The CDC Guidelines for Environmental Infection Control in Health-Care Facilities 2003 used to guide the development of policies and procedures

J. **INTERVENING DIRECTLY TO PREVENT TRANSMISSION OF INFECTIOUS DISEASES**

1. TFHS will have the capacity to identify the occurrence of outbreaks or clusters of infectious diseases. See Policy: Outbreak Investigation, AIPC-89. TFHS will work under the guidance of the Nevada County Public Health Department and other agencies to conduct outbreak investigations. When an outbreak occurs, the infection control program will have resources and authority to ensure a comprehensive and timely investigation and the implementation of appropriate control measures.
2. **Review Microbiology Results:** The IP will review microbiology records regularly to identify unusual clusters or a greater-than-usual incidence of certain species or strains of microorganisms.
3. **Monitor Baseline Surveillance Data:** Baseline surveillance data will be used when appropriate to determine if an outbreak is occurring. When a cluster (2-3 cases of an illness or infection) occurs, this is the trigger for IP to begin investigation and direct the use of enhanced infection prevention and control measures as needed. Depending on the situation, one case of unexplained illness may prompt IC intervention; e.g. unexplained acute gastrointestinal illness in ECC. Outbreak investigation commences when more than 3 cases occur.
4. **Regularly Contact Patient-Care Areas:** The IP will maintain regular contact with clinical, medical, and nursing staff in order to ascertain the occurrence of disease clusters or outbreaks, to assist in maintenance and monitoring of infection control procedures, and to provide consultation as required. Opportunities for contact include but are not limited to: weekly case management conferences, communications with medical staff office and departmental ICC liaisons/ICC committee members, hospital rounding, communication logs, and phone/ email, staff meetings.
5. **Day-to-Day Management of the Infection Control Program:** The IP and/or designee (e.g. nursing supervisor) is responsible for the day-to-day management of the infection control program with guidance and input from the medical advisor of the Infection Control Program. Responsibilities will include, but may not be limited to:
    a. The IP may institute appropriate precaution procedures and collaborate with attending physicians to order cultures.
    b. When actions are taken, the IP will notify patient's nurse and/or he physician responsible for the patient's care.
    c. When the case involves a non-compliant issue with front line staff, IP will notify the appropriate director e.g. nursing: Chief Nursing Officer, housekeeping: EVS director or supervisor. etc. Non-compliance will be reported to IC committee, with subsequent reporting via the IC committee minutes to Safety Committee, Quality/Risk Mgt., and/or consultation with Human Resources as needed for determining appropriate action.
    d. The ICP will maintain close communication with nursing departments, surgical services, clinical support services, laboratory, and all departments throughout the facility regarding patients with infections and those at greatest risk of healthcare-associated infections and epidemiological issues within the community.
    e. The ICP will share health-care associated (nosocomial) infection information with Quality/Risk Management /Performance Improvement Department. Information sharing may occur via

current risk management process e.g. Quantros, Departmental PI, Dashboard and Infection Control Committee reports, and/or verbal communication on an ongoing basis. The IP will discuss process deviations with Risk Management and/or Performance Improvement in a timely manner.

K. **EDUCATION AND TRAINING OF HEALTHCARE WORKERS**

1. TFHS will provide ongoing educational programs in infection prevention and control to healthcare workers.
2. The IP will be an active participant in the planning and implementation of the educational programs.
3. Educational programs will be evaluated periodically for effectiveness, and attendance monitored.
4. The goal of the educational programs is to meet the needs of the group or department for which they are given and to provide learning experiences for people with a wide range of educational backgrounds and work responsibilities.
5. The IP:
    a. Serves as a consultant to physicians, personnel, patients, volunteers, students and/or visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.
    b. Provides informal education and serves as a consultant to the staff during routine rounding.
    c. Participates in the content of new employee orientation programs, and/or conducts a class in infection control principles and practices and area-specific in-services when requested. Infection Control principles and practices are also presented in the facility's annual review.
    d. Contributes regularly to hospital annual education plan with both planned and just-in-time education offerings; works directly with Clinical Resource Nurse and Nurse Educator on skills day content and other education events.

L. **REPORTING SYSTEMS AND OVERALL EVALUATION PLAN**

1. The risk of Healthcare-Associated Infections exists throughout the hospital. An effective IC program that can systematically identify risks and respond appropriately must involve all relevant programs and settings within the hospital.
2. The hospital shall have systems for reporting identified infections to the following:
    a. The appropriate staff within the hospital
    b. Federal, state, and local public health authorities in accordance with law and regulation
    c. Accrediting bodies
    d. The referring or receiving organization when a patient was transferred or referred and the presence of an HAI was not known at the time of referral
3. **Infection Classification and Intense Analysis:** Infections will be classified using a variety of sources rather than one comprehensive log. Sources used include Laboratory bug surveillance reports, SSI tracking forms, physician office post-discharge surveillance report and employee health records.
    a. All positive cultures will be reviewed using the laboratory bug surveillance report. Classification choices are:
        i. **Community Acquired Infection** - Organisms present or incubating at the time of

admission (culture collected 48 hours or less after admission). This includes Community-acquired (non-healthcare related) and Community-acquired (health care related) infections.

ii. **Healthcare Associated Infection** (HAI) is defined by the CDC, as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that occurs in a patient in a healthcare setting and was not present or incubating at the time of admission, unless the infection was related to a previous admission When the setting is a hospital, the localized or systemic site must meet the criteria for a specific infection (body) site as defined by CDC . When the setting is a hospital, and the above criteria are met, the HAI may also be called a nosocomial infection. A positive culture from a specimen collected 48hrs or more after admission is considered when identifying an infection as potentially nosocomial. An infection is considered a secondary nosocomial infection when it is linked to a pre-existing medical condition identified as the primary site of infection; i.e. admission with perforated bowel and subsequent positive blood cultures with GNRs.

iii. **Colonization** – Organisms present but not causing an infection from a normally non-sterile site.

iv. **Contamination**- Includes contamination; e.g., urine with a mixed culture, low colony counts in one of 2 blood cultures

v. **Cultures not followed further** include: normal flora, redundant /repeat cultures (same patient, same culture result already assessed).

b. In cooperation with the Quality and Risk Departments, the IP will participate in a root cause analysis of any infection that results in unanticipated death or permanent loss of function. All identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection shall be managed as sentinel events. An intense assessment may be done for infections as determined by the facility as being epidemiologically significant.

M. **Public Health Reporting:**

1. Compliance with Legislative Mandatory Public Reporting using NHSN, CDC's electronic database is maintained.(Figure 2)
2. CMS quality measurement reporting requirements are fulfilled.
3. Through the collaboration with and in conjunction with the Laboratory personnel, the IP reports reportable diseases/conditions to the public health authorities
4. The occurrence and follow-up of infections/communicable diseases among patients, staff, and visitors will be documented and reported to the Public Health Department and reported to the IC committee.
5. Rights may be conferred to other entities to access data submitted to NHSN; e.g. CalHIN, HSAG, CDPH

N. **EMERGENCY MANAGEMENT**

1. The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded or extended care capabilities over a prolonged period of time. Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced.

2. As part of emergency management activities, TFHS will be prepared to respond to an influx, or the risk of an influx, of infectious patients.
    a. See Policies for Emergency Management Plan - HEICS, DHOS-6016, Bioterrorism Readiness Plan, AIPC-4, Pandemic Flu Readiness/Response, AIPC-90.
    b. The planned response includes a broad range of options including the temporary halting of services/admissions, delaying or expediting transfer or discharge, limiting visitors, and all the steps in fully activating the organization's emergency management plan. The actual response depends on issues such as the extent to which the community is affected by the spread of infection, the types of services offered, and the capabilities of the organization at the time of the emergency.
    c. The plan includes but is not limited to: surge planning for taking in 50 more patients over the licensed beds, setting up alternate care sites as needed, keeping abreast of current information, and disseminating critical information to staff, other key practitioners, and the community, and identifying resources in the community through local, state and/or federal public health.

O. Participation in Best Practice Collaboratives
1. Small group opportunities include but are not limited to:
    a. Rural, Small and Critical Access Hospital Collaborative-HAI Prevention for California's Smallest Hospitals
    b. Nevada's Project ECHO Antibiotic Stewardship
    c. Sierra APIC chapter
    d. Northern Nevada Infection Control Group
    e. Nevada Rural Health Partners
2. Progress Updates resulting from participation are reported to Infection Control Committee

TABLE 1: Example Formulas/Calculations used to present data by infection control program.

Infection Rate or other metric	Calculation
Device-related infections	# device-related HAI x 1000 ---------- # of device days
Surgical site infections: Rate;	# of HAI surgical site infections ---------- # of patients with specific surgical procedure x 100
Standardized Infection Ratio (SIR)	Logistic regression modeling
Reportable diseases	Number of patients with the reportable diseases
Infection Rates per Patient Days	# of HAI ---------- # of patient care days x 1000

Figure 2: Mandatory Public Reporting using NHSN, CDC's Electronic Data base
09.20.2010 FINAL Monthly NHSN Reporting for California Hospitals
California Department of Public Health
Healthcare-Associated Infections (HAI) Program

This guide provides a "roadmap' to the NHSN data entry screens for meeting CDPH reporting requirements each month. To use this guide, please log in to your hospital's NHSN Patient Safety component. Remember to enter denominator data for both surveillance modules each month even if no infections occurred that month. When entering Events and Summary data, you must complete (at a minimum) each required field indicated by a red asterisk.

Device-Associated Module

CLIP - Central Line Insertion Practices
Enter each CLIP form as an "Event" into NHSN **LabID Event - MRSA and VRE bloodstream infections**

Numerator

Enter EACH positive blood culture for MRSA and VRE as an "Event"
Include only cultures from inpatients and the Emergency Department if the patient is admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted
If repeat cultures from same patent with the same pathogen, only enter if ≥2 weeks (14 days) from last positive culture
Event Type is "LabID – laboratory identified MDRO or CDAD event"

MDRO Module

Lab ID Event - *C difficil*e infections

Numerator

Enter EACH *C diff* positive lab assay (toxin or PCR test of unformed stool) as an "Event"
Include only positive assays from inpatients and the Emergency Department if the patient admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted
If duplicate *C diff* assays from same patent, only enter if ≥2 weeks (14 days) from last positive assay

MDRO Summary Data - MRSA, VRE, and *C difficile*

Denominator

A single NHSN data screen is used for entering all required MDRO Module denominators
Select **"Summary Data"** from blue task bar. Select Add

- For Summary Data Type, select "MDRO and CDAD Prevention Process Outcome Measures Monthly Monitoring"
- For Location Code, select Facility-Wide Inpatient - "FacWideIN"
- Enter Total hospital inpatient days and Total inpatient admissions
- Enter Total hospital inpatient *C diff* days and Total inpatient *C diff* admissions

  C diff Patient Days = total hospital inpatient days minus NICU and well baby nursery days
  C diff Admissions = total hospital inpatient admissions minus NICU and well baby nursery admissions
- If hospital has no NICU or well-baby units, *C diff* Patient Days and *C diff* Admissions will be the same as Total Patient Days and Total Admissions

  Required for each Critical Care Unit (i.e. ICU, NICU, PICU) and Level II Neonatal Care units

CLABSI - Central Line-Associated Blood Stream Infection

Numerator

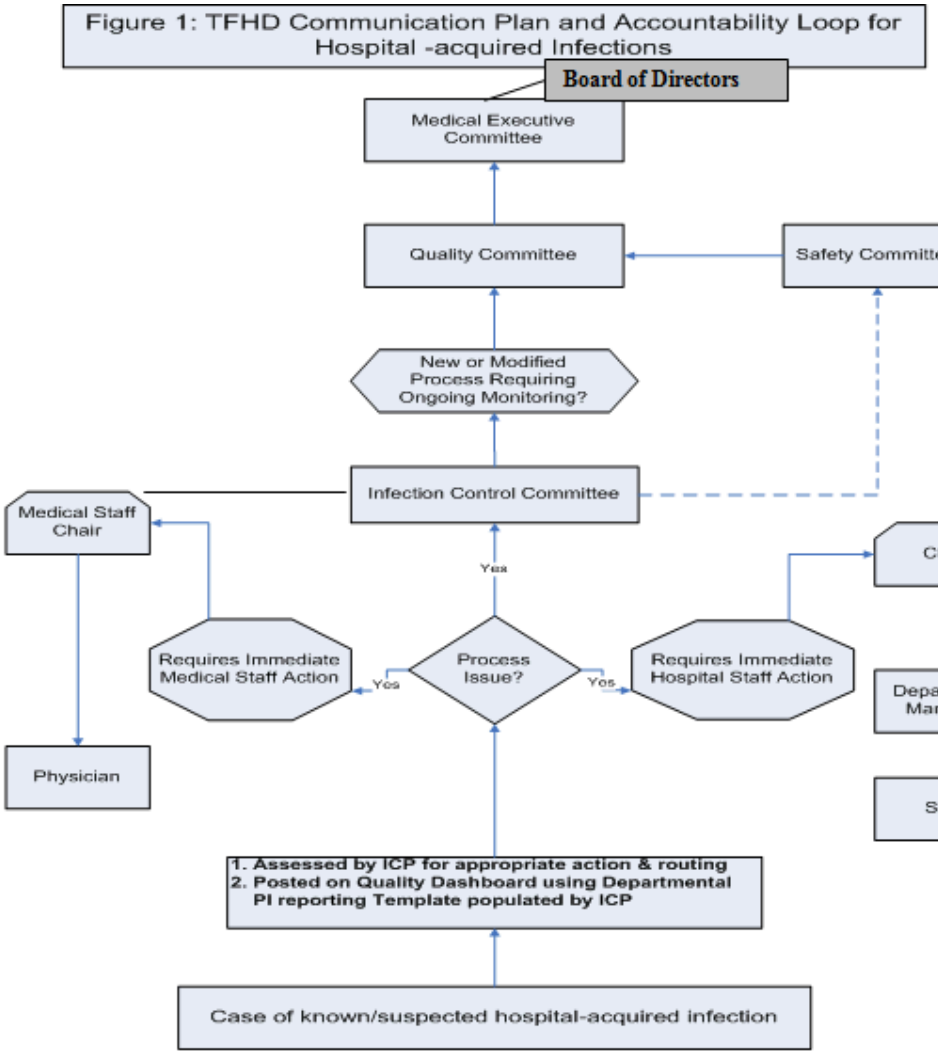
Enter CLABSI from every inpatient location as an "Event"
Event type is "BSI-Bloodstream infection"

Denominator

Select **"Summary Data"** from blue task bar. Select Add

For "Summary Data Type" select Device Associated Intensive Care Unit/other Locations (or Device Associated Neonatal Intensive Care Unit, Device Associated Specialty Care Unit)
Enter inpatient Central Line Days for each inpatient location with acute care beds (e.g. ICU, NICU, Med Surg wards, Medical wards, L/D)
Enter Total patient days for each inpatient location
NICU locations will require Central line days and patient days to be separated by birth weight categories
Umbilical lines versus other central lines (e.g. PICC) need to be tracked and entered separately
If you have a specialty care area (SCA) (e.g. hematology/oncology, transplant unit) you are required to track and enter separately temporary central line days (e.g. PICC) versus permanent line days

Please see A: View Monthly Reporting Plan



Please see C: Table 2

References:

HFAP 03.16.01; Current CDC guidelines including NHSN definitions; All Facility Letters (CDPH AFLS); State of Nevada Regulatory Stds; CMS COP 42 CFR parts 482, 485;
Requirements for Infrastructure & Essential Activities of Infection Control & Epidemiology in Hospitals: ICHE Feb'98.

All revision dates: 03/2019, 01/2019, 05/2018, 10/2017, 01/2017, 12/2015, 01/2015, 01/2014, 01/2013, 08/2012

Attachments

A: View Monthly Reporting Plan
B: TFHD communication Plan and Accountability Loop for Hospital -Acquired Infections
C: Table 2
Infection Control Plan Goals 2019.docx

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	03/2019
	Svetlana Schopp: Infection Preventionist	03/2019

2020 Infection Control/Employee Health Goals

(part of annual Infection Control Plan, AIPC-64)

Decrease risk of hospital-acquired infection: aim for Zero; sustain < 1% preventable HAI rate (Quality, Understanding, Excellence, Stewardship, and Teamwork):

Continue to Educate and Monitor for:

- Hand hygiene
- Standard precautions
- Transmission-based precautions
    - Continue to work on implementing of practices to reduce CDI rates
- Cleaning/disinfection
    - Incorporate ATP testing into teaching about cleaning and disinfection principals for EVS
- SSI prevention

How?

- Define
- Measure
- Analyze
- Improve
- Control

Achieve & sustain 100% HCW flu vaccine status documentation and 90% or greater vaccination rate (based on Healthy People 2020):

- Assess current vaccination administration and documentation process
- Identify improvement opportunities to achieve & sustain goals

Aim for zero occupational exposures:

- Minimize unprotected exposure to potential pathogens
- Review all reported events to identify process improvement opportunities
- Research and implement electronic tracking for employee flu vaccination

Use EMR to improve efficiency & accuracy of data capture

Comply with regulatory and public health reporting mandates

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*04/2013*
Last Approved:	*07/2019*
Last Revised:	*07/2019*
Next Review:	*07/2020*
Department:	*Environment of Care - AEOC*
Applies Towards:	*System*

Emergency Operations Plan (Comprehensive), AEOC-17

TABLE OF CONTENTS

PURPOSE:

A. The Tahoe Forest Health System (TFHS) mission is to make a difference in the health of our communities through excellence and compassion in all we do. TFHS stands by the following value: quality, understanding, excellence, stewardship and teamwork. The system is comprised of the following:

1. Two Critical Care Hospitals:
    a. Tahoe Forest Hospital located at 10121 Pine Ave, Truckee, CA 96161 (530) 587-6011
    b. Incline Village Community Hospital located at 880 Alder Ave, Incline Village, NV 89451 (775) 833-4100
2. Extended Care Facility at 10121 Pine Ave, Truckee, CA 96161 (530) 587-6011
3. Gene Upshaw memorial Cancer Center located at 10121 Pine Ave, Truckee, CA (530) 582-6450
4. Multi-Specialty Clinics, Surgery Center and Physical Therapy locations:
    a. Medical Office Building contains Occupational Health/Health Clinic, Tahoe Forest Pediatrics, Urology, Gastroenterology, General Surgery, Internal Medicine/Pulmonary, Ear, Nose and Throat, Neurology, Urology, Endocrinology, and Retail Pharmacy. All are located at 10956 Donner Pass Road, Truckee, CA 96161
    b. Internal Medicine/Cardiology: located at 10978 Donner Pass Rd, Truckee,?CA 96161
    c. Tahoe Forest Orthopedics and Sports Medicine: located at 10051 Lake Ave, Truckee, CA 96161
    d. Center for Health and Sports Performance: located at 10710 Donner Pass Road, Truckee, CA 96161
    e. Truckee Surgery Center at 10770 Donner Pass Road, Suite 201, Truckee, CA 96161
    f. Psychiatry/Mental Health Clinic, 10833 Donner Pass Road, Suite 203, Truckee, CA 96161
    g. Tahoe Forest Woman's Center: located at 10175 Levon Ave, Truckee, CA
    h. Tahoe Forest Therapy Services & Laboratory - Tahoe City, CA: located at 905 North lake Blvd. Suite 201, Tahoe City, CA 96145
    i. Incline Village Health Center: 880 Alder Ave, Second Floor: Incline Village, NV 89451
    j. Incline Village Physical Therapy & Medical Fitness: located at 333 Village Blvd., Suite 201, Incline Village, NV 89451
    k. Incline Village Lakeside Clinic: located at 889 Alder Ave, Suite 303, Incline Village, NV 89451

B. The Tahoe Forest System Organizational Chart structure can be found in Attachment B.

C. The Tahoe Forest Health System (TFHS) Emergency Operations Plan (EOP) is a comprehensive, all-hazards plan that will be used to manage the consequences of natural and technological disasters or other emergency situations that disrupt the hospitals or campus response to internal or community disasters.
    1. It delineates emergency and tactical response plans, procedures, and responsibilities, lines of authority and continuity of operations.
    2. Functional annexes to include the Emergency Codes provide guidelines and tactical response actions for specific emergencies whether they impact either hospital or the campus as a whole.

D. The format aligns itself with the National Response Framework (NRF) by incorporating the National Incident Management System (NIMS) as adopted by the medical center and the campus, while employing a functional approach to emergency management and includes Emergency Support Functions (ESFs).
    1. In accordance with NIMS, the hospital has elected to manage all incidents using the Hospital Incident Command System (HICS).
    2. This functional incident management system is a part of the NIMS structure and lends itself well to concurrent command and incident management for the TFHS campuses as a whole.
    3. Additionally, the EOP addresses seven Critical Function Areas to include: Communications; Resources/ Assets; Safety/Security; Staff Responsibilities; Utilities Management; Patient Clinical/Support Activities; and Disaster Volunteers.

E. As there is no further standard for incident management other than the NIMS, it is logical to adopt and adhere to its mandates in terms of emergency management.

POLICY:

A. TFHS will design and maintain an all-hazard EOP to manage the consequences of natural, technological, hazardous materials and human related or other emergency situations that disrupt the hospital or campus response to internal and community disasters as found within the Emergency Management Committee (EMC) and the Nevada County, and Washoe County Nevada Hazard Vulnerability Analyses(HVAs).

B. Furthermore, the use of the TFHS HVAs is the basis for defining mitigation activities as well as the effectiveness of the plan.

C. The EOP addresses the four phases of emergency management activities including Mitigation (inclusive of prevention), Preparedness, Response and Recovery.

SCOPE:

A. This plan shall apply to all Hospitals, Departments and entities of TFHS and incorporates the all-hazards approach that addresses a full range of complex and constantly changing requirements in anticipation of or in response to threats or acts such as major disasters (natural, technological, hazardous material and human), terrorism, and other emergencies.

B. The EOP details specific incident management roles and responsibilities using the Hospital Incident Command System (HICS) model and a unified command, in conjunction with the TFHS Plans and Codes.

ORGANIZATION:

A. The Emergency Management Committee (EMC) receives regular reports of the status of the Emergency Operations Plan and/or components of the EOP.

1. The Emergency Management Committee reviews the key issues, and communicates information, findings and concerns about identified issues to all appropriate bodies including the Environment of Care Committee and Senior Administration.
2. Department Directors and supervisors are responsible for orienting new employees, transferred employees, and volunteers to their respective departmental Emergency Operations plans and procedures, congruent with the overall EOP.
3. Individual staff members are responsible for learning and following the hospital-wide and campus departmental policies.
    a. This is accomplished through general information about the Hospital's Emergency Preparedness and their role in emergency response as part of new employee orientation as well as emergency management and response training as a part of their departmental continuing education in addition to annual competencies through learning based computer modules and drill participation.

B. **Self-Sustainability**

1. The Emergency Operations Plan addresses the ability of the System to operate without external support for at least 48 – 96 hours in the seven critical areas.
2. Contingency plans address alternate sources of resources, utilities, and staff; however if contingency plans cannot adequately support a safe environment, TFHS, through the Incident Commander, will initiate a phased evacuation of either the hospital complex and/or other buildings on campus as per the appropriate evacuation plan.
3. TFHS recognizes that when the President of the United States declares a disaster and the HHS Secretary declares a public health emergency, the Secretary is authorized to invoke a CMS 1135 Waiver that will allow TFHS to provide sufficient health care items and services to meet the needs of individuals enrolled in the Social Security Act programs in the emergency area and will be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). TFHS has systems in place as outlined in individual procedures as well as collaborative plans with local and county emergency officials to allow an organized

and systematic response to assure continuity of care even when services at their facilities have been severely disrupted.

4. *SOURCE:*
    a. *Disaster Surge Plan*
    b. *Food & Nutrition Plans*
    c. *Region IV Multi-Casualty Incident Plan*
    d. *Nevada County Healthcare Surge and Alternate Care Site Plan*
    e. *Washoe County Mutual Aid Evacuation Agreement*

C. **Continuity of Operations Goals and Planning Elements**

1. TFHS will take the following actions to increase its ability to maintain or rapidly restore essential services following a disaster to ensure patient, visitor and personal safety:
    a. Develop, train on and exercise plans for responding to internal emergencies and evacuating staff, patients and visitors when facility is threatened.
    b. Provide continuous performance or rapid restoration of essential services during an emergency by utilizing current plans to obtain needed medical supplies, equipment and personnel.
    c. Identify a backup site or make provision to transfer services to a nearby provider.
2. TFHS will, to the extent possible, protect medical records from fire, damage, theft and public exposure. If the Hospital is evacuated, all available measures will be taken to ensure privacy and security of medical records.
3. TFHS will:
    a. Ensure off-site back-up of financial and other data.
    b. Store copies of critical legal and financial documents in an off-site location.
    c. Protect financial records, passwords, credit cards, provider numbers and other sensitive financial information.
    d. Update plans for addressing interruption of computer processing capability.
    e. Maintain a contact list of vendors who can supply replacement equipment.
    f. Protect information technology assets from theft, virus attacks and unauthorized intrusion.
4. TFHS will take the following steps, as feasible and appropriate, to prepare for an event that makes the primary facility unusable. TFHS will:
    a. Maintain contact list(s) of utility emergency numbers.
    b. Ensure availability of phones and phone lines that do not rely on functioning electrical service.
5. TFHS maintains emergency generators to ensure its ability to continue operations in the event of an emergency that creates power outages. TFHS will:
    a. Maintain diesel fuel storage for extended operations (minimum 96 hour supply)
    b. Maintain MOU agreements to ensure fuels can be accessed in an emergency.
    c. Performance of recommended periodic maintenance.
    d. Conduction of regular generator start-up and load tests per requirements.

D. **Recovery Strategies and Actions**

1. Strategies and Actions for the recovery and continued operation of the hospital are outlined in individual procedures and planning documents within the California Medical and Health Resource Requesting Tool and the Washoe County Mutual Aid Evacuation Agreement (MAEA).

2. Furthermore, the EMC will conduct debriefings as well as After Action reporting and develop an After Action Report and Corrective Action Plan.
3. This documentation will be presented to the Environment of Care Committee after each HICS activation.

E. **Activation and Deactivation of the Plan**

1. The decision to activate or deactivate the emergency operations plan rests with the Incident Commander.
2. Depending on the time of day or circumstance, the Incident Commander will either be the Administrator on Duty, House Supervisor or other related position.
3. The Incident Commander is responsible for deactivating the response phase of the plan once conditions have returned to normal and by initiating the recovery phase.
4. Certain personnel are always operating in the preparedness and mitigation phase even when no emergency conditions are present.
5. The response and recovery phases are activated as outlined within the Code Plans as well as the EOP, usually before a disaster is expected to occur or after it has occurred.
    a. These include but are not limited to: natural disasters, technological disasters, and loss of operations, vendor shortages, loss of medical or non-medical supplies, equipment or services.

PLAN FOUNDATION:

A. The Emergency Operations Plan and supporting policies and procedures were developed and are maintained by the Emergency Management Committee.

1. Representatives include medical staff, including the physicians, nursing, operations, and administrative leadership.
2. This group provides a diverse and multidisciplinary representation of knowledge and experience.
3. The following summary explains the essential elements of the Emergency Operations Plan. Specific details on how this plan is implemented are found within the TFHS Code Documents.
    a. *SOURCE:*
        i. *TFHS Codes & Emergency/Security Plans*

B. **Hazard Vulnerability Analysis** (HVA)

1. Separate Hazard Vulnerability Analyses has been developed for each hospital to anticipate threats and hazards that may affect not only hospital themselves, but the campus as a whole.
2. For each hospital, an analysis of the listed hazards was conducted with respect to the outcome and our ability to address the emergency and then continue operations.
3. The Hazard Vulnerability Analyses will be reviewed and updated annually by the Emergency Management Committee and submitted to the Environment of Care Committee for final review and approval.
4. The TFHS hospitals are considered in Community-based HVAs that have been developed and annually reviewed in one or both of the following hospital coalitions:
    a. Washoe County Inter-Hospital Coordinating Council
    b. Nevada County Emergency Preparedness Interagency Coalition
5. TFHS has communicated our needs and vulnerabilities to community emergency response agencies through various means such as committees and task groups and by sharing a copy of the HVA.
6. In addition, the TFHS Codes and other documents are kept by the Emergency Manager.
    a. These documents are updated on a continual basis and factors into HVA planning and discussions.
7. *SOURCE:*

a. *TFHS Codes & Emergency/Security Plans*

b. *TFH and IVCH HVAs*

c. *Region IV Multi-Casualty Incident Plan*

d. *Nevada County Healthcare Surge and Alternate Care Site Plan*

e. *Washoe County Mutual Aid Evacuation Agreement*

C. **Community Partners**

1. Local medical facilities, public safety agencies, along with representatives of local and state governments are involved in emergency planning through the California component of the Hospital Preparedness Program, a division of The Office of the Assistant Secretary for Preparedness and Response (ASPR) within the U.S. Department of Health & Human Services and Centers for Disease Control (CDC) and related committees and groups.
2. Currently, the Emergency Management Committee Chair participates and coordinates with the California Region IV California/Nevada Border Committee as well as all applicable County and local Emergency Planning Committees.
3. The following is a sample list of the community partners and external authorities that we maintain relationships and/or agreements with.
4. The entire list of partners and vendors is maintained electronically and available to the Incident Command Center staff both before and during an emergency:

Agency	Phone Number
American Red Cross	916-993-7070
California Emergency Management Agency	916-845-8510
California Health & Human Services Agency	916-654-3454
Federal Bureau of Investigation	916-481-9110
Nevada County Emergency Management	530-265-1515
Nevada County Sheriff's Department	530-265-1471
Truckee Fire Protection District	530-582-7850
Truckee Police Department	530-550-2323
Washoe County Emergency Management	775-337-5898
Washoe County Health District	775-328-2400

5. Additionally, these community partners, vendors and external authorities are notified as necessary to assure that the needs of the staff, patients and families are met in the event of an emergency or upon notification of a probable incident.

D. **Annual Evaluation of the Emergency Operations Plan and HVAs**

1. At a minimum, an annual evaluation of the TFH, IVCH and community-wide hazard vulnerability analysis (HVA) objectives, scope, performance and effectiveness is conducted by the Emergency Manager and others to include the Emergency Management Committee Chair and the Environment of Care Committee.
2. During the annual evaluation, and whenever our needs and vulnerabilities change, we communicate our needs and vulnerabilities to our partners to ensure their ability to assist us in times of a crisis.
3. Backup plans and procedures are utilized as needed.
4. Finally, the Emergency Management Committee then reviews the plan and provides recommendations for change. The plan is also evaluated after each exercise or incident and then a corrective action plan is developed.

E. **Hazard Vulnerability Analyses (HVA)**

1. The TFH & IVCH Hazard Vulnerability Analyses (HVA) are used as a basis to define our emergency management program to analyze mitigation, preparedness and response and recovery activities.
2. The mitigation activities are designed to reduce the risk of and potential damage related to an actual emergency.
3. A multidisciplinary group from the EMC is convened every year to reevaluate and score the areas in which TFHS is vulnerable based on past and present experiences in conjunction with community factors.
4. The HVAs are updated annually.
    a. *SOURCE:*
        i. *TFH HVA*
        ii. *IVCH HVA*

F. **Incident Command Structure**

1. TFHS uses a modified (Rural) version of the Hospital Incident Command System (HICS); and has implemented the National Incident Management System (NIMS) as part of the National Response Framework (NRF) so as to follow the organizational structures used by local emergency response groups to allow for a command structure that can be expanded or contracted based upon the needs.
2. These positions include but are not limited to those listed below:
    a. Incident Commander
    b. Logistics Section Chief
    c. Planning Section Chief
    d. Finance/Administration Section Chief
    e. Operations Section Chief
    f. Safety Officer
    g. Liaison Officer
    h. Public Information Officer
    i. Medical/Technical Specialist
3. Utilizing the HICS model, staff will report information directly to the Emergency Operations Center (EOC) during an emergency via email, telephone, and facsimile or by runner.
    a. Once the Command Center has opened, the contact information for the Incident Command Center is as follows:

i. Hospital Command Center (HCC) -	6213
ii. Incident Commander (IC) -	6248
iii. Public Information Officer (PIO) -	6249
iv. Safety Officer -	6251
v. Liaison Officer -	6250
vi. Operations Section Chief (OPS) -	6252
vii. Planning Section Chief -	6262
viii. Logistics Section Chief -	6263

    b. In the event that runners are used, they would be called from the Labor Pool.
        i. Incline does not have a Labor Pool.

ii. The call will be directed to the appropriate position within the EOC that will handle the request or receive any information with regard to the incident.

c. In the event that the primary command center is not available then the secondary site will be any other room as designated by the Incident Commander.

i. This information will be provided to hospital staff via electronic systems or runners if needed.

4. *SOURCE:*

a. *TFHS Codes & Emergency/Security Plans*

COMMUNICATION WITHIN AND OUTSIDE OF THE SYSTEM:

A. TFHS understands the importance and need of communications both internally as well as externally in the event of a disastrous situation.

1. To that end, communication and the reliability and redundancy of such is critical to the effective performance and continued operations of the hospital in times of disaster and critical need.
2. The EOP has several instances throughout describing a variety of communications methods and processes.
3. However, an overall structure as well as guidance is described herein.

B. Staff notification of activation of emergency response procedures, advisories, actions and pre-planning initiatives will be accomplished in several manners.

1. Chief among these is the utilization of the phone broadcast system and the overhead Public Address (PA) system.
2. Other methods are as follows:
   a. Disaster Resource Lists
   b. Everbridge Mass Notification
   c. Phone Messaging
   d. Email
   e. Departmental Call Tree notification and call down/call back
   f. General Media (TV & radio)

C. In addition, staff will communicate to patients, families and visitors, at the time of the notification/activation, what the emergency procedure is as well as how it may affect/impact them and any actions needed to be taken at that time or in the future.

D. TFHS will make every effort to communicate to all external authorities and stakeholder agencies and suppliers of the existence of an emergency condition as appropriate as soon as possible.

1. This will be accomplished through a variety of means to include mobile/handheld radio, Telephone, Text, Email or Official Resource Request.
2. This includes all regional hospitals, local and state offices of emergency management as well as the local/state departments of health.

E. In the event it is necessary, existing partnerships with local, state and federal law enforcement agencies will be activated and appropriate officials notified depending on the situation.

F. Additionally, healthcare facilities identified to potentially receive patient transfers will also be communicated with through multiple means and procedures.

1. This is dependent upon whether patients go to Nevada or California hospitals.

G. The Public Information Officer (PIO), will communicate with the media in consultation with the Incident Commander and Command Staff as to any emergency condition as warranted. Employees should refer to the

Media Communications Policy APR-4 for further guidelines.

H. At the inception of an emergency condition that may or is expected to last several operational periods and have an impact on hospital services, supplies and operations; each section chief will report to the Command Staff of potential impacts.

I. Furthermore, in conjunction with the Liaison Officer and with authorization of the Incident Commander, each respective director facing impact on services, supplies and utilities will communicate with their respective vendors, suppliers and providers; providing contact information and status to them as well as report back to the Liaison Officer.

    1. Any identified needs not able to be accommodated through normal means will be reported to the Command Staff and the Liaison Officer will make an official resource request through appropriate channels.

J. Any potential transfers of patients and patient records will be conducted with the utmost safety and regard for privacy.

    1. A reduced patient chart will be sent with each patient and or family member/care giver – staff member accompanying the patient.
    2. Upon arrival at the final destination whether alternate care site or alternative healthcare facility, the receiving party will contact TFHS through the number listed on the patient chart to the Command Center.
    3. Additionally, TFHS personnel accompanying will report back to the Command Center.

K. A number of redundant communications strategies are employed by TFHS to include:

    1. Handheld and/or mobile radios
    2. Email
    3. Fax
    4. Runners
    5. Phones
    6. Amateur radio
    7. Text
    8. GETS Cards
    9. Satellite Phones

L. *SOURCE:*

    a. *TFHS Codes & Emergency/Security Plans*

RESOURCES AND ASSETS:

A. TFHS recognizes the need to sustain essential resources, materials, and facilities in order to continue to provide care, treatment, and services to its patients, visitors, staff and employees.

B. The EOP as well as the Disaster Surge Plan identify how resources and assets will be solicited and acquired from a range of possible sources.

    1. TFHS recognizes the potential for emergencies of long duration or broad geographical scope and, as a result, critical resources and supplies are proactively identified, located, acquired, distributed and accounted for.

        a. It is recognized that multiple organizations may be vying for a limited supply from the same vendor.
        b. The EOP and Disaster Surge Plan also recognize the risk that some assets may not be available from planned sources and that contingency plans will be necessary for critical supplies.

    2. The EOP addresses managing and maintaining the facility but also considers evacuation of the entire facility

when the environment is no longer deemed safe.

3. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*
    b. *Medical Health Operational Area Coordinator Planning*
    c. *Mutual Aid Planning (Washoe/Nevada County entities)*

C. **Monitoring the Quantities of Assets and Resources**

1. TFHS has the ability to track all assets, supplies, and resources both internally and externally.
2. This is accomplished by electronic means through Supply Chain, Materials Management, Pharmacy, and other departments throughout the System. During an incident this information is provided to the EOC via periodic reports from the Logistics and Planning Sections.

D. **Obtaining Supplies that will be needed at the Onset of an Emergency**

1. TFHS maintains both lists and databases to indicate the actual amount of emergency supplies that are on-site.
2. These lists include but are not limited to fuel for generators, medical, surgical and pharmaceutical supplies, food, linens, PPE, staffing, and medical supplies.

E. **Replenishing Medical Supplies and Equipment**

1. Replenishing medical supplies and equipment will be the responsibility of the Liaison Officer in conjunction with the Logistics Section. Emergency contact information for both suppliers and vendors is kept at the individual departmental level.
2. The Logistics Chief provides updates as to the status of resources during emergencies.

F. **Replenishing Non-Medical Supplies and Equipment**

1. Replenishing non-medical supplies and equipment such as food, linen, water, fuel for generators and vehicles will be addressed by the various departmental directors and both the Logistics and Planning Sections during a disaster.

G. **Staff and Family Support Activities**

1. Staff Support Activities - Staff needs will be evaluated on an ongoing basis and will include sleeping quarters, transportation from designated pick-up points to the campus, and Critical Incident Stress Management (CISM).
2. All staff are encouraged to develop pet care plans and alternate care arrangements but assistance with locating alternate care arrangements will be provided if needed.
3. Family Support Activities - Staff and families will be afforded support (i.e. Childcare, Critical Incident Stress Management, etc.) during and after disasters.
4. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*
    b. *Disaster Supply Planning*
    c. *Food & Nutrition Plans*

H. **Emergency Operations Plan**

1. The Emergency Operations Plan for TFHS is designed to integrate our specific role to meet emergencies within the community and work with other healthcare facilities and emergency response agencies.
2. The TFHS Emergency Operations Plan was designed around the management of the seven critical areas, which are: *Communications; Resources and Assets; Safety and Security; Staffing; Utilities; Clinical*

Activities; Volunteer Management; and by focusing on the TFHS and community-wide HVAs.

