2020-04-23 Regular Meeting of the Board of Directors

Thursday, April 23, 2020 at 4:00 p.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for April 23, 2020 will be conducted telephonically through Zoom.

Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting.

Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

Meeting Book - 2020-04-23 Regular Meeting of the Board of Directors

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REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, April 23, 2020 at 4:00 p.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for April 23, 2020 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely:
Please use this web link: https://zoom.us/j/91893367689

Or join by phone:
If you prefer to use your phone, you may call in using the numbers below.
(346) 248 7799 or (301) 715 8592
Meeting ID: 918 9336 7689

Public comment will also be accepted by email to mrochefort@tfhd.com. Please list the item number you wish to comment on and submit your written comments 24 hours prior to the start of the meeting.

Oral public comments will be subject to the three minute time limitation (approximately 350 words). Written comments will be distributed to the board prior to the meeting but not read at the meeting.

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. **CLOSED SESSION**
   5.1. Hearing (Health & Safety Code § 32155) ◈
   Subject Matter: First Quarter 2020 Corporate Compliance Program Report
   Number of items: One (1)
   5.2. 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 District 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.

◈ Denotes Action Item

228793.1

Statement made outside an open meeting of District (Gov. Code §54956.9(e)(5)) by Corrine Zack regarding access to medical records, and a written record of the statement was made prior to the meeting and is available for public inspection in the Clerk's office.

5.3. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: 2019 Annual Quality Report
Number of items: One (1)

5.4. Hearing (Health & Safety Code § 32155)
Subject Matter: Quality Assurance Report
Number of items: One (1)

5.5. Approval of Closed Session Minutes ◈
03/26/2020

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

APPROXIMATELY 6:00 P.M.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

10. 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 Chair 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.

11. 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.

12. ACKNOWLEDGMENTS

12.1. April 2020 Employee of the Month .... ATTACHMENT

13. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda .... ATTACHMENT

◈ Denotes Action Item

MEC recommends the following for approval by the Board of Directors:
With content changes
- *Bylaws*
- *Rules & Regulation*
- *Standardized Procedures for PA's and NP's*
- *Trauma Activation Algorithm*
- *AHP Guidelines*
- *NP-PA Privilege Form*

New Privilege Forms
- *Licensed Clinical Social Workers*
- *Licensed Marriage Family Therapist*
- *PA CA Practice Agreement*
- *Collaborative Practice Agreement NP*

14. 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.

14.1. Approval of Minutes of Meetings

14.1.1. 03/26/2020 .... ATTACHMENT

14.2. Financial Reports

14.2.1. Financial Report – March 2020 .... ATTACHMENT

14.3. Approve Board Policies

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

14.3.2. Emergency On-Call Policy, ABD-10 .... ATTACHMENT

14.4. Ratify new TFHS Foundation Board Member

14.4.1. Alan Kern - Resume .... ATTACHMENT

14.5. Accept Quarterly Compliance Report

14.5.1. First Quarter 2020 Corporate Compliance Program Report .... ATTACHMENT

15. ITEMS FOR BOARD DISCUSSION

15.1. Annual Foundations Update .... ATTACHMENT

The Board of Directors will receive an annual update on the Tahoe Forest Health System Foundation and Incline Village Community Hospital Foundation.

15.2. COVID-19 Update

The Board of Directors will receive an update on hospital and clinic operations related to COVID-19.

16. ITEMS FOR BOARD ACTION

16.1. Resolution 2020-04 Declaration of Emergency .... ATTACHMENT

The Board of Directors will review and consider approval of a resolution declaring and confirming a state of emergency due to spread and threatened spread of COVID-19.

16.2. Moss Adams Engagement Letter .... ATTACHMENT

The Board of Directors will review and consider approval of a three-year engagement letter with Moss Adams for audit and nonattest services.

◈ Denotes Action Item

228793.1

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD COMMITTEE REPORTS

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

20. CLOSED SESSION CONTINUED, IF NECESSARY

21. OPEN SESSION

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

23. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is May 28, 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 telephonic 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 or a reasonable modification of the teleconference procedures are necessary (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.

◈ Denotes Action Item

April 2020 Employee of the Month

Svieta Schopp

Infection Preventionist – Infection Control

We are honored to announce Svieta Schopp as our April 2020 Employee of the Month! Svieta has been with the Tahoe Forest Health System since June of 1994. Here are some of the great things Svieta's colleagues have to say about her:

"Svieta has always been extremely conscientious about her work in infection control. What she does not know, she always find out! I enjoy working with her so much as she is always ready and willing to help with any questions anyone has about her role here and infection control at Tahoe Forest Hospital. Watching her through this coronavirus situation, she is calm, collected and extremely helpful. She won't leave the office until everyone's questions are answered. She is working tirelessly to make sure all employees and the community have the information they need in order to be smart and safe. I have watched her working and she is amazing!

Thank you Svieta, and congratulations!

Please join us in congratulating all of our Terrific Nominees!

Maria Rizo
Gillian Collom
Jordan Gaines
Geulian Ferrer
Suzanne Lagrandeur
Alexis Hummer
Ernesto Garcia
Todd Johnson
Sara Ayers
Dolores Corona

AGENDA ITEM COVER SHEET

ITEM	Medical Executive Committee Consent Agenda
RESPONSIBLE PARTY	Greg Tirdel, MD, Chief of Staff
ACTION REQUESTED?	For Board Action

BACKGROUND:
During the April 17, 2020 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the April 23, 2020 meeting.

SUMMARY/OBJECTIVES:
Approval of the following consent agenda items:

With Content Changes
1. Bylaws
2. Rules & Regulation
3. Standardized Procedures for PA's and NP's
4. Trauma Activation Algorithm
5. AHP Guidelines
6. NP-PA Privilege Form

New Forms
7. Licensed Clinical Social Workers
8. Licensed Marriage Family Therapist
9. PA CA Practice Agreement
10. Collaborative Practice Agreement NP

SUGGESTED DISCUSSION POINTS:
- None

SUGGESTED MOTION/ALTERNATIVES:
Move to approve Medical Executive Committee Consent Agenda as presented.

LIST OF ATTACHMENTS:
- Bylaws
- Rules & Regulation
- Standardized Procedures for PA's and NP's
- Trauma Activation Algorithm
- AHP Guidelines
- NP-PA Privilege Form
- Licensed Clinical Social Workers
- Licensed Marriage Family Therapist
- PA CA Practice Agreement
- Collaborative Practice Agreement NP

TAHOE FOREST HOSPITAL DISTRICT MEDICAL STAFF

DATE: March 23, 2020

TO: All Non-Provisional Active Staff Members of the Medical Staff

FROM: Greg Tirdel, MD, Chief of Staff

RE: Ballot: Bylaws

One February 27, 2020, the Bylaws Committee met and conducted its annual review of the Medical Staff Bylaws. Recommendations to amend the Bylaws and Rules and Regulations were proposed and on March 19, 2020 the Medical Executive Committee (MEC) recommended the following revisions to the existing Bylaws. These changes are now being distributed to the Active Medical Staff for your consideration and vote.

Attached are the following:

- BALLOT FORM
- SUMMARY OF CHANGES ***(PLEASE REVIEW THE COMMENTS ON THE RIGHT SIDE OF THE DOCUMENT)***

Please review proposed revisions and vote for each revision individually on the attached Ballot.

Per the Medical Staff Bylaws, Page 74, Article XIV-14.2 - Adoption and Amendment of Bylaws:

(a) The affirmative vote of two-thirds (2/3) of the Staff members voting on the matter by mailed secret ballot provided at least 14 days' advance written notice, accompanied by the proposed Bylaws and/or alterations; and amendments shall become effective when approved by the Board of Directors"

PLEASE RETURN THE BALLOT FORMS TO THE MEDICAL STAFF SERVICES OFFICE
NO LATER THAN APRIL 7, 2020

FAX TO 530-582-6660 OR EMAIL TO dpiper@tfhd.com

DOROTHY PIPER, CPMSM, CPCS
DIRECTOR OF MEDICAL STAFF SERVICES

TAHOE FOREST HOSPITAL DISTRICT MEDICAL STAFF

TAHOE FOREST HOSPITAL DISTRICT MEDICAL STAFF
MEDICAL STAFF BYLAWS, RULES AND REGULATIONS
BALLOT FORM
(Please indicate your vote by checking off Yes or No for each section & returning this ballot)

_____YES _____NO **ARTICLE 2.4 NON-DISCRIMINATION**

_____YES _____NO **ARTICLE 2.7 PARTICULAR QUALIFICATIONS MOVED TO ARTICLE 2.2-3**

_____YES _____NO **ARTICLE 3.2-1 (C) ACTIVE STAFF QUALIFICATIONS**

_____YES _____NO **ARTICLE 4.2-3 ACTIVE STAFF QUALIFICATIONS**

_____YES _____NO **ARTICLE 10.3-1 MEDICAL EXECUTIVE COMMITTEE COMPOSITION**

PRINT NAME **DATE**

PLEASE RETURN THE BALLOT FORMS TO MEDICAL STAFF SERVICES
FAX TO 530-582-6660 OR EMAIL TO dpiper@tfhd.com
DOROTHY PIPER, CPMSM, CPCS
DIRECTOR OF MEDICAL STAFF SERVICES

SUMMARY OF CHANGES******

2.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or clinical privileges shall be determined on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status.

2.2-3 PARTICULAR QUALIFICATIONS

A practitioner who does not meet the above basic qualifications is ineligible to apply for Medical Staff membership, and the application will not be accepted for review, except that members of the Honorary Status do not need to comply with the basic qualifications. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application will be discontinued. An Applicant who does not meeting the basic qualifications is not entitled to the procedural rights set forth in Article Seven, but may submit comments and a request for reconsideration of the specific qualifications that adversely affect such practitioner. The comments and requests will be reviewed by the Medical Executive Committee and the Board of Directors, which will have the sole discretion whether to consider any changes in the basic qualifications.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

a. have offices or residences that, in the opinion of the Medical Executive Committee, are located close enough to the hospital to provide appropriate continuity of care;

Commented [PD1]: Gov. Code section 12940 lists out the following: race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status. See also 2 CCR Section 11030, which includes in the definition of sex (not gender) – pregnancy, childbirth, medical conditions related to pregnancy, and breastfeeding. Suggest using narrower language from Section1 2940 since it includes some of the additional listed categories.

Commented [A2]: Moved up from Section 2.7.

Commented [A3]: Section 4.18-3 of the R&R's state "A physician on call, upon being called for an acute emergency patient, must respond within 30 minutes."

TAHOE FOREST HOSPITAL DISTRICT MEDICAL STAFF

4.2-3 INCOMPLETE APPLICATION

An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Notwithstanding any other provision of these Bylaws, an application that is determined to be incomplete shall not qualify for credentialing recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given sixty (60) days to do so, the credentialing process will be terminated at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or at a meeting, as determined by the Medical Executive Committee. An incomplete application will not be processed. Termination of the credentialing process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

> **Commented [A4]:** It is important to afford the applicant at least some opportunity to be heard, since termination of the credentialing process is functionally the same as denying the application, though formal hearing rights are not required. I'd recommend keeping this language.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

a. The officers of the Medical Staff;

b. The Department chairs;

c. The Chairman of Quality;

d. The Chairman of Ethics Committee;

e. The Incline Village Community Hospital Committee Chair;

f. The Chief Executive Officer, the Chief Operating Officer, the Chief Nursing Officer, the Director of Quality, the Chief Medical Officer, Diagnostic Imaging Representative, and a member of the IDPC representing Allied Health Professionals may attend on an ex-officio basis without a vote.

> **Commented [PD5]:** Diagnostic Imaging Representative removed from voting member of the MEC to an ex-officio member

TAHOE FOREST HOSPITAL DISTRICT

MEDICAL STAFF
RULES AND REGULATIONS

2018

2057436.1 Approved by MEC 1/20/16, 7/21/16; BOD 1/28/16, 9/22/16, 06/22/2017; 10/25/18

MEDICAL STAFF RULES AND REGULATIONS

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MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I

PREAMBLE

1.1 These Rules are intended to provide for the operation and governance of the Medical Staff in accordance with the guidance and structure set forth in the Medical Staff Bylaws ("Bylaws"). In the event of any conflict between the Bylaws and the Rules, the Medical Staff Bylaws shall prevail.

1.2 All Rules contained herein have been recommended by the Medical Executive Committee of the Tahoe Forest Hospital District Medical Staff and approved by the Board of Trustees in accordance with Section 13.1 of the Medical Staff Bylaws. These Rules are binding on all Members of the Medical Staff and holders of clinical privileges, to the extent consistent with the Bylaws.

1.3 All definitions contained in the Bylaws are incorporated in these Rules.

ARTICLE II
COMMITTEES

2.1 ETHICS COMMITTEE

2.1-1 COMPOSITION

The Ethics Committee shall be composed of at least the following members: One physician, one registered nurse, one clergy, one medical social worker (or comparable), one member of Hospital administration, and one non-Hospital local community member at large. Additional members may be appointed by the Chief of Staff. The chairperson shall be the Member-at-Large, and the vice-chairperson shall be a member selected by the Ethics Committee. The chairman of the Ethics Committee shall serve as a voting member of the Medical Executive Committee.

2.1-2 PURPOSE

The purpose of the Ethics Committee is to impact positively upon the quality of health care provided by the Hospital by:

(a) Providing assistance and resources in decision-making processes that have bioethical implications. The Ethics Committee shall not, however, be a decision maker in any such processes.

(b) Educating members within the Hospital community of bioethical issues and dilemmas.

(c) Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

(d) Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and educative guidance relating to such matters.

2.1-3 MEETINGS

The Ethics Committee shall meet as often as necessary to accomplish its purpose and shall maintain a limited record of its proceedings and report its activities to the Medical Executive Committee.

2.2 BYLAWS COMMITTEE

2.2-1 COMPOSITION

The Bylaws Committee shall consist of at least three (3) members of the Medical Staff, including at least the Vice Chief of Staff and a past Chief of Staff appointed by the Chief of Staff.

2.2-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) conducting a periodic review of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and its Departments;

(b) submitting recommendations to the Medical Executive Committee for changes in these documents as necessary and desirable; and

(c) receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of those items.

2.2-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

2.3 QUALITY ASSESSMENT COMMITTEE

2.3-1 COMPOSITION

The Quality Assessment Committee shall consist of a chair of the Committee appointed by the Chief of Staff in consultation with Administration, interested physicians from each clinical Department, and such members as may be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, including representatives from the Quality Department, Nursing Services, and from Hospital Administration.

2.3-2 DUTIES

The Quality Assessment Committee shall perform the following duties:

(a) Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These may include mechanisms to:

(1) establish systems to identify potential problems in patient care;
(2) set priorities for action on problem correction;
(3) refer priority problems for assessment and corrective action to appropriate Department or committees;
(4) monitor the results of quality assessment activities throughout the Hospital; and
(5) coordinate quality assessment activities.

(b) Submit regular reports to the Medical Executive Committee and Board of Directors on the quality of medical care provided, quality review activities conducted, and Professional Review Committee (PRC) and Professional Performance Evaluation Committee (PPEC) functions:
 (1) Periodic review of Peer Review Policy
 (2) Review of individual cases as requested by department Chairs.

(c) Risk management practices as they relate to aspects of patient care and safety within the Hospital, and ensure that the Medical Staff actively participates, as appropriate, in the following risk management activities related to the clinical aspects of patient care and safety:

 (1) The identification of general areas of potential risk in the clinical aspects of patient care.

 (2) The development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety and evaluation of these cases.

 (3) The correction of problems in the clinical aspects of patient care and safety identified by risk management activities.

 (4) The design of programs to reduce risk in the clinical aspects of patient care and safety.

(d) Medical Records: Review and evaluate health information management including paper and electronic health records for compliance with Hospital needs and regulatory requirements. Additional medical record functions include:

 (1) ensuring that medical records are maintained at an acceptable standard of completeness
 (2) submitting written reports to the Medical Executive Committee and providing recommendations to the Medical Executive Committee regarding corrective action recommendations pertaining to compliance with medical records policies;
 (3) recommending new use or changes in the format of medical records;
 (4) recommending policies for medical record maintenance including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement; and policies related to privileged communication and release of information;

(e) Blood Usage: The Quality Assessment Committee shall receive quarterly reports to evaluate blood and blood product transfusion appropriateness and usage.

(f) Drug Usage: The Quality Assessment Committee shall be responsible for the oversight of the Pharmacy and Therapeutics Committee and an annual review of the Medication Error Reporting Policy (MERP)

(g) Infection Control: The Quality Assessment Committee shall be responsible for the oversight of the Infection Control Committee.

(h) Tissue Review: The Quality Assessment Committee shall also be responsible for receiving quarterly reports from a pathologist, who is a member of the Medical Staff with privileges in pathology concerning (I) pre-operative, post-operative, and

pathological diagnoses for surgical cases in which no specimen is removed; (II) all transfusions of whole blood and blood derivatives;(III) all removed tissue where the tissue is found to be normal or not consistent with clinical diagnosis. Any cases not meeting criteria established by policy shall be referred to the appropriate Medical Staff Committee or Department for discussion.

(i) The Quality Assessment Committee shall review all deaths and all removed tissue where the tissue is found to be normal or not consistent with the clinical diagnosis, and shall develop and implement measures to correct any problems discovered. It shall develop rules governing which cases must be reviewed, and outlining any exceptions to this general rule. Such rules shall be subject to Medical Executive Committee and Board of Directors approval. The Quality Assessment Committee shall also develop and implement measures to promote autopsies in all cases of unusual death or deaths of medico-legal or educational interest.

(j) The Quality Assessment Committee shall review utilization of resources as they relate to aspects of patient care within Hospital-provided services as outlined in the Utilization Review Plan.

(k) Surgical and other invasive procedures, including: selecting appropriate procedures; preparing the patient for the procedure; equipment availability; safety of the environment; performing the procedure and monitoring the patient; and providing post-procedure care.

(l) Radiation Safety: Report from Radiation Safety Officer regarding research, diagnostic, and therapeutic uses of radioactive materials

- (i) Reduction of both personnel and patient exposure to the minimum while pursuing the medical objective.
- (ii) All applications for uses or authorizations for uses of radiation will be reviewed by the Radiation Safety Officer to assure that “as low as reasonably achievable” (ALARA) exposures will be maintained.
- (iii) When reviewing new uses of radiation, details of efforts of applicants to maintain exposures ALARA must be included.

(m) Imaging Services: The Quality Assessment Committee shall be responsible for establishing, approving and enforcing policies relating to administration of imaging services through the hospital; and

- (i) Conducting, approving and interpreting a quality assessment review for radiology services

(n) Trauma Program: The Quality Assessment Committee shall be responsible for oversight of the Trauma Program and monitoring of compliance with the Trauma Performance Improvement Plan.

(o~~n~~) The Quality Assessment Committee shall be responsible for annual review of the

following:

(i) All clinical/critical pathways.
(ii) Quality Assessment Plan.
(iii) The Utilization Review and Discharge Plan.
(ivii) The Risk Management Plan
(iv) (iv) The Patient Safety Plan
(v) Discharge Plan
(vi) Infection Control Plan
(vii) Emergency Operations Plan
(viii) Environment of Care Management Program
(ix) Medication Error Reduction Plan.
(x) (v) The Social Service Plan. The Trauma Performance Improvement Plan

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2.3-3 MEETINGS

The Committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

2.4 INTERDISCIPLINARY PRACTICE COMMITTEE

2.4-1 COMPOSITION

The Interdisciplinary Practice Committee ("IDPC") shall be appointed by the Medical Executive Committee of the Medical Staff and shall include at least five (5) representatives of the various allied health professionals and two (2) physicians, as voting members of the committee. The Chief Nursing Officer and the Chief Executive Officer or designee may also attend meetings of the IDPC on an ex-officio basis without a vote.

The chair of the Committee, who shall be a nurse practitioner or physician assistant, shall be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, and may attend meetings of the Medical Executive Committee on an ex-officio basis without a vote.

2.4-2 DUTIES

The Interdisciplinary Practice Committee shall establish written policies and procedure for the conduct of its business including serving as consultants regarding expanded role privileges to advanced practice nurses, whether or not employed by the facility and other allied health professionals. These policies and procedures will be administered by the Committee. The Committee shall be responsible for the formulation and adoption of standardized procedures and for initiating the preparation of such standardized procedure in accordance with Title 22.

2.4-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to

the Medical Executive Committee.

2.5 WELL-BEING COMMITTEE

2.5-1 COMPOSITION

(a) In order to improve the quality of care and promote the competence of the Medical Staff, the Chief of Staff, with the approval of the Medical Executive Committee, shall appoint the Well-Being Committee composed of at least two (2) active members of the Medical Staff. The majority of the committee, including the chair, shall be physicians.

(b) Individuals who are not members of the Medical Staff (including non-physician(s)) may be appointed when such appointment will materially increase the effectiveness of the work of the committee.

(c) The members shall be appointed as appropriate to achieve continuity.

(d) Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

2.5-2 DUTIES

(a) The Well-Being Committee shall serve as an identified resource to take note of and evaluate issues related to health, well-being, or impairment of Medical Staff members and shall provide assistance to Department Chairs and Medical Staff officers when information and/or concerns are brought forth regarding a Practitioner's health or behavior related to physical, emotional, or drug dependency related conditions.

(b) The committee shall provide advice, recommendations and assistance to any practitioner who is referred and to the referring source, but shall act only in an advisory capacity and not as a substitute for a personal physician.

(c) The Well-Being Committee will receive reports, information and concerns related to the health, well-being, or impairment of Medical Staff members, whether from third parties, upon request of a Medical Staff or department committee or office or upon self-referrals from the practitioners themselves and, as it deems appropriate, may investigate such reports.

(d) With respect to matters involving individual Medical Staff members, the committee may offer advice, counseling, or referrals as may seem appropriate.

(e) Activities shall be confidential; however, if unreasonable risk of harm to patients is perceived, that information must be referred to appropriate officials of the Medical Staff for action as necessary to protect patients and/or for corrective action. This shall include instances in which a practitioner fails to complete a required rehabilitation program.

(f) The committee shall assess and determine appropriate outside assistance resources and programs for practitioners also consider general matters related to the health and well being of the Medic al Staff and, with the approval of the Medical Executive Committee, shall develop educational programs or related activities.

(g) The Committee will make a response to the referral source of any written letter of concern regarding well-being but shall not compromise the confidentiality of its

activities or the privacy of the individuals concerned.

(h) The Well-Being Committee may be asked to review responses from applicants concerning physical or mental disabilities, and recommend what, If any, reasonable accommodations may be indicated to assure that the practitioner will provide care in accordance with the Hospital and Medical Staff's standard of care. The Committee shall also perform this function during a Staff membership. The Committee shall also perform this function during member's term, upon request from the Medical Executive Committee.

2.5-3 MEETINGS

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings, as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee. Any records regarding individual practitioners shall be kept strictly confidential and maintained separate from credentials files and other Medical Staff records.

2.6 CANCER COMMITTEE

2.6-1 COMPOSITION

The Cancer Committee is a standing committee of the Medical Staff. It is multidisciplinary and provides leadership to the Cancer Program. The Cancer Committee and Cancer Conference are also known as the Tahoe Forest Hospital's Tumor Board.

The Cancer Committee shall be a multidisciplinary committee composed of physician representatives who care for cancer patients including, but it is not limited to the following:

a. Cancer Committee Chair
b. Cancer Liaison physician
c. Diagnostic Radiologist
d. Medical Oncologist
e. Radiation Oncologist
f. Pathologist
g. Surgeon
h. Gynecologist

Non-physician members must include, but are not necessarily limited to, the following:

a. Cancer program Administrator
b. Oncology nurse
c. Social Workers and/or Case Manager
d. Certified Tumor Registrar
e. Performance Improvement or quality management representative
f. Hospice manager
g. Palliative Care Nurse Specialist
h. Clinical Research Coordinator
i. CoC Appointed Coordinators
j. American Cancer Society Representative
k. Nurse Navigator

The Cancer Committee chair is elected by the physician committee membership for a 2 year term and may also fulfill the role of one of the required physician specialties. Individual members of the Committee are appointed to coordinate important aspects of the Cancer

Program. An individual cannot fulfill more than 1 coordinator role (for the CoC appointed coordinator positions). Each person coordinates one of each of the following four major areas of program activity:

a. Cancer Conference
b. Quality Control of Cancer Registry Data
c. Quality Improvement
d. Community Outreach
e. Clinical Research
f. Psychosocial Services

2.6.2 DUTIES

a. The Cancer Committee develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and programmatic endeavors related to cancer care;
b. The Cancer Committee establishes the frequency, format and multidisciplinary attendance requirements for cancer conferences on an annual basis;
c. The Cancer Committee ensures that the required number of cases are discussed at the Cancer Conference on an annual basis and that a minimum of 75% of the cases discussed are presented prospectively;
The Cancer Committee monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective cases presentation annually. Each year, the Cancer Committee participates in the CoC CP3R National Data Outcomes measures. Committee annually reviews outcomes, develops outcomes as indicated and follows the measures through to Quality Improvements projects.
Each year, the Cancer Committee analyses patient outcomes and disseminates the results of the analysis. This will be accomplished by publishing an Annual Report that includes a cancer site analysis with survival analysis and comparison of our data to NCDB data.

2.6.3 MEETINGS

The Committee shall meet at least quarterly, for a minimum of 4 times each year or as often as necessary at the call of its Chair (currently meets every other month for a total of six meetings per year)). It shall maintain a record of its proceedings and report its activities to the Medical Staff Quality Assessment Committee. Each member is required to attend at least 75% of the Cancer Committee meeting held annually. Participation may include through teleconference. The Cancer Committee needs to monitor the individual attendance of all members and address attendance that does not fulfill the needs of the program or falls below the requirements set forth.

2.7 CANCER CONFERENCE

2.7-1 COMPOSITION:

The Cancer Conference reports to the Cancer Committee. The Cancer Conference shall consist of a multidisciplinary group of physicians including the major disciplines involved in the management of cancer; surgery, medical oncology, radiation oncology, diagnostic imaging and pathology and other specialties as needed. The Chair will be elected by the Cancer Committee**.**

2.7-2 DUTIES

(a) Utilize the clinical case presentation format to educate the staff in oncology and oncologic
practice;
(b) Promote an active interchange of ideas for case management, assuring that patients with malignancies will benefit from the combined thinking of the staff;
(c) Ensure that a broad base of oncology knowledge is available, either from within the Cancer Conference, or from guest participants;
(d) Accept and consider any responsible and practical method established by a hospital to evaluate cases of malignancy. Whether done by a representative cross section of the staff or specified departments, evaluations shall reflect a broad base of knowledge of oncology, assuring that all patients with malignancies will benefit from the combined thinking of the staff in case management.
(e) Report on new trends in the diagnosis and therapy of malignancy;
(f) Encourage presentations to the Cancer Conference early in the patient's management;
(g) Recommend the most appropriate diagnostic and therapeutic approaches for the patients presented and their malignancies;
(h) Cases presented, at a minimum, include 15% of the annual analytic case load) and the prospective presentation rate (a minimum of 80% or a maximum of 450 of the annual analytic case presentations). Prospective cases include, but are not limited to, the following:
(i) 1. Newly diagnosed and treatment not yet initiated;
(j) 2. Newly diagnosed and treatment initiated, but discussion of additional treatment is needed;
(k) 3. Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed;
(l) 4. Previously diagnosed, and discussion of supportive or palliative care is needed;
(m) 5. Note that cases may be discussed more than once and counted each time as a prospective presentation if management issues are discussed.

Cancer Conference activities are reported to the Cancer Care Committee at least quarterly.

2.7.3 MEETINGS

The Cancer Conference is held monthly or as often as necessary at the call of its chair. Each member is required to attend at least 50% of the Cancer Conferences. The Cancer Committee reviews the annual Cancer Conference attendance rate to ensure compliance with

the CoC standard.

2.8 INCLINE VILLAGE COMMITTEE

2.8-1 COMPOSITION

(a) The Incline Village Committee shall consist of all physicians who are on the Medical Staff and exercising clinical privileges at Incline Village Community Hospital.

(b) The Chairperson shall be elected on a bi-annual basis by majority vote of physicians on the committee. The Chairperson shall serve for a three (3)-year term with election held 3 months prior to the last meeting of the calendar year. In addition to the physicians, there will be representation by nursing and Hospital administration.

(c) All medical and hospital staff may attend the Open Session of this meeting, however, agenda Items must be cleared In advance with the Chairperson.

(d) The Chairperson will serve as liaison between the Administration and the physicians practicing at Incline Village Community Hospital. The Chairperson will report directly to the Medical Executive Committee and attend Medical Executive Committee as a voting member.

2.8-2 DUTIES

a) Review policies and procedures relating to nursing and ancillary services throughout the Incline Village Community Hospital.

b) Conduct all quality review of care at Incline Village Community Hospital with further review or optional alternative review by appropriate Tahoe Forest Hospital District Medical Staff departments if requested. Those specialties that only have one physician representing the specialty will have cases reviewed by the appropriate department of the Tahoe Forest Hospital District Medical Staff . (Department of Surgery will review surgical cases, etc.)

c) Conduct, participate, and make recommendations regarding educational programs pertinent to clinical practice;

d) Reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

e) Coordinate patient care provided at Incline Village Community Hospital by the Medical Staff with nursing and ancillary patient care services;

f) Submit written reports to the Medical Executive Committee concerning: (1) the Committee's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided at Incline Village Community Hospital and the Hospital; and (3) how quality and utilization review functions will be addressed;

g) Meet regularly for the purpose of considering patient care review findings and the result of the Committee's other review and evaluation activities, as well as reports on

other Committee and Medical Staff functions;

h) Take appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

i) Account to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Committee; and

j) Recommend space and other resources needed by the Committee; and assess and recommend off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Committee.

2.8-3 MEETINGS

The Incline Village Committee shall meet on a quarterly basis. Additional meetings or cancellations may be determined by the Chairperson. A Committee report will be submitted to the Medical Executive Committee for review. Each member of the Active Staff whose primary practice is at Incline Village Community Hospital shall be encouraged to attend the Annual Medical Staff meeting; and required to attend at least fifty percent (50%) of all meetings of the Incline Village Committee or the appropriate Tahoe Forest Hospital Department meetings. There will be no exceptions from the meeting attendance requirements.

2.9 MEDICAL EDUCATION COMMITTEE

2.9-1 COMPOSITION

The Medical Education Committee will consist of, at a minimum, the Medical Director of Medical Education who will also act as the chair. The committee will include designated Clerkship Directors and any other participating preceptors. The committee members will be appointed by the Medical Executive Committee. In addition, representatives of the various nursing and allied health professions will participate on an as-needed basis. The Medical Education Committee is accountable to the Medical Executive Committee.

2.9-2 DUTIES

The Medical Education Committee shall establish written policies and procedures for the conduct of its business, including oversight of the medical students, interns, and residents in coordination with the University, College, or School of Medicine. The committee will ensure that the program operates in a structured manner according to the teaching policies of the affiliated University, College or School of Medicine. They will also provide oversight of the medical students, interns, and residents activities and progress in collaboration with the Instructors of Record. The Committee will also provide oversight of telemedicine conferencing, continuing medical education for the Medical Staff, and other programs as assigned. The Committee recommends the acquisition, purchase, or disposal of educational materials and assists in establishing rules and regulations for use of the medical library services by the members of the Medical Staff.

2.9-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair. Meetings may be held in person or via electronic or e-mail communication. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive

Committee.

ARTICLE III

MEETINGS

3.1 AGENDA FOR GENERAL MEDICAL STAFF MEETINGS

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda may include the following:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) verbal or written administrative reports from the Chief of Staff, Departments, and committees, and the Chief Executive Officer;

(c) verbal or written reports by responsible officers, committees, and Departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;

(d) old business; and

(e) new business.

ARTICLE IV

PATIENT CARE

4.1 ADMISSION AND DISCHARGE OF PATIENTS

4.1-1 The Hospital will accept all patients for care and treatment to the extent it has appropriate facilities and qualified personnel available to provide necessary services or care. All physicians shall be governed by the official admitting policy of the Hospital. A patient can be admitted to the Hospital only by practitioners with admitting privileges who holds appropriate licensure and clinical privileges.

4.1-2 A member of the Medical Staff with clinical privileges appropriate to the patient's needs shall be responsible for the medical care and treatment for each patient in the Hospital, for the prompt completion and accuracy of the medical record, for the necessary special instructions, and for transmitting reports of the condition of the patient to other members of the health care team and to relatives of the patient, subject to legal and privacy limitations. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record stating the date and time of such transfer.

4.1-3 A Conditions of Admission Form signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending Medical Staff member whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the member's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, specific consent that informs the patient of the nature of, and

risks inherent in, any special treatment or surgical procedure shall be obtained.

4.1-4 Current medications being used by patients at the time of admission may be used on a continuing basis following admission providing that all such drugs be identified by the Hospital pharmacist and be in authorized identifiable pharmacy containers with appropriate labeling.

4.1-5 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. The admitting practitioner is responsible for informing Hospital administration and the nursing staff at the time of admission if the practitioner suspects the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The attending physician shall initiate any appropriate restrictions with respect to where in the Hospital the patient will be placed (i.e. isolated area for contagious disease) and shall recommend appropriate precautionary measures to protect the patient and others. In the event the patient or others cannot be appropriately protected, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed.

4.1-6 Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded in the patient's medical record as soon as possible after admission.

4.1-8 Each member of the Medical Staff must assure continuing timely, adequate, professional care for patients under his/her care in the Hospital. Failure of an attending physician to meet these requirements may be a ground for corrective action under the Medical Staff Bylaws. A member of the Medical Staff who will be unavailable must, in the medical record of each patient, indicate the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. It is the responsibility of the attending practitioner to make prior arrangements to provide appropriate continuing care.

4.1-9 In the event of a need to categorize admitting priorities in an emergency situation, the Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical Department and approved by the Medical Executive Committee.

4.1-10 As a routine basis for admitting, the admitting policies of the Hospital will be based on the following order of priorities:

(a) Emergency admissions

(b) Urgent admissions

(c) Pre-operative admissions

(d) Routine admissions

4.1-11 Patient transfer priorities shall be as follows:

(a) Emergency Department to appropriate bed.

(b) From obstetrical patient care area to general care area, when medically indicated.

(c) From Intensive Care Unit to general care area. No patient will be transferred from the ICU without such transfer being approved by the responsible physician.

4.1-12 For the protection of patients, the medical and nursing staffs and the Hospital, due to the lack of adequate facilities and personnel for the treatment of patients with serious mental illness and patients who may be dangerous to themselves and/or others, such patients shall be transferred to an appropriate facility when medically stable. When the transfer of such patients is not possible, the patient may be temporarily admitted to the general area of the Hospital with appropriate nursing and security supervision to allow for crisis intervention as available through community and Medical Staff clinical psychological/psychiatric services.

4.1-13 Any patient known or suspected to be suicidal or otherwise a danger to self, who is treated as a Hospital inpatient or through the Emergency Department should be offered a psychological or psychiatric consultation through available community and Medical Staff resources.

4.1-14 If any question as to the necessity of admission to, or discharge from the Intensive Care Unit should arise, appropriate review of the decision is to be made by the Medical Director of the Intensive Care Unit in consultation with the attending physician.

4.1-15 The attending physician is required to document the need for continued hospitalization after specific periods of stay per disease categories as defined by the Medical Staff. This medical record documentation must contain:

(a) An adequate record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not considered sufficient.

(b) The estimated period of time the patient will need to remain in the Hospital.

(c) Plans for post-Hospital care.

4.1-16 The patient shall be discharged from the Hospital only on a written order of the attending Medical Staff member. If the patient indicates an intent to leave the hospital before the completion of treatment or contrary to the advice of the patient's attending practitioner, the nursing staff shall contact the patient's attending practitioner to arrange for the patient to discuss his or her plan with the attending practitioner before the patient leaves. The attending practitioner shall advise the patient of the implications of leaving the hospital against medical advice, including the risks involved and the benefits of remaining for treatment, and shall

document this in the medical record. Should a patient insist upon leaving, the Hospital against the advice of the attending Medical Staff member or without proper discharge, a notation of the incident shall be made on the patient's medical record, and the patient shall be asked to sign the appropriate "Leaving Hospital Against Medical Advice" form acknowledging that they are leaving against medical advice and their understanding of the medical risks and possible consequences of refusing continued treatment at the hospital. If the patient cannot be located or refuses to sign the form, the nursing staff who witnessed the refusal shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

4.1-17 In the event of a hospital death, the deceased patient shall be pronounced dead by the attending physician or his/her designated covering physician within a reasonable period of time, or by a registered nurse who has been certified to pronounce a patient's death pursuant to the nursing standardized procedure. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease where the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of deceased patients shall conform to local law.

The patient's attending physician is responsible for notifying the next of kin in all cases of patient death and shall facilitate the reporting of patient deaths to the coroner or to other agencies as required by laws.

(a) If the basis for pronouncement of death is "brain death" (i.e. the total and irreversible cessation of all functions of the entire brain, including the brain stem), death must be pronounced by a physician, and a second, independent physician must confirm the determination of brain death. Both physicians must document their findings in the patient's record. The patient's family must be informed of the patient's death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, hospital administration shall be advised and consulted before medical interventions (e.g. respiratory) are discontinued.

(b) If the patient or the patient's family indicates that the patient has or will contribute anatomical gifts, the hospital protocol for identifying potential organ and tissue donors shall be followed.

4.1-18 Except in the case of patients hospitalized less than 48 hours and in cases of normal obstetrical deliveries and normal newborn infants, in which case a final progress note may be substituted, a clinical resume discharge summary shall be written or dictated on all medical records of hospitalized patients. In the event a patient expires within 48 hours following admission, a clinical discharge summary will be required.

4.2 AUTOPSIES

4.2-1 It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever appropriate, as described below, and consistent with applicable law. An autopsy may be performed only with a written authorization signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded in the medical record within 72 hours and the complete autopsy protocol should be made a part of the deceased's medical record within 60 days. Autopsies are felt to be of particular value in the following circumstances and the Medical Staff is encouraged to actively seek family permission for autopsy for all in-patient

deaths meeting these criteria:

(a) Deaths where there are significant questions related to the effectiveness of therapy.

(b) Deaths where there are significant questions relating to the extent of disease.

(c) Deaths where ante mortem diagnostic procedures have resulted in unusual or unexplained findings.

(d) Deaths where genetic diseases are suspected but not confirmed prior to death. An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy costs.

An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy rates.

4.3 MEDICAL RECORDS

4.3-1 The attending Medical Staff member shall be responsible for the complete and legible medical record for each patient. The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Its contents shall be pertinent and current. The inpatient record shall have appropriate identification data; including, but not limited to:

(a) Chief complaint resulting in admission

(b) History of present illness

(c) Personal and family history

(d) Applicable systems review

(e) Physical examination

(f) Special reports such as consultation, clinical laboratory and radiology services

(g) Provisional diagnosis

(h) Medical or surgical treatment

(i) Operative reports, when appropriate

(j) Pathological finding, when appropriate

(k) Progress notes

(l) Final diagnosis

(m) Condition on discharge

(n) Summarizing clinical resume

(o) Autopsy report when performed

(p) Procedural, therapeutic, and operative consents when appropriate

(q) Post-discharge follow-up plans and medications

4.3-2 All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by signature. Clinical entries may be counter signed by physicians caring for the same patient.

4.3-3 **Authentication shall be** by legible written signature, computer-generated or electronic signature, or unique physician ID number and shall be completed only by the individual responsible for the entry.

4.3-4 **Systems of authentication** of dictated, computer, or electronically generated documents must ensure that the author of the entry has verified the accuracy of the document after it has

been transcribed or generated.

4.3-5 The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission, but an interval admission note must be written at the time of admission that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.4 HISTORY AND PHYSICAL

4.4.1 A complete admission history and physical examination shall be signed and completed no more than 30 days before or 24 hours after the inpatient admission, and it must be recorded in the patient's medical record within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history and physical examination has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports the report may be used in lieu of the admission history and report of the physical examination report, provided that an appropriate assessment is performed, including a physical examination within the previous 24 hours to update any components of the patient's medical status that may have changed since the earlier history and physical or to address any areas where more current data is needed. In such instances, a physician or other practitioner qualified to perform the history and physical writes an interval admission note addressing the patient's current status and/or any changes to such status, which includes all additions to the history and any subsequent changes in the physical findings. This update examination must be completed, signed, and documented in the patient's medical record by an appropriately qualified and privileged member of the Medical Staff within 24 hours after admission. If the history and physical that was performed prior to the patient's admission is determined to be incomplete, inaccurate or otherwise unacceptable, the physician responsible for the update examination may disregard the existing history and physical, and perform a new history and physical. Any such history and physical must be completed, signed and documented in a timely manner, as described in these Rules. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded at the time of admission. All such outside records of histories and physicals shall be on a form approved by the Hospital and compatible with the current medical record system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the Hospital's medical record.

4.4-2 When a patient is readmitted to the Hospital within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available in a unit record.

4.4-3 When a patient is admitted for observation or outpatient hospitalization under 48 hours, a Short Stay History and Physical may be performed in lieu of a regular history and physical. On patients admitted from the emergency room for a short stay, the emergency room record will be deemed sufficient, provided that it is complete and contains at least the same information as indicated necessary for a Short Stay History and Physical.

4.4-5 When a history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending physician states in writing that such delay would be detrimental to the patient. However, this requirement shall not preclude rendering emergency medical or surgical care to

a patient in dire circumstances, as documented by the attending physician.

4.4-6 The attending physician shall authenticate by countersignature the history, physical examination and preoperative note when they have been recorded by an authorized allied health professional, a medical student, or resident staff physician from an outside educational institution performing preceptorship at the Hospital.

4.4-7 The history and physical examination may be performed and documented by any physician permitted by law as long as a physician who is currently a member of the Medical Staff, with privileges to perform a history and physical examination, updates the history and physical examination consistent with these Rules and Regulations. This shall include at least the following:

a. Review of the history and physical examination document;
b. Determination that the information is compliant with the hospital's defined content requirements for history and physical examinations;
c. Obtaining missing information through further assessment as needed;
d. Update information and findings as necessary:
    1. Inclusion of absent or incomplete required information;
    2. A description of the patient's condition and course of care since the history and physical examination was performed;
    3. A signature, date and time on any document with updated or revised information as an attestation that it is current.

The history and physical examination must have been performed within thirty days prior to the patient's admission to the hospital and the update must be completed and documented in the patient's medical record within 24 hours of admission and on the day of any outpatient surgical procedure.

4.5 PROGRESS NOTES

4.5-1 Attending physician of record, or the covering physician, or the appropriate practitioner shall be required to make daily rounds on their inpatients followed by the timely documentation of a progress note. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written daily on all acute care patients. In addition, appropriate progress notes shall be written at least every week on swing bed patients.

4.6 OPERATIVE NOTE

4.6-1 Complete operative reports shall be dictated or written immediately after surgery, specifying the name of surgeon, procedure, diagnosis, anesthesia, and pertinent findings. The complete operative report shall include, but not be limited to:

(a) Name of surgeons, assistant surgeons, and anesthesiologist
(b) Pre-operative and post-operative diagnosis
(c) Name of specific surgical procedure performed

(b) Type of anesthesia

(c) Detailed procedural account with description of techniques

(d) Any remarkable or unusual findings

(e) Complications

(f) Tissue removal and disposition

(g) Drains, appliances, or prostheses used

(h) Post-op condition

(i) Disposition from the operating room

4.7 CONSULTATIONS

4.7-1 Consultation reports shall show evidence of a review of the patient's medical record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of the consultation. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the record, be recorded prior to the operation. Consultations must be signed by the consultant.

