TAHOE FOREST HOSPITAL DISTRICT

2018-04-26 Regular Meeting of the Board of Directors

Thursday, April 26, 2018 at 4:00pm

Tahoe Truckee Unified School District

11603 Donner Pass Road, Truckee, CA 96161

Meeting Book - 2018-04-26 Regular Meeting of the Board of Directors

04/26/18 Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, April 26, 2018 at 4:00 p.m.

Tahoe Truckee Unified School District
11603 Donner Pass Road, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**

   5.1. Conference with Legal Counsel; Initiation of Litigation (Gov. Code § 54956.9(d)(4))◈
   Number of Potential Cases: One (1)

   5.2. Hearing (Health & Safety Code § 32155)◈
   Subject Matter: First Quarter 2018 Corporate Compliance Report
   Number of items: One (1)

   5.3. 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. Number of Potential Cases: One

   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: Jessica Dias

   5.4. 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. Number of Potential Cases: One

   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: Ian Barton

◈ Denotes Action Item

5.5. Hearing (Health & Safety Code § 32155)◈
Subject Matter: 2017 Annual Quality Assurance/Performance Improvement Report
Number of items: One (1)

5.6. Conference with Legal Counsel; Existing Litigation (Gov. Code § 54956.9(d)(1))
The District Board finds, based on advice from legal counsel, that discussion in open session will prejudice the position of the local agency in the litigation.

Name of Cases: Tahoe Forest Hospital Employees Association v. Tahoe Forest Hospital District and Tahoe Forest Hospital Employees Association of Professionals v. Tahoe Forest Hospital District

Name of Parties/Claimants: Tahoe Forest Hospital Employees Association and Tahoe Forest Hospital Employees Association of Professionals

PERB Case No.: –IR No. 742 (SA-CE-1048-M)

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

5.8. Report Involving Trade Secrets (Health & Safety Code § 32106)
Discussion will concern: potential new service
Estimated date of disclosure: April 2019

5.9. Conference with Legal Counsel; Initiation of Litigation (Gov. Code § 54956.9(d)(4))
Number of Potential Cases: One (1)

5.10. Approval of Closed Session Minutes◈
03/22/2018 (Regular Meeting), 03/22/2018 (Special Meeting)

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

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 President may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

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.

◈ Denotes Action Item

12. ACKNOWLEDGMENTS

12.1. April 2018 Employee of the Month .....ATTACHMENT
12.2. Jake Dorst named on Becker's 2018 CIOs to Know list.....ATTACHMENT
12.3. National Volunteer Week – April 15-21.....ATTACHMENT
12.4. National Nurses Week – May 6-12
12.5. National Hospital Week – May 6-12 .....ATTACHMENT

13. 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.

13.1. Approval of Minutes of Meetings

13.1.1. 03/20/2018 .....ATTACHMENT
13.1.2. 03/22/2018 (Regular Meeting) .....ATTACHMENT
13.1.3. 03/22/2018 (Special Meeting) .....ATTACHMENT

13.2. Financial Reports

13.2.1. Financial Report – March 2018.....ATTACHMENT

13.3. Staff Reports

13.3.1. CEO Board Report .....ATTACHMENT
13.3.2. COO Board Report.....ATTACHMENT
13.3.3. CNO Board Report.....ATTACHMENT
13.3.4. CIIO Board Report .....ATTACHMENT
13.3.5. CMO Board Report.....ATTACHMENT

13.4. Contracts

13.4.1. Mark Wainstein, M.D. – Professional Services Agreement .....ATTACHMENT
13.4.2. Mark Wainstein, M.D. – Physician Recruitment Agreement.....ATTACHMENT
13.4.3. Jonathan Hagen, M.D. – Professional Services Agreement.....ATTACHMENT
13.4.4. Jonathan Hagen, M.D. – Physician Recruitment Agreement .....ATTACHMENT

13.5. Policy Review

13.5.1. ABD-04 Board of Directors Qualifications .....ATTACHMENT
13.5.2. ABD-18 New Program and Services.....ATTACHMENT

13.6. Employee Associations

13.6.1. Employees Association (EA) Affiliation Election Results.....ATTACHMENT
13.6.2. Employees Association of Professionals (EAP) Affiliation Election Results.....ATTACHMENT

14. ITEMS FOR BOARD DISCUSSION

14.1. Board Education – Corporate Compliance/HIPAA Training.....ATTACHMENT
The Board of Directors will receive training on the District's Corporate Compliance Program and HIPAA.

14.2. Telemedicine Presentation .....ATTACHMENT
The Board of Directors will receive a presentation on telemedicine.

14.3. Strategic Planning Update.....ATTACHMENT
The Board of Directors will receive an update on the Strategic Planning process.

15. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

◈ Denotes Action Item
193397.1

16. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

16.1. Executive Compensation Committee Meeting – 03/22/2018 ..... ATTACHMENT

16.2. Governance Committee Meeting – No meeting held in April.

16.3. Quality Committee Meeting – No meeting held in April.

16.4. Finance Committee Meeting – No meeting held in April.

17. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

18. ITEMS FOR NEXT MEETING

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 24, 2018 at Tahoe Truckee School District, 11603 Donner Pass Road, Truckee, CA 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

◈ Denotes Action Item

Employee of the Month, April 2018
Jessica Dias, Diagnostic Imagining Assistant-DI

We are honored to announce Jessica Dias, Diagnostic Imagining Assistant, DI as our April Employee of the Month.

Jessica has been a part of Tahoe Forest Health System for almost 17 years. Jessica's wealth of knowledge in radiology brings as much value to her coworkers as it does our patients. Her ability to go to different departments and assist them with viewing and troubleshooting would explain why she is considered the "go-to" person for help. She is accountable and responsible for all aspects of her position in diagnostic imagining and willing to fill in when/if necessary to keep the department flow in order. She anticipates and monitors comparison imaging on patients assuring the best diagnostic read outcome. She eases any nerves the patients may have by providing them with all the necessary information about their exams. Jessica is a hard worker who is constantly looking for ways to improve the department

Jessica demonstrates excellence through her implementation of a new method for making sure that the patients has all the necessary imagining prior to seeing the patient. Not only is she a great team player and is always willing to help, she's also a great team leader. She cares for the patients in a friendly, compassionate manner so it is not uncommon for a patient to return to the front desk after their exam just to thank Jessica for her quality care. It is obvious that both patients and coworkers appreciate Jessica's dedication to the team.

Jessica meets and exceeds the definition of the TFHS mission and values but most of all has been an asset to our hospital through her quality patient care and wealth of knowledge.

Please join us in congratulating all of our Terrific Nominees!

Juan Valdivia- Facilities Engineer Assistant II, Facilities Mgmt
Tina VanSambeek- Sterile Processing Tech II, SPD
Elizabeth Kolodge- Cook, Dietary

Jake Dorst | 105 Hospital and Health System CIOs to Know | 2018

Written by Staff | February 19, 2018 | Print | Email

Jake Dorst. Chief Innovation Officer and CIO of Tahoe Forest Health District (Truckee, Calif.). Mr. Dorst became CIO of Tahoe Forest Health District in 2014 and took on chief innovation officer responsibilities in 2015. He led the hospital's efforts to work with Mercy Technology Services, the IT arm of Mercy, to deploy an EHR at its California and Nevada locations in 2017, aiming to push forward patient care innovation. The health system moved from seven EHR s to a single, unified patient record, which he expects will boost population health and community outreach initiatives, as well as provide better coordinated care. Prior to joining Tahoe Forest Health District, Mr. Dorst gained experience as the vice president and CIO of Hagerstown, Md.-based Meritus Health and CIO of Petersburg, Va.-based Southside Regional Medical Center.

RETURN TO FULL LIST


Honoring Our Volunteers
Thank you
For making a difference in our community
Tahoe Forest Health System thanks our passionate volunteers for the time and effort they provide to numerous health system programs. Their support makes the difference in the lives of so many people in our community.
Tahoe Forest Hospital Volunteer Services
Best of Tahoe Chefs Volunteers
Foundation Board Members
Foundation Office Volunteers
Gene Upshaw Memorial Golf Classic Volunteers and Advisory Board
Hospice Thrift Stores, Truckee and Kings Beach
Hospice Volunteers
Humane Society of Truckee Tahoe Pet Therapy Program
North Lake Tahoe Community Health Care Auxiliary
Pastoral Care
Special Events Planning Committees
TFHD Employee Giving Committee Volunteers
Tahoe Forest Health System

National Hospital Week
May 6-12, 2018

Caring is our Calling™

www.nationalhospitalweek.com

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Tuesday, March 20, 2018 at 9:00 a.m.
Tahoe Conference Room – Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 9:00 a.m.

2. ROLL CALL
Board: Dale Chamblin, Board President; Randy Hill, Vice President; Charles Zipkin, M.D., Treasurer; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Karen Baffone, Chief Nursing Officer; Jake Dorst, Chief Information and Innovation Officer; Alex MacLennan, Chief Human Resources Officer; Matt Mushet, In-House Counsel; Jaye Chasseur, Controller; Jeremy Bennett, Director of Revenue Cycle; Martina Rochefort, Clerk of the Board

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
No public comment was received.

5. ITEMS FOR BOARD ACTION

5.1. Financial Review
The Board of Directors reviewed the District's financial performance through February 28, 2018 and financial projections for the remainder of the fiscal year.

5.1.1. Financial Report – January 2018
Discussion was held on the January 2018 financial report.

ACTION: **Motion made by Director Zipkin, seconded by Director Wong, to approve the January 2018 Financial Report.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

5.1.2. Financial Report – February 2018
Discussion was held on the February 2018 financial report.

ACTION: **Motion made by Director Zipkin, seconded by Director Wong, to approve the February 2018 Financial Report.**

AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

6. ADJOURN

Meeting adjourned at 10:35 a.m.

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, March 22, 2018 at 4:00 p.m.
Tahoe Truckee Unified School District
11603 Donner Pass Road, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 5:03 p.m.

2. ROLL CALL
Board: Dale Chamblin, Board President; Randy Hill, Vice President; Charles Zipkin, M.D., Treasurer; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Matt Mushet, In-House Counsel; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
Items 5.1. and 5.3. were removed from the agenda.

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 5:05 p.m.

5. CLOSED SESSION

5.1. Conference with Legal Counsel; Initiation of Litigation (Gov. Code § 54956.9(d)(4))
Number of Cases: One (1)
Item was removed from the agenda.

5.2. Hearing (Health & Safety Code § 32155)
Subject Matter: Fourth Quarter 2017 Service Excellence Report
Number of items: One (1)
Discussion was held on a privileged item.

5.3. Conference with Labor Negotiator (Government Code § 54957.6)
Name of District Negotiator(s) to Attend Closed Session: Alex MacLennan
Employee Organization(s): Employees Association and Employees Association of Professionals
Item was removed from the agenda.

5.4. Approval of Closed Session Minutes
02/22/2018
Discussion was held on a privileged item.

5.5. 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 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel reported that items 5.1 and 5.3 were removed from the agenda. There was no reportable action on item 5.2. Item 5.4 Closed Session Minutes were approved on a 5-0 vote and item 5.5 Medical Staff Credentials were approved as amended 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. Donn Demostene was named March 2018 Employee of the Month.

12.2. Doctor's Day is March 30, 2018.

13. 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.

13.1. Approval of Minutes of Meetings

02/22/2018

13.2. Staff Reports

13.2.1. CEO Board Report
13.2.2. COO Board Report
13.2.3. CNO Board Report
13.2.4. CIIO Board Report
13.2.5. CMO Board Report
13.2.6. CHRO Update on Employee Engagement Survey
13.2.7. Legislative Update Report

13.3. Contracts

13.3.1. Jennifer Racca, M.D. – Professional Services Agreement

13.4. Policy Review

13.4.1. ABD-01 CEO Performance Evaluation
13.4.2. ABD-02 CEO Compensation
13.4.3. Order and Decorum
13.4.4. Board Executive Compensation Committee Charter

Director Zipkin pulled item 13.4.2. for a correction.

ACTION: **Motion made by Director Brown, seconded by Director Zipkin, to approve the Consent Calendar excluding item 13.4.2.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

14. ITEMS FOR BOARD DISCUSSION

14.1. Children's Center Update

Discussion was held.

No public comment was received.

14.2. Infection Control Presentation

Discussion was held.

No public comment was received.

14.3. Strategic Update on Patient Navigation/Care Coordination

Discussion was held.

No public comment was received.

14.4. Strategic Planning Update

Discussion was held.

No public comment was received.

15. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Discussion was held on item 13.4.2.

On page 64 in the Purpose statement, change "Chief Executive Officer's compensation decisions" to "compensation decisions regarding the Chief Executive Officer".

ACTION: **Motion made by Director Zipkin, seconded by Director Wong, to approve item 13.4.2. with the correction noted above.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

16. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

16.1. Finance Committee Meeting – 03/08/2018

No discussion was held as there was a Special Meeting on 03/20/2018 to review the financial reports.

16.2. Governance Committee Meeting – 03/21/2018

Director Brown provided an update from the recent Governance Committee meeting.

16.3. Quality Committee Meeting – No meeting held in March.

16.4. Executive Compensation Committee Meeting – No meeting held in March.

17. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

None.

18. ITEMS FOR NEXT MEETING

None.

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

-Director Zipkin noted March is Colon Cancer Awareness month and reminded those over 50 to have a colonoscopy.

20. CLOSED SESSION CONTINUED, IF NECESSARY

Not applicable.

21. OPEN SESSION

Not applicable.

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

Not applicable.

23. ADJOURN

Meeting adjourned at 7:11 p.m.

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Thursday, March 22, 2018 at 4:00 p.m.
Tahoe Truckee Unified School District
11603 Donner Pass Road, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 4:00 p.m.

2. ROLL CALL
Board: Dale Chamblin, Board President; Randy Hill, Vice President; Charles Zipkin, M.D., Treasurer; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Alex MacLennan, Chief Human Resources Officer; Matt Mushet, In-House Counsel; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel; Rick Rybicki, Labor Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
No public comment was received.

Open Session recessed at 4:01 p.m.

5. CLOSED SESSION

5.1. Conference with Legal Counsel; Existing Litigation (Gov. Code § 54956.9(d)(1))

The District Board finds, based on advice from legal counsel, that discussion in open session will prejudice the position of the local agency in the litigation.

Name of Cases: Tahoe Forest Hospital Employees Association v. Tahoe Forest Hospital District and Tahoe Forest Hospital Employees Association of Professionals v. Tahoe Forest Hospital District

Name of Parties/Claimants: Tahoe Forest Hospital Employees Association and Tahoe Forest Hospital Employees Association of Professionals

Case No.: PERB - Unknown

Discussion was held on a privileged item.

6. OPEN SESSION
Open Session reconvened at 5:00 p.m.

7. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
General Counsel stated there was no reportable action taken in closed session.

8. ADJOURN

Meeting adjourned at 5:01 p.m.

TAHOE FOREST HOSPITAL DISTRICT
MARCH 2018 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District
MARCH 2018 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the nine months ended March 31, 2018.

Activity Statistics

- We continue working with our vendor, Mercy Health System, to identify the reporting criterions needed to gather our monthly departmental statistics and are targeting completion of the project in May.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 53.2% in the current month compared to budget of 55.5% and to last month's 63.1%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 55.5%, compared to budget of 55.5% and prior year's 55.2%.

- EBIDA was $(406,282) (-1.9%) for the current month compared to budget of $413,088 (1.9%), or $(819,369) (-3.7%) below budget. Year-to-date EBIDA was $6,088,505 (3.1%) compared to budget of $7,045,446 (3.5%), or $(956,941) (-.4%) below budget.

- Cash Collections for the current month were $11,104,276 which is 76% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $40,143,282 at the end of March compared to $37,494,694 at the end of February. Legacy Gross Accounts Receivable was $7,403,748 at the end of March compared to $9,344,201 at the end of February, a reduction of $1,940,453.

Balance Sheet

- Working Capital Days Cash on Hand is 44.0 days. S&P Days Cash on Hand is 159.1. Working Capital cash increased $2,461,000. Accounts Payable increased $1,155,000, Accrued Payroll & Related Costs increased $913,000 and cash collections fell short of goal by 24%.

- Net Patients Accounts Receivable decreased approximately $1,941,000 and Cash collections were at 76% of target.

- The District received the final, unexpended funds from the Banc of America Municipal Lease and deposited the monies into our Maintenance and Operating account.

- 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.

- Accounts Payable increased $1,155,000 due to the timing of the final check run in March.

- Accrued Payroll & Related Costs increased $913,000 due to additional payroll accrual days in the month.

Operating Revenue

- Current month's Total Gross Revenue was $21,847,227, compared to budget of $22,240,928 or $393,701 below budget.

- Current month's Gross Inpatient Revenue was $5,489,339, compared to budget of $6,454,896 or $965,557 below budget.

- Current month's Gross Outpatient Revenue was $16,357,888 compared to budget of $15,786,032 or $571,856 above budget.

- Current month's Gross Revenue Mix was 35.0% Medicare, 19.7% Medi-Cal, .0% County, 2.0% Other, and 43.3% Insurance compared to budget of 34.7% Medicare, 17.7% Medi-Cal, .0% County, 3.7% Other, and 43.9% Insurance. Last month's mix was 31.1% Medicare, 19.0% Medi-Cal, .0% County, 3.4% Other, and 46.5% Insurance. Year-to-date Gross Revenue Mix was 36.3% Medicare, 17.8% Medi-Cal, .0% County, 3.9% Other, and 42.0% Insurance compared to budget of 34.8% Medicare, 17.5% Medi-Cal, .0% County, 3.9% Other, and 43.8% Insurance.

- Current month's Deductions from Revenue were $10,235,225 compared to budget of $9,888,281 or $346,944 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a .24% increase in Medicare, a 2.03% increase to Medi-Cal, County at budget, a 1.75% decrease in Other, and Commercial was under budget .52%.