3. The plan is developed by the Emergency Management Team in consultation with members of hospital administration, medical staff, operations, as well as others in key leadership positions.
4. The plan is reviewed annually by the Emergency Management Committee for changes.
5. It is expected that the Incident Command System (ICS) will be implemented by one of the appropriate local emergency agencies who will then communicate their assessment and needs to healthcare facilities including TFHS through designated communication routes. TFHS will participate in the community unified command structure.

I. **Specific Plan Procedures**

1. The Hazard Vulnerability Analysis consists of the following:
    a. Hazard
    b. Mitigation, including prevention
    c. Emergency Operations Plan to address the emergency
    d. Response
    e. Recovery
2. The HVA is comprehensive and incorporates an all-hazards approach to planning, mitigation, response and recovery.

J. **Management of Resources and Assets during Emergencies/Replenishing Pharmaceutical and Related Supplies**

1. The Pharmacy Director, working with the Logistics Section, will address the replenishment of medication and related pharmaceutical supplies in a disaster.
2. In the event of a large-scale incident which causes a disruption of the normal supply chain, or during certain emergencies, TFHS will make a request for additional quantities of medications and related supplies to the Nevada County (CA) Office of Emergency Services or the Washoe County Emergency Management Office and to the Washoe County Health District or Nevada Department of Public Safety.
    a. The resource request(s) will follow the appropriate pathway to ensure requests that can be filled locally are, prior to tapping into state or federal resources, depending on the scope and magnitude of the disaster.

K. **Obtaining and Replenishment of Medical Supplies and Personal Protective Equipment during Response and Recovery**

1. Medical, non-medical supplies, equipment and personal protective equipment (PPE), will be replenished via normal supply means as well as through any backup supplies maintained by the System or regional collaborations.
2. Hospital and System resources and assets will be shared with other facilities both within and outside of the community through Memoranda of Agreements (MOAs) that are in currently place with the Medical Health Operational Area Coordinator.
3. Additional request will be reviewed by the Incident Commander or designee as they are received.
4. Resources and assets will be tracked both before and as they are being used to ensure that the hospital maintains adequate supplies for the incident or the outside request for assistance.
5. This will be accomplished by the responsible department and forwarded to both the Logistics and Planning Section Chiefs in the EOC.
6. The fundamental goal of the TFHS Emergency Operations Plan is to protect life and prevent disability.

a. Depending on the type of emergency, services may vary; however, certain clinical activities are fundamental and may require any organization to determine how it will re-schedule or manage clinical needs even under the most dynamic situations or in the most austere care environments.

7. TFHS recognizes the importance of triaging patients as appropriate in an emergency and that a catastrophic emergency may result in the decision to keep all patients on the premises in the interest of safety or, conversely, in the decision to evacuate all patients because facilities are no longer safe.

L. **Required Clinical Activities**

1. Required clinical activities will be managed in accordance with the TFHS Codes and appropriate clinical practices and policies, including the Disaster Surge Plan.
2. This includes managing vulnerable population patients including pediatric (stabilize then transfer if appropriate), geriatric, disabled, and those having serious chronic conditions or addictions as well as providing for the personal hygiene and sanitation needs of the patients served by TFHS hospitals.

M. **Evacuation of Facility and Alternate Care Sites**

1. If the facility environment cannot support adequate patient care and treatment, the patients will be moved into areas of safe haven beginning with the area under the adverse environment and continuing as needed.
2. Areas will be evacuated horizontally and then vertically using the TFHS Evacuation Plan and patients will be staged at various locations on the campus as outlined in this plan until a determination is made as to wither the patients can return.
3. Should the facility be deemed unsafe the hospital in coordination with Truckee Fire will request activation of the Washoe County Mutual Aid Evacuation Agreement (MAEA) and/or the Nevada County Healthcare Surge and Alternate Care Site Plan.
    a. This plan includes transporting patients, their medication and any needed equipment to other locations.
    b. Hospitals and other facilities within the regional service area have a cooperative agreement to accept a patient(s) if a local facility becomes uninhabitable.
    c. Critical patient information will be transported with the patient.
    d. Both the patient and the staff member(s) will be accounted for at all times by their supervisors using the appropriate HICS and other tracking forms as outlined in the hospital/county evacuation plan.
4. Patients will be transferred by various means to include:
    a. EMS agencies
    b. TFHS owned vehicles
    c. Vehicles dispatched by Nevada or Washoe County Emergency Management or designee
    d. Aircraft
    e. National Guard Medivac – Sourced through the State Office of Emergency Management
    f. Careflight as well as any other Private Air Ambulance
5. *SOURCE:*
    a. *TFHS Codes & Emergency Plans*
    b. *Washoe County Mutual Aid Evacuation Agreement (MAEA)*
    c. *Nevada County Healthcare Surge and Alternate Care Site Plan*

N. **Advanced Preparation to Provide for Resources and Assets**

1. Components of this plan will be implemented in advance so as to provide for both the resources and assets that may be used during an emergency.

2. The Incident Commander (IC) and his/her staff will review the emergency and activate various parts of this plan and its attendant Codes in anticipation of the needs related to a particular incident.
3. These includes but are not limited to:
    a. Food and water
    b. Maintenance issues such as generators and fuel
    c. Transportation of assets from remote storage sites
    d. Recalling personnel
    e. Activation of alternate care sites
    f. Communication

O. **Alternate Care Sites**

1. Alternate Care Sites/Transportation of Patients – Patients will be transferred to a local alternate care site using the Nevada County Healthcare Surge and Alternate Care Site Plan or the Washoe County Mutual Aid Evacuation Agreement (MAEA) as well as input from the Medical Health Operational Area Coordinator.
    a. It is to be understood that local hospitals and/or pre-designated sites are to be considered as the primary and most immediate Alternate Care Site to TFHS, prior to any other site.
    b. Local agreements have been established between TFHS and public emergency management officials, hospitals within the Nevada County, CA and Washoe County, NV regional area and statewide; ambulance services and public transportation authorities to provide transportation and care in the event of a hospital only or community wide emergency.
    c. In addition to local Emergency Medical Services (EMS), hospital owned vehicles may be used as deemed necessary.
    d. TFHS staff will provide protection for both staff and patients being transported or they will be assisted by local law enforcement authorities as needed.
2. Patient Necessities –
    a. Patient medications, charts, and portable equipment will be sent with the patient and documented using the appropriate HICS forms.
3. Patient Tracking –
    a. Patient tracking information will be available for staff to assure patient location and transportation to other medical facilities is controlled. This information will also be provided to the EOC and documented using the appropriate HICS forms.
4. Communication-
    a. Communication between the facility and the alternate care site will be maintained using those systems as noted in the section below. All communications will be documented using appropriate HICS communications forms.

P. **Incident Notification and Communication with Other Agencies and Vendors**

1. Staff, patients and visitors will be notified of a disaster or probable disaster following the procedures within the appropriate policy such as the TFHS Codes.
    a. This notification will be made via overhead announcements, the Everbridge Mass Notification System, pager, radio, internal email, runners, and similar devices and processes.
    b. Additionally, departments will make notification in person as outlined within their disaster plans.
    c. Emergency instructions will be delivered at this time.
2. In the event of an emergency, the Incident Commander or his/her designee will notify local, county, state

and/or federal emergency management/health agencies and hospitals that emergency measures have been initiated.

   a. This communication will include contact information, key roles and names, and the nature of the activation.

3. This information will be shared by the following ways:
   a. Calling 9-9-1-1
   b. Radio
   c. Email
   d. Amateur Radio
   e. Fax
   f. Runners
   g. Text
4. Typically, in a large scale disaster affecting large geographical areas, the Medical Health Area Operational Coordinator will activate various communications means and platforms to inform and advise partner agencies, institutions and others of the severity and magnitude of the incident.
5. Should the President of the United States declare a disaster and the HSS Secretary authorize a CMS 1135 Waiver, TFHS will submit requests to operate under that authority or for other relief that may be possible outside the authority to the CMS Regional Office with a copy to HFAP. TFHS will then work with the Medical Health Area Operational Coordinator to provide the necessary resources and/or services to assure continuity of care.
6. Instructions and requests for information may also accompany these messages.
7. Communication will be maintained with other agencies, alternate care sites, hospitals or other entities via the following systems:
   a. Handheld/mobile radios
   b. Email
   c. Fax
   d. Runners
   e. Phones
   f. Amateur radio
   g. Text
   h. Satellite Phones
   i. The GETS System can be used to provide phone priority status.
8. The PIO working through and on behalf of the Incident Commander will make contact with the community and the media through normal means.
   a. Any messages will be approved by the Incident Commander prior to release.
9. Messages will be developed and disseminated to the appropriate groups at the beginning of an incident and throughout the disaster at the discretion of the Incident Commander.
10. Patient information will only be shared on an as needed basis and as per current local, state and federal law.
11. However, should an evacuation be ordered the patient's medical information will be provided to the transferring ambulance provider as well as to the receiving hospital.

12. This information may also be shared with the Nevada/Washoe County Health Districts and/or Nevada and California State Health Agencies, or other agency as required for tracking or other applicable purposes.
13. Communication systems are tested on a regular basis and are always in standby mode and ready to be deployed on a moment's notice. Primary and backup communication systems are placed at strategic locations throughout the campus to provide for the advance preparation of emergency communication.

Q. **Transportation of Patients to Alternate Care Sites**

1. See Alternate Care Sites in previous section.
2. *SOURCE:*
    a. *TFHS Codes* & Emergency/Security Plans
    b. *Washoe County Mutual Aid Evacuation Agreement (MAEA)*
    c. *Nevada County Healthcare Surge and Alternate Care Site Plan*

R. **Managing Safety and Security during Emergencies**

1. Controlling the movement of individuals into, throughout, and out of the organization during an emergency is essential for the safety of patients and staff, and to the security of critical supplies, equipment, and utilities.
2. The TFHS Security Committee, in conjunction with the Emergency Management Committee as well as TFHS staff; have identified the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated.
3. In the event of an emergency affecting the campus or immediate environment around the facility, the Incident Commander will work within the community's Unified Command structure to provide for on-going communication and coordination.
    a. The Security Branch Director will report actions taken to the Operations Section Chief in the Hospital Command Center (HCC) and await further instructions.
4. It is important to the continuity of operations that the control of movement of individuals within the facility during an emergency be observed and followed.
    a. This includes the use of identification badges by all personnel as well as identification of approved visitors.
    b. Furthermore, the placement of TFHS staff to control certain areas of disaster operation will be employed in keeping with established code or departmental procedures.
5. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*

S. **Internal Security and Safety Operations during an Emergency (including access control)**

1. TFHS staff is responsible for controlling access, crowds, and traffic into the hospital.
2. The HCC will coordinate with local law enforcement agencies with regard to lockdown, suspension of visitation and restriction of movement in an emergency and traffic control operations, depending upon the type of incident.
3. This includes the placement of uniformed officers and marked staff members at key locations, controlling access via available physical and/or electronic systems, and manual controls such as key access only.
4. Staff members, volunteers, family and visitors are required to wear hospital identification at all times which allows for a secondary method of controlling movement inside TFHS facilities.
5. The Safety Officer, working within the command structure, will establish safety measures during emergencies using current departmental plans.

a. The Safety Officer can be identified by his/her command vest.

6. Parking and vehicle access during an emergency are controlled by the TFHS staff and/or security/local law enforcement.
    a. Signs may be placed at various TFHS locations directing staff, family and visitors where to park.
    b. Local partners such as municipal Police, County Sheriff or private security firms may be used to supplement these services as needed.
7. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*
    b. *Washoe County Mutual Evacuation Agreement*
    c. *Nevada County Healthcare Surge and Alternate Care Site Plan*

T. **Advanced Preparation to Provide Support to Security and Safety during an Emergency**

1. Components of this plan will be implemented in advance so as to provide support to security and safety during an emergency.
    a. Vigorous adherence to ID Badge use and display as well as adherence to all visitation policies and procedures along with identification of visitors will be enforced.
2. The Incident Commander (IC) and his/her staff will review the emergency and activate various parts of this plan in conjunction with TFHS staff, security and/or law enforcement in anticipation of the needs related to a particular incident.
    a. These include but are not limited to:
        i. Activation of resources and assets
        ii. Activation of additional staff
        iii. Requesting assistance of outside agencies or partners
        iv. Roles and Coordination of Outside Agencies
3. Incidents that require the assistance of outside Security or Safety agencies will be managed using a unified command concept which allows for a coordinated management of the incident by all responders.
4. However, the TFHS Incident Command or designee shall retain authority for the System and each Hospital/ department will report to the EOC/Incident Commander.
5. The following describes the services of each potential agency:
    a. Truckee Police, Nevada and Washoe County Sheriff – Traffic control, investigation, detention, law enforcement support to TFHS including lockdown, escort, transportation, and other protective services.
    b. Federal Partners (USSS, FBI, ATF, DHS, etc.) – Investigation, law enforcement, scene control, detention, bomb investigation, securing crime scene, training, support of emergency management as well as security staff.
    c. US Marshalls Office, California Highway Patrol and Nevada Department of Public Safety – In addition to normal duties as listed above, provide protection and escort of supplies and pharmaceuticals per current state and federal plans, including the Strategic National Stockpile (SNS), Chempak, and support of security.
    d. Military Authorities-As assigned by state or federal authorities. The 95 th Civil Support Team (Northern California) and/or the 92nd Civil Support Team (Nevada); is available to directly assist the hospital with any Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) incident.
    e. These teams and other military partners can assist with patient care, transportation or security support as directed or in response to a given situation, such as acts of terrorism.

f. United States Secret Service (USSS) will control all protective functions in the event a USSS Protectee is at TFHS.

6. It is important to note that due to the large number of agencies that are located within the coverage area of TFHS, all of our law enforcement and protective partners are not listed within this plan.

U. **Hazardous Materials and Waste during an Emergency**

1. Written procedures for Chemical, Biological, Radiological, Nuclear and High Yield Explosive (CBRNE) contaminants have been established and are located within the TFHS Weapons of Mass Destruction (WMD) Procedures, as referenced in Annex 5 of this EOP.
2. *SOURCE:*
   a. *TFHS HICS*
   b. *TFHS WMD Procedures*
   c. *Disaster Surge Plan*

STAFF ROLES AND RESPONSIBILITIES:

A. TFHS provides safe and effective patient care, while safeguarding staff and visitors, during an emergency by having well defined staff roles.

B. Staff are oriented and trained in the assigned roles and responsibilities to include communications, resources and assets, safety and security, utilities, and patient management during emergencies.

C. The roles for all seven of the critical areas are included on the Incident Command Center Job Action Sheets that identify immediate, intermediate and extended tasks that must be performed during an emergency by key staff.

D. **Chain of Command in an Emergency**

1. Departments have conducted training on staff responsibilities and alternate specific roles and are assigned to those roles by the Incident Command Center.
2. Reporting structure is described in the TFHS HICS.

E. **Staff Support Needs**

1. The Incident Commander or his/her designee will assist staff with support for food, water, transportation, housing, stress debriefing and other services in the event of an emergency.
2. The HCC, depending upon the needs of the incident, will designate resources and areas to support staff.
3. As with any emergency; food, water and transportation will be provided on a routine basis during disasters as prescribed by the Incident Commander or designee.
4. Incident stress counseling, debriefing and any family support such as child care will be coordinated through Logistics.

F. **Pets**

1. It is understood that pet care can become an issue in terms of staff recall.
2. All staff are encouraged to develop personal pet care plans and alternate care arrangements in the event of a disaster impacting TFHS and/or the region.
3. Assistance with locating alternate care arrangements will be provided if needed.

G. **Training**

1. Multiple key staff and others receive both HICS training and training on the requirements of the National Incident Command System (NIMS) through a variety of means at TFHS.
2. Other employees receive competency based and theory training on numerous emergency management topics throughout the year by educational offerings through TFHS Staff Education, California and Nevada

Hospital Associations, County Coalitions, and various other organizations.

H. **Credentialing and Role of Licensed and Non-Licensed Independent Practitioners**

1. Credentialing of additional healthcare personnel may be necessary in the event of Surge Levels III & IV as defined within the Disaster Surge Plan.
2. This may also be necessary in the event of a public health emergency such as a pandemic event.
3. TFHS maintains policies for credentialing licensed medical practitioners and other staff approved by the Medical Board.
4. Any assignment of disaster privileges to licensed, volunteer, independent practitioners will be considered by the IC along with the Chief Operating Officer with referral to TFHS Human Resources and/or Medical Board for expedited review and approval.
5. *SOURCE:*
    a. *TFHS Disaster Surge Plans*
    b. *TFHS Policy on Credentialing*
    c. *Nevada County Healthcare Surge and Alternate Care Site Plan*

I. **Personnel Identification**

1. All employees reporting to work during an emergency must have a hospital issued ID badge clearly displayed per current policy.
2. Provisions have been made to issue temporary ID's to employees who report without their ID badges, volunteers and licensed independent practitioners.

J. **Advanced Preparation for EOP Implementation**

1. Components of this plan will be implemented in advance of an emergency so that staff can be supported when the disaster occurs.
2. The Administrator on Call and/or House Supervisor will assign various tasks as needed to ensure that staff is supported.
3. This includes but is not limited to:
    a. Securing extra food and water
    b. Securing extra supplies
    c. Opening of staff sleeping quarters
    d. Recalling support staff to assist with day care and/or other patient, visitor, staff support needs
4. *SOURCE:*
    a. *Disaster Surge Plan*

MANAGING UTILITIES DURING AN EMERGENCY:

A. TFHS realizes that different types of emergencies can have the same detrimental impact on its utility systems thus TFHS has determined how long it can expect to remain open to care for patients, provide support to staff, and plan for utilities accordingly.

B. Because emergencies may be regional in scope or of long duration, TFHS does not rely solely on single source providers in the community and has identified other suppliers outside of the local community in the event that the local infrastructure is severely compromised and unable to provide support.

C. Managing electrical power, potable and non-potable water, fuel for building and transportation assets, and other essential utilities is addressed in departmental and engineering plans.

1. The hospital does maintain its own generators and key locations are connected to alternate power sources.

2. These are identified by red electrical plugs.
3. Alternate sources of essential utilities (electricity, water, ventilation, fuel, and medical gas and vacuum systems) to support TFHS have been identified and the list of contractor's is maintained by several entities including Facilities Management, Logistics Chief, Purchasing, Dietary/Nutritional Services, Pharmacy and the Emergency Manager with emergency contact numbers.
4. In the event of an emergency, appropriate and assigned staff will be directed to contact outside vendors to support the mission of TFHS.

D. **Advanced Preparation to Provide Utilities during an Emergency**

1. Components of this plan will be implemented in advance of an emergency.
2. The Incident Commander will assign various tasks as needed to ensure that the hospital can be supported with alternate essential utility services before the disaster actually occurs.
3. This includes but is not limited to:
    a. Required testing of generators
    b. Dispatching of alternate supplies such as potable water
    c. Working with local, state and federal partners who can assist with providing these services
4. *SOURCE:*
    a. *TFHS Disaster Surge Plan*
    b. *TFHS Facilities Management Emergency Plans*
    c. *TFHS Safety Plans*
    d. *Nevada County Healthcare Surge and Alternate Care Site Plan*

PATIENT MANAGEMENT DURING EMERGENCIES:

A. Ultimately, any emergency or disaster situation will require significant patient management skills and activities.

B. Upon notification of an impending change in operating procedures, necessitating HICS activation, all necessary steps to accommodate and manage patients will be taken.

C. Particularly in the event of Code Triage Internal and Triage External activation, the following will be triggered, resulting in:

1. Cessation of Out Patient Procedures – dependent upon disaster/emergency;
2. Examination of all inpatients and determination of whether they can be rapidly discharged, sent to alternate areas for therapies/procedures, etc. in support of discharge;
3. Identification of all available existing bed space and surge space to include inpatient rooms, operative and diagnostic areas and Emergency Department (ED) capacity;
4. Decision as to whether or not to implement additional components of Disaster Surge Plan.

D. Each of these steps will be performed by multiple personnel, ultimately reporting back to the Command Center.

1. All of the above steps are done based upon the level and severity of the condition.
2. Each emergency or disaster is different.
3. Consequently, not all of the patient management procedures may be implemented or evaluated.

E. TFHS understands the management of patients and related activities does not end in the event of an emergency/ disaster.

F. Accordingly, changes to typical procedures are to be expected in the event of operational tempos that do not resemble normal operations, typically during emergency situations.

G. In the event of a Code Triage Internal, Code Triage External or related TFHS codes that disrupts normal operations, the following procedures will be observed with respect to each of the referenced areas below:

H. **Scheduling**

1. All ambulatory/outpatient scheduling will either be halted or evaluated in terms of logistical needs and the patient condition.
2. All ambulatory/outpatient procedures, particularly in the event of a Code Triage External will be cancelled and re-evaluated after the first operational period.

I. **Triage**

1. Triage of incoming or disaster related patients will be done primarily from the ER utilizing accepted START protocols and identifying patients as the following:
   a. Red – Emergent/Critical,
   b. Yellow – Urgent,
   c. Green – Walking Wounded, or
   d. Black – Dead/Expectant.

J. **Assessment & Treatment**

1. All assessment and treatment options will be based upon triage classification as well as personnel and supply availability, understanding that surge areas will be established according to procedures.

K. **Admission**

1. All admissions will be based upon initial and secondary treatment and need for admission based upon mechanism of injury or illness.
2. Furthermore, at the inception of the emergency condition, particularly a Code Triage External, rapid discharge assessments will be performed by each floor and communicated with the EOC as well as the Chief Medical and Nursing Officers.
3. This is done to ensure a maximum number of beds and staff is available to accommodate the influx of disaster patients.

L. **Transfers**

1. Any transfers will be done according to normal means and/or due to lack of specialty or ability.

M. **Discharges**

1. Discharges will be accomplished through either rapid discharge assessment or normal means once a patient is able to be discharged from inpatient or observation status.

N. **Hygiene**

1. TFHS will make every effort to continue to provide all normal hygiene and sanitation needs as well as procedures for staff, patients and visitors dependent upon the operational condition of the facility at the time.
2. Backup procedures are established to ensure continuity in terms of hygienic practice.

O. **Mental Health**

1. It is understood and expected that patients and/or family members may not fully understand or have difficulty dealing with the impact of an emergency or disaster situation.
2. Accordingly, mental health needs of patients and/or families will be addressed on an as needed basis as identified by staff and reported through the chain of command.
3. The EOC will advise the Logistics Chief to notify the Support Branch Director and affiliated staff of this need and to provide assistance/resources dependent on needs and operational status.

4. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*

P. **Mortuary Services**

1. TFHS understands that there may be an excess number of deceased patients that cannot be accommodated at TFHS facilities.
2. Consequently, the Nevada County Mass Fatality Plans as well as the Washoe County Mass Fatality Management Plan; provides the needed guidance, information and/or personnel to assist with all facets of a disaster creating mass fatalities at TFHS facilities.
3. These plans will be implemented by the Incident Commander who requests these services from the appropriate agency depending on the nature, size and scope of the disaster.
4. *SOURCE:*
    a. *Disaster Surge Plan*
    b. *Nevada County Mass Fatality Plan*
    c. *Washoe County Mass Fatality Management Plan*

Q. **Advanced Preparation to Manage Patients**

1. The Incident Commander, at his/her discretion, may implement parts of the Emergency Operations Plan prior to a disaster so as to better manage patient care when the actual emergency occurs.
    a. This includes but is not limited to:
        i. Evacuation
        ii. Activation of Surge / Alternate Care Sites
        iii. Transportation
        iv. Ordering supplies or medication
    b. It is important to note that each disaster condition is different and requires constant monitoring and evaluation by the Command and other staff.
    c. Should advance preparation be needed particularly with respect to a large influx in patients, mechanisms are in place and have been previously mentioned to determine current census as well as patients available for discharge, implement rapid/emergency discharge procedures and prepare clinical areas including the designated Surge areas for patient reception, to include all areas listed with the Disaster Surge Plan.
    d. *SOURCE:*
        i. *TFHS Codes & Emergency/Security Plans*

R. **Privileges of Volunteer Licensed Independent Practitioners**

1. The hospital may grant privileges to volunteer licensed practitioners when the EOP has been activated in response to a disaster and when the hospital is unable to meet the immediate patient needs.
2. The purview for granting these privileges and management of volunteer licensed independent practitioners is under the Incident Commander, Human Resources and the Chief of Staff/Medical Board.
3. *SOURCE:*
    a. *TFHS Credentialing Procedures*

S. **Management and Granting of Privileges of Non-Licensed Volunteer Practitioners**

1. The management and granting of privileges of non-licensed volunteers is also within the purview of the Incident Commander and the Chief Operator Officer.

2. However, as the volunteers are unlicensed, the TFHS may follow accepted California and/or Nevada Health Department guidance in this regard.

BUSINESS CONTINUITY:

A. Introduction

1. TFHS recognizes the importance of the continuity of performing essential services across a wide range of emergencies and incidents, and to enable our organization to continue functions on which our customers and community depend. Business Continuity activities are activated after emergency conditions are stabilized as directed by the Incident Commander using the Hospital Incident Command System (HICS). The Business Continuity Branch Director reports to the Operations Section Chief and is responsible for coordinating continuity activities, including:

   a. Facilitate the acquisition of and access to essential recovery resources, including business records (e.g., patient medical records, personnel records, purchasing contracts)

   b. Support the Infrastructure and Security Branches with needed movement or relocation to alternate business operation sites.

   c. Coordinate with the impacted area to restore business functions and review technology requirements.

   d. Assist other branches and impacted areas with restoring and resuming normal operations.

B. Orders of Succession and Delegation of Authority

1. Continuity of leadership and delegation of authority during an emergency situation is critical to ensure continuity of essential functions. TFHS has established and maintains leadership roles and administrative oversight for key positions in the absence of responsible administrators as outlined in TFHS Policy: Adminitrative Delegation of Authority, AGOV-14.

C. Continuity of Essential Services

1. Restoration of essential services such as equipment or service failure will be addressed immediately. Annex – Essential Equipment or Service Failure addresses all the foreseen failures and procedures to rapid restoration.

D. Staffing

1. Each Department Director will work with the HCC to minimize the impact to departmental operations by maintaining, resuming and recovering critical functions to normal service levels. Evaluation of immediate and ongoing staffing levels will be performed based on existing and predicted levels of staff availability. Each department has an emergency Disaster Resource List that is updated on a semi-annual basis so appropriate staff can be contacted and scheduled as needed.

E. Continuity of Communications

1. Comprehensive downtime procedures covering clinical information systems as well as facilities, infrastructure and hardware, software, data, personnel and processes are in place and are covered in Annex 14 of this EOP as well as the following TFHS Policy: AIT-128 Downtime Procedures for HIS.

F. Vital Records Management

1. Each clinical department has written policies regarding procedures to obtain vital records in the event of an emergency. The departmental procedures should be followed.

G. Financial Sustainability

1. Financial sustainability is an integral part of ensuring business continuity. Examples of direct financial impact that result from responding to an incident may include:

   a. Lost revenue from canceled scheduled procedures

   b. Lost revenue due to discharging patients early

c. Costs due to staff time required for planning for an impending incident
d. Costs due to overtime or additional staff
e. Costs due to the purchase of additional supplies
f. Costs due to the need to purchase from non-usual vendors
g. Costs due to the support of on-duty (and possibly off-duty) staff such as meals, shelter
h. Costs due to damage and/or loss of equipment
i. Costs due to disruption of services

2. All costs should be documented for possible submittal to insurance, County, State or Federal for reimbursement purposes.

H. Psychological Needs of Staff and Patients

1. Depending on the disaster situation, the mental health of patients and staff need to be monitored for and responded to. Case Management and Care Coordination staff should be on standby to help should it be deemed necessary.

I. After-Action Report

1. After the conclusion of an event TFHS will conduct debriefings with staff and, depending on the incident, with other emergency agencies who were also involved in the incident. An after-action report will be produced which will include noted measures necessary to improve response to and recovery in future emergency situations.

EVALUATION OF EFFECTIVENESS AND TESTING OF THE EMERGENCY OPERATIONS PLAN:

A. TFHS recognizes the importance of periodic evaluation and testing of its Emergency Operations Plan to assess the plan's appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols.

1. This allows TFHS to assess all of the aforementioned.
2. Exercises are also designed to stress the limits of our facilities with the goal to assess the organization's preparedness capabilities and performance when systems are stressed during an actual emergency.
3. Exercises are developed using plausible scenarios that are realistic and relevant to TFHS based on the organization's HVA and intended to validate the effectiveness of the plan and identify opportunities for improvement.
4. These exercises also test our plan, identify deficiencies, and take corrective actions to continuously improve the effectiveness the plan.
5. All exercise are developed using the Homeland Security Exercise Evaluation Program (HSEEP) as well as any local, state or federal requirements.
6. TFHS conducts an annual review of our risks, hazards and potential emergencies and reviews the scope of the Emergency Operations Plan. The plan is tested at least once a year, either in response to an actual emergency or in a planned exercise, potentially including an influx of actual or simulated patients.
7. TFHS also endeavors to exercise and learn how effectively TFHS performs when it cannot be supported by the local community.
8. In addition, TFHS participates in community-wide exercises.
9. Planned exercise scenarios attempt to be realistic and relevant to the priority of the emergencies identified within our HVAs.
10. During the planned exercises, an individual whose sole responsibility is to monitor performance and who is

knowledgeable in the goals and expectations of the exercise, will document opportunities for improvement.

11. Using the HVA as a guide for the exercise, at a minimum the following critical areas will be monitored:
    a. Communication, including the effectiveness of communication both within the facility as well as with response entities external to TFHS such as local government leaders, police, fire, public health, and other health care organizations within the community;
    b. Resource mobilization and allocation, including responders, equipment, supplies, PPE, and transportation;
    c. Safety and security;
    d. Staff roles and responsibilities;
    e. Utility systems;
    f. Patient clinical and support care activities.
12. All exercises are critiqued to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.
    a. The critique process will be performed by the Emergency Management Committee – a multi-disciplinary group that includes administration, clinical (including physicians), and support staff.
    b. As a result of the critiques of these exercises, TFHS will modify its EOP as needed.
    c. Planned exercises will also evaluate the effectiveness of improvements that were made in response to critiques of the previous exercises.
    d. When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvement will be put into place until final resolution.
    e. The strengths and weaknesses identified during exercises are communicated to the Environment of Care Committee responsible for monitoring environment of care issues.
    f. All weaknesses are tracked using a corrective action plan to ensure they are addressed.
13. *SOURCE:*
    a. *TFHS After Action Reports*

CYBERSECURITY – INFORMATION TECHNOLOGY:

A. TFHS recognizes the critical importance of information technology in all facets of campus, academic, clinical, and research areas.
    1. a. Moreover, life safety myriad of other components on campus are run completely online.
       b. Increasingly, attacks on critical technological infrastructure are being observed and recorded.
       c. Furthermore, any number of hazards can impact the ability to function electronically.
    2. TFHS Information Technology (IT) has a robust disaster recovery plan in place as well as infrastructure support and redundancy in place.
       a. In the event of a Cyber security or other Information Technology related incident; the IT Disaster Recovery Plan will take precedence unless there is a disaster that has a greater impact on more than just the information technology infrastructure.
          i. In that event, the IT Disaster Recovery Plan will work hand in hand with the tactical portions of the EOP.
          ii. A Unified Command will be established with both elements represented with the Emergency Operations Center.

FUNCTIONAL ANNEXES:

A. This EOP does not stand alone; rather several functional annexes support the emergency operations of the TFHS and its staff.

1. These annexes are listed in the following pages as well as specific Code polices thatdescribe with some specificity, how TFHS, its staff and partners are to respond to a particular incident and/or event.
2. It should be noted, the following Annexes do not replace the actual Policy and Procedure documents governing each Code and or Activation Procedure.
3. Rather they synthesize the pertinent information to allow for rapid visualization and dissemination to staff not familiar with the procedures and responding to an incident and/or event.
4. These Annexes exist concomitantly with the Policies referenced.

B. The following are the Annexes with an introductory Commonalities and Convention usage document:

C. **TFHS Functional Annexes**

1. Annex 1 – Commonalities and Convention
2. Annex 2 – Activation and Setup
3. Annex 3 – Command Center Set Up
4. Annex 4 – Telephone Instructions for HCC
5. Annex 5 – TFHS Codes & Emergency/Security Plans
6. Annex 6 – Essential Equipment or Service Failure
7. Annex 7 – Communication Failure Plan

ANNEX 1 – COMMONALITIES & CONVENTION

A. The following functional annexes are reference points taken from the actual Policy, Procedure and/or Plan they reference and are synthesized for rapid assimilation and dissemination by staff needing immediate instruction and deployment of the information contained therein.

1. These do not in any way replace existing Policies, Procedures and Plans.
2. Rather, they augment them using a format that lends itself to easy use and interpretation.
3. It is important to note, that should there be any confusion on the part of a TFHS staff member, the referenced Policy, Plan and/or Procedure should be accessed and reviewed.

B. As with all of the functional annexes, there is commonality in terms of activation procedures and set up, as illustrated in Annexes 2 – 4.

C. However, there is also specific TFHS convention (procedures) that are used each and every time, independent of the Code.

1. This is illustrated below.

D. All Codes with the exception of Code Yellow (Bomb Threat) and Code Orange (Internal Hazardous Spill/Material) are activated in the same manner.

1. **Activation:**
   a. Call 222 and request that the particular Code be paged.
   b. Give the department and exact location to the operator as well as any other pertinent information.
   c. For situations that require the assistance of outside agencies including law enforcement, fire, and EMS, the affected department should either call 9-911directly or have the hospital operator do so.
   d. Exception is Code YELLOW – the AOD or House Supervisor will contact law enforcement.

2. **Incident Command:**
    a. Either the AOD or the House Supervisor will assume Command and initiate HCC activities as well as the Incident Management Team.
    b. Engineering should also be activated in the event of Mass Decontamination and/or Code Orange and asked to respond to the particular area or Emergency Department.

ANNEX 2 – Activation and Set-Up of the Command Center

What do you do?	How do you do it?	What happens?
Activate the Disaster Protocol	• After assuming the role of Incident Commander (IC), determine the level of activation needed – Alert, Partial or Full. (See " **Disaster Activation Levels** " sheet) • Call 222 to initiate announcement: CODE TRIAGE INTERNAL (or EXTERNAL) and add the word: "ALERT", "PARTIAL" or "FULL" to indicate the level of activation. *IVCH activation is the same 24/7.* *TFH After hours activation:* • Determine which business hour Department Heads should be notified. • Instruct ECC to call those individuals. • Have those department heads activate their department DRL's as indicated.	• 'Alert' Activation – ◦ Departments will have a heightened state of awareness but will maintain normal operations until instructed to do otherwise. • 'Partial' Activation – ◦ All departments on the Truckee campus will activate their Disaster Resource List's (DRL's), document availability of staff and fax to Human Resources. • 'Full' Activation – ◦ All departments on the Truckee campus will activate their DRL's and fax to the Labor Pool. ◦ Designated staff will report to the Labor Pool. *TFH After hours activation* : • 'Alert' Activation – ◦ Open departments will notify their director. • 'Partial' Activation – ◦ ECC will notify the business hour department heads ***as directed* by the IC** . ◦ Business hour department heads will not activate their DRL's unless directed to do so by the IC. • 'Full' Activation– ◦ ECC will notify all business hour department heads and instruct them to activate their department DRL's,
Activate and Set Up the Hospital Command Center* (HCC)	• Immediately choose a room for the HCC, i.e. TFH Eskridge Conference Room or IVCH Conference Room. • Have Patient Registration announce: ***"The Command Center will be located***	• Directors report to the command center for an incident briefing. • Info boards, large post-its and easels are available for recording information by the scribe.

What do you do?	How do you do it?	What happens?
*(For large incidents, consider assigning a room manager)	***in the _____ Room. All Directors report for an incident briefing at ____ o'clock."*** • TFH: Move the *HICS Security Cart* and the *Rolling Communication Cart* (located in the TFH Lobby Disaster Closet near the restrooms) to the HCC. • *IVCH: Bring Emergency Binders to HCC.* • Set up the HCC (see ' **Command Center Set Up** ' sheet) including phone distribution if necessary.	• Phones are distributed, if necessary, to the Incident Management Team and the ' *Hospital Command Center Telephone Directory'* is given to the operator.

ANNEX 3 – COMMAND CENTER SETUP

TFH Primary Command Center : is to be located in Eskridge (Lobby) Conference Room
TFH Secondary Command Center : will be determined. Options include:

Internally: Labor & Delivery Conference Room
Externally: Human Resource Conference Room

IVCH Primary Command Center : is to be located in the first floor Conference Room
IVCH Secondary Command Center : at the ED Nurse Station if incident is small in nature

Keys:

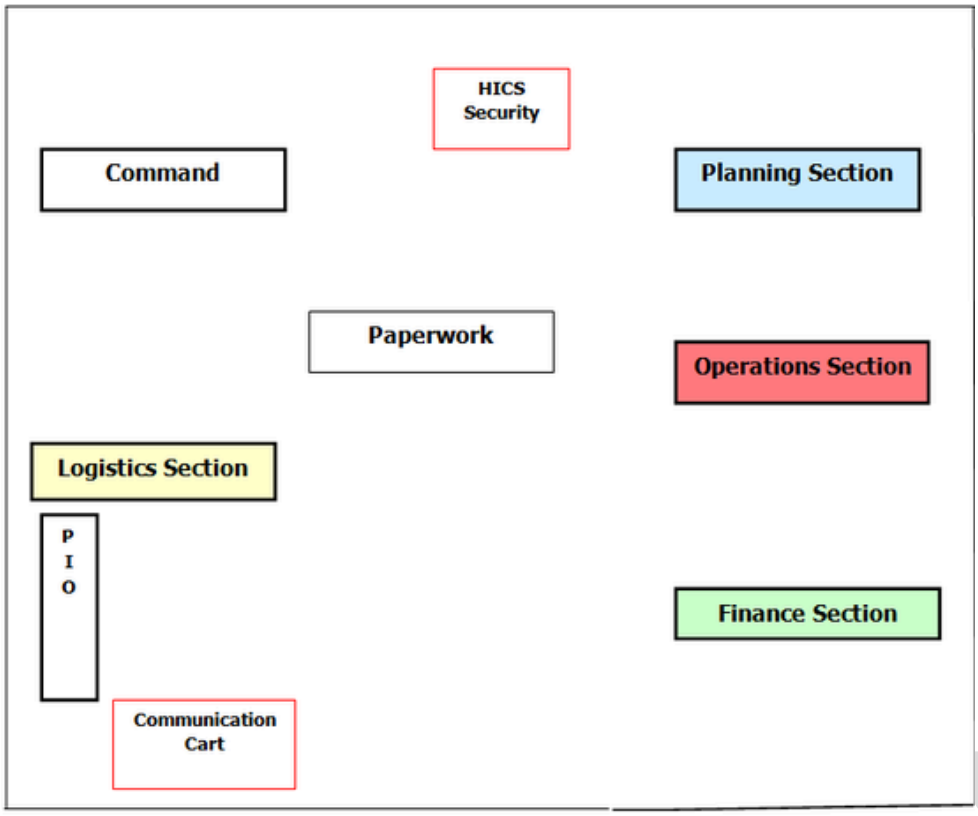
The House Supervisor and Facilities Management staff have a key for the TFH Emergency Preparedness Supplies Closet.