4.7-2 Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.

4.7-3 The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rest with the practitioner responsible for the care of the patient. Except in cases of emergency, when time does not permit, consultation should be obtained in the following situations:

(a) when the patient is not a good risk for operation or treatment;

(b) when the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) where there is doubt as to the choice of therapeutic measures to be utilized;

(d) in unusually complicated situations where specific skills of other practitioners may be

needed;

(e) in instances in which the patient exhibits severe psychiatric symptoms; and

(f) when requested by the patient or his/her family.

4.7-4 Appropriate pediatric consultation in the wards should be considered for sick children under the following circumstances:

(a) A prolonged hospitalization if a child is involved with potential medical pediatric problems (e.g., multiple trauma, septic orthopedic problems, acute burns).

(b) Infectious problems of a life threatening nature (e.g., epiglotitis, meningitis).

(c) Other problems involving intensive care hospitalization (e.g., diabetes, ketoacidosis, and status asthmaticus).

(d) All patients admitted for surgical procedures less than two years of age.

4.7-5 The attending Medical Staff member should request consultations when the patient would seemingly benefit by the additional skills or abilities of other practitioners. The attending Medical Staff member is responsible for directly requesting the consultant to assist and he/she shall provide written authorization to permit another practitioner to attend or examine the patient, except in an emergency. The attending physician shall document the order for the consultant in the Physician Orders section and also indicate of the reason for the consultation on the Physician Orders section or Progress Notes in the patient's medical record. A consultation has not been fully requested or authorized unless the attending Medical Staff member has personally contacted the consultant or the consultant's office and the attending member has written a note in the chart. No practitioner is obligated to accept any request for consultation.

4.7-6 If a nurse or licensed registered pharmacist has any reason to doubt or question the care provided to any patient or believes appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the nursing supervisor who in turn may refer the matter to the Nursing Executive. The Nursing Executive may bring the matter to the attention of the chief of the Department where the practitioner has privileges. Where circumstances are such to justify such action, the chief of the Department may himself/herself request the consultation.

4.8 ABBREVIATIONS

4.8-1 Symbols and abbreviations may be used except when prohibited by the Medical Staff, hospital policy, bylaw, statute, or regulation. TFHD will maintain an official record of approved abbreviations and they shall be kept on file in the Medical Record Department and made available through the TFHD Intranet.

4.8-2 Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and timed, dated and signed by the responsible Medical Staff member at the time of discharge of all patients.

4.9 CONSENTS

4.9-1 Unless otherwise authorized by law, written authorization of the patient, guardian or other legally authorized individual is required for release of medical information to persons not otherwise authorized to receive this information.

4.10 REMOVAL AND ACCESS OF MEDICAL RECORDS: CONFIDENTIALITY

4.10-1 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without the written approval of the Chief Executive Officer. Unauthorized removal of charts from the Hospital is grounds for corrective action, to be determined by the Medical Executive Committee of the Medical Staff.

4.10-2 In case of re-admission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or another.

4.10-3 Access to medical records may be afforded to members of the Medical Staff for a bona fide study and research consistent with preserving the confidentiality of professional individually-identifiable information concerning the individual patients. All such projects and access shall be approved by a duly constituted Institutional Review Committee in accordance with applicable state and federal law, including the HIPAA Privacy Regulations. Approval must also be obtained from the Medical Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, and in accordance with applicable laws, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering the periods during which they attended such patients in the Hospital.

4.10-4 A medical record shall not be permanently filed until it is completed by the responsible Medical Staff member or is ordered filed by the Medical Executive Committee in the event that the Medical Staff member is permanently unable to sign.

4.11 ORDERS

4.11-1 A Medical Staff member's routine orders, when applicable to a given patient, shall be reproduced in detail in the patient's record, dated, timed, and signed by the Medical Staff member. .

4.12 MEDICAL RECORD DELINQUENCY

4.12-1 The patient's medical records shall be completed and signed at the time of discharge, or in no event later than 14 days following discharge. This will include progress notes, final diagnosis, and a dictated clinical resume. If the record still remains incomplete 15 days after discharge, the Medical Records Manager shall notify the Medical Staff member by certified, receipted mail that his/her privileges to admit or attend patients shall be suspended 7 days from the date of notice, and such Medical Staff members shall remain suspended until the records have been completed. The admitting office shall be notified of this action. Ongoing care of patients already in the Hospital may be continued. The suspended member shall not care for any patients other than those currently admitted under his/her own name and may not provide consults on Hospital or emergency room patients. If the suspended member is on call, he/she is responsible for finding another physician to see any patients requiring care while he/she is on call. Suspension of admitting privileges does not affect the Medical Staff member's

privilege to provide patient care in emergency circumstances when the suspended member is the only provider available to provide that necessary care. Any member whose privileges have been suspended for failure to complete medical records in a timely fashion for a total of thirty (30) days or longer in a twelve (12) month period may be reported to the Medical Board of California by the Chief Executive Officer, pursuant to California Business and Professions Code section 805 and the National Practitioner Data Bank.

4.13 LONG TERM CARE

4.13-1 Physicians must visit their Long Term Care residents in the Extended Care Center (ECC) as needed and at least every 30 days unless there is an alternate schedule. Any change of condition must be documented in the progress notes. Progress notes and orders must be signed and dated at the time of the visit. Histories and physicals must be updated yearly. Histories and Physicals for residents, and updated Histories and Physicals for residents returning to ECC from Acute must be completed within 48 hours of admission to ECC. Failure to comply with the above constitutes a deficiency. Physicians will be notified by the Extended Care Center Director of Nursing, in writing, of any Extended Care Center record deficiencies. address the matter as warranted. A suspension may be imposed pending correction of the deficiency.

4.14 VERBAL AND WRITTEN ORDERS

4.14-1 All orders for treatment shall be in writing. Verbal orders are to be used infrequently. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom the orders were dictated, with the name of the ordering practitioner per his/her own name noted. The date and time the orders were received shall also be noted. The responsible prescriber or another practitioner who is responsible for the care of the patient and is authorized to write orders shall authenticate such orders by signature, date and time, within 48 hours. Duly authorized persons who may receive verbal orders or telephone orders for orders within their scope of practice are licensed registered nurses, licensed vocational nurses, occupational therapists, speech therapists, pharmacists, laboratory technologists, respiratory therapists, physical therapists, and medical nutritional therapists.

4.14-2 A practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

4.14-3 Surgery Orders: All previous orders are cancelled when patients are transferred to surgery.

4.14-3.1. Inpatient Surgical Orders.

A) Specific pre-operative orders are required for all patients going to surgery.

B) All prior inpatient orders cease when patient is taken to surgery.

C) All intraoperative orders must be authenticated at the end of surgery.

4.14-3.2. Outpatient Surgical Orders.

A) All outpatients must have pre-operative orders prior to the patient's arrival.

B) All intraoperative orders must be authenticated at the end of surgery.

C) Post-operatively, all orders must be completed.

4.14-4 A qualified full-time, part time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. The radiologist or other practitioner who performs radiology services including nuclear medicine must sign reports of his or her own interpretations.

4.14-5 Radiology Services must be provided only on the order of practitioners with clinical privileges or, consistent with State Law, other practitioners authorized by the medical staff and the governing body to order the services.

4.15 GENERAL RULES REGARDING SURGICAL CARE

4.15-1 All surgical patients must receive a pre-operative study so that an accurate diagnostic impression as well as an estimated operative risk to the patient can be clearly established prior to proceeding with the surgical treatment.

4.15-2 Surgeons must be in the operating room and ready to commence operations at the time scheduled. As the anesthesiologist will not administer anesthesia until the surgeon is present or is in the immediate area, the surgeon should arrive at least 10 minutes before the scheduled surgery. Repeated tardiness problems shall be handled by the Chair of Surgery and/or the OR supervisor and may result in the temporary restriction of scheduling privileges.

4.15-3 Surgery scheduling:

(a) Surgery shall be scheduled on the following priority situations:

(1) Emergency:

(a) Acute life threatening situation.

(b) Acute sensory or limb threatening situation - surgery must begin with all deliberate speed.

(2) Urgency: Sub acute situation where undue delay will produce irreversible damage. Surgery will begin at the earliest available time appropriate for the degree of urgency.

(3) Elective: Chronic, relapsing, or volitional situations where postponement would create no undue risk or hardship. Surgery is scheduled at a time mutually convenient for the patient, surgeon, and Hospital.

(b) Priority scheduling should appropriately reflect the patient's situation and not reflect the surgeon's situation. Abuse of priority scheduling may result in restriction or suspension of OR privileges.

4.15-4 The medical record must document a thorough physical examination prior to the performance of surgery. When the history and physical examination is not recorded prior to the time stated for the operation, the patient will not be taken into the surgical suite.

4.15-5 Except in severe emergencies, the pre-operative diagnosis and laboratory tests must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, there must be adequate documentation. In any emergency, the physician shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and

start of surgery.

4.15-6 All anatomical parts, foreign objects and tissues removed at the operation shall be sent to the Hospital pathologist for examination excluding teeth. The pathologist's authenticated report shall be made a part of the patient's medical record.

4.15-7 All tissues of potential diagnostic value removed in the Emergency Department shall be sent to the Hospital pathologist for examination. Other tissues, such as fragments from debridement of wounds, foreign bodies, etc., removed in the Emergency Department shall be submitted to the Hospital pathologist at the discretion of the physician performing the removal excluding teeth.

4.15-8 Written and signed surgical consents shall be obtained prior to the operative procedure except in situations wherein the patient's life is in jeopardy, when suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a temporarily or permanently incompetent adult or minor for whom consent for surgery cannot be immediately obtained, the circumstances should be fully explained in the patient's medical record.

4.15-9 The surgeon should exercise professional judgment in selecting an assistant who is capable of safely concluding the procedure if necessary.

4.15-10 Oral and maxillofacial surgeons may admit and perform history and physical examinations without supervision as long as they provide documentation of training and experience and are granted the clinical privilege to do so. Otherwise, a patient admitted for dental or podiatric care is a dual responsibility involving the dentist and/or podiatrist and a physician member of the Medical Staff.

(a) Dentist and podiatrist responsibilities:

(1) A detailed dental and/or podiatric history justifying the Hospital admission.

(2) A detailed description of the examination of the oral cavity/lower extremity and a pre-operative diagnosis.

(3) A complete operative report, describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissues with the exception of teeth and fragments shall be sent to the Hospital pathologist for examination.

(4) Progress notes pertinent to the oral/podiatric condition.

(5) Clinical resume statement at the time of discharge.

(b) Physician's responsibilities:

(1) A medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general medical status while hospitalized.

(c) The discharge of patients shall be on written order of the dentist and/or podiatrist member of the Medical Staff with the written concurrence of the attending physician

involved.

4.15-11 Operations shall be scheduled through the surgical services office, or with the appropriate nursing shift supervisor. A surgical log shall be maintained for the scheduling of all surgeries. The surgical assistant, if required, shall be stated at the time surgery is scheduled.

4.15-12 For all outpatient surgical cases, local post-operative coverage will be provided by the attending Medical Staff member or by an alternate Medical Staff member by pre-arrangement.

4.15-13 A complete admission history and physician examination shall be recorded within 24-hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports may be used In lieu of the admission history and report of the physician examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within 24 hours prior to commencing any invasive procedure, or a procedure requiring anesthesia services. All such outside records shall be on a form approved by the Hospital and compatible with the current medical records system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the hospital's medical records.

4.16 GENERAL RULES REGARDING ANESTHESIA CARE

4.16-1 A pre anesthesia evaluation (is documented) by an individual qualified to administer anesthesia performed within 48 hours prior to surgery. Anesthesia is defined as general, regional, or MAC. The pre anesthesia evaluation documentation must include the following:

- 4.16-1.1 A patient interview to assess medical history, anesthetic history and medication history, and allergy history, including anesthesia risk.
- 4.16-1.2 An appropriate physician exam that includes, at a minimum airway assessment, a pulmonary exam to include auscultation of the lungs, and a cardiovascular exam.
- 4.16-1.3 Review of objective diagnostic data.
- 4.16.1-4 Assignment of ASA physical status.
- 4.16.1-5 The anesthesia plan and discussion of risks and benefits of the plan with the patient or the patient's legal representative.
- 4.16.1-6 Assessment of pain management using visual scale of zero to ten or the "FACES" tool for children.

4.16-2 There is an intra-operative Anesthesia Record. This record accurately reflects critical techniques, management, and patient responses including condition at the end of the anesthetic. The intra operative anesthesia record must include the following time-based record of events.

- 4.16-2.1 Immediate review prior to initiation of anesthetic procedures including patient re-evaluation and a check of equipment, drugs and gas supply.
- 4.16-2.2 Monitoring of the patient.
- 4.16-2.3 Amounts of drugs and agents used, and times of administration.
- 4.16-2.4 The types and amounts of intravenous fluids used, including blood and blood products, and times of administration.
- 4.16-2.5 The techniques used.
- 4.16-2.6 Unusual events during the administration of anesthesia.
- 4.16-2.7 The status of the patient at the conclusion of anesthesia.

4.**16-3** With respect to inpatients, a postanesthesia evaluation must be completed and documented

by an individual qualified to administer anesthesia within 48 hours after surgery. For the outpatient surgical patient, this post anesthesia assessment must be done prior to discharge from the facility. At a minimum, the post anesthesia assessment follow up report documents the following:

4.16-3.1 Cardiopulmonary status.
4.16-3.2 Level of consciousness.
4.16-3.3 Any follow up care and/or observations, and patient instructions.
4.16-3-4 Any complications occurring during post-anesthesia recovery.

4.17 GENERAL RULES REGARDING HOME CARE

4.17-1 Patients requiring home care services shall have a written order from the attending physician. Such orders shall be reviewed at least every sixty (60) days.

4.17-2 Treatment plans shall be signed by the physician no later than thirty (30) days after initiation of service.

4.18 GENERAL RULES REGARDING EMERGENCY CARE

4.18-1 All patients who present to the Emergency Department of either Tahoe Forest Hospital or IVCH shall be given a medical screening examination by an Emergency Department physician. Patients determined to have an emergency medical condition shall be given such stabilizing treatment as necessary within the capabilities of the facility, including consultation and treatment by specialty physicians if applicable. Any discharge or transfer of emergency patients shall be done in accordance with the Hospital's policy regarding the treatment and transfer of emergency patients. Such policy shall be in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Classifications of staff who may conduct medical screening examinations in accordance with EMTALA shall include: (a) in the Emergency Department, licensed physicians in accordance with their privileges; and (b) in the Women and Family Center, licensed physicians in accordance with their privileges and registered nurses who have been approved to perform such examinations based on demonstrated competence and action pursuant to approved standardized procedures.

4.18-2 Medical Staff members shall provide call coverage according to schedules drawn up by the Chiefs of the Anesthesia, Medicine, Ob/Pediatrics and Surgical Departments for Tahoe Forest Hospital, and by the IVCH Committee's Chair or designee.

4.18-3 A physician on call, upon being called for an acute emergency patient, must respond within 30 minutes.

4.18-4

Should a difference of opinion exist between the referring emergency physician and the on-call physician as to the need for the latter to come in and personally evaluate the patient, the emergency physician, being physically present and responsible for the patient's care, shall decide that issue.

If the on-call physician comes in and personally evaluates the patient, and there is a difference of clinical opinion with the emergency physician with respect to stabilization, treatment, and/or transfer (including discharge) that the on-call physician and emergency physician are unable to resolve, either of them may contact the on-call physician's Department chairperson for assistance in resolving the matter. This may include having the on-call physician assume the

responsibility for the patient, arranging for another appropriate physician who may be available to evaluate the patient, or other means of resolving the difference of opinion.

All decisions shall be based on a good-faith determination of what is best for the patient, taking into account the nature and seriousness of the patient's condition(s), the capabilities of the hospital, the on-call physician's scope of clinical privileges, emergency department policies and EMTALA obligations, and any other relevant clinical factors. Pending the resolution of the dispute, the emergency physician, in consultation with the on-call physician, shall be responsible for further evaluation, monitoring and treatment for the patient.

If these options are not pursued or do not result in a resolution that meets the immediate needs of the patient involved, the emergency physician and the on-call physician shall be obligated to meet their respective responsibilities as described above. Residual issues or disputes shall be reported to the appropriate Department chairperson(s) and/or the Chief of Staff for resolution through the Medical Staff's peer review process

4.18-5 Any on-call Medical Staff member who fails to respond in a timely manner or who refuses to consult on and attend an emergency patient at the request of the Emergency Department physician shall be subject to corrective action by the Medical Executive Committee, in accordance with the Medical Staff Bylaws.

4.18-6 Out of town practitioners who are not members of the Medical Staff shall not use the Emergency Department to care for any patients, friends or relatives. All practitioners wishing to utilize the Emergency Department must submit applications and satisfy all other requirements for staff privileges as stated in the Medical Staff Bylaws and these Rules.

4.18-7 An appropriate medical record shall be kept for every patient receiving emergency service and this record shall be incorporated into the patient's records, if such exists. The records shall include:

(a) Adequate patient information.

(b) Information concerning the time of the patient's arrival.

(c) Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his arrival at the Hospital.

(d) Description of significant clinical, laboratory, and radiographic findings.

(e) Diagnosis.

(f) Treatment given.

(g) Condition of the patient on discharge or transfer.

(h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

(I) Method of arrival.

4.18-8 Each patient's medical record shall be signed by the physician in attendance who is responsible for its clinical accuracy.

4.18-9 The above provisions are to be read in conjunction with applicable Hospital Policies relating to the provision of emergency care, including but not necessarily limited to those entitled "Notification of On-Call Physicians, DED-20," and "Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, ~~AGOV-18~~ALG-1907."

4.19 **Rehabilitative Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology)**

4.19-1 Rehabilitative Services must be provided by individuals who are licensed as specified in the California Business & Professions Code for the functions to be performed. A licensed physical therapist, occupational therapist or speech therapist may be authorized by the Medical Staff, through the process described in the Allied Health Professional Manual, to hold and exercise such privileges as are consistent with the scope of his or her license and the hospital licensing laws. These privileges shall include, but not necessarily be limited to, the authority to receive and implement orders as described below.

4.19-2 Rehabilitative Services must be furnished in accordance with a written plan of treatment, and in accordance with the orders of duly authorized practitioners. The orders must be incorporated in the patient's medical record.

4.19-3 The initial order for Rehabilitative Services must be issued in writing by a physician, who shall retain overall responsibility for the patient's care. The order should state the reasons for the referral, and may specify: "Evaluate patient, develop a plan of care, and implement plan." It may also be more limited in scope or more detailed, at the discretion of the physician. It may not state, simply: "Evaluate and treat." Pre-printed orders may be approved by the Medical Executive Committee to enhance the efficiency of the ordering process.

4.19-4 If the physician's order provides for the therapist to develop and implement a plan of care, the therapist shall document the plan in the medical record, and shall collaborate with the physician before the plan is implemented or modified. The documented plan shall include the type, amount, frequency and duration of the service to be provided, and indicate the diagnosis and anticipated goals. The physician's approval of the plan or modification, which may be conveyed orally while collaborating with the therapist, shall be documented by the therapist in the medical record.

4.20 CRITICAL/INTENSIVE CARE UNIT:

4.20-1. The intensive care unit (ICU) has been established to provide a facility for the intensive care of the critically ill patient; to improve the actual nursing care by concentrating personnel specifically qualified for this type of service and by making available in one place all commonly used emergency drugs, instruments, and supplies necessary for the proper care of critically ill patients; to serve as a recovery room for postoperative patients at times when the recovery room is closed; and to provide assurance for the physicians that their patients will be receiving the best continuous care available within the most economical means of the patient and the hospital.

4.20-2 The admitting physician will consult appropriate specialist(s). Proper critical care requires coverage for each case by appropriate medical and surgical specialties.

ARTICLE V

DISASTER PLANNING

5.1 DISASTER PLANNING (Detailed information about the TFHD emergency preparedness procedure is referenced in hospital policy.)

5.1-1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency programs in the community. It shall be developed by a disaster planning committee. Membership shall include a member of the medical staff, the nurse executive, or designee, and a representative from hospital administration. The disaster plan shall be approved by the Executive Committee and the governing board.

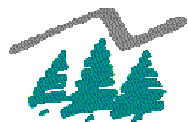
5.1-2 The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing and other hospital personnel. Actual evacuation of patients during drills is optional. There should be a written report and evaluation of all drills.

ARTICLE VI

NEW PHYSICIAN ORIENTATION

6.1 NEW PHYSICIAN ORIENTATION

6.1-1 Orientation is mandatory for all new members to the medical staff, except for those appointed to the Honorary Staff.



TAHOE FOREST HOSPITAL DISTRICT MEDICAL STAFF

DATE: March 20, 2020

TO: Members of the Medical Staff

FROM: Medical Staff – Executive Committee

RE: Rules and Regulation Proposed Revisions

On February 20, 2020, the Medical Executive Committee met and conducted its annual review of the Medical Staff Rules & Regulations. Recommendations to amend areas of the Rules and Regulations were then provided to legal counsel to review, comment, and recommend. The Medical Executive Committee (MEC) recommended the following revisions to the existing Rules and Regulations.

These changes are now being distributed to the Medical Staff, per the medical staff bylaws, Article 13.1-1 (b):

"Any new or amended provisions for the Rules and Regulations proposed by the Medical Executive Committee shall be announced to the Medical Staff, which shall be afforded a period of at least thirty (30) days to submit written comments for consideration by the Medical Executive Committee before the provisions are submitted to the Board of Directors."

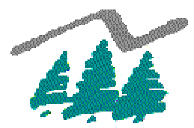
- "Red line" version of proposed changes. Underlined sections are proposed additions. Deleted language is indicated by a ~~strikethrough~~.

Please submit any written comment to:

MEDICAL STAFF SERVICES OFFICE
E-Mail to: dpiper@tfhd.com
Or FAX TO 530-582-6660

Dorothy Piper, CPMSM, CPCS
530-582-6640
DIRECTOR OF MEDICAL STAFF SERVICES

Please return your comments by Wednesday, April 19, 2020.



TAHOE
FOREST
HOSPITAL
DISTRICT
MEDICAL STAFF

TAHOE FOREST HOSPITAL DISTRICT MEDICAL STAFF MEDICAL STAFF RULES AND REGULATIONS REVISION

RULES AND REGULTIONS:

ARTICLE 2.3-2 (N) ADDITION OF THE TRUAMA PROGRAM TO THE QAC

COMMENTS:____
____

ARTICLE 2.3-2 (O) ADDITION OF ANNUAL PLAN REVIEW TO THE QAC

COMMENTS:____
____

ARTICLE 4.18-9 CHANGED POLICY NUMBER TO THE CORRECT POLICY NUMBER

COMMENTS:____
____

____
PRINT NAME **DATE**

PLEASE RETURN COMMENTS TO dpiper@tfhd.com or fax to 530-582-6660

Standardized Procedures and Protocols for Physician Assistants and Nurse Practitioners

A. Provision for initial and continuing evaluation
B. Supervision
A.C. Record Keeping
D. Consent

STANDARDIZED PROCEDURES AND PROTOCOLS (for both PA and NP unless otherwise specified)

B. Furnishing Medication/Medication ManagementOutpatient Management of Medical Conditions
E.
F. Ordering Lab Work, Diagnostic Studies and Therapies
C. Inpatient Management of Medical Conditions
D. Outpatient Management of Medical ConditionsEmergent Care
E. Drug Formulary (PA)
F. Furnishing Medication / Medication Management
G.
G. Outpatient Procedures and Minor Surgery
H.
H. Inpatient Management of Medical ConditionsOrdering Lab Work, Diagnostic Studies, & Therapies
I.
I. Specialty Consultation
J. Emergent CareSurgical First Assist (PA/NP)
J.
K. Surgery First AssistantOncology Outpatient/Inpatient
K.
L. Oncology
M. Bibliography

Appendix A: Clinical Resources
Appendix B: Controlled Substances Protocol for California NPs

L. Appendix A

These procedures and treatments may be performed by

THESE PROCEDURES AND TREATMENTS MAY BE PERFORMED BY

Privileged Nurse Practitioners (NP) and Physician Assistants (PA) per approved privilege criteria who have been approved for practice at Tahoe Forest Hospital, Incline Village Community Hospital, Gene Upshaw Memorial Tahoe Forest Cancer Center, Occupational Health, Skilled Nursing Facility, Emergency Department, or any TFHD Clinic. Training and education include:

Nurse Practitioner:

A. Certification from an accredited school for nurse practitioner training
B. Current advance practice RN unrestricted license to practice in California and/or in Nevada, as appropriate
C. Current American Nurses Credentialing Center ("ANCC"), or American Academy of Nurse Practitioner's ("AANP") certification. If requesting to work solely in pediatrics, certification by the Pediatric Nursing Certification Board (PNCB) is also acceptable.
D. Must have an identified supervising physician ~~Physician Supervisor~~ who is a member of the Hospital's Medical Staff.
E. Current evidence of a Collaborative Service Agreement
F. Current unrestricted DEA certificate in CA (must be approved for Schedules II-V) and, if practicing in NV, current DEA certificate in NV, and registration certificate ~~license~~ from the Nevada State Board of Pharmacy, as appropriate
G. Current professional liability insurance in the amount of $1 Million/$3 Million, minimum.
H. Current BLS/CPR

Physician Assistant:

A. Completion of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant
B. Current unrestricted California and/or Nevada license.
C. Current NCCPA (National Commission on Certification of Physician Assistants) certified.
D. Must have an identified Physician Supervisor who is a member of the Hospital's Medical Staff.
E. Current evidence of a Practice Agreement ~~Delegation of Service Agreement~~ (CA) or Supervising Physician Agreement (NV)
F. Current unrestricted DEA certificate in CA (must be approved for Schedules II-V) and, if practicing in NV, current DEA certificate in NV, and registration certificate~~license~~ from the Nevada State Board of Pharmacy, as appropriate
G. PA's practicing in California must complete an educational course in controlled substances that meets the standards of practice by TFHD and State of California (California Code of Regulations Sections: 1399.541(h), 1399.610 and 1399.612) within ~~four (4) to~~ six~~six~~ (6) months of being granted privileges and Allied Health Professional ("AHP") membership
H. Current professional liability insurance in the amount of $1 Million/$3 Million, minimum.
I. Current BLS/CPR

Setting

1. Tahoe Forest Hospital Clinics and Incline Village Hospital Clinics
2. Gene Upshaw Memorial Tahoe Forest Cancer Center
3. Tahoe Forest Hospital
4. Incline Village Community Hospital

Review

1. All standardized procedures and protocols are to be reviewed annually by the Interdisciplinary Practice Committee ("IDPC")
2. Changes in, or additions to, the standardized procedures and protocols may be initiated by any of the authorized or covered personnel.
~~1.~~3. All changes or additions to the standardized procedures and protocols are to be approved by the IDPC and MEC and accompanied by a dated, signed approval sheet.

A. Provision for initial and continuing evaluation

~~PROVISION FOR INITIAL AND CONTINUING EVALUATION~~

1. Evaluations of NP and PA performance of standardized procedures and protocol functions will be done in conjunction with existing job performance policies and/or clinical privilege delineations and according to the following:.
    a. For initial appointment – Proctoring of ten (10) cases and three and six month reviews by random chart reviews with physician feedback.
    b. Ongoing chart review by supervising physician. The process for chart review will be determined at the practice level after discussion with the NP/PA and the supervising physician.
    c. Through a peer review process based on the standard of care, and as required by state law, NP and PAs will have ongoing competency assessments. NPs and PAs participate in OPPE.

~~c.~~2. Provision for Review of privileges will be done by established credentialing and re-credentialing process through the TFHD Medical Staff and shall not exceed two (2) years from date of last appointment. ~~On-going monthly chart review (5% of charts) by Supervising Physician and special review when necessary.~~

B. Supervision~~UPERVISION~~

~~1.~~

~~a.~~ No physician can supervise more than four NPs or four PAs in CA at any moment in time.~~time.~~

1.

~~b.~~ Nevada Administrative Code precludes a physician from simultaneously supervising more than three physician assistants or collaborating with more than three advanced practitioners of nursing, or with a combination thereof. To supervise more than 3 NP/PAs, physicians must first file a petition with the Board for approval to supervise more than three.

2.

~~c.~~ NP and PA will be supervised by a TFHD Medical Staff Physician ~~versed in the management of primary care problems or specialist~~ appropriate to the field. ~~medical problem encountered.~~ The relationship between the physician and the non-physician medical practitioner shall be that of a shared and continuing responsibility to follow the progress of the patient in a manner which assures the NP/PA's adherence to the ~~limits of the specific professional practice established by law and regulations, while maximizing patient safety, health and well-being.~~ standard of care. Standard of care is defined as "the level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent NPs or PAs in the same or similar circumstances at the time in question".

3.

~~d.~~ The supervising physician shall be available to NP or PA ~~the non-physician medical practitioners~~ in person, by telephone or through electronic means to provide supervision to the extent required by California and or Nevada professional licensing laws. ~~,~~ The supervising physician need not be physically present while the NP or PA provides medical services. ~~necessary instruction in patient management, consultation and referral to appropriate care and services by specialist physicians or other licensed health care professionals, as may be required in each case.~~

4.

~~e.~~ In cases of emergencies, the NP or PA~~non-physician medical practitioner~~, to the extent permitted by the laws relating to the license or certificate involved, may render emergency services to a patient .~~pending contacting the supervising physician.~~

~~f.~~5. ~~In all cases, the non-physician medical practitioner shall be responsible to maintain reasonable communication with the physician, to keep the physician informed, to follow~~

instructions and, in any case of doubt, to seek assistance or additional instructions.

2.6. The NP or PA shall consult with and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the NP or PA's competency, education, training or experience.

1. Physician consultation should always occur under the following circumstances as specified in the protocols.

3. Emergent conditions requiring prompt medical intervention.

4. Acute decompensation of patient situation.

5. Problem which is not resolving as anticipated.

6. Unexplainable historical, physical, or laboratory findings.

7. Conditions that may be unfamiliar, uncommon, unstable, or complex.

8. Upon request of patient, PA, NP or supervising physician.

C. SETTING

1. **Tahoe Forest Hospital Clinics and Incline Village Hospital Clinics**
2. **Cancer Center**
3. **Tahoe Forest Hospital**
4. **Incline Village Community Hospital**

PERIODIC REVIEW

1. **All standardized procedures and protocols are to be reviewed annually by the Interdisciplinary Practice Committee ("IDPC")**
2. **Changes in, or additions to, the standardized procedures and protocols may be initiated by any of the authorized or covered personnel.**
3. **All changes or additions to the standardized procedures and protocols are to be approved by the IDPC and accompanied by a dated, signed approval sheet.**

Record Keeping

RECORD KEEPING/QUALITY ASSURANCE

Records of patient contacts and visits are to be kept in accordance with standard practice at Tahoe Forest Hospital District.

D. Consent

PAs and NPs may only obtain informed consent on procedures they perform independently.

E. Furnishing Medication/Medication Management

In compliance with State and Federal prescribing laws, the NP or PA may order and furnish those drugs and devices, including schedule II through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA or NP's education, training, experience and competency, under physician supervision as provided above in "Supervision".

For PA's working in California who have not yet completed their controlled substance course, patient specific approval is required. [NOTE: PAs must complete course within six (6) months of being granted clinical privileges.]

NPs working in California are required to complete a Board of Registered Nursing Approved Controlled Substances II (CS II) Authority Course. When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by an NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury or condition for which the Schedule II controlled substance is to be furnished. (Appendix B: California NP Controlled Substances Protocol)

PROTOCOLS

1. The NP/PA has a current DEA number for their state and practice location.
2. A practice agreement authorizing a NP/PA to order or furnish a drug or device shall specify which PA/PAs or NP/NPs may furnish or order a drug or device, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the NP/PA's competence, including peer review, and review of the practice agreement.
3. The drug or device is being ordered in accordance with the standard of care and per formulary.
4. The drug or device is appropriate to the condition being treated
5. Medication history has been obtained including:
    1. Other medications being taken.
    2. Medication allergies and adverse reactions.
    3. Prior medications used for current conditions.
6. Plan for follow-up and refills is written in the patient's chart.
7. Patient education regarding the medications is given and documented in the patient's chart.
8. The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the NP/PA.
9. All other applicable Standardized Procedures in this document are followed during health care management.
10. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision, and consultation in the Standardized Procedures are in force.

F. Ordering Lab work, Diagnostic Studies and Therapies

The NP/PA is authorized to collect, order and interpret lab work and diagnostic studies per standard of care and in accordance with NV or CA state law.

NP PROTOCOLS

1. Lab work and diagnostic studies obtained (such as CBC, chemistry panel, vaginal smears, urinalysis, throat cultures, radiology, etc.) must be appropriate as outlined in resources from Appendix A.
2. Therapies are ordered as part of a treatment plan as referenced in Appendix A.
3. All other applicable Protocols/Standardized Procedures in this document are followed during health care management.

4. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

G. Outpatient Management of Medical Conditionss

POLICY

: Pursuant to applicable state laws, the NP or PA is authorized to perform those medical services for which they have demonstrated competency through education, training or experience, under physician supervision as outlined in the individual Practice Agreement.

H. Outpatient Procedures and minor surgery

If approved through the TFHD Medical Staff credentialing process, the NP/PA may perform procedures, as consistent with their privileges

PROTOCOLS

1. The NP/PA has been observed satisfactorily performing the procedure(s) or a sampling of procedures by another provider competent in that skill, as required by privileging.
2. The NP/PA is following standard of care

The NP or PA is authorized to diagnose and manage common acute conditions and common chronic stable conditions and provide health care maintenance under the following protocols. The NP or PA has responsibility to consult the supervising physician per the protocol delineated above about supervision.

PROTOCOLS

A treatment plan is developed based on references from Appendix A.

All other applicable Standardized Procedures in this document are followed during health care management.

All general policies regarding review, approval, setting, education, evaluation, patient records, supervision, and consultation in the Standardized Procedures are in force.

I. Inpatient Management of Medical Conditions

POLICY

The NP or PA may facilitate a hospital admission on behalf of the physician, if their condition or disease

requires inpatient management. The Supervising Physician must be contacted to review the diagnostic and treatment plan for the care of the patient. The Supervising Physician must see the patient within 24 hours of admission and cosign the admission history and physical. Any ICU admissions need to be referred to supervising physician, hospitalist or emergency room physician.

PROTOCOLS

A. The PA or NP will communicate with the supervising physician regarding any changes to the evaluation, diagnosis, and treatment plan.
B. All inpatient history and physicals and discharge summaries are co-signed by a physician.
C. A treatment plan is developed based on Standard of Care ~~references from Appendix A.~~
D. All other applicable Standardized Procedures in this document are followed during health care management.
E. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision, and consultation in the Standardized Procedures are in force.

J. Emergent Care~~EMERGENT CARE~~

~~**POLICY**~~

Emergent care conditions are acute, life-threatening conditions such as respiratory arrest or cardiac arrest. The NP/PA is authorized to evaluate emergent/urgent care conditions consistent with the standard of care and to the extent permitted under their license, privileging and state law. ~~under the following protocols.~~

~~**PROTOCOLS**~~

~~5. See Departmental Code Blue Policy and Procedure.~~

~~6. Initial evaluation and stabilization of the patient may be performed with concomitant notification of and immediate management by a physician.~~

~~7. Initial treatment may include initiation of appropriate Emergency procedures.~~

~~The referral is noted in the patient's chart including name of physician or agency, (e.g. ER), referred to.~~ ~~DRUG FORMULARY (PA)~~

~~**DRUG FORMULARY TO BE USED BY PHYSICIAN ASSISTANT**~~

~~Medications that a PA may prescribe include all medications listed in Up-To-Date, or a current edition of Physician Assistant's Prescribing Reference, Tarascon Pharmacopeia, Physicians' Desk Reference, the Lexi Drug Handbook, or the Pediatrics Dose Handbook. The PA will refer to these sources for information pertaining to criteria for use, dosages, contraindications, and patient education. The PA will use medications which are appropriate to the clinical setting in which he/she is practicing including medications used in the management of chronic pain. Routes of administration are to include PO, IM, IV, Transdermal, PR, SC.~~

~~FURNISHING MEDICATION / MEDICATION MANAGEMENT~~

~~**POLICY**~~

For PA's working in California who have not yet completed their controlled substance course, patient specific approval is required. [NOTE: PAs must complete course within six (6) months of being granted clinical privileges.]

NPs working in California are required to complete a Board of Registered Nursing Approved Controlled Substances II (CS II) Authority Course. When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Heath and Safety Code, are furnished or ordered by an NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury or condition for which the Schedule II controlled substance is to be furnished. (Appendix B)

The NP/PA may write a transmittal order for drugs or devices pursuant to Section 3502.1 of the Business and Professions Code for Physician Assistant and according to Senate Bill 816. The nurse practitioner may write a prescription order for drugs or devices pursuant to Section 2836.1-2836.3 of the Nursing Practice Act and under the following protocols.

PROTOCOLS

1. The NP/PA has a current DEA number for their state and practice location.
2.
3. The drug or device is being ordered in accordance with the Standardized Procedures and as referenced in Appendix A or the drug formulary.
4. The ordering of drugs or devices includes the initiation, discontinuation, and/or renewal of prescriptive medications and/or their over-the-counter equivalents.
5. The drug or device is appropriate to the condition being treated and the following principles followed:

F. Use lowest dosage effective per pharmaceutical references.

G. Do not to exceed upper limit dosage per pharmaceutical references.

H. Order generic medications if appropriate.

9. Medication history has been obtained including:

1. Other medications being taken.
2. Medication allergies and adverse reactions.
3. Prior medications used for current conditions.

10. Plan for follow-up and refills is written in the patient's chart.
11. Patient education regarding the medications is given and documented in the patient's chart.
12. A physician is consulted in the following situations:

1. For PA's working in California: With the use of controlled substances for chronic pain management, with the exception of Schedule III, IV and V substances, which may be ordered for the limited treatment of acute primary care conditions and as part of an on-going plan established with or by a physician. Practitioner must provide evidence of completing an approved educational course in controlled substances. Supervising physician must review, countersign and date twenty percent (20%) of the medical records of any patient issued a Schedule II controlled substance by a PA within seven (7) days.
2. For PA's working in California who have not yet completed their controlled substance course, patient specific approval is required. [NOTE: PAs must complete course within four (4) months of being granted clinical privileges.]

Before adding medication when six or more concurrent medications are being taken.

13. Consultation with a physician, if made, is noted in the patient's chart, including the physician's name and co-signature.
14. The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the NP/PA.
15. All other applicable Standardized Procedures in this document are followed during health care management.

16. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision, and consultation in the Standardized Procedures are in force.
17. The list of NP/PAs who can furnish will be maintained in the medical staff office and the clinics.

PROCEDURES AND MINOR SURGERY

POLICY

If approved through the TFHD Medical Staff credentialing process, the NP/PA may perform the listed procedures:

1. Splinting
2. Casting, simple
3. Incision and drainage of non-facial abscess less than 5cm in size
4. Suture non-facial laceration less than 5cm in size
5. Wart removal with cryotherapy y
6. Toe nail removal
7. Excision and biopsy
8. Joint Injections and aspirations
9.

PROTOCOLS

1. The NP/PA has been observed satisfactorily performing the procedure(s) or a sampling of procedures by another provider competent in that skill, as required by privileging. .
2. The NP/PA is following standard medical technique for the procedures as described in the Appendix A.
3. Any underlying condition that requires co-management with physician, will also require consultation prior to performing any of the above procedures.

ORDERING LAB WORK, DIAGNOSTIC STUDIES & THERAPIES

POLICY

The NP/PA is authorized to collect, order and interpret lab work and diagnostic studies and in accordance with NV or CA state law. under the following protocols. The NP/PA is authorized to order therapies such as occupational, speech and physical therapy and psychological counseling, under the following protocols.

PROTOCOLS

1. Lab work and diagnostic studies obtained (such as CBC, chemistry panel, vaginal smears, urinalysis, throat cultures, radiology, etc.) must be appropriate as outlined in resources from Appendix A.
2. Advanced studies such as Thallium scans, MRI, or PET scans should also be obtained in conjunction with an appropriate physician.
3. Therapies are ordered as part of a treatment plan as referenced in Appendix A.
4. All other applicable Protocols/Standardized Procedures in this document are followed during health care management.
5. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

~~SPECIALTY CONSULTATION (Duplication)~~

~~**POLICY:**~~

~~A PA/NP may only provide those medical services which he or she is competent to perform, are consistent with the PA/NP's education, training and experience, are delegated in writing by the Supervising Physician, and have been approved by the TFHD Board of Directors. A PA/NP shall consult with a physician regarding any tasks, procedures or diagnostic problem which the PA/NP determines exceeds his or her level of competence, or shall refer such cases to a physician.~~

~~**PROTOCOL:**~~

~~A. The PA/NP and consulting physician will communicate regarding the patient assessment, diagnosis and treatment plan.~~

~~B. Management of the patient will be either in conjunction with the consulting physician or by complete referral to the specialty physician or inpatient treatment facility.~~

~~C. The consultation will be noted in the patient's chart including the name of the supervising physician.~~

~~D. All inpatient consults will be reviewed by a Supervising Physician.~~

~~E. All other applicable protocols/standard procedures in this document will be followed during health care management.~~

K. Surgery First Assistant

PA or NP has been granted first assist privileges and approved as an Allied Health Professional at Tahoe Forest Hospital and/or at Incline Village Community Hospital. PA or NP must meet all the qualifications per approved privilege criteria before being permitted to function in the expanded perioperative role of first assisting:

~~**URGERY FIRST ASSISTANT**~~

~~**FUNCTION**~~

Function: The PA or NP renders direct patient care as part of the perioperative role by assisting the approved supervising surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation, formal instruction and supervised practice.

~~**THIS PROCEDURE MAY BE PERFORMED BY**~~

~~PA or NP must meet all the qualifications per approved privilege criteria before being permitted to function in the expanded perioperative role of first assisting:~~

~~1. Has been granted first assist privileges and approved as an Allied Health Professional at Tahoe Forest Hospital and/or at Incline Village Community Hospital.~~

Provision for ~~PROVISION FOR INITIAL AND CONTINUING EDUCATION~~

Review of privileges will be done by established credentialing and re-credentialing process through the TFHD Medical Staff and shall not exceed two (2) years from date of last appointment.

SUPERVISION

1. The PA/NP First Assistant practices under the direct supervision of the surgeon.
The PA/NP may surgically close all layers, affix and stabilize drains deemed appropriate by the supervising physician. The supervising physician is responsible for all aspects of the invasive/surgical procedure including wound closure and must provide supervision, but need not be present in the room when the PA/NP closes the wound. Supervising surgeons must be *immediately available* when the PA/NP closes the wound . ("Immediately available" is defined as "able to return to the patient without delay, upon the request of the PA/NP or to address any situation requiring the supervising physician's services.").

2.