DESCRIPTION	March 2018 Actual	March 2018 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	4,411,482	4,683,701	272,219	
Employee Benefits	1,536,753	1,404,046	(132,707)	
Benefits – Workers Compensation	16,435	53,880	37,445	
Benefits – Medical Insurance	780,758	621,624	(159,134)	The District is self-insured. Actual expense is based on utilization. More claims were processed in March creating a negative variance in Benefits-Medical Insurance.
Professional Fees	2,076,015	2,142,589	66,574	We saw positive variances in fees paid for our MSC Orthopedic and MSC ENT physician fees and Administration Legal fees.
Supplies	2,121,349	1,657,489	(463,860)	Negative variance in Supplies related to system conversion posting processes which were discovered and corrected in March.
Purchased Services	1,450,884	1,408,019	(42,865)	Purchased Services for outsourced lab testing, 340B pharmacy, and IT System Conversion exceeded budget, creating a negative variance in this category.
Other Expenses	896,377	728,835	(167,542)	Negative variance in Other Expenses related to November 2017 Mercy go-live travel reimbursement invoice received in March.
Total Expenses	13,290,053	12,700,183	(589,870)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
MARCH 2018

	Mar-18	Feb-18	Mar-17	
ASSETS				
CURRENT ASSETS				
* CASH	$ 17,864,998	$ 15,404,192	$ 13,928,287	1
PATIENT ACCOUNTS RECEIVABLE - NET	20,417,259	22,357,790	19,052,390	2
OTHER RECEIVABLES	6,890,082	6,430,584	4,854,560	
GO BOND RECEIVABLES	634,457	301,576	91,511	
ASSETS LIMITED OR RESTRICTED	6,433,834	6,391,652	5,574,025	
INVENTORIES	3,025,942	3,027,372	2,721,126	
PREPAID EXPENSES & DEPOSITS	1,743,866	1,747,793	2,007,063	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	11,759,084	11,666,356	436,856	
TOTAL CURRENT ASSETS	68,769,522	67,327,315	48,665,818	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	46,724,481	46,724,481	56,137,411	1
BANC OF AMERICA MUNICIPAL LEASE	-	34,042	981,619	3
TOTAL BOND TRUSTEE 2017	19,849	19,831	3	
TOTAL BOND TRUSTEE 2015	1,369,080	1,369,080	1,300,822	
GO BOND PROJECT FUND	-	1	232,003	
GO BOND TAX REVENUE FUND	1,900,012	1,900,012	2,103,577	
DIAGNOSTIC IMAGING FUND	3,204	3,204	3,174	
DONOR RESTRICTED FUND	1,449,722	1,449,722	1,144,350	
WORKERS COMPENSATION FUND	25,080	3,722	23,719	
TOTAL	51,491,429	51,504,095	61,926,677	
LESS CURRENT PORTION	(6,433,834)	(6,391,652)	(5,574,025)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	45,057,594	45,112,443	56,352,653	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	-	-	(140,146)	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	132,161,547	131,916,995	130,403,841	
GO BOND CIP, PROPERTY & EQUIPMENT NET	33,435,528	33,433,796	32,585,589	
TOTAL ASSETS	280,260,543	278,626,901	268,704,108	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	475,159	478,392	513,948	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,117,841	1,395,414	1,469,762	4
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	6,054,201	6,077,906	6,338,658	
GO BOND DEFERRED FINANCING COSTS	473,891	475,826	497,106	
DEFERRED FINANCING COSTS	190,371	191,411	202,854	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 8,311,464	$ 8,618,948	$ 9,022,327	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 5,777,754	$ 4,623,084	$ 3,418,687	5
ACCRUED PAYROLL & RELATED COSTS	11,462,313	10,548,824	9,490,530	6
INTEREST PAYABLE	659,270	566,152	708,821	
INTEREST PAYABLE GO BOND	1,036,896	716,081	659,834	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	225,030	225,030	1,221,622	
HEALTH INSURANCE PLAN	1,211,751	1,211,751	1,307,731	
WORKERS COMPENSATION PLAN	1,704,215	1,704,017	1,120,980	
COMPREHENSIVE LIABILITY INSURANCE PLAN	858,290	858,290	751,298	
CURRENT MATURITIES OF GO BOND DEBT	860,000	860,000	1,260,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,049,645	1,049,645	1,953,186	
TOTAL CURRENT LIABILITIES	24,845,163	22,362,873	21,892,688	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	27,335,091	27,337,734	27,926,882	
GO BOND DEBT NET OF CURRENT MATURITIES	102,646,399	102,659,819	103,382,447	
DERIVATIVE INSTRUMENT LIABILITY	1,117,841	1,395,414	1,469,762	4
TOTAL LIABILITIES	155,944,494	153,755,840	154,671,779	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	131,177,791	132,040,287	121,910,306	
RESTRICTED	1,449,722	1,449,722	1,144,350	
TOTAL NET POSITION	$ 132,627,513	$ 133,490,009	$ 123,054,656	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
MARCH 2018

1. Working Capital is at 44.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 159.1 days. Working Capital cash increased a net $2,461,000. Accounts Payable increased $1,155,000 (See Note 5), Accrued Payroll & Related Costs increased $913,000 and Cash Collections fell short of target by 24%.

2. Net Patient Accounts Receivable decreased approximately $1,941,000 and Cash collections were 76% of target.

3. Banc of America Municipal Lease decreased $34,000. The District received the final, unexpended funds and deposited them into our operating cash account.

4. 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.

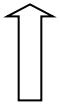
5. Accounts Payable increased $1,155,000 due to the timing of the final check run in the month.

6. Accrued Payroll & Related Costs increased $913,000 due to additional payroll accrual days in March.

Tahoe Forest Hospital District
Cash Investment
March 2018

WORKING CAPITAL				
US Bank	$ 16,589,411			
US Bank/Kings Beach Thrift Store	48,373			
US Bank/Truckee Thrift Store	215,566			
US Bank/Payroll Clearing	7,926			
Umpqua Bank	1,003,721	0.40%		
Total			$	17,864,998
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	46,724,481	1.52%		
Local Agency Investment Fund			$	46,724,481
Banc of America Muni Lease			$	-
Bonds Cash 2017			$	19,849
Bonds Cash 2015			$	1,369,080
GO Bonds Cash 2008			$	1,900,012
DX Imaging Education	$ 3,204			
Workers Comp Fund - B of A	25,080			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	28,285
TOTAL FUNDS			$	67,906,705
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,364	0.03%		
Foundation Restricted Donations	364,320			
Local Agency Investment Fund	1,077,039	1.11%		
TOTAL RESTRICTED FUNDS			$	1,449,722
TOTAL ALL FUNDS			$	69,356,427

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2018

	Current Status	Desired Position	Target	Bond Covenants	FY 2018 Jul 17 to Mar 2018	FY 2017 Jul 16 to June 2017	FY 2016 Jul 15 to June 16	FY 2015 Jul 14 to June 15	FY 2014 Jul 13 to June 14	FY 2013 Jul 12 to June 13	FY 2012 Jul 11 to June 12
Return On Equity: Increase (Decrease) in Net Position Net Position			1.8% (1)		1.8%	14.4%	10.9%	2.19%	.001%	-4.0%	8.7%
EPIC Days in Accounts Receivable (excludes SNF, Home Health & Hospice) Gross Accounts Receivable 90 Days Gross Accounts Receivable 365 Days	 		FYE 63 Days		53 56	55 55	57 55	60 62	75 75	97 93	64 64
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments (Total Expenses - Depreciation Expense)/ by 365	 		Budget FYE 173 Days Budget 3rd Qtr 172 Days Projected 3rd Qtr 149 Days	60 Days A- 203 Days BBB- 142 Days	159	191	201	156	164	148	203
EPIC Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)			13%		8%	17%	19%	18%	22%	29%	15%
EPIC Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)			18%		9%	18%	24%	23%	25%	34%	19%
Cash Receipts Per Day (based on 60 day lag on Patient Net Revenue) excludes managed care reserve and IGT	 		FYE Budget $437,885 End 3rd Qtr Budget $450,478 End 3rd Qtr Actual $371,669		$334,433	$348,962	$313,153	$290,776	$286,394	$255,901	$254,806
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation Debt Principal Payments + Interest Expense			Without GO Bond 9.27 With GO Bond 2.07	1.95	8.72 2.97	6.64 3.54	6.19 2.77	3.28 1.59	2.18 1.29	.66 .89	4.83 2.70

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
MARCH 2018

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 2017
				OPERATING REVENUE						
$ 21,847,227	$ 22,240,928	$ (393,701)	-1.8%	Total Gross Revenue	$ 197,248,742	$ 200,219,305	$ (2,970,563)	-1.5%	1	$ 189,175,302
				Gross Revenues - Inpatient						
$ 2,278,594	$ 2,047,227	$ 231,367	11.3%	Daily Hospital Service	$ 20,203,971	$ 17,873,907	$ 2,330,064	13.0%		$ 17,641,592
3,210,745	4,407,669	(1,196,924)	-27.2%	Ancillary Service - Inpatient	32,985,720	36,900,006	(3,914,286)	-10.6%		36,530,108
5,489,339	6,454,896	(965,557)	-15.0%	Total Gross Revenue - Inpatient	53,189,691	54,773,913	(1,584,222)	-2.9%	1	54,171,700
16,357,888	15,786,032	571,856	3.6%	Gross Revenue - Outpatient	144,059,051	145,445,392	(1,386,341)	-1.0%		135,003,602
16,357,888	15,786,032	571,856	3.6%	Total Gross Revenue - Outpatient	144,059,051	145,445,392	(1,386,341)	-1.0%	1	135,003,602
				Deductions from Revenue:						
9,244,910	8,894,323	(350,587)	-3.9%	Contractual Allowances	84,564,503	80,185,819	(4,378,684)	-5.5%	2	80,258,413
679,674	720,907	41,233	5.7%	Charity Care	6,231,100	6,478,220	247,120	3.8%	2	5,725,991
-	-	-	0.0%	Charity Care - Catastrophic Events	258,788	-	(258,788)	0.0%	2	272,105
308,763	273,051	(35,712)	13.1%	Bad Debt	1,557,778	2,454,519	896,741	-36.5%	2	(1,129,619)
1,877	-	(1,877)	0.0%	Prior Period Settlements	(4,791,938)	-	4,791,938	0.0%	2	(444,361)
10,235,225	9,888,281	(346,944)	-3.5%	Total Deductions from Revenue	87,820,232	89,118,558	1,298,326	1.5%		84,682,529
78,134	101,626	23,492	23.1%	Property Tax Revenue- Wellness Neighborhood	605,614	919,021	(313,407)	-34.1%		461,473
1,193,635	658,998	534,637	81.1%	Other Operating Revenue	6,410,942	6,107,106	303,836	5.0%	3	6,666,183
12,883,772	13,113,271	(229,499)	-1.8%	TOTAL OPERATING REVENUE	116,445,067	118,126,874	(1,681,807)	-1.4%		111,620,428
				OPERATING EXPENSES						
4,411,482	4,683,701	272,219	5.8%	Salaries and Wages	40,390,574	40,496,875	106,301	0.3%	4	34,738,714
1,536,753	1,404,046	(132,707)	-9.5%	Benefits	13,690,686	12,536,713	(1,153,973)	-9.2%	4	11,578,554
16,435	53,880	37,445	69.5%	Benefits Workers Compensation	482,940	484,923	1,983	0.4%	4	489,296
780,758	621,624	(159,134)	-25.6%	Benefits Medical Insurance	5,232,467	5,594,617	362,150	6.5%	4	5,653,456
2,076,015	2,142,589	66,574	3.1%	Professional Fees	17,563,000	18,779,101	1,216,101	6.5%	5	16,248,309
2,121,349	1,657,489	(463,860)	-28.0%	Supplies	15,992,923	15,226,244	(766,679)	-5.0%	6	14,594,975
1,450,884	1,408,019	(42,865)	-3.0%	Purchased Services	10,784,249	11,550,661	766,412	6.6%	7	8,936,897
896,377	728,835	(167,542)	-23.0%	Other	6,219,722	6,412,294	192,572	3.0%	8	5,217,395
13,290,053	12,700,183	(589,870)	-4.6%	TOTAL OPERATING EXPENSE	110,356,562	111,081,428	724,866	0.7%		97,457,596
(406,282)	**413,088**	**(819,369)**	**-198.4%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**6,088,505**	**7,045,446**	**(956,941)**	**-13.6%**		**14,162,832**
				NON-OPERATING REVENUE/(EXPENSE)						
561,940	538,448	23,492	4.4%	District and County Taxes	5,188,045	4,841,644	346,401	7.2%	9	4,125,396
320,802	332,881	(12,079)	-3.6%	District and County Taxes - GO Bond	2,983,850	2,995,930	(12,080)	-0.4%		3,527,400
76,255	70,867	5,388	7.6%	Interest Income	668,708	637,806	30,902	4.8%	10	434,338
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		356
7,947	74,917	(66,970)	-89.4%	Donations	160,922	674,250	(513,328)	-76.1%	11	369,817
-	(20,000)	20,000	100.0%	Gain/ (Loss) on Joint Investment	-	(180,000)	180,000	100.0%	12	(183,517)
-	-	-	0.0%	Loss on Impairment of Asset	-	-	-	0.0%	12	-
900	-	900	0.0%	Gain/ (Loss) on Sale of Equipment	9,494	-	9,494	0.0%	13	-
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(994,665)	(993,555)	(1,110)	-0.1%	Depreciation	(8,869,988)	(8,941,998)	72,010	0.8%	15	(8,233,274)
(96,362)	(98,944)	2,582	2.6%	Interest Expense	(853,962)	(890,617)	36,655	4.1%	16	(921,925)
(333,034)	(320,815)	(12,219)	-3.8%	Interest Expense-GO Bond	(2,948,427)	(2,887,332)	(61,095)	-2.1%		(1,752,045)
(456,215)	(416,201)	(40,015)	-9.6%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,661,358)	(3,750,317)	88,959	2.4%		(2,633,454)
$ (862,497)	**$ (3,113)**	**$ (859,384)**	**27606.3%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 2,427,147**	**$ 3,295,129**	**$ (867,982)**	**-26.3%**		**$ 11,529,378**
				NET POSITION - BEGINNING OF YEAR	**130,200,366**					
				NET POSITION - AS OF MARCH 31, 2018	**$ 132,627,513**					
-1.9%	**1.9%**	**-3.7%**		**RETURN ON GROSS REVENUE EBIDA**	**3.1%**	**3.5%**	**-0.4%**			**7.5%**

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2018

	Current Status	Desired Position	Target	FY 2018 Jul 17 to March 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	FY 2013 Jul 12 to June 13	FY 2012 Jul 11 to June 12
Total Margin: Increase (Decrease) In Net Position / Total Gross Revenue			FYE .1% 3rd Qtr 1.7%	1.2%	7.4%	5.5%	1.0%	.01%	-2.2%	5.3%
Charity Care: Charity Care Expense / Gross Patient Revenue			FYE 3.2% 3rd Qtr 3.2%	3.3%	3.1%	3.4%	3.1%	3.2%	3.2%	2.6%
Bad Debt Expense: Bad Debt Expense / Gross Patient Revenue			FYE 1.2% 3rd Qtr 1.2%	.1%	-.0%	-.2%	1.6%	1.6%	4.6%	4.3%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue			FYE 8.0% 3rd Qtr 8.3%	7.6%	7.9%	11.3%	9.1%	4.9%	11.5%	10.8%
Operating Expense Variance to Budget (Under<Over>)			-0-	$724,866	$(9,700,270)	$(7,548,217)	$(6,371,653)	$2,129,279	$(1,498,683)	$790,439
EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue			FYE 2.7% 3rd Qtr 3.5%	3.1%	7.9%	7.3%	3.5%	2.0%	.9%	5.6%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
MARCH 2018

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 2017
				OPERATING REVENUE						
$ 1,410,788	$ 1,640,173	$ (229,385)	-14.0%	Total Gross Revenue	$ 13,892,597	$ 15,033,340	$ (1,140,743)	-7.6%	1	$ 14,247,583
				Gross Revenues - Inpatient						
$ 9,076	$ 5,657	$ 3,419	60.4%	Daily Hospital Service	$ 101,764	$ 45,259	$ 56,505	124.8%		$ 32,328
12,360	3,282	9,077	276.5%	Ancillary Service - Inpatient	99,198	27,941	71,257	255.0%		44,416
21,436	8,940	12,496	139.8%	Total Gross Revenue - Inpatient	200,962	73,200	127,762	174.5%	1	76,744
1,389,352	1,631,233	(241,881)	-14.8%	Gross Revenue - Outpatient	13,691,634	14,960,140	(1,268,505)	-8.5%		14,170,839
1,389,352	1,631,233	(241,881)	-14.8%	Total Gross Revenue - Outpatient	13,691,634	14,960,140	(1,268,505)	-8.5%	1	14,170,839
				Deductions from Revenue:						
676,556	598,162	(78,394)	-13.1%	Contractual Allowances	5,792,714	5,462,489	(330,225)	-6.0%	2	5,100,412
51,494	61,691	10,197	16.5%	Charity Care	485,506	556,956	71,450	12.8%	2	483,744
-	-	-	0.0%	Charity Care - Catastrophic Events	41,996	-	(41,996)	0.0%	2	34,137
54,633	56,745	2,113	3.7%	Bad Debt	414,348	511,604	97,256	19.0%	2	448,048
-	-	-	0.0%	Prior Period Settlements	(106,438)	-	106,438	0.0%	2	(22,833)
782,683	716,598	(66,084)	-9.2%	Total Deductions from Revenue	6,628,126	6,531,050	(97,077)	-1.5%	2	6,043,508
232,308	76,214	156,094	204.8%	Other Operating Revenue	915,537	728,426	187,111	25.7%	3	724,310
860,413	999,789	(139,376)	-13.9%	TOTAL OPERATING REVENUE	8,180,008	9,230,716	(1,050,709)	-11.4%		8,928,385
				OPERATING EXPENSES						
256,485	312,271	55,786	17.9%	Salaries and Wages	2,607,521	2,798,432	190,911	6.8%	4	2,371,623
95,552	95,996	444	0.5%	Benefits	858,234	843,815	(14,419)	-1.7%	4	891,574
2,357	2,357	(0)	0.0%	Benefits Workers Compensation	22,047	21,209	(839)	-4.0%	4	18,096
49,171	39,151	(10,020)	-25.6%	Benefits Medical Insurance	325,707	352,362	26,655	7.6%	4	362,675
201,471	274,160	72,689	26.5%	Professional Fees	2,069,212	2,335,285	266,073	11.4%	5	2,142,825
33,559	74,130	40,571	54.7%	Supplies	395,772	640,201	244,429	38.2%	6	594,059
29,003	60,050	31,047	51.7%	Purchased Services	354,155	476,196	122,041	25.6%	7	430,086
51,014	68,086	17,073	25.1%	Other	497,778	522,675	24,897	4.8%	8	482,614
718,611	926,201	207,590	22.4%	TOTAL OPERATING EXPENSE	7,130,426	7,990,175	859,749	10.8%		7,293,553
141,802	**73,588**	**68,214**	**92.7%**	**NET OPERATING REV(EXP) EBIDA**	**1,049,582**	**1,240,541**	**(190,960)**	**-15.4%**		**1,634,832**
				NON-OPERATING REVENUE/(EXPENSE)						
8,861	-	8,861	0.0%	Donations-IVCH	22,361	-	22,361	0.0%	9	24,267
-	-	-	0.0%	Gain/ (Loss) on Sale		-	-	0.0%	10	-
(56,857)	(56,857)	0	0.0%	Depreciation	(533,970)	(511,711)	(22,258)	-4.3%	11	(523,880)
(47,996)	(56,857)	8,861	-15.6%	TOTAL NON-OPERATING REVENUE/(EXP)	(511,608)	(511,711)	103	0.0%		(499,613)
$ 93,806	**$ 16,731**	**$ 77,075**	**460.7%**	**EXCESS REVENUE(EXPENSE)**	**$ 537,973**	**$ 728,830**	**$ (190,857)**	**-26.2%**		**$ 1,135,219**
10.1%	**4.5%**	**5.6%**		**RETURN ON GROSS REVENUE EBIDA**	**7.6%**	**8.3%**	**-0.7%**			**11.5%**