Equipment/Supplies:

TFH: The HICS Security Cart is located in the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms - Plans, HICS forms, Job Action Sheets, laptops, maps etc. are located here.
The Rolling Communication Carts are located in the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms - Phones, radios, and satellite phones are locked and charged here.

IVCH: The HICS binders are located in a storage cabinet within the Emergency Department.

TFH Room Set-Up (unnecessary at IVCH):



ANNEX 4 – TELEPHONE INSTRUCTIONS FOR HCC

TFH Telephones & Electronic Equipment –

1. One wall mount and three portable telephones are immediately available in the Rolling Communication Cart.
    a. These dedicated phones have pre-assigned numbers for the Hospital Command Center (***HCC),*** *Incident Commander* ***(IC),*** *Public Information Officer* ***(PIO),*** *and Operations* ***(OPS).***
2. When additional phones are needed for the other Command and General Staff, portable phones can be requisitioned from the Childcare Center, OB, or Med/Surg.
3. ***The telephone profile needs to be changed to match your assigned position by following these instructions.***
    a. On a Cisco Portable phone, push the left arrow next to the center gray button to display *Extension Mobility Services.* Push 'select'.
    b. Enter the User ID and PIN for the specific position (listed below) then push the center round button to enter.
4. Fill in the Telephone Directory and distribute to the hospital operator and to those in the command center.
5. Command Center Resources
    a. Cisco Command Center wireless / wired Phone – 582-6213
    b. Cisco Labor Pool wireless / wired Phone – 582-6553
    c. Cisco Wireless phones (hold red phone button to turn on)
        i. IC – 582-6248
        ii. PIO – 582-6249
        iii. OCS –582-6252
        iv. Liaison – 582-6250

v. Med Brach Specialist – 582-6253

vi. Labor Pool#1 – 582-6562

vii. Labor Pool #2 – 582-6563

d. 14 Radios

e. 3 Laptops

i. User Name: EMCWL

f. 1 Portable printer

g. 1 MFP

h. 1 Monitor/TV

i. 1 Portable Projector

j. Power Strips

IVCH Telephones & Electronic Equipment

1. IVCH to use the Cisco phones located within the HCC.
2. Electronic equipment: existing computers, printers, etc within the Administration office and/or the Emergency Department will be utilized if needed.

ANNEX 5 – TFHS Codes & Emergency/Security Plans

Policy Reference for TFHS Codes

- Code Gray, AEOC-1 - Combative or Aggressive Individual
- Code Triage Internal or External, AEOC-2 - Response to an Emergency Event
- Code Silver, AEOC-3 - Person with Weapon/Hostage Situation
- Code Pink/Purple, AEOC-4 - Infant/Child Abduction
- Code Orange, AEOC-5 - Hazardous Materials
- Code Yellow, AEOC-6 - Bomb Threat
- Code Red - AEOC-11 - Fire Response Plan

Policy Reference for Emergency/Security Plans

- Disaster Surge Capacity Plan, AEOC-8
- Evacuation/Shelter in Place Plan, AEOC-10
- Mass Casualty Decontamination, AEOC-12
- Weapons of Mass Destruction Procedures, AEOC-7
- ChemPack Deployment, AEOC-18
- Building Security & Access Control, AEOC-76
- Facility Lockdown, AEOC-77

ANNEX 6 – ESSENTIAL EQUIPMENT OR SERVICE FAILURE

A. In the event of essential equipment or service failure, the Facilities Management Department will take action to restore the system as soon as possible.

B. **ELECTRICAL POWER FAILURE**

1. In case of normal electrical power failure, emergency generators will provide power, in less than ten seconds, to:

a. Tahoe Forest Hospital including the Cancer Center and Warehouse.

b. Incline Village Community Hospital

2. The following buildings may or may not have their own generator as follows:
    a. Medical Office Building has an emergency generator with an automatic transfer switch which is managed by CAMCO.
    b. The Pioneer Center has an emergency generator with an automaticl transfer switch.
    c. All other outlying buildings do not have emergency generators.
3. The Engineer on duty will:
    a. Check for generator operation during a power outage.
    b. Check for transfer switch operation.
        i. If there is no transfer and power is still off, manually transfer the switches.
    c. For emergency problems with the generator see Emergency Phone Numbers "Generator".
    d. Walk through the hospital to check equipment operation in the order of importance (i.e., life and safety first, air conditioning equipment last).
    e. Call TDPUD for TFH, NV Energy for IVCH (See Emergency phone list) and try to find out if the problem is in their equipment or internal malfunctioning.
        i. If it is theirs, try to get an estimated time of repair.
        ii. If it is ours, determine if outside help is needed.
        iii. If outside help or rental generator is needed see "Emergency Phone Numbers" under Generator.
    f. Determine whether extra fuel will be needed for extended generator operation.
        i. If additional fuel is required see Emergency Phone Numbers under "Fuel".

C. **OXYGEN SUPPLY FAILURE**

1. **I** n the event of a failure in the system that supplies oxygen to the hospital, prompt action will be taken by the Facilities Management Department to restore the system to operating condition as soon as possible.
2. Notify Respiratory Therapy and Nursing departments about the failure, determine their needs and, if appropriate, advise them to utilize portable oxygen tanks until repairs are made.
3. Assess the problem: Determine estimated repair time, and notify departments affected.
4. Initiate repairs utilizing maintenance personnel and outside agencies as needed.
    a. TFH: Emergency bulk oxygen connection is located at east wall near Med Gas Building.
    b. IVCH: Backup H-cylinders and regulators are located in the outside Med Gas Storage Room.
5. Call medical gas supplier (See Emergency Phone List) for additional oxygen tanks that may be needed.
    a. Full oxygen tanks can be used from the reserve supply if failure is in the switching units.
    b. A vendor may be able to supply portable tanks until liquid oxygen delivery.

D. **NATURAL GAS FAILURE**

1. In the event of a disruption of the natural gas supply, the Facilities Management Department will take all necessary actions to assure a quick resumption of fuel service.
    a. Call gas company (See Emergency Phone List).
        i. Try to find out if the problem is in their lines or in our equipment.
        ii. Try to get an estimate of repair time, and keep in close contact with them.
    b. Advise affected departments of the problem and how long repairs will take.
        i. All departments would be affected by the lose of domestic hot water.

ii. Equipment affected: hot water is needed for the sterilizers in Sterile Processing. Natural gas is needed for ovens and stoves in Dietary.

iii. A backup propane tank would be utilized to keep the heating system functional.

c. Initiate repairs, if needed, utilizing Facilities Management personnel and outside agencies, if required.

i. If necessary, call for fuel service (See Emergency Phone List) for service, assistance, and parts.

d. Contact Environmental Services Department to provide additional blankets to patient rooms if necessary.

e. Dietary Department should utilize paper plates, plastic silverware, cold foods, etc.

E. **FIRE SPRINKLER WATER LOSS**

1. In the event of loss of water to fire protection system, ultimate measures must be taken to prevent possible loss of life and/or property until repairs are made.
   a. Notification and cooperation with the Fire Department is essential.
2. Contact TDPUD for TFH, IVGID for IVCH, if it seems to be an external problem.
   a. Try to get an estimate of the time needed for repairs.
3. If it is an internal problem, assess the situation to determine actual repair time and advise CEO of your findings.
4. Contact the Truckee Fire Dept/North Lake Tahoe Fire Protection District for possible standby fire protection until repairs can be made.
5. If it is an internal problem, initiate repairs utilizing Facilities Management staff or outside contractors as needed. See Emergency Phone Listing "Fire Sprinkler".
6. Notify Fire Department and Administration when repairs are completed.
7. A fire watch must be conducted should the sprinkler system be out of service for more than 10 hours in a 24 hour period.

F. **FAILURE OF NURSE CALL SYSTEM**

1. In the event of a failure of the nurse call system, action will be taken by the Facilities Management Department or the IT Department to repair the system as soon as possible.
2. Assess the problem and determine actual estimated repair time and advise Administration and affected departments of the situation.
3. Initiate the repairs with the vendor as soon as possible.
4. Departments involved will keep up vigilance in the affected areas to ensure patient needs are met.
   a. TFH MedSurg: use the JTECH Paging System.
   b. All other areas: utilize bells, gongs, or similar devices of notification.
5. If no Facilities Management or IT personnel are available refer to Emergency Phone Listing "Nurse Call System".

G. **FAILURE OF MEDICAL AIR SYSTEM**

1. In the event of failure of the medical air system, swift action will be taken by Facilities Management to ensure that an adequate supply of medical air is reestablished as soon as possible.
2. At TFH, two oil-free compressors are located in the Mechanical Room area along with a storage tank and associated controls.
3. A failure in this system would interrupt the supply of medical air to the various locations that use it in delivery of patient care.

4. Assess the problem and determine repair time.
5. Advise Administration and any affected department of the situation.
6. Initiate repairs using Facilities Management personnel and outside contractors as required.
    a. If necessary call emergency repair vendor (see emergency phone list) for assistance in repair or for rental replacement unit.
    b. If line repair is necessary, secure the particular zone, purge the zone with nitrogen, and certify the system prior to restarting the equipment.
7. Notify Respiratory Therapist to obtain portable medical air compressor units which can be used until repairs are made.

H. **FAILURE OF MEDICAL VACUUM SYSTEM**

1. In the event of the failure of the medical vacuum system, swift action will be taken to restore the system to operating condition as soon as possible.
2. At TFH, the central system, consisting of two vacuum pumps, is located in the Boiler Room #8 with corresponding storage tank and associated controls.
3. A failure in this system would interrupt the supply of vacuum to patient areas and negatively impact routine patient care.
4. Facilities Management will assess the problem, determine actual estimated repair time, and advise affected departments.
5. Facilities Management will initiate repairs and will use outside agencies as, and if, needed.
6. Portable suction machines will be used until repairs can be made.
    a. Additional portable rental units, if necessary, will be obtained through Materials Management Department.
    b. The Facilities Management Department may obtain rental or replacement equipment or repair assistance from emergency vendor.

I. **CONTROL AIR COMPRESSOR FAILURE**

1. In the event of control air compressor failure, the Facilities Management Department shall take all necessary action to re-establish this service as soon as possible.
2. At TFH, compressed air for the control of heating and cooling of the building is supplied by one compressor located in the '78 Boiler Room, Room #8. At IVCH, the compressor is located in the Boiler Room exterior first floor door on the east side of the building.
3. In the event of a failure, the entire hospital would be without air conditioning until repairs could be made.
    a. Quick action should be made to minimize discomfort to patients and staff.
4. Assess problem and determine actual estimated time needed for repairs and advise hospital of the problem.
5. Establish bypass from medical air compressor or utilize portable compressors used in maintenance work, or portable air cylinder with proper regulator.
6. Initiate repairs utilizing Facilities Management personnel and/or outside service, if required.

J. **EMERGENCY WATER SUPPLY**

1. Emergency water should be available at all times.
    a. Potable water is stored and secured on the hospital site.
2. In case of normal water supply interruption, the Facilities Management Department will take all necessary steps to obtain and provide emergency water as needed.

3. Upon water interruption, the engineer on duty will contact affected departments.
    a. This will alert nursing and dietary personnel of the need to conserve water.
    b. Dietary will manage drinking water and ice distribution.
4. If problem is internal due to main line failure:
    a. Call TDPUD for TFH, IVGID for IVCH, to advise normal water supply interruption since they may be able to provide portable water.
    b. Emergency water connection is located in the Facilities Management 65 Shop.
5. In case of major disaster, with water supply failure:
    a. Secure all household bleach.
    b. Notify infection control practitioner of the problem.
    c. Obtain plastic liners to place in toilets for collection of urine, stool and other wastes. Instruct staff and patients not to flush toilets.
        i. Place large plastic containers with lids (garbage size) in dirty utilities areas.
6. In an emergency, chlorine bleach is to be used as an emergency water purifier.
    a. In the absence of testing, two drops of bleach, 5.25 sodium hypochlorite solution should be mixed with each quart of water.
    b. Four drops of the bleach should be added if the water is cloudy or cold below 40 degrees.
    c. Let stand for 30 minutes.
7. Upon restoration of normal water supply, Environmental Health will assist the hospital in taking water samples for analysis for potability to an outside agency e.g. TTSA, Cranmer or Sierra Environmental Monitoring.
    a. As this analysis can take up to 24 hours, continue using alternative sources of potable water and/or purifying water before use.
8. Dietary should keep enough paper products to serve patient/personnel meals to supply a 72 hour period.

K. **ELEVATOR FAILURE**

1. It shall be a policy of Tahoe Forest Hospital District to take all necessary action to evacuate passengers from disabled or malfunctioning elevator in a safe and timely manner.
    a. The Facilities Management Department shall be notified immediately whenever an elevator emergency bell is sounded. Engineer on duty will:
        i. Proceed to the elevator affected and establish communication with the passengers. Reassure trapped passengers that help is forthcoming.
        ii. The Engineer on duty shall use Elevator Emergency Evacuation Procedures.
        iii. Contact the elevator company and advise them of the situation requesting emergency service.

L. **MAJOR SEWER LINE FAILURE**

1. In case of main or branch sewerage line failure, action shall be taken to restore sewage disposal capabilities as soon as possible.
2. If a sewer problem occurs, the Facilities Management Department should be called, and a response time determined immediately.
3. Facilities Management will assess the situation.
    a. If Facilities Management is unavailable refer to Emergency Phone Listing "Plumbing".

b. If portable toilets are needed contact Materials Management to procure.

4. Advise House Supervisor and Dietary to institute water conservation policy, i.e., paper plates and plastic utensils, etc.

M. **FAILURE OF FIRE ALARM SYSTEM**

1. A fire watch must be conducted should the fire alarm system in whole or in part, be out of service for more than 4 hours in a 24 hour period.
   a. Personnel will be designated to perform a continuous fire inspection of all affected areas of the hospital.
   b. Personnel will contact the local fire department as well as, for TFH, the California Department of Public Health (CDPH) at the beginning and end of the fire watch.
   c. This inspection will need to be logged and documentation then kept in the Facilities Management office.
   d. The continuous fire inspection is a visual inspection of all affected areas of the hospital including unoccupied areas to ensure that a fire has not gone undetected.

ANNEX 7 – COMMUNICATION FAILURE PLAN

A. When communication by telephone is not possible, or when augmented communication is necessary, computer, radio, and other means are needed in order to exchange information.

B. This section describes the different means of communication available at Tahoe Forest Hospital and Incline Village Community Hospital.

C. Immediate Procedure for a Telephone System Failure:

Priority	Check when Complete	TFH TASKS	IVCH TASKS
1.	?	The employee who discovers the phone failure will notify the AOD or after hours call 530-582-6362. (Use a red phone or a personal cell phone.)	The employee who discovers the phone failure will notify an IVCH or TFH administrator. After hours call 530-582-6362. (Use a red hot phone or a personal cell phone.)
2.	?	For a complete phone system failure, the supervisor or administrator will notify Patient Registration to page "Telephone System Failure" three times. (Use the hand held PA in ED Admitting during a power outage.)	Notify each department via runner or overhead page there is a telephone system failure. Distribute emergency radios.
3.	?	The supervisor or administrator will notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)	Notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)
4.	?	Incoming calls made to 530-587-6011 will automatically redirect to the top four red phones: ED Admitting, ED, M/S, and ICU. The supervisor will ensure these phones are manned to receive incoming calls.	Contact Washoe County Sheriff's Office Dispatch at 775-831-0555 (using a red phone or a personal cell phone) and request that they notify North Lake Tahoe Fire and the Incline Sheriff's office that the phones are out of service. Provide them with the red hot phone number.

Priority	Check when Complete	TFH TASKS	IVCH TASKS
5.	?	For a complete phone failure, if the phone system is not restored within a reasonable amount of time (30-60 minutes), consider activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.	If the phone system is not restored within one hour, consider activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.

D. **Red Phones:**

1. In the event that the phone system is unavailable or in a disaster scenario, the RED phones will provide a back-up strategy for the hospital's main number, 530-587-6011.
    a. The top four phones listed in the table below will need to be covered in the event of a phone system failure.
        i. The House Supervisor or AOD will assure the top four phones have an assigned person to answer calls.
    b. To keep lines 1-4 and line 15 open, outgoing calls should be made on phones 5-14.
    c. These phones function just like a single home line, and require a seven digit number be dialed to communicate with the other red hot phones.
        i. You do not dial 9 before the seven digit number.
        ii. You cannot transfer calls.
2. The location and extension of the internal phones are as follows:

	Department	Phone Type	Phone Number	HUNT group
1	**ER Patient Registration**	Wall	**530-550-9293**	Initial HUNT
2	**Emergency Dept. (radio area)**	wall	**530-550-7662**	Initial HUNT
3	**Med Surg**	desk	**530-550-9269**	Initial HUNT
4	**ICU**	wall	**530-550-9276**	Initial HUNT
5	**OB**	wall	**530-550-9257**	Full Disaster
6	**ECC**	desk	**530-550-9282**	Full Disaster
7	**Pharmacy**	desk	**530-550-9238**	Full Disaster
8	**Lab (Across from middle entrance)**	wall	**530-550-8410**	Full Disaster
9	**Radiology Office**	wall	**530-550-7852**	Full Disaster
10	**Ambulatory Surgery Desk**	desk	**530-550-8475**	Full Disaster
11	**OR Hallway**	wall	**530-550-8740**	Full Disaster
12	**OR Physician's Lounge Dictation Area**	desk	**530-550-8955**	Full Disaster
13	**Eskridge Conference Room**	wall	**530-550-7101**	
14	**IVCH ED**	desk	**775-832-3820**	Full Disaster
15	**IVCH ED Patient Registration**	desk	**775-831-0745**	Full Disaster
The red phones at the Eskridge Conference Room ED Patient Registration is NOT in the HUNT group. These red phones will only be used for outgoing calls.				

3. Answering Incoming Calls:
    a. If the call is not a wrong number, then the person answering the red phone should notify the House Supervisor who will follow the Immediate Procedure for a Phone System Failure.
    b. Ask if the call is emergent, and if so, instruct caller to hang up and dial 911.
        i. If call is of an urgent nature, take all pertinent information including caller's name, telephone number and purpose of call and forward information to the AOD or House Supervisor.

E. **Other TFH Communication Devices**

1. The communication cart is well marked and located the TFH Hospital Lobby Emergeny Preparedness Supplies Closet near the restrooms.
2. The House Supervisor or AOD maintains the key to unlock the closet. The contents of the Communication cart are as follows:
3. **2 Iridium 9505A Satellite Phones:**

Phone Numbers
a. Phone A: **8816-514-58482** b. Phone B: **8816-514-58483**

    a. **Text messages** can be sent and received on the satellite phone. The phone must be on to receive messages.
    b. For more detailed information, please see the User Guide located in the Communication Cart.
4. **14 Hand Held radios**
5. **External Ham Radio Operators**
    a. Tahoe Forest works with the following local ham radio operators:

Name	Phone Numbers
Rob Gilmore KI6TRK	530-587-1330 (Home) 408-888-5565 (Cell)
Barry Bettman K6ST	775-622-3801 (Reno Home) 650-465-0151 (Cell)

F. **Other IVCH Communication Devices**

1. Incline Village Community Hospital works with the following local ham radio operator:

Name	Phone Numbers
Doug Willinger KF7ZKS	714-720-3402 (Cell)

1. **EMResource:**
    1. The Hospital participates in a state-wide web based alert system called EMResource.
    2. See Policy AEOC-8 "Disaster Surge Capacity Plan" for further instructions.
2. **Written Messages**
    1. If cell/telephone or radio communications are unavailable or inadequate, HICS form 213, a messaging form, is available in triplicate with the HICS forms in the TFH Hospital Lobby Emergency Preparedness Closet near the restrooms.
3. **GETS Cards**
    1. Government Emergency Telecommunication Service is a Federal service that prioritizes calls over landline

networks.

2. This means that our calls receive calling queue priority over regular calls.
    a. This greatly increases the probability that our call will get through the network even with congestion.
    b. These cards have been issued individually to hospital administration as well as members of the Emergency Management Committee.

4. **Redundant Communication Systems**
    1. In addition to the above communications system Tahoe Forest Hospital has other redundant systems available:
        a. Internal – Overhead Paging system
        b. External – Med Channel 6 in the ED

5. **Incline Village Community Hospital**
    1. In Nevada, the 800 MHz radio is the regional and state-recommended communication device during emergencies.
    2. IVCH is equipped with one radio located in the ED lounge.
    3. IVCH is also equipped with a HamLink Communication System.

APPROVAL OF EOP

This version of the EOP was approved by the Emergency Management Committee on: June 25, 2019.

Submitted to the Environment of Care Committee on: July 11, 2019

Related Policies/Forms:

TFHS Codes & Emergency/Security Plans as outlined in Annex 5, Sources as documented in this policy

References:

National Incident Management System (NIMS), National Response Framework (NRF)

All revision dates: 07/2019, 07/2018, 07/2017, 05/2017, 03/2017, 05/2016, 02/2014, 01/2014

Attachments:

THFS Leadership Org Chart 06.05.19.pdf

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	07/2019
	Myra Tanner: Coordinator, EOC	07/2019

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*09/2013*
Last Approved:	*01/2019*
Last Revised:	*01/2019*
Next Review:	*01/2020*
Department:	*Environment of Care - AEOC*
Applies Towards:	*System*

Environment of Care Management Program, AEOC-908

PURPOSE:

Provide a safe and secure environment for patients, visitors, and staff.

POLICY:

The Tahoe Forest Health System is committed to minimizing risk to patients, visitors, and staff by managing the identified hazards or risks that may exist in the physical environment or are associated with providing services for patients and staff performing their daily functions.

PROCEDURE:

A. **GOALS**

1. Identify, assess and manage risks related to the environment of care to minimize the potential for harm.

B. **OBJECTIVES**

1. Safety
   a. Enhance education of employees via articles in Pacesetter.
   b. Conduct Environment of Care rounds in all departments.
2. Security
   a. Manage access control on exterior doors and security sensitive interior doors.
   b. Comply with the Workplace Violence Prevention Plan requirements which includes the following:
      i. Incident reporting
      ii. Annual security assessments
      iii. Staff training per requirements
3. Hazardous Materials and Wastes
   a. Complete annual hazardous materials inventories.
   b. Ensure the storage and disposal of hazardous materials comply with regulatory requirements.
4. Fire Life Safety

a. Conduct Alternate Life Safety Measures (ALSM) assessments and implement daily checklists as needed.
b. Conduct hands-on fire extinguisher training.
c. Conduct fire drills per the frequency required for hospital and business occupancies.

5. Medical Equipment
   a. Ensure biomed inventory is updated when changes occur.
   b. Perform required preventative maintenance and safety checks.
6. Utility Systems
   a. Conduct utility shutdown and recovery training with appropriate staff.
   b. Conduct underground storage tank training with appropriate staff.
   c. Perform required preventative maintenance on all systems.
7. Emergency and Disaster Preparedness
   a. Conduct disaster drills twice per year, one of which involves the community.
   b. Evaluate and coordinate training of staff on an as-needed basis.

C. **SCOPE OF THE PLAN**

1. This plan is district wide in scope and applies to all locations of the hospital district, including:
   a. Truckee hospital facility, including Extended Care
   b. Cancer Center
   c. Multi-specialty Clinic Offices
   d. Center for Health and Sports Performance
   e. Hospice
   f. Home Health
   g. Children's Center
   h. Administration Offices: Administration Services and Pioneer Center
   i. Warehouse
   j. Foundation Offices
   k. Incline Village Community Hospital
   l. Incline Village Physical Therapy and Medical Fitness
   m. Tahoe City Physical Therapy
2. This plan applies to all areas of the physical environment, including:
   a. Building Safety
   b. Building Security
   c. Hazardous Materials and Wastes
   d. Fire Safety Control
   e. Medical Equipment

f. Utilities

g. Emergency Management

D. **RESPONSIBILITIES**

1. The Safety Officer and Safety Facilitator shall be appointed by the CEO and be granted sufficient administrative authority to assure support for the EOC Committee. Note that the Safety Officer and Safety Facilitator may be the same person.
    a. Establish a Safety/Environment of Care (EOC) Committee to review and act upon applicable safety and security issues within the hospital district.
    b. Create subcommittees to address safety concerns as needed.
2. The Director of Facilities Management is responsible for overseeing all areas of the physical environment, as listed in section C.2, but may appoint other individuals to oversee any or all aspects of each area.
3. The Safety Officer or Environment of Care (EOC) Coordinator develops and maintains safety policies and procedures which shall be reviewed and approved by the Safety/EOC Committee as conditions change or at least every 3 years unless required annually per regulations.

E. **SAFETY**

1. Conduct safety inspections every six months in patient care areas and annually in non-patient care areas to identify safety related concerns and evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.
2. Conduct EOC Rounds to identify environmental deficiencies, hazards, and unsafe practices.
3. Develop and maintain processes to identify and minimize safety and security risks associated with the physical environment and activities associated with its operations.
4. Maintain all grounds and equipment via a preventive maintenance program which complies with all applicable Federal, State, and Local laws, regulations, and guidelines.
5. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
6. Maintain the District's Injury and Illness Prevention Program.

F. **SECURITY**

1. Develop and maintain policies and procedures to:
    a. Identify and minimize security risks to patients, visitors, and staff.
    b. Provide instructions that staff must follow in the event of a security incident.
2. Identify individual(s) responsible for security management and ensure all staff are knowledgeable of them.
3. Identify security sensitive areas and implement controls to secure these areas.
4. Develop and maintain relationships with local law enforcement to understand response if external law enforcement assistance is required.
5. Develop and maintain the Workplace Violence Prevention Plan which includes incident reporting, security assessments and staff training.

G. **HAZARDOUS MATERIALS AND WASTES**

1. Develop and maintain a program to identify, handle, process, and dispose of hazardous materials and wastes (including spills) that minimizes the potential exposure of patients, visitors, staff, and the surrounding community.
2. Develop and maintain inventories of all hazardous materials and wastes.
3. Ensure all hazardous materials and wastes are properly labeled and that Safety Data Sheets (formerly MSDS) are available for all hazardous materials in all facilities.
4. Ensure routine monitoring of hazardous materials and waste is conducted to reduce the exposure potential to harmful agents.
5. Ensure that the storage and disposal of trash is in accordance with all applicable Federal, State, and Local regulations.
6. Ensure all employees are trained as per the OSHA Hazard Communication Plan.
7. Ensure Personal Protective Equipment (PPE) is provided as necessary to staff to ensure against possible exposure to hazardous materials.

H. **FIRE LIFE SAFETY**

1. Develop and maintain policies and procedures that contain provisions for the prompt reporting of fires; extinguishing of fires; protection, and evacuation of patients, personnel, and guests; and cooperation with fire fighting authorities.
2. Train staff as to their roles and responsibilities in the event of fire, both at the location of the fire and away from the fire. "Staff" includes all individuals performing job functions at the facility, whether they are employees, volunteers, students, or contract workers.
3. Conduct and critique fire drills as per regulations.
    a. In hospital occupancies, fire drills must be conducted at least once per shift per quarter.
    b. In business occupancies such as the Cancer Center and off-site clinics, fire drills must be conducted once per shift per year.
4. Ensure full compliance of Life Safety codes for both inpatient and outpatient locations as per the National Fire Protection Association (NFPA), including but not limited to:
    a. Fire and smoke separations
    b. Smoke detection and fire alarm systems
    c. Fire extinguishing systems
    d. Means of egress
    e. Corridor door latching
    f. Alternate life safety measures (ALSM) during construction, renovation, and discovery of ALSM deficiencies
    g. Maintenance of emergency lighting batteries
5. Coordinate regular inspections by state or local fire control agencies.

I. **MEDICAL EQUIPMENT**

1. Develop and maintain a preventive maintenance program for all medical equipment relating directly or indirectly to patient care.
2. Incorporate the preventive maintenance program into the Quality Assurance / Performance

Improvement program.

3. Maintain a written or electronic inventory of all medical equipment available for use.
4. Ensure that the equipment procurement process includes the opinions and suggestions from individuals who operate and service the equipment.
5. Ensure compliance with the Safe Medical Device Act.

J. **UTILITY SYSTEMS**

1. Develop a preventive maintenance and inspection plan that complies with all applicable federal, state, and local laws, and other regulatory bodies, including but not limited to the Life Safety Code (NFPA 101), Health Care Facilities (NFPA 99), Standard for Emergency and Standby Power Systems (NFPA 110), and National Electrical Codes, for the following:
    a. Power and lighting, including emergency needs
    b. Electrical systems and equipment, including emergency needs
    c. Generators
    d. Automatic transfer switches
    e. Potable water and water temperature control
    f. Medical gas systems, including shut-off valves
    g. All hospital plant equipment, including but not limited to elevators, air handlers, air compressors, and vacuum systems
2. Maintain an inventory of all plant equipment available for use.
3. Ensure all utility lines, chases, and controls are properly labeled.
4. Ensure proper ventilation, lighting, and temperature controls in all pharmaceutical, patient care, food preparation, equipment processing, sterile processing, soiled utility, and other support areas as required.

K. **EMERGENCY MANAGEMENT**

1. Develop and maintain a comprehensive emergency management plan and review it with local authorities.
2. Within the emergency management plan, policies and procedures, address at least the following:
    a. Prompt transfer of casualties and records
    b. Identification and notification of community emergency personnel
    c. Communication needs both internal and external
    d. Fire response plan
    e. Evacuation routes and procedures for leaving the facility, including transfer and discharge of patients
    f. Victim triage
    g. Special needs of the patient population
    h. Handling of communicable disease outbreaks and chemical exposure victims
    i. Identification and maintenance of supplies, including pharmaceuticals and food, which would be needed during a disaster.

j. Provisions for utilities if access is lost.

3. The emergency management plan should provide for patients, staff, and other persons who come to the hospital during an emergency.
4. Maintain adequate fuel supplies and procedures for fuel replenishment in the event of an emergency for the emergency power system.
5. Develop and maintain procedures for emergency water and fuel.
6. Conduct disaster drills twice per year, one of which involves the community.
7. Develop and maintain polices and procedures to address weapons of mass destruction, educate staff on mass destruction response preparedness, and participate in weapons of mass destruction drills with others as appropriate.

L. **COMPLIANCE**

1. Compliance with all objectives in this management plan will be obtained through appropriate Policies and Procedures, Risk Assessment responses, Environmental Rounds, and the Preventive Maintenance program.

M. **RISK ASSESSMENT**

1. **A variety of tools are used to complete the risk assessment as follows:**
   a. Environmental rounds
   b. Department safety inspections/observations
   c. Health system experience
   d. Internal/external safety assessments

N. **POLICIES AND PROCEDURES**

1. A wide variety of policies and procedures (P&P) support the Environment of Care Management Plan.
2. The Environment of Care P&Ps are located in the Policies and Procedures on the intranet and can be found under "AEOC" (Administrative, Environment of Care)
3. Department specific P&Ps are also available in Policies and Procedures on the intranet
4. EOC policies and procedures address at least the following:
   a. Hazardous Materials
   b. Utilities
   c. Life Safety
   d. Medical Equipment
   e. Emergency Management
   f. Safety
   g. Security

O. **INFORMATION COLLECTION AND EVALUATION**

1. The Facilitator of the Environment of Care Committee or EOC Coordinator is assigned to monitor and coordinate the health system wide collection of information about deficiencies and opportunities for improvement in the environment of care.

2. A variety of data acquisition sources will be utilized as follows:
    a. Employee reports
    b. Performance management data
    c. Risk management data
    d. Regulatory data
    e. Employee health data
    f. Environmental rounds results
    g. Product and device recall reports
    h. Fire drill critiques
    i. Emergency exercise critiques
    j. Proactive risk assessments
3. The Facilitator of the Environment of Care Committee or EOC Coordinator collects the data and prepares aggregates for evaluation by the Environment of Care Committee.
    a. These results of the aggregation are summarized in the EOC Committee minutes.
    b. Any recommendations for improvement are stated as well as assignments for follow-up reporting.
    c. Recommendations are monitored for effectiveness and are reported to the Committee.

P. **STAFF ORIENTATION AND EDUCATION**

1. At new employee orientation, an overview of the Environment of Care Management Plan is provided to each employee.
2. Annually all employees are provided education about the Environment of Care.
3. Department specific Environment of Care orientation is provided to employees by their individual department.
4. All training classes that employees attend are recorded by the Human Resource Department.

Q. **PERFORMANCE IMPROVEMENT**

1. Performance monitoring of the Environment of Care Management Plan identifies improvement needs.
2. Review improvement goals and achievements with the Performance Improvement Committee.
3. Deficiencies identified during environmental rounds are corrected.
4. Staff knowledge will be measured and evaluated for acceptable responses. Staff knowledge data will be collected during one or more of the following; environmental rounds, annual-training sessions, and during fire/emergnecy management drills.
5. Implementation of corrective procedures and controls for safety and security risk management.

R. **EVALUATION OF THE MANAGEMENT PLAN**

1. At least annually the Environment of Care Management Plan is evaluated for objectives, scope, performance, and effectiveness.
2. The Safety Officer or EOC Coordinator is responsible for preparing the evaluation.

3. The Safety/EOC Committee reviews the evaluation in order to plan new goals for the next year.
4. Health system leadership is provided copies of the evaluation for their review and information.

References:

HFAP Chapter 3 and 14, NFPA

All revision dates: 01/2019, 01/2018, 01/2017, 07/2014, 05/2014, 01/2014, 11/2013

Attachments:

Approval Signatures

Step Description	Approver	Date
	Michael Ruggiero: Director, Facilities Management	01/2019
	Myra Tanner: Coordinator, EOC	01/2019

Tahoe Forest Hospital District (TFHD)

TRAUMA PERFORMANCE IMPROVEMENT PLAN

Approved by: Date: Dec 2019

Dr. Ellen Cooper, TMD Natasha Lukasiewich, TPC Karen Baffone, CNO

Med Executive Committee Representative

V.12.18.19

TRAUMA CENTER PERFORMANCE IMPROVEMENT PLAN

Mission

To provide comprehensive and compassionate care to trauma victims in Truckee, CA, Lake Tahoe and neighboring Sierra Sacramento Valley counties consistent with national level 3 trauma designation standards.

Vision

TFHD and EMS partners will provide and maintain a trained and ready healthcare force that provides the best trauma medical outcomes. TFHD and EMS partners seeks, thrives on, and embraces change while accomplishing the health care mission, utilizing outcomes to drive medical decisions. TFHD will provide the best level three trauma care and TFHD will improve patient outcome by continuously refining and improving the process of care. TFHD will constantly strive to raising the bar on trauma care for the injured patient.

Scope and Authority

The trauma performance improvement process falls under the direction of Dr. Ellen Cooper, MD, FACS. The Trauma Medical Director and the Trauma Program Coordinator are responsible for reporting pertinent information to hospital risk management. The Trauma Medical Director has overall institutional responsibility for trauma quality. The committee will report to TFHD med staff, med executive committee and the board of directors as needed.

Goals

The primary purpose of the trauma performance improvement program is to deliver optimal care to victims of trauma-related incidents. The care of injured patients depends on complex network of people working together as a team. The emergent nature of trauma care relies on each member of the team to perform well on a regular basis. The performance improvement program is designed to monitor systems and practices and if needed determine ways in which performance can improve.

When a component of the system is not functioning, the performance improvement program should be able to identify any deficiency and formulate a plan to improve performance. An effective performance improvement process should identify an issue/event, determine why the issue exists and mediate improvement outcomes in a dignified manner, leading to improved trauma care for the injured patient(s).

In order to sustain effectiveness, the performance improvement process must be an inclusive process that draws from the expertise of each individual member of the trauma care team. The performance improvement program should function according to trauma principles; therefore, it can function in a fair and autonomous way. These principles include; objectivity, a data driven process, an issue oriented process, efficiency, effectiveness, trauma care directed, Education-oriented and non-punitive.

It is essential that each member of the trauma peer performance improvement team engage in the performance improvement (PI) program process. In this way, each member of the

trauma PI team will be able to improve the trauma system of care by offering objective insight as to improve. The net result of the process should be a system of trauma care that allows team members to provide care in an effective and efficient manner.

Patient Population

The injured patient is a victim of an external cause of injury that results in major or minor tissue damage or destruction. Those with a major injury have a significant risk of adverse outcome that is influenced by the patient's age, the magnitude or severity of the anatomic injury, the physiologic status of the patient at the time of admission to the hospital, the pre-existing medical conditions, and the external cause of injury.

The trauma patient population includes any patient with at least one injury included within the diagnosis codes ICD10-CM discharge diagnosis of S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9.

Data Collection

Primary data collection is achieved through EPIC's electronic health records (EHR's) and Trauma One Lancet Technologies hosted on SSV (Sierra Sacramento Valley) EMS database. Quality indicators for continuous or periodic evaluation of aspects of care are determined from the American College of Surgeons, NTDB (National Trauma Data Bank) Dictionary, the California Department of State Health Services, and Tahoe Forest Hospital District institution specific audit filters designed to evaluate provided trauma care.

Complications are defined utilizing clear, concise, and explicit definitions according to the yearly NTDB Dictionary. In order to utilize the data from Trauma One registry it is necessary to relate it to provider-specific information, which can then facilitate process improvement and corrective action process.

Confidentiality Protection

Each member involved in trauma peer and performance improvement program will review, sign and adhere to Tahoe Forests Hospital District policies regarding confidentiality, while adhering to all local, state, and federal laws regarding patient and provider confidentiality. The PIPS (performance improvement patient safety) peer program is protected under California Evidence Code § 1157.

Sources

Identification of performance issues will be done in a timely and accurate manner. Data abstraction is a weekly review process, whereby all activities in the trauma center are evaluated, abstracted and entered directly into Trauma One registry within 60 days requirement. Any part of the trauma care system that does not perform well should be identified in a timely and accurate manner. In order to achieve this goal, several mechanisms are needed. These include but are not limited to;

1. EMS run sheets
2. Trauma Morning Report/Rounds

3. Word of mouth
4. Email
5. Concurrent medical record review
6. Diagnostic interpretations (lab, x-ray, etc.)
7. Trended reports from trauma registry
8. Trauma logs
9. Other appropriate sources as needed

Monthly Performance improvement review should include:

- Review all trauma admissions/deaths/trauma team activations
- Review all trauma transfers out for issues to include timelessness of transfer according to SSV Trauma Transfer Guidelines
- Review system issues identified
- Identify any lab or radiology issues
- Clarify any complications or audit filter fallouts

Data Analysis

The trauma program analyzes information identified through the peer review process. This information will be tabulated on a monthly or as needed basis. Trend analysis will be computed and compared with the trends identified in the concurrent process and reported at the Multidisciplinary Peer Review Committee.