CIRCUMSTANCES

1. PA/NP Protocol may be performed in any Tahoe Forest Hospital District facility.
2. A PA/NP may only provide those medical services which:

1. he or she is competent to perform, as determined by the supervising physician;

2. are consistent with his/her education, training, and experience and ;
are delegated in writing by the supervising physician responsible for the patients cared for by the PA; and which

3.2. have been approved by the TFHD Board of Directors.
3. There will be a Practice Agreement Delegation of Services Agreement (CA), or a Supervising Physician Agreement (NV) between a supervising physician and a PA on file at all times. There will be evidence of a Collaborative Service Agreement between a supervising physician and an NP on file at all times.
4. The PA/NP will be listed as Assistant on all patient records and documents.
5. The PA/NP must adhere to the policies of the hospital and must remain within the scope of practice as stated by their state of license and practice.

The PA/NP will be directed by an approved supervising physician at all times and only perform surgical procedures with the personal presence of the approved supervising physician. (see above)

PROCEDURESPROCEDURE

The PA/NP may perform the following under the direct supervision of the surgeon:

1. Assist with the positioning, prepping and draping of the patient or perform these independently
2. Initiate surgical entry as directed by the physician
3. Manipulate tissue by use of surgical instruments and/or suture material as directed by the surgeon to:
    a. Expose and retract tissue.
    b. Clamp, incise and/or sever tissue.
    c. Grasp and fix tissue with screws, staples and other devices.
    d. Drill, ream and modify tissue.
    e. Cauterize and approximate tissue.
    f. Place trochars
4. Provide retraction by:
    a. Placing and holding surgical retractors, closely observing the operative field.

b. Packing sponges or laparotomy pads into body cavities to hold tissue or organs out of the operative field.
c. Managing all instruments in the operative field to prevent obstruction of the surgeon's view and provide patient safety.
d. Anticipating retraction needs with knowledge of surgeon's preferences, anatomical structures, and the procedure being performed.

5. Provide hemostasis by:
   a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
   b. Sponging and utilizing pressure as necessary.
   c. Utilizing suctioning techniques.
   d. Applying clamps on vessels and tying them as directed by the surgeon.
   e. Placing suture ligatures in the muscle, subcutaneous, and skin layers.
   f. Placing hemoclips on bleeders as directed by the surgeon.
6. Perform knot tying by:
   a. Demonstrating various knot- tying techniques.
   b. Tying knots appropriately for suture material.
   c. Approximating tissue, rather than pulling tightly, to prevent tissue necrosis.
7. Provide closure of tissue layers by:
   a. Correctly approximating the layers under the direction of the surgeon.
   b. Demonstrating knowledge of different types of closure.
   c. Correctly approximating skin edges when utilizing skin staples.
8. Assist the surgeon at the completion of the surgical procedure by:
   a. Affixing and stabilizing all drains.
   b. Cleaning the wound and applying the dressing.
   c. Applying casts or splints as directed.
9. Provide continuity of care.
   a. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the PA will:
      1. Maintain hemostasis, according to the approved standardized procedure.
      2. Keep the surgical site moistened, as necessary, according to the type of surgery.
      3. Maintain the integrity of the sterile field.
      4. Remain at the field while a replacement surgeon is being located.
   b. The RN circulator/charge nurse will initiate the procedure for obtaining a surgeon in an emergency.

RECORD KEEPING/QUALITY ASSURANCE

A. The Director of Surgical Services will maintain a list of the surgeons utilizing the PA/NP and a current list of PA/NPs with hospital privileges.
—A QA/QI Program will be put in place and approved by the Surgical Department.

B.

L. ~~PERIODIC REVIEW~~

~~**Standardized Procedures and Protocols will be reviewed annually by the Interdisciplinary Practice Committee.**~~

~~**BIBLIOGRAPHY**~~

~~**Physician Assistant Scope of Practice issues by the State of California**~~
~~**California Code of Regulations: Title 16**~~

~~Policies and Procedures of Tahoe Forest Hospital District Department of Surgery~~

ONCOLOGY ~~SETTING~~ (inpatient and outpatient)

~~POLICY~~

POLICY

The Nurse Practitioner or Physician Assistant is authorized to follow the supervising -physician's chemotherapy treatment plan as outlined in the physician orders. Prior to authorizing a continued treatment for a patient, the PA/NP~~nurse practitioner~~ will review the level of toxicity induced by treatment, as appropriate to the drugs utilized. The PA/NP~~nurse practitioner~~ is authorized to modify doses of chemotherapy as outlined in the supervising physician's treatment plan.

PROTOCOL

A. The PA/NP is authorized to modify doses of chemotherapy as outlined in National Comprehensive Cancer Network (NCCN) guidelines. This may include dosage reduction and discontinuation of therapy due to toxicity. The PA/NP is required to consult with the medical oncologist within 24 hours of modifying the attending physician's treatment plan, and documentation by the PA/NP must reflect such consultation.

B. The primary signature of chemotherapy orders must be from the medical oncologist.

~~C.~~ All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

C.

M. BIBLIOGRAPHY

Physician Assistant Scope of Practice issued~~s~~ by the State of California

California B&P Code, § 3502.1

SB-697 Physician A~~a~~ssistants: practice agreement: supervision.(2019-2020)
California Code of Regulations: Title 16

Policies and Procedures of Tahoe Forest Hospital District Department of Surgery

APPENDIX A: Clinical Resources

The following are examples of clinical resources that may be consulted: ~~resources may be consulted:~~

Up To Date

Epocrates

Micromedex

Tarson's Pharmacopeia

APPENDIX B:

Controlled Substances Protocol for California NPs

A. Schedule III Patient Specific Protocols

1) Schedule III substances may be furnished or ordered when the patient is in one of the following categories, including but not limited to the following conditions:

   a) Acute Illness, Injury or Infection

   b) Acute intermittent but recurrent pain

   c) Chronic continuous pain

   d) Hormone replacement

2) Limited order for acute illness, injury or infection per Standard of Care

3) For chronic conditions:

   a) pain management protocol or department guidelines is/are adhered to if appropriate

   b) Amount given, including all refills is not to exceed a 120 days supply as appropriate for the condition.

   c) Treatment plan must be established in collaboration with the patient's primary care provider and reviewed, with documentation every 12 months

   d) Refills with evaluation at regular intervals

e) Education and follow up is provided

B. Schedule II Patient Specific Protocol

1) Schedule II substances may be furnished or ordered when the patient has one of the following diagnoses and under the following conditions:

a) Pain secondary to malignancy, trauma or post-operative pain

b) Pain unresponsive to, or inappropriately treated by CS III-V substances

c) Attention Deficit Disorders

d) Neuropsychiatric Conditions

2) Limited orders for acute and chronic conditions as specified in Schedule III Patient Specific Protocol

3) No refills are authorized for CSII medications except where authorized by the DEA

4) Pain management protocol or TFHD system guidelines are adhered to if appropriate

~~APPENDIX A~~

~~Reference Resource List~~

~~Up-to-date online resource~~

~~Red Book, CDC~~

~~A Guide To Physical Examination & History Taking, Bates~~

~~Procedures in Primary Care, Pfenninger~~

~~The Harriet Lane Handbook (The Johns Hopkins Hospital), A Manual For Pediatric House Officers~~

Tahoe Forest Trauma Activation Algorithm

TRAUMA ACTIVATION

FULL TRAUMA ACTIVATION

PRIMARY SURVEY: PHYSIOLOGIC

- GCS ≤ 13 attributed to trauma
- SBP ≤ 90 at any time in the adults and age specific hypotension in pediatrics
- RR < 10 or > 29/minute (<20 in infants age <1 year) and/or requirement for intubation
- Any respiratory compromise
- Deterioration of previously stable patient
- Transfers requiring blood transfusions

SECONDARY SURVEY: ANATOMIC

- Penetrating injuries to the head, neck, torso, or extremities proximal to the elbow/knee.
- Open or depressed skull fracture
- Paralysis or suspected spinal cord injury
- Flail chest
- Unstable Pelvic Fracture
- Amputation proximal to wrist or ankle
- Crushed, degloved, pulseless, or mangled extremity
- Blunt abdominal injury with firm or distended abdomen or + F.A.S.T exam

Mechanism Of Injury

- Auto v. pedestrian/cyclist thrown, run over, or at speed >20 mph
- Fall from height of ≥20 feet for adults. Fall from height of ≥ 10 feet or 2x height for children
- Multi Casualty event with ≥3 patients that meet modified criteria.
- Any patient that meets modified criteria that is ≥20 weeks pregnant, or on anticoagulants*
- Patient transferred from another hospital receiving blood to maintain vital signs
- ED physician/Charge RN discretion

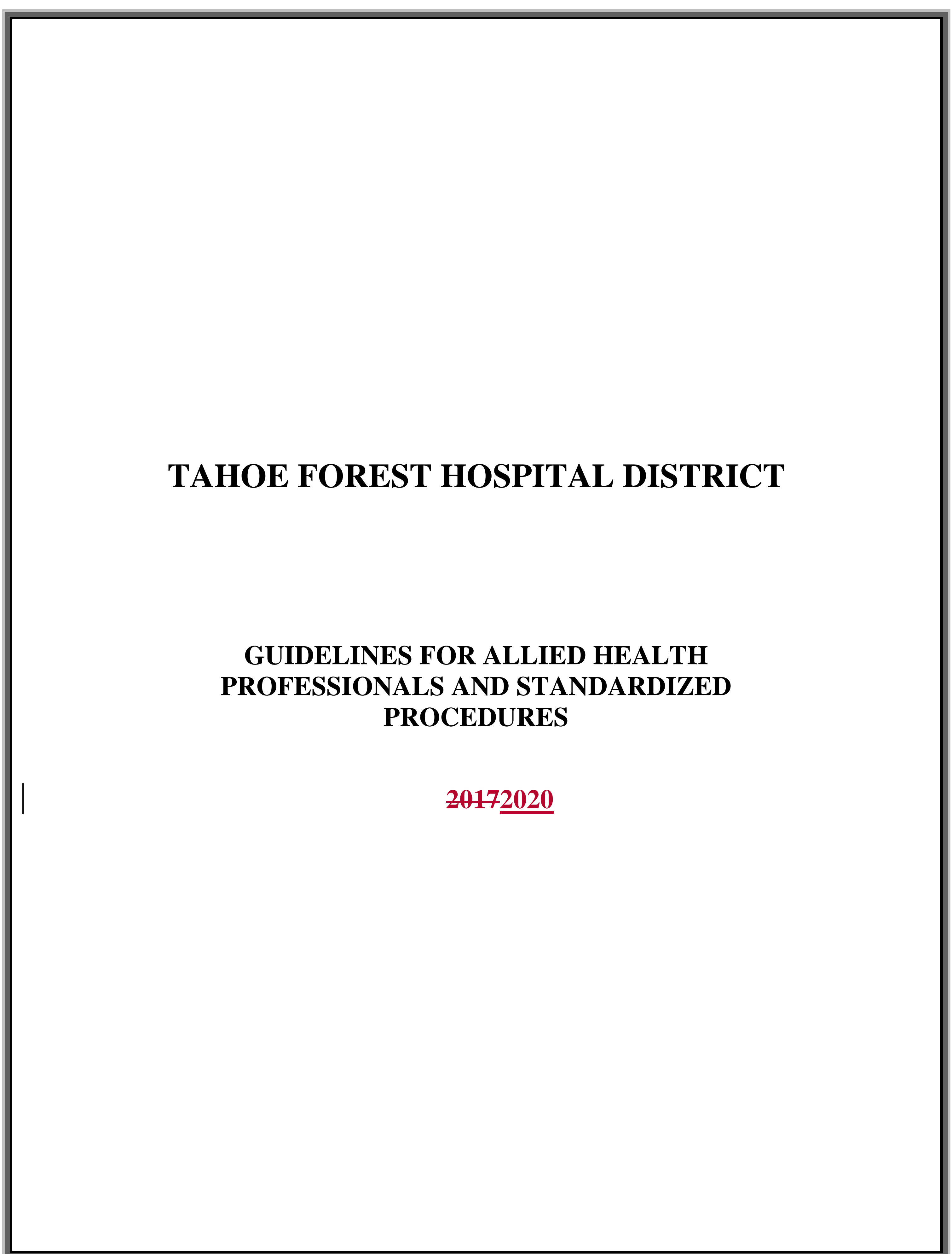
*Warfarin, Plavix, Pradaxa, Xarelto

MODIFIED TRAUMA ACTIVATION

- GCS 14 with mechanism attributed to trauma or found down
- MVC obvious injuries, roll over or speed ≥ 40mph, or noted seatbelt sign
- Auto v. pedestrian/cyclist that does not meet above criteria
- All penetrating injuries distal to the knee or elbow
- Fall from 10-19 feet for adults
- Any obvious two system trauma or multiple long bone fractures
- High risk auto crash with:
  - ✓ Intrusion of vehicle >12" occupant compartment; >18" other site
  - ✓ Ejection (partial/complete) from vehicle
  - ✓ Death in same passenger compartment
- High energy dissipation or rapid deceleration
  - ✓ Striking fixed object with momentum
- EMS/Charge RN/Physician judgement

SPECIAL CONSIDERATIONS

- **Age >65**
  - GCS < 15 with evidence of head strike (or below baseline)
  - Systolic BP <100
  - Struck by moving vehicle
  - ANY fall with e/o or "suspicion" of head strike
- **Recreational trauma** (ex:ski or biking) from outlying clinic or scene, with concern for:
  - ✓ TBI
  - ✓ Chest trauma
  - ✓ Abdominal trauma
  - ✓ Pelvic or lower extremity fracture excluding ankle/foot fractures
  - ✓ Upper extremity trauma including humerus but excluding radius/ulna fractures
  - ✓ SBP <100 or HR>120 w/mechanism attributed to trauma
  - ✓ Physician/RN discretion



TAHOE FOREST HOSPITAL DISTRICT

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

~~2017~~2020

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

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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~~ Practice Nurse
3. Physician Assistants
4. Dental Assistants
5. Audiologists
6. Acupuncturists
7. Licensed Clinical Social Worker
~~6.~~8. Licensed Marriage Family Therapist

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

NAME: ____

Check which applies:
□ Tahoe Forest Hospital (TFH), Inpatient, Oncology, ECC, Outpatient, Emergency, TFH Clinics
□ Incline Village Community Hospital (IVCH), Inpatient, Outpatient, Emergency, Health Clinic

Check which applies: □ Nurse Practitioner □ Physician Assistant
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, Training, Licensure, and Experience	Nurse Practitioner: • Certification from an accredited school for nurse practitioner training • Current advance practice RN licensure to practice in California and/or Nevada, as appropriate. • Provide evidence of Collaborative Service Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable. • Provide evidence of completion of a program meeting AORN (Assoc. of periOperative Registered Nurses) standards for RN First Assistant Education Programs as an NP, if applying for surgical assist privileges, or provide certification with 9 months of appointment.
	Physician Assistant: • Completion of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant. • Current California and/or Nevada license in good standing, as applicable. • Provide evidence of Delegation of Service Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable.
Certification:	**Nurse Practitioner:** Current ANCC (American Nurses Credentialing Center) or AANP (American Academy of Nurse Practitioners) certification required. Current PNCB (Pediatric Nursing Certification Board) or ANCC certification is required if requesting to work in pediatrics. **Physician Assistant:** Current NCCPA (National Commission on Certification of Physician Assistants) certified **NP and PA:** Current BLS (Basic Life Support) certified (must submit copy & maintain current certification.)
Clinical Competency References: 3	***Initial and Reappointment***: At least one peer reference should have the same licensure as the applicant; e.g., nurse practitioner or physician assistant. Other references should include physicians with whom the applicant has worked and/or been employed. ***Reappointment***: At least one reference from a supervising physician, if applicable.
Proctoring/Evaluation:	See "Proctoring New Applicant" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring/evaluation may be required if minimum number of cases cannot be documented.
Other:	• Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate in CA and/or NV, as applicable (Schedules II-V). Nevada Pharmacy Board Certificate, if applicable • Ability to participate in federally funded program (Medicare or Medicaid) • Physician Assistants must have an identified Physician Supervisor who is a member of the Hospital's medical staff. • PA's must complete an educational course in controlled substances that meets the standards of practice by TFHD and State of California witihin six (6) months of being granted privileges and AHP membership. [CA Code of Regulations Sections: 1399.541(h), 1399.610 and 1399.612] • Nurse Practitioners must have a Collaborative Agreement with a designated *supervising physician member of the Hospital's medical staff. Must function under defined standardized procedures or protocols.

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

DRAFT

Name: ______________________________

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
☐	☐	**OUTPATIENT** (Tahoe Forest/Incline Village Hospital) This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in this specialty. Please mark through and initial any privileges that you do not wish to include in our core practice privileges: • History documentation and physical examinations. • Conduct initial and ongoing assessment of the patient's medical and physical status. • Refer to hospital for admission and treatment. • Evaluate, diagnose, and treat in outpatient clinic. • Management of acute and chronic conditions. • Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. • Collecting, ordering, and interpreting lab work, therapies, x-rays and other diagnostic studies following approved protocols. • Ordering therapies as part of treatment plans such as speech and physical therapy, psychological counseling following approved protocols. • Medication management, including controlled substances, with physician consultation following approved protocols. • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. • Specialty consultation with physician when level of competence or comfort exceeded per approved protocols. **<u>Procedures and minor surgery including</u>**: • Splinting & Casting, simple • Incision and drainage of non-facial abscess less than 5 cm in size • Suture non-facial laceration less than 5 cm in size • Wart removal with cryotherapy • Toenail removal • Excision and Biopsy • Joint Injections	_______	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Actively seeing patients in occ health/health clinic setting (minimum of 100 in two years) On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist

TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request

Name: ____

(R)	(A)	**GENERAL PRIVILEGES** **Please check the appropriate "core privileges" for your practice area**	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
☐	☐	**INPATIENT or OUTPATIENT HOSPITAL SETTING** Core privileges for the inpatient or outpatient hospital setting include the following: [NOTE: Any patient requiring ICU or step-down ICU status will be transferred to the on-call physician.] • History documentation and Physical examinations, • Preop/Preadmission • Dictation of admission H&P and initiation of admitting orders. • Obtain informed consent • POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. • Patient visits and recording progress notes. • Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. • Assess medical risks and appropriately prevent and treat risks (e.g., VTE). • Ordering of diagnostic lab, wound cultures, radiology services, and therapies in consultation with or using procedures approved by supervising and/or employing physician/s. • Consultation with care coordinators, nursing staff, or clinical educators. • Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. • Specialty consultation with physician when level of competence exceeded per approved protocols. • Provision of patient education and make appropriate referrals	________	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Minimum of 5 patients managed in inpatient setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years) On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist
☐	☐	**Procedures and minor surgery including:** • Apply and remove wound vacs • Arthrocentesis for joint & bursa aspirations to rule out infections • Casting, simple • Closed reductions of dislocations • Reductions of extremity fractures • Hardware removal requiring only local anesthesia • ~~Incision and drainage of non-facial abscess less than 5 cm in size~~ • Suture non-facial laceration less than 5 cm in size • Excision and Biopsy • Joint injections • Injections of hematoma blocks for reductions • Injections IM, IV, Intra articular, SQ and Tendon Sheaths • Traction and Insertion of Steinman Pins for Skeletal Traction • Wound care, assessment & dressing changes • Pronounce a patient death.			

Name: ____

☐	☐	**PA/NP SURGICAL FIRST ASSIST – OPERATING ROOM** **Core privileges include:** The supervising physician may delegate to a PA/NP only those tasks and procedures consistent with the supervising physician's specialty. The PA/NP may assist with any procedure/surgery approved by the Department of Surgery for the supervising physician/surgeon: • Positioning, prepping and draping the patient • Manipulation tissue/bone • Providing retraction • Drilling, reaming, nail/plate and screw placement • Intraoperative fracture reductions • Providing hemostasis • Performing suturing and knot tying • *Providing closure of tissue layers with suture, staples, or steristrips • *Affixing and stabilize drains • Reduction of fractures/dislocations • Removal of external fixaters • Joint/tissue injections • Applying dressings and splints or casts **NOTE**: *The PA/NP may surgically close all layers, affix and stabilize drains deemed appropriate by the supervising physician. The supervising physician is responsible for all aspects of the invasive/surgical procedure including wound closure and must be **immediately available (need not be present in the room) when the PA/NP closes the wound. [***Immediately available* is defined as "able to return to the patient without delay, upon the request of the PA/NP or to address any situation requiring the supervising physician's services".]	_______	Ten cases reviewed at random (list of patients are provided by practitioner if needed) Review and evaluation of care by surgeons and surgical supervisor	Actively assisting surgeons (minimum of 5 in two years) with annual review and favorable competency evaluations On going monthly chart review(5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist
☐	☐	**Fluoroscopy** [Current CA Department of Health Services fluoroscopy certificate (required in CA only)]		TFH Only	Maintain Current Fluoroscopy License (CA Only)

Name: ____

		SKILLED NURSING FACILITY (SNF)			
☐	☐	Core privileges for the skilled nursing facility are limited to performing alternating federally mandated physician visits, at the option of the physician, after initial visit by the physician in the SNF, and medically necessary visits for the diagnosis or treatment of an illness or injury as needed. • History documentation and Physical examinations. • Patient visits and recording progress notes. • Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. • Assess medical risks and appropriately prevent and treat risks (e.g., VTE). • Ordering of diagnostic lab, radiology services, and therapies in consultation with or using procedures approved by supervising and/or employing physician/s. • Consultation with care coordinators, nursing staff, or clinical educators. • Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. • Provision of patient education and make appropriate referrals. • POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. • Pronounce a patient death. Specialty consultation with physician when level of competence exceeded per approved protocols.	_________	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Minimum of 5 patients managed in Skilled Nursing setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years) On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist
		INPATIENT / OUTPATIENT CHEMOTHERAPY			
☐	☐	• Order adjustment per protocol. Specialty consultation with physician when level of competence exceeded per approved protocols.	_________	Ten cases proctored at random (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Actively seeing patients in cancer center setting/inpatient (minimum of 100 in two years, including 5 inpatient cases) On going monthly chart review(5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist

Name: ____

EMERGENCY DEPARTMENT (TFH or IVCH)					
☐	☐	Core privileges for physician assistants and nurse practitioners in emergency medicine include the care for patients of all ages to correct or treat various conditions, illnesses, or injuries including the provision of consultation on behalf of their supervising physician. Core privileges also include assisting the supervising physician with diagnosis and management in the following areas: • History documentation and physical examinations. • Perform a Medical Screening Examination. • Conduct initial and ongoing assessment of the patient's medical and physical status. • Refer to hospital for admission and treatment. • Evaluate, diagnose, and treat in outpatient clinic. • Management of acute and chronic conditions. • Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. • Collecting, ordering, and interpreting lab work, therapies, x-rays, ECGs, and other diagnostic studies following approved protocols. • Ordering therapies as part of treatment plans such as speech and physical therapy, psychological counseling following approved protocols. • Medication management, including controlled substances, with physician consultation following approved protocols. • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. **Procedures:** Procedures within scope of practice may be performed with consultation when appropriate. These may include but are not limited to: • Splinting & casting • Local anesthesia • Incision and drainage • Wound management and closure • Nail removal • Joint, bursa, and trigger point injection • Foreign body removal • Urinary bladder catheterization		3 and 6 month reviews through random chart review and physician feedback Ten cases proctored (list of patients seen are provided by practitioner)	Actively seeing patients in ER setting (minimum of 100 in two years, may include outpatient or ortho) On going monthly chart review(5% of charts) by Medical Director or Supervising Physician); special review as needed
☐	☐	**URGENT CARE – ADULT and PEDIATRIC MEDICINE (Must also request Outpatient General NP/PA 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	________	Review of 10 cases proctored	Current demonstrated competence and provision of care for approximately 25 urgent care cases in past two years. Office records may be requested. *

Name: ____

		DIAGNOSES • Adult and Pediatric dislocations • Adult and Pediatric fractures			
		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:
____

INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC)
□ privileges as requested □ privileges with modifications (see modifications below_) □ do not recommend (explain)

__________________________ ____
Date IDPC Chair/Designee 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)

Name: ____

□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

Department Review Dates: previously approved as separate privilege forms
IDPC Review Dates 10/14/08; 3/12; 4/13/16; 11/11/16; 2/6/17; 10/10/18; 1/9/18, 4/24/19
Medicine/Emerg Department: 5/5/16; 11/14/16
Surgery Department: 6/1/16
Medical Executive Committee: 10/15/08; 3/12; 6/15/16; 11/16/16; 3/16/17; 10/18/18, 5/16/19
Board of Directors: 10/28/08; 3/12; 6/23/16; 11/17/16; 3/23/17; 10/25/18, 5/23/19

TAHOE FOREST HOSPITAL DISTRICT

Department of Medicine
Delineated Clinical Privilege Request

SPECIALTY: LICENSED CLINICAL SOCIAL WORKER LCSW **NAME:** ______________________
Please print

Check which applies: □ **Tahoe Forest Hospital (TFH)** □ **Incline Village Community Hospital**
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, Training, Licensure, and Experience	• ~~Masters Degree in Social Work from accredited graduate school of Social Work.~~ • Current California State LCSW license issued by the Behavioral Science-Examiners, and/or Current Nevada State LCSW license issued by the State of Nevada Board of Examiners for Social Workers • Must have provided inpatient, outpatient, or consultative services to at least 30 patients during the past 12 months.
Certification:	If held, certification by the State for involuntary holds.
Clinical Competency References (3): (required for new applicants)	At least one peer reference must have the same licensure and be familiar with your work and current professional status; and at least one clinical reference from a physician with whom the applicants have worked and/or been employed. Medical Staff Office will request letters of reference.
Proctoring/Evaluation:	See "Proctoring New Applicant" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring/evaluation may be required if minimum number of cases cannot be documented.
Other:	• Malpractice insurance in the amount of $1m/$3m • Ability to participate in federally funded program (Medicare or Medicaid)

Commented [PD1]: Check licensing requirement

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence. Any practitioners who hold the following privileges prior to the revision date are grandfathered for those privileges; however, all practitioners must meet any new criteria defined for maintaining privileges if applicable (at reappointment).

TAHOE FOREST HOSPITAL DISTRICT

Department of Medicine **Name:** ________________________________

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number patients seen/treated during the past 24 months.
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 – LICENSED CLINICAL SOCIAL WORKER	Estimate # of patients seen in last 24 months	Setting	Proctoring New applicants	Reappointment Criteria

☐	☐	Does NOT include hospital admitting privileges
		
		Basic privileges include ability to diagnose, provide treatment and/or consult for patients with mental, behavioral or emotional disorders at the request of the attending medical staff member for one or more of the following:
		
		• Individual psychotherapy
		  ○ Adult
		  ○ Adolescent
		  ○ Child
			________	TFH or IVCH	5 cases	Evidence of current clinical competence.

☐	☐	Does NOT include hospital admitting privileges
		
		Basic privileges include ability to diagnose, provide treatment and/or consult for patients with mental, behavioral or emotional disorders at the request of the attending medical staff member for one or more of the following:
		
		• Group psychotherapy
		  ○ Adult
		  ○ Adolescent
		  ○ Child
			________	TFH or IVCH	5 cases	Evidence of current clinical competence.

☐	☐	**Family/Couple Psychotherapy**	________	TFH or IVCH	5 cases	Evidence of current clinical competence.
☐	☐	**Chemical Dependency Counseling**	________	TFH or IVCH	5 cases	Evidence of current clinical competence.
☐		REMOVAL FROM BASIC PRIVILEGES: Should applicant's current practice limitations or current competence exclude performance of any privileges specified in the list of basic privileges, please indicate here. Applicant and/or MEC must document reasons for exclusion. ____ ____				
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**				
☐	☐	**Assessment/determination for involuntary hold** Requires contract with County and holds certification	_______	TFH IVCH		Utilization of privilege in previous two years

TAHOE FOREST HOSPITAL DISTRICT

Department of Medicine **Name:** ______________________________

		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**

TAHOE FOREST HOSPITAL DISTRICT

Department of Medicine **Name:** ________________________________

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:
____

INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC)
□ privileges as requested □ privileges with modifications (see modifications below_) □ do not recommend (explain)

_______________________ ____
Date IDPC Chair/Designee 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 □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

Department Review Dates:
IDPC Review Dates:
Medical Executive Committee:
Board of Directors:

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

SPECIALTY: LICENSED MARRIAGE FAMILY THERAPIST, LMFT **NAME:** ____________________
Please print

Check which applies: ☐ **Tahoe Forest Hospital (TFH)** ☐ **Incline Village Community Hospital**
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, Training, Licensure, and Experience	• ~~Masters Degree in Marriage Family Therapy from accredited graduate school of Marriage Family Therapy.~~ • Current California State LMFT license issued by the Board of Behavioral Science-Examiners, and/or Current Nevada State LMFT license issued by the State of Nevada Board of Examiners for Marriage Family Therapists • Must have provided inpatient, outpatient, or consultative services to at least 30 patients during the past 12 months.
Certification:	If held, certification by the State for involuntary holds.
Clinical Competency References (3): (required for new applicants)	At least one peer reference must have the same licensure and be familiar with your work and current professional status; and at least one clinical reference from a physician with whom the applicants have worked and/or been employed. Medical Staff Office will request letters of reference.
Proctoring/Evaluation:	See "Proctoring New Applicant" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring/evaluation may be required if minimum number of cases cannot be documented.
Other:	• Malpractice insurance in the amount of $1m/$3m • 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. Any practitioners who hold the following privileges prior to the revision date are grandfathered for those privileges; however, all practitioners must meet any new criteria defined for maintaining privileges if applicable (at reappointment).

TAHOE FOREST HOSPITAL DISTRICT

Department of Medicine **Name:** ________________________________

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number patients seen/treated during the past 24 months.
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 – LICENSED MARRIAGE FAMILY THERAPIST	Estimate # of patients seen in last 24 months	Setting	Proctoring New applicants	Reappointment Criteria
☐	☐	Does NOT include hospital admitting privileges **Basic privileges include ability to diagnose, provide treatment and/or consult for patients with mental, behavioral or emotional disorders at the request of the attending medical staff member for one or more of the following:** • Individual psychotherapy ○ Adult ○ Adolescent ○ Child	________	TFH or IVCH	5 cases	Evidence of current clinical competence.
☐	☐	Does NOT include hospital admitting privileges **Basic privileges include ability to diagnose, provide treatment and/or consult for patients with mental, behavioral or emotional disorders at the request of the attending medical staff member for one or more of the following:** • Group psychotherapy ○ Adult ○ Adolescent ○ Child	________	TFH or IVCH	5 cases	Evidence of current clinical competence.
☐	☐	**Family/Couple Psychotherapy**	________	TFH or IVCH	5 cases	Evidence of current clinical competence.
☐	☐	**Chemical Dependency Counseling**	________	TFH or IVCH	5 cases	Evidence of current clinical competence.
☐		REMOVAL FROM BASIC PRIVILEGES: Should applicant's current practice limitations or current competence exclude performance of any privileges specified in the list of basic privileges, please indicate here. Applicant and/or MEC must document reasons for exclusion. ____ ____				
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**				
☐	☐	**Assessment/determination for involuntary hold** Requires contract with County and holds certification	_______	TFH IVCH		Utilization of privilege in previous two years

		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**

TAHOE FOREST HOSPITAL DISTRICT

Department of Medicine **Name:** ________________________________

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:

____

INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC)

□ privileges as requested □ privileges with modifications (see modifications below_) □ do not recommend (explain)

________________________ ____

Date IDPC Chair/Designee 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 □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

Department Review Dates:
IDPC Review Dates:
Medical Executive Committee:
Board of Directors:

Physician Assistant Practice Agreement (CA)

This Practice Agreement has been developed through collaboration among physician(s) and physician assistant(s) in **Tahoe Forest Health System**, an Organized Health Care System (as defined in Business & Professions Code (BPC) §3501(j) and hereinafter referred to as the "Practice"), for the purpose of defining the medical services which each and every physician assistant ("PA") who executes this Practice Agreement is authorized to perform and to meet the statutory requirement set forth in BPC §3502.3.

1. **Medical Services Authorized**: Pursuant to BPC §3502, the PA is authorized to perform those medical services for which the PA has demonstrated competency through education, training, or experience, under physician supervision as provided in Section 3 of this Practice Agreement. Subject to the foregoing, the PA is further authorized to: (a) perform the medical functions set forth in BPC §3502.3(b); to supervise medical assistants pursuant to BPC §2069; (c) to provide care and sign forms under the workers' compensation program pursuant to Labor Code §3209.10; and (d) any other services or activities authorized under California law.

2. **Ordering and Furnishing of Drugs and Devices**: In compliance with State and Federal prescribing laws, the PA may order and furnish those drugs and devices, including schedule II through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA's education, training, experience, and competency, under physician supervision as provided in Section 3 of this Practice Agreement. The furnishing and ordering of schedule II drugs shall be only for those illnesses, injuries, and/or conditions for which the standard of care indicates the use of such schedule II drugs. The PA may dispense drugs and devices as provided for in BPC §4170 and request, sign, and receive drug samples as provided for in BPC §4061.

3. **Physician Supervision**: Any physician and surgeon of the Practice, who meets the definition of a supervising physician in BPC §3501(e), may provide supervision of a PA in the Practice acting under this Practice Agreement. A supervising physician need not be physically present while the PA provides medical services, but be available by telephone or other electronic means at the time the PA is providing medical services in the Practice. Supervision means that a physician and surgeon oversees and accepts responsibility for the activities of the PA.

4. **Patient Care Policies and Procedure**: PA shall consult with, and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the PA's competency, education, training, or experience.

5. **PA Competency and Qualification Evaluation**: Through a peer review process based on the standard of care, the Practice shall regularly evaluate the competency of a PA. The Practice may credential and privilege the PA to ensure that the PA has the qualifications, training, and experience, to perform the medical services, procedures, and drug and device ordering and furnishing authorized under this Practice Agreement.

6. **Review of Practice Agreement**: This Practice Agreement shall be reviewed on a regular basis and updated by the Practice when warranted by a change in conditions or circumstances.

The physician and PA(s) listed below collaboratively approve this Practice Agreement governing the medical services of PA(s) in the Practice, on behalf of the Practice, and authorize the physicians on the staff of the Practice to supervise the PA(s) named below effective as of the date signed by the PA. The physician named below authorizing this Practice Agreement may or may not also serve as a supervising physician of a PA. Signing this Practice Agreement does not mean the named physician below is accepting responsibility for the medical services provided by the PA(s) named below, rather any physician of the Practice, including a physician named below, would only accept responsibility for a specific PA if, and only during those times, they are serving as a supervising physician as set forth in Section 3 of this Practice Agreement.

Physician: ______________________ Title: __________________________

____

Physician Signature Date

PA: ___________________________ PA: ___________________________

______________________________ ______________________________

PA Signature Date PA Signature Date

PA: ___________________________ PA: ___________________________

______________________________ ______________________________

PA Signature Date PA Signature Date

PA: ___________________________ PA: ___________________________

______________________________ ______________________________

PA Signature Date PA Signature Date

TAHOE FOREST HOSPITAL DISTRICT

COLLABORATIVE PRACTICE AGREEMENT BETWEEN PHYSICIAN AND NURSE PRACTITIONER

It is the intent of this document to authorize the nurse practitioner at Tahoe Forest Health District to practice under Standardized Procedures without direct supervision in compliance with this Collaborative Practice Agreement.

Setting
The Nurse Practitioners will operate under Standardized Procedures in the following settings:

1-Tahoe Forest Health Clinics
2-Gene Upshaw Memorial Tahoe Forest Cancer Center
3-Tahoe Forest Hospital
4-Incline Village Community Hospital

Collaboration
The nurse practitioner shall begin formal collaboration on signing of this agreement or on this specified date___________. The nurse practitioner will practice under approved Standardized Procedures at all times.

Certification
The advanced practice nurse is certified as a Nurse Practitioner with a specialized certification as a _____________________ (FNP, PNP, etc.)

Evaluation of Clinical Care
Through a peer review process based on the standard of care, and as required by state law, NPs will have ongoing competency assessments. NPs participate in OPPE.

Drug Prescriptions
Nurse practitioners shall be authorized to prescribe drugs as authorized by state law, DEA licensing and per standardized procedures and protocols.

Collaborating Parties: Statement of Approval:
We, the undersigned, agree to the terms of the Collaborative Practice Agreement as set forth in this document.

_________________________________Collaborating Physician

_________________________________ Nurse Practitioner

Approval Date:________________________

REGULAR MEETING OF THE BOARD OF DIRECTORS DRAFT MINUTES

Thursday, March 26, 2020 at 4:00 p.m.

Due to COVID-19 shelter in place orders and under the authority of the Governor's Executive Order N-29-20, this meeting was conducted entirely by teleconference. No physical location was available. Members of the public to attend and provide public comment via teleconference.

1. CALL TO ORDER

Meeting was called to order at 4:03 p.m.

2. ROLL CALL

Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Art King, Secretary; Dale Chamblin, Treasurer; Michael McGarry, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Janet Van Gelder, Director of Quality; Todd Johnson, Risk Manager; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

Todd Johnson would like to present 5.2. before 5.1.

4. INPUT AUDIENCE

No public comment was received.

General Counsel read the board into closed session.

Open Session recessed at 4:06 p.m.

5. CLOSED SESSION

5.1. 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: Blake Hoffman

Discussion was held on a privileged item.

5.2. 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: Clay Teramo

Discussion was held on a privileged item.

5.3. Conference with Real Property Negotiator (Gov. Code § 54956.8)

Property Parcel Number: 019-460-047
Agency Negotiator: Judith Newland
Negotiating Parties: Dennis Chez
Under Negotiation: Price & Terms of Payment

Discussion was held on a privileged item.

5.4. Approval of Closed Session Minutes

02/27/2020

Discussion was held on a privileged item.

5.5. Hearing (Health & Safety Code § 32155)

Subject Matter: Quality Assurance Report
Number of items: One (1)

Discussion was held on a privileged item.

5.6. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)

Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:26 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel reviewed the actions taken in closed session There were no reportable action on items 5.1-5.3. Item 5.4 Closed Minutes was approved on a 5-0 vote. There was no reportable action on item 5.5. Item 5.6 Medical Staff Credentialing was approved on a 5-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

10. INPUT – AUDIENCE

No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment was received.

12. ACKNOWLEDGMENTS

12.1. Jena Kozitza was named March 2020 Employee of the Month.

13. MEDICAL STAFF EXECUTIVE COMMITTEE

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda

MEC recommends the following for approval by the Board of Directors:

Annual Policy Review (no content changes)

- *TFH/IVCH Emergency Department Policies*
- *IVCH Emergency Department Policies*
- *DPS-2001 Surgical Specimens to be Submitted to Pathology for Examination*

Plan Update (with content changes)

- *Emergency Operations Plan*

Medical Staff Privileges (with content changes)

- *Neurology Privilege Form*
- *NA/PA Privilege Form*
- *Anesthesia Privilege Form*

Discussion was held.

ACTION: Motion made by Director Chamblin, seconded by Director King, to approve the Medical Executive Committee Meeting Consent Agenda as presented. Roll call vote taken.
McGarry - AYE
Chamblin - AYE
King - AYE
Brown – AYE
Wong - AYE

14. 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.

14.1. Approval of Minutes of Meetings

14.1.1. 02/27/2020 – Special Meeting

14.1.2. 02/27/2020 – Regular Meeting

14.2. Financial Reports

14.2.1. Financial Report – February 2020

14.3. Staff Reports

14.3.1. CHRO Board Report

14.4. Policy Review

14.4.1. Trade Secrets, ABD-22

No public comment was received.

DRAFT

<u>**ACTION:**</u> **Motion made by Director Brown, seconded by Director King, to approve the Consent Calendar as presented. Roll call vote taken.**
McGarry - AYE
Chamblin - AYE
King - AYE
Brown – AYE
Wong - AYE

15. ITEMS FOR BOARD ACTION
15.1. Resolution 2020-03
Discussion was held.

<u>**ACTION:**</u> **Motion made by Director King, seconded by Director Chamblin, to approve Resolution 2020-03 to adopt an Initial Study/Mitigated Negative Declaration and Mitigation Monitoring and Reporting Program and approve an amendment to the Tahoe Forest Hospital Parking Management Plan. Roll call vote taken.**
McGarry - AYE
Chamblin - AYE
King - AYE
Brown – AYE
Wong - AYE

16. ITEMS FOR BOARD DISCUSSION
16.1. COVID-19 Update
Harry Weis, Chief Executive Officer, provided an update on hospital and clinic operations related to COVID-19.

No public comment was received.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY
Not applicable.

18. BOARD COMMITTEE REPORTS
Director McGarry provided an update from a recent TFHS Foundation meeting.

19. BOARD MEMBERS REPORTS/CLOSING REMARKS
Board members expressed their gratitude to staff.

20. CLOSED SESSION CONTINUED, IF NECESSARY

21. OPEN SESSION

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

23. ADJOURN
Meeting adjourned at 7:28 p.m.

TAHOE FOREST HOSPITAL DISTRICT
MARCH 2020 FINANCIAL REPORT
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Board of Directors

Of Tahoe Forest Hospital District

MARCH 2020 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the nine months ended March 31, 2020.

Activity Statistics

- TFH acute patient days were 426 for the current month compared to budget of 314. This equates to an average daily census of 13.7 compared to budget of 10.1.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Clinic visits, Hospice visits, Laboratory tests, Diagnostic Imaging, Mammography, MRI, Ultrasounds, Pharmacy units, Respiratory Therapy, Physical Therapy, and Occupational Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 53.0% in the current month compared to budget of 50.3% and to last month's 51.5%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue was 50.4% compared to budget of 50.0% and prior year's 51.2%.
- EBIDA was $(962,181) (-3.5%) for the current month compared to budget of $(85,476) (-.3%), or $(876,705) (-3.2%) below budget. Year-to-date EBIDA was $18,986,177 (6.3%) compared to budget of $11,102,710 (3.9%), or $7,883,467 (2.4%) above budget.
- Net Income was $(1,412,466) for the current month compared to budget of $(485,334) or $(927,132) below budget. Year-to-date Net Income was $14,090,109 compared to budget of $7,427,625 or $6,662,484 above budget.
- Cash Collections for the current month were $16,721,915, which is 99% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $89,173,217 at the end of March compared to $92,767,107 at the end of February.

Balance Sheet

- Working Capital is at 56.3 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 178.5 days. Working Capital cash increased a net $3,648,000. Accrued Payroll & Related Costs increased $1,236,000, the District received its tentative settlements on the FY19 As Filed Medicare cost reports in the amount $2,925,000, $556,000 from our Municipal Lease reimbursement request, $755,000 from the Anthem HQAF program, remitted $2,222,000 to the State for participation in the FY18-19 RR IGT program, and cash collections were below budget 1%.
- Net Patient Accounts Receivable decreased approximately $2,823,000 and Cash collections were 99% of target. EPIC Days in A/R were 77.1 compared to 75.0 at the close of February, a 2.1 days increase.
- Estimated Settlements, Medi-Cal & Medicare increased a net $452,000. The District recorded the estimated March FY20 receivable from the Rate Range IGT, Medi-Cal PRIME, and Quality Assurance Fee programs and remitted funds to the State of $2,222,000 for participation in the FY18-19 Rate Range IGT Program. The District received and recorded $755,000 from Anthem Blue Cross for the HQAF program and funds from the Medicare program of $2,925,000 for the FY19 As Filed Medicare cost reports.
- Municipal Lease 2018 decreased $555,000 after receiving funding from our recent Muni Lease purchase reimbursement request.
- To comply with GASB No. 63, the District booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of March 2020.
- Accrued Payroll & Related Costs increased $1,236,000 due to an increase in accrued payroll days in March, Personal Leave and Long-term Sick liabilities.
- Estimated Settlements, Medi-Cal & Medicare, increased $783,000. The District recorded a reserve on the FY19 As Filed Cost Reports until the final desk audit is performed and received notification from our intermediary of overpayments on our FY20 Inpatient claims so recorded a liability.