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2017		BUDGET FYE 2018	PROJECTED FYE 2018	ACTUAL MAR 2018	BUDGET MAR 2018	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	ACTUAL 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 19,312,107		$ 7,189,726	$ 6,259,352	$ (406,282)	$ 413,088	$ (819,370)	$ 3,884,930	$ (7,352,907)	$ 9,527,121	$ 200,207
Interest Income	361,479		725,902	702,192	-	-	-	133,270	356,321	-	212,601
Property Tax Revenue	6,497,384		7,681,300	7,772,350	-	-	-	393,337	85,046	3,753,968	3,540,000
Donations	1,537,778		890,200	611,680	133,088	200,000	(66,912)	25,091	13,500	133,088	440,000
Debt Service Payments	(3,553,754)		(2,678,403)	(2,562,264)	(959)	(138,057)	137,098	(516,336)	(663,487)	(386,688)	(995,753)
Bank of America - 2012 Muni Lease	(1,243,406)		(103,637)	(103,515)	-	-	-	(103,515)	-	-	-
Copier	(11,295)		(11,520)	(11,532)	(959)	(960)	1	(2,894)	(2,419)	(3,338)	(2,880)
2017 VR Demand Bond	(677,214)		(918,082)	(803,416)	-	-	-	-	(112,679)	(109,155)	(581,582)
2015 Revenue Bond	(1,621,839)		(1,645,164)	(1,643,801)	-	(137,097)	137,097	(409,926)	(548,389)	(274,195)	(411,291)
Physician Recruitment	-		(120,000)	(190,536)	-	(10,000)	10,000	(25,536)	(30,000)	(105,000)	(30,000)
Investment in Capital											
Equipment	(1,388,213)		(3,744,975)	(3,301,984)	(357,297)	(326,283)	(31,014)	(163,719)	(930,500)	(510,565)	(1,697,200)
Municipal Lease Reimbursement	735,082		219,363	219,363	-	-	-	219,363	-	-	-
GO Bond Project Personal Property	(1,175,083)		-	-	-	-	-	-	-	-	-
IT	(176,532)		(2,122,817)	(389,623)	(7,624)	(13,306)	5,682	(88,529)	(71,000)	(20,094)	(210,000)
Building Projects	(3,511,541)		(12,540,118)	(9,288,647)	(701,092)	(1,338,316)	637,224	(971,928)	(672,341)	(1,328,812)	(6,315,566)
Health Information/Business System	(4,478,846)		(2,050,000)	(3,841,146)	(173,894)	(300,000)	126,106	(726,407)	(2,228,554)	(886,185)	-
Capital Investments											
Properties	(2,373,193)		(1,355,000)	(1,355,000)	-	-	-	-	(475,000)	-	(880,000)
Measure C Scope Modifications	(1,725,552)		-	-	-	-	-	-	-	-	-
										-	
Change in Accounts Receivable	(2,134,289)	N1	304,109	383,707	1,940,531	(888,383)	2,828,914	(16,563)	412,276	(2,629,268)	2,617,262
Change in Settlement Accounts	(5,374,275)	N2	5,453,885	5,794,491	-	(320,000)	320,000	(2,777,362)	8,201,107	(4,728,312)	5,099,058
Change in Other Assets	(923,047)	N3	(1,962,591)	(2,994,264)	(126,943)	782,794	(909,737)	(1,741,634)	(3,164,013)	(394,398)	2,305,781
Change in Other Liabilities	2,649,423	N4	1,920,000	(184,617)	2,161,277	707,000	1,454,277	(1,914,066)	(2,862,455)	2,920,974	1,670,930
Change in Cash Balance	4,278,928		(2,189,419)	(2,364,945)	2,460,805	(1,231,464)	3,692,269	(4,286,088)	(9,382,006)	5,345,830	5,957,320
Beginning Unrestricted Cash	68,632,815		72,911,743	72,911,743	62,128,673	62,128,673	-	72,911,743	68,625,655	59,243,649	64,589,479
Ending Unrestricted Cash	72,911,743		70,722,324	70,546,799	64,589,479	60,897,210	3,692,269	68,625,655	59,243,649	64,589,479	70,546,799
Expense Per Day	382,387		408,686	406,601	405,878	408,656	(2,778)	382,013	400,457	405,878	406,601
Days Cash On Hand	191		173	174	159	149	10	180	148	159	174

Footnotes:
N1 - Change in Accounts Receivable reflects the 60 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 4/13/18

Well March did turn out to be one of the highest precipitation months in many years. That being said, our patient volumes seem to be in an approximate range that is 1 to 2% below the overall volumes of the prior year which was a heavy influence on our budgeted revenues this year.

We are still working closely with Mercy EPIC to nail down key statistical volumes for all aspects of our health system. This remains one of the very highest priorities for us to obtain post go live.

Further, our teams continue to work on post go live "tuning of the EPIC tool," or training of our personnel, and other issues to fully optimize all aspects of this new IT system. We have a very focused goal to restore a full equilibrium mode which would mean our Days in AR would be reduced to where it was before go live and our AR would be also reduced to the levels we were prior to go live along with many other relevant indicators. We are continuing to make real progress each month in this journey to reach operational equilibrium by June 30.

We are happy to be in the black YTD through February 28, an 8 month period with Net Income of $3.2 M. We await the March monthly and YTD financial information which should be available momentarily.

We are excited to share that no later than this summer we will see "hammers swinging" and construction begin for several critical "early" topic areas of our Master Plan. We will be doing some remodeling in the Internal Medicine/Cardiology building to create more exam rooms for more provider activity. We will begin to remodel the 3rd floor of our medical office building and begin build out of the 2nd floor of the cancer center. Further, the Administration building will be going away and staff are relocating to the former quality and home health houses near the ECC. This will allow us to add more patient parking in front of the hospital which is vital for all of our patients. There are several other activities happening as well.

We will likely have an "Open House" event after these staffing moves happen so that our healthcare team can see where key members have relocated at an appropriate time as well.

The second half of this calendar year will likely be the busiest half year ever relative to the arrival of several new physicians to our health system. We have two new family practice physicians, a gastroenterologist, and an urologist joining us this summer and we are hoping to be able to keep our locums ENT physician for the long term which could be known later this year.

Moving forward on our Rural Health Clinic strategy is underway and remains a very high priority for our health system.

We are actively looking and planning for external board education either late summer or early fall.

We will share the beginning of a multi-session presentation on telemedicine, how it is being used in healthcare and in rural settings, and what are some of the real challenges that are holding it back from it reaching its full potential.

At an upcoming board meeting we will circle back with a more in-depth discussion on our Community Health Needs Assessment. We will review prior board goals and the impacts of our wellness work since the previous update.

From a strategic planning perspective, we are in the “input from stakeholder and data gathering stage” of our journey. Several interviews have been conducted of key stakeholders and several more are scheduled. We have many internal and external stakeholder surveys that are going out now as well.

We are actively monitoring state level bills in both Nevada and California as there are several of serious concern that we must voice our views on so that healthcare is not unreasonably harmed. We are also watching and engaging on federal changes as well. We cannot overstate how important these actions are for our health system and for healthcare in general.

We believe California is positioning itself to see if it can implement material change in how healthcare is going to be paid for within the next 5 years or so.

Keeping you informed!

Harry

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Judith B. Newland **DATE: April 2018**

Just Do It" – Demonstrate measurable improvements annually in both Quality and Patient Satisfaction.

As part of our commitment to the BETA Heart program, we asked our hospital and medical staff to participate in the SCORE survey during the month of March. This Safety, Communication, Operational Reliability and Engagement (SCORE) Survey assists us in understanding the attitude and perceptions of the work environment in our departments. We needed to achieve a 60% response rate from both hospital and medical staff and we were able to accomplish a 63% response rate. Thank you to the hospital and medical staff for their participation. We are awaiting the results.

All Multi-Specialty Clinic front line staff attended a two hour training on empathy and communication to discuss setting expectations around creating a positive patient experience every time. This training was well received with good involvement and feedback from staff. Key concepts taught in the training were:

- Say hi when patients first arrive, welcome them and tell them who you are
- Connect with your eyes and let them know you will be taking good care of them
- Smile to help patients and families feel welcome and cared for
- Always end with "Is there anything else I can do for you before you leave?"

Triumph Protection Group will have security officers on the Tahoe Forest Hospital campus starting Monday, April 23rd on the swing shift (4:00pm – 12:00am) and night shift (12:00am – 8:00am). As more staff are hired the day shift will be covered. Some of their responsibilities will include TFH campus security rounds, assisting the emergency department in monitoring behavioral health patients, escorting staff to their vehicles, responding to helicopter landings and codes. The security staff have attended orientation similar to TFHS staff. Their orientation included review of our values, HIPAA/Privacy, and customer service training. Staff can contact the Security Officer by dialing "0" and say "Security". The phone will ring directly to the Security Officer. Triumph Security staff will be wearing black polo shirts, khaki pants and a name badge.

Creating and implementing a New Master Plan

Report provided by Dylan Crosby, Manger Facilities and Construction Management

Moves:

- The Quality Department has moved to the Red House
- Case Management will be moving to the ICU waiting room.
- Accounting, Business Office and Home Health will move to Pioneer Center in May.

Projects in Progress:

Project: TFH Fire Alarm Replacement Project
Start of Construction: 3/12/2018
Estimated Completion: 7/12/2019
Summary of Work: Remove and replace existing Fire Alarm System.
Update Summary: New panel has been installed and loop cut over started 4/16/2018. When a department's work area is to be effected, engineering will coordinate with the Director.

Project: Pioneer Phase 2
Start of Construction: 2/5/2018
Estimated Completion: 4/30/2018
Summary of Work: Construct leased space at Pioneer for: Access Center will be relocating within the building, HIM, Home Health and Business Office to relocate to Pioneer Center space.
Update Summary: Construction is scheduled to be completed 4/30/2018.

Project: IVCH Lab
Start of Construction: 2/12/2018
Estimated Completion: 6/5/2018
Summary of Work: Reconstruct existing IVCH Lab draw area and ED Exam Room 5.
Update Summary: Phase 2 continues in which all new framing and utilities are being installed.

Project: First Floor Corridor Doors, OSHPD S163426-29-00
Start of Construction: 2/5/2018
Estimated Completion: 7/18/2018
Summary of Work: Install magnetic hold opens on first floor South Building/1966 Building doors to improve work flow and access. Remove and replace 1978 Building smoke compartment doors for proper exiting. Modify Imaging Department door for security.
Update Summary: Project is currently on hold waiting for OSHPD Alternative Means of Compliance approval.

Project: TFHD Pharmacy Clean Room, OSHPD S170926-29-00
Estimated Start of Construction: 4/30/2018
Estimated Completion: 11/7/2018
Summary of Work: To meet new federal USP 800 regulations the surgical special procedures room will be reconstructed to house pharmacy compounding during construction, Phase 1. Phase 2 will be to reconstruct the Pharmacy to meet USP 800 requirements.
Update Summary: Permit has been received with Construction tentatively scheduled to begin 4/30/2018.

Projects in Permitting:

Project: TFHD Retail Pharmacy
Estimated Start of Construction: 4/30/2018
Estimated Completion: 5/14/2018
Summary of Work: To improve security of the Retail Pharmacy. An enclosure and door will be installed to limit access to the medication area of the pharmacy.
Update Summary: Plans are under review by the town of Truckee.

Project: IM Cardiology Expansion
Estimated Start of Construction: 6/11/2018
Estimated Completion: 8/31/2018

Summary of Work: Construct 3 new exam rooms and a MD/MA office in the west end of IM Cardiology to increase access for care.
Update Summary: Plans are under review by the town of Truckee.

Projects in Design:

Project: 3rd Floor MOB
Estimated Start of Construction: 8/6/2018
Estimated Completion: 5/10/2019
Summary of Work: Phase 1 reconstruct the 3rd Floor MOB 2 western suites for increased flexibility and additional exam rooms. Phase 2 reconstruct and integrate the 3rd Floor MOB adjacent suite for increased flexibility and additional exam rooms.
Update Summary: Project is in the process of being designed.

Project: Cancer Center 2nd Floor
Estimated Start of Construction: 8/6/2018
Estimated Completion: 5/10/2018
Summary of Work: Construct the 2nd floor of the Cancer Center for expansion of Rural Health Clinic Services.
Update Summary: Project is in the process of being designed.

Project: Tahoe Forest Hospital Site Improvements
Estimated Start of Construction: 5/25/2018
Estimated Completion: 8/16/2018
Summary of Work: Demolish the existing curves building to increase patient parking. Demolish the North Levon Apartments for additional parking and snow storage.
Update Summary: Project is in the process of being designed.

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Karen Baffone, RN, MS **DATE: April 2018**
Chief Nursing Officer

Strategy Two: Choosing and implementing the correct new Electronic Health Record for our system that spans all physician, OP and IP services.

- All CNO areas achieved <3% on late charge entry for EPIC
- EPIC build for Care Coordination started.
- Expanded daily huddle to include charge capture and revenue for the month

Strategy Four: Care Coordination

- Perinatal Mood and Anxiety Disorders (PMAD) counselling on the increase for care coordination
- Screening, Brief Intervention and Referral to Treatment (SBIRT) capture moving to MSC staff in concert with the Care Coordination program as well as the need for capture of this data for the PRIME – Chronic Nonmalignant Pain Management Program
- Speaking at Becker's CNO/CIO conference in May to highlight our Integrated Care Coordination Program

Strategy Six: Just Do IT

PRIME: Mid-year report was submitted on March 31, 2018 and has been accepted by the State.

CORE MEASURES: VTE and Flu documentation has been reviewed with education to staff provided. Given that we are completed for the year on Flu vaccination we will re-educate staff again in the fall. VTE has had 100% compliance with the training updates.

PRODUCTIVITY: All nursing departments have develop a daily process of measuring the productivity that are consistent with their hours per unit of service. This will allow for easier flexing of staff based on current volumes and meeting the budget.

NURSES OF EXCELLENCE: A total of 20 nurses have been nominated for the "Nurses of Excellence" award that are a tradition during Nurses' Week at Tahoe Forest Hospital. This is an amazing number of nurses that were identified by physicians, peers, and directors as demonstrated leaders of our values. The ceremony for these awards will be on May 7 from 4:30pm-5:30pm.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst **DATE:** 3/14/2018

CIIO

- Progress on Infrastructure projects
- Upgrading the Microsoft email exchange server
- Upgrading the Microsoft Domain Controllers
- Working on eliminating the old Citrix Environment and presenting a unified desktop.
- Network team working on connectivity projects at Levon, Dr. Koch, and Pioneer Center
- Genesys software and phones setup for the access center complete
- PYXIS- This is a large project
- Nuance power scribe for radiology software update
- Starting prep work for a printing contract request for proposals (RFP)
- Home Health and Hospice Epic software integration kicked off with Mercy
- Continuing work on moving cancer center to Epic
- Training is going on to support the physicians with IT Individuals when Sean leaves
- Starting a project to send radiology PACS images and reports to UCSF, Stanford, and Kaiser. They all use a specific software to receive images.
- IT and project management are looking at expenses along with the rest of the District to reduce costs
- Current training and certifying many support personnel on the Epic software

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Shawni L. Coll D.O., FACOG
Chief Medical Officer

DATE: April 17, 2018

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1. **GOAL: A complete makeover of our Physician service line**
   We have a contract out for signature for a new orthopedic surgeon, who would start in August/September. We continue to interview Primary Care Providers to help expand to offer weekend services and have a strong candidate. We have a potential neurology candidate and are working on telephone interviews and references prior to an in-person interview.

2. **GOAL: Electronic Health Record**
   IT team, along with medical staff leaders, are making a strong transition plan for when Sean Melicher (our main Mercy Epic provider support) leaves.

3. **GOAL: New Master Space Plan**
   We are now looking at finishes for both the second floor of the cancer center and for the 3rd floor of the MOB. We continue to have strategy meetings for upcoming projects as our medical staff expands and the increase need for space arises.

4. **GOAL: Just Do It**
   Customer service training completed for the MSC front office staff. Good reception from staff to the training and our Press Ganey Scores have already improved!

13.4. Contracts

Contracts redacted.

Available for public viewing via a Public Records request.

ABD-04 Board of Directors Qualifications

PURPOSE:

To provide a written list of qualifications for prospective candidates seeking a seat on the hospital board of directors.