Once information has been abstracted, it is analyzed and the identified issues are reviewed in the context of what type of deficiency, and if the event is recurrent. The PI team looks at several factors in order to make this determination. These factors include but are not limited to the following issues;

a. Occurrence based
b. Audit filter based
c. System issue based
d. Provider specific
e. Trended data relevant to the issue
f. Resource deficiency
g. Other issues as needed

Trauma PI Team Members Responsible:

- Trauma Medical Director
- Trauma Program Coordinator
- Emergency Physician Representative
- Trauma Nurse Clinicians
- Trauma Registrar
- Emergency Manager/Director
- Radiologist
- Anesthesia liaison
- Other department representative as needed to the event

Audit Filters, Practice Guidelines Variance Tracking

Tahoe Forest Health District utilizes a selection of filtering events pertinent to American College of Surgeons (ACS) and Trauma One audit filters which are assessed on an ongoing manner and do not have a projected completion date. The following indicators are reported to the Trauma Committee on a monthly basis.

Audit Filters, Practice Guidelines Variance Tracking

1. Absence of EMS Runsheet
2. Inadequate pre-hospital airway
3. No trauma team activation/consultation for patient meeting Trauma Team Activation (TTA) criteria
4. Lack of ER Nursing documentation (V/S, temp, GCS)
5. Pediatric weight/Broselow color not documented
6. Over/under fluid resuscitation for pediatric patient
7. Trauma resuscitation record not used
8. No documentation of Burn resuscitation to include weight, % TBSA and fluid
9. No staff note ER LOS >2 hours
10. Initiation of Massive Transfusion Protocol
11. Death
12. Transfers Out
13. Diversion
14. Tertiary Survey not documented
15. Admit to non-Surgical Service
16. Unplanned return to the OR
17. Readmission to the ICU
18. Missed Injury
19. Delay in Diagnosis
20. Reintubation within 48 hours of extubation
21. Readmission within 72 hours
22. Complications
23. No trauma surgeon consulted
24. TFHD Trauma Clinical Practice Guideline deviations
25. Other pertinent events seen as appropriate

Issue identification

Once the data has been analyzed and interpreted, event identification takes place. Each issue is looked at carefully, taking every detail into consideration. An accurately identified issue will include several elements, which include but are not limited to;

- Types of issues
  - Occurrences
    - Complications
    - Outcomes based
  - Audit filters
    - Institution Specific Audit Filters
  - Provider specific issues
    - Physician
    - Nursing
    - Hospital staff
    - Pre-Hospital
  - System specific issues
    - ICU
    - OR
    - PACU
    - MED/Surg Units
    - Respiratory care
    - Radiology /PACs
    - Anesthesiology
    - Blood bank
    - Laboratory
    - Physical/Occupational therapy/Rehabilitation
    - Social Services/Case Management

Concurrent and Retrospective Review

Concurrent

1. Review of PI events takes place at designated multidisciplinary trauma peer review committee meetings. Report on an as needed basis and all trauma patients are reviewed from previous month.
2. Events are presented to the team for discussion and validation.
3. Registry identified patients will be reviewed for appropriateness of inclusion into the registry. Any deviations from Trauma Clinical Practice Guidelines, or care issues identified are referred to the appropriate individuals.

Retrospective

1. All responses received from the concurrent process are reviewed for appropriateness.
2. Judgments are rendered based upon the American College of Surgeons definitions and the input of identified clinical experts. Clinical Practice Guideline development and/or revision, standard operating procedures (SOP) development/policies, counseling or education is then put into action as indicated.

Levels of Review

Primary

Primary review of performance issues will occur by the trauma program staff concurrently or TPC (Trauma Program Coordinator/Manager) with data abstraction and collection while care is being delivered. PI Events are identified and validated, as they occur. This may occur during morning report, patient care rounds, chart review, and direct staff and patient interaction. Changes in patient's plan of care or implementation of clinical guidelines may be implemented immediately. Prompt feedback to providers will occur in parallel. Retrospective review may be necessary, but the case may also be able to be closed.

Secondary

PI Events which have been identified concurrently may require additional review, input from various providers, and/or review by the Trauma Medical Director or the Trauma Program Coordinator. PI events are validated, additional information collected, and analyzed. If peer review is indicated, the case is forwarded to the monthly Multidisciplinary Peer Review Meeting.

Tertiary

Criteria for determining which cases go to Multidisciplinary Peer Review conference are:

- Selected deaths
- Selected complications
- Some specialty referral cases
- Selected Transfer Outs

Cases are reviewed, factor determinations made, preventability established, surgical grading defined, corrective actions developed, and resolution of event is completed, if indicated at the time.

Determination of Preventability

One of the essential tasks of a trauma PI forum is to identify opportunities for improvement in care outcomes. This step is necessary or an effective action plan is developed. When confronted with an issue/event, each forum will use an objective process to determine preventability. Each forum will use the criteria defined below;

Unanticipated event with opportunity for improvement

- Anatomic injury or combination of injuries considered survivable.
- Standard protocols not followed with unfavorable consequences.
- Inappropriate provider care with unfavorable consequences.

Anticipated event with opportunity for improvement

- Anatomic injury or combination of injuries severe but survivable under optimal conditions.
- Standard protocols not followed, possibly resulting in unfavorable consequence.
- Provider care considered sub-optimal, possibly resulting in unfavorable consequence.

Event without opportunity for improvement

- anatomic injury or combination of injuries considered non- survivable with optimal care.
- standard protocols followed or if not followed, did not result in unfavorable consequence.
- Provider related care appropriate or if sub-optimal, did not result in unfavorable consequence.

Factors Related to Events or Opportunities

When an event is determined to have opportunities for improvement, the PI team must also decide which contributory factors that the event occurred. This is a necessary part of the PI process because effective action plans need to address the factors that led to the variation of practice. The factors that relate to an event include but are not limited to;

<u>Factors related to issue</u>

1. No factors identified
2. Error in management
3. Error in technique
4. Delayed diagnosis
5. Missed diagnosis
6. Deviation from protocol
7. Deviation from standard of care
8. Equipment failure
9. Equipment/Supply Deficiency
10. Protocol Deficiency
11. Protocol Failure
12. Departmental Deficiency
13. Communication Deficiency
14. Communication Failure
15. Mortality - Anatomic diagnosis

16. Mortality survival probability
17. DNR Order
18. Withdrawal of Care
19. DOA/DOS
20. Pre-Existing Conditions
21. Disease Related/Co-Morbidity

Credentialing

Physicians

Credentialing is essential in order to permit practitioners, who have competency, commitment and experience to participate in the care of this unique population. Physician and Nursing requirements include those outlined by the ACS Standards for Accreditation and Tahoe Forest Hospital Health System.

In addition, satisfactory physician performance in the management of a trauma patient is determined by outcome analysis in the peer review process through annual performance evaluations.

The Trauma Medical Director is responsible for recommending physician appointment to and removal from the trauma on call service, along with the medical staff credentials committee.

Nursing

The Chief Nursing Officer is responsible for overseeing the credentialing and continuing education of nurses working on units who admit injured patients. Trauma nursing orientation may include verification in TNCC, ENPC, PALS, ACLS, unit based competencies, courses such as TCAR (Trauma Care After Resuscitation and trauma/emergency specific board certifications such as TCRN (Trauma Certified RN/CEN (Certified Emergency Nurse/CCRN)Critical Care RN.

Physician Assistants and Nurse Practitioners

The trauma medical director/trauma surgeons are responsible for oversight of NP's and PA's. No NP or PA shall be permitted to take primary care on full trauma activation patients.

Data Management

Data is collected and organized for review under the direction of the Trauma Medical Director and the Trauma Program Coordinator/Registrar. The primary source of trauma data is the Trauma Registry. The Trauma Registrars enter all data into the National Trauma Data Bank Registry.

Trauma Registry:
This is provided through Trauma One Lancet Technologies through SSV EMS.

Data Validation and Inter-Rater Reliability

The Trauma Program Coordinator and the Trauma Medical Director routinely abstract data elements and audit filters to review accuracy. Resuscitation interventions, injury coding and complications are reviewed for consistency with data dictionary definitions. All data abstracted from the registry for reporting is validated on an on-going basis through trauma one data base. Inter-Rate Reliability is provided by the trauma registrar and/or trauma registrar contracted persons.

TFHD Multidisciplinary Peer Committee

1. **PURPOSE:** To optimize trauma performance through monitoring of trauma related hospital operations by a multidisciplinary committee that includes representatives from all phases of care provided to injured patients. This committee will review operational issues and provide appropriate analyses and proposed corrective actions. This process is in place to identify problems and demonstrate problem resolution with adequate loop closure.

2. **REFERENCES:**
   a. Resources for Optimal Care of the Injured Patient: Committee on Trauma, American College of Surgeons.
   b. Trauma Outcomes and Performance Improvement Course: Society of Trauma Nurses Course. (2017)
   c. Overview of the ACS COT Trauma Quality Programs: A Reference Manual; https://www.facs.org/quality-programs/trauma/tqp

3. **MEMEBERSHIP:**

Trauma Medical Director (Chairperson)
Trauma Program Coordinator
(Serves as Trauma Registrar/PI RN/Injury Prevention RN)
Core Emergency/Trauma Staff Physicians
Chief Nursing Officer (Silent Membership)
ER Manager/Director
Representative Surgery
Representative, Anesthesiology
Representative, ER Nursing
Representative, Med/Surg Nursing
Representative, ICU Nursing
Representative, Radiology
Representative, Blood Bank/Lab
Representative, Rehabilitation/OT/PT
Representative, Infection Control
Trauma Registrar
EPIC Liaison
Trauma Social Workers

4. **MINUTES APPROVING AUTHORITY:** TFHD multidisciplinary committee

5. **ISSUES ELEVATED TO:** Tahoe Forest Hospital Risk Management

6. **MEETS:** Monthly and as needed.

7. **OFFICE OF RECORD FOR APPROVED MINUTES:** Committee Files, Trauma Services

8. **COMMITTEE REQUIRED BY**: American College of Surgeons, Committee on Trauma.

Corrective Action Plan Development and Implementation

In the event of corrective action, the PI team will decide on an action plan. The details of the plan need not be decided in a formal meeting, but a decision as to what type of action to take is possible. Working with members of the PI team and appropriate hospital staff, the trauma service can help formulate a plan that meets the specific recommendations of the committee. Categories of specific action plans include but are not limited to;

Action plan:

- Action pending review
- Change in policy or procedure
- Educational Offering
- Equipment obtained/repaired
- Findings presented at M&M
- Formulation of new policy/procedure
- Individual counseling and discussion
- Institution of formal QA audit
- Letter to Chief of Service
- Letter to MD
- Limit/suspend/revoke privileges
- MD reply
- Modifications of department training/Education program
- No action required
- Other: describe in comments
- System related PI event
- Tabulation & tracking for further reporting

Implementation

Action plans may be multidisciplinary and involve many areas of the hospital. Because of this, it is essential to have an inclusive process that collaboratively works with all areas of the institution that involve care of the trauma patient. The PI process must be able to develop action plans and recommend in association with the appropriate people and departments that relate to the PI event. Once this is done, the plan is ready to be implemented. Frequently, action plans require the involvement of more than one provider or element of the system. There will be clearly defined time frames for action plans implementation.

Resolution of PI Event and Re-evaluation

After the action plan is implemented, the process must shift focus back to the data. The plan must include data points that allow the changes made to the system to be monitored. If the data is followed and the PI event is resolved, the PI loop is closed. This is recorded in Trauma One quality Improvement section. The effectiveness of corrective action will be monitored following corrective action. There will be a defined end state for example, event resolution will occur and be satisfied within 6 months.

In order for a PI event to be resolved, it must be followed through the above-mentioned steps. Even after a PI event is thought to be resolved, it must be tracked from time to time to ensure that it does not recur. The trauma PI process must be able to follow a PI event closely over an extended period of time. Many PI events can recur if factors that relate to the PI event change, making it possible for original circumstances to return and cause the same issue to manifest. Documentation of the entire PI process from issue identification to resolution is imperative. This is tracked in Trauma One data base under the QI section.

Integration into Hospital Performance Improvement Process

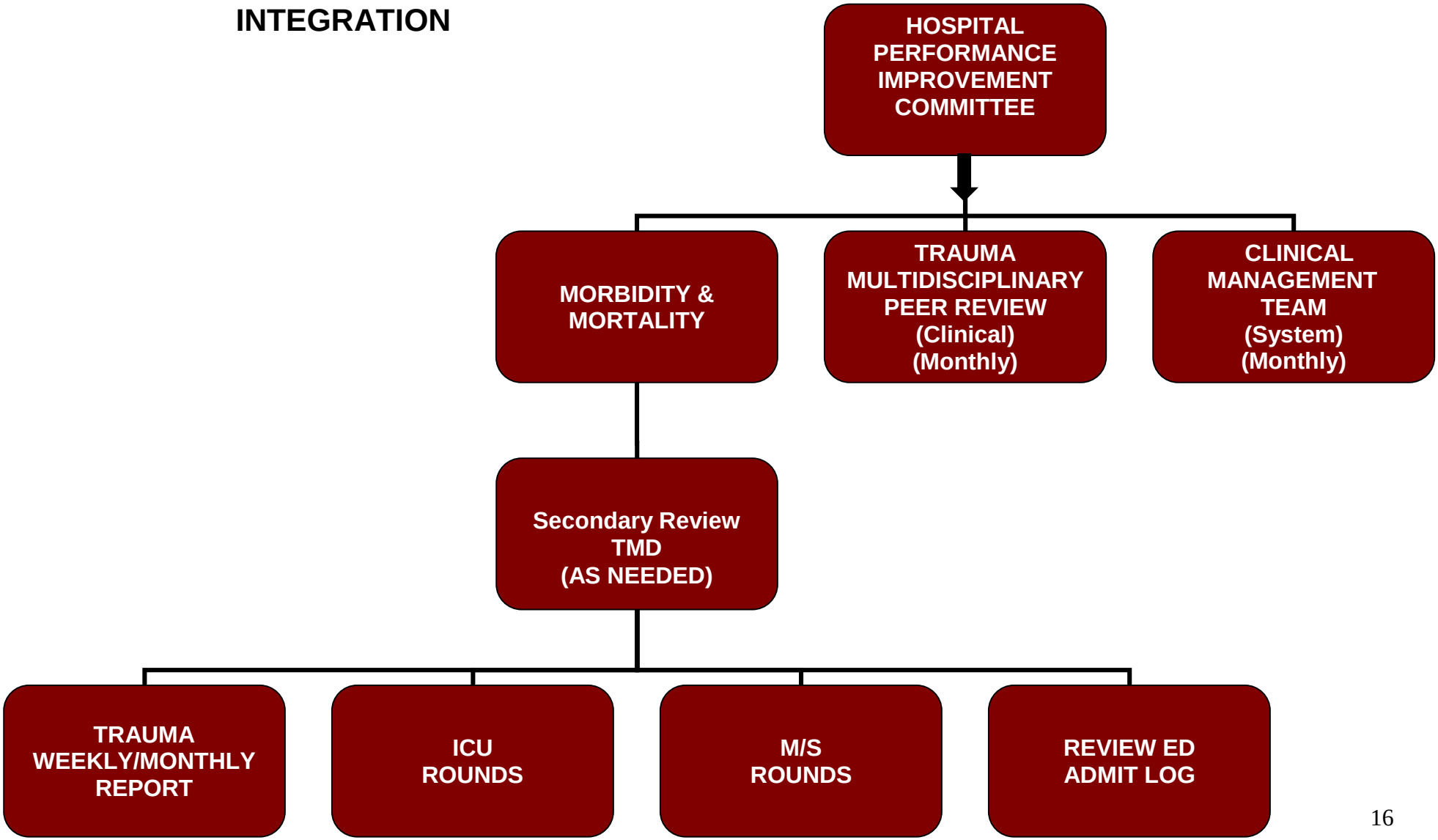
The trauma performance improvement program and committee members will collaborate with the hospital performance improvement process by means of open communication and involving appropriate personnel in order to improve loop closures. It is the expectation that the hospital performance improvement/quality will include the TMD and/ TPC in loop closure processes as this required to according to ACS trauma standards of performance improvement.

Addendum

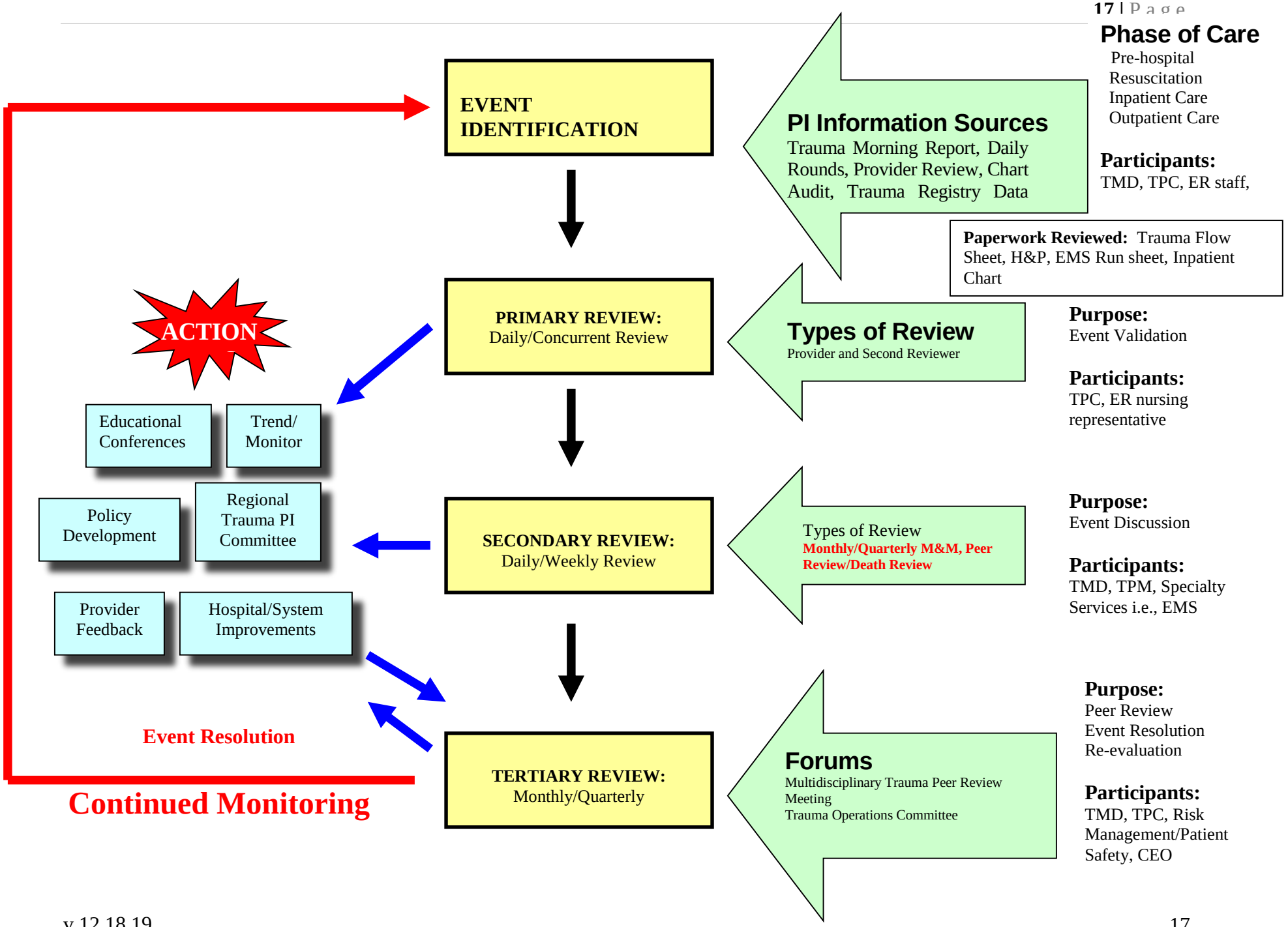
Changes to PI Plan

Date	Changes

TRAUMA PROGRAM PERFORMANCE IMPROVEMENT TAHOE FOREST HOSPITAL INTEGRATION



TAHOE FOREST HEALT SYSTEM TRAUMA PERFORMANCE IMPROVEMENT PROCESS



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LEGEND: Trauma Medical Director (TMD), Trauma Program Coordinator (TPC)

Tahoe Forest Hospital
Home Health Services
Quality Assurance Performance Improvement Plan, 2020

I. **Overview (philosophy):**

This Quality Plan supports the systematic approach to plan, design, measure, assess, and improve performance under Home Health Services at Tahoe Forest Hospital System. Initiatives are intended to achieve optimal patient outcomes and patient family experience, enhance appropriate utilization and minimize risks and hazards of care. The Plan is intended to provide a framework of guiding principles for all staff members in the facility. This structure will set the expectation and encourage staff to participate proactively in the improvement process. The Quality Plan facilitates the identification of key functions of the hospital, the assessment of the quality and appropriateness of these functions, and the generation of measurable improvements.

II. Mission:

At Tahoe Forest Health System our mission we exist to make a difference in the health of our communities through excellence and compassion in all we do.

III. Vision:

Tahoe Forest Hospital System has the vision to serve our region by striving to be the best mountain health system in the nation. The vision for this Quality Assessment and Process Improvement Program (QA) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

A. Model for Improvement:

The model used for Continuous Improvement is the DMAIC model. DMAIC refers to a data-driven quality strategy for improving processes. DMAIC is an acronym for five interconnected phases: Define, Measure, Analyze, Improve, and Control. The model is a step-by-step methodology used to solve problems by identifying and addressing the root cause of a problem

B. The primary method of continuous quality improvement is to define, measure, analyze, improve, and control.

1. Define: Define a problem or improvement opportunity.
2. Measure: Measure process performance
3. Analyze: Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned
4. Improve: Improve the process by addressing root causes
5. Control: Control the improved process to hold the gains

Once the basic problem-solving or quality improvement process is understood, the addition of quality tools can make the process proceed more quickly and systematically.

V. Strategic Objectives (Guiding Principles)

A. Provide high quality, safe Home Health services and demonstrate superior patient outcomes
B. Assess the Home Health performance with objective and relevant measures
C. Achieve Quality Improvement goals in a systematic manner through collaboration with our physicians, staff, patients, families, payers, and our community through education, goal-oriented change processes, evaluation, and feedback
D. Provide a mechanism to assure that all patients receive equitable high-quality care
E. Provide a culture where care is delivered in a safe and timely manner and care dimensions are measured, monitored, and continuously improved.
F. Utilize Quality Improvement information in formulating and achieving objectives of the strategic plan. Promote and support processes which improve organizational performance
G. Identify and focus on functions that are important to our customers; implement changes which will increase customer satisfaction
H. Optimize the allocation of resources to ensure the delivery of quality and efficacious care
I. Enhance the national and international art and science of healthcare quality by embracing the principles of a "learning organization" and presenting lessons learned and original research at professional meetings, journals, and forums.

VI. The Tahoe Forest Health System utilizes the following standards/regulations from which the Quality Plan has been developed:

A. Medicare Home Health Conditions of Participations
    - **i.** Subpart C – Conditions of Participation
    - **ii.** Subpart D – Organizational Environment
    - **iii.** Subpart F – Covered Services
B. Title 22 Regulations
    - **i.** Article 2 – License
    - **ii.** Article 3 – Services
    - **iii.** Article 4 – Administration
    - **iv.** Article 5 Qualifications for Home Health Aide Certification
C. Nevada Home Health Standards
    - **i.** NSR 449.037 Adoption of standards, qualifications and other regulations
    - **ii.** NAC 449.749 –NAC 449.800
D. Regulation Detail
    - **i.** ***MEDICARE HOME HEALTH COP***

SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart C: Furnishing of Services
484.52 - Condition of participation: Evaluation of the agency's program. The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) Standard: Policy and administrative review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.

(b) Standard: Clinical record review. At least quarterly, appropriate health

professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.

CHAPTER IV: CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)
SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart B: Administration
484.16 - Condition of participation: Group of professional personnel.
A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.

(a) Standard: Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. The meetings are documented by dated minutes.

ii. Title 22

VII. Scope:

Tahoe Forest Healthcare System – Home Health Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

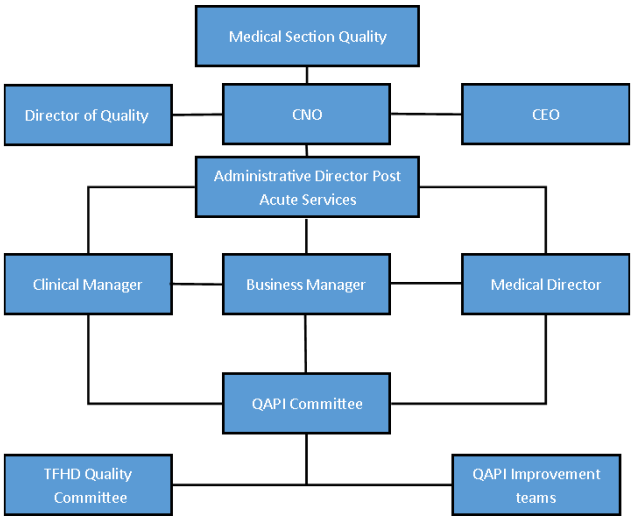
A. Clinical quality: Standardize minimum competency
   1. Standardize processes to assure competency of all staff with online testing and clinical demonstrations as necessary, licensure, certification, evaluation, and annual performance appraisals
   2. Perception/Service Surveys: HHCAHPS survey
   3. Safety which includes Patient Safety, Medication Safety, and Environmental Safety
   4. Measurement and evaluation: general subjects of continuous measurement and evaluation will include the following subjects/issues:
      a. Service excellence, expectations and needs, and the degree to which these needs are met
      b. Patient safety
      c. Medication safety
      d. Risk and compliance
      e. Patient care process/outcome measures and evaluation
      f. Staff satisfaction, expectations and needs, and degree to which these are met
      g. Physician satisfaction, expectations and needs, and the degree to which these are met through interaction between staff and MD office.
      h. Regulatory and compliance standards
      i. Operational improvement: design of new processes or service lines, or re-engineering of existing processes. When Tahoe Forest Home Health Services is adopting a new process, individuals and groups will ensure the new process includes:
         i. The organization’s mission, vision, values, and strategic plan

ii. Patient and community needs
iii. Information about performance, safety and outcomes of the process. This is accomplished by using current evaluation tools, established to identify flaws in the process.

j. Regulatory and accreditation continuous readiness
k. Communication
i. Medical Staff
ii. Hospital Staff

VIII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOME HEALTH SERVICES



Medical Section Quality Committee:
The Medical Section Quality Committee is responsible for approving and maintaining the organization's QA Plan that includes the Home Health Quality Plan. The effectiveness of quality improvement activities is reported to the Quality Committee and evaluated at regular intervals.

Quality Assurance Performance Improvement Committee (QA):
The composition of this inter-disciplinary committee is approved annually by the Tahoe Forest Hospital Medical Section Quality Committee. The composition includes: the Medical Director of Home Health Services, the Administrative Director of Post Acute Services, Clinical Manager, MSW, Quality Coordinator, and others as needed. The function of this group is to address issues that impact Home Health service effectiveness. Topics selected for discussion on the annual calendar would include, but are not limited to those that address interventions for clinical improvement; satisfaction improvement; documentation; removal of barriers to improvement; continued readiness; operational improvement; as well as systems and processes of care. The meetings include review of data and sharing of best practice.

Unit-based Practice Council:
Composition of this inter-disciplinary committee is comprised of members of the Home Health and Home Health staff. This group utilizes a shared decision making model with a goal of improving the services the Home Health provides, the quality of care, and overall operations of the department. Examples of the functions related to the UBPC include, but are not limited clinical, patient safety and issues brought forward from various risk advisories and reporting processes, as well as addressing interventions to promote a culture of safety.

Quality Improvement Teams:
Interdisciplinary QI Teams are approved by the QA Committee after an assessment and prioritization of organizational needs. Teams may be used to study processes, design new processes, and to make improvements in current processes based on best practices or by eliminating root causes of identified problems. QI teams will use the DMAIC methodology. Each team will have a leader and facilitator. Teams will be given a charter indicating their mission, a statement of the problem, expected outcomes, constraints, and a reporting schedule to the committee. Upon completion of their mission, teams will write a summary report, and present their projects to the QA committee as appropriate. Teams will be recognized via the approved mechanisms.

Key Elements of PI

IX. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining initiatives on which to focus. The QA Committee will use the following criteria to identify and prioritize the quality initiatives identified in the organization using the following criteria:

- Incident Reports
- Sentinel Events
- High volume/problem prone/high cost.
- Low volume/high risk-problem prone/high cost
- Problem prone areas
- High Risk for negative outcomes
- High cost issue
- Promotion of patient safety issues
- Initiatives consistent with mission values, strategic plan and directions
- Availability of system resources to devote to project
- Financial Risk
- Availability of resources

The Plan's elements are designed to work in tandem with one another to build a strong foundation of continuous quality improvement. A strong QA Plan demands involvement and participation from all levels of the organization. This plan is develop on the following 5 foundations of excellence in which we have indicators that are measured under each pillar.

A. Quality- Providing excellence in clinical outcomes
    1. Home Health Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Home Health quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Satisfaction survey's-HHCAHPS
    2. People- Best place to work and practice
    3. Oversight/communication
    4. Staff competency
    5. Employee satisfaction
    6. Unit based council
C. Finance- Providing superior financial performance
    1. Financial performance
D. Growth- Meeting the needs of the community
    1. Strategies for growth and partnerships in region

2. Education of staff and community

X. Sources of Data for Quality Improvement:

A. Administrative data
B. Survey data
C. Clinical data
D. Reference Databases
   1. The Home Health will use state and national reports to compare the Home Health's performance with other facilities.
   2. Home Health provides data to external databases for comparative studies comparing our Home Health to other peers and national rates. This information will be utilized to determine areas for improvement.

XI. Data Collection, Analysis, and Reporting:

A. Evaluation of collected data will be completed to monitor and identify levels of performance, trends or patterns that vary significantly from the norm, or that exceed threshold levels of acceptable performance.

B. Data and findings will be reported to the appropriate groups and individuals on a quarterly basis or more frequently as indicated.

C. A quality Dashboard and Scorecard will be created for use by management, TFHD Quality Committee, QA Committee, the Medical Section Quality Committee.

D. Home Health will utilize national survey database reports to compare the performance with other facilities. In addition, the Home Health will provide data to external databases for comparative studies comparing our Home Health to other peer Home Health's and national rates. This information will be utilized to determine areas for improvement.

E. All quality committee minutes are recorded within the organization will be documented utilizing the format of topic, findings/conclusions, and recommendations/actions.

F. The Data Collection Plan should be clearly defined in each QI Initiative/Report and CQI Team Charter and defined as the Data Collection Plan. Plans should include:
   1. The period of time the data was collected
   2. Identify whether it is a concurrent or retrospective review
   3. Sources of data for collection include, but are not limited to: electronic data bases, patient medical records, log books, surveys, direct observation, occurrence reports, and patient/Family complaints and grievances, and focus group discussions.
   4. The appropriate sample size
   5. The sample size will be representative of the diagnoses of patients' treated and services provided. The review of a patient's clinical record shall be based on a sample of five (5) percent of the total patient census with a minimum of twenty records and a maximum of 100 records every six months.

G. Prior to analysis, data must be validated by identifying the sources and the processes used to collect it. Any analysis of the data must be presented with a definition of the measure and identification of the type of measure (rate, ratio, raw number, etc.)

H. Aggregating and analyzing data allows the organization to draw conclusions about its performance specific to processes or outcomes Data analysis is interdisciplinary when appropriate. Analysis and comparison should include:
   1. Performance compared internally over time (patterns/trends)
   2. Performance compared with similar processes in other organizations
   3. Performance compared to up-to-date external sources (benchmarking)

4. Control limits established for expected variation

I. Using statistical tools and techniques, data is systematically collected and aggregated for analysis, learning, and display. Data and analysis is used to:
   1. Establish the performance baseline as the initial step in assessment and improvement activities
   2. Determine the stability or instability of processes
   3. Describe the dimensions of performance relevant to functions, processes, and outcomes
   4. Identify opportunities where additional data is needed to better understand process or variation

J. At a minimum, the organization collects and analyzes data on the measures listed below:
   1.

XII. Education:

Education on improvement philosophy, strategies and tools in multiple venues throughout the organization that include:

- New employee orientation
- Formal management education in terminology, strategies and tools
- Team education on a annual basis thru "Healthstream"
- Regularly scheduled in-services open to all staff on use of tools and quality improvement processes and methodology
- Departmental in-service programs to meet the needs of the department
- CHHA required in-service training

XIII. Evaluation/Review:

The hospital leadership reviews the effectiveness of the specific annual QA plan at least yearly to ensure that the collective effort is comprehensive and improving patient safety. An annual evaluation is completed by the QA Committee to identify components of the plan that require development, revision or deletion. This evaluation will include the following:

- A description and evaluation of the role the hospital leadership has played in the design and execution of the QA Plan.
- Assessment of the key data trended with comparisons to the benchmarks and the previous calendar year.
- Re-evaluation of the annual quality priorities
- The changes in Home Health processes that were made as a result of the improvement activities
- An assessment of the costs or savings resulting from these changes (if applicable)
- A discussion of whether or not work on this particular area will continue in the next QA Plan year.

Each year, specific goals will be attached to the above summary and be endorsed for implementation in the upcoming year.

The evaluation and goals for the following year are submitted to the Board of Governors on an annual basis. Review and discussion of the evaluation are noted in the minutes of the Board of Governors in addition to approval of the quality goals for the following year.