March 2020 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $27,488,899, compared to budget of $27,936,028 or $447,129 below budget.

- Current month's Gross Inpatient Revenue was $6,580,798, compared to budget of $6,782,564 or $201,767 below budget.

- Current month's Gross Outpatient Revenue was $20,908,101 compared to budget of $21,153,464 or $245,362 below budget.

- Current month's Gross Revenue Mix was 32.2% Medicare, 18.2% Medi-Cal, .0% County, 3.5% Other, and 46.1% Insurance compared to budget of 37.5% Medicare, 16.3% Medi-Cal, .0% County, 3.2% Other, and 43.0% Insurance. Last month's mix was 32.3% Medicare, 13.1% Medi-Cal, .0% County, 4.0% Other, and 50.6% Insurance. Year-to-date Gross Revenue Mix was 38.4% Medicare, 14.3% Medi-Cal, .0% County, 3.0% Other, and 44.3% Insurance compared to budget of 38.1% Medicare, 15.8% Medi-Cal, .0% County, 3.1% Other, and 43.0% Insurance.

- Current month's Deductions from Revenue were $12,918,109 compared to budget of $13,872,258 or $954,149 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 5.29% decrease in Medicare, a 1.90% increase to Medi-Cal, County at budget, a .19% increase in Other, and Commercial was above budget 3.20%, 2) Revenues fell short of budget by 1.6%, and 3) the District booked an adjustment to its FY19 Medicare Cost Report reserve which resulted in a positive pickup in Prior Period Settlements.

DESCRIPTION	March 2020 Actual	March 2020 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	6,867,113	6,105,066	(762,047)	Negative variance in Salaries & Wages due to the addition of TTMG Physicians and Employees (unbudgeted) and increases in Technical, RN, and Clerical wages preparing for and treating Coronavirus patients.
Employee Benefits	2,062,579	2,015,216	(47,363)	Negative variance in Employee Benefits related to increased use of Paid Leave for staff who chose to Stay in Place and not remain available for the Labor Pool and Employer Related Payroll Taxes.
Benefits – Workers Compensation	51,682	78,105	26,423	
Benefits – Medical Insurance	1,378,403	1,177,057	(201,346)	
Medical Professional Fees	976,052	1,177,183	201,131	We saw positive variances in Multi-Specialty Clinic physicians and Oncology professional fees.
Other Professional Fees	148,868	204,262	55,394	A reduction in expense accruals for Administration created a positive variance in Other Professional Fees.
Supplies	2,773,132	2,008,073	(765,059)	Oncology Drugs Sold to Patients revenues exceeded budget by 46.90%, Patient & Other Medical Supplies exceeded budget in Blood products, implants, and COVID-19 treatment supplies, and Other Non-Medical Supplies exceeded budget as the District acquired supplies for a possible surge in COVID-19 patients.
Purchased Services	1,807,246	1,607,850	(199,397)	Snow removal, services provided to the COVID-19 Emergency Preparedness department, outsourced coding and patient record storage & retrieval, along with I/T system software maintenance agreements created a negative variance in Purchased Services.
Other Expenses	541,545	883,709	342,164	Senior Leadership continues to closely monitor Controllable expenses, creating a positive variance in the Other Expenses categories.
Total Expenses	16,606,620	15,256,521	(1,350,099)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
MARCH 2020

	Mar-20	Feb-20	Mar-19	
ASSETS				
CURRENT ASSETS				
* CASH	$ 29,708,096	$ 26,059,985	$ 9,602,067	1
PATIENT ACCOUNTS RECEIVABLE - NET	22,635,874	25,458,934	30,330,995	2
OTHER RECEIVABLES	7,949,356	7,357,105	7,139,523	
GO BOND RECEIVABLES	820,024	407,104	348,548	
ASSETS LIMITED OR RESTRICTED	8,503,673	7,821,535	8,027,059	
INVENTORIES	3,517,097	3,478,508	3,133,711	
PREPAID EXPENSES & DEPOSITS	2,564,000	2,477,764	2,478,029	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	14,324,603	14,776,271	9,444,273	3
TOTAL CURRENT ASSETS	90,022,722	87,837,207	70,504,205	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	64,390,780	64,390,780	63,814,560	1
MUNICIPAL LEASE 2018	2,350,316	2,905,081	5,149,709	4
TOTAL BOND TRUSTEE 2017	20,520	20,500	20,117	
TOTAL BOND TRUSTEE 2015	898,812	761,102	884,578	
GO BOND PROJECT FUND	-	-	-	
GO BOND TAX REVENUE FUND	1,902,146	1,902,146	1,617,792	
DIAGNOSTIC IMAGING FUND	3,307	3,307	3,266	
DONOR RESTRICTED FUND	1,131,399	1,131,399	1,131,128	
WORKERS COMPENSATION FUND	39,696	66,874	9,892	
TOTAL	70,736,977	71,181,191	72,631,042	
LESS CURRENT PORTION	(8,503,673)	(7,821,535)	(8,027,059)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	62,233,304	63,359,656	64,603,983	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(381,754)	(381,754)	701,785	
PROPERTY HELD FOR FUTURE EXPANSION	892,545	882,033	927,633	
PROPERTY & EQUIPMENT NET	178,096,531	178,561,273	172,705,282	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,791,406	1,791,406	1,864,055	
TOTAL ASSETS	332,654,754	332,049,821	311,306,943	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	397,582	400,815	436,371	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,782,460	1,343,392	1,137,905	5
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,485,289	5,508,993	5,769,745	
GO BOND DEFERRED FINANCING COSTS	427,462	429,396	450,676	
DEFERRED FINANCING COSTS	165,404	166,444	177,887	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 8,258,197	$ 7,849,041	$ 7,972,584	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 7,465,590	$ 7,598,155	$ 7,760,387	
ACCRUED PAYROLL & RELATED COSTS	15,742,376	14,506,767	11,896,028	6
INTEREST PAYABLE	271,246	188,870	273,928	
INTEREST PAYABLE GO BOND	687,475	406,985	710,514	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	2,495,860	1,713,280	1,082,689	7
HEALTH INSURANCE PLAN	2,166,758	2,166,758	1,463,491	
WORKERS COMPENSATION PLAN	2,396,860	2,396,860	1,887,945	
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	2,612,247	2,590,438	2,534,956	
TOTAL CURRENT LIABILITIES	36,340,643	34,070,345	30,124,357	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,323,325	33,592,715	36,819,589	
GO BOND DEBT NET OF CURRENT MATURITIES	99,379,302	99,392,723	100,870,350	
DERIVATIVE INSTRUMENT LIABILITY	1,782,460	1,343,392	1,137,905	5
TOTAL LIABILITIES	170,825,730	168,399,174	168,952,201	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	168,955,821	170,368,287	149,196,198	
RESTRICTED	1,131,399	1,131,399	1,131,128	
TOTAL NET POSITION	$ 170,087,220	$ 171,499,687	$ 150,327,326	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
MARCH 2020

1. Working Capital is at 56.3 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 178.5 days. Working Capital cash increased a net $3,648,000. Accrued Payroll & Related Costs increased $1,236,000 (See Note 6), the District received remittance of $2,925,000 on its FY19 As Filed Medicare Cost Reports for TFH and IVCH, $556,000 from our Municipal Lease reimbursement request (See Note 4), $755,000 from the Anthem HQAF program (See Note 3), remitted $2,222,000 to the State for participation in the FY18-19 RR IGT program (See Note 3), and cash collections were below budget by 1%.

2. Net Patient Accounts Receivable decreased approximately $2,823,000 and cash collections were 99% of target. EPIC Days in A/R were 77.1 compared to 75.0 at the close of February, a 2.1 days increase.

3. Estimated Settlements, Medi-Cal & Medicare decreased a net $452,000. The District recorded the estimated March FY20 receivable from the Rate Range IGT, Medi-Cal PRIME, and Quality Assurance Fee programs and remitted funds to the State of $2,222,000 for participation in the FY18-19 Rate Range IGT Program. The District received and recorded $755,000 from Anthem Blue Cross for the HQAF program and funds from the Medicare program of $2,925,000 for the FY19 As Filed Cost Reports.

4. Municipal Lease 2018 decreased a net $555,000 after receiving funding from our March Muni Lease purchase reimbursement request.

5. To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of March.

6. Accrued Payroll & Related Costs increased $1,236,000 due to an increase in accrued payroll days in March, Personal Leave and Long-term Sick liabilities.

7. Estimated Settlements, Medi-Cal & Medicare increased $783,000. The District recorded a reserve on the FY19 As Filed Cost Reports until the final desk audit is performed and received notification from our Intermediary of overpayments on our FY20 Inpatient claims so recorded a liability.

Tahoe Forest Hospital District
Cash Investment
March 2020

WORKING CAPITAL				
US Bank	$ 28,679,839	0.49%		
US Bank/Kings Beach Thrift Store	8,020			
US Bank/Truckee Thrift Store	5,361			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,014,876	0.35%		
Total			$	29,708,096
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.02%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	64,390,780	1.91%		
Local Agency Investment Fund			$	64,390,780
Municipal Lease 2018			$	2,350,316
Bonds Cash 2017			$	20,520
Bonds Cash 2015			$	898,812
GO Bonds Cash 2008			$	1,902,146
DX Imaging Education	$ 3,307			
Workers Comp Fund - B of A	39,696			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	43,004
TOTAL FUNDS			$	99,313,673
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,360	0.02%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,095,730	1.91%		
TOTAL RESTRICTED FUNDS			$	1,131,399
TOTAL ALL FUNDS			$	100,445,073

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2020

	Current Status	Desired Position	Target	Bond Covenants	FY 2020 Jul 19 to Mar 20	FY 2019 Jul 18 to June 19	FY 2018 Jul 17 to June 18	FY 2017 Jul 16 to June 17	FY 2016 Jul 15 to June 16	FY 2015 Jul 14 to June 15	FY 2014 Jul 13 to June 14
Return On Equity: Increase (Decrease) in Net Position Net Position		⇧	4.6%		8.3%	13.1%	5.1%	14.4%	10.9%	2.19%	.001%
EPIC Days in Accounts Receivable (excludes SNF) Gross Accounts Receivable 90 Days		⇩	FYE 63 Days		77	69	68	55	57	60	75
Gross Accounts Receivable 365 Days					83	71	73	55	55	62	75
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments (Total Expenses - Depreciation Expense)/ by 365		⇧	Budget FYE 147 Days Budget 3rd Qtr 146 Days Projected 3rd Qtr 166 Days	60 Days A- 214 Days BBB- 129 Days	179	179	176	191	201	156	164
EPIC Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)		⇩	13%		42%	35%	22%	17%	19%	18%	22%
EPIC Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)		⇩	18%		48%	42%	25%	18%	24%	23%	25%
Cash Receipts Per Day (based on 60 day lag on Patient Net Revenue)		⇧	FYE Budget $505,733 End 3rd Qtr Budget $547,313 End 3rd Qtr Actual $540,097		$531,482	$473,890	$333,963	$348,962	$313,153	$290,776	$286,394
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation Debt Principal Payments + Interest Expense		⇧	Without GO Bond 12.80 With GO Bond 2.75	1.95	5.87 3.38	20.45 4.12	9.27 2.07	6.64 3.54	6.19 2.77	3.28 1.59	2.18 1.29

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
MARCH 2020

CURRENT MONTH					YEAR TO DATE					PRIOR YTD MAR 2019
ACTUAL	BUDGET	VAR$	VAR%		ACTUAL	BUDGET	VAR$	VAR%		
				OPERATING REVENUE						
$ 27,488,899	$ 27,936,028	$ (447,129)	-1.6%	Total Gross Revenue	$ 301,599,005	$ 285,837,263	$ 15,761,742	5.5%	1	$ 262,381,019
				Gross Revenues - Inpatient						
$ 2,799,761	$ 2,046,089	$ 753,672	36.8%	Daily Hospital Service	$ 26,791,303	$ 23,243,200	$ 3,548,103	15.3%		$ 26,441,138
3,781,037	4,736,476	(955,438)	-20.2%	Ancillary Service - Inpatient	42,475,079	50,917,248	(8,442,169)	-16.6%		43,447,131
6,580,798	6,782,564	(201,767)	-3.0%	Total Gross Revenue - Inpatient	69,266,382	74,160,448	(4,894,066)	-6.6%	1	69,888,269
20,908,101	21,153,464	(245,362)	-1.2%	Gross Revenue - Outpatient	232,332,623	211,676,815	20,655,808	9.8%		192,492,750
20,908,101	21,153,464	(245,362)	-1.2%	Total Gross Revenue - Outpatient	232,332,623	211,676,815	20,655,808	9.8%	1	192,492,750
				Deductions from Revenue:						
11,916,125	12,362,811	446,686	3.6%	Contractual Allowances	134,173,618	127,723,370	(6,450,248)	-5.1%	2	116,867,315
-	-	-	0.0%	Managed Care Reserve	1,000,000	-	(1,000,000)	0.0%	2	1,200,000
1,021,254	1,006,673	(14,581)	-1.4%	Charity Care	11,231,715	10,261,909	(969,806)	-9.5%	2	9,046,326
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
214,309	502,774	288,465	57.4%	Bad Debt	4,897,583	5,027,744	130,161	2.6%	2	2,918,581
(233,578)	-	233,578	0.0%	Prior Period Settlements	(1,597,100)	-	1,597,100	0.0%	2	(1,944,724)
12,918,109	13,872,258	954,149	6.9%	Total Deductions from Revenue	149,705,815	143,013,024	(6,692,792)	-4.7%		128,087,498
96,941	103,172	6,231	6.0%	Property Tax Revenue- Wellness Neighborhood	877,017	947,161	70,144	7.4%		816,984
976,709	1,004,104	(27,396)	-2.7%	Other Operating Revenue	10,134,013	8,824,355	1,309,657	14.8%	3	7,948,359
15,644,439	15,171,046	473,394	3.1%	TOTAL OPERATING REVENUE	162,904,220	152,595,755	10,308,464	6.8%		143,058,864
				OPERATING EXPENSES						
6,867,113	6,105,066	(762,047)	-12.5%	Salaries and Wages	54,577,864	54,931,046	353,182	0.6%	4	44,351,341
2,062,579	2,015,216	(47,363)	-2.4%	Benefits	18,080,863	16,630,698	(1,450,165)	-8.7%	4	14,215,879
51,682	78,105	26,423	33.8%	Benefits Workers Compensation	720,326	702,943	(17,383)	-2.5%	4	554,441
1,378,403	1,177,057	(201,346)	-17.1%	Benefits Medical Insurance	10,150,363	10,593,515	443,152	4.2%	4	7,949,184
976,052	1,177,183	201,131	17.1%	Medical Professional Fees	13,972,221	13,344,553	(627,668)	-4.7%	5	18,244,128
148,868	204,262	55,394	27.1%	Other Professional Fees	2,117,811	2,152,574	34,763	1.6%	5	1,640,837
2,773,132	2,008,073	(765,059)	-38.1%	Supplies	22,830,899	20,615,950	(2,214,949)	-10.7%	6	18,807,645
1,807,246	1,607,850	(199,397)	-12.4%	Purchased Services	15,097,550	14,530,836	(566,715)	-3.9%	7	12,094,894
541,545	883,709	342,164	38.7%	Other	6,370,145	7,990,930	1,620,785	20.3%	8	6,364,800
16,606,620	15,256,521	(1,350,099)	-8.8%	TOTAL OPERATING EXPENSE	143,918,043	141,493,045	(2,424,997)	-1.7%		124,223,149
(962,181)	**(85,476)**	**(876,705)**	**1025.7%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**18,986,177**	**11,102,710**	**7,883,467**	**71.0%**		**18,835,715**
				NON-OPERATING REVENUE/(EXPENSE)						
512,642	506,412	6,231	1.2%	District and County Taxes	4,609,233	4,539,090	70,143	1.5%	9	5,011,399
412,919	412,919	-	0.0%	District and County Taxes - GO Bond	3,716,275	3,716,275	(0)	0.0%		3,373,972
134,723	164,115	(29,392)	-17.9%	Interest Income	1,471,563	1,440,500	31,063	2.2%	10	1,271,508
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
66,281	88,155	(21,874)	-24.8%	Donations	354,508	793,396	(438,889)	-55.3%	11	679,135
-	-	-	0.0%	Gain/ (Loss) on Joint Investment	(833,539)	-	(833,539)	0.0%	12	-
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	12	(538,384)
-	-	-	0.0%	Gain/ (Loss) on Sale of Equipment	7,546	-	7,546	0.0%	13	5,850
(1,154,497)	(1,154,616)	119	0.0%	Depreciation	(10,390,472)	(10,391,540)	1,068	0.0%	15	(10,007,225)
(129,646)	(115,058)	(14,588)	-12.7%	Interest Expense	(1,083,837)	(1,053,135)	(30,702)	-2.9%	16	(912,074)
(292,708)	(301,788)	9,079	3.0%	Interest Expense-GO Bond	(2,747,346)	(2,719,671)	(27,675)	-1.0%		(2,961,112)
(450,286)	(399,860)	(50,426)	-12.6%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(4,896,068)	(3,675,085)	(1,220,983)	-33.2%		(4,076,931)
$ (1,412,466)	**$ (485,334)**	**$ (927,132)**	**191.0%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 14,090,109**	**$ 7,427,625**	**$ 6,662,484**	**89.7%**		**$ 14,758,784**
				NET POSITION - BEGINNING OF YEAR	**155,997,111**					
				NET POSITION - AS OF MARCH 31, 2020	**$ 170,087,220**					
-3.5%	**-0.3%**	**-3.2%**		**RETURN ON GROSS REVENUE EBIDA**	**6.3%**	**3.9%**	**2.4%**			**7.2%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
MARCH 2020

Variance from Budget — Fav / <Unfav>

1) Gross Revenues

Acute Patient Days were above budget 35.66% or 112 days. Swing Bed days were below budget 80.00% or 8 days. Inpatient Ancillary revenues were below budget due to the cancellation of Inpatient Surgical cases in March stemming from COVID-19.

Outpatient volumes were below budget in the following departments: Emergency Department visits, Clinic visits, Hospice visits, Pain Clinic consultations, Laboratory tests, Diagnostic Imaging, Mammography, Medical Oncology procedures, MRI exams, PET CT, Drugs Sold to Patients, Respiratory Therapy, Gastroenterology procedures, Physical Therapy and Occupational Therapy.

	MAR 2020	YTD 2020
Gross Revenue -- Inpatient	$ (201,767)	$ (4,894,066)
Gross Revenue -- Outpatient	(245,362)	20,655,808
Gross Revenue -- Total	$ (447,129)	$ 15,761,742

2) Total Deductions from Revenue

The payor mix for March shows a 5.29% decrease to Medicare, a 1.90% increase to Medi-Cal, .19% increase to Other, County at budget , and a 3.20% increase to Commercial when compared to budget. We saw a positive variance in Contractual Allowances due to revenues coming in below budget 1.6% along with a shift in our Payor Mix from Medicare to Commercial.

The District received its tentative settlement from Medicare for the FY19 As Filed Cost Report. A true-up was made to the reserve until the final desk audit is completed. This created a positive variance in Prior Period Settlements.

	MAR 2020	YTD 2020
Contractual Allowances	$ 446,686	$ (6,450,248)
Managed Care	$ -	$ (1,000,000)
Charity Care	(14,581)	(969,806)
Charity Care - Catastrophic	-	-
Bad Debt	288,465	130,161
Prior Period Settlements	233,578	1,597,100
Total	$ 954,149	$ (6,692,792)

3) Other Operating Revenue

Retail Pharmacy revenues exceeded budget by 51.54%.

We witnessed negative variances in Thrift Store revenues, Fitness & Wellness classes offered at the The Center, Children's Center revenues, Cafeteria sales, and Community Wellness classes due to temporarily closing down retail services stemming from COVID-19 and social distancing requirements.

	MAR 2020	YTD 2020
Retail Pharmacy	$ 134,848	$ 675,483
Hospice Thrift Stores	(71,246)	(191,027)
The Center (non-therapy)	(17,869)	27,706
IVCH ER Physician Guarantee	(2,626)	105,073
Children's Center	(20,604)	(27,397)
Miscellaneous	(42,399)	728,119
Oncology Drug Replacement	-	-
Grants	(7,500)	(8,300)
Total	$ (27,396)	$ 1,309,657

4) Salaries and Wages

	MAR 2020	YTD 2020
Total	$ (762,047)	$ 353,182

Negative variance related to TTMG Physician and Staff salaries which were non budgeted items and increases in Technical & RN salaries preparing for and treating Coronavirus patients.

Employee Benefits

Negative variance in PL/SL related to greater usage of Paid Leave for staff who chose to Stay in Place and not remain available for the Labor Pool.

Negative variance in Other related to Employer Payroll Taxes.

	MAR 2020	YTD 2020
PL/SL	$ (45,719)	$ (1,047,451)
Nonproductive	49,187	(206,371)
Pension/Deferred Comp	-	(1,038)
Standby	(8,605)	(17,103)
Other	(42,225)	(178,201)
Total	$ (47,363)	$ (1,450,165)

Employee Benefits - Workers Compensation

	MAR 2020	YTD 2020
Total	$ 26,423	$ (17,383)

Employee Benefits - Medical Insurance

	MAR 2020	YTD 2020
Total	$ (201,346)	$ 443,152

Negative variance in Medical Insurance due to an increase in paid claims.

5) Professional Fees

Positive variance in Multi-Specialty Clinics related to a reduction in accrued expenses from prior periods.

Anesthesia Physician Guarantee and consulting services provided to Accounting for the Cost Accounting/Decision Support software implementations created a negative variance in Miscellaneous.

Legal services provided to Human Resources created a negative variance in this category.

	MAR 2020	YTD 2020
Multi-Specialty Clinics	$ 140,353	$ (784,607)
The Center (includes OP Therapy)	(7,418)	(300,296)
Miscellaneous	(120,225)	(152,816)
Human Resources	(35,215)	(75,576)
Information Technology	30,937	(69,365)
TFH/IVCH Therapy Services	3,077	(60,874)
Home Health/Hospice	(10,589)	(20,261)
Financial Administration	2,328	(15,975)
Medical Staff Services	1,872	(1,637)
Truckee Surgery Center	-	(146)
Patient Accounting/Admitting	13,500	-
Respiratory Therapy	-	-
Multi-Specialty Clinics Administration	421	7,698
IVCH ER Physicians	(2,550)	13,548
Corporate Compliance	2,000	18,000

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
MARCH 2020

5) Professional Fees (cont.)

Positive variance in Administration related to a reduction in accrued expenses.

Positive variance in Oncology also related to a reduction in accrued expenses.

	Variance from Budget Fav / <Unfav>	
	MAR 2020	YTD 2020
Managed Care	7,056	28,852
Sleep Clinic	(4,897)	48,875
Marketing	1,583	54,242
Administration	56,692	115,125
Oncology	124,779	145,220
TFH Locums	52,821	457,087
Total	$ 256,525	$ (592,905)

6) Supplies

Oncology Drugs Sold to Patients revenues were above budget by 46.90%, creating a negative variance in Pharmacy Supplies.

Negative variance in Patient & Other Medical Supplies for Blood products, Implants, and supplies purchased for the treatment of Coronavirus patients.

Purchase of required supplies for a potential COVID-19 surge created a negative variance in Other Non-Medical Supplies.

	MAR 2020	YTD 2020
Pharmacy Supplies	$ (356,649)	$ (1,582,367)
Patient & Other Medical Supplies	(215,828)	(619,367)
Other Non-Medical Supplies	(132,070)	(103,772)
Minor Equipment	(68,396)	(76,833)
Office Supplies	696	71,532
Food	7,189	95,857
Total	$ (765,059)	$ (2,214,949)

7) Purchased Services

Snow removal and services provided to the Emergency Preparedness department created a negative variance in Miscellaneous.

Negative variance in Medical Records related to remote coding services and patient record storage and retrieval.

System software maintenance agreements created a negative variance in Information Technology.

Human Resources Pre-Employment and Employee Health screenings came in below budget, creating a positive variance in this category.

	MAR 2020	YTD 2020
Miscellaneous	$ (147,820)	$ (404,294)
Medical Records	(77,942)	(390,046)
Patient Accounting	(14,722)	(88,722)
Department Repairs	(39,037)	(58,241)
Diagnostic Imaging Services - All	(3,716)	(41,056)
The Center	2,315	(18,218)
Community Development	225	2,182
Pharmacy IP	(684)	20,431
Information Technology	(7,326)	36,293
Home Health/Hospice	10,279	48,952
Multi-Specialty Clinics	17,803	92,071
Laboratory	705	101,142
Human Resources	60,524	132,790
Total	$ (199,397)	$ (566,715)

8) Other Expenses

An increase in Oxygen tank rentals created a negative variance in Equipment Rent.

Negative variance in Insurance is being caused by additional malpractice policies being carried on our employed physicians.

Transfer of Construction Labor to Capital Asset accounts and a reclassification of expenses paid on behalf of Truckee Surgery Center as a receivable created a positive variance in Miscellaneous.

	MAR 2020	YTD 2020
Equipment Rent	$ (35,991)	$ (112,121)
Physician Services	366	(10,002)
Multi-Specialty Clinics Equip Rent	232	389
Other Building Rent	5,110	11,678
Multi-Specialty Clinics Bldg Rent	10,204	55,368
Dues and Subscriptions	6,463	61,883
Insurance	(7,145)	63,556
Human Resources Recruitment	8,791	89,644
Utilities	16,746	149,803
Marketing	51,827	276,341
Outside Training & Travel	48,784	385,271
Miscellaneous	236,778	648,977
Total	$ 342,164	$ 1,620,785

		MAR 2020	YTD 2020
9) District and County Taxes	Total	$ 6,231	$ 70,143
10) Interest Income	Total	$ (29,392)	$ 31,063
11) Donations	IVCH	$ (41,334)	$ (358,347)
	Operational	19,460	(80,542)
	Total	$ (21,874)	$ (438,889)
12) Gain/(Loss) on Joint Investment	Total	$ -	$ (833,589)
13) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ 7,546
15) Depreciation Expense	Total	$ 119	$ 1,068
16) Interest Expense	Total	$ (14,588)	$ (30,702)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2020

	Current Status	Desired Position	Target	FY 2020 Jul 19 to Mar 20	FY 2019 Jul 18 to June 19	FY 2018 Jul 17 to June 18	FY 2017 Jul 16 to June 17	FY 2016 Jul 15 to June 16	FY 2015 Jul 14 to June 15	FY 2014 Jul 13 to June 14
Total Margin: Increase (Decrease) In Net Position Total Gross Revenue			FYE 1.9% 3rd Qtr 2.6%	4.7%	5.7%	2.6%	7.4%	5.5%	1.0%	.01%
Charity Care: Charity Care Expense Gross Patient Revenue			FYE 3.6% 3rd Qtr 3.6%	3.7%	3.8%	3.3%	3.1%	3.4%	3.1%	3.2%
Bad Debt Expense: Bad Debt Expense Gross Patient Revenue			FYE 1.8% 3rd Qtr 1.8%	1.6%	.1%	.1%	-.0%	-.2%	1.6%	1.6%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization Net Operating Revenue <Expense> Gross Revenue			FYE 10.2% 3rd Qtr 11.1%	5.5%	11.5%	4.8%	7.9%	11.3%	9.1%	4.9%
Operating Expense Variance to Budget (Under<Over>)			-0-	$(2,424,997)	$(13,825,198)	$1,061,378	$(9,700,270)	$(7,548,217)	$(6,371,653)	$2,129,279
EBIDA: Earnings before interest, Depreciation, amortization Net Operating Revenue <Expense> Gross Revenue			FYE 3.2% 3rd Qtr 3.9%	6.3%	7.1%	4.5%	7.9%	7.3%	3.5%	2.0%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
MARCH 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 MAR 2019
				OPERATING REVENUE						
$ 1,243,001	$ 2,384,826	$ (1,141,825)	-47.9%	Total Gross Revenue	$ 19,164,160	$ 21,172,062	$ (2,007,902)	-9.5%	1	$ 18,150,665
				Gross Revenues - Inpatient						
$ -	$ 4,724	$ (4,724)	-100.0%	Daily Hospital Service	$ 16,423	$ 98,978	$ (82,555)	-83.4%		$ 73,173
-	2,879	(2,879)	-100.0%	Ancillary Service - Inpatient	18,864	78,068	(59,205)	-75.8%		57,966
-	7,603	(7,603)	-100.0%	Total Gross Revenue - Inpatient	35,287	177,046	(141,760)	-80.1%	1	131,139
1,243,001	2,377,223	(1,134,222)	-47.7%	Gross Revenue - Outpatient	19,128,874	20,995,016	(1,866,142)	-8.9%		18,019,526
1,243,001	2,377,223	(1,134,222)	-47.7%	Total Gross Revenue - Outpatient	19,128,874	20,995,016	(1,866,142)	-8.9%	1	18,019,526
				Deductions from Revenue:						
520,581	954,711	434,130	45.5%	Contractual Allowances	8,358,512	8,523,394	164,882	1.9%	2	7,104,378
72,438	111,644	39,206	35.1%	Charity Care	956,194	991,158	34,964	3.5%	2	784,477
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
201,489	111,644	(89,845)	-80.5%	Bad Debt	1,028,056	991,158	(36,898)	-3.7%	2	592,335
(110,254)	-	110,254	0.0%	Prior Period Settlements	(229,532)	-	229,532	0.0%	2	74,873
684,254	1,177,999	493,745	41.9%	Total Deductions from Revenue	10,113,231	10,505,710	392,479	3.7%	2	8,556,063
106,828	110,714	(3,886)	-3.5%	Other Operating Revenue	972,973	871,189	101,783	11.7%	3	867,263
665,575	1,317,542	(651,967)	-49.5%	TOTAL OPERATING REVENUE	10,023,902	11,537,541	(1,513,639)	-13.1%		10,461,865
				OPERATING EXPENSES						
404,247	370,872	(33,375)	-9.0%	Salaries and Wages	3,179,823	3,406,066	226,244	6.6%	4	2,727,778
136,093	126,979	(9,114)	-7.2%	Benefits	1,169,292	1,056,165	(113,126)	-10.7%	4	949,297
3,013	4,303	1,290	30.0%	Benefits Workers Compensation	52,581	38,727	(13,853)	-35.8%	4	33,359
78,919	67,391	(11,528)	-17.1%	Benefits Medical Insurance	581,073	606,517	25,444	4.2%	4	464,210
217,088	212,279	(4,809)	-2.3%	Medical Professional Fees	2,311,551	2,278,145	(33,406)	-1.5%	5	2,424,402
2,027	1,536	(491)	-32.0%	Other Professional Fees	16,097	13,826	(2,271)	-16.4%	5	19,161
56,649	56,735	86	0.2%	Supplies	495,145	570,731	75,586	13.2%	6	478,673
86,437	57,223	(29,214)	-51.1%	Purchased Services	545,920	525,004	(20,916)	-4.0%	7	448,627
56,649	71,576	14,927	20.9%	Other	619,920	692,761	72,841	10.5%	8	643,169
1,041,122	968,895	(72,227)	-7.5%	TOTAL OPERATING EXPENSE	8,971,402	9,187,943	216,542	2.4%		8,188,676
(375,547)	**348,647**	**(724,194)**	**-207.7%**	**NET OPERATING REV(EXP) EBIDA**	**1,052,500**	**2,349,598**	**(1,297,098)**	**-55.2%**		**2,273,189**
				NON-OPERATING REVENUE/(EXPENSE)						
-	41,334	(41,334)	-100.0%	Donations-IVCH	13,656	372,003	(358,347)	-96.3%	9	16,670
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	
(65,676)	(65,043)	(633)	1.0%	Depreciation	(591,083)	(585,385)	(5,697)	-1.0%	11	(533,211)
(65,676)	(23,709)	(41,967)	-177.0%	TOTAL NON-OPERATING REVENUE/(EXP)	(577,427)	(213,383)	(364,044)	-170.6%		(516,541)
$ (441,223)	**$ 324,938**	**$ (766,161)**	**-235.8%**	**EXCESS REVENUE(EXPENSE)**	**$ 475,073**	**$ 2,136,215**	**$ (1,661,142)**	**-77.8%**		**$ 1,756,648**
-30.2%	**14.6%**	**-44.8%**		**RETURN ON GROSS REVENUE EBIDA**	**5.5%**	**11.1%**	**-5.6%**			**12.5%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
MARCH 2020

Variance from Budget Fav<Unfav>

1) Gross Revenues

Acute Patient Days were below budget by 1 at 0 and Observation Days were below budget by .50 at 0.

Outpatient volumes were below budget in Emergency Department visits, Clinic visits, Surgical cases, Diagnostic Imaging, Cat Scans, Drugs Sold to Patients, Respiratory Therapy, and Physical Therapy.

	MAR 2020	YTD 2020
Gross Revenue -- Inpatient	$ (7,603)	$ (141,760)
Gross Revenue -- Outpatient	(1,134,222)	(1,866,142)
	$ (1,141,825)	$ (2,007,902)

2) Total Deductions from Revenue

We saw a shift in our payor mix with a 4.80% increase in Medicare, a .09% increase in Medicaid, a 9.83% decrease in Commercial insurance, a 4.95% increase in Other, and County was below budget by .01%. We saw a positive variance in Contractuals due to revenues falling short of budget by 47.9% along with a shift to Bad Debt

The FY19 Medicare Cost report liability reserved against final desk audit review was adjusted after receiving our tentative settlement, creating a positive variance in Prior Period Settlements.

	MAR 2020	YTD 2020
Contractual Allowances	$ 434,130	$ 164,882
Charity Care	39,206	34,964
Charity Care-Catastrophic Event	-	-
Bad Debt	(89,845)	(36,898)
Prior Period Settlement	110,254	229,532
Total	$ 493,745	$ 392,479

3) Other Operating Revenue

	MAR 2020	YTD 2020
IVCH ER Physician Guarantee	$ (2,626)	$ 105,073
Miscellaneous	(1,260)	(3,290)
Total	$ (3,886)	$ 101,783

4) Salaries and Wages

We saw negative variances in Technical and Clerical salaries in March.

	MAR 2020	YTD 2020
Total	$ (33,375)	$ 226,244

Employee Benefits

	MAR 2020	YTD 2020
PL/SL	$ (4,777)	$ (119,048)
Standby	(2,436)	14,682
Other	(1,901)	(6,589)
Nonproductive	-	(1,179)
Pension/Deferred Comp	-	(992)
Total	$ (9,114)	$ (113,126)

Employee Benefits - Workers Compensation

	MAR 2020	YTD 2020
Total	$ 1,290	$ (13,853)

Employee Benefits - Medical Insurance

	MAR 2020	YTD 2020
Total	$ (11,528)	$ 25,444

5) Professional Fees

Negative variance in Multi-Specialty Clinics related to physician fees in MSC IM/Pediatrics.

Additional Call Coverage in the Emergency Department created a negative variance in IVCH ER Physicians.

Sleep Clinic professional fees are tied to collections which exceeded budget in March.

	MAR 2020	YTD 2020
Multi-Specialty Clinics	$ (1,982)	$ (111,907)
Foundation	(491)	(2,271)
Administration	-	-
Miscellaneous	777	991
IVCH ER Physicians	(2,550)	13,548
Therapy Services	3,844	15,088
Sleep Clinic	(4,897)	48,875
Total	$ (5,300)	$ (35,677)

6) Supplies

Negative variance in Non-Medical Supplies related to the purchase of PAPR's and Hepa Filters.

	MAR 2020	YTD 2020
Non-Medical Supplies	$ (3,542)	$ (1,917)
Food	136	(1,388)
Imaging Film	-	-
Office Supplies	466	3,505
Minor Equipment	1,254	6,327
Patient & Other Medical Supplies	2,095	12,862
Pharmacy Supplies	(323)	56,196
Total	$ 86	$ 75,586

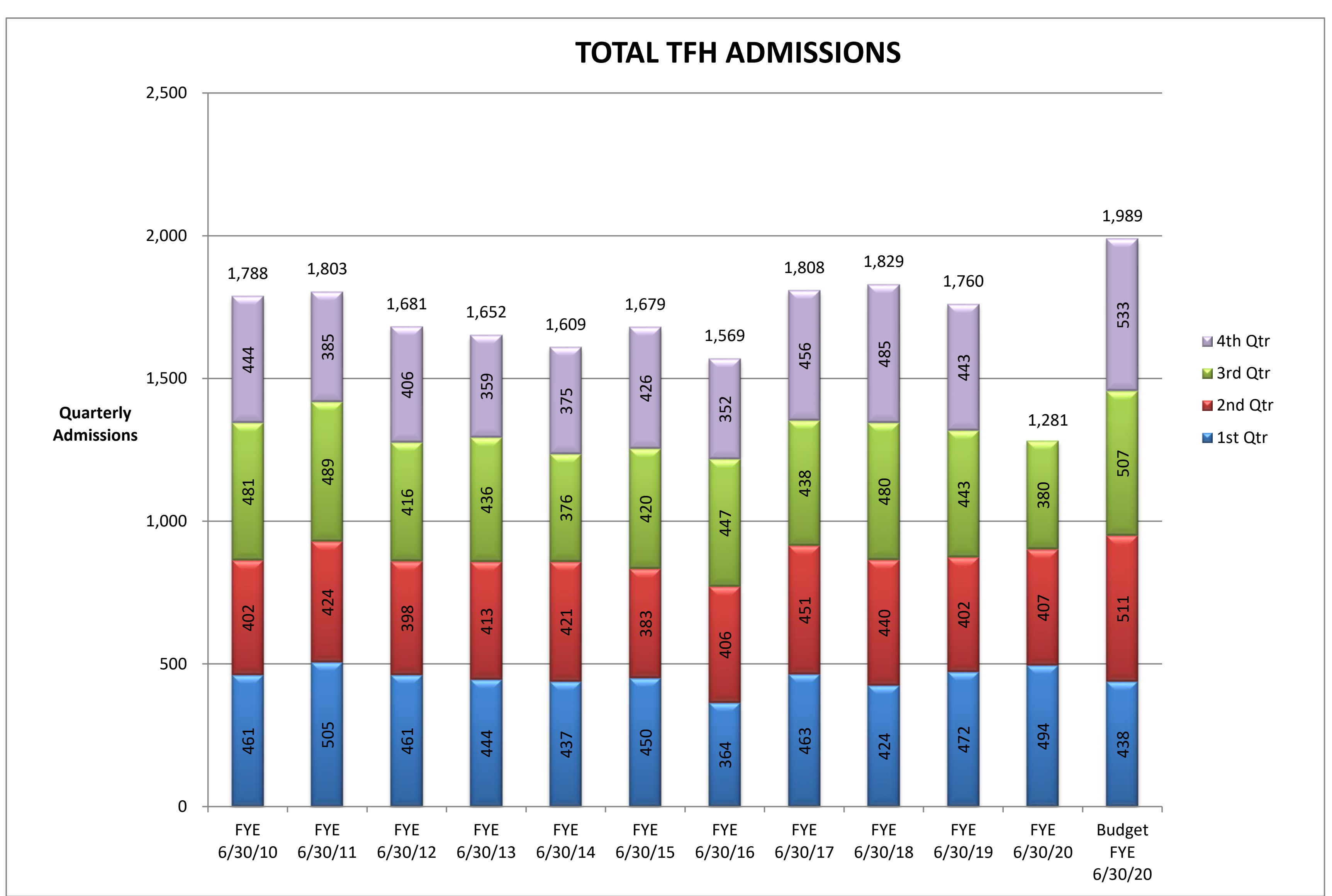
INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
MARCH 2020

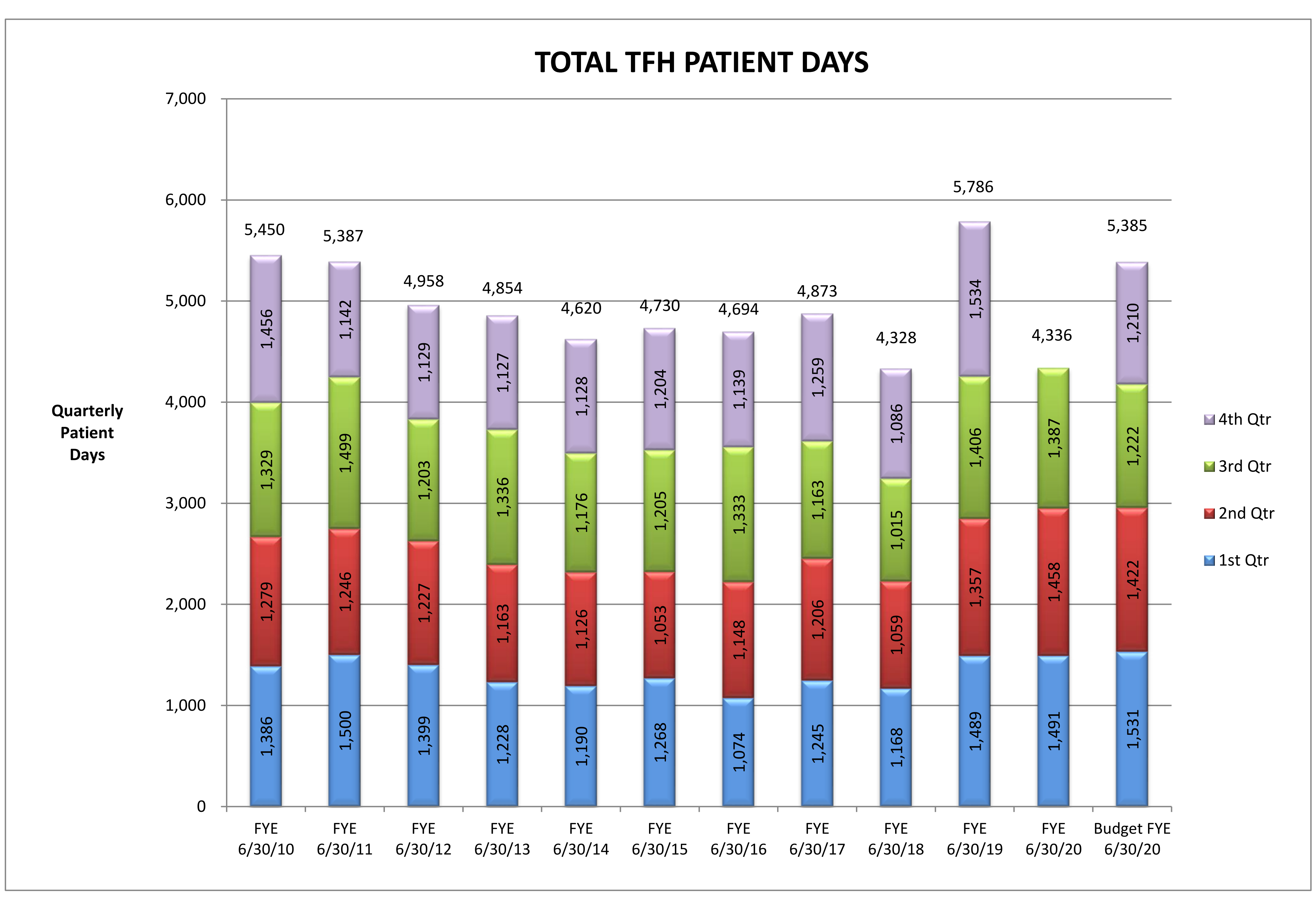
Note	Explanation	Line Item	Variance from Budget Fav<Unfav> MAR 2020	Variance from Budget Fav<Unfav> YTD 2020
7) **Purchased Services**		Miscellaneous	$ (11,875)	$ (25,215)
	Snow Removal and increased Security for COVID-19 operations created a	Department Repairs	(8,687)	(11,044)
	negative variance in Miscellaneous.	Diagnostic Imaging Services - All	(4,710)	(10,670)
		Multi-Specialty Clinics	(196)	(4,419)
	Equipment repairs in Sterile Processing and Diagnostic Imaging created a	Pharmacy	(491)	(3,039)
	negative variance in Department Repairs.	Foundation	83	(498)
		Surgical Services	-	-
	Maintenance agreements for Cat Scan and Diagnostic Imaging created a	Laboratory	(1,795)	8,844
	negative variance in Diagnostic Imaging Services-All.	EVS/Laundry	(449)	9,547
		Engineering/Plant/Communications	(1,093)	15,578
		Total	$ (29,214)	$ (20,916)
8) **Other Expenses**		Utilities	$ (5,560)	$ (11,168)
	Natural Gas/Propane and Telephone expenses created a negative variance	Other Building Rent	(886)	(5,453)
	in Utilities.	Dues and Subscriptions	1,634	(4,261)
		Physician Services	-	-
		Multi-Specialty Clinics Bldg Rent	-	-
		Equipment Rent	2,419	1,027
		Insurance	1,366	9,618
		Marketing	4,167	9,671
		Outside Training & Travel	5,144	29,380
		Miscellaneous	6,644	44,028
		Total	$ 14,927	$ 72,841
9) **Donations**		Total	$ (41,334)	$ (358,347)
10) **Gain/(Loss) on Sale**		Total	$ -	$ -
11) **Depreciation Expense**		Total	$ (633)	$ (5,697)