POLICY:

A. Must be a registered voter and reside in the District. Health and Safety Code 32100
The elective officers of a local hospital district shall be a board of hospital directors consisting of five members, each of whom shall be a registered voter residing in the district and whose term shall be four years, with the exception of the first board.

B. Must not have been convicted of a felony. Government Code 1021
   1. A person is disqualified from holding any office upon conviction of designated crimes as specified in the Constitution and laws of the State.
   2. Within the meaning of Const. Art. 20, § 11 , Govt. Code §§ 1770(h), 3000 and this section, a conviction consists of a jury verdict or court finding of guilt followed by a judgment upholding and implementing such verdict or finding, and the taking of an appeal would not stay or delay the effects of such a conviction.

C. May not possess an ownership interest in another hospital serving the same area in the District. Health and Safety Code 32110.
   1. Except as provided in subdivision (d) of Section 32110, no person who is a director, policymaking, management employee or medical staff officer of a hospital owned or operated by a district shall do either of the following:
      a. Possess any ownership interest in any other hospital serving the same area as that served by the district hospital of which the person is a director, policymaking management employee or medical staff officer.
      b. Be a director, policymaking management employee, or medical staff officer of any hospital serving the same area as the area served by the district hospital.
   2. For purposes of this section, a hospital shall be considered to serve the same area as a district hospital when more than five percent (5%) of the hospital's patient admissions are residents of the district.
   3. For purposes of this section, the possession of an ownership interest, including stocks, bonds, or other securities by the spouse, registered domestic partner, or minor children or any person shall be deemed to be the possession or interest of the person.
   4. No person shall serve concurrently as a director or policymaking management employee of a district and as a director or policymaking management employee of any other hospital serving the same area as the district, unless the boards of directors of the district and the hospital have determined that the situation will further joint planning, efficient delivery of health care services and the best interest of the areas served by their respective hospitals, or unless the district and the hospital are affiliated under common ownership, lease or any combination thereof.

D. Candidate for Director must disclose on the ballot occupation and place of employment if s/he has stock in or works for a health care facility that does not serve the same area served by the District. Health and Safety Code 32110(e).
   1. Any candidate who elects to run for the office of member of the board of directors of a district, and who owns stock in, or who works for any health care facility that does not serve the same area served by the district in which the office is sought, shall disclose on the ballot his or her occupation and place of employment.

E. May be a physician and provide services to the District under certain circumstances. Health and Safety Code 32111.
   1. A member of a health care district's medical or allied health professional staff who is an officer of the district shall not be deemed to be "financially interested," for purposes of Section

1090 of the Government Code, in any of the contracts set forth in subdivision (b) made by any district body or board of which the officer is a member if all of the following conditions are satisfied:
    a. The officer abstains from any participation in the making of the contract.
    b. The officer's relationship to the contract is disclosed to the body or board and noted in its official records.
    c. If the requirements of paragraphs (1) and (2) are satisfied, the body or board does both of the following, without any participation by the officer:
        i. Finds that the contract is fair to the district and in its best interest.
        ii. Authorizes the contract in good faith.
2. Subdivision 6.1 shall apply to the following contracts:
    a. A contract between the district and the officer for the officer to provide professional services to the district's patients, employees or medical staff members and their respective dependents, provided that similar contracts exist with other staff members and the amounts payable under the contract are no greater than the amounts payable under similar contracts covering the same or similar services.
    b. A contract to provide services to covered persons between the district and any insurance company, health care service plan, employer or other entity that provides health care coverage, and that also has a contract with the officer to provide professional services to its covered persons.
    c. A contract in which the district and the officer are both parties, if other members of the district's medical or allied health professional staff are also parties, directly or through their professional corporations or other practice entities, provided the officer is offered terms no more favorable than those offered any other party who is a member of the district's medical or allied health professional staff.
3. This section does not permit an otherwise prohibited individual to be a member of the board of directors of a district, including, but not limited to, individuals described in Section 32110 of the Health & Safety Code or in Section 53227 of the Government Code. Nothing in this section shall authorize a contract that would otherwise be prohibited by Section 2400 of the Business and Professions Code.
4. For purposes of this section, a contract entered into by a professional corporation or other practice entity in which the officer has an interest shall be deemed the same as a contract entered into by the officer directly.

F. May not be an employee of the District. Government Code 53227.
1. An employee of a local agency may not be sworn into office as an elected or appointed member of the legislative body of that local agency unless he or she resigns as an employee. If the employee does not resign, his or her employment shall automatically terminate upon his or her being sworn into office.

G. May not be a Director and simultaneously hold another public office. Government Code 1099.
1. A public officer, including, but not limited to, an appointed or elected member of a governmental board, commission, committee or other body, shall not simultaneously hold two public offices that are incompatible. Offices are incompatible when any of the following circumstances are present, unless simultaneous holding of the particular offices is compelled or expressly authorized by law:
    a. Either of the offices may audit, overrule, remove members of, dismiss employees of, or exercise supervisory powers over the other office or body.
    b. Based on the powers and jurisdiction of the offices, there is a possibility of a significant clash of duties or loyalties between the offices.
    c. Public policy considerations make it improper for one person to hold both offices.
2. When two public offices are incompatible, a public officer shall be deemed to have forfeited the first office upon acceding to the second. This provision is enforceable pursuant to Section 803 of the Code of Civil Procedure.
3. This section does not apply to a position of employment, including a civil service position that

does not constitute a public office.

4. This section shall not apply to a governmental body that has only advisory powers.
5. For purposes of paragraph (1) of subdivision (a), a member of a multimember body holds an office that may audit, overrule, remove members of, dismiss employees of, or exercise supervisory powers over another office when the body has any of these powers over the other office or over a multimember body that includes that other office.

H. As a Director, you may not make, participate in making or in any way attempt to use your position as a Director to influence a decision of the District when you know or have a reason to know that you have a financial interest in the decision. Government Code 87100
    1. No public official at any level of state or local government shall make, participate in making or in any way attempt to use his official position to influence a governmental decision in which he knows or has reason to know he has a material financial interest distinguishable from its effect on the public generally.
I. When you are a director, neither you nor the District may make any contract you are financially interested in. Government Code 1090.
    1. Members of the Legislature, state, county, district, judicial district, and city officers or employees shall not be financially interested in any contract made by them in their official capacity, or by any body or board of which they are members. Nor shall state, county, district, judicial district, and city officers or employees be purchasers at any sale or vendors at any purchase made by them in their official capacity.

Related Policies/Forms: Conflict of Interest Policy ABD-7

References:

Policy Owner: Clerk of the Board

Approved by: Chief Executive Officer

ABD-04 Board of Directors Qualifications

PURPOSE:

To provide a written list of qualifications for prospective candidates ~~who would like to run for a seat~~seeking a seat on the hospital board of directors~~ or for the hospital board of directors to use when, in the event of a vacancy, it must appoint a new board member~~.

POLICY:

A. Must be a registered voter and reside in the District. Health and Safety Code 32100
The elective officers of a local hospital district shall be a board of hospital directors consisting of five members, each of whom shall be a registered voter residing in the district and whose term shall be four years, with the exception of the first board.

~~B. Must reside in the District. Health and Safety Code 32100~~
~~The elective officers of a local hospital district shall be a board of hospital directors consisting of five members, each of whom shall be a registered voter residing in the district and whose term shall be four years, with the exception of the first board~~

~~C.~~B. Must not have been convicted of a felony. Government Code 1021

1. A person is disqualified from holding any office upon conviction of designated crimes as specified in the Constitution and laws of the State.
2. Within the meaning of Const. Art. 20, § 11 , Govt. Code §§ 1770(h), 3000 and this section, a conviction consists of a jury verdict or court finding of guilt followed by a judgment upholding and implementing such verdict or finding, and the taking of an appeal would not stay or delay the effects of such a conviction.

~~D.~~C. May not possess an ownership interest in another hospital serving the same area in the District. Health and Safety Code 32110.

1. Except as provided in subdivision (d) of Section 32110, no person who is a director, policymaking, management employee or medical staff officer of a hospital owned or operated by a district shall do either of the following:
    a. Possess any ownership interest in any other hospital serving the same area as that served by the district hospital of which the person is a director, policymaking management employee or medical staff officer.
    b. Be a director, policymaking management employee, or medical staff officer of any hospital serving the same area as the area served by the district hospital.
2. For purposes of this section, a hospital shall be considered to serve the same area as a district hospital when more than five percent (5%) of the hospital's patient admissions are residents of the district.
3. For purposes of this section, the possession of an ownership interest, including stocks, bonds, or other securities by the spouse, registered domestic partner, or minor children or any person shall be deemed to be the possession or interest of the person.
4. No person shall serve concurrently as a director or policymaking management employee of a district and as a director or policymaking management employee of any other hospital serving the same area as the district, unless the boards of directors of the district and the hospital have determined that the situation will further joint planning, efficient delivery of health care services and the best interest of the areas served by their respective hospitals, or unless the district and the hospital are affiliated under common ownership, lease or any combination thereof.

~~E.~~D. Candidate for Director must disclose on the ballot occupation and place of employment if s/he has stock in or works for a health care facility that does not serve the same area served by the District. Health and Safety Code 32110(e).

1. Any candidate who elects to run for the office of member of the board of directors of a district, and who owns stock in, or who works for any health care facility that does not serve the same area served by the district in which the office is sought, shall disclose on the ballot his or her

occupation and place of employment.

~~F.~~E. May be a physician and provide services to the District under certain circumstances. Health and Safety Code 32111.

1. A member of a health care district's medical or allied health professional staff who is an officer of the district shall not be deemed to be "financially interested," for purposes of Section 1090 of the Government Code, in any of the contracts set forth in subdivision (b) made by any district body or board of which the officer is a member if all of the following conditions are satisfied:
    a. The officer abstains from any participation in the making of the contract.
    b. The officer's relationship to the contract is disclosed to the body or board and noted in its official records.
    c. If the requirements of paragraphs (1) and (2) are satisfied, the body or board does both of the following, without any participation by the officer:
        i. Finds that the contract is fair to the district and in its best interest.
        ii. Authorizes the contract in good faith.
2. Subdivision 6.1 shall apply to the following contracts:
    a. A contract between the district and the officer for the officer to provide professional services to the district's patients, employees or medical staff members and their respective dependents, provided that similar contracts exist with other staff members and the amounts payable under the contract are no greater than the amounts payable under similar contracts covering the same or similar services.
    b. A contract to provide services to covered persons between the district and any insurance company, health care service plan, employer or other entity that provides health care coverage, and that also has a contract with the officer to provide professional services to its covered persons.
    c. A contract in which the district and the officer are both parties, if other members of the district's medical or allied health professional staff are also parties, directly or through their professional corporations or other practice entities, provided the officer is offered terms no more favorable than those offered any other party who is a member of the district's medical or allied health professional staff.
3. This section does not permit an otherwise prohibited individual to be a member of the board of directors of a district, including, but not limited to, individuals described in Section 32110 of the Health & Safety Code or in Section 53227 of the Government Code. Nothing in this section shall authorize a contract that would otherwise be prohibited by Section 2400 of the Business and Professions Code.
4. For purposes of this section, a contract entered into by a professional corporation or other practice entity in which the officer has an interest shall be deemed the same as a contract entered into by the officer directly.

~~G.~~F. May not be an employee of the District. Government Code 53227.

1. An employee of a local agency may not be sworn into office as an elected or appointed member of the legislative body of that local agency unless he or she resigns as an employee. If the employee does not resign, his or her employment shall automatically terminate upon his or her being sworn into office.

~~H.~~G. May not be a Director and simultaneously hold another public office. Government Code 1099.

1. A public officer, including, but not limited to, an appointed or elected member of a governmental board, commission, committee or other body, shall not simultaneously hold two public offices that are incompatible. Offices are incompatible when any of the following circumstances are present, unless simultaneous holding of the particular offices is compelled or expressly authorized by law:
    a. Either of the offices may audit, overrule, remove members of, dismiss employees of, or exercise supervisory powers over the other office or body.
    b. Based on the powers and jurisdiction of the offices, there is a possibility of a significant clash of duties or loyalties between the offices.

c. Public policy considerations make it improper for one person to hold both offices.

2. When two public offices are incompatible, a public officer shall be deemed to have forfeited the first office upon acceding to the second. This provision is enforceable pursuant to Section 803 of the Code of Civil Procedure.
3. This section does not apply to a position of employment, including a civil service position that does not constitute a public office.
4. This section shall not apply to a governmental body that has only advisory powers.
5. For purposes of paragraph (1) of subdivision (a), a member of a multimember body holds an office that may audit, overrule, remove members of, dismiss employees of, or exercise supervisory powers over another office when the body has any of these powers over the other office or over a multimember body that includes that other office.

~~I.~~H. As a Director, you may not make, participate in making or in any way attempt to use your position as a Director to influence a decision of the District when you know or have a reason to know that you have a financial interest in the decision. Government Code 87100

1. No public official at any level of state or local government shall make, participate in making or in any way attempt to use his official position to influence a governmental decision in which he knows or has reason to know he has a material financial interest distinguishable from its effect on the public generally.

~~J.~~I. When you are a director, neither you nor the District may make any contract you are financially interested in. Government Code 1090.

1. Members of the Legislature, state, county, district, judicial district, and city officers or employees shall not be financially interested in any contract made by them in their official capacity, or by any body or board of which they are members. Nor shall state, county, district, judicial district, and city officers or employees be purchasers at any sale or vendors at any purchase made by them in their official capacity.

Related Policies/Forms: Conflict of Interest Policy ABD-7

References:

Policy Owner: Clerk of the Board

Approved by: Chief Executive Officer

ABD-18 New Programs and Services

PURPOSE:

A. To assist the Board of Directors with the Board's oversight and evaluation of new programs and/or services.
B. To assist the Board of Directors in the Board's responsibility to affirm the organization's strategic direction in a manner consistent with the organization's mission, vision, and values.

POLICY:

A. The Board (or designated Board committee) will consider the following when evaluating new programs and services:
    1. Congruence with mission, vision, and values
    2. Financial feasibility
    3. Impact on quality and safety with a requirement to meet quality related performance criteria
    4. Market potential
    5. Redundancy
    6. Impact on other organizational units (e.g., employed physician groups, independent physicians on the medical staff, the medical staff as a whole, etc.)
B. Management will present to the Board a written analysis of proposed new programs and services that addresses, at a minimum, the components listed above.
C. The Board will first consider the information presented in the analysis during a Board meeting; discussion will take place and additional information/input from others may be required. The Board will ensure that management provides the additional information/input as requested.
D. In general, Board decisions on whether to move forward with a new program or service will **not** be taken during the meeting at which the proposed new program or service is initiated. The final decision will be made at a subsequent Board meeting in order to allow board members to have additional time for discussion/consideration and to assess all information before voting.

Related Policies/Forms:

References:

Policy Owner: Clerk of the Board

Approved by: Chief Executive Officer

ABD-18 New Programs and Services

PURPOSE:

A. To assist the Board of Directors ~~in~~ with the Board's ~~exercise of~~ oversight and ~~with respect to duty of care in~~ evaluation~~g~~ ~~the impact~~ of new programs and/or services ~~of the organization~~. ~~The duty of care requires Board members to have knowledge of all reasonably available and pertinent information before taking action. The Board member must act in good faith, with the care of an ordinarily prudent businessperson in similar circumstances, and in a manner he or she reasonably believes to be in the best interest of the organization.~~

B. To assist the Board of Directors in the Board's responsibility to ~~set~~ affirm the organization's strategic direction in a manner consistent with the organization's mission, vision, and values.

POLICY:

A. The Board ~~[~~(or ~~relevant~~ designated Board committee~~)]~~ will consider the following when evaluating new programs and services:
    1. Congruence with mission, vision, and values
    2. Financial feasibility
    3. Impact on quality and safety with a requirement to meet quality related performance criteria
    4. Market potential
    5. Redundancy
    6. Impact on other organizational units ~~[~~(e.g., employed physician groups, independent physicians on the medical staff, the medical staff as a whole, etc.~~)]~~

B. Management will present to the Board ~~[committee]~~ a written analysis of proposed new programs and services that addresses, at a minimum, the components listed above.

C. The Board ~~[committee]~~ will first consider the information presented in the analysis during a Board ~~[committee]~~ meeting; discussion will take place and additional information/input from others may be required. The Board ~~[committee]~~ will ensure that management provides the additional information/input as requested.

D. In general, Board ~~[committee]~~ decisions on whether to move forward with a new program or service will **not** be taken during the meeting at which the proposed new program or service is initiated. The final decision will be made at a subsequent Board ~~[committee]~~ meeting in order to allow Board ~~[committee]~~ members to have additional time for discussion/consideration and to assess all information before voting.

Related Policies/Forms:

References:

Policy Owner: Clerk of the Board

Approved by: Chief Executive Officer

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Alex MacLennan, CHRO

DATE: 4/19/2018

Employee Association affiliation election:

The election to affiliate or not affiliate with American Federation of State, County and Municipal Employees (AFSCME) has taken place and the votes have been counted. The Employees Association (EA) has voted to affiliate with AFSCME.

We are pleased that all represented employees had the opportunity for their voices to be heard during this election process.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Alex MacLennan, CHRO

DATE: 4/19/2018

Employee Association of Professionals affiliation election:

The election to affiliate or not affiliate with American Federation of State, County and Municipal Employees (AFSCME) has taken place and the votes have been counted. The Employees Association of Professionals (EAP) has voted to affiliate with AFSCME.

We are pleased that all represented employees had the opportunity for their voices to be heard during this election process.

Tahoe Forest Health System

Healthcare Corporate Compliance and HIPAA: An Update

THE FOX GROUP, LLC

consultants to the healthcare industry

TAHOE FOREST HEALTH SYSTEM

Agenda

1. Welcome
2. Healthcare Fraud and Abuse Laws
3. The TFHS Corporate Compliance Program
4. HIPAA Privacy and Security Rule

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Healthcare Fraud and Abuse and other Laws

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There are what kind of penalties for violating laws related to compliance?