XIV. Confidentiality:

All Quality Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, TFH Patient Safety Organization and State laws
Confidential information may include but is not limited to:

- Quality Improvement minutes;
- Electronic data gathering and reporting;

- Sentinel event and untoward event reporting; and
- Clinical profiling

Some information may be disseminated on a “need to know basis” as required by agencies such as:
- Federal review agencies;
- Regulatory bodies;
- The National Practitioner Data Bank; or
- Any individual or agency that proved a “need to know basis” as approved by the Medical Executive Committee, Hospital Administration and/or the Governing Board

Relevant information from the following is integrated into quality improvement initiatives in a way consistent with hospital policies or procedures to preserve confidentiality or privileged information established by applicable law:
- Risk management
- Utilization management

XV. Related policies, procedures, and guides:
- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: Jan 31, 2020

XIX. Reviewed by: Performance Advisory Group for Home Health

XX. Approved by:

Jim Sturtevant, MSN, RN, CCRN – Administrative Director of Transitions
Shana Kennon, MSN, RN - Clinical Manager
Jena Raber, Business Manager
Dr. Gina Barta, Medical Director
Chelsea Roth, MSW
Lauren Kilbourne, Quality Coordinator Home Health/Hospice
Judy Newland, CNO
Janet Van Gelder, Director of Quality
Medical Section – Quality Committee
Tahoe Forest Hospital Board of Directors

XXI. References:

- A Comparison of the Federal Home Health Conditions of Participation, California Standards of Quality Home Health Care, and Title 22 Regulations

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Quality Committee and Utilization Review	Quality Committee/Utilization Review takes oversight role to plan and monitor improvement activities in Home Health: • Identifies process Improvement priorities • Quality Team prioritizes improvement projects • Review adverse and sentinel events • Patient/Employee Safety • Infection Control • Performance improvement projects • Statistical Analysis • Monitors to assure that improvements are sustained • Develops and refines the annual Quality Assessment Plan	Administrative Director of Post Acute Services Clinical Manager Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Medical Section Quality Committee	Quarterly meetings with QA Committee One annual meeting with Administrative Director of Post Acute Services Clinical Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Annual review and approval by the Medical Section – Quality Committee	Meeting Minutes

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survey readiness Conditions of participation (COPs), California Home Health Standards and Nevada regulatory services	• Revision of policies and procedures as required – • Ongoing training of staff on COPs & Home Health Standards • Ongoing documentation audits • Chart review as needed per COPs • Mock surveys	QA Committee	Quarterly as needed	Policy review Meeting minutes reflect education plan, audit statistics Written Testing
Infection Control	Track, trend, and identify areas for improvement. Minimize issues related to infection control including but not limited to foley related UTIs, CLABS, and community acquired infections.	QA Committee	Quarterly as needed	Meeting minutes % of infections Annual observation and surveillance of hand washing
Clinical Indicators	• Improvement in Outcomes related to start rating of department • Improvement in Ambulation, Bed transferring, Shortness of breath, Pain interfering w/activity • Drug education on all meds	Clinical Manager Manager Nursing & Therapy staff	Weekly, Monthly as needed	Home Health Compare

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Star Report	Track and Monitor star ratings items through SHP reports for annual improvement in star rating. Focus improvement of scoring as noted above in clinical indicators and • Emergent care needs while on service • Acute care hospitalization • Timely initiation of care	All Staff	Monthly/Weekly, Quarterly as needed	SHP CAHPS
30-day/60-day readmission rate on patients discharge to home health	• Continuous communication between all Post Acute Services and the Inpatient Hospital • % of 30-day readmission • Monitor tracking mechanism for readmissions	QA Committee Home Health Staff	Quarterly as needed	NHPCO Survey
ICD-10 Update **OASIS D** **PDMG**	• Ongoing education to ensure knowledge and skill set related to ICD-10 and changes. • Ongoing communications with financial billing to ensure documentation will support the coding in the HH arena • Updates and education provided to staff for OASIS D changes • Updates and education to staff for PDMG implementation	All Staff HMB Billing Administrative Director	Monthly Review as needed	Coding/Billing/OASIS
Face-To-Face Completion for Home Bound Status with appropriate doc.	• Monitor Face to Face completeness, Daily recording of completion and compliance	Clinical Manager Business Manager	Monthly/Weekly, Quarterly as needed	Chart review

Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
HHCAHPS Survey for patient perceptions	• Priority Index Action plan on lowest HHCAHPS indicators • Increase survey return rate	QA Committee	Quarterly review	HHCAHPS Survey Department Scorecard N=from HHCAHPS Survey
Oversight/communication	• Annual executive summary to Quality Committee • Annual approval of quality plan to Medical Section Quality Committee • Bi Annual quality reports to the Medical staff Quality and Quality Committee • Staff meeting updates • Accident reports • Patient perceptions/grievances • HHCAHPS Satisfaction Survey Results • Performance boards • Internal communication process	QA Committee	Bi-monthly, Bi-Annual, quarterly and annually as needed	Meeting Minutes Quantros Scorecard

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Staff Competency	• Annual educational needs assessment of staff • Annual infection control education • Annual competencies via healthstreams • Ongoing educational instruction for staff at meetings as identified • Annual direct observation of field staff by supervisor • Annual regulatory compliance Healthstream • Continuing education provided to CHHA (minimum of 12 hours a year CMS requirement) • Completion of "Your Legal Duty" upon hire of new employees	TFHD Education department Clinical Manager NUBE Manager QA Committee	Competency training at least annually	Healthstream Completion Reports
Employee Satisfaction	Shared decision-making model for governance, employee gainsharing program with a minimum Quality score and total profit for hospital system.	Home Health and Home Health Staff	As needed	Employee Satisfaction Survey Employee Gainsharing

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Budget daily census • Productivity	Review budgets and productivity: • Benchmark data for maximum productivity standards • Develop staffing patterns that are consistent with meeting 100% productivity • Total expense to budget (within 3%) Performance improvement projects as needed	Quality Committee Administrative Director Clinical Manger Manager Home Health Quality Committee	Daily, Weekly, and Monthly	Average Daily Census Budget Advisor Budget vs. Actual Productivity Monitoring system in conjunction with ADP
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Administrative Director	Semi-Annually	Contract spreadsheet

Growth				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Strategies for growth and partnerships in region	Develop a strategic plan for growth in Home Health • Benchmark data • Staff visit to physicians • Regular communication with partners • CHA forums	Administrative Director, Clinical Manager, Manager, or Medical Director Clinical Manager may appoint a designee to attend if needed	As needed	Volume Net Income
Education of staff and community	Identify needs of the community and staff though: • Media • Community presentations • County program • Staff input • Director and Administrative leadership • Customer input • Other	QA Committee Manager	As needed	Volume

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

SPECIALTY: FAMILY MEDICINE **NAME:** _____
Please Print

Check one or more:
- □ **Tahoe Forest Hospital (TFH)**
- □ **Incline Village Community Hospital (IVCH)**
- □ **Multi-Specialty Clinics (Tahoe Forest Health System)**
- □ **Ski Clinic**

Check one: □ **Initial** □ **Change in Privileges** □ **Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in Family Medicine, or internal medicine if requesting privileges for pediatrics or urgent care.
Board Certification:	Board qualification/certification required. Current ABFP Board Certification (or AOA equivalent Board); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required for reappointment eligibility. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges.*
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has managed minimum number of hospital patients as indicated for each core group within the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. (At least one peer reference must be a Family Medicine practitioner.) Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring and evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA and/or NV • Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in NV • Ability to participate in federally funded program (Medicare or Medicaid) • ATLS – required to provide services at all ski clinics. (ATLS required within 12 months of initial appointment to the Ski Clinic(s))

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. **Unless otherwise noted, privileges are available at both Hospitals, and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
□	□	**BASIC – ADULT FAMILY MEDICINE OUTPATIENT** Basic privileges include the ability to review medical records, order outpatient labs and studies, and receive results of inpatient and/or outpatient lab/radiology studies, and records. Must include management of at least 50 adults within the last two years for initial appointment.	_____			
□	□	**BASIC – ADULT FAMILY MEDICINE INPATIENT/HOSPITAL** Basic privileges in adult inpatient family medicine include the ability to admit, perform histories and physicals, evaluate, treat and provide non-surgical care to patients above 14 years of age to correct or treat various conditions, illnesses, injuries, including geriatric disorders, and medical consultation. Includes ability to admit to critical care unit per medical staff rules and regulations, swing bed admissions, consultation/admission from emergency room, and Extended Care Center (long term care). Must include management of at least 50 hospital adult patients within last two years for initial appointment. **Cross out & INITIAL any privilege(s) you are not applying for in this set of Basic Privileges in outpatient or inpatient/hospital privileges** Management of general medical conditions privileges include: Allergy/Rheumatology • Anaphylaxis • Autoimmune Hematological Disorders • Arthritis • Gout • Lupus erythematosus • Scleroderma • Serum sickness • Vasculitis Cardiac / Vascular Diseases • Bacterial endocarditis • Cardiac arrhythmias • Congenital heart disease • Congestive heart failure – acute and chronic • Coronary artery disease – stable and unstable • EKG interpretations • Hypertension • Lipodystrophies • Myocardial infarction • Myocarditis • Pericarditis • Rheumatic fever				

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		• Vascular arterial insufficiency • Chest pain Gastrointestinal Diseases • Cholecystitis • Cirrhosis • Dehydration • Diverticulitis • Gastrointestinal bleeding and fecal occult blood testing • Hepatitis • Inflammatory bowel disease • Intestinal obstruction • Malabsorption • Pancreatitis • Peptic Ulcer Disease • Trauma GU/Gynecology • Prostatitis • Urethritis • UTI • Pyelonephritis • Trauma • STI • Endometriosis • DUB • Amenorrhea • Breast Mass • Mastitis • Galactorrhea • Contraceptive Management • Family Planning Hematologic Diseases • Aplastic and hemolytic anemia • Hemorrhagic diathesis • Hemophilia • Thrombosis / Thromboembolism • Iron-deficiency anemia requiring transfusion • Leukemia Metabolic and Endocrine Disorders • Addison's Disease • Aldosteronism • Cushing's syndrome • Diabetes mellitus Type I including acidosis, coma • Diabetes mellitus Type II • Disturbance of water/electrolytes • Parathyroid conditions • Pheochromocytoma • Pituitary conditions • Sex hormone abnormalities • Thyroid conditions including coma and thyrotoxic crisis Neurological Diseases • Degenerative diseases • Demyelinating disorders				

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		• Meningitis/encephalitis • Parkinson's disorder • Seizure disorders • Stroke – acute and rehabilitation • Trauma Pulmonary Diseases: • Asthma • Emphysema/ COPD • Hemothorax • Pneumonia, complicated and uncomplicated • Pneumothorax • Pulmonary embolism • Pulmonary infarction • Respiratory Distress • Trauma Renal Diseases • Acute and chronic insufficiency • Nephritis • Nephrolithiasis • Obstructive nephropathy • Pyelonephritis • Trauma Miscellaneous • Alcohol/Drug intoxication and overdose • Acute Pain • Chemotherapy treatment under supervision • Fat embolism • Infections • Malignant neoplasms • Non-operative ENT conditions • Non-operative orthopedic fractures/ Dislocations • Osteomyelitis • Post-operative care • Psychiatric disorders • Sepsis				
□	□	**HOSPITAL PROCEDURES:** • Cardiac EKG stress testing • EKG and rhythm strip analysis • Ventilation Management • I&D (incision and drainage)				

□	□	**OUTPATIENT PROCEDURES:**
		• Endometrial Biopsy
		• I&D (incision and drainage)
		• IUD Insertion/Removal
		• Microscopy
		  ○ Urinalysis
		  ○ Saline Wet Mount
		  ○ Potassium Hydroxide Wet Mount
		• Amine Test
		• Nexplanon Insertion/Removal (Certificate of Training Required)				

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		• Removal of non-penetrating foreign body from the eye, nose, ear or vagina • Simple fractures and dislocation management, including splinting and casting • Skin biopsy or excision • Suture lacerations • Anesthetic & Trigger point injections • Spirometry/ Peak Flows • EKG and rhythm strip analysis • Teaching of PT/rehab activities • Urinary Catheterization • Ear lavage and cerumen extraction • FB removal • Joint Aspirations and Injections • Wound Debridement • Venipuncture and IV insertion • Cryotherapy				
☐	☐	**BASIC – PEDIATRIC FAMILY MEDICINE OUTPATIENT** Basic privileges in pediatric family medicine include the ability to perform histories and physicals, evaluate and provide non-surgical care to patients 14 and under. Must include management of at least 15 pediatric patients within last two years for initial appointment. **Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges** Management of general medical pediatric privileges include: • Anemia • Asthma • Behavior problems / Psychiatric • Failure to thrive • Hyperbilirubinemia in newborn • Hypoglycemia in newborn • Infections • Respiratory distress syndrome • Well Child Care • Contraceptive Management • Trauma • Non-operative fracture management **SURGERY/PROCEDURES** • I&D (incision and drainage) • Removal of non-penetrating foreign body from the eye, nose, ear or vagina • Simple fractures and dislocation management, including splinting and casting • Skin biopsy or excision • Suture lacerations (uncomplicated) • Anesthetic & Trigger point injections • Spirometry/ Peak Flows • EKG and rhythm strip analysis • Teaching of PT/rehab activities • Urinary Catheterization • Ear lavage and cerumen extraction	_____			

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		• FB removal • Joint Aspirations and Injections • Venipuncture and IV insertion • Cryotherapy				
☐	☐	**BASIC – PEDIATRIC FAMILY MEDICINE INPATIENT** Inpatient newborn care privileges which includes admission, evaluation of newborn infant, evaluation of newborn conditions, including but not limited to: • Hypoglycemia • Hyperbilirubinemia • Infection • GBS exposure		Newborn admits at TFH only		
☐	☐	**URGENT CARE – ADULT and PEDIATRIC MEDICINE (Must also request Family Medicine Privileges** • ACLS Required (Certification Required within 6 months of Initial Appointment and Current Thereafter) Management of general medical conditions privileges include: PROCEDURES • Dislocation and Fracture Reductions • IM injections • IV injections • IO insertion DIAGNOSES • Adult and Pediatric dislocations	_____	TFHS URGENT CARE CLINICS	Review of 10 representative cases	Current demonstrated competence and provision of care for approximately 25 urgent care cases in past two years. Office records may be requested. *

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES – URGENT CARE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**	Estimate # of procedures performed in the past 24 months		Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required or privilege specific CME
☐ ☐	☐ ☐	**Cardiac EKG stress testing:** • Treadmill • Nuclear medicine	_____		3 cases proctored	5 cases/2 years
☐	☐	**Chest tube placement**	_____		1 case proctored	Current demonstrated competence and provision of care
☐	☐	**Circumcision (newborn only)**	_____	TFH only	3 cases proctored	5 cases/2 years If insufficient cases, add'l proctoring may be required.
☐	☐	**Stool Guaiac Testing**				
☐	☐	**Thoracentesis**	_____		1 case proctored	Current demonstrated competence and provision of care
☐	☐	**Lumbar Puncture**	_____		1 case proctored	Current demonstrated competence and provision of care
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____ _____

Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:
□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

_____ _____
Date Department Chair Signature

Modifications or Other Comments:
_____

Medical Executive Committee:_____ (date of Committee review/recommendation)
□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

Board of Directors:_____(date of Board review/action)
□ privileges as requested □ with modifications (see attached description of modifications) □ not approved (explain)

Form Approval/Revision Dates:
Medicine Department: 8/2/07
OB/Peds Department: 7/5/07
Updated: 11/2016- See Proctoring Policy

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

SPECIALTY: INTERNAL MEDICINE **NAME:** _____
(Please print)

~~**Check one or both: □ Tahoe Forest Hospital (TFH) □ Incline Village Community Hospital (IVCH)**~~

~~**Check one: □ Initial □ Change in Privileges □ Renewal of Privileges**~~

Check one or more:

□ Tahoe Forest Hospital (TFH)
□ Incline Village Community Hospital (IVCH)
□ Multi-Specialty Clinics (Tahoe Forest Health System)

Check one: □ Initial □ Change in Privileges □ Renewal of Privileges

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Core Education:	MD or DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in Internal Medicine. See additional sub specialty requirements related to residencies, fellowships
Board Certification:	Board qualification/certification required. Current ABIM Board Certification (or AOA equivalent Board); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges (applies to all specialties).*
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has managed minimum number of hospital patients as indicated for each core group within the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. (At least one peer reference must be a general internist) Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring, evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA and/or NV • Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in NV • Use of Fluoroscopy Equipment: Current State of California Department of Health Services fluoroscopy certificate required.

	• Ability to participate in federally funded program (Medicare or Medicaid)

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. **Unless otherwise noted, privileges are available at both Hospitals and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
☐	☐	**BASIC – ADULT INTERNAL MEDICINE OUTPATIENT** Basic privileges include the ability to review medical records, order outpatient labs and studies, and receive results of inpatient and/or outpatient lab/radiology studies, and records. Must include management of at least 50 adults within the last two years for initial appointment.	_____	Inpatient Outpt	Review of 10 representative cases	Current demonstrated competence and provision of care for approximately 25 inpatients (can include some outpatients), together with some procedures in last 24 months * Insufficient pt care activity may require proctoring and/or privilege specific CME * some must be inpatient
☐	☐	**Core Internal Medicine - Non Procedural** Core privileges in internal medicine include the ability to admit(including swing admissions, critical care unit per medical staff rules and regulations, and ECC long term care), perform H&Ps, work up, consult, and provide non-surgical care to patients for illnesses, injuries, and disorders of general medical problems. Must include management of at least 50 hospital adult patients within the last two years. **Cross out/INITIAL any privilege/s you are not applying for in this set of Core Privileges** Management of general medical conditions include: Allergy/Rheumatology • Anaphylaxis • Dermatomyositis • Lupus erythematosis • Necrotizing granulomatosis • Periarteritis nodosa • Schleroderma • Serum sickness • Thrombotic thrombocytopenia purpura • Urticaria Arthritis • Gout • Inflammatory arthritis • Osteoarthritis • Rheumatoid arthritis Cardiac Diseases • Bacterial endocarditis • Cardiac arrhythmias • Congenital heart disease • Congestive heart failure – acute and chronic • Coronary artery – stable and unstable • EKG interpretations • Hypertension • Lipodystrophies • Myocardial infarction including thrombolytic therapy • Myocarditis				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		• Pericarditis • Rheumatic fever Gastrointestinal Diseases – no procedures included • Cholecystitis • Cirrhosis • Diverticulitis • Hepatitis • Inflammatory bowel disease • Intestinal obstruction • Malabsorption • Pancreatitis • Peptic Ulcer • Trauma • Upper and lower GI bleeds Hemotologic Diseases • Aplastic and hemolytic anemia • Hemorrhagic diathesis • Hemophilia • Thromboembolism • Iron deficiency anemia requiring transfusion • Leukemia Metabolic and Endocrine Disorders • Addison's Disease • Aldosteronism • Cushing's syndrome • Diabetes mellitus Type I including acidosis, coma • Diabetes mellitus Type II • Disturbance of water/electrolytes • Parathyroid conditions • Pheochromocytoma • Pituitary conditions • Sex hormone abnormalities • Thyroid conditions including coma and thyrotoxic crisis Neurological Diseases • Degenerative diseases • Demyelinating disorders • Encephalopathy • Meningitis/encephalitis • Parkinson's • Seizure disorders • Stroke –acute and rehabilitation • Trauma Pulmonary Diseases: • Asthma • COPD • Hemothorax • Interstitial lung disease • Pneumonia, complicated and uncomplicated • Pneumothorax • Pulmonary embolism • Pulmonary infarction • Trauma				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		Renal Diseases • Acute and chronic insufficiency • Nephritis • Obstructive nephropathy • Pyelonephritis • Trauma Miscellaneous • Alcohol/Drug intoxication and overdose • Chemotherapy treatment under supervision • Fat embolism • Malignant neoplasms • Non-operative ENT conditions • Non-operative orthopedic fractures • Osteomyelitis • Post-operative care • Psychiatric disorders • Sepsis • Vascular arterial insufficiency				
☐	☐	**CORE – SURGERY/PROCEDURES** Must be able to document participation in at least 25 cases during past two years. **Cross out & INITIAL any privilege/s you are not applying for in this set of Core Privileges** Core privileges include the performance of procedures and/or assisting in the following areas: • Arthrocentesis • I&D (incision and drainage) abscesses • Lumbar Puncture • Perform simple skin biopsy or excision • Peripheral arterial puncture • Percutaneous venous catheter placement • Remove non-penetrating foreign body from the eye, nose, or ear • Manage uncomplicated closed fractures and dislocations including splinting and casting • Suture uncomplicated lacerations • Ventilator management, including endotracheal intubation with appropriate consultation per medical staff rules	_____		3 cases proctored of various procedures	Current demonstrated competence and provision of care for approximately 15 inpatients and outpatients. Office records may be requested for review* *Some must be inpatient
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**				
☐	☐	**Arterial Line placement** Documentation of training/experience	_____		2 cases proctored for each kind of biopsy	Current demonstrated competence and provision of care
☐	☐	**Biopsies (invasive)** • Bone marrow • Liver __ Lung (must be boarded in pulmonary medicine)	_____		2 cases proctored for each kind of biopsy	Current demonstrated competence and provision of care

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		Documentation of training/experience				
☐	☐	**Bronchoscopy** Board certified in pulmonology	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Cardiac EKG stress testing – treadmill and nuclear medicine testing** Documentation of training/experience in the ability to rapidly recognize, diagnose and treat a life-threatening cardiac arrhythmias.	_____	TFH/IVCH	2 cases proctored prior to performing unsupervised Stress EKGs.	5 cases/2 years
☐	☐	**Trans Thoracic Echoes** Cardiology Fellowship or documentation of training/experience	_____	TFH only	2 cases proctored	5 cases/2 years
☐	☐	**Central venous line insertion** Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Chest tube placement** Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Elective Cardioversion** Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Occult Blood Testing** Completion of competency provided under separate cover	_____		None	None
☐	☐	**Intravenous Procedural Sedation** See attached criteria	NA		Successfully complete test	Maintain privileges requiring the procedure
☐	☐	**Use of Propofol is limited to the ED and ICU. The physician must complete the additional credentialing requirements for the use of Propofol.**	Emergency Department ICU	TFH only	Successfully complete test	Successfully Complete test
☐	☐	**Gastric Occult Testing**		TFH IVCH	Successfully complete competency	Demonstration of ongoing work in the Medicine Department
☐	☐	**EKG interpretation** Documentation of training/experience	_____	TFH IVCH		Current demonstrated competence and provision of care
☐	☐	**Dermatology** Consultation Chemical Peel Cyrosurgery Curettage and Dessication Dermabrasion Excision of Cutaneous Lesions Complex Excision of Cutaneous Lesions Simple Skin Biopsy Nail avulsion Completion of am ACGME or AOA approved residency training in	_____	TFH IVCH	5 proctored cases	Current demonstrated competence and provision of care

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		Dermatology and Board certified within 5 years of completion of training)				
☐	☐	**Endocrinology** Core privileges in endocrinology include the ability to admit (including swing admissions and ECC long term care), diagnose, treat, and provide consultation to patients of all ages with injuries or disorders of the internal (endocrine) glands, such as the thyroid and adrenal glands. Core privileges also include management of disorders such as diabetes, metabolic and nutritional disorders, obesity, pituitary diseases, and menstrual and sexual problems and non-surgical care to patients. Endocrinologists may assess, stabilize, and determine disposition of patients with emergency conditions consistent with staff policy regarding emergency and consultative call services. • Performance of history and physical exam • Interpretation of laboratory studies, including the effects of non-endocrine disorders • Interpretation of hormone assays • Performance and interpretation of stimulation and suppression tests • Performance of fine needle aspiration thyroid, parathyroid and lymph nodes of the neck • Ultrasonography of the soft tissues of the neck Completion of ACGME/AOA accredited residency program or clinical fellowship within the past 12 months in endocrinology (and Board certified within 5 years of completion of training)	_____	TFH IVCH	Review of 10 representative cases	Current demonstrated competence and provision of care for approximately 25 inpatients (can include some outpatients), together with some procedures in last 24 months.
☐	☐	**Gastroenterology** Core privileges in gastroenterology include the ability to admit (including swing admissions, critical care unit per medical staff rules and regulations, and ECC long term care), perform H&Ps, work up, consult, and provide non-surgical and surgical care to patients of all ages. Must include management of at least 50 hospital patients within the last two years. • Bougie Dilation • Capsule endoscopy • Colonoscopy with/without biopsy • EGD – with biopsy, hemorrhage control, • ERCP – with sphincterotomy, stent placement, nasobiliary drain placement, stone extraction, lithotripsy, or biopsy • Esophageal stent placement • Flexible sigmoidoscopy (with/without biopsy)/rigid sigmoidoscopy/anoscopy • Foreign body removal, sclerotherapy and banding of upper GI varices • Percutaneous endoscopic gastrostomy • Percutaneous Liver biopsy • Peritoneoscopy for diagnosis and treatment • Colonpolypectomy • Proctosigmoidoscopy Completion of ACGME/AOA accredited residency program in gastroenterology (and Board certified within 5 years of completion of training.)	_____	TFH only	1st case proctored and 4 add'l cases representative cases proctored	50 cases/2 years
☐	☐	**Fluoroscopy**	_____		None	maintain current certificate

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		Current Department of Health Services fluoroscopy certificate (required in CA only)				(CA only)
☐	☐	**Oncology – provided service to at least 6 oncology patients in last 12 months** Successful completion of an accredited training program in oncology. Current Board certification within five years of completion of training program. Admit, evaluate, diagnose, treat and provide consultation to patients of all ages, except as specifically excluded from practice, with all types of cancer and other benign and malignant tumors. Includes: • Bone marrow biopsy and interpretation • Administration of chemotherapy agents and biological response modifiers through all therapeutic routes; • Management and maintenance of indwelling venous access catheters.	_____	**TFH only**	10 cases will be reviewed	10 cases/2 years and Current demonstrated competence and provision of care
☐	☐	**Oncology – provided service to at least 6 oncology patients in last 12 months** Successful completion of an accredited training program in oncology. Current Board certification within five years of completion of training program. Treatment of cancer or hematology patients on an outpatient basis for dehydration, injections including but not limited to Neulasta, Procrit, or administration of blood products, etc.	_____	**IVCH**	10 cases will be reviewed	10 cases/2 years and Current demonstrated competence and provision of care
☐	☐	**Paracentesis** Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Pericardiocentesis** Board certified cardiologist, OR Documented training, experience must be submitted for consideration.	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Pulmonary artery catheter insertion and management** Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Sleep medicine studies** – admission, evaluation, interpretation, and/or treatment Documentation of AASM or ACGME training; board certification in sleep medicine required; submission of case summaries if requested	_____	IVCH only	5 cases reviewed	Based on objective results of care through quality review mechanism If no cases, CME required
☐	☐	**Temporary Transvenous Pacemaker Insertion** Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
☐	☐	**Thoracentesis**	_____		2 cases proctored	Current demonstrated competence and

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		Documentation of training/experience				provision of care
☐	☐	**TEE (Transesophageal Echocardiogram)** Fellowship in cardiology or documentation of a successful completion of approved course related to TEE performance and interpretation, including preceptored cases	_____		2 cases proctored	Current demonstrated competence and provision of care If no cases, CME required
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____ _____
Date Applicant's Signature

DEPARTMENT CHAIR REVIEW
I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:
□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

_____ _____
Date Department Chair Signature

Modifications or Other Comments:
_____
_____

Medical Executive Committee:_____ (date of Committee review/recommendation)
□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

Board of Directors:_____(date of Board review/action)
□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

Modifications or Other Comments:
_____
_____

Department Review Dates: 2/07/2008, 3/2015; 01/04/19
Medical Executive Committee: 2/20/2008; 4/15/2015; 01/22/19
Board of Directors: 2/26/2008; 4/28/2015; 01/29/19

TAHOE FOREST HOSPITAL DISTRICT
Department of Surgery
Delineated Clinical Privilege Request

SPECIALTY: ORTHOPEDIC SURGERY **NAME:** _____
(Please print)

~~**Check one or both: □ Tahoe Forest Hospital (TFH) □ Incline Village Community Hospital (IVCH)**~~
~~**Check one: □ Initial □ Change in Privileges □ Renewal of Privileges**~~

Check one or more:
- **□ Tahoe Forest Hospital (TFH)**
- **□ Incline Village Community Hospital (IVCH)**
- **□ Multi-Specialty Clinics (Tahoe Forest Health System)**

Check one: □ Initial □ Change in Privileges □ Renewal of Privileges

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Core Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-accredited residency training program in orthopedic surgery.
Board Certification:	Board certified or board eligible by the American Board of Orthopedic Surgery required. (or AOA equivalent Board - ABOS); or attain Board Certification within five years of completion of residency or fellowship training program. Maintain board certification and to the extent required by the specialty board, satisfy recertification requirements. .
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has managed orthopedic care for 100 hospital orthopedic surgery cases in the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. At least one peer reference must be an orthopedic surgeon.
Proctoring Requirements:	See "additional criteria" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring, evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA and/or NV • **Current State of California Dept. of Health Services Fluoroscopy certificate required (TFH only)** • Malpractice insurance in the amount of $1m/$3m, minimum. • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or DEA to practice in the (NV) with an unrestricted Nevada State Board of Pharmacy Certificate • Ability to participate in federally funded program (Medicare or Medicaid).

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name:** _____

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

Applicant: Place a check in the (R) column	**APPROVED**	**GENERAL PRIVILEGES - ORTHOPEDIC SURGERY**	Estimate # of procedures performed in the past 24 months	Setting	Proctoring	Reappointment Criteria
☐	☐	**Core Privileges:** History and Physical examinations. Admitting privileges for patients related to orthopedic procedures including swing admissions. Core privileges in orthopedic surgery include the ability to admit, work up, and provide nonsurgical and surgical care to patients of all ages to correct or treat various conditions, illnesses, injuries, an disorders of the musculoskeletal system, its articulations and associated structures, including joints, ligaments, and tendons and the provision of consultation. Core privileges also include the performance of procedures in the following areas**:** • Amputation • Arthrodesis • Arthroplasty • Arthroscopy • Arthrotomy, ligament repair and/or reconstruction of joints (ankle, knee, hip, shoulder, elbow, wrist, hand) • Casting • Closed reduction • Excision of ganglion/mass • Laceration repair • Management of benign and malignant tumors • Metastatic disease • Microdissection • Orthotics and prosthetics • Osteotomy • Peripheral nerve surgery • Repair of tendons, primary or secondary • Simple and complex suture repair and excision of benign skin lesions • Skin grafting • Tenotomy • Wounds major • **Fluoroscopy** [Current CA Department of Health Services fluoroscopy certificate (required in CA only)]	_____	Both Hospitals TFH Only	First case proctored and four add'l cases proctored of various procedures	50 cases/2 years Maintain Current Fluoroscopy License (CA Only)

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name:** _____

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

☐	☐	**Core Privileges - OUTPATIENT** History and Physical examinations. Admitting privileges for patients related to orthopedic procedures including swing admissions. Core privileges in orthopedic surgery include the ability to admit, work up, and provide nonsurgical and surgical care to patients of all ages to correct or treat various conditions, illnesses, injuries, an disorders of the musculoskeletal system, its articulations and associated structures, including joints, ligaments, and tendons and the provision of consultation. Core privileges also include the performance of procedures in the following areas: • Amputation • Casting • Closed reduction • Excision of ganglion/mass • Joint Aspiration/ Injection • Laceration repair • Management of benign and malignant tumors • Metastatic disease • Minor Hardwar Removal • Minor Skin Wound Debridement • Orthotics and prosthetics • Repair of tendons, primary or secondary • Simple and complex suture repair and excision of benign skin lesions • Tenotomy • Wounds major • **Fluoroscopy** [Current CA Department of Health Services fluoroscopy certificate (required in CA only)]	_____	TFHS MSC CLINICS TFH Only	First case proctored and four add'l cases proctored of various procedures	50 cases/2 years Maintain Current Fluoroscopy License (CA Only)
☐	☐	Surgical Assist Only				
☐		REMOVAL FROM CORE PRIVILEGES: Should applicant's current practice limitations or current competence exclude performance of any privileges specified in the list of Core privileges, please indicate here. Applicant and/or MEC must document reasons for exclusion. _____ _____ _____				
REQUESTED	**APPROVED**	**SELECTED PROCEDURES** **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**	Estimate # of procedures performed in the past 24 months	Setting	Proctoring	Reappointment Criteria
☐	☐	**Intravenous Procedural Sedation** – See attached criteria Successful completion of conscious sedation written exam	NA		Take and pass the test	Maintain privileges requiring this procedure

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TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name:** _____

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

☐	☐	**Spinal procedures – cross out any procedures not applied for:** • Anterior endoscopic spine surgery • Discectomy • Fusion with or without instrumentation • Laminectomy • Scoliosis surgery • Spinal decompression • Outpatient spine surgery Documentation of one year fellowship in spinal surgery with documentation provided by training director (or program completion documentation if over 5 years) and/or current competence references from facility where procedures are currently being performed. Minimum of 100 procedures performed within last two years. ☐ **Kyphoplasty** Documentation of completion of spine fellowship program in spinal surgery and completion of Kyphon Inc. training course including • Indications, techniques, outcomes, complications • Anatomy • Hands-on laboratory experience (provide documentation of course) Provide documentation of performing at least 10 cases with acceptable success and complication rates submitted in case listing. Letter of reference will be obtained from director of program and department chair where applicant most recently practiced.	_____	TFH only TFH only	First case to be proctored and evaluated Plus 4 add'l cases First 2 cases proctored	50 assorted cases/2 years 5 cases/ two years or add'l proctoring required
☐	☐	**Use of Laser – what type:** _____ (must currently be available at hospital) _____ Included in residency/fellowship program (must be confirmed) _____ Documentation of course inc. hands on surgery and evaluation of procedures performed	_____	TFH only	First 2 cases proctored	2 cases/2 years
☐	☐	**Re-implantation** Documentation of training in this area with documentation provided by training program/director. Documentation of hand surgery fellowship and recent experience	_____	TFH only	First 2 cases proctored	20 cases/2 years
~~☐~~	~~☐~~	~~**Fluoroscopy**~~ ~~Current Department of Health Services fluoroscopy certificate (required in CA only)~~	~~_____~~	~~Both hospitals~~	~~none~~	~~Maintain current certificate (CA only)~~
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				

TAHOE FOREST HOSPITAL DISTRICT

Department of Surgery **Name:** _____

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____ _____
Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

_____ _____
Date Department Chair Signature

Modifications or Other Comments:

_____

_____

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)
Medical Executive Committee:_____ (date of Committee review/recommendation)

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)
Board of Directors:_____ (date of Board review/action)

Form Approval/Revision Dates:
Department II: 3/12/07, 5/07; 9/09; 10/10/2016; 04/09/2018
Medical Executive Committee: 3/21/07; 5/07; 1019/2016; 01/19/17; 05/17/2018
Board of Directors: 3/27/07; 5/07; 1027/2016; 01/26/17; 05/24/2018

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, January 23, 2020 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 4:06 p.m.

2. ROLL CALL
Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Art King, Secretary; Dale Chamblin, Treasurer

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Karen Baffone, Chief Nursing Officer; Dr. Shawni Coll, Chief Medical Officer; Matt Mushet, In-house Counsel; Scott Baker, VP Provider Services; Janet Van Gelder, Director of Quality; Dawn Colvin, Patient Safety Officer; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
Board Chair pulled items 5 and 6 from the agenda.

4. INPUT AUDIENCE
No public comment was received.

5. BOARD VACANCY APPOINTMENT
Item was removed from the agenda.

6. BOARD MEMBER OATH OF OFFICE
Item was removed from the agenda.

CMO departed the meeting at 4:08 p.m.
Open Session recessed at 4:08 p.m.

7. CLOSED SESSION

7.1. Conference with Legal Counsel; Anticipated Litigation (Gov. Code § 54956.9(d)(2) & (d)(3))

A point has been reached where, in the opinion of the Board on the advice of its legal counsel, based on the below-described existing facts and circumstances, there is a significant exposure to litigation against the District.

Receipt of Claim pursuant to Tort Claims Act or other written communication threatening litigation (copy available for public inspection in Clerk's office). (Gov. Code 54956.9 (e)(3))

Name of Person Threatening Litigation: Robert Lynn
Discussion was held on a privileged item.

7.2. Hearing (Health & Safety Code § 32155)
Subject Matter: Quality Assurance Report
Number of items: One (1)
Discussion was held on a privileged item.

7.3. Hearing (Health & Safety Code § 32155)
Subject Matter: Fourth Quarter 2019 Corporate Compliance Report
Number of items: One (1)
Discussion was held on a privileged item.

7.4. Approval of Closed Session Minutes
12/19/2019
Discussion was held on a privileged item.

7.5. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)
Subject Matter: Medical Staff Credentials
Discussion was held on a privileged item.

8. DINNER BREAK

9. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 6:00 p.m.

10. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel reported the board considered five items in closed session. There were no reportable actions on items 7.1.- 7.3. Item 7.4. Closed Session Minutes was approved on a 4-0 vote. Item 7.5. Medical Staff Credentials was also approved on 4-0 vote.

11. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
Items 5 and 6 were pulled from the agenda.

12. INPUT – AUDIENCE
No public comment was received.

13. INPUT FROM EMPLOYEE ASSOCIATIONS
No public comment was received.

14. SAFETY FIRST
14.1. Chief Nursing Officer Karen Baffone presented the January Safety First Topic on coronavirus.

15. ACKNOWLEDGMENTS
15.1. Dan Dotta was named January 2020 Employee of the Month.
15.2. Tahoe Forest Hospital received recognition from CHHS for the 2019 Opioid Care Honor Roll Program.

16. MEDICAL STAFF EXECUTIVE COMMITTEE

16.1. Medical Executive Committee (MEC) Meeting Consent Agenda

MEC recommends the following for approval by the Board of Directors:

Annual Policy Review (no content changes)

- *Postpartum-Post Partum Hemorrhage, DWFC-1490*
- *Labor-Trial of Labor after Cesarean, DWFC-1502*

Discussion was held.

ACTION: Motion made by Director King, seconded by Director Chamblin, to approve the Medical Executive Committee Meeting Consent Agenda as presented.
AYES: Directors Chamblin, King, Brown and Wong
Abstention: None
NAYS: None
Absent: None

17. CONSENT CALENDAR

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

17.1. Approval of Minutes of Meetings

17.1.1. 12/19/2019

17.2. Financial Reports

17.2.1. Financial Report – December 2019

17.3. Staff Reports

17.3.1. CEO Board Report
17.3.2. COO Board Report
17.3.3. CNO Board Report
17.3.4. CIIO Board Report
17.3.5. CMO Board Report

17.4. Approve Resolution of Endorsement for Mountain Gateway Center

17.4.1. Resolution 2020-01

17.5. Approve Resolution Adopting Board Compensation Policy

17.5.1. Resolution 2020-02

No public comment was received.

ACTION: Motion made by Director Brown, seconded by Director King, to approve the consent calendar as presented.
AYES: Directors Chamblin, King, Brown and Wong
Abstention: None
NAYS: None
Absent: None

18. ITEMS FOR BOARD DISCUSSION

18.1. Retirement Committee Update

Brian Montanez of Multnomah Group provided a semi-annual update from the Retirement Committee.

The Board of Director directed the Retirement Committee to bring a redline version of the charter to the next board meeting.

18.2. BETA HEART Update

Patient Safety Officer provided an update on the five domains of the BETA HEART program.

18.3. Navigation Program Update

CNO provided an update on the District's Care Navigation program.

18.4. Board Education

18.4.1. Rural Health Clinics

VP Provider Services provided education on rural health clinics.

19. ITEMS FOR BOARD ACTION

19.1. Corporate Compliance Report

Jim Hook of the Fox Group, Corporate Compliance Officer, presented Fourth Quarter 2019 Corporate Compliance Report. Discussion was held.

ACTION: **Motion made by Director Chamblin, seconded by Director King, to approve the Fourth Quarter 2019 Corporate Compliance Report.**
AYES: Directors Chamblin, King, Brown and Wong
Abstention: None
NAYS: None
Absent: None

19.2. Corporate Compliance Work Plan

Jim Hook of the Fox Group, Corporate Compliance Officer, presented 2020 Corporate Compliance Work Plan.

Public comment was received from Judy Newland, Chief Operating Officer.

ACTION: **Motion made by Director Brown, seconded by Director King, to approve the 2020 Corporate Compliance Work Plan.**
AYES: Directors Chamblin, King, Brown and Wong
Abstention: None
NAYS: None
Absent: None

20. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Not applicable.

21. BOARD COMMITTEE REPORTS

Director Chamblin provided an update from yesterday's Board Finance Committee. CFO provided

additional information on challenges the District is facing with its accounts receivables post conversion.

Director Brown provided an update from yesterday's Board Quality Committee.

Director Wong shared an update from the January Tahoe Forest Health System Foundation meeting.

22. BOARD MEMBERS REPORTS/CLOSING REMARKS
Director King reported Best of Tahoe Chefs is set for May 31, 2020 this year.

23. CLOSED SESSION CONTINUED, IF NECESSARY
Not applicable.

24. OPEN SESSION

25. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY

26. ADJOURN
Meeting adjourned at 7:37 p.m.

TAHOE FOREST HOSPITAL DISTRICT
JANUARY 2020 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

JANUARY 2020 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the seven months ended January 31, 2020.

Activity Statistics

- TFH acute patient days were 434 for the current month compared to budget of 434. This equates to an average daily census of 14.0 compared to budget of 14.0.

- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Hospice visits, Surgery cases, Pain Clinic procedures, Diagnostic Imaging, Mammography, Radiation Oncology procedures, CAT Scans, PET CT, Respiratory Therapy, Tahoe City Physical Therapy, Tahoe City Occupational Therapy, Physical Therapy, Speech Therapy, and Occupational Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 48.6% in the current month compared to budget of 49.7% and to last month's 50.1%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue was 49.9% compared to budget of 49.8% and prior year's 51.2%.

- EBIDA was $1,607,538 (4.4%) for the current month compared to budget of $2,178,391 (6.1%), or $570,853 (1.7%) below budget. Year-to-date EBIDA was $18,239,388 (7.6%) compared to budget of $10,750,675 (4.7%), or $7,488,713 (2.9%) above budget.

- Net Income was $948,603 for the current month compared to budget of $1,765,704 or $817,101 below budget. Year-to-date Net Income was $14,218,759 compared to budget of $7,881,479 or $6,337,280 above budget.

- Cash Collections for the current month were $17,574,481 which is 116% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $88,575,914 at the end of January compared to $86,672,291 at the end of December.

Balance Sheet

- Working Capital is at 52.8 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 176.9 days. Working Capital cash increased a net $4,543,000. Accounts Payable decreased $1,165,000, Accrued Payroll & Related Costs increased $706,000, and the District received $4,301,000 in Property Tax revenues from Nevada and Placer counties.

- Net Patient Accounts Receivable decreased approximately $1,616,000 and Cash collections were 116% of target. EPIC Days in A/R were 74.5 compared to 76.2 at the close of December, a 1.70 days decrease.

- Other Receivables decreased a net $3,609,000 after booking receipt of Property Tax revenues from Nevada and Placer counties.

- GO Bond Receivables also decreased a net $2,436,000 after record Property Tax revenues received from Nevada and Placer counties.

- Estimated Settlements, Medi-Cal & Medicare increased $1,364,000 after recording the estimated January FY20 receivable from the Rate Range IGT, Medi-Cal PRIME, and Quality Assurance Fee programs along with booking additional amounts due from the State for the FY19 Medi-Cal Outpatient Supplemental Reimbursement program and transfer of funds to the State for participation in the FY18-19 AB113 program.

- GO Bond Tax Revenue Fund increased a net $1,204,000 after booking Property Tax revenue receipts and remitting the interest payments due on the General Obligation Bonds.

- Investment in TSC, LLC decreased $207,000 after recording the District's 99% share of losses for November and December 2019.

- Accounts Payable decreased $1,165,000 due to the timing of the final check run in the month.

- Accrued Payroll & Related Costs increased $706,000 due to an increase in accrued payroll days in January.

- Interest Payable GO Bond decreased $1,363,000 after recording payment of interest on the General Obligation Bonds.