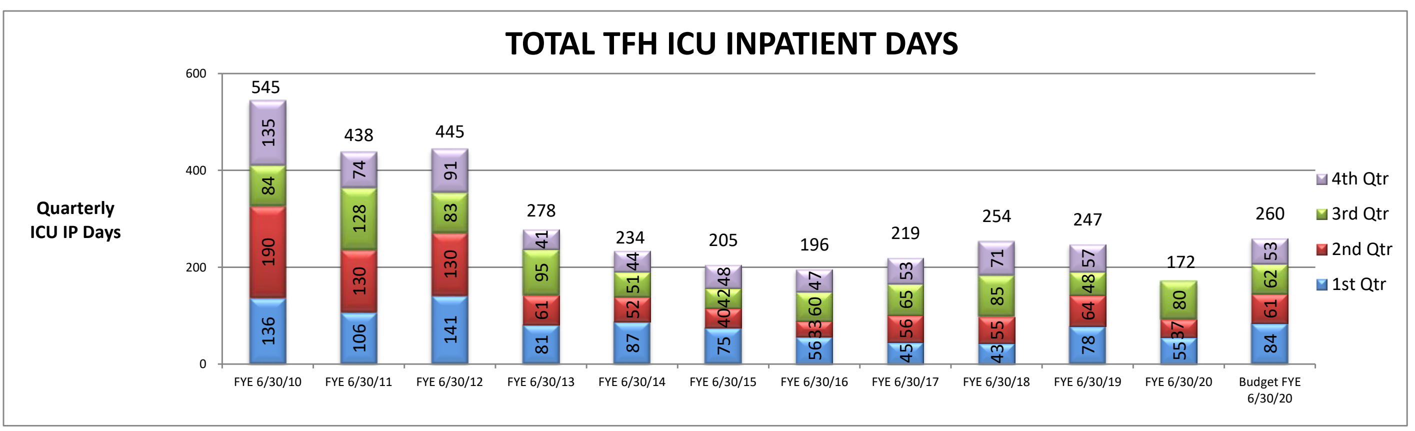
TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

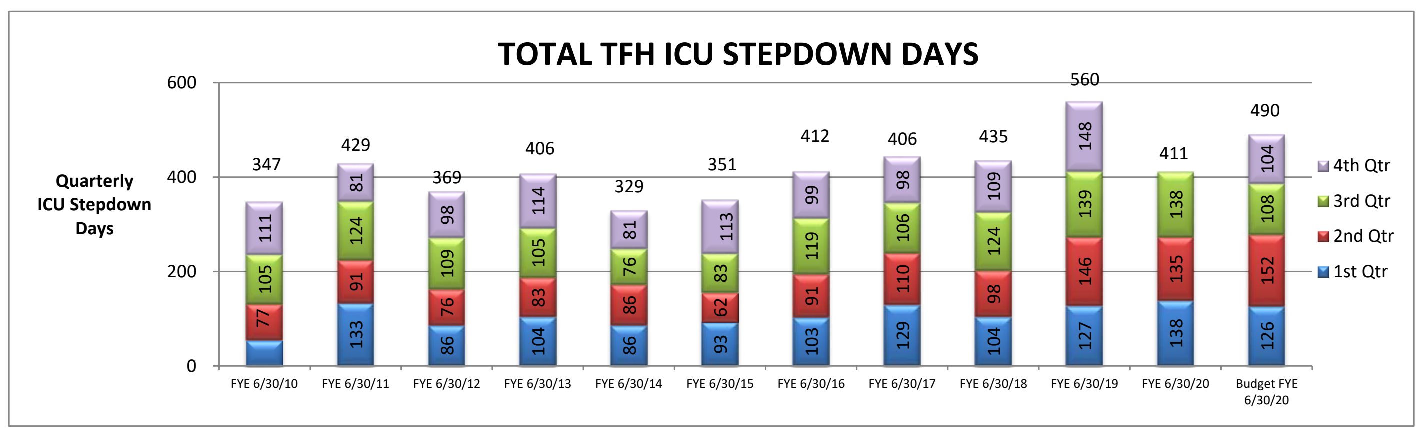
	AUDITED FYE 2019		BUDGET FYE 2020	PROJECTED FYE 2020	ACTUAL MAR 2020	PROJECTED MAR 2020	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	ACTUAL 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 25,310,161		$ 12,072,919	$ 1,371,090	$ (962,181)	$ (85,476)	$ (876,705)	$ 9,856,557	$ 6,757,769	$ 2,354,328	$ (17,597,564)
Interest Income	1,322,573		1,854,579	1,776,375	12,206	35,000	(22,794)	414,192	423,396	387,673	551,114
Property Tax Revenue	7,435,543		7,125,000	7,846,475		-	-	496,314	96,653	4,303,508	2,950,000
Donations	968,991		1,060,000	582,863	112,302	80,000	32,302	75,072	69,371	198,420	240,000
Debt Service Payments	(3,938,422)		(5,031,900)	(5,524,516)	(420,180)	(353,249)	(66,931)	(1,522,582)	(1,060,089)	(1,291,601)	(1,650,244)
Property Purchase Agreement	(270,643)		(811,932)	(805,927)	(135,321)	(67,661)	(67,660)	(202,982)	(202,982)	(264,642)	(135,321)
2018 Municipal Lease	(1,148,646)		(1,717,332)	(1,574,217)	(143,111)	(143,111)	0	(286,221)	(429,332)	(429,332)	(429,333)
Copier	(24,163)		(64,560)	(64,515)	(4,650)	(5,380)	730	(16,235)	(16,139)	(16,001)	(16,140)
2017 VR Demand Bond	(853,995)		(792,912)	(1,448,714)	-	-	-	(620,221)	-	(170,334)	(658,159)
2015 Revenue Bond	(1,640,975)		(1,645,164)	(1,631,143)	(137,097)	(137,097)	(0)	(396,924)	(411,636)	(411,292)	(411,291)
Physician Recruitment	(145,863)		(180,000)	(308,670)	-	(15,000)	15,000	(152,500)	(111,170)	-	(45,000)
Investment in Capital											
Equipment	(3,296,438)		(5,320,498)	(4,640,596)	(1,179,355)	(690,945)	(488,410)	(688,769)	(983,613)	(1,382,675)	(1,585,539)
Municipal Lease Reimbursement	4,530,323		4,650,000	1,714,582	556,303	556,000	303	-	608,279	556,303	550,000
IT/EMR/Business Systems	(3,016,084)		(4,222,246)	(2,928,232)	(469,543)	(636,680)	167,137	(667,043)	(501,585)	(1,069,604)	(690,000)
Building Projects/Properties	(12,443,362)		(23,169,292)	(8,465,701)	960,185	(1,140,983)	2,101,168	(2,220,489)	(3,431,604)	(1,234,758)	(1,578,850)
Capital Investments	(916,898)		-	-	-	-	-	-	-	-	-
Change in Accounts Receivable	(2,492,148)	N1	2,451,297	3,008,441	2,823,060	328,943	2,494,117	(708,340)	1,165,101	3,075,661	(523,981)
Change in Settlement Accounts	265,612	N2	1,615,831	2,229,926	1,234,249	(2,780,333)	4,014,582	(4,680,479)	(410,433)	(805,682)	8,126,520
Change in Other Assets	(5,018,346)	N3	(2,400,000)	(270,129)	(204,356)	(600,000)	395,644	3,116,473	(479,352)	(1,407,249)	(1,500,000)
Change in Other Liabilities	7,647,518	N4	(695,000)	(640,283)	1,185,421	800,000	385,421	507,806	(5,762,386)	3,189,297	1,425,000
Change in Cash Balance	16,213,160		(10,189,310)	(4,248,374)	3,648,111	(4,502,723)	8,150,834	3,826,212	(3,619,663)	6,873,620	(11,328,544)
Beginning Unrestricted Cash	70,805,546		87,018,706	87,018,706	90,450,765	90,450,765	-	87,018,706	90,844,918	87,225,255	94,098,876
Ending Unrestricted Cash	87,018,706		76,829,396	82,770,332	94,098,876	85,948,042	8,150,834	90,844,918	87,225,255	94,098,876	82,770,332
Expense Per Day	486,737		516,504	532,048	527,280	518,350	8,930	519,036	509,924	518,350	532,048
Days Cash On Hand	179		149	156	178	166	13	175	171	182	156

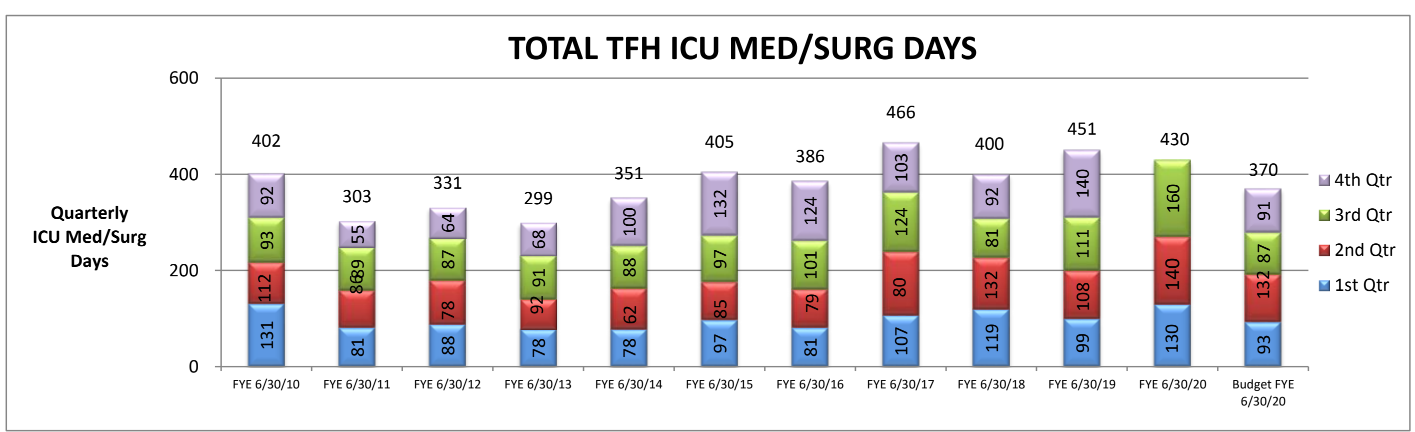
Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts 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.

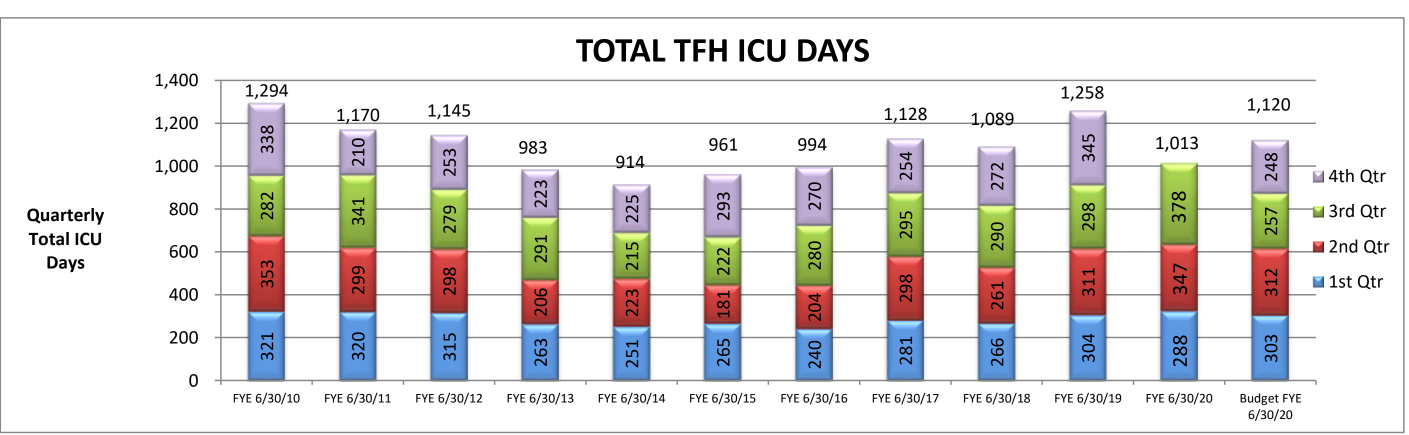

TOTAL TFH ADMISSIONS
Quarterly Admissions
2,500
2,000
1,500
1,000
500
0
1,788
1,803
1,681
1,652
1,609
1,679
1,569
1,808
1,829
1,760
1,281
1,989
444
385
406
359
375
426
352
456
485
443
533
481
489
416
436
376
420
447
438
480
443
380
507
402
424
398
413
421
383
406
451
440
402
407
511
461
505
461
444
437
450
364
463
424
472
494
438
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

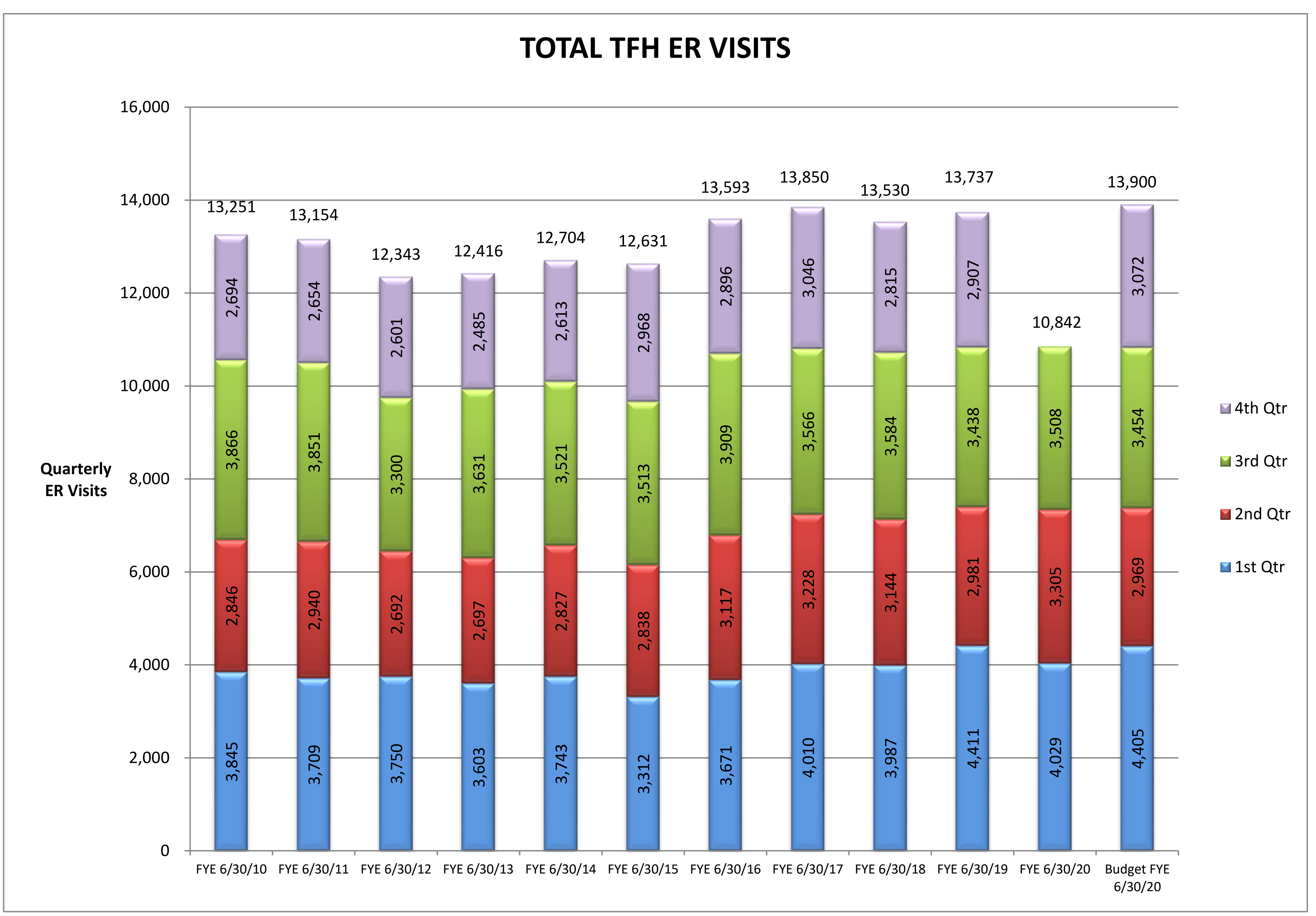

TOTAL TFH PATIENT DAYS
Quarterly Patient Days
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
5,450
5,387
4,958
4,854
4,620
4,730
4,694
4,873
4,328
5,786
4,336
5,385
1,456
1,329
1,279
1,386
1,142
1,499
1,246
1,500
1,129
1,203
1,227
1,399
1,127
1,336
1,163
1,228
1,128
1,176
1,126
1,190
1,204
1,205
1,053
1,268
1,139
1,333
1,148
1,074
1,259
1,163
1,206
1,245
1,086
1,015
1,059
1,168
1,534
1,406
1,357
1,489
1,387
1,458
1,491
1,210
1,222
1,422
1,531
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

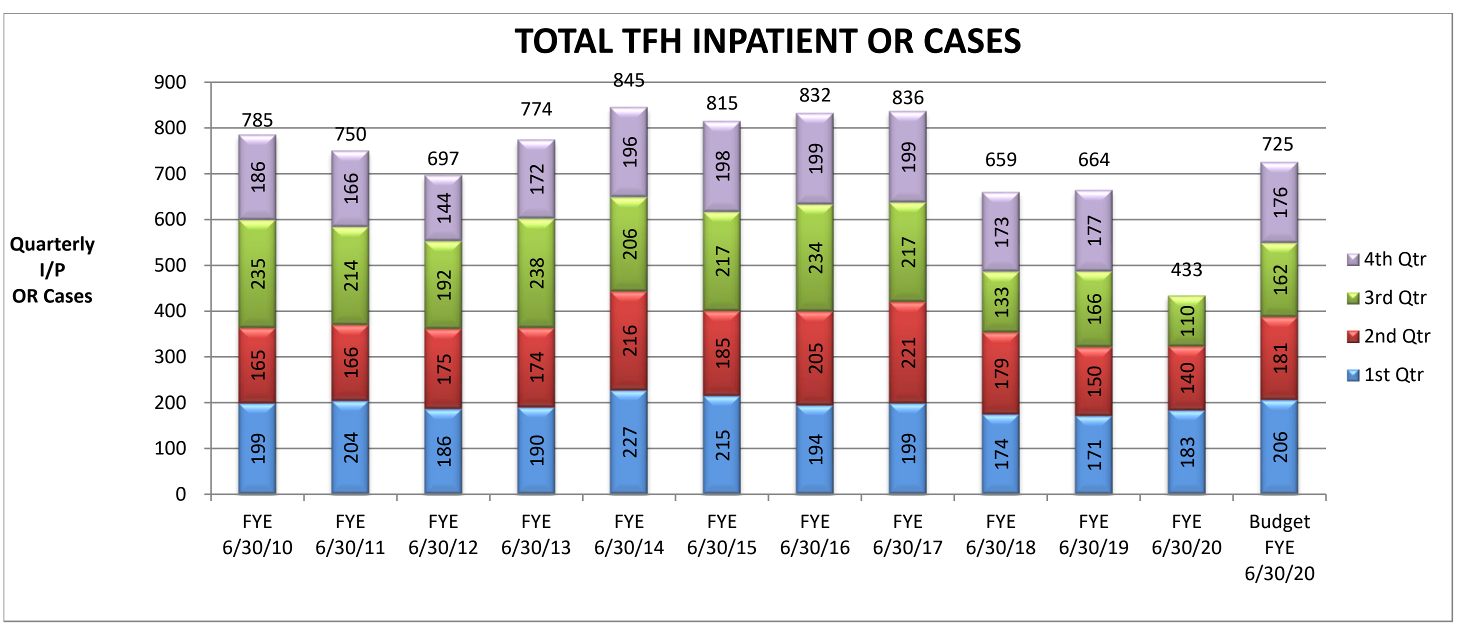

TOTAL TFH ICU INPATIENT DAYS
Quarterly ICU IP Days
600
400
200
0
545
438
445
278
234
205
196
219
254
247
172
260
136 190 84 135
106 130 128 74
141 130 83 91
81 61 95 41
87 52 51 44
75 40 42 48
56 33 60 47
45 56 65 53
43 55 85 71
78 64 48 57
55 37 80
84 61 62 53
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ICU STEPDOWN DAYS
Quarterly ICU Stepdown Days
600
400
200
0
347
429
369
406
329
351
412
406
435
560
411
490
77 105 111
133 91 124 81
86 76 109 98
104 83 105 114
86 86 76 81
93 62 83 113
103 91 119 99
129 110 106 98
104 98 124 109
127 146 139 148
138 135 138
126 152 108 104
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

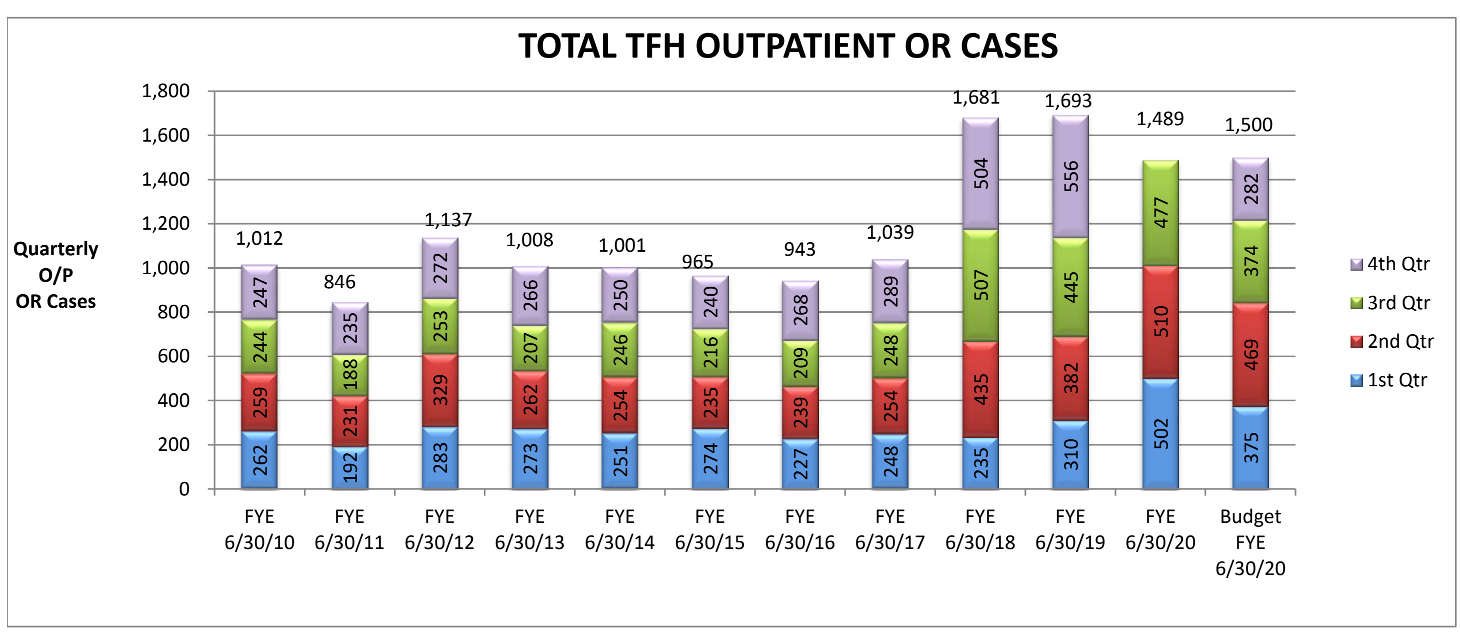

TOTAL TFH ICU MED/SURG DAYS
Quarterly ICU Med/Surg Days
600
400
200
0
402
303
331
299
351
405
386
466
400
451
430
370
131 112 93 92
81 55
88 78 87 64
78 92 91 68
78 62 88 100
97 85 97 132
81 79 101 124
107 80 124 103
119 132 81 92
99 108 111 140
130 140 160
93 132 87 91
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ICU DAYS
Quarterly Total ICU Days
1,400
1,200
1,000
800
600
400
200
0
1,294
1,170
1,145
983
914
961
994
1,128
1,089
1,258
1,013
1,120
321 353 282 338
320 299 341 210
315 298 279 253
263 206 291 223
251 223 215 225
265 181 222 293
240 204 280 270
281 298 295 254
266 261 290 272
304 311 298 345
288 347 378
303 312 257 248
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

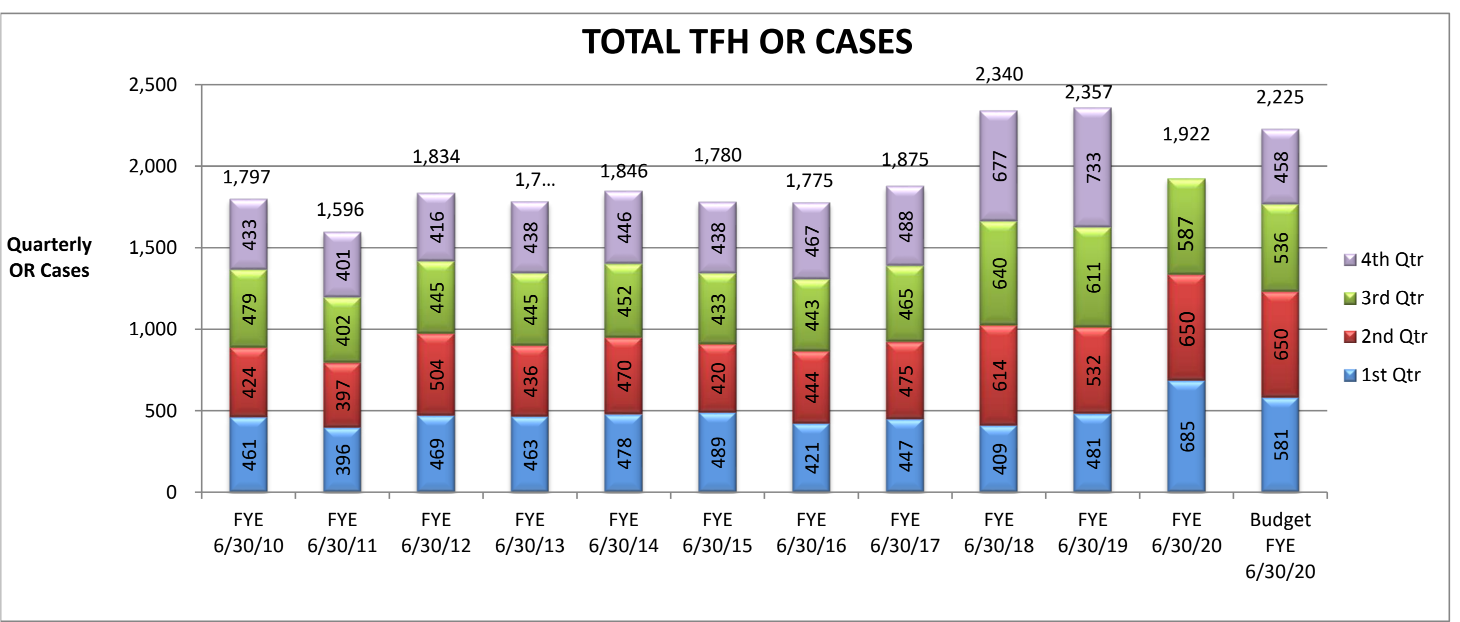

TOTAL TFH ER VISITS
Quarterly ER Visits
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
13,251
13,154
12,343
12,416
12,704
12,631
13,593
13,850
13,530
13,737
10,842
13,900
2,694
2,654
2,601
2,485
2,613
2,968
2,896
3,046
2,815
2,907
3,072
3,866
3,851
3,300
3,631
3,521
3,513
3,909
3,566
3,584
3,438
3,508
3,454
2,846
2,940
2,692
2,697
2,827
2,838
3,117
3,228
3,144
2,981
3,305
2,969
3,845
3,709
3,750
3,603
3,743
3,312
3,671
4,010
3,987
4,411
4,029
4,405
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



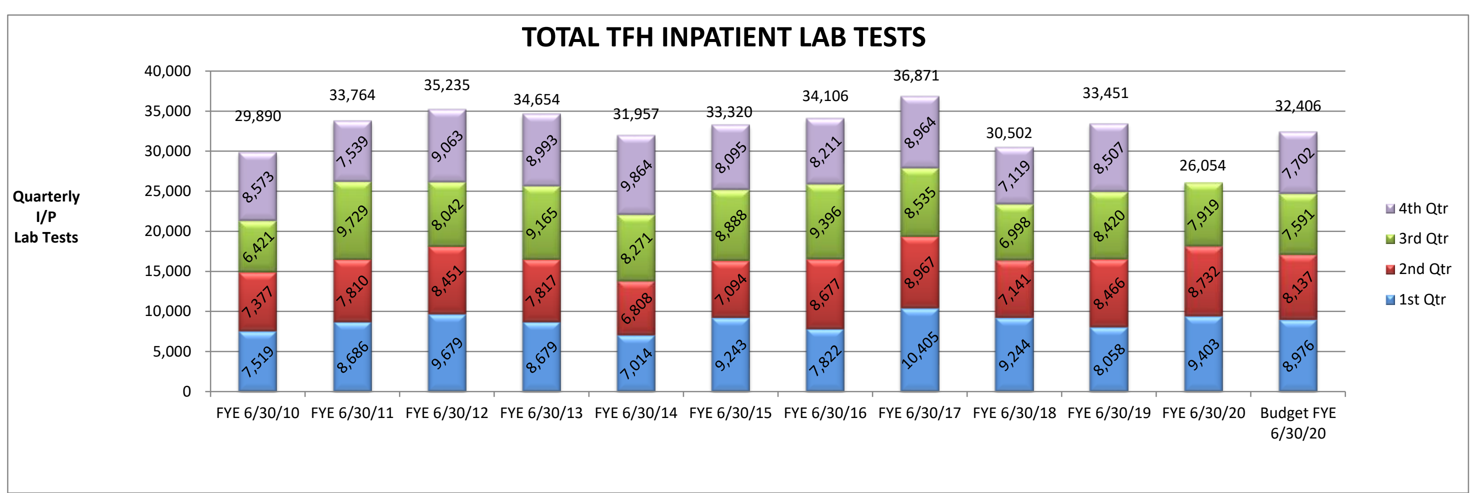
TOTAL TFH INPATIENT OR CASES
Quarterly I/P OR Cases
900
800
700
600
500
400
300
200
100
0
785 750 697 774 845 815 832 836 659 664 433 725
4th Qtr: 186 166 144 172 196 198 199 199 173 177 176
3rd Qtr: 235 214 192 238 206 217 234 217 133 166 110 162
2nd Qtr: 165 166 175 174 216 185 205 221 179 150 140 181
1st Qtr: 199 204 186 190 227 215 194 199 174 171 183 206
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



TOTAL TFH OUTPATIENT OR CASES
Quarterly O/P OR Cases
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,012 846 1,137 1,008 1,001 965 943 1,039 1,681 1,693 1,489 1,500
4th Qtr: 247 235 272 266 250 240 268 289 504 556 282
3rd Qtr: 244 188 253 207 246 216 209 248 507 445 477 374
2nd Qtr: 259 231 329 262 254 235 239 254 435 382 510 469
1st Qtr: 262 192 283 273 251 274 227 248 235 310 502 375
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



TOTAL TFH OR CASES
Quarterly OR Cases
2,500
2,000
1,500
1,000
500
0
1,797 1,596 1,834 1,7... 1,846 1,780 1,775 1,875 2,340 2,357 1,922 2,225
4th Qtr: 433 401 416 438 446 438 467 488 677 733 458
3rd Qtr: 479 402 445 445 452 433 443 465 640 611 587 536
2nd Qtr: 424 397 504 436 470 420 444 475 614 532 650 650
1st Qtr: 461 396 469 463 478 489 421 447 409 481 685 581
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



TOTAL TFH INPATIENT LAB TESTS
Quarterly I/P Lab Tests
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
29,890
33,764
35,235
34,654
31,957
33,320
34,106
36,871
30,502
33,451
26,054
32,406
8,573
7,539
9,063
8,993
9,864
8,095
8,211
8,964
7,119
8,507
7,702
6,421
9,729
8,042
9,165
8,271
8,888
9,396
8,535
6,998
8,420
7,919
7,591
7,377
7,810
8,451
7,817
6,808
7,094
8,677
8,967
7,141
8,466
8,732
8,137
7,519
8,686
9,679
8,679
7,014
9,243
7,822
10,405
9,244
8,058
9,403
8,976
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
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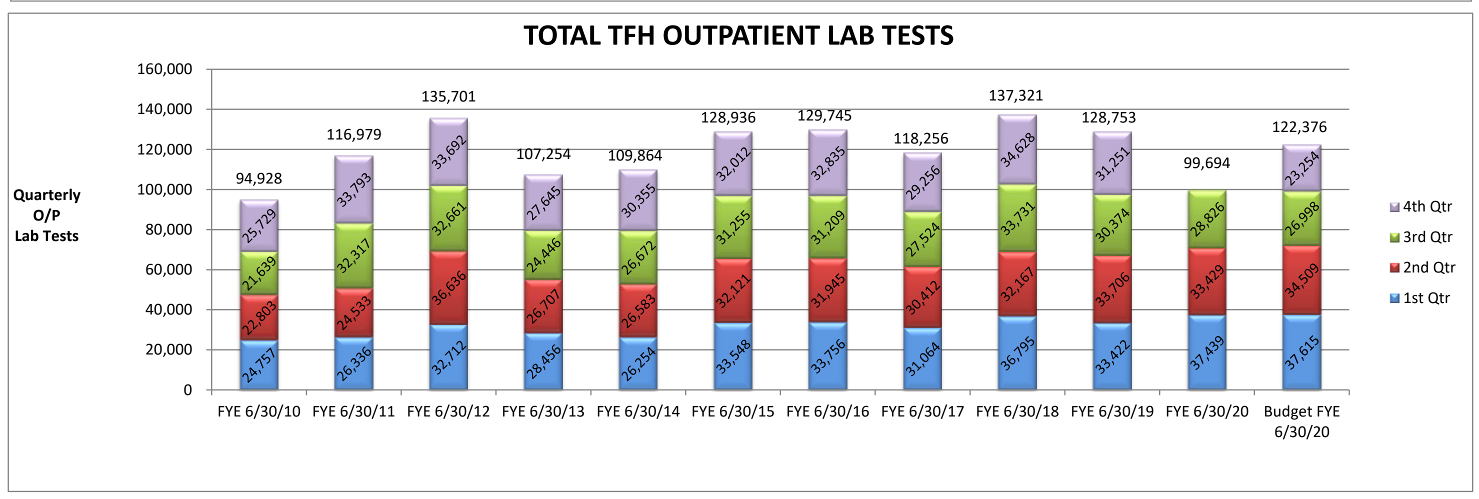
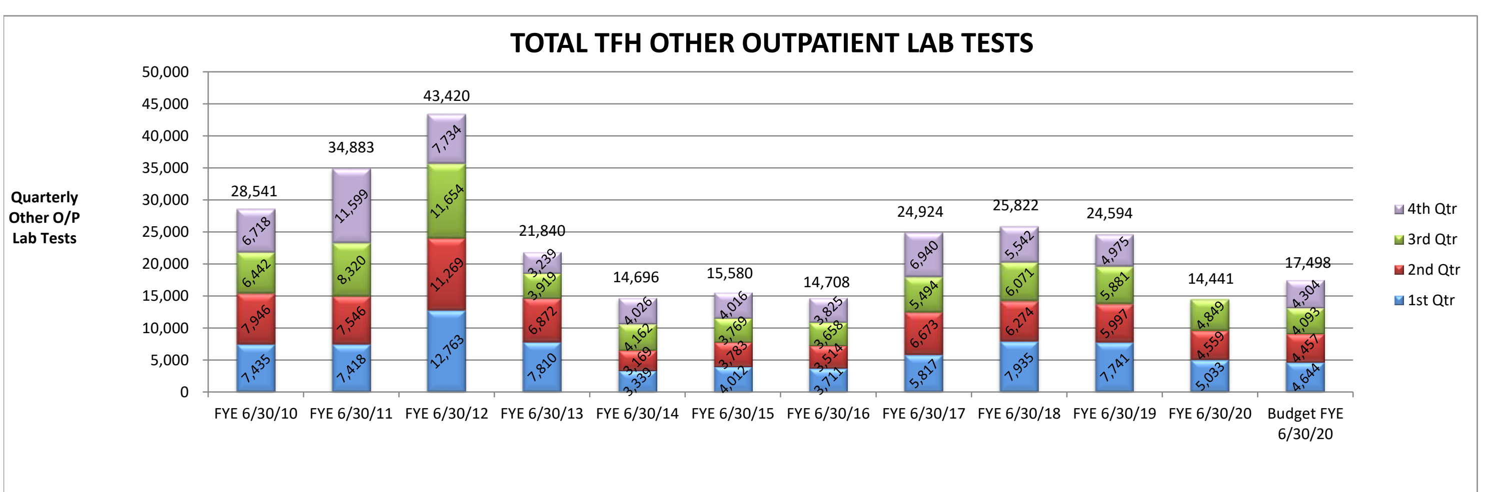
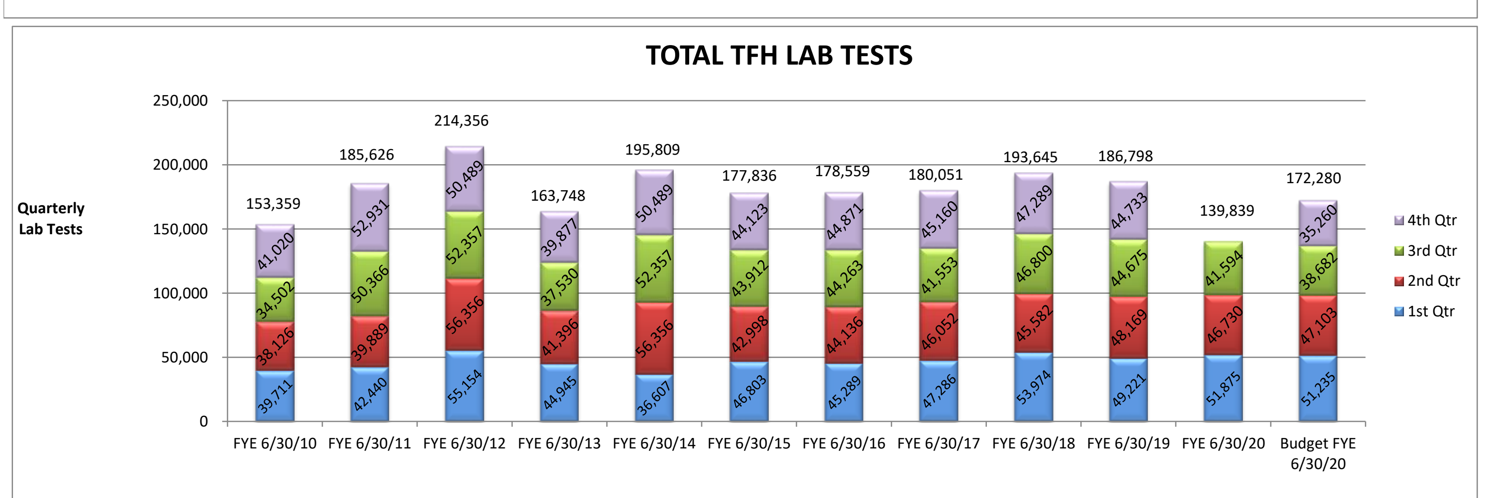
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