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Recent Cases

- Tri-City Medical Center (Oceanside, CA) paid $3.3m related to 92 arrangements (Stark)
- Toumey Health System paid $237m for arrangements related to a surgery center.
  - CEO later paid $1m in personal fines.
  - Stark and False Claims (FCA) allegations

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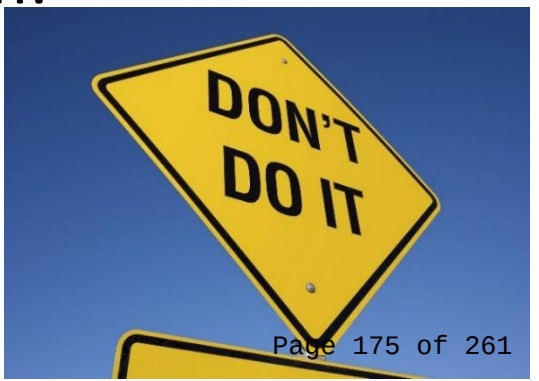
Recent Cases

- North Broward Hospital District paid $65.9m:
  - Compensation was over 90th percentile of MGMA survey
  - Hospital tracked "contribution margins"
  - Stark and FCA
- Columbus Regional, GA paid $25-$35m:
  - paying above FMV for practice.
  - Physician paid $425k!
  - Stark and FCA



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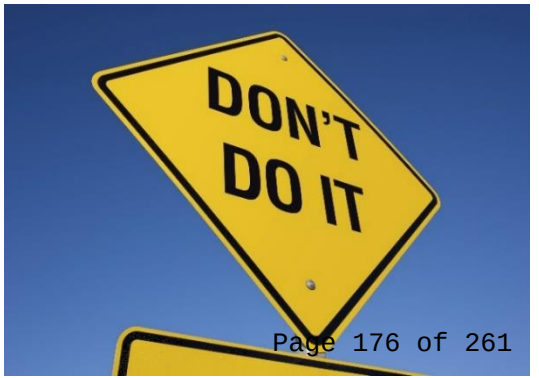
Recent Cases Involving CAHs

- Stone County Hospital, Inc. (MS CAH)
  - Whistleblower suit taken over by OIG
  - Reported excessive expenses for cars, etc., plus payments to owners for services duplicating services of hospital staff
- Wheaton Community Hospital (MN CAH)
  - $846k settlement for admitting patients to acute care when not medically necessary
  - Physician whistleblower got $203k



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Stark – A Civil Statute

Why: Inappropriate financial incentives should not influence medical decisions

Tahoe Forest Health System

Physician may not refer patients to DHS if they have a financial relationship

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10 DHS

- Clinical Lab
- Radiology
- Inpatient and Outpatient Hospital services

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Strict Liability:
Intent doesn't matter!

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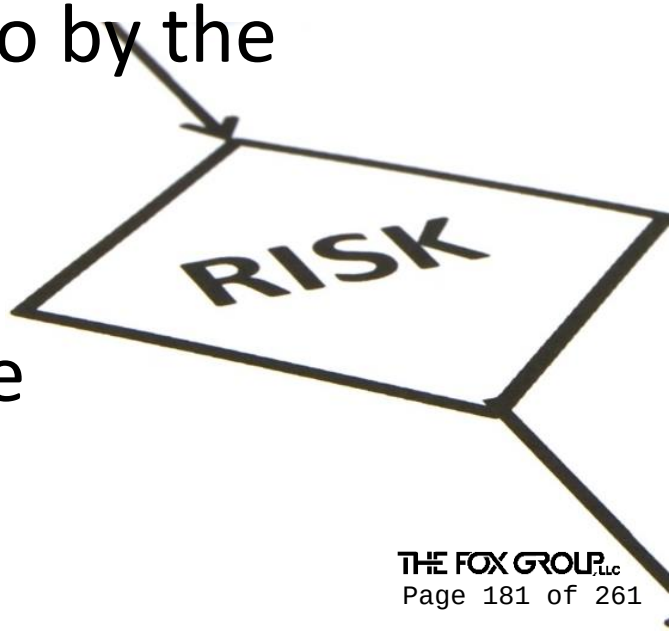
Safe Harbor

- Arrangement in writing, documenting terms agreed to by the parties
- Specific Services & Schedule
- Compensation set in advance and can't change for 1 year



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Safe Harbor

- FMV, no reference to volume of referrals
- Commercially Reasonable

Technical Violations Matter!
Intent Doesn't matter!

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Sanctions

- Medicare denies or recoups payment
- CMP
- False Claims
- Suspension or exclusion

Stark vs. Anti-Kickback

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Anti-Kickback Statute

Criminal Liability!

- Offers to pay
- Payments
- Solicitation
- Receiving

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Recent Cases

- DaVita Healthcare Partners paid $389m in 2014
  - DaVita targeted young physicians in debt, offering joint ventures in exchange for non-competition and referrals
  - Whistleblower Case included False Claims Act allegations
- Adventist Health System, FL paid $118.7m
  - Paid above FMV for physician practices to capture referrals
  - Used a spreadsheet to track referrals and revenue

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Recent Cases

- Medical Device company C.R. Bard Inc. paid $48.2m
  - Bard allegedly offered doctors many forms of kickbacks, including unrestricted “grant” money, rebates, advertising campaigns and free medical equipment
- TAP Pharmaceuticals paid $875m
  - Whistleblower case alleging TAP conspired with doctors to charge Medicare and Medicare beneficiaries for free samples of Lupron.

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Scope

- Criminal Intent
- Covers more than healthcare
- Liability for both parties
- Penalties – fines and prison

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Safe Harbors

- EHR System subsidies
- Medicare Beneficiary Waivers
- Risk-Sharing arrangements
- PSAs meeting Stark requirements

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Stark and Anti-Kickback

- Stark investigations often lead to Anti-kickback allegations – and vice-versa
- They also lead to False Claims Act allegations and penalties

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False Claims - A Very Thin Perch

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False Claims Act - Civil Liability

- False request for payment
- False record or statement
- Whistleblower protections

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Civil Liability

- $21k per claims, plus triple damages
- Reverse false claims . . .
  not refunding overpayments

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Civil Liability

- Public agency gift of public funds, etc.
- Exclusion from Federal Programs
- Civil Monetary Penalties
- Corporate Integrity Agreement (CIA)

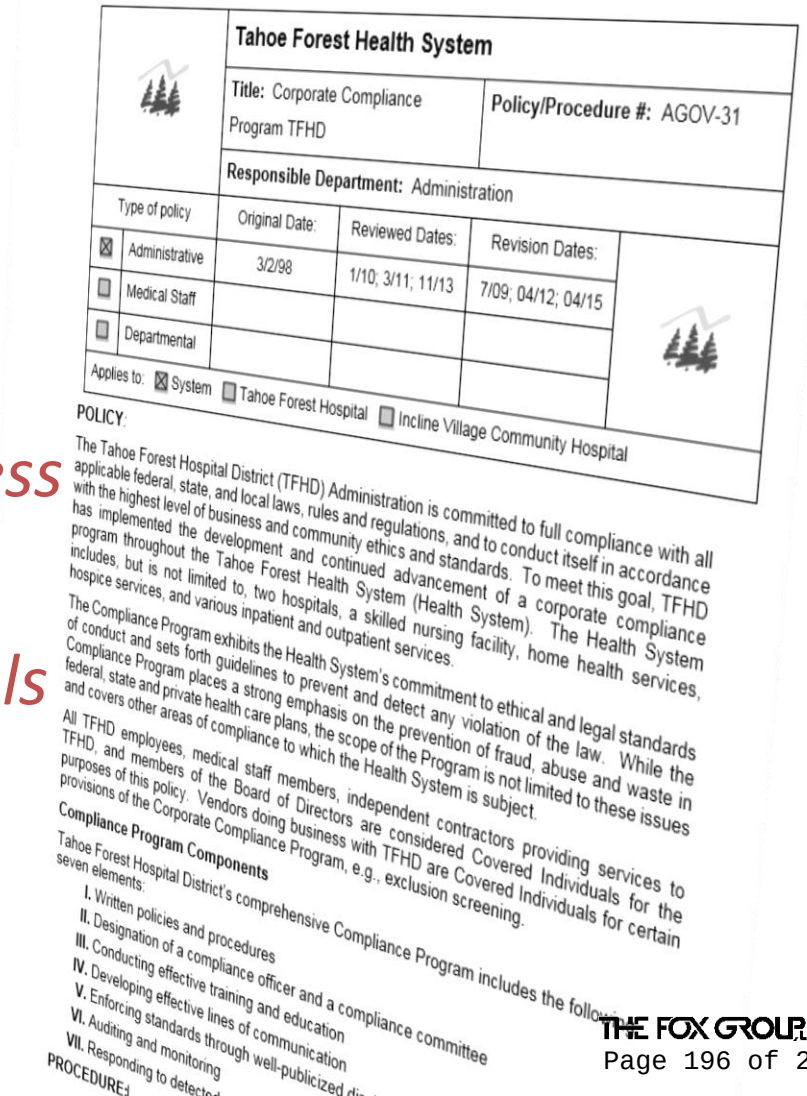
TAHOE FOREST HEALTH SYSTEM

TFHS 2018 Compliance Program

Purpose/Implementation

TAHOE FOREST HEALTH SYSTEM

- ✓ Prevent
  fraud and abuse
- ✓ Commitment
  to the compliance process
- ✓ Develop
  effective internal controls
- ✓ Perform
  regular periodic audits



Tahoe Forest Health System

Title: Corporate Compliance Program TFHD

Policy/Procedure #: AGOV-31

Responsible Department: Administration

Type of policy	Original Date:	Reviewed Dates:	Revision Dates:
☒ Administrative	3/2/98	1/10; 3/11; 11/13	7/09; 04/12; 04/15
☐ Medical Staff			
☐ Departmental			

Applies to: ☒ System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital

POLICY:

The Tahoe Forest Hospital District (TFHD) Administration is committed to full compliance with all applicable federal, state, and local laws, rules and regulations, and to conduct itself in accordance with the highest level of business and community ethics and standards. To meet this goal, TFHD has implemented the development and continued advancement of a corporate compliance program throughout the Tahoe Forest Health System (Health System). The Health System includes, but is not limited to, two hospitals, a skilled nursing facility, home health services, hospice services, and various inpatient and outpatient services.

The Compliance Program exhibits the Health System's commitment to ethical and legal standards of conduct and sets forth guidelines to prevent and detect any violation of the law. While the Compliance Program places a strong emphasis on the prevention of fraud, abuse and waste in federal, state and private health care plans, the scope of the Program is not limited to these issues and covers other areas of compliance to which the Health System is subject.

All TFHD employees, medical staff members, independent contractors providing services to TFHD, and members of the Board of Directors are considered Covered Individuals for the purposes of this policy. Vendors doing business with TFHD are Covered Individuals for certain provisions of the Corporate Compliance Program, e.g., exclusion screening.

Compliance Program Components

Tahoe Forest Hospital District's comprehensive Compliance Program includes the following seven elements:

I. Written policies and procedures
II. Designation of a compliance officer and a compliance committee
III. Conducting effective training and education
IV. Developing effective lines of communication
V. Enforcing standards through well-publicized
VI. Auditing and monitoring
VII. Responding to

PROCEDURE:

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Policies

- TFHS Compliance Program
- Code of Conduct Policy
- Compliance Investigations
- OIG Exclusion Screening

Risk Areas

- Providing medically Unnecessary services
- Outpatient services rendered in connection with inpatient stays
- Stark physician self-referral law

Risk Areas, cont.

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- ✓ Duplicate Billing
- ✓ Billing for services NOT rendered
- ✓ Failure to refund credit balances
- ✓ Patients “Freedom of Choice”
- ✓ and 9 others

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Compliance Officer

- Overseeing and monitoring
- Investigating and reporting
- Education and training
- Encourage reporting suspected fraud and abuse

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Compliance Committee

- Advise Compliance Officer
- Develop standards of conduct
- Develop Policies and procedures
- Monitor and develop controls

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Board of Directors

- Support, review, adopt compliance program and annual work plan
- Be familiar with healthcare laws
- Require an effective reporting system
- Review results of compliance activities
  - ➢ Performance evaluations | Internal/external audits

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Report Compliance Concerns

- Compliance Hotline x 6655
- Email compliance@tfhd.com
- Report to a Medical Staff Officer
- Contact the Compliance Analyst (shanson@tfhd.com) or the Compliance Consultant (jhook@tfhd.com)

TAHOE FOREST HEALTH SYSTEM

2018 TFHD Workplan

- Provides focus for Compliance Program
- 34 total objectives
- Activities in each of the 7 areas

Polices and Procedures	**Investigation & Reporting**
Oversight	Enforcement & Discipline
Education & Communication	Responding and Corrective Action
Monitoring and Auditing	

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2018 TFHD Workplan, cont.

- Sample Audits
  - Physician payments
  - Physician credentialing
  - Annual Health Stream training

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2017 TFHD Workplan, cont

- Sample Audits
  - E&M coding
  - Patient Admission (2 midnight rule)
  - NP/PA Incident-to Billing
  - ICD-10 Coding

TAHOE FOREST HEALTH SYSTEM

What is HIPAA?

Health

Insurance

Portability and

Accountability **A**ct

(*Signed August 21, 1996)*

TAHOE FOREST HEALTH SYSTEM

What Does HIPAA Do?

It requires standards for:

1. Privacy of Identifiable Health Information
2. Security of Electronic Protected Health Information
3. Electronic Health Care Transactions and Code Sets

Topics Covered Under HIPAA Privacy and Security

Tahoe Forest Health System

HIPAA Privacy Rule

- Protected Health Information
- Minimum Necessary
- Use vs. Disclosure of PHI
- Patient Privacy Rights
- Notice of Privacy Practices
- Privacy Officer

HIPAA Security Rule

- Electronic Health Information
- User Identity
- Password Management
- Workstation Security
- Security Officer
- Periodic Risk Assessments

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What is Protected Health Information (PHI)?

PHI is:

- Individually Identifiable Health Information
  - which is created in the process of caring for the patient, and
  - is transmitted or maintained in an electronic, written, or oral manner.

Tahoe Forest Health System

Covered Entities:

- Health Plans
- Healthcare Clearinghouses
- Healthcare Providers
- Business Associates of Providers or Plans

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Who is a Business Associate?

A Business Associate:

- Is a person or entity who performs or assists in performing
  - Services that involve the use of or access to Protected Health Information maintained by BAH

Example: Collection agency, Consulting companies with access to PHI, etc.

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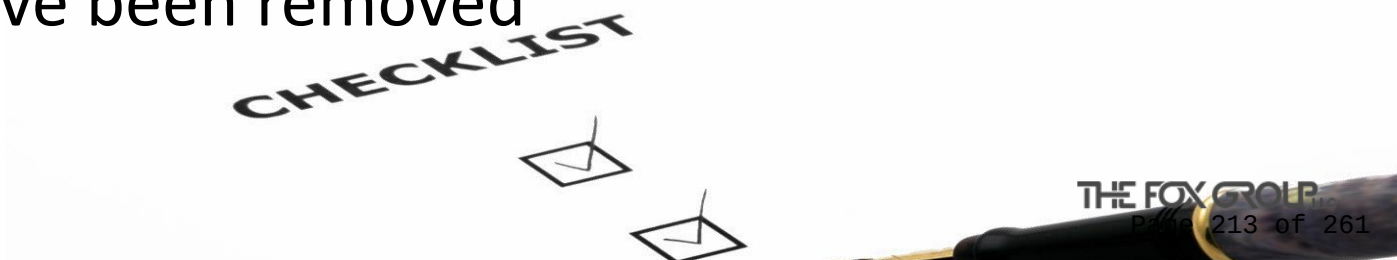
What is not considered PHI?

- Health information is not PHI if it is de-identified
- De-identified information may be used without restriction and without patient authorization
- The de-identification rule states that you can disclose health information after all of the 18 identifying elements have been removed



Tahoe Forest Health System

Patient Privacy Rights

- The right to **access and copy patient's PHI**
- The right to request **amendments to information**
- The right to an **accounting of the disclosures of PHI**
- The right to **request restriction** of PHI uses & disclosures
- The right to **request alternative** forms of **communications** (mail to P.O. Box, not street address; no message on answering machine, etc.)
- The right to **a paper copy** of the "Notice of Privacy Practices"

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Use of PHI

The sharing, utilization, examination or analysis of PHI ***within*** the organization or with Business Associates

Disclosure of PHI

The release, transfer, provision of access to or divulging in any other manner of PHI ***outside*** the department or organization

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HIPAA Security Rule

- Electronic Health Information
- User Identity
- Password Management
- Workstation Security
- Security Officer
- Periodic Risk Assessments

TAHOE FOREST HEALTH SYSTEM

What is Electronic Protected Health Information (ePHI)?

e-PHI (electronic Protected Health Information) is

- computer-based patient health information
- that is **used, created, stored, received or transmitted** by a Covered Entity
- using any type of electronic information resource.

Breach Notification

A Breach is:

- an impermissible use or disclosure under the Privacy Rule
- that compromises the security or privacy of the PHI
- that poses a significant risk of financial, reputational, or other harm to the affected individual .

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Breach Notification

What is the TFHS Policy?

- Investigate and perform a risk assessment.
- Notify affected individuals by mail or email;
- Publish information on-line if patient contact info is out of date;
- Publish information in the media if the breach involves 500 or more individuals;
- Notify the Secretary of HHS at least annually;

Privacy Breaches – 500+ Records – CMP and Resolution Agreements

- Reported Breaches from 2010-2016: 1,780
  - 29 cases settled for $100k to $4.8m
- Reported Breaches from 2016-2017: 404
  - 23 cases settled for $31k to $5.5m

Privacy Breaches – 500+ Records

- In April 2012, Memorial Healthcare System (FL) reported that the login credentials of a former employee of a non-employed physician were used to access ePHI on a daily basis for the preceeding 12 months. Over 80,000 records were accessed. MHS did not follow its procedures for modifying/terminating user privileges. Fine: $5.5m!
- Dawnielle Vaca, 35, a CNA at St. Charles Bend, "viewed thousands of patient records that she was unauthorized to view," according to the local DA. Vaca faces two counts of computer crime for accessing the St. Charles computer system to view the records, the DA said.