Operating Revenue

- Current month's Total Gross Revenue was $36,349,464, compared to budget of $35,566,765 or $782,699 above budget.
- Current month's Gross Inpatient Revenue was $7,181,413, compared to budget of $8,649,634 or $1,468,221 below budget.
- Current month's Gross Outpatient Revenue was $29,168,052 compared to budget of $26,917,131 or $2,250,921 above budget.
- Current month's Gross Revenue Mix was 34.9% Medicare, 14.6% Medi-Cal, .0% County, 3.5% Other, and 47.0% Insurance compared to budget of 38.8% Medicare, 15.5% Medi-Cal, .0% County, 3.0% Other, and 42.7% Insurance. Last month's mix was 37.6% Medicare, 14.4% Medi-Cal, .0% County, 1.5% Other, and 46.5% Insurance. Year-to-date Gross Revenue Mix was 39.9% Medicare, 14.0% Medi-Cal, .0% County, 2.8% Other, and 43.3% Insurance compared to budget of 38.3% Medicare, 15.8% Medi-Cal, .0% County, 3.1% Other, and 42.8% Insurance.
- Current month's Deductions from Revenue were $18,682,409 compared to budget of $17,895,959 or $786,450 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 3.84% decrease in Medicare, a .90% decrease to Medi-Cal, County at budget, a .40% increase in Other, and Commercial was above budget 4.34%, 2) Revenues exceeded budget by 2.20%, 3) Days in A/R over 120 increased 3.12%, and 4) the District booked additional amounts due from the Medi-Cal Outpatient Supplemental Reimbursement program creating a positive variance in Prior Period Settlements.

DESCRIPTION	January 2020 Actual	January 2020 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	6,382,171	6,602,644	220,473	Positive variance in Salaries & Wages was offset, in part, by TTMG on payroll starting 1/1/2020, which was unbudgeted, and the negative variance in Paid Leave/Sick Leave.
Employee Benefits	2,288,246	1,881,439	(406,807)	Negative variance in Employee Benefits related to increased use of Paid Leave and greater use of Sick Leave during this heavy flu and cold season along with an increase in Gain Share/Incentive Comp paid out in January that exceeded the accrual estimates booked at the close of FY19. Variance also due to TTMG on payroll starting 1/1/2020, which was unbudgeted.
Benefits – Workers Compensation	156,107	78,105	(78,002)	Variance due to the settlement of a few older outstanding workers compensation cases.
Benefits – Medical Insurance	1,243,307	1,177,057	(66,250)	
Medical Professional Fees	1,328,858	1,229,448	(99,410)	We saw negative variances in Multi-Specialty Clinic physician fees due to RVU Production Bonuses, Anesthesia Physician Guarantee fees, and Infectious Disease Medical Director fees.
Other Professional Fees	309,198	200,062	(109,136)	Negative variance in Other Professional Fees related to consulting services provided for the EPIC conversions, Management Reporting and Cost Accounting system implementations, and services provided for the JPA Housing Project.
Supplies	3,280,803	2,897,568	(383,235)	Medical Supplies Sold to Patients revenues exceeded budget by 37.45%, creating a negative variance in Patient & Other Medical Supplies.
Purchased Services	1,717,494	1,663,418	(54,076)	Remote coding services, patient medical record storage and retrieval, Courier/Shuttle services, Credit Card & Analysis Fees, Equipment repairs, and Pharmacy excess order volumes created a negative variance in Purchased Services.
Other Expenses	843,194	898,707	55,513	Senior Leadership is closely monitoring controllable expenses, creating positive variances in most of the Other Expenses categories.
Total Expenses	17,549,378	16,628,448	(920,930)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JANUARY 2020

	Jan-20	Dec-19	Jan-19	
ASSETS				
CURRENT ASSETS				
* CASH	$ 27,377,557	$ 22,834,475	$ 7,298,287	1
PATIENT ACCOUNTS RECEIVABLE - NET	24,095,869	25,711,535	31,011,490	2
OTHER RECEIVABLES	6,370,819	9,979,464	5,767,927	3
GO BOND RECEIVABLES	(4,458)	2,431,544	(401,171)	4
ASSETS LIMITED OR RESTRICTED	8,090,505	7,870,372	7,922,759	
INVENTORIES	3,476,102	3,477,439	3,125,062	
PREPAID EXPENSES & DEPOSITS	2,597,270	2,544,015	1,657,563	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	14,085,473	12,721,164	7,752,951	5
TOTAL CURRENT ASSETS	86,089,138	87,570,008	64,134,868	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	64,390,780	64,390,780	63,814,560	1
MUNICIPAL LEASE 2018	2,903,410	2,901,562	5,818,864	
TOTAL BOND TRUSTEE 2017	20,459	20,459	20,084	
TOTAL BOND TRUSTEE 2015	961,896	824,799	1,100,417	
GO BOND PROJECT FUND	-	-	-	
GO BOND TAX REVENUE FUND	1,900,789	696,400	1,617,792	6
DIAGNOSTIC IMAGING FUND	3,307	3,307	3,266	
DONOR RESTRICTED FUND	1,131,399	1,133,611	1,131,128	
WORKERS COMPENSATION FUND	38,043	29,130	16,497	
TOTAL	71,350,085	70,000,049	73,522,608	
LESS CURRENT PORTION	(8,090,505)	(7,870,372)	(7,922,759)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	63,259,579	62,129,677	65,599,849	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(391,893)	(184,713)	601,785	7
PROPERTY HELD FOR FUTURE EXPANSION	883,198	877,798	904,117	
PROPERTY & EQUIPMENT NET	177,322,477	177,868,828	172,980,833	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,792,440	1,792,440	1,855,472	
TOTAL ASSETS	328,954,938	330,054,038	306,076,924	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	404,047	407,279	442,835	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,343,392	1,343,392	1,081,858	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,532,698	5,556,403	5,817,154	
GO BOND DEFERRED FINANCING COSTS	431,331	433,265	454,546	
DEFERRED FINANCING COSTS	167,485	168,525	179,968	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 7,878,952	$ 7,908,864	$ 7,976,361	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,683,310	$ 7,847,988	$ 6,544,584	8
ACCRUED PAYROLL & RELATED COSTS	13,635,604	12,929,114	10,789,730	9
INTEREST PAYABLE	445,664	518,376	465,360	
INTEREST PAYABLE GO BOND	126,496	1,489,090	74,829	10
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	1,698,103	1,698,103	771,628	
HEALTH INSURANCE PLAN	2,042,670	2,042,670	1,463,491	
WORKERS COMPENSATION PLAN	2,396,860	2,396,860	1,887,549	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,172,232	1,172,232	1,184,419	
CURRENT MATURITIES OF GO BOND DEBT	1,330,000	1,330,000	1,330,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,585,948	2,585,948	2,536,876	
TOTAL CURRENT LIABILITIES	32,116,887	34,010,380	27,048,466	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,751,598	33,939,824	36,999,345	
GO BOND DEBT NET OF CURRENT MATURITIES	99,406,143	99,419,564	100,897,192	
DERIVATIVE INSTRUMENT LIABILITY	1,343,392	1,343,392	1,081,858	
TOTAL LIABILITIES	166,618,021	168,713,160	166,026,861	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	169,084,471	168,116,131	146,895,296	
RESTRICTED	1,131,399	1,133,611	1,131,128	
TOTAL NET POSITION	$ 170,215,870	$ 169,249,743	$ 148,026,424	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
JANUARY 2020

1. Working Capital is at 52.8 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 176.9 days. Working Capital cash increased a net $4,543,000. Accounts Payable decreased $1,165,000 (See Note 8), Accrued Payroll & Related Costs increased $706,000 (See Note 9), the District received $4,301,000 in Property Tax revenues from Nevada and Placer counties (See Note 3) and cash collections exceeded budget by 16%.

2. Net Patient Accounts Receivable decreased approximately $1,616,000 and cash collections were 116% of target. EPIC Days in A/R were 74.5 compared to 76.2 at the close of December, a 1.70 days decrease.

3. Other Receivables decreased a net $3,609,000 after booking receipt of Property Tax revenues from Nevada and Placer counties.

4. GO Bond Receivables also decreased a net $2,436,000 after recording Property Tax revenues received from Nevada and Placer counties.

5. Estimated Settlements, Medi-Cal & Medicare increased a net $1,364,000 after recording the estimated January FY20 receivable from the Rate Range IGT, Medi-Cal PRIME, and Quality Assurance Fee programs, transfer of funds to the State for participation in the FY18-19 AB113 program, and booking additional amounts due from the State for the FY19 Medi-Cal Outpatient Supplemental Reimbursement program.

6. GO Bond Tax Revenue Fund increased a net $1,204,000 after booking receipt of Property Tax revenues and remitting the interest payments due on the General Obligation Bonds.

7. Investment in TSC, LLC decreased $207,000 after the District booked its 99% share of losses for November and December 2019.

8. Accounts payable decreased $1,165,000 due to the timing of the final check run in January.

9. Accrued Payroll & Related Costs increased $706,000 due to an increase in accrued payroll days in January.

10. Interest Payable GO Bond decreased $1,363,000 after recording payment of interest on the General Obligation Bonds.

Tahoe Forest Hospital District
Cash Investment
January 2020

WORKING CAPITAL				
US Bank	$ 26,098,043			
US Bank/Kings Beach Thrift Store	39,128			
US Bank/Truckee Thrift Store	225,976			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,014,410	0.35%		
Total			$	27,377,557
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.02%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	64,390,780	1.97%		
Local Agency Investment Fund			$	64,390,780
Municipal Lease 2018			$	2,903,410
Bonds Cash 2017			$	20,459
Bonds Cash 2015			$	961,896
GO Bonds Cash 2008			$	1,900,789
DX Imaging Education	$ 3,307			
Workers Comp Fund - B of A	38,043			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	41,351
TOTAL FUNDS			$	97,596,243
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,360	0.02%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,095,730	1.97%		
TOTAL RESTRICTED FUNDS			$	1,131,399
TOTAL ALL FUNDS			$	98,727,642

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2020

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JAN 2019
				OPERATING REVENUE						
$ 36,349,464	$ 35,566,765	$ 782,699	2.2%	Total Gross Revenue	$ 241,161,456	$ 230,176,065	$ 10,985,391	4.8%	1	$ 204,569,975
				Gross Revenues - Inpatient						
$ 2,819,264	$ 2,738,899	$ 80,365	2.9%	Daily Hospital Service	$ 20,934,062	$ 18,860,177	$ 2,073,885	11.0%		$ 20,051,348
4,362,149	5,910,735	(1,548,586)	-26.2%	Ancillary Service - Inpatient	34,553,465	41,207,041	(6,653,576)	-16.1%		34,060,937
7,181,413	8,649,634	(1,468,221)	-17.0%	Total Gross Revenue - Inpatient	55,487,527	60,067,218	(4,579,691)	-7.6%	1	54,112,285
29,168,052	26,917,131	2,250,921	8.4%	Gross Revenue - Outpatient	185,673,929	170,108,847	15,565,082	9.2%		150,457,690
29,168,052	26,917,131	2,250,921	8.4%	Total Gross Revenue - Outpatient	185,673,929	170,108,847	15,565,082	9.2%	1	150,457,690
				Deductions from Revenue:						
17,206,395	15,929,186	(1,277,209)	-8.0%	Contractual Allowances	108,829,076	103,076,823	(5,752,253)	-5.6%	2	93,121,397
-	-	-	0.0%	Managed Care Reserve	-	-	-	0.0%	2	1,200,000
1,416,127	1,309,488	(106,639)	-8.1%	Charity Care	9,049,944	8,300,303	(749,641)	-9.0%	2	6,819,687
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
755,232	657,285	(97,947)	-14.9%	Bad Debt	4,291,014	4,072,133	(218,881)	-5.4%	2	874,458
(695,344)	-	695,344	0.0%	Prior Period Settlements	(1,365,081)	-	1,365,081	0.0%	2	(2,102,127)
18,682,409	17,895,959	(786,450)	-4.4%	Total Deductions from Revenue	120,804,953	115,449,259	(5,355,694)	-4.6%		99,913,415
108,775	114,335	5,561	4.9%	Property Tax Revenue- Wellness Neighborhood	690,730	745,691	54,961	7.4%		622,491
1,381,087	1,021,698	359,389	35.2%	Other Operating Revenue	7,860,594	6,865,001	995,593	14.5%	3	6,240,854
19,156,916	18,806,839	350,077	1.9%	TOTAL OPERATING REVENUE	128,907,827	122,337,498	6,570,329	5.4%		111,519,905
				OPERATING EXPENSES						
6,382,171	6,602,644	220,473	3.3%	Salaries and Wages	40,881,944	43,027,978	2,146,034	5.0%	4	34,175,857
2,288,246	1,881,439	(406,807)	-21.6%	Benefits	13,966,945	12,838,827	(1,128,118)	-8.8%	4	11,052,564
156,107	78,105	(78,002)	-99.9%	Benefits Workers Compensation	617,971	546,735	(71,236)	-13.0%	4	411,266
1,243,307	1,177,057	(66,250)	-5.6%	Benefits Medical Insurance	7,361,495	8,239,399	877,904	10.7%	4	6,492,917
1,328,858	1,229,448	(99,410)	-8.1%	Medical Professional Fees	11,701,733	11,019,321	(682,412)	-6.2%	5	13,995,973
309,198	200,062	(109,136)	-54.6%	Other Professional Fees	1,786,467	1,749,371	(37,096)	-2.1%	5	1,280,961
3,280,803	2,897,568	(383,235)	-13.2%	Supplies	17,717,781	16,702,682	(1,015,099)	-6.1%	6	14,661,295
1,717,494	1,663,418	(54,076)	-3.3%	Purchased Services	11,697,880	11,252,791	(445,089)	-4.0%	7	9,442,567
843,194	898,707	55,513	6.2%	Other	4,936,222	6,209,719	1,273,497	20.5%	8	5,001,558
17,549,378	16,628,448	(920,930)	-5.5%	TOTAL OPERATING EXPENSE	110,668,439	111,586,823	918,384	0.8%		96,514,958
1,607,538	**2,178,391**	**(570,853)**	**-26.2%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**18,239,388**	**10,750,675**	**7,488,713**	**69.7%**		**15,004,947**
				NON-OPERATING REVENUE/(EXPENSE)						
500,809	495,248	5,561	1.1%	District and County Taxes	3,576,353	3,521,392	54,961	1.6%	9	3,919,976
412,919	412,919	0	0.0%	District and County Taxes - GO Bond	2,890,436	2,890,436	0	0.0%		2,624,200
188,288	163,435	24,853	15.2%	Interest Income	1,186,272	1,122,821	63,451	5.7%	10	951,225
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
26,318	88,155	(61,837)	-70.1%	Donations	244,675	617,086	(372,411)	-60.3%	11	636,839
(207,181)	-	(207,181)	0.0%	Gain/ (Loss) on Joint Investment	(843,678)	-	(636,498)	0.0%	12	-
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	12	-
-	-	0	0.0%	Gain/ (Loss) on Sale of Equipment	7,200	-	7,200	0.0%	13	5,850
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(1,154,497)	(1,154,615)	118	0.0%	Depreciation	(8,081,478)	(8,082,308)	830	0.0%	15	(7,678,937)
(131,433)	(116,041)	(15,392)	-13.3%	Interest Expense	(838,479)	(822,527)	(15,952)	-1.9%	16	(705,228)
(294,158)	(301,788)	7,630	2.5%	Interest Expense-GO Bond	(2,161,930)	(2,116,096)	(45,834)	-2.2%		(2,300,990)
(658,935)	(412,687)	(246,248)	-59.7%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(4,020,629)	(2,869,196)	(1,151,433)	-40.1%		(2,547,065)
$ 948,603	**$ 1,765,704**	**$ (817,101)**	**-46.3%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 14,218,759**	**$ 7,881,479**	**$ 6,337,280**	**80.4%**		**$ 12,457,882**
				NET POSITION - BEGINNING OF YEAR	**155,997,111**					
				NET POSITION - AS OF JANUARY 31, 2020	**$ 170,215,870**					
4.4%	**6.1%**	**-1.7%**		**RETURN ON GROSS REVENUE EBIDA**	**7.6%**	**4.7%**	**2.9%**			**7.3%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2020

		Variance from Budget Fav / <Unfav> JAN 2020	YTD 2020
1) Gross Revenues			
Acute Patient Days were at budget at 434 days. Swing Bed days were below budget 66.67% or 40 days. Inpatient Ancillary revenues were below budget due to the decrease in Swing Patient days.	Gross Revenue -- Inpatient	$ (1,468,221)	$ (4,579,691)
	Gross Revenue -- Outpatient	2,250,921	15,565,082
Outpatient volumes were above budget in the following departments: Emergency Department visits, Clinic visits, Hospice visits, Surgical cases, Pain Clinic procedures, Diagnostic Imaging, Mammography, Radiation Oncology procedures, MRI exams, Ultrasounds, Cat Scans, PET CT, Respiratory Therapy, Medical Supplies Sold to Patients, Tahoe City Physical & Occupational Therapies, and Physical Therapy, Speech Therapy, and Occupational Therapy.	Gross Revenue -- Total	$ 782,699	$ 10,985,391
2) Total Deductions from Revenue			
The payor mix for January shows a 3.84% decrease to Medicare, a .90% decrease to Medi-Cal, .40% increase to Other, County at budget , and a 4.34% increase to Commercial when compared to budget. The Payor Mix for January continues to be strong, however revenues exceeded budget by 2.2% and A/R Days over 120 increased, lending to the negative variance in Contractual Allowances.	Contractual Allowances	$ (1,277,209)	$ (5,752,253)
	Charity Care	(106,639)	(749,641)
	Charity Care - Catastrophic	-	-
	Bad Debt	(97,947)	(218,881)
	Prior Period Settlements	695,344	1,365,081
The District filed its FY19 Medi-Cal Outpatient Supplemental reports with the State. The final numbers came in stronger than anticipated during the FY19 final close, creating a positive variance in Prior Period Settlements.	Total	$ (786,450)	$ (5,355,694)
3) Other Operating Revenue	Retail Pharmacy	$ 129,919	$ 439,037
Retail Pharmacy revenues exceeded budget by 50.17%.	Hospice Thrift Stores	(14,976)	(102,103)
	The Center (non-therapy)	(1,454)	53,569
IVCH ER Physician Guarantee is tied to collections which fell short of budget in January.	IVCH ER Physician Guarantee	(6,219)	107,152
	Children's Center	(8,941)	(16,649)
	Miscellaneous	263,159	514,107
Positive variance in Miscellaneous related to funds received from Medicare for E.H.R. Demonstration Incentive payments, IVCH Health Promotion monies received from Washoe County School District, and TTMG Leased Employee reimbursement.	Oncology Drug Replacement	-	-
	Grants	(2,099)	480
	Total	$ 359,389	$ 995,593
4) Salaries and Wages	Total	$ 220,473	$ 2,146,034
Positive variance in Salaries and Wages was offset, in part, by TTMG on payroll starting 1/1/2020, which was unbudgeted, and the negative variance in PL/SL.			
Employee Benefits	PL/SL	$ (210,226)	$ (847,758)
Negative variance in PL/SL related to greater usage of Paid Leave and an increased use of Sick Leave during this heavy flu and cold season.	Nonproductive	(143,470)	(157,611)
	Pension/Deferred Comp	-	(54)
	Standby	(12,576)	(19,238)
Negative variance in Nonproductive related to Gain Share/Incentive Comp coming in higher than the estimated accrual at the close of FY19.	Other	(40,536)	(103,457)
	Total	$ (406,807)	$ (1,128,118)
Negative variance in Other related to Employer Payroll Taxes and the addition of TTMG on payroll 1/1/2020, which was unbudgeted.			
Employee Benefits - Workers Compensation	Total	$ (78,002)	$ (71,236)
Negative variance due to the settlement of a few older outstanding workers compensation cases.			
Employee Benefits - Medical Insurance	Total	$ (66,250)	$ 877,904
5) Professional Fees	Multi-Specialty Clinics	$ (24,633)	$ (814,608)
RVU Production Bonuses created a negative variance in Multi-Specialty Clinics.	The Center (includes OP Therapy)	23,839	(237,343)
	Information Technology	(94,993)	(103,435)
Consulting services for the EPIC conversions created a negative variance in Information Technology.	Oncology	(782)	(45,409)
	TFH/IVCH Therapy Services	2,225	(37,692)
	Human Resources	(6,403)	(37,079)
Negative variance in Miscellaneous attributed to Anesthesia Physician Guarantee, consulting services provided to Accounting for the implementation of Productivity Management reporting and Cost Accounting, Infectious Disease Medical Director fees provided to Inpatient Pharmacy, and costs related to the JPA Housing Project.	Miscellaneous	(168,548)	(23,609)
	Financial Administration	(1,072)	(14,550)
	Patient Accounting/Admitting	-	(13,500)
	Medical Staff Services	3,193	(5,105)
	Home Health/Hospice	(560)	(541)
	Truckee Surgery Center	-	(146)
	Respiratory Therapy	-	-
	IVCH ER Physicians	(128)	5,201
	Multi-Specialty Clinics Administration	833	6,694

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2020

		Variance from Budget Fav / <Unfav>	
		JAN 2020	YTD 2020
5) Professional Fees (cont.)	Corporate Compliance	2,000	14,000
	Managed Care	3,111	27,369
	Marketing	9,583	47,225
	Sleep Clinic	71	55,396
	Administration	11,992	68,533
	TFH Locums	31,725	389,090
	Total	$ (208,546)	$ (719,508)
6) Supplies	Pharmacy Supplies	$ (189,036)	$ (1,033,398)
Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues fell short of budget by 24.49%, however, the mix of drugs administered to patients were higher cost pharmaceuticals.	Patient & Other Medical Supplies	(218,245)	(192,013)
	Minor Equipment	9,690	25,669
	Other Non-Medical Supplies	(2,506)	37,601
	Office Supplies	6,311	58,961
Medical Supplies Sold to Patients revenues exceeded budget by 37.45%, creating a negative variance in Patient & Other Medical Supplies.	Food	10,551	88,081
	Total	$ (383,235)	$ (1,015,099)
7) Purchased Services	Medical Records	$ (47,470)	$ (252,101)
Negative variance in Medical Records related to remote coding services and patient medical record storage and retrieval.	Miscellaneous	(45,568)	(241,647)
	Patient Accounting	19,147	(61,595)
	Department Repairs	(24,754)	(34,376)
Courier/Shuttle services and Credit Card Fees & Analysis Charges created a negative variance in Miscellaneous.	Diagnostic Imaging Services - All	(4,889)	(32,617)
	The Center	(255)	(14,461)
	Community Development	179	1,666
Equipment repairs in Surgery, Sterile Processing, Nuclear Medicine, Dietary and Employee Housing created a negative variance in Department Repairs.	Information Technology	6,280	13,769
	Laboratory	1,043	15,164
	Pharmacy IP	(25,297)	28,923
Excess Order Volumes created a negative variance in Pharmacy IP.	Home Health/Hospice	2,249	29,963
	Human Resources	(38,774)	39,622
A reclassification of prior period Employee Health and Pre-Employment Screenings created a negative variance in Human Resources.	Multi-Specialty Clinics	104,031	62,601
	Total	$ (54,076)	$ (445,089)
Positive variance in Multi-Specialty Clinics primarily related to the reclassification of Employee Health and Pre-Employment Screenings from Occupational Health to Human Resources.			
8) Other Expenses	Equipment Rent	$ (12,665)	$ (67,364)
Oxygen tank rentals and equipment needed during a generator repair created a negative variance in Equipment Rent.	Physician Services	(8,286)	(1,258)
	Multi-Specialty Clinics Equip Rent	(32)	142
	Other Building Rent	3,732	7,294
Physician Loan Forgiveness programs created a negative variance in Physician Services.	Multi-Specialty Clinics Bldg Rent	11,974	33,190
	Dues and Subscriptions	2,993	52,865
	Human Resources Recruitment	9,973	69,978
Controllable costs continue to be monitored by Senior Leadership, creating a positive variance in the remainder of the Other Expense categories.	Insurance	9,512	91,681
	Utilities	3,704	157,623
	Marketing	812	213,975
	Outside Training & Travel	21,127	337,098
	Miscellaneous	12,668	378,272
	Total	$ 55,513	$ 1,273,497
9) District and County Taxes	Total	$ 5,561	$ 54,961
10) Interest Income	Total	$ 24,853	$ 63,451
11) Donations	IVCH	$ (37,438)	$ (275,679)
	Operational	(24,399)	(96,732)
	Total	$ (61,837)	$ (372,411)
12) Gain/(Loss) on Joint Investment	Total	$ (207,181)	$ (636,498)
The District booked its 99% share in losses at the Truckee Surgery Center for the months of November and December 2019, creating a negative variance in Gain/(Loss) on Joint Venture.			
13) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ 7,200
15) Depreciation Expense	Total	$ 118	$ 830
16) Interest Expense	Total	$ (15,392)	$ (15,952)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JANUARY 2020

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JAN 2019
				OPERATING REVENUE						
$ 2,398,197	$ 2,609,885	$ (211,688)	-8.1%	Total Gross Revenue	$ 15,935,232	$ 16,434,644	$ (499,412)	-3.0%	1	$ 14,286,162
				Gross Revenues - Inpatient						
$ -	$ 18,896	$ (18,896)	-100.0%	Daily Hospital Service	$ 16,423	$ 89,530	$ (73,107)	-81.7%		$ 58,487
-	33,883	(33,883)	-100.0%	Ancillary Service - Inpatient	18,864	74,098	(55,235)	-74.5%		70,064
-	52,779	(52,779)	-100.0%	Total Gross Revenue - Inpatient	35,287	163,628	(128,342)	-78.4%	1	128,551
2,398,197	2,557,106	(158,909)	-6.2%	Gross Revenue - Outpatient	15,899,945	16,271,016	(371,071)	-2.3%		14,157,611
2,398,197	2,557,106	(158,909)	-6.2%	Total Gross Revenue - Outpatient	15,899,945	16,271,016	(371,071)	-2.3%	1	14,157,611
				Deductions from Revenue:						
1,047,983	1,040,910	(7,073)	-0.7%	Contractual Allowances	7,048,060	6,622,123	(425,937)	-6.4%	2	5,650,518
119,571	155,063	35,492	22.9%	Charity Care	790,815	814,468	23,653	2.9%	2	570,864
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
171,593	155,063	(16,530)	-10.7%	Bad Debt	704,558	814,468	109,910	13.5%	2	315,215
-	-	-	0.0%	Prior Period Settlements	(130,220)	-	130,220	0.0%	2	74,873
1,339,148	1,351,036	11,888	0.9%	Total Deductions from Revenue	8,413,213	8,251,059	(162,154)	-2.0%	2	6,611,470
115,353	117,824	(2,471)	-2.1%	Other Operating Revenue	755,605	649,602	106,003	16.3%	3	643,742
1,174,402	1,376,673	(202,271)	-14.7%	TOTAL OPERATING REVENUE	8,277,624	8,833,187	(555,563)	-6.3%		8,318,434
				OPERATING EXPENSES						
411,541	472,243	60,702	12.9%	Salaries and Wages	2,381,257	2,679,397	298,140	11.1%	4	2,148,157
140,054	123,950	(16,104)	-13.0%	Benefits	923,687	816,540	(107,147)	-13.1%	4	740,349
3,013	4,303	1,290	30.0%	Benefits Workers Compensation	46,554	30,121	(16,433)	-54.6%	4	27,254
71,184	67,391	(3,793)	-5.6%	Benefits Medical Insurance	421,400	471,737	50,337	10.7%	4	382,438
198,685	220,799	22,114	10.0%	Medical Professional Fees	1,867,236	1,856,428	(10,808)	-0.6%	5	1,907,542
1,782	1,536	(246)	-16.0%	Other Professional Fees	12,326	10,754	(1,572)	-14.6%	5	14,928
55,234	66,347	11,113	16.7%	Supplies	394,278	462,763	68,485	14.8%	6	371,468
58,616	63,713	5,097	8.0%	Purchased Services	394,198	406,739	12,541	3.1%	7	343,127
60,633	77,097	16,464	21.4%	Other	487,627	553,296	65,669	11.9%	8	518,142
1,000,744	1,097,379	96,635	8.8%	TOTAL OPERATING EXPENSE	6,928,563	7,287,775	359,212	4.9%		6,453,405
173,659	**279,294**	**(105,635)**	**-37.8%**	**NET OPERATING REV(EXP) EBIDA**	**1,349,061**	**1,545,412**	**(196,351)**	**-12.7%**		**1,865,029**
				NON-OPERATING REVENUE/(EXPENSE)						
3,896	41,334	(37,438)	-90.6%	Donations-IVCH	13,656	289,335	(275,679)	-95.3%	9	16,670
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	
(65,676)	(65,043)	(633)	1.0%	Depreciation	(459,731)	(455,300)	(4,431)	-1.0%	11	(416,443)
(61,780)	(23,709)	(38,071)	-160.6%	TOTAL NON-OPERATING REVENUE/(EXP)	(446,075)	(165,965)	(280,110)	-168.8%		(399,773)
$ 111,878	**$ 255,585**	**$ (143,707)**	**-56.2%**	**EXCESS REVENUE(EXPENSE)**	**$ 902,986**	**$ 1,379,447**	**$ (476,461)**	**-34.5%**		**$ 1,465,256**
7.2%	**10.7%**	**-3.5%**		**RETURN ON GROSS REVENUE EBIDA**	**8.5%**	**9.4%**	**-0.9%**			**13.1%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2020

		Variance from Budget Fav<Unfav> JAN 2020	YTD 2020
1) Gross Revenues			
Acute Patient Days were below budget by 4 at 0 and Observation Days were above budget by 1 at 1.	Gross Revenue -- Inpatient	$ (52,779)	$ (128,342)
	Gross Revenue -- Outpatient	(158,909)	(371,071)
		$ (211,688)	$ (499,412)
Outpatient volumes were below budget in Emergency Department visits, Clinic visits, Surgery cases, Laboratory tests, Drugs Sold to Patients, and Sleep Clinic procedures.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a .31% decrease in Medicare, a 1.54% increase in Medicaid, a 1.78% decrease in Commercial insurance, a .56% increase in Other, and County was below budget by .01%. We saw a negative variance in Contractual Allowances due to a shift in A/R Days over 120.	Contractual Allowances	$ (7,073)	$ (425,937)
	Charity Care	35,492	23,653
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(16,530)	109,910
	Prior Period Settlement	-	130,220
	Total	$ 11,888	$ (162,154)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is based on collections which fell short of budget in January.	IVCH ER Physician Guarantee	$ (6,219)	$ 107,152
	Miscellaneous	3,748	(1,149)
	Total	$ (2,471)	$ 106,003
4) Salaries and Wages	Total	$ 60,702	$ 298,140
Employee Benefits	PL/SL	$ (17,077)	$ (117,558)
Negative variance in PL/SL related to greater usage of Paid Leave and an increase in Sick Leave due to the heavy flu and cold season.	Standby	1,731	15,585
	Other	(961)	(3,003)
	Nonproductive	204	(1,179)
	Pension/Deferred Comp	-	(992)
	Total	$ (16,104)	$ (107,147)
Employee Benefits - Workers Compensation	Total	$ 1,290	$ (16,433)
Employee Benefits - Medical Insurance	Total	$ (3,793)	$ 50,337
5) Professional Fees	Multi-Specialty Clinics	$ (182)	$ (96,225)
Physical, Speech, and Occupational Therapy visits exceeded budget by 29.28%, however, accrued therapy fees for December were higher than the actual invoice received creating a positive variance in Therapy Services.	Foundation	(246)	(1,572)
	Administration	-	-
	Miscellaneous	(723)	187
	IVCH ER Physicians	(128)	5,201
	Therapy Services	23,076	24,634
	Sleep Clinic	71	55,396
	Total	$ 21,868	$ (12,380)
6) Supplies	Food	$ (261)	$ (1,343)
Drugs Sold to Patients revenues exceeded budget by 8.03%. Budgeted transfer of drug supplies from TFH to IVCH fell short of budget creating a positive variance in Pharmacy Supplies.	Imaging Film	-	-
	Office Supplies	794	2,126
	Non-Medical Supplies	925	2,849
	Minor Equipment	936	3,133
	Patient & Other Medical Supplies	(6,657)	23,297
	Pharmacy Supplies	15,376	38,424
	Total	$ 11,113	$ 68,485

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2020

		Variance from Budget Fav<Unfav>	
		JAN 2020	YTD 2020
7) Purchased Services	Miscellaneous	$ 599	$ (14,833)
RHC Accreditation services created a negative variance in Multi-Specialty Clinics.	Diagnostic Imaging Services - All	(1,037)	(6,640)
	Multi-Specialty Clinics	(4,049)	(4,340)
	Foundation	(1,228)	(2,155)
Negative variance in Foundation related to Stewardship services.	Pharmacy	(1,132)	(2,076)
	Surgical Services	-	-
Laboratory tests fell short of budget 20.78% creating a positive variance in Laboratory.	Department Repairs	989	1,727
	EVS/Laundry	(162)	8,377
	Laboratory	7,118	13,730
	Engineering/Plant/Communications	3,998	18,750
	Total	$ 5,097	$ 12,541
8) Other Expenses	Dues and Subscriptions	$ 2,294	$ (6,150)
Natural Gas/Propane expenses created a negative variance in Utilities.	Other Building Rent	(614)	(3,680)
	Physician Services	-	-
Oxygen tank rentals created a negative variance in Equipment Rent.	Multi-Specialty Clinics Bldg Rent	-	-
	Utilities	(2,085)	1,615
Advertising expenses for the IVCH Primary Care Clinic created a negative variance in Marketing.	Equipment Rent	(3,260)	4,138
	Marketing	(2,027)	6,086
	Insurance	1,366	9,565
	Outside Training & Travel	4,451	19,140
	Miscellaneous	16,339	34,956
	Total	$ 16,464	$ 65,669
9) Donations	Total	$ (37,438)	$ (275,679)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ (633)	$ (4,431)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2019		BUDGET FYE 2020	PROJECTED FYE 2020	ACTUAL JAN 2020	PROJECTED JAN 2020	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 25,310,161		$ 12,072,919	$ 19,544,107	$ 1,607,538	$ 2,178,391	$ (570,853)	$ 9,856,557	$ 6,757,769	$ 1,918,123	$ 1,011,658
Interest Income	1,322,573		1,854,579	1,804,876	346,174	481,808	(135,634)	414,192	423,396	416,174	551,114
Property Tax Revenue	7,435,543		7,125,000	7,844,431	4,301,464	3,950,000	351,464	496,314	96,653	4,301,464	2,950,000
Donations	968,991		1,060,000	608,717	64,274	80,000	(15,726)	75,072	69,371	224,274	240,000
Debt Service Payments	(3,938,422)		(5,031,900)	(5,531,534)	(524,459)	(488,002)	(36,457)	(1,522,582)	(1,060,089)	(1,230,957)	(1,717,906)
Property Purchase Agreement	(270,643)		(811,932)	(811,929)	(67,661)	(67,661)	0	(202,982)	(202,982)	(202,983)	(202,983)
2018 Municipal Lease	(1,148,646)		(1,717,332)	(1,574,218)	(143,111)	(143,111)	0	(286,221)	(429,332)	(429,333)	(429,333)
Copier	(24,163)		(64,560)	(65,530)	(6,256)	(5,380)	(876)	(16,235)	(16,139)	(17,016)	(16,140)
2017 VR Demand Bond	(853,995)		(792,912)	(1,448,714)	(170,334)	(134,753)	(35,581)	(620,221)	-	(170,334)	(658,159)
2015 Revenue Bond	(1,640,975)		(1,645,164)	(1,631,142)	(137,097)	(137,097)	(0)	(396,924)	(411,636)	(411,291)	(411,291)
Physician Recruitment	(145,863)		(180,000)	(338,670)	-	(15,000)	15,000	(152,500)	(111,170)	(30,000)	(45,000)
Investment in Capital											
Equipment	(3,296,438)		(5,320,498)	(4,320,498)	(80,688)	(690,945)	610,257	(688,769)	(983,613)	(1,062,577)	(1,585,539)
Municipal Lease Reimbursement	4,530,323		4,650,000	2,458,279	-	-	-	-	608,279	500,000	1,350,000
IT/EMR/Business Systems	(3,016,084)		(4,222,246)	(4,222,246)	(183,363)	(536,680)	353,317	(667,043)	(501,585)	(1,356,724)	(1,696,894)
Building Projects/Properties	(12,443,362)		(23,169,292)	(18,879,173)	(343,054)	(2,313,238)	1,970,184	(2,220,489)	(3,431,604)	(4,307,238)	(8,919,842)
Capital Investments	(916,898)		-	-		-	-	-	-	-	-
Change in Accounts Receivable	(2,492,148)	N1	2,451,297	2,275,874	1,615,666	(1,871,288)	3,486,954	(708,340)	1,165,101	2,095,463	(276,350)
Change in Settlement Accounts	265,612	N2	1,615,831	(1,964,481)	(1,364,309)	1,040,840	(2,405,149)	(4,680,479)	(410,433)	(4,303,375)	7,429,806
Change in Other Assets	(5,018,346)	N3	(2,400,000)	(428,139)	(365,260)	(600,000)	234,740	3,116,473	(479,352)	(1,565,260)	(1,500,000)
Change in Other Liabilities	7,647,518	N4	(695,000)	(2,260,480)	(530,900)	(1,000,000)	469,100	507,806	(5,762,386)	1,569,100	1,425,000
Change in Cash Balance	16,213,160		(10,189,310)	(3,408,937)	4,543,082	215,886	4,327,197	3,826,212	(3,619,663)	(2,831,534)	(783,953)
Beginning Unrestricted Cash	70,805,546		87,018,706	87,018,706	87,225,255	87,225,255	-	87,018,706	90,844,918	87,225,255	84,393,722
Ending Unrestricted Cash	87,018,706		76,829,396	83,609,769	91,768,338	87,441,141	4,327,197	90,844,918	87,225,255	84,393,722	83,609,769
Expense Per Day	486,737		516,504	514,031	518,637	522,834	(4,197)	519,036	509,924	520,242	514,031
Days Cash On Hand	179		149	163	177	167	10	175	171	162	163

Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 2/14/20

Finance Strategies:

To review, our health system experienced overall estimated volume increases on a broad basis, of about 28% in fiscal year 2019 versus fiscal year 2018. From fiscal year 2015 to fiscal year 2019, we have experienced about 65% cumulative overall growth in the health system. During the first seven months of fiscal year 2020, we are seeing approximately 14% additional growth over the prior year. This continued level of year over year growth is quite remarkable and rare.

We are performing in a very strong, positive manner year to date against budget.

TFHS finished last fiscal year with approximately 82,000 provider office visits, compared to 67,000 provider office visits. This fiscal year we are on track for at least 88K provider office visits. I believe this annualized trend for fiscal year 2020 will continue to elevate as the second half of our fiscal year is completed.

People Strategies:

Our team continues to grow to meet the increased year over year patient care demands of our region.

Our team is presently engaged in taking a survey to see if TFHS will again be the Best Place to Work in all of Northern Nevada and the Lake Tahoe region. This would be amazing as there are very tough competitors in many industries out there.

Our theme this calendar year is further progress as a “Team of One” and a strong outward unselfish focus on Gratitude and Thankfulness. Kindness is also a close partner to this area of focus which we believe will set a firm foundation for material further improvements in our teamwork, quality and patient satisfaction. This all ties back to our People strategies in our Strategic Plan.

We will be sharing the Press Ganey Physician survey results at our February meeting as well.

Service Strategies:

Our team continues to deliver higher year over year patient satisfaction scores in six areas measured which cover our two hospital campuses, physician office services and components within our hospitals.