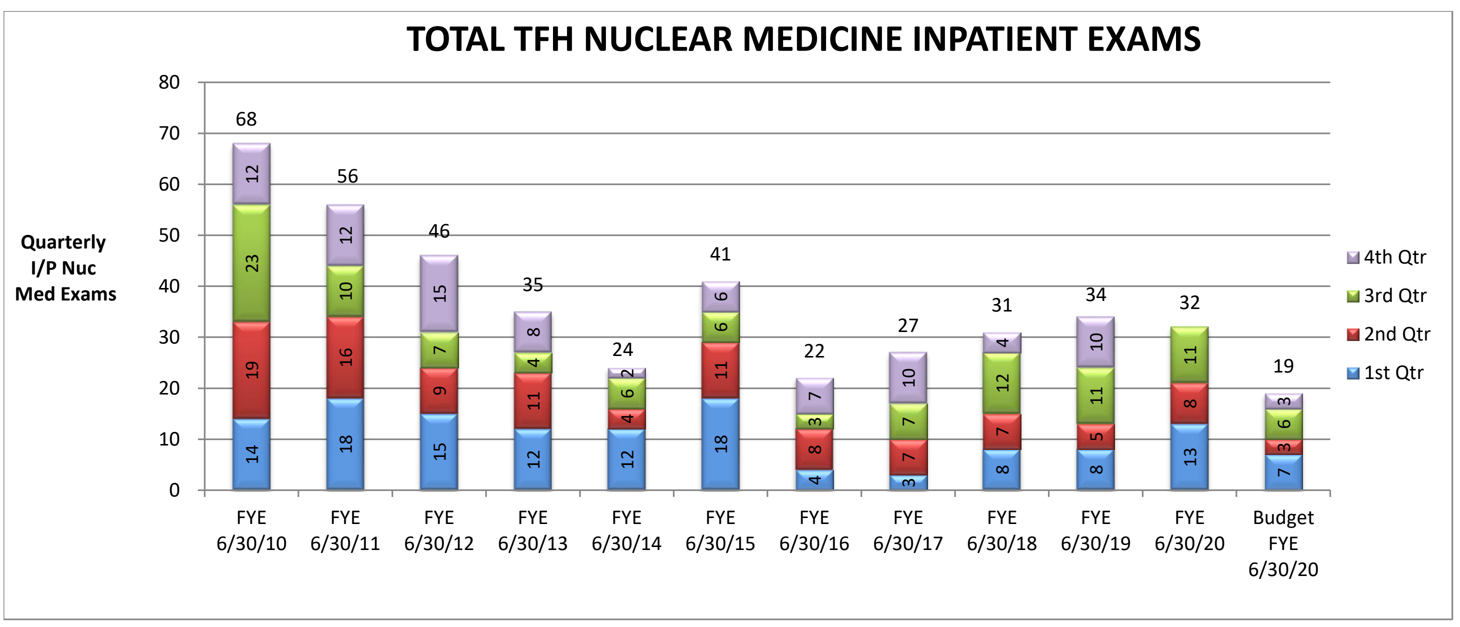
TOTAL TFH OUTPATIENT LAB TESTS
Quarterly O/P Lab Tests
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
94,928
116,979
135,701
107,254
109,864
128,936
129,745
118,256
137,321
128,753
99,694
122,376
25,729
33,793
33,692
27,645
30,355
32,012
32,835
29,256
34,628
31,251
23,254
21,639
32,317
32,661
24,446
26,672
31,255
31,209
27,524
33,731
30,374
28,826
26,998
22,803
24,533
36,636
26,707
26,583
32,121
31,945
30,412
32,167
33,706
33,429
34,509
24,757
26,336
32,712
28,456
26,254
33,548
33,756
31,064
36,795
33,422
37,439
37,615
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

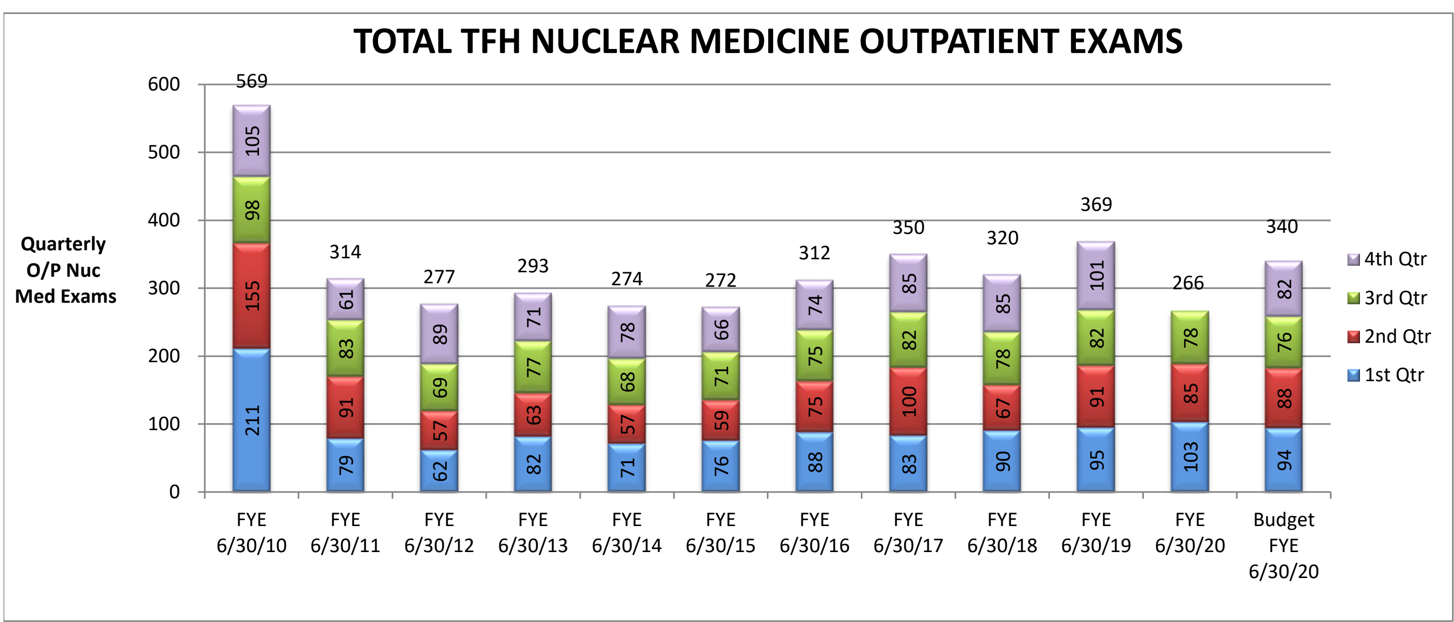


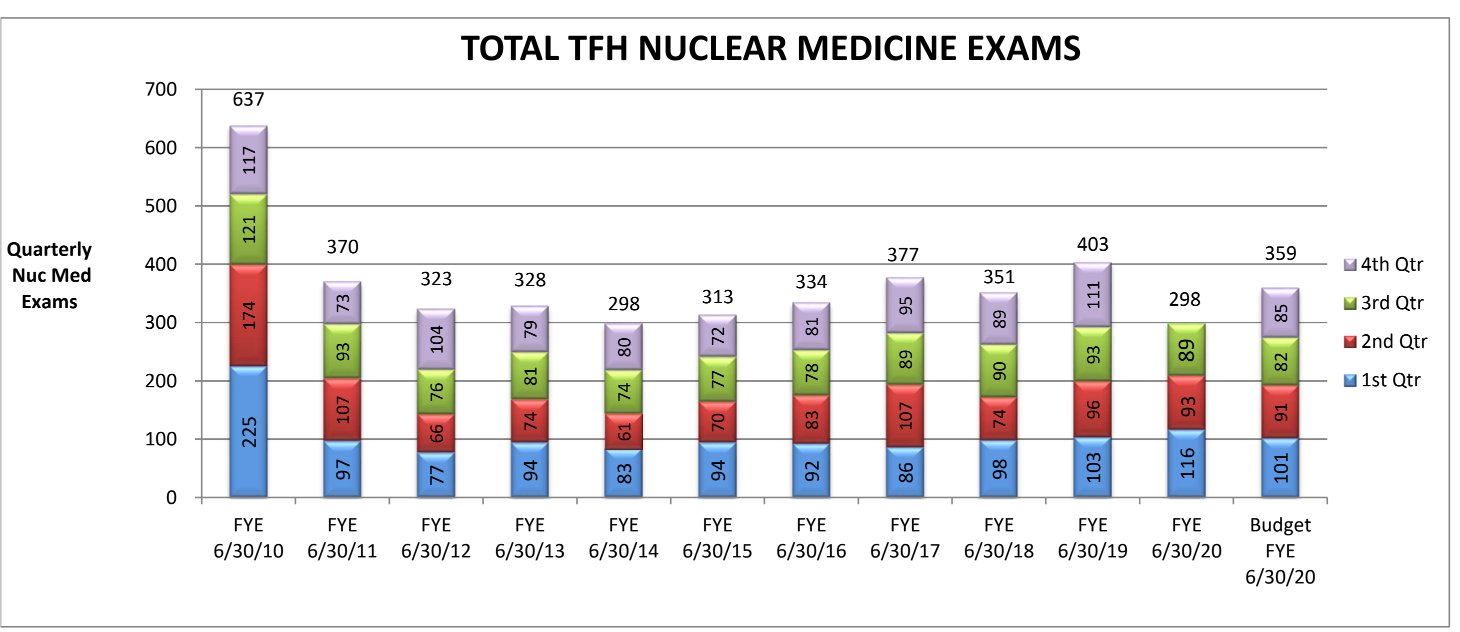
TOTAL TFH OTHER OUTPATIENT LAB TESTS
Quarterly Other O/P Lab Tests
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
28,541
34,883
43,420
21,840
14,696
15,580
14,708
24,924
25,822
24,594
14,441
17,498
6,718
11,599
7,734
3,239
4,026
4,016
3,825
6,940
5,542
4,975
4,304
6,442
8,320
11,654
3,919
4,162
3,769
3,658
5,494
6,071
5,881
4,849
4,093
7,946
7,546
11,269
6,872
3,169
3,783
3,514
6,673
6,274
5,997
4,559
4,457
7,435
7,418
12,763
7,810
3,339
4,012
3,711
5,817
7,935
7,741
5,033
4,644
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

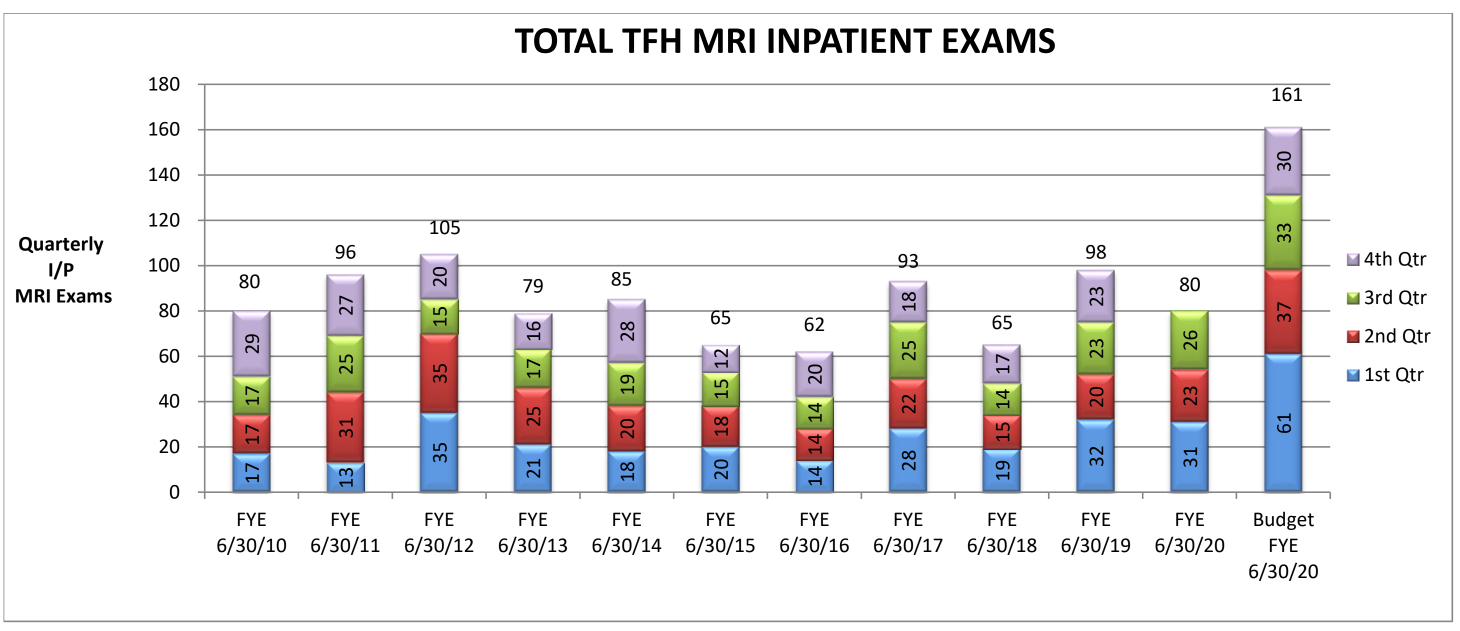


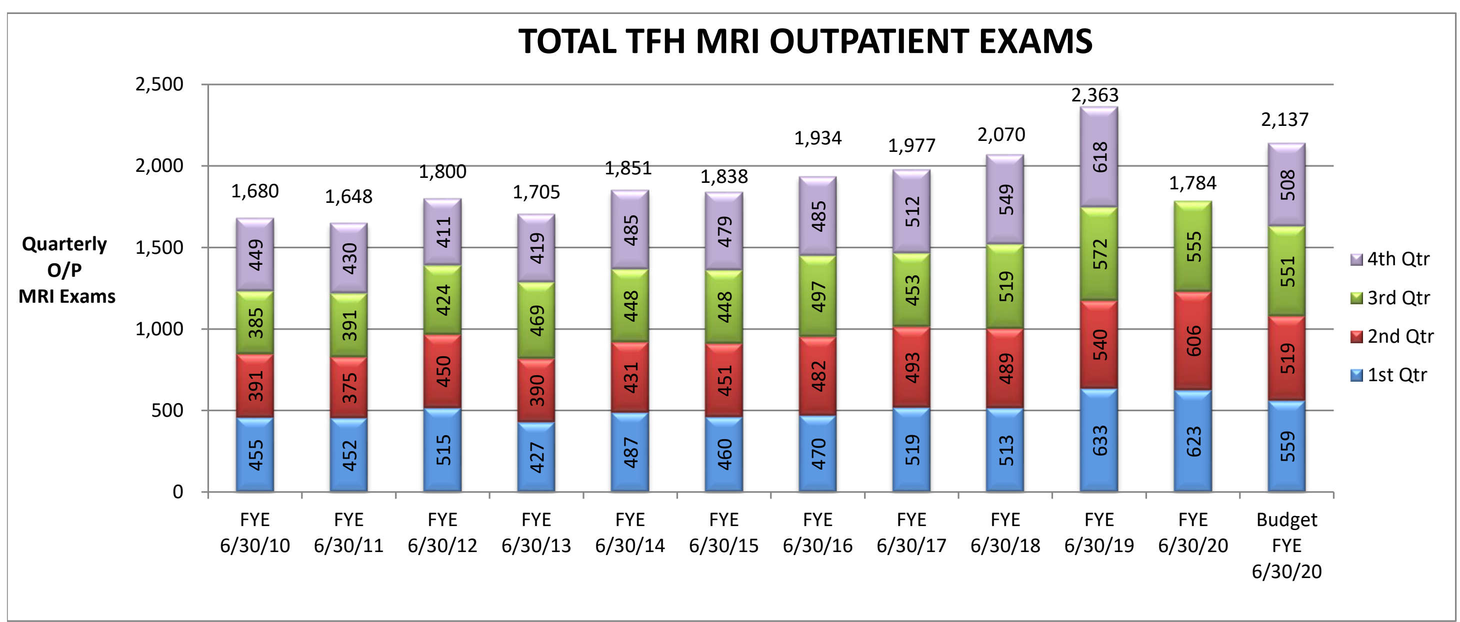
TOTAL TFH LAB TESTS
Quarterly Lab Tests
250,000
200,000
150,000
100,000
50,000
0
153,359
185,626
214,356
163,748
195,809
177,836
178,559
180,051
193,645
186,798
139,839
172,280
41,020
52,931
50,489
39,877
50,489
44,123
44,871
45,160
47,289
44,733
35,260
34,502
50,366
52,357
37,530
52,357
43,912
44,263
41,553
46,800
44,675
41,594
38,682
38,126
39,889
56,356
41,396
56,356
42,998
44,136
46,052
45,582
48,169
46,730
47,103
39,711
42,440
55,154
44,945
36,607
46,803
45,289
47,286
53,974
49,221
51,875
51,235
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

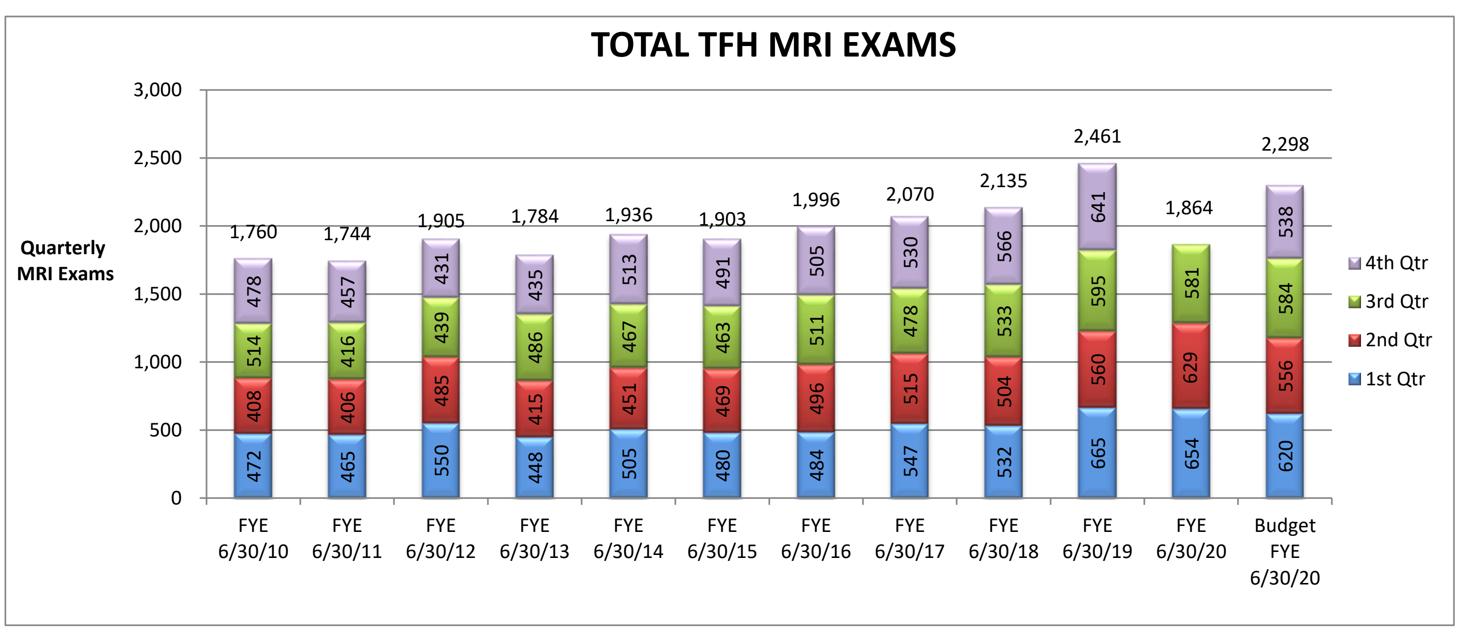

TOTAL TFH NUCLEAR MEDICINE INPATIENT EXAMS
Quarterly I/P Nuc Med Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/10: 14, 19, 23, 12; 68
FYE 6/30/11: 18, 16, 10, 12; 56
FYE 6/30/12: 15, 9, 7, 15; 46
FYE 6/30/13: 12, 11, 4, 8; 35
FYE 6/30/14: 12, 4, 6, 2; 24
FYE 6/30/15: 18, 11, 6, 6; 41
FYE 6/30/16: 4, 8, 3, 7; 22
FYE 6/30/17: 3, 7, 7, 10; 27
FYE 6/30/18: 8, 7, 12, 4; 31
FYE 6/30/19: 8, 5, 11, 10; 34
FYE 6/30/20: 13, 8, 11; 32
Budget FYE 6/30/20: 7, 3, 6, 3; 19

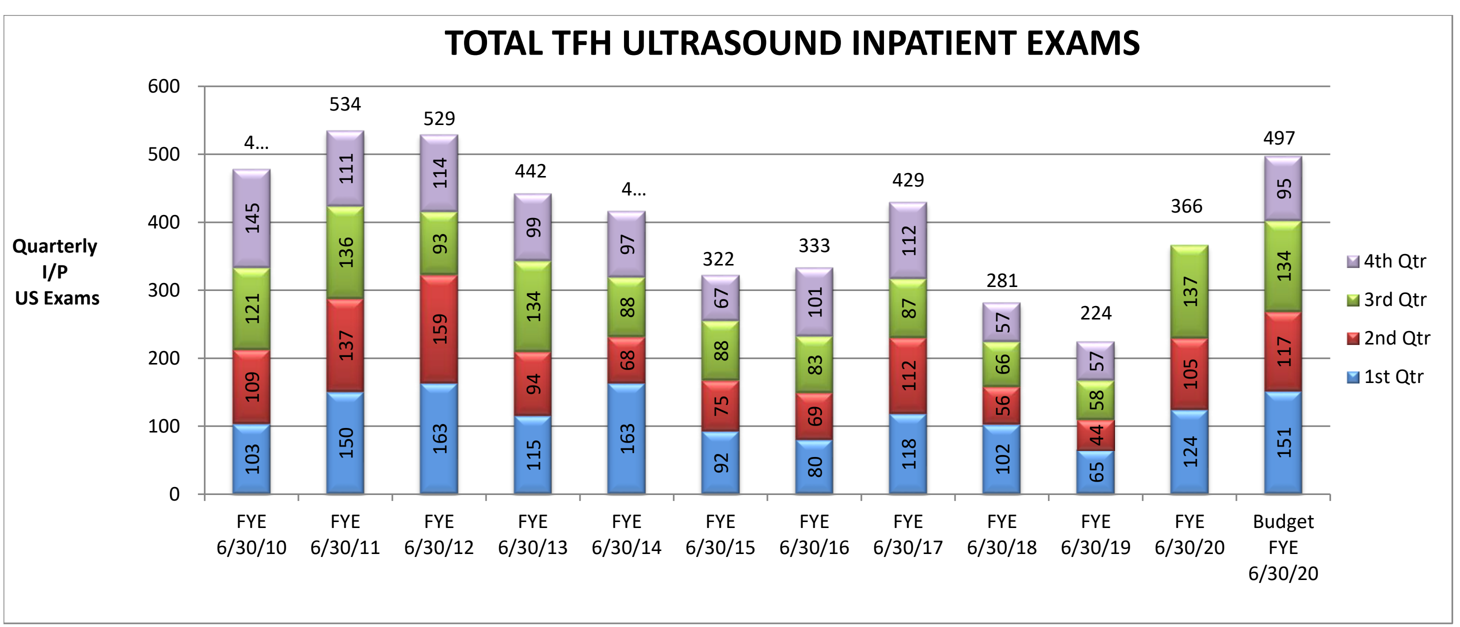

TOTAL TFH NUCLEAR MEDICINE OUTPATIENT EXAMS
Quarterly O/P Nuc Med Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/10: 211, 155, 98, 105; 569
FYE 6/30/11: 79, 91, 83, 61; 314
FYE 6/30/12: 62, 57, 69, 89; 277
FYE 6/30/13: 82, 63, 77, 71; 293
FYE 6/30/14: 71, 57, 68, 78; 274
FYE 6/30/15: 76, 59, 71, 66; 272
FYE 6/30/16: 88, 75, 75, 74; 312
FYE 6/30/17: 83, 100, 82, 85; 350
FYE 6/30/18: 90, 67, 78, 85; 320
FYE 6/30/19: 95, 91, 82, 101; 369
FYE 6/30/20: 103, 85, 78; 266
Budget FYE 6/30/20: 94, 88, 76, 82; 340

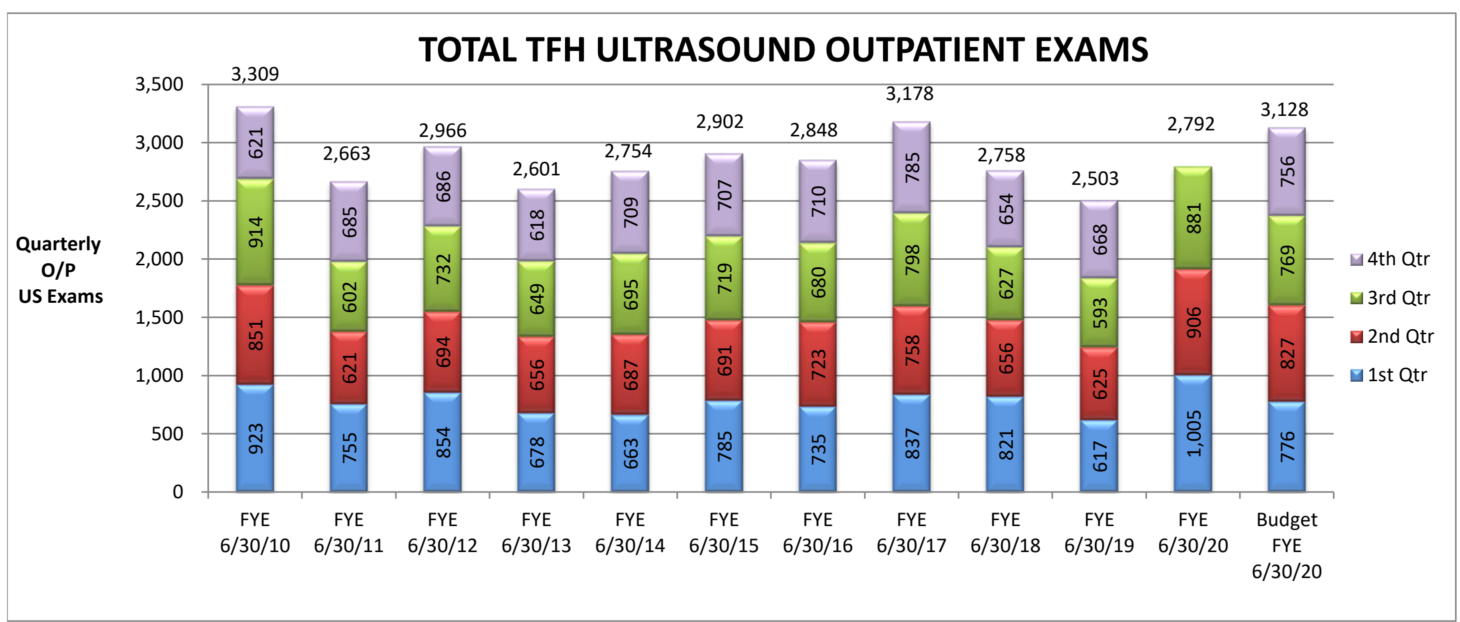

TOTAL TFH NUCLEAR MEDICINE EXAMS
Quarterly Nuc Med Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/10: 225, 174, 121, 117; 637
FYE 6/30/11: 97, 107, 93, 73; 370
FYE 6/30/12: 77, 66, 76, 104; 323
FYE 6/30/13: 94, 74, 81, 79; 328
FYE 6/30/14: 83, 61, 74, 80; 298
FYE 6/30/15: 94, 70, 77, 72; 313
FYE 6/30/16: 92, 83, 78, 81; 334
FYE 6/30/17: 86, 107, 89, 95; 377
FYE 6/30/18: 98, 74, 90, 89; 351
FYE 6/30/19: 103, 96, 93, 111; 403
FYE 6/30/20: 116, 93, 89; 298
Budget FYE 6/30/20: 101, 91, 82, 85; 359

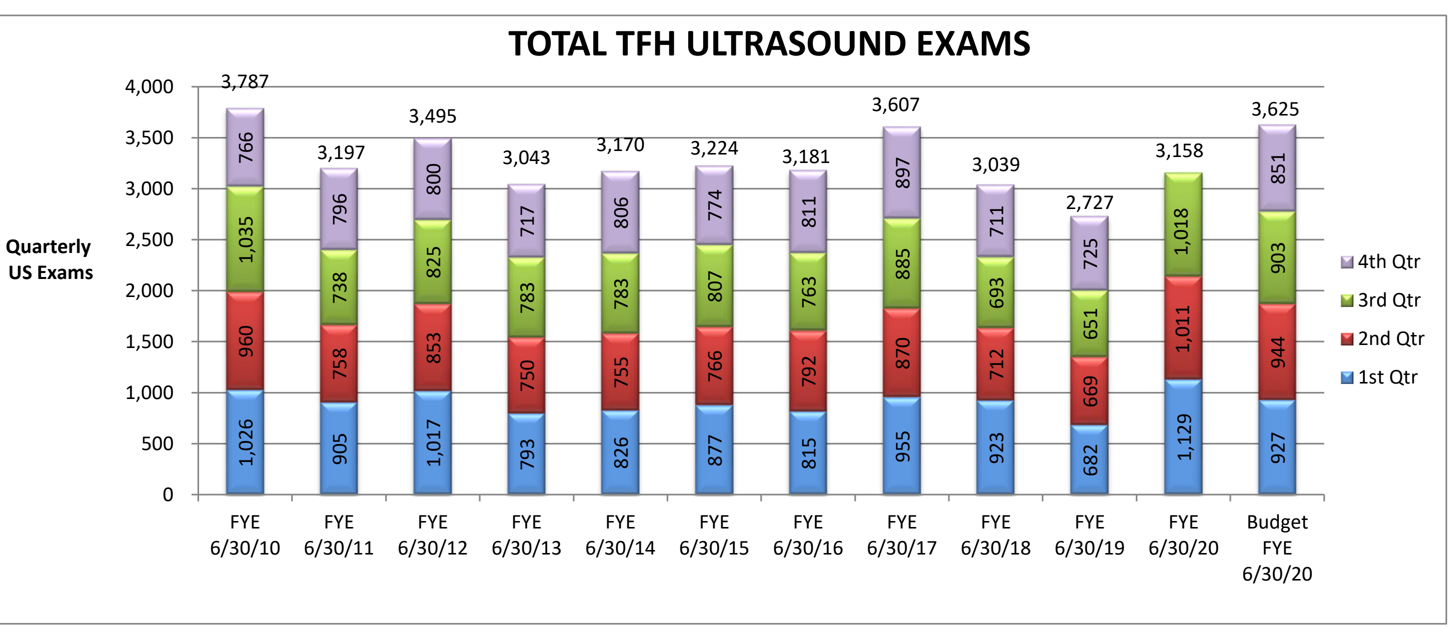

TOTAL TFH MRI INPATIENT EXAMS
Quarterly I/P MRI Exams
0
20
40
60
80
100
120
140
160
180
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
80
96
105
79
85
65
62
93
65
98
80
161
17 17 17 29
13 31 25 27
35 35 15 20
21 25 17 16
18 20 19 28
20 18 15 12
14 14 14 20
28 22 25 18
19 15 14 17
32 20 23 23
31 23 26
61 37 33 30

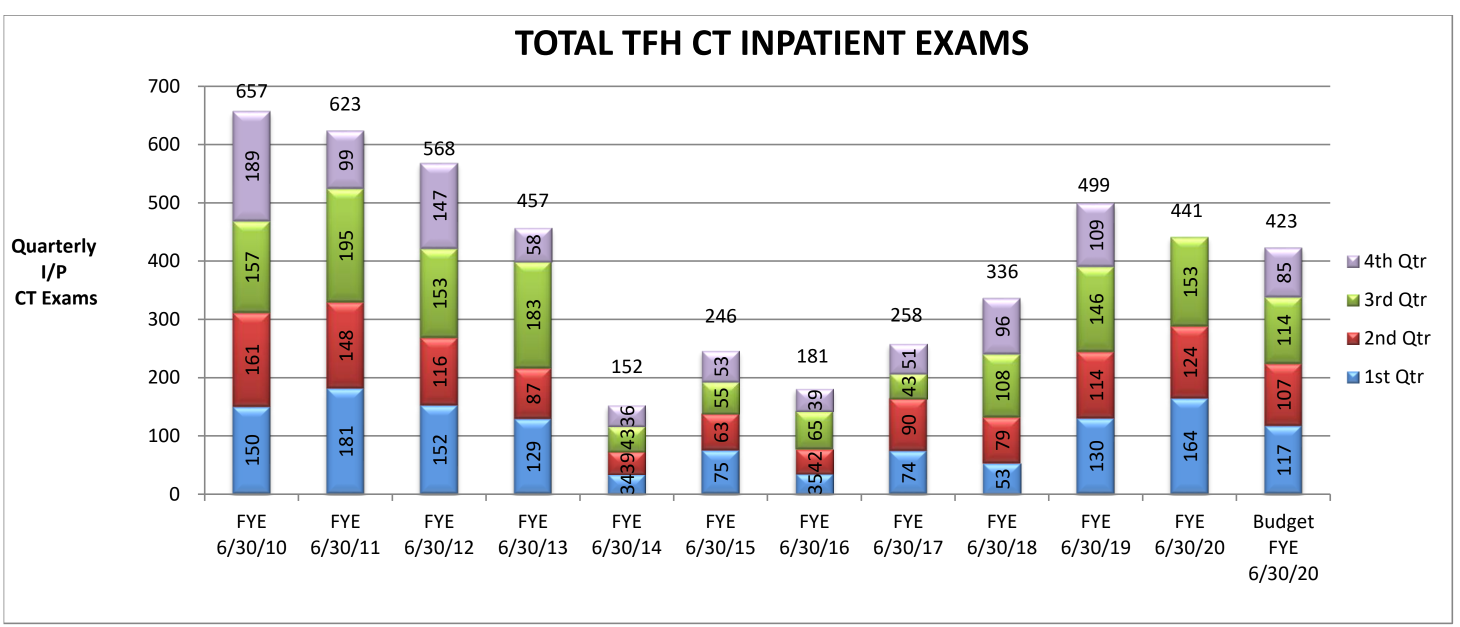

TOTAL TFH MRI OUTPATIENT EXAMS
Quarterly O/P MRI Exams
0
500
1,000
1,500
2,000
2,500
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
1,680
1,648
1,800
1,705
1,851
1,838
1,934
1,977
2,070
2,363
1,784
2,137
455 391 385 449
452 375 391 430
515 450 424 411
427 390 469 419
487 431 448 485
460 451 448 479
470 482 497 485
519 493 453 512
513 489 519 549
633 540 572 618
623 606 555
559 519 551 508

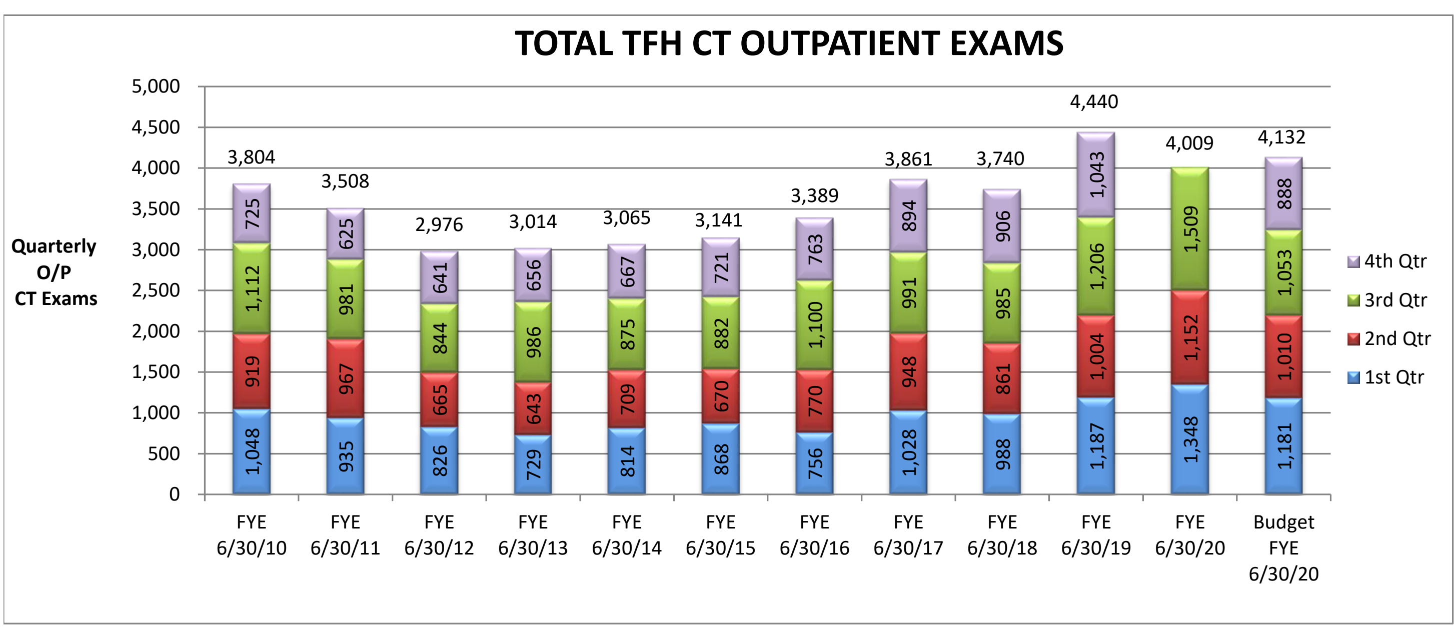

TOTAL TFH MRI EXAMS
Quarterly MRI Exams
0
500
1,000
1,500
2,000
2,500
3,000
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
1,760
1,744
1,905
1,784
1,936
1,903
1,996
2,070
2,135
2,461
1,864
2,298
472 408 514 478
465 406 416 457
550 485 439 431
448 415 486 435
505 451 467 513
480 469 463 491
484 496 511 505
547 515 478 530
532 504 533 566
665 560 595 641
654 629 581
620 556 584 538

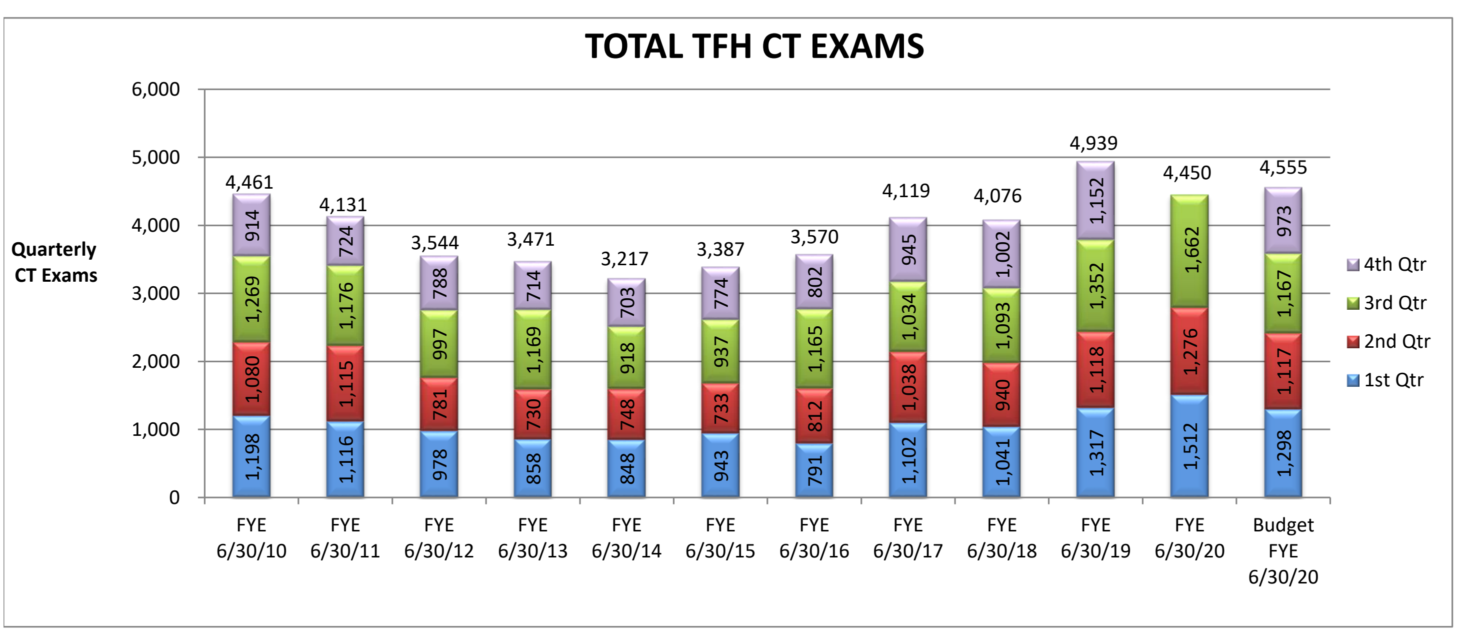

TOTAL TFH ULTRASOUND INPATIENT EXAMS
Quarterly I/P US Exams
600
500
400
300
200
100
0
4…
534
529
442
4…
322
333
429
281
224
366
497
145
111
114
99
97
67
101
112
57
57
95
121
136
93
134
88
88
83
87
66
58
137
134
109
137
159
94
68
75
69
112
56
44
105
117
103
150
163
115
163
92
80
118
102
65
124
151
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

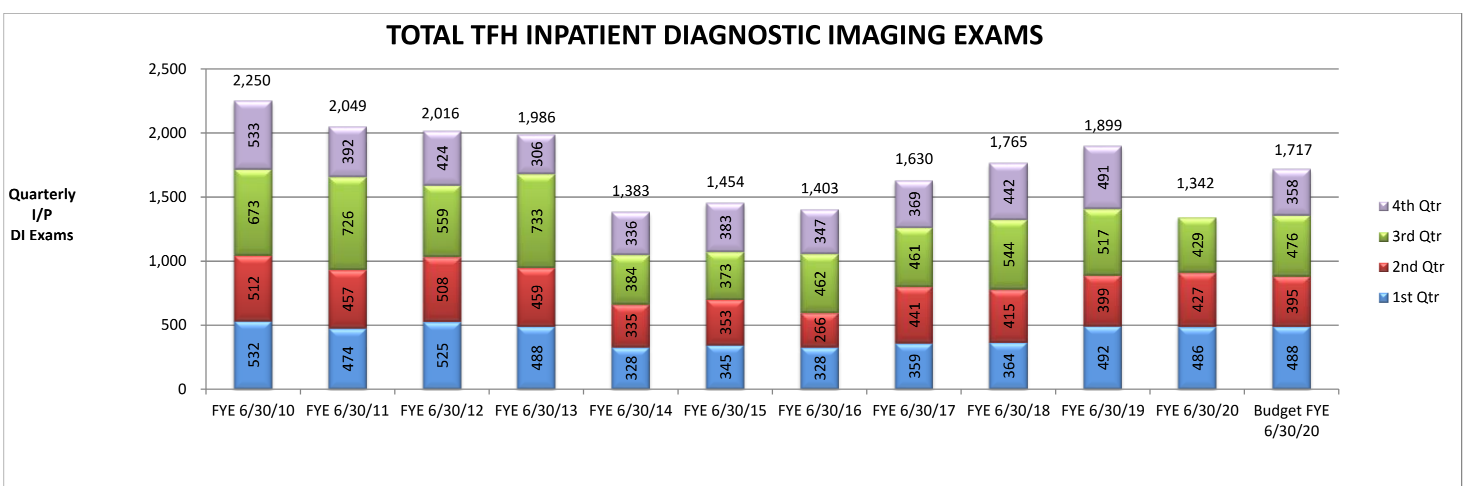

TOTAL TFH ULTRASOUND OUTPATIENT EXAMS
Quarterly O/P US Exams
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,309
2,663
2,966
2,601
2,754
2,902
2,848
3,178
2,758
2,503
2,792
3,128
621
685
686
618
709
707
710
785
654
668
756
914
602
732
649
695
719
680
798
627
593
881
769
851
621
694
656
687
691
723
758
656
625
906
827
923
755
854
678
663
785
735
837
821
617
1,005
776
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