Privacy Breaches – 500+ Records

- Oregon Health & Science University (OHSU) has agreed to settle potential violations of HIPAA Privacy and Security Rules following an investigation by the OCR. The settlement includes a payment by OHSU to the OCR for $2.7m. OHSU performed risk analyses in 2003, 2005, 2006, 2008, 2010, and 2013, but OCR's investigation found that these analyses did not cover all ePHI in OHSU's enterprise, as required by the Security Rule.
- Three desktop computers, one laptop computer, and a backup drive, containing the EPHI of 4,328 individuals, were stolen on July 5, 2010. The EPHI involved in the breach included names, addresses, phone numbers, dates of birth, Social Security numbers, reason for visits, and insurance information.

TAHOE FOREST HEALTH SYSTEM

Privacy Breaches – 500+ Records

- 4/24/2017: CardioNet (provides remote mobile cardiac monitoring) settled potential noncompliance with the HIPAA Privacy and Security Rules by paying $2.5m and implementing a CAP. This settlement is the first involving a wireless health services provider.
- 4/20/2017: The Center for Children's Digestive Health (CCDH) has paid HHS $31k to settle potential violations of the HIPAA Privacy Rule. CCDH used FileFax to store records with PHI, but had no Business Associate Agreement.
- 10/17/2016: St. Joseph Health (SJH) has agreed to settle potential violations following the report that files containing PHI were publicly accessible through internet search engines from 2011 until 2012. SJH will pay a settlement amount of $2.1m and adopt a comprehensive CAP.

TAHOE FOREST HEALTH SYSTEM

Questions?

Thank You!

THE FOX GROUP, LLC

CONSULTANTS TO THE HEALTHCARE INDUSTRY

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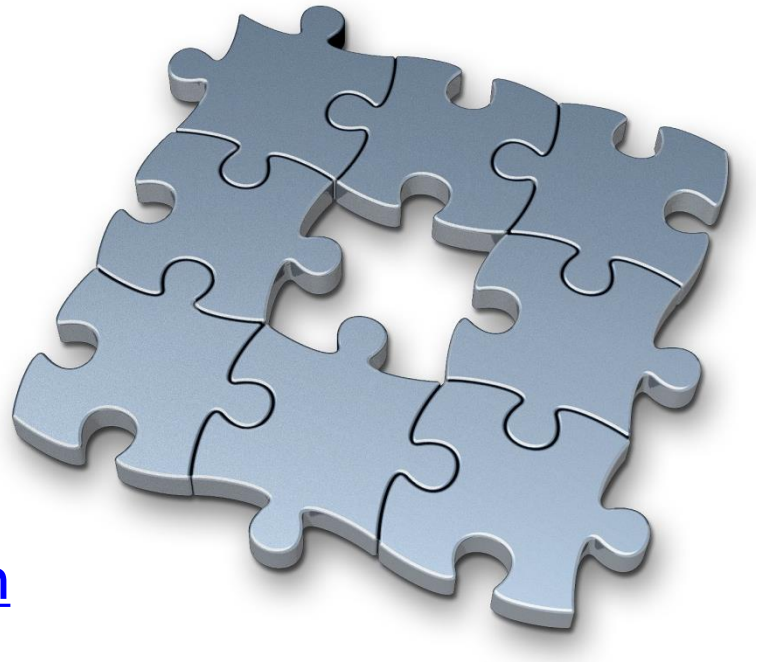

Providing Excellence Since 1989

TAHOE FOREST HOSPITAL DISTRICT

INITIAL DISCUSSION
ON A MULTI-PART PRESENTATION OF TELEMEDICINE SERVICES AND ITS IMPACT ON HEALTHCARE AND HOW IT MIGHT FIT IN AT TAHOE FOREST HEALTH SYSTEM

TELEMEDICINE PRESENTATION TABLE OF CONTENTS

TAHOE FOREST HOSPITAL DISTRICT

Executive Summary on Telemedicine

By: Harry Weis, CEO **DATE: 4/12/18**

We are beginning a multi-session discussion on Telemedicine as a tool to improve timely access to quality healthcare in a geographically rural region that is both large and poses challenges many months of the year, including a scarcity of healthcare providers.

Kaiser Health System, Geisinger Health System in PA, Presbyterian Health System in Albuquerque, NM, Anthem Blue Cross and many other health systems or payors have found real value in "non face-to-face" virtual physician or other healthcare provider patient engagements.

Capitated payor healthcare payment systems where healthcare is paid for on a "per member per month" basis are especially motivated to communicate with patients via telemedicine, telephone, texting and via e mail processes to improve patient access and to lower healthcare costs. Capitated health plans have no limits on their creativity to utilize and implement telemedicine programs for their enrolled members.

In rural areas of America, in contrast to large urban areas and with large healthcare payors, it is doubtful that capitated healthcare payment models will arrive soon for many complex reasons.

Medicare, Medicaid, Medicaid Managed Care Plans and many insurance companies are still not fully prepared to pay for telemedicine visits on a "per visit basis" in many rural markets. Federal and State law is also "behind the times" on this topic area. So this means that the telemedicine revenues are very low per visit and the expense per visit is still quite high in most rural communities in America who provide telemedicine services.

For this reason we are asking a series of detailed questions of the payors we deal with in our health system to find out how and if they will pay for telemedicine services in contexts that we would need to be paid for in our region.

There are many telemedicine companies out there across America who offer 24/7 telemedicine services generally for a fee at the time of service, requiring that the service be paid for via a credit card. This type of service is available immediately or within minutes 24 hours a day.

As we look forward to new and growing desires people of all generations to access rapid healthcare, we should expect that a growing percent of provider and patient interactions will happen each year in a non face-to-face manner.

It is important for our health system to understand what the best phased approach is to be involved in telemedicine in our region.

FOR A TELEMEDICINE PROGRAM TO HAVE VIABILITY AT TAHOE FOREST WE HAVE TO UNDERSTAND THE RESPONSES FROM PAYORS WHO ACTUALLY PAY FOR SERVICES OF PATIENTS WE SEE. HERE ARE SOME QUESTIONS WE ARE RESEARCHING.

Can we have one of our team members call at least the following payors and ask them the following questions?

Call our Medicare intermediary, call the state for generic MediCal, and call each of our 2 MediCal managed care companies, call Anthem, and any other large commercial payor you believe we do a decent amount of business through.

The contextual and payment questions to ask are:

Will they each pay for patient E & M consultation services by telemedicine for our physicians or other physicians who are providing a telemedicine service to our patients for whom we need to bill for and for which we would normally bill for if we had the physician physically present treating/evaluating the patient in a patient care setting within our health system?

Patient Settings we would need telemedicine payments for -- would these telemedicine payments be the same as if the a physician was physically there in front of the patient or do these payors reduce the payment to us because it's in a telemedicine setting or no payment at all because it is a telemedicine setting?

Our ER patients?
Our ICU inpatients?
Our Med/Surg inpatients?
Our in-house OB patients?

Our Out Patient physician office clinic patients where the patient is physically there sitting in an exam room?

Would each of these payor pay us for our physician to examine the patient via telemedicine technology while our patient is in their home or other distant location? This setting means we have started our own telemedicine program with our own physicians.

Am I missing anything? I want to find out if we could use telemedicine for ICU or med/surg hospitalist services? Also what about Neurology or Psychiatry or any other service in our ED or clinics as well, these are the types of bases I'm trying to cover. It would be nice to have patients be treated in our clinics by telemedicine specialists of many types for prompt service when we don't have those doctors to physically see our patients.

36 TELEMEDICINE STATISTICS YOU SHOULD KNOW

Posted by Teresa Iafolla

Telemedicine is changing the way we experience healthcare. There's no doubt about it. Patients are becoming more and more open to the idea every day, especially when they realize telemedicine means more convenient, accessible healthcare. Healthcare providers too are starting to see the benefits: better care outcomes, less hospital readmissions, happier patients, and more profitable practices. As a result, telemedicine is on the rise. But don't just take our word for it! We did an extensive survey of the current data and research on telemedicine to back up these claims. Check out the 36 stats below for all the details on current trends and findings in the telemedicine field.

The Growth of Telemedicine

1. More than half of all U.S. hospitals currently have a telemedicine program.[1]
2. The global telemedicine technologies market, including hardware, software, and services, was valued at $17.8 billion in 2014 and is predicted to grow at a compound annual growth rate of 18.4% from 2014 to 2020.[2]
3. There will be about 800,000 online consultations in the U.S. in 2015.[3]
4. About 90% of surveyed healthcare executives report that their organizations have already begun developing or implementing a telemedicine program.[4]
5. About 84% of surveyed healthcare executives felt that the development of telemedicine services is either very important (52%) or important (32%) to their organizations.[4]
6. About 22% of employers with 1,000 or more employees currently offer telemedicine services, and another 37% of employers plan to offer telemedicine services to their employees by the end of this year.[5]
7. The three states with the highest telemedicine adoption rates are Alaska (75%), Arkansas (71%), and South Dakota (70%).[6]
8. Telemedicine makes up nearly one-fourth of the health IT market, which was valued at $15.6 billion in 2014 and is expected to increase to nearly $20 billion by 2019 with a compound annual growth rate of 4.8%.[7]
9. As of August 2015, Congress has 26 bills pending that could affect telemedicine across the country.[1]
10. The number of patients using telemedicine services will increase to 7 million in 2018, up from less than 350,000 in 2013.[8]
11. Already, 29 states require health insurers to pay for telemedicine services (as of August 2015).[1]

How Patients Feel About Telemedicine

12. About 74% of patients in the U.S. would use telehealth services.[9]
13. Most patients are comfortable with having all of their health records securely available on the cloud.[10]
14. About 74% of patients are comfortable with communicating with their doctors using technology instead of seeing them in person.[10]
15. About 76% of patients care more about access to healthcare than need for human interactions with their healthcare providers.[11]
16. Only 16% of patients would prefer to go to the emergency room for a minor ailment if they also could access telemedicine services.[12]
17. About 67% of patients said that using telemedicine somewhat or significantly increases their satisfaction with medical care.[12]
18. About 30% of patients already use computers or mobile devices to check their medical or diagnostic information.[11]

Telemedicine In Action

19. After telemedicine services were employed by the Veterans Health Administration post-cardiac arrest care program, hospital readmissions decreased by 51% for heart failure and 44% for other illnesses.[11]
20. According to a study on the Geisinger Health Plan, patient readmissions were 44% lower over 30 days and 38% lower over 90 days, compared to patients not enrolled in the telemedicine program.[11]
21. A study of the outcomes of care for 8,000 patients who used telemedicine services found no difference between the virtual appointment and an in-person office visit.[13]
22. About 21% of patients who have used telemedicine services say the quality of care was similar to or higher than an in-person visit.[12]

Benefits of Telemedicine

23. Half of surveyed healthcare executives ranked improving the quality of care as their top reason for implementing telemedicine, and another 18% were most excited about reaching new patients.[4]
24. About 42.5% of one survey's health system respondents found that their primary motivation behind investing in telemedicine tools was filling in gaps in care.[14]

25. When asked what the top benefit of telemedicine was, about 19% of surveyed health system respondents said it was the ability to provide round-the-clock care, and about 18.4% said it was the ability to provide remote consultations to patients.[14]
26. Almost 75% of all doctor, urgent care, and ER visits are either unnecessary or could be handled safely and effectively over the phone or video.[13]
27. In one survey, 21% of patients said not having to travel to the doctor's visit was the top benefit of telemedicine, while 20% said it was the ability to be cared for from their homes.[12]
28. About 53% of patients said that telemedicine somewhat or significantly increases their involvement in treatment decisions. [12]
29. In a 2014 survey of 15 physician practices in 15 metropolitan areas across the U.S., the average wait time for a new patient to see a physician in five surveyed medical specialties was 18.5 days.[15]

Cost Savings from Telemedicine

30. U.S. employers could save up to $6 billion per year by providing telemedicine technologies to their employees.[5]
31. The Geisinger Health Plan study found that implementation of a telemedicine program generated about 11% in cost savings during that study period. This led to an estimated return on investment of about $3.30 in cost savings for every $1 spent on program implementation.[11]

Read more: 5 Ways Telehealth Saves Doctors Money

Patients in Rural Areas

32. About 20% of Americans live in rural areas without easy access to primary care or specialist medical services.[11]
33. Patients in rural areas have limited access to medical specialists; on average, there are only 40 specialists serving a 100,000 rural population.[16]
34. Only about one in 10 physicians practice in rural areas in the U.S.[16]
35. In one survey, 44.3% of healthcare system respondents said that patient care gaps due to community remoteness were the main reason for adopting telemedicine.[14]
36. Adoption numbers for telemedicine are significantly higher at hospitals in more rural areas as compared to urban areas.[6]

Special thanks to the sources of our statistics: American Telemedicine Association, Global Telemedicine Market Outlook 2020, Foley and Lardner LLP, Towers Watson, Center for Connected Health Policy, BCC Research, IHS Technology, NTT Data, Cisco, American Hospital Association, Software Advice, Journal of the American Medical Association, HIMSS Analytics, American Medical Association and Wellness Council of America, Merritt Hawkins, and National Rural Health Association.

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About Teresa Iafolla

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17 BEST TELEMEDICINE COMPANIES

Medically reviewed by Steven Kim, MD on October 27, 2015 — Written by James Roland

It can be difficult to make time to see your doctor. Between busy schedules and limited appointment availability, staying healthy can lead to extra stress. Telemedicine allows you to discuss non-emergency medical issues with a doctor by phone or online at a time that's convenient for you.
Here are 17 of the best telemedicine companies.

1. CareClix

CareClix was founded in 2010. They work with board-certified practicing physicians to provide a wide range of telehealth and telemedicine services around the world. Some of the services they cover include:

- home care
- infectious diseases
- pediatrics
- primary care
- urgent care

The company also launched an innovative program for schools in Maryland. Using Skype, off-site doctors are able to examine elementary school students, such as those complaining of a sore throat, without the students having to leave school grounds.

2. ConsultADoctor

If you have a non-emergency medical question, ConsultADoctor can help connect you with doctors by phone and online. The company specializes in offering basic medical services that don't require visits in person. If necessary, doctors can also order tests and write prescriptions that you can fill anywhere in the United States.

3. Teladoc

Teladoc was one of the first telehealth providers in the United States. They have maintained a highly favorable rating among physicians and patients. Ninety-two percent of Teladoc members have reported that the consultations resolved their medical questions. Teladoc also claims an average callback time of 16 minutes from the moment a person seeks out a phone or online video consultation.

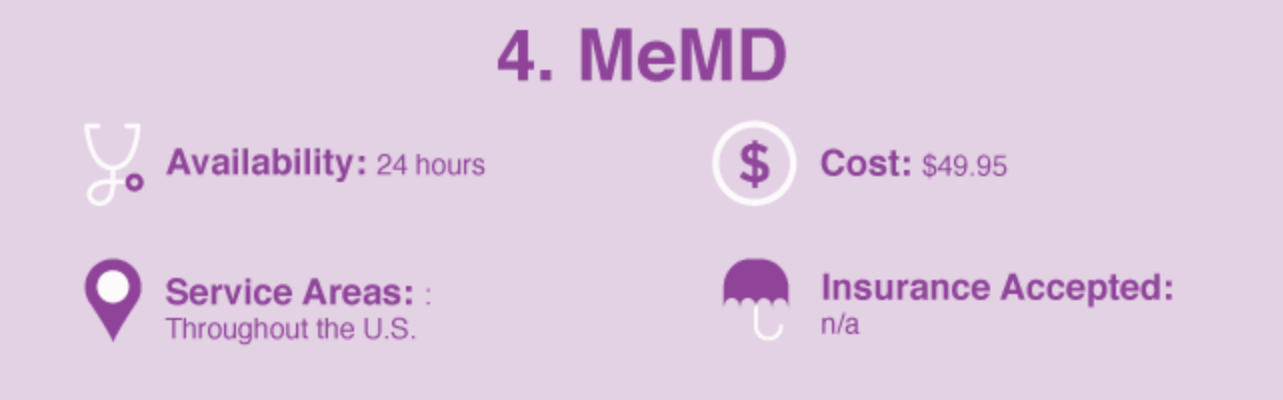
Fees vary depending on your plan. If you have a flexible spending or health spending account, you may be able to use it to cover services through Teladoc.

Teledoc can be used for a wide-range of medical issues, including:

- pediatric services
- non-emergency medical issues
- dermatological conditions
- mental health consultations for issues such as depression and addiction
- sexual health consultations

Teladoc physicians can also write prescriptions or analyze your lab results.

4. MeMD



Creating an account on MeMD is simple. Once your account is set up, you can speak with a nurse practitioner or physician directly through your computer's webcam.
You can discuss multiple symptoms or conditions during a single consultation without needing to pay an additional fee, provided your healthcare provider feels comfortable discussing a second issue. Lab tests can't be ordered through MeMD, but healthcare providers can answer questions about an existing lab report.

5. iCliniq

The website iCliniq provides a variety of services. You can submit written questions or request a phone consultation or online video.
If you submit a written question, one of the more than 1,000 doctors representing about 80 different specialties will provide an answer on the website. You can also access archived questions and answers.
If you need to speak with a doctor, phone or online video consultations are available based on the doctor's schedule. The company also operates a "virtual hospital" for healthcare professionals and medical centers.
Consultations are available in these areas:

psychiatry

oncology

obstetrics and gynecology

dentistry

sexology

dermatology

general medicine

6. American Well

Two brothers who are both doctors founded American Well. They wanted to make basic health care more affordable and eliminate barriers such as distance, mobility, and time. In addition to the website, American Well's mobile application, available on iPhone and Android, can also connect you with a doctor.
When using the service, you'll be matched up with doctors in your state. In addition to general medicine questions, American Well also has mental health therapists and nutritionists available for consultation. The company is steadily building up its network of doctors.

7. MDlive

MDlive was founded in 2009. They're continuously building up their partnerships with healthcare systems across the United States.

Board-certified physicians and other healthcare professionals are available by phone or online video 24 hours a day. They can help answer your questions about non-emergency medical conditions, such as:

- allergies
- urinary tract infections (UTIs)
- headaches
- rashes
- fever

Mental health professionals are also available.