We are focused on how we can improve our customer experience each year, especially for any individual who has never used our health system before so that our people and our systems are more clear and easy to access. We also continue a very strong service recovery program.

Please see the other board reports for Service progress in alignment with our Strategic Plan.

Quality Strategies:

We have many Quality improvement activities underway. Several of these are covered in our other monthly board reports. All quality improvement activities focus back on our Strategic Plan.

Growth Strategies:

In alignment with our Strategic Plan under Growth, we continue to actively collaborate with many area health systems to the north, south, east and west of our health system, always looking for ways we can learn and also produce higher quality, more cost efficient health care.

As a reminder of the urgent focus our team has to rapidly transform our health system for long term high quality sustainability, we have a very long list of Project Management Team health system improvements we are working on, its north of 120 projects. Separately we also have a very long list of more than 70 construction and capital type repair projects that we are managing as well. Our health system is correctly focused on putting in place the right building blocks for stability, efficiency and sustainability even if major market force or regulatory force changes occur.

As we have shared in the last month or so, we regret that we will not have our parking garage available in 2020. We are working hard on our Master Plan and all of the regulatory approvals needed with the town so we can complete surface parking in three other locations of our general campus during 2020.

We continue to look for longer term offsite employee parking locations that are safe and reasonable, as our offsite locations to date have all had limited duration time frames. This offsite parking for employees is critical to provide increased patient parking on our campus due to the greatly increased demand by patients for our services.

We are very active at the state, federal and local levels on new or changing laws and how they might impact us positively or negatively. The volume uptick in new laws is at a very high level with many very concerning laws we have to be very proactive on.

Board COO Report

By: Judith B. Newland **DATE: February 2020**

Quality: Pursue Excellence in Quality, Safety and Patient Experience
Focus on our culture of safety

Our Reliability Management Team (RMT) continues to be active with weekly huddles and monthly training. Our Directors, Managers and Supervisors have completed online Reliability Management training modules and a one-day training is scheduled in March of 2020. We are preparing to expand the education to physician and staff.

We continue to focus on our preparation in anticipation for the triennial unannounced deemed accreditation survey by the Healthcare Facilities Accreditation Program (HFAP) that can occur at any time. HFAP is authorized by the Centers for Medicare and Medicaid Services (CMS) to survey hospital for compliance with the Medicare Conditions of Participation and Converge. An educational fair for staff is scheduled in March at TFH and IVCH. All leadership are involved in this preparation for both Tahoe Forest Hospital District and Incline Village Community Hospital.

Prioritize patient and family perspective
To improve our Outpatient Satisfaction Press Ganey results, Laboratory Services at TFH have made changes to decrease wait times for blood draw services. Changes that have recently gone into place are adding a third draw chair in the laboratory department to accommodate more patients, adding a phlebotomist within the multispecialty clinic on the second floor of the Cancer Center to perform lab draws in the clinic at time of visit, and promoting self-scheduling.

Strive for a continual 5-star HCAHPS status
To assure ongoing 5-star HCAHPS results a multidisciplinary process improvement team has been established to identify opportunities for improvement and develop action plans to improve our results.

Service: Optimize Deliver Model to Achieve Operational and Clinical Efficiency
Implement a focused master plan

Report provided by Dylan Crosby, Director Facilities and Construction Management

Moves:

- Internal Medicine, Pulmonology and Endocrinology are schedule to move to the Medical Office Building, Suite 130 on March 13, 2020.

Projects in Progress:

Project: Tahoe City Physical Therapy Expansion
Estimated Start of Construction: October 2019

Estimated Completion: March 2020
Summary of Work: Lease and renovate the remainder of the second floor of existing building.
Update Summary: Finishes are being installed in project area.

Project: ECC Interior Upgrades
Estimated Start of Construction: March 2020
Estimated Completion: November 2020
Summary of Work: Remodel all patient rooms and dining area of the 1985 building of the ECC
Update Summary: Project is in Submittal Phase. Pre-construction meeting has been completed with Contractor, Designer, and Staff. A Pre-construction meeting is scheduled with OSHPD March 5th.

Project: Security Upgrades
Estimated Start of Construction: Winter 2019
Estimated Completion: Summer 2020
Summary of Work: Make the necessary modifications to improve security in Surgery, Diagnostic Imaging and Emergency Departments.
Update Summary: Project has been approved and is being prepared to go out to bid.

Projects in Permitting:

Project: Site Improvements Phase 2
Estimated Start of Construction: Summer 2020
Estimated Completion: Winter 2020
Summary of Work: Project includes three site improvements for parking, these sites include Pat and Ollies, Gateway Temporary Lot and MOB East Parking Extension.
Update Summary: Project has been submitted to the Town of Truckee for a development permit.

Project: Campus Water Improvements
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Move the PRV station to Donner Pass Rd allowing the Hospital campus to tie into the high pressure water line in Donner Pass Rd. This will allow for a higher average of water pressure throughout the campus.
Update Summary: Electrical has been approved, water improvements and grading permit are under review. Project is being prepared for bid.

Projects in Design:

Project: Day tank and Underground Storage tank replacement.
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remove and replace the 30-year-old underground storage tank and existing day tank.
Update Summary: Project is in the process of being designed.

Project: 2nd Floor MOB
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remodel 3 suites of the 2nd floor of the MOB.
Update Summary: Project is in the process of programming.

Project: MRI/ X-Ray Room 2 replacement
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Replace MRI with new 3T MRI. Replace X-Ray, room 2, with Digital X-Ray.
Update Summary: Project is in the process of programming.

Project: Gateway Medical Office Building
Estimated Start of Construction: Spring 2021
Estimated Completion: Winter 2024
Summary of Work: Create a new medical office building to house multiple hospital entities.
Update Summary: Procurement method is in development.

Project: Incline SPD Remodel
Estimated Start of Construction: Spring 2021
Estimated Completion: Winter 2021
Summary of Work: Remodel and upgrade of equipment in SPD.
Update Summary: Project is being prepared for submittal to Washoe County.

Project: Incline Endoscopy
Estimated Start of Construction: Spring 2021
Estimated Completion: Winter 2021
Summary of Work: Create a new procedure room for ENDO procedures.
Update Summary: Project is in design.

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Karen Baffone, RN, MS **DATE: February 2020**
Chief Nursing Officer

Service: Optimize delivery model to achieve operational and clinical efficiency

Use technology to improve efficiencies

- The Nihon Kodan monitor project – Training set up began Monday February 17. The project is still on track for the March go live
- Data registry for Chronic Care Coordination with 1bios is being developed that assist tracking of time spent with these patients as well as the care plans necessary to keep the chronically ill at their highest level of functioning. This technology will be used later this year or beginning of next year as a best practice for these patients.

Quality: Provide clinical excellence in clinical outcomes

Identify and promote best practice and evidence-based medicine

- **Level III Trauma:**
  - We had our first official full trauma this month. The response times for everyone was excellent and we met all of our activation times. The patient was treated and admitted to the ICU.
- **HFAP Prep**
  - The entire clinical team continues to prep for our HFAP survey. We are having additional training for all of the staff at both organizations on March 4 and March 10

Growth: Meets the needs of the community

Enhance and promote our value to the community-COMMUNITY BENEFIT

- North Tahoe had a field save that involved bystander CPR. These events are rare and the North Tahoe Fire District have contacted the family and they are willing and excited to participate in what we call the "Chain of Survival Award". This patient was transported to and treated at TFHD so the staff that was involved in this save will be recognized for this "Chain of Survival Award" in March.
- The Wellness Neighborhood is beginning plans for the triannual community health needs assessment. Given that this is a "census" year, we have targeted August as the month to complete this assessment. It will take us several months to complete and report back to the Board.
- February is American Heart Month. We are providing community "healthy heart" education in the Eskridge Conference room on February 5,12,19,26.
- Parents and Babies Community Benefit
  - Nutrition for a Health Pregnancy is held on the 1st Friday of the Month
  - Breastfeeding support is held every Friday
  - Infant and Child CPR – February 7, 2020
  - Infant Nutrition – February 12, 2020
- Population Health Community Benefits
  - We have self-management classes that are offered 3 times throughout the year
    - Chronic Pain Management

        - Diabetes Self-Management (Spanish)
        - Type 2 Diabetes Prevention
        - Multiple Sclerosis Support Group – 2nd Tuesday
        - Parkinson's Support Group – 3rd Friday
- Community Collaborative
    - CCTT Resource Sharing Meeting: Feb 4th
    - Placer County Oral Health Alliance - Feb 7th
    - Youth Health Initiative - Feb 10th

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst **DATE:** 2/14/2019

Chief Information & Innovation Officer

- Imprivata SSO project is in planning phase. Trial deployment underway. Expect to move into execution and enterprise wide deployment by April 2019
- EEO project is in Executing phase
- TFCC Cancer Center project is in executing phase
- Network uplift project executing, all operational downtimes complete
- Kaufmann Hall Axiom Implementation is in executing phase
- Successful go live of Cancer Center Epic project Feb.1
- Successful Varian Upgrade Feb.1
- Clinical work for Epic Upgrade readiness April 15
- Clinical Informatics work for HFAP readiness
- Nihon Khoden Cardiac Monitor rollout Feb 24-March 10
- Imprivata project for E-Prescribe of Controlled Substances started
- TTMG Project
- Report writing to handle data changes with all of the MSC office moves, EEO project-Professional billing, Data extract updates for the same
- Contracted Epic report writer to cover Maternity Leave
- EEO Project
- TTMG Equipment received and systems configured. Testing underway
- Nihon Kohden Network Staging to occur 2/18 (Maintenance Window 9-10pm)
- Engaged with vendor to centralize retired/archived system data into a single searchable database
- Standing up new Public Key Infrastructure (PKI) server with vendor partner 3/9
- Established long term Multi-Factor Authentication strategy (Duo vs. Imprivata). Performing deep dive evaluation of Imprivata as an across the board solution
- Evaluating existing and new security camera options in order to take advantage of improvements in technology
- CTF application submitted inclusive of sites coming on board March 1
- New project portfolio & governance processes
- Successful Glooko (diabetes management software) enablement
- Endocrinology and Pulmonology will move to new location in Suite 130 on March 13

TAHOE FOREST HOSPITAL DISTRICT

Board CMO Report

By: Shawni Coll, D.O., FACOG
Chief Medical Officer

DATE: February 18, 2020

People: Strengthen a highly-engaged culture that inspires teamwork

Build Trust

- Working hard with multiple different aspects of the organization to ensure a smooth transition for the physicians from Tahoe Truckee Medical Group, as they transition on March 1, 2020.

Build a culture based on the foundations of our values

- We have seen a dramatic improvement in engagement from the physicians with our new Engagement Bonus structure.

Attract, develop, and retain strong talent and promote great careers

- We have a team working on projections and future needs of Primary Care to optimize our future recruitment needs.

Service: Optimize delivery model to achieve operational and clinical efficiency

Develop integrated, standardized and innovative processes across all services

- Our team has been revising the Conscious Sedation policy to be consistent throughout the inpatient and outpatient arenas.

Use technology to improve efficiencies

- We will begin a pilot program with a new scribe company in Primary Care. If the pilot program goes well (30 days), we will begin planning for large scale roll out.

Implement a focused master plan

- Two clinics (IM/Pulm/Endu and Primary Care in Occ Health) are schedule to move in the next 30. This is the next phase in the construction planned for the 2nd floor of the MOB.

Quality: Provide clinical excellence in clinical outcomes

Focus on our culture of safety

- High Reliability Organization (HRO) Modules recently were assigned to the Medical Staff to learn principles of HRO and continued importance of our culture of safety.

Identify and promote best practice and evidence-based medicine

- Medicine Committee has done a fabulous job revising their privilege form, which will also include Urgent Care privileges. We continue to revise the membership and participation of the Level 3 Trauma committee for a broader diversity of input and quality. Anesthesia group is working on the pre-op clinic, which will encompass Ambulatory Surgery Center standards vs. Hospital Operating Room standards along with looking at a pre-regional block checklist and time out process.

Finance: Ensure a highly sustainable financial future

Continue to improve revenue cycle efficiency and effectiveness

- Working with HIM and Medical Staff to bring Coding Education to the Medical Staff in March. This will include general sessions and elbow-to-elbow support with Epic IT staff to optimize the physician workflow.

Growth: Meets the needs of the community

Define opportunities for growth and recapture outmigration

- A new full time GI physician, Dr. Julie Torman, has started in Truckee.
- We have hired and in the process of credentialing of a Nurse Practitioner for our growing Urology practice.

AGENDA ITEM COVER SHEET

ITEM	ABD-08 Credit and Collection Policy ABD-09 Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies ABD-25 Debt Management Policy
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board
ACTION REQUESTED?	For Board Action

BACKGROUND:

The following policies were reviewed by the Finance Committee at their January 22, 2020 meeting:

- ABD-08 Credit and Collection
- ABD-09 Financial Assistance Program Full Charity Care and Discount Partial Charity Care
- ABD-25 Debt Management Policy

SUMMARY/OBJECTIVES:

CFO, Director of Revenue Cycle and Director of Patient Registration provided edits to ABD-08 and ABD-09.

ABD-25 was also reviewed by General Counsel and TFHD's Financial Advisor, Gary Hicks. There are no proposed changes to ABD-25 at this time.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via Consent Calendar.

LIST OF ATTACHMENTS:

- ABD-08 Credit and Collection Policy
- ABD-09 Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies
- ABD-25 Debt Management Policy

Credit and Collection Policy, ABD-08

PURPOSE:

A. Tahoe Forest Hospital District (hereinafter known as "TFHD") provides high quality care to patients when they are in need of healthcare ~~hospital~~ services. All patients or their guarantor have a financial responsibility related to services received at TFHD and must make arrangements for payment to TFHD either before or after services are rendered. Such arrangements may include payment by an insurance plan, including coverage programs offered through the federal and state government. Payment arrangements may also be made directly with the patient, subject to the payment terms and conditions of TFHD.

B. Emergency patients will always receive all medically necessary care within the scope resources available at TFHD, to assure that their medical condition is stabilized prior to consideration of any financial arrangements.

C. The Credit and Collection Policy establishes the guidelines, policies and procedures for use by TFHD~~hospital~~ personnel in evaluating and determining patient payment arrangements. This policy is intended to establish fair and effective means for collection of patient accounts owed to TFHD~~the hospital~~. In addition, other TFHD policies such as the Financial Assistance Policy which contains provisions for full charity care and discount partial charity care will be considered by TFHD personnel when establishing payment arrangements for each specific patient or their guarantor.

SCOPE:

A. The Credit and Collection Policy will apply to all patients who receive services at TFHD. This policy defines the requirements and processes used by the TFHD ~~hospital~~ Patient Financial Services department when making payment arrangements with individual patients or their account guarantors. The Credit and Collection Policy also specifies the standards and practices used by TFHD~~the hospital~~ for the collection of debts arising from the provision of services to patients at TFHD. The Credit and Collection Policy acknowledges that some patients may have special payment arrangements as defined by an insurance contract to which TFHD is a party, or in accordance with hospital conditions of participation in state and federal programs. TFHD endeavors to treat every patient or their guarantor with fair consideration and respect when making payment arrangements.

B. All requests for payment arrangements from patients, patient families, patient financial guarantors, physicians, hospital staff, or others shall be addressed in accordance with this policy.

POLICY:

All patients who receive care at TFHD must make arrangements for payment of any or all amounts owed for ~~hospital~~ services rendered in good faith by TFHD. TFHD reserves the right and retains sole authority for establishing the terms and conditions of payment by individual patients and/or their guarantor, subject to requirements established under state and federal law or regulation.

GENERAL PRACTICES:

A. TFHD and the patient share responsibility for timely and accurate resolution of all patient accounts. Patient cooperation and communication is essential to this process. TFHD will make reasonable, cost-effective efforts to assist patients with fulfillment of their financial responsibility.

B. Health~~ospital~~ care at TFHD is available to all those who may be in need of necessary services. To facilitate financial arrangements for persons who may be of low or moderate income, both those who are uninsured or underinsured, TFHD provides the following special assistance to patients as part of the routine billing process:

1. For uninsured patients, a written statement of charges for services rendered by TFHD~~the hospital~~ is provided in a revenue code summary format which shows the patient a synopsis of all charges by the department in which the charges arose. Upon patient request, a complete itemized statement of charges will be provided;
2. Patients who have third party insurance will be provided a revenue code summary statement which identifies the charges related to ~~hospital~~ services provided by TFHD.

Insured patients will receive a balance due from patient statement once TFHD~~the hospital~~ has received payment from the insurance payer. Upon patient request, a complete itemized statement of charges will be provided;

3. A written request that the patient inform TFHD if the patient has any health insurance coverage, Medicare, ~~Healthy Families,~~ Medi-Cal or other form of ~~insurance~~ coverage;
4. A written statement informing the patient or guarantor that they may be eligible for Medicare, ~~Healthy Families,~~ Medi-Cal, ~~California Children's Services Program, or~~ the TFHD Financial Assistance Program, or appropriate government coverage programs;
5. A written statement indicating how the patient may obtain an application for the Medi-Cal, ~~Healthy Families Program~~ or other appropriate government coverage program;
6. If a patient is uninsured, an application to the Medi-Cal, ~~Healthy Families Program~~ or other appropriate government assistance program will be provided prior to discharge from the hospital;
7. A TFHD representative is available at no cost to the patient to assist with application to relevant government assistance programs;
8. A written statement regarding eligibility criteria and qualification procedures for full charity care and/or discount partial charity care under the TFHD Financial Assistance Program. This statement shall include the name and telephone number of TFHD~~hospital~~ personnel who can assist the patient or guarantor with information about and an application for the TFHD Financial Assistance Program.

C. The TFHD Patient Financial Service Representatives~~s department~~ and designees are ~~is~~ primarily responsible for the timely and accurate collection of all patient accounts. Patient Financial Service Representatives~~s personnel work~~ work cooperatively with other TFHD~~hospital~~ departments, members of the Medical Staff, patients, insurance companies, collection agencies and others to assure that timely and accurate processing of patient accounts can occur.

D. Accurate information provides the basis for TFHD to correctly bill patients or their insurer. Patient billing information should be obtained in advance of ~~hospital~~ services whenever possible so that verification, prior authorization or other approvals may be completed prior to the provision of services. When information cannot be obtained prior to the time of service, TFHD ~~hospital~~ personnel will work with each patient or their guarantor to assure that all necessary billing information is received by TFHD prior to the completion of services.

PROCEDURE:

A. Each patient account will be assigned to an appropriate Patient Financial Services representative based upon the type of account payer and current individual staff workloads. The Head of Patient Financial Services ~~Manager~~ will periodically review staff workloads and may change or adjust the process or specific assignment of patient accounts to assure timely, accurate and cost-effective collection of such accounts.

B. Once a patient account is assigned to a Patient Financial Services representative, the account details will be reviewed to assure accuracy and completeness of information necessary for the account to be billed.

C. If the account is payable by the patient's insurer, the initial bill will be forwarded directly to the designated insurer. TFHD Patient Financial Services personnel will work with the patient's insurer to obtain any or all amounts owed on the account by the insurer. This will include calculation of contracted rates or other special arrangements that may apply. Once payment by the insurer has been determined by TFHD, any residual patient liability balance, for example a patient co-payment or deductible amount, will be billed directly to the patient. Any or all patient balances are due and payable within 30 days from the date of this first patient billing. Patients may~~be~~ dispute balances or charges within ~~XXX~~60 days of the balances becoming patient responsibility.

D. If the account is payable only by the patient, it will be classified as a ~~private~~ self-pay account. ~~Private~~Self- pay accounts may potentially qualify for ~~a prompt payment discount,~~ government coverage programs~~,~~ or financial aid under the TFHD Financial Assistance Policy. Patients with accounts in ~~private~~ self- pay status should contact a ~~Patient~~ Financial Counselor~~ Services representative~~ to ~~-~~make payment arrangements or be screened for assistance programs.~~ obtain assistance with qualifying for one or more of these options.~~

~~D.~~

E. In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services and subsequently is determined to qualify for full Financial Assistancecharity care or discount partial- Financial Assistance-charity care, all amounts paid which exceed the payment obligation, if any, as determined through the Financial Assistance Program process, shall be refunded to the patient. with interest. Any overpayment due to the patient under this obligation may not be applied to other open balance accounts or debt owed to TFHDthe hospital by the patient or family representative. Any or all amounts owed shall be reimbursed to the patient or family representative within a reasonable time period. Such interest shall begin to accrue on the first day that the patient or guarantor's payment obligation is determined through the Financial Assistance Program process. Interest payments shall be accrued at Two Percent (2%) per annum.

F.E. All private pay accounts may be subject to a credit history review. Any private pay patient who has applied for the TFHD Financial Assistance Program will not have a credit history review performed as an element of Financial Assistance Program qualification. TFHD will use a reputable, nationally-based credit reporting system for the purposes of obtaining the patient or guarantor's historical credit experience.

G.F. TFHD offers patients a payment plan options when they are not able to settle the account in one lump sum payment. Payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient to TFHD and the patient's or patient family representative's financial circumstances. Payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan shall not exceed ninety (90) days -or three (3) monthstwelve (12) months. This minimum monthly payment amount shall be determined by dividing the total outstanding patient liability balance by three (3). 12. Payment plans are free of any interest charges or set-up fees. Some situations, such as patients qualified for partial financial assistance, may necessitate special payment plan arrangements based on negotiation between TFHDthe hospital and patient or their representative. Such payment plans may be arranged by contacting a TFHD Patient Financial CounselingorServices representative. Once a payment plan has been approved, any failure to pay in accordance with the plan terms will constitute a plan default. It is the patient or guarantor's responsibility to contact the TFHD Patient Financial CounselingorServices department if circumstances change and payment plan terms cannot be met. In addition, TFHD works with an outside vendor if patients need payment plan terms that exceed 12 three (3) months. Payment plan terms are subject to vendor requirements.

H.G. Patient account balances in private self-pay status will be considered past due after 30 days from the date of status change to self-pay or status of self-pay. initial billing.. Accounts may be advanced to collection status according to the following schedule:

I. Any or all self-private pay account balances where it is determined by TFHD that the patient or guarantor provided fraudulent, misleading or purposely inaccurate demographic or billing information may be considered as advanced for collection immediately upon such a determination by TFHD. Any such account will be reviewed and approved for advancement by the Patient Access Director Revenue Cycle Director or or her/his designee;

1.

J. Any or all self-private pay account balances where no payment has been received, and the patient has not communicated with TFHD within 60 days of initial billing and a minimum of one bill showing details at the revenue code summary level and twothree cycle statements have been sent to the patient or guarantor. Any such account will be reviewed and approved for advancement by the Patient Access DirectorRevenue Cycle Director or her/his designee;

2.

3. Any or all other self-paypatient accounts, including those where there has been no payment within the past 6120 days, may be forwarded to collection status when:

K. a.

L. Notice is provided to the patient or guarantor that payments have not been made in a timely manner and the account will be subject to collection 30 days from the notice date;

~~M.~~ b. The patient or guarantor refuses to communicate or cooperate with TFHD Patient Financial Services representatives or ~~Patient~~ Financial Counselorings; and

~~N.~~ c. The Patient Access Director ~~Revenue Cycle Director~~ or her/his management designee has reviewed the account prior to forwarding it to collection status.

~~O.~~H. Patient accounts will not be forwarded to collection status when the patient or guarantor makes reasonable efforts to communicate with TFHD Patient Financial Services representatives or ~~Patient~~ Financial Counselingors and makes good faith efforts to resolve the outstanding account. The TFHD Patient Access Director ~~Revenue Cycle Director~~ or her/his designee will determine if the patient or guarantor are continuing to make good faith efforts to resolve the patient account and may use indicators such as: application for Medi-Cal ~~, Healthy Families~~ or other government programs; application for the TFHD Financial Assistance Program; ~~regular partial payments of a reasonable amount;~~ negotiation of a payment plan with TFHD and other such indicators that demonstrate the patient's effort to fulfill their payment obligation.

~~P.~~I. After 30 days or anytime when an account otherwise becomes past due and subject to internal or external collection, TFHD will provide every patient with written notice in the following form:

1. "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov ."
2. Non-profit credit counseling services may be available in the area. Please contact the TFHD ~~Patient~~ Financial Counselingors~~Services~~ if you need more information or assistance in contacting a credit counseling service.

~~Q.~~J. For all patient accounts where there is no 3~~-~~rd party insurer *and/or* whenever a patient provides information that he or she may have high medical costs, Financial Counseling ~~the Patient Financial Services representative~~ will assure that the patient has been provided all elements of information as listed above ~~in number 2, parts (a) through (h)~~. ~~This will be accomplished by sending a written billing supplement with the first patient bill. The Patient Financial Services representative will document that the billing supplement was sent by placing an affirmative statement in the "notes" section of the patient's account.~~

~~R.~~K. For all patient accounts where there is no 3 rd party insurer *and/or* whenever a patient provides information that he or she may have high medical costs, TFHD will not report adverse information to a credit reporting agency or commence any civil action prior to 150 days after initial billing of the account. Furthermore, TFHD will not send an unpaid bill for such patients to an external collection agency unless the collection agency has agreed to comply with this requirement.

~~S.~~L. If a patient or guarantor has filed an appeal for coverage of services in accordance with Health & Safety Code Section 127426, TFHD will extend the 150~~-~~day limit on reporting of adverse information to a credit reporting agency and/or will not commence any civil action until a final determination of the pending appeal has been made.

~~T.~~M. TFHD will only utilize external collection agencies with which it has established written contractual agreements. Every collection agency performing services on behalf of TFHD must agree to comply with the terms and conditions of such contracts as specified by TFHD. All collection agencies contracted to provide services for or on behalf of TFHD shall agree to comply with the standards and practices defined in the collection agency agreement; including this Credit and Collection Policy, the TFHD Financial Assistance Policy and all legal requirements including those specified in Health & Safety Code Section 127420 et seq.

~~U.~~N. TFHD and/or its external collection agencies will not use wage garnishments or liens on a primary residence without an order of the court. Any or all legal action to collect an outstanding patient account by TFHD and/or its collection agencies must be authorized and approved in advance, in writing by the TFHD Patient Access Director ~~D Revenue Cycle Director.~~ Any such

legal action must conform to the requirements of Health & Safety Code Section 127420 et seq.

~~V.~~O. TFHD, its collection agencies, or any assignee may use any or all legal means to pursue reimbursement, debt collection and any enforcement remedy from third-party liability settlements, tortfeasors, or other legally responsible parties. Such actions shall be conducted only with the prior written approval of the hospital director of patient financial services.

References:

California Health and Safety Code §§127400 - 127446

TFHD Policy: Review of Accounts for Bad Debt, DPTREG-1907

TFHD Policy: Payment Plans, DPTREG-1908

TFHD Policy: Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies ABD-09

Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies ABD-09

PURPOSE:

A. Tahoe Forest Hospital District (hereinafter referred to as "TFHD") provides hospital and related medical services to residents and visitors within district boundaries and the surrounding region. As a regional healthcare ~~hospital~~ provider, TFHD is dedicated to providing high quality, customer oriented and financially strong healthcare services that meet the needs of its patients. Providing patients with opportunities for financial assistance coverage for healthcare services is also an essential element of fulfilling the TFHD mission. This policy defines the TFHD Financial Assistance Program; its criteria, systems, and methods.

B. California acute care hospitals must comply with the "Hospital Fair Pricing Policies" law at Health & Safety Code Section 127400 et seq. (the "Fair Pricing Law"), including requirements for written policies providing discounts and charity care to financially qualified patients. Under the Fair Pricing Law, uninsured patients or patients with high medical costs who are at or below 350 percent (350%) of the federal poverty level shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. This policy is intended to fully comply with all such legal obligations by providing for both charity care and discounts to patients who qualify under the terms and conditions of the TFHD Financial Assistance Program. Additionally, although the Fair Pricing Law requires hospitals to provide financial assistance to certain qualifying patients for services they have received, it does not require hospitals to provide future services. Nevertheless, TFHD has allowed individuals to apply for financial assistance for future services under this policy. However, any individuals who qualify for such assistance will still be subject to admission and other criteria for receiving services and becoming patients, and will have to demonstrate their ability to meet any applicable financial obligation which is not covered by any discount or other financial assistance granted.

C. The finance department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at TFHD. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of TFHD.

D. Patients are hereby notified that a physician employed or contracted to provide services in the emergency department of TFHD's hospital in Truckee, California is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent (350%) of the federal poverty level.

DEFINITIONS:

A. "Discount Partial Charity Care" means an amount charged for services to a patient who qualifies for financial assistance under the TFHD Financial Assistance Program which is discounted to the amount Medicare would pay for the same services or less. Discount Partial Charity Care, when granted to a patient, will in no case excuse a third party, or the patient, from their respective obligations to pay for services provided to such patient.

B. "Elective Services" means any services which are not medically necessary services.

C. "Emergency Services" means services required to stabilize a patient's medical condition initially provided in the TFHD emergency department or otherwise classified as "emergency services" under the federal EMTALA Law or Section 1317.1 et.seq. of the California Health & Safety Code, and continuing until the patient is medically stable and discharged, transferred, or otherwise released from treatment.

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

E. "Financial Assistance Program" means the TFHD Financial Assistance Program established by this policy for providing Full Charity Care or Partial Discount Charity Care (each, as defined below) to qualified patients.

F. "Full Charity Care" means medically necessary services provided by TFHD to a patient who qualifies under the TFHD Financial Assistance Program which are not covered by a third party, and for which the patient is otherwise responsible for paying, for which the patient will not be charged. Full Charity Care, when granted to a patient, in no case will excuse a third party from its

obligation to pay for services provided to such patient.

G. "Medically Necessary Services" means hospital-based medical services determined, based upon a medical evaluation, to be necessary to preserve a patient's life or health.

H. "Monetary Assets" means all monetary assets of the patient's family excluding retirement or deferred compensation plans (both qualified and non-qualified under the Internal Revenue Code), not counting the first $10,000 of such assets, nor fifty percent (50%) of the amount of such assets over the first $10,000.

I. "Non-Eemergency Services" means medically necessary services that are not Emergency Services.

J. "Patient" means an individual who has received Emergency Services or Non-Eemergency Services at a facility operated by TFHD who is requesting financial assistance with respect to such services.

K. "The amount Medicare would have paid" means the amount Medicare would pay for the services provided, or, in the event there is no specific amount that can be determined that Medicare would pay for such services, the highest amount payable for such services by any other state-funded program designed to provide health coverage.

L. "Third Party Insurance" means health benefits coverage by a public or private program, insurer, health plan, employer, multiple employer trust, or any other third party obligated to provide health benefits coverage to a patient.

SCOPE:

A. This policy applies to all TFHD patients. This policy does not require TFHD to accept as a patient and provide services to any person who does not qualify for treatment or admission under any of TFHD's applicable policies, practices, and procedures, and does not prohibit TFHD from discharging, or otherwise limiting the scope of services provided to, any person in accordance with its normal policies, practices and procedures. This policy does not require TFHD to provide patients with any services that are not medically necessary or to provide access to non-emergency services or to elective services.

B. The acute care hospital operated by TFHD provides many specialized inpatient and outpatient services. In addition to services provided at the main hospital location, Tahoe Forest Hospital operates primary care and multi-specialty clinics, and therapy service programs at sites in the same community but not located on the main hospital campus. Tahoe Forest Hospital also operates a distinct part skilled nursing facility. Only medically necessary services provided at facilities listed on the Tahoe Forest Hospital acute care license are included within the scope of this Financial Assistance Policy. TFHD has extended this policy to services proved at the Incline Village Community Hospital location, and clinics and therapy service programs.

C. This policy pertains to financial assistance provided by TFHD. All requests for financial assistance from patients shall be addressed in accordance with this policy.

Hospital Inpatient, Outpatient and Emergency Service Programs:

A. Introduction:

1. This policy sets forth a program to assist patients who are uninsured or underinsured in obtaining financial assistance in paying their hospital bill. Such financial assistance may include government sponsored coverage programs, Full Charity Care, and Discount Partial Charity Care.

B. Full Charity Care and Discount Partial Charity Care Reporting

1. TFHD will report actual Charity Care (including both Full Charity Care and Discount Partial Charity Care) provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. The hospital will maintain written documentation regarding its Charity Care criteria and, for individual patients, written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.
2. TFHD will provide OSHPD with a copy of this Financial Assistance Policy which includes the Full Charity Care and Discount Partial Charity Care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification

procedures; 2) the unified application for full charity care and discount partial charity care; and 3) the review process for both full charity care and discount partial charity care. Forms of these documents shall be supplied to OSHPD every two years or whenever a substantial change is made.

C. Full and Discount Charity Care Eligibility: General Process and Responsibilities:

1. Any patient whose family[1] income is less than 350% of the FPL, is ~~f~~not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account, is eligible to apply for financial assistance under the TFHD Financial Assistance Program.
2. The TFHD Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to apply for the maximum financial assistance benefit for which he or she may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the hospital and such information will be used to determine the maximum coverage under the TFHD Financial Assistance Program for which the patient or patient's family may qualify.
3. Eligible patients may apply for financial assistance under the TFHD Financial Assistance Program by completing an application consistent with application instructions, together with documentation and health benefits coverage information sufficient to determine the patient's eligibility for coverage under the program. Eligibility alone is not an entitlement to financial assistance under the TFHD Financial Assistance Program. TFHD must complete a process of applicant evaluation and determine, in accordance with this policy, whether financial assistance will be granted.
4. The TFHD Financial Assistance Program relies upon the cooperation of individual patients to determine who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, TFHD will use a financial assistance application. All patients without adequate financial coverage by Third Party Insurance will be offered an opportunity to complete the financial assistance application. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a financial assistance application.
5. The financial assistance application should be made as soon as there is an indication by the patient or the patient's representative that he/she may be in need of and requests financial assistance. The application form may be completed at any time prior to or within one year after discharge, or within one year after the patient became eligible, whichever comes first.
6. To the extent it deems necessary, in its sole and reasonable discretion, TFHD may require an applicant for financial assistance to provide supplemental information in addition to a complete financial assistance application to provide:
    a. Confirmation of the patient's income and health benefits coverage;
    b. Complete documentation of the patient's monetary assets;
    c. Other documentation as needed to confirm the applicant's qualification for financial assistance; and
    d. Documentation confirming the hospital's decision to provide financial assistance, if financial assistance is provided.
7. However, a completed financial assistance application may not be required if TFHD determines, in its sole discretion, that it has sufficient patient information from which to make a financial assistance qualification decision.

PROCEDURES:

A. **Qualification: Full Charity Care and Discount Partial Charity Care**

1. Eligibility for financial assistance shall be determined based on the patient's and/or patient's family's ability to pay and on the other factors set forth in this policy. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

2. The patient and/or the patient's family representative who requests assistance in meeting their financial obligation to TFHD~~the hospital~~ shall make every reasonable effort to provide information necessary for TFHD~~the hospital~~ to make a financial assistance qualification determination. TFHD~~he hospital~~ will provide guidance and assistance to patients or their family representative as reasonably needed to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
3. Whether financial assistance will be granted is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy, as it may be amended from time to time. While financial assistance shall not be provided on a discriminatory or arbitrary basis, TFHD~~the hospital~~ retains full discretion, consistent with this policy, laws and regulations, to determine when a patient has provided sufficient evidence to establish eligibility for financial assistance, and what level of financial assistance an eligible patient is will receive.
4. Except as otherwise approved by TFHD, patients or their family representative must complete an application for the Financial Assistance Program in order to qualify for eligibility. The application and required supplemental documents are submitted to ~~the Patient~~ Financial Counseling~~Services~~ ~~department~~ at TFHD. This office shall be clearly identified on the application instructions.
5. TFHD will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.
6. Approval of an application for financial assistance to eligible patients will be made only by approved TFHD~~hospital~~ personnel according to the following levels of authority:
    ~~a. Clinic Manager: Accounts less than $500~~
    ~~b.~~a. Financial Counselor: Accounts less than $2,500
    ~~c.~~b. Director of Patient Access ~~Financial Services~~: Accounts less than $10,000
    ~~d.~~c. Chief Financial Officer: Accounts less than $50,000
    ~~e.~~d. Chief Executive Officer: Accounts greater than $50,000
7. Factors considered when determining whether to grant an individual financial assistance pursuant to this policy may include (but are not limited to):
    a. Extent of Third Party Insurance;
    b. Family income based upon tax returns or recent pay stubs;
    c. Monetary assets, if the patient requests any level of financial assistance greater than the Basic Discount (as defined below);
    d. The nature and scope of services for which the patient seeks financial assistance;
    e. Family size and circumstances;
    f. Hospital budget for financial assistance;
    g. Other criteria set forth in this policy.
8. Financial assistance will be granted based upon consideration of each individual application for financial assistance in accordance with the Financial Assistance Program set forth in this policy.
9. Financial assistance may be granted for Full Charity Care or Discount Partial Charity Care, based upon this Financial Assistance Program policy.
10. Once granted, financial assistance will apply only to the specific services and service dates for which the application has been approved by TFHD. In cases of care relating to a patient diagnosis which requires continuous, on-going related services, the hospital, at its sole discretion, may treat such continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of qualification determination by the hospital will not be included unless applied for and approved by TFHD pursuant to this policy.
11. Patient obligations for Medi-Cal/Medicaid Sshare of Ceost payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/ patient (such as a provided

service where coverage is denied) may be considered for financial assistance.

B. **Full and Discount Partial Charity Care Qualification Criteria**

1. Cap On Patient Liability For Services Rendered to Patients Eligible for Financial Assistance:
   Following completion of the application process for financial assistance, if it is established that the patient's family income is at or below 350% of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the entire patient liability portion of the bill for services rendered will be no greater than the amount Medicare would have paid for the services, net of any Third Party Insurance ("the Basic Discount"). This shall apply to all medically necessary hospital inpatient, outpatient and emergency services provided by TFHD.
2. Financial Assistance For Emergency Services
   If an individual receives Emergency Services and applies for financial assistance under the Financial Assistance Program, the following will apply:
   a. If the patient's family income is at or below 200% or less of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Full Charity Care for Emergency Services provided.
   b. If the patient's family income is between 201% and 350% of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Partial Discount Charity Care for Emergency Services provided in accordance with the following:
      i. Patient's care is not covered by Third Party Insurance. If the services are not covered by Third Party Insurance, the patient's payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1
Sliding Scale Payment Schedule

Family Percentage of FPL	**Percentage of Medicare Amount Payable** (subject to an additional discount if TFHD determines, in its sole discretion, that unusual circumstances warrant an additional discount).
201 – 215%	10%
216 – 230%	20%
231 – 245%	30%

246 – 260% 40%

261 – 275% 50%

276 – 290% 60%

291 - 305% 70%

306 - 320% 80%

321 – 335% 90%

336 – 350% 100

ii. Patient's care is covered by Third Party Insurance. If the services are covered by Third Party Insurance, but such coverage or liability is insufficient to pay TFHD's billed charges, leaving the patient responsible for a portion of the billed charges (including, without limitation, any applicable deductible or co-payment), the patient's payment obligation will be an amount equal to the difference between the gross amount paid by Third Party Insurance and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by Third Party Insurance exceeds what Medicare would have paid, the patient will have no further payment obligation. In no event shall the patient's obligation to pay a percentage of the unpaid amount be greater than the percentages of the amounts Medicare would pay for the same services set forth in Table 1, above.

c. If a patient who meets all other Financial Assistance Program requirements whose family income is either greater than 350% the current FPL, or has family income of less than 350% of the FPL and the seeks a discount for emergency services greater than the discount set forth above, then TFHD may decide, in its sole discretion, whether to provide such financial assistance, and the extent to which it will be provided, if at all. In making its decision, TFHD may consider the following factors, without limitation:
   i. The patient's need for financial assistance.
   ii. The extent of TFHD's limited charitable resources, and whether they are best spent providing these services at an additional discount or whether there are other patients with greater immediate need for TFHD's charitable assistance.
   iii. Any other facts (such as the patient's monetary assets) that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's request for charity care.