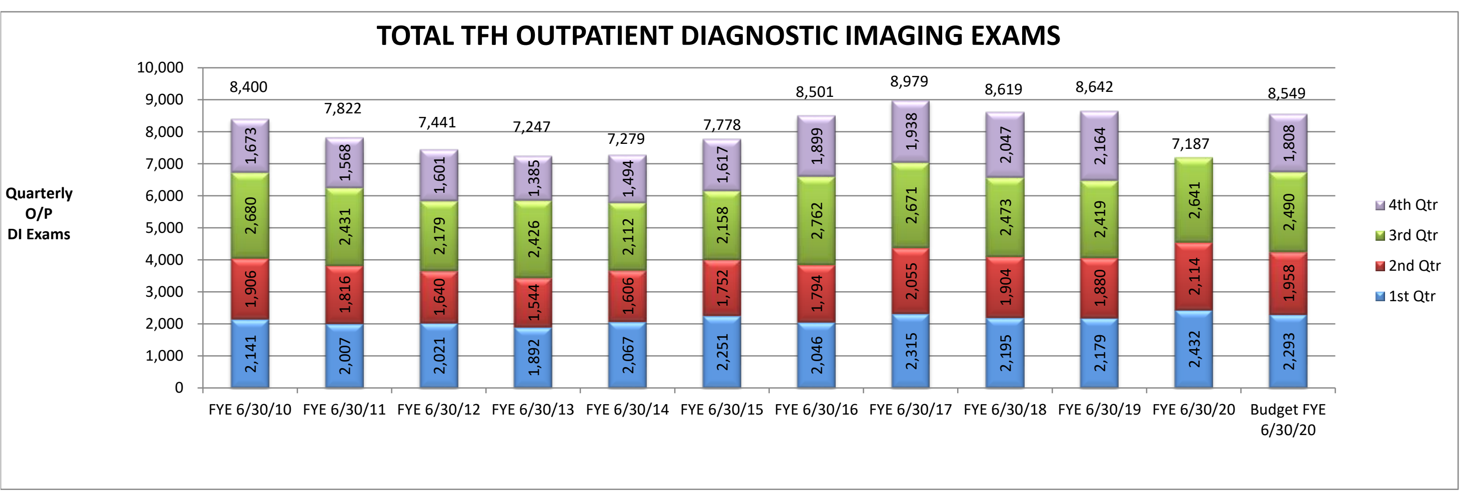

TOTAL TFH ULTRASOUND EXAMS
Quarterly US Exams
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,787
3,197
3,495
3,043
3,170
3,224
3,181
3,607
3,039
2,727
3,158
3,625
766
796
800
717
806
774
811
897
711
725
851
1,035
738
825
783
783
807
763
885
693
651
1,018
903
960
758
853
750
755
766
792
870
712
669
1,011
944
1,026
905
1,017
793
826
877
815
955
923
682
1,129
927
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

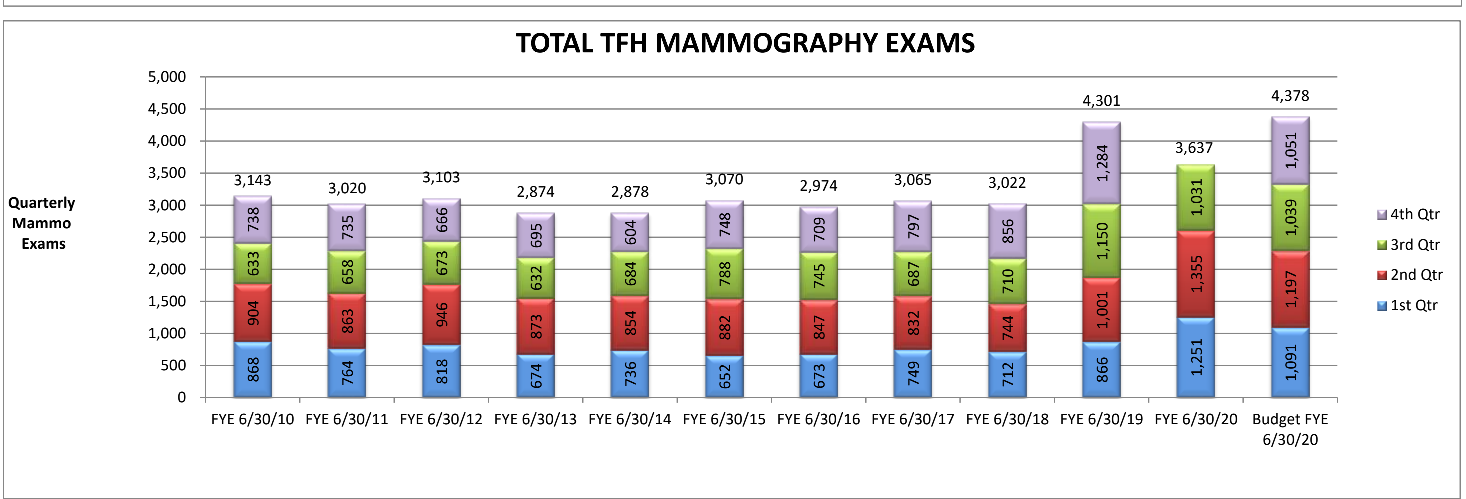

TOTAL TFH CT INPATIENT EXAMS
Quarterly I/P CT Exams
700
600
500
400
300
200
100
0
657
623
568
457
152
246
181
258
336
499
441
423
150 161 157 189
181 148 195 99
152 116 153 147
129 87 183 58
34 39 43 36
75 63 55 53
35 42 65 39
74 90 43 51
53 79 108 96
130 114 146 109
164 124 153
117 107 114 85
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

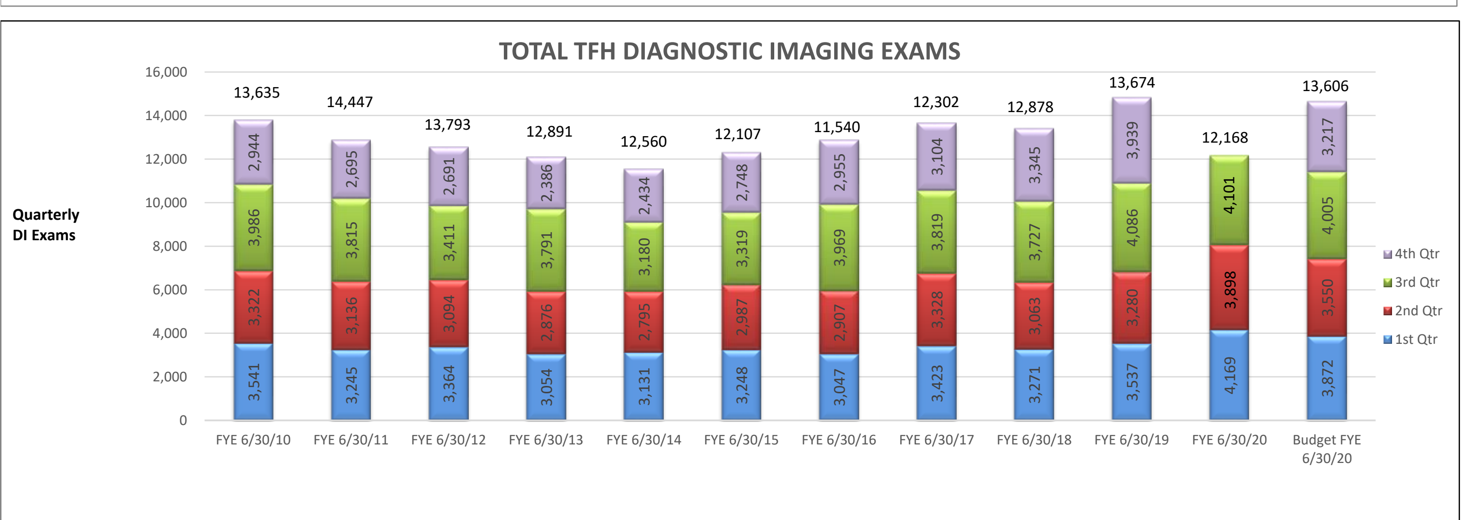

TOTAL TFH CT OUTPATIENT EXAMS
Quarterly O/P CT Exams
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,804
3,508
2,976
3,014
3,065
3,141
3,389
3,861
3,740
4,440
4,009
4,132
1,048 919 1,112 725
935 967 981 625
826 665 844 641
729 643 986 656
814 709 875 667
868 670 882 721
756 770 1,100 763
1,028 948 991 894
988 861 985 906
1,187 1,004 1,206 1,043
1,348 1,152 1,509
1,181 1,010 1,053 888
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

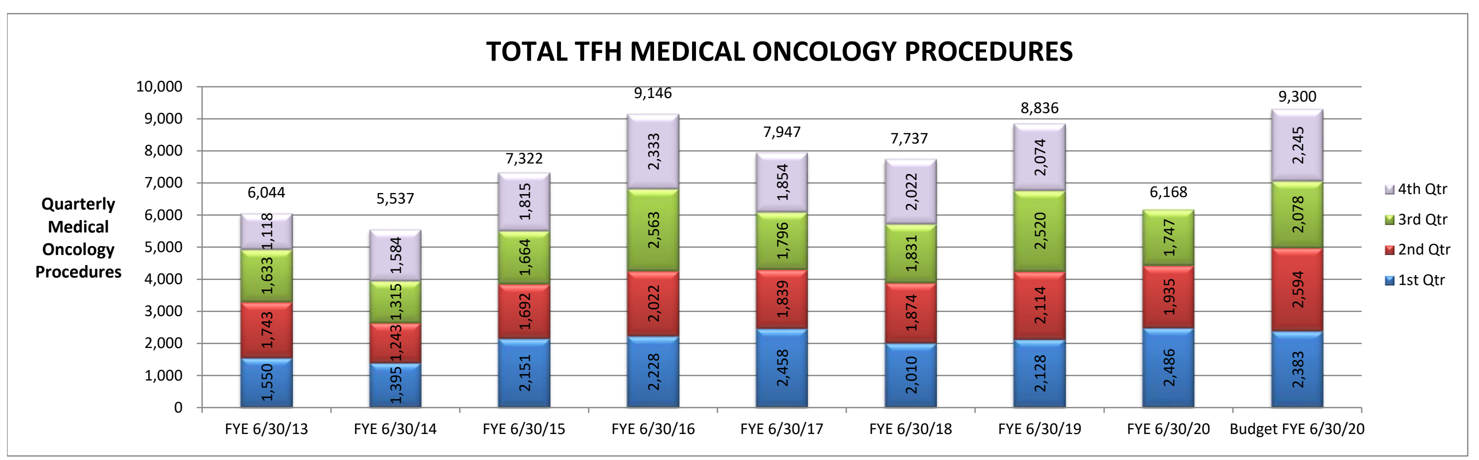

TOTAL TFH CT EXAMS
Quarterly CT Exams
6,000
5,000
4,000
3,000
2,000
1,000
0
4,461
4,131
3,544
3,471
3,217
3,387
3,570
4,119
4,076
4,939
4,450
4,555
1,198 1,080 1,269 914
1,116 1,115 1,176 724
978 781 997 788
858 730 1,169 714
848 748 918 703
943 733 937 774
791 812 1,165 802
1,102 1,038 1,034 945
1,041 940 1,093 1,002
1,317 1,118 1,352 1,152
1,512 1,276 1,662
1,298 1,117 1,167 973
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH INPATIENT DIAGNOSTIC IMAGING EXAMS
Quarterly I/P DI Exams
0
500
1,000
1,500
2,000
2,500
FYE 6/30/10: 532, 512, 673, 533, 2,250
FYE 6/30/11: 474, 457, 726, 392, 2,049
FYE 6/30/12: 525, 508, 559, 424, 2,016
FYE 6/30/13: 488, 459, 733, 306, 1,986
FYE 6/30/14: 328, 335, 384, 336, 1,383
FYE 6/30/15: 345, 353, 373, 383, 1,454
FYE 6/30/16: 328, 266, 462, 347, 1,403
FYE 6/30/17: 359, 441, 461, 369, 1,630
FYE 6/30/18: 364, 415, 544, 442, 1,765
FYE 6/30/19: 492, 399, 517, 491, 1,899
FYE 6/30/20: 486, 427, 429, 1,342
Budget FYE 6/30/20: 488, 395, 476, 358, 1,717
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

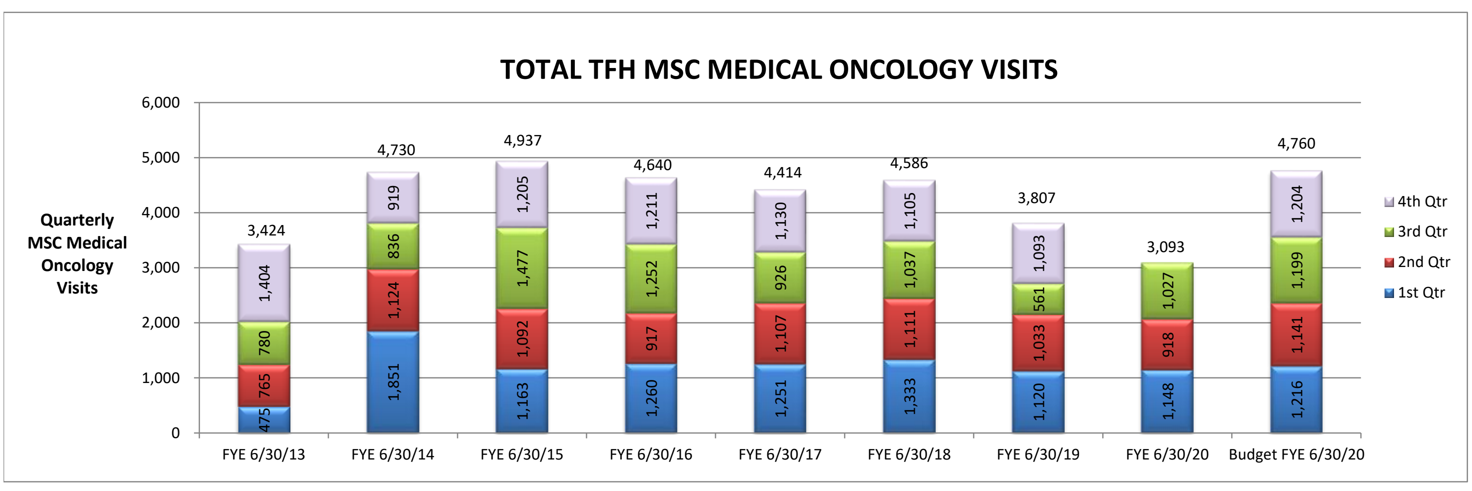

TOTAL TFH OUTPATIENT DIAGNOSTIC IMAGING EXAMS
Quarterly O/P DI Exams
0
1,000
2,000
3,000
4,000
5,000
6,000
7,000
8,000
9,000
10,000
FYE 6/30/10: 2,141, 1,906, 2,680, 1,673, 8,400
FYE 6/30/11: 2,007, 1,816, 2,431, 1,568, 7,822
FYE 6/30/12: 2,021, 1,640, 2,179, 1,601, 7,441
FYE 6/30/13: 1,892, 1,544, 2,426, 1,385, 7,247
FYE 6/30/14: 2,067, 1,606, 2,112, 1,494, 7,279
FYE 6/30/15: 2,251, 1,752, 2,158, 1,617, 7,778
FYE 6/30/16: 2,046, 1,794, 2,762, 1,899, 8,501
FYE 6/30/17: 2,315, 2,055, 2,671, 1,938, 8,979
FYE 6/30/18: 2,195, 1,904, 2,473, 2,047, 8,619
FYE 6/30/19: 2,179, 1,880, 2,419, 2,164, 8,642
FYE 6/30/20: 2,432, 2,114, 2,641, 7,187
Budget FYE 6/30/20: 2,293, 1,958, 2,490, 1,808, 8,549
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH MAMMOGRAPHY EXAMS
Quarterly Mammo Exams
0
500
1,000
1,500
2,000
2,500
3,000
3,500
4,000
4,500
5,000
FYE 6/30/10: 868, 904, 633, 738, 3,143
FYE 6/30/11: 764, 863, 658, 735, 3,020
FYE 6/30/12: 818, 946, 673, 666, 3,103
FYE 6/30/13: 674, 873, 632, 695, 2,874
FYE 6/30/14: 736, 854, 684, 604, 2,878
FYE 6/30/15: 652, 882, 788, 748, 3,070
FYE 6/30/16: 673, 847, 745, 709, 2,974
FYE 6/30/17: 749, 832, 687, 797, 3,065
FYE 6/30/18: 712, 744, 710, 856, 3,022
FYE 6/30/19: 866, 1,001, 1,150, 1,284, 4,301
FYE 6/30/20: 1,251, 1,355, 1,031, 3,637
Budget FYE 6/30/20: 1,091, 1,197, 1,039, 1,051, 4,378
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

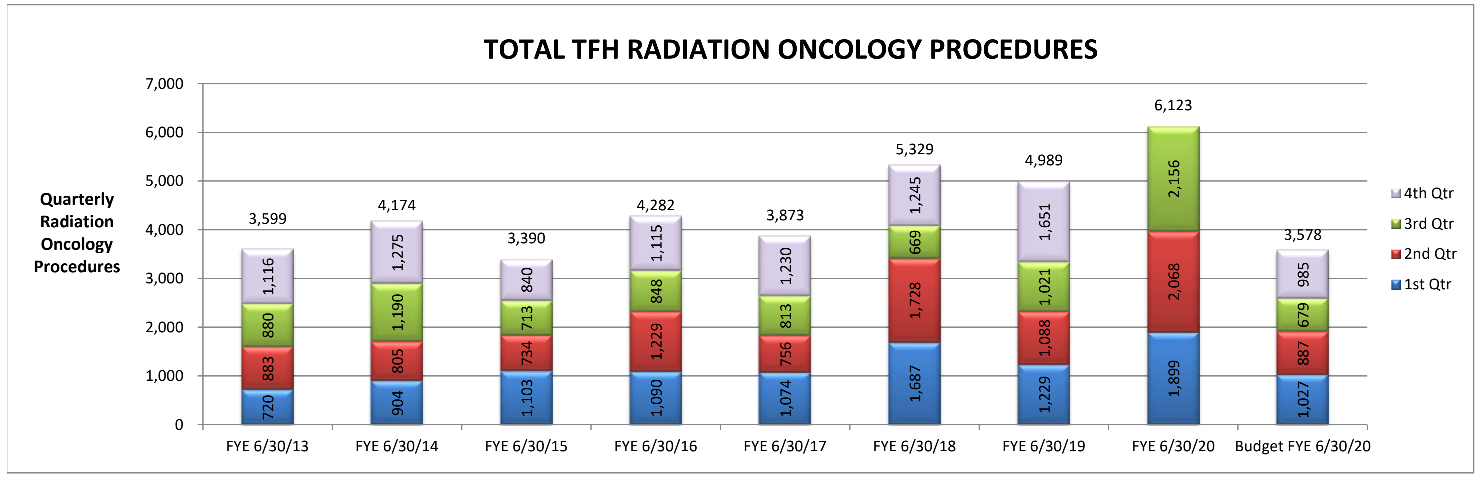

TOTAL TFH DIAGNOSTIC IMAGING EXAMS
Quarterly DI Exams
0
2,000
4,000
6,000
8,000
10,000
12,000
14,000
16,000
FYE 6/30/10: 3,541, 3,322, 3,986, 2,944, 13,635
FYE 6/30/11: 3,245, 3,136, 3,815, 2,695, 14,447
FYE 6/30/12: 3,364, 3,094, 3,411, 2,691, 13,793
FYE 6/30/13: 3,054, 2,876, 3,791, 2,386, 12,891
FYE 6/30/14: 3,131, 2,795, 3,180, 2,434, 12,560
FYE 6/30/15: 3,248, 2,987, 3,319, 2,748, 12,107
FYE 6/30/16: 3,047, 2,907, 3,969, 2,955, 11,540
FYE 6/30/17: 3,423, 3,328, 3,819, 3,104, 12,302
FYE 6/30/18: 3,271, 3,063, 3,727, 3,345, 12,878
FYE 6/30/19: 3,537, 3,280, 4,086, 3,939, 13,674
FYE 6/30/20: 4,169, 3,898, 4,101, 12,168
Budget FYE 6/30/20: 3,872, 3,550, 4,005, 3,217, 13,606
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



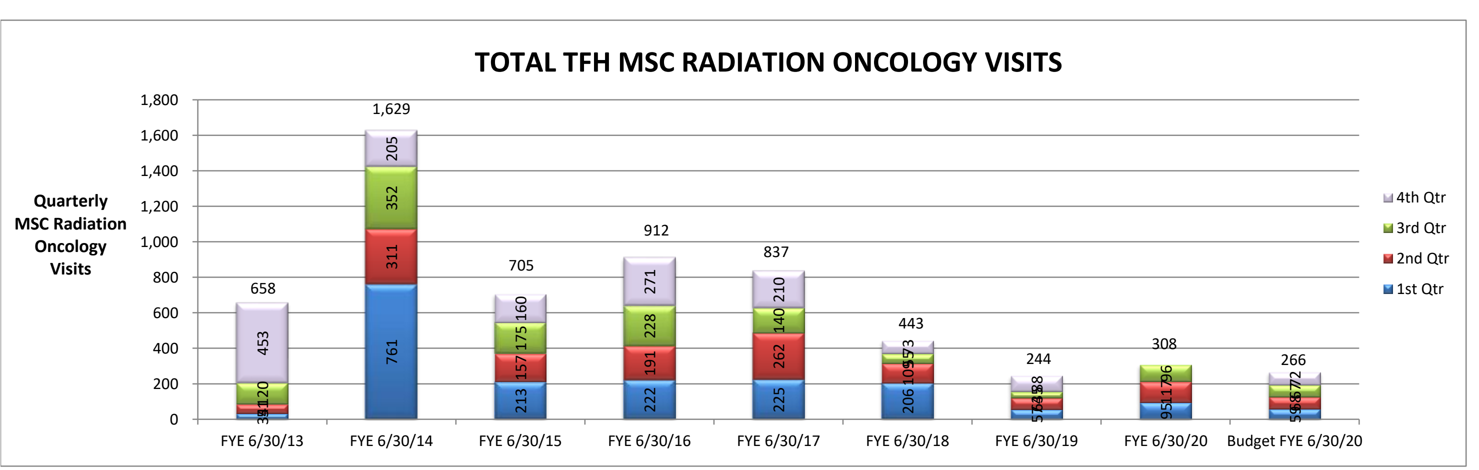
TOTAL TFH MEDICAL ONCOLOGY PROCEDURES
Quarterly Medical Oncology Procedures
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
6,044
1,118
1,633
1,743
1,550
5,537
1,584
1,315
1,243
1,395
7,322
1,815
1,664
1,692
2,151
9,146
2,333
2,563
2,022
2,228
7,947
1,854
1,796
1,839
2,458
7,737
2,022
1,831
1,874
2,010
8,836
2,074
2,520
2,114
2,128
6,168
1,747
1,935
2,486
9,300
2,245
2,078
2,594
2,383
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



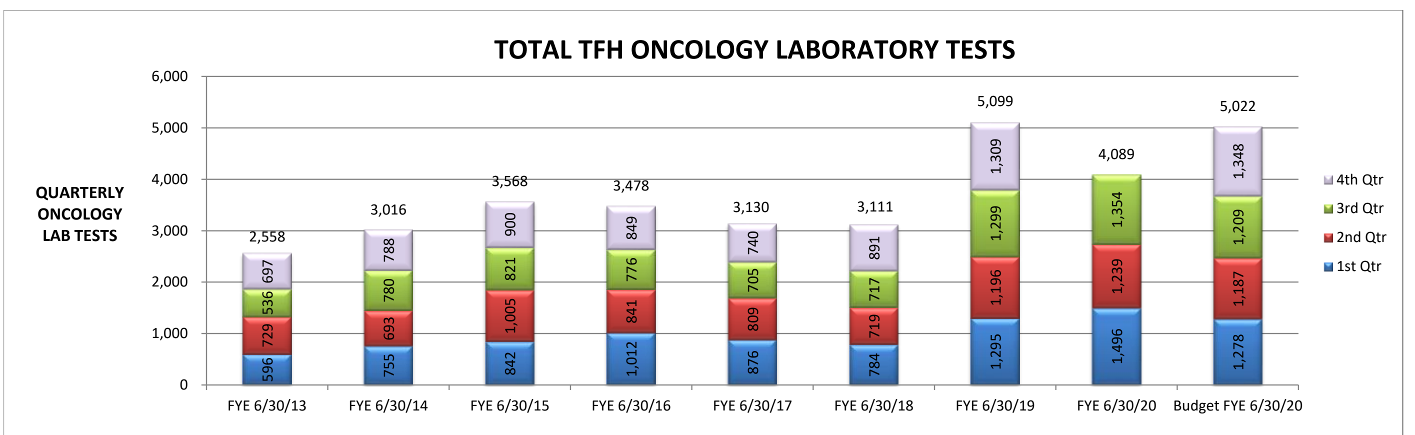
TOTAL TFH MSC MEDICAL ONCOLOGY VISITS
Quarterly MSC Medical Oncology Visits
6,000
5,000
4,000
3,000
2,000
1,000
0
3,424
1,404
780
765
475
4,730
919
836
1,124
1,851
4,937
1,205
1,477
1,092
1,163
4,640
1,211
1,252
917
1,260
4,414
1,130
926
1,107
1,251
4,586
1,105
1,037
1,111
1,333
3,807
1,093
561
1,033
1,120
3,093
1,027
918
1,148
4,760
1,204
1,199
1,141
1,216
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

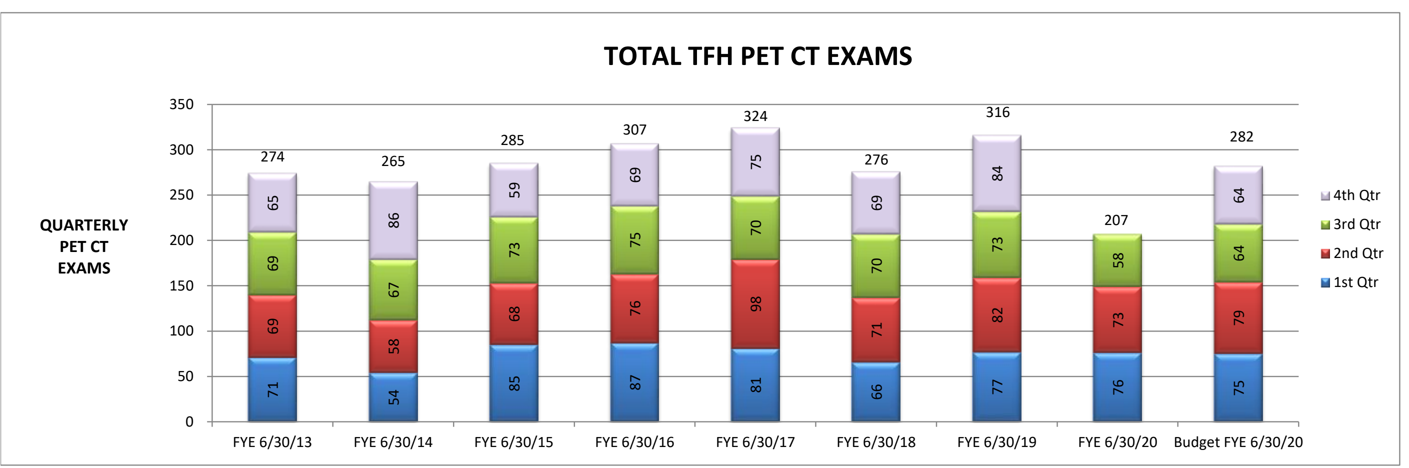


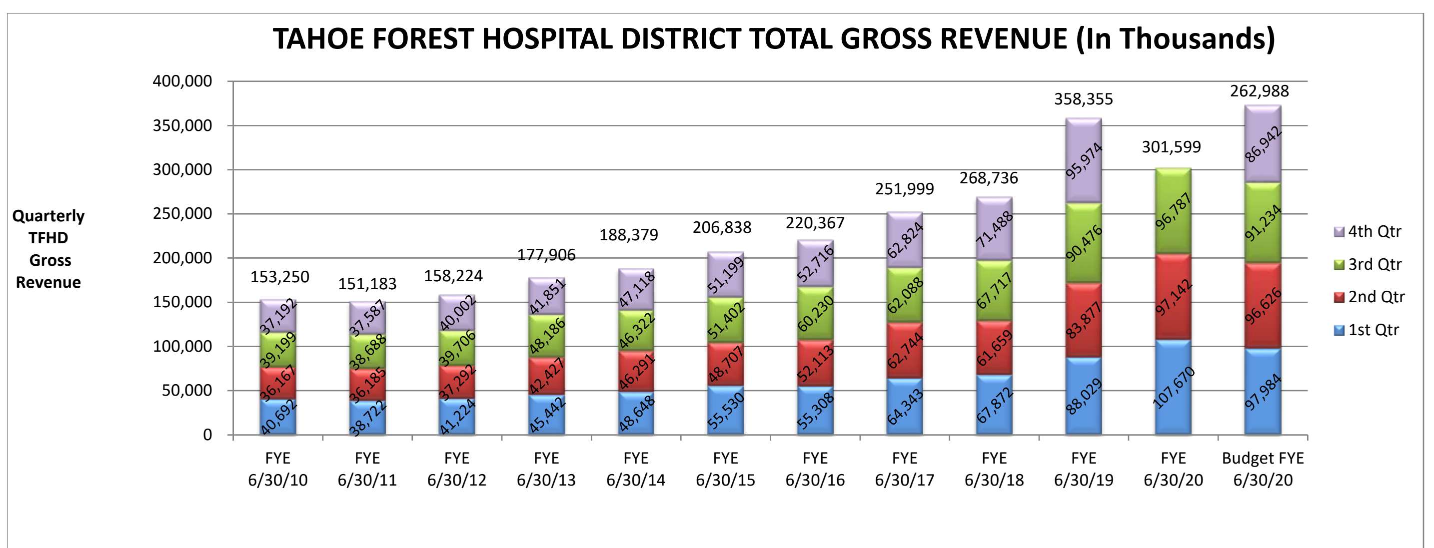
TOTAL TFH RADIATION ONCOLOGY PROCEDURES
Quarterly Radiation Oncology Procedures
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,599
1,116
880
883
720
4,174
1,275
1,190
805
904
3,390
840
713
734
1,103
4,282
1,115
848
1,229
1,090
3,873
1,230
813
756
1,074
5,329
1,245
669
1,728
1,687
4,989
1,651
1,021
1,088
1,229
6,123
2,156
2,068
1,899
3,578
985
679
887
1,027
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

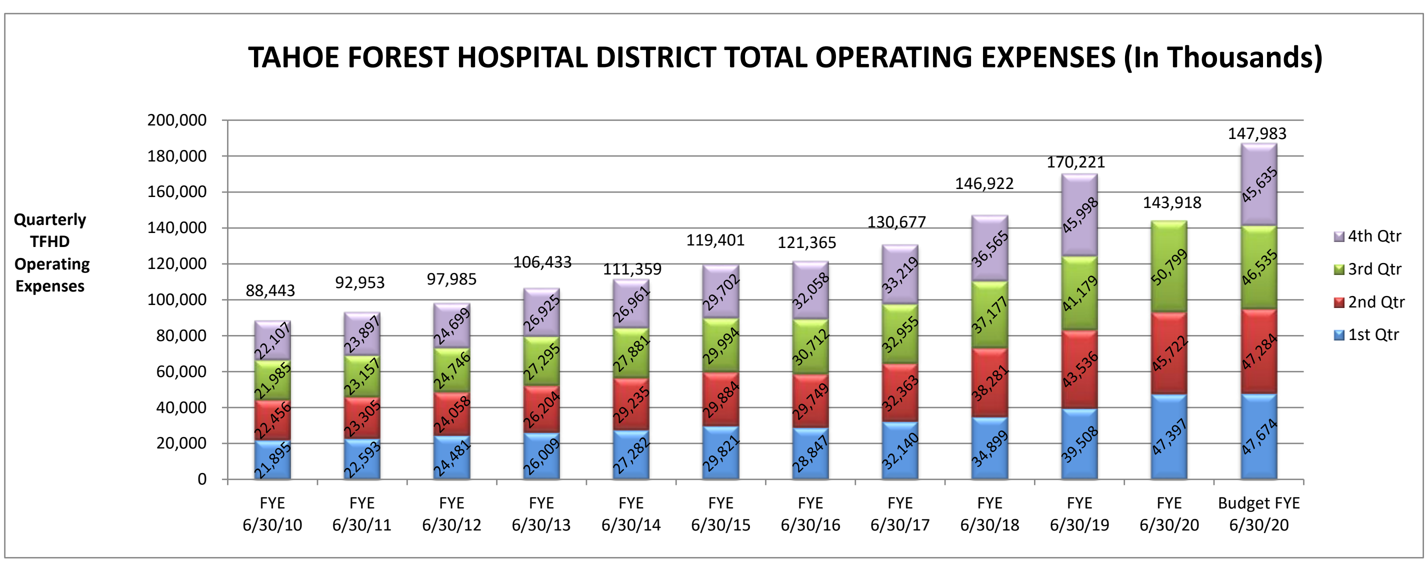


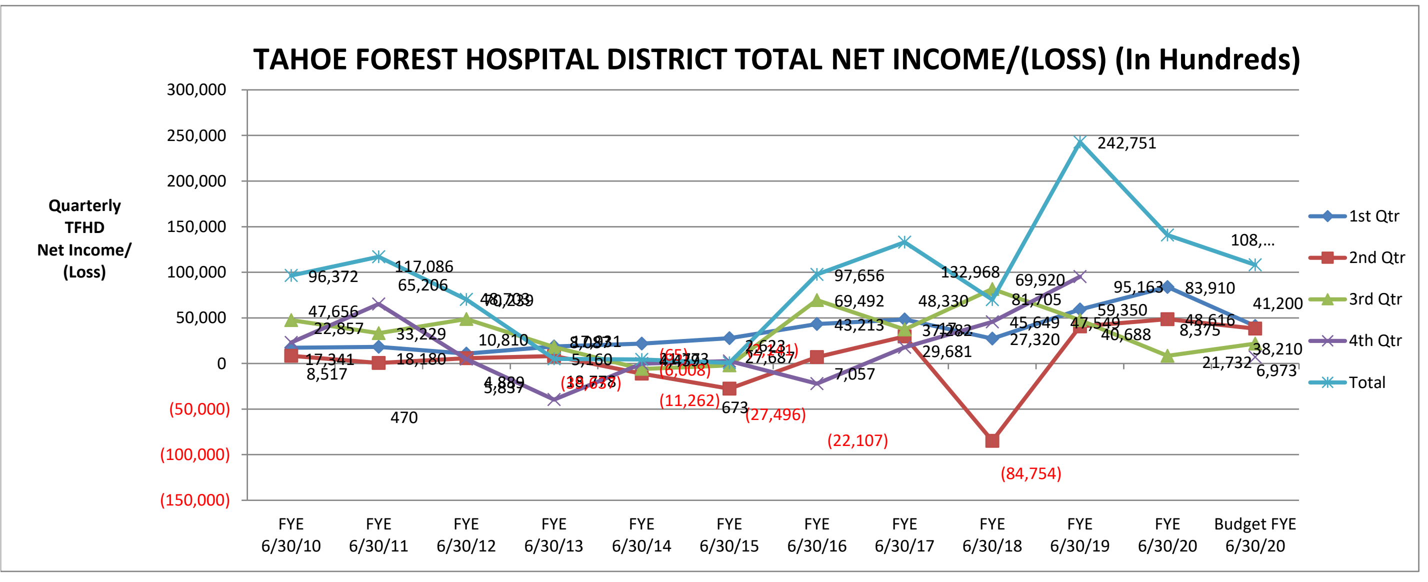
TOTAL TFH MSC RADIATION ONCOLOGY VISITS
Quarterly MSC Radiation Oncology Visits
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
658
453
1,629
205
352
311
761
705
160
175
157
213
912
271
228
191
222
837
210
140
262
225
443
206
244
308
266
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ONCOLOGY LABORATORY TESTS
QUARTERLY ONCOLOGY LAB TESTS
6,000
5,000
4,000
3,000
2,000
1,000
0
2,558
3,016
3,568
3,478
3,130
3,111
5,099
4,089
5,022
596
729
536
697
755
693
780
788
842
1,005
821
900
1,012
841
776
849
876
809
705
740
784
719
717
891
1,295
1,196
1,299
1,309
1,496
1,239
1,354
1,278
1,187
1,209
1,348
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH PET CT EXAMS
QUARTERLY PET CT EXAMS
350
300
250
200
150
100
50
0
274
265
285
307
324
276
316
207
282
71
69
69
65
54
58
67
86
85
68
73
59
87
76
75
69
81
98
70
75
66
71
70
69
77
82
73
84
76
73
58
75
79
64
64
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TAHOE FOREST HOSPITAL DISTRICT TOTAL GROSS REVENUE (In Thousands)
Quarterly TFHD Gross Revenue
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
153,250
151,183
158,224
177,906
188,379
206,838
220,367
251,999
268,736
358,355
301,599
262,988


TAHOE FOREST HOSPITAL DISTRICT TOTAL OPERATING EXPENSES (In Thousands)
Quarterly TFHD Operating Expenses
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
88,443
92,953
97,985
106,433
111,359
119,401
121,365
130,677
146,922
170,221
143,918
147,983


TAHOE FOREST HOSPITAL DISTRICT TOTAL NET INCOME/(LOSS) (In Hundreds)
Quarterly TFHD Net Income/(Loss)
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
Total
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
Budget FYE 6/30/20
96,372
117,086
242,751
132,968
97,656
(84,754)
(22,107)
(27,496)
(11,262)

AGENDA ITEM COVER SHEET

ITEM	Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09
RESPONSIBLE PARTY	Crystal Betts, Chief Financial Officer
ACTION REQUESTED?	For Board Action

BACKGROUND:

Tahoe Forest Health System recognized the novel coronavirus (COVID-19) pandemic as an Access to Healthcare Crisis and is enacting its right to flex its Financial Assistance policy to meet the immediate needs of the community in regards to care and testing related to the virus.

SUMMARY/OBJECTIVES:

CFO updated the policy to include a provision for Home Health and Hospice, as well as for declared emergencies such as COVID-19 pandemic. The policy edits were also reviewed by Director of Revenue Cycle, Director of Patient Registration and Corporate Compliance Officer.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via Consent Calendar.

LIST OF ATTACHMENTS:

- Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09
- COVID-19 Pandemic Addendum

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 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 Partial 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 billed~~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-Emergency Services" means medically necessary services that are not Emergency Services.
J. "Patient" means an individual who has received Emergency Services or Non-Emergency 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, home health, hospice 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.

~~C.~~D. During an Access to Healthcare Crisis, TFHD may "flex" its patient financial assistance policy to meet the needs of the community in crisis. It must be proclaimed by hospital leadership and attached to this patient financial assistance document as an addendum. An Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of the hospital's community during the Access to Healthcare Crisis. These changes will be included in the patient financial assistance policy as included as an addendum. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis).

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 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 shall make every reasonable effort to provide information necessary for TFHD to make a financial assistance qualification determination. TFHD 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 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 Financial Counseling 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 personnel according to the following levels of authority:
    a. Financial Counselor: Accounts less than $2,500
    b. Director of Patient Access : Accounts less than $10,000
    c. Chief Financial Officer: Accounts less than $50,000
    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 Share of Cost 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, multispecialty care clinic, home health, hospice, 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. ."

D. Primary Care and Multi-Specialty Clinics

TFHD operates certain outpatient clinics which can be located apart from the main campus of the hospital. Because of the lower cost of these services performed on an outpatient basis, the following shall apply to office visit services and professional fees 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

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

E. Home Health and Hospice Services

TFHD operates both Home Health and Hospice Services that are located apart from the hospital campus and provide care and services in patient homes per Medicare and Medi-Cal/Medicaid guidelines. Due to the lower cost related to providing care in the home for patients who are homebound verses the related additional cost of transportation and follow up in outpatient clinic or the hospital, the following shall apply to services rendered in the home setting:

a. Home Health and Hospice patients are patients of TFHD, 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 or Home Health and Hospice personnel determine 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 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.

Home Health and Hospice Sliding Scale

Patient/Family FPL Qualification	***Amount of Payment Due for Home Visit***
Incomes less than or equal to 200%	50% of the Medicare Payment Rate
Incomes	Actual Medicare

Patient/Family FPL Qualification	*Amount of Payment Due for Home Visit*
between 201% and 350%	Fee Schedule

~~E.~~F. 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 350%	100% of the Medi-Cal Payment Rate

~~F.~~G. **Payment Plans**

1. When a determination to grant Discount Partial Charity Care has been made by TFHD, 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 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) 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. TFHD 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.~~H. **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 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.~~I. **Other Eligible Circumstances**

1. TFHD deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid 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 which the government program does not cover, are eligible for Financial Assistance Program coverage. Under TFHD'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.~~J. **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.~~K. **Criteria for Re-Assignment from Bad Debt to Charity Care** (Why would we do this?)

1. Any account returned to TFHD 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.
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 a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by TFHD Patient Access Director, or Chief Financial Officer prior to any re-classification within the TFHD accounting system and records.

~~K.~~L. **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: 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 TFHD 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.~~M. **Reconsideration of Eligibility Denial**

1. In the event that a patient disputes TFHD's determination of eligibility, the patient may file a written request for reconsideration with TFHD 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's Chief Financial Officer. The Chief Financial Officer 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 Chief Financial Officer shall provide the patient with a written explanation of the results of the reconsideration of the patient's eligibility. All determinations by the Chief Financial Officer shall be final. There are no further appeals.
3. All discretionary decisions by TFHD shall not be subject to further review or reconsideration.

~~M.~~N. **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.~~O. **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.~~P. **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 TFHD'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.

COVID-19 Pandemic Addendum

Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09

Purpose:

Tahoe Forest Health System recognizes the novel coronavirus (COVID-19) pandemic as an Access to Healthcare Crisis and is enacting its right to flex its Financial Assistance policy to meet the immediate needs of the community in regards to care and testing related to the virus.

Procedure:

A. On March 11, 2020 the World Health Organization (WHO) declared the novel coronavirus outbreak a pandemic.
B. Steps taken by Tahoe Forest Health System (TFHS) prior to and after this declaration to meet the needs of the community include but are not limited to:
    a. A hotline to screen community members for potential testing needs
    b. Two drive-through clinics to facilitate evaluation and testing of patients
    c. A dedicated COVID-19 unit within the hospital for COVID-19 positive and rule out patients
    d. Transition to telemedicine visits to minimize exposure
C. TFHS recognizes that cost can be a barrier to medical care and believes it in the best interest of the community to waive cost sharing for COVID-19 care and testing.
D. TFHS will continue to monitor new legislation and payor guidelines and amend this addendum as needed.
E. This addendum is intended to be an extension of the existing policy. All other conditions apply as stated in Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09.
F. COVID-19 Care and Testing Financial Assistance Write-Off's:
    a. To assist the community in crisis, TFHS has extended its Financial Assistance policy to include COVID -19 related care and testing.
    b. The following items may be eligible for Financial Assistance Write Off:
        i. Deductibles, co-insurance, and co-pays not covered by commercial insurance/health plans or government programs.
            1. TFHS will first attempt to have these charges covered by the payor in accordance with the payor's COVID-19 cost-sharing guidelines.
        ii. All eligible charges for self-pay patients
    c. Services eligible for Financial Assistance Write-Off:
        i. COVID-19 Laboratory testing
        ii. Physician office visits including telehealth with a diagnosis of COVID-19 or COVID-19 rule out
        iii. Hospital inpatient or observation admissions with a diagnosis of COVID-19 or COVID-19 rule out
    d. Patient procedure:
        i. TFHS will monitor all accounts that meet the above criteria and process write-off's automatically without action needed from patients.

    ii. Patients will not be required to supply completed applications or submit proof on income as is normally required under the Financial Assistance policy.