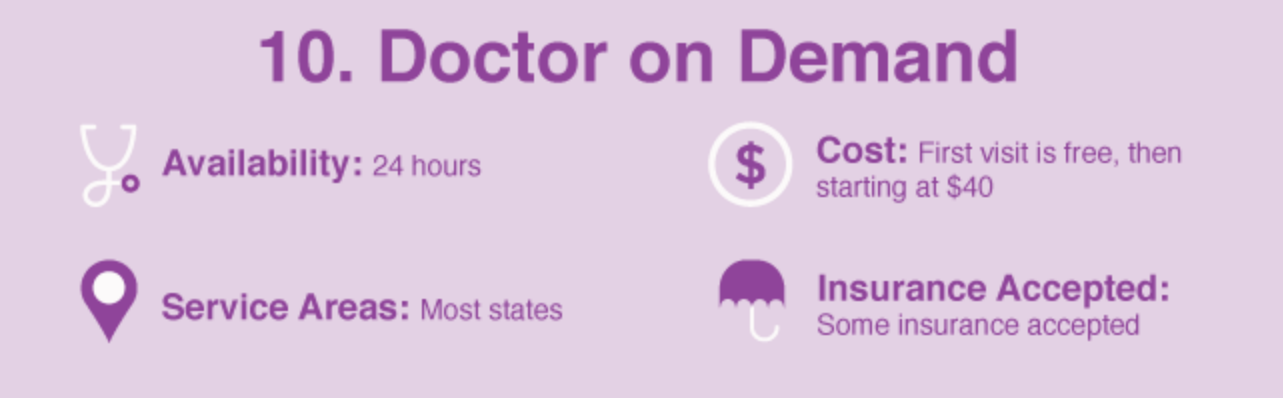
8. MDAligne

MDAligne has provided more than 1 million online and telephone consultations since 2004. They help people with a wide range of health and wellness concerns.
MDAligne sets itself apart from some other telemedicine companies by partnering with labs and imaging companies. They also offer health supplements and products for weight loss.

9. StatDoctors

StatDoctors has been around since 2009. They boast short wait times to hear back from doctors. The wait time is about six minutes on average. A nationwide network of doctors is available 24 hours a day for phone consultations or online video evaluations.

10. Doctor on Demand



One thing that sets Doctor on Demand apart from its competitors is that it allows people to add a doctor to their "favorites." If that doctor is available, you can call them back directly to make future appointments.
Doctor on Demand also offers new moms online assistance from board-certified lactation consultants.

11. Specialists On Call

Specialists on Call provide their services to hospitals and physician practices instead of individual consumers. The company is designed as a consulting practice for medical facilities around the country.
If a hospital needs a stroke specialist, for example, an online or phone consultation is arranged with one of Specialists On Call's doctors.

12. LiveHealth Online

LiveHealth Online lets members select the doctors they speak with via two-way video conferencing. Once you sign up, you can see who's available in your state and then request a consultation. You should be connected with the doctor you have chosen within a few minutes. Doctors are available 24 hours a day, seven days a week. LiveHealth Online's website also features health tips.

13. Virtuwell

Virtuwell handles the diagnostic part of telemedicine by asking you to describe your symptoms in an online interview. If the symptoms and condition sound like something Virtuwell can treat, a nurse practitioner will receive the report. They can then look at a visible symptom, if necessary, and create a treatment plan.
Conditions eligible for virtual consultations include:

colds and flus

acne

birth control

skin conditions

certain sexually transmitted diseases

allergies

other basic non-emergency health problems

14. Ringadoc

Ringadoc specializes in supporting other physicians by handling their after-hours calls. When you call, you're condition will be triaged and key information will be provided to the doctors contracting with Ringadoc. The idea is that only urgent calls are forwarded after hours.

15. PlushCare

In addition to matching you with a physician for online video chats or phone calls, PlushCare also gives back to the community. With every consultation, PlushCare provides funds or services to help California children get vaccinations or checkups.
PlushCare is currently available in eight states.

16. HealthTap

HealthTap claims to have 72,000 doctors around the world ready to answer your health questions. Experts are available for video chats or simply to answer text messages. Their mobile application, HealthTap, available on iPhone and Android, also provides health news.

17. HealthExpress

HealthExpress helps people in Oregon and Washington with non-emergency healthcare consultations. Consultations are available via phone or two-way video conferencing. Unlike many telemedicine companies, HealthExpress isn't open 24 hours. Doctors and nurse practitioners are available from 8 a.m. to 8 p.m. during the week and from 9 a.m. to 5 p.m. on weekends. You can go online and choose a medical professional to help you.

HOW TELEMEDICINE IS TRANSFORMING TREATMENT IN RURAL COMMUNITIES

Written by JT Ripton & C. Stefan Winkler | April 08, 2016 |

There's no denying it: rural hospitals are in trouble.

More than 48 rural hospitals have closed since 2010, according to the National Rural Health Association, and another 283 are in danger of closing.

The malaise effecting rural healthcare comes from several vectors. Reduced populations, higher percentage of uninsured and elderly patients, equipment underuse, and the absence of high-margin specialty services makes for a bleak economic outlook. A shortage of doctors willing to work in remote areas creates quality of care and a staffing issues. Then, there is the challenge of getting patients into rural hospitals in a timely manner because travel distances sometimes are too great.

Many believe that telemedicine and mHealth offer a way out for struggling rural hospitals, however.

A 2012 report by the Institute of Medicine for the National Academies, entitled *The Role of Telehealth in an Evolving Health Care Environment*, found that telehealth drives volume, increases quality of care, and reduces costs by reducing readmissions and unnecessary emergency department visits for rural communities. Through telemedicine, rural hospitals can serve rural patients at better costs and help cut down on the time it takes rural patients to receive care, particularly specialty care.

"When rural patients know their hospital is using telemedicine, they have higher regard for that hospital and are less likely to bypass it for treatment at an urban facility," noted James Marcin, director of the UC Davis Children's Hospital Pediatric Telemedicine Program, a pioneer in remote medicine.

The ways that rural hospitals can take advantage of telemedicine and mHealth technology advancements are many, and include remote consultations, in-home monitoring, outsourced diagnostic analysis, and remote specialist consultations.

Instead of waiting days or weeks for a healthcare professional to travel to a remote area, or traveling into a hospital and waiting for an appointment, telemedicine enables remote physician consultations that are faster, cheaper and more efficient than traditional healthcare appointments. For consultations on simple health concerns, or follow up on existing conditions, remote consultations can dramatically improve the patient experience while helping rural hospital economics at the same time.

The Georgia Partnership for Telehealth, for instance, assesses and treats students so that they do not need to travel to a clinic for healthcare, and currently has replaced more than 350 locations where a traditional doctor's visit was formerly required.

A second way that rural hospitals are leveraging telemedicine is through in-home monitoring. One example is decreased hospitalization rates for seniors enrolled in the FirstHealth Home Care Chronic Disease model in North Carolina. Patients previously diagnosed with heart failure, diabetes, or COPD and who experienced frequent hospitalizations are monitored by telehealth at home between periodic visits from nursing staff. Response and intervention times have improved substantially, according to the program.

Another benefit to struggling rural hospitals is outsourced diagnostic analysis and access to remote specialists. It is difficult for many rural communities to staff their own diagnosticians, but mobile imaging centers and lab specimen kiosks that can take X-rays and perform collections can work in conjunction with remote analysis labs in larger urban areas to bridge the gap.

One study that looked at 24 hospitals in four rural states in the Midwest including Kansas, Oklahoma, Arkansas, and Texas found that telemedicine brought an annual economic impact of at least $20,000 per year, with an impact of up to $1,300,000. The majority of these savings came from increased lab and pharmacy revenues due to additional work performed locally.

In addition to outsourced diagnostics, telemedicine also enables consultation with remote specialists at larger, urban hospitals instead of the need for having these specialists on staff. This can be particularly good for attracting doctors to rural hospital settings.

"Telemedicine fosters a collaboration that reduces the feelings of isolation that physicians may experience when they go to practice in a small town," noted Dr. Wilbur Hitt in a report, *Telemedicine: Changing the Landscape of Rural Physician Practice*. "With telemedicine, it's like having one foot in the city but being able to live and practice out in a rural area. It's also reassuring to know that you're on the right track with the treatment plan and are staying current."

Still, roughly 66 percent of rural hospitals had no telehealth services or were only in the process of implementing a telehealth application when the RUPRI Center for Rural Health Analysis reviewed 4,727 hospitals in the 2013 HIMSS Analytics database. Part of the reason comes from broadband access challenges.

Rural communities not only suffer from a population shortage and a lack of resources, they also typically have trouble with the necessary broadband infrastructure for telemedicine. The benefit of remote consultation by video conference for rural patients is clear, for instance, but these remote consultations amount to nothing if there isn't the broadband infrastructure to support it.

"The ability for physicians to connect with those in areas that don't have much of a wireless connection is the biggest problem when trying to treat these patients," noted Tony Zhao the CEO of Agora.io, a video SDK company that provides easy video conferencing with quality-of-service guarantees so telemedicine and e-learning initiatives work even in rural settings.

"With weak connections, video streams for telehealth are blurry, choppy or just won't work," he added. "Implementing technology that doesn't rely on the general internet but which relies on an infrastructure that strengthens signals in the most remote areas is crucial."

Another barrier for rural hospitals is the challenges that surround reimbursements. Medicare reimbursement is a major challenge for telemedicine, with states each having their own standards by which their Medicaid programs will reimburse for telemedicine expenses.

There is no single standard telemedicine reimbursement system for private payers, either. Some insurance companies value telemedicine and will reimburse for a wide variety of services while others do not.

These and other challenges put a drag on rural telemedicine at the same time as the need for it grows. Rural hospitals have a path toward recovery in the form of telemedicine, but obstacles still remain.

PROS AND CONS OF TELEMEDICINE

Telemedicine has revolutionized how patients today can access modern health care, but its adoption rate is still limited by several disadvantages

If you are deliberating if your medical practice has become ready to adopt telemedicine, but you are still not sure if all the advantages are worth the investment, know that you are not alone. As over half of all U.S. hospitals have adopted telemedicine services, medical professionals have managed to detect all the possible pros and cons of telemedicine.

According to the recent studies, the adoption rate of telemedicine grows with the steady pace, healthcare executives are devising new plans for implementing or developing new telemedicine programs into their organizations, and even smaller healthcare providers are starting to seriously consider moving a part or their entire organizations into the online space. The entire shift to telemedicine enables health organizations, from the smallest local clinics to the regional hospitals, to not only enable better access to healthcare for their patients but also attract new customers who would be enticed by the ease of use to get more in touch with their healthcare.

The fast growth of telemedicine industry has brought to spotlight several issues that are challenging the efforts of medical professionals to adopt new Internet-powered services. The adoption of such services is not an easy task, especially because health organizations must be concerned not only with the (sometimes very expensive) process of introducing new hardware and software solutions into their daily workflow, but also educating all their employees, keeping in touch with changes in regulatory landscape, and following all the rules and guidelines that are set by the HIPAA.

Here you can get informed more about the various pros and cons of telemedicine that every owner of a medical company in the U.S. needs to consider strongly before they decide to upgrade their patient services.

Advantages of Telemedicine in Healthcare

It is clear that adoption of telemedicine can provide healthcare practices with wide array of benefits, most important one being the lowering of operating and healthcare costs, significantly increase the efficiency of the practice, provide patients with better and more accessible healthcare, drive up revenue,

1. Healthcare Cost Savings

One of the core abilities of telemedicine is to drastically reduce the number of non-urgent ER visits to healthcare offices, and eliminate eliminates transportation expenses for regular checkups and appointments.

Having an ability to monitor patients from a remote location and analyze their health status has the potential to significantly reduce healthcare service costs both for the healthcare operators, insurance companies and of course patients.

Beyond the direct possibility of cost reduction, telemedicine is also proven to be highly effective in attracting new patients and reducing no-show appointments.

Benefits of telemedicine for doctors also include boosting of revenue for those who can turn on-call hours into billable time and reduce overhead costs for physicians who can now start working from home during the part of their work week.

2. Convenient and Accessible Patient Care

A Recent global study commissioned by Cisco has showcased that 74% of the study participants preferred easy access to healthcare over in-person interactions with health providers. This proves that in modern society convenience is a very important aspect of patient lives.

Augmenting your health practice with telehealth services can enable you to increase your efficiency in handling increased number of patient, provide faster care, better care, and reduce your cost of physically attending the needs of each patient. Since telemedicine allows patients to contact you no matter where they are (at home, at work or traveling), you can reach a much wider base of patients without needed to expand capabilities of your physician offices. Additionally, health providers can stay in closer touch with their patients by providing services such as vital signs monitoring, telecare with mHealth devices, and healthcare advice delivered by medical apps.

3. Easier physician referrals and access to specialists

Online consultation with doctors is just one aspect of telemedicine. Telemedicine is primarily used as a tool for communication, as such it represents an excellent way for getting second opinions from remote health professionals. Your primary health providers can use telemedicine to easily gain opinions from specialists, they can easily share with them your medical data such as X-rays (which is especially useful if they don't have radiologists on staff, which is true for majority of smaller health clinics who don't have budget to keep one permanently on the payroll), and get more precise diagnosis and treatment plans that can be used to treat specific diseases or chronic medical conditions.
If you are planning for expansion of your healthcare clinic patient base or are a specialist in the need of expanding your reach, telemedicine can represent a perfect way to do so. And increased number of patients you are serving will remain manageable since modern telemedicine platforms enable you to easily handle signing up of new patients and scheduling follow-up meetings. Telemedicine is especially important for patients who live in rural or remote areas where access to healthcare involves significant transportation issues. According to some studies, in rural areas of the U.S., only 43 specialists are available for every 100 thousand patients. Telemedicine enables those patients to contact specialists with ease. However one of the possible disadvantages of telemedicine in rural areas are issues with internet connection bandwidth and stability.

4. Increased Patient Engagement

One of the core advantages of telemedicine in healthcare are reductions of cost and increase of convenience. A significant amount of cost reductions is achieved by the fact that telemedicine allows patients to become committed to their own healthcare goals. Healthcare organizations can engage patients with telemedicine by keeping them informed about their upcoming appointments, and encouraging them to follow their care schedules and giving them health care

advice, and giving them access to see overviews of their medical status that is collected by health monitoring hardware.
Patients with increased interest into their own healthcare can better maintain their tobacco abstinence, curb obesity and lead a higher quality of life.

The strong patient interest rate is best achieved via regular online consultations via telemedicine. This enables the patient to quickly get answers to their health-related questions, report the progress of their treatment, an appearance of warning signs, and make follow-up appointment plans.

5. Better Patient Care Quality

Patients who engage in telemedicine services often report how their quick access to medical professionals has led to the improvement in the quality of their care. Patient's regard convenience very highly, and having an ability to address their needs in real-time, no matter from where they are establishing a video conference call leads to the increase of their satisfaction. This is especially notable in real-time urgent care consultations which can be used to deliver treatment options to the patient within minutes.

Increased level of care that telemedicine offers has led to the dramatic reduction in hospital admissions and readmissions for patients who suffer medical conditions such as depression, anxiety, and stress.

Negative aspects of Telemedicine

Not everything is of course perfect. While the benefits can be spotted easily, challenges of telemedicine also play a big role in the rate of the adoption of this new and exciting technology. Learn more about some practical and technical problems that health providers may experience when interacting with telemedicine.

1. Reduced Care Continuity

Telemedicine can be a great tool for building relationships between patients and doctors, but many services are not using that kind of approach. Those services enable patients to get in touch with the random health professional, which introduces care continuity issues. Those random patient care providers may not have access to patient's previous medical records from other remote visits and can end up treating patient symptoms without knowing their full medical history. Such doctors are often handling hundreds of new patients each week, and they cannot manage to fully learn complete medical histories of their patients or have notes about care routines they have accustomed to receiving.
Reduction in care continuity is one of the most reported issues when patients are describing negative aspects of telemedicine. One of the ways telemedicine providers can enhance their level of care continuity is to adopt sound solutions to for maintaining adequate and accessible patient records. Wider adoption of such measures could enable patients to more freely seek medical help from telemedicine providers that could continue their care from the spot the previous doctor left

it. Such a measure would dramatically lower the chance that patient would choose to physically go and seek help from urgent care centers or local retail clinic.

2. Equipment and Technical Training issues

Any time a health organization is going through the period of restructuring, their workforce and daily routines get destabilized. Adoption of telemedicine represents a big shift for health clinic of any size, requiring large monetary investment, learning to use new hardware, how to properly use digital health platforms, handle confidential patient data and most of all learn how to build an effective telemedicine platform that could offer patients enhanced levels of care. This can all be done only when entire employee pool (which includes physicians, practice managers, and all other staff) gets properly trained and learn how to efficiently and securely use new digital systems.

Adoption of telemedicine systems can often lead to the reduction of the staff size, which may cause strain to the overall moral of the healthcare team.

3. Worries About Fewer In-Person Consultations

Many healthcare practitioners are worried that they cannot properly treat patients if they don't have physical access to them. There is also a considerable belief that technical problems may cause health providers to loose active real-time connection with their patients, thus leading to the possible " patient mismanagement".
Many physicians (and patients) still prefer to have physical meetings where they can freely interact and perform all necessary examinations that are not possible to be done via telemedicine meetings. This includes even the most simple checkups where the doctor can in few seconds examine patient and determine a precise diagnosis. Telehealth services are because of this used mostly for diagnosing conditions that don't require such a 'personal touch' during physician's examination.

A word from Telehealther

Telemedicine industry is growing with each passing year, managing to reach the level when in one year an incredible $17.8 billion is moved between patients, telemedicine companies, and their business partners. As this industry is expected to grow at the pace of around 18% until the year 2020, you can expect that in very short time public will gain access to not only streamlined and new telemedicine services, but also newly developed ways of eliminating some of the negative aspects of telemedicine.
Telehealther hopes that you will remain with us on this journey to the future of telemedicine.