3. **Financial Assistance For Non-Emergency Services:**
If a patient requests financial assistance for Non-emergency Services (with the exception of primary care clinic, multi-specialty care clinic, or skilled nursing services, which are covered as described below), the following will apply:

If the patient's family income is 350% or less of FPL and meets all other Financial Assistance Program qualification requirements, the patient will be granted the Basic Discount. TFHD may decide, in its sole discretion, whether and to what extent additional financial assistance will be provided, such as whether to provide the level of assistance the patient would receive if he/she had received Emergency Services.

a. In addition to the information required by the financial assistance application, TFHD may require the individual to provide additional information regarding the individual's family monetary assets, as it deems appropriate in its sole discretion.

b. TFHD will decide, in its sole discretion, whether and to what extent to grant financial assistance in addition to the Basic Discount. Only medically necessary services will be considered. In making its determination, TFHD may, in addition to any other criteria set forth in this policy and without limitation, consider the following factors: ~~:~~

i. The degree of urgency that the services be performed promptly.
ii. Whether the services must be performed at TFHD, or whether there are other providers in the patient's geographic area that could provide the services in question.
iii. Whether the services can most efficiently be performed at TFHD, or whether there are other providers that could perform the services more efficiently.
iv. The extent, if any, that TFHD's limited charitable resources are best spent providing the requested service and whether there are others with greater immediate need for TFHD's charitable assistance.
v. The patient's need for financial assistance.
vi. Any other facts that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's request for financial assistance.

C. **Refunds**

In the event that a patient is determined to be eligible for financial assistance for services for which he/she or his/her guarantor has made a deposit or partial payment, and it is determined that the patient is due a refund because the payments already made exceed the patient's liability under this policy, any refund due shall be processed under TFHD's Credit and Collection Policy, which provides, in pertinent part, as follows:

" In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services and subsequently is determined to qualify for full Financial Assistance or discount partial Financial Assistance, all amounts paid which exceed the payment obligation, if any, as determined through the Financial Assistance Program process, shall be refunded to the patient. Any overpayment due to the patient under this obligation may not be applied to other open balance accounts or debt owed to TFHD by the patient or family representative. Any or all amounts owed shall be reimbursed to the patient or family representative within a reasonable time period. ~~In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services for which the patient has requested financial assistance, and subsequently is granted financial assistance through the Financial Assistance Program, any amounts paid at a time when the patient was eligible for financial assistance which exceed the patient's payment obligation, if any, shall be refunded to the patient, with interest. Any refund due to the patient under this paragraph may not be applied to other open balance accounts or debt owed to TFHDthe hospital by the patient or his/her family, representative, or guarantor. Any refunds due shall be reimbursed to the patient or his/her representative within a reasonable time. Such interest shall accrue from the first day that TFHD received payment of the amount to be refunded, at the rate set forth in Section 685.010 of the California Code of Civil Procedure~~."

D. ~~**Flow Chart**~~

~~Following is a flow chart describing the process for determining financial assistance for applicants for Emergency Services, Non-emergency Services, and Prior Services:~~

E. ~~Hospital-Based~~ Primary Care and Multi-Specialty Clinics

TFHD operates certain outpatient ~~services of the hospital as~~ clinics which can be ~~are~~ located apart from the main campus of the hospital. ~~These include a multi-specialty clinic, and a primary care clinic, both of which provide mainly primary care services.~~ Because of the lower cost of these services ~~primary care procedures~~ performed on an outpatient basis, the following shall apply to office visit services and professional fees ~~hospital services~~ rendered in these outpatient clinics:

a. Clinic patients are patients of the hospital, and will complete the same basic financial assistance application form
b. The patient's family income will primarily be determined using pay stubs
c. Tax returns will not be required as proof of income unless Financial Counseling ~~clinic personnel~~ determines it is reasonable and necessary due to unusual

circumstances

d. A patient attestation letter may be used on a limited basis when appropriate to an individual patient's circumstance
e. Subject to consideration of the factors set forth in paragraph 3 above for non-emergency services, to be determined by TFHD in its sole discretion, patients will pay a reduced fee based on the sliding scale below. If the Patient is covered by a third party obligation, the Patient's obligation will be to pay the difference between the amount paid by the third party and the amounts of the sliding scale, if any.

Clinic Sliding Scale

Patient/Family FPL Qualification	***Amount of Payment Due for Clinic Visit***
Incomes less than or equal to 200%	$25 flat fee, not to exceed what Medicare would pay for the clinic visit
Incomes between 201% and 350%	Actual Medicare Fee Schedule

2. Distinct Part Skilled Nursing Services
    a. Skilled nursing services are also quite different in nature than acute care inpatient, outpatient and emergency services. Patients at the distinct part skilled nursing facility are often residents at the hospital and require special programs designed to meet their long-term care needs.
    b. Given the unique nature of providing care to skilled nursing facility patients, the following financial assistance requirements shall apply:
        i. All skilled nursing patients and/or their family representatives shall complete the TFHD financial assistance application and provide supporting documents as required by the standard application
        ii. Patients will pay a reduced fee based on the following sliding scale

Distinct Part Skilled Nursing Sliding Scale

Patient/Family FPL Qualification	***Amount of Payment Due for Distinct Part Skilled Nursing Facility Services***
Incomes less than or equal to 200%	50% of the Medi-Cal Payment Rate
Incomes between 201% and	100% of the Medi-Cal

Patient/Family FPL Qualification	*Amount of Payment Due for Distinct Part Skilled Nursing Facility Services*
350%	Payment Rate

F. **Payment Plans**

1. When a determination to grant Discount Partial Charity Care has been made by TFHD~~the hospital~~, the patient may be given the option to pay any or all outstanding amount due through a scheduled term payment plan, as an alternative to a single lump sum payment.
2. TFHD~~he hospital~~ will discuss payment plan options with each patient that requests to make arrangements for long-term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than three (3) ~~12~~ months. In addition, TFHD works with an outside vendor if patients need payment plan terms that exceed three (3) months. Payment plan terms are subject to vendor requirements. ~~However, monthly payments will be negotiated so as not to exceed 10% of family income after deductions for essential living expenses.~~ TFHD~~he hospital~~ shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

G. **Special Circumstances**

1. Any application for financial assistance by or on behalf of patients covered by the Medicare Program must be made prior to service completion by TFHD.
2. If a patient is determined to be homeless he/she may be deemed eligible for charity care, in the sole discretion of TFHD.
3. Deceased patients who do not have any third party coverage, an identifiable estate, or for whom no probate hearing is to occur, may be deemed eligible for charity care, in the sole discretion of TFHD.
4. Charges for patients who receive Emergency Services for whom TFHD~~the hospital~~ is unable to issue a billing statement may be written off as Full Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

H. **Other Eligible Circumstances**

1. TFHD deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid ~~, Healthy Families, California Children's Services~~ and any other applicable state or local low-income program) to be eligible under the Financial Assistance Policy when services are provided which are not covered by the governmental program. For example, services to patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients ~~(e.g. CHDP, Healthy Families, and CCS)~~ which the government program does not cover, are eligible for Financial Assistance Program coverage. Under TFHD~~the hospital~~'s Financial Assistance Policy, these resulting non-reimbursed patient account balances are eligible for full write-off as Full Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care if, at the time that the services were provided TFHD believed that the services rendered were

medically necessary.

2. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payor including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:
    a. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or
    b. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

I. **Catastrophic Care Consideration**

Patients who do not qualify for charity care or discount partial charity care may nevertheless be eligible for financial assistance in the event of an illness or condition qualifying as a catastrophic event. Determination of a catastrophic event shall be made on a case-by-case basis. The determination of a catastrophic event shall be based upon the amount of the patient's liability at billed charges, and consideration of the individual's family income and assets as reported at the time of occurrence. Management may use its reasonable discretion on a case-by-case basis to determine whether and to what extent an individual or family is eligible for financial assistance based upon a catastrophic event. Financial assistance will be in the form of a percentage discount of some or all of the applicable monthly charges. The Catastrophic Event Eligibility Table will be used as a guideline by management to determine eligibility and the level of any financial assistance. The Catastrophic Event Eligibility Table does not guarantee that any individual will receive financial assistance, or the level of any assistance given.

J. **Criteria for Re-Assignment from Bad Debt to Charity Care** (Why would we do this?)

1. Any account returned to TFHD~~the hospital~~ from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation ~~file~~.
2. All outside collection agencies contracted with TFHD to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change recommendation from bad debt to charity care:.
    a. Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers); and
    b. The patient or family representative must have a credit score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and
    c. The patient or family representative has not made a payment within 150 days of assignment to the collection agency;
    d. The collection agency has determined that the patient/family representative is unable to pay; and/or
    e. The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score
3. All accounts recommended by ~~returned from~~ a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by TFHD~~hospital~~ Patient Access Director, or Chief Financial Officer ~~personnel~~ prior to any re-classification within the TFHD ~~hospital~~ accounting system and records.

K. **Notification**

Once a determination of eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

1. Approval: The letter will indicate that financial assistance has been approved, the level of assistance, and any outstanding or prospective liability by the patient.
2. Denial: If the patient is not eligible for financial assistance due to his/her income and/or monetary assets, the reasons for denial of eligibility will be explained to the patient. Any outstanding amount owed by the patient will also be identified.
3. Incomplete~~Pending~~: The applicant will be informed as to why the financial assistance application is incomplete. All outstanding information will be identified and requested to

be supplied to TFHDthe Hospital by the patient or family representative within a specified timeframe. In general, patients will have thirty (30) days from receipt of the application to return the completed application and applicable supporting documents.

L. **Reconsideration of Eligibility Denial**

1. In the event that a patient disputes TFHDthe hospital's determination of eligibility, the patient may file a written request for reconsideration with TFHDthe Hospital within 60 days of receiving notification of eligibility. The written request should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any additional relevant documentation to support the patient's claim should be attached to the written appeal.
2. Any or all appeals will be reviewed by TFHD'sthe hospital Cehief Ffinancial Oefficer. The Cehief Ffinancial Oefficer or his/her designee shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Cehief Ffinancial Oefficer shall provide the patient with a written explanation of the results of the reconsideration of the patient's eligibility. All determinations by the Cehief Fifinancial Oefficer shall be final. There are no further appeals.
3. All discretionary decisions by TFHDthe hospital shall not be subject to further review or reconsideration.

M. **Public Notice**

1. TFHD shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay his/her bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. Notices will also include information about obtaining applications for potential coverage through the California Health Benefit Exchange and other contact information related to consumer advocacy resources.
2. These notices shall be posted in English and Spanish and any other languages that are representative of the primary language of 5% or greater of residents in the hospital's service area.
3. A copy of this Financial Assistance Policy will be made available to the public on a reasonable basis.

N. **Confidentiality**

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

O. **Good Faith Requirements**

1. TFHD makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.
2. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all Full Charity Care or Partial Discount Charity Care services when information has been intentionally withheld or inaccurate information has been intentionally provided by the patient or family representative to the extent such inaccurate or withheld information affects the eligibility of the patient for financial assistance, or any financial assistance provided at TFHDthe hospital's discretion. In addition, TFHD reserves the right to seek all remedies, including but not limited to civil and criminal remedies from those patients or family representatives who have intentionally withheld or provided inaccurate information in order qualify for the TFHD Financial Assistance Program.

References:

See TFHD BOD Meeting Minutes of January 26, 2015 and May 24, 2011;
The Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119) (2010) Section 9007; Health and Safety Code Sections 127360-127360; Health and Safety Code Sections 127400-127440

[1] A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*03/2017*
Last Approved:	*03/2017*
Last Revised:	*03/2017*
Next Review:	*01/2020*
Department:	*Board - ABD*
Applicabilities:	*System*

Debt Management Policy, ABD-25

This Debt Management Policy (the "Debt Policy") of the TAHOE FOREST HOSPITAL DISTRICT (the "District") was approved by the Board of Directors of the District (the "Board"). The Debt Policy may be amended by the Board as it deems appropriate from time to time in the prudent management of the debt of the District.

This Debt Policy will also apply to any debt issued by any other public agency for which the Board of the District acts as its legislative body.

The Debt Policy has been developed to provide guidance in the issuance and management of debt by the District or its related entities and is intended to comply with Section 8855(i) of the California Government Code effective on January 1, 2017. The main objectives are to establish conditions for the use of debt; to ensure that debt capacity and affordability are adequately considered; to minimize the District's interest and issuance costs; to maintain the highest possible credit rating; to provide complete financial disclosure and reporting; and to maintain financial flexibility for the District.

Debt, properly issued and managed, is a critical element in any financial management program. It assists in the District's effort to allocate limited resources to provide the highest quality of service to the public. The District understands that poor debt management can have ripple effects that hurt other areas of the District. On the other hand, a properly managed debt program promotes economic growth and enhances the vitality of the District for its residents and businesses.

1. **Findings**
   This Debt Policy shall govern all debt undertaken by the District. The District hereby recognizes that a fiscally prudent debt policy is required in order to:
   • Maintain the District's sound financial position.
   • Ensure the District has the flexibility to respond to changes in future service priorities, revenue levels, and operating expenses.
   • Protect the District's credit-worthiness.
   • Ensure that all debt is structured in order to protect both current and future taxpayers, ratepayers and constituents of the District.
   • Ensure that the District's debt is consistent with the District's planning goals and objectives and capital improvement program or budget, as applicable.
   • Encourage those that benefit from a facility/improvement to pay the cost of that facility/improvement without the need for the expenditure of limited general fund resources.
2. **Policies**

A. **Purposes For Which Debt May Be Issued**

The District will consider the use of debt financing primarily for capital improvement projects (CIP) when the project's useful life will equal or exceed the term of the financing and when resources are identified sufficient to fund the debt service requirements. An exception to this CIP driven focus is the issuance of short-term instruments such as tax and revenue anticipation notes, which are to be used for prudent cash management purposes and conduit financing, as described below. Bonded debt should not be issued for projects with minimal public benefit or support, or to finance normal operating expenses.

If a department has any project which is expected to use debt financing, the department director is responsible for expeditiously providing the Chief Executive Officer and the Chief Financial Officer with reasonable cost estimates, including specific revenue accounts that will provide payment for the debt service. This will allow an analysis of the project's potential impact on the District's debt capacity and limitations. The department director shall also provide an estimate of any incremental operating and/or additional maintenance costs associated with the project and identify sources of revenue, if any, to pay for such incremental costs.

i. **Long-Term Debt**. Long-term debt may be issued to finance or refinance the construction, acquisition, and rehabilitation of capital improvements and facilities, equipment and land to be owned and/or operated by the District.

   a. Long-term debt financings are appropriate when the following conditions exist:
   • When the project to be financed is necessary to provide basic services.
   • When the project to be financed will provide benefit to constituents over multiple years.
   • When total debt does not constitute an unreasonable burden to the District and its taxpayers and ratepayers.
   • When the debt is used to refinance outstanding debt in order to produce debt service savings or to realize the benefits of a debt restructuring.

   b. Long-term debt financings will not generally be considered appropriate for current operating expenses and routine maintenance expenses.

   c. The District may use long-term debt financings subject to the following conditions:
   • The project to be financed has been or will be approved by the Board.
   • The weighted average maturity of the debt (or the portion of the debt allocated to the project) will not exceed the average useful life of the project to be financed by more than 20%, unless specific conditions exist that would mitigate the extension of time to repay the debt and it would not cause the District to violate any covenants to maintain the tax-exempt status of such debt, if applicable.
   • The District estimates that sufficient income or revenues will be available to service the debt through its maturity.
   • The District determines that the issuance of the debt will comply with the applicable requirements of state and federal law.
   • The District considers the improvement/facility to be of vital, time-sensitive need of the community and there are no plausible alternative financing sources

   d. Periodic reviews of outstanding long-term debt will be undertaken to identify refunding opportunities. Refundings will be considered (within federal tax law constraints, if applicable) if and when there is a net economic benefit of the refunding. Refundings which are non-economic may be undertaken to achieve District objectives relating to changes in covenants, call provisions, operational flexibility, tax status of the issuer, or the debt service

profile.

In general, refundings which produce a net present value savings of at least 4% of the principal amount of refunded debt will be considered economically viable. Refundings which produce a net present value savings of less than 4% or negative savings will be considered on a case-by-case basis.

(ii) **Short-term debt**. Short-term borrowings may be issued to generate funding for cash flow needs in the form of Tax and Revenue Anticipation Notes (TRAN).

Short-term borrowings, such as commercial paper, and lines of credit, will be considered as an interim source of funding in anticipation of long-term borrowing. Short-term debt may be issued for any purpose for which long-term debt may be issued, including capitalized interest and other financing-related costs. Prior to issuance of the short-term debt, a reliable revenue source shall be identified to secure repayment of the debt. The final maturity of the debt issued to finance the project shall be consistent with the economic or useful life of the project and, unless the Board determines that extraordinary circumstances exist, must not exceed seven years.

Short-term debt may also be used to finance short-lived capital projects; for example, the District may undertake lease-purchase financing for equipment, and such equipment leases may be longer than seven years.

(iii) **Financings on Behalf of Other Entities**. The District may also find it beneficial to issue debt on behalf of other governmental agencies or private third parties in order to further the public purposes of the District. In such cases, the District shall take reasonable steps to confirm the financial feasibility of the project to be financed and the financial solvency of any borrower and that the issuance of such debt is consistent with the policies set forth herein. In no event will the District incur any liability or assume responsibility for payment of debt service on such debt.

B. Types of Debt

In order to maximize the financial options available to benefit the public, it is the policy of the District to allow for the consideration of issuing all generally accepted types of debt, including, but not exclusive to the following:

- **General Obligation (GO) Bonds**: General Obligation Bonds are suitable for use in the construction or acquisition of improvements to real property that benefit the public at large. Examples of projects include hospitals, and public safety facilities. All GO bonds shall be authorized by the requisite number of voters in order to pass.
- **Revenue Bonds**: Revenue Bonds are limited-liability obligations tied to a specific enterprise or special fund revenue stream where the projects financed clearly benefit or relate to the enterprise or are otherwise permissible uses of the special revenue. An example of projects that would be financed by a Revenue Bond would be improvements to a health facility, which would be paid back with money raised from the rates and charges to health facility users. Generally, no voter approval is required to issue this type of obligation.
- **Lease-Backed Debt/Certificates of Participation (COP/Lease Revenue Bonds)**: Issuance of Lease-backed debt is a commonly used form of debt that allows a public entity to finance projects where the debt service is secured via a lease agreement or installment sale agreement and where the payments are budgeted in the annual operating budget of the District. Lease-Backed debt does not constitute indebtedness under the state or the District's constitutional debt limit and does not require voter approval.

The District may from time to time find that other forms of debt would be beneficial to further its public purposes and may approve such debt without an amendment of this Debt Policy.

To maintain a predictable debt service burden, the District will give preference to debt that carries a fixed interest rate. An alternative to the use of fixed rate debt is variable rate debt. The District may choose to issue securities that pay a rate of interest that varies according to a pre-determined formula or results from a periodic remarketing of securities. When making the determination to issue bonds in a variable rate mode, consideration will be given in regards to the useful life of the project or facility being financed or the term of the project requiring the funding, market conditions, credit risk and third party risk analysis, and the overall debt portfolio structure when issuing variable rate debt for any purpose. The maximum amount of variable-rate debt should be limited to no more than 20 percent of the total debt portfolio.

The District will limit the use of derivatives, such as interest rate swaps, in its debt program. A derivative product is a financial instrument which derives its own value from the value of another instrument, usually an underlying asset such as a stock, bond, or an underlying reference such as an interest rate. Derivatives are commonly used as hedging devices in managing interest rate risk and thereby reducing borrowing costs. However, these products bear certain risks not associated with standard debt instruments.

C. Relationship of Debt to Capital Improvement Program and Budget

The District intends to issue debt for the purposes stated in this Debt Policy and to implement policy decisions incorporated in the District's capital budget and its capital improvement plan.

The District shall strive to fund the upkeep and maintenance of its infrastructure and facilities due to normal wear and tear through the expenditure of available operating revenues. The District shall seek to avoid the use of debt to fund infrastructure and facilities improvements that are the result of normal wear and tear, unless a specific revenue source has been identified for this purpose.

The District shall integrate its debt issuances with the goals of its capital improvement program by timing the issuance of debt to ensure that projects are available when needed in furtherance of the District's public purposes.

The District shall seek to issue debt in a timely manner to avoid having to make unplanned expenditures for capital improvements or equipment from its operating funds.

D. Policy Goals Related to Planning Goals and Objectives

The District is committed to financial planning, maintaining appropriate reserve levels and employing prudent practices in governance, management and budget administration. The District intends to issue debt for the purposes stated in this Debt Policy and to implement policy decisions incorporated in the District's annual operating budget.

It is a policy goal of the District to protect taxpayers, ratepayers and constituents by utilizing conservative financing methods and techniques so as to obtain the highest practical credit ratings (if applicable) and the lowest practical borrowing costs.

The District will comply with applicable state and federal law as it pertains to the maximum term of debt and the procedures for levying and imposing any related taxes, assessments, rates and charges.

Except as described in Section 2.A., when refinancing debt, it shall be the policy goal of the District to realize, whenever possible, and subject to any overriding non-financial policy considerations minimum

net present value debt service savings equal to or greater than 4% of the principal amount of refunded debt.

E. Internal Control Procedures

When issuing debt, in addition to complying with the terms of this Debt Policy, the District shall comply with any other applicable policies regarding initial bond disclosure, continuing disclosure, post-issuance compliance, and investment of bond proceeds.

The District will periodically review the requirements of and will remain in compliance with the following:

• any continuing disclosure undertakings under SEC Rule 15c2-12,

• any federal tax compliance requirements, including without limitation arbitrage and rebate compliance, related to any prior bond issues, and

• the District's investment policies as they relate to the investment of bond proceeds.

Whenever reasonably possible, proceeds of debt will be held by a third-party trustee and the District will submit written requisitions for such proceeds. The District will submit a requisition only after obtaining the signature of the Chief Executive Officer or the Chief Financial Officer.

F. Waivers of Debt Policy

There may be circumstances from time to time when strict adherence to a provision of this Debt Policy is not possible or in the best interests of the District and the failure of a debt financing to comply with one or more provisions of this Debt Policy shall in no way affect the validity of any debt issued by the District in accordance with applicable laws.

All revision dates: 03/2017

Attachments:

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	03/2017
	Martina Rochefort: Clerk of the Board	03/2017

Original Adoption Date: January 25, 2018

TAHOE FOREST HOSPITAL DISTRICT

FIDUCIARY RESPONSIBILITY DELEGATION CHARTER

I. Purpose and Objectives

The purpose of this Fiduciary Responsibility Delegation Charter ("Charter") is to guide the **Tahoe Forest Hospital District** ("Plan Sponsor") in executing its fiduciary responsibilities with respect to the following plan(s) (the "Plan").

Tahoe Forest Hospital District Eligible Deferred Compensation Plan
Tahoe Forest Hospital District Money Purchase Pension Plan

This Charter defines the fiduciary responsibility of the Plan Sponsor and the delegation of certain rights, powers and duties under the Plan to others as designated by the Plan Sponsor. Fiduciaries who fail to meet the responsibilities delineated herein may be personally liable for breach of fiduciary duty.

However, the Plan Sponsor indemnifies and holds harmless each member of the Retirement Plan Committee (the "Committee") for an alleged breach of fiduciary duty, except in the case of the delegate's gross negligence or willful misconduct.

Plan Sponsor's objectives as they relate to fiduciary responsibility and maintenance and operation of the Plan are to:

a) Maintain the Plan for the exclusive benefit of participants while avoiding any prohibited transactions and/or conflicts of interest;

b) Exercise prudence in all respects while executing fiduciary responsibilities;

c) Diversify designated investment alternatives available to participants under the Plan; and,

d) Ensure conformity of the Plan's operations to the Plan document provisions and applicable law.

II. Fiduciary Authority and Responsibilities Under the Plan

The Plan Sponsor shall bear responsibility for delegating specific fiduciary duties. Certain fiduciary responsibilities shall be delegated by the Plan Sponsor's Board of Directors (the "Board") to other persons under and pursuant to this Charter. The Board shall retain decision rights regarding any substantive changes to the Plan that may impact annual Plan costs in excess of a de minimus amount, including changes to eligibility for benefits and/or changes in employer contributions.

Original Adoption Date: January 25, 2018

III. Committee Membership

The Board hereby delegates certain functional fiduciary responsibilities to the Plan Sponsor's Retirement Plan Committee (the "Committee"). The Board shall select Committee members.

a) The Committee's membership shall include Tahoe Forest Hospital District employees in the following roles, or successor positions as confirmed by the Committee Chair:

1. Chief Human Resources, as Committee Chair, and;
2. Chief Executive Officer, and;
3. Chief Financial Officer, and;
4. Benefits Coordinator, and;
5. Additional Members as appointed by the Committee Chair.

b) The Committee may name a Secretary, an employee who may, but need not be, a Committee member.

c) If any individual, who is a member of the Committee, ceases to be an employee, then the removal of the Committee member shall occur automatically and without any requirement for action by the Board or any notice to the individual.

d) Any employee will automatically be added to the Committee upon filling one of the roles above.

IV. Committee Procedures

The Committee shall ensure the execution of certain administrative responsibilities with respect to Plan operations. Such administrative responsibilities shall include:

a) Committee Chair. The Chair shall be responsible for the preparation of the meeting agenda, meeting materials, and conducting the meeting.

b) Majority Decisions. Any action of the Committee may be taken by a simple majority of those members qualified to vote, with or without the concurrence of the minority. In the event of a deadlock, the matter shall be decided by the Plan Sponsor.

c) Delegation to Act in Behalf of Committee. The Committee may delegate to one or more of its members to act on its behalf, to give notice in writing of any action taken by the Committee, and to contract for legal, recordkeeping, accounting, clerical, and other services to carry out the purposes of the Plans. The Committee may appoint such officers and/or subcommittees (the members of which need not be members of the Committee) with such powers as it shall determine and may authorize to execute or deliver on behalf of the Plans.

d) Committee Rules. Subject to the limitations of the Plans, the Committee shall from time to time establish rules for the administration of the Committee and the transaction of its business, including the times and places for holding meetings, the notices to be given with respect for such meetings and the number of members who shall constitute a quorum for the transaction of business.

e) Frequency of Meetings. Except to the extent that the Committee shall otherwise determine, meetings of the Committee shall be held at least once each semi-annual period.

f) Reports to the Board. Twice per year, within 90 days after the fiscal year end and calendar year end, the Committee shall present a report to the Board. Such report shall include a summary of the activities of the Committee respecting the status of the administrative and investment activities of the Plans and such other information as the Committee or the Board deems advisable.

g) There will be public notice to Tahoe Forest Hospital District Employees notifying them when and where the meetings will be held so that employees can attend if they choose.

V. Plan Administrative Responsibilities

The Plan administrative responsibilities of the Committee shall include, but shall not be limited to, the following:

a) Require any person to furnish information for the proper administration of the Plans as a condition to receiving benefits.

b) Make and enforce rules and prescribe procedures for efficient Plan administration.

c) Maintain all records necessary for Plan administration, other than those maintained by the recordkeeper.

d) Interpret and construe the Plans and their related documents.

e) Determine guidelines for the amount of benefits payable and claims for benefits under the Plans.

f) Designate persons to carry out any fiduciary responsibilities of the Plan Administrator for the Plans.

g) Executing amendments to Plan documents and/or policies as may be required by changes in applicable law and/or regulation.

h) Executing amendments to Plan documents as may be required by operational decisions resulting from the Plan Sponsor's changed objectives.

i) Executing amendments to Plan documents and/or policies as may be required by changes in Plan benefit design approved by the Committee.

j) Communicate the Plan's provisions to participants as required by applicable law and oversee information provided to participants on the nature and characteristics of the investment alternatives available in the Plans to assist participants with making prudent asset allocation decisions.

k) Determining employee eligibility to participate in the Plan in accordance with applicable Plan document provisions.

l) Enrolling participants in the Plan in accordance with applicable Plan document provisions.

m) Ensuring the timely deposit of participant salary deferrals to the participants' separate accounts under the Plan.

n) Approving and administering participant loans and distributions in accordance with applicable Plan document provisions.

o) Preparing and reviewing consolidated financial reporting for the Plan, including governmental reporting.

~~p) Maintaining the required fidelity bond.~~

~~o)~~p) Providing general oversight of the Plan's compliance with applicable laws and/or regulations.

~~r)~~q) Retaining recordkeepers/administrators, consultants, attorneys, auditors and other advisers to the plan as appropriate to assist with the aforementioned responsibilities.

~~s)~~r) Monitoring and evaluating the recordkeeper/administrator and other parties hired to perform delegated responsibilities to ensure reasonability of fees and appropriate execution of delegated responsibilities.

~~t)~~s) Establishing policies and procedures to allocate reasonable expenses incurred by the Plan.

VI. Plan Investment Responsibilities

The Board hereby delegates certain investment related responsibilities to the Committee. The Committee's investment related responsibilities shall include, but shall not be limited to, the following:

a) Investment Policy. Develop investment objectives, guidelines and performance measurement standards consistent with the needs of the investments of the Plans as documented in an Investment Policy Statement.

b) Selection of Investment Managers. Select investment funds for the Plans, ensuring their proper diversification, and monitoring their performance against appropriate benchmarks.

c) Selection of Default Investment Alternative. Determine the default investment to be used in the event that a participant does not make an investment election.

d) Monitoring Investments. Provide on-going monitoring with respect to the investments of the Plans in the context of established standards of performance, and taking whatever corrective action is deemed prudent and appropriate if objectives are not being met or if policies and guidelines are not being followed.

e) Monitoring Fees and Expenses. Monitoring the reasonableness of investment costs passed to Plan participants.

f) Investment Adviser. Retain independent advisers and investment consultants as appropriate to assist with the aforementioned responsibilities.

g) Other Responsibilities. The Committee may take such other and further actions with respect to the investments of the Plans as are consistent with this Charter or as are set forth in the documents of the Plans or their related trusts or contracts, or which the Committee determines in its discretion are in the best interests of the Plans and participants.

VII. Construction

This Charter shall not be interpreted to limit the discretion of the Plan Sponsor. The Plan Sponsor, by its Board, reserves the discretion to make exceptions to this Charter as may be appropriate.

As used herein, the term "participants" shall be deemed to include participants and their beneficiaries, as appropriate.

Original Adoption Date: January 25, 2018

VIII. Charter Review and Amendment

This Charter shall be reviewed periodically by the Board and, if appropriate, shall be amended to reflect any relevant changes in the Plan's operations, philosophy and/or objectives, as well as any relevant changes to applicable law.

IX. Plan Document Coordination

In the event of any conflict between the provisions of this Charter, or any delegation of authority made pursuant to this Charter, and the provisions of the Plan document, the terms of the Plan document shall govern.

X. Fiduciary Responsibility

The Committee, in the exercise of each and every power or discretion vested in it, shall fulfill their fiduciary responsibilities and discharge their duties, with respect to the plan, solely in the interest of the participants and beneficiaries. The fiduciaries are to perform their duties with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

AS AUTHORIZED BY THE BOARD RESOLUTION DATED JANUARY 25, 2018, EXECUTED FOR THE COMMITTEE:

BY:

_____ _____

Signature Date

_____

Printed Name

_____

Title

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System, Truckee Surgery Center*

Quality Assessment/ Performance Improvement (QA/PI) Plan, AQPI-05

PURPOSE:

The purpose of the Quality Assessment/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and High Reliability tenets to promote and improve awareness of patient safety. Tahoe Forest Health System has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

POLICY:

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"We exist to make a difference in the health of our communities through excellence and compassion in all we do."*

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To serve our region by striving to be the best mountain health system in the nation."*

VALUES STATEMENT

Our vision and mission is supported by our values. These include:

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.

B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.

D. Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality health care.

E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.

1. Quality – provide excellence in clinical outcomes
2. Service – best place to be cared for
3. People – best place to work, practice, and volunteer
4. Finance – provide superior financial performance
5. Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2020 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations;
3. Reducing the per capita cost of health care;
4. Staff engagement and joy in work.

B. Priorities identified include:

1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    a. Striving for the Perfect Care Experience
    b. Identify and promote best practice and evidence-based medicine
2. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial Healthcare Facilities Accreditation Program (HFAP) survey
3. Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    a. Continued participatioin in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting
4. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system

c. Understand vulnerabilities
d. Recognize bias
e. Efficient resource management
f. Evaluate system based on risk, not rules

5. Support Patient and Family Centered Care and the Patient and Family Advisory Council
   a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
   b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
   c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
   d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
6. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
7. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
8. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

C. Tahoe Forest Health System's vision will be achieved through these strategic priorities and performance improvement initiatives. Each strategic priority is driven by leadership oversight and teams developed to ensure improvement and implementation (Attachment A -- Quality Initiatives).

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all departments, services, and external partners, including third-party payors and other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement and positive outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Governing Board

A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for the quality of care and services provided throughout the system Attachment B – CAH Services). The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.

B. The Board:
   1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
   2. Responsible for determining, implementing, and monitoring policies governing the Critical Access

Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))

3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities.

B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

The Board Quality Committee is to provide oversight for the Health System QA/PI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.

B. The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

A. The Department Chairs:

1. Provide a communications channel to the Medical Executive Committee;
2. Monitor Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE) and make recommendations regarding reappointment based on data regarding quality of care;
3. Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:

1. Foster an environment of collaboration and open communication with both internal and external customers;
2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
3. Advance the philosophy of High Reliability within their departments;
4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/

Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

C. Employees are expected to do the following:

1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

With designated authority from the Medical Executive Committee, the Medical Staff Quality Assessment Committee (MS QAC) is responsible for prioritizing the performance improvement activities in the organization, chartering cross-functional teams, improving processes within the Health System, and supporting the efforts of all performance improvement activities. The MS QAC is an interdisciplinary committee led by the Medical Director of Quality. The committee has representatives from each Medical Staff department, Health System leadership, nursing, ancillary and support services ad hoc. Meetings are held at least quarterly each year. The Medical Director of Quality, Chief Medical Officer, and the Vice Chief of Staff are members of the Board of Director's Quality Committee.

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Emergency Operations Plan, Utilization Review Plan, Risk Management Plan, Trauma Performance Improvement Plan, and the Patient Safety Plan.

B. Regularly reviews progress to the aforementioned plans.

C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;

D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;

E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety

standards that may require further investigation;

F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;

G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;

H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.

J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.

K. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.

B. The Performance Improvement Committee will:

1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
2. Set performance improvement priorities and provide the resources to achieve improvement
3. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

Tahoe Forest Health System utilizes DMAIC Rapid Cycle Teams (Define, Measure, Analyze, Improve, Control). The Administrative Council, Director of Quality & Regulations, or the Medical Staff Quality Committee charter formal cross-functional teams to improve current processes and design new services, while each department utilizes tools and techniques to address opportunities for improvement within their individual areas.

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

B. Performance Improvement Teams will:

1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
2. Establish specific, measurable goals and monitoring for identified initiatives
3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.

C. Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.

D. Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

B. Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
5. Processes related to patient flow
6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:

1. Identified needs from data collection and analysis
2. Unanticipated adverse occurrences affecting patients
3. Processes identified as error prone or high risk regarding patient safety
4. Processes identified by proactive risk assessment
5. Changing regulatory requirements
6. Significant needs of patients and/or staff
7. Changes in the environment of care
8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:
        a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
        b. It is clinically sound and current
        c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
        d. It is consistent with sound business practices
        e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
        f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
        g. It incorporates the results of performance improvement activities
        h. It incorporates consideration of staffing effectiveness
        i. It incorporates consideration of patient safety issues
        j. It incorporates consideration of patient flow issues
    4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
        a. They can identify the events it is intended to identify
        b. They have a documented numerator and denominator or description of the population to which

it is applicable

c. They have defined data elements and allowable values

d. They can detect changes in performance over time

e. They allow for comparison over time within the organization and between other entities

f. The data to be collected is available

g. Results can be reported in a way that is useful to the organization and other interested stakeholders

B. An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:

1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
    a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
    b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
    c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.
    d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
    e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
    f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
    g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written

infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:

1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
19. Summaries of performance improvement actions and actions to reduce risks to patients

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:

1. Quality measures delineated in clinical contracts will be reviewed annually

2. Pharmacy transactions as required by law and to control and account for all drugs
3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
4. Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
5. Reports of required reporting to federal, state, authorities
6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

C. These data are reviewed regularly by the PIC, MSQAC, and the BOD with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

B. The data is used to monitor the effectiveness and safety of services and quality of care. The data analysis identifies opportunities for process improvement and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.

C. Data is analyzed in many ways including:
1. Using appropriate performance improvement problem solving tools
2. Making internal comparisons of the performance of processes and outcomes over time
3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

D. Intensive analysis is completed for:
1. Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
2. Significant and undesirable performance variations from the performance of other operations
3. Significant and undesirable performance variations from recognized standards
4. A sentinel event which has occurred (see Sentinel Event Policy)
5. Variations which have occurred in the performance of processes that affect patient safety
6. Hazardous conditions which would place patients at risk
7. The occurrence of an undesirable variation which changes priorities

E. The following events will automatically result in intense analysis:

1. Significant confirmed transfusion reactions
2. Significant adverse drug reactions
3. Significant medication errors
4. All major discrepancies between preoperative and postoperative diagnosis
5. Adverse events or patterns related to the use of sedation or anesthesia
6. Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
7. Staffing effectiveness issues
8. Deaths associated with a hospital acquired infection
9. Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC annually.

C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

E. Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in quality reporting initiatives (See Attachment E for External Reporting listing).

CONFIDENTIALITY AND CONFLICT OF INTEREST

A. All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any Medical Staff Department or Committee, the Administrative Council, or Health System department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure.

B. Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to participate in the review. All information related to performance improvement activities performed by the Medical Staff or Health System staff in accordance with this plan is confidential and are protected by disclosure and discoverability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

Quality Assessment Performance Improvement Plan will be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Trauma Performance Improvement Plan, ??

Discharge Planning, ANS-238

References:

HFAP and CMS

All revision dates:

Attachments

A. Quality Initiatives 2020.docx
B. CAH Services by Agreement 2020
C. QA PI Reporting Measures 2020
D. QI Indicator Definitions 2020
E. External Reporting 2020