G. Financial Assistance consideration for patients economically affected by the pandemic:
   a. TFHS recognizes that many community members have been economically affected by the pandemic including layoff's, furloughs, and job loss. This may affect patients' ability to pay new or outstanding balances with TFHS not related to COVID-19 services.
   b. TFHS will first attempt to help patients experiencing financial difficulty with payment options including but not limited to:
      i. Enrollment into federal or state programs such as disability, Medi-Cal/Medicaid, state exchanges, and unemployment
      ii. Payment Plans
   c. TFHS may then assist the patient to apply for Financial Assistance following the normal procedure.
      i. TFHS may ask for additional income documentation from patients to support claims of reduced income in addition to the application such as:
         1. Proof of applying for federal or state programs
         2. Recent pay stubs reflecting reduced income
         3. Recent bank statements
         4. Letter from patient employer regarding work status

AGENDA ITEM COVER SHEET

ITEM	Emergency On-Call Policy, ABD-10
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board
ACTION REQUESTED?	For Board Action

BACKGROUND:

Emergency On-Call policy, ABD-10 is due for its annual board approval.

SUMMARY/OBJECTIVES:

Emergency On-Call policy, ABD-10 was reviewed by the Chief Operating Officer, Director of Quality & Regulations, and Risk Manager with no proposed changes.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via Consent Calendar.

LIST OF ATTACHMENTS:

- Emergency On-Call policy, ABD-10

Current Status: *Active* **PolicyStat ID:** *6215707*

Origination Date:	*04/2001*
Last Approved:	*04/2019*
Last Revised:	*04/2019*
Next Review:	*04/2020*
Department:	*Board - ABD*
Applicabilities:	*System*

Emergency On-Call, ABD-10

PURPOSE:

Tahoe Forest Hospital District has an ethical, moral, social, and legal responsibility to provide screening examination and care to patients presenting to its facilities with emergency conditions. The Board understands the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "Act"), and federal and state regulations, require hospitals with a dedicated emergency department to maintain a list of physicians who are on call to come to the hospital and provide treatment as necessary to stabilize an individual with an emergency medical condition, within the capabilities of the District.

COPY

POLICY:

A. Patients who present to the Tahoe Forest Hospital District facilities requesting emergency care are entitled to a "Medical Screening Examination" as described in the Act, regardless of their ability to pay.

B. The District's Board of Directors, Administration and Medical Staff leadership will work collaboratively to determine the District's capabilities for providing 24-hour emergency health care.

C. Tahoe Forest Hospital District operates Tahoe Forest Hospital and Incline Village Community Hospital.

1. Tahoe Forest Hospital (TFH), a Critical Access Hospital has been licensed by the State of California to provide Basic Emergency Services. TFH will provide on-call physician coverage in the Emergency Department for the basic services and supplemental services listed on the hospital license:
   a. Emergency Medicine
   b. General Medicine
   c. General Surgery
   d. Radiology
   e. Anesthesia
   f. Pathology
   g. OB/Gyn
   h. Pediatrics
   i. Orthopedics
2. Incline Village Community Hospital, in Incline Village, Nevada will provide 24-hour physician coverage for Emergency and Medicine Services.
3. TFH may provide specialty activation coverage for emergency consultations and services according

to the capabilities of members of the medical staff who have privileges in that specialty.

D. The Chief Executive Officer will work with the Medical Staff to provide emergency consultative coverage that meets federal and state laws, licensing requirements and the needs of the community. To achieve these goals, the Chief Executive Officer may utilize, but not be limited to:
   1. Stipends for call coverage
   2. Contracts for professional services
   3. Locum tenens privileges
   4. Transfer agreements with other healthcare facilities
E. At least annually, Tahoe Forest Hospital District Board of Directors will review and approve the level of emergency on-call services available. We will utilize the hospital's quality assurance system to monitor emergency on-call practices.
F. In order to provide this coverage, effort will be made to create a system that is voluntary, fair and equitable without imposing an undue burden on physicians or on the Tahoe Forest Hospital District. Collaboration with members of the Tahoe Forest Hospital District's Medical Staff will be the method for providing these services, with recruitment of new physicians as needed.
G. Physicians who seek charity care fund reimbursement at Medicare rates for emergency services provided in the hospital to indigent patients, should refer to *Financial Assistance Program Full Charity Care And Discount partial Charity Care (ABD-09)* for guidance and distribution criteria. Tahoe Forest Hospital District will keep abreast of other funds, state or otherwise, that might be available for the purpose of providing payment to physicians who treat the under/uninsured population.
H. A roster and procedure are in place to address the provision of specialty medical care when services are needed which are outside the capabilities of the Tahoe Forest Hospital District and its Medical Staff.

COPY

Related Policies/Forms:

Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, ALG-1907

References:

EMTALA-California Hospital Association manual

All revision dates: 04/2019, 03/2018, 03/2017, 11/2015, 01/2014, 01/2012, 02/2010

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	04/2019

Step Description	Approver	Date
	Martina Rochefort: Clerk of the Board	04/2019

Date: April 6, 2020

To: Tahoe Forest Hospital District Board of Directors

From: Karli Epstein, Executive Director – Tahoe Forest Health System Foundation

Re: Request to ratify new TFHSF Board Candidate

Dear Tahoe Forest Hospital District Board of Directors:

At the March 19, 2020 meeting of the TFHSF Board of Directors, the board agreed to vote a new candidate, for the seating of the Foundation Board.

The Board approved this nomination on 3/19/20. These candidates will maintain the membership of the Foundation Board of no less than 6 voting members and 1 ex-officio non-voting member. Full resume is attached.

1. Alan Kern, CPA & MBA, *Alan Kern Consulting*

Respectfully submitted on behalf of Karli Epstein.

Alan Kern

SUMMARY

Operational and financial professional with expertise in helping healthcare organizations grow and develop. Skill in leading cross functional teams to accomplish goals and improvement in processes and quality of care. CPA/MBA with strong analytical skills.

PROFESSIONAL EXPERIENCE

Alan Kern Consulting **2014-Present**

Emphasis on providing interim CFO and controller services including support of daily operations, process improvement, team leadership and development, cross-functional project leadership and budgeting/forecasting:

- CFO for a software development company specializing in Salesforce application implementation and integration.
- Controller for a provider of distribution and technology solutions to the wine industry.
- CFO for a multi-state commercial construction company specializing in refurbishment of multi-unit apartments complexes.
- CFO for multi-level retirement community which provides housing, care and services to low and moderate income elders.
- CFO for a manufacturer of inspection equipment for medical devices and consumer electronic components.

PACIFIC PULMONARY SERVICES, Novato, CA **2000-2013**

PPS is a home health care provider of equipment and supplies to patients with chronic respiratory diseases. Integral part of team which grew the company to the fifth largest national provider: Annual revenue of $20mm to $250mm; 15 locations to 150+ locations; and 275 employees to 1,600 employees.

Director of Operations, 2004-2013

Developed and implemented process improvements which led to increases in quality of patient care and efficiency. Managed purchasing, logistics, fleet operations, facilities leasing and administration.

- Designed workflow and reporting system in Salesforce for insurance claims which enabled the additional submission of over $4 million of claims in 2013.
- Developed a highly efficient, third-party direct ship system for patient supplies which significantly reduced delivery time and saved $1.5mm per year.
- Led implementation of a GPS routing system which improved patient service and provided visibility and accountability for 250+ delivery technicians. Over a three year period, increased technician productivity 65% with savings in excess of $2mm per year.
- Introduced key metrics and metrics based reporting to field operations managers with associated incentive structure.
- Directed field integration for approximately 10 add-on acquisitions.

CFO, 2000-2004
Built finance and accounting team, structured capital and developed facilities to support growth of company. Directed acquisition efforts, budgeting, regulatory compliance, insurance, legal, and treasury:

- Converted company to new financial software system (Microsoft Dynamics) which enabled the company to scale to over $200 million in revenue and provide necessary financial information to managers to effectively operate the business
- Completed outside annual audits with no internal control weaknesses or adjustments.
- Developed a cash flow forecasting model which reduced the average line of credit by $500k.
- Introduced two new lenders and increased senior debt capacity from $10mm to $30mm.
- Completed 8-10 acquisitions including due diligence, financing, documentation and negotiations which represented approximately 15% of company revenue.
- Managed company compliance with Federal, state and local regulatory agencies which achieved accreditation with TJC (JCAHO) and ACHC and resulted in no fines or penalties with any regulatory agency.

REHRIG INTERNATIONAL, Richmond, VA
President **1987-1998**
Rehrig is a leading manufacturer of plastic equipment for retail stores, primarily shopping carts, material handling and product displays. 400 employees with direct sales force servicing 3,000 accounts internationally. Major customers included Target, Wal-Mart, Lowes, Home Depot, Marshalls, Costco and Safeway.

EDUCATION, CERTIFICATIONS AND TRAINING:

MBA, Stanford Graduate School of Business
BSE, Industrial Engineering, Princeton University
CPA, State of California. Active license #122668

Financial Systems: Computers Unlimited (TIMS); MFiles Document Management System; Microsoft Dynamics (Great Plains, Navision), Oracle eBusiness Suite; QuickBooks Pro/QuickBooks Online, Sage 100, Sage 300 (Timberline).

Training: Working with Emotional Intelligence; Situational Leadership; Best Match; Inside Out Coaching; Total Quality Management; (TQM), 7 Step Problem Solving Method, Lean Processes; Voice of the Customer; H&R Block income tax course, business taxation

COMMUNITY INVOLVEMENT:

Current:

- Project Redwood Grant Review Committee. Project Redwood empowers social entrepreneurs worldwide to alleviate global poverty and to improve the lives and prospects of the at-risk and disenfranchised. www.projectredwood.org

Past:

- Supporter of Novato Human Needs, now North Marin Community Services, which assists low-income people to overcome personal crises and move toward self-sufficiency. www.northmarincs.org
- Sponsor to Wellbody Alliance, a US based non-profit foundation now part of Partners in Health which provides medical and health services to underserved people in Sierra Leone. Collaborated on a grant application and received funding to construct a palm kernel processing facility in Koidu, S.L. www.pih.org

Board Informational Report

By: Jim Hook
Corporate Compliance
Consultant, The Fox Group

DATE: April 23, 2020

<u>2020 Compliance Program 1st Quarter Report (Open Session)</u>

The Compliance Committee is providing the Board of Directors (BOD) with a report of the 1st Quarter 2020 Compliance Program activities (Open Session). This report assists the BOD to meet its obligations to be knowledgeable about the content and operation of the seven components of the Compliance Program.

OPEN SESSION

Period Covered by Report: **January 1, 2020 - March 31, 2020**
Completed by: James Hook, Compliance Officer, The Fox Group

1. Written Policies and Procedures

1.1. The District's Corporate Compliance Policies and Procedures are reviewed and updated as needed.

2. Compliance Oversight / Designation of Compliance Individuals

2.1. Corporate Compliance Committee Membership as of March 31, 2020:
Jim Hook, The Fox Group – Compliance Consultants
Judy Newland, RN – Chief Operating Officer
Karen Baffone RN- Chief Nursing Officer
Harry Weiss – Chief Executive Officer
Crystal Betts – Chief Financial Officer
Jake Dorst – Chief Information and Innovation Officer
Alex MacLennan – Chief Human Resources Officer
Matt Mushet – In-house Legal Counsel
Stephanie Hanson, RN – Compliance Analyst
Helen Zurek, Interim Health Information Management Director
Temera Royston, Health Information Management Director
Scott Baker, Vice President of Physician Services
Todd Johnson, Privacy Officer and Risk Manager

3. Education & Training

3.1. All employees are assigned HIPAA Privacy and Security Rule training, and Compliance Program training, via Health Stream.

3.2. Code of Conduct and Health Stream compliance and privacy training for new Medical staff members and physician employees are completed as part of initial orientation.

4. Effective Lines of Communication/Reporting

4.1. A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Department. No reports were made either directly to the Compliance Department or through the hot line in the 1st Quarter of 2020.

4.2. HIPAA violations are reported to the Privacy Officer. The Privacy Officer maintains a log of reported events and investigations. Eight reports were made to the Privacy Officer in the 1st Quarter of 2020.

4.3. The Compliance Department published one article in the Pacesetter in the first quarter of 2020.

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1. New hires completed 75% of the required Health Stream courses in the 1st quarter. The final date to complete Health Stream corporate compliance modules for new hires in the 1st Quarter of 2020 has been extended to June 30, 2020.

5.2. All new staff hires, and newly privileged physicians, receive criminal background checks and are checked against the OIG and GSA list of exclusions prior to hiring/appointment. Members of the Medical Staff are checked against the OIG/GSA exclusion lists each month. All employees are screened against the OIG/GSA exclusion list every quarter. All vendors are checked continuously using the vendor credentialing program.

6. Auditing &Monitoring

6.1. Three audits were completed during the 1st Quarter of 2020 as part of the 2020 corporate compliance work plan.

6.1.1. Employed Physician Payments: an audit of payments to all employed physicians for the pay period ending 02/01/2020 showed no discrepancies between salaries specified in employment offer letters and actual payments in the pay period.

6.1.2. Anesthesia Administration vs. Pyxis records: There continues to be discrepancies between the medical record entries by anesthesiologists and others in Surgery and other procedural departments. However, these discrepancies do not affect the billing for medications, which are being captured in the EPIC Pharmacy application.

6.1.3. MSC/Clinic/Hospitalists/Cancer Center E/M billing and medical records audit: AQuity (outside coding company) completed an audit of the accuracy of its coding staff for the 2nd through 4th quarters of 2019. Only area of concern was accuracy of Professional Evaluation and Management services coding at 81% or less during the quarters. Sixty-six visits were “over-coded”; 106 visits were “under-coded”. All visits with changes were rebilled. Corrective actions included:

6.1.3.1. One AQuity coder no longer utilized for TFHS.

6.1.3.2. Feedback to physicians on changes to codes.

6.1.3.3. Education and corrective action for coders.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1. No investigations of suspected and actual compliance issues incidents were initiated during the 1st Quarter of 2020.

8. Routine Compliance Support

8.1. The Compliance Department provides routine support to important TFHD initiatives, such as the terms and conditions of physician employment, and questions about billing, and compliance with other laws and regulations.

FY2020 FOUNDATION UPDATE

Tahoe Forest Health System Foundation FUNDRAISING Totals:

End of Year Appeal 2019: $144,600

End of Year Appeal 2018: $84,967

Annual Contributions:

FY 20 (July 1- April 16, 2020): $1,136,304

FY 19 (July 1- April 6, 2019): $472,290

TFHSF COVID 19 Emergency Response Fund (as of 4/16/20): $202,390

Incline Village Community Hospital Foundation FUNDRAISING Totals:

End of Year Appeal 2019: $212,046

End of Year Appeal 2018: $159,750

Annual Contributions:

FY 20 (July 1-April 16, 2020): $936,531

FY 19 (July 1- April 16, 2019): $415,205

2019 Kern Event: $486,947

2018 Kern Event: $226,356

IVCHF COVID 19 Emergency Response Fund (as of 4/16/20): $166,367

The Dave & Cheryl Duffield Foundation have also committed $350,000 to support this fund, which will increase the total to $516,367!

Donor Engagement:

Recognizing, thanking, and engaging with our donors is essential for the overall success of both Foundations. We have solidified a donor recognition plan which includes calling, emailing, and sending hand written thank you notes to donors at different donor levels. This structured stewardship plan (see attached) will help build lasting relationships with Tahoe Forest Health System supporters. Both Foundations are also working on creating a more solidified Planned Giving program, which will provide several ways for donors to support the Foundations through their estate planning.

TFHSF Highlights

This Fiscal Year the Tahoe Forest Health System Foundation held a donor recognition event where donors as well as physicians were invited to hear updates on the Health System, and

learn more about the impact of their giving. Over 70 donors attended, and we plan on making this an annual event.

IVCHF Highlights

Every summer IVCHF holds its annual Lakefront Reception for major donors. This year the Foundation was raising funds for a surgical services expansion at IVCH, which would include new sterile processing equipment. That evening almost $500,000 was raised for the project.

In addition, a generous IVCHF Board Member hosted a Physician Reception to help welcome two new IVCH physicians; Dr. Marshall Clyde and Dr. Jonathan Hagen. The event had a dual purpose; to help build practices for the new physicians and engage our donors. Over 50 people attended.

Team Member Giving:

Last year both Foundations revamped Team Member Giving to be a more robust and inclusive program. The launch period is held for 6 weeks starting the week of February 14th. Tahoe Forest team members are encouraged to share their stories about why they choose to give, and that is shared organization wide. A volunteer committee helps to direct the funds that are given to the Team Member Giving Fund, and this year employees voted to support the purchase of IPads for the Behavioral Health Program. We hope with more transparency and trust this program will continue to grow.

Total giving for team member giving has increased from $17,000 to over $50,000, and will fund essential programs and services at both TFHS and IVCH.

Awareness:

This year TFHSF wanted to improve community awareness of both the Foundation and the Health System. This involved created more opportunities to share the mission one on one with individuals, and have a stronger social media presence through the Tahoe Forest Health System channels.

In Home Events

This FY TFHSF hosted 3 in home events, including one at Martis Camp and one at Lahontan. Tahoe Forest Leadership spoke about the Hospital's long term vision, and how the Health System is addressing the health care needs of both full time and part time residents. These events were strongly attended, and opened the door to future conversations with both of those communities.

#GivingTuesday

This year the Health System participated in its first ever #GivingTuesday. The TFHSF Board created a $1,000 match, and all gifts over $25 were entered to win an Epic Local season pass thanks to the Epic Promise program. Over the course of 6 weeks leading up to #GivingTuesday the Foundation shared donor stories through social media and constant contact. The goal was to create momentum around giving to the hospital, and share all of the programs that the Foundation supports. In total $26,000 was raised for #GivingTuesday. TFHSF plans to participate next year, and will start planning early in the fall for an even more successful roll out.

Special Events:

Best of Tahoe Chefs 2020

Unfortunately, due to the COVID-19 pandemic, Best of Tahoe Chefs 2020 has been cancelled. The Ritz has rolled over all deposits to May 23, 2021. Our team had solidified over $75,000 in sponsorships for the event, and 30 chefs were once again participating. All sponsors, chefs, volunteers, and community members who purchased tickets have been contacted. TFHSF is incredibly grateful to have received a planned gift, of which $119,000 has been allocated to Oncology Support Services for this year. Between this gift and community members and sponsors who donated their tickets to support the cause; the Foundation will be able to provide over $150,000 to the Oncology Support Services program for FY21. We look forward to celebrating with our community in 2021!

2019 TFHS Stewardship Matrix

Tahoe Forest Health System Foundation

	MAJOR $10K+	$5K	$1K	GRATEFUL PATIENT	EMPLOYEES	ANNUAL	BOTC	LEGACY DONORS
COMMUNICATIONS								
Acknowledgement Letter	●	●	●	●	●	●		●
Handwritten Thank you note	●	●	●					●
Thank you call	●	●	●	●				
Thank you email	●	●	●		●	●		
Birthday Card	●	●	●					●
Quarterly E-Newsletter	●	●	●	●	●	●		●
Stewardship Report	●	●	●	●	●	●		●
Save the Date(s) Postcard	●	●	●	●		●		●
EVENTS								
Best of Tahoe Chefs	●	●	●				●	●
Insider's Update - Planned Giving/ Tax	●	●	●					●
Philanthropy Luncheon	●	●	●					●
Prospect/Donor Reception	*varied*	*varied*	*varied*					*varied*
Major Donor Recognition Event	●	●						●
OTHER								
Volunteer Opportunities	●			●	●		●	
Gift Tree Events	●	●	●	●	●			
Post-Event Framed Photos	●	●					●	
Donor Wall	●	●						*varied*
Naming Recognition	*varied*	*varied*	*varied*					*varied*
TOTAL CONTACTS	**17**	**15**	**13**	**7**	**6**	**5**	**3**	**11**

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2020-__

RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT DECLARING AND CONFIRMING A STATE OF EMERGENCY DUE TO SPREAD AND THREATENED SPREAD OF COVID-19

WHEREAS, on March 3, 2020, the Placer County Public Health Department declared a local health emergency and a local emergency under Government Code section 8630 due to a novel coronavirus named SARSCoV-2, and the disease it causes, abbreviated COVID-19;

WHEREAS, on March 4, 2020, the Governor of California declared a Statewide state of emergency due to COVID-19;

WHEREAS, on March 6, 2020, Nevada County declared a local health emergency and a local emergency under Government Code section 8630 due to COVID-19;

WHEREAS, on March 10, 2020, the Town of Truckee declared a local emergency under Government Code section 8630 due to COVID-19;

WHEREAS, on March 13, 2020, the President of the United States declared a national emergency because of COVID-19;

WHEREAS, Tahoe Forest Hospital District ("District") is a local health care district duly organized and existing under the Local Health Care District Law of the State of California;

WHEREAS, COVID-19 continues to pose a substantial threat to public health, safety and welfare within the District and the communities it serves, and imposes new and significant burdens on District operations;

WHEREAS, the District is empowered to take certain actions under the Local Health Care District Law and other applicable State laws upon determination that an emergency exists warranting such actions; and

WHEREAS, the District is authorized under Health and Safety Code section 32121, subdivision (k) do any and all other acts and things necessary to carry out the Local Health Care District Law.

NOW, THEREFORE, BE IT RESOLVED, the Board of Directors of the Tahoe Forest Hospital District hereby declares that a state of emergency exists and has existed due to the spread and threatened continued spread of COVID-19.

NOW, THEREFORE, BE IT FURTHER RESOLVED, that the Board of Directors of the Tahoe Forest Hospital District hereby declares that the District is empowered to take

all actions pursuant to this emergency declaration that are permitted in a state of emergency under the Local Healthcare District Law and other applicable State laws.

The state of emergency shall remain in effect until terminated by the Board of Directors of the Tahoe Forest Hospital District at the earliest date conditions warrant.

PASSED AND ADOPTED at a regular meeting of the Board of Directors of the Tahoe Forest Hospital District duly called and held in the District this 23rd day of April, 2020 by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

APPROVED:

____
ALYCE WONG
Chair, Board of Directors
Tahoe Forest Hospital District

ATTEST:

____
MARTINA ROCHEFORT, Clerk of the Board
Tahoe Forest Hospital District

T (916) 503-8100
F (916) 503-8101

2882 Prospect Park Drive
Suite 300
Rancho Cordova, CA 95670

October 24, 2019

Crystal Betts
Chief Financial Officer
Tahoe Forest Health System
P.O. Box 759
Truckee, CA 96160

Re: Audit and Nonattest Services

Dear Ms. Betts,

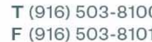
Thank you for the opportunity to provide services to Tahoe Forest Hospital District, Tahoe Forest Health System Foundation, and Incline Village Community Hospital Foundation. This engagement letter (“Engagement Letter”) and the attached Professional Services Agreement, which is incorporated by this reference, confirm our acceptance and understanding of the terms and objectives of our engagement, and limitations of the services that Moss Adams LLP (“Moss Adams,” “we,” “us,” and “our”) will provide to Tahoe Forest Hospital District (“TFHD”), Tahoe Forest Health System Foundation (“TFHSF”), and Incline Village Community Hospital Foundation (“IVCHF”) (“you,” “your,” and “Organization”).

Scope of Services – Audit

You have requested that we audit the TFHD’s combined financial statements, which comprise the combined statements of net position as of June 30, 2020; June 30, 2021; and June 30, 2022, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements. We have not been engaged to report on whether the Management's Discussion and Analysis, presented as required supplementary information, is fairly stated, in all material respects, in relation to the combined financial statements as a whole.

You have requested that we audit the TFHSF’s financial statements, which comprise the statements of financial position as of June 30, 2020; June 30, 2021; and June 30, 2022, and the related statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the financial statements.

You have requested that we audit the IVCHF’s financial statements, which comprise the statements of financial position as of June 30, 2020; June 30, 2021; and June 30, 2022, and the related statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the financial statements.



Scope of Services and Limitations – Nonattest

We will provide the Organization's with the following nonattest services:

1. Assist you in drafting TFHD's combined financial statements and related footnotes as of and for each of the years ending June 30, 2020; June 30, 2021; and June 30, 2022.
2. Assist you in drafting TFHSF's financial statements and related footnotes as of and for each of the years ending June 30, 2020; June 30, 2021; and June 30, 2022.
3. Assist you in drafting IVCHF's financial statements and related footnotes as of and for each of the years ending June 30, 2020; June 30, 2021; and June 30, 2022.

Our professional standards require that we remain independent with respect to our attest clients, including those situations where we also provide nonattest services such as those identified in the preceding paragraphs. As a result, Organization's management must accept the responsibilities set forth below related to this engagement:

- Assume all management responsibilities.
- Oversee the service by designating an individual, preferably within senior management, who possesses skill, knowledge, and/or experience to oversee our nonattest services. The individual is not required to possess the expertise to perform or reperform the services.
- Evaluate the adequacy and results of the nonattest services performed.
- Accept responsibility for the results of the nonattest services performed.

It is our understanding that you have been designated by the Organization's to oversee the nonattest services and that in the opinion of the Organization's you are qualified to oversee our nonattest services as outlined above. If any issues or concerns in this area arise during the course of our engagement, we will discuss them with you prior to continuing with the engagement.

Timing

Kate Jackson is responsible for supervising the engagement and authorizing the signing of the report. We expect to begin the audit fieldwork for this engagement at your offices in early May of each year, and the audit engagement plan calls for two weeks of on-site procedures at year end from approximately August 31st through September 11th of each year. As we reach the conclusion of the audit, we will coordinate with you the date the audited combined financial statements for TFHD and audited financial statements for TFHSF and IVCHF will be available for issuance. You understand that (1) you will be required to consider subsequent events through the date the combined financial statements for TFHD and financial statements for TFHSF and IVCHF are available for issuance, (2) you will disclose in the notes to the combined financial statements for TFHD and financial statements for TFHSF and IVCHF the date through which subsequent events have been considered, and (3) the

subsequent event date disclosed in the footnotes will not be earlier than the date of the management representation letter and the date of the report of independent auditors.

Our scheduling depends on your completion of the year-end closing and adjusting process prior to our arrival to begin the fieldwork. We may experience delays in completing our services due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

Fees

Our fees for the services will be:

Entity	FY 2020	FY 2021	FY 2022
Tahoe Forest Hospital District	$72,500	$75,500	$78,500
Tahoe Forest Health System Foundation	$21,500	$22,350	$23,250
Incline Village Community Hospital Foundation	$18,000	$18,750	$19,500
Estimated Out-of-pocket Expenses	$9,500	$9,500	$9,500
Total	$121,500	$126,100	$130,750

Our ability to provide services in accordance with our estimated fees depends on the quality, timeliness, and accuracy of the Organization's records, and, for example, the number of general ledger adjustments required as a result of our work. To assist you in this process, we will provide you with a Client Audit Preparation Schedule that identifies the key work you will need to perform in preparation for the audit. We will also need your accounting staff to be readily available during the engagement to respond in a timely manner to our requests. Lack of preparation, poor records, general ledger adjustments, and/or untimely assistance will result in an increase of our fees.

Reporting

We will issue a written report upon completion of our audit of the TFHD's combined financial statements and TFHSF's and IVCHF's financial statements. Our report will be addressed to the Board of Directors of the Organization's. We cannot provide assurance that an unmodified opinion will be expressed. Circumstances may arise in which it is necessary for us to modify our opinion, add an emphasis-of-matter or other-matter paragraph(s), or withdraw from the engagement. Our services will be concluded upon delivery to you of our report on your combined financial statements for TFHD and financial statements for TFHSF and IVCHF for each of the years ending June 30, 2020; June 30, 2021; and June 30, 2022.

We appreciate the opportunity to be of service to you. If you agree with the terms of our engagement as set forth in the Agreement, please sign the enclosed copy of this letter and return it to us with the Professional Services Agreement.

Very truly yours,

Kate Jackson, Partner, for
Moss Adams LLP

Enclosures

Accepted and Agreed:

This Engagement Letter and the attached Professional Services Agreement set forth the entire understanding of Tahoe Forest Hospital District, Tahoe Forest Health System Foundation, and Incline Village Community Hospital Foundation with respect to this engagement and the services to be provided by Moss Adams LLP:

Tahoe Forest Hospital District

Signature:________________________________

Print Name:______________________________

Title:___________________________________

Date:___________________________________

Tahoe Forest Health System Foundation

Signature:________________________________

Print Name:______________________________

Title:___________________________________

Date:___________________________________

Incline Village Community Hospital Foundation

Signature:________________________________

Print Name:______________________________

Title:___________________________________

Date:___________________________________

Client: #642541
v. 2/18/2019

PROFESSIONAL SERVICES AGREEMENT
Audit and Nonattest Services

This Professional Services Agreement (the "PSA") together with the Engagement Letter, which is hereby incorporated by reference, represents the entire agreement (the "Agreement") relating to services that Moss Adams will provide to the Organization's. Any undefined terms in this PSA shall have the same meaning as set forth in the Engagement Letter.

Objective of the Audit

The objective of our audit is the expression of an opinion on the financial statements and supplementary information. We will conduct our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). It will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion. If our opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or to issue a report as a result of this engagement.

Procedures and Limitations

Our procedures may include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of certain receivables and certain other assets, liabilities and transaction details by correspondence with selected customers, creditors, and financial institutions. We may also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. The supplementary information will be subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves. At the conclusion of our audit, we will require certain written representations from management about the financial statements and supplementary information and related matters. Management's failure to provide representations to our satisfaction will preclude us from issuing our report.

An audit includes examining evidence, on a test basis, supporting the amounts and disclosures in the financial statements. Therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. Also, we will plan and perform the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. Such material misstatements may include errors, fraudulent financial reporting, misappropriation of assets, or noncompliance with the provisions of laws or regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity that may have a direct financial statement impact. Because of the inherent limitations of an audit, together with the inherent limitations of internal control, an unavoidable risk exists that some material misstatements and noncompliance may not be detected, even though the audit is properly planned and performed in accordance with U.S. GAAS. An audit is not designed to detect immaterial misstatements or noncompliance with the provisions of laws or regulations that do not have a direct and material effect on the financial statements. However, we will inform you of any material errors, fraudulent financial reporting, misappropriation of assets, and noncompliance with the provisions of laws or regulations that come to our attention, unless clearly inconsequential. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any time period for which we are not engaged as auditors.

Our audit will include obtaining an understanding of the Organization's and its environment, including its internal control sufficient to assess the risks of material misstatements of the financial statements whether due to error or fraud and to design the nature, timing, and extent of further audit procedures to be performed. An audit is not designed to provide assurance on internal control or to identify deficiencies in the design or operation of internal control. However, if, during the audit, we become aware of any matters involving internal control or its operation that we consider to be significant deficiencies under standards established by the American Institute of Certified Public Accountants, we will communicate them in writing to management and those charged with governance. We will also identify if we consider any significant deficiency, or combination of significant deficiencies, to be a material weakness.

We may assist management in the preparation of the Organization's financial statements and supplementary information. Regardless of any assistance we may render, all information included in the financial statements and supplementary information remains the representation of management. We may issue a preliminary draft of the financial statements and supplementary information to you for your review. Any preliminary draft financial statements and supplementary information should not be relied upon, reproduced, or otherwise distributed without the written permission of Moss Adams.

Management's Responsibility for Financial Statements

As a condition of our engagement, management acknowledges and understands that management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America. We may advise management about appropriate accounting principles and their application and may assist in the preparation of your financial statements, but management remains responsible for the financial statements. Management also acknowledges and understands that management is responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to error or fraud. This responsibility includes the maintenance of

adequate records, the selection and application of accounting principles, and the safeguarding of assets. You are responsible for informing us about all known or suspected fraud affecting the Organization's involving: (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on the financial statements. You are responsible for informing us of your knowledge of any allegations of fraud or suspected fraud affecting the Organization's received in communications from employees, former employees, regulators or others. Management is responsible for adjusting the financial statements to correct material misstatements and for confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements as a whole. Management is also responsible for identifying and ensuring that the Organization's comply with applicable laws and regulations.

Management is responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. Management agrees that as a condition of our engagement, management will provide us with:

4. access to all information of which management is aware that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters;
5. additional information that we may request from management for the purpose of the audit; and
6. unrestricted access to persons within the Organization's from whom we determine it necessary to obtain audit evidence.

Management's Responsibility for Supplementary Information

Management is responsible for the preparation of the supplementary information in accordance with the applicable criteria. Management agrees to include the auditor's report on the supplementary information in any document that contains the supplementary information and that indicates that we have reported on such supplementary information. Management is responsible to present the supplementary information with the audited financial statements or, if the supplementary information will not be presented with the audited financial statements, to make the audited financial statements readily available to the intended users of the supplementary information no later than the date of issuance by the entity of the supplementary information and the auditor's report thereon. For purposes of this Agreement, audited financial statements are deemed to be readily available if a third party user can obtain the audited financial statements without any further action by management. For example, financial statements on your Web site may be considered readily available, but being available upon request is not considered readily available.

Dissemination of Financial Statements

Our report on the financial statements must be associated only with the financial statements that were the subject of our engagement. You may make copies of our report, but only if the entire financial statements (including related footnotes and supplementary information, as appropriate) are reproduced and distributed with our report. You agree not to reproduce or associate our report with any other financial statements, or portions thereof, that are not the subject of this engagement.

Offering of Securities

This Agreement does not contemplate Moss Adams providing any services in connection with the offering of securities, whether registered or exempt from registration, and Moss Adams will charge additional fees to provide any such services. You agree not to incorporate or reference our report in a private placement or other offering of your equity or debt securities without our express written permission. You further agree we are under no obligation to reissue our report or provide written permission for the use of our report at a later date in connection with an offering of securities, the issuance of debt instruments, or for any other circumstance. We will determine, at our sole discretion, whether we will reissue our report or provide written permission for the use of our report only after we have conducted any procedures we deem necessary in the circumstances. You agree to provide us with adequate time to review documents where (a) our report is requested to be reissued, (b) our report is included in the offering document or referred to therein, or (c) reference to our firm is expected to be made. If we decide to reissue our report or provide written permission to the use of our report, you agree that Moss Adams will be included on each distribution of draft offering materials and we will receive a complete set of final documents. If we decide not to reissue our report or withhold our written permission to use our report, you may be required to engage another firm to audit periods covered by our audit reports, and that firm will likely bill you for its services. While the successor auditor may request access to our engagement documentation for those periods, we are under no obligation to permit such access.

Changes in Professional or Accounting Standards

To the extent that future federal, state, or professional rule-making activities require modification of our audit approach, procedures, scope of work, etc., we will advise you of such changes and the impact on our fee estimate. If we are unable to agree on the additional fees, if any, that may be required to implement any new accounting and auditing standards that are required to be adopted and applied as part of our engagement, we may terminate this Agreement as provided herein, regardless of the stage of completion.

Representations of Management

During the course of our engagement, we may request information and explanations from management regarding, among other matters, the Organization's operations, internal control, future plans, specific transactions, and accounting systems and procedures. At the conclusion of our engagement, we will require, as a precondition to the issuance of our report, that management provide us with a written representation letter confirming some or all of the representations made during the engagement. The procedures that we will perform in our engagement will be heavily influenced by the representations that we receive from management. Accordingly, false representations could cause us to expend unnecessary efforts or could cause a material error or fraud to go undetected by our procedures. In view of the foregoing, you agree that we will not be responsible for any misstatements in the Organization's financial statements and supplementary information that we fail to detect as a result of false or misleading representations, whether oral or written, that are made to us by the Organization's management. While we may assist management in the preparation of the representation letter, it is management's responsibility to carefully review and understand the representations made therein.

In addition, because our failure to detect material misstatements could cause others relying upon our audit report to incur damages, the Organization's further agrees to indemnify and hold us harmless from any liability and all costs (including legal fees) that we may incur in connection with claims based upon our failure to detect material misstatements in the Organization's financial statements and supplementary information resulting in whole or in part from knowingly false or misleading representations made to us by any member of the Organization's management.

Fees and Expenses

The Organization's acknowledge that the following circumstances will result in an increase of our fees:

7. Failure to prepare for the audit as evidenced by accounts and records that have not been subject to normal year-end closing and reconciliation procedures;
8. Failure to complete the audit preparation work by the applicable due dates;
9. Significant unanticipated transactions, audit issues, or other such circumstances;
10. Delays causing scheduling changes or disruption of fieldwork;
11. After audit or post fieldwork circumstances requiring revisions to work previously completed or delays in resolution of issues that extend the period of time necessary to complete the audit;
12. Issues with the prior audit firm, prior year account balances or report disclosures that impact the current year engagement; and
13. An excessive number of audit adjustments.

We will endeavor to advise you in the event these circumstances occur, however we may be unable to determine the impact on the estimated fee until the conclusion of the engagement. We will bill any additional amounts based on the experience of the individuals involved and the amount of work performed.

Billings are due upon presentation and become delinquent if not paid within 30 days of the invoice date. Any past due fee under this Agreement shall bear interest at the highest rate allowed by law on any unpaid balance. In addition to fees, you may be billed for expenses and any applicable sales and gross receipts tax. Direct expenses may be charged based on out-of-pocket expenditures, per diem allotments, and mileage reimbursements, depending on the nature of the expense. Indirect expenses, such as processing time and technology expenses, may be passed through at our estimated cost and may be billed as a flat charge or a percentage of fees. If we elect to suspend our engagement for nonpayment, we may not resume our work until the account is paid in full. If we elect to terminate our services for nonpayment, or as otherwise provided in this Agreement, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our work. You will be obligated to compensate us for fees earned for services

rendered and to reimburse us for expenses. You acknowledge and agree that in the event we stop work or terminate this Agreement as a result of your failure to pay on a timely basis for services rendered by Moss Adams as provided in this Agreement, or if we terminate this Agreement for any other reason, we shall not be liable to you for any damages that occur as a result of our ceasing to render services.

Limitation on Liability

IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES IN CONNECTION WITH OR OTHERWISE ARISING OUT OF THIS AGREEMENT, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT.

Subpoena or Other Release of Documents

As a result of our services to you, we may be required or requested to provide information or documents to you or a third-party in connection with governmental regulations or activities, or a legal, arbitration or administrative proceeding (including a grand jury investigation), in which we are not a party. You may, within the time permitted for our firm to respond to any request, initiate such legal action as you deem appropriate to protect information from discovery. If you take no action within the time permitted for us to respond or if your action does not result in a judicial order protecting us from supplying requested information, we will construe your inaction or failure as consent to comply with the request. Our efforts in complying with such requests or demands will be deemed a part of this engagement and we shall be entitled to additional compensation for our time and reimbursement for our out-of-pocket expenditures (including legal fees) in complying with such request or demand.

Document Retention Policy

At the conclusion of this engagement, we will return to you all original records you supplied to us. Your Organization's records are the primary records for your operations and comprise the backup and support for the results of this engagement. Our records and files, including our engagement documentation whether kept on paper or electronic media, are our property and are not a substitute for your own records. Our firm policy calls for us to destroy our engagement files and all pertinent engagement documentation after a retention period of seven years (or longer, if required by law or regulation), after which time these items will no longer be available. We are under no obligation to notify you regarding the destruction of our records. We reserve the right to modify the retention period without notifying you. Catastrophic events or physical deterioration may result in our firm's records being unavailable before the expiration of the above retention period.

Except as set forth above, you agree that Moss Adams may destroy paper originals and copies of any documents, including, without limitation, correspondence, agreements, and representation letters, and retain only digital images thereof.

Use of Electronic Communication

In the interest of facilitating our services to you, we may communicate by facsimile transmission or send electronic mail over the Internet. Such communications may include information that is confidential. We employ measures in the use of electronic communications designed to provide reasonable assurance that data security is maintained. While we will use our best efforts to keep such communications secure in accordance with our obligations under applicable laws and professional standards, you recognize and accept we have no control over the unauthorized interception of these communications once they have been sent. Unless you issue specific instructions to do otherwise, we will assume you consent to our use of electronic communications to your representatives and other use of these electronic devices during the term of this Agreement as we deem appropriate.

Use of Third-Party Service Providers

We may use third-party service providers in serving you. In such circumstances, if we need to share confidential information with these service providers, we will require that they maintain the confidentiality of your information.

Enforceability

In the event that any portion of this Agreement is deemed invalid or unenforceable, said finding shall not operate to invalidate the remainder of this Agreement.

Entire Agreement

This Professional Services Agreement and Engagement Letter constitute the entire agreement and understanding between Moss Adams and the Organization's. The Organization's agrees that in entering into this Agreement it is not relying and has not relied upon any oral or other representations, promise or statement made by anyone which is not set forth herein.

In the event the parties fail to enter into a new Agreement for each subsequent calendar year in which Moss Adams provides services to the Organization's, the terms and conditions of this PSA shall continue in force until such time as the parties execute a new written Agreement or terminate their relationship, whichever occurs first.

Use of Moss Adams' Name

The Organization's may not use any of Moss Adams' name, trademarks, service marks or logo in connection with the services contemplated by this Agreement or otherwise without the prior written permission of Moss Adams, which permission may be withheld for any or no reason and may be subject to certain conditions.

Use of Nonlicensed Personnel

Certain engagement personnel who are not licensed as certified public accountants may provide services during this engagement.

Dispute Resolution Procedure, Venue and Limitation Period

This Agreement shall be governed by the laws of the state of Washington, without giving effect to any conflicts of laws principles. If a dispute arises out of or relates to the engagement described herein, and if the dispute cannot be settled through negotiations, the parties agree first to try in good faith to settle the dispute by mediation using an agreed upon mediator. If the parties are unable to agree on a mediator, the parties shall petition the state court that would have jurisdiction over this matter if litigation were to ensue and request the appointment of a mediator, and such appointment shall be binding on the parties. Each party shall be responsible for its own mediation expenses, and shall share equally in the mediator's fees and expenses.

If the claim or dispute cannot be settled through mediation, each party hereby irrevocably (a) consents to the exclusive jurisdiction and venue of the appropriate state or federal court located in King County, state of Washington, in connection with any dispute hereunder or the enforcement of any right or obligation hereunder, and (b) WAIVES ITS RIGHT TO A JURY TRIAL. EACH PARTY FURTHER AGREES THAT ANY SUIT ARISING OUT OF OR RELATED TO THIS AGREEMENT MUST BE FILED WITHIN ONE (1) YEAR AFTER THE CAUSE OF ACTION ARISES.

Termination

This Agreement may be terminated by either party, with or without cause, upon ten (10) days' written notice. In such event, we will stop providing services hereunder except on work, mutually agreed upon in writing, necessary to carry out such termination. In the event of termination: (a) you shall pay us for services provided and expenses incurred through the effective date of termination, (b) we will provide you with all finished reports that we have prepared pursuant to this Agreement, (c) neither party shall be liable to the other for any damages that occur as a result of our ceasing to render services, and (d) we will require any new accounting firm that you may retain to execute access letters satisfactory to Moss Adams prior to reviewing our files.