5 WAYS TELEMEDICINE IS HELPING RURAL HOSPITALS & THEIR COMMUNITIES

Home / Blog / 5 Ways Telemedicine Is Helping Rural Hospitals & Their Communities

Change has been hard on rural hospitals and their communities. Since 2010, more than 48 rural hospitals have closed and much more are on the brink of the same fate. Patients are seeking higher levels of specialized care from urban hospitals while rural communities are struggling to find top-notch providers willing to reside in remote areas. Lack of resources, provider shortages, and all-time low patient censuses are causing more and more hospitals to consider closing their doors.

But according to a Becker's Hospital Review article, many believe that virtual health could be the answer to much of the woes rural hospitals are experiencing.

1- Patients are looking for more specialized services

When patients within rural communities contract long-term illnesses that require more extensive testing and monitoring, they're often forced to spend additional time and resources on traveling to larger hospitals and health systems that are more equipped to provide the care they need. This could include regular check-up appointments with specialty physicians or more in-depth tests that require equipment their rural hospital doesn't have access to. This can cause a snowball effect by taking away the same patient for general care needs that they can certainly receive from their community hospital.

Rural hospitals have quite a number of options when it comes to providing telemedicine to their patients and all are helpful in their own ways to combat the potential churn of a patient.

Remote specialist consultations can allow a rural hospital to connect with the nearest urban hospital and their physicians for specialized services while still retaining the patient and making their care more convenient and low-cost.

Outsourced diagnostic analysis allows patients to receive diagnostic tests followed by top-notch care depending on the outcome. Patients no longer need to travel for hours just to have an x-ray or specialty lab work performed.

Remote consultations allow doctors to perform routine check-in appointments with patients from home. Not only do they get to skip the long drive to their nearest urban hospital, they can even avoid the short commute to their rural hospital while still seeing their same physician.
Direct-to-consumer telemedicine allows rural hospitals to expand their services to new patients. Patients who don't typically take the time to see a doctor can now have virtual consultations for urgent care needs without making an appointment, driving to an urgent care, or spending time waiting in the emergency department. Telemedicine consultations of any kind save time for both the patient and the doctor, leaving room in the physician's schedule for more appointments with other patients who do require in-person care. Patients in rural areas benefit by removing the barrier of transportation, long drive times and the costs associated with both.

2- Rural hospitals are experiencing provider shortages

There is expected to be an overall shortage of 46,000 to 90,000 physicians by the year 2025 and rural hospitals will feel it. Rural communities are having a hard time attracting physicians who are willing to live in remote areas. Rural communities have about 68 primary care doctors per 100,000 people compared with 84 in urban areas.
Rural hospitals who are experiencing provider shortages can utilize telemedicine platforms that come completely staffed with physicians who are fully trained in providing virtual care, and at a much less expensive rate. Telemedicine platforms who come staffed with 24/7 physician coverage are the perfect solution for small rural hospitals whose emergency departments get overwhelmed with patients not experiencing a true emergency. Patients can access a doctor from home and leave the resident physicians available for truly urgent conditions. Most physicians who staff a telemedicine platform are not primary care physicians, so there is no risk of losing patients to outside providers. In most cases, the physicians can help refer patients back to the hospital for other medical needs.
For hospitals who need an extra benefit to attract physicians from urban areas, according to Dr. Wilbur Hitt in an NEJM career resources article, "telemedicine fosters a collaboration that reduces the feelings of isolation that physicians may experience when they go to practice in a small town," he said. "With telemedicine, it's like having one foot in the city but being able to live and practice out in a rural area. It's also reassuring to know that you're on the right track with the treatment plan and are staying current." In addition, it gives rural physicians the opportunity to specialize in something high-tech and innovative that will surely be the way of the future.

3- A high percentage of a rural hospital's patients receive Medicare

Medicare and the subject of reimbursement often hinder the way a rural hospital can deploy telemedicine to their patients, especially in North Carolina where telemedicine parity doesn't exist.
Currently, patients in rural areas who are covered by Medicare Part B can be reimbursed for telemedicine services, like office visits and consultations, as long as they are located at one of these places during the telemedicine consultation:

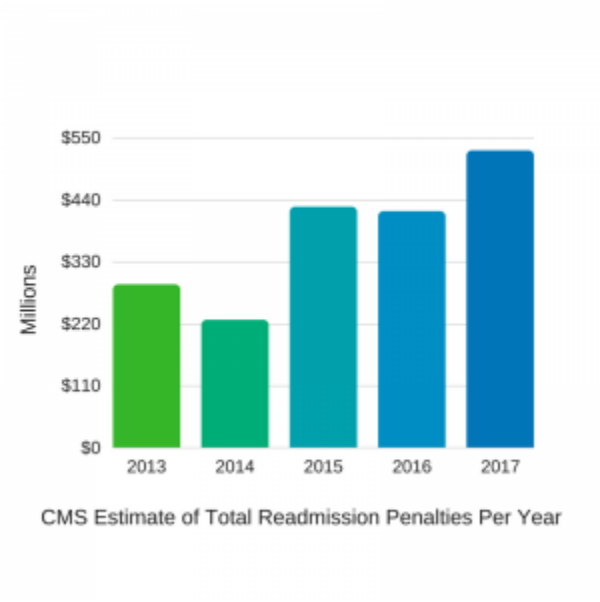
- A doctor's office
- A hospital
- A critical access hospital

- A rural health clinic
- A federally qualified health center
- A hospital-based or critical access hospital-based dialysis facility
- A skilled nursing facility
- A community mental health center

An additional advantage of telemedicine for any patient, including those on Medicare, is that the cost of a visit is much less expensive compared to an urgent care facility or an emergency department visit which often tend to be the first choice for unscheduled care. With most virtual consultations costing less than $50 per visit, patients are able to save on both routine and urgent medical care costs. The savings also applies where insurance isn't concerned. Non-existant commutes save on the cost of transportation and allow those without means of reliable transit to see a doctor from the comfort of their home.

4- Helping rural hospitals reduce readmissions

Telemedicine is already a proven tool for helping rural hospitals lessen the penalties they receive from value-based reimbursement policies. Rural hospitals who are using telemedicine in addition to implementing care coordination and patient experience improvement strategies are receiving fewer penalties than their urban counterparts.



While rural hospitals are already excelling, there is always room for improvement. According to RevCycle Intelligence, rural hospitals still have ways to go under the Hospital Readmissions Reduction Program. 79% of participating rural hospitals faced value-based penalties in 2015 under the program. This year, hospitals will see a 3% maximum rate of penalty and CMS estimates that will total $528 million dollars in penalties across the US.

A big factor in reducing readmissions is providing better preventive care, this is where telemedicine excels. Remote monitoring allows patients to check in more frequently with their physicians or nurses and also increases the chance that they'll seek advice when experiencing an unscheduled medical care need before it advances to a more serious condition. By catching a sudden change in status, a patient can be seen by a primary care physician rather than being readmitted to the hospital, thus impacting a hospital's penalties.

For some patients managing at-home care can be the challenge, especially when dealing with lengthy discharge instructions. When patients aren't following their discharge instructions correctly, disease symptoms can flare, causing a trip back to the hospital. With remote monitoring via a HIPAA secure video connection, physicians and nurses have the ability to check in on a patient to see if they're following their discharge instructions correctly and can also administer help remotely for patients who need a little extra hand-holding, this is especially useful for those who do not have at-home care or someone to assist with the fine details.

Prescriptions can also cause problems. Elderly patients may have trouble remembering to fill a prescription, especially when it involves scheduling an additional doctor appointment. By communicating via telemedicine, prescriptions can be refilled during a regular, virtual consultation and can be ready for pick-up at their preferred pharmacy in just a few short hours.

5- Increase patient census & reach the remote and underserved

As mentioned under section #1, direct-to-consumer telemedicine increases a hospital's reach by attracting patients who otherwise wouldn't seek care from a rural hospital's network. Those who live and work in the corners of rural areas have the longest drive time and those who are underserved and do not have reliable transportation usually go without medical care. Even established patients will find value in seeing a doctor from home, greatly increasing their satisfaction of care received.

Telemedicine providers today are able to provide a white-labeled app, meaning they can design both the desktop and mobile interface where patients receive care to use a specific hospital's brand standards- allowing a patient to seek care from a known and trusted healthcare provider. But, the branding isn't the most important part. You should also consider how a patient is recognized when using telemedicine provided by your hospital and how their PHI is delivered back to your EHR. While most telemedicine providers can white-label the app, some cannot connect the patient back to your hospital, this creates a fragmented patient record contributing to disparate care coordination.

In addition to being able to tell where a patient is coming from, it also allows the physician providing the virtual care to help the patient determine where they should receive follow-on, in-person care, if necessary.

Patients who are linked to one rural hospital can be referred back to that hospital's network if it makes the most sense.

While rural hospitals are facing increasing challenges, the importance of staying open for the residents of their community is paramount. Telemedicine has proven to be a way forward for many of these hospitals. If you are considering telemedicine and would like to learn more about RelyMD, please submit the form below. We're happy to help guide you in the best direction.

TELEMEDICINE IS PROVING ITS ROI IN RURAL COMMUNITIES

Two studies see communities and hospitals recouping travel and other costs through telehealth tech.

By: Juliet Van Wagenen

A pair of reports released in March are touting the positive economic impact telemedicine programs can have on healthcare organizations' bottom lines.

The NTCA Rural Broadband Association's "Anticipating Economic Returns on Rural Telehealth" report found that, annually, **hospitals could save more than $81,000 in states such as Arkansas, Kansas, Oklahoma and Texas**, while the **rural communities in these states could save an average of $41,000** by using telemedicine technologies in lieu of traveling.

By accessing physicians through telehealth technology, those in rural communities can save big on travel expenses — an average of $24,000 — and lost wages — an average of $16,769 — associated with taking time off work to travel long distances to qualified physicians.

Already, states are implementing new regulations that make telepsychiatry available to folks in rural communities.

Keeping Care in the Community

Meanwhile, by implementing telehealth programs, **hospitals stand to save on hiring new physicians and boost earnings through procedures**, such as MRIs and CT scans, as patients are able to stay local to reach experts.

"These are expenditures that, in the absence of telemedicine, likely would go outside of the local community. When telemedicine is available locally, these expenditures tend to remain in the local economy," the report notes.

Moreover, with care sometimes hundreds of miles away, the **technology can allow rural communities to access care more quickly than they normally would have, saving lives**.

"Very often, by the time a patient shows up in our waiting room, it's too late to reverse the long-term course of their illness," Jennifer Dittes, PA-C, founder and CEO of HOPE Family Health, a federally qualified health center in rural Macon County, Tenn., says in the report. "Cancer, heart disease, diabetes, chronic kidney disease and substance abuse are all killers in our rural community, where the life expectancy is almost 20 years shorter than the national average due to poverty, other socioeconomic disparities, and lack of access to preventive, primary, behavioral and specialty care."

A similar report published in Value in Health Journal seems to back up these findings. In a study of the University of California Davis Health System, **telemedicine visits saved upwards of 11,000 patients a total of 9 years of time and $2.8 million in travel costs**. The average cost saving was $156 per patient. The study goes a step further, noting that telemedicine visits had a positive impact on the environment as well, keeping car emissions out of the atmosphere.

"I believe that telemedicine not only results in equivalent health care for patients in remote areas but better care, particularly for those with complex medical conditions," principal investigator James Marcin said in a statement, MobiHealthNews reports. "Our goal of telemedicine is not to save the health care system money but to improve patient care, and I believe it does this."

CISCO CLINICAL ASSISTANT

Cisco's TelePresence VX Clinical Assistant, is a high end telemedicine system designed specifically for the clinical environment in a very mobile and easy to use system.

Overview

Designed for patient encounters, the VX Clinical Assistant delivers specialized functionality for providers in healthcare settings with an easy to use purpose built mobile cart.

AVTEQ TELEMEDICINE CARTS

AVTEQ's telemedicine carts are a great solution for remote medical clinics or care facilities located in remote areas. The mobile carts offer ample storage space to accommodate the medical equipment needed for comprehensive patient care.

Models to Fit Any Space or Budget

- **TMP-800** has sleek design, small footprint and secure 10RU storage unit and is highly customizable making it ideal for remote patient care facilities.
- **TMP-600/TMP-600-TT2** comes with ample secure storage (16RU) to accommodate essential medical equipment. Its large 6" dual-wheel casters make it easy to move through a clinic or medical facility.
- **TMP-200** is a lightweight telemedicine cart and can be customized to meet the needs of any medical facility. Its slim profile make it ideal for use in clinics and medical offices with multiple exam rooms.

Polycom Solutions for Healthcare

The healthcare of the future. Delivered now. Video, voice and content solutions for exceptional healthcare experiences.

Telemedicine/ Patient Care

Login. The doctor will see you now. Video collaboration solutions that connect doctors to doctors, doctors to patients, and the entire patient care team.

Telemedicine/Patient Care

Geography no longer limits the level of care you can provide. With crystal clear visual and audio performance and an intuitive, easy to use interface, Polycom healthcare solutions empower you to deliver better, more efficient care.

What you can do

- Reduce re-hospitalizations by extending the care presence in the home
- Deliver specialist consults via video for TeleStroke, TeleMental Health, and Primary Care
- Mitigate in-office time and travel costs for specialty consults


Polycom
Empowering Healthcare Worldwide
Polycom healthcare collaboration and video conferencing solutions help medical facilities around the world reach more patients, lower costs, bring medical expertise to rural areas, and improve patient outcomes.
UK
National Health Service
• 520+ patients received telestroke care
• Speed of treatment
• 45% mortality rate
• 20% ER admissions
• 15% accident ER admissions
• £30,000 per patient
NETHERLANDS
UMC Utrecht
• Stereoscopic 3D surgery broadcasts
• Worldwide high-speed, interactive distance learning community
• Surgical training costs
ARMENIA
Medical Missions for Children
• 100+ specialty consultations per year
• More rapid diagnosis and prescription for life-saving treatment
• Pediatric mortality rates in severely ill children
USA
South Carolina Department of Mental Health
• 200% adherence to treatment
• More than 25,000 telepsychiatry consultations completed
• 53% in overall length of stay
• 50% in length of ER stays
• $3,000 per consultation
CHINA
Xuanwu Hospital
• Field personnel conducting complex surgeries
• Expanded reach of China's national telestroke network
• Time to treat acute stroke
• Decreased risk of disability and recurring stroke
USA
Orlando Health
• Access to patients
• Real-time authorization by remote physicians of stroke protocol treatment
• Travel time for stroke patients
• Reduced likelihood of permanent disability from brain damage
VIETNAM
Quang Ninh Department of Health
• 1,000 staff trained via video
• Increased efficiency in managing emergency response
• 50% leadership meeting costs 3–4 hours travel per meeting
• Costs saved through more efficient patient care workflows
BRAZIL
Unimed
• Real-time knowledge sharing
• Expands reach to 20 million customers and 110,000 physicians
• R$18 Million in costs
• Gas emissions from travel to conventions
SOUTH AFRICA
Red Cross Children's Hospital
• Physician education by remote learning
• Expanded access to highly experienced pediatric cardiologists
• Reduced patient waiting lists
THAILAND
Royal Thai Ministry of Public Health
• Video conference usage grew 75%
• 30,000 employees and 9,700 public health centers now connected by video
• 500,000 Thai Baht conference travel costs per doctor
How can Polycom help your organization?
Video collaboration
• Connect physicians with specialists worldwide
• Provide telemedicine services
• Extend faster access to rural areas with video consultations
Medical professional education
• Bring advanced training to your physicians through video
• Reduce travel time and costs

3142 Tiger Run Court ● Suite 113 ● Carlsbad, CA 92010

April 17, 2018

TO: Tahoe Forest Healthcare District (TFHD) Board of Directors

FROM: Karma Bass and Erica Osborne
Via Healthcare Consulting

SUBJECT: Monthly Strategic Planning Project Update

Since the board last met in March, we have continued to move forward with the development of TFHD's new strategic plan. Data collection and analysis for both the environmental assessment and stakeholder input are progressing well and are on-track to be presented at the June 4th Strategic Planning Task Force (SPTF) Assessment Session. The following are a list of key dates and next steps:

Key dates:

- SPTF Strategic Assessment Session: June 4, 2018, 12:00 – 4:00 pm
- Half-day board review of strategic framework: July 10, 9:00 am – 12:00 pm
- SPTF review of draft plan: (tentative dates) July 30 – Aug 3
- Final SPTF conference call: (tentative dates) August 27 – 31
- Presentation to the full board: Sept 27, 2018

Environmental Assessment:

- Krentz and Associates continue to work with the members of the Administrative team on the quantitative data collection and analyses as part of the Environmental Assessment process.
- Tracey Camp of Krentz and Associates will be on site at the June 4, 2018 Strategic Assessment session to present the results and answer questions.

Stakeholder Input:

- Internal and external interviews are going well with the majority completed or scheduled to be completed by April 30th.
- The process of summarizing results will begin in early May.

In-person Focus Groups:

- Internal focus groups with directors and managers will be held and facilitated by Via Consultant Cindy Fineran on April 17-18.
- Results will be summarized and included as part of the assessment report.

Web-based Survey:

- Both the internal and external stakeholder surveys have been finalized and sent out to identified groups and individuals.
- The survey will be open for input by stakeholders until April 23.
- Please let us know if you have any questions or comments. Thank you for entrusting us with this important work.

TAHOE FOREST HOSPITAL DISTRICT

BOARD EXECUTIVE COMPENSATION COMMITTEE
AGENDA

Monday, April 23, 2018 at 11:00 a.m.
Pine Street Cafe Conference Room - Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, R.N., Chair; Randy Hill, Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee 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 Committee cannot take action on any item not on the agenda. The Committee 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.

5. APPROVAL OF MINUTES OF: 02/20/2018..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Sample CEO Performance Evaluation Forms ..... ATTACHMENT
Executive Compensation Committee will review sample CEO performance evaluation forms.

6.2. CEO Job Description ..... ATTACHMENT
Executive Compensation Committee will review the job description of the CEO.

6.3. CEO Succession Plan Policy ..... ATTACHMENT
Executive Compensation Committee will review the District's CEO Succession Plan Policy.

6.4. CEO Incentive Compensation
Executive Compensation Committee will discuss developing metrics for FY19 CEO Incentive Compensation.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
Executive Compensation Committee will meet quarterly or as needed.

9. ADJOURN

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

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.